

AvMed Medicare 2023 Formulary List of Covered Drugs

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

HPMS Approved Formulary File Submission
ID, 0023092 Version Number 10
Inventory ID: H1016_PH272-092022_C

This Condensed, Comprehensive formulary was updated on 03/01/2023. For more recent information or other questions, please contact AvMed Medicare Member Engagement Center at 1-800-782-8633 or for TTY users, 711, October 1 – March 31: 8:00 a.m. to 8:00 p.m., 7 days a week. April 1 - September 30: 8:00 a.m. to 8:00 p.m., Monday through Friday and Saturday 9:00 a.m. to 1:00 p.m., or visit www.avmed.org

o **Important Message About What You Pay for Vaccines** - Our plan covers most Part D vaccines at no cost to you, even if you haven't paid your deductible. Call Member Services for more information.

o **Important Message About What You Pay for Insulin** - You won't pay more than \$35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on, even if you haven't paid your deductible.



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

When this drug list (formulary) refers to “we,” “us”, or “our,” it means AvMed. When it refers to “plan” or “our plan,” it means AvMed Medicare.

This document includes a list of the drugs (formulary) for our plan which is current as of 03/01/2023. For an updated formulary, please contact us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

You must generally use network pharmacies to use your prescription drug benefit. Benefits, formulary, pharmacy network, and/or copayments/coinsurance may change on January 1, 2023, and from time to time during the year.

What is the AvMed Medicare Formulary?

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

Can the Formulary (drug list) change?

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

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

- **New generic drugs.** We may immediately remove a brand name drug on our Drug List if we are replacing it with a new generic drug that will appear on the same or lower cost sharing tier and with the same or fewer restrictions. Also, when adding the new generic drug, we may decide to keep the brand name drug on our Drug List, but immediately move it to a different cost-sharing tier or add new restrictions. If you are currently taking that brand name drug, we may not tell you in advance before we make that change, but we will later provide you with information about the specific change(s) we have made.
 - If we make such a change, you or your prescriber can ask us to make an exception and continue to cover the brand name drug for you. The notice we provide you will also include information on how to request an exception, and you can find information in the section below entitled “How do I request an exception to the AvMed Medicare Formulary?”
- **Drugs removed from the market.** If the Food and Drug Administration deems a drug on our formulary to be unsafe or the drug’s manufacturer removes the drug from the market,

we will immediately remove the drug from our formulary and provide notice to members who take the drug.

- **Other changes.** We may make other changes that affect members currently taking a drug. For instance, we may add a new generic drug to replace a brand name drug currently on the formulary; or add new restrictions to the brand name drug or move it to a different cost-sharing tier or both. Or we may make changes based on new clinical guidelines. If we remove drugs from our formulary, [or] add prior authorization, quantity limits and/or step therapy restrictions on a drug or move a drug to a higher cost-sharing tier, we must notify affected members of the change at least 30 days before the change becomes effective, or at the time the member requests a refill of the drug, at which time the member will receive a 30-day supply of the drug.
 - If we make these other changes, you or your prescriber can ask us to make an exception and continue to cover the brand name drug for you. The notice we provide you will also include information on how to request an exception, and you can also find information in the section below entitled “How do I request an exception to the AvMed Medicare Formulary?”

Changes that will not affect you if you are currently taking the drug. Generally, if you are taking a drug on our 2023 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2023 coverage year except as described above. This means these drugs will remain available at the same cost sharing and with no new restrictions for those members taking them for the remainder of the coverage year. You will not get direct notice this year about changes that do not affect you. However, on January 1 of the next year, such changes would affect you, and it is important to check the Drug List for the new benefit year for any changes to drugs.

The enclosed formulary is current as of 01/01/2023. To get updated information about the drugs covered by AvMed Medicare, please contact us. Our contact information appears on the front and back cover pages.

How do I use the Formulary?

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

Medical Condition

The formulary begins on page 8. The drugs in this formulary are grouped into categories depending on the type of medical conditions that they are used to treat. For example, drugs used to treat a heart condition are listed under the category, “Cardiovascular.” If you know what your drug is used for, look for the category name in the list that begins on page number 8. Then look under the category name for your drug.

Alphabetical Listing

If you are not sure what category to look under, you should look for your drug in the Index that begins on page 64. The Index provides an alphabetical list of all of the drugs included in this document. Both brand name drugs and generic drugs are listed in the Index. Look in the Index and find your drug. Next to your drug, you will see the page number where you can find coverage information. Turn to the page listed in the Index and find the name of your drug in the first column of the list.

What are generic drugs?

AvMed Medicare covers both brand name drugs and generic drugs. A generic drug is approved by the FDA as having the same active ingredient as the brand name drug. Generally, generic drugs cost less than brand name drugs.

Are there any restrictions on my coverage?

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

- **Prior Authorization:** AvMed Medicare requires you [or your physician] to get prior authorization for certain drugs. This means that you will need to get approval from AvMed Medicare before you fill your prescriptions. If you don't get approval, AvMed Medicare may not cover the drug.
- **Quantity Limits:** For certain drugs, AvMed Medicare limits the amount of the drug that AvMed Medicare will cover. For example, AvMed Medicare provides 30 per prescription for OPSUMIT. This may be in addition to a standard one-month or three-month supply.
- **Step Therapy:** In some cases, AvMed Medicare requires you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, AvMed Medicare may not cover Drug B unless you try Drug A first. If Drug A does not work for you, AvMed Medicare will then cover Drug B.

You can find out if your drug has any additional requirements or limits by looking in the formulary that begins on page 9. You can also get more information about the restrictions applied to specific covered drugs by visiting our Web site. We have posted on line documents that explain our prior authorization and step therapy restrictions. You may also ask us to send you a copy. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

You can ask AvMed Medicare to make an exception to these restrictions or limits or for a list of other, similar drugs that may treat your health condition. See the section, "How do I request an

exception to the AvMed Medicare formulary?” on page 4 for information about how to request an exception.

What if my drug is not on the Formulary?

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

If you learn that AvMed Medicare does not cover your drug, you have two options:

- You can ask Member Services for a list of similar drugs that are covered by AvMed Medicare. When you receive the list, show it to your doctor and ask him or her to prescribe a similar drug that is covered by AvMed Medicare.
- You can ask AvMed Medicare to make an exception and cover your drug. See below for information about how to request an exception.

How do I request an exception to the AvMed Medicare Formulary?

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

- You can ask us to cover a drug even if it is not on our formulary. If approved, this drug will be covered at a pre-determined cost-sharing level, and you would not be able to ask us to provide the drug at a lower cost-sharing level.
- You can ask us to cover a formulary drug at a lower cost-sharing level unless the drug is on the specialty tier. If approved this would lower the amount you must pay for your drug.
- You can ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, AvMed Medicare limits the amount of the drug that we will cover. If your drug has a quantity limit, you can ask us to waive the limit and cover a greater amount.

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

You should contact us to ask us for an initial coverage decision for a formulary, tier, or utilization restriction exception. **When you request a formulary, tier, or utilization restriction exception you should submit a statement from your prescriber or physician supporting your request.** Generally, we must make our decision within 72 hours of getting your prescriber's supporting

statement. You can request an expedited (fast) exception if you or your doctor believe that your health could be seriously harmed by waiting up to 72 hours for a decision. If your request to expedite is granted, we must give you a decision no later than 24 hours after we get a supporting statement from your doctor or other prescriber.

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

As a new or continuing member in our plan you may be taking drugs that are not on our formulary. Or, you may be taking a drug that is on our formulary but your ability to get it is limited. For example, you may need a prior authorization from us before you can fill your prescription. You should talk to your doctor to decide if you should switch to an appropriate drug that we cover or request a formulary exception so that we will cover the drug you take. While you talk to your doctor to determine the right course of action for you, we may cover your drug in certain cases during the first 90 days you are a member of our plan.

For each of your drugs that is not on our formulary or if your ability to get your drugs is limited, we will cover a temporary 30 day supply. If your prescription is written for fewer days, we'll allow refills to provide up to a maximum 30 day supply of medication. After your first 30 day supply, we will not pay for these drugs, even if you have been a member of the plan less than 90 days.

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

Transition Supply for Current Members with changes in treatment setting:

If the setting where you receive treatment changes during the plan year, you may need a short-term supply of your drugs during the transition. For example:

- You're discharged from a hospital or skilled nursing facility (where your Medicare Part A payments include drug costs) and need a prescription from a pharmacy to continue taking a drug at home (using your Part D plan benefit); or
- You transfer from one skilled nursing facility to another

If you do change treatment settings and need to fill a prescription at a pharmacy, we'll cover up to a 30-day supply of a drug covered by Medicare Part D, so your drug treatment won't be interrupted. To ask for a temporary supply, call AvMed Member Engagement (phone numbers are printed on the front and back cover of this booklet).

If you change treatment settings multiple times within the same month, you may have to request an exception or prior authorization for continued coverage of your drug. See the "How do I request an exception to the AvMed Medicare Formulary?" section on page 4.

For more information

For more detailed information about your AvMed Medicare prescription drug coverage, please review your Evidence of Coverage and other plan materials.

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

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

AvMed's Medicare Formulary

The formulary below provides coverage information about the drugs covered by AvMed Medicare. If you have trouble finding your drug in the list, turn to the Index that begins on page 64. The first column of the chart lists the drug name. Brand name drugs are capitalized (e.g., CHANTIX) and generic drugs are listed in lower-case italics (e.g., *simvastatin*).

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

Below is a list of abbreviations that may appear on the following pages in the Requirements/Limits column that tells you if there are any special requirements for coverage of your drug.

B/D PA: This prescription drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination. For more information, call Member Engagement at 1-800- 782-8633 or for TTY users, 711, October 1 – March 31: 8:00 a.m. to 8:00 p.m., 7 days a week. April 1 - September 30: 8:00 a.m. to 8:00 p.m., Monday through Friday and Saturday 9:00 a.m. to 1:00 p.m.

ED: Excluded Drug. This prescription drug is not normally covered in a Medicare prescription drug plan. The amount you pay when you fill a prescription for this drug does not count toward your total drug costs (that is, the amount you pay does not help you qualify for catastrophic coverage). In addition, if you are receiving extra help to pay for your prescriptions, you will not get any extra help to pay for this drug.

GC: Gap Coverage. We provide coverage of this prescription drug in the Coverage Gap. Please refer to our Evidence of Coverage for more information about this coverage.

LA: Limited Availability. This prescription may be available only at certain pharmacies. For more information, please call the Member Engagement Center.

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

QL: Quantity Limit. For certain drugs, the Plan limits the amount of the drug that we will cover.

SI: Select Insulins: Insulins available at a set copay in the initial coverage and gap coverage phases. Does not apply to AvMed Medicare Premium Saver Broward County (HMO).

AvMed Medicare_Effective 03/01/2023

Drug Name	Drug Requirements/ Tier	Limits
ANALGESICS		
GOUT		
<i>allopurinol</i> TABS 100mg, 300mg	1	GC
<i>colchicine</i> TABS .6mg QL (120 tabs / 30 days)	4	QL
<i>colchicine w/ probenecid tab</i> 0.5-500 mg	3	
<i>febuxostat</i> TABS 40mg, 80mg	4	PA
MITIGARE CAPS .6mg QL (60 caps / 30 days)	3	QL
<i>probenecid</i> TABS 500mg	3	
NSAIDS		
<i>celecoxib</i> CAPS 50mg, 100mg, 200mg QL (60 caps / 30 days)	3	QL
<i>celecoxib</i> CAPS 400mg QL (30 caps / 30 days)	3	QL
<i>diclofenac potassium</i> TABS 50mg QL (120 tabs / 30 days)	3	QL
<i>diclofenac sodium</i> TB24 100mg	3	
<i>diclofenac sodium</i> TBEC 25mg, 50mg, 75mg	2	GC
<i>diclofenac w/ misoprostol tab</i> delayed release 50-0.2 mg	4	
<i>diclofenac w/ misoprostol tab</i> delayed release 75-0.2 mg	4	
<i>diflunisal</i> TABS 500mg	3	
<i>ec-naproxen</i> TBEC 375mg QL (120 tabs / 30 days)	2	GC QL
<i>ec-naproxen</i> TBEC 500mg QL (90 tabs / 30 days)	4	QL
<i>etodolac</i> CAPS 200mg, 300mg; TABS 400mg, 500mg; TB24 400mg, 500mg, 600mg	3	
<i>flurbiprofen</i> TABS 100mg	3	
<i>ibu</i> TABS 600mg, 800mg	1	GC
<i>ibuprofen</i> SUSP 100mg/5ml	3	

Drug Name	Drug Requirements/ Tier	Limits
<i>ibuprofen</i> TABS 400mg, 600mg, 800mg	1	GC
<i>meloxicam</i> TABS 7.5mg, 15mg	1	GC
<i>nabumetone</i> TABS 500mg, 750mg	2	GC
<i>naproxen</i> TABS 250mg, 375mg, 500mg	1	GC
<i>naproxen</i> TBEC 375mg QL (120 tabs / 30 days)	2	GC QL
<i>naproxen</i> TBEC 500mg QL (90 tabs / 30 days)	4	QL
<i>naproxen sodium</i> TABS 275mg, 550mg	3	
<i>oxaprozin</i> TABS 600mg	4	
<i>piroxicam</i> CAPS 10mg, 20mg	3	
<i>sulindac</i> TABS 150mg, 200mg	2	GC
OPIOID ANALGESICS, LONG-ACTING		
<i>fentanyl</i> PT72 12mcg/hr, 25mcg/hr, 50mcg/hr, 75mcg/hr, 100mcg/hr QL (10 patches / 30 days)	4	QL PA
<i>hydrocodone bitartrate</i> T24A 20mg, 30mg, 40mg, 60mg, 80mg, 100mg, 120mg QL (30 tabs / 30 days)	3	QL PA
HYSINGLA ER T24A 20mg, 30mg, 40mg, 60mg, 80mg, 100mg, 120mg QL (30 tabs / 30 days)	3	QL PA
<i>methadone hcl</i> SOLN 5mg/5ml, 10mg/5ml QL (450 mL / 30 days)	3	QL PA
<i>methadone hcl</i> TABS 5mg, 10mg QL (90 tabs / 30 days)	3	QL PA
<i>methadone hydrochloride i</i> CONC 10mg/ml QL (90 mL / 30 days)	3	QL PA
<i>morphine sulfate</i> TBCR 15mg, 30mg, 60mg, 100mg, 200mg QL (90 tabs / 30 days)	3	QL PA

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **B/D** - Prior Authorization, Part D vs. Part B only **LA** - Limited Availability **ED** - Excluded Drug **GC** - Gap Coverage . **SI** - Select Insulins. Does not apply to AvMed Medicare Premium Saver Broward County (HMO)

All Tier 1 and Tier 2 generics are covered in the Gap Coverage.

Drug Name	Drug Requirements/ Tier	Limits
OPIOID ANALGESICS, SHORT-ACTING		
<i>acetaminophen w/ codeine soln 120-12 mg/5ml</i> QL (2700 mL / 30 days)	3	QL
<i>acetaminophen w/ codeine tab 300-15 mg</i> QL (400 tabs / 30 days)	3	QL
<i>acetaminophen w/ codeine tab 300-30 mg</i> QL (360 tabs / 30 days)	3	QL
<i>acetaminophen w/ codeine tab 300-60 mg</i> QL (180 tabs / 30 days)	3	QL
<i>butorphanol tartrate SOLN 1mg/ml, 2mg/ml</i>	4	
<i>butorphanol tartrate SOLN 10mg/ml</i> QL (10 mL / 30 days)	3	QL
<i>endocet tab 2.5-325mg</i> QL (360 tabs / 30 days)	3	QL
<i>endocet tab 5-325mg</i> QL (360 tabs / 30 days)	3	QL
<i>endocet tab 7.5-325mg</i> QL (240 tabs / 30 days)	3	QL
<i>endocet tab 10-325mg</i> QL (180 tabs / 30 days)	3	QL
<i>fentanyl citrate LPOP 200mcg</i> QL (120 lozenges / 30 days)	4	QL PA
<i>fentanyl citrate LPOP 400mcg, 600mcg, 800mcg, 1200mcg, 1600mcg</i> QL (120 lozenges / 30 days)	5	QL PA
<i>hydrocodone-acetaminophen soln 7.5-325 mg/15ml</i> QL (2700 mL / 30 days)	4	QL
<i>hydrocodone-acetaminophen tab 5-325 mg</i> QL (240 tabs / 30 days)	3	QL
<i>hydrocodone-acetaminophen tab 7.5-325 mg</i> QL (180 tabs / 30 days)	3	QL

Drug Name	Drug Requirements/ Tier	Limits
<i>hydrocodone-acetaminophen tab 10-325 mg</i> QL (180 tabs / 30 days)	3	QL
<i>hydrocodone-ibuprofen tab 7.5-200 mg</i> QL (150 tabs / 30 days)	3	QL
<i>hydromorphone hcl LIQD 1mg/ml</i> QL (600 mL / 30 days)	4	QL
<i>hydromorphone hcl TABS 2mg, 4mg, 8mg</i> QL (180 tabs / 30 days)	3	QL
MORPHINE SULFATE SOLN 2mg/ml, 4mg/ml, 5mg/ml, 8mg/ml, 10mg/ml	4	B/D
<i>morphine sulfate SOLN 4mg/ml, 8mg/ml, 10mg/ml</i>	4	B/D
<i>morphine sulfate SOLN 10mg/5ml, 20mg/5ml</i> QL (900 mL / 30 days)	3	QL
<i>morphine sulfate SOLN 20mg/ml</i> QL (180 mL / 30 days)	3	QL
<i>morphine sulfate TABS 15mg, 30mg</i> QL (180 tabs / 30 days)	3	QL
MORPHINE SULFATE/SODIUM C SOLN 1mg/ml	4	B/D
<i>nalbuphine hcl SOLN 10mg/ml, 20mg/ml</i>	4	
<i>oxycodone hcl CAPS 5mg</i> QL (180 caps / 30 days)	4	QL
<i>oxycodone hcl CONC 100mg/5ml</i> QL (180 mL / 30 days)	4	QL
<i>oxycodone hcl SOLN 5mg/5ml</i> QL (900 mL / 30 days)	4	QL
<i>oxycodone hcl TABS 5mg, 10mg, 15mg, 20mg, 30mg</i> QL (180 tabs / 30 days)	3	QL
<i>oxycodone w/ acetaminophen tab 2.5-325 mg</i> QL (360 tabs / 30 days)	3	QL

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **B/D** - Prior Authorization, Part D vs. Part B only **LA** - Limited Availability **ED** - Excluded Drug **GC** - Gap Coverage . **SI** - Select Insulins. Does not apply to AvMed Medicare Premium Saver Broward County (HMO)

All Tier 1 and Tier 2 generics are covered in the Gap Coverage.

Drug Name	Drug Requirements/ Tier	Limits
oxycodone w/ acetaminophen tab 5-325 mg QL (360 tabs / 30 days)	3	QL
oxycodone w/ acetaminophen tab 7.5-325 mg QL (240 tabs / 30 days)	3	QL
oxycodone w/ acetaminophen tab 10-325 mg QL (180 tabs / 30 days)	3	QL
tramadol hcl TABS 50mg QL (240 tabs / 30 days)	2	GC QL
tramadol-acetaminophen tab 37.5-325 mg QL (240 tabs / 30 days)	3	QL
ANESTHETICS		
LOCAL ANESTHETICS		
lidocaine hcl (local anesth.) SOLN .5%, 1%, 1.5%, 2%	3	B/D
ANTI-INFECTIVES		
ANTI-INFECTIVES - MISCELLANEOUS		
albendazole TABS 200mg	5	
amikacin sulfate SOLN 1gm/4ml, 500mg/2ml	4	
atovaquone SUSP 750mg/5ml	4	
aztreonam SOLR 1gm, 2gm	4	
CAYSTON SOLR 75mg	5	LA PA
clindamycin hcl CAPS 75mg, 150mg, 300mg	2	GC
clindamycin palmitate hydrochloride SOLR 75mg/5ml	4	
clindamycin phosphate SOLN 300mg/2ml, 600mg/4ml, 900mg/6ml, 9000mg/60ml	3	
clindamycin phosphate in d5w iv soln 300 mg/50ml	4	
clindamycin phosphate in d5w iv soln 600 mg/50ml	4	
clindamycin phosphate in d5w iv soln 900 mg/50ml	4	
CLINDMYC/NAC INJ 300/50ML	4	
CLINDMYC/NAC INJ 600/50ML	4	

Drug Name	Drug Requirements/ Tier	Limits
CLINDMYC/NAC INJ 900/50ML	4	
colistimethate sodium SOLR 150mg	4	
dapsone TABS 25mg, 100mg	3	
DAPTOMYCIN SOLR 350mg	5	
daptomycin SOLR 350mg, 500mg	5	
EMVERM CHEW 100mg QL (12 tabs / year)	5	QL
ertapenem sodium SOLR 1gm	4	
gentamicin in saline inj 0.8 mg/ml	3	
gentamicin in saline inj 1 mg/ml	3	
gentamicin in saline inj 1.2 mg/ml	3	
gentamicin in saline inj 1.6 mg/ml	3	
gentamicin in saline inj 2 mg/ml	3	
gentamicin sulfate SOLN 10mg/ml, 40mg/ml	3	
imipenem-cilastatin intravenous for soln 250 mg	4	
imipenem-cilastatin intravenous for soln 500 mg	4	
ivermectin TABS 3mg QL (12 tabs / 90 days)	3	QL PA
linezolid SOLN 600mg/300ml	4	
linezolid SUSR 100mg/5ml QL (1800 mL / 30 days)	5	QL
linezolid TABS 600mg QL (60 tabs / 30 days)	4	QL
linezolid in sodium chloride iv soln 600 mg/300ml-0.9%	4	
meropenem SOLR 1gm, 500mg	4	
methenamine hippurate TABS 1gm	4	
metronidazole SOLN 500mg/100ml	3	
metronidazole TABS 250mg, 500mg	1	GC

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **B/D** - Prior Authorization, Part D vs. Part B only **LA** - Limited Availability **ED** - Excluded Drug **GC** - Gap Coverage . **SI** - Select Insulins. Does not apply to AvMed Medicare Premium Saver Broward County (HMO)

10

All Tier 1 and Tier 2 generics are covered in the Gap Coverage.

Drug Name	Drug Requirements/ Tier	Limits
neomycin sulfate TABS 500mg	2	GC
nitazoxanide TABS 500mg QL (6 tabs / 30 days)	5	QL
nitrofurantoin macrocrystal CAPS 50mg, 100mg	3	
nitrofurantoin monohyd macro CAPS 100mg	3	
paromomycin sulfate CAPS 250mg	4	
pentamidine isethionate inh SOLR 300mg	4	B/D
pentamidine isethionate inj SOLR 300mg	4	
praziquantel TABS 600mg	4	
SIVEXTRO SOLR 200mg; TABS 200mg	5	
streptomycin sulfate SOLR 1gm	4	
sulfadiazine TABS 500mg	4	
sulfamethoxazole- trimethoprim iv soln 400-80 mg/5ml	4	
sulfamethoxazole- trimethoprim susp 200-40 mg/5ml	3	
sulfamethoxazole- trimethoprim tab 400-80 mg	1	GC
sulfamethoxazole- trimethoprim tab 800-160 mg	1	GC
SYNERCID INJ 500MG	5	
tinidazole TABS 250mg, 500mg	3	
tobramycin NEBU 300mg/5ml	5	PA
tobramycin sulfate SOLN 1.2gm/30ml, 10mg/ml, 40mg/ml, 80mg/2ml	3	
trimethoprim TABS 100mg	3	
TRIMETHOPRIM TABS 100mg	3	
vancomycin hcl CAPS 125mg QL (80 caps / 180 days)	4	QL
vancomycin hcl CAPS 250mg QL (160 caps / 180 days)	4	QL

Drug Name	Drug Requirements/ Tier	Limits
vancomycin hcl SOLR 1gm, 5gm, 10gm, 500mg, 750mg	4	
VANCOMYCIN INJ 1 GM	4	
VANCOMYCIN INJ 500MG	4	
VANCOMYCIN INJ 750MG	4	
ANTIFUNGALS		
ABELCET SUSP 5mg/ml	4	B/D
amphotericin b SOLR 50mg	4	B/D
amphotericin b liposome SUSR 50mg	5	B/D
caspofungin acetate SOLR 50mg, 70mg	4	
fluconazole SUSR 10mg/ml, 40mg/ml; TABS 50mg, 100mg, 200mg	3	
fluconazole TABS 150mg	2	GC
fluconazole in nacl 0.9% inj 200 mg/100ml	3	
fluconazole in nacl 0.9% inj 400 mg/200ml	3	
flucytosine CAPS 250mg, 500mg	5	PA
griseofulvin microsize SUSP 125mg/5ml; TABS 500mg	4	
griseofulvin ultramicrosize TABS 125mg, 250mg	4	
itraconazole CAPS 100mg	4	PA
ketoconazole TABS 200mg	3	PA
miconazole sodium SOLR 50mg, 100mg	5	
NOXAFIL SUSP 40mg/ml QL (630 mL / 30 days)	5	QL PA
nystatin TABS 500000unit	3	
posaconazole TBEC 100mg QL (93 tabs / 30 days)	5	QL PA
terbinafine hcl TABS 250mg QL (90 tabs / year)	1	GC QL
voriconazole SOLR 200mg; SUSR 40mg/ml	5	PA
voriconazole TABS 50mg QL (480 tabs / 30 days)	4	QL PA
voriconazole TABS 200mg QL (120 tabs / 30 days)	4	QL PA

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **B/D** - Prior Authorization, Part D vs. Part B only **LA** - Limited Availability **ED** - Excluded Drug **GC** - Gap Coverage . **SI** - Select Insulins. Does not apply to AvMed Medicare Premium Saver Broward County (HMO)

11

All Tier 1 and Tier 2 generics are covered in the Gap Coverage.

Drug Name	Drug Requirements/ Tier	Limits
ANTIMALARIALS		
<i>atovaquone-proguanil hcl tab</i> 62.5-25 mg	4	
<i>atovaquone-proguanil hcl tab</i> 250-100 mg	4	
<i>chloroquine phosphate</i> TABS 250mg, 500mg	4	
COARTEM TAB 20-120MG	4	
<i>mefloquine hcl</i> TABS 250mg	3	
<i>primaquine phosphate</i> TABS 26.3mg	3	
PRIMAQUINE PHOSPHATE TABS 26.3mg	3	
<i>quinine sulfate</i> CAPS 324mg	4	PA
ANTIRETROVIRAL AGENTS		
<i>abacavir sulfate</i> SOLN 20mg/ml	4	
<i>abacavir sulfate</i> TABS 300mg	3	
APTIVUS CAPS 250mg	5	
<i>atazanavir sulfate</i> CAPS 150mg, 200mg, 300mg	4	
EDURANT TABS 25mg	5	
<i>efavirenz</i> CAPS 50mg, 200mg; TABS 600mg	4	
<i>emtricitabine</i> CAPS 200mg	3	
EMTRIVA SOLN 10mg/ml	4	
<i>etravirine</i> TABS 100mg, 200mg	5	
<i>fosamprenavir calcium</i> TABS 700mg	5	
FUZEON SOLR 90mg	5	
INTELENCE TABS 25mg	4	
ISENTRESS CHEW 25mg	4	
ISENTRESS CHEW 100mg; PACK 100mg; TABS 400mg	5	
ISENTRESS HD TABS 600mg	5	
<i>lamivudine</i> SOLN 10mg/ml; TABS 150mg, 300mg	3	
LEXIVA SUSP 50mg/ml	4	
<i>maraviroc</i> TABS 150mg, 300mg	5	
<i>nevirapine</i> SUSP 50mg/5ml; TB24 100mg, 400mg	4	

Drug Name	Drug Requirements/ Tier	Limits
<i>nevirapine</i> TABS 200mg	2	GC
NORVIR PACK 100mg; SOLN 80mg/ml	4	
PIFELTRO TABS 100mg	5	
PREZISTA SUSP 100mg/ml QL (400 mL / 30 days)	5	QL
PREZISTA TABS 75mg QL (480 tabs / 30 days)	4	QL
PREZISTA TABS 150mg QL (240 tabs / 30 days)	5	QL
PREZISTA TABS 600mg QL (60 tabs / 30 days)	5	QL
PREZISTA TABS 800mg QL (30 tabs / 30 days)	5	QL
REYATAZ PACK 50mg	5	
<i>ritonavir</i> TABS 100mg	3	
RUKOBIA TB12 600mg	5	
SELZENTRY SOLN 20mg/ml; TABS 75mg	5	
SELZENTRY TABS 25mg	4	
<i>stavudine</i> CAPS 15mg, 20mg, 30mg, 40mg	4	
<i>tenofovir disoproxil fumarate</i> TABS 300mg	3	
TIVICAY TABS 10mg	3	
TIVICAY TABS 25mg, 50mg	5	
TIVICAY PD TBSO 5mg	5	
TROGARZO SOLN 200mg/1.33ml	5	LA
TYBOST TABS 150mg	3	
VIRACEPT TABS 250mg, 625mg	5	
VIREAD POWD 40mg/gm; TABS 150mg, 200mg, 250mg	5	
<i>zidovudine</i> CAPS 100mg; SYRP 50mg/5ml	4	
<i>zidovudine</i> TABS 300mg	3	
ANTIRETROVIRAL COMBINATION AGENTS		
<i>abacavir sulfate-lamivudine tab</i> 600-300 mg	3	
BIKTARVY TAB 30-120-15 MG	5	
BIKTARVY TAB 50-200-25 MG	5	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **B/D** - Prior Authorization, Part D vs. Part B only **LA** - Limited Availability **ED** - Excluded Drug **GC** - Gap Coverage . **SI** - Select Insulins. Does not apply to AvMed Medicare Premium Saver Broward County (HMO)

12

All Tier 1 and Tier 2 generics are covered in the Gap Coverage.

Drug Name	Drug Requirements/ Tier	Limits
CIMDUO TAB 300-300	5	
COMPLERA TAB	5	
DELSTRIGO TAB	5	
DESCOVY TAB 120-15MG QL (30 tabs / 30 days)	5	QL
DESCOVY TAB 200/25MG QL (30 tabs / 30 days)	5	QL
DOVATO TAB 50-300MG	5	
efavirenz-emtricitabine- tenofovir df tab 600-200-300 mg	5	
efavirenz-lamivudine-tenofovir df tab 400-300-300 mg	5	
efavirenz-lamivudine-tenofovir df tab 600-300-300 mg	5	
emtricitabine-tenofovir disoproxil fumarate tab 100- 150 mg QL (30 tabs / 30 days)	5	QL
emtricitabine-tenofovir disoproxil fumarate tab 133- 200 mg QL (30 tabs / 30 days)	5	QL
emtricitabine-tenofovir disoproxil fumarate tab 167- 250 mg QL (30 tabs / 30 days)	5	QL
emtricitabine-tenofovir disoproxil fumarate tab 200- 300 mg QL (30 tabs / 30 days)	5	QL
EVOTAZ TAB 300-150	5	
GENVOYA TAB	5	
JULUCA TAB 50-25MG	5	
lamivudine-zidovudine tab 150-300 mg	4	
lopinavir-ritonavir soln 400- 100 mg/5ml (80-20 mg/ml)	4	
lopinavir-ritonavir tab 100-25 mg	4	
lopinavir-ritonavir tab 200-50 mg	4	
ODEFSEY TAB	5	
PREZCOBIX TAB 800-150	5	
STRIBILD TAB	5	

Drug Name	Drug Requirements/ Tier	Limits
SYMTUZA TAB	5	
TRIUMEQ PD TAB	5	
TRIUMEQ TAB	5	
TRIZIVIR TAB	5	
ANTITUBERCULAR AGENTS		
cycloserine CAPS 250mg	5	
ethambutol hcl TABS 100mg, 3 400mg	3	
isoniazid SYRP 50mg/5ml	4	
isoniazid TABS 100mg, 300mg	1	GC
PRIFTIN TABS 150mg	4	
pyrazinamide TABS 500mg	4	
rifabutin CAPS 150mg	4	
rifampin CAPS 150mg, 300mg	3	
rifampin SOLR 600mg	4	
SIRTURO TABS 20mg, 100mg	5	LA PA
TRECTOR TABS 250mg	4	
ANTIVIRALS		
acyclovir CAPS 200mg; TABS 400mg, 800mg	2	GC
acyclovir SUSP 200mg/5ml	4	
acyclovir sodium SOLN 50mg/ml	4	B/D
adefovir dipivoxil TABS 10mg	5	
BARACLUDE SOLN .05mg/ml	5	
entecavir TABS .5mg, 1mg	4	
EPCLUSA PAK 150-37.5	5	PA
EPCLUSA PAK 200-50MG	5	PA
EPCLUSA TAB 200-50MG	5	PA
EPCLUSA TAB 400-100	5	PA
EPIVIR HBV SOLN 5mg/ml	4	
famciclovir TABS 125mg, 250mg, 500mg	3	
ganciclovir sodium SOLR 500mg	4	B/D
HARVONI PAK 33.75-150MG	5	PA
HARVONI PAK 45-200MG	5	PA
HARVONI TAB 45-200MG	5	PA
HARVONI TAB 90-400MG	5	PA

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **B/D** - Prior Authorization, Part D vs. Part B only **LA** - Limited Availability **ED** - Excluded Drug **GC** - Gap Coverage . **SI** - Select Insulins. Does not apply to AvMed Medicare Premium Saver Broward County (HMO)

All Tier 1 and Tier 2 generics are covered in the Gap Coverage.

Drug Name	Drug Requirements/ Tier	Limits
<i>lamivudine (hbv)</i> TABS 100mg	4	
MAVYRET PAK 50-20MG	5	PA
MAVYRET TAB 100-40MG	5	PA
<i>oseltamivir phosphate</i> CAPS 30mg	3	QL
QL (168 caps / year)		
<i>oseltamivir phosphate</i> CAPS 45mg, 75mg	3	QL
QL (84 caps / year)		
<i>oseltamivir phosphate</i> SUSR 6mg/ml	3	QL
QL (1080 mL / year)		
PEGASYS SOLN 180mcg/ml; SOSY 180mcg/0.5ml	5	PA
PREVYMIS TABS 240mg, 480mg	5	QL PA
QL (28 tabs / 28 days)		
RELENZA DISKHALER AEPB 5mg/blister	3	QL
QL (6 inhalers / year)		
<i>ribavirin (hepatitis c)</i> CAPS 200mg	3	
<i>ribavirin (hepatitis c)</i> TABS 200mg	4	
<i>rimantadine hydrochloride</i> TABS 100mg	4	
<i>valacyclovir hcl</i> TABS 1gm, 500mg	3	
<i>valganciclovir hcl</i> SOLR 50mg/ml	5	
<i>valganciclovir hcl</i> TABS 450mg	3	
VEMLIDY TABS 25mg	5	
VOSEVI TAB	5	PA
CEPHALOSPORINS		
<i>cefaclor</i> CAPS 250mg, 500mg	3	
<i>cefaclor</i> SUSR 125mg/5ml, 250mg/5ml, 375mg/5ml	4	
CEFACTOR ER TB12 500mg	4	
<i>cefadroxil</i> CAPS 500mg	2	GC
<i>cefadroxil</i> SUSR 250mg/5ml, 500mg/5ml	3	
CEFAZOLIN INJ 1GM/50ML	4	

Drug Name	Drug Requirements/ Tier	Limits
<i>cefazolin sodium</i> SOLR 1gm, 2gm, 10gm, 500mg	3	
CEFAZOLIN SOLN 2GM/100ML-4%	4	
<i>cefdinir</i> CAPS 300mg	2	GC
<i>cefdinir</i> SUSR 125mg/5ml, 250mg/5ml	3	
<i>cefepime hcl</i> SOLR 1gm, 2gm	4	
<i>cefixime</i> CAPS 400mg; SUSR 100mg/5ml, 200mg/5ml	4	
<i>cefoxitin sodium</i> SOLR 1gm, 2gm, 10gm	4	
<i>cefpodoxime proxetil</i> SUSR 50mg/5ml, 100mg/5ml	4	
<i>cefpodoxime proxetil</i> TABS 100mg, 200mg	3	
<i>cefprozil</i> SUSR 125mg/5ml, 250mg/5ml; TABS 250mg, 500mg	3	
<i>ceftazidime</i> SOLR 1gm, 2gm, 6gm	4	
CEFTAZIDIME/ SOL D5W 1GM	4	
CEFTAZIDIME/ SOL D5W 2GM	4	
<i>ceftriaxone sodium</i> SOLR 1gm, 2gm, 10gm, 250mg, 500mg	4	
<i>cefuroxime axetil</i> TABS 250mg, 500mg	3	
<i>cefuroxime sodium</i> SOLR 1.5gm, 750mg	3	
<i>cephalexin</i> CAPS 250mg, 500mg	1	GC
<i>cephalexin</i> SUSR 125mg/5ml, 250mg/5ml	3	
<i>tazicef</i> SOLR 1gm, 2gm, 6gm	4	
TEFLARO SOLR 400mg, 600mg	5	
ERYTHROMYCINS/MACROLIDES		
<i>azithromycin</i> PACK 1gm; SOLR 500mg; SUSR 100mg/5ml, 200mg/5ml	3	
<i>azithromycin</i> TABS 250mg, 500mg, 600mg	1	GC

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **B/D** - Prior Authorization, Part D vs. Part B only **LA** - Limited Availability **ED** - Excluded Drug **GC** - Gap Coverage . **SI** - Select Insulins. Does not apply to AvMed Medicare Premium Saver Broward County (HMO)

14

All Tier 1 and Tier 2 generics are covered in the Gap Coverage.

Drug Name	Drug Requirements/ Tier Limits
<i>clarithromycin</i> SUSR 125mg/5ml, 250mg/5ml	4
<i>clarithromycin</i> TABS 250mg, 500mg; TB24 500mg	3
DIFICID SUSR 40mg/ml; TABS 200mg	5
e.e.s. 400 TABS 400mg	4
<i>ery-tab</i> TBEC 250mg, 333mg, 500mg	4
ERYTHROCIN LACTOBIONATE SOLR 500mg	4
<i>erythrocin stearate</i> TABS 250mg	4
<i>erythromycin base</i> CPEP 250mg; TABS 250mg, 500mg; TBEC 250mg, 333mg, 500mg	4
<i>erythromycin ethylsuccinate</i> TABS 400mg	4
<i>erythromycin lactobionate</i> SOLR 500mg	4
FLUOROQUINOLONES	
CIPRO SUSR 500mg/5ml	4
<i>ciprofloxacin</i> 200 mg/100ml in d5w	3
<i>ciprofloxacin</i> 400 mg/200ml in d5w	3
<i>ciprofloxacin hcl</i> TABS 100mg	4
<i>ciprofloxacin hcl</i> TABS 250mg, 500mg, 750mg	1 GC
<i>levofloxacin</i> SOLN 25mg/ml	4
<i>levofloxacin</i> TABS 250mg, 500mg, 750mg	1 GC
<i>levofloxacin</i> in d5w iv soln 250 mg/50ml	3
<i>levofloxacin</i> in d5w iv soln 500 mg/100ml	3
<i>levofloxacin</i> in d5w iv soln 750 mg/150ml	3
<i>moxifloxacin hcl</i> TABS 400mg	4

Drug Name	Drug Requirements/ Tier Limits
PENICILLINS	
<i>amoxicillin</i> CAPS 250mg, 500mg; SUSR 125mg/5ml, 200mg/5ml, 250mg/5ml, 400mg/5ml; TABS 500mg, 875mg	1 GC
<i>amoxicillin</i> CHEW 125mg, 250mg	2 GC
<i>amoxicillin & k clavulanate chew tab</i> 200-28.5 mg	4
<i>amoxicillin & k clavulanate chew tab</i> 400-57 mg	4
<i>amoxicillin & k clavulanate for susp</i> 200-28.5 mg/5ml	3
<i>amoxicillin & k clavulanate for susp</i> 250-62.5 mg/5ml	4
<i>amoxicillin & k clavulanate for susp</i> 400-57 mg/5ml	3
<i>amoxicillin & k clavulanate for susp</i> 600-42.9 mg/5ml	3
<i>amoxicillin & k clavulanate tab</i> 250-125 mg	3
<i>amoxicillin & k clavulanate tab</i> 500-125 mg	2 GC
<i>amoxicillin & k clavulanate tab</i> 875-125 mg	2 GC
<i>amoxicillin & k clavulanate tab</i> er 12hr 1000-62.5 mg	4
<i>ampicillin</i> CAPS 500mg	2 GC
<i>ampicillin & sulbactam sodium for inj</i> 1.5 (1-0.5) gm	4
<i>ampicillin & sulbactam sodium for inj</i> 3 (2-1) gm	4
<i>ampicillin & sulbactam sodium for iv soln</i> 1.5 (1-0.5) gm	4
<i>ampicillin & sulbactam sodium for iv soln</i> 3 (2-1) gm	4
<i>ampicillin & sulbactam sodium for iv soln</i> 15 (10-5) gm	4
<i>ampicillin sodium</i> SOLR 1gm, 2gm, 10gm, 125mg, 250mg, 500mg	4
BICILLIN L-A SUSP 2400000unit/4ml; SUSY 600000unit/ml, 1200000unit/2ml	4

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **B/D** - Prior Authorization, Part D vs. Part B only **LA** - Limited Availability **ED** - Excluded Drug **GC** - Gap Coverage . **SI** - Select Insulins. Does not apply to AvMed Medicare Premium Saver Broward County (HMO)

15

All Tier 1 and Tier 2 generics are covered in the Gap Coverage.

