



L.A. Care Covered Formulary

www.lacare.org

LA1308C 02/15_EN

Last Updated: 11/1/2017



**L.A. Care
Covered™
For All of L.A.**

L.A. Care Covered & L.A. Care Covered Direct Formulary

INTRODUCTION

Foreword

The L.A. Care Covered & L.A. Care Covered Direct formulary is a preferred list of covered drugs, approved by the L.A. Care Health Plan Pharmacy Quality Oversight Committee. This formulary applies only to outpatient drugs and self-administered drugs.

It does not apply to medications used in the inpatient setting or medical offices.

The formulary is a continually reviewed and revised list of preferred drugs based on safety, clinical efficacy, and cost-effectiveness. The formulary is updated monthly, updated documents are available online at: <http://www.lacare.org>.

How to Use the Formulary

The formulary drug listing begins on Page 4. Drugs available in generic formulations are listed by their generic names and it's most common proprietary (branded) name is capitalized next to the generic name in parenthesis. Drugs that are only available in brand name formulations are listed in ALL CAPITAL letters.

The formulary can be searched by using the "Ctrl + F" function or the index. Drugs can be searched by the generic name, proprietary name, or therapeutic drug category.

Generic and Brand Name Medications

L.A. Care Covered & L.A. Care Covered Direct Plans cover generic and brand name drugs. However, when available, FDA approved generic drugs are to be used in all situations, regardless of the availability of a brand. Generic drugs generally cost less than brand name drugs. All drugs that are or become available generically are subject to review by L.A. Care's Pharmacy Quality Oversight Committee.

A prescriber may request a brand name product in lieu of an approved generic, if the prescriber determines that there is a documented medical need for the brand equivalent. This type of request for coverage may be made using the 'Medication Request Process' described on Page 3.

Non-Formulary Medications

Any drug not found in this formulary listing published by L.A. Care Health Plan shall be considered a non-formulary drug.

A prescriber may request an exception to coverage for a non-formulary drug if the prescriber determines that there is a documented medical need. This type of request for coverage may be made using the 'Medication Request Process' described on Page 3.

Benefit Coverage and Limitations

This printed formulary does not provide information regarding the specific coverage and limitations an individual may have. The individual may have specific benefit inclusions, exclusions, and/or cost share which are not reflected in the formulary.

The formulary applies only to outpatient drugs provided to members, and does not apply to medications used in inpatient settings. Any specific questions regarding their coverage should be directed to L.A. Care Health Plan Member Services at 1-888-839-9909 (TTY: 711).

Restrictions on Medication Coverage

Certain covered drugs may have additional requirements or limits on coverage. These are denoted throughout the document using the following symbols:

Symbol	Restriction	Description
INF	Infertility	Infertility drugs
NC	Not Covered	Drug that is non-formulary and will not be paid for by the plan without prior approval/prior authorization
QL	Quantity Limit	Coverage may be limited to specific quantities per prescription and/or time period
SP	Specialty Pharmacy Availability	Drug is considered a specialty drug and is available through the specialty pharmacy vendor, however they are not restricted to a specific pharmacy
VAC	Vaccine Program	Coverage is available through a vaccine program
LD	Limited Distribution	Coverage is available through a limited distributor or limited number of distributors
OTC	Over the Counter	Coverage of OTC medication
RS	Restricted to Specialist	Coverage may be dependent on the specialty of the prescribing physician
MSP	Mandatory Specialty Pharmacy Program	All fills, including the initial fill MUST be dispensed at the specialty pharmacy provider of the plans
PA	Prior Authorization	Requires specific physician request process
SMKG	Smoking Cessation	Coverage for the treatment of smoking cessation drugs, which may have specific restrictions
ST	Step Therapy	Coverage may require one or more "prerequisite" first step drugs to be tried before progressing to the second step drug

Please refer to the formulary listing beginning on Page 4 for details regarding specific agents.

Medication Request Process

Formulary Agents

- A. Prior Authorization (PA): These drugs require approval prior to being dispensed at a network pharmacy. Requests are reviewed with specific Prior Authorization guidelines. Each request will be reviewed on individual patient need. If the request does not meet the guidelines established by the P&T Committee, the request will not be approved and alternative therapy may be recommended.
- B. Quantity Limits (QL): These drugs have quantity limits. If quantities exceeding the limit are necessary, an exception to coverage may be requested by the prescriber. Each request will be reviewed on individual patient need. Approval will be given if a documented medical need exists without compromising safety.
- C. Step Therapy (ST): These drugs require one or more first step drugs to be tried before progressing to the second step drug. If there is a medical need to use a second step drug without trying a first step drug, an exception to coverage may be requested by the prescriber. Each request will be reviewed on an individual patient need. Approval will be given if a documented medical need exists.

Non-Formulary Agents

- A. Any drug not found on this list is considered non-formulary. Coverage for non-formulary agents may be requested by the prescriber. Each request will be reviewed on individual patient need. Approval will be given if a documented medical need exists.
- B. The 'Medication Request Process' is generally not available for drugs that are specifically excluded by benefit design. For benefit exclusions refer to the 'General Exclusions' section below.

Non-approved requests may be appealed. The prescriber must provide information to support the appeal on the basis of medical necessity.

General Benefit Exclusions (Not Covered)

Please note that this list is subject to change.

- A. Drugs specifically listed as not covered
- B. Any drug products used for cosmetic purposes
- C. Infertility agents
- D. Experimental drug products, or any drug product used in an experimental manner
- E. Non self-administered injectable drug products are not covered unless otherwise specified in the formulary listing
- F. Foreign drugs or drugs not approved by the United States Food & Drug Administration

Pharmacist and Physician Feedback

The formulary is a tool to promote cost-effective prescription drug use. L.A. Care has made every attempt to create a document that meets all therapeutic needs; however, the art of medicine makes this a formidable task. L.A. Care welcomes the participation of physicians, pharmacists, and ancillary medical providers, in this dynamic process. Physicians and pharmacists are highly encouraged to direct any suggestions or comments to L.A. Care via e-mail to PharmacyandFormulary@lacare.org.

Search Tip:

This is a large document, but you can search quickly and easily by clicking on the binocular icon on your toolbar. It will then display a search box for you to type in the name of the drug you want to locate. If you do not know the correct spelling, you can start your search by entering just the first few letters of the name.

L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Alphabetical Index
Last Updated 11/1/2017

Drug Name	Special Code	Tier	Category
8-MOP CAP	KMSP	2	DERMATOLOGICALS
abacavir soln (ZIAGEN equiv)	-	4	ANTIVIRALS
abacavir tab (ZIAGEN equiv)	-	4	ANTIVIRALS
abacavir/lamivudine tab (EPZICOM equiv)	-	4	ANTIVIRALS
abacavir/lamivudine/zidovudine tab (TRIZIVIR equiv)	-	4	ANTIVIRALS
ABILIFY DISCMELT (QL= 2 tabs/day)	PA-QL	3	ANTI PSYCHOTICS/ANTIMANIC AGENTS
ABILIFY SOLN	PA	3	ANTI PSYCHOTICS/ANTIMANIC AGENTS
ABILIFY TAB	-	3	ANTI PSYCHOTICS/ANTIMANIC AGENTS
ABSORICA CAP	-	NC	DERMATOLOGICALS
ABSTRAL SL TAB (QL= 120 tabs/30 days)	PA-QL	3	ANALGESICS - OPIOID
acamprosate calcium DR tab (CAMPRAL equiv)	-	1	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
ACANYA GEL, ONEXTON GEL	-	3	DERMATOLOGICALS
acarbose tab (PRECOSE equiv)	-	1	ANTIDIABETICS
ACCOLATE TAB	-	3	ANTI ASTHMATIC AND BRONCHODILATOR AGENTS
ACCU-CHECK GUIDE CARE METER	OTC	\$0	MEDICAL DEVICES AND SUPPLIES
ACCU-CHEK AVIVA PLUS METER	OTC	\$0	MEDICAL DEVICES AND SUPPLIES
ACCU-CHEK AVIVA PLUS TEST STRIP (Limited to 50 strips per month for members not on diabetes medication)	OTC	2	DIAGNOSTIC PRODUCTS
ACCU-CHEK GUIDE TEST STRIP (Limited to 50 strips per month for members not on diabetes medication)	OTC	2	DIAGNOSTIC PRODUCTS
ACCU-CHEK NANO METER	OTC	\$0	MEDICAL DEVICES AND SUPPLIES
ACCU-CHEK SMARTVIEW TEST STRIP (Limited to 50 strips per month for members not on diabetes medication)	OTC	2	DIAGNOSTIC PRODUCTS
ACCU-CHEK TEST STRIP (Limited to 50 strips per month for members not on diabetes medication)	OTC	2	DIAGNOSTIC PRODUCTS
ACCUNEb NEB SOLN	-	3	ANTI ASTHMATIC AND BRONCHODILATOR AGENTS
ACCU PRIL TAB	-	3	ANTI HYPERTENSIVES
ACCURETIC TAB	-	3	ANTI HYPERTENSIVES
acebutolol cap (SECTRAL equiv)	-	1	BETA BLOCKERS
ACEON TAB	-	3	ANTI HYPERTENSIVES
ACETAMINOPHEN/CAFFEINE/DIHYDROCODEINE CAP	-	3	ANALGESICS - OPIOID
ACETAMINOPHEN/CAFFEINE/DIHYDROCODEINE TAB	-	3	ANALGESICS - OPIOID
acetaminophen/codeine soln	-	1	ANALGESICS - OPIOID
acetaminophen/codeine tab (TYLENOL/CODEINE equiv)	-	1	ANALGESICS - OPIOID
acetaminophen/isometheptene/dichloral cap (MIDRIN equiv)	-	NC	MIGRAINE PRODUCTS
ACETASOL HC OTIC SOLN	-	3	OTIC AGENTS
acetazolamide ER cap (DIAMOX SEQUEL equiv)	-	1	DIURETICS
acetazolamide tab	-	1	DIURETICS
acetic acid otic soln (VOSOL equiv)	-	1	OTIC AGENTS
ACETIC ACID/ALUMINUM ACETATE OTIC SOLN	-	1	OTIC AGENTS
acetic acid/hydrocortisone otic soln (VOSOL HC equiv)	-	1	OTIC AGENTS
acetylcysteine soln (MUCOMYST equiv)	-	1	COUGH/COLD/ALLERGY
ACIDIC VAGINAL JELLY	-	2	VAGINAL PRODUCTS

INF	NC =Not Covered Infertility	KMSP	generic =small letters Kroger Mandatory Specialty Pharmacy Program	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 N	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary Cont.
Alphabetical Index
Last Updated 11/1/2017

Drug Name	Special Code	Tier	Category
ACIPHEX SPRINKLE CAP	-	NC	ULCER DRUGS
ACIPHEX TAB	-	NC	ULCER DRUGS
acitretin cap (SORIATANE equiv)	KMSP	4	DERMATOLOGICALS
ACLOVATE CREAM	-	3	DERMATOLOGICALS
ACLOVATE OINT	-	3	DERMATOLOGICALS
ACTEMRA SC INJ (QL= 2 inj/28 days)	LMSP-PA-QL	4	ANALGESICS - ANTI-INFLAMMATORY
ACTICLATE TAB 75MG, 150MG	-	NC	TETRACYCLINES
ACTIGALL CAP	-	3	GASTROINTESTINAL AGENTS - MISC.
ACTIMMUNE INJ (Only available through Walgreens 888-347-3416)	LD	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ACTIQ LOZENGE (QL= 120 units/30 days)	PA-QL	3	ANALGESICS - OPIOID
ACTIVELLA TAB	-	3	ESTROGENS
ACTONEL TAB	-	3	ENDOCRINE AND METABOLIC AGENTS - MISC.
ACTOPLUS MET TAB	-	3	ANTIDIABETICS
ACTOPLUS MET XR TAB	-	3	ANTIDIABETICS
ACTOS TAB	-	3	ANTIDIABETICS
ACULAR (LS) OPHTH SOLN	-	3	OPHTHALMIC AGENTS
ACUVAIL OPHTH SOLN	-	3	OPHTHALMIC AGENTS
acyclovir cap (ZOVIRAX equiv)	-	1	ANTIVIRALS
acyclovir oint (ZOVIRAX OINT equiv)	-	NC	DERMATOLOGICALS
acyclovir susp (ZOVIRAX equiv)	-	1	ANTIVIRALS
acyclovir tab (ZOVIRAX equiv)	-	1	ANTIVIRALS
ACZONE GEL	-	NC	DERMATOLOGICALS
ACZONE GEL 7.5%	-	NC	DERMATOLOGICALS
ADAGEN INJ	M	M	BIOLOGICALS MISC
ADALAT CC TAB	-	3	CALCIUM CHANNEL BLOCKERS
adapalene cream (DIFFERIN equiv) (Acne Only – members age 26 or older require Prior Authorization)	PA	1	DERMATOLOGICALS
adapalene gel (DIFFERIN equiv) (Acne Only – members age 26 or older require Prior Authorization)	PA	1	DERMATOLOGICALS
ADAPALENE LOTION (Acne Only – members age 26 or older require Prior Authorization)	PA	2	DERMATOLOGICALS
adapalene/benzoyl peroxide gel 0.1-2.5% (EPIDUO equiv) (Acne Only – members age 26 or older require Prior Authorization)	PA	1	DERMATOLOGICALS
ADASUVE INHALER	-	NC	ANTIPSYCHOTICS/ANTIMANIC AGENTS
ADAZIN CREAM	-	NC	DERMATOLOGICALS
ADCIRCA TAB	LMSP-PA	4	CARDIOVASCULAR AGENTS - MISC.
ADDERALL TAB	-	3	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS
ADDERALL XR CAP	-	1	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS
ADDYI TAB	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
adefovir dipivoxil tab (HEPSERA equiv)	KMSP	4	ANTIVIRALS
ADEMPAS TAB (QL= 3 tabs/day; Only available through Accredo 888-773-7376)	LD-PA-QL	4	CARDIOVASCULAR AGENTS - MISC.
ADIPEX-P CAP	PA-QL	3	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS
ADIPEX-P TAB	PA-QL	3	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS

INF	NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS
LMSP	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program	LD	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	PA	Prior Authorization	QL	Quantity Limit
SP	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 M	SMKG	Smoking Cessation
	Available through Specialty Pharmacy Program	ST	Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary Cont.
Alphabetical Index
Last Updated 11/1/2017

Drug Name	Special Code	Tier	Category
ADLYXIN INJ	-	NC	ANTIDIABETICS
ADOXA PAK	-	NC	TETRACYCLINES
ADOXA TAB	-	3	TETRACYCLINES
ADRENALICK INJ, EPINEPHRINE INJ (QL= 2 inj/fill; Step Therapy requires t of EPINEPHRINE PEN (MYLAN))	QL-ST	3	VASOPRESSORS
ADVAIR DISKUS INHALER	-	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ADVAIR HFA INHALER	-	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ADVICOR TAB	-	NC	ANTIHYPERTENSIVES
ADZENYS XR TAB	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
AEROCHAMBER	OTC	2	MEDICAL DEVICES AND SUPPLIES
AEROCHAMBER SUPPLIES	-	2	MEDICAL DEVICES AND SUPPLIES
AEROSPAN HFA INHALER	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
AFINITOR DISPERZ (QL= 1 tab/day)	KMSP-PA-QL-SF	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
AFINITOR TAB (QL= 1 tab/day)	KMSP-PA-QL-SF	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
AFLURIA INJ	VAC	\$0	VACCINES
AFLURIA INJ, FLUZONE INJ	VAC	\$0	VACCINES
AFSTYLA KIT	-	NC	HEMATOLOGICAL AGENTS - MISC.
AGGRENOX CAP	-	3	HEMATOLOGICAL AGENTS - MISC.
AGRYLIN CAP	-	3	HEMATOLOGICAL AGENTS - MISC.
AIRDUO RESPICLICK	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
AKNE-MYCIN OINT	-	3	DERMATOLOGICALS
AKYNZEO CAP (QL= 1 cap/fill; Restricted to Oncology or Hematology Specialist)	QL-RS	2	ANTIEMETICS
ALAMAST OPHTH SOLN	-	2	OPHTHALMIC AGENTS
ALBATUSIN LIQUID	-	3	COUGH/COLD/ALLERGY
ALBENZA TAB	-	3	ANTHELMINTICS
albuterol neb soln 0.083% (PROVENTIL equiv)	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
albuterol neb soln 0.5% (VENTOLIN equiv)	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
albuterol neb soln 0.63mg (ACCUNEB equiv)	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
albuterol neb soln 1.25mg (ACCUNEB equiv)	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
albuterol sulfate ER tab (VOSPIRE ER equiv)	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
albuterol sulfate syrup	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
albuterol sulfate tab	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
albuterol/ipratropium neb soln (DUONEB equiv)	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ALCAINE OPHTH SOLN	-	3	OPHTHALMIC AGENTS
alclometasone cream (ACLOVATE equiv)	-	1	DERMATOLOGICALS

INF	NC =Not Covered	KMSP	generic =small letters	LD	BRANDS =CAPITAL LETTERS
LMSP	Infertility	M	Kroger Mandatory Specialty Pharmacy Program	MSP	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	PA	Medical Benefit	QL	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	SF	Prior Authorization	SMKG	Quantity Limit
SP	Restricted to Specialist	ST	Limited to Two 15 Day Fills per Month for the First 3 Months	VAC	Smoking Cessation
	Available through Specialty Pharmacy Program		Step Therapy		Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary Cont.
Alphabetical Index
Last Updated 11/1/2017

Drug Name	Special Code	Tier	Category
alclometasone oint (ACLOVATE OINT equiv)	-	1	DERMATOLOGICALS
ALCOHOL SWABS	OTC	1	MEDICAL DEVICES AND SUPPLIES
ALCORTIN A GEL	-	NC	DERMATOLOGICALS
ALDACTAZIDE TAB	-	3	DIURETICS
ALDACTAZIDE TAB 50-50MG	-	3	DIURETICS
ALDACTONE TAB	-	3	DIURETICS
ALDARA CREAM	-	3	DERMATOLOGICALS
ALDURAZYME INJ	M	M	ENDOCRINE AND METABOLIC AGENTS - MISC.
ALECENSA CAP (QL= 8 caps/day)	MSP-PA-QL	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ALENDRONATE SOLN	-	3	ENDOCRINE AND METABOLIC AGENTS - MISC.
alendronate tab (FOSAMAX equiv)	-	1	ENDOCRINE AND METABOLIC AGENTS - MISC.
ALENDRONATE TAB 40MG	-	2	ENDOCRINE AND METABOLIC AGENTS - MISC.
ALFERON-N INJ	KMSP	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
alfuzosin SR tab (UROXATRAL equiv)	-	1	GENITOURINARY AGENTS - MISCELLANEOUS
ALINIA SUSP (QL= 60ml/3 days)	PA-QL	2	ANTI-INFECTIVE AGENTS - MISC.
ALINIA TAB (QL= 6 tabs/3 days)	PA-QL	2	ANTI-INFECTIVE AGENTS - MISC.
ALKERAN TAB	KMSP	3	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
allopurinol tab (ZYLOPRIM equiv)	-	1	GOUT AGENTS
almotriptan tab (AXERT equiv) (QL= 9 tabs/fill, 2 fills/30 days)	QL	1	MIGRAINE PRODUCTS
ALOCRILOPHTH SOLN	-	2	OPHTHALMIC AGENTS
ALOGLIPTIN TAB (QL= 1 tab/day)	QL	2	ANTIDIABETICS
ALOGLIPTIN-METFORMIN TAB (QL= 2 tabs/day)	QL	2	ANTIDIABETICS
ALOGLIPTIN-PIOGLITAZONE TAB (QL= 1 tab/day)	QL	2	ANTIDIABETICS
ALOMIDE OPHTH SOLN	-	2	OPHTHALMIC AGENTS
ALOQUIN GEL	-	NC	DERMATOLOGICALS
ALORA PATCH	-	3	ESTROGENS
alosetron tab (LOTRONEX equiv)	-	1	GASTROINTESTINAL AGENTS - MISC.
ALPHAGAN P OPHTH SOLN	-	2	OPHTHALMIC AGENTS
ALPHAGAN P OPHTH SOLN 0.1%	-	2	OPHTHALMIC AGENTS
alprazolam ER tab (XANAX XR equiv)	-	1	ANTI-ANXIETY AGENTS
alprazolam ODT (NIRAVAM equiv)	-	1	ANTI-ANXIETY AGENTS
alprazolam tab (XANAX equiv)	-	1	ANTI-ANXIETY AGENTS
ALREX OPHTH SUSP, LOTEMAX OPHTH SUSP	-	2	OPHTHALMIC AGENTS
ALSUMA INJ, ZEMBRACE SYMTOUCH INJ	-	NC	MIGRAINE PRODUCTS
ALTABAX OINT	-	3	DERMATOLOGICALS
ALTACE CAP	-	3	ANTI-HYPERTENSIVES
ALTACE TAB	-	3	ANTI-HYPERTENSIVES
ALTOPREV TAB	-	3	ANTI-HYPERLIPIDEMICS
aluminum chloride soln (DRYSOL equiv)	-	1	DERMATOLOGICALS
ALUNBRIG TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ALVESCO INHALER	-	NC	ANTI-ASTHMATIC AND BRONCHODILATOR AGENTS

INF	NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS
LMSP	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program	LD	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	PA	Prior Authorization	QL	Quantity Limit
SP	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 Months	SMKG	Smoking Cessation
	Available through Specialty Pharmacy Program	ST	Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary Cont.
Alphabetical Index
Last Updated 11/1/2017

Drug Name	Special Code	Tier	Category
ALZAIR NASAL SPRAY	-	NC	NASAL AGENTS - SYSTEMIC AND TOPICAL
amantadine cap (SYMMETREL equiv)	-	1	ANTIPARKINSON AGENTS
amantadine syrup (SYMMETREL equiv)	-	1	ANTIPARKINSON AGENTS
amantadine tab	-	1	ANTIPARKINSON AGENTS
AMARYL TAB	-	3	ANTIDIABETICS
AMBIEN CR TAB	-	NC	HYPNOTICS/SEDATIVES/SLEEP DISORDEI AGENTS
AMBIEN TAB (QL= 1 tab/day)	QL	3	HYPNOTICS/SEDATIVES/SLEEP DISORDEI AGENTS
AMCINONIDE CREAM 0.1%	-	NC	DERMATOLOGICALS
AMCINONIDE LOTION	-	NC	DERMATOLOGICALS
AMCINONIDE OINT	-	NC	DERMATOLOGICALS
AMERGE TAB (QL= 9 tabs/fill, 2 fills/30 days)	QL	3	MIGRAINE PRODUCTS
amethyst tab (LYBREL equiv)	-	\$0	CONTRACEPTIVES
AMICAR SOLN	-	2	HEMOSTATICS
AMICAR SYRUP	-	3	HEMOSTATICS
AMICAR TAB	-	2	HEMOSTATICS
amikacin inj (KANAMYCIN equiv)	M	M	AMINOGLYCOSIDES
amiloride tab (MIDAMOR equiv)	-	1	DIURETICS
amiloride/hydrochlorothiazide tab (MODURETIC equiv)	-	1	DIURETICS
aminocaproic acid syrup (AMICAR equiv)	-	1	HEMOSTATICS
aminocaproic acid tab (AMICAR equiv)	-	1	HEMOSTATICS
AMINOCAPROIC ACID TAB	-	3	HEMOSTATICS
aminophylline tab	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
amiodarone tab (CORDARONE equiv)	-	1	ANTIARRHYTHMICS
AMITIZA CAP	PA	3	GASTROINTESTINAL AGENTS - MISC.
amitriptyline tab (ELAVIL equiv)	-	1	ANTIDEPRESSANTS
amlodipine tab (NORVASC equiv)	-	1	CALCIUM CHANNEL BLOCKERS
amlodipine/atorvastatin tab (CADUET equiv)	-	1	CARDIOVASCULAR AGENTS - MISC.
amlodipine/benazepril cap (LOTREL equiv)	-	1	ANTIHYPERTENSIVES
amlodipine/olmesartan tab (AZOR TAB equiv)	-	NC	ANTIHYPERTENSIVES
amlodipine/valsartan tab (EXFORGE equiv)	-	1	ANTIHYPERTENSIVES
amlodipine/valsartan/hydrochlorothiazide tab (EXFORGE HCT equiv)	-	1	ANTIHYPERTENSIVES
AMMONIUM CHLORIDE INJ	M	M	MINERALS & ELECTROLYTES
ammonium lactate cream (LAC-HYDRIN equiv)	-	1	DERMATOLOGICALS
ammonium lactate lotion (LAC-HYDRIN equiv)	-	1	DERMATOLOGICALS
AMOXAPINE TAB	-	1	ANTIDEPRESSANTS
amoxicillin cap (TRIMOX equiv)	-	1	PENICILLINS
amoxicillin chew tab (AMOXIL equiv)	-	1	PENICILLINS
AMOXICILLIN CHEW TAB 250MG	-	1	PENICILLINS
amoxicillin susp (TRIMOX equiv)	-	1	PENICILLINS
amoxicillin tab (AMOXIL equiv)	-	1	PENICILLINS
amoxicillin/clavulanate chew tab (AUGMENTIN equiv)	-	1	PENICILLINS
amoxicillin/clavulanate ER tab (AUGMENTIN XR equiv)	-	1	PENICILLINS
amoxicillin/clavulanate susp (AUGMENTIN ES equiv)	-	1	PENICILLINS
amoxicillin/clavulanate tab (AUGMENTIN equiv)	-	1	PENICILLINS
amphetamine ER cap (ADDERALL XR equiv)	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS

INF	NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS
LMSP	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program	LD	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	PA	Prior Authorization	QL	Quantity Limit
SP	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 M	SMKG	Smoking Cessation
	Available through Specialty Pharmacy Program	ST	Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary Cont.
Alphabetical Index
Last Updated 11/1/2017

Drug Name	Special Code	Tier	Category
amphetamine/dextroamphetamine tab (ADDERALL equiv)	-	1	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
AMPICILLIN CAP	-	1	PENICILLINS
ampicillin cap (PRINCIPEN equiv)	-	1	PENICILLINS
ampicillin susp (PRINCIPEN equiv)	-	1	PENICILLINS
ampicillin/sulbactam inj	M	M	PENICILLINS
AMPYRA TAB (QL= 2 tabs/day)	MSP-PA-QL	3	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
AMTURNIDE TAB	-	3	ANTIHYPERTENSIVES
ANADROL TAB	-	3	ANDROGENS-ANABOLIC
ANAFRANIL CAP	-	3	ANTIDEPRESSANTS
anagrelide cap (AGRYLIN equiv)	-	1	HEMATOLOGICAL AGENTS - MISC.
ANALPRAM-E KIT	-	3	ANORECTAL AGENTS
ANALPRAM-HC CREAM	-	NC	ANORECTAL AGENTS
ANAPROX TAB	-	3	ANALGESICS - ANTI-INFLAMMATORY
ANASPAZ ODT	-	3	ULCER DRUGS
ANASTIA LOTION	-	NC	DERMATOLOGICALS
anastrozole tab (ARIMIDEX equiv)	-	1	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ANCOBON CAP	-	3	ANTIFUNGALS
ANDRODERM PATCH (QL= 1 patch/day)	PA-QL	2	ANDROGENS-ANABOLIC
ANDROGEL 1% 25MG (QL= 1 packet/day)	PA-QL	3	ANDROGENS-ANABOLIC
ANDROGEL 1% 50MG, TESTIM GEL 1% (QL= 2 packets/day)	PA-QL	3	ANDROGENS-ANABOLIC
ANDROGEL 1.62% 1.25GM (QL= 1 packet/day)	PA-QL	2	ANDROGENS-ANABOLIC
ANDROGEL 1.62% 2.5GM (QL= 2 packets/day)	PA-QL	2	ANDROGENS-ANABOLIC
ANDROGEL PUMP 1% (QL= 4 bottles/30 days)	PA-QL	3	ANDROGENS-ANABOLIC
ANDROGEL PUMP 1.62% (QL= 2 bottles/30 days)	PA-QL	2	ANDROGENS-ANABOLIC
ANDROID CAP, TESTRED CAP	PA	3	ANDROGENS-ANABOLIC
ANDROXY TAB	-	2	ANDROGENS-ANABOLIC
ANGELIQ TAB	-	3	ESTROGENS
ANORO ELLIPTA INHALER	-	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ANTABUSE TAB	-	2	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
ANTARA CAP	-	NC	ANTIHYPERLIPIDEMICS
ANTARA CAP, LOFIBRA CAP	-	NC	ANTIHYPERLIPIDEMICS
antipyrine/benzocaine otic soln (AURALGAN equiv)	-	NC	OTIC AGENTS
ANTIVERT TAB	-	1	ANTIEMETICS
ANUSOL-HC CREAM	-	3	ANORECTAL AGENTS
ANUSOL-HC SUPP	-	NC	ANORECTAL AGENTS
ANZEMET TAB (QL= 9 tabs/fill)	QL-SP	4	ANTIEMETICS
APEXICON E CREAM (PSORCON E equiv)	-	NC	DERMATOLOGICALS
APHTHASOL PASTE	-	2	MOUTH/THROAT/DENTAL AGENTS
APIDRA INJ (Step Therapy requires trial of NOVLOG)	ST	3	ANTIDIABETICS
APIDRA SOLOSTAR INJ (Step Therapy requires trial of NOVLOG)	ST	3	ANTIDIABETICS
APLENZIN TAB	-	NC	ANTIDEPRESSANTS
APOKYN INJ (Only available through Walgreens 888-347-3416)	LD	4	ANTIPARKINSON AGENTS
apraclonidine ophth soln (IOPIDINE equiv)	-	1	OPHTHALMIC AGENTS
aprepitant cap (EMEND equiv) (QL= 3 caps/fill; Restricted to Oncology or Hematology Specialist)	QL-RS	1	ANTIEMETICS

INF	NC =Not Covered	KMSP	generic =small letters	LD	BRANDS =CAPITAL LETTERS
LMSP	Infertility	M	Kroger Mandatory Specialty Pharmacy Program	MSP	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	PA	Medical Benefit	QL	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	SF	Prior Authorization	SMKG	Quantity Limit
SP	Restricted to Specialist	ST	Limited to Two 15 Day Fills per Month for the First 3 M	VAC	Smoking Cessation
	Available through Specialty Pharmacy Program		Step Therapy		Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary Cont.
Alphabetical Index
Last Updated 11/1/2017

Drug Name	Special Code	Tier	Category
aprepitant pak (EMEND equiv) (QL= 3 caps/fill; Restricted to Oncology or Hematology Specialist)	QL-RS	1	ANTIEMETICS
apri tab (DESOGEN equiv)	-	\$0	CONTRACEPTIVES
APRISO CAP	-	2	GASTROINTESTINAL AGENTS - MISC.
APTIOM TAB	-	NC	ANTICONSULTANTS
APTIVUS CAP	-	4	ANTIVIRALS
APTIVUS SOLN	-	4	ANTIVIRALS
ARALEN TAB	-	3	ANTIMALARIALS
aranelle tab (TRI-NORINYL equiv)	-	\$0	CONTRACEPTIVES
ARANESP INJ (Step Therapy requires trial of EPOGEN or PROCRT)	KMSP-ST	4	HEMATOPOIETIC AGENTS
ARAVA TAB	-	3	ANALGESICS - ANTI-INFLAMMATORY
ARICEPT ODT (QL= 1 tab/day)	QL	3	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
ARICEPT TAB (QL= 2 tabs/day)	QL	3	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
ARICEPT TAB 23MG (QL= 1 tab/day; Step Therapy requires trial of donepezil 10mg)	QL-ST	3	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
ARIMIDEX TAB	-	3	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
aripiprazole ODT (ABILIFY equiv) (QL= 2 tabs/day)	PA-QL	1	ANTIPSYCHOTICS/ANTIMANIC AGENTS
aripiprazole soln (ABILIFY equiv)	PA	1	ANTIPSYCHOTICS/ANTIMANIC AGENTS
aripiprazole tab (ABILIFY equiv)	-	1	ANTIPSYCHOTICS/ANTIMANIC AGENTS
ARIXTRA INJ	PA	3	ANTICOAGULANTS
armodafinil tab (NUVIGIL equiv) (QL= 1 tab/day)	PA-QL	1	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
ARMONAIR RESPICLICK	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ARMOUR THYROID TAB, NATURE THROID TAB	-	1	THYROID AGENTS
ARNUIITY ELLIPTA INHALER	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
AROMASIN TAB	-	3	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ARTHROTEC TAB	-	3	ANALGESICS - ANTI-INFLAMMATORY
ARYMO ER TAB	-	NC	ANALGESICS - OPIOID
ASACOL HD TAB, MESALAMINE TAB	-	NC	GASTROINTESTINAL AGENTS - MISC.
ASMANEX HFA INHALER	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ASMANEX INHALER	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ASPIRIN CHEW TAB 75MG (Covered for males age 45-79 and females age 55-79)	OTC	\$0	ANALGESICS - NONNARCOTIC
aspirin chew tab 81mg (Covered for males age 45-79; Covered for females (no age restriction))	OTC	\$0	ANALGESICS - NONNARCOTIC
aspirin ec tab 325mg (Covered for males age 45-79 and females age 55-79)	OTC	\$0	ANALGESICS - NONNARCOTIC
aspirin ec tab 81mg (Covered for males age 45-79; Covered for females (no age restriction))	OTC	\$0	ANALGESICS - NONNARCOTIC
aspirin tab 325mg (Covered for males age 45-79 and females age 55-79)	OTC	\$0	ANALGESICS - NONNARCOTIC
ASPIRIN TAB 81MG (Covered for males age 45-79; Covered for females (no age restriction))	OTC	\$0	ANALGESICS - NONNARCOTIC
aspirin/codeine tab	-	1	ANALGESICS - OPIOID
aspirin/dipyridamole cap (AGGRENOX equiv)	-	1	HEMATOLOGICAL AGENTS - MISC.

INF	NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS
LMSP	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program	LD	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	PA	Prior Authorization	QL	Quantity Limit
SP	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 M	SMKG	Smoking Cessation
	Available through Specialty Pharmacy Program	ST	Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary Cont.
Alphabetical Index
Last Updated 11/1/2017

Drug Name	Special Code	Tier	Category
ASTAMED MYO CAP	-	NC	DIETARY PRODUCTS/DIETARY MANAGEMENT PRODUCTS
ASTELIN NASAL SPRAY, ASTEPRO NASAL SPRAY	-	3	NASAL AGENTS - SYSTEMIC AND TOPICAL
ATACAND HCT TAB	-	3	ANTIHYPERTENSIVES
ATACAND TAB	-	NC	ANTIHYPERTENSIVES
ATELVIA TAB (Step Therapy requires trial of alendronate)	ST	3	ENDOCRINE AND METABOLIC AGENTS - MISC.
atenolol tab (TENORMIN equiv)	-	1	BETA BLOCKERS
atenolol/chlorthalidone tab (TENORETIC equiv)	-	1	ANTIHYPERTENSIVES
ATIVAN TAB	-	3	ANTIAXIETY AGENTS
atomoxetine cap (STRATTERA equiv)	-	1	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
atorvastatin tab 10mg (LIPITOR equiv)	-	1	ANTIHYPERLIPIDEMICS
atorvastatin tab 20mg (LIPITOR equiv)	-	1	ANTIHYPERLIPIDEMICS
atorvastatin tab 40mg (LIPITOR equiv)	-	1	ANTIHYPERLIPIDEMICS
atorvastatin tab 80mg (LIPITOR equiv)	-	1	ANTIHYPERLIPIDEMICS
atovaquone susp (MEPRON equiv)	-	1	ANTI-INFECTIVE AGENTS - MISC.
atovaquone/proguanil tab (MALARONE equiv)	-	1	ANTIMALARIALS
ATRALIN GEL, RETIN-A GEL	PA	3	DERMATOLOGICALS
ATRIPLA TAB (QL= 1 tab/day)	QL	4	ANTIVIRALS
atropine ophth oint	-	1	OPHTHALMIC AGENTS
atropine ophth soln (ISOPTO ATROPINE equiv)	-	1	OPHTHALMIC AGENTS
ATROVENT HFA INHALER	-	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ATROVENT NASAL SPRAY	-	3	NASAL AGENTS - SYSTEMIC AND TOPICAL
AUBAGIO TAB	LMSP	4	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
AUGMENTIN ES-600 SUSP	-	3	PENICILLINS
AUGMENTIN SUSP	-	3	PENICILLINS
AUGMENTIN TAB	-	3	PENICILLINS
AUGMENTIN XR TAB	-	3	PENICILLINS
AURYXIA TAB	-	3	GASTROINTESTINAL AGENTS - MISC.
AUSTEDO TAB	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
AUVI-Q INJ (QL= 2 inj/fill; Step Therapy requires trial of EPINEPHRINE PEN (MYLAN))	QL-ST	3	VASOPRESSORS
AVALIDE TAB	-	3	ANTIHYPERTENSIVES
AVANDAMET TAB	-	2	ANTIDIABETICS
AVANDARYL TAB	-	2	ANTIDIABETICS
AVANDIA TAB	-	2	ANTIDIABETICS
AVAPRO TAB	-	3	ANTIHYPERTENSIVES
AVAR AEROSOL FOAM	-	3	DERMATOLOGICALS
AVAR GEL	-	2	DERMATOLOGICALS
AVAR PAD	-	NC	DERMATOLOGICALS
AVC VAGINAL CREAM	-	2	VAGINAL PRODUCTS
AVELOX TAB	-	3	FLUOROQUINOLONES
aviane tab (ALESSE equiv)	-	\$0	CONTRACEPTIVES
AVINZA CAP (QL= 2 caps/day)	QL	3	ANALGESICS - OPIOID
AVODART CAP	-	3	GENITOURINARY AGENTS - MISCELLANEOUS

INF	NC =Not Covered Infertility	KMSP	generic =small letters Kroger Mandatory Specialty Pharmacy Program	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 M	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary Cont.
Alphabetical Index
Last Updated 11/1/2017

Drug Name	Special Code	Tier	Category
AVONEX INJ	LMSP	4	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
AXERT TAB (QL= 9 tabs/fill, 2 fills/30 days)	QL	3	MIGRAINE PRODUCTS
AXID CAP	-	3	ULCER DRUGS
AXID SOLN	-	3	ULCER DRUGS
AXIRON SOLN (QL= 2 bottles/30 days)	PA-QL	3	ANDROGENS-ANABOLIC
AYGESTIN TAB	-	3	PROGESTINS
AZASAN TAB	-	3	ASSORTED CLASSES
AZASITE SOLN	-	2	OPHTHALMIC AGENTS
azathioprine tab (IMURAN equiv)	-	1	ASSORTED CLASSES
azelastine nasal spray (ASTELIN, ASTEPRO equiv)	-	1	NASAL AGENTS - SYSTEMIC AND TOPICAL
azelastine ophth soln (OPTIVAR equiv)	-	1	OPHTHALMIC AGENTS
AZELEX CREAM	PA	3	DERMATOLOGICALS
AZENASE PAK	-	NC	NASAL AGENTS - SYSTEMIC AND TOPICAL
AZILECT TAB	-	3	ANTIPARKINSON AGENTS
azithromycin susp (ZITHROMAX equiv)	-	1	MACROLIDES
azithromycin tab (ZITHROMAX equiv)	-	1	MACROLIDES
AZOPT OPTH SUSP	-	2	OPHTHALMIC AGENTS
AZOR TAB	-	NC	ANTIHYPERTENSIVES
AZULFIDINE EN TAB	-	3	GASTROINTESTINAL AGENTS - MISC.
AZULFIDINE TAB	-	3	GASTROINTESTINAL AGENTS - MISC.
BACITRACIN OPTH OINT	-	2	OPHTHALMIC AGENTS
bacitracin/neomycin/polymyxin b ophth oint (NEOSPORIN equiv)	-	1	OPHTHALMIC AGENTS
bacitracin/polymyxin b ophth oint (POLYSPORIN equiv)	-	1	OPHTHALMIC AGENTS
bacitracin/polymyxin/neomycin/hydrocortisone ophth oint (CORTISPORIN equiv)	-	1	OPHTHALMIC AGENTS
BACLOFEN CREAM COMPOUND KIT	-	NC	DERMATOLOGICALS
baclofen tab	-	1	MUSCULOSKELETAL THERAPY AGENTS
BACTRIM DS TAB	-	3	ANTI-INFECTIVE AGENTS - MISC.
BACTROBAN CREAM	-	3	DERMATOLOGICALS
BACTROBAN NASAL OINT	-	3	NASAL AGENTS - SYSTEMIC AND TOPICAL
BACTROBAN OINT	-	3	DERMATOLOGICALS
balsalazide cap (COLAZAL equiv)	-	1	GASTROINTESTINAL AGENTS - MISC.
BANZEL SUSP	-	2	ANTICONVULSANTS
BANZEL TAB	-	2	ANTICONVULSANTS
BARACLUDE TAB (QL= 1 tab/day)	KMSP-QL	4	ANTIVIRALS
BASAGLAR INJ	-	2	ANTIDIABETICS
BAXDELA TAB	-	NC	FLUOROQUINOLONES
B-D INSULIN SYRINGE	OTC	1	MEDICAL DEVICES AND SUPPLIES
B-D PEN NEEDLE	OTC	1	MEDICAL DEVICES AND SUPPLIES
b-donna tab (DONNATAL equiv)	-	NC	ULCER DRUGS
BECONASE AQ NASAL SPRAY (QL= 2 bottles/fill; Step Therapy requires trial of 2: flunisolide, fluticasone, triamcinolone or NASONEX)	QL-ST	3	NASAL AGENTS - SYSTEMIC AND TOPICAL
BELBUCA FILM	-	NC	ANALGESICS - OPIOID
BELLADONNA ALKALOID/OPIUM SUPP	-	2	ULCER DRUGS
BELSOMRA TAB	-	NC	HYPNOTICS
BELVIQ TAB (QL= 2 tabs/day)	PA-QL	2	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS
BELVIQ XR TAB (QL= 1 tab/day)	PA-QL	2	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS

INF	NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS
LMSP	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program	LD	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	PA	Prior Authorization	QL	Quantity Limit
SP	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 M	SMKG	Smoking Cessation
	Available through Specialty Pharmacy Program	ST	Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary Cont.
Alphabetical Index
Last Updated 11/1/2017

Drug Name	Special Code	Tier	Category
benazepril tab (LOTENSIN equiv)	-	1	ANTIHYPERTENSIVES
benazepril/hydrochlorothiazide tab (LOTENSIN HCT equiv)	-	1	ANTIHYPERTENSIVES
BENICAR HCT TAB	-	NC	ANTIHYPERTENSIVES
BENICAR TAB	-	NC	ANTIHYPERTENSIVES
BENLYSTA AUTO-INJECTOR	-	NC	MISCELLANEOUS THERAPEUTIC CLASSE
BENLYSTA INJ	-	NC	MISCELLANEOUS THERAPEUTIC CLASSE
BENTYL CAP	-	3	ULCER DRUGS
BENTYL SYRUP	-	3	ULCER DRUGS
BENTYL TAB	-	3	ULCER DRUGS
BENZAC WASH	-	NC	DERMATOLOGICALS
BENZACLIN GEL	-	3	DERMATOLOGICALS
BENZAMYCIN GEL	-	3	DERMATOLOGICALS
BENZAMYCIN GEL PACK	-	3	DERMATOLOGICALS
benzonatate cap (TESSALON equiv)	-	1	COUGH/COLD/ALLERGY
BENZOYL PEROXIDE CREAM	OTC	NC	DERMATOLOGICALS
benztropine tab	-	1	ANTIPARKINSON AGENTS
BEPREVE OPTH SOLN	-	3	OPHTHALMIC AGENTS
BESIVANCE OPTH SUSP (Step Therapy requires trial of ciprofloxacin, levofloxacin, ofloxacin or VIGAMOX/MOXEZA)	ST	3	OPHTHALMIC AGENTS
BETAGAN OPTH SOLN	-	3	OPHTHALMIC AGENTS
betamethasone augmented cream (DIPROLENE AF CREAM equiv)	-	1	DERMATOLOGICALS
betamethasone augmented gel	-	1	DERMATOLOGICALS
betamethasone augmented lotion (DIPROLENE LOTION equiv)	-	1	DERMATOLOGICALS
betamethasone augmented oint (DIPROLENE OINT equiv)	-	1	DERMATOLOGICALS
betamethasone dipropionate cream (DIPROSONE CREAM equiv)	-	1	DERMATOLOGICALS
betamethasone dipropionate lotion	-	1	DERMATOLOGICALS
betamethasone dipropionate oint (DIPROSONE OINT equiv)	-	1	DERMATOLOGICALS
betamethasone valerate cream	-	1	DERMATOLOGICALS
betamethasone valerate foam (LUXIQ FOAM equiv)	-	NC	DERMATOLOGICALS
betamethasone valerate lotion	-	1	DERMATOLOGICALS
betamethasone valerate oint	-	1	DERMATOLOGICALS
BETAPACE AF TAB	-	3	BETA BLOCKERS
BETAPACE TAB	-	3	BETA BLOCKERS
BETASERON INJ	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
betaxolol ophth soln (BETOPTIC-S equiv)	-	1	OPHTHALMIC AGENTS
betaxolol tab (KERLONE equiv)	-	1	BETA BLOCKERS
bethanechol tab (URECHOLINE equiv)	-	1	URINARY ANTISPASMODICS
BETHKIS NEB SOLN	-	NC	AMINOGLYCOSIDES
BETIMOL OPTH SOLN	-	2	OPHTHALMIC AGENTS
BETOPTIC-S OPTH SOLN	-	2	OPHTHALMIC AGENTS
BEVESPI AEROSPHERE INHALER	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
BEVYXXA CAP	-	NC	ANTICOAGULANTS
bexarotene cap (TARGRETIN equiv)	KMSP-PA-SF	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
BEYAZ TAB	-	\$0	CONTRACEPTIVES
BIAFINE EMULSION	-	NC	DERMATOLOGICALS
BIAXIN SUSP	-	3	MACROLIDES
BIAXIN TAB	-	3	MACROLIDES

INF	NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS
LMSP	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program	LD	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	PA	Prior Authorization	QL	Quantity Limit
SP	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 M	SMKG	Smoking Cessation
	Available through Specialty Pharmacy Program	ST	Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary Cont.
Alphabetical Index
Last Updated 11/1/2017

Drug Name	Special Code	Tier	Category
BIAXIN XL TAB	-	3	MACROLIDES
bicalutamide tab (CASODEX equiv)	-	1	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
BIFERARX TAB	-	NC	HEMATOPOIETIC AGENTS
BILTRICIDE TAB	-	2	ANTHELMINTICS
BIMATOPROST OPHTH SOLN, LUMIGAN OPHTH SOLN (QL= 2.5ml/30 days)	QL	2	OPHTHALMIC AGENTS
bisoprolol tab (ZEBETA equiv)	-	1	BETA BLOCKERS
bisoprolol/hydrochlorothiazide tab (ZIAC equiv)	-	1	ANTIHYPERTENSIVES
BLEPH-10 OPHTH SOLN	-	3	OPHTHALMIC AGENTS
BLEPHAMIDE OPHTH SOLN	-	2	OPHTHALMIC AGENTS
BLEPHAMIDE S.O.P. OPHTH OINT	-	3	OPHTHALMIC AGENTS
BONIVA TAB 150MG (QL= 1 tab/30 days; Step Therapy requires trial of alendronate)	QL-ST	3	ENDOCRINE AND METABOLIC AGENTS - MISC.
BOSULIF TAB	KMSP-PA-SF	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
BREO ELLIPTA INHALER	-	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
BRETHINE TAB	-	3	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
BRILINTA TAB (Restricted to Cardiology Specialist)	RS	3	HEMATOLOGICAL AGENTS - MISC.
brimonidine ophth soln (ALPHAGAN P equiv)	-	1	OPHTHALMIC AGENTS
BRISDELLE CAP	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
BRIVIACT INJ 50MG/5ML	-	NC	ANTICONVULSANTS
BRIVIACT SOLN 10MG/ML	-	NC	ANTICONVULSANTS
BRIVIACT TAB	-	NC	ANTICONVULSANTS
bromfenac ophth soln (BROMDAY equiv)	-	1	OPHTHALMIC AGENTS
BROMFENAC OPHTH SOLN 0.09% (ONCE DAILY)	-	1	OPHTHALMIC AGENTS
BROMFENAC OPHTH SOLN 0.09% (TWICE DAILY)	-	1	OPHTHALMIC AGENTS
bromocriptine cap (PARLODEL equiv)	-	1	ANTIPARKINSON AGENTS
bromocriptine tab (PARLODEL equiv)	-	1	ANTIPARKINSON AGENTS
BROMSITE OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
BRONCOPECTOL SYRUP	-	3	COUGH/COLD/ALLERGY
BROVANA NEB SOLN	-	3	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
B-SERENE PAD	-	NC	HEMATOPOIETIC AGENTS
budesonide inh susp (PULMICORT equiv)	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
budesonide nasal spray (RHINOCORT AQUA equiv) (QL= 2 bottles/fill; Step Therapy requires trial of 2: flunisolide, fluticasone, triamcinolone or NASONEX)	QL-ST	1	NASAL AGENTS - SYSTEMIC AND TOPICAL
budesonide SR cap (ENTOCORT EC equiv) (Step Therapy requires trial of APRISO, LIALDA, or sulfasalazine)	ST	1	CORTICOSTEROIDS
bumetanide tab (BUMEX equiv)	-	1	DIURETICS
BUNAVAIL SL FILM	-	NC	ANALGESICS - OPIOID
BUPHENYL POWDER	KMSP	3	ENDOCRINE AND METABOLIC AGENTS - MISC.
BUPHENYL TAB	KMSP	4	ENDOCRINE AND METABOLIC AGENTS - MISC.
BUPRENORPHINE PATCH, BUTRANS PATCH (QL= 4 patches/28 days)	QL	3	ANALGESICS - OPIOID
buprenorphine SL tab (SUBUTEX equiv) (QL= 21 tabs/7 days)	PA-QL	1	ANALGESICS - OPIOID

INF	NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS
LMSP	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program	LD	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	PA	Prior Authorization	QL	Quantity Limit
SP	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 N	SMKG	Smoking Cessation
	Available through Specialty Pharmacy Program	ST	Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary Cont.
Alphabetical Index
Last Updated 11/1/2017

Drug Name	Special Code	Tier	Category
buprenorphine/naloxone SL tab (SUBOXONE equiv)	-	1	ANALGESICS - OPIOID
bupropion ER tab (WELLBUTRIN equiv)	-	1	ANTIDEPRESSANTS
bupropion SR tab (ZYBAN equiv) (Limited to 180 days/plan year)	QL-SMKG	\$0	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
bupropion tab (WELLBUTRIN equiv)	-	1	ANTIDEPRESSANTS
bupropion XL tab (WELLBUTRIN XL equiv)	-	1	ANTIDEPRESSANTS
BUSPAR TAB	-	3	ANTIANKXIETY AGENTS
bupirone tab (BUSPAR equiv)	-	1	ANTIANKXIETY AGENTS
bupirone tab 30mg (BUSPAR equiv)	-	NC	ANTIANKXIETY AGENTS
busulfan inj	M	M	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
BUSULFEX INJ	M	M	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
butalbital/acetaminophen/caffeine tab (FIORICET equiv)	-	NC	ANALGESICS - NONNARCOTIC
BUTALBITAL/ASPIRIN/CAFFEINE TAB	-	NC	ANALGESICS - NONNARCOTIC
BUTISOL ELIXIR	-	3	HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS
BUTISOL TAB	-	3	HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS
butorphanol nasal spray (STADOL equiv) (QL= 1 bottle/fill, 2 fills/30 days)	QL	1	ANALGESICS - OPIOID
BYDUREON INJ (QL= 4 inj/28 days)	QL	2	ANTIDIABETICS
BYDUREON PEN INJ (QL= 4 inj/28 days)	QL	2	ANTIDIABETICS
BYETTA INJ	-	3	ANTIDIABETICS
BYSTOLIC TAB	-	2	BETA BLOCKERS
BYVALSON TAB	-	NC	ANTIHYPERTENSIVES
cabergoline tab (DOSTINEX equiv)	-	1	ENDOCRINE AND METABOLIC AGENTS - MISC.
CABOMETYX TAB (QL= 1 tab/day)	MSP-PA-QL-SF	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
CADUET TAB	-	3	CARDIOVASCULAR AGENTS - MISC.
CAFCIT INJ	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS
CAFCIT SOLN	-	2	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS
caffeine citrate soln (CAFCIT equiv) (Only covered for members less than 1 year old)	-	1	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS
CALAN SR TAB	-	3	CALCIUM CHANNEL BLOCKERS
CALAN TAB	-	3	CALCIUM CHANNEL BLOCKERS
calcipotriene cream (DOVONEX CREAM equiv)	-	1	DERMATOLOGICALS
calcipotriene oint	-	1	DERMATOLOGICALS
calcipotriene soln (DOVONEX SOLN equiv)	-	1	DERMATOLOGICALS
calcipotriene/betamethasone oint (TACLONEX equiv)	-	1	DERMATOLOGICALS
calcitonin nasal spray (MIACALCIN equiv)	-	1	ENDOCRINE AND METABOLIC AGENTS - MISC.
calcitriol cap (ROCALTROL equiv)	-	1	ENDOCRINE AND METABOLIC AGENTS - MISC.
calcitriol inj (CALCIJEX equiv)	LMSP	4	ENDOCRINE AND METABOLIC AGENTS - MISC.
calcitriol soln (ROCALTROL equiv)	-	1	ENDOCRINE AND METABOLIC AGENTS - MISC.
calcium acetate cap (PHOSLO equiv)	-	1	GASTROINTESTINAL AGENTS - MISC.

INF	NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS
LMSP	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program	LD	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	PA	Prior Authorization	QL	Quantity Limit
SP	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 Months	SMKG	Smoking Cessation
	Available through Specialty Pharmacy Program	ST	Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary Cont.
Alphabetical Index
Last Updated 11/1/2017

Drug Name	Special Code	Tier	Category
calcium acetate tab (ELIPHOS equiv)	-	1	GASTROINTESTINAL AGENTS - MISC.
CALIBRATION LIQUID	OTC	1	MEDICAL DEVICES AND SUPPLIES
CALOMIST NASAL SPRAY	-	NC	HEMATOPOIETIC AGENTS
CAMBIA POWDER PACKET	-	NC	MIGRAINE PRODUCTS
CAMPRAL TAB	-	3	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
CANASA SUPP	-	2	GASTROINTESTINAL AGENTS - MISC.
candesartan tab (ATACAND equiv)	-	1	ANTIHYPERTENSIVES
candesartan/hydrochlorothiazide tab (ATACAND HCT equiv)	-	1	ANTIHYPERTENSIVES
CANTIL TAB	-	3	ULCER DRUGS
capecitabine tab (XELODA equiv)	KMSP	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
CAPEX SHAMPOO	-	3	DERMATOLOGICALS
CAPITAL/CODEINE SUSP	-	3	ANALGESICS - OPIOID
CAPRELSA TAB (Only available through Biologics 800-850-4306)	LD-PA	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
capsaicin/menthol topical patch (SINELEE equiv)	-	NC	DERMATOLOGICALS
captopril tab (CAPOTEN equiv)	-	1	ANTIHYPERTENSIVES
captopril/hydrochlorothiazide tab (CAPOZIDE equiv)	-	1	ANTIHYPERTENSIVES
CAPTOPRIL/HYDROCHLOROTHIAZIDE TAB	-	2	ANTIHYPERTENSIVES
CARAC CREAM	-	NC	DERMATOLOGICALS
CARAFATE SUSP	-	1	ULCER DRUGS
CARAFATE TAB	-	3	ULCER DRUGS
CARBAGLU TAB (Only available through Accredo 888-773-7376)	LD-PA	4	ENDOCRINE AND METABOLIC AGENTS - MISC.
carbamazepine chew tab (TEGRETOL equiv)	-	1	ANTICONVULSANTS
carbamazepine ER cap (CARBATROL equiv)	-	1	ANTICONVULSANTS
carbamazepine ER tab (TEGRETOL XR equiv)	-	1	ANTICONVULSANTS
carbamazepine susp (TEGRETOL equiv)	-	1	ANTICONVULSANTS
carbamazepine tab (TEGRETOL equiv)	-	1	ANTICONVULSANTS
CARBATROL CAP	-	3	ANTICONVULSANTS
carbidopa tab (LODOSYN equiv)	-	1	ANTIPARKINSON AGENTS
carbidopa/levodopa ER tab (SINEMET CR equiv)	-	1	ANTIPARKINSON AGENTS
carbidopa/levodopa ODT (PARCOPA equiv)	-	1	ANTIPARKINSON AGENTS
carbidopa/levodopa tab (SINEMET equiv)	-	1	ANTIPARKINSON AGENTS
CARBIDOPA/LEVODOPA/ENTACAPONE TAB (STALEVO equiv)	-	2	ANTIPARKINSON AGENTS
carbinoxamine soln (PALGIC equiv)	-	1	ANTIHISTAMINES
carbinoxamine tab (PALGIC equiv)	-	1	ANTIHISTAMINES
CARDENE SR CAP	-	3	CALCIUM CHANNEL BLOCKERS
CARDIZEM CD CAP	-	3	CALCIUM CHANNEL BLOCKERS
CARDIZEM LA TAB	-	3	CALCIUM CHANNEL BLOCKERS
CARDIZEM TAB	-	3	CALCIUM CHANNEL BLOCKERS
CARDURA TAB	-	3	ANTIHYPERTENSIVES
CARDURA XL TAB	-	3	GENITOURINARY AGENTS - MISCELLANEOUS
carisoprodol tab (SOMA equiv)	-	1	MUSCULOSKELETAL THERAPY AGENTS
carisoprodol tab 250mg (SOMA equiv)	-	NC	MUSCULOSKELETAL THERAPY AGENTS
carisoprodol/aspirin tab (SOMA COMPOUND equiv)	-	NC	MUSCULOSKELETAL THERAPY AGENTS
carisoprodol/aspirin/codeine tab (SOMA COMPOUND/CODEINE equiv)	-	NC	MUSCULOSKELETAL THERAPY AGENTS
CARMOL LOTION	-	NC	DERMATOLOGICALS

INF	NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS
LMSP	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program	LD	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	PA	Prior Authorization	QL	Quantity Limit
SP	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 M	SMKG	Smoking Cessation
	Available through Specialty Pharmacy Program	ST	Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary Cont.
Alphabetical Index
Last Updated 11/1/2017

Drug Name	Special Code	Tier	Category
CARMOL-HC CREAM	-	3	DERMATOLOGICALS
CARNITOR SOLN	-	3	ENDOCRINE AND METABOLIC AGENTS - MISC.
CARNITOR TAB	-	3	ENDOCRINE AND METABOLIC AGENTS - MISC.
carteolol ophth soln (OCUPRESS equiv)	-	1	OPHTHALMIC AGENTS
carvedilol tab (COREG equiv)	-	1	BETA BLOCKERS
CASODEX TAB	-	3	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
CATAFLAM TAB	-	3	ANALGESICS - ANTI-INFLAMMATORY
CATAPRES TAB	-	3	ANTIHYPERTENSIVES
CATAPRES-TTS PATCH	-	3	ANTIHYPERTENSIVES
CAVERJECT INJ (QL= 6 inj/30 days)	QL	2	CARDIOVASCULAR AGENTS - MISC.
CAYSTON INH SOLN (Restricted to Infectious Disease or Pulmonology Specialist)	KMSP-RS	4	ANTI-INFECTIVE AGENTS - MISC.
CEDAX CAP	-	3	CEPHALOSPORINS
CEDAX SUSP	-	3	CEPHALOSPORINS
CEENU CAP	-	2	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
cefaclor cap (CECLOR equiv)	-	1	CEPHALOSPORINS
CEFACTOR ER TAB	-	3	CEPHALOSPORINS
CEFACTOR SUSP	-	3	CEPHALOSPORINS
cefadroxil cap (DURICEF equiv)	-	1	CEPHALOSPORINS
cefadroxil susp (DURICEF equiv)	-	1	CEPHALOSPORINS
cefadroxil tab (DURICEF equiv)	-	1	CEPHALOSPORINS
cefazolin inj	M	M	CEPHALOSPORINS
CEFAZOLIN INJ	M	M	CEPHALOSPORINS
cefdinir cap (OMNICEF equiv)	-	1	CEPHALOSPORINS
cefdinir susp (OMNICEF equiv)	-	1	CEPHALOSPORINS
CEFDITOREN TAB	-	3	CEPHALOSPORINS
cefixime susp (SUPRAX equiv)	-	1	CEPHALOSPORINS
CEFOTAXIME INJ	M	M	CEPHALOSPORINS
cefoxitin inj	M	M	CEPHALOSPORINS
cefpodoxime proxetil susp (VANTIN equiv)	-	1	CEPHALOSPORINS
cefpodoxime proxetil tab (VANTIN equiv)	-	1	CEPHALOSPORINS
cefprozil susp (CEFZIL equiv)	-	1	CEPHALOSPORINS
cefprozil tab (CEFZIL equiv)	-	1	CEPHALOSPORINS
CEFTIN SUSP	-	3	CEPHALOSPORINS
CEFTIN TAB	-	3	CEPHALOSPORINS
ceftriaxone inj	M	M	CEPHALOSPORINS
cefuroxime susp (CEFTIN equiv)	-	1	CEPHALOSPORINS
cefuroxime tab (CEFTIN equiv)	-	1	CEPHALOSPORINS
CELEBREX CAP (QL= 2 caps/day)	QL	3	ANALGESICS - ANTI-INFLAMMATORY
celecoxib cap (CELEBREX equiv) (QL= 2 caps/day)	QL	1	ANALGESICS - ANTI-INFLAMMATORY
CELEXA SOLN	-	3	ANTIDEPRESSANTS
CELEXA TAB	-	3	ANTIDEPRESSANTS
CELLCEPT CAP	-	4	ASSORTED CLASSES
CELLCEPT SUSP	-	4	ASSORTED CLASSES
CELLCEPT TAB	-	4	ASSORTED CLASSES
CELONTIN CAP	-	2	ANTICONVULSANTS

INF	NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS
LMSP	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program	LD	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	PA	Prior Authorization	QL	Quantity Limit
SP	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 M	SMKG	Smoking Cessation
	Available through Specialty Pharmacy Program	ST	Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary Cont.
Alphabetical Index
Last Updated 11/1/2017

Drug Name	Special Code	Tier	Category
CENESTIN TAB	-	3	ESTROGENS
CENTANY OINT	-	3	DERMATOLOGICALS
cephalexin cap (KEFLEX equiv)	-	1	CEPHALOSPORINS
cephalexin susp (KEFLEX equiv)	-	1	CEPHALOSPORINS
CEPHALEXIN TAB	-	NC	CEPHALOSPORINS
CERDELGA CAP	MSP-PA	4	HEMATOPOIETIC AGENTS
CEREZYME INJ	M	M	HEMATOPOIETIC AGENTS
CERVICAL CAP	-	\$0	MEDICAL DEVICES AND SUPPLIES
CESAMET CAP	-	3	ANTIEMETICS
cesia tab (CYCLESSA equiv)	-	\$0	CONTRACEPTIVES
CETYLEV TAB	-	NC	ANTIDOTES AND SPECIFIC ANTAGONISTS
cevimeline cap (EVOXAC equiv)	-	1	MOUTH/THROAT/DENTAL AGENTS
CHANTIX PAK (Limited to 168 days/plan year)	QL-SMKG	\$0	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
CHANTIX TAB (Limited to 168 days/plan year)	QL-SMKG	\$0	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
CHEMET CAP	-	2	ANTIDOTES
chlordiazepoxide cap (LIBRIUM equiv)	-	1	ANTIANKXIETY AGENTS
chlordiazepoxide/amitriptyline tab (LIMBITROL equiv)	-	1	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
chlordiazepoxide/clidinium cap (LIBRAX equiv)	-	NC	ULCER DRUGS
chlorhexidine gluconate soln (PERIDEX equiv)	-	1	MOUTH/THROAT/DENTAL AGENTS
chloroquine tab (ARALEN equiv)	-	1	ANTIMALARIALS
chlorothiazide tab (DIURIL equiv)	-	1	DIURETICS
CHLOROTHIAZIDE TAB 250MG	-	1	DIURETICS
chlorpheniramine ER cap	-	1	ANTIHISTAMINES
chlorpromazine tab (THORAZINE equiv)	-	1	ANTI-PSYCHOTICS/ANTIMANIC AGENTS
CHLORPROPAMIDE TAB	-	1	ANTIDIABETICS
chlorpropamide tab (DIABINESE equiv)	-	1	ANTIDIABETICS
chlorthalidone tab	-	1	DIURETICS
chlorzoxazone tab (PARAFON FORTE equiv)	-	1	MUSCULOSKELETAL THERAPY AGENTS
CHOLBAM CAP (Only available through Dohmen LSS 844-246-5226)	LD-PA	4	GASTROINTESTINAL AGENTS - MISC.
cholecalciferol cap 50000 unit	OTC	1	VITAMINS
cholestyramine lite powder (QUESTRAN LITE equiv)	-	1	ANTIHYPERLIPIDEMICS
cholestyramine lite powder pack (QUESTRAN LITE equiv)	-	1	ANTIHYPERLIPIDEMICS
cholestyramine powder (QUESTRAN equiv)	-	1	ANTIHYPERLIPIDEMICS
cholestyramine powder pack (QUESTRAN equiv)	-	1	ANTIHYPERLIPIDEMICS
CHOLINE MAGNESIUM TRISALICYLATE TAB	-	1	ANALGESICS - NONNARCOTIC
choline magnesium trisalicylate tab (TRILISATE equiv)	-	1	ANALGESICS - NONNARCOTIC
CHROMAGEN FA TAB	-	3	HEMATOPOIETIC AGENTS
CIALIS TAB (QL= 6 tabs/30 days)	QL	2	CARDIOVASCULAR AGENTS - MISC.
CIALIS TAB 2.5MG, 5MG (QL= 6 tabs/30 days)	QL	2	CARDIOVASCULAR AGENTS - MISC.
ciclopirox cream (LOPROX CREAM equiv)	-	1	DERMATOLOGICALS
ciclopirox gel (LOPROX GEL equiv)	-	1	DERMATOLOGICALS
ciclopirox nail soln (PENLAC equiv)	-	1	DERMATOLOGICALS
ciclopirox shampoo (LOPROX SHAMPOO equiv)	-	1	DERMATOLOGICALS
ciclopirox topical susp (LOPROX SUSP equiv)	-	1	DERMATOLOGICALS
cilostazol tab (PLETAL equiv)	-	1	HEMATOLOGICAL AGENTS - MISC.
CILOXAN OPHTH OINT	-	3	OPHTHALMIC AGENTS
CILOXAN OPHTH SOLN	-	3	OPHTHALMIC AGENTS

INF	NC =Not Covered		generic =small letters	LD	BRANDS =CAPITAL LETTERS
LMSP	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program	LD	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	PA	Prior Authorization	QL	Quantity Limit
SP	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 M	SMKG	Smoking Cessation
	Available through Specialty Pharmacy Program	ST	Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary Cont.
Alphabetical Index
Last Updated 11/1/2017

Drug Name	Special Code	Tier	Category
cimetidine soln (TAGAMET equiv)	-	1	ULCER DRUGS
cimetidine tab (TAGAMET equiv)	-	1	ULCER DRUGS
CIMZIA INJ (QL= 2 inj/28 days)	LMSP-PA-QL	4	GASTROINTESTINAL AGENTS - MISC.
CIPRO HC OTIC SUSP	-	3	OTIC AGENTS
CIPRO SUSP	-	3	FLUOROQUINOLONES
CIPRO TAB	-	3	FLUOROQUINOLONES
CIPRO XR TAB	-	3	FLUOROQUINOLONES
CIPRODEX OTIC SUSP	-	2	OTIC AGENTS
CIPROFLOXACIN 100MG TAB	-	3	FLUOROQUINOLONES
ciprofloxacin ER tab (CIPRO XR equiv)	-	1	FLUOROQUINOLONES
ciprofloxacin ophth soln (CLOXAN equiv)	-	1	OPHTHALMIC AGENTS
CIPROFLOXACIN OTIC SOLN	-	2	OTIC AGENTS
ciprofloxacin susp (CIPRO equiv)	-	1	FLUOROQUINOLONES
ciprofloxacin tab (CIPRO equiv)	-	1	FLUOROQUINOLONES
citalopram soln (CELEXA equiv)	-	1	ANTIDEPRESSANTS
citalopram tab (CELEXA equiv)	-	1	ANTIDEPRESSANTS
CLARIFOAM EF FOAM	-	3	DERMATOLOGICALS
CLARINEX REDITAB	-	NC	ANTIHISTAMINES
CLARINEX SYRUP	-	NC	ANTIHISTAMINES
CLARINEX TAB	-	NC	ANTIHISTAMINES
CLARINEX-D TAB	-	NC	COUGH/COLD/ALLERGY
clarithromycin ER tab (BIAXIN XL equiv)	-	1	MACROLIDES
clarithromycin susp (BIAXIN equiv)	-	1	MACROLIDES
CLARITHROMYCIN SUSP	-	2	MACROLIDES
clarithromycin tab (BIAXIN equiv)	-	1	MACROLIDES
clemastine syrup (TAVIST equiv)	-	1	ANTIHISTAMINES
CLEMASTINE TAB	-	1	ANTIHISTAMINES
clemastine tab (TAVIST equiv)	-	1	ANTIHISTAMINES
CLEOCIN CAP	-	3	ANTI-INFECTIVE AGENTS - MISC.
CLEOCIN SOLN	-	3	ANTI-INFECTIVE AGENTS - MISC.
CLEOCIN VAGINAL CREAM	-	3	VAGINAL PRODUCTS
CLEOCIN VAGINAL SUPP	-	3	VAGINAL PRODUCTS
CLEOCIN-T GEL	-	3	DERMATOLOGICALS
CLEOCIN-T LOTION	-	3	DERMATOLOGICALS
CLEOCIN-T PAD	-	3	DERMATOLOGICALS
CLEOCIN-T SOLN	-	3	DERMATOLOGICALS
CLIMARA PATCH	-	3	ESTROGENS
CLIMARA PRO PATCH	-	3	ESTROGENS
CLINDACIN KIT	-	NC	DERMATOLOGICALS
CLINDAGEL	-	3	DERMATOLOGICALS
clindamycin cap (CLEOCIN equiv)	-	1	ANTI-INFECTIVE AGENTS - MISC.
clindamycin foam (EVOCLIN equiv)	-	NC	DERMATOLOGICALS
clindamycin gel (CLEOCIN GEL equiv)	-	1	DERMATOLOGICALS
clindamycin lotion (CLEOCIN- T equiv)	-	1	DERMATOLOGICALS
clindamycin pad (CLEOCIN-T equiv)	-	1	DERMATOLOGICALS
clindamycin soln (CLEOCIN equiv)	-	1	ANTI-INFECTIVE AGENTS - MISC.
clindamycin topical soln (CLEOCIN-T equiv)	-	1	DERMATOLOGICALS
clindamycin vaginal cream (CLEOCIN equiv)	-	1	VAGINAL PRODUCTS
clindamycin/benzoyl peroxide gel (BENZACLIN equiv)	-	1	DERMATOLOGICALS
clindamycin/benzoyl peroxide gel (DUAC GEL equiv)	-	1	DERMATOLOGICALS

INF	NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS
LMSP	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program	LD	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	PA	Prior Authorization	QL	Quantity Limit
SP	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 M	SMKG	Smoking Cessation
	Available through Specialty Pharmacy Program	ST	Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary Cont.
Alphabetical Index
Last Updated 11/1/2017

Drug Name	Special Code	Tier	Category
clindamycin/tretinoin gel (ZIANA equiv)	-	1	DERMATOLOGICALS
CLINDESSE VAGINAL CREAM	-	3	VAGINAL PRODUCTS
CLINISTIX TEST STRIP	OTC	1	DIAGNOSTIC PRODUCTS
CLINORIL TAB	-	3	ANALGESICS - ANTI-INFLAMMATORY
clobetasol E foam (OLUX E equiv)	-	NC	DERMATOLOGICALS
clobetasol foam (OLUX equiv)	PA	1	DERMATOLOGICALS
clobetasol lotion (CLOBEX equiv)	PA	1	DERMATOLOGICALS
clobetasol propionate cream (TEMOVATE equiv)	PA	1	DERMATOLOGICALS
clobetasol propionate emollient cream (TEMOVATE E equiv)	-	1	DERMATOLOGICALS
clobetasol propionate gel (TEMOVATE GEL equiv)	PA	1	DERMATOLOGICALS
clobetasol propionate oint (TEMOVATE equiv)	PA	1	DERMATOLOGICALS
clobetasol propionate soln (TEMOVATE equiv)	PA	1	DERMATOLOGICALS
clobetasol shampoo (CLOBEX equiv)	PA	1	DERMATOLOGICALS
clobetasol spray (CLOBEX equiv)	PA	1	DERMATOLOGICALS
CLOBEX LOTION	PA	3	DERMATOLOGICALS
CLOBEX SHAMPOO	PA	3	DERMATOLOGICALS
CLOBEX SPRAY	PA	3	DERMATOLOGICALS
CLOCORTOLONE CREAM, CLODERM CREAM	-	3	DERMATOLOGICALS
clomipramine cap (ANAFRANIL equiv)	-	1	ANTIDEPRESSANTS
clonazepam ODT (KLONOPIN equiv)	-	1	ANTICONVULSANTS
clonazepam tab (KLONOPIN equiv)	-	1	ANTICONVULSANTS
clonidine ER tab (KAPVAY equiv)	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
clonidine patch (CATAPRES-TTS equiv)	-	1	ANTIHYPERTENSIVES
clonidine tab (CATAPRES equiv)	-	1	ANTIHYPERTENSIVES
clopidogrel tab 75mg (PLAVIX equiv)	-	1	HEMATOLOGICAL AGENTS - MISC.
CLOPIDOGREL THERAPY PACK	-	NC	HEMATOLOGICAL AGENTS - MISC.
clorazepate tab (TRANXENE-T equiv)	-	1	ANTIANKXIETY AGENTS
clotrimazole cream (LOTRIMIN AF CREAM equiv)	-	NC	DERMATOLOGICALS
clotrimazole troches (MYCELEX TROCHES equiv)	-	1	MOUTH/THROAT/DENTAL AGENTS
clotrimazole/betamethasone cream (LORTRISONE CREAM equiv)	-	1	DERMATOLOGICALS
clotrimazole/betamethasone lotion (LOTRISONE LOTION equiv)	-	1	DERMATOLOGICALS
clozapine ODT 25mg, 100mg (CLOZAPINE, FAZACLO equiv)	-	1	ANTIPSYCHOTICS/ANTIMANIC AGENTS
CLOZAPINE ODT, FAZACLO ODT	-	2	ANTIPSYCHOTICS/ANTIMANIC AGENTS
clozapine tab (CLOZARIL equiv)	-	1	ANTIPSYCHOTICS/ANTIMANIC AGENTS
CLOZARIL TAB	-	3	ANTIPSYCHOTICS/ANTIMANIC AGENTS
COARTEM TAB	-	3	ANTIMALARIALS
CODEINE SULFATE SOLN	-	3	ANALGESICS - OPIOID
codeine sulfate tab	-	1	ANALGESICS - OPIOID
COLAZAL CAP	-	3	GASTROINTESTINAL AGENTS - MISC.
COLCHICINE CAP	-	NC	GOUT AGENTS
COLCHICINE TAB	PA	2	GOUT AGENTS
colchicine/probenecid tab (COL-BENEMID equiv)	-	1	GOUT AGENTS
COLESTID GRANULE	-	3	ANTIHYPERLIPIDEMICS
COLESTID POWDER PACK	-	3	ANTIHYPERLIPIDEMICS
COLESTID TAB	-	3	ANTIHYPERLIPIDEMICS
colestipol granule (COLESTID equiv)	-	1	ANTIHYPERLIPIDEMICS
colestipol powder packet (COLESTID equiv)	-	1	ANTIHYPERLIPIDEMICS
colestipol tab (COLESTID equiv)	-	1	ANTIHYPERLIPIDEMICS
COLY-MYCIN S OTIC SUSP	-	2	OTIC AGENTS

INF	NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS
LMSP	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program	LD	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	PA	Prior Authorization	QL	Quantity Limit
SP	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 N	SMKG	Smoking Cessation
	Available through Specialty Pharmacy Program	ST	Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary Cont.
Alphabetical Index
Last Updated 11/1/2017

Drug Name	Special Code	Tier	Category
COLYTE SOLN	-	2	LAXATIVES
COMBIGAN OPHTH SOLN	-	2	OPHTHALMIC AGENTS
COMBIPATCH	-	3	ESTROGENS
COMBIVENT INHALER	-	2	ASTHMA AND BRONCHODILATOR AGENTS
COMBIVENT RESPIMAT INHALER	-	2	ASTHMA AND BRONCHODILATOR AGENTS
COMBIVIR TAB	-	4	ANTIVIRALS
COMETRIQ KIT (Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-SF	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
COMPLERA TAB (QL= 1 tab/day)	QL	4	ANTIVIRALS
COMTAN TAB	-	3	ANTIPARKINSON AGENTS
CONCEPTROL GEL	OTC	\$0	VAGINAL PRODUCTS
CONCERTA TAB, RITALIN SR TAB	-	3	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS
CONDYLOX GEL	-	3	DERMATOLOGICALS
CONDYLOX SOLN	-	3	DERMATOLOGICALS
CONTRACEPTIVE FILM	OTC	\$0	VAGINAL PRODUCTS
CONTRACEPTIVE FOAM	OTC	\$0	VAGINAL PRODUCTS
CONTRACEPTIVE GEL	OTC	\$0	VAGINAL PRODUCTS
CONTRACEPTIVE SUPP	OTC	\$0	VAGINAL PRODUCTS
CONTRACEPTIVE SUPP	OTC	\$0	VAGINAL PRODUCTS
CONTRACEPTIVE SUPP	OTC	\$0	VAGINAL PRODUCTS
CONTRACEPTIVE SUPP	OTC	\$0	VAGINAL PRODUCTS
CONTRAVE TAB (QL= 4 tabs/day)	PA-QL	2	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS
COPAXONE INJ	LMSP	4	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
CORDARONE TAB	-	3	ANTIARRHYTHMICS
CORDRAN CREAM	-	3	DERMATOLOGICALS
CORDRAN LOTION	-	3	DERMATOLOGICALS
CORDRAN TAPE	-	3	DERMATOLOGICALS
COREG CR CAP	-	3	BETA BLOCKERS
COREG TAB	-	3	BETA BLOCKERS
CORGARD TAB	-	3	BETA BLOCKERS
CORLANOR TAB	PA	3	CARDIOVASCULAR AGENTS - MISC.
CORTANE-B AQUEOUS OTIC SOLN	-	3	OTIC AGENTS
CORTANE-B OTIC SOLN	-	NC	OTIC AGENTS
CORTEF TAB	-	1	CORTICOSTEROIDS
CORTENEMA	-	3	ANORECTAL AGENTS
CORTIFOAM	-	3	ANORECTAL AGENTS
CORTISONE ACETATE TAB	-	2	CORTICOSTEROIDS
CORTISPORIN CREAM	-	3	DERMATOLOGICALS
CORTISPORIN OINT	-	3	DERMATOLOGICALS
CORTISPORIN OPHTH SOLN	-	3	OPHTHALMIC AGENTS
CORTISPORIN OTIC SOLN	-	3	OTIC AGENTS
CORZIDE TAB	-	3	ANTIHYPERTENSIVES
COSENTYX INJ (QL= 2 inj/28 days)	LMSP-PA-QL	4	DERMATOLOGICALS
COSOPT OPHTH SOLN	-	3	OPHTHALMIC AGENTS
COSOPT PF OPHTH SOLN	-	2	OPHTHALMIC AGENTS
COTELLIC TAB (QL= 3 tabs/day)	MSP-PA-QL	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES

INF	NC =Not Covered Infertility	KMSP	generic =small letters Kroger Mandatory Specialty Pharmacy Program	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 M	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary Cont.
Alphabetical Index
Last Updated 11/1/2017

Drug Name	Special Code	Tier	Category
COTEMPLA XR ODT	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
COUMADIN TAB	-	3	ANTICOAGULANTS
COVERA-HS TAB	-	3	CALCIUM CHANNEL BLOCKERS
COZAAR TAB	-	3	ANTIHYPERTENSIVES
CPM CAP	-	3	ANTIHISTAMINES
CREON CAP	-	2	DIGESTIVE AIDS
CRESEMBA CAP	-	NC	ANTIFUNGALS
CRESTOR TAB (QL= 1 tab/day)	QL	3	ANTIHYPERLIPIDEMICS
CRESTOR TAB 20MG (QL= 1.5 tabs/day)	QL	3	ANTIHYPERLIPIDEMICS
CRESYLATE OTIC SOLN	-	3	OTIC AGENTS
CRINONE GEL	PA	2	VAGINAL PRODUCTS
CRIVIVAN CAP	-	4	ANTIVIRALS
CROLOM OPHTH SOLN	-	3	OPHTHALMIC AGENTS
cromolyn conc (GASTROCROM equiv)	-	1	GASTROINTESTINAL AGENTS - MISC.
cromolyn neb soln (INTAL equiv)	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
cromolyn ophth soln (CROLOM equiv)	-	1	OPHTHALMIC AGENTS
cryselle tab (OGESTREL equiv)	-	\$0	CONTRACEPTIVES
CUPRIMINE CAP	-	NC	ASSORTED CLASSES
CUTIVATE CREAM	-	3	DERMATOLOGICALS
CUTIVATE LOTION	-	NC	DERMATOLOGICALS
CUTIVATE OINT	-	3	DERMATOLOGICALS
CUVPOSA SOLN	MSP	4	ULCER DRUGS
cyanocobalamin inj	-	1	HEMATOPOIETIC AGENTS
CYCLESSA TAB	-	3	CONTRACEPTIVES
CYCLOBENZAPRINE COMPOUND KIT	-	NC	MUSCULOSKELETAL THERAPY AGENTS
cyclobenzaprine tab 10mg (FLEXERIL equiv)	-	1	MUSCULOSKELETAL THERAPY AGENTS
cyclobenzaprine tab 5mg (FLEXERIL equiv)	-	1	MUSCULOSKELETAL THERAPY AGENTS
cyclobenzaprine tab 7.5mg (FEXMID equiv)	-	1	MUSCULOSKELETAL THERAPY AGENTS
CYCLOGYL OPHTH SOLN	-	3	OPHTHALMIC AGENTS
CYCLOMYDRIL OPHTH SOLN	-	2	OPHTHALMIC AGENTS
cyclopentolate ophth soln (CYCLOGYL equiv)	-	1	OPHTHALMIC AGENTS
CYCLOPHOSPHAMIDE CAP	-	2	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
cyclophosphamide tab (CYTOXAN equiv)	-	1	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
CYCLOSERINE CAP	-	NC	ANTIMYCOBACTERIAL AGENTS
CYCLOSET TAB	-	3	ANTIDIABETICS
cyclosporine cap (SANDIMMUNE equiv)	-	4	ASSORTED CLASSES
cyclosporine modified cap (NEORAL equiv)	-	4	ASSORTED CLASSES
cyclosporine modified soln (NEORAL equiv)	-	4	ASSORTED CLASSES
CYFOLEX CAP	-	NC	HEMATOPOIETIC AGENTS
CYKLOKAPRON INJ	M	M	HEMOSTATICS
CYMBALTA CAP	-	NC	ANTIDEPRESSANTS
cyproheptadine syrup	-	1	ANTIHISTAMINES
cyproheptadine tab	-	1	ANTIHISTAMINES
CYSTAGON CAP (Only available through CVS Specialty 800-238-7828)	LD-PA	4	GENITOURINARY AGENTS - MISCELLANEOUS

