



EOCCO Pharmacy Formulary

Effective 4/1/2025

Medications that are new to the market are not included within your pharmacy benefit until reviewed by the Pharmacy and Therapeutics Committee. Please contact Moda Health Customer Service if you are taking a medication that is new to the market. Please note that this list is subject to change at any time.

Questions?

Call Pharmacy Customer Service at 888-474-8539.

How to read your pharmacy formulary

Refer to the chart below for a list of prescription medications covered by Moda Health. Medications that are new to the market are subject to a review period. Please contact us if you are taking a medication that is new to the market.

Medication Tier Key		Medication Restrictions Key	
Capital letters	Brand name medications	SMKG	Smoking Cessation – Smoking cessation medications are in the preventive tier and covered at no cost to you. Certain restrictions may apply.
Small letters	Generic medications	VAC	Vaccine Program – Certain immunizations and related administration fees are covered at no cost to you if received at in-network retail pharmacies.
Tier 1	Generic Retail	AMSP	Ardon Mandatory Specialty Pharmacy Program – You must access these specialty medications through the exclusive Ardon Health Specialty pharmacy. All specialty medications require a prior authorization before they can be dispensed. To enroll with Ardon Health Specialty Pharmacy, call toll-free at 855-425-4085.
Tier 2	Brand Retail	LMSP	Lumicera Mandatory Specialty Pharmacy Program – You must access these specialty medications through the exclusive Lumicera Specialty pharmacy. All

			specialty medications require a prior authorization before they can be dispensed. To enroll with Lumicera Specialty Pharmacy, call toll-free at 855-847-3553.
Tier 3	Generic Specialty	LD	Limited Distribution – You must access these specialty medications through the exclusive specialty pharmacy indicated. All specialty medications require a prior authorization before they can be dispensed.
Tier 4	Brand Specialty	ST	Step therapy – You must try one or more “first line” medications before you can get this step therapy medication.
OTC	Over-the-Counter – Medications may be purchased without a professional provider’s prescription. Moda Health follows the federal designation of OTC medications to decide if an OTC medication is covered	PA	Prior authorization required – Your healthcare provider must work directly with Moda Health to obtain approval before we can process payment for a specific medication.
		QL	Quantity limits – Some medications have limits to how much you can get per prescription or refill.

Bold Italic = Brand name; Regular Font = Generic;

SP = Specialty medications; **PA** = Prior authorization required; **ST** = Step therapy required; **QL** = Quantity limits; **A** = Age limits

2022.3 (4/1/2025).

For prior effective dates, please contact EOCCO.com

This document is provided for informational purposes only and is intended as a quick reference. For cost and further details of the coverage, including exclusions, prior authorization requirements, any reduction or limitations and the terms under which the policy may be continued in force, contact your producer or Moda Health.

Bold Italic = Brand name; Regular Font = Generic;

SP = Specialty medications; **PA** = Prior authorization required; **ST** = Step therapy required; **QL** = Quantity limits; **A** = Age limits

2022.3 (4/1/2025).

For prior effective dates, please contact EOCCO.com

Search Tip:

This is a large document, but you can search quickly and easily by clicking on the binocular icon on your toolbar or using the CTRL+F search function from your keyboard. 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.

EOCCO Formulary
Alphabetical Index
Last Updated 4/1/2025

Drug Name	Special Code	Tier Category	
abacavir soln (ZIAGEN equiv) (QL= 960ml/30 days)	QL	1	ANTIVIRALS
abacavir tab (ZIAGEN equiv) (QL= 2 tabs/day)	QL	1	ANTIVIRALS
abacavir/lamivudine tab (EPZICOM equiv) (QL= 1 tab/day)	QL	1	ANTIVIRALS
abacavir/lamivudine/zidovudine tab (TRIZIVIR equiv) (QL= 2 tabs/day)	QL	1	ANTIVIRALS
abaneu sl tab	-	1	HEMATOPOIETIC AGENTS
abiraterone acetate tab 500mg (ZYTIGA equiv) (QL: 2 tabs/day)	AMSP-PA-QL	3	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
abiraterone tab 250mg (ZYTIGA equiv)	AMSP	3	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ABRYSVO INJ (QL= 1 inj/day, 1 fill/lifetime, Covered for ages over 60 and weeks 32-36 of pregnancy)	QL-VAC	2	VACCINES
ACAM2000 INJ	-	2	VACCINES
acarbose tab (PRECOSE equiv) (QL=3 tabs/day)	QL	1	ANTIDIABETICS

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
ACCU-CHEK TENDER	-	1	MEDICAL DEVICES AND SUPPLIES
acebutolol cap (SECTRAL equiv)	-	1	BETA BLOCKERS
acetaminophen chew tab 80mg	OTC	1	ANALGESICS - NONNARCOTIC
acetaminophen elixir	OTC	1	ANALGESICS - NONNARCOTIC
acetaminophen er tab	OTC	1	ANALGESICS - NONNARCOTIC
acetaminophen soln	OTC	1	ANALGESICS - NONNARCOTIC
acetaminophen susp	OTC	1	ANALGESICS - NONNARCOTIC
acetaminophen tab	OTC	1	ANALGESICS - NONNARCOTIC
acetaminophen/codeine tab (TYLENOL/CODEINE equiv) (QL= 12 tabs/day)	QL	1	ANALGESICS - OPIOID
acetaminophen/codeine tab 300mg/60mg (TYLENOL/CODEINE equiv) (QL= 6 tabs/day)	QL	1	ANALGESICS - OPIOID
ACETAMINOPHEN/ISOMETHEPTENE/DICHLORAL CAP	-	3	MIGRAINE PRODUCTS
acetazolamide ER cap (DIAMOX SEQUEL equiv)	-	1	DIURETICS
acetazolamide tab	-	1	DIURETICS

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
acetic acid otic soln (VOSOL equiv)	-	1	OTIC AGENTS
acetylcysteine soln (MUCOMYST equiv)	-	1	COUGH / COLD / ALLERGY
ACIPHEX SPRINKLE CAP	-	2	ULCER DRUGS
ACIPHEX SPRINKLE CAP (QL= 1 cap/day)	QL	2	ULCER DRUGS / ANTISPASMODICS / ANTICHOLINERGICS
ACNOMEL CREAM (QL= 360g/30 days)	OTC-QL	2	DERMATOLOGICALS
ACTHIB INJ	-	2	VACCINES
ACTIMMUNE INJ (Only available through Accredo 877-826-7657 or Walgreens 888-347-3416)	LD-PA	4	ANTINEOPLASTICS
ACTIVE FE TAB	-	2	HEMATOPOIETIC AGENTS
ACUVAIL OPHTH SOLN	-	2	OPHTHALMIC AGENTS
acyclovir cap (ZOVIRAX equiv)	-	1	ANTIVIRALS
acyclovir oint (ZOVIRAX OINT equiv)	-	1	DERMATOLOGICALS
acyclovir susp (ZOVIRAX equiv)	-	1	ANTIVIRALS
acyclovir tab (ZOVIRAX equiv)	-	1	ANTIVIRALS
ADACEL/BOOSTRIX INJ	VAC	2	TOXOIDS
ADALIMU-ADAZ INJ 80/0.8ML (QL=2 inj/28days)	AMSP-QL	4	ANALGESICS - ANTI-INFLAMMATORY
ADALIMUMAB-ADAZ INJ (QL= 2 syringes/28 days)	AMSP-PA-QL	4	ANALGESICS - ANTI-INFLAMMATORY

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
ADALIMUMAB-ADAZ PEN INJ (QL=2 pens/28 days)	AMSP-PA-QL	4	ANALGESICS - ANTI-INFLAMMATORY
adapalene cream (DIFFERIN equiv) (Step Therapy requires trial of adapalene gel, followed by tretinoin cream 0.025%.)	ST	1	DERMATOLOGICALS
adapalene gel (DIFFERIN equiv) (QL= 360g/30 days)	QL	1	DERMATOLOGICALS
ADAPALENE SOLN (QL= 360 mL/30 days; Step therapy requires adapalene gel)	QL-ST	1	DERMATOLOGICALS
ADC/FLUORIDE DROP	-	1	MULTIVITAMINS
adefovir dipivoxil tab (HEPSERA equiv) (QL= 1 tab/day)	AMSP	3	ANTIVIRALS
ADMELOG INJ (QL= 60ml/30 days)	QL	2	ANTIDIABETICS
ADMELOG SOLOSTAR INJ (QL= 60ml/30 days)	QL	2	ANTIDIABETICS
ADVATE INJ 1000UNIT	AMSP-PA	4	HEMATOLOGICAL AGENTS - MISC.
ADVATE INJ 1500UNIT	AMSP-PA	4	HEMATOLOGICAL AGENTS - MISC.
ADVATE INJ 2000UNIT	AMSP-PA	4	HEMATOLOGICAL AGENTS - MISC.
ADVATE INJ 250UNIT	AMSP-PA	4	HEMATOLOGICAL AGENTS - MISC.

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
ADVATE INJ 3000UNIT	AMSP-PA	4	HEMATOLOGICAL AGENTS - MISC.
ADVATE INJ 4000UNIT	AMSP-PA	4	HEMATOLOGICAL AGENTS - MISC.
ADVATE INJ 500UNIT	AMSP-PA	4	HEMATOLOGICAL AGENTS - MISC.
AEMCOLO TAB	-	2	ANTI-INFECTIVE AGENTS MISC.
AEROCHAMBER (QL= 1 device/365 days)	OTC-QL	2	MEDICAL DEVICES AND SUPPLIES
AFLURIA INJ (QL = 0.5mL/fill)	QL-VAC	2	VACCINES
AFLURIA INJ, FLUZONE INJ	VAC	2	VACCINES
AFREZZA INH POWDER	--PA	2	ANTIDIABETICS
AJOVY INJ (QL= 1 inj/28 days)	PA-QL	2	MIGRAINE PRODUCTS
AKTEN OPTH GEL	-	2	OPHTHALMIC AGENTS
AKYNZEO CAP (Step Therapy requires trial of aprepitant, granisetron, or ondansetron)	ST	2	ANTIEMETICS
albendazole tab (ALBENZA equiv)	-	1	ANTHELMINTICS
ALBUTEROL HFA INHALER (QL= 2 inhalers/30 days)	QL	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
albuterol HFA inhaler (PROAIR equiv)	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
albuterol HFA inhaler (PROVENTIL equiv) (QL= 2 inhalers/30 days)	QL	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ALBUTEROL NEB SOLN	-	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	-	1	OPHTHALMIC AGENTS
alclometasone cream (ACLOVATE equiv)	-	1	DERMATOLOGICALS

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
ALCLOMETASONE OINT	-	1	DERMATOLOGICALS
alclometasone oint (ACLOVATE OINT equiv)	-	1	DERMATOLOGICALS
ALCORTIN A GEL	-	2	DERMATOLOGICALS
ALDACTAZIDE TAB 50-50MG	-	2	DIURETICS
ALECENSA CAP (QL=8 caps/day)	AMSP-PA-QL	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
alendronate sodium oral soln (FOSAMAX equiv) (QL=300 ml/28 days)	QL	1	ENDOCRINE AND METABOLIC AGENTS - MISC.
alendronate tab (FOSAMAX equiv)	-	1	ENDOCRINE AND METABOLIC AGENTS - MISC.
ALENDRONATE TAB 40MG	-	2	ENDOCRINE AND METABOLIC AGENTS - MISC.
alfuzosin SR tab (UROXATRAL equiv)	-	1	GENITOURINARY AGENTS - MISCELLANEOUS
ALKINDI SPRINKLE CAP	PA	4	CORTICOSTEROIDS
allopurinol tab (ZYLOPRIM equiv)	-	1	GOUT AGENTS
ALOCRILOPHTH SOLN	-	2	OPHTHALMIC AGENTS
ALOGLIPTIN TAB (QL = 1 tab/day)	QL	2	ANTIDIABETICS
ALOGLIPTIN/METFORMIN TAB (QL = 1 tab/day)	QL	2	ANTIDIABETICS
ALOGLIPTIN/PIOGLITAZONE TAB (QL = 1 tab/day)	QL	2	ANTIDIABETICS

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
ALOMIDE OPTH SOLN	-	2	OPHTHALMIC AGENTS
ALOQUIN GEL	-	2	DERMATOLOGICALS
alosetron tab (LOTIRONEX equiv)	-	1	GASTROINTESTINAL AGENTS - MISC.
ALPROLIX INJ (Only available through Accredo 800-803-2523)	LD-PA	4	HEMATOLOGICAL AGENTS - MISC.
ALTABAX OINT	-	2	DERMATOLOGICALS
altafluor benox ophth soln	-	1	OPHTHALMIC AGENTS
ALTOPREV TAB	-	2	ANTIHYPERLIPIDEMICS
amantadine cap (SYMMETREL equiv)	-	1	ANTIPARKINSON AGENTS
amantadine syrup (SYMMETREL equiv)	-	1	ANTIPARKINSON AGENTS
amantadine tab	-	1	ANTIPARKINSON AGENTS
ambrisentan tab (LETAIRIS equiv) (Only available through Ardon 855-425-4085)	AMSP-PA	3	CARDIOVASCULAR AGENTS - MISC.
AMCINONIDE CREAM 0.1%	-	1	DERMATOLOGICALS
AMCINONIDE LOTION	-	1	DERMATOLOGICALS
amethyst tab (LYBREL equiv)	-	1	CONTRACEPTIVES
amiloride tab (MIDAMOR equiv)	-	1	DIURETICS
AMILORIDE/HYDROCHLOROTHIAZIDE TAB	-	1	DIURETICS
amiloride/hydrochlorothiazide tab (MODURETIC equiv)	-	1	DIURETICS
aminocaproic acid soln (AMICAR equiv)	-	1	HEMOSTATICS

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier Category
amiodarone tab (CORDARONE equiv)	-	1 ANTIARRHYTHMICS
amlodipine tab (NORVASC equiv)	-	1 CALCIUM CHANNEL BLOCKERS
amlodipine/benazepril cap (LOTREL equiv)	-	1 ANTIHYPERTENSIVES
amlodipine/olmesartan tab (AZOR TAB equiv)	-	1 ANTIHYPERTENSIVES
amlodipine/valsartan tab (EXFORGE equiv)	-	1 ANTIHYPERTENSIVES
ammonium lactate cream (LAC-HYDRIN equiv)	OTC	1 DERMATOLOGICALS
amnesteam cap, claravis cap, isotretinoin cap, myorisan cap, zenatane cap (AC CUTANE equiv)	-	1 DERMATOLOGICALS
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	-	1 PENICILLINS
amoxicillin/clavulanate chew tab (AUGMENTIN equiv)	-	1 PENICILLINS
AMOXICILLIN/CLAVULANATE ER TAB	-	1 PENICILLINS
amoxicillin/clavulanate susp (AUGMENTIN ES equiv)	-	1 PENICILLINS
amoxicillin/clavulanate tab (AUGMENTIN equiv)	-	1 PENICILLINS

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
amphetamine/dextroamphetamine ER cap (ADDERALL XR equiv) (QL=2 caps/day)	QL	1	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
amphetamine/dextroamphetamine tab 10mg (QL=180 tabs/30 days)	QL	1	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
amphetamine/dextroamphetamine tab 12.5mg (QL=150 tabs/30 days)	QL	1	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
amphetamine/dextroamphetamine tab 15mg (QL=120 tabs/30 days)	QL	1	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
amphetamine/dextroamphetamine tab 20mg (QL=90 tabs/30 days)	QL	1	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier Category
amphetamine/dextroamphetamine tab 30mg (QL=60 tabs/30 days)	QL	1 ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
amphetamine/dextroamphetamine tab 5mg (QL=360 tabs/30 days)	QL	1 ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
amphetamine/dextroamphetamine tab 7.5mg (QL=240 tabs/30 days)	QL	1 ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
ampicillin cap (PRINCIPEN equiv)	-	1 PENICILLINS
ampicillin susp	-	1 PENICILLINS
anagrelide cap (AGRYLIN equiv)	-	1 HEMATOLOGICAL AGENTS - MISC.
ANALPRAM HC LOTION	-	2 ANORECTAL AGENTS
ANALPRAM-E KIT	-	2 ANORECTAL AGENTS
ANASTIA LOTION	-	2 DERMATOLOGICALS
anastrozole tab (ARIMIDEX equiv)	-	1 ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ANGELIQ TAB	-	2 ESTROGENS
ANIMI-3 CAP	-	2 HEMATOPOIETIC AGENTS

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
ANNOVERA RING (QL=1 ring/273 days)	QL	2	CONTRACEPTIVES
ANORO ELLIPTA INHALER (QL= 1 inhaler/30 days)	QL	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
antacid chew tab	OTC	1	ANTACIDS
antacid susp	OTC	1	ANTACIDS
ANTICOAGULANT SODIUM CITRATE INJ	-	1	ANTICOAGULANTS
ANTIPYRINE/BENZOCAINE OTIC SOLN 1.4-5.5%	-	2	OTIC AGENTS
APAP/CODEINE SOLN (QL=990ml/30 days)	QL	1	ANALGESICS - OPIOID
APEXICON E CREAM (PSORCON E equiv)	-	2	DERMATOLOGICALS
APLIGRAF DISK	-	2	DERMATOLOGICALS
apomorphine inj (QL= 54ml/30 days; Only available through Caremark/CVS Specialty 800-237-2767)	LD-QL	3	ANTIPARKINSON AND RELATED THERAPY AGENTS
aprepitant cap 125mg (EMEND equiv) (QL= 1 cap/21 days)	QL	1	ANTIEMETICS
aprepitant cap 40mg (EMEND equiv) (QL= 1 cap/28 days)	QL	1	ANTIEMETICS
APTOM TAB (QL= 60 tabs/30 days)	QL	2	ANTICONVULSANTS
APTIVUS CAP	-	2	ANTIVIRALS
APTIVUS SOLN	-	2	ANTIVIRALS
ARANESP INJ (QL=4 syringes/30 days)	AMSP-PA-QL	4	HEMATOPOIETIC AGENTS

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
ARANESP INJ (QL=4 vials/30 days)	AMSP-PA-QL	4	HEMATOPOIETIC AGENTS
ARCAPTA NEOHALER	-	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
AREXVY INJ (QL= 1 inj/day, 1 fill/lifetime, Covered for members 60 years of age and older)	QL-VAC	2	VACCINES
artificial tear drops	OTC	1	OPHTHALMIC AGENTS
artificial tears	OTC	1	OPHTHALMIC AGENTS
artificial tears soln	-	1	OPHTHALMIC AGENTS
ARTISS INJ	-	2	HEMOSTATICS
ashlyna tab, daysee tab (SEASONALE, SEASONIQUE equiv)	-	1	CONTRACEPTIVES
ASMANEX HFA INHALER (QL= 1 inhaler/30 days)	QL	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ASMANEX INHALER (QL= 1 inhaler/30 days)	QL	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
aspirin chew tab 81mg (Covered for males age 45-79; Covered for females (no age restriction))	OTC	1	ANALGESICS - NONNARCOTIC
aspirin ec tab 325mg (Covered for males age 45-79 and females age 55-79)	OTC	1	ANALGESICS - NONNARCOTIC

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
aspirin ec tab 81mg (Covered for males age 45-79; Covered for females (no age restriction))	OTC	1	ANALGESICS - NONNARCOTIC
aspirin tab 325mg (Covered for males age 45-79 and females age 55-79)	OTC	1	ANALGESICS - NONNARCOTIC
ASPRUZYO SPRINKLE GRANULES (QL= 2 packets/day; Step Therpay requires trial of ranolazine ER tab)	QL-ST	2	ANTIANGINAL AGENTS
ASTAGRAF XL CAP	-	2	MISCELLANEOUS THERAPEUTIC CLASSES
ASTRINGYN SOLN	-	2	HEMOSTATICS
atazanavir cap 150mg (REYATAZ equiv) (QL= 2 caps/day)	QL	1	ANTIVIRALS
atazanavir cap 200mg (REYATAZ equiv) (QL= 2 caps/day)	QL	1	ANTIVIRALS
atazanavir cap 300mg (REYATAZ equiv) (QL= 1 cap/day)	QL	1	ANTIVIRALS
atenolol tab (TENORMIN equiv)	-	1	BETA BLOCKERS
atenolol/chlorthalidone tab (TENORETIC equiv)	-	1	ANTIHYPERTENSIVES
atorvastatin tab (LIPITOR equiv) (QL= 1 tab/day)	QL	1	ANTIHYPERLIPIDEMICS
atorvastatin tab 10mg (QL= 60 tabs/30 days)	QL	1	ANTIHYPERLIPIDEMICS
atorvastatin tab 20mg (QL= 60 tabs/30 days)	QL	1	ANTIHYPERLIPIDEMICS
atorvastatin tab 40mg (QL= 60 tabs/30 days)	QL	1	ANTIHYPERLIPIDEMICS

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
atovaquone susp (MEPRON equiv)	-	1	ANTI-INFECTIVE AGENTS MISC.
atovaquone/proguanil tab (MALARONE equiv)	-	1	ANTIMALARIALS
atropine ophth oint	-	1	OPHTHALMIC AGENTS
ATROPINE OPTH SOLN	-	1	OPHTHALMIC AGENTS
atropine ophth soln (ISOPTO ATROPINE equiv) (QL=1 bottle/30 days)	QL	1	OPHTHALMIC AGENTS
ATROVENT HFA INHALER (QL = 2 inhalers (25.8g)/30 days)	QL	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
AUVI-Q INJ (QL=2 inj/fill)	QL	2	VASOPRESSORS
AUVI-Q INJ 0.15MG (QL=2 inj/30 days)	QL	2	VASOPRESSORS
AVANDIA TAB	-	2	ANTIDIABETICS
AVIDOXY DK KIT	-	2	TETRACYCLINES
AVITENE POWDER	-	2	HEMOSTATICS
AVITENE SHEET	-	2	HEMOSTATICS
AVONEX INJ (QL=1 inj/28 days)	AMSP-QL	4	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
AZASITE SOLN	-	2	OPHTHALMIC AGENTS
azathioprine tab (IMURAN equiv)	-	1	ASSORTED CLASSES

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
azelaic acid gel (FINACEA equiv) (QL= 360 g/30 days; Step therapy requires adapalene gel OR topical clindamycin)	QL-ST	1	DERMATOLOGICALS
azelastine ophth soln (OPTIVAR equiv)	-	1	OPHTHALMIC AGENTS
azithromycin susp (ZITHROMAX equiv)	-	1	MACROLIDES
azithromycin tab (ZITHROMAX equiv)	-	1	MACROLIDES
B-12 DOTS TAB	OTC	1	HEMATOPOIETIC AGENTS
bacitracin oint	OTC	1	DERMATOLOGICALS
BACITRACIN OPHTH OINT	-	1	OPHTHALMIC AGENTS
bacitracin zinc oint	OTC	1	DERMATOLOGICALS
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 tab (BACLOFEN equiv)	-	1	MUSCULOSKELETAL THERAPY AGENTS
BACLOFEN TAB 5MG	-	1	MUSCULOSKELETAL THERAPY AGENTS
balsalazide cap (COLAZAL equiv)	-	1	GASTROINTESTINAL AGENTS - MISC.
BAQSIMI NASAL POWDER	-	2	ANTIDIABETICS

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
BARACLUDE SOLN	AMSP	4	ANTIVIRALS
BAXDELA TAB (QL= 28 tabs/14 day)	QL	2	FLUOROQUINOLONES
BCG VACCINE INJ	-	2	VACCINES
BD INSULIN SYRINGES	--OTC	2	MEDICAL DEVICES AND SUPPLIES
BD PEN NEEDLES	OTC	2	MEDICAL DEVICES AND SUPPLIES
b-donna tab (DONNATAL equiv) (QL= 8 tabs/day)	QL	1	ULCER DRUGS
BECONASE AQ NASAL SPRAY (QL= 1 bottle/15 days; 2 fills/month)	QL	2	NASAL AGENTS - SYSTEMIC AND TOPICAL
BELLADONNA ALKALOID/OPIUM SUPP	-	1	ULCER DRUGS
benazepril tab (LOTENSIN equiv)	-	1	ANTIHYPERTENSIVES
benazepril/hydrochlorothiazide tab (LOTENSIN HCT equiv)	-	1	ANTIHYPERTENSIVES
BENEFIX KIT	AMSP-PA	4	HEMATOLOGICAL AGENTS - MISC.
BENSAL HP OINT	-	2	DERMATOLOGICALS
BENZAC WASH (QL= 360g/30 days)	QL	2	DERMATOLOGICALS
BENZHYDROCODONE-ACETAMINOPHEN TAB (QL= 12 tabs/day)	QL	1	ANALGESICS - OPIOID
BENZNIDAZOLE TAB (QL= 360 tabs/365 days)	QL	1	ANTHELMINTICS
BENZODOX PAK	-	2	TETRACYCLINES

