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Common Sense Initiative

Mike DeWine, *Governor*
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Business Impact Analysis

Agency, Board, or Commission Name: Ohio Bureau of Workers' Compensation

Rule Contact Name and Contact Information:
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Regulation/Package Title (a general description of the rules' substantive content):

Outpatient medication formulary and First fill of outpatient medications

Rule Number(s): 4123-6-21.3 and 4123-6-21.6

Date of Submission for CSI Review: April 8, 2026

Public Comment Period End Date: April 22, 2026.

Rule Type/Number of Rules:

New/___ rules

No Change/____ rules (FYR? ___)

Amended/__2__ rules (FYR? _No__)

Rescinded/____ rules (FYR? ___)

The Common Sense Initiative is established in R.C. 107.61 to eliminate excessive and duplicative rules and regulations that stand in the way of job creation. Under the Common Sense Initiative, agencies must balance the critical objectives of regulations that have an adverse impact on business with the costs of compliance by the regulated parties. Agencies should promote transparency, responsiveness, predictability, and flexibility while developing regulations that are fair and easy to follow. Agencies should prioritize compliance over punishment, and to that end, should utilize plain language in the development of regulations.

Reason for Submission

1. **R.C. 106.03 and 106.031 require agencies, when reviewing a rule, to determine whether the rule has an adverse impact on businesses as defined by R.C. 107.52. If the agency determines that it does, it must complete a business impact analysis and submit the rule for CSI review.**

   Which adverse impact(s) to businesses has the agency determined the rule(s) create?

   The rule(s):

   a. ☐ **Requires a license, permit, or any other prior authorization to engage in or operate a line of business.**

   b. ☐ **Imposes a criminal penalty, a civil penalty, or another sanction, or creates a cause of action for failure to comply with its terms.**

   c. ☒ **Requires specific expenditures or the report of information as a condition of compliance.**

   d. ☐ **Is likely to directly reduce the revenue or increase the expenses of the lines of business to which it will apply or applies.**

Regulatory Intent

2. Please briefly describe the draft regulation in plain language.
Please include the key provisions of the regulation as well as any proposed amendments.

BWC adopted Rule 4123-6-21.3 effective September 1, 2011 to establish an outpatient medication formulary. A formulary is a list of drugs approved for reimbursement when prescribed to treat conditions allowed in the claim. The formulary is maintained by BWC with input from the BWC Pharmacy and Therapeutics Committee.

The proposed changes to the Appendix to OAC 4123-6-21.3, the formulary drug list, are:

MEDICATIONS/CLASSES WITH CHANGES IN COVERAGE

- Antidepressants
  - Misc. and Selective Serotonin Reuptake Inhibitors (SSRIs): Add allowed condition needed.
  - Fluvoxamine Cap ER and Paroxetine Tab SR: add may be considered for reimbursement upon submission of a prior authorization request that reflects a minimum of a 90-day trial and documented inadequate response to at least two (2) antidepressants within the past 240 days.
- Metaxalone: Remove baclofen exclusion from required trial.
- Olanzapine-Fluoxetine Cap: add antipsychotic coverage restrictions.
- Prochlorperazine: remove antipsychotic coverage restrictions.
- Antiemetics
  - Meclizine: Remove allowed condition needed.
  - Aprepitant Cap and Trimethobenzamide Cap: Add may be considered for reimbursement upon submission of a prior authorization request that reflects a documented allergic reaction, adverse event, or an inadequate response after a minimum of a three (3) day trial of another agent in this class within the past 180 days.
  - Dronabinol: add minimum trial of one (1) antiemetic.
- Migraine products
  - Remove reimbursement will not be approved for duplicate therapy with other calcitonin gene-related peptide (CGRP) antagonists.
  - Add reimbursement will not be approved for duplicate CGRP acute or prophylaxis treatment.
  - Clarify which products are used for acute and prophylaxis treatment.
  - Serotonin agonists: add reimbursement will not be approved for duplicate therapy.
  - Sumatriptan nasal sprays, auto-injectors, and solution cartridges and Zolmitriptan nasal sprays: add reimbursement is limited to claims with an allowed condition that results in the inability to swallow or absorb oral medications or documented inadequate response to oral dosage form.

MEDICATIONS/CLASSES WITH CHANGES IN COVERAGE

- Dupilumab: add restrictions for asthma, COPD, chronic rhinosinusitis with nasal polyps, and atopic dermatitis.
- Tobramycin inhal cap: add may be considered for reimbursement upon submission of a prior authorization request that reflects a documented inadequate response after a minimum of a 28-day trial of tobramycin nebulizer solution in the past 90 days.
- Fluticasone-Umeclidinium-Vilanterol AEPB: clarify trial and failure requirements.
- Ulcer drugs
    - H-2 antagonists: add reimbursement is limited to two (2) doses per day.
    - Proton pump inhibitors: add reimbursement will not be approved for duplicate therapy with other proton pump inhibitors.
- Pyrethrins-Piperonyl Butoxide
    - Add allowed condition needed.
- Sodium Hypochlorite
    - Remove allowed condition needed.
- Dietary Management Products, Vitamins & Minerals & Electrolytes
    - Change from allowed condition needed to prior authorization required.
- Antihyperlipidemics, Cough/Cold/Allergy
    - Change from prior authorization required to allowed condition needed.

MEDICATIONS TO BE ADDED TO THE FORMULARY

- Brensocatib Tab 10, 25 MG with coverage restrictions:
    - May be considered for reimbursement upon submission of a prior authorization request that reflects:
        1. Bronchiectasis is an allowed condition.
        2. Not diagnosed with cystic fibrosis.
        3. Chronic obstructive pulmonary disease (COPD) or asthma diagnosis are not the primary driver of respiratory illness.
        4. Documentation of >2 exacerbations in the past 12 months requiring antibiotics or hospitalization.
        5. Trial and failure (or intolerance) of chronic oral azithromycin or inhaled tobramycin suppressive therapy for at least six months, unless these therapies are contraindicated.
    - Initial approval will be no greater than six (6) months, and subsequent requests may be considered if there is a documented decrease in exacerbations requiring antibiotics or hospitalization, improvement in pulmonary function tests, or improvement in pulmonary symptoms. Reimbursement is limited to one (1) tablet per day.
- Vibegron 75 MG with coverage restrictions:
    - May be considered for reimbursement upon submission of a prior authorization request that reflects a minimum of a 60-day trial and documented inadequate response to at least two (2) urinary antispasmodic agents within the past 180 days, and the injured worker has overactive bladder that is related to an allowed condition in the claim.
- Insulin Aspart-szjj Soln Pen-injector 100 Unit/ML
- Insulin Aspart-szjj Subcutaneous Soln 100 Unit/ML
- Omalizumab Subcutaneous Soln Auto-Injector 75 MG/0.5ML
- Omalizumab Subcutaneous Soln Auto-Injector 150 MG/ML
- Omalizumab Subcutaneous Soln Auto-Injector 300 MG/2ML
- Omalizumab Subcutaneous Soln Prefilled Syringe 75 MG/0.5ML
- Omalizumab Subcutaneous Soln Prefilled Syringe 300 MG/2ML
- Benralizumab Subcutaneous Soln Prefilled Syringe 10 MG/0.5ML

MEDICATIONS TO BE REMOVED FROM THE FORMULARY

- Maprotiline 25, 50, 75 MG
- Alprostadil Urethral Pellet 250, 500, 1000 MCG

BWC adopted rule OAC 4123-6-21.6 effective February 1, 2015 governing reimbursement for the first fill of prescription medications prior to the initial determination order of a claim.

The proposed changes to the Appendix to OAC 4123-6-21.6, the first fill formulary drug list, are:

MEDICATIONS TO BE ADDED TO THE FORMULARY

- Amitriptyline Tab 10 MG (Quantity limit 30)
- Amitriptyline Tab 25 MG (Quantity limit 30)
- Bictegravir-Emtricitabine-Tenofovir AF Tab 50-200-25 MG (Quantity limit 30)
- Diazepam Tab 5MG (Quantity limit 5)
- Epinephrine Solution Auto-injector 0.3 MG/0.3ML (1:1000) (Quantity limit 2)
- Hydrocodone/Acetaminophen Tab 7.5-325 MG (Limited to 7-day supply)
- Hydrocodone/Acetaminophen Tab 10-325 MG (Limited to 7-day supply)
- Oxycodone/Acetaminophen Tab 7.5-325 MG (Limited to 7-day supply)
- Oxycodone/Acetaminophen Tab 10-325 MG (Limited to 7-day supply)
- Oxycodone Tab 10 MG (Limited to 7-day supply)
- Pregabalin Cap 25 MG (Quantity limit 30)
- Pregabalin Cap 50 MG (Quantity limit 30)
- Pregabalin Cap 75 MG (Quantity limit 30)
- Sumatriptan Succinate Tab 25 MG (Quantity limit 9)
- Sumatriptan Succinate Tab 50 MG (Quantity limit 9)
- Sumatriptan Succinate Tab 100 MG (Quantity limit 9)

3. Please list the Ohio statute(s) that authorize the agency, board or commission to adopt the rule(s) and the statute(s) that amplify that authority.

Authorize: 4121.12, 4121.121, 4121.30, 4121.31, 4121.44, 4121.441, 4123.05, 4123.34, 4123.66

Amplify: 4121.12, 4121.121, 4121.44, 4121.441, 4123.66

4. Does the regulation implement a federal requirement? Is the proposed regulation being adopted or amended to enable the state to obtain or maintain approval to administer and enforce a federal law or to participate in a federal program?
If yes, please briefly explain the source and substance of the federal requirement.

No.

5. **If the regulation implements a federal requirement, but includes provisions not specifically required by the federal government, please explain the rationale for exceeding the federal requirement.**

Not Applicable.

6. **What is the public purpose for this regulation (i.e., why does the Agency feel that there needs to be any regulation in this area at all)?**

The purpose of Rule 4123-6-21.3 is to improve the efficiency of treatment for injured workers by providing prescribers with a concise list of medications that can be utilized for treatment of approved conditions related to the claim. The formulary also provides the prescriber with information regarding any restrictions or limitations to the use of an approved medication. Likewise, the prescriber will know that if a medication is not listed in the formulary, then it will not be reimbursed for treatment of any conditions in a claim. The use of a formulary enhances medication safety by allowing time for BWC's Pharmacy and Therapeutics Committee to conduct a thorough review of the clinical merits of new medications before they are approved for use. It also provides a process by which BWC may remove or limit the inappropriate utilization of medications in keeping with FDA recommendations as well as current clinical literature and best medical practices.

The purpose of OAC 4123-6-21.6 to implement R.C. 4123.66(B), which allows the BWC Administrator to adopt rules specifying the circumstances under which BWC will reimburse for the first fill of prescription drugs for medical conditions identified in an application for workers' compensation or benefits prior to the date BWC issues an initial claim determination order.

7. **How will the Agency measure the success of this regulation in terms of outputs and/or outcomes?**

Per rule OAC 4123-6-21.2, BWC's Pharmacy and Therapeutics Committee is charged with making recommendations to BWC regarding the creation and ongoing management of the BWC drug formulary. The committee fulfills this charge through routine monitoring of prescription data from our pharmacy benefit manager, reviews of current clinical literature, and current best practice guidelines.

8. **Are any of the proposed rules contained in this rule package being submitted pursuant to R.C. 101.352, 101.353, 106.032, 121.93, or 121.931?**
If yes, please specify the rule number(s), the specific R.C. section requiring this submission, and a detailed explanation.

No.

Development of the Regulation

9. **Please list the stakeholders included by the Agency in the development or initial review of the draft regulation.**
If applicable, please include the date and medium by which the stakeholders were initially contacted.

BWC emailed proposed revisions to rules OAC 4123-6-21.3 and OAC 4123-6-21.6 to stakeholders on February 27, 2026, with comments due back by March 17,2026. No feedback was received.

BWC emailed notice to the following list of stakeholders:

- BWC's Managed Care Organizations
- BWC's internal medical provider stakeholder list - 68 persons representing 56 medical provider associations/groups
- BWC's Healthcare Quality Assurance Advisory Committee
- Ohio Association for Justice
- Employer Organizations
    - Council of Smaller Enterprises (COSE)
    - Ohio Manufacturers' Association (OMA)
    - National Federation of Independent Business (NFIB)
    - Ohio Chamber of Commerce
- BWC's Self-Insured Division's employer distribution list
- BWC's Employer Services Division's Third-Party Administrator (TPA) distribution list
- Ohio Medical and Pharmacy Boards

10. **What input was provided by the stakeholders, and how did that input affect the draft regulation being proposed by the Agency?**

None; Not applicable

11. What scientific data was used to develop the rule or the measurable outcomes of the rule? How does this data support the regulation being proposed?

The proposed revisions to rule 4123-6-21.3 and 4123-6-21.6 were based on recommendations accepted by the BWC Pharmacy and Therapeutics Committee. The committee reviews data from clinical trials, published studies, and relevant guidelines regarding medications prior to making recommendations.

12. What alternative regulations (or specific provisions within the regulation) did the Agency consider, and why did it determine that these alternatives were not appropriate? If none, why didn't the Agency consider regulatory alternatives? ***Alternative regulations may include performance-based regulations, which define the required outcome, but do not dictate the process the regulated stakeholders must use to comply.***

The rule applies specifically to prescription coverage for Ohio injured workers. BWC is the only state agency charged with this statutory responsibility. Performance-based regulations are not applicable to drug formulary management.

13. What measures did the Agency take to ensure that this regulation does not duplicate an existing Ohio regulation?

This rule only affects injured workers receiving prescription benefits from BWC. No other state agency has adopted regulations regarding what drugs are reimbursed by BWC.

14. Please describe the Agency's plan for implementation of the regulation, including any measures to ensure that the regulation is applied consistently and predictably for the regulated community.

Once the rule is approved and through the JCARR process, BWC staff impacted by the rule will be informed of the effective date. Providers caring for injured workers will be notified of the key points contained in the rule by email, fax, or direct mail. They will also be provided with a link to find a complete copy of the rule.

BWC's Medical Services Division will ensure that relevant sections of the MCO Policy Reference Guide and the Provider Billing and Reimbursement Manual are updated to reflect appropriate rule modifications.

Adverse Impact to Business

15. Provide a summary of the estimated cost of compliance with the rule(s). Specifically, please do the following:

a. Identify the scope of the impacted business community, and

The prescriber and pharmacy business communities are involved with the prescribing and dispensing of medications. The impacted segments of those communities are the BWC enrolled or certified providers who prescribe and dispense medication to injured workers.

b. Quantify and identify the nature of all adverse impact (e.g., fees, fines, employer time for compliance, etc.).

The adverse impact can be quantified in terms of dollars, hours to comply, or other factors; and may be estimated for the entire regulated population or for a representative business. Please include the source for your information/estimated impact.

There will not be an adverse impact on either of the two business communities identified in that both prescribers and pharmacies currently prescribe and dispense prescriptions based on the BWC formulary. These revisions do not change the process of prescribing or dispensing, nor do they make any changes to reimbursement for those activities.

There should be no negative financial impact on the prescriber community as any necessary changes to the injured worker's drug regimen should be done in the context of routine office visits. Any prescriptions that result from the changes in the drug regimen would continue to be processed by a pharmacy.

However, the proposed formulary rule requires that clinical documentation and evidence of medical necessity be provided to the BWC for short term reimbursement of new drugs or new dosage forms or strengths of existing drugs approved for use in the United States by the FDA on or after the effective date of the rule.

Also, under the first fill rule prescribers have to indicate the first fill prescription is for a work-related injury for payment of first fill medications.

16. Are there any proposed changes to the rules that will reduce a regulatory burden imposed on the business community? Please identify. ***(Reductions in regulatory burden may include streamlining reporting processes, simplifying rules to improve readability, eliminating requirements, reducing compliance time or fees, or other related factors).***

No.

17. Why did the Agency determine that the regulatory intent justifies the adverse impact to the regulated business community?

Rule 4123-6-21.2 charges the BWC Pharmacy and Therapeutics Committee to conduct regular reviews of the drug formulary and to make recommendations to the Administrator directed at improving overall efficiency and effectiveness of drug utilization. These changes to drug coverage result from that activity. Formulary revisions are routinely made based on opportunities to improve the clinical impact of the formulary, pricing, or incorporate changes in federal drug regulations.

Regulatory Flexibility

18. Does the regulation provide any exemptions or alternative means of compliance for small businesses? Please explain.

No. All prescribers are required to utilize formulary medications if BWC is to reimburse for those prescriptions.

19. How will the agency apply Ohio Revised Code section 119.14 (waiver of fines and penalties for paperwork violations and first-time offenders) into implementation of the regulation?

Not Applicable.

20. What resources are available to assist small businesses with compliance of the regulation?

Prescribers may access the BWC website for a complete list of formulary medications and any restrictions to those drugs. The BWC Pharmacy Department also maintains an email address (pharmacy.benefits@bwc.ohio.gov) that prescribers can use to ask questions about drug coverage.

4123-6-21.3 Outpatient medication formulary.

(A) The administrator hereby adopts the formulary indicated in the appendix to this rule, developed with the recommendation of the bureau's pharmacy and therapeutics committee.

(B) Except as otherwise provided in paragraph (F) of this rule, the formulary indicated in the appendix to this rule shall constitute the complete list of medications that are approved for reimbursement by the bureau for the treatment of a work related injury or disease in an allowed claim when dispensed to an injured worker by a registered pharmacist from an enrolled outpatient pharmacy provider.

(C) The formulary indicated in the appendix to this rule also contains specific reimbursement, prescribing or dispensing restrictions that have been placed on the use of listed drugs. The formulary will be reviewed and updated as necessary. The most current version will be electronically published by the bureau.

(D) The administrator will consider current medical literature and best practices and the recommendations of the bureau's pharmacy and therapeutics committee when making additions, deletions, or modifications of coverage of medications listed in the formulary.

(E) The bureau shall provide an expedited review process for clinically or therapeutically unique medications when necessary.

(F) Notwithstanding paragraph (B) of this rule, in cases of medical necessity supported by medical documentation and evidence of need the bureau may reimburse for:

(1) New drugs approved for use in the United States by the food and drug administration (FDA) on or after the effective date of the formulary, and for new indications approved by the FDA on or after the effective date of the formulary for existing drugs that are not on the formulary, with prior authorization, for a period not to exceed one hundred eighty days from the adjudication date of the first prescription for the requested drug.

(2) Antineoplastic drugs prescribed for treatment of an allowed cancer condition in a claim.

(3) Antiretroviral drugs prescribed for:

(a) Treatment of an allowed condition of human immunodeficiency virus in a claim; or

(b) Post exposure treatment in an allowed claim or pursuant to section 4123.026 of the Revised Code.

(G) Notwithstanding the appendix to this rule, in cases of medical necessity supported by medical documentation and evidence of need the bureau may reimburse for new dosage forms or strengths approved by the FDA on or after the effective date of the formulary for existing drugs that are on the formulary, with prior authorization, for a period not to exceed one hundred eighty days from the adjudication date of the first prescription for the requested drug.

APPENDIX TO RULE 4123-6-21.3
Formulary List of Medications Covered by the Ohio Bureau of Workers' Compensation

Medication Class Name	Medication Generic Name	Brand name (if applicable)	Allowed Condition Needed	Reimbursement restrictions or limitations for specific medications or dosage forms are listed with the respective medications below.
Acne Products	Isotretinoin Cap 25 MG		✓	
	Isotretinoin Cap 30 MG		✓	
	Isotretinoin Cap 35 MG		✓	
	Benzoyl Peroxide Liq 5%			
	Benzoyl Peroxide Liq 10%			
	Benzoyl Peroxide Gel 5%			
	Benzoyl Peroxide Gel 10%			
	Benzoyl Peroxide-Erythromycin Gel 5-3%		✓	
	Clindamycin Phosphate Foam 1%		✓	
	Clindamycin Phosphate Gel 1%		✓	
	Clindamycin Phosphate Lotion 1%		✓	
	Clindamycin Phosphate Soln 1%		✓	
	Clindamycin Phosphate Swab 1%		✓	
	Erythromycin Gel 2%		✓	
	Erythromycin Soln 2%		✓	
	Sulfacetamide Sodium w/ Sulfur Cleanser 10-5%		✓	
	Sulfacetamide Sodium w/ Sulfur Cream 10-5%		✓	
	Sulfacetamide Sodium w/ Sulfur Emulsion 10-1%		✓	
	Sulfacetamide Sodium w/ Sulfur Foam 10-5%		✓	
	Sulfacetamide Sodium w/ Sulfur Lotion 10-5%		✓	
	Sulfacetamide Sodium-Sulfur in Urea Emulsion 10-4%		✓	
Psychostimulants (ADHD)	ALL psychostimulants (amphetamines, stimulants, and ADHD agents)			Will only be considered for reimbursement for allowed conditions in the claim related to post-concussion syndrome or concussion, as defined in OAC 4123-6-34.
ADHD - Amphetamines	Amphetamine-Dextroamphetamine Cap ER 24HR 5 MG		✓	
	Amphetamine-Dextroamphetamine Cap ER 24HR 10 MG		✓	
	Amphetamine-Dextroamphetamine Cap ER 24HR 15 MG		✓	
	Amphetamine-Dextroamphetamine Cap ER 24HR 20 MG		✓	
	Amphetamine-Dextroamphetamine Cap ER 24HR 25 MG		✓	
	Amphetamine-Dextroamphetamine Cap ER 24HR 30 MG		✓	
	Amphetamine-Dextroamphetamine Tab 5 MG		✓	See ALL psychostimulant agents reimbursement restrictions.
	Amphetamine-Dextroamphetamine Tab 7.5 MG		✓	
	Amphetamine-Dextroamphetamine Tab 10 MG		✓	
	Amphetamine-Dextroamphetamine Tab 12.5 MG		✓	
	Amphetamine-Dextroamphetamine Tab 15 MG		✓	
	Amphetamine-Dextroamphetamine Tab 20 MG		✓	
	Amphetamine-Dextroamphetamine Tab 30 MG		✓	
	Dextroamphetamine Sulfate Cap SR 24HR 10 MG		✓	
	Dextroamphetamine Sulfate Cap SR 24HR 15 MG		✓	
	Dextroamphetamine Sulfate Tab 5 MG		✓	
	Dextroamphetamine Sulfate Tab 10 MG		✓	
	Lisdexamfetamine Dimesylate Cap 10 MG		✓	
	Lisdexamfetamine Dimesylate Cap 20 MG		✓	
	Lisdexamfetamine Dimesylate Cap 30 MG		✓	
	Lisdexamfetamine Dimesylate Cap 40 MG		✓	
	Lisdexamfetamine Dimesylate Cap 50 MG		✓	
	Lisdexamfetamine Dimesylate Cap 60 MG		✓	
	Lisdexamfetamine Dimesylate Cap 70 MG		✓	
ADHD - Stimulants – Misc.	Armodafinil Tab 50 MG		✓	
	Armodafinil Tab 150 MG		✓	
	Armodafinil Tab 200 MG		✓	
	Armodafinil Tab 250 MG		✓	
	Dexmethylphenidate HCl Cap ER 24 HR 10 MG		✓	
	Dexmethylphenidate HCl Cap ER 24 HR 15 MG		✓	
	Dexmethylphenidate HCl Cap ER 24 HR 20 MG		✓	
	Dexmethylphenidate HCl Cap ER 24 HR 30 MG		✓	
	Methylphenidate HCl Cap ER 30 MG (CD)		✓	
	Methylphenidate HCl Cap ER 24HR 10 MG (LA)		✓	See ALL psychostimulant agents reimbursement restrictions.
	Methylphenidate HCl Cap SR 24HR 20 MG		✓	
	Methylphenidate HCl Cap SR 24HR 30 MG		✓	
	Methylphenidate HCl Cap SR 24HR 40 MG		✓	
	Methylphenidate HCl Cap ER 24HR 60 MG (LA)		✓	
	Methylphenidate HCl Tab 5 MG		✓	
	Methylphenidate HCl Tab 10 MG		✓	
	Methylphenidate HCl Tab 20 MG		✓	
	Methylphenidate HCl Tab ER 10 MG		✓	
	Methylphenidate HCl Tab ER 20 MG		✓	
	Methylphenidate HCl Tab ER 24HR 18 MG		✓	
	Methylphenidate HCl Tab ER 24HR 27 MG		✓	
	Methylphenidate HCl Tab ER 24HR 36 MG		✓	
	Methylphenidate HCl Tab ER 24HR 54 MG		✓	
	Methylphenidate HCl Tab SA OSM 18 MG		✓	
	Methylphenidate HCl Tab SA OSM 27 MG		✓	
	Methylphenidate HCl Tab SA OSM 36 MG		✓	
	Methylphenidate HCl Tab SA OSM 54 MG		✓	
	Methylphenidate HCl Tab ER Osmotic Release (OSM) 72 MG		✓	
	Modafinil Tab 100 MG		✓	
	Modafinil Tab 200 MG		✓	
ADHD Agents	Atomoxetine HCl Cap 10 MG (Base Equiv)		✓	

APPENDIX TO RULE 4123-6-21.3
Formulary List of Medications Covered by the Ohio Bureau of Workers' Compensation

Medication Class Name	Medication Generic Name	Brand name (if applicable)	Allowed Condition Needed	Reimbursement restrictions or limitations for specific medications or dosage forms are listed with the respective medications below.
	Atomoxetine HCl Cap 18 MG (Base Equiv)		✓	
	Atomoxetine HCl Cap 25 MG (Base Equiv)		✓	
	Atomoxetine HCl Cap 40 MG (Base Equiv)		✓	
	Atomoxetine HCl Cap 60 MG (Base Equiv)		✓	See ALL psychostimulant agents reimbursement restrictions.
	Atomoxetine HCl Cap 80 MG (Base Equiv)		✓	
	Atomoxetine HCl Cap 100 MG (Base Equiv)		✓	
	Guanfacine HCl Tab ER 24HR 3 MG (Base Equiv)		✓	
	Guanfacine HCl Tab ER 24HR 4 MG (Base Equiv)		✓	
Agents for Chemical Dependency	Acamprosate Calcium Tab Delayed Release 333 MG		✓	
	Disulfiram Tab 250 MG			
	Disulfiram Tab 500 MG			
Alternative Medicine	Glucosamine Sulfate Cap 500 MG		✓	
	Glucosamine Sulfate Tab 500 MG		✓	
	Glucosamine-Chondroitin Cap 500-400 MG		✓	
	Glucosamine-Chondroitin Tab 500-400 MG		✓	
	Glucosamine-Chondroitin Tab 750-600 MG		✓	
	Lutein-Zeaxanthin Cap 6-0.24 MG			
	Lutein-Zeaxanthin Cap 20-0.8 MG			
	Lutein-Zeaxanthin Cap 20-1 MG			
	Lutein-Zeaxanthin Cap 25-5 MG			
	Lutein-Zeaxanthin Cap 45-1.8 MG			
	Melatonin Cap 5 MG			
	Melatonin Cap 10 MG			
	Melatonin Tab 300 MCG			
	Melatonin Tab 1 MG			
	Melatonin Tab 3 MG			
	Melatonin Tab 5 MG			
	Melatonin Tab 10 MG			
Amyotrophic Lateral Sclerosis (ALS) Agents	Riluzole Tab 50 MG		✓	
Analgesics – Nonsteroidal Anti-inflammatory Agents (NSAIDs)	Celecoxib Cap 50 MG			Reimbursement is limited to 400 MG per day.
	Celecoxib Cap 100 MG			
	Celecoxib Cap 200 MG			
	Celecoxib Cap 400 MG			
	Diclofenac Potassium Tab 50 MG			
	Diclofenac Sodium Tab Delayed Release 25 MG			
	Diclofenac Sodium Tab Delayed Release 50 MG			
	Diclofenac Sodium Tab Delayed Release 75 MG			
	Diclofenac Sodium Tab SR 24HR 100 MG			
	Etodolac Cap 200 MG			
	Etodolac Cap 300 MG			
	Etodolac Tab 400 MG			
	Etodolac Tab 500 MG			
	Etodolac Tab SR 24HR 400 MG			
	Etodolac Tab SR 24HR 500 MG			
	Etodolac Tab SR 24HR 600 MG			
	Flurbiprofen Tab 50 MG			
	Flurbiprofen Tab 100 MG			
	Ibuprofen Cap 200 MG			
	Ibuprofen Susp 100 MG/5ML			
	Ibuprofen Tab 200 MG			
	Ibuprofen Tab 400 MG			
	Ibuprofen Tab 600 MG			
	Ibuprofen Tab 800 MG			
	Indomethacin Cap 25 MG			
	Indomethacin Cap 50 MG			
	Indomethacin Cap ER 75 MG			
	Ketorolac Tromethamine Tab 10 MG			Reimbursement is limited to 20 tablets or a five (5)-day supply, whichever is less, during a rolling 12-month period.
	Ketorolac Tromethamine Inj 15 MG/ML			
	Ketorolac Tromethamine Inj 30 MG/ML			
	Ketorolac Tromethamine IM Inj 60 MG/2ML (30 MG/ML)			
	Meloxicam Tab 7.5 MG			
	Meloxicam Tab 15 MG			
	Nabumetone Tab 500 MG			
	Nabumetone Tab 750 MG			
	Naproxen Sodium Tab 220 MG			
	Naproxen Sodium Tab 275 MG			
	Naproxen Sodium Tab 550 MG			
	Naproxen Susp 125 MG/5ML			
	Naproxen Tab 250 MG			
	Naproxen Tab 375 MG			
	Naproxen Tab 500 MG			
	Naproxen Tab EC 375 MG			
	Naproxen Tab EC 500 MG			
	Oxaprozin Tab 600 MG			
	Piroxicam Cap 10 MG			
	Piroxicam Cap 20 MG			
	Sulindac Tab 150 MG			
	Sulindac Tab 200 MG			
Analgesics – Non-narcotic - Combinations	Acetaminophen-Caffeine Tab 500-65 MG			
	Aspirin-Acetaminophen-Caffeine Tab 250-250-65 MG			
	Aspirin-Caffeine Tab 400-32 MG			
	Butalbital-Acetaminophen Tab 50-325 MG		✓	Reimbursement is limited to four (4) grams of acetaminophen

Medication Class Name	Medication Generic Name	Brand name (if applicable)	Allowed Condition Needed	Reimbursement restrictions or limitations for specific medications or dosage forms are listed with the respective medications below.
	Butalbital-Acetaminophen-Caffeine Cap 50-325-40 MG		✓	per day or 24 doses per 30 days and to claims in which headache is related to an allowed condition in the claim.
	Butalbital-Acetaminophen-Caffeine Soln 50-325-40 MG/15ML		✓	
	Butalbital-Acetaminophen-Caffeine Tab 50-325-40 MG		✓	
	Butalbital-Aspirin-Caffeine Cap 50-325-40 MG		✓	
Analgesics – Nonnarcotic- – Other	Acetaminophen Cap 500 MG			
	Acetaminophen Liquid 160 MG/5ML			
	Acetaminophen Liquid 167 MG/5ML			
	Acetaminophen Suppos 325 MG			
	Acetaminophen Suppos 650 MG			
	Acetaminophen Susp 160 MG/5ML			
	Acetaminophen Tab 325 MG			
	Acetaminophen Tab 500 MG			
Analgesics – Nonnarcotic- – Peptide Channel Blockers	Ziconotide Acetate Intrathecal Inj 100 MCG/ML	PRIALT		May be considered for reimbursement upon submission of a prior authorization request and history of previous approval of intrathecal pain pump.
	Ziconotide Acetate Intrathecal Inj 500 MCG/20ML (25 MCG/ML)			
	Ziconotide Acetate Intrathecal Inj 500 MCG/5ML			
Analgesics – Nonnarcotic- Salicylates	Aspirin Buffered (Ca Carb-Mg Carb-Mg Ox) Tab 325 MG			
	Aspirin Buffered (Ca Carb-Mg Carb-Mg Ox) Tab 500 MG			
	Aspirin Chew Tab 81 MG			
	Aspirin Tab 325 MG			
	Aspirin Tab 500 MG			
	Aspirin Tab Delayed Release 81 MG			
	Aspirin Tab Delayed Release 325 MG			
	Aspirin Tab Delayed Release 500 MG			
	Diflunisal Tab 500 MG			
	Salsalate Tab 500 MG			
	Salsalate Tab 750 MG			
Analgesics – Nonnarcotic - Sodium Channel Pain Signal Inhibitors	Suzetrigine Tab 50 MG	JOURNAVX		Will not be reimbursed for more than 30 tablets without prior authorization. Prior authorization will only be considered for a period of acute care.
Analgesics – Opioid Agonists – Immediate Release	ALL Opioid Immediate Release products			Immediate Release Opioid Dose Formulations Restrictions: • Reimbursement of any immediate release opioid in an opioid naïve (no opioid use in the last 108 days) injured worker is limited to seven (7) days of use. • Reimbursement limited to six (6) tablets per day for any immediate release opioid unless otherwise noted in this appendix. • Prior authorization (PA) may be submitted to request to exceed the initial coverage limitations for: post-operative situations, or, if the injured worker is not opioid naïve, as verified by a prescription drug monitoring program (PDMP). • PA may be submitted to request use of more than one immediate release opioid agent for post-operative situations only. • PA may be submitted to request use of two (2) different strengths of the same immediate release opioid agent. • Claims in which this quantity limit was exceeded prior to January 1, 2017 and has been continuously reimbursed since then may continue to be reimbursed, but reimbursement is limited to the last quantity prescribed before that date or lower.
	Codeine Sulfate Tab 15 MG			
	Codeine Sulfate Tab 30 MG			
	Codeine Sulfate Tab 60 MG			
	Fentanyl Citrate Buccal Tab 100 MCG (Base Equiv)			Reimbursement is limited to claims in which the injured worker has an allowed condition of cancer.
	Fentanyl Citrate Buccal Tab 200 MCG (Base Equiv)			
	Fentanyl Citrate Buccal Tab 400 MCG (Base Equiv)			
	Fentanyl Citrate Buccal Tab 600 MCG (Base Equiv)			
	Fentanyl Citrate Buccal Tab 800 MCG (Base Equiv)			
	Fentanyl Citrate Lozenge on a Handle 200 MCG			
	Fentanyl Citrate Lozenge on a Handle 400 MCG			
	Fentanyl Citrate Lozenge on a Handle 600 MCG			
	Fentanyl Citrate Lozenge on a Handle 800 MCG			
	Fentanyl Citrate Lozenge on a Handle 1200 MCG			
	Fentanyl Citrate Lozenge on a Handle 1600 MCG			
	Hydromorphone HCl Liqd 1 MG/ML			
	Hydromorphone HCl Suppos 3 MG			
	Hydromorphone HCl Tab 2 MG			
	Hydromorphone HCl Tab 4 MG			
	Hydromorphone HCl Tab 8 MG			
	Meperidine HCl Oral Soln 50 MG/5ML			
	Meperidine HCl Tab 50 MG			
	Morphine Sulfate Oral Soln 10 MG/5ML			Reimbursement is limited to 400 MG per day.
	Morphine Sulfate Oral Soln 20 MG/5ML			
	Morphine Sulfate Oral Soln 100 MG/5ML (20 MG/ML)			
	Morphine Sulfate Tab 15 MG			
	Morphine Sulfate Tab 30 MG			
	Oxycodone HCl Cap 5 MG			
	Oxycodone HCl Conc 20 MG/ML			