Drug Name	Drug Requirements/ Tier	Limits
<i>dicloxacillin sodium</i> CAPS 250mg, 500mg	3	
<i>nafcillin sodium</i> SOLR 1gm, 2gm	4	
<i>nafcillin sodium</i> SOLR 10gm	5	
<i>oxacillin sodium</i> SOLR 1gm, 2gm, 10gm	4	
PEN GK/DEXTR INJ 40000/ML	4	
PEN GK/DEXTR INJ 60000/ML	4	
<i>penicillin g potassium</i> SOLR 5000000unit, 20000000unit	4	
PENICILLIN G PROCAINE SUSP 600000unit/ml	4	
<i>penicillin g sodium</i> SOLR 5000000unit	4	
<i>penicillin v potassium</i> SOLR 125mg/5ml, 250mg/5ml	2	GC
<i>penicillin v potassium</i> TABS 250mg, 500mg	1	GC
<i>pfizerpen</i> SOLR 5000000unit, 20000000unit	4	
<i>piperacillin sod-tazobactam na for inj 3.375 gm (3-0.375 gm)</i>	4	
<i>piperacillin sod-tazobactam sod for inj 2.25 gm (2-0.25 gm)</i>	4	
<i>piperacillin sod-tazobactam sod for inj 4.5 gm (4-0.5 gm)</i>	4	
<i>piperacillin sod-tazobactam sod for inj 13.5 gm (12-1.5 gm)</i>	4	
<i>piperacillin sod-tazobactam sod for inj 40.5 gm (36-4.5 gm)</i>	4	
TETRACYCLINES		
<i>doxy 100</i> SOLR 100mg	4	
<i>doxycycline (monohydrate)</i> CAPS 50mg, 100mg	2	GC
<i>doxycycline (monohydrate)</i> TABS 50mg, 75mg, 100mg	3	
<i>doxycycline hyclate</i> CAPS 50mg, 100mg; TABS 20mg, 100mg	3	

Drug Name	Drug Requirements/ Tier	Limits
<i>doxycycline hyclate</i> SOLR 100mg	4	
<i>minocycline hcl</i> CAPS 50mg, 75mg, 100mg	3	
NUZYRA SOLR 100mg; TABS 150mg	5	LA
<i>tetracycline hcl</i> CAPS 250mg, 500mg	4	PA
<i>tigecycline</i> SOLR 50mg	5	
TIGECYCLINE SOLR 50mg	5	
ANTINEOPLASTIC AGENTS		
ALKYLATING AGENTS		
BENDEKA SOLN 100mg/4ml	5	B/D LA
<i>carboplatin</i> SOLN 50mg/5ml, 150mg/15ml, 450mg/45ml, 600mg/60ml	3	B/D
<i>cisplatin</i> SOLN 50mg/50ml, 100mg/100ml, 200mg/200ml	3	B/D
<i>cyclophosphamide</i> CAPS 25mg, 50mg	3	B/D
CYCLOPHOSPHAMIDE SOLN 1gm/5ml, 500mg/2.5ml	5	B/D
<i>cyclophosphamide</i> SOLR 1gm, 2gm, 500mg	5	B/D
CYCLOPHOSPHAMIDE TABS 25mg, 50mg	4	B/D
CYCLOPHOSPHAMIDE MONOHYDR SOLN 2gm/10ml	5	B/D
GLEOSTINE CAPS 10mg, 40mg	4	
GLEOSTINE CAPS 100mg	5	
LEUKERAN TABS 2mg	4	
<i>oxaliplatin</i> SOLN 50mg/10ml, 100mg/20ml, 200mg/40ml	4	B/D
<i>oxaliplatin</i> SOLR 50mg, 100mg	5	B/D
<i>paraplatin</i> SOLN 1000mg/100ml	3	B/D
ANTIBIOTICS		
<i>doxorubicin hcl</i> SOLN 2mg/ml	4	B/D
<i>doxorubicin hcl liposomal</i> INJ 2mg/ml	5	B/D
ELLECE SOLN 50mg/25ml, 200mg/100ml	4	B/D

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **B/D** - Prior Authorization, Part D vs. Part B only **LA** - Limited Availability **ED** - Excluded Drug **GC** - Gap Coverage . **SI** - Select Insulins. Does not apply to AvMed Medicare Premium Saver Broward County (HMO)

All Tier 1 and Tier 2 generics are covered in the Gap Coverage.

Drug Name	Drug Requirements/ Tier	Limits
ANTIMETABOLITES		
<i>azacitidine</i> SUSR 100mg	5	B/D
<i>cytarabine</i> SOLN 20mg/ml	3	B/D
<i>fluorouracil</i> SOLN 1gm/20ml, 2.5gm/50ml, 5gm/100ml, 500mg/10ml	3	B/D
<i>gemcitabine hcl</i> SOLN 1gm/26.3ml, 2gm/52.6ml, 200mg/5.26ml; SOLR 1gm, 2gm, 200mg	4	B/D
INQOVI TAB 35-100MG	5	LA PA
LONSURF TAB 15-6.14	5	LA PA
LONSURF TAB 20-8.19	5	LA PA
<i>mercaptopurine</i> TABS 50mg	3	
<i>methotrexate sodium</i> SOLN 1gm/40ml, 50mg/2ml, 250mg/10ml; SOLR 1gm	3	B/D
ONUREG TABS 200mg, 300mg	5	LA PA
<i>pemetrexed disodium</i> SOLR 100mg, 500mg, 750mg, 1000mg	5	B/D
PURIXAN SUSP 2000mg/100ml	5	
TABLOID TABS 40mg	4	
HORMONAL ANTINEOPLASTIC AGENTS		
<i>abiraterone acetate</i> TABS 250mg, 500mg	5	PA
<i>anastrozole</i> TABS 1mg	2	GC
<i>bicalutamide</i> TABS 50mg	2	GC
ELIGARD KIT 7.5mg, 22.5mg, 30mg, 45mg	4	PA
EMCYT CAPS 140mg	5	
ERLEADA TABS 60mg	5	LA PA
EULEXIN CAPS 125mg	5	
<i>exemestane</i> TABS 25mg	4	
<i>fulvestrant</i> SOSY 250mg/5ml	5	B/D
<i>letrozole</i> TABS 2.5mg	2	GC
<i>leuprolide acetate</i> KIT 1mg/0.2ml	4	PA
LUPRON DEPOT (1-MONTH) KIT 3.75mg	5	PA
LUPRON DEPOT (3-MONTH) KIT 11.25mg	5	PA
LYSODREN TABS 500mg	5	

Drug Name	Drug Requirements/ Tier	Limits
<i>megestrol acetate</i> TABS 20mg, 40mg	3	
<i>nilutamide</i> TABS 150mg	5	
NUBEQA TABS 300mg	5	LA PA
ORGOVYX TABS 120mg	5	LA PA
SOLTAMOX SOLN 10mg/5ml	5	
<i>tamoxifen citrate</i> TABS 10mg, 20mg	2	GC
<i>toremifene citrate</i> TABS 60mg	5	
XTANDI CAPS 40mg; TABS 40mg, 80mg	5	LA PA
IMMUNOMODULATORS		
<i>lenalidomide</i> CAPS 2.5mg, 5mg, 10mg, 15mg QL (28 caps / 28 days)	5	QL LA PA
<i>lenalidomide</i> CAPS 20mg, 25mg QL (21 caps / 28 days)	5	QL LA PA
POMALYST CAPS 1mg, 2mg, 3mg, 4mg QL (21 caps / 28 days)	5	QL LA PA
REVLIMID CAPS 2.5mg, 5mg, 10mg, 15mg QL (28 caps / 28 days)	5	QL LA PA
REVLIMID CAPS 20mg, 25mg QL (21 caps / 28 days)	5	QL LA PA
THALOMID CAPS 50mg, 100mg QL (28 caps / 28 days)	5	QL LA PA
THALOMID CAPS 150mg, 200mg QL (56 caps / 28 days)	5	QL LA PA
MISCELLANEOUS		
BESREMI SOSY 500mcg/ml	5	LA PA
<i>bexarotene</i> CAPS 75mg	5	PA
<i>hydroxyurea</i> CAPS 500mg	2	GC
<i>irinotecan hcl</i> SOLN 40mg/2ml, 100mg/5ml, 300mg/15ml, 500mg/25ml	4	B/D
KISQALI 200 PAK FEMARA QL (49 tabs / 28 days)	5	QL PA
KISQALI 400 PAK FEMARA QL (70 tabs / 28 days)	5	QL PA

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **B/D** - Prior Authorization, Part D vs. Part B only **LA** - Limited Availability **ED** - Excluded Drug **GC** - Gap Coverage . **SI** - Select Insulins. Does not apply to AvMed Medicare Premium Saver Broward County (HMO)

All Tier 1 and Tier 2 generics are covered in the Gap Coverage.

Drug Name	Drug Requirements/ Tier	Limits
KISQALI 600 PAK FEMARA QL (91 tabs / 28 days)	5	QL PA
MATULANE CAPS 50mg	5	LA
SYNRIBO SOLR 3.5mg	5	PA
<i>tretinoin (chemotherapy)</i> CAPS 10mg	5	
WELIREG TABS 40mg	5	LA PA
MITOTIC INHIBITORS		
<i>docetaxel</i> CONC 20mg/ml	4	B/D
<i>docetaxel</i> CONC 80mg/4ml, 160mg/8ml; SOLN 20mg/2ml, 80mg/8ml, 160mg/16ml	5	B/D
DOCETAXEL CONC 80mg/4ml, 160mg/8ml; SOLN 20mg/2ml, 80mg/8ml, 160mg/16ml	5	B/D
<i>etoposide</i> SOLN 100mg/5ml, 500mg/25ml	3	B/D
<i>paclitaxel</i> CONC 6mg/ml, 30mg/5ml, 150mg/25ml, 300mg/50ml	4	B/D
<i>paclitaxel protein-bound particles for iv susp 100 mg</i>	5	B/D
<i>toposar</i> SOLN 1gm/50ml, 100mg/5ml	3	B/D
<i>vincristine sulfate</i> SOLN 1mg/ml	2	GC B/D
<i>vinorelbine tartrate</i> SOLN 10mg/ml, 50mg/5ml	4	B/D
MOLECULAR TARGET AGENTS		
ALECENSA CAPS 150mg	5	LA PA
ALUNBRIG TABS 30mg, 90mg, 180mg	5	LA PA
ALUNBRIG PAK	5	LA PA
AYVAKIT TABS 25mg, 50mg, 100mg, 200mg, 300mg QL (30 tabs / 30 days)	5	QL LA PA
BALVERSA TABS 3mg, 4mg, 5mg	5	LA PA
BORTEZOMIB SOLR 1mg, 2.5mg, 3.5mg	5	PA
<i>bortezomib</i> SOLR 3.5mg	5	PA
BOSULIF TABS 100mg, 400mg, 500mg	5	PA
BRAFTOVI CAPS 75mg	5	LA PA
BRUKINSA CAPS 80mg	5	LA PA

Drug Name	Drug Requirements/ Tier	Limits
CABOMETYX TABS 20mg, 40mg, 60mg QL (30 tabs / 30 days)	5	QL LA PA
CALQUENCE CAPS 100mg QL (60 caps / 30 days)	5	QL LA PA
CALQUENCE TABS 100mg QL (60 tabs / 30 days)	5	QL LA PA
CAPRELSA TABS 100mg, 300mg	5	LA PA
COMETRIQ (60MG DOSE) KIT 20mg	5	LA PA
COMETRIQ KIT 100MG	5	LA PA
COMETRIQ KIT 140MG	5	LA PA
COPIKTRA CAPS 15mg, 25mg	5	LA PA
COTELLIC TABS 20mg	5	LA PA
DAURISMO TABS 25mg, 100mg	5	LA PA
ERIVEDGE CAPS 150mg	5	LA PA
<i>erlotinib hcl</i> TABS 25mg QL (90 tabs / 30 days)	5	QL PA
<i>erlotinib hcl</i> TABS 100mg, 150mg QL (30 tabs / 30 days)	5	QL PA
<i>everolimus</i> TABS 2.5mg, 5mg, 7.5mg, 10mg QL (30 tabs / 30 days)	5	QL PA
<i>everolimus</i> TBSO 2mg QL (150 tabs / 30 days)	5	QL PA
<i>everolimus</i> TBSO 3mg QL (90 tabs / 30 days)	5	QL PA
<i>everolimus</i> TBSO 5mg QL (60 tabs / 30 days)	5	QL PA
EXKIVITY CAPS 40mg	5	LA PA
FOTIVDA CAPS .89mg, 1.34mg QL (21 caps / 28 days)	5	QL LA PA
GAVRETO CAPS 100mg	5	LA PA
GILOTRIF TABS 20mg, 30mg, 40mg	5	LA PA
HERCEP HYLEC SOL 60- 10000	5	LA PA
HERCEPTIN SOLR 150mg	5	LA PA
HERZUMA SOLR 150mg, 420mg	5	LA PA

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **B/D** - Prior Authorization, Part D vs. Part B only **LA** - Limited Availability **ED** - Excluded Drug **GC** - Gap Coverage . **SI** - Select Insulins. Does not apply to AvMed Medicare Premium Saver Broward County (HMO)

All Tier 1 and Tier 2 generics are covered in the Gap Coverage.

Drug Name	Drug Requirements/ Tier	Limits
IBRANCE CAPS 75mg, 100mg, 125mg QL (21 caps / 28 days)	5	QL LA PA
IBRANCE TABS 75mg, 100mg, 125mg QL (21 tabs / 28 days)	5	QL LA PA
ICLUSIG TABS 10mg, 15mg, 30mg, 45mg QL (30 tabs / 30 days)	5	QL LA PA
IDHIFA TABS 50mg, 100mg QL (30 tabs / 30 days)	5	QL LA PA
<i>imatinib mesylate</i> TABS 100mg QL (90 tabs / 30 days)	5	QL PA
<i>imatinib mesylate</i> TABS 400mg QL (60 tabs / 30 days)	5	QL PA
IMBRUVICA CAPS 70mg QL (30 caps / 30 days)	5	QL LA PA
IMBRUVICA CAPS 140mg QL (120 caps / 30 days)	5	QL LA PA
IMBRUVICA SUSP 70mg/ml QL (216 mL / 27 days)	5	QL LA PA
IMBRUVICA TABS 140mg, 280mg, 420mg, 560mg QL (30 tabs / 30 days)	5	QL LA PA
INLYTA TABS 1mg QL (180 tabs / 30 days)	5	QL LA PA
INLYTA TABS 5mg QL (120 tabs / 30 days)	5	QL LA PA
INREBIC CAPS 100mg	5	LA PA
IRESSA TABS 250mg	5	LA PA
JAKAFI TABS 5mg, 10mg, 15mg, 20mg, 25mg QL (60 tabs / 30 days)	5	QL LA PA
KADCYLA SOLR 100mg, 160mg	5	B/D LA
KANJINTI SOLR 150mg, 420mg	5	LA PA
KEYTRUDA SOLN 100mg/4ml	5	LA PA
KISQALI 200 DOSE TBPK 200mg QL (21 tabs / 28 days)	5	QL PA

Drug Name	Drug Requirements/ Tier	Limits
KISQALI 400 DOSE TBPK 200mg QL (42 tabs / 28 days)	5	QL PA
KISQALI 600 DOSE TBPK 200mg QL (63 tabs / 28 days)	5	QL PA
<i>lapatinib ditosylate</i> TABS 250mg	5	PA
LENVIMA 4 MG DAILY DOSE CPPK 4mg QL (30 caps / 30 days)	5	QL LA PA
LENVIMA 8 MG DAILY DOSE CPPK 4mg QL (60 caps / 30 days)	5	QL LA PA
LENVIMA 10 MG DAILY DOSE CPPK 10mg QL (30 caps / 30 days)	5	QL LA PA
LENVIMA 12MG DAILY DOSE CPPK 4mg QL (90 caps / 30 days)	5	QL LA PA
LENVIMA 20 MG DAILY DOSE CPPK 10mg QL (60 caps / 30 days)	5	QL LA PA
LENVIMA CAP 14 MG QL (60 caps / 30 days)	5	QL LA PA
LENVIMA CAP 18 MG QL (90 caps / 30 days)	5	QL LA PA
LENVIMA CAP 24 MG QL (90 caps / 30 days)	5	QL LA PA
LORBRENA TABS 25mg, 100mg	5	LA PA
LUMAKRAS TABS 120mg	5	LA PA
LYNPARZA TABS 100mg, 150mg QL (120 tabs / 30 days)	5	QL LA PA
MEKINIST TABS .5mg, 2mg	5	LA PA
MEKTOVI TABS 15mg	5	LA PA
MONJUVI SOLR 200mg	5	LA PA
MVASI SOLN 100mg/4ml, 400mg/16ml	5	LA PA
NERLYNX TABS 40mg	5	LA PA
NEXAVAR TABS 200mg QL (120 tabs / 30 days)	5	QL LA PA
NINLARO CAPS 2.3mg, 3mg, 4mg QL (3 caps / 28 days)	5	QL PA

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **B/D** - Prior Authorization, Part D vs. Part B only **LA** - Limited Availability **ED** - Excluded Drug **GC** - Gap Coverage . **SI** - Select Insulins. Does not apply to AvMed Medicare Premium Saver Broward County (HMO)

19

All Tier 1 and Tier 2 generics are covered in the Gap Coverage.

Drug Name	Drug Requirements/ Tier	Limits
ODOMZO CAPS 200mg	5	LA PA
OGIVRI SOLR 150mg	5	LA PA
OGIVRI INJ 420MG	5	LA PA
ONTRUZANT SOLR 150mg, 420mg	5	LA PA
PEMAZYRE TABS 4.5mg, 9mg, 13.5mg	5	LA PA
PHESGO SOL	5	LA PA
PIQRAY 200MG DAILY DOSE TBPK 200mg	5	PA
PIQRAY 250MG TAB DOSE	5	PA
PIQRAY 300MG DAILY DOSE TBPK 150mg	5	PA
QINLOCK TABS 50mg	5	LA PA
RETEVMO CAPS 40mg, 80mg	5	LA PA
ROZLYTREK CAPS 100mg, 200mg	5	LA PA
RUBRACA TABS 200mg, 250mg, 300mg QL (120 tabs / 30 days)	5	QL LA PA
RYDAPT CAPS 25mg	5	PA
SCSEMBLIX TABS 20mg QL (60 tabs / 30 days)	5	QL PA
SCSEMBLIX TABS 40mg QL (300 tabs / 30 days)	5	QL PA
<i>sorafenib tosylate</i> TABS 200mg QL (120 tabs / 30 days)	5	QL PA
SPRYCEL TABS 20mg, 50mg, 70mg, 80mg, 100mg, 140mg	5	PA
STIVARGA TABS 40mg	5	LA PA
<i>sunitinib malate</i> CAPS 12.5mg, 25mg, 37.5mg, 50mg QL (30 caps / 30 days)	5	QL PA
TABRECTA TABS 150mg, 200mg	5	PA
TAFINLAR CAPS 50mg, 75mg	5	LA PA
TAGRISO TABS 40mg, 80mg QL (30 tabs / 30 days)	5	QL LA PA
TALZENNA CAPS .5mg, .75mg, 1mg QL (30 caps / 30 days)	5	QL LA PA

Drug Name	Drug Requirements/ Tier	Limits
TALZENNA CAPS .25mg QL (90 caps / 30 days)	5	QL LA PA
TASIGNA CAPS 50mg, 150mg, 200mg	5	PA
TAZVERIK TABS 200mg	5	LA PA
TECENTRIQ SOLN 840mg/14ml, 1200mg/20ml	5	LA PA
TEPMETKO TABS 225mg	5	LA PA
TIBSOVO TABS 250mg	5	LA PA
TRAZIMERA SOLR 150mg, 420mg	5	PA
TRUSELTIQ 50 MG DAILY DOSE CPPK 25mg	5	LA PA
TRUSELTIQ 75 MG DAILY DOSE CPPK 25mg	5	LA PA
TRUSELTIQ 100 MG DAILY DOSE CPPK 100mg	5	LA PA
TRUSELTIQ 125 MG DAILY DOSE	5	LA PA
TRUXIMA SOLN 100mg/10ml, 500mg/50ml	5	PA
TUKYSA TABS 50mg, 150mg	5	LA PA
TURALIO CAPS 200mg	5	LA PA
VENCLEXTA TABS 10mg QL (112 tabs / 28 days)	4	QL LA PA
VENCLEXTA TABS 50mg QL (112 tabs / 28 days)	5	QL LA PA
VENCLEXTA TABS 100mg QL (180 tabs / 30 days)	5	QL LA PA
VENCLEXTA TAB START PK QL (42 tabs / 28 days)	5	QL LA PA
VERZENIO TABS 50mg, 100mg, 150mg, 200mg QL (56 tabs / 28 days)	5	QL LA PA
VITRAKVI CAPS 25mg, 100mg; SOLN 20mg/ml	5	LA PA
VIZIMPRO TABS 15mg, 30mg, 45mg	5	LA PA
VONJO CAPS 100mg QL (120 caps / 30 days)	5	QL LA PA
VOTRIENT TABS 200mg	5	LA PA
XALKORI CAPS 200mg, 250mg	5	LA PA
XOSPATA TABS 40mg	5	LA PA

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **B/D** - Prior Authorization, Part D vs. Part B only **LA** - Limited Availability **ED** - Excluded Drug **GC** - Gap Coverage . **SI** - Select Insulins. Does not apply to AvMed Medicare Premium Saver Broward County (HMO)

20

All Tier 1 and Tier 2 generics are covered in the Gap Coverage.

Drug Name	Drug Requirements/ Tier	Limits
XPOVIO 40 MG ONCE WEEKLY TBPk 40mg QL (4 tabs / 28 days)	5	QL LA PA
XPOVIO 40 MG TWICE WEEKLY TBPk 40mg QL (8 tabs / 28 days)	5	QL LA PA
XPOVIO 60 MG ONCE WEEKLY TBPk 60mg QL (4 tabs / 28 days)	5	QL LA PA
XPOVIO 60 MG TWICE WEEKLY TBPk 20mg QL (24 tabs / 28 days)	5	QL LA PA
XPOVIO 80 MG ONCE WEEKLY TBPk 40mg QL (8 tabs / 28 days)	5	QL LA PA
XPOVIO 80 MG TWICE WEEKLY TBPk 20mg QL (32 tabs / 28 days)	5	QL LA PA
XPOVIO 100 MG ONCE WEEKLY TBPk 50mg QL (8 tabs / 28 days)	5	QL LA PA
ZEJULA CAPS 100mg QL (90 caps / 30 days)	5	QL LA PA
ZELBORAF TABS 240mg	5	LA PA
ZIRABEV SOLN 100mg/4ml, 400mg/16ml	5	LA PA
ZOLINZA CAPS 100mg	5	PA
ZYDELIG TABS 100mg, 150mg	5	LA PA
ZYKADIA TABS 150mg	5	LA PA
PROTECTIVE AGENTS		
leucovorin calcium SOLN 500mg/50ml; SOLR 50mg, 100mg, 200mg, 350mg, 500mg	4	B/D
leucovorin calcium TABS 5mg, 10mg, 15mg	3	
leucovorin calcium TABS 25mg	4	
MESNEX TABS 400mg	5	
CARDIOVASCULAR ACE INHIBITOR COMBINATIONS		
amlodipine besylate- benazepril hcl cap 2.5-10 mg QL (30 caps / 30 days)	1	GC QL

Drug Name	Drug Requirements/ Tier	Limits
amlodipine besylate- benazepril hcl cap 5-10 mg QL (30 caps / 30 days)	1	GC QL
amlodipine besylate- benazepril hcl cap 5-20 mg QL (30 caps / 30 days)	1	GC QL
amlodipine besylate- benazepril hcl cap 5-40 mg QL (30 caps / 30 days)	1	GC QL
amlodipine besylate- benazepril hcl cap 10-20 mg QL (30 caps / 30 days)	1	GC QL
amlodipine besylate- benazepril hcl cap 10-40 mg QL (30 caps / 30 days)	1	GC QL
benazepril & hydrochlorothiazide tab 5- 6.25mg	1	GC
benazepril & hydrochlorothiazide tab 10- 12.5 mg	1	GC
benazepril & hydrochlorothiazide tab 20- 12.5 mg	1	GC
benazepril & hydrochlorothiazide tab 20-25 mg	1	GC
enalapril maleate & hydrochlorothiazide tab 5-12.5 mg	1	GC
enalapril maleate & hydrochlorothiazide tab 10-25 mg	1	GC
fosinopril sodium & hydrochlorothiazide tab 10- 12.5 mg	1	GC
fosinopril sodium & hydrochlorothiazide tab 20- 12.5 mg	1	GC
lisinopril & hydrochlorothiazide tab 10-12.5 mg	1	GC
lisinopril & hydrochlorothiazide tab 20-12.5 mg	1	GC
lisinopril & hydrochlorothiazide tab 20-25 mg	1	GC

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **B/D** - Prior Authorization, Part D vs. Part B only **LA** - Limited Availability **ED** - Excluded Drug **GC** - Gap Coverage . **SI** - Select Insulins. Does not apply to AvMed Medicare Premium Saver Broward County (HMO)

All Tier 1 and Tier 2 generics are covered in the Gap Coverage.

Drug Name	Drug Requirements/ Tier	Limits
<i>quinapril-hydrochlorothiazide</i> tab 10-12.5 mg	1	GC
<i>quinapril-hydrochlorothiazide</i> tab 20-12.5 mg	1	GC
<i>quinapril-hydrochlorothiazide</i> tab 20-25 mg	1	GC
ACE INHIBITORS		
<i>benazepril hcl</i> TABS 5mg, 10mg, 20mg, 40mg	1	GC
<i>captopril</i> TABS 12.5mg, 25mg, 50mg, 100mg	1	GC
<i>enalapril maleate</i> TABS 2.5mg, 5mg, 10mg, 20mg	1	GC
<i>fosinopril sodium</i> TABS 10mg, 20mg, 40mg	1	GC
<i>lisinopril</i> TABS 2.5mg, 5mg, 10mg, 20mg, 30mg, 40mg	1	GC
<i>moexipril hcl</i> TABS 7.5mg, 15mg	1	GC
<i>perindopril erbumine</i> TABS 2mg, 4mg, 8mg	1	GC
<i>quinapril hcl</i> TABS 5mg, 10mg, 20mg, 40mg	1	GC
<i>ramipril</i> CAPS 1.25mg, 2.5mg, 5mg, 10mg	1	GC
<i>trandolapril</i> TABS 1mg, 2mg, 4mg	1	GC
ALDOSTERONE RECEPTOR ANTAGONISTS		
<i>eplerenone</i> TABS 25mg, 50mg	3	
<i>KERENDIA</i> TABS 10mg, 20mg	3	QL
QL (30 tabs / 30 days)		
<i>spironolactone</i> TABS 25mg, 50mg, 100mg	1	GC
ALPHA BLOCKERS		
<i>doxazosin mesylate</i> TABS 1mg, 2mg, 4mg, 8mg	2	GC
<i>prazosin hcl</i> CAPS 1mg, 2mg, 5mg	3	
<i>terazosin hcl</i> CAPS 1mg, 2mg, 5mg, 10mg	2	GC

Drug Name	Drug Requirements/ Tier	Limits
ANGIOTENSIN II RECEPTOR ANTAGONIST COMBINATIONS		
<i>amlodipine besylate-</i> <i>olmesartan medoxomil</i> tab 5- 20 mg	1	GC QL
QL (30 tabs / 30 days)		
<i>amlodipine besylate-</i> <i>olmesartan medoxomil</i> tab 5- 40 mg	1	GC QL
QL (30 tabs / 30 days)		
<i>amlodipine besylate-</i> <i>olmesartan medoxomil</i> tab 10- 20 mg	1	GC QL
QL (30 tabs / 30 days)		
<i>amlodipine besylate-</i> <i>olmesartan medoxomil</i> tab 10- 40 mg	1	GC QL
QL (30 tabs / 30 days)		
<i>amlodipine besylate-valsartan</i> tab 5-160 mg	1	GC QL
QL (30 tabs / 30 days)		
<i>amlodipine besylate-valsartan</i> tab 5-320 mg	1	GC QL
QL (30 tabs / 30 days)		
<i>amlodipine besylate-valsartan</i> tab 10-160 mg	1	GC QL
QL (30 tabs / 30 days)		
<i>amlodipine besylate-valsartan</i> tab 10-320 mg	1	GC QL
QL (30 tabs / 30 days)		
<i>candesartan cilexetil-</i> <i>hydrochlorothiazide</i> tab 16- 12.5 mg	1	GC QL
QL (60 tabs / 30 days)		
<i>candesartan cilexetil-</i> <i>hydrochlorothiazide</i> tab 32- 12.5 mg	1	GC QL
QL (30 tabs / 30 days)		
<i>candesartan cilexetil-</i> <i>hydrochlorothiazide</i> tab 32-25 mg	1	GC QL
QL (30 tabs / 30 days)		
<i>EDARBYCLOR</i> TAB 40-12.5	4	QL
QL (30 tabs / 30 days)		

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **B/D** - Prior Authorization, Part D vs. Part B only **LA** - Limited Availability **ED** - Excluded Drug **GC** - Gap Coverage . **SI** - Select Insulins. Does not apply to AvMed Medicare Premium Saver Broward County (HMO)

All Tier 1 and Tier 2 generics are covered in the Gap Coverage.

Drug Name	Drug Requirements/ Tier	Limits
EDARBYCLOR TAB 40-25MG QL (30 tabs / 30 days)	4	QL
ENTRESTO TAB 24-26MG	3	
ENTRESTO TAB 49-51MG	3	
ENTRESTO TAB 97-103MG	3	
irbesartan-hydrochlorothiazide tab 150-12.5 mg QL (60 tabs / 30 days)	1	GC QL
irbesartan-hydrochlorothiazide tab 300-12.5 mg QL (30 tabs / 30 days)	1	GC QL
losartan potassium & hydrochlorothiazide tab 50-12.5 mg	1	GC
losartan potassium & hydrochlorothiazide tab 100-12.5 mg	1	GC
losartan potassium & hydrochlorothiazide tab 100-25 mg	1	GC
olmesartan medoxomil-hydrochlorothiazide tab 20-12.5 mg QL (30 tabs / 30 days)	1	GC QL
olmesartan medoxomil-hydrochlorothiazide tab 40-12.5 mg QL (30 tabs / 30 days)	1	GC QL
olmesartan medoxomil-hydrochlorothiazide tab 40-25 mg QL (30 tabs / 30 days)	1	GC QL
olmesartan-amlodipine-hydrochlorothiazide tab 20-5-12.5 mg QL (30 tabs / 30 days)	1	GC QL
olmesartan-amlodipine-hydrochlorothiazide tab 40-5-12.5 mg QL (30 tabs / 30 days)	1	GC QL
olmesartan-amlodipine-hydrochlorothiazide tab 40-5-25 mg QL (30 tabs / 30 days)	1	GC QL

Drug Name	Drug Requirements/ Tier	Limits
olmesartan-amlodipine-hydrochlorothiazide tab 40-10-12.5 mg QL (30 tabs / 30 days)	1	GC QL
olmesartan-amlodipine-hydrochlorothiazide tab 40-10-25 mg QL (30 tabs / 30 days)	1	GC QL
telmisartan-amlodipine tab 40-5 mg QL (30 tabs / 30 days)	1	GC QL
telmisartan-amlodipine tab 40-10 mg QL (30 tabs / 30 days)	1	GC QL
telmisartan-amlodipine tab 80-5 mg QL (30 tabs / 30 days)	1	GC QL
telmisartan-amlodipine tab 80-10 mg QL (30 tabs / 30 days)	1	GC QL
telmisartan-hydrochlorothiazide tab 40-12.5 mg QL (30 tabs / 30 days)	1	GC QL
telmisartan-hydrochlorothiazide tab 80-12.5 mg QL (60 tabs / 30 days)	1	GC QL
telmisartan-hydrochlorothiazide tab 80-25 mg QL (30 tabs / 30 days)	1	GC QL
valsartan-hydrochlorothiazide tab 80-12.5 mg QL (30 tabs / 30 days)	1	GC QL
valsartan-hydrochlorothiazide tab 160-12.5 mg QL (30 tabs / 30 days)	1	GC QL
valsartan-hydrochlorothiazide tab 160-25 mg QL (30 tabs / 30 days)	1	GC QL
valsartan-hydrochlorothiazide tab 320-12.5 mg QL (30 tabs / 30 days)	1	GC QL
valsartan-hydrochlorothiazide tab 320-25 mg QL (30 tabs / 30 days)	1	GC QL

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **B/D** - Prior Authorization, Part D vs. Part B only **LA** - Limited Availability **ED** - Excluded Drug **GC** - Gap Coverage . **SI** - Select Insulins. Does not apply to AvMed Medicare Premium Saver Broward County (HMO) 23

All Tier 1 and Tier 2 generics are covered in the Gap Coverage.

Drug Name	Drug Requirements/ Tier	Limits
ANGIOTENSIN II RECEPTOR ANTAGONISTS		
<i>candesartan cilexetil</i> TABS 4mg, 8mg, 16mg QL (60 tabs / 30 days)	1	GC QL
<i>candesartan cilexetil</i> TABS 32mg QL (30 tabs / 30 days)	1	GC QL
EDARBI TABS 40mg, 80mg QL (30 tabs / 30 days)	4	QL
<i>irbesartan</i> TABS 75mg, 150mg, 300mg QL (30 tabs / 30 days)	1	GC QL
<i>losartan potassium</i> TABS 25mg, 50mg, 100mg	1	GC
<i>olmesartan medoxomil</i> TABS 5mg QL (60 tabs / 30 days)	1	GC QL
<i>olmesartan medoxomil</i> TABS 20mg, 40mg QL (30 tabs / 30 days)	1	GC QL
<i>telmisartan</i> TABS 20mg, 40mg, 80mg QL (30 tabs / 30 days)	1	GC QL
<i>valsartan</i> TABS 40mg, 80mg, 160mg QL (60 tabs / 30 days)	1	GC QL
<i>valsartan</i> TABS 320mg QL (30 tabs / 30 days)	1	GC QL
ANTIARRHYTHMICS		
<i>amiodarone hcl</i> SOLN 50mg/ml, 900mg/18ml; TABS 100mg, 400mg	4	
<i>amiodarone hcl</i> TABS 200mg	1	GC
<i>disopyramide phosphate</i> CAPS 100mg, 150mg	4	
<i>dofetilide</i> CAPS 125mcg, 250mcg, 500mcg	4	
<i>flecainide acetate</i> TABS 50mg, 100mg, 150mg	3	
MULTAQ TABS 400mg	4	
NORPACE CR CP12 100mg, 150mg	4	
<i>pacerone</i> TABS 100mg, 400mg	4	
<i>pacerone</i> TABS 200mg	1	GC

Drug Name	Drug Requirements/ Tier	Limits
<i>propafenone hcl</i> CP12 225mg, 325mg, 425mg	4	
<i>propafenone hcl</i> TABS 150mg, 225mg, 300mg	3	
<i>quinidine sulfate</i> TABS 200mg, 300mg	3	
<i>sorine</i> TABS 80mg, 120mg, 160mg, 240mg	2	GC
<i>sotalol hcl</i> TABS 80mg, 120mg, 160mg, 240mg	2	GC
<i>sotalol hcl (afib/af)</i> TABS 80mg, 120mg, 160mg	3	
ANTIPEMICS, FIBRATES		
<i>choline fenofibrate</i> CPDR 45mg, 135mg	3	
<i>fenofibrate</i> TABS 48mg, 54mg, 145mg, 160mg	3	
<i>fenofibrate micronized</i> CAPS 67mg, 134mg, 200mg	3	
<i>gemfibrozil</i> TABS 600mg	1	GC
ANTIPEMICS, HMG-CoA REDUCTASE INHIBITORS		
ALTOPREV TB24 20mg, 40mg, 60mg QL (30 tabs / 30 days)	5	QL ST
<i>atorvastatin calcium</i> TABS 10mg, 20mg, 40mg, 80mg QL (30 tabs / 30 days)	1	GC QL
EZALLOR SPRINKLE CPSP 5mg, 10mg, 20mg, 40mg QL (30 caps / 30 days)	4	QL ST
<i>fluvastatin sodium</i> CAPS 20mg, 40mg QL (60 caps / 30 days)	1	GC QL
<i>fluvastatin sodium</i> TB24 80mg QL (30 tabs / 30 days)	1	GC QL
LIVALO TABS 1mg, 2mg, 4mg QL (30 tabs / 30 days)	4	QL ST
<i>lovastatin</i> TABS 10mg, 20mg, 40mg QL (60 tabs / 30 days)	1	GC QL
<i>pravastatin sodium</i> TABS 10mg, 20mg, 40mg, 80mg QL (30 tabs / 30 days)	1	GC QL

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **B/D** - Prior Authorization, Part D vs. Part B only **LA** - Limited Availability **ED** - Excluded Drug **GC** - Gap Coverage . **SI** - Select Insulins. Does not apply to AvMed Medicare Premium Saver Broward County (HMO)

All Tier 1 and Tier 2 generics are covered in the Gap Coverage.