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
BENZONATATE CAP (QL= 3 caps/day)	QL	1	COUGH / COLD / ALLERGY
benzonatate cap (TESSALON equiv)	-	1	COUGH / COLD / ALLERGY
benzoyl peroxide gel (QL= 360g/30 days)	OTC-QL	1	DERMATOLOGICALS
BENZOYL PEROXIDE LOTION (QL= 360g/30 days)	OTC-QL	2	DERMATOLOGICALS
BENZOYL PEROXIDE WASH (QL= 360g/30 days)	QL	2	DERMATOLOGICALS
benztropine tab	-	1	ANTIPARKINSON AGENTS
betaine powder for oral solution (QL=540 grams/30 days; Only available through Walgreens 888-347-3416)	LD-QL	3	ENDOCRINE AND METABOLIC AGENTS - MISC.
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

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
betamethasone valerate lotion	-	1	DERMATOLOGICALS
betamethasone valerate oint	-	1	DERMATOLOGICALS
betasept liquid	OTC	1	ANTISEPTICS & DISINFECTANTS
betaxolol ophth soln (BETOPTIC-S equiv)	-	1	OPHTHALMIC AGENTS
betaxolol tab (KERLONE equiv)	-	1	BETA BLOCKERS
bethanechol tab (URECHOLINE equiv)	-	1	URINARY ANTISPASMODICS
bexarotene gel	AMSP-PA	3	DERMATOLOGICALS
BEXSERO INJ	VAC	2	VACCINES
BIAFINE EMULSION	-	1	DERMATOLOGICALS
bicalutamide tab (CASODEX equiv)	-	1	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
BIFERARX TAB	-	1	HEMATOPOIETIC AGENTS
BIKTARVY TAB	-	2	ANTIVIRALS
BIKTARVY TAB 30-120-15MG (QL=1 tab/day)	QL	2	ANTIVIRALS
bimatoprost ophth soln (Step Therapy requires trial of latanoprost ophth soln; QL=2.5ml/25 days)	QL-ST	1	OPHTHALMIC AGENTS
BINOSTO TAB (QL= 4 tabs/28 days)	QL	2	ENDOCRINE AND METABOLIC AGENTS - MISC.
BIONECT CREAM	-	2	DERMATOLOGICALS

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
BIOTHRAX INJ	-	2	VACCINES
bisacodyl supp	OTC	1	LAXATIVES
bisacodyl tab	OTC	1	LAXATIVES
bismuth-metronidazole-tetracycline cap (QL=120 tabs/10 days)	QL	1	ULCER DRUGS / ANTISPASMODICS / ANTICHOLINERGICS
bisoprolol tab (ZEBETA equiv)	-	1	BETA BLOCKERS
bisoprolol/hydrochlorothiazide tab (ZIAC equiv)	-	1	ANTIHYPERTENSIVES
BLEPH-10 OPTH SOLN	-	1	OPHTHALMIC AGENTS
BLEPHAMIDE OPTH SOLN	-	2	OPHTHALMIC AGENTS
BLEPHAMIDE S.O.P. OPTH OINT	-	2	OPHTHALMIC AGENTS
BLOOD PRESSURE MONITOR	-	1	MEDICAL DEVICES AND SUPPLIES
bosentan tab (TRACLEER equiv) (Only available through Lumicera 855-847-3553)	LD-PA	3	CARDIOVASCULAR AGENTS - MISC.
BOSULIF CAP (QL=5 caps/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
BOSULIF TAB (Only available through Walgreens 888-347-3416)	LD-PA	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
BPO GEL 8%	-	1	DERMATOLOGICALS
BREYNA AER 160/4.5 (Step Therapy requires trial of fluticasone/salmeterol or wixela and Dulera.)	QL-ST	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
BREYNA AER 80/4.5 (Step Therapy requires trial of fluticasone/salmeterol or wixela and Dulera.)	QL-ST	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
brimonidine ophth soln 0.15% (ALPHAGAN P 0.15% equiv) (Step Therapy requires trial of brimonidine ophth soln 0.2%)	ST	1	OPHTHALMIC AGENTS
brimonidine ophth soln 0.2% (ALPHAGAN equiv)	-	1	OPHTHALMIC AGENTS
brinzolamide ophth susp (AZOPT equiv) (Step Therapy requires trial of dorzolamide 2% ophth soln)	ST	1	OPHTHALMIC AGENTS
BRIXADI SOLN	-	4	ANALGESICS - OPIOID
bromocriptine cap (PARLODEL equiv)	-	1	ANTIPARKINSON AGENTS
bromocriptine tab (PARLODEL equiv)	-	1	ANTIPARKINSON AGENTS
BRYHALI LOTION	-	2	DERMATOLOGICALS
budesonide ER tab (UCERIS equiv)	-	1	CORTICOSTEROIDS
budesonide inh susp (PULMICORT equiv) (QL= 120 units/30 days)	QL	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
budesonide SR cap (ENTOCORT EC equiv)	-	1	CORTICOSTEROIDS
buffered aspirin tab	OTC	1	ANALGESICS - NONNARCOTIC
BUFFERIN TAB 325MG	OTC	1	ANALGESICS - NONNARCOTIC
bumetanide tab (BUMEX equiv)	-	1	DIURETICS

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
BUNAVAIL FILM	-	2	ANALGESICS - OPIOID
buprenorphine patch (BUTRANS equiv)	-	1	ANALGESICS - OPIOID
buprenorphine SL tab (SUBUTEX equiv)	-	1	ANALGESICS - OPIOID
buprenorphine/naloxone sl film	-	1	ANALGESICS - OPIOID
buprenorphine/naloxone SL tab (SUBOXONE equiv)	-	1	ANALGESICS - OPIOID
bupropion SR tab (ZYBAN equiv)	SMKG	1	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
butalbital/acetaminophen tab (PHRENILIN equiv) (QL= 6 tabs/day)	QL	1	ANALGESICS - NONNARCOTIC
butalbital/acetaminophen/caffeine cap (FIORICET equiv) (QL=6 caps/day)	QL	1	ANALGESICS - NONNARCOTIC
butalbital/acetaminophen/caffeine soln	-	1	ANALGESICS - NONNARCOTIC
butalbital/acetaminophen/caffeine tab (FIORICET equiv)	-	1	ANALGESICS - NONNARCOTIC
butalbital/acetaminophen/caffeine/codeine cap (FIORICET/CODEINE equiv) (QL= 6 caps/day)	QL	1	ANALGESICS - OPIOID
butalbital/aspirin/caffeine cap (FIORINAL equiv)	-	1	ANALGESICS - NONNARCOTIC
BUTALBITAL/ASPIRIN/CAFFEINE TAB	-	1	ANALGESICS - NONNARCOTIC

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
butalbital/aspirin/caffeine/codeine cap (FIORINAL/CODEINE equiv)	-	1	ANALGESICS - OPIOID
butenafine cream	OTC	1	DERMATOLOGICALS
butorphanol nasal spray (QL= 1 bottle/15 days; 2 fills/30 days)	QL	1	ANALGESICS - OPIOID
cabergoline tab (DOSTINEX equiv) (QL=16 tabs/30 days)	QL	1	ENDOCRINE AND METABOLIC AGENTS - MISC.
caffeine citrate soln (CAFCIT equiv)	-	1	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
calcipotriene cream (DOVONEX CREAM equiv)	-	1	DERMATOLOGICALS
calcipotriene oint	-	1	DERMATOLOGICALS
CALCIPOTRIENE SOLN	-	1	DERMATOLOGICALS
calcipotriene soln (DOVONEX SOLN equiv)	-	1	DERMATOLOGICALS
calcitonin nasal spray (MIACALCIN equiv)	-	1	ENDOCRINE AND METABOLIC AGENTS - MISC.
calcitriol cap (ROCALTROL equiv)	-	1	ENDOCRINE AND METABOLIC AGENTS - MISC.

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
calcitriol soln (CALCITRIOL equiv)	-	1	ENDOCRINE AND METABOLIC AGENTS - MISC.
calcium acetate cap (PHOSLO equiv)	-	1	GASTROINTESTINAL AGENTS - MISC.
calcium acetate tab (ELIPHOS equiv)	-	1	GASTROINTESTINAL AGENTS - MISC.
calcium carbonate tab	OTC	1	MINERALS & ELECTROLYTES
CALCIUM CITRATE TAB 200MG	OTC	1	MINERALS & ELECTROLYTES
calcium citrate/vitamin d3 tab	OTC	1	MINERALS & ELECTROLYTES
calcium citrate/vitamin d3 tab 315mg/200unit	OTC	1	MINERALS & ELECTROLYTES
calcium/vitamin d3 tab	OTC	1	MINERALS & ELECTROLYTES
calcium/vitamin d3 tab 600mg/200unit	OTC	1	MINERALS & ELECTROLYTES
calcium/vitamin d3 tab 600mg/400unit	OTC	1	MINERALS & ELECTROLYTES
calcium/vitamin d3 tab 600mg/800unit	OTC	1	MINERALS & ELECTROLYTES

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
CALIBRATION LIQUID	OTC	1	MEDICAL DEVICES AND SUPPLIES
CALQUENCE CAP (QL=2 caps/day)	AMSP-PA-QL	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
CALQUENCE TAB (QL=2 tabs/day)	AMSP-PA-QL	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
camrese lo tab, lojaimiess tab (QL= 91 tabs/91 days)	QL	1	CONTRACEPTIVES
candesartan tab (ATACAND equiv) (Step Therapy requires trial of 2: irbesartan, irbesartan/hctz. losartan, or losartan/hctz)	ST	1	ANTIHYPERTENSIVES
candesartan/hydrochlorothiazide tab (ATACAND HCT equiv) (Step Therapy requires trial of 2: irbesartan, irbesartan/hctz. losartan, or losartan/hctz)	ST	1	ANTIHYPERTENSIVES
capecitabine tab (XELODA equiv)	AMSP	3	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
CAPEX SHAMPOO	-	2	DERMATOLOGICALS
capsaicin cream 0.025%	OTC	1	DERMATOLOGICALS
CAPTOPRIL/HYDROCHLOROTHIAZIDE TAB (Step Therapy requires trial of HCTZ/benazepril, enalapril, fosinopril, lisinopril, moexipril, or quinapril)	ST	1	ANTIHYPERTENSIVES
captopril/hydrochlorothiazide tab (CAPOZIDE equiv)	-	1	ANTIHYPERTENSIVES

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
CAPVAXIVE INJ (QL= 0.5 mL/fill; Covered for ages 19 years and older)	QL-VAC	2	VACCINES
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
carbidopa tab (LODOSYN equiv)	-	1	ANTIPARKINSON AGENTS
carbidopa/levodopa ER tab (SINEMET CR equiv)	-	1	ANTIPARKINSON AGENTS
CARBIDOPA/LEVODOPA ODT	-	1	ANTIPARKINSON AND RELATED THERAPY AGENTS
carbidopa/levodopa ODT (PARCOPA equiv)	-	1	ANTIPARKINSON AGENTS
carbidopa/levodopa tab (SINEMET equiv)	-	1	ANTIPARKINSON AGENTS
carbidopa-levodopa-entacapone tab 12.5-50-200 mg (QL= 8 tabs/day)	QL	1	ANTIPARKINSON AND RELATED THERAPY AGENTS
carbidopa-levodopa-entacapone tab 18.75-75-200 mg (QL= 8 tabs/day)	QL	1	ANTIPARKINSON AND RELATED THERAPY AGENTS
carbidopa-levodopa-entacapone tab 25-100-200 mg (QL= 8 tabs/day)	QL	1	ANTIPARKINSON AND RELATED THERAPY AGENTS

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
carbidopa-levodopa-entacapone tab 31.25-125-200 mg (QL= 8 tabs/day)	QL	1	ANTIPARKINSON AND RELATED THERAPY AGENTS
carbidopa-levodopa-entacapone tab 37.5-150-200 mg (QL= 8 tabs/day)	QL	1	ANTIPARKINSON AND RELATED THERAPY AGENTS
carbidopa-levodopa-entacapone tab 50-200-200 mg (QL= 6 tabs/day)	QL	1	ANTIPARKINSON AND RELATED THERAPY AGENTS
CARBINOXAMINE SOLN (QL=40ml/day)	QL	1	ANTIHISTAMINES
carbinoxamine soln (PALGIC equiv)	-	1	ANTIHISTAMINES
carbinoxamine tab (PALGIC equiv) (QL=240 tabs/30 days)	QL	1	ANTIHISTAMINES
CARDIOVID PLUS CAP	-	1	NUTRIENTS
CARDURA XL TAB	-	2	GENITOURINARY AGENTS - MISCELLANEOUS
carglumic acid tab (Only available through AnovoR 844-288-5007)	LD-PA	3	ENDOCRINE AND METABOLIC AGENTS - MISC.
carisoprodol tab (SOMA equiv) (Step Therapy requires trial of 2: cyclobenzaprine, tizanidine, methocarbamol, or orphenadrine ER)	ST	1	MUSCULOSKELETAL THERAPY AGENTS

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier Category
CARISOPRODOL/ASPIRIN TAB	-	1 MUSCULOSKELETAL THERAPY AGENTS
carisoprodol/aspirin tab (SOMA COMPOUND equiv)	-	1 MUSCULOSKELETAL THERAPY AGENTS
CARISOPRODOL/ASPIRIN/CODEINE TAB	-	1 MUSCULOSKELETAL THERAPY AGENTS
CARTEOLOL OPHTH SOLN	-	1 OPHTHALMIC AGENTS
carteolol ophth soln (OCUPRESS equiv)	-	1 OPHTHALMIC AGENTS
carvedilol tab (COREG equiv)	-	1 BETA BLOCKERS
CEFACLOR CAP	-	1 CEPHALOSPORINS
cefaclor cap (CECLOR equiv)	-	1 CEPHALOSPORINS
CEFACLOR ER TAB	-	1 CEPHALOSPORINS
CEFACLOR SUSP	-	1 CEPHALOSPORINS
cefaclor susp (CEFACLOR equiv)	-	1 CEPHALOSPORINS
cefadroxil cap (DURICEF equiv)	-	1 CEPHALOSPORINS
cefadroxil susp (DURICEF equiv)	-	1 CEPHALOSPORINS
CEFADROXIL TAB	-	1 CEPHALOSPORINS
cefadroxil tab (DURICEF equiv)	-	1 CEPHALOSPORINS
cefdinir cap (OMNICEF equiv)	-	1 CEPHALOSPORINS
cefdinir susp (OMNICEF equiv)	-	1 CEPHALOSPORINS
CEFDITOREN TAB	-	1 CEPHALOSPORINS
cefixime cap (SUPRAX equiv)	-	1 CEPHALOSPORINS

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
cefixime susp (SUPRAX equiv)	-	1	CEPHALOSPORINS
CEFPODOXIME PROXETIL SUSP	-	1	CEPHALOSPORINS
cefpodoxime proxetil tab (VANTIN equiv)	-	1	CEPHALOSPORINS
cefprozil susp (CEFZIL equiv)	-	1	CEPHALOSPORINS
cefprozil tab (CEFZIL equiv)	-	1	CEPHALOSPORINS
cefuroxime susp (CEFTIN equiv)	-	1	CEPHALOSPORINS
cefuroxime tab (CEFTIN equiv)	-	1	CEPHALOSPORINS
celecoxib cap (CELEBREX equiv) (QL= 2 caps/day)	QL	1	ANALGESICS - ANTI-INFLAMMATORY
celecoxib cap 400mg (QL= 2 caps/day; Step therapy requires trial of celecoxib 50mg, celecoxib 100mg, OR celecoxib 200mg.)	QL-ST	1	ANALGESICS - ANTI-INFLAMMATORY
CENTANY AT KIT	-	2	DERMATOLOGICALS
CENTRATEX CAP	-	2	HEMATOPOIETIC AGENTS
cephalexin cap (KEFLEX equiv)	-	1	CEPHALOSPORINS
cephalexin susp (KEFLEX equiv)	-	1	CEPHALOSPORINS
cephalexin tab	-	1	CEPHALOSPORINS
CERDELGA CAP (QL= 1 cap/day; Only available through Accredo 877-826-7657)	LD-PA-QL	4	HEMATOPOIETIC AGENTS
CERVARIX INJ	VAC	2	VACCINES
CERVIDIL INSERTS	-	2	OXYTOCICS
CESAMET CAP (QL= 1 cap/day)	QL	2	ANTIEMETICS

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
CETACAIN ANESTHETIC LIQUID	-	2	DERMATOLOGICALS
CETACAIN SPRAY	-	2	DERMATOLOGICALS
cetirizine chew tab (ZYRTEC equiv) (QL=1 tab/day)	OTC-QL	1	ANTIHISTAMINES
cetirizine hcl orally disintegrating tab (QL = 1 tab/day)	OTC-QL	1	ANTIHISTAMINES
cetirizine syrup (ZYRTEC equiv)	OTC	1	ANTIHISTAMINES
cetirizine tab (ZYRTEC equiv)	OTC	1	ANTIHISTAMINES
cevimeline cap (EVOXAC equiv)	-	1	MOUTH / THROAT / DENTAL AGENTS
CHANTIX PAK (Limited to 180 days/plan year)	QL-SMKG	2	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
CHANTIX TAB	SMKG	2	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
CHEMET CAP	-	2	ANTIDOTES
chlordiazepoxide/clidinium cap (LIBRAX equiv)	-	1	ULCER DRUGS
chlorhexidine gluconate soln (PERIDEX equiv)	-	1	MOUTH / THROAT / DENTAL AGENTS
chloroquine tab (ARALEN equiv)	-	1	ANTIMALARIALS
CHLOROTHIAZIDE TAB	-	1	DIURETICS
chlorothiazide tab (DIURIL equiv)	-	1	DIURETICS

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
chlorpheniramine ER cap	-	1	ANTIHISTAMINES
chlorpheniramine tab	OTC	1	ANTIHISTAMINES
chlorthalidone tab	-	1	DIURETICS
chlorzoxazone tab 250mg (QL=4 tabs/day)	QL	1	MUSCULOSKELETAL THERAPY AGENTS
chlorzoxazone tab 500mg	-	1	MUSCULOSKELETAL THERAPY AGENTS
cholestyramine lite powder (QUESTRAN LITE equiv)	-	1	ANTIHYPERTENSIVES
cholestyramine lite powder pack (QUESTRAN LITE equiv)	-	1	ANTIHYPERTENSIVES
cholestyramine powder (QUESTRAN equiv)	-	1	ANTIHYPERTENSIVES
cholestyramine powder pack (QUESTRAN equiv)	-	1	ANTIHYPERTENSIVES
CHOLINE MAGNESIUM TRISALICYLATE TAB	-	1	ANALGESICS - NONNARCOTIC
choline/mag salicylate liquid	-	1	ANALGESICS - NONNARCOTIC
ciclopirox cream (LOPROX CREAM equiv)	-	1	DERMATOLOGICALS
ciclopirox gel (LOPROX GEL 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.

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
CILOXAN OPHTH OINT	-	2	OPHTHALMIC AGENTS
CIMDUO TAB (QL= 1 tab/day)	QL	2	ANTIVIRALS
cimetidine tab (TAGAMET equiv)	OTC	1	ULCER DRUGS
CIPRO HC OTIC SUSP	-	2	OTIC AGENTS
CIPRO SUSP	-	1	FLUOROQUINOLONES
CIPROFLOXACIN 100MG TAB	-	1	FLUOROQUINOLONES
ciprofloxacin for oral susp 5gm/100ml	-	1	FLUOROQUINOLONES
ciprofloxacin hcl otic soln	-	1	OTIC AGENTS
ciprofloxacin ophth soln (CILOXAN equiv)	-	1	OPHTHALMIC AGENTS
ciprofloxacin susp (CIPRO equiv)	-	1	FLUOROQUINOLONES
ciprofloxacin tab 250mg, 500mg, 750mg (CIPRO equiv)	-	1	FLUOROQUINOLONES
CIPROFLOXACIN/FLUOCINOLONE OTIC SOLN (QL= 1 bottle/7 days)	QL	1	OTIC AGENTS
CITRACAL MAXIMUM TAB	OTC	1	MINERALS & ELECTROLYTES
CITRANATAL RX TAB	-	2	MULTIVITAMINS
CITRATE PHOSPHATE DEXTROSE SOLN	-	1	ANTICOAGULANTS
CLARINEX-D 12 HOUR	-	2	COUGH / COLD / ALLERGY
CLARITHROMYC SUSP	-	1	MACROLIDES
clarithromycin ER tab (BIAXIN XL equiv)	-	1	MACROLIDES
clarithromycin susp (BIAXIN equiv)	-	1	MACROLIDES

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
clarithromycin tab (BIAXIN equiv)	-	1	MACROLIDES
CLEOCIN VAGINAL SUPP	-	2	VAGINAL PRODUCTS
clindamycin cap (CLEOCIN equiv)	-	1	ANTI-INFECTIVE AGENTS MISC.
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) (QL= 1 tube/fill)	QL	1	VAGINAL PRODUCTS
clindamycin/benzoyl peroxide gel 1-5% (QL= 360g/30 days)	QL	1	DERMATOLOGICALS
CLINDESSE VAGINAL CREAM	-	2	VAGINAL PRODUCTS
clobazam susp (ONFI equiv) (QL= 16ml/day)	QL	1	ANTICONVULSANTS
clobazam tab (ONFI equiv)	-	1	ANTICONVULSANTS
clobazam tab 10mg	QL	1	ANTICONVULSANTS
clobetasol E foam (OLUX E equiv)	-	1	DERMATOLOGICALS
clobetasol foam (OLUX equiv)	-	1	DERMATOLOGICALS
clobetasol lotion (CLOBEX equiv)	-	1	DERMATOLOGICALS
clobetasol propionate cream (TEMOVATE equiv)	-	1	DERMATOLOGICALS

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
clobetasol propionate emollient cream (TEMOVATE E equiv)	-	1	DERMATOLOGICALS
clobetasol propionate gel (TEMOVATE GEL equiv)	-	1	DERMATOLOGICALS
clobetasol propionate oint (TEMOVATE equiv)	-	1	DERMATOLOGICALS
clobetasol propionate soln (TEMOVATE equiv)	-	1	DERMATOLOGICALS
clobetasol shampoo (CLOBEX equiv)	-	1	DERMATOLOGICALS
clobetasol spray (CLOBEX equiv)	-	1	DERMATOLOGICALS
CLODAN KIT	-	2	DERMATOLOGICALS
clonazepam ODT (KLONOPIN equiv)	-	1	ANTICONVULSANTS
clonazepam tab (KLONOPIN equiv)	-	1	ANTICONVULSANTS
clonidine patch (CATAPRES-TTS equiv) (QL=1 patch/7 days)	QL	1	ANTIHYPERTENSIVES
clonidine tab (CATAPRES equiv)	-	1	ANTIHYPERTENSIVES
clopidogrel tab 300mg (PLAVIX equiv) (QL= 4 tabs/30 days)	QL	1	HEMATOLOGICAL AGENTS - MISC.
clopidogrel tab 75mg (PLAVIX equiv)	-	1	HEMATOLOGICAL AGENTS - MISC.
clotrimazole cream (LOTRIMIN AF CREAM equiv)	OTC	1	DERMATOLOGICALS
clotrimazole soln	OTC	1	DERMATOLOGICALS
clotrimazole troches (MYCELEX TROCHES equiv)	-	1	MOUTH / THROAT / DENTAL AGENTS
clotrimazole vaginal cream	OTC	1	VAGINAL PRODUCTS

