



2021 Formulary

(List of Covered Prescription Drugs for Urgent Care in the U.S.)

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

Small Group Plans

- P5 HMO Plan
- P10 HMO Plan
- PM 90 HMO Plan
- GM 80 HMO Plan

Large Group Plans

- VP5 HMO Plan
- VP10 HMO Plan
- VP20 HMO Plan
- MEP HMO Plan
- QEP HMO Plan

This formulary was last updated on 4/7/2021. This formulary is subject to change and all previous versions of the formulary no longer apply.

For more recent information or other questions, please contact MediExcel Health Plan Member Services at Tel (619) 365-4346; Email: memberservices@mediexcel.com; or visit <https://www.mediexcel.com/home>.

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INFORMATIONAL SECTION

Introduction to the formulary drug list

The MediExcel Health Plan Drug Formulary for Urgent Care in the U.S. is a list of medications that are commonly prescribed **for Urgent Care Services in the U.S.** These drugs are selected based on safety, effectiveness, and cost.

In addition to providing covered health benefits through its contracted provider networks in Mexico, MediExcel Health Plan also covers emergency care and urgent care in the U.S. The U.S. Emergency or Urgent Care Provider may prescribe medication(s) for you to take as soon as possible. If you cannot make it to a MediExcel Provider Network in Mexico to pick up your prescription drugs from a contracted pharmacy, you may obtain them from a local pharmacy in the U.S. near the emergency care or urgent care provider.

As MediExcel Health Plan does not contract with Pharmacies in the U.S., you may need to pay out of pocket for these prescription drugs and request a reimbursement from MediExcel Health Plan, see Page 14 in your Evidence of Coverage (EOC). MediExcel Health Plan will reimburse you as long as the care you get is a covered service and you can present substantiating documentation.

Definitions

The following words and definitions will be used throughout the formulary drug list.

Brand name drug	A drug that is marketed under a proprietary, trademark protected name.
Coinsurance	A percentage of the cost of a covered health care benefit that an enrollee pays after the enrollee has paid the deductible, if a deductible applies to the health care benefit, such as the prescription drug benefit.
Copayment	A fixed dollar amount that an enrollee pays for a covered health care benefit after the enrollee has paid the deductible, if a deductible applies to the health care benefit, such as the prescription drug benefit.
Deductible	The amount an enrollee pays for covered health care benefits before the enrollee's health plan begins payment for all or part of the cost of the health care benefit under the terms of the policy.
Drug tier	A group of prescription drugs that corresponds to a specified cost sharing tier in the health plan's prescription drug coverage. The tier in which a prescription drug is placed determines the enrollee's portion of the cost for the drug.
Enrollee	Also known as "Member." A person enrolled in a health plan who is entitled to receive services from the plan. All references to enrollees in this this formulary template shall also include subscriber as defined in this section below.

Exception request	A request for coverage of a prescription drug. If an enrollee, his or her designee, or prescribing health care provider submits an exception request for coverage of a prescription drug, the health plan must cover the prescription drug when the drug is determined to be medically necessary to treat the enrollee's condition.
Exigent circumstances	Are when an enrollee is suffering from a health condition that may seriously jeopardize the enrollee's life, health, or ability to regain maximum function, or when an enrollee is undergoing a current course of treatment using a non-formulary drug.
Formulary	The complete list of drugs preferred for use and eligible for coverage under a health plan product, and includes all drugs covered under the outpatient prescription drug benefit of the health plan product. Formulary is also known as a prescription drug list.
Generic drug	The same drug as its brand name equivalent in dosage, safety, strength, how it is taken, quality, performance, and intended use. A generic drug is listed in bold and italicized lowercase letters.
Non-formulary drug	A prescription drug that is not listed on the health plan's formulary.
Out-of-pocket costs	Are copayments, coinsurance, and the applicable deductible, plus all costs for health care services that are not covered by the health plan.
Prescribing provider	A health care provider authorized to write a prescription to treat a medical condition for a health plan enrollee.
Prescription	An oral, written, or electronic order by a prescribing provider for a specific enrollee that contains the name of the prescription drug, the quantity of the prescribed drug, the date of issue, the name and contact information of the prescribing provider, the signature of the prescribing provider if the prescription is in writing, and if requested by the enrollee, the medical condition or purpose for which the drug is being prescribed.
Prescription drug	A drug that is prescribed by the enrollee's prescribing provider and requires a prescription under applicable law.
Prior authorization	Health plan's requirement that the enrollee or the enrollee's prescribing provider obtain the health plan's authorization for a prescription drug before the health plan will cover the drug. The health plan shall grant a prior authorization when it is medically necessary for the enrollee to obtain the drug.
Quantity limit	Restriction on the number of doses or any other limitations on the quantity of a prescription drug a health plan will cover during a specific time period.