Drug Name	Drug Requirements/ Tier	Limits
<i>rosuvastatin calcium</i> TABS 5mg, 10mg, 20mg, 40mg QL (30 tabs / 30 days)	1	GC QL
<i>simvastatin</i> TABS 5mg, 10mg, 20mg, 40mg, 80mg QL (30 tabs / 30 days)	1	GC QL
ZYPITAMAG TABS 2mg, 4mg QL (30 tabs / 30 days)	4	QL ST
ANTILIPEMICS, MISCELLANEOUS		
<i>cholestyramine</i> PACK 4gm; POWD 4gm/dose	3	
<i>cholestyramine light</i> PACK 4gm; POWD 4gm/dose	3	
<i>colesevelam hcl</i> PACK 3.75gm; TABS 625mg	4	
<i>colestipol hcl</i> GRAN 5gm; PACK 5gm	4	
<i>colestipol hcl</i> TABS 1gm	3	
<i>ezetimibe</i> TABS 10mg	3	
<i>ezetimibe-simvastatin tab</i> 10-10 mg QL (30 tabs / 30 days)	1	GC QL
<i>ezetimibe-simvastatin tab</i> 10-20 mg QL (30 tabs / 30 days)	1	GC QL
<i>ezetimibe-simvastatin tab</i> 10-40 mg QL (30 tabs / 30 days)	1	GC QL
<i>ezetimibe-simvastatin tab</i> 10-80 mg QL (30 tabs / 30 days)	1	GC QL
<i>niacin (antihyperlipidemic)</i> TBCR 500mg, 750mg, 1000mg QL (60 tabs / 30 days)	3	QL
PRALUENT SOAJ 75mg/ml, 150mg/ml	3	PA
<i>prevalite</i> PACK 4gm; POWD 4gm/dose	3	
VASCEPA CAPS .5gm, 1gm	4	
BETA-BLOCKER/DIURETIC COMBINATIONS		
<i>atenolol & chlorthalidone tab</i> 50-25 mg	2	GC

Drug Name	Drug Requirements/ Tier	Limits
<i>atenolol & chlorthalidone tab</i> 100-25 mg	2	GC
<i>bisoprolol & hydrochlorothiazide tab</i> 2.5-6.25 mg	2	GC
<i>bisoprolol & hydrochlorothiazide tab</i> 5-6.25 mg	2	GC
<i>bisoprolol & hydrochlorothiazide tab</i> 10-6.25 mg	2	GC
<i>metoprolol & hydrochlorothiazide tab</i> 50-25 mg	3	
<i>metoprolol & hydrochlorothiazide tab</i> 100-25 mg	3	
<i>metoprolol & hydrochlorothiazide tab</i> 100-50 mg	3	
BETA-BLOCKERS		
<i>acebutolol hcl</i> CAPS 200mg, 400mg	3	
<i>atenolol</i> TABS 25mg, 50mg, 100mg	1	GC
<i>bisoprolol fumarate</i> TABS 5mg, 10mg	2	GC
<i>carvedilol</i> TABS 3.125mg, 6.25mg, 12.5mg, 25mg	1	GC
<i>labetalol hcl</i> TABS 100mg, 200mg, 300mg	3	
<i>metoprolol succinate</i> TB24 25mg, 50mg, 100mg, 200mg	2	GC
<i>metoprolol tartrate</i> SOLN 5mg/5ml	4	
<i>metoprolol tartrate</i> TABS 25mg, 50mg, 100mg	1	GC
<i>nadolol</i> TABS 20mg, 40mg, 80mg	3	
<i>nebivolol hcl</i> TABS 2.5mg, 5mg, 10mg QL (30 tabs / 30 days)	3	QL
<i>nebivolol hcl</i> TABS 20mg QL (60 tabs / 30 days)	3	QL
<i>pindolol</i> TABS 5mg, 10mg	3	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **B/D** - Prior Authorization, Part D vs. Part B only **LA** - Limited Availability **ED** - Excluded Drug **GC** - Gap Coverage . **SI** - Select Insulins. Does not apply to AvMed Medicare Premium Saver Broward County (HMO)

25

All Tier 1 and Tier 2 generics are covered in the Gap Coverage.

Drug Name	Drug Requirements/ Tier	Limits
<i>propranolol hcl</i> CP24 60mg, 80mg, 120mg, 160mg; SOLN 20mg/5ml, 40mg/5ml	3	
<i>propranolol hcl</i> TABS 10mg, 20mg, 40mg, 60mg, 80mg	2	GC
<i>timolol maleate</i> TABS 5mg, 10mg, 20mg	4	
CALCIUM CHANNEL BLOCKERS		
<i>amlodipine besylate</i> TABS 2.5mg, 5mg, 10mg	1	GC
<i>cartia xt</i> CP24 120mg, 180mg, 240mg, 300mg	2	GC
<i>dilt-xr</i> CP24 120mg, 180mg, 240mg	3	
<i>diltiazem hcl</i> CP12 60mg, 90mg, 120mg	4	
<i>diltiazem hcl</i> SOLN 25mg/5ml, 50mg/10ml, 125mg/25ml	3	
<i>diltiazem hcl</i> TABS 30mg, 60mg, 90mg, 120mg	2	GC
<i>diltiazem hcl coated beads</i> CP24 120mg, 180mg, 240mg, 300mg	2	GC
<i>diltiazem hcl coated beads</i> CP24 360mg; TB24 180mg, 240mg, 300mg, 360mg, 420mg	4	
<i>diltiazem hcl extended release beads</i> CP24 120mg, 180mg, 240mg, 300mg, 360mg, 420mg	2	GC
<i>felodipine</i> TB24 2.5mg, 5mg, 10mg	2	GC
<i>isradipine</i> CAPS 2.5mg, 5mg	4	
<i>matzim la</i> TB24 180mg, 240mg, 300mg, 360mg, 420mg	4	
<i>nicardipine hcl</i> CAPS 20mg, 30mg	4	
<i>nifedipine</i> TB24 30mg, 60mg, 90mg	3	
<i>nimodipine</i> CAPS 30mg	4	
<i>nisoldipine</i> TB24 8.5mg, 17mg, 20mg, 25.5mg, 30mg, 34mg, 40mg	4	

Drug Name	Drug Requirements/ Tier	Limits
NYMALIZE SOLN 6mg/ml	5	
<i>taztia xt</i> CP24 120mg, 180mg, 240mg, 300mg, 360mg	2	GC
<i>tiadylt er</i> CP24 120mg, 180mg, 240mg, 300mg, 360mg, 420mg	2	GC
<i>verapamil hcl</i> CP24 100mg, 120mg, 200mg, 300mg, 360mg; SOLN 2.5mg/ml	4	
<i>verapamil hcl</i> CP24 180mg, 240mg	3	
<i>verapamil hcl</i> TABS 40mg, 80mg, 120mg	1	GC
<i>verapamil hcl</i> TBCR 120mg, 180mg, 240mg	2	GC
DIURETICS		
<i>acetazolamide</i> CP12 500mg	4	
<i>acetazolamide</i> TABS 125mg, 250mg	3	
<i>amiloride & hydrochlorothiazide tab 5-50 mg</i>	2	GC
<i>amiloride hcl</i> TABS 5mg	2	GC
<i>bumetanide</i> SOLN .25mg/ml; TABS .5mg, 1mg, 2mg	3	
<i>chlorthalidone</i> TABS 25mg, 50mg	2	GC
<i>furosemide</i> SOLN 10mg/ml, 40mg/5ml	2	GC
<i>furosemide</i> TABS 20mg, 40mg, 80mg	1	GC
<i>furosemide inj</i> SOLN 10mg/ml	3	
<i>hydrochlorothiazide</i> CAPS 12.5mg; TABS 12.5mg, 25mg, 50mg	1	GC
<i>indapamide</i> TABS 1.25mg, 2.5mg	1	GC
<i>methazolamide</i> TABS 25mg, 50mg	4	
<i>metolazone</i> TABS 2.5mg, 5mg, 10mg	3	
<i>spironolactone & hydrochlorothiazide tab 25-25 mg</i>	3	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **B/D** - Prior Authorization, Part D vs. Part B only **LA** - Limited Availability **ED** - Excluded Drug **GC** - Gap Coverage . **SI** - Select Insulins. Does not apply to AvMed Medicare Premium Saver Broward County (HMO)

26

All Tier 1 and Tier 2 generics are covered in the Gap Coverage.

Drug Name	Drug Requirements/ Tier	Limits
<i>torsemide</i> TABS 5mg, 10mg, 20mg, 100mg	2	GC
<i>triamterene & hydrochlorothiazide cap</i> 37.5-25 mg	1	GC
<i>triamterene & hydrochlorothiazide tab</i> 37.5-25 mg	1	GC
<i>triamterene & hydrochlorothiazide tab</i> 75-50 mg	1	GC
MISCELLANEOUS		
<i>ADRENALIN</i> SOLN 1mg/ml	4	
<i>aliskiren fumarate</i> TABS 150mg, 300mg	4	
<i>amlodipine besylate-atorvastatin calcium tab</i> 2.5-10 mg	1	GC
<i>amlodipine besylate-atorvastatin calcium tab</i> 2.5-20 mg	1	GC
<i>amlodipine besylate-atorvastatin calcium tab</i> 2.5-40 mg	1	GC
<i>amlodipine besylate-atorvastatin calcium tab</i> 5-10 mg	1	GC
<i>amlodipine besylate-atorvastatin calcium tab</i> 5-20 mg	1	GC
<i>amlodipine besylate-atorvastatin calcium tab</i> 5-40 mg	1	GC
<i>amlodipine besylate-atorvastatin calcium tab</i> 5-80 mg	1	GC
<i>amlodipine besylate-atorvastatin calcium tab</i> 10-10 mg	1	GC
<i>amlodipine besylate-atorvastatin calcium tab</i> 10-20 mg	1	GC
<i>amlodipine besylate-atorvastatin calcium tab</i> 10-40 mg	1	GC

Drug Name	Drug Requirements/ Tier	Limits
<i>amlodipine besylate-atorvastatin calcium tab</i> 10-80 mg	1	GC
<i>clonidine</i> PTWK .1mg/24hr, .2mg/24hr, .3mg/24hr	3	
<i>clonidine hcl</i> TABS .1mg, .2mg, .3mg	1	GC
<i>CORLANOR</i> SOLN 5mg/5ml; TABS 5mg, 7.5mg	4	
<i>digoxin</i> SOLN .05mg/ml, .25mg/ml	4	
<i>digoxin</i> TABS 125mcg, 250mcg	2	GC QL
QL (30 tabs / 30 days)		
<i>droxidopa</i> CAPS 100mg	5	QL PA
QL (90 caps / 30 days)		
<i>droxidopa</i> CAPS 200mg, 300mg	5	QL PA
QL (180 caps / 30 days)		
<i>guanfacine hcl</i> TABS 1mg, 2mg	3	PA
PA if 70 years and older		
<i>hydralazine hcl</i> SOLN 20mg/ml	4	
<i>hydralazine hcl</i> TABS 10mg, 25mg, 50mg, 100mg	2	GC
<i>metyrosine</i> CAPS 250mg	5	PA
<i>midodrine hcl</i> TABS 2.5mg, 5mg	3	
<i>midodrine hcl</i> TABS 10mg	4	
<i>minoxidil</i> TABS 2.5mg, 10mg	2	GC
<i>ranolazine</i> TB12 500mg, 1000mg	4	
<i>VERQUVO</i> TABS 2.5mg, 5mg, 10mg	3	
NITRATES		
<i>isosorbide dinitrate</i> TABS 5mg, 10mg, 20mg, 30mg	3	
<i>isosorbide mononitrate</i> TABS 10mg, 20mg	2	GC
<i>isosorbide mononitrate</i> TB24 30mg, 60mg, 120mg	1	GC
<i>NITRO-BID</i> OINT 2%	3	
<i>nitroglycerin</i> PT24 .1mg/hr, .2mg/hr, .4mg/hr, .6mg/hr; SUBL .3mg, .4mg, .6mg	3	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **B/D** - Prior Authorization, Part D vs. Part B only **LA** - Limited Availability **ED** - Excluded Drug **GC** - Gap Coverage . **SI** - Select Insulins. Does not apply to AvMed Medicare Premium Saver Broward County (HMO)

27

All Tier 1 and Tier 2 generics are covered in the Gap Coverage.

Drug Name	Drug Requirements/ Tier	Limits
PULMONARY ARTERIAL HYPERTENSION		
ADEMPAS TABS .5mg, 1mg, 1.5mg, 2mg, 2.5mg QL (90 tabs / 30 days)	5	QL LA PA
<i>ambrisentan</i> TABS 5mg, 10mg QL (30 tabs / 30 days)	5	QL LA PA
<i>bosentan</i> TABS 62.5mg, 125mg QL (60 tabs / 30 days)	5	QL LA PA
OPSUMIT TABS 10mg QL (30 tabs / 30 days)	5	QL LA PA
<i>sildenafil citrate (pulmonary hypertension)</i> TABS 20mg QL (90 tabs / 30 days)	3	QL PA
<i>treprostinil</i> SOLN 20mg/20ml, 50mg/20ml, 100mg/20ml, 200mg/20ml	5	LA PA
VENTAVIS SOLN 10mcg/ml, 20mcg/ml	5	LA PA
CENTRAL NERVOUS SYSTEM ANTIANXIETY		
<i>alprazolam</i> TABS .25mg, .5mg, 1mg, 2mg QL (150 tabs / 30 days)	2	GC QL
<i>buspirone hcl</i> TABS 5mg, 10mg, 15mg	1	GC
<i>buspirone hcl</i> TABS 7.5mg, 30mg	3	
<i>fluvoxamine maleate</i> TABS 25mg, 50mg, 100mg	3	
<i>lorazepam</i> CONC 2mg/ml QL (150 mL / 30 days)	3	QL
<i>lorazepam</i> SOLN 2mg/ml, 4mg/ml	2	GC
<i>lorazepam</i> TABS .5mg, 1mg, 2mg QL (150 tabs / 30 days)	2	GC QL
<i>lorazepam intensol</i> CONC 2mg/ml QL (150 mL / 30 days)	3	QL
ANTICONVULSANTS		
APTOM TABS 200mg, 400mg QL (30 tabs / 30 days)	5	QL

Drug Name	Drug Requirements/ Tier	Limits
APTOM TABS 600mg, 800mg QL (60 tabs / 30 days)	5	QL
BRIVIACT SOLN 10mg/ml QL (600 mL / 30 days)	5	QL PA
BRIVIACT SOLN 50mg/5ml	4	PA
BRIVIACT TABS 10mg, 25mg, 50mg, 75mg, 100mg QL (60 tabs / 30 days)	5	QL PA
<i>carbamazepine</i> CHEW 100mg; TABS 200mg	3	
<i>carbamazepine</i> CP12 100mg, 200mg, 300mg; SUSP 100mg/5ml; TB12 100mg, 200mg, 400mg	4	
CELONTIN CAPS 300mg	4	
<i>clobazam</i> SUSP 2.5mg/ml QL (480 mL / 30 days)	4	QL PA
<i>clobazam</i> TABS 10mg, 20mg QL (60 tabs / 30 days)	4	QL PA
<i>clonazepam</i> TABS 2mg QL (300 tabs / 30 days)	2	GC QL
<i>clonazepam</i> TABS .5mg, 1mg QL (90 tabs / 30 days)	2	GC QL
<i>clonazepam</i> TBDP 2mg QL (300 tabs / 30 days)	3	QL
<i>clonazepam</i> TBDP .125mg, .25mg, .5mg, 1mg QL (90 tabs / 30 days)	3	QL
<i>clorazepate dipotassium</i> TABS 3.75mg, 7.5mg, 15mg QL (180 tabs / 30 days) PA if 65 years and older	4	QL PA
DIACOMIT CAPS 250mg QL (360 caps / 30 days)	5	QL LA PA
DIACOMIT CAPS 500mg QL (180 caps / 30 days)	5	QL LA PA
DIACOMIT PACK 250mg QL (360 packets / 30 days)	5	QL LA PA
DIACOMIT PACK 500mg QL (180 packets / 30 days)	5	QL LA PA

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **B/D** - Prior Authorization, Part D vs. Part B only **LA** - Limited Availability **ED** - Excluded Drug **GC** - Gap Coverage . **SI** - Select Insulins. Does not apply to AvMed Medicare Premium Saver Broward County (HMO)

All Tier 1 and Tier 2 generics are covered in the Gap Coverage.

Drug Name	Drug Requirements/ Tier	Limits
<i>diazepam</i> CONC 5mg/ml QL (240 mL / 30 days) PA if 65 years and older	3	QL PA
<i>diazepam</i> SOLN 5mg/5ml QL (1200 mL / 30 days) PA if 65 years and older	3	QL PA
<i>diazepam</i> TABS 2mg, 5mg, 10mg QL (120 tabs / 30 days) PA if 65 years and older	2	GC QL PA
<i>diazepam (anticonvulsant)</i> GEL 2.5mg, 10mg, 20mg	4	
<i>diazepam inj</i> SOLN 5mg/ml	4	
DILANTIN CAPS 30mg, 100mg	4	
DILANTIN INFATABS CHEW 50mg	4	
DILANTIN-125 SUSP 125mg/5ml	4	
<i>divalproex sodium</i> CSDR 125mg; TB24 250mg, 500mg	4	
<i>divalproex sodium</i> TBEC 125mg, 250mg, 500mg	3	
EPIDIOLEX SOLN 100mg/ml QL (600 mL / 30 days)	5	QL LA PA
<i>epitol</i> TABS 200mg	3	
EPRONTIA SOLN 25mg/ml QL (480 mL / 30 days)	4	QL PA
<i>ethosuximide</i> CAPS 250mg	4	
<i>ethosuximide</i> SOLN 250mg/5ml	3	
<i>felbamate</i> SUSP 600mg/5ml	5	
<i>felbamate</i> TABS 400mg, 600mg	4	
FINTEPLA SOLN 2.2mg/ml QL (360 mL / 30 days)	5	QL LA PA
FYCOMPA SUSP .5mg/ml QL (720 mL / 30 days)	5	QL PA
FYCOMPA TABS 2mg QL (60 tabs / 30 days)	4	QL PA
FYCOMPA TABS 4mg, 6mg, 8mg, 10mg, 12mg QL (30 tabs / 30 days)	5	QL PA
<i>gabapentin</i> CAPS 100mg, 300mg, 400mg QL (180 caps / 30 days)	2	GC QL

Drug Name	Drug Requirements/ Tier	Limits
<i>gabapentin</i> SOLN 250mg/5ml QL (2160 mL / 30 days)	3	QL
<i>gabapentin</i> TABS 600mg QL (180 tabs / 30 days)	3	QL
<i>gabapentin</i> TABS 800mg QL (120 tabs / 30 days)	3	QL
<i>lacosamide</i> SOLN 200mg/20ml	5	
<i>lacosamide</i> TABS 50mg QL (120 tabs / 30 days)	4	QL
<i>lacosamide</i> TABS 100mg, 150mg, 200mg QL (60 tabs / 30 days)	4	QL
<i>lacosamide oral</i> SOLN 10mg/ml QL (1200 mL / 30 days)	4	QL
<i>lamotrigine</i> CHEW 5mg, 25mg	3	
<i>lamotrigine</i> TABS 25mg, 100mg, 150mg, 200mg	1	GC
<i>lamotrigine</i> TB24 25mg, 50mg, 100mg, 200mg, 250mg, 300mg; TBDP 25mg, 50mg, 100mg, 200mg	4	
<i>levetiracetam</i> SOLN 100mg/ml; TABS 250mg, 500mg, 750mg, 1000mg; TB24 500mg, 750mg	3	
<i>levetiracetam</i> SOLN 500mg/5ml	4	
<i>levetiracetam in sodium chloride iv soln 500 mg/100ml</i>	4	
<i>levetiracetam in sodium chloride iv soln 1000 mg/100ml</i>	4	
<i>levetiracetam in sodium chloride iv soln 1500 mg/100ml</i>	4	
NAYZILAM SOLN 5mg/0.1ml	4	
<i>oxcarbazepine</i> SUSP 300mg/5ml	4	
<i>oxcarbazepine</i> TABS 150mg, 300mg, 600mg	3	
<i>phenobarbital</i> ELIX 20mg/5ml PA if 70 years and older	4	PA

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **B/D** - Prior Authorization, Part D vs. Part B only **LA** - Limited Availability **ED** - Excluded Drug **GC** - Gap Coverage . **SI** - Select Insulins. Does not apply to AvMed Medicare Premium Saver Broward County (HMO)

All Tier 1 and Tier 2 generics are covered in the Gap Coverage.

Drug Name	Drug Requirements/ Tier	Limits
<i>phenobarbital</i> TABS 15mg, 16.2mg, 30mg, 32.4mg, 60mg, 64.8mg, 97.2mg, 100mg PA if 70 years and older	3	PA
<i>phenobarbital sodium</i> SOLN 65mg/ml, 130mg/ml PA if 70 years and older	4	PA
PHENYTEK CAPS 200mg, 300mg	4	
<i>phenytoin</i> CHEW 50mg; SUSP 125mg/5ml	3	
<i>phenytoin sodium</i> SOLN 50mg/ml	3	
<i>phenytoin sodium extended</i> CAPS 100mg, 200mg, 300mg	3	
<i>pregabalin</i> CAPS 25mg, 50mg, 75mg, 100mg, 150mg QL (120 caps / 30 days)	3	QL PA
<i>pregabalin</i> CAPS 200mg QL (90 caps / 30 days)	3	QL PA
<i>pregabalin</i> CAPS 225mg, 300mg QL (60 caps / 30 days)	3	QL PA
<i>pregabalin</i> SOLN 20mg/ml QL (900 mL / 30 days)	4	QL PA
<i>primidone</i> TABS 50mg, 250mg	2	GC
<i>roovepra</i> TABS 500mg	3	
<i>rufinamide</i> SUSP 40mg/ml QL (2400 mL / 30 days)	5	QL PA
<i>rufinamide</i> TABS 200mg QL (480 tabs / 30 days)	4	QL PA
<i>rufinamide</i> TABS 400mg QL (240 tabs / 30 days)	5	QL PA
SPRITAM TB3D 250mg QL (360 tabs / 30 days)	4	QL
SPRITAM TB3D 500mg QL (180 tabs / 30 days)	4	QL
SPRITAM TB3D 750mg QL (120 tabs / 30 days)	4	QL
SPRITAM TB3D 1000mg QL (90 tabs / 30 days)	4	QL
<i>subvenite</i> TABS 25mg, 100mg, 150mg, 200mg	1	GC

Drug Name	Drug Requirements/ Tier	Limits
SYMPAZAN FILM 5mg, 10mg, 20mg QL (60 films / 30 days)	5	QL PA
<i>tiagabine hcl</i> TABS 2mg, 4mg, 12mg, 16mg	4	
<i>topiramate</i> CPSP 15mg, 25mg	3	
<i>topiramate</i> TABS 25mg, 50mg, 100mg, 200mg	2	GC
<i>valproate sodium</i> SOLN 100mg/ml	4	
<i>valproate sodium</i> SOLN 250mg/5ml	3	
<i>valproic acid</i> CAPS 250mg	3	
VALTOCO LIQD 5mg/0.1ml, 10mg/0.1ml; LQPK 7.5mg/0.1ml, 10mg/0.1ml	4	
<i>vigabatrin</i> PACK 500mg QL (180 packets / 30 days)	5	QL LA PA
<i>vigabatrin</i> TABS 500mg QL (180 tabs / 30 days)	5	QL LA PA
<i>vigadrone</i> PACK 500mg QL (180 packets / 30 days)	5	QL LA PA
VIMPAT SOLN 10mg/ml QL (1200 mL / 30 days)	5	QL
XCOPRI TABS 50mg, 100mg QL (30 tabs / 30 days)	5	QL
XCOPRI TABS 150mg, 200mg QL (60 tabs / 30 days)	5	QL
XCOPRI PAK 12.5-25 QL (28 tabs / 28 days)	4	QL
XCOPRI PAK 50-100MG QL (28 tabs / 28 days)	5	QL
XCOPRI PAK 100-150 QL (56 tabs / 28 days)	5	QL
XCOPRI PAK 150-200MG (MAINTENANCE) QL (56 tabs / 28 days)	5	QL
XCOPRI PAK 150-200MG (TITRATION) QL (28 tabs / 28 days)	5	QL

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **B/D** - Prior Authorization, Part D vs. Part B only **LA** - Limited Availability **ED** - Excluded Drug **GC** - Gap Coverage . **SI** - Select Insulins. Does not apply to AvMed Medicare Premium Saver Broward County (HMO)

30

All Tier 1 and Tier 2 generics are covered in the Gap Coverage.

Drug Name	Drug Requirements/ Tier	Limits
ZONISADE SUSP 100mg/5ml QL (900 mL / 30 days)	4	QL PA
zonisamide CAPS 25mg, 50mg, 100mg	2	GC
ZTALMY SUSP 50mg/ml QL (1100 mL / 30 days)	5	QL LA PA
ANTIDEMENTIA		
donepezil hydrochloride TABS 5mg; TBDP 5mg QL (30 tabs / 30 days)	2	GC QL
donepezil hydrochloride TABS 10mg; TBDP 10mg	2	GC
galantamine hydrobromide CP24 8mg, 16mg, 24mg QL (30 caps / 30 days)	3	QL
galantamine hydrobromide SOLN 4mg/ml	4	
galantamine hydrobromide TABS 4mg, 8mg, 12mg QL (60 tabs / 30 days)	3	QL
memantine hcl CP24 7mg, 14mg, 21mg, 28mg; SOLN 2mg/ml PA if < 30 yrs	4	PA
memantine hcl TABS 5mg, 10mg PA if < 30 yrs	3	PA
NAMZARIC CAP 7-10MG	4	
NAMZARIC CAP 14-10MG	4	
NAMZARIC CAP 21-10MG	4	
NAMZARIC CAP 28-10MG	4	
NAMZARIC CAP PACK	4	
rivastigmine PT24 4.6mg/24hr, 9.5mg/24hr, 13.3mg/24hr QL (30 patches / 30 days)	4	QL
rivastigmine tartrate CAPS 1.5mg, 3mg, 4.5mg, 6mg QL (60 caps / 30 days)	3	QL
ANTIDEPRESSANTS		
amitriptyline hcl TABS 10mg, 25mg, 50mg, 75mg, 100mg, 150mg	3	

Drug Name	Drug Requirements/ Tier	Limits
amoxapine TABS 25mg, 50mg, 100mg, 150mg	3	
AUVELITY TAB 45-105MG QL (60 tabs / 30 days)	4	QL PA
bupropion hcl TABS 75mg, 100mg; TB12 100mg, 150mg, 200mg; TB24 150mg, 300mg	3	
citalopram hydrobromide SOLN 10mg/5ml	3	
citalopram hydrobromide TABS 10mg, 20mg, 40mg	1	GC
clomipramine hcl CAPS 25mg, 50mg, 75mg	4	PA
desipramine hcl TABS 10mg, 25mg, 50mg, 75mg, 100mg, 150mg	4	
desvenlafaxine succinate TB24 25mg, 50mg, 100mg QL (30 tabs / 30 days)	4	QL PA
doxepin hcl CAPS 10mg, 25mg, 50mg, 75mg, 100mg; CONC 10mg/ml	3	
doxepin hcl CAPS 150mg	4	
DRIZALMA SPRINKLE CSDR 20mg, 30mg, 40mg, 60mg QL (60 caps / 30 days)	4	QL PA
duloxetine hcl CPEP 20mg, 30mg, 60mg QL (60 caps / 30 days)	3	QL
duloxetine hcl CPEP 40mg QL (60 caps / 30 days)	4	QL
EMSAM PT24 6mg/24hr, 9mg/24hr, 12mg/24hr QL (30 patches / 30 days)	5	QL PA
escitalopram oxalate SOLN 5mg/5ml	4	
escitalopram oxalate TABS 5mg, 10mg, 20mg	1	GC
FETZIMA CP24 20mg, 40mg QL (60 caps / 30 days)	4	QL PA
FETZIMA CP24 80mg, 120mg QL (30 caps / 30 days)	4	QL PA
FETZIMA CAP TITRATIO	4	PA

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **B/D** - Prior Authorization, Part D vs. Part B only **LA** - Limited Availability **ED** - Excluded Drug **GC** - Gap Coverage . **SI** - Select Insulins. Does not apply to AvMed Medicare Premium Saver Broward County (HMO)

31

All Tier 1 and Tier 2 generics are covered in the Gap Coverage.

Drug Name	Drug Requirements/ Tier	Limits
<i>fluoxetine hcl</i> CAPS 10mg, 20mg	1	GC
<i>fluoxetine hcl</i> CAPS 40mg	2	GC
<i>fluoxetine hcl</i> SOLN 20mg/5ml	3	
<i>imipramine hcl</i> TABS 10mg, 25mg, 50mg	2	GC
MARPLAN TABS 10mg QL (180 tabs / 30 days)	4	QL
<i>mirtazapine</i> TABS 7.5mg; TBDP 15mg, 30mg, 45mg	3	
<i>mirtazapine</i> TABS 15mg, 30mg, 45mg	2	GC
<i>nefazodone hcl</i> TABS 50mg, 100mg, 150mg, 200mg, 250mg	4	
<i>nortriptyline hcl</i> CAPS 10mg, 25mg, 50mg, 75mg	2	GC
<i>nortriptyline hcl</i> SOLN 10mg/5ml	4	
<i>paroxetine hcl</i> SUSP 10mg/5ml QL (900 mL / 30 days)	4	QL PA
<i>paroxetine hcl</i> TABS 10mg, 20mg, 30mg, 40mg	2	GC
<i>paroxetine hcl</i> TB24 12.5mg, 25mg, 37.5mg QL (60 tabs / 30 days)	4	QL
<i>phenelzine sulfate</i> TABS 15mg	3	
<i>protriptyline hcl</i> TABS 5mg, 10mg	4	
<i>sertraline hcl</i> CONC 20mg/ml	3	
<i>sertraline hcl</i> TABS 25mg, 50mg, 100mg	1	GC
<i>tranylcypromine sulfate</i> TABS 10mg	4	
<i>trazodone hcl</i> TABS 50mg, 100mg, 150mg	1	GC
<i>trimipramine maleate</i> CAPS 25mg, 50mg QL (120 caps / 30 days)	4	QL
<i>trimipramine maleate</i> CAPS 100mg QL (60 caps / 30 days)	4	QL

Drug Name	Drug Requirements/ Tier	Limits
TRINTELLIX TABS 5mg, 10mg, 20mg QL (30 tabs / 30 days)	4	QL
<i>venlafaxine hcl</i> CP24 37.5mg, 75mg, 150mg	2	GC
<i>venlafaxine hcl</i> TABS 25mg, 37.5mg, 50mg, 75mg, 100mg	3	
VIIBRYD KIT STARTER	4	
<i>vilazodone hcl</i> TABS 10mg, 20mg, 40mg QL (30 tabs / 30 days)	4	QL
ANTIPARKINSONIAN AGENTS		
<i>amantadine hcl</i> CAPS 100mg QL (120 caps / 30 days)	3	QL
<i>amantadine hcl</i> SOLN 50mg/5ml	3	
<i>amantadine hcl</i> TABS 100mg	4	
<i>benztropine mesylate</i> SOLN 1mg/ml	4	
<i>benztropine mesylate</i> TABS .5mg, 1mg, 2mg PA if 70 years and older	3	PA
<i>bromocriptine mesylate</i> CAPS 5mg; TABS 2.5mg	4	
<i>carb/levo orally disintegrating tab</i> 10-100mg	4	
<i>carb/levo orally disintegrating tab</i> 25-100mg	4	
<i>carb/levo orally disintegrating tab</i> 25-250mg	4	
<i>carbidopa</i> TABS 25mg	4	
<i>carbidopa & levodopa tab</i> 10-100 mg	2	GC
<i>carbidopa & levodopa tab</i> 25-100 mg	2	GC
<i>carbidopa & levodopa tab</i> 25-250 mg	2	GC
<i>carbidopa & levodopa tab er</i> 25-100 mg	3	
<i>carbidopa & levodopa tab er</i> 50-200 mg	3	
<i>carbidopa-levodopa-entacapone tabs</i> 12.5-50-200 mg	4	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **B/D** - Prior Authorization, Part D vs. Part B only **LA** - Limited Availability **ED** - Excluded Drug **GC** - Gap Coverage . **SI** - Select Insulins. Does not apply to AvMed Medicare Premium Saver Broward County (HMO)

32

All Tier 1 and Tier 2 generics are covered in the Gap Coverage.

Drug Name	Drug Requirements/ Tier	Limits
<i>carbidopa-levodopa-entacapone tabs 18.75-75-200 mg</i>	4	
<i>carbidopa-levodopa-entacapone tabs 25-100-200 mg</i>	4	
<i>carbidopa-levodopa-entacapone tabs 31.25-125-200 mg</i>	4	
<i>carbidopa-levodopa-entacapone tabs 37.5-150-200 mg</i>	4	
<i>carbidopa-levodopa-entacapone tabs 50-200-200 mg</i>	4	
<i>entacapone TABS 200mg</i>	4	
KYNMOBI FILM 10mg, 15mg, 20mg, 25mg, 30mg QL (150 films / 30 days)	5	QL PA
NEUPRO PT24 1mg/24hr, 2mg/24hr, 3mg/24hr, 4mg/24hr, 6mg/24hr, 8mg/24hr	4	
<i>pramipexole dihydrochloride TABS .125mg, .25mg, .5mg, .75mg, 1mg, 1.5mg</i>	2	GC
<i>pramipexole dihydrochloride TB24 .375mg, .75mg, 1.5mg, 2.25mg, 3mg, 3.75mg, 4.5mg</i>	4	
<i>rasagiline mesylate TABS .5mg, 1mg</i> QL (30 tabs / 30 days)	4	QL
<i>ropinirole hydrochloride TABS .25mg, .5mg, 1mg, 2mg, 3mg, 4mg, 5mg</i>	2	GC
<i>ropinirole hydrochloride TB24 2mg, 4mg, 6mg, 8mg, 12mg</i>	4	
<i>selegiline hcl CAPS 5mg; TABS 5mg</i>	3	
<i>trihexyphenidyl hcl SOLN .4mg/ml; TABS 2mg, 5mg</i> PA if 70 years and older	3	PA
ANTIPSYCHOTICS		
ABILIFY MAINTENA PRSY 300mg, 400mg QL (1 syringe / 28 days)	5	QL

Drug Name	Drug Requirements/ Tier	Limits
ABILIFY MAINTENA SRER 300mg, 400mg QL (1 injection / 28 days)	5	QL
<i>aripiprazole SOLN 1mg/ml</i> QL (900 mL / 30 days)	4	QL
<i>aripiprazole TABS 2mg, 5mg, 10mg, 15mg, 20mg, 30mg</i> QL (30 tabs / 30 days)	4	QL
<i>aripiprazole TBDP 10mg, 15mg</i> QL (60 tabs / 30 days)	5	QL
ARISTADA PRSY 441mg/1.6ml, 662mg/2.4ml, 882mg/3.2ml QL (1 syringe / 28 days)	5	QL
ARISTADA PRSY 1064mg/3.9ml QL (1 syringe / 56 days)	5	QL
ARISTADA INITIO PRSY 675mg/2.4ml	5	
<i>asenapine maleate SUBL 2.5mg, 5mg, 10mg</i> QL (60 tabs / 30 days)	4	QL
CAPLYTA CAPS 10.5mg, 21mg, 42mg QL (30 caps / 30 days)	4	QL PA
<i>chlorpromazine hcl SOLN 25mg/ml, 50mg/2ml; TABS 10mg, 25mg, 50mg, 100mg, 200mg</i>	4	
CHLORPROMAZINE HYDROCHLOR CONC 30mg/ml, 100mg/ml	4	
<i>clozapine TABS 25mg, 50mg</i>	3	
<i>clozapine TABS 100mg</i> QL (270 tabs / 30 days)	4	QL
<i>clozapine TABS 200mg</i> QL (120 tabs / 30 days)	4	QL
<i>clozapine TBDP 12.5mg, 25mg</i>	4	PA
<i>clozapine TBDP 100mg</i> QL (270 tabs / 30 days)	4	QL PA
<i>clozapine TBDP 150mg</i> QL (180 tabs / 30 days)	4	QL PA

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **B/D** - Prior Authorization, Part D vs. Part B only **LA** - Limited Availability **ED** - Excluded Drug **GC** - Gap Coverage . **SI** - Select Insulins. Does not apply to AvMed Medicare Premium Saver Broward County (HMO)

All Tier 1 and Tier 2 generics are covered in the Gap Coverage.

Drug Name	Drug Requirements/ Tier	Limits
<i>clozapine</i> TBDP 200mg QL (120 tabs / 30 days)	5	QL PA
FANAPT TABS 1mg, 2mg, 4mg, 6mg, 8mg, 10mg, 12mg QL (60 tabs / 30 days)	4	QL PA
FANAPT PAK	4	PA
<i>fluphenazine decanoate</i> SOLN 25mg/ml	4	
<i>fluphenazine hcl</i> CONC 5mg/ml; ELIX 2.5mg/5ml; SOLN 2.5mg/ml; TABS 1mg, 2.5mg, 5mg, 10mg	4	
<i>haloperidol</i> TABS .5mg, 1mg, 2mg, 5mg, 10mg, 20mg	3	
<i>haloperidol decanoate</i> SOLN 50mg/ml, 100mg/ml	3	
<i>haloperidol lactate</i> CONC 2mg/ml; SOLN 5mg/ml	3	
INVEGA HAFYERA SUSY 1092mg/3.5ml, 1560mg/5ml QL (1 injection / 180 days)	5	QL
INVEGA SUSTENNA SUSY 39mg/0.25ml QL (1 syringe / 28 days)	4	QL
INVEGA SUSTENNA SUSY 78mg/0.5ml, 117mg/0.75ml, 156mg/ml, 234mg/1.5ml QL (1 syringe / 28 days)	5	QL
INVEGA TRINZA SUSY 273mg/0.88ml, 410mg/1.32ml, 546mg/1.75ml, 819mg/2.63ml QL (1 syringe / 90 days)	5	QL
LATUDA TABS 20mg, 40mg, 60mg, 120mg QL (30 tabs / 30 days)	4	QL
LATUDA TABS 80mg QL (60 tabs / 30 days)	4	QL
<i>loxapine succinate</i> CAPS 5mg, 10mg, 25mg, 50mg	3	
<i>molindone hcl</i> TABS 5mg, 10mg, 25mg	4	
NUPLAZID CAPS 34mg QL (30 caps / 30 days)	4	QL LA PA
NUPLAZID TABS 10mg QL (30 tabs / 30 days)	4	QL LA PA

Drug Name	Drug Requirements/ Tier	Limits
<i>olanzapine</i> SOLR 10mg QL (3 vials / 1 day)	4	QL
<i>olanzapine</i> TABS 2.5mg, 5mg, 10mg QL (60 tabs / 30 days)	3	QL
<i>olanzapine</i> TABS 7.5mg, 15mg, 20mg QL (30 tabs / 30 days)	3	QL
<i>olanzapine</i> TBDP 5mg, 15mg, 20mg QL (30 tabs / 30 days)	4	QL
<i>olanzapine</i> TBDP 10mg QL (60 tabs / 30 days)	4	QL
<i>paliperidone</i> TB24 1.5mg, 3mg, 9mg QL (30 tabs / 30 days)	4	QL
<i>paliperidone</i> TB24 6mg QL (60 tabs / 30 days)	4	QL
<i>perphenazine</i> TABS 2mg, 4mg, 8mg, 16mg	3	
PERSERIS PRSY 90mg, 120mg QL (1 syringe / 30 days)	5	QL
<i>pimozide</i> TABS 1mg, 2mg	4	
<i>quetiapine fumarate</i> TABS 25mg, 50mg, 100mg, 150mg, 200mg, 300mg, 400mg	3	
<i>quetiapine fumarate</i> TB24 50mg, 300mg, 400mg QL (60 tabs / 30 days)	4	QL PA
<i>quetiapine fumarate</i> TB24 150mg, 200mg QL (30 tabs / 30 days)	4	QL PA
REXULTI TABS 3mg, 4mg QL (30 tabs / 30 days)	4	QL
REXULTI TABS .25mg, .5mg, 1mg, 2mg QL (60 tabs / 30 days)	4	QL
RISPERDAL CONSTA SRER 12.5mg, 25mg QL (2 injections / 28 days)	4	QL
RISPERDAL CONSTA SRER 37.5mg, 50mg QL (2 injections / 28 days)	5	QL

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **B/D** - Prior Authorization, Part D vs. Part B only **LA** - Limited Availability **ED** - Excluded Drug **GC** - Gap Coverage . **SI** - Select Insulins. Does not apply to AvMed Medicare Premium Saver Broward County (HMO)

34

All Tier 1 and Tier 2 generics are covered in the Gap Coverage.

