IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA
HUNTINGTON DIVISION

Christopher Fain, individually and on behalf of all others similarly situated, et al.,

Plaintiffs,

vs. CIVIL ACTION NO. 3:20-cv-00740

William Crouch, et al.,

Defendants.

REMOTE DEPOSITION OF BRIAN THOMPSON

DATE: April 13, 2022
TIME: 8:00 a.m. CST
PLACE: Veritext Virtual Videoconference

REPORTED BY: KELLEY E. ZILLES, RPR (Via Videoconference)
JOB NUMBER: 5128144

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NOTE: The original deposition transcript will be delivered to Attorney Smith, Esq., as the taking attorney.

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(Original exhibits attached to original transcript. Copies attached to transcript copies.)

BRIAN THOMPSON,

duly sworn, was examined and testified as follows:

EXAMINATION

BY ATTORNEY SMITH:

Q. Good morning, Mr. Thompson. My name is Avatara Smith-Carrington, I'm an attorney with Lambda Legal. I use they/them pronouns, so feel free to use either counsel or Counsel Smith if needed during this. And also, just so you know, I represent the plaintiffs in this matter, okay?

A. Nice to meet you.

Q. It's nice to meet you as well. So before we get into the substance of this, I wanted to go over some ground rules with the hopes of making things a little easier and we don't hit any bumpy pieces, okay?

A. All right.

Q. So, let's see. Let's do our best to not speak over each other and please use verbal answers so the court reporter can transcribe your answers accurately. Nodding or shaking your head cannot be captured by the court reporter. Is that fair?

A. Yes.

Q. You're aware that this deposition is happening virtually and that means that we are not in a shared physical space, so to the extent that you have any

documents in front of you or that you're planning to refer to something or you're looking at something else on your screen, it would be helpful to know what that might be, of course this is besides Exhibit Share, okay?

A. Okay.

Q. All right. We can take breaks whenever you need to, however, if there's an outstanding question that I have asked that you have not answered, I would ask that you answer that question first before we take a break, okay?

A. Okay.

Q. As to be expected, sometimes we have technology issues. So if ever there's a moment that you can't hear me or you're having issues on your end, whether it's being heard or your camera is acting wonky, just wave your hand. Also, it might be beneficial to pay attention to your screen because sometimes the court reporter will also wave her hand to let you know if she can't hear you or if she needs you to slow down or needs you to repeat something, okay?

A. Okay.

Q. I am going to ask you questions and you must answer unless your counsel instructs you otherwise, okay?

A. Okay.

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Q. If your counsel objects you still need to answer my question unless they specifically instruct you not to answer. Do you understand?
A. Yes.
Q. Okay. If you don't understand a question that I have asked, please let me know and I'm happy to try to rephrase it and to clear it up for you. If you answer the question I will assume that you understood. Do you understand?
A. I do.
Q. Great. So, Mr. Thompson, how are you doing today?
A. I'm fine. How are you?
Q. I'm doing well, thank you for asking. Is there anything that would prevent you from testifying truthfully today?
A. No.
Q. Okay. Have you ever been deposed before?
A. No, this is my first time.
Q. All right. Well, I will hopefully make this a relatively smooth process for you, okay?
A. Okay.
Q. Have you ever testified in court before?
A. No, I have not.
Q. Okay. So are you aware that you're giving

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deposition testimony today in a case called Fain versus Crouch?
A. I am, yes.
Q. Okay. And are you familiar with what the lawsuit is about?
A. I am.
Q. Okay. What is your understanding of what this lawsuit is about?
A. So initially I, I thought it was about denial of services for treatment of gender dysphoria. From a pharmacy standpoint I understand, my understanding is that the plaintiffs agree that we did not deny services, so now this is to clarify policy surrounding gender dysphoria.
Q. Okay. I'd like to make sure that we're using common vocabulary for some of the questions that I'm going to be asking today, okay?
A. Okay.
Q. We'll be talking about the West Virginia Department of Health and Human Resources, Bureau for Medical Services. If I refer to that governmental entity as BMS, will you understand what I mean?
A. Mm-hmm.
Q. Okay, great. We will also be discussing managed care organizations today. Do you know what a managed

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care organization is?
A. Yes.
Q. Okay. Can you tell me what one is?
A. Okay. We have three of them in West Virginia and they typically manage the care of their own members, and we have something called fee for services, which is what I'm in charge of. The managed care is paid a rate to take care of their members, they're given a certain amount of money, and with that money they are expected to provide medical care as necessary for their own members.
Q. Okay. So if I refer to managed care organization by the abbreviation MCO, will you know what I mean?
A. Yes.
Q. Great. We will be discussing care that transgender people receive for the treatment of gender dysphoria, this care can include hormone replacement therapy, surgery, medical appointments and therapy. If I use gender confirming care during the deposition, will you understand what I mean?
A. I do, yes.
Q. Okay. We will also be talking today about the exclusion of care in Medicaid coverage for transgender people. Are you familiar with the specific exclusion

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being challenged?
A. I believe so, yes.
Q. Okay. And what is your understanding of that exclusion?
A. My understanding is that we, we do not pay for, we do not cover the medical part of this, the surgeries, but we do cover hormone therapy.
Q. Okay. So if I refer to the exclusion throughout today you'll understand what I mean?
A. Yes, from a broad standpoint, yes.
Q. Okay. So, Mr. Thompson, you are the director of pharmacy services of BMS at the West Virginia Department of Health and Human Resources, correct?
A. Correct.
Q. All right. And what responsibilities fall under your role within BMS?
A. So I'm expected to make policy regarding pharmaceutical coverage, I manage the budget for the pharmacy department and I have staff that configure benefits for certain drugs and I also make policy around exceptions to our criteria. In those cases a lot of times things are used off label, which we are given some leeway as to how, how to choose to cover as a state.
Q. Got it. And who is your direct supervisor?
A. Fred Lewis.

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Q. Okay. And how often do you report to him on your work?
A. I try to talk to him if not on a daily basis, every couple days we do lunch, I see him twice a week maybe.
Q. Okay. And does anyone report to you?
A. Yes, I have seven staff.
Q. Okay. And do you mind going through who the seven staff would be?
A. Sure, sure. So I have Bill Hopkins, he's our operations manager, essentially a pharmacy technician; I've got Gail Goodnight, she's our rebate pharmacist; I've got Anita Souder, she's a temp, long-time temp, she works for outstanding claims, unusual claims, helps us kind of manage our fraud abuse; Vickie Cunningham still works part-time doing various, right now she's managing Methadone reports and making sure patients are not getting treated with dangerous combinations of medication; I've got Lori Moles who is my appeals pharmacist; and I have Priya Shah who is my drug utilization review coordinator, she's also a pharmacist; and I have Doug Sorvig, he's a data analyst.
Q. Okay. And how long have you held your current role at BMS?
A. This would be going on I believe three years

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now. I, I've been at Medicaid for about eight years first as a DUR coordinator and then now as director the last three.
Q. And just so I understand what you just mentioned, what exactly is a DUR coordinator?
A. Sure, sure. DUR stands for drug utilization review, so it's the generation, the DUR coordinator is a federally required position that generates criteria for prior authorization and also ensures appropriate safety edits are being used so the patient doesn't get harmed when we are covering medications.
Q. Great. So can you walk me through some of your previous employment history prior to joining BMS?
A. Sure. Well, before I became a pharmacist I was a biochemist for 13 years and then started pharmacy school kind of late, got into pharmacy. My first job was at CAMC here, a hospital pharmacist as an inpatient, I did that for five years before coming to Medicaid.
Q. And you quickly, you just mentioned CAMC, what does that stand for?
A. Charleston Area Medical Center, it's the largest hospital system in the state.
Q. Got it.
A. And I was specifically at the Memorial Division which is like considered the heart of the hospital.

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Q. Got it. And is there anything else before that or would you say that that kind of accurately describes your previous history before BMS?
A. I would say that describes most of the work. I did, you know, I went through college, got my bachelors, went to graduate school and got my masters in biochemistry, worked for a while in various labs, academic labs before deciding to get into pharmacy.
Q. Got it. So I think you kind of started discussing a little bit of your education history, but let's see if I got this correct. Did you attend Case Western University?
A. I did.
Q. Okay. And what degree was that for?
A. That was for biochemistry.
Q. Okay. And what years?
A. '91 to '95.
Q. Okay. And then did you also attend University of Kentucky?
A. Yes, that was for graduate school.
Q. Okay. And what degree?
A. That was a masters in biochemistry and medical sciences.
Q. Got it. And did you have any additional schooling?

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A. Pharm-D, a pharmacy degree, so I did that at University of Kentucky as well, and that's a four-year program.
Q. Okay.
A. And pharm-D is doctor of pharmacy.
Q. Thank you very much, you caught onto what I was getting to next. So, Mr. Thompson, we're here to take the deposition of an organizational representative for BMS. Do you understand that?
A. Yes.
Q. Okay. And you have been designated to give testimony as the organizational representative for BMS on certain topics that we'll discuss today. Do you understand that?
A. Yes.
Q. Okay. When were you notified that you would be giving testimony as the organizational representative for BMS on some topics that plaintiffs have identified?
A. February, like towards the end of February. I don't know the exact date, I was at a conference and I got a text saying that I was a person of interest, so. Fred Lewis let me know, yeah.
Q. Okay. What did you do today, or what did you do to prepare to testify today as the organizational representative for BMS?

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A. I met with Kim Bandy, we went over various exhibits that were submitted to, to the plaintiffs as well, so we did that. When this first came to my attention I also specifically looked into Christopher Fain's profile to see if there was anything I could do at the time to assist in coverage, and so I became a little familiarized with, I became pretty familiar with that particular member's situation. And it's only been recently that I became, you know, became aware of Shawn Anderson's, Shauntae Anderson's as well. So I looked at the profiles, I looked at the exhibits that you had as well.

Q. Okay. And did you have any other conversations besides the one that you had with your attorney?

A. No, just I'm aware of some of the people that have been deposed as well, so we've had casual conversations over, you know, what, what certain, where some of the information came from, you know, just in helping them get prepared as well, but nothing in depth. Most of the conversations with, with Kim and Lou Ann Cyrus.

Q. Okay.

A. I guess I did speak to Angie Wowczuk as well, she's the director at Rational Drug Therapy Program, so I asked her specifically what she knew about the

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situation as well since they are our prior authorization vendor.

Q. Got it. And just to make sure that I understood you correctly, so you said Angie Wowczuk, and what is her position again?

A. She's the director of Rational Drug Therapy Program, which we commonly refer to as RDTP, they're our prior authorization vendor, so they would have been the first level of prior authorization. So if a drug gets denied when you go to the pharmacy, they have to call Rational Drug Therapy Program to find out what's going on. And so I called her to see if she could get me any information about the case. Normally I have access to the prior authorization software, I wanted to make sure I had everything that they had because sometimes they record calls and things like that that I don't see.

Q. Got it. Understood. All right. So I believe, Mr. Thompson, you said that you have access to Exhibit Share?

A. Yes, yeah, I have it pulled up here.

Q. All right. And were you able to find your folder specifically?

A. I just pulled it up. I haven't done, I've never even seen this. So is it, let me see here. Deposition of Brian Thompson, is that the one, marked exhibits?

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Q. Exactly. So if you go into that folder you probably won't see anything yet, but there's a reason for me asking this question because I'm going to actually introduce the first exhibit, okay?

A. Okay.

(Exhibit 1 marked for identification.)

Q. Okay. So if you refresh your screen you should be able to view an exhibit.

A. Okay, yeah, I see Exhibit 1.

Q. Okay. So I'm guessing that you see what has been marked as, let's see, and I have Exhibit BT0001 and I'm showing you what is essentially, what is the amended notice of 30(b)(6) deposition. Mr. Thompson, please take a minute to review the document. Do you, do you recognize this document?

A. Yes, it looks like basically the explanation of the, of the case, isn't it? Let's see -- well, this is the notification of deposition, yes.

Q. Got it.

A. It's a list of everybody that you wanted to talk to.

Q. Exactly. Okay. And have you seen this document before?

A. I think I saw it yesterday actually, I can't say for sure it's the same one, but I remember seeing the

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list and I remember seeing, you know, there was a lot of exhibits.

Q. Okay.

A. I think I have seen this one, yes.

Q. Okay. And have you been told that you've been designated to speak as the organizational representative of BMS in response to certain topics contained in this deposition notice?

A. Yes, yeah.

Q. Okay, great. So we'll come back to this document throughout the day as we get through each topic, but I just wanted to show it to you, okay?

A. Okay. I thought the one I saw had my name on it too.

Q. Let's see. So this is interesting, this is the one that doesn't actually have your name on it. Okay. All right. I'm going to pull up the right one that has your name on it. Actually, if it's okay, can we take a quick five-minute break.

A. Sure.

Q. Great. Thank you very much, I'll be right back.

ATTORNEY SMITH: Kelley, can we go off the record.

(A break was taken at 8:20 a.m.)

ATTORNEY SMITH: All right. So I am going

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to introduce another exhibit.
(Exhibit 2 marked for identification.)
BY ATTORNEY SMITH:
Q. Okay. Mr. Thompson, if you refresh your page for Exhibit Share you should see a new exhibit, it will have the Exhibit Number BT0002.
A. Yep, I see it.
Q. Great, okay. I have just introduced plaintiffs' second amended notice of 30(b)(6) deposition, Exhibit Number BT0002. If you want to take a minute to review this document as well, Mr. Thompson, please feel free to do so.
A. Okay.
Q. Okay. So do you recognize this document?
A. Yes.
Q. And do you see your name at No. 10?
A. I do.
Q. Okay, great. So this is the document that we will come back to throughout the rest of the day and specifically as we discuss each topic, okay?
A. Okay.
Q. All right. As an organizational representative did you meet with any Medicaid participants who are transgender to prepare for today?
A. No, I have several acquaintances that are

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transgender, but I did not meet about this case with them, I just know them.
Q. Okay. And as an organizational representative did you meet with any mental health providers who specialize in care for transgender people to prepare for today?
A. I did not.
Q. Okay. As an organizational representative did you meet with any mental health providers who provide any care for transgender people to prepare for today?
A. No.
Q. Okay. As an organizational representative did you meet with any medical providers who specialize in care for transgender people to prepare for today?
A. I did not.
Q. As an organizational representative did you meet with any medical providers who provide any care for transgender people to prepare for today?
A. No.
Q. All right. So we are going to return to Exhibit BT0002. And let's scroll to No. 18, which is on Page 4. And just let me know when you've reached that point.
A. I'm there.
Q. Okay. So you have been designated to testify about Topic 18. Topic 18 reads, "All interrogatory

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requests, requests for admissions and request for production of documents directed to Defendants William Crouch, Cynthia Beane and West Virginia Department of Health and Human Resources, Bureau for Medical Services, and any discovery responses, responsive documents, filings or productions by or on behalf of Defendants William Crouch, Cynthia Beane and West Virginia Department of Health and Human Resources, Bureau for Medical Services." Did I read that correctly?
A. Yes.
Q. Okay. If you will just hold on one second, I'm going to introduce another exhibit.
(Exhibit 3 marked for identification.)
Q. So if you refresh your Exhibit Share you should see what is marked as BT0003.
A. Okay, I have it open.
Q. Okay. So as we discussed earlier, you have been identified to speak about the following interrogatory. And just so you know, I am showing you what has been marked as BT0003, "Defendants' response to plaintiffs' first set of interrogatories to Defendants William Crouch, Cynthia Beane and West Virginia Department of Health and Human Resources, Bureau for Medical Services." Mr. Thompson, you have been designated to testify in response to interrogatory No. 3. Please take

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a moment to review this document, specifically the bottom of Page 2 and top of Page 3. Do you recognize this document?
A. Yeah, it does look familiar, yes.
Q. Okay. And then did you review this document in connection with your testimony as the organizational representative for BMS today?
A. Yes.
Q. Okay. So near the bottom of Page 2 you'll see text that reads, "Interrogatory 3, identify and describe in detail every instance in which a health plan offered through West Virginia's Medicaid program provides partial or full coverage of gender confirming care of any kind, including but not limited to, counseling and/or therapy, hormone therapy or surgery. Include in your answer the coverage criteria for such care and the date such coverage began." Did I read that correctly?
A. You did.
Q. Okay. And are you aware that counsel identified you as the organizational representative to testify about BMS's response to interrogatory 3?
MS. BANDY: Let me just pose a comment that Sarah Young was designated as the designee to address this interrogatory as it relates to medical claims and that Mr. Thompson is to address it as it relates to

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pharmacy claims. I just wanted to pose that objection there to the extent that there's any question about the extent to which he was designated on this question.

ATTORNEY SMITH: Understood.

Q. So I'll follow up. I understand from your counsel that you have been designated to address this interrogatory as it relates to pharmacy claims, is that your understanding as well?

A. Yes.

Q. Okay. Are you prepared to testify about this interrogatory?

A. I am.

Q. Okay. And with respect to interrogatory 3 specifically, what did you do to prepare to testify today?

A. I tried to look at the history of our edits and coverage over certain medications that might be of interest to the case. You know, I had to research which drugs might be of interest. With pharmacy claims we don't, we don't separate things necessarily by diagnosis, they have to come in very quickly, so diagnoses take a long time to get in there. So I had to kind of look and see what the coverage policies were, there's lots of different edits, some of them come from federal sources, national sources, some of them are

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things that we have customized over the course of the generation of the program, you know, through multiple directors and with as many drugs as there are, you know, there's no way for me to know every edit on every drug, so I had to do a little bit of research on that.

Q. Okay. So just as a follow-up to that, what is an edit?

A. So an edit is anything that might -- well, it's generally electronic, well, it is electronic. So if you imagine going to the pharmacy with your prescription and they try and lump bill it to Medicaid, Medicaid's pharmacy software will take that drug and look to see if there's any other dangerous drugs that you have that might be dangerous if taken at the same time.

It is also going to look at things like age, in some cases it might be gender depending on, there are some drugs that are handled differently by a female versus a male, different dosing. Early refills, so if you go and you filled it two days ago and you're trying to get another 30-day supply, those are edits, anything that will stop a claim from paying immediately.

And so there's a whole library of these, there's hundreds of them. Some of them, as I said, some of them are, the information used in those edits are sent from national sources like First Databank, things like that,

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and some of them we can create and customize according to our needs.

Q. Okay. And, let's see. I'm going to read the response that was provided to this interrogatory. So if you start at the top of Page 3, I will read a section of that response, okay?

A. Okay.

Q. Okay. So, "Further without waiving the objection with regard to hormone therapy, these defendants do not have a database where they keep track of the information in the manner requested. The data is not kept in a manner which would allow them to identify which patients have requested hormone therapy for gender confirming care. Information is tracked by the medication or drug requested, not the diagnosis or reason for the request. Upon information and belief, there are no gender edits for most estrogen and testosterone containing products, so coverage would not be denied on the basis that the hormone therapy was sought as part of gender confirming care." Did I read that correctly?

A. You did.

Q. Okay. And then, let's see. So just to confirm, BMS covers hormone replacement therapy for treatment of gender dysphoria, correct?

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A. Yes. I think it would be more accurate to say that we don't restrict it. We would never, for instance, if testosterone is run through, we would never know what it was being used for unless a human being told us what it was being used for. There's not a diagnosis requirement when you enter a claim at a retail pharmacy that would stop it. It might get stopped for some other reason at which case then you would have a conversation and find out what it's being used for.

Q. Okay. So just to make sure that I understand what you're describing, so essentially, and correct me if I'm wrong, the diagnosis would not stop the claim, but there are other data points that could?

A. Yeah, like those edits that I was talking about, if you try to fill it too early. A lot of injectables are only stopped because they are an injectable because of the nature, it's just a little bit more of a concern for safety when you're injecting something as opposed to giving somebody pills that you can discontinue the pills mid therapy. If you inject it, you know, there's nothing you can do until they metabolize the drug, so. So in the conversation of, if you do have a conversation about say testosterone or whatever, we do not restrict according to gender dysphoria, if we are made aware that's why it's being used, there is no restriction for

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that, no policy for that.
Q. Okay. And does that apply, or does that include both estrogen and testosterone, so talking about hormone replacement therapy broadly, does that when you narrow it down include estrogen and testosterone?
A. It does, yes.
Q. And does that include any other hormones?
A. Yeah, if it's -- so all of these, so the use of testosterone and estrogen in various other drugs that are typically used in gender confirming care, they are all off label use right now, the FDA hasn't approved those. So there's not, there's not a policy around, so I guess what I'm saying is that with off label use they often require discussion about why it's being used, about the proper dosing and the proper frequency of use. So there is no, like there are no edits that would stop those from going through for various diagnoses.
The only time that we would even become aware of why it would be used would be if there's some other reason that the drug stops. Estrogens don't get stopped a lot because of birth control, things like that, they're oral. Testosterones get stopped a little bit more because they are very common used injectables, so they are stopped just simply because they're an injectable.

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Q. Understood. And I think you clarified this, but just to make sure, so if a claim was submitted and the only code attached was for gender dysphoria, that care would be covered?
A. Yeah, I don't even know how you would attach that code. So in the specific case if somebody was to order testosterone cypionate, an injectable form of testosterone, it would require a PA, a prior authorization simply because it's an injectable and in the course of the conversation it might be asked why they're using it. Because normally if you're using it for hypogonadism, there would be levels, testosterone levels that you'd have to get because it could harm a patient, if you gave it to somebody who had normal testosterone levels you could actually cause infertility, so there are safety reasons to ask why you're using it. But in this case when you're made aware it's for gender dysphoria, you don't have to worry about those levels as much because you're not, you're using it for a different reason.
So in the course of conversation for any drug, the reason, the diagnosis is very important to how you handle the dosing, how a pharmacist looks at the safety, the questions that would be asked necessary to make sure the drug would be used safely.

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Q. Okay. But claims for hormone replacement therapy must have a diagnosis code at some point in the process, correct?
A. Not for pharmacy. So pharmacy claims are real-time, they have to, you know, in any given second, I forgot what it is, it's like .2 seconds or something, they have to go very quickly. And when you have a drug that requires prior authorization the typical standard is to get a prior authorization handled in three days.
The problem with requiring a diagnosis is on the medical side a diagnosis might not be documented for up to a year, so it's impractical from the pharmacy side to require somebody enter a diagnosis on every claim because that diagnosis might simply not exist. But in the course of a conversation with a physician's office, that is a little different, you can ask them why they prescribed it. But as I said, we don't have a requirement for any, for ICD-10 codes, things like that, diagnosis codes on these drugs.
There are drugs that do have criteria where we want to know what they're using it for because there's different dosing regimens and things like that, but in general we can't, it's not practical to require diagnosis codes on a pharmacy claim.
Q. Understood. And just as a follow-up to that, on

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prior authorization forms is there a field that collects information regarding diagnosis?
A. Yeah, yes. So some drugs have specific prior authorization forms designed to help the flow of questions for that drug, but we have a general PA form which can be used for any drug, anything that you're using off label or whatever and there is a little spot where you put in what it's being used for and also what you previously used for treatment of whatever you're asking it for.
Q. Okay. And just to confirm what I think I heard you say earlier, if a patient required hormone replacement therapy for treatment of gender dysphoria only, they would receive treatment for that hormone replacement therapy, correct?
A. Oh, definitely, yes.
Q. Okay. BMS sometimes covers puberty delaying care for the treatment of gender dysphoria, correct?
A. Yes, we have. It's a little bit more, there's a little bit more safety concern when you're dealing with children because there are long-term effects from delaying puberty. So every case with something like this is always going to be reviewed by the medical director for safety.
Q. Okay. And who is the medical director?

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A. Jim Becker.
Q. Okay. And I'm sorry if I cut you off, were you going to explain something further?
A. I was just going to say in my memory I think we've maybe only done, we've maybe done this two or three times since I've been here. Usually there is, the FDA approves indications for precocious puberty, but specifically delaying puberty for gender dysphoria is a, that's a very, that's something we have to review on very case-by-case basis.
Q. Okay.
A. Because there's long-term effects, yeah.
Q. And just to make sure I understood or heard you correctly, in the past there have been times where BMS has covered puberty delaying treatment at least two or three times, correct?
A. Yes, but as I said, I think most of those may have been for precocious puberty, which is an FDA approved indication. I may have only seen one where there was a discussion over gender, you know, gender dysphoria for a very young child and that is sort of a policy decision that goes above me.
Q. And by policy decision that goes above you, could you explain what that means?
A. It was a medical claim. So some drugs are, they

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are implants, so they're not really a pharmacy claim, you know, they're not something you can just go into the pharmacy and just get or have the doctor administer it. This was one that required a surgical procedure I believe. And so ultimately I was asked my opinion on it, I discussed it with Dr. Becker, but I think it went up to the commissioner as well about it, so.
Q. Okay. Are you familiar with the early and periodic screening diagnosis and treatment program?
A. Mm-hmm, yes.
Q. Okay. And what is it?
A. It's a, it's a benefit that's offered, it's actually required for children. It's basically, the simplest way to say it is it's a route to get anything you need that can be demonstrated medically necessary for a child that would not normally be covered under Medicaid. So you can get probiotics, you can get soaps, anything that if the doctor can give medical reasoning why it needs to be covered, you can get it through EPSDT. It's not a guarantee that it will be covered, you still have a bunch of forms that you have to fill out, but it's a program that will provide care to children under the age of 18.
Q. And if I were to refer to it as EPSDT program, you would understand what I mean, correct?

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A. Yes.
Q. Okay. And does the EPSDT program sometimes approve broader coverage for minors than the Medicaid program does for adults? I think I heard you say yes, but I just want to make sure I'm correct on that.
A. Yes, they definitely do, yes.
Q. Okay. And is it possible for puberty delaying treatment to be covered through the EPSDT program?
A. I imagine it could be, I've never seen one requested in that manner. As I said, as both father and a pharmacist, I'm concerned when you are doing a care for a child that is very young and still developing that could have long-term health effects like detrimental effects because there are a lot of concerns when you're treating a child. So I think that might be why I don't get requests very commonly.
Like I said, I can only recall one request for gender care, it was actually in I think an 11-year-old. So the vast majority of these things come on in adults that can make decisions for themselves. So I, I haven't seen any EPSDT requests used in that manner. Usually they're used for nutritional supplements and things like that for very young children because those are not, nutritional supplements are not normally covered by Medicaid.

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Q. But you said that puberty delaying coverage could conceivably be covered through EPSDT, is that correct?
A. I say that only because I've always been told that anything could get approved through EPSDT if you could defend why it was medically necessary.
Q. Okay.
A. But the other thing you have to remember is with EPSDT it's not really necessary if they have full Medicaid and it's already something we cover, it's generally used for those things that we don't already cover or for children that don't have full Medicaid.
Q. You testified earlier that requests for puberty delaying treatment are subject to a review process, correct?
A. Yeah. Well, every drug is subject to some sort of drug utilization review, whether it's automatic or electronic edits or because it requires a prior authorization. And in those cases they would require prior authorization just because a lot of those are injectable if you're talking about the delaying, they're typically injectable, long-acting injectable agents.
Q. Does that mean that under the right circumstances puberty delaying treatment could be approved to treat gender dysphoria?

A. Yes, I would say so.
Q. I'm going to introduce another exhibit.
(Exhibit 4 marked for identification.)
Q. All right. Do you see what has been marked as Exhibit BT0004?
A. Let me refresh. Yep, I have it.
Q. Okay. I'm showing you what has been marked as Exhibit BT0004, it is an email with a subject, "Gender dysphoria." In the lower right-hand corner of the document is Bates stamped DHHRBMS012665. Do you see that?
A. I do.
Q. Okay. Please take a moment to review this email.
A. Yes.
Q. Okay.
A. This is the one I was referring to, yes.
Q. So you recognize this email, correct?
A. Yes.
Q. Okay. So please scroll down to the page with the Bates stamp DHHRBMS012666.
A. Okay.
Q. All right. I am going to read a portion of that email, it says, "Unfortunately Jim and I discussed this case today before I saw your email. I did determine

that this isn't coverable through pharmacy services because Vantas is a medical claim that requires surgical implementation. We were in favor of approving their request however and I faxed our response to RDTP before seeing your request to hold on a decision." Did I read that correctly?
A. Yes.
Q. And what is Vantas?
A. So Vantas is a drug called Histrelin, it's often used to, it's actually FDA's, the FDA indication is for prostate cancer. So it's also something called a GnRH antagonist, so it's a gonadotropin-releasing hormone antagonist, so it can delay puberty in an off label sense. So it's one of these hormone therapies that I said a lot of them require prior authorization because they're an injectable, this one is an implant. So when you're talking about using it in anybody, it's something you want to make sure it's being used safely. But when you're talking about using it in a child, you know, there's a lot more to take into consideration.
Q. Is Vantas sometimes prescribed for the treatment of precocious puberty?
A. There's a similar drug called Supprelin LA is used for precocious puberty. Vantas itself, the drug itself doesn't have, the manufacturer did not get that

indication. So they're the same, they're the same drug. Histrelin has two different names, brand names. I don't know if the dosing is different or anything like that, but Supprelin LA I believe is, I believe that's an injection and that's used for precocious puberty. But Vantas itself, the implant, is not used for, that's typically used for prostate cancer.
Q. Has Vantas ever been used for precocious puberty, because I heard you mention typically?
A. I've never seen, that was the first time I ever seen Vantas actually requested. As I said, it's a medical claim. So that's when I looked it up and I was like this is an implant, this isn't even something that we would be responsible for covering as a pharmacy, we're an outpatient pharmacy. So I didn't know that it would be, I've never seen it used for that, I don't know if it's got a history of being used off label for that use either.
Q. Okay. So what led you to drafting this email?
A. Excuse me?
Q. I'm sorry, what led you to drafting the email? So if I'm correct, it says, "Hi, Cindy," and I believe it's from you, correct?
A. Yes, yes. So my recollection is Jim walked into my office one day and said that there was a request for

this Vantas for use in a child and he wanted to know my thoughts on it, so we had this discussion. And I believe that after he and I discussed it we were in favor of covering it, and so we were going to send an approval. Then we realized that there was actually some opinions from above us that, you know, that were not sure that we should cover it, and partly because I think it's a medical claim and the policies are a little different from the medical side is my understanding. You know, I'm just in charge of pharmacy, so.
So that's why I figured I better tell Cindy about the conversation that we had. And I think that's, I have to reread this whole email again, but I believe that's why is because Cindy is my boss' boss, so I don't want to go against what she wants us to do either, so I like to make sure that everybody is on the same page. And so I think that when I realized that there had already been a discussion at the higher level, I wrote the email to let her know what we had talked about.
Q. But after the discussion you had with Dr. Becker the two of you were in favor of covering it, correct?
A. Yeah, if asked our opinion would have been to cover it. And to be honest, I don't know if I'd make that same decision right now, I'd have to see the case again, it's been a long time since I looked at it, I

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don't know that I'd always make that decision.
But as I said, these are very case-by-case basis. Off label use, any time you're looking at a drug off label you're kind of putting yourself out there because the last thing you want to do is harm a patient, and so we take that job very seriously. So I can't say that we would have approved this on any other patient and I can't exactly remember all the details about this case, why we decided in our opinion it should be covered.
Q. But in the appropriate case you might decide that coverage for puberty delaying treatment should be covered for gender dysphoria?
A. Yes, I wouldn't rule it out. Again, you would have to have a good case, I would have to make sure that the doctors involved were experts in the field, it wasn't just, you know, a mid level practitioner doing this, yeah.
Q. You mentioned earlier and I did too Cindy, who exactly is Cindy?
A. Cindy Beane is the commissioner for Medicaid.
Q. Okay.
A. For BMS.
Q. Okay. I'm going to introduce another exhibit shortly.

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A. And actually specifically, just to take a step back, it looks like my email was drafted in response to Cindy sending out an email asking us to hold off on the approval while she discussed with leadership. So that's why I sent that when I saw that she wanted us to hold off and we had already, you know, recommended that we would cover it, yeah.
Q. All right.
(Exhibit 5 marked for identification.)
Q. Okay. Do you see what has been marked as BT0005?
A. I do.
Q. Okay. I'm showing you what has been marked as BT0005, "Defendants' ninth supplement response to plaintiffs' first set of requests for production to Defendants William Crouch, Cynthia Beane and West Virginia Department of Health and Human Resources, Bureau for Medical Services." Mr. Thompson, you have been designated to testify about the response to request for production 15. Please take a moment to review this document, specifically the middle of Page 4.
A. Okay.
Q. Do you recognize this document?
A. They all kind of blend together, but I think I recognize this one.

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Q. Did you review this document in connection with your testimony as the organizational representative for BMS?
A. Let me see if I can recognize it for sure. I'm sure we did, I can specifically speak to 15, but I think we have, yes.
Q. Okay. In the middle of Page 4 you'll see text for plaintiffs' request for production of documents No. 15 that reads, "The Rational Drug Therapy Program criteria for coverage of hormone therapy for transgender and non-transgender West Virginia Medicaid participants." Did I read that correctly?
A. Yes.
Q. Okay. And are you aware that counsel identified you as the organizational representative to testify about documents produced by BMS in response to request for production 15?
A. Yes.
Q. Are you prepared to testify about this response?
A. I am.
Q. And with respect to request for production 15 specifically, what did you do to prepare to testify today?
A. So I talked to Angie Wowczuk, asked for any policies that they might have, internal policies.

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Sometimes in the past they have generated sort of business rules where they have to have like seven or eight or nine pharmacists there, maybe a few more, I don't remember how large their staff is right now, but you have people coming in and out. So they established policy to interpret the criteria that we put out and at times they, we become aware that they are doing something or maybe they misunderstood what we wanted them to do.
So I wanted to talk to her and make sure that we were on the same page, that they were applying policy the way that we wanted them to apply it. I asked if there were any other emails that I wasn't aware of with prior directors, so Angie looked into that.
I also talked to Gainwell, they're the claims processor, to see if there were any, any documentation or anything like that regarding policy that might have involved Rational Drug Therapy. Because Rational Drug does the PA's, but they have to enter into the claim system edits, edit overrides, prior authorization approvals and everything, and that all gets translated over to the claims vendor, so they have to be able to communicate together. So I tried to dig for any sort of historical documentation that might have existed. Since Angie is a new director, she became director roughly

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about the same time I did, and I believe that the policy around this developed over the course of the previous two directors really, so.

Q. And just specifically when you're talking about the policy around this, can you explain a little bit more about what policy you're talking about?

A. Yeah. So prior to me Vickie Cunningham was director, prior to her Peggy King was director, and I believe that in 2017 or so, well, 2017 is when we had the carveout, the pharmacy carveout and that's when everything went through pharmacy, but before that I believe there were some gender edits initially put on these drugs and then they were taken off and there was some communication around that, that all happened well before I was even in the Bureau, it happened before Angie was even an employee I think.

So I had to dig in there and see what kind of conversations had because since I've been in Medicaid my understanding is we cover this, we've never had a problem with covering it, but before that I think there were some issues around how to handle requests for gender dysphoria. And we've had sort of an incline in the number of requests over the years I think as this has become more of a, like I said, this is all off label use, but there have been guidelines advising doctors how

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to handle gender affirming care, and so as that knowledge base grows, the requests grow, and the policy has to adapt to it.

Q. Okay. Please look at the page again while I read defendants' response to request for production 15, "Supplemental response. Upon information and belief, see RDTP email correspondence and attachments marked as Exhibit 175, Bates No. DHHRBMS021582 through 21620." Did I read that correctly?

A. Yes.

Q. Okay. You should see Exhibit BT0006.

(Exhibit 6 marked for identification.)

A. Okay.

Q. Okay. I am showing you what has been marked as Exhibit BT0006, it is an email with the subject, "Transgender information." In the lower right-hand corner of the document do you see Bates stamp DHHRBMS021582?

A. I do, yes.

Q. Okay. And I believe that you'll also see that defendants affixed their exhibit number which is 175. Do you see that as well?

A. Yes.

Q. I will represent to you that this corresponds to the Bates number identified in response to RFP15.

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Please take a moment to review this email. And just so you know, it's pretty much the first three pages.

A. Yeah, I recall seeing this.

Q. Okay. So you recognize this email?

A. I do.

Q. Okay. I'm going to direct your attention to the message in the middle of the chain on Page 2, you'll see the Bates number at the bottom DHHRBMS021583.

A. Okay.

Q. Okay. So it reads, "Thank you. It is fine to override the edit when hormones are prescribed for transgender members." Did I read that correctly?

A. You did, yes.

Q. Okay. Who's the email from?

A. That is from Vickie Cunningham who was the director of pharmacy at the time and it's sent to the director of Rational Drug Therapy Program at the time to Stephen Small.

Q. Okay. Is the edit being discussed in the email the gender edit that we've discussed?

A. That's what I was about to say, I can't say from the text that they're talking about a gender edit, but that would be my assumption that that's what they're talking about.

Q. Okay. And the removal of the gender edit allows

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for the coverage of pharmaceuticals for treatment of gender dysphoria, correct?

A. Yes. So there are, as I said before, there are reasons to have gender edits for safety purposes. You would typically not want to give testosterone to say a woman of child bearing age because it could cause harm to the pregnancy, so there is a reason to have a gender edit. This looks to me that Vickie was telling them that in cases where there was gender dysphoria that she is approving the general coverage of gender dysphoria with hormone therapy.

Q. You testified a little bit earlier that there can be gender edits and specifically that they can vary in terms of what state and federal policies I believe, do you remember that?

A. I think I misspoke when I said federal. I meant the national database that we use, First Databank, sometimes sends I believe, and I don't know which drugs they put gender edits on, but I believe they do send information saying this drug should not be used in females, this one should not be used in males because there are, there are differences.

Sometimes inherently if you're using a drug that say affects testosterone, like I said, you can affect pregnancies, so that would not be considered safe. But

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a lot of these edits you can kind of massage into the way your state wants to have policy driven.
Q. Understood. I'm now going to direct your attention to the message on Page 1.
A. Yes.
Q. Okay. It says, "This is a change of policy from the WVBMS. Please approve appropriate medications for these medical conditions." What is the change in policy that Stephen Small is discussing in this message?
A. So as I go through this, I think the email chain starts at the bottom and goes up, and so it looks like he brought up a case where they're seeing increased requests for testosterone or Estradiol in a gender that you would not normally expect for its FDA approved use and he wanted to make sure that, like I said, Rational Drug is a vendor, so they don't want to approve things off label when we don't want them to do that because they could get in a lot of trouble for doing that. And so it looks to me like he wanted to clarify with Vickie that this was okay to do. And so his last email on Page 1 is to his staff saying that they all should be approving it for gender dysphoria, that it's fine.
Q. Who's responsible for approving medications or pharmaceuticals, generally speaking?
A. You mean for like individual members?

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Q. For a policy purpose?
A. Could you rephrase the question, I just want to make sure at what level.
Q. Sure. So for a policy change that can impact individual members, who would be responsible for approving that type of change?
A. Ultimately the policy comes from the director of pharmacy, although the director of pharmacy reports to the commissioner, the deputy commissioner and commissioner and sometimes even to the secretary cabinet, the cabinet secretary, but ultimately we are given pretty free rein to determine policy.
And I in return have had a drug utilization coordinator who generates 90 percent of our policy for drugs under FDA approved uses. When we get new drugs the policy around approving the drug, the drug criteria is run through what's called a DUR board which has 15 practicing physicians, nurses, pharmacists, people who are out there, and they vote on the criteria. So at that level there is a lot of review over the appropriate use of medication. Once they approve it that policy goes in and that becomes the general black and white policy to how you handle any drug.
That being said, we have an appeals process that is in place so that you could get a drug for anything if

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you can defend its medical necessity. That, that process, so at the retail pharmacy if there's a prior authorization it goes to Rational Drug Therapy Program, they look at it to see if they met the black and white criteria.
Sometimes there's off label use that we, we approve on a pretty routine basis like this, and so they don't have to send that up to us. Other times there's a little bit more of a gray area so they would say deny it and a doctor can then appeal it and say wait, this is why I want to do this. So he can write a letter and that comes up to the Bureau and the DUR coordinator and sometimes myself review those. So it's kind of, I don't know if that's a good way of describing it to you, but it goes, reviews go both ways from top down and bottom up.
Q. Understood. So are you fine, I know that we've been going for a bit, but we've taken a break, are you fine continuing or would you like a five-minute break?
A. I'm fine, we can continue if you'd like to.
Q. All right.
(Exhibit 7 marked for identification.)
Q. Okay. Do you see what I've introduced as BT0007?
A. Yes.

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Q. Okay. I am showing you what has been marked as Exhibit BT0007 titled, "Defendants' first supplemental response to plaintiffs' first set of requests for production to Defendants William Crouch, Cynthia Beane, and the West Virginia Department of Health and Human Resources, Bureau for Medical Services." You have been designated to testify about the response to request for production 9. Please take a moment to review this document, specifically the middle of Page 2. Do you recognize this document?
A. Yes.
Q. Did you review this document in connection with your testimony as the organizational representative for BMS today?
A. Yes.
Q. Okay. On Page 2 you'll see text that is plaintiffs' request for production No. 9 and it reads, "Documents sufficient to identify the circumstances in which hormone therapy is covered through the West Virginia Medicaid program, including but not limited to, diagnostic codes, procedure codes, contracts, health plans, clinical guidelines and/or criteria, medical necessity criteria and pre or prior authorization requirements and procedures where applicable." Did I read that correctly?

A. You did, yes.
Q. All right. And are you aware that counsel identified you as the organizational representative to testify about documents produced by BMS in response to request for production 9?
A. Yes.
Q. And are you prepared to testify about this response?
A. I am.
Q. With respect to request for production 9 specifically, what did you do to prepare to testify today?
A. I contacted our claims processor to find out if there were any edits, codes, anything that would be put on drugs that we identified as being likely to be used in gender dysphoria, so testosterones, estrogens, things like that. So I identified those drugs using the Endocrine Society guidelines, drugs typically used in gender care, so that was the primary thing I did.
I also looked to see if Rational Drug was asking any specific questions when they became aware of what the drug was being used for. They didn't have anything, in fact, every time that I've seen the specific patients have been made aware of, there's every interaction where it says, you know, caller has identified this as being

used for gender dysphoria and approved. So there's never been anything that I saw that has resulted in a denial, there were no diagnosis codes or anything like that that I identified that would stop these related to gender.
Q. And the claims processor is Gainwell, correct?
A. Yes, Gainwell.
Q. Okay. And you said that you reviewed the Endocrine Society guidelines to make a determination about specific drugs that would be used for treatment of gender dysphoria, correct?
A. Yes. So I wanted to familiarize myself because, you know, you typically think testosterone and estrogen, Spironolactone which is a diuretic can be used, you know, some of these other drugs are related to gender dysphoria treatment, and so I wanted to see which ones were the most likely to be used. Because across the broad spectrum of drugs, there's probably a number of drugs that we use, we wouldn't think would be used for that. As I said, there's not, to my knowledge there's not a single drug that is FDA approved for that use, so you have to kind of look and see across the medical journals and things like that what is typically being used.
Q. Please look at that page again while I read

defendants' request for production No. 9.
A. Okay.
Q. "Supplemental response. Please see BMS provider manual Chapter 518 Pharmacy Services attached as Exhibit 5, beginning with Bates No. DHHRBMS000109 and the most recently updated preferred drug list with prior authorization criteria attached as Exhibit 6 beginning with Bates No. DHHRBMS000145. Please note that to the extent that the provider manual states in Section 518.4 that other drugs may be limited in quantity, duration or based on gender. The information regarding these drug products and their limitations is available on the BMS Website. The drug limits list available online was last updated June 1st, 2016 and does not reflect the removal of the gender edit for most estrogen and testosterone containing products." Did I read that correctly?
A. Yes.
Q. I'm just going to introduce another exhibit.
(Exhibit 8 marked for identification.)
Q. Okay. Can you see what has been marked as BT0008?
A. Yes.
Q. Okay. I'm showing you what has been marked as Exhibit BT0008, it is a document with the subject, "BMS provider manual, Chapter 518 Pharmacy Services." In the

lower right-hand corner on the first page the document is Bates stamped DHHRBMS000109. Do you see that?
A. Yes.
Q. I will represent to you that this corresponds to the first Bates number identified in the first supplemental response to RFP9. Please take a moment to review this document. It's a pretty long document, so I'm going to actually point you to certain sections.
A. Sure, I'm pretty familiar with this document.
Q. Okay. So you recognize this document, correct?
A. Yes, yeah.
Q. All right. So I'm going to direct your attention to Page 14 which has Bates No. DHHRBMS000122 at the bottom.
A. Okay.
Q. All right.
A. Probably looking at that second bullet point?
Q. Exactly. So the second bullet point reads, "Other drugs may be limited in quantity, duration or based on gender." Did I read that correctly?
A. Yes.
Q. We've gone over this earlier, but just to confirm, with regard to hormone replacement therapy, pharmaceuticals are not limited based on gender?
A. And as I said, there's thousands of these drugs,

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so I don't know if any of them have gender limits. I know that the ones that we're discussing don't.
Q. Okay. And then with regard to puberty delaying treatment, is this treatment limited based on gender?
A. No, that would not be limited, that I know of. But again, I'd have to, you know, get the name of specific drugs you're looking at and then I could look and see all the restrictions on them, but by intent and by my knowledge, they are not.
Q. I'm going to introduce another exhibit.
(Exhibit 9 marked for identification.)
Q. Okay. Do you see what has been marked as Exhibit BT0009?
A. Let me refresh. Yes.
Q. Okay. I'm showing you what has been marked as Exhibit BT0009, it is the document with the subject, "Preferred drug list with prior authorization criteria," and the lower right-hand corner of the document is Bates stamped DHHRBMS000145. Do you see that?
A. I do, yeah.
Q. Okay. I will represent to you that this corresponds to the second Bates number identified in the first supplemental response to RFP9. Do you recognize this document?
A. I do, it's a preferred drug list.

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Q. Okay. And what is this document?
A. So it's a list of, it's a list of our preferred drugs and nonpreferred drugs and the general policy surrounding how you get a nonpreferred drug if requested. We generally, not every drug we cover is on this list, it's generally a method of extracting rebates and creating competition between different products that compete with each other.
So it's kind of like a formulary in a hospital in a way, except we cover lots of things that aren't listed on this because either they don't have competitors or they have criteria that is much larger than could be put on this document in a section, you know, just in a few sentences. And so this is a primary coverage document that we use to try and allow the public to know how they could get a drug, how a doctor could get a drug, which ones that they should be trying to prescribe if they're trying to get coverage from Medicaid.
Q. So just to make sure that I understood you correctly, this is not an all inclusive list of drugs that can be covered through BMS, correct?
A. That is correct.
Q. Okay. And I might have missed this, but what are managed categories?

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A. So this is something that is very difficult to handle for us and this may be changing on a national level, but what we're trying to do is when you look at this document, it says, for instance, acne agents, topical, and we have Alzheimer's agents. What we try to do is group medications based on what they're used for.
So when manufacturers are offering rebates they look at things from a financial standpoint, what are they competing against, they consider that their market basket. And so we try and categorize this so if a doctor is looking and saying I want to use something for pain, they can find it on here a little easier. Of course you can search for the specific drug you're looking for, but if you want to see if it's covered, this is an effort to organize things into something that makes sense. But it gets hard because you have drugs that have multiple different unrelated diagnoses, so it's getting harder and harder to just categorize them by their use.
But that's how most PDL's, preferred drug lists, around the nation are organized right now is by overall, not really diagnosis, but the general category of what they're being used for, like antibiotics, for instance, anticoagulants.
Q. So I'm going to direct your attention to Bates

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No. DHHRBMS000150. If you are looking at the document in the viewer, it comes up as Page 5 of 54.
A. Yeah, so androgenic agents?
Q. Exactly. Can you explain to me what this section discusses?
A. So what it's showing is we have a lot of different types of testosterone that we prefer, Androderm, Androgel, those are topical forms, testosterone cypionate, which I believe is the one that was requested in this, by Christopher Fain's physician. That one is injectable, so it's got a little CL above it which means it requires a clinical prior authorization simply because it's injectable, same with that testosterone enanthate. The other ones are topical, they don't require the same level of safety.
So and then you have, so the first column is preferred, the second column is nonpreferred. So if you wanted to get Jatenzo, you would have to say why you couldn't use one of those preferred agents, because they're all testosterone, they all do the same thing.
And so in some cases nonpreferred drugs can cost 10, 20 times as much as a preferred medication. And the criteria here when it says, "Will only be authorized if one of the exceptions on the PA form is present," that's just a general, exceptions are generally things like

allergies, you know, some sort of sensitivity to dosage form, things like that.

Q. Okay. I am now going to direct your attention to Bates No. DHHRBMS000189. If you're looking in the viewer, it's going to be Page 45 out of 54.

A. Okay.

Q. Looking at the section that says, "Pituitary suppressive agents"?

A. Yes.

Q. So can you explain to me what this section discusses.

A. Well, I see one thing on here that could be an error, it shows Vantas on here, and as we determined, that's an implant, so we wouldn't be covering that through pharmacy. But what it is showing is a lot of these pituitary suppressive agents, they affect the gonadotropin releasing hormone which self suppresses testosterone and through a downstream, through a series of hormonal messengers it will eventually resolve in a suppression of testosterone. So you have a lot of different uses for these, Leuprolide, Triptorelin, these are all things that will suppress certain actions of the pituitary gland which is considered a master gland which does a lot of different things in the body.

So this is one of these categories that it's

hard to lump a bunch of medications in because they have a lot of different uses. But one of the ways we lump these in together is we have a vendor, the preferred drug list vendor, Change Healthcare, they are our rebate vendor, so they try and get rebates and they recommend how to categorize these meds so that they're competing against drugs that they should be competing against. So you want to make sure that we're not requiring a drug to be used to get to a nonpreferred drug that has nothing to do with the same thing that the nonpreferred drug is being used for.

Q. Understood. And as you noted earlier, this isn't an all inclusive list, correct, of the drugs?

A. Right. As you can see, it's a huge list, it's like 70 something page, it's varied between 50 to 70 pages at times. So there's a lot of, a lot of drugs on here that sometimes things get on there that we didn't intend, sometimes things are left off that we didn't intend, but it's definitely not inclusive. It's meant to be our best effort to communicate our policy to the public.

Q. Okay. And would you be able to direct my attention to at least on this list anything with regard to estrogen?

A. Yeah, so estrogens, let me double check here,

but estrogens are not on here because they're typically used in oral contraceptives. And we're actually developing new policy around that because we did, partially because of this case we looked to see what we covered and what we didn't.

We actually cover 194 different forms of estrogen and with that many, I mean, if we put this on the PDL, which we will eventually here, it's going to expand the PDL by three or four pages, you know. So we cover 194 and there was only a few we didn't cover and there are vast price differences, so we're actually going to start restricting them by price because they all do about the same thing, you know. There's different formulations and things, but when you've got some that are virtually free and some that are $300 a script, there should be some that are not preferred.

So if they're not on this list because historically they weren't managed because I think in the policy in developing this, I think people looked at it saying why would you interfere with birth control in the Medicaid population, if people want to use birth control, why would you stand between them. But there's so many options now that I think we can do that and still provide many choices to West Virginians without spending $300 on one member's birth control versus $2 on

another and they're getting the same benefit. So that's why it's not on here, but we're going to start managing that, there's just so many options.

Q. And could you direct my attention to testosterone blockers.

A. Testosterone blockers. Like I'm not sure exactly, do you have like a --

Q. Is it possible that testosterone blockers would not be on this list?

A. When I think of testosterone blockers, I'm trying to think of what drugs would fall into what I would consider maybe a testosterone blocker. I mean, if you're talking about things used in a male converting to female, Spironolactone. Probably, I don't know if that would be on this list. That's a very old, yeah, that's a very old, used for diuresis actually, but at high enough doses can suppress testosterone, so it's typically used in conversions. It's not managed on here because a lot of times, sometimes we don't manage things that are super cheap, they have been around forever, and so that one is not listed on here, but we do cover it, no PA required.

I'm trying to think of other things. I would have to pull up the guidelines to see some drugs here, you just caught me off-guard here a little bit, I'm

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trying to come up with names of specific drugs. We don't have a category specifically for testosterone blockers on here.

Q. Understood. Could you direct my attention to Progesterone?

A. Progesterone, again, I think most of the things like that are not going to be on this list. Let me see if we have anything. So it looks like there's four instances, so we have a category called Progestins for cachexia, but that's, that's, cachexia is like your loss of appetite, you're not eating enough food, so Megestrol can be used. Those are typically used I think when you have cancer, things like that, you're trying to stimulate appetite.

Let me see. We have Progestational agents, so that would be things for, so like Makena which actually is a very controversial drug right now because it's been proven to not be very effective, but we still cover it. So that's for preventing premature birth, that was the reason for using it. If you have a woman with a history of having premature childbirth, they have at least one instance of it, Makena is indicated to try and prevent that from happening again, but long-term research I think has shown that it's not very effective, even though we're still required to cover it because the FDA

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hasn't removed the indication yet.

Q. Understood. So just to make sure that I understand this correctly, this is not an all inclusive list, but is there another place where a list of the pharmaceuticals that can be used with regard to hormone replacement therapy, where those specific drugs could be found?

A. Yeah, so on our Website, and you can find this just by even going through Google, but when you get to our Website there's a little ribbon on top, there's a tab for PA criteria, so you can go there and there will be a list of drugs that we have criteria for. Some of those are on the PDL. So a hepatitis B drug has a lot of criteria around them, they're on our PDL, but we couldn't put all the criteria, it's like seven pages of criteria, so we couldn't put it all on that document, so we have a separate link there. But there are other drugs that just aren't listed on the PDL that we have some coverage policies around, but even that's not all inclusive.

A lot of times, to be honest, sometimes the retail pharmacist doesn't know the policy until they try and bill it and then it gets stopped. Because we're getting new drugs every day, so we have to configure them so we can pay, but we may not have had time to

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create policy around them and not every drug is part of policy. A lot of oncology agents don't have policy around them, that's typically a controversial thing to do to restrict chemotherapies, although a lot of states are starting to do that now because there's so many choices.

So like I said, due to the simple number of agents, there's not really a way to create a public document of every single thing we cover, but we're always, you know, one call away to find out what our coverage is on new agents. A lot of the older agents do have some sort of list that they appear on.

Q. Understood. Okay. Well, let's return to Exhibit BT0005.

A. Okay.

Q. And do you recall that we discussed this document earlier today?

A. Yes.

Q. Okay. On Page 4 you'll see defendants' response to request for production 9.

A. Yes.

Q. Okay. I'm just going to read it, "Supplemental response. See limits 2022 preferred drug list attached as Exhibit 174, Bates No. DHHRBMS021564 through 21581." Did I read that correctly?

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A. Yes.

Q. Okay. I am going to pull up another exhibit.

(Exhibit 10 marked for identification.)

Q. Okay. Do you see what has been marked as BT0010?

A. Yes.

Q. Okay. I'm showing you what has been marked as Exhibit BT0010, it is a document with the subject, "Preferred drug list." In the lower right-hand corner of the document is Bates stamped DHHRBMS021564. Do you see that?

A. Yes.

Q. Okay. I'll represent to you that this corresponds to the Bates number identified in the ninth supplemental response to RFP9. Please take a moment to review this document.

A. I have. This is a limits list.

Q. Okay. So it's fair to say that you recognize this document?

A. I do.

Q. Okay. And what is it?

A. So Doug Sorvig our data analyst has tried to create a list to help people understand where we have limits on certain, like quantity limits on certain drugs. This is definitely not all inclusive, he's not a

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pharmacist, he tried to pull this through the databases that we have. But it's mainly to try and make things a little bit easier for people who are ordering and want to know how much they can order, things like that. Again, it's not all inclusive. I believe he may have updated this this year. Yeah, so this is kind of for the pharmacist so that they know if they were ordering something and they could look on here and see, oh, I'm not allowed to order that much at one time.

Q. Okay. I think I understood what you were saying, but just so I understand, this document can be used by pharmacists to understand what the limits are on specific types of drugs?

A. Yeah. A lot of drugs don't have specific numerical limits on how much you can get at one time, some of them do. And this document is trying to help people understand where we do have some quantity limits and refill limits, daily dose limits, things like that.

Q. Understood. Okay. I think let's take a five-minute break, if that's okay with you?

A. Sure.

Q. Great.

ATTORNEY SMITH: And, Kelley, can we go off the record.

(A break was taken at 9:48 a.m.)

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BY ATTORNEY SMITH:

Q. So, Mr. Thompson, we're going to return to Exhibit BT0005.

A. Okay.

Q. And I'm sure you might remember this, but just to make sure, do you recall that we've discussed this document earlier today?

A. Yes.

Q. Okay. You have been designated to testify about the response to request for production 3. Please take a moment to review this document, specifically the bottom of Page 2. Do you recognize this document?

A. I do.

Q. Did you review this document in connection with your testimony as the organizational representative for BMS today?

A. Yes.

Q. Okay. At the bottom of Page 2 you'll see text that reads, "Taking necessary steps to comply with applicable privacy laws and making all necessary redactions to protect any personal health information. Documents in electronic, delimited and importable format, example, Excel spreadsheet, sufficient to show number of individuals who have requested coverage for gender confirming care, the number of claims each

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individual has made for gender confirming care, whether those claims were approved or denied, the factual reasons for each decision, and whether any denials were based in whole or in part on the exclusion." Did I read that correctly?

A. You did.

Q. And I understand from your counsel that you have been designated to address this topic as it relates to pharmacy claims, is that your understanding as well?

A. Yes.

Q. Okay. And are you aware that your counsel identified you as the organizational representative to testify about documents produced by BMS in response to request for production 3?

A. I am.

Q. Okay. Are you prepared to testify about this response?

A. Yes.

Q. With respect to request for production 3 specifically, what did you do to prepare to testify today?

A. I asked Doug Sorvig, who his previous role is administrative assistant, I asked him to see if he could pull together the number of people that we may have treated for gender dysphoria. As I said earlier, we

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don't keep track of the diagnoses, we don't require the diagnoses on these. So what I instructed him to do was to look for patients where we had used a hormone that you might not normally associate with that gender, so testosterone in females, estrogen in males, and by that way sort of make an assumption of the number of patients that we've treated for gender dysphoria over the course of the last five, six years or so.

But other than that, since we don't track the diagnosis, I did look in our PO's folder, we try and keep a, when we get documentation regarding a denied drug and we collect information to see why, if we want to approve it, I try to see if there was anything that stood out. We organize them by patient name and the drug being requested, but there's no, you know, it's a file name so you can only put in so much information in a file name, so there's not really anything diagnosis in there. I looked and I didn't see anything specific.

I also checked with Rational Drug to see if they had anything, but like I said, since we don't categorize the drugs or diagnosis, it was very difficult to find anything specific.

Q. Okay. Please look at the page again while I read the response to request for production 3, "Defendants' supplemental response. See hormones data

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attached as Exhibit 173, Bates No. DHHRBMS021563." Did I read that correctly?
A. Yes.
Q. Okay.
(Exhibit 11 marked for identification.)
Q. Do you see what I've marked as BT0011?
A. Let me refresh again here. Yes, I see it now.
Q. Okay. I'm showing you what has been marked as Exhibit BT0011, it is a document entitled, "Hormones data." In the lower right-hand corner of the document is Bates stamped DHHRBMS021563. Do you see that?
A. Mm-hmm, yes.
Q. Okay. I will represent to you that this corresponds to the Bates number identified in the ninth supplemental response to RFP No. 3. Please take a moment to review the document.
A. Okay.
Q. Are you familiar with this document?
A. Yes.
Q. And what is this document?
A. This is actually the results of what I had just referred to. Doug, I asked him to see if he could tell me the number of patients that we might have treated for gender dysphoria as sort of a demonstration that we hadn't been restricting the use of hormone therapy.

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And so as you can see here, I think, you know, I think that that email that we saw about the gender coverage was from 2016, so you could see we really picked up after it was clarified there. So some of these are probably the same patients, I think he looked to see how many members we were, males that were getting estrogen, females that were getting testosterone over the years, so they would continue to add up as you added new patients who seemingly were still getting care, you would add a new one on top of that. So these are not, you know, you didn't have 61 new patients and then 114 new patients in each year, it was an accumulation of coverage. So we have a fair number of patients that we are treating presumably for gender dysphoria. But I would have to look at each individual one and really look at the communications to really determine what they were actually using the therapies for.
Q. Okay. And what system was this information pulled from?
A. So he used the, what's called the data warehouse which is operated by IBM. So my, to my knowledge what happens is the claim system stores about five years of data in it that I can access through what's called Health Pass, which is the claim system that we use. But because of the amount of data, they have to move that

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and archive it essentially, so this is from archived data. I think they do that every two months or something like that. And so the data that he would have been accessing was probably no older than two months or so, and then it has the ability to go back to the start of the warehouse I think.
Q. And do you know by chance how this information was categorized? So, for example, you know, you mentioned earlier that one of the ways you had this, the search done was by looking at medications that as you said wouldn't be typically prescribed to a certain gender?
A. Yes.
Q. Can you describe that a little bit more?
A. Yeah. So when I was, I was trying to find something useful to both sides of the case here, this wasn't something I was requested to do, I just thought I'd get creative and see if we could find something. Since we don't track by diagnosis, I thought I could attack it from looking at things you might not expect. Now initially before these edits were removed, part of the reason there was an edit was because it wasn't very common to see testosterone used in a female and estrogen in a male years and years past. So you would normally look at it as something that could potentially be

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dangerous in the wrong patient.
So I took that kind of thought process and I asked him just to run a quick, you know, just look in the warehouse, see if you can get me a total on the number of males that were getting estrogen, females that were getting testosterone, and that's what he did. And I asked him specifically when he got these numbers if he had to see individual -- he's trained in using the data warehouse, I don't use it on a daily basis, you know, I deal with real-time things, so I haven't seen what the raw data looks like, but I did clarify with him yesterday if I needed to pull up individual cases, how easy would that be. And he said that the data warehouse has a function that totals the number of patients, you can do it by gender and the drug, it will tell you that number. But he was not pulling up individual cases there, he said that would be much more tedious, but he could do it if we needed to.
So that's how the data was presented as a total. They have a reporting function I guess in that warehouse that will give you certain metrics if you program it in.
Q. And as a follow-up, how is gender typically captured? And just to make sure I'm correct in my understanding of this, for example, based off of what you described, essentially a transgender woman who would

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be receiving estrogen might have her gender marker still in the system as M and that's possibly one of the ways used to kind of track this information, correct?
A. Right. So that's a very good question. I think that you can look at it from the standpoint of like a hospital as well. If you're going into care, it is important to know the birth gender for reasons of dosing and understanding the patient in front of you. That's separate I think from the identification of the patient, the way the patient views themselves. You have to know, you know, you have to be able to dose pharmacogenetically.
So from that standpoint, our system is kind of saying when you get enrolled, and I don't work in enrollment so I don't know what liberties a patient has, or a member I should say has in providing the information, I don't know if they're required to provide an ID or something to say what their birth gender is or not, but what I believe is that when you are enrolled you're enrolled by your birth gender and that is in the system. However, when you go to a retail pharmacy and you say I am so and so picking up my medication, and they can enter anything they want. So they can enter in the case with Christopher Fain, they can enter the male gender, but in our system Christopher Fain is listed as

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female. So that causes certain edits to fire.
So a female member that is under the age of 49 I think it is, I forget the cutoff, who's prescribed something that potentially could be dangerous if they were pregnant will fire a pregnancy edit to make sure to have, that will remind the retail pharmacist to check and see if they're aware whether or not they're pregnant or not. So things like that can happen.
So in our system the gender may very well be different from the way the claim was submitted. The claim is submitted by the pharmacist typing in that information when they're submitting the claim to us for payment.
Q. Okay. Was this information possibly categorized by diagnosis codes?
A. No, no. Again, diagnosis code, the only way, the only place to find diagnosis codes, unless Rational Drug gets a phone call and writes it down or somebody wrote it on a piece of paper when they sent in a prior authorization, the only way to get diagnosis codes in any sort of official fashion would be through the medical side because they do require medical codes and diagnoses on that, on their claim submissions. So very different from pharmacy, yeah.
Q. And then I think you might have said this

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earlier, but correct me if I'm wrong, this data represents claims that were received by BMS, correct?
A. Yeah, this data that you're looking at represents claims that were paid by BMS.
Q. Okay. And if a claim was paid by BMS, it's fair to say then that it was approved, correct?
A. Yes.
Q. All right. Let's return to Exhibit BT0002.
A. Okay.
Q. And if you would scroll to Page 3.
A. Okay.
Q. You have been designated to discuss about Topic 8. Topic 8 reads, "Healthcare coverage and/or denials through Medicaid for transgender West Virginians generally and Christopher Fain and Shauntae Anderson specifically." Did I read that correctly?
A. Yes.
Q. And I understand from your counsel that you have been designated to address this topic as it relates to pharmacy claims. Is that your understanding as well?
A. It is.
Q. And with respect to Topic 8, are you prepared to testify about this topic today as the organizational representative?
A. I am.

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Q. Okay. And what did you do to prepare to testify today?
A. I specifically looked into Christopher Fain and Shauntae Anderson's profiles to see if I could determine whether we denied any of their coverage for any reason related to gender dysphoria.
Q. Have MCO's ever communicated with BMS regarding denials or approvals of hormone replacement therapy for treatment of gender dysphoria?
A. I believe I saw an email that did not involve me where they were trying, one of them was trying to clarify policy when they still covered some pharmacy claims, you know, we carved it out. When I say carved it out, we took all responsibility for doing outpatient pharmacy from them in 2017. But no, I don't have conversations with them about coverage of medications for gender dysphoria.
Q. Okay. And then just to make sure that I'm understanding what you just said, so in or around 2017 there was a carveout where pharmacy was no longer handled by the MCO's, correct?
A. That's correct.
Q. Okay.
A. Now they are still responsible for medical pharmacy, like physician administered drugs, so things

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that you might have to go to the doctor's office to get them to inject or to administer, so for their own members they're responsible for making those coverage decisions. But if we cover it, they're supposed to provide some way of covering it as well. They might have different policies around it, but they have to provide some way of getting something that we cover by contract, is my understanding.

Q. Understood. And are there any reasons why coverage for hormone replacement therapy for treatment of gender dysphoria would be denied?

A. Other than safety, no, I can't, for that specific diagnosis, I can't imagine, you know, from a pharmacy standpoint why we would.

Q. And has BMS ever denied coverage for Mr. Fain's hormone replacement therapy?

A. There was one, when I looked at the profile there was one denial. There was several edits that prevented it from paying because it required, I think there was, it might have been a pregnancy, I can't remember all the edits that have fired, but in general every time, they called Rational Drug three times, got two approvals, there was one denial, and that was simply because they were trying to use it every five days and it was supposed to be used every seven days, so as soon

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as they clarified that, it got paid. So I would say no, we did not deny it for gender dysphoria.

Q. Okay. And has BMS ever denied coverage for Ms. Anderson's hormone replacement therapy?

A. No. There were some edits that prevented the claim from going through initially, I think most of those were like early refills, things like that, and I think there was maybe an injectable at one point, but no. And I would also add that on both of these patients none of their claims for estrogen or testosterone ever made it up to us for review, they were always approved eventually at Rational Drug level.

Q. Understood. And you have already gone through the breakdown of the review process, so.

(Exhibit 12 marked for identification.)

Q. I've just introduced another exhibit, but before I turn to this, Mr. Thompson, just to make sure, are you looking at anything else on your screen other than Exhibit Share?

A. No, I'm just looking at the exhibits that you have pulled up.

Q. Okay. So do you see what has been marked as BT0012?

A. Sixth supplement to plaintiffs?

Q. Yes.

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A. Yes.

Q. Okay. I am showing you what has been marked as Exhibit BT0012, it's titled, "Defendants' sixth supplemental response to plaintiffs' first set of requests for production to Defendants William Crouch, Cynthia Beane and the West Virginia Department of Health and Human Resources, Bureau for Medical Services." Mr. Thompson, you have been designated to testify about the response to request for production 2. Please take a moment to review this document, specifically the bottom of Page 1 and top of Page 2. Do you recognize this document?

A. I do, yes.

Q. Okay. Did you review this document in connection with your testimony as the organizational representative for BMS today?

A. I did.

Q. On Page 1 you'll see plaintiffs' request for production No. 2 which reads, "All documents relating to plaintiffs' communications, injuries, requests for coverage, request for prior authorization, request for reimbursement and/or complaints regarding coverage for gender confirming care through the West Virginia Medicaid program. This request includes, but is not limited to, A, all communications to and from plaintiff

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relating to coverage for gender confirming care; B, all documents and communications regarding plaintiffs' request for gender confirming care, including but not limited to, communications among defendants and/or the employees' entities, agents, representatives, contractors, vendors and/or consultants of defendants and/or West Virginia Department of Health and Human Resources, Bureau for Medical Services; C, all documents and communications relating to consideration or processing by third-party administrators, contractors and/or vendors of requests for gender confirming care by plaintiff." Did I read that correctly?

A. Yes.

Q. And are you aware that counsel identified you as the organizational representative to testify about documents produced by BMS in response to production No. 2?

A. I am.

Q. And please look at that page again while I read defendants' response to request for production 2, "Supplemental response. See attached Excel spreadsheet with claim information for hormones for Plaintiffs Fain and Anderson attached as Exhibit 97, Bates No. DHHRBMS016224. With regard to Fain, see the attached audio recording regarding request for approval for

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medication attached as Exhibit 98, Bates No. DHHRBMS016225; West Virginia controlled substance report from Board of Pharmacy records attached as Exhibit 99, Bates No. DHHRBMS016226 through 16228; and member notes attached as Exhibit 100, Bates No. DHHRBMS016229 - 16230. All materials are confidential." Did I read that correctly?

A. Yes.

Q. I'm going to introduce another exhibit.

(Exhibit 13 marked for identification.)

ATTORNEY SMITH: Kelley, just so you know, this is an Excel spreadsheet, so I won't be able to attach the Bates stamp, but it will be Exhibit BT0013.

I will now designate this portion of the deposition transcript as confidential pursuant to the protective order entered in this matter. Plaintiffs reserve their right to make further confidentiality designations after this deposition in accordance with the terms of the protective order and recognize defendants' right to do the same.

BY ATTORNEY SMITH:

Q. Mr. Thompson, do you see what is Exhibit 0013 and it's Bates DHHRBMS016224?

A. Yes.

Q. Okay. I will represent to you that this

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corresponds with the first Bates number identified in the sixth supplemental response to RFP2. Please take a moment to review the document.

A. Okay.

Q. I believe that there are two tabs, one is for Christopher and one is for Shauntae.

A. Yes. Okay, I'm ready when you are.

Q. Okay. What is this document?

A. So this is produced by our claims vendor Gainwell. I asked them to pull together a record of all, since it seemed like this case was involved mainly around the testosterone and estrogen pulled up together, I wanted to see all the paid and denied claims on these two patients for those specific medications so I could see their, so I could demonstrate the exact reason why something may have been denied or not got paid. So that's what you're looking at here is basically a summary of the claims that were submitted for testosterone and estrogen products on both of these patients.

Q. Okay.

A. I think there might be other drugs on here, if I remember correctly too.

Q. Just to walk through a little bit of this document. If you would click the tab for Shauntae

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Anderson.

A. Yes.

Q. All right. There is a range of dates from 8/12 to around 8/26/20?

A. Yes.

Q. The claims status shows denied. Do you know what the reason would be for that?

A. Needs a prior authorization. So the Estradiol Valerate 100 milligram from 5 mil is an injectable, so that alone would mean it would need a prior authorization. The tablets don't have that description on them, so they generally pay a lot easier.

Q. Okay. And what exactly is a rule ID?

A. Let's see, rule ID, so that would be the edit number. So they have a dictionary and it just identifies the specific programming edit that fired. And then I believe that the next column over tells you what that edit was. So like, for example, all the 205's that need a PA, contact Rational Drug, so that would tell that information conveyed to the pharmacist that's billing the claim, telling them that they needed to call Rational Drug to request a prior authorization. 7301 would be an edit override because they ordered a quantity or supply that was, again, it was over the limit.

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So you can have multiple edits fire on the same claim. So when you look at these, how you would read this is in column A they have an claim ID number. Some of these if you notice 24, 25 and 26, they're all the same claim number, that means there are three edits that fired on that single claim that either would have been resulting in a warning, a denial or something like that.

Q. Okay. All right. I'm going to introduce another exhibit.

(Exhibit 14 marked for identification.)

Q. Okay. Do you see what has been marked as Exhibit BT0014?

A. I do.

Q. Okay. I'm showing you what has been marked as Exhibit BT0014, it is a document entitled, "West Virginia controlled substance report from Board of Pharmacy." In the lower right-hand corner the document is Bates stamped DHHRBMS016226. Do you see that?

A. Yes.

Q. I will represent to you that this corresponds with the third Bates number identified in the sixth supplemental response to RFP2. Please take a moment to review this document.

A. Okay, I'm ready.

Q. Okay. Do you recognize this document?

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A. I do.
Q. And what is it?
A. It's a copy of the results from the controlled substance administration report, commonly known as a PDMP. So PDMP stands for Prescription Drug Monitoring Program, so it's a way of, most states have one of these and it's a way of keeping track of controlled substances. So retail pharmacies are required to submit data to show even cash payments, even if you went and you paid out of your own pocket, it should show up on here if it's a controlled substance.
Q. Okay. And what is the West Virginia Board of Pharmacy?
A. So they're the regulatory body in West Virginia that controls the practice of pharmacy in the state of West Virginia, establishes rules and regulations regarding pharmacy practice.
Q. And this document is specific to Christopher Fain, correct?
A. It is.
Q. Okay.
(Exhibit 15 marked for identification.)
Q. Okay. Do you see Exhibit BT0015?
A. Yes.
Q. Okay. I'm showing you what has been marked as

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Exhibit BT0015, it is a document titled, "Member notes." In the lower right-hand corner the document is Bates stamped DHHRBMS016229. Do you see that?
A. Yes.
Q. Okay. And I will represent to you that this corresponds with the fourth Bates number identified in the sixth supplemental response to RFP2. Please take a moment to review this document.
A. Okay. I'm ready when you are.
Q. Okay. What is this document?
A. So every time somebody contacts Rational Drug regarding a patient seeking a prior authorization, any time they call or communicate to Rational Drug, Rational Drug records, in shorthand many times, the interaction. So that's what we're looking at here. These are the notes related to any calls on Christopher Fain going back as far as we have records it looks like.
Q. And this document is specific to Christopher Fain, correct?
A. It is.
Q. Okay. Let's return to document BT0005.
A. Okay.
Q. Do you recall that we discussed this document earlier?
A. Yes.

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Q. Okay. Please take a look at the top of Page 2 while I read defendants' response to request for production 2, "Supplemental response. Pursuant to the protective order, see member notes (pharmacy) for Plaintiff Anderson attached as Exhibit 172, Bates No. DHHRBMS021560 through 21562." Did I read that correctly?
A. You did.
Q. Okay. Are you prepared to testify about this response?
A. I am.
Q. And with respect to request for production 2 specifically, what did you do to prepare to testify today?
A. I went into the member profile and looked at the member notes and downloaded them.
(Exhibit 16 marked for identification.)
Q. Okay. Do you see Exhibit BT0016?
A. Yes.
Q. Okay. I'm showing you what is marked as BT0016, it is a document titled, "Member notes." In the lower right-hand corner the document is Bates stamped DHHRBMS021560. Do you see that?
A. I do.
Q. Okay. I will represent to you that this

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corresponds with the Bates number identified in the ninth supplemental response to RFP2. Please take a moment to review the document.
A. Okay, I'm ready.
Q. Okay. And do you recognize this document?
A. I do.
Q. And we discussed this already a little bit before, but just to confirm, this is also a document that contains member notes for Shauntae Anderson, correct?
A. Yes.
Q. And based on my understanding of what you described earlier, this document shows communications from Ms. Anderson to BMS, correct?
A. Well, it wouldn't be from Ms. Anderson, patients don't talk directly to Rational Drug. So it would be somebody from either the pharmacy billing the claim, most likely, or the doctor's office requesting prior authorization before it gets billed. In this case, I'd have to read it a little bit more closely and try and figure out who, where the call was coming from, but members never get to talk to Rational Drug.
Q. Understood. And this is specific to Shauntae Anderson, correct?
A. Yes.

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Q. All right.
(Exhibit 17 marked for identification.)
Q. Okay. Do you see Exhibit BT0017?
A. Yes.
Q. Okay. I'm showing you Exhibit BT0017 titled, "Defendants William Crouch, Cynthia Beane and West Virginia Department of Health and Human Resources, Bureau for Medical Services, second supplemental response to plaintiffs' second set of request for production of documents and things." Mr. Thompson, you have been designated to testify about the response to request for production 25. Please take a moment to review this document, specifically at the bottom of Page 1 and the top of Page 2.
A. Okay.
Q. Do you recognize this document?
A. I do.
Q. And did you review this document in connection with your testimony as the organizational representative for BMS today?
A. Yes.
Q. Okay. On Page 1 you'll see text that reads, "To the extent not already produced, all documents related to Plaintiff Christopher Fain and proposed Plaintiff Shauntae Anderson." Did I read that correctly?

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A. Yes.
Q. And are you aware that counsel identified you as the organizational representative to testify about documents produced by BMS in response to request for production 25?
A. Yes.
Q. Okay. Please look at that page again while I read the response to request for production 25, "Supplemental response. Please see three Excel spreadsheets regarding Plaintiff Fain's medical information attached as Exhibit 87, 88 and 89, Bates No. DHHRBMS016069, DHHRBMS016070, and DHHRBMS016071 respectively. Additionally, please see other patient information regarding Plaintiff Fain attached as Exhibit 90, Bates No. DHHRBMS016072 through 16077. With regard to Plaintiff Anderson, please see two Excel spreadsheets with medical information attached as Exhibits 91 and 92, Bates No. DHHRBMS016078 and DHHRBMS016079." Did I read that correctly?
A. Yes.
Q. Okay.
(Exhibit 18 marked for identification.)
Q. Okay. Do you see Exhibit BT0018?
A. Yes.
Q. Okay. I'm showing you what has been marked as

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Exhibit BT0018, it is a document titled, "Fain patient information." In the lower right-hand corner the document is Bates stamped DHHRBMS016072. Do you see that?
A. Yes.
Q. I will represent to you that this corresponds with the fourth Bates number identified in the second supplemental response to RFP25. Please take a moment to review this document.
A. Okay, I'm ready.
Q. Okay. Do you recognize this document?
A. I do.
Q. Okay. And what is it?
A. So the top portion of this is what's called the member screen and it shows their demographics, name, the gender that we have them in our system as, marital status, mailing address, you have various tabs for eligibility, lock-ins would be like for controlled substances, sometimes they get locked into one pharmacy that they can fill, and various other things there.
And then the next page is, it looks like it's just an excerpt from the member notes showing the approval of the injectable testosterone. The PA request it looks like the next page after that. So this is like the general drug PA form that I had mentioned very early

Page 97

in our conversation. The next page after that is what's called the quick reference screen. So when you get a claim on any drug I can get details about how that claim was submitted. So I don't know what the screen looks like at say your CVS or Walgreens, but they would be entering information, the retail pharmacist enters the information that appears on this quick claim reference screen. So in this case you see the gender is marked as male, that was entered by the billing pharmacist. So this is all the billing information, they had to put in how much they're asking for, the amount of days it's supposed to last, that sort of thing.
Q. Okay. And if we scroll back to what is technically Page 3 of 6 if you're viewing it in this viewer on the platform, the bottom is DHHRBMS016074. Do you see that?
A. 074, yes, the PA form?
Q. Yes. So on the PA form it shows a box that has diagnosis and then an ICD diagnosis code. Does the diagnosis there say transgender?
A. Yes.
Q. And does the ICD diagnosis code say F64.0?
A. It does.
Q. Okay. And this is specific to Christopher Fain, correct?

A. That's correct.
Q. Okay.
ATTORNEY SMITH: Let's take a quick five-minute break. And, Kelley, can we go off the record, please.
(A break was taken at 10:45 a.m.)
ATTORNEY SMITH: I have no further questions for you today, Mr. Thompson, but I do reserve the right to ask further questions if your counsel has any questions for you.
THE WITNESS: Okay. It was nice talking to you though.
MS. BANDY: I don't have any questions. I would just indicate that the witness will read the transcript.
(Proceedings concluded for the day at 10:52 a.m., 04-13-2022)

REPORTER'S CERTIFICATE

STATE OF MINNESOTA)
) ss.
COUNTY OF WASHINGTON)

I hereby certify that I reported the Zoom deposition of Brian Thompson on the 13th day of April 2022, and that the witness was by me first duly sworn to tell the whole truth;

That the testimony was transcribed by me and is a true record of the testimony of the witness;
That the cost of the original has been charged to the party who noticed the deposition, and that all parties who ordered copies have been charged at the same rate for such copies;

That I am not a relative or employee or attorney or counsel of any of the parties, or a relative or employee of such attorney or counsel;

That I am not financially interested in the action and have no contract with the parties, attorneys, or persons with an interest in the action that affects or has a substantial tendency to affect my impartiality;
That the right to read and sign the deposition by the witness was reserved.

WITNESS MY HAND AND SEAL THIS 13th day of April 2022.

Kelley E Zilles

Notary Public, Washington County, Minnesota
My commission expires 1-31-2025

Veritext Legal Solutions
1100 Superior Ave
Suite 1820
Cleveland, Ohio 44114
Phone: 216-523-1313

April 25, 2022

To: Ms. Bandy

Case Name: Fain, Christopher Et Al. v. Crouch, William Et Al.

Veritext Reference Number: 5128144

Witness: Brian Thompson Deposition Date: 4/13/2022

Dear Sir/Madam:

Enclosed please find a deposition transcript. Please have the witness review the transcript and note any changes or corrections on the included errata sheet, indicating the page, line number, change, and the reason for the change. Have the witness' signature notarized and forward the completed page(s) back to us at the Production address shown above, or email to production-midwest@veritext.com.