Medication Class Name	Medication Generic Name	Brand name (if applicable)	Allowed Condition Needed	Reimbursement restrictions or limitations for specific medications or dosage forms are listed with the respective medications below.
	Oxycodone HCl Soln 5 MG/5ML			
	Oxycodone HCl Tab 5 MG			
	Oxycodone HCl Tab 10 MG			
	Oxycodone HCl Tab 15 MG			
	Oxycodone HCl Tab 20 MG			
	Oxycodone HCl Tab 30 MG			
	Oxymorphone HCl Tab 5 MG			
	Oxymorphone HCl Tab 10 MG			
	Tapentadol HCl Tab 50 MG			Reimbursement is limited to 600 MG per day and will not be reimbursed concurrently with sustained release tapentadol products.
	Tapentadol HCl Tab 75 MG			
	Tapentadol HCl Tab 100 MG			
	Tramadol HCl Tab 50 MG			Reimbursement is limited to 400 MG per day.
Analgesics – Opioid Agonists – Sustained Release	ALL Opioid Sustained Release products			Sustained Release Opioid Dosage Form Class Restrictions: • Treatment with multiple sustained release opioids (including methadone) will not be covered. • Duplicate use of any sustained release opioid with any parenteral pain management medication(s) (e.g., IM, SC, IV, IT analgesic medications) will not be covered. • Treatment with sustained release opioids for post-operative conditions will not be covered unless the injured worker was being treated with the drug prior to surgery.
	Fentanyl TD Patch 72HR 12 MCG/HR			Tier 2 sustained release opioid. • Reimbursement restricted to 10 patches every 30 days (every 72-hour dosing). • PA may be submitted to show documented allergic reaction to or inadequate response to at least two (2) Tier 1 sustained release opioids or a documented inability to swallow or absorb oral medications. • PA may be submitted for 15 patches every 30 days (every 48-hour dosing) if documentation supports clinical failure of 10 patches every 30 days (72-hour dosing interval) and evidence of an escalation of the dose before a reduction in frequency. • PA may be submitted for concurrent use of the 12 MCG/HR and 25 MCG/HR patches.
	Fentanyl TD Patch 72HR 25 MCG/HR			
	Fentanyl TD Patch 72HR 50 MCG/HR			
	Fentanyl TD Patch 72HR 75 MCG/HR			
	Fentanyl TD Patch 72HR 100 MCG/HR			
	Hydrocodone Bitartrate Tab ER 24HR Deter 20 MG			Tier 1 sustained release opioid. • Reimbursement is limited to one (1) tablet per day.
	Hydrocodone Bitartrate Tab ER 24HR Deter 30 MG			
	Hydrocodone Bitartrate Tab ER 24HR Deter 40 MG			
	Hydrocodone Bitartrate Tab ER 24HR Deter 60 MG			
	Hydrocodone Bitartrate Tab ER 24HR Deter 80 MG			
	Hydrocodone Bitartrate Tab ER 24HR Deter 100 MG			
	Hydrocodone Bitartrate Tab ER 24HR Deter 120 MG			
	Hydromorphone HCl Tab ER 24HR 8 MG			Tier 3 sustained release opioid. • Reimbursement is limited to one (1) tablet per day. • Prior authorization may be submitted to show documented allergic reaction to or inadequate response to at least two (2) Tier 2 sustained release opioids. • Claims in which this dose limitation was exceeded prior to January 1, 2017 and has been continuously reimbursed since then may continue to be reimbursed, but reimbursement is limited to the last quantity prescribed before that date or lower.
	Hydromorphone HCl Tab ER 24HR 12 MG			
	Hydromorphone HCl Tab ER 24HR 16 MG			
	Hydromorphone HCl Tab ER 24HR 32 MG			
	Methadone HCl Tab 5 MG			Tier 2 sustained release opioid. • All forms of methadone are considered sustained release opioids. • Reimbursement is limited to 90 MG per day. • PA may be submitted to show documented allergic reaction to or inadequate response to at least two (2) Tier 1 sustained release opioids.
	Methadone HCl Tab 10 MG			
	Methadone HCl Soln 5 MG/5ML			
	Methadone HCl Soln 10 MG/5ML			
	Morphine Sulfate Tab ER 15 MG			Tier 1 sustained release opioid • Reimbursement is limited to three (3) tablets per day all strengths except 200 MG, which is limited to two (2) tablets per day. PA is required for reimbursement for any doses above this level.
	Morphine Sulfate Tab ER 30 MG			
	Morphine Sulfate Tab ER 60 MG			
	Morphine Sulfate Tab ER 100 MG			
	Morphine Sulfate Tab ER 200 MG			
	Oxycodone Cap ER 12hr Abuse-Deterrent 27 Mg	XTAMPZA		Tier 4 sustained release opioid. • Reimbursement is limited to two (2) tablets per day. • PA may be submitted to show documented allergic reaction to or inadequate response to at least two (2) Tier 3 sustained release opioids.
	Oxycodone Cap ER 12hr Abuse-Deterrent 13.5 Mg			
	Oxycodone Cap ER 12hr Abuse-Deterrent 9 Mg			
	Oxycodone Cap ER 12hr Abuse-Deterrent 36 Mg			
	Oxycodone Cap ER 12hr Abuse-Deterrent 18 Mg			
	Oxymorphone HCl Tab SR 12HR 5 MG			Tier 3 sustained release opioid • Reimbursement is limited to two (2) tablets per day. • Prior authorization may be submitted to show documentation of allergic reaction to or inadequate response to at least two (2) Tier 2. • Claims in which this dose limitation was exceeded prior to January 1, 2017 and has been continuously reimbursed since then may continue to be reimbursed, but reimbursement is limited to the last quantity prescribed before that date or lower.
	Oxymorphone HCl Tab SR 12HR 7.5 MG			
	Oxymorphone HCl Tab SR 12HR 10 MG			
	Oxymorphone HCl Tab SR 12HR 15 MG			
	Oxymorphone HCl Tab SR 12HR 20 MG			
	Oxymorphone HCl Tab SR 12HR 30 MG			
	Oxymorphone HCl Tab SR 12HR 40 MG			
	Tapentadol HCl Tab ER 12HR 50 MG	NUCYNTA ER		Tier 2 sustained release opioid • Reimbursement is limited to 500 MG per day. • Will not be reimbursed concurrently with immediate release tapentadol products. • PA may be submitted to show documented allergic reaction to or inadequate response to at least two (2) Tier 1 sustained release opioids.
	Tapentadol HCl Tab ER 12HR 100 MG			
	Tapentadol HCl Tab ER 12HR 150 MG			
	Tapentadol HCl Tab ER 12HR 200 MG			
	Tapentadol HCl Tab ER 12HR 250 MG			
	Tramadol HCl Tab SR 24HR 100 MG			Tier 1 sustained release opioid

Medication Class Name	Medication Generic Name	Brand name (if applicable)	Allowed Condition Needed	Reimbursement restrictions or limitations for specific medications or dosage forms are listed with the respective medications below.
	Tramadol HCl Tab SR 24HR 200 MG			• Reimbursement is limited to 300 MG per day.
	Tramadol HCl Tab SR 24HR 300 MG			
	Tramadol HCl Tab ER 24HR Biphasic Release 100 MG			
	Tramadol HCl Tab ER 24HR Biphasic Release 200 MG			
	Tramadol HCl Tab ER 24HR Biphasic Release 300 MG			
Analgesics – Opioid Partial Agonists	Buprenorphine HCl Buccal Film 75 MCG (Base equivalent)			
	Buprenorphine HCl Buccal Film 150 MCG (Base equivalent)			
	Buprenorphine HCl Buccal Film 300 MCG (Base equivalent)			~~Tier 1 sustained release opioid.~~ Reimbursement is limited to two (2) films per day and ~~.~~ ~~W~~will not be reimbursed concurrently with any other sustained release opioid or opioid partial agonist. This product will not be covered in the post-operative period unless routinely prescribed pre-operatively.
	Buprenorphine HCl Buccal Film 450 MCG (Base equivalent)			
	Buprenorphine HCl Buccal Film 600 MCG (Base equivalent)			
	Buprenorphine HCl Buccal Film 750 MCG (Base equivalent)			
	Buprenorphine HCl Buccal Film 900 MCG (Base equivalent)			
	Buprenorphine TD Patch Weekly 5 MCG/HR			~~Tier 1 sustained release opioid.~~ Reimbursement is limited to a maximum quantity of four (4) patches per 28 days and ~~.~~ ~~Reimbursement~~ will not be permitted for this product concurrently with any other sustained release opioid or opioid partial agonist.
	Buprenorphine TD Patch Weekly 7.5 MCG/HR			
	Buprenorphine TD Patch Weekly 10 MCG/HR			
	Buprenorphine TD Patch Weekly 15 MCG/HR			
	Buprenorphine TD Patch Weekly 20 MCG/HR			
	Butorphanol Tartrate Nasal Soln 10 MG/ML			May be considered for reimbursement upon submission of a prior authorization request that reflects a documented allergic reaction or inadequate response of nonopioid analgesics and opioid combination products.
	Pentazocine w/ Naloxone Tab 50-0.5 MG			May be considered for reimbursement upon submission of a prior authorization request that reflects a documented allergic reaction or inadequate response of nonopioid analgesics and opioid combination products.
Analgesics – Opioid Partial Agonists, Agents for Opioid Use Disorder	Buprenorphine HCl-Naloxone HCl SL Tab 2-0.5 MG (Base Equiv)		✓	May be reimbursed in claims with an allowed condition of opioid use disorder or as part of approved treatment under OAC 4123-6-21.8. Reimbursement is limited to two (2) tablets or films per day.
	Buprenorphine HCl-Naloxone HCl SL Tab 8-2 MG (Base Equiv)		✓	
	Buprenorphine HCl-Naloxone HCl SL Film 2-0.5 MG (Base Equiv)		✓	
	Buprenorphine HCl-Naloxone HCl SL Film 8-2 MG (Base Equiv)		✓	
Analgesics – Opioid Combinations	ALL Opioid combination products			Immediate Release Opioid Dose Formulations Restrictions: • Reimbursement of any immediate release opioid in an opioid naïve (no opioid use in the last 108 days) injured worker will be limited to seven (7) days of coverage or 30 doses, whichever is less. • Reimbursement is limited to six (6) doses per day for any immediate release opioid unless otherwise noted in this appendix. • Prior Authorization (PA) may be submitted to request to exceed the initial coverage limitations for: post-operative situations, or if the IW is not opioid naïve, as verified by a prescription drug monitoring program (PDMP). • PA may be submitted to request use of more than one (1) immediate release combination opioid agent for post-operative situations only. • Acetaminophen content may not exceed four (4) grams per day. • Claims in which this quantity limit was exceeded prior to January 1, 2017 and has been continuously reimbursed since then may continue to be reimbursed, but reimbursement is limited to the last quantity prescribed before that date or lower.
	Acetaminophen w/ Codeine Soln 120-12 MG/5ML			
	Acetaminophen w/ Codeine Tab 300-15 MG			
	Acetaminophen w/ Codeine Tab 300-30 MG			
	Acetaminophen w/ Codeine Tab 300-60 MG			
	Butalbital-Acetaminophen-Caff w/ Cod Cap 50-325-40-30 MG		✓	Reimbursement is limited to four (4) grams of acetaminophen per day or 24 doses per 30 days and is restricted to only those claims in which headache is related to an allowed condition in the claim.
	Butalbital-Aspirin-Caff w/ Codeine Cap 50-325-40-30 MG		✓	
	Hydrocodone-Acetaminophen Tab 5-325 MG			
	Hydrocodone-Acetaminophen Tab 7.5-325 MG			
	Hydrocodone-Acetaminophen Tab 10-325 MG			
	Hydrocodone-Acetaminophen Soln 7.5-325 MG/15ML			Reimbursement is limited to 180 ML/ day (4 grams/day of acetaminophen).
	Hydrocodone-Acetaminophen Soln 10-325 MG/15ML			
	Hydrocodone-Ibuprofen Tab 5-200 MG			Reimbursement is limited to five (5) tablets per day.
	Hydrocodone-Ibuprofen Tab 7.5-200 MG			
	Hydrocodone-Ibuprofen Tab 10-200 MG			
	Oxycodone w/ Acetaminophen Tab 2.5-325 MG			
	Oxycodone w/ Acetaminophen Tab 5-325 MG			
	Oxycodone w/ Acetaminophen Tab 7.5-325 MG			
	Oxycodone w/ Acetaminophen Tab 10-325 MG			
	Tramadol-Acetaminophen Tab 37.5-325 MG			

Medication Class Name	Medication Generic Name	Brand name (if applicable)	Allowed Condition Needed	Reimbursement restrictions or limitations for specific medications or dosage forms are listed with the respective medications below.
Antidotes – Opioid Antagonists	Naloxone HCl Nasal Spray 4 MG/0.1ML			Reimbursement is limited to claims in which a prior authorization request or prescription history look-back has documented that BWC is currently or has recently been reimbursing for opioid drugs.
	Naltrexone HCl Tab 50 MG			Reimbursement is limited to claims with an allowed condition of opioid use disorder or as part of approved treatment under OAC 4123-6-21.8.
	Naltrexone For IM Extended Release Susp 380 MG			Reimbursement is limited to claims with an allowed condition of opioid use disorder or as part of approved treatment under OAC 4123-6-21.8.
Anaphylaxis Therapy Agents	Epinephrine Solution Auto-injector 0.15 MG/0.15ML (1:1000)		✓	
	Epinephrine Solution Auto-injector 0.15 MG/0.3ML (1:2000)		✓	
	Epinephrine Solution Auto-injector 0.3 MG/0.3ML (1:1000)		✓	
~~Androgens -~ Anabolic Steroids and Androgens	Methyltestosterone Cap 10 MG		✓	Reimbursement is limited to claims that have allowed medical conditions involving the genitourinary or endocrine systems.
	Oxandrolone Tab 2.5 MG		✓	
	Oxandrolone Tab 10 MG		✓	
	Testosterone Cypionate IM Inj in Oil 100 MG/ML		✓	
	Testosterone Cypionate IM Inj in Oil 200 MG/ML		✓	
	Testosterone Cyp IM or Subcutaneous Inj in Oil 200 MG/ML		✓	
	Testosterone Enanthate IM Inj in Oil 200 MG/ML		✓	
	Testosterone TD Gel 10MG/ACT (2%)		✓	
	Testosterone TD Gel 12.5 MG/ACT (1%)		✓	
	Testosterone TD Gel 20.25 MG/ACT (1.62%)		✓	
	Testosterone TD Gel 25 MG/2.5GM (1%)		✓	
	Testosterone TD Gel 50 MG/5GM (1%)		✓	
	Testosterone TD Patch 24HR 2 MG/24HR		✓	
	Testosterone TD Patch 24HR 4 MG/24HR		✓	
	Testosterone TD Soln 30 MG/ACT		✓	
Antacids	Aluminum & Magnesium Hydroxides Susp 200-200 MG/5ML			
	Alum & Mag Hydroxide-Simethicone Susp 200-200-20 MG/5ML			
	Alum & Mag Hydroxide-Simethicone Susp 400-400-40 MG/5ML			
	Aluminum Hydroxide-Magnesium Carbonate Chew Tab 160-105 MG			
	Aluminum Hydroxide-Magnesium Carbonate Susp 95-358 MG/15ML			
	Aluminum Hydroxide-Magnesium Trisilicate Chew Tab 80-14.2 MG			
	Aluminum Hydroxide-Magnesium Trisilicate Chew Tab 80-20 MG			
	Calcium Carbonate (Antacid) Chew Tab 500 MG			
	Calcium Carbonate (Antacid) Chew Tab 750 MG			
	Calcium Carbonate (Antacid) Chew Tab 1000 MG			
	Calcium Carbonate (Antacid) Tab 648 MG			
	Calcium Carbonate-Mag Hydroxide Chew Tab 550-110 MG			
	Calcium Carbonate-Mag Hydroxide Chew Tab 1000-200 MG			
	Calcium Carbonate-Simethicone Chew Tab 750-80 MG			
	Calcium Carbonate-Simethicone Chew Tab 1000-60 MG			
	Magnesium Oxide Cap 140 MG (85 MG Elemental MG)			
	Magnesium Oxide Cap 500 MG			
	Magnesium Oxide Tab 400 MG			
	Sodium Bicarbonate Tab 325 MG			
	Sodium Bicarbonate Tab 650 MG			
	Sodium Bicarbonate-Citric Acid Effer Tab 1940-1000 MG			
Anthelmintics	Mebendazole Chew Tab 100 MG		✓	
Antianginal Agents and Nitrates	Isosorbide Dinitrate Cap ER 40 MG		✓	
	Isosorbide Dinitrate Tab 10 MG		✓	
	Isosorbide Dinitrate Tab 20 MG		✓	
	Isosorbide Mononitrate Tab 20 MG		✓	
	Isosorbide Mononitrate Tab SR 24HR 30 MG		✓	
	Isosorbide Mononitrate Tab SR 24HR 60 MG		✓	
	Isosorbide Mononitrate Tab SR 24HR 120 MG		✓	
	Nitroglycerin Oint 2%		✓	
	Nitroglycerin SL Tab 0.3 MG		✓	
	Nitroglycerin SL Tab 0.4 MG		✓	
	Nitroglycerin TD Patch 24HR 0.1 MG/HR		✓	
	Nitroglycerin TD Patch 24HR 0.2 MG/HR		✓	
	Nitroglycerin TD Patch 24HR 0.3 MG/HR		✓	
	Nitroglycerin TD Patch 24HR 0.4 MG/HR		✓	
	Nitroglycerin TL Soln 0.4 MG/SPRAY (400 MCG/SPRAY)		✓	
	Ranolazine Tab SR 12HR 500 MG		✓	
	Ranolazine Tab SR 12HR 1000 MG		✓	

Medication Class Name	Medication Generic Name	Brand name (if applicable)	Allowed Condition Needed	Reimbursement restrictions or limitations for specific medications or dosage forms are listed with the respective medications below.
Antianxiety Agents– Benzodiazepines	All Benzodiazepine products			For all oral benzodiazepines, excluding clobazam, after 30 days of use, may be considered for reimbursement upon submission of a prior authorization request that reflects use for an allowed condition in the claim. Reimbursement for all oral benzodiazepines is limited to one (1) product per month. For psychological conditions: may be considered for reimbursement upon submission of a prior authorization that reflects a minimum of a 90-day trial and documented inadequate response to at least two (2) SSRIs and/or SNRIs within the past 180 days.
	Alprazolam Products			Effective August 1, 2017, alprazolam products were removed from the outpatient medication formulary. Claims in which alprazolam was reimbursed prior to August 1, 2017, and has been continuously reimbursed since then may continue to be reimbursed, but reimbursement is limited to the daily dose that was last covered or lower.
	Chlordiazepoxide HCl Cap 5 MG			Reimbursement is limited to 100 MG per day.
	Chlordiazepoxide HCl Cap 10 MG			
	Chlordiazepoxide HCl Cap 25 MG			
	Clorazepate Dipotassium Tab 3.75 MG			Reimbursement is limited to 80 MG per day.
	Clorazepate Dipotassium Tab 7.5 MG			
	Clorazepate Dipotassium Tab 15 MG			
	Diazepam Conc 5 MG/ML			Reimbursement is limited to 40 MG per day.
	Diazepam Oral Soln 1 MG/ML			
	Diazepam Tab 2 MG			
	Diazepam Tab 5 MG			
	Diazepam Tab 10 MG			
	Lorazepam Conc 2 MG/ML			Reimbursement is limited to 8 MG per day.
	Lorazepam Tab 0.5 MG			
	Lorazepam Tab 1 MG			
	Lorazepam Tab 2 MG			
	Oxazepam Cap 10 MG			Reimbursement is limited to 120 MG per day.
	Oxazepam Cap 15 MG			
	Oxazepam Cap 30 MG			
Antianxiety Agents – Psychotherapeutic Combinations	Chlordiazepoxide-Amitriptyline Tab 5-12.5 MG		✓	
	Chlordiazepoxide-Amitriptyline Tab 10-25 MG		✓	
Antianxiety Agents – Misc.	Buspirone HCl Tab 5 MG			
	Buspirone HCl Tab 7.5 MG			
	Buspirone HCl Tab 10 MG			
	Buspirone HCl Tab 15 MG			
	Buspirone HCl Tab 30 MG			
	Hydroxyzine HCl Syrup 10 MG/5ML			
	Hydroxyzine HCl Tab 10 MG			
	Hydroxyzine HCl Tab 25 MG			
	Hydroxyzine HCl Tab 50 MG			
	Hydroxyzine Pamoate Cap 25 MG			
	Hydroxyzine Pamoate Cap 50 MG			
	Hydroxyzine Pamoate Cap 100 MG			
	Meprobamate Tab 200 MG			
	Meprobamate Tab 400 MG			
Antiarrhythmics	Amiodarone HCl Tab 200 MG		✓	
	Amiodarone HCl Tab 400 MG		✓	
	Dofetilide Cap 125 MCG (0.125 MG)		✓	
	Dofetilide Cap 250 MCG (0.25 MG)		✓	
	Dofetilide Cap 500 MCG (0.5 MG)		✓	
	Dronedarone HCl Tab 400 MG (Base Equivalent)		✓	
	Flecainide Acetate Tab 50 MG		✓	
	Flecainide Acetate Tab 100 MG		✓	
	Flecainide Acetate Tab 150 MG		✓	
	Mexiletine HCl Cap 150 MG		✓	
	Mexiletine HCl Cap 200 MG		✓	
	Propafenone HCl Cap SR 12HR 225 MG		✓	
	Propafenone HCl Cap SR 12HR 325 MG		✓	
	Propafenone HCl Cap SR 12HR 425 MG		✓	
	Propafenone HCl Tab 150 MG		✓	
	Propafenone HCl Tab 225 MG		✓	
	Propafenone HCl Tab 300 MG		✓	
	Quinidine Gluconate Tab ER 324 MG		✓	
Antibiotic – Aminoglycosides	Neomycin Sulfate Tab 500 MG		✓	
	Tobramycin Inhal Cap 28 MG		~~✓~~	May be considered for reimbursement upon submission of a prior authorization request that reflects a documented inadequate response after a minimum of a 28-day trial of tobramycin nebulizer solution in the past 90 days.
	Tobramycin Nebu Soln 300 MG/5ML		✓	
Antibiotic –Cephalosporins - 1st Generation	Cefadroxil Cap 500 MG		✓	
	Cefadroxil For Susp 500 MG/5ML		✓	
	Cefadroxil Tab 1 GM		✓	
	Cephalexin Cap 250 MG		✓	
	Cephalexin Cap 500 MG		✓	
	Cephalexin Cap 750 MG		✓	
	Cephalexin For Susp 250 MG/5ML		✓	
Antibiotic –Cephalosporins - 2nd Generation	Cefaclor Cap 250 MG		✓	
	Cefaclor Cap 500 MG		✓	
	Cefprozil Tab 250 MG		✓	
	Cefprozil Tab 500 MG		✓	
	Cefuroxime Axetil Tab 250 MG		✓	

Medication Class Name	Medication Generic Name	Brand name (if applicable)	Allowed Condition Needed	Reimbursement restrictions or limitations for specific medications or dosage forms are listed with the respective medications below.
	Cefuroxime Axetil Tab 500 MG		✓	
Antibiotic –Cephalosporins - 3rd Generation	Cefdinir Cap 300 MG		✓	
	Cefdinir For Susp 250 MG/5ML		✓	
	Cefixime Cap 400 MG		✓	
	Cefixime For Susp 500 MG/5ML		✓	
	Cefpodoxime Proxetil Tab 100 MG		✓	
	Cefpodoxime Proxetil Tab 200 MG		✓	
Antibiotic – Fluoroquinolones	Ciprofloxacin For Oral Susp 500 MG/5ML (10%) (10 GM/100ML)		✓	
	Ciprofloxacin HCl Tab 250 MG (Base Equiv)		✓	
	Ciprofloxacin HCl Tab 500 MG (Base Equiv)		✓	
	Ciprofloxacin HCl Tab 750 MG (Base Equiv)		✓	
	Levofloxacin Tab 250 MG		✓	
	Levofloxacin Tab 500 MG		✓	
	Levofloxacin Tab 750 MG		✓	
	Moxifloxacin HCl Tab 400 MG (Base Equiv)		✓	
	Ofloxacin Tab 300 MG		✓	
	Ofloxacin Tab 400 MG		✓	
Antibiotic – Macrolides	Azithromycin For Susp 100 MG/5ML		✓	
	Azithromycin For Susp 200 MG/5ML		✓	
	Azithromycin Tab 250 MG		✓	
	Azithromycin Tab 500 MG		✓	
	Clarithromycin Tab 250 MG		✓	
	Clarithromycin Tab 500 MG		✓	
	Clarithromycin Tab SR 24HR 500 MG		✓	
	Erythromycin Ethylsuccinate For Susp 200 MG/5ML		✓	
	Erythromycin Ethylsuccinate Tab 400 MG		✓	
	Erythromycin Stearate Tab 250 MG		✓	
	Erythromycin Tab 250 MG		✓	
	Erythromycin Tab 500 MG		✓	
	Erythromycin Tab Delayed Release 250 MG		✓	
	Erythromycin Tab Delayed Release 333 MG		✓	
	Erythromycin Tab Delayed Release 500 MG		✓	
	Erythromycin w/ Delayed Release Particles Cap 250 MG		✓	
Antibiotic – Penicillins	Amoxicillin & K Clavulanate Chew Tab 400-57 MG		✓	
	Amoxicillin & K Clavulanate For Susp 250-62.5 MG/5ML		✓	
	Amoxicillin & K Clavulanate For Susp 400-57 MG/5ML		✓	
	Amoxicillin & K Clavulanate For Susp 600-42.9 MG/5ML		✓	
	Amoxicillin & K Clavulanate Tab 250-125 MG		✓	
	Amoxicillin & K Clavulanate Tab 500-125 MG		✓	
	Amoxicillin & K Clavulanate Tab 875-125 MG		✓	
	Amoxicillin & K Clavulanate Tab SR 12HR 1000-62.5 MG		✓	
	Amoxicillin (Trihydrate) Cap 250 MG		✓	
	Amoxicillin (Trihydrate) Cap 500 MG		✓	
	Amoxicillin (Trihydrate) Chew Tab 250 MG		✓	
	Amoxicillin (Trihydrate) For Susp 250 MG/5ML		✓	
	Amoxicillin (Trihydrate) For Susp 400 MG/5ML		✓	
	Amoxicillin (Trihydrate) Tab 500 MG		✓	
	Amoxicillin (Trihydrate) Tab 875 MG		✓	
	Ampicillin Cap 500 MG		✓	
	Dicloxacillin Sodium Cap 250 MG		✓	
	Dicloxacillin Sodium Cap 500 MG		✓	
	Penicillin V Potassium For Soln 250 MG/5ML		✓	
	Penicillin V Potassium Tab 250 MG		✓	
	Penicillin V Potassium Tab 500 MG		✓	
Antibiotic – Tetracyclines	Demeclocycline HCl Tab 150 MG		✓	
	Demeclocycline HCl Tab 300 MG		✓	
	Doxycycline Calcium Syrup 50 MG/5ML		✓	
	Doxycycline Hyclate Cap 50 MG		✓	
	Doxycycline Hyclate Cap 100 MG		✓	
	Doxycycline Hyclate Tab 20 MG		✓	
	Doxycycline Hyclate Tab 100 MG		✓	
	Doxycycline Hyclate Tab Delayed Release 50 MG		✓	
	Doxycycline Hyclate Tab Delayed Release 75 MG		✓	
	Doxycycline Hyclate Tab Delayed Release 100 MG		✓	
	Doxycycline Hyclate Tab Delayed Release 150 MG		✓	
	Doxycycline Hyclate Tab Delayed Release 200 MG		✓	
	Doxycycline Monohydrate Cap 50 MG		✓	
	Doxycycline Monohydrate Cap 100 MG		✓	
	Doxycycline Monohydrate Tab 50 MG		✓	
	Doxycycline Monohydrate Tab 100 MG		✓	
	Doxycycline Monohydrate Tab 150 MG		✓	
	Minocycline HCl Cap 50 MG		✓	
	Minocycline HCl Cap 75 MG		✓	
	Minocycline HCl Cap 100 MG		✓	
	Tetracycline HCl Cap 250 MG		✓	
	Tetracycline HCl Cap 500 MG		✓	
Anti-Cataplectic Agents	Sodium Oxybate Oral Solution 500 MG/ML		✓	
Anticoagulants – Coumarin Anticoagulants	Warfarin Sodium Tab 1 MG		✓	After 30 days of use, may be considered for reimbursement upon submission of a prior authorization request that reflects use for an allowed condition in the claim.
	Warfarin Sodium Tab 2 MG		✓	
	Warfarin Sodium Tab 2.5 MG		✓	
	Warfarin Sodium Tab 3 MG		✓	
	Warfarin Sodium Tab 4 MG		✓	

Medication Class Name	Medication Generic Name	Brand name (if applicable)	Allowed Condition Needed	Reimbursement restrictions or limitations for specific medications or dosage forms are listed with the respective medications below.
	Warfarin Sodium Tab 5 MG		✓	
	Warfarin Sodium Tab 6 MG		✓	
	Warfarin Sodium Tab 7.5 MG		✓	
	Warfarin Sodium Tab 10 MG		✓	
Anticoagulants – Direct Factor Xa Inhibitors	Apixaban Tab 2.5 MG	ELIQUIS	✓	After 30 days of use, may be considered for reimbursement upon submission of a prior authorization request that reflects use for an allowed condition in the claim.
	Apixaban Tab 5 MG		✓	
	Apixaban Tab Starter Pack 5 MG		✓	
	Edoxaban Tosylate Tab 15 MG (Base Equivalent)	SAVAYSA	✓	
	Edoxaban Tosylate Tab 30 MG (Base Equivalent)		✓	
	Edoxaban Tosylate Tab 60 MG (Base Equivalent)		✓	
	Rivaroxaban Tab 2.5 MG	XARELTO	✓	
	Rivaroxaban Tab 10 MG		✓	
	Rivaroxaban Tab 15 MG		✓	
	Rivaroxaban Tab 20 MG		✓	
	Rivaroxaban Tab Starter Therapy Pack 15 MG & 20 MG		✓	
Anticoagulants – Heparins and Heparinoid-Like Agents	Dalteparin Sodium Subcutaneous Soln 95000 Unit/3.8ML		✓	After 30 days of use, may be considered for reimbursement upon submission of a prior authorization request that reflects use for an allowed condition in the claim.
	Dalteparin Sodium Soln Prefilled Syr 2500 Unit/0.2ML		✓	
	Dalteparin Sodium Soln Prefilled Syr 5000 Unit/0.2ML		✓	
	Dalteparin Sodium Soln Prefilled Syr 7500 Unit/0.3ML		✓	
	Dalteparin Sodium Soln Prefilled Syr 10000 Unit/ML		✓	
	Dalteparin Sodium Soln Prefilled Syr 12500 Unit/0.5ML		✓	
	Dalteparin Sodium Soln Prefilled Syr 15000 Unit/0.6ML		✓	
	Dalteparin Sodium Soln Prefilled Syr 18000 Unit/0.72ML		✓	
	Enoxaparin Sodium Inj 300 MG/3ML		✓	
	Enoxaparin Sodium Inj Soln Pref Syr 30 MG/0.3ML		✓	
	Enoxaparin Sodium Inj Soln Pref Syr 40 MG/0.4ML		✓	
	Enoxaparin Sodium Inj Soln Pref Syr 60 MG/0.6ML		✓	
	Enoxaparin Sodium Inj Soln Pref Syr 80 MG/0.8ML		✓	
	Enoxaparin Sodium Inj Soln Pref Syr 100 MG/ML		✓	
	Enoxaparin Sodium Inj Soln Pref Syr 120 MG/0.8ML		✓	
	Enoxaparin Sodium Inj Soln Pref Syr 150 MG/ML		✓	
	Fondaparinux Sodium Subcutaneous Inj 2.5 MG/0.5ML		✓	
	Fondaparinux Sodium Subcutaneous Inj 5 MG/0.4ML		✓	
	Fondaparinux Sodium Subcutaneous Inj 7.5 MG/0.6ML		✓	
	Fondaparinux Sodium Subcutaneous Inj 10 MG/0.8ML		✓	
	Heparin Sodium (Porcine) Inj 5000 Unit/ML		✓	
	Heparin Sodium (Porcine) PF Inj 5000 Unit/0.5ML		✓	
	Heparin Sodium (Porcine) Inj 10000 Unit/ML		✓	
	Heparin Sodium (Porcine) Inj 20000 Unit/ML		✓	
Anticoagulants – Thrombin Inhibitors	Dabigatran Etexilate Mesylate Cap 75 MG (Etexilate Base Eq)	PRADAXA	✓	After 30 days of use, may be considered for reimbursement upon submission of a prior authorization request that reflects use for an allowed condition in the claim.
	Dabigatran Etexilate Mesylate Cap 110 MG (Etexilate Base Eq)		✓	
	Dabigatran Etexilate Mesylate Cap 150 MG (Etexilate Base Eq)		✓	
Anticonvulsants– Benzodiazepines	Clobazam Tab 10 MG			May be considered for reimbursement upon submission of a prior authorization request that reflects a minimum of a 30-day trial and documented inadequate response to at least one (1) anticonvulsant within the past 180 days and the injured worker has an allowed condition of seizure disorder.
	Clobazam Tab 20 MG			
	Clonazepam Orally Disintegrating Tab 0.125 MG			Reimbursement for oral disintegrating dosage form is limited to claims with an allowed condition that results in the inability to swallow or absorb oral medications. Reimbursement is limited to four (4) MG per day.
	Clonazepam Orally Disintegrating Tab 0.25 MG			
	Clonazepam Orally Disintegrating Tab 0.5 MG			
	Clonazepam Orally Disintegrating Tab 1 MG			
	Clonazepam Orally Disintegrating Tab 2 MG			
	Clonazepam Tab 0.5 MG			Reimbursement is limited to four (4) MG per day.
	Clonazepam Tab 1 MG			
	Clonazepam Tab 2 MG			
	Diazepam Rectal Gel Delivery System 10 MG			
	Diazepam Rectal Gel Delivery System 20 MG			
	Midazolam Nasal Spray Soln 5 MG/0.1 ML			May be considered for reimbursement upon submission of a prior authorization request in which all of the following are documented: frequent seizure activity that is related to allowed condition(s) in the claim and the injured worker is concurrently receiving maintenance anticonvulsant medication. Reimbursement is limited to one (1) package every 30 days.
Anticonvulsants – Carbamates	Cenobamate Tab 25 MG	XCOPRI		May be considered for reimbursement upon submission of a prior authorization request that reflects a minimum of a 60-day trial and documented inadequate response to at least two (2) anticonvulsants within the past 180 days and the injured worker has an allowed condition of seizure disorder.
	Cenobamate Tab 50 MG			
	Cenobamate Tab 100 MG			
	Cenobamate Tab 150 MG			
	Cenobamate Tab 200 MG			
	Cenobamate Tab Titration Pack 14 x 12.5 MG & 14 x 25 MG			
	Cenobamate Tab Titration Pack 14 X 50 MG & 14 X 100 MG			

Medication Class Name	Medication Generic Name	Brand name (if applicable)	Allowed Condition Needed	Reimbursement restrictions or limitations for specific medications or dosage forms are listed with the respective medications below.
	Cenobamate Tab Titration Pack 14 X 150 MG & 14 X 200 MG			
	Cenobamate Tab Pack 150 MG & 200 MG TABS (350 MG DAILY DOSE)			
	Cenobamate Tab Pack 100 MG & 150 MG TABS (250 MG DAILY DOSE)			
	Felbamate Tab 600 MG		✓	
Anticonvulsants – GABA Modulators	Tiagabine HCl Tab 2 MG	GABITRIL	✓	
	Tiagabine HCl Tab 4 MG		✓	
	Tiagabine HCl Tab 12 MG		✓	
	Tiagabine HCl Tab 16 MG		✓	
Anticonvulsants – Hydantoins	Phenytoin Chew Tab 50 MG			Reimbursement for chewable dosage form is limited to claims with an allowed condition that results in the inability to swallow or absorb oral medications.
	Phenytoin Sodium Extended Cap 30 MG		✓	
	Phenytoin Sodium Extended Cap 100 MG		✓	
	Phenytoin Sodium Extended Cap 200 MG		✓	
	Phenytoin Sodium Extended Cap 300 MG		✓	
	Phenytoin Susp 125 MG/5ML		✓	
Anticonvulsants – Misc.	Brivaracetam Tab 10 MG	BRIVIACT		May be considered for reimbursement upon submission of a prior authorization request that reflects a minimum of a 60-day trial and documented inadequate response to at least two (2) anticonvulsants within the past 180 days and the injured worker has an allowed condition of seizure disorder.
	Brivaracetam Tab 25 MG			
	Brivaracetam Tab 50 MG			
	Brivaracetam Tab 75 MG			
	Brivaracetam Tab 100 MG			
	Carbamazepine Cap ER 12HR 100 MG		✓	
	Carbamazepine Cap ER 12HR 200 MG		✓	
	Carbamazepine Cap ER 12HR 300 MG		✓	
	Carbamazepine Chew Tab 100 MG			Reimbursement for chewable dosage form is limited to claims with an allowed condition that results in the inability to swallow or absorb oral medications.
	Carbamazepine Susp 100 MG/5ML		✓	
	Carbamazepine Tab 200 MG		✓	
	Carbamazepine Tab SR 12HR 100 MG		✓	
	Carbamazepine Tab SR 12HR 200 MG		✓	
	Carbamazepine Tab SR 12HR 400 MG		✓	
	Gabapentin Cap 100 MG			Reimbursement is limited to 3,600 MG/day. Coverage of all gabapentin products is restricted to a single form at any one time.
	Gabapentin Cap 300 MG			
	Gabapentin Cap 400 MG			
	Gabapentin Oral Soln 250 MG/5ML			
	Gabapentin Tab 600 MG			
	Gabapentin Tab 800 MG			
	Lacosamide Tab 50 MG		✓	
	Lacosamide Tab 100 MG		✓	
	Lacosamide Tab 150 MG		✓	
	Lacosamide Tab 200 MG		✓	
	Lamotrigine Orally Disintegrating Tab 25 MG			Reimbursement for oral disintegrating dosage form is limited to claims with an allowed condition that results in the inability to swallow or absorb oral medications.
	Lamotrigine Orally Disintegrating Tab 50 MG			
	Lamotrigine Orally Disintegrating Tab 100 MG			
	Lamotrigine Orally Disintegrating Tab 200 MG			
	Lamotrigine Tab 25 MG		✓	
	Lamotrigine Tab 100 MG		✓	
	Lamotrigine Tab 150 MG		✓	
	Lamotrigine Tab 200 MG		✓	
	Lamotrigine Tab 35 X 25 MG Starter Kit			Starter kit may be reimbursed upon submission of a prior authorization request with documented medical justification for starter kit in lieu of individual dosage strengths.
	Lamotrigine Tab 25 MG (42) & 100 MG (7) Starter Kit			
	Lamotrigine Tab 84 X 25 MG & 14 X 100 MG Starter Kit			
	Lamotrigine Tab ER 24HR 25 (14) & 50 MG (14) & 100 MG(7) Kit			
	Lamotrigine Tab ER 24HR 50 MG		✓	
	Lamotrigine Tab ER 24HR 100 MG		✓	
	Lamotrigine Tab ER 24HR 200 MG		✓	
	Lamotrigine Tab ER 24HR 250 MG		✓	
	Levetiracetam Oral Soln 100 MG/ML		✓	
	Levetiracetam Tab 250 MG		✓	
	Levetiracetam Tab 500 MG		✓	
	Levetiracetam Tab 750 MG		✓	
	Levetiracetam Tab 1000 MG		✓	
	Levetiracetam Tab SR 24HR 500 MG		✓	
	Levetiracetam Tab SR 24HR 750 MG		✓	
	Oxcarbazepine Tab 150 MG		✓	
	Oxcarbazepine Tab 300 MG		✓	
	Oxcarbazepine Tab 600 MG		✓	
	Pregabalin Cap 25 MG			Reimbursement is limited to 600 MG per day.
	Pregabalin Cap 50 MG			
	Pregabalin Cap 75 MG			
	Pregabalin Cap 100 MG			
	Pregabalin Cap 150 MG			
	Pregabalin Cap 200 MG			
	Pregabalin Cap 225 MG			
	Pregabalin Cap 300 MG			
	Primidone Tab 50 MG		✓	
	Primidone Tab 250 MG		✓	
	Topiramate Sprinkle Cap 15 MG		✓	
	Topiramate Sprinkle Cap 25 MG		✓	
	Topiramate Tab 25 MG		✓	