Drug Name	Drug Requirements/ Tier	Limits
<i>risperidone</i> SOLN 1mg/ml QL (240 mL / 30 days)	3	QL
<i>risperidone</i> TABS .25mg, .5mg, 1mg, 2mg, 3mg, 4mg	2	GC
<i>risperidone</i> TBDP 1mg, 2mg, 3mg QL (60 tabs / 30 days)	4	QL
<i>risperidone</i> TBDP 4mg QL (120 tabs / 30 days)	4	QL
<i>risperidone</i> TBDP .25mg, .5mg QL (90 tabs / 30 days)	4	QL
SECUADO PT24 3.8mg/24hr, 5.7mg/24hr, 7.6mg/24hr QL (30 patches / 30 days)	4	QL
<i>thioridazine hcl</i> TABS 10mg, 25mg, 50mg, 100mg	3	
<i>thiothixene</i> CAPS 1mg, 2mg, 5mg, 10mg	4	
<i>trifluoperazine hcl</i> TABS 1mg, 3 2mg, 5mg, 10mg	3	
VERSACLOZ SUSP 50mg/ml QL (600 mL / 30 days)	4	QL PA
VRAYLAR CAPS 1.5mg QL (60 caps / 30 days)	4	QL
VRAYLAR CAPS 3mg, 4.5mg, 6mg QL (30 caps / 30 days)	4	QL
VRAYLAR CAP 1.5-3MG	4	
<i>ziprasidone hcl</i> CAPS 20mg, 40mg, 60mg, 80mg QL (60 caps / 30 days)	4	QL
<i>ziprasidone mesylate</i> SOLR 20mg QL (6 injections / 3 days)	4	QL
ZYPREXA RELPREVV SUSR 210mg QL (2 vials / 28 days)	4	QL PA
ZYPREXA RELPREVV SUSR 300mg QL (2 vials / 28 days)	5	QL PA
ZYPREXA RELPREVV SUSR 405mg QL (1 vial / 28 days)	5	QL PA

Drug Name	Drug Requirements/ Tier	Limits
ATTENTION DEFICIT HYPERACTIVITY DISORDER		
<i>amphetamine- dextroamphetamine cap er</i> 24hr 5 mg QL (30 caps / 30 days)	4	QL PA
<i>amphetamine- dextroamphetamine cap er</i> 24hr 10 mg QL (30 caps / 30 days)	4	QL PA
<i>amphetamine- dextroamphetamine cap er</i> 24hr 15 mg QL (30 caps / 30 days)	4	QL PA
<i>amphetamine- dextroamphetamine cap er</i> 24hr 20 mg QL (30 caps / 30 days)	4	QL PA
<i>amphetamine- dextroamphetamine cap er</i> 24hr 25 mg QL (30 caps / 30 days)	4	QL PA
<i>amphetamine- dextroamphetamine cap er</i> 24hr 30 mg QL (30 caps / 30 days)	4	QL PA
<i>amphetamine- dextroamphetamine tab 5 mg</i> QL (60 tabs / 30 days)	3	QL PA
<i>amphetamine- dextroamphetamine tab 7.5 mg</i> QL (60 tabs / 30 days)	3	QL PA
<i>amphetamine- dextroamphetamine tab 10 mg</i> QL (60 tabs / 30 days)	3	QL PA
<i>amphetamine- dextroamphetamine tab 12.5 mg</i> QL (60 tabs / 30 days)	3	QL PA
<i>amphetamine- dextroamphetamine tab 15 mg</i> QL (60 tabs / 30 days)	3	QL PA

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **B/D** - Prior Authorization, Part D vs. Part B only **LA** - Limited Availability **ED** - Excluded Drug **GC** - Gap Coverage . **SI** - Select Insulins. Does not apply to AvMed Medicare Premium Saver Broward County (HMO)

All Tier 1 and Tier 2 generics are covered in the Gap Coverage.

Drug Name	Drug Requirements/ Tier	Limits
<i>amphetamine-dextroamphetamine tab 20 mg</i> QL (90 tabs / 30 days)	3	QL PA
<i>amphetamine-dextroamphetamine tab 30 mg</i> QL (60 tabs / 30 days)	3	QL PA
<i>atomoxetine hcl CAPS 10mg, 18mg, 25mg</i> QL (120 caps / 30 days)	4	QL
<i>atomoxetine hcl CAPS 40mg</i> QL (60 caps / 30 days)	4	QL
<i>atomoxetine hcl CAPS 60mg, 80mg, 100mg</i> QL (30 caps / 30 days)	4	QL
<i>dexmethylphenidate hcl TABS 2.5mg, 5mg</i> QL (120 tabs / 30 days)	3	QL PA
<i>dexmethylphenidate hcl TABS 10mg</i> QL (60 tabs / 30 days)	3	QL PA
<i>guanfacine hcl (adhd) TB24 1mg, 2mg, 4mg</i> QL (30 tabs / 30 days) PA if 70 years and older	3	QL PA
<i>guanfacine hcl (adhd) TB24 3mg</i> QL (60 tabs / 30 days) PA if 70 years and older	3	QL PA
<i>metadate er TBCR 20mg</i> QL (90 tabs / 30 days)	4	QL PA
<i>methylphenidate hcl CHEW 2.5mg, 5mg, 10mg</i> QL (180 tabs / 30 days)	4	QL PA
<i>methylphenidate hcl SOLN 5mg/5ml</i> QL (1800 mL / 30 days)	4	QL PA
<i>methylphenidate hcl SOLN 10mg/5ml</i> QL (900 mL / 30 days)	4	QL PA
<i>methylphenidate hcl TABS 5mg, 10mg</i> QL (180 tabs / 30 days)	3	QL PA

Drug Name	Drug Requirements/ Tier	Limits
<i>methylphenidate hcl TABS 20mg</i> QL (90 tabs / 30 days)	3	QL PA
<i>methylphenidate hcl TBCR 10mg, 20mg</i> QL (90 tabs / 30 days)	4	QL PA
<i>VYVANSE CAPS 10mg, 20mg, 30mg</i> QL (60 caps / 30 days)	4	QL PA
<i>VYVANSE CAPS 40mg, 50mg, 60mg, 70mg</i> QL (30 caps / 30 days)	4	QL PA
<i>VYVANSE CHEW 10mg, 20mg, 30mg</i> QL (60 tabs / 30 days)	4	QL PA
<i>VYVANSE CHEW 40mg, 50mg, 60mg</i> QL (30 tabs / 30 days)	4	QL PA
HYPNOTICS		
<i>BELSOMRA TABS 5mg, 10mg, 15mg, 20mg</i> QL (30 tabs / 30 days)	4	QL
<i>doxepin hcl (sleep) TABS 3mg, 6mg</i> QL (30 tabs / 30 days)	3	QL
<i>HETLIOZ CAPS 20mg</i> QL (30 caps / 30 days)	5	QL LA PA
<i>tasimelteon CAPS 20mg</i> QL (30 caps / 30 days)	5	QL PA
<i>temazepam CAPS 7.5mg, 30mg</i> QL (30 caps / 30 days) PA if 65 years and older	4	QL PA
<i>temazepam CAPS 15mg</i> QL (60 caps / 30 days) PA if 65 years and older	4	QL PA
<i>zolpidem tartrate TABS 5mg, 10mg</i> QL (30 tabs / 30 days) PA applies if 70 years and older after a 90 day supply in a calendar year	2	GC QL PA
MIGRAINE		
<i>AIMOVIG SOAJ 70mg/ml, 140mg/ml</i> QL (1 pen / 30 days)	3	QL PA

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **B/D** - Prior Authorization, Part D vs. Part B only **LA** - Limited Availability **ED** - Excluded Drug **GC** - Gap Coverage . **SI** - Select Insulins. Does not apply to AvMed Medicare Premium Saver Broward County (HMO)

36

All Tier 1 and Tier 2 generics are covered in the Gap Coverage.

Drug Name	Drug Requirements/ Tier	Limits
<i>dihydroergotamine mesylate</i> SOLN 1mg/ml	5	
<i>dihydroergotamine mesylate</i> SOLN 4mg/ml QL (8 mL / 30 days)	5	QL PA
<i>ergotamine w/ caffeine tab 1-100 mg</i> QL (40 tabs / 28 days)	3	QL PA
<i>naratriptan hcl</i> TABS 1mg, 2.5mg QL (12 tabs / 30 days)	3	QL
<i>NURTEC</i> TBDP 75mg QL (16 tabs / 30 days)	3	QL PA
<i>rizatriptan benzoate</i> TABS 5mg, 10mg; TBDP 5mg, 10mg QL (18 tabs / 30 days)	3	QL
<i>sumatriptan</i> SOLN 5mg/act QL (24 units / 30 days)	4	QL
<i>sumatriptan</i> SOLN 20mg/act QL (12 units / 30 days)	4	QL
<i>sumatriptan succinate</i> SOAJ 4mg/0.5ml; SOCT 4mg/0.5ml QL (18 injections / 30 days)	4	QL
<i>sumatriptan succinate</i> SOAJ 6mg/0.5ml; SOCT 6mg/0.5ml; SOLN 6mg/0.5ml QL (12 injections / 30 days)	4	QL
<i>sumatriptan succinate</i> TABS 25mg, 50mg, 100mg QL (12 tabs / 30 days)	2	GC QL
<i>zolmitriptan</i> TABS 2.5mg, 5mg; TBDP 2.5mg, 5mg QL (12 tabs / 30 days)	4	QL
MISCELLANEOUS		
<i>AUSTEDO</i> TABS 6mg QL (60 tabs / 30 days)	5	QL LA PA
<i>AUSTEDO</i> TABS 9mg, 12mg QL (120 tabs / 30 days)	5	QL LA PA
<i>GRALISE</i> TABS 300mg QL (180 tabs / 30 days)	4	QL PA
<i>GRALISE</i> TABS 600mg QL (90 tabs / 30 days)	4	QL PA

Drug Name	Drug Requirements/ Tier	Limits
<i>INGREZZA</i> CAPS 40mg, 60mg, 80mg QL (30 caps / 30 days)	5	QL LA PA
<i>INGREZZA</i> CAP 40-80MG QL (28 caps / 28 days)	5	QL LA PA
<i>lithium carbonate</i> CAPS 150mg, 300mg, 600mg	1	GC
<i>lithium carbonate</i> TABS 300mg; TBCR 300mg, 450mg	2	GC
<i>NUDEXTA</i> CAP 20-10MG QL (60 caps / 30 days)	4	QL PA
<i>pyridostigmine bromide</i> TABS 60mg	3	
<i>riluzole</i> TABS 50mg	4	
<i>SAVELLA</i> TABS 12.5mg, 25mg, 50mg, 100mg QL (60 tabs / 30 days)	4	QL PA
<i>SAVELLA</i> MIS TITR PAK	4	PA
<i>tetrabenazine</i> TABS 12.5mg QL (90 tabs / 30 days)	5	QL PA
<i>tetrabenazine</i> TABS 25mg QL (120 tabs / 30 days)	5	QL PA
MULTIPLE SCLEROSIS AGENTS		
<i>BAFIERTAM</i> CPDR 95mg QL (120 caps / 30 days)	5	QL LA PA
<i>BETASERON</i> KIT .3mg QL (14 syringes / 28 days)	5	QL PA
<i>dalfampridine</i> TB12 10mg	3	PA
<i> fingolimod hcl</i> CAPS .5mg QL (28 caps / 28 days)	5	QL PA
<i>GILENYA</i> CAPS .5mg QL (28 caps / 28 days)	5	QL PA
<i>glatiramer acetate</i> SOSY 20mg/ml QL (30 syringes / 30 days)	5	QL PA
<i>glatiramer acetate</i> SOSY 40mg/ml QL (12 syringes / 28 days)	5	QL PA
<i>glatopa</i> SOSY 20mg/ml QL (30 syringes / 30 days)	5	QL PA

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **B/D** - Prior Authorization, Part D vs. Part B only **LA** - Limited Availability **ED** - Excluded Drug **GC** - Gap Coverage . **SI** - Select Insulins. Does not apply to AvMed Medicare Premium Saver Broward County (HMO)

37

All Tier 1 and Tier 2 generics are covered in the Gap Coverage.

Drug Name	Drug Requirements/ Tier	Limits
<i>glatopa</i> SOSY 40mg/ml QL (12 syringes / 28 days)	5	QL PA
KESIMPTA SOAJ 20mg/0.4ml QL (16 pens / year)	5	QL LA PA
MUSCULOSKELETAL THERAPY AGENTS		
<i>baclofen</i> TABS 5mg, 10mg, 20mg	3	
<i>cyclobenzaprine hcl</i> TABS 5mg, 10mg PA if 70 years and older	3	PA
<i>dantrolene sodium</i> CAPS 25mg, 50mg, 100mg	4	
<i>tizanidine hcl</i> TABS 2mg, 4mg	2	GC
NARCOLEPSY/CATAPLEXY		
<i>armodafinil</i> TABS 50mg QL (60 tabs / 30 days)	3	QL PA
<i>armodafinil</i> TABS 150mg, 200mg, 250mg QL (30 tabs / 30 days)	3	QL PA
<i>modafinil</i> TABS 100mg QL (30 tabs / 30 days)	4	QL PA
<i>modafinil</i> TABS 200mg QL (60 tabs / 30 days)	4	QL PA
XYREM SOLN 500mg/ml QL (540 mL / 30 days)	5	QL LA PA
PSYCHOTHERAPEUTIC-MISC		
<i>acamprosate calcium</i> TBEC 333mg	4	
<i>buprenorphine hcl</i> SUBL 2mg, 8mg QL (90 tabs / 30 days)	3	QL PA
<i>buprenorphine hcl-naloxone hcl sl film</i> 2-0.5 mg (base equiv) QL (90 films / 30 days)	4	QL
<i>buprenorphine hcl-naloxone hcl sl film</i> 4-1 mg (base equiv) QL (90 films / 30 days)	4	QL
<i>buprenorphine hcl-naloxone hcl sl film</i> 8-2 mg (base equiv) QL (90 films / 30 days)	4	QL

Drug Name	Drug Requirements/ Tier	Limits
<i>buprenorphine hcl-naloxone hcl sl film</i> 12-3 mg (base equiv) QL (60 films / 30 days)	4	QL
<i>buprenorphine hcl-naloxone hcl sl tab</i> 2-0.5 mg (base equiv) QL (90 tabs / 30 days)	2	GC QL
<i>buprenorphine hcl-naloxone hcl sl tab</i> 8-2 mg (base equiv) QL (90 tabs / 30 days)	2	GC QL
<i>bupropion hcl</i> (smoking deterrent) TB12 150mg	3	
<i>disulfiram</i> TABS 250mg, 500mg	3	
<i>naloxone hcl</i> LIQD 4mg/0.1ml	3	
<i>naloxone hcl</i> SOCT .4mg/ml; SOLN .4mg/ml, 4mg/10ml; SOSY 2mg/2ml	2	GC
<i>naltrexone hcl</i> TABS 50mg	3	
NICOTROL INHALER INHA 10mg	4	
NICOTROL NS SOLN 10mg/ml	4	
<i>varenicline tartrate</i> TABS .5mg, 1mg QL (56 tabs / 28 days)	4	QL PA
<i>varenicline tartrate tab</i> 11 x 0.5 mg & 42 x 1 mg start pack	4	PA
VIVITROL SUSR 380mg	5	
ENDOCRINE AND METABOLIC ANDROGENS		
<i>oxandrolone</i> TABS 2.5mg QL (120 tabs / 30 days)	3	QL PA
<i>oxandrolone</i> TABS 10mg QL (60 tabs / 30 days)	4	QL PA
<i>testosterone</i> GEL 1%, 25mg/2.5gm, 50mg/5gm QL (300 gm / 30 days)	4	QL PA
<i>testosterone</i> GEL 1.62% QL (150 gm / 30 days)	4	QL PA
<i>testosterone cypionate</i> SOLN 100mg/ml, 200mg/ml	3	PA
<i>testosterone enanthate</i> SOLN 200mg/ml	3	PA

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **B/D** - Prior Authorization, Part D vs. Part B only **LA** - Limited Availability **ED** - Excluded Drug **GC** - Gap Coverage . **SI** - Select Insulins. Does not apply to AvMed Medicare Premium Saver Broward County (HMO)

38

All Tier 1 and Tier 2 generics are covered in the Gap Coverage.

Drug Name	Drug Requirements/ Tier	Limits
ANTIDIABETICS		
<i>acarbose</i> TABS 25mg, 50mg, 100mg	3	QL
BYDUREON BCISE AUIJ 2mg/0.85ml QL (4 pens / 28 days)	3	QL
BYETTA SOPN 5mcg/0.02ml, 10mcg/0.04ml QL (1 pen / 30 days)	4	QL
FARXIGA TABS 5mg, 10mg QL (30 tabs / 30 days)	3	QL
<i>glimepiride</i> TABS 1mg, 2mg QL (90 tabs / 30 days)	1	GC QL
<i>glimepiride</i> TABS 4mg QL (60 tabs / 30 days)	1	GC QL
<i>glipizide</i> TABS 5mg QL (240 tabs / 30 days)	1	GC QL
<i>glipizide</i> TABS 10mg QL (120 tabs / 30 days)	1	GC QL
<i>glipizide</i> TB24 2.5mg, 5mg QL (90 tabs / 30 days)	1	GC QL
<i>glipizide</i> TB24 10mg QL (60 tabs / 30 days)	1	GC QL
<i>glipizide xl</i> TB24 2.5mg, 5mg QL (90 tabs / 30 days)	1	GC QL
<i>glipizide xl</i> TB24 10mg QL (60 tabs / 30 days)	1	GC QL
<i>glipizide-metformin hcl tab</i> 2.5-250 mg QL (240 tabs / 30 days)	1	GC QL
<i>glipizide-metformin hcl tab</i> 2.5-500 mg QL (120 tabs / 30 days)	1	GC QL
<i>glipizide-metformin hcl tab</i> 5-500 mg QL (120 tabs / 30 days)	1	GC QL
GLYXAMBI TAB 10-5 MG QL (30 tabs / 30 days)	3	QL
GLYXAMBI TAB 25-5 MG QL (30 tabs / 30 days)	3	QL
JANUMET TAB 50-500MG QL (60 tabs / 30 days)	3	QL
JANUMET TAB 50-1000 QL (60 tabs / 30 days)	3	QL

Drug Name	Drug Requirements/ Tier	Limits
JANUMET XR TAB 50-500MG QL (60 tabs / 30 days)	3	QL
JANUMET XR TAB 50-1000 QL (60 tabs / 30 days)	3	QL
JANUMET XR TAB 100-1000 QL (30 tabs / 30 days)	3	QL
JANUVIA TABS 25mg, 50mg, 100mg QL (30 tabs / 30 days)	3	QL
JARDIANCE TABS 10mg QL (60 tabs / 30 days)	3	QL
JARDIANCE TABS 25mg QL (30 tabs / 30 days)	3	QL
JENTADUETO TAB 2.5-500 QL (60 tabs / 30 days)	3	QL
JENTADUETO TAB 2.5-850 QL (60 tabs / 30 days)	3	QL
JENTADUETO TAB 2.5-1000 QL (60 tabs / 30 days)	3	QL
JENTADUETO TAB XR 2.5-1000MG QL (60 tabs / 30 days)	3	QL
JENTADUETO TAB XR 5-1000MG QL (30 tabs / 30 days)	3	QL
<i>metformin hcl</i> TABS 500mg QL (150 tabs / 30 days)	1	GC QL
<i>metformin hcl</i> TABS 850mg QL (90 tabs / 30 days)	1	GC QL
<i>metformin hcl</i> TABS 1000mg QL (75 tabs / 30 days)	1	GC QL
<i>metformin hcl</i> TB24 500mg QL (120 tabs / 30 days) (generic of GLUCOPHAGE XR)	1	GC QL
<i>metformin hcl</i> TB24 750mg QL (60 tabs / 30 days) (generic of GLUCOPHAGE XR)	1	GC QL
<i>nateglinide</i> TABS 60mg, 120mg QL (90 tabs / 30 days)	1	GC QL

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **B/D** - Prior Authorization, Part D vs. Part B only **LA** - Limited Availability **ED** - Excluded Drug **GC** - Gap Coverage . **SI** - Select Insulins. Does not apply to AvMed Medicare Premium Saver Broward County (HMO)

All Tier 1 and Tier 2 generics are covered in the Gap Coverage.

Drug Name	Drug Requirements/ Tier	Limits
OZEMPIC (0.25 OR 0.5MG/DOSE) SOPN 2mg/1.5ml, 2mg/3ml QL (1 pen / 28 days)	3	QL
OZEMPIC (1MG/DOSE) SOPN 4mg/3ml QL (1 pen / 28 days)	3	QL
OZEMPIC (2MG/DOSE) SOPN 8MG/3ML QL (1 pen / 28 days)	3	QL
<i>pioglitazone hcl</i> TABS 15mg, 30mg, 45mg QL (30 tabs / 30 days)	1	GC QL
<i>repaglinide</i> TABS 2mg QL (240 tabs / 30 days)	1	GC QL
<i>repaglinide</i> TABS .5mg, 1mg QL (120 tabs / 30 days)	1	GC QL
RYBELSUS TABS 3mg, 7mg, 14mg QL (30 tabs / 30 days)	3	QL
SYNJARDY TAB 5-500MG QL (120 tabs / 30 days)	3	QL
SYNJARDY TAB 5-1000MG QL (60 tabs / 30 days)	3	QL
SYNJARDY TAB 12.5-500 QL (60 tabs / 30 days)	3	QL
SYNJARDY TAB 12.5-1000MG QL (60 tabs / 30 days)	3	QL
SYNJARDY XR TAB 5-1000MG QL (60 tabs / 30 days)	3	QL
SYNJARDY XR TAB 10-1000 QL (60 tabs / 30 days)	3	QL
SYNJARDY XR TAB 12.5-1000MG QL (60 tabs / 30 days)	3	QL
SYNJARDY XR TAB 25-1000 QL (30 tabs / 30 days)	3	QL
TRADJENTA TABS 5mg QL (30 tabs / 30 days)	3	QL
TRIJARDY XR TAB ER 24HR 5-2.5-1000MG QL (60 tabs / 30 days)	3	QL

Drug Name	Drug Requirements/ Tier	Limits
TRIJARDY XR TAB ER 24HR 10-5-1000MG QL (30 tabs / 30 days)	3	QL
TRIJARDY XR TAB ER 24HR 12.5-2.5-1000MG QL (60 tabs / 30 days)	3	QL
TRIJARDY XR TAB ER 24HR 25-5-1000MG QL (30 tabs / 30 days)	3	QL
TRULICITY SOPN .75mg/0.5ml, 1.5mg/0.5ml, 3mg/0.5ml, 4.5mg/0.5ml QL (4 pens / 28 days)	3	QL
VICTOZA SOPN 18mg/3ml QL (3 pens / 30 days)	3	QL
XIGDUO XR TAB 2.5-1000 QL (60 tabs / 30 days)	3	QL
XIGDUO XR TAB 5-500MG QL (60 tabs / 30 days)	3	QL
XIGDUO XR TAB 5-1000MG QL (60 tabs / 30 days)	3	QL
XIGDUO XR TAB 10-500MG QL (30 tabs / 30 days)	3	QL
XIGDUO XR TAB 10-1000 QL (30 tabs / 30 days)	3	QL
ANTIDIABETICS, INSULINS		
BASAGLAR KWIKPEN SOPN 100unit/ml SI	3	
BD ALCOHOL SWABS	3	
FIASP FLEX INJ TOUCH SI	3	
FIASP INJ 100/ML SI	3	
FIASP PENFIL INJ U-100 SI	3	
GAUZE PADS 2" X 2"	3	
HUMULIN R U-500 (CONCENTR SOLN 500unit/ml SI	5	B/D
HUMULIN R U-500 KWIKPEN SOPN 500unit/ml SI	5	
INSULIN PEN NEEDLES: BD/NOVO	3	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **B/D** - Prior Authorization, Part D vs. Part B only **LA** - Limited Availability **ED** - Excluded Drug **GC** - Gap Coverage . **SI** - Select Insulins. Does not apply to AvMed Medicare Premium Saver Broward County (HMO)

40

All Tier 1 and Tier 2 generics are covered in the Gap Coverage.

Drug Name	Drug Requirements/ Tier Limits
INSULIN SAFETY NEEDLES	3
INSULIN SYRINGES: BD	3
LANTUS SOLN 100unit/ml SI	3
LANTUS SOLOSTAR SOPN 100unit/ml SI	3
LEVEMIR SOLN 100unit/ml SI	3
LEVEMIR FLEXTOUCH SOPN 100unit/ml SI	3
NOVOLIN INJ 70/30 SI (brand RELION not covered)	3
NOVOLIN INJ 70/30 FP SI (brand RELION not covered)	3
NOVOLIN N SUSP 100unit/ml SI (brand RELION not covered)	3
NOVOLIN N FLEXPEN SUPN 100unit/ml SI (brand RELION not covered)	3
NOVOLIN R SOLN 100unit/ml SI (brand RELION not covered)	3
NOVOLIN R FLEXPEN SOPN 100unit/ml SI (brand RELION not covered)	3
NOVOLOG SOLN 100unit/ml SI (brand RELION not covered)	3
NOVOLOG FLEXPEN SOPN 100unit/ml SI (brand RELION not covered)	3
NOVOLOG MIX INJ 70/30 SI (brand RELION not covered)	3

Drug Name	Drug Requirements/ Tier Limits
NOVOLOG MIX INJ FLEXPEN SI (brand RELION not covered)	3
NOVOLOG PENFILL SOCT 100unit/ml SI (brand RELION not covered)	3
OMNIPOD 5 G6 KIT INTRO QL (1 kit / year)	4 QL PA
OMNIPOD 5 G6 MIS PODS QL (15 pods / 30 days)	4 QL PA
OMNIPOD DASH KIT INTRO QL (1 kit / year)	4 QL PA
OMNIPOD DASH MIS PODS QL (15 pods / 30 days)	4 QL PA
OMNIPOD MIS CLASSIC QL (15 pods / 30 days)	4 QL PA
OMNIPOD PDM KIT CLASSIC QL (1 kit / year)	4 QL PA
SOLIQUA INJ 100/33 QL (5 pens / 25 days) SI	3 QL
TOUJEO MAX SOLOSTAR SOPN 300unit/ml SI	3
TOUJEO SOLOSTAR SOPN 300unit/ml SI	3
TRESIBA SOLN 100unit/ml SI	3
TRESIBA FLEXTOUCH SOPN 100unit/ml, 200unit/ml SI	3
V-GO 20 KIT QL (1 kit / 30 days)	4 QL PA
V-GO 30 KIT QL (1 kit / 30 days)	4 QL PA
V-GO 40 KIT QL (1 kit / 30 days)	4 QL PA
XULTOPHY INJ 100/3.6 QL (5 pens / 30 days) SI	3 QL

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **B/D** - Prior Authorization, Part D vs. Part B only **LA** - Limited Availability **ED** - Excluded Drug **GC** - Gap Coverage . **SI** - Select Insulins. Does not apply to AvMed Medicare Premium Saver Broward County (HMO)

All Tier 1 and Tier 2 generics are covered in the Gap Coverage.

Drug Name	Drug Requirements/ Tier	Limits
CALCIUM REGULATORS		
<i>alendronate sodium</i> SOLN 70mg/75ml	4	
<i>alendronate sodium</i> TABS 10mg, 35mg, 70mg	1	GC
<i>calcitonin (salmon) spray</i> SOLN 200unit/act	3	B/D
FORTEO SOPN 600mcg/2.4ml	5	PA
FOSAMAX + D TAB 70-2800	4	ST
FOSAMAX + D TAB 70-5600	4	ST
<i>ibandronate sodium</i> SOLN 3mg/3ml QL (1 injection / 90 days)	4	B/D QL
<i>ibandronate sodium</i> TABS 150mg	3	B/D
NATPARA CART 25mcg, 50mcg, 75mcg, 100mcg	5	LA PA
PAMIDRONATE DISODIUM SOLN 6mg/ml	3	B/D
<i>pamidronate disodium</i> SOLN 30mg/10ml, 90mg/10ml	3	B/D
PROLIA SOSY 60mg/ml QL (1 syringe / 180 days)	4	QL
<i>risedronate sodium</i> TABS 5mg, 35mg, 150mg	3	
<i>risedronate sodium</i> TABS 30mg; TBEC 35mg	4	
TERIPARATIDE SOPN 620mcg/2.48ml	5	PA
XGEVA SOLN 120mg/1.7ml	5	PA
<i>zoledronic acid</i> CONC 4mg/5ml; SOLN 4mg/100ml, 5mg/100ml	4	B/D
CHELATING AGENTS		
CHEMET CAPS 100mg	4	
<i>deferasirox</i> PACK 90mg, 180mg, 360mg; TABS 180mg, 360mg; TBSO 125mg, 250mg, 500mg	5	PA
<i>deferasirox</i> TABS 90mg	3	PA
LOKELMA PACK 5gm, 10gm	3	
<i>penicillamine</i> TABS 250mg	5	

Drug Name	Drug Requirements/ Tier	Limits
<i>sodium polystyrene sulfonate powder</i>	3	
<i>sps</i> SUSP 15gm/60ml	3	
<i>trientine hcl</i> CAPS 250mg	5	PA
VELTASSA PACK 8.4gm, 16.8gm, 25.2gm	3	
CONTRACEPTIVES		
<i>afirmelle</i>	2	GC
<i>altavera</i>	3	
<i>alyacen 1/35</i>	3	
<i>alyacen 7/7/7</i>	3	
<i>apri</i>	2	GC
<i>aranelle</i>	3	
<i>aubra eq</i>	2	GC
<i>aurovela 1/20</i>	3	
<i>aurovela fe 1.5/30</i>	2	GC
<i>aurovela fe 1/20</i>	2	GC
<i>aviane</i>	2	GC
<i>ayuna</i>	3	
<i>azurette</i>	3	
<i>balziva</i>	3	
<i>blisovi fe 1.5/30</i>	2	GC
<i>briellyn</i>	3	
<i>camila</i> TABS .35mg	2	GC
<i>chateal</i>	3	
<i>cryselle-28</i>	3	
<i>cyred eq</i>	2	GC
<i>dasetta 1/35</i>	3	
<i>dasetta 7/7/7</i>	3	
<i>deblitane</i> TABS .35mg	2	GC
<i>desogest-eth estrad & eth estrad tab 0.15-0.02/0.01 mg(21/5)</i>	3	
<i>desogestrel & ethinyl estradiol tab 0.15 mg-30 mcg</i>	2	GC
<i>drospirenone-ethinyl estradiol tab 3-0.02 mg</i>	3	
<i>drospirenone-ethinyl estradiol tab 3-0.03 mg</i>	3	
<i>elinest</i>	3	
ELLA TABS 30mg	3	
<i>eluryng</i>	4	
<i>emoquette</i>	2	GC
<i>enpresse-28</i>	2	GC

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **B/D** - Prior Authorization, Part D vs. Part B only **LA** - Limited Availability **ED** - Excluded Drug **GC** - Gap Coverage . **SI** - Select Insulins. Does not apply to AvMed Medicare Premium Saver Broward County (HMO)

42

All Tier 1 and Tier 2 generics are covered in the Gap Coverage.

Drug Name	Drug Requirements/ Tier	Limits
enskyce	2	GC
errin TABS .35mg	2	GC
estarylla	2	GC
ethynodiol diacetate & ethinyl estradiol tab 1 mg-35 mcg	2	GC
ethynodiol diacetate & ethinyl estradiol tab 1 mg-50 mcg	3	
etonogestrel-ethinyl estradiol va ring 0.120-0.015 mg/24hr	4	
falmina	2	GC
femynor	2	GC
hailey 1.5/30	3	
heather TABS .35mg	2	GC
iclevia	3	
incassia TABS .35mg	2	GC
introvale	3	
isibloom	2	GC
jasmiel	3	
jolessa	3	
juleber	2	GC
junel 1.5/30	3	
junel 1/20	3	
junel fe 1.5/30	2	GC
junel fe 1/20	2	GC
kariva	3	
kelnor 1/35	2	GC
kelnor 1/50	3	
kurvelo	3	
larin 1.5/30	3	
larin 1/20	3	
larin fe 1.5/30	2	GC
larin fe 1/20	2	GC
leena	3	
lessina	2	GC
levonest	2	GC
levonorgestrel & ethinyl estradiol (91-day) tab 0.15- 0.03 mg	3	
levonorgestrel & ethinyl estradiol tab 0.1 mg-20 mcg	2	GC
levonorgestrel & ethinyl estradiol tab 0.15 mg-30 mcg	3	

Drug Name	Drug Requirements/ Tier	Limits
levonorgestrel-eth estra tab 0.05-30/0.075-40/0.125- 30mg-mcg	2	GC
levora 0.15/30-28	3	
lillow	3	
loestrin 1.5/30-21	3	
loestrin 1/20-21	3	
loestrin fe 1.5/30	2	GC
loestrin fe 1/20	2	GC
loryna	3	
low-ogestrel	3	
luteria	2	GC
lyleq TABS .35mg	2	GC
lyza TABS .35mg	2	GC
marlissa	3	
medroxyprogesterone acetate (contraceptive) SUSP 150mg/ml; SUSY 150mg/ml	3	
microgestin 1.5/30	3	
microgestin 1/20	3	
microgestin fe 1.5/30	2	GC
microgestin fe 1/20	2	GC
mili	2	GC
mono-lynyah	2	GC
necon 0.5/35-28	3	
nikki	3	
nora-be TABS .35mg	2	GC
norethindrone (contraceptive) TABS .35mg	2	GC
norethindrone ac-ethinyl estradiol-fe tab 1-20/1-30/1-35 mg-mcg	4	
norethindrone ace & ethinyl estradiol tab 1 mg-20 mcg	3	
norethindrone ace & ethinyl estradiol tab 1.5 mg-30 mcg	3	
norethindrone ace & ethinyl estradiol-fe tab 1 mg-20 mcg	2	GC
norgestimate & ethinyl estradiol tab 0.25 mg-35 mcg	2	GC
norgestimate-eth estrad tab 0.18-25/0.215-25/0.25-25 mg- mcg	3	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **B/D** - Prior Authorization, Part D vs. Part B only **LA** - Limited Availability **ED** - Excluded Drug **GC** - Gap Coverage . **SI** - Select Insulins. Does not apply to AvMed Medicare Premium Saver Broward County (HMO)

All Tier 1 and Tier 2 generics are covered in the Gap Coverage.

Drug Name	Drug Requirements/ Tier	Limits
<i>norgestimate-eth estrad tab</i> 0.18-35/0.215-35/0.25-35 mg- mcg	3	
<i>norlyroc TABS .35mg</i>	2	GC
<i>nortrel 0.5/35 (28)</i>	3	
<i>nortrel 1/35 (21)</i>	3	
<i>nortrel 1/35 (28)</i>	3	
<i>nortrel 7/7/7</i>	3	
<i>nylia 1/35</i>	3	
<i>nylia 7/7/7</i>	3	
<i>nymyo</i>	2	GC
<i>ocella</i>	3	
<i>philith</i>	3	
<i>pimtrea</i>	3	
<i>pirmella 1/35</i>	3	
<i>portia-28</i>	3	
<i>reclipsen</i>	2	GC
<i>setlakin</i>	3	
<i>sharobel TABS .35mg</i>	2	GC
<i>simliya</i>	3	
<i>sprintec 28</i>	2	GC
<i>sronyx</i>	2	GC
<i>syeda</i>	3	
<i>tarina fe 1/20 eq</i>	2	GC
<i>tilia fe</i>	4	
<i>tri-estarylla</i>	3	
<i>tri-legest fe</i>	4	
<i>tri-lynyah</i>	3	
<i>tri-lo-estarylla</i>	3	
<i>tri-lo-marzia</i>	3	
<i>tri-lo-mili</i>	3	
<i>tri-lo-sprintec</i>	3	
<i>tri-mili</i>	3	
<i>tri-nymyo</i>	3	
<i>tri-sprintec</i>	3	
<i>tri-vylibra</i>	3	
<i>tri-vylibra lo</i>	3	
<i>trivora-28</i>	2	GC
<i>velivet</i>	3	
<i>vestura</i>	3	
<i>vienva</i>	2	GC
<i>viorele</i>	3	

Drug Name	Drug Requirements/ Tier	Limits
<i>vyfemla</i>	3	
<i>vylibra</i>	2	GC
<i>wera</i>	3	
<i>xulane</i>	4	
<i>zafemy</i>	4	
<i>zovia 1/35</i>	2	GC
<i>zumandimine</i>	3	
ENDOMETRIOSIS		
<i>danazol CAPS 50mg, 100mg, 200mg</i>	4	
<i>SYNAREL SOLN 2mg/ml</i>	5	
ESTROGENS		
<i>amabelz</i>	3	
<i>DELESTROGEN OIL 10mg/ml</i>	4	
<i>dotti PTTW .025mg/24hr, .037mg/24hr, .05mg/24hr, .075mg/24hr, .1mg/24hr</i>	3	
<i>estradiol PTTW .025mg/24hr, .037mg/24hr, .05mg/24hr, .075mg/24hr, .1mg/24hr; PTWK .025mg/24hr, .05mg/24hr, .06mg/24hr, .075mg/24hr, .1mg/24hr, 37.5mcg/24hr</i>	3	
<i>estradiol TABS .5mg, 1mg, 2mg</i>	2	GC
<i>estradiol & norethindrone acetate tab 0.5-0.1 mg</i>	3	
<i>estradiol & norethindrone acetate tab 1-0.5 mg</i>	3	
<i>estradiol vaginal CREA .1mg/gm</i>	3	
<i>estradiol vaginal TABS 10mcg</i>	4	
<i>estradiol valerate OIL 20mg/ml, 40mg/ml</i>	4	
<i>fyavolv tab 0.5mg-2.5mcg</i>	3	
<i>fyavolv tab 1mg-5mcg</i>	3	
<i>jinteli</i>	3	
<i>lyllana PTTW .025mg/24hr, .037mg/24hr, .05mg/24hr, .075mg/24hr, .1mg/24hr</i>	3	
<i>mimvey</i>	3	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **B/D** - Prior Authorization, Part D vs. Part B only **LA** - Limited Availability **ED** - Excluded Drug **GC** - Gap Coverage . **SI** - Select Insulins. Does not apply to AvMed Medicare Premium Saver Broward County (HMO)

All Tier 1 and Tier 2 generics are covered in the Gap Coverage.