If the errata is not returned within thirty days of your receipt of this letter, the reading and signing will be deemed waived.

Sincerely,
Production Department

NO NOTARY REQUIRED IN CA

DEPOSITION REVIEW
CERTIFICATION OF WITNESS

ASSIGNMENT REFERENCE NO: 5128144
CASE NAME: Fain, Christopher Et Al. v. Crouch, William Et Al.
DATE OF DEPOSITION: 4/13/2022
WITNESS' NAME: Brian Thompson
In accordance with the Rules of Civil Procedure, I have read the entire transcript of my testimony or it has been read to me.
I have made no changes to the testimony as transcribed by the court reporter.

_____ _____
Date Brian Thompson
Sworn to and subscribed before me, a Notary Public in and for the State and County, the referenced witness did personally appear and acknowledge that:

They have read the transcript;
They signed the foregoing Sworn Statement; and
Their execution of this Statement is of their free act and deed.

I have affixed my name and official seal this _____ day of_____, 20____.

_____
Notary Public
_____
Commission Expiration Date

DEPOSITION REVIEW
CERTIFICATION OF WITNESS

ASSIGNMENT REFERENCE NO: 5128144
CASE NAME: Fain, Christopher Et Al. v. Crouch, William Et Al.
DATE OF DEPOSITION: 4/13/2022
WITNESS' NAME: Brian Thompson
In accordance with the Rules of Civil Procedure, I have read the entire transcript of my testimony or it has been read to me.
I have listed my changes on the attached Errata Sheet, listing page and line numbers as well as the reason(s) for the change(s).
I request that these changes be entered as part of the record of my testimony.

I have executed the Errata Sheet, as well as this Certificate, and request and authorize that both be appended to the transcript of my testimony and be incorporated therein.

_____ _____
Date Brian Thompson

Sworn to and subscribed before me, a Notary Public in and for the State and County, the referenced witness did personally appear and acknowledge that:
They have read the transcript;
They have listed all of their corrections in the appended Errata Sheet;
They signed the foregoing Sworn Statement; and
Their execution of this Statement is of their free act and deed.
I have affixed my name and official seal this _____ day of_____, 20____.

_____
Notary Public

_____
Commission Expiration Date

ERRATA SHEET
VERITEXT LEGAL SOLUTIONS MIDWEST
ASSIGNMENT NO: 5128144

PAGE/LINE(S) / CHANGE /REASON

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_____ _____
Date Brian Thompson

SUBSCRIBED AND SWORN TO BEFORE ME THIS _____ DAY OF _____, 20_____ .

_____
Notary Public

_____
Commission Expiration Date

DEPOSITION REVIEW
CERTIFICATION OF WITNESS

ASSIGNMENT REFERENCE NO: 5128144
CASE NAME: Fain, Christopher Et Al. v. Crouch, William Et Al.
DATE OF DEPOSITION: 4/13/2022
WITNESS' NAME: Brian Thompson

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I have executed the Errata Sheet, as well as this Certificate, and request and authorize that both be appended to the transcript of my testimony and be incorporated therein.

5-18-2022 Brian Thompson
Date Brian Thompson

Sworn to and subscribed before me, a Notary Public in and for the State and County, the referenced witness did personally appear and acknowledge that:

They have read the transcript;
They have listed all of their corrections in the appended Errata Sheet;
They signed the foregoing Sworn Statement; and
Their execution of this Statement is of their free act and deed.

I have affixed my name and official seal this 18th day of May, 2022.

Kimberly M O'Brien
Notary Public

July 28, 2026
Commission Expiration Date

OFFICIAL SEAL
NOTARY PUBLIC
STATE OF WEST VIRGINIA
Kimberly Michelle O'Brien
WV DHHR Bureau for Medical Services
350 Capitol St. Rm 251, Charleston, WV 25301
My Commission Expires July 28, 2026

ERRATA SHEET

VERITEXT LEGAL SOLUTIONS MIDWEST

ASSIGNMENT NO: 5128144

PAGE/LINE(S) / CHANGE /REASON

p.14 / 14-15 "looks for outstanding & unusual claims to help us manage fraud & waste." By unusual I mean excessive quantities or claims billed to Medicaid 1st when the member ~~already~~ had unreported ~~primary~~ primary insurance. / Clarification

p. 15 / 17 "... in the ~~clinic~~ inpatient pharmacy" / Clarification

p. 15 / 25 "considered the Heart Hospital" / Clarification

p.35/ 12-13 EPSDT is not required for children. - It is
/ & 23 a benefit that provides comprehensive & preventative health care services for children under age 21 who are enrolled in Medicaid. The EPSDT benefit ~~screens~~ can cover medically necessary services not normally covered under Medicaid. / Clarification & Correction

p.67/ 13 Hepatic "B" → Should be Hepatitic C / Correction

p.73 / 10 ~~PO~~ "POs" folder → Should be "PA folder" / Correction

5-18-2022 Brian Thompson

Date Brian Thompson

SUBSCRIBED AND SWORN TO BEFORE ME THIS 18th

DAY OF May, 2022.

Kimberly M O'Brien

Notary Public

July 28, 2026

Commission Expiration Date

OFFICIAL SEAL
NOTARY PUBLIC
STATE OF WEST VIRGINIA
Kimberly Michelle O'Brien
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My Commission Expires July 28, 2026

ERRATA SHEET

VERITEXT LEGAL SOLUTIONS MIDWEST

ASSIGNMENT NO: 5128144

PAGE/LINE(S) / CHANGE /REASON

p.76 / 3-5 "And so the data that he would have been accessing was probably at least 2 months old or so ....." / Correction.

p.78 pharmacogentically → "Pharmacokinetically" / Spelling Correction

5-18-2022 Brian Thompson

Date Brian Thompson

SUBSCRIBED AND SWORN TO BEFORE ME THIS 18th

DAY OF May, 2022.

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My Commission Expires July 28, 2026

e

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Federal Rules of Civil Procedure

Rule 30

(e) Review By the Witness; Changes.

(1) Review; Statement of Changes. On request by the deponent or a party before the deposition is completed, the deponent must be allowed 30 days after being notified by the officer that the transcript or recording is available in which:

(A) to review the transcript or recording; and

(B) if there are changes in form or substance, to sign a statement listing the changes and the reasons for making them.

(2) Changes Indicated in the Officer's Certificate. The officer must note in the certificate prescribed by Rule 30(f)(1) whether a review was requested and, if so, must attach any changes the deponent makes during the 30-day period.

DISCLAIMER: THE FOREGOING FEDERAL PROCEDURE RULES ARE PROVIDED FOR INFORMATIONAL PURPOSES ONLY. THE ABOVE RULES ARE CURRENT AS OF APRIL 1, 2019. PLEASE REFER TO THE APPLICABLE FEDERAL RULES OF CIVIL PROCEDURE FOR UP-TO-DATE INFORMATION.

VERITEXT LEGAL SOLUTIONS
COMPANY CERTIFICATE AND DISCLOSURE STATEMENT

Veritext Legal Solutions represents that the foregoing transcript is a true, correct and complete transcript of the colloquies, questions and answers as submitted by the court reporter. Veritext Legal Solutions further represents that the attached exhibits, if any, are true, correct and complete documents as submitted by the court reporter and/or attorneys in relation to this deposition and that the documents were processed in accordance with our litigation support and production standards.

Veritext Legal Solutions is committed to maintaining the confidentiality of client and witness information, in accordance with the regulations promulgated under the Health Insurance Portability and Accountability Act (HIPAA), as amended with respect to protected health information and the Gramm-Leach-Bliley Act, as amended, with respect to Personally Identifiable Information (PII). Physical transcripts and exhibits are managed under strict facility and personnel access controls. Electronic files of documents are stored in encrypted form and are transmitted in an encrypted fashion to authenticated parties who are permitted to access the material. Our data is hosted in a Tier 4 SSAE 16 certified facility.

Veritext Legal Solutions complies with all federal and State regulations with respect to the provision of court reporting services, and maintains its neutrality and independence regardless of relationship or the financial outcome of any litigation. Veritext requires adherence to the foregoing professional and ethical standards from all of its subcontractors in their independent contractor agreements.

Inquiries about Veritext Legal Solutions' confidentiality and security policies and practices should be directed to Veritext's Client Services Associates indicated on the cover of this document or at www.veritext.com.

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA
HUNTINGTON DIVISION

CHRISTOPHER FAIN, individually and on behalf of all others similarly situated, *et al.*, *Plaintiffs,* v. WILLIAM CROUCH, *et al.*, *Defendants.*	CIVIL ACTION NO. 3:20-cv-00740 HON. ROBERT C. CHAMBERS

PLAINTIFFS' AMENDED NOTICE OF 30(b)(6) DEPOSITION

PLEASE TAKE NOTICE THAT pursuant to Rule 30(b)(6) of the Federal Rules of Civil Procedure, Plaintiffs, individually and on behalf of the proposed classes, will take the deposition of Defendant West Virginia Department of Health and Human Resources, Bureau for Medical Services through its corporate representatives most knowledgeable about the topics listed herein at the following dates and times, and continuing thereafter until completed:

1. **Frederick Lewis**, February 25, 2022, beginning at 9:00 a.m. E.T.
2. **Sarah Young**, March 11, 2022, beginning at 9 a.m. E.T.
3. **Secretary Crouch**, March 17, 2022, beginning at 11:30 a.m. E.T. to 4 p.m. E.T.
4. **Secretary Crouch**, March 18, 2022, beginning 12:30 p.m. E.T. until completion
5. **Commissioner Beane**, as a Rule 30(b)(6) designee and in her individual capacity, March 29, 2022, 9:00 a.m. E.T.
6. **Dr. Becker**, March 30, 2022, 8:00 a.m. E.T. to 4:00 p.m. E.T.

Exhibit
BT 0001

7. **Brandon Lewis**, April 5, 2022, 10:00 a.m. E.T.

8. **Jennifer Myers**, April 8, 2022, 9:00 a.m. E.T.

9. **Becky Manning**, April 12, 10:00 a.m. E.T.

If needed, and to the extent any of the designees above are not able to provide the seven hours of testimony on the record provided for under Federal Rules on the dates specified above, Plaintiffs reserve their right to continue the deposition on another date until it is completed.

The depositions will be taken remotely via video teleconference offered by Veritext. The depositions of each designee will continue from day to day until concluded. The depositions will be taken under oath before a certified shorthand reporter or other officer authorized to administer oaths. The deposition will be recorded by stenographic means, and on videotape. The deposition shall be used for discovery purposes and may be used as evidence in this action, including at trial.

The definitions contained in Plaintiffs' First Set of Requests for the Production of Documents apply to this deposition notice. The relevant time period is January 1, 2016 to the present unless otherwise noted below.

Pursuant to Rule 30(b)(6), Deponents provided by Defendant West Virginia Department of Health and Human Resources, Bureau for Medical Services shall be knowledgeable officers, directors, managing agents, or other persons who consent to testify on their behalf concerning the above-captioned matter regarding the following:

1. Your authority to and/or role in establishing eligibility standards for Medicaid providers, determining benefits, and reimbursing providers.

2. Your receipt of federal and/or state funds, including funds from the U.S. Department of Health and Human Services, and all representations made to the federal

and/or state government in the course of securing such funds.

3. Your choice to participate in the Medicaid program.

4. The development, creation, and/or use of the Medicaid Plan.

5. Your efforts to administer the Medicaid Program in West Virginia and/or affirm Your compliance with the Medicaid Act and the Patient Protection and Affordable Care Act.

6. Your relationship with each of the following, including any written or unwritten agreements, policies, practices, and/or procedures, and/or communications as they relate to the provision of healthcare coverage to West Virginia Medicaid participants: Mountain Health Trust, UniCare Health Plan of West Virginia, Inc., The Health Plan, Aetna Better Health of West Virginia, and the Rational Drug Therapy Program.

7. Your role in determining and/or offering healthcare coverage to West Virginia Medicaid participants, including Your authority, responsibility, and duties as they relate to determining and/or offering healthcare coverage to West Virginia Medicaid participants.

8. Healthcare coverage and/or denials through Medicaid for transgender West Virginians generally and Christopher Fain and Shauntae Anderson specifically.

9. The decision to stop excluding hormone therapy from coverage in 2017 and/or Your experience covering and/or denying coverage for hormone therapy before and after 2017.

10. Your policies, practices, and procedures related to the Exclusion, including but not limited to how the Exclusion is developed, approved, and maintained.

11. Any government interests that you contend support the Exclusion, and their factual bases.

12. Any research, consideration, and/or analysis by or on behalf of You regarding providing access to gender-confirming care for West Virginia Medicaid participants.

13. Any research, consideration, and/or analysis by or on behalf of You regarding the legality of the Exclusion.

14. As to healthcare coverage for West Virginia Medicaid participants, Your data and documents systems, including but not limited to hardware configuration, software configuration, network configuration, internet structure, and document and data retention systems.

15. As to healthcare coverage for West Virginia Medicaid participants, Your organizational structure including its units, divisions, and departments.

16. The number of Medicaid participants who are transgender and/or have sought any form of care for the treatment of gender dysphoria.

17. All lawsuits, counterclaims, arbitrations, complaints, or judicial or quasi-judicial actions brought or threatened against You related to the denial of gender-confirming care.

18. All interrogatory requests, requests for admission, and requests for production of documents directed to Defendants William Crouch, Cynthia Beane, and West Virginia Department of Health and Human Resources, Bureau for Medical Services, and any discovery responses, responsive documents, filings, or productions by or on behalf of Defendants William Crouch, Cynthia Beane, and West Virginia Department of Health and Human Resources, Bureau for Medical Services.

Dated: February 22, 2022

/s/ Walt Auvil

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Attorneys for Plaintiffs

* Admitted Pro Hac Vice

CERTIFICATE OF SERVICE

I hereby certify that I electronically filed the foregoing document on February 22, 2022 with the Clerk of the Court using the CM/ECF system, which will send notification of filing, and a copy of the same, to the following CM/ECF participants:

Lou Ann S. Cyrus (WVSB # 6558)
Roberta F. Green (WVSB #6598)
Caleb B. David (WVSB #12732)
Kimberly M. Bandy (WVSB #10081)
SHUMAN MCCUSKEY SLICER PLLC
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kbandy@shumanlaw.com

Attorneys for Defendants William Crouch; Cynthia Beane; and West Virginia Department of Health and Human Resources, Bureau for Medical Services

Eric D. Salyers (WVSB #13042)
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Attorneys for Defendant Jason Haught

Dated: February 22, 2022

s/ Walt Auvil
Walt Auvil, WV Bar No. 190
THE EMPLOYMENT LAW CENTER, PLLC
1208 Market Street
Parkersburg, WV 26101
Phone: 304-485-3058
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IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA
HUNTINGTON DIVISION

CHRISTOPHER FAIN, individually and on behalf of all others similarly situated, *et al.*, *Plaintiffs,* v. WILLIAM CROUCH, *et al.*, *Defendants.*	CIVIL ACTION NO. 3:20-cv-00740 HON. ROBERT C. CHAMBERS

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7. **Brandon Lewis**, April 5, 2022, beginning at 10:00 a.m. E.T.

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18. All interrogatory requests, requests for admission, and requests for production of documents directed to Defendants William Crouch, Cynthia Beane, and West Virginia Department of Health and Human Resources, Bureau for Medical Services, and any discovery responses, responsive documents, filings, or productions by or on behalf of Defendants William Crouch, Cynthia Beane, and West Virginia Department of Health and Human Resources, Bureau for Medical Services.

Dated: March 1, 2022

/s/ Walt Auvil

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Attorneys for Plaintiffs

* Admitted Pro Hac Vice

CERTIFICATE OF SERVICE

I hereby certify that I electronically filed the foregoing document on March 1, 2022 with the Clerk of the Court using the CM/ECF system, which will send notification of filing, and a copy of the same, to the following CM/ECF participants:

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IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA
HUNTINGTON DIVISION

CHRISTOPHER FAIN; ZACHARY MARTELL; and **BRIAN MCNEMAR,** Individually and on behalf of all others similarly situated,

Plaintiffs,

Civil Action No. 3:20-cv-00740
Hon. Robert C. Chambers, Judge

v.

WILLIAM CROUCH, in his official capacity as Cabinet Secretary of the West Virginia Department of Health and Human Resources; **CYNTHIA BEANE,** in her official capacity as Commissioner for the West Virginia Bureau for Medical Services; **WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES; TED CHEATHAM,** in his official Capacity as Director of the West Virginia Public Employees Insurance Agency; and **THE HEALTH PLAN OF WEST VIRGINIA, INC.**

Exhibit
BT 0003

DEFENDANTS' RESPONSE TO PLAINTIFF'S FIRST SET OF INTERROGATORIES TO DEFENDANTS WILLIAM CROUCH, CYNTHIA BEANE, AND WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES

INTERROGATORIES

1. Identify all persons with involvement in, or knowledge of, the creation, review, and maintenance of the Exclusion of coverage for Gender-Confirming Care in the Health Plans offered through West Virginia's Medicaid Program.

   RESPONSE: Objection. All persons having "knowledge of" any exclusion is overly broad and burdensome and could entail countless people inside and outside of the Defendant WVDHHR. Knowledge of the creation of any exclusion by the individual Managed Care Organizations, as well as review and maintenance of any such exclusion, would be with the individual MCOs.

Without waiving these objections, the following individuals have been involved in the process of determining whether coverage is excluded:

Dr. James Becker, Medical Director, West Virginia Bureau for Medical Services

Jennifer J. Myers, Director of Professional Services, Bureau for Medical Services

Tanya Cyrus, Chief Quality and Integrity Officer, Bureau for Medical Services

Carrie Mallory, Program Manager, Bureau for Medical Services

Karen Burgess, Certified Coder, Office of Program Integrity

Cynthia Shelton, former Director of Operations, Bureau for Medical Services.

2. Describe in detail the factual basis for each governmental interest that Defendants contend supports the Exclusion.

RESPONSE: These Defendants state that they provide coverage that is mandated for coverage by the Centers for Medicare and Medicaid Services (CMS). These defendants are constrained by budgetary/cost considerations.

3. Identify and describe in detail every instance in which a Health Plan offered through West Virginia's Medicaid Program provides partial or full coverage for Gender-Confirming Care of any kind, including but not limited to counseling and/or therapy, hormone therapy, or surgery. Include in you answer the coverage criteria for such care and the date such coverage began.

RESPONSE: Objection. This question seeking "every instance" is overly broad and burdensome. Without waiving the objection, with respect to any gender-confirming care that it is requested through the Managed Care Organizations, these Defendants are not in possession of this information. This question would best be directed to the individual MCOs regarding any care requested through them.

Upon information and belief, counseling is a covered service. These defendants would not necessarily know the reason for counseling and whether it was related to gender-confirming care or some other reason.

To the extent that this Request includes hormone therapy, these defendants object to this question on the basis it is not calculated to lead to the discovery of admissible evidence due to the fact the Plaintiff's claim regarding hormones has been voluntarily dismissed.

Further, without waiving the objection, with regard to hormone therapy, these Defendants do not have a database where they keep track of the information in the manner requested. The data is not kept in a manner which would allow them to identify which patients have requested hormone therapy for gender confirming care. Information is tracked by the medication or drug requested, not the diagnosis or reason for the request. Upon information and belief, there are no gender edits for most estrogen and testosterone containing products, so coverage would not be denied on the basis that the hormone therapy was sought as part of gender-confirming care.

With respect to pharmacy services, please see BMS Provider Manual Chapter 518 Pharmacy Services that can be accessed online at:

https://dhhr.wv.gov/bms/Provider/Documents/Manuals/Chapter_518_Pharmacy_Services%20.pdf

and the most recently updated Preferred Drug List with Prior Authorization Criteria that can be accessed online at:

https://dhhr.wv.gov/bms/BMS%20Pharmacy/Documents/Preferred%20Drug%20List/2021/WV%20PDL%202021.Q3b%20v11.pdf.

Please note that to the extent that the Provider Manual states in section 518.4 that "Other drugs may be limited in quantity, duration, or based on gender. The information regarding these drug products and their limitations is available on the BMS website[,]" the "Drug Limits" list available online was last updated June 1, 2016, and does not reflect the removal of the gender edit for most estrogen and testosterone containing products.

4. Identify all conditions, diagnostic codes, or instances where coverage for hormone therapy is available under the Health Plans offered through West Virginia's Medicaid Program. Include in that identification:
    a. Diagnostic code(s);
    b. Procedure code(s);
    c. Medical necessity criteria.

RESPONSE: These defendants object to this question on the basis it is not calculated to lead to the discovery of admissible evidence due to the fact the Plaintiff's claim regarding hormones has been voluntarily dismissed. Without waiving this objection please see BMS Provider Manual Chapter 518 Pharmacy Services that can be accessed online at:

https://dhhr.wv.gov/bms/Provider/Documents/Manuals/Chapter_518_Pharmacy_Services%20.pdf

and the most recently updated Preferred Drug List with Prior Authorization Criteria that can be accessed online at:

https://dhhr.wv.gov/bms/BMS%20Pharmacy/Documents/Preferred%20Drug%20List/2021/WV%20PDL%202021.Q3b%20v11.pdf.

Please note that to the extent that the Provider Manual states in section 518.4 that "Other drugs may be limited in quantity, duration, or based on gender. The information regarding these drug products and their limitations is available on the BMS website[,]" the "Drug Limits" list available online was last updated June 1, 2016, and does not reflect the removal of the gender edit for most estrogen and testosterone containing products.

5. Identify all conditions, diagnostic codes, or instances where coverage for mastectomy, breast reduction surgery, and chest reconstruction surgery is available under the Health Plans offered through West Virginia's Medicaid Program. Include in that identification:
    d. Diagnostic code(s);
    e. Procedure code(s);
    f. Medical necessity criteria.

RESPONSE: With respect to any such care requested or provided through the Managed Care Organizations, these Defendants are not in possession of this information. This question would best be directed to the individual MCOs.

Please see BMS Provider Manual Chapter 519.16 Surgical Services that can be accessed online at:

https://dhhr.wv.gov/bms/Provider/Documents/Manuals/Chapter%20519%20Practitioner%20Services/Policy_519.16_Surgical_Services.pdf.

6. Describe in detail the factual basis for the decision to no longer exclude coverage for hormone therapy as treatment for gender dysphoria in the Health Plans offered through West Virginia's Medicaid Program.

RESPONSE: Upon information and belief, in or around 2017 it came to the attention of then-Pharmacy Director that claims were being denied based on gender edits that were in place for estrogen and testosterone containing products. After consulting with the Medical Director, a decision was made to remove the gender edits so that the hormone therapy would not be denied on the basis of gender.

7. Identify all persons, including but not limited to persons affiliated with the Rational Drug Therapy Program, who have been involved in the decision to provide coverage for hormone therapy as treatment for gender dysphoria.

RESPONSE: Upon information and belief, former Pharmacy Director Vicki Cunningham and Medical Director Dr. James Becker were involved in removal of the gender edit.

WILLIAM CROUCH,
CYNTHIA BEANE, and
WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES,

By counsel

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IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA
HUNTINGTON DIVISION

CHRISTOPHER FAIN; ZACHARY MARTELL; and **BRIAN MCNEMAR,** Individually and on behalf of all others similarly situated,

Plaintiffs,

Civil Action No. 3:20-cv-00740
Hon. Robert C. Chambers, Judge

v.

WILLIAM CROUCH, in his official capacity as Cabinet Secretary of the West Virginia Department Of Health and Human Resources; **CYNTHIA BEANE,** in her official capacity as Commissioner for the West Virginia Bureau for Medical Services; **WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES; TED CHEATHAM,** in his official Capacity as Director of the West Virginia Public Employees Insurance Agency; and **THE HEALTH PLAN OF WEST VIRGINIA, INC.**

Defendants.

CERTIFICATE OF SERVICE

Now come Defendants William Crouch, Cynthia Beane and West Virginia Department of Health and Human Resources, by counsel, and do hereby certify that on the 27th day of August, 2021, a true and exact copy of **DEFENDANTS RESPONSE TO PLAINTIFF'SFIRST SET OF INTERROGATORIES TO DEFENDANTS WILLIAM CROUCH, CYNTHIA BEANE, AND WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES** was served on counsel via electronic means as follows:

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IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA
HUNTINGTON DIVISION

CHRISTOPHER FAIN, and
SHAWN ANDERSON,
a/k/a Shauntae Anderson,
individually and on behalf of all others
similarly situated,

Plaintiffs,

Civil Action No. 3:20-cv-00740
Hon. Robert C. Chambers, Judge

v.

WILLIAM CROUCH, in his official capacity as Cabinet Secretary of the West Virginia Department Of Health and Human Resources; **CYNTHIA BEANE,** in her official capacity as Commissioner for the West Virginia Bureau for Medical Services; and **WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES,**

Exhibit
BT 0005

Defendants.

DEFENDANTS' NINTH SUPPLEMENTAL RESPONSE TO PLAINTIFF'S FIRST SET OF REQUESTS FOR PRODUCTION TO DEFENDANTS WILLIAM CROUCH, CYNTHIA BEANE, AND WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES

DOCUMENT REQUESTS

2. All documents relating to Plaintiff' s communications, injuries, requests for coverage, requests for prior authorization, requests for reimbursement and/or complaints regarding coverage for Gender-Confirming Care through the West Virginia Medicaid Program. This Request includes but is not limited to:

a. All communications to and from Plaintiff relating to coverage for Gender-Confirming Care;

b. All Documents and communications regarding Plaintiff's requests for Gender-Confirming Care, including but not limited to communications among Defendants, and/or the employees, entities, agents, representatives, contractors, vendors, and/or consultants of Defendants and/or West Virginia Department of Health and Human Resources, Bureau of Medical Services;

c. All Documents and communications relating to consideration or processing by third-party administrators, contractors, and/or vendors of requests for Gender-Confirming Care by Plaintiff.

SUPPLEMENTAL RESPONSE: Pursuant to the Protective Order, *see* Member Notes (pharmacy) for Plaintiff Anderson, attached as Exhibit 172 (Bates No. DHHRBMS021560 - 21562).

3. Taking necessary steps to comply with applicable privacy laws and making all necessary redactions to protect any personal health information. Documents in electronic, delimited, and importable format (e.g., excel spreadsheet) sufficient to show number of individuals who have requested coverage for Gender-Confirming Care, the number of claims each individual has made for Gender-Confirming Care, whether those claims were approved or denied, the factual reasons for each decision, and whether any denials were based in whole or in part on the Exclusion.

SUPPLEMENTAL RESPONSE: *See* hormones data, attached as Exhibit 173 (Bates No. DHHRBMS021563).

6. All Documents and communications relating to the Exclusion and/or Gender-Confirming Care considered by the individuals responsible for adopting and/or maintaining the Exclusion in the Health Plans. Please identify the responsive Documents by Bates number. This includes, but is not limited to:

a. Documents and communications regarding the safety or efficacy of Gender-Confirming Care;

b. Documents and communications regarding the medical necessity of Gender-Confirming Care; and

c. Documents and communications regarding the cost of Gender-Confirming Care.

SUPPLEMENTAL RESPONSE: Upon information and belief, *see* the following documents that have previously been produced as part of Exhibit 86: DHHRBMS012313-012314; DHHRBMS012318; DHHRBMS012322-012323; DHHRBMS012333; DHHRBMS012338; DHHRBMS012434-012447; DHHRBMS012483-012501; DHHRBMS012648-012653; DHHRBMS012665-012668; DHHRBMS012711-012823; DHHRBMS013523-013524; DHHRBMS015304; and DHHRBMS015453-15489. The following documents are designated CONFIDENTIAL: DHHRBMS012649-012653 and DHHRBMS012714-12823.

9. Documents sufficient to identify the circumstances in which hormone therapy is covered through the West Virginia Medicaid Program, including but not limited to Diagnostic Codes, Procedure Codes, contracts, Health Plans, clinical guidelines and/or criteria, medical necessity criteria, and pre/prior authorization requirements and procedures where applicable.

SUPPLEMENTAL RESPONSE: *See* Limits 2022 Preferred Drug List, attached as Exhibit 174 (Bates No. DHHRBMS021564 – 21581).

15. The Rational Drug Therapy Program's criteria for coverage of hormone therapy for transgender and non-transgender West Virginia Medicaid participants.

SUPPLEMENTAL RESPONSE: Upon information and belief, *see* RDTP Email Correspondence and Attachments, marked as Exhibit 175 (Bates No. DHHRBMS021582 – 21620).

18. Documents that Defendants intend to use as exhibits at deposition, summary judgment, or trial, or that may be used to refresh the recollection of a witness at depositions or trial.

SUPPLEMENTAL RESPONSE: *See* Exhibits 176 to 187 (Bates No. DHHRBMS021621 - 21691), which represent materials that may be referred to by Brandon Lewis in connection with his anticipated testimony on Topic 14 in the Second Amended 30(b) Notice.

24. To the extent not requested above, all Documents that Defendants may rely upon to support their defenses against Plaintiff's claims in this action.

SUPPLEMENTAL RESPONSE: ***See*** **Gender Edit Information 2010, attached as Exhibit 188 (Bates No. DHHRBMS021692 - 21700), and Gender Edit Information 2011, attached as Exhibit 189 (DHHRBMS021701 - 21709).**

WILLIAM CROUCH,
CYNTHIA BEANE, and
WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES,

By counsel

/s/Kimberly M. Bandy
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CHRISTOPHER FAIN, and
SHAWN ANDERSON,
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individually and on behalf of all others
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Plaintiffs,

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Hon. Robert C. Chambers, Judge

v.

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Defendants.

CERTIFICATE OF SERVICE

Now come Defendants William Crouch, Cynthia Beane and West Virginia Department of Health and Human Resources, by counsel, and do hereby certify that on the 25th day of March, 2022, a true and exact copy of **DEFENDANTS' NINTH SUPPLEMENTAL RESPONSE TO PLAINTIFF'S FIRST SET OF REQUESTS FOR PRODUCTION TO DEFENDANTS WILLIAM CROUCH, CYNTHIA BEANE, AND WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES** was served on counsel via electronic means as follows:

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IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA
HUNTINGTON DIVISION

CHRISTOPHER FAIN; ZACHARY MARTELL; and **BRIAN MCNEMAR,** Individually and on behalf of all others similarly situated,

Plaintiffs,

Civil Action No. 3:20-cv-00740
Hon. Robert C. Chambers, Judge

v.

WILLIAM CROUCH, in his official capacity as Cabinet Secretary of the West Virginia Department of Health and Human Resources; **CYNTHIA BEANE,** in her official capacity as Commissioner for the West Virginia Bureau for Medical Services; **WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES; TED CHEATHAM,** in his official Capacity as Director of the West Virginia Public Employees Insurance Agency; and **THE HEALTH PLAN OF WEST VIRGINIA, INC.**

Exhibit
BT 0007

DEFENDANTS' FIRST SUPPLEMENTAL RESPONSE TO PLAINTIFF'S FIRST SET OF REQUESTS FOR PRODUCTION TO DEFENDANTS WILLIAM CROUCH, CYNTHIA BEANE, AND WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES

DOCUMENT REQUESTS

8. Documents sufficient to identify the circumstances in which counseling and/or therapy is covered through the West Virginia Medicaid Program, including but not limited to Diagnostic Codes, Procedure Codes, contracts, Health Plans, clinical guidelines and/or criteria, medical necessity criteria, and pre/prior authorization requirements and procedures where applicable.

SUPPLEMENTAL RESPONSE: Please see BMS Provider Manual Chapter 519.22, attached as Exhibit 4, beginning with Bates Number DHHRBMS000107.

9. Documents sufficient to identify the circumstances in which hormone therapy is covered through the West Virginia Medicaid Program, including but not limited to Diagnostic Codes, Procedure Codes, contracts, Health Plans, clinical guidelines and/or criteria, medical necessity criteria, and pre/prior authorization requirements and procedures where applicable.

SUPPLEMENTAL RESPONSE: Please see BMS Provider Manual Chapter 518 Pharmacy Services, attached as Exhibit 5, beginning with Bates Number DHHRBMS000109, and the most recently updated Preferred Drug List with Prior Authorization Criteria, attached as Exhibit 6, beginning with Bates Number DHHRBMS000145.

Please note that to the extent that the Provider Manual states in section 518.4 that "Other drugs may be limited in quantity, duration, or based on gender. The information regarding these drug products and their limitations is available on the BMS website[,]" the "Drug Limits" list available online was last updated June 1, 2016, and does not reflect the removal of the gender edit for most estrogen and testosterone containing products.

10. Documents sufficient to identify the circumstances in which orchiectomy, penectomy, vaginoplasty, hysterectomy, phalloplasty, mammoplasty, breast reconstruction surgery, and/or mastectomy are covered through the West Virginia Medicaid Program, including but not limited to Diagnostic Codes, Procedure Codes, contracts, health plans, clinical guidelines and/or criteria, medical necessity criteria, and pre/prior authorization requirements and procedures where applicable.

SUPPLEMENTAL RESPONSE: Please see BMS Provider Manual Chapter 519.16 Surgical Services, attached as Exhibit 7, beginning with Bates Number DHHRBMS000199.

22. All documents upon which Defendants considered, relied upon, or intend to rely upon, in support of their admissions and/or denials of any of the allegations contained in the Complaint.

SUPPLEMENTAL RESPONSE: Please see the Medicaid State Plan, attached as Exhibit 8, beginning with Bates Number DHHRBMS000203, and the online table of contents, attached as Exhibit 9, beginning with Bates Number DHHRBMS001003.

WILLIAM CROUCH,
CYNTHIA BEANE, and
WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES,

By counsel

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Hon. Robert C. Chambers, Judge

v.

WILLIAM CROUCH, in his official capacity as Cabinet Secretary of the West Virginia Department Of Health and Human Resources; **CYNTHIA BEANE,** in her official capacity as Commissioner for the West Virginia Bureau for Medical Services; **WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES; TED CHEATHAM,** in his official Capacity as Director of the West Virginia Public Employees Insurance Agency; and **THE HEALTH PLAN OF WEST VIRGINIA, INC.**

Defendants.

CERTIFICATE OF SERVICE

Now come Defendants William Crouch, Cynthia Beane and West Virginia Department of Health and Human Resources, by counsel, and do hereby certify that on the 13th day of October, 2021, a true and exact copy of **DEFENDANTS' FIRST SUPPLEMENTAL RESPONSE TO PLAINTIFF'S FIRST SET OF REQUESTS FOR PRODUCTION TO DEFENDANTS WILLIAM CROUCH, CYNTHIA BEANE, AND WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES** was served on counsel via electronic means as follows:

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WEST VIRGINIA Department of Health & Human Resources
BUREAU FOR MEDICAL SERVICES

Exhibit
BT 0008

CHAPTER 518 PHARMACY SERVICES

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DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations, and other practitioner information.

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WEST VIRGINIA Department of Health & Human Resources BUREAU FOR MEDICAL SERVICES

CHAPTER 518 PHARMACY SERVICES

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CHAPTER 518 PHARMACY SERVICES

CHAPTER 518 PHARMACY SERVICES

WEST VIRGINIA Department of Health & Human Resources BUREAU FOR MEDICAL SERVICES

CHAPTER 518 PHARMACY SERVICES

BACKGROUND

West Virginia Medicaid offers a comprehensive scope of Pharmacy services to Medicaid members as an optional program, subject to medical necessity, appropriateness criteria, and prior authorization requirements. All covered drugs, whether legend or over the counter, must be prescribed by a practitioner qualified under state law within the scope of his/her license and in accordance with all state and Federal requirements.

The Omnibus Budget Reconciliation Act of 1990 (OBRA '90) mandated major changes in coverage and reimbursement for Medicaid-covered outpatient drugs. West Virginia Medicaid reimbursement is limited to drugs whose manufacturers have entered into and have in effect a rebate agreement with the Secretary, US Department of Health and Human Services.

POLICY

518.1 COVERED SERVICES

Except for certain limitations and exclusions, West Virginia Medicaid will reimburse for the following:

- Outpatient legend drugs;
- Specific over-the-counter drugs;
- Compounded prescriptions;
- Drugs that require prior authorization, when approved by the Bureau for Medical Services (BMS);
- Family planning supplies, including certain over-the-counter supplies;
- Certain diabetic supplies;
- Influenza, pneumonia, Hepatitis A, Hepatitis B, tetanus, tetanus-diphtheria (Td), and tetanus-diphtheria-and-pertussis (Tdap) vaccines for adults 19 years of age and older administered by a pharmacist. Members up to 19 years of age have access to vaccines via the Vaccines for Children Program; and
- Herpes zoster vaccine for adults 50 years of age and older administered by a pharmacist.

Drugs covered under the Medicaid outpatient pharmacy program are those that have been approved for safety and effectiveness under the Federal Food, Drug, and Cosmetic Act, when used for medically accepted indications.

Medically accepted indication means any use that is supported by one or more of the following official compendia:

1. The American Hospital Formulary Service Drug Information
2. The United States Pharmacopoeia Drug Information or its approved replacement
3. The DrugDex Information System

All covered drugs, whether legend or over the counter, must be prescribed by a practitioner qualified under state law within the scope of his/her license and in accordance with all state and Federal requirements.

The West Virginia Medicaid program follows the US Office of Inspector General's (OIG) guidelines in excluding prescribers from participating with West Virginia Medicaid who are barred from participating in Federal health programs. Reimbursement of prescriptions issued by these excluded prescribers is denied.

West Virginia Medicaid also excludes from reimbursement any prescription ordered by a prescriber who is not enrolled with West Virginia Medicaid.

518.1.1 Preferred Drug List (PDL)

The West Virginia Preferred Drug List (PDL) is a list of medications recommended to the BMS by the West Virginia Medicaid Pharmaceutical and Therapeutics (P&T) Committee and approved by the U.S. Secretary of the Department of Health and Human Resources. The P&T Committee is composed of actively practicing physicians, pharmacists, a nurse practitioner, and a physician's assistant. The P&T Committee meetings are held a minimum of three times per year and are open to the public.

The drugs that are designated as "preferred" have been selected for their clinical significance and overall cost efficiencies. All Medicaid-covered drugs noted as "non-preferred" continue to be available through the prior authorization process.

The PDL only contains drugs from certain drug classes. Some classes of drugs will not be reviewed for preferential agents because there are no, or limited cost savings associated with these classes. Drugs that meet the criteria for coverage and have no preferred status are considered covered drugs.

The PDL is updated at minimum annually and as needed. Newly released drugs in classes that are included in the PDL will be considered non-preferred until the new drug has been reviewed.

The complete PDL, criteria for coverage of non-preferred drugs, minutes of P&T Committee meetings, and other pertinent information are available on the BMS website.

518.1.2 Over-the-Counter Drugs

Certain over-the-counter (OTC) drugs are reimbursed for eligible Medicaid members when prescribed by a qualified practitioner. The OTC drugs must be manufactured by companies participating in the Federal drug rebate program and are limited to generic products when available. Any OTC drug available in packaging designed for OTC sale to the public must be dispensed in the original packaging. These products must be billed at the shelf price of the pharmacy. If a pharmacy is not accessible to, or frequented by the general public, or if the OTC drug is not on display for sale to the general public, then the product will be reimbursed at the same rate as legend drugs.

The OTC drugs are not covered for residents of skilled nursing home facilities or intermediate care facilities for individuals with intellectual disabilities (ICF/IID) except for insulin. These drugs are included in the rates paid to these facilities.

A current list of covered OTC drugs is available on the BMS website.

518.1.3 Diabetic Testing Supplies and Syringes/Needles

Certain supplies used by eligible diabetic Medicaid members are covered through the Outpatient Pharmacy program. A prescription issued by a licensed prescriber within the scope of his/her practice is required for coverage of these items. Verbal prescriptions that meet Federal and state regulations are

permitted. Prescriptions must state the number of tests to be performed per day. Co-payments are not required on prescriptions for these items. Covered supplies include:

- Blood glucose testing strips;
- Urine testing tablets and strips;
- Lancets;
- Insulin syringe and needle combinations for the administration of insulin; and
- Needles for insulin pen systems.

Needle and syringe combinations and disposable pen needles for insulin pens are reimbursed through the Pharmacy Point-Of-Sale (POS) program only for the administration of insulin.

Diabetic testing supplies and syringes/needles are not covered pharmacy services for members residing in skilled nursing or ICF/IID facilities.

The following limits apply for those members who have insulin dependent diabetes:

Urine and blood glucose testing tablets and strips	150 per 30 days
Lancets	200 per 30 days
Insulin syringe and needle combinations	100 per 30 days
Pen needles	100 per 30 days

The following limits apply for those members who have non-insulin dependent diabetes:

Urine and blood glucose testing tablets and strips	100 per 30 days
Lancets	100 per 30 days

Prescriptions for quantities greater than the above referenced amounts require prior authorization through the pharmacy prior authorization vendor.

Dual eligible members have coverage of diabetic supplies through Medicare. Medicaid will not cover these supplies for dual eligible individuals, except for amounts that may be reimbursed on Medicare Part B crossover.

518.1.4 Home Infusion Therapy Pharmacy Services

Drugs used for home infusion therapy services are covered under the West Virginia Medicaid Pharmacy program. These drugs require prior authorization and must be justified by the ordering practitioner, including why oral therapy is unsuitable for the patient. Dual eligible members have coverage of home infusion pharmacy services through their Medicare Part D plans.

Total Parenteral Nutrition (TPN) supplies are considered Durable Medical Equipment (DME) and supplies and are not pharmacy POS covered services.

518.1.5 In-Home Parenteral Therapy (IHPT)

In-Home Parenteral Therapy (IHPT) is a Medicaid-covered service. Medicaid coverage for this service will include drugs and services that are:

- Medically necessary;
- Prescribed by a licensed physician;
- Administered through central line, peripheral line, infusion port, epidural, intrathecal or subcutaneous site;
- Provided by a licensed pharmacy enrolled with West Virginia Medicaid;
- Billed through electronic transmission according to standard guidelines or on the approved pharmacy paper claim form; and
- Prior authorized as directed by the BMS.

MEMBER REQUIREMENTS

Members receiving IHPT must meet the following requirements:

- The member must reside in either a private home or domiciliary care facility, such as an adult care residence. Members who are residents or patients of hospitals, nursing homes (including ICF/IID group homes), rehabilitation centers, and other institutional settings are not eligible for this service;
- The member must be under the care of a physician who prescribes the in-home infusion therapy and monitors the progress of the therapy;
- The member must have sites available for intravenous catheters or needle placement or have central venous access; and
- The member must be capable of self-administering or have a nurse or a caregiver who can be adequately trained, and is capable and willing to administer/monitor home infusion therapy safely and efficiently following appropriate teaching and adequate monitoring.

PRIOR AUTHORIZATION

All IHPT services require prior authorization. Requests must be made through the pharmacy prior authorization vendor. The approved prior authorization forms are available on the BMS website.

- **Pre-Mixed Solutions or Products Requiring No Compounding:** Pre-mixed solutions or products include those injectable items that do not require compounding by the pharmacist because a) the items are marketed as pre-mixed, thus requiring no dilution and/or compounding, or b) compounding is performed by the patient, the nurse or the caregiver. Commercially prepared products are mandated to be dispensed if available. Compounded products and related professional services shall not be reimbursed when the commercially prepared product is available.
- **Products Requiring Compounding:** Certain injectable products require compounding in order to meet the needs of the member, and are not available commercially.

The request for prior authorization must include the diagnosis, duration of therapy, prescribing physician information, and appropriate documentation. The prior approval will be effective from the date of the physician's original order and continue for the specified length of therapy unless there is a change in prescription or level of care. Changes in therapy require new prior authorizations. Written requests for prior authorization must be submitted via fax or mail to the pharmacy prior authorization vendor on form IV-1. Signed physicians' orders for compounded IHPT medications must be provided to the pharmacy prior authorization vendor if reimbursement for compounding activities is requested.

Please refer to *Chapter 600 Reimbursement Methodologies* for further information on IHPT billing and reimbursement by POS.

518.1.6 Tobacco Cessation Program

West Virginia Medicaid, in partnership with the Bureau for Public Health (BPH), offers a tobacco cessation program, known as the West Virginia Tobacco Quitline, to assist members to discontinue use of tobacco products. See *Chapter 519.18, Tobacco Cessation Services* for more information on the Quitline, covered cessation agents, and limitations.

Nicotine replacement therapy and other smoking cessation agents are covered for West Virginia Medicaid members enrolled in the Quitline's telephone coaching program. Smoking cessation agents fall in three general categories: Nicotine Replacement Therapy (NRT), Bupropion (Zyban), and Varenicline (Chantix®). All agents are first line therapy and are covered for 12 weeks per calendar year, with additional treatment at the request by the member's physician. Authorization for therapy beyond the initial 12 weeks requires a written appeal from the prescriber with documentation of efficacy and patient compliance. A claims review must confirm compliance with no more than a five-day lapse between pharmacy fills of current therapy. Covered products include:

- Nicotine gum – 24 pieces per day;
- Nicotine patches – 1 patch per day;
- Nicotine lozenges – 20 lozenges per day;
- Nicotine inhaler – 168 inhalers per 30 days;
- Nicotine nasal spray – 4 spray bottles per 30 days (This therapy is reserved for members that have failed other forms of NRT);
- Bupropion – 300 mg per day (NRT and bupropion will not be covered concurrently); and
- Varenicline – 2 mg per day.

Drugs in this category may be combined for concurrent use, unless indicated. All tobacco cessation products must be prescribed by an enrolled practitioner within the scope of his/her license under West Virginia law. Prior authorization is required for coverage of tobacco cessation drugs and is coordinated through the Quitline. If the caller has the prescription information for nicotine replacement therapy available, the coach can send it to Rational Drug Therapy for approval. Women who are pregnant are also eligible for treatment, when appropriate.

Dual eligible members have coverage of legend drugs through their Medicare Part D plans, and coverage of over-the-counter drugs and tobacco cessation counseling services through Medicaid.

518.1.7 Buprenorphine-Naloxone (Suboxone®) / Buprenorphine (Subutex®) Coverage

Buprenorphine-Naloxone and Buprenorphine are covered through the Pharmacy program and must have a prescription written by an enrolled prescriber approved to prescribe these services. Other limitations may apply. Additional information and detailed coverage criteria is available on the BMS website.

518.1.8 Bulk Chemicals

Per CMS Medicaid Drug Rebate Program Release No. 155, bulk chemicals are substances which when used in the manufacturing of a drug become the active ingredient of the drug product. As such they do not meet the definition of covered outpatient drugs as defined in section 1927(k)(2) of the Social Security Act.

However, bulk chemicals may be considered covered in rare circumstances if prescribed for a Food and Drug Administration (FDA) approved indication and/or medically accepted indication supported in official compendia. Prior authorization is required. All rules, regulations, limitations, and exclusions set forth in the Pharmacy Services manual apply also to bulk chemicals.

A list of covered bulk chemicals and criteria for coverage is available on the BMS website.

518.1.9 Brand Name versus Generic Drugs

Brand name multi-source legend drugs that have therapeutic equivalents available will be denied for payment. Generic drugs must be substituted, if available. In certain instances, pharmacies may indicate brand name drug usage on submitted electronic and paper pharmacy claims by using Dispensed as Written (DAW) codes. The DAW codes that are recognized by West Virginia Medicaid and can be used by providers to explain the dispensing of a brand name product instead of a generic one are as follows:

- **DAW 1:** Prescriber states that the brand name drug is “medically necessary. This information must be supplied in writing by the prescriber via written prescriptions in his or her own handwriting, and must write on the prescription “Brand Medically Necessary. A checkbox or other methods to indicate that the brand should be dispensed shall not be accepted. Approval from the pharmacy prior authorization vendor help desk is required for the use of DAW 1 and appropriate justification must be provided.
- **DAW 4:** A generic equivalent is not available or not stocked at the time of dispensing. This code shall only be used when a generic drug is sold out or a generic drug is unavailable on a wide-spread basis. It shall not be used routinely to circumvent the mandatory generic program for other reasons. A call to the pharmacy prior authorization vendor help desk is required for the use of DAW 4 and appropriate justification must be provided. The brand name rate will be reimbursed when approved.
- **DAW 5:** Pharmacy uses this brand as a generic and realizes it will be paid at the generic rate.
- **DAW 6:** Pharmacy is dispensing a generic drug that has been identified by the drug database as a brand name drug due to pricing issues. These generic drugs have high Average Wholesale Prices (AWP) in relation to other generic drugs that are available. An effort shall be made to obtain lower-priced alternatives.
- **DAW 8:** Substitution not allowed - generic drug not available in marketplace.
- **DAW 9:** Substitution allowed by prescriber, but plan requires brand

For auditing purposes, documentation shall be made on the prescription to justify use of the DAW codes. All other DAW codes that are recognized by the National Council on Prescription Drug Programs (NCPDP) are not active in the West Virginia Medicaid program and will not affect the processing of claims, if submitted. The use of DAW codes is not permitted for non-preferred drugs included in the PDL program.

Completion of an FDA MedWatch form is required for the failure of a generic product to produce the same outcome as the equivalent brand name drug. The MedWatch form shall be sent by mail or fax to the pharmacy prior authorization vendor. The MedWatch form is available on the FDA website.
Please note that some generic drugs may be classified as non-preferred by West Virginia Medicaid and require prior authorization. This occurs when brand name drugs are less expensive to Medicaid due to supplemental rebate negotiations. In this case, the pharmacy will be required to dispense the brand name drug instead of the generic equivalent.

518.2 PRIOR AUTHORIZATION

Prior authorization for Medicaid-covered drugs is required for reimbursement of certain drugs to assure the appropriateness of drug therapy. Specific prior authorization criteria are based on review of the most current clinical information, FDA-approved indications, and manufacturers' recommendations. These criteria are reviewed by the Medicaid Drug Utilization Review (DUR) Board and recommended to the BMS. These criteria then form the basis of acceptable drug therapy for members with Medicaid pharmacy benefits. Current criteria for coverage of non-preferred drugs and other drugs requiring prior authorization is available on the BMS website. Drugs which require prior authorization and for which prior authorization criteria have not been met are considered non-reimbursable unless, upon appeal by the prescribing provider, the Medicaid medical director determines that the drug meets the appropriateness and medical necessity criteria.

The use of pharmaceutical samples will not be considered when evaluating the members' medical condition or prior prescription history for drugs that require prior authorization.

Federal regulations state that Medicaid-covered drugs that require prior authorization must have a 24-hour decision turnaround. In emergent situations, a 72-hour supply of medication must be made available to members until the prior authorization process can be completed. No more than a 72-hour supply shall be dispensed. Submitting a quantity greater than a 72-hour supply constitutes an improper claim unless it is for a package that cannot be broken. If a product package cannot be broken, then the whole package may be dispensed, if necessary, to meet the member's needs. Documentation of this action shall be made on the prescription for auditing purposes. Repeated submissions of 72-hour supplies for the same patient and same drug to circumvent the prior authorization process constitute an improper billing method. This practice is subject to audit.

518.2.1 Process of Requesting Prior Authorization

The pharmacy prior authorization vendor is the agency contracted to provide prior authorization services to the West Virginia Medicaid Pharmacy program. Prior authorization may be initiated either by the dispensing pharmacist, the prescriber, or the prescriber's designee. Prior authorization requests from third party vendors or contractors will be denied. Requests may be made by telephone, fax, or mail. If all the necessary information is provided, requests will be addressed within 24 hours. It is the responsibility of the provider of the service, either the physician or pharmacist, to obtain the authorization before rendering the service. Requests for prior authorization after the service is rendered will be denied. In cases of back-dated eligibility, prior authorizations may be considered on a case by case basis using coverage policies in place on the dates the services were rendered. If the service is provided before prior authorization is obtained, the Medicaid member must be informed that he/she will be responsible for the bill. There is a maximum approval limit of one year.

Prior authorization requests shall include the following:

- Member name, address, and Medicaid identification number;
- Name of drug, strength, dosage, and duration of treatment;
- Diagnosis;
- Pertinent laboratory information;
- Justification for the use of the drug;
- Return fax number; and

- Signature of prescriber or pharmacist.

Prior authorization forms are available on the BMS website. These forms may be duplicated.

518.2.2 Prior Authorization Denial Appeals Process

If a prior authorization request is not approved, the prescriber may appeal the decision to the Pharmacy Prior Authorization Vendor Appeals Department in writing (first level appeal). Requests must include the following information:

- Member name, address, and Medicaid identification number;
- Name of drug, strength, dosage, and duration of treatment;
- Diagnosis;
- Pertinent laboratory information;
- Justification for the use of the drug, including any other treatments that have been tried;
- Supporting literature;
- Return fax number; and
- Signature of prescriber.

Office and/or hospital notes, including signed ones, are not acceptable and do not constitute an appeal. The appeal decision will be returned to the fax number of the *prescriber* on record.

Appeals will be processed within three business days of their receipt. All appeals denied by the pharmacy prior authorization vendor will be sent to the BMS for physician review. Any denial resulting from physician review is final.

The Medicaid member is notified of this denial and of the right to request a fair hearing.

518.3 NON-COVERED SERVICES

The following list of drugs, drug products, and related services are not reimbursable. Non-covered services include, but are not limited to:

- Drugs supplied by drug manufacturers who have not entered into a drug rebate agreement with the Centers for Medicare and Medicaid Services (CMS);
- Agents used for weight loss, anorexia, or weight gain, including binge-eating disorder;
- Agents used for cosmetic purposes or hair growth;
- Drugs identified by the CMS as being less-than-effective (DESI);
- Agents used for fertility;
- Drugs used to treat erectile dysfunction;
- Drugs that are investigational or approved drugs used for investigational purpose;
- Drugs used for off-label indications that are not found in official compendia or generally accepted in peer reviewed literature;
- Drugs dispensed after their expiration date;
- The cost of shipping or delivering a drug;
- Herbal or homeopathic products;

- Drugs that result in therapeutic duplication, ingredient duplication, early refills, or other DUR events that are not medically necessary;
- Drugs that are not medically necessary;
- Covered outpatient drugs for which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee;
- Nutritional supplements;
- Free pharmaceutical samples;
- Diagnostic agents;
- Vacation supplies;
- Allergenic extracts;
- Excipients except when used in compounded prescriptions containing a covered legend drug. Excipients must be eligible for Federal rebates in order to be eligible for reimbursement;
- Vaccines through the pharmacy POS, except for Influenza, pneumonia, Hepatitis A, Hepatitis B, tetanus, tetanus-diphtheria (Td), and tetanus-diphtheria-and-pertussis (Tdap) vaccines for adults 19 years of age and older administered by a pharmacist; vaccines and vaccine administration approved during a public health emergency declaration, and herpes zoster vaccine for adults 50 years of age and older administered by a pharmacist; and
- Methadone for the treatment of opioid addiction/dependence is not covered as a pharmacy benefit. *See Chapter 504, Substance Use Disorder Services*.

Non-covered services are not eligible for a Department of Health and Human Resources' (DHHR) Fair Hearing. See 42 § 431.220 When a hearing is required for more information.

518.4 SERVICE LIMITATIONS

Service limitations governing the provision of all West Virginia Medicaid pharmacy services will apply for eligible members as follows:

- Covered drugs are limited to their FDA-approved or medically accepted indications and dosing limits.
- When appropriate, PDL-preferred drugs must be tried before non-preferred drugs are approved.
- All covered outpatient drugs must be prescribed by a practitioner qualified under state law within the scope of his/her license and in accordance with all state and Federal requirements.
- Prescriptions may be written or verbal, and must meet all the Federal and state guidelines for legal prescriptions.
- Covered outpatient drugs are reimbursed up to a 34-day supply and may be refilled according to state and Federal Laws. Certain exceptions apply, for example, most oral systemic antibiotics are covered for a 14-day supply with one refill. Exceptions to this policy may apply if the only available package size of the product is one that exceeds the 34-day supply limit.
- Only those legend drugs for the symptomatic relief of cough and colds that appear on the approved BMS list are covered for this therapeutic indication. Certain over-the-counter cough and cold medications are also covered. This list is available on the BMS website. Dual eligible members have coverage of cough and cold medications through Medicaid if these products are not covered by their Medicare Part D or Part C plans.
- Barbiturates are not covered except for phenobarbital and mephobarbital, unless the barbiturate is in combination with another active ingredient. Dual eligible members have coverage of phenobarbital; mephobarbital; and butalbital, acetaminophen, and caffeine combination products

through Medicaid if these products are not covered by their Medicare Part D plans. (Note: Combination products of butalbital, acetaminophen, caffeine, and codeine will be covered by Medicare Part D or Part C plans for dual eligible members.)

- Vitamins and minerals are limited to:
  - Legend vitamins A, D, K, folic acid, B-12 for injection, iron preparations, and niacin.
  - Minerals including calcium, iron, magnesium, fluoride, and additional mineral requirements for the treatment of End Stage Renal Disease.
  - Multivitamins for children through age 20.
  - Prenatal vitamins for women through age 45.
  - Legend fluoride preparations.
- Other drugs may be limited in quantity, duration, or based on gender. The information regarding these drug products and their limitations is available on the BMS website. Exceptions are considered on a case-by-case basis through the pharmacy prior authorization vendor.
- Additional drugs may have quantity limits to assure accurate billing of units.
- Limitations apply to diabetic testing supplies and insulin syringes/needles depending on the member's diagnosis, i.e. insulin dependent or non-insulin dependent diabetes. Medicaid does not cover diabetic supplies for dual eligible members, except for coverage of Part B deductibles and coinsurance amounts. These individuals have coverage for diabetic supplies either through Medicare Part B or Part D.
- Dual eligible members are limited to coverage of Medicare Part D excluded drugs. Coverage is limited to drugs that are covered for other Medicaid eligible members in the following classes:
  - Barbiturates (if not for treatment of epilepsy, cancer, or mental health disorder, as Medicare Part D covers these conditions).
  - Over-the-counter medications.
  - Agents for the symptomatic relief of cough and cold symptoms.
  - Prescription vitamins and minerals.

518.5 DRUG UTILIZATION REVIEW (DUR)

The Omnibus Budget Reconciliation Act (OBRA '90) required that states establish a DUR program which consists of prospective and retrospective components as well as components to educate physicians and pharmacists on common drug therapy problems and assessments of whether usage complies with predetermined standards. In order to meet the requirements of the statute, the DUR program must assure that prescriptions are appropriate, medically necessary, and not likely to result in adverse medical results. The two primary objectives of DUR systems are to improve quality of care and to assist in containing health care costs.

The establishment of a DUR Board was required by OBRA '90. This Board consists of local pharmacists, physicians, and other healthcare providers from around the state. The Board is charged with making recommendations for educational interventions to prescribers and pharmacists to identify and reduce, for both providers and patients, the frequency of patterns of fraud, abuse, gross overuse, and inappropriate or medically unnecessary care. Specific drugs or classes of drugs may be targeted in regard to:

- Therapeutic appropriateness
- Overutilization
- Under utilization
- Appropriate use of generic products

- Therapeutic duplication (same or different prescriber)
- Drug-disease contraindications
- Drug-drug interactions
- Incorrect drug dosage
- Incorrect duration of drug treatment
- Drug-allergy interactions
- Clinical abuse/misuse

The West Virginia Medicaid DUR Board meets quarterly to discuss methods of achieving the goals of assuring the appropriate use of drugs in the Medicaid program. These meetings are open to the public. The DUR Board also assists the BMS in defining criteria for coverage of drugs that require prior authorization.

The DUR Board meeting agendas, minutes, and other DUR information are available on the BMS website.

518.5.1 Prospective Drug Utilization Review (DUR)

Prospective DUR is conducted at the pharmacy POS before delivery of a medication by the pharmacist to the Medicaid member or caregiver. Prescription claims are screened to identify potential drug therapy problems of the following types:

- Therapeutic duplication
- Ingredient duplication
- Adverse drug-drug interactions
- Early refill
- Late refill
- High dosage
- Low dosage
- Incorrect duration of drug treatment
- Age/gender precaution
- Pregnancy precaution
- Breast feeding precaution

Dispensing pharmacists use the information provided by the pharmacy POS and their professional judgment to determine if the prescription shall be filled. The pharmacist determines the appropriateness of the prescribed therapy and intervenes with the prescribing physician and/or member in the event of a suspected problem.

Pharmacists may continue to process claims that contain prospective DUR messages by using DUR outcome and intervention codes. A call to the pharmacy prior authorization vendor help desk may be required in certain instances as determined by the BMS to obtain an edit override. Requests for edit overrides after the service is rendered will be denied, except in cases of back-dated eligibility. More detailed information regarding DUR may be accessed through the Health PAS-RX pharmacy POS User Guide found on the BMS fiscal agent's website.

518.5.2 Retrospective Drug Utilization Review (DUR)

Retrospective DUR is required in order to identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists, and Medicaid members, or associated with specific drugs or groups of drugs. West Virginia Medicaid conducts retrospective DUR with the assistance of a vendor. They provide patient profiles addressing drug use that may be inappropriate based on predetermined standards. A Retrospective DUR Committee, consisting of healthcare professionals, meets monthly to review these patient profiles that are used to generate letters to physicians and pharmacists relating to these issues.

518.5.3 Pharmacy Lock-in Program

Members who use pharmacy services excessively or inappropriately may be assigned to a single pharmacy provider where they receive their Medicaid-covered medications. The purpose of this program is to assist members in using pharmacy services appropriately.

As part of this program, the Retrospective DUR Committee reviews Medicaid member utilization profiles to determine if controlled substances are being used at a frequency or amount that results in a level that may be harmful or not medically necessary. Inappropriate utilization can include frequent use of multiple controlled substances, use of multiple prescribing physicians and/or pharmacies, overlapping prescription drugs within the same drug class and drug seeking behavior, i.e., doctor shopping.

A series of letters is sent to prescribers and/or the member to seek information regarding his/her drug utilization or to warn that continued overutilization may result in restricting the member to a single pharmacy provider. If the pharmacy lock-in criteria are met, the member is given the opportunity to select a pharmacy, but pharmacy participation is voluntary. Pharmacists serving these members are requested to use their professional judgment in regard to filling prescriptions for controlled substances.

Criteria for Lock-in Determination is available on the BMS website. Members, upon discharge from a substance abuse program, or while receiving outpatient substance abuse treatment, will be locked into a single pharmacy provider. Upon admission to a facility for treatment of substance abuse or during the initial visit for outpatient substance abuse services, the member will be required to choose a pharmacy from which to receive all controlled substances.

518.6 PROVIDER PARTICIPATION REQUIREMENTS

Provider enrollment requirements in general are detailed in the BMS Manual *Chapter 300, Provider Participation and Requirements*.

518.7 CERTIFICATION

A pharmacy eligible to participate in Medicaid must hold a current permit from the West Virginia State Board of Pharmacy (BOP) and adhere to all state and Federal regulations. Pharmacies located out-of-state and filling prescriptions for West Virginia Medicaid members must be licensed by the state in which they are located. Pharmacies located out-of-state and are shipping or mailing prescriptions into West Virginia, must be licensed by the state in which they are located **and** hold a permit from the West Virginia BOP. Pharmacies are required to file a copy of their current permits with the BMS annually. Failure to do so may result in the withholding of payments and/or enrollment termination.

When the current license and/or permit is not on file, the provider shall not be reimbursed by Medicaid until such time as the BMS Provider Enrollment Unit receives a copy of the current license and/or permit.

West Virginia only enrolls providers outside of West Virginia within a 30-mile radius of the state border, unless it is a specialty pharmacy with exclusive distribution rights for certain drug(s). These out-of-state specialty pharmacy providers will be limited to the National Drug Codes (NDCs) requested on their enrollment applications.

518.8 DISPENSING PHYSICIANS

The BMS does not enroll dispensing physicians for reimbursement as a pharmacy provider type. Reimbursement for self-administered prescription drugs is limited to licensed and participating pharmacies.

518.9 IN-HOME PARENTERAL THERAPY PROVIDER REQUIREMENTS AND RESPONSIBILITIES

Pharmacies requesting reimbursement for IHPT compounding services must meet all state and Federal licensure and certification requirements. In order to participate in the West Virginia Medicaid program and receive payment from the BMS, IHPT providers must:

- Submit an IHPT Medicaid Provider Enrollment Form to the BMS; and
- Submit a copy of the provider's West Virginia BOP Sterile Compounding Permit or respective state Board of Pharmacy Sterile Compounding Permit.

Participating pharmacies that bill services for West Virginia Medicaid members shall be subject to the laws and regulations set forth by the West Virginia BOP that govern the requirements to hold a Sterile Compounding Permit.

518.10 PHARMACIES PARTICIPATING IN THE 340B PROGRAM

Pharmacies participating in the program established by Section 340B of the Public Health Services Act of 1992 dispense drugs with discounts generated from participation in the program. These drugs are not eligible for Federal drug rebates.

Actual acquisition costs must be submitted when billing Medicaid. Submission of invoices may be required for audit purposes.

All 340B pharmacy providers for West Virginia Medicaid are required to bill each pharmacy POS claim with the following NCPDP values:

- Claim Segment-Submission Clarification Code (420-DK) - Use value 20 in Position 1 or 2
- Pricing Segment- Basis of Cost Determination (423-DN) - Use value 08

These updates may be found on the updated West Virginia Medicaid Vendor Specification Sheet, D.0. vs.1.7, September 2016.

The NCPDP values above identify claims to be removed from the rebate file which avoids billing manufacturers for duplicate discounts. As per 42 USC 256b(a)(5) a manufacturer may audit and seek

recoupment of the duplicate discount from covered entities found to be non-compliant with 340B requirements. In these instances, the rebate is due to the State and the duplicate discount will be recouped from the non-compliant covered entity.

The Health Resources & Services Administration (HRSA) maintains a current listing of participating providers who intend to bill Medicaid for 340B drugs on the HRSA website. It is the providers' responsibility to verify that the HRSA listing of their participation is current and accurate. Providers must report any changes in Medicaid 340B program participation to HRSA.

518.11 PHARMACY CHANGE OF OWNERSHIP

Change of ownership policy is addressed in the BMS Manual *Chapter 300, Provider Participation Requirements* and additional information may be found on the fiscal agent's website, see BMS Manual *Chapter 100, General Information*.

518.12 CASH PAYMENTS

Pharmacies are encouraged to report to the BMS when a member pays cash for prescriptions that would otherwise be covered by Medicaid or considered for reimbursement upon a call to the pharmacy prior authorization vendor, or when the pharmacy provider suspects overutilization by the member. The cash waiver form used for this reporting is available on the BMS website. Information collected through this process may be used for member lock-in consideration.

Medicaid reserves the right to deny coverage of controlled substances when the member has been found to be paying cash to bypass Medicaid's prior authorization and/or quantity limit requirements.

518.13 MEMBER COUNSELING

The OBRA '90 requires that pharmacists offer counseling to Medicaid members and must include the following:

- Name and description of the medication;
- The route of administration, dosage form, dosage, and duration of therapy;
- Special directions and precautions for preparation, administration and use by the patient;
- Common severe side or adverse effects or interactions and therapeutic contraindications that may be encountered, including their avoidance, and the action required if they occur;
- Techniques for self-monitoring prescription therapy;
- Proper storage;
- Prescription refill information; and
- Action to be taken in the event of a missed dose.

The West Virginia Medicaid program relies on the West Virginia BOP to monitor these activities, but the BMS may audit these requirements through routine or special reviews.

518.14 DOCUMENTATION AND RECORD RETENTION REQUIREMENTS

518.14.1 Tamper-Resistant Prescription Pad Requirement

All prescriptions written for West Virginia Medicaid members must be on tamper-resistant pads/paper which meet all three characteristics set forth in the guidelines from the CMS. The three characteristics to meet the tamper-resistant prescription requirement are:

1. Prevent unauthorized copying of a completed or blank prescription form;
2. Prevent the erasure or modification of information written on the prescription, and
3. Prevent the use of counterfeit prescription forms.

Written prescriptions must contain **ALL** of the following:

Feature	Description
"Void" pantograph	The word "Void" appears when document is photocopied. Pharmacy will need to record on document if received by fax.
Uniform non-white background color – preferably green	Background is one color (preferably green), inhibits a forger from physically erasing written or printed information on a prescription form. If an attempt is made to erase copy – the consistent background color will look altered.
Quantity check off boxes	In addition to the written quantity on the prescription, quantities are indicated in ranges of 25's (or some other, similar range). Box MUST be checked for this feature to be valid.
Refill indicator	Refill indicator (circle or check number of refills or "NR"). Refill indicator must be used to be a valid feature.
Security features and descriptions listed on the front of the prescription	Listing of the security features of the prescription for compliance purposes. This will assist the pharmacist and auditors on what security features are included on the pads/paper.

Computer-generated prescriptions, electronic medical records (EMR), or ePrescribing generated prescriptions may be printed on plain paper and be fully compliant with all three categories of tamper resistance, provided they contain the features listed in the table below. Prescribers are urged to contact their software companies to ensure that computer generated prescriptions have all requirements necessary for tamper resistance.

Computer-generated prescriptions must contain the following:

1.One or more industry-recognized features designed to prevent unauthorized copying of a completed or blank prescription form.

Feature	Description
"Void" pantograph	The word "Void" appears when document is photocopied. Pharmacy will need to record on document if received via fax. *This requires the purchase of special paper.*

Feature	Description
OR	
Micro print signature line	Very small font which is legible (readable) when viewed at 5x magnification or greater, and illegible when copied.

2.One or more industry-recognized features designed to prevent the erasure or modification of information written on the prescription by the prescriber.

Feature	Description
Uniform non-white background color – preferably green OR "Toner-lock" paper for laser printed prescriptions, or plain bond paper for inkjet printed prescriptions	Background is one color (*preferably green*), inhibits a forger from physically erasing written or printed information on a prescription form. If someone tries to erase copy – the consistent background color will look altered. Toner-lock paper is special printer paper that establishes a strong bond between laser-printed text and paper, making erasure obvious. Note – this is NOT necessary for inkjet printers – as the ink from the inkjet printers is absorbed into normal "bond" paper.
Quantity written and quantity with border characteristics for computer generated printed prescriptions	Quantity written, and Quantity surrounded by special characters such as asterisks to prevent modification, e.g. QTY Fifty ***50****.
Refill written and refill with border Characteristic for computer generated printed prescriptions	Refills written, and Refill surrounded by special characters such as asterisks to prevent modification, e.g. Five refills ****5 refills*****.

3. One or more industry-recognized features designed to prevent the use of counterfeit prescription forms.

Feature	Description
Security features and descriptions listed on the prescription	A complete list of the security features of the prescription for compliance purposes. This will assist the pharmacist and auditors on what security features are included on the paper.

Prescriptions for West Virginia Medicaid members written by prescribers that reside outside of West Virginia may meet the Federal tamper-resistant prescription requirement if the prescription addresses the three distinct characteristics outlined above, and may contain the same or other features than those adopted by the BMS.

518.14.2 Prescriptions Returned to Stock

Claims for prescriptions which have been filled by the participating pharmacy, but not dispensed to the patient, shall be reversed. This shall be done on a timely basis, within 15 days. A log of these returns must be maintained by the pharmacy for a period of five years for auditing purposes.

518.14.3 Nursing Home Returns

Drugs dispensed to nursing home residents that are not used by the member must be either returned to the dispensing pharmacy or destroyed according to applicable rules and regulations. Drugs that are returned unused by the Medicaid member and are available for re-dispensing, per West Virginia State BOP rules and regulations, must be credited to Medicaid. Claims for these returned medications must be reversed and resubmitted for the quantity used by the member.

518.14.4 Medication Dispensing/Shipping/Receiving

Providers shall take all necessary and prudent steps to prevent loss of medications in the shipping process and to assure that the member receives the shipment when needed, as Medicaid will not reimburse for medications not received by the member. In the case of a dispute, the only definitive proof of delivery accepted by BMS shall be a copy of the member's signature on the delivery log. Reimbursement shall be withheld should a dispute arise where proof of signature is not available from the pharmacy. It is recommended that a log of these signatures be maintained by the pharmacy for a period of five years should a dispute of delivery arise.

Claims for medications not received by the member in a timely manner, and which the member was compelled to obtain from a local pharmacy, may be reversed by the fiscal agent, if necessary, in order to allow for billing by a local pharmacy provider to meet the member's needs.

518.15 PHARMACY SERVICES FOR MEDICAID MEMBERS

Medicaid members eligible for pharmacy services have access to legend and over-the-counter drugs as defined in the State Plan filed with CMS. Any person requesting services shall be advised that he/she is responsible for furnishing proof of coverage to the provider prior to services being rendered. Eligibility may be verified through the Medicaid Voice Response System at 1-888-483-0801 or by sending an electronic NCPDP E-1 transaction through the pharmacy POS billing system.

518.15.1 Dual Eligible Members

Members eligible for both Medicare and Medicaid are called dual eligible members. Medicare is the primary payer for dual eligible members. Medicare, a Federal health insurance program for the aged and disabled, covers certain hospital (Part A), outpatient medical benefits and physicians' services (Part B) and prescription benefits (Part D) for participating individuals. Some dual eligible members may participate in Medicare Managed Care plans (Advantage or Part C plans) which include pharmacy services.

Dual eligible members have prescription drug coverage through Medicare Part D, or Part C if enrolled in a Medicare Managed Care plan. Medicaid is not responsible for covering pharmacy benefits for these individuals, except for drugs in the Medicare excluded categories. Medicaid does not reimburse for Medicare Part D or Part C co-payments. Medicaid does not pay as the secondary payer on Medicare Part D or Part C covered drugs.

518.15.2 Medicaid Members Enrolled in Managed Care Organization Plans

Medicaid members enrolled in the managed care organization plans receive pharmacy benefits from the fee-for-service (FFS) pharmacy program. The FFS pharmacy program covers drugs which are submitted to pharmacies by written, telephonic, or electronic prescriptions.

Drugs that are billed with J Codes or Healthcare Common Procedure Coding System (HCPCS) Codes are covered by the managed care programs and cannot be billed to the fee-for-service program at the point of sale.

518.15.3 Medicaid Members with End Stage Renal Disease (ESRD)

Members diagnosed with End Stage Renal Disease (ESRD) may require additional vitamin/mineral supplements not usually covered by the pharmacy program. In order to accommodate these members, the prescriber must contact the prior authorization vendor (Rational Drug Therapy Program (RDTP)) by fax, phone or mail in order to confirm the ESRD diagnosis.

Once a member receives a kidney transplant, the member is no longer considered as having ESRD, and no longer qualifies for these additional supplements. To allow for clinical stabilization following transplant, a six-month extension of the ESRD coverage will be permitted before being terminated.

518.15.4 Qualified Medicare Beneficiary (QMB)

Qualified Medicare Beneficiary (QMB) members do not receive pharmacy coverage benefits through the Medicaid program. Medicaid does provide coverage of deductibles and co-insurance amounts for Medicare Part B covered drugs and other Medicare covered services with the exception of those covered under Part D.

518.15.5 Children in Foster and Adoptive Placement

Children in state custody and entered into foster, residential, or adoptive placements may be Medicaid eligible and receive a medical identification card. The eligibility number usually begins with “039.” Drug claims may be submitted online through the pharmacy POS system or on the approved paper claim form. Medicaid coverage rules apply.

518.15.6 Incarcerated Members

Medicaid members who are incarcerated are restricted from coverage of pharmacy benefits until they are released from the correctional system. Claims submitted with dates of service during a period of incarceration will deny. If the member has been released before the restriction is updated, positive identification is required. A call to the pharmacy prior authorization vendor help desk must be made to request an override.

518.16 PHARMACY SERVICES FOR NON-MEDICAID INDIVIDUALS

Individuals who do not qualify for the Medicaid program may have pharmacy coverage under other Federal or state-funded programs. These individuals do not receive medical identification cards, but may receive a letter or other form of eligibility authorization.

518.16.1 Limited Pharmacy Services or Ryan White Program

The Limited Pharmacy Services program is funded under Part B of the Ryan White HIV/AIDS Treatment Extension Act in West Virginia, and claims are processed through the BMS claims processing system. The program assists eligible persons with HIV infection in obtaining drugs covered by the Limited Pharmacy Services formulary. To be eligible for the Limited Pharmacy Services program, a person must meet the following criteria:

- Be an HIV infected resident of West Virginia;
- Have family income less than 400% of the Federal poverty level (FPL);
- Not be eligible for other forms of reimbursement such as Medicaid or full insurance coverage; and
- Have completed the Limited Pharmacy Services and Medicaid application at their local DHHR county office.

Limited Pharmacy Services participants do not receive a medical identification card, but do receive a letter that verifies eligibility and includes their identification number with a prefix of “69.” All claims except those for vaccines may be submitted online through the pharmacy POS system or by using the approved paper claim form. Covered drugs are limited to a 30-day supply. Claims must be submitted within one year from the date of service. Formulary drugs must be dispensed in generic form if available. Brand-name drugs that have generic equivalents require prior authorization. There are no co-payment requirements for this program. Limited Pharmacy Services program may cover co-pays for eligible residents who are covered by insurance or Medicare Part D. Claims for vaccines must be submitted on the approved pharmacy paper claim form and mailed to ATF, PO Box 6360, Wheeling, West Virginia 26003. Certain drugs may require prior authorization and emergency supplies of these drugs may not be dispensed. Please refer to the BMS website for the Limited Pharmacy Services formulary. More information regarding Limited Pharmacy Services is available at the DHHR Office of Epidemiology and Prevention Services website or by calling the local AIDS Task Force.

518.16.2 Children with Special Health Care Needs (CSHCN)

Pharmacy services are available for certain children under 21 years of age receiving medical care under the Children with Special Health Care Needs (CSHCN) program. Services are not limited to children of families receiving public assistance grants. Coverage is established by the CSHCN program. These members do not receive a medical identification card. An identification number with a prefix of “99” is assigned. Claims may be submitted online using the pharmacy POS system or by using the approved paper claim form. Policy questions regarding this program shall be directed to CSHCN.

518.16.3 Individuals Eligible for Immunosuppressant or Antipsychotic Medications

Certain individuals who are not eligible for Medicaid services may be eligible for coverage of immunosuppressant or antipsychotic medications using all state funds. Eligibility for these services is

determined at the individual's local county DHHR office. A six-month eligibility period is established, and it is the member's responsibility to reapply for these services. No identification card will be issued. Medicaid receives a written communication from the Division of Family Assistance defining the drug(s) that will be covered for a particular individual. A letter including the services to be covered and the individual's identification number, prefix "39", will be forwarded to the pharmacy provider and the individual. Claims for these services may be submitted online through the pharmacy POS system or on the approved paper claim form. Medicaid coverage rules apply to these claims. Some individuals may also be eligible for coverage of immunosuppressant drugs by Medicare Part B. Medicare must be billed first. This state program will pay co-insurance and deductible amounts on Medicare Part B crossover claims only. All other Medicare eligible individuals must pursue coverage of immunosuppressant drugs and antipsychotic medications through their Part D plans.

518.16.4 James "Tiger" Morton Catastrophic Illness Fund

Certain individuals who are not eligible for Medicaid services may be eligible for coverage of selected medications using state funds through the James "Tiger" Morton Catastrophic Illness Fund. These individuals will not have an identification card and coverage will be communicated to the pharmacy provider on a case-by-case basis. Claims for these services must be submitted using the approved paper claim form.

518.16.5 Emergency Medical Assistance or Other State Programs

Certain individuals who are not eligible for Medicaid services may be eligible for emergency medical assistance or other pharmacy services using state funds. These individuals will present a letter to the pharmacy provider listing particular drug(s) to be covered. A prefix of "15" or "38" along with the respective county code will be noted on the authorization letter to identify the eligible individual. Claims for these services must be submitted using the approved paper claim form with a copy of the eligibility letter attached.

518.16.6 Juvenile Services

Incarcerated minors have pharmacy services coverage through Juvenile Services. A letter of eligibility will be presented to the pharmacy which includes the individual's identification number beginning with prefix "17". Claims for these services may be submitted through the online POS system or by using the approved paper claim form. Medicaid coverage rules apply.

518.16.7 Adult Family Care and Protective Services

Children and adults receiving protective services as a result of abuse and/or neglect or other individuals in need of assistance may be provided limited eligibility for state-funded services. A Special Medical Authorization Letter is issued as needed by the DHHR field staff. This letter specifies the individual, the medical provider authorized to provide services, the services authorized and the coverage period. An identification number for use in billing the services is also provided. Pharmacy claims for these individuals may be submitted online or on the approved paper claim form. Medicaid coverage rules apply.

518.17 DENIALS DUE TO ELIGIBILITY ISSUES

If an online denial occurs due to eligibility problems and the member presents a valid medical identification card or other proof of eligibility, the pharmacist should take the following steps:

- Dispense the prescription for valid and covered services, and
- Obtain proof of eligibility

Choose one of two options:

1. Resubmit the claim online at a later date, using the original date of service; or
2. Submit the claim on the approved paper claim form and attach a copy of the valid medical identification card or other proof of eligibility. Mail these claims to:

Gainwell Technologies
Pharmacy Claims
Post Office Box 3765
Charleston, West Virginia 25327-3709

518.18 BILLING PROCEDURES

Claims for prescribed drugs dispensed to Medicaid members may be submitted electronically using the POS system or on paper claim forms. Claims must be filed within 12 months from the date of service.

Submitting claims via electronic media offers the advantage of speed and accuracy in processing. All claims, regardless of method of submission, are subject to DUR edits, prior authorization, and other Medicaid requirements.

Medications must be dispensed at the facility from which the drug products are prepared, and the services rendered.

Claims must accurately report the National Drug Code (NDC) dispensed, the number of units dispensed, days' supply, and other required data for claims processing. Use of an incorrect NDC or inaccurate reporting of a drug quantity will cause the BMS to report false data to drug manufacturers when billed for drug rebates. The BMS will recover payments made on erroneous claims discovered during dispute resolution with drug manufacturers or during claim reviews. Pharmacies are required to submit documentation for purchases of drugs reimbursed by the BMS upon request.

518.18.1 Point-of-Sale (POS) System

Currently, online processing for Medicaid pharmacy claims is available for all pharmacies using NCPDP Version D.0. The provider must complete and submit the provider trading partner agreement prior to use of POS submission for claims.