INF	NC =Not Covered Infertility	KMSP	generic =small letters Kroger Mandatory Specialty Pharmacy Program	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 M	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary Cont.
Alphabetical Index
Last Updated 11/1/2017

Drug Name	Special Code	Tier	Category
CYSTARAN OPHTH SOLN (QL= 4 bottles/30 days; Only available through Walgreens 888-347-3416)	LD-PA-QL	4	OPHTHALMIC AGENTS
CYTOMEL TAB	-	3	THYROID AGENTS
CYTOTEC TAB	-	3	ULCER DRUGS
CYTRA-3 SYRUP	-	1	GENITOURINARY AGENTS - MISCELLANEOUS
D.H.E. INJ	-	3	MIGRAINE PRODUCTS
DAKLINZA TAB	-	NC	ANTIVIRALS
DALIRESP TAB	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
danazol cap (DANOCRINE equiv)	-	1	ANDROGENS-ANABOLIC
DANTRIUM CAP	-	3	MUSCULOSKELETAL THERAPY AGENTS
dantrolene cap (DANTRIUM equiv)	-	1	MUSCULOSKELETAL THERAPY AGENTS
dapsone gel (ACZONE equiv)	-	NC	DERMATOLOGICALS
dapsone tab	-	1	ANTI-INFECTIVE AGENTS - MISC.
DARAPRIM TAB	MSP-PA	4	ANTIMALARIALS
darifenacin SR tab (ENABLEX equiv)	PA	1	URINARY ANTISPASMODICS
DAXBIA CAP	-	NC	CEPHALOSPORINS
DAYPRO TAB	-	3	ANALGESICS - ANTI-INFLAMMATORY
DAYTRANA PATCH	-	3	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS
DAZIDOX TAB	-	3	ANALGESICS - OPIOID
DDAVP INJ	-	3	ENDOCRINE AND METABOLIC AGENTS - MISC.
DDAVP NASAL SOLN	-	3	ENDOCRINE AND METABOLIC AGENTS - MISC.
DDAVP NASAL SPRAY	-	3	ENDOCRINE AND METABOLIC AGENTS - MISC.
DDAVP TAB	-	3	ENDOCRINE AND METABOLIC AGENTS - MISC.
DEBACTEROL SOLN	-	NC	MOUTH/THROAT/DENTAL AGENTS
DECON-A ELIXIR	-	3	COUGH/COLD/ALLERGY
DELZICOL CAP	-	NC	GASTROINTESTINAL AGENTS - MISC.
DEMADEX TAB	-	3	DIURETICS
demeclocycline tab (DECLOMYCIN equiv)	-	1	TETRACYCLINES
DEMEROL TAB	-	3	ANALGESICS - OPIOID
DENAVIR CREAM	-	2	DERMATOLOGICALS
DEPACON INJ	-	NC	ANTICONSULTANTS
DEPAKENE CAP	-	3	ANTICONSULTANTS
DEPAKENE SYRUP	-	3	ANTICONSULTANTS
DEPAKOTE ER TAB	-	3	ANTICONSULTANTS
DEPAKOTE SPRINKLE CAP	-	3	ANTICONSULTANTS
DEPAKOTE TAB	-	3	ANTICONSULTANTS
DEPEN TITRATAB	-	2	ASSORTED CLASSES
DEPLIN CAP	-	NC	DIETARY PRODUCTS/DIETARY MANAGEMENT PRODUCTS
DEPO-PROVERA INJ	-	NC	CONTRACEPTIVES
DEPO-PROVERA SC INJ 104MG	-	NC	CONTRACEPTIVES
DEPO-TESTOSTERONE INJ	-	3	ANDROGENS-ANABOLIC
DERMACINRX KIT	-	NC	DERMATOLOGICALS

INF	NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS
LMSP	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program	LD	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	PA	Prior Authorization	QL	Quantity Limit
SP	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 M	SMKG	Smoking Cessation
	Available through Specialty Pharmacy Program	ST	Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary Cont.
Alphabetical Index
Last Updated 11/1/2017

Drug Name	Special Code	Tier	Category
DERMA-SMOOTH/FS OIL	-	3	DERMATOLOGICALS
DERMATOP CREAM	-	3	DERMATOLOGICALS
DERMATOP OINT	-	3	DERMATOLOGICALS
DERMOTIC OIL	-	3	OTIC AGENTS
DESCOVY TAB	PA	4	ANTIVIRALS
desipramine tab (NORPRAMIN equiv)	-	1	ANTIDEPRESSANTS
DESLORATADINE ODT	-	NC	ANTIHISTAMINES
desloratadine tab (CLARINEX equiv)	-	NC	ANTIHISTAMINES
desmopressin acetate inj (DDAVP equiv)	-	1	ENDOCRINE AND METABOLIC AGENTS - MISC.
desmopressin acetate nasal spray (DDAVP equiv)	-	1	ENDOCRINE AND METABOLIC AGENTS - MISC.
desmopressin acetate tab (DDAVP equiv)	-	1	ENDOCRINE AND METABOLIC AGENTS - MISC.
desmopressin nasal soln (DDAVP equiv)	-	1	ENDOCRINE AND METABOLIC AGENTS - MISC.
DESOGEN TAB	-	3	CONTRACEPTIVES
DESONATE GEL	-	NC	DERMATOLOGICALS
desonide cream	-	NC	DERMATOLOGICALS
desonide lotion	-	NC	DERMATOLOGICALS
desonide oint	-	NC	DERMATOLOGICALS
DESOWEN CREAM	-	NC	DERMATOLOGICALS
DESOWEN CREAM KIT	-	NC	DERMATOLOGICALS
DESOWEN LOTION	-	NC	DERMATOLOGICALS
DESOWEN LOTION KIT	-	NC	DERMATOLOGICALS
DESOWEN OINT	-	NC	DERMATOLOGICALS
DESOWEN OINT KIT	-	NC	DERMATOLOGICALS
desoximetasone cream (TOPICORT CREAM equiv)	-	1	DERMATOLOGICALS
desoximetasone gel (TOPICORT equiv)	-	NC	DERMATOLOGICALS
desoximetasone oint (TOPICORT equiv)	-	NC	DERMATOLOGICALS
DESOXYN TAB	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
desvenlafaxine ER tab (PRISTIQ equiv)	-	1	ANTIDEPRESSANTS
DESVENLAFAXINE ER TAB	-	NC	ANTIDEPRESSANTS
DETROL LA CAP	-	3	URINARY ANTISPASMODICS
DETROL TAB	-	3	URINARY ANTISPASMODICS
DEXAMETHASONE CONC	-	1	CORTICOSTEROIDS
dexamethasone elixir	-	1	CORTICOSTEROIDS
dexamethasone ophth soln	-	1	OPHTHALMIC AGENTS
dexamethasone soln	-	1	CORTICOSTEROIDS
DEXAMETHASONE TAB	-	1	CORTICOSTEROIDS
dexamethasone tab (DECADRON equiv)	-	1	CORTICOSTEROIDS
DEXEDRINE CAP	-	3	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
DEXILANT CAP (QL= 1 cap/day; Step Therapy requires trial of omeprazole, pantoprazole, or rabeprazole)	QL-ST	3	ULCER DRUGS
dexmethylphenidate ER cap (FOCALIN XR equiv)	-	1	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
dexmethylphenidate tab (FOCALIN equiv)	-	1	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS

INF	NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS
LMSP	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program	LD	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	PA	Prior Authorization	QL	Quantity Limit
SP	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 M	SMKG	Smoking Cessation
	Available through Specialty Pharmacy Program	ST	Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary Cont.
Alphabetical Index
Last Updated 11/1/2017

Drug Name	Special Code	Tier	Category
DEXPAK TAB	-	3	CORTICOSTEROIDS
dextroamphetamine ER cap (DEXEDRINE equiv)	-	1	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
dextroamphetamine soln (PROCENTRA equiv)	-	1	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
dextroamphetamine tab (DEXEDRINE equiv)	-	1	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
DIABETA TAB	-	3	ANTIDIABETICS
DIABETIC METER (all other diabetic meters)	OTC	NC	MEDICAL DEVICES AND SUPPLIES
DIALYVITE TAB	-	1	MULTIVITAMINS
dialyvite tab (NEPHRO-VITE equiv)	-	1	MULTIVITAMINS
DIALYVITE/ZINC TAB	-	1	MULTIVITAMINS
DIAMOX SEQUEL CAP	-	3	DIURETICS
DIAPHRAGM	-	\$0	MEDICAL DEVICES AND SUPPLIES
DIASTAT RECTAL GEL, DIAZEPAM RECTAL GEL	-	3	ANTICONVULSANTS
DIATZ ZN TAB	-	3	MULTIVITAMINS
diazepam conc (VALIUM equiv)	-	1	ANTIANKXIETY AGENTS
DIAZEPAM SOLN	-	1	ANTIANKXIETY AGENTS
diazepam tab (VALIUM equiv)	-	1	ANTIANKXIETY AGENTS
DIBENZYLIN CAP	KMSP	3	ANTIHYPERTENSIVES
DICLEGIS TAB	-	NC	ANTIEMETICS
diclofenac gel (SOLARAZE equiv)	PA	1	DERMATOLOGICALS
diclofenac gel 1% (VOLTAREN equiv) (QL= 5 tubes/fill)	QL	1	DERMATOLOGICALS
diclofenac potassium tab (CATAFLAM equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
diclofenac sodium EC tab (VOLTAREN equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
diclofenac sodium ophth soln (VOLTAREN equiv)	-	1	OPHTHALMIC AGENTS
diclofenac sodium XR tab (VOLTAREN XR equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
diclofenac soln 1.5% (PENNSAID equiv)	-	NC	DERMATOLOGICALS
diclofenac/misoprostol DR tab (ARTHROTEC equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
dicloxacillin cap (DYNAPEN equiv)	-	1	PENICILLINS
dicyclomine cap (BENTYL equiv)	-	1	ULCER DRUGS
dicyclomine soln (BENTYL equiv)	-	1	ULCER DRUGS
dicyclomine tab (BENTYL equiv)	-	1	ULCER DRUGS
didanosine DR cap (VIDEX EC equiv)	-	4	ANTIVIRALS
DIFFERIN CREAM	PA	3	DERMATOLOGICALS
DIFFERIN GEL	PA	3	DERMATOLOGICALS
DIFFERIN OTC GEL 0.1%	OTC	NC	DERMATOLOGICALS
DIFICID TAB (QL= 20 tabs/fill; Step Therapy requires trial of vancomycin cap)	QL-ST	2	MACROLIDES
DIFLORASONE CREAM	-	NC	DERMATOLOGICALS
diflorasone oint	-	1	DERMATOLOGICALS
DIFLORASONE OINT (PSORCON equiv)	-	NC	DERMATOLOGICALS
DIFLUCAN SUSP	-	3	ANTIFUNGALS
DIFLUCAN TAB	-	3	ANTIFUNGALS
diflunisal tab (DOLOBID equiv)	-	1	ANALGESICS - NONNARCOTIC
digoxin soln (LANOXIN equiv)	-	1	CARDIOTONICS
digoxin tab (LANOXIN equiv)	-	1	CARDIOTONICS
dihydroergotamine mesylate inj (D.H.E. equiv)	-	1	MIGRAINE PRODUCTS
DIHYDROERGOTAMINE SPRAY, MIGRANAL SPRAY (QL= 8 sprays/fill, 2 fills/30 days)	QL	3	MIGRAINE PRODUCTS
DILACOR XR CAP	-	3	CALCIUM CHANNEL BLOCKERS

INF	NC =Not Covered	KMSP	generic =small letters	LD	BRANDS =CAPITAL LETTERS
LMSP	Infertility	M	Kroger Mandatory Specialty Pharmacy Program	MSP	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	PA	Medical Benefit	QL	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	SF	Prior Authorization	SMKG	Quantity Limit
SP	Restricted to Specialist	ST	Limited to Two 15 Day Fills per Month for the First 3 Months	VAC	Smoking Cessation
	Available through Specialty Pharmacy Program		Step Therapy		Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary Cont.
Alphabetical Index
Last Updated 11/1/2017

Drug Name	Special Code	Tier	Category
DILANTIN CAP 100MG	-	3	ANTICONVULSANTS
DILANTIN CAP 30MG	-	2	ANTICONVULSANTS
DILANTIN INFATABS	-	3	ANTICONVULSANTS
DILANTIN SUSP	-	3	ANTICONVULSANTS
DILATRATE SR CAP	-	3	ANTIANGINAL AGENTS
DILAUDID TAB	-	3	ANALGESICS - OPIOID
diltiazem ER cap (CARDIZEM CD equiv)	-	1	CALCIUM CHANNEL BLOCKERS
diltiazem ER cap (CARDIZEM SR equiv)	-	1	CALCIUM CHANNEL BLOCKERS
diltiazem ER cap (DILACOR XR equiv)	-	1	CALCIUM CHANNEL BLOCKERS
diltiazem ER cap (TIAZAC equiv)	-	1	CALCIUM CHANNEL BLOCKERS
diltiazem ER tab (CARDIZEM LA equiv)	-	1	CALCIUM CHANNEL BLOCKERS
diltiazem tab (CARDIZEM equiv)	-	1	CALCIUM CHANNEL BLOCKERS
DIOVAN HCT TAB	-	3	ANTIHYPERTENSIVES
DIOVAN TAB	-	3	ANTIHYPERTENSIVES
DIPENTUM CAP	-	3	GASTROINTESTINAL AGENTS - MISC.
diphenhydramine cap 50mg (BENADRYL equiv) (Only 50mg covered)	-	1	ANTIHISTAMINES
diphenhydramine inj (BENADRYL equiv)	-	M	ANTIHISTAMINES
diphenoxylate/atropine liquid (LOMOTIL equiv)	-	1	ANTIDIARRHEALS
diphenoxylate/atropine tab (LOMOTIL equiv)	-	1	ANTIDIARRHEALS
DIPROLENE AF CREAM	-	3	DERMATOLOGICALS
DIPROLENE LOTION	-	3	DERMATOLOGICALS
DIPROLENE OINT	-	3	DERMATOLOGICALS
dipyridamole tab (PERSANTINE equiv)	-	1	HEMATOLOGICAL AGENTS - MISC.
disopyramide cap (NORPACE equiv)	-	1	ANTIARRHYTHMICS
disopyramide ER cap (NORPACE CR equiv)	-	1	ANTIARRHYTHMICS
disulfiram tab (ANTABUSE equiv)	-	1	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
DITROPAN XL TAB	-	3	URINARY ANTISPASMODICS
DIURIL SUSP	-	2	DIURETICS
divalproex ER tab (DEPAKOTE ER equiv)	-	1	ANTICONVULSANTS
divalproex sodium DR tab (DEPAKOTE equiv)	-	1	ANTICONVULSANTS
divalproex sprinkle cap (DEPAKOTE equiv)	-	1	ANTICONVULSANTS
DIVIGEL GEL, ELESTRIN GEL	-	3	ESTROGENS
dofetilide cap (TIKOSYN equiv)	-	1	ANTIARRHYTHMICS
DOLGIC PLUS TAB	-	NC	ANALGESICS - NONNARCOTIC
DOLOPHINE TAB	-	3	ANALGESICS - OPIOID
DOMETUSS-DMX LIQ	-	NC	COUGH/COLD/ALLERGY
donepezil ODT (ARICEPT equiv) (QL= 1 tab/day)	QL	1	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
donepezil tab (ARICEPT equiv) (QL= 2 tabs/day)	QL	1	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
donepezil tab 23mg (ARICEPT equiv) (QL= 1 tab/day; Step Therapy requires trial of donepezil 10mg)	QL-ST	1	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
DONNATAL ELIXIR	-	NC	ULCER DRUGS
DONNATAL EXTENTABS	-	2	ULCER DRUGS
DONNATAL TAB	-	NC	ULCER DRUGS
DORAL TAB	-	NC	HYPNOTICS/SEDATIVES/SLEEP DISORDEI AGENTS
DORIBAX INJ	M	M	ANTI-INFECTIVE AGENTS - MISC.
DORYX MPC TAB	-	NC	TETRACYCLINES

INF	NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS
LMSP	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program	LD	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	PA	Prior Authorization	QL	Quantity Limit
SP	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 M	SMKG	Smoking Cessation
	Available through Specialty Pharmacy Program	ST	Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary Cont.
 Alphabetical Index
 Last Updated 11/1/2017**

Drug Name	Special Code	Tier	Category
DORYX TAB	-	3	TETRACYCLINES
DORYX TAB 200MG	-	NC	TETRACYCLINES
dorzolamide ophth soln (TRUSOPT equiv)	-	1	OPHTHALMIC AGENTS
dorzolamide/timolol ophth soln (COSOPT equiv)	-	1	OPHTHALMIC AGENTS
DOVONEX CREAM	-	3	DERMATOLOGICALS
DOVONEX SOLN	-	3	DERMATOLOGICALS
doxazosin tab (CARDURA equiv)	-	1	ANTIHYPERTENSIVES
doxepin cap (SINEQUAN equiv)	-	1	ANTIDEPRESSANTS
doxepin conc (SINEQUAN equiv)	-	1	ANTIDEPRESSANTS
DOXEPIN CREAM, PRUDOXIN CREAM, ZONALON CREAM	-	3	DERMATOLOGICALS
doxercalciferol cap (HECTOROL equiv)	MSP	4	ENDOCRINE AND METABOLIC AGENTS - MISC.
DOXYCYCLINE CAP, ORACEA CAP	-	NC	DERMATOLOGICALS
doxycycline hyclate cap (VIBRAMYCIN equiv)	-	1	TETRACYCLINES
DOXYCYCLINE HYCLATE DR CAP	-	3	TETRACYCLINES
doxycycline hyclate DR tab (DORYX equiv)	-	1	TETRACYCLINES
doxycycline hyclate DR tab 200mg (DORYX equiv)	-	NC	TETRACYCLINES
doxycycline hyclate tab (VIBRATAB equiv)	-	1	TETRACYCLINES
doxycycline hyclate tab 75mg, 150mg (ACTICLATE equiv)	-	NC	TETRACYCLINES
doxycycline monohydrate cap 100mg (MONODOX equiv)	-	1	TETRACYCLINES
doxycycline monohydrate cap 150mg (MONODOX equiv)	-	1	TETRACYCLINES
doxycycline monohydrate cap 50mg (MONODOX equiv)	-	1	TETRACYCLINES
doxycycline monohydrate cap 75mg (MONODOX equiv)	-	1	TETRACYCLINES
doxycycline monohydrate tab (ADOXA equiv)	-	1	TETRACYCLINES
doxycycline monohydrate tab 150mg (ADOXA equiv)	-	NC	TETRACYCLINES
doxycycline susp (VIBRAMYCIN equiv)	-	1	TETRACYCLINES
DRISDOL CAP	-	3	VITAMINS
DRITHO-SCALP CREAM	-	3	DERMATOLOGICALS
dronabinol cap (MARINOL equiv)	PA	1	ANTIEMETICS
DROXIA CAP	-	2	HEMATOPOIETIC AGENTS
DRYSOL SOLN	-	1	DERMATOLOGICALS
DST PLUS PAK KIT	-	NC	DERMATOLOGICALS
DUAC CS KIT	-	3	DERMATOLOGICALS
DUAC GEL	-	3	DERMATOLOGICALS
DUAVEE TAB	-	NC	ESTROGENS
DUETACT TAB	-	3	ANTIDIABETICS
DULERA INHALER	-	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
duloxetine EC cap (CYMBALTA equiv)	-	1	ANTIDEPRESSANTS
DUONEB NEB SOLN	-	3	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
DUOPA ENTERAL SUSP	-	NC	ANTIPARKINSON AGENTS
DUPIXENT INJ	-	NC	DERMATOLOGICALS
DURAGESIC PATCH	-	3	ANALGESICS - OPIOID
DUREZOL OPHTH EMULSION	-	2	OPHTHALMIC AGENTS
dutasteride cap (AVODART equiv)	-	1	GENITOURINARY AGENTS - MISCELLANEOUS
dutasteride/tamsulosin cap (JALYN equiv)	-	1	GENITOURINARY AGENTS - MISCELLANEOUS
DUTOPROL TAB	-	NC	ANTIHYPERTENSIVES

INF	NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS
LMSP	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program	LD	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	PA	Prior Authorization	QL	Quantity Limit
SP	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 M	SMKG	Smoking Cessation
	Available through Specialty Pharmacy Program	ST	Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary Cont.
Alphabetical Index
Last Updated 11/1/2017

Drug Name	Special Code	Tier	Category
DUZALLO TAB	-	NC	GOUT AGENTS
DYAZIDE CAP	-	3	DIURETICS
DYMISTA NASAL SPRAY	PA	3	NASAL AGENTS - SYSTEMIC AND TOPICAL
DYNACIN TAB	-	3	TETRACYCLINES
DYNACIRC CR TAB	-	3	CALCIUM CHANNEL BLOCKERS
DYRENIUM CAP	-	2	DIURETICS
econazole cream (SPECTAZOLE equiv)	-	1	DERMATOLOGICALS
ECOZA FOAM	-	NC	DERMATOLOGICALS
EDARBI TAB	-	3	ANTIHYPERTENSIVES
EDARBYCLOR TAB	-	3	ANTIHYPERTENSIVES
EDECIN TAB	-	3	DIURETICS
EDEX INJ (QL= 6 inj/30 days)	QL	2	CARDIOVASCULAR AGENTS - MISC.
EDLUAR SL TAB	-	NC	HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS
EDURANT TAB	-	4	ANTIVIRALS
EFFEXOR TAB	-	3	ANTIDEPRESSANTS
EFFEXOR XR CAP	-	3	ANTIDEPRESSANTS
EFFIENT TAB	-	3	HEMATOLOGICAL AGENTS - MISC.
EFUDEX CREAM	-	3	DERMATOLOGICALS
EGRIFTA INJ	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
ELDEPYRL CAP	-	3	ANTIPARKINSON AGENTS
ELESTAT OPHTH SOLN	-	3	OPHTHALMIC AGENTS
ELIDEL CREAM	-	2	DERMATOLOGICALS
ELIGEN B12 TAB	-	NC	DIETARY PRODUCTS/DIETARY MANAGEMENT PRODUCTS
ELIMITE CREAM	-	3	DERMATOLOGICALS
ELIPHOS TAB	-	3	GASTROINTESTINAL AGENTS - MISC.
ELIQUIS TAB	-	2	ANTICOAGULANTS
ELIXOPHYLLIN ELIXIR	-	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ELLA TAB	-	\$0	CONTRACEPTIVES
ELMIRON CAP	-	2	GENITOURINARY AGENTS - MISCELLANEOUS
ELOCON CREAM	-	3	DERMATOLOGICALS
ELOCON OINT	-	3	DERMATOLOGICALS
ELOCON SOLN	-	3	DERMATOLOGICALS
EMADINE OPHTH SOLN	-	3	OPHTHALMIC AGENTS
EMBEDA CAP	-	3	ANALGESICS - OPIOID
EMCYT CAP	-	2	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
EMEND PAK (QL= 3 caps/fill; Restricted to Oncology or Hematology Specialist)	QL-RS	3	ANTIEMETICS
EMEND SUSP	-	NC	ANTIEMETICS
EMFLAZA SUSP	-	NC	CORTICOSTEROIDS
EMFLAZA TAB	-	NC	CORTICOSTEROIDS
EMLA CREAM	-	3	DERMATOLOGICALS
EMSAM PATCH	-	3	ANTIDEPRESSANTS
EMTRIVA CAP	-	4	ANTIVIRALS
EMTRIVA SOLN	-	4	ANTIVIRALS

INF	NC =Not Covered Infertility	KMSP	generic =small letters Kroger Mandatory Specialty Pharmacy Program	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 N	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary Cont.
 Alphabetical Index
 Last Updated 11/1/2017**

Drug Name	Special Code	Tier	Category
EMVERM TAB	PA	2	ANTHELMINTICS
ENABLEX TAB	PA	3	URINARY ANTISPASMODICS
enalapril tab (VASOTEC equiv)	-	1	ANTIHYPERTENSIVES
enalapril/hydrochlorothiazide tab (VASERETIC equiv)	-	1	ANTIHYPERTENSIVES
ENBREL INJ 25MG (QL= 8 inj/28 days)	LMSP-PA-QL	4	ANALGESICS - ANTI-INFLAMMATORY
ENBREL INJ 50MG (QL= 4 inj/28 days)	LMSP-PA-QL	4	ANALGESICS - ANTI-INFLAMMATORY
ENBREL MINI INJ (QL= 4 inj/28 days)	LMSP-PA-QL	4	ANALGESICS - ANTI-INFLAMMATORY
ENBREL SURECLICK INJ 50MG (QL= 4 inj/28 days)	LMSP-PA-QL	4	ANALGESICS - ANTI-INFLAMMATORY
ENDARI POWDER PACK	-	NC	HEMATOPOIETIC AGENTS
ENDOMETRIN INSERT	PA	2	VAGINAL PRODUCTS
ENJUVA TAB	-	3	ESTROGENS
enoxaparin inj (LOVENOX equiv) (QL= 17 days supply)	QL	1	ANTICOAGULANTS
enpresse tab (TRI-LEVELLEN equiv)	-	\$0	CONTRACEPTIVES
ENSTILAR FOAM	-	NC	DERMATOLOGICALS
entacapone tab (COMTAN equiv)	-	1	ANTIPARKINSON AGENTS
entecavir tab (BARACLUDE equiv) (QL= 1 tab/day)	KMSP-QL	4	ANTIVIRALS
ENTOCORT EC CAP (Step Therapy requires trial of APRISO, LIALDA, or sulfasalazine)	ST	3	CORTICOSTEROIDS
ENTRESTO TAB (QL= 2 tabs/day)	PA-QL	2	CARDIOVASCULAR AGENTS - MISC.
ENVARUSUS XR TAB	-	NC	ASSORTED CLASSES
EPANED PREMIXED SOLN	PA	3	ANTIHYPERTENSIVES
EPANED SOLN	PA	3	ANTIHYPERTENSIVES
EPCLUSA TAB (QL= 1 tab/day)	KMSP-PA-QL	4	ANTIVIRALS
EPIDUO FORTE GEL (Acne Only – members age 26 or older require Prior Authorization)	PA	2	DERMATOLOGICALS
EPIDUO GEL 0.1-2.5% (Acne Only – members age 26 or older require Prior Authorization)	PA	2	DERMATOLOGICALS
EPIFOAM AEROSOL	-	2	DERMATOLOGICALS
epinastine ophth soln (ELESTAT equiv)	-	1	OPHTHALMIC AGENTS
EPINEPHRINE PEN INJ 0.15MG (MYLAN) (QL= 2 inj/fill)	QL	2	VASOPRESSORS
EPINEPHRINE PEN INJ 0.3MG (MYLAN) (QL= 2 inj/fill)	QL	2	VASOPRESSORS
EPIVIR HBV SOLN	-	4	ANTIVIRALS
EPIVIR HBV TAB	-	4	ANTIVIRALS
EPIVIR SOLN	-	4	ANTIVIRALS
EPIVIR TAB	-	4	ANTIVIRALS
eperenone tab (INSPRA equiv)	-	1	ANTIHYPERTENSIVES
EPOGEN INJ	KMSP	4	HEMATOPOIETIC AGENTS
EPROSARTAN TAB	-	3	ANTIHYPERTENSIVES
EPZICOM TAB	-	4	ANTIVIRALS
EQUETRO CAP	-	2	ANTI-PSYCHOTICS/ANTI-MANIC AGENTS
ERGOCAL CAP	-	NC	VITAMINS
ergoloid mesylates tab (HYDERGINE equiv)	-	1	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
ERGOLOID MESYLATES TAB	-	3	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
ERGOMAR SL TAB	-	3	MIGRAINE PRODUCTS
ergotamine tartrate/caffeine tab (CAFERGOT equiv)	-	1	MIGRAINE PRODUCTS
ERIVEDGE CAP	KMSP-PA-SF	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ERTACZO CREAM	-	3	DERMATOLOGICALS

INF	NC =Not Covered		generic =small letters	LD	BRANDS =CAPITAL LETTERS
LMSP	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program	MSP	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	QL	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	PA	Prior Authorization	SMKG	Quantity Limit
SP	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 M	VAC	Smoking Cessation
	Available through Specialty Pharmacy Program	ST	Step Therapy		Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary Cont.
Alphabetical Index
Last Updated 11/1/2017

Drug Name	Special Code	Tier	Category
ERYPED SUSP	-	2	MACROLIDES
ERYPED SUSP 200MG/5ML	-	3	MACROLIDES
ERY-TAB	-	1	MACROLIDES
ERYTHROMYCIN CAP	-	1	MACROLIDES
erythromycin DR cap (ERYC equiv)	-	1	MACROLIDES
erythromycin ethylsuccinate susp (ERYPED equiv)	-	1	MACROLIDES
erythromycin ethylsuccinate tab (E.E.S. equiv)	-	1	MACROLIDES
ERYTHROMYCIN ETHYLSUCCINATE TAB	-	2	MACROLIDES
erythromycin gel	-	1	DERMATOLOGICALS
erythromycin ophth oint	-	1	OPHTHALMIC AGENTS
erythromycin pad	-	1	DERMATOLOGICALS
erythromycin soln	-	1	DERMATOLOGICALS
erythromycin stearate tab	-	1	MACROLIDES
ERYTHROMYCIN TAB (all forms except PCE)	-	3	MACROLIDES
erythromycin/benzoyl peroxide gel (BENZAMYCIN equiv)	-	1	DERMATOLOGICALS
erythromycin/sulfisoxazole susp (PEDIAZOLE equiv)	-	1	ANTI-INFECTIVE AGENTS - MISC.
ESBRIET CAP (QL= 9 caps/day)	MSP-PA-QL-SF	4	RESPIRATORY AGENTS - MISC.
ESBRIET TAB 267MG (QL= 9 tabs/day)	MSP-PA-QL-SF	4	RESPIRATORY AGENTS - MISC.
ESBRIET TAB 801MG (QL= 3 tabs/day)	MSP-PA-QL-SF	4	RESPIRATORY AGENTS - MISC.
ESCAVITE CHEW TAB	-	3	MULTIVITAMINS
escitalopram soln (LEXAPRO equiv)	-	1	ANTIDEPRESSANTS
escitalopram tab (LEXAPRO equiv)	-	1	ANTIDEPRESSANTS
ESGIC TAB	-	NC	ANALGESICS - NONNARCOTIC
esomeprazole cap (NEXIUM equiv)	-	NC	ULCER DRUGS
ESOMEPRAZOLE STRONTIUM CAP	-	NC	ULCER DRUGS
estazolam tab (PROSOM equiv)	-	1	HYPNOTICS/SEDATIVES/SLEEP DISORDEI AGENTS
esterified estrogens/methyltestosterone tab (ESTRATEST equiv)	-	NC	ESTROGENS
ESTRACE TAB	-	3	ESTROGENS
ESTRACE VAGINAL CREAM	-	2	VAGINAL PRODUCTS
estradiol patch (CLIMARA equiv)	-	1	ESTROGENS
estradiol patch (VIVELLE-DOT equiv)	-	1	ESTROGENS
estradiol tab (ESTRACE equiv)	-	1	ESTROGENS
estradiol vaginal tab, yuvafem vaginal tab (VAGIFEM equiv) (QL= 8 tabs/28 days (18 tabs on first fill))	QL	1	VAGINAL PRODUCTS
estradiol/norethindrone tab (ACTIVEVELLA equiv)	-	1	ESTROGENS
ESTRASORB EMULSION	-	3	ESTROGENS
ESTRATEST TAB	-	NC	ESTROGENS
ESTRING	-	2	VAGINAL PRODUCTS
ESTROPIPATE TAB	-	1	ESTROGENS
estropipate tab (OGEN equiv)	-	1	ESTROGENS
ESTROSTEP FE TAB	-	3	CONTRACEPTIVES
eszopiclone tab (LUNESTA equiv) (QL= 1 tab/day)	QL	1	HYPNOTICS/SEDATIVES/SLEEP DISORDEI AGENTS
ethacrynic tab (EDECIN equiv)	-	1	DIURETICS
ethambutol tab (MYAMBUTOL equiv)	-	1	ANTIMYCOBACTERIAL AGENTS
ethosuximide cap (ZARONTIN equiv)	-	1	ANTICONSULSANTS
ethosuximide soln (ZARONTIN equiv)	-	1	ANTICONSULSANTS
etidronate disodium tab 200mg (DIDRONEL equiv)	-	1	ENDOCRINE AND METABOLIC AGENTS - MISC.

INF	NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS
LMSP	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program	LD	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	PA	Prior Authorization	QL	Quantity Limit
SP	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 M	SMKG	Smoking Cessation
	Available through Specialty Pharmacy Program	ST	Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary Cont.
Alphabetical Index
Last Updated 11/1/2017

Drug Name	Special Code	Tier	Category
ETIDRONATE DISODIUM TAB 400MG	-	1	ENDOCRINE AND METABOLIC AGENTS - MISC.
etodolac cap (LODINE equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
etodolac ER tab (LODINE XL equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
etodolac tab	-	1	ANALGESICS - ANTI-INFLAMMATORY
etoposide cap (VEPESID equiv)	KMSP	4	ANTINEOPLASTICS
EUCRISA OINT	-	NC	DERMATOLOGICALS
EURAX CREAM	-	2	DERMATOLOGICALS
EURAX LOTION	-	3	DERMATOLOGICALS
EVAMIST SPRAY	-	3	ESTROGENS
EVISTA TAB	-	3	ENDOCRINE AND METABOLIC AGENTS - MISC.
EVOCLIN FOAM	-	NC	DERMATOLOGICALS
EVOTAZ TAB	-	4	ANTIVIRALS
EVOXAC CAP	-	3	MOUTH/THROAT/DENTAL AGENTS
EVZIO INJ	-	NC	ANTIDOTES
EXALGO TAB	-	NC	ANALGESICS - OPIOID
EXELDERM CREAM	-	3	DERMATOLOGICALS
EXELDERM SOLN	-	3	DERMATOLOGICALS
EXELON CAP	-	3	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
EXELON PATCH	-	3	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
EXELON SOLN	-	2	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
exemestane tab (AROMASIN equiv)	-	1	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
EXFORGE HCT TAB	-	3	ANTIHYPERTENSIVES
EXFORGE TAB	-	3	ANTIHYPERTENSIVES
EXJADE TAB	MSP	4	ANTIDOTES
EXTAVIA INJ	LMSP	4	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
ezetimibe tab (ZETIA equiv)	-	1	ANTHYPERLIPIDEMICS
ezetimibe/simvastatin tab (VYTORIN equiv) (QL= 1 tab/day (10-80mg is Not Covered))	QL	1	ANTHYPERLIPIDEMICS
ezetimibe/simvastatin tab 10-80mg (VYTORIN equiv)	-	NC	ANTHYPERLIPIDEMICS
FABIOR AEROSOL FOAM	-	NC	DERMATOLOGICALS
FABRAZYME INJ	M	M	ENDOCRINE AND METABOLIC AGENTS - MISC.
FACTIVE TAB	-	NC	FLUOROQUINOLONES
FALESSA KIT	-	NC	CONTRACEPTIVES
FALESSA TAB	-	NC	DIETARY PRODUCTS/DIETARY MANAGEMENT PRODUCTS
famciclovir tab (FAMVIR equiv)	-	1	ANTIVIRALS
famotidine susp (PEPCID equiv)	-	1	ULCER DRUGS
famotidine tab (PEPCID equiv)	-	1	ULCER DRUGS
FAMVIR TAB	-	3	ANTIVIRALS
FANAPT TAB (QL= 2 tabs/day)	PA-QL	3	ANTIPSYCHOTICS/ANTIMANIC AGENTS
FANAPT TITRATION PACK (QL= 1 pack/plan year)	PA-QL	3	ANTIPSYCHOTICS/ANTIMANIC AGENTS
FANSIDAR TAB	-	3	ANTIMALARIALS

INF	NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS
LMSP	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program	LD	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	PA	Prior Authorization	QL	Quantity Limit
SP	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 M	SMKG	Smoking Cessation
	Available through Specialty Pharmacy Program	ST	Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary Cont.
Alphabetical Index
Last Updated 11/1/2017

Drug Name	Special Code	Tier	Category
FARESTON TAB	-	2	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
FARXIGA TAB	-	NC	ANTIDIABETICS
FARYDAK CAP (QL= 6 caps/21 days)	MSP-PA-QL	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
FAZACLO ODT 25MG, 100MG	-	3	ANTIPSYCHOTICS/ANTIMANIC AGENTS
felbamate susp (FELBATOL equiv)	-	1	ANTICONVULSANTS
felbamate tab (FELBATOL equiv)	-	1	ANTICONVULSANTS
FELBATOL SUSP	-	3	ANTICONVULSANTS
FELBATOL TAB	-	2	ANTICONVULSANTS
FELDENE CAP	-	3	ANALGESICS - ANTI-INFLAMMATORY
felodipine ER tab (PLENDIL equiv)	-	1	CALCIUM CHANNEL BLOCKERS
FEM PH GEL	-	3	VAGINAL PRODUCTS
FEMALE CONDOMS	OTC	\$0	MEDICAL DEVICES AND SUPPLIES
FEMARA TAB	-	3	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
FEMCON FE CHEW TAB	-	3	CONTRACEPTIVES
FEMHRT TAB	-	3	ESTROGENS
FEMRING (3 copays per Rx)	-	3	VAGINAL PRODUCTS
fenofibrate cap 43mg, 130mg (ANTARA equiv)	-	NC	ANTIHYPERTENSIVES
fenofibrate cap 67mg, 134mg, 200mg (ANTARA equiv)	-	1	ANTIHYPERTENSIVES
FENOFIBRATE CAP, LIPOFEN CAP 50MG, 150MG	-	NC	ANTIHYPERTENSIVES
fenofibrate tab 40mg, 120mg (FENOGLIDE equiv)	-	NC	ANTIHYPERTENSIVES
fenofibrate tab 48mg, 54mg, 145mg, 160mg (TRICOR equiv)	-	1	ANTIHYPERTENSIVES
fenofibric acid DR cap (TRILIPIX equiv)	-	NC	ANTIHYPERTENSIVES
FENOFIBRIC TAB, FIBRICOR TAB	-	3	ANTIHYPERTENSIVES
FENOGLIDE TAB	-	NC	ANTIHYPERTENSIVES
fenoprofen calcium tab	-	1	ANALGESICS - ANTI-INFLAMMATORY
FENOPROFEN CAP	-	3	ANALGESICS - ANTI-INFLAMMATORY
fantanyl citrate lollipop (ACTIQ equiv) (QL= 120 lozenges/30 days)	PA-QL	1	ANALGESICS - OPIOID
fantanyl patch (DURAGESIC equiv)	-	1	ANALGESICS - OPIOID
FENTORA TAB (QL= 120 tabs/30 days)	PA-QL	3	ANALGESICS - OPIOID
ferrex 150 forte cap	-	1	HEMATOPOIETIC AGENTS
ferrex 150 forte cap (NIFEREX 150 FORTE equiv)	-	1	HEMATOPOIETIC AGENTS
FERREX 28 TAB	-	3	HEMATOPOIETIC AGENTS
FERRIPROX SOLN (Only available through Ferriprox Total Care 866-758-7071)	LD-PA	4	ANTIDOTES
FERRIPROX TAB (Only available through Ferriprox Total Care 866-758-7071)	LD-PA	4	ANTIDOTES
ferrous sulfate elixir (Covered for members 1 year or younger)	OTC	\$0	HEMATOPOIETIC AGENTS
FERROUS SULFATE LIQUID (Covered for members 1 year or younger)	OTC	\$0	HEMATOPOIETIC AGENTS
ferrous sulfate soln (Covered for members 1 year or younger)	OTC	\$0	HEMATOPOIETIC AGENTS
FERROUS SULFATE SYRUP (Covered for members 1 year or younger)	OTC	\$0	HEMATOPOIETIC AGENTS
FETZIMA CAP (QL= 1 cap/day)	PA-QL	3	ANTIDEPRESSANTS
FETZIMA TITRATION PACK (QL= 1 cap/day)	PA-QL	3	ANTIDEPRESSANTS
FEXMID TAB	-	3	MUSCULOSKELETAL THERAPY AGENTS
FINACEA FOAM	-	2	DERMATOLOGICALS
FINACEA GEL	-	2	DERMATOLOGICALS
FINACEA PLUS KIT	-	2	DERMATOLOGICALS
finasteride tab (PROSCAR equiv)	-	1	GENITOURINARY AGENTS - MISCELLANEOUS

INF	NC =Not Covered		generic =small letters	LD	BRANDS =CAPITAL LETTERS
LMSP	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program	MSP	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	QL	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	PA	Prior Authorization	SMKG	Quantity Limit
SP	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 Months	VAC	Smoking Cessation
	Available through Specialty Pharmacy Program	ST	Step Therapy		Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary Cont.
Alphabetical Index
Last Updated 11/1/2017

Drug Name	Special Code	Tier	Category
finasteride tab (PROPECIA equiv)	-	NC	DERMATOLOGICALS
FIORICET CAP	-	NC	ANALGESICS - NONNARCOTIC
FIORICET/CODEINE CAP	-	NC	ANALGESICS - OPIOID
FIORINAL CAP	-	NC	ANALGESICS - NONNARCOTIC
FIORINAL/CODEINE CAP	-	NC	ANALGESICS - OPIOID
FIRST BACLOFEN SUSP KIT	-	NC	MUSCULOSKELETAL THERAPY AGENTS
FIRST DUKES MOUTHWASH	-	3	MOUTH/THROAT/DENTAL AGENTS
FIRST MARYS MOUTHWASH	-	3	MOUTH/THROAT/DENTAL AGENTS
FIRST METRONIDAZOLE SUSP	-	3	ANTI-INFECTIVE AGENTS - MISC.
FIRST MOUTHWASH BLM	-	3	MOUTH/THROAT/DENTAL AGENTS
FIRST OMEPRAZOLE SUSP	-	3	ULCER DRUGS
FLAGYL CAP	-	3	ANTI-INFECTIVE AGENTS - MISC.
FLAGYL ER TAB	-	3	ANTI-INFECTIVE AGENTS - MISC.
FLAGYL TAB	-	3	ANTI-INFECTIVE AGENTS - MISC.
FLAREX OPHTH SUSP	-	3	OPHTHALMIC AGENTS
flavoxate tab (URISPAS equiv)	-	NC	URINARY ANTISPASMODICS
flecainide tab (TAMBOCOR equiv)	-	1	ANTIARRHYTHMICS
FLECTOR PATCH (QL= 30 patches/fill)	QL	3	DERMATOLOGICALS
FLEXERIL TAB	-	3	MUSCULOSKELETAL THERAPY AGENTS
FLOLIPID SUSP	-	NC	ANTIHYPERLIPIDEMICS
FLOMAX CAP	-	3	GENITOURINARY AGENTS - MISCELLANEOUS
FLO-PRED SUSP	-	NC	CORTICOSTEROIDS
FLORIVA CHEW TAB	-	NC	MULTIVITAMINS
FLORIVA PLUS DROPS	-	2	MULTIVITAMINS
FLOVENT DISKUS INHALER	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
FLOVENT HFA INHALER	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
FLUAD INJ	VAC	\$0	VACCINES
FLUBLOK INJ	VAC	\$0	VACCINES
FLUBLOK QUAD PF INJ	VAC	\$0	VACCINES
FLUCELVAX INJ	VAC	\$0	VACCINES
FLUCELVAX QUAD INJ	VAC	\$0	VACCINES
fluconazole susp (DIFLUCAN equiv)	-	1	ANTIFUNGALS
fluconazole tab (DIFLUCAN equiv)	-	1	ANTIFUNGALS
flucytosine cap (ANCOBON equiv)	-	1	ANTIFUNGALS
fludrocortisone tab (FLORINEF equiv)	-	1	CORTICOSTEROIDS
FLULAVAL QUAD INJ, FLUZONE QUAD INJ	VAC	\$0	VACCINES
FLUMADINE TAB	-	3	ANTIVIRALS
FLUNISOLIDE NASAL SPRAY (QL= 2 bottles/fill)	QL	1	NASAL AGENTS - SYSTEMIC AND TOPICAL
fluocinolone acetonide cream	-	1	DERMATOLOGICALS
fluocinolone acetonide oil (DERMA-SMOOTH/FS equiv)	-	1	DERMATOLOGICALS
fluocinolone acetonide oint	-	1	DERMATOLOGICALS
fluocinolone acetonide soln	-	1	DERMATOLOGICALS
fluocinolone otic oil (DERMOTIC equiv)	-	1	OTIC AGENTS
fluocinonide cream 0.05% (LIDEX equiv)	-	1	DERMATOLOGICALS
fluocinonide cream 0.1% (VANOS CREAM equiv)	-	NC	DERMATOLOGICALS
fluocinonide emollient cream	-	1	DERMATOLOGICALS
fluocinonide gel	-	1	DERMATOLOGICALS

INF	NC =Not Covered		generic =small letters	LD	BRANDS =CAPITAL LETTERS
LMSP	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program	MSP	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	QL	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	PA	Prior Authorization	SMKG	Quantity Limit
SP	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 M	VAC	Smoking Cessation
	Available through Specialty Pharmacy Program	ST	Step Therapy		Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary Cont.
Alphabetical Index
Last Updated 11/1/2017

Drug Name	Special Code	Tier	Category
fluocinonide oint	-	1	DERMATOLOGICALS
fluocinonide soln	-	1	DERMATOLOGICALS
FLUORABON SOLN (Covered at \$0 for members 5 years or younger; All other members covered at preferred brand copay)	-	\$0	MINERALS & ELECTROLYTES
FLUORAC CREAM	-	NC	DERMATOLOGICALS
FLUOR-A-DAY CHEW TAB	-	1	MINERALS & ELECTROLYTES
fluorometholone ophth soln (FML LIQUIFILM equiv)	-	1	OPHTHALMIC AGENTS
FLUOROPLEX CREAM	-	2	DERMATOLOGICALS
fluorouracil cream (EFUDEX CREAM equiv)	-	1	DERMATOLOGICALS
FLUOROURACIL CREAM 0.5%	-	2	DERMATOLOGICALS
FLUOROURACIL SOLN	-	2	DERMATOLOGICALS
fluoxetine (pmdd) tab (SARAFEM equiv)	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
fluoxetine cap (PROZAC equiv)	-	1	ANTIDEPRESSANTS
FLUOXETINE CAP (PMDD)	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
fluoxetine soln (PROZAC equiv)	-	1	ANTIDEPRESSANTS
fluoxetine tab (PROZAC equiv)	-	1	ANTIDEPRESSANTS
FLUOXETINE TAB 60MG	-	NC	ANTIDEPRESSANTS
fluoxetine weekly cap (PROZAC equiv)	-	NC	ANTIDEPRESSANTS
fluphenazine tab (PROLIXIN equiv)	-	1	ANTIPSYCHOTICS/ANTIMANIC AGENTS
flurandrenolide Cream (CORDRAN equiv)	-	1	DERMATOLOGICALS
flurandrenolide lotion (CORDRAN equiv)	-	1	DERMATOLOGICALS
FLURAZEPAM CAP	-	1	HYPNOTICS/SEDATIVES/SLEEP DISORDEI AGENTS
FLURBIPROFEN OPHTH SOLN	-	1	OPHTHALMIC AGENTS
flurbiprofen ophth soln (OCUFEN equiv)	-	1	OPHTHALMIC AGENTS
flurbiprofen tab (ANSAID equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
flutamide cap (EULEXIN equiv)	-	1	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
fluticasone nasal spray (FLONASE equiv) (QL= 2 bottles/fill)	QL	1	NASAL AGENTS - SYSTEMIC AND TOPICAL
fluticasone propionate cream (CUTIVATE equiv)	-	1	DERMATOLOGICALS
fluticasone propionate lotion (CUTIVATE equiv)	-	NC	DERMATOLOGICALS
fluticasone propionate oint (CUTIVATE equiv)	-	1	DERMATOLOGICALS
FLUTICASONE/SALMETEROL INHALER	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
fluvastatin cap (LESCOL equiv)	-	1	ANTIHYPERLIPIDEMICS
fluvastatin ER tab (LESCOL XL equiv)	-	1	ANTIHYPERLIPIDEMICS
FLUVIRIN INJ	VAC	\$0	VACCINES
FLUVIRIN PF INJ	VAC	\$0	VACCINES
fluvoxamine ER cap (LUVOX CR equiv) (Step Therapy requires trial of citalopram, escitalopram, sertraline, fluoxetine, fluvoxamine or paroxetine)	ST	1	ANTIDEPRESSANTS
fluvoxamine tab (LUVOX equiv)	-	1	ANTIDEPRESSANTS
FLUZONE HIGH DOSE PF INJ	VAC	\$0	VACCINES
FLUZONE INTRADERMAL INJ	VAC	\$0	VACCINES
FLUZONE QUADRIVALENT INJ	VAC	\$0	VACCINES
FLUZONE/FLUARIX QUAD INJ	VAC	\$0	VACCINES
FML FORTE OPHTH SUSP	-	3	OPHTHALMIC AGENTS
FML LIQUIFLIM OPHTH SUSP	-	3	OPHTHALMIC AGENTS
FML S.O.P. OPHTH OINT	-	3	OPHTHALMIC AGENTS

INF	NC =Not Covered		generic =small letters	LD	BRANDS =CAPITAL LETTERS
LMSP	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program	MSP	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	QL	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	PA	Prior Authorization	SMKG	Quantity Limit
SP	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 M	VAC	Smoking Cessation
	Available through Specialty Pharmacy Program	ST	Step Therapy		Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary Cont.
Alphabetical Index
Last Updated 11/1/2017

Drug Name	Special Code	Tier	Category
FOCALIN TAB	-	3	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
FOCALIN XR CAP	-	3	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
FOLBEE PLUS CZ TAB	-	1	MULTIVITAMINS
folbee tab	-	1	HEMATOPOIETIC AGENTS
folic acid tab 1mg (Covered at \$0 for females only; All other members covered at generic copay)	-	\$0	HEMATOPOIETIC AGENTS
folic acid tab 400mcg (Covered for females only)	OTC	\$0	HEMATOPOIETIC AGENTS
folic acid tab 800mcg (Covered for females only)	OTC	\$0	HEMATOPOIETIC AGENTS
fondaparinux inj (ARIXTRA equiv)	PA	1	ANTICOAGULANTS
FORADIL AEROLIZER	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
FORTAMET TAB	-	NC	ANTIDIABETICS
FORTEO INJ	KMSP	4	ENDOCRINE AND METABOLIC AGENTS - MISC.
FORTESTA GEL, TESTOSTERONE GEL (QL= 2 bottles/30 days)	PA-QL	3	ANDROGENS-ANABOLIC
FORTICAL NASAL SPRAY	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
FOSAMAX TAB	-	3	ENDOCRINE AND METABOLIC AGENTS - MISC.
FOSAMAX+D TAB	-	3	ENDOCRINE AND METABOLIC AGENTS - MISC.
fosamprenavir tab (LEXIVA equiv)	-	4	ANTIVIRALS
FOSCARNET INJ	M	M	ANTIVIRALS
fosinopril tab (MONOPRIL equiv)	-	1	ANTIHYPERTENSIVES
fosinopril/hydrochlorothiazide tab (MONOPRIL HCT equiv)	-	1	ANTIHYPERTENSIVES
FOSRENOL CHEW TAB	-	3	GASTROINTESTINAL AGENTS - MISC.
FOSRENOL POWDER PACK	-	2	GASTROINTESTINAL AGENTS - MISC.
FRAGMIN INJ	-	3	ANTICOAGULANTS
FREESTYLE FREEDOM LITE METER	OTC	\$0	MEDICAL DEVICES AND SUPPLIES
FREESTYLE INSULIN SYRINGE	OTC	1	MEDICAL DEVICES AND SUPPLIES
FREESTYLE INSULINX METER	OTC	\$0	MEDICAL DEVICES AND SUPPLIES
FREESTYLE INSULINX TEST STRIP (Limited to 50 strips per month for members not on diabetes medication)	OTC	2	DIAGNOSTIC PRODUCTS
FREESTYLE LITE METER	OTC	\$0	MEDICAL DEVICES AND SUPPLIES
FREESTYLE LITE TEST STRIP (Limited to 50 strips per month for members not on diabetes medication)	OTC	2	DIAGNOSTIC PRODUCTS
FREESTYLE PRECISION NEO METER	OTC	\$0	MEDICAL DEVICES AND SUPPLIES
FREESTYLE PRECISION NEO TEST STRIP (Limited to 50 strips per month for members not on diabetes medication)	OTC	2	DIAGNOSTIC PRODUCTS
FREESTYLE TEST STRIP (Limited to 50 strips per month for members not on diabetes medication)	OTC	2	DIAGNOSTIC PRODUCTS
FROVA TAB (QL= 9 tabs/fill, 2 fills/30 days)	QL	3	MIGRAINE PRODUCTS
frovatriptan tab (FROVA equiv) (QL= 9 tabs/fill, 2 fills/30 days)	QL	1	MIGRAINE PRODUCTS
FURADANTIN SUSP	-	2	URINARY ANTI-INFECTIVES
FUROSEMIDE SOLN	-	1	DIURETICS
furosemide soln (LASIX equiv)	-	1	DIURETICS
furosemide tab (LASIX equiv)	-	1	DIURETICS
FUZEON INJ	-	4	ANTIVIRALS
FYCOMPA TAB	-	NC	ANTICONVULSANTS

INF	NC =Not Covered Infertility	KMSP	generic =small letters Kroger Mandatory Specialty Pharmacy Program	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 Months	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary Cont.
Alphabetical Index
Last Updated 11/1/2017

Drug Name	Special Code	Tier	Category
FYCOMPA SUSP	-	NC	ANTICONVULSANTS
gabapentin cap (NEURONTIN equiv)	-	1	ANTICONVULSANTS
gabapentin soln (NEURONTIN equiv)	-	1	ANTICONVULSANTS
gabapentin tab (NEURONTIN equiv)	-	1	ANTICONVULSANTS
GABITRIL TAB	-	3	ANTICONVULSANTS
GABITRIL TAB 12MG, 16MG	-	2	ANTICONVULSANTS
galantamine ER cap (RAZADYNE ER equiv)	-	1	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
GALANTAMINE SOLN	-	1	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
galantamine tab (RAZADYNE equiv)	-	1	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
GALZIN CAP	-	2	MINERALS & ELECTROLYTES
GAMASTAN INJ	M	M	PASSIVE IMMUNIZING AGENTS
GAMMAGARD INJ	M	M	PASSIVE IMMUNIZING AGENTS
GANCICLOVIR CAP	-	4	ANTIVIRALS
GASTROCROM CONC	-	2	GASTROINTESTINAL AGENTS - MISC.
gatifloxacin ophth soln (ZYMAXID equiv) (Step Therapy requires trial of ciprofloxacin, levofloxacin, ofloxacin or VIGAMOX/MOXEZA)	ST	1	OPHTHALMIC AGENTS
GATTEX KIT	-	NC	GASTROINTESTINAL AGENTS - MISC.
gavilyte-h kit	-	NC	LAXATIVES
GAZYVA INJ	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
GELCLAIR GEL	-	NC	MOUTH/THROAT/DENTAL AGENTS
GELNIQUE	-	3	URINARY ANTISPASMODICS
gemfibrozil tab (LOPID equiv)	-	1	ANTIHYPERLIPIDEMICS
GENOTROPIN INJ	KMSP-PA	4	ENDOCRINE AND METABOLIC AGENTS - MISC.
GENTAK OPHTH OINT	-	1	OPHTHALMIC AGENTS
gentamicin ophth oint (GARAMYCIN equiv)	-	1	OPHTHALMIC AGENTS
gentamicin ophth soln (GARAMYCIN equiv)	-	1	OPHTHALMIC AGENTS
gentamicin sulfate cream	-	1	DERMATOLOGICALS
gentamicin sulfate oint	-	1	DERMATOLOGICALS
GENVOYA TAB	-	4	ANTIVIRALS
GEODON CAP	-	3	ANTI PSYCHOTICS/ANTIMANIC AGENTS
GIALAX KIT	-	NC	LAXATIVES
gianvi tab, ocella tab (YASMIN, YAZ equiv)	-	NC	CONTRACEPTIVES
GILENYA CAP (QL= 1 cap/day)	LMSP-QL	4	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
GILOTRIF TAB (QL= 1 tab/day; Only available through Accredo 888-773-7376)	LD-PA-QL	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
GILTUSS LIQUID	-	3	COUGH/COLD/ALLERGY
GILTUSS TR TAB	-	3	COUGH/COLD/ALLERGY
glatiramer inj (COPAXONE equiv)	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
GLEEVEC TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
GLEOSTINE/LOMUSTINE CAP	-	2	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
glimepiride tab (AMARYL equiv)	-	1	ANTIDIABETICS
glipizide ER tab (GLUCOTROL XL equiv)	-	1	ANTIDIABETICS

INF	NC =Not Covered		generic =small letters	LD	BRANDS =CAPITAL LETTERS
LMSP	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program	MSP	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	QL	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	PA	Prior Authorization	SMKG	Quantity Limit
SP	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 M	VAC	Smoking Cessation
	Available through Specialty Pharmacy Program	ST	Step Therapy		Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary Cont.
Alphabetical Index
Last Updated 11/1/2017

Drug Name	Special Code	Tier	Category
glipizide tab (GLUCOTROL equiv)	-	1	ANTIDIABETICS
glipizide/metformin tab (METAGLIP equiv)	-	1	ANTIDIABETICS
GLUCAGEN HYPOKIT INJ	-	2	ANTIDIABETICS
GLUCAGEN INJ	-	2	DIAGNOSTIC PRODUCTS
GLUCAGON DIAGNOSTIC INJ	-	NC	DIAGNOSTIC PRODUCTS
GLUCAGON INJ KIT	-	2	ANTIDIABETICS
GLUCOPHAGE TAB	-	3	ANTIDIABETICS
GLUCOPHAGE XR TAB	-	3	ANTIDIABETICS
GLUCOTROL TAB	-	3	ANTIDIABETICS
GLUCOTROL XL TAB	-	3	ANTIDIABETICS
GLUCOVANCE TAB	-	3	ANTIDIABETICS
GLUMETZA TAB 1000MG	-	NC	ANTIDIABETICS
GLUMETZA TAB 500MG	-	NC	ANTIDIABETICS
glyburide micronized tab (GLYNASE equiv)	-	1	ANTIDIABETICS
glyburide tab (MICRONASE equiv)	-	1	ANTIDIABETICS
glyburide/metformin tab (GLUCOVANCE equiv)	-	1	ANTIDIABETICS
GLYCATE TAB 1.5MG	-	NC	ULCER DRUGS
glycopyrrolate tab (ROBINUL equiv)	-	1	ULCER DRUGS
GLYGEST PAK	-	NC	DIETARY PRODUCTS/DIETARY MANAGEMENT PRODUCTS
GLYNASE TAB	-	3	ANTIDIABETICS
GLYSET TAB	-	3	ANTIDIABETICS
GLYXAMBI TAB (QL= 1 tab/day)	QL	2	ANTIDIABETICS
GOCOVRI CAP	-	NC	ANTIPARKINSON AGENTS
GOLYTELY PACKET	-	1	LAXATIVES
GOLYTELY SOLN	-	NC	LAXATIVES
GONITRO POWDER	-	NC	ANTIANGINAL AGENTS
GORDON'S UREA OINT 40%	-	NC	DERMATOLOGICALS
GRALISE TAB	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
granisetron tab (KYTRIL equiv) (QL= 9 tabs/fill)	QL-SP	4	ANTIEMETICS
GRANISOL SOLN (QL= 60ml/fill)	QL-SP	4	ANTIEMETICS
GRANIX INJ	KMSP	4	HEMATOPOIETIC AGENTS
GRASTEK SL TAB	-	NC	BIOLOGICALS MISC
GRIFULVIN V TAB	-	3	ANTIFUNGALS
griseofulvin micro tab (GRIFULVIN V equiv)	-	1	ANTIFUNGALS
griseofulvin susp (GRIFULVIN equiv)	-	1	ANTIFUNGALS
griseofulvin tab (GRIS-PEG equiv)	-	1	ANTIFUNGALS
GRIS-PEG TAB	-	3	ANTIFUNGALS
GUAIFENESEN SYRUP	-	NC	COUGH/COLD/ALLERGY
guaifenesin tab (ALLFEN JR equiv)	-	NC	COUGH/COLD/ALLERGY
guaifenesin/codeine soln (BRONTEX equiv)	OTC	1	COUGH/COLD/ALLERGY
guaifenesin/codeine syrup (TUSSI-ORGANIDIN-S equiv) (QL= 240ml/fill)	OTC-QL	1	COUGH/COLD/ALLERGY
GUANABENZ TAB	-	3	ANTIHYPERTENSIVES
guanfacine ER tab (INTUNIV equiv)	-	1	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
guanfacine IR tab (TENEX equiv)	-	1	ANTIHYPERTENSIVES
GUANIDINE TAB	-	3	ANTIMYASTHENIC/CHOLINERGIC AGENTS
GYNAZOLE CREAM	-	NC	VAGINAL PRODUCTS
HAEGARDA INJ	-	NC	HEMATOLOGICAL AGENTS - MISC.

INF	NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS
LMSP	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program	LD	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	PA	Prior Authorization	QL	Quantity Limit
SP	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 M	SMKG	Smoking Cessation
	Available through Specialty Pharmacy Program	ST	Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary Cont.
Alphabetical Index
Last Updated 11/1/2017

Drug Name	Special Code	Tier	Category
HALCION TAB	-	3	HYPNOTICS/SEDATIVES/SLEEP DISORDEI AGENTS
HALFLYTELY BOWEL PREP KIT	-	NC	LAXATIVES
halobetasol propionate cream (ULTRAVATE equiv)	-	1	DERMATOLOGICALS
halobetasol propionate oint (ULTRAVATE equiv)	PA	1	DERMATOLOGICALS
HALOG CREAM	-	3	DERMATOLOGICALS
HALOG OINT	-	3	DERMATOLOGICALS
halonate pac kit (ULTRAVATE KIT equiv)	-	NC	DERMATOLOGICALS
haloperidol lactate conc (HALDOL equiv)	-	1	ANTIPSYCHOTICS/ANTIMANIC AGENTS
haloperidol tab (HALDOL equiv)	-	1	ANTIPSYCHOTICS/ANTIMANIC AGENTS
HARVONI TAB (QL= 1 tab/day)	KMSP-PA-QL	4	ANTIVIRALS
HEMANGEOL SOLN	-	NC	BETA BLOCKERS
HEPSERA TAB	KMSP	4	ANTIVIRALS
HETLIOZ CAP	-	NC	HYPNOTICS/SEDATIVES/SLEEP DISORDEI AGENTS
HEXALEN CAP	KMSP	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
HIPREX TAB	-	3	URINARY ANTI-INFECTIVES
HIZENTRA INJ	KMSP	3	PASSIVE IMMUNIZING AGENTS
homatropine ophth soln (ISOPTO HOMATROPINE equiv)	-	1	OPHTHALMIC AGENTS
HORIZANT TAB	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
HUMALOG INJ (Step Therapy requires trial of NOVOLOG)	ST	3	ANTIDIABETICS
HUMALOG KWIKPEN INJ (Step Therapy requires trial of NOVOLOG)	ST	3	ANTIDIABETICS
HUMALOG MIX INJ (Step Therapy requires trial of NOVOLOG)	ST	3	ANTIDIABETICS
HUMALOG MIX KWIKPEN INJ (Step Therapy requires trial of NOVOLOG)	ST	3	ANTIDIABETICS
HUMALOG PEN INJ (Step Therapy requires trial of NOVOLOG)	ST	3	ANTIDIABETICS
HUMATROPE INJ, ZOMACTON INJ	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
HUMIRA INJ (QL= 2 inj/28 days)	LMSP-PA-QL	4	ANALGESICS - ANTI-INFLAMMATORY
HUMIRA PEN INJ (QL= 2 inj/28 days)	LMSP-PA-QL	4	ANALGESICS - ANTI-INFLAMMATORY
HUMULIN MIX INJ (Step Therapy requires trial of NOVOLIN)	OTC-ST	3	ANTIDIABETICS
HUMULIN MIX PEN INJ (Step Therapy requires trial of NOVOLIN)	OTC-ST	3	ANTIDIABETICS
HUMULIN N INJ (Step Therapy requires trial of NOVOLIN)	OTC-ST	3	ANTIDIABETICS
HUMULIN N PEN INJ (Step Therapy requires trial of NOVOLIN)	OTC-ST	3	ANTIDIABETICS
HUMULIN R INJ (Step Therapy requires trial of NOVOLIN)	OTC-ST	3	ANTIDIABETICS
HUMULIN R INJ U-500	-	2	ANTIDIABETICS
HUMULIN R U-500 KWIKPEN INJ	-	2	ANTIDIABETICS
HYCAMTIN CAP	KMSP-PA	4	ANTINEOPLASTICS
HYCET SOLN	-	3	ANALGESICS - OPIOID
HYCODAN SYRUP	-	3	COUGH/COLD/ALLERGY
HYCOFENIX SOLN	-	NC	COUGH/COLD/ALLERGY
hydralazine tab (APRESOLINE equiv)	-	1	ANTIHYPERTENSIVES
HYDREA CAP	-	3	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
hydrochlorothiazide cap (MICROZIDE equiv)	-	1	DIURETICS
hydrochlorothiazide tab (HYDRODIURIL equiv)	-	1	DIURETICS
hydrocodone/acetaminophen cap (LORCET equiv)	-	1	ANALGESICS - OPIOID
hydrocodone/acetaminophen soln (HYCET, LORTAB equiv)	-	1	ANALGESICS - OPIOID
hydrocodone/acetaminophen tab (LORTAB equiv)	-	1	ANALGESICS - OPIOID

INF	NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS
LMSP	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program	LD	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	PA	Prior Authorization	QL	Quantity Limit
SP	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 M	SMKG	Smoking Cessation
	Available through Specialty Pharmacy Program	ST	Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary Cont.
Alphabetical Index
Last Updated 11/1/2017

Drug Name	Special Code	Tier	Category
hydrocodone/acetaminophen tab 10mg-300mg (XODOL equiv)	-	NC	ANALGESICS - OPIOID
hydrocodone/acetaminophen tab 2.5-325mg (NORCO equiv)	-	1	ANALGESICS - OPIOID
hydrocodone/acetaminophen tab 5mg-300mg (XODOL equiv)	-	NC	ANALGESICS - OPIOID
hydrocodone/acetaminophen tab 7.5mg-300mg (XODOL equiv)	-	NC	ANALGESICS - OPIOID
hydrocodone/chlorpheniramine CR susp (TUSSIONEX equiv) (QL= 120ml/fill; 2 fills/30 days)	QL	1	COUGH/COLD/ALLERGY
hydrocodone/chlorpheniramine/pseudoephedrine liquid (ZUTRIPRO equiv) (QL= 120ml/fill, 2 fills/30 days)	QL	1	COUGH/COLD/ALLERGY
hydrocodone/homatropine syrup (HYCODAN equiv)	-	1	COUGH/COLD/ALLERGY
hydrocodone/ibuprofen tab (VICOPROFEN equiv)	-	1	ANALGESICS - OPIOID
hydrocortisone butyrate cream (LOCOID equiv)	-	NC	DERMATOLOGICALS
hydrocortisone butyrate lipocream (LOCOID equiv)	-	NC	DERMATOLOGICALS
hydrocortisone butyrate oint (LOCOID equiv)	-	NC	DERMATOLOGICALS
hydrocortisone butyrate soln (LOCOID equiv)	-	NC	DERMATOLOGICALS
hydrocortisone cream (PROCTOCORT equiv)	-	1	DERMATOLOGICALS
hydrocortisone enema (CORTENEMA equiv)	-	1	ANORECTAL AGENTS
hydrocortisone lotion (HYTONE equiv)	-	1	DERMATOLOGICALS
hydrocortisone oint	-	1	DERMATOLOGICALS
hydrocortisone supp (ANUSOL HC equiv)	-	NC	ANORECTAL AGENTS
hydrocortisone tab (CORTEF equiv)	-	1	CORTICOSTEROIDS
hydrocortisone valerate cream	-	NC	DERMATOLOGICALS
hydrocortisone valerate oint (WESTCORT equiv)	-	NC	DERMATOLOGICALS
hydrocortisone/pramoxine cream 2.5-1% (PRAMOSONE equiv)	-	NC	DERMATOLOGICALS
hydromorphone ER tab (EXALGO equiv)	-	NC	ANALGESICS - OPIOID
HYDROMORPHONE SUPP	-	1	ANALGESICS - OPIOID
hydromorphone tab (DILAUDID equiv)	-	1	ANALGESICS - OPIOID
hydroquinone cream (LUSTRA equiv)	-	NC	DERMATOLOGICALS
hydroxychloroquine tab (PLAQUENIL equiv)	-	1	ANTIMALARIALS
HYDROXYPROGESTERONE CAPROATE INJ	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
hydroxyurea cap (HYDREA equiv)	-	1	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
hydroxyzine pamoate cap (VISTARIL equiv)	-	1	ANTIAXIETY AGENTS
HYDROXYZINE PAMOATE CAP 100MG	-	1	ANTIAXIETY AGENTS
hydroxyzine syrup (ATARAX equiv)	-	1	ANTIAXIETY AGENTS
hydroxyzine tab (ATARAX equiv)	-	1	ANTIAXIETY AGENTS
hyoscyamine sulfate CR tab (LEVBID equiv)	-	1	ULCER DRUGS
hyoscyamine sulfate elixir (LEVSIN equiv)	-	1	ULCER DRUGS
hyoscyamine sulfate ODT (ANASPAZ equiv)	-	1	ULCER DRUGS
hyoscyamine sulfate SL tab (LEVSIN equiv)	-	1	ULCER DRUGS
hyoscyamine sulfate soln (LEVSIN equiv)	-	1	ULCER DRUGS
hyoscyamine sulfate SR cap (LEVSINEX equiv)	-	1	ULCER DRUGS
hyoscyamine tab (LEVSIN equiv)	-	1	ULCER DRUGS
HYPER-SAL NEB SOLN	-	3	COUGH/COLD/ALLERGY
HYSINGLA ER TAB	-	NC	ANALGESICS - OPIOID
HYTONE LOTION	-	3	DERMATOLOGICALS
HYTRIN CAP	-	3	ANTIHYPERTENSIVES
HYZAAR TAB	-	3	ANTIHYPERTENSIVES
ibandronate tab 150mg (BONIVA equiv) (QL= 1 tab/30 days; Step Therapy requires trial of alendronate)	QL-ST	1	ENDOCRINE AND METABOLIC AGENTS - MISC.

INF	NC =Not Covered		generic =small letters	LD	BRANDS =CAPITAL LETTERS
LMSP	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program	MSP	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	QL	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	PA	Prior Authorization	SMKG	Quantity Limit
SP	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 M	VAC	Smoking Cessation
	Available through Specialty Pharmacy Program	ST	Step Therapy		Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary Cont.
Alphabetical Index
Last Updated 11/1/2017

Drug Name	Special Code	Tier	Category
IBRANCE CAP (QL= 21 caps/28 days)	KMSP-PA-QL	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ibuprofen susp (Rx ONLY) (ADVIL, MOTRIN equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
ibuprofen tab	-	1	ANALGESICS - ANTI-INFLAMMATORY
ibuprofen tab (Rx covered Only)	-	1	ANALGESICS - ANTI-INFLAMMATORY
ICLUSIG TAB (Only available through Biologics 800-850-4306)	LD-PA-SF	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
IDHIFA TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ILEVRO OPHTH SUSP	-	2	OPHTHALMIC AGENTS
imatinib tab (GLEEVEC equiv) (QL= 3 tabs/day)	KMSP-PA-QL-SF	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
IMBRUVICA CAP (QL= 4 caps/day; Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-QL-SF	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
IMDUR TAB	-	3	ANTIANGINAL AGENTS
imipramine pamoate cap (TOFRANIL PM equiv)	-	1	ANTIDEPRESSANTS
imipramine tab (TOFRANIL equiv)	-	1	ANTIDEPRESSANTS
imiquimod cream (ALDARA equiv)	-	1	DERMATOLOGICALS
IMITREX INJ (QL= 4 inj/fill, 2 fills/30 days)	QL	3	MIGRAINE PRODUCTS
IMITREX TAB (QL= 9 tabs/fill, 2 fills/30 days)	QL	3	MIGRAINE PRODUCTS
IMITREX VIAL INJ (QL= 5 inj/fill, 2 fills/30 days)	QL	3	MIGRAINE PRODUCTS
IMPAVIDO CAP	PA	4	ANTI-INFECTIVE AGENTS - MISC.
IMPLANON IMPLANT, NEXPLANON IMPLANT	-	NC	CONTRACEPTIVES
IMURAN TAB	-	3	ASSORTED CLASSES
INCIVEK TAB	MSP-PA-SF	4	ANTIVIRALS
INCRELEX INJ	MSP	4	ENDOCRINE AND METABOLIC AGENTS - MISC.
INCRUSE ELLIPTA INHALER	-	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
indapamide tab (LOZOL equiv)	-	1	DIURETICS
INDERAL LA CAP	-	3	BETA BLOCKERS
INDOCIN SUPP	-	2	ANALGESICS - ANTI-INFLAMMATORY
INDOCIN SUSP	-	2	ANALGESICS - ANTI-INFLAMMATORY
indomethacin cap (INDOCIN equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
indomethacin CR cap (INDOCIN SR equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
INFANT FORMULA LIQUID	OTC-PA	2	DIETARY PRODUCTS/DIETARY MANAGEMENT PRODUCTS
INFANT FORMULA POWDER	OTC-PA	2	DIETARY PRODUCTS/DIETARY MANAGEMENT PRODUCTS
INFERGEN INJ	MSP	4	ANTIVIRALS
INFLAMMA-K KIT	-	NC	DERMATOLOGICALS
INGREZZA CAP	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
INLYTA TAB (QL= 8 tabs/day)	KMSP-PA-QL-SF	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
INNOPRAN XL CAP	-	3	BETA BLOCKERS
INSPRA TAB	-	3	ANTIHYPERTENSIVES
INSULIN SYRINGE	OTC	3	MEDICAL DEVICES AND SUPPLIES
INTELENCE TAB	-	4	ANTIVIRALS
INTERMEZZO SL TAB	-	NC	HYPNOTICS/SEDATIVES/SLEEP DISORDEI AGENTS

INF	NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS
LMSP	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program	LD	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	PA	Prior Authorization	QL	Quantity Limit
SP	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 M	SMKG	Smoking Cessation
	Available through Specialty Pharmacy Program	ST	Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary Cont.
Alphabetical Index
Last Updated 11/1/2017

Drug Name	Special Code	Tier	Category
INTRAROSA SUPP	-	NC	VAGINAL PRODUCTS
INTRON-A INJ	KMSP	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
INTUNIV TAB	-	3	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS
INVANZ INJ	M	M	ANTI-INFECTIVE AGENTS - MISC.
INVEGA INJ	-	NC	ANTIPSYCHOTICS/ANTIMANIC AGENTS
INVEGA TAB	PA	3	ANTIPSYCHOTICS/ANTIMANIC AGENTS
INVIRASE CAP	-	4	ANTIVIRALS
INVIRASE TAB	-	4	ANTIVIRALS
INVOKAMET TAB	-	NC	ANTIDIABETICS
INVOKAMET XR TAB	-	NC	ANTIDIABETICS
INVOKANA TAB	-	NC	ANTIDIABETICS
IODOFLEX PAD	-	NC	ANTISEPTICS & DISINFECTANTS
iodoquinol/hydrocortisone cream 1% (VYTONA equiv)	-	NC	DERMATOLOGICALS
iodoquinol/hydrocortisone cream 1.9-1% (VYTONA equiv)	-	NC	DERMATOLOGICALS
iodoquinol/hydrocortisone/aloe polysaccharide gel (ALCORTIN A equiv)	-	NC	DERMATOLOGICALS
IOPIDINE OPHTH SOLN	-	3	OPHTHALMIC AGENTS
IOPIDINE OPHTH SOLN 1%	-	2	OPHTHALMIC AGENTS
ipratropium nasal spray (ATROVENT equiv)	-	1	NASAL AGENTS - SYSTEMIC AND TOPICAL
ipratropium neb soln (ATROVENT equiv)	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
irbesartan tab (AVAPRO equiv)	-	1	ANTIHYPERTENSIVES
irbesartan/hydrochlorothiazide tab (AVALIDE equiv)	-	1	ANTIHYPERTENSIVES
IRESSA TAB (Only available through Diplomat Pharmacy 877-977-9118)	LD-PA	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
IRON POLYSACCH/THREONIC ACID/B12/FA CAP	-	1	HEMATOPOIETIC AGENTS
IRON SUSP (Covered for members 1 year or younger)	OTC	\$0	HEMATOPOIETIC AGENTS
ISENTRESS (HD) TAB	-	3	ANTIVIRALS
ISENTRESS CHEW TAB	-	3	ANTIVIRALS
ISENTRESS POWDER PACK	-	3	ANTIVIRALS
isometheptene/caffeine/acetaminophen tab (PRODRIN equiv)	-	NC	MIGRAINE PRODUCTS
ISONIAZID SYRUP	-	1	ANTIMYCOBACTERIAL AGENTS
isoniazid tab	-	1	ANTIMYCOBACTERIAL AGENTS
ISOPTO ATROPINE OPHTH SOLN	-	3	OPHTHALMIC AGENTS
ISOPTO CARBACHOL OPHTH SOLN	-	2	OPHTHALMIC AGENTS
ISOPTO CARPINE OPHTH SOLN	-	3	OPHTHALMIC AGENTS
ISOPTO HOMATROPINE OPHTH SOLN 2%	-	2	OPHTHALMIC AGENTS
ISOPTO HOMATROPINE OPHTH SOLN 5%	-	2	OPHTHALMIC AGENTS
ISOPTO HYOSCINE OPHTH SOLN	-	2	OPHTHALMIC AGENTS
ISORDIL TITRADOSE TAB	-	3	ANTIANGINAL AGENTS
ISOSORBIDE DINITRATE ER TAB	-	1	ANTIANGINAL AGENTS
isosorbide dinitrate ER tab (ISOCHRON equiv)	-	1	ANTIANGINAL AGENTS
isosorbide dinitrate SL tab	-	1	ANTIANGINAL AGENTS
isosorbide dinitrate tab (ISORDIL equiv)	-	1	ANTIANGINAL AGENTS
ISOSORBIDE DINITRATE TAB 30MG, 40MG	-	3	ANTIANGINAL AGENTS
isosorbide mononitrate ER tab (IMDUR equiv)	-	1	ANTIANGINAL AGENTS
isosorbide mononitrate tab (MONOKET equiv)	-	1	ANTIANGINAL AGENTS
isotretinoin cap (ACCUTANE equiv)	-	1	DERMATOLOGICALS
isoxsuprine tab	-	1	CARDIOVASCULAR AGENTS - MISC.