Drug Name	Drug Requirements/ Tier	Limits
<i>norethindrone acetate-ethinyl estradiol tab 0.5 mg-2.5 mcg</i>	3	
<i>norethindrone acetate-ethinyl estradiol tab 1 mg-5 mcg</i>	3	
<i>yuvaferm TABS 10mcg</i>	4	
GLUCOCORTICOIDS		
<i>dexamethasone ELIX .5mg/5ml; SOLN .5mg/5ml; TABS .5mg, .75mg, 1mg, 1.5mg, 2mg, 4mg, 6mg</i>	3	
<i>DEXAMETHASONE INTENSOL CONC 1mg/ml</i>	4	
<i>dexamethasone sodium phosphate SOLN 4mg/ml, 10mg/ml, 20mg/5ml, 100mg/10ml, 120mg/30ml</i>	3	
<i>fludrocortisone acetate TABS .1mg</i>	2	GC
<i>hydrocortisone TABS 5mg, 10mg, 20mg</i>	3	
<i>methylprednisolone TABS 4mg, 8mg, 16mg, 32mg</i>	3	B/D
<i>methylprednisolone TBPk 4mg</i>	2	GC
<i>methylprednisolone acetate SUSP 40mg/ml, 80mg/ml</i>	3	B/D
<i>methylprednisolone sod succ SOLR 40mg, 125mg, 1000mg</i>	3	B/D
<i>prednisolone SOLN 15mg/5ml</i>	2	GC B/D
<i>prednisolone sodium phosphate SOLN 5mg/5ml</i>	4	B/D
<i>prednisolone sodium phosphate SOLN 15mg/5ml</i>	2	GC B/D
<i>prednisolone sodium phosphate SOLN 25mg/5ml</i>	3	B/D
<i>prednisone SOLN 5mg/5ml</i>	4	B/D
<i>prednisone TABS 1mg, 2.5mg, 5mg, 10mg, 20mg, 50mg</i>	2	GC B/D
<i>prednisone TBPk 5mg, 10mg</i>	3	
<i>PREDNISONE INTENSOL CONC 5mg/ml</i>	4	B/D
<i>SOLU-CORTEF SOLR 100mg, 250mg, 500mg, 1000mg</i>	4	

Drug Name	Drug Requirements/ Tier	Limits
GLUCOSE ELEVATING AGENTS		
<i>diazoxide SUSP 50mg/ml</i>	5	
<i>GVOKE HYPOPEN 2-PACK SOAJ .5mg/0.1ml, 1mg/0.2ml</i>	3	
<i>GVOKE KIT SOLN 1mg/0.2ml</i>	3	
<i>GVOKE PFS SOSY .5mg/0.1ml, 1mg/0.2ml</i>	3	
MISCELLANEOUS		
<i>ALDURAZYME SOLN 2.9mg/5ml</i>	5	LA PA
<i>betaine powder for oral solution</i>	5	LA
<i>cabergoline TABS .5mg</i>	3	
<i>carglumic acid TBSO 200mg</i>	5	LA PA
<i>CERDELGA CAPS 84mg</i>	5	LA PA
<i>CEREZYME SOLR 400unit</i>	5	LA PA
<i>cinacalcet hcl TABS 30mg QL (60 tabs / 30 days)</i>	4	B/D QL
<i>cinacalcet hcl TABS 60mg QL (60 tabs / 30 days)</i>	5	B/D QL
<i>cinacalcet hcl TABS 90mg QL (120 tabs / 30 days)</i>	5	B/D QL
<i>CYSTAGON CAPS 50mg, 150mg</i>	4	LA PA
<i>desmopressin acetate SOLN 4mcg/ml</i>	5	
<i>desmopressin acetate TABS .1mg, .2mg</i>	3	
<i>desmopressin acetate spray SOLN .01%</i>	4	
<i>desmopressin acetate spray refrigerated SOLN .01%</i>	4	
<i>FABRAZYME SOLR 5mg, 35mg</i>	5	LA PA
<i>GENOTROPIN CART 5mg, 12mg</i>	5	PA
<i>GENOTROPIN MINQUICK PRSY .2mg, .4mg, .6mg, .8mg, 1mg, 1.2mg, 1.4mg, 1.6mg, 1.8mg, 2mg</i>	5	PA
<i>INCRELEX SOLN 40mg/4ml</i>	5	LA PA
<i>javygtor PACK 100mg, 500mg; TABS 100mg</i>	5	LA PA
<i>KORLYM TABS 300mg</i>	5	LA PA

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **B/D** - Prior Authorization, Part D vs. Part B only **LA** - Limited Availability **ED** - Excluded Drug **GC** - Gap Coverage . **SI** - Select Insulins. Does not apply to AvMed Medicare Premium Saver Broward County (HMO)

45

All Tier 1 and Tier 2 generics are covered in the Gap Coverage.

Drug Name	Drug Requirements/ Tier	Limits
<i>levocarnitine (metabolic modifiers)</i> SOLN 1gm/10ml; TABS 330mg	4	B/D
LUMIZYME SOLR 50mg	5	LA PA
LUPRON DEPOT-PED (1-MONTH KIT 7.5mg, 11.25mg, 15mg	5	PA
LUPRON DEPOT-PED (3-MONTH KIT 11.25mg, 30mg	5	PA
<i>miglustat</i> CAPS 100mg QL (90 caps / 30 days)	5	QL PA
NAGLAZYME SOLN 1mg/ml	5	LA PA
<i>nitisinone</i> CAPS 2mg, 5mg, 10mg	5	PA
<i>octreotide acetate</i> SOLN 50mcg/ml, 100mcg/ml, 200mcg/ml; SOSY 50mcg/ml, 100mcg/ml	4	PA
<i>octreotide acetate</i> SOLN 500mcg/ml, 1000mcg/ml; SOSY 500mcg/ml	5	PA
<i>raloxifene hcl</i> TABS 60mg	3	
<i>sapropterin dihydrochloride</i> PACK 100mg, 500mg; TABS 100mg	5	PA
SIGNIFOR SOLN .3mg/ml, .6mg/ml, .9mg/ml	5	LA PA
<i>sodium phenylbutyrate</i> POWD 3gm/tsp; TABS 500mg	5	PA
SOMATULINE DEPOT SOLN 60mg/0.2ml, 90mg/0.3ml, 120mg/0.5ml	5	LA PA
SOMAVERT SOLR 10mg, 15mg, 20mg, 25mg, 30mg	5	LA PA
PHOSPHATE BINDER AGENTS		
<i>calcium acetate (phosphate binder)</i> CAPS 667mg QL (360 caps / 30 days)	3	QL
<i>calcium acetate (phosphate binder)</i> TABS 667mg QL (360 tabs / 30 days)	3	QL
<i>sevelamer carbonate</i> PACK 2.4gm QL (180 packets / 30 days)	5	QL

Drug Name	Drug Requirements/ Tier	Limits
<i>sevelamer carbonate</i> PACK .8gm QL (540 packets / 30 days)	5	QL
<i>sevelamer carbonate</i> TABS 800mg QL (540 tabs / 30 days)	4	QL
VELPHORO CHEW 500mg QL (180 tabs / 30 days)	5	QL
PROGESTINS		
<i>medroxyprogesterone acetate</i> TABS 2.5mg, 5mg, 10mg	1	GC
<i>megestrol acetate</i> SUSP 40mg/ml	3	
<i>megestrol acetate (appetite)</i> SUSP 625mg/5ml	4	PA
<i>norethindrone acetate</i> TABS 5mg	3	
THYROID AGENTS		
<i>euthyrox</i> TABS 25mcg, 50mcg, 75mcg, 88mcg, 100mcg, 112mcg, 125mcg, 137mcg, 150mcg, 175mcg, 200mcg	1	GC
<i>levo-t</i> TABS 25mcg, 50mcg, 75mcg, 88mcg, 100mcg, 112mcg, 125mcg, 137mcg, 150mcg, 175mcg, 200mcg, 300mcg	1	GC
<i>levothyroxine sodium</i> TABS 25mcg, 50mcg, 75mcg, 88mcg, 100mcg, 112mcg, 125mcg, 137mcg, 150mcg, 175mcg, 200mcg, 300mcg	1	GC
<i>levoxyl</i> TABS 25mcg, 50mcg, 75mcg, 88mcg, 100mcg, 112mcg, 125mcg, 137mcg, 150mcg, 175mcg, 200mcg	1	GC
<i>liothyronine sodium</i> TABS 5mcg, 25mcg, 50mcg	3	
<i>methimazole</i> TABS 5mg, 10mg	1	GC
<i>propylthiouracil</i> TABS 50mg	3	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **B/D** - Prior Authorization, Part D vs. Part B only **LA** - Limited Availability **ED** - Excluded Drug **GC** - Gap Coverage . **SI** - Select Insulins. Does not apply to AvMed Medicare Premium Saver Broward County (HMO)

All Tier 1 and Tier 2 generics are covered in the Gap Coverage.

Drug Name	Drug Requirements/ Tier	Limits
SYNTHROID TABS 25mcg, 50mcg, 75mcg, 88mcg, 100mcg, 112mcg, 125mcg, 137mcg, 150mcg, 175mcg, 200mcg, 300mcg	4	
unithroid TABS 25mcg, 50mcg, 75mcg, 88mcg, 100mcg, 112mcg, 125mcg, 137mcg, 150mcg, 175mcg, 200mcg, 300mcg	1	GC
VITAMIN D ANALOGS		
calcitriol CAPS .25mcg, .5mcg	2	GC B/D
calcitriol SOLN 1mcg/ml	4	B/D
doxercalciferol CAPS .5mcg, 1mcg, 2.5mcg	4	B/D
paricalcitol CAPS 1mcg, 2mcg, 4mcg	4	B/D
RAYALDEE CPCR 30mcg	5	
GASTROINTESTINAL ANTIEMETICS		
aprepitant CAPS 40mg, 80mg, 125mg	4	B/D
aprepitant capsule therapy pack 80 & 125 mg	4	B/D
compro SUPP 25mg	4	
dronabinol CAPS 2.5mg, 5mg, 10mg	4	B/D QL
QL (60 caps / 30 days)		
granisetron hcl SOLN 1mg/ml, 4mg/4ml	4	
granisetron hcl TABS 1mg	4	B/D
meclizine hcl TABS 12.5mg, 25mg	2	GC
metoclopramide hcl SOLN 5mg/5ml, 5mg/ml	3	
metoclopramide hcl TABS 5mg, 10mg	1	GC
ondansetron TBDP 4mg, 8mg	3	B/D
ondansetron hcl SOLN 4mg/2ml, 40mg/20ml; SOSY 4mg/2ml	3	
ondansetron hcl SOLN 4mg/5ml	4	B/D
ondansetron hcl TABS 4mg, 8mg	3	B/D

Drug Name	Drug Requirements/ Tier	Limits
prochlorperazine SUPP 25mg	4	
prochlorperazine edisylate SOLN 10mg/2ml	4	
prochlorperazine maleate TABS 5mg, 10mg	2	GC
promethazine hcl SOLN 25mg/ml, 50mg/ml; SYRP 6.25mg/5ml; TABS 12.5mg, 25mg, 50mg	3	PA
PA if 70 years and older		
scopolamine PT72 1mg/3days	4	QL PA
QL (10 patches / 30 days)		
PA if 70 years and older		
ANTISPASMODICS		
dicyclomine hcl CAPS 10mg; TABS 20mg	3	
dicyclomine hcl SOLN 10mg/5ml	4	
glycopyrrolate TABS 1mg, 2mg	3	
H2-RECEPTOR ANTAGONISTS		
famotidine SOLN 20mg/2ml, 40mg/4ml, 200mg/20ml	3	
famotidine SUSR 40mg/5ml	4	QL
QL (300 mL / 30 days)		
famotidine TABS 20mg	1	GC QL
QL (120 tabs / 30 days)		
famotidine TABS 40mg	1	GC QL
QL (60 tabs / 30 days)		
famotidine in nacl 0.9% iv soln 20 mg/50ml	3	
nizatidine CAPS 150mg, 300mg	4	
INFLAMMATORY BOWEL DISEASE		
balsalazide disodium CAPS 750mg	3	
budesonide CPEP 3mg	4	QL PA
QL (90 caps / 30 days)		
budesonide TB24 9mg	5	QL PA
QL (30 tabs / 30 days)		
hydrocortisone (intrarectal) ENEM 100mg/60ml	4	
mesalamine CP24 .375gm	4	QL
QL (120 caps / 30 days)		

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **B/D** - Prior Authorization, Part D vs. Part B only **LA** - Limited Availability **ED** - Excluded Drug **GC** - Gap Coverage . **SI** - Select Insulins. Does not apply to AvMed Medicare Premium Saver Broward County (HMO)

47

All Tier 1 and Tier 2 generics are covered in the Gap Coverage.

Drug Name	Drug Requirements/ Tier	Limits
<i>mesalamine</i> CPDR 400mg QL (180 caps / 30 days)	4	QL
<i>mesalamine</i> ENEM 4gm; SUPP 1000mg	4	
<i>mesalamine</i> TBEC 1.2gm QL (120 tabs / 30 days)	4	QL
<i>mesalamine w/ cleanser</i> KIT 4gm	4	
<i>sulfasalazine</i> TABS 500mg	2	GC
<i>sulfasalazine</i> TBEC 500mg	3	
LAXATIVES		
<i>constulose</i> SOLN 10gm/15ml	3	
<i>enulose</i> SOLN 10gm/15ml	3	
<i>gavilyte-c</i>	2	GC
<i>gavilyte-g</i>	2	GC
<i>generlac</i> SOLN 10gm/15ml	3	
GOLYTELY SOL	3	
<i>lactulose</i> SOLN 10gm/15ml	3	
<i>lactulose (encephalopathy)</i> SOLN 10gm/15ml	3	
<i>peg 3350-kcl-na bicarb-nacl- na sulfate for soln 236 gm</i>	2	GC
<i>peg 3350-kcl-sod bicarb-nacl for soln 420 gm</i>	2	GC
PLENVU SOL	4	
<i>sod sulfate-pot sulf-mg sulf oral sol 17.5-3.13-1.6 gm/177ml</i>	4	
SUPREP BOWEL SOL PREP KIT	4	
MISCELLANEOUS		
<i>alosetron hcl</i> TABS .5mg, 1mg QL (60 tabs / 30 days)	5	QL PA
<i>cromolyn sodium (mastocytosis)</i> CONC 100mg/5ml	4	
<i>diphenoxylate w/ atropine liq 2.5-0.025 mg/5ml</i>	4	
<i>diphenoxylate w/ atropine tab 2.5-0.025 mg</i>	3	
GATTEX KIT 5mg	5	LA PA
LINZESS CAPS 72mcg, 145mcg, 290mcg QL (30 caps / 30 days)	4	QL

Drug Name	Drug Requirements/ Tier	Limits
<i>loperamide hcl</i> CAPS 2mg	3	
<i>misoprostol</i> TABS 100mcg, 200mcg	3	
MOVANTIK TABS 12.5mg, 25mg QL (30 tabs / 30 days)	3	QL
RELISTOR SOLN 8mg/0.4ml, 12mg/0.6ml	5	PA
<i>sucralfate</i> TABS 1gm	3	
<i>ursodiol</i> CAPS 300mg	3	
<i>ursodiol</i> TABS 250mg, 500mg	4	
XERMELO TABS 250mg QL (90 tabs / 30 days)	5	QL LA PA
XIFAXAN TABS 550mg	5	PA
PANCREATIC ENZYMES		
CREON CAP 3000UNIT	3	
CREON CAP 6000UNIT	3	
CREON CAP 12000UNIT	3	
CREON CAP 24000UNIT	3	
CREON CAP 36000UNIT	3	
ZENPEP CAP 3000UNIT	4	
ZENPEP CAP 5000UNIT	4	
ZENPEP CAP 10000UNIT	4	
ZENPEP CAP 15000UNIT	4	
ZENPEP CAP 20000UNIT	4	
ZENPEP CAP 25000UNIT	4	
ZENPEP CAP 40000UNIT	4	
PROTON PUMP INHIBITORS		
<i>esomeprazole magnesium</i> CPDR 20mg, 40mg QL (30 caps / 30 days)	4	QL ST
<i>lansoprazole</i> CPDR 15mg, 30mg QL (60 caps / 30 days)	3	QL
<i>lansoprazole</i> TBDD 15mg, 30mg QL (60 tabs / 30 days)	4	QL ST
<i>omeprazole</i> CPDR 10mg, 20mg, 40mg	1	GC
<i>pantoprazole sodium</i> SOLR 40mg	4	
<i>pantoprazole sodium</i> TBEC 20mg, 40mg	1	GC

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **B/D** - Prior Authorization, Part D vs. Part B only **LA** - Limited Availability **ED** - Excluded Drug **GC** - Gap Coverage . **SI** - Select Insulins. Does not apply to AvMed Medicare Premium Saver Broward County (HMO)

48

All Tier 1 and Tier 2 generics are covered in the Gap Coverage.

Drug Name	Drug Requirements/ Tier	Limits
<i>rabeprazole sodium</i> TBEC 20mg QL (30 tabs / 30 days)	3	QL
GENITOURINARY		
BENIGN PROSTATIC HYPERPLASIA		
<i>alfuzosin hcl</i> TB24 10mg QL (30 tabs / 30 days)	2	GC QL
<i>dutasteride</i> CAPS .5mg QL (30 caps / 30 days)	3	QL
<i>dutasteride-tamsulosin hcl cap</i> 0.5-0.4 mg QL (30 caps / 30 days)	4	QL
<i>finasteride</i> TABS 5mg	1	GC
<i>silodosin</i> CAPS 4mg, 8mg QL (30 caps / 30 days)	3	QL
<i>tamsulosin hcl</i> CAPS .4mg	2	GC
MISCELLANEOUS		
<i>acetic acid</i> SOLN .25%	2	GC
<i>bethanechol chloride</i> TABS 5mg, 10mg, 25mg, 50mg	3	
<i>potassium citrate (alkalinizer)</i> TBCR 15meq, 540mg, 1080mg	4	
URINARY ANTISPASMODICS		
<i>darifenacin hydrobromide</i> TB24 7.5mg, 15mg QL (30 tabs / 30 days)	4	QL ST
<i>fesoterodine fumarate</i> TB24 4mg, 8mg QL (30 tabs / 30 days)	4	QL
<i>GEMTESA</i> TABS 75mg QL (30 tabs / 30 days)	4	QL
<i>MYRBETRIQ</i> SRER 8mg/ml QL (300 mL / 28 days)	4	QL
<i>MYRBETRIQ</i> TB24 25mg, 50mg QL (30 tabs / 30 days)	4	QL
<i>oxybutynin chloride</i> SYRP 5mg/5ml; TABS 5mg	3	
<i>oxybutynin chloride</i> TB24 5mg QL (30 tabs / 30 days)	3	QL
<i>oxybutynin chloride</i> TB24 10mg, 15mg QL (60 tabs / 30 days)	3	QL

Drug Name	Drug Requirements/ Tier	Limits
<i>solifenacin succinate</i> TABS 5mg, 10mg QL (30 tabs / 30 days)	4	QL
<i>tolterodine tartrate</i> CP24 2mg, 4mg QL (30 caps / 30 days)	4	QL ST
<i>tolterodine tartrate</i> TABS 1mg, 2mg QL (60 tabs / 30 days)	4	QL
<i>trospium chloride</i> CP24 60mg QL (30 caps / 30 days)	4	QL
<i>trospium chloride</i> TABS 20mg QL (60 tabs / 30 days)	3	QL
VAGINAL ANTI-INFECTIVES		
<i>clindamycin phosphate</i> vaginal CREA 2% metronidazole vaginal GEL .75%	3	
<i>terconazole vaginal</i> CREA .4%, .8%; SUPP 80mg	3	
HEMATOLOGIC ANTICOAGULANTS		
<i>dabigatran etexilate mesylate</i> CAPS 75mg, 150mg QL (60 caps / 30 days)	4	QL
<i>ELIQUIS</i> TABS 2.5mg QL (60 tabs / 30 days)	3	QL
<i>ELIQUIS</i> TABS 5mg QL (74 tabs / 30 days)	3	QL
<i>ELIQUIS STARTER PACK</i> TBPK 5mg QL (74 tabs / 30 days)	3	QL
<i>enoxaparin sodium</i> SOLN 300mg/3ml; SOSY 30mg/0.3ml, 40mg/0.4ml, 60mg/0.6ml, 80mg/0.8ml, 100mg/ml, 120mg/0.8ml, 150mg/ml	4	
<i>fondaparinux sodium</i> SOLN 2.5mg/0.5ml	4	
<i>fondaparinux sodium</i> SOLN 5mg/0.4ml, 7.5mg/0.6ml, 10mg/0.8ml	5	
<i>HEP SOD/D5W INJ</i> 20000UNT	3	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **B/D** - Prior Authorization, Part D vs. Part B only **LA** - Limited Availability **ED** - Excluded Drug **GC** - Gap Coverage . **SI** - Select Insulins. Does not apply to AvMed Medicare Premium Saver Broward County (HMO)

All Tier 1 and Tier 2 generics are covered in the Gap Coverage.

Drug Name	Drug Requirements/ Tier	Limits
HEP SOD/D5W INJ 25000UNT	3	
HEP SOD/NACL INJ 25000UNT	3	
<i>heparin sodium (porcine)</i> SOLN 1000unit/ml, 5000unit/ml, 10000unit/ml, 20000unit/ml	3	B/D
HEPARIN/NACL INJ 25000UNT	3	
<i>jantoven</i> TABS 1mg, 2mg, 2.5mg, 3mg, 4mg, 5mg, 6mg, 7.5mg, 10mg	1	GC
PRADAXA CAPS 75mg, 150mg QL (60 caps / 30 days)	4	QL
PRADAXA CAPS 110mg QL (120 caps / 30 days)	4	QL
<i>warfarin sodium</i> TABS 1mg, 2mg, 2.5mg, 3mg, 4mg, 5mg, 6mg, 7.5mg, 10mg	1	GC
XARELTO SUSR 1mg/ml QL (620 mL / 30 days)	3	QL
XARELTO TABS 2.5mg QL (60 tabs / 30 days)	3	QL
XARELTO TABS 10mg, 15mg, 20mg QL (30 tabs / 30 days)	3	QL
XARELTO STAR TAB 15/20MG QL (51 tabs / 30 days)	3	QL
HEMATOPOIETIC GROWTH FACTORS		
PROCRIT SOLN 2000unit/ml, 3 3000unit/ml, 4000unit/ml, 10000unit/ml	3	PA
PROCRIT SOLN 20000unit/ml, 40000unit/ml	5	PA
ZARXIO SOSY 300mcg/0.5ml, 480mcg/0.8ml	5	PA
ZIEXTENZO SOSY 6mg/0.6ml	5	PA
MISCELLANEOUS		
<i>anagrelide hcl</i> CAPS .5mg, 1mg	4	
BERINERT KIT 500unit QL (24 boxes / 30 days)	5	QL LA PA

Drug Name	Drug Requirements/ Tier	Limits
<i>cilostazol</i> TABS 50mg, 100mg	2	GC
DOPTELET TABS 20mg	5	LA PA
DROXIA CAPS 200mg, 300mg, 400mg	3	
ENDARI PACK 5gm	5	LA PA
HAEGARDA SOLR 2000unit QL (30 vials / 30 days)	5	QL LA PA
HAEGARDA SOLR 3000unit QL (20 vials / 30 days)	5	QL LA PA
<i>icatibant acetate</i> SOLN 30mg/3ml QL (9 syringes / 30 days)	5	QL PA
<i>pentoxifylline</i> TBCR 400mg	2	GC
PROMACTA PACK 12.5mg QL (360 packets / 30 days)	5	QL LA PA
PROMACTA PACK 25mg QL (180 packets / 30 days)	5	QL LA PA
PROMACTA TABS 12.5mg, 25mg QL (30 tabs / 30 days)	5	QL LA PA
PROMACTA TABS 50mg, 75mg QL (60 tabs / 30 days)	5	QL LA PA
<i>sajazir</i> SOLN 30mg/3ml QL (9 syringes / 30 days)	5	QL LA PA
<i>tranexamic acid</i> SOLN 1000mg/10ml	4	
<i>tranexamic acid</i> TABS 650mg	3	
PLATELET AGGREGATION INHIBITORS		
<i>aspirin-dipyridamole cap er</i> 12hr 25-200 mg	4	
BRILINTA TABS 60mg, 90mg	3	
<i>clopidogrel bisulfate</i> TABS 75mg	1	GC
<i>dipyridamole</i> TABS 25mg, 50mg, 75mg PA if 70 years and older	3	PA
<i>prasugrel hcl</i> TABS 5mg, 10mg	3	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **B/D** - Prior Authorization, Part D vs. Part B only **LA** - Limited Availability **ED** - Excluded Drug **GC** - Gap Coverage . **SI** - Select Insulins. Does not apply to AvMed Medicare Premium Saver Broward County (HMO)

50

All Tier 1 and Tier 2 generics are covered in the Gap Coverage.

Drug Name	Drug Requirements/ Tier	Limits
IMMUNOLOGIC AGENTS		
AUTOIMMUNE AGENTS		
DUPIXENT SOPN 200mg/1.14ml, 300mg/2ml; SOSY 100mg/0.67ml, 200mg/1.14ml, 300mg/2ml	5	PA
ENBREL SOLN 25mg/0.5ml; SOLR 25mg QL (16 vials / 28 days)	5	QL PA
ENBREL SOSY 25mg/0.5ml QL (16 syringes / 28 days)	5	QL PA
ENBREL SOSY 50mg/ml QL (8 syringes / 28 days)	5	QL PA
ENBREL MINI SOCT 50mg/ml QL (8 cartridges / 28 days)	5	QL PA
ENBREL SURECLICK SOAJ 50mg/ml QL (8 pens / 28 days)	5	QL PA
HUMIRA PSKT 10mg/0.1ml, 20mg/0.2ml QL (2 syringes / 28 days)	5	QL PA
HUMIRA PSKT 40mg/0.4ml, 40mg/0.8ml QL (6 syringes / 28 days)	5	QL PA
HUMIRA PEDIA INJ CROHNS	5	PA
HUMIRA PEDIATRIC CROHNS D PSKT 80mg/0.8ml	5	PA
HUMIRA PEN PNKT 40mg/0.4ml, 40mg/0.8ml QL (6 pens / 28 days)	5	QL PA
HUMIRA PEN PNKT 80mg/0.8ml QL (4 pens / 28 days)	5	QL PA
HUMIRA PEN KIT PS/UV	5	PA
HUMIRA PEN-CD/UC/HS START PNKT 40mg/0.8ml, 80mg/0.8ml	5	PA

Drug Name	Drug Requirements/ Tier	Limits
HUMIRA PEN-PEDIATRIC UC S PNKT 80mg/0.8ml	5	PA
HUMIRA PEN-PS/UV STARTER PNKT 40mg/0.8ml	5	PA
INFLIXIMAB SOLR 100mg	5	LA PA
KEVZARA SOAJ 150mg/1.14ml, 200mg/1.14ml QL (2 pens / 28 days)	5	QL PA
KEVZARA SOSY 150mg/1.14ml, 200mg/1.14ml QL (2 syringes / 28 days)	5	QL PA
OTEZLA TABS 30mg QL (60 tabs / 30 days)	5	QL PA
OTEZLA TAB 10/20/30 QL (110 tabs / year)	5	QL PA
REMICADE SOLR 100mg	5	LA PA
RENFLEXIS SOLR 100mg	5	LA PA
RINVOQ TB24 15mg, 30mg QL (30 tabs / 30 days)	5	QL PA
RINVOQ TB24 45mg QL (112 tabs / year)	5	QL PA
SKYRIZI SOCT 180mg/1.2ml, 360mg/2.4ml QL (1 cartridge / 56 days)	5	QL PA
SKYRIZI SOLN 600mg/10ml QL (6 vials / year)	5	QL PA
SKYRIZI SOSY 150mg/ml QL (6 syringes / 365 days)	5	QL PA
SKYRIZI PEN SOAJ 150mg/ml QL (6 pens / 365 days)	5	QL PA
TALTZ SOAJ 80mg/ml; SOSY 80mg/ml QL (3 syringes / 28 days)	5	QL LA PA
XELJANZ SOLN 1mg/ml QL (480 mL / 24 days)	5	QL PA
XELJANZ TABS 5mg, 10mg QL (60 tabs / 30 days)	5	QL PA
XELJANZ XR TB24 11mg, 22mg QL (30 tabs / 30 days)	5	QL PA

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **B/D** - Prior Authorization, Part D vs. Part B only **LA** - Limited Availability **ED** - Excluded Drug **GC** - Gap Coverage . **SI** - Select Insulins. Does not apply to AvMed Medicare Premium Saver Broward County (HMO)

51

All Tier 1 and Tier 2 generics are covered in the Gap Coverage.

Drug Name	Drug Requirements/ Tier	Limits
DISEASE-MODIFYING ANTI-RHEUMATIC DRUGS (DMARDS)		
<i>hydroxychloroquine sulfate</i> TABS 200mg	3	
<i>leflunomide</i> TABS 10mg, 20mg	3	QL
QL (30 tabs / 30 days)		
<i>methotrexate sodium</i> TABS 2.5mg	3	
TREXALL TABS 5mg, 7.5mg, 10mg, 15mg	4	B/D
XATMEP SOLN 2.5mg/ml	4	B/D
IMMUNOGLOBULINS		
BIVIGAM SOLN 5gm/50ml, 10%	5	LA PA
FLEBOGAMMA DIF SOLN 2.5gm/50ml, 5gm/100ml, 5gm/50ml, 10gm/100ml, 10gm/200ml, 20gm/200ml, 20gm/400ml	5	PA
GAMASTAN INJ	4	B/D LA
GAMMAGARD LIQUID SOLN 1gm/10ml, 2.5gm/25ml, 5gm/50ml, 10gm/100ml, 20gm/200ml, 30gm/300ml	5	PA
GAMMAGARD S/D IGA LESS TH SOLR 5gm, 10gm	5	PA
GAMMAKED SOLN 1gm/10ml, 5gm/50ml, 10gm/100ml, 20gm/200ml	5	PA
GAMMAPLEX SOLN 5gm/100ml, 5gm/50ml, 10gm/100ml, 10gm/200ml, 20gm/200ml, 20gm/400ml	5	LA PA
GAMUNEX-C SOLN 1gm/10ml, 2.5gm/25ml, 5gm/50ml, 10gm/100ml, 20gm/200ml, 40gm/400ml	5	PA
OCTAGAM SOLN 1gm/20ml, 2gm/20ml, 2.5gm/50ml, 5gm/100ml, 5gm/50ml, 10gm/100ml, 10gm/200ml, 20gm/200ml, 25gm/500ml, 30gm/300ml	5	PA

Drug Name	Drug Requirements/ Tier	Limits
PANZYGA SOLN 1gm/10ml, 2.5gm/25ml, 5gm/50ml, 10gm/100ml, 20gm/200ml, 30gm/300ml	5	PA
PRIVIGEN SOLN 5gm/50ml, 10gm/100ml, 20gm/200ml, 40gm/400ml	5	PA
IMMUNOMODULATORS		
ACTIMMUNE SOLN 2000000unit/0.5ml	5	LA PA
ARCALYST SOLR 220mg	5	LA PA
INTRON A SOLR 10000000unit, 18000000unit, 50000000unit	5	B/D LA
IMMUNOSUPPRESSANTS		
<i>azathioprine</i> TABS 50mg	3	B/D
BENLYSTA SOAJ 200mg/ml; SOSY 200mg/ml	5	QL LA PA
QL (8 syringes / 28 days)		
BENLYSTA SOLR 120mg, 400mg	5	LA PA
<i>cyclosporine</i> CAPS 25mg, 100mg; SOLN 50mg/ml	4	B/D
<i>cyclosporine modified (for microemulsion)</i> CAPS 25mg, 50mg, 100mg; SOLN 100mg/ml	4	B/D
<i>everolimus (immunosuppressant)</i> TABS .25mg, .5mg, .75mg, 1mg	5	B/D
<i>engraf</i> CAPS 25mg, 100mg; SOLN 100mg/ml	4	B/D
<i>mycophenolate mofetil</i> CAPS 250mg; TABS 500mg	3	B/D
<i>mycophenolate mofetil</i> SUSR 200mg/ml	5	B/D
<i>mycophenolate sodium</i> TBEC 180mg, 360mg	4	B/D
NULOJIX SOLR 250mg	5	B/D
PROGRAF PACK .2mg, 1mg	4	B/D
REZUROCK TABS 200mg	5	LA PA
SANDIMMUNE SOLN 100mg/ml	4	B/D
<i>sirolimus</i> SOLN 1mg/ml	5	B/D

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **B/D** - Prior Authorization, Part D vs. Part B only **LA** - Limited Availability **ED** - Excluded Drug **GC** - Gap Coverage . **SI** - Select Insulins. Does not apply to AvMed Medicare Premium Saver Broward County (HMO)

52

All Tier 1 and Tier 2 generics are covered in the Gap Coverage.

Drug Name	Drug Requirements/ Tier	Limits
<i>sirolimus</i> TABS .5mg, 1mg, 2mg	4	B/D
<i>tacrolimus</i> CAPS .5mg, 1mg, 5mg	4	B/D
VACCINES		
ACTHIB INJ	3	
ADACEL INJ	3	
BCG VACCINE SOLR 50mg	3	
BEXSERO INJ	3	
BOOSTRIX INJ	3	
DAPTACEL INJ	3	
DENG VAXIA SUS	3	
DIP/TET PED INJ 25-5LFU	3	B/D
ENGERIX-B SUSP 20mcg/ml; SUSY 10mcg/0.5ml, 20mcg/ml	3	B/D
GARDASIL 9 INJ	3	
HAVRIX SUSP 720elu/0.5ml, 1440elu/ml	3	
HIBERIX SOLR 10mcg	3	
IMOVAX RABIES (H.D.C.V.) SUSR 2.5unit/ml	3	B/D
INFANRIX INJ	3	
I POL INJ INACTIVE	3	
IXIARO INJ	3	
KINRIX INJ	3	
M-M-R II INJ	3	
MENACTRA INJ	3	
MENQUADFI INJ	3	
MENVEO INJ	3	
MENVEO SOL	3	
PEDIARIX INJ 0.5ML	3	
PEDVAX HIB SUSP 7.5mcg/0.5ml	3	
PENTACEL INJ	3	
PREHEVBRIO SUSP 10mcg/ml	3	B/D
PRIORIX INJ	3	
PROQUAD INJ	3	
QUADRACEL INJ	3	
QUADRACEL INJ 0.5ML	3	
RABAVERT INJ	3	B/D

Drug Name	Drug Requirements/ Tier	Limits
RECOMBIVAX HB SUSP 5mcg/0.5ml, 10mcg/ml, 40mcg/ml; SUSY 5mcg/0.5ml, 10mcg/ml	3	B/D
ROTARIX SUS	3	
ROTATEQ SOL	3	
SHINGRIX SUSR 50mcg/0.5ml QL (2 vials per lifetime)	3	QL
TDVAX INJ 2-2 LF	3	B/D
TENIVAC INJ 5-2LF	3	B/D
TICOVAC SUSY 1.2mcg/0.25ml, 2.4mcg/0.5ml	3	
TRUMENBA INJ	3	
TWINRIX INJ	3	
TYPHIM VI SOLN 25mcg/0.5ml; SOSY 25mcg/0.5ml	3	
VAQTA SUSP 25unit/0.5ml, 50unit/ml	3	
VARIVAX INJ 1350pfu/0.5ml	3	
YF-VAX INJ	3	
NUTRITIONAL/SUPPLEMENTS ELECTROLYTES/MINERALS, INJECTABLE		
D2.5W/NACL INJ 0.45%	4	
D5W/LYTES INJ #48	4	
D10W/NACL INJ 0.2%	3	
dextrose 2.5% w/ sodium chloride 0.45%	3	
dextrose 5% in lactated ringers	3	
dextrose 5% w/ sodium chloride 0.2%	3	
dextrose 5% w/ sodium chloride 0.3%	3	
dextrose 5% w/ sodium chloride 0.9%	3	
dextrose 5% w/ sodium chloride 0.45%	3	
dextrose 5% w/ sodium chloride 0.225%	3	
dextrose 10% w/ sodium chloride 0.45%	3	
ISOLYTE-P INJ /D5W	4	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **B/D** - Prior Authorization, Part D vs. Part B only **LA** - Limited Availability **ED** - Excluded Drug **GC** - Gap Coverage . **SI** - Select Insulins. Does not apply to AvMed Medicare Premium Saver Broward County (HMO)

53

All Tier 1 and Tier 2 generics are covered in the Gap Coverage.

Drug Name	Drug Requirements/ Tier Limits
ISOLYTE-S INJ	4
ISOLYTE-S INJ PH 7.4	4
<i>kcl 10 meq/l (0.075%) in dextrose 5% & nacl 0.45% inj</i>	3
<i>kcl 20 meq/l (0.15%) in dextrose 5% & nacl 0.2% inj</i>	3
<i>kcl 20 meq/l (0.15%) in dextrose 5% & nacl 0.9% inj</i>	3
<i>kcl 20 meq/l (0.15%) in dextrose 5% & nacl 0.45% inj</i>	3
<i>kcl 20 meq/l (0.15%) in nacl 0.9% inj</i>	3
<i>kcl 20 meq/l (0.15%) in nacl 0.45% inj</i>	3
<i>kcl 30 meq/l (0.224%) in dextrose 5% & nacl 0.45% inj</i>	3
<i>kcl 40 meq/l (0.3%) in dextrose 5% & nacl 0.45% inj</i>	3
<i>kcl 40 meq/l (0.3%) in nacl 0.9% inj</i>	3
KCL/D5W/NACL INJ 0.3/0.9%	4
<i>lactated ringer's solution</i>	3
MAGNESIUM SULFATE SOLN 2gm/50ml, 4gm/100ml, 4gm/500ml, 40gm/1000ml	3
<i>magnesium sulfate SOLN 2gm/50ml, 4gm/100ml, 4gm/500ml, 20gm/500ml, 40gm/1000ml, 50%</i>	3
<i>magnesium sulfate in dextrose 5% iv soln 1 gm/100ml</i>	3
MG SO4/D5W INJ 10MG/ML	3
PLASMA-LYTE INJ -148	4
PLASMA-LYTE INJ -A	4
POT CHL 20MEQ/L IN NACL 0.9% INJ	3
POT CHL 20MEQ/L IN NACL 0.45% INJ	4
POT CHL 40MEQ/L IN NACL 0.9% INJ	4
<i>potassium chloride SOLN 2meq/ml</i>	3

Drug Name	Drug Requirements/ Tier Limits
POTASSIUM CHLORIDE SOLN 10meq/50ml, 20meq/50ml	4
<i>potassium chloride SOLN 10meq/100ml, 20meq/100ml, 40meq/100ml</i>	4
<i>potassium chloride 20 meq/l (0.15%) in dextrose 5% inj</i>	3
<i>sodium chloride SOLN .45%, .9%, 2.5meq/ml, 3%, 5%</i>	3
TPN ELECTROL INJ	4 B/D
ELECTROLYTES/MINERALS/VITAMINS, ORAL	
<i>klor-con PACK 20meq</i>	4
<i>klor-con 8 TBCR 8meq</i>	2 GC
<i>klor-con 10 TBCR 10meq</i>	2 GC
<i>klor-con m10 TBCR 10meq</i>	2 GC
<i>klor-con m15 TBCR 15meq</i>	3
<i>klor-con m20 TBCR 20meq</i>	2 GC
M-NATAL PLUS TAB	3
<i>potassium chloride CPCR 8meq, 10meq</i>	3
<i>potassium chloride PACK 20meq; SOLN 10%, 20%</i>	4
<i>potassium chloride TBCR 8meq, 10meq, 20meq</i>	2 GC
<i>potassium chloride microencapsulated crystals er TBCR 10meq, 20meq</i>	2 GC
<i>potassium chloride microencapsulated crystals er TBCR 15meq</i>	3
PRENATAL TAB 27-1MG	3
PRENATAL TAB PLUS	3
<i>sodium fluoride chew; tab; 1.1 (0.5 f) mg/ml soln</i>	2 GC
TRICARE TAB PRENATAL	3
IV NUTRITION	
CLINIMIX INJ 4.25/D5W	4 B/D
CLINIMIX INJ 4.25/D10	4 B/D
CLINIMIX INJ 5%/D15W	4 B/D
CLINIMIX INJ 5%/D20W	4 B/D
CLINIMIX INJ 6/5	4 B/D
CLINIMIX INJ 8/10	4 B/D
CLINIMIX INJ 8/14	4 B/D

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **B/D** - Prior Authorization, Part D vs. Part B only **LA** - Limited Availability **ED** - Excluded Drug **GC** - Gap Coverage . **SI** - Select Insulins. Does not apply to AvMed Medicare Premium Saver Broward County (HMO)

All Tier 1 and Tier 2 generics are covered in the Gap Coverage.