Step therapy	A process specifying the sequence in which different prescription drugs for a given medical condition and medically appropriate for a particular patient are prescribed. The health plan may require the enrollee to try one or more drugs to treat the enrollee's medical condition before the health plan will cover a particular drug for the condition pursuant to a step therapy request. If the enrollee's prescribing provider submits a request for step therapy exception, the health plans shall make exceptions to step therapy when the criteria is met.
Subscriber	The person who is responsible for payment to a plan or whose employment or other status, exception for family dependency, is the basis for eligibility for membership in the plan.

How do I find a drug on this list?

The drugs are listed alphabetically under the column titled "Prescription Drug Name" by its brand or generic name under the therapeutic category and class to which it belongs. You can search this list using the brand or generic name of the drug by:

- Searching for the category or class to which the drug belongs and search for the name of the drug in alphabetical order or
- Searching the Alphabetical Index of Drugs by the name of the drug.

If a generic equivalent for a brand name drug is not available or is not covered, the drug will not be separately listed by its generic name.

What are drug tiers?

Drugs are placed into drug tiers based on defined categories. The amount you pay for drugs in different tiers will vary. You can find information about what you pay by drug tier in the Summary of Benefits of your Evidence of Coverage (EOC).

The column titled "Drug Tier" is the cost level you pay for a drug.

Drug Tier	Description
1	Most generic drugs or low-cost, preferred brand drugs.
2	Non-preferred generic drugs, preferred brand drugs, or drugs recommended by the P&T Committee based on drug safety, efficacy, and cost.
3	Non-preferred brand drugs; drugs recommended by the P&T Committee based on safety, efficacy, and cost; or drugs that generally have a preferred and often less costly therapeutic alternative at a lower tier.
4	Drugs that are biologics; drugs that the FDA or drug manufacturer requires to be distributed by specialty pharmacies; drugs that require training or clinical monitoring for self-administration; or drugs with a plan cost (net of rebates) greater than \$600 for a one-month supply.

PV	Select drugs covered with no Copayment, including certain generic and over-the-counter contraceptives for women.
MB	Drugs covered under the medical benefit. Please refer to your medical benefit coverage information.

There is a maximum limit on the copayment/coinsurance amount for orally administered anti-cancer drugs. Please see your Summary of Benefits or contact MediExcel Health Plan Member Services at Tel (619) 365-4346 at any time for more detailed information.

How to read the formulary

The column titled “Coverage Requirements and Limits” identifies coverage restrictions or limits for drugs when applicable.

Coverage Requirements and Limits	Description
Age Limit (AGE)	The prescription is covered when certain age criteria are met.
Gender Limit (GL)	Prior authorization may be required if the FDA, manufacturer, or treatment guidelines do not recommend the drug for a gender.
Specialty Pharmacy (SP)	These drugs are available exclusively through select specialty pharmacies.
Prescriber Restriction (PR)	The prescription is covered when prescribed by certain providers.
Prior Authorization (PA)	Prior authorization is required to determine coverage.
Quantity Limit (QL)	The prescription quantity covered is limited. A prior authorization request for quantity exception is required for amounts greater than the limit.
Step Therapy (ST)	If a drug is subject to step therapy, you may have to try one or more other drugs before your health insurance policy will cover that drug for your medical condition

How often will the formulary change?

This formulary is subject to change quarterly. Formulary changes that may not have prior notice include the following:

- A brand name drug may be moved to a higher tier or removed from the formulary if a new generic drug is added to the formulary,
- A drug may be removed from the formulary when is it removed from the market because the Food and Drug Administration (FDA) deems a drug to be unsafe or the drug’s manufacturer removes the drug from the market, or
- A drug is added to the formulary, moved to a lower tier, or has a utilization management requirement removed.

When a drug or dosage form is removed from the formulary and a drug was previously approved for coverage for your medical condition, coverage for the drug will continue if your provider continues to prescribe the drug for your condition and the drug is prescribed appropriately and is safe and effective for your condition.

What if your drug is covered under the medical benefit?

A prescription drugs may be covered under the medical benefit and are not listed in this drug formulary. You should contact the Member Services Center at Tel (619) 365-4346 to ensure that the drug may be covered under the medical benefit. If the Member Services Center confirms that we may cover your drug under the medical benefit, you, your representative, or your doctor may submit a Service Authorization Request to the MediExcel Health Plan Utilization Management Department.

What is step therapy?

Step therapy means a specific sequence in which prescription drugs for a particular medical condition must be tried. If a drug is subject to step therapy in this formulary, you may have to try one or more other drugs before your health insurance policy will cover that drug for your medical condition.

Step therapy requirements are based on how the FDA recommends that a drug should be used, nationally recognized treatment guidelines, medical studies, information from the drug manufacturer, and the relative cost of treatment for a condition. Your provider may submit a request for an exception to the step therapy requirement.