INF	NC =Not Covered		generic =small letters	LD	BRANDS =CAPITAL LETTERS
LMSP	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program	LD	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	PA	Prior Authorization	QL	Quantity Limit
SP	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 M	SMKG	Smoking Cessation
	Available through Specialty Pharmacy Program	ST	Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary Cont.
Alphabetical Index
Last Updated 11/1/2017

Drug Name	Special Code	Tier	Category
isradipine cap (DYNACIRC equiv)	-	1	CALCIUM CHANNEL BLOCKERS
ISTALOL OPHTH SOLN	-	2	OPHTHALMIC AGENTS
itraconazole cap (SPORANOX equiv)	PA	1	ANTIFUNGALS
ivermectin tab (STROMEKTOL equiv)	-	1	ANTHELMINTICS
JADENU SPRINKLE	KMSP	4	ANTIDOTES AND SPECIFIC ANTAGONISTS
JADENU TAB	KMSP	4	ANTIDOTES
JAKAFI TAB (QL= 2 tabs/day)	MSP-PA-QL	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
JALYN CAP	-	3	GENITOURINARY AGENTS - MISCELLANEOUS
JANUMET TAB (QL= 2 tabs/day)	QL	2	ANTIDIABETICS
JANUMET XR TAB (QL= 2 tabs/day)	QL	2	ANTIDIABETICS
JANUVIA TAB (QL= 1 tab/day)	QL	2	ANTIDIABETICS
JARDIANCE TAB (QL= 1 tab/day)	QL	2	ANTIDIABETICS
JENTADUETO TAB (QL= 2 tabs/day)	PA-QL	3	ANTIDIABETICS
JENTADUETO XR TAB (QL= 2 tabs/day)	QL	2	ANTIDIABETICS
jinteli tab (FEMHRT equiv)	-	1	ESTROGENS
jolessa tab, amethia tab (SEASONALE, SEASONIQUE equiv) (3 copays per Rx)	-	\$0	CONTRACEPTIVES
JUBLIA SOLN	-	NC	DERMATOLOGICALS
junel FE tab (LOESTRIN FE equiv)	-	\$0	CONTRACEPTIVES
junel tab (LOESTRIN equiv)	-	\$0	CONTRACEPTIVES
JUXTAPID CAP	-	NC	ANTIHYPERTENSIVES
KADIAN CAP	-	NC	ANALGESICS - OPIOID
KALETRA SOLN	-	4	ANTIVIRALS
KALETRA TAB	-	4	ANTIVIRALS
KALYDECO PAK (QL= 2 packets/day)	KMSP-PA-QL-SF	4	RESPIRATORY AGENTS - MISC.
KALYDECO TAB (QL= 2 tabs/day)	KMSP-PA-QL-SF	4	RESPIRATORY AGENTS - MISC.
KANAMYCIN INJ	M	M	AMINOGLYCOSIDES
KAPVAY TAB	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS
KARBINAL ER SUSP	-	NC	ANTIHISTAMINES
kariva tab (MIRCETTE equiv)	-	\$0	CONTRACEPTIVES
KAYEXALATE POWDER	-	3	ASSORTED CLASSES
KAZANO TAB	-	NC	ANTIDIABETICS
KEFLEX CAP	-	3	CEPHALOSPORINS
kelnor tab (DEMULEN equiv)	-	\$0	CONTRACEPTIVES
KENALOG SPRAY	-	3	DERMATOLOGICALS
KEPPRA SOLN	-	3	ANTICONVULSANTS
KEPPRA TAB	-	3	ANTICONVULSANTS
KEPPRA XR TAB	-	3	ANTICONVULSANTS
KERAFOAM	-	NC	DERMATOLOGICALS
KERALAC CREAM	-	NC	DERMATOLOGICALS
KERLONE TAB	-	3	BETA BLOCKERS
KERYDIN SOLN	-	NC	DERMATOLOGICALS
KETEK TAB	-	3	ANTI-INFECTIVE AGENTS - MISC.
ketoconazole cream (NIZORAL CREAM equiv)	-	1	DERMATOLOGICALS
ketoconazole shampoo (NIZORAL SHAMPOO equiv)	-	1	DERMATOLOGICALS
ketoconazole tab (NIZORAL equiv)	-	1	ANTIFUNGALS
KETO-DIASTIX TEST STRIP	OTC	1	DIAGNOSTIC PRODUCTS

INF	NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS
LMSP	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program	LD	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	PA	Prior Authorization	QL	Quantity Limit
SP	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 M	SMKG	Smoking Cessation
	Available through Specialty Pharmacy Program	ST	Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary Cont.
Alphabetical Index
Last Updated 11/1/2017

Drug Name	Special Code	Tier	Category
ketoprofen cap (ORUDIS equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
KETOPROFEN ER CAP	-	3	ANALGESICS - ANTI-INFLAMMATORY
KETOROLAC INJ	-	NC	ANALGESICS - ANTI-INFLAMMATORY
ketorolac inj (TORADOL equiv)	-	NC	ANALGESICS - ANTI-INFLAMMATORY
ketorolac ophth soln (ACULAR (LS) equiv)	-	1	OPHTHALMIC AGENTS
ketorolac tab (TORADOL equiv) (QL= 20 tabs/5 days)	QL	1	ANALGESICS - ANTI-INFLAMMATORY
KETOSTIX	OTC	1	DIAGNOSTIC PRODUCTS
ketotifen ophth soln (ZADITOR equiv) (OTC covered only)	OTC	1	OPHTHALMIC AGENTS
KEVEYIS TAB	-	NC	DIURETICS
KEVZARA INJ	-	NC	ANALGESICS - ANTI-INFLAMMATORY
KHEDEZLA ER TAB	-	NC	ANTIDEPRESSANTS
KINERET INJ (QL= 1 inj/day; Only available through Rx Crossroads: 1-866-547-0644)	LD-PA-QL	4	ANALGESICS - ANTI-INFLAMMATORY
KISQALI PAK (QL= 91 tabs/28 days)	KMSP-PA-QL	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
KISQALI TAB (QL= 63 tabs/28 days)	KMSP-PA-QL	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
KITABIS PAK NEB SOLN	-	NC	AMINOGLYCOSIDES
KLARON LOTION	-	3	DERMATOLOGICALS
KLONOPIN TAB	-	3	ANTICONSULTANTS
KLOR-CON M15 TAB	-	2	MINERALS & ELECTROLYTES
KLOR-CON POWDER PACKET	-	3	MINERALS & ELECTROLYTES
KLOR-CON POWDER PACKET 25MEQ	-	3	MINERALS & ELECTROLYTES
KLOR-CON TAB	-	3	MINERALS & ELECTROLYTES
KOMBIGLYZE XR TAB	-	NC	ANTIDIABETICS
KORLYM TAB (Only available through Korlym SPARK program 855-4Korlym (855-456-7596))	LD-PA	4	ANTIDIABETICS
K-PHOS NEUTRAL TAB	-	3	MINERALS & ELECTROLYTES
K-PHOS TAB	-	2	MINERALS & ELECTROLYTES
KRISTALOSE PACKET	-	3	LAXATIVES
KUVAN POWDER PACK (Only available through Walgreens 888-347-3416)	LD-PA	4	ENDOCRINE AND METABOLIC AGENTS - MISC.
KUVAN TAB (Only available through Walgreens 888-347-3416)	LD-PA	4	ENDOCRINE AND METABOLIC AGENTS - MISC.
KYBELLA INJ	-	NC	DERMATOLOGICALS
KYNAMRO INJ	-	NC	ANTHYPERLIPIDEMICS
KYTRIL TAB (QL= 9 tabs/fill)	QL-SP	4	ANTIEMETICS
labetalol tab (NORMODYNE equiv)	-	1	BETA BLOCKERS
LAC-HYDRIN CREAM	-	3	DERMATOLOGICALS
LAC-HYDRIN LOTION	-	3	DERMATOLOGICALS
LACRISERT OPHTH INSERT	-	2	OPHTHALMIC AGENTS
lactulose soln	-	1	GASTROINTESTINAL AGENTS - MISC.
LAMICTAL CHEW TAB	-	3	ANTICONSULTANTS
LAMICTAL CHEW TAB 2MG	-	2	ANTICONSULTANTS
LAMICTAL ODT	-	3	ANTICONSULTANTS
LAMICTAL ODT KIT	-	3	ANTICONSULTANTS
LAMICTAL TAB	-	3	ANTICONSULTANTS
LAMICTAL XR KIT	-	3	ANTICONSULTANTS
LAMICTAL XR TAB	-	3	ANTICONSULTANTS
LAMISIL TAB	-	3	ANTIFUNGALS

INF	NC =Not Covered		generic =small letters	LD	BRANDS =CAPITAL LETTERS
LMSP	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program	LD	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	PA	Prior Authorization	QL	Quantity Limit
SP	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 M	SMKG	Smoking Cessation
	Available through Specialty Pharmacy Program	ST	Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary Cont.
Alphabetical Index
Last Updated 11/1/2017

Drug Name	Special Code	Tier	Category
lamivudine soln (EPIVIR equiv)	-	1	ANTIVIRALS
lamivudine tab (EPIVIR equiv)	-	1	ANTIVIRALS
lamivudine tab 100mg (EPIVIR HBV equiv)	-	4	ANTIVIRALS
lamivudine/zidovudine tab (COMBIVIR equiv)	-	4	ANTIVIRALS
lamotrigine chew tab (LAMICTAL equiv)	-	1	ANTICONVULSANTS
lamotrigine ER tab (LAMICTAL XR equiv)	-	1	ANTICONVULSANTS
lamotrigine ODT (LAMICTAL equiv)	-	1	ANTICONVULSANTS
lamotrigine ODT kit (LAMICTAL ODT KIT equiv)	-	1	ANTICONVULSANTS
lamotrigine tab (LAMICTAL equiv)	-	1	ANTICONVULSANTS
LANCET DEVICE	OTC	1	MEDICAL DEVICES AND SUPPLIES
LANCET KIT	OTC	1	MEDICAL DEVICES AND SUPPLIES
LANCETS	OTC	1	MEDICAL DEVICES AND SUPPLIES
LANOXIN TAB	-	3	CARDIOTONICS
LANOXIN TAB 0.0625MG, 0.1875MG	-	NC	CARDIOTONICS
lansoprazole cap (PREVACID equiv)	OTC	1	ULCER DRUGS
LANSOPRAZOLE SUSP	-	3	ULCER DRUGS
lansoprazole/amoxicillin/clarithromycin kit (PREVPAC equiv)	-	1	ULCER DRUGS
lanthanum carbonate chew tab (FOSRENOL equiv)	-	1	GASTROINTESTINAL AGENTS - MISC.
LANTUS INJ	-	NC	ANTIDIABETICS
LANTUS SOLOSTAR INJ	-	NC	ANTIDIABETICS
LARIAM TAB	-	3	ANTIMALARIALS
LASIX TAB	-	3	DIURETICS
LASTACFT OPTH SOLN (QL= 3ml/30 days)	QL	3	OPHTHALMIC AGENTS
latanoprost ophth soln (XALATAN equiv) (QL= 2.5ml/30 days)	QL	1	OPHTHALMIC AGENTS
LATUDA TAB	-	NC	ANTIPSYCHOTICS/ANTIMANIC AGENTS
LAZANDA NASAL SPRAY (QL= 15 bottles/30 days)	PA-QL	3	ANALGESICS - OPIOID
leflunomide tab (ARAVA equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
LENVIMA CAP (QL= 3 caps/day; Only available through Accredo 888-773-7376)	LD-PA-QL	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
LESCOL CAP	-	3	ANTHYPERLIPIDEMICS
LESCOL XL TAB	-	3	ANTHYPERLIPIDEMICS
LETAIRIS TAB (QL= 1 tab/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	4	CARDIOVASCULAR AGENTS - MISC.
letrozole tab (FEMARA equiv)	-	1	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
LEUCOVORIN TAB	-	1	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
LEUKERAN TAB	KMSP	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
LEUKINE INJ	KMSP-PA	4	HEMATOPOIETIC AGENTS
leuprolide inj (LUPRON equiv)	M	M	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
LEVALBUTEROL INHALER, XOPENEX HFA INHALER (QL= 2 inhalers/fill, 2 fills/30 days; Step Therapy requires trial of VENTOLIN HFA)	QL-ST	3	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
levalbuterol neb soln (XOPENEX equiv)	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
LEVAQUIN SOLN	-	3	FLUOROQUINOLONES
LEVAQUIN TAB	-	3	FLUOROQUINOLONES
LEVATOL TAB	-	3	BETA BLOCKERS
LEVBID TAB	-	3	ULCER DRUGS

INF	NC =Not Covered Infertility	KMSP	generic =small letters Kroger Mandatory Specialty Pharmacy Program	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 M	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary Cont.
Alphabetical Index
Last Updated 11/1/2017

Drug Name	Special Code	Tier	Category
LEVEMIR FLEXTOUCH INJ	-	NC	ANTIDIABETICS
LEVEMIR INJ	-	NC	ANTIDIABETICS
levetiracetam ER tab (KEPPRA XR equiv)	-	1	ANTICONVULSANTS
levetiracetam soln (KEPPRA equiv)	-	1	ANTICONVULSANTS
levetiracetam tab (KEPPRA equiv)	-	1	ANTICONVULSANTS
LEVITRA TAB (QL= 6 tabs/30 days)	QL	2	CARDIOVASCULAR AGENTS - MISC.
levobunolol ophth soln (BETAGAN equiv)	-	1	OPHTHALMIC AGENTS
levocarnitine soln (CARNITOR equiv)	-	1	ENDOCRINE AND METABOLIC AGENTS - MISC.
levocarnitine tab (CARNITOR equiv)	-	1	ENDOCRINE AND METABOLIC AGENTS - MISC.
levocetirizine soln (XYZAL equiv)	-	NC	ANTIHISTAMINES
levocetirizine tab (XYZAL equiv)	-	NC	ANTIHISTAMINES
levofloxacin ophth soln (QUIXIN equiv)	-	1	OPHTHALMIC AGENTS
LEVOFLOXACIN SOLN	-	1	FLUOROQUINOLONES
levofloxacin soln (LEVAQUIN equiv)	-	1	FLUOROQUINOLONES
levofloxacin tab (LEVAQUIN equiv)	-	1	FLUOROQUINOLONES
levonorgestrel tab (PLAN B equiv)	OTC	\$0	CONTRACEPTIVES
LEVONORGESTREL TAB 0.75MG	-	\$0	CONTRACEPTIVES
LEVONORGESTREL/ETHINYL ESTRADIOL TAB	-	\$0	CONTRACEPTIVES
LEVORPHANOL TAB	-	2	ANALGESICS - OPIOID
levothyroxine tab (SYNTHROID equiv)	-	NC	THYROID AGENTS
LEVSIN INJ	-	3	ULCER DRUGS
LEVSIN SL TAB	-	3	ULCER DRUGS
LEVSIN SOLN	-	3	ULCER DRUGS
LEVSIN TAB	-	3	ULCER DRUGS
LEVSINEX CAP	-	3	ULCER DRUGS
LEXAPRO SOLN	-	3	ANTIDEPRESSANTS
LEXAPRO TAB	-	3	ANTIDEPRESSANTS
LEXIVA SUSP	-	4	ANTIVIRALS
LEXIVA TAB	-	4	ANTIVIRALS
LIALDA TAB	-	1	GASTROINTESTINAL AGENTS - MISC.
LIBRAX CAP	-	NC	ULCER DRUGS
LIBRIUM CAP	-	3	ANTIAXIETY AGENTS
LIDAMANTLE LOTION	-	NC	DERMATOLOGICALS
LIDOCAINE CREAM	-	NC	DERMATOLOGICALS
lidocaine cream 3% (LIDAMANTLE equiv)	-	1	DERMATOLOGICALS
lidocaine cream 3.88% (LIDOTRAL equiv)	-	NC	DERMATOLOGICALS
lidocaine gel (XYLOCAINE equiv)	-	1	DERMATOLOGICALS
lidocaine lotion (LIDAMANTLE equiv)	-	NC	DERMATOLOGICALS
lidocaine oint (QL= 107gm/30 days)	QL	1	DERMATOLOGICALS
LIDOCAINE ORAL SOLN 4%	-	2	MOUTH/THROAT/DENTAL AGENTS
lidocaine patch (LIDODERM equiv) (QL= 3 patches/day)	QL	1	DERMATOLOGICALS
lidocaine soln (XYLOCAINE equiv)	-	1	DERMATOLOGICALS
lidocaine viscous soln	-	1	MOUTH/THROAT/DENTAL AGENTS
lidocaine/hydrocortisone cream (ANAMANTLE equiv)	-	1	ANORECTAL AGENTS
lidocaine/prilocaine cream (EMLA equiv)	-	1	DERMATOLOGICALS
LIDOCIN GEL	-	NC	DERMATOLOGICALS
LIDODERM PATCH (QL= 3 patches/day)	QL	3	DERMATOLOGICALS
LIDOLOG KIT	-	NC	CORTICOSTEROIDS

INF	NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS
LMSP	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program	LD	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	PA	Prior Authorization	QL	Quantity Limit
SP	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 M	SMKG	Smoking Cessation
	Available through Specialty Pharmacy Program	ST	Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary Cont.
Alphabetical Index
Last Updated 11/1/2017

Drug Name	Special Code	Tier	Category
LIDOTRAL CREAM	-	NC	DERMATOLOGICALS
LIDOTREX GEL	-	NC	DERMATOLOGICALS
LIMBITROL TAB	-	3	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
lindane lotion	-	1	DERMATOLOGICALS
LINDANE LOTION	-	3	DERMATOLOGICALS
lindane shampoo	-	1	DERMATOLOGICALS
linezolid susp (ZYVOX equiv) (Restricted to Infectious Disease Specialist)	RS	1	ANTI-INFECTIVE AGENTS - MISC.
linezolid tab (ZYVOX equiv) (Restricted to Infectious Disease Specialist)	RS	1	ANTI-INFECTIVE AGENTS - MISC.
LINZESS CAP	PA	2	GASTROINTESTINAL AGENTS - MISC.
liothyronine tab (CYTOMEL equiv)	-	1	THYROID AGENTS
LIPITOR TAB	-	3	ANTIHYPERTENSIVES
LIPTRUZET TAB	-	3	ANTIHYPERTENSIVES
lisinopril tab (PRINIVIL/ZESTRIL equiv)	-	1	ANTIHYPERTENSIVES
lisinopril/hydrochlorothiazide tab (ZESTORETIC equiv)	-	1	ANTIHYPERTENSIVES
lithium carbonate cap (ESKALITH ER equiv)	-	1	ANTIPSYCHOTICS/ANTIMANIC AGENTS
lithium carbonate ER tab (LITHOBID equiv)	-	1	ANTIPSYCHOTICS/ANTIMANIC AGENTS
lithium carbonate tab	-	1	ANTIPSYCHOTICS/ANTIMANIC AGENTS
lithium citrate soln	-	1	ANTIPSYCHOTICS/ANTIMANIC AGENTS
LITHOBID TAB	-	3	ANTIPSYCHOTICS/ANTIMANIC AGENTS
LITHOSTAT TAB	-	3	GENITOURINARY AGENTS - MISCELLANEOUS
LIVALO TAB	-	3	ANTIHYPERTENSIVES
L-METHYLFOLATE TAB	-	NC	DIETARY PRODUCTS/DIETARY MANAGEMENT PRODUCTS
LO LOESTRIN TAB	-	3	CONTRACEPTIVES
LO MINASTRIN 24 FE CHEW TAB	-	3	CONTRACEPTIVES
LOCOID CREAM	-	NC	DERMATOLOGICALS
LOCOID LIPOCREAM	-	NC	DERMATOLOGICALS
LOCOID OINT	-	NC	DERMATOLOGICALS
LOCOID SOLN	-	NC	DERMATOLOGICALS
LODOSYN TAB	-	3	ANTIPARKINSON AGENTS
LOESTRIN 24 FE TAB	-	3	CONTRACEPTIVES
LOESTRIN FE TAB	-	3	CONTRACEPTIVES
LOESTRIN TAB	-	3	CONTRACEPTIVES
LOFIBRA TAB, TRIGLIDE TAB	-	NC	ANTIHYPERTENSIVES
LOMOTIL LIQUID	-	3	ANTIDIARRHEALS
LOMOTIL TAB	-	3	ANTIDIARRHEALS
LONSURF TAB	MSP-PA	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
loperamide cap	-	NC	ANTIDIARRHEALS
LOPID TAB	-	3	ANTIHYPERTENSIVES
lopinavir/ritonavir soln (KALETRA equiv)	-	4	ANTIVIRALS
LOPRESSOR HCT TAB	-	3	ANTIHYPERTENSIVES
LOPRESSOR TAB	-	3	BETA BLOCKERS
LOPROX CREAM	-	3	DERMATOLOGICALS
LOPROX GEL	-	3	DERMATOLOGICALS
LOPROX SHAMPOO	-	3	DERMATOLOGICALS
loratadine cap (CLARITIN equiv)	OTC	NC	ANTIHISTAMINES
lorazepam conc (ATIVAN equiv)	-	1	ANTIANKXIETY AGENTS

INF	NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS
LMSP	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program	LD	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	PA	Prior Authorization	QL	Quantity Limit
SP	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 M	SMKG	Smoking Cessation
	Available through Specialty Pharmacy Program	ST	Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary Cont.
Alphabetical Index
Last Updated 11/1/2017

Drug Name	Special Code	Tier	Category
lorazepam tab (ATIVAN equiv)	-	1	ANTIANKXIETY AGENTS
LORTAB	-	3	ANALGESICS - OPIOID
LORTAB ELIXIR	-	3	ANALGESICS - OPIOID
LORVATUS PHARMAPAK KIT	-	NC	MUSCULOSKELETAL THERAPY AGENTS
LORZONE TAB	-	NC	MUSCULOSKELETAL THERAPY AGENTS
losartan tab (COZAAR equiv)	-	1	ANTIHYPERTENSIVES
losartan/hydrochlorothiazide tab (HYZAAR equiv)	-	1	ANTIHYPERTENSIVES
LOTEMAX OPHTH GEL	-	2	OPHTHALMIC AGENTS
LOTEMAX OPHTH OINT	-	2	OPHTHALMIC AGENTS
LOTENSIN HCT TAB	-	3	ANTIHYPERTENSIVES
LOTENSIN TAB	-	3	ANTIHYPERTENSIVES
LOTREL CAP	-	3	ANTIHYPERTENSIVES
LOTRIMIN AF CREAM	-	NC	DERMATOLOGICALS
LOTRISONE CREAM	-	3	DERMATOLOGICALS
LOTRISONE LOTION	-	3	DERMATOLOGICALS
LOTRONEX TAB	-	3	GASTROINTESTINAL AGENTS - MISC.
lovastatin tab (MEVACOR equiv)	-	1	ANTHYPERLIPIDEMICS
LOVAZA CAP	-	3	ANTHYPERLIPIDEMICS
LOVENOX INJ (QL= 17 days supply)	QL	3	ANTICOAGULANTS
loxapine cap (LOXITANE equiv)	-	1	ANTIPSYCHOTICS/ANTIMANIC AGENTS
LOXITANE CAP	-	3	ANTIPSYCHOTICS/ANTIMANIC AGENTS
LTA 360 KIT	-	3	MOUTH/THROAT/DENTAL AGENTS
LUFYLLIN TAB	-	3	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
LUNESTA TAB (QL= 1 tab/day)	QL	3	HYPNOTICS/SEDATIVES/SLEEP DISORDEI AGENTS
LUPANETA PACK	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
LUPRON DEPOT INJ	M	M	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
LUPRON DEPOT PED INJ	M	M	ENDOCRINE AND METABOLIC AGENTS - MISC.
LUPRON DEPOT-PED INJ	M	M	ENDOCRINE AND METABOLIC AGENTS - MISC.
LURIDE SOLN (Covered at \$0 for members 5 years or younger; All other members covered at non-preferred brand copay)	-	\$0	MINERALS & ELECTROLYTES
LURIDE TAB (Covered at \$0 for members 5 years or younger; All other members covered at non-preferred brand copay)	-	\$0	MINERALS & ELECTROLYTES
LUVOX CR CAP (Step Therapy requires trial of citalopram, escitalopram, sertraline, fluoxetine, fluvoxamine or paroxetine)	ST	3	ANTIDEPRESSANTS
LUXIQ FOAM	-	NC	DERMATOLOGICALS
LUZU CREAM	-	NC	DERMATOLOGICALS
LYNPARZA CAP (Only available through Biologics 800-850-4306)	LD-PA-SF	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
LYNPARZA TAB (Only available through Biologics 800-850-4306)	LD-PA-SF	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
LYRICA CAP	-	2	ANTICONVULSANTS
LYRICA SOLN	-	2	ANTICONVULSANTS
LYSODREN TAB	KMSP	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
LYSTEDA TAB	-	3	HEMOSTATICS

INF	NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS
LMSP	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program	LD	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	PA	Prior Authorization	QL	Quantity Limit
SP	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 M	SMKG	Smoking Cessation
	Available through Specialty Pharmacy Program	ST	Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary Cont.
Alphabetical Index
Last Updated 11/1/2017

Drug Name	Special Code	Tier	Category
MACROBID CAP	-	3	URINARY ANTI-INFECTIVES
MACRODANTIN CAP	-	3	URINARY ANTI-INFECTIVES
magnesium sulfate inj	M	M	MINERALS & ELECTROLYTES
MALARONE TAB	-	2	ANTIMALARIALS
malathion lotion (OVIDE equiv) (QL= 2 bottles/fill)	QL	1	DERMATOLOGICALS
maldemar tab (SCOPACE equiv)	-	1	ANTIEMETICS
MAPROTILINE TAB	-	1	ANTIDEPRESSANTS
MARINOL CAP	PA	3	ANTIEMETICS
MARPLAN TAB	-	2	ANTIDEPRESSANTS
MATULANE CAP	-	2	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
MAVIK TAB	-	3	ANTIHYPERTENSIVES
MAVYRET TAB	-	NC	ANTIVIRALS
MAXALT MLT TAB (QL= 12 tabs/fill, 3 fills/60 days)	QL	3	MIGRAINE PRODUCTS
MAXALT TAB (QL= 12 tabs/fill, 3 fills/60 days)	QL	3	MIGRAINE PRODUCTS
MAXIDEX OPHTH SOLN	-	2	OPHTHALMIC AGENTS
MAXITROL OPHTH OINT	-	3	OPHTHALMIC AGENTS
MAXITROL OPHTH SUSP	-	3	OPHTHALMIC AGENTS
MAXZIDE TAB	-	3	DIURETICS
mebendazole chew tab (VERMOX equiv)	-	1	ANTHELMINTICS
meclizine chew tab (BONINE equiv)	OTC	1	ANTIEMETICS
meclizine tab (ANTIVERT equiv)	OTC	1	ANTIEMETICS
MECLOFENAMATE CAP	-	1	ANALGESICS - ANTI-INFLAMMATORY
MEDROL DOSE PACK	-	3	CORTICOSTEROIDS
MEDROL TAB	-	1	CORTICOSTEROIDS
MEDROL TAB	-	3	CORTICOSTEROIDS
medroxyprogesterone inj (DEPO-PROVERA equiv)	-	NC	CONTRACEPTIVES
medroxyprogesterone tab (PROVERA equiv)	-	1	PROGESTINS
mefenamic acid cap (PONSTEL equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
mefloquine tab (LARIAM equiv)	-	1	ANTIMALARIALS
MEGACE ES SUSP	-	3	PROGESTINS
MEGACE SUSP	-	3	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
megestrol ES susp (MEGACE ES equiv)	-	1	PROGESTINS
megestrol susp (MEGACE equiv)	-	1	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
megestrol tab (MEGACE equiv)	-	1	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
MEKINIST TAB	KMSP-PA	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
MELOXICAM COMFORT KIT	-	NC	ANALGESICS - ANTI-INFLAMMATORY
MELOXICAM SUSP	-	3	ANALGESICS - ANTI-INFLAMMATORY
meloxicam tab (MOBIC equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
melphalan inj (ALKERAN equiv)	M	M	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
melphalan tab (ALKERAN equiv)	KMSP	1	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
memantine sol (NAMENDA equiv)	-	1	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.

INF	NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS
LMSP	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program	LD	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	PA	Prior Authorization	QL	Quantity Limit
SP	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 N	SMKG	Smoking Cessation
	Available through Specialty Pharmacy Program	ST	Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary Cont.
Alphabetical Index
Last Updated 11/1/2017

Drug Name	Special Code	Tier	Category
memantine tab (NAMENDA equiv)	-	1	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
MENEST TAB	-	3	ESTROGENS
MENOSTAR PATCH	-	3	ESTROGENS
MENTAX CREAM	-	3	DERMATOLOGICALS
meperidine tab (DEMEROL equiv)	-	1	ANALGESICS - OPIOID
MEPHYTON TAB	-	2	VITAMINS
meprobamate tab (MILTOWN equiv)	-	1	ANTI-ANXIETY AGENTS
MEPRON SUSP	-	3	ANTI-INFECTIVE AGENTS - MISC.
mercaptapurine tab (PURINETHOL equiv)	-	1	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
meropenem inj	M	M	ANTI-INFECTIVE AGENTS - MISC.
mesalamine DR tab (LIALDA equiv)	-	NC	GASTROINTESTINAL AGENTS - MISC.
mesalamine enema (ROWASA equiv)	-	1	GASTROINTESTINAL AGENTS - MISC.
MESNEX TAB	KMSP	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
MESTINON SYRUP	-	3	ANTIMYASTHENIC/CHOLINERGIC AGENTS
MESTINON TAB	-	3	ANTIMYASTHENIC/CHOLINERGIC AGENTS
MESTINON TIMESPAN TAB	-	3	ANTIMYASTHENIC/CHOLINERGIC AGENTS
METADATE CD CAP	-	3	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS
METAGLIP TAB	-	3	ANTIDIABETICS
METANX CAP	-	NC	DIETARY PRODUCTS/DIETARY MANAGEMENT PRODUCTS
METAPROTERENOL SYRUP	-	1	ANTI-ASTHMATIC AND BRONCHODILATOR AGENTS
METAPROTERENOL TAB	-	3	ANTI-ASTHMATIC AND BRONCHODILATOR AGENTS
metaxalone tab (SKELAXIN equiv)	-	1	MUSCULOSKELETAL THERAPY AGENTS
METAXALONE TAB 400MG	-	3	MUSCULOSKELETAL THERAPY AGENTS
metformin ER osmotic tab (FORTAMET equiv)	-	NC	ANTIDIABETICS
metformin ER tab (GLUCOPHAGE XR equiv)	-	1	ANTIDIABETICS
metformin tab (GLUCOPHAGE equiv)	-	1	ANTIDIABETICS
methadone soln	-	1	ANALGESICS - OPIOID
methadone tab (DOLOPHINE equiv)	-	1	ANALGESICS - OPIOID
METHADOSE CONC	-	3	ANALGESICS - OPIOID
methadose tab	-	1	ANALGESICS - OPIOID
methamphetamine tab (DESOXYN equiv)	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS
methazolamide tab (NEPTAZANE equiv)	-	1	DIURETICS
methenamine hippurate tab (HIPREX equiv)	-	1	URINARY ANTI-INFECTIVES
methenamine mandelate tab	-	1	URINARY ANTI-INFECTIVES
METHENAMINE MANDELATE TAB	-	3	URINARY ANTI-INFECTIVES
METHERGINE TAB (QL= 28 tabs/fill, 1 fill/365 days)	QL	1	OXYTOCICS
METHERGINE TAB (QL= 28 tabs/fill, 1 fill/365 days)	QL	2	OXYTOCICS
methimazole tab (TAPAZOLE equiv)	-	1	THYROID AGENTS
METHITEST TAB	PA	3	ANDROGENS-ANABOLIC
methocarbamol tab (ROBAXIN equiv)	-	1	MUSCULOSKELETAL THERAPY AGENTS
methotrexate inj	-	1	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES

INF	NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS
LMSP	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program	LD	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	PA	Prior Authorization	QL	Quantity Limit
SP	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 M	SMKG	Smoking Cessation
	Available through Specialty Pharmacy Program	ST	Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary Cont.
Alphabetical Index
Last Updated 11/1/2017

Drug Name	Special Code	Tier	Category
METHOTREXATE INJ	-	2	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
methotrexate tab (TREXALL equiv)	-	1	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
methoxsalen cap (OXSORALEN ULTRA equiv)	KMSP	1	DERMATOLOGICALS
methscopolamine tab (PAMINE equiv)	-	1	ULCER DRUGS
METHYCLOTHIAZIDE TAB	-	1	DIURETICS
methyldopa tab (ALDOMET equiv)	-	1	ANTIHYPERTENSIVES
methyldopa/hydrochlorothiazide tab (ALDORIL equiv)	-	1	ANTIHYPERTENSIVES
methylergonovine tab (METHERGINE equiv) (QL= 28 tabs/fill, 1 fill/365 days)	QL	1	OXYTOCICS
METHYLIN CHEW TAB	-	3	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS
METHYLIN SOLN	-	2	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS
methylphenidate CD cap (METADATE CD equiv)	-	1	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS
METHYLPHENIDATE CHEW TAB	-	3	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS
methylphenidate ER cap (RITALIN LA equiv)	-	1	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS
methylphenidate ER tab	-	1	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS
METHYLPHENIDATE ER TAB	-	2	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS
methylphenidate soln (METHYLIN equiv)	-	1	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS
methylphenidate tab (RITALIN equiv)	-	1	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS
methylprednisolone dose pack (MEDROL equiv)	-	1	CORTICOSTEROIDS
methylprednisolone tab (MEDROL equiv)	-	1	CORTICOSTEROIDS
methyltestosterone cap (ANDROID, TESTRED equiv)	PA	1	ANDROGENS-ANABOLIC
METIPRANOLOL OPHTH SOLN	-	2	OPHTHALMIC AGENTS
metoclopramide soln (REGLAN equiv)	-	1	GASTROINTESTINAL AGENTS - MISC.
metoclopramide tab (REGLAN equiv)	-	1	GASTROINTESTINAL AGENTS - MISC.
metolazone tab (ZAROXOLYN equiv)	-	1	DIURETICS
metoprolol ER tab (TOPROL XL equiv)	-	1	BETA BLOCKERS
metoprolol tab (LOPRESSOR equiv)	-	1	BETA BLOCKERS
METOPROLOL TARTRATE TAB 37.5MG, 75MG	-	NC	BETA BLOCKERS
metoprolol/hydrochlorothiazide tab (LOPRESSOR HCT equiv)	-	1	ANTIHYPERTENSIVES
METZOZLV ODT	-	NC	GASTROINTESTINAL AGENTS - MISC.
METROCREAM	-	3	DERMATOLOGICALS
METROGEL 1% (Step Therapy requires trial of FINACEA)	ST	3	DERMATOLOGICALS
METROGEL VAGINAL GEL	-	3	VAGINAL PRODUCTS
METROLOTION	-	3	DERMATOLOGICALS
metronidazole cap (FLAGYL equiv)	-	1	ANTI-INFECTIVE AGENTS - MISC.
metronidazole cream (METROCREAM equiv)	-	1	DERMATOLOGICALS
metronidazole gel (METROGEL equiv)	-	1	DERMATOLOGICALS
metronidazole lotion (METROLOTION equiv)	-	1	DERMATOLOGICALS
metronidazole tab (FLAGYL equiv)	-	1	ANTI-INFECTIVE AGENTS - MISC.
metronidazole vaginal gel (METROGEL equiv)	-	1	VAGINAL PRODUCTS
MEVACOR TAB	-	3	ANTIHYPERLIPIDEMICS

INF	NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS
LMSP	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program	LD	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	PA	Prior Authorization	QL	Quantity Limit
SP	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 N	SMKG	Smoking Cessation
	Available through Specialty Pharmacy Program	ST	Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary Cont.
Alphabetical Index
Last Updated 11/1/2017

Drug Name	Special Code	Tier	Category
mexiletine cap (MEXITIL equiv)	-	1	ANTIARRHYTHMICS
MIACALCIN INJ	KMSP	4	ENDOCRINE AND METABOLIC AGENTS - MISC.
MIACALCIN NASAL SPRAY	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
mibelas chew tab (MINASTRIN equiv)	-	1	CONTRACEPTIVES
MICARDIS HCT TAB	-	NC	ANTIHYPERTENSIVES
MICARDIS TAB	-	3	ANTIHYPERTENSIVES
MICONAZOLE 3 SUPP 200MG	-	3	VAGINAL PRODUCTS
MICORT-HC CREAM	-	NC	DERMATOLOGICALS
MICRO-K CAP	-	3	MINERALS & ELECTROLYTES
MICROZIDE CAP	-	3	DIURETICS
MIDAMOR TAB	-	3	DIURETICS
midodrine tab (PROAMATINE equiv)	-	1	VASOPRESSORS
MIDRIN CAP	-	NC	MIGRAINE PRODUCTS
MIGERGOT SUPP	-	2	MIGRAINE PRODUCTS
miglitol tab (GLYSET equiv)	-	1	ANTIDIABETICS
MILLIPRED DP PAK	-	3	CORTICOSTEROIDS
MILLIPRED TAB	-	3	CORTICOSTEROIDS
MINASTRIN CHEW TAB	-	3	CONTRACEPTIVES
MINIPRESS CAP	-	3	ANTIHYPERTENSIVES
MINOCIN CAP	-	3	TETRACYCLINES
minocycline cap (MINOCIN equiv)	-	1	TETRACYCLINES
minocycline ER tab (SOLODYN equiv)	-	NC	TETRACYCLINES
minocycline tab (DYNACIN equiv)	-	1	TETRACYCLINES
minoxidil tab (LONITEN equiv)	-	1	ANTIHYPERTENSIVES
MIRALAX PACKET	-	NC	LAXATIVES
MIRALAX POWDER	-	NC	LAXATIVES
MIRAPEX ER TAB	-	3	ANTIPARKINSON AGENTS
MIRAPEX TAB	-	3	ANTIPARKINSON AGENTS
MIRCERA INJ	-	NC	HEMATOPOIETIC AGENTS
MIRCETTE TAB	-	3	CONTRACEPTIVES
MIRENA IUD	-	NC	CONTRACEPTIVES
mirtazapine ODT (REMERON equiv)	-	1	ANTIDEPRESSANTS
mirtazapine tab (REMERON equiv)	-	1	ANTIDEPRESSANTS
MIRVASO GEL	-	NC	DERMATOLOGICALS
misoprostol tab (CYTOTEC equiv)	-	1	ULCER DRUGS
MITIGARE CAP	-	2	GOUT AGENTS
MOBIC TAB	-	3	ANALGESICS - ANTI-INFLAMMATORY
modafinil tab (PROVIGIL equiv) (QL= 2 tabs/day)	PA-QL	1	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
moexipril tab (UNIVASC equiv)	-	1	ANTIHYPERTENSIVES
moexipril/hydrochlorothiazide tab (UNIRETIC equiv)	-	1	ANTIHYPERTENSIVES
mometasone cream (ELOCON equiv)	-	1	DERMATOLOGICALS
mometasone nasal spray (NASONEX equiv)	-	NC	NASAL AGENTS - SYSTEMIC AND TOPICAL
mometasone oint (ELOCON equiv)	-	1	DERMATOLOGICALS
mometasone soln (ELOCON equiv)	-	1	DERMATOLOGICALS
MONODOX CAP	-	3	TETRACYCLINES
mononessa tab (ORTHO-CYCLEN equiv)	-	\$0	CONTRACEPTIVES
MONOPRIL HCT TAB	-	3	ANTIHYPERTENSIVES

INF	NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS
LMSP	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program	LD	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	PA	Prior Authorization	QL	Quantity Limit
SP	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 M	SMKG	Smoking Cessation
	Available through Specialty Pharmacy Program	ST	Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary Cont.
Alphabetical Index
Last Updated 11/1/2017

Drug Name	Special Code	Tier	Category
MONOPRIL TAB	-	3	ANTIHYPERTENSIVES
montelukast chew tab (SINGULAIR equiv)	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
montelukast granule pack (SINGULAIR equiv)	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
montelukast tab (SINGULAIR equiv)	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
MONUROL GRANULE PACK	-	3	URINARY ANTI-INFECTIVES
MORPHABOND TAB	-	NC	ANALGESICS - OPIOID
MORPHINE SULFATE ER BEAD CAP (QL= 2 caps/day)	QL	3	ANALGESICS - OPIOID
morphine sulfate ER cap (KADIAN equiv)	-	NC	ANALGESICS - OPIOID
morphine sulfate ER tab (MS CONTIN equiv) (QL= 90 tabs/ 30 days)	QL	1	ANALGESICS - OPIOID
morphine sulfate soln	-	1	ANALGESICS - OPIOID
morphine sulfate supp	-	1	ANALGESICS - OPIOID
morphine sulfate tab	-	1	ANALGESICS - OPIOID
MOTOFEN TAB	-	3	ANTIIDIARRHEALS
MOTRIN SUSP	-	3	ANALGESICS - ANTI-INFLAMMATORY
MOVANTIK TAB	PA	2	GASTROINTESTINAL AGENTS - MISC.
MOVIPREP SOLN (QL= 1 bottle/fill)	QL	2	LAXATIVES
MOXATAG TAB	-	NC	PENICILLINS
MOXATAG TAB 775MG	-	NC	PENICILLINS
MOXEZA OPHTH SOLN	-	2	OPHTHALMIC AGENTS
moxifloxacin ophth soln (VIGAMOX OPHTH SOLN equiv)	-	1	OPHTHALMIC AGENTS
moxifloxacin tab (AVELOX equiv)	-	1	FLUOROQUINOLONES
MUCINEX LIQUID	-	NC	COUGH/COLD/ALLERGY
MUCINEX TAB	-	NC	COUGH/COLD/ALLERGY
MULTAQ TAB	-	2	ANTIARRHYTHMICS
multigen folic tab (CHROMAGEN FA equiv)	-	1	HEMATOPOIETIC AGENTS
multigen plus tab (CHROMAGEN FORTE equiv)	-	1	HEMATOPOIETIC AGENTS
multigen tab (CHROMAGEN equiv)	-	1	HEMATOPOIETIC AGENTS
multivitamin tab	-	1	HEMATOPOIETIC AGENTS
MULTIVITAMIN TAB	-	3	HEMATOPOIETIC AGENTS
MULTIVITAMIN/FLUORIDE CHEW TAB	-	NC	MULTIVITAMINS
multivitamin/minerals tab (STROVITE equiv)	-	1	MULTIVITAMINS
mupirocin cream (BACTROBAN equiv)	-	1	DERMATOLOGICALS
mupirocin oint (BACTROBAN OINT equiv)	-	1	DERMATOLOGICALS
MUSE SUPP (QL= 6 inj/30 days)	QL	2	CARDIOVASCULAR AGENTS - MISC.
MYALEPT INJ	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
MYAMBUTOL TAB	-	3	ANTIMYCOBACTERIAL AGENTS
MYCELEX TROCHES	-	3	MOUTH/THROAT/DENTAL AGENTS
MYCOBUTIN CAP	-	3	ANTIMYCOBACTERIAL AGENTS
mycophenolate DR tab (MYFORTIC equiv)	-	4	ASSORTED CLASSES
mycophenolate mofetil cap (CELLCEPT equiv)	-	4	ASSORTED CLASSES
mycophenolate mofetil susp (CELLCEPT SUSP equiv)	-	4	ASSORTED CLASSES
mycophenolate mofetil tab (CELLCEPT equiv)	-	4	ASSORTED CLASSES
MYDAYIS CAP	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
MYDFRIN OPHTH SOLN	-	3	OPHTHALMIC AGENTS
MYDRIACYL OPHTH SOLN	-	3	OPHTHALMIC AGENTS

INF	NC =Not Covered	KMSP	generic =small letters	LD	BRANDS =CAPITAL LETTERS
LMSP	Infertility	M	Kroger Mandatory Specialty Pharmacy Program	MSP	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	PA	Medical Benefit	QL	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	SF	Prior Authorization	SMKG	Quantity Limit
SP	Restricted to Specialist	ST	Limited to Two 15 Day Fills per Month for the First 3 M	VAC	Smoking Cessation
	Available through Specialty Pharmacy Program		Step Therapy		Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary Cont.
Alphabetical Index
Last Updated 11/1/2017

Drug Name	Special Code	Tier	Category
MYFORTIC TAB	-	4	ASSORTED CLASSES
MYLERAN TAB	KMSP	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
MYRBETRIQ TAB	-	2	URINARY ANTISPASMODICS
MYSOLINE TAB	-	3	ANTICONVULSANTS
MYTELASE TAB	-	3	ANTIMYASTHENIC/CHOLINERGIC AGENTS
MYTESI TAB	-	NC	ANTI-DIARRHEALS
nabumetone tab (RELAFEN equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
nadolol tab (CORGARD equiv)	-	1	BETA BLOCKERS
nadolol/bendroflumethiazide tab (CORZIDE equiv)	-	1	ANTI-HYPERTENSIVES
naftillin inj	M	M	PENICILLINS
naftifine cream (NAFTIN equiv)	-	1	DERMATOLOGICALS
NAFTIN CREAM	-	3	DERMATOLOGICALS
NAFTIN GEL	-	3	DERMATOLOGICALS
NAFTIN GEL 2%	-	NC	DERMATOLOGICALS
naloxone inj	-	1	ANTIDOTES
NALOXONE INJ	-	2	ANTIDOTES AND SPECIFIC ANTAGONISTS
naltrexone tab (REVIA equiv)	-	1	ANTIDOTES
NAMENDA SOL	-	3	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
NAMENDA TAB	-	3	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
NAMENDA XR CAP	-	2	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
NAMZARIC CAP (Step Therapy requires trial of donepezil and memantine)	ST	2	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
NAMZARIC STARTER PACK (Step Therapy requires trial of donepezil and memantine)	ST	2	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
naphazoline ophth soln	-	1	OPHTHALMIC AGENTS
NAPRELAN CR TAB	-	NC	ANALGESICS - ANTI-INFLAMMATORY
NAPROSYN EC TAB	-	3	ANALGESICS - ANTI-INFLAMMATORY
NAPROSYN SUSP	-	3	ANALGESICS - ANTI-INFLAMMATORY
NAPROSYN TAB	-	3	ANALGESICS - ANTI-INFLAMMATORY
NAPROXEN CREAM COMPOUND KIT	-	NC	DERMATOLOGICALS
naproxen EC tab (NAPROSYN EC equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
naproxen sodium CR tab (NAPRELAN CR equiv)	-	NC	ANALGESICS - ANTI-INFLAMMATORY
naproxen sodium tab (ANAPROX equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
naproxen susp (NAPROSYN equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
NAPROXEN SUSP	-	2	ANALGESICS - ANTI-INFLAMMATORY
naproxen tab (NAPROSYN equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
naratriptan tab (AMERGE equiv) (QL= 9 tabs/fill, 2 fills/30 days)	QL	1	MIGRAINE PRODUCTS
NARCAN NASAL SPRAY	-	2	ANTIDOTES AND SPECIFIC ANTAGONISTS
NARDIL TAB	-	2	ANTIDEPRESSANTS
NASACORT AQ NASAL SPRAY (QL= 2 bottles/fill)	QL	3	NASAL AGENTS - SYSTEMIC AND TOPICAL
NASACORT OTC NASAL SPRAY (QL= 2 bottles/fill)	OTC-QL	1	NASAL AGENTS - SYSTEMIC AND TOPICAL
NASCOBAL NASAL SPRAY	-	3	HEMATOPOIETIC AGENTS
NASONEX NASAL SPRAY (QL= 2 bottles/fill)	QL	1	NASAL AGENTS - SYSTEMIC AND TOPICAL
NATACYN OPTH SUSP	-	NC	OPHTHALMIC AGENTS
NATAZIA TAB	-	3	CONTRACEPTIVES
nateglinide tab (STARLIX equiv)	-	1	ANTI-DIABETICS

INF	NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS
LMSP	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program	LD	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	PA	Prior Authorization	QL	Quantity Limit
SP	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 Months	SMKG	Smoking Cessation
	Available through Specialty Pharmacy Program	ST	Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary Cont.
Alphabetical Index
Last Updated 11/1/2017

Drug Name	Special Code	Tier	Category
NATPARA INJ (Only available through Walgreens 888-347-3416)	LD-PA	4	ENDOCRINE AND METABOLIC AGENTS - MISC.
NATROBA SUSP (QL= 1 bottle/fill)	QL	3	DERMATOLOGICALS
NAVANE CAP	-	3	ANTIPSYCHOTICS/ANTIMANIC AGENTS
NEBUPENT NEB SOLN	KMSP	4	ANTI-INFECTIVE AGENTS - MISC.
NEBUSAL NEB SOLN	-	2	COUGH/COLD/ALLERGY
necon tab (ORTHO-NOVUM equiv)	-	\$0	CONTRACEPTIVES
necon tab 1-50 (NORYNIL equiv)	-	\$0	CONTRACEPTIVES
NEFAZODONE TAB	-	1	ANTIDEPRESSANTS
nefazodone tab 50mg, 250mg	-	1	ANTIDEPRESSANTS
neomycin tab	-	1	AMINOGLYCOSIDES
neomycin/polymixin/hydrocortisone otic soln (CORTISPORIN equiv)	-	1	OTIC AGENTS
neomycin/polymixin/hydrocortisone otic susp (CORTISPORIN equiv)	-	1	OTIC AGENTS
neomycin/polymyxin b/gramicidin ophth soln (NEOSPORIN equiv)	-	1	OPHTHALMIC AGENTS
neomycin/polymyxin/dexamethasone ophth oint (MAXITROL equiv)	-	1	OPHTHALMIC AGENTS
neomycin/polymyxin/dexamethasone ophth soln (MAXITROL equiv)	-	1	OPHTHALMIC AGENTS
neomycin/polymyxin/hydrocortisone ophth soln (CORTISPORIN equiv)	-	1	OPHTHALMIC AGENTS
NEORAL CAP	-	4	ASSORTED CLASSES
NEORAL SOLN	-	4	ASSORTED CLASSES
NEOSALUS FOAM	-	NC	DERMATOLOGICALS
NEOSPORIN OPHTH SOLN	-	3	OPHTHALMIC AGENTS
NEO-SYNALAR CREAM	-	NC	DERMATOLOGICALS
NEOTUSS-D LIQUID	-	3	COUGH/COLD/ALLERGY
NEPHROCAP	-	3	MULTIVITAMINS
NEPHRON FA TAB	-	2	HEMATOPOIETIC AGENTS
NEPHRO-VITE TAB	-	3	MULTIVITAMINS
NEPTAZANE TAB	-	3	DIURETICS
NERLYNX TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
NESINA TAB	-	NC	ANTIDIABETICS
NEULASTA INJ	KMSP	4	HEMATOPOIETIC AGENTS
NEUMEGA INJ	KMSP	4	HEMATOPOIETIC AGENTS
NEUPOGEN INJ	-	NC	HEMATOPOIETIC AGENTS
NEUPRO PATCH	-	3	ANTIPARKINSON AGENTS
NEURONTIN CAP	-	3	ANTICONVULSANTS
NEURONTIN SOLN	-	3	ANTICONVULSANTS
NEURONTIN TAB	-	3	ANTICONVULSANTS
NEVANAC OPHTH SUSP	-	2	OPHTHALMIC AGENTS
nevirapine ER tab (VIRAMUNE XR equiv) (Step Therapy requires trial of nevirapine)	ST	4	ANTIVIRALS
NEVIRAPINE SUSP	-	4	ANTIVIRALS
nevirapine tab (VIRAMUNE equiv)	-	1	ANTIVIRALS
NEXAVAR TAB	MSP-PA-SF	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
NEXICLON XR SUSP	-	3	ANTIHYPERTENSIVES
NEXICLON XR TAB	-	3	ANTIHYPERTENSIVES
NEXIUM 24HR TAB	-	NC	ULCER DRUGS
NEXIUM CAP	-	NC	ULCER DRUGS
NEXIUM GRANULE PACK	-	NC	ULCER DRUGS
NEXIUM OTC CAP	OTC	NC	ULCER DRUGS

INF	NC =Not Covered		generic =small letters	LD	BRANDS =CAPITAL LETTERS
LMSP	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program	LD	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	PA	Prior Authorization	QL	Quantity Limit
SP	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 N	SMKG	Smoking Cessation
	Available through Specialty Pharmacy Program	ST	Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary Cont.
Alphabetical Index
Last Updated 11/1/2017

Drug Name	Special Code	Tier	Category
niacin cap	OTC	1	VITAMINS
niacin CR tab (SLO-NIACIN equiv)	OTC	1	VITAMINS
niacin ER tab (NIASPAN equiv)	-	NC	ANTIHYPERLIPIDEMICS
niacin tab	OTC	1	VITAMINS
NIACIN TR TAB	OTC	1	VITAMINS
niacinamide tab	OTC	1	VITAMINS
NIACOR TAB	-	NC	ANTIHYPERLIPIDEMICS
NIASPAN ER TAB	-	1	ANTIHYPERLIPIDEMICS
nicardipine cap (CARDENE equiv)	-	1	CALCIUM CHANNEL BLOCKERS
NICODERM PATCH (Limited to 182 days/plan year)	OTC-QL-SMKG	\$0	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
NICORETTE GUM (Limited to 180 days/plan year)	OTC-QL-SMKG	\$0	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
NICORETTE LOZENGE (Limited to 180 days/plan year)	OTC-QL-SMKG	\$0	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
nicotine gum (NICORETTE equiv) (Limited to 180 days/plan year)	OTC-QL-SMKG	\$0	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
NICOTINE KIT (Limited to 182 days/plan year)	OTC-QL-SMKG	\$0	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
nicotine lozenge (COMMIT equiv) (Limited to 180 days/plan year)	OTC-QL-SMKG	\$0	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
nicotine patch (NICODERM equiv) (Limited to 182 days/plan year)	OTC-QL-SMKG	\$0	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
NICOTROL INHALER (Limited to 180 days/plan year)	QL-SMKG	\$0	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
NICOTROL NASAL SPRAY (Limited to 180 days/plan year)	QL-SMKG	\$0	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
nifedipine cap (PROCARDIA equiv)	-	1	CALCIUM CHANNEL BLOCKERS
nifedipine ER tab (ADALAT CC equiv)	-	1	CALCIUM CHANNEL BLOCKERS
nilutamide tab (NILANDRON equiv)	KMSP	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
nimodipine cap (NIMOTOP equiv)	-	1	CALCIUM CHANNEL BLOCKERS
NIMOTOP CAP	-	3	CALCIUM CHANNEL BLOCKERS
NINJACOF-XG LIQUID	OTC	1	COUGH/COLD/ALLERGY
NINLARO CAP	KMSP-PA	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
NIRAVAM ODT	-	3	ANTIANGIETY AGENTS
nisoldipine ER tab (SULAR equiv)	-	1	CALCIUM CHANNEL BLOCKERS
NISOLDIPINE ER TAB 25.5MG	-	1	CALCIUM CHANNEL BLOCKERS
NITRO-BID OINT	-	3	ANTIANGINAL AGENTS
NITRO-DUR PATCH	-	3	ANTIANGINAL AGENTS
NITRO-DUR PATCH 0.3MG/HR, 0.8MG/HR	-	2	ANTIANGINAL AGENTS
nitrofurantoin macrocrystals cap (MACRODANTIN equiv)	-	1	URINARY ANTI-INFECTIVES
nitrofurantoin monohydrate cap (MACROBID equiv)	-	1	URINARY ANTI-INFECTIVES
nitrofurantoin susp (FURADANTIN equiv)	-	1	URINARY ANTI-INFECTIVES
nitroglycerin lingual spray (NITROLINGUAL equiv)	-	1	ANTIANGINAL AGENTS
nitroglycerin patch (NITRO-DUR equiv)	-	1	ANTIANGINAL AGENTS
nitroglycerin SL tab (NITROSTAT equiv)	-	1	ANTIANGINAL AGENTS
nitroglycerin SR cap	-	1	ANTIANGINAL AGENTS
NITROLINGUAL PUMP SPRAY	-	3	ANTIANGINAL AGENTS
NITROMIST SPRAY	-	3	ANTIANGINAL AGENTS

INF	NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS
LMSP	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program	LD	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	PA	Prior Authorization	QL	Quantity Limit
SP	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 M	SMKG	Smoking Cessation
	Available through Specialty Pharmacy Program	ST	Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary Cont.
Alphabetical Index
Last Updated 11/1/2017

Drug Name	Special Code	Tier	Category
NITROSTAT SL TAB	-	3	ANTIANGINAL AGENTS
NITYR TAB	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
nizatidine cap (AXID equiv)	-	1	ULCER DRUGS
nizatidine soln (AXID equiv)	-	1	ULCER DRUGS
NIZORAL SHAMPOO	-	3	DERMATOLOGICALS
NORDITROPIN INJ, NUTROPIN AQ INJ, OMNITROPE INJ	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
norethindrone tab (NORA-QD equiv)	-	\$0	CONTRACEPTIVES
norethindrone tab (AYGESTIN equiv)	-	1	PROGESTINS
NORINYL TAB 1-50	-	3	CONTRACEPTIVES
NORITATE CREAM (Step Therapy requires trial of FINACEA)	ST	3	DERMATOLOGICALS
NOROXIN TAB	-	3	FLUOROQUINOLONES
NORPACE CAP	-	3	ANTIARRHYTHMICS
NORPACE CR CAP	-	2	ANTIARRHYTHMICS
NORPRAMIN TAB	-	3	ANTIDEPRESSANTS
NOR-QD TAB	-	3	CONTRACEPTIVES
NORTHERA CAP	-	NC	VASOPRESSORS
nortrel tab (OVCON 35 equiv)	-	\$0	CONTRACEPTIVES
nortriptyline cap (PAMELOR equiv)	-	1	ANTIDEPRESSANTS
NORTRIPTYLINE SOLN	-	1	ANTIDEPRESSANTS
NORVASC TAB	-	3	CALCIUM CHANNEL BLOCKERS
NORVIR CAP	-	3	ANTIVIRALS
NORVIR SOLN	-	3	ANTIVIRALS
NORVIR TAB	-	3	ANTIVIRALS
NOVACORT GEL	-	NC	DERMATOLOGICALS
NOVOFINE PEN NEEDLE	OTC	1	MEDICAL DEVICES AND SUPPLIES
NOVOLIN INJ	OTC	2	ANTIDIABETICS
NOVOLOG FLEXPEN INJ	-	2	ANTIDIABETICS
NOVOLOG INJ	-	2	ANTIDIABETICS
NOVOLOG MIX FLEXPEN INJ	-	2	ANTIDIABETICS
NOVOLOG MIX INJ	-	2	ANTIDIABETICS
NOVOLOG PENFILL INJ	-	2	ANTIDIABETICS
NOVOTWIST PEN NEEDLE	OTC	1	MEDICAL DEVICES AND SUPPLIES
NOXAFIL SUSP	-	2	ANTIFUNGALS
NOXAFIL TAB	-	NC	ANTIFUNGALS
np thyroid tab (ARMOUR THYROID, NATURE THROID equiv)	-	1	THYROID AGENTS
NUCORT LOTION	-	3	DERMATOLOGICALS
NUCYNTA ER TAB	-	NC	ANALGESICS - OPIOID
NUCYNTA TAB	-	3	ANALGESICS - OPIOID
NUEDEXTA CAP (QL= 2 caps/day)	QL	2	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
NULYTELY SOLN	-	NC	LAXATIVES
NUPLAZID TAB	-	NC	ANTIPSYCHOTICS/ANTIMANIC AGENTS
NUTRITIONAL SUPPLEMENT LIQUID	OTC-PA	2	DIETARY PRODUCTS/DIETARY MANAGEMENT PRODUCTS
NUTRITIONAL SUPPLEMENT POWDER	OTC-PA	2	DIETARY PRODUCTS/DIETARY MANAGEMENT PRODUCTS
NUVARING	-	\$0	CONTRACEPTIVES

INF	NC =Not Covered Infertility	KMSP	generic =small letters Kroger Mandatory Specialty Pharmacy Program	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 M	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary Cont.
Alphabetical Index
Last Updated 11/1/2017

Drug Name	Special Code	Tier	Category
NUVIGIL TAB	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
NYATA KIT	-	NC	DERMATOLOGICALS
nystatin cream (MYCOSTATIN CREAM equiv)	-	1	DERMATOLOGICALS
nystatin oint	-	1	DERMATOLOGICALS
nystatin powder	-	1	ANTIFUNGALS
nystatin susp	-	1	MOUTH/THROAT/DENTAL AGENTS
nystatin tab	-	1	ANTIFUNGALS
nystatin topical powder	-	1	DERMATOLOGICALS
NYSTATIN VAGINAL TAB	-	1	VAGINAL PRODUCTS
nystatin/triamcinolone cream	-	1	DERMATOLOGICALS
nystatin/triamcinolone oint	-	1	DERMATOLOGICALS
OCALIVA TAB (QL= 1 tab/day; Only available through Walgreens 888-347-3416)	LD-PA-QL-SF	4	GASTROINTESTINAL AGENTS - MISC.
octreotide inj (SANDOSTATIN equiv)	LMSP	4	ENDOCRINE AND METABOLIC AGENTS - MISC.
OCUFEN OPHTH SOLN	-	3	OPHTHALMIC AGENTS
OCUFLOX OPHTH SOLN	-	3	OPHTHALMIC AGENTS
ODEFSEY TAB (QL= 1 tab/day)	QL	4	ANTIVIRALS
ODOMZO CAP (QL= 1 cap/day)	KMSP-PA-QL-SF	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
OFEV CAP (QL= 2 caps/day)	MSP-PA-QL-SF	4	RESPIRATORY AGENTS - MISC.
ofloxacin ophth soln (OCUFLOX equiv)	-	1	OPHTHALMIC AGENTS
ofloxacin otic soln (FLOXIN equiv)	-	1	OTIC AGENTS
ofloxacin tab (FLOXIN equiv)	-	1	FLUOROQUINOLONES
OGESTREL TAB	-	3	CONTRACEPTIVES
olanzapine ODT (ZYPREXA equiv)	-	1	ANTIPSYCHOTICS/ANTIMANIC AGENTS
olanzapine tab (ZYPREXA equiv)	-	1	ANTIPSYCHOTICS/ANTIMANIC AGENTS
olanzapine/fluoxetine cap (SYMBYAX equiv)	-	1	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
OLEPTRO TAB	-	3	ANTIDEPRESSANTS
OLLIZAC POWDER	-	NC	DIETARY PRODUCTS/DIETARY MANAGEMENT PRODUCTS
olmesartan tab (BENICAR equiv)	-	NC	ANTIHYPERTENSIVES
olmesartan/amlodipine/hydrochlorothiazide tab (TRIBENZOR TAB equiv)	-	NC	ANTIHYPERTENSIVES
olmesartan/hydrochlorothiazide tab (BENICAR HCT equiv)	-	NC	ANTIHYPERTENSIVES
olopatadine nasal spray (PATANASE equiv)	-	1	NASAL AGENTS - SYSTEMIC AND TOPICAL
olopatadine ophth soln (PATANOL equiv)	-	1	OPHTHALMIC AGENTS
olopatadine ophth soln 0.2% (PATADAY equiv)	-	NC	OPHTHALMIC AGENTS
OLUX E FOAM	-	NC	DERMATOLOGICALS
OLUX FOAM	PA	3	DERMATOLOGICALS
OLYSIO CAP	-	NC	ANTIVIRALS
omedia otic soln (AMERICAINE equiv)	-	1	OTIC AGENTS
omega-3-acid ethyl esters cap (LOVAZA equiv)	-	1	ANTIHYPERLIPIDEMICS
omeprazole DR cap (PRILOSEC equiv)	-	1	ULCER DRUGS
OMEPRAZOLE TAB	OTC	NC	ULCER DRUGS
omeprazole/sodium bicarbonate cap (ZEGERID equiv)	-	NC	ULCER DRUGS
omeprazole/sodium bicarbonate powder pack (ZEGERID equiv)	-	1	ULCER DRUGS
OMNARIS NASAL SPRAY (QL= 2 bottles/fill; Step Therapy requires trial of 2: flunisolide, fluticasone, triamcinolone or NASONEX)	QL-ST	3	NASAL AGENTS - SYSTEMIC AND TOPICAL

INF	NC =Not Covered Infertility	KMSP	generic =small letters Kroger Mandatory Specialty Pharmacy Program	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 M	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary Cont.
Alphabetical Index
Last Updated 11/1/2017

Drug Name	Special Code	Tier	Category
OMNICEF SUSP	-	3	CEPHALOSPORINS
ondansetron ODT (ZOFTRAN equiv)	-	1	ANTIEMETICS
ondansetron soln (ZOFTRAN equiv)	-	1	ANTIEMETICS
ondansetron tab (ZOFTRAN equiv)	-	1	ANTIEMETICS
ONFI SUSP	-	NC	ANTICONVULSANTS
ONFI TAB	PA	2	ANTICONVULSANTS
ONGLYZA TAB	-	NC	ANTIDIABETICS
ONZETRA XSAIL	-	NC	MIGRAINE PRODUCTS
OPANA ER TAB	-	NC	ANALGESICS - OPIOID
OPANA ER TAB (CRUSH RESISTANT)	-	NC	ANALGESICS - OPIOID
OPANA TAB	-	NC	ANALGESICS - OPIOID
opium tincture	-	1	ANTIDIARRHEALS
OPSUMIT TAB (QL= 1 tab/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	4	CARDIOVASCULAR AGENTS - MISC.
OPTIVAR OPHTH SOLN	-	3	OPHTHALMIC AGENTS
ORACIT SOLN	-	1	GENITOURINARY AGENTS - MISCELLANEOUS
ORALAIR SL TAB	-	NC	BIOLOGICALS MISC
ORAP TAB	-	3	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
ORAPRED ODT	-	2	CORTICOSTEROIDS
ORAPRED ODT	-	3	CORTICOSTEROIDS
ORAPRED SOLN	-	3	CORTICOSTEROIDS
ORAVIG TAB	-	3	MOUTH/THROAT/DENTAL AGENTS
ORAXYL CAP	-	3	TETRACYCLINES
ORENCIA CLICK INJ (QL= 4 inj/28 days)	LMSP-PA-QL	4	ANALGESICS - ANTI-INFLAMMATORY
ORENCIA SC INJ 125MG/ML (QL= 4 inj/28 days)	LMSP-PA-QL	4	ANALGESICS - ANTI-INFLAMMATORY
ORENCIA SC INJ 50MG/0.4ML (QL= 4 inj/28 days)	LMSP-PA-QL	4	ANALGESICS - ANTI-INFLAMMATORY
ORENCIA SC INJ 87.5MG/0.7ML (QL= 4 inj/28 days)	LMSP-PA-QL	4	ANALGESICS - ANTI-INFLAMMATORY
ORENITRAM TAB	-	NC	CARDIOVASCULAR AGENTS - MISC.
ORFADIN CAP (Only available through Dohmen LSS 844-246-5226)	LD-PA	4	ENDOCRINE AND METABOLIC AGENTS - MISC.
ORFADIN SUSP	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
ORKAMBI TAB (QL= 4 tabs/day)	KMSP-PA-QL-SF	4	RESPIRATORY AGENTS - MISC.
orphenadrine citrate ER tab (NORFLEX equiv)	-	1	MUSCULOSKELETAL THERAPY AGENTS
orphenadrine/aspirin/caffeine tab (NORGESIC FORTE equiv)	-	1	MUSCULOSKELETAL THERAPY AGENTS
ORPHENADRINE/ASPIRIN/CAFFEINE TAB	-	3	MUSCULOSKELETAL THERAPY AGENTS
ORTHO TRI-CYCLEN (LO) TAB	-	3	CONTRACEPTIVES
ORTHO-CYCLEN TAB	-	3	CONTRACEPTIVES
ORTHO-EVRA PATCH	-	3	CONTRACEPTIVES
oseltamivir cap (TAMIFLU equiv) (QL= 10 caps/fill)	QL	1	ANTIVIRALS
oseltamivir cap 30mg (TAMIFLU equiv) (QL= 20 caps/fill)	QL	1	ANTIVIRALS
OSENI TAB	-	NC	ANTIDIABETICS
OSMOPREP TAB	-	3	LAXATIVES
OSPHENA TAB	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
OTEZLA STARTER PACK	-	NC	ANALGESICS - ANTI-INFLAMMATORY
OTEZLA TAB	-	NC	ANALGESICS - ANTI-INFLAMMATORY
otomax-HC otic soln (CORTANE-B equiv)	-	NC	OTIC AGENTS

INF	NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS
LMSP	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program	LD	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	PA	Prior Authorization	QL	Quantity Limit
SP	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 M	SMKG	Smoking Cessation
	Available through Specialty Pharmacy Program	ST	Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary Cont.
Alphabetical Index
Last Updated 11/1/2017

Drug Name	Special Code	Tier	Category
OTOVEL OTIC SOLN	-	NC	OTIC AGENTS
OTOZIN OTIC DROPS	-	3	OTIC AGENTS
OVACE PLUS CREAM	-	3	DERMATOLOGICALS
OVACE PLUS GEL	-	3	DERMATOLOGICALS
OVACE PLUS LOTION	-	NC	DERMATOLOGICALS
OVACE PLUS SHAMPOO	-	3	DERMATOLOGICALS
OVACE PLUS FOAM	-	NC	DERMATOLOGICALS
OVACE WASH	-	3	DERMATOLOGICALS
OVCON 35 TAB	-	3	CONTRACEPTIVES
OVIDE LOTION (QL= 2 bottles/fill)	QL	3	DERMATOLOGICALS
oxacillin inj	M	M	PENICILLINS
OXANDRIN TAB	-	3	ANDROGENS-ANABOLIC
oxandrolone tab (OXANDRIN equiv)	-	1	ANDROGENS-ANABOLIC
oxaprozin tab (DAYPRO equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
oxazepam cap (SERAX equiv)	-	1	ANTIANKXIETY AGENTS
oxcarbazepine susp (TRILEPTAL equiv)	-	1	ANTICONVULSANTS
oxcarbazepine tab (TRILEPTAL equiv)	-	1	ANTICONVULSANTS
oxiconazole nitrate cream (OXISTAT equiv)	-	1	DERMATOLOGICALS
OXISTAT CREAM	-	3	DERMATOLOGICALS
OXISTAT LOTION	-	3	DERMATOLOGICALS
OXSORALEN ULTRA CAP	KMSP	3	DERMATOLOGICALS
oxybutynin ER tab (DITROPAN XL equiv)	-	1	URINARY ANTISPASMODICS
oxybutynin syrup	-	1	URINARY ANTISPASMODICS
oxybutynin tab (DITROPAN equiv)	-	1	URINARY ANTISPASMODICS
oxycodone cap (OXYIR equiv)	-	1	ANALGESICS - OPIOID
oxycodone conc (ROXICODONE equiv)	-	1	ANALGESICS - OPIOID
OXYCODONE ER TAB, OXYCONTIN CR TAB	-	NC	ANALGESICS - OPIOID
oxycodone soln (ROXICODONE equiv)	-	1	ANALGESICS - OPIOID
oxycodone tab (ROXICODONE equiv)	-	1	ANALGESICS - OPIOID
oxycodone/acetaminophen cap (TYLOX equiv)	-	1	ANALGESICS - OPIOID
OXYCODONE/ACETAMINOPHEN SOLN	-	1	ANALGESICS - OPIOID
oxycodone/acetaminophen tab (PERCOCET equiv)	-	1	ANALGESICS - OPIOID
oxycodone/aspirin tab (PERCODAN equiv)	-	1	ANALGESICS - OPIOID
oxycodone/ibuprofen tab (COMBUNOX equiv)	-	1	ANALGESICS - OPIOID
OXYCONTIN CR TAB	-	NC	ANALGESICS - OPIOID
OXYIR CAP	-	2	ANALGESICS - OPIOID
oxymorphone tab (OPANA equiv)	-	NC	ANALGESICS - OPIOID
OXYTROL PATCH	PA	3	URINARY ANTISPASMODICS
PALGIC SOLN	-	3	ANTIHISTAMINES
PALGIC TAB	-	3	ANTIHISTAMINES
paliperidone ER tab (INVEGA equiv)	PA	1	ANTIPSYCHOTICS/ANTIMANIC AGENTS
PAMELOR CAP	-	3	ANTIDEPRESSANTS
PAMINE TAB	-	3	ULCER DRUGS
PANCREAZE CAP (Step Therapy requires trial of CREON)	ST	3	DIGESTIVE AIDS
PANCRELIPASE CAP (Step Therapy requires trial of CREON)	ST	3	DIGESTIVE AIDS
PANDEL CREAM	-	3	DERMATOLOGICALS
PANRETIN GEL	KMSP-PA	4	DERMATOLOGICALS
pantoprazole EC tab (PROTONIX equiv)	-	1	ULCER DRUGS
PAPAVERINE/ALPROSTADIL INJ	-	NC	CARDIOVASCULAR AGENTS - MISC.
PAPAVERINE/PHENTOLAMINE INJ	-	NC	CARDIOVASCULAR AGENTS - MISC.

INF	NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS
LMSP	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program	LD	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	PA	Prior Authorization	QL	Quantity Limit
SP	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 N	SMKG	Smoking Cessation
	Available through Specialty Pharmacy Program	ST	Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary Cont.
Alphabetical Index
Last Updated 11/1/2017

Drug Name	Special Code	Tier	Category
PAPAVERINE/PHENTOLAMINE/ALPROSTADIL INJ	-	NC	CARDIOVASCULAR AGENTS - MISC.
PARAFON FORTE TAB	-	3	MUSCULOSKELETAL THERAPY AGENTS
PARAGARD IUD	-	NC	CONTRACEPTIVES
PARCOPA ODT	-	3	ANTIPARKINSON AGENTS
PAREGORIC TINCTURE	-	NC	ANTIDIARRHEALS
paricalcitol cap (ZEMPLAR equiv)	MSP	4	ENDOCRINE AND METABOLIC AGENTS - MISC.
PARLODEL CAP	-	3	ANTIPARKINSON AGENTS
PARLODEL TAB	-	3	ANTIPARKINSON AGENTS
PARNATE TAB	-	3	ANTIDEPRESSANTS
paromomycin cap (HUMATIN equiv)	-	1	AMINOGLYCOSIDES
paroxetine cap (BRISDELLE equiv)	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
paroxetine ER tab (PAXIL CR equiv)	-	1	ANTIDEPRESSANTS
paroxetine tab (PAXIL equiv)	-	1	ANTIDEPRESSANTS
PASER GRANULE	-	NC	ANTIMYCOBACTERIAL AGENTS
PATADAY OPHTH SOLN (QL= 2.5ml/30 days)	QL	1	OPHTHALMIC AGENTS
PATANASE NASAL SPRAY	-	3	NASAL AGENTS - SYSTEMIC AND TOPICAL
PATANOL OPHTH SOLN	-	3	OPHTHALMIC AGENTS
PAXIL CR TAB	-	3	ANTIDEPRESSANTS
PAXIL SUSP	-	3	ANTIDEPRESSANTS
PAXIL TAB	-	3	ANTIDEPRESSANTS
PAZEO OPHTH SOLN 0.7%	-	NC	OPHTHALMIC AGENTS
PCE TAB	-	3	MACROLIDES
PEAK FLOW METER	OTC	1	MEDICAL DEVICES AND SUPPLIES
PEDIATEX TDM SUSP	-	3	COUGH/COLD/ALLERGY
pediatric multiple vitamins/fluoride chew tab	-	1	MULTIVITAMINS
pediatric multiple vitamins/fluoride soln	-	1	MULTIVITAMINS
pediatric multiple vitamins/fluoride/iron soln	-	1	MULTIVITAMINS
PEDIAZOLE SUSP	-	3	ANTI-INFECTIVE AGENTS - MISC.
peg 3350/electrolytes soln (COLYTE equiv) (Covered at \$0 for members 50-75 years-Limited to 2 fills/calendar year; All other members covered at generic copay)	QL	\$0	LAXATIVES
PEGANONE TAB	-	2	ANTICONVULSANTS
PEGASYS INJ	KMSP	4	ANTIVIRALS
PEGASYS INJ KIT	KMSP	4	ANTIVIRALS
PEG-INTRON INJ	KMSP	4	ANTIVIRALS
PEN NEEDLE	OTC	3	MEDICAL DEVICES AND SUPPLIES
PENICILLIN G PROCAINE INJ	M	M	PENICILLINS
PENICILLIN G SODIUM INJ	M	M	PENICILLINS
PENICILLIN VK SOLN	-	1	PENICILLINS
penicillin vk soln (VEETIDS equiv)	-	1	PENICILLINS
penicillin vk tab (VEETIDS equiv)	-	1	PENICILLINS
PENLAC SOLN	-	NC	DERMATOLOGICALS
PENNSAID SOLN	-	NC	DERMATOLOGICALS
PENNSAID SOLN 1.5%	-	NC	DERMATOLOGICALS
PENTASA CAP	-	NC	GASTROINTESTINAL AGENTS - MISC.
pentazocine/acetaminophen tab (TALACEN equiv)	-	1	ANALGESICS - OPIOID
pentazocine/naloxone tab (TALWIN NX equiv)	-	1	ANALGESICS - OPIOID
pentoxifylline ER tab (TRENTAL equiv)	-	1	HEMATOLOGICAL AGENTS - MISC.