The Pharmacy POS User Guide provides complete billing instructions for the POS system. The Pharmacy POS NCPDP Version D.0 Vendor Specification Document provides specifications and information for switch vendors. These documents and other billing information are available on the fiscal agent website.

518.18.2 National Council on Prescription Drug Programs (NCPDP) Payer Sheet

West Virginia Medicaid accepts pharmacy POS claims submitted using NCPDP Version D.0 or Batch Version 1.1. According to the NCPDP accepted standards, some fields are required, optional, or conditional. The Pharmacy POS NCPDP Version D.0 Vendor Specification Document and the West Virginia Medicaid payer sheet are available on the BMS website.

518.18.3 Paper Claim Submission for Pharmacy Services

Pharmacies have the alternative of submitting a manual claim using a paper claim form, when necessary. The Universal Claim Form (UCF) provides a standard format for paper submission of drug claims to Medicaid. The UCF adheres to the data elements found in the NCPDP Telecommunication Standard and Data Dictionary. **Medicaid will not supply these forms to providers**.

518.18.4 Claim Reversals

Pharmacy claims submitted by POS cannot be adjusted. To correct information submitted on a POS claim, the claim must be reversed online and then resubmitted using the corrected information. There is currently no paper reversal claim form. If a paper claim submission requires corrections, the pharmacy Help Desk must be contacted.

518.18.5 Pharmacy Identification Number

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated the use of the National Provider Identifier (NPI) as the standard for identifying covered healthcare providers, including pharmacies. Pharmacies must use their NPI number on electronic submissions for reimbursement of pharmacy claims. NCPDP numbers will no longer be accepted on electronic claims. The NPI or NCPDP number will continue to be used on the approved paper claim form. For additional NPI information or to complete an NPI application, visit the CMS website.

518.18.6 Prescriber Identification Number

The NPI is required for the prescriber identification information on electronic POS claims. Either the DEA number or the NPI is allowed on the manual claim form. Only prescribing NPI entities are permissible. Claims submitted with non-prescribing NPI entities will be denied, including but not limited to pharmacies, laboratories, hospitals, and dialysis centers.

518.18.7 National Drug Codes (NDC)

All pharmacy claims submitted to West Virginia Medicaid must identify the 11-digit NDC printed on the stock container in which the drug was purchased. **Using the correct NDC is extremely important in order to avoid disputes with manufacturers for rebate payments**. For example, if a drug is purchased in a 5000-count bottle and repackaged in 100-count bottles prior to dispensing, submitting the NDC for a 100-count bottle is not permitted. Most drugs distributed by repackagers are not covered by Medicaid because the repackager has not signed a rebate agreement with CMS. A pharmacy may not dispense a repackager's drug and then bill Medicaid using the original manufacturer's NDC.

518.18.8 Decimal Units

The Medicaid pharmacy system is capable of accepting quantity amounts which contain decimal units. Pharmacy claims must be submitted using the standard units, including any decimal increments. Units must not be rounded up or down. Rounding results in over or under payments and creates inaccurate invoicing to manufacturers for the drug rebates owed to the state.

518.18.9 Days' Supply

For non-controlled substances, each Medicaid-covered prescription is limited to a maximum dispensed supply of 90 days, with some exceptions to accommodate packaging that cannot be broken.

All controlled substances are limited to a maximum supply of 34 days, with no exceptions.

If the member has coverage by a third party and is required to obtain up to a 93-day supply, coverage will be provided beyond the standard 90-day supply limit.

The pharmacist is responsible for submitting prescription claims up to the appropriate limit. Should a prescription be written for a quantity that is greater than the allowed limit, the pharmacist is responsible for notifying the prescriber of this limit and asking permission to reduce the number of units to be dispensed.

If the prescriber does not allow the prescription quantity to be reduced to the maximum Medicaid limit, the member shall be told that the cost of the prescription is his/her responsibility. The pharmacist must enter the actual day supply written on the prescription when attempting to fill a claim. Artificially adjusting the amount filled in order to meet Medicaid requirements when the prescription was written to last longer constitutes a false claim and is subject to recovery of the paid amounts.

518.18.10 Compounded Prescriptions

A compounded prescription is defined as any prescription requiring the combination of two or more substances, one of which must be a covered legend drug. The covered legend drug must be the first NDC submitted on a compounded prescription claim. The Drug Efficacy Study Implementation (DESI) drugs or non-covered drugs **not appearing as the first NDC** in a compounded product will not cause the claim to deny, but those ingredients will not be included in the reimbursement. Over-the-counter ancillary products will be reimbursed provided the drug is manufactured by a company which participates in the Federal drug rebate program. A compound may contain up to 25 ingredients.

Products such as suppository molds and other items identified as supplies included in a compounded prescription will not be reimbursed by West Virginia Medicaid.

Billing compounded prescriptions follows NCPDP Version D.0 guidelines. For a compounded prescription, an additional $6.00 will be added to the dispensing fee. Compounding is considered an integral part of the prescription services and must not be billed separately. More information can be found in the User Guide, located using the BMS link to the fiscal agent website.

518.18.11 Abuse and Inappropriate Utilization

The following practices constitute abuse and inappropriate utilization, and are subject to audit:

- Excessive fees (commonly known as prescription splitting or incorrect or excessive dispensing fees): Billing inappropriately in order to obtain dispensing fees in excess of those allowed by:
  - Supplying medication in amounts less than necessary to cover the period of the prescription; and/or
  - Supplying multiple medications in strengths less than those prescribed to gain more than one dispensing fee.
- Excessive filling: Billing for an amount of a drug or supply greater than the prescribed quantity.
- Prescription shorting: Billing for drug or supply greater than the quantity actually dispensed.
- Substitution to achieve a higher price: Billing for a higher priced drug than prescribed even though the prescribed lower priced drug was available.
- Automated refills and automatic shipments are prohibited. Medicaid does not pay for any prescription without an explicit request from a member or the member's responsible party, such as a caregiver, for each refilling event. The pharmacy provider shall not contact the member in an effort to initiate a refill unless it is part of a good faith clinical effort to assess the member's medication regimen. The possession, by a provider, of a prescription with remaining refills authorized does not in itself constitute a request to refill the prescription. Members or providers cannot waive the explicit refill request and enroll in an electronic automatic refill program. Any prescriptions filled without a request from a member or his or her responsible party will be subject to recovery. Any pharmacy provider with a policy that includes filling prescriptions on a regular date or any type of cyclical procedure will be subject to audit, claim recovery or possible suspension or termination of the provider agreement.

518.18.12 Lost/Stolen Medications

For members who report to the pharmacy that their medications have either been lost or stolen, the following procedure applies:

- The member must supply the pharmacy with a police report for stolen controlled substances; the pharmacy must retain a copy for audit purposes.
- The prescribing practitioner must agree that the lost or stolen medication shall be replaced.
- Lost/stolen medication approvals are limited to one occurrence per drug per year.
- In cases of natural disaster, the BMS will address the situation on a case-by-case basis.

518.18.13 Wasted Medication

Members who have wasted medication due to improper use or storage may have their medication replaced. This will be determined on a case-by-case basis. Members shall be properly instructed on the storage and use of their medications and any special delivery device used to administer their medications. Requests for replacement of wasted medications due to improper storage or delivery by the pharmacy or improper handling by the administrating provider will be denied.

518.18.14 False Claims

Pharmacies are prohibited from submitting false claims to test for drug coverage, member eligibility, or for other purposes. Claims of this type result in false member drug history records and may result in the member or prescriber being included in lawsuits or reviews in error. All claims submitted for reimbursement must be the result of actual prescription requests.

518.19 REIMBURSEMENT

Federal Medicaid regulations governing pharmacy services establish upper limits for payment; i.e., the payment shall be based on the lower of the allowable cost of the drug, plus a dispensing fee or the provider's usual and customary charge to the general public.

Reimbursement for outpatient drugs is limited to products manufactured by companies participating in the Federal Drug Rebate program.
If a provider accepts the member as a Medicaid patient, the provider must bill West Virginia Medicaid for covered services and must accept the Medicaid reimbursement amount as full payment. No charge may be billed to a Medicaid member for a covered service unless a co-payment is applicable by regulation. However, the provider may bill the member for services not covered by the West Virginia Medicaid program if the parties agree in writing to this payment arrangement before such services are rendered. Please refer to *Chapter 300, Provider Participation Requirements* for more information about billing Medicaid members.

518.19.1 Ingredient Cost

Reimbursement for covered outpatient drugs is based on the following methodology. Reimbursement for brand (single source) and generic (multiple source) drugs shall be **the lower of**:

1. **National Average Drug Acquisition Cost (NADAC) plus the professional dispensing fee.** The NADAC is based on the retail price survey of pharmacies and focuses on the average acquition cost of retail community pharmacies. The NADAC represents the average acquisition cost of pharmacies surveyed and includes independent retail community pharmacies and chain pharmacies. The prices are updated and loaded into the West Virginia Medicaid Pharmacy POS claims system on a weekly basis. To view the NADAC weekly files and the NADAC Week to Week File Comparison, please visit the Pharmacy Drug Pricing Page on the CMS website.
2. **If no NADAC is available, then Wholesale Acquistion Cost (WAC) plus 0% plus the professional dispensing fee.**
3. **The Federal Upper Limit (FUL) as supplied by CMS plus the professional dispensing fee.** The FUL is calculated at no less than 175% of the weighted average (as determined on the basis of utilization) of the most recently reported monthly Average Manufacturer's Price (AMP) for pharmaceutically and therapeutically equivalent multiple source drug products that are available for purchase by retail community pharmacies on a nationwide basis. In situations where the FUL is less than the community pharmacies' average cost, the FUL is established using a higher multiplier so the FUL amount will equal the most current average retail community pharmacies' acquisition cost as determined by the most current national survey of such costs. This methodology is codified in 42 CFR §447.514 (b)(1) and (2).

   EXCEPTION: The FUL shall not apply in any case where a physician certifies in his/her own handwriting that, in his/her medical judgment, a specific brand is medically necessary for a particular patient. A notation like "brand medically necessary" written by the physician on the prescription above his/her signature is an acceptable certification. A procedure for checking a box on a form will not constitute an acceptable certification. All such certified prescriptions must be maintained in the pharmacy files and are subject to audit by the BMS.

4. **The State Maximum Allowable Cost (SMAC) plus the professional dispensing fee.** The SMAC rate is applied to all brand and generic drug products in each drug group. Non-AB rated drugs recognized by national drug information suppliers as comparable to a particular brand drug are subjected to the same SMAC rate applicable to the brand and "AB" rated generic drugs of the same chemical composition, package size, dose, and drug group.

   The determination of which drugs will be part of the SMAC list will be designated by BMS. Drugs no longer available at SMAC prices are removed. New drugs will be added to the SMAC list as they are identified. The SMAC vendor on behalf of BMS will continually monitor pharmacies and industry information and make changes to the SMAC to reflect current pharmaceutical market conditions. The SMAC list may be accessed on the BMS website. Comments and questions regarding the SMAC list can be made to the vendor.

   EXCEPTION: The SMAC shall not apply in any case where a physician certifies in his/her own handwriting that, in his/her medical judgment, a specific brand is medically necessary for a particular patient. A notation like "brand medically necessary" written by the physician on the prescription above his/her signature is an acceptable certification. A procedure for checking a box on a form will not constitute an acceptable certification. All such certified prescriptions must be maintained in the pharmacy files and are subject to audit by the BMS.

5. **The submitted ingredient cost plus the professional dispensing fee.**

6. **The provider's usual and customary charges to the general public, including any sale price in effect on the date of dispensing.**

518.19.2 Application of Dispensing Fee

- For covered legend and over-the-counter drugs, a professional dispensing fee of $10.49 per prescription will be added to the NADAC (or WAC when NADAC is not available), FUL, SMAC, or submitted ingredient cost.
- Pharmacies participating in the 340B program will receive a dispensing fee of $10.49 per prescription. These pharmacies are required to submit their Actual Acquisition Costs (AAC) to Medicaid.
- For a compounded prescription, an additional $6.00 will be added to the dispensing fee. A compounded prescription is defined as any prescription requiring the combination of two or more substances, one of which must be a legend drug. Compounding is considered an integral part of the prescription services and must not be billed separately.
- The dispensing fee may only be paid once every 30 days per drug entity for members residing in ICF/IID or nursing facilities.
- Claims paid on the basis of the usual and customary charge to the general public do not include an additional dispensing fee.

518.19.3 Co-Payments

A co-payment is required for each prescription with the exception of prescriptions for members excluded by regulation and/or those items specifically excluded from the co-payment requirement. The member co-

payment per prescription will be deducted from the allowed total charge to determine the amount payable for each prescription billed to the program. The deduction will apply as follows:

- If the allowed total charge is $5.00 or less, there is no co-payment per prescription.
- If the allowed total charge is $5.01 through $10.00, the co-payment is $.50 per prescription.
- If the allowed total charge is $10.01 through $25.00, the co-payment is $1.00 per prescription.
- If the allowed total charge is $25.01 through $50.00, the co-payment is $2.00 per prescription.
- If the allowed total charge is $50.01 or more, the co-payment is $3.00 per prescription.

The following populations and services are exempt from copays:

- Family planning services and supplies
- Members in long-term care facilities (i.e., nursing facilities or ICF/IID)
- Pregnant women including 60 days post-partum
- Native Americans and Alaska natives
- Members under age 21
- Members receiving Hospice services
- Members receiving Medicaid Waiver services, or covered through the Breast and Cervical Cancer Treatment program
- Three-day emergency supplies
- Diabetic testing supplies and syringes/needles
- BMS approved home infusion supplies
- POS-approved vaccines
- Agents for smoking cessation including nicotine replacement drugs, buproprion (Zyban) and Chantix

Please refer to *Chapter 600, Reimbursement Methodologies* regarding maximum quarterly out-of-pocket limits.

Members have been informed of co-payment requirements and the exclusions from co-payment. Federal regulations stipulate that no provider may deny services to an eligible individual in situations when the member is unable to pay co-payment charges. However, this does not preclude the member's liability for payment of the co-payment due the provider.

Providers may bill the member or refer the member to a collection agency, etc., in the same manner that the provider initiates collections from private pay customers.

Providers are prohibited from advertising or soliciting business by waiving members' co-payment responsibility. Members are responsible for applicable copays, and providers are prohibited from waiving the copay requirement to attract business from other providers.

518.19.4 Third-Party Liability (TPL) or Coordination of Benefits (COB)

Medicaid is the payer of last resort. The TPL ensures that Medicaid is the last payer to reimburse for covered Medicaid services. In particular, Medicaid participating providers must always seek reimbursement from other liable resources, including private or public insurance entities. Before submitting

claims to Medicaid, providers must pursue all requirements of the primary insurer including, but not limited to prior authorization, brand name justifications, and DUR events.

Federal regulations require that state Medicaid administration identify any third-party resource available to meet the medical expenses of a member. The "third party" may be an individual, institution, corporation, or a public/private agency liable for all or part of the member's medical costs; e.g., private health insurance, United Mine Workers of America (UMWA) benefits, Veterans Administration benefits, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), Medicare, Hospice, etc. Additionally, no Medicaid reimbursement may be made if the service is the responsibility of a public or private Workers Compensation Plan.

Medicaid covered drugs which currently require a prior authorization from BMS will continue to require a prior authorization if a primary insurer approves that service, and Medicaid reimburses any part of the cost.

Medicaid co-payment is still required, if applicable, for claims considered by third party payers and reimbursed by the BMS.
Chapter 600, Reimbursement Methodologies, of the BMS Provider Manual provides more detailed information regarding Third Party Liability.

More information regarding the billing of COB for NCPDP Version D.0 can be found on the fiscal agent website.

518.19.5 Medicare-Covered Drugs and Supplies, Part B

Pharmacies are required to verify and pursue members' Medicare coverage and to submit pharmacy claims to Medicare for those pharmacy services covered by Medicare. Pharmacies can submit claims to Medicare Part B either on the acceptable paper claim form (CMS 1500) or electronically. Once the Medicare claim has been approved and processed, Medicare will automatically submit the balance of the claim as a "crossover" to Medicaid electronically, if the provider's Medicare number is on file with Medicaid. These claims should not be submitted to Medicaid separately if the claim crossed over from Medicare.

For Dually Eligible members and Qualified Medicare Beneficiary (QMB), if the service is covered by Medicare and Medicaid, Medicaid will pay the lesser of:

- The full coinsurance and deductible amounts due, based upon the Medicare allowed amount, or
- Medicaid's maximum allowable fee for that service minus the amount paid by Medicare.

For QMB, if the service is not covered or is denied by Medicare, Medicaid will not reimburse.

Drugs that are not covered by Medicare Part B may be covered by Medicare Part D. Medicaid does not reimburse for Part D co-payments.

518.19.6 Medicare-Covered Drugs, Part D

Dual eligible members have prescription drug coverage through Medicare Part D. Medicaid is not responsible for covering pharmacy benefits for these individuals, except for drugs in the Medicare excluded categories. Dual eligible members are limited to coverage of Medicare Part D excluded drugs. Coverage is limited to drugs that are covered for other Medicaid eligible members in the following classes:

- Barbiturates (if not for treatment of epilepsy, cancer, or mental health disorder, as Medicare Part D covers these conditions)
- OTC medications
- Agents for the symptomatic relief of cough and cold symptoms
- Prescription vitamins and minerals

Medicaid does not reimburse for Medicare Part D co-payments. Medicaid does not pay as the secondary payer on Medicare Part D covered drugs.

518.19.7 In-Home Parenteral Therapy (IHPT) Billing and Reimbursement Via Point-of-Sale

Billing for IHPT claims is accomplished through NCPDP Version D.0 electronic or 1.1 batch (paper claim) system. Instructions for the processing of claims are found in the general pharmacy manual information.

The active ingredient(s) for each prescription is/are to be billed using the NDC and its respective unit of use. The drug portion of IHPT will be reimbursed online according to the current reimbursement policy. The codes used for the reimbursement of compounding services are inclusive of, but not limited to, diluents for reconstitution, IV fluids, and other supplies used in the compounding process.
Billing shall correspond to those items and fees reflecting therapy for a duration of a maximum of 34 days as prior authorized by the Pharmacy prior authorization vendor. If the order is discontinued, any billing for agents that have not been delivered to the member must be reversed.

- **Pre-mixed Solutions or products requiring no compounding:** After receiving prior authorization, prescriptions for items which are dispensed with no compounding requirements shall be submitted for payment via POS or approved paper claim form using the NDC number of the product and the quantity dispensed. Reimbursement will be made using the established retail reimbursement policy. Do not use the NCPDP compound indicator.
- **IV Drugs Requiring Compounding:** Products for IHPT requiring compounding involve billing in multiple parts. Drug components shall be submitted online or on the approved paper claim form using the actual NDC's that were used and quantity of each drug component, as approved by the Pharmacy prior authorization vendor. Use the NCPDP compound indicator when the product includes multiple agents. **Please note:** reimbursement for the diluting agent is included in the compounding fee and shall not be billed as a component of the compounded IHPT product if reimbursement for a compounding fee is requested.
- **Compounding Fee:** The compounding fee which includes all components of the prescription compounding, such as sterile water, alcohol swabs, IV fluids, needles/syringes, etc., and professional services shall be submitted online or on the approved paper claim form. The authorization for reimbursement of the compounding fee will be issued from the Pharmacy prior authorization vendor upon receipt of a copy of the signed order from the prescribing physician. Do not use the NCPDP compound indicator.
- **Units Dispensed:** Units are defined by First Data Bank product classification. In general, if a drug requires reconstitution, the units submitted will be the number of vials. For example, a 2-gm vial of cephazolin is submitted as a quantity of "1" for each vial. If the drug or component is available in solution, the units are submitted in milliliters. For example, a 2ml vial of gentamicin injection (80mg/vial) is submitted as "2" for each vial. The actual amount used in compounding shall be

submitted. Wastage shall be kept to a minimum. The units dispensed must match the amount prior authorized by the pharmacy prior authorization vendor.

The pharmacy prior authorization vendor Help Desk is available to assist providers with questions regarding proper unit billing. In all cases, the amount and duration of therapy for which the BMS is billed must match those ordered by the physician and delivered to the member.

- **Brand Name Justification:** If a drug being dispensed is a product for which a generic equivalent exists, the generic must be dispensed. The use of brand name products must be justified, as referenced in the general pharmacy instructions.
- **Supplies:** Please refer to *Chapter 506, Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)* for coverage policy and billing instructions for supplies associated with IHPT.

REFERENCES

West Virginia State Plan references pharmacy services at sections 3.1-A(12)(a), 3.1-B(12)(a), supplement 2 to attachments 3.1-A and 3.1-B(12)(a) and reimbursement at 4.19-B(12)(a). The Plan also references vaccine administration by a pharmacist (other licensed practitioner) at supplement 2 to attachments 3.1-A and 3.1-B(6)(d)(3) and reimbursement at 4.19-B(6)(d)(3), 4.18-A outlines required copayments.

GLOSSARY

Definitions in *Chapter 200, Definitions and Acronyms* apply to all West Virginia Medicaid services, including those covered by this chapter. Definitions in this glossary are specific to this chapter.

340B Program: A Federal program administered by the Health Resources and Services Administration (HRSA) whereby certain designated facilities purchase prescription medications at deep discounts, allowing these facilities to offer some medications to their patients at greatly reduced prices.

Dispense As Written (DAW): A numerical value used by providers to explain the dispensing of a brand-name product instead of a generic one.

Drug Efficacy Study and Implementation Program (DESI): Drugs determined by the Food and Drug Administration as lacking substantial evidence of effectiveness.

End Stage Renal Disease (ESRD): The stage of renal impairment that appears irreversible and permanent, and requires a regular course of dialysis or kidney transplantation to maintain life.

First Data Bank (FDB): A database company for drug pricing and drug utilization review (DUR) edits.

Federal Drug Rebates: Payments made by pharmaceutical manufacturers to the states for drugs dispensed to Medicaid members.

Federal Upper Limit (FUL): Maximum allowable cost established by CMS for certain prescribed drugs.

Home IV: Intravenous medications administered in the home, provided by specialized pharmacies, which require the services of a nurse or trained caregiver.

In-Home Parenteral Therapy (IHPT): The parenteral administration of fluids, drugs, chemical agents, or nutritional substances to members in the home setting.

Lock-In: Program administered through the retrospective DUR process to limit members to the use of one pharmacy provider.

Multi-Source Drugs: Drugs that are marketed or sold by two or more manufacturers or labelers.

National Provider Identifier (NPI): A standard unique healthcare provider identification number mandated by the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

Parenteral: All routes of administration of substances other than gastrointestinal.

Pharmaceutical and Therapeutics Committee (P&T Committee): An advisory body that recommends drugs to West Virginia Medicaid for inclusion or exclusion relating to the PDL.

Pharmacy Prior Authorization Vendor: Agency designated by the BMS for prior authorizing prescription drugs.

Qualified Medicare Beneficiary (QMB): A Medicaid program for beneficiaries who need help in paying for Medicare services. The beneficiary must have Medicare Part A and limited income and resources. For those who qualify, the Medicaid program pays Medicare Part A premiums, Part B premiums, and Medicare deductibles and coinsurance amounts for Medicare services.

Retrospective Drug Utilization Review (**DUR):** Review of member drug history records against predetermined standards to improve quality of healthcare and to educate physicians and pharmacists on common drug therapy issues.

Single-Source Drug: A drug that is available from only one manufacturer.

State MAC (SMAC): Maximum allowable cost for drug products or supplies established by the state Medicaid agency.

Supplemental Drug Rebate: A payment from a pharmaceutical manufacturer, negotiated by the state, in addition to the Federal rebate.

CHANGE LOG

REPLACE	TITLE	EFFECTIVE DATE
Entire Chapter	Pharmacy Services	October 1, 2015

WEST VIRGINIA Department of Health & Human Resources BUREAU FOR MEDICAL SERVICES

CHAPTER 518 PHARMACY SERVICES

Entire Chapter	Changes were made to: 518.1.9 Brand Name versus Generic Drugs 518.1.10 Pharmacies Participating in the 340B Program 518.15.2 Medicaid Members Enrolled in Managed Care Organizations 518.19.1 Ingredient Cost 518.19.2 Application of Dispensing Fee	July 20, 2018
Entire Chapter	Changes were made to: 518.1.6 Tobacco Cessation Program 518.1.7 Buprenorphine-Naloxone (Suboxone®) / Buprenorphine (Subutex®) Coverage (PA and Lock-In requirements were removed 518.3 Non-Covered Services 518.10 Pharmacies Participating in the 340B Program 518.12 Reporting of Cash Payments (also renamed to "Cash Payments")	December 1, 2020
Entire Chapter	Changes were made to: 518.15.3 Medicaid Members With End Stage Renal Disease (ESRD)	February 4, 2021
Entire Chapter	518.16.1 Limited Pharmacy Services or Ryan White Program claims updated.	July 28, 2021

Exhibit
BT 0009

BUREAU FOR MEDICAL SERVICES
WEST VIRGINIA MEDICAID
PREFERRED DRUG LIST WITH PRIOR AUTHORIZATION CRITERIA
This is not an all-inclusive list of available covered drugs and includes only managed categories. Refer to cover page for complete list of rules governing this PDL.

EFFECTIVE
07/01/2021
Version 2021.3b

- Prior authorization for a non-preferred agent in any class will be given only if there has been a trial of the preferred brand/generic equivalent or preferred formulation of the active ingredient, at a therapeutic dose, that resulted in a partial response with a documented intolerance.
- Prior authorization of a non-preferred isomer, pro-drug, or metabolite will be considered with a trial of a preferred parent drug of the same chemical entity, at a therapeutic dose, that resulted in a partial response with documented intolerance or a previous trial and therapy failure, at a therapeutic dose, with a preferred drug of a different chemical entity indicated to treat the submitted diagnosis. The required trial may be overridden when documented evidence is provided that the use of these preferred agent(s) would be medically contraindicated.
- Unless otherwise specified, the listing of a particular brand or generic name includes all legend forms of that drug. OTC drugs are not covered unless specified.
- PA criteria for non-preferred agents apply in addition to general Drug Utilization Review policy that is in effect for the entire pharmacy program, including, but not limited to, appropriate dosing, duplication of therapy, etc.
- The use of pharmaceutical samples will not be considered when evaluating the members' medical condition or prior prescription history for drugs that require prior authorization.
- Quantity limits may apply. Refer to the Limits List on the BMS Website by clicking the hyperlink.
- Unless otherwise indicated, non-preferred combination products require medical reasoning beyond convenience or enhanced compliance as to why the clinical need cannot be met with a preferred agent or combination of preferred single-ingredient agents.
- Acronyms
  - CL - Requires clinical PA. For detailed clinical criteria, please go to the PA criteria page by clicking the hyperlink.
  - NR – Denotes a new drug which has not yet been reviewed by the P & T Committee. **These agents are available only on appeal to the BMS Medical Director.**
  - AP - Non-preferred and selected preferred drugs, where indicated, are subject to auto-PA criteria. See PA criteria column.

EXHIBIT
tabbies
6

BUREAU FOR MEDICAL SERVICES
WEST VIRGINIA MEDICAID
PREFERRED DRUG LIST WITH PRIOR AUTHORIZATION CRITERIA
This is not an all-inclusive list of available covered drugs and includes only managed categories. Refer to cover page for complete list of rules governing this PDL.

EFFECTIVE
07/01/2021
Version 2021.3b

CLASSES CHANGING	Status Changes	PA Criteria Changes	New Drugs
ANTIHEMOPHILIA FACTOR AGENTS			XXX
ANTIPARKINSONS AGENTS			XXX
GLUCOCORTICOIDS, INHALED			XXX
GUANYLATE CYCLASE STIMULATORS			XXX
HYPOGLYCEMICS, INSULIN AND RELATED AGENTS	XXX		XXX
IMMUNOSUPPRESSIVES, ORAL			XXX
LAXATIVES AND CATHARTICS			XXX
MULTIPLE SCLEROSIS AGENTS			XXX
OPHTHALMICS, ANTI-INFLAMMATORIES- IMMUNOMODULATORS			XXX
PAH AGENTS, PROSTACYCLINS			XXX
STEROIDS, TOPICAL			XXX
SPINAL MUSCULAR ATROPHY AGENTS		XXX	XXX

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
ACNE AGENTS, TOPICAL[AP]		
CLASS PA CRITERIA: Non-preferred agents require a thirty (30) day trial of one (1) preferred retinoid and two (2) unique chemical entities in two (2) other subclasses, including the generic version of the requested non-preferred product, before they will be approved, unless one (1) of the exceptions on the PA form is present. In cases of pregnancy, a trial of retinoids will *not* be required. For members eighteen (18) years of age or older, a trial of retinoids will *not* be required. Acne kits are non-preferred. **Specific Criteria for sub-class will be listed below.** NOTE: Non-preferred agents in the Rosacea sub-class are available only on appeal and require at least a 30-day trial of all preferred agents in that sub-class.		
ANTI-INFECTIVE		
CLINDAGEL (clindamycin) clindamycin lotion, medicated swab, solution erythromycin gel, solution	AMZEEQ FOAM (minocycline) CLEOCIN-T (clindamycin) CLINDACIN ETZ kit, medicated swab (clindamycin) CLINDACIN P (clindamycin) CLINDACIN PAC (clindamycin) clindamycin gel, foam dapsone ERYGEL (erythromycin) erythromycin medicated swab EVOCLIN (clindamycin) FABIOR (tazarotene) KLARON (sulfacetamide) OVACE/PLUS (sulfacetamide) sodium sulfacetamide 10% cleansing gel sulfacetamide	
RETINOIDS		
DIFFERIN (adapalene) RETIN-A (tretinoin) RETIN-A MICRO (tretinoin)	adapalene AKLIEF CREAM (trifarotene) ALTRENO LOTION (tretinoin) ARAZLO (tazarotene) ATRALIN (tretinoin) AVITA (tretinoin) tazarotene cream tretinoin cream, gel tretinoin gel micro	**In addition to the Class Criteria**: PA required for members eighteen (18) years of age or older.
KERATOLYTICS		

benzoyl peroxide cleanser Rx & OTC, 10% cream OTC, gel Rx & OTC, lotion OTC, wash OTC PANOXYL-4 OTC (benzoyl peroxide)	BENZEFOAM benzoyl peroxide) BP 10-1 (benzoyl peroxide) BPO (benzoyl peroxide)	
COMBINATION AGENTS		
ACANYA (clindamycin phosphate/benzoyl peroxide) BENZAMYCIN PAK (benzoyl peroxide/ erythromycin) benzoyl peroxide/clindamycin gel (generic DUAC only) EPIDUO (adapalene/benzoyl peroxide)* EPIDUO FORTE (adapalene/benzoyl peroxide)* ONEXTON (clindamycin phosphate/benzoyl peroxide) sulfacetamide sodium/sulfur suspension ZIANA (clindamycin/tretinoin)*	adapalene-benzoyl peroxide* AVAR/-E/LS (sulfur/sulfacetamide) BENZACLIN GEL (benzoyl peroxide/ clindamycin) benzoyl peroxide/clindamycin gel (all generics other than DUAC) benzoyl peroxide/urea clindamycin phosphate/benzoyl peroxide (generic Acanya) clindamycin-tretinoin gel* erythromycin/benzoyl peroxide NEUAC (clindamycin phosphate/benzoyl peroxide) SSS 10-4 (sulfacetamide /sulfur) SSS 10-5 foam (sulfacetamide /sulfur) sulfacetamide sodium/sulfur cloths, lotion, pads sulfacetamide/sulfur wash/cleanser sulfacetamide/sulfur wash kit sulfacetamide sodium/sulfur/ urea SUMADAN/XLT (sulfacetamide/sulfur) SUMAXIN/TS (sulfacetamide sodium/sulfur)	**In addition to the Class Criteria:** Non-preferred combination agents require thirty (30) day trials of the corresponding preferred single agents before they will be approved. *PA required for combination agents with Retinoid products for members eighteen (18) years of age or older.
ROSACEA AGENTS		
FINACEA GEL (azelaic acid) MIRVASO GEL (brimonidine) metronidazole cream metronidazole gel 0.75% (NDCs 00115-1474-46, 00168-0275-45, 51672-4116-06, 66993-0962-45 only)	azelaic acid gel FINACEA FOAM (azelaic acid) ivermectin METROCREAM (metronidazole) METROGEL GEL (metronidazole) metronidazole lotion metronidazole gel (all other NDCs) NORITATE CREAM (metronidazole) RHOFADE (oxymetazoline) ROSADAN (metronidazole) SOOLANTRA CREAM (ivermectin) ZILXI (minocycline) foam	**Subclass criteria**: Non-preferred agents are available only on appeal and require evidence of 30-day trials of all chemically-unique preferred agents in the sub-class.

ALZHEIMER'S AGENTS[AP]

CLASS PA CRITERIA: Non-preferred agents require a thirty (30) day trial of a preferred agent in the same sub-class before they will be approved, unless one (1) of the exceptions on the PA form is present.

Prior authorization is required for members up to forty-five (45) years of age if there is no diagnosis of Alzheimer's disease.

CHOLINESTERASE INHIBITORS		
donepezil 5 and 10 mg donepezil ODT	ARICEPT (donepezil) donepezil 23 mg* EXELON PATCH (rivastigmine) galantamine galantamine ER RAZADYNE ER (galantamine) Rivastigmine	*Donepezil 23 mg tablets will be authorized if the following criteria are met: 1. There is a diagnosis of moderate-to-severe Alzheimer's Disease **and** 2. There has been a trial of donepezil 10 mg daily for at least three (3) months and donepezil 20 mg daily for an additional one (1) month.
NMDA RECEPTOR ANTAGONIST		
memantine	memantine ER memantine solution NAMENDA (memantine) NAMENDA XR (memantine)*	***Namenda XR requires ninety (90) days of compliant therapy with Namenda.
CHOLINESTERASE INHIBITOR/NMDA RECEPTOR ANTAGONIST COMBINATIONS		
	NAMZARIC (donepezil/memantine)	Combination agents require thirty (30) day trials of each corresponding preferred single agent.

ANALGESICS, NARCOTIC LONG ACTING (Non-parenteral)[AP]

CLASS PA CRITERIA: Non-preferred agents require six (6) day trials of three (3) chemically distinct preferred agents **AND** a six (6) day trial of the generic form of the requested non-preferred agent (if available) before they will be approved, unless one (1) of the exceptions on the PA form is present. If no generic form is available for the requested non-preferred brand agent, then another generic non-preferred agent must be trialed instead. **NOTE: All long-acting opioid agents require a prior authorization for children under 18 years of age.** Requests must be for an FDA approved age and indication and specify previous opioid and non-opioid therapies attempted.

BUTRANS (buprenorphine) fentanyl transdermal 12, 25, 50, 75, 100 mcg/hr morphine ER tablets tramadol ER tablets (generic Ultram ER) XTAMPZA ER (oxycodone)	ARYMO ER (morphine sulfate) BELBUCA (buprenorphine buccal film)* buprenorphine patch (all labelers including 00093) CONZIP ER (tramadol) fentanyl transdermal 37.5, 62.5, 87.5 mcg/hr hydromorphone ER HYSINGLA ER (hydrocodone) hydrocodone ER capsule and tablet KADIAN (morphine) methadone** MORPHABOND ER (morphine sulfate) morphine ER capsules (generic for Avinza) morphine ER capsules (generic for Kadian) MS CONTIN (morphine) NUCYNTA ER (tapentadol)**** oxycodone ER OXYCONTIN (oxycodone) oxymorphone ER tramadol ER (generic Conzip ER)*** ULTRAM ER (tramadol) ZOHYDRO ER (hydrocodone)	*Belbuca prior authorization requires manual review. Full PA criteria may be found on the PA Criteria page by clicking the hyperlink. **Methadone will be authorized without a trial of the preferred agents if a diagnosis of cancer is submitted. ***Tramadol ER (generic Conzip) requires a manual review and may be authorized for ninety (90) days with submission of a detailed treatment plan including anticipated duration of treatment and scheduled follow-ups with the prescriber. ****Nucynta requires six (6) day trials of three (3) chemically distinct preferred agents

ANALGESICS, NARCOTIC SHORT ACTING (Non-parenteral)[AP]

CLASS PA CRITERIA: Non-preferred agents require six (6) day trials of at least four (4) chemically distinct preferred agents (based on the narcotic ingredient only), including the generic formulation of the requested non-preferred agent, before they will be approved, unless one (1) of the exceptions on the PA form is present.
NOTE: All tramadol and codeine products require a prior authorization for children under 18 years of age. Requests must be for an FDA approved age and indication and specify non-opioid therapies attempted.

APAP/codeine butalbital/APAP/caffeine/codeine codeine hydrocodone/APAP 2.5/325 mg, 5/325 mg, 7.5/325 mg,10/325 mg hydrocodone/APAP solution hydrocodone/ibuprofen hydromorphone tablets LORTAB SOLUTION (hydrocodone/acetaminophen) morphine oxycodone tablets, concentrate, solution oxycodone/APAP oxycodone/ASA pentazocine/naloxone tramadol tramadol/APAP	ABSTRAL (fentanyl) ACTIQ (fentanyl) butalbital/ASA/caffeine/codeine butorphanol DEMEROL (meperidine) dihydrocodeine/ APAP/caffeine DILAUDID (hydromorphone) fentanyl FENTORA (fentanyl) FIORICET W/ CODEINE (butalbital/APAP/caffeine/codeine) FIORINAL W/ CODEINE (butalbital/ASA/caffeine/codeine) hydrocodone/APAP 5/300 mg, 7.5/300 mg, 10/300 mg hydromorphone liquid, suppositories levorphanol LORCET (hydrocodone/APAP) LORTAB (hydrocodone/APAP) meperidine NORCO (hydrocodone/APAP) NUCYNTA (tapentadol) oxycodone capsules oxycodone/ibuprofen oxymorphone PERCOCET (oxycodone/APAP) ROXICODONE (oxycodone) ULTRACET (tramadol/APAP) VICOPROFEN (hydrocodone/ibuprofen)	Fentanyl buccal, nasal and sublingual products will only be authorized for a diagnosis of cancer and as an adjunct to a long-acting agent. These dosage forms will not be authorized for monotherapy. **Limits:** Unless the patient has escalating cancer pain or another diagnosis supporting increased quantities of short-acting opioids, all short acting solid forms of the narcotic analgesics are limited to 120 tablets per thirty (30) days. Longer-acting medications should be maximized to prevent unnecessary breakthrough pain in chronic pain therapy. Immediate-release tramadol is limited to 240 tablets per thirty (30) days.

ANDROGENIC AGENTS

CLASS PA CRITERIA: A non-preferred agent will only be authorized if one (1) of the exceptions on the PA form is present.

ANDRODERM (testosterone) ANDROGEL (testosterone) METHITEST (methyltestosterone) testosterone cypionate vial[CL] testosterone enanthate vial[CL]	ANDROID (methyltestosterone) FORTESTA (testosterone) JATENZO (testosterone undecanoate) methyltestosterone capsule NATESTO (testosterone) TESTIM (testosterone) TESTRED (methyltestosterone) testosterone gel VOGELXO (testosterone) XYOSTED (testosterone enanthate)	

ANESTHETICS, TOPICAL[AP]

CLASS PA CRITERIA: Non-preferred agents require ten (10) day trials of each preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.

lidocaine lidocaine/prilocaine xylocaine	lidocaine/hydrocortisone LIDOTRAL CREAM (lidocaine) LIDOZION LOTION (lidocaine) SYNERA (lidocaine/tetracaine)	

ANGIOTENSIN MODULATORS[AP]

CLASS PA CRITERIA: Non-preferred agents require fourteen (14) day trials of each preferred agent in the same sub-class, with the exception of the Direct Renin Inhibitors, before they will be approved, unless one (1) of the exceptions on the PA form is present.

ACE INHIBITORS		
benazepril captopril enalapril fosinopril lisinopril quinapril ramipril	ACCUPRIL (quinapril) ALTACE (ramipril) EPANED (enalapril)* LOTENSIN (benazepril) moexipril perindopril PRINIVIL (lisinopril) QBRELIS SOLUTION (lisinopril)** trandolapril VASOTEC (enalapril) ZESTRIL (lisinopril)	*Epaned will be authorized with a diagnosis of hypertension, symptomatic heart failure or asymptomatic left ventricular dysfunction provided that the patient is less than seven (7) years of age **OR** is unable to ingest a solid dosage form due to documented oral-motor difficulties or dysphagia. **Qbrelis solution may be authorized for children ages 6-10 who are unable to tolerate a solid dosage form. Qbrelis may also be authorized for older patients with clinical documentation indicating oral-motor difficulties or dysphagia.
ACE INHIBITOR COMBINATION DRUGS		
benazepril/amlodipine benazepril/HCTZ captopril/HCTZ enalapril/HCTZ fosinopril/HCTZ lisinopril/HCTZ quinapril/HCTZ	ACCURETIC (quinapril/HCTZ) LOTENSIN HCT (benazepril/HCTZ) LOTREL (benazepril/amlodipine) TARKA (trandolapril/verapamil) trandolapril/verapamil VASERETIC (enalapril/HCTZ) ZESTORETIC (lisinopril/HCTZ)	
ANGIOTENSIN II RECEPTOR BLOCKERS (ARBs)		
irbesartan losartan valsartan olmesartan	ATACAND (candesartan) AVAPRO (irbesartan) BENICAR (olmesartan) candesartan COZAAR (losartan) DIOVAN (valsartan) EDARBI (azilsartan) MICARDIS (telmisartan) telmisartan	
ARB COMBINATIONS		
ENTRESTO (valsartan/sacubitril)[AP]* irbesartan/HCTZ losartan/HCTZ olmesartan/amlodipine	ATACAND-HCT (candesartan/HCTZ) AVALIDE (irbesartan/HCTZ) AZOR (olmesartan/amlodipine) BENICAR-HCT (olmesartan/HCTZ)	*Entresto will only be authorized for patients 18 years of age or older who are diagnosed with chronic heart-failure.

olmesartan/HCTZ TRIBENZOR (olmesartan/amlodipine/HCTZ) valsartan/amlodipine valsartan/amlodipine/HCTZ valsartan/HCTZ	candesartan/HCTZ DIOVAN-HCT (valsartan/HCTZ) EDARBYCLOR (azilsartan/chlorthalidone) EXFORGE (valsartan/amlodipine) EXFORGE HCT (valsartan/amlodipine/HCTZ) HYZAAR (losartan/HCTZ) MICARDIS-HCT (telmisartan/HCTZ) olmesartan/amlodipine/HCTZ telmisartan/amlodipine telmisartan HCTZ	
	DIRECT RENIN INHIBITORS	
	aliskiren TEKTURNA (aliskiren) TEKTURNA HCT (aliskiren/HCTZ)	**Substitute for Class Criteria**: Tekturna requires a thirty (30) day trial of one (1) preferred ACE, ARB, or combination agent, at the maximum tolerable dose, before it will be authorized unless one (1) of the exceptions on the PA form is present. Amturnide, Tekamlo, Tekturna HCT or Valturna will be authorized if the criteria for Tekturna are met and the patient also needs the other agents in the combination.
ANTIANGINAL & ANTI-ISCHEMIC		
CLASS PA CRITERIA: Agents in this class may only be authorized for patients with angina who are also taking a calcium channel blocker, a beta blocker, or a nitrite as single agents or a combination agent containing one (1) of these ingredients.		
ranolazine[AP]	RANEXA	
ANTIBIOTICS, GI & RELATED AGENTS		
CLASS PA CRITERIA: Non-preferred agents require a fourteen (14) day trial of a preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.		
FIRVANQ (vancomycin) metronidazole tablet neomycin tinidazole	DIFICID (fidaxomicin)* FLAGYL (metronidazole) metronidazole capsule paromomycin VANCOCIN (vancomycin) vancomycin XIFAXAN (rifaximin)*	*Full PA criteria may be found on the PA Criteria page by clicking the hyperlink.
ANTIBIOTICS, INHALED		
CLASS PA CRITERIA: Non-preferred agents require a twenty-eight (28) day trial of a preferred agent and documentation of therapeutic failure before they will be approved, unless one (1) of the exceptions on the PA form is present.		
BETHKIS (tobramycin) KITABIS PAK (tobramycin)	CAYSTON (aztreonam) TOBI (tobramycin) TOBI PODHALER (tobramycin) tobramycin	
ANTIBIOTICS, TOPICAL		
CLASS PA CRITERIA: Non-preferred agents require ten (10) day trials of at least one preferred agent, including the generic formulation of the requested non-preferred agent, before they will be approved, unless one (1) of the exceptions on the PA form is present.		

bacitracin (Rx, OTC) gentamicin sulfate mupirocin ointment	CENTANY (mupirocin) CORTISPORIN (bacitracin/neomycin/polymyxin/HC) mupirocin cream neomycin/polymyxin/pramoxine XEPI CREAM (ozenoxacin)	

ANTIBIOTICS, VAGINAL

CLASS PA CRITERIA: Non-preferred agents require trials of each chemically unique preferred agent at the manufacturer's recommended duration, before they will be approved, unless one (1) of the exceptions on the PA form is present.

CLEOCIN OVULE (clindamycin) CLINDESSE (clindamycin) metronidazole gel NUVESSA (metronidazole)	CLEOCIN CREAM (clindamycin) clindamycin cream METROGEL (metronidazole) SOLOSEC (secnidazole) VANDAZOLE (metronidazole)	

ANTICOAGULANTS

CLASS PA CRITERIA: Non-preferred agents require a trial of each preferred agent in the same sub-class, unless one (1) of the exceptions on the PA form is present.

INJECTABLE[CL]		
enoxaparin	ARIXTRA (fondaparinux) fondaparinux FRAGMIN (dalteparin) LOVENOX (enoxaparin)	
ORAL		
ELIQUIS (apixaban) PRADAXA (dabigatran) warfarin XARELTO (rivaroxaban)	SAVAYSA (edoxaban)	

ANTICONVULSANTS

CLASS PA CRITERIA: For a diagnosis of seizure disorder, non-preferred agents require a fourteen (14) day trial of a preferred agent in the same sub-class before they will be approved, unless one (1) of the exceptions on the PA form is present; patients currently on established therapies shall be grandfathered.

For all other diagnoses, non-preferred agents require a thirty (30) day trial of a preferred agent in the same sub-class before they will be approved, unless one (1) of the exceptions on the PA form is present.

In situations where AB-rated generic equivalent products are available, "Brand Medically Necessary" must be hand-written by the prescriber on the prescription for the brand name product to be reimbursed.

ADJUVANTS		
carbamazepine carbamazepine ER divalproex divalproex ER divalproex sprinkle EPITOL (carbamazepine) GABITRIL (tiagabine) lamotrigine levetiracetam IR levetiracetam ER levetiracetam IR suspension oxcarbazepine suspension and tablets TEGRETOL SUSPENSION (carbamazepine) topiramate IR topiramate ER* valproic acid VIMPAT (lacosamide) zonisamide	APTIOM (eslicarbazepine) BANZEL (rufinamide) BRIVIACT (brivaracetam) carbamazepine oral suspension CARBATROL (carbamazepine) DEPAKOTE (divalproex) DEPAKOTE ER (divalproex) DEPAKOTE SPRINKLE (divalproex) DIACOMIT CAPSULE/POWDER PACK (stripentol)** EQUETRO (carbamazepine) felbamate FELBATOL (felbamate) FINTEPLA (fenfluramine) SOLUTION**** FYCOMPA (perampanel) KEPPRA (levetiracetam) KEPPRA SOLUTION (levetiracetam) KEPPRA XR (levetiracetam) LAMICTAL (lamotrigine) LAMICTAL CHEWABLE (lamotrigine) LAMICTAL ODT (lamotrigine) LAMICTAL XR (lamotrigine) lamotrigine dose pack lamotrigine ER lamotrigine ODT OXTELLAR XR (oxcarbazepine) QUDEXY XR (topiramate ER)*** rufinamide oral suspension SABRIL (vigabatrin) SPRITAM (levetiracetam) TEGRETOL TABLETS (carbamazepine) TEGRETOL XR (carbamazepine) tiagabine TOPAMAX (topiramate) TRILEPTAL SUSPENSION and TABLETS (oxcarbazepine) TROKENDI XR (topiramate)*** vigabatrin tablet/powder pack XCOPRI (cenobamate)	*Topiramate ER will be authorized after a thirty (30) day trial of topiramate IR. **Diacomit may only be approved as adjunctive therapy for diagnosis of Dravet Syndrome when prescribed by, or in consultation with, a neurologist AND requires a thirty (30) day trial of valproate and clobazam unless one (1) of the exceptions on the PA form is present. Diacomit must be used concurrently with clobazam. ***Qudexy XR and Trokendi XR are only approvable on appeal. ****Full PA criteria for Fintepla may be found on the PA Criteria page by clicking the hyperlink.
BARBITURATES[AP]		
phenobarbital primidone	MYSOLINE (primidone)	
BENZODIAZEPINES[AP]		
clonazepam diazepam rectal gel diazepam tablets	clobazam* clonazepam ODT DIASTAT (diazepam rectal)	*Onfi shall be authorized as adjunctive therapy for treatment of Lennox-Gastaut Syndrome and Dravet Syndrome without further restrictions. All other indications require an appeal to

NAYZILAM NASAL SPRAY (midazolam) VALTOCO NASAL SPRAY (diazepam)	KLONOPIN (clonazepam) ONFI (clobazam)* ONFI SUSPENSION (clobazam)* SYMPAZAN (clobazam film)*	the Medical Director. NOTE: generic clobazam is preferred over brand ONFI.
	CANNABINOIDS	
	EPIDIOLEX SOLUTION (cannabidiol)*	* Full PA criteria may be found on the PA Criteria page by clicking the hyperlink.
	HYDANTOINS[AP]	
DILANTIN (phenytoin sodium, extended) PEGANONE (ethotoin) phenytoin capsules, chewable tablets, suspension	DILANTIN INFATABS (phenytoin) PHENYTEK (phenytoin)	
	SUCCINIMIDES	
CELONTIN (methsuximide) ethosuximide capsules ethosuximide syrup	ZARONTIN (ethosuximide) capsules ZARONTIN (ethosuximide) syrup	
ANTIDEPRESSANTS, OTHER		
CLASS PA CRITERIA: See below for individual sub-class criteria.		
	MAOIs[AP]	
	MARPLAN (isocarboxazid) NARDIL (phenelzine) phenelzine tranylcypromine	Patients stabilized on MAOI agents will be grandfathered.
	SNRIS[AP]	
duloxetine capulses venlafaxine ER capsules	CYMBALTA (duloxetine) desvenlafaxine ER desvenlafaxine fumarate ER EFFEXOR XR (venlafaxine) FETZIMA (levomilnacipran) PRISTIQ (desvenlafaxine) venlafaxine IR venlafaxine ER tablets (venlafaxine)	Non-preferred agents require separate thirty (30) day trials of a preferred agent in this sub-class **AND** an SSRI before they will be approved, unless one (1) of the exceptions on the PA form is present.
	SECOND GENERATION NON-SSRI, OTHER[AP]	
bupropion IR bupropion SR bupropion XL mirtazapine trazodone	APLENZIN (bupropion hbr) EMSAM (selegiline) FORFIVO XL (bupropion) nefazodone REMERON (mirtazapine) TRINTELLIX (vortioxetine) VIIBRYD (vilazodone HCl) WELLBUTRIN SR (bupropion) WELLBUTRIN XL (bupropion)	Non-preferred agents require separate thirty (30) day trials of a preferred agent in this sub-class **AND** an SSRI before they will be approved, unless one (1) of the exceptions on the PA form is present.
	SELECTED TCAs	

imipramine HCl	imipramine pamoate	Non-preferred agents require a twelve (12) week trial of imipramine HCl before they will be approved, unless one (1) of the exceptions on the PA form is present.
ANTIDEPRESSANTS, SSRIs[AP]		
CLASS PA CRITERIA: Non-preferred agents require thirty (30) day trials of at least two (2) preferred agents before they will be approved, unless one (1) of the exceptions on the PA form is present. Upon hospital discharge, patients admitted with a primary mental health diagnosis who have been stabilized on a non-preferred SSRI will receive an authorization to continue that drug.		
citalopram escitalopram tablets fluoxetine capsules, solution fluvoxamine paroxetine sertraline	BRISDELLE (paroxetine) CELEXA (citalopram) escitalopram solution fluoxetine tablets fluvoxamine ER LEXAPRO (escitalopram) paroxetine 7.5 mg capsules paroxetine ER PAXIL (paroxetine) PAXIL CR (paroxetine) PEXEVA (paroxetine) PROZAC (fluoxetine) SARAFEM (fluoxetine) ZOLOFT (sertraline)	
ANTIEMETICS[AP]		
CLASS PA CRITERIA: See below for sub-class criteria.		
	5HT3 RECEPTOR BLOCKERS	
granisetron ondansetron ODT, solution, tablets	ondansetron vials SANCUSO (granisetron) SUSTOL (granisetron) ZOFRAN (ondansetron) ZUPLENZ (ondansetron)	Non-preferred agents require a three (3) day trial of a preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.
	CANNABINOIDS	
	dronabinol* MARINOL (dronabinol)*	*Dronabinol will only be authorized for: 1. The treatment of anorexia associated with weight loss in patients with AIDS or cancer and unresponsive to megestrol **or** 2. The prophylaxis of chemotherapy induced nausea and vomiting unresponsive to three (3) day trials of ondansetron or promethazine for patients from eighteen (18) up to sixty-five (65) years of age.

SUBSTANCE P ANTAGONISTS		
EMEND (aprepitant)	aprepitant VARUBI (rolapitant)	Non-preferred agents require a three (3) day trial of a preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.
COMBINATIONS		
	AKYNZEO (netupitant/palonosetron) BONJESTA (doxylamine/pyridoxine) DICLEGIS (doxylamine/pyridoxine) doxylamine/pyridoxine (generic Diclegis)	Non-preferred agents will only be approved on appeal.
ANTIFUNGALS, ORAL		
CLASS PA CRITERIA: Non-preferred agents will only be authorized if one (1) of the exceptions on the PA form is present.		
clotrimazole fluconazole* nystatin terbinafine[CL]	ANCOBON (flucytosine) CRESEMBA (isovuconazonium)[CL]** DIFLUCAN (fluconazole) flucytosine griseofulvin*** itraconazole ketoconazole**** MYCELEX (clotrimazole) NOXAFIL (posaconazole) ORAVIG (miconazole) posaconazole tablet SPORANOX (itraconazole) TOLSURA (itraconazole) VFEND (voriconazole) voriconazole suspension voriconazole tablets	*PA is required when limits are exceeded. **Full PA criteria may be found on the PA Criteria page by clicking the hyperlink. ***PA is not required for griseofulvin suspension for children up to eighteen (18) years of age for the treatment of tinea capitis. ****Ketoconazole will be authorized if the following criteria are met: 1. Diagnosis of one of the following fungal infections: blastomycosis, coccidioidomycosis, histoplasmosis, chromomycosis, or paracoccidioidomycosis **and** 2. Documented failure or intolerance of all other diagnosis-appropriate antifungal therapies, i.e. itraconazole, fluconazole, flucytosine, etc **and** 3. Baseline assessment of the liver status including alanine aminotransferase (ALT), aspartate aminotransferase (AST), total bilirubin, alkaline phosphatase, prothrombin time, and international normalized ratio (INR) before starting treatment **and** 4. Weekly monitoring of serum ALT for the duration of treatment (If ALT values increase to a level above the upper limit of normal or 30% above baseline, or if the patient develops symptoms of abnormal liver function, treatment should be interrupted and a full set of liver tests be obtained. Liver tests should be repeated to ensure normalization of values.) **and** 5. Assessment of all concomitant medications for potential adverse drug interactions with ketoconazole. **Ketoconazole will not be authorized for treatment for fungal infections of the skin and nails.**

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ANTIFUNGALS, TOPICAL[AP]

CLASS PA CRITERIA: Non-preferred agents require fourteen (14) day trials of two (2) preferred agents before they will be approved, unless one (1) of the exceptions on the PA form is present. If a non-preferred shampoo is requested, a fourteen (14) day trial of one (1) preferred product (i.e. ketoconazole shampoo) is required.

ANTIFUNGALS		
econazole ketoconazole cream, shampoo MENTAX (butenafine) miconazole (OTC) nystatin	CICLODAN (ciclopirox) ciclopirox ERTACZO (sertaconazole) EXELDERM (sulconazole) EXTINA (ketoconazole) GYNAZOLE 1 CREAM (butoconazole) JUBLIA (efinaconazole) ketoconazole foam KERYDIN (tavaborole) KETODAN (ketoconazole) LOPROX (ciclopirox) LUZU (luliconazole) miconazole/petrolatum/zinc oxide NAFTIN GEL (naftifine) OXISTAT (oxiconazole)* tavaborole 5% topical solution VUSION (miconazole/petrolatum/zinc oxide)	*Oxistat cream will be authorized for children up to thirteen (13) years of age for tinea corporis, tinea cruris, tinea pedis, and tinea (pityriasis) versicolor.
ANTIFUNGAL/STEROID COMBINATIONS		
clotrimazole/betamethasone cream	clotrimazole/betamethasone lotion nystatin/triamcinolone	

ANTIHEMOPHILIA FACTOR AGENTS[CL]

CLASS PA CRITERIA: All agents will require prior-authorization, and non-preferred agents require medical reasoning explaining why the need cannot be met using a preferred product.

All currently established regimens shall be grandfathered with documentation of adherence to therapy.

FACTOR VIII		
ADVATE AFSTYLA ALPHANATE HEMOFIL M HUMATE-P KOATE KOGENATE FS NOVOEIGHT NUWIQ WILATE XYNTHA XYNTHA SOLOFUSE	ADYNOVATE ELOCTATE ESPEROCT JIVI KOVALTRY RECOMBINATE VONVENDI	
FACTOR VII		

	NOVOSEVEN[NR] SEVENFACT[NR]	
FACTOR IX		
ALPHANINE SD ALPROLIX BENEFIX IXINITY MONONINE PROFILNINE RIXUBIS	IDELVION REBINYN	
FACTOR IXa/IX		
	HEMLIBRA (emicizumab-kxwh)*	*Hemlibra shall be approved without further restriction for patients with Hemophilia A with documented presence of Factor VIII inhibitors.
ANTIHYPERTENSIVES, SYMPATHOLYTICS		
CLASS PA CRITERIA: Non-preferred agents require thirty (30) day trials of each preferred unique chemical entity in the corresponding formulation before they will be approved, unless one (1) of the exceptions on the PA form is present.		
CATAPRES-TTS (clonidine) clonidine patch clonidine tablets	CATAPRES TABLETS (clonidine)	
ANTIHYPERURICEMICS		
CLASS PA CRITERIA: Non-preferred agents require a thirty (30) day trial of one (1) of the preferred agents for the prevention of gouty arthritis attacks (colchicine/probenecid, probenecid, or allopurinol) before they will be approved, unless one (1) of the exceptions on the PA form is present.		
ANTIMITOTICS		
COLCRYS (colchicine) tablets	colchicine capsules colchicine tablets MITIGARE (colchicine) GLOPERBA (colchicine)*	In the case of acute gouty attacks, a ten (10) day supply (twenty (20) units) of the preferred agent(s) in this subclass will be authorized per ninety (90) days. *Gloperba may only be authorized for those who are unable to ingest solid dosage forms due to documented oral-motor difficulties or dysphagia.
ANTIMITOTIC-URICOSURIC COMBINATION		
colchicine/probenecid		
URICOSURIC		
probenecid		
XANTHINE OXIDASE INHIBITORS		
allopurinol	febuxostat tablets ULORIC (febuxostat) ZYLOPRIM (allopurinol)	

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ANTIMIGRAINE AGENTS, PROPHYLAXIS[CL]

CLASS PA CRITERIA: All agents require a prior authorization. Full PA criteria may be found on the PA Criteria page by clicking the hyperlink. Non-preferred agents require a 90-day trial of all preferred agents. All currently established regimens may be grandfathered with documentation of efficacy and adherence to therapy.

AIMOVIG (erenumab) AJOVY (fremanezumab)	EMGALITY (galcanezumab) 120mg/mL EMGALITY (galcanezumab) 300mg/3 mL*	*Emgality 300 mg/3 mL requires review by the Medical Director and is available only on appeal.

ANTIMIGRAINE AGENTS, ACUTE[AP]

CLASS PA CRITERIA: Non-preferred agents require three (3) day trials of each preferred unique chemical entity as well as a three (3) day trial using the same route of administration as the requested agent (if available), before they will be approved, unless one (1) of the exceptions on the PA form is present.

TRIPTANS		
naratriptan rizatriptan ODT rizatriptan tablet sumatriptan injection[CL] sumatriptan nasal spray sumatriptan tablets	almotriptan AMERGE (naratriptan) eletriptan FROVA (frovatriptan) frovatriptan IMITREX NASAL SPRAY (sumatriptan) IMITREX tablets (sumatriptan) MAXALT MLT (rizatriptan) MAXALT (rizatriptan) ONZETRA XSAIL (sumatriptan)* RELPAX (eletriptan) TOSYMRA NASAL SPRAY (sumatriptan)* ZEMBRACE SYMTOUCH (sumatriptan) zolmitriptan zolmitriptan ODT ZOMIG (zolmitriptan) ZOMIG ZMT (zolmitriptan)	***In addition to the Class Criteria**: Onzetra Xsail and Tosymra require three (3) day trials of each preferred oral, nasal and injectable forms of sumatriptan.
TRIPTAN COMBINATIONS		
	TREXIMET (sumatriptan/naproxen sodium)	
OTHER		
NURTEC ODT (rimegepant)*	CAMBIA (diclofenac) UBRELVY (ubrogepant)** REYVOW (lasmiditan)**	*Nurtec ODT requires three (3) day trials of two (2) preferred chemically distinct triptans before it may be approved, unless one (1) of the exceptions on the PA form is present. **Ubrelvy and Reyvow require three (3) day trials of two (2) preferred chemically distinct triptans as well as a three (3) day trial of Nurtec ODT before they may be approved, unless one (1) of the exceptions on the PA form is present.

ANTIPARASITICS, TOPICAL[AP]

CLASS PA CRITERIA: Non-preferred agents require trials of each preferred agent (which are age and weight appropriate) before they will be approved, unless one (1) of the exceptions on the PA form is present.

NATROBA (spinosad) permethrin 5% cream pyrethrins-piperonyl butoxide OTC	ELIMITE CREAM (permethrin) EURAX (crotamiton) ivermectin 0.5% lotion LICE EGG REMOVER OTC (benzalkonium chloride) lindane malathion OVIDE (malathion) SKLICE (ivermectin) spinosad VANALICE (piperonyl/pyrethin)	
ANTIPARKINSON'S AGENTS		
CLASS PA CRITERIA: Patients starting therapy on drugs in this class must show a documented allergy to all preferred agents in the corresponding sub-class, before a non-preferred agent will be authorized.		
ANTICHOLINERGICS		
benztropine trihexyphenidyl		
COMT INHIBITORS		
entacapone	COMTAN (entacapone) ONGENTYS (opicapone) TASMAR (tolcapone) tolcapone	COMT Inhibitor agents will only be approved as add-on therapy to a levodopa-containing regimen for treatment of documented motor complications.
DOPAMINE AGONISTS		
APOKYN (apomorphine) PEN bromocriptine pramipexole ropinirole	KYNMOBI (apomorphine) FILM MIRAPEX ER (pramipexole)* NEUPRO (rotigotine) pramipexole ER ropinirole ER	*Mirapex ER will be authorized for a diagnosis of Parkinsonism without a trial of preferred agents.
OTHER ANTIPARKINSON'S AGENTS		
amantadine*AP carbidopa/levodopa levodopa/carbidopa/entacapone selegiline	AZILECT (rasagiline) carbidopa GOCOVRI ER (amantadine) INBRIJA (levodopa) levodopa/carbidopa ODT LODOSYN (carbidopa) NOURIANZ (istradefylline) OSMOLEX ER (amantadine) PARLODEL (bromocriptine) rasagiline RYTARY (levodopa/carbidopa) SINEMET (levodopa/carbidopa) STALEVO (levodopa/carbidopa/entacapone) XADAGO (safinamide) ZELAPAR (selegiline)	*Amantadine will not be authorized for the treatment or prophylaxis of influenza.

ANTIPSORIATICS, TOPICAL

CLASS PA CRITERIA: Non-preferred agents require thirty (30) day trials of two (2) preferred unique chemical entities before they will be approved, unless one (1) of the exceptions on the PA form is present.

TACLONEX (calcipotriene/ betamethasone) VECTICAL (calcitriol)	calcipotriene cream calcipotriene ointment calcipotriene solution calcipotriene/betamethasone ointment, suspension calcitriol DOVONEX (calcipotriene) ENSTILAR (calcipotriene/betamethasone) SORILUX (calcipotriene) tazarotene cream	

ANTIPSYCHOTICS, ATYPICAL

CLASS PA CRITERIA: All antipsychotic agents require prior authorization for children up to eighteen (18) years of age. All PA requests for antipsychotics for children 6 years of age and younger will be reviewed by Medicaid's consultant psychiatrist.

Non-preferred agents require thirty (30) day trials of two (2) preferred agents, including the generic formulation of the requested agent (if available), before they will be approved unless one (1) of the exceptions on the PA form is present. All trials must be at the maximum recommended dose for the diagnosis provided before they would be considered a failure unless an adverse reaction is documented necessitating a change in therapy.

Patients shall be grandfathered onto their existing therapy, provided the requested agent is being used according to the manufacturer label. Continuation of therapy for an off-label indication or non-standard dosage may be granted a thirty (30) day prior-authorization while the Medical Director reviews the request.

SINGLE INGREDIENT

ABILIFY MAINTENA (aripiprazole)[CL] aripiprazole tablets ARISTADA (aripiprazole)[CL] ARISTADA INITIO (aripiprazole)[CL] clozapine INVEGA SUSTENNA (paliperidone)[CL] INVEGA TRINZA (paliperidone)* [CL] olanzapine olanzapine ODT PERSERIS (risperidone)[CL] quetiapine ER	ABILIFY MYCITE (aripiprazole) ABILIFY TABLETS (aripiprazole) ADASUVE (loxapine) aripiprazole solution asenapine sublingual tablets CAPLYTA (lumateperone) clozapine ODT CLOZARIL (clozapine) FANAPT (iloperidone) GEODON (ziprasidone) GEODON IM (ziprasidone)	**The following criteria exceptions apply to the specified products:** *Invega Trinza will be authorized after four months' treatment with Invega Sustenna **Quetiapine 25 mg will be authorized: 1. For a diagnosis of schizophrenia **or** 2. For a diagnosis of bipolar disorder **or** 3. When prescribed concurrently with other strengths of Seroquel in order to achieve therapeutic treatment levels.

BUREAU FOR MEDICAL SERVICES
WEST VIRGINIA MEDICAID
PREFERRED DRUG LIST WITH PRIOR AUTHORIZATION CRITERIA
This is not an all-inclusive list of available covered drugs and includes only managed categories. Refer to cover page for complete list of rules governing this PDL.

EFFECTIVE
07/01/2021
Version 2021.3b

quetiapine** AP for the 25 mg Tablet Only RISPERDAL CONSTA (risperidone)CL risperidone ODT risperidone solution, tablet ziprasidone ZYPREXA RELPREVV (olanzapine)	INVEGA ER (paliperidone) LATUDA (lurasidone)*** NUPLAZID (pimavanserin) **** olanzapine IMCL paliperidone ER REXULTI (brexipiprazole) RISPERDAL (risperidone) SAPHRIS (asenapine) SECUADO (asenapine) SEROQUEL (quetiapine) SEROQUEL XR (quetiapine) VERSACLOZ (clozapine) VRAYLAR (capriprazine)***** VRAYLAR DOSE PAK (capriprazine)***** ZYPREXA (olanzapine) ZYPREXA IM (olanzapine)CL	**Quetiapine 25 mg will not be authorized for use as a sedative hypnotic.** *** Latuda will be be authorized for the indication of Bipolar Depression with documentation of the diagnosis. All other indications require class criteria to be followed. ****Nuplazid may only be authorized for the treatment of Parkinson Disease Induced Psychosis after documented treatment failure with quetiapine. ***** Vraylar may be authorized for the indication of Bipolar Depression only after failure of a 30-day trial of Latuda and a 30-day trial of either quetiapine OR a combination of olanzapine + fluoxetine. All other indications require class criteria to be followed.
ATYPICAL ANTIPSYCHOTIC/SSRI COMBINATIONS		
	olanzapine/fluoxetine	

ANTIRETROVIRALS[AP]

CLASS PA CRITERIA: Non-preferred drugs require medical reasoning beyond convenience or enhanced compliance as to why the clinical need cannot be met with a preferred agent or combination of preferred agents. NOTE: Regimens consisting of preferred agents will result in no more than one additional unit per day over equivalent regimens composed of non-preferred agents. Patients already on a non-preferred regimen shall be grandfathered.

SINGLE TABLET REGIMENS		
BIKTARVY (bictegravir/emtricitabine/ tenofovir alafenamide) COMPLERA (emtricitabine/rilpivirine/tenofovir) DELSTRIGO (doravirine/lamivudine/ tenofovir df) GENVOYA (elvitegravir/cobicistat/ emtricitabine/tenofovir) ODEFSEY (emtricitabine/rilpivirine/tenofovir) SYMFI (efavirenz/lamivudine/tenofovir) SYMFI LO (efavirenz/lamivudine/tenofovir)	ATRIPLA (efavirenz/emtricitabine/tenofovir) DOVATO (dolutegravir/lamivudine) efavirenz/emtricitabine/tenofovir JULUCA (dolutegravir/rilpivirine) SYMTUZA (darunavir/cobicistat/ emtricitabine/tenofovir alafenamide) STRIBILD (elvitegravir/cobicistat/ emtricitabine/tenofovir)* TRIUMEQ (abacavir/lamivudine/ dolutegravir)**	*Stribild requires medical reasoning beyond convenience or enhanced compliance as to why the medical need cannot be met with the the preferred agent Genvoya. **Triumeq requires medical reasoning beyond convenience or enhanced compliance as to why the medical need cannot be met with the preferred agents Epzicom and Tivicay.
INTEGRASE STRAND TRANSFER INHIBITORS		
ISENTRESS (raltegravir potassium) TIVICAY (dolutegravir sodium) TIVICAY PD (dolutegravir sodium)	ISENTRESS HD (raltegravir potassium)	
NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS (NRTI)		
abacavir sulfate tablet EMTRIVA (emtricitabine) EPIVIR SOLUTION (lamivudine) lamivudine	abacavir sulfate solution didanosine DR capsule emtricitabine capsule EPIVIR TABLET (lamivudine)	

tenofovir disoproxil fumarate VIREAD ORAL POWDER (tenofovir disoproxil fumarate) ZIAGEN SOLUTION (abacavir sulfate) zidovudine	RETROVIR (zidovudine) stavudine VIDEX EC (didanosine) VIDEX SOLUTION (didanosine) VIREAD TABLETS (tenofovir disoproxil fumarate) ZIAGEN TABLET (abacavir sulfate)	
NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITOR (NNRTI)		
SUSTIVA (efavirenz)	EDURANT (rilpivirine) efavirenz etravirine INTELENCE (etravirine) nevirapine nevirapine ER PIFELTRO (doravirine) VIRAMUNE ER 24H (nevirapine) VIRAMUNE SUSPENSION (nevirapine)	
PHARMACOENHANCER – CYTOCHROME P450 INHIBITOR		
TYBOST (cobicistat)		
PROTEASE INHIBITORS (PEPTIDIC)		
atazanavir EVOTAZ (atazanavir/cobicistat) NORVIR (ritonavir) REYATAZ POWDER PACK (atazanavir)	fosamprenavir LEXIVA (fosamprenavir) REYATAZ CAPSULE (atazanavir) ritonavir tablet VIRACEPT (nelfinavir mesylate)	
PROTEASE INHIBITORS (NON-PEPTIDIC)		
PREZCOBIX (darunavir/cobicistat) PREZISTA (darunavir ethanolate)	APTIVUS (tipranavir)	
ENTRY INHIBITORS – CCR5 CO-RECEPTOR ANTAGONISTS		
	SELZENTRY (maraviroc)	
ENTRY INHIBITORS – FUSION INHIBITORS		
	FUZEON (enfuvirtide)	
COMBINATION PRODUCTS – NRTIs		
abacavir/lamivudine CIMDUO (lamivudine/tenofovir) lamivudine/zidovudine	abacavir/lamivudine/zidovudine COMBIVIR (lamivudine/zidovudine) EPZICOM (abacavir/lamivudine) TEMIXYS (lamivudine/tenofovir) TRIZIVIR (abacavir/lamivudine/zidovudine)	
COMBINATION PRODUCTS – NUCLEOSIDE & NUCLEOTIDE ANALOG RTIs		
DESCOVY (emtricitabine/tenofovir)	TRUVADA (emtricitabine/tenofovir)* emtricitabine/tenofovir	*Truvada shall be treated as preferred when prescribed for PrEP in members assigned female at birth. Truvada may also be approved over Descovy where guidelines clearly indicate superiority over Descovy (documentation may be required to support the request for PA).
COMBINATION PRODUCTS – PROTEASE INHIBITORS		
KALETRA (lopinavir/ritonavir)	lopinavir/ritonavir	

GP 120 DIRECTED ATTACHMENT INHIBITORS		
RUKOBIA (fostemsavir tromethamine) TABLETS		
ANTIVIRALS, ORAL		
CLASS PA CRITERIA: Non-preferred agents require five (5) day trials of each preferred agent in the same sub-class before they will be approved, unless one (1) of the exceptions on the PA form is present.		
ANTI HERPES		
acyclovir valacyclovir	famciclovir SITAVIG (acyclovir) VALTREX (valacyclovir) ZOVIRAX (acyclovir)	
ANTI-INFLUENZA		
oseltamivir RELENZA (zanamivir) TAMIFLU (oseltamivir)	FLUMADINE (rimantadine) rimantadine XOFLUZA (baloxavir)	**In addition to the Class Criteria**: The anti-influenza agents will be authorized only for a diagnosis of influenza.
ANTIVIRALS, TOPICAL[AP]		
CLASS PA CRITERIA: Non-preferred agents require a five (5) day trial of the preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.		
ZOVIRAX CREAM (acyclovir) ZOVIRAX OINTMENT (acyclovir)	acyclovir ointment docosanol cream DENAVIR (penciclovir)	
BETA BLOCKERS[AP]		
CLASS PA CRITERIA: Non-preferred agents require fourteen (14) day trials of three (3) chemically distinct preferred agents, including the generic formulation of the requested non-preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.		
BETA BLOCKERS		
acebutolol atenolol betaxolol bisoprolol CORGARD (nadolol) metoprolol metoprolol ER pindolol propranolol SORINE (sotalol) sotalol timolol	BETAPACE (sotalol) BYSTOLIC (nebivolol) HEMANGEOL (propranolol)* INDERAL LA (propranolol) INDERAL XL (propranolol) INNOPRAN XL (propranolol) KAPSPARGO SPRINKLE (metoprolol) LOPRESSOR (metoprolol) nadolol propranolol ER** TENORMIN (atenolol) TOPROL XL (metoprolol)	*Hemangeol will be authorized for the treatment of proliferating infantile hemangioma requiring systemic therapy. **Propranolol ER shall be authorized for patients with a diagnosis of migraines. Existing users will be grandfathered for use in migraine prophylaxis.
BETA BLOCKER/DIURETIC COMBINATION DRUGS		
atenolol/chlorthalidone bisoprolol/HCTZ metoprolol/HCTZ propranolol/HCTZ	nadolol/bendroflumethiazide TENORETIC (atenolol/chlorthalidone) ZIAC (bisoprolol/HCTZ)	
BETA- AND ALPHA-BLOCKERS		

carvedilol labetalol	COREG (carvedilol) COREG CR (carvedilol)	
BLADDER RELAXANT PREPARATIONS[AP]		
CLASS PA CRITERIA: Non-preferred agents require thirty (30) day trials of each chemically distinct preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present		
GELNIQUE (oxybutynin) oxybutynin IR oxybutynin ER solifenacin TOVIAZ (fesoterodine)	darifenacin ER tablet DETROL (tolterodine) DITROPAN XL (oxybutynin) ENABLEX (darifenacin) flavoxate GEMTESA (vibegron)[NR] MYRBETRIQ (mirabegron) OXYTROL (oxybutynin) tolterodine tolterodine ER trospium trospium ER VESICARE (solifenacin)	
BONE RESORPTION SUPPRESSION AND RELATED AGENTS		
CLASS PA CRITERIA: See below for class criteria.		
BISPHOSPHONATES		
alendronate tablets ibandronate	ACTONEL (risedronate) alendronate solution ATELVIA (risedronate) BINOSTO (alendronate) BONIVA (ibandronate) FOSAMAX TABLETS (alendronate) FOSAMAX PLUS D (alendronate/vitamin D) Risedronate	Non-preferred agents require thirty (30) day trials of **each** preferred Bisphosphonate agent before they will be approved, unless one (1) of the exceptions on the PA form is present.
OTHER BONE RESORPTION SUPPRESSION AND RELATED AGENTS		
	calcitonin EVISTA (raloxifene)* FORTEO (teriparatide) MIACALCIN (calcitonin) raloxifene* teriparatide TYMLOS (abaloparatide)	Non-preferred agents require a thirty (30) day trial of a preferred Bisphosphonate agent before they will be approved, unless one (1) of the exceptions on the PA form is present. *Raloxifene will be authorized for postmenopausal women with osteoporosis who are at high risk for invasive breast cancer.

BPH TREATMENTS

CLASS PA CRITERIA: Non-preferred agents require thirty (30) day trials of at least two (2) chemically distinct preferred agents, including the generic formulation of the requested non-preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.

5-ALPHA-REDUCTASE (5AR) INHIBITORS AND PDE-5 AGENTS		
finasteride	AVODART (dutasteride) CIALIS 5 mg (tadalafil) dutasteride PROSCAR (finasteride)	
ALPHA BLOCKERS		
alfuzosin doxazosin tamsulosin terazosin	CARDURA (doxazosin) CARDURA XL (doxazosin) FLOMAX (tamsulosin) RAPAFLO (silodosin) silodosin	
5-ALPHA-REDUCTASE (5AR) INHIBITORS/ALPHA BLOCKER COMBINATION		
	dutasteride/tamsulosin JALYN (dutasteride/tamsulosin)	**Substitute for Class Criteria**: Concurrent thirty (30) day trials of dutasteride and tamsulosin are required before the non-preferred agent will be authorized.

BRONCHODILATORS, BETA AGONIST[AP]

CLASS PA CRITERIA: Non-preferred agents require thirty (30) day trials of each chemically distinct preferred agent in their corresponding sub-class unless one (1) of the exceptions on the PA form is present.

INHALATION SOLUTION		
albuterol	BROVANA (arformoterol) levalbuterol metaproterenol PERFOROMIST (formoterol) XOPENEX (levalbuterol)*	*Xopenex Inhalation Solution will be authorized for twelve (12) months for a diagnosis of asthma or COPD for patients on concurrent asthma controller therapy (either oral or inhaled) with documentation of failure on a trial of albuterol or documented intolerance of albuterol, or for concurrent diagnosis of heart disease.
INHALERS, LONG-ACTING		
SEREVENT (salmeterol)	STRIVERDI RESPIMAT (olodaterol)	
INHALERS, SHORT-ACTING		
PROAIR HFA (albuterol) PROAIR RESPICLICK (albuterol) VENTOLIN HFA (albuterol)	albuterol HFA PROAIR DIGIHALER (albuterol) PROVENTIL HFA (albuterol) XOPENEX HFA (levalbuterol)	
ORAL		
	albuterol ER albuterol IR metaproterenol terbutaline	

CALCIUM CHANNEL BLOCKERS[AP]

CLASS PA CRITERIA: Non-preferred agents require fourteen (14) day trials of each preferred agent within the corresponding sub-class before they will be approved, unless one (1) of the exceptions on the PA form is present.

LONG-ACTING		
amlodipine diltiazem ER felodipine ER nifedipine ER verapamil ER	ADALAT CC (nifedipine) CALAN SR (verapamil) CARDIZEM CD, LA (diltiazem) diltiazem LA KATERZIA SUSPENSION (amlodipine)* MATZIM LA (diltiazem) nisoldipine NORVASC (amlodipine) PROCARDIA XL (nifedipine) SULAR (nisoldipine) TIAZAC (diltiazem) verapamil ER PM VERELAN/VERELAN PM (verapamil)	*Katerzia will be authorized for children who are 6-10 years of age who are unable to ingest solid dosage forms. Katerzia may also be authorized for older patients with clinical documentation indicating oral-motor difficulties or dysphagia.
SHORT-ACTING		
diltiazem verapamil	CARDIZEM (diltiazem) isradipine nicardipine nifedipine nimodipine NYMALIZE SOLUTION (nimodipine) PROCARDIA (nifedipine)	

CEPHALOSPORINS AND RELATED ANTIBIOTICS

CLASS PA CRITERIA: Non-preferred agents require a five (5) day trial of a preferred agent within the corresponding sub-class before they will be approved, unless one (1) of the exceptions on the PA form is present.

BETA LACTAMS AND BETA LACTAM/BETA-LACTAMASE INHIBITOR COMBINATIONS		
amoxicillin/clavulanate IR	amoxicillin/clavulanate ER AUGMENTIN (amoxicillin/clavulanate)	
CEPHALOSPORINS		
cefaclor capsule cefadroxil capsule, tablet cefdinir cefuroxime tablet cephalexin capsule, suspension	cefaclor suspension cefaclor ER tablet cefadroxil suspension cefixime cefpodoxime cefprozil cefuroxime suspension cephalexin tablet KEFLEX (cephalexin) SUPRAX (cefixime)	

COPD AGENTS

CLASS PA CRITERIA: Non-preferred agents require a sixty (60) day trial of one preferred agent from the corresponding sub-class before they will be approved, unless one (1) of the exceptions on the PA form is present.