To request an exception, please contact MediExcel Health Plan Member Services at Tel (619) 365-0346 at any time for more detailed information. You, your representative, or your doctor may submit an exception request.

What is the prior authorization/exception request process?

Drug prior authorization is not necessary as long as the medication is medically necessary for a covered service and pursuant to an urgent care visit.

Participating retail pharmacies

MediExcel Health Plan does not contract with retail pharmacies in the U.S.

How to Get Reimbursed for your Prescription Drug(s) Obtained in the U.S.:

You must ask MediExcel Health Plan to reimburse you.

- We must receive your request no later than 180 days after you get the prescription drug(s), unless you show that you could not reasonably file your request within this time period.
- Only covered benefit services will be considered for reimbursement.
- You must include a copy of the bill, a receipt for your payment, and supporting documentation such as medical records that annotates the medical services rendered.
- Send your request to:
MediExcel Health Plan, 750 Medical Center Ct, Ste 2, Chula Vista, CA 91911
- You may also e-mail your request to: claims@mediexcel.com
- Your reimbursement for your prescription drug(s) expense will be less your applicable drug co-pay or co-insurance. The co-pay or coinsurance dollar amount is based on the Prescription Drug Tier (Level I, II, III, or IV) listed in your Summary of Benefits and Coverage.

Drug Formulary Listing

The listing has the 161 drug categories. Even though this listing is confined to urgent care drugs, all 161 drug categories are listed. Some categories will not contain any associated prescription drugs as these categories are not considered to be applicable to an urgent care visit.

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ANALGESICS

1. ANALGESICS NONSTEROIDAL ANTI-INFLAMMATORY DRUGS

Drug name (Active Ingredient)	Tier	Coverage Rules or Limits on Use/ Requirements
DICLOFENAC ORAL SUSPENSION 180MG x 100ML (4.5MG/2.5ML) W 120ML	1	
DICLOFENAC ORAL TABLETS 50MG W 30	2	
KETOROLAC SUBLINGUAL TABLETS 30MG W 6 1	1	
IBUPROFEN ORAL CAPSULES 400MG W 20 1	1	

2. ANALGESICS OPIOID ANALGESICS, LONG- ACTING

3. ANALGESICS OPIOID ANALGESICS, SHORT- ACTING

4. ANESTHETICS LOCAL ANESTHETICS

5. ANTI- ADDICTION/ SUBSTANCE ABUSE TREATMENT AGENTS ALCOHOL DETERRENTS/ANTI-CRAVING

6. ANTI- ADDICTION/ SUBSTANCE ABUSE TREATMENT AGENTS OPIOID DEPENDENCE TREATMENTS

7. ANTI- ADDICTION/ SUBSTANCE ABUSE TREATMENT AGENTS OPIOID REVERSAL AGENTS

8. ANTI- ADDICTION/ SUBSTANCE ABUSE TREATMENT AGENTS SMOKING CESSATION AGENTS (NOT REQUIRED)

ANTI-INFLAMMATORY AGENTS

9. ANTI-INFLAMMATORY AGENTS GLUCOCORTICOIDS

Drug name (Active Ingredient)	Tier	Coverage Rules or Limits on Use/ Requirements
LORATADINE/BETAMETHASONE ORAL TABLETS 5MG/0.25MG	1	
BETAMETHASONE TOPIC CREAM 0.1/100G 40G	2	
LORATADINE/BETAMETHASONE ORAL TABLETS 5MG/0.25MG 10	1	

10. ANTI-INFLAMMATORY AGENTS NONSTEROIDAL ANTI- INFLAMMATORY DRUGS

Drug name (Active Ingredient)	Tier	Coverage Rules or Limits on Use/ Requirements
KETOPROFEN/ACETAMINOPHEN ORAL TABLETS 100MG/300MG 12	2	
IBUPROFEN ORAL CAPSULES 600MG 10	1	
IBUPROFEN ORAL CAPSULES 400MG 10 1	1	
NAPROXEN ORAL CAPSULES 275 MG 20	1	

11. ANTIBACTERIALS AMINOGLYCOSIDES
12. ANTIBACTERIALS ANTIBACTERIALS, OTHER

Drug name (Active Ingredient)	Tier	Coverage Rules or Limits on Use/ Requirements
AMOXICILLIN ORAL CAPSULES 500MG 15	1	
AMOXICILLIN ORAL SUSPENSION 500MG 75ML	1	
AMOXICILLINE ORAL TABLET 750MG 12	1	
AMOXICILLIN/CLAVULANIC ACID ORAL SUSPENSION 250MG/62.5MG/5ML 70ML	1	
CLINDAMYCIN VAGINAL PRESENTATION 100MG 7	1	
DICLOXACILLIN ORAL SUSPENSION 125MG/5ML 90ML	1	