Medication Class Name	Medication Generic Name	Brand name (if applicable)	Allowed Condition Needed	Reimbursement restrictions or limitations for specific medications or dosage forms are listed with the respective medications below.
	Topiramate Tab 50 MG		✓	
	Topiramate Tab 100 MG		✓	
	Topiramate Tab 200 MG		✓	
	Zonisamide Cap 25 MG		✓	
	Zonisamide Cap 50 MG		✓	
	Zonisamide Cap 100 MG		✓	
Anticonvulsants – Succinimides	Ethosuximide Cap 250 MG		✓	
Anticonvulsants – Valproic Acid	Divalproex Sodium Cap Delayed Release Sprinkle 125 MG		✓	
	Divalproex Sodium Tab Delayed Release 125 MG		✓	
	Divalproex Sodium Tab Delayed Release 250 MG		✓	
	Divalproex Sodium Tab Delayed Release 500 MG		✓	
	Divalproex Sodium Tab SR 24 HR 250 MG		✓	
	Divalproex Sodium Tab SR 24 HR 500 MG		✓	
	Valproate Sodium Oral Soln 250 MG/5ML (Base Equiv)		✓	
	Valproic Acid Cap 250 MG		✓	
Antidementia Agents	Donepezil Hydrochloride Tab 5 MG		✓	
	Donepezil Hydrochloride Tab 10 MG		✓	
	Donepezil Hydrochloride Tab 23 MG		✓	
	Galantamine Hydrobromide Cap ER 24HR 8 MG		✓	
	Galantamine Hydrobromide Cap ER 24HR 16 MG		✓	
	Galantamine Hydrobromide Tab 4 MG		✓	
	Galantamine Hydrobromide Tab 8 MG		✓	
	Galantamine Hydrobromide Tab 12 MG		✓	
	Memantine HCl Cap ER 24HR 7 MG		✓	
	Memantine HCl Cap ER 24HR 14 MG		✓	
	Memantine HCl Cap ER 24HR 21 MG		✓	
	Memantine HCl Cap ER 24HR 28 MG		✓	
	Memantine HCl Cap ER 24HR 7 MG & 14 MG & 21 MG & 28 MG Pack		✓	
	Memantine HCl Tab 5 MG		✓	
	Memantine HCl Tab 10 MG		✓	
	Memantine HCl Tab 28 X 5 MG & 21 x 10 MG Titration Pack		✓	
	Rivastigmine Tartrate Cap 3 MG (Base Equivalent)		✓	
	Rivastigmine Tartrate Cap 4.5 MG (Base Equivalent)		✓	
	Rivastigmine Tartrate Cap 6 MG (Base Equivalent)		✓	
	Rivastigmine TD Patch 24HR 4.6 MG/24HR		✓	
	Rivastigmine TD Patch 24HR 9.5 MG/24HR		✓	
Antidepressants – Alpha-2 Receptor Antagonists (Tetracyclics)	Mirtazapine Orally Disintegrating Tab 15 MG			Reimbursement for oral disintegrating dosage form is limited to claims with an allowed condition that results in the inability to swallow or absorb oral medications.
	Mirtazapine Orally Disintegrating Tab 30 MG			
	Mirtazapine Orally Disintegrating Tab 45 MG			
	Mirtazapine Tab 7.5 MG			
	Mirtazapine Tab 15 MG			
	Mirtazapine Tab 30 MG			
	Mirtazapine Tab 45 MG			
Antidepressants – Misc.	Bupropion HCl Tab 75 MG		✓	
	Bupropion HCl Tab 100 MG		✓	
	Bupropion HCl Tab SR 12HR 100 MG		✓	
	Bupropion HCl Tab SR 12HR 150 MG		✓	
	Bupropion HCl Tab SR 12HR 200 MG		✓	
	Bupropion HCl Tab SR 24HR 150 MG		✓	
	Bupropion HCl Tab SR 24HR 300 MG		✓	
	~~Maprotiline HCl Tab 25 MG~~			
	~~Maprotiline HCl Tab 50 MG~~			
	~~Maprotiline HCl Tab 75 MG~~			
Antidepressants – Monoamine Oxidase Inhibitors (MAOIs)	Phenelzine Sulfate Tab 15 MG		✓	
	Selegiline TD Patch 24HR 6 MG/24HR		✓	
	Selegiline TD Patch 24HR 9 MG/24HR		✓	
	Selegiline TD Patch 24HR 12 MG/24HR		✓	
	Tranylcypromine Sulfate Tab 10 MG		✓	
Antidepressants – Selective Serotonin Reuptake Inhibitors (SSRIs)	Citalopram Hydrobromide Oral Soln 10 MG/5ML		✓	
	Citalopram Hydrobromide Tab 10 MG (Base Equiv)		✓	
	Citalopram Hydrobromide Tab 20 MG (Base Equiv)		✓	
	Citalopram Hydrobromide Tab 40 MG (Base Equiv)		✓	
	Escitalopram Oxalate Soln 5 MG/5ML (Base Equiv)		✓	
	Escitalopram Oxalate Tab 5 MG (Base Equiv)		✓	
	Escitalopram Oxalate Tab 10 MG (Base Equiv)		✓	
	Escitalopram Oxalate Tab 20 MG (Base Equiv)		✓	
	Fluoxetine HCl Cap 10 MG		✓	
	Fluoxetine HCl Cap 20 MG		✓	
	Fluoxetine HCl Cap 40 MG		✓	
	Fluoxetine HCl Cap Delayed Release 90 MG		✓	
	Fluoxetine HCl Solution 20 MG/5ML		✓	
	Fluvoxamine Maleate Cap ER 24HR 100 MG			May be considered for reimbursement upon submission of a prior authorization request that reflects a minimum of a 90-day trial and documented inadequate response to at least two (2) antidepressants within the past 240 days.
	Fluvoxamine Maleate Cap ER 24HR 150 MG			
	Fluvoxamine Maleate Tab 25 MG		✓	
	Fluvoxamine Maleate Tab 50 MG		✓	
	Fluvoxamine Maleate Tab 100 MG		✓	
	Paroxetine HCl Oral Susp 10 MG/5ML (Base Equiv)		✓	
	Paroxetine HCl Tab 10 MG		✓	
	Paroxetine HCl Tab 20 MG		✓	
	Paroxetine HCl Tab 30 MG		✓	
	Paroxetine HCl Tab 40 MG		✓	

Medication Class Name	Medication Generic Name	Brand name (if applicable)	Allowed Condition Needed	Reimbursement restrictions or limitations for specific medications or dosage forms are listed with the respective medications below.
	Paroxetine HCl Tab SR 24HR 12.5 MG			May be considered for reimbursement upon submission of a prior authorization request that reflects a minimum of a 90-day trial and documented inadequate response to at least two (2) antidepressants within the past 240 days.
	Paroxetine HCl Tab SR 24HR 25 MG			
	Paroxetine HCl Tab SR 24HR 37.5 MG			
	Sertraline HCl Oral Concentrate for Solution 20 MG/ML		✓	
	Sertraline HCl Tab 25 MG		✓	
	Sertraline HCl Tab 50 MG		✓	
	Sertraline HCl Tab 100 MG		✓	
Antidepressants – Serotonin Modulators	Nefazodone HCl Tab 50 MG			
	Nefazodone HCl Tab 100 MG			
	Nefazodone HCl Tab 150 MG			
	Nefazodone HCl Tab 200 MG			
	Nefazodone HCl Tab 250 MG			
	Trazodone HCl Tab 50 MG			
	Trazodone HCl Tab 100 MG			
	Trazodone HCl Tab 150 MG			
	Trazodone HCl Tab 300 MG			
	Vilazodone HCl Tab 10 MG		✓	
	Vilazodone HCl Tab 20 MG		✓	
	Vilazodone HCl Tab 40 MG		✓	
	Vilazodone HCl Tab Starter Kit 10 (7) & 20 (23) MG		✓	
Antidepressants – Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)	Desvenlafaxine Succinate Tab ER 24HR 25 MG (Base Equiv)			
	Desvenlafaxine Succinate Tab ER 24HR 50 MG (Base Equiv)			
	Desvenlafaxine Succinate Tab ER 24HR 100 MG (Base Equiv)			
	Desvenlafaxine Tab ER 24HR 50 MG			
	Desvenlafaxine Tab ER 24HR 100 MG			
	Duloxetine HCl Enteric Coated Pellets Cap 20 MG (Base Eq)			
	Duloxetine HCl Enteric Coated Pellets Cap 30 MG (Base Eq)			
	Duloxetine HCl Enteric Coated Pellets Cap 60 MG (Base Eq)			
	Venlafaxine HCl Cap SR 24HR 37.5 MG (Base Equivalent)			
	Venlafaxine HCl Cap SR 24HR 75 MG (Base Equivalent)			
	Venlafaxine HCl Cap SR 24HR 150 MG (Base Equivalent)			
	Venlafaxine HCl Tab 25 MG (Base Equivalent)			
	Venlafaxine HCl Tab 37.5 MG (Base Equivalent)			
	Venlafaxine HCl Tab 50 MG (Base Equivalent)			
	Venlafaxine HCl Tab 75 MG (Base Equivalent)			
	Venlafaxine HCl Tab 100 MG (Base Equivalent)			
	Venlafaxine HCl Tab ER 24HR 37.5 MG (Base Equivalent)			
	Venlafaxine HCl Tab ER 24HR 75 MG (Base Equivalent)			
	Venlafaxine HCl Tab ER 24HR 150 MG (Base Equivalent)			
	Venlafaxine HCl Tab ER 24HR 225 MG (Base Equivalent)			
Antidepressants – Tricyclic Agents	Amitriptyline HCl Tab 10 MG			
	Amitriptyline HCl Tab 25 MG			
	Amitriptyline HCl Tab 50 MG			
	Amitriptyline HCl Tab 75 MG			
	Amitriptyline HCl Tab 100 MG			
	Amitriptyline HCl Tab 150 MG			
	Amoxapine Tab 25 MG			
	Amoxapine Tab 50 MG			
	Amoxapine Tab 100 MG			
	Amoxapine Tab 150 MG			
	Clomipramine HCl Cap 25 MG			
	Clomipramine HCl Cap 50 MG			
	Clomipramine HCl Cap 75 MG			
	Desipramine HCl Tab 10 MG			
	Desipramine HCl Tab 25 MG			
	Desipramine HCl Tab 50 MG			
	Desipramine HCl Tab 75 MG			
	Desipramine HCl Tab 100 MG			
	Desipramine HCl Tab 150 MG			
	Doxepin HCl Cap 10 MG			
	Doxepin HCl Cap 25 MG			
	Doxepin HCl Cap 50 MG			
	Doxepin HCl Cap 75 MG			
	Doxepin HCl Cap 100 MG			
	Doxepin HCl Cap 150 MG			
	Doxepin HCl Conc 10 MG/ML			
	Imipramine HCl Tab 10 MG			
	Imipramine HCl Tab 25 MG			
	Imipramine HCl Tab 50 MG			
	Imipramine Pamoate Cap 75 MG			
	Imipramine Pamoate Cap 100 MG			
	Imipramine Pamoate Cap 125 MG			
	Imipramine Pamoate Cap 150 MG			
	Nortriptyline HCl Cap 10 MG			

Medication Class Name	Medication Generic Name	Brand name (if applicable)	Allowed Condition Needed	Reimbursement restrictions or limitations for specific medications or dosage forms are listed with the respective medications below.
	Nortriptyline HCl Cap 25 MG			
	Nortriptyline HCl Cap 50 MG			
	Nortriptyline HCl Cap 75 MG			
	Nortriptyline HCl Soln 10 MG/5ML			
	Protriptyline HCl Tab 5 MG			
	Protriptyline HCl Tab 10 MG			
	Trimipramine Maleate Cap 25 MG			
	Trimipramine Maleate Cap 50 MG			
	Trimipramine Maleate Cap 100 MG			
Antidiabetic – Alpha-Glucosidase Inhibitors	Acarbose Tab 25 MG		✓	
	Acarbose Tab 50 MG		✓	
	Acarbose Tab 100 MG		✓	
	Miglitol Tab 25 MG		✓	
	Miglitol Tab 50 MG		✓	
	Miglitol Tab 100 MG		✓	
Antidiabetic – Amylin Analogs	Pramlintide Acetate Pen-inj 1500 MCG/1.5ML (1000 MCG/ML)		✓	
	Pramlintide Acetate Pen-inj 2700 MCG/2.7ML (1000 MCG/ML)		✓	
Antidiabetic – Biguanides	Metformin HCl Tab 500 MG		✓	
	Metformin HCl Tab 850 MG		✓	
	Metformin HCl Tab 1000 MG		✓	
	Metformin HCl Tab SR 24HR 500 MG		✓	
	Metformin HCl Tab SR 24HR 750 MG		✓	
Antidiabetic – Diabetic Other	Glucagon ~~(rDNA)~~ For Inj ~~Kit~~ 1 MG		✓	
	Glucagon HCl ~~(rDNA)~~ For Inj 1 MG ~~(Base Equiv)~~		✓	
	Glucose Chew Tab 1 GM		✓	
	Glucose Chew Tab 4 GM (Rounded)		✓	
	Glucose Chew Tab 5 GM		✓	
	Glucose Gel 15 GM/32ML		✓	
	Glucose Gel 15 GM/33GM		✓	
	Glucose Gel 40%		✓	
	Glucose Gel 77.4%		✓	
	Glucose Oral Liquid 15 GM/59ML		✓	
	Glucose Oral Liquid 15 GM/60ML		✓	
Antidiabetic – Dipeptidyl Peptidase-4 (DPP-4) Inhibitors	Alogliptin Benzoate Tab 6.25 MG (Base Equiv)		✓	
	Alogliptin Benzoate Tab 12.5 MG (Base Equiv)		✓	
	Alogliptin Benzoate Tab 25 MG (Base Equiv)		✓	
	Linagliptin Tab 5 MG	TRADJENTA	✓	
	Saxagliptin HCl Tab 2.5 MG (Base Equiv)	ONGLYZA	✓	
	Saxagliptin HCl Tab 5 MG (Base Equiv)		✓	
	Sitagliptin Phosphate Tab 25 MG (Base Equiv)	JANUVIA	✓	
	Sitagliptin Phosphate Tab 50 MG (Base Equiv)		✓	
	Sitagliptin Phosphate Tab 100 MG (Base Equiv)		✓	
Antidiabetic – Incretin Mimetic Agents (GLP-1 Receptor Agonists)	Dulaglutide Soln Auto-injector 0.75 MG/0.5ML	TRULICITY	✓	Reimbursement limited to two (2) ML per 28 days.
	Dulaglutide Soln Auto-injector 1.5 MG/0.5ML		✓	
	Dulaglutide Soln Auto-injector 3 MG/0.5ML		✓	
	Dulaglutide Soln Auto-injector 4.5 MG/0.5ML		✓	
	Exenatide Extended Release for Susp Pen-injector 2 MG	BYDUREON	✓	
	Exenatide Extended Release Susp Auto-Injector 2 MG/0.85ML		✓	
	Exenatide Soln Pen-injector 5 MCG/0.02ML	BYETTA	✓	
	Exenatide Soln Pen-injector 10 MCG/0.04ML		✓	
	Liraglutide Soln Pen-injector 18 MG/3ML (6 MG/ML)	VICTOZA	✓	
	Semaglutide Tab 3 MG	RYBELSUS	✓	
	Semaglutide Tab 7 MG		✓	
	Semaglutide Tab 14 MG		✓	
	Semaglutide Soln Pen-Inj 0.25 or 0.5 MG/Dose (2 MG/1.5ML)	OZEMPIC	✓	
	Semaglutide Soln Pen-Inj 0.25 or 0.5 MG/Dose (2 MG/3ML)		✓	
	Semaglutide Soln Pen-Inj 1 MG/Dose (2 MG/1.5ML)		✓	
	Semaglutide Soln Pen-inj 1 MG/DOSE (4 MG/3ML)		✓	
	Semaglutide Soln Pen-inj 2 MG/DOSE (8 MG/3ML)		✓	
Antidiabetic – Incretin Mimetic Agents (GIP & GLP-1 Receptor Agonists)	Tirzepatide Soln Auto-injector 2.5 MG/0.5ML	MOUNJARO	✓	
	Tirzepatide Soln Auto-injector 5 MG/0.5ML		✓	
	Tirzepatide Soln Auto-injector 7.5 MG/0.5ML		✓	
	Tirzepatide Soln Auto-injector 10 MG/0.5ML		✓	
	Tirzepatide Soln Auto-injector 12.5 MG/0.5ML		✓	
	Tirzepatide Soln Auto-injector 15 MG/0.5ML		✓	
Antidiabetic – Insulin	Insulin Aspart (with Niacinamide) Inj 100 Unit/ML		✓	
	Insulin Aspart (with Niacinamide) Sol Pen-inj 100 Unit/ML		✓	
	Insulin Aspart Inj Soln 100 Unit/ML		✓	
	Insulin Aspart Prot & Aspart (Human) Inj 100 Unit/ML (70-30)		✓	
	Insulin Aspart Prot & Aspart Sus Pen-inj 100 Unit/ML (70-30)		✓	
	Insulin Aspart Soln Cartridge 100 Unit/ML		✓	
	Insulin Aspart Soln Pen-injector 100 Unit/ML		✓	
	Insulin Aspart-szjj Soln Pen-injector 100 Unit/ML		✓	
	Insulin Aspart-szjj Subcutaneous Soln 100 Unit/ML		✓	
	Insulin Degludec Soln Pen-Injector 100 Unit/ML		✓	
	Insulin Degludec Soln Pen-Injector 200 Unit/ML		✓	
	Insulin Glargine Inj 100 Unit/ML		✓	May be considered for reimbursement upon submission of a prior authorization request that reflects a documented allergic

Medication Class Name	Medication Generic Name	Brand name (if applicable)	Allowed Condition Needed	Reimbursement restrictions or limitations for specific medications or dosage forms are listed with the respective medications below.
	Insulin Glargine Soln Pen-Injector 100 Unit/ML		✓	reaction, adverse event, or an inadequate response after a minimum of a 90-day trial to insulin glargine-yfgn within the past 180 days.
	Insulin Glargine-yfgn Inj 100 Unit/ML		✓	
	Insulin Glargine-yfgn Soln Pen-Injector 100 Unit/ML		✓	
	Insulin Glargine Soln Pen-Injector 300 Unit/ML (1 Unit Dial)		✓	
	Insulin Glargine Soln Pen-Injector 300 Unit/ML (2 Unit Dial)		✓	
	Insulin Glulisine Inj 100 Unit/ML		✓	
	Insulin Glulisine Soln Pen-Injector Inj 100 Unit/ML		✓	
	Insulin Lispro Inj Soln 100 Unit/ML		✓	
	Insulin Lispro Soln Cartridge 100 Unit/ML		✓	
	Insulin Lispro Soln Pen-injector 200 Unit/ML		✓	
	Insulin Lispro Prot & Lispro Inj 100 Unit/ML (75-25)		✓	
	Insulin Lispro Prot & Lispro Sus Pen-inj 100 Unit/ML (50-50)		✓	
	Insulin Lispro Prot & Lispro Sus Pen-inj 100 Unit/ML (75-25)		✓	
	Insulin Lispro Protamine & Lispro Inj 100 Unit/ML (50-50)		✓	
	Insulin Lispro Soln Pen-injector 100 Unit/ML (1 Unit Dial)		✓	
	Insulin Lispro Soln Pen-injector 100 Unit/ML (0.5 Unit Dial)		✓	
	Insulin NPH & Regular Susp Pen-Inj 100 Unit/ML (70-30)		✓	
	Insulin NPH (Human) (Isophane) Inj 100 Unit/ML		✓	
	Insulin NPH (Human) (Isophane) Susp Pen-injector 100 Unit/ML		✓	
	Insulin NPH Isophane & Regular Human Inj 100 Unit/ML (70-30)		✓	
	Insulin Regular (Human) Inj 100 Unit/ML		✓	
	Insulin Regular (Human) Inj 500 Unit/ML		✓	
	Insulin Regular (Human) Soln Pen-Injector 500 Unit/ML		✓	
Antidiabetic – Meglitinide Analogues	Nateglinide Tab 60 MG		✓	
	Nateglinide Tab 120 MG		✓	
	Repaglinide Tab 0.5 MG		✓	
	Repaglinide Tab 1 MG		✓	
	Repaglinide Tab 2 MG		✓	
Antidiabetic – Sodium-Glucose Co-Transporter 2 (SGLT2) Inhibitors	Bexagliflozin Tab 20 MG	BRENZAVVY	✓	
	Canagliflozin Tab 100 MG	INVOKANA	✓	
	Canagliflozin Tab 300 MG		✓	
	Dapagliflozin Propanediol Tab 5 MG (Base Equivalent)	FARXIGA	✓	
	Dapagliflozin Propanediol Tab 10 MG (Base Equivalent)		✓	
	Empagliflozin Tab 10 MG	JARDIANCE	✓	
	Empagliflozin Tab 25 MG		✓	
	Ertugliflozin L-Pyroglutamic Acid Tab 5 MG (Base Equiv)	STEGLATRO	✓	
	Ertugliflozin L-Pyroglutamic Acid Tab 15 MG (Base Equiv)		✓	
Antidiabetic – Sulfonylurea	Glimepiride Tab 1 MG		✓	
	Glimepiride Tab 2 MG		✓	
	Glimepiride Tab 4 MG		✓	
	Glipizide Tab 5 MG		✓	
	Glipizide Tab 10 MG		✓	
	Glipizide Tab SR 24HR 2.5 MG		✓	
	Glipizide Tab SR 24HR 5 MG		✓	
	Glipizide Tab SR 24HR 10 MG		✓	
	Glyburide Micronized Tab 1.5 MG		✓	
	Glyburide Micronized Tab 3 MG		✓	
	Glyburide Micronized Tab 6 MG		✓	
	Glyburide Tab 1.25 MG		✓	
	Glyburide Tab 2.5 MG		✓	
	Glyburide Tab 5 MG		✓	
Antidiabetic – Thiazolidinediones (TZDs)	Pioglitazone HCl Tab 15 MG (Base Equiv)		✓	
	Pioglitazone HCl Tab 30 MG (Base Equiv)		✓	
	Pioglitazone HCl Tab 45 MG (Base Equiv)		✓	
Antidiarrheal/Probiotic Agents – Misc.	Bismuth Subsalicylate Chew Tab 262 MG		✓	
	Bismuth Subsalicylate Susp 262 MG/15ML		✓	
	Bismuth Subsalicylate Tab 262 MG		✓	
	Lactobacillus - Packet			May be considered for reimbursement upon submission of a prior authorization request with documented medical justification.
	Lactobacillus Cap			
	Lactobacillus Chew Tab			
	Lactobacillus Rhamnosus (GG) Cap			
	Lactobacillus Tab			
	Probiotic Product - Cap			
	Saccharomyces boulardii Cap 250 MG			
Antidiarrheal— Antiperistaltic Agents	Difenoxin w/ Atropine Tab 1-0.025 MG		✓	
	Diphenoxylate w/ Atropine Liq 2.5-0.025 MG/5ML		✓	
	Diphenoxylate w/ Atropine Tab 2.5-0.025 MG		✓	
	Loperamide HCl Cap 2 MG		✓	
	Loperamide HCl Liq 1 MG/5ML (0.2 MG/ML)		✓	
	Loperamide HCl Tab 2 MG		✓	

Medication Class Name	Medication Generic Name	Brand name (if applicable)	Allowed Condition Needed	Reimbursement restrictions or limitations for specific medications or dosage forms are listed with the respective medications below.
Antidotes – Chelating Agents	Succimer Cap 100 MG		✓	
Antiemetics	Aprepitant Capsule 80 MG		~~✓~~	May be considered for reimbursement upon submission of a prior authorization request that reflects a documented allergic reaction, adverse event, or an inadequate response after a minimum of a three (3) day trial of another agent in this class within the past 180 days.
	Aprepitant Capsule Therapy Pack 80 & 125 MG		~~✓~~	
	Dimenhydrinate Chew Tab 25 MG		✓	
	Dimenhydrinate Chew Tab 50 MG		✓	
	Dimenhydrinate Tab 50 MG		✓	
	Dronabinol Cap 2.5 MG			May be considered for reimbursement upon submission of a prior authorization request that reflects an allowed condition ~~of~~related to chemotherapy induced nausea and vomiting, or ~~a previous trial and~~ an inadequate response after a minimum of a three (3) day trial with at least one (1) antiemetic within the past 180 days.
	Dronabinol Cap 5 MG			
	Dronabinol Cap 10 MG			
	Granisetron HCl Tab 1 MG		✓	
	Meclizine HCl Chew Tab 25 MG		~~✓~~	
	Meclizine HCl Tab 12.5 MG		~~✓~~	
	Meclizine HCl Tab 25 MG		~~✓~~	
	Ondansetron Orally Disintegrating Tab 4 MG			
	Ondansetron Orally Disintegrating Tab 8 MG			
	Ondansetron HCl Tab 4 MG			
	Ondansetron HCl Tab 8 MG			
	Ondansetron HCl Oral Soln 4 MG/5ML		✓	
	Scopolamine TD Patch 72HR 1 MG/3DAYS		✓	
	Trimethobenzamide HCl Cap 300 MG		~~✓~~	May be considered for reimbursement upon submission of a prior authorization request that reflects a documented allergic reaction, adverse event, or an inadequate response after a minimum of a three (3) day trial of another agent in this class within the past 180 days.
Antifungals	Fluconazole For Susp 40 MG/ML		✓	
	Fluconazole Tab 50 MG		✓	
	Fluconazole Tab 100 MG		✓	
	Fluconazole Tab 150 MG		✓	
	Fluconazole Tab 200 MG		✓	
	Griseofulvin Microsize Susp 125 MG/5ML		✓	
	Griseofulvin Microsize Tab 500 MG		✓	
	Griseofulvin Ultramicrosize Tab 250 MG		✓	
	Isavuconazonium Sulfate Cap 186 MG	CRESEMBA		May be considered for reimbursement upon submission of a prior authorization request that reflects treatment for a fungal infection related to an allowed condition in the claim and previous trial and inadequate response of another agent in this class within the past 120 days.
	Itraconazole Cap 100 MG		✓	
	Itraconazole Oral Soln 10 MG/ML		✓	
	Ketoconazole Tab 200 MG		✓	
	Nystatin Tab 500000 Unit		✓	
	Posaconazole Susp 40 MG/ML		✓	
	Posaconazole Tab Delayed Release 100 MG		✓	
	Terbinafine HCl Tab 250 MG		✓	
	Voriconazole Tab 200 MG		✓	
Antihistamines	Carbinoxamine Maleate Tab 4 MG			
	Cetirizine HCl Oral Soln 1 MG/ML (5 MG/5ML)		✓	
	Cetirizine HCl Tab 5 MG		✓	
	Cetirizine HCl Tab 10 MG		✓	
	Chlorpheniramine Maleate Tab 4 MG			
	Clemastine Fumarate Tab 2.68 MG			
	Cyproheptadine HCl Tab 4 MG			
	Desloratadine Tab 5 MG		✓	
	Diphenhydramine HCl Cap 25 MG			
	Diphenhydramine HCl Cap 50 MG			
	Diphenhydramine HCl Liquid 12.5 MG/5ML			
	Diphenhydramine HCl Tab 25 MG			
	Fexofenadine HCl Tab 60 MG		✓	
	Fexofenadine HCl Tab 180 MG		✓	
	Levocetirizine Dihydrochloride Tab 5 MG		✓	
	Loratadine Oral Soln 5 MG/5ML		✓	
	Loratadine Tab 10 MG		✓	
	Promethazine HCl Suppos 12.5 MG		✓	
	Promethazine HCl Suppos 25 MG		✓	
	Promethazine HCl Suppos 50 MG		✓	
	Promethazine HCl ~~Syrup~~ Oral Soln 6.25 MG/5ML			
	Promethazine HCl Tab 12.5 MG			
	Promethazine HCl Tab 25 MG			
	Promethazine HCl Tab 50 MG			
Antihyperlipidemics – Bile Acid Sequestrants	Cholestyramine Light Powder 4 GM/DOSE		✓	
	Cholestyramine Light Powder Packets 4 GM		✓	
	Cholestyramine Powder 4 GM/DOSE		✓	
	Cholestyramine Powder Packets 4 GM		✓	
	Colesevelam HCl Packet For Susp 3.75 GM		✓	
	Colesevelam HCl Tab 625 MG		✓	
	Colestipol HCl Granule Packets 5 GM		✓	
	Colestipol HCl Tab 1 GM		✓	
Antihyperlipidemics – Combinations	Ezetimibe-Simvastatin Tab 10-10 MG		✓	
	Ezetimibe-Simvastatin Tab 10-20 MG		✓	
	Ezetimibe-Simvastatin Tab 10-40 MG		✓	
	Ezetimibe-Simvastatin Tab 10-80 MG		✓	

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Antihyperlipidemics – Fibric Acid Derivatives	Choline Fenofibrate Cap DR 45 MG (Fenofibric Acid Equiv)		✓	
	Choline Fenofibrate Cap DR 135 MG (Fenofibric Acid Equiv)		✓	
	Fenofibrate Cap 150 MG		✓	
	Fenofibrate Micronized Cap 130 MG		✓	
	Fenofibrate Micronized Cap 134 MG		✓	
	Fenofibrate Micronized Cap 200 MG		✓	
	Fenofibrate Tab 48 MG		✓	
	Fenofibrate Tab 54 MG		✓	
	Fenofibrate Tab 120 MG		✓	
	Fenofibrate Tab 145 MG		✓	
	Fenofibrate Tab 160 MG		✓	
	Gemfibrozil Tab 600 MG		✓	
Antihyperlipidemics – HMG CoA Reductase Inhibitors	Atorvastatin Calcium Tab 10 MG (Base Equivalent)		✓	
	Atorvastatin Calcium Tab 20 MG (Base Equivalent)		✓	
	Atorvastatin Calcium Tab 40 MG (Base Equivalent)		✓	
	Atorvastatin Calcium Tab 80 MG (Base Equivalent)		✓	
	Fluvastatin Sodium Tab SR 24 HR 80 MG		✓	
	Lovastatin Tab 10 MG		✓	
	Lovastatin Tab 20 MG		✓	
	Lovastatin Tab 40 MG		✓	
	Lovastatin Tab ER 24HR 60 MG		✓	
	Pitavastatin Calcium Tab 1 MG		✓	
	Pitavastatin Calcium Tab 2 MG		✓	
	Pitavastatin Calcium Tab 4 MG		✓	
	Pravastatin Sodium Tab 10 MG		✓	
	Pravastatin Sodium Tab 20 MG		✓	
	Pravastatin Sodium Tab 40 MG		✓	
	Pravastatin Sodium Tab 80 MG		✓	
	Rosuvastatin Calcium Tab 5 MG		✓	
	Rosuvastatin Calcium Tab 10 MG		✓	
	Rosuvastatin Calcium Tab 20 MG		✓	
	Rosuvastatin Calcium Tab 40 MG		✓	
	Simvastatin Tab 5 MG		✓	
	Simvastatin Tab 10 MG		✓	
	Simvastatin Tab 20 MG		✓	
	Simvastatin Tab 40 MG		✓	
	Simvastatin Tab 80 MG		✓	
Antihyperlipidemics – Intestinal Cholesterol Absorption Inhibitors	Ezetimibe Tab 10 MG		✓	
Antihyperlipidemics – Lecithin	Lecithin Cap 1200 MG		✓	~~May be considered for reimbursement upon submission of a prior authorization request with documented medical justification.~~
	Lecithin Chew Tab 1000 MG		✓	
Antihyperlipidemics – Misc.	Omega-3-acid Ethyl Esters Cap 1 GM		✓	
Antihyperlipidemics – Nicotinic Acid Derivatives	Niacin Tab ER 500 MG (Antihyperlipidemic)		✓	
	Niacin Tab ER 750 MG (Antihyperlipidemic)		✓	
	Niacin Tab ER 1000 MG (Antihyperlipidemic)		✓	
Antihyperlipidemics – Omega-3 Fatty Acids	Omega-3 Fatty Acids Cap 183.33 MG		✓	~~May be considered for reimbursement upon submission of a prior authorization request with documented medical justification.~~
	Omega-3 Fatty Acids Cap 150 MG		✓	
	Omega-3 Fatty Acids Cap 180 MG		✓	~~May be considered for reimbursement upon submission of a prior authorization request with documented medical justification.~~
	Omega-3 Fatty Acids Cap 554 MG		✓	
	Omega-3 Fatty Acids Cap 645 MG		✓	
	Omega-3 Fatty Acids Cap 875 MG		✓	
	Omega-3 Fatty Acids Cap 1000 MG		✓	
	Omega-3 Fatty Acids Cap 1200 MG		✓	
	Omega-3 Fatty Acids Cap Delayed Release 332.5 MG		✓	
	Omega-3 Fatty Acids Cap Delayed Release 350 MG		✓	~~May be considered for reimbursement upon submission of a prior authorization request with documented medical justification.~~
	Omega-3 Fatty Acids Cap Delayed Release 600 MG		✓	
	Omega-3 Fatty Acids Cap Delayed Release 1400 MG		✓	
Antihyperlipidemics – PCSK9 Inhibitors	Alirocumab Subcutaneous Solution Auto-injector 75 MG/ML	PRALUENT		May be considered for reimbursement upon submission of a prior authorization request that reflects atherosclerotic cardiovascular disease as an allowed condition and LDL ≥ 70 MG/dL despite maximally tolerated statin plus ezetimibe therapy for at least 90 days within the past 180 days.
	Alirocumab Subcutaneous Solution Auto-injector 150 MG/ML			
Antihypertensive Combinations	Aliskiren-Hydrochlorothiazide Tab 150-12.5 MG	TEKTURNA	✓	
	Aliskiren-Hydrochlorothiazide Tab 300-12.5 MG		✓	
	Amlodipine Besylate-Benazepril HCl Cap 2.5-10 MG		✓	
	Amlodipine Besylate-Benazepril HCl Cap 5-10 MG		✓	
	Amlodipine Besylate-Benazepril HCl Cap 5-20 MG		✓	
	Amlodipine Besylate-Benazepril HCl Cap 5-40 MG		✓	
	Amlodipine Besylate-Benazepril HCl Cap 10-20 MG		✓	
	Amlodipine Besylate-Benazepril HCl Cap 10-40 MG		✓	
	Amlodipine Besylate-Olmesartan Medoxomil Tab 5-20 MG		✓	
	Amlodipine Besylate-Olmesartan Medoxomil Tab 10-20 MG		✓	
	Amlodipine Besylate-Olmesartan Medoxomil Tab 10-40 MG		✓	

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	Amlodipine Besylate-Valsartan Tab 5-160 MG		✓	
	Amlodipine Besylate-Valsartan Tab 10-160 MG		✓	
	Amlodipine Besylate-Valsartan Tab 10-320 MG		✓	
	Amlodipine-Valsartan-Hydrochlorothiazide Tab 5-160-12.5 MG		✓	
	Amlodipine-Valsartan-Hydrochlorothiazide Tab 5-160-25 MG		✓	
	Amlodipine-Valsartan-Hydrochlorothiazide Tab 10-160-12.5 MG		✓	
	Amlodipine-Valsartan-Hydrochlorothiazide Tab 10-320-25 MG		✓	
	Atenolol & Chlorthalidone Tab 50-25 MG		✓	
	Atenolol & Chlorthalidone Tab 100-25 MG		✓	
	Bisoprolol & Hydrochlorothiazide Tab 2.5-6.25 MG		✓	
	Bisoprolol & Hydrochlorothiazide Tab 5-6.25 MG		✓	
	Bisoprolol & Hydrochlorothiazide Tab 10-6.25 MG		✓	
	Candesartan Cilexetil-Hydrochlorothiazide Tab 16-12.5 MG		✓	
	Candesartan Cilexetil-Hydrochlorothiazide Tab 32-12.5 MG		✓	
	Candesartan Cilexetil-Hydrochlorothiazide Tab 32-25 MG		✓	
	Enalapril Maleate & Hydrochlorothiazide Tab 10-25 MG		✓	
	Irbesartan-Hydrochlorothiazide Tab 150-12.5 MG		✓	
	Irbesartan-Hydrochlorothiazide Tab 300-12.5 MG		✓	
	Lisinopril & Hydrochlorothiazide Tab 10-12.5 MG		✓	
	Lisinopril & Hydrochlorothiazide Tab 20-12.5 MG		✓	
	Lisinopril & Hydrochlorothiazide Tab 20-25 MG		✓	
	Losartan Potassium & Hydrochlorothiazide Tab 50-12.5 MG		✓	
	Losartan Potassium & Hydrochlorothiazide Tab 100-12.5 MG		✓	
	Losartan Potassium & Hydrochlorothiazide Tab 100-25 MG		✓	
	Metoprolol & Hydrochlorothiazide Tab 50-25 MG		✓	
	Olmesartan Medoxomil-Hydrochlorothiazide Tab 20-12.5 MG		✓	
	Olmesartan Medoxomil-Hydrochlorothiazide Tab 40-12.5 MG		✓	
	Olmesartan Medoxomil-Hydrochlorothiazide Tab 40-25 MG		✓	
	Olmesartan-Amlodipine-Hydrochlorothiazide Tab 20-5-12.5 MG		✓	
	Olmesartan-Amlodipine-Hydrochlorothiazide Tab 40-5-12.5 MG		✓	
	Olmesartan-Amlodipine-Hydrochlorothiazide Tab 40-5-25 MG		✓	
	Olmesartan-Amlodipine-Hydrochlorothiazide Tab 40-10-25 MG		✓	
	Quinapril-Hydrochlorothiazide Tab 20-12.5 MG		✓	
	Quinapril-Hydrochlorothiazide Tab 20-25 MG		✓	
	Telmisartan-Amlodipine Tab 40-5 MG		✓	
	Telmisartan-Amlodipine Tab 80-10 MG		✓	
	Trandolapril-Verapamil HCl Tab ER 2-240 MG		✓	
	Trandolapril-Verapamil HCl Tab ER 4-240 MG		✓	
	Valsartan-Hydrochlorothiazide Tab 80-12.5 MG		✓	
	Valsartan-Hydrochlorothiazide Tab 160-12.5 MG		✓	
	Valsartan-Hydrochlorothiazide Tab 160-25 MG		✓	
	Valsartan-Hydrochlorothiazide Tab 320-12.5 MG		✓	
	Valsartan-Hydrochlorothiazide Tab 320-25 MG		✓	
Antihypertensive – ACE Inhibitors	Benazepril HCl Tab 5 MG		✓	
	Benazepril HCl Tab 10 MG		✓	
	Benazepril HCl Tab 20 MG		✓	
	Benazepril HCl Tab 40 MG		✓	
	Captopril Tab 12.5 MG		✓	
	Captopril Tab 25 MG		✓	
	Captopril Tab 50 MG		✓	
	Captopril Tab 100 MG		✓	
	Enalapril Maleate Tab 2.5 MG		✓	
	Enalapril Maleate Tab 5 MG		✓	
	Enalapril Maleate Tab 10 MG		✓	
	Enalapril Maleate Tab 20 MG		✓	
	Fosinopril Sodium Tab 10 MG		✓	
	Fosinopril Sodium Tab 20 MG		✓	
	Lisinopril Tab 2.5 MG		✓	
	Lisinopril Tab 5 MG		✓	
	Lisinopril Tab 10 MG		✓	
	Lisinopril Tab 20 MG		✓	
	Lisinopril Tab 30 MG		✓	
	Lisinopril Tab 40 MG		✓	
	Moexipril HCl Tab 15 MG		✓	
	Quinapril HCl Tab 5 MG		✓	
	Quinapril HCl Tab 10 MG		✓	
	Quinapril HCl Tab 20 MG		✓	
	Quinapril HCl Tab 40 MG		✓	
	Ramipril Cap 1.25 MG		✓	
	Ramipril Cap 2.5 MG		✓	
	Ramipril Cap 5 MG		✓	