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
clotrimazole/betamethasone cream (LORTRISONE CREAM equiv)	-	1	DERMATOLOGICALS
CLOTRIMAZOLE/BETAMETHASONE LOTION	-	1	DERMATOLOGICALS
clotrimazole/betamethasone lotion (LOTRISONE LOTION equiv)	-	1	DERMATOLOGICALS
COARTEM TAB	-	2	ANTIMALARIALS
CODEINE SULFATE SOLN	-	1	ANALGESICS - OPIOID
CODEINE SULFATE TAB	-	1	ANALGESICS - OPIOID
colchicine tab (COLCRYS equiv) (QL= 4 tabs/day)	QL	1	GOUT AGENTS
colchicine/probenecid tab (COL-BENEMID equiv)	-	1	GOUT AGENTS
colesevelam tab (WELCHOL equiv)	-	1	ANTIHYPERTENSIVES
colestipol granule (COLESTID equiv)	-	1	ANTIHYPERTENSIVES
colestipol powder packet (COLESTID equiv)	-	1	ANTIHYPERTENSIVES
colestipol tab (COLESTID equiv)	-	1	ANTIHYPERTENSIVES
COMBIVENT RESPIMAT INHALER (QL= 2 inhalers/30 days)	QL	2	ANTI-ASTHMATIC AND BRONCHODILATOR AGENTS
COMFORT PAC-NAPROXEN KIT	-	2	ANALGESICS - ANTI-INFLAMMATORY
COMIRNATY INJ	VAC	2	VACCINES
COMPLERA TAB (QL= 1 tab/day)	QL	2	ANTIVIRALS
COMPLETE NATAL DHA PACK	-	2	MULTIVITAMINS

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
CONCEPTION KIT	-	1	MEDICAL DEVICES AND SUPPLIES
CORDRAN TAPE	-	2	DERMATOLOGICALS
CORLANOR SOLN (QL=15 ml/day)	QL	2	CARDIOVASCULAR AGENTS - MISC.
CORLANOR TAB (QL = 60 tabs/30 days)	QL	2	CARDIOVASCULAR AGENTS - MISC.
CORTANE-B LOTION	-	2	DERMATOLOGICALS
CORTIFOAM	-	2	ANORECTAL AGENTS
CORTISONE ACETATE TAB	-	2	CORTICOSTEROIDS
CORTISPORIN CREAM	-	2	DERMATOLOGICALS
CORTISPORIN OINT	-	2	DERMATOLOGICALS
corvita 150 tab	-	1	HEMATOPOIETIC AGENTS
CORVITE TAB	-	2	MULTIVITAMINS
COSENTYX INJ (QL = 1 inj/28 days)	AMSP-PA-QL	4	DERMATOLOGICALS
COSENTYX INJ (1-PACK) (QL=1 inj/28 days)	AMSP-PA-QL	4	DERMATOLOGICALS
COSENTYX INJ (2-PACK) (QL=2 inj/56 days)	AMSP-PA-QL	4	DERMATOLOGICALS
COTEMPLA XR ODT 25.9MG	-	2	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
COTEMPLA XR ODT 8.6MG	-	2	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
COVID-19 HOME COLLECTION TEST KIT (QL= 8 kits/30 days)	OTC-QL	1	DIAGNOSTIC PRODUCTS
COVID-19 TEST SPECIMEN COLLECTION KIT (Q= 8 kits/30 days)	OTC-QL	1	DIAGNOSTIC PRODUCTS
COVID-19 VACCINE INJ	VAC	2	VACCINES
COVID-19 VACCINE INJ 6M-11Y (MODERNA)	VAC	2	VACCINES
CREON CAP	-	2	DIGESTIVE AIDS
CRINONE GEL	-	2	VAGINAL PRODUCTS
CRIXIVAN CAP	-	2	ANTIVIRALS
cromolyn neb soln (INTAL equiv)	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
CROMOLYN OPHTH SOLN	-	1	OPHTHALMIC AGENTS
cryselle tab	-	1	CONTRACEPTIVES
CUE HEALTH MONITOR (QL=1 kit/year)	OTC-QL	1	DIAGNOSTIC PRODUCTS
CUROSURF INJ	-	2	RESPIRATORY AGENTS - MISC.
CUTAQUIG INJ (QL= 576ml/28 days; Only available through Caremark/CVS Specialty 800-237-2767)	LD-PA-QL	2	PASSIVE IMMUNIZING AND TREATMENT AGENTS

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
CVS DIGITAL TEST PREGNANCY	-	1	DIAGNOSTIC PRODUCTS
cvs nasal decongestant cap (QL=240 caps/30 days)	QL	1	NASAL AGENTS - SYSTEMIC AND TOPICAL
cyanocobalamin inj	-	1	HEMATOPOIETIC AGENTS
cyclobenzaprine tab (FLEXERIL equiv)	-	1	MUSCULOSKELETAL THERAPY AGENTS
CYCLOMYDRIL OPHTH SOLN	-	2	OPHTHALMIC AGENTS
cyclopentolate ophth soln (CYCLOGYL equiv)	-	1	OPHTHALMIC AGENTS
cyclophosphamide cap	-	1	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
CYCLOPHOSPHAMIDE TAB	-	1	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
cyclophosphamide tab (CYTOXAN equiv)	-	1	ANTINEOPLASTICS
cyclosporine cap (SANDIMMUNE equiv)	-	1	ASSORTED CLASSES
cyclosporine modified cap (NEORAL equiv)	-	1	ASSORTED CLASSES
cyclosporine modified soln (NEORAL equiv)	-	1	ASSORTED CLASSES
cyclosporine ophth emulsion (QL=60 vials/30 days)	QL	1	OPHTHALMIC AGENTS
cyproheptadine syrup	-	1	ANTIHISTAMINES
cyproheptadine tab	-	1	ANTIHISTAMINES
CYSTADANE POWDER (QL=540 grams/30 days; Only available through AnovoRx 844-288-5007)	LD-QL	4	ENDOCRINE AND METABOLIC AGENTS - MISC.

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
CYTRA K CRYSTALS	-	3	GENITOURINARY AGENTS - MISCELLANEOUS
CYTRA-3 SYRUP	OTC	1	GENITOURINARY AGENTS - MISCELLANEOUS
dabigatran etexilate mesylate cap (QL= 2 caps/day)	QL	1	ANTICOAGULANTS
daily multi vitamin tab	OTC	1	MULTIVITAMINS
dailyvite tab	OTC	1	MULTIVITAMINS
dalfampridine ER tab (AMPYRA equiv)	AMSP-PA	3	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
danazol cap (DANOCRINE equiv) (QL= 4 caps/day)	QL	1	ANDROGENS-ANABOLIC
DAPAGLIFLOZIN TAB 10MG (QL = 1 tab/day)	QL	2	ANTIDIABETICS
DAPAGLIFLOZIN TAB 5MG (QL = 1 tab/day)	QL	2	ANTIDIABETICS
DAPAGLIFLOZIN-METFORMIN ER TAB 10-1000 MG (QL = 1 tab/day)	QL	2	ANTIDIABETICS
DAPAGLIFLOZIN-METFORMIN ER TAB 5-1000 MG (QL = 2 tabs/day)	QL	2	ANTIDIABETICS
dapsone tab	-	1	ANTI-INFECTIVE AGENTS MISC.
DAPTACEL DTAP INJ	VAC	2	TOXOIDS
darunavir tab (QL= 1 tab/day)	QL	1	ANTIVIRALS
darunavir tab (QL=2 tabs/day)	QL	1	ANTIVIRALS

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
dasatinib tab	AMSP-PA	3	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
DEBACTEROL SOLN	-	2	MOUTH / THROAT / DENTAL AGENTS
DEBROX OTIC SOLN	OTC	1	OTIC AGENTS
deferasirox granules packet (JADENU equiv)	AMSP-PA	4	ANTIDOTES AND SPECIFIC ANTAGONISTS
deferasirox tab (EXJADE equiv)	AMSP	3	ANTIDOTES AND SPECIFIC ANTAGONISTS
deferasirox tab (JADENU equiv)	AMSP	3	ANTIDOTES AND SPECIFIC ANTAGONISTS
deferiprone tab (FERRIPROX equiv) (Only available through Lumicera 855-847-3553)	LD-PA	3	ANTIDOTES AND SPECIFIC ANTAGONISTS
DELSTRIGO TAB	-	2	ANTIVIRALS
demeclocycline tab (DECLOMYCIN equiv)	-	1	TETRACYCLINES
DEPO-PROVERA SC INJ 104MG (QL= 1 inj/84 days)	QL	2	CONTRACEPTIVES
depo-testosterone inj (QL=1 vial/28 days)	QL	1	ANDROGENS-ANABOLIC
DEPO-TESTOSTERONE INJ (QL= 4 vials/28 days)	PA-QL	2	ANDROGENS-ANABOLIC
DEPO-TESTOSTERONE INJ (QL=1 vial/28 days)	PA-QL	2	ANDROGENS-ANABOLIC
DERMACINRX LEXITRAL PAK	-	2	DERMATOLOGICALS
DERMACINRX PUREFOLIX TAB	-	2	HEMATOPOIETIC AGENTS
DERMAGRAFT SHEET	-	2	DERMATOLOGICALS

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
DESCOVY TAB (QL= 1 tab/day)	PA-QL	2	ANTIVIRALS
desflurane liquid	-	1	GENERAL ANESTHETICS
desloratadine tab (CLARINEX equiv) (QL= 1 tab/day)	QL	1	ANTIHISTAMINES
desmopressin acetate nasal spray (DDAVP equiv)	-	1	ENDOCRINE AND METABOLIC AGENTS - MISC.
desmopressin acetate tab (DDAVP equiv)	-	1	ENDOCRINE AND METABOLIC AGENTS - MISC.
desonate gel	-	1	DERMATOLOGICALS
DESONATE GEL	-	2	DERMATOLOGICALS
desonide cream	-	1	DERMATOLOGICALS
desonide lotion	-	1	DERMATOLOGICALS
desonide oint	-	1	DERMATOLOGICALS
desoximetasone cream (TOPICORT CREAM equiv)	-	1	DERMATOLOGICALS
desoximetasone gel (TOPICORT equiv)	-	1	DERMATOLOGICALS
desoximetasone oint (TOPICORT equiv)	-	1	DERMATOLOGICALS
DEXAMETHASONE CONC	-	2	CORTICOSTEROIDS
dexamethasone elixir	-	1	CORTICOSTEROIDS
dexamethasone ophth soln	-	1	OPHTHALMIC AGENTS
dexamethasone pak (DEXPAK equiv)	-	1	CORTICOSTEROIDS

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
DEXAMETHASONE SOLN	-	1	CORTICOSTEROIDS
dexamethasone tab (DECADRON equiv)	-	1	CORTICOSTEROIDS
DEXAMETHASONE TAB (QL=8 tabs/30 days)	QL	2	CORTICOSTEROIDS
DEXCHLORPHENIRAMINE SYRUP	-	1	ANTIHISTAMINES
DEXCOM G6 RECEIVER (QL= 1 receiver/year)	PA-QL	2	MEDICAL DEVICES AND SUPPLIES
DEXCOM G6 SENSOR (QL= 3 sensors/30 days)	PA-QL	2	MEDICAL DEVICES AND SUPPLIES
DEXCOM G6 TRANSMITTER (QL= 4 transmitters/365 days)	PA-QL	2	MEDICAL DEVICES AND SUPPLIES
DEXCOM G7 RECEIVER (QL=1 receiver/year)	PA-QL	2	MEDICAL DEVICES AND SUPPLIES
DEXCOM G7 SENSOR (QL=3 sensors/30 days)	PA-QL	2	MEDICAL DEVICES AND SUPPLIES
dexmethylphenidate ER cap (FOCALIN XR equiv) (QL=1 cap/day)	QL	1	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
dexmethylphenidate ER cap 10mg (QL=60 caps/30 days)	QL	1	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
dexmethylphenidate ER cap 15mg (QL=60 caps/30 days)	QL	1	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
dexmethylphenidate ER cap 20mg (QL=60 caps/30 days)	QL	1	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
dexmethylphenidate ER cap 5mg (QL=60 caps/30 days)	QL	1	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
dexmethylphenidate tab (FOCALIN equiv) (QL= 2 tabs/day)	QL	1	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
dextroamphetamine 5mg tab (QL= 9 tabs/day)	QL	1	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
dextroamphetamine ER cap 10mg (DEXEDRINE equiv) (QL= 4 caps/day)	QL	1	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
dextroamphetamine ER cap 15mg (QL= 4 caps/day)	QL	1	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
dextroamphetamine ER cap 5mg (DEXEDRINE equiv) (QL= 2 caps/day)	QL	1	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
dextroamphetamine tab 10mg (QL= 6 tabs/day)	QL	1	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
DIALYVITE 5000 TAB	-	2	MULTIVITAMINS
DIALYVITE 800 WITH IRON TAB	OTC	1	MULTIVITAMINS
DIALYVITE TAB	-	1	MULTIVITAMINS
DIAPHRAGM	-	1	MEDICAL DEVICES AND SUPPLIES
diazepam rectal gel (QL= 1 kit/30 days)	QL	1	ANTICONVULSANTS
DIAZEPAM RECTAL GEL (QL= 1 unit/30 days)	QL	1	ANTICONVULSANTS

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
DIAZEPAM RECTAL GEL (QL= 1 kit/30 days)	QL	2	ANTICONVULSANTS
diazoxide susp (PROGLYCEM equiv) (QL=336 ml/30 days)	QL	1	ANTIDIABETICS
dichlorphenamide tab (QL= 4 tabs/day)	AMSP-PA-QL	3	DIURETICS
diclofenac gel (SOLARAZE equiv)	-	1	DERMATOLOGICALS
diclofenac gel 1% (VOLTAREN equiv) (QL=400grams/30 days)	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)	-	1	DERMATOLOGICALS
diclofenac/capsaicin kit	-	2	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

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
didanosine DR cap (VIDEX EC equiv) (QL= 1 cap/day)	QL	1	ANTIVIRALS
DIFICID SUSP (QL= 136 mL/10 days)	QL	2	MACROLIDES
DIFICID TAB (QL=20 tabs/10 days)	QL	2	MACROLIDES
diflunisal tab (DOLOBID equiv)	-	1	ANALGESICS - NONNARCOTIC
DIGITAL THERAPY APPLICATION - SLEEP (QL=1 membership/lifetime)	OTC-PA-QL	2	MISCELLANEOUS THERAPEUTIC CLASSES
digoxin soln (LANOXIN equiv)	-	2	CARDIOTONICS
digoxin tab (LANOXIN equiv) (QL=1 tab/day)	QL	1	CARDIOTONICS
DILANTIN CAP 30MG	-	2	ANTICONVULSANTS
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	-	1	CALCIUM CHANNEL BLOCKERS
diltiazem tab (CARDIZEM equiv)	-	1	CALCIUM CHANNEL BLOCKERS

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
dimethyl fumarate DR cap (TECFIDERA equiv) (QL= 2 caps/day)	AMSP-QL	3	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
dimethyl fumarate DR starter pack (TECFIDERA STARTER PACK equiv) (QL= 2 caps/day)	AMSP-QL	3	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
DIPENTUM CAP	-	2	GASTROINTESTINAL AGENTS - MISC.
diphenhydramine cap	OTC	1	HYPNOTICS / SEDATIVES SLEEP DISORDER AGENTS
diphenhydramine chew tab	OTC	1	ANTIHISTAMINES
DIPHENHYDRAMINE ELIXIR	-	2	ANTIHISTAMINES
diphenhydramine liquid	--OTC	1	ANTIHISTAMINES
diphenhydramine ODT	OTC	1	HYPNOTICS / SEDATIVES SLEEP DISORDER AGENTS
diphenhydramine tab	OTC	1	HYPNOTICS
diphenhydramine/acetaminophen tab	OTC	1	HYPNOTICS / SEDATIVES SLEEP DISORDER AGENTS
DIPHENOXYLATE/ATROPINE LIQUID	-	1	ANTIDIARRHEAL / PROBIOTIC AGENTS

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
diphenoxylate/atropine tab (LOMOTIL equiv)	-	1	ANTIDIARRHEALS
DIPHTHERIA-TETANUS TOXOIDS-PED INJ	-	2	TOXOIDS
dipyridamole tab (PERSANTINE equiv)	-	1	HEMATOLOGICAL AGENTS - MISC.
disopyramide cap (NORPACE equiv)	-	1	ANTIARRHYTHMICS
disulfiram tab (ANTABUSE equiv)	-	1	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
DIURIL SUSP	-	2	DIURETICS
docusate cap	OTC	1	LAXATIVES
docusate liquid	OTC	1	LAXATIVES
DOCUSATE SYRUP	OTC	1	LAXATIVES
dofetilide cap 500mcg	-	1	ANTIARRHYTHMICS
donepezil ODT (ARICEPT equiv)	-	1	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
donepezil tab 10mg (ARICEPT equiv) (QL=60 tabs/30 days)	QL	1	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
donepezil tab 23mg (ARICEPT equiv) (QL=1 tab/day)	QL	1	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier Category
donepezil tab 5mg (ARICEPT equiv) (QL=60 tabs/30 days)	QL	1 PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
DONNATAL ELIXIR	-	2 ULCER DRUGS
DONNATAL TAB	-	2 ULCER DRUGS
DORYX MPC TAB 120MG	-	2 TETRACYCLINES
dorzolamide ophth soln (TRUSOPT equiv)	-	1 OPHTHALMIC AGENTS
dorzolamide/timolol (pf) ophth soln (Step Therapy requires trial of dorzolamide/timolol ophth soln)	ST	1 OPHTHALMIC AGENTS
dorzolamide/timolol ophth soln (COSOPT equiv)	-	1 OPHTHALMIC AGENTS
doxazosin tab (CARDURA equiv)	-	1 ANTIHYPERTENSIVES
doxycycline hyclate cap 100mg	-	1 TETRACYCLINES
doxycycline hyclate cap 50mg	-	1 TETRACYCLINES
doxycycline hyclate DR tab 100mg (DORYX equiv) (QL= 2 tabs/day)	QL	1 TETRACYCLINES
doxycycline hyclate tab 100mg	-	1 TETRACYCLINES
doxycycline hyclate tab 20mg	-	1 TETRACYCLINES
doxycycline monohydrate cap (MONODOX equiv) (QL= 2 caps/day)	QL	1 TETRACYCLINES
doxycycline monohydrate tab (ADOXA equiv) (QL= 2 tabs/day)	QL	1 TETRACYCLINES
doxycycline susp (VIBRAMYCIN equiv)	-	1 TETRACYCLINES

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier Category	
doxylamine/pyridoxine dr tab (DICLEGIS equiv) (QL= 120 tabs/30 days)	QL	1	ANTIEMETICS
dronabinol cap (MARINOL equiv)	-	1	ANTIEMETICS
drospirenone/ethinyl estradiol/levomefolate tab (BEYAZ equiv)	-	1	CONTRACEPTIVES
DROSPIRENONE/ETHINYL ESTRADIOL/LEVOMEFOLATE TAB, SAFYRAL TAB	-	2	CONTRACEPTIVES
DROXIA CAP	-	2	HEMATOPOIETIC AGENTS
DSUVIA SL TAB	-	2	ANALGESICS - OPIOID
DUAVEE TAB	-	2	ESTROGENS
DUET DHA 400 PACK	-	2	MULTIVITAMINS
DULERA INHALER (QL= 1 inhaler/30 days)	QL	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
DULERA INHALER (QL=1 inhaler/30 days)	QL	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
DUOBRII LOTION (QL=1 tube/30 days; Step Therapy requires trial of a high potency topical steroid)	QL-ST	2	DERMATOLOGICALS
DUPIXENT INJ (QL= 2 inj/28 days)	AMSP-PA-QL	4	DERMATOLOGICALS
DUPIXENT INJ (QL=2 inj/28 days)	AMSP-PA-QL	4	DERMATOLOGICALS

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
DUPIXENT PEN INJ (QL= 2 inj/28 days)	AMSP-PA-QL	4	DERMATOLOGICALS
DURLAZA CAP	-	2	HEMATOLOGICAL AGENTS - MISC.
dutasteride cap (AVODART equiv)	-	1	GENITOURINARY AGENTS - MISCELLANEOUS
dvorah tab	-	1	ANALGESICS - OPIOID
DXEVO 11-DAY PAK	-	2	CORTICOSTEROIDS
E.E.S. TAB	-	1	MACROLIDES
ear wax removal drops	OTC	1	OTIC AGENTS
econazole cream (SPECTAZOLE equiv)	-	1	DERMATOLOGICALS
ECOTRIN EC TAB 325MG	OTC	1	ANALGESICS - NONNARCOTIC
ECOZA FOAM	-	2	DERMATOLOGICALS
EDARBI TAB	-	2	ANTIHYPERTENSIVES
EDARBYCLOR TAB	-	2	ANTIHYPERTENSIVES
EDURANT TAB	-	2	ANTIVIRALS
EFAVIRENZ CAP	-	1	ANTIVIRALS
efavirenz tab (SUSTIVA equiv)	-	1	ANTIVIRALS
efavirenz/emtricitabine/tenofovir df tab (ATRIPLA equiv) (QL= 1 tab/day)	QL	1	ANTIVIRALS
efavirenz/lamivudine/tenofovir df (lo) tab (SYMFI (LO) equiv) (QL= 1 tab/day)	QL	1	ANTIVIRALS

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
EFFER-K TAB	-	2	MINERALS & ELECTROLYTES
EGATEN TAB	-	2	ANTHELMINTICS
ELIQUIS STARTER PACK (QL= 1 pack /30 days)	QL	2	ANTICOAGULANTS
ELIQUIS TAB 2.5MG (QL= 2 tabs/1 day)	QL	2	ANTICOAGULANTS
ELIQUIS TAB 5MG (QL= 74 tabs/30 days)	QL	2	ANTICOAGULANTS
ELIXOPHYLLIN ELIXIR	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ELLA TAB	-	2	CONTRACEPTIVES
ELMIRON CAP (QL= 3 caps/day; ST requires trial of hydroxyzine)	QL-ST	2	GENITOURINARY AGENTS - MISCELLANEOUS
ELOCTATE INJ	AMSP-PA	4	HEMATOLOGICAL AGENTS - MISC.
eluryng vaginal ring (NUVARING equiv) (QL=1 ring/21 days)	QL	1	CONTRACEPTIVES
EMCYT CAP	-	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
EMGALITY INJ (QL= 1 inj/28 days)	PA-QL	2	MIGRAINE PRODUCTS
emtricitabine cap (EMTRIVA equiv) (QL= 1 cap/day)	QL	1	ANTIVIRALS
emtricitabine/tenofovir disoproxil fumarate tab (TRUVADA equiv) (QL= 1 tab/day)	QL	1	ANTIVIRALS
EMTRIVA SOLN	-	2	ANTIVIRALS

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
EMVERM TAB	-	2	ANTHELMINTICS
enalapril tab (VASOTEC equiv)	-	1	ANTIHYPERTENSIVES
enalapril/hydrochlorothiazide tab (VASERETIC equiv)	-	1	ANTIHYPERTENSIVES
ENBREL INJ (QL= 8 inj/28 days)	AMSP-PA-QL	4	ANALGESICS - ANTI-INFLAMMATORY
ENBREL INJ 25MG (QL= 8 inj/28 days)	AMSP-PA-QL	4	ANALGESICS - ANTI-INFLAMMATORY
ENBREL INJ 50MG (QL= 4 inj/28 days)	AMSP-PA-QL	4	ANALGESICS - ANTI-INFLAMMATORY
ENBREL MINI INJ (QL=4 inj/28 days)	AMSP-PA-QL	4	ANALGESICS - ANTI-INFLAMMATORY
ENBREL SURECLICK INJ 50MG (QL= 4 inj/28 days)	AMSP-PA-QL	4	ANALGESICS - ANTI-INFLAMMATORY
ENDO-AVITENE SHEET	-	2	HEMOSTATICS
ENGERIX-B INJ, RECOMBIVAX-HB INJ	VAC	2	VACCINES
enoxaparin inj 100mg (LOVENOX equiv)	-	1	ANTICOAGULANTS
enoxaparin inj 120mg (LOVENOX equiv)	-	1	ANTICOAGULANTS
enoxaparin inj 150mg (LOVENOX equiv)	-	1	ANTICOAGULANTS
enoxaparin inj 300mg (LOVENOX equiv)	-	1	ANTICOAGULANTS
enoxaparin inj 30mg (LOVENOX equiv)	-	1	ANTICOAGULANTS
enoxaparin inj 40mg (LOVENOX equiv)	-	1	ANTICOAGULANTS