13. ANTIBACTERIALS BETA-LACTAM, CEPHALOSPORINS

Drug name (Active Ingredient)	Tier	Coverage Rules or Limits on Use/ Requirements
CEFALEXIN ORAL CAPSULES 250MG 24	2	
CEFALEXIN ORAL TABLETS 500 MG 12	2	
CEFALEXIN ORAL SUSPENSION 125MG/5ML 100ML	2	

14. ANTIBACTERIALS BETA-LACTAM, OTHER
15. ANTIBACTERIALS BETA-LACTAM, PENICILLINS

Drug name (Active Ingredient)	Tier	Coverage Rules or Limits on Use/ Requirements
AMPICILLIN ORAL ORAL SUSPENSION 250MG 90ML	1	
BENCILPENICILLIN IV/IM INYECTABLE SOLUTION 1000000/2ML 2ML	1	
COMBINED PENICILLIN INTRAMUSCULAR INYECTABLE SUSPENSION 600,000U/300,000U/300,000U 1X3ML	1	
PENICILLIN G INTRAMUSCULAR INYECTABLE SOLUTION 300000UI/500MG 1	1	

16. ANTIBACTERIALS MACROLIDES

Drug name (Active Ingredient)	Tier	Coverage Rules or Limits on Use/ Requirements
ERYTHROMYCIN ORAL TABLETS 500MG 20	2	

17. ANTIBACTERIALS QUINOLONES

Drug name (Active Ingredient)	Tier	Coverage Rules or Limits on Use/ Requirements
CIPROFLOXACIN ORAL TABLETS 500MG	1	
CIPROFLOXACIN ORAL CAPSULES 250MG 12	1	

18. ANTIBACTERIALS SULFONAMIDES

Drug name (Active Ingredient)	Tier	Coverage Rules or Limits on Use/ Requirements
SULFAMETOXAZOL/TRIMETROM ORAL TABLETS 80/400MG 30	1	
SULFAMETOXAZOL/TRIMETROPIM ORAL SUSPENSION 200MG/40 MG/5ML 120ML	1	

19. ANTIBACTERIALS TETRACYCLINES

Drug name (Active Ingredient)	Tier	Coverage Rules or Limits on Use/ Requirements
MINOCYCLINE ORAL TABLETS 50MG 24	2	
DICLOXACILLIN ORAL SUSPENSION 125MG/5ML 90ML	1	

- 20. ANTICONVULSANTS ANTICONVULSANTS, OTHER
- 21. ANTICONVULSANTS CALCIUM CHANNEL MODIFYING AGENTS
- 22. ANTICONVULSANTS GAMMA-AMINO BUTYRIC ACID (GABA) AUGMENTING AGENTS
- 23. ANTICONVULSANTS GLUTAMATE REDUCING AGENTS
- 24. ANTICONVULSANTS SODIUM CHANNEL AGENTS
- 25. ANTIDEMENTIA AGENTS ANTIDEMENTIA AGENTS, OTHER
- 26. ANTIDEMENTIA AGENTS CHOLINESTERASE INHIBITORS
- 27. ANTIDEMENTIA AGENTS N-METHYL-D-ASPARTATE (NMDA) RECEPTOR ANTAGONIST
- 28. ANTIDEPRESSANTS, ANTIDEPRESSANTS, OTHER
- 29. ANTIDEPRESSANTS MONOAMINE OXIDASE INHIBITORS
- 30. ANTIDEPRESSANTS SEROTONIN/NOREPINEPHRINE REUPTAKE INHIBITORS
- 31. ANTIDEPRESSANTS TRICYCLICS

ANTIEMETICS

32. ANTIEMETICS ANTIEMETICS, OTHER

Drug name (Active Ingredient)	Tier	Coverage Rules or Limits on Use/ Requirements
HYDROXYZINE ORAL TABLETS 10MG 30	1	
METOCLOPRAMIDE ORAL DROPS 400MG 20ML	1	
METOCLOPRAMIDE ORAL TABLET 10MG W 20	1	

33. ANTIEMETICS EMETOGENIC THERAPY ADJUNCTS

ANTIFUNGALS

34. ANTIFUNGALS NO USP CLASS

Drug name (Active Ingredient)	Tier	Coverage Rules or Limits on Use/ Requirements
ITRACONAZOLE TOPIC CREAM 10MG/GR 20G	1	
KETOCONAZOLE VAGINAL CREAM 10MG/GR 7 APLIC C/5G CU	2	

35. ANTIGOUT AGENTS NO USP CLASS

Drug name (Active Ingredient)	Tier	Coverage Rules or Limits on Use/ Requirements
ALOPURINOL ORAL TABLETS 300MG 20	1	
ALOPURINOL ORAL TABLETS 100MG 60	1	

ANTIMIGRAINE AGENTS

36. ANTIMIGRAINE AGENTS ERGOT ALKALOIDS

Drug name (Active Ingredient)	Tier	Coverage Rules or Limits on Use/ Requirements
IBUPROFEN/CAFFEINE ORAL CAPSULES 400MG/100MG 10	2	