Medication Class Name	Medication Generic Name	Brand name (if applicable)	Allowed Condition Needed	Reimbursement restrictions or limitations for specific medications or dosage forms are listed with the respective medications below.
	Ramipril Cap 10 MG		✓	
	Trandolapril Tab 1 MG		✓	
	Trandolapril Tab 2 MG		✓	
Antihypertensives – Agents for Pheochromocytoma	Phenoxybenzamine HCl Cap 10 MG		✓	
Antihypertensives – Angiotensin II Receptor Antagonists	Candesartan Cilexetil Tab 8 MG		✓	
	Candesartan Cilexetil Tab 16 MG		✓	
	Candesartan Cilexetil Tab 32 MG		✓	
	Irbesartan Tab 75 MG		✓	
	Irbesartan Tab 150 MG		✓	
	Irbesartan Tab 300 MG		✓	
	Losartan Potassium Tab 25 MG		✓	
	Losartan Potassium Tab 50 MG		✓	
	Losartan Potassium Tab 100 MG		✓	
	Olmesartan Medoxomil Tab 5 MG		✓	
	Olmesartan Medoxomil Tab 20 MG		✓	
	Olmesartan Medoxomil Tab 40 MG		✓	
	Telmisartan Tab 80 MG		✓	
	Valsartan Tab 40 MG		✓	
	Valsartan Tab 80 MG		✓	
	Valsartan Tab 160 MG		✓	
	Valsartan Tab 320 MG		✓	
Antihypertensives – Antiadrenergic Antihypertensives	Clonidine HCl Tab 0.1 MG			
	Clonidine HCl Tab 0.2 MG			
	Clonidine HCl Tab 0.3 MG			
	Clonidine TD Patch Weekly 0.1 MG/24HR		✓	
	Clonidine TD Patch Weekly 0.2 MG/24HR		✓	
	Clonidine TD Patch Weekly 0.3 MG/24HR		✓	
	Doxazosin Mesylate Tab 1 MG		✓	
	Doxazosin Mesylate Tab 2 MG		✓	
	Doxazosin Mesylate Tab 4 MG		✓	
	Doxazosin Mesylate Tab 8 MG		✓	
	Guanfacine HCl Tab 1 MG		✓	
	Guanfacine HCl Tab 2 MG		✓	
	Prazosin HCl Cap 1 MG		✓	
	Prazosin HCl Cap 2 MG		✓	
	Prazosin HCl Cap 5 MG		✓	
	Terazosin HCl Cap 1 MG (Base Equivalent)		✓	
	Terazosin HCl Cap 2 MG (Base Equivalent)		✓	
	Terazosin HCl Cap 5 MG (Base Equivalent)		✓	
	Terazosin HCl Cap 10 MG (Base Equivalent)		✓	
Antihypertensive – Direct Renin Inhibitors	Aliskiren Fumarate Tab 150 MG (Base Equivalent)		✓	
	Aliskiren Fumarate Tab 300 MG (Base Equivalent)		✓	
Antihypertensive – Selective Aldosterone Receptor Antagonists	Eplerenone Tab 25 MG		✓	
	Eplerenone Tab 50 MG		✓	
Antihypertensive – Vasodilators	Hydralazine HCl Tab 10 MG		✓	
	Hydralazine HCl Tab 25 MG		✓	
	Hydralazine HCl Tab 50 MG		✓	
	Hydralazine HCl Tab 100 MG		✓	
	Minoxidil Tab 2.5 MG		✓	
	Minoxidil Tab 10 MG		✓	
Anti-infective Agents – Misc.	Atovaquone Susp 750 MG/5ML		✓	
	Clindamycin HCl Cap 150 MG		✓	
	Clindamycin HCl Cap 300 MG		✓	
	Clindamycin Palmitate HCl For Soln 75 MG/5ML (Base Equiv)		✓	
	Dapsone Tab 25 MG		✓	
	Dapsone Tab 100 MG		✓	
	Linezolid For Susp 100 MG/5ML		✓	
	Linezolid Tab 600 MG		✓	
	Metronidazole Cap 375 MG		✓	
	Metronidazole Tab 250 MG		✓	
	Metronidazole Tab 500 MG		✓	
	Nitazoxanide Tab 500 MG		✓	
	Rifaximin Tab 200 MG	XIFAXIN	✓	
	Rifaximin Tab 550 MG		✓	
	Sulfamethoxazole-Trimethoprim Susp 200-40 MG/5ML		✓	
	Sulfamethoxazole-Trimethoprim Tab 400-80 MG		✓	
	Sulfamethoxazole-Trimethoprim Tab 800-160 MG		✓	
	Tinidazole Tab 500 MG		✓	
	Trimethoprim Tab 100 MG		✓	
	Vancomycin HCl Cap 125 MG (Base Equivalent)		✓	
	Vancomycin HCl Cap 250 MG (Base Equivalent)		✓	
Antimalarial	Atovaquone-Proguanil HCl Tab 250-100 MG		✓	
	Chloroquine Phosphate Tab 250 MG		✓	
	Hydroxychloroquine Sulfate Tab 200 MG		✓	
	Mefloquine HCl Tab 250 MG		✓	
	Quinine Sulfate Cap 324 MG		✓	
Antimyasthenic/ Cholinergic Agents	Pyridostigmine Bromide Tab 60 MG		✓	
	Pyridostigmine Bromide Tab ER 180 MG		✓	
Antimycobacterial Agents	Ethambutol HCl Tab 100 MG		✓	
	Ethambutol HCl Tab 400 MG		✓	
	Isoniazid Tab 300 MG		✓	
	Pyrazinamide Tab 500 MG		✓	
	Rifampin Cap 150 MG		✓	

Medication Class Name	Medication Generic Name	Brand name (if applicable)	Allowed Condition Needed	Reimbursement restrictions or limitations for specific medications or dosage forms are listed with the respective medications below.
	Rifampin Cap 300 MG		✓	
Antineoplastic – (Cancer Agents)	Antineoplastic drugs prescribed per OAC 4123-6-21.3(F)(2).		✓	
Antineoplastic – Antimetabolites	Methotrexate Oral Soln 2 MG/ML		✓	
	Methotrexate Oral Soln 2.5 MG/ML		✓	
	Methotrexate Sodium Tab 2.5 MG (Base Equiv)		✓	
	Methotrexate Sodium Tab 5 MG (Base Equiv)		✓	
	Methotrexate Sodium Tab 7.5 MG (Base Equiv)		✓	
	Methotrexate Sodium Tab 10 MG (Base Equiv)		✓	
	Methotrexate Sodium Tab 15 MG (Base Equiv)		✓	
Antiparkinson Agents	Amantadine HCl Cap 100 MG		✓	
	Amantadine HCl Tab 100 MG		✓	
	Benztropine Mesylate Tab 0.5 MG		✓	
	Benztropine Mesylate Tab 1 MG		✓	
	Benztropine Mesylate Tab 2 MG		✓	
	Bromocriptine Mesylate Cap 5 MG (Base Equivalent)		✓	
	Carbidopa & Levodopa Tab 10-100 MG		✓	
	Carbidopa & Levodopa Tab 25-100 MG		✓	
	Carbidopa & Levodopa Tab 25-250 MG		✓	
	Carbidopa & Levodopa Tab ER 25-100 MG		✓	
	Carbidopa & Levodopa Tab ER 50-200 MG		✓	
	Entacapone Tab 200 MG		✓	
	Pramipexole Dihydrochloride Tab 0.125 MG		✓	
	Pramipexole Dihydrochloride Tab 0.25 MG		✓	
	Pramipexole Dihydrochloride Tab 0.5 MG		✓	
	Pramipexole Dihydrochloride Tab 1 MG		✓	
	Pramipexole Dihydrochloride Tab 1.5 MG		✓	
	Pramipexole Dihydrochloride Tab ER 24HR 0.375 MG		✓	
	Pramipexole Dihydrochloride Tab ER 24HR 0.75 MG		✓	
	Pramipexole Dihydrochloride Tab ER 24HR 1.5 MG		✓	
	Rasagiline Mesylate Tab 1 MG (Base Equiv)		✓	
	Ropinirole Hydrochloride Tab 0.25 MG		✓	
	Ropinirole Hydrochloride Tab 0.5 MG		✓	
	Ropinirole Hydrochloride Tab 1 MG		✓	
	Ropinirole Hydrochloride Tab 2 MG		✓	
	Ropinirole Hydrochloride Tab 3 MG		✓	
	Ropinirole Hydrochloride Tab 4 MG		✓	
	Ropinirole Hydrochloride Tab 5 MG		✓	
	Ropinirole Hydrochloride Tab ER 24HR 2 MG (Base Equivalent)		✓	
	Ropinirole Hydrochloride Tab ER 24HR 4 MG (Base Equivalent)		✓	
	Ropinirole Hydrochloride Tab ER 24HR 6 MG (Base Equivalent)		✓	
	Ropinirole Hydrochloride Tab ER 24HR 8 MG (Base Equivalent)		✓	
	Ropinirole Hydrochloride Tab ER 24HR 12 MG (Base Equivalent)		✓	
	Trihexyphenidyl HCl Tab 2 MG		✓	
	Trihexyphenidyl HCl Tab 5 MG		✓	
Antipsoriatics	Acitretin Cap 25 MG		✓	
	Calcipotriene Cream 0.005%		✓	
	Calcipotriene Soln 0.005% (50 MCG/ML)		✓	
	Tazarotene Cream 0.1%		✓	
Antipsychotics	ALL antipsychotic agents			Except as noted for specific agents below, these restrictions apply to all antipsychotic agents: • May be reimbursed in claims with an allowed condition of schizophrenia, bipolar disorder, or psychosis. • Prior authorization request with documentation of Abnormal Involuntary Movement Scale (AIMS) testing is required at initial antipsychotic prescribing and every six (6) months thereafter for ongoing use of all antipsychotic medications. • Concurrent use of multiple antipsychotics will not be approved.
Antipsychotics – Antimanic Agents	Lithium Carbonate Cap 150 MG		✓	Class restriction does not apply.
	Lithium Carbonate Cap 300 MG		✓	
	Lithium Carbonate Cap 600 MG		✓	
	Lithium Carbonate Tab 300 MG		✓	
	Lithium Carbonate Tab ER 300 MG		✓	
	Lithium Carbonate Tab ER 450 MG		✓	
	Lithium Oral Solution 8 mEq/5ML		✓	
Antipsychotics – Benzisoxazoles	Paliperidone Tab ER 24HR 1.5 MG			See ALL antipsychotic agents reimbursement restrictions.
	Paliperidone Tab SR 24HR 3 MG			
	Paliperidone Tab SR 24HR 6 MG			
	Paliperidone Tab SR 24HR 9 MG			
	Risperidone Orally Disintegrating Tab 0.25 MG			See ALL antipsychotic agents reimbursement restrictions. Additionally, reimbursement for oral disintegrating dosage form is limited to claims with an allowed condition that results in the inability to swallow or absorb oral medications.
	Risperidone Orally Disintegrating Tab 0.5 MG			
	Risperidone Orally Disintegrating Tab 1 MG			
	Risperidone Orally Disintegrating Tab 2 MG			
	Risperidone Orally Disintegrating Tab 3 MG			
	Risperidone Orally Disintegrating Tab 4 MG			
	Risperidone Soln 1 MG/ML			See ALL antipsychotic agents reimbursement restrictions.
	Risperidone Tab 0.25 MG			
	Risperidone Tab 0.5 MG			
	Risperidone Tab 1 MG			
	Risperidone Tab 2 MG			

Medication Class Name	Medication Generic Name	Brand name (if applicable)	Allowed Condition Needed	Reimbursement restrictions or limitations for specific medications or dosage forms are listed with the respective medications below.
	Risperidone Tab 3 MG			
	Risperidone Tab 4 MG			
Antipsychotics – Butyrophenones	Haloperidol Lactate Oral Conc 2 MG/ML			See ALL antipsychotic agents reimbursement restrictions.
	Haloperidol Tab 0.5 MG			
	Haloperidol Tab 1 MG			
	Haloperidol Tab 2 MG			
	Haloperidol Tab 5 MG			
	Haloperidol Tab 10 MG			
	Haloperidol Tab 20 MG			
Antipsychotics– Psychotherapeutics Combination	Olanzapine-Fluoxetine HCl Cap 3-25 MG			See ALL antipsychotic agents reimbursement restrictions. Additionally, may be considered for reimbursement for augmentation of antidepressant therapy upon submission of a prior authorization request that reflects: • The injured worker has an allowed condition of major depressive disorder or dysthymic disorder, and • A minimum of a 90-day trial and documented inadequate response or intolerance to at least two antidepressants of different classes within the past 240 days.
	Olanzapine-Fluoxetine HCl Cap 6-25 MG			
	Olanzapine-Fluoxetine HCl Cap 6-50 MG			
	Olanzapine-Fluoxetine HCl Cap 12-25 MG			
	Olanzapine-Fluoxetine HCl Cap 12-50 MG			
	Perphenazine-Amitriptyline Tab 2-10 MG			See ALL antipsychotic agents reimbursement restrictions.
	Perphenazine-Amitriptyline Tab 2-25 MG			
	Perphenazine-Amitriptyline Tab 4-10 MG			
	Perphenazine-Amitriptyline Tab 4-25 MG			
	Perphenazine-Amitriptyline Tab 4-50 MG			
Antipsychotics – Dibenzapines	Asenapine Maleate SL Tab 2.5 MG (Base Equiv)			See ALL antipsychotic agents reimbursement restrictions. Additionally, reimbursement for sublingual dosage form is limited to claims with an allowed condition that results in the inability to swallow or absorb oral medications.
	Asenapine Maleate SL Tab 5 MG (Base Equiv)			
	Asenapine Maleate SL Tab 10 MG (Base Equiv)			
	Clozapine Orally Disintegrating Tab 12.5 MG			See ALL antipsychotic agents reimbursement restrictions. Additionally, reimbursement for oral disintegrating dosage form is limited to claims with an allowed condition that results in the inability to swallow or absorb oral medications.
	Clozapine Orally Disintegrating Tab 25 MG			
	Clozapine Orally Disintegrating Tab 100 MG			
	Clozapine Orally Disintegrating Tab 150 MG			
	Clozapine Orally Disintegrating Tab 200 MG			
	Clozapine Tab 25 MG			See ALL antipsychotic agents reimbursement restrictions.
	Clozapine Tab 50 MG			
	Clozapine Tab 100 MG			
	Clozapine Tab 200 MG			
	Loxapine Succinate Cap 5 MG			
	Loxapine Succinate Cap 10 MG			
	Loxapine Succinate Cap 25 MG			
	Loxapine Succinate Cap 50 MG			
	Olanzapine Orally Disintegrating Tab 5 MG			See ALL antipsychotic agents reimbursement restrictions. Additionally, may be considered for reimbursement for augmentation of antidepressant therapy upon submission of a prior authorization request that reflects: • Olanzapine is being used in combination with fluoxetine, and • The injured worker has an allowed condition of major depressive disorder or dysthymic disorder, and • A minimum of a 90-day trial and documented inadequate response or intolerance to at least two antidepressants of different classes within the past 240 days. Reimbursement for oral disintegrating dosage form is limited to claims with an allowed condition that results in the inability to swallow or absorb oral medications.
	Olanzapine Orally Disintegrating Tab 10 MG			
	Olanzapine Orally Disintegrating Tab 15 MG			
	Olanzapine Orally Disintegrating Tab 20 MG			
	Olanzapine Tab 2.5 MG			
	Olanzapine Tab 5 MG			
	Olanzapine Tab 7.5 MG			
	Olanzapine Tab 10 MG			
	Olanzapine Tab 15 MG			
	Olanzapine Tab 20 MG			
	Quetiapine Fumarate Tab 25 MG			See ALL antipsychotic agents reimbursement restrictions.
	Quetiapine Fumarate Tab 50 MG			
	Quetiapine Fumarate Tab 100 MG			
	Quetiapine Fumarate Tab 200 MG			
	Quetiapine Fumarate Tab 300 MG			
	Quetiapine Fumarate Tab 400 MG			
	Quetiapine Fumarate Tab ER 24HR 50 MG			See ALL antipsychotic agents reimbursement restrictions. Additionally, may be considered for reimbursement for augmentation of antidepressant therapy upon submission of a prior authorization request that reflects: • Quetiapine ER is being used in combination with an antidepressant, and • The injured worker has an allowed condition of major depressive disorder or dysthymic disorder, and • A minimum of a 90-day trial and documented inadequate response or intolerance to at least two antidepressants of different classes within the past 240 days.
	Quetiapine Fumarate Tab ER 24HR 150 MG			
	Quetiapine Fumarate Tab SR 24HR 200 MG			
	Quetiapine Fumarate Tab SR 24HR 300 MG			
	Quetiapine Fumarate Tab SR 24HR 400 MG			
Antipsychotics – Dihydroindolones	Molindone HCl Tab 5 MG			See ALL antipsychotic agents reimbursement restrictions.
	Molindone HCl Tab 10 MG			
	Molindone HCl Tab 25 MG			
Antipsychotics – Misc.	Lurasidone HCl Tab 20 MG			See ALL antipsychotic agents reimbursement restrictions.
	Lurasidone HCl Tab 40 MG			
	Lurasidone HCl Tab 60 MG			
	Lurasidone HCl Tab 80 MG			
	Lurasidone HCl Tab 120 MG			
	Ziprasidone HCl Cap 20 MG			
	Ziprasidone HCl Cap 40 MG			
	Ziprasidone HCl Cap 60 MG			
	Ziprasidone HCl Cap 80 MG			
Antipsychotics – Phenothiazines	Chlorpromazine HCl Tab 10 MG			See ALL antipsychotic agents reimbursement restrictions.
	Chlorpromazine HCl Tab 25 MG			
	Chlorpromazine HCl Tab 50 MG			

Medication Class Name	Medication Generic Name	Brand name (if applicable)	Allowed Condition Needed	Reimbursement restrictions or limitations for specific medications or dosage forms are listed with the respective medications below.
	Chlorpromazine HCl Tab 100 MG			
	Chlorpromazine HCl Tab 200 MG			
	Fluphenazine HCl Elixir 2.5 MG/5ML			
	Fluphenazine HCl Oral Conc 5 MG/ML			
	Fluphenazine HCl Tab 1 MG			
	Fluphenazine HCl Tab 2.5 MG			
	Fluphenazine HCl Tab 5 MG			
	Fluphenazine HCl Tab 10 MG			
	Perphenazine Tab 2 MG			
	Perphenazine Tab 4 MG			
	Perphenazine Tab 8 MG			
	Perphenazine Tab 16 MG			
	Prochlorperazine Maleate Tab 5 MG (Base Equivalent)			Class restriction does not apply.
	Prochlorperazine Maleate Tab 10 MG (Base Equivalent)			
	Prochlorperazine Suppos 25 MG			
	Thioridazine HCl Tab 10 MG			See ALL antipsychotic agents reimbursement restrictions.
	Thioridazine HCl Tab 25 MG			
	Thioridazine HCl Tab 50 MG			
	Thioridazine HCl Tab 100 MG			
	Trifluoperazine HCl Tab 1 MG (Base Equivalent)			
	Trifluoperazine HCl Tab 2 MG (Base Equivalent)			
	Trifluoperazine HCl Tab 5 MG (Base Equivalent)			
	Trifluoperazine HCl Tab 10 MG (Base Equivalent)			
Antipsychotics – Quinolinone Derivatives	Aripiprazole Oral Solution 1 MG/ML			See ALL antipsychotic agents reimbursement restrictions. Additionally, may be considered for reimbursement for augmentation of antidepressant therapy upon submission of a prior authorization request that reflects: • Aripiprazole is being used in combination with an antidepressant • The injured worker has an allowed condition of major depressive disorder or dysthymic disorder, and • A minimum of a 90-day trial and documented inadequate response or intolerance to at least two antidepressants of different classes within the past 240 days. Reimbursement for oral disintegrating dosage form is limited to claims with an allowed condition that results in the inability to swallow or absorb oral medications.
	Aripiprazole Orally Disintegrating Tab 10 MG			
	Aripiprazole Orally Disintegrating Tab 15 MG			
	Aripiprazole Tab 2 MG			
	Aripiprazole Tab 5 MG			
	Aripiprazole Tab 10 MG			
	Aripiprazole Tab 15 MG			
	Aripiprazole Tab 20 MG			
	Aripiprazole Tab 30 MG			
Antipsychotics – Thioxanthenes	Thiothixene Cap 1 MG			See ALL antipsychotic agents reimbursement restrictions.
	Thiothixene Cap 2 MG			
	Thiothixene Cap 5 MG			
	Thiothixene Cap 10 MG			
Antivirals— Antiretrovirals	Antiretroviral drugs prescribed per OAC 4123-6-21.3(F)(3).		✓	
Antivirals – Cytomegalovirus (CMV) Agents	Valganciclovir HCl Tab 450 MG (Base Equivalent)		✓	
Antivirals – Hepatitis Agents	Elbasvir-Grazoprevir Tab 50-100 MG		✓	
	Glecaprevir-Pibrentasvir Tab 100-40 MG		✓	
	Ledipasvir-Sofosbuvir Tab 90-400 MG		✓	
	Peginterferon alfa-2a Soln Prefilled Syr 180 MCG/0.5ML		✓	
	Peginterferon alfa-2b For Inj Kit 50 MCG/0.5ML		✓	
	Ribavirin Cap 200 MG		✓	
	Ribavirin Tab 200 MG		✓	
	Sofosbuvir Tab 400 MG		✓	
	Sofosbuvir-Velpatasvir Tab 400-100 MG		✓	
Antivirals – Herpes Agents	Acyclovir Cap 200 MG		✓	
	Acyclovir Susp 200 MG/5ML		✓	
	Acyclovir Tab 400 MG		✓	
	Acyclovir Tab 800 MG		✓	
	Famciclovir Tab 125 MG		✓	
	Famciclovir Tab 250 MG		✓	
	Famciclovir Tab 500 MG		✓	
	Valacyclovir HCl Tab 500 MG		✓	
	Valacyclovir HCl Tab 1 GM		✓	
Antiviral— Influenza Agents	Oseltamivir Phosphate Cap 75 MG (Base Equiv)		✓	
	Zanamivir Aerosol Powder Breath Activated 5 MG/ACT		✓	
Antirheumatic – Anti-TNF-alpha – Monoclonal Antibodies	Adalimumab Auto-injector Kit 40 MG/0.4ML	HUMIRA		May be considered for reimbursement upon submission of a prior authorization request that reflects a documented allergic reaction, adverse event, or an inadequate response after a minimum of a 90-day trial to adalimumab-bwwd within the past 180 days.
	Adalimumab Auto-injector Kit 40 MG/0.8ML			
	Adalimumab Prefilled Syringe Kit 40 MG/0.4ML			
	Adalimumab Prefilled Syringe Kit 40 MG/0.8ML			
	Adalimumab-bwwd Soln Auto-injector 40 MG/0.4ML		✓	
	Adalimumab-bwwd Soln Auto-injector 40 MG/0.8ML		✓	
	Adalimumab-bwwd Soln Prefilled Syringe 40 MG/0.4ML		✓	
	Adalimumab-bwwd Soln Prefilled Syringe 40 MG/0.8ML		✓	
	Certolizumab Pegol For Inj Kit 2 x 200 MG	CIMZIA		May be considered for reimbursement upon submission of a prior authorization request. Reimbursement will only be considered in claims with an allowed condition of rheumatoid arthritis.
	Certolizumab Pegol Prefilled Syringe Kit 200 MG/ML			
	Golimumab Subcutaneous Soln Auto-injector 50 MG/0.5ML	SIMPONI		

Medication Class Name	Medication Generic Name	Brand name (if applicable)	Allowed Condition Needed	Reimbursement restrictions or limitations for specific medications or dosage forms are listed with the respective medications below.
	Golimumab Subcutaneous Soln Auto-injector 100 MG/ML			
	Golimumab Subcutaneous Soln Prefilled Syringe 50 MG/0.5ML			
	Golimumab Subcutaneous Soln Prefilled Syringe 100 MG/ML			
Antirheumatic – Enzyme Inhibitors	Baricitinib Tab 1 MG	OLUMIANT		May be considered for reimbursement upon submission of a prior authorization request. Reimbursement will only be considered in claims with an allowed condition of rheumatoid arthritis.
	Baricitinib Tab 2 MG			
	Tofacitinib Citrate Tab 5 MG (Base equivalent)	XELJANZ		
	Tofacitinib Citrate Tab 10 MG (Base equivalent)			
	Tofacitinib Citrate Tab ER 24HR 11 MG (Base equivalent)			
	Tofacitinib Citrate Tab ER 24HR 22 MG (Base equivalent)			
	Upadacitinib Tab ER 24HR 15 MG	RINVOQ		
Antirheumatic – Pyrimidine Synthesis Inhibitors	Leflunomide Tab 10 MG		✓	
	Leflunomide Tab 20 MG		✓	
Antirheumatic – Selective Costimulation Modulator	Abatacept Subcutaneous Soln Auto-Injector 125 MG/ML	ORENCIA		May be considered for reimbursement upon submission of a prior authorization request. Reimbursement will only be considered in claims with an allowed condition of rheumatoid arthritis.
	Abatacept Subcutaneous Soln Prefilled Syringe 50 MG/0.4ML			
	Abatacept Subcutaneous Soln Prefilled Syringe 87.5 MG/0.7ML			
	Abatacept Subcutaneous Soln Prefilled Syringe 125 MG/ML			
Antirheumatic TNF – Soluble Tumor Necrosis Factor Receptor Agents	Etanercept Subcutaneous Soln Prefilled Syringe 25 MG/0.5ML	ENBREL	✓	
	Etanercept Subcutaneous Soln Prefilled Syringe 50 MG/ML		✓	
	Etanercept Subcutaneous Solution Auto-injector 50 MG/ML		✓	
	Etanercept Subcutaneous Solution Cartridge 50 MG/ML		✓	
Antiseptics & Disinfectants	Cadexomer Iodine Gel 0.9%			May be considered for reimbursement upon submission of a prior authorization request with documented medical justification.
	Chlorhexidine Gluconate Liquid 4%			
	Chlorhexidine Gluconate Soln 4%			
	Sodium Hypochlorite Soln 0.125%		✓	
	Sodium Hypochlorite Soln 0.25%		✓	
	Sodium Hypochlorite Soln 0.5%		✓	
	Formaldehyde Solution 10%			
	Hydrogen Peroxide Soln 3%			
	Povidone-Iodine Oint 10%			
	Povidone-Iodine Soln 7.5%			
	Povidone-Iodine Soln 10%			
	Povidone-Iodine Swabs 10%			
Beta Blockers	Acebutolol HCl Cap 200 MG		✓	
	Acebutolol HCl Cap 400 MG		✓	
	Atenolol Tab 25 MG		✓	
	Atenolol Tab 50 MG		✓	
	Atenolol Tab 100 MG		✓	
	Bisoprolol Fumarate Tab 5 MG		✓	
	Bisoprolol Fumarate Tab 10 MG		✓	
	Carvedilol Phosphate Cap SR 24HR 10 MG		✓	
	Carvedilol Phosphate Cap SR 24HR 20 MG		✓	
	Carvedilol Phosphate Cap SR 24HR 40 MG		✓	
	Carvedilol Phosphate Cap SR 24HR 80 MG		✓	
	Carvedilol Tab 3.125 MG		✓	
	Carvedilol Tab 6.25 MG		✓	
	Carvedilol Tab 12.5 MG		✓	
	Carvedilol Tab 25 MG		✓	
	Labetalol HCl Tab 100 MG		✓	
	Labetalol HCl Tab 200 MG		✓	
	Labetalol HCl Tab 300 MG		✓	
	Metoprolol Succinate Tab SR 24HR 25 MG (Tartrate Equiv)		✓	
	Metoprolol Succinate Tab SR 24HR 50 MG (Tartrate Equiv)		✓	
	Metoprolol Succinate Tab SR 24HR 100 MG (Tartrate Equiv)		✓	
	Metoprolol Succinate Tab SR 24HR 200 MG (Tartrate Equiv)		✓	
	Metoprolol Tartrate Tab 25 MG		✓	
	Metoprolol Tartrate Tab 50 MG		✓	
	Metoprolol Tartrate Tab 100 MG		✓	
	Nadolol Tab 20 MG		✓	
	Nadolol Tab 40 MG		✓	
	Nadolol Tab 80 MG		✓	
	Nebivolol HCl Tab 2.5 MG (Base Equivalent)		✓	
	Nebivolol HCl Tab 5 MG (Base Equivalent)		✓	
	Nebivolol HCl Tab 10 MG (Base Equivalent)		✓	
	Nebivolol HCl Tab 20 MG (Base Equivalent)		✓	
	Pindolol Tab 5 MG		✓	

Medication Class Name	Medication Generic Name	Brand name (if applicable)	Allowed Condition Needed	Reimbursement restrictions or limitations for specific medications or dosage forms are listed with the respective medications below.
	Pindolol Tab 10 MG		✓	
	Propranolol HCl Cap SR 24HR 60 MG		✓	
	Propranolol HCl Cap SR 24HR 80 MG		✓	
	Propranolol HCl Cap SR 24HR 120 MG		✓	
	Propranolol HCl Cap SR 24HR 160 MG		✓	
	Propranolol HCl Tab 10 MG		✓	
	Propranolol HCl Tab 20 MG		✓	
	Propranolol HCl Tab 40 MG		✓	
	Propranolol HCl Tab 60 MG		✓	
	Propranolol HCl Tab 80 MG		✓	
	Sotalol HCl (AFIB/AFL) Tab 80 MG		✓	
	Sotalol HCl Tab 80 MG		✓	
	Sotalol HCl Tab 120 MG		✓	
	Sotalol HCl Tab 160 MG		✓	
	Timolol Maleate Tab 10 MG		✓	
Calcium Channel Blockers	Amlodipine Besylate Tab 2.5 MG (Base Equivalent)		✓	
	Amlodipine Besylate Tab 5 MG (Base Equivalent)		✓	
	Amlodipine Besylate Tab 10 MG (Base Equivalent)		✓	
	Diltiazem HCl Cap SR 24HR 120 MG		✓	
	Diltiazem HCl Cap SR 24HR 180 MG		✓	
	Diltiazem HCl Cap SR 24HR 240 MG		✓	
	Diltiazem HCl Coated Beads Cap SR 24HR 120 MG		✓	
	Diltiazem HCl Coated Beads Cap SR 24HR 180 MG		✓	
	Diltiazem HCl Coated Beads Cap SR 24HR 240 MG		✓	
	Diltiazem HCl Coated Beads Cap SR 24HR 300 MG		✓	
	Diltiazem HCl Coated Beads Cap SR 24HR 360 MG		✓	
	Diltiazem HCl Extended Release Beads Cap SR 24HR 180 MG		✓	
	Diltiazem HCl Extended Release Beads Cap SR 24HR 240 MG		✓	
	Diltiazem HCl Extended Release Beads Cap SR 24HR 300 MG		✓	
	Diltiazem HCl Extended Release Beads Cap SR 24HR 360 MG		✓	
	Diltiazem HCl Tab 30 MG		✓	
	Diltiazem HCl Tab 60 MG		✓	
	Diltiazem HCl Tab 90 MG		✓	
	Diltiazem HCl Tab 120 MG		✓	
	Diltiazem HCl Tab ER 24HR 240 MG		✓	
	Diltiazem HCl Tab ER 24HR 360 MG		✓	
	Felodipine Tab SR 24HR 5 MG		✓	
	Felodipine Tab SR 24HR 10 MG		✓	
	Nicardipine HCl Cap 20 MG		✓	
	Nifedipine Cap 10 MG		✓	
	Nifedipine Cap 20 MG		✓	
	Nifedipine Tab SR 24HR 30 MG		✓	
	Nifedipine Tab SR 24HR 60 MG		✓	
	Nifedipine Tab SR 24HR 90 MG		✓	
	Nifedipine Tab SR 24HR Osmotic Release 30 MG		✓	
	Nifedipine Tab SR 24HR Osmotic Release 60 MG		✓	
	Nifedipine Tab SR 24HR Osmotic 90 MG		✓	
	Nisoldipine Tab SR 24HR 20 MG		✓	
	Nisoldipine Tab SR 24HR 25.5 MG		✓	
	Verapamil HCl Cap ER 24HR 120 MG		✓	
	Verapamil HCl Cap SR 24HR 180 MG		✓	
	Verapamil HCl Cap SR 24HR 240 MG		✓	
	Verapamil HCl Tab 40 MG		✓	
	Verapamil HCl Tab 80 MG		✓	
	Verapamil HCl Tab 120 MG		✓	
	Verapamil HCl Tab ER 120 MG		✓	
	Verapamil HCl Tab ER 180 MG		✓	
	Verapamil HCl Tab ER 240 MG		✓	
Cardiotonics – Cardiac Glycosides	Digoxin Tab 125 MCG (0.125 MG)		✓	
	Digoxin Tab 250 MCG (0.25 MG)		✓	
Cardiovascular Agents Misc. Combinations	Amlodipine Besylate-Atorvastatin Calcium Tab 5-10 MG		✓	
	Amlodipine Besylate-Atorvastatin Calcium Tab 5-20 MG		✓	
	Amlodipine Besylate-Atorvastatin Calcium Tab 5-40 MG		✓	
	Amlodipine Besylate-Atorvastatin Calcium Tab 5-80 MG		✓	
	Amlodipine Besylate-Atorvastatin Calcium Tab 10-10 MG		✓	
	Amlodipine Besylate-Atorvastatin Calcium Tab 10-20 MG		✓	
	Amlodipine Besylate-Atorvastatin Calcium Tab 10-40 MG		✓	
	Amlodipine Besylate-Atorvastatin Calcium Tab 10-80 MG		✓	
	Isosorbide Dinitrate-Hydralazine HCl Tab 20-37.5 MG		✓	
	Sacubitril-Valsartan Tab 24-26 MG	ENTRESTO	✓	
	Sacubitril-Valsartan Tab 49-51 MG		✓	
	Sacubitril-Valsartan Tab 97-103 MG		✓	
Chelating Agents	Penicillamine Cap 250 MG		✓	
	Penicillamine Tab 250 MG		✓	
Corticosteroids—	Cortisone Acetate Tab 25 MG			