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
enoxaparin inj 60mg (LOVENOX equiv)	-	1	ANTICOAGULANTS
enoxaparin inj 80mg (LOVENOX equiv)	-	1	ANTICOAGULANTS
enpresse tab (TRI-LEVELLEN equiv)	-	1	CONTRACEPTIVES
ENSTILAR FOAM	-	2	DERMATOLOGICALS
entecavir tab (BARACLUDE equiv) (QL= 1 tab/day)	QL	3	ANTIVIRALS
ENTRESTO CAP (QL= 8 caps/day)	QL	2	CARDIOVASCULAR AGENTS - MISC.
ENTRESTO TAB (QL= 2 tabs/day)	QL	2	CARDIOVASCULAR AGENTS - MISC.
ENVARUSUS XR TAB	-	2	ASSORTED CLASSES
EOHILIA SUSP (Step therapy requires trial of budesonide vials)	RDX-ST	2	CORTICOSTEROIDS
ephedrine hcl tab (QL= 12 tablets/day)	OTC-QL	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
EPICERAM EMULSION	-	2	DERMATOLOGICALS
EPIFOAM AEROSOL	-	2	DERMATOLOGICALS
epinephrine hcl nasal soln (ADRENALIN equiv)	-	1	NASAL AGENTS - SYSTEMIC AND TOPICAL
epinephrine inj	-	1	VASOPRESSORS
EPINEPHRINE INJ 0.15MG (QL= 2 inj/fill)	QL	1	VASOPRESSORS
EPINEPHRINE INJ 0.3MG (QL= 2 inj/fill)	QL	1	VASOPRESSORS

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
epinephrine pen inj 0.15mg (1-Pack) (QL= 2 inj/fill)	QL	1	VASOPRESSORS
epinephrine pen inj 0.15mg, 0.3mg (EPIPEN (JR) equiv) (QL= 2 inj/fill)	QL	1	VASOPRESSORS
epinephrine pen inj 0.3mg (1-Pack) (QL= 2 inj/fill)	QL	1	VASOPRESSORS
EPIVIR HBV SOLN	AMSP	4	ANTIVIRALS
eplerenone tab (INSPRA equiv) (QL= 2 tabs/day)	QL	1	ANTIHYPERTENSIVES
ERGOLOID MESYLATES TAB	-	1	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
ergoloid mesylates tab (HYDERGINE equiv)	-	1	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
ERLEADA TAB (QL= 4 tabs/day)	AMSP-PA-QL	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ERLEADA TAB 240MG (QL= 1 tab/day)	AMSP-PA-QL	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
erlotinib tab 100mg (TARCEVA equiv)	AMSP	3	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
erlotinib tab 150mg (TARCEVA equiv)	AMSP	3	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
erlotinib tab 25mg (TARCEVA equiv) (QL = 3 tabs/day)	AMSP-QL	3	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ERTACZO CREAM	-	2	DERMATOLOGICALS

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
ERY PAD (Step therapy requires trial of topical clindamycin or erythromycin gel/soln)	QL-ST	2	DERMATOLOGICALS
ERYTHROCIN TAB	-	1	MACROLIDES
erythromycin DR cap (ERYC equiv)	-	1	MACROLIDES
ERYTHROMYCIN DR CAP	-	2	MACROLIDES
ERYTHROMYCIN EC CAP	-	2	MACROLIDES
erythromycin ethylsuccinate susp (ERYPED equiv)	-	1	MACROLIDES
erythromycin ethylsuccinate tab	-	1	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 (ERY-TAB equiv)	-	1	MACROLIDES
erythromycin tab (ERYTHROMYCIN equiv) (all form except PCE)	-	1	MACROLIDES
esomeprazole DR granule pack (NEXIUM equiv) (QL=1 pack/day)	QL	1	ULCER DRUGS / ANTISPASMODICS / ANTICHOLINERGICS
ESOMEPRAZOLE STRONTIUM CAP	-	1	ULCER DRUGS
ESOMEPRAZOLE-EZS KIT	-	2	ULCER DRUGS

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier Category
estazolam tab (PROSOM equiv)	-	1 HYPNOTICS / SEDATIVES SLEEP DISORDER AGENTS
esterified estrogens/methyltestosterone tab (ESTRATEST equiv)	-	1 ESTROGENS
estradiol cream (ESTRACE equiv)	-	1 VAGINAL PRODUCTS
estradiol patch (CLIMARA equiv) (QL= 4 patches/28 days)	QL	1 ESTROGENS
estradiol patch (VIVELLE-DOT equiv) (QL= 8 patches/28 days)	QL	1 ESTROGENS
estradiol tab (ESTRACE equiv)	-	1 ESTROGENS
estradiol vaginal tab, yuvafem vaginal tab (VAGIFEM equiv)	-	1 VAGINAL PRODUCTS
estradiol valerate inj	-	1 ESTROGENS
estradiol/norethindrone tab (ACTIVEVELLA equiv)	-	1 ESTROGENS
ethambutol tab (MYAMBUTOL equiv)	-	1 ANTIMYCOBACTERIAL AGENTS
ethosuximide cap (ZARONTIN equiv)	-	1 ANTICONVULSANTS
ethosuximide soln (ZARONTIN equiv)	-	1 ANTICONVULSANTS
ETHYL CHLORIDE SPRAY	-	1 DERMATOLOGICALS
etodolac cap (LODINE equiv)	-	1 ANALGESICS - ANTI-INFLAMMATORY

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
etodolac ER tab (LODINE XL equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
etodolac tab	-	1	ANALGESICS - ANTI-INFLAMMATORY
ETOPOSIDE CAP (QL= 20 caps/30 days)	QL	3	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
etoposide cap (VEPESID equiv)	-	3	ANTINEOPLASTICS
etravirine tab 100mg (QL=4 tabs/day)	QL	1	ANTIVIRALS
etravirine tab 200mg (QL=2 tabs/day)	QL	1	ANTIVIRALS
EURAX CREAM	-	2	DERMATOLOGICALS
EURAX LOTION	-	2	DERMATOLOGICALS
EVAMIST SPRAY	-	2	ESTROGENS
everolimus tab (AFINITOR equiv) (QL=1 tab/day)	AMSP-PA-QL	1	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
everolimus tab (ZORTRESS equiv) (QL=2 tabs/day)	QL	1	MISCELLANEOUS THERAPEUTIC CLASSES
everolimus tab for oral susp (QL=1 tab/day)	AMSP-PA-QL	3	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
EVOTAZ TAB	-	2	ANTIVIRALS
exemestane tab (AROMASIN equiv) (QL=1 tab/day)	QL	1	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
EXODERM LOTION	-	2	DERMATOLOGICALS

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
EXSERVAN FILM (Only available through PantherRx Pharmacy 855-726-8479; QL=60 films/30 days)	LD-PA-QL	4	NEUROMUSCULAR AGENTS
EXU-DRY BANDAGE	-	2	MEDICAL DEVICES AND SUPPLIES
EZ FLU SHOT KIT	VAC	2	VACCINES
EZ FLU SHOT PF KIT	VAC	2	VACCINES
EZ FLU SHOT QUAD KIT	VAC	2	VACCINES
ezetimibe tab (ZETIA equiv) (QL= 1 tab/day)	QL	1	ANTIHYPERTENSIVES
ezetimibe/simvastatin tab (VYTORIN equiv)	QL	1	ANTIHYPERTENSIVES
FACTIVE TAB (QL= 7 tabs/30 days)	QL	2	FLUOROQUINOLONES
famciclovir tab 125mg (FAMVIR equiv) (QL= 2 tabs/day)	QL	1	ANTIVIRALS
famciclovir tab 250mg (FAMVIR equiv) (QL= 30 tabs/10 days)	QL	1	ANTIVIRALS
famciclovir tab 500mg (FAMVIR equiv) (QL= 42 tabs/fill, 2 fills/month)	QL	1	ANTIVIRALS
famotidine susp (PEPCID equiv)	-	1	ULCER DRUGS
famotidine tab (PEPCID equiv)	OTC	1	ULCER DRUGS
febuxostat tab (ULORIC equiv) (QL=1 tab/day)	QL	1	GOUT AGENTS
felbamate susp (FELBATOL equiv) (QL= 30ml/day)	QL	1	ANTICONVULSANTS
felbamate tab 400mg (FELBATOL equiv) (QL= 9 tabs/day)	QL	1	ANTICONVULSANTS

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
felbamate tab 600mg (FELBATOL equiv) (QL= 6 tabs/day)	QL	1	ANTICONVULSANTS
felodipine ER tab (PLENDIL equiv)	-	1	CALCIUM CHANNEL BLOCKERS
FEM PH GEL	-	2	VAGINAL PRODUCTS
FEMALE CONDOMS	OTC	1	MEDICAL DEVICES AND SUPPLIES
FEMLYV TAB (QL=28 tabs/24 days)	QL	1	CONTRACEPTIVES
FEMRING (3 copays per Rx)	-	2	VAGINAL PRODUCTS
FENOFIBRATE CAP	-	1	ANTIHYPERTENSIVES
fenofibrate cap 43mg, 130mg (ANTARA equiv)	-	1	ANTIHYPERTENSIVES
fenofibrate cap 67mg, 134mg, 200mg (LOFIBRA equiv)	-	1	ANTIHYPERTENSIVES
fenofibrate tab 40mg, 120mg (FENOGLIDE equiv)	-	1	ANTIHYPERTENSIVES
fenofibrate tab 48mg, 54mg, 145mg, 160mg (TRICOR equiv)	-	1	ANTIHYPERTENSIVES
fenofibric acid DR cap (TRILIPIX equiv)	-	1	ANTIHYPERTENSIVES
FENOFIBRIC TAB	-	1	ANTIHYPERTENSIVES
FENTANYL BUCCAL TAB (QL= 3 tabs/day)	QL	1	ANALGESICS - OPIOID
FENTANYL CITRATE LOLLIPOP (QL= 120 lozenges/30 days)	QL	2	ANALGESICS - OPIOID

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
fentanyl patch (DURAGESIC equiv) (QL=15 patches/30 days; Step Therapy requires trial of morphine sulfate ER tab)	QL-ST	1	ANALGESICS - OPIOID
FENTORA TAB (QL= 3 tabs/day)	QL	2	ANALGESICS - OPIOID
FEOSOL TAB	OTC	1	HEMATOPOIETIC AGENTS
FERIVA 21-7 TAB	-	2	HEMATOPOIETIC AGENTS
ferocon cap	-	1	HEMATOPOIETIC AGENTS
FERRAPLUS 90 TAB	-	1	HEMATOPOIETIC AGENTS
ferrocite plus tab	-	1	HEMATOPOIETIC AGENTS
FERROUS SULFATE LIQUID	OTC	1	HEMATOPOIETIC AGENTS
ferrous sulfate soln	OTC	1	HEMATOPOIETIC AGENTS
FEVERALL SUPP	OTC	2	ANALGESICS - NONNARCOTIC
FEVERALL SUPP 325MG	OTC	1	ANALGESICS - NONNARCOTIC
fexofenadine tab 180mg (QL=1 tab/day)	OTC-QL	1	ANTIHISTAMINES
fexofenadine/pseudoephedrine 24-hour tab (ALLEGRA-D equiv) (QL=1 tab/day)	QL	1	COUGH / COLD / ALLERGY
fiber cap	OTC	1	LAXATIVES
fiber therapy powder	OTC	1	LAXATIVES
fiber therapy tab	OTC	1	LAXATIVES

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
finasteride tab (PROSCAR equiv)	-	1	GENITOURINARY AGENTS - MISCELLANEOUS
fingolimod hcl cap 0.5mg (QL=1 cap/day)	AMSP-QL	3	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
fish oil cap	OTC	1	NUTRIENTS
fish oil dr cap	OTC	1	NUTRIENTS
FLAREX OPTH SUSP	-	2	OPHTHALMIC AGENTS
flecainide tab (TAMBOCOR equiv)	-	1	ANTIARRHYTHMICS
FLORIVA CHEW TAB	-	2	MULTIVITAMINS
FLORIVA DROPS	-	2	MINERALS & ELECTROLYTES
FLORIVA PLUS DROPS	-	1	MULTIVITAMINS
FLUAD INJ	VAC	2	VACCINES
FLUBLOK INJ	VAC	2	VACCINES
FLUBLOK INJ (QL = 0.5mL/fill)	QL-VAC	2	VACCINES
FLUCELVAX INJ (QL = 0.5mL/fill)	QL-VAC	2	VACCINES
FLUCELVAX INJ (QL= 0.5ml/fill)	QL-VAC	2	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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
FLUMIST NASAL (QL= 1 dose/fill; Limited to members aged 2 to 49 years old)	QL-VAC	2	VACCINES
fluocinolone acetonide cream	-	1	DERMATOLOGICALS
fluocinolone acetonide oil (QL=119ml/30 days)	QL	1	DERMATOLOGICALS
fluocinolone acetonide oint	-	1	DERMATOLOGICALS
fluocinolone acetonide soln	-	1	DERMATOLOGICALS
fluocinonide cream 0.05% (LIDEX equiv)	-	1	DERMATOLOGICALS
fluocinonide emollient cream	-	1	DERMATOLOGICALS
fluocinonide gel	-	1	DERMATOLOGICALS
fluocinonide oint	-	1	DERMATOLOGICALS
fluocinonide soln	-	1	DERMATOLOGICALS
fluorescein/proparacaine ophth soln	-	1	OPHTHALMIC AGENTS
fluorometholone ophth soln (FML LIQUIFILM equiv)	-	1	OPHTHALMIC AGENTS
FLUOROPLEX CREAM	-	2	DERMATOLOGICALS
fluorouracil cream (EFUDEX CREAM equiv)	-	1	DERMATOLOGICALS
fluorouracil soln	-	1	DERMATOLOGICALS
FLUOVIX PAK	-	2	DERMATOLOGICALS
FLUOXETINE CAP (PMDD)	-	2	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
FLURA-DROPS	-	2	MINERALS & ELECTROLYTES

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
FLURBIPROFEN TAB	-	1	ANALGESICS - ANTI-INFLAMMATORY
flurbiprofen tab (ANSAID equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
flutamide cap (EULEXIN equiv)	-	1	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
FLUTICASONE DISKUS INHALER (QL=2 inhalers/30 days)	QL	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
fluticasone nasal spray (FLONASE equiv) (QL= 16gm/30 days)	QL	1	NASAL AGENTS - SYSTEMIC AND TOPICAL
fluticasone propionate cream (CUTIVATE equiv)	-	1	DERMATOLOGICALS
fluticasone propionate oint (CUTIVATE equiv)	-	1	DERMATOLOGICALS
FLUTICASONE/SALMETEROL INHALER (QL= 1 inhaler/30 days)	QL	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
fluticasone/salmeterol inhaler, wixela inhaler (ADVAIR equiv) (QL= 1 inhaler/30 days)	QL	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
FLUVIRIN INJ	VAC	2	VACCINES
FLUVIRIN PF INJ	VAC	2	VACCINES
FLUZONE HIGH DOSE PF INJ	VAC	2	VACCINES
FLUZONE INTRADERMAL INJ	VAC	2	VACCINES

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
FLUZONE QUAD INJ	VAC	2	VACCINES
FML FORTE OPTH SUSP	-	2	OPHTHALMIC AGENTS
FML S.O.P. OPTH OINT	-	2	OPHTHALMIC AGENTS
FOLBEE PLUS CZ TAB	-	1	MULTIVITAMINS
folbee plus tab	-	1	MULTIVITAMINS
folbee tab	OTC	1	HEMATOPOIETIC AGENTS
folbic tab	-	1	DIETARY PRODUCTS / DIETARY MANAGEMENT PRODUCTS
folic acid cap	OTC	1	HEMATOPOIETIC AGENTS
folic acid tab 1mg	-	1	HEMATOPOIETIC AGENTS
folic acid tab 800mcg (Covered for females only)	OTC	1	HEMATOPOIETIC AGENTS
FOLIVANE-PLUS CAP	-	1	HEMATOPOIETIC AGENTS
fondaparinux inj 10mg/0.8ml (ARIXTRA equiv)	-	1	ANTICOAGULANTS
fondaparinux inj 2.5mg/0.5ml (ARIXTRA equiv)	-	1	ANTICOAGULANTS
fondaparinux inj 5mg/0.4ml (ARIXTRA equiv)	-	1	ANTICOAGULANTS
fondaparinux inj 7.5mg/0.6ml (ARIXTRA equiv)	-	1	ANTICOAGULANTS
FORTAVIT CAP	-	2	MULTIVITAMINS
FOSAMAX+D TAB (QL= 4 tabs/28 days)	QL	2	ENDOCRINE AND METABOLIC AGENTS - MISC.
fosamprenavir tab (LEXIVA equiv) (QL= 4 tabs/day)	QL	1	ANTIVIRALS

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
fosfomycin tromethamine powder pack (MONUROL equiv)	-	1	ANTI-INFECTIVE AGENTS MISC.
fosinopril tab (MONOPRIL equiv)	-	1	ANTIHYPERTENSIVES
fosinopril/hydrochlorothiazide tab (MONOPRIL HCT equiv)	-	1	ANTIHYPERTENSIVES
FREE LIBRE 3-PLUS SENSOR (QL = 2 sensors/30 days)	PA-QL	2	MEDICAL DEVICES AND SUPPLIES
FREESTYLE INSULINX TEST STRIP (QL= 300 test strips/30 days)	OTC-QL	1	DIAGNOSTIC PRODUCTS
FREESTYLE LIBRE 2 (QL= 2 sensors/28 days)	PA-QL	2	MEDICAL DEVICES AND SUPPLIES
FREESTYLE LIBRE 2 RECEIVER (QL= 1 receiver/year)	PA-QL	2	MEDICAL DEVICES AND SUPPLIES
FREESTYLE LIBRE 2-PLUS SENSOR (QL= 2 sensors/30 days)	PA-QL	2	MEDICAL DEVICES AND SUPPLIES
FREESTYLE LIBRE 3 READER (QL = 1 receiver/1 year)	PA-QL	2	MEDICAL DEVICES AND SUPPLIES
FREESTYLE LIBRE KIT 3 SENSOR (QL= 2 sensors/28 days)	PA-QL	2	MEDICAL DEVICES AND SUPPLIES
FREESTYLE LIBRE RECEIVER (QL= 1 receiver/year)	PA-QL	2	MEDICAL DEVICES AND SUPPLIES
FREESTYLE LIBRE SENSOR (10-DAY) (QL= 3 sensors/30 days)	PA-QL	2	MEDICAL DEVICES AND SUPPLIES

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
FREESTYLE LIBRE SENSOR (14-DAY) (QL= 2 sensors/28 days)	PA-QL	2	MEDICAL DEVICES AND SUPPLIES
FREESTYLE LITE TEST STRIP (QL= 300 test strips/30 days)	OTC-QL	1	DIAGNOSTIC PRODUCTS
FREESTYLE PRECISION NEO TEST STRIP (QL= 300 test strips/30 days)	OTC-QL	1	DIAGNOSTIC PRODUCTS
FREESTYLE TEST STRIP (QL= 300 test strips/30 days)	OTC-QL	1	DIAGNOSTIC PRODUCTS
FREESTYLE TEST STRIPS (QL= 300 strips/30 days)	OTC-QL	1	DIAGNOSTIC PRODUCTS
FULPHILA INJ (QL= 2 syringes/28 days)	AMSP-QL	4	HEMATOPOIETIC AGENTS
FUROSEMIDE SOLN	-	1	DIURETICS
furosemide soln (LASIX equiv)	-	1	DIURETICS
furosemide tab (LASIX equiv)	-	1	DIURETICS
FUSION PLUS CAP	-	2	HEMATOPOIETIC AGENTS
FYCOMPA TAB	-	2	ANTICONSULSANTS
FYCOMPA SUSP	-	2	ANTICONSULSANTS
gabapentin cap (NEURONTIN equiv)	-	1	ANTICONSULSANTS
gabapentin soln	-	1	ANTICONSULSANTS
gabapentin tab (NEURONTIN equiv)	-	1	ANTICONSULSANTS
galantamine ER cap (RAZADYNE ER equiv) (QL= 1 cap/day)	QL	1	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
GALANTAMINE SOLN	-	1	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
galantamine tab (RAZADYNE equiv) (QL= 2 tabs/day)	QL	1	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
GALZIN CAP	-	2	MINERALS & ELECTROLYTES
GAMASTAN INJ	-	2	PASSIVE IMMUNIZING AND TREATMENT AGENTS
GAMMAGARD LIQUID INJ (QL= 690ml/28 days)	PA-QL	2	PASSIVE IMMUNIZING AND TREATMENT AGENTS
GAMUNEX-C INJ (QL= 960ml/28 days)	PA-QL	2	PASSIVE IMMUNIZING AND TREATMENT AGENTS
GARDASIL 9 INJ	VAC	2	VACCINES
GARDASIL INJ	VAC	2	VACCINES
gatifloxacin ophth soln (ZYMAXID equiv)	-	1	OPHTHALMIC AGENTS
GAVILYTE-C SOLN	-	1	LAXATIVES
gefitinib tab (QL=1 tab/day)	AMSP-PA-QL	3	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
GELCLAIR GEL	-	2	MOUTH / THROAT / DENTAL AGENTS
GELFILM	-	2	OPHTHALMIC AGENTS

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
GELFOAM SPONGE	-	2	HEMOSTATICS
GELNIQUE	-	2	URINARY ANTISPASMODICS
GELNIQUE (QL= 30 packets/30 days)	QL	2	URINARY ANTISPASMODICS
gemfibrozil tab (LOPID equiv)	-	1	ANTIHYPERLIPIDEMICS
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	-	2	ANTIVIRALS
GIALAX KIT	-	2	LAXATIVES
gianvi tab, ocella tab (YASMIN, YAZ equiv)	-	1	CONTRACEPTIVES
glatiramer inj 20mg/ml (COPAXONE equiv) (QL= 30 syringes (30ml)/30 days)	AMSP-QL	3	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
glatiramer inj 40mg/ml (QL= 12 syringes (12ml)/28 days)	AMSP-QL	3	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
glimepiride tab (AMARYL equiv)	-	1	ANTIDIABETICS
glipizide ER tab (GLUCOTROL XL equiv)	-	1	ANTIDIABETICS

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
glipizide tab (GLUCOTROL equiv)	-	1	ANTIDIABETICS
glipizide/metformin tab (METAGLIP equiv)	-	1	ANTIDIABETICS
GLOPERBA SOLN (QL= 300ml/30 days)	QL	2	GOUT AGENTS
glucagon (rdna) for inj kit (QL = 2 inj/fill, 2 fill/month)	QL	1	ANTIDIABETICS
GLUCAGON INJ KIT	-	2	ANTIDIABETICS
glucose chew tab	OTC	1	ANTIDIABETICS
glucose gel packet	OTC	1	ANTIDIABETICS
glutamine (sickle cell) powder pack (Step Therapy requires trial of hydroxyurea cap; QL = 6 packets/day)	AMSP-QL-ST	3	HEMATOPOIETIC AGENTS
GLYBURIDE MICRONIZED TAB	-	1	ANTIDIABETICS
glyburide tab (MICRONASE equiv)	-	1	ANTIDIABETICS
glyburide/metformin tab (GLUCOVANCE equiv)	-	1	ANTIDIABETICS
glycerin supp	OTC	1	LAXATIVES
glycopyrrolate oral soln (QL=9 ml/day)	QL	1	ULCER DRUGS / ANTISPASMODICS / ANTICHOLINERGICS
glycopyrrolate tab (ROBINUL equiv)	-	1	ULCER DRUGS
GLYXAMBI TAB (Step Therapy requires trial of metformin or metformin ER or metformin combinations)	ST	2	ANTIDIABETICS
GONITRO POWDER	-	2	ANTIANGINAL AGENTS