37. ANTIMIGRAINE AGENTS PROPHYLACTIC

Drug name (Active Ingredient)	Tier	Coverage Rules or Limits on Use/ Requirements
IBUPROFEN 600 MG W 10C	1	
ACETAMINOPHEN 1G W 20T	1	

- 38. ANTIMIGRAINE AGENTS SEROTONIN (5-HT) 1B/1D RECEPTOR AGONISTS
- 39. ANTIMYASTHENIC AGENTS PARASYMPATHOMIMETICS
- 40. ANTIMYCOBACTERIALS ANTIMYCOBACTERIALS, OTHER
- 41. ANTIMYCOBACTERIALS ANTITUBERCULARS
- 42. ANTINEOPLASTICS ALKYLATING AGENTS
- 43. ANTINEOPLASTICS ANTI ANDROGENS
- 44. ANTINEOPLASTICS ANTI ANGIOGENIC AGENTS
- 45. ANTINEOPLASTICS ANTIESTROGENS/MODIFIERS
- 46. ANTINEOPLASTICS ANTIMETABOLITES
- 47. ANTINEOPLASTICS ANTINEOPLASTICS, OTHER
- 48. ANTINEOPLASTICS AROMATASE INHIBITORS, 3RD GENERATION
- 49. ANTINEOPLASTICS ENZYME INHIBITORS
- 50. ANTINEOPLASTICS MOLECULAR TARGET INHIBITORS
- 51. ANTINEOPLASTICS MONOCLONAL ANTIBODIES
- 52. ANTINEOPLASTICS RETINOIDS

53. ANTIPARASITICS ANTHELMINTICS

Drug name (Active Ingredient)	Tier	Coverage Rules or Limits on Use/ Requirements
ALBENDAZOLE ORAL SUSPENSION 4G/100ML 10ML	1	
ALBENDAZOLE ORAL TABLETS 200MG 10	1	
MEBENDAZOLE ORAL SUSPENSION 20MG/1ML 30ML	1	

54. ANTIPARASITICS ANTIPROTOZOALS

Drug name (Active Ingredient)	Tier	Coverage Rules or Limits on Use/ Requirements
NITAXOZANIDE ORAL TABLETS 200MG 6	1	
METRONIDAZOLE ORAL TABLETS 500MG 30	1	

55. ANTIPARASITICS PEDICULICIDES/SCABICIDES

Drug name (Active Ingredient)	Tier	Coverage Rules or Limits on Use/ Requirements
IIVERMECTIN ORAL TABLETS 6MG 4	1	
PERMETHRIN TOPIC CREAM 5G/100G 60G	1	

- 56. ANTIPARKINSON AGENTS ANTICHOLINERGICS
- 57. ANTIPARKINSON AGENTS ANTIPARKINSON AGENTS, OTHER
- 58. ANTIPARKINSON AGENTS DOPAMINE AGONISTS
- 59. ANTIPARKINSON AGENTS DOPAMINE PRECURSORS/L-AMINO ACID DECARBOXYLASE INHIBITORS
- 60. ANTIPARKINSON AGENTS MONOAMINE OXIDASE B (MAO-B) INHIBITORS
- 61. ANTIPSYCHOTICS 1ST GENERATION/TYPICAL
- 62. ANTIPSYCHOTICS 2ND GENERATION/ATYPICAL
- 63. ANTIPSYCHOTICS TREATMENT-RESISTANT
- 64. ANTISPASTICITY AGENTS NO USP CLASS
- 65. ANTIVIRALS ANTI-CYTOMEGALOVIRUS (CMV) AGENTS
- 66. ANTIVIRALS ANTI-HEPATITIS B (HBV) AGENTS

- 67. ANTIVIRALS ANTI-HEPATITIS C (HBC) AGENTS
- 68. ANTIVIRALS ANTI-HIV AGENTS, NON- NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS
- 69. ANTIVIRALS ANTI-HIV AGENTS, NUCLEOSIDE AND NUCLEOTIDE REVERSE TRANSCRIPTASE INHIBITORS
- 70. ANTIVIRALS ANTI-HIV AGENTS, INTEGRASE INHIBITORS
- 71. ANTIVIRALS ANTI-HIV AGENTS, OTHER
- 72. ANTIVIRALS ANTI-HIV AGENTS, PROTEASE INHIBITORS
- 73. ANTIVIRALS ANTI-INFLUENZA AGENTS

74. ANTIVIRALS ANTIHERPETIC AGENTS

Drug name (Active Ingredient)	Tier	Coverage Rules or Limits on Use/ Requirements
ACICLOVIR ORAL SUSPENSION 4G/125ML 125ML	1	
ACICLOVIR TOPIC CREAM 2G 5% 2G	1	