Medication Class Name	Medication Generic Name	Brand name (if applicable)	Allowed Condition Needed	Reimbursement restrictions or limitations for specific medications or dosage forms are listed with the respective medications below.
Glucocorticosteroids	Dexamethasone Conc 1 MG/ML			
	Dexamethasone Elixir 0.5 MG/5ML			
	Dexamethasone Soln 0.5 MG/5ML			
	Dexamethasone Tab 0.5 MG			
	Dexamethasone Tab 0.75 MG			
	Dexamethasone Tab 1 MG			
	Dexamethasone Tab 1.5 MG			
	Dexamethasone Tab 2 MG			
	Dexamethasone Tab 4 MG			
	Dexamethasone Tab 6 MG			
	Dexamethasone Tab Therapy Pack 1.5 MG (21)			
	Dexamethasone Tab Therapy Pack 1.5 MG (35)			
	Dexamethasone Tab Therapy Pack 1.5 MG (51)			
	Hydrocortisone Tab 5 MG			
	Hydrocortisone Tab 10 MG			
	Hydrocortisone Tab 20 MG			
	Methylprednisolone Tab 2 MG			
	Methylprednisolone Tab 4 MG			
	Methylprednisolone Tab 8 MG			
	Methylprednisolone Tab 16 MG			
	Methylprednisolone Tab 32 MG			
	Methylprednisolone Tab Therapy Pack 4 MG (21)			
	Prednisolone Sod Phosphate Oral Soln 5 MG/5ML (Base Equiv)			
	Prednisolone Sod Phosphate Oral Soln 15 MG/5ML (Base Equiv)			
	Prednisolone Sodium Phosphate Oral Soln 25 MG/5ML (Base Eq)			
	Prednisolone Soln 15 MG/5ML			
	Prednisolone Tab 5 MG			
	Prednisolone Tab Therapy Pack 5 MG (21)			
	Prednisolone Tab Therapy Pack 5 MG (48)			
	Prednisone Oral Soln 5 MG/5ML			
	Prednisone Tab 1 MG			
	Prednisone Tab 2.5 MG			
	Prednisone Tab 5 MG			
	Prednisone Tab 10 MG			
	Prednisone Tab 20 MG			
	Prednisone Tab 50 MG			
	Prednisone Tab Therapy Pack 5 MG (21)			
	Prednisone Tab Therapy Pack 5 MG (48)			
	Prednisone Tab Therapy Pack 10 MG (21)			
	Prednisone Tab Therapy Pack 10 MG (48)			
Corticosteroids— Mineralocorticoids	Fludrocortisone Acetate Tab 0.1 MG		✓	
Cough/Cold/Allergy – Antitussives	Benzonatate Cap 100 MG		✓	
	Benzonatate Cap 200 MG		✓	
	Dextromethorphan Polistirex Extended Release Susp 30 MG/5ML		✓	
	Hydrocodone Bitart-Homatropine Methylbromide Tab 5-1.5 MG		✓	
	Hydrocodone Bitart-Homatropine Methylbrom Soln 5-1.5 MG/5ML		✓	
Cough/Cold/Allergy – Combinations	Brompheniramine & Phenylephrine Elixir 1-2.5 MG/5ML		✓	
	Cetirizine-Pseudoephedrine Tab SR 12HR 5-120 MG		✓	
	Chlorpheniramine-DM Tab 4-30 MG		✓	~~May be considered for reimbursement upon submission of a prior authorization request with documented medical justification.~~
	Dextromethorphan-Doxylamine-APAP Liquid 10-6.25-325 MG/15ML		✓	
	Dextromethorphan-Guaifenesin Liquid 10-100 MG/5ML		✓	
	Dextromethorphan-Guaifenesin Liquid 10-187 MG/5ML		✓	~~May be considered for reimbursement upon submission of a prior authorization request with documented medical justification.~~
	Dextromethorphan-Guaifenesin Liquid 10-200 MG/5ML		✓	
	Dextromethorphan-Guaifenesin Liquid 5-100 MG/5ML		✓	
	Dextromethorphan-Guaifenesin Liquid 5-50 MG/ML		✓	
	Dextromethorphan-Guaifenesin Liquid 20-200 MG/20ML		✓	~~May be considered for reimbursement upon submission of a prior authorization request with documented medical justification.~~
	Dextromethorphan-Guaifenesin Syrup 10-100 MG/5ML		✓	
	Diphenhydramine-Acetaminophen Tab 12.5-325 MG		✓	
	Fexofenadine-Pseudoephedrine Tab SR 12HR 60-120 MG		✓	
	Fexofenadine-Pseudoephedrine Tab SR 24HR 180-240 MG		✓	
	Guaifenesin-Codeine Soln 100-10 MG/5ML		✓	
	Hydrocod Polst-Chlorphen Polst Cap ER 12HR 10-8 MG		✓	
	Hydrocod Polst-Chlorphen Polst ER Susp 10-8 MG/5ML		✓	
	Loratadine & Pseudoephedrine Tab SR 12HR 5-120 MG		✓	

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	Loratadine & Pseudoephedrine Tab SR 24HR 10-240 MG		✓	
	Phenylephrine w/ Acetaminophen Tab 5-325 MG		✓	
	Phenylephrine w/ DM-GG Liqd 10-18-200 MG/15ML		✓	
	Phenylephrine w/ DM-GG Liqd 2.5-5-100 MG/ML		✓	
	Phenylephrine w/ DM-GG Liqd 5-10-100 MG/5ML		✓	
	Phenylephrine w/ DM-GG Liquid 10-15-350 MG/5ML		✓	~~May be considered for reimbursement upon submission of a prior authorization request with documented medical justification~~.
	Phenylephrine w/ DM-GG Tab 10-15-400 MG		✓	
	Phenylephrine w/ DM-GG Tab 5-10-200 MG		✓	
	Phenylephrine-Chlorphen-DM Liquid 10-4-10 MG/5ML		✓	~~May be considered for reimbursement upon submission of a prior authorization request with documented medical justification.~~
	Phenylephrine-Chlorphen-DM Tab 10-4-10 MG		✓	
	Promethazine-Phenylephrine-Codeine Syrup 6.25-5-10 MG/5ML		✓	
	Promethazine & Phenylephrine Syrup 6.25-5 MG/5ML		✓	
	Promethazine w/ Codeine Syrup 6.25-10 MG/5ML		✓	
	Promethazine-DM Syrup 6.25-15 MG/5ML		✓	
	Pseudoephed-Bromphen-DM Syrup 30-2-10 MG/5ML		✓	
	Pseudoephedrine w/ COD-GG Soln 30-10-100 MG/5ML		✓	
	Pseudoephedrine w/ DM-GG Tab 60-15-400 MG		✓	~~May be considered for reimbursement upon submission of a prior authorization request with documented medical justification.~~
	Pseudoephedrine w/ DM-GG Tab 60-20-380 MG		✓	
	Pseudoephedrine-Guaifenesin Tab SR 12HR 120-1200 MG		✓	
	Pseudoephedrine-Guaifenesin Tab SR 12HR 60-600 MG		✓	
Cough/Cold/Allergy – Expectorants	Guaifenesin Liquid 100 MG/5ML		✓	
	Guaifenesin Tab 200 MG		✓	
	Guaifenesin Tab 400 MG		✓	
	Guaifenesin Tab SR 12HR 600 MG		✓	
	Guaifenesin Tab SR 12HR 1200 MG		✓	
	Potassium Iodide Oral Soln 1 GM/ML		✓	
Cough/Cold/Allergy – Misc. Respiratory Inhalants	Sodium Chloride Aero Soln 0.9%		✓	
	Sodium Chloride Soln Nebu 0.9%			
	Sodium Chloride Soln Nebu 3%			
Cough/Cold/Allergy – Mucolytics	Acetylcysteine Inhal Soln 10%		✓	
	Acetylcysteine Inhal Soln 20%		✓	
Dietary Management Products	L-Methylfolate Tab 7.5 MG		~~✓~~	
	L-Methylfolate Tab 15 MG		~~✓~~	
	L-Methylfolate w/ Vit B12-Vit B6-Vit B2 Tab 6-1-50-5 MG		~~✓~~	
	L-Methylfolate w/ Vit B6-Vit B12 Tab 3-35-2 MG			May be considered for reimbursement upon submission of a prior authorization request with documented medical justification.
	L-Methylfolate-Algae Cap 15-90.314 MG			
	L-Methylfolate-Algae-Vit B12-B6 Cap 3-90.314-2-35 MG			
	L-Methylfolate-Methylcobalamin-Acetylcyst Tab 6-2-600 MG			
	Folic Acid-Pyridoxine-Cyanocobalamin Tab 2.5-25-2 MG			
Digestive Enzymes	Lactase Tab 3000 Unit		✓	
	Pancrelipase (Lip-Prot-Amyl) DR Cap 6000-19000-30000 Unit		✓	
	Pancrelipase (Lip-Prot-Amyl) DR Cap 8000-28750-30250 Unit		✓	
	Pancrelipase (Lip-Prot-Amyl) DR Cap 10000-32000-42000 Unit		✓	
	Pancrelipase (Lip-Prot-Amyl) DR Cap 10500-35500-61500 Unit		✓	
	Pancrelipase (Lip-Prot-Amyl) DR Cap 12000-38000-60000 Unit		✓	
	Pancrelipase (Lip-Prot-Amyl) DR Cap 15000-47000-63000 Unit		✓	
	Pancrelipase (Lip-Prot-Amyl) DR Cap 16000-57500-60500 Unit		✓	
	Pancrelipase (Lip-Prot-Amyl) DR Cap 16800-56800-98400 Unit		✓	
	Pancrelipase (Lip-Prot-Amyl) DR Cap 20000-63000-84000 Unit		✓	
	Pancrelipase (Lip-Prot-Amyl) DR Cap 24000-76000-120000 Unit		✓	
	Pancrelipase (Lip-Prot-Amyl) DR Cap 25000-79000-105000 Unit		✓	
	Pancrelipase (Lip-Prot-Amyl) DR Cap 36000-114000-180000 Unit		✓	
	Pancrelipase (Lip-Prot-Amyl) DR Cap 40000-126000-168000 Unit		✓	
	Pancrelipase (Lip-Prot-Amyl) Tab 10440-39150-39150 Unit		✓	
	Pancrelipase (Lip-Prot-Amyl) Tab 20880-78300-78300 Unit		✓	
Diuretics	Acetazolamide Cap SR 12HR 500 MG		✓	

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	Acetazolamide Tab 125 MG		✓	
	Acetazolamide Tab 250 MG		✓	
	Amiloride & Hydrochlorothiazide Tab 5-50 MG		✓	
	Amiloride HCl Tab 5 MG		✓	
	Bumetanide Tab 0.5 MG		✓	
	Bumetanide Tab 1 MG		✓	
	Bumetanide Tab 2 MG		✓	
	Chlorthalidone Tab 25 MG		✓	
	Chlorthalidone Tab 50 MG		✓	
	Furosemide Oral Soln 10 MG/ML		✓	
	Furosemide Tab 20 MG		✓	
	Furosemide Tab 40 MG		✓	
	Furosemide Tab 80 MG		✓	
	Hydrochlorothiazide Cap 12.5 MG		✓	
	Hydrochlorothiazide Tab 25 MG		✓	
	Hydrochlorothiazide Tab 50 MG		✓	
	Indapamide Tab 1.25 MG		✓	
	Methazolamide Tab 25 MG		✓	
	Methazolamide Tab 50 MG		✓	
	Metolazone Tab 2.5 MG		✓	
	Metolazone Tab 5 MG		✓	
	Spironolactone Tab 25 MG		✓	
	Spironolactone Tab 50 MG		✓	
	Spironolactone Tab 100 MG		✓	
	Torsemide Tab 10 MG		✓	
	Torsemide Tab 20 MG		✓	
	Torsemide Tab 100 MG		✓	
	Triamterene & Hydrochlorothiazide Cap 37.5-25 MG		✓	
	Triamterene & Hydrochlorothiazide Tab 37.5-25 MG		✓	
	Triamterene & Hydrochlorothiazide Tab 75-50 MG		✓	
Endocrine – Bone Density Regulators	Alendronate Sodium Oral Soln 70 MG/75ML		✓	
	Alendronate Sodium Tab 5 MG		✓	
	Alendronate Sodium Tab 35 MG		✓	
	Alendronate Sodium Tab 70 MG		✓	
	Alendronate Sodium-Cholecalciferol Tab 70-2800 MG-Unit		✓	
	Calcitonin (Salmon) Nasal Soln 200 Unit/ACT		✓	
	Ibandronate Sodium Tab 150 MG (Base Equivalent)		✓	
	Risedronate Sodium Tab 30 MG		✓	
	Risedronate Sodium Tab 35 MG		✓	
	Risedronate Sodium Tab 150 MG		✓	
	Risedronate Sodium Tab Delayed Release 35 MG		✓	
	Teriparatide Soln Pen-inj 560 MCG/2.24ML		✓	
Endocrine – Corticotropin	Corticotropin Inj Gel 80 Unit/ML		✓	
Endocrine— Fertility Regulators	Clomiphene Citrate Tab 50 MG			May be considered for reimbursement upon submission of a prior authorization request. Reimbursement is limited to claims in which low testosterone is related to an allowed condition in the claim.
Endocrine – Growth Hormones	Somatropin For Inj Cartridge 6 MG (18 Unit)		✓	
Endocrine – Hormone Receptor Modulators	Raloxifene HCl Tab 60 MG		✓	
Endocrine – Metabolic Modifiers	Calcitriol Cap 0.25 MCG		✓	
	Calcitriol Cap 0.5 MCG		✓	
	Cinacalcet HCl Tab 30 MG (Base Equiv)		✓	
	Doxercalciferol Cap 0.5 MCG		✓	
	Doxercalciferol Cap 2.5 MCG		✓	
	Paricalcitol Cap 1 MCG		✓	
	Paricalcitol Cap 2 MCG		✓	
Endocrine – Posterior Pituitary Hormones	Desmopressin Acetate Inj 4 MCG/ML		✓	
	Desmopressin Acetate Nasal Soln 0.01% (Refrigerated)		✓	
	Desmopressin Acetate Nasal Spray Soln 0.01%		✓	
	Desmopressin Acetate Nasal Spray Soln 0.01% (Refrigerated)		✓	
	Desmopressin Acetate Tab 0.1 MG		✓	
	Desmopressin Acetate Tab 0.2 MG		✓	
Estrogens	Estradiol Tab 0.5 MG			
Fibromyalgia Agents	Milnacipran HCl Tab 12.5 MG	SAVELLA	✓	
	Milnacipran HCl Tab 25 MG		✓	
	Milnacipran HCl Tab 50 MG		✓	
	Milnacipran HCl Tab 100 MG		✓	
	Milnacipran HCl Tab 12.5 MG (5) & 25 MG (8) & 50 MG (42) Pak		✓	
G.I. Agent – Antiflatulents	Simethicone Cap 125 MG		✓	
	Simethicone Cap 180 MG		✓	
	Simethicone Chew Tab 80 MG		✓	
	Simethicone Chew Tab 125 MG		✓	
	Simethicone Susp 40 MG/0.6ML		✓	
G.I. Agent – Gallstone Solubilizing Agents	Ursodiol Cap 300 MG		✓	
G.I. Agent – Gastrointestinal Chloride Channel Activators	Lubiprostone Cap 8 MCG			May be considered for reimbursement upon submission of a prior authorization request that reflects: a diagnosis of opioid induced constipation, defined as fewer than three (3) bowel movements per week or two (2) consecutive days without a

Medication Class Name	Medication Generic Name	Brand name (if applicable)	Allowed Condition Needed	Reimbursement restrictions or limitations for specific medications or dosage forms are listed with the respective medications below.
	Lubiprostone Cap 24 MCG			bowel movement; the injured worker has received opioid prescriptions reimbursed by BWC for at least eight (8) consecutive weeks immediately prior to the request; the opioid prescription(s) are ongoing; and office notes document previous failed therapy with at least two (2) osmotic (PEG 3350, etc.) or stimulant (bisacodyl, senna, etc.) laxatives. Reimbursement is limited to two (2) capsules per day.
G.I. Agent – Gastrointestinal Stimulants	Metoclopramide HCl Soln 5 MG/5ML (10 MG/10ML) (Base Equiv)		✓	
	Metoclopramide HCl Tab 5 MG (Base Equivalent)		✓	
	Metoclopramide HCl Tab 10 MG (Base Equivalent)		✓	
G.I. Agent – Inflammatory Bowel Agents	Balsalazide Disodium Cap 750 MG		✓	
	Mesalamine Cap ER 500 MG		✓	
	Mesalamine Cap DR 400 MG		✓	
	Mesalamine Enema 4 GM		✓	
	Mesalamine Suppos 1000 MG		✓	
	Mesalamine Tab Delayed Release 800 MG		✓	
	Mesalamine Tab Delayed Release 1.2 GM		✓	
	Olsalazine Sodium Cap 250 MG		✓	
	Sulfasalazine Tab 500 MG		✓	
	Sulfasalazine Tab Delayed Release 500 MG		✓	
G.I. Agent – Intestinal Acidifiers	Lactulose (Encephalopathy) Solution 10 GM/15ML		✓	
G.I. Agent – Peripheral Opioid Receptor Antagonists	Naldemedine Tosylate Tab 0.2 MG (Base Equivalent)	SYMPROIC		May be considered for reimbursement upon submission of a prior authorization request that reflects: a diagnosis of opioid induced constipation, defined as fewer than three (3) bowel movements per week or two (2) consecutive days without a bowel movement; the injured worker has received opioid prescriptions reimbursed by BWC for at least eight (8) consecutive weeks immediately prior to the request; the opioid prescription(s) are ongoing; and office notes document previous failed therapy with at least two osmotic (PEG 3350, etc.) or stimulant (bisacodyl, senna, etc.) laxatives. Reimbursement is limited to one (1) tablet per day.
	Naloxegol Oxalate Tab 12.5 MG (Base Equivalent)	MOVANTIK		
	Naloxegol Oxalate Tab 25 MG (Base Equivalent)			
Genitourinary Agents– Alkalinizers	Potassium Citrate Tab ER 5 MEQ (540 MG)		✓	
	Potassium Citrate Tab ER 10 MEQ (1080 MG)		✓	
Genitourinary Agents— Genitourinary Irrigants	Acetic Acid Irrigation Soln 0.25%		✓	
	Sodium Chloride Irrigation Soln 0.9%			
	*Citric Acid-Gluconolactone-Magnesium Carbonate Soln**		✓	
Genitourinary Agents— Interstitial Cystitis Agents	Pentosan Polysulfate Sodium Caps 100 MG		✓	
Genitourinary Agents— Prostatic Hypertrophy Agents	Alfuzosin HCl Tab SR 24HR 10 MG		✓	
	Dutasteride Cap 0.5 MG		✓	
	Dutasteride-Tamsulosin HCl Cap 0.5-0.4 MG		✓	
	Finasteride Tab 5 MG		✓	
	Silodosin Cap 4 MG		✓	
	Silodosin Cap 8 MG		✓	
	Tamsulosin HCl Cap 0.4 MG		✓	
Genitourinary Agents— Urinary Analgesics	Phenazopyridine HCl Tab 100 MG		✓	
	Phenazopyridine HCl Tab 200 MG		✓	
Genitourinary Agents— Urinary Stone Agents	Acetohydroxamic Acid Tab 250 MG		✓	
Gout Agents	Allopurinol Tab 100 MG		✓	
	Allopurinol Tab 300 MG		✓	
	Colchicine Cap 0.6 MG		✓	
	Colchicine Tab 0.6 MG		✓	
	Febuxostat Tab 40 MG		✓	
	Febuxostat Tab 80 MG		✓	
Hematological Agents— ~~C1 Esterase~~Complement Inhibitors	C1 Esterase Inhibitor (Human) for Subcutaneous Inj 2000 Unit	HAEGARDA	✓	May be considered for reimbursement upon submission of a prior authorization request that reflects an allowed condition of angioedema. Initial approval will be no greater than six (6) months, and subsequent requests may be considered if there is a documented positive response to therapy demonstrated by a reduction in angioedema attacks.
	C1 Esterase Inhibitor (Human) for Subcutaneous Inj 2000 Unit		✓	
Hematological Agents— Hematorheologic Agents	Pentoxifylline Tab ER 400 MG		✓	
Hematological Agents— Platelet Aggregation Inhibitors	Aspirin-Dipyridamole Cap SR 12HR 25-200 MG	AGGRENOX	✓	After 30 days of use, may be considered for reimbursement upon submission of a prior authorization request that reflects use for an allowed condition in the claim.
	Cilostazol Tab 50 MG		✓	
	Cilostazol Tab 100 MG		✓	
	Clopidogrel Bisulfate Tab 75 MG (Base Equiv)		✓	
	Prasugrel HCl Tab 10 MG (Base Equiv)	EFFIENT	✓	
	Ticagrelor Tab 90 MG	BRILINTA	✓	
Hematopoietic Agents— Cobalamins	Cyanocobalamin Cap 1000 MCG		✓	
	Cyanocobalamin Cap 3000 MCG		✓	
	Cyanocobalamin Cap 5000 MCG		✓	
	Cyanocobalamin Tab 500 MCG		✓	
	Cyanocobalamin Tab 1000 MCG		✓	
	Cyanocobalamin Tab 2500 MCG		✓	
	Cyanocobalamin SL Tab 500 MCG		✓	
	Cyanocobalamin Tab SL 1000 MCG		✓	
	Cyanocobalamin SL Tab 2500 MCG		✓	
	Cyanocobalamin SL Tab 3000 MCG		✓	
	Cyanocobalamin SL Tab 5000 MCG		✓	
	Cyanocobalamin SL Tab 6000 MCG		✓	
	Cyanocobalamin Inj 1000 MCG/ML		✓	
Hematopoietic Agents – Folic Acid/Folates	Folic Acid Tab 800 MCG		✓	
	Folic Acid Tab 1 MG		✓	
Hematopoietic Agents –	Carbonyl Iron Tab 45 MG (Elemental Iron)		✓	

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Iron	Ferrous Gluconate Tab 239 MG (27 MG Fe Equivalent)		✓	
	Ferrous Gluconate Tab 324 MG (38 MG Elemental Iron)		✓	
	Ferrous Sulfate Dried Tab ER 160 MG (50 MG Fe Equivalent)		✓	
	Ferrous Sulfate Soln 220 MG/5ML (44 MG/5ML Elemental Fe)		✓	
	Ferrous Sulfate Soln 300 MG/5ML (60 MG/5ML Elemental Fe)		✓	
	Ferrous Sulfate Tab 325 MG (65 MG Elemental Fe)		✓	
	Ferrous Sulfate Tab ER 142 MG (45 MG Fe Equivalent)		✓	
	Ferrous Sulfate Tab ER 143 MG (45 MG Fe Equivalent)		✓	
	Ferrous Sulfate Tab ER 47.5 MG (Elemental Fe)		✓	
	Ferrous Sulfate Tab EC 324 MG (65 MG Fe Equivalent)		✓	
	Ferrous Sulfate Tab EC 325 MG (65 MG Fe Equivalent)		✓	
	Polysaccharide Iron Complex Cap 150 MG (Iron Equivalent)		✓	
	Polysaccharide Iron Complex Cap 391.3 MG (180 MG Elem Fe)		✓	
Hematopoietic Growth Factors	Darbepoetin Alfa Soln Prefilled Syringe 10 MCG/0.4ML		✓	
	Darbepoetin Alfa Soln Prefilled Syringe 60 MCG/0.3ML		✓	
	Epoetin Alfa Inj 40000 Unit/ML			May be considered for reimbursement upon submission of a prior authorization request that reflects a documented allergic reaction, adverse event, or an inadequate response after a minimum of a 14-day trial to epoetin alfa-epbx within the past 120 days.
	Epoetin Alfa-epbx Inj 2000 Unit/ML		✓	
	Epoetin Alfa-epbx Inj 3000 Unit/ML		✓	
	Epoetin Alfa-epbx Inj 4000 Unit/ML		✓	
	Epoetin Alfa-epbx Inj 10000 Unit/ML		✓	
	Epoetin Alfa-epbx Inj 20000 Unit/ML		✓	
	Epoetin Alfa-epbx Inj 40000 Unit/ML		✓	
	Filgrastim Soln Prefilled Syringe 300 MCG/0.5ML		✓	
	Filgrastim-sndz Soln Prefilled Syringe 300 MCG/0.5ML		✓	
	Filgrastim-sndz Soln Prefilled Syringe 480 MCG/0.8ML		✓	
	Pegfilgrastim-jmdb Soln Prefilled Syringe 6 MG/0.6ML		✓	
	Pegfilgrastim Soln Prefilled Syringe 6 MG/0.6ML			May be considered for reimbursement upon submission of a prior authorization request that reflects a documented allergic reaction, adverse event, or an inadequate response after a minimum of a 14-day trial to pegfilgrastim-jmdb within the past 120 days.
	Pegfilgrastim Soln ~~Prefilled Syringe Kit~~Prefill Syr/Infusion Dev 6 MG/0.6ML			
Hematopoietic Mixtures	Fe Asp Gly-Fe Polysacch-Succ Ac-C-Threon Ac-B12-FA Cap		✓	
	Fe Asparto Gly-Succ Acd-C-Threonic Acd-B12-Des Stom Tab		✓	
	Fe Fumarate w/ B12-Vit C-FA-IFC Cap 110-0.015-75-0.5-240 MG		✓	
	Folic Acid-Vitamin B6-Vitamin B12 Tab 2.2-25-1 MG		✓	
	Iron Polysacch Complex-Vit B12-FA Cap 150-0.025-1 MG			May be considered for reimbursement upon submission of a prior authorization request with documented medical justification.
Hemostatics – Systemic	Aminocaproic Acid Oral Soln 0.25 GM/ML			
	Aminocaproic Acid Tab 500 MG			
	Aminocaproic Acid Tab 1000 MG			
Hypnotics – Antihistamine	Diphenhydramine-Acetaminophen Tab 25-500 MG (sleep)			
	Ibuprofen-Diphenhydramine Citrate Tab 200-38 MG			
Hypnotics – Barbiturate	Phenobarbital Elixir 20 MG/5ML		✓	
	Phenobarbital Tab 15 MG		✓	
	Phenobarbital Tab 16.2 MG		✓	
	Phenobarbital Tab 30 MG		✓	
	Phenobarbital Tab 32.4 MG		✓	
	Phenobarbital Tab 60 MG		✓	
	Phenobarbital Tab 64.8 MG		✓	
	Phenobarbital Tab 97.2 MG		✓	
Hypnotics – Non-Barbiturate	Eszopiclone Tab 1 MG			Will not be reimbursed for more than a 30-day supply without prior authorization. Prior authorization will only be considered for a period of acute care. Additionally, these drugs will not be reimbursed concurrently with opioids or stimulants.
	Eszopiclone Tab 2 MG			
	Eszopiclone Tab 3 MG			
	Temazepam Cap 15 MG			
	Temazepam Cap 30 MG			
	Zaleplon Cap 5 MG			
	Zaleplon Cap 10 MG			
	Zolpidem Tartrate Tab 5 MG			
	Zolpidem Tartrate Tab 10 MG			
	Zolpidem Tartrate Tab ER 6.25 MG			
	Zolpidem Tartrate Tab ER 12.5 MG			
Immunomodulators	Lenalidomide Caps 2.5 MG		✓	
	Lenalidomide Cap 5 MG		✓	
	Lenalidomide Cap 10 MG		✓	

Medication Class Name	Medication Generic Name	Brand name (if applicable)	Allowed Condition Needed	Reimbursement restrictions or limitations for specific medications or dosage forms are listed with the respective medications below.
	Lenalidomide Cap 20 MG		✓	
Immunosuppressive Agents	Azathioprine Tab 50 MG		✓	
	Cyclosporine Cap 100 MG		✓	
	Cyclosporine Modified Cap 25 MG		✓	
	Cyclosporine Modified Cap 100 MG		✓	
	Cyclosporine Modified Oral Soln 100 MG/ML		✓	
	Cyclosporine Oral Soln 100 MG/ML		✓	
	Everolimus Tab 0.25 MG		✓	
	Everolimus Tab 0.5 MG		✓	
	Everolimus Tab 0.75 MG		✓	
	Everolimus Tab 1 MG		✓	
	Mycophenolate Mofetil Cap 250 MG		✓	
	Mycophenolate Mofetil Tab 500 MG		✓	
	Mycophenolate Mofetil For Oral Susp 200 MG/ML			
	Mycophenolate Sodium Tab DR 180 MG (Mycophenolic Acid Equiv)		✓	
	Mycophenolate Sodium Tab DR 360 MG (Mycophenolic Acid Equiv)		✓	
	Sirolimus Oral Soln 1 MG/ML		✓	
	Sirolimus Tab 0.5 MG		✓	
	Sirolimus Tab 1 MG		✓	
	Sirolimus Tab 2 MG		✓	
	Tacrolimus Cap 0.5 MG		✓	
	Tacrolimus Cap 1 MG		✓	
	Tacrolimus Cap 5 MG		✓	
	Tacrolimus Tab ER 24HR 0.75 MG	ENVARSUS	✓	
	Tacrolimus Tab ER 24HR 1 MG		✓	
	Tacrolimus Tab ER 24HR 4 MG		✓	
Impotence Agents	ALL impotence agents			Reimbursement for impotence medications is limited to one (1) product per month.
	Alprostadil For Inj 20 MCG		✓	Reimbursement is limited to six (6) units per 30 days.
	Alprostadil For Inj Kit 10 MCG	EDEX	✓	
	Alprostadil For Inj Kit 20 MCG		✓	
	Alprostadil For Inj Kit 40 MCG		✓	
	~~Alprostadil Urethral Pellet 250 MCG~~		~~✓~~	~~Reimbursement is limited to six (6) pellet per 30 days.~~
	~~Alprostadil Urethral Pellet 500 MCG~~		~~✓~~	
	~~Alprostadil Urethral Pellet 1000 MCG~~		~~✓~~	
	Sildenafil Citrate Tab 25 MG		✓	Reimbursement is limited to six (6) tablets per 30 days.
	Sildenafil Citrate Tab 50 MG		✓	
	Sildenafil Citrate Tab 100 MG		✓	
	Tadalafil Tab 2.5 MG		✓	Reimbursement is limited to 30 tablets per 30 days.
	Tadalafil Tab 5 MG		✓	
	Tadalafil Tab 10 MG		✓	Reimbursement is limited to six (6) tablets per 30 days.
	Tadalafil Tab 20 MG		✓	
	Vardenafil HCl Tab 5 MG		✓	Reimbursement is limited to six (6) tablets per 30 days.
	Vardenafil HCl Tab 10 MG		✓	
	Vardenafil HCl Tab 20 MG		✓	
Irrigation Solutions	Water For Irrigation, Sterile Irrigation Soln			
Laxative – Combinations	Bisacodyl Tab & PEG 3350-KCl-Sod Bicarb-NaCl For Soln Kit			May be considered for reimbursement upon submission of a prior authorization request with documented medical justification.
	PEG 3350-KCl-Na Bicarb-NaCl-Na Sulfate For Soln 236 GM			
	PEG 3350-KCl-Na Bicarb-NaCl-Na Sulfate For Soln 240 GM			
	PEG 3350-KCl-NaCl-Na Sulfate-Na Ascorbate-C For Soln 100 GM			
	PEG 3350-KCl-Sod Bicarb-NaCl For Soln 420 GM			
	Sod Sulfate-Pot Sulf-Mg Sulf Oral Sol 17.5-3.13-1.6 GM/177ML			
	Psyllium w/ Calcium Capsule			
	Sennosides-Docusate Sodium Tab 8.6-50 MG			
Laxatives – Bulk	Calcium Polycarbophil Tab 625 MG			
	Cellulose Powder			
	Methylcellulose Powder Laxative			
	Methylcellulose Tab 500 MG			
	Psyllium Cap 0.36 GM			
	Psyllium Cap 0.52 GM			
	Psyllium Powder 27%			
	Psyllium Powder 28.3%			
	Psyllium Powder 30.9%			
	Psyllium Powder 33%			
	Psyllium Powder 48.57%			
	Psyllium Powder 49%			
	Psyllium Powder 51.7%			
	Psyllium Powder 52.3%			
	Psyllium Powder 58.6%			
	Psyllium Powder Packet 51.7%			
	Psyllium Powder Packet 58.12%			
	Psyllium Powder Packet 58.6%			
	Psyllium Powder Packet 60.3%			
	Wheat Dextrin Oral Powder**			
	Wheat Dextrin Packet**			
Laxatives – Lubricant	Mineral Oil			
	Mineral Oil Emul 50%			
	Mineral Oil Enema			
Laxatives – Miscellaneous	Glycerin Enema Adult 5.4 GM/Average Delivered Dose			

Medication Class Name	Medication Generic Name	Brand name (if applicable)	Allowed Condition Needed	Reimbursement restrictions or limitations for specific medications or dosage forms are listed with the respective medications below.
	Glycerin Suppos 2 GM			
	Glycerin Suppos 2.1 GM			
	Glycerin Suppos 80.7%			
	Lactulose Oral Crystal Packet 10 GM			
	Lactulose Oral Crystal Packet 20 GM			
	Lactulose Solution 10 GM/15ML			
	Polyethylene Glycol 3350 Oral Packet 17 GM			
	Polyethylene Glycol 3350 Oral ~~Powder 17 GM/SCOOP~~Packet 8.5 GM			
	Sorbitol Oral Solution 70%			
Laxatives – Saline	Magnesium Citrate Soln			
	Magnesium Hydroxide Susp 400 MG/5ML			
	Sod Phos Mono-Sod Phos Di Tabs 1.102-0.398 GM(1.5GM Na Phos)			
	Sodium Phosphates - Enema			
Laxatives – Stimulant	Bisacodyl Enema 10 MG/30ML			
	Bisacodyl Suppos 10 MG			
	Bisacodyl Tab Delayed Release 5 MG			
	Sennosides Cap 8.6 MG			
	Sennosides Syrup 8.8 MG/5ML			
	Sennosides Tab 15 MG			
	Sennosides Tab 17.2 MG			
	Sennosides Tab 25 MG			
	Sennosides Tab 8.6 MG			
Laxatives – Surfactant	Benzocaine-Docusate Sodium Rectal Enema 20-283 MG			
	Docusate Calcium Cap 240 MG			
	Docusate Sodium Cap 50 MG			
	Docusate Sodium Cap 100 MG			
	Docusate Sodium Cap 250 MG			
	Docusate Sodium Enema 283 MG/5ML			
	Docusate Sodium Liquid 150 MG/15ML			
	Docusate Sodium Syrup 60 MG/15ML			
Liquid Vehicles	Sorbitol Solution (Bulk)			
	Water For Injection			May be reimbursed with documented approval of intrathecal pain pump.
	Sodium Chloride IV Soln 0.9%			
Medical Devices and Supplies— Diabetic Supplies	Alcohol, Rubbing 70%		✓	
	Alcohol Sheets		✓	
	Alcohol Swabs		✓	
	Lancet Devices		✓	
	Lancets Misc.		✓	
	Lancets		✓	
Medical Devices and Supplies—Diagnostic Tests	Glucose Blood Test Strips		✓	
Medical Devices and Supplies— ~~Insulin Administration Supplies~~Parenteral Therapy Supplies	Insulin Pen Needles		✓	
	Insulin Syringes		✓	
	Insulin Syringe/Needles		✓	
Migraine Products – calcitonin gene-related peptide (CGRP) receptor antagonists	ALL CGRP products			May be considered for reimbursement upon submission of a prior authorization request. Reimbursement is limited to claims in which migraine headaches are related to an allowed condition in the claim. ~~Reimbursement will not be approved for duplicate therapy with other CGRP antagonists.~~ The initial reimbursement may be for up to three (3) months. Subsequent approvals may be granted if there is a documented positive response to therapy (objective documentation of severity, frequency, and number of headache days per month). CGRP products for **acute** treatment: Reimbursement will be considered for individuals who have a documented inadequate response to at least two (2) triptan medications, or if the injured worker has a contraindication for triptans. Reimbursement will not be approved for duplicate CGRP acute treatment. CGRP products for **prophylaxis**: Reimbursement will be considered for individuals who have a minimum of a 90-day trial and documented inadequate response to at least one (1) medication from three (3) of the four (4) following different classes within the past 180 days: 1. Topiramate, sodium valproate, divalproex sodium 2. Amitriptyline, nortriptyline 3. Venlafaxine, duloxetine 4. Atenolol, metoprolol, nadolol, propranolol, timolol. Reimbursement will not be approved for duplicate CGRP prophylaxis treatment.~~The initial reimbursement may be for up to three (3) months. Subsequent approvals may be granted if there is a documented positive response to therapy demonstrated by a reduction in migraines AND there is documented improvement in function.~~
	Atogepant Tab 10 MG Atogepant Tab 30 MG Atogepant Tab 60 MG	QULIPTA		May only be approved for reimbursement for **prophylaxis**. Reimbursement is limited to one (1) tablet per day.
	Rimegepant Sulfate Tab Disint 75 MG	NURTEC		For **prophylaxis**, reimbursement ~~Reimbursement~~ is limited to 18 tablets per 30 days. For **acute** treatment, reimbursement is limited to 8 tablets per 30 days.