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
GRAFIX CORE SHEET	-	2	DERMATOLOGICALS
granisetron tab (KYTRIL equiv) (QL= 1 tab/15 days; Step therapy requires trial of ondansetron)	QL-ST	1	ANTIEMETICS
GRASTEK SL TAB (QL= 30 tabs/30 days)	QL	2	BIOLOGICALS MISC
griseofulvin susp (GRIFULVIN equiv)	-	1	ANTIFUNGALS
guaifenesin dac syrup	-	1	COUGH / COLD / ALLERGY
guaifenesin tab (ALLFEN JR equiv)	-	1	COUGH / COLD / ALLERGY
guanfacine IR tab (TENEX equiv)	-	1	ANTIHYPERTENSIVES
GUANIDINE TAB	-	1	ANTIMYASTHENIC / CHOLINERGIC AGENTS
GVOKE INJ	-	2	ANTIDIABETICS
GVOKE INJ KIT (QL=2 vials/fill, 2 fills/30 days)	QL	2	ANTIDIABETICS
GVOKE PFS INJ	-	2	ANTIDIABETICS
GYNAZOLE CREAM	-	2	VAGINAL PRODUCTS
HADLIMA INJ (QL= 2 syringes/28 days)	AMSP-PA-QL	4	ANALGESICS - ANTI-INFLAMMATORY
HADLIMA PUSH INJ 40/0.4ML (QL= 2 inj/28 days)	AMSP-PA-QL	4	ANALGESICS - ANTI-INFLAMMATORY
HADLIMA PUSH INJ 40/0.8ML (QL= 2 inj/28 days)	AMSP-PA-QL	4	ANALGESICS - ANTI-INFLAMMATORY
HADLIMA PUSHTOUCH INJ (QL= 2 inj/28 days)	AMSP-PA-QL	4	ANALGESICS - ANTI-INFLAMMATORY

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
halcinonide cream (HALOG equiv) (Step Therapy requires trial of 2 High potency corticosteroids)	ST	1	DERMATOLOGICALS
halobetasol propionate cream (ULTRAVATE equiv)	-	1	DERMATOLOGICALS
halobetasol propionate oint (ULTRAVATE equiv)	-	1	DERMATOLOGICALS
HALOG OINT	-	2	DERMATOLOGICALS
halonate pac kit (ULTRAVATE KIT equiv)	-	1	DERMATOLOGICALS
HAVRIX INJ, VAQTA INJ	VAC	2	VACCINES
HC BUTYRATE CREAM	-	1	DERMATOLOGICALS
HC BUTYRATE SOLN	-	1	DERMATOLOGICALS
HEMANGEOL SOLN	-	2	BETA BLOCKERS
HEMATINIC PL TAB VITAMIN	-	2	HEMATOPOIETIC AGENTS
HEMATOGEN FA CAP	-	1	HEMATOPOIETIC AGENTS
HEMATRON-AF TAB	-	2	HEMATOPOIETIC AGENTS
HEMLIBRA INJ	AMSP-PA	4	HEMATOLOGICAL AGENTS - MISC.
hemoglobin test	-	1	DIAGNOSTIC PRODUCTS
heparin porcine inj	-	1	ANTICOAGULANTS
HEPLISAV-B INJ	VAC	1	VACCINES
HEPLISAV-B INJ	VAC	2	VACCINES
HIZENTRA INJ (Only available through Emerging Health 971-290-2010)	LD	2	PASSIVE IMMUNIZING AND TREATMENT AGENTS

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
homatropine ophth soln (ISOPTO HOMATROPINE equiv)	-	1	OPHTHALMIC AGENTS
HORIZANT TAB (QL= 30 tabs/30 days)	PA-QL	2	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
HORIZANT TAB 600MG (QL= 60 tabs/30 days)	PA-QL	2	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
HUMALOG MIX 50-50 KWIKPEN (QL= 60ml/30 days)	QL	2	ANTIDIABETICS
HUMALOG MIX INJ (QL= 60ml/30 days)	QL	2	ANTIDIABETICS
HUMATE-P INJ	AMSP-PA	4	HEMATOLOGICAL AGENTS - MISC.
HUMULIN MIX INJ (QL= 60ml/30 days)	OTC-QL	2	ANTIDIABETICS
HUMULIN MIX PEN INJ (QL= 60ml/30 days)	OTC-QL	2	ANTIDIABETICS
HUMULIN N INJ (QL= 60ml/30 days)	OTC-QL	2	ANTIDIABETICS
HUMULIN N PEN INJ (QL= 60ml/30 days)	OTC-QL	2	ANTIDIABETICS
HUMULIN R INJ (QL= 60ml/30days)	OTC-QL	2	ANTIDIABETICS
HUMULIN R INJ U-500 (QL= 40ml/30 days)	QL	2	ANTIDIABETICS
HUMULIN R U-500 KWIKPEN INJ (QL= 24ml/30 days)	QL	2	ANTIDIABETICS
HYCAMTIN CAP	-	2	ANTINEOPLASTICS
HYCLODEX SOLN	-	2	DERMATOLOGICALS

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier Category
HYD POL/CPM SUSP (QL=10ml/day)	QL	1 COUGH / COLD / ALLERGY
hydralazine tab (APRESOLINE equiv)	-	1 ANTIHYPERTENSIVES
hydrochlorothiazide cap (MICROZIDE equiv)	-	1 DIURETICS
hydrochlorothiazide tab (HYDRODIURIL equiv)	-	1 DIURETICS
hydrocodone/acetaminophen soln (HYCET, LORTAB equiv) (QL= 90ml/day)	QL	1 ANALGESICS - OPIOID
hydrocodone/acetaminophen tab 10-325mg (QL= 12 tabs/day)	QL	1 ANALGESICS - OPIOID
hydrocodone/acetaminophen tab 2.5-325mg (NORCO equiv) (QL= 12 tabs/day)	QL	1 ANALGESICS - OPIOID
hydrocodone/acetaminophen tab 5-325mg (QL= 12 tabs/day)	QL	1 ANALGESICS - OPIOID
hydrocodone/acetaminophen tab 7.5mg-325mg (QL= 12 tabs/day)	QL	1 ANALGESICS - OPIOID
hydrocodone/chlorpheniramine/pseudoephedrine liquid (ZUTRIPRO equiv)	-	1 COUGH / COLD / ALLERGY
hydrocodone/ibuprofen tab (VICOPROFEN equiv)	-	1 ANALGESICS - OPIOID
hydrocortisone butyrate cream (LOCOID equiv)	-	1 DERMATOLOGICALS
hydrocortisone butyrate lipocream (LOCOID equiv)	-	1 DERMATOLOGICALS
HYDROCORTISONE BUTYRATE OINT	-	1 DERMATOLOGICALS
hydrocortisone butyrate oint (LOCOID equiv)	-	1 DERMATOLOGICALS
hydrocortisone butyrate soln (LOCOID equiv)	-	1 DERMATOLOGICALS

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
hydrocortisone cream (PROCTOCORT equiv)	OTC	1	DERMATOLOGICALS
hydrocortisone enema (CORTENEMA equiv)	-	1	ANORECTAL AGENTS
hydrocortisone lotion 2.5%	-	1	DERMATOLOGICALS
hydrocortisone oint	OTC	1	DERMATOLOGICALS
hydrocortisone pramoxine cream (PRAMOSONE equiv)	-	1	DERMATOLOGICALS
hydrocortisone sodium succinate pf for inj	-	1	CORTICOSTEROIDS
hydrocortisone supp (ANUSOL HC equiv)	-	1	ANORECTAL AGENTS
hydrocortisone tab (CORTEF equiv)	-	1	CORTICOSTEROIDS
hydrocortisone valerate cream	-	1	DERMATOLOGICALS
hydrocortisone valerate oint (WESTCORT equiv)	-	1	DERMATOLOGICALS
hydrogen peroxide soln	-	1	ANTISEPTICS & DISINFECTANTS
hydromorphone liquid (DILAUDID equiv)	-	1	ANALGESICS - OPIOID
HYDROMORPHONE SUPP	-	1	ANALGESICS - OPIOID
hydromorphone tab (DILAUDID equiv)	-	1	ANALGESICS - OPIOID
hydroxychloroquine tab (PLAQUENIL equiv)	-	1	ANTIMALARIALS
HYDROXYPROGESTERONE CAPROATE INJ (QL=1 vial/35 days)	AMSP-PA-QL	3	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
hydroxyprogesterone inj (QL=4 vials/28 days)	AMSP-PA-QL	3	PROGESTINS
hydroxyurea cap (HYDREA equiv)	-	1	ANTINEOPLASTICS
hydroxyzine pamoate cap (VISTARIL equiv)	-	1	ANTI-ANXIETY AGENTS

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
HYDROXYZINE PAMOATE CAP 100MG	-	1	ANTIANXIETY AGENTS
hydroxyzine syrup (ATARAX equiv)	-	1	ANTIANXIETY AGENTS
hydroxyzine tab (ATARAX equiv)	-	1	ANTIANXIETY AGENTS
hyoscyamine sulfate CR tab (LEVVID 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 tab (LEVSIN equiv)	-	1	ULCER DRUGS
HYPERHEP B INJ	-	2	PASSIVE IMMUNIZING AND TREATMENT AGENTS
HYPERRHO S-D INJ	-	2	PASSIVE IMMUNIZING AGENTS
HYPERTET S-D INJ	-	2	PASSIVE IMMUNIZING AGENTS
HYPODERMIC NEEDLES	OTC	1	MEDICAL DEVICES AND SUPPLIES
HYQVIA INJ (Only available through Walgreens 888-347-3416)	LD-PA	2	PASSIVE IMMUNIZING AGENTS
ibandronate tab 150mg (BONIVA equiv) (QL=1 tab/28 days)	QL	1	ENDOCRINE AND METABOLIC AGENTS - MISC.

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
ibuprofen cap	OTC	1	ANALGESICS - ANTI-INFLAMMATORY
ibuprofen chew tab	-	1	ANALGESICS - ANTI-INFLAMMATORY
ibuprofen susp (ADVIL, MOTRIN equiv)	OTC	1	ANALGESICS - ANTI-INFLAMMATORY
ibuprofen tab	OTC	1	ANALGESICS - ANTI-INFLAMMATORY
ibuprofen tab 100mg	-	1	ANALGESICS - ANTI-INFLAMMATORY
ICAR-C PLUS TAB	-	1	HEMATOPOIETIC AGENTS
icatibant inj (QL=36 ml/30 days; Only available through Accredo 877-826-7657)	LD-PA-QL	3	HEMATOLOGICAL AGENTS - MISC.
icatibant inj (FIRAZYR equiv) (QL=36 ml/30 days)	AMSP-PA-QL	3	HEMATOLOGICAL AGENTS - MISC.
ICLUSIG TAB (QL= 30 tabs/30 days; Only available through AcariaHealth 1-800-511-5144)	LD-PA-QL	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
icosapent ethyl cap 0.5gm (QL=2 caps/day)	QL	1	ANTHYPERLIPIDEMICS
icosapent ethyl cap 1gm (VASCEPA equiv) (QL= 4 caps/day)	QL	1	ANTHYPERLIPIDEMICS
iferex 150 forte cap	-	1	HEMATOPOIETIC AGENTS
imatinib tab 100mg (GLEEVEC equiv)	AMSP	3	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
imatinib tab 400mg (GLEEVEC equiv)	AMSP	3	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
IMBRUVICA CAP 140MG (QL=4 caps/day; Only available through OPTUM - 877-445-6874)	LD-PA-QL	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
IMBRUVICA CAP 70MG (QL=1 cap/day; Only available through OPTUM - 877-445-6874)	LD-PA-QL	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
IMBRUVICA SUSP (QL=216 ml/30 days; Only available through OPTUM - 877-445-6874)	LD-PA-QL	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
IMBRUVICA TAB (QL=1 tab/day; Only available through OPTUM - 877-445-6874)	LD-PA-QL	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
imiquimod cream 5% (ALDARA equiv) (QL= 24gm/30 days)	QL	1	DERMATOLOGICALS
IMOVAX RABIES VACCINE INJ	-	2	VACCINES
IMPAVIDO CAP	AMSP-PA	4	ANTI-INFECTIVE AGENTS - MISC.
IMPLANON IMPLANT, NEXPLANON IMPLANT	-	2	CONTRACEPTIVES
IMPOYZ CREAM	-	2	DERMATOLOGICALS
INCRELEX INJ (Only available through AnovoRx 844-288-5007)	LD-PA	4	ENDOCRINE AND METABOLIC AGENTS - MISC.
INCRUSE ELLIPTA INHALER (QL= 1 inhaler/30 days)	QL	2	ANTI-ASTHMATIC AND BRONCHODILATOR AGENTS

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
indapamide tab (LOZOL equiv)	-	1	DIURETICS
INDERAL XL CAP, INNOPRAN XL CAP	-	2	BETA BLOCKERS
INDOCIN SUPP	-	2	ANALGESICS - ANTI-INFLAMMATORY
indomethacin cap (INDOCIN equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
indomethacin CR cap (INDOCIN SR equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
INFASURF INJ	-	2	RESPIRATORY AGENTS - MISC.
INLYTA TAB (QL= 4 tabs/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
INLYTA TAB 1MG (QL= 8 tabs/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
INOVA KIT	-	2	DERMATOLOGICALS
INSTA-GLUCOSE GEL	OTC	1	ANTIDIABETICS
INSUFLON	-	1	MEDICAL DEVICES AND SUPPLIES
INSULIN ASPART FLEXPEN INJ (NOVOLOG equiv) (QL= 60ml/30 days)	QL	1	ANTIDIABETICS
INSULIN ASPART INJ (NOVOLOG equiv) (QL= 60ml/30 days)	QL	1	ANTIDIABETICS

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
INSULIN ASPART MIX FLEXPEN INJ (NOVOLOG equiv) (QL= 60ml/30 days)	QL	1	ANTIDIABETICS
INSULIN ASPART MIX INJ (NOVOLOG equiv) (QL= 60ml/30 days)	QL	1	ANTIDIABETICS
INSULIN ASPART PENFILL INJ (NOVOLOG equiv) (QL= 60ml/30 days)	QL	1	ANTIDIABETICS
INSULIN GLARGINE INJ (QL= 60ml/30 days)	QL	2	ANTIDIABETICS
INSULIN GLARGINE, SEMGLEE INJ (QL= 60ml/30 days)	QL	2	ANTIDIABETICS
INSULIN GLARGINE-YFGN (QL= 60ml/30 days)	QL	2	ANTIDIABETICS
INSULIN LISPRO INJ (QL= 60ml/30 days)	QL	1	ANTIDIABETICS
INSULIN LISPRO KWIKPEN INJ (JUNIOR) (QL= 60ml/30 days)	QL	1	ANTIDIABETICS
INSULIN LISPRO PROTAMINE INJ (QL= 60ml/30 days)	QL	1	ANTIDIABETICS
INTEGRA F CAP	-	1	HEMATOPOIETIC AGENTS
INTELENCE TAB	-	2	ANTIVIRALS
INTELENCE TAB 25MG	-	2	ANTIVIRALS
INTRON-A INJ	AMSP	4	ANTINEOPLASTICS
INVIRASE TAB	-	2	ANTIVIRALS
IODINE SOLN	--OTC	1	CHEMICALS
IODOFLEX PAD	-	2	ANTISEPTICS & DISINFECTANTS

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
iodoquinol/hydrocortisone cream 1% (VYTONE equiv)	-	1	DERMATOLOGICALS
iodoquinol/hydrocortisone/aloe polysaccharide gel (ALCORTIN A equiv)	-	1	DERMATOLOGICALS
IPOL VACCINE INJ	-	2	VACCINES
ipratropium neb soln (ATROVENT equiv)	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
irbesartan tab (AVAPRO equiv)	-	1	ANTIHYPERTENSIVES
irbesartan/hydrochlorothiazide tab (AVALIDE equiv)	-	1	ANTIHYPERTENSIVES
iron 100 plus tab	OTC	1	HEMATOPOIETIC AGENTS
IRON POLYSACCH/THREONIC ACID/B12/FA CAP	OTC	1	HEMATOPOIETIC AGENTS
iron tab	OTC	1	HEMATOPOIETIC AGENTS
IROSPAN 24/6 PACK	-	2	HEMATOPOIETIC AGENTS
ISENTRESS (HD) TAB	-	2	ANTIVIRALS
ISENTRESS CHEW TAB	-	2	ANTIVIRALS
ISENTRESS POWDER PACK	-	2	ANTIVIRALS
isibloom tab, enskyce tab, apri tab (DESOGEN equiv)	-	1	CONTRACEPTIVES
isoflurane liquid	-	1	GENERAL ANESTHETICS
isoniazid syrup	-	1	ANTIMYCOBACTERIAL AGENTS

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
isoniazid tab	-	1	ANTIMYCOBACTERIAL AGENTS
ISOSORBIDE DINITRATE ER TAB	-	1	ANTIANGINAL AGENTS
isosorbide dinitrate tab 5mg (ISORDIL equiv)	-	1	ANTIANGINAL AGENTS
isosorbide dinitrate-hydralazine tab (QL=6 tabs/day)	QL	1	CARDIOVASCULAR AGENTS - MISC.
isosorbide mononitrate ER tab (IMDUR equiv)	-	1	ANTIANGINAL AGENTS
ISOSORBIDE MONONITRATE TAB	-	1	ANTIANGINAL AGENTS
isosorbide mononitrate tab (MONOKET equiv)	-	1	ANTIANGINAL AGENTS
isoxsuprine tab	-	1	CARDIOVASCULAR AGENTS - MISC.
ISOXSUPRINE TAB (QL=4 tabs/day)	QL	2	CARDIOVASCULAR AGENTS - MISC.
isradipine cap (DYNACIRC equiv)	-	1	CALCIUM CHANNEL BLOCKERS
itraconazole cap (SPORANOX equiv)	-	1	ANTIFUNGALS
itraconazole soln (SPORANOX equiv)	-	1	ANTIFUNGALS
ivabradine hcl tab (QL = 60 tabs/30 days)	QL	3	CARDIOVASCULAR AGENTS - MISC.
ivermectin cream (SOOLANTRA equiv) (QL=45gm/30 days)	QL	1	DERMATOLOGICALS
ivermectin tab (STROMEKTOL equiv)	-	1	ANTHELMINTICS

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
javygtor pak 100mg	LMSP-PA	3	ENDOCRINE AND METABOLIC AGENTS - MISC.
javygtor powder 500mg	LMSP-PA	3	ENDOCRINE AND METABOLIC AGENTS - MISC.
javygtor tab 100mg	LMSP-PA	3	ENDOCRINE AND METABOLIC AGENTS - MISC.
jinteli tab (FEMHRT equiv)	-	1	ESTROGENS
JORNAY PM CAP (QL=1 cap/day)	QL	2	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXICANTS
JULUCA TAB	-	2	ANTIVIRALS
junel FE tab (LOESTRIN FE equiv)	-	1	CONTRACEPTIVES
junel tab (LOESTRIN equiv)	-	1	CONTRACEPTIVES
JYNARQUE PAK (QL= 2 tabs/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	4	ENDOCRINE AND METABOLIC AGENTS - MISC.
JYNARQUE TAB 15MG (QL= 2 tabs/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	4	ENDOCRINE AND METABOLIC AGENTS - MISC.

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
JYNNEOS INJ	-	2	VACCINES
KALYDECO PAK (Only available through Walgreens 888-347-3416)	LD-PA	4	RESPIRATORY AGENTS - MISC.
KALYDECO PAK (QL=2 packets/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	4	RESPIRATORY AGENTS - MISC.
KALYDECO PAK 13.4MG (QL=2 packets/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	4	RESPIRATORY AGENTS - MISC.
KALYDECO TAB (QL= 2 tabs/day; Only available through Walgreens 888-347-3416)	LD-QL	4	RESPIRATORY AGENTS - MISC.
KAPSPARGO CAP	-	2	BETA BLOCKERS
KEDRAB INJ	-	2	PASSIVE IMMUNIZING AND TREATMENT AGENTS
kelnor tab (DEMULEN equiv)	-	1	CONTRACEPTIVES
KERALYT SCALP KIT	-	2	DERMATOLOGICALS
ketoconazole cream (NIZORAL CREAM equiv)	-	1	DERMATOLOGICALS
ketoconazole shampoo	-	1	DERMATOLOGICALS
ketoconazole tab (NIZORAL equiv)	-	1	ANTIFUNGALS
KETOPROFEN CAP	-	1	ANALGESICS - ANTI-INFLAMMATORY
ketorolac ophth soln .05% (ACULAR (LS) equiv)	-	1	OPHTHALMIC AGENTS
ketorolac ophth soln .4% (ACULAR (LS) equiv)	-	1	OPHTHALMIC AGENTS
ketorolac tab (TORADOL equiv) (QL= 20 tabs/30 days)	QL	1	ANALGESICS - ANTI-INFLAMMATORY

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
KINRIX INJ	-	2	TOXOIDS
KLOXXADO SPRAY, RIVIVE SPRAY	OTC	2	ANTIDOTES
KOATE INJ	AMSP-PA	4	HEMATOLOGICAL AGENTS - MISC.
KYLEENA IUD	-	2	CONTRACEPTIVES
KYNMOBI FILM (QL= 150 films/30 days. Only available through Ardon 855-425-4085)	AMSP-QL	4	ANTIPARKINSON AND RELATED THERAPY AGENTS
KYNMOBI TITRATION KIT (Only available through Ardon 855-425-4085)	AMSP-PA	4	ANTIPARKINSON AND RELATED THERAPY AGENTS
L.E.T. GEL	-	1	DERMATOLOGICALS
labetalol tab (NORMODYNE equiv)	-	1	BETA BLOCKERS
lacosamide oral solution (QL= 1200ml/30 days)	QL	1	ANTICONVULSANTS
lacosamide tab (QL=2 tabs/day)	QL	1	ANTICONVULSANTS
LACRISERT INSERT	-	2	OPHTHALMIC AGENTS
lactulose soln	-	1	LAXATIVES
LAGEVRIO CAP (QL=40 caps/5 days, 40 caps/fill; Covered for members age 18 years or older)	QL	2	ANTIVIRALS
LAGEVRIO CAP (EUA) (QL=40 caps/fill)	QL	1	ANTIVIRALS
lamivudine soln (EPIVIR equiv) (QL= 960ml/30 days)	QL	1	ANTIVIRALS

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
lamivudine tab 100mg (EPIVIR HBV equiv) (QL= 1 tab/day)	AMSP	1	ANTIVIRALS
lamivudine tab 150mg (EPIVIR equiv) (QL= 2 tabs/day)	QL	1	ANTIVIRALS
lamivudine tab 300mg (EPIVIR equiv) (QL= 1 tab/day)	QL	1	ANTIVIRALS
lamivudine/zidovudine tab (COMBIVIR equiv) (QL= tabs/day)	QL	1	ANTIVIRALS
LAMPIT TAB	-	2	ANTI-INFECTIVE AGENTS MISC.
LANCET DEVICE	OTC	1	MEDICAL DEVICES AND SUPPLIES
LANCET KIT	OTC	1	MEDICAL DEVICES AND SUPPLIES
LANCET MISC	OTC	1	MEDICAL DEVICES AND SUPPLIES
LANCETS	OTC	1	MEDICAL DEVICES AND SUPPLIES
lansoprazole/amoxicillin/clarithromycin kit (PREVPAC equiv)	-	1	ULCER DRUGS / ANTISPASMODICS / ANTICHOLINERGICS

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
lanthanum carbonate chew tab 1000mg (QL=3 tabs/day; Step Therapy requires trial of sevelamer carbonate tab or sevelamer HCL tab)	QL-ST	1	GASTROINTESTINAL AGENTS - MISC.
lanthanum carbonate chew tab 500mg (QL=5 tabs/day; Step Therapy requires trial of sevelamer carbonate tab or sevelamer HCL tab)	QL-ST	1	GASTROINTESTINAL AGENTS - MISC.
lanthanum carbonate chew tab 750mg (QL=3 tabs/day; Step Therapy requires trial of sevelamer carbonate tab or sevelamer HCL tab)	QL-ST	1	GASTROINTESTINAL AGENTS - MISC.
lapatinib ditosylate tab (TYKERB equiv)	AMSP-PA	3	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
LASTACRAFT OPTH SOLN	-	2	OPHTHALMIC AGENTS
latanoprost ophth soln (XALATAN equiv)	-	1	OPHTHALMIC AGENTS
LATANOPROST OPTH SOLN (QL=30 single use containers/30 days; Step therapy requires trial of latanoprost ophth soln)	QL-ST	2	OPHTHALMIC AGENTS
layolis FE tab (FEMCON FE equiv)	-	1	CONTRACEPTIVES
LAZANDA NASAL SPRAY	-	2	ANALGESICS - OPIOID
leflunomide tab (ARAVA equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
lenalidomide cap (QL= 1 cap/day; Only available through Onco360 877-662-6633)	LD-PA-QL	3	MISCELLANEOUS THERAPEUTIC CLASSES

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
LENVIMA CAP (QL= 3 caps/day; Only available through OPTUM - 877-445-6874)	LD-PA-QL	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
letrozole tab (FEMARA equiv)	-	1	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
leucovorin tab	-	1	ANTINEOPLASTICS
leuprolide inj (LUPRON equiv)	PA	3	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
LEVALBUTEROL INHALER (QL= 2 inhalers/fill, 2 fills/30 days; Step Therapy requires trial of albuterol hfa inhaler)	QL-ST	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
levalbuterol neb soln (XOPENEX equiv) (QL= 96 vials/30 days; Step Therapy requires trial of albuterol neb soln)	QL-ST	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
LEVATOL TAB	-	2	BETA BLOCKERS
levetiracetam ER tab (KEPPRA XR equiv)	-	1	ANTICONVULSANTS
levetiracetam soln (KEPPRA equiv)	-	1	ANTICONVULSANTS
levetiracetam tab (KEPPRA equiv)	-	1	ANTICONVULSANTS
LEVOBUNOLOL OPHTH SOLN	-	1	OPHTHALMIC AGENTS
levobunolol ophth soln (BETAGAN equiv)	-	1	OPHTHALMIC AGENTS
levocarnitine soln (CARNITOR equiv)	-	1	ENDOCRINE AND METABOLIC AGENTS - MISC.