75. ANXIOLYTICS ANXIOLYTICS, OTHER

76. ANXIOLYTICS SSRIS/SNRIS (SELECTIVE SEROTONIN REUPTAKE INHIBITORS/SEROTONIN AND NOREPINEPHRINE REUPTAKE INHIBITORS)

77. ANXOLYTICS BENZODIASEPINES

78. BIPOLAR AGENTS BIPOLAR AGENTS, OTHER

79. BIPOLAR AGENTS MOOD STABILIZERS

80. BLOOD GLUCOSE REGULATORS ANTIDIABETIC AGENTS

Drug name (Active Ingredient)	Tier	Coverage Rules or Limits on Use/ Requirements
METFORMIN ORAL TABLETS 850MG 30	1	
METFORMIN ORAL TABLETS 1000MG 30	1	
METFORMIN ORAL TABLET 500MG 60	1	

81. BLOOD GLUCOSE REGULATORS GLYCEMIC AGENTS

82. BLOOD GLUCOSE REGULATORS INSULINS

83. BLOOD PRODUCTS/ MODIFIERS/ VOLUME EXPANDERS ANTICOAGULANTS

84. BLOOD PRODUCTS/ MODIFIERS/ VOLUME EXPANDERS BLOOD FORMATION MODIFIERS

85. BLOOD PRODUCTS/ MODIFIERS/ VOLUME EXPANDERS COAGULANTS

86. BLOOD PRODUCTS/ MODIFIERS/ VOLUME EXPANDERS PLATELET MODIFYING AGENTS

87. CARDIOVASCULAR AGENTS ALPHA-ADRENERGIC AGONISTS

88. CARDIOVASCULAR AGENTS ALPHA-ADRENERGIC BLOCKING AGENTS

89. CARDIOVASCULAR AGENTS ANGIOTENSIN II RECEPTOR ANTAGONISTS

90. CARDIOVASCULAR AGENTS ANGIOTENSIN-CONVERTING ENZYME (ACE) INHIBITORS

Drug name (Active Ingredient)	Tier	Coverage Rules or Limits on Use/ Requirements
LOSARTAN ORAL TABLET 100MG W 30	1	

91. CARDIOVASCULAR AGENTS ANTIARRHYTHMICS

92. CARDIOVASCULAR AGENTS BETA-ADRENERGIC BLOCKING AGENTS

93. CARDIOVASCULAR AGENTS CALCIUM CHANNEL BLOCKING AGENTS

Drug name (Active Ingredient)	Tier	Coverage Rules or Limits on Use/ Requirements
AMLODIPINE ORAL CAPSULES 5MG 30	1	
NIFEDIPINE ORAL CAPSULES 30MG W 30	1	
NIFEDIPINE ORAL CAPSULES 10MG 30	1	

94. CARDIOVASCULAR AGENTS CARDIOVASCULAR AGENTS, OTHER

Drug name (Active Ingredient)	Tier	Coverage Rules or Limits on Use/ Requirements
DIOSMINE/HESPERIDINE ORAL TABLETS 450MG/50MG 20	1	

95. CARDIOVASCULAR AGENTS DIURETICS, CARBONIC ANHYDRASE INHIBITORS**96. CARDIOVASCULAR AGENTS DIURETICS, LOOP**

Drug name (Active Ingredient)	Tier	Coverage Rules or Limits on Use/ Requirements
FUROSEMIDA FUROSEMIDE ORAL PILLS 40MG 24	2	

97. CARDIOVASCULAR AGENTS DIURETICS, POTASSIUM-SPARING

Drug name (Active Ingredient)	Tier	Coverage Rules or Limits on Use/ Requirements
SPIRONOLACTONE ORAL TABLETS 25MG 30	1	
SPIRONOLACTONE ORAL TABLETS 25MG 14	1	

98. CARDIOVASCULAR AGENTS DIURETICS, THIAZIDE

Drug name (Active Ingredient)	Tier	Coverage Rules or Limits on Use/ Requirements
CLORTALIDONE ORAL TABLETS 50MG 30	1	
HYDROCHLOROTIAZIDE ORAL TABLETS 25MG 30	2	

99. CARDIOVASCULAR AGENTS DYSLIPIDEMICS, FIBRIC ACID DERIVATIVES**100. CARDIOVASCULAR AGENTS DYSLIPIDEMICS, HMG COA REDUCTASE INHIBITORS****101. CARDIOVASCULAR AGENTS DYSLIPIDEMICS, OTHER****102. CARDIOVASCULAR AGENTS VASODILATORS, DIRECT-ACTING ARTERIAL/VENOUS**

Drug name (Active Ingredient)	Tier	Coverage Rules or Limits on Use/ Requirements
DINITRATE OF ISOSORBIDE ORAL TABLETS 10MG 40	1	
DINITRATE OF ISOSORBIDE SUBLINGUAL TABLETS 5MG 40	1	