Medication Class Name	Medication Generic Name	Brand name (if applicable)	Allowed Condition Needed	Reimbursement restrictions or limitations for specific medications or dosage forms are listed with the respective medications below.
	Ubrogepant Tab 50 MG	UBRELVY		May only be approved for reimbursement for **acute** treatment. Reimbursement is limited to 16 tablets per 30 days.
	Ubrogepant Tab 100 MG			
	Erenumab-aooe Subcutaneous Soln Auto-injector 70 MG/ML	AIMOVIG		May only be approved for reimbursement for **prophylaxis**.
	Erenumab-aooe Subcutaneous Soln Auto-injector 140 MG/ML			
	Fremanezumab-vfrm Subcutaneous Soln Auto-inj 225 MG/1.5ML	AJOVY		
	Fremanezumab-vfrm Subcutaneous Soln Pref Syr 225 MG/1.5ML			
	Galcanezumab-gnlm Subcutaneous Soln Prefilled Syr 100 MG/ML	EMGALITY		
	Galcanezumab-gnlm Subcutaneous Soln Prefilled Syr 120 MG/ML			
	Galcanezumab-gnlm Subcutaneous Soln Auto-injector 120 MG/ML			
Migraine Products – Misc.	Dihydroergotamine Mesylate Nasal Spray 4 MG/ML		✓	
	Ergotamine w/ Caffeine Tab 1-100 MG		✓	
Migraine Products – Serotonin Agonists	ALL Triptan migraine products			~~Reimbursement for triptan migraine medications is limited to one (1) product per month.~~Reimbursement will not be approved for duplicate therapy.
	Almotriptan Malate Tab 12.5 MG		✓	Reimbursement is limited to 12 tablets per 30 days.
	Eletriptan Hydrobromide Tab 20 MG (Base Equivalent)		✓	Reimbursement is limited to six (6) tablets per 30 days.
	Eletriptan Hydrobromide Tab 40 MG (Base Equivalent)		✓	
	Frovatriptan Succinate Tab 2.5 MG (Base Equivalent)		✓	Reimbursement is limited to nine (9) tablets per 30 days.
	Lasmiditan Succinate Tab 50 MG	REYVOW		May be considered for reimbursement upon submission of a prior authorization request that reflects the injured worker has not received an adequate response from use of at least one triptan medication, or if the injured worker has a contraindication to triptans. ~~Reimbursement is limited to claims in which migraine headaches are related to an allowed condition in the claim.~~ Reimbursement is limited to four (4) tablets per 30 days.
	Lasmiditan Succinate Tab 100 MG			
	Naratriptan HCl Tab 2.5 MG (Base Equiv)		✓	Reimbursement is limited to nine (9) tablets per 30 days.
	Rizatriptan Benzoate Oral Disintegrating Tab 5 MG (Base Eq)		✓	Reimbursement is limited to 12 tablets per 30 days. ~~Reimbursement for oral disintegrating dosage form is limited to claims with an allowed condition that results in the inability to swallow or absorb oral medications~~
	Rizatriptan Benzoate Orally Disintegrating Tab 10 MG		✓	
	Rizatriptan Benzoate Tab 5 MG (Base Equivalent)		✓	Reimbursement is limited to 12 tablets per 30 days.
	Rizatriptan Benzoate Tab 10 MG (Base Equivalent)		✓	
	Sumatriptan Nasal Spray 5 MG/ACT		~~✓~~	Reimbursement is limited to claims with an allowed condition that results in the inability to swallow or absorb oral medications or documented inadequate response to oral dosage form. Reimbursement is limited to 12 units per 30 days.
	Sumatriptan Nasal Spray 20 MG/ACT		~~✓~~	Reimbursement is limited to claims with an allowed condition that results in the inability to swallow or absorb oral medications or documented inadequate response to oral dosage form. Reimbursement is limited to six (6) units per 30 days.
	Sumatriptan Succinate Inj 6 MG/0.5ML		✓	Reimbursement is limited to 10 units per 30 days.
	Sumatriptan Succinate Solution Auto-injector 4 MG/0.5ML		~~✓~~	Reimbursement is limited to claims with an allowed condition that results in the inability to swallow or absorb oral medications or documented inadequate response to oral dosage form. Reimbursement is limited to eight (8) units per 30 days.
	Sumatriptan Succinate Solution Cartridge 4 MG/0.5ML			
	Sumatriptan Succinate Solution Auto-injector 6 MG/0.5ML		~~✓~~	Reimbursement is limited to claims with an allowed condition that results in the inability to swallow or absorb oral medications or documented inadequate response to oral dosage form. Reimbursement is limited to 10 units per 30 days.
	Sumatriptan Succinate Solution Cartridge 6 MG/0.5ML			
	~~Sumatriptan Succinate Solution Prefilled Syringe 6 MG/0.5ML~~		~~✓~~	~~Reimbursement is limited to 10 units per 30 days.~~
	Sumatriptan Succinate Tab 25 MG		✓	Reimbursement is limited to 18 tablets per 30 days.
	Sumatriptan Succinate Tab 50 MG		✓	Reimbursement is limited to nine (9) tablets per 30 days.
	Sumatriptan Succinate Tab 100 MG		✓	
	Zolmitriptan Nasal Spray 2.5 MG/Spray Unit	ZOMIG	~~✓~~	Reimbursement is limited to claims with an allowed condition that results in the inability to swallow or absorb oral medications or documented inadequate response to oral dosage form. Reimbursement is limited to 12 units per 30 days.
	Zolmitriptan Nasal Spray 5 MG/Spray Unit		~~✓~~	
	Zolmitriptan Orally Disintegrating Tab 2.5 MG			Reimbursement is limited to 12 tablets per 30 days. Reimbursement for oral disintegrating dosage form is limited to claims with an allowed condition that results in the inability to swallow or absorb oral medications
	Zolmitriptan Orally Disintegrating Tab 5 MG			Reimbursement is limited to six (6) tablets per 30 days. Reimbursement for oral disintegrating dosage form is limited to claims with an allowed condition that results in the inability to swallow or absorb oral medications
	Zolmitriptan Tab 2.5 MG		✓	Reimbursement is limited to 12 tablets per 30 days.
	Zolmitriptan Tab 5 MG		✓	Reimbursement is limited to six (6) tablets per 30 days.
Mouth/Throat – Anesthetics Topical Oral	Benzocaine Dental Gel 20%			May be considered for reimbursement upon submission of a prior authorization request with documented medical justification.
	Benzocaine Dental Paste 20%			
	Benzocaine Dental Soln 20%			
	Benzocaine-Menthol Lozenge 15-3.6 MG			
	Benzocaine-Menthol Lozenge 15-4 MG			
	Benzocaine Mouth/Throat Aerosol 20%			
	Lidocaine HCl Viscous Soln 2%		✓	
Mouth/Throat – Anti-infectives	Clotrimazole Troche 10 MG		✓	
	Hydrogen Peroxide Soln 1.5%			
	Nystatin Susp 100000 Unit/ML		✓	

Medication Class Name	Medication Generic Name	Brand name (if applicable)	Allowed Condition Needed	Reimbursement restrictions or limitations for specific medications or dosage forms are listed with the respective medications below.
Mouth/Throat – Antiseptics	Chlorhexidine Gluconate Soln 0.12%		✓	
	Phenol Liquid 1.4%			May be considered for reimbursement upon submission of a prior authorization request with documented medical justification.
Mouth/Throat – Dental Products	Sodium Fluoride Cream 1.1%		✓	
	Sodium Fluoride Gel 1.1% (0.5% F)		✓	
	Stannous Fluoride Paste 0.454%			May be considered for reimbursement upon submission of a prior authorization request with documented medical justification.
Mouth/Throat – Lozenge	Menthol Lozenge 5.4 MG			May be considered for reimbursement upon submission of a prior authorization request with documented medical justification.
Mouth/Throat – Steroids	Triamcinolone Acetonide Dental Paste 0.1%		✓	
Mouth/Throat – Throat Products – Misc.	Artificial Saliva - Solution			
	Cevimeline HCl Cap 30 MG		✓	
	Misc Throat Products - Liquid			May be considered for reimbursement upon submission of a prior authorization request with documented medical justification.
	Pilocarpine HCl Tab 5 MG		✓	
	Pilocarpine HCl Tab 7.5 MG		✓	
	Povidone-Sodium Hyaluronate-Glycyrrhetinic Acid Gel			
Movement Disorder Drug Therapy	Deutetrabenazine Tab 6 MG	AUSTEDO		May be considered for reimbursement upon submission of a prior authorization request that reflects an allowed condition of tardive dyskinesia and baseline Abnormal Involuntary Movement Scale (AIMS) test. Each reimbursement is limited to 12 weeks. Documentation of new AIMS testing is required for all subsequent renewals.
	Deutetrabenazine Tab 9 MG			
	Deutetrabenazine Tab 12 MG			
	Tetrabenazine Tab 12.5 MG			
	Tetrabenazine Tab 25 MG			
	Valbenazine Tosylate Cap 40 MG (Base Equiv)	INGREZZA		
	Valbenazine Tosylate Cap 60 MG (Base Equiv)			
	Valbenazine Tosylate Cap 80 MG (Base Equiv)			
	Valbenazine Tosylate Cap Therapy Pack 40 MG (7) & 80 MG (21)			
Multiple Sclerosis Agents	Fingolimod HCl Cap 0.5 MG (Base Equiv)		✓	
	Glatiramer Acetate Soln Prefilled Syringe 20 MG/ML		✓	
	Glatiramer Acetate Soln Prefilled Syringe 40 MG/ML		✓	
	Interferon Beta-1a IM Auto-Injector Kit 30 MCG/0.5ML		✓	
	Interferon Beta-1a IM Prefilled Syringe Kit 30 MCG/0.5ML		✓	
	Interferon Beta-1a Soln Auto-inj 44 MCG/0.5ML		✓	
	Interferon Beta-1a Soln Pref Syr 44 MCG/0.5ML		✓	
	Teriflunomide Tab 7 MG		✓	
	Teriflunomide Tab 14 MG		✓	
Muscle Relaxants	ALL muscle relaxant products			After 90 days of use, may be considered for reimbursement upon submission of a prior authorization request that reflects use for an allowed condition in the claim. Prior authorization is not needed for dantrolene. A prior authorization request may be submitted to request reimbursement of more than one (1) muscle relaxant.
	Baclofen Tab 5 MG			Reimbursement is limited to 120 MG per day.
	Baclofen Tab 10 MG			
	Baclofen Tab 20 MG			
	Chlorzoxazone Tab 500 MG			Reimbursement is limited to 2000 MG per day.
	Cyclobenzaprine HCl Tab 5 MG			Reimbursement is limited to 30 MG per day.
	Cyclobenzaprine HCl Tab 7.5 MG			
	Cyclobenzaprine HCl Tab 10 MG			
	Dantrolene Sodium Cap 25 MG			Reimbursement is limited to 400 MG per day.
	Dantrolene Sodium Cap 50 MG			
	Dantrolene Sodium Cap 100 MG			
	Metaxalone Tab 800 MG			May be considered for reimbursement upon submission of a prior authorization request that reflects a minimum of a 14-day trial and documented inadequate response of another covered muscle relaxant (excluding ~~baclofen and~~ dantrolene) within the past 180 days. Reimbursement is limited to 3200 MG per day.
	Methocarbamol Tab 500 MG			Reimbursement is limited to 6000 MG per day.
	Methocarbamol Tab 750 MG			
	Orphenadrine Citrate Tab SR 12HR 100 MG			Reimbursement is limited to 200 MG per day.
	Tizanidine HCl Cap 2 MG (Base Equivalent)			Reimbursement is limited to 36 MG per day.
	Tizanidine HCl Cap 4 MG (Base Equivalent)			
	Tizanidine HCl Cap 6 MG (Base Equivalent)			
	Tizanidine HCl Tab 2 MG (Base Equivalent)			
	Tizanidine HCl Tab 4 MG (Base Equivalent)			
Nasal Agents – Misc.	Saline Nasal Spray 0.65%		✓	
Nasal Antiallergy	Azelastine HCl Nasal Spray 137 MCG/SPRAY (1 MG/ML)		✓	
	Azelastine HCl Nasal Spray 0.15% (205.5 MCG/SPRAY)		✓	
	Cromolyn Sodium Nasal Aerosol Soln 5.2 MG/ACT (4%)		✓	
	Olopatadine HCl Nasal Soln 0.6%		✓	
Nasal Anticholinergics	Ipratropium Bromide Nasal Soln 0.03% (21 MCG/SPRAY)		✓	
	Ipratropium Bromide Nasal Soln 0.06% (42 MCG/SPRAY)		✓	
Nasal Steroids	Beclomethasone Dipropionate Monohyd Nasal Susp 42 MCG/SPRAY		✓	
	Budesonide Nasal Susp 32 MCG/ACT		✓	

Medication Class Name	Medication Generic Name	Brand name (if applicable)	Allowed Condition Needed	Reimbursement restrictions or limitations for specific medications or dosage forms are listed with the respective medications below.
	Ciclesonide Nasal Susp 50 MCG/ACT		✓	
	Flunisolide Nasal Soln 25 MCG/ACT (0.025%)		✓	
	Fluticasone Furoate Nasal Susp 27.5 MCG/SPRAY		✓	
	Fluticasone Propionate Nasal Susp 50 MCG/ACT		✓	
	Mometasone Furoate Nasal Susp 50 MCG/ACT		✓	
	Triamcinolone Acetonide Nasal Aerosol Suspension 55 MCG/ACT		✓	
Nasal Sympathomimetic – Topical Decongestants	Oxymetazoline HCl Nasal Gel 0.05%		✓	Reimbursement is limited to one (1) package per 30 days.
	Oxymetazoline HCl Nasal Soln 0.05%		✓	
Nasal Sympathomimetic – Systemic Decongestants	Phenylephrine HCl Tab 10 MG		✓	Reimbursement is limited to 60 MG per day.
	Pseudoephedrine HCl Tab 30 MG		✓	Reimbursement is limited to 240 MG per day.
	Pseudoephedrine HCl Tab 60 MG		✓	
	Pseudoephedrine HCl Tab SR 12HR 120 MG		✓	
	Pseudoephedrine HCl Tab SR 24HR 240 MG		✓	
Ophthalmic Adrenergic Agents	Apraclonidine HCl Ophth Soln 0.5% (Base Equivalent)		✓	
	Brimonidine Tartrate Ophth Soln 0.025%			
	Brimonidine Tartrate Ophth Soln 0.1%			May be considered for reimbursement upon submission of a prior authorization request that reflects a documented allergic reaction, adverse event, or an inadequate response after a minimum of a 14-day trial of another agent in this class within the past 30 days.
	Brimonidine Tartrate Ophth Soln 0.15%			
	Brimonidine Tartrate Ophth Soln 0.2%		✓	
Ophthalmic ~~Antibiotics~~Anti-infectives	Azithromycin Ophth Soln 1%			
	Bacitracin Ophth Oint 500 Unit/GM			
	Bacitracin-Polymyxin B Ophth Oint			
	Besifloxacin HCl Ophth Susp 0.6% (Base Equiv)			
	Ciprofloxacin HCl Ophth Oint 0.3%			
	Ciprofloxacin HCl Ophth Soln 0.3% (Base Equivalent)			
	Erythromycin Ophth Oint 5 MG/GM			
	Ganciclovir Ophth Gel 0.15%			
	Gatifloxacin Ophth Soln 0.5%			
	Gentamicin Sulfate Ophth Oint 0.3%			
	Gentamicin Sulfate Ophth Soln 0.3%			
	Levofloxacin Ophth Soln 0.5%			
	Moxifloxacin HCl Ophth Soln 0.5% (Base Eq) (2 Times Daily)			
	Moxifloxacin HCl Ophth Soln 0.5% (Base Equiv)			
	Natamycin Ophth Susp 5%			
	Neomycin-Bacitrac Zn-Polymyx 5(3.5)MG-400Unt-10000Unt Op Oin			
	Neomycin-Polymyxin B-Gramicidin Ophth Soln			
	Ofloxacin Ophth Soln 0.3%			
	Polymyxin B-Trimethoprim Ophth Soln 10000 Unit/ML-0.1%			
	Sulfacetamide Sodium Ophth Soln 10%			
	Tobramycin Sulfate Ophth Oint 0.3%			
	Tobramycin Sulfate Ophth Soln 0.3%			
	Trifluridine Ophth Soln 1%			
Ophthalmic Artificial Tears and Lubricants	Artificial Tear Ophth Insert		✓	
	~~Artificial Tear Ophth Solution~~Perfluorohexyloctane Ophth Soln 100%		✓	
	Carboxymethylcell-Glycerin-Polysorb 80 Ophth Soln 0.5-1-0.5%			
	Carboxymethylcell-Glyc-Polysorb 80 (PF) Ophth Sol 0.5-1-0.5%			
	Carboxymethylcellulose Sodium Ophth Gel 1%		✓	
	Carboxymethylcellulose Sodium (PF) Ophth Gel 1%		✓	
	Carboxymethylcellulose Sodium Ophth Liquid 0.7%		✓	
	Carboxymethylcellulose Sodium Ophth Soln 0.25%		✓	
	Carboxymethylcellulose Sodium (PF) Ophth Soln 0.25%		✓	
	Carboxymethylcellulose Sodium Ophth Soln 0.5%		✓	
	Carboxymethylcellulose Sodium (PF) Ophth Soln 0.5%		✓	
	Carboxymethylcellulose Sodium Ophth Soln 1%		✓	
	Carboxymethylcellulose-Glycerin Ophth Gel 1-0.9%			
	Carboxymethylcellulose-Glycerin Ophth Soln 0.5-0.9%		✓	
	Carboxymethylcellulose-Glycerin (PF) Ophth Soln 0.5-0.9%		✓	
	Carboxymethylcellulose-Hypromellose Gel 0.25-0.3%			
	Dextran 70-Hypromellose (PF) Ophth Soln 0.1-0.3%		✓	
	Glycerin-Hypromellose-PEG 400 Ophth Soln 0.2-0.2-1%		✓	
	Hypromellose Ophth Gel 0.3%		✓	
	Hypromellose Ophth Soln 0.3%		✓	
	Hypromellose Ophth Soln 0.5%		✓	
	Light Mineral Oil-Mineral Oil Ophth Emulsion 0.5-0.5%			
	Polyethylene Glycol 400 Ophth Soln 1%		✓	
	Polyethylene Glycol-Propylene Glycol Ophth Gel 0.4-0.3%		✓	
	Polyethylene Glycol-Propylene Glycol Ophth Soln 0.4-0.3%		✓	

Medication Class Name	Medication Generic Name	Brand name (if applicable)	Allowed Condition Needed	Reimbursement restrictions or limitations for specific medications or dosage forms are listed with the respective medications below.
	Polyethylene Glycol-Propylene Glycol PF Op Soln 0.4-0.3%		✓	
	Polysorbate 80 (PF) Ophth Soln 1%			
	Polyvinyl Alcohol Ophth Soln 1.4%			
	Polyvinyl Alcohol-Povidone (PF) Ophth Soln 1.4-0.6%			
	Polyvinyl Alcohol-Povidone Ophth Soln 2.7-2%			
	Polyvinyl Alcohol-Povidone Ophth Soln 5-6 MG/ML (0.5-0.6%)			
	Propylene Glycol Ophth Soln 0.6%		✓	
	Propylene Glycol-Glycerin Ophth Soln 0.6-0.6%			
	Propylene Glycol-Glycerin Ophth Soln 1-0.3%		✓	
	White Petrolatum-Mineral Oil Ophth Ointment			
Ophthalmic Beta-blockers	Betaxolol HCl Ophth Susp 0.25%			May be considered for reimbursement upon submission of a prior authorization request that reflects a documented allergic reaction, adverse event, or an inadequate response after a minimum of a 14-day trial of another agent in this class within the past 30 days.
	Betaxolol HCl Ophth Soln 0.5%			
	Brimonidine Tartrate-Timolol Maleate Ophth Soln 0.2-0.5%		✓	
	Carteolol HCl Ophth Soln 1%		✓	
	Dorzolamide HCl-Timolol Maleate PF Ophth Soln 2-0.5%		✓	
	Dorzolamide HCl-Timolol Maleate Ophth Soln 22.3-6.8 MG/ML		✓	
	Levobunolol HCl Ophth Soln 0.5%		✓	
	Timolol Maleate Ophth Gel Forming Soln 0.25%		✓	
	Timolol Maleate Ophth Gel Forming Soln 0.5%		✓	
	Timolol Maleate Ophth Soln 0.25%		✓	
	Timolol Maleate Ophth Soln 0.5%		✓	
	Timolol Maleate Ophth Soln 0.5% (Once-Daily)			May be considered for reimbursement upon submission of a prior authorization request that reflects the injured worker is unable to use non-once daily formulation.
	Timolol Maleate Preservative Free Ophth Soln 0.25%			May be considered for reimbursement upon submission of a prior authorization request that reflects the injured worker is unable to use non-preservative free.
	Timolol Maleate Preservative Free Ophth Soln 0.5%			
	Timolol Ophth Soln 0.25%			May be considered for reimbursement upon submission of a prior authorization request that reflects a documented allergic reaction, adverse event, or an inadequate response after a minimum of a 14-day trial of another agent in this class within the past 30 days.
	Timolol Ophth Soln 0.5%			
Ophthalmic Cycloplegic Mydriatics	Atropine Sulfate Ophth Oint 1%		✓	
	Atropine Sulfate Ophth Soln 1%		✓	
	Cyclopentolate HCl Ophth Soln 1%		✓	
	Cyclopentolate HCl Ophth Soln 2%		✓	
	Homatropine HBr Ophth Soln 5%		✓	
Ophthalmic Decongestants	Naphazoline w/ Pheniramine Ophth Soln 0.025-0.3%		✓	
Ophthalmic Immunomodulators	Cyclosporine (Ophth) Emulsion 0.05%		✓	
Ophthalmic Integrin Antagonists	Lifitegrast Ophth Soln 5%		✓	
Ophthalmic Miotics	Pilocarpine HCl Ophth Soln 1%		✓	
	Pilocarpine HCl Ophth Soln 2%		✓	
	Pilocarpine HCl Ophth Soln 4%		✓	
Ophthalmic Misc.	Azelastine HCl Ophth Soln 0.05%		✓	
	Brinzolamide Ophth Susp 1%		✓	
	Bromfenac Sodium Ophth Soln 0.07% (Base Equivalent)			
	Bromfenac Sodium Ophth Soln 0.09% (Base Equiv) (Once-Daily)			
	Cromolyn Sodium Ophth Soln 4%		✓	
	Diclofenac Sodium Ophth Soln 0.1%			
	Dorzolamide HCl Ophth Soln 2%		✓	
	Epinastine HCl Ophth Soln 0.05%		✓	
	Flurbiprofen Sodium Ophth Soln 0.03%			
	Ketotifen Fumarate Ophth Soln 0.025% (Base Equiv)		✓	
	Ketotifen Fumarate Ophth Soln 0.035%		✓	
	Ketorolac Tromethamine Ophth Soln 0.4%			
	Ketorolac Tromethamine (PF) Ophth Soln 0.45%			
	Ketorolac Tromethamine Ophth Soln 0.5%			
	Nepafenac Ophth Susp 0.1%			
	Olopatadine HCl Ophth Soln 0.1% (Base Equivalent)		✓	
	Olopatadine HCl Ophth Soln 0.2% (Base Equivalent)		✓	
	Sodium Chloride Hypertonic Ophth Oint 5%		✓	
	Sodium Chloride Hypertonic Ophth Soln 2%		✓	
	Sodium Chloride Hypertonic Ophth Soln 5%		✓	
Ophthalmic Prostaglandins	Bimatoprost Ophth Soln 0.01%			May be considered for reimbursement upon submission of a prior authorization request that reflects a documented allergic reaction, adverse event, or an inadequate response after a minimum of a 14-day trial of another agent in this class within the past 30 days.
	Latanoprost Ophth Soln 0.005%		✓	
	Travoprost Ophth Soln 0.004% (Benzalkonium Free) (BAK Free)			May be considered for reimbursement upon submission of a prior authorization request that reflects the injured worker is unable to use non-BAK Free.
Ophthalmic Steroids	Bacitracin-Polymyxin-Neomycin-HC Ophth Oint 1%			
	Dexamethasone Ophth Susp 0.1%			

Medication Class Name	Medication Generic Name	Brand name (if applicable)	Allowed Condition Needed	Reimbursement restrictions or limitations for specific medications or dosage forms are listed with the respective medications below.
	Dexamethasone Sodium Phosphate Ophth Soln 0.1%			
	Difluprednate Ophth Emulsion 0.05%			
	Fluorometholone Acetate Ophth Susp 0.1%			
	Fluorometholone Ophth Oint 0.1%			
	Fluorometholone Ophth Susp 0.1%			
	Fluorometholone Ophth Susp 0.25%			
	Gentamicin-Prednisolone Ace Ophth Susp 0.3-1%			
	Loteprednol Etabonate Ophth Gel 0.5%			
	Loteprednol Etabonate Ophth Oint 0.5%			
	Loteprednol Etabonate Ophth Susp 0.2%			
	Loteprednol Etabonate Ophth Susp 0.5%			
	Loteprednol Etabonate-Tobramycin Ophth Susp 0.5-0.3%			
	Neomycin-Polymyxin-Dexamethasone Ophth Oint 0.1%			
	Neomycin-Polymyxin-Dexamethasone Ophth Susp 0.1%			
	Neomycin-Polymyxin-HC Ophth Susp			
	Prednisolone Acetate Ophth Susp 0.12%			
	Prednisolone Acetate Ophth Susp 1%			
	Prednisolone Sodium Phosphate Ophth Soln 1%			
	Sulfacetamide Sodium-Prednisolone Ophth Oint 10-0.2%			
	Sulfacetamide Sodium-Prednisolone Ophth Soln 10-0.23(0.25)%			
	Sulfacetamide Sodium-Prednisolone Ophth Susp 10-0.2%			
	Tobramycin-Dexamethasone Ophth Oint 0.3-0.1%			
	Tobramycin-Dexamethasone Ophth Oint 0.3-0.1%			
	Tobramycin-Dexamethasone Ophth Susp 0.3-0.05%			
	Tobramycin-Dexamethasone Ophth Susp 0.3-0.1%			
Otic Agents – Misc.	Acetic Acid Otic Soln 2%		✓	
Otic Agents –Anti-infectives	Ofloxacin Otic Soln 0.3%		✓	
Otic Agents—Combinations	Ciprofloxacin-Dexamethasone Otic Susp 0.3-0.1%		✓	
	Ciprofloxacin-Hydrocortisone Otic Susp 0.2-1%		✓	
	Neomycin-Colistin-HC-Thonzonium Otic Susp 3.3-3-10-0.5 MG/ML		✓	
	Neomycin-Polymyxin-HC Otic Soln 1%		✓	
	Neomycin-Polymyxin-HC Otic Susp 3.5 MG/ML-10000 Unit/ML-1%		✓	
Otic Agents—Steroids	Fluocinolone Acetonide (Otic) Oil 0.01%		✓	
	Hydrocortisone w/ Acetic Acid Otic Soln 1-2%		✓	
Oxytocics	Methylergonovine Maleate Tab 0.2 MG		✓	
Phosphate Binder Agents	Calcium Acetate (Phosphate Binder) Cap 667 MG (169 MG Ca)		✓	
	Lanthanum Carbonate Chew Tab 500 MG (Elemental)		✓	
	Lanthanum Carbonate Chew Tab 750 MG (Elemental)		✓	
	Lanthanum Carbonate Chew Tab 1000 MG (Elemental)		✓	
	Lanthanum Carbonate Oral Powder Pack 750 MG (Elemental)		✓	
	Lanthanum Carbonate Oral Powder Pack 1000 MG (Elemental)		✓	
	Sevelamer Carbonate Packet 2.4 GM		✓	
	Sevelamer Carbonate Tab 800 MG		✓	
	Sevelamer HCl Tab 800 MG		✓	
Postherpetic Neuralgia (PHN)/Neuropathic Pain Agents	Gabapentin (Once-Daily) Tab 300 MG			~~Gabapentin Extended-Release product class restriction:~~ Gabapentin Extended-Release products may be considered for reimbursement upon submission of a prior authorization request that reflects a minimum of a 90-day trial and documented inadequate response of the immediate release form of gabapentin within the past 120 days. Coverage of all gabapentin products is restricted to a single form at any one time. Claims in which an extended-release gabapentin product was approved prior to February 1, 2023 and has been continuously reimbursed since then are not subject to the 90-day trial and failure of immediate release gabapentin. Reimbursement is limited to 1,800 MG/day.
	Gabapentin (Once-Daily) Tab 600 MG			
Potassium Removing ~~Agents~~Resins	Sodium Polystyrene Sulfonate Powder		✓	
~~Endocrine —~~Progestins	Medroxyprogesterone Acetate Tab 10 MG		✓	
	Megestrol Acetate Susp 625 MG/5ML		✓	
Pseudobulbar Affect (PBA) Agents	Dextromethorphan HBr-Quinidine Sulfate Cap 20-10 MG	NUEDEXTA	✓	
Pulmonary Hypertension – Endothelin Receptor Antagonists	Ambrisentan Tab 10 MG		✓	
Pulmonary Hypertension – Phosphodiesterase Inhibitors	Sildenafil Citrate Tab 20 MG		✓	
Rectal – Intrarectal Steroids	Hydrocortisone Enema 100 MG/60ML		✓	
Rectal – Local Anesthetics	Dibucaine Rectal Ointment 1%			
	Hydrocortisone Acetate w/ Pramoxine Rectal Cream 1-1%		✓	

Medication Class Name	Medication Generic Name	Brand name (if applicable)	Allowed Condition Needed	Reimbursement restrictions or limitations for specific medications or dosage forms are listed with the respective medications below.
	Hydrocortisone Acetate w/ Pramoxine Rectal Cream 2.5-1%		✓	
	Hydrocortisone Acetate w/ Pramoxine Rectal Foam 1-1%		✓	
	Lidocaine Anorectal Cream 5%			
	Lidocaine Anorectal Gel 5%			
	Lidocaine-Hydrocortisone Acetate Rectal Cream 3-0.5%		✓	
	Phenylephrine-Mineral Oil-Petrolatum Oint 0.25-14-71.9%			
	Phenylephrine-Shark Liver Oil-MO-Pet Oint 0.25-3-14-71.9%			
	Phenyleph-Shark Liver Oil-Cocoa Butter Suppos 0.25-3-85.5%			
	Pramoxine HCl Rectal Foam 1%			
	Pramox-PE-Glycerin-Petrolatum Rectal Cream 1-0.25-14.4-15%			
Rectal – Steroids	Hydrocortisone Rectal Cream 1%		✓	
	Hydrocortisone Rectal Cream 2.5%		✓	
Respiratory Agents– Antiasthmatic – Monoclonal Antibodies	Benralizumab Subcutaneous Soln Auto-injector 30 MG/ML			May be considered for reimbursement as add-on maintenance treatment upon submission of a prior authorization request that reflects: 1. Asthma as an allowed condition 2. Inadequate control of asthma after at least three (3) months of use of an inhaled corticosteroid plus a long-acting beta-agonist, or an inhaled corticosteroid plus a long-acting muscarinic antagonist 3. A peripheral eosinophil count greater than or equal to 300 cells/mcL in the past 12 months. Initial approval will be no greater than six (6) months, and subsequent requests may be considered if there is a documented decrease in exacerbations, improvement in pulmonary function tests, improvement in symptoms, or decrease in utilization of rescue medications.
	Benralizumab Subcutaneous Soln Prefilled Syringe 10 MG/0.5ML	FASENRA		
	Benralizumab Subcutaneous Soln Prefilled Syringe 30 MG/ML			
	Omalizumab Subcutaneous Soln Auto-Injector 75 MG/0.5ML	XOLAIR		May be considered for reimbursement upon submission of a prior authorization request that reflects: 1. Asthma as an allowed condition 2. A positive skin test or specific IgE 3. Inadequate control of asthma after at least three (3) months of use of an inhaled corticosteroid Initial approval will be no greater than six (6) months, and subsequent requests may be considered if there is a documented decrease in exacerbations, improvement in pulmonary function tests, improvement in symptoms, or decrease in utilization of rescue medications.
	Omalizumab Subcutaneous Soln Auto-Injector 150 MG/ML			
	Omalizumab Subcutaneous Soln Auto-Injector 300 MG/2ML			
	Omalizumab Subcutaneous Soln Prefilled Syringe 75 MG/0.5ML			
	Omalizumab Subcutaneous Soln Prefilled Syringe 150 MG/ML			
	Omalizumab Subcutaneous Soln Prefilled Syringe 300 MG/2ML			
	Dupilumab Subcutaneous Soln Auto-injector 300 MG/2ML	DUPIXENT		May be considered for reimbursement upon submission of a prior authorization request that reflects: For Asthma: 1. Asthma is allowed or related to an allowed condition in the claim. 2. Inadequate control of asthma after at least three (3) months of use of an inhaled corticosteroid (ICS) plus a long-acting beta-agonist (LABA), or an ~~inhaled corticosteroid~~ ICS plus a long-acting muscarinic antagonist (LAMA). 3. ~~A peripheral~~An eosinophil count greater than or equal to ~~300~~ 150 cells/mcL within the past 12 months prior to the initiation of therapy. For Chronic Obstructive Pulmonary Disease (COPD): 1. COPD is allowed or related to an allowed condition in the claim. 2. Inadequate control of COPD after at least three (3) months of use of a LAMA+LABA+ICS.

Medication Class Name	Medication Generic Name	Brand name (if applicable)	Allowed Condition Needed	Reimbursement restrictions or limitations for specific medications or dosage forms are listed with the respective medications below.
	Dupilumab Subcutaneous Soln Prefilled Syringe 300 MG/2ML			3. An eosinophil count greater than or equal to 300 cells/mcL within the past 12 months prior to the initiation of therapy. For Chronic Rhinosinusitis with Nasal Polyps: 1. Chronic rhinosinusitis with nasal polyps is allowed or related to an allowed condition in the claim. 2. Inadequate response to at least one (1) month of use of one (1) intranasal corticosteroid plus one (1) oral corticosteroid. For Atopic Dermatitis: 1. Atopic dermatitis is allowed or related to an allowed condition in the claim. 2. A minimum of 10% body surface area (BSA) involvement and inadequate response to two (2) months of use of two (2) topical corticosteroids or topical calcineurin inhibitors unless severe disease with BSA >25%. Initial approval will be no greater than six (6) months. ~~and s~~Subsequent requests may be considered if there is a documented improvement of condition and/or benefit (e.g. decrease in exacerbations, improvement in pulmonary function tests, improvement in symptoms, or decrease in utilization of rescue medications).
Respiratory Agents– Short-Acting Anticholinergics (SAMA)	Ipratropium Bromide HFA Inhal Aerosol 17 MCG/ACT	ATROVENT HFA	✓	
Respiratory Agents– Long-Acting Anticholinergics (LAMA)	Aclidinium Bromide Aerosol Powd Breath Activated 400 MCG/ACT	TUDORZA PRESSAIR	✓	
	Glycopyrrolate Inhal Cap 15.6 MCG	SEEBRI	✓	
	Ipratropium Bromide Inhal Soln 0.02%		✓	
	Tiotropium Bromide ~~Monohydrate~~ Inhal Aerosol 1.25 MCG/ACT	SPIRIVA RESPIMAT		May be considered for reimbursement upon submission of a prior authorization request that reflects a documented allergic reaction, adverse event, or an inadequate response after a minimum of a 30-day trial of another agent in this class within the past 120 days.
	Tiotropium Bromide ~~Monohydrate~~ Inhal Aerosol 2.5 MCG/ACT			
	Tiotropium Bromide ~~Monohydrate~~ Inhal Cap 18 MCG (Base Equiv)	SPIRIVA HANDIHALER		
	Umeclidinium Br Aero Powd Breath Act 62.5 MCG/ACT (Base Eq)	INCRUSE ELLIPTA	✓	
Respiratory Agents – Leukotriene Modulators	Montelukast Sodium Chew Tab 5 MG (Base Equiv)		✓	
	Montelukast Sodium Tab 10 MG (Base Equiv)		✓	
	Zafirlukast Tab 20 MG		✓	
	Zileuton Tab SR 12HR 600 MG			May be considered for reimbursement upon submission of a prior authorization request that reflects a documented allergic reaction, adverse event, or an inadequate response after a minimum of a 60-day trial of another agent in this class within the past 120 days.
Respiratory Agents– Selective Phosphodiesterase 4 (PDE4) Inhibitors	Roflumilast Tab 250 MCG		✓	
	Roflumilast Tab 500 MCG		✓	
Respiratory Agents– Steroid Inhalants (ICS)	Beclomethasone Diprop HFA Breath Act Inh Aer 40 MCG/ACT	QVAR REDIHALER	✓	
	Beclomethasone Diprop HFA Breath Act Inh Aer 80 MCG/ACT		✓	
	Budesonide Inhal Aero Powd 90 MCG/ACT (Breath Activated)	PULMICORT FLEXIHALER	✓	
	Budesonide Inhal Aero Powd 180 MCG/ACT (Breath Activated)		✓	
	Budesonide Inhalation Susp 0.25 MG/2ML		✓	
	Budesonide Inhalation Susp 0.5 MG/2ML		✓	
	Budesonide Inhalation Susp 1 MG/2ML		✓	
	Ciclesonide Inhal Aerosol 80 MCG/ACT	ALVESCO	✓	
	Ciclesonide Inhal Aerosol 160 MCG/ACT		✓	
	Fluticasone Furoate Aerosol Powder Breath Activ 100 MCG/ACT	ARNUITY ELLIPTA	✓	
	Fluticasone Furoate Aerosol Powder Breath Activ 200 MCG/ACT		✓	
	Fluticasone Propionate Aer Pow BA 50 MCG/ACT	FLOVENT DISKUS	✓	
	Fluticasone Propionate Aer Pow BA 100 MCG/BLISTER		✓	
	Fluticasone Propionate Aer Pow BA 250 MCG/ACT		✓	
	Fluticasone Propionate HFA Inhal Aero 44 MCG/ACT (50/Valve)	FLOVENT HFA	✓	
	Fluticasone Propionate HFA Inhal Aer 110 MCG/ACT (125/Valve)		✓	
	Fluticasone Propionate HFA Inhal Aer 220 MCG/ACT (250/Valve)		✓	
	Mometasone Furoate Inhal Aerosol Suspension 50 MCG/ACT	ASMANEX HFA	✓	
	Mometasone Furoate Inhal Aerosol Suspension 100 MCG/ACT		✓	
	Mometasone Furoate Inhal Aerosol Suspension 200 MCG/ACT		✓	
	Mometasone Furoate Inhal Powd 110 MCG/ACT (Breath Activated)	ASMANEX TWISTHALER	✓	
	Mometasone Furoate Inhal Powd 220 MCG/INH (Breath Activated)		✓	