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
levocarnitine tab (CARNITOR equiv)	-	1	ENDOCRINE AND METABOLIC AGENTS - MISC.
levocetirizine soln (XYZAL equiv) (QL= 10ml/day)	QL	1	ANTIHISTAMINES
levofloxacin ophth soln (QUIXIN equiv)	-	1	OPHTHALMIC AGENTS
levofloxacin oral soln 25mg/ml	-	1	FLUOROQUINOLONES
LEVOFLOXACIN SOLN	-	1	FLUOROQUINOLONES
levofloxacin tab (LEVAQUIN equiv)	-	1	FLUOROQUINOLONES
levonorgestrel tab (PLAN B equiv)	OTC	1	CONTRACEPTIVES
levonorgestrel-ethinyl estradiol-fe tab	-	1	CONTRACEPTIVES
levothyroxine tab (SYNTHROID equiv)	-	1	THYROID AGENTS
LEXIVA SUSP	-	2	ANTIVIRALS
LIDOCAINE ORAL SOLN 4%	-	1	MOUTH / THROAT / DENTAL AGENTS
lidocaine soln (XYLOCAINE equiv)	-	1	DERMATOLOGICALS
lidocaine/hydrocortisone cream (ANAMANTLE equiv)	-	1	ANORECTAL AGENTS
lidocaine/prilocaine cream (EMLA equiv)	-	1	DERMATOLOGICALS
lidocaine/prilocaine cream kit	-	1	DERMATOLOGICALS
LIDO-EP-TETR SOLN	-	1	DERMATOLOGICALS
lidopac kit	-	2	DERMATOLOGICALS
LIDOPIN CREAM	-	2	DERMATOLOGICALS

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
LIDOTREX GEL	-	2	DERMATOLOGICALS
LIDOVEX CREAM	-	2	DERMATOLOGICALS
LIKMEZ SUSP (QL = 210 mL/14 days)	QL	2	ANTI-INFECTIVE AGENTS MISC.
LINDANE LOTION	-	1	DERMATOLOGICALS
linezolid susp	-	1	ANTI-INFECTIVE AGENTS MISC.
liothyronine tab (CYTOMEL equiv)	-	1	THYROID AGENTS
LIPOCHOL PLUS TAB	OTC	2	NUTRIENTS
LIQUIMAT LOTION (QL= 360g/30 days)	OTC-QL	2	DERMATOLOGICALS
liraglutide soln pen-injector	QL-RDX	1	ANTIDIABETICS
lisinopril tab (PRINIVIL/ZESTRIL equiv)	-	1	ANTIHYPERTENSIVES
lisinopril/hydrochlorothiazide tab (ZESTORETIC equiv)	-	1	ANTIHYPERTENSIVES
LITHOSTAT TAB	-	2	GENITOURINARY AGENTS - MISCELLANEOUS
LO LOESTRIN TAB	-	2	CONTRACEPTIVES
LOCOID LIPOCREAM	-	1	DERMATOLOGICALS
lofexidine tab (QL= 224 tablets/fill; 1 fill/month)	QL	1	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
LOKELMA PAK (QL=1 pak/day; Step Therapy requires trial of 1 diuretic: chlorothiazide, chlorthalidone, bumetanide, hydrochlorothiazide, torsemide, indapamide, furosemide, ethacrynic acid, metolazone, chlorothiazide or hydrochlorothiazide)	QL-ST	2	MISCELLANEOUS THERAPEUTIC CLASSES
LONSURF TAB (QL= 80 tabs/28 days; Only available through OPTUM - 877-445-6874 or Walgreens 888-347-3416)	LD-PA-QL	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
loperamide cap (IMODIUM equiv)	-	1	ANTIDIARRHEALS
lopinavir/ritonavir soln (KALETRA equiv) (QL= 480ml/30 days)	QL	1	ANTIVIRALS
lopinavir-ritonavir tab 100-25mg (QL=2 tabs/day)	QL	1	ANTIVIRALS
lopinavir-ritonavir tab 200-50mg (QL=4 tabs/day)	QL	1	ANTIVIRALS
LOPROX KIT	-	2	DERMATOLOGICALS
loratadine ODT (CLARITIN equiv)	OTC	1	ANTIHISTAMINES
loratadine syrup (CLARITIN equiv)	OTC	1	ANTIHISTAMINES
loratadine tab (CLARITIN equiv)	OTC	1	ANTIHISTAMINES
LORTUSS EX LIQUID	-	2	COUGH / COLD / ALLERGY
losartan tab (COZAAR equiv)	-	1	ANTIHYPERTENSIVES
losartan/hydrochlorothiazide tab (HYZAAR equiv)	-	1	ANTIHYPERTENSIVES
LOTEMAX OPHTH OINT	-	2	OPHTHALMIC AGENTS

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
loteprednol etabonate ophth gel (LOTEMAX equiv) (QL= 5 grams/28 days)	QL	1	OPHTHALMIC AGENTS
lovastatin tab (MEVACOR equiv) (QL= 2 tabs/day)	QL	1	ANTIHYPERTENSIVES
lubiprostone cap (QL=2 caps/day)	QL	1	GASTROINTESTINAL AGENTS - MISC.
lubricant eye oint	OTC	2	OPHTHALMIC AGENTS
LUPRON DEPOT INJ	AMSP-PA	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
LUXAMEND CREAM	-	2	DERMATOLOGICALS
MACUZIN CAP	-	2	DIETARY PRODUCTS / DIETARY MANAGEMENT PRODUCTS
mafenide acetate soln packet (SULFAMYLON equiv)	-	1	DERMATOLOGICALS
MAG 64 TAB	OTC	1	MINERALS & ELECTROLYTES
magnesium chloride dr tab	OTC	1	MINERALS & ELECTROLYTES
magnesium citrate soln	OTC	1	LAXATIVES
MAGNESIUM OXIDE CHEW TAB	OTC	1	MINERALS & ELECTROLYTES
magnesium oxide tab	OTC	1	MINERALS & ELECTROLYTES

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA		Prior Authorization
QL	Quantity Limit	RDX		Restricted to Diagnosis
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
magnesium oxide tab 400mg	OTC	1	MINERALS & ELECTROLYTES
magnesium tab 400mg	OTC	1	MINERALS & ELECTROLYTES
malathion lotion (OVIDE equiv)	-	1	DERMATOLOGICALS
MALE CONDOMS	OTC	1	MEDICAL DEVICES AND SUPPLIES
maraviroc tab 150mg (QL=2 tabs/day)	QL	1	ANTIVIRALS
maraviroc tab 300mg (QL=4 tabs/day)	QL	1	ANTIVIRALS
MASTISOL LIQUID	-	1	DERMATOLOGICALS
MATULANE CAP (Only available through Walgreens 888-347-3416)	LD	4	ANTINEOPLASTICS
MAVYRET PAK (QL=5 packets/day)	AMSP-PA-QL	4	ANTIVIRALS
MAVYRET TAB (QL= 3 tabs/day)	AMSP-QL	4	ANTIVIRALS
MAXIDEX OPHTH SOLN	-	2	OPHTHALMIC AGENTS
MAXI-TUSS CD LIQUID	OTC	2	COUGH / COLD / ALLERGY
meclizine tab (ANTIVERT equiv)	-	1	ANTIEMETICS
MEDROL TAB	-	2	CORTICOSTEROIDS
medroxyprogesterone inj (DEPO-PROVERA equiv) (QL= 1 inj/84 days)	QL	1	CONTRACEPTIVES
medroxyprogesterone tab (PROVERA equiv)	-	1	PROGESTINS
mefloquine tab (LARIAM equiv)	-	1	ANTIMALARIALS

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
megestrol ES susp (MEGACE ES equiv)	-	1	PROGESTINS
MEGESTROL SUSP	-	1	PROGESTINS
megestrol susp (MEGACE equiv)	-	1	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
megestrol tab (MEGACE equiv)	-	1	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
MEKINIST SOLN (QL=40 ml/day)	LMSP-PA-QL	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
MEKINIST TAB 0.5MG (QL= 3 tabs/day)	AMSP-PA-QL	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
MEKINIST TAB 2MG (QL= 1 tab/day)	AMSP-PA-QL	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
MELATONIN TAB	OTC	1	ALTERNATIVE MEDICINES
melatonin tab 3mg	OTC	1	ALTERNATIVE MEDICINES
meloxicam cap (VIVLODEX equiv) (QL= 1 cap/day; Step Therapy requires trial of meloxicam, aspirin, naproxen, diclofenac, ketoprofen, oxaprozin, sulindac, or tolmetin)	QL-ST	1	ANALGESICS - ANTI-INFLAMMATORY
meloxicam tab (MOBIC equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
MELPHALAN TAB	AMSP	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
memantine ER cap (NAMENDA XR equiv) (QL= 1 cap/day; Step Therapy requires trial of memantine tab)	QL-ST	1	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
memantine tab	-	1	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
MENACTRA INJ	VAC	2	VACCINES
MENEST TAB	-	2	ESTROGENS
MENHIBRIX INJ	VAC	2	VACCINES
MENOMUNE INJ	VAC	2	VACCINES
MENOSTAR PATCH	-	2	ESTROGENS
MENQUADFI INJ	VAC	2	VACCINES
MENVEO INJ	VAC	2	VACCINES
MENVEO SOLN	VAC	2	VACCINES
MEPERIDINE SOLN	-	1	ANALGESICS - OPIOID
mercaptopurine susp	AMSP	3	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
mercaptopurine tab (PURINETHOL equiv)	-	1	ANTINEOPLASTICS
mesalamine DR cap (DELZICOL equiv) (QL= 6 caps/day)	QL	1	GASTROINTESTINAL AGENTS - MISC.
MESALAMINE DR TAB	-	1	GASTROINTESTINAL AGENTS - MISC.

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
mesalamine DR tab 1.2 GM (LIALDA equiv) (QL 120 tabs/30 days)	QL	1	GASTROINTESTINAL AGENTS - MISC.
mesalamine enema (ROWASA equiv) (QL= 60mL/day)	QL	1	GASTROINTESTINAL AGENTS - MISC.
mesalamine ER cap (APRISO equiv) (QL= 8 caps/day)	QL	1	GASTROINTESTINAL AGENTS - MISC.
mesalamine supp (CANASA equiv) (QL= 1 supp/day)	QL	1	GASTROINTESTINAL AGENTS - MISC.
mesna tab	AMSP	3	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
metformin ER osmotic tab (FORTAMET equiv)	-	1	ANTIDIABETICS
metformin ER tab (GLUCOPHAGE XR equiv)	-	1	ANTIDIABETICS
metformin tab (GLUCOPHAGE equiv)	-	1	ANTIDIABETICS
METHADONE SOLN	-	1	ANALGESICS - OPIOID
methadone soln (QL= 4 ml/day)	QL	1	ANALGESICS - OPIOID
METHADONE SOLN 10MG/5ML (QL= 20ml/day)	QL	1	ANALGESICS - OPIOID
METHADONE SOLN 5MG/5ML (QL= 40ml/day)	QL	1	ANALGESICS - OPIOID
methadone tab 10mg (DOLOPHINE equiv) (QL= 4 tabs/day)	QL	1	ANALGESICS - OPIOID
methadone tab 5mg (DOLOPHINE equiv) (QL= 8 tabs/day)	QL	1	ANALGESICS - OPIOID
methadose tab (QL= 1 tab/day)	QL	1	ANALGESICS - OPIOID

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
methenamine mandelate tab	-	1	ANTI-INFECTIVE AGENTS MISC.
methimazole tab (TAPAZOLE equiv)	-	1	THYROID AGENTS
methocarbamol tab (ROBAXIN equiv)	-	1	MUSCULOSKELETAL THERAPY AGENTS
METHOTREXATE INJ	-	1	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
methotrexate tab (Trexall equiv)	-	1	ANTINEOPLASTICS
methoxsalen cap (Oxsoralen Ultra equiv)	-	1	DERMATOLOGICALS
methscopolamine tab (Pamine equiv)	-	1	ULCER DRUGS
METHYCLOTHIAZIDE TAB	-	2	DIURETICS
methyl dopa tab (Aldomet equiv)	-	1	ANTIHYPERTENSIVES
METHYLDOPA TAB	-	2	ANTIHYPERTENSIVES
methyl dopa/hydrochlorothiazide tab (Aldoril equiv)	-	1	ANTIHYPERTENSIVES
methylergonovine tab (Methergine equiv)	-	1	OXYTOCICS
methylphenidate CD cap (Metadate CD equiv) (QL= 1 cap/day)	QL	1	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier Category
methylphenidate chew tab (METHYLIN equiv) (QL= 3 tabs/day)	QL	1 ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
methylphenidate ER cap 10mg (QL=60 caps/30 days)	QL	1 ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
methylphenidate ER cap 10mg (RITALIN LA equiv) (QL= 1 cap/day)	QL	1 ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
methylphenidate ER cap 20mg (QL= 2 caps/day)	QL	1 ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
methylphenidate ER cap 20mg (QL=60 caps/30 days)	QL	1 ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA		Prior Authorization
QL	Quantity Limit	RDX		Restricted to Diagnosis
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
methylphenidate ER cap 30mg (QL=60 caps/30 days)	QL	1	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
methylphenidate ER cap 30mg (RITALIN LA equiv) (QL= 2 caps/day)	QL	1	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
methylphenidate ER cap 40mg (RITALIN LA equiv) (QL= 1 cap/day)	QL	1	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
methylphenidate ER cap 60mg (RITALIN LA equiv) (QL= 1 cap/day)	QL	1	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
methylphenidate ER tab (QL= 1 tab/day)	QL	1	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier Category
methylphenidate ER tab 10mg (QL= 3 tabs/day)	QL	1 ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
methylphenidate ER tab 18mg (QL=60 tabs/30 days)	QL	1 ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
methylphenidate ER tab 20mg (QL= 3 tabs/day)	QL	1 ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
methylphenidate ER tab 27mg (QL=60 tabs/30 days)	QL	1 ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
METHYLPHENIDATE ER TAB 36MG (QL=60 tabs/30 days)	QL	1 ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA		Prior Authorization
QL	Quantity Limit	RDX		Restricted to Diagnosis
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
methylphenidate soln 10mg/5ml (QL= 900ml/30 days)	QL	1	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
methylphenidate soln 5mg/5ml (METHYLIN equiv) (QL= 1800ml/30 days)	QL	1	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
methylphenidate tab (RITALIN equiv) (QL= 3 tabs/day)	QL	1	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
methylprednisolone dose pack (MEDROL equiv)	-	1	CORTICOSTEROIDS
methylprednisolone tab (MEDROL equiv)	-	1	CORTICOSTEROIDS
methyltestosterone cap (QL= 150 caps/30 days)	PA-QL	2	ANDROGENS-ANABOLIC
METIPRANOLOL OPTH SOLN	-	1	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

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
metoprolol/hydrochlorothiazide tab (LOPRESSOR HCT equiv)	-	1	ANTIHYPERTENSIVES
metronidazole cap (FLAGYL equiv)	-	1	ANTI-INFECTIVE AGENTS MISC.
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
metyrosine cap (DEMSER equiv) (QL= 448 caps/28 days)	PA-QL	3	ANTIHYPERTENSIVES
mexiletine hcl cap	-	1	ANTIARRHYTHMICS
mibelas chew tab (MINASTRIN equiv)	-	1	CONTRACEPTIVES
MICATIN CREAM 2%	OTC	1	DERMATOLOGICALS
MICONAZOLE 3 SUPP 200MG	-	1	VAGINAL PRODUCTS
miconazole cream	OTC	1	DERMATOLOGICALS
miconazole nitrate cream	OTC	1	VAGINAL PRODUCTS
miconazole nitrate kit	OTC	1	VAGINAL AND RELATED PRODUCTS
miconazole nitrate vaginal supp	OTC	1	VAGINAL PRODUCTS
midazolam hcl syrup	-	1	HYPNOTICS / SEDATIVES SLEEP DISORDER AGENTS

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier Category
MIDAZOLAM INJ	-	1 HYPNOTICS / SEDATIVES SLEEP DISORDER AGENTS
midazolam inj (MIDAZOLAM equiv)	-	1 HYPNOTICS / SEDATIVES SLEEP DISORDER AGENTS
mifepristone tab (MIFEPREX equiv)	-	1 ENDOCRINE AND METABOLIC AGENTS - MISC.
mifepristone tab (QL = 4 tabs/day)	AMSP-PA-QL	3 ANTIDIABETICS
MIGERGOT SUPP	-	2 MIGRAINE PRODUCTS
miglustat cap (ZAVESCA equiv) (QL= 3 caps/day; Only available through Accredo 877-826-7657)	LD-PA-QL	3 HEMATOPOIETIC AGENTS
migraine relief tab	OTC	1 ANALGESICS - NONNARCOTIC
milk of magnesia susp	OTC	1 LAXATIVES
MILLIPRED DP PAK	-	2 CORTICOSTEROIDS
MILLIPRED TAB	-	2 CORTICOSTEROIDS
minocycline cap (MINOCIN equiv)	-	1 TETRACYCLINES
minocycline er tab 65mg	-	1 TETRACYCLINES
minocycline tab (DYNACIN equiv)	-	1 TETRACYCLINES
minoxidil tab (LONITEN equiv)	-	1 ANTIHYPERTENSIVES
MIRENA IUD	-	2 CONTRACEPTIVES

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
misoprostol tab (CYTOTEC equiv)	-	1	ULCER DRUGS
MITOSOL KIT	-	2	OPHTHALMIC AGENTS
M-M-R II INJ	VAC	2	VACCINES
moexipril tab (UNIVASC equiv)	-	1	ANTIHYPERTENSIVES
mometasone cream (ELOCON equiv)	-	1	DERMATOLOGICALS
mometasone oint (ELOCON equiv)	-	1	DERMATOLOGICALS
mometasone soln (ELOCON equiv)	-	1	DERMATOLOGICALS
MONISTAT 3 COMBO PACK	OTC	2	VAGINAL AND RELATED PRODUCTS
MONISTAT SOOTHING CARE CREAM 1%	OTC	1	VAGINAL AND RELATED PRODUCTS
MONSEL'S SOLN	-	1	HEMOSTATICS
montelukast chew tab (SINGULAIR equiv)	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
montelukast tab (SINGULAIR equiv)	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
morphine sulfate ER cap 100mg (QL= 2 caps/day)	QL	1	ANALGESICS - OPIOID
morphine sulfate ER cap 10mg (KADIAN equiv) (QL= 2 caps/day)	QL	1	ANALGESICS - OPIOID
morphine sulfate ER cap 30mg (QL= 2 caps/day)	QL	1	ANALGESICS - OPIOID

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
morphine sulfate ER tab (MS CONTIN equiv) (QL= 3 tabs/day)	QL	1	ANALGESICS - OPIOID
morphine sulfate oral soln	-	1	ANALGESICS - OPIOID
morphine sulfate oral soln 20mg/5ml	-	1	ANALGESICS - OPIOID
morphine sulfate soln	-	1	ANALGESICS - OPIOID
MORPHINE SULFATE SOLN	-	2	ANALGESICS - OPIOID
MORPHINE SULFATE SOLN 20MG/5ML	-	2	ANALGESICS - OPIOID
MORPHINE SULFATE SUPP	-	1	ANALGESICS - OPIOID
morphine sulfate tab	-	1	ANALGESICS - OPIOID
MOTOFEN TAB	-	2	ANTIDIARRHEALS
MOXATAG TAB	-	2	PENICILLINS
moxifloxacin ophth soln (VIGAMOX OPHTH SOLN equiv) (QL=3 ml/7 days; Step therapy requires trial of ciprofloxacin ophth soln, levofloxacin ophth soln, or ofloxacin ophth soln)	QL-ST	1	OPHTHALMIC AGENTS
moxifloxacin tab (AVELOX equiv)	-	1	FLUOROQUINOLONES
MRESVIA INJ (QL= 0.5 mL/fill; Covered for ages 6 years and older)	QL-VAC	2	VACCINES
MTX SUPPORT TAB	OTC	1	HEMATOPOIETIC AGENTS
MULPLETA TAB (QL= 7 tabs/fill, 3 fills/365 days; Only available through Lumicera 855-847-3553)	LMSP-PA-QL	4	HEMATOPOIETIC AGENTS
MULTAQ TAB	-	2	ANTIARRHYTHMICS

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
multi vitamin with iron tab	OTC	1	MULTIVITAMINS
MULTIGEN FOLIC TAB	-	1	HEMATOPOIETIC AGENTS
MULTIGEN PLUS TAB	-	1	HEMATOPOIETIC AGENTS
multivitamin tab	OTC	1	MULTIVITAMINS
multivitamin/flouride/iron drops	OTC	1	MULTIVITAMINS
mupirocin cream (BACTROBAN CREAM equiv)	-	1	DERMATOLOGICALS
mupirocin oint (BACTROBAN OINT equiv)	-	1	DERMATOLOGICALS
MURO-128 OINT 5%	OTC	1	OPHTHALMIC AGENTS
MVW COMPLETE MULTIVITAMIN CAP	OTC	1	MULTIVITAMINS
mycophenolate DR tab (MYFORTIC equiv)	-	1	ASSORTED CLASSES
mycophenolate mofetil cap (CELLCEPT equiv)	-	1	ASSORTED CLASSES
mycophenolate mofetil susp (CELLCEPT SUSP equiv)	-	1	ASSORTED CLASSES
mycophenolate mofetil tab (CELLCEPT equiv)	-	1	ASSORTED CLASSES
MYHIBBIN SUSP	-	2	MISCELLANEOUS THERAPEUTIC CLASSES
MYLERAN TAB	AMSP	4	ANTINEOPLASTICS
mynephron cap	OTC	1	MULTIVITAMINS
MYTESI TAB (QL= 2 tabs/day)	QL	2	ANTIDIARRHEALS
NABI-HB INJ	-	2	PASSIVE IMMUNIZING AND TREATMENT AGENTS