INF	NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS
LMSP	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program	LD	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	PA	Prior Authorization	QL	Quantity Limit
SP	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 M	SMKG	Smoking Cessation
	Available through Specialty Pharmacy Program	ST	Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary Cont.
Alphabetical Index
Last Updated 11/1/2017

Drug Name	Special Code	Tier	Category
PEPCID SUSP	-	2	ULCER DRUGS
PEPCID TAB	-	3	ULCER DRUGS
PERCOCET TAB	-	3	ANALGESICS - OPIOID
PERCODAN TAB	-	3	ANALGESICS - OPIOID
PERFOROMIST NEB SOLN	-	3	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
PERIDEX SOLN	-	3	MOUTH/THROAT/DENTAL AGENTS
perindopril tab (ACEON equiv)	-	1	ANTIHYPERTENSIVES
permethrin cream (ELIMITE CREAM equiv)	-	1	DERMATOLOGICALS
perphenazine tab (TRILAFON equiv)	-	1	ANTIPSYCHOTICS/ANTIMANIC AGENTS
PERPHENAZINE/ AMITRIPTYLINE TAB	-	1	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
PERSANTINE TAB	-	3	HEMATOLOGICAL AGENTS - MISC.
PERTZYE CAP (Step Therapy requires trial of CREON)	ST	3	DIGESTIVE AIDS
PEXEVA TAB (Step Therapy requires trial of citalopram, escitalopram, sertraline, fluoxetine, fluvoxamine or paroxetine)	ST	3	ANTIDEPRESSANTS
PFIZERPEN G INJ	M	M	PENICILLINS
pfizerpen g inj (PFIZERPEN G equiv)	M	M	PENICILLINS
phenazopyridine tab (PYRIDIUM equiv)	-	1	GENITOURINARY AGENTS - MISCELLANEOUS
phendimetrazine tab	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS
phenelzine tab (NARDIL equiv)	-	1	ANTIDEPRESSANTS
phenobarbital elixir	-	1	HYPNOTICS/SEDATIVES/SLEEP DISORDEI AGENTS
phenobarbital tab	-	1	HYPNOTICS/SEDATIVES/SLEEP DISORDEI AGENTS
phenoxybenzamine cap (DIBENZYLINE equiv)	KMSP	1	ANTIHYPERTENSIVES
phentermine cap (ADIPEX equiv) (QL= 1 cap/day)	PA-QL	1	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS
phentermine tab (ADIPEX equiv) (QL= 1 tab/day)	PA-QL	1	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS
PHENTOLAMINE/ALPROSTADIL INJ	-	NC	CARDIOVASCULAR AGENTS - MISC.
phenylephrine ophth soln (MYDFRIN equiv)	-	1	OPHTHALMIC AGENTS
phenytoin cap (DILANTIN equiv)	-	1	ANTICONVULSANTS
phenytoin chew tab (DILANTIN equiv)	-	1	ANTICONVULSANTS
phenytoin susp (DILANTIN equiv)	-	1	ANTICONVULSANTS
PHISOHEX LIQUID	-	3	ANTISEPTICS & DISINFECTANTS
PHOSLO CAP	-	3	GASTROINTESTINAL AGENTS - MISC.
PHOSLYRA SOLN	-	2	GASTROINTESTINAL AGENTS - MISC.
phospha 250 neutral tab (K-PHOS NEUTRAL equiv)	-	1	MINERALS & ELECTROLYTES
PHOSPHOLINE OPHTH SOLN	-	2	OPHTHALMIC AGENTS
PHOTREXA OP KIT	-	NC	OPHTHALMIC AGENTS
PHOTREXA VISCOUS OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
PICATO GEL (QL= 1 box/fill)	QL	3	DERMATOLOGICALS
pilocarpine ophth soln (ISOPTO CARPINE equiv)	-	1	OPHTHALMIC AGENTS
pilocarpine tab (SALAGEN equiv)	-	1	MOUTH/THROAT/DENTAL AGENTS
PILOPINE HS OPHTH GEL	-	3	OPHTHALMIC AGENTS
pimozide tab	-	1	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
pindolol tab (VISKEN equiv)	-	1	BETA BLOCKERS

INF	NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS
LMSP	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program	LD	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	PA	Prior Authorization	QL	Quantity Limit
SP	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 M	SMKG	Smoking Cessation
	Available through Specialty Pharmacy Program	ST	Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary Cont.
Alphabetical Index
Last Updated 11/1/2017

Drug Name	Special Code	Tier	Category
pioglitazone tab (ACTOS equiv)	-	1	ANTIDIABETICS
pioglitazone/glimepiride tab (DUETACT equiv)	-	1	ANTIDIABETICS
pioglitazone/metformin tab (ACTOPLUS MET equiv)	-	1	ANTIDIABETICS
piperacillin/tazobactam inj	M	M	PENICILLINS
piroxicam cap (FELDENE equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
PLAN B TAB	OTC	\$0	CONTRACEPTIVES
PLAQUENIL TAB	-	3	ANTIMALARIALS
PLAVIX TAB 300MG	-	NC	HEMATOLOGICAL AGENTS - MISC.
PLAVIX TAB 75MG	-	3	HEMATOLOGICAL AGENTS - MISC.
PLEGRIDY INJ	LMSP	4	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
PLEGRIDY PEN INJ	LMSP	4	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
PLENDIL TAB	-	3	CALCIUM CHANNEL BLOCKERS
PLETAL TAB	-	3	HEMATOLOGICAL AGENTS - MISC.
PLEXION LOTION	-	3	DERMATOLOGICALS
PLEXION SCT CREAM	-	3	DERMATOLOGICALS
PODIAPN CAP	-	NC	DIETARY PRODUCTS/DIETARY MANAGEMENT PRODUCTS
PODOCON SOLN	-	2	DERMATOLOGICALS
podofilox soln (CONDYLOX equiv)	-	1	DERMATOLOGICALS
POLYCITRA CRYSTAL PACK	-	3	GENITOURINARY AGENTS - MISCELLANEOUS
POLYCITRA-LC SOLN	-	3	GENITOURINARY AGENTS - MISCELLANEOUS
polyethylene glycol 3350 powder (MIRALAX equiv)	-	NC	LAXATIVES
POLYETHYLENE GLYCOL 8000 GRANULES	-	2	PHARMACEUTICAL ADJUVANTS
polymyxin b/trimethoprim ophth soln (POLYTRIM equiv)	-	1	OPHTHALMIC AGENTS
POLYTRIM OPHTH SOLN	-	3	OPHTHALMIC AGENTS
POLY-TUSSIN DM SYRUP	-	NC	COUGH/COLD/ALLERGY
POMALYST CAP	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
PONSTEL CAP	-	3	ANALGESICS - ANTI-INFLAMMATORY
POTABA CAP	-	3	VITAMINS
POTABA POWDER PACKET	-	2	VITAMINS
POTABA TAB	-	2	VITAMINS
potassium bicarbonate effer tab (K-LYTE equiv)	-	1	MINERALS & ELECTROLYTES
potassium chloride effer tab (K-LYTE/CL equiv)	-	1	MINERALS & ELECTROLYTES
potassium chloride ER cap (MICRO-K equiv)	-	1	MINERALS & ELECTROLYTES
POTASSIUM CHLORIDE ER TAB	-	1	MINERALS & ELECTROLYTES
potassium chloride ER tab (KLOR-CON equiv)	-	1	MINERALS & ELECTROLYTES
potassium chloride micro tab (K-DUR equiv)	-	1	MINERALS & ELECTROLYTES
potassium chloride powder packet (KLOR-CON equiv)	-	1	MINERALS & ELECTROLYTES
potassium chloride soln	-	1	MINERALS & ELECTROLYTES
potassium citrate CR tab (UROKIT-K TAB equiv)	-	1	GENITOURINARY AGENTS - MISCELLANEOUS
potassium citrate/citric acid powder pack (POLYCITRA equiv)	-	1	GENITOURINARY AGENTS - MISCELLANEOUS
potassium citrate/citric acid soln (POLYCITRA-K equiv)	-	1	GENITOURINARY AGENTS - MISCELLANEOUS

INF	NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS
LMSP	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program	LD	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	PA	Prior Authorization	QL	Quantity Limit
SP	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 M	SMKG	Smoking Cessation
	Available through Specialty Pharmacy Program	ST	Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary Cont.
Alphabetical Index
Last Updated 11/1/2017

Drug Name	Special Code	Tier	Category
POTIGA TAB (QL= 3 tabs/day)	QL	2	ANTICONVULSANTS
POTIGA TAB 50MG (QL= 9 tabs/day)	QL	2	ANTICONVULSANTS
PRADAXA CAP	-	2	ANTICOAGULANTS
PRALUENT INJ (QL= 2 inj/28 days)	KMSP-PA-QL	4	ANTIHYPERLIPIDEMICS
pramipexole ER tab (MIRAPEX ER equiv)	-	1	ANTIPARKINSON AGENTS
pramipexole tab (MIRAPEX equiv)	-	1	ANTIPARKINSON AGENTS
PRAMOSONE CREAM 1%	-	2	DERMATOLOGICALS
PRAMOSONE CREAM 2.5-1%	-	NC	DERMATOLOGICALS
PRAMOSONE E CREAM	-	NC	DERMATOLOGICALS
PRAMOSONE LOTION	-	3	DERMATOLOGICALS
PRAMOSONE OINT	-	2	DERMATOLOGICALS
pramoxine/hydrocortisone cream (ANALPRAM-HC equiv)	-	NC	ANORECTAL AGENTS
pramoxine/hydrocortisone cream kit (ANALPRAM-HC equiv)	-	1	ANORECTAL AGENTS
pramoxine-HC AQ otic soln (CORTANE-B AQUEOUS equiv)	-	1	OTIC AGENTS
PRANDIMET TAB	-	NC	ANTIDIABETICS
PRANDIN TAB	-	3	ANTIDIABETICS
PRASCION RA CREAM	-	2	DERMATOLOGICALS
prasugrel tab (EFFIENT equiv)	-	1	HEMATOLOGICAL AGENTS - MISC.
PRAVACHOL TAB	-	3	ANTIHYPERLIPIDEMICS
pravastatin tab (PRAVACHOL equiv)	-	1	ANTIHYPERLIPIDEMICS
prazosin cap (MINIPRESS equiv)	-	1	ANTIHYPERTENSIVES
PRECISION INSULIN SYRINGE	OTC	1	MEDICAL DEVICES AND SUPPLIES
PRECISION XTRA METER	OTC	\$0	MEDICAL DEVICES AND SUPPLIES
PRECISION XTRA TEST STRIP (Limited to 50 strips per month for members n on diabetes medication)	OTC	2	DIAGNOSTIC PRODUCTS
PRECOSE TAB	-	3	ANTIDIABETICS
PRED FORTE OPHTH SUSP	-	3	OPHTHALMIC AGENTS
PRED MILD OPHTH SOLN	-	2	OPHTHALMIC AGENTS
PRED-G OPHTH SOLN	-	2	OPHTHALMIC AGENTS
prednicarbate cream (DERMATOP equiv)	-	1	DERMATOLOGICALS
prednicarbate oint (DERMATOP equiv)	-	1	DERMATOLOGICALS
prednisolone ODT (ORAPRED equiv)	-	1	CORTICOSTEROIDS
prednisolone ophth soln (PRED FORTE equiv)	-	1	OPHTHALMIC AGENTS
PREDNISOLONE SODIUM PHOSPHATE OPHTH SOLN	-	2	OPHTHALMIC AGENTS
prednisolone soln (PEDIAPRED equiv)	-	1	CORTICOSTEROIDS
prednisolone syrup (PRELONE equiv)	-	1	CORTICOSTEROIDS
PREDNISOLONE/MOXIFLOXACIN OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
PREDNISOLONE/MOXIFLOXACIN/BROMFENAC OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
PREDNISOLONE/MOXIFLOXACIN/KETOROLAC OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
PREDNISON PAK	-	2	CORTICOSTEROIDS
PREDNISON SOLN	-	1	CORTICOSTEROIDS
PREDNISON TAB	-	1	CORTICOSTEROIDS
prednisone tab (DELTASONE equiv)	-	1	CORTICOSTEROIDS
PREDNISON/DIPHENHYDRAMINE KIT	-	NC	CORTICOSTEROIDS
PREFEST TAB	-	3	ESTROGENS
PRELONE SYRUP	-	3	CORTICOSTEROIDS
PREMARIN TAB	-	2	ESTROGENS
PREMARIN VAGINAL CREAM	-	2	VAGINAL PRODUCTS
PREMPHASE TAB, PREMPRO TAB	-	2	ESTROGENS
PRENATAL VITAMINS (NON-PREFERRED)	-	3	VITAMINS

INF	NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS
LMSP	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program	LD	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	PA	Prior Authorization	QL	Quantity Limit
SP	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 N	SMKG	Smoking Cessation
	Available through Specialty Pharmacy Program	ST	Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary Cont.
Alphabetical Index
Last Updated 11/1/2017

Drug Name	Special Code	Tier	Category
PRENATAL VITAMINS (PRENATAL PLUS, PREPLUS, PRENAPLUS)	-	1	VITAMINS
PREPOPIK PAK	-	NC	LAXATIVES
PRESTALIA TAB	-	NC	ANTIHYPERTENSIVES
PREVACID CAP	-	NC	ULCER DRUGS
PREVACID OTC CAP	OTC	1	ULCER DRUGS
PREVACID SOLUTAB	-	2	ULCER DRUGS
PREVIDENT 5000 PLUS CREAM (Covered at \$0 for members 5 years or younger; All other members covered at preferred brand copay)	-	\$0	MOUTH/THROAT/DENTAL AGENTS
PREVIDENT GEL	-	2	MOUTH/THROAT/DENTAL AGENTS
PREVIDENT PASTE	-	2	MOUTH/THROAT/DENTAL AGENTS
PREVIDENT RINSE	-	2	MOUTH/THROAT/DENTAL AGENTS
PREVPAC KIT	-	3	ULCER DRUGS
PREZCOBIX TAB	-	4	ANTIVIRALS
PREZISTA SUSP	-	4	ANTIVIRALS
PREZISTA TAB	-	4	ANTIVIRALS
PRIFTIN TAB	-	2	ANTIMYCOBACTERIAL AGENTS
PRILOSEC CAP	-	NC	ULCER DRUGS
PRILOSEC OTC DR TAB	-	NC	ULCER DRUGS
PRIMAQUINE TAB	-	2	ANTIMALARIALS
primidone tab (MYSOLINE equiv)	-	1	ANTICONVULSANTS
PRIMLEV TAB	-	NC	ANALGESICS - OPIOID
PRIMSOL SOLN	-	3	ANTI-INFECTIVE AGENTS - MISC.
PRINIVIL TAB, ZESTRIL TAB	-	3	ANTIHYPERTENSIVES
PRISTIQ TAB	-	3	ANTIDEPRESSANTS
PROAIR HFA INHALER	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
PROAMATINE TAB	-	3	VASOPRESSORS
probenecid tab (BENEMID equiv)	-	1	GOUT AGENTS
PROCARDIA CAP	-	3	CALCIUM CHANNEL BLOCKERS
PROCENTRA SOLN	-	3	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
prochlorperazine supp (COMPAZINE equiv)	-	1	ANTIPSYCHOTICS/ANTIMANIC AGENTS
prochlorperazine tab (COMPAZINE equiv)	-	1	ANTIPSYCHOTICS/ANTIMANIC AGENTS
PROCORT CREAM	-	NC	ANORECTAL AGENTS
PROCRIT INJ	KMSP	4	HEMATOPOIETIC AGENTS
PROCTOCORT CREAM	-	3	DERMATOLOGICALS
PROCTOFOAM HC FOAM	-	2	ANORECTAL AGENTS
proctosol HC cream (ANUSOL HC equiv)	-	1	ANORECTAL AGENTS
PRODRIN TAB	-	NC	MIGRAINE PRODUCTS
progesterone cap (PROMETRIUM equiv)	-	1	PROGESTINS
progesterone oil inj	-	NC	PROGESTINS
PROGESTERONE SUPP	PA	3	VAGINAL PRODUCTS
PROGLYCEM SUSP	-	3	ANTIDIABETICS
PROGRAF CAP	-	4	ASSORTED CLASSES
PROLENSA OPHTH SOLN	-	2	OPHTHALMIC AGENTS
PROLEUKIN INJ	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
PROMACTA TAB	KMSP-PA	4	HEMATOPOIETIC AGENTS
promethazine DM syrup	-	1	COUGH/COLD/ALLERGY
promethazine supp (PHENERGAN equiv)	-	1	ANTIHISTAMINES

INF	NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS
LMSP	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program	LD	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	PA	Prior Authorization	QL	Quantity Limit
SP	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 M	SMKG	Smoking Cessation
	Available through Specialty Pharmacy Program	ST	Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary Cont.
Alphabetical Index
Last Updated 11/1/2017

Drug Name	Special Code	Tier	Category
promethazine syrup	-	1	ANTIHISTAMINES
promethazine tab (PHENERGAN equiv)	-	1	ANTIHISTAMINES
promethazine VC syrup (PHENERGAN VC equiv)	-	1	COUGH/COLD/ALLERGY
promethazine VC/codeine syrup (PHENERGAN VC/CODEINE equiv)	-	1	COUGH/COLD/ALLERGY
promethazine/codeine syrup (PHENERGAN/CODEINE equiv)	-	1	COUGH/COLD/ALLERGY
PROMETRIUM CAP	-	3	PROGESTINS
propafenone ER cap (RYTHMOL SR equiv)	-	1	ANTIARRHYTHMICS
propafenone tab (RYTHMOL equiv)	-	1	ANTIARRHYTHMICS
PROPANTHELINE TAB	-	2	ULCER DRUGS
proparacaine ophth soln (ALCAINE equiv)	-	1	OPHTHALMIC AGENTS
propranolol ER cap (INDERAL LA equiv)	-	1	BETA BLOCKERS
PROPRANOLOL SOLN	-	1	BETA BLOCKERS
propranolol tab (INDERAL equiv)	-	1	BETA BLOCKERS
propranolol/hydrochlorothiazide tab (INDERIDE equiv)	-	1	ANTIHYPERTENSIVES
propylthiouracil tab	-	1	THYROID AGENTS
PROQUIN XR TAB	-	NC	FLUOROQUINOLONES
PROSCAR TAB	-	3	GENITOURINARY AGENTS - MISCELLANEOUS
PROSED DS TAB	-	NC	URINARY ANTI-INFECTIVES
PROSOM TAB	-	3	HYPNOTICS/SEDATIVES/SLEEP DISORDEI AGENTS
PROSTIGMIN TAB	-	2	ANTIMYASTHENIC/CHOLINERGIC AGENTS
PROTHELIAL PASTE	-	NC	MOUTH/THROAT/DENTAL AGENTS
PROTONIX EC TAB	-	NC	ULCER DRUGS
PROTONIX PAK	-	NC	ULCER DRUGS
PROTOPIC OINT	-	3	DERMATOLOGICALS
protriptyline tab (VIVACTIL equiv)	-	1	ANTIDEPRESSANTS
PROVENTIL HFA INHALER	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
PROVERA TAB	-	3	PROGESTINS
PROVIGIL TAB (QL= 2 tabs/day)	PA-QL	3	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
PROZAC CAP	-	3	ANTIDEPRESSANTS
PROZAC SOLN	-	3	ANTIDEPRESSANTS
PROZAC TAB	-	3	ANTIDEPRESSANTS
PROZAC WEEKLY CAP	-	NC	ANTIDEPRESSANTS
pseudoephedrine/brompheniramine/codeine liquid (CPB WC LIQUID equiv)	OTC	1	COUGH/COLD/ALLERGY
PULMICORT FLEXHALER	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
PULMICORT INH SUSP	-	3	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
PULMOZYME INH SOLN	KMSP	4	RESPIRATORY AGENTS - MISC.
PUREFOLIX TAB	-	NC	HEMATOPOIETIC AGENTS
PURINETHOL TAB	-	3	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
PURIXAN SUSP	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
PYLERA CAP	-	3	ULCER DRUGS
pyrazinamide tab	-	1	ANTIMYCOBACTERIAL AGENTS

INF	NC =Not Covered		generic =small letters	LD	BRANDS =CAPITAL LETTERS
LMSP	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program	MSP	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	QL	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	PA	Prior Authorization	SMKG	Quantity Limit
SP	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 M	VAC	Smoking Cessation
	Available through Specialty Pharmacy Program	ST	Step Therapy		Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary Cont.
Alphabetical Index
Last Updated 11/1/2017

Drug Name	Special Code	Tier	Category
PYRIDIDIUM TAB	-	3	GENITOURINARY AGENTS - MISCELLANEOUS
pyridostigmine CR tab (MESTINON equiv)	-	1	ANTIMYASTHENIC/CHOLINERGIC AGENTS
pyridostigmine tab (MESTINON equiv)	-	1	ANTIMYASTHENIC/CHOLINERGIC AGENTS
QBRELIS SOLN	-	NC	ANTIHYPERTENSIVES
QNASL NASAL SPRAY (QL= 2 bottles/fill; Step Therapy requires trial of 2: flunisolide, fluticasone, triamcinolone or NASONEX)	QL-ST	3	NASAL AGENTS - SYSTEMIC AND TOPICAL
QSYMIA CAP (QL= 1 cap/day)	PA-QL	3	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
QUALAQUIN CAP	-	3	ANTIMALARIALS
QUDEXY XR CAP, TOPIRAMATE ER CAP	-	NC	ANTICONVULSANTS
QUESTRAN LITE POWDER	-	3	ANTIHYPERLIPIDEMICS
QUESTRAN LITE POWDER PACK	-	3	ANTIHYPERLIPIDEMICS
QUESTRAN POWDER	-	3	ANTIHYPERLIPIDEMICS
QUESTRAN POWDER PACK	-	3	ANTIHYPERLIPIDEMICS
quetiapine tab (SEROQUEL equiv)	-	1	ANTIPSYCHOTICS/ANTIMANIC AGENTS
quetiapine XR tab (SEROQUEL XR equiv)	-	1	ANTIPSYCHOTICS/ANTIMANIC AGENTS
QUFLORA PEDIATRIC CHEW TAB	-	3	MULTIVITAMINS
QUILLIVANT XR SUSP	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
quinapril tab (ACCUPRIL equiv)	-	1	ANTIHYPERTENSIVES
quinapril/hydrochlorothiazide tab (ACCURETIC equiv)	-	1	ANTIHYPERTENSIVES
quinidine gluconate CR tab	-	1	ANTIARRHYTHMICS
QUINIDINE SULFATE ER TAB	-	3	ANTIARRHYTHMICS
QUINIDINE SULFATE TAB	-	1	ANTIARRHYTHMICS
quinine sulfate cap (QUALAQUIN equiv)	-	1	ANTIMALARIALS
QVAR INHALER	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
rabeprazole EC tab (ACIPHEX equiv)	-	1	ULCER DRUGS
RAGWITEK SL TAB	-	NC	BIOLOGICALS MISC
rajani tab (BEYAZ equiv)	-	NC	CONTRACEPTIVES
raloxifene tab (EVISTA equiv) (Covered at \$0 for women 35 years or older; All other members covered at generic copay)	-	\$0	ENDOCRINE AND METABOLIC AGENTS - MISC.
ramipril cap (ALTACE equiv)	-	1	ANTIHYPERTENSIVES
RANEXA TAB	-	2	ANTIANGINAL AGENTS
ranitidine cap (ZANTAC equiv)	-	1	ULCER DRUGS
ranitidine syrup (ZANTAC equiv)	-	1	ULCER DRUGS
ranitidine tab (Rx Only) (ZANTAC equiv)	-	1	ULCER DRUGS
RAPAFLO CAP (Restricted to Urology Specialist)	RS	2	GENITOURINARY AGENTS - MISCELLANEOUS
RAPAMUNE SOLN	-	4	ASSORTED CLASSES
RAPAMUNE TAB	-	4	ASSORTED CLASSES
rasagiline tab (AZILECT equiv)	-	1	ANTIPARKINSON AGENTS
RAVICTI LIQUID	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
RAYALDEE CAP	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
RAYOS TAB	-	NC	CORTICOSTEROIDS
RAZADYNE ER CAP	-	3	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.

INF	NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS
LMSP	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program	LD	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	PA	Prior Authorization	QL	Quantity Limit
SP	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 M	SMKG	Smoking Cessation
	Available through Specialty Pharmacy Program	ST	Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary Cont.
Alphabetical Index
Last Updated 11/1/2017

Drug Name	Special Code	Tier	Category
RAZADYNE SOLN	-	3	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
RAZADYNE TAB	-	3	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
REBETOL SOLN	KMSP	4	ANTIVIRALS
REBIF INJ	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
RECTIV OINT	-	NC	ANORECTAL AGENTS
REGLAN TAB	-	3	GASTROINTESTINAL AGENTS - MISC.
REGRANEX GEL (QL= 30gm/fill)	QL	2	DERMATOLOGICALS
RELENZA DISKHALER (QL= 1 inhaler/fill)	QL	2	ANTIVIRALS
RELISTOR INJ	-	NC	GASTROINTESTINAL AGENTS - MISC.
RELISTOR INJ KIT	-	NC	GASTROINTESTINAL AGENTS - MISC.
RELISTOR TAB	-	NC	GASTROINTESTINAL AGENTS - MISC.
REMERON SOLUTAB	-	3	ANTIDEPRESSANTS
REMERON TAB	-	3	ANTIDEPRESSANTS
RENAGEL TAB	-	3	GASTROINTESTINAL AGENTS - MISC.
renaphro cap (NEPHROCAP equiv)	-	1	MULTIVITAMINS
RENOVA CREAM	-	NC	DERMATOLOGICALS
RENVELA TAB	-	3	GASTROINTESTINAL AGENTS - MISC.
repaglinide tab (PRANDIN equiv)	-	1	ANTIDIABETICS
REPATHA INJ (QL= 2 inj/28 days)	KMSP-PA-QL	4	ANTIHYPERLIPIDEMICS
REPATHA PUSHTRONEX INJ (QL= 1 inj/28 days)	KMSP-PA-QL	4	ANTIHYPERLIPIDEMICS
REPREXAIN TAB	-	3	ANALGESICS - OPIOID
REQUIP TAB	-	3	ANTIPARKINSON AGENTS
REQUIP XL TAB	-	3	ANTIPARKINSON AGENTS
RESCON TAB	-	3	COUGH/COLD/ALLERGY
RESCRIPTOR TAB	-	4	ANTIVIRALS
RESERPINE TAB	-	3	ANTIHYPERTENSIVES
RESERVAPAK SYRUP	-	NC	ALTERNATIVE MEDICINES
RESTASIS OPHTH EMULSION (Restricted to Ophthalmology or Optometry Specialist)	RS	2	OPHTHALMIC AGENTS
RESTORIL CAP 15MG	-	3	HYPNOTICS/SEDATIVES/SLEEP DISORDEI AGENTS
RESTORIL CAP 22.5MG	-	3	HYPNOTICS/SEDATIVES/SLEEP DISORDEI AGENTS
RESTORIL CAP 30MG	-	3	HYPNOTICS/SEDATIVES/SLEEP DISORDEI AGENTS
RESTORIL CAP 7.5MG	-	3	HYPNOTICS/SEDATIVES/SLEEP DISORDEI AGENTS
RETIN-A CREAM	PA	3	DERMATOLOGICALS
RETIN-A MICRO GEL 0.04%, 0.1% (Acne Only – members age 26 or older require Prior Authorization)	PA	1	DERMATOLOGICALS
RETIN-A MICRO GEL 0.08%	-	NC	DERMATOLOGICALS
RETROVIR CAP	-	4	ANTIVIRALS
RETROVIR SYRUP	-	4	ANTIVIRALS
RETROVIR TAB	-	4	ANTIVIRALS
REVATIO SUSP	-	NC	CARDIOVASCULAR AGENTS - MISC.
REVATIO TAB	PA	3	CARDIOVASCULAR AGENTS - MISC.
RE VIA TAB	-	3	ANTIDOTES

INF	NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS
LMSP	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program	LD	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	PA	Prior Authorization	QL	Quantity Limit
SP	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 N	SMKG	Smoking Cessation
	Available through Specialty Pharmacy Program	ST	Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary Cont.
Alphabetical Index
Last Updated 11/1/2017

Drug Name	Special Code	Tier	Category
REVLIMID CAP (QL= 1 cap/day)	KMSP-PA-QL	3	ASSORTED CLASSES
REXAPHENAC CREAM	-	NC	DERMATOLOGICALS
REXULTI TAB	-	NC	ANTIPSYCHOTICS/ANTIMANIC AGENTS
REYATAZ CAP	-	4	ANTIVIRALS
REYATAZ POWDER PACK	-	4	ANTIVIRALS
REZIRA SOLN	-	3	COUGH/COLD/ALLERGY
REZYST CHEW TAB	-	NC	ANTIDIARRHEALS
RHEUMATREX TAB	-	3	ANALGESICS - ANTI-INFLAMMATORY
RHINOCORT AQUA NASAL SPRAY (QL= 2 bottles/fill; Step Therapy requires trial of 2: flunisolide, fluticasone, triamcinolone or NASONEX)	QL-ST	3	NASAL AGENTS - SYSTEMIC AND TOPICAL
RHOFADE CREAM	-	NC	DERMATOLOGICALS
RIBAPAK TAB	-	NC	ANTIVIRALS
RIBATAB	KMSP	4	ANTIVIRALS
ribavirin cap (REBETOL equiv)	KMSP	1	ANTIVIRALS
ribavirin inh soln (VIRAZOLE equiv)	-	NC	ANTIVIRALS
ribavirin tab (COPEGUS equiv)	KMSP	1	ANTIVIRALS
RIDAURA CAP	-	2	ANALGESICS - ANTI-INFLAMMATORY
rifabutin cap (MYCOBUTIN equiv)	-	1	ANTIMYCOBACTERIAL AGENTS
RIFADIN CAP	-	3	ANTIMYCOBACTERIAL AGENTS
RIFAMATE CAP	-	2	ANTIMYCOBACTERIAL AGENTS
rifampin cap (RIFADIN equiv)	-	1	ANTIMYCOBACTERIAL AGENTS
RIFATER TAB	PA	3	ANTIMYCOBACTERIAL AGENTS
RILUTEK TAB	-	NC	NEUROMUSCULAR AGENTS
riluzole tab (RILUTEK equiv)	-	1	NEUROMUSCULAR AGENTS
rimantadine tab (FLUMADINE equiv)	-	1	ANTIVIRALS
RIOMET SOLN	-	3	ANTIDIABETICS
risedronate DR tab (ATELVIA equiv) (Step Therapy requires trial of alendronate)	ST	1	ENDOCRINE AND METABOLIC AGENTS - MISC.
risedronate tab (ACTONEL equiv) (Step Therapy requires trial of alendronate)	ST	1	ENDOCRINE AND METABOLIC AGENTS - MISC.
RISPERDAL CONSTA INJ	MSP	4	ANTIPSYCHOTICS/ANTIMANIC AGENTS
RISPERDAL M ODT	-	3	ANTIPSYCHOTICS/ANTIMANIC AGENTS
RISPERDAL SOLN	-	3	ANTIPSYCHOTICS/ANTIMANIC AGENTS
RISPERDAL TAB	-	3	ANTIPSYCHOTICS/ANTIMANIC AGENTS
risperidone ODT (RISPERDAL M equiv)	-	1	ANTIPSYCHOTICS/ANTIMANIC AGENTS
risperidone soln (RISPERDAL equiv)	-	1	ANTIPSYCHOTICS/ANTIMANIC AGENTS
risperidone tab (RISPERDAL equiv)	-	1	ANTIPSYCHOTICS/ANTIMANIC AGENTS
RITALIN LA CAP	-	3	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
RITALIN LA CAP 10MG	-	3	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
RITALIN LA CAP 60MG	-	3	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
RITALIN TAB	-	3	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
RITUXAN INJ	M	M	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
rivastigmine cap (EXELON equiv)	-	1	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
rivastigmine patch (EXELON equiv)	-	1	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.

INF	NC =Not Covered Infertility	KMSP	generic =small letters Kroger Mandatory Specialty Pharmacy Program	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 M	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary Cont.
Alphabetical Index
Last Updated 11/1/2017

Drug Name	Special Code	Tier	Category
rizatriptan ODT (MAXALT equiv) (QL= 12 tabs/fill, 3 fills/60 days)	QL	1	MIGRAINE PRODUCTS
rizatriptan tab (MAXALT equiv) (QL= 12 tabs/fill, 3 fills/60 days)	QL	1	MIGRAINE PRODUCTS
ROBAXIN TAB	-	3	MUSCULOSKELETAL THERAPY AGENTS
ROBINUL TAB	-	3	ULCER DRUGS
ROCALTROL CAP	-	3	ENDOCRINE AND METABOLIC AGENTS - MISC.
ROCALTROL SOLN	-	3	ENDOCRINE AND METABOLIC AGENTS - MISC.
ropinirole ER tab (REQUIP XL equiv)	-	1	ANTIPARKINSON AGENTS
ropinirole tab (REQUIP equiv)	-	1	ANTIPARKINSON AGENTS
ROSADAN KIT	-	NC	DERMATOLOGICALS
ROSULA EMULSION	-	3	DERMATOLOGICALS
ROSULA GEL	-	3	DERMATOLOGICALS
ROSULA PAD	-	3	DERMATOLOGICALS
ROSULA WASH	-	NC	DERMATOLOGICALS
rosuvastatin tab 10mg (CRESTOR equiv) (QL= 1 tab/day)	QL	1	ANTIHYPERLIPIDEMICS
rosuvastatin tab 20mg (CRESTOR equiv) (QL= 1.5 tabs/day)	QL	1	ANTIHYPERLIPIDEMICS
rosuvastatin tab 40mg (CRESTOR equiv) (QL= 1 tab/day)	QL	1	ANTIHYPERLIPIDEMICS
rosuvastatin tab 5mg (CRESTOR equiv) (QL= 1 tab/day)	QL	1	ANTIHYPERLIPIDEMICS
ROWASA KIT	-	NC	GASTROINTESTINAL AGENTS - MISC.
ROXICET SOLN	-	3	ANALGESICS - OPIOID
ROXICODONE TAB	-	3	ANALGESICS - OPIOID
ROZEREM TAB (QL= 1 tab/day)	QL	3	HYPNOTICS/SEDATIVES/SLEEP DISORDEI AGENTS
RUBRACA TAB (QL= 4 tabs/day; Only available through Avella Pharmacy (877) 546-5779)	LD-PA-QL-SF	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
RYBIX ODT	-	NC	ANALGESICS - OPIOID
RYDAPT CAP	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
RYTARY CAP (Step Therapy requires trial of carbidopa/levodopa ER)	ST	3	ANTIPARKINSON AGENTS
RYTHMOL SR CAP	-	3	ANTIARRHYTHMICS
RYTHMOL TAB	-	3	ANTIARRHYTHMICS
RYVENT TAB	-	NC	ANTIHISTAMINES
SABRIL POWDER PACK	-	NC	ANTICONVULSANTS
SABRIL TAB (Only available through Walgreens 888-347-3416)	LD-PA	4	ANTICONVULSANTS
SAFYRAL TAB	-	NC	CONTRACEPTIVES
SAIZEN INJ, SEROSTIM INJ, ZORBTIVE INJ	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
SALAGEN TAB	-	3	MOUTH/THROAT/DENTAL AGENTS
SALEX SHAMPOO	-	3	DERMATOLOGICALS
salicylic acid shampoo (SALEX equiv)	-	1	DERMATOLOGICALS
salsalate tab (DISALCID equiv)	-	1	ANALGESICS - NONNARCOTIC
SAMSCA TAB	-	4	ENDOCRINE AND METABOLIC AGENTS - MISC.
SANCTURA TAB	-	3	URINARY ANTISPASMODICS
SANCTURA XR CAP	PA	3	URINARY ANTISPASMODICS
SANCUSO PATCH (QL= 4 patches/fill)	QL-SP	4	ANTIEMETICS
SANDIMMUNE CAP	-	4	ASSORTED CLASSES
SANDIMMUNE SOLN 100MG/ML	-	4	ASSORTED CLASSES

INF	NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS
LMSP	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program	LD	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	PA	Prior Authorization	QL	Quantity Limit
SP	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 M	SMKG	Smoking Cessation
	Available through Specialty Pharmacy Program	ST	Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary Cont.
Alphabetical Index
Last Updated 11/1/2017

Drug Name	Special Code	Tier	Category
SANDOSTATIN LAR INJ KIT	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
SANTYL OINT (QL= 90gm/30 days)	QL	2	DERMATOLOGICALS
SAPHRIS SL TAB (QL= 2 tabs/day)	PA-QL	3	ANTIPSYCHOTICS/ANTIMANIC AGENTS
SARAFEM TAB	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
SAVELLA PAK	-	2	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
SAVELLA TAB (QL= 2 tabs/day)	QL	2	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
scopolamine patch (TRANSDERM-SCOP equiv)	-	1	ANTIEMETICS
SEASONIQUE TAB	-	3	CONTRACEPTIVES
seb-prev cream (OVACE CREAM equiv)	-	1	DERMATOLOGICALS
SECONAL CAP	-	2	HYPNOTICS/SEDATIVES/SLEEP DISORDEI AGENTS
SECTRAL CAP	-	3	BETA BLOCKERS
SEEBRI NEOHALER CAP	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
selegiline cap (ELDEPRYL equiv)	-	1	ANTIPARKINSON AGENTS
selegiline tab (ELDEPRYL equiv)	-	1	ANTIPARKINSON AGENTS
selenium sulfide lotion	-	1	DERMATOLOGICALS
SELENIUM SULFIDE LOTION	-	NC	DERMATOLOGICALS
selenium sulfide shampoo (SELSEB equiv)	-	1	DERMATOLOGICALS
SELRX SHAMPOO 2.3%	-	NC	DERMATOLOGICALS
SELZENTRY SOLN	-	4	ANTIVIRALS
SELZENTRY TAB	-	4	ANTIVIRALS
SEMPREX-D CAP	-	3	COUGH/COLD/ALLERGY
SENSIPAR TAB	LMSP	4	ENDOCRINE AND METABOLIC AGENTS - MISC.
SEREVENT DISKUS INHALER	-	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
SERNIVO SPRAY	-	NC	DERMATOLOGICALS
SEROQUEL TAB	-	3	ANTIPSYCHOTICS/ANTIMANIC AGENTS
SEROQUEL XR TAB	-	NC	ANTIPSYCHOTICS/ANTIMANIC AGENTS
sertraline conc (ZOLOFT equiv)	-	1	ANTIDEPRESSANTS
sertraline tab (ZOLOFT equiv)	-	1	ANTIDEPRESSANTS
SEVELAMER CARBONATE TAB	-	2	GASTROINTESTINAL AGENTS - MISC.
sevelamer powder pak (RENVELA equiv)	-	1	GASTROINTESTINAL AGENTS - MISC.
sevelamer tab (RENVELA TAB equiv)	-	1	GASTROINTESTINAL AGENTS - MISC.
SFROWASA ENEMA	-	3	GASTROINTESTINAL AGENTS - MISC.
SHOHLs SOLN	-	2	GENITOURINARY AGENTS - MISCELLANEOUS
SIGNIFOR INJ (QL= 2 vials/day; Only available through Accredo 888-773-7376)	LD-PA-QL	4	ENDOCRINE AND METABOLIC AGENTS - MISC.
sildenafil tab (REVIATIO equiv)	PA	1	CARDIOVASCULAR AGENTS - MISC.
SILENOR TAB	-	NC	HYPNOTICS/SEDATIVES/SLEEP DISORDEI AGENTS
SILIQ INJ	-	NC	DERMATOLOGICALS
SILVADENE CREAM	-	3	DERMATOLOGICALS
silver sulfadiazine cream (SILVADENE CREAM equiv)	-	1	DERMATOLOGICALS
SILVERA PAD	-	NC	DERMATOLOGICALS

INF	NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS
LMSP	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program	LD	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	PA	Prior Authorization	QL	Quantity Limit
SP	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 M	SMKG	Smoking Cessation
	Available through Specialty Pharmacy Program	ST	Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary Cont.
Alphabetical Index
Last Updated 11/1/2017

Drug Name	Special Code	Tier	Category
SIMBRINZA OPHTH SUSP	-	2	OPHTHALMIC AGENTS
SIMCOR TAB	-	NC	ANTHYPERLIPIDEMICS
SIMPONI ARIA INJ	-	NC	ANALGESICS - ANTI-INFLAMMATORY
SIMPONI SC INJ (QL= 1 inj/28 days)	LMSP-PA-QL	4	ANALGESICS - ANTI-INFLAMMATORY
simvastatin tab (80mg is Not Covered)	-	1	ANTHYPERLIPIDEMICS
simvastatin tab 80mg (This strength excluded from coverage)	-	NC	ANTHYPERLIPIDEMICS
SINEMET CR TAB	-	3	ANTIPARKINSON AGENTS
SINEMET TAB	-	3	ANTIPARKINSON AGENTS
SINGULAIR CHEW TAB	-	3	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
SINGULAIR GRANULE PACK	-	3	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
SINGULAIR TAB	-	3	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
sirolimus tab (RAPAMUNE equiv)	-	4	ASSORTED CLASSES
SIRTURO TAB	-	NC	ANTIMYCOBACTERIAL AGENTS
SITAVIG TAB	-	NC	ANTIVIRALS
SIVEXTRO TAB (QL= 6 tabs/fill; Restricted to Infectious Disease Specialist)	QL-RS	2	ANTI-INFECTIVE AGENTS - MISC.
SKELAXIN TAB	-	3	MUSCULOSKELETAL THERAPY AGENTS
SKELID TAB	-	3	ENDOCRINE AND METABOLIC AGENTS - MISC.
SKLICE LOTION (QL= 1 tube/fill)	PA-QL	3	DERMATOLOGICALS
SLO-NIACIN TAB	OTC	3	VITAMINS
smz/tmp (DS) tab (BACTRIM DS equiv)	-	1	ANTI-INFECTIVE AGENTS - MISC.
smz/tmp susp (BACTRIM, SEPTRA equiv)	-	1	ANTI-INFECTIVE AGENTS - MISC.
sodium chloride 0.9% irr soln	-	1	GENITOURINARY AGENTS - MISCELLANEOUS
sodium chloride inj	M	M	MINERALS & ELECTROLYTES
sodium chloride neb soln (HYPER-SAL equiv)	-	1	COUGH/COLD/ALLERGY
sodium citrate/citric acid soln (BICITRA equiv)	-	1	GENITOURINARY AGENTS - MISCELLANEOUS
sodium fluoride cream (PREVIDENT equiv) (Covered at \$0 for members 5 years or younger; All other members covered at generic copay)	-	\$0	MOUTH/THROAT/DENTAL AGENTS
sodium fluoride gel (PREVIDENT equiv)	-	1	MOUTH/THROAT/DENTAL AGENTS
SODIUM FLUORIDE LOZENGE (Covered at \$0 for members 5 years or younger; All other members covered at generic copay)	-	\$0	MINERALS & ELECTROLYTES
sodium fluoride paste (PREVIDENT equiv)	-	1	MOUTH/THROAT/DENTAL AGENTS
sodium fluoride rinse (PREVIDENT equiv)	-	1	MOUTH/THROAT/DENTAL AGENTS
sodium fluoride soln (LURIDE equiv) (Covered at \$0 for members 5 years or younger; All other members covered at generic copay)	-	\$0	MINERALS & ELECTROLYTES
SODIUM FLUORIDE TAB (Covered at \$0 for members 5 years or younger; All other members covered at generic copay)	-	\$0	MINERALS & ELECTROLYTES
sodium fluoride tab (LURIDE equiv) (Covered at \$0 for members 5 years or younger; All other members covered at generic copay)	-	\$0	MINERALS & ELECTROLYTES
sodium fluoride/potassium nitrate paste (PREVIDENT equiv)	-	1	MOUTH/THROAT/DENTAL AGENTS
sodium phenylbutyrate powder (BUPHENYL equiv)	KMSP	1	ENDOCRINE AND METABOLIC AGENTS - MISC.
sodium phenylbutyrate tab (BUPHENYL equiv)	KMSP	4	ENDOCRINE AND METABOLIC AGENTS - MISC.
sodium polystyrene powder (KAYEXALATE equiv)	-	1	ASSORTED CLASSES
sodium polystyrene susp (SPS equiv)	-	1	ASSORTED CLASSES

INF	NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS
LMSP	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program	LD	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	PA	Prior Authorization	QL	Quantity Limit
SP	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 M	SMKG	Smoking Cessation
	Available through Specialty Pharmacy Program	ST	Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary Cont.
Alphabetical Index
Last Updated 11/1/2017

Drug Name	Special Code	Tier	Category
sodium sulfacetamide gel (OVACE PLUS equiv)	-	1	DERMATOLOGICALS
sodium sulfacetamide lotion (KLARON equiv)	-	1	DERMATOLOGICALS
sodium sulfacetamide shampoo (OVACE equiv)	-	1	DERMATOLOGICALS
sodium sulfacetamide wash (OVACE WASH equiv)	-	1	DERMATOLOGICALS
sodium sulfacetamide/sulfur cream (PLEXION SCT equiv)	-	1	DERMATOLOGICALS
SODIUM SULFACETAMIDE/SULFUR EMULSION	-	1	DERMATOLOGICALS
sodium sulfacetamide/sulfur emulsion (ROSAC WASH equiv)	-	1	DERMATOLOGICALS
sodium sulfacetamide/sulfur emulsion (ROSULA equiv)	-	1	DERMATOLOGICALS
sodium sulfacetamide/sulfur foam (CLARIFOAM EF equiv)	-	1	DERMATOLOGICALS
sodium sulfacetamide/sulfur gel (ROSULA equiv)	-	1	DERMATOLOGICALS
sodium sulfacetamide/sulfur lotion (SULFACET R equiv)	-	1	DERMATOLOGICALS
SODIUM SULFACETAMIDE/SULFUR LOTION	-	2	DERMATOLOGICALS
sodium sulfacetamide/sulfur pad (PLEXION CLEANSING CLOTH equiv)	-	1	DERMATOLOGICALS
sodium sulfacetamide/sulfur susp (SUMAXIN equiv)	-	1	DERMATOLOGICALS
sodium sulfacetamide/sulfur wash (SUMAXIN equiv)	-	1	DERMATOLOGICALS
sodium sulfacetamide/sunscreen kit (SUMADEN XLT equiv)	-	NC	DERMATOLOGICALS
sodium sulfacetamide/urea pad (ROSULA equiv)	-	1	DERMATOLOGICALS
SOLAICE PATCH	-	NC	DERMATOLOGICALS
SOLARAZE GEL	PA	3	DERMATOLOGICALS
SOLARCAINE EXTRA GEL	-	3	DERMATOLOGICALS
SOLIQUA INJ	-	NC	ANTIDIABETICS
SOMA TAB	-	3	MUSCULOSKELETAL THERAPY AGENTS
SOMA TAB 250MG	-	NC	MUSCULOSKELETAL THERAPY AGENTS
SOMATULINE INJ	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
SOMAVERT INJ (Only available through Walgreens 888-347-3416)	LD-PA	4	ENDOCRINE AND METABOLIC AGENTS - MISC.
SOMNOTE CAP	-	3	HYPNOTICS/SEDATIVES/SLEEP DISORDEI AGENTS
SONATA CAP	-	3	HYPNOTICS/SEDATIVES/SLEEP DISORDEI AGENTS
SORIATANE CAP	KMSP	4	DERMATOLOGICALS
SORIATANE CK KIT	KMSP	2	DERMATOLOGICALS
SORILUX FOAM	-	3	DERMATOLOGICALS
sotalol AF tab (BETAPACE AF equiv)	-	1	BETA BLOCKERS
sotalol tab (BETAPACE equiv)	-	1	BETA BLOCKERS
SOTYLIZE SOLN	-	NC	BETA BLOCKERS
SOVALDI TAB	-	NC	ANTIVIRALS
SPECTRACEF TAB	-	3	CEPHALOSPORINS
SPINOSAD SUSP (QL= 1 bottle/fill)	QL	2	DERMATOLOGICALS
SPIRIVA HANDIHALER (For use with Handihaler device)	PA	3	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
SPIRIVA RESPIMAT INHALER	PA	3	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
spironolactone tab (ALDACTONE equiv)	-	1	DIURETICS
spironolactone/hydrochlorothiazide tab (ALDACTAZIDE equiv)	-	1	DIURETICS
SPORANOX CAP	PA	3	ANTIFUNGALS
SPORANOX SOLN	PA	3	ANTIFUNGALS
SPRITAM TAB	-	NC	ANTICONVULSANTS
SPRIX NASAL SPRAY	-	NC	ANALGESICS - ANTI-INFLAMMATORY

INF	NC =Not Covered		generic =small letters	LD	BRANDS =CAPITAL LETTERS
LMSP	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program	LD	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	PA	Prior Authorization	QL	Quantity Limit
SP	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 M	SMKG	Smoking Cessation
	Available through Specialty Pharmacy Program	ST	Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary Cont.
Alphabetical Index
Last Updated 11/1/2017

Drug Name	Special Code	Tier	Category
SPRYCEL TAB	KMSP-PA-SF	3	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
SSKI SOLN	-	2	MINERALS & ELECTROLYTES
STAMARIL INJ	-	NC	VACCINES
STARLIX TAB	-	3	ANTIDIABETICS
stavudine cap (ZERIT equiv)	-	1	ANTIVIRALS
stavudine soln (ZERIT equiv)	-	1	ANTIVIRALS
STAVZOR CAP	-	NC	ANTICONVULSANTS
STAXYN ODT (QL= 6 tabs/30 days)	QL	2	CARDIOVASCULAR AGENTS - MISC.
STELARA INJ	-	NC	DERMATOLOGICALS
STENDRA TAB (QL= 6 tabs/30 days)	QL	2	CARDIOVASCULAR AGENTS - MISC.
STIMATE NASAL SOLN	KMSP	2	ENDOCRINE AND METABOLIC AGENTS - MISC.
STIOLTO INHALER	-	3	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
STIVARGA TAB (QL= 4 tabs/day)	MSP-PA-QL-SF	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
STRATTERA CAP	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
STRENSIQ INJ (Only available through PantherRx Pharmacy 855-726-8479)	LD-PA	4	ENDOCRINE AND METABOLIC AGENTS - MISC.
STRIBILD TAB	-	4	ANTIVIRALS
STRIVERDI RESPIMAT INHALER (QL= 1 inhaler/30 days)	QL	3	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
STROMEKTOL TAB	-	3	ANTHELMINTICS
STROVITE TAB	-	3	MULTIVITAMINS
SUBOXONE SL FILM	-	2	ANALGESICS - OPIOID
SUBOXONE SL TAB	-	NC	ANALGESICS - OPIOID
SUBSYS SPRAY	-	NC	ANALGESICS - OPIOID
SUCLEAR KIT	-	NC	LAXATIVES
SUCRAID SOLN	-	NC	DIGESTIVE AIDS
sucralfate tab (CARAFATE equiv)	-	1	ULCER DRUGS
SULAR TAB	-	3	CALCIUM CHANNEL BLOCKERS
sulfacetamide sodium ophth soln (BLEPH-10 equiv)	-	1	OPHTHALMIC AGENTS
sulfacetamide sodium/prednisolone ophth soln (VASOCIDIN equiv)	-	1	OPHTHALMIC AGENTS
SULFADIAZINE TAB	-	1	SULFONAMIDES
SULFAMYLON CREAM	-	2	DERMATOLOGICALS
sulfasalazine EC tab (AZULFIDINE equiv)	-	1	GASTROINTESTINAL AGENTS - MISC.
sulfasalazine tab (AZULFIDINE equiv)	-	1	GASTROINTESTINAL AGENTS - MISC.
sulindac tab (CLINORIL equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
SUMADAN KIT	-	NC	DERMATOLOGICALS
SUMADEN XLT KIT	-	NC	DERMATOLOGICALS
sumatriptan inj (IMITREX equiv) (QL= 4 inj/fill, 2 fills/30 days)	QL	1	MIGRAINE PRODUCTS
SUMATRIPTAN INJ 6MG/0.5ML (QL= 4 inj/fill, 2 fills/30 days)	QL	2	MIGRAINE PRODUCTS
sumatriptan nasal spray (IMITREX, SUMATRIPTAN equiv) (QL= 6 sprays/fill, 2 fills/30 days)	QL	1	MIGRAINE PRODUCTS
sumatriptan tab (IMITREX equiv) (QL= 9 tabs/fill, 2 fills/30 days)	QL	1	MIGRAINE PRODUCTS
sumatriptan vial inj (IMITREX equiv) (QL= 5 inj/fill, 2 fills/30 days)	QL	1	MIGRAINE PRODUCTS
SUMAVEL DOSEPRO INJ	-	NC	MIGRAINE PRODUCTS
SUMAXIN PAD	-	3	DERMATOLOGICALS

INF	NC =Not Covered	KMSP	generic =small letters	LD	BRANDS =CAPITAL LETTERS
LMSP	Infertility	M	Kroger Mandatory Specialty Pharmacy Program	MSP	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	PA	Medical Benefit	QL	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	SF	Prior Authorization	SMKG	Quantity Limit
SP	Restricted to Specialist	ST	Limited to Two 15 Day Fills per Month for the First 3 Months	VAC	Smoking Cessation
	Available through Specialty Pharmacy Program		Step Therapy		Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary Cont.
Alphabetical Index
Last Updated 11/1/2017

Drug Name	Special Code	Tier	Category
SUMAXIN TS SUSP	-	3	DERMATOLOGICALS
SUMAXIN WASH	-	3	DERMATOLOGICALS
SUPRAX CAP	-	3	CEPHALOSPORINS
SUPRAX CHEW TAB	-	3	CEPHALOSPORINS
SUPRAX SUSP	-	3	CEPHALOSPORINS
SUPRAX SUSP 500MG/5ML	-	3	CEPHALOSPORINS
SUPRAX TAB	-	3	CEPHALOSPORINS
SUPREP SOLN (Step therapy requires trial of MOVIPREP)	ST	3	LAXATIVES
SURMONTIL CAP	-	3	ANTIDEPRESSANTS
SUSTIVA CAP	-	4	ANTIVIRALS
SUSTIVA TAB	-	4	ANTIVIRALS
SUSTOL INJ	-	NC	ANTIEMETICS
SUTENT CAP	KMSP-PA-SF	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
SUTTAR SF SYRUP	-	3	COUGH/COLD/ALLERGY
SYLATRON INJ	MSP-PA	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
SYMAX DUOTAB	-	3	ULCER DRUGS
SYMBICORT INHALER	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
SYMBYAX CAP	-	3	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
SYMLINPEN INJ	-	NC	ANTIDIABETICS
SYMPROIC TAB	-	NC	GASTROINTESTINAL AGENTS - MISC.
SYNAREL NASAL SOLN	KMSP	4	ENDOCRINE AND METABOLIC AGENTS - MISC.
SYNDROS SOLN	-	NC	ANTIEMETICS
SYNERA PATCH	-	3	DERMATOLOGICALS
SYNJARDY TAB (QL= 2 tabs/day)	QL	2	ANTIDIABETICS
SYNJARDY XR TAB 10-1000MG, 25-1000MG (QL= 1 tab/day)	QL	2	ANTIDIABETICS
SYNJARDY XR TAB 5-1000MG, 12.5-1000MG (QL= 2 tabs/day)	QL	2	ANTIDIABETICS
SYNRIBO INJ	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
SYNTHROID TAB	-	1	THYROID AGENTS
SYNVEXIA TC CREAM	-	NC	DERMATOLOGICALS
SYPRINE CAP	KMSP-PA	4	ASSORTED CLASSES
TABLOID TAB	-	2	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
TACLONEX OINT	-	3	DERMATOLOGICALS
TACLONEX SCALP SUSP	-	3	DERMATOLOGICALS
tacrolimus cap (PROGRAF equiv)	-	4	ASSORTED CLASSES
tacrolimus oint (PROTOPIC OINT equiv)	-	1	DERMATOLOGICALS
TAFINLAR CAP (QL= 4 caps/day)	KMSP-PA-QL-SF	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
TAGAMET TAB	-	3	ULCER DRUGS
TAGRISSO TAB (QL= 1 tab/day; Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-QL-SF	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
TALTZ INJ	-	NC	DERMATOLOGICALS
TAMBOCOR TAB	-	3	ANTIARRHYTHMICS
TAMIFLU CAP (QL= 10 caps/fill)	QL	3	ANTIVIRALS

INF	NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS
LMSP	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program	LD	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	PA	Prior Authorization	QL	Quantity Limit
SP	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 M	SMKG	Smoking Cessation
	Available through Specialty Pharmacy Program	ST	Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary Cont.
Alphabetical Index
Last Updated 11/1/2017

Drug Name	Special Code	Tier	Category
TAMIFLU CAP 30MG (QL= 20 caps/fill)	QL	3	ANTIVIRALS
TAMIFLU SUSP 6MG/ML (QL= 250ml/fill)	QL	2	ANTIVIRALS
tamoxifen tab (NOLVADEX equiv) (Covered at \$0 for women 35 years or older; All other members covered at generic copay)	-	\$0	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
tamsulosin cap (FLOMAX equiv)	-	1	GENITOURINARY AGENTS - MISCELLANEOUS
TANZEUM INJ	-	NC	ANTIDIABETICS
TAPAZOLE TAB	-	3	THYROID AGENTS
TARCEVA TAB	KMSP-PA-SF	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
TARGRETIN GEL	KMSP	4	DERMATOLOGICALS
TARKA TAB	-	3	ANTIHYPERTENSIVES
TASIGNA CAP	KMSP-PA-SF	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
TASMAR TAB	-	3	ANTIPARKINSON AGENTS
TAYTULLA CAP	-	NC	CONTRACEPTIVES
tazarotene cream (TAZORAC equiv)	-	1	DERMATOLOGICALS
TAZORAC CREAM	-	3	DERMATOLOGICALS
TAZORAC GEL	-	3	DERMATOLOGICALS
TECFIDERA CAP	LMSP	4	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
TECFIDERA STARTER PACK	LMSP	4	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
TECHNIVIE TAB	-	NC	ANTIVIRALS
TEGRETOL CHEW TAB	-	3	ANTICONVULSANTS
TEGRETOL SUSP	-	3	ANTICONVULSANTS
TEGRETOL TAB	-	3	ANTICONVULSANTS
TEGRETOL XR TAB	-	3	ANTICONVULSANTS
TEKAMLO TAB	-	3	ANTIHYPERTENSIVES
TEKTURNA HCT TAB	-	3	ANTIHYPERTENSIVES
TEKTURNA TAB	-	3	ANTIHYPERTENSIVES
telmisartan tab (MICARDIS equiv)	-	1	ANTIHYPERTENSIVES
telmisartan/amlodipine tab (TWINSTA equiv)	-	1	ANTIHYPERTENSIVES
telmisartan/hydrochlorothiazide tab (MICARDIS HCT equiv)	-	NC	ANTIHYPERTENSIVES
temazepam cap 15mg (RESTORIL equiv)	-	1	HYPNOTICS/SEDATIVES/SLEEP DISORDEI AGENTS
temazepam cap 22.5mg (RESTORIL equiv)	-	1	HYPNOTICS/SEDATIVES/SLEEP DISORDEI AGENTS
temazepam cap 30mg (RESTORIL equiv)	-	1	HYPNOTICS/SEDATIVES/SLEEP DISORDEI AGENTS
temazepam cap 7.5mg (RESTORIL equiv)	-	1	HYPNOTICS/SEDATIVES/SLEEP DISORDEI AGENTS
TEMOVATE CREAM	PA	3	DERMATOLOGICALS
TEMOVATE GEL	PA	3	DERMATOLOGICALS
TEMOVATE OINT	PA	3	DERMATOLOGICALS
TEMOVATE SOLN	PA	3	DERMATOLOGICALS
TEMOVATE-E CREAM	PA	3	DERMATOLOGICALS
temozolomide cap (TEMODAR equiv)	KMSP	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
TENEX TAB	-	3	ANTIHYPERTENSIVES
TENORETIC TAB	-	3	ANTIHYPERTENSIVES

INF	NC =Not Covered		generic =small letters	LD	BRANDS =CAPITAL LETTERS
LMSP	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program	MSP	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	QL	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	PA	Prior Authorization	SMKG	Quantity Limit
SP	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 N	VAC	Smoking Cessation
	Available through Specialty Pharmacy Program	ST	Step Therapy		Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary Cont.
Alphabetical Index
Last Updated 11/1/2017

Drug Name	Special Code	Tier	Category
TENORMIN TAB	-	3	BETA BLOCKERS
TERAZOL CREAM	-	3	VAGINAL PRODUCTS
TERAZOL SUPP	-	3	VAGINAL PRODUCTS
terazosin cap (HYTRIN equiv)	-	1	ANTIHYPERTENSIVES
terbinafine tab (LAMISIL equiv)	-	1	ANTIFUNGALS
terbutaline sulfate tab (BRETHINE equiv)	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
terconazole cream (TERAZOL equiv)	-	1	VAGINAL PRODUCTS
terconazole supp (TERAZOL equiv)	-	1	VAGINAL PRODUCTS
TESSALON CAP	-	3	COUGH/COLD/ALLERGY
TEST STRIP (all other test strips)	OTC	NC	DIAGNOSTIC PRODUCTS
testosterone cypionate inj (DEPO-TESTOSTERONE equiv)	-	1	ANDROGENS-ANABOLIC
testosterone gel 1% 25mg (ANDROGEL equiv) (QL= 1 packet/day)	PA-QL	1	ANDROGENS-ANABOLIC
TESTOSTERONE GEL 1% 25MG (QL= 1 packet/day)	PA-QL	2	ANDROGENS-ANABOLIC
testosterone gel 1% 50mg (ANDROGEL equiv) (QL= 2 packets/day)	PA-QL	1	ANDROGENS-ANABOLIC
TESTOSTERONE GEL 1% 50MG (QL= 2 packets/day)	PA-QL	2	ANDROGENS-ANABOLIC
testosterone gel 1% pump (ANDROGEL equiv) (QL= 4 bottles/30 days)	PA-QL	1	ANDROGENS-ANABOLIC
TESTOSTERONE GEL PUMP (QL= 4 bottles/30 days)	PA-QL	2	ANDROGENS-ANABOLIC
TESTOSTERONE GEL, VOGELXO GEL (QL= 2 packets/day)	PA-QL	3	ANDROGENS-ANABOLIC
testosterone soln (AXIRON equiv) (QL= 2 bottles/30 days)	PA-QL	1	ANDROGENS-ANABOLIC
tetrabenazine tab (XENAZINE equiv)	LMSP-PA	4	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
tetracycline cap	-	1	TETRACYCLINES
TETRACYCLINE CAP	-	3	TETRACYCLINES
TEVETEN HCT TAB	-	3	ANTIHYPERTENSIVES
TEVETEN TAB	-	3	ANTIHYPERTENSIVES
TEXACORT SOLN	-	3	DERMATOLOGICALS
THALOMID CAP	KMSP-PA	4	ASSORTED CLASSES
THEO-24 CAP	-	3	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
theophylline CR tab (QUIBRON-T equiv)	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
theophylline ER tab (UNIPHYL equiv)	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
theophylline soln	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
THIOLA TAB	-	NC	GENITOURINARY AGENTS - MISCELLANEOUS
thioridazine tab (MELLARIL equiv)	-	1	ANTIPSYCHOTICS/ANTIMANIC AGENTS
thiothixene cap (NAVANE equiv)	-	1	ANTIPSYCHOTICS/ANTIMANIC AGENTS
THYROLAR TAB	-	2	THYROID AGENTS
tiagabine tab (GABITRIL equiv)	-	1	ANTICONVULSANTS
TIAZAC CAP	-	3	CALCIUM CHANNEL BLOCKERS
TICANASE PAK	-	NC	NASAL AGENTS - SYSTEMIC AND TOPICAL
TICLOPIDINE TAB	-	1	HEMATOLOGICAL AGENTS - MISC.
ticlopidine tab (TICLID equiv)	-	1	HEMATOLOGICAL AGENTS - MISC.
TIGAN CAP	-	3	ANTIEMETICS
TIKOSYN CAP	-	3	ANTIARRHYTHMICS
TIMENTIN INJ	M	M	PENICILLINS
timolol maleate ophth gel (TIMOPTIC-XE equiv)	-	1	OPHTHALMIC AGENTS

INF	NC =Not Covered		generic =small letters	LD	BRANDS =CAPITAL LETTERS
LMSP	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program	MSP	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	QL	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	PA	Prior Authorization	SMKG	Quantity Limit
SP	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 M	VAC	Smoking Cessation
	Available through Specialty Pharmacy Program	ST	Step Therapy		Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary Cont.
Alphabetical Index
Last Updated 11/1/2017

Drug Name	Special Code	Tier	Category
timolol maleate ophth soln (TIMOPTIC equiv)	-	1	OPHTHALMIC AGENTS
timolol maleate tab (BLOCADREN equiv)	-	1	BETA BLOCKERS
TIMOPTIC OCUDOSE OPHTH SOLN	-	3	OPHTHALMIC AGENTS
TIMOPTIC OPHTH SOLN	-	3	OPHTHALMIC AGENTS
TIMOPTIC-XE OPHTH GEL	-	3	OPHTHALMIC AGENTS
TINDAMAX TAB	-	3	ANTI-INFECTIVE AGENTS - MISC.
tinidazole tab (TINDAMAX equiv)	-	1	ANTI-INFECTIVE AGENTS - MISC.
TIROSINT CAP	-	3	THYROID AGENTS
TIVICAY TAB (QL= 2 tabs/day)	QL	4	ANTIVIRALS
tizanidine cap (ZANAFLEX equiv)	-	1	MUSCULOSKELETAL THERAPY AGENTS
TIZANIDINE COMFORT KIT	-	NC	MUSCULOSKELETAL THERAPY AGENTS
tizanidine tab (ZANAFLEX equiv)	-	1	MUSCULOSKELETAL THERAPY AGENTS
TOBI NEB SOLN	-	NC	AMINOGLYCOSIDES
TOBI PODHALER (Restricted to Infectious Disease or Pulmonology Specialist)	KMSP-RS	4	AMINOGLYCOSIDES
TOBRADEX OPHTH OINT	-	2	OPHTHALMIC AGENTS
TOBRADEX OPHTH SOLN	-	3	OPHTHALMIC AGENTS
TOBRADEX ST OPHTH SUSP	-	3	OPHTHALMIC AGENTS
tobramycin neb soln (TOBI equiv) (Restricted to Infectious Disease or Pulmonology Specialist)	KMSP-RS	4	AMINOGLYCOSIDES
tobramycin ophth soln (TOBEX equiv)	-	1	OPHTHALMIC AGENTS
tobramycin/dexamethasone ophth soln (TOBRADEX equiv)	-	1	OPHTHALMIC AGENTS
TOBEX OPHTH OINT	-	3	OPHTHALMIC AGENTS
TOBEX OPHTH SOLN	-	3	OPHTHALMIC AGENTS
TODAY SPONGE	OTC	\$0	VAGINAL PRODUCTS
TOFRANIL PM CAP	-	3	ANTIDEPRESSANTS
TOFRANIL TAB	-	3	ANTIDEPRESSANTS
tolazamide tab (TOLINASE equiv)	-	1	ANTIDIABETICS
TOLBUTAMIDE TAB	-	2	ANTIDIABETICS
tolcapone tab (TASMAR equiv)	-	1	ANTIPARKINSON AGENTS
TOLMETIN CAP	-	1	ANALGESICS - ANTI-INFLAMMATORY
tolmetin cap (TOLECTIN DS equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
TOLMETIN TAB	-	3	ANALGESICS - ANTI-INFLAMMATORY
tolterodine SR cap (DETROL LA equiv)	-	1	URINARY ANTISPASMODICS
tolterodine tab (DETROL equiv)	-	1	URINARY ANTISPASMODICS
TOPAMAX SPRINKLE CAP	-	3	ANTICONVULSANTS
TOPAMAX TAB	-	3	ANTICONVULSANTS
TOPICORT CREAM	-	3	DERMATOLOGICALS
TOPICORT GEL	-	NC	DERMATOLOGICALS
TOPICORT OINT	-	NC	DERMATOLOGICALS
topiramate sprinkle cap (TOPAMAX equiv)	-	1	ANTICONVULSANTS
topiramate tab (TOPAMAX equiv)	-	1	ANTICONVULSANTS
TOPROL XL TAB	-	3	BETA BLOCKERS
torsemide tab (DEMADEX equiv)	-	1	DIURETICS
TOUJEO SOLOSTAR INJ	-	NC	ANTIDIABETICS
TOVIAZ TAB	PA	3	URINARY ANTISPASMODICS
TRACLEER TAB (QL= 2 tabs/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	4	CARDIOVASCULAR AGENTS - MISC.
TRADJENTA TAB (QL= 1 tab/day)	PA-QL	3	ANTIDIABETICS
TRAMADOL COMPOUND KIT	-	NC	DERMATOLOGICALS
TRAMADOL ER CAP	-	NC	ANALGESICS - OPIOID

INF	NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS
LMSP	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program	LD	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	PA	Prior Authorization	QL	Quantity Limit
SP	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 M	SMKG	Smoking Cessation
	Available through Specialty Pharmacy Program	ST	Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary Cont.
Alphabetical Index
Last Updated 11/1/2017

Drug Name	Special Code	Tier	Category
tramadol ER tab (ULTRAM ER equiv)	-	1	ANALGESICS - OPIOID
tramadol tab (ULTRAM equiv)	-	1	ANALGESICS - OPIOID
tramadol/acetaminophen tab (ULTRACET equiv)	-	1	ANALGESICS - OPIOID
TRANDATE TAB	-	3	BETA BLOCKERS
trandolapril tab (MAVIK equiv)	-	1	ANTIHYPERTENSIVES
trandolapril/verapamil ER tab (TARKA equiv)	-	1	ANTIHYPERTENSIVES
tranexamic acid inj (CYKLOKAPRON equiv)	M	M	HEMOSTATICS
tranexamic acid tab (LYSTEDA equiv)	-	1	HEMOSTATICS
TRANSDERM-SCOP PATCH	-	3	ANTIEMETICS
TRANXENE-T TAB	-	3	ANTIANKXIETY AGENTS
tranylcypromine tab (PARNATE equiv)	-	1	ANTIDEPRESSANTS
TRAVATAN Z OPHTH SOLN (QL= 5ml/30 days)	QL	2	OPHTHALMIC AGENTS
trazodone tab (DESYREL equiv)	-	1	ANTIDEPRESSANTS
trazodone tab 300mg (DESYREL equiv)	-	NC	ANTIDEPRESSANTS
TRECTOR TAB	PA	3	ANTIMYCOBACTERIAL AGENTS
TRELEGY ELLIPTA INHALER	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
TRELSTAR INJ	M	M	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
TREMFYA INJ	-	NC	DERMATOLOGICALS
TRENTAL TAB	-	3	HEMATOLOGICAL AGENTS - MISC.
TRESIBA INJ	-	NC	ANTIDIABETICS
tretinoin cap (VESANOID equiv)	KMSP	4	ANTINEOPLASTICS
tretinoin cream (Acne Only – members age 26 or older require Prior Authorization)	PA	1	DERMATOLOGICALS
tretinoin gel (RETIN-A GEL equiv) (Acne Only – members age 26 or older require Prior Authorization)	PA	1	DERMATOLOGICALS
TRETIN-X CREAM	PA	3	DERMATOLOGICALS
TREXALL TAB	-	2	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
TREXIMET TAB	-	NC	MIGRAINE PRODUCTS
triamcinolone cream	-	1	DERMATOLOGICALS
triamcinolone in orabase paste (KENALOG/ORABASE equiv)	-	1	MOUTH/THROAT/DENTAL AGENTS
triamcinolone lotion	-	1	DERMATOLOGICALS
triamcinolone nasal spray (NASACORT equiv) (QL= 2 bottles/fill)	QL	1	NASAL AGENTS - SYSTEMIC AND TOPICAL
triamcinolone oint	-	1	DERMATOLOGICALS
triamcinolone OTC nasal spray (NASACORT equiv) (QL= 2 bottles/fill)	OTC-QL	1	NASAL AGENTS - SYSTEMIC AND TOPICAL
triamcinolone spray (KENALOG equiv)	-	1	DERMATOLOGICALS
triamterene/hydrochlorothiazide cap (DYAZIDE equiv)	-	1	DIURETICS
TRIAMTERENE/HYDROCHLOROTHIAZIDE CAP 50-25mg	-	2	DIURETICS
triamterene/hydrochlorothiazide tab (MAXZIDE equiv)	-	1	DIURETICS
TRIANEX OINT	-	NC	DERMATOLOGICALS
TRIAZOLAM TAB	-	1	HYPNOTICS/SEDATIVES/SLEEP DISORDEI AGENTS
triazolam tab (HALCION equiv)	-	1	HYPNOTICS/SEDATIVES/SLEEP DISORDEI AGENTS
TRIBENZOR TAB	-	NC	ANTIHYPERTENSIVES
tricitrates soln (POLYCITRA-LC equiv)	-	1	GENITOURINARY AGENTS - MISCELLANEOUS
tricon cap (TRINSICON equiv)	-	1	HEMATOPOIETIC AGENTS

INF	NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS
LMSP	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program	LD	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	PA	Prior Authorization	QL	Quantity Limit
SP	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 M	SMKG	Smoking Cessation
	Available through Specialty Pharmacy Program	ST	Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary Cont.
Alphabetical Index
Last Updated 11/1/2017

Drug Name	Special Code	Tier	Category
TRICOR TAB	-	3	ANTIHYPERLIPIDEMICS
trifluoperazine tab (STELAZINE equiv)	-	1	ANTIPSYCHOTICS/ANTIMANIC AGENTS
trifluridine ophth soln (VIROPTIC equiv)	-	1	OPHTHALMIC AGENTS
trihexyphenidyl elixir (ARTANE equiv)	-	1	ANTIPARKINSON AGENTS
trihexyphenidyl tab (ARTANE equiv)	-	1	ANTIPARKINSON AGENTS
tri-legest tab (ESTROSTEP FE equiv)	-	\$0	CONTRACEPTIVES
TRILEPTAL SUSP	-	2	ANTICONVULSANTS
TRILEPTAL TAB	-	3	ANTICONVULSANTS
TRILIPIX CAP	-	1	ANTIHYPERLIPIDEMICS
TRI-LUMA CREAM	-	NC	DERMATOLOGICALS
trilyte soln (NULYTELY equiv) (Covered at \$0 for members 50-75 years, all other members covered at generic copay; Limited to 2 fills/calendar year)	QL	\$0	LAXATIVES
trimethobenzamide cap (TIGAN equiv)	-	1	ANTIEMETICS
trimethoprim tab (PROLOPRIM equiv)	-	1	ANTI-INFECTIVE AGENTS - MISC.
trimipramine cap (SURMONTIL equiv)	-	1	ANTIDEPRESSANTS
tri-nessa (LO) tab (ORTHO TRI-CYCLEN (LO) equiv)	-	\$0	CONTRACEPTIVES
TRI-NORINYL TAB	-	3	CONTRACEPTIVES
TRINTELLIX TAB (QL= 1 tab/day)	PA-QL	3	ANTIDEPRESSANTS
TRIUMEQ TAB	-	4	ANTIVIRALS
TRIZIVIR TAB	-	4	ANTIVIRALS
TROKENDI XR CAP	-	NC	ANTICONVULSANTS
tropicamide ophth soln (MYDRIACYL equiv)	-	1	OPHTHALMIC AGENTS
tospium chloride SR cap (SANCTURA XR equiv)	PA	1	URINARY ANTISPASMODICS
tospium tab (SANCTURA equiv)	-	1	URINARY ANTISPASMODICS
TRULANCE TAB	-	NC	GASTROINTESTINAL AGENTS - MISC.
TRULICITY INJ	-	NC	ANTIDIABETICS
TRUSOPT OPHTH SOLN	-	3	OPHTHALMIC AGENTS
TRUVADA TAB	PA	4	ANTIVIRALS
TUDORZA PRESSAIR INHALER	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
TUSNEL SYRUP	-	3	COUGH/COLD/ALLERGY
TUSSICAPS (QL= 20 caps/fill, 2 fills/30 days)	QL	3	COUGH/COLD/ALLERGY
tussigon tab (HYCODAN equiv)	-	1	COUGH/COLD/ALLERGY
TUSSIONEX SUSP (QL= 120ml/fill; 2 fills/30 days)	QL	3	COUGH/COLD/ALLERGY
TUSSI-ORGANI SYRUP (QL= 240ml/fill)	QL	3	COUGH/COLD/ALLERGY
TUSSI-PRES LIQUID	-	NC	COUGH/COLD/ALLERGY
TUZISTRA XR SUSP	-	NC	COUGH/COLD/ALLERGY
TWYNSTA TAB	-	3	ANTIHYPERTENSIVES
TYBOST TAB	-	NC	ANTIVIRALS
TYKERB TAB	KMSP-PA	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
TYLENOL/CODEINE TAB	-	3	ANALGESICS - OPIOID
TYMLOS INJ	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
TYVASO INH SOLN (QL= 1 ampule/day; Only available through Accredo 888-773-7376)	LD-PA-QL	4	CARDIOVASCULAR AGENTS - MISC.
TYZEKA TAB	KMSP-PA	4	ANTIVIRALS
TYZINE NASAL SOLN	-	3	NASAL AGENTS - SYSTEMIC AND TOPICAL
UCERIS RECTAL FOAM	PA	3	ANORECTAL AGENTS
UCERIS TAB (QL= 1 tab/day)	PA-QL	3	CORTICOSTEROIDS

INF	NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS
LMSP	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program	LD	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	PA	Prior Authorization	QL	Quantity Limit
SP	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 Months	SMKG	Smoking Cessation
	Available through Specialty Pharmacy Program	ST	Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary Cont.
Alphabetical Index
Last Updated 11/1/2017

Drug Name	Special Code	Tier	Category
U-CORT CREAM	-	2	DERMATOLOGICALS
ULESFIA LOTION (QL= 4 bottles/fill)	QL	3	DERMATOLOGICALS
ULORIC TAB (Step Therapy requires trial of allopurinol)	ST	2	GOUT AGENTS
ULTRACET TAB	-	3	ANALGESICS - OPIOID
ULTRAM ER TAB	-	3	ANALGESICS - OPIOID
ULTRAM TAB	-	3	ANALGESICS - OPIOID
ULTRAVATE CREAM	-	3	DERMATOLOGICALS
ULTRAVATE LOTION	-	3	DERMATOLOGICALS
ULTRAVATE OINT	-	3	DERMATOLOGICALS
ULTRAVATE PAC KIT	-	NC	DERMATOLOGICALS
ULTRESA CAP (Step Therapy requires trial of CREON)	ST	3	DIGESTIVE AIDS
UMECTA EMULSION	-	NC	DERMATOLOGICALS
UMECTA SUSP	-	NC	DERMATOLOGICALS
UNIPHYL TAB	-	3	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
UNIRETIC TAB	-	3	ANTIHYPERTENSIVES
UNIVASC TAB	-	3	ANTIHYPERTENSIVES
UPTRAVI TAB (QL= 2 tabs/day; Only available through Accredo 888-773-7376)	LD-PA-QL	4	CARDIOVASCULAR AGENTS - MISC.
URAMAXIN CREAM	-	NC	DERMATOLOGICALS
URAMAXIN GEL	-	NC	DERMATOLOGICALS
urea cream	-	NC	DERMATOLOGICALS
urea emulsion	-	NC	DERMATOLOGICALS
urea gel (URAMAXIN equiv)	-	NC	DERMATOLOGICALS
UREA NAIL KIT	-	NC	DERMATOLOGICALS
UREA SUSP	-	NC	DERMATOLOGICALS
urea susp 40% (UMECTA equiv)	-	NC	DERMATOLOGICALS
URECHOLINE TAB	-	3	URINARY ANTISPASMODICS
URELIEF PLUS TAB	-	NC	URINARY ANTISPASMODICS
UROCIT-K TAB	-	3	GENITOURINARY AGENTS - MISCELLANEOUS
UROQID #2 TAB	-	3	URINARY ANTI-INFECTIVES
UROXATRAL TAB	-	2	GENITOURINARY AGENTS - MISCELLANEOUS
URSO FORTE TAB	-	3	GASTROINTESTINAL AGENTS - MISC.
ursodiol cap (ACTIGALL equiv)	-	1	GASTROINTESTINAL AGENTS - MISC.
ursodiol tab (URSO (FORTE) equiv)	-	1	GASTROINTESTINAL AGENTS - MISC.
UTA cap	-	NC	URINARY ANTI-INFECTIVES
UTIBRON NEOHALER CAP	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
VAGIFEM TAB (QL= 8 tabs/28 days (18 tabs on first fill))	QL	3	VAGINAL PRODUCTS
valacyclovir tab (VALTREX equiv)	-	1	ANTIVIRALS
VALCHLOR GEL (QL= 4 tubes/30 days; Only available through Accredo 888-773-7376)	LD-PA-QL	4	DERMATOLOGICALS
VALCYTE SOLN	-	4	ANTIVIRALS
VALCYTE TAB	-	3	ANTIVIRALS
valganciclovir soln (VALCYTE equiv)	-	4	ANTIVIRALS
valganciclovir tab (VALCYTE equiv)	-	1	ANTIVIRALS
VALIUM TAB	-	3	ANTIANKXIETY AGENTS
valproate inj (DEPAICON equiv)	-	NC	ANTICONVULSANTS

INF	NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS
LMSP	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program	LD	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	PA	Prior Authorization	QL	Quantity Limit
SP	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 M	SMKG	Smoking Cessation
	Available through Specialty Pharmacy Program	ST	Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary Cont.
Alphabetical Index
Last Updated 11/1/2017

Drug Name	Special Code	Tier	Category
valproic acid cap (DEPAKENE equiv)	-	1	ANTICONVULSANTS
valproic acid syrup (DEPAKENE equiv)	-	1	ANTICONVULSANTS
valsartan tab (DIOVAN equiv)	-	1	ANTIHYPERTENSIVES
valsartan/hydrochlorothiazide tab (DIOVAN HCT equiv)	-	1	ANTIHYPERTENSIVES
VALTREX TAB	-	3	ANTIVIRALS
VALTURNA TAB	-	3	ANTIHYPERTENSIVES
VANOCOCIN CAP (QL= 56 caps/fill; Step Therapy requires trial of vancomycin soln)	QL-ST	3	ANTI-INFECTIVE AGENTS - MISC.
vancomycin cap (VANOCOCIN equiv) (QL= 56 caps/fill; Step Therapy requires trial of vancomycin soln)	QL-ST	1	ANTI-INFECTIVE AGENTS - MISC.
VANCOMYCIN SOLN KIT	-	1	ANTI-INFECTIVE AGENTS - MISC.
VANIQA CREAM	-	NC	DERMATOLOGICALS
VANOS CREAM	-	3	DERMATOLOGICALS
VANTIN TAB	-	3	CEPHALOSPORINS
VARUBI TAB (QL= 2 tabs/day; Restricted to Oncology or Hematology Specialist)	QL-RS	2	ANTIEMETICS
VASCEPA CAP	-	NC	ANTIHYPERLIPIDEMICS
VASERETIC TAB	-	3	ANTIHYPERTENSIVES
vasolex oint (XENADERM equiv)	-	NC	DERMATOLOGICALS
VASOTEC TAB	-	3	ANTIHYPERTENSIVES
VAXCHORA SUSP	-	NC	VACCINES
V-C FORTE CAP	-	3	MULTIVITAMINS
vcf vaginal gel (CONCEPTROL equiv)	OTC	\$0	VAGINAL PRODUCTS
VECTICAL OINT	-	3	DERMATOLOGICALS
VELPHORO CHEW TAB	-	3	GASTROINTESTINAL AGENTS - MISC.
VELTASSA POWDER	KMSP-PA	4	ASSORTED CLASSES
VELTIN GEL	-	3	DERMATOLOGICALS
VEMLIDY TAB	KMSP	4	ANTIVIRALS
VENCLEXTA STARTER PACK (Only available through Diplomat Pharmacy 877-977-9118)	LD-PA	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
VENCLEXTA TAB (Only available through Diplomat Pharmacy 877-977-9118)	LD-PA	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
VENELEX OINT	-	2	DERMATOLOGICALS
venlafaxine ER cap (EFFEXOR XR equiv)	-	1	ANTIDEPRESSANTS
venlafaxine ER tab	-	NC	ANTIDEPRESSANTS
venlafaxine tab (EFFEXOR equiv)	-	1	ANTIDEPRESSANTS
VENTAVIS INH SOLN (QL= 9 ampules/day; Only available through Accredo 888-773-7376)	LD-PA-QL	4	CARDIOVASCULAR AGENTS - MISC.
VENTOLIN HFA INHALER (QL= 2 inhalers/30 days)	QL	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
VERAMYST NASAL SPRAY (QL= 2 bottles/fill; Step Therapy requires trial of 2: flunisolide, fluticasone, triamcinolone or NASONEX)	QL-ST	3	NASAL AGENTS - SYSTEMIC AND TOPICAL
verapamil SR cap (VERELAN PM equiv)	-	1	CALCIUM CHANNEL BLOCKERS
verapamil SR cap (VERELAN SR equiv)	-	1	CALCIUM CHANNEL BLOCKERS
verapamil SR tab (CALAN SR, ISOPTIN SR equiv)	-	1	CALCIUM CHANNEL BLOCKERS
verapamil tab (CALAN equiv)	-	1	CALCIUM CHANNEL BLOCKERS
VERDESO FOAM	-	3	DERMATOLOGICALS
VEREGEN OINT	-	NC	DERMATOLOGICALS
VERELAN CAP	-	3	CALCIUM CHANNEL BLOCKERS
VERELAN PM CAP	-	3	CALCIUM CHANNEL BLOCKERS

INF	NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS
LMSP	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program	LD	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	PA	Prior Authorization	QL	Quantity Limit
SP	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 N	SMKG	Smoking Cessation
	Available through Specialty Pharmacy Program	ST	Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary Cont.
Alphabetical Index
Last Updated 11/1/2017

Drug Name	Special Code	Tier	Category
VERIPRED SOLN	-	3	CORTICOSTEROIDS
VERSACLOZ SUSP	-	NC	ANTIPSYCHOTICS/ANTIMANIC AGENTS
VERZENIO TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
VESICARE TAB	-	2	URINARY ANTISPASMODICS
VEXOL OPHTH SUSP	-	2	OPHTHALMIC AGENTS
VFEND SUSP (Restricted to Infectious Disease Specialist)	RS	3	ANTIFUNGALS
VFEND TAB (Restricted to Infectious Disease Specialist)	RS	3	ANTIFUNGALS
V-GO INJ KIT (QL= 1 kit/day)	QL	2	MEDICAL DEVICES AND SUPPLIES
VIAGRA TAB (QL= 6 tabs/30 days)	QL	2	CARDIOVASCULAR AGENTS - MISC.
VIBERZI TAB	-	NC	GASTROINTESTINAL AGENTS - MISC.
VIBRAMYCIN CAP	-	3	TETRACYCLINES
VIBRAMYCIN SUSP	-	3	TETRACYCLINES
VIBRAMYCIN SYRUP	-	3	TETRACYCLINES
VICOPROFEN TAB	-	3	ANALGESICS - OPIOID
VICTOZA INJ (QL= 9ml/30 days)	QL	2	ANTIDIABETICS
VICTRELIS CAP	MSP-PA-SF	4	ANTIVIRALS
VIDEX EC CAP	-	4	ANTIVIRALS
VIDEX SOLN	-	4	ANTIVIRALS
VIEKIRA XR TAB	-	NC	ANTIVIRALS
vigabatrin powder pack (SABRIL POWDER equiv) (Only available through Walgreens 888-347-3416)	LD-PA	4	ANTICONVULSANTS
VIGAMOX OPHTH SOLN	-	3	OPHTHALMIC AGENTS
VIIBRYD STARTER KIT	-	NC	ANTIDEPRESSANTS
VIIBRYD TAB	-	NC	ANTIDEPRESSANTS
VIMOVO TAB	-	NC	ANALGESICS - ANTI-INFLAMMATORY
VIMPAT SOLN	-	2	ANTICONVULSANTS
VIMPAT TAB (QL= 2 tabs/day)	QL	2	ANTICONVULSANTS
VIRACEPT POWDER	-	4	ANTIVIRALS
VIRACEPT TAB	-	4	ANTIVIRALS
VIRAMUNE SUSP	-	4	ANTIVIRALS
VIRAMUNE TAB	-	4	ANTIVIRALS
VIRAMUNE XR TAB (Step Therapy requires trial of nevirapine)	ST	4	ANTIVIRALS
VIREAD TAB	-	4	ANTIVIRALS
VIROPTIC OPHTH SOLN	-	3	OPHTHALMIC AGENTS
VISICOL TAB	-	3	LAXATIVES
VISTARIL CAP	-	3	ANTIANKXIETY AGENTS
VISTOGARD PAK	-	NC	ANTIDOTES
vitamin D cap (Rx covered Only)	-	1	VITAMINS
vitamin D cap 1000unit (Covered for members 65 years or older)	OTC	\$0	VITAMINS
vitamin D cap 400unit (Covered for members 65 years or older)	OTC	\$0	VITAMINS
VITAMIN D TAB 400UNIT (Covered for members 65 years or older)	OTC	\$0	VITAMINS
VITEKTA TAB	-	3	ANTIVIRALS
VIVACTIL TAB	-	3	ANTIDEPRESSANTS
VIVELLE-DOT PATCH	-	3	ESTROGENS
VIVITROL INJ	-	NC	ANTIDOTES
VIVLODEX CAP	-	NC	ANALGESICS - ANTI-INFLAMMATORY
VIVOTIF CAP (QL= 4 caps/fill)	QL-VAC	2	VACCINES
VOGELXO PUMP	-	NC	ANDROGENS-ANABOLIC
VOLTAREN GEL (QL= 5 tubes/fill)	QL	3	DERMATOLOGICALS

INF	NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS
LMSP	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program	LD	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	PA	Prior Authorization	QL	Quantity Limit
SP	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 N	SMKG	Smoking Cessation
	Available through Specialty Pharmacy Program	ST	Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary Cont.
Alphabetical Index
Last Updated 11/1/2017