Medication Class Name	Medication Generic Name	Brand name (if applicable)	Allowed Condition Needed	Reimbursement restrictions or limitations for specific medications or dosage forms are listed with the respective medications below.
Respiratory Agents– ~~Sympathomimetics – Short-acting Beta Agonists (SABA)~~	Albuterol Sulfate Aer Pow BA 108 MCG/ACT (90 MCG Base Equiv)	PROAIR RESPICLICK		May be considered for reimbursement upon submission of a prior authorization request that reflects a documented allergic reaction, adverse event, inability to use, or an inadequate response after a minimum of a 14-day trial of another agent in this class within the past 60 days.
	Albuterol Sulfate Inhal Aero 108 MCG/ACT (90MCG Base Equiv)		✓	
	Albuterol Sulfate Soln Nebu 0.083% (2.5 MG/3ML)		✓	
	Albuterol Sulfate Soln Nebu 0.5% (5 MG/ML)		✓	
	Albuterol Sulfate Soln Nebu 0.63 MG/3ML (Base Equiv)		✓	
	Albuterol Sulfate Soln Nebu 1.25 MG/3ML (Base Equiv)		✓	
	Albuterol Sulfate Syrup 2 MG/5ML		✓	
	Albuterol Sulfate Tab 2 MG		✓	
	Albuterol Sulfate Tab 4 MG		✓	
	Albuterol Sulfate Tab SR 12HR 4 MG		✓	
	Albuterol Sulfate Tab ER 12HR 8 MG		✓	
	Levalbuterol HCl Soln Nebu 0.31 MG/3ML (Base Equiv)		✓	
	Levalbuterol HCl Soln Nebu 0.63 MG/3ML (Base Equiv)		✓	
	Levalbuterol HCl Soln Nebu 1.25 MG/3ML (Base Equiv)		✓	
	Levalbuterol HCl Soln Nebu Conc 1.25 MG/0.5ML (Base Equiv)		✓	
	Levalbuterol Tartrate Inhal Aerosol 45 MCG/ACT (Base Equiv)		✓	
Respiratory Agents– Long-acting Beta Agonists (LABA)	Arformoterol Tartrate Soln Nebu 15 MCG/2ML (Base Equiv)		✓	
	Formoterol Fumarate Soln Nebu 20 MCG/2ML		✓	
	Olodaterol HCl Inhal Aerosol Soln 2.5 MCG/ACT (Base Equiv)		✓	
	Salmeterol Xinafoate Aer Pow BA 50 MCG/DOSE (Base Equiv)	SEREVENT DISKUS	✓	
Respiratory Agents— Combination Long-Acting Beta Agonist plus Corticosteroid (LABA+ICS)	Budesonide-Formoterol Fumarate Dihyd Aerosol 80-4.5 MCG/ACT	SYMBICORT	✓	
	Budesonide-Formoterol Fumarate Dihyd Aerosol 160-4.5 MCG/ACT		✓	
	Fluticasone Furoate-Vilanterol Aero Powd BA 100-25 MCG/ACT	BREO ELLIPTA	✓	
	Fluticasone Furoate-Vilanterol Aero Powd BA 200-25 MCG/ACT		✓	
	Fluticasone-Salmeterol Aer Powder BA 55-14 MCG/ACT	ADVAIR DISKUS	✓	
	Fluticasone-Salmeterol Aer Powder BA 113-14 MCG/ACT		✓	
	Fluticasone-Salmeterol Aer Powder BA 100-50 MCG/DOSE		✓	
	Fluticasone-Salmeterol Aer Powder BA 232-14 MCG/ACT		✓	
	Fluticasone-Salmeterol Aer Powder BA 250-50 MCG/DOSE		✓	
	Fluticasone-Salmeterol Aer Powder BA 500-50 MCG/DOSE		✓	
	Fluticasone-Salmeterol Inhal Aerosol 45-21 MCG/ACT	ADVAIR HFA	✓	
	Fluticasone-Salmeterol Inhal Aerosol 115-21 MCG/ACT		✓	
	Fluticasone-Salmeterol Inhal Aerosol 230-21 MCG/ACT		✓	
	Mometasone Furoate-Formoterol Fumarate Aerosol MCG/ACT		✓	
	Mometasone Furoate-Formoterol Fumarate Aerosol 100-5 MCG/ACT	DULERA	✓	
	Mometasone Furoate-Formoterol Fumarate Aerosol 200-5 MCG/ACT		✓	
Respiratory— Combination LABA plus Long-Acting Anticholinergic (LAMA)	Glycopyrrolate-Formoterol Fumarate Aerosol 9-4.8 MCG/ACT	BEVESPI	✓	
	Tiotropium Br-Olodaterol Inhal Aero Soln 2.5-2.5 MCG/ACT	STIOLTO		May be considered for reimbursement upon submission of a prior authorization request that reflects a documented allergic reaction or inadequate response to at least one (1) other medication in this class other than short-acting beta agonist products.
	Umeclidinium-Vilanterol Aero Powd BA 62.5-25 MCG/ACT	ANORO ELLIPTA		
Respiratory—SAMA + SABA	Ipratropium-Albuterol Inhal Aerosol Soln 20-100 MCG/ACT		✓	
	Ipratropium-Albuterol Nebu Soln 0.5-2.5(3) MG/3ML		✓	
Respiratory Agents— Triple Combination (LABA+LAMA+ICS)	Fluticasone-Umeclidinium-Vilanterol AEPB 100-62.5-25 MCG/ACT	TRELEGY ELLIPTA		May be considered for reimbursement upon submission of a prior authorization that reflects a documented allergic reaction or inadequate response to at least ~~two (2) other~~ one (1) inhaled respiratory medication~~s~~ from two (2) different classes, which may include dual therapy medications, ~~in this class~~ other than short-acting beta agonist products.
	Fluticasone-Umeclidinium-Vilanterol AEPB 200-62.5-25 MCG/ACT			
Respiratory Agents— Sympathomimetics	Racepinephrine HCl Soln Nebu 2.25% (Base equivalent)		✓	
	Terbutaline Sulfate Tab 2.5 MG		✓	
	Terbutaline Sulfate Tab 5 MG		✓	
Respiratory Agents– Xanthines	Theophylline Cap ER 24HR 100 MG		✓	
	Theophylline Cap SR 24HR 200 MG		✓	
	Theophylline Cap SR 24HR 300 MG		✓	

Medication Class Name	Medication Generic Name	Brand name (if applicable)	Allowed Condition Needed	Reimbursement restrictions or limitations for specific medications or dosage forms are listed with the respective medications below.
	Theophylline Cap ER 24HR 400 MG		✓	
	Theophylline Tab SR 12HR 300 MG		✓	
	Theophylline Tab SR 24HR 400 MG		✓	
	Theophylline Tab SR 24HR 600 MG		✓	
Respiratory Agents – Misc.	Brensocatib Tab 10 MG	BRINSUPRI		May be considered for reimbursement upon submission of a prior authorization request that reflects: 1. Bronchiectasis is an allowed condition. 2. Not diagnosed with cystic fibrosis. 3. Chronic obstructive pulmonary disease (COPD) or asthma diagnosis are not the primary driver of respiratory illness. 4. Documentation of ≥2 exacerbations in the past 12 months requiring antibiotics or hospitalization. 5. Trial and failure (or intolerance) of chronic oral azithromycin or inhaled tobramycin suppressive therapy for at least six months, unless these therapies are contraindicated. Initial approval will be no greater than six (6) months, and subsequent requests may be considered if there is a documented decrease in exacerbations requiring antibiotics or hospitalization, improvement in pulmonary function tests, or improvement in pulmonary symptoms. Reimbursement is limited to one (1) tablet per day.
	Brensocatib Tab 25 MG			
Respiratory Agents – Misc. Cystic Fibrosis Agents	Dornase Alfa Inhal Soln 2.5 MG/2.5ML		✓	
Respiratory Agents – Misc. Pulmonary Fibrosis Agents	Nintedanib Esylate Cap 100 MG (Base Equivalent)	OFEV		May be considered for reimbursement upon submission of a prior authorization request that reflects the injured worker is being treated for interstitial lung disease related to an allowed condition in the claim and includes documentation of clinical signs of progression (defined as Forced Vital Capacity (FVC) decline with worsening symptoms or imaging) within the past year and an FVC greater than or equal to forty percent of predicted.
	Nintedanib Esylate Cap 150 MG (Base Equivalent)			
Restless Leg Syndrome (RLS) Agents	Gabapentin Enacarbil Tab ER 300 MG	HORIZANT		Gabapentin Extended-Release products may be considered for reimbursement upon submission of a prior authorization request that reflects a minimum of a 90-day trial and documented inadequate response of the immediate release form of gabapentin within the past 120 days. Coverage of all gabapentin products is restricted to a single form at any one time. Claims in which an extended-release gabapentin product was approved prior to February 1, 2023 and has been continuously reimbursed since then are not subject to the 90-day trial and failure of immediate release gabapentin. Reimbursement is limited to 1,200 MG/day.
	Gabapentin Enacarbil Tab ER 600 MG			
Rosacea Agents – Oral	Doxycycline (Rosacea) Cap Delayed Release 40 MG		✓	
Thyroid Hormones	Levothyroxine Sodium Tab 25 MCG		✓	
	Levothyroxine Sodium Tab 50 MCG		✓	
	Levothyroxine Sodium Tab 75 MCG		✓	
	Levothyroxine Sodium Tab 88 MCG		✓	
	Levothyroxine Sodium Tab 100 MCG		✓	
	Levothyroxine Sodium Tab 112 MCG		✓	
	Levothyroxine Sodium Tab 125 MCG		✓	
	Levothyroxine Sodium Tab 137 MCG		✓	
	Levothyroxine Sodium Tab 150 MCG		✓	
	Levothyroxine Sodium Tab 175 MCG		✓	
	Levothyroxine Sodium Tab 200 MCG		✓	
	Levothyroxine Sodium Tab 300 MCG		✓	
	Liothyronine Sodium Tab 5 MCG		✓	
	Liothyronine Sodium Tab 25 MCG		✓	
	Liothyronine Sodium Tab 50 MCG		✓	
	Thyroid Tab 30 MG (1/2 Grain)		✓	
	Thyroid Tab 60 MG (1 Grain)		✓	
	Thyroid Tab 81.25 MG		✓	
	Thyroid Tab 90 MG (1 1/2 Grain)		✓	
	Thyroid Tab 162.5 MG (2 1/2 Grain)		✓	
Topical – Agents for External Genital and Perianal Warts	Sinecatechins Oint 15%		✓	
Topical – Analgesics	Menthol Aerosol 10.5%			
	Menthol Aerosol Powder 1%			
	Menthol Cream 7.5%			
	Menthol Cream 16%			
	Menthol Gel 2%			
	Menthol Gel 2.5%			
	Menthol Gel 3.1%			
	Menthol Gel 3.5%			
	Menthol Gel 3.7%			
	Menthol Gel 4%			
	Menthol Gel 4.5%			
	Menthol Gel 5%			
	Menthol Gel 5.5%			
	Menthol Gel 6%			
	Menthol Gel 7%			
	Menthol Gel 10%			
	Menthol Gel 16%			
	Menthol Liquid 2.5%			

APPENDIX TO RULE 4123-6-21.3
Formulary List of Medications Covered by the Ohio Bureau of Workers' Compensation

Medication Class Name	Medication Generic Name	Brand name (if applicable)	Allowed Condition Needed	Reimbursement restrictions or limitations for specific medications or dosage forms are listed with the respective medications below.
	Menthol Liquid 3.5%			
	Menthol Liquid 3.7%			
	Menthol Liquid 8%			
	Menthol Liquid 10%			
	Menthol Liquid 16%			
	Menthol Lotion 0.1%			
	Menthol Lotion 7.5%			
	Menthol Lotion 8.5%			
	Menthol Patch 5%			
	Menthol Patch 7.5%			
	Menthol Roll 7.5%			
	Menthol Sleeve 16%			
Topical – Antibiotics	Bacitracin Oint 500 Unit/GM			
	Bacitracin Zinc Oint 500 Unit/GM			
	Bacitracin-Polymyxin B Oint			
	Gentamicin Sulfate Cream 0.1%			
	Gentamicin Sulfate Oint 0.1%			
	Mupirocin Calcium Cream 2%			
	Mupirocin Oint 2%			
	Neomycin-Bacitracin-Polymyxin Oint			
	Neomycin-Bacitracin-Polymyxin-Pramoxine Oint 1%			
	Neomycin-Polymyxin w/ Pramoxine Cream 1%			
	Retapamulin Oint 1%		✓	
Topical – Antifungals	Butenafine HCl Cream 1%		✓	
	Ciclopirox Gel 0.77%		✓	
	Ciclopirox Olamine Cream 0.77% (Base Equiv)		✓	
	Ciclopirox Olamine Susp 0.77% (Base Equiv)		✓	
	Ciclopirox Shampoo 1%		✓	
	Ciclopirox Solution 8%		✓	
	Clotrimazole Cream 1%		✓	
	Clotrimazole Ointment 1%		✓	
	Clotrimazole Soln 1%		✓	
	Clotrimazole w/ Betamethasone Cream 1-0.05%		✓	
	Clotrimazole w/ Betamethasone Lotion 1-0.05%		✓	
	Econazole Nitrate Cream 1%		✓	
	Gentian Violet Soln 1%		✓	
	Ketoconazole Cream 2%		✓	
	Ketoconazole Foam 2%		✓	
	Ketoconazole Shampoo 2%		✓	
	Miconazole Nitrate Cream 2%		✓	
	Miconazole Nitrate Ointment 2%		✓	
	Miconazole Nitrate Powder 2%		✓	
	Miconazole Nitrate Soln 2%		✓	
	Miconazole-Zinc Oxide-White Petrolatum Oint 0.25-15-81.35%		✓	
	Naftifine HCl Cream 1%		✓	
	Naftifine HCl Gel 1%		✓	
	Nystatin Cream 100000 Unit/GM		✓	
	Nystatin Oint 100000 Unit/GM		✓	
	Nystatin Topical Powder 100000 Unit/GM		✓	
	Nystatin-Triamcinolone Cream 100000-0.1 Unit/GM-%		✓	
	Nystatin-Triamcinolone Oint 100000-0.1 Unit/GM-%		✓	
	Oxiconazole Nitrate Cream 1%		✓	
	Oxiconazole Nitrate Lotion 1%		✓	
	Sertaconazole Nitrate Cream 2%		✓	
	Sulconazole Nitrate Cream 1%		✓	
	Terbinafine HCl Cream 1%		✓	
	Tolnaftate Aerosol Pow 1%		✓	
	Tolnaftate Cream 1%		✓	
	Tolnaftate Powder 1%		✓	
	Tolnaftate Soln 1%		✓	
Topical – Antihistamines	Diphenhydramine HCl Cream 2%			
Topical – Anti-inflammatory Agents	Diclofenac Sodium Gel 1% (1.16% Diethylamine Equiv)			
	Diclofenac Sodium Soln 1.5%	PENNSAID	✓	May be reimbursed in claims with osteoarthritis of the knee as an allowed condition.
	Diclofenac Epolamine Patch 1.3%	FLECTOR		May be considered for reimbursement upon submission of a prior authorization request that reflects a contraindication, intolerance, or clinical failure to at least two (2) other non-steroidal anti-inflammatory drugs on the formulary. Reimbursement is limited to the first 12 weeks following the date of injury and may not exceed two (2) patches per day. Will not be reimbursed concurrently with other non-steroidal anti-inflammatory drugs.
Topical – Antineoplastic or Premalignant Lesion Agents	Diclofenac Sodium (Actinic Keratoses) Gel 3%		✓	May be reimbursed in claims with Actinic Keratosis as an allowed condition.
	Fluorouracil Cream 0.5%		✓	-
	Fluorouracil Cream 4%		✓	
	Fluorouracil Cream 5%		✓	
Topical – Antipruritics	Camphor & Menthol Gel 0.2-3.5%			
	Camphor & Menthol Lotion 0.5-0.5%			
	Doxepin HCl Cream 5%			May be considered for reimbursement upon submission of a prior authorization request with documented medical justification.
Topical – Antivirals	Acyclovir Cream 5%		✓	
	Acyclovir Oint 5%		✓	
	Penciclovir Cream 1%		✓	

Medication Class Name	Medication Generic Name	Brand name (if applicable)	Allowed Condition Needed	Reimbursement restrictions or limitations for specific medications or dosage forms are listed with the respective medications below.
Topical – Burn Products	Mafenide Acetate Cream 85 MG/GM			
	Mafenide Acetate Packet For Topical Soln 5% (50 GM)			
	Silver Sulfadiazine Cream 1%			
Topical – Cauterizing Agents	Silver Nitrate-Potassium Nitrate Applicator 75-25%			
Topical – Corticosteroids Very High Potency	Betamethasone Dipropionate Augmented Gel 0.05%		✓	Reimbursement is only permitted when prescribed for an allowed dermatological condition. Topical corticosteroids will not be approved for the treatment of pain.
	Betamethasone Dipropionate Augmented Lotion 0.05%		✓	
	Betamethasone Dipropionate Augmented Oint 0.05%		✓	
	Clobetasol Propionate Cream 0.05%		✓	
	Clobetasol Propionate Emollient Base Cream 0.05%		✓	
	Clobetasol Propionate Emulsion Foam 0.05%		✓	
	Clobetasol Propionate Foam 0.05%		✓	
	Clobetasol Propionate Gel 0.05%		✓	
	Clobetasol Propionate Lotion 0.05%		✓	
	Clobetasol Propionate Oint 0.05%		✓	
	Clobetasol Propionate Shampoo 0.05%		✓	
	Clobetasol Propionate Soln 0.05%		✓	
	Clobetasol Propionate Spray 0.05%		✓	
	Diflorasone Diacetate Oint 0.05%		✓	
	Fluocinonide Cream 0.1%		✓	
	Flurandrenolide Tape 4 MCG/SQCM		✓	
	Halobetasol Propionate Cream 0.05%		✓	
	Halobetasol Propionate Oint 0.05%		✓	
Topical – Corticosteroids High Potency	Amcinonide Cream 0.1%		✓	Reimbursement is only permitted when prescribed for an allowed dermatological condition. Topical corticosteroids will not be approved for the treatment of pain.
	Amcinonide Oint 0.1%		✓	
	Betamethasone Dipropionate Augmented Cream 0.05%		✓	
	Betamethasone Dipropionate Oint 0.05%		✓	
	Calcipotriene-Betamethasone Dipropionate Foam 0.005-0.064%		✓	
	Calcipotriene-Betamethasone Dipropionate Oint 0.005-0.064%		✓	
	Desoximetasone Cream 0.25%		✓	
	Desoximetasone Gel 0.05%		✓	
	Desoximetasone Oint 0.25%		✓	
	Diflorasone Diacetate Cream 0.05%		✓	
	Diflorasone Diacetate Emollient Base Cream 0.05%		✓	
	Fluocinonide Cream 0.05%		✓	
	Fluocinonide Gel 0.05%		✓	
	Fluocinonide Oint 0.05%		✓	
	Fluocinonide Soln 0.05%		✓	
	Halcinonide Cream 0.1%		✓	
	Halcinonide Oint 0.1%		✓	
	Mometasone Furoate Oint 0.1%		✓	
	Triamcinolone Acetonide Cream 0.5%		✓	
	Triamcinolone Acetonide Oint 0.5%		✓	
Topical – Corticosteroids Medium Potency	Betamethasone Dipropionate Cream 0.05%		✓	Reimbursement is only permitted when prescribed for an allowed dermatological condition. Topical corticosteroids will not be approved for the treatment of pain.
	Betamethasone Dipropionate Lotion 0.05%		✓	
	Betamethasone Valerate Aerosol Foam 0.12%		✓	
	Betamethasone Valerate Cream 0.1% (Base Equivalent)		✓	
	Betamethasone Valerate Lotion 0.1% (Base Equivalent)		✓	
	Betamethasone Valerate Oint 0.1% (Base Equivalent)		✓	
	Clocortolone Pivalate Cream 0.1%		✓	
	Desoximetasone Cream 0.05%		✓	
	Fluocinolone Acetonide Cream 0.025%		✓	
	Fluocinolone Acetonide Oint 0.025%		✓	
	Fluocinolone Acetonide Shampoo 0.01%		✓	
	Fluocinonide Emulsified Base Cream 0.05%		✓	
	Flurandrenolide Cream 0.05%		✓	
	Fluticasone Propionate Cream 0.05%		✓	
	Fluticasone Propionate Lotion 0.05%		✓	
	Fluticasone Propionate Oint 0.005%		✓	
	Hydrocortisone Butyrate Cream 0.1%		✓	
	Hydrocortisone Butyrate Hydrophilic Lipo Base Cream 0.1%		✓	
	Hydrocortisone Butyrate Lotion 0.1%		✓	
	Hydrocortisone Butyrate Oint 0.1%		✓	
	Hydrocortisone Butyrate Soln 0.1%		✓	
	Hydrocortisone Probutate Cream 0.1%		✓	
	Hydrocortisone Valerate Cream 0.2%		✓	
	Hydrocortisone Valerate Oint 0.2%		✓	
	Mometasone Furoate Cream 0.1%		✓	
	Prednicarbate Oint 0.1%		✓	
	Triamcinolone Acetonide Aerosol Soln 0.147 MG/GM		✓	
	Triamcinolone Acetonide Cream 0.025%		✓	
	Triamcinolone Acetonide Cream 0.1%		✓	
	Triamcinolone Acetonide Lotion 0.025%		✓	
	Triamcinolone Acetonide Lotion 0.1%		✓	
	Triamcinolone Acetonide Oint 0.025%		✓	
	Triamcinolone Acetonide Oint 0.05%		✓	
	Triamcinolone Acetonide Oint 0.1%		✓	

Medication Class Name	Medication Generic Name	Brand name (if applicable)	Allowed Condition Needed	Reimbursement restrictions or limitations for specific medications or dosage forms are listed with the respective medications below.
Topical – Corticosteroids Low Potency	Alclometasone Dipropionate Cream 0.05%		✓	Reimbursement is only permitted when prescribed for an allowed dermatological condition. Topical corticosteroids will not be approved for the treatment of pain.
	Alclometasone Dipropionate Oint 0.05%		✓	
	Desonide Cream 0.05%		✓	
	Desonide Foam 0.05%		✓	
	Desonide Gel 0.05%		✓	
	Desonide Lotion 0.05%		✓	
	Desonide Oint 0.05%		✓	
	Fluocinolone Acetonide Cream 0.01%		✓	
	Fluocinolone Acetonide Oil 0.01% (Body Oil)		✓	
	Fluocinolone Acetonide Oil 0.01% (Scalp Oil)		✓	
	Fluocinolone Acetonide Soln 0.01%		✓	
	Hydrocortisone Cream 0.5%		✓	
	Hydrocortisone Cream 1%		✓	
	Hydrocortisone Cream 2.5%		✓	
	Hydrocortisone Gel 1%		✓	
	Hydrocortisone Lotion 1%		✓	
	Hydrocortisone Lotion 2.5%		✓	
	Hydrocortisone Oint 0.5%		✓	
	Hydrocortisone Oint 1%		✓	
	Hydrocortisone Oint 2.5%		✓	
	Mometasone Furoate Solution 0.1% (Lotion)		✓	
Topical – Emollient/Keratolytic Agents	Urea Lotion 10%			
Topical – Emollients	Emollient - Cream			
	Emollient - Lotion			
	Emollient - Ointment			
	Lactic Acid (Ammonium Lactate) Cream 12%			
	Lactic Acid (Ammonium Lactate) Lotion 12%			
	Lactic Acid (Ammonium Lactate) Lotion 5%			
	Vitamins A & D Oint			
Topical – Enzymes	Collagenase Oint 250 Unit/GM		✓	
Topical – Immunosuppressive Agents	Pimecrolimus Cream 1%		✓	
	Tacrolimus Oint 0.1%		✓	
	Tacrolimus (Topical) Soln 0.1%			
Topical – Immunomodulating Agents	Imiquimod Cream 3.75%		✓	
	Imiquimod Cream 5%		✓	
Topical – Liniments	Camphor-Eucalyptus-Menthol - Oint			
	Camphor-Menthol-Capsicum Topical Patch 80-24-16 MG			
	Camphor-Menthol-Methyl Salicylate Cream 3-5-15%			
	Camphor-Menthol-Methyl Salicylate Cream 4-10-30%			
	Camphor-Menthol-Methyl Salicylate Gel 0.2-4-8%			
	Camphor-Menthol-Methyl Salicylate Gel 3.1-16-10%			
	Camphor-Menthol-Methyl Salicylate Liqd 4-10-30%			
	Camphor-Menthol-Methyl Salicylate Oint 4-10-30%			
	Camphor-Menthol-Methyl Salicylate Topical Patch 1.2-5.7-6.3%			
	Capsaicin-Menthol-Methyl Salicylate Cream 0.025-1-12%			
	Capsaicin-Menthol-Methyl Salicylate Cream 0.035-10-25%			
	Liniments & Rubs - Cream			
	Liniments & Rubs - Gel			
	Liniments & Rubs - Lotion			
	Menthol-Camphor Cream 10-11%			
	Menthol-Camphor Cream 11-11%			
	Menthol-Camphor Cream 16-11%			
	Menthol-Camphor Gel 3-3%			
	Menthol-Camphor Gel 3.5-0.8%			
	Menthol-Camphor Lotion 16-4%			
	Menthol-Camphor Oint 5.1-5.1%			
	Menthol-Camphor Patch 70-230 MG			
	Menthol-Methyl Salicylate Cream			
	Menthol-Methyl Salicylate Gel			
	Menthol-Methyl Salicylate Liquid			
	Menthol-Methyl Salicylate Lotion			
	Menthol-Methyl Salicylate Ointment			
	Menthol-Methyl Salicylate Patch			
	Menthol-Methyl Salicylate Stick			
	Methyl Salicylate Lotion 10%			
	Trolamine Salicylate Cream 10%			
	Trolamine Salicylate Lotion 10%			
Topical – Local Anesthetics	Capsaicin Cream 0.025%			
	Capsaicin Cream 0.033%			
	Capsaicin Cream 0.035%			
	Capsaicin Cream 0.075%			
	Capsaicin Cream 0.1%			
	Capsaicin in Lidocaine Vehicle Cream 0.25%			
	Capsaicin Liquid 0.15%			
	Capsaicin Lotion 0.035%			
	Capsaicin Patch 0.025%			
	Capsaicin-Menthol Gel 0.025-10%			
	Capsaicin-Menthol Topical Patch 0.05-5%			
	Dibucaine Oint 1%			
	Ethyl Chloride Aerosol Spray			
	Lidocaine Cream 3%		✓	

Medication Class Name	Medication Generic Name	Brand name (if applicable)	Allowed Condition Needed	Reimbursement restrictions or limitations for specific medications or dosage forms are listed with the respective medications below.
	Lidocaine Cream 4%			
	Lidocaine Gel 4%			
	Lidocaine HCl Soln 4%			
	Lidocaine HCl Cream 3%			
	Lidocaine HCl Cream 4%			
	Lidocaine HCl Gel 2%		✓	
	Lidocaine HCl Gel 2.5%			
	Lidocaine HCl Gel 4%			
	Lidocaine HCl Urethral/Mucosal Gel 2%		✓	
	Lidocaine HCl Urethral/Mucosal Gel Prefilled Syringe 2%		✓	
	Lidocaine Oint 5%			May be considered for reimbursement upon submission of a prior authorization request that reflects a minimum of a 14-day trial and documented inadequate response of a lidocaine 4% topical product within the past 30 days. Claims in which lidocaine 5% ointment was covered in the 60 days prior to 10/1/2017 and has been continuously reimbursed since then are not subject to the 14-day trial and failure of a lidocaine 4% topical product.
	Lidocaine Patch 4%			
	Lidocaine Patch 5%			May be considered for reimbursement upon submission of a prior authorization request that reflects a minimum of a 14-day trial and documented inadequate response of lidocaine patch 4% within the past 30 days. Reimbursement is limited to one (1) patch per day.
	Lidocaine-Prilocaine Cream 2.5-2.5%			
	Pentafluoropropane-Tetrafluoroethane Aero Spray			
	Pramoxine HCl Lotion 1%			
	Pramoxine-Benzyl Alcohol Gel 1-10%			
	Pramoxine-Zinc Acetate Lotion 1-0.1%			
Topical – Misc.	Aloe Vera Liquid			
	Aloe Vera Lotion			
	Aluminum Acetate Soln			
	Aluminum Chloride Soln 20%		✓	
	Aluminum Hydroxide Oint			
	Benzoin Tincture			
	Starch Powder			
	Dimethicone Cream 1%			
	Dimethicone-Petrolatum Cream 3-30%			
	Lanolin-Petrolatum Oint 15.5-53.4%			
	Menthol-Zinc Oxide Oint 0.44-20.6%			
	Menthol-Zinc Oxide Oint 0.44-20.625%			
	Petrolatum-Zinc Oxide Oint 49-15%			
	Skin Protectants Misc - Cream			
	Skin Protectants Misc - Ointment			
	Skin Protectants Misc - Paste			
	Sodium Chloride External Soln 0.9%			
	Talc Topical Powder			
	Witch Hazel-Glycerin Cleansing Pads			
	Zinc Oxide Cream 13%			
	Zinc Oxide Oint 12.8%			
	Zinc Oxide Oint 20%			
	Zinc Oxide Oint 40%			
Topical – Misc. Dermatological Products	Dermatological Products Misc - Cream			May be considered for reimbursement upon submission of a prior authorization request with documented medical justification.
	Dermatological Products Misc - Emulsion			
Topical – Rosacea Agents	Metronidazole Cream 0.75%		✓	
	Metronidazole Gel 0.75%		✓	
	Metronidazole Gel 1%		✓	
Topical – Scabicides & Pediculicides	Crotamiton Lotion 10%		✓	
	Lindane Shampoo 1%		✓	
	Malathion Lotion 0.5%		✓	
	Permethrin Cream 5%		✓	
	Permethrin Lotion 1%		✓	
	Pyrethrins-Piperonyl Butoxide Liq 0.33-4%		✓	
	Pyrethrins-Piperonyl Butoxide Shampoo 0.33-4%		✓	
Topical – Scar Treatment	Scar Treatment Products - Cream			May be considered for reimbursement upon submission of a prior authorization request with documented medical justification.
	Scar Treatment Products - Gel			
Topical – Wound Care	Becaplermin Gel 0.01%		✓	
	Hyaluronate Sodium Gel 0.2%			
	Lidocaine HCl-Collagen-Aloe Vera Gel 2%			
	Wound Cleansers - Liquid			
	Wound Dressings - Emulsion			
	Wound Dressings - Gel			
	Silver - Gel			
Ulcer Drugs – Antispasmodics	Belladonna Alkaloids & Opium Suppos 16.2-30 MG		✓	
	Belladonna Alkaloids & Opium Suppos 16.2-60 MG		✓	
	Dicyclomine HCl Cap 10 MG		✓	
	Dicyclomine HCl Oral Soln 10 MG/5ML		✓	
	Dicyclomine HCl Tab 20 MG		✓	
	Glycopyrrolate Oral Soln 1 MG/5ML			
	Glycopyrrolate Tab 1 MG		✓	
	Glycopyrrolate Tab 2 MG		✓	
	Hyoscyamine Sulfate Tab ER 0.375 MG (0.125 MG IR/0.25 MG ER)		✓	
	Hyoscyamine Sulfate Tab SR 12HR 0.375 MG		✓	
	Methscopolamine Bromide Tab 2.5 MG		✓	
	Methscopolamine Bromide Tab 5 MG		✓	

Medication Class Name	Medication Generic Name	Brand name (if applicable)	Allowed Condition Needed	Reimbursement restrictions or limitations for specific medications or dosage forms are listed with the respective medications below.
	Propantheline Bromide Tab 15 MG		✓	
Ulcer Drugs – H-2 Antagonists	Famotidine Tab 10 MG		✓	Reimbursement is only permitted for treatment of an allowed condition that involves a gastrointestinal disorder such as ulcer or gastrointestinal esophageal reflux disease (GERD) or to prevent gastrointestinal bleeding during concurrent non-steroidal anti-inflammatory drug (NSAID), anticoagulant, or antiplatelet drug therapy. Reimbursement is limited to two (2) doses per day.
	Famotidine Tab 20 MG		✓	
	Famotidine Tab 40 MG		✓	
Ulcer Drugs – Misc. Anti-Ulcer	Sucralfate Susp 1 GM/10ML		✓	
	Sucralfate Tab 1 GM		✓	
Ulcer Drugs – Prostaglandins	Misoprostol Tab 100 MCG		✓	
	Misoprostol Tab 200 MCG		✓	
Ulcer Drugs – Proton Pump Inhibitors	Lansoprazole Cap Delayed Release 15 MG		✓	Reimbursement is only permitted for treatment of an allowed condition that involves a gastrointestinal disorder such as ulcer or gastrointestinal esophageal reflux disease (GERD) or to prevent gastrointestinal bleeding during concurrent non-steroidal anti-inflammatory drug (NSAID), anticoagulant, or antiplatelet drug therapy. Reimbursement is limited to two (2) doses per day. Reimbursement for oral disintegrating dosage form is limited to claims with an allowed condition that results in the inability to swallow or absorb oral medications. Reimbursement will not be approved for duplicate therapy with other proton pump inhibitors.
	Lansoprazole Cap Delayed Release 30 MG		✓	
	Lansoprazole Tab Delayed Release Orally Disintegrating 15 MG			
	Lansoprazole Tab Delayed Release Orally Disintegrating 30 MG			
	Esomeprazole Magnesium Cap Delayed Release 20 MG		✓	
	Esomeprazole Magnesium Cap Delayed Release 40 MG		✓	
	Esomeprazole Magnesium Tab Delayed Release 20 MG		✓	
	Omeprazole Cap Delayed Release 10 MG		✓	
	Omeprazole Cap Delayed Release 20 MG		✓	
	Omeprazole Cap Delayed Release 40 MG		✓	
	Omeprazole Delayed Release Tab 20 MG		✓	
	Omeprazole Magnesium Delayed Release Tab 20 MG (Base Equiv)		✓	
	Pantoprazole Sodium EC Tab 20 MG (Base Equiv)		✓	
	Pantoprazole Sodium EC Tab 40 MG (Base Equiv)		✓	
Ulcer Therapy Combinations	Amoxicil Cap &Clarithro Tab &Lansopraz Cap DR 500 &500 &30MG		✓	
	Metronidaz Tab-Tetracyc Cap-Bis Subsal Chew Tab Therapy Pack		✓	
Urinary Anti-infectives	Fosfomycin Tromethamine Powd Pack 3 GM (Base Equivalent)		✓	
	Methenamine Hippurate Tab 1 GM		✓	
	Methenamine Mandelate Tab 1 GM		✓	
	Methenamine-Hyosc-Meth Blue-Benz Acid-Phenyl Sal Tab 81.6MG		✓	
	Methenamine-Hyos-Meth Blue-Sod Phos-Phen Sal Tab 81.6 MG		✓	
	Nitrofurantoin Macrocrystalline Cap 100 MG		✓	
	Nitrofurantoin Macrocrystalline Cap 50 MG		✓	
	Nitrofurantoin Monohydrate Macrocrystalline Cap 100 MG		✓	
Urinary Antispasmodic	Bethanechol Chloride Tab 5 MG		✓	
	Bethanechol Chloride Tab 10 MG		✓	
	Bethanechol Chloride Tab 25 MG		✓	
	Bethanechol Chloride Tab 50 MG		✓	
	Darifenacin Hydrobromide Tab ER 24HR 7.5 MG (Base Equiv)		✓	
	Darifenacin Hydrobromide Tab ER 24HR 15 MG (Base Equiv)		✓	
	Fesoterodine Fumarate Tab ER 24HR 4 MG	TOVIAZ	✓	
	Fesoterodine Fumarate Tab ER 24HR 8 MG		✓	
	Flavoxate HCl Tab 100 MG		✓	
	Mirabegron Tab ER 24 HR 25 MG	MYRBETRIQ	✓	
	Mirabegron Tab ER 24 HR 50 MG		✓	
	Oxybutynin Chloride Solution 5 MG/5ML		✓	
	Oxybutynin Chloride Tab 5 MG		✓	
	Oxybutynin Chloride Tab ER 24HR 5 MG		✓	
	Oxybutynin Chloride Tab ER 24HR 10 MG		✓	
	Oxybutynin Chloride Tab ER 24HR 15 MG		✓	
	Oxybutynin Chloride TD Gel 10%		✓	
	Oxybutynin TD Patch Twice Weekly 3.9 MG/24HR		✓	
	Solifenacin Succinate Tab 5 MG		✓	
	Solifenacin Succinate Tab 10 MG		✓	
	Tolterodine Tartrate Cap ER 24HR 2 MG	DETROL LA	✓	
	Tolterodine Tartrate Cap ER 24HR 4 MG		✓	
	Tolterodine Tartrate Tab 1 MG	DETROL	✓	
	Tolterodine Tartrate Tab 2 MG		✓	
	Trospium Chloride Cap ER 24HR 60 MG		✓	
	Trospium Chloride Tab 20 MG		✓	
	Vibegron Tab 75 MG	GEMTESA		May be considered for reimbursement upon submission of a prior authorization request that reflects a minimum of a 60-day trial and documented inadequate response to at least two (2) urinary antispasmodic agents within the past 180 days, and the injured worker has overactive bladder related to an allowed condition in the claim.
Vaccines	Zoster Vac Recombinant Adjuvanted for IM Inj 50 MCG/0.5ML	SHINGRIX	✓	
Vaginal Anti-infectives	Metronidazole Vaginal Gel 0.75%		✓	
	Miconazole Nitrate Vaginal Cream 2%		✓	
	Miconazole Nitrate Vaginal Cream 4% (200 MG/5GM)		✓	