ANTICHOLINERGIC[AP]		
ATROVENT HFA (ipratropium) ipratropium nebulizer solution SPIRIVA (tiotropium) SPIRIVA RESPIMAT (tiotropium) TUDORZA (aclidinium)	INCRUSE ELLIPTA (umeclidinium) LONHALA MAGNAIR (glycopyrrolate) YUPELRI SOLUTION (revefenacin)	
ANTICHOLINERGIC-BETA AGONIST COMBINATIONS[AP]		
ANORO ELLIPTA (umeclidinium/vilanterol) albuterol/ipratropium nebulizer solution BEVESPI (glycopyrrolate/formoterol) COMBIVENT RESPIMAT (albuterol/ipratropium)	DUAKLIR PRESSAIR (aclidinium/formoterol)* STIOLTO RESPIMAT (tiotropium/olodaterol)**	*In addition to the Class PA criteria, Duaklir Pressair requires sixty (60) day trials of each long acting preferred agent, as well as a 60-day trial of Stiolto Respimat. **In addition to the Class PA criteria, Stiolto Respimat requires a sixty (60) day trial of a long acting preferred agent.
ANTICHOLINERGIC-BETA AGONIST-GLUCOCORTICOID COMBINATIONS		
	TRELEGY ELLIPTA (fluticasone/umeclidinium/vilanterol)* BREZTRI AEROSPHERE (budesonide/glycopyrrolate/formoterol)**	* Trelegy Ellipta may be prior authorized for patients currently established on the individual components for at least 30 days. **Breztri may be prior authorized for patients currently established on the individual components for at least 30 days.
PDE4 INHIBITOR		
	DALIRESP (roflumilast)*	*Daliresp will be authorized if the following criteria are met: 1. Patient is forty (40) years of age or older **and** 2. Diagnosis of severe chronic obstructive pulmonary disease (COPD) associated with chronic bronchitis and multiple exacerbations requiring systemic glucocorticoids in the preceding six (6) months **and** 3. Concurrent therapy with an inhaled corticosteroid and long-acting bronchodilator and evidence of compliance **and** 4. No evidence of moderate to severe liver impairment (Child-Pugh Class B or C) **and** 5. No concurrent use with strong cytochrome P450 inducers (rifampicin, phenobarbital, carbamazepine or phenytoin)

CROHNS DISEASE ORAL STEROIDS

ORAL		
budesonide ER capsule (generic Entocort EC)	ENTOCORT EC (budesonide)* ORTIKOS (budesonide)*	*Please see the following PDL classes for PDL status of additional agents used for induction and remission (Cytokine and CAM Antagonists/ Immunosuppressives, Oral/ Ulcerative Colitis Agents)

		*Entocort EC and Ortikos may only be authorized if the patient has a documented allergy or intolerance to the generic budesonide 3mg 24-hour capsules.
CYTOKINE & CAM ANTAGONISTS[CL]		
CLASS PA CRITERIA: Non-preferred agents require ninety (90) day trials of all preferred agents which are indicated for the diagnosis, unless one (1) of the exceptions on the PA form is present. *Patients stabilized for at least 6-months on their existing non-preferred regimen shall be grandfathered (provided the current therapy is for a labeled indication). All off-label requests require review by the Medical Director.*		
ANTI-TNFs		
ENBREL (etanercept)* HUMIRA (adalimumab)*	CIMZIA (certolizumab pegol) REMICADE (infliximab) RENFLEXIS (infliximab) SIMPONI subcutaneous (golimumab)	*Full PA criteria may be found on the PA Criteria page by clicking the hyperlink.
OTHERS		
TALTZ (ixekizumab)* XELJANZ (tofacitinib)**	ACTEMRA subcutaneous (tocilizumab) COSENTYX (secukinumab) ENTYVIO (vedolizumab) ILARIS (canakinumab) ILUMYA (tildrakizumab) KEVZARA (sarilumab) KINERET (anakinra) OLUMIANT (baricitinib) ORENCIA subcutaneous (abatacept) OTEZLA (apremilast) RINVOQ ER (upadacitinib) SILIQ (brodalumab) SKYRIZI (risankizumab) STELARA subcutaneous (ustekinumab) TREMFYA (guselkumab) XELJANZ XR (tofacitinib)	*Taltz will be authorized for treatment of plaque psoriasis, psoriatic arthritis, and ankylosing spondylitis only after inadequate response to a ninety (90) day trial of one preferred agent. **Xeljanz will only be preferred for the treatment of rheumatoid arthritis and ulcerative colitis. For all other indications it is non preferred. Full PA criteria may be found on the PA Criteria page by clicking the hyperlink.
EPINEPHRINE, SELF-INJECTED		
CLASS PA CRITERIA: A non-preferred agent may be authorized with documentation showing the patient's inability to follow the instructions, or the patient's failure to understand the training for the preferred agent(s).		
epinephrine (labeler 49502 only)	epinephrine (all labelers except 49502) EPIPEN (epinephrine) EPIPEN JR (epinephrine) SYMJEPI (epinephrine)	
ERYTHROPOIESIS STIMULATING PROTEINS[CL]		
CLASS PA CRITERIA: Non-preferred agents require a thirty (30) day trial of a preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.		

EPOGEN (rHuEPO) RETACRIT (epoetin alfa)	ARANESP (darbepoetin) MIRCERA (methoxy PEG-epoetin) PROCRIT (rHuEPO)	Erythropoiesis agents will be authorized if the following criteria are met: 1. Hemoglobin or Hematocrit less than 10/30 respectively. For renewal, hemoglobin or hematocrit levels greater than 12/36 will require dosage reduction or discontinuation. Exceptions will be considered on an individual basis after medical documentation is reviewed. (Lab oratory values must be dated within six (6) weeks of request.) **and** 2. Transferrin saturation ≥ 20%, ferritin levels ≥100 mg/ml, or on concurrent therapeutic iron therapy. (Laboratory values must be dated within three (3) weeks of request. For re-authorization, transferrin saturation or ferritin levels are not required if the patient has been responsive to the erythropoietin agent **and** 3. For HIV-infected patients, endogenous serum erythropoietin level must be ≤ 500mU/ml to initiate therapy **and** 4. No evidence of untreated GI bleeding, hemolysis, or Vitamin B-12, iron or folate deficiency.
FLUOROQUINOLONES (Oral)[AP]		
CLASS PA CRITERIA: Non-preferred agents require a five (5) day trial of a preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.		
CIPRO SUSPENSION (ciprofloxacin) ciprofloxacin levofloxacin tablet	BAXDELA (delafloxacin) CIPRO TABLETS (ciprofloxacin) ciprofloxacin suspension levofloxacin solution moxifloxacin ofloxacin	
GLUCOCORTICOIDS, INHALED[AP]		
CLASS PA CRITERIA: Non-preferred agents require thirty (30) day trials of each chemically unique preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.		
GLUCOCORTICOIDS		

ASMANEX TWISTHALER (mometasone) budesonide nebulizer 0.5 mg/2 ml & 0.25 mg/2 ml solution* FLOVENT DISKUS (fluticasone) FLOVENT HFA (fluticasone) PULMICORT FLEXHALER (budesonide)	ARMONAIR DIGIHALER (fluticasone) ALVESCO (ciclesonide) ARNUITY ELLIPTA (fluticasone) ASMANEX HFA (mometasone) budesonide nebulizer 1 mg/2ml solution PULMICORT NEBULIZER SOLUTION (budesonide) QVAR REDIHALER (beclomethasone)	*Budesonide Respules are only preferred for children up to nine (9) years of age. For patients nine (9) and older, prior authorization is required and will be approved only for a diagnosis of severe nasal polyps.
GLUCOCORTICOID/BRONCHODILATOR COMBINATIONS		
ADVAIR DISKUS (fluticasone/salmeterol) ADVAIR HFA (fluticasone/salmeterol) DULERA (mometasone/formoterol) SYMBICORT(budesonide/formoterol)	AIRDUO DIGIHALER (fluticasone/salmeterol) AIRDUO RESPICLICK (fluticasone/salmeterol) budesonide/formoterol BREO ELLIPTA (fluticasone/vilanterol) fluticasone/salmeterol WIXELA (fluticasone/salmeterol)	
GUANYLATE CYCLASE STIMULATORS[CL]		
	ADEMPAS (riociguat)* VERQUVO (vericiguat)**	*Adempas requires a thirty (30) day trial of a preferred agent from any other PAH Class before it may be approved, unless one (1) of the exceptions on the PA form is present. **Full PA criteria for Verquvo may be found on the PA Criteria page by clicking the hyperlink.
GROWTH HORMONE[CL]		
CLASS PA CRITERIA: Non-preferred agents require three (3) month trials of each preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.		
GENOTROPIN (somatropin) NORDITROPIN (somatropin)	INCRELEX (mecasermin) NUTROPIN AQ (somatropin) OMNITROPE (somatropin) SAIZEN (somatropin) SEROSTIM (somatropin) ZOMACTON (somatropin) ZORBTIVE (somatropin)	Patients already on a non-preferred agent will receive authorization to continue therapy on that agent for the duration of the existing PA.
***H. PYLORI* TREATMENT**		
CLASS PA CRITERIA: Non-preferred agents require a trial of the combination of individual preferred components of the requested non-preferred agent and must be used at the recommended dosages, frequencies and duration of the non-preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.		

Please use individual components: preferred PPI (omeprazole or pantoprazole) amoxicillin tetracycline metronidazole clarithromycin bismuth PYLERA (bismuth/metronidazole/tetracycline)	HELIDAC (bismuth/metronidazole/tetracycline) lansoprazole/amoxicillin/clarithromycin OMECLAMOX-PAK (omeprazole/amoxicillin/clarithromycin) TALICIA (omeprazole/amoxicillin/rifabutin)	
HEPATITIS B TREATMENTS		
CLASS PA CRITERIA: Non-preferred agents require ninety (90) day trials of each preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.		
BARACLUDE SOLUTION (entecavir) * entecavir lamivudine HBV	adefovir BARACLUDE TABLET (entecavir) EPIVIR HBV (lamivudine) HEPSERA (adefovir) VEMLIDY (tenofovir alafenamide fumarate)	*Baraclude solution will be authorized only for patients with documentation of dysphagia.
HEPATITIS C TREATMENTS[CL]		
CLASS PA CRITERIA: For patients starting therapy in this class, preferred regimens may be found on the PA Criteria page. Requests for non-preferred regimens require medical reasoning why a preferred regimen cannot be used.		
MAVYRET (pibrentasvir/glecaprevir)* ribavirin sofosbuvir/velpatasvir (labeler 72626)* ZEPATIER (elbasvir/grazoprevir)*	EPCLUSA (sofosbuvir/velpatasvir)* HARVONI (ledipasvir/sofosbuvir)* ledipasvir/sofosbuvir* PEGASYS (pegylated interferon) PEG-INTRON (pegylated interferon) RIBASPHERE RIBAPAK (ribavirin) RIBASPHERE 400 mg, 600 mg (ribavirin) SOVALDI (sofosbuvir)* VIEKIRA XR (dasabuvir/ombitasvir/ paritaprevir/ritonavir)* VOSEVI (sofosbuvir/velpatasvir/voxilaprevir)	*Full PA criteria may be found on the PA Criteria page by clicking the hyperlink.
HYPERPARATHYROID AGENTS[AP]		
CLASS PA CRITERIA: Non-preferred agents require thirty (30) day trials of each preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.		
paricalcitol capsule	cinacalcet doxercalciferol HECTOROL (doxercalciferol) paricalcitol injection RAYALDEE (calcifediol) SENSIPAR (cinacalcet) ZEMPLAR (paricalcitol)	

HYPOGLYCEMICS, BIGUANIDES

CLASS PA CRITERIA: Non-preferred agents require a ninety (90) day trial of a preferred agent of similar duration before they will be approved, unless one (1) of the exceptions on the PA form is present.

metformin metformin ER (generic Glucophage XR)	FORTAMET (metformin ER) GLUCOPHAGE XR (metformin ER) GLUMETZA (metformin ER)* metformin solution (generic Riomet) metformin ER (generic Glumetza & Fortamet) RIOMET (metformin)	*Glumetza will be approved only after a 30-day trial of Fortamet.

HYPOGLYCEMICS, DPP-4 INHIBITORS

CLASS PA CRITERIA: Non-preferred agents are available only on appeal.

NOTE: DPP-4 inhibitors will NOT be approved in combination with a GLP-1 agonist.

JANUMET (sitagliptin/metformin) JANUMET XR (sitagliptin/metformin) JANUVIA (sitagliptin) JENTADUETO (linagliptin/metformin) TRADJENTA (linagliptin)	alogliptin alogliptin/metformin alogliptin/pioglitazone JENTADUETO XR (linagliptin/metformin) KAZANO (alogliptin/metformin) KOMBIGLYZE XR (saxagliptin/metformin) NESINA (alogliptin) ONGLYZA (saxagliptin) OSENI (alogliptin/pioglitazone)	

HYPOGLYCEMICS, GLP-1 AGONISTS[CL]

CLASS PA CRITERIA: Non-preferred agents will only be approved (in 6-month intervals) if ALL of the following criteria has been met:

1) Current A1C must be submitted. Agents in this class will not be approved for patients with a starting A1C of less than (<) 7%.
2) Documentation demonstrating 90 days of compliance on all current diabetic therapies is provided.
3) Documentation demonstrating treatment failure with all unique preferred agents in the same class.

Re-authorizations will require documentation of continued compliance on all diabetic therapies and A1C levels must reach goal, (either an A1C of ≤8%, or demonstrated continued improvement).

NOTE: GLP-1 agents will NOT be approved in combination with a DPP-4 inhibitor.

OZEMPIC (semaglutide) TRULICITY (dulaglutide) VICTOZA (liraglutide)	ADLYXIN (lixisenatide) BYETTA (exenatide) BYDUREON BCISE (exenatide) RYBELSUS (semaglutide)	

HYPOGLYCEMICS, INSULIN AND RELATED AGENTS

CLASS PA CRITERIA: Non-preferred agents require a ninety (90) day trial of a pharmacokinetically similar agent before they will be approved, unless one (1) of the exceptions on the PA form is present.

APIDRA (insulin gluisine)[AP]* FIASP (insulin aspart) HUMALOG (insulin lispro) HUMALOG JR KWIKPEN (insulin lispro) HUMALOG KWIKPEN U-100 (insulin lispro) HUMALOG MIX PENS (insulin lispro/lispro protamine) HUMALOG MIX VIALS (insulin lispro/lispro protamine) HUMULIN N VIAL (insulin) HUMULIN R U-500 VIAL (insulin) HUMULIN R U-500 KWIKPEN (insulin) LANTUS (insulin glargine) LEVEMIR (insulin detemir) NOVOLOG (insulin aspart) NOVOLOG MIX (insulin aspart/aspart protamine) TOUJEO SOLOSTAR (insulin glargine) TOUJEO MAX SOLOSTAR (insulin glargine	ADMELOG (insulin lispro) AFREZZA (insulin)[CL] BASAGLAR (insulin glargine) HUMALOG KWIKPEN U-200 (insulin lispro) HUMULIN PENS (insulin) HUMULIN R VIAL (insulin) HUMULIN 70/30 (insulin) insulin aspart insulin aspart/aspart protamine insulin lispro LYUMJEV (insulin lispro) NOVOLIN (insulin) SEMGLEE (insulin glargine) SOLIQUA (insulin glargine/lixisenatide)** TRESIBA (insulin degludec)*** TRESIBA FLEXTOUCH (insulin degludec)*** XULTOPHY (insulin degludec/liraglutide)**	*Apidra will be authorized if the following criteria are met: 1. Patient is four (4) years of age or older; **and** 2. Patient is currently on a regimen including a longer acting or basal insulin, **and** 3. Patient has had a trial of a similar preferred agent, Novolog or Humalog, with documentation that the desired results were not achieved.. ** Non-preferred insulin combination products require that the patient must already be established on the individual agents at doses not exceeding the maximum dose achievable with the combination product, and require medical reasoning beyond convenience or enhanced compliance as to why the clinical need cannot be met with a combination of preferred single-ingredient agents. ***Patients stabilized on Tresiba may be grandfathered at the request of the prescriber, if the prescriber considers the preferred products to be clinically inappropriate. ***Tresiba U-100 may be approved only for: Patients who have demonstrated at least a 6-month history of compliance on a preferred long-acting insulin and who continue to have regular incidents of hypoglycemia. ***Tresiba U-200 may be approved only for: Patients who require once-daily doses of at least 60 units of long-acting insulin and have demonstrated at least a 6-month history of compliance on preferred long-acting insulin and who continue to have regular incidents of hypoglycemia.
HYPOGLYCEMICS, MEGLITINIDES **CLASS PA CRITERIA: Non-preferred agents are available only on appeal.**		
MEGLITINIDES		
nateglinide repaglinide	PRANDIN (repaglinide) STARLIX (nateglinide)	
MEGLITINIDE COMBINATIONS		
	repaglinide/metformin	

BUREAU FOR MEDICAL SERVICES
WEST VIRGINIA MEDICAID
PREFERRED DRUG LIST WITH PRIOR AUTHORIZATION CRITERIA
This is not an all-inclusive list of available covered drugs and includes only managed categories. Refer to cover page for complete list of rules governing this PDL.

EFFECTIVE
07/01/2021
Version 2021.3b

HYPOGLYCEMICS, MISCELLANEOUS AGENTS

CLASS PA CRITERIA: Welchol will be authorized for add-on therapy for type 2 diabetes when there is a previous history of a thirty (30) day trial of an oral diabetic agent.

WELCHOL (colesevelam)[AP]	colesevelam SYMLIN (pramlintide)*	*Symlin will be authorized with a history of bolus insulin utilization in the past ninety (90) days with no gaps in insulin therapy greater than thirty (30) days.

HYPOGLYCEMICS, SGLT2 INHIBITORS

CLASS PA CRITERIA: Non-preferred agents will only be approved (in 6-month intervals) if ALL of the following criteria has been met:

1) Current A1C must be submitted. Agents in this class will not be approved for patients with a starting A1C of less than (<) 7%.
2) Documentation demonstrating 90 days of compliance on all current diabetic therapies is provided.
3) Documentation demonstrating treatment failure with all unique preferred agents in the same class.

Re-authorizations will require documentation of continued compliance on all diabetic therapies and A1C levels must reach goal, (either an A1C of ≤8%, or demonstrated continued improvement).

*Preferred SGLT2 inhibitors and combinations may be approved for a diagnosis of Heart Failure with Reduced Ejection Fraction (HFrEF) with or without Type II DM, Chronic Kidney Disease (CKD) with or without Type II DM, or Atherosclerotic Cardiovascular Disease (ASCVD) with Type II DM without further restrictions.

SGLT2 INHIBITORS		
FARXIGA (dapagliflozin)* INVOKANA (canagliflozin)* JARDIANCE (empagliflozin)*	STEGLATRO (ertugliflozin)	
SGLT2 COMBINATIONS		
INVOKAMET (canagliflozin/metformin)* SYNJARDY (empagliflozin/metformin)*	GLYXAMBI (empagliflozin/linagliptin) INVOKAMET XR (canagliflozin/metformin) SEGLUROMET (ertugliflozin/metformin STEGLUJAN (ertugliflozin/sitagliptin) SYNJARDY XR (empagliflozin/metformin) TRIJARDY XR (empagliflozin/linagliptin/metformin) QTERN (dapagliflozin/saxagliptin) XIGDUO XR (dapagliflozin/metformin)	

HYPOGLYCEMICS, TZD

CLASS PA CRITERIA: Non-preferred agents are available only on appeal.

THIAZOLIDINEDIONES		
pioglitazone	ACTOS (pioglitazone) AVANDIA (rosiglitazone)	
TZD COMBINATIONS		

	ACTOPLUS MET (pioglitazone/ metformin) DUETACT (pioglitazone/glimepiride) pioglitazone/glimepiride pioglitazone/ metformin	Patients are required to use the components of Actoplus Met and Duetact separately. Exceptions will be handled on a case-by-case basis.
IMMUNOMODULATORS, ATOPIC DERMATITIS		
CLASS PA CRITERIA: Non-preferred agents require 30-day trial of a medium to high potency topical corticosteroid **AND all** preferred agents in this class unless one (1) of the exceptions on the PA form is present. Requirement for topical corticosteroids may be excluded with involvement of sensitive areas such as the face and skin folds.		
ELIDEL (pimecrolimus) PROTOPIC (tacrolimus)	DUPIXENT (dupilumab)* EUCRISA (crisaborole)[AP]** pimecrolimus cream tacrolimus ointment	*Full PA criteria for Dupixent may be found on the PA Criteria page by clicking the hyperlink **Eucrisa requires a 30-day trial of Elidel **OR** a medium to high potency corticosteroid unless contraindicated.
IMMUNOMODULATORS, GENITAL WARTS & ACTINIC KERATOSIS AGENTS		
CLASS PA CRITERIA: Non-preferred agents require thirty (30) day trials of each preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.		
CONDYLOX GEL (podofilox) EFUDEX (fluorouracil) imiquimod	ALDARA (imiquimod) CARAC (fluorouracil) diclofenac 3% gel fluorouracil 0.5% cream fluorouracil 5% cream podofilox TOLAK (fluorouracil 4% cream) VEREGEN (sinecatechins) ZYCLARA (imiquimod)*	*Zyclara will be authorized for a diagnosis of actinic keratosis.
IMMUNOSUPPRESSIVES, ORAL		
CLASS PA CRITERIA: Non-preferred agents require a fourteen (14) day trial of a preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.		
azathioprine cyclosporine cyclosporine, modified mycophenolate mofetil sirolimus tacrolimus capsule	ASTAGRAF XL (tacrolimus) AZASAN (azathioprine) CELLCEPT (mycophenolate mofetil) ENVARSUS XR (tacrolimus) IMURAN (azathioprine) LUPKYNIS (voclosporin)* mycophenolic acid mycophenolic mofetil suspension MYFORTIC (mycophenolic acid) NEORAL (cyclosporine, modified) PROGRAF (tacrolimus) RAPAMUNE (sirolimus) SANDIMMUNE (cyclosporine)	*Lupkynis requires a ninety (90) day trial of Benlysta prior to approval. Full PA criteria for Lupkynis may be found on the PA Criteria page by clicking the hyperlink.

	ZORTRESS (everolimus)	
INTRANASAL RHINITIS AGENTS[AP]		
CLASS PA CRITERIA: See below for individual sub-class criteria.		
ANTICHOLINERGICS		
ipratropium	ATROVENT (ipratropium)	Non-preferred agents require thirty (30) day trials of one (1) preferred nasal anti-cholinergic agent, **AND** one (1) preferred antihistamine **AND** one (1) preferred intranasal corticosteroid agent before they will be approved, unless one (1) of the exceptions on the PA form is present.
ANTIHISTAMINES		
azelastine	olopatadine PATANASE (olopatadine)	Non-preferred agents require thirty (30) day trials of one (1) preferred antihistamine **AND** one (1) preferred intranasal corticosteroid before they will be approved, unless one (1) of the exceptions on the PA form is present.
COMBINATIONS		
	azelastine/fluticasone DYMISTA (azelastine / fluticasone)	Dymista requires a concurrent thirty (30) day trial of each preferred component before it will be approved, unless one (1) of the exceptions on the PA form is present.
CORTICOSTEROIDS		
fluticasone propionate OMNARIS (ciclesonide) QNASL HFA (beclomethasone) ZETONNA (ciclesonide)	BECONASE AQ (beclomethasone) flunisolide mometasone NASONEX (mometasone)	Non-preferred agents require thirty (30) day trials of each preferred agent in this sub-class before they will be approved, unless one (1) of the exceptions on the PA form is present
IRRITABLE BOWEL SYNDROME/SHORT BOWEL SYNDROME/SELECTED GI AGENTS [CL]		
CLASS PA CRITERIA: All agents are approvable only for patients age eighteen (18) and older. **See below for additional sub-class criteria.**		
CONSTIPATION		
AMITIZA (lubiprostone) MOVANTIK (naloxegol) LINZESS (linaclotide)	LINZESS 72 mcg (linaclotide) lubiprostone capsule MOTEGRITY (prucalopride) RELISTOR INJECTION (methylnaltrexone) RELISTOR TABLET (methylnaltrexone) SYMPROIC (naldemedine) TRULANCE (plecanatide) ZELNORM (tegaserod maleate)	All agents in this subclass require documentation of the current diagnosis and evidence that the patient has failed to find relief with dietary modification and a fourteen (14) day trial of an osmotic laxative. No agent shall be approved to treat opioid induced constipation (OIC) without evidence of at least 90-days of opioid use preceding the request. Continuation of coverage shall be granted with evidence of continuous and concurrent opioid use. **Agents may be authorized only for their FDA-approved labeled indication. The following agent-specific criteria**

		shall also apply, unless one (1) of the exceptions on the PA form is present: **Motegrity** requires a 30-day trial of both Amitiza and Linzess. **Relistor** and **Symproic** are indicated for OIC and require thirty (30) day trials of both Movantik and Amitiza. **Trulance** requires thirty (30) day trials of both Amitiza and Linzess, however for the indication of IBS-C in males, a trial of Amitiza is not required. **Linzess 72mcg** may only be approved for a diagnosis of chronic idiopathic constipation (CIC) AND for those who cannot tolerate the 145mcg dose. **Zelnorm** is indicated for females < 65 years of age diagnosed with irritable bowel syndrome with constipation (IBS-C) AND requires thirty (30) day trials of Amitiza and Linzess. **Lubiprostone** may only be authorized with a documented allergy or intolerance to Amitiza.
	DIARRHEA	
	Alosetron MYTESI (crofelemer) LOTRONEX (alosetron) VIBERZI (eluxadoline)	Full PA criteria may be found on the PA Criteria page by clicking the hyperlink
LAXATIVES AND CATHARTICS		
CLASS PA CRITERIA: Non-preferred agents require thirty (30) day trials of each preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present		
COLYTE GOLYTELY NULYTELY peg 3350	CLENPIQ (sodium picosulfate, magnesium oxide, citric acid) MOVIPREP OSMOPREP SUPREP SUTAB (magnesium sulfate, potassium sulfate, sodium sulfate)	
LEUKOTRIENE MODIFIERS		
CLASS PA CRITERIA: Non-preferred agents require thirty (30) day trials of each preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.		
montelukast zafirlukast	ACCOLATE (zafirlukast) SINGULAIR (montelukast) zileuton ZYFLO (zileuton)	

LIPOTROPICS, OTHER (Non-statins)

CLASS PA CRITERIA: Non-preferred agents require a twelve (12) week trial of a preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.

BILE ACID SEQUESTRANTS[AP]		
cholestyramine colestipol tablets	COLESTID (colestipol) colesevelam colestipol granules QUESTRAN (cholestyramine) WELCHOL (colesevelam)*	*Welchol will be authorized for add-on therapy for type 2 diabetes when there is a previous history of a thirty (30) day trial of an oral agent (metformin, sulfonylurea or thiazolidinedione (TZD)). See HYPOGLYCEMICS, MISCELLANEOUS.
CHOLESTEROL ABSORPTION INHIBITORS		
ezetimibe	ZETIA (ezetimibe)	
FATTY ACIDS[CL]		
omega-3 acid ethyl esters VASCEPA (icosapent ethyl)*	icosapent ethyl capsules LOVAZA (omega-3-acid ethyl esters)	[CL]All agents in this subclass require a prior authorization and an initial triglyceride level ≥ 500 mg/dL. *Additionally, Vascepa may be approved if the following criteria is met: 1. The patient has an initial triglyceride level of ≥ 150 mg/dL prior to start of therapy; AND 2. The patient has established cardiovascular disease or diabetes; AND 3. The patient is concomitantly receiving a statin.
FIBRIC ACID DERIVATIVES[AP]		
fenofibrate 54 and 160 mg fenofibrate micronized 67mg, 134mg & 200mg fenofibrate nanocrystallized 48 mg, 145 mg gemfibrozil	ANTARA (fenofibrate) FENOGLIDE (fenofibrate) FIBRICOR (fenofibric acid) fenofibrate 40 mg tablet fenofibrate 150 mg capsules fenofibrate 43, 50, 120 and 130 mg fenofibric acid LIPOFEN (fenofibrate) LOPID (gemfibrozil) TRICOR (fenofibrate nanocrystallized) TRILIPIX (fenofibric acid)	
MTP INHIBITORS		
	JUXTAPID (lomitapide)*	*Full PA criteria may be found on the PA Criteria page by clicking the hyperlink.
NIACIN		
niacin niacin ER (OTC) NIASPAN (niacin)	niacin ER (Rx)	
PCSK-9 INHIBITORS/BEMPEDOIC ACID		

	PRALUENT (alirocumab)* REPATHA (evolocumab)* NEXLETOL (bempedoic acid)* NEXLIZET (bempedoic acid/ezetimibe)*	*Full PA criteria may be found on the PA Criteria page by clicking the hyperlink.
LIPOTROPICS, STATINS[AP]		
CLASS PA CRITERIA: See below for individual sub-class criteria.		
	STATINS	
atorvastatin lovastatin pravastatin rosuvastatin simvastatin*	ALTOPREV (lovastatin) CRESTOR (rosuvastatin) EZALLOR (rosuvastatin)[NR] EZALLOR SPRINKLE (rosuvastatin)* fluvastatin fluvastatin ER LESCOL XL (fluvastatin) LIPITOR (atorvastatin) LIVALO (pitavastatin) PRAVACHOL (pravastatin) ZOCOR (simvastatin)** ZYPITAMAG (pitavastatin)	Non-preferred agents require twelve (12) week trials of two (2) preferred agents, including the generic formulation of the requested non-preferred agent, before they will be approved, unless one (1) of the exceptions on the PA form is present. *Ezallor SPRINKLE will only be authorized for those who are unable to ingest solid dosage forms due to documented oral-motor difficulties or dysphagia. **Zocor/simvastatin 80mg tablets will require a clinical PA.
	STATIN COMBINATIONS	
	amlodipine/atorvastatin CADUET (atorvastatin/amlodipine) ezetimibe/simvastatin VYTORIN (simvastatin/ezetimibe)*	Non-preferred agents require thirty (30) day concurrent trials of the corresponding preferred single agents before they will be approved, unless one (1) of the exceptions on the PA form is present. *Vytorin will be authorized only after an insufficient response to a twelve (12) week trial of the maximum tolerable dose of atorvastatin or rosuvastatin, unless one (1) of the exceptions on the PA form is present. Vytorin 80/10mg tablets will require a clinical PA.
MABS, ANTI-IL/IgE		
CLASS PA CRITERIA: For FDA-approved indications, non-preferred agents require a ninety (90) day trial of Xolair. **Full PA Criteria may be found on the PA Criteria page by clicking the hyperlink.**		
XOLAIR (omalizumab)	DUPIXENT (dupilumab) FASENRA (benralizumab) FASENRA PEN (benralizumab) NUCALA SYRINGE/VIAL (mepolizumab) NUCALA AUTO INJECTOR (mepolizumab)	

MACROLIDES		
CLASS PA CRITERIA: Non-preferred agents require a five (5) day trial of each preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.		
MACROLIDES		
azithromycin erythromycin base	clarithromycin tablets clarithromycin ER clarithromycin suspension E.E.S. (erythromycin ethylsuccinate) ERYPED (erythromycin ethylsuccinate) ERY-TAB (erythromycin) ERYTHROCIN (erythromycin stearate) erythromycin estolate ZITHROMAX (azithromycin)	
MULTIPLE SCLEROSIS AGENTS[CL]		
CLASS PA CRITERIA: All agents require a prior authorization and documented diagnosis of multiple sclerosis. Preferred oral agents require a ninety (90) day trial of any preferred injectable agent. Non-preferred agents require ninety (90) day trials of two (2) chemically unique preferred agents (in the same sub-class) before they will be approved, unless one (1) of the exceptions on the PA form is present.		
INTERFERONS[AP]		
AVONEX (interferon beta-1a) AVONEX PEN (interferon beta-1a) BETASERON (interferon beta-1b) REBIF (interferon beta-1a) REBIF REBIDOSE (interferon beta-1a)	EXTAVIA KIT (interferon beta-1b) EXTAVIA VIAL (interferon beta-1b) PLEGRIDY (peginterferon beta-1a)	
NON-INTERFERONS		
AUBAGIO (teriflunomide)* dalfampridine ER** COPAXONE 20 mg (glatiramer) GILENYA (fingolimod) TECFIDERA (dimethyl fumarate)***	AMPYRA (dalfampridine)** BAFIERTAM CAPSULES (monomethyl fumarate) COPAXONE 40 mg (glatiramer)**** dimethyl fumerate*** glatiramer GLATOPA (glatiramer) KESIMPTA INJECTION (ofatumumab) MAYZENT (siponimod)***** MAVENCLAD (cladribine) VUMERITY (diroximel) ZEPOSIA (ozanimod)	**In addition to class PA criteria, the following conditions and criteria may also apply:** *Aubagio requires the following additional criteria to be met: 1. Diagnosis of relapsing multiple sclerosis **and** 2. Measurement of transaminase and bilirubin levels within the (6) months before initiation of therapy and ALT levels at least monthly for six (6) months after initiation of therapy **and** 3. Complete blood cell count (CBC) within six (6) months before initiation of therapy **and** 4. Female patients must have a negative pregnancy test before initiation of therapy and be established on a reliable method of contraception if appropriate **and** 5. Patient is between eighteen (18) up to sixty-five (65) years of age **and** 6. Negative tuberculin skin test before initiation of therapy

		Dalfampridine ER and Ampyra require the following additional criteria to be met: 1. Diagnosis of multiple sclerosis **and 2. No history of seizures **and** 3. No evidence of moderate or severe renal impairment. ***Dimethyl fumerate and Tecfidera require the following additional criteria to be met: 1. Diagnosis of relapsing multiple sclerosis **and** 2. Complete blood count (CBC) within six (6) months of initiation of therapy and six (6) months after initiation **and** 3. Complete blood count (CBC) annually during therapy. ****Copaxone 40mg will only be authorized for documented injection site issues. *****Mayzent may be authorized with no additional requirement beyond the diagnosis for patients with documented secondary progressive MS.

NEUROPATHIC PAIN

CLASS PA CRITERIA: Non-preferred agents require a thirty (30) day trial of a preferred agent in the corresponding dosage form (oral or topical) before they will be approved, unless one (1) of the exceptions on the PA form is present.

capsaicin OTC duloxetine gabapentin lidocaine patch 5% pregabalin capsule ZTLIDO PATCH (lidocaine)	CYMBALTA (duloxetine) DRIZALMA SPRINKLE (duloxetine)* GRALISE (gabapentin)** HORIZANT (gabapentin) lidocaine patch 4% LIDODERM (lidocaine) LYRICA CR (pregabalin)*** LYRICA SOLUTION (pregabalin)*** NEURONTIN (gabapentin)[AP] pregabalin ER tablet (generic Lyrica CR) QUTENZA (capsaicin) SAVELLA (milnacipran)**** LYRICA CAPSULE (pregabalin)	*Drizalma SPRINKLE will only be authorized for those who are unable to ingest solid dosage forms due to documented oral-motor difficulties or dysphagia. **Gralise will be authorized only if the following criteria are met: 1. Diagnosis of post herpetic neuralgia **and** 2. Trial of a tricyclic antidepressant for a least thirty (30) days **and** 3. 90-day trial of gabapentin immediate release formulation (positive response without adequate duration) **and** 4. Request is for once daily dosing with 1800 mg maximum daily dosage. ***Lyrica CR and Lyrica Solution require medical reasoning beyond convenience as to why the need cannot be met using preferred pregabalin capsules. ****Savella will be authorized for a diagnosis of fibromyalgia only after a 90-day trial of one preferred agent

NSAIDS[AP]		
CLASS PA CRITERIA: See below for sub-class PA criteria.		
NON-SELECTIVE		
diclofenac (IR, SR) flurbiprofen ibuprofen (Rx and OTC) INDOCIN SUSPENSION (indomethacin) indomethacin ketoprofen ketorolac meloxicam tablet nabumetone naproxen sodium tablet naproxen sodium DS tablet naproxen suspension EC-naproxen DR tablet piroxicam sulindac	DAYPRO (oxaprozin) diflunisal DUEXIS (famotidine/ibuprofen) etodolac IR etodolac SR FELDENE (piroxicam) fenoprofen INDOCIN SUPPOSITORIES (indomethacin) indomethacin ER ketoprofen ER meclofenamate mefenamic acid meloxicam submicronized capsule (generic Vivlodex) meloxicam suspension MOBIC TABLET (meloxicam) NALFON (fenoprofen) NAPRELAN (naproxen) naproxen CR oxaprozin RELAFEN DS (nabumetone) SPRIX (ketorolac) TIVORBEX (indomethacin) tolmetin VIVLODEX (meloxicam) VOLTAREN (diclofenac) ZIPSOR (diclofenac potassium) ZORVOLEX (diclofenac)	Non-preferred agents require thirty (30) day trials of each preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.
NSAID/GI PROTECTANT COMBINATIONS		
	ARTHROTEC (diclofenac/misoprostol) diclofenac/misoprostol naproxen/esomeprazole VIMOVO (naproxen/esomeprazole)	Non-preferred agents are only available on appeal and require medical reasoning beyond convenience as to why the need cannot be met with the combination of preferred single agents.
COX-II SELECTIVE		
	CELEBREX (celecoxib) celecoxib	COX-II Selective agents require thirty (30) day trials of each preferred Non-Selective Oral NSAID, **UNLESS** the following criteria are met: Patient has a history or risk of a serious GI complication; **OR**

		Agent is requested for treatment of a chronic condition **and** 1. Patient is seventy (70) years of age or older, **or** 2. Patient is currently on anticoagulation therapy**.**
	TOPICAL	
FLECTOR PATCH (diclofenac)* diclofenac gel (RX)**	diclofenac patch diclofenac solution LICART PATCH (diclofenac) PENNSAID (diclofenac)	*Flector patches are limited to two per day. **diclofenac gel will be limited to 100 grams per month. Non-preferred agents require a thirty (30) day trial of the preferred Topical agent and thirty (30) day trials of each preferred oral NSAID before they will be approved, unless one(1) of the exceptions on the PA form is present.
OPHTHALMIC ANTIBIOTICS[AP]		
CLASS PA CRITERIA: Non-preferred agents require three (3) day trials of each preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.		
bacitracin/polymyxin ointment ciprofloxacin* erythromycin gentamicin levofloxacin* MOXEZA (moxifloxacin) neomycin/bacitracin/polymyxin ofloxacin* polymyxin/trimethoprim tobramycin TOBREX OINT (tobramycin)	AZASITE (azithromycin) bacitracin BLEPH-10 (sulfacetamide) BESIVANCE (besifloxacin)* CILOXAN (ciprofloxacin) gatifloxacin moxifloxacin** NATACYN (natamycin) neomycin/polymyxin/gramicidin OCUFLOX (ofloxacin) POLYTRIM (polymyxin/trimethoprim) sulfacetamide drops sulfacetamide ointment TOBREX (tobramycin) VIGAMOX (moxifloxacin) ZYMAXID (gatifloxacin)	*Prior authorization of any fluoroquinolone agent requires three (3) day trials of all other preferred agents unless definitive laboratory cultures exist indicating the need to use a fluoroquinolone.
OPHTHALMIC ANTIBIOTIC/STEROID COMBINATIONS[AP]		
CLASS PA CRITERIA: Non-preferred agents require three (3) day trials of each preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.		
neomycin/polymyxin/dexamethasone sulfacetamide/prednisolone TOBRADEX OINTMENT (tobramycin/ dexamethasone) TOBRADEX SUSPENSION (tobramycin/ dexamethasone) ZYLET (loteprednol/tobramycin)	BLEPHAMIDE (prednisolone/sulfacetamide) MAXITROL ointment (neomycin/polymyxin/ dexamethasone) MAXITROL suspension (neomycin/polymyxin/ dexamethasone) neomycin/bacitracin/polymyxin/ hydrocortisone neomycin/polymyxin/hydrocortisone PRED-G (prednisolone/gentamicin) TOBRADEX ST (tobramycin/ dexamethasone) tobramycin/dexamethasone suspension	

OPHTHALMICS FOR ALLERGIC CONJUNCTIVITIS[AP]

CLASS PA CRITERIA: Non-preferred agents require thirty (30) day trials of three (3) preferred chemically unique agents before they will be approved, unless one (1) of the exceptions on the PA form is present.

ALAWAY (ketotifen) ALREX (loteprednol) BEPREVE (bepotastine) cromolyn ketotifen LASTACAFT (alcaftadine) olopatadine 0.1% (Generic PATANOL labeler 61314 only) ZADITOR OTC (ketotifen)	ALOCRIL (nedocromil) ALOMIDE (lodoxamide) azelastine Epinastine LUMIFY (brimonidine) olopatadine 0.1% (all formulations except Generic PATANOL labeler 61314) olopatadine 0.2% (all labelers) PATANOL (olopatadine) ZERVIATE (cetirizine)	

OPHTHALMICS, ANTI-INFLAMMATORIES- IMMUNOMODULATORS[CL]

CLASS PA CRITERIA: All agents require a prior authorization. Non-preferred agents require a 60-day trial of the preferred agent(s).

RESTASIS (cyclosporine)	CEQUA (cyclosporine) EYSUVIS (loteprednol) RESTASIS MULTIDOSE (cyclosporine)* XIIDRA (lifitegrast)	***Restasis Multidose** is approvable only on appeal and requires medical reasoning as to why the clinical need cannot be met with the preferred product (Restasis). **All agents must meet the following prior-authorization criteria:** 1.) Patient must be sixteen (16) years of age or greater; **AND** 2.) Prior Authorization must be requested by an ophthalmologist or optometrist; **AND** 3.) Clinically diagnosed tear deficiency due to ocular inflammation in patients with keratoconjunctivitis sicca or dry eye syndrome (also known as dry eye); **AND** 4.) Patient must have a functioning lacrimal gland; **AND** 5.) Patient using artificial tears at least four (4) times a day over the last thirty (30) days; **AND** Patient must not have an active ocular infection

OPHTHALMICS, ANTI-INFLAMMATORIES

CLASS PA CRITERIA: Non-preferred agents require five (5) day trials of at least two (2) preferred agents before they will be approved, unless one (1) of the exceptions on the PA form is present. Trials must include at least one agent with the same mechanism of action as the requested non-preferred agent.

dexamethasone diclofenac DUREZOL (difluprednate) fluorometholone FML FORTE (fluorometholone) FML S.O.P. (fluorometholone)	ACULAR (ketorolac) ACULAR LS (ketorolac) ACUVAIL (ketorolac tromethamine) bromfenac BROMSITE (bromfenac) FLAREX (fluorometholone)	

ketorolac LOTEMAX DROPS, OINTMENT (loteprednol) MAXIDEX (dexamethasone) NEVANAC (nepafenac) PRED MILD (prednisolone) prednisolone acetate prednisolone sodium phosphate	flurbiprofen FML (fluorometholone) ILEVRO (nepafenac) INVELTYS (loteprednol) LOTEMAX GEL (loteprednol) loteprednol drops, gel OMNIPRED (prednisolone) OZURDEX (dexamethasone) PRED FORTE (prednisolone) PROLENSA (bromfenac) RETISERT (fluocinolone) TRIESENCE (triamcinolone)	
OPHTHALMICS, GLAUCOMA AGENTS		
CLASS PA CRITERIA: Non-preferred agents will only be authorized if there is an allergy to all preferred agents in the corresponding sub-class.		
COMBINATION AGENTS		
COMBIGAN (brimonidine/timolol) dorzolamide/timolol SIMBRINZA (brinzolamide/brimonidine)	COSOPT PF (dorzolamide/timolol)	
BETA BLOCKERS		
BETOPTIC S (betaxolol) carteolol levobunolol timolol drops	betaxolol ISTALOL (timolol) timolol gel TIMOPTIC (timolol)	
CARBONIC ANHYDRASE INHIBITORS		
AZOPT (brinzolamide) dorzolamide	brinzolamide TRUSOPT (dorzolamide)	
PARASYMPATHOMIMETICS		
PHOSPHOLINE IODIDE (echothiophate iodide)	pilocarpine	
PROSTAGLANDIN ANALOGS		
latanoprost TRAVATAN-Z (travoprost)	bimatoprost LUMIGAN (bimatoprost) travoprost VYZULTA (latanoprostene)* XALATAN (latanoprost) XELPROS (latanoprost) ZIOPTAN (tafluprost)	*Vyzulta – prior authorization requires failure on a 3-month trial of at least one preferred prostaglandin eye drop used in combination with an agent from another subclass.
RHO-KINASE INHIBITORS		
RHOPRESSA (netarsudil) ROCKLATAN (netarsudil/latanoprost)		
SYMPATHOMIMETICS		
brimonidine 0.2%	ALPHAGAN P 0.1% Solution (brimonidine) ALPHAGAN P 0.15% Solution (brimonidine) apraclonidine	

	IOPIDINE (apraclonidine)	
OPIATE DEPENDENCE TREATMENTS		
CLASS PA CRITERIA: Bunavail and Zubsolv may only be approved with a documented intolerance or allergy to Suboxone strips AND buprenorphine/naloxone tablets. WV Medicaid's buprenorphine coverage policy may be viewed by clicking on the following hyperlink: Buprenorphine Coverage Policy and Related Forms		
buprenorphine/naloxone tablets* naloxone NARCAN NASAL SPRAY (naloxone) SUBOXONE FILM (buprenorphine/naloxone)* VIVITROL (naltrexone)	BUNAVAIL (buprenorphine/naloxone) buprenorphine tablets buprenorphine/naloxone film LUCEMYRA (lofexidine) SUBLOCADE (buprenorphine soln)** ZUBSOLV (buprenorphine/naloxone)	* Full PA criteria may be found on the PA Criteria page by clicking the hyperlink. **Sublocade is approvable only on appeal and requires medical reasoning as to why the clinical need cannot be met with a preferred product.
OTIC ANTIBIOTICS[AP]		
CLASS PA CRITERIA: Non-preferred agents require five (5) day trials of each preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.		
CIPRO HC (ciprofloxacin/hydrocortisone) CIPRODEX (ciprofloxacin/dexamethasone) ofloxacin CORTISPORIN-TC (colistin/hydrocortisone/ neomycin)	ciprofloxacin ciprofloxacin/dexamethasone) ciprofloxacin/fluocinolone neomycin/polymyxin/HC solution/suspension OTOVEL (ciprofloxacin/fluocinolone)	
PAH AGENTS – ENDOTHELIN RECEPTOR ANTAGONISTS[CL]		
CLASS PA CRITERIA: Non-preferred agents require a thirty (30) day trial of a preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.		
LETAIRIS (ambrisentan) TRACLEER TABLET (bosentan)	ambrisentan bosentan OPSUMIT (macitentan) TRACLEER SUSP (bosentan)	
PAH AGENTS – PDE5s[CL]		
CLASS PA CRITERIA: Non-preferred agents require a thirty (30) day trial of a preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present. Patients stabilized on non-preferred agents will be grandfathered.		
sildenafil tablets	ADCIRCA (tadalafil) REVATIO IV (sildenafil) REVATIO SUSPENSION (sildenafil) REVATIO TABLETS (sildenafil) sildenafil suspension (generic Revatio)	
PAH AGENTS – PROSTACYCLINS[CL]		

CLASS PA CRITERIA: Non-preferred agents require a thirty (30) day trial of a preferred agent, including the preferred generic form of the non-preferred agent (if available), before they will be approved, unless one (1) of the exceptions on the PA form is present.		
epoprostenol (generic Flolan) VENTAVIS (iloprost)*	epoprostenol (generic Veletri) FLOLAN (epoprostenol) ORENITRAM ER (treprostinil) REMODULIN (treprostinil sodium) TYVASO (treprostinil) UPTRAVI (selexipag) VELETRI (epoprostenol)	*Ventavis will only be authorized for the treatment of pulmonary artery hypertension (WHO Group 1) in patients with NYHA Class III or IV symptoms.
PANCREATIC ENZYMES[AP]		
CLASS PA CRITERIA: Non-preferred agents require a thirty (30) day trial of a preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present. For members with cystic fibrosis, a trial of a preferred agent will not be required.		
CREON ZENPEP	PANCREAZE PERTZYE VIOKACE	
PHOSPHATE BINDERS[AP]		
CLASS PA CRITERIA: Non-preferred agents require a thirty (30) day trial of at least two (2) preferred agents before they will be approved, unless one (1) of the exceptions on the PA form is present.		
calcium acetate CALPHRON (calcium acetate) MAGNEBIND RX (calcium carbonate, folic acid, magnesium carbonate) PHOSLYRA (calcium acetate) sevelamer carbonate	AURYXIA (ferric citrate) FOSRENOL (lanthanum) lanthanum chewable RENAGEL (sevelamer) RENVELA (sevelamer carbonate) VELPHORO (sucroferric oxyhydroxide)	
PITUITARY SUPPRESSIVE AGENTS, LHRH[CL]		
CLASS PA CRITERIA: Unless otherwise noted, non-preferred agents are available only on appeal.		
LUPANETA (leuprolide) LUPRON DEPOT KIT (leuprolide) LUPRON DEPOT-PED KIT (leuprolide) SYNAREL (nafarelin) TRELSTAR (triptorelin) TRIPTODUR (triptorelin) VANTAS (histrelin) ZOLADEX (goserelin)	leuprolide ORILISSA (elagolix)* ORIAHNN (elagolix-estradiol-norethindrone)* SUPPRELIN LA KIT (histrelin)	* Full PA criteria may be found on the PA Criteria page by clicking the hyperlink.
PLATELET AGGREGATION INHIBITORS		
CLASS PA CRITERIA: Non-preferred agents require a thirty (30) day trial of a preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.		
BRILINTA (ticagrelor) clopidogrel	clopidogrel kit dipyridamole/aspirin	

dipyridamole prasugrel	EFFIENT (prasugrel) PLAVIX (clopidogrel) ZONTIVITY (vorapaxar)	
PROGESTATIONAL AGENTS		
CLASS PA CRITERIA: Full PA criteria may be found on the PA Criteria page by clicking the hyperlink.		
MAKENA (hydroxyprogesterone caproate) AUTO INJECTOR MAKENA (hydroxyprogesterone caproate) VIAL	hydroxyprogesterone caproate	
PROGESTINS FOR CACHEXIA		
CLASS PA CRITERIA: Non-preferred agents require a thirty (30) day trial of a preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.		
Megestrol		
PROTON PUMP INHIBITORS[AP]		
CLASS PA CRITERIA: Non-preferred agents require sixty (60) day trials of both omeprazole (Rx) and pantoprazole at the maximum recommended dose*, inclusive of a concurrent thirty (30) day trial at the maximum dose of an H_2 antagonist before they will be approved, unless one (1) of the exceptions on the PA form is present.		
NEXIUM PACKETS (esomeprazole)** omeprazole (Rx) pantoprazole PROTONIX GRANULES (pantoprazole)**	ACIPHEX (rabeprazole) ACIPHEX SPRINKLE (rabeprazole) DEXILANT (dexlansoprazole) esomeprazole magnesium lansoprazole Rx NEXIUM (esomeprazole) omeprazole/sodium bicarbonate (Rx) PREVACID CAPSULES (lansoprazole) PREVACID SOLUTABS (lansoprazole)** PRILOSEC Rx (omeprazole) PROTONIX DR TABLETS (pantoprazole) rabeprazole ZEGERID Rx (omeprazole/sodium bicarbonate)	*Maximum recommended doses of the PPIs and H2-receptor antagonists may be located at the BMS Pharmacy PA criteria page titled "Max PPI and H2RA" by clicking on the hyperlink. **Prior authorization is required for members nine (9) years of age or older for these agents.
SEDATIVE HYPNOTICS[AP]		
CLASS PA CRITERIA: Non-preferred agents require thirty (30) day trials of all preferred agents in **BOTH** sub-classes before they will be approved, unless one (1) of the exceptions on the PA form is present. All agents except melatonin will be limited to fifteen (15) tablets in a thirty (30) day period. NOTE: WV Medicaid covers melatonin up to a maximum dose of 9 mg/day without a PA. Melatonin labeler code 51645 is preferred if available, however all NDCs are payable.		
BENZODIAZEPINES		
temazepam 15, 30 mg	estazolam flurazepam HALCION (triazolam) RESTORIL (temazepam) temazepam 7.5, 22.5 mg triazolam	

OTHERS		
melatonin ROZEREM (ramelteon) zolpidem 5, 10 mg	AMBIEN (zolpidem) AMBIEN CR (zolpidem) BELSOMRA (suvorexant) DAYVIGO (lemborexant) EDLUAR (zolpidem) eszopiclone HETLIOZ (tasimelteon)[CL]* LUNESTA (eszopiclone) ramelteon SILENOR (doxepin) zaleplon zolpidem ER 6.25, 12.5 mg	Strengths of zolpidem that are non-preferred (6.25 and 12.5 mg) must be created by combining or splitting the preferred doses (5 and 10 mg) of zolpidem, if appropriate. For treatment naïve female patients, zolpidem and zolpidem ER maximum dosages will be limited to 5 mg and 6.25 mg respectively per day. *Full PA criteria may be found on the PA Criteria page by clicking the hyperlink.
SKELETAL MUSCLE RELAXANTS[AP]		
CLASS PA CRITERIA: See below for individual sub-class criteria.		
ACUTE MUSCULOSKELETAL RELAXANT AGENTS		
chlorzoxazone (generic PARAFON FORTE) cyclobenzaprine IR 5, 10 mg methocarbamol	AMRIX (cyclobenzaprine) carisoprodol* carisoprodol/ASA* carisoprodol/ASA/codeine* chlorzoxazone (generic LORZONE) cyclobenzaprine ER cyclobenzaprine IR 7.5 mg FEXMID (cyclobenzaprine) LORZONE (chlorzoxazone) metaxalone orphenadrine orphenadrine ER ROBAXIN (methocarbamol) SKELAXIN (metaxalone) SOMA (carisoprodol)	Non-preferred agents require thirty (30) day trials of each preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present, with the exception of carisoprodol. *Carisoprodol requires thirty (30) day trials of each of the preferred acute musculoskeletal relaxants and Skelaxin before it will be approved.
MUSCULOSKELETAL RELAXANT AGENTS USED FOR SPASTICITY		
baclofen tizanidine tablets	DANTRIUM (dantrolene) dantrolene tizanidine capsules ZANAFLEX (tizanidine)	Non-preferred agents require thirty (30) day trials of each preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.
STEROIDS, TOPICAL		
CLASS PA CRITERIA: Non-preferred agents require five (5) day trials of one (1) form of **EACH** preferred unique active ingredient in the corresponding potency group before they will be approved, unless one (1) of the exceptions on the PA form is present.		

VERY HIGH & HIGH POTENCY		
betamethasone dipropionate cream betamethasone valerate cream betamethasone valerate lotion betamethasone valerate oint clobetasol propionatecream, gel, ointment, solution clobetasol emollient clobetasol propionate shampoo fluocinonide gel triamcinolone acetonide cream, ointment triamcinolone acetonide lotion	amcinonide APEXICON E (diflorasone diacetate) betamethasone dipropionate gel, lotion, ointment BRYHALI LOTION (halobetasol) clobetasol lotion clobetasol propionate foam CLOBEX (clobetasol propionate) CLODAN KIT (clobetasol propionate) CLODAN SHAMPOO (clobetasol propionate) desoximetasone cream/gel/ointment diflorasone diacetate DIPROLENE (betamethasone dipropionate/propylene glycol) fluocinonide cream fluocinonide ointment fluocinonide solution fluocinonide/emollient halcinonide cream halobetasol propionate HALOG (halcinonide) IMPEKLO LOTION (clobetasol propionate) KENALOG (triamcinolone acetonide) LEXETTE FOAM (halobetasol) OLUX (clobetasol propionate) OLUX-E (clobetasol propionate/emollient) PSORCON (diflorasone diacetate) TEMOVATE (clobetasol propionate) TOPICORT CREAM, GEL, OINTMENT (desoximetasone) TOPICORT SPRAY (desoximetasone) TOVET FOAM (clobetasol) ULTRAVATE (halobetasol propionate) ULTRAVATE PAC cream VANOS (fluocinonide)	
MEDIUM POTENCY		
fluticasone propionate cream, ointment mometasone furoate triamcinolone acetonide 0.025% and 0.1% cream	BESER LOTION (fluticasone) betamethasone valerate foam CLODERM (clocortolone pivalate) clocortolone cream CORDRAN (flurandrenolide) CUTIVATE (fluticasone propionate) fluocinolone acetonide cream, ointment, solution fluticasone propionate lotion hydrocortisone butyrate cream hydrocortisone butyrate ointment, solution hydrocortisone valerate	

	LOCOID (hydrocortisone butyrate) LOCOID LIPOCREAM (hydrocortisone butyrate/emollient) LUXIQ (betamethasone valerate) PANDEL (hydrocortisone probutate) prednicarbate	
	LOW POTENCY	
DERMA-SMOOTHE FS (fluocinolone acetonide) hydrocortisone acetate (Rx, OTC) hydrocortisone cream (Rx, OTC) hydrocortisone lotion OTC hydrocortisone ointment (Rx, OTC) hydrocortisone solution OTC hydrocortisone-aloe cream OTC hydrocortisone-aloe ointment OTC	alclometasone dipropionate AQUA GLYCOLIC HC (hydrocortisone) CAPEX (fluocinolone acetonide) DESONATE (desonide) desonide cream, ointment desonide lotion fluocinolone oil hydrocortisone/mineral oil/petrolatum hydrocortisone acetate/urea hydrocortisone lotion hydrocortisone/aloe gel SCALPICIN OTC (hydrocortisone) SYNALAR (fluocinolone) TEXACORT (hydrocortisone)	
STIMULANTS AND RELATED AGENTS		
CLASS PA CRITERIA: A PA is required for adults eighteen (18) years of age or older. Non-preferred agents require a thirty (30) day trial of at least one preferred agent in the same subclass and with a similar duration of effect and mechanism of action, unless one (1) of the exceptions on the PA form is present. **NOTE**: Non-preferred agents will NOT be "grandfathered" for adults. Children under the age of 18 may continue their current therapy until the end of the school year after which they will be required to switch to a preferred agent.		
	AMPHETAMINES	
amphetamine salt combination ER amphetamine salt combination IR dextroamphetamine ER dextroamphetamine IR VYVANSE CHEWABLE (lisdexamfetamine) VYVANSE CAPSULE (lisdexamfetamine)	ADDERALL (amphetamine salt combination) ADDERALL XR (amphetamine salt combination) ADZENYS XR ODT (amphetamine) ADZENYS ER SUSP (amphetamine) amphetamine tablets DESOXYN (methamphetamine) DEXEDRINE ER (dextroamphetamine) dextroamphetamine solution DYANAVEL XR SUSP (amphetamine) EVEKEO (amphetamine) EVEKEO ODT (amphetamine) methamphetamine MYDAYIS (dextroamphetamine/amphetamine salt)* PROCENTRA solution (dextroamphetamine) ZENZEDI (dextroamphetamine)	**In addition to the Class Criteria**: Thirty (30) day trials of at least three (3) antidepressants are required before amphetamines will be authorized for depression. *Mydayis requires a 30-day trial of at least one long-acting preferred agent in this subclass and a trial of Adderall XR.

NON-AMPHETAMINE		
atomoxetine CONCERTA (methylphenidate) clonidine IR dexmethylphenidate IR FOCALIN XR (dexmethylphenidate) guanfacine ER guanfacine IR methylphenidate IR methylphenidate ER tablet (generic RITALIN SR) methylphenidate solution QUILLICHEW ER (methylphenidate) QUILLIVANT XR (methylphenidate)	ADHANSIA XR (methylphenidate) APTENSIO XR (methylphenidate) clonidine ER COTEMPLA XR ODT (methylphenidate) DAYTRANA (methylphenidate) dexmethylphenidate XR FOCALIN IR (dexmethylphenidate) INTUNIV (guanfacine extended-release) JORNAY PM (methylphenidate) METHYLIN SOLUTION (methylphenidate) methylphenidate CD methylphenidate chewable tablets methylphenidate ER 24 tablet (generic CONCERTA) methylphenidate ER capsule methylphenidate LA capsule RITALIN (methylphenidate) RITALIN LA (methylphenidate) STRATTERA (atomoxetine)*	* Strattera is limited to a maximum of 100 mg per day.
NARCOLEPTIC AGENTS		
armodafinil[CL] modafinil[CL]	NUVIGIL (armodafinil) PROVIGIL (modafinil) SUNOSI (solriamfetol)* WAKIX (pitolisant)**	* Sunosi is approvable only with documentation of treatment failure after 30-day trials of both armodafinil and modafinil. **Wakix is approvable only with documentation of treatment failure after 30-day trials of armodafinil, modafinil and Sunosi.
TETRACYCLINES		
CLASS PA CRITERIA: Non-preferred agents require ten (10) day trials of each preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.		
doxycycline hyclate capsules doxycycline hyclate 100 mg tablets doxycycline monohydrate 50, 100 mg capsules minocycline capsules	demeclocycline* DORYX (doxycycline hyclate) doxycycline hyclate 75, 150 mg tablets doxycycline hyclate tablet DR 75, 100, 150, 200 mg doxycycline hyclate tablet DR 50 mg doxycycline monohydrate 40, 75, 150 mg capsule doxycycline monohydrate tablet doxycycline monohydrate suspension MINOCIN (minocycline) minocycline ER capsules minocycline tablets MINOLIRA ER (minocycline) MORGIDOX KIT (doxycycline) ORACEA (doxycycline monohydrate)	*Demeclocycline will be authorized for conditions caused by susceptible strains of organisms designated in the product information supplied by the manufacturer. A C&S report must accompany this request. Demeclocycline will also be authorized for SIADH.

	SOLODYN (minocycline) tetracycline VIBRAMYCIN CAPSULES, SUSPENSION, SYRUP (doxycycline) XIMINO (minocycline)	

ULCERATIVE COLITIS AGENTS[AP]

CLASS PA CRITERIA: Non-preferred agents require thirty (30) day trials of each preferred dosage form or chemical entity before the corresponding non-preferred agent of that dosage form or chemical entity will be approved, unless one (1) of the exceptions on the PA form is present.

ORAL

APRISO (mesalamine) ASACOL HD (mesalamine) balsalazide PENTASA (mesalamine) 250 mg PENTASA (mesalamine) 500 mg sulfasalazine	AZULFIDINE (sulfasalazine) COLAZAL (balsalazide) DELZICOL (mesalamine) DIPENTUM (olsalazine) LIALDA (mesalamine) mesalamine UCERIS (budesonide) ZEPOSIA (ozanimod)	

RECTAL

mesalamine	DELZICOL DR (mesalamine) mesalamine kit ROWASA (mesalamine) SF ROWASA (mesalamine) UCERIS (budesonide)	

VASODILATORS, CORONARY

CLASS PA CRITERIA: Non-preferred agents require thirty (30) day trials of each preferred dosage form before they will be approved, unless one (1) of the exceptions on the PA form is present.

SUBLINGUAL NITROGLYCERIN

nitroglycerin spray (generic NITROLINGUAL) nitroglycerin sublingual NITROSTAT SUBLINGUAL (nitroglycerin)	GONITRO SPRAY POWDER (nitroglycerin) nitroglycerin spray (generic NITROMIST) NITROLINGUAL SPRAY (nitroglycerin) NITROMIST (nitroglycerin)	

MISCELLANEOUS COVERED AGENTS

This category contains covered agents which either did not easily fit into a single PDL category or had criteria that was too lengthy to cite within the PDL itself. Full criteria for the agents listed below may be found by following this hyperlink: (https://dhhr.wv.gov/bms/BMS%20Pharmacy/Pages/PA-Criteria.aspx). Please note that some agents may be available only by billing the appropriate HCPCS code noted in the criteria.

Afinitor
Albenza and Emverm
Ampyra
Antifungal Agents
Austedo

Belbuca
Benlysta
Botox
Carbaglu
CGRP Receptor Antagonists
Continuous Glucose Monitors
Corlanor
Cresemba
Cuvposa
Cytokine & CAM Antagonists
Diclegis
Dificid
Dojolvi
Droxidopa
Duavee
Dupixent
Epidiolex
Emflaza
Enspryng
Esbriet
Evrysdi
ExJade
Exondys 51
Fasenra
Ferriprox
Firazyr
Fuzeon
Gattex
Gralise
Growth Hormone for Adults
Growth Hormone for Children
Hepatitis C PA Criteria
Hereditary Angioedema Agents
Hetlioz
Home Infusion Drugs and Supplies
Horizant
HP Acthar
HyQvia
Increlex
Ingrezza
Jublia
Juxtapid
Kalydeco
Ketoconazole
Korlym
Kuvan

Kymriah
Kynamro
Lucemyra
Lutathera
Lupkynis
Luxturna
Makena
Max PPI an H2RA
Mozobil
Myalept
Mytesi
Natpara
Nexletol and Nexlizet
Non-Sedating Antihistamines
Nuvigil
Nucala
OFEV
Oforta
Omnipod
Orilissa
Oralair
Oriahnn
Orkambi
Osphena
Oxlumo
Palforzia
Palynziq
PCSK9 Inhibitor
Provigil
Qbrexza
Rectiv
Regranex
Remicade
Restasis
Rilutek
Riluzole
Risperdal Consta
Ruconest
Sirturo
Spinraza
Spravato
Sprycel
Suboxone Policy
Symdeko
Synagis
Testosterone
Thalomid

Tobacco Cessation Policy
Trikafta
V-Go
Viberzi and Lotronex
Verquvo
Vyondys 53
Xanax XR
Xenazine
Xhance
Xifaxan
Xolair
Xyrem and Xywav
Yescarta
Zolgensma
Zulresso
Zurampic
Zyvox

Class	GSN	HIC3	THERAPEUTIC CLASS	Order	Post Y/N	GENERIC DRUG NAME and STRENGTHS	Generic / Strength	BRAND NAME	Units	Until Refill	Daily Dose	Max Days	Refills	Pkg Bill	Updated
1	0	HIC3	THERAPEUTIC CLASS	0	Y	ACNE AGENTS (Topical)	ACNE AGENTS (Topical)	BRAND	Units	Until Refill	Daily Dose	Max Days	Refills	Pkg Bill	Updated
1	031789	L9B	ACNE AGENTS,TOPICAL	1	Y	ADAPALENE 0.1% CREAM 45UNIT PACKAGES	ADAPALENE 0.1% CREAM 45UNIT PACKAGES	DIFFERIN	90	30				Y	
1	026436	L9B	ACNE AGENTS,TOPICAL	2	Y	ADAPALENE 0.1% GEL	ADAPALENE 0.1% GEL	DIFFERIN	90	30				Y	
1	068878	L9B	ACNE AGENTS,TOPICAL	3	Y	ADAPALENE 0.3% GEL PUMP 45GRAM	ADAPALENE 0.3% GEL PUMP 45GRAM	DIFFERIN	45	30				Y	
1	066179	L9B	ACNE AGENTS,TOPICAL	4	Y	ADAPALENE 0.1% LOTION 59ML	ADAPALENE 0.1% LOTION 59ML	DIFFERIN	59	30				Y	
1	068880	L5H	ACNE AGENTS,TOPICAL	5	Y	ADAPALENE-BENZOYL PEROXIDE 0.1-2.5% GEL 45GRAM	ADAPALENE-BENZOYL PEROXIDE 0.1-2.5% GEL 45G	EPIDUO	45	30				Y	
1	080592	L5A	ACNE AGENTS,TOPICAL	6	Y	BENZOYL PEROXIDE 5.2% EMOLLIENT FOAM	BENZOYL PEROXIDE 5.2% EMOLLIENT FOAM	BENZEPRO	60	30					
1	081619	L5A	ACNE AGENTS,TOPICAL	7	Y	BENZOYL PEROXIDE MICRONIZED 5.8% FOAMING CLOTHS	BENZOYL PEROXIDE MICRONIZED 5.8% FOAMING C	BENZEPRO	60						
1	037628	L5H	ACNE AGENTS,TOPICAL	8	Y	CLINDAMYCIN PHOS/BENZOYL PEROX GEL 25, 50GRAMS	CLINDAMYCIN PHOS/BENZOYL PEROX GEL 25, 50G	BENZACLIN	50	30				Y	
1	082561	L5H	ACNE AGENTS,TOPICAL	9	Y	CLINDAMYCIN/DIMETH/ZINC OXIDE KIT	CLINDAMYCIN/DIMETH/ZINC OXIDE KIT	CLINDAVIX	1						1/1/2022
1	067870	L5G	ACNE AGENTS,TOPICAL	10	Y	METRONIDAZOLE/SKIN CLEANSR #23 0.75% CREAM OR G	METRONIDAZOLE/SKIN CLEANSR #23 0.75% CREAN	ROSADAN	1						
1.5	0	HIC3	THERAPEUTIC CLASS	0	Y	ACNE AGENTS (Systemic)	ACNE AGENTS (Systemic)	BRAND	Units	Until Refill	Daily Dose	Max Days	Refills	Pkg Bill	Updated
1.5	080449	L1B	ACNE AGENTS,SYSTEMIC	1	Y	ISOTRETINOIN, MICRONIZED CAPSULES, ALL STRENGTHS	ISOTRETINOIN, MICRONIZED 8 MG CAPSULE	ABSORICA LD			2				
2	2	HIC3	THERAPEUTIC CLASS	0	Y	ALZHEIMER'S AGENTS	ALZHEIMER'S AGENTS	BRAND	Units	Until Refill	Daily Dose	Max Days	Refills	Pkg Bill	Updated
2	059039	J1B	ALZHEIMER'S AGENTS	1	Y	DONEPEZIL HCL TABLETS	DONEPEZIL HCL 5MG TABLET	ARICEPT / ARICEPT ODT			1				
2	046926	J1B	ALZHEIMER'S AGENTS	2	Y	GALANTAMINE HBR TABLETS	GALANTAMINE HBR 4MG TABLET	RAZADYNE			2				
2	058238	J1B	ALZHEIMER'S AGENTS	3	Y	GALANTAMINE HBR ER CAPSULES	GALANTAMINE HBR 8MG CAPSULE	RAZADYNE ER			1				
2	048437	J1B	ALZHEIMER'S AGENTS	4	Y	GALANTAMINE HBR 4MG/ML ORAL SOLUTION 100ML	GALANTAMINE HBR 4MG/ML ORAL SOLUTION 100	RAZADYNE	200	30					
2	053324	H1A	ALZHEIMER S THERAPY, NMDA RECEPTOR ANTAGONISTS	5	Y	MEMANTINE HCL 5, 7, 14, 21 and 28MG CAPSULE	MEMANTINE HCL 5MG TABLET	NAMENDA			1				
2	032492	H1A	ALZHEIMER S THERAPY, NMDA RECEPTOR ANTAGONISTS	6	Y	MEMANTINE HCL 10MG TABLET	MEMANTINE HCL 10MG TABLET	NAMENDA			2				
2	058996	H1A	ALZHEIMER S THERAPY, NMDA RECEPTOR ANTAGONISTS	8	Y	MEMANTINE HCL 10MG/5ML SOLUTION	MEMANTINE HCL 10MG/5ML SOLUTION	NAMENDA			10				
2	053325	H1A	ALZHEIMER S THERAPY, NMDA RECEPTOR ANTAGONISTS	10	Y	MEMANTINE HCL 5-10MG TITRATION PACK 49 TABLETS	MEMANTINE HCL 5-10MG TITRATION PACK 49 TAB	NAMENDA	49	365			0	Y	
2	040155	J1B	ALZHEIMER'S AGENTS	11	Y	RIVASTIGMINE TARTRATE 1.5MG CAPSULE	RIVASTIGMINE TARTRATE 1.5MG CAPSULE	EXELON			1				
2	040156	J1B	ALZHEIMER'S AGENTS	12	Y	RIVASTIGMINE TARTRATE 3, 4.5 and 6MG CAPSULE	RIVASTIGMINE TARTRATE 3MG CAPSULE	EXELON / RIVASTIGMINE			2				
2	062870	J1B	ALZHEIMER'S AGENTS	14	Y	RIVASTIGMINE PATCHES	RIVASTIGMINE 4.6MG / 24HR PATCH	EXELON			1			Y	
3	3	HIC3	THERAPEUTIC CLASS	0	Y	ANALGESICS, NARCOTIC - SHORT & LONG ACTING (Non-I	ANALGESICS, NARCOTIC - SHORT & LONG ACTING	BRAND	Units	Until Refill	Daily Dose	Max Days	Refills	Pkg Bill	Updated
3	080402	H3E	ANALGESIC/ANTIPYRETICS,NON-SALICYLATE	1	Y	ACETAMINOPHEN 500 MG CHEW GEL	ACETAMINOPHEN 500 MG CHEW GEL	7T GUMMY ES			8				
3	045155	H3U	NARCOTIC ANALGESIC & NON-SALICYLATE ANALGESIC COMB	2	Y	ACETAMINOPHEN WITH CODEINE 120-12MG/5ML SOLUT	ACETAMINOPHEN WITH CODEINE 120-12MG/5ML	GENERIC ONLY	600	30	167				1/1/2022
3	070222	H3U	NARCOTIC ANALGESIC & NON-SALICYLATE ANALGESIC COMB	2.1	Y	ACETAMINOPHEN WITH CODEINE 240-24MG/10ML SOLU	ACETAMINOPHEN WITH CODEINE 240-24MG/10M	GENERIC ONLY	600	30	167				1/1/2022
3	070212	H3U	NARCOTIC ANALGESIC & NON-SALICYLATE ANALGESIC COMB	2.2	Y	ACETAMINOPHEN WITH CODEINE 120-12MG/5ML SOLUT	ACETAMINOPHEN WITH CODEINE 120-12MG/5ML	GENERIC ONLY	600	30	167				1/1/2022
3	070224	H3U	NARCOTIC ANALGESIC & NON-SALICYLATE ANALGESIC COMB	3	Y	ACETAMINOPHEN WITH CODEINE 300/12.5ML SOLUTION	ACETAMINOPHEN WITH CODEINE 300/12.5ML SOL	GENERIC ONLY	300	30	167				1/1/2022
3	004163	H3U	NARCOTIC ANALGESIC & NON-SALICYLATE ANALGESIC COMB	4	Y	ACETAMINOPHEN WITH CODEINE 300-15MG TABLET	ACETAMINOPHEN WITH CODEINE 300-15MG TABL	GENERIC ONLY	120	30	13				1/1/2022
3	077292	H3Z	NARCOTIC ANALGESICNON-SALICYLATEXANTHINE	5	Y	ACETAMINOPHEN/CAFFEINE/DIHYDROCODEINE BITARTRA	ACETAMINOPHEN/CAFFEINE/DIHYDROCODEINE BI	GENERIC ONLY	120	30					
3	004165	H3U	NARCOTIC ANALGESIC & NON-SALICYLATE ANALGESIC COMB	6	Y	ACETAMINOPHEN-COD #3 300MG-30MG & 60MG TABLET	ACETAMINOPHEN-COD #3 300MG-30MG TABLET	TYLENOL 3	120	30	13				1/1/2022
3	004257	H3A	ANALGESICS, NARCOTICS	7	Y	BELLADONNA-OPIUM SUPPOSITORIES	BELLADONNA-OPIUM 16.2-30 SUPPOSITORY	GENERIC ONLY	60		2				1/1/2022
3	079489	H3U	NARCOTIC ANALGESIC & NON-SALICYLATE ANALGESIC COMB	8	Y	BENZHYDROCODONE/ACETAMINOPHEN TABLETS	BENZHYDROCODONE/ACETAMINOPHEN 4.08-325N	APADAZ	120		12	14			1/1/2022
3	059589	H3A	ANALGESICS, NARCOTICS	9	Y	BUPRENORPHINE PATCHES	BUPRENORPHINE 5MCG/HR PATCH	BUTRANS	4	30					
3	075050	H3A	ANALGESICS, NARCOTICS	10	Y	BUPRENORPHINE HCL FILMS	BUPRENORPHINE HCL 75MCG FILM	BELBUCA	60		2				1/1/2022
3	004308	H3O	ANALGESIC, SALICYLATE, BARBITURATE,& XANTHINE CMB	11	Y	BUTALBITAL-ACETAMINOPHN 50-325 MG CAPSULE	BUTALBITAL-ACETAMINOPHN 50-325 MG CAPSULE	FIORINAL	120	30	6				
3	078660	H3L	ANALGESIC,NON-SALICYLATE,BARBITURATE,&XANTHINE CMB	12	Y	BUTALBITAL-ACETAMINOPHN 50-300 MG TABLET	BUTALBITAL-ACETAMINOPHN 50-300 MG TABLET	GENERIC ONLY	180	30	6				
3	066372	H3L	ANALGESIC,NON-SALICYLATE,BARBITURATE,&XANTHINE CMB	13	Y	BUTALBIT/ACETAMINOPHEN/CAFFEINE CAPSULE & TABLE	BUTALBIT/ACETAMINOPHEN/CAFFEINE 50-300-40 (	ORBIVAN	120	30					
3	071253	H3M	NARC.& NON-SAL.ANALGESIC,BARBITURATE &XANTHINE CMB	14	Y	BUTALBIT/ACETAMIN/CAFF/CODEINE 50-300-40-30 CAPSU	BUTALBIT/ACETAMIN/CAFF/CODEINE 50-300-40-30	FIORICET	120	30	6				1/1/2022
3	004459	H3L	ANALGESIC,NON-SALICYLATE,BARBITURATE,&XANTHINE CMB	15	Y	BUTALBITAL-ACETAMINOPHN TABLETS	BUTALBITAL-ACETAMINOPHN 50-325 MG TABLET	GENERIC ONLY	180	30	6				
3	016674	H3A	ANALGESICS, NARCOTICS	16	Y	BUTORPHANOL TARTRATE 10 MG/ML SPRAY 2.5ML	BUTORPHANOL TARTRATE 10MG/ML SPRAY 2.5ML	GENERIC ONLY	2.5	30				Y	
3	004120	H3R	NARCOTIC & SALICYLATE ANALGESICS, BARB.& XANTHINE	16.5	Y	CODEINE/BUTALBITAL/ASA/CAFFEIN 50-325-40MG CAPSU	CODEINE/BUTALBITAL/ASA/CAFFEIN 50-325-40MG	FIORINAL w/CODEINE	120	30	6				1/1/2022
3	004185	H3A	ANALGESICS, NARCOTICS	17	Y	CODEINE SULFATE TABLETS	CODEINE SULFATE 15MG TABLET	GENERIC ONLY	120	30					
3	073169	H3Z	NARCOTIC ANALGESICNON-SALICYLATEXANTHINE	18	Y	DIHYDROCODEINE BUTALBITAL/ACETMAINPHONIE/CAFFE	DIHYDROCODEINE BUTALBITAL/ACETMAINPHONIE	TREZIX	120	30					
3	068412	H3A	ANALGESICS, NARCOTICS	19	Y	FENTANYL SPRAYS ALL STRENGTHS	FENTANYL 100MCG SPRAY	SUBSYS	30	30				Y	
3	059102	H3A	ANALGESICS, NARCOTICS	20	Y	FENTANYL PATCHES ALL STRENGHTS	FENTANYL 12MCG/HR PATCH	DURAGESIC	10	30					
3	061492	H3A	ANALGESICS, NARCOTICS	21	Y	FENTANYL CITRATE TABLETS ALL STRENGTHS	FENTANYL CITRATE 100MCG BUCCAL TABLET	FENTORA	120	30					
3	065633	H3A	ANALGESICS, NARCOTICS	22	Y	FENTANYL CITRATE NASAL SPRAYS ALL STRENGTHS	FENTANYL CITRATE 100MCG NASAL SPRAY	LAZANDA	1	30					
3	022358	H3A	ANALGESICS, NARCOTICS	23	Y	FENTANYL CITRATE LOZENGES ALL STRENGTHS	FENTANYL CITRATE 200MCG LOZENGE	ACTIQ	120	30					
3	064712	H3A	ANALGESICS, NARCOTICS	24	Y	FENTANYL CITRATE SUBLINGUAL TABLETS ALL STRENGTHS	FENTANYL CITRATE SUBLINGUAL 100MCG TAB	ABSTRAL	120	30					
3	030623	H3U	NARCOTIC ANALGESIC & NON-SALICYLATE ANALGESIC COMB	25	Y	HYDROCODONE BIT/ACETAMINOPHEN TABLETS ALL STRE	HYDROCODONE BIT/ACETAMINOPHEN 10-325MG	NORCO	120	30	12	30			1/1/2022
3	073176	H3A	ANALGESICS, NARCOTICS	26	Y	HYDROCODONE BITARTRATE TABLETS/CAPSULES HYSLINL	HYDROCODONE BITARTRATE 20MG TABLET	HYSINGLA ER	30		1				1/1/2022
3	073621	H3A	ANALGESICS, NARCOTICS	27	Y	HYDROCODONE BITARTRATE TABLETS/CAPSULES ZOHYDR	HYDROCODONE BITARTRATE 10MG CAPSULE	ZOHYDRO ER	60		2				1/1/2022
3	064753	H3U	NARCOTIC ANALGESIC & NON-SALICYLATE ANALGESIC COMB	28	Y	HYDROCODONE BITARTRATE/ACETAMINOPHEN SOLUTIOI	HYDROCODONE BITARTRATE/ACETAMINOPHEN 10	GENERIC ONLY	1800	30		30			1/1/2022
3	000846	H3A	ANALGESICS, NARCOTICS	29	Y	HYDROCODONE BITRATE - HOMATROPINE 5 MG-1.5MG T	HYDROCODONE BITRATE - HOMATROPINE 5 MG-1	TUSSIGON				30			
3	048491	H3A	ANALGESICS, NARCOTICS	30	Y	HYDROCODONE BITRATE - HOMATROPINE 5-1.5 MG/5ML	HYDROCODONE BITRATE - HOMATROPINE 5-1.5 M	GENERIC ONLY				30			
3	070078	H3A	ANALGESICS, NARCOTICS	31	Y	HYDROCODONE BITRATE - HOMATROPINE 5-1.5 MG/5ML	HYDROCODONE BITRATE - HOMATROPINE 5-1.5 M	GENERIC ONLY	600	30		30			
3	066836	H3U	NARCOTIC ANALGESIC & NON-SALICYLATE ANALGESIC COMB	32	Y	HYDROCODONE/ACETAMINOPHEN 15ML SOLUTIONS	HYDROCODONE/ACETAMINOPHEN 10-300MG/15N	HYCET/LORTAB/ZAMICET	1800	30		30			
3	054674	H3N	ANALGESICS, NARCOTIC AGONIST AND NSAID COMBINATION	33	Y	HYDROCODONE/IBUPROFEN TABLETS	HYDROCODONE/IBUPROFEN 5-200MG TABLET	IBUDONE / REPRAXIN	120	30	16	30			1/1/2022
3	071384	H3U	NARCOTIC ANALGESIC & NON-SALICYLATE ANALGESIC COMB	34	Y	HYDROCODONE-ACETAMINOPHEN 2.5-108/5ML, 5-217/5	HYDROCODONE-ACETAMINOPHEN 2.5-108/5ML	GENERIC ONLY	600	30		30			
3	071385	H3U	NARCOTIC ANALGESIC & NON-SALICYLATE ANALGESIC COMB	35	Y	HYDROCODONE-ACETAMINOPHEN 5-217/5ML	HYDROCODONE-ACETAMINOPHEN 5-217/5ML	GENERIC ONLY	1200	30		30			1/1/2022
3	063156	H3A	ANALGESICS, NARCOTICS	36	Y	HYDROCODONE-CHLORPHENIRAMNE ER CAPSULES	HYDROCODONE-CHLORPHENIRAMNE ER 10-8 MG	TUSSICAPS				30			
3	048492	H3A	ANALGESICS, NARCOTICS	37	Y	HYDROCODONE-CHLORPHENIRAMNE ER 10-8MG/5ML SU	HYDROCODONE-CHLORPHENIRAMNE ER 10-8MG/	TUSSIONEX				30			
3	004108	H3A	ANALGESICS, NARCOTICS	38	Y	HYDROMORPHONE 3 MG SUPPOSITORY	HYDROMORPHONE 3 MG SUPPOSITORY	DILAUDID	120	30					1/1/2022
3	069890	H3A	ANALGESICS, NARCOTICS	39	Y	HYDROMORPHONE HCL ER TABLETS	HYDROMORPHONE HCL ER 8MG TABLET	EXALGO ER	30		1				1/1/2022
3	016156	H3A	ANALGESICS, NARCOTICS	40	Y	HYDROMORPHONE HCL 1MG/ML SOLUTION	HYDROMORPHONE HCL 1MG/ML SOLUTION	DILAUDID	960	30	32				1/1/2022
3	004110	H3A	ANALGESICS, NARCOTICS	41	Y	HYDROMORPHONE HCL IR TABLETS	HYDROMORPHONE HCL 2MG TABLET	DILAUDID	120	30					
3	058402	H3N	ANALGESICS, NARCOTIC AGONIST AND NSAID COMBINATION	42	Y	IBUPROFEN/OXYCODONE HCL 5-400MG TABLET	IBUPROFEN/OXYCODONE HCL 5-400MG TABLET	GENERIC ONLY	120	30					
3	004228	H3A	ANALGESICS, NARCOTICS	43	Y	LEVORPHANOL TARTRATE TABLETS	LEVORPHANOL TARTRATE 2MG TABLET	GENERIC ONLY	120	30					
3	004051	H3A	ANALGESICS, NARCOTICS	44	Y	MEPERIDINE 50MG/5ML SOLUTION	MEPERIDINE 50MG/5ML SOLUTION	MEPERIDINE	140	30		7			1/1/2022
3	004053	H3A	ANALGESICS, NARCOTICS	45	Y	MEPERIDINE HCL TABLETS	MEPERIDINE HCL 50MG TABLET	DEMEROL / MEPERITAB	28	30	4	7			1/1/2022
3	004240	H3A	ANALGESICS, NARCOTICS	46	Y	METHADONE TABLETS & ODT	METHADONE HCL 10 MG TABLET	GENERIC ONLY	90		3				1/1/2022
3	004238	H3A	ANALGESICS, NARCOTICS	47	Y	METHADONE SOLUTIONS	METHADONE 5 MG/5 ML SOLUTION	GENERIC ONLY	450		15				1/1/2022