Drug Name	Special Code	Tier	Category
VOLTAREN OPTH SOLN	-	3	OPHTHALMIC AGENTS
VOLTAREN TAB	-	3	ANALGESICS - ANTI-INFLAMMATORY
VOLTAREN XR TAB	-	3	ANALGESICS - ANTI-INFLAMMATORY
VOPAC 5 CREAM	-	NC	DERMATOLOGICALS
VOPAC CREAM	-	NC	DERMATOLOGICALS
VOPAC GB CREAM	-	NC	DERMATOLOGICALS
voriconazole susp (VFEND equiv) (Restricted to Infectious Disease Specialist)	RS	1	ANTIFUNGALS
voriconazole tab (VFEND equiv) (Restricted to Infectious Disease Specialist)	RS	1	ANTIFUNGALS
VOSEVI TAB	-	NC	ANTIVIRALS
VOSOL HC OTIC SOLN	-	3	OTIC AGENTS
VOSOL OTIC SOLN	-	3	OTIC AGENTS
VOSPIRE ER TAB	-	3	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
VOTRIENT TAB	KMSP-PA-SF	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
VRAYLAR CAP	-	NC	ANTIPSYCHOTICS/ANTIMANIC AGENTS
VRAYLAR PACK	-	NC	ANTIPSYCHOTICS/ANTIMANIC AGENTS
VSL #3 CAP	-	NC	ANTIDIARRHEALS
VYTONER CREAM 1.9-1%	-	NC	DERMATOLOGICALS
VYTORIN TAB (QL= 1 tab/day (10/80mg is Not Covered))	QL	3	ANTIHYPERTENSIVES
VYTORIN TAB 10-80MG	-	NC	ANTIHYPERTENSIVES
VYVANSE CAP	-	2	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS
VYVANSE CHEW TAB	-	2	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS
warfarin tab (COUMADIN equiv)	-	1	ANTICOAGULANTS
WELCHOL PAK	-	2	ANTIHYPERTENSIVES
WELCHOL TAB	-	2	ANTIHYPERTENSIVES
WELLBUTRIN SR TAB	-	3	ANTIDEPRESSANTS
WELLBUTRIN TAB	-	3	ANTIDEPRESSANTS
WELLBUTRIN XL TAB	-	3	ANTIDEPRESSANTS
WESTCORT OINT	-	NC	DERMATOLOGICALS
wymzya FE tab (FEMCON FE equiv)	-	\$0	CONTRACEPTIVES
XADAGO TAB	-	NC	ANTIPARKINSON AGENTS
XALATAN OPTH SOLN (QL= 2.5ml/30 days)	QL	3	OPHTHALMIC AGENTS
XALKORI CAP	KMSP-PA-SF	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
XANAX TAB	-	3	ANTI-ANXIETY AGENTS
XANAX XR TAB	-	3	ANTI-ANXIETY AGENTS
XAQUIL XR TAB	-	NC	DIETARY PRODUCTS/DIETARY MANAGEMENT PRODUCTS
XARELTO STARTER PACK	-	2	ANTICOAGULANTS
XARELTO TAB	-	2	ANTICOAGULANTS
XARTEMIS XR TAB	-	NC	ANALGESICS - OPIOID
XATMEP SOLN	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
XELJANZ TAB (QL= 2 tabs/day)	LMSP-PA-QL	4	ANALGESICS - ANTI-INFLAMMATORY
XELJANZ XR TAB (QL= 1 tab/day)	LMSP-PA-QL	4	ANALGESICS - ANTI-INFLAMMATORY
XENADERM OINT	-	NC	DERMATOLOGICALS

INF	NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS
LMSP	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program	LD	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	PA	Prior Authorization	QL	Quantity Limit
SP	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 Months	SMKG	Smoking Cessation
	Available through Specialty Pharmacy Program	ST	Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary Cont.
Alphabetical Index
Last Updated 11/1/2017

Drug Name	Special Code	Tier	Category
XENAZINE TAB	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
XERESE CREAM	-	3	DERMATOLOGICALS
XERMELO TAB	-	NC	GASTROINTESTINAL AGENTS - MISC.
XHANCE NASAL EXHALER	-	NC	NASAL AGENTS - SYSTEMIC AND TOPICAL
XIFAXAN TAB 200MG (QL= 9 tabs/3 days)	QL	3	ANTI-INFECTIVE AGENTS - MISC.
XIFAXAN TAB 550MG (QL= 2 tabs/day; Quantities up to 3 tabs/day for the treatment of IBS-D allowed via PA)	PA-QL	3	ANTI-INFECTIVE AGENTS - MISC.
XIGDUO XR TAB	-	NC	ANTIDIABETICS
XIGDUO XR TAB 5-1000MG	-	NC	ANTIDIABETICS
XIIDRA OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
XIMINO CAP	-	NC	TETRACYCLINES
XODOL TAB 10MG-300MG	-	NC	ANALGESICS - OPIOID
XODOL TAB 5MG-300MG	-	NC	ANALGESICS - OPIOID
XODOL TAB 7.5MG-300MG	-	NC	ANALGESICS - OPIOID
XOLEGEL	-	NC	DERMATOLOGICALS
XOPENEX NEB SOLN	-	3	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
XTAMPZA ER CAP (QL= 120 tabs/30 days)	PA-QL	2	ANALGESICS - OPIOID
XTANDI CAP (QL= 4 caps/day)	KMSP-PA-QL-SF	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
XULANE PATCH	-	\$0	CONTRACEPTIVES
XULTOPHY INJ	-	NC	ANTIDIABETICS
XURIDEN POWDER	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
XYLOCAINE SOLN	-	3	DERMATOLOGICALS
XYREM SOLN (QL= 540ml/30 days; Only available through Xyrem Central Pharmacy 866-997-3688)	LD-PA-QL	4	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
XYZAL SOLN	-	NC	ANTIHISTAMINES
XYZAL TAB	-	NC	ANTIHISTAMINES
XYZBAC TAB	-	NC	DIETARY PRODUCTS/DIETARY MANAGEMENT PRODUCTS
YASMIN TAB	-	\$0	CONTRACEPTIVES
YAZ TAB	-	\$0	CONTRACEPTIVES
YODOXIN TAB	-	3	AMEBICIDES
YOSPRALA TAB	-	NC	HEMATOLOGICAL AGENTS - MISC.
ZADITOR OPHTH SOLN	OTC	NC	OPHTHALMIC AGENTS
zafirlukast tab (ACCOLATE equiv)	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
zaleplon cap (SONATA equiv)	-	1	HYPNOTICS/SEDATIVES/SLEEP DISORDEI AGENTS
ZANAFLEX CAP	-	3	MUSCULOSKELETAL THERAPY AGENTS
ZANAFLEX TAB	-	3	MUSCULOSKELETAL THERAPY AGENTS
ZANOSAR INJ	M	M	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ZANTAC CAP	-	3	ULCER DRUGS
ZANTAC EFFER TAB	-	3	ULCER DRUGS
ZANTAC GRANULE PACKET	-	3	ULCER DRUGS
ZANTAC SYRUP	-	3	ULCER DRUGS
ZANTAC TAB	-	3	ULCER DRUGS
ZARONTIN CAP	-	3	ANTICONVULSANTS

INF	NC =Not Covered Infertility	KMSP	generic =small letters Kroger Mandatory Specialty Pharmacy Program	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 M	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary Cont.
Alphabetical Index
Last Updated 11/1/2017

Drug Name	Special Code	Tier	Category
ZARONTIN SOLN	-	3	ANTICONVULSANTS
ZAROXOLYN TAB	-	3	DIURETICS
ZARXIO INJ	KMSP	4	HEMATOPOIETIC AGENTS
ZAVESCA CAP (Only available through Accredo 888-773-7376)	LD-PA	4	HEMATOPOIETIC AGENTS
ZEBETA TAB	-	3	BETA BLOCKERS
ZECUITY PAD	-	NC	MIGRAINE PRODUCTS
ZEGERID CAP	-	NC	ULCER DRUGS
ZEGERID CAP OTC	OTC	1	ULCER DRUGS
ZEGERID POWDER PACK	-	3	ULCER DRUGS
ZEJULA CAP	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ZELAPAR ODT	-	3	ANTIPARKINSON AGENTS
ZELBORAF TAB	MSP-PA-SF	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ZENPEP CAP (Step Therapy requires trial of CREON)	ST	3	DIGESTIVE AIDS
ZENZEDI TAB	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS
zenzedi tab 5mg (DEXEDRINE equiv)	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS
ZEPATIER TAB (QL= 1 tab/day)	KMSP-PA-QL	4	ANTIVIRALS
ZERIT CAP	-	4	ANTIVIRALS
ZERIT SOLN	-	4	ANTIVIRALS
ZESTORETIC TAB	-	3	ANTIHYPERTENSIVES
ZETIA TAB	-	NC	ANTIHYPERLIPIDEMICS
ZETONNA NASAL SPRAY (QL= 2 bottles/fill; Step Therapy requires trial of 2: flunisolide, fluticasone, triamcinolone or NASONEX)	QL-ST	3	NASAL AGENTS - SYSTEMIC AND TOPICAL
ZIAC TAB	-	3	ANTIHYPERTENSIVES
ZIAGEN SOLN	-	4	ANTIVIRALS
ZIAGEN TAB	-	4	ANTIVIRALS
ZIANA GEL	-	3	DERMATOLOGICALS
zidovudine cap (RETROVIR equiv)	-	1	ANTIVIRALS
zidovudine syrup (RETROVIR equiv)	-	1	ANTIVIRALS
zidovudine tab (RETROVIR equiv)	-	1	ANTIVIRALS
zileuton ER tab (ZYFLO CR equiv)	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ZINBRYTA INJ	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
zinc sulfate cap	-	1	MINERALS & ELECTROLYTES
ZIOPTAN OPHTH SOLN (QL= 1 bottle/day; Step Therapy requires trial of latanoprost)	QL-ST	3	OPHTHALMIC AGENTS
ziprasidone cap (GEODON equiv)	-	1	ANTIPSYCHOTICS/ANTIMANIC AGENTS
ZIRGAN OPHTH GEL	-	2	OPHTHALMIC AGENTS
ZITHROMAX POWDER PACK	-	3	MACROLIDES
ZITHROMAX SUSP	-	3	MACROLIDES
ZITHROMAX TAB	-	3	MACROLIDES
ZMAX SUSP	-	3	MACROLIDES
ZOCOR TAB	-	3	ANTIHYPERLIPIDEMICS
ZOCOR TAB 80MG	-	NC	ANTIHYPERLIPIDEMICS
ZOFRAN ODT	-	3	ANTIEMETICS
ZOFRAN SOLN	-	3	ANTIEMETICS

INF	NC =Not Covered Infertility	KMSP	generic =small letters Kroger Mandatory Specialty Pharmacy Program	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 M	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary Cont.
Alphabetical Index
Last Updated 11/1/2017

Drug Name	Special Code	Tier	Category
ZOFRAN TAB	-	3	ANTIEMETICS
ZOHYDRO ER CAP	-	NC	ANALGESICS - OPIOID
ZOLINZA CAP	KMSP-PA-SF	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
zolmitriptan ODT (ZOMIG equiv) (QL= 9 tabs/fill, 2 fills/30 days)	QL	1	MIGRAINE PRODUCTS
zolmitriptan tab (ZOMIG equiv) (QL= 9 tabs/fill, 2 fills/30 days)	QL	1	MIGRAINE PRODUCTS
ZOLOFT CONC	-	3	ANTIDEPRESSANTS
ZOLOFT TAB	-	3	ANTIDEPRESSANTS
zolpidem ER tab (AMBIEN CR equiv)	-	NC	HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS
zolpidem tab (AMBIEN equiv) (QL= 1 tab/day)	QL	1	HYPNOTICS
zolpidem tartrate SL tab (INTERMEZZO equiv)	-	NC	HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS
ZOLPIMIST SPRAY	-	NC	HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS
ZOMIG NASAL SPRAY (QL= 6 sprays/fill, 2 fills/30 days)	QL	3	MIGRAINE PRODUCTS
ZOMIG TAB (QL= 9 tabs/fill, 2 fills/30 days)	QL	3	MIGRAINE PRODUCTS
ZOMIG ZMT (QL= 9 tabs/fill, 2 fills/30 days)	QL	3	MIGRAINE PRODUCTS
ZONEGRAN CAP	-	3	ANTICONVULSANTS
zonisamide cap (ZONEGRAN equiv)	-	1	ANTICONVULSANTS
ZONTIVITY TAB (Restricted to Cardiology Specialist)	RS	3	HEMATOLOGICAL AGENTS - MISC.
ZORPRIN TAB	-	3	ANALGESICS - NONNARCOTIC
ZORTRESS TAB	KMSP-PA	4	ASSORTED CLASSES
ZORVOLEX CAP	-	NC	ANALGESICS - ANTI-INFLAMMATORY
ZOVIRAX CAP	-	3	ANTIVIRALS
ZOVIRAX CREAM	-	3	DERMATOLOGICALS
ZOVIRAX OINT	-	1	DERMATOLOGICALS
ZOVIRAX SUSP	-	3	ANTIVIRALS
ZOVIRAX TAB	-	3	ANTIVIRALS
ZUBSOLV SL TAB	-	NC	ANALGESICS - OPIOID
ZUPLENZ SL FILM	-	NC	ANTIEMETICS
ZURAMPIC TAB	-	NC	GOUT AGENTS
ZUTRIPRO LIQUID (QL= 120ml/fill, 2 fills/30 days)	QL	3	COUGH/COLD/ALLERGY
ZYBAN TAB (Limited to 180 days/plan year)	QL-SMKG	\$0	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
ZYCLARA CREAM	-	NC	DERMATOLOGICALS
ZYDELIG TAB (Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-SF	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ZYFLO CR TAB	-	3	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ZYFLO TAB	-	3	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ZYKADIA CAP	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ZYLET OPHTH SUSP (QL= 5ml/fill (10ml bottle is Not Covered))	QL	2	OPHTHALMIC AGENTS
ZYLOPRIM TAB	-	3	GOUT AGENTS
ZYMAXID OPHTH SOLN (Step Therapy requires trial of ciprofloxacin, levofloxacin, ofloxacin or VIGAMOX/MOXEZA)	ST	3	OPHTHALMIC AGENTS
ZYPREXA TAB	-	3	ANTIPSYCHOTICS/ANTIMANIC AGENTS
ZYPREXA ZYDIS TAB	-	3	ANTIPSYCHOTICS/ANTIMANIC AGENTS

INF	NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS
LMSP	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program	LD	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	PA	Prior Authorization	QL	Quantity Limit
SP	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 M	SMKG	Smoking Cessation
	Available through Specialty Pharmacy Program	ST	Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary Cont.
Alphabetical Index
Last Updated 11/1/2017

Drug Name	Special Code	Tier	Category
ZYTIGA TAB 250MG (QL= 4 tabs/day)	KMSP-PA-QL-SF	3	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ZYTIGA TAB 500MG (QL= 2 tabs/day)	KMSP-PA-QL-SF	3	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ZYVOX SUSP (Restricted to Infectious Disease Specialist)	RS	3	ANTI-INFECTIVE AGENTS - MISC.
ZYVOX TAB (Restricted to Infectious Disease Specialist)	RS	3	ANTI-INFECTIVE AGENTS - MISC.

INF	NC =Not Covered Infertility	KMSP	generic =small letters Kroger Mandatory Specialty Pharmacy Program	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 N	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Category/Class**

Last Updated* 11/1/2017

DrugName	Special Code	Tier
ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS		
AMPHETAMINES		
ADDERALL XR CAP	-	1
amphetamine/dextroamphetamine tab (ADDERALL equiv)	-	1
dextroamphetamine ER cap (DEXEDRINE equiv)	-	1
dextroamphetamine soln (PROCENTRA equiv)	-	1
dextroamphetamine tab (DEXEDRINE equiv)	-	1
VYVANSE CAP	-	2
VYVANSE CHEW TAB	-	2
ADDERALL TAB	-	3
DEXEDRINE CAP	-	3
PROCENTRA SOLN	-	3
ADZENYS XR TAB	-	NC
amphetamine ER cap (ADDERALL XR equiv)	-	NC
DESOXYN TAB	-	NC
methamphetamine tab (DESOXYN equiv)	-	NC
MYDAYIS CAP	-	NC
ZENZEDI TAB	-	NC
zenzedi tab 5mg (DEXEDRINE equiv)	-	NC
ANALECTICS		
caffeine citrate soln (CAFCIT equiv) (Only covered for members less than 1 year old)	-	1
CAFCIT SOLN	-	2
CAFCIT INJ	-	NC
ANOREXIANTS NON-AMPHETAMINE		
phentermine cap (ADIPEX equiv) (QL= 1 cap/day)	PA-QL	1
phentermine tab (ADIPEX equiv) (QL= 1 tab/day)	PA-QL	1
ADIPEX-P CAP	PA-QL	3
ADIPEX-P TAB	PA-QL	3
QSYMIA CAP (QL= 1 cap/day)	PA-QL	3
phendimetrazine tab	-	NC
ANTI-OBESITY AGENTS		
BELVIQ TAB (QL= 2 tabs/day)	PA-QL	2
BELVIQ XR TAB (QL= 1 tab/day)	PA-QL	2
CONTRAVE TAB (QL= 4 tabs/day)	PA-QL	2
ATTENTION-DEFICIT/HYPERACTIVITY DISORDER (ADHD) AGENTS		
atomoxetine cap (STRATTERA equiv)	-	1
guanfacine ER tab (INTUNIV equiv)	-	1
INTUNIV TAB	-	3
clonidine ER tab (KAPVAY equiv)	-	NC
KAPVAY TAB	-	NC
STRATTERA CAP	-	NC
STIMULANTS - MISC.		
armodafinil tab (NUVIGIL equiv) (QL= 1 tab/day)	PA-QL	1
dexmethylphenidate ER cap (FOCALIN XR equiv)	-	1
dexmethylphenidate tab (FOCALIN equiv)	-	1
methylphenidate CD cap (METADATE CD equiv)	-	1
methylphenidate ER cap (RITALIN LA equiv)	-	1
Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.		
INF Infertility LMSP Lumicera Mandatory Specialty Pharmacy Program OTC Over-the-Counter RS Restricted to Specialist SP Available through Specialty Pharmacy Program	KMSP Kroger Mandatory Specialty Pharmacy Program M Medical Benefit PA Prior Authorization SF Limited to Two 15 Day Fills per Month for the First 3 M ST Step Therapy	LD Limited Distribution MSP Mandatory Specialty Pharmacy Program QL Quantity Limit SMKG Smoking Cessation VAC Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Category/Class**

Last Updated* 11/1/2017

DrugName	Special Code	Tier
ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS Cont.		
methylphenidate ER tab	-	1
methylphenidate soln (METHYLIN equiv)	-	1
methylphenidate tab (RITALIN equiv)	-	1
modafinil tab (PROVIGIL equiv) (QL= 2 tabs/day)	PA-QL	1
METHYLIN SOLN	-	2
METHYLPHENIDATE ER TAB	-	2
CONCERTA TAB, RITALIN SR TAB	-	3
DAYTRANA PATCH	-	3
FOCALIN TAB	-	3
FOCALIN XR CAP	-	3
METADATE CD CAP	-	3
METHYLIN CHEW TAB	-	3
METHYLPHENIDATE CHEW TAB	-	3
PROVIGIL TAB (QL= 2 tabs/day)	PA-QL	3
RITALIN LA CAP	-	3
RITALIN LA CAP 10MG	-	3
RITALIN LA CAP 60MG	-	3
RITALIN TAB	-	3
COTEMPLA XR ODT	-	NC
NUVIGIL TAB	-	NC
QUILLIVANT XR SUSP	-	NC

ALTERNATIVE MEDICINES

ALTERNATIVE MEDICINE - R'S

RESERVAPAK SYRUP	-	NC
------------------	---	----

AMEBICIDES

AMEBICIDES

YODOXIN TAB	-	3
-------------	---	---

AMINOGLYCOSIDES

AMINOGLYCOSIDES

neomycin tab	-	1
paromomycin cap (HUMATIN equiv)	-	1
TOBI PODHALER (Restricted to Infectious Disease or Pulmonology Specialist)	KMSP-RS	4
tobramycin neb soln (TOBI equiv) (Restricted to Infectious Disease or Pulmonology Specialist)	KMSP-RS	4
amikacin inj (KANAMYCIN equiv)	M	M
KANAMYCIN INJ	M	M
BETHKIS NEB SOLN	-	NC
KITABIS PAK NEB SOLN	-	NC
TOBI NEB SOLN	-	NC

ANALGESICS - ANTI-INFLAMMATORY

ANTIRHEUMATIC - ENZYME INHIBITORS

XELJANZ TAB (QL= 2 tabs/day)	LMSP-PA-QL	4
XELJANZ XR TAB (QL= 1 tab/day)	LMSP-PA-QL	4

ANTIRHEUMATIC ANTIMETABOLITES

RHEUMATREX TAB	-	3
----------------	---	---

ANTI-TNF-ALPHA - MONOCLONAL ANTIBODIES

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	KMSP	generic =small letters	LD	BRANDS =CAPITAL LETTERS
LMSP	Infertility	M	Kroger Mandatory Specialty Pharmacy Program	MSP	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	PA	Medical Benefit	QL	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	SF	Prior Authorization	SMKG	Quantity Limit
SP	Restricted to Specialist	ST	Limited to Two 15 Day Fills per Month for the First 3 M	VAC	Smoking Cessation
	Available through Specialty Pharmacy Program		Step Therapy		Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Category/Class**

Last Updated* 11/1/2017

DrugName	Special Code	Tier
ANALGESICS - ANTI-INFLAMMATORY Cont.		
HUMIRA INJ (QL= 2 inj/28 days)	LMSP-PA-QL	4
HUMIRA PEN INJ (QL= 2 inj/28 days)	LMSP-PA-QL	4
SIMPONI SC INJ (QL= 1 inj/28 days)	LMSP-PA-QL	4
SIMPONI ARIA INJ	-	NC
GOLD COMPOUNDS		
RIDAURA CAP	-	2
INTERLEUKIN-1 RECEPTOR ANTAGONIST (IL-1RA)		
KINERET INJ (QL= 1 inj/day; Only available through Rx Crossroads: 1-866-547-0644)	LD-PA-QL	4
INTERLEUKIN-6 RECEPTOR INHIBITORS		
ACTEMRA SC INJ (QL= 2 inj/28 days)	LMSP-PA-QL	4
KEVZARA INJ	-	NC
NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (NSAIDS)		
celecoxib cap (CELEBREX equiv) (QL= 2 caps/day)	QL	1
diclofenac potassium tab (CATAFLAM equiv)	-	1
diclofenac sodium EC tab (VOLTAREN equiv)	-	1
diclofenac sodium XR tab (VOLTAREN XR equiv)	-	1
diclofenac/misoprostol DR tab (ARTHROTEC equiv)	-	1
etodolac cap (LODINE equiv)	-	1
etodolac ER tab (LODINE XL equiv)	-	1
etodolac tab	-	1
fenoprofen calcium tab	-	1
flurbiprofen tab (ANSAID equiv)	-	1
ibuprofen susp (Rx ONLY) (ADVIL, MOTRIN equiv)	-	1
ibuprofen tab	-	1
ibuprofen tab (Rx covered Only)	-	1
indomethacin cap (INDOCIN equiv)	-	1
indomethacin CR cap (INDOCIN SR equiv)	-	1
ketoprofen cap (ORUDIS equiv)	-	1
ketorolac tab (TORADOL equiv) (QL= 20 tabs/5 days)	QL	1
MECLOFENAMATE CAP	-	1
mefenamic acid cap (PONSTEL equiv)	-	1
meloxicam tab (MOBIC equiv)	-	1
nabumetone tab (RELAFEN equiv)	-	1
naproxen EC tab (NAPROSYN EC equiv)	-	1
naproxen sodium tab (ANAPROX equiv)	-	1
naproxen susp (NAPROSYN equiv)	-	1
naproxen tab (NAPROSYN equiv)	-	1
oxaprozin tab (DAYPRO equiv)	-	1
piroxicam cap (FELDENE equiv)	-	1
sulindac tab (CLINORIL equiv)	-	1
TOLMETIN CAP	-	1
tolmetin cap (TOLECTIN DS equiv)	-	1
INDOCIN SUPP	-	2
INDOCIN SUSP	-	2
NAPROXEN SUSP	-	2
ANAPROX TAB	-	3

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	KMSP	generic =small letters	LD	BRANDS =CAPITAL LETTERS
LMSP	Infertility	M	Kroger Mandatory Specialty Pharmacy Program	LD	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	PA	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	SF	Prior Authorization	QL	Quantity Limit
SP	Restricted to Specialist	ST	Limited to Two 15 Day Fills per Month for the First 3 M	SMKG	Smoking Cessation
	Available through Specialty Pharmacy Program		Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Category/Class**

Last Updated* 11/1/2017

DrugName	Special Code	Tier
ANALGESICS - ANTI-INFLAMMATORY Cont.		
ARTHROTEC TAB	-	3
CATAFLAM TAB	-	3
CELEBREX CAP (QL= 2 caps/day)	QL	3
CLINORIL TAB	-	3
DAYPRO TAB	-	3
FELDENE CAP	-	3
FENOPROFEN CAP	-	3
KETOPROFEN ER CAP	-	3
MELOXICAM SUSP	-	3
MOBIC TAB	-	3
MOTRIN SUSP	-	3
NAPROSYN EC TAB	-	3
NAPROSYN SUSP	-	3
NAPROSYN TAB	-	3
PONSTEL CAP	-	3
TOLMETIN TAB	-	3
VOLTAREN TAB	-	3
VOLTAREN XR TAB	-	3
KETOROLAC INJ	-	NC
ketorolac inj (TORADOL equiv)	-	NC
MELOXICAM COMFORT KIT	-	NC
NAPRELAN CR TAB	-	NC
naproxen sodium CR tab (NAPRELAN CR equiv)	-	NC
SPRIX NASAL SPRAY	-	NC
VIMOVO TAB	-	NC
VIVLODEX CAP	-	NC
ZORVOLEX CAP	-	NC
PHOSPHODIESTERASE 4 (PDE4) INHIBITORS		
OTEZLA STARTER PACK	-	NC
OTEZLA TAB	-	NC
PYRIMIDINE SYNTHESIS INHIBITORS		
leflunomide tab (ARAVA equiv)	-	1
ARAVA TAB	-	3
SELECTIVE COSTIMULATION MODULATORS		
ORENCIA CLICK INJ (QL= 4 inj/28 days)	LMSP-PA-QL	4
ORENCIA SC INJ 125MG/ML (QL= 4 inj/28 days)	LMSP-PA-QL	4
ORENCIA SC INJ 50MG/0.4ML (QL= 4 inj/28 days)	LMSP-PA-QL	4
ORENCIA SC INJ 87.5MG/0.7ML (QL= 4 inj/28 days)	LMSP-PA-QL	4
SOLUBLE TUMOR NECROSIS FACTOR RECEPTOR AGENTS		
ENBREL INJ 25MG (QL= 8 inj/28 days)	LMSP-PA-QL	4
ENBREL INJ 50MG (QL= 4 inj/28 days)	LMSP-PA-QL	4
ENBREL MINI INJ (QL= 4 inj/28 days)	LMSP-PA-QL	4
ENBREL SURECLICK INJ 50MG (QL= 4 inj/28 days)	LMSP-PA-QL	4
ANALGESICS - NONNARCOTIC		
ANALGESIC COMBINATIONS		
butalbital/acetaminophen/caffeine tab (FIORICET equiv)	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	KMSP	generic =small letters	LD	BRANDS =CAPITAL LETTERS
LMSP	Infertility	M	Kroger Mandatory Specialty Pharmacy Program	MSP	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	PA	Medical Benefit	QL	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	SF	Prior Authorization	SMKG	Quantity Limit
SP	Restricted to Specialist	ST	Limited to Two 15 Day Fills per Month for the First 3 M	VAC	Smoking Cessation
	Available through Specialty Pharmacy Program		Step Therapy		Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Category/Class**

Last Updated* 11/1/2017

DrugName	Special Code	Tier
ANALGESICS - NONNARCOTIC Cont.		
BUTALBITAL/ASPIRIN/CAFFEINE TAB	-	NC
DOLGIC PLUS TAB	-	NC
ESGIC TAB	-	NC
FIORICET CAP	-	NC
FIORINAL CAP	-	NC
SALICYLATES		
ASPIRIN CHEW TAB 75MG (Covered for males age 45-79 and females age 55-79)	OTC	\$0
aspirin chew tab 81mg (Covered for males age 45-79; Covered for females (no age restriction))	OTC	\$0
aspirin ec tab 325mg (Covered for males age 45-79 and females age 55-79)	OTC	\$0
aspirin ec tab 81mg (Covered for males age 45-79; Covered for females (no age restriction))	OTC	\$0
aspirin tab 325mg (Covered for males age 45-79 and females age 55-79)	OTC	\$0
ASPIRIN TAB 81MG (Covered for males age 45-79; Covered for females (no age restriction))	OTC	\$0
CHOLINE MAGNESIUM TRISALICYLATE TAB	-	1
choline magnesium trisaliclylate tab (TRILISATE equiv)	-	1
diffunisal tab (DOLOBID equiv)	-	1
salsalate tab (DISALCID equiv)	-	1
ZORPRIN TAB	-	3

ANALGESICS - OPIOID

OPIOID AGONISTS		
codeine sulfate tab	-	1
fentanyl citrate lollipop (ACTIQ equiv) (QL= 120 lozenges/30 days)	PA-QL	1
fentanyl patch (DURAGESIC equiv)	-	1
HYDROMORPHONE SUPP	-	1
hydromorphone tab (DILAUDID equiv)	-	1
meperidine tab (DEMEROL equiv)	-	1
METHADONE SOLN	-	1
methadone tab (DOLOPHINE equiv)	-	1
methadose tab	-	1
morphine sulfate ER tab (MS CONTIN equiv) (QL= 90 tabs/ 30 days)	QL	1
morphine sulfate soln	-	1
morphine sulfate supp	-	1
morphine sulfate tab	-	1
oxycodone cap (OXYIR equiv)	-	1
oxycodone conc (ROXICODONE equiv)	-	1
oxycodone soln (ROXICODONE equiv)	-	1
oxycodone tab (ROXICODONE equiv)	-	1
tramadol ER tab (ULTRAM ER equiv)	-	1
tramadol tab (ULTRAM equiv)	-	1
LEVORPHANOL TAB	-	2
OXYIR CAP	-	2
XTAMPZA ER CAP (QL= 120 tabs/30 days)	PA-QL	2
ABSTRAL SL TAB (QL= 120 tabs/30 days)	PA-QL	3
ACTIQ LOZENGE (QL= 120 units/30 days)	PA-QL	3
AVINZA CAP (QL= 2 caps/day)	QL	3
CODEINE SULFATE SOLN	-	3
DAZIDOX TAB	-	3

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	KMSP	generic =small letters	LD	BRANDS =CAPITAL LETTERS
LMSP	Infertility	M	Kroger Mandatory Specialty Pharmacy Program	MSP	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	PA	Medical Benefit	QL	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	SF	Prior Authorization	SMKG	Quantity Limit
SP	Restricted to Specialist	ST	Limited to Two 15 Day Fills per Month for the First 3 M	VAC	Smoking Cessation
	Available through Specialty Pharmacy Program		Step Therapy		Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Category/Class**

Last Updated* 11/1/2017

DrugName	Special Code	Tier
ANALGESICS - OPIOID Cont.		
DEMEROL TAB	-	3
DILAUDID TAB	-	3
DOLOPHINE TAB	-	3
DURAGESIC PATCH	-	3
EMBEDA CAP	-	3
FENTORA TAB (QL= 120 tabs/30 days)	PA-QL	3
LAZANDA NASAL SPRAY (QL= 15 bottles/30 days)	PA-QL	3
METHADOSE CONC	-	3
MORPHINE SULFATE ER BEAD CAP (QL= 2 caps/day)	QL	3
NUCYNTA TAB	-	3
ROXICODONE TAB	-	3
ULTRAM ER TAB	-	3
ULTRAM TAB	-	3
ARYMO ER TAB	-	NC
EXALGO TAB	-	NC
hydromorphone ER tab (EXALGO equiv)	-	NC
HYSINGLA ER TAB	-	NC
KADIAN CAP	-	NC
MORPHABOND TAB	-	NC
morphine sulfate ER cap (KADIAN equiv)	-	NC
NUCYNTA ER TAB	-	NC
OPANA ER TAB	-	NC
OPANA ER TAB (CRUSH RESISTANT)	-	NC
OPANA TAB	-	NC
OXYCODONE ER TAB, OXYCONTIN CR TAB	-	NC
OXYCONTIN CR TAB	-	NC
oxymorphone tab (OPANA equiv)	-	NC
RYBIX ODT	-	NC
SUBSYS SPRAY	-	NC
TRAMADOL ER CAP	-	NC
ZOHYDRO ER CAP	-	NC

OPIOID COMBINATIONS

acetaminophen/codeine soln	-	1
acetaminophen/codeine tab (TYLENOL/CODEINE equiv)	-	1
aspirin/codeine tab	-	1
hydrocodone/acetaminophen cap (LORCET equiv)	-	1
hydrocodone/acetaminophen soln (HYCET, LORTAB equiv)	-	1
hydrocodone/acetaminophen tab (LORTAB equiv)	-	1
hydrocodone/acetaminophen tab 2.5-325mg (NORCO equiv)	-	1
hydrocodone/ibuprofen tab (VICOPROFEN equiv)	-	1
oxycodone/acetaminophen cap (TYLOX equiv)	-	1
OXYCODONE/ACETAMINOPHEN SOLN	-	1
oxycodone/acetaminophen tab (PERCOCET equiv)	-	1
oxycodone/aspirin tab (PERCODAN equiv)	-	1
oxycodone/ibuprofen tab (COMBUNOX equiv)	-	1
pentazocine/acetaminophen tab (TALACEN equiv)	-	1
tramadol/acetaminophen tab (ULTRACET equiv)	-	1

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	KMSP	generic =small letters	LD	BRANDS =CAPITAL LETTERS
LMSP	Infertility	M	Kroger Mandatory Specialty Pharmacy Program	MSP	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	PA	Medical Benefit	QL	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	SF	Prior Authorization	SMKG	Quantity Limit
SP	Restricted to Specialist	ST	Limited to Two 15 Day Fills per Month for the First 3 M	VAC	Smoking Cessation
	Available through Specialty Pharmacy Program		Step Therapy		Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Category/Class**

Last Updated* 11/1/2017

DrugName	Special Code	Tier
ANALGESICS - OPIOID Cont.		
ACETAMINOPHEN/CAFFEINE/DIHYDROCODEINE CAP	-	3
ACETAMINOPHEN/CAFFEINE/DIHYDROCODEINE TAB	-	3
CAPITAL/CODEINE SUSP	-	3
HYCET SOLN	-	3
LORTAB	-	3
LORTAB ELIXIR	-	3
PERCOCET TAB	-	3
PERCODAN TAB	-	3
REPREXAIN TAB	-	3
ROXICET SOLN	-	3
TYLENOL/CODEINE TAB	-	3
ULTRACET TAB	-	3
VICOPROFEN TAB	-	3
FIORICET/CODEINE CAP	-	NC
FIORINAL/CODEINE CAP	-	NC
hydrocodone/acetaminophen tab 10mg-300mg (XODOL equiv)	-	NC
hydrocodone/acetaminophen tab 5mg-300mg (XODOL equiv)	-	NC
hydrocodone/acetaminophen tab 7.5mg-300mg (XODOL equiv)	-	NC
PRIMLEV TAB	-	NC
XARTEMIS XR TAB	-	NC
XODOL TAB 10MG-300MG	-	NC
XODOL TAB 5MG-300MG	-	NC
XODOL TAB 7.5MG-300MG	-	NC
OPIOID PARTIAL AGONISTS		
buprenorphine SL tab (SUBUTEX equiv) (QL= 21 tabs/7 days)	PA-QL	1
buprenorphine/naloxone SL tab (SUBOXONE equiv)	-	1
butorphanol nasal spray (STADOL equiv) (QL= 1 bottle/fill, 2 fills/30 days)	QL	1
pentazocine/naloxone tab (TALWIN NX equiv)	-	1
SUBOXONE SL FILM	-	2
BUPRENORPHINE PATCH, BUTRANS PATCH (QL= 4 patches/28 days)	QL	3
BELBUCA FILM	-	NC
BUNAVAIL SL FILM	-	NC
SUBOXONE SL TAB	-	NC
ZUBSOLV SL TAB	-	NC

ANDROGENS-ANABOLIC

ANABOLIC STEROIDS

oxandrolone tab (OXANDRIN equiv)	-	1
ANADROL TAB	-	3
OXANDRIN TAB	-	3

ANDROGENS

danazol cap (DANOCRINE equiv)	-	1
methyltestosterone cap (ANDROID, TESTRED equiv)	PA	1
testosterone cypionate inj (DEPO-TESTOSTERONE equiv)	-	1
testosterone gel 1% 25mg (ANDROGEL equiv) (QL= 1 packet/day)	PA-QL	1
testosterone gel 1% 50mg (ANDROGEL equiv) (QL= 2 packets/day)	PA-QL	1
testosterone gel 1% pump (ANDROGEL equiv) (QL= 4 bottles/30 days)	PA-QL	1

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	KMSP	generic =small letters	LD	BRANDS =CAPITAL LETTERS
LMSP	Infertility	M	Kroger Mandatory Specialty Pharmacy Program	MSP	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	PA	Medical Benefit	QL	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	SF	Prior Authorization	SMKG	Quantity Limit
SP	Restricted to Specialist	ST	Limited to Two 15 Day Fills per Month for the First 3 M	VAC	Smoking Cessation
	Available through Specialty Pharmacy Program		Step Therapy		Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Category/Class**

Last Updated* 11/1/2017

DrugName	Special Code	Tier
ANDROGENS-ANABOLIC Cont.		
testosterone soln (AXIRON equiv) (QL= 2 bottles/30 days)	PA-QL	1
ANDRODERM PATCH (QL= 1 patch/day)	PA-QL	2
ANDROGEL 1.62% 1.25GM (QL= 1 packet/day)	PA-QL	2
ANDROGEL 1.62% 2.5GM (QL= 2 packets/day)	PA-QL	2
ANDROGEL PUMP 1.62% (QL= 2 bottles/30 days)	PA-QL	2
ANDROXY TAB	-	2
TESTOSTERONE GEL 1% 25MG (QL= 1 packet/day)	PA-QL	2
TESTOSTERONE GEL 1% 50MG (QL= 2 packets/day)	PA-QL	2
TESTOSTERONE GEL PUMP (QL= 4 bottles/30 days)	PA-QL	2
ANDROGEL 1% 25MG (QL= 1 packet/day)	PA-QL	3
ANDROGEL 1% 50MG, TESTIM GEL 1% (QL= 2 packets/day)	PA-QL	3
ANDROGEL PUMP 1% (QL= 4 bottles/30 days)	PA-QL	3
ANDROID CAP, TESTRED CAP	PA	3
AXIRON SOLN (QL= 2 bottles/30 days)	PA-QL	3
DEPO-TESTOSTERONE INJ	-	3
FORTESTA GEL, TESTOSTERONE GEL (QL= 2 bottles/30 days)	PA-QL	3
METHITEST TAB	PA	3
TESTOSTERONE GEL, VOGELXO GEL (QL= 2 packets/day)	PA-QL	3
VOGELXO PUMP	-	NC

ANORECTAL AGENTS

INTRARECTAL STEROIDS

hydrocortisone enema (CORTENEMA equiv)	-	1
CORTENEMA	-	3
CORTIFOAM	-	3
UCERIS RECTAL FOAM	PA	3

RECTAL COMBINATIONS

lidocaine/hydrocortisone cream (ANAMANTLE equiv)	-	1
pramoxine/hydrocortisone cream kit (ANALPRAM-HC equiv)	-	1
PROCTOFOAM HC FOAM	-	2
ANALPRAM-E KIT	-	3
ANALPRAM-HC CREAM	-	NC
pramoxine/hydrocortisone cream (ANALPRAM-HC equiv)	-	NC
PROCORT CREAM	-	NC

RECTAL STEROIDS

proctosol HC cream (ANUSOL HC equiv)	-	1
ANUSOL-HC CREAM	-	3
ANUSOL-HC SUPP	-	NC
hydrocortisone supp (ANUSOL HC equiv)	-	NC

VASODILATING AGENTS

RECTIV OINT	-	NC
-------------	---	----

ANTHELMINTICS

ANTHELMINTICS

ivermectin tab (STROMECTOL equiv)	-	1
mebendazole chew tab (VERMOX equiv)	-	1
BILTRICIDE TAB	-	2

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	KMSP	generic =small letters	LD	BRANDS =CAPITAL LETTERS
LMSP	Infertility	M	Kroger Mandatory Specialty Pharmacy Program	MSP	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	PA	Medical Benefit	QL	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	SF	Prior Authorization	SMKG	Quantity Limit
SP	Restricted to Specialist	ST	Limited to Two 15 Day Fills per Month for the First 3 M	VAC	Smoking Cessation
	Available through Specialty Pharmacy Program		Step Therapy		Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Category/Class**

Last Updated* 11/1/2017

DrugName	Special Code	Tier
----------	--------------	------

ANTHELMINTICS Cont.

EMVERM TAB	PA	2
ALBENZA TAB	-	3
STROMEKTOL TAB	-	3

ANTIANGINAL AGENTS

ANTIANGINALS-OTHER

RANEXA TAB	-	2
------------	---	---

NITRATES

ISOSORBIDE DINITRATE ER TAB	-	1
isosorbide dinitrate ER tab (ISOCHRON equiv)	-	1
isosorbide dinitrate SL tab	-	1
isosorbide dinitrate tab (ISORDIL equiv)	-	1
isosorbide mononitrate ER tab (IMDUR equiv)	-	1
isosorbide mononitrate tab (MONOKET equiv)	-	1
nitroglycerin lingual spray (NITROLINGUAL equiv)	-	1
nitroglycerin patch (NITRO-DUR equiv)	-	1
nitroglycerin SL tab (NITROSTAT equiv)	-	1
nitroglycerin SR cap	-	1
NITRO-DUR PATCH 0.3MG/HR, 0.8MG/HR	-	2
DILATRATE SR CAP	-	3
IMDUR TAB	-	3
ISORDIL TITRADOSE TAB	-	3
ISOSORBIDE DINITRATE TAB 30MG, 40MG	-	3
NITRO-BID OINT	-	3
NITRO-DUR PATCH	-	3
NITROLINGUAL PUMP SPRAY	-	3
NITROMIST SPRAY	-	3
NITROSTAT SL TAB	-	3
GONITRO POWDER	-	NC

ANTIANSXIETY AGENTS

ANTIANSXIETY AGENTS - MISC.

buspirone tab (BUSPAR equiv)	-	1
hydroxyzine pamoate cap (VISTARIL equiv)	-	1
HYDROXYZINE PAMOATE CAP 100MG	-	1
hydroxyzine syrup (ATARAX equiv)	-	1
hydroxyzine tab (ATARAX equiv)	-	1
meprobamate tab (MILTOWN equiv)	-	1
BUSPAR TAB	-	3
VISTARIL CAP	-	3
buspirone tab 30mg (BUSPAR equiv)	-	NC

BENZODIAZEPINES

alprazolam ER tab (XANAX XR equiv)	-	1
alprazolam ODT (NIRAVAM equiv)	-	1
alprazolam tab (XANAX equiv)	-	1
chlordiazepoxide cap (LIBRIUM equiv)	-	1
clorazepate tab (TRANXENE-T equiv)	-	1
diazepam conc (VALIUM equiv)	-	1

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	generic	=small letters	BRANDS	=CAPITAL LETTERS
LMSP	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program	LD	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	PA	Prior Authorization	QL	Quantity Limit
SP	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 M	SMKG	Smoking Cessation
	Available through Specialty Pharmacy Program	ST	Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Category/Class**

Last Updated* 11/1/2017

DrugName	Special Code	Tier
ANTIANGIENIC AGENTS Cont.		
DIAZEPAM SOLN	-	1
diazepam tab (VALIUM equiv)	-	1
lorazepam conc (ATIVAN equiv)	-	1
lorazepam tab (ATIVAN equiv)	-	1
oxazepam cap (SERAX equiv)	-	1
ATIVAN TAB	-	3
LIBRIUM CAP	-	3
NIRAVAM ODT	-	3
TRANXENE-T TAB	-	3
VALIUM TAB	-	3
XANAX TAB	-	3
XANAX XR TAB	-	3
ANTIARRHYTHMICS		
ANTIARRHYTHMICS TYPE I-A		
disopyramide cap (NORPACE equiv)	-	1
disopyramide ER cap (NORPACE CR equiv)	-	1
quinidine gluconate CR tab	-	1
quinidine sulfate tab	-	1
NORPACE CR CAP	-	2
NORPACE CAP	-	3
QUINIDINE SULFATE ER TAB	-	3
ANTIARRHYTHMICS TYPE I-B		
mexiletine cap (MEXITIL equiv)	-	1
ANTIARRHYTHMICS TYPE I-C		
flecainide tab (TAMBOCOR equiv)	-	1
propafenone ER cap (RYTHMOL SR equiv)	-	1
propafenone tab (RYTHMOL equiv)	-	1
RYTHMOL SR CAP	-	3
RYTHMOL TAB	-	3
TAMBOCOR TAB	-	3
ANTIARRHYTHMICS TYPE III		
amiodarone tab (CORDARONE equiv)	-	1
dofetilide cap (TIKOSYN equiv)	-	1
MULTAQ TAB	-	2
CORDARONE TAB	-	3
TIKOSYN CAP	-	3
ANTIASTHMATIC AND BRONCHODILATOR AGENTS		
ANTI-INFLAMMATORY AGENTS		
cromolyn neb soln (INTAL equiv)	-	1
BRONCHODILATORS - ANTICHOLINERGICS		
ipratropium neb soln (ATROVENT equiv)	-	1
ATROVENT HFA INHALER	-	2
INCRUSE ELLIPTA INHALER	-	2
SPIRIVA HANDIHALER (For use with Handihaler device)	PA	3
SPIRIVA RESPIMAT INHALER	PA	3

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered Infertility	KMSP	generic =small letters Kroger Mandatory Specialty Pharmacy Program	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 M	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Category/Class**

Last Updated* 11/1/2017

DrugName	Special Code	Tier
ANTI-ASTHMATIC AND BRONCHODILATOR AGENTS Cont.		
SEEBRI NEOHALER CAP	-	NC
TUDORZA PRESSAIR INHALER	-	NC
LEUKOTRIENE MODULATORS		
montelukast chew tab (SINGULAIR equiv)	-	1
montelukast granule pack (SINGULAIR equiv)	-	1
montelukast tab (SINGULAIR equiv)	-	1
zafirlukast tab (ACCOLATE equiv)	-	1
zileuton ER tab (ZYFLO CR equiv)	-	1
ACCOLATE TAB	-	3
SINGULAIR CHEW TAB	-	3
SINGULAIR GRANULE PACK	-	3
SINGULAIR TAB	-	3
ZYFLO CR TAB	-	3
ZYFLO TAB	-	3
SELECTIVE PHOSPHODIESTERASE 4 (PDE4) INHIBITORS		
DALIRESP TAB	-	NC
STERIOD INHALANTS		
ARNUITY ELLIPTA INHALER	-	1
ASMANEX HFA INHALER	-	1
ASMANEX INHALER	-	1
budesonide inh susp (PULMICORT equiv)	-	1
FLOVENT DISKUS INHALER	-	1
FLOVENT HFA INHALER	-	1
PULMICORT INH SUSP	-	3
AEROSPAN HFA INHALER	-	NC
ALVESCO INHALER	-	NC
ARMONAIR RESPICLICK	-	NC
PULMICORT FLEXHALER	-	NC
QVAR INHALER	-	NC
SYMPATHOMIMETICS		
albuterol neb soln 0.083% (PROVENTIL equiv)	-	1
albuterol neb soln 0.5% (VENTOLIN equiv)	-	1
albuterol neb soln 0.63mg (ACCUNEB equiv)	-	1
albuterol neb soln 1.25mg (ACCUNEB equiv)	-	1
albuterol sulfate ER tab (VOSPIRE ER equiv)	-	1
albuterol sulfate syrup	-	1
albuterol sulfate tab	-	1
albuterol/ipratropium neb soln (DUONEB equiv)	-	1
FLUTICASONE/SALMETEROL INHALER	-	1
levalbuterol neb soln (XOPENEX equiv)	-	1
METAPROTERENOL SYRUP	-	1
terbutaline sulfate tab (BRETHINE equiv)	-	1
ADVAIR DISKUS INHALER	-	2
ADVAIR HFA INHALER	-	2
ANORO ELLIPTA INHALER	-	2
BREO ELLIPTA INHALER	-	2

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	KMSP	generic =small letters	LD	BRANDS =CAPITAL LETTERS
LMSP	Infertility	M	Kroger Mandatory Specialty Pharmacy Program	MSP	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	PA	Medical Benefit	QL	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	SF	Prior Authorization	SMKG	Quantity Limit
SP	Restricted to Specialist	ST	Limited to Two 15 Day Fills per Month for the First 3 M	VAC	Smoking Cessation
	Available through Specialty Pharmacy Program		Step Therapy		Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Category/Class**

Last Updated* 11/1/2017

DrugName	Special Code	Tier																																				
ANTIASTHMATIC AND BRONCHODILATOR AGENTS Cont.																																						
COMBIVENT INHALER	-	2																																				
COMBIVENT RESPIMAT INHALER	-	2																																				
DULERA INHALER	-	2																																				
SEREVENT DISKUS INHALER	-	2																																				
VENTOLIN HFA INHALER (QL= 2 inhalers/30 days)	QL	2																																				
ACCUNEB NEB SOLN	-	3																																				
BRETHINE TAB	-	3																																				
BROVANA NEB SOLN	-	3																																				
DUONEB NEB SOLN	-	3																																				
LEVALBUTEROL INHALER, XOPENEX HFA INHALER (QL= 2 inhalers/fill, 2 fills/30 days; Step Therapy requires trial of VENTOLIN HFA)	QL-ST	3																																				
METAPROTERENOL TAB	-	3																																				
PERFOROMIST NEB SOLN	-	3																																				
STIOLTO INHALER	-	3																																				
STRIVERDI RESPIMAT INHALER (QL= 1 inhaler/30 days)	QL	3																																				
VOSPIRE ER TAB	-	3																																				
XOPENEX NEB SOLN	-	3																																				
AIRDUO RESPICLICK	-	NC																																				
BEVESPI AEROSPHERE INHALER	-	NC																																				
FORADIL AEROLIZER	-	NC																																				
PROAIR HFA INHALER	-	NC																																				
PROVENTIL HFA INHALER	-	NC																																				
SYMBICORT INHALER	-	NC																																				
TRELEGY ELLIPTA INHALER	-	NC																																				
UTIBRON NEOHALER CAP	-	NC																																				
XANTHINES																																						
aminophylline tab	-	1																																				
theophylline CR tab (QUIBRON-T equiv)	-	1																																				
theophylline ER tab (UNIPHYL equiv)	-	1																																				
theophylline soln	-	1																																				
ELIXOPHYLLIN ELIXIR	-	2																																				
LUFYLLIN TAB	-	3																																				
THEO-24 CAP	-	3																																				
UNIPHYL TAB	-	3																																				
ANTICOAGULANTS																																						
COUMARIN ANTICOAGULANTS																																						
warfarin tab (COUMADIN equiv)	-	1																																				
COUMADIN TAB	-	3																																				
DIRECT FACTOR XA INHIBITORS																																						
ELIQUIS TAB	-	2																																				
XARELTO STARTER PACK	-	2																																				
XARELTO TAB	-	2																																				
BEVYXXA CAP	-	NC																																				
HEPARINS AND HEPARINOID-LIKE AGENTS																																						
enoxaparin inj (LOVENOX equiv) (QL= 17 days supply)	QL	1																																				
fondaparinux inj (ARIXTRA equiv)	PA	1																																				
Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.																																						
<table border="1"> <tr> <td>INF</td> <td>NC =Not Covered</td> <td>KMSP</td> <td>generic =small letters</td> <td>LD</td> <td>BRANDS =CAPITAL LETTERS</td> </tr> <tr> <td>LMSP</td> <td>Infertility</td> <td>M</td> <td>Kroger Mandatory Specialty Pharmacy Program</td> <td>MSP</td> <td>Limited Distribution</td> </tr> <tr> <td>OTC</td> <td>Lumicera Mandatory Specialty Pharmacy Program</td> <td>PA</td> <td>Medical Benefit</td> <td>QL</td> <td>Mandatory Specialty Pharmacy Program</td> </tr> <tr> <td>RS</td> <td>Over-the-Counter</td> <td>SF</td> <td>Prior Authorization</td> <td>SMKG</td> <td>Quantity Limit</td> </tr> <tr> <td>SP</td> <td>Restricted to Specialist</td> <td>ST</td> <td>Limited to Two 15 Day Fills per Month for the First 3 M</td> <td>VAC</td> <td>Smoking Cessation</td> </tr> <tr> <td></td> <td>Available through Specialty Pharmacy Program</td> <td></td> <td>Step Therapy</td> <td></td> <td>Vaccine Program</td> </tr> </table>			INF	NC =Not Covered	KMSP	generic =small letters	LD	BRANDS =CAPITAL LETTERS	LMSP	Infertility	M	Kroger Mandatory Specialty Pharmacy Program	MSP	Limited Distribution	OTC	Lumicera Mandatory Specialty Pharmacy Program	PA	Medical Benefit	QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization	SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to Two 15 Day Fills per Month for the First 3 M	VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy		Vaccine Program
INF	NC =Not Covered	KMSP	generic =small letters	LD	BRANDS =CAPITAL LETTERS																																	
LMSP	Infertility	M	Kroger Mandatory Specialty Pharmacy Program	MSP	Limited Distribution																																	
OTC	Lumicera Mandatory Specialty Pharmacy Program	PA	Medical Benefit	QL	Mandatory Specialty Pharmacy Program																																	
RS	Over-the-Counter	SF	Prior Authorization	SMKG	Quantity Limit																																	
SP	Restricted to Specialist	ST	Limited to Two 15 Day Fills per Month for the First 3 M	VAC	Smoking Cessation																																	
	Available through Specialty Pharmacy Program		Step Therapy		Vaccine Program																																	

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Category/Class**

Last Updated* 11/1/2017

DrugName	Special Code	Tier
ANTICOAGULANTS Cont.		
ARIXTRA INJ	PA	3
FRAGMIN INJ	-	3
LOVENOX INJ (QL= 17 days supply)	QL	3
THROMBIN INHIBITORS		
PRADAXA CAP	-	2
ANTICONVULSANTS		
AMPA GLUTAMATE RECEPTOR ANTAGONISTS		
FYCOMPA TAB	-	NC
FYCOMPA SUSP	-	NC
ANTICONVULSANTS - BENZODIAZEPINES		
clonazepam ODT (KLONOPIN equiv)	-	1
clonazepam tab (KLONOPIN equiv)	-	1
ONFI TAB	PA	2
DIASTAT RECTAL GEL, DIAZEPAM RECTAL GEL	-	3
KLONOPIN TAB	-	3
ONFI SUSP	-	NC
ANTICONVULSANTS - MISC.		
carbamazepine chew tab (TEGRETOL equiv)	-	1
carbamazepine ER cap (CARBATROL equiv)	-	1
carbamazepine ER tab (TEGRETOL XR equiv)	-	1
carbamazepine susp (TEGRETOL equiv)	-	1
carbamazepine tab (TEGRETOL equiv)	-	1
gabapentin cap (NEURONTIN equiv)	-	1
gabapentin soln (NEURONTIN equiv)	-	1
gabapentin tab (NEURONTIN equiv)	-	1
lamotrigine chew tab (LAMICTAL equiv)	-	1
lamotrigine ER tab (LAMICTAL XR equiv)	-	1
lamotrigine ODT (LAMICTAL equiv)	-	1
lamotrigine ODT kit (LAMICTAL ODT KIT equiv)	-	1
lamotrigine tab (LAMICTAL equiv)	-	1
levetiracetam ER tab (KEPPRA XR equiv)	-	1
levetiracetam soln (KEPPRA equiv)	-	1
levetiracetam tab (KEPPRA equiv)	-	1
oxcarbazepine susp (TRILEPTAL equiv)	-	1
oxcarbazepine tab (TRILEPTAL equiv)	-	1
primidone tab (MYSOLINE equiv)	-	1
topiramate sprinkle cap (TOPAMAX equiv)	-	1
topiramate tab (TOPAMAX equiv)	-	1
zonisamide cap (ZONEGRAN equiv)	-	1
BANZEL SUSP	-	2
BANZEL TAB	-	2
LAMICTAL CHEW TAB 2MG	-	2
LYRICA CAP	-	2
LYRICA SOLN	-	2
POTIGA TAB (QL= 3 tabs/day)	QL	2
POTIGA TAB 50MG (QL= 9 tabs/day)	QL	2

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	KMSP	generic =small letters	LD	BRANDS =CAPITAL LETTERS
LMSP	Infertility	M	Kroger Mandatory Specialty Pharmacy Program	MSP	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	PA	Medical Benefit	QL	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	SF	Prior Authorization	SMKG	Quantity Limit
SP	Restricted to Specialist	ST	Limited to Two 15 Day Fills per Month for the First 3 M	VAC	Smoking Cessation
	Available through Specialty Pharmacy Program		Step Therapy		Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Category/Class**

Last Updated* 11/1/2017

DrugName	Special Code	Tier
ANTICONVULSANTS Cont.		
TRILEPTAL SUSP	-	2
VIMPAT SOLN	-	2
VIMPAT TAB (QL= 2 tabs/day)	QL	2
CARBATROL CAP	-	3
KEPPRA SOLN	-	3
KEPPRA TAB	-	3
KEPPRA XR TAB	-	3
LAMICTAL CHEW TAB	-	3
LAMICTAL ODT	-	3
LAMICTAL ODT KIT	-	3
LAMICTAL TAB	-	3
LAMICTAL XR KIT	-	3
LAMICTAL XR TAB	-	3
MYSOLINE TAB	-	3
NEURONTIN CAP	-	3
NEURONTIN SOLN	-	3
NEURONTIN TAB	-	3
TEGRETOL CHEW TAB	-	3
TEGRETOL SUSP	-	3
TEGRETOL TAB	-	3
TEGRETOL XR TAB	-	3
TOPAMAX SPRINKLE CAP	-	3
TOPAMAX TAB	-	3
TRILEPTAL TAB	-	3
ZONEGRAN CAP	-	3
APTiom TAB	-	NC
BRIVIACT INJ 50MG/5ML	-	NC
BRIVIACT SOLN 10MG/ML	-	NC
BRIVIACT TAB	-	NC
QUDEXY XR CAP, TOPIRAMATE ER CAP	-	NC
SPRITAM TAB	-	NC
TROKENDI XR CAP	-	NC
CARBAMATES		
felbamate susp (FELBATOL equiv)	-	1
felbamate tab (FELBATOL equiv)	-	1
FELBATOL TAB	-	2
FELBATOL SUSP	-	3
GABA MODULATORS		
tiagabine tab (GABITRIL equiv)	-	1
GABITRIL TAB 12MG, 16MG	-	2
GABITRIL TAB	-	3
SABRIL TAB (Only available through Walgreens 888-347-3416)	LD-PA	4
vigabatrin powder pack (SABRIL POWDER equiv) (Only available through Walgreens 888-347-3416)	LD-PA	4
SABRIL POWDER PACK	-	NC
HYDANTOINS		
phenytoin cap (DILANTIN equiv)	-	1

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered Infertility	KMSP	generic =small letters Kroger Mandatory Specialty Pharmacy Program	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 M	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Category/Class**

Last Updated* 11/1/2017

DrugName	Special Code	Tier
ANTICONVULSANTS Cont.		
phenytoin chew tab (DILANTIN equiv)	-	1
phenytoin susp (DILANTIN equiv)	-	1
DILANTIN CAP 30MG	-	2
PEGANONE TAB	-	2
DILANTIN CAP 100MG	-	3
DILANTIN INFATABS	-	3
DILANTIN SUSP	-	3
SUCCINIMIDES		
ethosuximide cap (ZARONTIN equiv)	-	1
ethosuximide soln (ZARONTIN equiv)	-	1
CELONTIN CAP	-	2
ZARONTIN CAP	-	3
ZARONTIN SOLN	-	3
VALPROIC ACID		
divalproex ER tab (DEPAKOTE ER equiv)	-	1
divalproex sodium DR tab (DEPAKOTE equiv)	-	1
divalproex sprinkle cap (DEPAKOTE equiv)	-	1
valproic acid cap (DEPAKENE equiv)	-	1
valproic acid syrup (DEPAKENE equiv)	-	1
DEPAKENE CAP	-	3
DEPAKENE SYRUP	-	3
DEPAKOTE ER TAB	-	3
DEPAKOTE SPRINKLE CAP	-	3
DEPAKOTE TAB	-	3
DEPACON INJ	-	NC
STAVZOR CAP	-	NC
valproate inj (DEPACON equiv)	-	NC
ANTIDEPRESSANTS		
ALPHA-2 RECEPTOR ANTAGONISTS (TETRACYCLICS)		
mirtazapine ODT (REMERON equiv)	-	1
mirtazapine tab (REMERON equiv)	-	1
REMERON SOLUTAB	-	3
REMERON TAB	-	3
ANTIDEPRESSANTS - MISC.		
bupropion ER tab (WELLBUTRIN equiv)	-	1
bupropion tab (WELLBUTRIN equiv)	-	1
bupropion XL tab (WELLBUTRIN XL equiv)	-	1
MAPROTILINE TAB	-	1
WELLBUTRIN SR TAB	-	3
WELLBUTRIN TAB	-	3
WELLBUTRIN XL TAB	-	3
APLENZIN TAB	-	NC
MONOAMINE OXIDASE INHIBITORS (MAOIS)		
phenelzine tab (NARDIL equiv)	-	1
tranylcypromine tab (PARNATE equiv)	-	1
MARPLAN TAB	-	2
Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.		
INF Infertility LMSP Lumicera Mandatory Specialty Pharmacy Program OTC Over-the-Counter RS Restricted to Specialist SP Available through Specialty Pharmacy Program	KMSP Kroger Mandatory Specialty Pharmacy Program M Medical Benefit PA Prior Authorization SF Limited to Two 15 Day Fills per Month for the First 3 M ST Step Therapy	generic =small letters LD Limited Distribution MSP Mandatory Specialty Pharmacy Program QL Quantity Limit SMKG Smoking Cessation VAC Vaccine Program
BRANDS =CAPITAL LETTERS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Category/Class**

Last Updated* 11/1/2017

DrugName	Special Code	Tier
ANTIDEPRESSANTS Cont.		
NARDIL TAB	-	2
EMSAM PATCH	-	3
PARNATE TAB	-	3
SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIS)		
citalopram soln (CELEXA equiv)	-	1
citalopram tab (CELEXA equiv)	-	1
escitalopram soln (LEXAPRO equiv)	-	1
escitalopram tab (LEXAPRO equiv)	-	1
fluoxetine cap (PROZAC equiv)	-	1
fluoxetine soln (PROZAC equiv)	-	1
fluoxetine tab (PROZAC equiv)	-	1
fluvoxamine ER cap (LUVOX CR equiv) (Step Therapy requires trial of citalopram, escitalopram, sertraline, fluoxetine, fluvoxamine or paroxetine)	ST	1
fluvoxamine tab (LUVOX equiv)	-	1
paroxetine ER tab (PAXIL CR equiv)	-	1
paroxetine tab (PAXIL equiv)	-	1
sertraline conc (ZOLOFT equiv)	-	1
sertraline tab (ZOLOFT equiv)	-	1
CELEXA SOLN	-	3
CELEXA TAB	-	3
LEXAPRO SOLN	-	3
LEXAPRO TAB	-	3
LUVOX CR CAP (Step Therapy requires trial of citalopram, escitalopram, sertraline, fluoxetine, fluvoxamine or paroxetine)	ST	3
PAXIL CR TAB	-	3
PAXIL SUSP	-	3
PAXIL TAB	-	3
PEXEVA TAB (Step Therapy requires trial of citalopram, escitalopram, sertraline, fluoxetine, fluvoxamine or paroxetine)	ST	3
PROZAC CAP	-	3
PROZAC SOLN	-	3
PROZAC TAB	-	3
ZOLOFT CONC	-	3
ZOLOFT TAB	-	3
FLUOXETINE TAB 60MG	-	NC
fluoxetine weekly cap (PROZAC equiv)	-	NC
PROZAC WEEKLY CAP	-	NC
SEROTONIN MODULATORS		
NEFAZODONE TAB	-	1
nefazodone tab 50mg, 250mg	-	1
trazodone tab (DESYREL equiv)	-	1
OLEPTRO TAB	-	3
TRINTELLIX TAB (QL= 1 tab/day)	PA-QL	3
trazodone tab 300mg (DESYREL equiv)	-	NC
VIIBRYD STARTER KIT	-	NC
VIIBRYD TAB	-	NC
SEROTONIN-NOREPINEPHRINE REUPTAKE INHIBITORS (SNRIS)		
desvenlafaxine ER tab (PRISTIQ equiv)	-	1

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered Infertility	KMSP	generic =small letters Kroger Mandatory Specialty Pharmacy Program	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 M	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Category/Class**

Last Updated* 11/1/2017

DrugName	Special Code	Tier		
ANTIDEPRESSANTS Cont.				
duloxetine EC cap (CYMBALTA equiv)	-	1		
venlafaxine ER cap (EFFEXOR XR equiv)	-	1		
venlafaxine tab (EFFEXOR equiv)	-	1		
EFFEXOR TAB	-	3		
EFFEXOR XR CAP	-	3		
FETZIMA CAP (QL= 1 cap/day)	PA-QL	3		
FETZIMA TITRATION PACK (QL= 1 cap/day)	PA-QL	3		
PRISTIQ TAB	-	3		
CYMBALTA CAP	-	NC		
DESVENLAFAXINE ER TAB	-	NC		
KHEDEZLA ER TAB	-	NC		
venlafaxine ER tab	-	NC		
TRICYCLIC AGENTS				
amitriptyline tab (ELAVIL equiv)	-	1		
AMOXAPINE TAB	-	1		
clomipramine cap (ANAFRANIL equiv)	-	1		
desipramine tab (NORPRAMIN equiv)	-	1		
doxepin cap (SINEQUAN equiv)	-	1		
doxepin conc (SINEQUAN equiv)	-	1		
imipramine pamoate cap (TOFRANIL PM equiv)	-	1		
imipramine tab (TOFRANIL equiv)	-	1		
nortriptyline cap (PAMELOR equiv)	-	1		
NORTRIPTYLINE SOLN	-	1		
protriptyline tab (VIVACTIL equiv)	-	1		
trimipramine cap (SURMONTIL equiv)	-	1		
ANAFRANIL CAP	-	3		
NORPRAMIN TAB	-	3		
PAMELOR CAP	-	3		
SURMONTIL CAP	-	3		
TOFRANIL PM CAP	-	3		
TOFRANIL TAB	-	3		
VIVACTIL TAB	-	3		
ANTIDIABETICS				
ALPHA-GLUCOSIDASE INHIBITORS				
acarbose tab (PRECOSE equiv)	-	1		
miglitol tab (GLYSET equiv)	-	1		
GLYSET TAB	-	3		
PRECOSE TAB	-	3		
ANTIDIABETIC - AMYLIN ANALOGS				
SYMLINPEN INJ	-	NC		
ANTIDIABETIC COMBINATIONS				
glipizide/metformin tab (METAGLIP equiv)	-	1		
glyburide/metformin tab (GLUCOVANCE equiv)	-	1		
pioglitazone/glimepiride tab (DUETACT equiv)	-	1		
pioglitazone/metformin tab (ACTOPLUS MET equiv)	-	1		
ALOGLIPTIN-METFORMIN TAB (QL= 2 tabs/day)	QL	2		
Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.				
INF Infertility LMSP Lumicera Mandatory Specialty Pharmacy Program OTC Over-the-Counter RS Restricted to Specialist SP Available through Specialty Pharmacy Program	KMSP M PA SF ST	generic =small letters Kroger Mandatory Specialty Pharmacy Program Medical Benefit Prior Authorization Limited to Two 15 Day Fills per Month for the First 3 M Step Therapy	LD MSP QL SMKG VAC	BRANDS =CAPITAL LETTERS Limited Distribution Mandatory Specialty Pharmacy Program Quantity Limit Smoking Cessation Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Category/Class**

Last Updated* 11/1/2017

DrugName	Special Code	Tier
ANTIDIABETICS Cont.		
ALOGLIPTIN-PIOGLITAZONE TAB (QL= 1 tab/day)	QL	2
AVANDAMET TAB	-	2
AVANDARYL TAB	-	2
GLYXAMBI TAB (QL= 1 tab/day)	QL	2
JANUMET TAB (QL= 2 tabs/day)	QL	2
JANUMET XR TAB (QL= 2 tabs/day)	QL	2
JENTADUETO XR TAB (QL= 2 tabs/day)	QL	2
SYNJARDY TAB (QL= 2 tabs/day)	QL	2
SYNJARDY XR TAB 10-1000MG, 25-1000MG (QL= 1 tab/day)	QL	2
SYNJARDY XR TAB 5-1000MG, 12.5-1000MG (QL= 2 tabs/day)	QL	2
ACTOPLUS MET TAB	-	3
ACTOPLUS MET XR TAB	-	3
DUETACT TAB	-	3
GLUCOVANCE TAB	-	3
JENTADUETO TAB (QL= 2 tabs/day)	PA-QL	3
METAGLIP TAB	-	3
INVOKAMET TAB	-	NC
INVOKAMET XR TAB	-	NC
KAZANO TAB	-	NC
KOMBIGLYZE XR TAB	-	NC
OSENI TAB	-	NC
PRANDIMET TAB	-	NC
SOLIQUA INJ	-	NC
XIGDUO XR TAB	-	NC
XIGDUO XR TAB 5-1000MG	-	NC
XULTOPHY INJ	-	NC
BIGUANIDES		
metformin ER tab (GLUCOPHAGE XR equiv)	-	1
metformin tab (GLUCOPHAGE equiv)	-	1
GLUCOPHAGE TAB	-	3
GLUCOPHAGE XR TAB	-	3
RIOMET SOLN	-	3
FORTAMET TAB	-	NC
GLUMETZA TAB 1000MG	-	NC
GLUMETZA TAB 500MG	-	NC
metformin ER osmotic tab (FORTAMET equiv)	-	NC
DIABETIC OTHER		
GLUCAGEN HYPOKIT INJ	-	2
GLUCAGON INJ KIT	-	2
PROGLYCEM SUSP	-	3
KORLYM TAB (Only available through Korlym SPARK program 855-4Korlym (855-456-7596))	LD-PA	4
DIPEPTIDYL PEPTIDASE-4 (DPP-4) INHIBITORS		
ALOGLIPTIN TAB (QL= 1 tab/day)	QL	2
JANUVIA TAB (QL= 1 tab/day)	QL	2
TRADJENTA TAB (QL= 1 tab/day)	PA-QL	3
NESINA TAB	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered Infertility	KMSP	generic =small letters Kroger Mandatory Specialty Pharmacy Program	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 M	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Category/Class**

Last Updated* 11/1/2017

DrugName	Special Code	Tier
ANTIDIABETICS Cont.		
ONGLYZA TAB	-	NC
DOPAMINE RECEPTOR AGONISTS - ANTIDIABETIC		
CYCLOSET TAB	-	3
INCRETIN MIMETIC AGENTS (GLP-1 RECEPTOR AGONISTS)		
BYDUREON INJ (QL= 4 inj/28 days)	QL	2
BYDUREON PEN INJ (QL= 4 inj/28 days)	QL	2
VICTOZA INJ (QL= 9ml/30 days)	QL	2
BYETTA INJ	-	3
ADLYXIN INJ	-	NC
TANZEUM INJ	-	NC
TRULICITY INJ	-	NC
INSULIN		
BASAGLAR INJ	-	2
HUMULIN R INJ U-500	-	2
HUMULIN R U-500 KWIKPEN INJ	-	2
NOVOLIN INJ	OTC	2
NOVOLOG FLEXPEN INJ	-	2
NOVOLOG INJ	-	2
NOVOLOG MIX FLEXPEN INJ	-	2
NOVOLOG MIX INJ	-	2
NOVOLOG PENFILL INJ	-	2
APIDRA INJ (Step Therapy requires trial of NOVOLOG)	ST	3
APIDRA SOLOSTAR INJ (Step Therapy requires trial of NOVOLOG)	ST	3
HUMALOG INJ (Step Therapy requires trial of NOVOLOG)	ST	3
HUMALOG KWIKPEN INJ (Step Therapy requires trial of NOVOLOG)	ST	3
HUMALOG MIX INJ (Step Therapy requires trial of NOVOLOG)	ST	3
HUMALOG MIX KWIKPEN INJ (Step Therapy requires trial of NOVOLOG)	ST	3
HUMALOG PEN INJ (Step Therapy requires trial of NOVOLOG)	ST	3
HUMULIN MIX INJ (Step Therapy requires trial of NOVOLIN)	OTC-ST	3
HUMULIN MIX PEN INJ (Step Therapy requires trial of NOVOLIN)	OTC-ST	3
HUMULIN N INJ (Step Therapy requires trial of NOVOLIN)	OTC-ST	3
HUMULIN N PEN INJ (Step Therapy requires trial of NOVOLIN)	OTC-ST	3
HUMULIN R INJ (Step Therapy requires trial of NOVOLIN)	OTC-ST	3
LANTUS INJ	-	NC
LANTUS SOLOSTAR INJ	-	NC
LEVEMIR FLEXTOUCH INJ	-	NC
LEVEMIR INJ	-	NC
TOUJEO SOLOSTAR INJ	-	NC
TRESIBA INJ	-	NC
INSULIN SENSITIZING AGENTS		
pioglitazone tab (ACTOS equiv)	-	1
AVANDIA TAB	-	2
ACTOS TAB	-	3
MEGLITINIDE ANALOGUES		
nateglinide tab (STARLIX equiv)	-	1
repaglinide tab (PRANDIN equiv)	-	1

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	KMSP	generic =small letters	LD	BRANDS =CAPITAL LETTERS
LMSP	Infertility	M	Kroger Mandatory Specialty Pharmacy Program	MSP	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	PA	Medical Benefit	QL	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	SF	Prior Authorization	SMKG	Quantity Limit
SP	Restricted to Specialist	ST	Limited to Two 15 Day Fills per Month for the First 3 M	VAC	Smoking Cessation
	Available through Specialty Pharmacy Program		Step Therapy		Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Category/Class**

Last Updated* 11/1/2017

DrugName	Special Code	Tier
ANTIDIABETICS Cont.		
PRANDIN TAB	-	3
STARLIX TAB	-	3
SODIUM-GLUCOSE CO-TRANSPORTER 2 (SGLT2) INHIBITORS		
JARDIANCE TAB (QL= 1 tab/day)	QL	2
FARXIGA TAB	-	NC
INVOKANA TAB	-	NC
SULFONYLUREAS		
CHLORPROPAMIDE TAB	-	1
chlorpropamide tab (DIABINESE equiv)	-	1
glimepiride tab (AMARYL equiv)	-	1
glipizide ER tab (GLUCOTROL XL equiv)	-	1
glipizide tab (GLUCOTROL equiv)	-	1
glyburide micronized tab (GLYNASE equiv)	-	1
glyburide tab (MICRONASE equiv)	-	1
tolazamide tab (TOLINASE equiv)	-	1
TOLBUTAMIDE TAB	-	2
AMARYL TAB	-	3
DIABETA TAB	-	3
GLUCOTROL TAB	-	3
GLUCOTROL XL TAB	-	3
GLYNASE TAB	-	3
ANTIDIARRHEALS		
ANTIDIARRHEAL - CHLORIDE CHANNEL ANTAGONISTS		
MYTESI TAB	-	NC
ANTIDIARRHEAL AGENTS - MISC.		
REZYST CHEW TAB	-	NC
VSL #3 CAP	-	NC
ANTIPERISTALTIC AGENTS		
diphenoxylate/atropine liquid (LOMOTIL equiv)	-	1
diphenoxylate/atropine tab (LOMOTIL equiv)	-	1
opium tincture	-	1
LOMOTIL LIQUID	-	3
LOMOTIL TAB	-	3
MOTOFEN TAB	-	3
loperamide cap	-	NC
PAREGORIC TINCTURE	-	NC
ANTIDOTES		
ANTIDOTES		
VISTOGARD PAK	-	NC
ANTIDOTES - CHELATING AGENTS		
CHEMET CAP	-	2
EXJADE TAB	MSP	4
FERRIPROX SOLN (Only available through Ferriprox Total Care 866-758-7071)	LD-PA	4
FERRIPROX TAB (Only available through Ferriprox Total Care 866-758-7071)	LD-PA	4
JADENU TAB	KMSP	4

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	KMSP	generic =small letters	LD	BRANDS =CAPITAL LETTERS
LMSP	Infertility	M	Kroger Mandatory Specialty Pharmacy Program	MSP	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	PA	Medical Benefit	QL	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	SF	Prior Authorization	SMKG	Quantity Limit
SP	Restricted to Specialist	ST	Limited to Two 15 Day Fills per Month for the First 3 M	VAC	Smoking Cessation
	Available through Specialty Pharmacy Program		Step Therapy		Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Category/Class**

Last Updated* 11/1/2017

DrugName	Special Code	Tier
ANTIDOTES Cont.		
OPIOID ANTAGONISTS		
naloxone inj	-	1
naltrexone tab (REVIA equiv)	-	1
REVIA TAB	-	3
EVZIO INJ	-	NC
VIVITROL INJ	-	NC

ANTIDOTES AND SPECIFIC ANTAGONISTS

ANTIDOTES - CHELATING AGENTS		
JADENU SPRINKLE	KMSP	4
ANTIDOTES AND SPECIFIC ANTAGONISTS		
CETYLEV TAB	-	NC
OPIOID ANTAGONISTS		
NALOXONE INJ	-	2
NARCAN NASAL SPRAY	-	2

ANTIEMETICS

5-HT3 RECEPTOR ANTAGONISTS		
ondansetron ODT (ZOFRAN equiv)	-	1
ondansetron soln (ZOFRAN equiv)	-	1
ondansetron tab (ZOFRAN equiv)	-	1
ZOFRAN ODT	-	3
ZOFRAN SOLN	-	3
ZOFRAN TAB	-	3
ANZEMET TAB (QL= 9 tabs/fill)	QL-SP	4
granisetron tab (KYTRIL equiv) (QL= 9 tabs/fill)	QL-SP	4
GRANISOL SOLN (QL= 60ml/fill)	QL-SP	4
KYTRIL TAB (QL= 9 tabs/fill)	QL-SP	4
SANCUSO PATCH (QL= 4 patchs/fill)	QL-SP	4
SUSTOL INJ	-	NC
ZUPLENZ SL FILM	-	NC
ANTIEMETICS - ANTICHOLINERGIC		
ANTIVERT TAB	-	1
maldemar tab (SCOPACE equiv)	-	1
meclizine chew tab (BONINE equiv)	OTC	1
meclizine tab (ANTIVERT equiv)	OTC	1
scopolamine patch (TRANSDERM-SCOP equiv)	-	1
trimethobenzamide cap (TIGAN equiv)	-	1
TIGAN CAP	-	3
TRANSDERM-SCOP PATCH	-	3
ANTIEMETICS - MISCELLANEOUS		
dronabinol cap (MARINOL equiv)	PA	1
AKYNZEO CAP (QL= 1 cap/fill; Restricted to Oncology or Hematology Specialist)	QL-RS	2
CESAMET CAP	-	3
MARINOL CAP	PA	3
DICLEGIS TAB	-	NC
SYNDROS SOLN	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	KMSP	generic =small letters	LD	BRANDS =CAPITAL LETTERS
LMSP	Infertility	M	Kroger Mandatory Specialty Pharmacy Program	MSP	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	PA	Medical Benefit	QL	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	SF	Prior Authorization	SMKG	Quantity Limit
SP	Restricted to Specialist	ST	Limited to Two 15 Day Fills per Month for the First 3 M	VAC	Smoking Cessation
	Available through Specialty Pharmacy Program		Step Therapy		Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Category/Class**

Last Updated* 11/1/2017

DrugName	Special Code	Tier
ANTIEMETICS Cont.		
SUBSTANCE P/NEUROKININ 1 (NK1) RECEPTOR ANTAGONISTS		
aprepitant cap (EMEND equiv) (QL= 3 caps/fill; Restricted to Oncology or Hematology Specialist)	QL-RS	1
aprepitant pak (EMEND equiv) (QL= 3 caps/fill; Restricted to Oncology or Hematology Specialist)	QL-RS	1
VARUBI TAB (QL= 2 tabs/day; Restricted to Oncology or Hematology Specialist)	QL-RS	2
EMEND PAK (QL= 3 caps/fill; Restricted to Oncology or Hematology Specialist)	QL-RS	3
EMEND SUSP	-	NC

ANTIFUNGALS

ANTIFUNGALS		
flucytosine cap (ANCOBON equiv)	-	1
griseofulvin micro tab (GRIFULVIN V equiv)	-	1
griseofulvin susp (GRIFULVIN equiv)	-	1
griseofulvin tab (GRIS-PEG equiv)	-	1
nystatin powder	-	1
nystatin tab	-	1
terbinafine tab (LAMISIL equiv)	-	1
ANCOBON CAP	-	3
GRIFULVIN V TAB	-	3
GRIS-PEG TAB	-	3
LAMISIL TAB	-	3

IMIDAZOLE-RELATED ANTIFUNGALS

fluconazole susp (DIFLUCAN equiv)	-	1
fluconazole tab (DIFLUCAN equiv)	-	1
itraconazole cap (SPORANOX equiv)	PA	1
ketoconazole tab (NIZORAL equiv)	-	1
voriconazole susp (VFEND equiv) (Restricted to Infectious Disease Specialist)	RS	1
voriconazole tab (VFEND equiv) (Restricted to Infectious Disease Specialist)	RS	1
NOXAFIL SUSP	-	2
DIFLUCAN SUSP	-	3
DIFLUCAN TAB	-	3
SPORANOX CAP	PA	3
SPORANOX SOLN	PA	3
VFEND SUSP (Restricted to Infectious Disease Specialist)	RS	3
VFEND TAB (Restricted to Infectious Disease Specialist)	RS	3
CRESEMBA CAP	-	NC
NOXAFIL TAB	-	NC

ANTIHISTAMINES

ANTIHISTAMINES - ALKYLAMINES

chlorpheniramine ER cap	-	1
CPM CAP	-	3

ANTIHISTAMINES - ETHANOLAMINES

carbinoxamine soln (PALGIC equiv)	-	1
carbinoxamine tab (PALGIC equiv)	-	1
clemastine syrup (TAVIST equiv)	-	1
CLEMASTINE TAB	-	1
clemastine tab (TAVIST equiv)	-	1

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	KMSP	generic =small letters	LD	BRANDS =CAPITAL LETTERS
LMSP	Infertility	M	Kroger Mandatory Specialty Pharmacy Program	MSP	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	PA	Medical Benefit	QL	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	SF	Prior Authorization	SMKG	Quantity Limit
SP	Restricted to Specialist	ST	Limited to Two 15 Day Fills per Month for the First 3 M	VAC	Smoking Cessation
	Available through Specialty Pharmacy Program		Step Therapy		Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Category/Class**