Medication Class Name	Medication Generic Name	Brand name (if applicable)	Allowed Condition Needed	Reimbursement restrictions or limitations for specific medications or dosage forms are listed with the respective medications below.
	Terconazole Vaginal Cream 0.8%		✓	
Vaginal Estrogens	Estradiol Vaginal Cream 0.1 MG/GM		✓	
	Estradiol Vaginal Tab 10 MCG		✓	
Vasopressors	Midodrine HCl Tab 2.5 MG		✓	
	Midodrine HCl Tab 5 MG		✓	
	Midodrine HCl Tab 10 MG		✓	
Vitamins, Minerals, & Electrolytes	ALL Vitamins, Minerals, & Electrolytes			May be considered for reimbursement upon submission of a prior authorization request with documented medical justification.
	*Fe Gluc-C-FA-B12-Manganese-Copper-Sorbitol Cap 250-1 MG***			See ALL vitamin, mineral, & electrolyte agents reimbursement restrictions.
	Ascorbic Acid Cap ER 500 MG			
	Ascorbic Acid Chew Tab 250 MG			
	Ascorbic Acid Chew Tab 500 MG			
	Ascorbic Acid Liquid 500 MG/5ML			
	Ascorbic Acid Tab 1000 MG			
	Ascorbic Acid Tab 250 MG			
	Ascorbic Acid Tab 500 MG			
	Ascorbic Acid Tab Disint 60 MG			
	Ascorbic Acid Tab ER 500 MG			
	B-Complex w/ C & E + Zn Tab			
	B-Complex w/ C & Folic Acid Cap 1 MG			
	B-Complex w/ C & Folic Acid Tab			
	B-Complex w/ C & Folic Acid Tab 0.8 MG			
	B-Complex w/ C Tab			
	B-Complex w/ C-Biotin-Vit E & Folic Acid Tab 0.4 MG			
	B-Complex w/Biotin & Folic Acid Tab ER			See ALL vitamin, mineral, & electrolyte agents reimbursement restrictions.
	Calcium & Phosphorus w/ Vit D Chew Tab 250 MG-100 MG-500 Unt			
	Calcium & Phosphorus w/ Vit D Chew Tab 250 MG-107 MG-500 Unt			
	Calcium & Phosphorus w/ Vit D Chew Tab 250 MG-115 MG-250 Unt			
	Calcium & Phosphorus w/ Vit D Chew Tab 250 MG-135 MG-200 Unt			
	Calcium & Phosphorus w/Vit D Chew Tab 200 MG-96.6 MG-200 Unt			
	Calcium Acetate Tab 668 MG (169 MG Elemental Ca)			
	Calcium Cap 250 MG			
	Calcium Carb-Cholecalcif Chew Tab 500 MG-2.5MCG (100 Unit)			
	Calcium Carb-Cholecalcif Chew Tab 600 MG-20 MCG (800 Unit)			
	Calcium Carb-Cholecalciferol Cap 600 MG-10 MCG (400 Unit)			
	Calcium Carb-Cholecalciferol Cap 600 MG-2.5 MCG (100 Unit)			
	Calcium Carb-Cholecalciferol Cap 600 MG-62.5 MCG (2500 Unit)			
	Calcium Carb-Cholecalciferol Liq 500 MG-10 MCG(400 UNIT)/5ML			
	Calcium Carb-Cholecalciferol Tab 500 MG-10 MCG (400 Unit)			
	Calcium Carb-Cholecalciferol Tab 500 MG-15 MCG (600 Unit)			
	Calcium Carb-Cholecalciferol Tab 600 MG-3.125 MCG (125 Unit)			
	Calcium Carb-Magnesium Oxide-Vit C Tab 400-116.7-166.7 MG			
	Calcium Carbonate Chew Tab 1250 MG (500 MG Elemental Ca)			
	Calcium Carbonate Chewable Wafer 500 MG (200 MG Calcium)			
	Calcium Carbonate Tab 1250 MG (500 MG Elemental Ca)			
	Calcium Carbonate Tab 1500 MG (600 MG Elemental Ca)			
	Calcium Carbonate-Cholecalciferol Chew Tab 600 MG-400 Unit			
	Calcium Carbonate-Cholecalciferol Tab 250 MG-125 Unit			
	Calcium Carbonate-Cholecalciferol Tab 500 MG-5 MCG(200 Unit)			
	Calcium Carbonate-Cholecalciferol Tab 600 MG-400 Unit			
	Calcium Carbonate-Cholecalciferol Tab 600 MG-5 MCG(200 Unit)			
	Calcium Carbonate-Cholecalciferol Tab 600 MG-800 Unit			
	Calcium Carbonate-Ergocalciferol Tab 500MG-200 Unit			
	Calcium Carbonate-Vitamin D Tab 250 MG-3.125 MCG (125 Unit)			

Medication Class Name	Medication Generic Name	Brand name (if applicable)	Allowed Condition Needed	Reimbursement restrictions or limitations for specific medications or dosage forms are listed with the respective medications below.
	Calcium Carbonate-Vitamin D Tab 500 MG-5 MCG (200 Unit)			
	Calcium Carbonate-Vitamin D Tab 600 MG-400 Unit			
	Calcium Carbonate-Vitamin D Tab 600 MG-5 MCG (200 Unit)			
	Calcium Carb-Vit D w/ Minerals Chew Tab 600 MG-800 Unit			
	Calcium Carb-Vit D w/ Minerals Tabs 600 MG-800 Unit			
	Calcium Cit Malate-Cholecalcif Tab 250 MG-2.5 MCG (100 Unit)			
	Calcium Citrate Cap 150 MG			
	Calcium Citrate Tab 333 MG (Elemental Ca)			
	Calcium Citrate Tab 950 MG (200 MG Elemental Ca)			
	Calcium Citrate-Vit D-Vit K w/ Minerals Tabs 200 MG			
	Calcium Citrate-Vitamin D Chew Tab 500 MG-12.5 MCG(500 Unit)			
	Calcium Citrate-Vitamin D Liquid 1000-0.01 MG(400 Unit)/30ML			
	Calcium Citrate-Vitamin D Tab 200 MG-250 Unit (Elemental Ca)			
	Calcium Citrate-Vitamin D Tab 250 MG-200 Unit (Elemental Ca)			
	Calcium Cit-Vitamin D Chew Tab 500 MG-8.325 MCG (333 Unit)			
	Calcium Phos-Cholecalcif Chew Tab 250 MG-10 MCG (400 Unit)			
	Calcium Phos-Cholecalcif Chew Tab 250 MG-12.5 MCG (500 Unit)			
	Calcium Phos-Cholecalcif Chew Tab 250 MG-2.5 MCG (100 Unit)			See ALL vitamin, mineral, & electrolyte agents reimbursement restrictions.
	Calcium Phos-Cholecalciferol Chew Tab 200 MG-5 MCG(200 Unit)			
	Calcium w/ Magnesium Cap 70-83 MG			
	Calcium w/ Magnesium Tab 166.67-83.33 MG			
	Calcium w/ Magnesium Tab 200-50 MG			
	Calcium w/ Vitamin D & K Chew Tab 500 MG-1000 Unit-40 MCG			
	Calcium w/ Vitamin D & K Tab 500 MG-200 Unit-90 MCG			
	Calcium w/ Vitamin D & K Tab 600 MG-1000 Unit-90 MCG			
	Calcium-Cholecalciferol Tab 200 MG-6.25 MCG (250 Unit)			
	Calcium-Cholecalciferol Tab 500 MG-5 MCG (200 Unit)			
	Calcium-Ergocalciferol Tab 250 MG-2.5 MCG (100 Unit)			
	Calcium-Ergocalciferol Tab 500 MG-5 MCG (200 Unit)			
	Calcium-Magnesium w/ Vit D Tab ER 24HR 600 MG-40 MG-500 Unit			
	Calcium-Magnesium w/ Vitamin D Chew Tab 300MG-20MG-200 Unit			
	Calcium-Magnesium w/ Vitamin D Tab 300 MG-150 MG-400 Unit			
	Calcium-Magnesium W/ Vitamin D Wafer 250 MG-125 MG-200 UNIT			
	Calcium-Phosphorus-D-Mag Tab 333.3MG-80MG-133.3Unt-133.3MG			
	Calcium-Vitamin D Tab 600 MG-5 MCG (200 Unit)			
	Calc-Phosphorus-Vit D-Mag Tab 600 MG-280 MG-500 Unit-50 MG			
	Cholecalciferol Cap 1.25 MG (50000 Unit)			
	Cholecalciferol Cap 25 MCG (1000 Unit)			
	Cholecalciferol Cap 250 MCG (10000 Unit)			
	Cholecalciferol Cap 400 Unit			
	Cholecalciferol Cap 50 MCG (2000 Unit)			
	Cholecalciferol Cap 5000 Unit			
	Cholecalciferol Chewable Wafer 1.25 MG (50000 Unit)			
	Cholecalciferol Tab 1.25 MG (50000 Unit)			
	Cholecalciferol Tab 25 MCG (1000 Unit)			
	Cholecalciferol Tab 250 MCG (10000 Unit)			
	Cholecalciferol Tab 400 Unit			
	Cholecalciferol Tab 50 MCG (2000 Unit)			
	Cholecalciferol Tab 5000 Unit			
	Cholecalciferol-Vitamin C Cap 1000 Unit-500 MG			
	Ergocalciferol Cap 50000 Unit			
	Ergocalciferol Soln 8000 Unit/ML			
	Ergocalciferol Tab 50 MCG (2000 Unit)			
	Magnesium Bisglycinate Tab 100 MG (Elemental Mg)			
	Magnesium Cap 125 MG			
	Magnesium Cap 400 MG			
	Magnesium Carbonate Oral Powder 250 MG/GM (Elemental Mg)			

Medication Class Name	Medication Generic Name	Brand name (if applicable)	Allowed Condition Needed	Reimbursement restrictions or limitations for specific medications or dosage forms are listed with the respective medications below.
	Magnesium Chewable Tablet 200 MG			
	Magnesium Chloride Tab DR 64 MG (Elemental Mg)			
	Magnesium Citrate Cap 125 MG (Elemental Mg)			
	Magnesium Citrate Tab 100 MG			
	Magnesium Citrate Tab 200 MG (Elemental Mg)			
	Magnesium Cl-Ca Carbonate Tab DR 71.5-119 MG (Elemental)			
	Magnesium Gluconate Tab 27.5 MG (Elemental Mg)			
	Magnesium Gluconate Tab 500 MG			
	Magnesium Gluconate Tab 500 MG (27 MG Elemental Mg)			
	Magnesium Lactate Tab ER 84 MG (Elemental Mg) (7 MEQ)			
	Magnesium Malate Tab 1250 MG (141.7 MG Magnesium Equivalent)			
	Magnesium Oral Powder			
	Magnesium Oxide Cap 400 MG (Elemental Mg) (Mg Supplement)			
	Magnesium Oxide Powder (Mg Supplement)			
	Magnesium Oxide Tab 250 MG (Mg Supplement)			
	Magnesium Oxide Tab 400 MG (240 MG Elemental Mg)			
	Magnesium Tab 250 MG			
	Magnesium Tab 400 MG			
	Multiple Minerals w/ Vitamins Liquid			
	Multiple Vitamin Liquid			
	Multiple Vitamin Tab			
	Multiple Vitamins w/ Calcium Cap			
	Multiple Vitamins w/ Calcium Tab			
	Multiple Vitamins w/ Iron Tab			See ALL vitamin, mineral, & electrolyte agents reimbursement restrictions.
	Multiple Vitamins w/ Minerals Effer Tab			
	Multiple Vitamins w/ Minerals Liquid			
	Multiple Vitamins w/ Minerals Tab			
	Niacin Tab ER 250 MG			
	Niacin Tab ER 750 MG			
	Niacinamide w/ Zn-Cu-Methylfol-Se-Cr Tab 750-27-2-0.5 MG			
	Oyster Shell Calcium Tab 500 MG			
	Phytonadione Tab 5 MG			
	Potassium Bicarbonate Effer Tab 25 mEq			
	Potassium Chloride Cap ER 10 mEq			
	Potassium Chloride Cap ER 8 mEq			
	Potassium Chloride Microencapsulated Crys ER Tab 20 mEq			
	Potassium Chloride Oral Soln 10% (20 MEQ/15ML)			
	Potassium Chloride Powder Packet 20 mEq			
	Potassium Chloride Tab ER 10 mEq			
	Potassium Chloride Tab ER 10 mEq			
	Potassium Chloride Tab ER 20 mEq (1500 MG)			
	Potassium Chloride Tab ER 8 mEq (600 MG)			
	Potassium Gluconate Tab 550 MG (90 MG Equiv K)			
	Potassium Gluconate Tab 80 MG (Elemental Potassium)			
	Pyridoxine HCl Tab 100 MG			
	Pyridoxine HCl Tab 50 MG			
	Riboflavin Tab 100 MG			
	Sodium Chloride Tab 1 GM			
	Specialty Vitamin Product Tab			
	Thiamine HCl Tab 100 MG			
	Thiamine HCl Tab 50 MG			
	Thiamine Mononitrate Tab 100 MG			
	Vit C-Cholecalciferol-Rose Hips Cap 500 MG-1000 Unit-20 MG			
	Vitamin A Tab 2400 MCG (8000 Unit)			
	Vitamin A-Vitamin D-Minerals Cap			
	Vitamin C-Vitamin D-Zinc Tab			
	Vitamin D & K Cap			
	Vitamin E Cap 1000 Unit			
	Vitamin E Cap 450 MG (1000 Unit)			
	Vitamin E Cap 670 MG (1000 Unit)			
	Vitamins A & C Chew Tab			
	Vitamins A & D Cap			
	Zinc Gluconate Tab 50 MG (Elemental Zn)			
	Zinc Sulfate Cap 220 MG (50 MG Elemental Zn)			
	Zinc Sulfate Tab 220 MG (50 MG Zinc Equivalent)			
	Zinc Tab 22.5 MG			
	Zinc Tab 50 MG			

4123-6-21.6 First fill of outpatient medications.

(A) In accordance with division (B) of section 4123.66 of the Revised Code, the administrator has established a program to make immediate payment, under the circumstances set forth in this rule, for the first fill of prescription drugs for medical conditions identified in an application for compensation or benefits under section 4123.84 or 4123.85 of the Revised Code that occurs prior to the date the administrator issues an initial determination order under division (B) of section 4123.511 of the Revised Code.

(B) The appendix to this rule shall constitute the complete list of medications, and the maximum quantity of such medications, that are approved for reimbursement by the bureau for first fill prior to issuance of an initial determination order. Except as otherwise provided in paragraph (C) of this rule, drugs not listed in the appendix to this rule are not eligible for reimbursement by the bureau under the first fill program.

(C) Notwithstanding paragraph (B) of this rule, in cases of medical necessity supported by clinical documentation and evidence of need the bureau may, with prior authorization, reimburse for the first fill of medications that are eligible for reimbursement under rule 4123-6-21.3 of the Administrative Code but are not listed in the appendix to this rule.

(D) Reimbursement of outpatient medications by the bureau under the first fill program shall be subject to the following limitations:

(1) Approval for reimbursement of medications under the first fill program will be limited to the quantity limits listed in the appendix to this rule, and no refills will be approved;

(2) With the exception of antivirals, antiretrovirals, and antibiotics, approval for reimbursement of medications under the first fill program will be limited to one drug per therapeutic drug class listed in the appendix to the rule;

(3) Extemporaneous compounded prescriptions are not eligible for reimbursement by the bureau under the first fill program.

(E) Pharmacy providers shall be reimbursed for dispensing drugs under this rule in the manner described in rule 4123-6-21 of the Administrative Code provided that the prescriber, or their agent has indicated the prescription is for a work related injury and signed the prescription blank. A pharmacist or pharmacy intern who receives a telephone prescription may also write and sign that it is work related on the prescription.

(F) If a claim in which the first fill of outpatient medication was reimbursed by the bureau pursuant to this rule is ultimately disallowed in a final administrative or judicial order, and if the employer is a state fund employer who pays assessments into the surplus fund account created under section 4123.34 of the Revised Code, the payment for outpatient medication made pursuant to this rule shall be charged to and paid from the surplus fund account and not charged through the state insurance fund to the employer against whom the claim was filed.

APPENDIX TO RULE 4123-6-21.6

First Fill Formulary List of Medications Covered by the Ohio Bureau of Workers' Compensation

Medication Generic Name	Quantity Limit (Billable units)
Anaphylaxis Therapy Agents	
EPINEPHRINE SOLUTION AUTO-INJECTOR 0.3 MG/0.3ML (1:1000)	2
Anti-infective Agents: Penicillins	
AMOXICILLIN & K CLAVULANATE TAB 250-125 MG	84
AMOXICILLIN & K CLAVULANATE TAB 500-125 MG	42
AMOXICILLIN & K CLAVULANATE TAB 875-125 MG	28
AMOXICILLIN (TRIHYDRATE) CAP 250 MG	84
AMOXICILLIN (TRIHYDRATE) CAP 500 MG	42
AMPICILLIN CAP 500 MG	40
PENICILLIN V POTASSIUM TAB 250 MG	60
PENICILLIN V POTASSIUM TAB 500 MG	40
Anti-infective Agents: Cephalosporins	
CEFACLOR CAP 250 MG	21
CEFACLOR CAP 500 MG	21
CEPHALEXIN CAP 250 MG	28
CEPHALEXIN CAP 500 MG	56
Anti-infective Agents: Macrolides	
AZITHROMYCIN TAB 250 MG	6
AZITHROMYCIN TAB 500 MG	7
ERYTHROMYCIN TAB 250 MG	56
ERYTHROMYCIN TAB 500 MG	56
Anti-infective Agents: Tetracyclines	
DOXYCYCLINE HYCLATE CAP 100 MG	28
DOXYCYCLINE HYCLATE CAP 50 MG	28
DOXYCYCLINE HYCLATE TAB 100 MG	28
DOXYCYCLINE MONOHYDRATE CAP 100 MG	28
DOXYCYCLINE MONOHYDRATE TAB 100 MG	28
TETRACYCLINE HCL CAP 250 MG	56
TETRACYCLINE HCL CAP 500 MG	56
Anti-infective Agents: Fluoroquinolones	
CIPROFLOXACIN HCL TAB 250 MG (BASE EQUIV)	84
CIPROFLOXACIN HCL TAB 500 MG (BASE EQUIV)	28
LEVOFLOXACIN TAB 250 MG	14
LEVOFLOXACIN TAB 500 MG	14
MOXIFLOXACIN HCL TAB 400 MG (BASE EQUIV)	14
Antivirals: Antiretrovirals	
ABACAVIR SULFATE-LAMIVUDINE TAB 600-300 MG	30
ATAZANAVIR SULFATE CAP 200 MG (BASE EQUIV)	60
ATAZANAVIR SULFATE CAP 300 MG (BASE EQUIV)	30
BICTEGRAVIR-EMTRICITABINE-TENOFOVIR AF TAB 50-200-25 MG	30
DOLUTEGRAVIR SODIUM TAB 50 MG (BASE EQUIV)	30
EFAVIRENZ-EMTRICITABINE-TENOFOVIR DF TAB 600-200-300 MG	30
EMTRICITABINE CAPS 200 MG	30

Medication Generic Name	Quantity Limit (Billable units)
EMTRICITABINE-TENOFOVIR DISOPROXIL FUMARATE TAB 200-300 MG	30
ETRAVIRINE TAB 200 MG	60
LAMIVUDINE TAB 150 MG	60
LAMIVUDINE-ZIDOVUDINE TAB 150-300 MG	60
LOPINAVIR-RITONAVIR TAB 200-50 MG	120
RALTEGRAVIR POTASSIUM TAB 400 MG (BASE EQUIV)	60
RILPIVIRINE HCl TAB 25 MG (BASE EQUIVALENT)	30
RITONAVIR TAB 100 MG	30
TENOFOVIR DISOPROXIL FUMARATE TAB 300 MG	30
ZIDOVUDINE TAB 300 MG	60
Antivirals: Herpes Agents	
VALACYCLOVIR HCL TAB 500 MG	20
Anti-infective Agents: Amebicides	
METRONIDAZOLE TAB 250 MG	42
METRONIDAZOLE TAB 500 MG	42
Anti-infective Agents: Lincosamides	
CLINDAMYCIN HCL CAP 150 MG	84
CLINDAMYCIN HCL CAP 300 MG	42
Anti-infective Agents: Combinations	
SULFAMETHOXAZOLE-TRIMETHOPRIM TAB 400-80 MG	28
SULFAMETHOXAZOLE-TRIMETHOPRIM TAB 800-160 MG	28
Antidepressants: Tricyclic Agents	
AMITRIPTYLINE TAB 10 MG	30
AMITRIPTYLINE TAB 25 MG	30
Benzodiazepines: Antianxiety	
DIAZEPAM TAB 5MG	5
Corticosteroids: Glucocorticosteroids	
DEXAMETHASONE TAB 0.5 MG	100
DEXAMETHASONE TAB 0.75 MG	60
DEXAMETHASONE TAB 4 MG	14
DEXAMETHASONE TAB THERAPY PACK 1.5 MG	51
HYDROCORTISONE TAB 5 MG	30
METHYLPREDNISOLONE TAB 4 MG	30
METHYLPREDNISOLONE TAB THERAPY PACK 4 MG	21
PREDNISONE TAB 5 MG	120
PREDNISONE TAB 10 MG	60
PREDNISONE TAB 20 MG	30
PREDNISONE TAB THERAPY PACK 5 MG	21
PREDNISONE TAB THERAPY PACK 10 MG	21
Antihistamines: Ethanolamines	
DIPHENHYDRAMINE HCL CAP 25 MG	30
DIPHENHYDRAMINE HCL TAB 25 MG	30
PROMETHAZINE HCL TAB 12.5 MG	30

Medication Generic Name	Quantity Limit (Billable units)
PROMETHAZINE HCL TAB 25 MG	30
Antiemetics: Anticholinergic	
MECLIZINE HCL TAB 12.5 MG	45
MECLIZINE HCL TAB 25 MG	45
MECLIZINE HCL CHEW TAB 25 MG	45
Antiemetics: 5-HT3 Receptor Antagonists	
ONDANSETRON ORALLY DISINTEGRATING TAB 4 MG	30
ONDANSETRON HCL TAB 4 MG	30
ONDANSETRON ORALLY DISINTEGRATING TAB 8 MG	30
ONDANSETRON HCL TAB 8 MG	30
Antiasthmatic and Bronchodilator Agents: Sympathomimetics	
ALBUTEROL SULFATE INHAL AERO 108 MCG/ACT (90MCG BASE EQUIV)	18
Laxatives: Stimulant Laxatives	
SENNOSIDES TAB 8.6 MG	28
Laxatives: Surfactant Laxatives	
DOCUSATE SODIUM CAP 100 MG	14
Laxatives: Misc.	
POLYETHYLENE GLYCOL 3350 ORAL POWDER 17 GM/SCOOP	255
~~POLYETHYLENE GLYCOL 3350 ORAL POWDER~~	~~255~~
Laxatives: Laxative Combinations	
SENNOSIDES-DOCUSATE SODIUM TAB 8.6-50 MG	28
Ulcer Drugs: H-2 Antagonists	
FAMOTIDINE TAB 10 MG	42
FAMOTIDINE TAB 20 MG	28
FAMOTIDINE TAB 40 MG	14
Antianxiety Agents: Misc.	
HYDROXYZINE HCL TAB 10 MG	30
HYDROXYZINE HCL TAB 25 MG	30
HYDROXYZINE PAMOATE CAP 25 MG	30
Analgesics: Non-narcotic	
ACETAMINOPHEN TAB 325 MG	84
ACETAMINOPHEN TAB 500 MG	56
ASPIRIN CHEW TAB 81 MG	60
ASPIRIN TAB 325 MG	60
ASPIRIN TAB DELAYED RELEASE 325 MG	60
ASPIRIN TAB DELAYED RELEASE 81 MG	60
SUZETRIGINE TAB 50 MG	30
Analgesics: Opioid Agonists	
ACETAMINOPHEN W/ CODEINE TAB 300-30 MG	Limited to a 7-day supply
ACETAMINOPHEN W/ CODEINE TAB 300-60 MG	
HYDROCODONE-ACETAMINOPHEN TAB 5-325 MG	
HYDROCODONE-ACETAMINOPHEN TAB 7.5-325 MG	
HYDROCODONE-ACETAMINOPHEN TAB 10-325 MG	
OXYCODONE HCL TAB 5 MG	
OXYCODONE HCL TAB 10 MG	
OXYCODONE W/ ACETAMINOPHEN TAB 5-325 MG	

Medication Generic Name	Quantity Limit (Billable units)
OXYCODONE W/ ACETAMINOPHEN TAB 7.5-325 MG	
OXYCODONE W/ ACETAMINOPHEN TAB 10-325 MG	
TRAMADOL HCL TAB 50 MG	
TRAMADOL-ACETAMINOPHEN TAB 37.5-325 MG	
Antidotes and Specific Antagonists: Opioid Antagonists	
NALOXONE HCL NASAL SPRAY 4 MG/0.1ML	2
Analgesics: Nonsteroidal Anti-inflammatory Agents (NSAIDs)	
CELECOXIB CAP 100 MG	30
CELECOXIB CAP 200 MG	30
DICLOFENAC POTASSIUM TAB 50 MG	30
DICLOFENAC SODIUM TAB DELAYED RELEASE 50 MG	30
DICLOFENAC SODIUM TAB DELAYED RELEASE 75 MG	30
DICLOFENAC SODIUM GEL 1% (1.16% DIETHYLAMINE EQUIV)	100
~~DICLOFENAC GEL 1%~~	~~100~~
ETODOLAC TAB 400 MG	28
ETODOLAC TAB 500 MG	28
IBUPROFEN TAB 200 MG	56
IBUPROFEN TAB 400 MG	56
IBUPROFEN TAB 600 MG	56
IBUPROFEN TAB 800 MG	56
IBUPROFEN SUSP 100 MG/5ML	946
INDOMETHACIN CAP 25 MG	84
INDOMETHACIN CAP 50 MG	28
KETOROLAC TROMETHAMINE TAB 10 MG	20
MELOXICAM TAB 7.5 MG	14
MELOXICAM TAB 15 MG	14
NABUMETONE TAB 500 MG	28
NABUMETONE TAB 750 MG	28
NAPROXEN TAB 250 MG	42
NAPROXEN TAB 500 MG	28
NAPROXEN SODIUM TAB 220 MG	42
NAPROXEN SODIUM TAB 275 MG	42
NAPROXEN SODIUM TAB 550 MG	28
OXAPROZIN TAB 600 MG	28
PIROXICAM CAP 10 MG	14
PIROXICAM CAP 20 MG	14
SULINDAC TAB 150 MG	28
SULINDAC TAB 200 MG	28
Anticonvulsants: Misc.	
CARBAMAZEPINE TAB 200 MG	60
DIVALPROEX SODIUM TAB DELAYED RELEASE 125 MG	60
DIVALPROEX SODIUM TAB DELAYED RELEASE 250 MG	60
DIVALPROEX SODIUM TAB DELAYED RELEASE 500 MG	60
GABAPENTIN CAP 100 MG	30
GABAPENTIN CAP 300 MG	30
LAMOTRIGINE TAB 25 MG	60
LEVETIRACETAM TAB 250 MG	60

Medication Generic Name	Quantity Limit (Billable units)
LEVETIRACETAM TAB 500 MG	60
OXCARBAZEPINE TAB 150 MG	60
OXCARBAZEPINE TAB 300 MG	60
PREGABALIN CAP 25 MG	30
PREGABALIN CAP 50 MG	30
PREGABALIN CAP 75 MG	30
TOPIRAMATE TAB 25 MG	60
TOPIRAMATE TAB 50 MG	60
Migraine Products: Serotonin Agonists	
SUMATRIPTAN SUCCINATE TAB 25 MG	9
SUMATRIPTAN SUCCINATE TAB 50 MG	9
SUMATRIPTAN SUCCINATE TAB 100 MG	9
Musculoskeletal Therapy Agents: Central Muscle Relaxants	
BACLOFEN TAB 5 MG	42
BACLOFEN TAB 10 MG	42
CHLORZOXAZONE TAB 500 MG	42
CYCLOBENZAPRINE HCL TAB 5 MG	42
CYCLOBENZAPRINE HCL TAB 10 MG	42
METHOCARBAMOL TAB 500 MG	42
METHOCARBAMOL TAB 750 MG	42
TIZANIDINE HCL TAB 2 MG	42
TIZANIDINE HCL TAB 4 MG	63
Anticoagulants: Heparins and Heparinoid-Like Agents	
DALTEPARIN SODIUM SOLN PREFILLED SYR 10000 UNIT/ML	14
DALTEPARIN SODIUM SOLN PREFILLED SYR 12500 UNIT/0.5ML	2.5
DALTEPARIN SODIUM SOLN PREFILLED SYR 15000 UNIT/0.6ML	3
DALTEPARIN SODIUM SOLN PREFILLED SYR 18000 UNIT/0.72ML	3.6
DALTEPARIN SODIUM SOLN PREFILLED SYR 2500 UNIT/0.2ML	5.6
DALTEPARIN SODIUM SOLN PREFILLED SYR 5000 UNIT/0.2ML	5.6
ENOXAPARIN SODIUM INJ 300 MG/3ML	30
ENOXAPARIN SODIUM INJ SOLN PREF SYR 30 MG/0.3ML	8.4
ENOXAPARIN SODIUM INJ SOLN PREF SYR 40 MG/0.4ML	11.2
ENOXAPARIN SODIUM INJ SOLN PREF SYR 60 MG/0.6ML	16.8
ENOXAPARIN SODIUM INJ SOLN PREF SYR 80 MG/0.8ML	22.4
ENOXAPARIN SODIUM INJ SOLN PREF SYR 100 MG/ML	28
ENOXAPARIN SODIUM INJ SOLN PREF SYR 120 MG/0.8ML	22.4
ENOXAPARIN SODIUM INJ SOLN PREF SYR 150 MG/ML	28
FONDAPARINUX SODIUM SUBCUTANEOUS INJ 10 MG/0.8ML	7.2
FONDAPARINUX SODIUM SUBCUTANEOUS INJ 2.5 MG/0.5ML	4.5
FONDAPARINUX SODIUM SUBCUTANEOUS INJ 5 MG/0.4ML	3.6
FONDAPARINUX SODIUM SUBCUTANEOUS INJ 7.5 MG/0.6ML	5.4
HEPARIN SODIUM (PORCINE) INJ 10000 UNIT/ML	10
HEPARIN SODIUM (PORCINE) INJ 5000 UNIT/ML	10
HEPARIN SODIUM (PORCINE) PF INJ 5000 UNIT/0.5ML	5
Anticoagulants: Coumarin Anticoagulants	
WARFARIN SODIUM TAB 1 MG	28
WARFARIN SODIUM TAB 2 MG	28

Medication Generic Name	Quantity Limit (Billable units)
WARFARIN SODIUM TAB 2.5 MG	28
WARFARIN SODIUM TAB 3 MG	28
WARFARIN SODIUM TAB 4 MG	28
WARFARIN SODIUM TAB 5 MG	28
WARFARIN SODIUM TAB 6 MG	28
WARFARIN SODIUM TAB 7.5 MG	28
WARFARIN SODIUM TAB 10 MG	28
Anticoagulants: Thrombin Inhibitors	
DABIGATRAN ETEXILATE MESYLATE CAP 75 MG (ETEXILATE BASE EQ)	60
DABIGATRAN ETEXILATE MESYLATE CAP 150 MG (ETEXILATE BASE EQ)	60
Anticoagulants: Direct Factor Xa Inhibitors	
APIXABAN TAB 2.5 MG	60
APIXABAN TAB 5 MG	60
APIXABAN TAB STARTER PACK 5 MG	74
RIVAROXABAN TAB 10 MG	28
RIVAROXABAN TAB 15 MG	42
RIVAROXABAN TAB 20 MG	28
RIVAROXABAN TAB STARTER THERAPY PACK 15 MG & 20 MG	51
Ophthalmic Agents: Anti-infectives	
AZITHROMYCIN OPHTH SOLN 1%	2.5
BACITRACIN OPHTH OINT 500 UNIT/GM	3.5
BACITRACIN-POLYMYXIN B OPHTH OINT	3.5
BESIFLOXACIN HCL OPHTH SUSP 0.6% (BASE EQUIV)	5
CIPROFLOXACIN HCL OPHTH OINT 0.3%	3.5
CIPROFLOXACIN HCL OPHTH SOLN 0.3%	5
ERYTHROMYCIN OPHTH OINT 5 MG/GM	3.5
GATIFLOXACIN OPHTH SOLN 0.5%	2.5
GENTAMICIN SULFATE OPHTH OINT 0.3%	3.5
GENTAMICIN SULFATE OPHTH SOLN 0.3%	5
LEVOFLOXACIN OPHTH SOLN 0.5%	5
MOXIFLOXACIN HCL OPHTH SOLN 0.5% (BASE EQ) (2 TIMES DAILY)	3
MOXIFLOXACIN HCL OPHTH SOLN 0.5% (BASE EQUIV)	3
NATAMYCIN OPHTH SUSP 5%	15
NEOMYCIN-BACITRAC ZN-POLYMYX 5(3.5)MG-400UNT-10000UNT OP OIN	3.5
NEOMYCIN-POLYMYXIN B-GRAMICIDIN OPHTH SOLN	10
~~NEOMYCIN-POLYMY-GRAMICID OP SOL 1.75-10000-0.025MG-UNT-MG/ML~~	~~10~~
OFLOXACIN OPHTH SOLN 0.3%	5
POLYMYXIN B-TRIMETHOPRIM OPHTH SOLN 10000 UNIT/ML-0.1%	10
SULFACETAMIDE SODIUM OPHTH SOLN 10%	15
TOBRAMYCIN OPHTH OINT 0.3%	3.5
TOBRAMYCIN OPHTH SOLN 0.3%	5
Ophthalmic Agents: Artificial Tears and Lubricants	
ARTIFICIAL TEAR OPHTH SOLUTION	30
Ophthalmic Agents: Ophthalmic Steroids	
BACITRACIN-POLYMYXIN-NEOMYCIN-HC OPHTH OINT 1%	3.5
DEXAMETHASONE OPHTH SUSP 0.1%	5

Medication Generic Name	Quantity Limit (Billable units)
DEXAMETHASONE SODIUM PHOSPHATE OPHTH SOLN 0.1%	5
DIFLUPREDNATE OPHTH EMULSION 0.05%	5
FLUOROMETHOLONE ACETATE OPHTH SUSP 0.1%	5
FLUOROMETHOLONE OPHTH OINT 0.1%	3.5
FLUOROMETHOLONE OPHTH SUSP 0.1%	5
FLUOROMETHOLONE OPHTH SUSP 0.25%	5
GENTAMICIN-PREDNISOLONE ACE OPHTH SUSP 0.3-1%	5
LOTEPREDNOL ETABONATE OPHTH GEL 0.5%	5
LOTEPREDNOL ETABONATE OPHTH OINT 0.5%	3.5
LOTEPREDNOL ETABONATE OPHTH SUSP 0.2%	5
LOTEPREDNOL ETABONATE OPHTH SUSP 0.5%	5
LOTEPREDNOL ETABONATE-TOBRAMYCIN OPHTH SUSP 0.5-0.3%	5
NEOMYCIN-POLYMYXIN-DEXAMETHASONE OPHTH OINT 0.1%	3.5
NEOMYCIN-POLYMYXIN-DEXAMETHASONE OPHTH SUSP 0.1%	5
NEOMYCIN-POLYMYXIN-HC OPHTH SUSP	7.5
PREDNISOLONE ACETATE OPHTH SUSP 0.12%	5
PREDNISOLONE ACETATE OPHTH SUSP 1%	5
PREDNISOLONE SODIUM PHOSPHATE OPHTH SOLN 1%	10
SULFACETAMIDE SODIUM-PREDNISOLONE OPHTH OINT 10-0.2%	3.5
SULFACETAMIDE SODIUM-PREDNISOLONE OPHTH SOLN 10-0.23(0.25)%	5
SULFACETAMIDE SODIUM-PREDNISOLONE OPHTH SUSP 10-0.2%	5
TOBRAMYCIN-DEXAMETHASONE OPHTH OINT 0.3-0.1%	3.5
TOBRAMYCIN-DEXAMETHASONE OPHTH SUSP 0.3-0.05%	5
TOBRAMYCIN-DEXAMETHASONE OPHTH SUSP 0.3-0.1%	5
Ophthalmic Agents: Nonsteroidal Anti-inflammatory Agents	
BROMFENAC SODIUM OPHTH SOLN 0.09% (BASE EQUIV) (ONCE-DAILY)	1.7
DICLOFENAC SODIUM OPHTH SOLN 0.1%	2.5
KETOROLAC TROMETHAMINE OPHTH SOLN 0.4%	5
KETOROLAC TROMETHAMINE (PF) OPHTH SOLN 0.45%	30
KETOROLAC TROMETHAMINE OPHTH SOLN 0.5%	5
NEPAFENAC OPHTH SUSP 0.1%	3
Dermatologicals: Antibiotics – Topical	
BACITRACIN OINT 500 UNIT/GM	30
BACITRACIN ZINC OINT 500 UNIT/GM	30
BACITRACIN-POLYMYXIN B OINT	30
GENTAMICIN SULFATE CREAM 0.1%	15
GENTAMICIN SULFATE OINT 0.1%	15
MUPIROCIN OINT 2%	22
NEOMYCIN-BACITRACIN-POLYMYXIN OINT	30
NEOMYCIN-BACITRACIN-POLYMYXIN-PRAMOXINE OINT 1%	30
NEOMYCIN-POLYMYXIN W/ PRAMOXINE CREAM 1%	30
Dermatologics: Antihistamines – Topical	
DIPHENHYDRAMINE HCL CREAM 2%	30
Dermatologics: Burn Products	
SILVER SULFADIAZINE CREAM 1%	100
Dermatologics: Corticosteroids – Topical	
BETAMETHASONE DIPROPIONATE CREAM 0.05%	15

Medication Generic Name	Quantity Limit (Billable units)
BETAMETHASONE VALERATE CREAM 0.1%	15
CLOBETASOL PROPIONATE CREAM 0.05%	15
CLOBETASOL PROPIONATE EMOLLIENT BASE CREAM 0.05%	15
FLUOCINOLONE ACETONIDE CREAM 0.01%	15
FLUOCINOLONE ACETONIDE CREAM 0.025%	15
FLUOCINONIDE CREAM 0.05%	15
FLUOCINONIDE CREAM 0.1%	30
FLUTICASONE PROPIONATE CREAM 0.05%	15
HALCINONIDE CREAM 0.1%	30
HALOBETASOL PROPIONATE CREAM 0.05%	15
HYDROCORTISONE CREAM 0.5%	30
HYDROCORTISONE CREAM 1%	30
HYDROCORTISONE CREAM 2.5%	30
HYDROCORTISONE VALERATE CREAM 0.2%	15
HYDROCORTISONE PROBUTATE CREAM 0.1%	45
HYDROCORTISONE BUTYRATE CREAM 0.1%	15
MOMETASONE FUROATE CREAM 0.1%	15
TRIAMCINOLONE ACETONIDE CREAM 0.025%	15
TRIAMCINOLONE ACETONIDE CREAM 0.1%	15
TRIAMCINOLONE ACETONIDE CREAM 0.5%	15
Dermatologics: Enzymes – Topical	
COLLAGENASE OINT 250 UNIT/GM	30
Dermatologics: Local Anesthetics – Topical	
CAPSAICIN CREAM 0.025%	60
CAPSAICIN CREAM 0.035%	42.5
CAPSAICIN CREAM 0.075%	60
CAPSAICIN CREAM 0.1%	42.5
LIDOCAINE CREAM 4%	30
LIDOCAINE PATCH 4%	15

No Stakeholder Feedback
Ohio Administrative Code 4123-6-21.3 and 4123-6-21.6