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier Category
nabumetone tab (RELAFEN equiv)	-	1 ANALGESICS - ANTI-INFLAMMATORY
nadolol tab (CORGARD equiv)	-	1 BETA BLOCKERS
nadolol/bendroflumethiazide tab (CORZIDE equiv)	-	1 ANTIHYPERTENSIVES
naftifine gel (NAFTIN equiv)	-	1 DERMATOLOGICALS
NALOXONE HCL SOLN 0.4MG/ML (QL = 2 mL/fill, 2 fills/30 days)	QL	1 ANTIDOTES AND SPECIFIC ANTAGONISTS
naloxone inj	-	1 ANTIDOTES AND SPECIFIC ANTAGONISTS
naloxone nasal spray	OTC	1 ANTIDOTES AND SPECIFIC ANTAGONISTS
naloxone prefilled inj	-	1 ANTIDOTES AND SPECIFIC ANTAGONISTS
naltrexone tab (REVIA equiv)	-	1 ANTIDOTES
NAMENDA XR TITRATION PACK (QL= 28 caps/28 days, Step Therapy requires trial of memantine tab)	QL-ST	2 PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
NAMZARIC CAP	-	2 PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
NAMZARIC STARTER PACK	-	2 PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA		Prior Authorization
QL	Quantity Limit	RDX		Restricted to Diagnosis
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
naproxen EC tab (NAPROSYN EC equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
naproxen sodium tab (ANAPROX equiv)	OTC	1	ANALGESICS - ANTI-INFLAMMATORY
NAPROXEN SUSP	-	1	ANALGESICS - ANTI-INFLAMMATORY
naproxen susp (NAPROSYN equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
naproxen tab (NAPROSYN equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
naratriptan tab (AMERGE equiv) (QL= 9 tabs/30 days)	QL	1	MIGRAINE PRODUCTS
NARCAN NASAL SPRAY	OTC	1	ANTIDOTES AND SPECIFIC ANTAGONISTS
NATACYN OPTH SUSP (QL=45 ml/30 days)	QL	2	OPHTHALMIC AGENTS
NATAZIA TAB	-	2	CONTRACEPTIVES
nateglinide tab (STARLIX equiv)	-	1	ANTIDIABETICS
NATESTO NASAL GEL (QL=3 bottles/30 days)	PA-QL	2	ANDROGENS-ANABOLIC
NAYZILAM SPRAY (QL = 4 doses/fill, 5 fills/month)	QL	2	ANTICONVULSANTS
nebivolol tab (QL=1 tab/day)	QL	1	BETA BLOCKERS
NEFFY SPRAY (QL=2 inj/fill)	QL	2	VASOPRESSORS
neomycin tab	-	1	AMINOGLYCOSIDES

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
NEOMYCIN/POLYMYXIN/GRAMICIDIN OPHTH SOLN	-	1	OPHTHALMIC AGENTS
neomycin/polymixin/hydrocortisone otic soln (CORTISPORIN equiv)	-	1	OTIC AGENTS
neomycin/polymixin/hydrocortisone otic susp (CORTISPORIN equiv)	-	1	OTIC 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	-	1	OPHTHALMIC AGENTS
NEOSALUS FOAM	-	2	DERMATOLOGICALS
NEO-SYNALAR CREAM	-	2	DERMATOLOGICALS
NEO-SYNALAR KIT	-	2	DERMATOLOGICALS
neo-tuss liquid	OTC	1	COUGH / COLD / ALLERGY
NEPHPLEX RX TAB	-	1	MULTIVITAMINS
NEUAC KIT	-	2	DERMATOLOGICALS
NEURAPTINE CREAM KIT	-	2	DERMATOLOGICALS
NEURIN-SL TAB	-	1	HEMATOPOIETIC AGENTS
NEVANAC OPHTH SUSP, ILEVRO OPHTH SUSP	-	2	OPHTHALMIC AGENTS
NEVIRAPINE ER TAB (QL= 1 tab/day)	QL	1	ANTIVIRALS

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
nevirapine ER tab (VIRAMUNE XR equiv) (QL= 1 tab/day)	QL	1	ANTIVIRALS
NEVIRAPINE SUSP (VIRAMUNE equiv)	-	1	ANTIVIRALS
NEVIRAPINE SUSP (QL=1200 ml/30 days)	QL	2	ANTIVIRALS
nevirapine tab (VIRAMUNE equiv) (QL= 2 tabs/day)	QL	1	ANTIVIRALS
NEXA PLUS CAP	-	2	MULTIVITAMINS
NEXPLANON IMPLANT	-	2	CONTRACEPTIVES
NEXTSTELLIS TAB (QL=28 tabs/24 days)	QL	2	CONTRACEPTIVES
niacin er tab	OTC	1	VITAMINS
niacin ER tab (NIASPAN equiv) (QL= 2 tabs/day)	QL	1	ANTIHYPERLIPIDEMICS
NIACOR TAB	-	1	ANTIHYPERLIPIDEMICS
NICADAN TAB	-	2	MULTIVITAMINS
nicardipine cap (CARDENE equiv)	-	1	CALCIUM CHANNEL BLOCKERS
NICAZEL TAB	-	2	MULTIVITAMINS
nicotine gum (NICORETTE equiv)	OTC-SMKG	1	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
nicotine lozenge (COMMIT equiv)	OTC-SMKG	1	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
nicotine patch (NICODERM equiv)	OTC-SMKG	1	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
NICOTROL INHALER	SMKG	2	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
NICOTROL NASAL SPRAY	SMKG	2	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) (QL= 2 tabs/day)	AMSP-QL	3	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
NINJACOF-XG LIQUID (QL=473 ml/month)	OTC-QL	2	COUGH / COLD / ALLERGY
nitisinone cap (ORFADIN equiv)	LMSP-PA	3	ENDOCRINE AND METABOLIC AGENTS - MISC.
NITRO-BID OINT	-	2	ANTIANGINAL AGENTS
NITRO-DUR PATCH 0.3MG/HR, 0.8MG/HR	-	2	ANTIANGINAL AGENTS
nitrofurantoin macrocrystals cap (MACRODANTIN equiv)	-	1	ANTI-INFECTIVE AGENTS - MISC.

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
nitrofurantoin monohydrate cap (MACROBID equiv)	-	1	ANTI-INFECTIVE AGENTS MISC.
nitrofurantoin susp (FURADANTIN equiv)	-	1	ANTI-INFECTIVE AGENTS MISC.
NITROGLYCERIN ER CAP	-	1	ANTIANGINAL AGENTS
nitroglycerin patch (NITRO-DUR equiv)	-	1	ANTIANGINAL AGENTS
nitroglycerin SL tab (NITROSTAT equiv)	-	1	ANTIANGINAL AGENTS
NIZATIDINE CAP	-	1	ULCER DRUGS / ANTISPASMODICS / ANTICHOLINERGICS
nizatidine cap (AXID equiv)	-	1	ULCER DRUGS
NOCDURNA SL TAB	-	2	ENDOCRINE AND METABOLIC AGENTS - MISC.
NOCTIVA EMULSION SPRAY	-	2	ENDOCRINE AND METABOLIC AGENTS - MISC.
NORDITROPIN FLEXPPO INJ	AMSP-PA	4	ENDOCRINE AND METABOLIC AGENTS - MISC.
norethindrone ace-ethinyl estradiol-fe cap 1 mg-20 mcg (24) (TAYTULLA equiv)	-	1	CONTRACEPTIVES
norethindrone tab (AYGESTIN equiv)	-	1	PROGESTINS

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA		Prior Authorization
QL	Quantity Limit	RDX		Restricted to Diagnosis
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
norethindrone tab (NORA-QD equiv)	-	1	CONTRACEPTIVES
NORITATE CREAM	-	2	DERMATOLOGICALS
NORPACE CR CAP	-	2	ANTIARRHYTHMICS
nortrel 7/7/7 tab, pirmella 7/7/7 tab (TRI-NORINYL equiv)	-	1	CONTRACEPTIVES
nortrel tab (OVCON 35 equiv)	-	1	CONTRACEPTIVES
NORVIR POWDER PACK	-	2	ANTIVIRALS
NORVIR SOLN	-	2	ANTIVIRALS
NOVAVAX INJ	VAC	2	VACCINES
NOVOLIN 70/30 FLEXPEN INJ (QL= 60ml/30 days)	OTC-QL	2	ANTIDIABETICS
NOVOLIN 70/30 INJ (QL= 60ml/30 days)	QL	2	ANTIDIABETICS
NOVOLIN N FLEXPEN INJ (QL=60ml/30 days)	QL	2	ANTIDIABETICS
NOVOLIN N INJ (QL= 60ml/30 days)	QL	2	ANTIDIABETICS
NOVOLIN N RELION INJ (QL= 60ml/30 days)	OTC-QL	2	ANTIDIABETICS
NOVOLIN R INJ 100 UNIT (QL = 60ml/30 days)	OTC-QL	1	ANTIDIABETICS
NOVOLIN R FLEXPEN INJ (QL= 60ml/30 days)	QL	2	ANTIDIABETICS
NOVOLIN R INJ (QL= 60ml/30 days)	QL	2	ANTIDIABETICS
NOVOLIN RELION INJ 70/30 (QL= 60mls/30 days)	OTC-QL	2	ANTIDIABETICS
NOVOLIN VIAL (QL= 60ml/30 days)	OTC-QL	2	ANTIDIABETICS

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
NUCALA INJ (QL= 1 inj/28 days)	AMSP-PA-QL	4	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
NUCALA INJ (QL=1 inj/28 days)	AMSP-PA-QL	4	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
NUCYNTA ER TAB (QL= 2 tabs/day)	QL	2	ANALGESICS - OPIOID
NUCYNTA TAB	-	2	ANALGESICS - OPIOID
NUDROXIPAK I-800 KIT	-	2	ANALGESICS - ANTI-INFLAMMATORY
NUDEXTA CAP (QL= 2 caps/day; Step therapy requires trial of 1 SSRI AND 1 TCA)	QL-ST	2	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
NUMOISYN LOZENGE	-	2	MOUTH / THROAT / DENTAL AGENTS
NUVESSA VAGINAL GEL	-	2	VAGINAL PRODUCTS
nystatin cream (MYCOSTATIN CREAM equiv)	-	1	DERMATOLOGICALS
nystatin oint	-	1	DERMATOLOGICALS
nystatin susp	-	1	MOUTH / THROAT / DENTAL AGENTS
nystatin tab	-	1	ANTIFUNGALS
nystatin topical powder	-	1	DERMATOLOGICALS
nystatin/triamcinolone cream	-	1	DERMATOLOGICALS

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
nystatin/triamcinolone oint	-	1	DERMATOLOGICALS
NYVEPRIA INJ (QL=2 inj/28 days)	AMSP-QL	4	HEMATOPOIETIC AGENTS
OB COMPLETE TAB	-	2	MULTIVITAMINS
OBIZUR INJ (Only available through Caremark/CV: Specialty 800-237-2767)	LD-PA	4	HEMATOLOGICAL AGENTS - MISC.
OBSTETRIX EC TAB	-	2	MULTIVITAMINS
O-CAL PRENATAL TAB	-	1	MULTIVITAMINS
OCALIVA TAB (Only available through Accredo 877-826-7657 or Walgreens 888-347-3416)	LD-PA	4	GASTROINTESTINAL AGENTS - MISC.
OCEAN NASAL SPRAY 0.65%	OTC	1	NASAL AGENTS - SYSTEMIC AND TOPICAL
OCTREOTIDE INJ	AMSP-PA	3	ENDOCRINE AND METABOLIC AGENTS - MISC.
octreotide inj (SANDOSTATIN equiv)	AMSP-PA	3	ENDOCRINE AND METABOLIC AGENTS - MISC.
ODACTRA SL TAB (QL= 30 tabs/30 days)	QL	2	ALLERGENIC EXTRACTS / BIOLOGICALS MISC
ODEFSEY TAB	-	2	ANTIVIRALS
ofloxacin ophth soln (OCUFLOX equiv)	-	1	OPHTHALMIC AGENTS
ofloxacin otic soln (FLOXIN equiv)	-	1	OTIC AGENTS
OFLOXACIN TAB	-	1	FLUOROQUINOLONES

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
ofloxacin tab (FLOXIN equiv)	-	1	FLUOROQUINOLONES
OGESTREL TAB	-	2	CONTRACEPTIVES
olmesartan tab (BENICAR equiv)	-	1	ANTIHYPERTENSIVES
olmesartan/amlodipine/hydrochlorothiazide tab (TRIBENZOR TAB equiv) (QL=1 tab/day)	QL	1	ANTIHYPERTENSIVES
olmesartan/hydrochlorothiazide tab (BENICAR HCT equiv)	-	1	ANTIHYPERTENSIVES
olopatadine ophth soln 0.1% (PATANOL equiv)	-	1	OPHTHALMIC AGENTS
omeprazole dr cap	OTC	1	ULCER DRUGS / ANTISPASMODICS / ANTICHOLINERGICS
omeprazole DR cap (PRILOSEC equiv) (QL=1 cap/day)	QL	1	ULCER DRUGS
OMEPRAZOLE DR TAB (QL= 2 tabs/day)	QL	1	ULCER DRUGS
omeprazole magnesium delayed release tab (PRILOSEC OTC equiv) (QL= 1 tab/day)	OTC-QL	1	ULCER DRUGS
omeprazole tab (QL=2 tabs/day)	OTC-QL	1	ULCER DRUGS / ANTISPASMODICS / ANTICHOLINERGICS
OMNIPOD 5 G6 INTRO KIT (QL= 1 kit/year)	QL	2	MEDICAL DEVICES AND SUPPLIES
OMNIPOD 5 G6 MIS PODS (QL= 15 pods/30 days)	QL	2	MEDICAL DEVICES AND SUPPLIES

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
OMNIPOD 5 G6 PODS MISC (QL= 15 pods/30 days)	QL	2	MEDICAL DEVICES AND SUPPLIES
OMNIPOD 5 G7 KIT INTRO (QL= 1 kit/year)	QL	2	MEDICAL DEVICES AND SUPPLIES
OMNIPOD 5 G7 MIS PODS (QL= 15 pods/30 days)	QL	2	MEDICAL DEVICES AND SUPPLIES
OMNIPOD 5 INTRO KIT (QL= 1 kit/year)	QL	2	MEDICAL DEVICES AND SUPPLIES
OMNIPOD 5 PACK PODS (QL = 15 pods/30 days)	QL	2	MEDICAL DEVICES AND SUPPLIES
OMNIPOD 5 PACK PODS (QL= 15 pods/30 days)	QL	2	MEDICAL DEVICES AND SUPPLIES
OMNIPOD DASH INTRO KIT (QL= 1 kit/year)	QL	2	MEDICAL DEVICES AND SUPPLIES
OMNIPOD DASH PODS (QL= 15 pods/30 days)	QL	2	MEDICAL DEVICES AND SUPPLIES
OMNIPOD GO KIT 20UNT/DY (QL= 10 pods/month)	QL	2	MEDICAL DEVICES AND SUPPLIES
OMNIPOD GO KIT 30UNT/DY (QL= 10 pods/month)	QL	2	MEDICAL DEVICES AND SUPPLIES
OMNIPOD GO KIT 40UNT/DY (QL= 10 pods/month)	QL	2	MEDICAL DEVICES AND SUPPLIES

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
OMNIPOD GO KIT (QL= 10 pods/month)	QL	2	MEDICAL DEVICES AND SUPPLIES
OMNIPOD STARTER KIT (QL= 1 kit/year)	QL	2	MEDICAL DEVICES AND SUPPLIES
ondansetron inj (QL= 24mL/fill, 1 fill/15 days)	QL	1	ANTIEMETICS
ondansetron ODT 4 MG (ZOFTRAN equiv) (QL=6 tabs/day)	QL	1	ANTIEMETICS
ondansetron ODT 8 MG (ZOFTRAN equiv) (QL=3 tabs/day)	QL	1	ANTIEMETICS
ondansetron soln 4 MG/5 ML (ZOFTRAN equiv) (QL= 5ml/day)	QL	1	ANTIEMETICS
ondansetron tab 4 MG (ZOFTRAN equiv) (QL=6 tabs/day)	QL	1	ANTIEMETICS
ondansetron tab 8 MG (ZOFTRAN equiv) (QL=90 tabs/30 days)	QL	1	ANTIEMETICS
ONE-A-DAY MENS TAB	OTC	1	MULTIVITAMINS
ONUREG TAB	PA	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
OPILL TAB	OTC	2	CONTRACEPTIVES
OPSUMIT TAB (Only available through Accredo 877-826-7657)	LD-PA	4	CARDIOVASCULAR AGENTS - MISC.
OPVEE NASAL SPRAY	-	2	ANTIDOTES AND SPECIFIC ANTAGONISTS

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA		Prior Authorization
QL	Quantity Limit	RDX		Restricted to Diagnosis
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
ORACIT SOLN	-	2	GENITOURINARY AGENTS - MISCELLANEOUS
oral electrolyte soln	OTC	1	MINERALS & ELECTROLYTES
ORALAIR SL TAB	-	2	ALLERGENIC EXTRACTS / BIOLOGICALS MISC
ORALAIR SL TAB (QL= 30 tabs/30 days)	QL	2	BIOLOGICALS MISC
ORAMAGICRX MOUTHWASH	-	2	MOUTH / THROAT / DENTAL AGENTS
ORKAMBI GRANULES PACKET (QL= 2 packets/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	4	RESPIRATORY AGENTS - MISC.
ORKAMBI TAB (Only available through Walgreens 888-347-3416)	LD-PA	4	RESPIRATORY AGENTS - MISC.
orphenadrine citrate ER tab (NORFLEX equiv)	-	1	MUSCULOSKELETAL THERAPY AGENTS
oseltamivir cap 30mg (TAMIFLU equiv) (QL= 28 caps/90 days, 1 fill/120 days)	QL	1	ANTIVIRALS
oseltamivir cap 45mg (TAMIFLU equiv) (QL= 14 caps/90 days, 1 fill/120 days)	QL	1	ANTIVIRALS
oseltamivir cap 75mg (TAMIFLU equiv) (QL= 14 caps/90 days, 1 fill/120 days)	QL	1	ANTIVIRALS

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
oseltamivir susp (TAMIFLU equiv) (QL= 120ml/10 days, 1 fill/120 days)	QL	1	ANTIVIRALS
OSMOLEX ER TAB	-	2	ANTIPARKINSON AND RELATED THERAPY AGENTS
OSMOPREP TAB	-	2	LAXATIVES
oxaprozin tab (DAYPRO equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
OXAYDO TAB, ROXYBOND TAB	-	2	ANALGESICS - OPIOID
oxcarbazepine susp (TRILEPTAL equiv)	-	1	ANTICONSULSANTS
oxcarbazepine tab (TRILEPTAL equiv)	-	1	ANTICONSULSANTS
OXISTAT LOTION	-	2	DERMATOLOGICALS
oxybutynin ER tab (DITROPAN XL equiv)	-	1	URINARY ANTISPASMODICS
oxybutynin ER tab 10 MG (DITROPAN XL equiv) (QL=2 tabs/day)	QL	1	URINARY ANTISPASMODICS
oxybutynin ER tab 5 MG (DITROPAN XL equiv) (QL=1 tab/day)	QL	1	URINARY ANTISPASMODICS
oxybutynin syrup (QL=20ml/day)	QL	1	URINARY ANTISPASMODICS
oxybutynin tab (DITROPAN equiv) (QL=4 tabs/day)	QL	1	URINARY ANTISPASMODICS
oxycodone cap (OXYIR equiv) (QL= 16 caps/day)	QL	1	ANALGESICS - OPIOID

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
oxycodone conc (ROXICODONE equiv) (QL= 240 syringes/30 days)	QL	1	ANALGESICS - OPIOID
OXYCODONE ER TAB 10MG (QL= 2 tabs/day; Step Therapy requires trial of morphine sulfate ER tab)	QL-ST	1	ANALGESICS - OPIOID
OXYCODONE ER TAB 15MG (QL= 2 tabs/day; Step Therapy requires trial of morphine sulfate ER tab)	QL-ST	1	ANALGESICS - OPIOID
OXYCODONE ER TAB 20MG (QL= 2 tabs/day; Step Therapy requires trial of morphine sulfate ER tab)	QL-ST	1	ANALGESICS - OPIOID
OXYCODONE ER TAB 30MG (QL= 2 tabs/day; Step Therapy requires trial of morphine sulfate ER tab)	QL-ST	1	ANALGESICS - OPIOID
OXYCODONE ER TAB 40MG (QL= 2 tabs/day; Step Therapy requires trial of morphine sulfate ER tab)	QL-ST	1	ANALGESICS - OPIOID
OXYCODONE ER TAB 60MG (QL= 2 tabs/day; Step Therapy requires trial of morphine sulfate ER tab)	QL-ST	1	ANALGESICS - OPIOID
OXYCODONE ER TAB 80MG (QL= 4 tabs/day; Step Therapy requires trial of morphine sulfate ER tab)	QL-ST	1	ANALGESICS - OPIOID

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
oxycodone soln (ROXICODONE equiv) (QL= 2400ml/30 days)	QL	1	ANALGESICS - OPIOID
oxycodone tab 10mg (ROXICODONE equiv) (QL= 8 tabs/day)	QL	1	ANALGESICS - OPIOID
oxycodone tab 15mg (ROXICODONE equiv) (QL= 5.34 tabs/day)	QL	1	ANALGESICS - OPIOID
oxycodone tab 20mg (ROXICODONE equiv) (QL= 4 tabs/day)	QL	1	ANALGESICS - OPIOID
oxycodone tab 30mg (ROXICODONE equiv) (QL= 2 tabs/day)	QL	1	ANALGESICS - OPIOID
oxycodone tab 5mg (ROXICODONE equiv) (QL= 16 tabs/day)	QL	1	ANALGESICS - OPIOID
oxycodone/acetaminophen tab 10-325mg (PERCOCET equiv) (QL= 12 tabs/day)	QL	1	ANALGESICS - OPIOID
oxycodone/acetaminophen tab 2.5-325mg (PERCOCET equiv) (QL= 12 tabs/day)	QL	1	ANALGESICS - OPIOID
oxycodone/acetaminophen tab 5-325mg (PERCOCET equiv) (QL= 12 tabs/day)	QL	1	ANALGESICS - OPIOID
oxycodone/acetaminophen tab 7.5-325mg (PERCOCET equiv) (QL= 12 tabs/day)	QL	1	ANALGESICS - OPIOID
OXYCODONE/ASPIRIN TAB	-	1	ANALGESICS - OPIOID
OXYCODONE/IBUPROFEN TAB	-	1	ANALGESICS - OPIOID
oxycodone/ibuprofen tab (COMBUNOX equiv)	-	1	ANALGESICS - OPIOID

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
OXYCONTIN ER 10MG TAB (QL= 2 tabs/day; Step Therapy requires trial of morphine sulfate ER tab)	QL-ST	1	ANALGESICS - OPIOID
OXYCONTIN ER 20MG TAB (QL= 2 tabs/day; Step Therapy requires trial of morphine sulfate ER tab)	QL-ST	1	ANALGESICS - OPIOID
OXYCONTIN ER 40MG TAB (QL= 2 tabs/day; Step Therapy requires trial of morphine sulfate ER tab)	QL-ST	1	ANALGESICS - OPIOID
oxymorphone ER tab 30mg (OPANA ER equiv) (QL= 4 tabs/day)	QL	1	ANALGESICS - OPIOID
oxymorphone ER tab 40mg (OPANA ER equiv) (QL= 4 tabs/day)	QL	1	ANALGESICS - OPIOID
oxymorphone tab (OPANA equiv)	-	1	ANALGESICS - OPIOID
OXYTROL PATCH (QL= 1 patch/3 days)	QL	2	URINARY ANTISPASMODICS
PAIN EASE MIST SPRAY	-	2	DERMATOLOGICALS
PANDEL CREAM	-	2	DERMATOLOGICALS
PANRETIN GEL	-	2	DERMATOLOGICALS
pantoprazole EC tab (PROTONIX equiv) (QL=2 tabs/day)	QL	1	ULCER DRUGS
pantoprazole packet (QL=1 packet/day)	QL	1	ULCER DRUGS / ANTISPASMODICS / ANTICHOLINERGICS
PARAGARD IUD	-	2	CONTRACEPTIVES
PAREGORIC TINCTURE	-	2	ANTIDIARRHEALS