Last Updated* 11/1/2017

DrugName	Special Code	Tier
ANTIHISTAMINES Cont.		
diphenhydramine cap 50mg (BENADRYL equiv) (Only 50mg covered)	-	1
PALGIC SOLN	-	3
PALGIC TAB	-	3
diphenhydramine inj (BENADRYL equiv)	-	M
KARBINAL ER SUSP	-	NC
RYVENT TAB	-	NC
ANTIHISTAMINES - NON-SEDATING		
CLARINEX REDITAB	-	NC
CLARINEX SYRUP	-	NC
CLARINEX TAB	-	NC
DES Loratadine ODT	-	NC
desloratadine tab (CLARINEX equiv)	-	NC
levocetirizine soln (XYZAL equiv)	-	NC
levocetirizine tab (XYZAL equiv)	-	NC
loratadine cap (CLARITIN equiv)	OTC	NC
XYZAL SOLN	-	NC
XYZAL TAB	-	NC
ANTIHISTAMINES - PHENOTHIAZINES		
promethazine supp (PHENERGAN equiv)	-	1
promethazine syrup	-	1
promethazine tab (PHENERGAN equiv)	-	1
ANTIHISTAMINES - PIPERIDINES		
cyproheptadine syrup	-	1
cyproheptadine tab	-	1
ANTIHYPERLIPIDEMICS		
ANTIHYPERLIPIDEMICS - COMBINATIONS		
ezetimibe/simvastatin tab (VYTORIN equiv) (QL= 1 tab/day (10-80mg is Not Covered))	QL	1
LIPTRUZET TAB	-	3
VYTORIN TAB (QL= 1 tab/day (10/80mg is Not Covered))	QL	3
ezetimibe/simvastatin tab 10-80mg (VYTORIN equiv)	-	NC
VYTORIN TAB 10-80MG	-	NC
ANTIHYPERLIPIDEMICS - MISC.		
omega-3-acid ethyl esters cap (LOVAZA equiv)	-	1
LOVAZA CAP	-	3
KYNAMRO INJ	-	NC
VASCEPA CAP	-	NC
BILE ACID SEQUESTRANTS		
cholestyramine lite powder (QUESTRAN LITE equiv)	-	1
cholestyramine lite powder pack (QUESTRAN LITE equiv)	-	1
cholestyramine powder (QUESTRAN equiv)	-	1
cholestyramine powder pack (QUESTRAN equiv)	-	1
colestipol granule (COLESTID equiv)	-	1
colestipol powder packet (COLESTID equiv)	-	1
colestipol tab (COLESTID equiv)	-	1
WELCHOL PAK	-	2

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	KMSP	generic =small letters	LD	BRANDS =CAPITAL LETTERS
LMSP	Infertility	M	Kroger Mandatory Specialty Pharmacy Program	MSP	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	PA	Medical Benefit	QL	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	SF	Prior Authorization	SMKG	Quantity Limit
SP	Restricted to Specialist	ST	Limited to Two 15 Day Fills per Month for the First 3 M	VAC	Smoking Cessation
	Available through Specialty Pharmacy Program		Step Therapy		Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Category/Class**

Last Updated* 11/1/2017

DrugName	Special Code	Tier
ANTIHYPERTENSIVES Cont.		
WELCHOL TAB	-	2
COLESTID GRANULE	-	3
COLESTID POWDER PACK	-	3
COLESTID TAB	-	3
QUESTRAN LITE POWDER	-	3
QUESTRAN LITE POWDER PACK	-	3
QUESTRAN POWDER	-	3
QUESTRAN POWDER PACK	-	3
FIBRIC ACID DERIVATIVES		
fenofibrate cap 67mg, 134mg, 200mg (ANTARA equiv)	-	1
fenofibrate tab 48mg, 54mg, 145mg, 160mg (TRICOR equiv)	-	1
gemfibrozil tab (LOPID equiv)	-	1
TRILIPIX CAP	-	1
FENOFIBRIC TAB, FIBRICOR TAB	-	3
LOPID TAB	-	3
TRICOR TAB	-	3
ANTARA CAP	-	NC
ANTARA CAP, LOFIBRA CAP	-	NC
fenofibrate cap 43mg, 130mg (ANTARA equiv)	-	NC
FENOFIBRATE CAP, LIPOFEN CAP 50MG, 150MG	-	NC
fenofibrate tab 40mg, 120mg (FENOGLIDE equiv)	-	NC
fenofibric acid DR cap (TRILIPIX equiv)	-	NC
FENOGLIDE TAB	-	NC
LOFIBRA TAB, TRIGLIDE TAB	-	NC
HMG COA REDUCTASE INHIBITORS		
atorvastatin tab 10mg (LIPITOR equiv)	-	1
atorvastatin tab 20mg (LIPITOR equiv)	-	1
atorvastatin tab 40mg (LIPITOR equiv)	-	1
atorvastatin tab 80mg (LIPITOR equiv)	-	1
fluvastatin cap (LESCOL equiv)	-	1
fluvastatin ER tab (LESCOL XL equiv)	-	1
lovastatin tab (MEVACOR equiv)	-	1
pravastatin tab (PRAVACHOL equiv)	-	1
rosuvastatin tab 10mg (CRESTOR equiv) (QL= 1 tab/day)	QL	1
rosuvastatin tab 20mg (CRESTOR equiv) (QL= 1.5 tabs/day)	QL	1
rosuvastatin tab 40mg (CRESTOR equiv) (QL= 1 tab/day)	QL	1
rosuvastatin tab 5mg (CRESTOR equiv) (QL= 1 tab/day)	QL	1
simvastatin tab (80mg is Not Covered)	-	1
ALTOPREV TAB	-	3
CRESTOR TAB (QL= 1 tab/day)	QL	3
CRESTOR TAB 20MG (QL= 1.5 tabs/day)	QL	3
LESCOL CAP	-	3
LESCOL XL TAB	-	3
LIPITOR TAB	-	3
LIVALO TAB	-	3
MEVACOR TAB	-	3

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	KMSP	generic =small letters	LD	BRANDS =CAPITAL LETTERS
LMSP	Infertility	M	Kroger Mandatory Specialty Pharmacy Program	MSP	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	PA	Medical Benefit	QL	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	SF	Prior Authorization	SMKG	Quantity Limit
SP	Restricted to Specialist	ST	Limited to Two 15 Day Fills per Month for the First 3 M	VAC	Smoking Cessation
	Available through Specialty Pharmacy Program		Step Therapy		Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Category/Class**

Last Updated* 11/1/2017

DrugName	Special Code	Tier
ANTIHYPERTENSIVES Cont.		
PRAVACHOL TAB	-	3
ZOCOR TAB	-	3
ADVICOR TAB	-	NC
FLOLIPID SUSP	-	NC
SIMCOR TAB	-	NC
simvastatin tab 80mg (This strength excluded from coverage)	-	NC
ZOCOR TAB 80MG	-	NC
INTESTINAL CHOLESTEROL ABSORPTION INHIBITORS		
ezetimibe tab (ZETIA equiv)	-	1
ZETIA TAB	-	NC
MICROSOMAL TRIGLYCERIDE TRANSFER PROTEIN (MTP) INHIBITORS		
JUXTAPID CAP	-	NC
NICOTINIC ACID DERIVATIVES		
NIASPAN ER TAB	-	1
niacin ER tab (NIASPAN equiv)	-	NC
NIACOR TAB	-	NC
PROPROTEIN CONVERTASE SUBTILISIN/KEXIN TYPE 9 INHIBITORS		
PRALUENT INJ (QL= 2 inj/28 days)	KMSP-PA-QL	4
REPATHA INJ (QL= 2 inj/28 days)	KMSP-PA-QL	4
REPATHA PUSHTRONEX INJ (QL= 1 inj/28 days)	KMSP-PA-QL	4

ANTIHYPERTENSIVES

DrugName	Special Code	Tier
ACE INHIBITORS		
benazepril tab (LOTENSIN equiv)	-	1
captopril tab (CAPOTEN equiv)	-	1
enalapril tab (VASOTEC equiv)	-	1
fosinopril tab (MONOPRIL equiv)	-	1
lisinopril tab (PRINIVIL/ZESTRIL equiv)	-	1
moexipril tab (UNIVASC equiv)	-	1
perindopril tab (ACEON equiv)	-	1
quinapril tab (ACCUPRIL equiv)	-	1
ramipril cap (ALTACE equiv)	-	1
trandolapril tab (MAVIK equiv)	-	1
ACCUPRIL TAB	-	3
ACEON TAB	-	3
ALTACE CAP	-	3
ALTACE TAB	-	3
EPANED PREMIXED SOLN	PA	3
EPANED SOLN	PA	3
LOTENSIN TAB	-	3
MAVIK TAB	-	3
MONOPRIL TAB	-	3
PRINIVIL TAB, ZESTRIL TAB	-	3
UNIVASC TAB	-	3
VASOTEC TAB	-	3
QBRELIS SOLN	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	KMSP	generic =small letters	LD	BRANDS =CAPITAL LETTERS
LMSP	Infertility	M	Kroger Mandatory Specialty Pharmacy Program	MSP	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	PA	Medical Benefit	QL	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	SF	Prior Authorization	SMKG	Quantity Limit
SP	Restricted to Specialist	ST	Limited to Two 15 Day Fills per Month for the First 3 Months	VAC	Smoking Cessation
	Available through Specialty Pharmacy Program		Step Therapy		Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Category/Class**

Last Updated* 11/1/2017

DrugName	Special Code	Tier
ANTIHYPERTENSIVES Cont.		
AGENTS FOR PHEOCHROMOCYTOMA		
phenoxybenzamine cap (DIBENZYLINE equiv)	KMSP	1
DIBENZYLINE CAP	KMSP	3
ANGIOTENSIN II RECEPTOR ANTAGONISTS		
candesartan tab (ATACAND equiv)	-	1
irbesartan tab (AVAPRO equiv)	-	1
losartan tab (COZAAR equiv)	-	1
telmisartan tab (MICARDIS equiv)	-	1
valsartan tab (DIOVAN equiv)	-	1
AVAPRO TAB	-	3
COZAAR TAB	-	3
DIOVAN TAB	-	3
EDARBI TAB	-	3
EPROSARTAN TAB	-	3
MICARDIS TAB	-	3
TEVETEN TAB	-	3
ATACAND TAB	-	NC
BENICAR TAB	-	NC
olmesartan tab (BENICAR equiv)	-	NC
ANTIADRENERGIC ANTIHYPERTENSIVES		
clonidine patch (CATAPRES-TTS equiv)	-	1
clonidine tab (CATAPRES equiv)	-	1
doxazosin tab (CARDURA equiv)	-	1
guanfacine IR tab (TENEX equiv)	-	1
methyldopa tab (ALDOMET equiv)	-	1
prazosin cap (MINIPRESS equiv)	-	1
terazosin cap (HYTRIN equiv)	-	1
CARDURA TAB	-	3
CATAPRES TAB	-	3
CATAPRES-TTS PATCH	-	3
GUANABENZ TAB	-	3
HYTRIN CAP	-	3
MINIPRESS CAP	-	3
NEXICLON XR SUSP	-	3
NEXICLON XR TAB	-	3
RESERPINE TAB	-	3
TENEX TAB	-	3
ANTIHYPERTENSIVE COMBINATIONS		
amlodipine/benazepril cap (LOTREL equiv)	-	1
amlodipine/valsartan tab (EXFORGE equiv)	-	1
amlodipine/valsartan/hydrochlorothiazide tab (EXFORGE HCT equiv)	-	1
atenolol/chlorthalidone tab (TENORETIC equiv)	-	1
benazepril/hydrochlorothiazide tab (LOTENSIN HCT equiv)	-	1
bisoprolol/hydrochlorothiazide tab (ZIAC equiv)	-	1
candesartan/hydrochlorothiazide tab (ATACAND HCT equiv)	-	1
captopril/hydrochlorothiazide tab (CAPOZIDE equiv)	-	1

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	KMSP	generic =small letters	LD	BRANDS =CAPITAL LETTERS
LMSP	Infertility	M	Kroger Mandatory Specialty Pharmacy Program	MSP	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	PA	Medical Benefit	QL	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	SF	Prior Authorization	SMKG	Quantity Limit
SP	Restricted to Specialist	ST	Limited to Two 15 Day Fills per Month for the First 3 M	VAC	Smoking Cessation
	Available through Specialty Pharmacy Program		Step Therapy		Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Category/Class**

Last Updated* 11/1/2017

DrugName	Special Code	Tier
ANTIHYPERTENSIVES Cont.		
enalapril/hydrochlorothiazide tab (VASERETIC equiv)	-	1
fosinopril/hydrochlorothiazide tab (MONOPRIL HCT equiv)	-	1
irbesartan/hydrochlorothiazide tab (AVALIDE equiv)	-	1
lisinopril/hydrochlorothiazide tab (ZESTORETIC equiv)	-	1
losartan/hydrochlorothiazide tab (HYZAAR equiv)	-	1
methyldopa/hydrochlorothiazide tab (ALDORIL equiv)	-	1
metoprolol/hydrochlorothiazide tab (LOPRESSOR HCT equiv)	-	1
moexipril/hydrochlorothiazide tab (UNIRETIC equiv)	-	1
nadolol/bendroflumethiazide tab (CORZIDE equiv)	-	1
propranolol/hydrochlorothiazide tab (INDERIDE equiv)	-	1
quinapril/hydrochlorothiazide tab (ACCURETIC equiv)	-	1
telmisartan/amlodipine tab (TWINSTA equiv)	-	1
trandolapril/verapamil ER tab (TARKA equiv)	-	1
valsartan/hydrochlorothiazide tab (DIOVAN HCT equiv)	-	1
CAPTOPRIL/HYDROCHLOROTHIAZIDE TAB	-	2
ACCURETIC TAB	-	3
AMTURNIDE TAB	-	3
ATACAND HCT TAB	-	3
AVALIDE TAB	-	3
CORZIDE TAB	-	3
DIOVAN HCT TAB	-	3
EDARBYCLOR TAB	-	3
EXFORGE HCT TAB	-	3
EXFORGE TAB	-	3
HYZAAR TAB	-	3
LOPRESSOR HCT TAB	-	3
LOTENSIN HCT TAB	-	3
LOTREL CAP	-	3
MONOPRIL HCT TAB	-	3
TARKA TAB	-	3
TEKAMLO TAB	-	3
TEKURNA HCT TAB	-	3
TENORETIC TAB	-	3
TEVETEN HCT TAB	-	3
TWINSTA TAB	-	3
UNIRETIC TAB	-	3
VALTURNA TAB	-	3
VASERETIC TAB	-	3
ZESTORETIC TAB	-	3
ZIAC TAB	-	3
amlodipine/olmesartan tab (AZOR TAB equiv)	-	NC
AZOR TAB	-	NC
BENICAR HCT TAB	-	NC
BYVALSON TAB	-	NC
DUTOPROL TAB	-	NC
MICARDIS HCT TAB	-	NC
olmesartan/amlodipine/hydrochlorothiazide tab (TRIBENZOR TAB equiv)	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	KMSP	generic =small letters	LD	BRANDS =CAPITAL LETTERS
LMSP	Infertility	M	Kroger Mandatory Specialty Pharmacy Program	MSP	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	PA	Medical Benefit	QL	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	SF	Prior Authorization	SMKG	Quantity Limit
SP	Restricted to Specialist	ST	Limited to Two 15 Day Fills per Month for the First 3 M	VAC	Smoking Cessation
	Available through Specialty Pharmacy Program		Step Therapy		Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Category/Class**

Last Updated* 11/1/2017

DrugName	Special Code	Tier
ANTIHYPERTENSIVES Cont.		
olmesartan/hydrochlorothiazide tab (BENICAR HCT equiv)	-	NC
PRESTALIA TAB	-	NC
telmisartan/hydrochlorothiazide tab (MICARDIS HCT equiv)	-	NC
TRIBENZOR TAB	-	NC
DIRECT RENIN INHIBITORS		
TEKTURNA TAB	-	3
SELECTIVE ALDOSTERONE RECEPTOR ANTAGONISTS (SARAS)		
eplerenone tab (INSPRA equiv)	-	1
INSPRA TAB	-	3
VASODILATORS		
hydralazine tab (APRESOLINE equiv)	-	1
minoxidil tab (LONITEN equiv)	-	1
ANTI-INFECTIVE AGENTS - MISC.		
ANTI-INFECTIVE AGENTS - MISC.		
metronidazole cap (FLAGYL equiv)	-	1
metronidazole tab (FLAGYL equiv)	-	1
tinidazole tab (TINDAMAX equiv)	-	1
trimethoprim tab (PROLOPRIM equiv)	-	1
vancomycin cap (VANCOCIN equiv) (QL= 56 caps/fill; Step Therapy requires trial of vancomycin soln)	QL-ST	1
VANCOMYCIN SOLN KIT	-	1
FIRST METRONIDAZOLE SUSP	-	3
FLAGYL CAP	-	3
FLAGYL ER TAB	-	3
FLAGYL TAB	-	3
PRIMSOL SOLN	-	3
TINDAMAX TAB	-	3
VANCOCIN CAP (QL= 56 caps/fill; Step Therapy requires trial of vancomycin soln)	QL-ST	3
XIFAXAN TAB 200MG (QL= 9 tabs/3 days)	QL	3
XIFAXAN TAB 550MG (QL= 2 tabs/day; Quantities up to 3 tabs/day for the treatment of IBS-D allowed via PA)	PA-QL	3
CAYSTON INH SOLN (Restricted to Infectious Disease or Pulmonology Specialist)	KMSP-RS	4
IMPAVIDO CAP	PA	4
NEBUPENT NEB SOLN	KMSP	4
ANTI-INFECTIVE MISC. - COMBINATIONS		
erythromycin/sulfisoxazole susp (PEDIAZOLE equiv)	-	1
smz/tmp (DS) tab (BACTRIM DS equiv)	-	1
smz/tmp susp (BACTRIM, SEPTRA equiv)	-	1
BACTRIM DS TAB	-	3
PEDIAZOLE SUSP	-	3
ANTIPROTOZOAL AGENTS		
atovaquone susp (MEPRON equiv)	-	1
ALINIA SUSP (QL= 60ml/3 days)	PA-QL	2
ALINIA TAB (QL= 6 tabs/3 days)	PA-QL	2
MEPRON SUSP	-	3
CARBAPENEMS		
DORIBAX INJ	M	M

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	KMSP	generic =small letters	LD	BRANDS =CAPITAL LETTERS
LMSP	Infertility	M	Kroger Mandatory Specialty Pharmacy Program	MSP	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	PA	Medical Benefit	QL	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	SF	Prior Authorization	SMKG	Quantity Limit
SP	Restricted to Specialist	ST	Limited to Two 15 Day Fills per Month for the First 3 M	VAC	Smoking Cessation
	Available through Specialty Pharmacy Program		Step Therapy		Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Category/Class**

Last Updated* 11/1/2017

DrugName	Special Code	Tier
ANTI-INFECTIVE AGENTS - MISC. Cont.		
INVANZ INJ	M	M
meropenem inj	M	M
KETOLIDES		
KETEK TAB	-	3
LEPROSTATICS		
dapsone tab	-	1
LINCOSAMIDES		
clindamycin cap (CLEOCIN equiv)	-	1
clindamycin soln (CLEOCIN equiv)	-	1
CLEOCIN CAP	-	3
CLEOCIN SOLN	-	3
OXAZOLIDINONES		
linezolid susp (ZYVOX equiv) (Restricted to Infectious Disease Specialist)	RS	1
linezolid tab (ZYVOX equiv) (Restricted to Infectious Disease Specialist)	RS	1
SIVEXTRO TAB (QL= 6 tabs/fill; Restricted to Infectious Disease Specialist)	QL-RS	2
ZYVOX SUSP (Restricted to Infectious Disease Specialist)	RS	3
ZYVOX TAB (Restricted to Infectious Disease Specialist)	RS	3
ANTIMALARIALS		
ANTIMALARIAL COMBINATIONS		
atovaquone/proguanil tab (MALARONE equiv)	-	1
MALARONE TAB	-	2
COARTEM TAB	-	3
FANSIDAR TAB	-	3
ANTIMALARIALS		
chloroquine tab (ARALEN equiv)	-	1
hydroxychloroquine tab (PLAQUENIL equiv)	-	1
mefloquine tab (LARIAM equiv)	-	1
quinine sulfate cap (QUALAQUIN equiv)	-	1
PRIMAQUINE TAB	-	2
ARALEN TAB	-	3
LARIAM TAB	-	3
PLAQUENIL TAB	-	3
QUALAQUIN CAP	-	3
DARAPRIM TAB	MSP-PA	4
ANTIMYASTHENIC/CHOLINERGIC AGENTS		
ANTIMYASTHENIC/CHOLINERGIC AGENTS		
pyridostigmine CR tab (MESTINON equiv)	-	1
pyridostigmine tab (MESTINON equiv)	-	1
PROSTIGMIN TAB	-	2
GUANIDINE TAB	-	3
MESTINON SYRUP	-	3
MESTINON TAB	-	3
MESTINON TIMESPAN TAB	-	3
MYTELASE TAB	-	3
ANTIMYCOBACTERIAL AGENTS		

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	KMSP	generic =small letters	LD	BRANDS =CAPITAL LETTERS
LMSP	Infertility	M	Kroger Mandatory Specialty Pharmacy Program	LD	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	PA	Prior Authorization	QL	Quantity Limit
SP	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 M	SMKG	Smoking Cessation
	Available through Specialty Pharmacy Program	ST	Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Category/Class**

Last Updated* 11/1/2017

DrugName	Special Code	Tier
ANTIMYCOBACTERIAL AGENTS Cont.		
ANTI TB COMBINATIONS		
RIFAMATE CAP	-	2
RIFATER TAB	PA	3
ANTIMYCOBACTERIAL AGENTS		
ethambutol tab (MYAMBUTOL equiv)	-	1
ISONIAZID SYRUP	-	1
isoniazid tab	-	1
pyrazinamide tab	-	1
rifabutin cap (MYCOBUTIN equiv)	-	1
rifampin cap (RIFADIN equiv)	-	1
PRIFTIN TAB	-	2
MYAMBUTOL TAB	-	3
MYCOBUTIN CAP	-	3
RIFADIN CAP	-	3
TRECTOR TAB	PA	3
CYCLOSERINE CAP	-	NC
PASER GRANULE	-	NC
SIRTURO TAB	-	NC
ANTINEOPLASTICS		
ANTINEOPLASTICS MISC.		
tretinoin cap (VESANOID equiv)	KMSP	4
MITOTIC INHIBITORS		
etoposide cap (VEPESID equiv)	KMSP	4
TOPOISOMERASE I INHIBITORS		
HYCAMTIN CAP	KMSP-PA	4
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES		
ALKYLATING AGENTS		
cyclophosphamide tab (CYTOXAN equiv)	-	1
melphalan tab (ALKERAN equiv)	KMSP	1
CEENU CAP	-	2
CYCLOPHOSPHAMIDE CAP	-	2
GLEOSTINE/LOMUSTINE CAP	-	2
ALKERAN TAB	KMSP	3
AFINITOR TAB (QL= 1 tab/day)	KMSP-PA-QL-SF	4
HEXALEN CAP	KMSP	4
LEUKERAN TAB	KMSP	4
MYLERAN TAB	KMSP	4
temozolomide cap (TEMODAR equiv)	KMSP	4
busulfan inj	M	M
BUSULFEX INJ	M	M
melphalan inj (ALKERAN equiv)	M	M
ZANOSAR INJ	M	M
ANTIMETABOLITES		
mercaptopurine tab (PURINETHOL equiv)	-	1
methotrexate inj	-	1

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	KMSP	generic =small letters	LD	BRANDS =CAPITAL LETTERS
LMSP	Infertility	M	Kroger Mandatory Specialty Pharmacy Program	MSP	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	PA	Medical Benefit	QL	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	SF	Prior Authorization	SMKG	Quantity Limit
SP	Restricted to Specialist	ST	Limited to Two 15 Day Fills per Month for the First 3 M	VAC	Smoking Cessation
	Available through Specialty Pharmacy Program		Step Therapy		Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Category/Class**

Last Updated* 11/1/2017

DrugName	Special Code	Tier
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES Cont.		
methotrexate tab (TREXALL equiv)	-	1
METHOTREXATE INJ	-	2
TABLOID TAB	-	2
TREXALL TAB	-	2
PURINETHOL TAB	-	3
capecitabine tab (XELODA equiv)	KMSP	4
PURIXAN SUSP	-	NC
XATMEP SOLN	-	NC
ANTINEOPLASTIC - ANTIBODIES		
RITUXAN INJ	M	M
GAZYVA INJ	-	NC
ANTINEOPLASTIC - BCL-2 INHIBITORS		
VENCLEXTA STARTER PACK (Only available through Diplomat Pharmacy 877-977-9118)	LD-PA	4
VENCLEXTA TAB (Only available through Diplomat Pharmacy 877-977-9118)	LD-PA	4
ANTINEOPLASTIC - HEDGEHOG PATHWAY INHIBITORS		
ERIVEDGE CAP	KMSP-PA-SF	4
ODOMZO CAP (QL= 1 cap/day)	KMSP-PA-QL-SF	4
ANTINEOPLASTIC - HORMONAL AND RELATED AGENTS		
tamoxifen tab (NOLVADEX equiv) (Covered at \$0 for women 35 years or older; All other members covered at generic copay)	-	\$0
anastrozole tab (ARIMIDEX equiv)	-	1
bicalutamide tab (CASODEX equiv)	-	1
exemestane tab (AROMASIN equiv)	-	1
flutamide cap (EULEXIN equiv)	-	1
letrozole tab (FEMARA equiv)	-	1
megestrol susp (MEGACE equiv)	-	1
megestrol tab (MEGACE equiv)	-	1
EMCYT CAP	-	2
FARESTON TAB	-	2
ARIMIDEX TAB	-	3
AROMASIN TAB	-	3
CASODEX TAB	-	3
FEMARA TAB	-	3
MEGACE SUSP	-	3
ZYTIGA TAB 250MG (QL= 4 tabs/day)	KMSP-PA-QL-SF	3
ZYTIGA TAB 500MG (QL= 2 tabs/day)	KMSP-PA-QL-SF	3
LYSODREN TAB	KMSP	4
nilutamide tab (NILANDRON equiv)	KMSP	4
XTANDI CAP (QL= 4 caps/day)	KMSP-PA-QL-SF	4
leuprolide inj (LUPRON equiv)	M	M
LUPRON DEPOT INJ	M	M
TRELSTAR INJ	M	M
HYDROXYPROGESTERONE CAPROATE INJ	-	NC
ANTINEOPLASTIC - IMMUNOMODULATORS		
POMALYST CAP	-	NC
ANTINEOPLASTIC COMBINATIONS		

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	KMSP	generic =small letters	LD	BRANDS =CAPITAL LETTERS
LMSP	Infertility	M	Kroger Mandatory Specialty Pharmacy Program	LD	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	PA	Prior Authorization	QL	Quantity Limit
SP	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 M	SMKG	Smoking Cessation
	Available through Specialty Pharmacy Program	ST	Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Category/Class**

Last Updated* 11/1/2017

DrugName	Special Code	Tier
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES Cont.		
KISQALI PAK (QL= 91 tabs/28 days)	KMSP-PA-QL	4
LONSURF TAB	MSP-PA	4
ANTINEOPLASTIC ENZYME INHIBITORS		
SPRYCEL TAB	KMSP-PA-SF	3
AFINITOR DISPERZ (QL= 1 tab/day)	KMSP-PA-QL-SF	4
ALECENSA CAP (QL= 8 caps/day)	MSP-PA-QL	4
BOSULIF TAB	KMSP-PA-SF	4
CABOMETYX TAB (QL= 1 tab/day)	MSP-PA-QL-SF	4
CAPRELSA TAB (Only available through Biologics 800-850-4306)	LD-PA	4
COMETRIQ KIT (Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-SF	4
COTELLIC TAB (QL= 3 tabs/day)	MSP-PA-QL	4
FARYDAK CAP (QL= 6 caps/21 days)	MSP-PA-QL	4
GILOTRIF TAB (QL= 1 tab/day; Only available through Accredo 888-773-7376)	LD-PA-QL	4
IBRANCE CAP (QL= 21 caps/28 days)	KMSP-PA-QL	4
ICLUSIG TAB (Only available through Biologics 800-850-4306)	LD-PA-SF	4
imatinib tab (GLEEVEC equiv) (QL= 3 tabs/day)	KMSP-PA-QL-SF	4
IMBRUVICA CAP (QL= 4 caps/day; Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-QL-SF	4
INLYTA TAB (QL= 8 tabs/day)	KMSP-PA-QL-SF	4
IRESSA TAB (Only available through Diplomat Pharmacy 877-977-9118)	LD-PA	4
JAKAFI TAB (QL= 2 tabs/day)	MSP-PA-QL	4
KISQALI TAB (QL= 63 tabs/28 days)	KMSP-PA-QL	4
LENVIMA CAP (QL= 3 caps/day; Only available through Accredo 888-773-7376)	LD-PA-QL	4
LYNPARZA CAP (Only available through Biologics 800-850-4306)	LD-PA-SF	4
LYNPARZA TAB (Only available through Biologics 800-850-4306)	LD-PA-SF	4
MEKINIST TAB	KMSP-PA	4
NEXAVAR TAB	MSP-PA-SF	4
NINLARO CAP	KMSP-PA	4
RUBRACA TAB (QL= 4 tabs/day; Only available through Avella Pharmacy (877) 546-5779)	LD-PA-QL-SF	4
STIVARGA TAB (QL= 4 tabs/day)	MSP-PA-QL-SF	4
SUTENT CAP	KMSP-PA-SF	4
TAFINLAR CAP (QL= 4 caps/day)	KMSP-PA-QL-SF	4
TAGRISSO TAB (QL= 1 tab/day; Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-QL-SF	4
TARCEVA TAB	KMSP-PA-SF	4
TASIGNA CAP	KMSP-PA-SF	4
TYKERB TAB	KMSP-PA	4
VOTRIENT TAB	KMSP-PA-SF	4
XALKORI CAP	KMSP-PA-SF	4
ZELBORAF TAB	MSP-PA-SF	4
ZOLINZA CAP	KMSP-PA-SF	4
ZYDELIG TAB (Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-SF	4
ALUNBRIG TAB	-	NC
GLEEVEC TAB	-	NC
IDHIFA TAB	-	NC
NERLYNX TAB	-	NC
RYDAPT CAP	-	NC
VERZENIO TAB	-	NC
ZEJULA CAP	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	KMSP	generic =small letters	LD	BRANDS =CAPITAL LETTERS
LMSP	Infertility	M	Kroger Mandatory Specialty Pharmacy Program	MSP	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	PA	Medical Benefit	QL	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	SF	Prior Authorization	SMKG	Quantity Limit
SP	Restricted to Specialist	ST	Limited to Two 15 Day Fills per Month for the First 3 M	VAC	Smoking Cessation
	Available through Specialty Pharmacy Program		Step Therapy		Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Category/Class**

Last Updated* 11/1/2017

DrugName	Special Code	Tier
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES Cont.		
ZYKADIA CAP	-	NC
ANTINEOPLASTICS MISC.		
hydroxyurea cap (HYDREA equiv)	-	1
MATULANE CAP	-	2
HYDREA CAP	-	3
ACTIMMUNE INJ (Only available through Walgreens 888-347-3416)	LD	4
ALFERON-N INJ	KMSP	4
bexarotene cap (TARGRETIN equiv)	KMSP-PA-SF	4
INTRON-A INJ	KMSP	4
SYLATRON INJ	MSP-PA	4
PROLEUKIN INJ	-	NC
SYNRIBO INJ	-	NC
CHEMOTHERAPY RESCUE/ANTIDOTE AGENTS		
LEUCOVORIN TAB	-	1
MESNEX TAB	KMSP	4
ANTIPARKINSON AGENTS		
ANTIPARKINSON ADJUVANTS		
carbidopa tab (LODOSYN equiv)	-	1
LODOSYN TAB	-	3
ANTIPARKINSON ANTICHOLINERGICS		
benztropine tab	-	1
trihexyphenidyl elixir (ARTANE equiv)	-	1
trihexyphenidyl tab (ARTANE equiv)	-	1
ANTIPARKINSON COMT INHIBITORS		
entacapone tab (COMTAN equiv)	-	1
tolcapone tab (TASMAR equiv)	-	1
COMTAN TAB	-	3
TASMAR TAB	-	3
ANTIPARKINSON DOPAMINERGICS		
amantadine cap (SYMMETREL equiv)	-	1
amantadine syrup (SYMMETREL equiv)	-	1
amantadine tab	-	1
bromocriptine cap (PARLODEL equiv)	-	1
bromocriptine tab (PARLODEL equiv)	-	1
carbidopa/levodopa ER tab (SINEMET CR equiv)	-	1
carbidopa/levodopa ODT (PARCOPA equiv)	-	1
carbidopa/levodopa tab (SINEMET equiv)	-	1
pramipexole ER tab (MIRAPEX ER equiv)	-	1
pramipexole tab (MIRAPEX equiv)	-	1
ropinirole ER tab (REQUIP XL equiv)	-	1
ropinirole tab (REQUIP equiv)	-	1
CARBIDOPA/LEVODOPA/ENTACAPONE TAB (STALEVO equiv)	-	2
MIRAPEX ER TAB	-	3
MIRAPEX TAB	-	3
NEUPRO PATCH	-	3

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	KMSP	generic =small letters	LD	BRANDS =CAPITAL LETTERS
LMSP	Infertility	M	Kroger Mandatory Specialty Pharmacy Program	MSP	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	PA	Medical Benefit	QL	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	SF	Prior Authorization	SMKG	Quantity Limit
SP	Restricted to Specialist	ST	Limited to Two 15 Day Fills per Month for the First 3 M	VAC	Smoking Cessation
	Available through Specialty Pharmacy Program		Step Therapy		Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Category/Class**

Last Updated* 11/1/2017

DrugName	Special Code	Tier
ANTIPARKINSON AGENTS Cont.		
PARCOPA ODT	-	3
PARLODEL CAP	-	3
PARLODEL TAB	-	3
REQUIP TAB	-	3
REQUIP XL TAB	-	3
RYTARY CAP (Step Therapy requires trial of carbidopa/levodopa ER)	ST	3
SINEMET CR TAB	-	3
SINEMET TAB	-	3
APOKYN INJ (Only available through Walgreens 888-347-3416)	LD	4
DUOPA ENTERAL SUSP	-	NC
GOCOVRI CAP	-	NC
ANTIPARKINSON MONOAMINE OXIDASE INHIBITORS		
rasagiline tab (AZILECT equiv)	-	1
selegiline cap (ELDEPRYL equiv)	-	1
selegiline tab (ELDEPRYL equiv)	-	1
AZILECT TAB	-	3
ELDEPYRL CAP	-	3
ZELAPAR ODT	-	3
XADAGO TAB	-	NC
ANTIPSYCHOTICS/ANTIMANIC AGENTS		
ANTIMANIC AGENTS		
lithium carbonate cap (ESKALITH ER equiv)	-	1
lithium carbonate ER tab (LITHOBID equiv)	-	1
lithium carbonate tab	-	1
lithium citrate soln	-	1
LITHOBID TAB	-	3
ANTIPSYCHOTICS - MISC.		
ziprasidone cap (GEODON equiv)	-	1
EQUETRO CAP	-	2
GEODON CAP	-	3
LATUDA TAB	-	NC
NUPLAZID TAB	-	NC
VRAYLAR CAP	-	NC
VRAYLAR PACK	-	NC
BENZISOXAZOLES		
paliperidone ER tab (INVEGA equiv)	PA	1
risperidone ODT (RISPERDAL M equiv)	-	1
risperidone soln (RISPERDAL equiv)	-	1
risperidone tab (RISPERDAL equiv)	-	1
FANAPT TAB (QL= 2 tabs/day)	PA-QL	3
FANAPT TITRATION PACK (QL= 1 pack/plan year)	PA-QL	3
INVEGA TAB	PA	3
RISPERDAL M ODT	-	3
RISPERDAL SOLN	-	3
RISPERDAL TAB	-	3
RISPERDAL CONSTA INJ	MSP	4
Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.		
NC =Not Covered INF Infertility LMSP Lumicera Mandatory Specialty Pharmacy Program OTC Over-the-Counter RS Restricted to Specialist SP Available through Specialty Pharmacy Program	KMSP Kroger Mandatory Specialty Pharmacy Program M Medical Benefit PA Prior Authorization SF Limited to Two 15 Day Fills per Month for the First 3 M ST Step Therapy	generic =small letters LD Limited Distribution MSP Mandatory Specialty Pharmacy Program QL Quantity Limit SMKG Smoking Cessation VAC Vaccine Program
BRANDS =CAPITAL LETTERS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Category/Class**

Last Updated* 11/1/2017

DrugName	Special Code	Tier
ANTIPSYCHOTICS/ANTIMANIC AGENTS Cont.		
INVEGA INJ	-	NC
BUTYROPHENONES		
haloperidol lactate conc (HALDOL equiv)	-	1
haloperidol tab (HALDOL equiv)	-	1
DIBENZAPINES		
clozapine ODT 25mg, 100mg (CLOZAPINE, FAZACLO equiv)	-	1
clozapine tab (CLOZARIL equiv)	-	1
loxapine cap (LOXITANE equiv)	-	1
olanzapine ODT (ZYPREXA equiv)	-	1
olanzapine tab (ZYPREXA equiv)	-	1
quetiapine tab (SEROQUEL equiv)	-	1
quetiapine XR tab (SEROQUEL XR equiv)	-	1
CLOZAPINE ODT, FAZACLO ODT	-	2
CLOZARIL TAB	-	3
FAZACLO ODT 25MG, 100MG	-	3
LOXITANE CAP	-	3
SAPHRIS SL TAB (QL= 2 tabs/day)	PA-QL	3
SEROQUEL TAB	-	3
ZYPREXA TAB	-	3
ZYPREXA ZYDIS TAB	-	3
ADASUVE INHALER	-	NC
SEROQUEL XR TAB	-	NC
VERSACLOZ SUSP	-	NC
PHENOTHIAZINES		
chlorpromazine tab (THORAZINE equiv)	-	1
fluphenazine tab (PROLIXIN equiv)	-	1
perphenazine tab (TRILAFON equiv)	-	1
prochlorperazine supp (COMPAZINE equiv)	-	1
prochlorperazine tab (COMPAZINE equiv)	-	1
thioridazine tab (MELLARIL equiv)	-	1
trifluoperazine tab (STELAZINE equiv)	-	1
QUINOLINONE DERIVATIVES		
aripiprazole ODT (ABILIFY equiv) (QL= 2 tabs/day)	PA-QL	1
aripiprazole soln (ABILIFY equiv)	PA	1
aripiprazole tab (ABILIFY equiv)	-	1
ABILIFY DISCMELT (QL= 2 tabs/day)	PA-QL	3
ABILIFY SOLN	PA	3
ABILIFY TAB	-	3
REXULTI TAB	-	NC
THIOXANTHENES		
thiothixene cap (NAVANE equiv)	-	1
NAVANE CAP	-	3
ANTISEPTICS & DISINFECTANTS		
CHLORINE ANTISEPTICS		
PHISOHEX LIQUID	-	3

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	KMSP	generic =small letters	LD	BRANDS =CAPITAL LETTERS
LMSP	Infertility	M	Kroger Mandatory Specialty Pharmacy Program	MSP	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	PA	Medical Benefit	QL	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	SF	Prior Authorization	SMKG	Quantity Limit
SP	Restricted to Specialist	ST	Limited to Two 15 Day Fills per Month for the First 3 M	VAC	Smoking Cessation
	Available through Specialty Pharmacy Program		Step Therapy		Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Category/Class**

Last Updated* 11/1/2017

DrugName	Special Code	Tier
ANTISEPTICS & DISINFECTANTS Cont.		
IODINE ANTISEPTICS		
IODOFLEX PAD	-	NC
ANTIVIRALS		
ANTIRETROVIRALS		
lamivudine soln (EPIVIR equiv)	-	1
lamivudine tab (EPIVIR equiv)	-	1
nevirapine tab (VIRAMUNE equiv)	-	1
stavudine cap (ZERIT equiv)	-	1
stavudine soln (ZERIT equiv)	-	1
zidovudine cap (RETROVIR equiv)	-	1
zidovudine syrup (RETROVIR equiv)	-	1
zidovudine tab (RETROVIR equiv)	-	1
ISENTRESS (HD) TAB	-	3
ISENTRESS CHEW TAB	-	3
ISENTRESS POWDER PACK	-	3
NORVIR CAP	-	3
NORVIR SOLN	-	3
NORVIR TAB	-	3
VITEKTA TAB	-	3
abacavir soln (ZIAGEN equiv)	-	4
abacavir tab (ZIAGEN equiv)	-	4
abacavir/lamivudine tab (EPZICOM equiv)	-	4
abacavir/lamivudine/zidovudine tab (TRIZIVIR equiv)	-	4
APTIVUS CAP	-	4
APTIVUS SOLN	-	4
ATRIPLA TAB (QL= 1 tab/day)	QL	4
COMBIVIR TAB	-	4
COMPLERA TAB (QL= 1 tab/day)	QL	4
CRIXIVAN CAP	-	4
DESCOVY TAB	PA	4
didanosine DR cap (VIDEX EC equiv)	-	4
EDURANT TAB	-	4
EMTRIVA CAP	-	4
EMTRIVA SOLN	-	4
EPIVIR SOLN	-	4
EPIVIR TAB	-	4
EPZICOM TAB	-	4
EVOTAZ TAB	-	4
fosamprenavir tab (LEXIVA equiv)	-	4
FUZEON INJ	-	4
GENVOYA TAB	-	4
INTELENCE TAB	-	4
INVIRASE CAP	-	4
INVIRASE TAB	-	4
KALETRA SOLN	-	4
KALETRA TAB	-	4

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	Infertility	KMSP	generic =small letters	LD	BRANDS =CAPITAL LETTERS
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	M	Kroger Mandatory Specialty Pharmacy Program	LD	Limited Distribution
OTC	Over-the-Counter	PA	M	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
RS	Restricted to Specialist	SF	PA	Prior Authorization	QL	Quantity Limit
SP	Available through Specialty Pharmacy Program	ST	SF	Limited to Two 15 Day Fills per Month for the First 3 M	SMKG	Smoking Cessation
			ST	Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Category/Class**

Last Updated* 11/1/2017

DrugName	Special Code	Tier
ANTIVIRALS Cont.		
lamivudine/zidovudine tab (COMBIVIR equiv)	-	4
LEXIVA SUSP	-	4
LEXIVA TAB	-	4
lopinavir/ritonavir soln (KALETRA equiv)	-	4
nevirapine ER tab (VIRAMUNE XR equiv) (Step Therapy requires trial of nevirapine)	ST	4
NEVIRAPINE SUSP	-	4
ODEFSEY TAB (QL= 1 tab/day)	QL	4
PREZCOBIX TAB	-	4
PREZISTA SUSP	-	4
PREZISTA TAB	-	4
RESCRIPTOR TAB	-	4
RETROVIR CAP	-	4
RETROVIR SYRUP	-	4
RETROVIR TAB	-	4
REYATAZ CAP	-	4
REYATAZ POWDER PACK	-	4
SELZENTRY SOLN	-	4
SELZENTRY TAB	-	4
STRIBILD TAB	-	4
SUSTIVA CAP	-	4
SUSTIVA TAB	-	4
TIVICAY TAB (QL= 2 tabs/day)	QL	4
TRIUMEQ TAB	-	4
TRIZIVIR TAB	-	4
TRUVADA TAB	PA	4
VIDEX EC CAP	-	4
VIDEX SOLN	-	4
VIRACEPT POWDER	-	4
VIRACEPT TAB	-	4
VIRAMUNE SUSP	-	4
VIRAMUNE TAB	-	4
VIRAMUNE XR TAB (Step Therapy requires trial of nevirapine)	ST	4
VIREAD TAB	-	4
ZERIT CAP	-	4
ZERIT SOLN	-	4
ZIAGEN SOLN	-	4
ZIAGEN TAB	-	4
TYBOST TAB	-	NC
CMV AGENTS		
valganciclovir tab (VALCYTE equiv)	-	1
VALCYTE TAB	-	3
GANCICLOVIR CAP	-	4
VALCYTE SOLN	-	4
valganciclovir soln (VALCYTE equiv)	-	4
FOSCARNET INJ	M	M
HEPATITIS AGENTS		

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered Infertility	KMSP	generic =small letters Kroger Mandatory Specialty Pharmacy Program	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 M	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Category/Class**

Last Updated* 11/1/2017

DrugName	Special Code	Tier
ANTIVIRALS Cont.		
ribavirin cap (REBETOL equiv)	KMSP	1
ribavirin tab (COPEGUS equiv)	KMSP	1
adefovir dipivoxil tab (HEPSERA equiv)	KMSP	4
BARACLUDE TAB (QL= 1 tab/day)	KMSP-QL	4
entecavir tab (BARACLUDE equiv) (QL= 1 tab/day)	KMSP-QL	4
EPCLUSA TAB (QL= 1 tab/day)	KMSP-PA-QL	4
EPIVIR HBV SOLN	-	4
EPIVIR HBV TAB	-	4
HARVONI TAB (QL= 1 tab/day)	KMSP-PA-QL	4
HEPSERA TAB	KMSP	4
INCIVEK TAB	MSP-PA-SF	4
INFERGEN INJ	MSP	4
lamivudine tab 100mg (EPIVIR HBV equiv)	-	4
PEGASYS INJ	KMSP	4
PEGASYS INJ KIT	KMSP	4
PEG-INTRON INJ	KMSP	4
REBETOL SOLN	KMSP	4
RIBATAB	KMSP	4
TYZEKA TAB	KMSP-PA	4
VEMLIDY TAB	KMSP	4
VICTRELIS CAP	MSP-PA-SF	4
ZEPATIER TAB (QL= 1 tab/day)	KMSP-PA-QL	4
DAKLINZA TAB	-	NC
MAVYRET TAB	-	NC
OLYSIO CAP	-	NC
RIBAPAK TAB	-	NC
SOVALDI TAB	-	NC
TECHNIVIE TAB	-	NC
VIEKIRA XR TAB	-	NC
VOSEVI TAB	-	NC
HERPES AGENTS		
acyclovir cap (ZOVIRAX equiv)	-	1
acyclovir susp (ZOVIRAX equiv)	-	1
acyclovir tab (ZOVIRAX equiv)	-	1
famciclovir tab (FAMVIR equiv)	-	1
valacyclovir tab (VALTREX equiv)	-	1
FAMVIR TAB	-	3
VALTREX TAB	-	3
ZOVIRAX CAP	-	3
ZOVIRAX SUSP	-	3
ZOVIRAX TAB	-	3
SITAVIG TAB	-	NC
INFLUENZA AGENTS		
oseltamivir cap (TAMIFLU equiv) (QL= 10 caps/fill)	QL	1
oseltamivir cap 30mg (TAMIFLU equiv) (QL= 20 caps/fill)	QL	1
rimantadine tab (FLUMADINE equiv)	-	1

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	KMSP	generic =small letters	LD	BRANDS =CAPITAL LETTERS
LMSP	Infertility	M	Kroger Mandatory Specialty Pharmacy Program	MSP	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	PA	Medical Benefit	QL	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	SF	Prior Authorization	SMKG	Quantity Limit
SP	Restricted to Specialist	ST	Limited to Two 15 Day Fills per Month for the First 3 M	VAC	Smoking Cessation
	Available through Specialty Pharmacy Program		Step Therapy		Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Category/Class**

Last Updated* 11/1/2017

DrugName	Special Code	Tier
ANTIVIRALS Cont.		
RELENZA DISKHALER (QL= 1 inhaler/fill)	QL	2
TAMIFLU SUSP 6MG/ML (QL= 250ml/fill)	QL	2
FLUMADINE TAB	-	3
TAMIFLU CAP (QL= 10 caps/fill)	QL	3
TAMIFLU CAP 30MG (QL= 20 caps/fill)	QL	3
RESPIRATORY SYNCYTIAL VIRUS (RSV) AGENTS		
ribavirin inh soln (VIRAZOLE equiv)	-	NC
ASSORTED CLASSES		
CHELATING AGENTS		
DEPEN TITRATAB	-	2
SYPRINE CAP	KMSP-PA	4
CUPRIMINE CAP	-	NC
IMMUNOMODULATORS		
REVLIMID CAP (QL= 1 cap/day)	KMSP-PA-QL	3
THALOMID CAP	KMSP-PA	4
IMMUNOSUPPRESSIVE AGENTS		
azathioprine tab (IMURAN equiv)	-	1
AZASAN TAB	-	3
IMURAN TAB	-	3
CELLCEPT CAP	-	4
CELLCEPT SUSP	-	4
CELLCEPT TAB	-	4
cyclosporine cap (SANDIMMUNE equiv)	-	4
cyclosporine modified cap (NEORAL equiv)	-	4
cyclosporine modified soln (NEORAL equiv)	-	4
mycophenolate DR tab (MYFORTIC equiv)	-	4
mycophenolate mofetil cap (CELLCEPT equiv)	-	4
mycophenolate mofetil susp (CELLCEPT SUSP equiv)	-	4
mycophenolate mofetil tab (CELLCEPT equiv)	-	4
MYFORTIC TAB	-	4
NEORAL CAP	-	4
NEORAL SOLN	-	4
PROGRAF CAP	-	4
RAPAMUNE SOLN	-	4
RAPAMUNE TAB	-	4
SANDIMMUNE CAP	-	4
SANDIMMUNE SOLN 100MG/ML	-	4
sirolimus tab (RAPAMUNE equiv)	-	4
tacrolimus cap (PROGRAF equiv)	-	4
ZORTRESS TAB	KMSP-PA	4
ENVARUSUS XR TAB	-	NC
POTASSIUM REMOVING RESINS		
sodium polystyrene powder (KAYEXALATE equiv)	-	1
sodium polystyrene susp (SPS equiv)	-	1
KAYEXALATE POWDER	-	3
VELTASSA POWDER	KMSP-PA	4

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	generic =small letters	BRANDS =CAPITAL LETTERS
LMSP	Infertility	KMSP	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	M	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	PA	Quantity Limit
SP	Restricted to Specialist	SF	Smoking Cessation
	Available through Specialty Pharmacy Program	ST	Vaccine Program
		LD	Limited Distribution
		MSP	Mandatory Specialty Pharmacy Program
		QL	Quantity Limit
		SMKG	Smoking Cessation
		VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Category/Class**

Last Updated* 11/1/2017

DrugName	Special Code	Tier
BETA BLOCKERS		
ALPHA-BETA BLOCKERS		
carvedilol tab (COREG equiv)	-	1
labetalol tab (NORMODYNE equiv)	-	1
COREG CR CAP	-	3
COREG TAB	-	3
TRANDATE TAB	-	3
BETA BLOCKERS CARDIO-SELECTIVE		
acebutolol cap (SECTRAL equiv)	-	1
atenolol tab (TENORMIN equiv)	-	1
betaxolol tab (KERLONE equiv)	-	1
bisoprolol tab (ZEBETA equiv)	-	1
metoprolol ER tab (TOPROL XL equiv)	-	1
metoprolol tab (LOPRESSOR equiv)	-	1
BYSTOLIC TAB	-	2
KERLONE TAB	-	3
LOPRESSOR TAB	-	3
SECTRAL CAP	-	3
TENORMIN TAB	-	3
TOPROL XL TAB	-	3
ZEBETA TAB	-	3
METOPROLOL TARTRATE TAB 37.5MG, 75MG	-	NC
BETA BLOCKERS NON-SELECTIVE		
nadolol tab (CORGARD equiv)	-	1
pindolol tab (VISKEN equiv)	-	1
propranolol ER cap (INDERAL LA equiv)	-	1
PROPRANOLOL SOLN	-	1
propranolol tab (INDERAL equiv)	-	1
sotalol AF tab (BETAPACE AF equiv)	-	1
sotalol tab (BETAPACE equiv)	-	1
timolol maleate tab (BLOCADREN equiv)	-	1
BETAPACE AF TAB	-	3
BETAPACE TAB	-	3
CORGARD TAB	-	3
INDERAL LA CAP	-	3
INNOPRAN XL CAP	-	3
LEVATOL TAB	-	3
HEMANGEOL SOLN	-	NC
SOTYLIZE SOLN	-	NC
BIOLOGICALS MISC		
ALLERGENIC EXTRACTS		
GRASTEK SL TAB	-	NC
ORALAIR SL TAB	-	NC
RAGWITEK SL TAB	-	NC
BIOLOGICALS MISC		
ADAGEN INJ	M	M

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	KMSP	generic =small letters	LD	BRANDS =CAPITAL LETTERS
LMSP	Infertility	M	Kroger Mandatory Specialty Pharmacy Program	MSP	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	PA	Medical Benefit	QL	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	SF	Prior Authorization	SMKG	Quantity Limit
SP	Restricted to Specialist	ST	Limited to Two 15 Day Fills per Month for the First 3 M	VAC	Smoking Cessation
	Available through Specialty Pharmacy Program		Step Therapy		Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Category/Class**

Last Updated* 11/1/2017

DrugName	Special Code	Tier
CALCIUM CHANNEL BLOCKERS		
CALCIUM CHANNEL BLOCKERS		
amlodipine tab (NORVASC equiv)	-	1
diltiazem ER cap (CARDIZEM CD equiv)	-	1
diltiazem ER cap (CARDIZEM SR equiv)	-	1
diltiazem ER cap (DILACOR XR equiv)	-	1
diltiazem ER cap (TIAZAC equiv)	-	1
diltiazem ER tab (CARDIZEM LA equiv)	-	1
diltiazem tab (CARDIZEM equiv)	-	1
felodipine ER tab (PLENDIL equiv)	-	1
isradipine cap (DYNACIRC equiv)	-	1
nicardipine cap (CARDENE equiv)	-	1
nifedipine cap (PROCARDIA equiv)	-	1
nifedipine ER tab (ADALAT CC equiv)	-	1
nimodipine cap (NIMOTOP equiv)	-	1
nisoldipine ER tab (SULAR equiv)	-	1
NISOLDIPINE ER TAB 25.5MG	-	1
verapamil SR cap (VERELAN PM equiv)	-	1
verapamil SR cap (VERELAN SR equiv)	-	1
verapamil SR tab (CALAN SR, ISOPTIN SR equiv)	-	1
verapamil tab (CALAN equiv)	-	1
ADALAT CC TAB	-	3
CALAN SR TAB	-	3
CALAN TAB	-	3
CARDENE SR CAP	-	3
CARDIZEM CD CAP	-	3
CARDIZEM LA TAB	-	3
CARDIZEM TAB	-	3
COVERA-HS TAB	-	3
DILACOR XR CAP	-	3
DYNACIRC CR TAB	-	3
NIMOTOP CAP	-	3
NORVASC TAB	-	3
PLENDIL TAB	-	3
PROCARDIA CAP	-	3
SULAR TAB	-	3
TIAZAC CAP	-	3
VERELAN CAP	-	3
VERELAN PM CAP	-	3

CARDIOTONICS

CARDIAC GLYCOSIDES

digoxin soln (LANOXIN equiv)	-	1
digoxin tab (LANOXIN equiv)	-	1
LANOXIN TAB	-	3
LANOXIN TAB 0.0625MG, 0.1875MG	-	NC

CARDIOVASCULAR AGENTS - MISC.

CARDIOVASCULAR AGENTS MISC. - COMBINATIONS

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	KMSP	generic =small letters	LD	BRANDS =CAPITAL LETTERS
LMSP	Infertility	M	Kroger Mandatory Specialty Pharmacy Program	MSP	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	PA	Medical Benefit	QL	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	SF	Prior Authorization	SMKG	Quantity Limit
SP	Restricted to Specialist	ST	Limited to Two 15 Day Fills per Month for the First 3 M	VAC	Smoking Cessation
	Available through Specialty Pharmacy Program		Step Therapy		Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Category/Class**

Last Updated* 11/1/2017

DrugName	Special Code	Tier
CARDIOVASCULAR AGENTS - MISC. Cont.		
amlodipine/atorvastatin tab (CADUET equiv)	-	1
ENTRESTO TAB (QL= 2 tabs/day)	PA-QL	2
CADUET TAB	-	3
IMPOTENCE AGENTS		
CAVERJECT INJ (QL= 6 inj/30 days)	QL	2
CIALIS TAB (QL= 6 tabs/30 days)	QL	2
CIALIS TAB 2.5MG, 5MG (QL= 6 tabs/30 days)	QL	2
EDEX INJ (QL= 6 inj/30 days)	QL	2
LEVITRA TAB (QL= 6 tabs/30 days)	QL	2
MUSE SUPP (QL= 6 inj/30 days)	QL	2
STAXYN ODT (QL= 6 tabs/30 days)	QL	2
STENDRA TAB (QL= 6 tabs/30 days)	QL	2
VIAGRA TAB (QL= 6 tabs/30 days)	QL	2
PAPAVERINE/ALPROSTADIL INJ	-	NC
PAPAVERINE/PHENTOLAMINE INJ	-	NC
PAPAVERINE/PHENTOLAMINE/ALPROSTADIL INJ	-	NC
PHENTOLAMINE/ALPROSTADIL INJ	-	NC
PERIPHERAL VASODILATORS		
ISOXSUPRINE TAB	-	1
PROSTAGLANDIN VASODILATORS		
TYVASO INH SOLN (QL= 1 ampule/day; Only available through Accredo 888-773-7376)	LD-PA-QL	4
VENTAVIS INH SOLN (QL= 9 ampules/day; Only available through Accredo 888-773-7376)	LD-PA-QL	4
ORENITRAM TAB	-	NC
PULMONARY HYPERTENSION - ENDOTHELIN RECEPTOR ANTAGONISTS		
LETAIRIS TAB (QL= 1 tab/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	4
OPSUMIT TAB (QL= 1 tab/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	4
TRACLEER TAB (QL= 2 tabs/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	4
PULMONARY HYPERTENSION - PHOSPHODIESTERASE INHIBITORS		
sildenafil tab (REVATIO equiv)	PA	1
REVATIO TAB	PA	3
ADCIRCA TAB	LMSP-PA	4
REVATIO SUSP	-	NC
PULMONARY HYPERTENSION - PROSTACYCLIN RECEPTOR AGONIST		
UPTRAVI TAB (QL= 2 tabs/day; Only available through Accredo 888-773-7376)	LD-PA-QL	4
PULMONARY HYPERTENSION - SOL GUANYLATE CYCLASE STIMULATOR		
ADEMPAS TAB (QL= 3 tabs/day; Only available through Accredo 888-773-7376)	LD-PA-QL	4
SINUS NODE INHIBITORS		
CORLANOR TAB	PA	3
CEPHALOSPORINS		
CEPHALOSPORINS - 1ST GENERATION		
cefadroxil cap (DURICEF equiv)	-	1
cefadroxil susp (DURICEF equiv)	-	1
cefadroxil tab (DURICEF equiv)	-	1
cephalexin cap (KEFLEX equiv)	-	1
cephalexin susp (KEFLEX equiv)	-	1
Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.		
INF Infertility LMSP Lumicera Mandatory Specialty Pharmacy Program OTC Over-the-Counter RS Restricted to Specialist SP Available through Specialty Pharmacy Program	KMSP Kroger Mandatory Specialty Pharmacy Program M Medical Benefit PA Prior Authorization SF Limited to Two 15 Day Fills per Month for the First 3 M ST Step Therapy	generic =small letters LD Limited Distribution MSP Mandatory Specialty Pharmacy Program QL Quantity Limit SMKG Smoking Cessation VAC Vaccine Program
BRANDS =CAPITAL LETTERS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Category/Class**

Last Updated* 11/1/2017

DrugName	Special Code	Tier
CEPHALOSPORINS Cont.		
KEFLEX CAP	-	3
cefazolin inj	M	M
CEFAZOLIN INJ	M	M
CEPHALEXIN TAB	-	NC
DAXBIA CAP	-	NC
CEPHALOSPORINS - 2ND GENERATION		
cefaclor cap (CECLOR equiv)	-	1
cefprozil susp (CEFZIL equiv)	-	1
cefprozil tab (CEFZIL equiv)	-	1
cefuroxime susp (CEFTIN equiv)	-	1
cefuroxime tab (CEFTIN equiv)	-	1
CEFACLOR ER TAB	-	3
CEFACLOR SUSP	-	3
CEFTIN SUSP	-	3
CEFTIN TAB	-	3
cefoxitin inj	M	M
CEPHALOSPORINS - 3RD GENERATION		
cefdinir cap (OMNICEF equiv)	-	1
cefdinir susp (OMNICEF equiv)	-	1
cefixime susp (SUPRAX equiv)	-	1
cefpodoxime proxetil susp (VANTIN equiv)	-	1
cefpodoxime proxetil tab (VANTIN equiv)	-	1
CEDAX CAP	-	3
CEDAX SUSP	-	3
CEFDITOREN TAB	-	3
OMNICEF SUSP	-	3
SPECTRACEF TAB	-	3
SUPRAX CAP	-	3
SUPRAX CHEW TAB	-	3
SUPRAX SUSP	-	3
SUPRAX SUSP 500MG/5ML	-	3
SUPRAX TAB	-	3
VANTIN TAB	-	3
CEFOTAXIME INJ	M	M
ceftriaxone inj	M	M

CONTRACEPTIVES

COMBINATION CONTRACEPTIVES - ORAL

amethyst tab (LYBREL equiv)	-	\$0
apri tab (DESOGEN equiv)	-	\$0
aranelle tab (TRI-NORINYL equiv)	-	\$0
aviane tab (ALESSE equiv)	-	\$0
BEYAZ TAB	-	\$0
cesia tab (CYCLESSA equiv)	-	\$0
cryselle tab (OGESTREL equiv)	-	\$0
enpresse tab (TRI-LEVELLEN equiv)	-	\$0
jolessa tab, amethia tab (SEASONALE, SEASONIQUE equiv) (3 copays per Rx)	-	\$0

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	KMSP	generic =small letters	LD	BRANDS =CAPITAL LETTERS
LMSP	Infertility	M	Kroger Mandatory Specialty Pharmacy Program	MSP	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	PA	Medical Benefit	QL	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	SF	Prior Authorization	SMKG	Quantity Limit
SP	Restricted to Specialist	ST	Limited to Two 15 Day Fills per Month for the First 3 M	VAC	Smoking Cessation
	Available through Specialty Pharmacy Program		Step Therapy		Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Category/Class**

Last Updated* 11/1/2017

DrugName	Special Code	Tier
CONTRACEPTIVES Cont.		
junel FE tab (LOESTRIN FE equiv)	-	\$0
junel tab (LOESTRIN equiv)	-	\$0
kariva tab (MIRCETTE equiv)	-	\$0
kelnor tab (DEMULEN equiv)	-	\$0
LEVONORGESTREL/ETHINYL ESTRADIOL TAB	-	\$0
mononessa tab (ORTHO-CYCLEN equiv)	-	\$0
necon tab (ORTHO-NOVUM equiv)	-	\$0
necon tab 1-50 (NORYNIL equiv)	-	\$0
nortrel tab (OVCON 35 equiv)	-	\$0
tri-legest tab (ESTROSTEP FE equiv)	-	\$0
tri-nessa (LO) tab (ORTHO TRI-CYCLEN (LO) equiv)	-	\$0
wymzya FE tab (FEMCON FE equiv)	-	\$0
YASMIN TAB	-	\$0
YAZ TAB	-	\$0
mibelas chew tab (MINASTRIN equiv)	-	1
CYCLESSA TAB	-	3
DESOGEN TAB	-	3
ESTROSTEP FE TAB	-	3
FEMCON FE CHEW TAB	-	3
LO LOESTRIN TAB	-	3
LO MINASTRIN 24 FE CHEW TAB	-	3
LOESTRIN 24 FE TAB	-	3
LOESTRIN FE TAB	-	3
LOESTRIN TAB	-	3
MINASTRIN CHEW TAB	-	3
MIRCETTE TAB	-	3
NATAZIA TAB	-	3
NORINYL TAB 1-50	-	3
OGESTREL TAB	-	3
ORTHO TRI-CYCLEN (LO) TAB	-	3
ORTHO-CYCLEN TAB	-	3
OVCON 35 TAB	-	3
SEASONIQUE TAB	-	3
TRI-NORINYL TAB	-	3
FALESSA KIT	-	NC
gianvi tab, ocella tab (YASMIN, YAZ equiv)	-	NC
rajani tab (BEYAZ equiv)	-	NC
SAFYRAL TAB	-	NC
TAYTULLA CAP	-	NC
COMBINATION CONTRACEPTIVES - TRANSDERMAL		
XULANE PATCH	-	\$0
ORTHO-EVRA PATCH	-	3
COMBINATION CONTRACEPTIVES - VAGINAL		
NUVARING	-	\$0
COPPER CONTRACEPTIVES - IUD		
PARAGARD IUD	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered Infertility	KMSP	generic =small letters Kroger Mandatory Specialty Pharmacy Program	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 M	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Category/Class**

Last Updated* 11/1/2017

DrugName	Special Code	Tier
CONTRACEPTIVES Cont.		
EMERGENCY CONTRACEPTIVES		
ELLA TAB	-	\$0
levonorgestrel tab (PLAN B equiv)	OTC	\$0
LEVONORGESTREL TAB 0.75MG	-	\$0
PLAN B TAB	OTC	\$0
PROGESTIN CONTRACEPTIVES - IMPLANTS		
IMPLANON IMPLANT, NEXPLANON IMPLANT	-	NC
PROGESTIN CONTRACEPTIVES - INJECTABLE		
DEPO-PROVERA INJ	-	NC
DEPO-PROVERA SC INJ 104MG	-	NC
medroxyprogesterone inj (DEPO-PROVERA equiv)	-	NC
PROGESTIN CONTRACEPTIVES - IUD		
MIRENA IUD	-	NC
PROGESTIN CONTRACEPTIVES - ORAL		
norethindrone tab (NORA-QD equiv)	-	\$0
NOR-QD TAB	-	3

CORTICOSTEROIDS

GLUCOCORTICOSTEROIDS		
budesonide SR cap (ENTOCORT EC equiv) (Step Therapy requires trial of APRISO, LIALDA, or sulfasalazine)	ST	1
CORTEF TAB	-	1
DEXAMETHASONE CONC	-	1
dexamethasone elixir	-	1
dexamethasone soln	-	1
DEXAMETHASONE TAB	-	1
dexamethasone tab (DECADRON equiv)	-	1
hydrocortisone tab (CORTEF equiv)	-	1
MEDROL TAB	-	1
methylprednisolone dose pack (MEDROL equiv)	-	1
methylprednisolone tab (MEDROL equiv)	-	1
prednisolone ODT (ORAPRED equiv)	-	1
prednisolone soln (PEDIAPRED equiv)	-	1
prednisolone syrup (PRELONE equiv)	-	1
PREDNISONE SOLN	-	1
PREDNISONE TAB	-	1
prednisone tab (DELTASONE equiv)	-	1
CORTISONE ACETATE TAB	-	2
ORAPRED ODT	-	2
PREDNISONE PAK	-	2
DEXPAK TAB	-	3
ENTOCORT EC CAP (Step Therapy requires trial of APRISO, LIALDA, or sulfasalazine)	ST	3
MEDROL DOSE PACK	-	3
MEDROL TAB	-	3
MILLIPRED DP PAK	-	3
MILLIPRED TAB	-	3
ORAPRED ODT	-	3

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	KMSP	generic =small letters	LD	BRANDS =CAPITAL LETTERS
LMSP	Infertility	M	Kroger Mandatory Specialty Pharmacy Program	MSP	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	PA	Medical Benefit	QL	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	SF	Prior Authorization	SMKG	Quantity Limit
SP	Restricted to Specialist	ST	Limited to Two 15 Day Fills per Month for the First 3 M	VAC	Smoking Cessation
	Available through Specialty Pharmacy Program		Step Therapy		Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Category/Class**

Last Updated* 11/1/2017

DrugName	Special Code	Tier
CORTICOSTEROIDS Cont.		
ORAPRED SOLN	-	3
PRELONE SYRUP	-	3
UCERIS TAB (QL= 1 tab/day)	PA-QL	3
VERIPRED SOLN	-	3
EMFLAZA SUSP	-	NC
EMFLAZA TAB	-	NC
FLO-PRED SUSP	-	NC
LIDOLOG KIT	-	NC
PREDNISONE/DIPHENHYDRAMINE KIT	-	NC
RAYOS TAB	-	NC

MINERALOCORTICIDS

fludrocortisone tab (FLORINEF equiv)	-	1
--------------------------------------	---	---

COUGH/COLD/ALLERGY

ANTITUSSIVES

benzonatate cap (TESSALON equiv)	-	1
hydrocodone/homatropine syrup (HYCODAN equiv)	-	1
tussion tab (HYCODAN equiv)	-	1
HYCODAN SYRUP	-	3
TESSALON CAP	-	3

COUGH/COLD/ALLERGY COMBINATIONS

guaifenesin/codeine soln (BRONTEX equiv)	OTC	1
guaifenesin/codeine syrup (TUSSI-ORGANIDIN-S equiv) (QL= 240ml/fill)	OTC-QL	1
hydrocodone/chlorpheniramine CR susp (TUSSIONEX equiv) (QL= 120ml/fill; 2 fills/30 days)	QL	1
hydrocodone/chlorpheniramine/pseudoephedrine liquid (ZUTRIPRO equiv) (QL= 120ml/fill, 2 fills/30 days)	QL	1
NINJACOF-XG LIQUID	OTC	1
promethazine DM syrup	-	1
promethazine VC syrup (PHENERGAN VC equiv)	-	1
promethazine VC/codeine syrup (PHENERGAN VC/CODEINE equiv)	-	1
promethazine/codeine syrup (PHENERGAN/CODEINE equiv)	-	1
pseudoephedrine/brompheniramine/codeine liquid (CPB WC LIQUID equiv)	OTC	1
ALBATUSSIN LIQUID	-	3
BRONCOPECTOL SYRUP	-	3
DECON-A ELIXIR	-	3
GILTUSS LIQUID	-	3
GILTUSS TR TAB	-	3
NEOTUSS-D LIQUID	-	3
PEDIATEX TDM SUSP	-	3
RESCON TAB	-	3
REZIRA SOLN	-	3
SEMPREX-D CAP	-	3
SUTTAR SF SYRUP	-	3
TUSNEL SYRUP	-	3
TUSSICAPS (QL= 20 caps/fill, 2 fills/30 days)	QL	3
TUSSIONEX SUSP (QL= 120ml/fill; 2 fills/30 days)	QL	3
TUSSI-ORGANI SYRUP (QL= 240ml/fill)	QL	3
ZUTRIPRO LIQUID (QL= 120ml/fill, 2 fills/30 days)	QL	3

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	KMSP	generic =small letters	LD	BRANDS =CAPITAL LETTERS
LMSP	Infertility	M	Kroger Mandatory Specialty Pharmacy Program	MSP	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	PA	Medical Benefit	QL	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	SF	Prior Authorization	SMKG	Quantity Limit
SP	Restricted to Specialist	ST	Limited to Two 15 Day Fills per Month for the First 3 M	VAC	Smoking Cessation
	Available through Specialty Pharmacy Program		Step Therapy		Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Category/Class**

Last Updated* 11/1/2017

DrugName	Special Code	Tier
COUGH/COLD/ALLERGY Cont.		
CLARINEX-D TAB	-	NC
DOMETUSS-DMX LIQ	-	NC
HYCOFENIX SOLN	-	NC
MUCINEX LIQUID	-	NC
POLY-TUSSIN DM SYRUP	-	NC
TUSSI-PRES LIQUID	-	NC
TUZISTRA XR SUSP	-	NC
EXPECTORANTS		
GUAIFENESEN SYRUP	-	NC
guaifenesin tab (ALLFEN JR equiv)	-	NC
MUCINEX TAB	-	NC
MISC. RESPIRATORY INHALANTS		
sodium chloride neb soln (HYPER-SAL equiv)	-	1
NEBUSAL NEB SOLN	-	2
HYPER-SAL NEB SOLN	-	3
MUCOLYTICS		
acetylcysteine soln (MUCOMYST equiv)	-	1
DERMATOLOGICALS		
ACNE PRODUCTS		
adapalene cream (DIFFERIN equiv) (Acne Only – members age 26 or older require Prior Authorization)	PA	1
adapalene gel (DIFFERIN equiv) (Acne Only – members age 26 or older require Prior Authorization)	PA	1
adapalene/benzoyl peroxide gel 0.1-2.5% (EPIDUO equiv) (Acne Only – members age 26 or older require Prior Authorization)	PA	1
clindamycin gel (CLEOCIN GEL equiv)	-	1
clindamycin lotion (CLEOCIN- T equiv)	-	1
clindamycin pad (CLEOCIN-T equiv)	-	1
clindamycin topical soln (CLEOCIN-T equiv)	-	1
clindamycin/benzoyl peroxide gel (BENZACLIN equiv)	-	1
clindamycin/benzoyl peroxide gel (DUAC GEL equiv)	-	1
clindamycin/tretinoin gel (ZIANA equiv)	-	1
erythromycin gel	-	1
erythromycin pad	-	1
erythromycin soln	-	1
erythromycin/benzoyl peroxide gel (BENZAMYCIN equiv)	-	1
isotretinoin cap (AC CUTANE equiv)	-	1
RETIN-A MICRO GEL 0.04%, 0.1% (Acne Only – members age 26 or older require Prior Authorization)	PA	1
sodium sulfacetamide lotion (KLARON equiv)	-	1
sodium sulfacetamide/sulfur cream (PLEXION SCT equiv)	-	1
SODIUM SULFACETAMIDE/SULFUR EMULSION	-	1
sodium sulfacetamide/sulfur emulsion (ROSAC WASH equiv)	-	1
sodium sulfacetamide/sulfur emulsion (ROSULA equiv)	-	1
sodium sulfacetamide/sulfur foam (CLARIFOAM EF equiv)	-	1
sodium sulfacetamide/sulfur gel (ROSULA equiv)	-	1
sodium sulfacetamide/sulfur lotion (SULFACET R equiv)	-	1
sodium sulfacetamide/sulfur pad (PLEXION CLEANSING CLOTH equiv)	-	1
sodium sulfacetamide/sulfur susp (SUMAXIN equiv)	-	1

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	KMSP	generic =small letters	LD	BRANDS =CAPITAL LETTERS
LMSP	Infertility	M	Kroger Mandatory Specialty Pharmacy Program	MSP	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	PA	Medical Benefit	QL	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	SF	Prior Authorization	SMKG	Quantity Limit
SP	Restricted to Specialist	ST	Limited to Two 15 Day Fills per Month for the First 3 M	VAC	Smoking Cessation
	Available through Specialty Pharmacy Program		Step Therapy		Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Category/Class**

Last Updated* 11/1/2017

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
sodium sulfacetamide/sulfur wash (SUMAXIN equiv)	-	1
tretinoin cream (Acne Only – members age 26 or older require Prior Authorization)	PA	1
tretinoin gel (RETIN-A GEL equiv) (Acne Only – members age 26 or older require Prior Authorization)	PA	1
ADAPALENE LOTION (Acne Only – members age 26 or older require Prior Authorization)	PA	2
AVAR GEL	-	2
EPIDUO FORTE GEL (Acne Only – members age 26 or older require Prior Authorization)	PA	2
EPIDUO GEL 0.1-2.5% (Acne Only – members age 26 or older require Prior Authorization)	PA	2
PRASCION RA CREAM	-	2
SODIUM SULFACETAMIDE/SULFUR LOTION	-	2
ACANYA GEL, ONEXTON GEL	-	3
AKNE-MYCIN OINT	-	3
ATRALIN GEL, RETIN-A GEL	PA	3
AVAR AEROSOL FOAM	-	3
AZELEX CREAM	PA	3
BENZACLIN GEL	-	3
BENZAMYCIN GEL	-	3
BENZAMYCIN GEL PACK	-	3
CLARIFOAM EF FOAM	-	3
CLEOCIN-T GEL	-	3
CLEOCIN-T LOTION	-	3
CLEOCIN-T PAD	-	3
CLEOCIN-T SOLN	-	3
CLINDAGEL	-	3
DIFFERIN CREAM	PA	3
DIFFERIN GEL	PA	3
DUAC CS KIT	-	3
DUAC GEL	-	3
KLARON LOTION	-	3
PLEXION LOTION	-	3
PLEXION SCT CREAM	-	3
RETIN-A CREAM	PA	3
ROSULA EMULSION	-	3
ROSULA GEL	-	3
SUMAXIN PAD	-	3
SUMAXIN TS SUSP	-	3
SUMAXIN WASH	-	3
TRETIN-X CREAM	PA	3
VELTIN GEL	-	3
ZIANA GEL	-	3
ABSORICA CAP	-	NC
ACZONE GEL	-	NC
ACZONE GEL 7.5%	-	NC
AVAR PAD	-	NC
BENZAC WASH	-	NC
BENZOYL PEROXIDE CREAM	OTC	NC
CLINDACIN KIT	-	NC
clindamycin foam (EVOCLIN equiv)	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS
	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 M	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Category/Class**

Last Updated* 11/1/2017

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
dapsone gel (ACZONE equiv)	-	NC
DIFFERIN OTC GEL 0.1%	OTC	NC
EVOCLIN FOAM	-	NC
FABIOR AEROSOL FOAM	-	NC
RETIN-A MICRO GEL 0.08%	-	NC
ROSULA WASH	-	NC
sodium sulfacetamide/sunscreen kit (SUMADEN XLT equiv)	-	NC
SUMADAN KIT	-	NC
SUMADEN XLT KIT	-	NC
AGENTS FOR EXTERNAL GENITAL AND PERIANAL WARTS		
VEREGEN OINT	-	NC
AGENTS FOR WRINKLES/LIPOATROPHY/OTHER AESTHETIC USES		
KYBELLA INJ	-	NC
RENOVA CREAM	-	NC
ANALGESICS - TOPICAL		
BACLOFEN CREAM COMPOUND KIT	-	NC
TRAMADOL COMPOUND KIT	-	NC
ANTIBIOTICS - TOPICAL		
gentamicin sulfate cream	-	1
gentamicin sulfate oint	-	1
mupirocin cream (BACTROBAN equiv)	-	1
mupirocin oint (BACTROBAN OINT equiv)	-	1
ALTABAX OINT	-	3
BACTROBAN CREAM	-	3
BACTROBAN OINT	-	3
CENTANY OINT	-	3
CORTISPORIN CREAM	-	3
CORTISPORIN OINT	-	3
NEO-SYNALAR CREAM	-	NC
ANTIFUNGALS - TOPICAL		
ciclopirox cream (LOPROX CREAM equiv)	-	1
ciclopirox gel (LOPROX GEL equiv)	-	1
ciclopirox nail soln (PENLAC equiv)	-	1
ciclopirox shampoo (LOPROX SHAMPOO equiv)	-	1
ciclopirox topical susp (LOPROX SUSP equiv)	-	1
clotrimazole/betamethasone cream (LORTRISONE CREAM equiv)	-	1
clotrimazole/betamethasone lotion (LOTRISONE LOTION equiv)	-	1
econazole cream (SPECTAZOLE equiv)	-	1
ketoconazole cream (NIZORAL CREAM equiv)	-	1
ketoconazole shampoo (NIZORAL SHAMPOO equiv)	-	1
naftifine cream (NAFTIN equiv)	-	1
nystatin cream (MYCOSTATIN CREAM equiv)	-	1
nystatin oint	-	1
nystatin topical powder	-	1
nystatin/triamcinolone cream	-	1
nystatin/triamcinolone oint	-	1

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered Infertility	KMSP	generic =small letters Kroger Mandatory Specialty Pharmacy Program	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 M	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Category/Class**

Last Updated* 11/1/2017

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
oxiconazole nitrate cream (OXISTAT equiv)	-	1
ERTACZO CREAM	-	3
EXELDERM CREAM	-	3
EXELDERM SOLN	-	3
LOPROX CREAM	-	3
LOPROX GEL	-	3
LOPROX SHAMPOO	-	3
LOTRISONE CREAM	-	3
LOTRISONE LOTION	-	3
MENTAX CREAM	-	3
NAFTIN CREAM	-	3
NAFTIN GEL	-	3
NIZORAL SHAMPOO	-	3
OXISTAT CREAM	-	3
OXISTAT LOTION	-	3
ALCORTIN A GEL	-	NC
ALOQUIN GEL	-	NC
clotrimazole cream (LOTRIMIN AF CREAM equiv)	-	NC
ECOZA FOAM	-	NC
iodoquinol/hydrocortisone cream 1% (VYTONE equiv)	-	NC
iodoquinol/hydrocortisone cream 1.9-1% (VYTONE equiv)	-	NC
iodoquinol/hydrocortisone/aloe polysaccharide gel (ALCORTIN A equiv)	-	NC
JUBLIA SOLN	-	NC
KERYDIN SOLN	-	NC
LOTRIMIN AF CREAM	-	NC
LUZU CREAM	-	NC
NAFTIN GEL 2%	-	NC
NYATA KIT	-	NC
PENLAC SOLN	-	NC
VYTONE CREAM 1.9-1%	-	NC
XOLEGEL	-	NC

ANTI-INFLAMMATORY AGENTS - TOPICAL

diclofenac gel 1% (VOLTAREN equiv) (QL= 5 tubes/fill)	QL	1
FLECTOR PATCH (QL= 30 patches/fill)	QL	3
VOLTAREN GEL (QL= 5 tubes/fill)	QL	3
diclofenac soln 1.5% (PENNSAID equiv)	-	NC
DST PLUS PAK KIT	-	NC
INFLAMMA-K KIT	-	NC
NAPROXEN CREAM COMPOUND KIT	-	NC
PENNSAID SOLN	-	NC
PENNSAID SOLN 1.5%	-	NC
REXAPHENAC CREAM	-	NC
VOPAC 5 CREAM	-	NC
VOPAC CREAM	-	NC
VOPAC GB CREAM	-	NC

ANTINEOPLASTIC OR PREMALIGNANT LESION AGENTS - TOPICAL

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	KMSP	generic =small letters	LD	BRANDS =CAPITAL LETTERS
LMSP	Infertility	M	Kroger Mandatory Specialty Pharmacy Program	MSP	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	PA	Medical Benefit	QL	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	SF	Prior Authorization	SMKG	Quantity Limit
SP	Restricted to Specialist	ST	Limited to Two 15 Day Fills per Month for the First 3 M	VAC	Smoking Cessation
	Available through Specialty Pharmacy Program		Step Therapy		Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Category/Class**

Last Updated* 11/1/2017

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
diclofenac gel (SOLARAZE equiv)	PA	1
fluorouracil cream (EFUDEX CREAM equiv)	-	1
FLUOROPLEX CREAM	-	2
FLUOROURACIL CREAM 0.5%	-	2
FLUOROURACIL SOLN	-	2
EFUDEX CREAM	-	3
PICATO GEL (QL= 1 box/fill)	QL	3
SOLARAZE GEL	PA	3
PANRETIN GEL	KMSP-PA	4
TARGRETIN GEL	KMSP	4
VALCHLOR GEL (QL= 4 tubes/30 days; Only available through Accredo 888-773-7376)	LD-PA-QL	4
CARAC CREAM	-	NC
FLUORAC CREAM	-	NC
ANTIPRURITICS - TOPICAL		
DOXEPIN CREAM, PRUDOXIN CREAM, ZONALON CREAM	-	3
ANTIPSORIATICS		
calcipotriene cream (DOVONEX CREAM equiv)	-	1
calcipotriene oint	-	1
calcipotriene soln (DOVONEX SOLN equiv)	-	1
methoxsalen cap (OXSORALEN ULTRA equiv)	KMSP	1
tazarotene cream (TAZORAC equiv)	-	1
8-MOP CAP	KMSP	2
SORIATANE CK KIT	KMSP	2
DOVONEX CREAM	-	3
DOVONEX SOLN	-	3
DRITHO-SCALP CREAM	-	3
OXSORALEN ULTRA CAP	KMSP	3
SORILUX FOAM	-	3
TAZORAC CREAM	-	3
TAZORAC GEL	-	3
VECTICAL OINT	-	3
acitretin cap (SORIATANE equiv)	KMSP	4
COSENTYX INJ (QL= 2 inj/28 days)	LMSP-PA-QL	4
SORIATANE CAP	KMSP	4
SILIQ INJ	-	NC
STELARA INJ	-	NC
TALTZ INJ	-	NC
TREMFYA INJ	-	NC
ANTISEBORRHEIC PRODUCTS		
seb-prev cream (OVACE CREAM equiv)	-	1
selenium sulfide lotion	-	1
selenium sulfide shampoo (SELSEB equiv)	-	1
sodium sulfacetamide gel (OVACE PLUS equiv)	-	1
sodium sulfacetamide shampoo (OVACE equiv)	-	1
sodium sulfacetamide wash (OVACE WASH equiv)	-	1
sodium sulfacetamide/urea pad (ROSULA equiv)	-	1