Drug Name	Drug Requirements/ Tier	Limits
<i>clinisol sf 15%</i>	4	B/D
CLINOLIPID EMU 20%	4	B/D
dextrose SOLN 5%, 10%	3	
dextrose SOLN 50%, 70%	3	B/D
FREAMINE III INJ 10%	4	B/D
INTRALIPID EMUL 20gm/100ml, 30gm/100ml	4	B/D
NUTRILIPID EMUL 20gm/100ml	4	B/D
<i>plenamine</i>	4	B/D
PREMASOL SOL 10%	5	B/D
PROCALAMINE INJ 3%	4	B/D
PROSOL INJ 20%	4	B/D
TRAVASOL INJ 10%	4	B/D
TROPHAMINE INJ 10%	4	B/D
OPHTHALMIC		
ANTI-INFECTIVE/ANTI-INFLAMMATORY		
<i>bacitracin-polymyxin- neomycin-hc ophth oint 1%</i>	3	
<i>neomycin-polymyxin- dexamethasone ophth oint 0.1%</i>	2	GC
<i>neomycin-polymyxin- dexamethasone ophth susp 0.1%</i>	2	GC
<i>neomycin-polymyxin-hc ophth susp</i>	4	
<i>sulfacetamide sodium- prednisolone ophth soln 10- 0.23(0.25)%</i>	2	GC
TOBRADEX OIN 0.3-0.1%	3	
TOBRADEX ST SUS 0.3-0.05	3	
<i>tobramycin-dexamethasone ophth susp 0.3-0.1%</i>	4	
ZYLET SUS 0.5-0.3%	3	
ANTI-INFECTIVES		
<i>bacitracin (ophthalmic) OINT 500unit/gm</i>	3	
<i>bacitracin-polymyxin b ophth oint</i>	2	GC
BESIVANCE SUSP .6%	3	
CILOXAN OINT .3%	3	
<i>ciprofloxacin hcl (ophth) SOLN .3%</i>	2	GC

Drug Name	Drug Requirements/ Tier	Limits
<i>erythromycin (ophth) OINT 5mg/gm</i>	2	GC
<i>gatifloxacin (ophth) SOLN .5%</i>	3	
<i>gentak OINT .3%</i>	3	
<i>gentamicin sulfate (ophth) SOLN .3%</i>	2	GC
<i>moxifloxacin hcl (ophth) SOLN .5%</i>	3	
NATACYN SUSP 5%	4	
<i>neomycin-bacitrac zn-polymyx 5(3.5)mg-400unt-10000unt op oin</i>	3	
<i>neomycin-polymy-gramicid op sol 1.75-10000-0.025mg-unt- mg/ml</i>	3	
<i>ofloxacin (ophth) SOLN .3%</i>	2	GC
<i>polymyxin b-trimethoprim ophth soln 10000 unit/ml-0.1%</i>	1	GC
<i>sulfacetamide sodium (ophth) OINT 10%; SOLN 10%</i>	3	
<i>tobramycin (ophth) SOLN .3%</i>	1	GC
<i>trifluridine SOLN 1%</i>	4	
ZIRGAN GEL .15%	4	
ANTI-INFLAMMATORIES		
ALREX SUSP .2%	3	
<i>bromfenac sodium (ophth) SOLN .09%</i>	4	
BROMSITE SOLN .075%	4	
<i>dexamethasone sodium phosphate (ophth) SOLN .1%</i>	3	
<i>diclofenac sodium (ophth) SOLN .1%</i>	2	GC
<i>difluprednate EMUL .05%</i>	4	
FLAREX SUSP .1%	4	
<i>fluorometholone (ophth) SUSP .1%</i>	3	
<i>flurbiprofen sodium SOLN .03%</i>	3	
ILEVRO SUSP .3%	3	
<i>ketorolac tromethamine (ophth) SOLN .4%</i>	3	
<i>ketorolac tromethamine (ophth) SOLN .5%</i>	2	GC

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **B/D** - Prior Authorization, Part D vs. Part B only **LA** - Limited Availability **ED** - Excluded Drug **GC** - Gap Coverage . **SI** - Select Insulins. Does not apply to AvMed Medicare Premium Saver Broward County (HMO)

55

All Tier 1 and Tier 2 generics are covered in the Gap Coverage.

Drug Name	Drug Requirements/ Tier	Limits
LOTEMAX OINT .5%	3	
<i>prednisolone acetate (ophth)</i> SUSP 1%	3	
PREDNISOLONE SODIUM PHOSP SOLN 1%	3	
PROLENSA SOLN .07%	3	
ANTIALLERGICS		
<i>azelastine hcl (ophth)</i> SOLN .05%	3	
<i>cromolyn sodium (ophth)</i> SOLN 4%	2	GC
<i>olopatadine hcl</i> SOLN .1%	3	
ZERVIAE SOLN .24%	4	
ANTIGLAUCOMA		
ALPHAGAN P SOLN .1%	3	
<i>betaxolol hcl (ophth)</i> SOLN .5%	3	
BETOPTIC-S SUSP .25%	3	
<i>brimonidine tartrate</i> SOLN .2%	1	GC
<i>brimonidine tartrate</i> SOLN .15%	4	
<i>brinzolamide</i> SUSP 1%	4	
<i>carteolol hcl (ophth)</i> SOLN 1%	2	GC
COMBIGAN SOL 0.2/0.5%	3	
<i>dorzolamide hcl</i> SOLN 2%	2	GC
<i>dorzolamide hcl-timolol maleate ophth soln</i> 22.3-6.8 mg/ml	2	GC
<i>latanoprost</i> SOLN .005%	1	GC
<i>levobunolol hcl</i> SOLN .5%	2	GC
LUMIGAN SOLN .01%	3	
<i>pilocarpine hcl</i> SOLN 1%, 2%, 4%	3	
RHOPRESSA SOLN .02%	3	
SIMBRINZA SUS 1-0.2%	3	
<i>timolol maleate (ophth)</i> SOLG .25%, .5%	4	
<i>timolol maleate (ophth)</i> SOLN .25%, .5%	1	GC
<i>travoprost</i> SOLN .004%	4	
VYZULTA SOLN .024%	4	

Drug Name	Drug Requirements/ Tier	Limits
MISCELLANEOUS		
ATROPINE SULFATE SOLN 1%	3	
<i>atropine sulfate (ophthalmic)</i> SOLN 1%	3	
CYSTADROPS SOLN .37%	5	LA PA
CYSTARAN SOLN .44%	5	LA PA
ISOPTO ATROPINE SOLN 1%	3	
<i>proparacaine hcl</i> SOLN .5%	3	
RESTASIS EMUL .05%	3	
RESTASIS MULTIDOSE EMUL .05%	3	
TYRVAYA SOLN .03mg/act	4	
XIIDRA SOLN 5%	3	
OTIC		
OTIC AGENTS		
<i>acetic acid (otic)</i> SOLN 2%	3	
CIPRO HC SUS OTIC	4	
<i>ciprofloxacin-dexamethasone otic susp</i> 0.3-0.1%	4	
<i>flac</i> OIL .01%	3	
<i>fluocinolone acetonide (otic)</i> OIL .01%	3	
<i>neomycin-polymyxin-hc otic soln</i> 1%	3	
<i>neomycin-polymyxin-hc otic susp</i> 3.5 mg/ml-10000 unit/ml-1%	3	
<i>ofloxacin (otic)</i> SOLN .3%	4	
Phosphodiesterase Type 5 Inhibitors		
Phosphodiesterase Type 5 Inhibitors		
<i>sildenafil citrate</i> TABS 25mg, 50mg, 100mg QL (4 tabs / 30 days)	3	ED QL
<i>tadalafil</i> TABS 10mg, 20mg QL (4 tabs / 30 days)	3	ED QL
RESPIRATORY		
ANTICHOLINERGIC/BETA AGONIST COMBINATIONS		
ANORO ELLIPT AER 62.5-25 QL (60 blisters / 30 days)	3	QL

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **B/D** - Prior Authorization, Part D vs. Part B only **LA** - Limited Availability **ED** - Excluded Drug **GC** - Gap Coverage . **SI** - Select Insulins. Does not apply to AvMed Medicare Premium Saver Broward County (HMO)

All Tier 1 and Tier 2 generics are covered in the Gap Coverage.

Drug Name	Drug Requirements/ Tier	Limits
BEVESPI AER 9-4.8MCG QL (1 inhaler / 30 days)	3	QL
BREZTRI AERO AER SPHERE QL (1 inhaler / 30 days)	3	QL
BREZTRI AERO AER SPHERE (INSTITUTIONAL PACK) QL (4 inhalers / 28 days)	3	QL
COMBIVENT AER 20-100 QL (2 inhalers / 30 days)	4	QL
<i>ipratropium-albuterol nebu soln 0.5-2.5(3) mg/3ml</i>	3	B/D
TRELEGY AER ELLIPTA 100-62.5-25 MCG QL (60 blisters / 30 days)	3	QL
TRELEGY AER ELLIPTA 200-62.5-25 MCG QL (60 blisters / 30 days)	3	QL
ANTICHOLINERGICS		
ATROVENT HFA AERS 17mcg/act QL (2 inhalers / 30 days)	4	QL
INCRUSE ELLIPTA AEPB 62.5mcg/inh QL (30 blisters / 30 days)	3	QL
<i>ipratropium bromide SOLN</i> .02%	2	GC B/D
<i>ipratropium bromide (nasal)</i> SOLN .03%, .06%	3	
ANTI-HISTAMINES		
<i>azelastine hcl SOLN</i> .1%, .15%	3	
<i>cetirizine hcl SOLN</i> 1mg/ml	2	GC
<i>cypheptadine hcl SYRP</i> 2mg/5ml; TABS 4mg PA if 70 years and older	3	PA
<i>desloratadine TABS</i> 5mg	3	
<i>diphenhydramine hcl SOLN</i> 50mg/ml	3	
<i>hydroxyzine hcl SOLN</i> 25mg/ml, 50mg/ml PA if 70 years and older	4	PA

Drug Name	Drug Requirements/ Tier	Limits
<i>hydroxyzine hcl SYRP</i> 10mg/5ml; TABS 10mg, 25mg, 50mg PA if 70 years and older	3	PA
<i>hydroxyzine pamoate CAPS</i> 25mg, 50mg PA if 70 years and older	3	PA
<i>levocetirizine dihydrochloride</i> SOLN 2.5mg/5ml	4	
<i>levocetirizine dihydrochloride</i> TABS 5mg	3	
<i>olopatadine hcl (nasal) SOLN</i> .6%	4	
BETA AGONISTS		
<i>albuterol sulfate AERS</i> 108mcg/act QL (2 inhalers / 30 days) (generic of Proair HFA)	3	QL
<i>albuterol sulfate AERS</i> 108mcg/act QL (2 inhalers / 30 days) (generic of Proventil HFA)	3	QL
<i>albuterol sulfate AERS</i> 108mcg/act QL (2 inhalers / 30 days) (generic of Ventolin HFA)	3	QL
<i>albuterol sulfate NEBU</i> .63mg/3ml, 1.25mg/3ml, 2.5mg/0.5ml	3	B/D
<i>albuterol sulfate NEBU</i> .083%	2	GC B/D
<i>albuterol sulfate SYRP</i> 2mg/5ml	3	
<i>albuterol sulfate TABS</i> 2mg, 4mg	4	
<i>arformoterol tartrate NEBU</i> 15mcg/2ml	4	B/D
<i>formoterol fumarate NEBU</i> 20mcg/2ml	5	B/D
<i>levalbuterol hcl NEBU</i> .31mg/3ml, .63mg/3ml, 1.25mg/0.5ml, 1.25mg/3ml	4	B/D
<i>levalbuterol tartrate AERO</i> 45mcg/act QL (2 inhalers / 30 days)	3	QL ST

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **B/D** - Prior Authorization, Part D vs. Part B only **LA** - Limited Availability **ED** - Excluded Drug **GC** - Gap Coverage . **SI** - Select Insulins. Does not apply to AvMed Medicare Premium Saver Broward County (HMO)

All Tier 1 and Tier 2 generics are covered in the Gap Coverage.

Drug Name	Drug Requirements/ Tier	Limits
SEREVENT DISKUS AEPB 50mcg/dose QL (60 inhalations / 30 days)	3	QL
terbutaline sulfate TABS 2.5mg, 5mg	4	
VENTOLIN HFA AERS 108mcg/act QL (2 inhalers / 30 days)	3	QL
VENTOLIN HFA (INSTITUTIONAL PACK) AERS 108mcg/act QL (6 inhalers / 30 days)	3	QL
LEUKOTRIENE MODULATORS		
montelukast sodium CHEW 4mg, 5mg	3	
montelukast sodium PACK 4mg	4	
montelukast sodium TABS 10mg	1	GC
zafirlukast TABS 10mg, 20mg	3	
MISCELLANEOUS		
acetylcysteine SOLN 10%, 20%	4	B/D
ARALAST NP SOLR 500mg, 1000mg	5	LA PA
cromolyn sodium NEBU 20mg/2ml	3	B/D
DALIRESP TABS 250mcg, 500mcg	4	
epinephrine (anaphylaxis) SOAJ .15mg/0.3ml, .3mg/0.3ml (generic of EpiPen)	3	
epinephrine (anaphylaxis) SOAJ .15mg/0.15ml, .3mg/0.3ml (generic of Adrenaclick)	3	
ESBRIET CAPS 267mg QL (270 caps / 30 days)	5	QL LA PA
FASENRA SOSY 30mg/ml	5	LA PA
FASENRA PEN SOAJ 30mg/ml	5	LA PA
KALYDECO PACK 25mg, 50mg, 75mg QL (56 packs / 28 days)	5	QL LA PA

Drug Name	Drug Requirements/ Tier	Limits
KALYDECO TABS 150mg QL (60 tabs / 30 days)	5	QL LA PA
OFEV CAPS 100mg, 150mg QL (60 caps / 30 days)	5	QL LA PA
ORKAMBI GRA 75-94MG QL (56 packs / 28 days)	5	QL LA PA
ORKAMBI GRA 100-125 QL (56 packs / 28 days)	5	QL LA PA
ORKAMBI GRA 150-188 QL (56 packs / 28 days)	5	QL LA PA
ORKAMBI TAB 100-125 QL (112 tabs / 28 days)	5	QL LA PA
ORKAMBI TAB 200-125 QL (112 tabs / 28 days)	5	QL LA PA
pirfenidone CAPS 267mg QL (270 caps / 30 days)	5	QL PA
pirfenidone TABS 267mg QL (270 tabs / 30 days)	5	QL PA
pirfenidone TABS 534mg, 801mg QL (90 tabs / 30 days)	5	QL PA
PROLASTIN-C SOLN 1000mg/20ml; SOLR 1000mg	5	LA PA
PULMOZYME SOLN 2.5mg/2.5ml	5	PA
roflumilast TABS 250mcg, 500mcg	3	
SYMDEKO TAB 50-75MG QL (56 tabs / 28 days)	5	QL LA PA
SYMDEKO TAB 100-150 QL (56 tabs / 28 days)	5	QL LA PA
SYMJEPI SOSY .15mg/0.3ml, .3mg/0.3ml	4	
THEO-24 CP24 100mg, 200mg, 300mg, 400mg	4	
theophylline ELIX 80mg/15ml; SOLN 80mg/15ml; TB12 300mg, 450mg	4	
theophylline TB24 400mg, 600mg	3	
TRIKAF TA TAB 50-25- 37.5MG & 75MG QL (84 tabs / 28 days)	5	QL LA PA

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **B/D** - Prior Authorization, Part D vs. Part B only **LA** - Limited Availability **ED** - Excluded Drug **GC** - Gap Coverage . **SI** - Select Insulins. Does not apply to AvMed Medicare Premium Saver Broward County (HMO)

All Tier 1 and Tier 2 generics are covered in the Gap Coverage.

Drug Name	Drug Requirements/ Tier	Limits
TRIKAFTA TAB 100-50-75MG & 150MG QL (84 tabs / 28 days)	5	QL LA PA
XOLAIR SOLR 150mg; SOSY 75mg/0.5ml, 150mg/ml	5	LA PA
ZEMAIRA SOLR 1000mg	5	LA PA
NASAL STEROIDS		
<i>flunisolide (nasal)</i> SOLN .025% QL (3 bottles / 30 days)	3	QL
<i>fluticasone propionate (nasal)</i> SUSP 50mcg/act QL (1 bottle / 30 days)	2	GC QL
<i>mometasone furoate (nasal)</i> SUSP 50mcg/act QL (2 inhalers / 30 days)	4	QL ST
OMNARIS SUSP 50mcg/act QL (1 inhaler / 30 days)	4	QL ST
XHANCE EXHU 93mcg/act QL (32 mL / 30 days)	4	QL PA
STERIOD INHALANTS		
ARNUITY ELLIPTA AEPB 50mcg/act, 100mcg/act, 200mcg/act QL (30 inhalations / 30 days)	3	QL
<i>budesonide (inhalation)</i> SUSP .25mg/2ml, .5mg/2ml	4	B/D
FLOVENT DISKUS AEPB 50mcg/blist QL (180 inhalations / 30 days)	3	QL
FLOVENT DISKUS AEPB 100mcg/blist, 250mcg/blist QL (240 inhalations / 30 days)	3	QL
FLOVENT HFA AERO 44mcg/act, 110mcg/act, 220mcg/act QL (2 inhalers / 30 days)	3	QL
PULMICORT FLEXHALER AEPB 90mcg/act QL (3 inhalers / 30 days)	4	QL
PULMICORT FLEXHALER AEPB 180mcg/act QL (2 inhalers / 30 days)	4	QL

Drug Name	Drug Requirements/ Tier	Limits
STERIOD/BETA-AGONIST COMBINATIONS		
ADVAIR DISKU AER 100/50 QL (60 inhalations / 30 days)	3	QL
ADVAIR DISKU AER 250/50 QL (60 inhalations / 30 days)	3	QL
ADVAIR DISKU AER 500/50 QL (60 inhalations / 30 days)	3	QL
ADVAIR HFA AER 45/21 QL (1 inhaler / 30 days)	3	QL
ADVAIR HFA AER 115/21 QL (1 inhaler / 30 days)	3	QL
ADVAIR HFA AER 230/21 QL (1 inhaler / 30 days)	3	QL
BREO ELLIPTA INH 100-25 QL (60 blisters / 30 days)	3	QL
BREO ELLIPTA INH 200-25 QL (60 blisters / 30 days)	3	QL
SYMBICORT AER 80-4.5 QL (1 inhaler / 30 days)	3	QL
SYMBICORT AER 160-4.5 QL (1 inhaler / 30 days)	3	QL
TOPICAL DERMATOLOGY, ACNE		
<i>accutane</i> CAPS 10mg, 20mg, 30mg, 40mg	4	PA
<i>amnesteem</i> CAPS 10mg, 20mg, 40mg	4	PA
<i>avita</i> CREA .025%; GEL .025% QL (45 gm / 30 days)	4	QL PA
<i>benzoyl peroxide-erythromycin gel</i> 5-3% QL (46.6 gm / 30 days)	4	QL
<i>claravis</i> CAPS 10mg, 20mg, 30mg, 40mg	4	PA
<i>clindamycin phosphate (topical)</i> GEL 1% QL (75 gm / 30 days)	4	QL

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **B/D** - Prior Authorization, Part D vs. Part B only **LA** - Limited Availability **ED** - Excluded Drug **GC** - Gap Coverage . **SI** - Select Insulins. Does not apply to AvMed Medicare Premium Saver Broward County (HMO)

All Tier 1 and Tier 2 generics are covered in the Gap Coverage.

Drug Name	Drug Requirements/ Tier	Limits
<i>clindamycin phosphate (topical)</i> LOTN 1%; SOLN 1% QL (60 mL / 30 days)	3	QL
<i>ery PADS</i> 2% QL (60 pledgets / 30 days)	3	QL
<i>erythromycin (acne aid)</i> SOLN 2% QL (60 mL / 30 days)	3	QL
<i>isotretinoin</i> CAPS 10mg, 20mg, 30mg, 40mg	4	PA
<i>myorisan</i> CAPS 10mg, 20mg, 30mg, 40mg	4	PA
<i>sulfacetamide sodium (acne)</i> LOTN 10% QL (118 mL / 30 days)	4	QL
<i>tretinoin</i> CREA .025%, .05%, .1%; GEL .01%, .025% QL (45 gm / 30 days)	4	QL PA
<i>zenatane</i> CAPS 10mg, 20mg, 30mg, 40mg	4	PA
DERMATOLOGY, ANTIBIOTICS		
<i>gentamicin sulfate (topical)</i> CREA .1% QL (30 gm / 30 days)	4	QL
<i>gentamicin sulfate (topical)</i> OINT .1% QL (30 gm / 30 days)	3	QL
<i>mupirocin</i> OINT 2% QL (220 gm / 30 days)	2	GC QL
<i>silver sulfadiazine</i> CREA 1%	2	GC
<i>ssd</i> CREA 1%	2	GC
<i>SULFAMYLON</i> CREA 85mg/gm QL (453.6 gm / 30 days)	4	QL
DERMATOLOGY, ANTIFUNGALS		
<i>ciclopirox olamine</i> CREA .77% QL (90 gm / 30 days)	3	QL
<i>ciclopirox olamine</i> SUSP .77% QL (60 mL / 30 days)	3	QL
<i>clotrimazole (topical)</i> 1% QL (45 gm / 30 days)	3	QL

Drug Name	Drug Requirements/ Tier	Limits
<i>clotrimazole (topical)</i> SOLN 1% QL (30 mL / 30 days)	3	QL
<i>clotrimazole w/ betamethasone cream</i> 1-0.05% QL (45 gm / 30 days)	3	QL
<i>ketoconazole (topical)</i> CREA 2% QL (60 gm / 30 days)	3	QL
<i>nyamyc</i> POWD 100000unit/gm QL (60 gm / 30 days)	3	QL
<i>nystatin (topical)</i> CREA 100000unit/gm; OINT 100000unit/gm QL (30 gm / 30 days)	3	QL
<i>nystatin (topical)</i> POWD 100000unit/gm QL (60 gm / 30 days)	3	QL
<i>nystop</i> POWD 100000unit/gm QL (60 gm / 30 days)	3	QL
DERMATOLOGY, ANTIPSORIATICS		
<i>acitretin</i> CAPS 10mg, 17.5mg, 25mg	4	PA
<i>calcipotriene</i> OINT .005% QL (120 gm / 30 days)	4	QL PA
<i>calcipotriene</i> SOLN .005% QL (120 mL / 30 days)	4	QL PA
<i>calcitrene</i> OINT .005% QL (120 gm / 30 days)	4	QL PA
<i>tazarotene</i> CREA .1% QL (60 gm / 30 days)	3	QL PA
<i>TAZORAC</i> CREA .05% QL (60 gm / 30 days)	4	QL PA
DERMATOLOGY, ANTISEBORRHEICS		
<i>ketoconazole (topical)</i> SHAM 2% QL (120 mL / 30 days)	2	GC QL
<i>selenium sulfide</i> LOTN 2.5%	2	GC
DERMATOLOGY, CORTICOSTEROIDS		
<i>ala-cort</i> CREA 1%	1	GC
<i>ala-cort</i> CREA 2.5%	2	GC
<i>alclometasone dipropionate</i> CREA .05%; OINT .05% QL (60 gm / 30 days)	3	QL

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **B/D** - Prior Authorization, Part D vs. Part B only **LA** - Limited Availability **ED** - Excluded Drug **GC** - Gap Coverage . **SI** - Select Insulins. Does not apply to AvMed Medicare Premium Saver Broward County (HMO)

60

All Tier 1 and Tier 2 generics are covered in the Gap Coverage.

Drug Name	Drug Requirements/ Tier	Limits
<i>betamethasone dipropionate (topical)</i> CREA .05% QL (120 gm / 30 days)	3	QL
<i>betamethasone dipropionate (topical)</i> LOTN .05% QL (120 mL / 30 days)	3	QL
<i>betamethasone dipropionate (topical)</i> OINT .05% QL (120 gm / 30 days)	4	QL
<i>betamethasone dipropionate augmented</i> CREA .05% QL (120 gm / 30 days)	2	GC QL
<i>betamethasone dipropionate augmented</i> GEL .05%; OINT .05% QL (120 gm / 30 days)	4	QL
<i>betamethasone dipropionate augmented</i> LOTN .05% QL (120 mL / 30 days)	4	QL
<i>betamethasone valerate</i> CREA .1%; OINT .1% QL (120 gm / 30 days)	3	QL
<i>betamethasone valerate</i> LOTN .1% QL (120 mL / 30 days)	3	QL
<i>clobetasol propionate</i> CREA .05% QL (60 gm / 30 days)	3	QL
<i>clobetasol propionate</i> GEL .05%; OINT .05% QL (60 gm / 30 days)	4	QL
<i>clobetasol propionate</i> SOLN .05% QL (50 mL / 30 days)	4	QL
<i>clobetasol propionate e</i> CREA .05% QL (60 gm / 30 days)	4	QL
ENSTILAR AER QL (120 gm / 30 days)	4	QL PA
<i>fluocinolone acetonide</i> CREA .01% QL (60 gm / 30 days)	4	QL
<i>fluocinolone acetonide</i> CREA .025% QL (120 gm / 30 days)	4	QL

Drug Name	Drug Requirements/ Tier	Limits
<i>fluocinolone acetonide</i> OIL .01% QL (118.28 mL / 30 days)	3	QL
<i>fluocinolone acetonide</i> OINT .025% QL (120 gm / 30 days)	3	QL
<i>fluocinolone acetonide</i> SOLN .01% QL (90 mL / 30 days)	4	QL
<i>fluocinonide</i> CREA .05% QL (120 gm / 30 days)	3	QL
<i>fluocinonide</i> GEL .05%; OINT .05% QL (60 gm / 30 days)	4	QL
<i>fluocinonide</i> SOLN .05% QL (60 mL / 30 days)	3	QL
<i>fluocinonide emulsified base</i> CREA .05% QL (120 gm / 30 days)	3	QL
<i>fluticasone propionate</i> CREA .05%; OINT .005%	3	
<i>halobetasol propionate</i> CREA .05%; OINT .05% QL (50 gm / 30 days)	4	QL
<i>hydrocortisone (topical)</i> CREA 1%	1	GC
<i>hydrocortisone (topical)</i> CREA 2.5%; LOTN 2.5%; OINT 2.5%	2	GC
<i>mometasone furoate</i> CREA .1%; OINT .1%; SOLN .1%	3	
<i>triamcinolone acetonide (topical)</i> CREA .1% QL (454 gm / 30 days)	2	GC QL
<i>triamcinolone acetonide (topical)</i> CREA .025%, .5%; OINT .025%, .1%, .5%	2	GC
<i>triamcinolone acetonide (topical)</i> LOTN .025%, .1%	3	
DERMATOLOGY, LOCAL ANESTHETICS		
<i>glydo</i> PRSY 2% QL (60 mL / 30 days)	4	QL PA
<i>lidocaine</i> OINT 5% QL (50 gm / 30 days)	4	QL PA

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **B/D** - Prior Authorization, Part D vs. Part B only **LA** - Limited Availability **ED** - Excluded Drug **GC** - Gap Coverage . **SI** - Select Insulins. Does not apply to AvMed Medicare Premium Saver Broward County (HMO)

61

All Tier 1 and Tier 2 generics are covered in the Gap Coverage.

Drug Name	Drug Requirements/ Tier	Limits
<i>lidocaine</i> PTCH 5% QL (3 patches / 1 day)	4	QL PA
<i>lidocaine hcl</i> GEL 2% QL (30 mL / 30 days)	4	QL PA
<i>lidocaine hcl</i> SOLN 4% QL (50 mL / 30 days)	3	QL PA
<i>lidocaine-prilocaine cream</i> 2.5-2.5% QL (30 gm / 30 days)	3	QL PA
DERMATOLOGY, MISCELLANEOUS SKIN AND MUCOUS MEMBRANE		
<i>azelaic acid</i> GEL 15% QL (50 gm / 30 days)	4	QL
<i>bexarotene (topical)</i> GEL 1% QL (60 gm / 30 days)	5	QL PA
<i>diclofenac sodium (topical)</i> GEL 1% QL (1000 gm / 30 days)	3	QL
<i>FINACEA</i> FOAM 15% QL (50 gm / 30 days)	4	QL
<i>fluorouracil (topical)</i> CREA 5% QL (40 gm / 30 days)	4	QL
<i>fluorouracil (topical)</i> SOLN 2%, 5% QL (10 mL / 30 days)	3	QL
<i>hydrocortisone (rectal)</i> CREA 2.5% QL (24 packets / 30 days)	2	GC
<i>imiquimod</i> CREA 5% QL (24 packets / 30 days)	3	QL
<i>lactic acid (ammonium lactate)</i> CREA 12% QL (45 gm / 30 days)	2	GC
<i>lactic acid (ammonium lactate)</i> LOTN 12% QL (45 gm / 30 days)	3	GC
<i>metronidazole (topical)</i> CREA .75% QL (45 gm / 30 days)	4	QL
<i>metronidazole (topical)</i> GEL .75% QL (45 gm / 30 days)	3	QL
<i>metronidazole (topical)</i> LOTN .75% QL (59 mL / 30 days)	4	QL
<i>NORITATE</i> CREA 1% QL (60 gm / 30 days)	5	QL

Drug Name	Drug Requirements/ Tier	Limits
<i>PANRETIN</i> GEL .1% QL (60 gm / 30 days)	5	QL PA
<i>podofilox</i> SOLN .5% QL (7 mL / 28 days)	3	QL
<i>procto-med hc</i> CREA 2.5% QL (100 gm / 30 days)	3	
<i>procto-pak</i> CREA 1% QL (100 gm / 30 days)	3	
<i>proctosol hc</i> CREA 2.5% QL (100 gm / 30 days)	3	
<i>proctozone-hc</i> CREA 2.5% QL (100 gm / 30 days)	3	
<i>RECTIV</i> OINT .4% QL (30 gm / 30 days)	4	QL
<i>tacrolimus (topical)</i> OINT .03%, .1% QL (100 gm / 30 days)	4	QL
<i>VALCHLOR</i> GEL .016% QL (60 gm / 30 days)	5	QL LA PA
<i>ZYCLARA PUMP</i> CREA 2.5% QL (7.5 gm / 28 days)	5	QL
DERMATOLOGY, SCABICIDES AND PEDICULIDES		
<i>malathion</i> LOTN .5% QL (59 mL / 30 days)	4	QL
<i>permethrin</i> CREA 5% QL (60 gm / 30 days)	3	QL
DERMATOLOGY, WOUND CARE AGENTS		
<i>REGRANEX</i> GEL .01% QL (30 gm / 30 days)	5	QL PA
<i>SANTYL</i> OINT 250unit/gm QL (180 gm / 30 days)	4	QL
<i>sodium chloride (gu irrigant)</i> SOLN .9% QL (180 gm / 30 days)	3	
<i>water for irrigation, sterile irrigation soln</i>	2	GC
MOUTH/THROAT/DENTAL AGENTS		
<i>cevimeline hcl</i> CAPS 30mg QL (150 lozenges / 30 days)	4	
<i>chlorhexidine gluconate (mouth-throat)</i> SOLN .12% QL (150 lozenges / 30 days)	1	GC
<i>clotrimazole</i> TROC 10mg QL (150 lozenges / 30 days)	4	QL
<i>lidocaine hcl (mouth-throat)</i> SOLN 2% QL (150 lozenges / 30 days)	2	GC
<i>nystatin (mouth-throat)</i> SUSP 100000unit/ml QL (150 lozenges / 30 days)	3	
<i>perio-gard</i> SOLN .12% QL (150 lozenges / 30 days)	1	GC

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **BID** - Prior Authorization, Part D vs. Part B only **LA** - Limited Availability **ED** - Excluded Drug **GC** - Gap Coverage . **SI** - Select Insulins. Does not apply to AvMed Medicare Premium Saver Broward County (HMO)

All Tier 1 and Tier 2 generics are covered in the Gap Coverage.

Drug Name	Drug Requirements/ Tier	Limits
<i>pilocarpine hcl (oral)</i> TABS 5mg, 7.5mg	3	
<i>triamcinolone acetonide</i> (mouth) PSTE .1%	3	
Vitamins		
<i>Vitamin B Complex</i>		
<i>cyanocobalamin</i> SOLN 1000mcg/ml	2	ED GC
<i>folic acid</i> TABS 1mg QL (30 tabs / 30 days)	1	ED GC QL
<i>Vitamin D</i>		
<i>ergocalciferol</i> CAPS 50000unit QL (4 caps / 28 days)	2	ED GC QL
<i>Vitamin K Activity</i>		
<i>phytonadione</i> TABS 5mg QL (60 tabs / 30 days)	4	ED QL

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **B/D** - Prior Authorization, Part D vs. Part B only **LA** - Limited Availability **ED** - Excluded Drug **GC** - Gap Coverage . **SI** - Select Insulins. Does not apply to AvMed Medicare Premium Saver Broward County (HMO)

All Tier 1 and Tier 2 generics are covered in the Gap Coverage.

Index

A		
abacavir sulfate.....	12	
abacavir sulfate-lamivudine tab 600-300 mg.....	12	
ABELCET	11	
ABILIFY MAINTENA.....	33	
abiraterone acetate.....	17	
acamprosate calcium.....	38	
acarbose	39	
accutane	59	
acebutolol hcl.....	25	
acetaminophen w/ codeine soln 120-12 mg/5ml.....	9	
acetaminophen w/ codeine tab 300-15 mg.....	9	
acetaminophen w/ codeine tab 300-30 mg.....	9	
acetaminophen w/ codeine tab 300-60 mg.....	9	
acetazolamide	26	
acetic acid.....	49	
acetic acid (otic).....	56	
acetylcysteine	58	
acitretin	60	
ACTHIB INJ.....	53	
ACTIMMUNE.....	52	
acyclovir.....	13	
acyclovir sodium	13	
ADACEL INJ.....	53	
adefovir dipivoxil	13	
ADEMPAS	28	
ADRENALIN	27	
ADVAIR DISKU AER 100/50	59	
ADVAIR DISKU AER 250/50	59	
ADVAIR DISKU AER 500/50	59	
ADVAIR HFA AER 115/21	59	
ADVAIR HFA AER 230/21	59	
ADVAIR HFA AER 45/21	59	
afirmelle	42	
AIMOVIG	36	
ala-cort.....	60	
albendazole	10	
albuterol sulfate	57	
alclometasone dipropionate	60	
ALDURAZYME	45	
ALECENSA	18	
alendronate sodium	42	
alfuzosin hcl	49	
aliskiren fumarate	27	
allopurinol	8	
alosetron hcl	48	
ALPHAGAN P.....	56	
alprazolam	28	
ALREX.....	55	
altavera	42	
ALTOPREV	24	
ALUNBRIG	18	
ALUNBRIG PAK	18	
alyacen 1/35	42	
alyacen 7/7/7	42	
amabelz	44	
amantadine hcl	32	
ambrisentan	28	
amikacin sulfate	10	
amiloride & hydrochlorothiazide tab 5-50 mg.....	26	
amiloride hcl.....	26	
amiodarone hcl	24	
amitriptyline hcl.....	31	
amlodipine besylate	26	
amlodipine besylate- atorvastatin calcium tab 10-10 mg.....	27	
amlodipine besylate- atorvastatin calcium tab 10-20 mg.....	27	
amlodipine besylate- atorvastatin calcium tab 10-40 mg.....	27	
amlodipine besylate- atorvastatin calcium tab 10-80 mg.....	27	
amlodipine besylate- atorvastatin calcium tab 2.5-10 mg.....	27	
amlodipine besylate- atorvastatin calcium tab 2.5-20 mg.....	27	
amlodipine besylate- atorvastatin calcium tab 2.5-40 mg.....	27	
amlodipine besylate- atorvastatin calcium tab 5-10 mg.....	27	
amlodipine besylate- atorvastatin calcium tab 5-20 mg.....	27	
amlodipine besylate- atorvastatin calcium tab 5-40 mg.....	27	
amlodipine besylate- atorvastatin calcium tab 5-80 mg.....	27	
amlodipine besylate- benazepril hcl cap 10-20 mg	21	
amlodipine besylate- benazepril hcl cap 10-40 mg	21	
amlodipine besylate- benazepril hcl cap 2.5-10 mg	21	
amlodipine besylate- benazepril hcl cap 5-10 mg	21	
amlodipine besylate- benazepril hcl cap 5-20 mg	21	
amlodipine besylate- benazepril hcl cap 5-40 mg	21	
amlodipine besylate- olmesartan medoxomil tab 10-20 mg.....	22	
amlodipine besylate- olmesartan medoxomil tab 10-40 mg.....	22	
amlodipine besylate- olmesartan medoxomil tab 5-20 mg.....	22	
amlodipine besylate- olmesartan medoxomil tab 5-40 mg.....	22	
amlodipine besylate- valsartan tab 10-160 mg	22	

amlodipine besylate- valsartan tab 10-320 mg.....22	amphetamine- dextroamphetamine cap er 24hr 30 mg.....35	ANORO ELLIPT AER 62.5- 25 .....56
amlodipine besylate- valsartan tab 5-160 mg22	amphetamine- dextroamphetamine cap er 24hr 5 mg.....35	aprepitant.....47
amlodipine besylate- valsartan tab 5-320 mg22	amphetamine- dextroamphetamine tab 10 mg .....35	aprepitant capsule therapy pack 80 & 125 mg .....47
amnestem .....59	amphetamine- dextroamphetamine tab 12.5 mg .....35	apri.....42
amoxapine .....31	amphetamine- dextroamphetamine tab 15 mg .....35	APTIOM .....28
amoxicillin .....15	amphetamine- dextroamphetamine tab 20 mg .....36	APTIVUS .....12
amoxicillin & k clavulanate chew tab 200-28.5 mg.15	amphetamine- dextroamphetamine tab 30 mg .....36	ARALAST NP .....58
amoxicillin & k clavulanate chew tab 400-57 mg....15	amphetamine- dextroamphetamine tab 7.5 mg .....35	aranelle .....42
amoxicillin & k clavulanate for susp 200-28.5 mg/5ml.....15	amphotericin b .....11	ARCALYST.....52
amoxicillin & k clavulanate for susp 250-62.5 mg/5ml.....15	amphotericin b liposome.11	arformoterol tartrate .....57
amoxicillin & k clavulanate for susp 400-57 mg/5ml.....15	ampicillin .....15	aripiprazole .....33
amoxicillin & k clavulanate for susp 600-42.9 mg/5ml.....15	ampicillin & sulbactam sodium for inj 1.5 (1-0.5) gm .....15	ARISTADA.....33
amoxicillin & k clavulanate tab 250-125 mg .....15	ampicillin & sulbactam sodium for inj 3 (2-1) gm.....15	ARISTADA INITIO .....33
amoxicillin & k clavulanate tab 500-125 mg .....15	ampicillin & sulbactam sodium for iv soln 1.5 (1- 0.5) gm .....15	armodafinil .....38
amoxicillin & k clavulanate tab 875-125 mg .....15	ampicillin & sulbactam sodium for iv soln 15 (10- 5) gm .....15	ARNUITY ELLIPTA.....59
amoxicillin & k clavulanate tab er 12hr 1000-62.5 mg.....15	ampicillin sodium .....15	asenapine maleate .....33
amphetamine- dextroamphetamine cap er 24hr 10 mg.....35	anagrelide hcl .....50	aspirin-dipyridamole cap er 12hr 25-200 mg.....50
amphetamine- dextroamphetamine cap er 24hr 15 mg.....35	anastrozole .....17	atazanavir sulfate.....12
amphetamine- dextroamphetamine cap er 24hr 20 mg.....35		atenolol .....25
amphetamine- dextroamphetamine cap er 24hr 25 mg.....35		atenolol & chlorthalidone tab 100-25 mg .....25
		atenolol & chlorthalidone tab 50-25 mg .....25
		atomoxetine hcl.....36
		atorvastatin calcium .....24
		atovaquone .....10
		atovaquone-proguanil hcl tab 250-100 mg .....12
		atovaquone-proguanil hcl tab 62.5-25 mg .....12
		ATROPINE SULFATE ....56
		atropine sulfate (ophthalmic) .....56
		ATROVENT HFA.....57
		aubra eq .....42
		aurovela 1/20 .....42
		aurovela fe 1.5/30 .....42
		aurovela fe 1/20 .....42
		AUSTEDO .....37
		AUVELITY TAB 45-105MG.....31
		aviane .....42
		avita .....59
		ayuna.....42
		AYVAKIT.....18
		azacitidine .....17