103. CARDIOVASCULAR AGENTS VASODILATORS, DIRECT-ACTING ARTERIAL/VENOUS

- 104.CENTRAL NERVOUS SYSTEM AGENTS ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS, AMPHETAMINES
 105.CENTRAL NERVOUS SYSTEM AGENTS ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS, NON-AMPHETAMINES
 106.CENTRAL NERVOUS SYSTEM AGENTS CENTRAL NERVOUS SYSTEM AGENTS, OTHER
 107.CENTRAL NERVOUS SYSTEM AGENTS FIBROMYALGIA AGENTS
 108.CENTRAL NERVOUS SYSTEM AGENTS MULTIPLE SCLEROSIS AGENTS
 109.DENTAL AND ORAL AGENTS NO USP CLASS

110.DERMATOLOGICAL AGENTS NO USP CLASS

Drug name (Active Ingredient)	Tier	Coverage Rules or Limits on Use/ Requirements
BETAMETHASONE TOPIC CREAM 30G 0.5/1G	2	

- 111.ENZYME REPLACEMENT/ MODIFIERS NO USP CLASS
 112.GASTROINTESTINAL AGENTS ANTISPASMODICS, GASTROINTESTINAL
 113.GASTROINTESTINAL AGENTS GASTROINTESTINAL AGENTS, OTHER
 114.GASTROINTESTINAL AGENTS HISTAMINE2 (H2) RECEPTOR ANTAGONISTS
 115.GASTROINTESTINAL AGENTS IRRITABLE BOWEL SYNDROME AGENTS
 116.GASTROINTESTINAL AGENTS LAXATIVES
 117.GASTROINTESTINAL AGENTS PROTECTANTS

Drug name (Active Ingredient)	Tier	Coverage Rules or Limits on Use/ Requirements
LACTULOSE ORAL SYRUP 66.7G W 120 ML	1	

118.GASTROINTESTINAL AGENTS PROTON PUMP INHIBITORS

Drug name (Active Ingredient)	Tier	Coverage Rules or Limits on Use/ Requirements
OMEPRAZOLE ORAL CAPSULES 40MG 7+7	1	

119.GENITOURINARY AGENTS ANTISPASMODICS, URINARY

Drug name (Active Ingredient)	Tier	Coverage Rules or Limits on Use/ Requirements
NITROFURANTOIN ORAL CAPSULES 100MG 40	1	
NITROFURANTOIN ORAL ORAL SUSPENSION 25MG X 5ML 120ML	1	

- 120.GENITOURINARY AGENTS BENIGN PROSTATIC HYPERTROPHY AGENTS
 121.GENITOURINARY AGENTS GENITOURINARY AGENTS, OTHER
 122.GENITOURINARY AGENTS PHOSPHATE BINDERS

123.HORMONAL AGENTS, STIMULANT/ REPLACEMENT/MODIFYING (ADRENAL) No USP CLASS

Drug name (Active Ingredient)	Tier	Coverage Rules or Limits on Use/ Requirements
DEXAMETHASONE ORAL TABLETS 0.5MG/ML 30	1	
DEXAMETHASONE ORAL TABLETS .75MG 1	1	
DEXAMETHASONE ORAL TABLETS 4MG 3'	1	

- 124.HORMONAL AGENTS, STIMULANT/ REPLACEMENT/MODIFY ING (PITUITARY) NO USP CLASS
 125.HORMONAL AGENTS, STIMULANT/ REPLACEMENT/MODIFY ING (PROSTAGLANDINS) NO USP CLASS
 126.HORMONAL AGENTS, STIMULANT/ REPLACEMENT/MODIFY ING (SEX HORMONES/ MODIFIERS) ANABOLIC STEROIDS
 127.HORMONAL AGENTS, STIMULANT/ REPLACEMENT/MODIFY ING (SEX HORMONES/ MODIFIERS) ANDROGENS
 128.HORMONAL AGENTS, STIMULANT/ REPLACEMENT/MODIFY ING (SEX HORMONES/ MODIFIERS) ESTROGENS
 129.HORMONAL AGENTS, STIMULANT/ REPLACEMENT/MODIFY ING (SEX HORMONES/ MODIFIERS) PROGESTERONE AGONISTS/ANTAGONISTS
 130.(SEX HORMONES/ MODIFIERS) HORMONAL AGENTS, STIMULANT/ REPLACEMENT/MODIFY ING PROGESTINS
 131.(SEX HORMONES/ MODIFIERS) SELECTIVE ESTROGEN RECEPTOR MODIFYING AGENTS
 132.HORMONAL AGENTS, STIMULANT/ REPLACEMENT/MODIFY ING (THYROID) NO USP CLASS
 133.SP CLASS
 134.HORMONAL AGENTS, SUPPRESSANT (PARATHYROID) NO USP CLASS
 135.HORMONAL AGENTS, SUPPRESSANT (PITUITARY) NO USP CLASS
 136.HORMONAL AGENTS, SUPPRESSANT (THYROID) ANTITHYROID AGENTS
 137.IMMUNOLOGICAL AGENTS ANGIOEDEMA (HAE) AGENTS
 138.IMMUNOLOGICAL AGENTS IMMUNE SUPPRESSANTS
 139.IMMUNOLOGICAL AGENTS IMMUNIZING AGENTS, PASSIVE
 140.IMMUNOLOGICAL AGENTS IMMUNOMODULATORS
 141.INFLAMMATORY BOWEL DISEASE AGENTSAMINOSALICYLATES
 142.INFLAMMATORY BOWEL DISEASE AGENTSGLUCOCORTICOIDS
 143.INFLAMMATORY BOWEL DISEASE AGENTSSULFONAMIDES
 144.METABOLIC BONE DISEASE AGENTS NO USP CLASS
 145.OPHTHALMIC AGENTS OPHTHALMIC PROSTAGLANDIN AND PROSTAMIDE ANALOGS
 146.OPHTHALMIC AGENTS OPHTHALMIC AGENTS, OTHER