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	KMSP	generic =small letters	LD	BRANDS =CAPITAL LETTERS
LMSP	Infertility	M	Kroger Mandatory Specialty Pharmacy Program	LD	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	PA	Prior Authorization	QL	Quantity Limit
SP	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 M	SMKG	Smoking Cessation
	Available through Specialty Pharmacy Program	ST	Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Category/Class**

Last Updated* 11/1/2017

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
OVACE PLUS CREAM	-	3
OVACE PLUS GEL	-	3
OVACE PLUS SHAMPOO	-	3
OVACE WASH	-	3
ROSULA PAD	-	3
OVACE PLUS LOTION	-	NC
OVACE PLUS FOAM	-	NC
SELENIUM SULFIDE LOTION	-	NC
SELRX SHAMPOO 2.3%	-	NC
ANTIVIRALS - TOPICAL		
ZOVIRAX OINT	-	1
DENAVIR CREAM	-	2
XERESE CREAM	-	3
ZOVIRAX CREAM	-	3
acyclovir oint (ZOVIRAX OINT equiv)	-	NC
BURN PRODUCTS		
silver sulfadiazine cream (SILVADENE CREAM equiv)	-	1
SULFAMYLON CREAM	-	2
SILVADENE CREAM	-	3
CORTICOSTEROIDS - TOPICAL		
alclometasone cream (ACLOVATE equiv)	-	1
alclometasone oint (ACLOVATE OINT equiv)	-	1
betamethasone augmented cream (DIPROLENE AF CREAM equiv)	-	1
betamethasone augmented gel	-	1
betamethasone augmented lotion (DIPROLENE LOTION equiv)	-	1
betamethasone augmented oint (DIPROLENE OINT equiv)	-	1
betamethasone dipropionate cream (DIPROSONE CREAM equiv)	-	1
betamethasone dipropionate lotion	-	1
betamethasone dipropionate oint (DIPROSONE OINT equiv)	-	1
betamethasone valerate cream	-	1
betamethasone valerate lotion	-	1
betamethasone valerate oint	-	1
calcipotriene/betamethasone oint (TACLONEX equiv)	-	1
clobetasol foam (OLUX equiv)	PA	1
clobetasol lotion (CLOBEX equiv)	PA	1
clobetasol propionate cream (TEMOVATE equiv)	PA	1
clobetasol propionate emollient cream (TEMOVATE E equiv)	-	1
clobetasol propionate gel (TEMOVATE GEL equiv)	PA	1
clobetasol propionate oint (TEMOVATE equiv)	PA	1
clobetasol propionate soln (TEMOVATE equiv)	PA	1
clobetasol shampoo (CLOBEX equiv)	PA	1
clobetasol spray (CLOBEX equiv)	PA	1
desoximetasone cream (TOPICORT CREAM equiv)	-	1
diflorasone oint	-	1
fluocinolone acetonide cream	-	1
fluocinolone acetonide oil (DERMA-SMOOTH/FS equiv)	-	1

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered Infertility	KMSP	generic =small letters Kroger Mandatory Specialty Pharmacy Program	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 M	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Category/Class**

Last Updated* 11/1/2017

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
fluocinolone acetonide oint	-	1
fluocinolone acetonide soln	-	1
fluocinonide cream 0.05% (LIDEX equiv)	-	1
fluocinonide emollient cream	-	1
fluocinonide gel	-	1
fluocinonide oint	-	1
fluocinonide soln	-	1
flurandrenolide Cream (CORDRAN equiv)	-	1
flurandrenolide lotion (CORDRAN equiv)	-	1
fluticasone propionate cream (CUTIVATE equiv)	-	1
fluticasone propionate oint (CUTIVATE equiv)	-	1
halobetasol propionate cream (ULTRAVATE equiv)	-	1
halobetasol propionate oint (ULTRAVATE equiv)	PA	1
hydrocortisone cream (PROCTOCORT equiv)	-	1
hydrocortisone lotion (HYTONE equiv)	-	1
hydrocortisone oint	-	1
mometasone cream (ELOCON equiv)	-	1
mometasone oint (ELOCON equiv)	-	1
mometasone soln (ELOCON equiv)	-	1
prednicarbate cream (DERMATOP equiv)	-	1
prednicarbate oint (DERMATOP equiv)	-	1
triamcinolone cream	-	1
triamcinolone lotion	-	1
triamcinolone oint	-	1
triamcinolone spray (KENALOG equiv)	-	1
EPIFOAM AEROSOL	-	2
PRAMOSONE CREAM 1%	-	2
PRAMOSONE OINT	-	2
U-CORT CREAM	-	2
ACLOVATE CREAM	-	3
ACLOVATE OINT	-	3
CAPEX SHAMPOO	-	3
CARMOL-HC CREAM	-	3
CLOBEX LOTION	PA	3
CLOBEX SHAMPOO	PA	3
CLOBEX SPRAY	PA	3
CLOCORTOLONE CREAM, CLODERM CREAM	-	3
CORDRAN CREAM	-	3
CORDRAN LOTION	-	3
CORDRAN TAPE	-	3
CUTIVATE CREAM	-	3
CUTIVATE OINT	-	3
DERMA-SMOOTH/FS OIL	-	3
DERMATOP CREAM	-	3
DERMATOP OINT	-	3
DIPROLENE AF CREAM	-	3
DIPROLENE LOTION	-	3

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered Infertility	KMSP	generic =small letters Kroger Mandatory Specialty Pharmacy Program	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 M	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Category/Class**

Last Updated* 11/1/2017

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
DIPROLENE OINT	-	3
ELOCON CREAM	-	3
ELOCON OINT	-	3
ELOCON SOLN	-	3
HALOG CREAM	-	3
HALOG OINT	-	3
HYTONE LOTION	-	3
KENALOG SPRAY	-	3
NUCORT LOTION	-	3
OLUX FOAM	PA	3
PANDEL CREAM	-	3
PRAMOSONE LOTION	-	3
PROCTOCORT CREAM	-	3
TACLONEX OINT	-	3
TACLONEX SCALP SUSP	-	3
TEMOVATE CREAM	PA	3
TEMOVATE GEL	PA	3
TEMOVATE OINT	PA	3
TEMOVATE SOLN	PA	3
TEMOVATE-E CREAM	PA	3
TEXACORT SOLN	-	3
TOPICORT CREAM	-	3
ULTRAVATE CREAM	-	3
ULTRAVATE LOTION	-	3
ULTRAVATE OINT	-	3
VANOS CREAM	-	3
VERDESO FOAM	-	3
AMCINONIDE CREAM 0.1%	-	NC
AMCINONIDE LOTION	-	NC
AMCINONIDE OINT	-	NC
APEXICON E CREAM (PSORCON E equiv)	-	NC
betamethasone valerate foam (LUXIQ FOAM equiv)	-	NC
clobetasol E foam (OLUX E equiv)	-	NC
CUTIVATE LOTION	-	NC
DERMACINRX KIT	-	NC
DESONATE GEL	-	NC
desonide cream	-	NC
desonide lotion	-	NC
desonide oint	-	NC
DESOWEN CREAM	-	NC
DESOWEN CREAM KIT	-	NC
DESOWEN LOTION	-	NC
DESOWEN LOTION KIT	-	NC
DESOWEN OINT	-	NC
DESOWEN OINT KIT	-	NC
desoximetasone gel (TOPICORT equiv)	-	NC
desoximetasone oint (TOPICORT equiv)	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered Infertility	KMSP	generic =small letters Kroger Mandatory Specialty Pharmacy Program	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 M	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Category/Class**

Last Updated* 11/1/2017

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
DIFLORASONE CREAM	-	NC
DIFLORASONE OINT (PSORCON equiv)	-	NC
ENSTILAR FOAM	-	NC
flucaninonide cream 0.1% (VANOS CREAM equiv)	-	NC
fluticasone propionate lotion (CUTIVATE equiv)	-	NC
halonate pac kit (ULTRAVATE KIT equiv)	-	NC
hydrocortisone butyrate cream (LOCOID equiv)	-	NC
hydrocortisone butyrate lipocream (LOCOID equiv)	-	NC
hydrocortisone butyrate oint (LOCOID equiv)	-	NC
hydrocortisone butyrate soln (LOCOID equiv)	-	NC
hydrocortisone valerate cream	-	NC
hydrocortisone valerate oint (WESTCORT equiv)	-	NC
hydrocortisone/pramoxine cream 2.5-1% (PRAMOSONE equiv)	-	NC
LOCOID CREAM	-	NC
LOCOID LIPOCREAM	-	NC
LOCOID OINT	-	NC
LOCOID SOLN	-	NC
LUXIQ FOAM	-	NC
MICORT-HC CREAM	-	NC
NOVACORT GEL	-	NC
OLUX E FOAM	-	NC
PRAMOSONE CREAM 2.5-1%	-	NC
PRAMOSONE E CREAM	-	NC
SERNIVO SPRAY	-	NC
TOPICORT GEL	-	NC
TOPICORT OINT	-	NC
TRIANEX OINT	-	NC
ULTRAVATE PAC KIT	-	NC
WESTCORT OINT	-	NC
ECZEMA AGENTS		
DUPIXENT INJ	-	NC
EMOLLIENT/KERATOLYTIC AGENTS		
CARMOL LOTION	-	NC
GORDON'S UREA OINT 40%	-	NC
KERAFOAM	-	NC
KERALAC CREAM	-	NC
UMECTA EMULSION	-	NC
UMECTA SUSP	-	NC
URAMAXIN CREAM	-	NC
URAMAXIN GEL	-	NC
urea cream	-	NC
UREA EMULSION	-	NC
urea gel (URAMAXIN equiv)	-	NC
UREA NAIL KIT	-	NC
UREA SUSP	-	NC
urea susp 40% (UMECTA equiv)	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered Infertility	KMSP	generic =small letters Kroger Mandatory Specialty Pharmacy Program	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 M	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Category/Class**

Last Updated* 11/1/2017

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
EMOLLIENTS		
ammonium lactate cream (LAC-HYDRIN equiv)	-	1
ammonium lactate lotion (LAC-HYDRIN equiv)	-	1
LAC-HYDRIN CREAM	-	3
LAC-HYDRIN LOTION	-	3
ENZYMES - TOPICAL		
SANTYL OINT (QL= 90gm/30 days)	QL	2
vasolex oint (XENADERM equiv)	-	NC
XENADERM OINT	-	NC
HAIR GROWTH AGENTS		
finasteride tab (PROPECIA equiv)	-	NC
HAIR REDUCTION AGENTS		
VANIQA CREAM	-	NC
IMMUNOMODULATING AGENTS - TOPICAL		
imiquimod cream (ALDARA equiv)	-	1
ALDARA CREAM	-	3
ZYCLARA CREAM	-	NC
IMMUNOSUPPRESSIVE AGENTS - TOPICAL		
tacrolimus oint (PROTOPIC OINT equiv)	-	1
ELIDEL CREAM	-	2
PROTOPIC OINT	-	3
KERATOLYTIC/ANTIMITOTIC AGENTS		
podofilox soln (CONDYLOX equiv)	-	1
salicylic acid shampoo (SALEX equiv)	-	1
PODOCON SOLN	-	2
CONDYLOX GEL	-	3
CONDYLOX SOLN	-	3
SALEX SHAMPOO	-	3
LOCAL ANESTHETICS - TOPICAL		
lidocaine cream 3% (LIDAMANTLE equiv)	-	1
lidocaine gel (XYLOCAINE equiv)	-	1
lidocaine oint (QL= 107gm/30 days)	QL	1
lidocaine patch (LIDODERM equiv) (QL= 3 patches/day)	QL	1
lidocaine soln (XYLOCAINE equiv)	-	1
lidocaine/prilocaine cream (EMLA equiv)	-	1
EMLA CREAM	-	3
LIDODERM PATCH (QL= 3 patches/day)	QL	3
SOLARCAINE EXTRA GEL	-	3
SYNERA PATCH	-	3
XYLOCAINE SOLN	-	3
ADAZIN CREAM	-	NC
ANASTIA LOTION	-	NC
capsaicin/menthol topical patch (SINELEE equiv)	-	NC
LIDAMANTLE LOTION	-	NC
LIDOCAINE CREAM	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	KMSP	generic =small letters	LD	BRANDS =CAPITAL LETTERS
LMSP	Infertility	M	Kroger Mandatory Specialty Pharmacy Program	MSP	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	PA	Medical Benefit	QL	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	SF	Prior Authorization	SMKG	Quantity Limit
SP	Restricted to Specialist	ST	Limited to Two 15 Day Fills per Month for the First 3 M	VAC	Smoking Cessation
	Available through Specialty Pharmacy Program		Step Therapy		Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Category/Class**

Last Updated* 11/1/2017

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
lidocaine cream 3.88% (LIDOTRAL equiv)	-	NC
lidocaine lotion (LIDAMANTLE equiv)	-	NC
LIDOCIN GEL	-	NC
LIDOTRAL CREAM	-	NC
LIDOTREX GEL	-	NC
SILVERA PAD	-	NC
SOLAICE PATCH	-	NC
SYNVEXIA TC CREAM	-	NC
MISC. DERMATOLOGICAL PRODUCTS		
NEOSALUS FOAM	-	NC
MISC. TOPICAL		
aluminum chloride soln (DRYSOL equiv)	-	1
DRYSOL SOLN	-	1
PHOSPHODIESTERASE 4 (PDE4) INHIBITORS - TOPICAL		
EUCRISA OINT	-	NC
PIGMENTING-DEPIGMENTING AGENTS		
hydroquinone cream (LUSTRA equiv)	-	NC
TRI-LUMA CREAM	-	NC
ROSACEA AGENTS		
metronidazole cream (METROCREAM equiv)	-	1
metronidazole gel (METROGEL equiv)	-	1
metronidazole lotion (METROLOTION equiv)	-	1
FINACEA FOAM	-	2
FINACEA GEL	-	2
FINACEA PLUS KIT	-	2
METROCREAM	-	3
METROGEL 1% (Step Therapy requires trial of FINACEA)	ST	3
METROLOTION	-	3
NORITATE CREAM (Step Therapy requires trial of FINACEA)	ST	3
DOXYCYCLINE CAP, ORACEA CAP	-	NC
MIRVASO GEL	-	NC
RHOFADE CREAM	-	NC
ROSDAN KIT	-	NC
SCABICIDES & PEDICULICIDES		
lindane lotion	-	1
lindane shampoo	-	1
malathion lotion (OVIDE equiv) (QL= 2 bottles/fill)	QL	1
permethrin cream (ELIMITE CREAM equiv)	-	1
EURAX CREAM	-	2
SPINOSAD SUSP (QL= 1 bottle/fill)	QL	2
ELIMITE CREAM	-	3
EURAX LOTION	-	3
LINDANE LOTION	-	3
NATROBA SUSP (QL= 1 bottle/fill)	QL	3
OVIDE LOTION (QL= 2 bottles/fill)	QL	3
SKLICE LOTION (QL= 1 tube/fill)	PA-QL	3

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	KMSP	generic =small letters	LD	BRANDS =CAPITAL LETTERS
LMSP	Infertility	M	Kroger Mandatory Specialty Pharmacy Program	MSP	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	PA	Medical Benefit	QL	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	SF	Prior Authorization	SMKG	Quantity Limit
SP	Restricted to Specialist	ST	Limited to Two 15 Day Fills per Month for the First 3 M	VAC	Smoking Cessation
	Available through Specialty Pharmacy Program		Step Therapy		Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Category/Class**

Last Updated* 11/1/2017

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
ULESFIA LOTION (QL= 4 bottles/fill)	QL	3
WOUND CARE PRODUCTS		
REGRANEX GEL (QL= 30gm/fill)	QL	2
VENELEX OINT	-	2
BIAFINE EMULSION	-	NC
DIAGNOSTIC PRODUCTS		
DIAGNOSTIC DRUGS		
GLUCAGEN INJ	-	2
GLUCAGON DIAGNOSTIC INJ	-	NC
DIAGNOSTIC PRODUCTS, MISC.		
FREESTYLE LITE TEST STRIP (Limited to 50 strips per month for members not on diabetes medication)	OTC	2
DIAGNOSTIC TESTS		
CLINISTIX TEST STRIP	OTC	1
KETO-DIASTIX TEST STRIP	OTC	1
KETOSTIX	OTC	1
ACCU-CHEK AVIVA PLUS TEST STRIP (Limited to 50 strips per month for members not on diabetes medication)	OTC	2
ACCU-CHEK GUIDE TEST STRIP (Limited to 50 strips per month for members not on diabetes medication)	OTC	2
ACCU-CHEK SMARTVIEW TEST STRIP (Limited to 50 strips per month for members not on diabetes medication)	OTC	2
ACCU-CHEK TEST STRIP (Limited to 50 strips per month for members not on diabetes medication)	OTC	2
FREESTYLE INSULINX TEST STRIP (Limited to 50 strips per month for members not on diabetes medication)	OTC	2
FREESTYLE PRECISION NEO TEST STRIP (Limited to 50 strips per month for members not on diabetes medication)	OTC	2
FREESTYLE TEST STRIP (Limited to 50 strips per month for members not on diabetes medication)	OTC	2
PRECISION XTRA TEST STRIP (Limited to 50 strips per month for members not on diabetes medication)	OTC	2
TEST STRIP (all other test strips)	OTC	NC
DIETARY PRODUCTS/DIETARY MANAGEMENT PRODUCTS		
DIETARY MANAGEMENT PRODUCTS		
ASTAMED MYO CAP	-	NC
DEPLIN CAP	-	NC
ELIGEN B12 TAB	-	NC
FALESSA TAB	-	NC
GLYGEST PAK	-	NC
L-METHYLFOLATE TAB	-	NC
METANX CAP	-	NC
OLLIZAC POWDER	-	NC
PODIAPN CAP	-	NC
XAQUIL XR TAB	-	NC
XYZBAC TAB	-	NC
INFANT FOODS		
INFANT FORMULA LIQUID	OTC-PA	2
INFANT FORMULA POWDER	OTC-PA	2
NUTRITIONAL SUPPLEMENTS		
NUTRITIONAL SUPPLEMENT LIQUID	OTC-PA	2
NUTRITIONAL SUPPLEMENT POWDER	OTC-PA	2
DIGESTIVE AIDS		
DIGESTIVE ENZYMES		

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	generic =small letters	BRANDS =CAPITAL LETTERS
LMSP	Infertility	KMSP	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	M	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	PA	Quantity Limit
SP	Restricted to Specialist	SF	Smoking Cessation
	Available through Specialty Pharmacy Program	ST	Vaccine Program
		LD	Limited Distribution
		MSP	Mandatory Specialty Pharmacy Program
		QL	Quantity Limit
		SMKG	Smoking Cessation
		VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Category/Class**

Last Updated* 11/1/2017

DrugName	Special Code	Tier
DIGESTIVE AIDS Cont.		
CREON CAP	-	2
PANCREAZE CAP (Step Therapy requires trial of CREON)	ST	3
PANCRELIPASE CAP (Step Therapy requires trial of CREON)	ST	3
PERTZYE CAP (Step Therapy requires trial of CREON)	ST	3
ULTRESA CAP (Step Therapy requires trial of CREON)	ST	3
ZENPEP CAP (Step Therapy requires trial of CREON)	ST	3
SUCRAID SOLN	-	NC

DIURETICS

CARBONIC ANHYDRASE INHIBITORS

acetazolamide ER cap (DIAMOX SEQUEL equiv)	-	1
acetazolamide tab	-	1
methazolamide tab (NEPTAZANE equiv)	-	1
DIAMOX SEQUEL CAP	-	3
NEPTAZANE TAB	-	3
KEVEYIS TAB	-	NC

DIURETIC COMBINATIONS

amiloride/hydrochlorothiazide tab (MODURETIC equiv)	-	1
spironolactone/hydrochlorothiazide tab (ALDACTAZIDE equiv)	-	1
triamterene/hydrochlorothiazide cap (DYAZIDE equiv)	-	1
triamterene/hydrochlorothiazide tab (MAXZIDE equiv)	-	1
TRIAMTERENE/HYDROCHLOROTHIAZIDE CAP 50-25mg	-	2
ALDACTAZIDE TAB	-	3
ALDACTAZIDE TAB 50-50MG	-	3
DYAZIDE CAP	-	3
MAXZIDE TAB	-	3

LOOP DIURETICS

bumetanide tab (BUMEX equiv)	-	1
ethacrynic tab (EDECIN equiv)	-	1
FUROSEMIDE SOLN	-	1
furosemide soln (LASIX equiv)	-	1
furosemide tab (LASIX equiv)	-	1
torsemide tab (DEMADEX equiv)	-	1
DEMADEX TAB	-	3
EDECIN TAB	-	3
LASIX TAB	-	3

POTASSIUM SPARING DIURETICS

amiloride tab (MIDAMOR equiv)	-	1
spironolactone tab (ALDACTONE equiv)	-	1
DYRENIUM CAP	-	2
ALDACTONE TAB	-	3
MIDAMOR TAB	-	3

THIAZIDES AND THIAZIDE-LIKE DIURETICS

chlorothiazide tab (DIURIL equiv)	-	1
CHLOROTHIAZIDE TAB 250MG	-	1
chlorthalidone tab	-	1
hydrochlorothiazide cap (MICROZIDE equiv)	-	1

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	KMSP	generic =small letters	LD	BRANDS =CAPITAL LETTERS
LMSP	Infertility	M	Kroger Mandatory Specialty Pharmacy Program	MSP	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	PA	Medical Benefit	QL	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	SF	Prior Authorization	SMKG	Quantity Limit
SP	Restricted to Specialist	ST	Limited to Two 15 Day Fills per Month for the First 3 M	VAC	Smoking Cessation
	Available through Specialty Pharmacy Program		Step Therapy		Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Category/Class**

Last Updated* 11/1/2017

DrugName	Special Code	Tier
DIURETICS Cont.		
hydrochlorothiazide tab (HYDRODIURIL equiv)	-	1
indapamide tab (LOZOL equiv)	-	1
METHYCLOTHIAZIDE TAB	-	1
metolazone tab (ZAROXOLYN equiv)	-	1
DIURIL SUSP	-	2
MICROZIDE CAP	-	3
ZAROXOLYN TAB	-	3
ENDOCRINE AND METABOLIC AGENTS - MISC.		
BONE DENSITY REGULATORS		
alendronate tab (FOSAMAX equiv)	-	1
ETIDRONATE DISODIUM TAB 400MG	-	1
ibandronate tab 150mg (BONIVA equiv) (QL= 1 tab/30 days; Step Therapy requires trial of alendronate)	QL-ST	1
risedronate DR tab (ATELVIA equiv) (Step Therapy requires trial of alendronate)	ST	1
risedronate tab (ACTONEL equiv) (Step Therapy requires trial of alendronate)	ST	1
ALENDRONATE TAB 40MG	-	2
ACTONEL TAB	-	3
ATELVIA TAB (Step Therapy requires trial of alendronate)	ST	3
BONIVA TAB 150MG (QL= 1 tab/30 days; Step Therapy requires trial of alendronate)	QL-ST	3
FOSAMAX+D TAB	-	3
SKELID TAB	-	3
NATPARA INJ (Only available through Walgreens 888-347-3416)	LD-PA	4
FORTICAL NASAL SPRAY	-	NC
TYMLOS INJ	-	NC
CALCIUM REGULATORS - MISC.		
calcitonin nasal spray (MIACALCIN equiv)	-	1
etidronate disodium tab 200mg (DIDRONEL equiv)	-	1
ALENDRONATE SOLN	-	3
FOSAMAX TAB	-	3
FORTEO INJ	KMSP	4
MIACALCIN INJ	KMSP	4
MIACALCIN NASAL SPRAY	-	NC
GROWTH HORMONE RECEPTOR ANTAGONISTS		
SOMAVERT INJ (Only available through Walgreens 888-347-3416)	LD-PA	4
GROWTH HORMONE RELEASING HORMONES (GHRH)		
EGRIFTA INJ	-	NC
GROWTH HORMONES		
GENOTROPIN INJ	KMSP-PA	4
HUMATROPE INJ, ZOMACTON INJ	-	NC
NORDITROPIN INJ, NUTROPIN AQ INJ, OMNITROPE INJ	-	NC
SAIZEN INJ, SEROSTIM INJ, ZORBTIVE INJ	-	NC
HORMONE RECEPTOR MODULATORS		
raloxifene tab (EVISTA equiv) (Covered at \$0 for women 35 years or older; All other members covered at generic copay)	-	\$0
EVISTA TAB	-	3
OSPHENA TAB	-	NC
INSULIN-LIKE GROWTH FACTORS (SOMATOMEDINS)		

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	KMSP	generic =small letters	LD	BRANDS =CAPITAL LETTERS
LMSP	Infertility	M	Kroger Mandatory Specialty Pharmacy Program	MSP	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	PA	Medical Benefit	QL	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	SF	Prior Authorization	SMKG	Quantity Limit
SP	Restricted to Specialist	ST	Limited to Two 15 Day Fills per Month for the First 3 M	VAC	Smoking Cessation
	Available through Specialty Pharmacy Program		Step Therapy		Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Category/Class**

Last Updated* 11/1/2017

DrugName	Special Code	Tier
ENDOCRINE AND METABOLIC AGENTS - MISC. Cont.		
INCRELEX INJ	MSP	4
LHRH/GNRH AGONIST ANALOG PITUITARY SUPPRESSANTS		
SYNAREL NASAL SOLN	KMSP	4
LUPRON DEPOT PED INJ	M	M
LUPRON DEPOT-PED INJ	M	M
LUPANETA PACK	-	NC
METABOLIC MODIFIERS		
calcitriol cap (ROCALTROL equiv)	-	1
calcitriol soln (ROCALTROL equiv)	-	1
levocarnitine soln (CARNITOR equiv)	-	1
levocarnitine tab (CARNITOR equiv)	-	1
sodium phenylbutyrate powder (BUPHENYL equiv)	KMSP	1
BUPHENYL POWDER	KMSP	3
CARNITOR SOLN	-	3
CARNITOR TAB	-	3
ROCALTROL CAP	-	3
ROCALTROL SOLN	-	3
BUPHENYL TAB	KMSP	4
calcitriol inj (CALCIJEX equiv)	LMSP	4
CARBAGLU TAB (Only available through Accredo 888-773-7376)	LD-PA	4
doxercalciferol cap (HECTOROL equiv)	MSP	4
KUVAN POWDER PACK (Only available through Walgreens 888-347-3416)	LD-PA	4
KUVAN TAB (Only available through Walgreens 888-347-3416)	LD-PA	4
ORFADIN CAP (Only available through Dohmen LSS 844-246-5226)	LD-PA	4
paricalcitol cap (ZEMPLAR equiv)	MSP	4
SENSIPAR TAB	LMSP	4
sodium phenylbutyrate tab (BUPHENYL equiv)	KMSP	4
STRENSIQ INJ (Only available through PantherRx Pharmacy 855-726-8479)	LD-PA	4
ALDURAZYME INJ	M	M
FABRAZYME INJ	M	M
MYALEPT INJ	-	NC
NITYR TAB	-	NC
ORFADIN SUSP	-	NC
RAVICTI LIQUID	-	NC
RAYALDEE CAP	-	NC
XURIDEN POWDER	-	NC
POSTERIOR PITUITARY HORMONES		
desmopressin acetate inj (DDAVP equiv)	-	1
desmopressin acetate nasal spray (DDAVP equiv)	-	1
desmopressin acetate tab (DDAVP equiv)	-	1
desmopressin nasal soln (DDAVP equiv)	-	1
STIMATE NASAL SOLN	KMSP	2
DDAVP INJ	-	3
DDAVP NASAL SOLN	-	3
DDAVP NASAL SPRAY	-	3
DDAVP TAB	-	3

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	KMSP	generic =small letters	LD	BRANDS =CAPITAL LETTERS
LMSP	Infertility	M	Kroger Mandatory Specialty Pharmacy Program	LD	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	PA	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	SF	Prior Authorization	QL	Quantity Limit
SP	Restricted to Specialist	SMKG	Limited to Two 15 Day Fills per Month for the First 3 M	SMKG	Smoking Cessation
	Available through Specialty Pharmacy Program	ST	Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Category/Class**

Last Updated* 11/1/2017

DrugName	Special Code	Tier
ENDOCRINE AND METABOLIC AGENTS - MISC. Cont.		
PROLACTIN INHIBITORS		
cabergoline tab (DOSTINEX equiv)	-	1
SOMATOSTATIC AGENTS		
octreotide inj (SANDOSTATIN equiv)	LMSP	4
SIGNIFOR INJ (QL= 2 vials/day; Only available through Accredo 888-773-7376)	LD-PA-QL	4
SANDOSTATIN LAR INJ KIT	-	NC
SOMATULINE INJ	-	NC
VASOPRESSIN RECEPTOR ANTAGONISTS		
SAMSCA TAB	-	4
ESTROGENS		
ESTROGEN COMBINATIONS		
estradiol/norethindrone tab (ACTIVEVELLA equiv)	-	1
jinteli tab (FEMHRT equiv)	-	1
PREMPHASE TAB, PREMPRO TAB	-	2
ACTIVEVELLA TAB	-	3
ANGELIQ TAB	-	3
CLIMARA PRO PATCH	-	3
COMBIPATCH	-	3
FEMHRT TAB	-	3
PREFEST TAB	-	3
DUAVEE TAB	-	NC
esterified estrogens/methyltestosterone tab (ESTRATEST equiv)	-	NC
ESTRATEST TAB	-	NC
ESTROGENS		
estradiol patch (CLIMARA equiv)	-	1
estradiol patch (VIVELLE-DOT equiv)	-	1
estradiol tab (ESTRACE equiv)	-	1
ESTROPIPATE TAB	-	1
estropipate tab (OGEN equiv)	-	1
PREMARIN TAB	-	2
ALORA PATCH	-	3
CENESTIN TAB	-	3
CLIMARA PATCH	-	3
DIVIGEL GEL, ELESTRIN GEL	-	3
ENJUVA TAB	-	3
ESTRACE TAB	-	3
ESTRASORB EMULSION	-	3
EVAMIST SPRAY	-	3
MENEST TAB	-	3
MENOSTAR PATCH	-	3
VIVELLE-DOT PATCH	-	3
FLUOROQUINOLONES		
FLUOROQUINOLONES		
ciprofloxacin ER tab (CIPRO XR equiv)	-	1
ciprofloxacin susp (CIPRO equiv)	-	1

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered Infertility	KMSP	generic =small letters Kroger Mandatory Specialty Pharmacy Program	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 M	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Category/Class**

Last Updated* 11/1/2017

DrugName	Special Code	Tier
FLUOROQUINOLONES Cont.		
ciprofloxacin tab (CIPRO equiv)	-	1
LEVOFLOXACIN SOLN	-	1
levofloxacin soln (LEVAQUIN equiv)	-	1
levofloxacin tab (LEVAQUIN equiv)	-	1
moxifloxacin tab (AVELOX equiv)	-	1
ofloxacin tab (FLOXIN equiv)	-	1
AVELOX TAB	-	3
CIPRO SUSP	-	3
CIPRO TAB	-	3
CIPRO XR TAB	-	3
CIPROFLOXACIN 100MG TAB	-	3
LEVAQUIN SOLN	-	3
LEVAQUIN TAB	-	3
NOROXIN TAB	-	3
BAXDELA TAB	-	NC
FACTIVE TAB	-	NC
PROQUIN XR TAB	-	NC

GASTROINTESTINAL AGENTS - MISC.

AGENTS FOR CHRONIC IDIOPATHIC CONSTIPATION (CIC)

TRULANCE TAB	-	NC
--------------	---	----

BILE ACID SYNTHESIS DISORDER AGENTS

CHOLBAM CAP (Only available through Dohmen LSS 844-246-5226)	LD-PA	4
--	-------	---

FARNESOID X RECEPTOR (FXR) AGONISTS

OCALIVA TAB (QL= 1 tab/day; Only available through Walgreens 888-347-3416)	LD-PA-QL-SF	4
--	-------------	---

GALLSTONE SOLUBILIZING AGENTS

ursodiol cap (ACTIGALL equiv)	-	1
ursodiol tab (URSO (FORTE) equiv)	-	1
ACTIGALL CAP	-	3
URSO FORTE TAB	-	3

GASTROINTESTINAL ANTIALLERGY AGENTS

cromolyn conc (GASTROCROM equiv)	-	1
GASTROCROM CONC	-	2

GASTROINTESTINAL CHLORIDE CHANNEL ACTIVATORS

AMITIZA CAP	PA	3
-------------	----	---

GASTROINTESTINAL STIMULANTS

metoclopramide soln (REGLAN equiv)	-	1
metoclopramide tab (REGLAN equiv)	-	1
REGLAN TAB	-	3
METOZOLV ODT	-	NC

INFLAMMATORY BOWEL AGENTS

balsalazide cap (COLAZAL equiv)	-	1
LIALDA TAB	-	1
mesalamine enema (ROWASA equiv)	-	1
sulfasalazine EC tab (AZULFIDINE equiv)	-	1
sulfasalazine tab (AZULFIDINE equiv)	-	1

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	KMSP	generic =small letters	LD	BRANDS =CAPITAL LETTERS
LMSP	Infertility	M	Kroger Mandatory Specialty Pharmacy Program	LD	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	PA	Prior Authorization	QL	Quantity Limit
SP	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 M	SMKG	Smoking Cessation
	Available through Specialty Pharmacy Program	ST	Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Category/Class**

Last Updated* 11/1/2017

DrugName	Special Code	Tier
GASTROINTESTINAL AGENTS - MISC. Cont.		
APRISO CAP	-	2
CANASA SUPP	-	2
AZULFIDINE EN TAB	-	3
AZULFIDINE TAB	-	3
COLAZAL CAP	-	3
DIPENTUM CAP	-	3
SFROWASA ENEMA	-	3
CIMZIA INJ (QL= 2 inj/28 days)	LMSP-PA-QL	4
ASACOL HD TAB, MESALAMINE TAB	-	NC
DELZICOL CAP	-	NC
mesalamine DR tab (LIALDA equiv)	-	NC
PENTASA CAP	-	NC
ROWASA KIT	-	NC
INTESTINAL ACIDIFIERS		
lactulose soln	-	1
IRRITABLE BOWEL SYNDROME (IBS) AGENTS		
alosetron tab (LOTROXEX equiv)	-	1
LINZESS CAP	PA	2
LOTROXEX TAB	-	3
VIBERZI TAB	-	NC
PERIPHERAL OPIOID RECEPTOR ANTAGONISTS		
MOVANTIK TAB	PA	2
RELISTOR INJ	-	NC
RELISTOR INJ KIT	-	NC
RELISTOR TAB	-	NC
SYMPROIC TAB	-	NC
PHOSPHATE BINDER AGENTS		
calcium acetate cap (PHOSLO equiv)	-	1
calcium acetate tab (ELIPHOS equiv)	-	1
lanthanum carbonate chew tab (FOSRENOL equiv)	-	1
sevelamer powder pak (RENVELA equiv)	-	1
sevelamer tab (RENVELA TAB equiv)	-	1
FOSRENOL POWDER PACK	-	2
PHOSLYRA SOLN	-	2
SEVELAMER CARBONATE TAB	-	2
AURYXIA TAB	-	3
ELIPHOS TAB	-	3
FOSRENOL CHEW TAB	-	3
PHOSLO CAP	-	3
RENAGEL TAB	-	3
RENVELA TAB	-	3
VELPHORO CHEW TAB	-	3
SHORT BOWEL SYNDROME (SBS) AGENTS		
GATTEX KIT	-	NC
TRYPTOPHAN HYDROXYLASE INHIBITORS		
XERMELO TAB	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered Infertility	KMSP	generic =small letters Kroger Mandatory Specialty Pharmacy Program	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 M	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Category/Class**

Last Updated* 11/1/2017

DrugName	Special Code	Tier		
GENITOURINARY AGENTS - MISCELLANEOUS				
ALKALINIZERS				
CYTRA-3 SYRUP	-	1		
ORACIT SOLN	-	1		
potassium citrate CR tab (UROCIT-K TAB equiv)	-	1		
potassium citrate/citric acid powder pack (POLYCITRA equiv)	-	1		
potassium citrate/citric acid soln (POLYCITRA-K equiv)	-	1		
sodium citrate/citric acid soln (BICITRA equiv)	-	1		
tricitrates soln (POLYCITRA-LC equiv)	-	1		
SHOHL'S SOLN	-	2		
POLYCITRA CRYSTAL PACK	-	3		
POLYCITRA-LC SOLN	-	3		
UROCIT-K TAB	-	3		
CYSTINOSIS AGENTS				
CYSTAGON CAP (Only available through CVS Specialty 800-238-7828)	LD-PA	4		
GENITOURINARY IRRIGANTS				
sodium chloride 0.9% irr soln	-	1		
INTERSTITIAL CYSTITIS AGENTS				
ELMIRON CAP	-	2		
PROSTATIC HYPERTROPHY AGENTS				
alfuzosin SR tab (UROXATRAL equiv)	-	1		
dutasteride cap (AVODART equiv)	-	1		
dutasteride/tamsulosin cap (JALYN equiv)	-	1		
finasteride tab (PROSCAR equiv)	-	1		
tamsulosin cap (FLOMAX equiv)	-	1		
RAPAFLO CAP (Restricted to Urology Specialist)	RS	2		
UROXATRAL TAB	-	2		
AVODART CAP	-	3		
CARDURA XL TAB	-	3		
FLOMAX CAP	-	3		
JALYN CAP	-	3		
PROSCAR TAB	-	3		
URINARY ANALGESICS				
phenazopyridine tab (PYRIDIDIUM equiv)	-	1		
PYRIDIDIUM TAB	-	3		
URINARY STONE AGENTS				
LITHOSTAT TAB	-	3		
THIOLA TAB	-	NC		
GOUT AGENTS				
GOUT AGENT COMBINATIONS				
colchicine/probenecid tab (COL-BENEMID equiv)	-	1		
DUZALLO TAB	-	NC		
GOUT AGENTS				
allopurinol tab (ZYLOPRIM equiv)	-	1		
COLCHICINE TAB	PA	2		
MITIGARE CAP	-	2		
Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.				
INF Infertility LMSP Lumicera Mandatory Specialty Pharmacy Program OTC Over-the-Counter RS Restricted to Specialist SP Available through Specialty Pharmacy Program	KMSP M PA SF ST	generic =small letters Kroger Mandatory Specialty Pharmacy Program Medical Benefit Prior Authorization Limited to Two 15 Day Fills per Month for the First 3 M Step Therapy	LD MSP QL SMKG VAC	BRANDS =CAPITAL LETTERS Limited Distribution Mandatory Specialty Pharmacy Program Quantity Limit Smoking Cessation Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Category/Class**

Last Updated* 11/1/2017

DrugName	Special Code	Tier
GOUT AGENTS Cont.		
ULORIC TAB (Step Therapy requires trial of allopurinol)	ST	2
ZYLOPRIM TAB	-	3
COLCHICINE CAP	-	NC
ZURAMPIC TAB	-	NC
URICOSURICS		
probenecid tab (BENEMID equiv)	-	1
HEMATOLOGICAL AGENTS - MISC.		
ANTIHEMOPHILIC PRODUCTS		
AFSTYLA KIT	-	NC
COMPLEMENT INHIBITORS		
HAEGARDA INJ	-	NC
HEMATORHEOLOGIC AGENTS		
pentoxifylline ER tab (TRENTAL equiv)	-	1
TRENTAL TAB	-	3
PLATELET AGGREGATION INHIBITORS		
anagrelide cap (AGRYLIN equiv)	-	1
aspirin/dipyridamole cap (AGGRENOX equiv)	-	1
cilostazol tab (PLETAL equiv)	-	1
clopidogrel tab 75mg (PLAVIX equiv)	-	1
dipyridamole tab (PERSANTINE equiv)	-	1
prasugrel tab (EFFIENT equiv)	-	1
TICLOPIDINE TAB	-	1
ticlopidine tab (TICLID equiv)	-	1
AGGRENOX CAP	-	3
AGRYLIN CAP	-	3
BRILINTA TAB (Restricted to Cardiology Specialist)	RS	3
EFFIENT TAB	-	3
PERSANTINE TAB	-	3
PLAVIX TAB 75MG	-	3
PLETAL TAB	-	3
ZONTIVITY TAB (Restricted to Cardiology Specialist)	RS	3
CLOPIDOGREL THERAPY PACK	-	NC
PLAVIX TAB 300MG	-	NC
YOSPRALA TAB	-	NC
HEMATOPOIETIC AGENTS		
AGENTS FOR GAUCHER DISEASE		
CERDELGA CAP	MSP-PA	4
ZAVESCA CAP (Only available through Accredo 888-773-7376)	LD-PA	4
CEREZYME INJ	M	M
AGENTS FOR SICKLE CELL ANEMIA		
DROXIA CAP	-	2
ENDARI POWDER PACK	-	NC
COBALAMINS		
cyanocobalamin inj	-	1
NASCOBAL NASAL SPRAY	-	3
Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.		

INF	NC =Not Covered	KMSP	generic =small letters	LD	BRANDS =CAPITAL LETTERS
LMSP	Infertility	M	Kroger Mandatory Specialty Pharmacy Program	MSP	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	PA	Medical Benefit	QL	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	SF	Prior Authorization	SMKG	Quantity Limit
SP	Restricted to Specialist	ST	Limited to Two 15 Day Fills per Month for the First 3 M	VAC	Smoking Cessation
	Available through Specialty Pharmacy Program		Step Therapy		Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Category/Class**

Last Updated* 11/1/2017

DrugName	Special Code	Tier
HEMATOPOIETIC AGENTS Cont.		
CALOMIST NASAL SPRAY	-	NC
FOLIC ACID/FOLATES		
folic acid tab 1mg (Covered at \$0 for females only; All other members covered at generic copay)	-	\$0
folic acid tab 400mcg (Covered for females only)	OTC	\$0
folic acid tab 800mcg (Covered for females only)	OTC	\$0
HEMATOPOIETIC GROWTH FACTORS		
ARANESP INJ (Step Therapy requires trial of EPOGEN or PROCRIT)	KMSP-ST	4
EPOGEN INJ	KMSP	4
GRANIX INJ	KMSP	4
LEUKINE INJ	KMSP-PA	4
NEULASTA INJ	KMSP	4
NEUMEGA INJ	KMSP	4
PROCRIT INJ	KMSP	4
PROMACTA TAB	KMSP-PA	4
ZARXIO INJ	KMSP	4
MIRCERA INJ	-	NC
NEUPOGEN INJ	-	NC
HEMATOPOIETIC MIXTURES		
ferrex 150 forte cap	-	1
ferrex 150 forte cap (NIFEREX 150 FORTE equiv)	-	1
folbee tab	-	1
IRON POLYSACCH/THREONIC ACID/B12/FA CAP	-	1
multigen folic tab (CHROMAGEN FA equiv)	-	1
multigen plus tab (CHROMAGEN FORTE equiv)	-	1
multigen tab (CHROMAGEN equiv)	-	1
multivitamin tab	-	1
tricon cap (TRINSICON equiv)	-	1
NEPHRON FA TAB	-	2
CHROMAGEN FA TAB	-	3
FERREX 28 TAB	-	3
MULTIVITAMIN TAB	-	3
BIFERARX TAB	-	NC
B-SERENE PAD	-	NC
CYFOLEX CAP	-	NC
PUREFOLIX TAB	-	NC
IRON		
ferrous sulfate elixir (Covered for members 1 year or younger)	OTC	\$0
FERROUS SULFATE LIQUID (Covered for members 1 year or younger)	OTC	\$0
ferrous sulfate soln (Covered for members 1 year or younger)	OTC	\$0
FERROUS SULFATE SYRUP (Covered for members 1 year or younger)	OTC	\$0
IRON SUSP (Covered for members 1 year or younger)	OTC	\$0

HEMOSTATICS

HEMOSTATICS - SYSTEMIC		
aminocaproic acid syrup (AMICAR equiv)	-	1
aminocaproic acid tab (AMICAR equiv)	-	1
tranexamic acid tab (LYSTEDA equiv)	-	1

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	KMSP	generic =small letters	LD	BRANDS =CAPITAL LETTERS
LMSP	Infertility	M	Kroger Mandatory Specialty Pharmacy Program	MSP	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	PA	Medical Benefit	QL	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	SF	Prior Authorization	SMKG	Quantity Limit
SP	Restricted to Specialist	ST	Limited to Two 15 Day Fills per Month for the First 3 M	VAC	Smoking Cessation
	Available through Specialty Pharmacy Program		Step Therapy		Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Category/Class**

Last Updated* 11/1/2017

DrugName	Special Code	Tier
HEMOSTATICS Cont.		
AMICAR SOLN	-	2
AMICAR TAB	-	2
AMICAR SYRUP	-	3
AMINOCAPROIC ACID TAB	-	3
LYSTEDA TAB	-	3
CYKLOKAPRON INJ	M	M
tranexamic acid inj (CYKLOKAPRON equiv)	M	M
HYPNOTICS		
NON-BARBITURATE HYPNOTICS		
zolpidem tab (AMBIEN equiv) (QL= 1 tab/day)	QL	1
OREXIN RECEPTOR ANTAGONISTS		
BELSOMRA TAB	-	NC
HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS		
BARBITURATE HYPNOTICS		
phenobarbital elixir	-	1
PHENOBARBITAL TAB	-	1
SECONAL CAP	-	2
BUTISOL ELIXIR	-	3
BUTISOL TAB	-	3
HYPNOTICS - TRICYCLIC AGENTS		
SILENOR TAB	-	NC
NON-BARBITURATE HYPNOTICS		
estazolam tab (PROSOM equiv)	-	1
eszopiclone tab (LUNESTA equiv) (QL= 1 tab/day)	QL	1
FLURAZEPAM CAP	-	1
temazepam cap 15mg (RESTORIL equiv)	-	1
temazepam cap 22.5mg (RESTORIL equiv)	-	1
temazepam cap 30mg (RESTORIL equiv)	-	1
temazepam cap 7.5mg (RESTORIL equiv)	-	1
TRIAZOLAM TAB	-	1
triazolam tab (HALCION equiv)	-	1
zaleplon cap (SONATA equiv)	-	1
AMBIEN TAB (QL= 1 tab/day)	QL	3
HALCION TAB	-	3
LUNESTA TAB (QL= 1 tab/day)	QL	3
PROSOM TAB	-	3
RESTORIL CAP 15MG	-	3
RESTORIL CAP 22.5MG	-	3
RESTORIL CAP 30MG	-	3
RESTORIL CAP 7.5MG	-	3
SOMNOTE CAP	-	3
SONATA CAP	-	3
AMBIEN CR TAB	-	NC
DORAL TAB	-	NC
EDLUAR SL TAB	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	KMSP	generic =small letters	LD	BRANDS =CAPITAL LETTERS
LMSP	Infertility	M	Kroger Mandatory Specialty Pharmacy Program	MSP	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	PA	Medical Benefit	QL	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	SF	Prior Authorization	SMKG	Quantity Limit
SP	Restricted to Specialist	ST	Limited to Two 15 Day Fills per Month for the First 3 M	VAC	Smoking Cessation
	Available through Specialty Pharmacy Program		Step Therapy		Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Category/Class**

Last Updated* 11/1/2017

DrugName	Special Code	Tier
HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS Cont.		
INTERMEZZO SL TAB	-	NC
zolpidem ER tab (AMBIEN CR equiv)	-	NC
zolpidem tartrate SL tab (INTERMEZZO equiv)	-	NC
ZOLPIMIST SPRAY	-	NC
SELECTIVE MELATONIN RECEPTOR AGONISTS		
ROZEREM TAB (QL= 1 tab/day)	QL	3
HETLIOZ CAP	-	NC

LAXATIVES

LAXATIVE COMBINATIONS		
peg 3350/electrolytes soln (COLYTE equiv) (Covered at \$0 for members 50-75 years-Limited to 2 fills/calendar year; All other members covered at generic copay)	QL	\$0
trilyte soln (NULYTELY equiv) (Covered at \$0 for members 50-75 years, all other members covered at generic copay; Limited to 2 fills/calendar year)	QL	\$0
GOLYTELY PACKET	-	1
COLYTE SOLN	-	2
MOVIPREP SOLN (QL= 1 bottle/fill)	QL	2
SUPREP SOLN (Step therapy requires trial of MOVIPREP)	ST	3
gavilyte-h kit	-	NC
GOLYTELY SOLN	-	NC
HALFLYTELY BOWEL PREP KIT	-	NC
NULYTELY SOLN	-	NC
PREPOPIK PAK	-	NC
SUCLEAR KIT	-	NC

LAXATIVES - MISCELLANEOUS		
lactulose soln	-	1
KRISTALOSE PACKET	-	3
GIALAX KIT	-	NC
MIRALAX PACKET	-	NC
MIRALAX POWDER	-	NC
polyethylene glycol 3350 powder (MIRALAX equiv)	-	NC

SALINE LAXATIVES		
OSMOPREP TAB	-	3
VISICOL TAB	-	3

MACROLIDES

AZITHROMYCIN		
azithromycin susp (ZITHROMAX equiv)	-	1
azithromycin tab (ZITHROMAX equiv)	-	1
ZITHROMAX POWDER PACK	-	3
ZITHROMAX SUSP	-	3
ZITHROMAX TAB	-	3
ZMAX SUSP	-	3

CLARITHROMYCIN		
clarithromycin ER tab (BIAXIN XL equiv)	-	1
clarithromycin susp (BIAXIN equiv)	-	1
clarithromycin tab (BIAXIN equiv)	-	1

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	KMSP	generic =small letters	LD	BRANDS =CAPITAL LETTERS
LMSP	Infertility	M	Kroger Mandatory Specialty Pharmacy Program	MSP	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	PA	Medical Benefit	QL	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	SF	Prior Authorization	SMKG	Quantity Limit
SP	Restricted to Specialist	ST	Limited to Two 15 Day Fills per Month for the First 3 M	VAC	Smoking Cessation
	Available through Specialty Pharmacy Program		Step Therapy		Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Category/Class**

Last Updated* 11/1/2017

DrugName	Special Code	Tier
MACROLIDES Cont.		
CLARITHROMYCIN SUSP	-	2
BIAXIN SUSP	-	3
BIAXIN TAB	-	3
BIAXIN XL TAB	-	3
ERYTHROMYCINS		
ERY-TAB	-	1
ERYTHROMYCIN CAP	-	1
erythromycin DR cap (ERYC equiv)	-	1
erythromycin ethylsuccinate susp (ERYPED equiv)	-	1
erythromycin ethylsuccinate tab (E.E.S. equiv)	-	1
erythromycin stearate tab	-	1
ERYPED SUSP	-	2
ERYTHROMYCIN ETHYLSUCCINATE TAB	-	2
ERYPED SUSP 200MG/5ML	-	3
ERYTHROMYCIN TAB (all forms except PCE)	-	3
PCE TAB	-	3
FIDAXOMICIN		
DIFICID TAB (QL= 20 tabs/fill; Step Therapy requires trial of vancomycin cap)	QL-ST	2
MEDICAL DEVICES AND SUPPLIES		
CONTRACEPTIVES		
CERVICAL CAP	-	\$0
DIAPHRAGM	-	\$0
FEMALE CONDOMS	OTC	\$0
DIABETIC SUPPLIES		
ACCU-CHECK GUIDE CARE METER	OTC	\$0
ACCU-CHEK AVIVA PLUS METER	OTC	\$0
ACCU-CHEK NANO METER	OTC	\$0
FREESTYLE FREEDOM LITE METER	OTC	\$0
FREESTYLE INSULINX METER	OTC	\$0
FREESTYLE LITE METER	OTC	\$0
FREESTYLE PRECISION NEO METER	OTC	\$0
PRECISION XTRA METER	OTC	\$0
CALIBRATION LIQUID	OTC	1
LANCET DEVICE	OTC	1
LANCET KIT	OTC	1
LANCETS	OTC	1
V-GO INJ KIT (QL= 1 kit/day)	QL	2
DIABETIC METER (all other diabetic meters)	OTC	NC
MISC. DEVICES		
ALCOHOL SWABS	OTC	1
PARENTERAL THERAPY SUPPLIES		
B-D INSULIN SYRINGE	OTC	1
B-D PEN NEEDLE	OTC	1
FREESTYLE INSULIN SYRINGE	OTC	1
NOVOFINE PEN NEEDLE	OTC	1

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered Infertility	KMSP	generic =small letters Kroger Mandatory Specialty Pharmacy Program	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 M	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Category/Class**

Last Updated* 11/1/2017

DrugName	Special Code	Tier
MEDICAL DEVICES AND SUPPLIES Cont.		
NOVOTWIST PEN NEEDLE	OTC	1
PRECISION INSULIN SYRINGE	OTC	1
INSULIN SYRINGE	OTC	3
PEN NEEDLE	OTC	3
RESPIRATORY THERAPY SUPPLIES		
PEAK FLOW METER	OTC	1
AEROCHAMBER	OTC	2
AEROCHAMBER SUPPLIES	-	2
MIGRAINE PRODUCTS		
MIGRAINE COMBINATIONS		
ergotamine tartrate/caffeine tab (CAFERGOT equiv)	-	1
MIGERGOT SUPP	-	2
acetaminophen/isometheptene/dichloral cap (MIDRIN equiv)	-	NC
isometheptene/caffeine/acetaminophen tab (PRODRIN equiv)	-	NC
MIDRIN CAP	-	NC
PRODRIN TAB	-	NC
TREXIMET TAB	-	NC
MIGRAINE PRODUCTS		
dihydroergotamine mesylate inj (D.H.E. equiv)	-	1
D.H.E. INJ	-	3
DIHYDROERGOTAMINE SPRAY, MIGRANAL SPRAY (QL= 8 sprays/fill, 2 fills/30 days)	QL	3
ERGOMAR SL TAB	-	3
MIGRAINE PRODUCTS - NSAIDS		
CAMBIA POWDER PACKET	-	NC
SEROTONIN AGONISTS		
almotriptan tab (AXERT equiv) (QL= 9 tabs/fill, 2 fills/30 days)	QL	1
frovatriptan tab (FROVA equiv) (QL= 9 tabs/fill, 2 fills/30 days)	QL	1
naratriptan tab (AMERGE equiv) (QL= 9 tabs/fill, 2 fills/30 days)	QL	1
rizatriptan ODT (MAXALT equiv) (QL= 12 tabs/fill, 3 fills/60 days)	QL	1
rizatriptan tab (MAXALT equiv) (QL= 12 tabs/fill, 3 fills/60 days)	QL	1
sumatriptan inj (IMITREX equiv) (QL= 4 inj/fill, 2 fills/30 days)	QL	1
sumatriptan nasal spray (IMITREX, SUMATRIPTAN equiv) (QL= 6 sprays/fill, 2 fills/30 days)	QL	1
sumatriptan tab (IMITREX equiv) (QL= 9 tabs/fill, 2 fills/30 days)	QL	1
sumatriptan vial inj (IMITREX equiv) (QL= 5 inj/fill, 2 fills/30 days)	QL	1
zolmitriptan ODT (ZOMIG equiv) (QL= 9 tabs/fill, 2 fills/30 days)	QL	1
zolmitriptan tab (ZOMIG equiv) (QL= 9 tabs/fill, 2 fills/30 days)	QL	1
SUMATRIPTAN INJ 6MG/0.5ML (QL= 4 inj/fill, 2 fills/30 days)	QL	2
AMERGE TAB (QL= 9 tabs/fill, 2 fills/30 days)	QL	3
AXERT TAB (QL= 9 tabs/fill, 2 fills/30 days)	QL	3
FROVA TAB (QL= 9 tabs/fill, 2 fills/30 days)	QL	3
IMITREX INJ (QL= 4 inj/fill, 2 fills/30 days)	QL	3
IMITREX TAB (QL= 9 tabs/fill, 2 fills/30 days)	QL	3
IMITREX VIAL INJ (QL= 5 inj/fill, 2 fills/30 days)	QL	3
MAXALT MLT TAB (QL= 12 tabs/fill, 3 fills/60 days)	QL	3
MAXALT TAB (QL= 12 tabs/fill, 3 fills/60 days)	QL	3
ZOMIG NASAL SPRAY (QL= 6 sprays/fill, 2 fills/30 days)	QL	3

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	KMSP	generic =small letters	LD	BRANDS =CAPITAL LETTERS
LMSP	Infertility	M	Kroger Mandatory Specialty Pharmacy Program	MSP	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	PA	Medical Benefit	QL	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	SF	Prior Authorization	SMKG	Quantity Limit
SP	Restricted to Specialist	ST	Limited to Two 15 Day Fills per Month for the First 3 M	VAC	Smoking Cessation
	Available through Specialty Pharmacy Program		Step Therapy		Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Category/Class**

Last Updated* 11/1/2017

DrugName	Special Code	Tier
MIGRAINE PRODUCTS Cont.		
ZOMIG TAB (QL= 9 tabs/fill, 2 fills/30 days)	QL	3
ZOMIG ZMT (QL= 9 tabs/fill, 2 fills/30 days)	QL	3
ALSUMA INJ, ZEMBRACE SYMTOUCH INJ	-	NC
ONZETRA XSAIL	-	NC
SUMAVEL DOSEPRO INJ	-	NC
ZECUITY PAD	-	NC
MINERALS & ELECTROLYTES		
CHLORIDE		
AMMONIUM CHLORIDE INJ	M	M
FLUORIDE		
FLUORABON SOLN (Covered at \$0 for members 5 years or younger; All other members covered at preferred brand copay)	-	\$0
LURIDE SOLN (Covered at \$0 for members 5 years or younger; All other members covered at non-preferred brand copay)	-	\$0
LURIDE TAB (Covered at \$0 for members 5 years or younger; All other members covered at non-preferred brand copay)	-	\$0
SODIUM FLUORIDE LOZENGE (Covered at \$0 for members 5 years or younger; All other members covered at generic copay)	-	\$0
sodium fluoride soln (LURIDE equiv) (Covered at \$0 for members 5 years or younger; All other members covered at generic copay)	-	\$0
SODIUM FLUORIDE TAB (Covered at \$0 for members 5 years or younger; All other members covered at generic copay)	-	\$0
sodium fluoride tab (LURIDE equiv) (Covered at \$0 for members 5 years or younger; All other members covered at generic copay)	-	\$0
FLUOR-A-DAY CHEW TAB	-	1
IODINE PRODUCTS		
SSKI SOLN	-	2
MAGNESIUM		
magnesium sulfate inj	M	M
PHOSPHATE		
phospha 250 neutral tab (K-PHOS NEUTRAL equiv)	-	1
K-PHOS TAB	-	2
K-PHOS NEUTRAL TAB	-	3
POTASSIUM		
potassium bicarbonate effer tab (K-LYTE equiv)	-	1
potassium chloride effer tab (K-LYTE/CL equiv)	-	1
potassium chloride ER cap (MICRO-K equiv)	-	1
POTASSIUM CHLORIDE ER TAB	-	1
potassium chloride ER tab (KLOR-CON equiv)	-	1
potassium chloride micro tab (K-DUR equiv)	-	1
potassium chloride powder packet (KLOR-CON equiv)	-	1
POTASSIUM CHLORIDE SOLN	-	1
KLOR-CON M15 TAB	-	2
KLOR-CON POWDER PACKET	-	3
KLOR-CON POWDER PACKET 25MEQ	-	3
KLOR-CON TAB	-	3
MICRO-K CAP	-	3
SODIUM		

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	KMSP	generic =small letters	LD	BRANDS =CAPITAL LETTERS
LMSP	Infertility	M	Kroger Mandatory Specialty Pharmacy Program	MSP	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	PA	Medical Benefit	QL	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	SF	Prior Authorization	SMKG	Quantity Limit
SP	Restricted to Specialist	ST	Limited to Two 15 Day Fills per Month for the First 3 M	VAC	Smoking Cessation
	Available through Specialty Pharmacy Program		Step Therapy		Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Category/Class**

Last Updated* 11/1/2017

DrugName	Special Code	Tier
MINERALS & ELECTROLYTES Cont.		
sodium chloride inj	M	M
ZINC		
zinc sulfate cap	-	1
GALZIN CAP	-	2
MISCELLANEOUS THERAPEUTIC CLASSES		
SYSTEMIC LUPUS ERYTHEMATOSUS AGENTS		
BENLYSTA AUTO-INJECTOR	-	NC
BENLYSTA INJ	-	NC
MOUTH/THROAT/DENTAL AGENTS		
ANESTHETICS TOPICAL ORAL		
lidocaine viscous soln	-	1
LIDOCAINE ORAL SOLN 4%	-	2
FIRST MOUTHWASH BLM	-	3
LTA 360 KIT	-	3
ANTIALLERGY AGENTS - MOUTH/THROAT		
APHTHASOL PASTE	-	2
ANTI-INFECTIVES - THROAT		
clotrimazole troches (MYCELEX TROCHES equiv)	-	1
nystatin susp	-	1
FIRST DUKES MOUTHWASH	-	3
FIRST MARYS MOUTHWASH	-	3
MYCELEX TROCHES	-	3
ORAVIG TAB	-	3
ANTISEPTICS - MOUTH/THROAT		
chlorhexidine gluconate soln (PERIDEX equiv)	-	1
PERIDEX SOLN	-	3
DEBACTEROL SOLN	-	NC
DENTAL PRODUCTS		
PREVIDENT 5000 PLUS CREAM (Covered at \$0 for members 5 years or younger; All other members covered at preferred brand copay)	-	\$0
sodium fluoride cream (PREVIDENT equiv) (Covered at \$0 for members 5 years or younger; All other members covered at generic copay)	-	\$0
sodium fluoride gel (PREVIDENT equiv)	-	1
sodium fluoride paste (PREVIDENT equiv)	-	1
sodium fluoride rinse (PREVIDENT equiv)	-	1
sodium fluoride/potassium nitrate paste (PREVIDENT equiv)	-	1
PREVIDENT GEL	-	2
PREVIDENT PASTE	-	2
PREVIDENT RINSE	-	2
STEROIDS - MOUTH/THROAT		
triamcinolone in orabase paste (KENALOG/ORABASE equiv)	-	1
THROAT PRODUCTS - MISC.		
cevimeline cap (EVOXAC equiv)	-	1
pilocarpine tab (SALAGEN equiv)	-	1
EVOXAC CAP	-	3

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	KMSP	generic =small letters	LD	BRANDS =CAPITAL LETTERS
LMSP	Infertility	M	Kroger Mandatory Specialty Pharmacy Program	MSP	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	PA	Medical Benefit	QL	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	SF	Prior Authorization	SMKG	Quantity Limit
SP	Restricted to Specialist	ST	Limited to Two 15 Day Fills per Month for the First 3 M	VAC	Smoking Cessation
	Available through Specialty Pharmacy Program		Step Therapy		Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Category/Class**

Last Updated* 11/1/2017

DrugName	Special Code	Tier
MOUTH/THROAT/DENTAL AGENTS Cont.		
SALAGEN TAB	-	3
GELCLAIR GEL	-	NC
PROTHELIAL PASTE	-	NC
MULTIVITAMINS		
B-COMPLEX W/ FOLIC ACID		
DIALYVITE TAB	-	1
dialyvite tab (NEPHRO-VITE equiv)	-	1
DIALYVITE/ZINC TAB	-	1
FOLBEE PLUS CZ TAB	-	1
renaphro cap (NEPHROCAP equiv)	-	1
DIATZ ZN TAB	-	3
NEPHROCAP	-	3
NEPHRO-VITE TAB	-	3
MULTIPLE VITAMINS & FLUORIDE-FOLIC ACID		
MULTIVITAMIN/FLUORIDE CHEW TAB	-	NC
MULTIPLE VITAMINS W/ MINERALS		
multivitamin/minerals tab (STROVITE equiv)	-	1
STROVITE TAB	-	3
V-C FORTE CAP	-	3
PED MULTI VITAMINS W/FL & FE		
pediatric multiple vitamins/fluoride/iron soln	-	1
ESCAVITE CHEW TAB	-	3
PED MV W/ FLUORIDE		
pediatric multiple vitamins/fluoride chew tab	-	1
pediatric multiple vitamins/fluoride soln	-	1
FLORIVA PLUS DROPS	-	2
QUFLORA PEDIATRIC CHEW TAB	-	3
PEDIATRIC MULTIPLE VITAMINS & MINERALS W/ FLUORIDE		
FLORIVA CHEW TAB	-	NC
PRENATAL VITAMINS		
PRENATAL VITAMINS (NON-PREFERRED)	-	3
MUSCULOSKELETAL THERAPY AGENTS		
CENTRAL MUSCLE RELAXANTS		
baclofen tab	-	1
carisoprodol tab (SOMA equiv)	-	1
chlorzoxazone tab (PARAFON FORTE equiv)	-	1
cyclobenzaprine tab 10mg (FLEXERIL equiv)	-	1
cyclobenzaprine tab 5mg (FLEXERIL equiv)	-	1
cyclobenzaprine tab 7.5mg (FEXMID equiv)	-	1
metaxalone tab (SKELAXIN equiv)	-	1
methocarbamol tab (ROBAXIN equiv)	-	1
orphenadrine citrate ER tab (NORFLEX equiv)	-	1
tizanidine cap (ZANAFLEX equiv)	-	1
tizanidine tab (ZANAFLEX equiv)	-	1
FEXMID TAB	-	3
Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.		
INF Infertility LMSP Lumicera Mandatory Specialty Pharmacy Program OTC Over-the-Counter RS Restricted to Specialist SP Available through Specialty Pharmacy Program	KMSP Kroger Mandatory Specialty Pharmacy Program M Medical Benefit PA Prior Authorization SF Limited to Two 15 Day Fills per Month for the First 3 M ST Step Therapy	LD Limited Distribution MSP Mandatory Specialty Pharmacy Program QL Quantity Limit SMKG Smoking Cessation VAC Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Category/Class**

Last Updated* 11/1/2017

DrugName	Special Code	Tier
MUSCULOSKELETAL THERAPY AGENTS Cont.		
FLEXERIL TAB	-	3
METAXALONE TAB 400MG	-	3
PARAFON FORTE TAB	-	3
ROBAXIN TAB	-	3
SKELAXIN TAB	-	3
SOMA TAB	-	3
ZANAFLEX CAP	-	3
ZANAFLEX TAB	-	3
carisoprodol tab 250mg (SOMA equiv)	-	NC
CYCLOBENZAPRINE COMPOUND KIT	-	NC
FIRST BACLOFEN SUSP KIT	-	NC
LORZONE TAB	-	NC
SOMA TAB 250MG	-	NC
DIRECT MUSCLE RELAXANTS		
dantrolene cap (DANTRIUM equiv)	-	1
DANTRIUM CAP	-	3
MUSCLE RELAXANT COMBINATIONS		
orphenadrine/aspirin/caffeine tab (NORGESIC FORTE equiv)	-	1
ORPHENADRINE/ASPIRIN/CAFFEINE TAB	-	3
carisoprodol/aspirin tab (SOMA COMPOUND equiv)	-	NC
carisoprodol/aspirin/codeine tab (SOMA COMPOUND/CODEINE equiv)	-	NC
LORVATUS PHARMAPAK KIT	-	NC
TIZANIDINE COMFORT KIT	-	NC
NASAL AGENTS - SYSTEMIC AND TOPICAL		
NASAL AGENT COMBINATIONS		
DYMISTA NASAL SPRAY	PA	3
AZENASE PAK	-	NC
NASAL AGENTS - MISC.		
ALZAIR NASAL SPRAY	-	NC
TICANASE PAK	-	NC
NASAL ANTIALLERGY		
azelastine nasal spray (ASTELIN, ASTEPRO equiv)	-	1
olopatadine nasal spray (PATANASE equiv)	-	1
ASTELIN NASAL SPRAY, ASTEPRO NASAL SPRAY	-	3
PATANASE NASAL SPRAY	-	3
NASAL ANTICHOLINERGICS		
ipratropium nasal spray (ATROVENT equiv)	-	1
ATROVENT NASAL SPRAY	-	3
NASAL ANTI-INFECTIVES		
BACTROBAN NASAL OINT	-	3
NASAL STEROIDS		
budesonide nasal spray (RHINOCORT AQUA equiv) (QL= 2 bottles/fill; Step Therapy requires trial of 2: flunisolide, fluticasone, triamcinolone or NASONEX)	QL-ST	1
FLUNISOLIDE NASAL SPRAY (QL= 2 bottles/fill)	QL	1
fluticasone nasal spray (FLONASE equiv) (QL= 2 bottles/fill)	QL	1

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	KMSP	generic =small letters	LD	BRANDS =CAPITAL LETTERS
LMSP	Infertility	M	Kroger Mandatory Specialty Pharmacy Program	LD	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	PA	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	SF	Prior Authorization	QL	Quantity Limit
SP	Restricted to Specialist	ST	Limited to Two 15 Day Fills per Month for the First 3 M	SMKG	Smoking Cessation
	Available through Specialty Pharmacy Program		Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Category/Class**

Last Updated* 11/1/2017

DrugName	Special Code	Tier
NASAL AGENTS - SYSTEMIC AND TOPICAL Cont.		
NASACORT OTC NASAL SPRAY (QL= 2 bottles/fill)	OTC-QL	1
NASONEX NASAL SPRAY (QL= 2 bottles/fill)	QL	1
triamcinolone nasal spray (NASACORT equiv) (QL= 2 bottles/fill)	QL	1
triamcinolone OTC nasal spray (NASACORT equiv) (QL= 2 bottles/fill)	OTC-QL	1
BECONASE AQ NASAL SPRAY (QL= 2 bottles/fill; Step Therapy requires trial of 2: flunisolide, fluticasone, triamcinolone or NASONEX)	QL-ST	3
NASACORT AQ NASAL SPRAY (QL= 2 bottles/fill)	QL	3
OMNARIS NASAL SPRAY (QL= 2 bottles/fill; Step Therapy requires trial of 2: flunisolide, fluticasone, triamcinolone or NASONEX)	QL-ST	3
QNASL NASAL SPRAY (QL= 2 bottles/fill; Step Therapy requires trial of 2: flunisolide, fluticasone, triamcinolone or NASONEX)	QL-ST	3
RHINOCORT AQUA NASAL SPRAY (QL= 2 bottles/fill; Step Therapy requires trial of 2: flunisolide, fluticasone, triamcinolone or NASONEX)	QL-ST	3
VERAMYST NASAL SPRAY (QL= 2 bottles/fill; Step Therapy requires trial of 2: flunisolide, fluticasone, triamcinolone or NASONEX)	QL-ST	3
ZETONNA NASAL SPRAY (QL= 2 bottles/fill; Step Therapy requires trial of 2: flunisolide, fluticasone, triamcinolone or NASONEX)	QL-ST	3
mometasone nasal spray (NASONEX equiv)	-	NC
XHANCE NASAL EXHALER	-	NC
SYMPATHOMIMETIC DECONGESTANTS		
TYZINE NASAL SOLN	-	3

NEUROMUSCULAR AGENTS

ALS AGENTS

riluzole tab (RILUTEK equiv)	-	1
RILUTEK TAB	-	NC

OPHTHALMIC AGENTS

ARTIFICIAL TEARS AND LUBRICANTS

LACRISERT OPHTH INSERT	-	2
------------------------	---	---

BETA-BLOCKERS - OPHTHALMIC

betaxolol ophth soln (BETOPTIC-S equiv)	-	1
carteolol ophth soln (OCUPRESS equiv)	-	1
dorzolamide/timolol ophth soln (COSOPT equiv)	-	1
levobunolol ophth soln (BETAGAN equiv)	-	1
timolol maleate ophth gel (TIMOPTIC-XE equiv)	-	1
timolol maleate ophth soln (TIMOPTIC equiv)	-	1
BETIMOL OPHTH SOLN	-	2
BETOPTIC-S OPHTH SOLN	-	2
COMBIGAN OPHTH SOLN	-	2
COSOPT PF OPHTH SOLN	-	2
ISTALOL OPHTH SOLN	-	2
METIPRANOLOL OPHTH SOLN	-	2
BETAGAN OPHTH SOLN	-	3
COSOPT OPHTH SOLN	-	3
TIMOPTIC OCUDOSE OPHTH SOLN	-	3
TIMOPTIC OPHTH SOLN	-	3
TIMOPTIC-XE OPHTH GEL	-	3

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	KMSP	generic =small letters	LD	BRANDS =CAPITAL LETTERS
LMSP	Infertility	M	Kroger Mandatory Specialty Pharmacy Program	MSP	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	PA	Medical Benefit	QL	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	SF	Prior Authorization	SMKG	Quantity Limit
SP	Restricted to Specialist	ST	Limited to Two 15 Day Fills per Month for the First 3 M	VAC	Smoking Cessation
	Available through Specialty Pharmacy Program		Step Therapy		Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Category/Class**

Last Updated* 11/1/2017

DrugName	Special Code	Tier
OPHTHALMIC AGENTS Cont.		
CYCLOPLEGIC MYDRIATICS		
atropine ophth oint	-	1
atropine ophth soln (ISOPTO ATROPINE equiv)	-	1
cyclopentolate ophth soln (CYCLOGYL equiv)	-	1
homatropine ophth soln (ISOPTO HOMATROPINE equiv)	-	1
tropicamide ophth soln (MYDRIACYL equiv)	-	1
CYCLOMYDRIL OPHTH SOLN	-	2
ISOPTO HOMATROPINE OPHTH SOLN 2%	-	2
ISOPTO HOMATROPINE OPHTH SOLN 5%	-	2
ISOPTO HYOSCINE OPHTH SOLN	-	2
CYCLOGYL OPHTH SOLN	-	3
ISOPTO ATROPINE OPHTH SOLN	-	3
MYDRIACYL OPHTH SOLN	-	3
MIOTICS		
pilocarpine ophth soln (ISOPTO CARPINE equiv)	-	1
ISOPTO CARBACHOL OPHTH SOLN	-	2
PHOSPHOLINE OPHTH SOLN	-	2
ISOPTO CARPINE OPHTH SOLN	-	3
PILOPINE HS OPHTH GEL	-	3
OPHTHALMIC ADRENERGIC AGENTS		
apraclonidine ophth soln (IOPIDINE equiv)	-	1
brimonidine ophth soln (ALPHAGAN P equiv)	-	1
ALPHAGAN P OPHTH SOLN	-	2
ALPHAGAN P OPHTH SOLN 0.1%	-	2
IOPIDINE OPHTH SOLN 1%	-	2
SIMBRINZA OPHTH SUSP	-	2
IOPIDINE OPHTH SOLN	-	3
OPHTHALMIC ANTI-INFECTIVES		
bacitracin/neomycin/polymyxin b ophth oint (NEOSPORIN equiv)	-	1
bacitracin/polymyxin b ophth oint (POLYSPORIN equiv)	-	1
ciprofloxacin ophth soln (CILOXAN equiv)	-	1
erythromycin ophth oint	-	1
gatifloxacin ophth soln (ZYMAGID equiv) (Step Therapy requires trial of ciprofloxacin, levofloxacin, ofloxacin or VIGAMOX/MOXEZA)	ST	1
GENTAK OPHTH OINT	-	1
gentamicin ophth oint (GARAMYCIN equiv)	-	1
gentamicin ophth soln (GARAMYCIN equiv)	-	1
levofloxacin ophth soln (QUIXIN equiv)	-	1
moxifloxacin ophth soln (VIGAMOX OPHTH SOLN equiv)	-	1
neomycin/polymyxin b/gramicidin ophth soln (NEOSPORIN equiv)	-	1
ofloxacin ophth soln (OCUFLOX equiv)	-	1
polymyxin b/trimethoprim ophth soln (POLYTRIM equiv)	-	1
sulfacetamide sodium ophth soln (BLEPH-10 equiv)	-	1
tobramycin ophth soln (TOBREX equiv)	-	1
trifluridine ophth soln (VIROPTIC equiv)	-	1
AZASITE SOLN	-	2

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered Infertility	KMSP	generic =small letters Kroger Mandatory Specialty Pharmacy Program	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 M	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Category/Class**

Last Updated* 11/1/2017

DrugName	Special Code	Tier
OPHTHALMIC AGENTS Cont.		
BACITRACIN OPHTH OINT	-	2
MOXEZA OPHTH SOLN	-	2
ZIRGAN OPHTH GEL	-	2
BESIVANCE OPHTH SUSP (Step Therapy requires trial of ciprofloxacin, levofloxacin, ofloxacin or VIGAMOX/MOXEZA)	ST	3
BLEPH-10 OPHTH SOLN	-	3
CILOXAN OPHTH OINT	-	3
CILOXAN OPHTH SOLN	-	3
NEOSPORIN OPHTH SOLN	-	3
OCUFLOX OPHTH SOLN	-	3
POLYTRIM OPHTH SOLN	-	3
TOBEX OPHTH OINT	-	3
TOBEX OPHTH SOLN	-	3
VIGAMOX OPHTH SOLN	-	3
VIROPTIC OPHTH SOLN	-	3
ZYMAXID OPHTH SOLN (Step Therapy requires trial of ciprofloxacin, levofloxacin, ofloxacin or VIGAMOX/MOXEZA)	ST	3
NATACYN OPHTH SUSP	-	NC
OPHTHALMIC DECONGESTANTS		
naphazoline ophth soln	-	1
phenylephrine ophth soln (MYDFRIN equiv)	-	1
MYDFRIN OPHTH SOLN	-	3
OPHTHALMIC IMMUNOMODULATORS		
RESTASIS OPHTH EMULSION (Restricted to Ophthalmology or Optometry Specialist)	RS	2
OPHTHALMIC INTEGRIN ANTAGONISTS		
XIIDRA OPHTH SOLN	-	NC
OPHTHALMIC LOCAL ANESTHETICS		
proparacaine ophth soln (ALCAINE equiv)	-	1
ALCAINE OPHTH SOLN	-	3
OPHTHALMIC PHOTOENHANCERS		
PHOTREXA OP KIT	-	NC
PHOTREXA VISCOUS OPHTH SOLN	-	NC
OPHTHALMIC STEROIDS		
bacitracin/polymyxin/neomycin/hydrocortisone ophth oint (CORTISPORIN equiv)	-	1
dexamethasone ophth soln	-	1
fluorometholone ophth soln (FML LIQUIFILM equiv)	-	1
neomycin/polymyxin/dexamethasone ophth oint (MAXITROL equiv)	-	1
neomycin/polymyxin/dexamethasone ophth soln (MAXITROL equiv)	-	1
neomycin/polymyxin/hydrocortisone ophth soln (CORTISPORIN equiv)	-	1
prednisolone ophth soln (PRED FORTE equiv)	-	1
sulfacetamide sodium/prednisolone ophth soln (VASOCIDIN equiv)	-	1
tobramycin/dexamethasone ophth soln (TOBRADEX equiv)	-	1
ALREX OPHTH SUSP, LOTEMAX OPHTH SUSP	-	2
BLEPHAMIDE OPHTH SOLN	-	2
DUREZOL OPHTH EMULSION	-	2
LOTEMAX OPHTH GEL	-	2
LOTEMAX OPHTH OINT	-	2
MAXIDEX OPHTH SOLN	-	2

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	KMSP	generic =small letters	LD	BRANDS =CAPITAL LETTERS
LMSP	Infertility	M	Kroger Mandatory Specialty Pharmacy Program	LD	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	PA	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	SF	Prior Authorization	QL	Quantity Limit
SP	Restricted to Specialist	ST	Limited to Two 15 Day Fills per Month for the First 3 M	SMKG	Smoking Cessation
	Available through Specialty Pharmacy Program		Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Category/Class**

Last Updated* 11/1/2017

DrugName	Special Code	Tier
OPHTHALMIC AGENTS Cont.		
PRED MILD OPHTH SOLN	-	2
PRED-G OPHTH SOLN	-	2
PREDNISOLONE SODIUM PHOSPHATE OPHTH SOLN	-	2
TOBRADEX OPHTH OINT	-	2
VEXOL OPHTH SUSP	-	2
ZYLET OPHTH SUSP (QL= 5ml/fill (10ml bottle is Not Covered))	QL	2
BLEPHAMIDE S.O.P. OPHTH OINT	-	3
CORTISPORIN OPHTH SOLN	-	3
FLAREX OPHTH SUSP	-	3
FML FORTE OPHTH SUSP	-	3
FML LIQUIFLIM OPHTH SUSP	-	3
FML S.O.P. OPHTH OINT	-	3
MAXITROL OPHTH OINT	-	3
MAXITROL OPHTH SUSP	-	3
PRED FORTE OPHTH SUSP	-	3
TOBRADEX OPHTH SOLN	-	3
TOBRADEX ST OPHTH SUSP	-	3
PREDNISOLONE/MOXIFLOXACIN OPHTH SOLN	-	NC
PREDNISOLONE/MOXIFLOXACIN/BROMFENAC OPHTH SOLN	-	NC
PREDNISOLONE/MOXIFLOXACIN/KETOROLAC OPHTH SOLN	-	NC
OPHTHALMICS - MISC.		
azelastine ophth soln (OPTIVAR equiv)	-	1
bromfenac ophth soln (BROMDAY equiv)	-	1
BROMFENAC OPHTH SOLN 0.09% (ONCE DAILY)	-	1
BROMFENAC OPHTH SOLN 0.09% (TWICE DAILY)	-	1
cromolyn ophth soln (CROLOM equiv)	-	1
diclofenac sodium ophth soln (VOLTAREN equiv)	-	1
dorzolamide ophth soln (TRUSOPT equiv)	-	1
epinastine ophth soln (ELESTAT equiv)	-	1
FLURBIPROFEN OPHTH SOLN	-	1
flurbiprofen ophth soln (OCUFEN equiv)	-	1
ketorolac ophth soln (ACULAR (LS) equiv)	-	1
ketotifen ophth soln (ZADITOR equiv) (OTC covered only)	OTC	1
olopatadine ophth soln (PATANOL equiv)	-	1
PATADAY OPHTH SOLN (QL= 2.5ml/30 days)	QL	1
ALAMAST OPHTH SOLN	-	2
ALOCRIAL OPHTH SOLN	-	2
ALOMIDE OPHTH SOLN	-	2
AZOPT OPHTH SUSP	-	2
ILEVRO OPHTH SUSP	-	2
NEVANAC OPHTH SUSP	-	2
PROLENSA OPHTH SOLN	-	2
ACULAR (LS) OPHTH SOLN	-	3
ACUVAIL OPHTH SOLN	-	3
BEPREVE OPHTH SOLN	-	3
CROLOM OPHTH SOLN	-	3
ELESTAT OPHTH SOLN	-	3
Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.		