<i>azathioprine</i>	52	<i>betamethasone</i>		<i>brimonidine tartrate</i>	56
<i>azelaic acid</i>	62	<i>dipropionate augmented</i>		<i>brinzolamide</i>	56
<i>azelastine hcl</i>	57	.....	61	BRIVIACT	28
<i>azelastine hcl (ophth)</i>	56	<i>betamethasone valerate</i> ..	61	<i>bromfenac sodium (ophth)</i>	
<i>azithromycin</i>	14	BETASERON	37	.....	55
<i>aztreonam</i>	10	<i>betaxolol hcl (ophth)</i>	56	<i>bromocriptine mesylate</i> ...	32
<i>azurette</i>	42	<i>bethanechol chloride</i>	49	BROMSITE	55
B		BETOPTIC-S	56	BRUKINSA	18
<i>bacitracin (ophthalmic)</i> ...	55	BEVESPI AER 9-4.8MCG		<i>budesonide</i>	47
<i>bacitracin-polymyxin b</i>		.....	57	<i>budesonide (inhalation)</i> ..	59
<i>ophth oint</i>	55	<i>bexarotene</i>	17	<i>bumetanide</i>	26
<i>bacitracin-polymyxin-</i>		<i>bexarotene (topical)</i>	62	<i>buprenorphine hcl</i>	38
<i>neomycin-hc ophth oint</i>		BEXSERO INJ	53	<i>buprenorphine hcl-</i>	
<i>1%</i>	55	<i>bicalutamide</i>	17	<i>naloxone hcl sl film 12-3</i>	
<i>baclofen</i>	38	BICILLIN L-A	15	<i>mg (base equiv)</i>	38
BAFIERTAM	37	BIKTARVY TAB 30-120-15		<i>buprenorphine hcl-</i>	
<i>balsalazide disodium</i>	47	MG	12	<i>naloxone hcl sl film 2-0.5</i>	
BALVERSA	18	BIKTARVY TAB 50-200-25		<i>mg (base equiv)</i>	38
<i>balziva</i>	42	MG	12	<i>buprenorphine hcl-</i>	
BARACLUDE	13	<i>bisoprolol &</i>		<i>naloxone hcl sl film 4-1</i>	
BASAGLAR KWIKPEN ...	40	<i>hydrochlorothiazide tab</i>		<i>mg (base equiv)</i>	38
BCG VACCINE	53	<i>10-6.25 mg</i>	25	<i>buprenorphine hcl-</i>	
BD ALCOHOL SWABS ...	40	<i>bisoprolol &</i>		<i>naloxone hcl sl film 8-2</i>	
BELSOMRA	36	<i>hydrochlorothiazide tab</i>		<i>mg (base equiv)</i>	38
<i>benazepril &</i>		<i>2.5-6.25 mg</i>	25	<i>buprenorphine hcl-</i>	
<i>hydrochlorothiazide tab</i>		<i>bisoprolol &</i>		<i>naloxone hcl sl tab 2-0.5</i>	
<i>10-12.5 mg</i>	21	<i>hydrochlorothiazide tab</i>		<i>mg (base equiv)</i>	38
<i>benazepril &</i>		<i>5-6.25 mg</i>	25	<i>buprenorphine hcl-</i>	
<i>hydrochlorothiazide tab</i>		<i>bisoprolol fumarate</i>	25	<i>naloxone hcl sl tab 8-2</i>	
<i>20-12.5 mg</i>	21	BIVIGAM	52	<i>mg (base equiv)</i>	38
<i>benazepril &</i>		<i>blisovi fe 1.5/30</i>	42	<i>bupropion hcl</i>	31
<i>hydrochlorothiazide tab</i>		BOOSTRIX INJ	53	<i>bupropion hcl (smoking</i>	
<i>20-25 mg</i>	21	<i>bortezomib</i>	18	<i>deterrent)</i>	38
<i>benazepril &</i>		BORTEZOMIB	18	<i>buspirone hcl</i>	28
<i>hydrochlorothiazide tab</i>		<i>bosentan</i>	28	<i>butorphanol tartrate</i>	9
<i>5-6.25mg</i>	21	BOSULIF	18	BYDUREON BCISE	39
<i>benazepril hcl</i>	22	BRAFTOVI	18	BYETTA	39
BENDEKA	16	BREO ELLIPTA INH 100-		C	
BENLYSTA	52	25	59	<i>cabergoline</i>	45
<i>benzoyl peroxide-</i>		BREO ELLIPTA INH 200-		CABOMETYX	18
<i>erythromycin gel 5-3%</i> ..	59	25	59	<i>calcipotriene</i>	60
<i>benztropine mesylate</i>	32	BREZTRI AERO AER		<i>calcitonin (salmon) spray</i> ..	42
BERINERT	50	SPHERE	57	<i>calcitrene</i>	60
BESIVANCE	55	BREZTRI AERO AER		<i>calcitriol</i>	47
BESREMI	17	SPHERE		<i>calcium acetate (phosphate</i>	
<i>betaine powder for oral</i>		(INSTITUTIONAL PACK)		<i>binder)</i>	46
<i>solution</i>	45	.....	57	CALQUENCE	18
<i>betamethasone</i>		<i>biellyn</i>	42	<i>camila</i>	42
<i>dipropionate (topical)</i> ...	61	BRILINTA	50	<i>candesartan cilexetil</i>	24

<i>candesartan cilexetil- hydrochlorothiazide tab 16-12.5 mg</i>.....22	<i>carbidopa-levodopa- entacapone tabs 50-200- 200 mg</i>.....33	<i>cholestyramine light</i>.....25
<i>candesartan cilexetil- hydrochlorothiazide tab 32-12.5 mg</i>.....22	<i>carboplatin</i>.....16	<i>choline fenofibrate</i>.....24
<i>candesartan cilexetil- hydrochlorothiazide tab 32-25 mg</i>.....22	<i>carglumic acid</i>.....45	<i>ciclopirox olamine</i>.....60
<i>CAPLYTA</i>.....33	<i>carteolol hcl (ophth)</i>.....56	<i>cilostazol</i>.....50
<i>CAPRELSA</i>.....18	<i>cartia xt</i>.....26	<i>CILOXAN</i>.....55
<i>captopril</i>.....22	<i>carvedilol</i>.....25	<i>CIMDUO TAB 300-300</i> ...13
<i>carb/levo orally disintegrating tab 10- 100mg</i>.....32	<i>caspofungin acetate</i>.....11	<i>cinacalcet hcl</i>.....45
<i>carb/levo orally disintegrating tab 25- 100mg</i>.....32	<i>CAYSTON</i>.....10	<i>CIPRO</i>.....15
<i>carb/levo orally disintegrating tab 25- 250mg</i>.....32	<i>cefaclor</i>.....14	<i>CIPRO HC SUS OTIC</i> ...56
<i>carbamazepine</i>.....28	<i>CEFACLO ER</i>.....14	<i>ciprofloxacin 200 mg/100ml in d5w</i>.....15
<i>carbidopa</i>.....32	<i>cefadroxil</i>.....14	<i>ciprofloxacin 400 mg/200ml in d5w</i>.....15
<i>carbidopa & levodopa tab 10-100 mg</i>.....32	<i>CEFAZOLIN INJ 1GM/50ML</i>.....14	<i>ciprofloxacin hcl</i>.....15
<i>carbidopa & levodopa tab 25-100 mg</i>.....32	<i>cefazolin sodium</i>.....14	<i>ciprofloxacin hcl (ophth)</i> ..55
<i>carbidopa & levodopa tab 25-250 mg</i>.....32	<i>CEFAZOLIN SOLN 2GM/100ML-4%</i>.....14	<i>ciprofloxacin- dexamethasone otic susp 0.3-0.1%</i>.....56
<i>carbidopa & levodopa tab er 25-100 mg</i>.....32	<i>cefdinir</i>.....14	<i>cisplatin</i>.....16
<i>carbidopa & levodopa tab er 50-200 mg</i>.....32	<i>cefepime hcl</i>.....14	<i>citalopram hydrobromide</i> 31
<i>carbidopa-levodopa- entacapone tabs 12.5- 50-200 mg</i>.....32	<i>cefixime</i>.....14	<i>claravis</i>.....59
<i>carbidopa-levodopa- entacapone tabs 18.75- 75-200 mg</i>.....33	<i>cefoxitin sodium</i>.....14	<i>clarithromycin</i>.....15
<i>carbidopa-levodopa- entacapone tabs 25-100- 200 mg</i>.....33	<i>cefpodoxime proxetil</i>.....14	<i>clindamycin hcl</i>.....10
<i>carbidopa-levodopa- entacapone tabs 31.25- 125-200 mg</i>.....33	<i>cefprozil</i>.....14	<i>clindamycin palmitate hydrochloride</i>.....10
<i>carbidopa-levodopa- entacapone tabs 37.5- 150-200 mg</i>.....33	<i>ceftazidime</i>.....14	<i>clindamycin phosphate</i> ...10
	<i>CEFTAZIDIME/ SOL D5W 1GM</i>.....14	<i>clindamycin phosphate (topical)</i> .....59, 60
	<i>CEFTAZIDIME/ SOL D5W 2GM</i>.....14	<i>clindamycin phosphate in d5w iv soln 300 mg/50ml</i>.....10
	<i>ceftriaxone sodium</i>.....14	<i>clindamycin phosphate in d5w iv soln 600 mg/50ml</i>.....10
	<i>cefuroxime axetil</i>.....14	<i>clindamycin phosphate in d5w iv soln 900 mg/50ml</i>.....10
	<i>cefuroxime sodium</i>.....14	<i>clindamycin phosphate vaginal</i>.....49
	<i>celecoxib</i>.....8	<i>CLINDMYC/NAC INJ 300/50ML</i>.....10
	<i>CELONTIN</i>.....28	<i>CLINDMYC/NAC INJ 600/50ML</i>.....10
	<i>cephalexin</i>.....14	<i>CLINDMYC/NAC INJ 900/50ML</i>.....10
	<i>CERDELGA</i>.....45	<i>CLINIMIX INJ 4.25/D10</i> ..54
	<i>CEREZYME</i>.....45	<i>CLINIMIX INJ 4.25/D5W</i> ..54
	<i>cetirizine hcl</i>.....57	<i>CLINIMIX INJ 5%/D15W</i> ..54
	<i>cevimeline hcl</i>.....62	<i>CLINIMIX INJ 5%/D20W</i> ..54
	<i>chateal</i>.....42	
	<i>CHEMET</i>.....42	
	<i>chlorhexidine gluconate (mouth-throat)</i>.....62	
	<i>chloroquine phosphate</i> ...12	
	<i>chlorpromazine hcl</i>.....33	
	<i>CHLORPROMAZINE HYDROCHLOR</i>.....33	
	<i>chlorthalidone</i>.....26	
	<i>cholestyramine</i>.....25	

CLINIMIX INJ 6/5.....54	<i>cromolyn sodium</i>	<i>desloratadine</i> .....57
CLINIMIX INJ 8/10.....54	(mastocytosis) .....48	<i>desmopressin acetate</i>.....45
CLINIMIX INJ 8/14.....54	<i>cromolyn sodium (ophth)</i> 56	<i>desmopressin acetate</i>
<i>clinisol sf 15%</i> .....55	<i>cryselle-28</i> .....42	<i>spray</i> .....45
CLINOLIPID EMU 20%...55	<i>cyanocobalamin</i> .....63	<i>desmopressin acetate</i>
<i>clobazam</i> .....28	<i>cyclobenzaprine hcl</i> .....38	<i>spray refrigerated</i> .....45
<i>clobetasol propionate</i>.....61	<i>cyclophosphamide</i> .....16	<i>desogest-eth estrad & eth</i>
<i>clobetasol propionate e</i> ...61	CYCLOPHOSPHAMIDE .16	<i>estrad tab 0.15-0.02/0.01</i>
<i>clomipramine hcl</i>.....31	CYCLOPHOSPHAMIDE	<i>mg(21/5)</i>.....42
<i>clonazepam</i> .....28	MONOHYDR.....16	<i>desogestrel & ethinyl</i>
<i>clonidine</i> .....27	<i>cycloserine</i>.....13	<i>estradiol tab 0.15 mg-30</i>
<i>clonidine hcl</i>.....27	<i>cyclosporine</i> .....52	<i>mcg</i> .....42
<i>clopidogrel bisulfate</i> .....50	<i>cyclosporine modified (for</i>	<i>desvenlafaxine succinate</i> 31
<i>clorazepate dipotassium</i> .28	<i>microemulsion)</i> .....52	<i>dexamethasone</i> .....45
<i>clotrimazole</i> .....62	<i>cyproheptadine hcl</i>.....57	DEXAMETHASONE
<i>clotrimazole (topical)</i> .....60	<i>cyred eq</i>.....42	INTENSOL .....45
<i>clotrimazole w/</i>	CYSTADROPS .....56	<i>dexamethasone sodium</i>
<i>betamethasone cream 1-</i>	CYSTAGON.....45	<i>phosphate</i> .....45
<i>0.05%</i> .....60	CYSTARAN .....56	<i>dexamethasone sodium</i>
<i>clozapine</i> .....33, 34	<i>cytarabine</i> .....17	<i>phosphate (ophth)</i> .....55
COARTEM TAB 20-120MG	D	<i>dexmethylphenidate hcl</i> ..36
.....12	D10W/NACL INJ 0.2%...53	<i>dextrose</i> .....55
<i>colchicine</i> .....8	D2.5W/NACL INJ 0.45%.53	<i>dextrose 10% w/ sodium</i>
<i>colchicine w/ probenecid</i>	D5W/LYTES INJ #48 .....53	<i>chloride 0.45%</i> .....53
<i>tab 0.5-500 mg</i> .....8	<i>dabigatran etexilate</i>	<i>dextrose 2.5% w/ sodium</i>
<i>colesevelam hcl</i> .....25	<i>mesylate</i>.....49	<i>chloride 0.45%</i> .....53
<i>colestipol hcl</i> .....25	<i>dalfampridine</i> .....37	<i>dextrose 5% in lactated</i>
<i>colistimethate sodium</i> ....10	DALIRESP .....58	<i>ringers</i> .....53
COMBIGAN SOL 0.2/0.5%	<i>danazol</i> .....44	<i>dextrose 5% w/ sodium</i>
.....56	<i>dantrolene sodium</i> .....38	<i>chloride 0.2%</i> .....53
COMBIVENT AER 20-100	<i>dapsone</i>.....10	<i>dextrose 5% w/ sodium</i>
.....57	DAPTACEL INJ .....53	<i>chloride 0.225%</i> .....53
COMETRIQ (60MG DOSE)	<i>daptomycin</i> .....10	<i>dextrose 5% w/ sodium</i>
.....18	DAPTOMYCIN.....10	<i>chloride 0.3%</i> .....53
COMETRIQ KIT 100MG .18	<i>darifenacin hydrobromide</i>	<i>dextrose 5% w/ sodium</i>
COMETRIQ KIT 140MG .18	49	<i>chloride 0.45%</i> .....53
COMPLERA TAB.....13	<i>dasetta 1/35</i>.....42	<i>dextrose 5% w/ sodium</i>
<i>compro</i>.....47	<i>dasetta 7/7/7</i> .....42	<i>chloride 0.9%</i> .....53
<i>constulose</i> .....48	DAURISMO .....18	DIACOMIT .....28
COPIKTRA .....18	<i>deblitane</i> .....42	<i>diazepam</i> .....29
CORLANOR .....27	<i>deferasirox</i>.....42	<i>diazepam (anticonvulsant)</i>
COTELLIC .....18	DELESTROGEN.....44	29
CREON CAP 12000UNT 48	DELSTRIGO TAB .....13	<i>diazepam inj</i>.....29
CREON CAP 24000UNT 48	DENG VAXIA SUS .....53	<i>diazoxide</i> .....45
CREON CAP 3000UNIT .48	DESCOVY TAB 120-15MG	<i>diclofenac potassium</i> .....8
CREON CAP 36000UNT 48	13	<i>diclofenac sodium</i> .....8
CREON CAP 6000UNIT .48	DESCOVY TAB 200/25MG	<i>diclofenac sodium (ophth)</i>
<i>cromolyn sodium</i>.....58	13	55
	<i>desipramine hcl</i>.....31	

<i>diclofenac sodium (topical)</i> .....62	<i>doxepin hcl</i> .....31	EMCYT .....17
<i>diclofenac w/ misoprostol</i> <i>tab delayed release 50-</i> <i>0.2 mg</i> .....8	<i>doxepin hcl (sleep)</i>.....36	<i>emoquette</i> .....42
<i>diclofenac w/ misoprostol</i> <i>tab delayed release 75-</i> <i>0.2 mg</i> .....8	<i>doxercalciferol</i>.....47	EMSAM .....31
<i>dicloxacillin sodium</i> .....16	<i>doxorubicin hcl</i>.....16	<i>emtricitabine</i> .....12
<i>dicyclomine hcl</i> .....47	<i>doxorubicin hcl liposomal</i> 16	<i>emtricitabine-tenofovir</i> <i>disoproxil fumarate tab</i> <i>100-150 mg</i> .....13
DIFICID.....15	<i>doxy 100</i> .....16	<i>emtricitabine-tenofovir</i> <i>disoproxil fumarate tab</i> <i>133-200 mg</i> .....13
<i>diflunisal</i>.....8	<i>doxycycline (monohydrate)</i> .....16	<i>emtricitabine-tenofovir</i> <i>disoproxil fumarate tab</i> <i>167-250 mg</i> .....13
<i>difluprednate</i> .....55	<i>doxycycline hyclate</i> .....16	<i>emtricitabine-tenofovir</i> <i>disoproxil fumarate tab</i> <i>200-300 mg</i> .....13
<i>digoxin</i> .....27	DRIZALMA SPRINKLE...31	EMTRIVA.....12
<i>dihydroergotamine</i> <i>mesylate</i>.....37	<i>dronabinol</i> .....47	EMVERM .....10
DILANTIN .....29	<i>drospirenone-ethinyl</i> <i>estradiol tab 3-0.02 mg</i> 42	<i>enalapril maleate</i> .....22
DILANTIN INFATABS....29	<i>drospirenone-ethinyl</i> <i>estradiol tab 3-0.03 mg</i> 42	<i>enalapril maleate &</i> <i>hydrochlorothiazide tab</i> <i>10-25 mg</i> .....21
DILANTIN-125 .....29	DROXIA.....50	<i>enalapril maleate &</i> <i>hydrochlorothiazide tab</i> <i>5-12.5 mg</i> .....21
<i>diltiazem hcl</i> .....26	<i>droxidopa</i> .....27	ENBREL .....51
<i>diltiazem hcl coated beads</i>.....26	<i>duloxetine hcl</i>.....31	ENBREL MINI.....51
<i>diltiazem hcl extended</i> <i>release beads</i>.....26	DUPIXENT .....51	ENBREL SURECLICK...51
<i>dilt-xr</i> .....26	<i>dutasteride</i> .....49	ENDARI .....50
DIP/TET PED INJ 25-5LFU.....53	<i>dutasteride-tamsulosin hcl</i> <i>cap 0.5-0.4 mg</i> .....49	<i>endocet tab 10-325mg</i>.....9
<i>diphenhydramine hcl</i>.....57	E	<i>endocet tab 2.5-325mg</i>.....9
<i>diphenoxylate w/ atropine</i> <i>liq 2.5-0.025 mg/5ml</i>....48	<i>e.e.s. 400</i> .....15	<i>endocet tab 5-325mg</i>.....9
<i>diphenoxylate w/ atropine</i> <i>tab 2.5-0.025 mg</i> .....48	<i>ec-naproxen</i> .....8	<i>endocet tab 7.5-325mg</i>.....9
<i>dipyridamole</i> .....50	EDARBI .....24	ENGERIX-B.....53
<i>disopyramide phosphate</i> ..24	EDARBYCLOR TAB 40- 12.5 .....22	<i>enoxaparin sodium</i> .....49
<i>disulfiram</i> .....38	EDARBYCLOR TAB 40- 25MG .....23	<i>enpresse-28</i>.....42
<i>divalproex sodium</i>.....29	EDURANT .....12	<i>enskyce</i> .....43
<i>docetaxel</i> .....18	<i>efavirenz</i> .....12	ENSTILAR AER.....61
DOCETAXEL .....18	<i>efavirenz-emtricitabine-</i> <i>tenofovir df tab 600-200-</i> <i>300 mg</i> .....13	<i>entacapone</i> .....33
<i>dofetilide</i> .....24	<i>efavirenz-lamivudine-</i> <i>tenofovir df tab 400-300-</i> <i>300 mg</i> .....13	<i>entecavir</i> .....13
<i>donepezil hydrochloride</i> ..31	<i>efavirenz-lamivudine-</i> <i>tenofovir df tab 600-300-</i> <i>300 mg</i> .....13	ENTRESTO TAB 24-26MG.....23
DOPTelet.....50	ELIGARD .....17	ENTRESTO TAB 49-51MG.....23
<i>dorzolamide hcl</i>.....56	<i>elinest</i> .....42	ENTRESTO TAB 97- 103MG .....23
<i>dorzolamide hcl-timolol</i> <i>maleate ophth soln 22.3-</i> <i>6.8 mg/ml</i> .....56	ELIQUIS .....49	<i>enulose</i> .....48
<i>dotti</i>.....44	ELIQUIS STARTER PACK.....49	EPCLUSA PAK 150-37.513
DOVATO TAB 50-300MG.....13	ELLA.....42	
<i>doxazosin mesylate</i> .....22	ELLENCE .....16	
	<i>eluryng</i> .....42	

EPCLUSA PAK 200-50MG.....13	<i>ethynodiol diacetate & ethinyl estradiol tab 1 mg-50 mcg</i> .....43	FETZIMA CAP TITRATIO.....31
EPCLUSA TAB 200-50MG.....13	<i>etodolac</i> .....8	FIASP FLEX INJ TOUCH40
EPCLUSA TAB 400-100.13	<i>etonogestrel-ethinyl estradiol va ring 0.120- 0.015 mg/24hr</i> .....43	FIASP INJ 100/ML .....40
EPIDIOLEX.....29	<i>etoposide</i> .....18	FIASP PENFIL INJ U-100.....40
<i>epinephrine (anaphylaxis)</i> .....58	<i>etravirine</i> .....12	FINACEA .....62
<i>epitol</i> .....29	EULEXIN .....17	<i>finasteride</i> .....49
EPIVIR HBV .....13	<i>euthyrox</i> .....46	<i>finlimod hcl</i>.....37
<i>eplerenone</i> .....22	<i>everolimus</i> .....18	FINTEPLA.....29
EPRONTIA .....29	<i>everolimus (immunosuppressant)</i> .52	<i>flac</i> .....56
<i>ergocalciferol</i> .....63	EVOTAZ TAB 300-150 ...13	FLAREX.....55
<i>ergotamine w/ caffeine tab 1-100 mg</i> .....37	<i>exemestane</i> .....17	FLEBOGAMMA DIF.....52
ERIVEDGE .....18	EXKIVITY .....18	<i>flecainide acetate</i> .....24
ERLEADA.....17	EZALLOR SPRINKLE....24	FLOVENT DISKUS .....59
<i>erlotinib hcl</i> .....18	<i>ezetimibe</i> .....25	FLOVENT HFA .....59
<i>errin</i> .....43	<i>ezetimibe-simvastatin tab 10-10 mg</i> .....25	<i>fluconazole</i>.....11
<i>ertapenem sodium</i> .....10	<i>ezetimibe-simvastatin tab 10-20 mg</i> .....25	<i>fluconazole in nacl 0.9% inj 200 mg/100ml</i> .....11
<i>ery</i>.....60	<i>ezetimibe-simvastatin tab 10-40 mg</i> .....25	<i>fluconazole in nacl 0.9% inj 400 mg/200ml</i> .....11
<i>ery-tab</i> .....15	<i>ezetimibe-simvastatin tab 10-80 mg</i> .....25	<i>flucytosine</i> .....11
ERYTHROCIN	F	<i>fludrocortisone acetate</i> ...45
LACTOBIONATE .....15	FABRAZYME .....45	<i>flunisolide (nasal)</i>.....59
<i>erythrocine stearate</i> .....15	<i>falmina</i> .....43	<i>fluocinolone acetate</i> ....61
<i>erythromycin (acne aid)</i> ..60	<i>famciclovir</i> .....13	<i>fluocinolone acetate (otic)</i> .....56
<i>erythromycin (ophth)</i>.....55	<i>famotidine</i> .....47	<i>fluocinonide</i>.....61
<i>erythromycin base</i> .....15	<i>famotidine in nacl 0.9% iv soln 20 mg/50ml</i>.....47	<i>fluocinonide emulsified base</i> .....61
<i>erythromycin ethylsuccinate</i>.....15	FANAPT .....34	<i>fluorometholone (ophth)</i> ..55
<i>erythromycin lactobionate</i>.....15	FANAPT PAK .....34	<i>fluorouracil</i> .....17
ESBRIET .....58	FARXIGA.....39	<i>fluorouracil (topical)</i> .....62
<i>escitalopram oxalate</i> .....31	FASENRA.....58	<i>fluoxetine hcl</i>.....32
<i>esomeprazole magnesium</i>.....48	FASENRA PEN .....58	<i>fluphenazine decanoate</i> ..34
<i>estarylla</i> .....43	<i>febuxostat</i> .....8	<i>fluphenazine hcl</i>.....34
<i>estradiol</i> .....44	<i>felbamate</i> .....29	<i>flurbiprofen</i>.....8
<i>estradiol & norethindrone acetate tab 0.5-0.1 mg</i> 44	<i>felodipine</i> .....26	<i>flurbiprofen sodium</i> .....55
<i>estradiol & norethindrone acetate tab 1-0.5 mg</i> ...44	<i>femynor</i> .....43	<i>fluticasone propionate</i>.....61
<i>estradiol vaginal</i>.....44	<i>fenofibrate</i>.....24	<i>fluticasone propionate (nasal)</i> .....59
<i>estradiol valerate</i> .....44	<i>fenofibrate micronized</i> ...24	<i>fluvastatin sodium</i> .....24
<i>ethambutol hcl</i> .....13	<i>fentanyl</i> .....8	<i>fluvoxamine maleate</i> .....28
<i>ethosuximide</i> .....29	<i>fentanyl citrate</i> .....9	<i>folic acid</i>.....63
<i>ethynodiol diacetate & ethinyl estradiol tab 1 mg-35 mcg</i> .....43	<i>fesoterodine fumarate</i> ....49	<i>fondaparinux sodium</i> .....49
	FETZIMA .....31	<i>formoterol fumarate</i> .....57
		FORTEO.....42
		FOSAMAX + D TAB 70- 2800 .....42

FOSAMAX + D TAB 70-560042
 fosamprenavir calcium12
 fosinopril sodium22
 fosinopril sodium & hydrochlorothiazide tab 10-12.5 mg21
 fosinopril sodium & hydrochlorothiazide tab 20-12.5 mg21
 FOTIVDA18
 FREAMINE III INJ 10%...55
 fulvestrant17
 furosemide26
 furosemide inj26
 FUZEON12
 fyavolv tab 0.5mg-2.5mcg44
 fyavolv tab 1mg-5mcg....44
 FYCOMPA.....29
G
 gabapentin29
 galantamine hydrobromide31
 GAMASTAN INJ52
 GAMMAGARD LIQUID...52
 GAMMAGARD S/D IGA LESS TH52
 GAMMAKED.....52
 GAMMAPLEX.....52
 GAMUNEX-C.....52
 ganciclovir sodium13
 GARDASIL 9 INJ53
 gatifloxacin (ophth)55
 GATTEX48
 GAUZE PADS 2.....40
 gavilyte-c48
 gavilyte-g48
 GAVRETO18
 gemcitabine hcl.....17
 gemfibrozil24
 GEMTESA49
 generlac48
 gengraf52
 GENOTROPIN.....45
 GENOTROPIN MINISQUICK45
 gentak55

gentamicin in saline inj 0.8 mg/ml10
 gentamicin in saline inj 1 mg/ml10
 gentamicin in saline inj 1.2 mg/ml10
 gentamicin in saline inj 1.6 mg/ml10
 gentamicin in saline inj 2 mg/ml10
 gentamicin sulfate10
 gentamicin sulfate (ophth)55
 gentamicin sulfate (topical)60
 GENVOYA TAB13
 GILENYA37
 GILOTTRIF18
 glatiramer acetate37
 glatopa37, 38
 GLEOSTINE16
 glimepiride39
 glipizide39
 glipizide xl39
 glipizide-metformin hcl tab 2.5-250 mg39
 glipizide-metformin hcl tab 2.5-500 mg39
 glipizide-metformin hcl tab 5-500 mg39
 glycopyrrolate47
 glydo61
 GLYXAMBI TAB 10-5 MG39
 GLYXAMBI TAB 25-5 MG39
 GOLYTELY SOL.....48
 GRALISE37
 granisetron hcl47
 griseofulvin microsize11
 griseofulvin ultramicrosize11
 guanfacine hcl.....27
 guanfacine hcl (adhd)36
 GVOKE HYPOPEN 2-PACK45
 GVOKE KIT45
 GVOKE PFS45

H
 HAEGARDA.....50
 hailey 1.5/3043
 halobetasol propionate ...61
 haloperidol34
 haloperidol decanoate34
 haloperidol lactate.....34
 HARVONI PAK 33.75-150MG13
 HARVONI PAK 45-200MG13
 HARVONI TAB 45-200MG13
 HARVONI TAB 90-400MG13
 HAVRIX53
 heather43
 HEP SOD/D5W INJ 20000UNT49
 HEP SOD/D5W INJ 25000UNT50
 HEP SOD/NACL INJ 25000UNT50
 heparin sodium (porcine) 50
 HEPARIN/NACL INJ 25000UNT50
 HERCEP HYLEC SOL 60-1000018
 HERCEPTIN18
 HERZUMA18
 HETLIOZ.....36
 HIBERIX53
 HUMIRA.....51
 HUMIRA PEDIA INJ CROHNS.....51
 HUMIRA PEDIATRIC CROHNS D51
 HUMIRA PEN51
 HUMIRA PEN KIT PS/UV51
 HUMIRA PEN-CD/UC/HS START51
 HUMIRA PEN-PEDIATRIC UC S51
 HUMIRA PEN-PS/UV STARTER51
 HUMULIN R U-500 (CONCENTR.....40

HUMULIN R U-500		
KWIKPEN	40	
hydralazine hcl.....	27	
hydrochlorothiazide.....	26	
hydrocodone bitartrate	8	
hydrocodone-		
acetaminophen soln 7.5-		
325 mg/15ml	9	
hydrocodone-		
acetaminophen tab 10-		
325 mg	9	
hydrocodone-		
acetaminophen tab 5-325		
mg	9	
hydrocodone-		
acetaminophen tab 7.5-		
325 mg	9	
hydrocodone-ibuprofen tab		
7.5-200 mg	9	
hydrocortisone	45	
hydrocortisone (intrarectal)		
.....	47	
hydrocortisone (rectal)	62	
hydrocortisone (topical) ..	61	
hydromorphone hcl.....	9	
hydroxychloroquine sulfate		
.....	52	
hydroxyurea.....	17	
hydroxyzine hcl.....	57	
hydroxyzine pamoate.....	57	
HYSINGLA ER.....	8	
I		
ibandronate sodium	42	
IBRANCE.....	19	
ibu.....	8	
ibuprofen.....	8	
icatibant acetate.....	50	
iclevia.....	43	
ICLUSIG	19	
IDHIFA.....	19	
ILEVRO	55	
imatinib mesylate	19	
IMBRUVICA.....	19	
imipenem-cilastatin		
intravenous for soln 250		
mg	10	
imipenem-cilastatin		
intravenous for soln 500		
mg	10	
imipramine hcl.....	32	
imiquimod	62	
IMOVAX RABIES		
(H.D.C.V.).....	53	
incassia.....	43	
INCRELEX.....	45	
INCRUSE ELLIPTA	57	
indapamide	26	
INFANRIX INJ.....	53	
INFLIXIMAB.....	51	
INGREZZA	37	
INGREZZA CAP 40-80MG		
.....	37	
INLYTA	19	
INQOVI TAB 35-100MG ..	17	
INREBIC	19	
INSULIN PEN NEEDLES:		
BD/NOVO.....	40	
INSULIN SAFETY		
NEEDLES	41	
INSULIN SYRINGES: BD		
.....	41	
INTELENCE.....	12	
INTRALIPID.....	55	
INTRON A	52	
introvale	43	
INVEGA HAFYERA	34	
INVEGA SUSTENNA.....	34	
INVEGA TRINZA	34	
IPOL INJ INACTIVE.....	53	
ipratropium bromide.....	57	
ipratropium bromide (nasal)		
.....	57	
ipratropium-albuterol nebu		
soln 0.5-2.5(3) mg/3ml	57	
irbesartan.....	24	
irbesartan-		
hydrochlorothiazide tab		
150-12.5 mg	23	
irbesartan-		
hydrochlorothiazide tab		
300-12.5 mg	23	
IRESSA	19	
irinotecan hcl.....	17	
ISENTRESS	12	
ISENTRESS HD	12	
isibloom	43	
ISOLYTE-P INJ /D5W.....	53	
ISOLYTE-S INJ.....	54	
ISOLYTE-S INJ PH 7.4...54		
isoniazid.....	13	
ISOPTO ATROPINE	56	
isosorbide dinitrate.....	27	
isosorbide mononitrate ...	27	
isotretinoin	60	
isradipine	26	
itraconazole	11	
ivermectin	10	
IXIARO INJ	53	
J		
JAKAFI	19	
jantoven	50	
JANUMET TAB 50-1000.39		
JANUMET TAB 50-500MG		
.....	39	
JANUMET XR TAB 100-		
1000	39	
JANUMET XR TAB 50-		
1000	39	
JANUMET XR TAB 50-		
500MG	39	
JANUVIA.....	39	
JARDIANCE	39	
jasmiel	43	
javygtor	45	
JENTADUETO TAB 2.5-		
1000	39	
JENTADUETO TAB 2.5-		
500	39	
JENTADUETO TAB 2.5-		
850	39	
JENTADUETO TAB XR		
2.5-1000MG	39	
JENTADUETO TAB XR 5-		
1000MG	39	
jinteli	44	
jolessa	43	
juleber	43	
JULUCA TAB 50-25MG ..	13	
junel 1.5/30	43	
junel 1/20	43	
junel fe 1.5/30	43	
junel fe 1/20	43	
K		
KADCYLA.....	19	
KALYDECO	58	
KANJINTI.....	19	
kariva	43	

<i>kcl 10 meq/l (0.075%) in dextrose 5% & nacl 0.45% inj</i>	54	<i>klor-con m10</i>	54	<i>leucovorin calcium</i>	21
<i>kcl 20 meq/l (0.15%) in dextrose 5% & nacl 0.2% inj</i>	54	<i>klor-con m15</i>	54	LEUKERAN	16
<i>kcl 20 meq/l (0.15%) in dextrose 5% & nacl 0.45% inj</i>	54	<i>klor-con m20</i>	54	<i>leuprolide acetate</i>	17
<i>kcl 20 meq/l (0.15%) in dextrose 5% & nacl 0.9% inj</i>	54	KORLYM	45	<i>levalbuterol hcl</i>	57
<i>kcl 20 meq/l (0.15%) in nacl 0.45% inj</i>	54	<i>kurvelo</i>	43	<i>levalbuterol tartrate</i>	57
<i>kcl 20 meq/l (0.15%) in nacl 0.9% inj</i>	54	KYNMOBI	33	LEVEMIR	41
<i>kcl 30 meq/l (0.224%) in dextrose 5% & nacl 0.45% inj</i>	54	L		LEVEMIR FLEXTOUCH	41
<i>kcl 40 meq/l (0.3%) in dextrose 5% & nacl 0.45% inj</i>	54	<i>labetalol hcl</i>	25	<i>levetiracetam</i>	29
<i>kcl 40 meq/l (0.3%) in nacl 0.9% inj</i>	54	<i>lacosamide</i>	29	<i>levetiracetam in sodium chloride iv soln 1000 mg/100ml</i>	29
KCL/D5W/NACL INJ	54	<i>lacosamide oral</i>	29	<i>levetiracetam in sodium chloride iv soln 1500 mg/100ml</i>	29
<i>kelnor 1/35</i>	43	<i>lactated ringer's solution</i>	54	<i>levetiracetam in sodium chloride iv soln 500 mg/100ml</i>	29
<i>kelnor 1/50</i>	43	<i>lactic acid (ammonium lactate)</i>	62	<i>levobunolol hcl</i>	56
KERENDIA	22	<i>lactulose</i>	48	<i>levocarnitine (metabolic modifiers)</i>	46
KESIMPTA	38	<i>lactulose (encephalopathy)</i>	48	<i>levocetirizine dihydrochloride</i>	57
<i>ketoconazole</i>	11	<i>lamivudine</i>	12	<i>levofloxacin</i>	15
<i>ketoconazole (topical)</i>	60	<i>lamivudine (hbv)</i>	14	<i>levofloxacin in d5w iv soln 250 mg/50ml</i>	15
<i>ketorolac tromethamine (ophth)</i>	55	<i>lamivudine-zidovudine tab 150-300 mg</i>	13	<i>levofloxacin in d5w iv soln 500 mg/100ml</i>	15
KEVZARA	51	<i>lamotrigine</i>	29	<i>levofloxacin in d5w iv soln 750 mg/150ml</i>	15
KEYTRUDA	19	<i>lansoprazole</i>	48	<i>levonest</i>	43
KINRIX INJ	53	LANTUS	41	<i>levonorgestrel & ethinyl estradiol (91-day) tab 0.15-0.03 mg</i>	43
KISQALI 200 DOSE	19	LANTUS SOLOSTAR	41	<i>levonorgestrel & ethinyl estradiol tab 0.1 mg-20 mcg</i>	43
KISQALI 200 PAK FEMARA	17	<i>lapatinib ditosylate</i>	19	<i>levonorgestrel & ethinyl estradiol tab 0.15 mg-30 mcg</i>	43
KISQALI 400 DOSE	19	<i>larin 1.5/30</i>	43	<i>levonorgestrel-eth estra tab 0.05-30/0.075-40/0.125-30mg-mcg</i>	43
KISQALI 400 PAK FEMARA	17	<i>larin 1/20</i>	43	<i>levora 0.15/30-28</i>	43
KISQALI 600 DOSE	19	<i>larin fe 1.5/30</i>	43	<i>levo-t</i>	46
KISQALI 600 PAK FEMARA	18	<i>larin fe 1/20</i>	43	<i>levothyroxine sodium</i>	46
<i>klor-con</i>	54	<i>latanoprost</i>	56	<i>levoxyl</i>	46
<i>klor-con 10</i>	54	LATUDA	34	LEXIVA	12
<i>klor-con 8</i>	54	<i>leena</i>	43	<i>lidocaine</i>	61, 62
		<i>leflunomide</i>	52	<i>lidocaine hcl</i>	62
		<i>lenalidomide</i>	17		
		LENVIMA 10 MG DAILY DOSE	19		
		LENVIMA 12MG DAILY DOSE	19		
		LENVIMA 20 MG DAILY DOSE	19		
		LENVIMA 4 MG DAILY DOSE	19		
		LENVIMA 8 MG DAILY DOSE	19		
		LENVIMA CAP 14 MG ...	19		
		LENVIMA CAP 18 MG ...	19		
		LENVIMA CAP 24 MG ...	19		
		<i>lessina</i>	43		
		<i>letrozole</i>	17		