3	079209	H3A	ANALGESICS, NARCOTICS	47	Y	MORPHINE SULFATE 0.4MG/ML ORAL SPRAY	MORPHINE SULFATE 0.4MG/ML ORAL SPRAY	GENERIC ONLY	120	30					
3	004239	H3A	ANALGESICS, NARCOTICS	47.5	Y	METHADONE 10 MG/ML CONCENTRATE	METHADONE 10 MG/ML CONCENTRATE	GENERIC ONLY	90		3				1/1/2022
3	004083	H3A	ANALGESICS, NARCOTICS	48	Y	MORPHINE SULFATE SUPPOSITORIES	MORPHINE SULFATE 10 MG SUPPOSITORY	GENERIC ONLY	120	30					1/1/2022
3	082101	H3A	ANALGESICS, NARCOTICS	49	Y	METHADONE 5 MG/0.5 ML ORAL SYRINGE	METHADONE 5 MG/0.5 ML ORAL SYRINGE	GENERIC ONLY	90		3				1/1/2022
3	071396	H3A	ANALGESICS, NARCOTICS	49	Y	MORPHINE SULFATE ORAL SYRINGES	MORPHINE SULFATE 10 MG/0.5 ML ORAL SYRINGE	GENERIC ONLY	120	30					1/1/2022
3	004090	H3A	ANALGESICS, NARCOTICS	50	Y	MORPHINE SULFATE 100MG / 5ML CONCENTRATE	MORPHINE SULFATE 100MG / 5ML CONCENTRATE	GENERIC ONLY	120	30	4				1/1/2022
3	004087	H3A	ANALGESICS, NARCOTICS	51	Y	MORPHINE SULFATE SOLUTIONS	MORPHINE SULFATE 10MG / 5ML SOLUTION	GENERIC ONLY	600	30					1/1/2022
3	077053	H3A	ANALGESICS, NARCOTICS	52	Y	MORPHINE SULFATE ARYMO ER TABLETS	MORPHINE SULFATE 15MG TABLET	ARYMO ER	120	30					
3	074971	H3A	ANALGESICS, NARCOTICS	54	Y	MORPHINE SULFATE ER MORPHABOND & MS CONTIN ER	MORPHINE SULFATE ER 100MG TABLET	MORPHABOND ER / MS CONTIN	90	30	3				1/1/2022
3	064740	H3A	ANALGESICS, NARCOTICS	55	Y	MORPHINE SULFATE ER AVINZA & KADIAN	MORPHINE SULFATE ER 30MG CAPSULES	AVINZA / KADIAN ER	60		2				1/1/2022
3	073302	H3A	ANALGESICS, NARCOTICS	56	Y	MORPHINE SULFATE/NALTREXONE CAPSULES	MORPHINE SULFATE/NALTREXONE 20-0.8MG CAPS	EMBEDA ER	60		2				1/1/2022
3	076361	H3A	ANALGESICS, NARCOTICS	57	Y	OXYCODONE 10 MG/0.5 ML ORAL SYRINGE	OXYCODONE 10 MG/0.5 ML ORAL SYRINGE	GENERIC ONLY	60	30					1/1/2022
3	015065	H3A	ANALGESICS, NARCOTICS	58	Y	OXYCODONE HCL 100 MG/5 ML CONCENTRATE	OXYCODONE HCL 100 MG/5 ML CONCENTRATE	GENERIC ONLY	120	30					1/1/2022
3	024507	H3A	ANALGESICS, NARCOTICS	59	Y	OXYCODONE HCL CAPSULES or TABLETS ALL STRENGTHS	OXYCODONE HCL 5MG CAPSULE	OXECTA / ROXICODONE / ROXYE	120	30					1/1/2022
3	004224	H3A	ANALGESICS, NARCOTICS	60	Y	OXYCODONE HCL 5 MG/5 ML SOLUTION	OXYCODONE HCL 5 MG/5 ML SOLUTION	GENERIC ONLY	600	30					1/1/2022
3	073307	H3A	ANALGESICS, NARCOTICS	61	Y	OXYCODONE HCL ACETAMINOPHEN 7.5-325MG XR TABLE	OXYCODONE HCL ACETAMINOPHEN 7.5-325MG TA	XARTEMIS XR	60		2				1/1/2022
3	072863	H3A	ANALGESICS, NARCOTICS	62	Y	OXYCODONE HCL ER and XR TABLETS	OXYCODONE HCL ER 15MG TABLET	OXYCONTIN	60		2				1/1/2022
3	013998	H3U	NARCOTIC ANALGESIC & NON-SALICYLATE ANALGESIC COMB	63	Y	OXYCODONE HCL/ACETAMINOPHEN TABLETS ALL STRENG	OXYCODONE HCL/ACETAMINOPHEN 2.5-325MG TA	ENDOCET / NALOCET / PERCOD/	120	30	12				1/1/2022
3	076032	H3A	ANALGESICS, NARCOTICS	64	Y	OXYCODONE MYRISTATE ER CAPSULES	OXYCODONE MYRISTATE ER 13.5MG CAPSULE	XTAMPZA ER	60		2				1/1/2022
3	061086	H3A	ANALGESICS, NARCOTICS	65	Y	OXYMORPHONE HCL 5 and 10MG TABLET	OXYMORPHONE HCL 5MG TABLET	OPANA	120	30					
3	063782	H3A	ANALGESICS, NARCOTICS	66	y	OXYMORPHONE HCL 7.5, 15 and 30MG TABLET	OXYMORPHONE HCL 7.5MG TABLET	OPANA ER	60		2				1/1/2022
3	061091	H3A	ANALGESICS, NARCOTICS	67	Y	OXYMORPHONE HCL ER 5, 10, 20 and 40MG TABLET	OXYMORPHONE HCL ER 5MG TABLET	OPANA ER	60		2				1/1/2022
3	004292	H3A	ANALGESICS, NARCOTICS	68	Y	PENTAZOCINE HCL/NALOXONE HCL 2.5-500MG TABLET	PENTAZOCINE HCL/NALOXONE HCL 2.5-500MG TAB	GENERIC ONLY	120	30					
3	079437	H3A	ANALGESICS, NARCOTICS	69	Y	SUFENTANIL CITRATE 30MCG SUBLINGUAL TABLET	SUFENTANIL CITRATE 30MCG SUBLINGUAL TABLET	DSUVIA	36		12	3			
3	065321	H3A	ANALGESICS, NARCOTICS	70	Y	TAPENTADOL HCL 100MG TABLET	TAPENTADOL HCL 100MG TABLET	NUCYNTA	120	30	6				1/1/2022
3	065319	H3A	ANALGESICS, NARCOTICS	71	Y	TAPENTADOL HCL 50MG TABLET	TAPENTADOL HCL 50MG TABLET	NUCYNTA	120	30	12				1/1/2022
3	065320	H3A	ANALGESICS, NARCOTICS	72	Y	TAPENTADOL HCL 75MG TABLET	TAPENTADOL HCL 75MG TABLET	NUCYNTA	120	30	8				1/1/2022
3	067266	H3A	ANALGESICS, NARCOTICS	73	Y	TAPENTADOL HCL ER TABLETS	TAPENTADOL HCL ER 50MG TABLET	NUCYNTA ER	60		2				
3	044975	H3A	ANALGESICS, NARCOTICS	74	Y	TRAMADOL HCL 100 MG TABLET	TRAMADOL HCL 100 MG TABLET	GENERIC ONLY	120	30	4				
3	023139	H3A	ANALGESICS, NARCOTICS	75	Y	TRAMADOL HCL 50MG TABLET	TRAMADOL HCL 50MG TABLET	ULTRAM / RYBIX ODT	240	30	8				1/1/2022
3	081474	H3A	ANALGESICS, NARCOTICS	76	Y	TRAMADOL HCL 5 MG/ML SOLUTION	TRAMADOL HCL 5 MG/ML SOLUTION	QDOLO	2400	30	80				
3	067760	H3A	ANALGESICS, NARCOTICS	77	Y	TRAMADOL ER HCL TABLETS or CAPSULES	TRAMADOL HCL ER 100MG CAPSULE	CONZIP / RYZOLT / ULTRAM ER	30		1				1/1/2022
3	048456	H3A	ANALGESICS, NARCOTICS	78	Y	TRAMADOL HCL/ACETAMINOPHEN 37.5-325 TABLET	TRAMADOL HCL/ACETAMINOPHEN 37.5-325 TABLE	ULTRACET	40	30	8	5			1/1/2022
5	5	HIC3	THERAPEUTIC CLASS	0	Y	ANDROGENIC AGENTS	ANDROGENIC AGENTS	BRAND	Units	Until Refill	Daily Dose	Max Days	Refills	Pkg Bill	Updated
5	045215	F1A	ANDROGENIC AGENTS	1	Y	TESTOSTERONE 1% & 1.62% GEL 2.5G PACKET	TESTOSTERONE 1% & 1.62% GEL 2.5G PACKET	ANDROGEL	75	30				Y	
5	045216	F1A	ANDROGENIC AGENTS	2	Y	TESTOSTERONE 1% GEL 5G PACKET	TESTOSTERONE 1% (5G) GEL PACKET	ANDROGEL	150	30				Y	
5	070128	F1A	ANDROGENIC AGENTS	3	Y	TESTOSTERONE 1.62% GEL 1.25G PACKET	TESTOSTERONE 1.62%(1.25G) GEL PACKET	ANDROGEL	37.5	30				Y	
5	068099	F1A	ANDROGENIC AGENTS	4	Y	TESTOSTERONE 2, 2.5, 4 and 5MG/24HR PATCH	TESTOSTERONE 2MG/24HR PATCH	ANDRODERM			1	60			
5	067154	F1A	ANDROGENIC AGENTS	5	Y	TESTOSTERONE 30MG SOLUTION 90ML	TESTOSTERONE 30MG SOLUTION 90ML	AXIRON	90	30				Y	
5	057874	F1A	ANDROGENIC AGENTS	6	Y	TESTOSTERONE 1% GEL & GEL PUMP	TESTOSTERONE 1% GEL PUMP	ANDROGEL	150	30				Y	
5	067366	F1A	ANDROGENIC AGENTS	8	Y	TESTOSTERONE 1.62% GEL PUMP 75 ML	TESTOSTERONE 1.62% GEL PUMP 75 ML	ANDROGEL	75	30				Y	
5	062542	F1A	ANDROGENIC AGENTS	9	Y	TESTOSTERONE 10MG GEL PUMP 60GRAM	TESTOSTERONE 10MG GEL PUMP 60GRAM	FORTESTA	60	30				Y	
5	073643	F1A	ANDROGENIC AGENTS	10	Y	TESTOSTERONE 5.5 MG/0.122 GM	TESTOSTERONE 5.5 MG/0.122 GM	NATESTO	7.32	28					
5	079087	F1A	ANDROGENIC AGENTS	11	Y	TESTOSTERONE ENANTHATE AUTO-INJECTORS	TESTOSTERONE ENANTHATE 100MG/0.5ML AUTO-	XYOSTED	2	30					
5	079619	F1A	ANDROGENIC AGENTS	12	Y	TESTOSTERONE UNDECANOATE 158 & 198 MG CAPSULES	TESTOSTERONE UNDECANOATE 158 MG CAPSULE	JATENZO			4				
5	079611	F1A	ANDROGENIC AGENTS	13	Y	TESTOSTERONE UNDECANOATE 237 MG CAPSULE	TESTOSTERONE UNDECANOATE 237 MG CAPSULE	JATENZO			2				
6	6	HIC3	THERAPEUTIC CLASS	0	Y	ANESTHETICS, TOPICAL	ANESTHETICS, TOPICAL	BRAND	Units	Until Refill	Daily Dose	Max Days	Refills	Pkg Bill	Updated
6	058447	Q3I	HEMORRHOIDAL PREP,ANTI-INFLAM STEROID/LOCAL ANESTH	2	Y	HYDROCORTISONE AC/LIDOCAINE 0.5-3% CREAM KIT 1 or	HYDROCORTISONE AC/LIDOCAINE 0.5-3% CREAM K	ANAMANTLE HC	1						
6	059283	Q3I	HEMORRHOIDAL PREP,ANTI-INFLAM STEROID/LOCAL ANESTH	3	Y	HYDROCORTISONE AC/LIDOCAINE 1-3% CREAM KIT 7GRA	HYDROCORTISONE AC/LIDOCAINE 1-3% CREAM KIT	ANAMANTLE HC FORTE	1						
6	060270	Q3I	HEMORRHOIDAL PREP,ANTI-INFLAM STEROID/LOCAL ANESTH	4	Y	HYDROCORTISONE/LIDOCAINE/ALOE 2.8-0.55% GEL 15 SI	HYDROCORTISONE/LIDOCAINE/ALOE 2.8-0.55% GE	GENERIC ONLY	100					Y	
6	060609	Q3I	HEMORRHOIDAL PREP,ANTI-INFLAM STEROID/LOCAL ANESTH	5	Y	HYDROCORTISONE/LIDOCAINE/ALOE 2.5-3% (7GRAM) 1 c	HYDROCORTISONE/LIDOCAINE/ALOE 2.5-3% (7GRA	LIDOCORT GEL KIT	20					Y	
6	062724	Q3I	HEMORRHOIDAL PREP,ANTI-INFLAM STEROID/LOCAL ANESTH	6	Y	HYDROCORTISONE/LIDOCAINE/ALOE 2-2% CREAM 24/7G	HYDROCORTISONE/LIDOCAINE/ALOE 2-2% CREAM	PERANEX HC	1					Y	
6	043256	Q5H	TOPICAL LOCAL ANESTHETICS	7	Y	LIDOCAINE 5% PATCH	LIDOCAINE 5% PATCH	LIDODERM			1				
6	081943	Q5H	TOPICAL LOCAL ANESTHETICS	8	Y	LIDOCAINE HCL 4% PATCH	LIDOCAINE HCL 4% PATCH	LIDAFLEX	30		1				
6	014476	Q5H	TOPICAL LOCAL ANESTHETICS	9	Y	LIDOCAINE 5% OINTMENT	LIDOCAINE 5% OINTMENT	GENERIC ONLY	120	30				Y	
6	061268	Q5H	TOPICAL LOCAL ANESTHETICS	10	Y	IDOCAINE 5% CREAM	IDOCAINE 5% CREAM	GENERIC ONLY	30	30					
6	078210	Q5H	TOPICAL LOCAL ANESTHETICS	11	Y	LIDOCAINE 1.8% TOPICAL SYSTEM	LIDOCAINE 1.8% TOPICAL SYSTEM	ZTLIDO			1				
7	7	HIC3	THERAPEUTIC CLASS	0	Y	ANGIOTENSIN MODULATORS	ANGIOTENSIN MODULATORS	BRAND	Units	Until Refill	Daily Dose	Max Days	Refills	Pkg Bill	Updated
7	062289	A4T	ANGIOTENSIN MODULATOR RENIN INHIBITOR, DIRECT	1	Y	ALISKIREN HEMIFUMARATE 150 and 300MG TABLET	ALISKIREN HEMIFUMARATE 150MG TABLET	TEKTURNA			1				
7	063589	A4U	RENIN INHIBITOR,DIRECT AND THIAZIDE DIURETIC COMB	2	Y	ALISKIREN/HCT TABLETS ALL STRENGTHS	ALISKIREN/HCT 150-12.5MG TABLET	TEKTURNA HCT			1				
7	063179	A4H	ANGIOTENSIN RECEPTOR ANTGNST & CALC.CHANNEL BLOCKR	3	Y	AMLODIPINE BESYLATE /OLMESARTAN MED TABLETS ALL	AMLODIPINE BES/OLMESARTAN MED 5-20MG TAB	AZOR			1				
7	023770	A4K	ACE INHIBITOR/CALCIUM CHANNEL BLOCKER COMBINATION	4	Y	AMLODIPINE BESYLATE/BENAZEPRIL CAPSULES ALL STREN	AMLODIPINE BESYLATE/BENAZEPRIL 2.5-10MG CA	LOTREL			1				
7	062180	A4H	ANGIOTENSIN RECEPTOR ANTGNST & CALC.CHANNEL BLOCKR	5	Y	AMLODIPINE/VALSARTAN TABLETS ALL STRENGTHS	AMLODIPINE/VALSARTAN 5-160MG TABLET	EXFORGE			1				
7	065148	A4V	ANGIOTEN.RECEPTR ANTAG./CAL.CHANL BLKR/THIAZIDE CB	6	Y	AMLODIPINE/VALSARTAN/HCTZ TABLETS ALL STRENGTHS	AMLODIPINE/VALSARTAN/HCTZ 5-160-12.5MG TAB	EXFORGE HCT			1				
7	068389	A4I	ANGIOTENSIN RECEPTOR ANTAG./THIAZIDE DIURETIC COMB	7	Y	AZILSARTAN MED/CHLORTHALIDONE TABLETS ALL STREN	AZILSARTAN MED/CHLORTHALIDONE 40-12.5 MG T	EDARBYCLOR			1				
7	067113	A4F	ANTIHYPERTENSIVES, ANGIOTENSIN RECEPTOR ANTAGONIST	8	Y	AZILSARTAN MEDOXOMIL TABLETS	AZILSARTAN MEDOXOMIL 40MG TABLET	EDARBI			1				
7	016039	A4D	ANTIHYPERTENSIVES, ACE INHIBITORS	9	Y	BENAZEPRIL HCL 5, 10 and 20MG TABLET	BENAZEPRIL HCL 5MG TABLET	LOTENSIN			1				
7	016042	A4D	ANTIHYPERTENSIVES, ACE INHIBITORS	10	Y	BENAZEPRIL HCL 40MG TABLET	BENAZEPRIL HCL 40MG TABLET	LOTENSIN			2				
7	021723	A4J	ACE INHIBITOR/THIAZIDE & THIAZIDE-LIKE DIURETIC	11	Y	BENAZEPRIL/HCT TABLETS ALL STRENGTHS	BENAZEPRIL/HCT 5-6.25MG TABLET	LOTENSIN HCT			1				
7	037015	A4F	ANTIHYPERTENSIVES, ANGIOTENSIN RECEPTOR ANTAGONIST	12	Y	CANDESARTAN CILEXETIL TABLETS	CANDESARTAN CILEXETIL 4MG TABLET	ATACAND			1				
7	045425	A4I	ANGIOTENSIN RECEPTOR ANTAG./THIAZIDE DIURETIC COMB	13	Y	CANDESARTAN/HYDROCHLOROTHIAZID 16-12.5MG TABL	CANDESARTAN/HYDROCHLOROTHIAZID 16-12.5MG	ATACAND HCT			1				
7	000379	A4D	ANTIHYPERTENSIVES, ACE INHIBITORS	14	Y	CAPTOPRIL TABLETS	CAPTOPRIL 12.5MG TABLET	GENERIC ONLY			3				
7	000374	A4J	ACE INHIBITOR/THIAZIDE & THIAZIDE-LIKE DIURETIC	16	Y	CAPTOPRIL/HCT TABLETS ALL STRENGTHS	CAPTOPRIL/HCT 25-15MG TABLET	GENERIC ONLY			1				
7	000385	A4D	ANTIHYPERTENSIVES, ACE INHIBITORS	17	Y	ENALAPRIL MALEATE 2.5, 5 and 10MG TABLET	ENALAPRIL MALEATE 2.5MG TABLET	VASOTEC			1				
7	000386	A4D	ANTIHYPERTENSIVES, ACE INHIBITORS	18	Y	ENALAPRIL MALEATE 20MG TABLET	ENALAPRIL MALEATE 20MG TABLET	VASOTEC			2				
7	000382	A4J	ACE INHIBITOR/THIAZIDE & THIAZIDE-LIKE DIURETIC	19	Y	ENALAPRIL/HCT 10-25MG TABLET	ENALAPRIL/HCT 10-25MG TABLET	VASERETIC			2				
7	024190	A4J	ACE INHIBITOR/THIAZIDE & THIAZIDE-LIKE DIURETIC	20	Y	ENALAPRIL/HCT 12.5MG TABLET	ENALAPRIL/HCT 12.5MG TABLET	GENERIC ONLY			1				

7	043063	A4F	ANTIHYPERTENSIVES, ANGIOTENSIN RECEPTOR ANTAGONIST	21	Y	EPROSARTAN MESYLATE 600MG TABLET	EPROSARTAN MESYLATE 600MG TABLET	TEVETEN			1				
7	037029	A4F	ANTIHYPERTENSIVES, ANGIOTENSIN RECEPTOR ANTAGONIST	22	Y	EPROSARTAN MESYLATE 400 MG TILTAB	EPROSARTAN MESYLATE 400 MG TILTAB	TEVETEN			2				
7	051562	A4I	ANGIOTENSIN RECEPTOR ANTAG./THIAZIDE DIURETIC COMB	23	Y	EPROSARTAN/HCT TABLETS	EPROSARTAN/HCT 600-12.5MG TABLET	TEVETEN HCT			1				
7	016017	A4D	ANTIHYPERTENSIVES, ACE INHIBITORS	24	Y	FOSINOPRIL SODIUM 10 and 20MG TABLET	FOSINOPRIL SODIUM 10MG TABLET	GENERIC ONLY			1				
7	024469	A4D	ANTIHYPERTENSIVES, ACE INHIBITORS	25	Y	FOSINOPRIL SODIUM 40MG TABLET	FOSINOPRIL SODIUM 40MG TABLET	GENERIC ONLY			2				
7	034470	A4F	ANTIHYPERTENSIVES, ANGIOTENSIN RECEPTOR ANTAGONIST	26	Y	IRBESARTAN TABLETS	IRBESARTAN 75MG TABLET	AVAPRO			1				
7	041234	A4I	ANGIOTENSIN RECEPTOR ANTAG./THIAZIDE DIURETIC COMB	27	Y	IRBESARTAN/HCT TABLETS	IRBESARTAN/HCT 150-12.5MG TABLET	AVALIDE			1				
7	017266	A4D	ANTIHYPERTENSIVES, ACE INHIBITORS	28	Y	LISINOPRIL 2.5, 5, 10, 20 and 30MG TABLET	LISINOPRIL 2.5MG TABLET	PRINIVIL/ZESTRIL			1				
7	000392	A4D	ANTIHYPERTENSIVES, ACE INHIBITORS	29	Y	LISINOPRIL 40MG TABLET	LISINOPRIL 40MG TABLET	PRINIVIL/ZESTRIL			2				
7	021277	A4J	ACE INHIBITOR/THIAZIDE & THIAZIDE-LIKE DIURETIC	30	Y	LISINOPRIL/HCT 10-12.5 and 20-12.5MG TABLET	LISINOPRIL/HCT 10-12.5MG TABLET	PRINZIDE / ZESTORETIC			1				
7	000389	A4J	ACE INHIBITOR/THIAZIDE & THIAZIDE-LIKE DIURETIC	31	Y	LISINOPRIL/HCT 20-25MG TABLET	LISINOPRIL/HCT 20-25MG TABLET	ZESTORETIC			2				
7	023381	A4F	ANTIHYPERTENSIVES, ANGIOTENSIN RECEPTOR ANTAGONIST	32	Y	LOSARTAN POTASSIUM 25 and 50MG TABLET	LOSARTAN POTASSIUM 25MG TABLET	COZAAR			2				
7	038686	A4F	ANTIHYPERTENSIVES, ANGIOTENSIN RECEPTOR ANTAGONIST	33	Y	LOSARTAN POTASSIUM 100MG TABLET	LOSARTAN POTASSIUM 100MG TABLET	COZAAR			1				
7	023465	A4I	ANGIOTENSIN RECEPTOR ANTAG./THIAZIDE DIURETIC COMB	34	Y	LOSARTAN/HCT TABLETS	LOSARTAN/HCT 50-12.5MG TABLET	HYZAAR			1				
7	023591	A4D	ANTIHYPERTENSIVES, ACE INHIBITORS	35	Y	MOEXIPRIL HCL 7.5MG TABLET	MOEXIPRIL HCL 7.5MG TABLET	UNIVASC			1				
7	023592	A4D	ANTIHYPERTENSIVES, ACE INHIBITORS	36	Y	MOEXIPRIL HCL 15MG TABLET	MOEXIPRIL HCL 15MG TABLET	UNIVASC			2				
7	034063	A4J	ACE INHIBITOR/THIAZIDE & THIAZIDE-LIKE DIURETIC	37	Y	MOEXIPRIL/HCT 7TABLETS	MOEXIPRIL/HCT 7.5-12.5MG TABLET	UNIRETIC			1				
7	066538	A4V	ANGIOTEN.RECEPTR ANTAG./CAL.CHANL BLKR/THIAZIDE CB	38	Y	OLMESARTAN MED/AMLODIPINE/HCTZ TABLETS ALL STRE	OLMESARTAN MED/AMLODIPINE/HCTZ 20-5-12.5M	TRIBENZOR			1				
7	052833	A4I	ANGIOTENSIN RECEPTOR ANTAG./THIAZIDE DIURETIC COMB	40	Y	OLMESARTAN/HCT TABLETS ALL STRENGTHS	OLMESARTAN/HCT 20-12.5MG TABLET	BENICAR HCT			1				
7	041337	A4D	ANTIHYPERTENSIVES, ACE INHIBITORS	40.5	Y	PERINDOPRIL ERBUMINE 2 and 4MG TABLET	PERINDOPRIL ERBUMINE 2MG TABLET	ACEON			1				
7	042783	A4D	ANTIHYPERTENSIVES, ACE INHIBITORS	40.75	Y	PERINDOPRIL ERBUMINE 8MG TABLET	PERINDOPRIL ERBUMINE 8MG TABLET	ACEON			2				
7	018774	A4D	ANTIHYPERTENSIVES, ACE INHIBITORS	41	Y	QUINAPRIL HCL 5, 10 and 20MG TABLET	QUINAPRIL HCL 5MG TABLET	ACCUPRIL			1				
7	021909	A4D	ANTIHYPERTENSIVES, ACE INHIBITORS	42	Y	QUINAPRIL HCL 40MG TABLET	QUINAPRIL HCL 40MG TABLET	ACCUPRIL			2				
7	019140	A4J	ACE INHIBITOR/THIAZIDE & THIAZIDE-LIKE DIURETIC	43	Y	QUINAPRIL HCTZ TABLETS	QUINAPRIL HCTZ 10-12.5MG TABLET	ACCURETIC			1				
7	015939	A4D	ANTIHYPERTENSIVES, ACE INHIBITORS	44	Y	RAMIPRIL 1.25, 2.5 and 5MG CAPSULE or TABLET	RAMIPRIL 1.25MG TABLET	ALTACE			1				
7	016031	A4D	ANTIHYPERTENSIVES, ACE INHIBITORS	45	Y	RAMIPRIL 10MG TABLET or CAPSULE	RAMIPRIL 10MG CAPSULE	ALTACE			2				
7	040911	A4F	ANTIHYPERTENSIVES, ANGIOTENSIN RECEPTOR ANTAGONIST	46	Y	TELMISARTAN 80MG TABLET	TELMISARTAN 80MG TABLET	MICARDIS			1				
7	065746	A4H	ANGIOTENSIN RECEPTOR ANTGNST & CALC.CHANNEL BLOCKR	47	Y	TELMISARTAN/AMLODIPINE TABLET ALL STRENGTHS	TELMISARTAN/AMLODIPINE 40-5MG TABLET	TWYNSTA			1				
7	047324	A4I	ANGIOTENSIN RECEPTOR ANTAG./THIAZIDE DIURETIC COMB	48	Y	TELMISARTAN/HYDROCHLOROTHIAZID 80-12.5MG TABLE	TELMISARTAN/HYDROCHLOROTHIAZID 80-12.5MG	MICARDIS HCT			1				
7	026376	A4D	ANTIHYPERTENSIVES, ACE INHIBITORS	49	Y	TRANDOLAPRIL 1 and 2MG TABLET	TRANDOLAPRIL 1MG TABLET	MAVIK			1				
7	026378	A4D	ANTIHYPERTENSIVES, ACE INHIBITORS	50	Y	TRANDOLAPRIL 4MG TABLET	TRANDOLAPRIL 4MG TABLET	MAVIK			2				
7	029252	A4K	ACE INHIBITOR/CALCIUM CHANNEL BLOCKER COMBINATION	51	Y	TRANDOLAPRIL/VERAPAMIL HCL TABLET ALL STRENGTHS	TRANDOLAPRIL/VERAPAMIL HCL 1-240MG TABLET	TARKA			1				
7	050805	A4F	ANTIHYPERTENSIVES, ANGIOTENSIN RECEPTOR ANTAGONIST	52	Y	VALSARTAN TABLETS	VALSARTAN 40MG TABLET	DIOVAN			1				
7	037354	A4I	ANGIOTENSIN RECEPTOR ANTAG./THIAZIDE DIURETIC COMB	53	Y	VALSARTAN/HCT TABLET ALL STRENGTHS	VALSARTAN/HCT 80-12.5 TABLET	DIOVAN HCT			1				
8	**8**	**HIC3**	**THERAPEUTIC CLASS**	**0**	**Y**	**ANTIANGINAL & ANTI-ISCHEMIC**	**ANTIANGINAL & ANTI-ISCHEMIC**	**BRAND**	**Units**	**Until Refill**	**Daily Dose**	**Max Days**	**Refills**	**Pkg Bill**	**Updated**
8	060333	A2C	ANTIANGINAL & ANTI-ISCHEMIC AGENTS,NON-HEMODYNAMIC	1	Y	RANOLAZINE TABLETS	RANOLAZINE 500MG TABLET	RANEXA			2				
9	**9**	**HIC3**	**THERAPEUTIC CLASS**	**0**	**Y**	**ANTIBIOTICS, GI**	**ANTIBIOTICS, GI**	**BRAND**	**Units**	**Until Refill**	**Daily Dose**	**Max Days**	**Refills**	**Pkg Bill**	**Updated**
9	029986	W4M	ANTIBIOTICS, GI & RELATED	1	Y	NITAZOXANIDE 100MG/5ML SUSPENSION	NITAZOXANIDE 100MG/5ML SUSPENSION	ALINIA	180	30					
9	029984	W4M	ANTIBIOTICS, GI & RELATED	2	Y	NITAZOXANIDE 500MG TABLET	NITAZOXANIDE 500MG TABLET	ALINIA	6	30					
9	079335	W9C	ANTIBIOTICS, GI & RELATED	3	Y	RIFAMYCIN SODIUM 194MG TABLET	RIFAMYCIN SODIUM 194MG TABLET	AEMCOLO	12		4				
9	041880	W9C	ANTIBIOTICS, GI & RELATED	4	Y	RIFAXIMIN 200MG TABLET	RIFAXIMIN 200MG TABLET	XIFAXAN	9	30		3			
9	066295	W9C	ANTIBIOTICS, GI & RELATED	5	Y	RIFAXIMIN 550MG TABLET	RIFAXIMIN 550MG TABLET	XIFAXAN			3				
9	057691	W4G	ANTIBIOTICS, GI & RELATED	6	Y	TINIDAZOLE 250MG TABLET	TINIDAZOLE 250MG TABLET	TINDAMAX	24	30		5			
9	019048	W4G	ANTIBIOTICS, GI & RELATED	7	Y	TINIDAZOLE 500MG TABLET	TINIDAZOLE 500MG TABLET	TINDAMAX	12	30		5			
9	009326	W1J	VANCOMYCIN AND DERIVATIVES	8	Y	VANCOMYCIN HCL 125 and 250MG CAPSULE	VANCOMYCIN HCL 125MG CAPSULE	VANCOCIN HCL				14	1		
9	009333	W1J	VANCOMYCIN AND DERIVATIVES	9	Y	VANCOMYCIN HCL SOLUTION	VANCOMYCIN HCL 50MG/ML SOLUTION	FIRVANQ				14	1		
10	**10**	**HIC3**	**THERAPEUTIC CLASS**	**0**	**Y**	**ANTIBIOTICS, INHALED**	**ANTIBIOTICS, INHALED**	**BRAND**	**Units**	**Until Refill**	**Daily Dose**	**Max Days**	**Refills**	**Pkg Bill**	**Updated**
10	079020	W1F	AMINOGLYCOSIDES	1	Y	AMIKACIN LIPOSOMAL/NEB.ACCESSR 590MG/8.4ML VIAL	AMIKACIN LIPOSOMAL/NEB.ACCESSR 590MG/8.4M	ARIKAYCE			8.4			Y	
10	065913	W1P	ANTIBIOTICS, INHALED	2	Y	AZTREONAM LYSINE 75MG/ML INHAL SOLUTION 84ML VI	AZTREONAM LYSINE 75MG/ML INHAL SOLUTION 8	CAYSTON			3				
10	009832	W1F	AMINOGLYCOSIDES	3	Y	NEOMY SULF/POLYMYXIN B SULFATE 40MG/ML AMPULE	NEOMY SULF/POLYMYXIN B SULFATE 40MG/ML AN	NEOSPORIN G.U. IRRIGANT			2				
10	037042	W1F	AMINOGLYCOSIDES	4	Y	TOBRAMYCIN IN 0.225% NACL 300MG/5ML SOLUTION	TOBRAMYCIN IN 0.225% NACL 300MG/5ML SOLUT	TOBI			10			Y	
11	**11**	**HIC3**	**THERAPEUTIC CLASS**	**0**	**Y**	**ANTIBIOTICS, TOPICAL**	**ANTIBIOTICS, TOPICAL**	**BRAND**	**Units**	**Until Refill**	**Daily Dose**	**Max Days**	**Refills**	**Pkg Bill**	**Updated**
11	007724	Q5W	TOPICAL ANTIBIOTICS	1	Y	GENTAMICIN 0.1% CREAM	GENTAMICIN 0.1% CREAM	GENERIC ONLY	60					Y	
11	081111	Q5W	TOPICAL ANTIBIOTICS	2	Y	MINOCYCLINE HCL 1.5% FOAM	MINOCYCLINE HCL 1.5% FOAM	ZILXI	30						
11	061996	Q5W	TOPICAL ANTIBIOTICS	3	Y	MUPIROCIN 2% OINTMENT KIT	MUPIROCIN 2% OINTMENT KIT	CENTANY AT	30	30				Y	
11	018370	Q7W	NOSE PREPARATIONS ANTIBIOTICS	4	Y	MUPIROCIN CALCIUM 2% NASAL OINTMENT	MUPIROCIN CALCIUM 2% NASAL OINTMENT	BACTROBAN NASAL	10	30				Y	
12	**12**	**HIC3**	**THERAPEUTIC CLASS**	**0**	**Y**	**ANTIBIOTICS, VAGINAL**	**ANTIBIOTICS, VAGINAL**	**BRAND**	**Units**	**Until Refill**	**Daily Dose**	**Max Days**	**Refills**	**Pkg Bill**	**Updated**
12	009341	W1K	ANTIBIOTICS, VAGINAL	1	Y	CLINDAMYCIN HCL CAPSULES ALL STRENGHTS	CLINDAMYCIN HCL 75MG CAPSULE	CLEOCIN				14	1		
12	009346	W1K	ANTIBIOTICS, VAGINAL	2	Y	CLINDAMYCIN PALMITATE HCL 75MG/5ML SOLUTION	CLINDAMYCIN PALMITATE HCL 75MG/5ML SOLUTI	GENERIC ONLY				14	1		
12	044397	Q4W	VAGINAL ANTIBIOTICS	3	Y	CLINDAMYCIN PHOSPHATE 100 MG VAGINAL OVULE	CLINDAMYCIN PHOSPHATE 100 MG VAGINAL OVU	CLEOCIN	3	14				Y	
12	058439	Q4W	VAGINAL ANTIBIOTICS	4	Y	CLINDAMYCIN PHOSPHATE 2% VAGINAL CREAM	CLINDAMYCIN PHOSPHATE 2% VAGINAL CREAM	CLINDESSE	5	14				Y	
12	007006	Q4F	VAGINAL ANTIFUNGALS	5	Y	MICONAZOLE NITRATE KITS AND PACKS	MICONAZOLE NITRATE 200MG-2% KIT	MONISTAT 3	1	30				Y	
13	**13**	**HIC3**	**THERAPEUTIC CLASS**	**0**	**Y**	**ANTICOAGULANTS**	**ANTICOAGULANTS**	**BRAND**	**Units**	**Until Refill**	**Daily Dose**	**Max Days**	**Refills**	**Pkg Bill**	**Updated**
13	067642	M9V	ANTICOAGULANTS	1	Y	APIXABAN 2.5 MG TABLET	APIXABAN 2.5 MG TABLET	ELIQUIS			2				
13	078093	M9V	ANTICOAGULANTS	2	Y	APIXABAN 5 MG STARTER PACK	APIXABAN 5 MG STARTER PACK	ELIQUIS	74	999			0	Y	
13	063997	W9I	ANTICOAGULANTS, LIPOGLYCOPEPTIDE ANTIBIOTICS	3	Y	DABIGATRAN ETEXILATE MESYLATE CAPSULES ALL STRENG	DABIGATRAN ETEXILATE MESYLATE 75MG CAPSULE	PRADAXA			2				
13	064493	M9V	ANTICOAGULANTS	4	Y	RIVAROXABAN 10MG TABLET	RIVAROXABAN 10MG TABLET	XARELTO	30	30	1		1		
13	068118	M9V	ANTICOAGULANTS	5	Y	RIVAROXABAN 15MG TABLET	RIVAROXABAN 15MG TABLET	XARELTO	42	30	2				
13	072661	M9V	ANTICOAGULANTS	6	Y	RIVAROXABAN 2.5MG TABLET	RIVAROXABAN 2.5MG TABLET	XARELTO			2				
13	068119	M9V	ANTICOAGULANTS	7	Y	RIVAROXABAN 20MG TABLET	RIVAROXABAN 20MG TABLET	XARELTO			1				
14	**14**	**HIC3**	**THERAPEUTIC CLASS**	**0**	**Y**	**ANTICONVULSANTS**	**ANTICONVULSANTS**	**BRAND**	**Units**	**Until Refill**	**Daily Dose**	**Max Days**	**Refills**	**Pkg Bill**	**Updated**
14	075598	H4B	ANTICONVULSANTS	1	Y	BRIVARACETAM TABLETS	BRIVARACETAM 10MG TABLET	BRIVIACT	60	30	2				
14	075593	H4B	ANTICONVULSANTS	1.1	Y	BRIVARACETAM 10MG/ML SOLUTION	BRIVARACETAM 10MG/ML SOLUTION	BRIVIACT	600	30	20				
14	080526	H4B	ANTICONVULSANTS	2	Y	CENOBAMATE 50, 100 & 150 MG TABLETS	CENOBAMATE 100 MG TABLET	XCOPRI			1				
14	080528	H4B	ANTICONVULSANTS	2.1	Y	CENOBAMATE 200 MG TABLET	CENOBAMATE 200 MG TABLET	XCOPRI			2				
14	080535	H4B	ANTICONVULSANTS	2.2	Y	CENOBAMATE TITRATION PACKS	CENOBAMATE 12.5-25 MG TITRATION PK	XCOPRI			1				
14	080538	H4B	ANTICONVULSANTS	3	Y	CENOBAMATE DAILY DOSE PACKS	CENOBAMATE 25 MG DAILY DOSE PACK	XCOPRI	56	30	2				

14	017026	H8R	ANTICONVULSANTS, BENZODIAZEPINES	4	Y	CLOBAZAM TABLETS	CLOBAZAM 10MG TABLET	ONFI			2				
14	004560	H4A	ANTICONVULSANTS, BENZODIAZEPINES	5	Y	CLONAZEPAM TABLETS AND ODT	CLONAZEPAM 0.5 MG TABLET	KLONOPIN	90	30	3				
14	003767	H2F	ANTICONVULSANT ANTI-ANXIETY DRUGS	8	Y	DIAZEPAM TABLETS	DIAZEPAM 2MG TABLET	VALIUM	120	30	4				
14	080630	H4A	ANTICONVULSANTS, BENZODIAZEPINES	8.5	Y	DIAZEPAM NASAL SPRAYS	DIAZEPAM 5 MG NASAL SPRAY	VALTOCO	10	30					
14	003762	H2F	ANTICONVULSANT ANTI-ANXIETY DRUGS	9	Y	DIAZEPAM 10MG / 2ML CARPUJECT	DIAZEPAM 10MG / 2ML CARPUJECT	GENERIC ONLY	240	30	8			Y	
14	003763	H2F	ANTICONVULSANT ANTI-ANXIETY DRUGS	9.1	Y	DIAZEPAM 50MG / 10ML VIAL	DIAZEPAM 50MG / 10ML VIAL	GENERIC ONLY	120	30	4				
14	003765	H2F	ANTICONVULSANT ANTI-ANXIETY DRUGS	9.2	Y	DIAZEPAM 5MG / ML ORAL CONC	DIAZEPAM 5MG / ML ORAL CONC	GENERIC ONLY	120	30	4				
14	003764	H2F	ANTICONVULSANT ANTI-ANXIETY DRUGS	9.3	Y	DIAZEPAM 5MG / 5ML SOLUTIONS	DIAZEPAM 5MG / 5ML SOLUTION	GENERIC ONLY	120	30	40				
14	081237	H4B	ANTICONVULSANTS	10	Y	FENFLURAMINE HCL 22 MG/ML SOLUTION	FENFLURAMINE HCL 22 MG/ML SOLUTION	FINTEPLA			26				
14	066386	H4B	ANTICONVULSANTS	13	Y	LACOSAMIDE 10 MG/ML SOLUTION	LACOSAMIDE 10 MG/ML SOLUTION	VIMPAT			40				
14	064432	H4B	ANTICONVULSANTS	14	Y	LACOSAMIDE TABLETS	LACOSAMIDE 50 MG TABLET	VIMPAT			2				
14	072700	H4B	ANTICONVULSANTS	15	Y	LACOSAMIDE STARTER KIT	LACOSAMIDE STARTER KIT	VIMPAT			2				
14	065171	H4B	ANTICONVULSANTS	16	Y	LAMOTRIGINE 25 (21)-50, 28 DOSE STARTER KIT	LAMOTRIGINE 25 (21)-50, 28 DOSE STARTER KIT	LAMICTAL ODT START KIT BLUE)	28	365			0	Y	
14	058518	H4B	ANTICONVULSANTS	17	Y	LAMOTRIGINE 25 (42)-100, 49 DOSE STARTER KIT	LAMOTRIGINE 25 (42)-100, 49 DOSE STARTER KIT	LAMICTAL TB START KIT (ORANG	49	365			0	Y	
14	065170	H4B	ANTICONVULSANTS	18	Y	LAMOTRIGINE 25-50-100, 35 DOSE STARTER KIT	LAMOTRIGINE 25-50-100, 35 DOSE STARTER KIT	LAMICTAL ODT START KIT (ORAN	35	365			0	Y	
14	058516	H4B	ANTICONVULSANTS	19	Y	LAMOTRIGINE 25MG TABLET, 35 DOSE STARTER KIT	LAMOTRIGINE 25MG TABLET, 35 DOSE STARTER KIT	LAMICTAL TAB START KIT (BLUE)	35	365			0	Y	
14	065172	H4B	ANTICONVULSANTS	20	Y	LAMOTRIGINE 50-(42)-100, 56 DOSE STARTER KIT	LAMOTRIGINE 50-(42)-100, 56 DOSE STARTER KIT	LAMICTAL ODT START KIT GREEN	56	365			0	Y	
14	065255	H4B	ANTICONVULSANTS	21	Y	LAMOTRIGINE 50-100-200, 35 DOSE STARTER KIT	LAMOTRIGINE 50-100-200, 35 DOSE STARTER KIT	LAMICTAL XR START KIT (GREEN	35	365			0	Y	
14	058517	H4B	ANTICONVULSANTS	22	Y	LAMOTRIGINE 25 (84)-100, 98 DOSE STARTER KIT	LAMOTRIGINE 25 (84)-100, 98 DOSE STARTER KIT	LAMICTAL TAB START KIT (GREE	98	365			0	Y	
14	076056	H4B	ANTICONVULSANTS	24	Y	PERAMPANEL 0.5MG/ML ORAL SUSP	PERAMPANEL 0.5MG/ML ORAL SUSP	FYCOMPA	720	30	24				
14	069988	H4B	ANTICONVULSANTS	25	Y	PERAMPANEL TABLETS	PERAMPANEL 2MG TABLET	FYCOMPA	30	30	1				
15	**15**	**HIC3**	**THERAPEUTIC CLASS**	**0**	**Y**	**ANTIDEPRESSANTS, OTHER**	**ANTIDEPRESSANTS, OTHER**	**BRAND**	**Units**	**Until Refill**	**Daily Dose**	**Max Days**	**Refills**	**Pkg Bill**	**Updated**
15	065345	H7D	NOREPINEPHRINE AND DOPAMINE REUPTAKE INHIB (NDRIS)	1	Y	BUPROPION HBR 174, 348 and 522MG TABLET	BUPROPION HBR 174MG TABLET	APLENZIN ER			1				
15	046236	H7D	NOREPINEPHRINE AND DOPAMINE REUPTAKE INHIB (NDRIS)	2	Y	BUPROPION HCL 75MG TABLET	BUPROPION HCL 75MG TABLET	BUDEPRION / WELLBUTRIN			6				
15	046237	H7D	NOREPINEPHRINE AND DOPAMINE REUPTAKE INHIB (NDRIS)	3	Y	BUPROPION HCL 100MG TABLET	BUPROPION HCL 100MG TABLET	BUDEPRION / WELLBUTRIN			3				
15	069853	H7D	NOREPINEPHRINE AND DOPAMINE REUPTAKE INHIB (NDRIS)	4	Y	BUPROPION HCL 450MG TABLET	BUPROPION HCL 450MG TABLET	FORFIVO XL			1				
15	046239	H7D	NOREPINEPHRINE AND DOPAMINE REUPTAKE INHIB (NDRIS)	5	Y	BUPROPION HCL SR 100 and 200MG TABLET	BUPROPION HCL SR 100MG TABLET	WELLBUTRIN SR			2				
15	053006	H7D	NOREPINEPHRINE AND DOPAMINE REUPTAKE INHIB (NDRIS)	6	Y	BUPROPION HCL XL 150MG TABLET	BUPROPION HCL XL 150MG TABLET	BUDEPRION / WELLBUTRIN			3				
15	053007	H7D	NOREPINEPHRINE AND DOPAMINE REUPTAKE INHIB (NDRIS)	7	Y	BUPROPION HCL XL 300MG TABLET	BUPROPION HCL XL 300MG TABLET	BUDEPRION / WELLBUTRIN			1				
15	063736	H7C	ANTIDEPRESSANT SNRIs	8	Y	DESVENLAFAXINE SUCCINATE TABLETS	DESVENLAFAXINE SUCCINATE 50MG TABLET	PRISTIQ ER			1				
15	080044	H7C	ANTIDEPRESSANT SNRIs	9	Y	DULOXETINE HCL DR CAPS	DULOXETINE HCL DR 20 MG CAP	DRIZALMA SPRINKLE			2				
15	079563	H8Z	ANTIDEPRESSANT - NMDA RECEPTOR ANTAGONIST	10	Y	ESKETAMINE HCl 28MG NASAL SPRAY	ESKETAMINE HCl 28MG NASAL SPRAY	SPRAVATO	1						
15	079564	H8Z	ANTIDEPRESSANT - NMDA RECEPTOR ANTAGONIST	11	Y	ESKETAMINE HCl 56MG DOSE PACK	ESKETAMINE HCl 56MG DOSE PACK	SPRAVATO	2						
15	079565	H8Z	ANTIDEPRESSANT - NMDA RECEPTOR ANTAGONIST	12	Y	ESKETAMINE HCl 84MG DOSE PACK	ESKETAMINE HCl 84MG DOSE PACK	SPRAVATO	3						
15	046068	H2U	TRICYCLIC ANTIDEPRESSANTS & REL. NON-SEL. RU-INHIB	13	Y	IMIPRAMINE HCL 10, 25MG TABLET	IMIPRAMINE HCL 10MG TABLET	TOFRANIL			3				
15	046070	H2U	TRICYCLIC ANTIDEPRESSANTS & REL. NON-SEL. RU-INHIB	14	Y	IMIPRAMINE HCL 50MG TABLET	IMIPRAMINE HCL 50MG TABLET	TOFRANIL			4				
15	046075	H2U	TRICYCLIC ANTIDEPRESSANTS & REL. NON-SEL. RU-INHIB	15	Y	IMIPRAMINE PAMOATE 100MG CAPSULE	IMIPRAMINE PAMOATE 100MG CAPSULE	TOFRANIL-PM			2				
15	046078	H2U	TRICYCLIC ANTIDEPRESSANTS & REL. NON-SEL. RU-INHIB	16	Y	IMIPRAMINE PAMOATE 75, 125 and 150MG CAPSULE	IMIPRAMINE PAMOATE 75MG CAPSULE	TOFRANIL-PM			1				
15	046262	H7J	MAOIS - NON-SELECTIVE & IRREVERSIBLE	17	Y	ISOCARBOXAZID 10MG TABLET	ISOCARBOXAZID 10MG TABLET	MARPLAN			4				
15	071499	H7C	ANTIDEPRESSANT SNRIs	18	Y	LEVOMILNACIPRAN HCL 20-40MG TITRATION PACK	LEVOMILNACIPRAN HCL 20-40MG TITRATION PACK	FETZIMA	28				0		
15	054009	H7B	ALPHA-2 RECEPTOR ANTAGONIST ANTIDEPRESSANTS	19	Y	MIRTAZAPINE TABLET & ODT TABLET	MIRTAZAPINE 7.5 MG TABLET	REMERON			1				
15	046253	H7E	SEROTONIN-2 ANTAGONIST/REUPTAKE INHIBITORS (SARIS)	20	Y	NEFAZODONE HCL TABLETS	NEFAZODONE HCL 50MG TABLET	GENERIC ONLY			2				
15	046263	H7J	MAOIS - NON-SELECTIVE & IRREVERSIBLE	21	Y	PHENELZINE SULFATE 15MG TABLET	PHENELZINE SULFATE 15MG TABLET	NARDIL			6				
15	060453	H2H	ANTIDEPRESSANT, OTHER	22	Y	SELEGILINE PATCHES	SELEGILINE 6MG/24HOUR PATCH	EMSAM			1				
15	046264	H7J	MAOIS - NON-SELECTIVE & IRREVERSIBLE	22.5	Y	TRANYLCYPROMINE SULFATE 10MG TABLET	TRANYLCYPROMINE SULFATE 10MG TABLET	PARNATE			6				
15	067376	H8P	SSRI & 5HT1A PARTIAL AGONIST ANTIDEPRESSANT	23	Y	VILAZODONE HYDROCHLORIDE TABLETS	VILAZODONE HYDROCHLORIDE 10MG TABLET	VIIBRYD			1				
15	046241	H7E	SEROTONIN-2 ANTAGONIST/REUPTAKE INHIBITORS (SARIS)	24	Y	TRAZODONE HCL 50 and 100MG TABLET	TRAZODONE HCL 50MG TABLET	GENERIC ONLY			3				
15	071509	H8T	SSRI & SEROTONIN RECEPTOR MODULATOR ANTIDEPRESSANT	24	Y	VORTIOXETINE HYDROBROMIDE TABLETS	VORTIOXETINE HYDROBROMIDE 5MG TABLET	BRINTELLIX	30	30	1				1/1/2022
15	046243	H7E	SEROTONIN-2 ANTAGONIST/REUPTAKE INHIBITORS (SARIS)	25	Y	TRAZODONE HCL 150MG TABLET	TRAZODONE HCL 150MG TABLET	GENERIC ONLY			2				
15	046244	H7E	SEROTONIN-2 ANTAGONIST/REUPTAKE INHIBITORS (SARIS)	26	Y	TRAZODONE HCL 300MG TABLET	TRAZODONE HCL 300MG TABLET	GENERIC ONLY			1				
15	046398	H7C	ANTIDEPRESSANT SNRIs	27	Y	VENLAFAXINE HCL TABLETS	VENLAFAXINE HCL 25MG TABLET	GENERIC ONLY			3				
15	064444	H7C	ANTIDEPRESSANT SNRIs	28	Y	VENLAFAXINE HCL ER and XR 37.5, 150, 225MG TABLETS	VENLAFAXINE HCL ER 37.5MG TABLET	EFFEXOR XR			1				
15	064445	H7C	ANTIDEPRESSANT SNRIs	29	Y	VENLAFAXINE HCL ER 75MG TABLET and CAPSULE	VENLAFAXINE HCL ER 75MG TABLET	GENERIC ONLY			3				
15	046405	H7C	ANTIDEPRESSANT SNRIs	30	Y	VENLAFAXINE HCL XR 150MG CAPSULE	VENLAFAXINE HCL XR 150MG CAPSULE	EFFEXOR XR			2				
15	071512	H8T	SSRI & SEROTONIN RECEPTOR MODULATOR ANTIDEPRESSANT	33	Y	VORTIOXETINE HYDROBROMIDE TABLETS	VORTIOXETINE HYDROBROMIDE 20MG TABLET	BRINTELLIX	30	30	1				
16	**16**	**HIC3**	**THERAPEUTIC CLASS**	**0**	**Y**	**ANTIDEPRESSANTS, SSRIs**	**ANTIDEPRESSANTS, SSRIs**	**BRAND**	**Units**	**Until Refill**	**Daily Dose**	**Max Days**	**Refills**	**Pkg Bill**	**Updated**
16	046205	H2S	SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS)	1	Y	CITALOPRAM HYDROBROMIDE 10 MG/5 ML SOLUTION	CITALOPRAM HYDROBROMIDE 10 MG/5 ML SOLUT	GENERIC ONLY			20				
16	046206	H2S	SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS)	2	Y	CITALOPRAM HYDROBROMIDE 10 and 20MG TABLET	CITALOPRAM HYDROBROMIDE 10MG TABLET	CELEXA			1.5				
16	046204	H2S	SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS)	3	Y	CITALOPRAM HYDROBROMIDE 40MG TABLET	CITALOPRAM HYDROBROMIDE 40MG TABLET	CELEXA			1				
16	051698	H2S	SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS)	4	Y	ESCITALOPRAM OXALATE SOLUTIONS	ESCITALOPRAM OXALATE 5MG/5ML SOLUTION	LEXAPRO			20				
16	051642	H2S	SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS)	5	Y	ESCITALOPRAM OXALATE TABLETS	ESCITALOPRAM OXALATE 5MG TABLET	LEXAPRO			1				
16	046217	H2S	SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS)	6	Y	FLUOXETINE HCL 20MG/5ML SOLUTION	FLUOXETINE HCL 20MG/5ML SOLUTION	PROZAC			20				
16	046213	H2S	SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS)	7	Y	FLUOXETINE HCL 10MG CAPSULE	FLUOXETINE HCL 10MG CAPSULE	PROZAC			1				
16	046214	H2S	SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS)	8	Y	FLUOXETINE HCL 20MG CAPSULE	FLUOXETINE HCL 20MG CAPSULE	PROZAC			3				
16	046215	H2S	SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS)	9	Y	FLUOXETINE HCL 40MG CAPSULE	FLUOXETINE HCL 40MG CAPSULE	PROZAC			2				
16	047571	H2S	SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS)	10	Y	FLUOXETINE HCL 90MG CAPSULE	FLUOXETINE HCL 90MG CAPSULE	PROZAC WEEKLY	4	30				Y	
16	046216	H2S	SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS)	11	Y	FLUOXETINE HCL TABLETS	FLUOXETINE HCL 10MG TABLET	SARAFEM			1				
16	046210	H2S	SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS)	12	Y	FLUVOXAMINE MALEATE 100MG TABLET	FLUVOXAMINE MALEATE 100MG TABLET	GENERIC ONLY			3				
16	063767	H2S	SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS)	13	Y	FLUVOXAMINE MALEATE ER CAPSULES	FLUVOXAMINE MALEATE ER 100MG CAPSULE	LUVOX CR			2				
16	046226	H2S	SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS)	14	Y	PAROXETINE HCL 10MG/5ML SOLUTION	PAROXETINE HCL 10MG/5ML SOLUTION	PAXIL			20				
16	046222	H2S	SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS)	15	Y	PAROXETINE HCL TABLETS	PAROXETINE HCL 10MG TABLET	PAXIL			1.5				
16	050137	H2S	SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS)	16	Y	PAROXETINE ER 12.5 & 37.5 MG TABLET	PAROXETINE ER 12.5 MG TABLET	PAXIL CR			1				1/1/2022
16	050136	H2S	SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS)	17	Y	PAROXETINE ER 25 MG TABLET	PAROXETINE ER 25 MG TABLET	PAXIL CR			2				1/1/2022
16	053387	H2S	SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS)	18	Y	PAROXETINE MESYLATE 10, 20 and 40MG TABLET	PAROXETINE MESYLATE 10MG TABLET	PEXEVA			1				
16	053389	H2S	SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS)	19	Y	PAROXETINE MESYLATE 30MG TABLET	PAROXETINE MESYLATE 30MG TABLET	PEXEVA			2				
16	046230	H2S	SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS)	20	Y	SERTRALINE HCL 20MG/ML ORAL CONC	SERTRALINE HCL 20MG/ML ORAL CONC	ZOLOFT			10				
16	046227	H2S	SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS)	21	Y	SERTRALINE HCL 25 and 50MG TABLET	SERTRALINE HCL 25MG TABLET	ZOLOFT			1.5				

16	046229	H2S	SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS)	22	Y	SERTRALINE HCL 100MG TABLET	SERTRALINE HCL 100MG TABLET	ZOLOFT			2					
17	17	HIC3	THERAPEUTIC CLASS	0	Y	ANTIEMETICS	ANTIEMETICS	BRAND	Units	Until Refill	Daily Dose	Max Days	Refills	Pkg Bill	Updated	
17	061115	H6J	ANTIEMETIC/ANTIVERTIGO AGENTS	1	Y	APREPITANT CAPSULES	APREPITANT 40MG CAPSULE	EMEND	3	30						
17	051913	H6J	ANTIEMETIC/ANTIVERTIGO AGENTS	2	Y	APREPITANT TRIFOLD PACK - 3 CAPSULES PER PACK	APREPITANT TRIFOLD PACK - 3 CAPSULES PER PACK	EMEND	3	30				Y		
17	034749	H6J	ANTIEMETIC/ANTIVERTIGO AGENTS	3	Y	DOLASETRON MESYLATE TABLETS	DOLASETRON MESYLATE 50MG TABLET	ANZEMET	5	30						
17	004694	H6J	ANTIEMETIC/ANTIVERTIGO AGENTS	4	Y	DRONABINOL CAPSULES	DRONABINOL 2.5MG CAPSULE	MARINOL			2					
17	064442	H6J	ANTIEMETIC/ANTIVERTIGO AGENTS	5	Y	GRANISETRON 3.1MG/24HR PATCH	GRANISETRON 3.1MG/24HR PATCH	SANCUSO	1	30						
17	021592	H6J	ANTIEMETIC/ANTIVERTIGO AGENTS	6	Y	GRANISETRON HCL 1MG TABLET	GRANISETRON HCL 1MG TABLET	GENERIC ONLY	10	30						
17	004696	H6J	ANTIEMETIC/ANTIVERTIGO AGENTS	7	Y	NABILONE 1MG CAPSULE	NABILONE 1MG CAPSULE	CESAMET			2					
17	066501	H6J	ANTIEMETIC/ANTIVERTIGO AGENTS	8	Y	ONDANSETRON 4 and 8MG SOLUBLE FILM	ONDANSETRON 4MG SOLUBLE FILM	ZUPLENZ	10	30						
17	043230	H6J	ANTIEMETIC/ANTIVERTIGO AGENTS	9	Y	ONDANSETRON HCL 24 MG TABLET	ONDANSETRON HCL 24 MG TABLET	GENERIC ONLY			1					
18	18	HIC3	THERAPEUTIC CLASS	0	Y	ANTIFUNGALS (Oral)	ANTIFUNGALS (Oral)	BRAND	Units	Until Refill	Daily Dose	Max Days	Refills	Pkg Bill	Updated	
18	013725	W3B	ANTIFUNGAL AGENTS	1	Y	FLUCONAZOLE TABLETS	FLUCONAZOLE 50MG TABLET	DIFLUCAN	2	30						
18	009517	W3A	ANTIFUNGAL ANTIBIOTICS	2	Y	GRISEOFULVIN,MICROSIZE 125MG/5ML SUSPENSION	GRISEOFULVIN,MICROSIZE 125MG/5ML SUSPENSIO	GENERIC ONLY			40					
18	009519	W3A	ANTIFUNGAL ANTIBIOTICS	3	Y	GRISEOFULVIN,MICROSIZE 500MG TABLET	GRISEOFULVIN,MICROSIZE 500MG TABLET	GRIFULVIN V			2					
18	082353	W3A	ANTIFUNGAL ANTIBIOTICS	3.5	Y	IBREXAFUNGERP CITRATE 150 MG TABLET	IBREXAFUNGERP CITRATE 150 MG TABLET	BREXAFEMME	2		2					1/1/2022
18	016949	W3B	ANTIFUNGAL AGENTS	4	Y	ITRACONAZOLE 100MG CAPSULE	ITRACONAZOLE 100MG CAPSULE	SPORANOX			2					
18	070295	W3B	ANTIFUNGAL AGENTS	5	Y	ITRACONAZOLE 200MG TABLET	ITRACONAZOLE 200MG TABLET	ONMEL			1					
18	079357	W3B	ANTIFUNGAL AGENTS	6	Y	ITRACONAZOLE 65MG CAPSULE	ITRACONAZOLE 65MG CAPSULE	TOLSURA			6					
18	063921	W3B	ANTIFUNGAL AGENTS	7	Y	MICONAZOLE 50MG BUCCAL TABLET	MICONAZOLE 50MG BUCCAL TABLET	ORAVIG	14	30						
18	009537	W3A	ANTIFUNGAL ANTIBIOTICS	8	Y	NYSTATIN 100K UNITS/ML SUSPENSION	NYSTATIN 100K UNITS/ML SUSPENSION	NILSTAT	240	30						
18	009538	W3A	ANTIFUNGAL ANTIBIOTICS	9	Y	NYSTATIN 500K UNITS TABLET	NYSTATIN 500K UNITS TABLET	MYCOSTATIN			4					
18	007284	W3A	ANTIFUNGAL ANTIBIOTICS	9.5	Y	NYSTATIN 100,000 UNIT/GM POWDER	NYSTATIN 100,000 UNIT/GM POWDER	NYSTOP	60	30						1/1/2022
18	060365	W3B	ANTIFUNGAL AGENTS	10	Y	POSACONAZOLE 40MG/ML SUSPENSION 105ML BOTTLE	POSACONAZOLE 40MG/ML SUSPENSION 105ML BO	NOXAFIL	105	30						
18	018638	W3B	ANTIFUNGAL AGENTS	11	Y	TERBINAFINE HCL 250MG TABLET	TERBINAFINE HCL 250MG TABLET	LAMISIL			1					
19	19	HIC3	THERAPEUTIC CLASS	0	Y	ANTIFUNGALS (Topical)	ANTIFUNGALS (Topical)	BRAND	Units	Until Refill	Daily Dose	Max Days	Refills	Pkg Bill	Updated	
19	037020	Q5F	TOPICAL ANTIFUNGALS	1	Y	CICLOPIROX 8% SOLUTION 6.6ML	CICLOPIROX 8% SOLUTION 6.6ML	CICLODAN / PENLAC	6.6	30			1	Y		
19	067434	Q5F	TOPICAL ANTIFUNGALS	2	Y	CICLOPIROX/URE/CAMPH/MENTH/EUC 8% KIT 34.6ML	CICLOPIROX/URE/CAMPH/MENTH/EUC 8% KIT 34.6	CICLODAN	34.6	30			1	Y		
19	081898	Q5M	TOPICAL ANTIFUNGAL/ANTI-INFLAMMATORY,STEROID AGENT	3	Y	CICLOPIROX/TRIAMCINOLONE ACET KIT	CICLOPIROX/TRIAMCINOLONE ACET KIT	TRILOCICLO	1							
19	081949	Q5M	TOPICAL ANTIFUNGAL/ANTI-INFLAMMATORY,STEROID AGENT	5	Y	ECONAZOLE/TRIAMCINOLONE 1%-0.1% COMBO PACK	ECONAZOLE/TRIAMCINOLONE 1%-0.1% COMBO PA	TRIAMAZOLE	165							
19	080296	Q5F	TOPICAL ANTIFUNGALS	6	Y	KETOCONAZOLE/MICONAZOLE PAK	KETOCONAZOLE/MICONAZOLE PAK	PEDIZOL	1							
19	007334	Q5F	TOPICAL ANTIFUNGALS	7	Y	KETOCONAZOLE 2% CREAM	KETOCONAZOLE 2% CREAM	GENERIC ONLY	60					Y		
20	20	HIC3	THERAPEUTIC CLASS	0	Y	ANTIHISTAMINES, MINIMALLY SEDATING	ANTIHISTAMINES, MINIMALLY SEDATING	BRAND	Units	Until Refill	Daily Dose	Max Days	Refills	Pkg Bill	Updated	
20	053980	Z2Q	ANTIHISTAMINES - 2ND GENERATION	1	Y	CETIRIZINE HCL CHEWABLE TABLETS, LIQUID GELS or TABL	CETIRIZINE HCL 5 MG CHEW TAB	ZYTREC			1					
20	065685	Z2Q	ANTIHISTAMINES - 2ND GENERATION	2	Y	CETIRIZINE HCL 5MG/5ML SOLUTION	CETIRIZINE HCL 5MG/5ML SOLUTION	GENERIC ONLY	150	30						
20	048415	Z2Q	ANTIHISTAMINES - 2ND GENERATION	3	Y	CETIRIZINE HCL/PSEUDOEPHEDRINE 5-120MG TABLET	CETIRIZINE HCL/PSEUDOEPHEDRINE 5-120MG TAB	ZYRTEC-D / CETIRI-D			2					
20	058445	Z2Q	ANTIHISTAMINES - 2ND GENERATION	4	Y	DESLORATADINE 2.5MG/5ML SYRUP	DESLORATADINE 2.5MG/5ML SYRUP	CLARINEX			10					
20	079794	Z2P	ANTIHISTAMINES - 1ST GENERATION	4	Y	DEXCHLORPHENIRAMINE 2 MG/5 ML	DEXCHLORPHENIRAMINE 2 MG/5 ML	RYCLORA	590	30	20					
20	059683	Z2Q	ANTIHISTAMINES - 2ND GENERATION	5	Y	DESLORATADINE ODT or TABLETS	DESLORATADINE 2.5MG ODT	CLARINEX			1					
20	060403	Z2Q	ANTIHISTAMINES - 2ND GENERATION	6	Y	DESLORATADINE/PSEUDOEPHEDRINE 12HR TABLET	DESLORATADINE/PSEUDOEPHEDRINE 12HR TABLET	CLARINEX-D 12 HR			2					
20	031689	Z2Q	ANTIHISTAMINES - 2ND GENERATION	7	Y	FEXOFENADINE HCL 60MG TABLET	FEXOFENADINE HCL 60MG TABLET	ALLEGRA			2					
20	058869	Z2Q	ANTIHISTAMINES - 2ND GENERATION	8	Y	FEXOFENADINE/PSEUDOPHEDRINE180-240 TABLET	FEXOFENADINE/PSEUDOPHEDRINE180-240 TABLET	ALLEGRA - D			1					
20	033716	Z2Q	ANTIHISTAMINES - 2ND GENERATION	9	Y	FEXOFENADINE HCL 180MG TABLET	FEXOFENADINE HCL 180MG TABLET	ALLEGRA			1					
20	062168	Z2Q	ANTIHISTAMINES - 2ND GENERATION	10	Y	LEVOCETIRIZINE DIHYDROCHLORIDE 2.5MG/5ML SOLUTI	LEVOCETIRIZINE DIHYDROCHLORIDE 2.5MG/5ML S	XYZAL	150	30						
20	048920	Z2Q	ANTIHISTAMINES - 2ND GENERATION	11	Y	LEVOCETIRIZINE DIHYDROCHLORIDE 5MG TABLET	LEVOCETIRIZINE DIHYDROCHLORIDE 5MG TABLET	XYZAL			1					
20	018698	Z2Q	ANTIHISTAMINES - 2ND GENERATION	12	Y	LORATADINE 10MG TABLETS	LORATADINE 10MG TABLET	ALAVERT / CLARITIN / TAVIST ND			1					
20	017181	Z2Q	ANTIHISTAMINES - 2ND GENERATION	13	Y	LORATADINE/PSEUDOEPHEDRINE 12HR TABLET	LORATADINE/PSEUDOEPHEDRINE 12HR TABLET	ALAVERT / CLARITIN-D			2					
20	027622	Z2Q	ANTIHISTAMINES - 2ND GENERATION	14	Y	LORATADINE/PSEUDOEPHEDRINE 24HR TABLET	LORATADINE/PSEUDOEPHEDRINE 24HR TABLET	CLARITIN-D			1					
20	079594	B4E	NON-OPIOID ANTITUSSIVE-1ST GEN ANTIHISTAMINE COMB	15	Y	PROMETHAZINE/DEXTROMETHORPHAN SOLUTION	PROMETHAZINE/DEXTROMETHORPHAN SOLUTION	GENERIC ONLY	480			30				
20	048496	B3Q	OPIOID ANTITUSSIV-1ST GEN. ANTIHISTAMINE-DECONGESTANT COMBO	16	Y	PROMETHAZINE/PHENYLEPH/CODEINE	PROMETHAZINE/PHENYLEPH/CODEINE	GENERIC ONLY	240	30						
20	048489	B4D	OPIOID ANTITUSSIVE-1ST GENERATION ANTIHISTAMINE	17	Y	PROMETHAZINE-CODEINE SYRUP	PROMETHAZINE-CODEINE SYRUP	PHENERGAN	240	30						
20	005089	Z2Q	ANTIHISTAMINES - 2ND GENERATION	18	Y	PSEUDOEPHEDRINE HCL 30MG TABLET	PSEUDOEPHEDRINE HCL 30MG TABLET	SUDAFED	12	30						
21	21	HIC3	THERAPEUTIC CLASS	0	Y	ANTIHYPERTENSIVES, SYMPATHOLYTICS	ANTIHYPERTENSIVES, SYMPATHOLYTICS	BRAND	Units	Until Refill	Daily Dose	Max Days	Refills	Pkg Bill	Updated	
21	000343	A4B	ANTIHYPERTENSIVES, SYMPATHOLYTIC	1	Y	CLONIDINE PATCHES	CLONIDINE 0.1MG PATCH / 1 PATCH	CATAPRES-TTS 1	4	30						
21	000346	A4B	ANTIHYPERTENSIVES, SYMPATHOLYTIC	2	Y	CLONIDINE HCL 0.1 and 0.2 MG TABLET	CLONIDINE HCL 0.1 MG TABLET	CATAPRES			10					
21	000348	A4B	ANTIHYPERTENSIVES, SYMPATHOLYTIC	3	Y	CLONIDINE HCL 0.3 MG TABLET	CLONIDINE HCL 0.3 MG TABLET	CATAPRES			8					
22	22	HIC3	THERAPEUTIC CLASS	0	Y	ANTIHYPERURICEMICS	ANTIHYPERURICEMICS	BRAND	Units	Until Refill	Daily Dose	Max Days	Refills	Pkg Bill	Updated	
22	008334	S2A	ANTIHYPERURICEMICS	1	Y	COLCHICINE 0.6MG TABLET	COLCHICINE 0.6 MG CAPSULE	COLCRYS	20	90						
22	079477	S2A	ANTIHYPERURICEMICS	2	Y	COLCHICINE 0.6 MG/5 ML SOLUTION	COLCHICINE 0.6 MG/5 ML SOLUTION	GLOPERBA	100	90						
22	064829	C7A	HYPERURICEMIA TX - XANTHINE OXIDASE INHIBITORS	3	Y	FEBUXOSTAT 40 and 80MG TABLET	FEBUXOSTAT 40MG TABLET	ULORIC			1					
23	23	HIC3	THERAPEUTIC CLASS	0	Y	ANTIMIGRAINE AGENTS, OTHER	ANTIMIGRAINE AGENTS, OTHER	BRAND	Units	Until Refill	Daily Dose	Max Days	Refills	Pkg Bill	Updated	
23	048155	H3F	ANTIMIGRAINE PREPARATIONS	1	Y	ALMOTRIPTAN MALATE TABLETS	ALMOTRIPTAN MALATE 6.25MG TABLET	AXERT	6	30						
23	081009	H3F	ANTIMIGRAINE PREPARATIONS	1.5	Y	CELECOXIB 120 MG/4.8 ML SOLUTION	CELECOXIB 120 MG/4.8 ML SOLUTION	ELYXYB			4.8					1/1/2022
23	068166	H3F	ANTIMIGRAINE PREPARATIONS	2	Y	DICLOFENAC POTASSIUM 50MG POWDER PACKET	DICLOFENAC POTASSIUM 50MG POWDER PACKET	CAMBIA	9	30				Y		
23	059189	H3F	ANTIMIGRAINE PREPARATIONS	3	Y	DIHYDROERGOTAMINE MESYLATE 4MG/ML SPRAY - MIGR	DIHYDROERGOTAMINE MESYLATE 4MG/ML SPRAY	MIGRANAL	8	30				Y		
23	082656	H3F	ANTIMIGRAINE PREPARATIONS	3.5	Y	DIHYDROERGOTAMINE MESYLATE NASAL SPRAY - TRUDH	DIHYDROERGOTAMINE MESYLATE NASAL SPRAY	TRUDHESA NASAL SPRAY	16	30						1/1/2022
23	049605	H3F	ANTIMIGRAINE PREPARATIONS	4	Y	ELETRIPTAN HBR TABLETS	ELETRIPTAN HBR 20MG TABLET	RELPAX	6	30						
23	078424	H3F	ANTIMIGRAINE PREPARATIONS	5	Y	ERENUMAB-AOOE 70MG/ML AUTOINJECTOR	ERENUMAB-AOOE 70MG/ML AUTOINJECTOR	AIMOVIG	2	30						
23	079588	H3F	ANTIMIGRAINE PREPARATIONS	6	Y	ERENUMAB-AOOE 140MG/ML AUTOINJECTOR	ERENUMAB-AOOE 140MG/ML AUTOINJECTOR	AIMOVIG	1							
23	078897	H3F	ANTIMIGRAINE PREPARATIONS	7	Y	FREMANEZUMAB-VFRM 225 MG/1.5 ML SYRINGE	FREMANEZUMAB-VFRM 225 MG/1.5 ML SYRINGE	AJOVY	225	30						
23	080875	H3F	ANTIMIGRAINE PREPARATIONS	8	Y	FREMANEZUMAB-VFRM 225 MG/1.5 ML SYRINGE	FREMANEZUMAB-VFRM 225 MG/1.5 ML SYRINGE	AJOVY	1.5	28						
23	048986	H3F	ANTIMIGRAINE PREPARATIONS	9	Y	FROVATRIPTAN SUCCINATE 2.5MG TABLET	FROVATRIPTAN SUCCINATE 2.5MG TABLET	FROVA	9	30						
23	079818	H3F	ANTIMIGRAINE PREPARATIONS	10	Y	GALCANEZUMAB-GNLM 100MG/ML SYRINGE	GALCANEZUMAB-GNLM 100MG/ML SYRINGE	EMGALITY SYRINGE	3	30						
23	078996	H3F	ANTIMIGRAINE PREPARATIONS	11	Y	GALCANEZUMAB-GNLM 120MG/ML PEN	GALCANEZUMAB-GNLM 120MG/ML PEN	EMGALITY PEN	2	30						
23	080308	H3F	ANTIMIGRAINE PREPARATIONS	12	Y	LASMIDITAN SUCCINATE 50 MG TABLET	LASMIDITAN SUCCINATE 50 MG TABLET	REYVOW	4	30	1					
23	080309	H3F	ANTIMIGRAINE PREPARATIONS	13	Y	LASMIDITAN SUCCINATE 100 MG TABLET	LASMIDITAN SUCCINATE 100 MG TABLET	REYVOW	8	30	2					
23	038275	H3F	ANTIMIGRAINE PREPARATIONS	14	Y	NARATRIPTAN HCL TABLETS	NARATRIPTAN HCL 1MG TABLET S	AMERGE	9	30						