INF	NC =Not Covered Infertility	KMSP	generic =small letters Kroger Mandatory Specialty Pharmacy Program	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 M	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Category/Class**

Last Updated* 11/1/2017

DrugName	Special Code	Tier
OPHTHALMIC AGENTS Cont.		
EMADINE OPHTH SOLN	-	3
LASTACFT OPHTH SOLN (QL= 3ml/30 days)	QL	3
OCUFEN OPHTH SOLN	-	3
OPTIVAR OPHTH SOLN	-	3
PATANOL OPHTH SOLN	-	3
TRUSOPT OPHTH SOLN	-	3
VOLTAREN OPTH SOLN	-	3
CYSTARAN OPHTH SOLN (QL= 4 bottles/30 days; Only available through Walgreens 888-347-3416)	LD-PA-QL	4
BROMSITE OPHTH SOLN	-	NC
olopatadine ophth soln 0.2% (PATADAY equiv)	-	NC
PAZEO OPHTH SOLN 0.7%	-	NC
ZADITOR OPHTH SOLN	OTC	NC
PROSTAGLANDINS - OPHTHALMIC		
latanoprost ophth soln (XALATAN equiv) (QL= 2.5ml/30 days)	QL	1
BIMATOPROST OPHTH SOLN, LUMIGAN OPHTH SOLN (QL= 2.5ml/30 days)	QL	2
TRAVATAN Z OPHTH SOLN (QL= 5ml/30 days)	QL	2
XALATAN OPHTH SOLN (QL= 2.5ml/30 days)	QL	3
ZIOPTAN OPHTH SOLN (QL= 1 bottle/day; Step Therapy requires trial of latanoprost)	QL-ST	3
OTIC AGENTS		
OTIC AGENTS - MISCELLANEOUS		
acetic acid otic soln (VOSOL equiv)	-	1
ACETIC ACID/ALUMINUM ACETATE OTIC SOLN	-	1
CRESYLATE OTIC SOLN	-	3
VOSOL OTIC SOLN	-	3
OTIC ANALGESICS		
omedia otic soln (AMERICAINE equiv)	-	1
OTIC ANTI-INFECTIVES		
ofloxacin otic soln (FLOXIN equiv)	-	1
CIPROFLOXACIN OTIC SOLN	-	2
OTIC COMBINATIONS		
neomycin/polymixin/hydrocortisone otic soln (CORTISPORIN equiv)	-	1
neomycin/polymixin/hydrocortisone otic susp (CORTISPORIN equiv)	-	1
pramoxine-HC AQ otic soln (CORTANE-B AQUEOUS equiv)	-	1
CIPRODEX OTIC SUSP	-	2
COLY-MYCIN S OTIC SUSP	-	2
CIPRO HC OTIC SUSP	-	3
CORTANE-B AQUEOUS OTIC SOLN	-	3
CORTISPORIN OTIC SOLN	-	3
OTOZIN OTIC DROPS	-	3
antipyrine/benzocaine otic soln (AURALGAN equiv)	-	NC
CORTANE-B OTIC SOLN	-	NC
otomax-HC otic soln (CORTANE-B equiv)	-	NC
OTOVEL OTIC SOLN	-	NC
OTIC STEROIDS		
acetic acid/hydrocortisone otic soln (VOSOL HC equiv)	-	1

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered Infertility	KMSP	generic =small letters Kroger Mandatory Specialty Pharmacy Program	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 M	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Category/Class**

Last Updated* 11/1/2017

DrugName	Special Code	Tier
OTIC AGENTS Cont.		
fluocinolone otic oil (DERMOTIC equiv)	-	1
ACETASOL HC OTIC SOLN	-	3
DERMOTIC OIL	-	3
VOSOL HC OTIC SOLN	-	3
OXYTOCICS		
OXYTOCICS		
METHERGINE TAB (QL= 28 tabs/fill, 1 fill/365 days)	QL	1
methylegonovine tab (METHERGINE equiv) (QL= 28 tabs/fill, 1 fill/365 days)	QL	1
METHERGINE TAB (QL= 28 tabs/fill, 1 fill/365 days)	QL	2
PASSIVE IMMUNIZING AGENTS		
IMMUNE SERUMS		
HIZENTRA INJ	KMSP	3
GAMASTAN INJ	M	M
GAMMAGARD INJ	M	M
PENICILLINS		
AMINOPENICILLINS		
amoxicillin cap (TRIMOX equiv)	-	1
amoxicillin chew tab (AMOXIL equiv)	-	1
AMOXICILLIN CHEW TAB 250MG	-	1
amoxicillin susp (TRIMOX equiv)	-	1
amoxicillin tab (AMOXIL equiv)	-	1
AMPICILLIN CAP	-	1
ampicillin cap (PRINCIPEN equiv)	-	1
ampicillin susp (PRINCIPEN equiv)	-	1
MOXATAG TAB	-	NC
MOXATAG TAB 775MG	-	NC
NATURAL PENICILLINS		
PENICILLIN VK SOLN	-	1
penicillin vk soln (VEETIDS equiv)	-	1
penicillin vk tab (VEETIDS equiv)	-	1
PENICILLIN G PROCAINE INJ	M	M
PENICILLIN G SODIUM INJ	M	M
PFIZERPEN G INJ	M	M
pfizerpen g inj (PFIZERPEN G equiv)	M	M
PENICILLIN COMBINATIONS		
amoxicillin/clavulanate chew tab (AUGMENTIN equiv)	-	1
amoxicillin/clavulanate ER tab (AUGMENTIN XR equiv)	-	1
amoxicillin/clavulanate susp (AUGMENTIN ES equiv)	-	1
amoxicillin/clavulanate tab (AUGMENTIN equiv)	-	1
AUGMENTIN ES-600 SUSP	-	3
AUGMENTIN SUSP	-	3
AUGMENTIN TAB	-	3
AUGMENTIN XR TAB	-	3
ampicillin/sulbactam inj	M	M
piperacillin/tazobactam inj	M	M

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	KMSP	generic =small letters	LD	BRANDS =CAPITAL LETTERS
LMSP	Infertility	M	Kroger Mandatory Specialty Pharmacy Program	LD	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	PA	Prior Authorization	QL	Quantity Limit
SP	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 M	SMKG	Smoking Cessation
	Available through Specialty Pharmacy Program	ST	Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Category/Class**

Last Updated* 11/1/2017

DrugName	Special Code	Tier																														
PENICILLINS Cont.																																
TIMENTIN INJ	M	M																														
PENICILLINASE-RESISTANT PENICILLINS																																
dicloxacillin cap (DYNAPEN equiv)	-	1																														
nafcillin inj	M	M																														
oxacillin inj	M	M																														
PHARMACEUTICAL ADJUVANTS																																
SEMI SOLID VEHICLES																																
POLYETHYLENE GLYCOL 8000 GRANULES	-	2																														
PROGESTINS																																
PROGESTINS																																
medroxyprogesterone tab (PROVERA equiv)	-	1																														
megestrol ES susp (MEGACE ES equiv)	-	1																														
norethindrone tab (AYGESTIN equiv)	-	1																														
progesterone cap (PROMETRIUM equiv)	-	1																														
AYGESTIN TAB	-	3																														
MEGACE ES SUSP	-	3																														
PROMETRIUM CAP	-	3																														
PROVERA TAB	-	3																														
progesterone oil inj	-	NC																														
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.																																
AGENTS FOR CHEMICAL DEPENDENCY																																
acamprosate calcium DR tab (CAMPRAL equiv)	-	1																														
disulfiram tab (ANTABUSE equiv)	-	1																														
ANTABUSE TAB	-	2																														
CAMPRAL TAB	-	3																														
ANTI-CATAPLECTIC AGENTS																																
XYREM SOLN (QL= 540ml/30 days; Only available through Xyrem Central Pharmacy 866-997-3688)	LD-PA-QL	4																														
ANTIDEMENTIA AGENTS																																
donepezil ODT (ARICEPT equiv) (QL= 1 tab/day)	QL	1																														
donepezil tab (ARICEPT equiv) (QL= 2 tabs/day)	QL	1																														
donepezil tab 23mg (ARICEPT equiv) (QL= 1 tab/day; Step Therapy requires trial of donepezil 10mg)	QL-ST	1																														
galantamine ER cap (RAZADYNE ER equiv)	-	1																														
GALANTAMINE SOLN	-	1																														
galantamine tab (RAZADYNE equiv)	-	1																														
memantine sol (NAMENDA equiv)	-	1																														
memantine tab (NAMENDA equiv)	-	1																														
rivastigmine cap (EXELON equiv)	-	1																														
rivastigmine patch (EXELON equiv)	-	1																														
EXELON SOLN	-	2																														
NAMENDA XR CAP	-	2																														
NAMZARIC CAP (Step Therapy requires trial of donepezil and memantine)	ST	2																														
NAMZARIC STARTER PACK (Step Therapy requires trial of donepezil and memantine)	ST	2																														
ARICEPT ODT (QL= 1 tab/day)	QL	3																														
ARICEPT TAB (QL= 2 tabs/day)	QL	3																														
ARICEPT TAB 23MG (QL= 1 tab/day; Step Therapy requires trial of donepezil 10mg)	QL-ST	3																														
Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.																																
<table border="1"> <tr> <td>INF</td> <td>NC =Not Covered Infertility</td> <td>KMSP</td> <td>generic =small letters Kroger Mandatory Specialty Pharmacy Program</td> <td>LD</td> <td>BRANDS =CAPITAL LETTERS Limited Distribution</td> </tr> <tr> <td>LMSP</td> <td>Lumicera Mandatory Specialty Pharmacy Program</td> <td>M</td> <td>Medical Benefit</td> <td>MSP</td> <td>Mandatory Specialty Pharmacy Program</td> </tr> <tr> <td>OTC</td> <td>Over-the-Counter</td> <td>PA</td> <td>Prior Authorization</td> <td>QL</td> <td>Quantity Limit</td> </tr> <tr> <td>RS</td> <td>Restricted to Specialist</td> <td>SF</td> <td>Limited to Two 15 Day Fills per Month for the First 3 M</td> <td>SMKG</td> <td>Smoking Cessation</td> </tr> <tr> <td>SP</td> <td>Available through Specialty Pharmacy Program</td> <td>ST</td> <td>Step Therapy</td> <td>VAC</td> <td>Vaccine Program</td> </tr> </table>			INF	NC =Not Covered Infertility	KMSP	generic =small letters Kroger Mandatory Specialty Pharmacy Program	LD	BRANDS =CAPITAL LETTERS Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 M	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program	ST	Step Therapy	VAC	Vaccine Program
INF	NC =Not Covered Infertility	KMSP	generic =small letters Kroger Mandatory Specialty Pharmacy Program	LD	BRANDS =CAPITAL LETTERS Limited Distribution																											
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program																											
OTC	Over-the-Counter	PA	Prior Authorization	QL	Quantity Limit																											
RS	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 M	SMKG	Smoking Cessation																											
SP	Available through Specialty Pharmacy Program	ST	Step Therapy	VAC	Vaccine Program																											

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Category/Class**

Last Updated* 11/1/2017

DrugName	Special Code	Tier
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. Cont.		
EXELON CAP	-	3
EXELON PATCH	-	3
NAMENDA SOL	-	3
NAMENDA TAB	-	3
RAZADYNE ER CAP	-	3
RAZADYNE SOLN	-	3
RAZADYNE TAB	-	3
COMBINATION PSYCHOTHERAPEUTICS		
chlordiazepoxide/amitriptyline tab (LIMBITROL equiv)	-	1
olanzapine/fluoxetine cap (SYMBYAX equiv)	-	1
PERPHENAZINE/ AMITRIPTYLINE TAB	-	1
LIMBITROL TAB	-	3
SYMBYAX CAP	-	3
FIBROMYALGIA AGENTS		
SAVELLA PAK	-	2
SAVELLA TAB (QL= 2 tabs/day)	QL	2
HYPOACTIVE SEXUAL DESIRE DISORDER (HSDD) AGENTS		
ADDYI TAB	-	NC
MOVEMENT DISORDER DRUG THERAPY		
tetrabenazine tab (XENAZINE equiv)	LMSP-PA	4
AUSTEDO TAB	-	NC
INGREZZA CAP	-	NC
XENAZINE TAB	-	NC
MULTIPLE SCLEROSIS AGENTS		
AMPYRA TAB (QL= 2 tabs/day)	MSP-PA-QL	3
AUBAGIO TAB	LMSP	4
AVONEX INJ	LMSP	4
COPAXONE INJ	LMSP	4
EXTAVIA INJ	LMSP	4
GILENYA CAP (QL= 1 cap/day)	LMSP-QL	4
PLEGRIDY INJ	LMSP	4
PLEGRIDY PEN INJ	LMSP	4
TECFIDERA CAP	LMSP	4
TECFIDERA STARTER PACK	LMSP	4
BETASERON INJ	-	NC
glatiramer inj (COPAXONE equiv)	-	NC
REBIF INJ	-	NC
ZINBRYTA INJ	-	NC
POSTHERPETIC NEURALGIA (PHN) AGENTS		
GRALISE TAB	-	NC
PREMENSTRUAL DYSPHORIC DISORDER (PMDD) AGENTS		
fluoxetine (pmdd) tab (SARAFEM equiv)	-	NC
FLUOXETINE CAP (PMDD)	-	NC
SARAFEM TAB	-	NC
PSEUDOBULBAR AFFECT (PBA) AGENTS		

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	KMSP	generic =small letters	LD	BRANDS =CAPITAL LETTERS
LMSP	Infertility	M	Kroger Mandatory Specialty Pharmacy Program	LD	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	PA	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	SF	Prior Authorization	QL	Quantity Limit
SP	Restricted to Specialist	SMKG	Limited to Two 15 Day Fills per Month for the First 3 M	SMKG	Smoking Cessation
	Available through Specialty Pharmacy Program	ST	Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Category/Class**

Last Updated* 11/1/2017

DrugName	Special Code	Tier
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. Cont.		
NUEDEXTA CAP (QL= 2 caps/day)	QL	2
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.		
ergoloid mesylates tab (HYDERGINE equiv)	-	1
pimozide tab	-	1
ERGOLOID MESYLATES TAB	-	3
ORAP TAB	-	3
RESTLESS LEG SYNDROME (RLS) AGENTS		
HORIZANT TAB	-	NC
SMOKING DETERRENTS		
bupropion SR tab (ZYBAN equiv) (Limited to 180 days/plan year)	QL-SMKG	\$0
CHANTIX PAK (Limited to 168 days/plan year)	QL-SMKG	\$0
CHANTIX TAB (Limited to 168 days/plan year)	QL-SMKG	\$0
NICODERM PATCH (Limited to 182 days/plan year)	OTC-QL-SMKG	\$0
NICORETTE GUM (Limited to 180 days/plan year)	OTC-QL-SMKG	\$0
NICORETTE LOZENGE (Limited to 180 days/plan year)	OTC-QL-SMKG	\$0
nicotine gum (NICORETTE equiv) (Limited to 180 days/plan year)	OTC-QL-SMKG	\$0
NICOTINE KIT (Limited to 182 days/plan year)	OTC-QL-SMKG	\$0
nicotine lozenge (COMMIT equiv) (Limited to 180 days/plan year)	OTC-QL-SMKG	\$0
nicotine patch (NICODERM equiv) (Limited to 182 days/plan year)	OTC-QL-SMKG	\$0
NICOTROL INHALER (Limited to 180 days/plan year)	QL-SMKG	\$0
NICOTROL NASAL SPRAY (Limited to 180 days/plan year)	QL-SMKG	\$0
ZYBAN TAB (Limited to 180 days/plan year)	QL-SMKG	\$0
VASOMOTOR SYMPTOM AGENTS		
BRISDELLE CAP	-	NC
paroxetine cap (BRISDELLE equiv)	-	NC
RESPIRATORY AGENTS - MISC.		
CYSTIC FIBROSIS AGENTS		
KALYDECO PAK (QL= 2 packets/day)	KMSP-PA-QL-SF	4
KALYDECO TAB (QL= 2 tabs/day)	KMSP-PA-QL-SF	4
ORKAMBI TAB (QL= 4 tabs/day)	KMSP-PA-QL-SF	4
PULMOZYME INH SOLN	KMSP	4
PULMONARY FIBROSIS AGENTS		
ESBRIET CAP (QL= 9 caps/day)	MSP-PA-QL-SF	4
ESBRIET TAB 267MG (QL= 9 tabs/day)	MSP-PA-QL-SF	4
ESBRIET TAB 801MG (QL= 3 tabs/day)	MSP-PA-QL-SF	4
OFEV CAP (QL= 2 caps/day)	MSP-PA-QL-SF	4
SULFONAMIDES		
SULFONAMIDES		
SULFADIAZINE TAB	-	1
TETRACYCLINES		
TETRACYCLINES		
demeclocycline tab (DECLOMYCIN equiv)	-	1
doxycycline hyclate cap (VIBRAMYCIN equiv)	-	1
doxycycline hyclate DR tab (DORYX equiv)	-	1
doxycycline hyclate tab (VIBRATAB equiv)	-	1

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	KMSP	generic =small letters	LD	BRANDS =CAPITAL LETTERS
LMSP	Infertility	M	Kroger Mandatory Specialty Pharmacy Program	LD	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	PA	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	SF	Prior Authorization	QL	Quantity Limit
SP	Restricted to Specialist	ST	Limited to Two 15 Day Fills per Month for the First 3 M	SMKG	Smoking Cessation
	Available through Specialty Pharmacy Program		Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Category/Class**

Last Updated* 11/1/2017

DrugName	Special Code	Tier
TETRACYCLINES Cont.		
doxycycline monohydrate cap 100mg (MONODOX equiv)	-	1
doxycycline monohydrate cap 150mg (MONODOX equiv)	-	1
doxycycline monohydrate cap 50mg (MONODOX equiv)	-	1
doxycycline monohydrate cap 75mg (MONODOX equiv)	-	1
doxycycline monohydrate tab (ADOXA equiv)	-	1
doxycycline susp (VIBRAMYCIN equiv)	-	1
minocycline cap (MINOCIN equiv)	-	1
minocycline tab (DYNACIN equiv)	-	1
tetracycline cap	-	1
ADOXA TAB	-	3
DORYX TAB	-	3
DOXYCYCLINE HYCLATE DR CAP	-	3
DYNACIN TAB	-	3
MINOCIN CAP	-	3
MONODOX CAP	-	3
ORAXYL CAP	-	3
TETRACYCLINE CAP	-	3
VIBRAMYCIN CAP	-	3
VIBRAMYCIN SUSP	-	3
VIBRAMYCIN SYRUP	-	3
ACTICLATE TAB 75MG, 150MG	-	NC
ADOXA PAK	-	NC
DORYX MPC TAB	-	NC
DORYX TAB 200MG	-	NC
doxycycline hyclate DR tab 200mg (DORYX equiv)	-	NC
doxycycline hyclate tab 75mg, 150mg (ACTICLATE equiv)	-	NC
doxycycline monohydrate tab 150mg (ADOXA equiv)	-	NC
minocycline ER tab (SOLODYN equiv)	-	NC
XIMINO CAP	-	NC

THYROID AGENTS

ANTITHYROID AGENTS

methimazole tab (TAPAZOLE equiv)	-	1
propylthiouracil tab	-	1
TAPAZOLE TAB	-	3

THYROID HORMONES

ARMOUR THYROID TAB, NATURE THROID TAB	-	1
liothyronine tab (CYTOMEL equiv)	-	1
np thyroid tab (ARMOUR THYROID, NATURE THROID equiv)	-	1
SYNTHROID TAB	-	1
THYROLAR TAB	-	2
CYTOMEL TAB	-	3
TIROSINT CAP	-	3
levothyroxine tab (SYNTHROID equiv)	-	NC

ULCER DRUGS

ANTISPASMODICS

dicyclomine cap (BENTYL equiv)	-	1
--------------------------------	---	---

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	KMSP	generic =small letters	LD	BRANDS =CAPITAL LETTERS
LMSP	Infertility	M	Kroger Mandatory Specialty Pharmacy Program	MSP	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	PA	Medical Benefit	QL	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	SF	Prior Authorization	SMKG	Quantity Limit
SP	Restricted to Specialist	ST	Limited to Two 15 Day Fills per Month for the First 3 M	VAC	Smoking Cessation
	Available through Specialty Pharmacy Program		Step Therapy		Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Category/Class**

Last Updated* 11/1/2017

DrugName	Special Code	Tier
ULCER DRUGS Cont.		
dicyclomine soln (BENTYL equiv)	-	1
dicyclomine tab (BENTYL equiv)	-	1
glycopyrrolate tab (ROBINUL equiv)	-	1
hyoscyamine sulfate CR tab (LEVBID equiv)	-	1
hyoscyamine sulfate elixir (LEVSIN equiv)	-	1
hyoscyamine sulfate ODT (ANASPAZ equiv)	-	1
hyoscyamine sulfate SL tab (LEVSIN equiv)	-	1
hyoscyamine sulfate soln (LEVSIN equiv)	-	1
hyoscyamine sulfate SR cap (LEVSINEX equiv)	-	1
hyoscyamine tab (LEVSIN equiv)	-	1
methscopolamine tab (PAMINE equiv)	-	1
BELLADONNA ALKALOID/OPIUM SUPP	-	2
DONNATAL EXTENTABS	-	2
PROPANTHELINE TAB	-	2
ANASPAZ ODT	-	3
BENTYL CAP	-	3
BENTYL SYRUP	-	3
BENTYL TAB	-	3
CANTIL TAB	-	3
LEVBID TAB	-	3
LEVSIN INJ	-	3
LEVSIN SL TAB	-	3
LEVSIN SOLN	-	3
LEVSIN TAB	-	3
LEVSINEX CAP	-	3
PAMINE TAB	-	3
ROBINUL TAB	-	3
SYMAX DUOTAB	-	3
CUVPOSA SOLN	MSP	4
b-donna tab (DONNATAL equiv)	-	NC
chlordiazepoxide/clidinium cap (LIBRAX equiv)	-	NC
DONNATAL ELIXIR	-	NC
DONNATAL TAB	-	NC
GLYCATE TAB 1.5MG	-	NC
LIBRAX CAP	-	NC

H-2 ANTAGONISTS

cimetidine soln (TAGAMET equiv)	-	1
cimetidine tab (TAGAMET equiv)	-	1
famotidine susp (PEPCID equiv)	-	1
famotidine tab (PEPCID equiv)	-	1
nizatidine cap (AXID equiv)	-	1
nizatidine soln (AXID equiv)	-	1
ranitidine cap (ZANTAC equiv)	-	1
ranitidine syrup (ZANTAC equiv)	-	1
ranitidine tab (Rx Only) (ZANTAC equiv)	-	1
PEPCID SUSP	-	2
AXID CAP	-	3

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	KMSP	generic =small letters	LD	BRANDS =CAPITAL LETTERS
LMSP	Infertility	M	Kroger Mandatory Specialty Pharmacy Program	MSP	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	PA	Medical Benefit	QL	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	SF	Prior Authorization	SMKG	Quantity Limit
SP	Restricted to Specialist	ST	Limited to Two 15 Day Fills per Month for the First 3 M	VAC	Smoking Cessation
	Available through Specialty Pharmacy Program		Step Therapy		Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Category/Class**

Last Updated* 11/1/2017

DrugName	Special Code	Tier
ULCER DRUGS Cont.		
AXID SOLN	-	3
PEPCID TAB	-	3
TAGAMET TAB	-	3
ZANTAC CAP	-	3
ZANTAC EFFER TAB	-	3
ZANTAC GRANULE PACKET	-	3
ZANTAC SYRUP	-	3
ZANTAC TAB	-	3
MISC. ANTI-ULCER		
CARAFATE SUSP	-	1
sucralfate tab (CARAFATE equiv)	-	1
CARAFATE TAB	-	3
PROTON PUMP INHIBITORS		
lansoprazole cap (PREVACID equiv)	OTC	1
omeprazole DR cap (PRILOSEC equiv)	-	1
pantoprazole EC tab (PROTONIX equiv)	-	1
PREVACID OTC CAP	OTC	1
rabeprazole EC tab (ACIPHEX equiv)	-	1
PREVACID SOLUTAB	-	2
DEXILANT CAP (QL= 1 cap/day; Step Therapy requires trial of omeprazole, pantoprazole, or rabeprazole)	QL-ST	3
FIRST OMEPRAZOLE SUSP	-	3
LANSOPRAZOLE SUSP	-	3
ACIPHEX SPRINKLE CAP	-	NC
ACIPHEX TAB	-	NC
esomeprazole cap (NEXIUM equiv)	-	NC
ESOMEPRAZOLE STRONTIUM CAP	-	NC
NEXIUM 24HR TAB	-	NC
NEXIUM CAP	-	NC
NEXIUM GRANULE PACK	-	NC
NEXIUM OTC CAP	OTC	NC
OMEPRAZOLE TAB	OTC	NC
PREVACID CAP	-	NC
PRILOSEC CAP	-	NC
PRILOSEC OTC DR TAB	-	NC
PROTONIX EC TAB	-	NC
PROTONIX PAK	-	NC
ULCER DRUGS - PROSTAGLANDINS		
misoprostol tab (CYTOTEC equiv)	-	1
CYTOTEC TAB	-	3
ULCER THERAPY COMBINATIONS		
lansoprazole/amoxicillin/clarithromycin kit (PREVPAC equiv)	-	1
omeprazole/sodium bicarbonate powder pack (ZEGERID equiv)	-	1
ZEGERID CAP OTC	OTC	1
PREVPAC KIT	-	3
PYLERA CAP	-	3
ZEGERID POWDER PACK	-	3

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	KMSP	generic =small letters	LD	BRANDS =CAPITAL LETTERS
LMSP	Infertility	M	Kroger Mandatory Specialty Pharmacy Program	MSP	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	PA	Medical Benefit	QL	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	SF	Prior Authorization	SMKG	Quantity Limit
SP	Restricted to Specialist	ST	Limited to Two 15 Day Fills per Month for the First 3 M	VAC	Smoking Cessation
	Available through Specialty Pharmacy Program		Step Therapy		Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Category/Class**

Last Updated* 11/1/2017

DrugName	Special Code	Tier
ULCER DRUGS Cont.		
omeprazole/sodium bicarbonate cap (ZEGERID equiv)	-	NC
ZEGERID CAP	-	NC
URINARY ANTI-INFECTIVES		
URINARY ANTI-INFECTIVE COMBINATIONS		
UROQID #2 TAB	-	3
PROSED DS TAB	-	NC
UTA cap	-	NC
URINARY ANTI-INFECTIVES		
methenamine hippurate tab (HIPREX equiv)	-	1
methenamine mandelate tab	-	1
nitrofurantoin macrocrystals cap (MACRODANTIN equiv)	-	1
nitrofurantoin monohydrate cap (MACROBID equiv)	-	1
nitrofurantoin susp (FURADANTIN equiv)	-	1
FURADANTIN SUSP	-	2
HIPREX TAB	-	3
MACROBID CAP	-	3
MACRODANTIN CAP	-	3
METHENAMINE MANDELATE TAB	-	3
MONUROL GRANULE PACK	-	3
URINARY ANTISPASMODICS		
BETA-3 ADRENERGIC AGONISTS		
MYRBETRIQ TAB	-	2
URINARY ANTISPASMODIC - ANTIMUSCARINICS (ANTICHOLIN) (NEW)		
oxybutynin ER tab (DITROPAN XL equiv)	-	1
oxybutynin syrup	-	1
oxybutynin tab (DITROPAN equiv)	-	1
tolterodine tab (DETROL equiv)	-	1
tropium chloride SR cap (SANCTURA XR equiv)	PA	1
tropium tab (SANCTURA equiv)	-	1
VESICARE TAB	-	2
DETROL TAB	-	3
DITROPAN XL TAB	-	3
GELNIQUE	-	3
OXYTROL PATCH	PA	3
SANCTURA TAB	-	3
SANCTURA XR CAP	PA	3
TOVIAZ TAB	PA	3
URINARY ANTISPASMODIC - ANTIMUSCARINICS (ANTICHOLINERGIC)		
darifenacin SR tab (ENABLEX equiv)	PA	1
tolterodine SR cap (DETROL LA equiv)	-	1
DETROL LA CAP	-	3
ENABLEX TAB	PA	3
URINARY ANTISPASMODIC COMBINATIONS		
URELIEF PLUS TAB	-	NC
URINARY ANTISPASMODICS		

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	KMSP	generic =small letters	LD	BRANDS =CAPITAL LETTERS
LMS	Infertility	M	Kroger Mandatory Specialty Pharmacy Program	LD	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	PA	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	SF	Prior Authorization	QL	Quantity Limit
SP	Restricted to Specialist	SMKG	Limited to Two 15 Day Fills per Month for the First 3 M	SMKG	Smoking Cessation
	Available through Specialty Pharmacy Program	ST	Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Category/Class**

Last Updated* 11/1/2017

DrugName	Special Code	Tier
URINARY ANTISPASMODICS Cont.		
hyoscyamine tab (LEVSIN equiv)	-	1
URINARY ANTISPASMODICS - CHOLINERGIC AGONISTS		
bethanechol tab (URECHOLINE equiv)	-	1
URECHOLINE TAB	-	3
URINARY ANTISPASMODICS - DIRECT MUSCLE RELAXANTS (NEW)		
flavoxate tab (URISPAS equiv)	-	NC
VACCINES		
BACTERIAL VACCINES		
VIVOTIF CAP (QL= 4 caps/fill)	QL-VAC	2
VAXCHORA SUSP	-	NC
VIRAL VACCINES		
AFLURIA INJ	VAC	\$0
AFLURIA INJ, FLUZONE INJ	VAC	\$0
FLUAD INJ	VAC	\$0
FLUBLOK INJ	VAC	\$0
FLUBLOK QUAD PF INJ	VAC	\$0
FLUCELVAX INJ	VAC	\$0
FLUCELVAX QUAD INJ	VAC	\$0
FLULAVAL QUAD INJ, FLUZONE QUAD INJ	VAC	\$0
FLUVIRIN INJ	VAC	\$0
FLUVIRIN PF INJ	VAC	\$0
FLUZONE HIGH DOSE PF INJ	VAC	\$0
FLUZONE INTRADERMAL INJ	VAC	\$0
FLUZONE QUADRIVALENT INJ	VAC	\$0
FLUZONE/FLUARIX QUAD INJ	VAC	\$0
STAMARIL INJ	-	NC
VAGINAL PRODUCTS		
MISCELLANEOUS VAGINAL PRODUCTS		
ACIDIC VAGINAL JELLY	-	2
FEM PH GEL	-	3
INTRAROSA SUPP	-	NC
SPERMICIDES		
CONCEPTROL GEL	OTC	\$0
CONTRACEPTIVE FILM	OTC	\$0
CONTRACEPTIVE FOAM	OTC	\$0
CONTRACEPTIVE GEL	OTC	\$0
CONTRACEPTIVE SUPP	OTC	\$0
TODAY SPONGE	OTC	\$0
vcf vaginal gel (CONCEPTROL equiv)	OTC	\$0
VAGINAL ANTI-INFECTIVES		
clindamycin vaginal cream (CLEOCIN equiv)	-	1
metronidazole vaginal gel (METROGEL equiv)	-	1
NYSTATIN VAGINAL TAB	-	1
terconazole cream (TERAZOL equiv)	-	1
terconazole supp (TERAZOL equiv)	-	1

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	KMSP	generic =small letters	LD	BRANDS =CAPITAL LETTERS
LMSP	Infertility	M	Kroger Mandatory Specialty Pharmacy Program	MSP	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	PA	Medical Benefit	QL	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	SF	Prior Authorization	SMKG	Quantity Limit
SP	Restricted to Specialist	ST	Limited to Two 15 Day Fills per Month for the First 3 M	VAC	Smoking Cessation
	Available through Specialty Pharmacy Program		Step Therapy		Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Category/Class**

Last Updated* 11/1/2017

DrugName	Special Code	Tier
VAGINAL PRODUCTS Cont.		
AVC VAGINAL CREAM	-	2
CLEOCIN VAGINAL CREAM	-	3
CLEOCIN VAGINAL SUPP	-	3
CLINDESSE VAGINAL CREAM	-	3
METROGEL VAGINAL GEL	-	3
MICONAZOLE 3 SUPP 200MG	-	3
TERAZOL CREAM	-	3
TERAZOL SUPP	-	3
GYNAZOLE CREAM	-	NC
VAGINAL ESTROGENS		
estradiol vaginal tab, yuvafem vaginal tab (VAGIFEM equiv) (QL= 8 tabs/28 days (18 tabs on first fill))	QL	1
ESTRACE VAGINAL CREAM	-	2
ESTRING	-	2
PREMARIN VAGINAL CREAM	-	2
FEMRING (3 copays per Rx)	-	3
VAGIFEM TAB (QL= 8 tabs/28 days (18 tabs on first fill))	QL	3
VAGINAL PROGESTINS		
CRINONE GEL	PA	2
ENDOMETRIN INSERT	PA	2
PROGESTERONE SUPP	PA	3
VASOPRESSORS		
ANAPHYLAXIS THERAPY AGENTS		
EPINEPHRINE PEN INJ 0.15MG (MYLAN) (QL= 2 inj/fill)	QL	2
EPINEPHRINE PEN INJ 0.3MG (MYLAN) (QL= 2 inj/fill)	QL	2
ADRENALICK INJ, EPINEPHRINE INJ (QL= 2 inj/fill; Step Therapy requires trial of EPINEPHRINE PEN (MYLAN))	QL-ST	3
AUVI-Q INJ (QL= 2 inj/fill; Step Therapy requires trial of EPINEPHRINE PEN (MYLAN))	QL-ST	3
NEUROGENIC ORTHOSTATIC HYPOTENSION (NOH) - AGENTS		
NORTHERA CAP	-	NC
VASOPRESSORS		
midodrine tab (PROAMATINE equiv)	-	1
PROAMATINE TAB	-	3
VITAMINS		
MISC. NUTRITIONAL FACTORS		
PRENATAL VITAMINS (PRENATAL PLUS, PREPLUS, PRENAPLUS)	-	1
PRENATAL VITAMINS (NON-PREFERRED)	-	3
OIL SOLUBLE VITAMINS		
vitamin D cap 1000unit (Covered for members 65 years or older)	OTC	\$0
vitamin D cap 400unit (Covered for members 65 years or older)	OTC	\$0
VITAMIN D TAB 400UNIT (Covered for members 65 years or older)	OTC	\$0
cholecalciferol cap 50000 unit	OTC	1
vitamin D cap (Rx covered Only)	-	1
MEPHYTON TAB	-	2
DRISDOL CAP	-	3
ERGOCAL CAP	-	NC
WATER SOLUBLE VITAMINS		

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	generic =small letters	BRANDS =CAPITAL LETTERS
LMSP	Infertility	KMSP	Limited Distribution
OTC	Lumicera Mandatory Specialty Pharmacy Program	M	Mandatory Specialty Pharmacy Program
RS	Over-the-Counter	PA	Quantity Limit
SP	Restricted to Specialist	SF	Smoking Cessation
	Available through Specialty Pharmacy Program	ST	Vaccine Program
		LD	Limited Distribution
		MSP	Mandatory Specialty Pharmacy Program
		QL	Quantity Limit
		SMKG	Smoking Cessation
		VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Category/Class**

Last Updated* 11/1/2017

DrugName	Special Code	Tier
VITAMINS Cont.		
niacin cap	OTC	1
niacin CR tab (SLO-NIACIN equiv)	OTC	1
niacin tab	OTC	1
NIACIN TR TAB	OTC	1
niacinamide tab	OTC	1
POTABA POWDER PACKET	-	2
POTABA TAB	-	2
POTABA CAP	-	3
SLO-NIACIN TAB	OTC	3

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered Infertility	KMSP	generic =small letters Kroger Mandatory Specialty Pharmacy Program	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	MSP	Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to Two 15 Day Fills per Month for the First 3 M	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy	VAC	Vaccine Program

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Prior Authorization Drug List
Last Updated* 11/1/2017**

Some products on the Formulary are only covered with a prior authorization approval. Drug products requiring prior authorization are listed below. The pharmacy will also alert members if the medication prescribed requires prior authorization. Please call Customer Service if you have further questions regarding prior authorizations.

Drug Name	Tier # for Drug Copay (if prior auth is approved)
ABILIFY DISCMELT	3
ABILIFY SOLN	3
ABSTRAL SL TAB	3
ACTEMRA SC INJ	4
ACTIQ LOZENGE	3
adapalene cream	1
adapalene gel	1
ADAPALENE LOTION	2
adapalene/benzoyl peroxide gel 0.1-2.5%	1
ADCIRCA TAB	4
ADEMPAS TAB	4
ADIPEX-P CAP	3
ADIPEX-P TAB	3
AFINITOR DISPERZ	4
AFINITOR TAB	4
ALECENSA CAP	4
ALINIA SUSP	2
ALINIA TAB	2
AMITIZA CAP	3
AMPYRA TAB	3
ANDRODERM PATCH	2
ANDROGEL 1% 25MG	3
ANDROGEL 1% 50MG, TESTIM GEL 1%	3
ANDROGEL 1.62% 1.25GM	2
ANDROGEL 1.62% 2.5GM	2
ANDROGEL PUMP 1%	3
ANDROGEL PUMP 1.62%	2
ANDROID CAP, TESTRED CAP	3
aripiprazole ODT	1
aripiprazole soln	1
ARIXTRA INJ	3
armodafinil tab	1
ATRALIN GEL, RETIN-A GEL	3
AXIRON SOLN	3
AZELEX CREAM	3
BELVIQ TAB	2
BELVIQ XR TAB	2
bexarotene cap	4
BOSULIF TAB	4
buprenorphine SL tab	1
CABOMETYX TAB	4
CAPRELSA TAB	4

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary cont.
 Prior Authorization Drug List
 Last Updated* 11/1/2017**

Some products on the Formulary are only covered with a prior authorization approval. Drug products requiring prior authorization are listed below. The pharmacy will also alert members if the medication prescribed requires prior authorization. Please call Customer Service if you have further questions regarding prior authorizations.

Drug Name	Tier # for Drug Copay (if prior auth is approved)
CARBAGLU TAB	4
CERDELGA CAP	4
CHOLBAM CAP	4
CIMZIA INJ	4
clobetasol foam	1
clobetasol lotion	1
clobetasol propionate cream	1
clobetasol propionate gel	1
clobetasol propionate oint	1
clobetasol propionate soln	1
clobetasol shampoo	1
clobetasol spray	1
CLOBEX LOTION	3
CLOBEX SHAMPOO	3
CLOBEX SPRAY	3
COLCHICINE TAB	2
COMETRIQ KIT	4
CONTRACE TAB	2
CORLANOR TAB	3
COSENTYX INJ	4
COTELLIC TAB	4
CRINONE GEL	2
CYSTAGON CAP	4
CYSTARAN OPHTH SOLN	4
DARAPRIM TAB	4
darifenacin SR tab	1
DESCOVY TAB	4
diclofenac gel	1
DIFFERIN CREAM	3
DIFFERIN GEL	3
dronabinol cap	1
DYMISTA NASAL SPRAY	3
EMVERM TAB	2
ENABLEX TAB	3
ENBREL INJ 25MG	4
ENBREL INJ 50MG	4
ENBREL MINI INJ	4
ENBREL SURECLICK INJ 50MG	4
ENDOMETRIN INSERT	2
ENTRESTO TAB	2
EPANED PREMIXED SOLN	3
EPANED SOLN	3

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary cont.
 Prior Authorization Drug List
 Last Updated* 11/1/2017**

Some products on the Formulary are only covered with a prior authorization approval. Drug products requiring prior authorization are listed below. The pharmacy will also alert members if the medication prescribed requires prior authorization. Please call Customer Service if you have further questions regarding prior authorizations.

Drug Name	Tier # for Drug Copay (if prior auth is approved)
EPCLUSA TAB	4
EPIDUO FORTE GEL	2
EPIDUO GEL 0.1-2.5%	2
ERIVEDGE CAP	4
ESBRIET CAP	4
ESBRIET TAB 267MG	4
ESBRIET TAB 801MG	4
FANAPT TAB	3
FANAPT TITRATION PACK	3
FARYDAK CAP	4
fentanyl citrate lollipop	1
FENTORA TAB	3
FERRIPROX SOLN	4
FERRIPROX TAB	4
FETZIMA CAP	3
FETZIMA TITRATION PACK	3
fondaparinux inj	1
FORTESTA GEL, TESTOSTERONE GEL	3
GENOTROPIN INJ	4
GILOTRIF TAB	4
halobetasol propionate oint	1
HARVONI TAB	4
HUMIRA INJ	4
HUMIRA PEN INJ	4
HYCAMTIN CAP	4
IBRANCE CAP	4
ICLUSIG TAB	4
imatinib tab	4
IMBRUVICA CAP	4
IMPAVIDO CAP	4
INCIVEK TAB	4
INFANT FORMULA LIQUID	2
INFANT FORMULA POWDER	2
INLYTA TAB	4
INVEGA TAB	3
IRESSA TAB	4
itraconazole cap	1
JAKAFI TAB	4
JENTADUETO TAB	3
KALYDECO PAK	4
KALYDECO TAB	4
KINERET INJ	4

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary cont.
 Prior Authorization Drug List
 Last Updated* 11/1/2017**

Some products on the Formulary are only covered with a prior authorization approval. Drug products requiring prior authorization are listed below. The pharmacy will also alert members if the medication prescribed requires prior authorization. Please call Customer Service if you have further questions regarding prior authorizations.

Drug Name	Tier # for Drug Copay (if prior auth is approved)
KISQALI PAK	4
KISQALI TAB	4
KORLYM TAB	4
KUVAN POWDER PACK	4
KUVAN TAB	4
LAZANDA NASAL SPRAY	3
LENVIMA CAP	4
LETAIRIS TAB	4
LEUKINE INJ	4
LINZESS CAP	2
LONSURF TAB	4
LYNPARZA CAP	4
LYNPARZA TAB	4
MARINOL CAP	3
MEKINIST TAB	4
METHITEST TAB	3
methyltestosterone cap	1
modafinil tab	1
MOVANTIK TAB	2
NATPARA INJ	4
NEXAVAR TAB	4
NINLARO CAP	4
NUTRITIONAL SUPPLEMENT LIQUID	2
NUTRITIONAL SUPPLEMENT POWDER	2
OCALIVA TAB	4
ODOMZO CAP	4
OFEV CAP	4
OLUX FOAM	3
ONFI TAB	2
OPSUMIT TAB	4
ORENCIA CLICK INJ	4
ORENCIA SC INJ 125MG/ML	4
ORENCIA SC INJ 50MG/0.4ML	4
ORENCIA SC INJ 87.5MG/0.7ML	4
ORFADIN CAP	4
ORKAMBI TAB	4
OXYTROL PATCH	3
paliperidone ER tab	1
PANRETIN GEL	4
phentermine cap	1
phentermine tab	1
PRALUENT INJ	4

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary cont.
 Prior Authorization Drug List
 Last Updated* 11/1/2017**

Some products on the Formulary are only covered with a prior authorization approval. Drug products requiring prior authorization are listed below. The pharmacy will also alert members if the medication prescribed requires prior authorization. Please call Customer Service if you have further questions regarding prior authorizations.

Drug Name	Tier # for Drug Copay (if prior auth is approved)
PROGESTERONE SUPP	3
PROMACTA TAB	4
PROVIGIL TAB	3
QSYMIA CAP	3
REPATHA INJ	4
REPATHA PUSHTRONEX INJ	4
RETIN-A CREAM	3
RETIN-A MICRO GEL 0.04%, 0.1%	1
REVATIO TAB	3
REVLIMID CAP	3
RIFATER TAB	3
RUBRACA TAB	4
SABRIL TAB	4
SANCTURA XR CAP	3
SAPHRIS SL TAB	3
SIGNIFOR INJ	4
sildenafil tab	1
SIMPONI SC INJ	4
SKLICE LOTION	3
SOLARAZE GEL	3
SOMAVERT INJ	4
SPIRIVA HANDIHALER	3
SPIRIVA RESPIMAT INHALER	3
SPORANOX CAP	3
SPORANOX SOLN	3
SPRYCEL TAB	3
STIVARGA TAB	4
STRENSIQ INJ	4
SUTENT CAP	4
SYLATRON INJ	4
SYPRINE CAP	4
TAFINLAR CAP	4
TAGRISSO TAB	4
TARCEVA TAB	4
TASIGNA CAP	4
TEMOVATE CREAM	3
TEMOVATE GEL	3
TEMOVATE OINT	3
TEMOVATE SOLN	3
TEMOVATE-E CREAM	3
TESTOSTERONE GEL 1% 25MG	2
TESTOSTERONE GEL 1% 50MG	2

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary cont.
 Prior Authorization Drug List
 Last Updated* 11/1/2017**

Some products on the Formulary are only covered with a prior authorization approval. Drug products requiring prior authorization are listed below. The pharmacy will also alert members if the medication prescribed requires prior authorization. Please call Customer Service if you have further questions regarding prior authorizations.

Drug Name	Tier # for Drug Copay (if prior auth is approved)
testosterone gel 1% pump	1
TESTOSTERONE GEL PUMP	2
TESTOSTERONE GEL, VOGELXO GEL	3
testosterone soln	1
tetrabenazine tab	4
THALOMID CAP	4
TOVIAZ TAB	3
TRACLEER TAB	4
TRADJENTA TAB	3
TRECATOR TAB	3
tretinoin cream	1
tretinoin gel	1
TRETIN-X CREAM	3
TRINTELLIX TAB	3
tropium chloride SR cap	1
TRUVADA TAB	4
TYKERB TAB	4
TYVASO INH SOLN	4
TYZEKA TAB	4
UCERIS RECTAL FOAM	3
UCERIS TAB	3
UPTRAVI TAB	4
VALCHLOR GEL	4
VELTASSA POWDER	4
VENCLEXTA STARTER PACK	4
VENCLEXTA TAB	4
VENTAVIS INH SOLN	4
VICTRELIS CAP	4
vigabatrin powder pack	4
VOTRIENT TAB	4
XALKORI CAP	4
XELJANZ TAB	4
XELJANZ XR TAB	4
XIFAXAN TAB 550MG	3
XTAMPZA ER CAP	2
XTANDI CAP	4
XYREM SOLN	4
ZAVESCA CAP	4
ZELBORAF TAB	4
ZEPATIER TAB	4
ZOLINZA CAP	4
ZORTRESS TAB	4

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary cont.
Prior Authorization Drug List
Last Updated* 11/1/2017**

Some products on the Formulary are only covered with a prior authorization approval. Drug products requiring prior authorization are listed below. The pharmacy will also alert members if the medication prescribed requires prior authorization. Please call Customer Service if you have further questions regarding prior authorizations.

Drug Name	Tier # for Drug Copay (if prior auth is approved)
ZYDELIG TAB	4
ZYTIGA TAB 250MG	3
ZYTIGA TAB 500MG	3

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Last Updated* 11/1/2017
Over-the-Counter (OTC)**

- The following OTC drugs are a covered benefit with a prescription

Over-the-Counter (OTC) Medications

ACCU-CHECK GUIDE CARE METER	ACCU-CHEK AVIVA PLUS METER	ACCU-CHEK AVIVA PLUS TEST STRIP	ACCU-CHEK GUIDE TEST STRIP
ACCU-CHEK NANO METER	ACCU-CHEK SMARTVIEW TEST STRIP	ACCU-CHEK TEST STRIP	AEROCHAMBER
ALCOHOL SWABS	ASPIRIN CHEW TAB 75MG	aspirin chew tab 81mg	aspirin ec tab 325mg
aspirin ec tab 81mg	aspirin tab 325mg	ASPIRIN TAB 81MG	B-D INSULIN SYRINGE
B-D PEN NEEDLE	CALIBRATION LIQUID	cholecalciferol cap 50000 unit	CLINISTIX TEST STRIP
CONCEPTROL GEL	CONTRACEPTIVE FILM	CONTRACEPTIVE FOAM	CONTRACEPTIVE GEL
CONTRACEPTIVE SUPP	FEMALE CONDOMS	ferrous sulfate elixir	FERROUS SULFATE LIQUIII
ferrous sulfate soln	FERROUS SULFATE SYRUP	folic acid tab 400mcg	folic acid tab 800mcg
FREESTYLE FREEDOM LITE METER	FREESTYLE INSULIN SYRINGE	FREESTYLE INSULINX METER	FREESTYLE INSULINX TEST STRIP
FREESTYLE LITE METER	FREESTYLE LITE TEST STRIP	FREESTYLE PRECISION NEO METER	FREESTYLE PRECISION NEO TEST STRIP
FREESTYLE TEST STRIP	guaifenesin/codeine soln	guaifenesin/codeine syrup	HUMULIN MIX INJ
HUMULIN MIX PEN INJ	HUMULIN N INJ	HUMULIN N PEN INJ	HUMULIN R INJ
INFANT FORMULA LIQUID	INFANT FORMULA POWDER	INSULIN SYRINGE	IRON SUSP
KETO-DIASTIX TEST STRIF	KETOSTIX	ketotifen ophth soln	LANCET DEVICE
LANCET KIT	LANCETS	lansoprazole cap	levonorgestrel tab
meclizine chew tab	meclizine tab	NASACORT OTC NASAL SPRAY	niacin cap
niacin CR tab	niacin tab	NIACIN TR TAB	niacinamide tab
NICODERM PATCH	NICORETTE GUM	NICORETTE LOZENGE	nicotine gum
NICOTINE KIT	nicotine lozenge	nicotine patch	NINJACOF-XG LIQUID
NOVOFINE PEN NEEDLE	NOVOLIN INJ	NOVOTWIST PEN NEEDLE	NUTRITIONAL SUPPLEMENT LIQUID
NUTRITIONAL SUPPLEMENT POWDER	PEAK FLOW METER	PEN NEEDLE	PLAN B TAB
PRECISION INSULIN SYRINGE	PRECISION XTRA METER	PRECISION XTRA TEST STRIP	PREVACID OTC CAP
pseudoephedrine/brompheni amine/codeine liquid	SLO-NIACIN TAB	TODAY SPONGE	triamcinolone OTC nasal spray
vcf vaginal gel	vitamin D cap 1000unit	vitamin D cap 400unit	VITAMIN D TAB 400UNIT
ZEGERID CAP OTC			

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Last Updated* 11/1/2017
Mandatory Specialty Pharmacy (MSP)**

- Navitus utilizes a specialty pharmacy, experienced in handling specialty drugs, to coordinate personalized support for members impacted by chronic illnesses and complex diseases.
- Specialty drugs are only available for a one month supply due to their high cost and use.
- The following drugs are required to be filled through a Specialty Pharmacy provider.

Mandatory Specialty Pharmacy (MSP) Medications

ACTEMRA SC INJ	ACTIMMUNE INJ	ADCIRCA TAB	ADEMPAS TAB
ALECENSA CAP	AMPYRA TAB	APOKYN INJ	AUBAGIO TAB
AVONEX INJ	CABOMETYX TAB	calcitriol inj	CAPRELSA TAB
CARBAGLU TAB	CERDELGA CAP	CHOLBAM CAP	CIMZIA INJ
COMETRIQ KIT	COPAXONE INJ	COSENTYX INJ	COTELLIC TAB
CUVPOSA SOLN	CYSTAGON CAP	CYSTARAN OPHTH SOLN	DARAPRIM TAB
doxercalciferol cap	ENBREL INJ 25MG	ENBREL INJ 50MG	ENBREL MINI INJ
ENBREL SURECLICK INJ 50MG	ESBRIET CAP	ESBRIET TAB 267MG	ESBRIET TAB 801MG
EXJADE TAB	EXTAVIA INJ	FARYDAK CAP	FERRIPROX SOLN
FERRIPROX TAB	GILENYA CAP	GILOTRIF TAB	HUMIRA INJ
HUMIRA PEN INJ	ICLUSIG TAB	IMBRUVICA CAP	INCIVEK TAB
INCRELEX INJ	INFERGEN INJ	IRESSA TAB	JAKAFI TAB
KINERET INJ	KORLYM TAB	KUVAN POWDER PACK	KUVAN TAB
LENVIMA CAP	LETAIRIS TAB	LONSURF TAB	LYNPARZA CAP
LYNPARZA TAB	NATPARA INJ	NEXAVAR TAB	OCALIVA TAB
octreotide inj	OFEV CAP	OPSUMIT TAB	ORENCIA CLICK INJ
ORENCIA SC INJ 125MG/ML	ORENCIA SC INJ 50MG/0.4ML	ORENCIA SC INJ 87.5MG/0.7ML	ORFADIN CAP
paricalcitol cap	PLEGRIDY INJ	PLEGRIDY PEN INJ	RISPERDAL CONSTA INJ
RUBRACA TAB	SABRIL TAB	SENSIPAR TAB	SIGNIFOR INJ
SIMPONI SC INJ	SOMAVERT INJ	STIVARGA TAB	STRENSIQ INJ
SYLATRON INJ	TAGRISSO TAB	TECFIDERA CAP	TECFIDERA STARTER PACK
tetrabenazine tab	TRACLEER TAB	TYVASO INH SOLN	UPTRAVI TAB
VALCHLOR GEL	VENCLEXTA STARTER PACK	VENCLEXTA TAB	VENTAVIS INH SOLN
VICTRELIS CAP	vigabatrin powder pack	XELJANZ TAB	XELJANZ XR TAB
XYREM SOLN	ZAVESCA CAP	ZELBORAF TAB	ZYDELIG TAB

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Last Updated* 11/1/2017
Step Therapy (ST)**

- The following drugs are covered on the formulary with a Step Therapy.

Step Therapy (ST) Medications

Drug Name	Step Therapy Requirements
ADRENALIN INJ, EPINEPHRINE INJ	QL= 2 inj/fill; Step Therapy requires trial of EPINEPHRINE PEN (MYLAN)
APIDRA INJ	Step Therapy requires trial of NOVOLOG
APIDRA SOLOSTAR INJ	Step Therapy requires trial of NOVOLOG
ARANESP INJ	Step Therapy requires trial of EPOGEN or PROCIT
ARICEPT TAB 23MG	QL= 1 tab/day; Step Therapy requires trial of donepezil 10mg
ATELVIA TAB	Step Therapy requires trial of alendronate
AUVI-Q INJ	QL= 2 inj/fill; Step Therapy requires trial of EPINEPHRINE PEN (MYLAN)
BECONASE AQ NASAL SPRAY	QL= 2 bottles/fill; Step Therapy requires trial of 2: flunisolide, fluticasone, triamcinolone or NASONEX
BESIVANCE OPHTH SUSP	Step Therapy requires trial of ciprofloxacin, levofloxacin, ofloxacin or VIGAMOX/MOXEZA
BONIVA TAB 150MG	QL= 1 tab/30 days; Step Therapy requires trial of alendronate
budesonide nasal spray	QL= 2 bottles/fill; Step Therapy requires trial of 2: flunisolide, fluticasone, triamcinolone or NASONEX
budesonide SR cap	Step Therapy requires trial of APRISO, LIALDA, or sulfasalazine
DEXILANT CAP	QL= 1 cap/day; Step Therapy requires trial of omeprazole, pantoprazole, or rabeprazole
DIFICID TAB	QL= 20 tabs/fill; Step Therapy requires trial of vancomycin cap
donepezil tab 23mg	QL= 1 tab/day; Step Therapy requires trial of donepezil 10mg
ENTOCORT EC CAP	Step Therapy requires trial of APRISO, LIALDA, or sulfasalazine
fluvoxamine ER cap	Step Therapy requires trial of citalopram, escitalopram, sertraline, fluoxetine, fluvoxamine or paroxetine
gatifloxacin ophth soln	Step Therapy requires trial of ciprofloxacin, levofloxacin, ofloxacin or VIGAMOX/MOXEZA
HUMALOG INJ	Step Therapy requires trial of NOVOLOG
HUMALOG KWIKPEN INJ	Step Therapy requires trial of NOVOLOG
HUMALOG MIX INJ	Step Therapy requires trial of NOVOLOG
HUMALOG MIX KWIKPEN INJ	Step Therapy requires trial of NOVOLOG
HUMALOG PEN INJ	Step Therapy requires trial of NOVOLOG
HUMULIN MIX INJ	Step Therapy requires trial of NOVOLIN
HUMULIN MIX PEN INJ	Step Therapy requires trial of NOVOLIN
HUMULIN N INJ	Step Therapy requires trial of NOVOLIN
HUMULIN N PEN INJ	Step Therapy requires trial of NOVOLIN
HUMULIN R INJ	Step Therapy requires trial of NOVOLIN
ibandronate tab 150mg	QL= 1 tab/30 days; Step Therapy requires trial of alendronate
LEVALBUTEROL INHALER, XOPENEX HFA INHALER	QL= 2 inhalers/fill, 2 fills/30 days; Step Therapy requires trial of VENTOLIN HFA
LUVOX CR CAP	Step Therapy requires trial of citalopram, escitalopram, sertraline, fluoxetine, fluvoxamine or paroxetine

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary Cont.
Last Updated* 11/1/2017
Step Therapy (ST)**

- The following drugs are covered on the formulary with a Step Therapy.

Step Therapy (ST) Medications

Drug Name	Step Therapy Requirements
METROGEL 1%	Step Therapy requires trial of FINACEA
NAMZARIC CAP	Step Therapy requires trial of donepezil and memantine
NAMZARIC STARTER PACK	Step Therapy requires trial of donepezil and memantine
nevirapine ER tab	Step Therapy requires trial of nevirapine
NORITATE CREAM	Step Therapy requires trial of FINACEA
OMNARIS NASAL SPRAY	QL= 2 bottles/fill; Step Therapy requires trial of 2: flunisolide, fluticasone, triamcinolone or NASONEX
PANCREAZE CAP	Step Therapy requires trial of CREON
PANCRELIPASE CAP	Step Therapy requires trial of CREON
PERTZYE CAP	Step Therapy requires trial of CREON
PEXEVA TAB	Step Therapy requires trial of citalopram, escitalopram, sertraline, fluoxetine, fluvoxamine or paroxetine
QNASL NASAL SPRAY	QL= 2 bottles/fill; Step Therapy requires trial of 2: flunisolide, fluticasone, triamcinolone or NASONEX
RHINOCORT AQUA NASAL SPRAY	QL= 2 bottles/fill; Step Therapy requires trial of 2: flunisolide, fluticasone, triamcinolone or NASONEX
risedronate DR tab	Step Therapy requires trial of alendronate
risedronate tab	Step Therapy requires trial of alendronate
RYTARY CAP	Step Therapy requires trial of carbidopa/levodopa ER
SUPREP SOLN	Step therapy requires trial of MOVIPREP
ULORIC TAB	Step Therapy requires trial of allopurinol
ULTRESA CAP	Step Therapy requires trial of CREON
VANCOGIN CAP	QL= 56 caps/fill; Step Therapy requires trial of vancomycin soln
vancomycin cap	QL= 56 caps/fill; Step Therapy requires trial of vancomycin soln
VERAMYST NASAL SPRAY	QL= 2 bottles/fill; Step Therapy requires trial of 2: flunisolide, fluticasone, triamcinolone or NASONEX
VIRAMUNE XR TAB	Step Therapy requires trial of nevirapine
ZENPEP CAP	Step Therapy requires trial of CREON
ZETONNA NASAL SPRAY	QL= 2 bottles/fill; Step Therapy requires trial of 2: flunisolide, fluticasone, triamcinolone or NASONEX
ZIOPTAN OPHTH SOLN	QL= 1 bottle/day; Step Therapy requires trial of latanoprost
ZYMAXID OPHTH SOLN	Step Therapy requires trial of ciprofloxacin, levofloxacin, ofloxacin or VIGAMOX/MOXEZA

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Smoking Cessation Agents
Last Updated* 11/1/2017**

Drug Name	Tier # for Drug Copay
bupropion SR tab(Limited to 180 days/plan year)	\$0
CHANTIX PAK(Limited to 168 days/plan year)	\$0
CHANTIX TAB(Limited to 168 days/plan year)	\$0
NICODERM PATCH(Limited to 182 days/plan year)	\$0
NICORETTE GUM(Limited to 180 days/plan year)	\$0
NICORETTE LOZENGE(Limited to 180 days/plan year)	\$0
nicotine gum(Limited to 180 days/plan year)	\$0
NICOTINE KIT(Limited to 182 days/plan year)	\$0
nicotine lozenge(Limited to 180 days/plan year)	\$0
nicotine patch(Limited to 182 days/plan year)	\$0
NICOTROL INHALER(Limited to 180 days/plan year)	\$0
NICOTROL NASAL SPRAY(Limited to 180 days/plan year)	\$0
ZYBAN TAB(Limited to 180 days/plan year)	\$0

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Last Updated* 11/1/2017
Quantity Limit (QL)

- The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
ABILIFY DISCMELT	QL= 2 tabs/day
ABSTRAL SL TAB	QL= 120 tabs/30 days
ACTEMRA SC INJ	QL= 2 inj/28 days
ACTIQ LOZENGE	QL= 120 units/30 days
ADEMPAS TAB	QL= 3 tabs/day; Only available through Accredo 888-773-7376
ADIPEX-P CAP	
ADIPEX-P TAB	
ADRENALIN INJ, EPINEPHRINE INJ	QL= 2 inj/fill; Step Therapy requires trial of EPINEPHRINE PEN (MYLAN)
AFINITOR DISPERZ	QL= 1 tab/day
AFINITOR TAB	QL= 1 tab/day
AKYNZEO CAP	QL= 1 cap/fill; Restricted to Oncology or Hematology Specialist
ALECENSA CAP	QL= 8 caps/day
ALINIA SUSP	QL= 60ml/3 days
ALINIA TAB	QL= 6 tabs/3 days
almotriptan tab	QL= 9 tabs/fill, 2 fills/30 days
ALOGLIPTIN TAB	QL= 1 tab/day
ALOGLIPTIN-METFORMIN TAB	QL= 2 tabs/day
ALOGLIPTIN-PIOGLITAZONE TAB	QL= 1 tab/day
AMBIEN TAB	QL= 1 tab/day
AMERGE TAB	QL= 9 tabs/fill, 2 fills/30 days
AMPYRA TAB	QL= 2 tabs/day
ANDRODERM PATCH	QL= 1 patch/day
ANDROGEL 1% 25MG	QL= 1 packet/day
ANDROGEL 1% 50MG, TESTIM GEL 1%	QL= 2 packets/day
ANDROGEL 1.62% 1.25GM	QL= 1 packet/day
ANDROGEL 1.62% 2.5GM	QL= 2 packets/day
ANDROGEL PUMP 1%	QL= 4 bottles/30 days
ANDROGEL PUMP 1.62%	QL= 2 bottles/30 days
ANZEMET TAB	QL= 9 tabs/fill
aprepitant cap	QL= 3 caps/fill; Restricted to Oncology or Hematology Specialist
aprepitant pak	QL= 3 caps/fill; Restricted to Oncology or Hematology Specialist
ARICEPT ODT	QL= 1 tab/day
ARICEPT TAB	QL= 2 tabs/day
ARICEPT TAB 23MG	QL= 1 tab/day; Step Therapy requires trial of donepezil 10mg
aripiprazole ODT	QL= 2 tabs/day
armodafinil tab	QL= 1 tab/day
ATRIPLA TAB	QL= 1 tab/day
AUVI-Q INJ	QL= 2 inj/fill; Step Therapy requires trial of EPINEPHRINE PEN (MYLAN)
AVINZA CAP	QL= 2 caps/day
AXERT TAB	QL= 9 tabs/fill, 2 fills/30 days
AXIRON SOLN	QL= 2 bottles/30 days
BARACLUDE TAB	QL= 1 tab/day

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary Cont.
Last Updated* 11/1/2017
Quantity Limit (QL)

• The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
BECONASE AQ NASAL SPRAY	QL= 2 bottles/fill; Step Therapy requires trial of 2: flunisolide, fluticasone, triamcinolon or NASONEX
BELVIQ TAB	QL= 2 tabs/day
BELVIQ XR TAB	QL= 1 tab/day
BIMATOPROST OPHTH SOLN, LUMIGAN OPHTH SOLN	QL= 2.5ml/30 days
BONIVA TAB 150MG	QL= 1 tab/30 days; Step Therapy requires trial of alendronate
budesonide nasal spray	QL= 2 bottles/fill; Step Therapy requires trial of 2: flunisolide, fluticasone, triamcinolon or NASONEX
BUPRENORPHINE PATCH, BUTRANS PATCH	QL= 4 patches/28 days
buprenorphine SL tab	QL= 21 tabs/7 days
bupropion SR tab	Limited to 180 days/plan year
butorphanol nasal spray	QL= 1 bottle/fill, 2 fills/30 days
BYDUREON INJ	QL= 4 inj/28 days
BYDUREON PEN INJ	QL= 4 inj/28 days
CABOMETYX TAB	QL= 1 tab/day
CAVERJECT INJ	QL= 6 inj/30 days
CELEBREX CAP	QL= 2 caps/day
celecoxib cap	QL= 2 caps/day
CHANTIX PAK	Limited to 168 days/plan year
CHANTIX TAB	Limited to 168 days/plan year
CIALIS TAB	QL= 6 tabs/30 days
CIALIS TAB 2.5MG, 5MG	QL= 6 tabs/30 days
CIMZIA INJ	QL= 2 inj/28 days
COMPLERA TAB	QL= 1 tab/day
CONTRAVE TAB	QL= 4 tabs/day
COSENTYX INJ	QL= 2 inj/28 days
COTELLIC TAB	QL= 3 tabs/day
CRESTOR TAB	QL= 1 tab/day
CRESTOR TAB 20MG	QL= 1.5 tabs/day
CYSTARAN OPHTH SOLN	QL= 4 bottles/30 days; Only available through Walgreens 888-347-3416
DEXILANT CAP	QL= 1 cap/day; Step Therapy requires trial of omeprazole, pantoprazole, or rabeprazole
diclofenac gel 1%	QL= 5 tubes/fill
DIFICID TAB	QL= 20 tabs/fill; Step Therapy requires trial of vancomycin cap
DIHYDROERGOTAMINE SPRAY, MIGRANAL SPRAY	QL= 8 sprays/fill, 2 fills/30 days
donepezil ODT	QL= 1 tab/day
donepezil tab	QL= 2 tabs/day
donepezil tab 23mg	QL= 1 tab/day; Step Therapy requires trial of donepezil 10mg
EDEX INJ	QL= 6 inj/30 days
EMEND PAK	QL= 3 caps/fill; Restricted to Oncology or Hematology Specialist

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary Cont.
Last Updated* 11/1/2017
Quantity Limit (QL)**

• The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
ENBREL INJ 25MG	QL= 8 inj/28 days
ENBREL INJ 50MG	QL= 4 inj/28 days
ENBREL MINI INJ	QL= 4 inj/28 days
ENBREL SURECLICK INJ 50MG	QL= 4 inj/28 days
enoxaparin inj	QL= 17 days supply
entecavir tab	QL= 1 tab/day
ENTRESTO TAB	QL= 2 tabs/day
EPCLUSA TAB	QL= 1 tab/day
EPINEPHRINE PEN INJ 0.15MG (MYLAN)	QL= 2 inj/fill
EPINEPHRINE PEN INJ 0.3MG (MYLAN)	QL= 2 inj/fill
ESBRIET CAP	QL= 9 caps/day
ESBRIET TAB 267MG	QL= 9 tabs/day
ESBRIET TAB 801MG	QL= 3 tabs/day
estradiol vaginal tab, yuvafem vaginal tab	QL= 8 tabs/28 days (18 tabs on first fill)
eszopiclone tab	QL= 1 tab/day
ezetimibe/simvastatin tab	QL= 1 tab/day (10-80mg is Not Covered)
FANAPT TAB	QL= 2 tabs/day
FANAPT TITRATION PACK	QL= 1 pack/plan year
FARYDAK CAP	QL= 6 caps/21 days
fentanyl citrate lollipop	QL= 120 lozenges/30 days
FENTORA TAB	QL= 120 tabs/30 days
FETZIMA CAP	QL= 1 cap/day
FETZIMA TITRATION PACK	QL= 1 cap/day
FLECTOR PATCH	QL= 30 patches/fill
FLUNISOLIDE NASAL SPRAY	QL= 2 bottles/fill
fluticasone nasal spray	QL= 2 bottles/fill
FORTESTA GEL, TESTOSTERONE GEL	QL= 2 bottles/30 days
FROVA TAB	QL= 9 tabs/fill, 2 fills/30 days
frovatriptan tab	QL= 9 tabs/fill, 2 fills/30 days
GILENYA CAP	QL= 1 cap/day
GILOTRIF TAB	QL= 1 tab/day; Only available through Accredo 888-773-7376
GLYXAMBI TAB	QL= 1 tab/day
granisetron tab	QL= 9 tabs/fill
GRANISOL SOLN	QL= 60ml/fill
guaifenesin/codeine syrup	QL= 240ml/fill
HARVONI TAB	QL= 1 tab/day
HUMIRA INJ	QL= 2 inj/28 days
HUMIRA PEN INJ	QL= 2 inj/28 days
hydrocodone/chlorpheniramine CR susp	QL= 120ml/fill; 2 fills/30 days
hydrocodone/chlorpheniramine/pseudoephedrine liquid	QL= 120ml/fill, 2 fills/30 days
ibandronate tab 150mg	QL= 1 tab/30 days; Step Therapy requires trial of alendronate
IBRANCE CAP	QL= 21 caps/28 days

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary Cont.
Last Updated* 11/1/2017
Quantity Limit (QL)

• The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
imatinib tab	QL= 3 tabs/day
IMBRUVICA CAP	QL= 4 caps/day; Only available through Diplomat Pharmacy 877-977-9118
IMITREX INJ	QL= 4 inj/fill, 2 fills/30 days
IMITREX TAB	QL= 9 tabs/fill, 2 fills/30 days
IMITREX VIAL INJ	QL= 5 inj/fill, 2 fills/30 days
INLYTA TAB	QL= 8 tabs/day
JAKAFI TAB	QL= 2 tabs/day
JANUMET TAB	QL= 2 tabs/day
JANUMET XR TAB	QL= 2 tabs/day
JANUVIA TAB	QL= 1 tab/day
JARDIANCE TAB	QL= 1 tab/day
JENTADUETO TAB	QL= 2 tabs/day
JENTADUETO XR TAB	QL= 2 tabs/day
KALYDECO PAK	QL= 2 packets/day
KALYDECO TAB	QL= 2 tabs/day
ketorolac tab	QL= 20 tabs/5 days
KINERET INJ	QL= 1 inj/day; Only available through Rx Crossroads: 1-866-547-0644
KISQALI PAK	QL= 91 tabs/28 days
KISQALI TAB	QL= 63 tabs/28 days
KYTRIL TAB	QL= 9 tabs/fill
LASTACAPT OPHTH SOLN	QL= 3ml/30 days
latanoprost ophth soln	QL= 2.5ml/30 days
LAZANDA NASAL SPRAY	QL= 15 bottles/30 days
LENVIMA CAP	QL= 3 caps/day; Only available through Accredo 888-773-7376
LETAIRIS TAB	QL= 1 tab/day; Only available through Walgreens 888-347-3416
LEVALBUTEROL INHALER, XOPENEX HFA INHALER	QL= 2 inhalers/fill, 2 fills/30 days; Step Therapy requires trial of VENTOLIN HFA
LEVITRA TAB	QL= 6 tabs/30 days
lidocaine oint	QL= 107gm/30 days
lidocaine patch	QL= 3 patches/day
LIDODERM PATCH	QL= 3 patches/day
LOVENOX INJ	QL= 17 days supply
LUNESTA TAB	QL= 1 tab/day
malathion lotion	QL= 2 bottles/fill
MAXALT MLT TAB	QL= 12 tabs/fill, 3 fills/60 days
MAXALT TAB	QL= 12 tabs/fill, 3 fills/60 days
METHERGINE TAB	QL= 28 tabs/fill, 1 fill/365 days
methylergonovine tab	QL= 28 tabs/fill, 1 fill/365 days
modafinil tab	QL= 2 tabs/day
MORPHINE SULFATE ER BEAD CAP	QL= 2 caps/day
morphine sulfate ER tab	QL= 90 tabs/ 30 days
MOVIPREP SOLN	QL= 1 bottle/fill
MUSE SUPP	QL= 6 inj/30 days

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary Cont.
Last Updated* 11/1/2017
Quantity Limit (QL)**

- The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
naratriptan tab	QL= 9 tabs/fill, 2 fills/30 days
NASACORT AQ NASAL SPRAY	QL= 2 bottles/fill
NASACORT OTC NASAL SPRAY	QL= 2 bottles/fill
NASONEX NASAL SPRAY	QL= 2 bottles/fill
NATROBA SUSP	QL= 1 bottle/fill
NICODERM PATCH	Limited to 182 days/plan year
NICORETTE GUM	Limited to 180 days/plan year
NICORETTE LOZENGE	Limited to 180 days/plan year
nicotine gum	Limited to 180 days/plan year
NICOTINE KIT	Limited to 182 days/plan year
nicotine lozenge	Limited to 180 days/plan year
nicotine patch	Limited to 182 days/plan year
NICOTROL INHALER	Limited to 180 days/plan year
NICOTROL NASAL SPRAY	Limited to 180 days/plan year
NUDEXTA CAP	QL= 2 caps/day
OCALIVA TAB	QL= 1 tab/day; Only available through Walgreens 888-347-3416
ODEFSEY TAB	QL= 1 tab/day
ODOMZO CAP	QL= 1 cap/day
OFEV CAP	QL= 2 caps/day
OMNARIS NASAL SPRAY	QL= 2 bottles/fill; Step Therapy requires trial of 2: flunisolide, fluticasone, triamcinolon or NASONEX
OPSUMIT TAB	QL= 1 tab/day; Only available through Walgreens 888-347-3416
ORENCIA CLICK INJ	QL= 4 inj/28 days
ORENCIA SC INJ 125MG/ML	QL= 4 inj/28 days
ORENCIA SC INJ 50MG/0.4ML	QL= 4 inj/28 days
ORENCIA SC INJ 87.5MG/0.7ML	QL= 4 inj/28 days
ORKAMBI TAB	QL= 4 tabs/day
oseltamivir cap	QL= 10 caps/fill
oseltamivir cap 30mg	QL= 20 caps/fill
OVIDE LOTION	QL= 2 bottles/fill
PATADAY OPHTH SOLN	QL= 2.5ml/30 days
peg 3350/electrolytes soln	Covered at \$0 for members 50-75 years-Limited to 2 fills/calendar year; All other members covered at generic copay
phentermine cap	QL= 1 cap/day
phentermine tab	QL= 1 tab/day
PICATO GEL	QL= 1 box/fill
POTIGA TAB	QL= 3 tabs/day
POTIGA TAB 50MG	QL= 9 tabs/day
PRALUENT INJ	QL= 2 inj/28 days
PROVIGIL TAB	QL= 2 tabs/day
QNASL NASAL SPRAY	QL= 2 bottles/fill; Step Therapy requires trial of 2: flunisolide, fluticasone, triamcinolon or NASONEX
QSYMIA CAP	QL= 1 cap/day

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary Cont.
Last Updated* 11/1/2017
Quantity Limit (QL)

• The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
REGRANEX GEL	QL= 30gm/fill
RELENZA DISKHALER	QL= 1 inhaler/fill
REPATHA INJ	QL= 2 inj/28 days
REPATHA PUSHTRONEX INJ	QL= 1 inj/28 days
REVLIMID CAP	QL= 1 cap/day
RHINOCORT AQUA NASAL SPRAY	QL= 2 bottles/fill; Step Therapy requires trial of 2: flunisolide, fluticasone, triamcinolon or NASONEX
rizatriptan ODT	QL= 12 tabs/fill, 3 fills/60 days
rizatriptan tab	QL= 12 tabs/fill, 3 fills/60 days
rosuvastatin tab 10mg	QL= 1 tab/day
rosuvastatin tab 20mg	QL= 1.5 tabs/day
rosuvastatin tab 40mg	QL= 1 tab/day
rosuvastatin tab 5mg	QL= 1 tab/day
ROZEREM TAB	QL= 1 tab/day
RUBRACA TAB	QL= 4 tabs/day; Only available through Avella Pharmacy (877) 546-5779
SANCUSO PATCH	QL= 4 patches/fill
SANTYL OINT	QL= 90gm/30 days
SAPHRIS SL TAB	QL= 2 tabs/day
SAVELLA TAB	QL= 2 tabs/day
SIGNIFOR INJ	QL= 2 vials/day; Only available through Accredo 888-773-7376
SIMPONI SC INJ	QL= 1 inj/28 days
SIVEXTRO TAB	QL= 6 tabs/fill; Restricted to Infectious Disease Specialist
SKLICE LOTION	QL= 1 tube/fill
SPINOSAD SUSP	QL= 1 bottle/fill
STAXYN ODT	QL= 6 tabs/30 days
STENDRA TAB	QL= 6 tabs/30 days
STIVARGA TAB	QL= 4 tabs/day
STRIVERDI RESPIMAT INHALER	QL= 1 inhaler/30 days
sumatriptan inj	QL= 4 inj/fill, 2 fills/30 days
SUMATRIPTAN INJ 6MG/0.5ML	QL= 4 inj/fill, 2 fills/30 days
sumatriptan nasal spray	QL= 6 sprays/fill, 2 fills/30 days
sumatriptan tab	QL= 9 tabs/fill, 2 fills/30 days
sumatriptan vial inj	QL= 5 inj/fill, 2 fills/30 days
SYNJARDY TAB	QL= 2 tabs/day
SYNJARDY XR TAB 10-1000MG, 25-1000MG	QL= 1 tab/day
SYNJARDY XR TAB 5-1000MG, 12.5-1000MG	QL= 2 tabs/day
TAFINLAR CAP	QL= 4 caps/day
TAGRISSO TAB	QL= 1 tab/day; Only available through Diplomat Pharmacy 877-977-9118
TAMIFLU CAP	QL= 10 caps/fill
TAMIFLU CAP 30MG	QL= 20 caps/fill
TAMIFLU SUSP 6MG/ML	QL= 250ml/fill

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary Cont.
Last Updated* 11/1/2017
Quantity Limit (QL)**

• The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
TESTOSTERONE GEL 1% 25MG	QL= 1 packet/day
testosterone gel 1% 50mg	QL= 2 packets/day
testosterone gel 1% pump	QL= 4 bottles/30 days
TESTOSTERONE GEL PUMP	QL= 4 bottles/30 days
TESTOSTERONE GEL, VOGELXO GEL	QL= 2 packets/day
testosterone soln	QL= 2 bottles/30 days
TIVICAY TAB	QL= 2 tabs/day
TRACLEER TAB	QL= 2 tabs/day; Only available through Walgreens 888-347-3416
TRADJENTA TAB	QL= 1 tab/day
TRAVATAN Z OPHTH SOLN	QL= 5ml/30 days
triamcinolone nasal spray	QL= 2 bottles/fill
triamcinolone OTC nasal spray	QL= 2 bottles/fill
trilyte soln	Covered at \$0 for members 50-75 years, all other members covered at generic copay Limited to 2 fills/calendar year
TRINTELLIX TAB	QL= 1 tab/day
TUSSICAPS	QL= 20 caps/fill, 2 fills/30 days
TUSSIONEX SUSP	QL= 120ml/fill; 2 fills/30 days
TUSSI-ORGANI SYRUP	QL= 240ml/fill
TYVASO INH SOLN	QL= 1 ampule/day; Only available through Accredo 888-773-7376
UCERIS TAB	QL= 1 tab/day
ULESFIA LOTION	QL= 4 bottles/fill
UPTRAVI TAB	QL= 2 tabs/day; Only available through Accredo 888-773-7376
VAGIFEM TAB	QL= 8 tabs/28 days (18 tabs on first fill)
VALCHLOR GEL	QL= 4 tubes/30 days; Only available through Accredo 888-773-7376
VANCOGIN CAP	QL= 56 caps/fill; Step Therapy requires trial of vancomycin soln
vancomycin cap	QL= 56 caps/fill; Step Therapy requires trial of vancomycin soln
VARUBI TAB	QL= 2 tabs/day; Restricted to Oncology or Hematology Specialist
VENTAVIS INH SOLN	QL= 9 ampules/day; Only available through Accredo 888-773-7376
VENTOLIN HFA INHALER	QL= 2 inhalers/30 days
VERAMYST NASAL SPRAY	QL= 2 bottles/fill; Step Therapy requires trial of 2: flunisolide, fluticasone, triamcinolon or NASONEX
V-GO INJ KIT	QL= 1 kit/day
VIAGRA TAB	QL= 6 tabs/30 days
VICTOZA INJ	QL= 9ml/30 days
VIMPAT TAB	QL= 2 tabs/day
VIVOTIF CAP	QL= 4 caps/fill
VOLTAREN GEL	QL= 5 tubes/fill
VYTORIN TAB	QL= 1 tab/day (10/80mg is Not Covered)
XALATAN OPHTH SOLN	QL= 2.5ml/30 days
XELJANZ TAB	QL= 2 tabs/day
XELJANZ XR TAB	QL= 1 tab/day
XIFAXAN TAB 200MG	QL= 9 tabs/3 days
XIFAXAN TAB 550MG	QL= 2 tabs/day; Quantities up to 3 tabs/day for the treatment of IBS-D allowed via PA

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary Cont.
Last Updated* 11/1/2017
Quantity Limit (QL)**

- The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
XTAMPZA ER CAP	QL= 120 tabs/30 days
XTANDI CAP	QL= 4 caps/day
XYREM SOLN	QL= 540ml/30 days; Only available through Xyrem Central Pharmacy 866-997-3688
ZEPATIER TAB	QL= 1 tab/day
ZETONNA NASAL SPRAY	QL= 2 bottles/fill; Step Therapy requires trial of 2: flunisolide, fluticasone, triamcinolon or NASONEX
ZIOPTAN OPHTH SOLN	QL= 1 bottle/day; Step Therapy requires trial of latanoprost
zolmitriptan ODT	QL= 9 tabs/fill, 2 fills/30 days
zolmitriptan tab	QL= 9 tabs/fill, 2 fills/30 days
zolpidem tab	QL= 1 tab/day
ZOMIG NASAL SPRAY	QL= 6 sprays/fill, 2 fills/30 days
ZOMIG TAB	QL= 9 tabs/fill, 2 fills/30 days
ZOMIG ZMT	QL= 9 tabs/fill, 2 fills/30 days
ZUTRIPRO LIQUID	QL= 120ml/fill, 2 fills/30 days
ZYBAN TAB	Limited to 180 days/plan year
ZYLET OPHTH SUSP	QL= 5ml/fill (10ml bottle is Not Covered)
ZYTIGA TAB 250MG	QL= 4 tabs/day
ZYTIGA TAB 500MG	QL= 2 tabs/day

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.