<i>lidocaine hcl (local anesth.)</i> .....10	<i>losartan potassium & hydrochlorothiazide tab 100-25 mg</i>.....23	<i>megestrol acetate</i> .....17, 46
<i>lidocaine hcl (mouth-throat)</i> .....62	<i>losartan potassium & hydrochlorothiazide tab 50-12.5 mg</i>.....23	<i>megestrol acetate (appetite)</i>.....46
<i>lidocaine-prilocaine cream 2.5-2.5%</i>.....62	LOTEMAX .....56	MEKINIST.....19
<i>lillow</i>.....43	<i>lovastatin</i> .....24	MEKTOVI.....19
<i>linezolid</i>.....10	<i>low-ogestrel</i> .....43	<i>meloxicam</i>.....8
<i>linezolid in sodium chloride iv soln 600 mg/300ml- 0.9%</i>.....10	<i>loxapine succinate</i> .....34	<i>memantine hcl</i> .....31
LINZESS.....48	LUMAKRAS.....19	MENACTRA INJ .....53
<i>liothyronine sodium</i>.....46	LUMIGAN .....56	MENQUADFI INJ.....53
<i>lisinopril</i>.....22	LUMIZYME .....46	MENVEO INJ.....53
<i>lisinopril & hydrochlorothiazide tab 10-12.5 mg</i>.....21	LUPRON DEPOT (1- MONTH).....17	MENVEO SOL .....53
<i>lisinopril & hydrochlorothiazide tab 20-12.5 mg</i>.....21	LUPRON DEPOT (3- MONTH).....17	<i>mercaptopurine</i>.....17
<i>lisinopril & hydrochlorothiazide tab 20-25 mg</i>.....21	LUPRON DEPOT-PED (1- MONTH).....46	<i>meropenem</i>.....10
<i>lithium carbonate</i> .....37	LUPRON DEPOT-PED (3- MONTH).....46	<i>mesalamine</i> .....47, 48
LIVALO .....24	<i>lutea</i>.....43	<i>mesalamine w/ cleanser</i> .48
<i>loestrin 1.5/30-21</i>.....43	<i>lyleq</i> .....43	MESNEX.....21
<i>loestrin 1/20-21</i>.....43	<i>lyllana</i> .....44	<i>metadate er</i>.....36
<i>loestrin fe 1.5/30</i>.....43	LYNPARZA.....19	<i>metformin hcl</i> .....39
<i>loestrin fe 1/20</i>.....43	LYSODREN.....17	<i>methadone hcl</i> .....8
LOKELMA.....42	<i>lyza</i> .....43	<i>methadone hydrochloride i8</i>
LONSURF TAB 15-6.14 .17	M	<i>methazolamide</i> .....26
LONSURF TAB 20-8.19 .17	<i>magnesium sulfate</i>.....54	<i>methenamine hippurate</i> ..10
<i>loperamide hcl</i> .....48	MAGNESIUM SULFATE 54	<i>methimazole</i> .....46
<i>lopinavir-ritonavir soln 400- 100 mg/5ml (80-20 mg/ml)</i> .....13	<i>magnesium sulfate in dextrose 5% iv soln 1 gm/100ml</i> .....54	<i>methotrexate sodium</i> 17, 52
<i>lopinavir-ritonavir tab 100- 25 mg</i>.....13	<i>malathion</i> .....62	<i>methylphenidate hcl</i>.....36
<i>lopinavir-ritonavir tab 200- 50 mg</i>.....13	<i>maraviroc</i>.....12	<i>methylprednisolone</i>.....45
<i>lorazepam</i>.....28	<i>marlissa</i> .....43	<i>methylprednisolone acetate</i>.....45
<i>lorazepam intensol</i>.....28	MARPLAN .....32	<i>methylprednisolone sod succ</i>.....45
LORBRENA.....19	MATULANE .....18	<i>metoclopramide hcl</i>.....47
<i>loryna</i>.....43	<i>matzim la</i> .....26	<i>metolazone</i> .....26
<i>losartan potassium</i>.....24	MAVYRET PAK 50-20MG.....14	<i>metoprolol & hydrochlorothiazide tab 100-25 mg</i>.....25
<i>losartan potassium & hydrochlorothiazide tab 100-12.5 mg</i>.....23	MAVYRET TAB 100-40MG.....14	<i>metoprolol & hydrochlorothiazide tab 100-50 mg</i>.....25
	<i>meclizine hcl</i> .....47	<i>metoprolol & hydrochlorothiazide tab 50-25 mg</i>.....25
	<i>medroxyprogesterone acetate</i> .....46	<i>metoprolol succinate</i> .....25
	<i>medroxyprogesterone acetate (contraceptive)</i> 43	<i>metoprolol tartrate</i>.....25
	<i>mefloquine hcl</i>.....12	<i>metronidazole</i> .....10
		<i>metronidazole (topical)</i> ...62
		<i>metronidazole vaginal</i>.....49
		<i>metyrosine</i> .....27
		MG SO4/D5W INJ 10MG/ML .....54

<i>micafungin sodium</i>.....11	NAMZARIC CAP 21-10MG.....31	<i>nilutamide</i> .....17
<i>microgestin 1.5/30</i> .....43	31	<i>nimodipine</i> .....26
<i>microgestin 1/20</i> .....43	NAMZARIC CAP 28-10MG.....31	NINLARO.....19
<i>microgestin fe 1.5/30</i> .....43	31	<i>nisoldipine</i>.....26
<i>microgestin fe 1/20</i> .....43	NAMZARIC CAP 7-10MG.....31	<i>nitazoxanide</i>.....11
<i>midodrine hcl</i> .....27	31	<i>nitisinone</i> .....46
<i>miglustat</i> .....46	NAMZARIC CAP PACK..31	NITRO-BID .....27
<i>mili</i> .....43	<i>naproxen</i>.....8	<i>nitrofurantoin macrocrystal</i>.....11
<i>mimvey</i> .....44	<i>naproxen sodium</i> .....8	<i>nitrofurantoin monohyd</i> <i>macro</i> .....11
<i>minocycline hcl</i> .....16	<i>naratriptan hcl</i>.....37	<i>nitroglycerin</i> .....27
<i>minoxidil</i>.....27	NATACYN .....55	<i>nizatidine</i> .....47
<i>mirtazapine</i> .....32	<i>nateglinide</i> .....39	<i>nora-be</i> .....43
<i>misoprostol</i> .....48	NATPARA.....42	<i>norethindrone</i> <i>(contraceptive)</i> .....43
MITIGARE .....8	NAYZILAM.....29	<i>norethindrone ace & ethinyl</i> <i>estradiol tab 1 mg-20</i> <i>mcg</i> .....43
M-M-R II INJ .....53	<i>nebivolol hcl</i>.....25	<i>norethindrone ace & ethinyl</i> <i>estradiol tab 1.5 mg-30</i> <i>mcg</i> .....43
M-NATAL PLUS TAB.....54	<i>necon 0.5/35-28</i>.....43	<i>norethindrone ace & ethinyl</i> <i>estradiol-fe tab 1 mg-20</i> <i>mcg</i> .....43
<i>modafinil</i> .....38	<i>nefazodone hcl</i> .....32	<i>norethindrone acetate</i> ....46
<i>moexipril hcl</i>.....22	<i>neomycin sulfate</i> .....11	<i>norethindrone acetate-</i> <i>ethinyl estradiol tab 0.5</i> <i>mg-2.5 mcg</i> .....45
<i>molindone hcl</i> .....34	<i>neomycin-bacitrac zn-</i> <i>polymyx 5(3.5)mg-</i> <i>400unt-10000unt op oin</i> .....55	<i>norethindrone acetate-</i> <i>ethinyl estradiol tab 1</i> <i>mg-5 mcg</i> .....45
<i>mometasone furoate</i> .....61	<i>neomycin-polymy-gramicid</i> <i>op sol 1.75-10000-</i> <i>0.025mg-unt-mg/ml</i> ....55	<i>norethindrone ac-ethinyl</i> <i>estrad-fe tab 1-20/1-30/1-</i> <i>35 mg-mcg</i> .....43
<i>(nasal)</i> .....59	<i>neomycin-polymyxin-</i> <i>dexamethasone ophth</i> <i>oint 0.1%</i> .....55	<i>norgestimate & ethinyl</i> <i>estradiol tab 0.25 mg-35</i> <i>mcg</i> .....43
MONJUVI .....19	<i>neomycin-polymyxin-</i> <i>dexamethasone ophth</i> <i>susp 0.1%</i> .....55	<i>norgestimate-eth estrad tab</i> <i>0.18-25/0.215-25/0.25-25</i> <i>mg-mcg</i> .....43
<i>mono-lynyah</i> .....43	<i>neomycin-polymyxin-hc</i> <i>ophth susp</i>.....55	<i>norgestimate-eth estrad tab</i> <i>0.18-35/0.215-35/0.25-35</i> <i>mg-mcg</i> .....44
<i>montelukast sodium</i>.....58	<i>neomycin-polymyxin-hc otic</i> <i>soln 1%</i> .....56	NORITATE.....62
<i>morphine sulfate</i> .....8, 9	<i>neomycin-polymyxin-hc otic</i> <i>susp 3.5 mg/ml-10000</i> <i>unit/ml-1%</i> .....56	<i>norlyroc</i> .....44
MORPHINE SULFATE .....9	NERLYNX.....19	NORPACE CR.....24
MORPHINE SULFATE/SODIUM C...9	NEUPRO .....33	<i>nortrel 0.5/35 (28)</i> .....44
MOVANTIK.....48	<i>nevirapine</i> .....12	<i>nortrel 1/35 (21)</i> .....44
<i>moxifloxacin hcl</i> .....15	NEXAVAR .....19	
<i>moxifloxacin hcl (ophth)</i> ..55	<i>niacin (antihyperlipidemic)</i> .....25	
MULTAQ.....24	<i>nicardipine hcl</i>.....26	
<i>mupirocin</i> .....60	NICOTROL INHALER.....38	
MVASI .....19	NICOTROL NS .....38	
<i>mycophenolate mofetil</i> ...52	<i>nifedipine</i> .....26	
<i>mycophenolate sodium</i> ...52	<i>nikki</i> .....43	
<i>myorisan</i> .....60		
MYRBETRIQ .....49		
N		
<i>nabumetone</i>.....8		
<i>nadolol</i> .....25		
<i>nafticillin sodium</i> .....16		
NAGLAZYME .....46		
<i>nalbuphine hcl</i> .....9		
<i>naloxone hcl</i> .....38		
<i>naltrexone hcl</i> .....38		
NAMZARIC CAP 14-10MG .....31		

<i>nortrel 1/35 (28)</i>	44	<i>olmesartan medoxomil-</i>		ORKAMBI GRA 75-94MG	
<i>nortrel 7/7/7</i>	44	<i>hydrochlorothiazide tab</i>		.....	58
<i>nortriptyline hcl</i>	32	<i>20-12.5 mg</i>	23	ORKAMBI TAB 100-125	58
NORVIR.....	12	<i>olmesartan medoxomil-</i>		ORKAMBI TAB 200-125	58
NOVOLIN INJ 70/30	41	<i>hydrochlorothiazide tab</i>		<i>oseltamivir phosphate</i>	14
NOVOLIN INJ 70/30 FP..	41	<i>40-12.5 mg</i>	23	OTEZLA.....	51
NOVOLIN N.....	41	<i>olmesartan medoxomil-</i>		OTEZLA TAB 10/20/30...	51
NOVOLIN N FLEXPEN...	41	<i>hydrochlorothiazide tab</i>		<i>oxacillin sodium</i>	16
NOVOLIN R.....	41	<i>40-25 mg</i>	23	<i>oxaliplatin</i>	16
NOVOLIN R FLEXPEN...	41	<i>olmesartan-amlodipine-</i>		<i>oxandrolone</i>	38
NOVOLOG	41	<i>hydrochlorothiazide tab</i>		<i>oxaprozin</i>	8
NOVOLOG FLEXPEN	41	<i>20-5-12.5 mg</i>	23	<i>oxcarbazepine</i>	29
NOVOLOG MIX INJ 70/30		<i>olmesartan-amlodipine-</i>		<i>oxybutynin chloride</i>	49
.....	41	<i>hydrochlorothiazide tab</i>		<i>oxycodone hcl</i>	9
NOVOLOG MIX INJ		<i>40-10-12.5 mg</i>	23	<i>oxycodone w/</i>	
FLEXPEN.....	41	<i>olmesartan-amlodipine-</i>		<i>acetaminophen tab 10-</i>	
NOVOLOG PENFILL	41	<i>hydrochlorothiazide tab</i>		<i>325 mg</i>	10
NOXAFIL	11	<i>40-10-25 mg</i>	23	<i>oxycodone w/</i>	
NUBEQA	17	<i>olmesartan-amlodipine-</i>		<i>acetaminophen tab 2.5-</i>	
NUDEXTA CAP 20-10MG		<i>hydrochlorothiazide tab</i>		<i>325 mg</i>	9
.....	37	<i>40-5-12.5 mg</i>	23	<i>oxycodone w/</i>	
NULOJIX	52	<i>olmesartan-amlodipine-</i>		<i>acetaminophen tab 5-325</i>	
NUPLAZID.....	34	<i>hydrochlorothiazide tab</i>		<i>mg</i>	10
NURTEC.....	37	<i>40-5-25 mg</i>	23	<i>oxycodone w/</i>	
NUTRILIPID.....	55	<i>olopatadine hcl</i>	56	<i>acetaminophen tab 7.5-</i>	
NUZYRA.....	16	<i>olopatadine hcl (nasal)</i>	57	<i>325 mg</i>	10
<i>nyamyc</i>	60	<i>omeprazole</i>	48	OZEMPIC (0.25 OR	
<i>nylia 1/35</i>	44	OMNARIS.....	59	0.5MG/DOSE)	40
<i>nylia 7/7/7</i>	44	OMNIPOD 5 G6 KIT		OZEMPIC (1MG/DOSE) .	40
NYMALIZE.....	26	INTRO	41	OZEMPIC (2MG/DOSE)	
<i>nymyo</i>	44	OMNIPOD 5 G6 MIS PODS		SOPN 8MG/3ML	40
<i>nystatin</i>	11	.....	41	P	
<i>nystatin (mouth-throat)</i>	62	OMNIPOD DASH KIT		<i>pacerone</i>	24
<i>nystatin (topical)</i>	60	INTRO	41	<i>paclitaxel</i>	18
<i>nystop</i>	60	OMNIPOD DASH MIS		<i>paclitaxel protein-bound</i>	
O		PODS.....	41	<i>particles for iv susp 100</i>	
<i>ocella</i>	44	OMNIPOD MIS CLASSIC		<i>mg</i>	18
OCTAGAM	52	.....	41	<i>paliperidone</i>	34
<i>octreotide acetate</i>	46	OMNIPOD PDM KIT		<i>pamidronate disodium</i>	42
ODEFSEY TAB.....	13	CLASSIC.....	41	PAMIDRONATE	
ODOMZO	20	<i>ondansetron</i>	47	DISODIUM	42
OFEV	58	<i>ondansetron hcl</i>	47	PANRETIN.....	62
<i>ofloxacin (ophth)</i>	55	ONTRUZANT.....	20	<i>pantoprazole sodium</i>	48
<i>ofloxacin (otic)</i>	56	ONUREG.....	17	PANZYGA.....	52
OGIVRI	20	OPSUMIT	28	<i>paraplatin</i>	16
OGIVRI INJ 420MG	20	ORGOVYX	17	<i>paricalcitol</i>	47
<i>olanzapine</i>	34	ORKAMBI GRA 100-125	58	<i>paromomycin sulfate</i>	11
<i>olmesartan medoxomil</i>	24	ORKAMBI GRA 150-188	58	<i>paroxetine hcl</i>	32
				PEDIARIX INJ 0.5ML.....	53

PEDVAX HIB	53	<i>piperacillin sod-tazobactam</i> <i>na for inj 3.375 gm (3-</i> <i>0.375 gm)</i>	16	<i>potassium chloride</i> <i>microencapsulated</i> <i>crystals er</i>	54
<i>peg 3350-kcl-na bicarb-</i> <i>nacl-na sulfate for soln</i> <i>236 gm</i>	48	<i>piperacillin sod-tazobactam</i> <i>sod for inj 13.5 gm (12-</i> <i>1.5 gm)</i>	16	<i>potassium citrate</i> <i>(alkalinizer)</i>	49
<i>peg 3350-kcl-sod bicarb-</i> <i>nacl for soln 420 gm</i>	48	<i>piperacillin sod-tazobactam</i> <i>sod for inj 2.25 gm (2-</i> <i>0.25 gm)</i>	16	PRADAXA	50
PEGASYS	14	<i>piperacillin sod-tazobactam</i> <i>sod for inj 4.5 gm (4-0.5</i> <i>gm)</i>	16	PRALUENT	25
PEMAZYRE	20	<i>piperacillin sod-tazobactam</i> <i>sod for inj 40.5 gm (36-</i> <i>4.5 gm)</i>	16	<i>pramipexole</i> <i>dihydrochloride</i>	33
pemetrexed disodium	17	PIQRAY 200MG DAILY DOSE	20	<i>prasugrel hcl</i>	50
PEN GK/DEXTR INJ 40000/ML	16	PIQRAY 250MG TAB DOSE	20	<i>pravastatin sodium</i>	24
PEN GK/DEXTR INJ 60000/ML	16	PIQRAY 300MG DAILY DOSE	20	<i>praziquantel</i>	11
<i>penicillamine</i>	42	<i>pirfenidone</i>	58	<i>prazosin hcl</i>	22
<i>penicillin g potassium</i>	16	<i>pirmella 1/35</i>	44	<i>prednisolone</i>	45
PENICILLIN G PROCAINE	16	<i>piroxicam</i>	8	<i>prednisolone acetate</i> <i>(ophth)</i>	56
<i>penicillin g sodium</i>	16	PLASMA-LYTE INJ -148 54		PREDNISOLONE SODIUM PHOSP	56
<i>penicillin v potassium</i>	16	PLASMA-LYTE INJ -A ...	54	<i>prednisolone sodium</i> <i>phosphate</i>	45
PENTACEL INJ	53	<i>plenamine</i>	55	<i>prednisone</i>	45
<i>pentamidine isethionate inh</i> <i>.....</i>	11	PLENVU SOL	48	PREDNISONE INTENSOL	45
<i>pentamidine isethionate inj</i> <i>.....</i>	11	<i>podofilox</i>	62	<i>pregabalin</i>	30
<i>pentoxifylline</i>	50	<i>polymyxin b-trimethoprim</i> <i>ophth soln 10000 unit/ml-</i> <i>0.1%</i>	55	PREHEVBRIO	53
<i>perindopril erbumine</i>	22	POMALYST	17	PREMASOL SOL 10% ...	55
<i>periogard</i>	62	<i>portia-28</i>	44	PRENATAL TAB 27-1MG	54
<i>permethrin</i>	62	<i>posaconazole</i>	11	PRENATAL TAB PLUS ..	54
<i>perphenazine</i>	34	POT CHL 20MEQ/L IN NACL 0.45% INJ	54	<i>prevalite</i>	25
PERSERIS	34	POT CHL 20MEQ/L IN NACL 0.9% INJ	54	PREVYMIS	14
<i>pfizerpen</i>	16	POT CHL 40MEQ/L IN NACL 0.9% INJ	54	PREZCOBIX TAB 800-150	13
<i>phenelzine sulfate</i>	32	<i>potassium chloride</i>	54	PREZISTA	12
<i>phenobarbital</i>	29, 30	POTASSIUM CHLORIDE	54	PRIFTIN	13
<i>phenobarbital sodium</i>	30	<i>potassium chloride 20</i> <i>meq/l (0.15%) in</i> <i>dextrose 5% inj</i>	54	<i>primaquine phosphate</i>	12
PHENYTEK	30			PRIMAQUINE PHOSPHATE	12
<i>phenytoin</i>	30			<i>primidone</i>	30
<i>phenytoin sodium</i>	30			PRIORIX INJ	53
<i>phenytoin sodium extended</i> <i>.....</i>	30			PRIVIGEN	52
PHESGO SOL	20			<i>probenecid</i>	8
<i>philith</i>	44			PROCALAMINE INJ 3% .	55
<i>phytonadione</i>	63			<i>prochlorperazine</i>	47
PIFELTRO	12			<i>prochlorperazine edisylate</i> <i>.....</i>	47
<i>pilocarpine hcl</i>	56			<i>prochlorperazine maleate</i> <i>.....</i>	47
<i>pilocarpine hcl (oral)</i>	63			PROCRIT	50
<i>pimozide</i>	34				
<i>pimtrea</i>	44				
<i>pindolol</i>	25				
<i>pioglitazone hcl</i>	40				

<i>procto-med hc</i>.....62	RECOMBIVAX HB.....53	SAVELLA MIS TITR PAK.....37
<i>procto-pak</i>.....62	RECTIV .....62	SCEMBLIX.....20
<i>proctosol hc</i> .....62	REGRANEX.....62	<i>scopolamine</i>.....47
<i>proctozone-hc</i>.....62	RELENZA DISKHALER..14	SECUADO .....35
PROGRAF .....52	RELISTOR.....48	<i>selegiline hcl</i> .....33
PROLASTIN-C.....58	REMICADE.....51	<i>selenium sulfide</i> .....60
PROLENSA.....56	RENFLEXIS.....51	SELZENTRY.....12
PROLIA .....42	<i>repaglinide</i> .....40	SEREVENT DISKUS .....58
PROMACTA .....50	RESTASIS.....56	<i>sertraline hcl</i> .....32
<i>promethazine hcl</i> .....47	RESTASIS MULTIDOSE 56	<i>setlakin</i> .....44
<i>propafenone hcl</i>.....24	RETEVMO.....20	<i>sevelamer carbonate</i> .....46
<i>proparacaine hcl</i> .....56	REVLIMID.....17	<i>sharobel</i>.....44
<i>propranolol hcl</i> .....26	REXULTI .....34	SHINGRIX .....53
<i>propylthiouracil</i> .....46	REYATAZ.....12	SIGNIFOR .....46
PROQUAD INJ .....53	REZUROCK.....52	<i>sildenafil citrate</i> .....56
PROSOL INJ 20% .....55	RHOPRESSA .....56	<i>sildenafil citrate (pulmonary hypertension)</i> .....28
<i>protriptyline hcl</i> .....32	<i>ribavirin (hepatitis c)</i>.....14	<i>silodosin</i>.....49
PULMICORT FLEXHALER.....59	<i>rifabutin</i> .....13	<i>silver sulfadiazine</i> .....60
PULMOZYME.....58	<i>rifampin</i> .....13	SIMBRINZA SUS 1-0.2%56
PURIXAN.....17	<i>riluzole</i> .....37	<i>simliya</i>.....44
<i>pyrazinamide</i> .....13	<i>rimantadine hydrochloride</i> .....14	<i>simvastatin</i>.....25
<i>pyridostigmine bromide</i> ...37	RINVOQ .....51	<i>sirolimus</i> .....52, 53
Q	<i>risedronate sodium</i> .....42	SIRTURO.....13
QINLOCK .....20	RISPERDAL CONSTA ...34	SIVEXTRO.....11
QUADRACEL INJ.....53	<i>risperidone</i> .....35	SKYRIZI.....51
QUADRACEL INJ 0.5ML 53	<i>ritonavir</i> .....12	SKYRIZI PEN .....51
<i>quetiapine fumarate</i> .....34	<i>rivastigmine</i> .....31	<i>sod sulfate-pot sulf-mg sulf oral sol 17.5-3.13-1.6 gm/177ml</i> .....48
<i>quinapril hcl</i> .....22	<i>rivastigmine tartrate</i> .....31	<i>sodium chloride</i>.....54
<i>quinapril-hydrochlorothiazide tab 10-12.5 mg</i>.....22	<i>rizatriptan benzoate</i> .....37	<i>sodium chloride (gu irrigant)</i> .....62
<i>quinapril-hydrochlorothiazide tab 20-12.5 mg</i>.....22	<i>roflumilast</i> .....58	<i>sodium fluoride chew; tab; 1.1 (0.5 f) mg/ml soln</i> ..54
<i>quinapril-hydrochlorothiazide tab 20-25 mg</i>.....22	<i>ropinirole hydrochloride</i> ..33	<i>sodium phenylbutyrate</i>....46
<i>quinidine sulfate</i>.....24	<i>rosuvastatin calcium</i> .....25	<i>sodium polystyrene sulfonate powder</i> .....42
<i>quinine sulfate</i> .....12	ROTARIX SUS .....53	<i>solifenacin succinate</i>.....49
R	ROTATEQ SOL .....53	SOLIQUA INJ 100/33 ....41
RABAVERT INJ.....53	<i>roweepra</i>.....30	SOLTAMOX.....17
<i>rabeprazole sodium</i> .....49	ROZLYTREK .....20	SOLU-CORTEF .....45
<i>raloxifene hcl</i> .....46	RUBRACA .....20	SOMATULINE DEPOT ..46
<i>ramipril</i>.....22	<i>rufinamide</i> .....30	SOMAVERT.....46
<i>ranolazine</i> .....27	RUKOBIA .....12	<i>sorafenib tosylate</i>.....20
<i>rasagiline mesylate</i> .....33	RYBELSUS .....40	<i>sorine</i> .....24
RAYALDEE .....47	RYDAPT .....20	<i>sotalol hcl</i>.....24
<i>reclipsen</i> .....44	S	<i>sotalol hcl (afib/afl)</i>.....24
	<i>sajazir</i> .....50	
	SANDIMMUNE .....52	
	SANTYL.....62	
	<i>sapropterin dihydrochloride</i> .....46	
	SAVELLA.....37	

<i>spironolactone</i>	22	SYMDEKO TAB 100-15058		<i>telmisartan</i>	24
<i>spironolactone &</i>		SYMDEKO TAB 50-75MG		<i>telmisartan-amlodipine tab</i>	
<i>hydrochlorothiazide tab</i>		.....	58	40-10 mg	23
25-25 mg	26	SYMJEPI	58	<i>telmisartan-amlodipine tab</i>	
<i>sprintec 28</i>	44	SYMPAZAN	30	40-5 mg	23
SPRITAM	30	SYMTUZA TAB	13	<i>telmisartan-amlodipine tab</i>	
SPRYCEL	20	SYNAREL	44	80-10 mg	23
<i>sps</i>	42	SYNERCID INJ 500MG ..	11	<i>telmisartan-amlodipine tab</i>	
<i>sronyx</i>	44	SYNJARDY TAB 12.5-		80-5 mg	23
<i>ssd</i>	60	1000MG	40	<i>telmisartan-</i>	
<i>stavudine</i>	12	SYNJARDY TAB 12.5-500		<i>hydrochlorothiazide tab</i>	
STIVARGA	20	.....	40	40-12.5 mg	23
<i>streptomycin sulfate</i>	11	SYNJARDY TAB 5-		<i>telmisartan-</i>	
STRIBILD TAB	13	1000MG	40	<i>hydrochlorothiazide tab</i>	
<i>subvenite</i>	30	SYNJARDY TAB 5-500MG		80-12.5 mg	23
<i>sucralfate</i>	48	.....	40	<i>telmisartan-</i>	
<i>sulfacetamide sodium</i>		SYNJARDY XR TAB 10-		<i>hydrochlorothiazide tab</i>	
(<i>acne</i>)	60	1000	40	80-25 mg	23
<i>sulfacetamide sodium</i>		SYNJARDY XR TAB 12.5-		<i>temazepam</i>	36
(<i>ophth</i>)	55	1000MG	40	TENIVAC INJ 5-2LF	53
<i>sulfacetamide sodium-</i>		SYNJARDY XR TAB 25-		<i>tenofovir disoproxil</i>	
<i>prednisolone ophth soln</i>		1000	40	<i>fumarate</i>	12
10-0.23(0.25)%	55	SYNJARDY XR TAB 5-		TEPMETKO	20
<i>sulfadiazine</i>	11	1000MG	40	<i>terazosin hcl</i>	22
<i>sulfamethoxazole-</i>		SYNRIBO	18	<i>terbinafine hcl</i>	11
<i>trimethoprim iv soln 400-</i>		SYNTHROID	47	<i>terbutaline sulfate</i>	58
80 mg/5ml	11	T		<i>terconazole vaginal</i>	49
<i>sulfamethoxazole-</i>		TABLOID	17	TERIPARATIDE	42
<i>trimethoprim susp 200-40</i>		TABRECTA	20	<i>testosterone</i>	38
mg/5ml	11	<i>tacrolimus</i>	53	<i>testosterone cypionate</i> ...	38
<i>sulfamethoxazole-</i>		<i>tacrolimus (topical)</i>	62	<i>testosterone enanthate</i> ...	38
<i>trimethoprim tab 400-80</i>		<i>tadalafil</i>	56	<i>tetrabenazine</i>	37
mg	11	TAFINLAR	20	<i>tetracycline hcl</i>	16
<i>sulfamethoxazole-</i>		TAGRISSO	20	THALOMID	17
<i>trimethoprim tab 800-160</i>		TALTZ	51	THEO-24	58
mg	11	TALZENNA	20	<i>theophylline</i>	58
SULFAMYLON	60	<i>tamoxifen citrate</i>	17	<i>thioridazine hcl</i>	35
<i>sulfasalazine</i>	48	<i>tamsulosin hcl</i>	49	<i>thiothixene</i>	35
<i>sulindac</i>	8	<i>tarina fe 1/20 eq</i>	44	<i>tiadylt er</i>	26
<i>sumatriptan</i>	37	TASIGNA	20	<i>tiagabine hcl</i>	30
<i>sumatriptan succinate</i>	37	<i>tasimelteon</i>	36	TIBSOVO	20
<i>sunitinib malate</i>	20	<i>tazarotene</i>	60	TICOVAC	53
SUPREP BOWEL SOL		<i>tazicef</i>	14	<i>tigecycline</i>	16
PREP KIT	48	TAZORAC	60	TIGECYCLINE	16
<i>syeda</i>	44	<i>taztia xt</i>	26	<i>tilia fe</i>	44
SYMBICORT AER 160-4.5		TAZVERIK	20	<i>timolol maleate</i>	26
.....	59	TDVAX INJ 2-2 LF	53	<i>timolol maleate (ophth)</i> ...	56
SYMBICORT AER 80-4.5		TECENTRIQ	20	<i>tinidazole</i>	11
.....	59	TEFLARO	14	TIVICAY	12

TIVICAY PD.....12	<i>triamterene &</i>	TRUMENBA INJ .....53
<i>tizanidine hcl</i>.....38	<i>hydrochlorothiazide tab</i>	TRUSELTIQ 100 MG
TOBRADEX OIN 0.3-0.1% .....55	37.5-25 mg .....27	DAILY DOSE.....20
TOBRADEX ST SUS 0.3- 0.05 .....55	<i>triamterene &</i>	TRUSELTIQ 125 MG
<i>tobramycin</i> .....11	<i>hydrochlorothiazide tab</i>	DAILY DOSE.....20
<i>tobramycin (ophth)</i>.....55	75-50 mg .....27	TRUSELTIQ 50 MG DAILY
<i>tobramycin sulfate</i>.....11	TRICARE TAB PRENATAL	DOSE .....20
<i>tobramycin-dexamethasone</i>	54	TRUSELTIQ 75 MG DAILY
<i>ophth susp 0.3-0.1% ...55</i>	<i>trientine hcl</i> .....42	DOSE .....20
<i>tolterodine tartrate</i>.....49	<i>tri-estarylla</i> .....44	TRUXIMA.....20
<i>topiramate</i>.....30	<i>trifluoperazine hcl</i>.....35	TUKYSA .....20
<i>toposar</i>.....18	<i>trifluridine</i> .....55	TURALIO .....20
<i>toremifene citrate</i> .....17	<i>trihexyphenidyl hcl</i> .....33	TWINRIX INJ .....53
<i>torsemide</i> .....27	TRIJARDY XR TAB ER	TYBOST .....12
TOUJEO MAX SOLOSTAR	24HR 10-5-1000MG ....40	TYPHIM VI.....53
.....41	TRIJARDY XR TAB ER	TYRVAYA.....56
TOUJEO SOLOSTAR.....41	24HR 12.5-2.5-1000MG	U
TPN ELECTROL INJ .....54	40	<i>unithroid</i> .....47
TRADJENTA .....40	TRIJARDY XR TAB ER	<i>ursodiol</i> .....48
<i>tramadol hcl</i> .....10	24HR 25-5-1000MG ....40	V
<i>tramadol-acetaminophen</i>	TRIJARDY XR TAB ER	<i>valacyclovir hcl</i>.....14
<i>tab 37.5-325 mg</i> .....10	24HR 5-2.5-1000MG ...40	VALCHLOR .....62
<i>trandolapril</i> .....22	TRIKAFTA TAB 100-50-	<i>valganciclovir hcl</i>.....14
<i>tranexamic acid</i>.....50	75MG & 150MG .....59	<i>valproate sodium</i> .....30
<i>tranylcypromine sulfate</i> ...32	TRIKAFTA TAB 50-25-	<i>valproic acid</i>.....30
TRAVASOL INJ 10% .....55	37.5MG & 75MG .....58	<i>valsartan</i> .....24
<i>travoprost</i>.....56	<i>tri-legest fe</i> .....44	<i>valsartan-</i>
TRAZIMERA.....20	<i>tri-lynyah</i> .....44	<i>hydrochlorothiazide tab</i>
<i>trazodone hcl</i> .....32	<i>tri-lo-estarylla</i> .....44	160-12.5 mg .....23
TRECTOR .....13	<i>tri-lo-marzia</i>.....44	<i>valsartan-</i>
TRELEGY AER ELLIPTA	<i>tri-lo-mili</i> .....44	<i>hydrochlorothiazide tab</i>
100-62.5-25 MCG .....57	<i>tri-lo-sprintec</i> .....44	160-25 mg .....23
TRELEGY AER ELLIPTA	<i>trimethoprim</i>.....11	<i>valsartan-</i>
200-62.5-25 MCG .....57	TRIMETHOPRIM .....11	<i>hydrochlorothiazide tab</i>
<i>treprostinil</i> .....28	<i>tri-mili</i> .....44	320-12.5 mg .....23
TRESIBA .....41	<i>trimipramine maleate</i> .....32	<i>valsartan-</i>
TRESIBA FLEXTOUCH..41	TRINTELLIX .....32	<i>hydrochlorothiazide tab</i>
<i>tretinoin</i> .....60	<i>tri-nymyo</i> .....44	320-25 mg .....23
<i>tretinoin (chemotherapy)</i> .18	<i>tri-sprintec</i> .....44	<i>valsartan-</i>
TREXALL.....52	TRIUMEQ PD TAB .....13	<i>hydrochlorothiazide tab</i>
<i>triamcinolone acetonide</i>	TRIUMEQ TAB .....13	80-12.5 mg .....23
(mouth).....63	<i>trivora-28</i> .....44	VALTOCO.....30
<i>triamcinolone acetonide</i>	<i>tri-vylibra</i> .....44	<i>vancomycin hcl</i> .....11
(topical) .....61	<i>tri-vylibra lo</i> .....44	VANCOMYCIN INJ 1 GM11
<i>triamterene &</i>	TRIZIVIR TAB.....13	VANCOMYCIN INJ 500MG
<i>hydrochlorothiazide cap</i>	TROGARZO .....12	11
37.5-25 mg .....27	TROPHAMINE INJ 10% .55	VANCOMYCIN INJ 750MG
	<i>trospium chloride</i> .....49	11
	TRULICITY .....40	VAQTA .....53

<i>varenicline tartrate</i>	38	<i>vylibra</i>	44	XPOVIO 60 MG ONCE	
<i>varenicline tartrate tab 11 x</i>		VYVANSE	36	WEEKLY	21
0.5 mg & 42 x 1 mg start		VYZULTA	56	XPOVIO 60 MG TWICE	
pack	38	W		WEEKLY	21
VARIVAX	53	<i>warfarin sodium</i>	50	XPOVIO 80 MG ONCE	
VASCEPA	25	<i>water for irrigation, sterile</i>		WEEKLY	21
<i>velivet</i>	44	<i>irrigation soln</i>	62	XPOVIO 80 MG TWICE	
VELPHORO	46	WELIREG	18	WEEKLY	21
VELTASSA	42	<i>wera</i>	44	XTANDI	17
VEMLIDY	14	X		<i>xulane</i>	44
VENCLEXTA	20	XALKORI	20	XULTOPHY INJ 100/3.6	41
VENCLEXTA TAB START		XARELTO	50	XYREM	38
PK	20	XARELTO STAR TAB		Y	
<i>venlafaxine hcl</i>	32	15/20MG	50	YF-VAX INJ	53
VENTAVIS	28	XATMEP	52	<i>yuvaferm</i>	45
VENTOLIN HFA	58	XCOPRI	30	Z	
VENTOLIN HFA		XCOPRI PAK 100-150...	30	<i>zafemy</i>	44
(INSTITUTIONAL PACK)		XCOPRI PAK 12.5-25....	30	<i>zafirlukast</i>	58
.....	58	XCOPRI PAK 150-200MG		ZARXIO	50
<i>verapamil hcl</i>	26	(MAINTENANCE).....	30	ZEJULA	21
VERQUVO	27	XCOPRI PAK 150-200MG		ZELBORAF	21
VERSACLOZ	35	(TITRATION).....	30	ZEMAIRA	59
VERZENIO	20	XCOPRI PAK 50-100MG	30	<i>zenatane</i>	60
<i>vestura</i>	44	XELJANZ	51	ZENPEP CAP 10000UNT	
V-GO 20 KIT	41	XELJANZ XR	51	.....	48
V-GO 30 KIT	41	XERMELO	48	ZENPEP CAP 15000UNT	
V-GO 40 KIT	41	XGEVA	42	.....	48
VICTOZA	40	XHANCE	59	ZENPEP CAP 20000UNT	
<i>vienna</i>	44	XIFAXAN	48	.....	48
<i>vigabatrin</i>	30	XIGDUO XR TAB 10-1000		ZENPEP CAP 25000UNT	
<i>vigadrone</i>	30	.....	40	.....	48
VIIBRYD KIT STARTER	32	XIGDUO XR TAB 10-		ZENPEP CAP 3000UNIT	48
<i>vilazodone hcl</i>	32	500MG	40	ZENPEP CAP 40000UNT	
VIMPAT	30	XIGDUO XR TAB 2.5-1000		.....	48
<i>vincristine sulfate</i>	18	.....	40	ZENPEP CAP 5000UNIT	48
<i>vinorelbine tartrate</i>	18	XIGDUO XR TAB 5-		ZERVIAE	56
<i>viorele</i>	44	1000MG	40	<i>zidovudine</i>	12
VIRACEPT	12	XIGDUO XR TAB 5-500MG		ZIEXTENZO	50
VIREAD	12	.....	40	<i>ziprasidone hcl</i>	35
VITRAKVI	20	XIIDRA	56	<i>ziprasidone mesylate</i>	35
VIVITROL	38	XOLAIR	59	ZIRABEV	21
VIZIMPRO	20	XOSPATA	20	ZIRGAN	55
VONJO	20	XPOVIO 100 MG ONCE		<i>zoledronic acid</i>	42
<i>voriconazole</i>	11	WEEKLY	21	ZOLINZA	21
VOSEVI TAB	14	XPOVIO 40 MG ONCE		<i>zolmitriptan</i>	37
VOTRIENT	20	WEEKLY	21	<i>zolpidem tartrate</i>	36
VRAYLAR	35	XPOVIO 40 MG TWICE		ZONISADE	31
VRAYLAR CAP 1.5-3MG	35	WEEKLY	21	<i>zonisamide</i>	31
<i>vyfemla</i>	44			<i>zovia 1/35</i>	44

ZTALMY31
zumandimine44
ZYCLARA PUMP62

ZYDELIG21
ZYKADIA21
ZYLET SUS 0.5-0.3%.....55

ZYPITAMAG25
ZYPREXA RELPREVV ...35

This formulary was updated on 03/01/2023. For more recent information or other questions, please contact AvMed Medicare Member Engagement Center at 1-800-782-8633 or for TTY users, 711, October 1 – March 31: 8:00 a.m. to 8:00 p.m., 7 days a week. April 1 - September 30: 8:00 a.m. to 8:00 p.m., Monday through Friday and Saturday 9:00 a.m. to 1:00 p.m., or visit www.avmed.org

Multi-Language Insert

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-800-882-8633. Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-800-882-8633. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-800-882-8633。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-800-882-8633。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-800-882-8633. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-800-882-8633. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quý vị cần thông dịch viên xin gọi 1-800-882-8633 sẽ có nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-800-882-8633. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-800-882-8633 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-800-882-8633. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على بمساعدتك. هذه خدمة . سيقوم شخص ما يتحدث العربية 1-800-882-8633 مترجم فوري، ليس عليك سوى الاتصال بنا على مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-800-882-8633 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-800-882-8633. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-800-882-8633. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-800-882-8633. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-800-882-8633. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがありますご致します。通訳をご用命になるには、1-800-882-8633 にお電話ください。日本語を話す人 者が支援いたします。これは無料のサービスです。