23	080787	H3F	ANTIMIGRAINE PREPARATIONS	15	Y	RIMEGEPANT SULFATE ODT 75 MG TABLET	RIMEGEPANT SULFATE ODT 75 MG TABLET	NURTEC ODT	8	30	1				1/1/2022
23	040221	H3F	ANTIMIGRAINE PREPARATIONS	16	Y	RIZATRIPTAN BENZOATE TABLETS	RIZATRIPTAN BENZOATE 5MG TABLET	MAXALT	9	30					
23	030735	H3F	ANTIMIGRAINE PREPARATIONS	17	Y	SUMATRIPTAN NASAL SPRAYS	SUMATRIPTAN 5MG NASAL SPRAY	IMITREX	6	30					
23	063885	H3F	ANTIMIGRAINE PREPARATIONS	18	Y	SUMATRIPTAN SUCC/NAPROXEN SOD 85-500MG TABLET	SUMATRIPTAN SUCC/NAPROXEN SOD 85-500MG TA	TREXIMET	9	30					
23	023799	H3F	ANTIMIGRAINE PREPARATIONS	19	Y	SUMATRIPTAN SUCCINATE 25, 50 and 100MG TABLET	SUMATRIPTAN SUCCINATE 25MG TABLET	IMITREX	9	30					
23	075510	H3F	ANTIMIGRAINE PREPARATIONS	20	Y	SUMATRIPTAN SUCCINATE 11MG TABLET	SUMATRIPTAN SUCCINATE 11MG TABLET	ONZETRA XSAIL	16	30					
23	060500	H3F	ANTIMIGRAINE PREPARATIONS	21	Y	SUMATRIPTAN SUCCINATE REFILL CARTRIDGES	SUMATRIPTAN SUCCINATE 4MG/0.5ML REFILL CAR	IMITREX	2	30					
23	060499	H3F	ANTIMIGRAINE PREPARATIONS	22	Y	SUMATRIPTAN SUCCINATE INJECTION	SUMATRIPTAN SUCCINATE 4MG/0.5ML PEN INJECT	ALSUMA / IMITREX	2	30				Y	
23	033592	H3F	ANTIMIGRAINE PREPARATIONS	23	Y	SUMATRIPTAN SUCCINATE SYRINGES	SUMATRIPTAN SUCCINATE 6MG/0.5ML SYRINGE	SUMAVEL DOSEPRO	2	30					
23	019193	H3F	ANTIMIGRAINE PREPARATIONS	24	Y	SUMATRIPTAN SUCCINATE 6MG/0.5ML VIAL	SUMATRIPTAN SUCCINATE 6MG/0.5ML VIAL	IMITREX	2.5	30					
23	080588	H3F	ANTIMIGRAINE PREPARATIONS	25	Y	UBROGEPANT TABLETS	UBROGEPANT 50 MG TABLET	UBRELVY	16	30	2				
23	031027	H3F	ANTIMIGRAINE PREPARATIONS	27	Y	ZOLMITRIPTAN 2.5MG TABLET	ZOLMITRIPTAN 2.5MG TABLET	ZOMIG / ZOMIG ZMT	6	30					
23	037036	H3F	ANTIMIGRAINE PREPARATIONS	28	Y	ZOLMITRIPTAN 5MG TABLET	ZOLMITRIPTAN 5MG TABLET	ZOMIG / ZOMIG ZMT	3	30					
23	051639	H3F	ANTIMIGRAINE PREPARATIONS	29	Y	ZOLMITRIPTAN 5MG NASAL SPRAY	ZOLMITRIPTAN 5MG NASAL SPRAY	ZOMIG	6	30				Y	
25	25	HIC3	THERAPEUTIC CLASS	0	Y	ANTIPARASITICS, TOPICAL	ANTIPARASITICS, TOPICAL	BRAND	Units	Until Refill	Daily Dose	Max Days	Refills	Pkg Bill	Updated
25	065242	Q5R	TOPICAL ANTIPARASITICS	1	Y	BENZYL ALCOHOL 5% LOTION	BENZYL ALCOHOL 5% LOTION	ULESFIA	681	30				Y	
25	068030	Q5R	TOPICAL ANTIPARASITICS	2	Y	CITRIC/CITRONELLYL/HYDROX/METH	CITRIC/CITRONELLYL/HYDROX/METH	LYCELLE HEAD LICE REMOVAL KI	1						
25	007651	Q5R	TOPICAL ANTIPARASITICS	3	Y	LINDANE 1% LOTION or SHAMPOO	LINDANE 1% SHAMPOO - ML	GENERIC ONLY	60	30				Y	
25	007657	Q5R	TOPICAL ANTIPARASITICS	4	Y	MALATHION 0.5% LOTION	MALATHION 0.5% LOTION - ML	OVIDE	59	30				Y	
25	047194	Q5R	TOPICAL ANTIPARASITICS	5	Y	PIP BUTOX/PYRETHRINS/PERMETH LICE KITS	PIP BUTOX/PYRETHRINS/PERMETH LICE KIT	CVS LICE SOLUTION KIT	1					Y	
25	013631	Q5R	TOPICAL ANTIPARASITICS	6	Y	PERMETHRIN 5% CREAM 60GRAM JAR	PERMETHRIN 5% CREAM 60GRAM JAR	ACTICIN	60	7				Y	
25	068579	Q5R	TOPICAL ANTIPARASITICS	7	Y	IVERMECTIN 0.5% LOTION 117GRAMS	IVERMECTIN 0.5% LOTION 117GRAMS	SKLICE	234	90				Y	
26	26	HIC3	THERAPEUTIC CLASS	0	Y	ANTIPARKINSON'S AGENTS (Oral)	ANTIPARKINSON'S AGENTS (Oral)	BRAND	Units	Until Refill	Daily Dose	Max Days	Refills	Pkg Bill	Updated
26	078185	H6A	ANTIPARKINSONISM DRUGS,OTHER	1	Y	AMANTADINE TABLETS	AMANTADINE 129 MG TABLET	OSMOLEX ER			1				
26	081019	H6A	ANTIPARKINSONISM DRUGS,OTHER	2	Y	AMANTADINE HCL 322 MG DAILY DOSE	AMANTADINE HCL 322 MG DAILY DOSE	OSMOLEX ER			1				
26	081092	H6A	ANTIPARKINSONISM DRUGS,OTHER	3	Y	APOMORPHINE HCL SL FILMS	APOMORPHINE HCL 10 MG SL FILM	KYNMOBI			5				
26	081100	H6A	ANTIPARKINSONISM DRUGS,OTHER	3	Y	APOMORPHINE HCL TRITATION KIT	APOMORPHINE HCL TRITATION KIT	KYNMOBI			5				
26	080177	H6A	ANTIPARKINSONISM DRUGS,OTHER	4	Y	ISTRADEFYLLINE TABLETS	ISTRADEFYLLINE 20 MG TABLET	NOURIANZ			1				
26	079392	H6A	ANTIPARKINSONISM DRUGS,OTHER	5	Y	LEVODOPA 42MG INHALATION CAP	LEVODOPA 42MG INHALATION CAP	INBRIJA			10				
26	080978	H6A	ANTIPARKINSONISM DRUGS,OTHER	6	Y	OPICAPONE CAPSULES	OPICAPONE 25 MG CAPSULE	ONGENTYS			1				
26	060915	H6A	ANTIPARKINSONISM DRUGS,OTHER	7	Y	RASAGILINE MESYLATE TABLETS	RASAGILINE MESYLATE 0.5MG TABLET	AZILECT			1				
26	063858	H6A	ANTIPARKINSONISM DRUGS,OTHER	8	Y	ROPINIROLE HCL 2, 4, 6 and 8MG TABLET	ROPINIROLE HCL 2MG TABLET	REQUIP XL			1				
26	064594	H6A	ANTIPARKINSONISM DRUGS,OTHER	9	Y	ROPINIROLE HCL 12MG TABLET	ROPINIROLE HCL ER 12MG TABLET	REQUIP XL			2				
26	065356	H6A	ANTIPARKINSONISM DRUGS,OTHER	10	Y	ROTIGOTINE 24HR PATCHS ALL STRENGTHS	ROTIGOTINE 1MG/24HR PATCH	NEUPRO			1				
26	075078	H6A	ANTIPARKINSONISM DRUGS,OTHER	11	Y	SAFINAMIDE MESYLATE TABLETS	SAFINAMIDE MESYLATE 50MG TABLET	XADAGO			1				
26	054736	H6A	ANTIPARKINSONISM DRUGS,OTHER	12	Y	SELEGILINE HCL 1.25MG ODT TABLET	SELEGILINE HCL 1.25MG ODT TABLET	ZELAPAR			2				
28	28	HIC3	THERAPEUTIC CLASS	0	Y	ANTIPSYCHOTICS, ATYPICAL	ANTIPSYCHOTICS, ATYPICAL	BRAND	Units	Until Refill	Daily Dose	Max Days	Refills	Pkg Bill	Updated
28	060225	H7X	ANTIPSYCHOTICS, ATYP, D2 PARTIAL AGONIST/5HT MIXED	1	Y	ARIPIPRAZOLE TABLETS, DISCMELT TABLETS	ARIPIPRAZOLE 2MG TABLET	ABILIFY			1				
28	080406	H7T	ANTIPSYCHOTICS,ATYPICAL,DOPAMINE,& SEROTONIN ANTAG	2	Y	ASENAPINE 24 HR PATCHES	ASENAPINE 3.8 MG/24 HR PATCH	SECUADO			1				
28	070669	H7X	ANTIPSYCHOTICS, ATYP, D2 PARTIAL AGONIST/5HT MIXED	3	Y	ARIPIPRAZOLE ER VIALS	ARIPIPRAZOLE ER 300MG VIAL	ABILIFY MAINTENA	1	30					
28	058594	H7X	ANTIPSYCHOTICS, ATYP, D2 PARTIAL AGONIST/5HT MIXED	4	Y	ARIPIPRAZOLE 1MG/ML SOLUTION	ARIPIPRAZOLE 1MG/ML SOLUTION	ABILIFY	150	30					
28	078157	H7X	ANTIPSYCHOTICS, ATYP, D2 PARTIAL AGONIST/5HT MIXED	5	Y	ARIPIPRAZOLE KITS	ARIPIPRAZOLE 10MG KIT	ABILIFY MYCITE			1				
28	078588	H7X	ANTIPSYCHOTICS, ATYP, D2 PARTIAL AGONIST/5HT MIXED	6	Y	ARIPIPRAZOLE LAUROXIL, SUBMICR 675 MG/2.4	ARIPIPRAZOLE LAUROXIL, SUBMICR 675 MG/2.4	ARISTADA	2.4						
28	074807	H8W	ANTI PSYCHOTICATYPICAL D3/D2 PARTIAL AG5HT MIXED	7	Y	CARIPRAZINE HCL TABLETS	CARIPRAZINE HCL 1.5MG TABLET	VRAYLAR	30	30	1				
28	075566	H8W	ANTI PSYCHOTICATYPICAL D3/D2 PARTIAL AG5HT MIXED	8	Y	CARIPRAZINE HCL 1.5MG - 3MG PACK	CARIPRAZINE HCL 1.5MG - 3MG PACK	VRAYLAR	7	999			0	Y	
28	065901	H7T	ANTIPSYCHOTICS,ATYPICAL,DOPAMINE,& SEROTONIN ANTAG	9	Y	ILOPERIDONE TABLETS	ILOPERIDONE 1MG TABLET	FANAPT			2				
28	065908	H7T	ANTIPSYCHOTICS,ATYPICAL,DOPAMINE,& SEROTONIN ANTAG	10	Y	ILOPERIDONE TITRATION PACK	ILOPERIDONE TITRATION PACK	FANAPT	8	999				Y	
28	080599	H7T	ANTIPSYCHOTICS,ATYPICAL,DOPAMINE,& SEROTONIN ANTAG	11	Y	LUMATEPERONE TOSYLATE 42 MG CAPSULE	LUMATEPERONE TOSYLATE 42 MG CAPSULE	CAPLYTA			1				
28	070405	H7U	ANTIPSYCHOTICS, ATYPICAL	12	Y	LOXAPINE 10MG INHALATION POWDER	LOXAPINE 10MG INHALATION POWDER	ADASUVE	1	30				Y	
28	082336	H7T	ANTIPSYCHOTICS,ATYPICAL,DOPAMINE,& SEROTONIN ANTAG	13	Y	OLANZAPINE/SAMIDORPHAN MALATE TABLETS	OLANZAPINE/SAMIDORPHAN MALATE 10-10 MG T	LYBALVI			1				1/1/2022
28	082645	H7T	ANTIPSYCHOTICS,ATYPICAL,DOPAMINE,& SEROTONIN ANTAG	13.5	Y	PALIPERIDONE PALMITATE 1092 MG/3.5 ML	PALIPERIDONE PALMITATE 1092 MG/3.5 ML	INVEGA HAFYERA	3.5	180					1/1/2022
28	082646	H7T	ANTIPSYCHOTICS,ATYPICAL,DOPAMINE,& SEROTONIN ANTAG	13.6	Y	PALIPERIDONE PALMITATE 1560 MG/5 ML	PALIPERIDONE PALMITATE 1560 MG/5 ML	INVEGA HAFYERA	5	180					1/1/2022
28	074140	H7T	ANTIPSYCHOTICS,ATYPICAL,DOPAMINE,& SEROTONIN ANTAG	14	Y	PALIPERIDONE PALMITATE ALL STRENGTHS	PALIPERIDONE PALMITATE 273MG/0.875ML	INVEGA TRINZA				90			
28	076025	H8Y	SELECTIVE SEROTONIN 5-HT2A INVERSE AGONISTS (SSIA)	15	Y	PIMAVANSERIN TARTRATE 17MG TABLET	PIMAVANSERIN TARTRATE 17MG TABLET	NUPLAZID	60	30	2				
28	078604	H8Y	SELECTIVE SEROTONIN 5-HT2A INVERSE AGONISTS (SSIA)	16	Y	PIMAVANSERIN TARTRATE 10MG and 34MG TABLETS	PIMAVANSERIN TARTRATE 10MG TABLET	NUPLAZID	30	30	1				1/1/2022
28	074076	H7T	ANTIPSYCHOTICS,ATYPICAL,DOPAMINE,& SEROTONIN ANTAG	17	Y	QUETIAPINE FUMARATE SAMPLE KIT	QUETIAPINE FUMARATE SAMPLE KIT	SEROQUEL XR	15				0	Y	
28	052934	H7T	ANTIPSYCHOTICS,ATYPICAL,DOPAMINE,& SEROTONIN ANTAG	18	Y	RISPERIDONE MICROSPHERES SYRINGES	RISPERIDONE MICROSPHERES 25 MG SYR	RISPERDAL CONSTA	2	30					
28	078741	H7T	ANTIPSYCHOTICS,ATYPICAL,DOPAMINE,& SEROTONIN ANTAG	19	Y	RISPERIDONE ER SYRINGE KITS	RISPERIDONE ER 120MG SYRINGE KIT	PERSERIS	1	30					
28.5	28.5	HIC3	THERAPEUTIC CLASS	0	Y	ANTIRETROVIRALS	ANTIRETROVIRALS	BRAND	Units	Until Refill	Daily Dose	Max Days	Refills	Pkg Bill	Updated
28.5	052747	W5C	ANTIRETROVIRAL - ANTIVIRALS, HIV-SPECIFIC, PROTEASE INHIBITORS	1	Y	ATAZANAVIR SULFATE 150 & 300MG CAPSULES	ATAZANAVIR SULFATE 150MG CAPSULE	REYATAZ			1				
28.5	052748	W5C	ANTIRETROVIRAL - ANTIVIRALS, HIV-SPECIFIC, PROTEASE INHIBITORS	2	Y	ATAZANAVIR SULFATE 200MG CAPSULES	ATAZANAVIR SULFATE 200MG CAPSULE	REYATAZ			2				
28.5	081868	W5U	ANTIRETROVIRALS	3	Y	CABOTEGRAVIR SODIUM 30 MG TABLET	CABOTEGRAVIR SODIUM 30 MG TABLET	VOCABRIA			1				
28.5	077819	W0H	ANTIRETROVIRAL	6	Y	DARUNAVIR/COB/EMTRI/TENOF ALAF 800-150-200-10 M	DARUNAVIR/COB/EMTRI/TENOF ALAF 800-150-200	SYMTUZA			1				
28.5	071322	W5U	ANTIRETROVIRALS	7	Y	DOLUTEGRAVIR SODIUM 50 MG TABLETS	DOLUTEGRAVIR SODIUM 50 MG TABLET	TIVICAY	60	30	2				
28.5	076226	W5U	ANTIRETROVIRALS	8	Y	DOLUTEGRAVIR SODIUM 10 & 25 MG TABLETS	DOLUTEGRAVIR SODIUM 10 MG TABLET	TIVICAY	30	30	1				
28.5	081177	W5U	ANTIRETROVIRALS	9	Y	DOLUTEGRAVIR SODIUM 5 MG TABLET FOR SUSPENSION	DOLUTEGRAVIR SODIUM 5 MG TABLET FOR SUSPE	TIVICAY			6				
28.5	079638	W0K	ANTIRETROVIRAL-INTEGRASE INHIBITOR AND NRTI COMB	10	Y	DOLUTEGRAVIR SODIUM/LAMIVUDINE 50-300MG TABLET	DOLUTEGRAVIR SODIUM/LAMIVUDINE 50-300MG	DOVATO			1				
28.5	078887	W5K	ANTIVIRALS, HIV-SPECIFIC, NON-NUCLEOSIDE, RTI	11	Y	DORAVIRINE 100MG TABLET	DORAVIRINE 100MG TABLET	PIFELTRO			2				
28.5	078822	W5Q	ARTV NUCLEOSIDE,NUCLEOTIDE,NON-NUCLEOSIDE RTI COMB	12	Y	DORAVIRINE/LAMIVU/TENOFOV DISO 100-300-300MG TA	DORAVIRINE/LAMIVU/TENOFOV DISO 100-300-300	DELSTRIGO			1				
28.5	075117	W5X	ANTIRETROVIRAL	13	Y	ELVITEG/COB/EMTRI/TENOF ALAFEN	ELVITEG/COB/EMTRI/TENOF ALAFEN	GENVOYA	30	30	1				
28.5	057883	W5O	ANTIRETROVIRAL	14	Y	EMTRICITABINE/TENOFOVIR (TDF) TABLETS	EMTRICITABINE/TENOFOVIR (TDF) 200-300 MG TA	TRUVADA	30	30	1				
28.5	075812	W5O	ANTIRETROVIRAL	15	Y	EMTRICITABINE/TENOFOV ALAFENAM 200-25 MG TABLET	EMTRICITABINE/TENOFOV ALAFENAM 200-25 MG	DESCOVY	30	30	1				
28.5	081260	W5O	ANTIVIRALS, HIV-SPECIFIC, CD4 ATTACHMENT INHIBITOR	17	Y	FOSTEMSAVIR TROMETHAMINE 600 MG TABLET	FOSTEMSAVIR TROMETHAMINE 600 MG TABLET	RUKOBIA ER			2				
28.5	077480	W5U	ANTIRETROVIRALS	18	Y	RALTEGRAVIR POTASSIUM 600MG TABLET	RALTEGRAVIR POTASSIUM 600MG TABLET	ISENTRESS			2				
29	29	HIC3	THERAPEUTIC CLASS	0	Y	ANTIVIRALS (Oral)	ANTIVIRALS (Oral)	BRAND	Units	Until Refill	Daily Dose	Max Days	Refills	Pkg Bill	Updated
29	009630	W5A	ANTIVIRALS, GENERAL	1	Y	ACYCLOVIR CAPSULES or TABLETS	ACYCLOVIR 200MG CAPSULE	ZOVIRAX			5	10			
29	072344	W5A	ANTIVIRALS, GENERAL	2	Y	ACYCLOVIR 50MG BUCCAL TABLET	ACYCLOVIR 50MG BUCCAL TABLET	SITAVIG	2	10					

29	079190	W5A	ANTIVIRALS, GENERAL	3	Y	BALOXAVIR MARBOXIL TALBET (DOSE PACKS)	BALOXAVIR MARBOXIL 20MG TAB (40MG DOSE)	XOFLUZA	2	180					
29	082142	W5A	ANTIVIRALS, GENERAL	3.5	Y	BALOXAVIR MARBOXIL 80 MG TABLET	BALOXAVIR MARBOXIL 80 MG TABLET	XOFLUZA	1						
29	023543	W5A	ANTIVIRALS, GENERAL	4	Y	FAMCICLOVIR TABLETS	FAMCICLOVIR 125MG TABLET	FAMVIR			3	7			
29	020987	W5A	ANTIVIRALS, GENERAL	5	Y	FLUMADINE 100 MG TABLET	FLUMADINE 100 MG TABLET	RIMANTADINE	14	180	2				
29	067561	W5A	ANTIVIRALS, GENERAL	6	Y	OSELTAMIVIR PHOSPHATE 6MG/ML SUSPENSION	OSELTAMIVIR PHOSPHATE 6MG/ML SUSPENSION	TAMIFLU	120	180			0		
29	063223	W5A	ANTIVIRALS, GENERAL	7	Y	OSELTAMIVIR PHOSPHATE 30MG GELCAP	OSELTAMIVIR PHOSPHATE 30MG GELCAP	TAMIFLU	20	180			0		
29	063224	W5A	ANTIVIRALS, GENERAL	8	Y	OSELTAMIVIR PHOSPHATE 45 and 75MG GELCAP	OSELTAMIVIR PHOSPHATE 45MG GELCAP	TAMIFLU	10	180			0		
29	023989	W5A	ANTIVIRALS, GENERAL	9	Y	VALACYCLOVIR HCL 500MG and 1GRAM CAPLET	VALACYCLOVIR HCL 500MG CAPSULE	VALTREX			3	7			
29	043119	W5A	ANTIVIRALS, GENERAL	10	Y	ZANAMIVIR 5MG DISKHALER 5 DISKS X 4 BLISTERS	ZANAMIVIR 5MG DISKHALER 5 DISKS X 4 BLISTERS	RELENZA	20	180			0		
31	31	HIC3	THERAPEUTIC CLASS	0	Y	BETA BLOCKERS (Oral) & MISCELLANEOUS ANTIANGINAL	BETA BLOCKERS (Oral) & MISCELLANEOUS ANTIAN	BRAND	Units	Until Refill	Daily Dose	Max Days	Refills	Pkg Bill	Updated
31	017956	J7C	BETA-ADRENERGIC BLOCKING AGENTS	1	Y	BISOPROLOL FUMARATE 5MG TABLET	BISOPROLOL FUMARATE 5MG TABLET	ZEBETA			1				
31	017955	J7C	BETA-ADRENERGIC BLOCKING AGENTS	2	Y	BISOPROLOL FUMARATE 10MG TABLET	BISOPROLOL FUMARATE 10MG TABLET	ZEBETA			4				
31	022233	J7A	BETA-ADRENERGIC BLOCKING AGENTS	3	Y	CARVEDILOL 3.125, 6.25 & 12.5MG TABLETS	CARVEDILOL 12.5MG TABLET	COREG			2				
31	019293	J7A	BETA-ADRENERGIC BLOCKING AGENTS	4	Y	CARVEDILOL 25MG TABLET	CARVEDILOL 25MG TABLET	COREG			4				
31	061811	J7A	BETA-ADRENERGIC BLOCKING AGENTS	5	Y	CARVEDILOL PHOSPHATE 10, 20, 40 and 80MG CAPSULE	CARVEDILOL PHOSPHATE 10MG CAPSULE	COREG CR			1				
31	047586	J7C	BETA-ADRENERGIC BLOCKING AGENTS	10	Y	METOPROLOL SUCCINATE 25MG TABLET	METOPROLOL SUCCINATE 25MG TABLET	TOPROL XL			1				
31	016599	J7C	BETA-ADRENERGIC BLOCKING AGENTS	12	Y	METOPROLOL SUCCINATE 50 and 100MG TABLET	METOPROLOL SUCCINATE 50MG TABLET	TOPROL XL			1.5				
31	078119	J7C	BETA-ADRENERGIC BLOCKING AGENTS	13	Y	METOPROLOL SUCCINATE 25, 50 AND 100 MG CAPSULE	METOPROLOL SUCCINATE 25 MG CAPSULE	KAPSPARGO SPRINKLE			1				
31	016601	J7C	BETA-ADRENERGIC BLOCKING AGENTS	13.5	Y	METOPROLOL SUCCINATE 200MG TABLET and CAPSULE	METOPROLOL SUCCINATE 200MG TABLET	TOPROL XL			2				
31	063510	J7C	BETA-ADRENERGIC BLOCKING AGENTS	15	Y	NEBIVOLOL HCL 2.5, 5, and 10MG TABLET	NEBIVOLOL HCL 2.5MG TABLET	BYSTOLIC			1				
31	064945	J7C	BETA-ADRENERGIC BLOCKING AGENTS	16	Y	NEBIVOLOL HCL 20MG TABLET	NEBIVOLOL HCL 20MG TABLET	BYSTOLIC			2				
31	005115	J7C	BETA-ADRENERGIC BLOCKING AGENTS	20	Y	PROPRANOLOL HCL CAPSULES	PROPRANOLOL HCL 60MG CAPSULE	INDERAL LA / INNOPRAN XL			1				
32	32	HIC3	THERAPEUTIC CLASS	0	Y	BLADDER RELAXANT PREPARATIONS	BLADDER RELAXANT PREPARATIONS	BRAND	Units	Until Refill	Daily Dose	Max Days	Refills	Pkg Bill	Updated
32	058576	R1I	BLADDER RELAXANT PREPARATIONS	1	Y	DARIFENACIN HYDROBROMIDE TABLETS	DARIFENACIN HYDROBROMIDE 7.5MG TABLET	ENABLEX			1				
32	064000	R1A	URINARY TRACT ANTISPASMODIC/ANTIINCONTINENCE AGENT	2	Y	FESOTERODINE FUMARATE TABLETS	FESOTERODINE FUMARATE 4 MG TABLET	TOVIAZ			1				
32	004927	R1A	URINARY TRACT ANTISPASMODIC/ANTIINCONTINENCE AGENT	3	Y	FLAVOXATE HCL 100MG TABLET	FLAVOXATE HCL 100MG TABLET	FLAVOXATE HCL			8				
32	069630	R1V	OVERACTIVE BLADDER AGENTS, BETA-3 ADRENERGIC RECEP	4	Y	MIRABEGRON TABLETS	MIRABEGRON 25MG TABLET	MYRBETRIQ			1				
32	082137	R1V	OVERACTIVE BLADDER AGENTS, BETA-3 ADRENERGIC RECEP	4.5	Y	MIRABEGRON ER 8 MG/ML SUSPENSION	MIRABEGRON ER 8 MG/ML SUSPENSION	MYRBETRIQ ER			10				
32	051909	R1A	BLADDER RELAXANTS	5	Y	OXYBUTYNIN 3.9MG/24HR PATCH	OXYBUTYNIN 3.9MG/24HR PATCH	OXYTROL	8	30				Y	
32	065081	R1A	BLADDER RELAXANTS	6	Y	OXYBUTYNIN CHLORIDE 10% GEL SACHET 1GRAM	OXYBUTYNIN CHLORIDE 10% GEL SACHET 1GRAM	GELNIQUE			1				
32	004928	R1A	BLADDER RELAXANTS	7	Y	OXYBUTYNIN CHLORIDE 5MG/5ML SYRUP	OXYBUTYNIN CHLORIDE 5MG/5ML SYRUP	GENERIC ONLY			15				
32	041046	R1A	BLADDER RELAXANTS	8	Y	OXYBUTYNIN CHLORIDE TABLETS	OXYBUTYNIN CHLORIDE 5MG ER TABLET	DITROPAN XL			1				
32	077273	R1A	BLADDER RELAXANTS	9	Y	OXYBUTYNIN CHLORIDE 10% GEL PUMP	OXYBUTYNIN CHLORIDE 10% GEL PUMP	GELNIQUE	30	30					
32	004929	R1A	BLADDER RELAXANTS	10	Y	OXYBUTYNIN CHLORIDE 5MG IR TABLET	OXYBUTYNIN CHLORIDE 5MG IR TABLET	GENERIC ONLY			3				
32	057982	R1I	BLADDER RELAXANTS	11	Y	SOLIFENACIN SUCCINATE 5 and 10MG TABLET	SOLIFENACIN SUCCINATE 5MG TABLET	VESICARE			1				
32	080587	R1I	BLADDER RELAXANTS	11.5	Y	SOLIFENACIN SUCCINATE 5 MG/5 ML SUSP	SOLIFENACIN SUCCINATE 5 MG/5 ML SUSP	VESICARE			10				
32	039138	R1A	URINARY TRACT ANTISPASMODIC/ANTIINCONTINENCE AGENT	12	Y	TOLTERODINE TARTRATE TABLETS	TOLTERODINE TARTRATE 1MG TABLET	DETROL			2				
32	047328	R1A	URINARY TRACT ANTISPASMODIC/ANTIINCONTINENCE AGENT	13	Y	TOLTERODINE TARTRATE CAPSULES	TOLTERODINE TARTRATE 2MG CAPSULE	DETROL LA			1				
32	038085	R1A	URINARY TRACT ANTISPASMODIC/ANTIINCONTINENCE AGENT	14	Y	TROSPIUM CHLORIDE 20MG TABLET	TROSPIUM CHLORIDE 20MG TABLET	SANCTURA			2				
32	063466	R1A	URINARY TRACT ANTISPASMODIC/ANTIINCONTINENCE AGENT	15	Y	TROSPIUM CHLORIDE 60MG CAPSULE	TROSPIUM CHLORIDE 60MG CAPSULE	SANCTURA XR			1				
32	081787	R1V	OVERACTIVE BLADDER AGENTS, BETA-3 ADRENERGIC RECEP	16	Y	VIBEGRON 7.5 MG TABLET	VIBEGRON 7.5 MG TABLET	GEMTESA			1				
33	33	HIC3	THERAPEUTIC CLASS	0	Y	BONE RESORPTION SUPPRESSION AND RELATED AGENTS	BONE RESORPTION SUPPRESSION AND RELATED A	BRAND	Units	Until Refill	Daily Dose	Max Days	Refills	Pkg Bill	Updated
33	031006	P4L	BONE RESORPTION SUPPRESSION AND RELATED AGENTS	1	Y	ALENDRONATE SODIUM 5, 10 and 40MG TABLET	ALENDRONATE SODIUM 5MG TABLET	FOSAMAX			1				
33	047381	P4L	BONE RESORPTION SUPPRESSION AND RELATED AGENTS	2	Y	ALENDRONATE SODIUM 35 and 70MG TABLET	ALENDRONATE SODIUM 35 MG TAB	FOSAMAX / BINOSTO	4	30					
33	053574	P4L	BONE RESORPTION SUPPRESSION AND RELATED AGENTS	3	Y	ALENDRONATE SODIUM 70MG/75ML SOLUTION	ALENDRONATE SODIUM 70MG/75ML SOLUTION	FOSAMAX	300	30					
33	062663	P4L	BONE RESORPTION SUPPRESSION AND RELATED AGENTS	4	Y	ALENDRONATE SODIUM/VITAMIN D3 70MG	ALENDRONATE SODIUM/VITAMIN D3 70MG	FOSAMAX+D	4	30				Y	
33	058947	P4L	BONE RESORPTION SUPPRESSION AND RELATED AGENTS	5	Y	ALENDRONATE SODIUM/VITAMIN D3 70MG - 2800IU	ALENDRONATE SODIUM/VITAMIN D3 70MG - 2800	FOSAMAX PLUS D	4	30					
33	024138	P4L	BONE RESORPTION SUPPRESSION AND RELATED AGENTS	6	Y	CALCITONIN,SALMON,SYNTHETIC 200 UNITS NASAL SPRA	CALCITONIN,SALMON,SYNTHETIC 200 UNITS NASA	FORTICAL	3.7	30				Y	
33	006678	P4L	BONE RESORPTION SUPPRESSION AND RELATED AGENTS	7	Y	ETIDRONATE DISODIUM 200MG TABLET	ETIDRONATE DISODIUM 200MG TABLET	GENERIC ONLY			3				
33	006679	P4L	BONE RESORPTION SUPPRESSION AND RELATED AGENTS	8	Y	ETIDRONATE DISODIUM 400MG TABLET	ETIDRONATE DISODIUM 400MG TABLET	DIDRONEL			5				
33	058915	P4L	BONE RESORPTION SUPPRESSION AND RELATED AGENTS	9	Y	IBANDRONATE SODIUM 150MG TABLET	IBANDRONATE SODIUM 150MG TABLET	BONIVA	1	30	0.034				
33	060257	P4L	BONE RESORPTION SUPPRESSION AND RELATED AGENTS	10	Y	IBANDRONATE SODIUM 3MG/3ML SYRINGE	IBANDRONATE SODIUM 3MG/3ML SYRINGE	BONIVA	3	90		90			
33	037022	P4L	BONE RESORPTION SUPPRESSION AND RELATED AGENTS	11	Y	RALOXIFENE HCL 60MG TABLET	RALOXIFENE HCL 60MG TABLET	EVISTA			1				
33	045102	P4L	BONE RESORPTION SUPPRESSION AND RELATED AGENTS	12	Y	RISEDRONATE SODIUM 5 and 30MG TABLET	RISEDRONATE SODIUM 5MG TABLET	ACTONEL			1				
33	063925	P4L	BONE RESORPTION SUPPRESSION AND RELATED AGENTS	14	Y	RISEDRONATE SODIUM 150MG TABLET	RISEDRONATE SODIUM 150MG TABLET	ACTONEL	1	30					
33	064481	94B	BONE FORMATION STIM. AGENTS - PARATHYROID HORMONE	15	Y	TERIPARATIDE 600 MCG/2.4 ML PEN	TERIPARATIDE 600 MCG/2.4 ML PEN	FORTEO	2.4	30					1/1/2022
34	34	HIC3	THERAPEUTIC CLASS	0	Y	BPH AGENTS	BPH AGENTS	BRAND	Units	Until Refill	Daily Dose	Max Days	Refills	Pkg Bill	Updated
34	045052	Q9B	BPH TREATMENTS	1	Y	ALFUZOSIN HCL 10MG TABLET	ALFUZOSIN HCL 10MG TABLET	UROXATRAL			1				
34	044421	J7B	BPH TREATMENTS	2	Y	DOXAZOSIN MESYLATE TABLETS	DOXAZOSIN MESYLATE 4MG ER TABLET	CARDURA XL			1				
34	015587	J7B	BPH TREATMENTS	3	Y	DOXAZOSIN MESYLATE 8MG TABLET	DOXAZOSIN MESYLATE 8MG TABLET	CARDURA			2				
34	051246	Q9B	BPH TREATMENTS	4	Y	DUTASTERIDE 0.5MG SOFTGEL	DUTASTERIDE 0.5MG SOFTGEL	AVODART			1				
34	066352	Q9C	BPH TREATMENTS	5	Y	DUTASTERIDE/TAMSULOSIN HCL 0.5-0.4MG CAPSULE	DUTASTERIDE/TAMSULOSIN HCL 0.5-0.4MG CAPSU	JALYN			1				
34	041440	Q9B	BPH TREATMENTS	6	Y	FINASTERIDE 5MG TABLET	FINASTERIDE 5MG TABLET	PROSCAR			1				
34	064846	Q9B	BPH TREATMENTS	7	Y	SILODOSIN CAPSULES	SILODOSIN 4MG CAPSULE	RAPAFLO			1				
34	027546	Q9B	BPH TREATMENTS	8	Y	TAMSULOSIN HCL 0.4MG CAPSULE	TAMSULOSIN HCL 0.4MG CAPSULE	FLOMAX			2				1/1/2022
34	022649	J7B	BPH TREATMENTS	9	Y	TERAZOSIN HCL 1 and 5MG CAPSULE	TERAZOSIN HCL 1MG CAPSULE	GENERIC ONLY			1				
34	022650	J7B	BPH TREATMENTS	10	Y	TERAZOSIN HCL 2 and 10MG CAPSULE	TERAZOSIN HCL 2MG CAPSULE	GENERIC ONLY			2				
35	35	HIC3	THERAPEUTIC CLASS	0	Y	BRONCHODILATORS & RESPIRATORY DRUGS	BRONCHODILATORS & RESPIRATORY DRUGS	BRAND	Units	Until Refill	Daily Dose	Max Days	Refills	Pkg Bill	Updated
35	005037	B6W	BRONCHODILATORS, BETA AGONIST	1	Y	ALBUTEROL 90 MCG INHALER & REFILL	ALBUTEROL 90 MCG INHALER	VENTOLIN	18	30				Y	
35	005039	B6W	BRONCHODILATORS, BETA AGONIST	2	Y	ALBUTEROL 0.83 MG/ML SOLUTION	ALBUTEROL 0.83 MG/ML SOLUTION	PROVENTIL	375	30				Y	
35	005040	B6W	BRONCHODILATORS, BETA AGONIST	3	Y	ALBUTEROL 5 MG/ML SOLUTION	ALBUTEROL 5 MG/ML SOLUTION	PROVENTIL	40	30				Y	
35	028090	B6W	BRONCHODILATORS, BETA AGONIST	4	Y	ALBUTEROL HFA 90 MCG INHALER	ALBUTEROL HFA 90 MCG INHALER	PROVENTIL HFA	54	30				Y	
35	080260	B6W	BRONCHODILATORS, BETA AGONIST	5	Y	ALBUTEROL SULFATE 90 MCG INHALR	ALBUTEROL SULFATE 90 MCG INHALR	PROAIR DIGIHALER	1						
35	048698	B6W	BRONCHODILATORS, BETA AGONIST	6	Y	ALBUTEROL SUL 0.63 MG/3 ML SOL	ALBUTEROL SUL 0.63 MG/3 ML SOL	GENERIC ONLY	375	30				Y	
35	048699	B6W	BRONCHODILATORS, BETA AGONIST	7	Y	ALBUTEROL SUL 1.25 MG/3 ML SOL	ALBUTEROL SUL 1.25 MG/3 ML SOL	GENERIC ONLY	375	30				Y	
35	054687	B6W	BRONCHODILATORS, BETA AGONIST	8	Y	ALBUTEROL SULFATE 2.5MG/0.5ML SOLUTION	ALBUTEROL SULFATE 2.5MG/0.5ML SOLUTION	GENERIC ONLY	120	30				Y	
35	073806	B6W	BRONCHODILATORS, BETA AGONIST	9	Y	ALBUTEROL SULFATE INHAL POWDER	ALBUTEROL SULFATE INHAL POWDER	PROAIR RESPICLICK	6	30				Y	

35	061579	B6Y	BRONCHODILATORS, BETA AGONIST	10	Y	ARFORMOTEROL TARTRATE 15MCG/2ML SOLUTION	ARFORMOTEROL TARTRATE 15MCG/2ML SOLUTIO	BROVANA	120	30				Y	
35	063016	B6Y	BRONCHODILATORS & RESPIRATORY DRUGS	12	Y	FORMOTEROL FUMARATE 20MCG/2ML SOLUTION	FORMOTEROL FUMARATE 20MCG/2ML SOLUTION	PERFOROMIST	120	30				Y	
35	067600	B6Z	BRONCHODILATORS & RESPIRATORY DRUGS	13	Y	INDACATEROL MALEATE 75MCG CAPSULE	INDACATEROL MALEATE 75MCG CAPSULE	ARCAPTA NEOHALER	30	30				Y	
35	049871	B6W	BRONCHODILATORS & RESPIRATORY DRUGS	14	Y	LEVALBUTEROL HCL 0.31MG/3ML SOLUTION	LEVALBUTEROL HCL 0.31MG/3ML SOLUTION	XOPENEX	270	30	12			Y	1/1/2022
35	041848	B6W	BRONCHODILATORS & RESPIRATORY DRUGS	15	Y	LEVALBUTEROL HCL 0.63MG/3ML SOLUTION	LEVALBUTEROL HCL 0.63MG/3ML SOLUTION	XOPENEX	270	30	9			Y	
35	057879	B6W	BRONCHODILATORS & RESPIRATORY DRUGS	16	Y	LEVALBUTEROL HCL 1.25MG/0.5ML VIALS	LEVALBUTEROL HCL 1.25MG/0.5ML VIALS	XOPENEX CONCENTRATE	90	30					
35	041849	B6W	BRONCHODILATORS & RESPIRATORY DRUGS	17	Y	LEVALBUTEROL HCL 1.25MG/3ML SOLUTION	LEVALBUTEROL HCL 1.25MG/3ML SOLUTION	XOPENEX	270	30	9			Y	
35	058890	B6W	BRONCHODILATORS & RESPIRATORY DRUGS	18	Y	LEVALBUTEROL TARTRATE 45MCG INHALER 15GRAMS	LEVALBUTEROL TARTRATE 45MCG INHALER 15GRA	XOPENEX HFA	30	30				Y	
36	**36**	**HIC3**	**THERAPEUTIC CLASS**	**0**	**Y**	**CALCIUM CHANNEL BLOCKERS**	**CALCIUM CHANNEL BLOCKERS**	**BRAND**	**Units**	**Until Refill**	**Daily Dose**	**Max Days**	**Refills**	**Pkg Bill**	**Updated**
36	079995	A9A	CALCIUM CHANNEL BLOCKERS	1	Y	AMLODIPINE BENZOATE 1 MG/ML SUSPENSION	AMLODIPINE BENZOATE 1 MG/ML SUSPENSION	KATERZIA			10				
36	016925	A9A	CALCIUM CHANNEL BLOCKERS	2	Y	AMLODIPINE BESYLATE TABLETS	AMLODIPINE BESYLATE 2.5MG TABLET	NORVASC			1				
36	017205	A9A	CALCIUM CHANNEL BLOCKERS	3	Y	DILTIAZEM HCL 120, 180, 300, 360 and 420MG CAPSULE	DILTIAZEM HCL 120MG CAPSULE	CARDIZEM CD / CARTIA XT / DILACOR XR / TIAZIC			1				
36	016571	A9A	CALCIUM CHANNEL BLOCKERS	4	Y	DILTIAZEM HCL 240MG CAPSULE	DILTIAZEM HCL 240MG CAPSULE	CARDIZEM CD / CARTIA XT / DILACOR XR / TIAZIC			2				
36	051801	A9A	CALCIUM CHANNEL BLOCKERS	5	Y	DILTIAZEM HCL TABLETS	DILTIAZEM HCL 120MG TABLET	CARDIZEM LA / MATZIM LA			1				
36	021743	A9A	CALCIUM CHANNEL BLOCKERS	6	Y	FELODIPINE 2TABLETS	FELODIPINE 2.5MG TABLET	GENERIC ONLY			1				
36	029258	A9A	CALCIUM CHANNEL BLOCKERS	7	Y	ISRADIPINE 5MG TABLET	ISRADIPINE 5MG TABLET	DYNACIRC CR			1				
36	080610	A9A	CALCIUM CHANNEL BLOCKERS	7.5	Y	LEVAMLODIPINE MALEATE TABLETS	LEVAMLODIPINE MALEATE 2.5 MG TABLET	CONJUPRI			1				
36	029259	A9A	CALCIUM CHANNEL BLOCKERS	8	Y	ISRADIPINE 10MG TABLET	ISRADIPINE 10MG TABLET	DYNACIRC CR			2				
36	012059	A9A	CALCIUM CHANNEL BLOCKERS	9	Y	NIFEDIPINE 30 and 90MG TABLET	NIFEDIPINE 30MG TABLET	ADALAT CC / NIFEDIAC / PROCARDIA			1				
36	012060	A9A	CALCIUM CHANNEL BLOCKERS	10	Y	NIFEDIPINE 60MG TABLET	NIFEDIPINE 60MG TABLET	PROCARDIA XL			2				
36	000579	A9A	CALCIUM CHANNEL BLOCKERS	11	Y	NIMODIPINE 30MG CAPSULE	NIMODIPINE 30MG CAPSULE	GENERIC ONLY			12				
36	080991	A9A	CALCIUM CHANNEL BLOCKERS	11.1	Y	NIMODIPINE 30 MG/5 ML ORAL SYRINGE	NIMODIPINE 30 MG/5 ML ORAL SYRINGE	NYMALIZE			30	21			
36	080992	A9A	CALCIUM CHANNEL BLOCKERS	11.2	Y	NIMODIPINE 60 MG/10 ML ORAL SYRINGE	NIMODIPINE 60 MG/10 ML ORAL SYRINGE	NYMALIZE			60	21			
36	082451	A9A	CALCIUM CHANNEL BLOCKERS	11.3	Y	NIMODIPINE 60 MG/10 ML SOLUTION	NIMODIPINE 60 MG/10 ML SOLUTION	NYMALIZE			120	21			1/1/2022
36	063730	A9A	CALCIUM CHANNEL BLOCKERS	12	Y	NISOLDIPINE ER 8.5, 17, 20, 25.5, 34 and 40MG TABLET	NISOLDIPINE 8.5MG TABLET	SULAR			1				
36	024500	A9A	CALCIUM CHANNEL BLOCKERS	13	Y	NISOLDIPINE ER 30MG TABLET	NISOLDIPINE 30MG TABLET	GENERIC ONLY			2				
36	041651	A9A	CALCIUM CHANNEL BLOCKERS	14	Y	VERAPAMIL HCL 100 and 300MG CAPLET	VERAPAMIL HCL 100MG CAPLET	VERELAN PM			1				
36	041652	A9A	CALCIUM CHANNEL BLOCKERS	15	Y	VERAPAMIL HCL 200MG CAPLET	VERAPAMIL HCL 200MG CAPLET	VERELAN PM			2				
36	026486	A9A	CALCIUM CHANNEL BLOCKERS	16	Y	VERAPAMIL HCL 360MG CAPLET	VERAPAMIL HCL 360MG CAPLET	VERELAN			1				
36	015066	A9A	CALCIUM CHANNEL BLOCKERS	17	Y	VERAPAMIL HCL 120, 180 and 240MG CAPSULE	VERAPAMIL HCL 120MG CAPSULE	VERELAN			1				
36	015067	A9A	CALCIUM CHANNEL BLOCKERS	18	Y	VERAPAMIL HCL 240MG CAPSULE	VERAPAMIL HCL 240MG CAPSULE	VERELAN			2				
36	015959	A9A	CALCIUM CHANNEL BLOCKERS	19	Y	VERAPAMIL HCL TABLETS	VERAPAMIL HCL 120MG TABLET	CALAN SR / ISOPTIN SR			2				
37	**37**	**HIC3**	**THERAPEUTIC CLASS**	**0**	**Y**	**CEPHALOSPORINS AND RELATED ANTIBIOTICS (Oral)**	**CEPHALOSPORINS AND RELATED ANTIBIOTICS (Or**	**BRAND**	**Units**	**Until Refill**	**Daily Dose**	**Max Days**	**Refills**	**Pkg Bill**	**Updated**
37	063606	W1A	CEPHALOSPORINS AND RELATED ANTIBIOTICS (Oral)	1	Y	AMOXICILLIN ALL STRENGTHS ALL FORMULATIONS	AMOXICILLIN 775MG TABLET	MOXATAG ER				14	1		
37	050991	W1A	CEPHALOSPORINS AND RELATED ANTIBIOTICS (Oral)	2	Y	AMOXICILLIN/POTASSIUM CLAVULANTE TABLETS ALL STR	AMOXICILLIN/POTASSIUM CLAVULANTE 1,000-6.25	AUGMENTIN XR				14	1		
37	026719	W1A	CEPHALOSPORINS AND RELATED ANTIBIOTICS (Oral)	3	Y	AMOXICILLIN/POTASSIUM CLAVULANTE CHEWABLE TABL	AMOXICILLIN/POTASSIUM CLAVULANTE 200-28.5 T	AMOX-TR				14	1		
37	008941	W1A	CEPHALOSPORINS AND RELATED ANTIBIOTICS (Oral)	4	Y	AMPICILLIN TRIHYDRATE ALL STRENGTHS	AMPICILLIN TRIHYDRATE 250 MG CAPSULE	GENERIC ONLY				14	1		
37	009105	W1X	CEPHALOSPORINS AND RELATED ANTIBIOTICS (Oral)	5	Y	CEFACLOR SUSPENSIONS, CAPSULE and ER TABLETS ALL S	CEFACLOR 500MG CAPSULE	GENERIC ONLY				14	1		
37	040257	W1X	CEPHALOSPORINS AND RELATED ANTIBIOTICS (Oral)	6	Y	CEFDINIR CAPSULES and SUSPENSIONS	CEFDINIR 300 MG CAPSULE	GENERIC ONLY				14	1		
37	048262	W1X	CEPHALOSPORINS AND RELATED ANTIBIOTICS (Oral)	7	Y	CEFADROXIL CAPSULES, SUSPENSIONS and TABLETS	CEFADROXIL 500 MG CAPSULE	GENERIC ONLY				14	1		
37	048978	W1X	CEPHALOSPORINS AND RELATED ANTIBIOTICS (Oral)	8	Y	CEFDITOREN PIVOXIL TABLETS	CEFDITOREN PIVOXIL 200 MG TAB	GENERIC ONLY				14	1		
37	009182	W1X	CEPHALOSPORINS AND RELATED ANTIBIOTICS (Oral)	9	Y	CEFIXIME SUSPENSIONS	CEFIXIME 100 MG/5 ML SUSP	SUPRAX				14	1		
37	016929	W1X	CEPHALOSPORINS AND RELATED ANTIBIOTICS (Oral)	11	Y	CEFPODOXIME SUSPENSIONS and TABLETS	CEFPODOXIME 50 MG/5 ML SUSP	GENERIC ONLY				14	1		
37	016582	W1X	CEPHALOSPORINS AND RELATED ANTIBIOTICS (Oral)	12	Y	CEFPROZIL SUSPENSIONS and TABLETS	CEFPROZIL 125 MG/5 ML SUSP	GENERIC ONLY				14	1		
37	009137	W1X	CEPHALOSPORINS AND RELATED ANTIBIOTICS (Oral)	13	Y	CEFUROXIME AXETIL TABLETS ALL STRENGTHS	CEFUROXIME AXETIL 500MG TAB	CEFTIN				14	1		
37	009042	W1W	CEPHALOSPORINS AND RELATED ANTIBIOTICS (Oral)	14	Y	CEPHALEXIN CAPSULE, TABLETS AND SUSPENSIONS	CEPHALEXIN 250 MG CAPSULE	KEFLEX				14	1		
37	008983	W1A	PENICILLIN	15	Y	DICLOXACILLIN SODIUM CAPSULES	DICLOXACILLIN SODIUM 250 MG CAPSULE	GENERIC ONLY				14	1		
37	008876	W1A	PENICILLIN ANTIBIOTICS	16	Y	PENICILLIN V POTASSIUM VK SOLUTIONS	PENICILLIN V POTASSIUM VK 125 MG/5 ML SOLUTI	GENERIC ONLY				14	1		
39	**39**	**HIC3**	**THERAPEUTIC CLASS**	**0**	**Y**	**COPD AGENTS**	**COPD AGENTS**	**BRAND**	**Units**	**Until Refill**	**Daily Dose**	**Max Days**	**Refills**	**Pkg Bill**	**Updated**
39	069855	B61	COPD AGENTS	1	Y	ACLIDINIUM BROMIDE 400MCG INHALER	ACLIDINIUM BROMIDE 400MCG INHALER	TUDORZA PRESSAIR	1	30				Y	
39	048018	B60	COPD AGENTS	2	Y	IPRATROPIUM/ALBUTEROL SULFATE 0.5MG-3MG/3ML SO	IPRATROPIUM/ALBUTEROL SULFATE 0.5MG-3MG/3	DUONEB	540	30				Y	
39	069371	B60	COPD AGENTS	3	Y	IPRATROPIUM/ALBUTEROL SULFATE INHALERS 4GRAMS	IPRATROPIUM/ALBUTEROL SULFATE INHALERS 4GR	COMBIVENT RESPIMAT	4	30				Y	
39	059081	B60	COPD AGENTS	4	Y	IPRATROPIUM BROMIDE INHALER	IPRATROPIUM BROMIDE INHALER	ATROVENT HFA	25.8	30				Y	
39	021700	B60	COPD AGENTS	5	Y	IPRATROPIUM BROMIDE 0.02% SOLUTION 0.25MG/ML 2.	IPRATROPIUM BROMIDE 0.02% SOLUTION 0.25MG	GENERIC ONLY	450	30				Y	
39	024457	Q7A	COPD AGENTS	6	Y	IPRATROPIUM BROMIDE 0.03% SPRAY 30ML	IPRATROPIUM BROMIDE 0.03% SPRAY 30ML	ATROVENT	30	30				Y	
39	024456	Q7A	COPD AGENTS	7	Y	IPRATROPIUM BROMIDE 0.06% SPRAY 15ML	IPRATROPIUM BROMIDE 0.06% SPRAY 15ML	ATROVENT	15	30				Y	
39	079272	B61	COPD AGENTS	8	Y	REVEFENACIN 175MCG/3ML SOLUTION	REVEFENACIN 175MCG/3ML SOLUTION	YUPELRI			3				
39	066612	Z2X	COPD AGENTS	9	Y	ROFLUMILAST 500MG TABLET	ROFLUMILAST 500MG TABLET	DALIRESP			1				
39	050714	B61	COPD AGENTS	10	Y	TIOTROPIUM BROMIDE 18MCG CAP-HANDIHALER	TIOTROPIUM BROMIDE 18MCG CAP-HANDIHALER	SPIRIVA			1			Y	
40	**40**	**HIC3**	**THERAPEUTIC CLASS**	**0**	**Y**	**CYTOKINE & CAM ANTAGONISTS**	**CYTOKINE & CAM ANTAGONISTS**	**BRAND**	**Units**	**Until Refill**	**Daily Dose**	**Max Days**	**Refills**	**Pkg Bill**	**Updated**
40	067681	S2Q	CYTOKINE & CAM ANTAGONISTS	1	Y	ABATACEPT 125MG/ML SYRINGE	ABATACEPT 125MG/ML SYRINGE	ORENCIA	4	30					
40	060226	S2Q	CYTOKINE & CAM ANTAGONISTS	2	Y	ABATACEPT/MALTOSE 250MG VIAL	ABATACEPT/MALTOSE 250MG VIAL	ORENCIA	4	30					
40	072952	S2Q	CYTOKINE & CAM ANTAGONISTS	3	Y	ADALIMUMAB SYRINGES	ADALIMUMAB 10MG/0.2ML SYRINGE	HUMIRA	2	28				Y	
40	078672	S2J	CYTOKINE & CAM ANTAGONISTS	4	Y	ADALIMUMAB PEN INJECTOR KIT	ADALIMUMAB PEN INJECTOR KIT	HUMIRA	3						
40	077870	S2J	CYTOKINE & CAM ANTAGONISTS	5	Y	ADALIMUMAB PEN 80 MG/0.8 ML	ADALIMUMAB PEN 80 MG/0.8 ML	HUMIRA(CF)	3						
40	048899	S2M	CYTOKINE & CAM ANTAGONISTS	6	Y	ANAKINRA 100MG/0.67ML SYPRINGE	ANAKINRA 100MG/0.67ML SYPRINGE	KINERET			0.67			Y	
40	072075	S2Z	CYTOKINE & CAM ANTAGONISTS	7	Y	APREMILAST 30MG TABLET	APREMILAST 30MG TABLET	OTEZLA			2				
40	073370	S2Z	CYTOKINE & CAM ANTAGONISTS	8	Y	APREMILAST STARTER PACKS	APREMILAST 28 DAY STARTER PACK	OTEZLA					0	Y	
40	077445	Z2Z	CYTOKINE & CAM ANTAGONISTS	9	Y	BARICITINIB TABLETS	BARICITINIB 2 MG TABLET	OLUMIANT			1				
40	065189	S2J	CYTOKINE & CAM ANTAGONISTS	10	Y	CERTOLIZUMAB PEGOL 200MG/ML SYRINGE KIT	CERTOLIZUMAB PEGOL 200MG/ML SYRINGE KIT	CIMZIA	1	28					
40	040869	S2J	CYTOKINE & CAM ANTAGONISTS	12	Y	ETANERCEPT 25MG KIT AND SYRINGES	ETANERCEPT 25MG KIT	ENBREL	8	28				Y	
40	062624	S2J	CYTOKINE & CAM ANTAGONISTS	13	Y	ETANERCEPT 250MG/0.5ML SYRINGE	ETANERCEPT 250MG/0.5ML SYRINGE	ENBREL	4	28				Y	
40	065113	S2J	CYTOKINE & CAM ANTAGONISTS	14	Y	GOLIMUMAB 50MG/0.5ML PEN INJECTOR AND SYRINGES	GOLIMUMAB 50MG/0.5ML PEN INJECTOR	SIMPONI	0.5	30					
40	077565	L1A	CYTOKINE & CAM ANTAGONISTS	15	Y	GUSELKUMAB 100 MG/ML SYRINGE	GUSELKUMAB 100 MG/ML SYRINGE	TREMFYA	1	30		56			
40	040650	S2J	CYTOKINE & CAM ANTAGONISTS	16	Y	INFLIXIMAB 100 MG VIALS	INFLIXIMAB 100 MG VIAL	REMICADE				56			
40	070233	Z2Z	CYTOKINE & CAM ANTAGONISTS	17	Y	TOFACITINIB CITRATE IR TABLETS	TOFACITINIB CITRATE 5MG TABLET	XELJANZ			2				
40	081537	Z2Z	CYTOKINE & CAM ANTAGONISTS	17.5	Y	TOFACITINIB CITRATE 1 MG/ML SOLUTION	TOFACITINIB CITRATE 1 MG/ML SOLUTION	XELJANZ	240	30	8				

40	080628	Z2Z	CYTOKINE & CAM ANTAGONISTS	18	Y	TOFACITINIB CITRATE XR TABLETS	TOFACITINIB CITRATE 22 MG TABLET	XELJANZ XR			1					
40	080125	Z2Z	CYTOKINE & CAM ANTAGONISTS	19	Y	UPADACITINIB ER 15 MG TABLET	UPADACITINIB ER 15 MG TABLET	RINVOQ			1					
40	065993	Z2U	CYTOKINE & CAM ANTAGONISTS	20	Y	USTEKINUMAB SYRINGES	USTEKINUMAB 45MG/0.5ML SYRINGE	STELARA				84				
43	43	HIC3	THERAPEUTIC CLASS	0	Y	FLUOROQUINOLONES (Oral)	FLUOROQUINOLONES (Oral)	BRAND	Units	Until Refill	Daily Dose	Max Days	Refills	Pkg Bill	Updated	
43	019874	W1Q	FLUOROQUINOLONES (Oral)	1	Y	CIPROFLOXACIN HCL TABLETS ALL STRENGTHS	CIPROFLOXACIN HCL 100MG TABLET	CIPRO				14	1			
43	053004	W1Q	FLUOROQUINOLONES (Oral)	2	Y	CIPROFLOXACIN ER TABLETS	CIPROFLOXACIN ER 1,000 MG TABLET	CIPRO XR				14	1			
43	039551	W1Q	FLUOROQUINOLONES (Oral)	3	Y	CIPROFLOXACIN SUSPENSIONS	CIPROFLOXACIN 250 MG/5 ML SUSP	CIPRO				14	1			
43	051576	W1Q	FLUOROQUINOLONES (Oral)	4	Y	CIPROFLOXACIN/CIPROFLOXA HCL TABLETS ALL STRENGTH	CIPROFLOXACIN/CIPROFLOXA HCL 500MG TABLET	CIPRO XR				14	1			
43	016368	W1D	FLUOROQUINOLONES (Oral)	5	Y	CLARITHROMYCIN SUSPENSIONS and TABLETS	CLARITHROMYCIN 500 MG TABLET	BIAXIN				14	1			
43	077492	W1Q	FLUOROQUINOLONES (Oral)	6	Y	DELAFLOXACIN MEGLUMINE 450 MG TABLET	DELAFLOXACIN MEGLUMINE 450 MG TABLET	BAXDELA				14	1			
43	053835	W1Q	FLUOROQUINOLONES (Oral)	7	Y	GEMIFLOXACIN MESYLATE 320MG TABLET	GEMIFLOXACIN MESYLATE 320MG TABLET	FACTIVE				14	1			
43	058310	W1Q	FLUOROQUINOLONES (Oral)	8	Y	LEVOFLOXACIN SOLUTIONS AND TABLETS	LEVOFLOXACIN 25MG/ML SOLUTION	LEVAQUIN				14	1			
43	043879	W1Q	FLUOROQUINOLONES (Oral)	9	Y	MOXIFLOXACIN HCL 400MG TABLET	MOXIFLOXACIN HCL 400MG TABLET	AVELOX				14	1			
43	015601	W1Q	FLUOROQUINOLONES (Oral)	10	Y	OFLOXACIN TABLETS	OFLOXACIN 300 MG TABLET	GENERIC ONLY				14	1			
44	44	HIC3	THERAPEUTIC CLASS	0	Y	GLUCOCORTICOIDS (Inhaled)	GLUCOCORTICOIDS (Inhaled)	BRAND	Units	Until Refill	Daily Dose	Max Days	Refills	Pkg Bill	Updated	
44	077643	B6M	GLUCOCORTICOIDS (Inhaled)	1	Y	BECLOMETHASONE DIPROPIONATE 40MCG INHALER	BECLOMETHASONE DIPROPIONATE 40MCG INHALE	QVAR REDIHALER	10.6	30				Y		
44	077644	B6M	GLUCOCORTICOIDS (Inhaled)	2	Y	BECLOMETHASONE DIPROPIONATE 80MCG INHALER	BECLOMETHASONE DIPROPIONATE 40MCG INHALE	QVAR REDIHALER	21.2	30				Y		
44	079891	P5A	GLUCOCORTICOIDS	3	Y	BUDESONIDE CAPSULES	BUDESONIDE 6 MG CAPSULE	ORTIKOS ER			1					
44	025750	P5A	GLUCOCORTICOIDS	4	Y	BUDESONIDE EC 3MG CAPSULE	BUDESONIDE EC 3MG CAPSULE	ENTOCORT			3					
44	062240	B6M	GLUCOCORTICOIDS (Inhaled)	5	Y	BUDESONIDE FLEXHALERS	BUDESONIDE 90MCG FLEXHALER	PULMICORT FLEXHALER	1	30				Y		
44	046525	B6M	GLUCOCORTICOIDS (Inhaled)	6	Y	BUDESONIDE RESPULES	BUDESONIDE 0.25MG/2ML SUSPENSION	PULMICORT	120	30				Y		
44	062725	B63	GLUCOCORTICOIDS (Inhaled)	7	Y	BUDESONIDE/FORMOTEROL FUMARATE INHALERS	BUDESONIDE/FORMOTEROL FUMARATE 80-4.5MC	SYMBICORT	10.2	30				Y		
44	081351	B64	GLUCOCORTICOIDS (Inhaled)	8	Y	BUDESONIDE/GLYCOPYR/FORMOTEROL INHALER	BUDESONIDE/GLYCOPYR/FORMOTEROL INHALER	BREZTRI AEROSPHERE	10.7							
44	058671	B6M	GLUCOCORTICOIDS (Inhaled)	9	Y	CICLESONIDE INHALERS	CICLESONIDE 80MCG INHALER 6.1GRAM	ALVESCO	6.1	30				Y		
44	061392	P5A	GLUCOCORTICOIDS	10	Y	DEXAMETHASONE 10 DAY 1.5 MG TB	DEXAMETHASONE 10 DAY 1.5 MG TB	DEXPAK	35					Y		
44	079576	P5A	GLUCOCORTICOIDS	11	Y	DEXAMETHASONE 11 DAY 1.5 MG TABLET	DEXAMETHASONE 11 DAY 1.5 MG TABLET	DXEVO	39			11				
44	046463	P5A	GLUCOCORTICOIDS	12	Y	DEXAMETHASONE 13 DAY 1.5 MG TB	DEXAMETHASONE 13 DAY 1.5 MG TB	DEXPAK	51					Y		
44	064893	P5A	GLUCOCORTICOIDS	13	Y	DEXAMETHASONE 6 DAY 1.5 MG TAB	DEXAMETHASONE 6 DAY 1.5 MG TAB	DEXPAK	21					Y		
44	077133	P5A	GLUCOCORTICOIDS	14	Y	TAPERDEX 7 DAY 1.5 MG TAB PACK	DEXAMETHASONE 7 DAY 1.5 MG TAB PACK	TAPERDEX	27					Y		
44	008079	Q7P	GLUCOCORTICOIDS (Inhaled)	15	Y	FLUNISOLIDE 0.025% SPRAY	FLUNISOLIDE 0.025% SPRAY	GENERIC ONLY	25	30				Y		
44	081399	B63	GLUCOCORTICOIDS (Inhaled)	16	Y	FLUTICASONE PROPION/SALMETEROL DIGIHALERS	FLUTICASONE PROPION/SALMETEROL 55-14 MCG	AIRDUO DIGIHALER	1							
44	019319	B6M	GLUCOCORTICOIDS (Inhaled)	17	Y	FLUTICASONE PROPIONATE DISKUS	FLUTICASONE PROPIONATE 50MCG DISKUS	FLOVENT DISKUS	60	30				Y		
44	021251	B6M	GLUCOCORTICOIDS (Inhaled)	18	Y	FLUTICASONE PROPIONATE 110 and 220MCG INHALER	FLUTICASONE PROPIONATE 110MCG INHALER	FLOVENT HFA	12	30				Y		
44	021253	B6M	GLUCOCORTICOIDS (Inhaled)	19	Y	FLUTICASONE PROPIONATE 44MCG INHALER	FLUTICASONE PROPIONATE 44MCG INHALER	FLOVENT HFA	10.6	30				Y		
44	081476	B6M	GLUCOCORTICOIDS (Inhaled)	20	Y	FLUTICASONE PROPIONATE DIGIHALERS	FLUTICASONE PROPIONATE 55 MCG	ARMONAIR DIGIHALER	1	30						
44	077089	B6M	GLUCOCORTICOIDS (Inhaled)	21	Y	FLUTICASONE PROPIONATE POWDERS	FLUTICASONE PROPIONATE 55 MCG POWDER	ARMONAIR RESPICLICK	1							
44	043366	B63	GLUCOCORTICOIDS (Inhaled)	22	Y	FLUTICASONE/SALMETEROL DISKUSES	FLUTICASONE/SALMETEROL 100-50MCG 60 UNITS	ADVAIR DISKUS	60	30				Y		
44	061343	B63	GLUCOCORTICOIDS (Inhaled)	23	Y	FLUTICASONE/SALMETEROL INHALERS	FLUTICASONE/SALMETEROL 45-21MCG INHALER	ADVAIR HFA	12	30				Y		
44	077072	B63	GLUCOCORTICOIDS (Inhaled)	24	Y	FLUTICASONE/SALMETEROL RESPICLICKS	FLUTICASONE/SALMETEROL 55-14 MCG	AIRDUO RESPICLICK	1					Y		
44	070972	B64	GLUCOCORTICOIDS (Inhaled)	25	Y	FLUTICASONE/VILANTEROL 100-25 MCG INH	FLUTICASONE/VILANTEROL 100-25 MCG INH	BREO ELLIPTA	60	30				Y		
44	045311	P5A	GLUCOCORTICOIDS	26	Y	METHYLPREDNISOLONE 4 MG DOSEPK	METHYLPREDNISOLONE 4 MG DOSEPK	MEDROL	21					Y		
44	059328	B6M	GLUCOCORTICOIDS (Inhaled)	27	Y	MOMETASONE FUROATE TWISTHALERS	MOMETASONE FUROATE 220MCG TWISTHALER #6	ASMANEX	1	30				Y		
44	080669	B6M	GLUCOCORTICOIDS (Inhaled)	28	Y	MOMETASONE FUROATE HFA 50 MCG INHALER	MOMETASONE FUROATE HFA 50 MCG INHALER	ASMANEX	13	30						
44	066480	B63	GLUCOCORTICOIDS (Inhaled)	29	Y	MOMETASONE/FORMOTEROL 100 and 200MCG/5MCG IN	MOMETASONE/FORMOTEROL 100MCG/5MCG INH	DULERA	17.6	30				Y		
44	067555	B63	GLUCOCORTICOIDS (Inhaled)	30	Y	MOMETASONE/FORMOTEROL 50 MCG-5 MCG INHALER	MOMETASONE/FORMOTEROL 50 MCG-5 MCG INH	DULERA	13	30						
44	066563	P5A	GLUCOCORTICOIDS (Inhaled)	31	Y	PREDNISOLONE 5 MG 12-DAY PACK	PREDNISOLONE 5 MG 12-DAY PACK	MILLIPRED DP	48					Y		
44	066562	P5A	GLUCOCORTICOIDS (Inhaled)	32	Y	PREDNISOLONE 5 MG 6-DAY PACK	PREDNISOLONE 5 MG 6-DAY PACK	MILLIPRED DP	21					Y		
44	060956	P5A	GLUCOCORTICOIDS	33	Y	PREDNISOLONE SODIUM PHOSHATE ODT TABLETS	PREDNISOLONE SODIUM PHOSHATE ODT 10MG TA	ORAPRED ODT	48					Y		
44	045267	P5A	GLUCOCORTICOIDS	34	Y	PREDNISONE DOSE PACKS	PREDNISONE 5 MG TAB DOSE PACK	GENERIC ONLY	48					Y		
46	46	HIC3	THERAPEUTIC CLASS	0	Y	H. PYLORI COMBINATION TREATMENTS	H. PYLORI COMBINATION TREATMENTS	BRAND	Units	Until Refill	Daily Dose	Max Days	Refills	Pkg Bill	Updated	
46	062462	D4F	H. PYLORI COMBINATION TREATMENTS	1	Y	BISMUTH/METRONID/TETRACYCLINE 125MG CAPSULE	BISMUTH/METRONID/TETRACYCLINE 125MG CAPS	PYLERA	120	30			0	Y		
46	027905	D4F	H. PYLORI COMBINATION TREATMENTS	2	Y	BISMUTH SSAL/METRONID/TETRACYC	HELIDAC THERAPY PACK	HELIDAC	224	30				Y		
46	037219	D4F	H. PYLORI COMBINATION TREATMENTS	3	Y	LANSOPRAZOLE/AMOXICILN/CLARITH PATIENT PACK	LANSOPRAZOLE/AMOXICILN/CLARITH PATIENT PAC	PREVPAC	112	30				Y		
46	069169	D4F	H. PYLORI COMBINATION TREATMENTS	4	Y	OMEPRAZOLE/CLARITH/AMOXICILLIN COMBO PACK	OMEPRAZOLE/CLARITH/AMOXICILLIN COMBO PAC	OMECLAMOX-PAK	80	30						
47	47	HIC3	THERAPEUTIC CLASS	0	Y	HEPATITIS B TREATMENTS	HEPATITIS B TREATMENTS	BRAND	Units	Until Refill	Daily Dose	Max Days	Refills	Pkg Bill	Updated	
47	050937	W5F	HEPATITIS B TREATMENT AGENTS	1	Y	ADEFOVIR DIPIVOXIL 10MG TABLET	ADEFOVIR DIPIVOXIL 10MG TABLET	HEPSERA			1					
47	058934	W5F	HEPATITIS B TREATMENT AGENTS	2	Y	ENTECAVIR TABLETS	ENTECAVIR 0.5MG TABLET	BARACLUDE			1					
47	078645	W7B	HEPATITIS B TREATMENTS	3	Y	HEPATITIS B VACCINE/CPG1018/PF 20MCG/0.5ML SYRING	HEPATITIS B VACCINE/CPG1018/PF 20MCG/0.5ML	HEPLISAV-B	0.5							
47	076823	W5F	HEPATITIS B TREATMENT AGENTS	4	Y	TENOFOVIR ALAFENAMID FUMARATE 25MG TABELT	TENOFOVIR ALAFENAMID FUMARATE 25MG TABEL	VEMLIDY			1					
48	48	HIC3	THERAPEUTIC CLASS	0	Y	HEPATITIS C TREATMENTS	HEPATITIS C TREATMENTS	BRAND	Units	Until Refill	Daily Dose	Max Days	Refills	Pkg Bill	Updated	
48	082438	W0E	HEPATITIS C VIRUS- NS5A AND NS3/4A INHIBITOR COMBO	1	Y	MAVYRET PELLET PACKET	GLECAPREVIR/PIBRENTASVIR 50-20 MG PELLET PA	MAVYRET			6				1/1/2022	
48	080180	W0B	HEPATITIS C TREATMENTS	2	Y	HARVONI TABLETS & PELLET PACKT	LEDIPASVIR/SOFOSBUVIR 33.75-100 MG PELLET PA	HARVONI			2					
48	051151	W5G	HEPATITIS C TREATMENTS	3	Y	PEGINTERFERON ALFA-2A 180MCG/ML VIAL	PEGINTERFERON ALFA-2A 180MCG/ML VIAL	PEGASYS	4	28						
48	080164	W5Y	HEPATITIS C TREATMENTS	4	Y	SOVALDI 150 MG PELLET PACKET	SOFOSBUVIR 150 MG PELLET PACKET	SOVALDI			1					
48	080163	W5Y	HEPATITIS C TREATMENTS	5	Y	SOVALDI 200 MG TABLET & PELLET PACKET	SOFOSBUVIR 200 MG TABLET	SOVALDI			2					
48	076305	W0B	HEPATITIS C TREATMENTS	6	Y	EPCLUSA TABLETS & PELLET PACKETS	SOFOSBUVIR-VELPATASVIR 400-100 TABLET	EPCLUSA			1					
49	49	HIC3	THERAPEUTIC CLASS	0	Y	HYPERPARATHYROID AGENTS	HYPERPARATHYROID AGENTS	BRAND	Units	Until Refill	Daily Dose	Max Days	Refills	Pkg Bill	Updated	
49	053762	P4M	HYPERPARATHYROID AGENTS	1	Y	CINACALCET HCL 30 and 60MG TABLET	CINACALCET HCL 30MG TABLET	SENSIPAR			2					
49	053764	P4M	HYPERPARATHYROID AGENTS	2	Y	CINACALCET HCL 90MG TABLET	CINACALCET HCL 90MG TABLET	SENSIPAR			4					
49	059181	P4D	HYPERPARATHYROID	3	Y	PARICALCITOL CAPSULES	PARICALCITOL 1MG CAPSULE	ZEMPLAR			1					
50.1	50.1	HIC3	THERAPEUTIC CLASS	0	Y	HYPOGLYCEMICS, DPP-4 INHIBITORS	HYPOGLYCEMICS, DPP-4 INHIBITORS	BRAND	Units	Until Refill	Daily Dose	Max Days	Refills	Pkg Bill	Updated	
50.1	070526	C4C	HYPOGLYCEMICS, DPP-4 INHIBITORS	1	Y	ALOGLIPTIN BENZOATE/METFORMIN HCL TABLETS ALL ST	ALOGLIPTIN BENZ/METFORMIN HCL 12.5-500MG T	KAZANO			2					
50.1	070521	C4C	HYPOGLYCEMICS, DPP-4 INHIBITORS	2	Y	ALOGLIPTIN BENZOATE/PIOGLITZONE TABLETS ALL STREN	ALOGLIPTIN BENZ/PIOGLITZONE 12.5-15MG TABLE	OSENI			1					
50.1	070525	C4C	HYPOGLYCEMICS, DPP-4 INHIBITORS	3	Y	ALOGLIPTIN BENZOATE TABLETS	ALOGLIPTIN BENZOATE 6.25MG TABLET	NESINA			1					
50.1	067353	C4J	HYPOGLYCEMICS, DPP-4 INHIBITORS	4	Y	LINAGLIPTIN 5MG TABLET	LINAGLIPTIN 5MG TABLET	TRADJENTA			1					
50.1	068516	C4J	HYPOGLYCEMICS, DPP-4 INHIBITORS	5	Y	LINAGLIPTIN/METFORMIN HCL TABLETS	LINAGLIPTIN/METFORMIN HCL 2.5-500MG TABLET	JENTADUETO			2					
50.1	076256	C4J	HYPOGLYCEMICS, DPP-4 INHIBITORS	6	Y	LINAGLIPTIN/METFORMIN HCL XR 2.5 MG-1,000 MG	LINAGLIPTIN/METFORMIN HCL XR 2.5 MG-1,000 M	JENTADUETO XR	60	30	2					