Drug name (Active Ingredient)	Tier	Coverage Rules or Limits on Use/ Requirements
NEOMICINA/POLIMINA B/GRAMICIDINA OPHTHALMIC DROPS 1.75MG/5000UI/0.025MG/1ML 15ML	1	

147.OPHTHALMIC AGENTS OPHTHALMIC ANTI-ALLERGY AGENTS

Drug name (Active Ingredient)	Tier	Coverage Rules or Limits on Use/ Requirements
SODIOOXYMETAZOLINE/SODIUM HYALURONATE OPHTHALMIC OPHTHALMIC SOLUTION 0.125MG/1MG X 0.5ML	1	

148.OPHTHALMIC AGENTS OPHTHALMIC ANTI- INFLAMMATORIES.

Drug name (Active Ingredient)	Tier	Coverage Rules or Limits on Use/ Requirements
DEXAMETHASONE/TOBRAMYCIN OPHTHALMIC OINTMENT 3MG/MG 3.5MG	1	

149.OPHTHALMIC AGENTS OPHTHALMIC ANTIGLAUCOMA AGENTS

150.OTIC AGENTS NO USP CLASS

151.RESPIRATORY TRACT AGENTS/PULMONARY AGENTS ANTI-INFLAMMATORIES, INHALED CORTICOSTEROIDS

152.RESPIRATORY TRACT AGENTS/PULMONARY AGENTS ANTIHISTAMINES

Drug name (Active Ingredient)	Tier	Coverage Rules or Limits on Use/ Requirements
LORATADINE ORAL TABLETS 10MG 10	1	
LORATADINE ORAL SYRUP 100MG/100ML 60ML	1	
LORATADINE ORAL ORAL SOLUTION 30MG 30ML	1	
LORATADINE/AMBROXOL ORAL SYRUP 100MG/600MG 120ML	1	
LORATADINE/AMBROXOL ORAL TABLETS 5MG/30MG 20	1	

- 153.RESPIRATORY TRACT AGENTS/PULMONARY AGENTS ANTILEUKOTRIENES**
- 154.RESPIRATORY TRACT AGENTS/PULMONARY AGENTS BRONCHODILATORS, ANTICHOLINERGIC**
- 155.RESPIRATORY TRACT AGENTS/PULMONARY AGENTS PHOSPHODIESTERASE INHIBITORS, AIRWAYS DISEASE**
- 156.RESPIRATORY TRACT AGENTS/PULMONARY AGENTS BRONCHODILATORS, SYMPATHOMIMETIC**
- 157.RESPIRATORY TRACT AGENTS/PULMONARY AGENTS CYSTIC FIBROSIS AGENTS**
- 158.RESPIRATORY TRACT AGENTS/PULMONARY AGENTS MAST CELL STABILIZERS**
- 159.RESPIRATORY TRACT AGENTS/PULMONARY AGENTS PULMONARY ANTIHYPERTENSIVES**
- 160.RESPIRATORY TRACT AGENTS/PULMONARY AGENTS RESPIRATORY TRACT AGENTS, OTHER**
- 161.SKELETAL MUSCLE RELAXANTS NO USP CLASS**
- 162.SLEEP DISORDER AGENTS GABA RECEPTOR MODULATORS**
- 163.SLEEP DISORDER AGENTS SLEEP DISORDERS, OTHER**
- 164.THERAPEUTIC NUTRIENTS/MINERALS/ ELECTROLYTES ELECTROLYTE/MINERAL MODIFIERS**
- 165.THERAPEUTIC NUTRIENTS/MINERALS/ ELECTROLYTES ELECTROLYTE/MINERAL REPLACEMENT**
- 166.THERAPEUTIC NUTRIENTS/MINERALS/ ELECTROLYTES VITAMINS**