50.1	076257	C4J	HYPOGLYCEMICS, DPP-4 INHIBITORS	7	Y	LINAGLIPTIN/METFORMIN HCL XR 5 MG-1,000 MG	LINAGLIPTIN/METFORMIN HCL XR 5 MG-1,000 MG	JENTADUETO XR	30	30	1				
50.1	065430	C4J	HYPOGLYCEMICS, DPP-4 INHIBITORS	8	Y	SAXAGLIPTIN HCL TABLETS	SAXAGLIPTIN HCL 2.5MG TABLET	ONGLYZA			1				
50.1	066818	C4J	HYPOGLYCEMICS, DPP-4 INHIBITORS	9	Y	SAXAGLIPTIN HCL/METFORMIN HCL 2.5-1000 MG TABLET	SAXAGLIPTIN HCL/METFORMIN HCL 2.5-1000 MG T	KOMBIGLYZE XR			2				
50.1	066816	C4J	HYPOGLYCEMICS, DPP-4 INHIBITORS	10	Y	SAXAGLIPTIN HCL/METFORMIN HCL 5-500 and 5-1000MG	SAXAGLIPTIN HCL/METFORMIN HCL 5-500MG TAB	KOMBIGLYZE XR			1				
50.1	068539	C4F	HYPOGLYCEMICS, DPP-4 INHIBITORS	11	Y	SITAGLIPTIN PHOS/METFORMIN HCL TABLETS ALL STRENG	SITAGLIPTIN PHOS/METFORMIN HCL 50-100MG TA	JANUMET XR			1				
50.1	062531	C4F	HYPOGLYCEMICS, DPP-4 INHIBITORS	12	Y	SITAGLIPTIN PHOS/METFORMIN HCL TABLET ALL STRENG	SITAGLIPTIN PHOS/METFORMIN HCL 50-500MG TA	JANUMET			2				
50.1	061612	C4F	HYPOGLYCEMICS, DPP-4 INHIBITORS	13	Y	SITAGLIPTIN PHOSPHATE TABLETS	SITAGLIPTIN PHOSPHATE 25MG TABLET	JANUVIA			1				
50.2	50.2	HIC3	THERAPEUTIC CLASS	0	Y	HYPOGLYCEMICS, GLP-1 AGONISTS	HYPOGLYCEMICS, GLP-1 AGONISTS	BRAND	Units	Until Refill	Daily Dose	Max Days	Refills	Pkg Bill	Updated
50.2	081455	C4I	HYPOGLYCEMICS, GLP-1 AGONISTS	1	Y	DULAGLUTIDE PENS	DULAGLUTIDE 3 MG/0.5 ML PEN	TRULICITY	2	30					
50.2	059072	C4I	HYPOGLYCEMICS, GLP-1 AGONISTS	2	Y	EXENATIDE 5MCG DOSE PEN INJECTOR 1.2ML	EXENATIDE 5MCG DOSE PEN INJECTOR 1.2ML	BYETTA			0.04			Y	
50.2	059073	C4I	HYPOGLYCEMICS, GLP-1 AGONISTS	3	Y	EXENATIDE 10MCG DOSE PEN INJECTOR 2.4ML	EXENATIDE 10MCG DOSE PEN INJECTOR 2.4ML	BYETTA			0.08			Y	
50.2	068505	C4I	HYPOGLYCEMICS, GLP-1 AGONISTS	4	Y	EXENATIDE MICROSPHERES 2MG VIAL	EXENATIDE MICROSPHERES 2MG VIAL	BYDUREON	4	28					
50.2	077890	C4I	HYPOGLYCEMICS, GLP-1 AGONISTS	5	Y	EXENATIDE MICROSPHERES 2 MG AUTOINJECT	EXENATIDE MICROSPHERES 2 MG AUTOINJECT	BYDUREON BCISE	3.4	30					
50.2	077985	C4I	HYPOGLYCEMICS, GLP-1 AGONISTS	6	Y	SEMAGLUTIDE 0.25-0.5MG DOSE PEN	SEMAGLUTIDE 0.25-0.5MG DOSE PEN	OZEMPIC	1.5	30		42			
50.2	080230	C4I	HYPOGLYCEMICS, GLP-1 AGONISTS	7	Y	SEMAGLUTIDE TABLETS	SEMAGLUTIDE 14 MG TABLET	RYBELSUS			1				
50.2	077986	C4I	HYPOGLYCEMICS, GLP-1 AGONISTS	8	Y	SEMAGLUTIDE 1MG DOSE PEN	SEMAGLUTIDE 1MG DOSE PEN	OZEMPIC	9	30					
50.4	080054	M4G	AGENTS TO TREAT HYPOGLYCEMIA	19	Y	GLUCAGON 3 MG SPRAY	GLUCAGON 3 MG SPRAY	BAQSIMI	2	30					
50.4	041660	M4G	AGENTS TO TREAT HYPOGLYCEMIA	20	Y	GLUCAGON,HUMAN RECOMBINANT 1MG VIAL HYPOKIT	GLUCAGON,HUMAN RECOMBINANT 1MG VIAL HY	GLUCAGEN	2	30				Y	
51	51	HIC3	THERAPEUTIC CLASS	0	Y	HYPOGLYCEMICS, INSULINS AND RELATED AGENTS	HYPOGLYCEMICS, INSULINS AND RELATED AGENT	BRAND	Units	Until Refill	Daily Dose	Max Days	Refills	Pkg Bill	Updated
51	058952	C4G	HYPOGLYCEMICS, INSULINS AND RELATED AGENTS	1	Y	HUM INSULIN NPH/REG INSULIN HM 70-30/ML PEN or VI	HUM INSULIN NPH/REG INSULIN HM 70-30/ML PE	HUMULIN	90	30				Y	
51	044093	C4G	HYPOGLYCEMICS, INSULINS AND RELATED AGENTS	2	Y	INSULIN ASPART 100UNIT/ML CARTRIDGE, VIAL or SYRIN	INSULIN ASPART 100UNIT/ML CARTRIDGE	FIASP / NOVOLOG	90	30				Y	
51	071842	C4G	HYPOGLYCEMICS, INSULINS AND RELATED AGENTS	3	Y	INSULIN DEGLUDEC PENS AND VIALS	INSULIN DEGLUDEC 100 UNIT/ML PEN	TRESIBA	90	30		91		Y	
51	073919	C4G	HYPOGLYCEMICS, INSULINS AND RELATED AGENTS	4	Y	INSULIN DEGLUDEC/LIRAGLUTIDE 100 UNIT-3.6MG/ML PE	INSULIN DEGLUDEC/LIRAGLUTIDE 100 UNIT-3.6MG	XULTOPHY				91			
51	057439	C4G	HYPOGLYCEMICS, INSULINS AND RELATED AGENTS	5	Y	INSULIN DETEMIR 100UNITS/ML PEN or VIAL	INSULIN DETEMIR 100UNITS/ML PEN	LEVEMIR / LEVEMIR FLEXPEN	90	30		91		Y	1/1/2022
51	062867	C4G	HYPOGLYCEMICS, INSULINS AND RELATED AGENTS	6	Y	INSULIN GLARGINE, HUM.REC.ANLOG CARTRIDGE, PEN o	INSULIN GLARGINE, HUM.REC.ANLOG 100UNITS/M	LANTUS / TOUJEO SOLOSTAR	90	30		91		Y	
51	076864	C4G	HYPOGLYCEMICS, INSULINS AND RELATED AGENTS	7	Y	INSULIN GLARGINE/LIXISENATIDE 100 UNIT-33MCG/ML P	INSULIN GLARGINE/LIXISENATIDE 100 UNIT-33MCG	SOLIQUA				91			
51	082542	C4G	HYPOGLYCEMICS, INSULINS AND RELATED AGENTS	8	Y	INSULIN GLARGINE-YFGN U100 PEN & VIAL	INSULIN GLARGINE-YFGN U100 PEN	SEMGLEE	90	30					1/1/2022
51	060371	C4G	HYPOGLYCEMICS, INSULINS AND RELATED AGENTS	9	Y	INSULIN GLULISINE 100UNITS/ML PEN or VIAL	INSULIN GLULISINE 100UNITS/ML PEN	APIDRA / APIDRA SOLOSTAR	90	30		91		Y	
51	077662	C4G	HYPOGLYCEMICS, INSULINS AND RELATED AGENTS	10	Y	INSULIN LISPRO 100 UNIT/ML KWIKPEN & CARTRIDGE	INSULIN LISPRO 100 UNIT/ML KWIKPEN	HUMALOG / HUMALOG JR	90	30					
51	081186	C4G	INSLUINS	11	Y	INSULIN LISPRO-AABC KWIKPENS AND VIALS	INSULIN LISPRO-AABC 100 UNIT/ML KWIKPEN	LYUMJEV	90	30					
51	043242	C4G	HYPOGLYCEMICS, INSULINS AND RELATED AGENTS	12	Y	INSULIN NPL/INSULIN LISPRO 50-50/ML KWIKPEN or VIAL	INSULIN NPL/INSULIN LISPRO 50-50/ML KWIKPEN	HUMALOG	90	30				Y	
51	001723	C4G	HYPOGLYCEMICS, INSULINS AND RELATED AGENTS	13	Y	INSULIN REGULAR, HUMAN 100UNITS/ML FLEXPEN & VIA	INSULIN REGULAR, HUMAN 100UNITS/ML VIAL	HUMULIN / HUMULIN R	90	30				Y	
51	075447	C4G	HYPOGLYCEMICS, INSULINS AND RELATED AGENTS	14	Y	INSULIN REGULAR, HUMAN 500 UNITS/ML KWIKPEN	INSULIN REGULAR, HUMAN 500 UNITS/ML KWIKPE	HUMULIN R	36	30				Y	
51	029916	C4G	HYPOGLYCEMICS, INSULINS AND RELATED AGENTS	15	Y	INSULIN REGULAR, HUMAN 500UNITS/ML VIAL	INSULIN REGULAR, HUMAN 500UNITS/ML VIAL	HUMULIN R	40	30				Y	
51	051718	C4G	HYPOGLYCEMICS, INSULINS AND RELATED AGENTS	16	Y	INSULN ASP PRT/INSULIN ASPART 70-30/ML 3ML or 10M	INSULN ASP PRT/INSULIN ASPART 70-30/ML 10ML	NOVOLOG MIX VIAL	90	30				Y	
51	001740	C4G	HYPOGLYCEMICS, INSULINS AND RELATED AGENTS	17	Y	NPH, HUMAN INSULIN ISOPHANE 100 UNITS/ML 3 or 10N	NPH, HUMAN INSULIN ISOPHANE 100 UNITS/ML -	HUMULIN / HUMULIN N	90	30				Y	
52	52	HIC3	THERAPEUTIC CLASS	0	Y	HYPOGLYCEMICS, MEGLITINIDES	HYPOGLYCEMICS, MEGLITINIDES	BRAND	Units	Until Refill	Daily Dose	Max Days	Refills	Pkg Bill	Updated
52	047333	C4K	HYPOGLYCEMICS, MEGLITINIDES	1	Y	NATEGLINIDE TABLETS	NATEGLINIDE 60MG TABLET	STARLIX			3				
52	038906	C4K	HYPOGLYCEMICS, MEGLITINIDES	2	Y	REPAGLINIDE 0.5 and 1MG TABLET	REPAGLINIDE 0.5MG TABLET	PRANDIN			4				
52	038908	C4K	HYPOGLYCEMICS, MEGLITINIDES	3	Y	REPAGLINIDE 2MG TABLET	REPAGLINIDE 2MG TABLET	PRANDIN			8				
52	064662	C4K	HYPOGLYCEMICS, MEGLITINIDES	4	Y	REPAGLINIDE/METFORMIN HCL TABLETS	REPAGLINIDE/METFORMIN HCL 1MG-500MG TABL	PRANDIMET			2				
53	53	HIC3	THERAPEUTIC CLASS	0	Y	HYPOGLYCEMICS, MISCELLANEOUS	HYPOGLYCEMICS, MISCELLANEOUS	BRAND	Units	Until Refill	Daily Dose	Max Days	Refills	Pkg Bill	Updated
53	063804	C4H	HYPOGLYCEMICS, MISCELLANEOUS AGENTS	1	Y	PRAMLINTIDE ACETATE 1500/1.5ML SYRINGE	PRAMLINTIDE ACETATE 1500/1.5ML SYRINGE	SYMLINPEN 60	12	30	0.4			Y	
53	063735	C4H	HYPOGLYCEMICS, MISCELLANEOUS AGENTS	2	Y	PRAMLINTIDE ACETATE 2700/2.7ML SYRINGE	PRAMLINTIDE ACETATE 2700/2.7ML SYRINGE	SYMLINPEN 120	13.5	30	0.45			Y	
54	54	HIC3	THERAPEUTIC CLASS	0	Y	HYPOGLYCEMICS, SGL-T2	HYPOGLYCEMICS, SGLT2	BRAND	Units	Until Refill	Daily Dose	Max Days	Refills	Pkg Bill	Updated
54	070791	C4D	HYPOGLYCEMICS, SGLT2	1	Y	CANAGLIFLOZIN 100MG TABLET	CANAGLIFLOZIN 100MG TABLET	INVOKANA			2				
54	070792	C4D	HYPOGLYCEMICS, SGLT2	2	Y	CANAGLIFLOZIN 300MG TABLET	CANAGLIFLOZIN 300MG TABLET	INVOKANA			1				
54	077192	C4W	ANTIHYPERGLYCEMIC, SGLT-2 AND DPP-4 INHIBITOR COMB	3	Y	DAPAGLIFLOZIN/SAXAGLIPTIN HCL TABLETS	DAPAGLIFLOZIN/SAXAGLIPTIN HCl 10MG-5MG TAB	QTERN			1				
54	080712	C4Y	ANTIHYPERGLY-SGLT-2 INHIB,DPP-4 INHIB,BIGUANIDE CB	4	Y	EMPAGLIFLOZ/LINAGLIP/METFORMIN 10-5-1,000 MG TAB	EMPAGLIFLOZ/LINAGLIP/METFORMIN 10-5-1,000 M	TRIJARDY XR			1				
54	080711	C4Y	ANTIHYPERGLY-SGLT-2 INHIB,DPP-4 INHIB,BIGUANIDE CB	5	Y	EMPAGLIFLOZ/LINAGLIP/METFORMIN 12.5-5-1,000 MG T	EMPAGLIFLOZ/LINAGLIP/METFORMIN 12.5-5-1,000	TRIJARDY XR			2				
54	080713	C4Y	ANTIHYPERGLY-SGLT-2 INHIB,DPP-4 INHIB,BIGUANIDE CB	6	Y	EMPAGLIFLOZ/LINAGLIP/METFORMIN 25-5-1,000 MG TAB	EMPAGLIFLOZ/LINAGLIP/METFORMIN 25-5-1,000 M	TRIJARDY XR			1				
54	080710	C4Y	ANTIHYPERGLY-SGLT-2 INHIB,DPP-4 INHIB,BIGUANIDE CB	7	Y	EMPAGLIFLOZ/LINAGLIP/METFORMIN 5-2.5-1,000 MG TA	EMPAGLIFLOZ/LINAGLIP/METFORMIN 5-2.5-1,000	TRIJARDY XR			2				
55	55	HIC3	THERAPEUTIC CLASS	0	Y	HYPOGLYCEMICS, TZDS	HYPOGLYCEMICS, TZDS	BRAND	Units	Until Refill	Daily Dose	Max Days	Refills	Pkg Bill	Updated
55	042943	C4N	HYPOGLYCEMICS, TZD	1	Y	PIOGLITAZONE HCL TABLETS	PIOGLITAZONE HCL 15MG	ACTOS			1				
55	061389	C4R	HYPOGLYCEMICS, TZD	2	Y	PIOGLITAZONE HCL/GLIMEPIRIDE TABLETS	PIOGLITAZONE HCL/GLIMEPIRIDE 30-2MG TABLET	DUETACT			1				
55	066367	C4T	HYPOGLYCEMICS, TZD	3	Y	PIOGLITAZONE HCL/METFORMIN HCL 15- and 30-1000M	PIOGLITAZONE HCL/METFORMIN HCL 15-1000MG	ACTOPLUS MET XR			1				
55	059685	C4T	HYPOGLYCEMICS, TZD	4	Y	PIOGLITAZONE HCL/METFORMIN HCL 15-5000 and -8500	PIOGLITAZONE HCL/METFORMIN HCL 15-5000MG	ACTOPLUS MET			2				
55	042661	C4N	HYPOGLYCEMICS, TZD	5	Y	ROSIGLITAZONE MALEATE TABLETS	ROSIGLITAZONE MALEATE 2MG TABLET	AVANDIA			1				
57	57	HIC3	THERAPEUTIC CLASS	0	Y	IMMUNOMODULATORS, ATOPIC DERMATITIS	IMMUNOMODULATORS, ATOPIC DERMATITIS	BRAND	Units	Until Refill	Daily Dose	Max Days	Refills	Pkg Bill	Updated
57	047346	Q5K	IMMUNOMODULATORS, ATOPIC DERMATITIS	1	Y	TACROLIMUS 0.03 and 0.1% OINTMENT 100GRAMS	TACROLIMUS 0.03% OINTMENT 100GRAMS	PROTOPIC	100	30				Y	
58	58	HIC3	THERAPEUTIC CLASS	0	Y	IMMUNOMODULATORS, TOPICAL & GENITAL WARTS AG	IMMUNOMODULATORS, TOPICAL & GENITAL WAR	BRAND	Units	Until Refill	Daily Dose	Max Days	Refills	Pkg Bill	Updated
58	069755	Z2G	IMMUNOMODULATORS, TOPICAL & GENITAL WARTS AGENTS	1	Y	IMIQUIMOD CREAM PUMPS	IMIQUIMOD 2.5% CREAM PUMP	ZYCLARA	7.5	28		14	1	Y	
58	066038	Z2G	IMMUNOMODULATORS, TOPICAL & GENITAL WARTS AGENTS	2	Y	IMIQUIMOD 3.75% CREAM	IMIQUIMOD 3.75% CREAM	ZYCLARA	28	28		14	1	Y	
58	031099	Z2G	IMMUNOMODULATORS, TOPICAL & GENITAL WARTS AGENTS	3	Y	IMIQUIMOD 5% CREAM 25MG PACKETS	IMIQUIMOD 5% CREAM 25MG PACKETS	ALDARA	12	30					
59	59	HIC3	THERAPEUTIC CLASS	0	Y	IMMUNOSUPPRESSIVES, ORAL	IMMUNOSUPPRESSIVES, ORAL	BRAND	Units	Until Refill	Daily Dose	Max Days	Refills	Pkg Bill	Updated
59	082532	Z28	RHO KINASE INHIBITOR	1	Y	BELUMOSUDIL MESYLATE 200 MG TABLET	BELUMOSUDIL MESYLATE 200 MG TABLET	REZUROCK			1				1/1/2022
59	066345	Z2E	MMUNOSUPPRESSIVE	1.5	Y	EVEROLUIMUS 1MG TABELT	EVEROLUIMUS 1MG TABELT	ZORTRESS			2				
59	041845	Z2E	MMUNOSUPPRESSIVE	2	Y	MYCOPHENOLATE 200 MG/ML SUSPENSION	MYCOPHENOLATE 200 MG/ML SUSPENSION	CELLCEPT	450	30	15				
59	081863	Z2E	MMUNOSUPPRESSIVE	3	Y	VOCLOSPORIN 7.9 MG CAPSULE	VOCLOSPORIN 7.9 MG CAPSULE	LUPKYNIS			6				
61	61	HIC3	THERAPEUTIC CLASS	0	Y	INTRANASAL RHINITIS AGENTS	INTRANASAL RHINITIS AGENTS	BRAND	Units	Until Refill	Daily Dose	Max Days	Refills	Pkg Bill	Updated
61	029893	Q7E	INTRANASAL RHINITIS AGENTS	1	Y	AZELASTINE HCL 0.1% 137MCG NASAL SPRAY 30ML	AZELASTINE HCL 0.1% 137MCG NASAL SPRAY 30M	GENERIC ONLY	30	30				Y	
61	065577	Q7E	INTRANASAL RHINITIS AGENTS	2	Y	AZELASTINE HCL 0.15% NASAL SPRAY 30ML	AZELASTINE HCL 0.15% NASAL SPRAY 30ML	ASTEPRO	30	30				Y	
61	069144	Q7O	INTRANASAL RHINITIS AGENTS	3	Y	AZELASTINE/FLUTICASONE NASAL SPRAY 23GRAMS	AZELASTINE/FLUTICASONE NASAL SPRAY 23GRAM	DYMISTA	23	30				Y	
61	008078	Q7P	INTRANASAL RHINITIS AGENTS	4	Y	BECLOMETHASONE DIPROPIONATE 0.042% SPRAY	BECLOMETHASONE DIPROPIONATE 0.042% SPRAY	BECONASE AQ	25	30				Y	
61	073274	Q7P	INTRANASAL RHINITIS AGENTS	5	Y	BECLOMETHASONE DIPROPIONATE 40MCG SPRAY	BECLOMETHASONE DIPROPIONATE 40MCG SPRAY	QNASL CHILDREN	6.8						
61	068876	Q7P	INTRANASAL RHINITIS AGENTS	6	Y	BECLOMETHASONE DIPROPIONATE 80MCG NASAL SPRAY	BECLOMETHASONE DIPROPIONATE 80MCG NASAL	QNASL	10.6	30				Y	
61	068479	Q7P	INTRANASAL RHINITIS AGENTS	8	Y	CICLESONIDE 37MCG NASAL SPRAY 6.1GRAMS	CICLESONIDE 37MCG NASAL SPRAY 6.1GRAMS	ZETONNA	6.1	30				Y	

61	061667	Q7P	INTRANASAL RHINITIS AGENTS	9	Y	CICLESONIDE 50MCG NASAL SPRAY 12.5GRAMS	CICLESONIDE 50MCG NASAL SPRAY 12.5GRAMS	OMNARIS	12.5	30				Y	
61	018368	Q7P	INTRANASAL RHINITIS AGENTS	10	Y	FLUTICASONE PROPIONATE 0.05% NASAL SPRAY	FLUTICASONE PROPIONATE 0.05% NASAL SPRAY	FLONASE	16	30				Y	
61	077749	Q7P	INTRANASAL RHINITIS AGENTS	11	Y	FLUTICASONE PROPIONATE 93 MCG NASAL SPRAY	FLUTICASONE PROPIONATE 93 MCG NASAL SPRAY	XHANCE	16					Y	
61	031186	Q7P	INTRANASAL RHINITIS AGENTS	12	Y	MOMETASONE FUROATE 50MCG NASAL SPRAY 17GM	MOMETASONE FUROATE 50MCG NASAL SPRAY 17(	NASONEX	17	30				Y	
61.5	**61.5**	**HIC3**	**THERAPEUTIC CLASS**	**0**	**Y**	**IRRITABLE BOWEL SYNDROME/SHORT BOWEL SYNDRON**	**IRRITABLE BOWEL SYNDROME/SHORT BOWEL SYI**	**BRAND**	**Units**	**Until Refill**	**Daily Dose**	**Max Days**	**Refills**	**Pkg Bill**	**Updated**
61.5	074654	D6L	IBS	1	Y	ELUXADOLINE TABLETS	ELUXADOLINE 75 MG TABLET	VIBERZI	60	30	2				1/1/2022
61.5	069922	D6G	IBS/SBS/GI AGENTS	2	Y	LINACLOTIDE CAPSULES	LINACLOTIDE 145 MCG CAPSULE	LINZESS			1			Y	
61.5	077047	D6G	IBS	3	Y	PLECANATIDE 3 MG TABLET	PLECANATIDE 3 MG TABLET	TRULANCE			1				
61.5	077178	D4O	ANTIDIARRHEAL - TRYPTOPHAN HYDROXYLASE INHIBITOR	4	Y	TELOTRISTAT ETIPRATE 250MG TABLET	TELOTRISTAT ETIPRATE 250MG TABLET	XERMELO	84						
61.75	**61.75**	**HIC3**	**THERAPEUTIC CLASS**	**0**	**Y**	**LAXATIVES AND CATHARTICS**	**LAXATIVES AND CATHARTICS**	**BRAND**	**Units**	**Until Refill**	**Daily Dose**	**Max Days**	**Refills**	**Pkg Bill**	**Updated**
61.8	061457	D6S	LAXATIVES AND CATHARTICS	1	Y	PED3350/SOD SUL/NACL/KCL/ASB/C PACK	PED3350/SOD SUL/NACL/KCL/ASB/C PACK	MOVIPREP	1					Y	
61.8	034313	D6S	LAXATIVES AND CATHARTICS	2	Y	POLYETHYLENE GLYCOL 3350 17GRAM POWDER PACKET	POLYETHYLENE GLYCOL 3350 17GRAM POWDER PA	MIRALAX			1				
61.8	041843	D6S	LAXATIVES AND CATHARTICS	3	Y	POLYETHYLENE GLYCOL 3350 17GRAM POWDER DOSEPAC	POLYETHYLENE GLYCOL 3350 17GRAM POWDER D(	MIRALAX			36			Y	
61.8	059931	D6S	LAXATIVES AND CATHARTICS	4	Y	SODIUM CHLORIDE/NaHCO0/KCl/PEG SOLUTION	SODIUM CHLORIDE/NaHCO0/KCl/PEG SOLUTION	PEG 3350-ELECTROLYTE SOLUTI	4000						
61.8	081680	D6S	LAXATIVES AND CATHARTICS	5	Y	SOD SULF/POT CHLORIDE/MAG SULF 1.479-0.225-01.88 (	SOD SULF/POT CHLORIDE/MAG SULF 1.479-0.225-(	SUTAB	24						
62	**62**	**HIC3**	**THERAPEUTIC CLASS**	**0**	**Y**	**LEUKOTRIENE MODIFIERS**	**LEUKOTRIENE MODIFIERS**	**BRAND**	**Units**	**Until Refill**	**Daily Dose**	**Max Days**	**Refills**	**Pkg Bill**	**Updated**
62	051512	Z4B	LEUKOTRIENE MODIFIERS	1	Y	MONTELUKAST SODIUM GRANULES and TABLETS	MONTELUKAST SODIUM 4MG GRANULES	SINGULAIR			1				
62	043557	Z4B	LEUKOTRIENE MODIFIERS	2	Y	ZAFIRLUKAST TABLETS	ZAFIRLUKAST 10MG TABLET	ACCOLATE			2				
62	029803	Z4E	LEUKOTRIENE MODIFIERS	3	Y	ZILEUTON 600MG FILMTAB	ZILEUTON 600MG FILMTAB	ZYFLO			4				
63	**63**	**HIC3**	**THERAPEUTIC CLASS**	**0**	**Y**	**LIPOTROPICS, OTHER (Non-statins)**	**LIPOTROPICS, OTHER (Non-statins)**	**BRAND**	**Units**	**Until Refill**	**Daily Dose**	**Max Days**	**Refills**	**Pkg Bill**	**Updated**
63	080782	M4V	ANTIHYPERLIPIDEMIC - ATP CITRATE LYASE INHIBITOR	1	Y	BEMPEDOIC ACID 180 MG TABLET	BEMPEDOIC ACID 180 MG TABLET	NEXLETOL			1				
63	080790	M4W	ANTIHYPERLIPIDEMIC-ATP CITRATE LYASE ABSORPTION INHIBITOR	1.2	Y	BEMPEDOIC ACID/EZETIMIBE 180-10 MG TABLET	BEMPEDOIC ACID/EZETIMIBE 180-10 MG TABLET	NEXLIZET			1				
63	051214	M4E	LIPOTROPICS, OTHER (Non-statins)	1.9	Y	EZETIMIBE 10MG TABLET	EZETIMIBE 10MG TABLET	ZETIA			1				
63	063693	M4E	LIPOTROPICS, OTHER (Non-statins)	2	Y	FENOFIBRATE TABLETS	FENOFIBRATE 40MG TABLET	FENOGLIDE			1				
63	061199	M4E	LIPOTROPICS, OTHER (Non-statins)	3	Y	FENOFIBRATE NANOCRYSTALLIZED TABLETS ALL STRENGT	FENOFIBRATE NANOCRYSTALLIZED 48MG TABLET	TRICOR			1				
63	064676	M4E	LIPOTROPICS, OTHER (Non-statins)	4	Y	FENOFIBRIC ACID (CHOLINE) 45 and 135MG CAPSULE	FENOFIBRIC ACID (CHOLINE) 45MG CAPSULE	TRILIPIX DR			1				
63	065479	M4E	LIPOTROPICS, OTHER (Non-statins)	5	Y	FENOFIBRIC ACID 35 and 105MG TABLET	FENOFIBRIC ACID 35MG TABLET	FIBRICOR			1				
63	058486	M4E	LIPOTROPICS, OTHER	6	Y	OMEGA-3 ACID ETHYL ESTERS 1MG CAPSULE	OMEGA-3 ACID ETHYL ESTERS 1MG CAPSULE	LOVAZA			4				
64	**64**	**HIC3**	**THERAPEUTIC CLASS**	**0**	**Y**	**LIPOTROPICS, STATINS**	**LIPOTROPICS, STATINS**	**BRAND**	**Units**	**Until Refill**	**Daily Dose**	**Max Days**	**Refills**	**Pkg Bill**	**Updated**
64	058432	M4I	LIPOTROPICS, STATINS	1	Y	AMLOPIDINE-ATORVASTATIN TABLETS ALL STRENGTHS	AMLODIPINE-ATORVASTATIN 2.5MG - 10MG TABLE	CADUET			1				
64	029967	M4D	LIPOTROPICS, STATINS	2	Y	ATORVASTATIN CALCIUM TABLETS ALL STRENGTHS	ATORVASTATIN CALCIUM 10MG TABLETS	LIPITOR			1				
64	057859	M4M	LIPOTROPICS, STATINS	3	Y	EZETIMIBE/SIMVASTATIN TABLETS ALL STRENGTHS	EZETIMIBE/SIMVASTATIN 10-10MG TABLET	VYTORIN			1				
64	021694	M4D	LIPOTROPICS, STATINS	4	Y	FLUVASTATIN SODIUM CAPSULES ALL STRENGTHS	FLUVASTATIN SODIUM 20MG CAPSULES	LESCOL / LESCOL XL			1				
64	016310	M4D	LIPOTROPICS, STATINS	5	Y	LOVASTATIN 10, 20 MG TABLET	LOVASTATIN 10 MG TABLET	ALTOPREV			1				
64	006461	M4D	LIPOTROPICS, STATINS	6	Y	LOVASTATIN 40 MG TABLET	LOVASTATIN 40 MG TABLET	GENERIC ONLY			2				
64	050557	M4D	LIPOTROPICS, STATINS	7	Y	LOVASTATIN ER 40, 60 MG TABLET	LOVASTATIN 40 MG TABLET	ALTOPREV			1				
64	066349	M4D	LIPOTROPICS, STATINS	8	Y	PITAVASTATIN CALCIUM TABLETS ALL STRENGTHS	PITAVASTATIN CALCIUM 1MG TABLET	LIVALO			1				
64	016366	M4D	LIPOTROPICS, STATINS	9	Y	PRAVASTATIN SODIUM TABLETS ALL STRENGTHS	PRAVASTATIN SODIUM 10MG TABLET	PRAVACHOL			1				
64	052944	M4D	LIPOTROPICS, STATINS	10	Y	ROSUVASTATIN CALCIUM TABLETS ALL STRENGTHS	ROSUVASTATIN CALCIUM 5MG TABLET	CRESTOR / EZALLOR SPRINKLE			1				
64	016576	M4D	LIPOTROPICS, STATINS	11	Y	SIMVASTATIN TABLETS ALL STRENGTHS	SIMVASTATIN 5MG TABLET	ZOCOR			1				
64	075976	M4D	LIPOTROPICS, STATINS	12	Y	SIMVASTATIN ORAL SUSPENSION	SIMVASTATIN 20 MG/5 ML ORAL SUSPENSION	FLOLIPID			5				
65	**65**	**HIC3**	**THERAPEUTIC CLASS**	**0**	**Y**	**MACROLIDES/KETOLIDES (Oral)**	**MACROLIDES/KETOLIDES (Oral)**	**BRAND**	**Units**	**Until Refill**	**Daily Dose**	**Max Days**	**Refills**	**Pkg Bill**	**Updated**
65	018544	W1D	MACROLIDES	1	Y	AZITHROMYCIN SUSPENSIONS	AZITHROMYCIN 200 MG/5 ML SUSP	ZITHROMAX	30	14		14	1	Y	
65	026721	W1D	MACROLIDES	3	Y	AZITHROMYCIN 250 MG TABLET	AZITHROMYCIN 250 MG TABLET	ZITHROMAX	6	14		14	1		
65	022624	W1D	MACROLIDES	4	Y	AZITHROMYCIN 500 MG TABLET	AZITHROMYCIN 500 MG TABLET	ZITHROMAX	3	14		14	1		
65	027252	W1D	MACROLIDES	5	Y	AZITHROMYCIN 600 MG TABLET	AZITHROMYCIN 600 MG TABLET	ZITHROMAX				14	1		
65	023789	W1D	MACROLIDES	6	Y	AZITHROMYCIN 1 GM PWD PACKET	AZITHROMYCIN 1 GM PWD PACKET	ZITHROMAX				14	1		
65	009258	W1D	MACROLIDES	7	Y	ERYTHROMYCIN ALL STRENGHTS, ALL FORMULATIONS	ERYTHROMYCIN DR 250 MG CAP	ERY-TAB				14	1		
65	009245	W1D	MACROLIDES	8	Y	ERYTHROMYCIN ETHYLSUCCINATE	ERYTHROMYCIN ETHYLSUCCINATE 400 MG TAB	E.E.S. 400 / ERYPED				14	1		
65	009255	W1D	MACROLIDES	9	Y	ERYTHROMYCIN STEARATE FILMTABS	ERYTHROMYCIN STEARATE 250 MG TABLET	GENERIC ONLY				14	1		
65	048564	W1D	MACROLIDES	10	Y	ERYTHROMYCIN/SULFISOX SUSP	ERYTHROMYCIN/SULFISOX SUSP	PEDIAZOLE				14	1		
65	067471	W1D	MACROLIDES	11	Y	FIDAXOMICIN 200 MG TABLET	FIDAXOMICIN 200 MG TABLET	DIFICID				14	1		
65	080794	W1D	MACROLIDES	12	Y	FIDAXOMICIN 40 MG/ML SUSPENSION	FIDAXOMICIN 40 MG/ML SUSPENSION	DIFICID			10				
66	**66**	**HIC3**	**THERAPEUTIC CLASS**	**0**	**Y**	**MULTIPLE SCLEROSIS AGENTS**	**MULTIPLE SCLEROSIS AGENTS**	**BRAND**	**Units**	**Until Refill**	**Daily Dose**	**Max Days**	**Refills**	**Pkg Bill**	**Updated**
66	066227	H0F	MULTIPLE SCLEROSIS AGENTS	1	Y	AMIFAMPRIDINE PHOSPHATE 10MG TABLET	AMIFAMPRIDINE PHOSPHATE 10MG TABLET	FIRDAPSE			8				
66	078079	H0E	MULTIPLE SCLEROSIS AGENTS	2	Y	CLADRIBINE 10MG X 4, 5, 6, 7, 8, 9 or 10TABLET PK	CLADRIBINE 10MG X 4, 5, 6, 7, 8, 9 or 10TABLET PK	MAVENCLAD	10		2		1		
66	066066	H0F	MULTIPLE SCLEROSIS AGENTS	3	Y	DALFAMPRIDINE 10MG TABLET	DALFAMPRIDINE 10MG TABLET	AMPYRA			2				
66	080393	H0E	MULTIPLE SCLEROSIS AGENTS	4	Y	DIROXIMEL FUMARATE DR 231 MG CAPSULE	DIROXIMEL FUMARATE DR 231 MG CAPSULE	VUMERITY			4				
66	066709	H0E	MULTIPLE SCLEROSIS AGENTS	5	Y	FINGOLIMOD HCL CAPSULES	FINGOLIMOD HCL 0.5MG CAPSULE	GILENYA			1				
66	071942	H0E	MULTIPLE SCLEROSIS AGENTS	6	Y	GLATIRAMER ACETATE 40MG/ML SYRINGE	GLATIRAMER ACETATE 40MG/ML SYRINGE	COPAXONE	12	30				Y	
66	067628	H0E	MULTIPLE SCLEROSIS AGENTS	7	Y	INTERFERON BETA-1A 30MG/0.5ML	INTERFERON BETA-1A 30MG/0.5ML KIT	AVONEX PEN	1	30				Y	
66	052882	H0E	MULTIPLE SCLEROSIS AGENTS	8	Y	INTERFERON BETA-1A PREFILLED 30MCG/0.5ML SYRINGE	INTERFERON BETA-1A PREFILLED 30MCG/0.5ML SY	AVONEX	1	30				Y	
66	050035	H0E	MULTIPLE SCLEROSIS AGENTS	9	Y	INTERFERON BETA-1A/ALBUMIN SYRINGES	INTERFERON BETA-1A/ALBUMIN 22MCG/0.5ML SY	REBIF / REBIF REBIDOSE	6	30				Y	
66	049812	H0E	MULTIPLE SCLEROSIS AGENTS	10	Y	INTERFERON BETA-1A/ALBUMIN 30MCG VIAL	INTERFERON BETA-1A/ALBUMIN 30MCG VIAL	AVONEX	4	30				Y	
66	070586	H0E	MULTIPLE SCLEROSIS AGENTS	11	Y	INTERFERON BETA-1A/ALBUMIN TRITATION PACKS	INTERFERON BETA-1A/ALBUMIN TRITATION PACK 4	REBIF / REBIF REBIDOSE PACK	4.2	365				Y	
66	062602	H0E	MULTIPLE SCLEROSIS AGENTS	12	Y	INTERFERON BETA-1B 0.3MG KIT	INTERFERON BETA-1B 0.3MG KIT	BETASERON / EXTAVIA	15	30				Y	
66	081120	H0E	MULTIPLE SCLEROSIS AGENTS	13	Y	MONOMETHYL FUMARATE 95 MG CAPSULE	MONOMETHYL FUMARATE 95 MG CAPSULE	BAFIERTAM DR			4				
66	080878	H0E	MULTIPLE SCLEROSIS AGENTS	14	Y	OZANIMOD HYDROCHLORIDE 0.23-0.46 MG STARTER PAC	OZANIMOD HYDROCHLORIDE 0.23-0.46 MG START	ZEPOSIA			1	7	0		
66	080879	H0E	MULTIPLE SCLEROSIS AGENTS	15	Y	OZANIMOD HYDROCHLORIDE 0.23-0.46-0.92 MG STARTE	OZANIMOD HYDROCHLORIDE 0.23-0.46-0.92 MG S	ZEPOSIA			1	37	0		
66	080877	H0E	MULTIPLE SCLEROSIS AGENTS	16	Y	OZANIMOD HYDROCHLORIDE 0.92MG CAPSULE	OZANIMOD HYDROCHLORIDE 0.92MG CAPSULE	ZEPOSIA			1				
66	081976	H0E	MULTIPLE SCLEROSIS AGENTS	17	Y	PEGINTERFERON BETA-1A 125 MCG/0.5 ML SYRINGE	PEGINTERFERON BETA-1A 125 MCG/0.5 ML SYRING	PLEGRIDY	2	30					
66	082093	H0E	MULTIPLE SCLEROSIS AGENTS	18	Y	PONESIMOD 14-DAY STARTER PACK	PONESIMOD 14-DAY STARTER PACK	PONVORY	14		1	14			
66	082092	H0E	MULTIPLE SCLEROSIS AGENTS	19	Y	PONESIMOD 20 MG TABLET	PONESIMOD 20 MG TABLET	PONVORY			1				
66	079603	H0E	MULTIPLE SCLEROSIS AGENTS	20	Y	SIPONIMOD 0.25MG STARTER PACK	SIPONIMOD 0.25MG STARTER PACK	MAYZENT	12			5			
66	079602	H0E	MULTIPLE SCLEROSIS AGENTS	21	Y	SIPONIMOD 0.25MG TABLET	SIPONIMOD 0.25MG TABLET	MAYZENT			4				
66	079601	H0E	MULTIPLE SCLEROSIS AGENTS	22	Y	SIPONIMOD 2MG TABLET	SIPONIMOD 2MG TABLET	MAYZENT			1				
66	069979	H0E	MULTIPLE SCLEROSIS AGENTS	23	Y	TERIFLUNOMIDE 7MG TABLET	TERIFLUNOMIDE 7MG TABLET	AUBAGIO			1				

66	080498	H6I	AMYOTROPHIC LATERAL SCLEROSIS AGENTS	47	Y	RILUZOLE 50 MG FILM	RILUZOLE 50 MG FILM	EXSERVAN			2				
66	077924	H6I	AMYOTROPHIC LATERAL SCLEROSIS AGENTS	48	Y	RILUZOLE 50MG/10ML SUSP	RILUZOLE 50MG/10ML SUSP	TIGLUTIK			20				
67	67	HIC3	THERAPEUTIC CLASS	0	Y	NEUROPATHIC PAIN	NEUROPATHIC PAIN	BRAND	Units	Until Refill	Daily Dose	Max Days	Refills	Pkg Bill	Updated
67	057892	H7C	NEUROPATHIC PAIN	1	Y	DULOXETINE HCL 30MG CAPSULE	DULOXETINE HCL 30MG CAPSULE	CYMBALTA			1				
67	057891	H7C	NEUROPATHIC PAIN	2	Y	DULOXETINE HCL 20 and 60MG CAPSULE	DULOXETINE HCL 20MG CAPSULE	CYMBALTA			2				
67	074166	H7C	NEUROPATHIC PAIN	3	Y	DULOXETINE HCL DR 40 MG CAPSULE	DULOXETINE HCL DR 40 MG CAPSULE	IRENKA			1				
67	021413	H4B	NEUROPATHIC PAIN	4	Y	GABAPENTIN 100MG, 300MG CAPSULE	GABAPENTIN 100MG CAPSULE	NEURONTIN			6				
67	021415	H4B	NEUROPATHIC PAIN	5	Y	GABAPENTIN 400MG CAPSULE	GABAPENTIN 400MG CAPSULE	NEURONTIN			8				
67	041805	H4B	NEUROPATHIC PAIN	6	Y	GABAPENTIN 600, 800MG TABLET	GABAPENTIN 600MG TABLET	NEURONTIN			4				
67	047927	H4B	NEUROPATHIC PAIN	7	Y	GABAPENTIN 50MG/ML SOLUTION 5 and 6ML	GABAPENTIN 250MG/5ML SOLUTION	NEURONTIN			36				
67	067685	H4B	NEUROPATHIC PAIN	8	Y	GABAPENTIN ER 300MG TABLET	GABAPENTIN 300MG TABLET	GRALISE ER			1				
67	067686	H4B	NEUROPATHIC PAIN	9	Y	GABAPENTIN ER 600MG TABLET	GABAPENTIN 600MG TABLET	GRALISE ER			3				
67	082302	H4B	NEUROPATHIC PAIN	10	Y	GABAPENTIN 300-600 MG SAMPLE PACK	GABAPENTIN 300-600 MG SAMPLE PACK	GRALISE	78			30			1/1/2022
67	067687	H4B	NEUROPATHIC PAIN	11	Y	GABAPENTIN 30-DAY STARTER PACK 78UNITS	GABAPENTIN 30-DAY STARTER PACK 78UNITS	GRALISE ER	78	365				Y	
67	065086	H0G	NEUROPATHIC PAIN	15	Y	MILNACIPRAN HCL TABLETS	MILNACIPRAN HCL 12.5MG TABLET	SAVELLA			2				
67	065091	H0G	NEUROPATHIC PAIN	16	Y	MILNACIPRAN HCL TRITATION PACK (55 TABLETS)	MILNACIPRAN HCL TRITATION PACK (55 TABLETS)	SAVELLA	55	365			0	Y	
67	057799	H4B	NEUROPATHIC PAIN	17	Y	PREGABALIN 25, 50, 75, 100, 150 and 200MG CAPSULE	PREGABALIN 25MG CAPSULE	LYRICA			3				
67	059401	H4B	NEUROPATHIC PAIN	18	Y	PREGABALIN 225 and 300MG CAPSULE	PREGABALIN 225MG CAPSULE	LYRICA			2				
67	069339	H4B	NEUROPATHIC PAIN	19	Y	PREGABALIN 20MG/ML ORAL SOLUTION	PREGABALIN 20MG/ML ORAL SOLUTION	LYRICA			30				
67	074071	H4B	NEUROPATHIC PAIN	23	Y	LEVETIRACETAM 1,000 MG TABLET	LEVETIRACETAM 1,000 MG TABLET	ELEPSIA			3				
67	074072	H4B	NEUROPATHIC PAIN	23.5	Y	LEVETIRACETAM 1,500 MG TABLET	LEVETIRACETAM 1,500 MG TABLET	ELEPSIA			2				
68	68	HIC3	THERAPEUTIC CLASS	0	Y	NSAIDs	NSAIDs	BRAND	Units	Until Refill	Daily Dose	Max Days	Refills	Pkg Bill	Updated
68	041285	S2L	NSAIDs	1	Y	CELECOXIB 50, 100, 200MG CAPSULE	CELECOXIB 100 MG CAPSULE	CELEBREX			2				
68	050832	S2L	NSAIDs	2	Y	CELECOXIB 400 MG CAPSULE	CELECOXIB 400 MG CAPSULE	CELEBREX			1				
68	062176	Q5E	NSAIDs	3	Y	DICLOFENAC EPOLAMINE 1.3% PATCH	DICLOFENAC EPOLAMINE 1.3% PATCH	FLECTOR			2				
68	071910	Q5E	NSAIDs	4	Y	DICLOFENAC SODIUM 2% PUMP	DICLOFENAC SODIUM 2% PUMP	PENNSAID	224	30				Y	
68	018293	Q5E	NSAIDs	5	Y	DICLOFENAC SODIUM 1% GEL	DICLOFENAC SODIUM 1% GEL	VOLTAREN	100	30				Y	
68	051971	Q5E	NSAIDs	6	Y	DICLOFENAC SODIUM 1.5% SOLUTION	DICLOFENAC SODIUM 1.5% SOLUTION	PENNSAID	150	30					
68	079702	T0J	TOPICAL ANTI-INFLAMMATORY NSAID-LOCAL ANESTHETIC	6.5	Y	DICLOFENAC/LIDO/ME-SAL/CAMPHOR KIT	DICLOFENAC/LIDO/ME-SAL/CAMPHOR KIT	DICLOVIX	1						
68	067901	S2X	NSAID AND HISTAMINE H2 RECEPTOR ANTAGONIST COMB	7	Y	IBUPROFEN/FAMOTIDINE 800-26.6 MG TABLET	IBUPROFEN/FAMOTIDINE 800-26.6 MG TABLET	DUEXIS			3				
68	081643	S2B	NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE ANALGESICS	7.5	Y	IBUPROFEN/GLYCERIN KIT	IBUPROFEN/GLYCERIN KIT	IBUPAN	1						
68	029156	S2B	NSAIDS	8	Y	MELOXICAM TABLETS and ODT	MELOXICAM 7.5 MG TABLET	MOBIC / QMIIZ ODT			1				
68	080770	S2B	NSAIDS	8.5	Y	MELOXICAM 30 MG / ML VIAL	MELOXICAM 30 MG / ML VIAL	ANJESO			1				
68	041308	S2B	NSAIDS	9	Y	NABUMETONE DS 1,000 MG TABLET	NABUMETONE DS 1,000 MG TABLET	RELAFEN			2				
68	066328	S2P	NSAIDS	10	Y	NAPROXEN/ESOMEPRAZOLE MAG TABLETS	NAPROXEN/ESOMEPRAZOLE MAG 500-20MG TABL	VIMOVO DR			2				
68	017204	S2B	NSAIDS	11	Y	OXAPROZIN 600 MG TABLET	OXAPROZIN 600 MG TABLET	DAYPRO			2				
69	69	HIC3	THERAPEUTIC CLASS	0	Y	OPHTHALMIC ANTIBIOTICS	OPHTHALMIC ANTIBIOTICS	BRAND	Units	Until Refill	Daily Dose	Max Days	Refills	Pkg Bill	Updated
69	080057	Q6W	OPHTHALMIC ANTIBIOTICS	1	Y	AZITHROMYCIN/CHONDROITIN/PF 1%	AZITHROMYCIN/CHONDROITIN/PF 1%	KLARITY-A	3.5	30					
69	080791	Q6R	EYE ANTIHISTAMINE	5	Y	CETIRIZINE HCL 0.24% EYE DROPS	CETIRIZINE HCL 0.24% EYE DROPS	ZERVIATE	30						
70	079114	Q6I	EYE ANTIBIOTIC AND GLUCOCORTICOID COMBINATIONS	3	Y	PREDNISOLONE PHOSHATE GATIFLOXACIN 1%-0.5%	PREDNISOLONE PHOSHATE GATIFLOXACIN 1%-0.5%	GENERIC ONLY	3.5					Y	
70	080062	Q2Q	EYE ANTIBIOTIC, GLUCOCORTICOID AND NSAID COMB	4	Y	PREDNISOLN SP/MOXIFLOX/BROMFEN 1-0.5-0.075%	PREDNISOLN SP/MOXIFLOX/BROMFEN 1-0.5-0.075	GENERIC ONLY	8	30					
70	079043	Q2Q	EYE ANTIBIOTIC, GLUCOCORTICOID AND NSAID COMB	5	Y	PREDNISOLONE PHOS-GATIFLO-BROM 1-0.5-0.075%	PREDNISOLONE PHOS-GATIFLO-BROM 1-0.5-0.075	GENERIC ONLY	3.5					Y	
71	71	HIC3	THERAPEUTIC CLASS	0	Y	OPHTHALMICS FOR ALLERGIC CONJUNCTIVITIS	OPHTHALMICS FOR ALLERGIC CONJUNCTIVITIS	BRAND	Units	Until Refill	Daily Dose	Max Days	Refills	Pkg Bill	Updated
71	066954	Q6R	OPHTHALMIC ALLERGIC CONJUNCTIVITIS	1	Y	ALCAFTADINE 0.25% EYE DROPS 3ML	ALCAFTADINE 0.25% EYE DROPS 3ML	LASTACAFT	3	30				Y	
71	040646	Q6R	OPHTHALMIC ALLERGIC CONJUNCTIVITIS	2	Y	AZELASTINE HCL 0.05% DROPS 6ML	AZELASTINE HCL 0.05% DROPS 6ML	OPTIVAR	6	30				Y	
71	044694	Q6U	OPHTHALMICS FOR ALLERGIC CONJUNCTIVITIS	3	Y	CROMOLYN SODIUM 4% EYE DROPS 10ML P/PACKAGE	CROMOLYN SODIUM 4% EYE DROPS 10ML P/PACKA	GENERIC ONLY	10	30				Y	
71	038434	Q6R	OPHTHALMICS FOR ALLERGIC CONJUNCTIVITIS	4	Y	EMEDASTINE DIFUMARATE 0.05% EYE DROPS 5ML	EMEDASTINE DIFUMARATE 0.05% EYE DROPS 5ML	EMADINE	5	30				Y	
71	053473	Q6R	OPHTHALMICS FOR ALLERGIC CONJUNCTIVITIS	5	Y	EPINASTINE HCL 0.05% EYE DROPS 5ML	EPINASTINE HCL 0.05% EYE DROPS 5ML	ELESTAT	5	30				Y	
71	044695	Q6U	OPHTHALMICS FOR ALLERGIC CONJUNCTIVITIS	6	Y	LODOXAMIDE TROMETHAMINE 0.1% EYE DROPS 10ML	LODOXAMIDE TROMETHAMINE 0.1% EYE DROPS 1	ALOMIDE	10	30				Y	
71	023551	Q6U	OPHTHALMICS FOR ALLERGIC CONJUNCTIVITIS	7	Y	NEDOCROMIL SODIUM 2% EYE DROPS 5ML	NEDOCROMIL SODIUM 2% EYE DROPS 5ML	ALOCRIL	5	30				Y	
71	030796	Q6R	OPHTHALMICS FOR ALLERGIC CONJUNCTIVITIS	8	Y	OLOPATADINE HCL 0.1% EYE DROPS 5ML	OLOPATADINE HCL 0.1% EYE DROPS 5ML	PATANOL	5	30				Y	
71	062065	Q6R	OPHTHALMICS FOR ALLERGIC CONJUNCTIVITIS	9	Y	OLOPATADINE HCL 0.2% EYE DROPS 2.5 ML	OLOPATADINE HCL 0.2% EYE DROPS 2.5 ML	PATADAY	2.5	30				Y	
71	063890	Q6R	OPHTHALMICS FOR ALLERGIC CONJUNCTIVITIS	10	Y	OLOPATADINE HCL 0.6% 665MCG NASAL SPRAY 30.5 GRA	OLOPATADINE HCL 0.6% 665MCG NASAL SPRAY 30.	PATANASE	30.5	30				Y	
72	72	HIC3	THERAPEUTIC CLASS	0	Y	OPHTHALMIC ANTI-INFLAMMATORIES	OPHTHALMIC ANTI-INFLAMMATORIES-IMUNOMO	BRAND	Units	Until Refill	Daily Dose	Max Days	Refills	Pkg Bill	Updated
72	080077	Q6P	OPHTHALMIC ANTI-INFLAMMATORIES	2	Y	BETAMETHASONE/CHONDROITIN/PF 0.1%	BETAMETHASONE/CHONDROITIN/PF 0.1%	KLARITY-B	5.5	30					
72	070835	Q6P	OPHTHALMIC ANTI-INFLAMMATORIES	3	Y	BROMFENAC SODIUM 0.07% EYE DROPS 1.6 or 3ML	BROMFENAC SODIUM 0.07% EYE DROPS 1.6 or 3M	PROLENSA	3	30				Y	
72	080273	Q2F	OPHTH. VEGF-A RECEPTOR ANTAG. RCMB MC ANTIBODY	3.5	Y	BROLUCIZUMAB-DBLL 6 MG/0.05 ML VIAL	BROLUCIZUMAB-DBLL 6 MG/0.05 ML VIAL	BEOVU	0.05	30					
72	051820	Q2C	OPHTHALMIC ANTI-INFLAMMATORIES-IMUNOMODULATORS	4	Y	CYCLOSPORINE 0.05% EYE EMULSION	CYCLOSPORINE 0.05% EYE EMULSION	RESTASIS	60	30				Y	
72	064354	Q6P	OPHTHALMIC ANTI-INFLAMMATORIES	5	Y	DIFLUPREDNATE 0.05% EYE DROPS 5ML	DIFLUPREDNATE 0.05% EYE DROPS 5ML	DUREZOL	5	30				Y	
72	079287	Q2S	OPHTHALMIC HUMAN NERVE GROWTH FACTOR (HNGF)	5.5	Y	CENEGERMIN-BKBJ 0.002% EYE DROP	CENEGERMIN-BKBJ 0.002% EYE DROP	OXERVATE	14	14					
72	075383	Q2L	OPHTHALMIC CYSTINE DEPLETING AGENTS	5.6	Y	CYSTADROPS 0.37% EYE DROPS	CYSTEAMINE 0.37% EYE DROPS	CYSTADROPS	5						
72	052960	Q6P	OPHTHALMIC ANTI-INFLAMMATORIES	6	Y	KETOROLAC TROMETHAMINE 0.4% OPTH SOLUTION 5ML	KETOROLAC TROMETHAMINE 0.4% OPTH SOLUTIO	ACULAR LS	5	30				Y	
72	065413	Q6P	OPHTHALMIC ANTI-INFLAMMATORIES	7	Y	KETOROLAC TROMETHAMINE/PF 0.45% OPHTHALMIC SO	KETOROLAC TROMETHAMINE/PF 0.45% OPHTHALI	ACUVAIL	30	30				Y	
72	016404	Q6P	OPHTHALMIC ANTI-INFLAMMATORIES	8	Y	KETOROLAC TROMETHAMINE 10 MG TABLET	KETOROLAC TROMETHAMINE 10 MG TABLET	GENERIC ONLY	20	30	4	5			
72	022518	Q6P	OPHTHALMIC ANTI-INFLAMMATORIES	9	Y	KETOROLAC TROMETHAMINE CARPUJECTS, SYRINGES AN	KETOROLAC TROMETHAMINE 30 MG/ML CARPUJE	GENERIC ONLY	4	30				Y	
72	043118	Q6R	OPHTHALMIC ANTI-INFLAMMATORIES	9	Y	KETOTIFEN FUMARATE 0.025% EYE DROPS 10ML	KETOTIFEN FUMARATE 0.025% EYE DROPS 10ML	ZADITOR / ALAWAY	10	30				Y	
72	079545	Q6P	OPHTHALMIC ANTI-INFLAMMATORIES	10	Y	LOTEPREDNOL ETABONATE 0.38% OPHTH GEL	LOTEPREDNOL ETABONATE 0.38% OPHTH GEL	LOTEMAX SM	5						
72	080003	Q6P	OPHTHALMIC ANTI-INFLAMMATORIES	11	Y	LOTEPREDNOL/CHONDROITIN/PF 0.2% & 0.5%	LOTEPREDNOL/CHONDROITIN/PF 0.2%	KLARITY-L	5	30					
72	081650	Q6P	OPHTHALMIC ANTI-INFLAMMATORIES	11.5	Y	LOTEPREDNOL ETABONATE 0.25% EYE DROPS	LOTEPREDNOL ETABONATE 0.25% EYE DROPS	EYSUVIS	8.3			14		Y	
72	077576	Q6P	OPHTHALMIC ANTI-INFLAMMATORIES	12	Y	PREDNISOLONE 1%-NEPAFENAC 0.1%	PREDNISOLONE 1%-NEPAFENAC 0.1% SUSPENSION	GENERIC ONLY	3.5			28		Y	
72	077587	Q6P	OPHTHALMIC ANTI-INFLAMMATORIES	13	Y	PREDNISOLONE 1%-GATIFLOXACIN 0.5% SUSPENSION	PREDNISOLONE 1%-GATIFLOXACIN 0.5% SUSPENSI	GENERIC ONLY	3.5			28		Y	
72	079060	Q6P	OPHTHALMIC ANTI-INFLAMMATORIES	14	Y	PREDNISOLONE PHOSHATE BROMFENAC 1%-0.075%	PREDNISOLONE PHOSHATE BROMFENAC 1%-0.075	GENERIC ONLY	3.5					Y	
73	73	HIC3	THERAPEUTIC CLASS	0	Y	OPHTHALMICS, GLAUCOMA AGENTS	OPHTHALMICS, GLAUCOMA AGENTS	BRAND	Units	Until Refill	Daily Dose	Max Days	Refills	Pkg Bill	Updated
73	027370	Q6G	OPHTHALMICS, GLAUCOMA AGENTS	1	Y	LATANOPROST 0.005% EYE DROPS	LATANOPROST 0.005% EYE DROPS	XALATAN	2.5	30				Y	
73	077915	Q6G	OPHTHALMICS, GLAUCOMA AGENTS	2	Y	LATANOPROSTENE BUNOD 0.024% OPHTH SOLUTION	LATANOPROSTENE BUNOD 0.024% OPHTH SOLUTI	VYZULTA	5			28		Y	
73	079572	Q6G	OPHTHALMICS, GLAUCOMA AGENTS	3	Y	NETARSUDIL MESYLAT/LATANOPROST 0.02%-0.005% EYE	NETARSUDIL MESYLAT/LATANOPROST 0.02%-0.005	ROCKLATAN	2.5						
73	065587	Q6G	OPHTHALMICS, GLAUCOMA AGENTS	4	Y	TAFLUPROST/PF 0.0015% EYE DROPS	TAFLUPROST/PF 0.0015% EYE DROPS	ZIOPTAN	30	30				Y	

74	74	HIC3	THERAPEUTIC CLASS	0	Y	OPIATE DEPENDENCE TREATMENTS	OPIATE DEPENDENCE TREATMENTS	BRAND	Units	Until Refill	Daily Dose	Max Days	Refills	Pkg Bill	Updated
74	072449	H3W	OPIATE DEPENDENCE TREATMENTS	1	Y	BUNAVAIL / BUPRENORPHINE HCL/ NALOXONE HCL FILMS	BUPRENORPHINE HCL/ NALOXONE HCL 2.1-0.3 MG	BUNAVAIL			2				
74	070262	H3W	OPIATE DEPENDENCE TREATMENTS	2	Y	SUBXONE / BUPRENORPHINE HCL/NALOXONE HCL 12MG	BUPRENORPHINE HCL/NALOXONE HCL 12MG-3MG	SUBOXONE	30		1	30			
74	051640	H3W	OPIATE DEPENDENCE TREATMENTS	3	Y	SUBXONE / BUPRENORPHINE HCL/NALOXONE HCL ALL OT	BUPRENORPHINE HCL/NALOXONE HCL 2MG-0.5MG	SUBOXONE	60		2	30			1/1/2022
74	071189	H3W	OPIATE DEPENDENCE TREATMENTS	4	Y	BUPRENORPHINE HCL / NALOXONE HCL TABLETS	BUPRENORPHINE HCL / NALOXONE HCL 1.4-0.36 M	ZUBSOLV			2				
74	019113	H33	OPIATE DEPENDENCE TREATMENTS	5	Y	LOXEFIDINE HCL 0.18MG TABLET	LOXEFIDINE HCL 0.18MG TABLET	LUCEMYRA			16	14			
74	004514	H3T	OPIATE DEPENDENCE TREATMENTS	7	Y	NALOXONE HCL 1MG/ML SYRINGE 2ML	NALOXONE HCL 1MG/ML SYRINGE 2ML	GENERIC ONLY	4					Y	1/1/2022
74	075222	H3T	OPIATE DEPENDENCE TREATMENTS	8	Y	NALOXONE HCL 4MG NASAL SPRAY	NALOXONE HCL 4MG NASAL SPRAY	NARCAN	2	30				Y	
74	060935	C0D	ANTI-ALCOHOLIC PREPARATIONS	9	Y	NALTREXONE MICROSPHERES	VIVITROL 380 MG VIAL-DILUENT	VIVITROL	1	28				Y	
75	75	HIC3	THERAPEUTIC CLASS	0	Y	OTIC ANTIBIOTICS	OTIC ANTIBIOTICS	BRAND	Units	Until Refill	Daily Dose	Max Days	Refills	Pkg Bill	Updated
75	052911	Q8F	OTIC ANTIBIOTICS	1	Y	CIPROFLOXACIN HCL/DEXAMETH SUSPENSION 7.5ML	CIPROFLOXACIN HCL/DEXAMETH SUSPENSION 7.5(	CIPRODEX	7.5	30				Y	
78	78	HIC3	THERAPEUTIC CLASS	0	Y	PAG AGENTS – PDE5s	PAG AGENTS – PDE5s	BRAND	Units	Until Refill	Daily Dose	Max Days	Refills	Pkg Bill	Updated
78	059211	B1D	PAH AGENTS - PDE5s	1	Y	SILDENAFIL CITRATE 20MG TABLET	SILDENAFIL CITRATE 20MG TABLET	REVATIO			3				
78	065368	B1D	PAH AGENTS - PDE5s	2	Y	TADALAFIL 20MG TABLET	TADALAFIL 20MG TABLET	ADCIRCA			2				
79	79	HIC3	THERAPEUTIC CLASS	0	Y	PAG AGENTS – PROSTACYCLINS	PAG AGENTS – PROSTACYCLINS	BRAND	Units	Until Refill	Daily Dose	Max Days	Refills	Pkg Bill	Updated
79	065502	B1C	PAG AGENTS – PROSTACYCLINS	1	Y	TREPROSTINIL 1.74MG/2.9ML SOLUTION	TREPROSTINIL 1.74MG/2.9ML SOLUTION	TYVASO			2.9				
81	078657	P1N	LHRH(GNRH) ANTAGONIST,PITUITARY SUPPRESSANT AGENTS	1	Y	ELAGOLIX SODIUM 150 MG TABLET	ELAGOLIX SODIUM 150 MG TABLET	ORILISSA			1				
81	078659	P1N	LHRH(GNRH) ANTAGONIST,PITUITARY SUPPRESSANT AGENTS	2	Y	ELAGOLIX SODIUM 200 MG TABLET	ELAGOLIX SODIUM 200 MG TABLET	ORILISSA			2				
81	081122	P1R	LHRH (GNRH) ANTAGONIST,ESTROGEN AND PROGESTIN COMB	3	Y	ELAGOLIX/ESTRADIOL/NORETHINDRN300-1-0.5MG / 300	ELAGOLIX/ESTRADIOL/NORETHINDRN300-1-0.5MG	ORIAHNN			2	28			
81	044967	V1O	ANTINEOPLASTIC LHRH(GNRH) AGONIST,PITUITARY SUPPRESSANT	4	Y	LEUPROLIDE ACETATE 1MG/0.2ML 2 WEEK KIT	LEUPROLIDE ACETATE 1MG/0.2ML 2 WEEK KIT	LUPRON DEPOT	1	14				Y	
81	044964	V1O	ANTINEOPLASTIC LHRH(GNRH) AGONIST,PITUITARY SUPPRESSANT	5	Y	LEUPROLIDE ACETATE 3 MONTH KITS	LEUPROLIDE ACETATE 22.5MG 3 MONTH KIT	LUPRON DEPOT	1	90		90		Y	
81	045017	V1O	ANTINEOPLASTIC LHRH(GNRH) AGONIST,PITUITARY SUPPRESSANT	6	Y	LEUPROLIDE ACETATE 3.75MG KIT	LEUPROLIDE ACETATE 3.75MG KIT	LUPRON DEPOT	1	30				Y	
81	044968	V1O	ANTINEOPLASTIC LHRH(GNRH) AGONIST,PITUITARY SUPPRESSANT	7	Y	LEUPROLIDE ACETATE 30MG 4 MONTH KIT	LEUPROLIDE ACETATE 30MG 4 MONTH KIT	LUPRON DEPOT	1	120		120		Y	
81	081002	P1P	LHRH(GNRH)AGNST PIT.SUP-CENTRAL PRECOCIOUS PUBERTY	8	Y	LEUPROLIDE ACETATE 45 MG SYRINGE	LEUPROLIDE ACETATE 45 MG SYRINGE	FENSOLVI	1	180					
81	067506	V1O	ANTINEOPLASTIC LHRH(GNRH) AGONIST,PITUITARY SUPPRESSANT	9	Y	LEUPROLIDE ACETATE 45MG 6MONTH KIT	LEUPROLIDE ACETATE 45MG 6MONTH KIT	LUPRON DEPOT	1	180		180			
81	081783	V1V	ANTINEOPLASTIC LHRH(GNRH) ANTAGONIST,PITUITARY SUPPRESANTS	10	Y	RELUGOLIX 120 MG TABLET	RELUGOLIX 120 MG TABLET	ORGOVYX			1.1				
81	082317	P1R	LHRH (GNRH) ANTAGONIST,ESTROGEN AND PROGESTIN COMB	11	Y	RELUGOLIX/ESTRADIOL/NORETHINDR 40 MG-1 MG-0.5 M	RELUGOLIX/ESTRADIOL/NORETHINDR 40 MG-1 MG	MYFEMBREE			1				1/1/2022
81	077557	P1P	LHRH(GNRH)AGNST PIT.SUP-CENTRAL PRECOCIOUS PUBERTY	12	Y	TRIPTORELIN PAMOATE 22.5MG VIAL KIT	TRIPTORELIN PAMOATE 22.5MG VIAL KIT	TRIPTADOUR	1						
81	070480	P1O	PROGESTATIONAL AGENT	3A	Y	LEUPROLIDE/NORETHINDRONE ACETAM 11.25-5MG KIT	LEUPROLIDE/NORETHINDRONE ACETAM 11.25-5M	LUPANETA PACK 3 MONTH	1	90		90		Y	
81	070481	P1O	PROGESTATIONAL AGENT	3A	Y	LEUPROLIDE/NORETHINDRONE ACETAM 3.75-5MG KIT	LEUPROLIDE/NORETHINDRONE ACETAM 3.75-5MG	LUPANETA PACK 1 MONTH	1	30				Y	
82	82	HIC3	THERAPEUTIC CLASS	0	Y	PLATELET AGGREGATION INHIBITORS	PLATELET AGGREGATION INHIBITORS	BRAND	Units	Until Refill	Daily Dose	Max Days	Refills	Pkg Bill	Updated
82	040303	M9P	PLATELET AGGREGATION INHIBITORS	1	Y	ASPIRIN/DIPYRIDAMOLE 25MG-200MG CAPSULE	ASPIRIN/DIPYRIDAMOLE 25MG-200MG CAPSULE	AGGRENOX			2				
82	038164	M9P	PLATELET AGGREGATION INHIBITORS	2	Y	CLOPIDOGREL BISULFATE 75MG TABLET	CLOPIDOGREL BISULFATE 75MG TABLET	PLAVIX			1				
82	063544	M9P	PLATELET AGGREGATION INHIBITORS	3	Y	CLOPIDOGREL BISULFATE 300MG TABLET	CLOPIDOGREL BISULFATE 300MG TABLET	PLAVIX	1	30					
82	064901	M9P	PLATELET AGGREGATION INHIBITORS	4	Y	PRASUGREL HCL TABLETS	PRASUGREL HCL 5MG TABLET	EFFIENT			1				
82	066950	M9P	PLATELET AGGREGATION INHIBITORS	5	Y	TICAGRELOR TABLETS	TICAGRELOR 90MG TABLET	BRILINTA			2				
84	84	HIC3	THERAPEUTIC CLASS	0	Y	PROTON PUMP INHIBITORS	PROTON PUMP INHIBITORS	BRAND	Units	Until Refill	Daily Dose	Max Days	Refills	Pkg Bill	Updated
84	064793	D4J	PROTON PUMP INHIBITORS	1	Y	DEXLANSOPRAZOLE CAPSULES	DEXLANSOPRAZOLE 30MG CAPSULE	DEXILANT			1				
84	069882	D4J	PROTON PUMP INHIBITORS	2	Y	ESOMEPRAZOLE MAGNESIUM CAPSULES or PACKETS	ESOMEPRAZOLE MAGNESIUM 2.5MG PACKET	NEXIUM			1				
84	078266	D4J	PROTON PUMP INHIBITORS	3	Y	ESOMEPRAZOLE MAG/GLYCERIN KIT	ESOMEPRAZOLE MAG/GLYCERIN KIT	ESOMEP-EZS	1						
84	030106	D4J	PROTON PUMP INHIBITORS	4	Y	LANSOPRAZOLE DR CAPSULES, SOLUTABS AND TABLETS	LANSOPRAZOLE DR 15 MG CAPSULE	PREVACID			1				
84	043136	D4J	PROTON PUMP INHIBITORS	5	Y	OMEPRAZOLE CAPSULES	OMEPRAZOLE 10MG CAPSULE	PRILOSEC			1				
84	060471	D4J	PROTON PUMP INHIBITORS	6	Y	OMEPRAZOLE/SODIUM BICARBONATE CAPSULES	OMEPRAZOLE/SODIUM BICARBONATE 20-1,100 CA	ZEGRID / ZEGERID OTC			1				
84	039545	D4J	PROTON PUMP INHIBITORS	7	Y	PANTOPRAZOLE SODIUM TABLETS	PANTOPRAZOLE SODIUM 20MG TABLET	PROTONIX			2				
84	063700	D4J	PROTON PUMP INHIBITORS	8	Y	PANTOPRAZOLE SODIUM 40MG SUSPENSION	PANTOPRAZOLE SODIUM 40MG SUSPENSION	PROTONIX			1				
84	040941	D4J	PROTON PUMP INHIBITORS	9	Y	RABEPRAZOLE SODIUM 20MG TABLET	RABEPRAZOLE SODIUM 20MG TABLET	ACIPHEX			1				
85	85	HIC3	THERAPEUTIC CLASS	0	Y	SEDATIVE HYPNOTICS	SEDATIVE HYPNOTICS	BRAND	Units	Until Refill	Daily Dose	Max Days	Refills	Pkg Bill	Updated
85	003773	H20	ANTI ANXIETY - BENZO	1	Y	ALPRAZOLAM TABLETS	ALPRAZOLAM 0.25 MG TABLET	XANAX	90	30	3				
85	021523	H20	ANTI ANXIETY - BENZO	2	Y	ALPRAZOLAM CONCENTRATES	ALPRAZOLAM 1 MG/ML ORAL CONC	GENERIC ONLY	90	30	3				
85	050399	H20	ANTI ANXIETY - BENZO	3	Y	ALPRAZOLAM ER TABLETS	ALPRAZOLAM ER 0.5 MG TABLET	XANAX XR	30	30	1				
85	058847	H20	ANTI ANXIETY - BENZO	4	Y	ALPRAZOLAM 0.25, 0.5, 1MG ODT TABLETS	ALPRAZOLAM ODT 0.25 MG TAB	GENERIC ONLY	90	30	3				
85	058850	H20	ANTI ANXIETY - BENZO	5	Y	ALPRAZOLAM ODT 2 MG TAB	ALPRAZOLAM ODT 2 MG TAB	GENERIC ONLY	30	30	1				
85	066591	H2E	SEDATIVE HYPNOTICS	6	Y	DOXEPIN HCL TABLETS	DOXEPIN HCL 3MG TABLET	SILENOR	15	30	1				
85	015603	H21	SEDATIVE HYPNOTICS	7	Y	ESTAZOLAM TABLETS	ESTAZOLAM 1MG TABLET	GENERIC ONLY	15	30	1				
85	058484	H2E	SEDATIVE HYPNOTICS	8	Y	ESZOPICLONE TABLETS	ESZOPICLONE 1MG TABLET	LUNESTA	15	30	1				
85	003691	H21	SEDATIVE HYPNOTICS	9	Y	FLURAZEPAM CAPSULES	FLURAZEPAM 15 MG CAPSULE	GENERIC ONLY	15	30	1				
85	080597	H2E	SEDATIVE HYPNOTICS	10	Y	LEMBOREXANT 1.25 MG GEL PACKET	LEMBOREXANT 1.25 MG GEL PACKET	DAYVIGO			1				
85	080590	H2E	SEDATIVE HYPNOTICS	10	Y	LEMBOREXANT TABLETS	LEMBOREXANT 5 MG TABLET	DAYVIGO			1				
85	003757	H20	ANTI ANXIETY - BENZO	11	Y	LORAZEPAM TABLETS	LORAZEPAM 0.5 MG TABLET	ATIVAN	90	30	3				
85	082632	H20	ANTI ANXIETY - BENZO	11.5	Y	LORAZEPAM 1 MG CAPSULE	LORAZEPAM 1 MG CAPSULE	LOREEV XR			6				1/1/2022
85	082634	H20	ANTI ANXIETY - BENZO	11.75	Y	LORAZEPAM 2 MG CAPSULE	LORAZEPAM 2 MG CAPSULE	LOREEV XR			3				1/1/2022
85	082633	H20	ANTI ANXIETY - BENZO	11.85	Y	LORAZEPAM 3 MG CAPSULE	LORAZEPAM 3 MG CAPSULE	LOREEV XR			2				1/1/2022
85	016363	H20	ANTI ANXIETY - BENZO	12	Y	LORAZEPAM 2 MG/ML ORAL CONCENT	LORAZEPAM 2 MG/ML ORAL CONCENT	ATIVAN	90	30	3				
85	024665	P6A	PINEAL HORMONE AGENTS	12.5	Y	MELATONIN 3 MG TABLET	MELATONIN 3 MG TABLET	MELATIN			3				
85	040822	H21	SEDATIVE-HYPNOTICS	13	Y	MIDAZOLAM HCL 2 MG/ML SYRUP	MIDAZOLAM HCL 2 MG/ML SYRUP	GENERIC ONLY	150	30	10				
85	073921	H21	SEDATIVE-HYPNOTICS	14	Y	MIDAZOLAM HCL 5 MG/2.5 ML SYRP	MIDAZOLAM HCL 5 MG/2.5 ML SYRP	GENERIC ONLY	75	30	2.5				
85	066755	H21	SEDATIVE-HYPNOTICS	15	Y	MIDAZOLAM HCL 10 MG/5 ML SYRUP	MIDAZOLAM HCL 10 MG/5 ML SYRUP	GENERIC ONLY	150	30	10				
85	003769	H2O	ANTI ANXIETY - BENZO	16	Y	OXAZEPAM CAPSULES	OXAZEPAM 10 MG CAPSULE	GENERIC ONLY	90	30	3				
85	003696	H21	SEDATIVE HYPNOTICS	17	Y	QUAZEPAM 15 MG TABLET	QUAZEPAM 15 MG TABLET	DORAL	15	30	1				
85	059509	H8B	SEDATIVE HYPNOTICS	18	Y	RAMELTEON 8MG TABLET	RAMELTEON 8MG TABLET	ROZEREM	15	30	1				
85	003630	H2D	SEDATIVE HYPNOTICS	19	Y	SECONAL SODIUM 100 MG CAPSULE	SECONAL SODIUM 100 MG CAPSULE	GENERIC ONLY	15	30	1				
85	072690	H2E	SEDATIVE HYPNOTICS	20	Y	SUVOREXANT TABLETS	SUVOREXANT 5MG TABLET	BELSOMRA	15	30	1				
85	072007	H8B	SEDATIVE HYPNOTICS	21	Y	TASIMELTEON 20MG CAPSULE	TASIMELTEON 20MG CAPSULE	HETLIOZ	30	30	1				
85	081738	H8B	SEDATIVE HYPNOTICS	21.5	Y	TASIMELTEON 4 MG/ML SOLUTION	TASIMELTEON 4 MG/ML SOLUTION	HELTIQZ LQ			5				
85	019182	H21	SEDATIVE HYPNOTICS	22	Y	TEMAZEPAM CAPSULES	TEMAZEPAM 7.5MG CAPSULE	RESTORIL	15	30	1				
85	003693	H21	SEDATIVE HYPNOTICS	23	Y	TRIAZOLAM TABLETS	TRIAZOLAM 0.125MG TABLET	HALCION	15	30	1				
85	042993	H2E	SEDATIVE HYPNOTICS	24	Y	ZALEPLON CAPSULES	ZALEPLON 5MG CAPSULE	SONATA	15	30	1				

85	068726	H2E	SEDATIVE HYPNOTICS	25	Y	ZOLPIDEM TARTRATE SUBLINGUAL TABLETS	ZOLPIDEM TARTRATE 1.75MG SUBLINGUAL TABLET	EDULAR / INTERMEZZO	15	30	1				
85	019187	H2E	SEDATIVE HYPNOTICS	26	Y	ZOLPIDEM TARTRATE TABLETS	ZOLPIDEM TARTRATE 5MG TABLET	AMBIEN / AMBIEN CR	15	30	1				
86	**86**	**HIC3**	**THERAPEUTIC CLASS**	**0**	**Y**	**SKELETAL MUSCLE RELAXANTS**	**SKELETAL MUSCLE RELAXANTS**	**BRAND**	**Units**	**Until Refill**	**Daily Dose**	**Max Days**	**Refills**	**Pkg Bill**	**Updated**
86	027229	H6H	SKELETAL MUSCLE RELAXANTS	1	Y	BACLOFEN 5 MG TABLET	BACLOFEN 5 MG TABLET	GENERIC ONLY			3				
86	004679	H6H	SKELETAL MUSCLE RELAXANTS	2	Y	BACLOFEN 10 and 20MG TABLET	BACLOFEN 10MG TABLET	GENERIC ONLY			4				
86	017884	H6H	SKELETAL MUSCLE RELAXANTS	3	Y	BACLOFEN 5 MG/5 ML SOLUTION	BACLOFEN 5 MG/5 ML SOLUTION	OZOBAX			80				
86	063097	H6H	SKELETAL MUSCLE RELAXANTS	4	Y	CARISOPRODOL TABLETS	CARISOPRODOL 250MG TABLET	SOMA			3				
86	004661	H6H	SKELETAL MUSCLE RELAXANTS	5	Y	CARISOPRODOL/ASPIRIN 200-325MG COMPOUND TABLE	CARISOPRODOL/ASPIRIN 200-325MG COMPOUND	GENERIC ONLY			4				
86	004660	H6H	SKELETAL MUSCLE RELAXANTS	6	Y	CHLORZOXAZONE 500MG TABLETS	CHLORZOXAZONE 500MG TABLETS	PARAFON FORTE DSC			4				
86	048518	S7G	SKELETAL MUSCLE RELAXANTS	7	Y	CODEINE/CARISOPRODOL/ASPIRIN 16-200-325 TAB	CODEINE/CARISOPRODOL/ASPIRIN 16-200-325 TAB	GENERIC ONLY			4				
86	047478	H6H	SKELETAL MUSCLE RELAXANTS	8	Y	CYCLOBENZAPRINE HCL TABLETS	CYCLOBENZAPRINE HCL 5MG TABLET	AMRIX ER / FLEXERIL / FLEXMID			3				
86	081844	H6G	SKELETAL MUSCLE RELAX.-TOP. IRRITANT COUNTER-IRRIT	8.5	Y	CYCLOBENZAP/LIDO/PRILOC/GLYCER KIT	CYCLOBENZAP/LIDO/PRILOC/GLYCER KIT	CYCLOPAK	1						
86	004667	H6H	SKELETAL MUSCLE RELAXANTS	9	Y	DANTROLENE SODIUM CAPSULES	DANTROLENE SODIUM 25MG CAPSULE	DANTRIUM			4				
86	051112	H6H	SKELETAL MUSCLE RELAXANTS	10	Y	METAXALONE 800MG TABLET	METAXALONE 800MG TABLET	SKELAXIN	56	30					
86	004654	H6H	SKELETAL MUSCLE RELAXANTS	11	Y	METHOCARBAMOL 500MG TABLET	METHOCARBAMOL 500MG TABLET	ROBAXIN			9				
86	004655	H6H	SKELETAL MUSCLE RELAXANTS	12	Y	METHOCARBAMOL 750MG TABLET	METHOCARBAMOL 750MG TABLET	ROBAXIN			6				
86	004595	H6H	SKELETAL MUSCLE RELAXANTS	13	Y	ORPHENADRINE ER 100 MG TABLET	ORPHENADRINE ER 100 MG TABLET	GENERIC ONLY			2				
86	058904	H6H	SKELETAL MUSCLE RELAXANTS	14	Y	TIZANIDINE HCL 2MG CAPSULES or TABLETS	TIZANIDINE HCL 2MG CAPSULE	ZANAFLEX			3				
86	058905	H6H	SKELETAL MUSCLE RELAXANTS	15	Y	TIZANIDINE HCL 4MG CAPSULES or TABLETS	TIZANIDINE HCL 4MG CAPSULE	ZANAFLEX			6				
86	058906	H6H	SKELETAL MUSCLE RELAXANTS	16	Y	TIZANIDINE HCL 6MG CAPSULE	TIZANIDINE HCL 6MG CAPSULE	ZANAFLEX			4				
87	**87**	**HIC3**	**THERAPEUTIC CLASS**	**0**	**Y**	**STEROIDS, TOPICAL**	**STEROIDS, TOPICAL**	**BRAND**	**Units**	**Until Refill**	**Daily Dose**	**Max Days**	**Refills**	**Pkg Bill**	**Updated**
87	082234	Q5P	STEROIDS, TOPICAL	1	Y	CLOBETASOL/DESLORATADINE 0.05%-MG KIT	CLOBETASOL/DESLORATADINE 0.05%-MG KIT	CLOBETEX	1	150					
87	080288	Q5P	STEROIDS, TOPICAL	2	Y	CLOBETASOL/EMOLLIENT NO.65 0.05% FOAM KIT	CLOBETASOL/EMOLLIENT NO.65 0.05% FOAM KIT	TOVET	355						
87	051810	Q3I	HEMORRHOIDAL PREP,ANTI-INFLAM STEROID/LOCAL ANESTH	3	Y	HYDROCORTISONE AC/LIDOCAINE 0.5-3% CREAM KIT 7GM	HYDROCORTISONE AC/LIDOCAINE 0.5-3% CREAM K	ANAMANTLE HC	98						
87	050288	Q5P	STEROIDS, TOPICAL	4	Y	OLMESARTAN MEDOXOMIL 5 MG TABLET	OLMESARTAN MEDOXOMIL 5 MG TABLET	GENERIC ONLY			1				1/1/2022
87	070318	Q5P	STEROIDS, TOPICAL	5	Y	FLUOCINOLONE/EMOL CMB#65 0.025% CREAM KIT	FLUOCINOLONE/EMOL CMB#65 0.025% CREAM KI	SYNALAR	375	30				Y	
87	070319	Q5P	STEROIDS, TOPICAL	6	Y	FLUOCINOLONE/EMOL CMB#65 0.025% OINTMENT KIT	FLUOCINOLONE/EMOL CMB#65 0.025% OINTMEN	SYNALAR	375	30				Y	
87	007601	Q5P	STEROIDS, TOPICAL	7	Y	FLURANDRENOLIDE 4MCG/SQ CM TAPE	FLURANDRENOLIDE 4MCG/SQ CM TAPE	CORDRAN	1	30					
87	079262	Q5P	STEROIDS, TOPICAL	8	Y	HALOBETASOL PROPIONATE 0.01% LOTION	HALOBETASOL PROPIONATE 0.01% LOTION	BRYHALI			8				
87	079214	Q5P	STEROIDS, TOPICAL	9	Y	HALOBETASOL PROPIONATE 0.05% FOAM	HALOBETASOL PROPIONATE 0.05% FOAM	LEXETTE	50						
87	079688	L5F	ANTIPSORIATICS AGENTS	10	Y	HALOBETASOL PROPIONATE/TAZAROTENE 0.01%-0.045%	HALOBETASOL PROPIONATE/TAZAROTENE 0.01%-0	DUOBRII			8			Y	
87	007599	Q5P	STEROIDS, TOPICAL	11	Y	TRIAMCINOLONE ACETONIDE 0.025% & 0.1% LOTION	TRIAMCINOLONE ACETONIDE 0.025% LOTION	KENALOG	60	30				Y	
87	007600	Q5P	STEROIDS, TOPICAL	12	Y	TRIAMCINOLONE ACETONIDE 0.1% LOTION 60ML	TRIAMCINOLONE ACETONIDE 0.1% LOTION 60ML	GENERIC ONLY	60	30				Y	
87	002599	Q5P	STEROIDS, TOPICAL	13	Y	TRIAMCINOLONE ACETONIDE 0.1% PASTE 5GRAM	TRIAMCINOLONE ACETONIDE 0.1% PASTE 5GRAM	ORALONE	5	30				Y	
87	007598	Q5P	STEROIDS, TOPICAL	14	Y	TRIAMCINOLONE ACETONIDE 0.5% OINTMENT 15GRAM	TRIAMCINOLONE ACETONIDE 0.5% OINTMENT 15G	GENERIC ONLY	15	30				Y	
87	080519	Q5P	STEROIDS, TOPICAL	15	Y	TRIAMCINOLONE/GAUZE/SILICONE 0.1% KIT	TRIAMCINOLONE/GAUZE/SILICONE 0.1% KIT	SILA III	1						
88	**88**	**HIC3**	**THERAPEUTIC CLASS**	**0**	**Y**	**STIMULANTS AND RELATED AGENTS**	**STIMULANTS AND RELATED AGENTS**	**BRAND**	**Units**	**Until Refill**	**Daily Dose**	**Max Days**	**Refills**	**Pkg Bill**	**Updated**
88	075544	J5B	STIMULANTS AND RELATED AGENTS	1	Y	AMPHETAMINE XR ODT TABLETS	AMPHETAMINE XR ODT 3.1 MG TABLET	ADZENYS XR-ODT	30	30	1				
88	062820	H8Q	STIMULANTS AND RELATED AGENTS - NARCOLEPSY	2	Y	ARMODAFINIL TABLETS	ARMODAFINIL 50MG TABLET	NUVIGIL	30	30	1				
88	051489	H7Y	STIMULANTS AND RELATED AGENTS - ADHD	3	Y	ATOMOXETINE HCL 10, 18, 25, 40MG CAPSULES	ATOMOXETINE HCL 10MG CAPSULE	STRATTERA			2				
88	051493	H7Y	STIMULANTS AND RELATED AGENTS - ADHD	4	Y	ATOMOXETINE HCL 60, 80, 100MG CAPSULES	ATOMOXETINE HCL 60MG CAPSULE	STRATTERA			1				
88	066895	H8M	STIMULANTS AND RELATED AGENTS - ADHD	5	Y	CLONIDINE HCL 0.1MG TABLET	CLONIDINE HCL 0.1MG TABLET	KAPVAY ER			4				
88	048982	H2V	STIMULANTS AND RELATED AGENTS - ADHD	6	Y	DEXMETHYLPHENIDATE HCL TABLETS	DEXMETHYLPHENIDATE HCL 2.5MG TABLET	FOCALIN			3				
88	072017	H7X	ANTIPSYCHOTICS, ATYP, D2 PARTIAL AGONIST/5HT MIXED	7	Y	ARMODAFINIL 200 MG TABLET	ARMODAFINIL 200 MG TABLET	NUVIGIL	30	30	1				
88	059190	H2V	STIMULANTS AND RELATED AGENTS - ADHD	7	Y	DEXMETHYLPHENIDATE HCL CAPSULES	DEXMETHYLPHENIDATE HCL 5MG CAPSULE	FOCALIN XR			1				
88	004999	J5B	STIMULANTS AND RELATED AGENTS - ADHD	8	Y	DEXTROAMPHETAMINE TABLETS	DEXTROAMPHETAMINE 5MG TABLET	ADDERALL			3				
88	005007	J5B	STIMULANTS AND RELATED AGENTS - ADHD	9	Y	DEXTROAMPHETAMINE ER CAPSULES	DEXTROAMPHETAMINE ER 5MG CAPSULE	DEXEDRINE			2				
88	047131	J5B	STIMULANTS AND RELATED AGENTS - ADHD	10	Y	DEXTROAMPHETAMINE/AMPHETAMINE IR TABLETS	DEXTROAMPHETAMINE/AMPHETAMINE 7.5MG TA	ADDERALL			3				
88	050428	J5B	STIMULANTS AND RELATED AGENTS - ADHD	11	Y	DEXTROAMPHETAMINE/AMPHETAMINE XR CAPSULES ALI	DEXTROAMPHETAMINE/AMPHETAMINE 5MG CAPS	ADDERALL XR			1				
88	071048	J5B	STIMULANTS AND RELATED AGENTS - ADHD	12	Y	DEXTROAMPHETAMINE SULFATE TABLETS	DEXTROAMPHETAMINE SULFATE 2.5MG TABLET	ZENZEDI			4				
88	064090	J5B	STIMULANTS AND RELATED AGENTS - ADHD	13	Y	DEXTROAMPHETAMINE SULFATE 5MG/5ML ORAL SOLUTI	DEXTROAMPHETAMINE SULFATE 5MG/5ML ORAL S	PROCENTRA			60				
88	065570	H8M	STIMULANTS AND RELATED AGENTS - ADHD	14	Y	GUANFACINE HCL ER TABLETS	GUANFACINE HCL 1MG TABLET	INTUNIV			1				
88	000364	A4B	STIMULANTS AND RELATED AGENTS - ADHD	15	Y	GUANFACINE HCL IR TABLETS	GUANFACINE HCL 1MG TABLET	TENEX			4				
88	063645	J5B	STIMULANTS AND RELATED AGENTS - ADHD	16	Y	LISDEXAMFETAMINE DIMESYLATE CAPSULES AND TABLET	LISDEXAMFETAMINE DIMESYLATE 20MG CAPSULE	VYVANSE			1				
88	077083	J5B	STIMULANTS AND RELATED AGENTS - ADHD	17	Y	LISDEXAMFETAMINE DIMESYLATE 10 MG CHEWABLE TAB	LISDEXAMFETAMINE DIMESYLATE 10 MG CHEWAB	VYVANSE			1				
88	005014	J5B	STIMULANTS AND RELATED AGENTS	18	Y	METHAMPHETAMINE HCL 5MG TABLET	METHAMPHETAMINE HCL 5MG TABLET	DESOXYN			5				
88	077494	H2V	STIMULANTS AND RELATED AGENTS	19	Y	METHYLPHENIDATE 8.6 MG TABLET	METHYLPHENIDATE 8.6 MG TABLET	COTEMPLA XR-ODT			1				
88	077495	H2V	STIMULANTS AND RELATED AGENTS	20	Y	METHYLPHENIDATE 17.3 AND 25.9 MG TABLET	METHYLPHENIDATE 17.3 MG TABLET	COTEMPLA XR-ODT			2				
88	078038	H2V	STIMULANTS AND RELATED AGENTS	21	Y	METHYLPHENIDATE HCL ER 72 MG TAB	METHYLPHENIDATE HCL ER 72 MG TAB	RELEXXII			1				
88	045981	H2V	STIMULANTS AND RELATED AGENTS	22	Y	METHYLPHENIDATE HCL TABLETS	METHYLPHENIDATE HCL 18MG TABLET	CONCERTA			1				
88	060615	H2V	STIMULANTS AND RELATED AGENTS	23	Y	METHYLPHENIDATE 10MG, 15MG, 20MG or 30MG/9HR P	METHYLPHENIDATE 10MG/9HR PATCH	DAYTRANA			1				
88	053056	H2V	STIMULANTS AND RELATED AGENTS	24	Y	METHYLPHENIDATE HCL CD 10, 20, 30MG CAPSULE	METHYLPHENIDATE HCL CD 10MG CAPSULE	METADATE			1				
88	060545	H2V	STIMULANTS AND RELATED AGENTS	25	Y	METHYLPHENIDATE CD 40, 50, 60MG CAPSULE	METHYLPHENIDATE CD 40MG CAPSULE	METADATE CD			1				
88	054676	H2V	STIMULANTS AND RELATED AGENTS	26	Y	METHYLPHENIDATE HCL 2.5, 5MG CHEWABLE TABLET	METHYLPHENIDATE HCL 2.5MG CHEWABLE TABLET	METHYLIN			3				
88	054678	H2V	STIMULANTS AND RELATED AGENTS	27	Y	METHYLPHENIDATE HCL 10MG CHEWABLE TABLET	METHYLPHENIDATE HCL 10MG CHEWABLE TABLET	METHYLIN			6				
88	054680	H2V	STIMULANTS AND RELATED AGENTS	28	Y	METHYLPHENIDATE HCL 10MG/5ML SOLUTION	METHYLPHENIDATE HCL 10MG/5ML SOLUTION	METHYLIN			30				
88	054679	H2V	STIMULANTS AND RELATED AGENTS	29	Y	METHYLPHENIDATE HCL 5MG/5ML SOLUTION	METHYLPHENIDATE HCL 5MG/5ML SOLUTION	METHYLIN			60				
88	044072	H2V	STIMULANTS AND RELATED AGENTS	30	Y	METHYLPHENIDATE HCL 10MG TABLET	METHYLPHENIDATE HCL 10MG TABLET	METHYLIN ER			1				
88	004028	H2V	STIMULANTS AND RELATED AGENTS	31	Y	METHYLPHENIDATE 5, 10, 20MG TABLET	METHYLPHENIDATE 5MG TABLET	RITALIN			3				
88	053974	H2V	STIMULANTS AND RELATED AGENTS	32	Y	METHYLPHENIDATE HCL 10, 20, 40MG CAPSULE	METHYLPHENIDATE HCL 10MG CAPSULE	RITALIN LA			1				
88	053060	H2V	STIMULANTS AND RELATED AGENTS	33	Y	METHYLPHENIDATE HCL 30MG CAPSULE	METHYLPHENIDATE HCL 30MG CAPSULE	RITALIN LA			2				
88	072092	H2V	STIMULANTS AND RELATED AGENTS	34	Y	METHYLPHENIDATE HCL LA 60 MG CAPSULE	METHYLPHENIDATE HCL LA 60 MG CAP	RITALIN LA			1				
88	004029	H2V	STIMULANTS AND RELATED AGENTS	35	Y	METHYLPHENIDATE ER 20MG TABLET	METHYLPHENIDATE ER 20MG TABLET	RITALIN SR			3				
88	078094	H2V	STIMULANTS AND RELATED AGENTS	36	Y	METHYLPHENIDATE HCL XR CAPSULES	METHYLPHENIDATE HCL XR 25MG CAPSULE	ADHANSIA XR			1				
88	025848	H8Q	STIMULANTS AND RELATED AGENTS - NARCOLEPSY	37	Y	MODAFINIL TABLETS	MODAFINIL 100MG TABLET	PROVIGIL			1				
88	079458	H1G	NARCOLEPSY TX-H3-RECEPT.ANTAGONIST/INVERSE AGONIST	38	Y	PITOLISANT HCL TABLETS	PITOLISANT HCL 17.8 MG TABLET	WAKIX			2				
88	082022	H2V	STIMULANTS AND RELATED AGENTS	39	Y	SERDEXMETHYLPHEN/DEXMETHYLPHEN CAPSULES	SERDEXMETHYLPHEN/DEXMETHYLPHEN 26.1 MG-(	AZSTARYS			1				

88	082132	H7Y	STIMULANTS AND RELATED AGENTS - ADHD	40	Y	VILOXAZINE HCL 100 MG CAPSULE	VILOXAZINE HCL 100 MG CAPSULE	QELBREE ER			1				
88	082134	H7Y	STIMULANTS AND RELATED AGENTS - ADHD	41	Y	VILOXAZINE HCL 150 AND 200MG CAPSULES	VILOXAZINE HCL 150 MG CAPSULE	QELBREE ER			2				
89	89	HIC3	THERAPEUTIC CLASS	0	Y	TETRACYCLINES	TETRACYCLINES	BRAND	Units	Until Refill	Daily Dose	Max Days	Refills	Pkg Bill	Updated
89	060942	W1C	TETRACYCLINES	1	Y	DOXYCYCLINE MONOHYDRATE CAPSULES or TABLETS	DOXYCYCLINE MONOHYDRATE 40MG CAPSULE	ADOXA / ORACEA			1				
89	060730	W1C	TETRACYCLINES	2	Y	MINOCYCLINE HCL ER TABLETS	MINOCYCLINE HCL ER 45MG TABLET	SOLODYN			1				
89	079079	W1C	TETRACYCLINES	3	Y	SARECYCLINE HCL TABLETS	SARECYCLINE HCL 100MG TABLET	SEYSARA			1				
90	90	HIC3	THERAPEUTIC CLASS	0	Y	ULCERATIVE COLITIS AGENTS	ULCERATIVE COLITIS AGENTS	BRAND	Units	Until Refill	Daily Dose	Max Days	Refills	Pkg Bill	Updated
90	064701	D6F	ULCERATIVE COLITIS AGENTS	1	Y	MESALAMINE 0.375GRAM CAPSULE	MESALAMINE 0.375GRAM CAPSULE	APRISO			4				
90	062058	D6F	ULCERATIVE COLITIS AGENTS	2	Y	MESALAMINE 1.2GM TABLET	MESALAMINE 1.2GM TABLET	LIALDA			4				
90	019863	D6F	ULCERATIVE COLITIS AGENTS	3	Y	MESALAMINE 250MG CAPSULE	MESALAMINE 250MG CAPSULE	PENTASA			16				
90	058091	D6F	ULCERATIVE COLITIS AGENTS	4	Y	MESALAMINE 500MG CAPSULE	MESALAMINE 500MG CAPSULE	PENTASA			8				
90	053882	D6F	ULCERATIVE COLITIS AGENTS	5	Y	MESALAMINE DR 800MG TABLET	MESALAMINE DR 800MG TABLET	ASACOL			6				
90	004444	Q3E	ULCERATIVE COLITIS AGENTS	6	Y	MESALAMINE 4GM/60ML ENEMA	MESALAMINE 4GM/60ML ENEMA	SFROWASA			60			Y	
90	064139	Q3E	ULCERATIVE COLITIS AGENTS	7	Y	MESALAMINE W/CLEANSING WIPES	MESALAMINE W/CLEANSING WIPES KIT	ROWASA	1	28					
90	076143	D6F	ULCERATIVE COLITIS AGENTS	8	Y	MESALAMINE 400 MG CAPSULE	MESALAMINE 400 MG CAPSULE	DELZICOL	180	30	6				
92	92	HIC3	THERAPEUTIC CLASS	0	Y	DIABETIC SUPPLIES	DIABETIC SUPPLIES	BRAND	Units	Until Refill	Daily Dose	Max Days	Refills	Pkg Bill	Updated
92	006373	M4A	DIABETIC SUPPLIES	1	Y	BLOOD SUGAR DIAGNOSTIC TEST STRIPS	BLOOD SUGAR DIAGNOSTIC TEST STRIPS	TEST STRIPS	153	30				Y	
92	049233	X2A	DIABETIC SUPPLIES	2	Y	INSULIN NEEDLES	NEEDLES, INSULIN DISPOSABLE 29GAUGE	NEEDLES	153	30				Y	
92	011186	Y3A	DIABETIC SUPPLIES	3	Y	LANCETS - ALL GAUGES	LANCETS 100 or 200 PAK	LANCETA	153	30				Y	
92	080413	X2A	DIABETIC SUPPLIES	4	Y	PEN NEEDLE, DIABETIC 30GX3/16"	PEN NEEDLE, DIABETIC 30GX3/16"	UNIFINE PENTIPS MAX	100	30					
92	081925	X2A	DIABETIC SUPPLIES	4	Y	PEN NEEDLE, DIABETIC 31G 6MM	PEN NEEDLE, DIABETIC 31G 6MM	PEN NEEDLE, DIABETIC 31G 6MI	100	30					
92	080274	X2B	DIABETIC SUPPLIES	4	Y	SYRINGE-NEEDLE,INSULIN, 0.5 ML 32GX5/16"	SYRINGE-NEEDLE,INSULIN, 0.5 ML 32GX5/16"	EASY COMFORT	100	30					
92	080415	X2B	DIABETIC SUPPLIES	4	Y	SYRINGE-NEEDLE,INSULIN, 1 ML 32GX5/16"	SYRINGE-NEEDLE,INSULIN, 1 ML 32GX5/16"	EASY COMFORT	100	30					
92	068529	Y9A	DIABETIC SUPPLIES	5	Y	SUB-Q INSULIN DEVICES	SUB-Q INSULIN DEVICE, 20 UNIT	VGO	30	30	1			Y	
92	008321	R3W	DIABETIC SUPPLIES	6	Y	URINE ACETONE TEST STRIPS	URINE ACETONE TEST STRIPS	KETOSTIX REAGENT STRIP	100					Y	
93	93	HIC3	THERAPEUTIC CLASS	0	Y	VACCINES	VACCINES	BRAND	Units	Until Refill	Daily Dose	Max Days	Refills	Pkg Bill	Updated
93	059079	W7Z	VACCINES	1	Y	TOXOID PREPARATIONS,COMBINATIONS	DIPHTH,PERTUSS(ACELL),TET VAC	BOOSTRIX	0.5	365					
93	063830	W7Q	GRAM NEGATIVE COCCI VACCINES	2	Y	MENING VAC A,C,Y,W-135 dip/PF	MENING VAC A,C,Y,W-135 dip/PF	MENACTRA	0.5						
93	071917	W7Q	GRAM NEGATIVE COCCI VACCINES	3	Y	MENINGOCOCCAL B VACCINE,4-COMP	MENINGOCOCCAL B VACCINE,4-COMP	BEXSERO	0.5						
93	048548	W7L	VACCINES	4	Y	PNEUMOCOCCAL 23-VAL P-SAC VACCINE 25MCG/0.5ML V	PNEUMOCOCCAL 23-VAL P-SAC VACCINE 25MCG/0	PNEUMOVAX	0.5	365					
93	066068	W7L	VACCINES	5	Y	PNEUMOC 13-VAL CONJ-DIP CRM/PF	PNEUMOC 13-VAL CONJ-DIP CRM/PF	GENERIC ONLY	0.5	999					
93	082386	W7L	VACCINES	6	Y	PNEUMOC 20-VAL CONJ-DIP CRM/PF SYRINGE	PNEUMOC 20-VAL CONJ-DIP CRM/PF SYRINGE	PREVNAR 20	0.5	999					1/1/2022
93	077849	W7B	VACCINES	7	Y	VARICELLA-ZOSTER GE VAC,2 OF 2 ANTIGEN COMPONENT	VARICELLA-ZOSTER GE VAC,2 OF 2 ANTIGEN COMP	SHINGRIX GE	1						
93	077837	W7B	VACCINES	8	Y	VARICELLA-ZOSTER Ge/AS01B/PF VIAL KIT	VARICELLA-ZOSTER Ge/AS01B/PF VIAL KIT	SHINGRIX VIAL KIT	1						
94	081748	Z0L	COVID-19 VACCINES	1	Y	ASTRAZENECA COVID-19 VACCINE	COVID-19 VAC,AZD1222(ASTRA)/PF	ASTRAZENECA COVID-19 VACCINE			0.5	1			1/1/2022
94	081779	Z0L	COVID-19 VACCINES	2	Y	JANSSEN COVID-19 VACCINE	COVID-19 VAC,AD26(JANSSEN)/PF	JANSSEN COVID-19 VACCINE			0.5	1			1/1/2022
94	081647	Z0L	COVID-19 VACCINES	3	Y	MODERNA COVID-19 VACCINE	COVID-19 VACC,MRNA(MODERNA)/PF	MODERNA COVID-19 VACCINE			0.5	1			1/1/2022
94	081648	Z0L	COVID-19 VACCINES	4	Y	PFIZER COVID-19 VACCINE	COVID-19 VACC, MRNA(PFIZER)/PF	PFIZER COVID-19 VACCINE			0.3	1			1/1/2022
94	082920	W0L	ANTIVIRAL - RNA POLYMERASE INHIBITOR	5	Y	MOLNUPIRAVIR 200 MG CAP (EUA)	MOLNUPIRAVIR 200 MG CAP (EUA)	GENERIC ONLY	40		8	5			1/1/2022
94	082939	W0M	ANTIVIRAL - MAIN PROTEASE (MPRO) INHIBITOR	6	Y	NIRMATRELVIR/RITONAVIR PAXLOVID CO-PACK (EUA)	NIRMATRELVIR/RITONAVIR PAXLOVID CO-PACK (EU	PAXLOVID CO-PACK	30		6	5			1/1/2022
94	082671	Z0L	COVID-19 VACCINES	7	Y	PFIZER COVID (12Y UP) VAC-GRAY	PFIZER COVID (12Y UP) VAC-GRAY	GENERIC ONLY			0.3	1			1/1/2022
94	082650	Z0L	COVID-19 VACCINES	8	Y	PFIZER COVID (5-11Y) VAC-ORANG	PFIZER COVID (5-11Y) VAC-ORANG	GENERIC ONLY			0.2	1			1/1/2022
95	95	HIC3	THERAPEUTIC CLASS	0	Y	CONTRACEPTIVES	CONTRACEPTIVES	BRAND	Units	Until Refill	Daily Dose	Max Days	Refills	Pkg Bill	Updated
95	079800	G8A	CONTRACEPTIVES	1	Y	DROSPIRENONE 4MG TABLET	DROSPIRENONE 4MG TABLET	SLYND			1				
95	050464	G9B	CONTRACEPTIVES	2	Y	VAGINAL RING	ETONOGESTREL/ETHINYL ESTRADIOL VAGINAL RIN	NUVARING	1	28					
95	003314	G8A	CONTRACEPTIVES	3	Y	LEVONORGESTREL ESTRADIOL TABLETS	LEVONORGESTREL-ETH ESTRADIOL 0.15-0.3MG TA	MULTIPLE OPTIONS			1			Y	
95	070814	G8A	CONTRACEPTIVES	4	Y	LEVONORGEST/E.ESTRADIOL-E.EXTRAD	LEVONORGEST/E.ESTRADIOL-E.EXTRAD	RIVELSA	91		1	91		Y	
95	078077	G8A	CONTRACEPTIVES	5	Y	LEVONORGEST/ETH.ESTRADIOL/IRON 0.1-0.2MG BLISTER	LEVONORGEST/ETH.ESTRADIOL/IRON 0.1-0.2MG B	BALCOLTRA			1				
95	017584	G8C	CONTRACEPTIVES	6	Y	MEDROXYPROGESTERONE ACETATE 150 MG/ML VIAL ANI	MEDROXYPROGESTERONE ACETATE 150 MG/ML VI	DEPO-PROVERA	1	90		90			
95	058938	G8C	CONTRACEPTIVES	7	Y	MEDROXYPROGESTERONE ACETATE 104 MG/0.65 ML SYR	MEDROXYPROGESTERONE ACETATE 104 MG/0.65 I	DEPO-SUBQ PROVERA SYRINGE	0.65	90		90		Y	
95	049828	G8F	CONTRACEPTIVES	8	Y	NORELGESTROMIN/ETHIN.ESTRADIOL PATCH	NORELGESTROMIN/ETHIN.ESTRADIOL PATCH	XULANE	3	30					
95	078751	G9B	CONTRACEPTIVES	9	Y	SEGESTERONE AC/ETHIN ESTRADIOL VAGINAL RINGS	SEGESTERONE AC/ETHIN ESTRADIOL VAGINAL RIN	ANNOVERA VAGINAL RING	1	365		365			
95	065578	G8A	CONTRACEPTIVES	10	Y	ULIPRISTAL ACETATE 30MG TABLET	ULIPRISTAL ACETATE 30MG TABLET	ELLA	1						
96	96	HIC3	THERAPEUTIC CLASS	0	Y	ESTROGEN	ESTROGEN	BRAND	Units	Until Refill	Daily Dose	Max Days	Refills	Pkg Bill	Updated
96	003202	G1A	ESTROGEN	1	Y	ESTRADIOL PATCH	ESTRADIOL 0.05 MG PATCH	COMBIPATCH / VIVELLE-DOT	8	30				Y	
96	022472	G1A	ESTROGEN	2	Y	ESTRADIOL 2 MG VAGINAL RING	ESTRADIOL 2 MG VAGINAL RING	ESTRING				90		Y	
96	023471	G1A	ESTROGEN	3	Y	ESTRADIOL DAILY PATCH	ESTRADIOL 0.1 MG/DAY PATCH	CLIMARA / MENOSTAR	4	30				Y	
96	062784	G1A	ESTROGEN	4	Y	ESTRADIOL GEL PACKETS	ESTRADIOL 0.25 MG GEL PACKET	DIVIGEL			1				
96	052093	Q4K	ESTROGEN	5	Y	ESTRADIOL ACETATE VAGINAL RINGS	ESTRADIOL ACETATE 0.05 MG/DAY VAGINAL RING	FEMRING	1	90		90		Y	
96	053383	G1A	ESTROGEN	6	Y	ESTRADIOL LEVONORGESTREL PATCH	ESTRADIOL LEVONORGESTREL PATCH	CLIMARA PRO	4	30				Y	
96	062960	G1A	ESTROGEN	7	Y	ESTRADIOL 1.53 MG/SPRAY	ESTRADIOL 1.53 MG/SPRAY	EVAMIST				56		Y	
96	070705	G1E	MENOPAUSAL SYMPT SUPP-SEL ESTROGEN RECEP MODULATOR	8	Y	OSPEMIFENE 60MG TABLET	OSPEMIFENE 60MG TABLET	OSPHENA			1				
96	044337	G1A	ESTROGEN	9	Y	NORETHINDRONE AC-ETH ESTRADIOL1 MG-5 MCG TABLE	NORETHINDRONE AC-ETH ESTRADIOL1 MG-5 MCG	JINTELI, FYAVOLV			1				
97	97	HIC3	THERAPEUTIC CLASS	0	Y	ONCOLOGY CLASS	ONCOLOGY CLASS	BRAND	Units	Until Refill	Daily Dose	Max Days	Refills	Pkg Bill	Updated
97	077779	V1Q	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS	1	Y	ABEMACICLIB TABLETS	ABEMACICLIB 50MG TABLET	VERZENIO			2				
97	078461	V1J	ANTINEOPLASTIC - ANTIANDROGENIC AGENTS	2	Y	ABIRATERONE ACET, SUBMICRONIZED 125MG TABLET	ABIRATERONE ACET, SUBMICRONIZED 125MG TAB	YONSA			4				
97	067349	V1J	ANTINEOPLASTIC - ANTIANDROGENIC AGENTS	3	Y	ABIRATERONE ACETATE 250MG TABLET	ABIRATERONE ACETATE 250MG TABLET	ZYTIGA			4				
97	077249	V1J	ANTINEOPLASTIC - ANTIANDROGENIC AGENTS	4	Y	ABIRATERONE ACETATE 500MG TABLET	ABIRATERONE ACETATE 500MG TABLET	ZYTIGA			2				
97	077883	V1Q	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS	5	Y	ACALABRUTINIB 100MG CAPSULE	ACALABRUTINIB 100MG CAPSULE	CALQUENCE			2				
97	079314	V3M	ANTINEOPLASTIC - HEDGEHOG PATHWAY INHIBITOR	5	Y	GLASDEGIB MALEATE 100MG TABLET	GLASDEGIB MALEATE 100MG TABLET	DAURISMO			1				
97	071229	V1Q	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS	6	Y	AFATINIB DIMALEATE TABLETS	AFATINIB DIMALEATE 20MG TABLET	GILOTRIF			1				
97	075271	V1Q	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS	7	Y	ALECTINIB 150 MG CAPSULE	ALECTINIB 150 MG CAPSULE	ALECENSA			8				
97	079791	V1Q	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS	8	Y	ALPELISIB 200MG DAILY DOSE	ALPELISIB 200MG DAILY DOSE	PIQRAY			1				
97	079790	V1Q	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS	9	Y	ALPELISIB 250MG , 300MG DAILY DOSE	ALPELISIB 250MG DAILY DOSE	PIQRAY			2				
97	024515	V3F	ANTINEOPLASTIC - AROMATASE INHIBITORS	10	Y	ANASTROZOLE 1 MG TABLET	ANASTROZOLE 1 MG TABLET	ARIMIDEX			1				
97	078163	V1J	ANTINEOPLASTIC - ANTIANDROGENIC AGENTS	11	Y	APALUTAMIDE 60 MG TABLET	APALUTAMIDE 60 MG TABLET	ERLEADA			4				
97	082783	V1Q	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS	11.5	Y	ASCIMINIB HYDROCHLORIDE 20 MG TABLET	ASCIMINIB HYDROCHLORIDE 20 MG TABLET	SCEMBLIX			20				1/1/2022

97	082784	V1Q	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS	11.6	Y	ASCIMINIB HYDROCHLORIDE 40 MG TABLET	ASCIMINIB HYDROCHLORIDE 40 MG TABLET	SCEMBLIX			10				1/1/2022
97	080619	V1Q	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS	12	Y	AVAPRITINIB TABLETS	AVAPRITINIB 100 MG TABLET	AYVAKIT			1				
97	068497	V1Q	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS	13	Y	AXITINIB 1 MG TABLET	AXITINIB 1 MG TABLET	INLYTA			2				
97	068498	V1Q	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS	14	Y	AXITINIB 5 MG TABLET	AXITINIB 5 MG TABLET	INLYTA			4				
97	081435	V1B	ANTINEOPLASTIC - ANTIMETABOLITES	15	Y	AZACITIDINE TABLETS	AZACITIDINE 200 MG TABLET	ONUREG	14	30	1	28			
97	082589	V16	ANTINEOPLASTIC-HYPOXIA INDUCIBLE FACTOR (HIF) INH	15.5	Y	BELZUTIFAN 40 MG TABLET	BELZUTIFAN 40 MG TABLET	WELIREG			3				1/1/2022
97	024153	V1J	ANTINEOPLASTIC - ANTIANDROGENIC AGENTS	16	Y	BICALUTAMIDE 50 MG TABLET	BICALUTAMIDE 50 MG TABLET	CASODEX			3				
97	078575	V3U	ANTINEOPLASTIC - MEK1 AND MEK2 KINASE INHIBITORS	17	Y	BINIMETINIB 15 MG TABLET	BINIMETINIB 15 MG TABLET	MEKTOVI			6				
97	077342	V1Q	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS	18	Y	BRIGATINIB 30 MG TABLET	BRIGATINIB 30 MG TABLET	ALUNBRIG			2				
97	077343	V1Q	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS	19	Y	BRIGATINIB 90 & 180 MG TABLET and TABLET PACK	BRIGATINIB 90 MG TABLET	ALUNBRIG			1				
97	069928	V1Q	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS	20	Y	BOSUTINIB 100MG TABLET	BOSUTINIB 100MG TABLET	BOSULIF			4				
97	077984	V1Q	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS	21	Y	BOSUTINIB 400 and 500MG TABLET	BOSUTINIB 400 MG TABLET	BOSULIF			1				
97	075944	V1Q	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS	22	Y	CABOZANTINIB S-MALATE TABLETS	CABOZANTINIB S-MALATE 20 MG TABLET	CABOMETYX	30	30	1				
97	070388	V1Q	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS	23	Y	CABOZANTINIB S-MALATE 60 MG DAILY-DOSE PK	CABOZANTINIB S-MALATE 60 MG DAILY-DOSE PK	COMETRIQ	84		3			Y	
97	070387	V1Q	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS	24	Y	CABOZANTINIB S-MALATE 100 MG DAILY-DOSE PK	CABOZANTINIB S-MALATE 100 MG DAILY-DOSE PK	COMETRIQ	56		2			Y	
97	070386	V1Q	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS	25	Y	CABOZANTINIB S-MALATE 140 MG DAILY DOSE PACK	CABOZANTINIB S-MALATE 140 MG DAILY DOSE PAC	COMETRIQ	112		4			Y	
97	081014	V1Q	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS	26	Y	CAPMATINIB HYDROCHLORIDE TABLETS	CAPMATINIB HYDROCHLORIDE 150 MG TABLET	TABRECTA			4				
97	079002	V3R	ANTINEOPLASTIC,ANTI-PROGRAMMED DEATH-1 (PD-1) MAB	27	Y	CEMIPLIMAB-RWLC 350MG/7ML VIAL	CEMIPLIMAB-RWLC 350MG/7ML VIAL	LIBTAYO	7		0.34			Y	
97	072296	V1Q	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS	28	Y	CERITINIB 150 MG CAPSULE & TABLET	CERITINIB 150 MG CAPSULE	ZYKADIA			1				
97	075138	V3U	ANTINEOPLASTIC - MEK1 AND MEK2 KINASE INHIBITORS	29	Y	COBIMETINIB FUMARATE 20 MG TABLET	COBIMETINIB FUMARATE 20 MG TABLET	COTELLIC			3				
97	067824	V1Q	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS	30	Y	CRIZOTINIB CAPSULES	CRIZOTINIB 200MG CAPSULE	XALKORI			2				
97	071488	V1A	ANTINEOPLASTIC - ALKYLATING AGENTS	31	Y	CYCLOPHOSPHAMIDE 25 MG CAPSULE & TABLET	CYCLOPHOSPHAMIDE 25 MG CAPSULE	GENERIC ONLY			1				
97	071033	V37	ANTINEOPLASTIC - BRAF KINASE INHIBITORS	32	Y	DABRAFENIB MESYLATE CAPSULES	DABRAFENIB MESYLATE 50MG CAPSULE	TAFINLAR	120	30	4				1/1/2022
97	078998	V1Q	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS	34	Y	DACOMITINIB TABLETS	DACOMITINIB 15MG TABLET	VIZIMPRO			1				
97	061100	V1Q	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS	35	Y	DASATINIB 50,75,80,100,140MG TABLET	DASATINIB 50MG TABLET	SPRYCEL			1				
97	061099	V1Q	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS	36	Y	DASATINIB 20MG TABLET	DASATINIB 20MG TABLET	SPRYCEL			2				
97	080069	V1J	ANTINEOPLASTIC - ANTIANDROGENIC AGENTS	37	Y	DAROLUTAMIDE 300 MG TABLET	DAROLUTAMIDE 300 MG TABLET	NUBEQA			4				
97	081267	V1B	ANTINEOPLASTIC - ANTIMETABOLITES	38	Y	DECITABINE/CEDAZURIDINE 35 MG-100 MG TABLET	DECITABINE/CEDAZURIDINE 35 MG-100 MG TABLE	INQOVI	5	30	1				
97	078971	V1Q	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS	39	Y	DUVELISIB CAPSULES	DUVELISIB 15MG CAPSULE	COPIKTRA			2				
97	077629	V32	ANTINEOPLASTIC-ISOCITRATE DEHYDROGENASE INH	40	Y	ENASIDENIB MESYLATE TABLETS	ENASIDENIB MESYLATE 50 MG TABLET	IDHIFA			1				
97	069918	V1J	ANTINEOPLASTIC - ANTIANDROGENIC AGENTS	41	Y	ENZALUTAMIDE 40MG CAPSULE / TABLET	ENZALUTAMIDE 40 MG CAPSULE	XTANDI			4				
97	078573	V37	ANTINEOPLASTIC - BRAF KINASE INHIBITORS	42	Y	ENCORAFENIB 50 MG CAPSULE	ENCORAFENIB 50 MG CAPSULE	BRAFTOVI			9				
97	078574	V37	ANTINEOPLASTIC - BRAF KINASE INHIBITORS	43	Y	ENCORAFENIB 75 MG CAPSULE	ENCORAFENIB 75 MG CAPSULE	BRAFTOVI			6				
97	081367	V1J	ANTINEOPLASTIC - ANTIANDROGENIC AGENTS	44	Y	ENZALUTAMIDE 80 MG TABLET	ENZALUTAMIDE 80 MG TABLET	XTANDI			2				
97	080120	V1Q	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS	45	Y	ENTRECTINIB 200 MG CAPSULE	ENTRECTINIB 200 MG CAPSULE	ROZLYTREK			3				
97	079650	V1Q	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS	46	Y	ERDAFITINIB 3MG TABLET	ERDAFITINIB 3MG TABLET	BALVERSA			3				
97	079651	V1Q	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS	47	Y	ERDAFITINIB 4MG TABLET	ERDAFITINIB 4MG TABLET	BALVERSA			2				
97	079652	V1Q	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS	48	Y	ERDAFITINIB 5MG TABLET	ERDAFITINIB 5MG TABLET	BALVERSA			1				
97	058376	V1Q	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS	49	Y	ERLOTINIB HCL 25MG TABLET	ERLOTINIB HCL 25MG TABLET	TARCEVA			3				
97	058375	V1Q	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS	50	Y	ERLOTINIB HCL 100,150MG TABLET	ERLOTINIB HCL 100MG TABLET	TARCEVA			1				
97	070919	V3C	ANTINEOPLASTIC - MTOR KINASE INHIBITORS	51	Y	EVEROLIMUS TABLETS and DISPERZ TABLETS	EVEROLIMUS 2 MG TABLET	AFINITOR DISPERZ			1			Y	
97	044186	V3F	ANTINEOPLASTIC - AROMATASE INHIBITORS	52	Y	EXEMESTANE 25 MG TABLET	EXEMESTANE 25 MG TABLET	AROMASIN			1				
97	080122	V1Q	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS	53	Y	FEDRATINIB DIHYDROCHLORIDE 100 MG CAPSULE	FEDRATINIB DIHYDROCHLORIDE 100 MG CAPSULE	INREBIC			4				
97	052086	V1Q	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS	54	Y	GEFITINIB 250 MG TABLET	GEFITINIB 250 MG TABLET	IRESSA			1				
97	079318	V1Q	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS	55	Y	GILTERITINIB FUMARATE 40MG TABLET	GILTERITINIB FUMARATE 40MG TABLET	XOSPATA			3				
97	079313	V3M	ANTINEOPLASTIC - HEDGEHOG PATHWAY INHIBITOR	56	Y	GLASDEGIB MALEATE 25MG TABLET	GLASDEGIB MALEATE 25MG TABLET	DAURISMO			2				
97	071674	V1Q	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS	57	Y	IBRUTINIB CAPSULES AND TABLETS	IBRUTINIB 140 MG CAPSULE	IMBRUVICA			1				
97	072610	V1Q	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS	58	Y	IDELALISIB TABLETS	IDELALISIB 100MG TABLET	ZYDELIG			2				
97	052712	V1Q	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS	59	Y	IMATINIB MESYLATE 100MG TABLET	IMATINIB MESYLATE 100MG TABLET	GLEEVEC			3				
97	052711	V1Q	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS	60	Y	IMATINIB MESYLATE 400MG TABLET	IMATINIB MESYLATE 400MG TABLET	GLEEVEC			2				
97	082326	V1Q	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS	60.5	Y	INFIGRATINIB PHOSPHATE DAILY DOSE PACKS	INFIGRATINIB PHOSPHATE 100 MG DAILY DOSE PAC	TRUSELTIQ	21	30					1/1/2022
97	078649	V32	ANTINEOPLASTIC-ISOCITRATE DEHYDROGENASE INH	61	Y	IVOSIDENIB 250 MG TABLET	IVOSIDENIB 250 MG TABLET	TIBSOVO			2				
97	075185	V1Q	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS	62	Y	IXAZOMIB CITRATE CAPSULES	IXAZOMIB CITRATE 2.3 MG CAPSULE	NINLARO	3	28	0.11			Y	
97	062364	V1Q	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS	63	Y	LAPATINIB DITOSYLATE 250MG TABLET	LAPATINIB DITOSYLATE 250MG TABLET	TYKERB			6				
97	079310	V1Q	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS	64	Y	LAROTRECTINIB SULFATE 100MG CAPSULE	LAROTRECTINIB SULFATE 100MG CAPSULE	VITRAKVI			2				
97	079308	V1Q	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS	65	Y	LAROTRECTINIB SULFATE 20MG/ML SOLUTION	LAROTRECTINIB SULFATE 20MG/ML SOLUTION	VITRAKVI			10				
97	079309	V1Q	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS	66	Y	LAROTRECTINIB SULFATE 25MG CAPSULE	LAROTRECTINIB SULFATE 25MG CAPSULE	VITRAKVI			6				
97	068980	V1M	ANTINEOPLASTIC IMMUNOMODULATOR AGENTS	67	Y	LENALIDOMIDE 2.5, 5, 10 ,15, 20MG CAPSULES	LENALIDOMIDE 2.5MG CAPSULE	REVLIMID			1				
97	061114	V1M	ANTINEOPLASTIC IMMUNOMODULATOR AGENTS	68	Y	LENALIDOMIDE 25MG CAPSULE	LENALIDOMIDE 25MG CAPSULE	REVLIMID	25	28	1	28			
97	074284	V1Q	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS	69	Y	LENVATINIB MESYLATE 4MG CAPSULE	LENVATINIB MESYLATE 4MG CAPSULE	LENVIMA			1				
97	076126	V1Q	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS	70	Y	LENVATINIB MESYLATE 8, 20MG DAILY DOSE	LENVATINIB MESYLATE 8MG DAILY DOSE	LENVIMA	60	30	2				
97	073486	V1Q	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS	71	Y	LENVATINIB MESYLATE 10MG DAILY DOSE	LENVATINIB MESYLATE 10MG DAILY DOSE	LENVIMA	30	30	1				
97	078769	V1Q	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS	72	Y	LENVATINIB MESYLATE 12, 18, 24MG DAILY DOSE	LENVATINIB MESYLATE 12MG DAILY DOSE	LENVIMA			3				
97	044536	V1I	CHEMOTHERAPY RESCUE/ANTIDOTE AGENTS	73	Y	LEUCOVORIN CALCIUM 10, 15 AND 25 MG TAB	LEUCOVORIN CALCIUM 10 MG TAB	GENERIC ONLY			2				
97	044539	V1I	CHEMOTHERAPY RESCUE/ANTIDOTE AGENTS	74	Y	LEUCOVORIN CALCIUM 5 MG TAB	LEUCOVORIN CALCIUM 5 MG TAB	GENERIC ONLY			1				
97	008779	V1A	ANTINEOPLASTIC - ALKYLATING AGENTS	80	Y	LOMUSTINE CAPSULES	LOMUSTINE 10 MG CAPSULE	GLEOSTINE	5						
97	079229	V1Q	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS	81	Y	LORLATINIB 100MG TABLET	LORLATINIB 100MG TABLET	LORBRENA			1				
97	079228	V1Q	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS	82	Y	LORLATINIB 25MG TABLET	LORLATINIB 25MG TABLET	LORBRENA			3				
97	008828	V1E	ANTINEOPLASTIC - STEROID ANTINEOPLASTICS	83	Y	MEGESTROL 20 MG TABLET	MEGESTROL 20 MG TABLET	GENERIC ONLY			1				
97	077344	V1Q	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS	84	Y	MIDOSTAURIN 25MG CAPSULE	MIDOSTAURIN 25MG CAPSULE	RYDAPT			8				
97	082673	V1Q	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS	84.5	Y	MOBOCERTINIB SUCCINATE 40 MG CAPSULE	MOBOCERTINIB SUCCINATE 40 MG CAPSULE	EXKIVITY			4				1/1/2022
97	077566	V1Q	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS	85	Y	NERATINIB MALEATE 40MG TABLET	NERATINIB MALEATE 40MG TABLET	NERLYNX			6				
97	066453	V1Q	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS	86	Y	NILOTINIB HCL CAPSULES	NILOTINIB HCL 150MG CAPSULE	TASIGNA			4				
97	024768	V1J	ANTINEOPLASTIC - ANTIANDROGENIC AGENTS	87	Y	NILUTAMIDE 150 MG TABLET	NILUTAMIDE 150 MG TABLET	NILANDRON			2				
97	077259	V1Q	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS	88	Y	NIRAPARIB TOSYLATE 100MG CAPSULE	NIRAPARIB TOSYLATE 100MG CAPSULE	ZEJULA			3				
97	073234	V1Q	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS	89	Y	OLAPARIB 50MG CAPSULE	OLAPARIB 50MG CAPSULE	LYNPARZA			16				
97	077672	V1Q	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS	90	Y	OLAPARIB 100 AND 150MG CAPSULES	OLAPARIB 150MG CAPSULE	LYNPARZA			4				

97	075146	V1Q	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS	91	Y	OSIMERTINIB MESYLATE 40MG TABLET	OSIMERTINIB MESYLATE 40MG TABLET	TAGRISSO	30	30	1				
97	075147	V1Q	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS	92	Y	OSIMERTINIB MESYLATE 80MG TABLET	OSIMERTINIB MESYLATE 80MG TABLET	TAGRISSO	60	30	2				
97	080427	V1Q	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS	93	Y	PALBOCICLIB TABLETS	PALBOCICLIB 100 MG TABLET	IBRANCE	21	30					
97	073426	V1Q	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS	94	Y	PALBOCICLIB CAPSULES	PALBOCICLIB 75MG CAPSULE	IBRANCE			1				
97	073586	V3A	ANTINEOPLAST,HISTONE DEACETYLASE (HDAC) INHIBITORS	95	Y	PANOBINOSTAT LACTATE CAPSULES	PANOBINOSTAT LACTATE 10MG CAPSULE	FARYDAK	6	21	1				
97	065777	V1Q	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS	96	Y	PAZOPANIB HCL 200MG TABLET	PAZOPANIB HCL 200MG TABLET	VOTRIENT			4				
97	080946	V1Q	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS	97	Y	PEMIGATINIB TABLETS	PEMIGATINIB 13.5 MG TABLET	PEMAZYRE			1				
97	080075	V1Q	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS	98	Y	PEXIDARTINIB HYDROCHLORIDE 200 MG CAPSULE	PEXIDARTINIB HYDROCHLORIDE 200 MG CAPSULE	TURALIO			4				
97	070569	V1M	ANTINEOPLASTIC IMMUNOMODULATOR AGENTS	99	Y	POMALIDOMIDE CAPSULES	POMALIDOMIDE 1MG CAPSULE	POMALYST	21	28	1				
97	081846	V1Q	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS	100	Y	PONTANIB HCL 10MG, 45MG AND 100MG TABLET	PONATINIB HCL 10 MG TABLET	ICLUSIG			1				
97	070360	V1Q	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS	101	Y	PONTANIB HCL 15MG TABLET	PONTANIB HCL 15MG TABLET	ICLUSIG			2				
97	070066	V1Q	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS	102	Y	REGORAFENIB 40MG TABLET	REGORAFENIB 40MG TABLET	STIVARGA	84	28	4	28			
97	077216	V1Q	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS	104	Y	RIBOCICLIB SUCCINATE 200MG DAILY DOSE	RIBOCICLIB SUCCINATE 200MG DAILY DOSE	KISQALI			1				
97	077220	V1Q	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS	105	Y	RIBOCICLIB SUCCINATE 400MG DAILY DOSE	RIBOCICLIB SUCCINATE 400MG DAILY DOSE	KISQALI			2				
97	077221	V1Q	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS	106	Y	RIBOCICLIB SUCCINATE 600MG DAILY DOSE	RIBOCICLIB SUCCINATE 600MG DAILY DOSE	KISQALI			3				
97	077379	V1Q	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS	107	Y	RIBOCICLIB SUCCINATE/LETROZOLE 200MG CO PACK	RIBOCICLIB SUCCINATE/LETROZOLE 200MG CO PAC	KISQALI FEMARA CO-PACK	49	30	2				
97	077381	V1Q	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS	108	Y	RIBOCICLIB SUCCINATE/LETROZOLE 400MG CO PACK	RIBOCICLIB SUCCINATE/LETROZOLE 400MG CO PAC	KISQALI FEMARA CO-PACK	70	30	3				
97	077382	V1Q	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS	109	Y	RIBOCICLIB SUCCINATE/LETROZOLE 600MG CO PACK	RIBOCICLIB SUCCINATE/LETROZOLE 600MG CO PAC	KISQALI FEMARA CO-PACK	91	30	4				
97	081060	V1Q	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS	110	Y	RIPRETINIB 50 MG TABLET	RIPRETINIB 50 MG TABLET	QINLOCK			3				
97	076947	V1Q	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS	111	Y	RUCAPARIB CAMSYLATE 200 MG TABLET	RUCAPARIB CAMSYLATE 200 MG TABLET	RUBRACA			2				
97	077432	V1Q	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS	112	Y	RUCAPARIB CAMSYLATE 250 AND 300 MG TABLET	RUCAPARIB CAMSYLATE 250 MG TABLET	RUBRACA			4				
97	068168	V3L	ANTINEOPLASTIC - JANUS KINASE (JAK) INHIBITORS	113	Y	RUXOLITINIB PHOSPHATE TABLETS	RUXOLITINIB PHOSPHATE 10MG TABLET	JAKAFI			2				
97	081220	V10	ANTINEOPLASTIC-SELECT INHIB OF NUCLEAR EXP (SINE)	113.5	Y	SELINEXOR 40 MG WEEKLY DOSE	SELINEXOR 40 MG WEEKLY DOSE	XPOVIO	8			28			1/1/2022
97	082191	V10	ANTINEOPLASTIC-SELECT INHIB OF NUCLEAR EXP (SINE)	114	Y	SELINEXOR 40 MG ONCE WEEKLY DOSE	SELINEXOR 40 MG ONCE WEEKLY DOSE	XPOVIO	4	30		28			1/1/2022
97	082194	V10	ANTINEOPLASTIC-SELECT INHIB OF NUCLEAR EXP (SINE)	115	Y	SELINEXOR 60 MG ONCE WEEKLY DOSE	SELINEXOR 60 MG ONCE WEEKLY DOSE	XPOVIO	4	30		28			1/1/2022
97	082195	V10	ANTINEOPLASTIC-SELECT INHIB OF NUCLEAR EXP (SINE)	116	Y	SELINEXOR 80 MG ONCE WEEKLY DOSE	SELINEXOR 80 MG ONCE WEEKLY DOSE	XPOVIO	8	30		28			1/1/2022
97	082196	V10	ANTINEOPLASTIC-SELECT INHIB OF NUCLEAR EXP (SINE)	117	Y	SELINEXOR 100 MG ONCE WEEKLY DOSE	SELINEXOR 100 MG ONCE WEEKLY DOSE	XPOVIO	8	30		28			1/1/2022
97	082190	V10	ANTINEOPLASTIC-SELECT INHIB OF NUCLEAR EXP (SINE)	118	Y	SELINEXOR 40 MG TWICE WEEKLY DOSE	SELINEXOR 40 MG TWICE WEEKLY DOSE	XPOVIO	8	30		28			1/1/2022
97	081221	V10	ANTINEOPLASTIC-SELECT INHIB OF NUCLEAR EXP (SINE)	119	Y	SELINEXOR 60 MG TWICE WEEKLY DOSE	SELINEXOR 60 MG TWICE WEEKLY DOSE	XPOVIO	24			28			1/1/2022
97	079979	V10	ANTINEOPLASTIC-SELECT INHIB OF NUCLEAR EXP (SINE)	120	Y	SELINEXOR 80 MG TWICE WEEKLY DOSE	SELINEXOR 80 MG TWICE WEEKLY DOSE	XPOVIO	32	30		28			1/1/2022
97	081025	V1Q	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS	121	Y	SELPERCATINIB 40 MG CAPSULE	SELPERCATINIB 40 MG CAPSULE	RETEVMO			6				
97	081026	V1Q	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS	122	Y	SELPERCATINIB 80 MG CAPSULE	SELPERCATINIB 80 MG CAPSULE	RETEVMO			4				
97	080921	V3U	ANTINEOPLASTIC - MEK1 AND MEK2 KINASE INHIBITORS	123	Y	SELUMETINIB/VITAMIN E TPGS 10 MG CAPSULE	SELUMETINIB/VITAMIN E TPGS 10 MG CAPSULE	KOSELUGO			8				
97	080922	V3U	ANTINEOPLASTIC - MEK1 AND MEK2 KINASE INHIBITORS	124	Y	SELUMETINIB/VITAMIN E TPGS 25 MG CAPSULE	SELUMETINIB/VITAMIN E TPGS 25 MG CAPSULE	KOSELUGO			4				
97	074547	V3M	ANTINEOPLASTIC - HEDGEHOG PATHWAY INHIBITOR	125	Y	SONIDEGIB PHOSPHATE 200MG CAPSULE	SONIDEGIB PHOSPHATE 200MG CAPSULE	ODOMZO			1				
97	060199	V1Q	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS	126	Y	SORAFENIB TOSYLATE 200MG TABLET	SORAFENIB TOSYLATE 200MG TABLET	NEXAVAR			4				
97	082328	V5A	ANTINEOPLASTIC - KRAS PROTEIN INHIBITOR	126.5	Y	SOTORASIB 120 MG TABLET	SOTORASIB 120 MG TABLET	LUMAKRAS			8				1/1/2022
97	060326	V1Q	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS	127	Y	SUNITINIB MALATE CAPSULES	SUNITINIB MALATE 12.5MG CAPSULE	SUTENT			1				
97	079147	V1Q	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS	128	Y	TALAZOPARIB TOSYLATE 0.25MG CAPSULE	TALAZOPARIB TOSYLATE 0.25MG CAPSULE	TALZENNA			3				
97	079148	V1Q	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS	129	Y	TALAZOPARIB TOSYLATE 1MG CAPSULE	TALAZOPARIB TOSYLATE 1MG CAPSULE	TALZENNA			1				
97	008832	V1T	ANTINEOPLASTIC - SELECTIVE ESTROGEN RECEPTOR MODULATORS (SERMS)	130	Y	TAMOXIFEN CITRATE 10MG TABLET	TAMOXIFEN CITRATE 10MG TABLET	GENERIC ONLY			1				
97	043532	V1T	ANTINEOPLASTIC - SELECTIVE ESTROGEN RECEPTOR MODULATORS (SERMS)	131	Y	TAMOXIFEN CITRATE 20 MG/10 ML SOLN	TAMOXIFEN CITRATE 20 MG/10 ML SOLN	SOLTAMOX			20				
97	080675	V11	ANTINEOPLASTIC - PROTEIN METHYLTRANSFERASE INHIBIT	132	Y	TAZEMETOSTAT HYDROBROMIDE 200 MG TABLET	TAZEMETOSTAT HYDROBROMIDE 200 MG TABLET	TAZVERIK			8				
97	043010	V1A	ANTINEOPLASTIC - ALKYLATING AGENTS	133	Y	TEMOZOLOMIDE 5MG CAPSULE	TEMOZOLOMIDE 5MG CAPSULE	TEMODAR			3				
97	043011	V1A	ANTINEOPLASTIC - ALKYLATING AGENTS	134	Y	TEMOZOLOMIDE 20MG CAPSULE	TEMOZOLOMIDE 20MG CAPSULE	TEMODAR			4				
97	043012	V1A	ANTINEOPLASTIC - ALKYLATING AGENTS	135	Y	TEMOZOLOMIDE 100, 140, 180, 250MG CAPSULE	TEMOZOLOMIDE 100MG CAPSULE	TEMODAR			2				
97	043013	V1A	ANTINEOPLASTIC - ALKYLATING AGENTS	136	Y	TEMOZOLOMIDE 250MG CAPSULE	TEMOZOLOMIDE 250MG CAPSULE	TEMODAR			1				
97	081894	V1Q	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS	137	Y	TEPOTINIB HCL 225 MG TABLET	TEPOTINIB HCL 225 MG TABLET	TEPMETKO			2				
97	079734	V1Q	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS	138	Y	TIVOZANIB CAPSULES	TIVOZANIB 0.89 MG CAPSULE	FOTIVDA	21	28					
97	064410	V3E	ANTINEOPLASTIC - TOPOISOMERASE I INHIBITORS	139	Y	TOPOTECAN HCL CAPSULES	TOPOTECAN HCL 0.25 MG CAPSULE	HYCAMTIN	10						
97	027544	V1T	ANTINEOPLASTIC - SELECTIVE ESTROGEN RECEPTOR MODULATORS (SERMS)	140	Y	TOREMIFENE CITRATE 60MG TABLET	TOREMIFENE CITRATE 60MG TABLET	FARESTON			3				
97	071036	V3U	ANTINEOPLASTIC - MEK1 AND MEK2 KINASE INHIBITORS	140	Y	TRAMETINIB DIMETHYL SULFOXIDE 0.5MG TABLET	TRAMETINIB DIMETHYL SULFOXIDE 0.5MG TABLET	MEKINIST	90	30	3				
97	071037	V3U	ANTINEOPLASTIC - MEK1 AND MEK2 KINASE INHIBITORS	140	Y	TRAMETINIB DIMETHYL SULFOXIDE 2MG TABLET	TRAMETINIB DIMETHYL SULFOXIDE 2MG TABLET	MEKINIST	30	30	1				
97	074821	V1B	ANTINEOPLASTIC - ANTIMETABOLITES	140	Y	TRIFLURIDINE/TIPIRACIL HCL 15MG-6.14MG TABLET	TRIFLURIDINE/TIPIRACIL HCL 15MG-6.14MG TABLE	LONSURF			6				
97	074822	V1B	ANTINEOPLASTIC - ANTIMETABOLITES	140	Y	TRIFLURIDINE/TIPIRACIL HCL 20MG-8.19MG TABLET	TRIFLURIDINE/TIPIRACIL HCL 20MG-8.19MG TABLE	LONSURF			4				
97	080941	V1Q	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS	141	Y	TUCATINIB TABLETS	TUCATINIB 50 MG TABLET	TUKYSA			4				
97	081907	V1Q	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS	142	Y	UMBRALISIB TOSYLATE 200 MG TABLET	UMBRALISIB TOSYLATE 200 MG TABLET	UKONIQ			4				
97	075268	V1I	CHEMOTHERAPY RESCUE/ANTIDOTE AGENTS	143	Y	URIDINE TRIACETATE 10GRAM PACKET	URIDINE TRIACETATE 10GRAM PACKET	VISTOGARD	20	30					
97	067290	V1Q	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS	144	Y	VANDETANIB 100, 300MG TABLET	VANDETANIB 100MG TABLET	VANDETANIB			1				
97	067716	V37	ANTINEOPLASTIC - BRAF KINASE INHIBITORS	145	Y	VEMURAFENIB 204MG TABLET	VEMURAFENIB 204MG TABLET	ZELBORAF			8				
97	075886	V3X	ANTINEOPLASTIC-B CELL LYMPHOMA-2(BCL-2) INHIBITORS	146	Y	VENETOCLAX 100MG TABLET	VENETOCLAX 100MG TABLET	VENCLEXTA	120	30	4				
97	075884	V3X	ANTINEOPLASTIC-B CELL LYMPHOMA-2(BCL-2) INHIBITORS	147	Y	VENETOCLAX 10MG TABLET	VENETOCLAX 10MG TABLET	VENCLEXTA	60	30	2				
97	075885	V3X	ANTINEOPLASTIC-B CELL LYMPHOMA-2(BCL-2) INHIBITORS	148	Y	VENETOCLAX 50MG TABLET	VENETOCLAX 50MG TABLET	VENCLEXTA	30	30	1				
97	075883	V3X	ANTINEOPLASTIC-B CELL LYMPHOMA-2(BCL-2) INHIBITORS	149	Y	VENETOCLAX STARTING PACK	VENETOCLAX STARTING PACK	VENCLEXTA	42	999					
97	068508	V3M	ANTINEOPLASTIC - HEDGEHOG PATHWAY INHIBITOR	150	Y	VISMODEGIB 150MG CAPSULE	VISMODEGIB 150MG CAPSULE	ERIVEDGE			1				
97	061557	V3A	ANTINEOPLAST,HISTONE DEACETYLASE (HDAC) INHIBITORS	151	Y	VORINOSTAT 100MG CAPSULE	VORINOSTAT 100MG CAPSULE	ZOLINZA	120	30	4				
97	080479	V1Q	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS	152	Y	ZANUBRUTINIB 80 MG CAPSULE	ZANUBRUTINIB 80 MG CAPSULE	BRUKINSA			4				
98	**0**	**HIC3**	**THERAPEUTIC CLASS**	**0**	**Y**	**MISCELLANEOUS DRUGS**	**MISCELLANEOUS DRUGS**	**BRAND**	**Units**	**Until Refill**	**Daily Dose**	**Max Days**	**Refills**	**Pkg Bill**	**Updated**
98	079934	Q6J	MYDRIATICS	1	Y	ATROPINE SULFATE 0.01% EYE DRP	ATROPINE SULFATE 0.01% EYE DRP	GENERIC ONLY	5	30				Y	
98	078453	N1F	THROMBOPOIETIN RECEPTOR AGONISTS	2	Y	AVATROMBOPAG MALEATE 20 MG TABLET	AVATROMBOPAG MALEATE 20 MG TABLET	DOPTELET			1	5			
98	081747	A7N	PLASMA KALLIKREIN INHIBITORS	6	Y	BEROTRALSTAT HYDROCHLORIDE 110 MG CAPSULE	BEROTRALSTAT HYDROCHLORIDE 110 MG CAPSULE	ORLADEYO			1				
98	080019	H8V	HYPOACTIVE SEXUAL DESIRE DISORDER (HSDD) TX AGENTS	7	Y	BREMELANOTIDE ACETATE 1.75 MG/0.3 ML AUTOINJ	BREMELANOTIDE ACETATE 1.75 MG/0.3 ML AUTOI	VYLEESI			1				
98	009575	W4A	ANTIMALARIAL DRUGS	8	Y	CHLOROQUINE PH 250 MG TABLET	CHLOROQUINE PH 250 MG TABLET	GENERIC ONLY			4				
98	009576	W4A	ANTIMALARIAL DRUGS	9	Y	CHLOROQUINE PH 500 MG TABLET	CHLOROQUINE PH 500 MG TABLET	GENERIC ONLY			2				
98	005258	L0B	TOPICAL/MUCOUS MEMBR./SUBCUT. ENZYMES	10	Y	COLLAGENASE CLOSTRIDIUM HIST OINTMENT	COLLAGENASE CLOSTRIDIUM HIST OINTMENT	SANTYL	60	30				Y	
98	078557	Q6J	MYDRIATICS	11	Y	CYCLOPENTOLAT/TROPIC/PHENYLEPH DROPS	CYCLOPENTOLAT/TROPIC/PHENYLEPH DROPS	GENERIC ONLY	1						
98	077271	H6L	DRUGS TO TREAT MOVEMENT DISORDERS	12	Y	DEUTETRABENAZINE 12 MG TABLET	DEUTETRABENAZINE 12 MG TABLET	AUSTEDO			4				

98	077269	H6L	DRUGS TO TREAT MOVEMENT DISORDERS	13	Y	DEUTETRABENAZINE 6 MG TABLET	DEUTETRABENAZINE 6 MG TABLET	AUSTEDO			1				
98	077270	H6L	DRUGS TO TREAT MOVEMENT DISORDERS	14	Y	DEUTETRABENAZINE 9 MG TABLET	DEUTETRABENAZINE 9 MG TABLET	AUSTEDO			3				
98	074933	S7F	AGENTS TO TX PERIODIC PARALYSIS	15	Y	DICHLORPHENAMIDE 50 MG TABLET	DICHLORPHENAMIDE 50 MG TABLET	KEVEYIS			4				
98	082226	C5O	DILUENT SOLUTIONS	16	Y	DILUENT,NALTREXONE MICROSPHERE	DILUENT,NALTREXONE MICROSPHERE	GENERIC ONLY	4						
98	021715	L3P	ANTIPRURITICS,TOPICAL	17	Y	DOXEPIN 5% CREAM	DOXEPIN 5% CREAM	PRUDOXIN	45	30				Y	
98	065367	A2A	ANTIARRHYTHMICS	18	Y	DRONEDARONE HCL 400 MG TABLET	DRONEDARONE HCL 400 MG TABLET	MULTAQ			2				
98	080343	B0F	CYSTIC FIBROSIS-CFTR POTENTIATOR-CORRECTOR COMBIN	19	Y	ELEXACAFTOR/TEZACAFTOR/IVACAFT TABLETS	ELEXACAFTOR/TEZACAFTOR/IVACAFT 100/50/75 M	TRIKAFTA	84	30	3				1/1/2022
98	079397	N1F	THROMBOPOIETIN RECEPTOR AGONISTS	20	Y	ELTROMBOPAG OLAMINE SUSPENSION PACKETS	ELTROMBOPAG OLAMINE 12.5MG SUSPENSION PA	PROMACTA			1				
98	082499	R1H	POTASSIUM SPARING DIURETICS	21	Y	FINERENONE 10 MG TABLET	FINERENONE 10 MG TABLET	KERENDIA			1				1/1/2022
98	078381	Z24	SPLEEN TYROSINE KINASE INHIBITORS	22	Y	FOSTAMATINIB DISODIUM TABLETS	FOSTAMATINIB DISODIUM 100 MG TABLET	TAVALISSE			2				
98	054261	W4A	ANTIMALARIAL DRUGS	23	Y	HYDROXYCHLOROQUINE 100 MG TABLET	HYDROXYCHLOROQUINE 100 MG TABLET	GENERIC ONLY			4				1/1/2022
98	009580	W4A	ANTIMALARIAL DRUGS	24	Y	HYDROXYCHLOROQUINE 200 MG TAB	HYDROXYCHLOROQUINE 200 MG TAB	PLAQUENIL			2				1/1/2022
98	082625	W4A	ANTIMALARIAL DRUGS	25	Y	HYDROXYCHLOROQUINE 300 MG TABLET	HYDROXYCHLOROQUINE 300 MG TABLET	GENERIC ONLY			1				1/1/2022
98	079122	P9B	AMYLOIDOSIS AGENTS-TRANSTHYRETIN (TTR) SUPPRESSION	26	Y	INOTERSEN SODIUM 284MG/1.5 ML SYRINGE	INOTERSEN SODIUM 284MG/1.5 ML SYRINGE	TEGSEDI	6						
98	080130	W9E	PLEUROMUTILIN DERIVATIVES	27	Y	LEFAMULIN ACETATE 150 MG/15 ML VIAL	LEFAMULIN ACETATE 150 MG/15 ML VIAL	XENLETA			30	7			
98	080129	W9E	PLEUROMUTILIN DERIVATIVES	28	Y	LEFAMULIN ACETATE 600 MG TABLET	LEFAMULIN ACETATE 600 MG TABLET	XENLETA			1	5			
98	078704	B0F	CYSTIC FIBROSIS-CFTR POTENTIATOR-CORRECTOR COMBIN	31	Y	LUMACAFTOR/IVACAFTOR GRANULE PACKETS	LUMACAFTOR/IVACAFTOR 100-125MG GRANULE P	ORKAMBI			4				
98	078683	N1F	THROMBOPOIETIN RECEPTOR AGONISTS	32	Y	LUSUTROMBOPAG 3MG TABLET	LUSUTROMBOPAG 3MG TABLET	MULPLETA	7		1	7			
98	078687	D4B	ANTACIDS	33	Y	MAGNESIUM OXIDE 400MG TABLET	MAGNESIUM OXIDE 400MG TABLET	GENERIC ONLY			2				
98	009607	W4L	ANTHELMINTICS	34	Y	MEBENDAZOLE 100 MG CHEWABLE TABLET	MEBENDAZOLE 100 MG CHEWABLE TABLET	EMVERM	1			21	1		
98	081226	J9A	INTESTINAL MOTILITY STIMULANTS	36	Y	METOCLOPRAMIDE HCL 15 MG NASAL SPRAY	METOCLOPRAMIDE HCL 15 MG NASAL SPRAY	GIMOTI	9.8						
98	077590	Z1S	PHARMACOLOGICAL CHAPERONE-ALPHA-GALACTOSID.A STABZ	37	Y	MIGALASTAT HCL 123MG CAPSULE	MIGALASTAT HCL 123MG CAPSULE	GALAFOLD	15	30					
98	072164	W4K	ANTIPROTOZOAL DRUGS,MISCELLANEOUS	38	Y	MILTEFOSINE 50MG CAPSULE	MILTEFOSINE 50MG CAPSULE	IMPAVIDO	84	30	3				
98	070448	W7W	ALLERGENIC EXTRACTS, THERAPEUTICS	39	Y	MIXED POLLENS ALLREGAN EXTRACT 300MG SUBLINGUA	MIXED POLLENS ALLREGAN EXTRACT 300MG SUBL	ORALAIR	30	30	1				
98	070447	W7W	ALLERGENIC EXTRACTS, THERAPEUTICS	40	Y	MIXED POLLENS ALLREGAN EXTRACT STARTER PACK	MIXED POLLENS ALLREGAN EXTRACT STARTER PAC	ORALAIR	3	365				Y	
98	076156	D7E	FARNESOID X RECEPTOR (FXR) AGONIST, BILE AC ANALOG	41	Y	OBETICHOLIC ACID TABLETS	OBETICHOLIC ACID 5MG TABLET	OCALIVA	30	30	1				
98	081277	P1B	SOMATOSTATIC AGENTS	42	Y	OCTREOTIDE ACETATE 20 MG CAPSULE	OCTREOTIDE ACETATE 20 MG CAPSULE	MYCAPSSA DR			4				
98	082530	D7F	ILEAL BILE ACID TRANSPORTER (IBAT) INHIBITOR	43	Y	ODEVIXIBAT 1200 MCG PELLET	ODEVIXIBAT 1200 MCG PELLET	BYLVAY			5				1/1/2022
98	082527	D7F	ILEAL BILE ACID TRANSPORTER (IBAT) INHIBITOR	44	Y	ODEVIXIBAT 200 MCG PELLET	ODEVIXIBAT 200 MCG PELLET	BYLVAY			30				1/1/2022
98	082529	D7F	ILEAL BILE ACID TRANSPORTER (IBAT) INHIBITOR	45	Y	ODEVIXIBAT 400 MCG PELLET	ODEVIXIBAT 400 MCG PELLET	BYLVAY			15				1/1/2022
98	082528	D7F	ILEAL BILE ACID TRANSPORTER (IBAT) INHIBITOR	46	Y	ODEVIXIBAT 600 MCG PELLET	ODEVIXIBAT 600 MCG PELLET	BYLVAY			10				1/1/2022
98	080814	P1G	ADRENAL STEROID INHIBITORS	47	Y	OSILODROSTAT PHOSPHATE 1 MG TABLET	OSILODROSTAT PHOSPHATE 1 MG TABLET	ISTURISA			8				
98	080816	P1G	ADRENAL STEROID INHIBITORS	48	Y	OSILODROSTAT PHOSPHATE 10 MG TABLET	OSILODROSTAT PHOSPHATE 10 MG TABLET	ISTURISA			6				
98	080815	P1G	ADRENAL STEROID INHIBITORS	49	Y	OSILODROSTAT PHOSPHATE 5 MG TABLET	OSILODROSTAT PHOSPHATE 5 MG TABLET	ISTURISA			2				
98	049872	N1C	LEUKOCYTE (WBC) STIMULANTS	50	Y	PEGFILGRASTIM 6MG/0.6ML SYRINGE	PEGFILGRASTIM 6MG/0.6ML SYRINGE	NEULASTA	1.2	30				Y	
98	017451	S2K	ANTI-ARTHRITIC AND CHELATING AGENTS	51	Y	PENICILLAMINE 125 MG TABLET	PENICILLAMINE 125 MG TABLET	D-PENAMINE 125 MG TABLET			32				
98	077032	Z1M	ANTIFIBROTIC THERAPY - PYRIDONE ANALOGS	52	Y	PIRFENIDONE 267MG TABLET	PIRFENIDONE 267MG TABLET	ESBRIET			6				
98	077034	Z1M	ANTIFIBROTIC THERAPY - PYRIDONE ANALOGS	53	Y	PIRFENIDONE 801MG TABLET	PIRFENIDONE 801MG TABLET	ESBRIET			3				
98	075816	C6F	PRENATAL VITAMINS	54	Y	PNV 112/IRON/FOLIC/OM3/DHA/EPA	PNV 112/IRON/FOLIC/OM3/DHA/EPA	VITAFOL GUMMIES			3				
98	069225	C6F	PRENATAL VITAMINS	55	Y	PRENATAL 48/IRON/FOLIC ACID/B6 PRENATAL COMBO PA	PRENATAL 48/IRON/FOLIC ACID/B6 PRENATAL COM	VINACAL B			3				
98	080112	W1G	ANTITUBERCULAR ANTIBIOTICS	56	Y	PRETOMANID 200 MG TABLET	PRETOMANID 200 MG TABLET	GENERIC ONLY			1				
98	021416	B3A	MUCOLYTICS	57	Y	DORNASE ALFA 1 MG/ML AMPUL	PULMOZYME 1 MG/ML AMPUL	PYLMOZYME			5			Y	
98	081371	Z1T	GENETIC D/O TX - SMN PROTEIN DEFICIENCY TREATMENT	58	Y	RISDIPLAM 60 MG/80 ML	RISDIPLAM 60 MG/80 ML	EVRYSDI				30			
98	079643	P4Q	BONE FORMATION AGENTS - SCLEROSTIN INHIBITOR, MONO	59	Y	ROMOSOZUMAB-AQQG SYRINGES	ROMOSOZUMAB-AQQG 105MG/1.17 ML SYRINGE	EVENITY	2.34	30					
98	081724	J8F	ANTI-OBESITY - MELANOCORTIN 4 RECEPTOR AGONISTS	60	Y	SETMELANOTIDE ACETATE 10 MG/ML VIAL	SETMELANOTIDE ACETATE 10 MG/ML VIAL	IMCIVREE			0.3				
98	079562	Q5B	TOPICAL PREPARATIONS,ANTIBACTERIALS	61	Y	SILVER NITRATE WOUND GEL	SILVER NITRATE WOUND GEL	SOLOX GEL	45						
98	026631	D9A	AMMONIA INHIBITORS	62	Y	SODIUM PHENYLBUTYRATE POWDER	SODIUM PHENYLBUTYRATE POWDER	BUPHENYL			20				
98	079710	P9A	PROTEIN STABILIZERS	63	Y	TAFAMIDIS 61 MG CAPSULE	TAFAMIDIS 61 MG CAPSULE	VYNDAMAX			1				
98	073210	P9A	PROTEIN STABILIZERS	64	Y	TAFAMIDIS MEGLUMINE 20MG CAPSULE	TAFAMIDIS MEGLUMINE 20MG CAPSULE	VYNDAQEL			4				
98	079924	B0F	CYSTIC FIBROSIS-CFTR POTENTIATOR-CORRECTOR COMBIN	65	Y	TEZACAFTOR/IVACAFTOR 50/75MG - 75MG TABLETS	TEZACAFTOR/IVACAFTOR 50/75MG - 75MG TABLET	SYMDEKO			2				
98	040279	W4P	ANTILEPROTICS	66	Y	THALIDOMIDE 100MG CAPSULE	THALIDOMIDE 100 MG CAPSULE	THALOMID			4				
98	062444	W4P	ANTILEPROTICS	67	Y	THALIDOMIDE 150, 200MG CAPSULE	THALIDOMIDE 150 MG CAPSULE	THALOMID			2				
98	040296	W4P	ANTILEPROTICS	68	Y	THALIDOMIDE 50 MG CAPSULE	THALIDOMIDE 50 MG CAPSULE	THALOMID			8				
98	081054	R1N	ARGININE VASOPRESSIN (AVP) RECEPTOR ANTAGONISTS	69	Y	TOLVAPTAN 15-15MG and 30-15MG TABLETS	TOLVAPTAN 15 MG - 15 MG TABLET	JYNARQUE	14		2				
98	081525	R1N	ARGININE VASOPRESSIN (AVP) RECEPTOR ANTAGONISTS	70	Y	TOLVAPTAN 15, 30 MG TABLET	TOLVAPTAN 15 MG TABLET	JYNARQUE			4				
98	075047	R1N	ARGININE VASOPRESSIN (AVP) RECEPTOR ANTAGONISTS	71	Y	TOLVAPTAN 45-15MG, 60-30MG, 90-30MG TABLETS	TOLVAPTAN 90MG-30MG TABLET	JYNARQUE			2				
98	077294	H6L	DRUGS TO TREAT MOVEMENT DISORDERS	72	Y	VALBENAZINE TOSYLATE CAPSULES	VALBENAZINE TOSYLATE 40MG CAPSULE	INGREZZA			1				
98	079676	H6L	DRUGS TO TREAT MOVEMENT DISORDERS	73	Y	VALBENAZINE TOSYLATE INITIATION PACK	VALBENAZINE TOSYLATE INITIATION PACK	INGREZZA	28		1	28			
98	081860	Z1Z	SOLUBLE GUANYLATE CYCLASE (SGC) STIMULATOR	74	Y	VERICIGUAT TABLETS	VERICIGUAT 10 MG TABLET	VERQUVO			1				

	Males on estrogen	Females on Testosterone (Including Oxandrolone)	Females on testosterone (Excluding Oxandrolone)
2012	1	4	0
2013	2	5	0
2014	2	2	0
2015	2	6	0
2016	0	4	1
2017	19	20	14
2018	39	48	41
2019	44	65	56
2020	61	79	71
2021	114	139	121

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA
HUNTINGTON DIVISION

Exhibit
BT 0012

CHRISTOPHER FAIN; ZACHARY MARTELL; and **BRIAN MCNEMAR,** Individually and on behalf of all others similarly situated,

Plaintiffs,

Civil Action No. 3:20-cv-00740
Hon. Robert C. Chambers, Judge

v.

WILLIAM CROUCH, in his official capacity as Cabinet Secretary of the West Virginia Department of Health and Human Resources; **CYNTHIA BEANE,** in her official capacity as Commissioner for the West Virginia Bureau for Medical Services; **WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES; TED CHEATHAM,** in his official Capacity as Director of the West Virginia Public Employees Insurance Agency; and **THE HEALTH PLAN OF WEST VIRGINIA, INC.**

DEFENDANTS' SIXTH SUPPLEMENTAL RESPONSE TO PLAINTIFF'S FIRST SET OF REQUESTS FOR PRODUCTION TO DEFENDANTS WILLIAM CROUCH, CYNTHIA BEANE, AND WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES

DOCUMENT REQUESTS

2. All documents relating to Plaintiff' s communications, injuries, requests for coverage, requests for prior authorization, requests for reimbursement and/or complaints regarding coverage for Gender-Confirming Care through the West Virginia Medicaid Program. This Request includes but is not limited to:

a. All communications to and from Plaintiff relating to coverage for Gender-Confirming Care;

b. All Documents and communications regarding Plaintiff's requests for Gender-Confirming Care, including but not limited to communications among Defendants, and/or the employees, entities, agents, representatives, contractors, vendors, and/or consultants of Defendants and/or West Virginia Department of Health and Human Resources, Bureau of Medical Services;

c. All Documents and communications relating to consideration or processing by third-party administrators, contractors, and/or vendors of requests for Gender-Confirming Care by Plaintiff.

SUPPLEMENTAL RESPONSE: See attached excel spreadsheet with claim information for hormones for Plaintiffs Fain and Anderson, attached as Exhibit 97, Bates No. DHHRBMS016224. With regard to Plaintiff Fain, see the attached audio recording regarding request for approval for medication, attached as Exhibit 98, Bates No. DHHRBMS016225; West Virginia Controlled Substance Report from Board of Pharmacy records, attached as Exhibit 99, Bates No. DHHRBMS016226-16228; and Member Notes attached as Exhibit 100, Bates No. DHHRBMS016229-16230. All materials are CONFIDENTIAL.

4. All Documents and communications relating to the Exclusion, including but not limited to:

a. All Documents and communications relating to the decision to maintain the Exclusion in the Health Plans in any plan year.

b. All Documents and communications relating to the decision to permit coverage for hormone therapy for the purpose of treating gender dysphoria.

c. All Document and communications relating to evaluating, examining, analyzing, and/or considering the Exclusion in any way.

SUPPLEMENTAL RESPONSE: See attached West Virginia Model Member Handbook, attached as Exhibit 105, Bates No. DHHRBMS016291-16320.

24. To the extent not requested above, all Documents that Defendants may rely upon to support their defenses against Plaintiff's claims in this action.

SUPPLEMENTAL RESPONSE: See the attached 2019-2020 Aetna Member Handbook attached as Exhibit 101, DHHRBMS016231-16278; See email with subject: Enrollment Data – Health Equity/ SDOH Accreditation, attached as Exhibit 102, Bates No. DHHRBMS016279-16283 ; email with subject: Enrollment Data - Health Equity / SDOH Accreditation, attached as Exhibit 103, Bates No. DHHRMBS016284-16287; and email with subject: Health Equity Follow Up, attached as Exhibit 104, Bates No. DHHRBMS016288-16290; Please note, confidential attorney/client privileged communication redacted.

WILLIAM CROUCH, CYNTHIA BEANE, and WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES,
By counsel

/s/Kimberly M. Bandy
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IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA
HUNTINGTON DIVISION

CHRISTOPHER FAIN; ZACHARY MARTELL; and **BRIAN MCNEMAR,** Individually and on behalf of all others similarly situated,

Plaintiffs,

Civil Action No. 3:20-cv-00740
Hon. Robert C. Chambers, Judge

v.

WILLIAM CROUCH, in his official capacity as Cabinet Secretary of the West Virginia Department Of Health and Human Resources; **CYNTHIA BEANE,** in her official capacity as Commissioner for the West Virginia Bureau for Medical Services; **WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES; TED CHEATHAM,** in his official Capacity as Director of the West Virginia Public Employees Insurance Agency; and **THE HEALTH PLAN OF WEST VIRGINIA, INC.**

Defendants.

CERTIFICATE OF SERVICE

Now come Defendants William Crouch, Cynthia Beane and West Virginia Department of Health and Human Resources, by counsel, and do hereby certify that on the 24th day of February, 2022, a true and exact copy of **DEFENDANTS' SIXTH SUPPLEMENTAL RESPONSE TO PLAINTIFF'S FIRST SET OF REQUESTS FOR PRODUCTION TO DEFENDANTS WILLIAM CROUCH, CYNTHIA BEANE, AND WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES** was served on counsel via electronic means as follows:

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IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA
HUNTINGTON DIVISION

CHRISTOPHER FAIN; ZACHARY MARTELL;BRIAN MCNEMAR, SHAWN ANDERSON a/k/a SHAUNTAE ANDERSON; and LEANNE JAMES, individually and on behalf of all others similarly situated,

Plaintiffs,

Civil Action No. 3:20-cv-00740
Hon. Robert C. Chambers, Judge

v.

WILLIAM CROUCH, in his official capacity as Cabinet Secretary of the West Virginia Department of Health and Human Resources; **CYNTHIA BEANE,** in her official capacity as Commissioner for the West Virginia Bureau for Medical Services; **WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES; JASON HAUGHT,** in his official Capacity as Director of the West Virginia Public Employees Insurance Agency; and **THE HEALTH PLAN OF WEST VIRGINIA, INC.**

Defendants.

Exhibit
BT 0017

DEFENDANTS WILLIAM CROUCH, CYNTHIA BEANE, AND WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES' SECOND SUPPLEMENTAL RESPONSES TO PLAINTIFFS' SECOND SET OF REQUESTS FOR PRODUCTION OF DOCUMENTS AND THINGS

DOCUMENT REQUESTS

25. To the extent not already produced, all Documents related to Plaintiff Christopher Fain, and proposed Plaintiff Shauntae Anderson.

SUPPLEMENTAL RESPONSE: Please see three excel spreadsheets regarding Plaintiff Fain's medical information attached as Exhibit 87, 88, and 89, Bates Nos. DHHRBMS016069; DHHRBMS016070 and DHHRBMS016071, respectively. Additionally,

please see other patient information regarding Plaintiff Fain, attached as Exhibit 90, Bates No. DHHRBMS016072-16077.

With regard to Plaintiff Anderson, please see two excel spreadsheets with medical information, attached as Exhibits 91 and 92, Bates No. DHHRBMS016078 and DHHRBMS016079.

WILLIAM CROUCH,
CYNTHIA BEANE, and
WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES,
BUREAU FOR MEDICAL SERVICES,

By counsel

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IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA
HUNTINGTON DIVISION

CHRISTOPHER FAIN; ZACHARY MARTELL; and **BRIAN MCNEMAR,** Individually and on behalf of all others similarly situated,

Plaintiffs,

Civil Action No. 3:20-cv-00740
Hon. Robert C. Chambers, Judge

v.

WILLIAM CROUCH, in his official capacity as Cabinet Secretary of the West Virginia Department Of Health and Human Resources; **CYNTHIA BEANE,** in her official capacity as Commissioner for the West Virginia Bureau for Medical Services; **WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES; JASON HAUGHT,** in his official Capacity as Director of the West Virginia Public Employees Insurance Agency; and **THE HEALTH PLAN OF WEST VIRGINIA, INC.**

Defendants.

CERTIFICATE OF SERVICE

Now come Defendants William Crouch, Cynthia Beane and West Virginia Department of Health and Human Resources, by counsel, and do hereby certify that on the 1st day of February, 2022, a true and exact copy of **DEFENDANTS WILLIAM CROUCH, CYNTHIA BEANE, AND WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES' SECOND SUPPLEMENTAL RESPONSES TO PLAINTIFFS' SECOND SET OF REQUESTS FOR PRODUCTION OF DOCUMENTS AND THINGS** was served on counsel via electronic means as follows:

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