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
PAREMYD DROPS	-	2	OPHTHALMIC AGENTS
paricalcitol cap (ZEMPLAR equiv)	-	1	ENDOCRINE AND METABOLIC AGENTS - MISC.
PASER GRANULE	-	2	ANTIMYCOBACTERIAL AGENTS
PAXLOVID TAB 150-100 (QL= 20 tabs/5 days; 20 tabs/fill; Covered for members age 12 years or older)	QL	2	ANTIVIRALS
PAXLOVID TAB 300-100 (QL= 30 tabs/5 days; 30 tabs/fill; Covered for members age 12 years or older)	QL	2	ANTIVIRALS
PAZEO OPHTH SOLN	-	2	OPHTHALMIC AGENTS
pazopanib hcl tab (QL = 120 tabs/30 days)	AMSP-PA-QL	3	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
pb-belladonna elixir (DONNATAL equiv) (QL= 1200ml/30 days)	QL	1	ULCER DRUGS
pedia tri-vite drops	OTC	1	MULTIVITAMINS
PEDIARIX INJ	-	2	TOXOIDS
pediatric multiple vitamins/fluoride soln	OTC	1	MULTIVITAMINS
PEDVAXHIB INJ	-	2	VACCINES
peg 3350/electrolytes soln (COLYTE equiv) (QL= 2 fills/calendar year)	QL	1	LAXATIVES
PEGANONE TAB	-	2	ANTICONVULSANTS
PEGASYS INJ (QL=2 inj/28 days)	PA-QL	4	ANTIVIRALS

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
PENBRAYA INJ (Covered for members age 10-25 years)	-	2	VACCINES
penicillamine tab (DEPEN TITRATAB equiv) (QL=480 tabs/30 days)	QL	1	MISCELLANEOUS THERAPEUTIC CLASSES
penicillin g potassium inj	-	1	PENICILLINS
PENICILLIN VK SOLN	-	1	PENICILLINS
penicillin vk tab (VEETIDS equiv)	-	1	PENICILLINS
PENTACEL INJ	-	2	TOXOIDS
pentamidine neb soln (NEBUPENT equiv) (QL=1 vial/month)	QL	1	ANTI-INFECTIVE AGENTS MISC.
pentazocine/naloxone tab (TALWIN NX equiv)	-	1	ANALGESICS - OPIOID
pentoxifylline ER tab (TRENTAL equiv)	-	1	HEMATOLOGICAL AGENTS - MISC.
perindopril tab (ACEON equiv)	-	1	ANTIHYPERTENSIVES
permethrin cream (ELIMITE CREAM equiv)	-	1	DERMATOLOGICALS
permethrin liquid	OTC	1	DERMATOLOGICALS
phenazopyridine tab 100mg	-	1	GENITOURINARY AGENTS - MISCELLANEOUS
phenazopyridine tab 200mg	-	1	GENITOURINARY AGENTS - MISCELLANEOUS
PHENOBARBITAL TAB	-	1	HYPNOTICS / SEDATIVES SLEEP DISORDER AGENTS

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
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
PHEXXI GEL	-	2	VAGINAL AND RELATED PRODUCTS
PHOSLYRA SOLN	-	2	GASTROINTESTINAL AGENTS - MISC.
phytonadione tab (MEPHYTON equiv)	OTC	1	VITAMINS
PICATO GEL	-	2	DERMATOLOGICALS
PIFELTRO TAB	-	2	ANTIVIRALS
pilocarpine ophth soln (ISOPTO CARPINE equiv)	-	1	OPHTHALMIC AGENTS
pilocarpine tab (SALAGEN equiv)	-	1	MOUTH / THROAT / DENTAL AGENTS
pindolol tab (VISKEN equiv)	-	1	BETA BLOCKERS
pink bismuth chew tab	OTC	1	ANTIDIARRHEALS
pink bismuth susp	OTC	1	ANTIDIARRHEAL / PROBIOTIC AGENTS
pioglitazone tab (ACTOS equiv) (QL= 1 tab/day)	QL	1	ANTIDIABETICS
pioglitazone/metformin tab (ACTOPLUS MET equiv) (QL= 3 tabs/day)	QL	1	ANTIDIABETICS

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
pirfenidone cap (QL=3 caps/day)	AMSP-PA-QL	3	RESPIRATORY AGENTS - MISC.
PIRFENIDONE TAB (QL=4 tabs/day; Only available through Lumicera 855-847-3553)	LD-PA-QL	3	RESPIRATORY AGENTS - MISC.
pirfenidone tab 267mg (QL=9 tabs/day)	AMSP-PA-QL	3	RESPIRATORY AGENTS - MISC.
pirfenidone tab 801mg (QL=3 tabs/day)	AMSP-PA-QL	3	RESPIRATORY AGENTS - MISC.
piroxicam cap (FELDENE equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
PNEUMOVAX INJ	VAC	2	VACCINES
PNV-SELECT TAB	-	1	MULTIVITAMINS
PODOCON SOLN	-	1	DERMATOLOGICALS
podofilox soln (CONDYLOX equiv)	-	1	DERMATOLOGICALS
PODOFILOX SOLN (QL= 0.5mL/day)	QL	2	DERMATOLOGICALS
polyethylene glycol 3350 powder (MIRALAX equiv)	OTC	1	LAXATIVES
polyethylene glycol packet (MIRALAX equiv)	OTC	1	LAXATIVES
poly-iron cap	OTC	1	HEMATOPOIETIC AGENTS
polymyxin b/trimethoprim ophth soln (POLYTRIM equiv)	-	1	OPHTHALMIC AGENTS
POLY-VI-FLOR DROPS	-	2	MULTIVITAMINS
POLY-VI-FLOR WITH IRON DROPS	-	2	MULTIVITAMINS

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
POLY-VI-SOL DROPS	OTC	1	MULTIVITAMINS
poly-vita drops	OTC	2	MULTIVITAMINS
POMALYST CAP (QL= 21 caps/28 days; Only available through Walgreens 888-347-3416)	LD-PA-QL	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
POT/CHLORIDE EFFER TAB	-	2	MINERALS & ELECTROLYTES
POTABA TAB	-	2	VITAMINS
potassium chloride ER cap (MICRO-K equiv)	-	1	MINERALS & ELECTROLYTES
POTASSIUM CHLORIDE ER TAB	-	1	MINERALS & ELECTROLYTES
potassium chloride ER tab (K-TAB 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 (UROCIT-K TAB equiv)	-	1	GENITOURINARY AGENTS - MISCELLANEOUS
potassium citrate/citric acid soln (POLYCITRA-K equiv)	-	1	GENITOURINARY AGENTS - MISCELLANEOUS

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
potassium iodide oral soln (QL=90 ml/30 days)	QL	1	COUGH / COLD / ALLERGY
potassium phosphate monobasic tab (QL=8 tabs/day)	QL	1	MINERALS & ELECTROLYTES
povidone-iodine oint	-	1	ANTISEPTICS & DISINFECTANTS
pramipexole ER tab (MIRAPEX ER equiv) (QL= 1 tab/day)	QL	1	ANTIPARKINSON AGENTS
pramipexole tab (MIRAPEX equiv)	-	1	ANTIPARKINSON AGENTS
PRAMOSONE CREAM 1-1%	-	2	DERMATOLOGICALS
PRAMOSONE LOTION	-	2	DERMATOLOGICALS
PRAMOSONE OINT	-	2	DERMATOLOGICALS
prasugrel tab (EFFIENT equiv) (QL=1 tab/day)	QL	1	HEMATOLOGICAL AGENTS - MISC.
pravastatin tab (PRAVACHOL equiv) (QL= 1 tab/day)	QL	1	ANTIHYPERTENSIVES
praziquantel tab (BILTRICIDE equiv)	-	1	ANTHELMINTICS
prazosin cap (MINIPRESS equiv)	-	1	ANTIHYPERTENSIVES
PRECISION XTRA KETONE TEST STRIP (QL=300 strips/30 days)	OTC-QL	1	DIAGNOSTIC PRODUCTS
PRECISION XTRA TEST STRIP (QL= 300 test strips/30 days)	OTC-QL	1	DIAGNOSTIC PRODUCTS
PRED MILD OPTH SOLN	-	2	OPHTHALMIC AGENTS
PRED-G OPTH SOLN	-	2	OPHTHALMIC AGENTS

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
PRED-G S.O.P OPTH OINTMENT	-	2	OPHTHALMIC AGENTS
PREDNICARBATE CREAM	-	1	DERMATOLOGICALS
prednicarbate cream (DERMATOP equiv)	-	1	DERMATOLOGICALS
PREDNICARBATE OIN	-	1	DERMATOLOGICALS
prednisolone acetate ophth susp	-	1	OPHTHALMIC AGENTS
PREDNISOLONE OPTH SUSP	-	1	OPHTHALMIC AGENTS
PREDNISOLONE SODIUM PHOSPHATE OPTH SOLN	-	1	OPHTHALMIC AGENTS
PREDNISOLONE SOLN	-	1	CORTICOSTEROIDS
prednisolone soln (PEDIAPRED equiv)	-	1	CORTICOSTEROIDS
prednisolone syrup	-	1	CORTICOSTEROIDS
PREDNISOLONE-GATIFLOXACIN-BROMFENAC SUSP	-	1	OPHTHALMIC AGENTS
PREDNISONONE CONC	-	2	CORTICOSTEROIDS
prednisone pack	-	1	CORTICOSTEROIDS
PREDNISONONE SOLN	-	1	CORTICOSTEROIDS
prednisone tab (DELTASONE equiv)	-	1	CORTICOSTEROIDS
PREFERAOB ONE CAP	-	2	MULTIVITAMINS
PREFEST TAB	-	2	ESTROGENS
pregabalin cap	-	1	ANTICONVULSANTS
pregabalin soln (LYRICA equiv) (QL= 30ml/day)	QL	1	ANTICONVULSANTS
PREMARIN TAB	-	2	ESTROGENS

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
PREMPHASE TAB, PREMPRO TAB	-	2	ESTROGENS
PRENATA CHEW TAB	-	2	MULTIVITAMINS
PRENATABS RX TAB	-	1	MULTIVITAMINS
PRENATAL 19 CHEW TAB	-	1	MULTIVITAMINS
PRENATAL 19 TAB	OTC	1	MULTIVITAMINS
prenatal dha cap	OTC	1	NUTRIENTS
PRENATAL VITAMINS (NON-PREFERRED)	-	1	MULTIVITAMINS
PRENATAL VITAMINS (NON-PREFERRED)	-	2	MULTIVITAMINS
PRENATAL VITAMINS (PRENATAL PLUS, PREPLUS, PRENAPLUS)	OTC	2	MULTIVITAMINS
PRENATE DHA CAP	-	2	MULTIVITAMINS
PRENATE ENHANCE CAP	-	2	MULTIVITAMINS
PRENATE RESTORE CAP	-	2	MULTIVITAMINS
PREPIDIL GEL	-	2	OXYTOCICS
PRESTALIA TAB	-	2	ANTIHYPERTENSIVES
PREVIDENT GEL (Excluded for members age 19 years and older)	-	2	MOUTH / THROAT / DENTAL AGENTS
PREVNAR 13 INJ	VAC	2	VACCINES
PREVNAR 20 INJ	VAC	2	VACCINES
PREZCOBIX TAB	-	2	ANTIVIRALS
PREZISTA SUSP	-	2	ANTIVIRALS
PREZISTA TAB	-	2	ANTIVIRALS

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
PREZISTA TAB 150MG	-	2	ANTIVIRALS
PREZISTA TAB 300MG	-	2	ANTIVIRALS
PREZISTA TAB 400MG	-	2	ANTIVIRALS
PREZISTA TAB 75MG	-	2	ANTIVIRALS
PRIFTIN TAB	-	2	ANTIMYCOBACTERIAL AGENTS
PRIMAQUINE TAB	-	2	ANTIMALARIALS
primaquine tab (PRIMAQUINE equiv)	-	2	ANTIMALARIALS
PRIMIDONE TAB (QL=4 tabs/day)	QL	1	ANTICONVULSANTS
primidone tab (MYSOLINE equiv)	-	1	ANTICONVULSANTS
PRIMSOL SOLN	-	2	ANTI-INFECTIVE AGENTS MISC.
PRIORIX INJ	VAC	2	VACCINES
probenecid tab (BENEMID equiv)	-	1	GOUT AGENTS
PRO-CEPTION FERTILITY PAK	-	1	VAGINAL PRODUCTS
prochlorperazine supp (COMPAZINE equiv)	-	1	ANTIPSYCHOTICS / ANTIMANIC AGENTS
prochlorperazine tab (COMPAZINE equiv)	-	1	ANTIPSYCHOTICS / ANTIMANIC AGENTS
PROCTOFOAM HC FOAM	-	2	ANORECTAL AGENTS
proctosol HC cream (ANUSOL HC equiv)	OTC	1	ANORECTAL AGENTS
PROFERRIN TAB	OTC	2	HEMATOPOIETIC AGENTS

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
PROFILNINE INJ	AMSP-PA	4	HEMATOLOGICAL AGENTS - MISC.
progesterone cap (PROMETRIUM equiv)	-	1	PROGESTINS
PROGRAF PACKET	-	2	MISCELLANEOUS THERAPEUTIC CLASSES
PROMACTA TAB	AMSP-PA-QL	4	HEMATOPOIETIC AGENTS
promethazine supp (PHENERGAN equiv)	-	1	ANTIHISTAMINES
promethazine syrup 6.25 mg/5ml	-	1	ANTIHISTAMINES
promethazine tab (PHENERGAN equiv)	-	1	ANTIHISTAMINES
PROMETHAZINE VC /CODEINE SYRUP	-	1	COUGH / COLD / ALLERGY
PROMETHAZINE VC SYRUP	-	1	COUGH / COLD / ALLERGY
PROMETHAZINE VC SYRUP (QL= 30 mL/day)	QL	1	COUGH / COLD / ALLERGY
promethazine VC syrup (PHENERGAN VC equiv)	-	1	COUGH / COLD / ALLERGY
PROMETHEGAN SUPP	-	1	ANTIHISTAMINES
propafenone er cap 325mg	-	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 SOLN 20MG/5ML	-	1	BETA BLOCKERS
propranolol tab (INDERAL equiv)	-	1	BETA BLOCKERS

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
propranolol/hydrochlorothiazide tab (INDERIDE equiv)	-	1	ANTIHYPERTENSIVES
propylthiouracil tab	-	1	THYROID AGENTS
PROQUAD INJ	-	2	VACCINES
PROSILK GEL	-	2	DERMATOLOGICALS
PROSTIN E2 SUPP	-	2	OXYTOCICS
PROVENT	-	1	MEDICAL DEVICES
pseudoephedrine ER tab 120mg (QL= 2 tabs/day)	QL	1	NASAL AGENTS - SYSTEMIC AND TOPICAL
pseudoephedrine tab 30mg (QL= 8 tabs/day)	QL	1	NASAL AGENTS - SYSTEMIC AND TOPICAL
pseudoephedrine tab 60mg (QL= 4 tabs/day)	QL	1	NASAL AGENTS - SYSTEMIC AND TOPICAL
PULMOZYME INH SOLN (QL= 30 ampules/30 days)	AMSP-QL-RDX	4	RESPIRATORY AGENTS - MISC.
PUMP SUPPLIES	OTC	1	MEDICAL DEVICES AND SUPPLIES
pyrazinamide tab	-	1	ANTIMYCOBACTERIAL AGENTS
pyridostigmine CR tab (MESTINON equiv)	-	1	ANTIMYASTHENIC / CHOLINERGIC AGENTS
pyridostigmine tab (MESTINON equiv)	-	1	ANTIMYASTHENIC / CHOLINERGIC AGENTS

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
pyridoxine tab	OTC	1	VITAMINS
QNASL CHILDRENS NASAL SPRAY	-	2	NASAL AGENTS - SYSTEMIC AND TOPICAL
QTERN TAB (Step Therapy requires trial of metformin or metformin ER or metformin combinations)	ST	2	ANTIDIABETICS
QUFLORA PEDIATRIC CHEW TAB	-	2	MULTIVITAMINS
QUILLICHEW ER TAB (QL= 1 tab/day)	QL	2	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
QUILLICHEW ER TAB 20MG (QL=3 tabs/day)	QL	2	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
QUILLICHEW ER TAB 30MG (QL=2 tabs/day)	QL	2	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
QUILLIVANT XR SUSP	-	2	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
quinapril tab (ACCUPRIL equiv)	-	1	ANTIHYPERTENSIVES
quinapril/hydrochlorothiazide tab (ACCURETIC equiv)	-	1	ANTIHYPERTENSIVES
quinidine sulfate tab (QL=8 tabs/day)	QL	1	ANTIARRHYTHMICS
QUINIDINE SULFATE TAB 200MG (QL= 8 tabs/day)	QL	2	ANTIARRHYTHMICS
QUINIDINE SULFATE TAB 300MG (QL= 5 tabs/day)	QL	2	ANTIARRHYTHMICS
quinine sulfate cap (QUALAQUIN equiv)	-	1	ANTIMALARIALS
RABAVERT INJ	-	2	VACCINES
RADIOGARDASE CAP	-	2	ANTIDOTES
RAGWITEK SL TAB (QL= 30 tabs/30 days)	QL	2	BIOLOGICALS MISC
raloxifene tab (EVISTA equiv) (QL= 1 tab/day)	QL	1	ENDOCRINE AND METABOLIC AGENTS - MISC.
ramipril cap (ALTACE equiv)	-	1	ANTIHYPERTENSIVES
ranolazine tab (RANEXA equiv) (QL=4 tabs/day)	QL	1	ANTIANGINAL AGENTS
RAPPORT VACUUM THERAPY KIT	-	1	MEDICAL DEVICES AND SUPPLIES
rasagiline tab (AZILECT equiv) (QL= 1 tab/day)	QL	1	ANTIPARKINSON AGENTS
RAYALDEE CAP (QL= 1 cap/day)	QL	2	ENDOCRINE AND METABOLIC AGENTS - MISC.

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
RAYOS TAB	-	2	CORTICOSTEROIDS
RECOTHROM INJ	-	2	HEMOSTATICS
REFRESH CLASSIC DROPS	OTC	2	OPHTHALMIC AGENTS
REFRESH OPTH GEL 1%	OTC	2	OPHTHALMIC AGENTS
REGENECARE GEL	-	2	DERMATOLOGICALS
REGRANEX GEL	-	2	DERMATOLOGICALS
RELAFEN DS TAB (QL= 2 tabs/day)	QL	2	ANALGESICS - ANTI-INFLAMMATORY
RELENZA DISKHALER (QL= 1 inhaler/fill, 1 fill/month)	QL	2	ANTIVIRALS
RENU REWETTING DROPS	-	1	OPHTHALMIC AGENTS
repaglinide tab (PRANDIN equiv) (Step Therapy requires trial of metformin or metformin ER)	ST	1	ANTIDIABETICS
REPATHA INJ (QL= 2 inj/28 days)	PA-QL	2	ANTIHYPERLIPIDEMICS
REPATHA PUSHTRONEX INJ (QL= 1 inj/28 days)	PA-QL	2	ANTIHYPERLIPIDEMICS
REPREXAIN TAB (QL=5 tabs/day)	QL	1	ANALGESICS - OPIOID
REQ49 PLUS TAB	-	2	MULTIVITAMINS
RESCRIPTOR TAB 200MG	-	2	ANTIVIRALS
RESTORA RX CAP	-	2	ANTIDIARRHEALS
RETACRIT INJ (QL= 12 vials/30 days)	AMSP-PA-QL	4	HEMATOPOIETIC AGENTS
RETACRIT INJ (QL= 4 vials/30 days)	AMSP-PA-QL	4	HEMATOPOIETIC AGENTS

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
REXTOVY SPRAY	-	2	ANTIDOTES AND SPECIFIC ANTAGONISTS
REYATAZ POWDER PACK	-	2	ANTIVIRALS
RIAX FOAM (QL= 360g/30 days)	OTC-QL	2	DERMATOLOGICALS
RIBAVIRIN CAP	-	3	ANTIVIRALS
RIBAVIRIN TAB	AMSP	3	ANTIVIRALS
rifabutin cap (MYCOBUTIN equiv)	-	1	ANTIMYCOBACTERIAL AGENTS
RIFAMATE CAP	-	2	ANTIMYCOBACTERIAL AGENTS
rifampin cap (RIFADIN equiv)	-	1	ANTIMYCOBACTERIAL AGENTS
RIFATER TAB	-	2	ANTIMYCOBACTERIAL AGENTS
riluzole tab (RILUTEK equiv) (QL=2 tabs/day)	AMSP-QL	3	NEUROMUSCULAR AGENTS
RIMANTADINE TAB	-	1	ANTIVIRALS
risedronate tab 30mg (ACTONEL equiv) (QL= 1 tab/day)	QL	1	ENDOCRINE AND METABOLIC AGENTS - MISC.
risedronate tab 35mg (ACTONEL equiv) (QL= 4 tabs/28 days)	QL	1	ENDOCRINE AND METABOLIC AGENTS - MISC.

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
risedronate tab 5mg (ACTONEL equiv) (QL= 1 tab/day)	QL	1	ENDOCRINE AND METABOLIC AGENTS - MISC.
ritonavir tab (NORVIR equiv) (QL= 12 tabs/30 days)	QL	1	ANTIVIRALS
rivastigmine cap (EXELON equiv)	-	1	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
rizatriptan ODT (MAXALT equiv) (QL= 12 tabs/30 days)	QL	1	MIGRAINE PRODUCTS
rizatriptan tab (MAXALT equiv) (QL= 12 tabs/30 days)	QL	1	MIGRAINE PRODUCTS
roflumilast tab (QL=1 tab/day)	PA-QL	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ropinirole ER tab (REQUIP XL equiv) (Step Therapy requires trial of ropinirole)	ST	1	ANTIPARKINSON AGENTS
ropinirole tab (REQUIP equiv)	-	1	ANTIPARKINSON AGENTS
rosuvastatin tab (CRESTOR equiv) (QL= 1 tab/day)	QL	1	ANTIHYPERTENSIVES
ROTARIX INJ	-	2	VACCINES
ROTATEQ INJ	-	2	VACCINES
RUBRACA TAB (QL= 4 tabs/day; Only available through OPTUM - 877-445-6874)	LD-PA-QL	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
RYDAPT CAP	AMSP-PA	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
SAFETYGLIDE SYRINGE	OTC	1	MEDICAL DEVICES AND SUPPLIES
SALICYLIC ACID LOTION 6%	-	1	DERMATOLOGICALS
SALIMEZ FORTE CREAM 10%	-	2	DERMATOLOGICALS
saline enema	OTC	1	LAXATIVES
saline nasal spray	OTC	1	NASAL AGENTS - SYSTEMIC AND TOPICAL
SALMON OIL-1000 CAP	OTC	1	DIETARY PRODUCTS / DIETARY MANAGEMENT PRODUCTS
salsalate tab (DISALCID equiv)	-	1	ANALGESICS - NONNARCOTIC
SALVAX DUO PLUS KIT	-	2	DERMATOLOGICALS
SANCUSO PATCH	-	2	ANTIEMETICS
SANDIMMUNE SOLN 100MG/ML	-	2	ASSORTED CLASSES
SANTYL OINT	-	2	DERMATOLOGICALS
sapropterin dihydrochloride powder packet (KUVAN equiv)	AMSP-PA	3	ENDOCRINE AND METABOLIC AGENTS - MISC.

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
sapropterin dihydrochloride soluble tab (KUVAN equiv)	AMSP-PA	3	ENDOCRINE AND METABOLIC AGENTS - MISC.
SAVAYSA TAB (QL= 1 tab/day)	QL	2	ANTICOAGULANTS
SCALACORT DK KIT	-	2	DERMATOLOGICALS
SCARCIN GEL	-	2	DERMATOLOGICALS
scopolamine patch (TRANSDERM-SCOP equiv) (QL= 10 patches/30 days)	QL	1	ANTIEMETICS
SECONAL CAP	-	2	HYPNOTICS / SEDATIVES SLEEP DISORDER AGENTS
SEGLUROMET TAB (QL= 2 tabs/day)	QL	2	ANTIDIABETICS
SEGLUROMET TAB 2.5-500MG (QL= 4 tabs/day)	QL	2	ANTIDIABETICS
selegiline cap (ELDEPRYL equiv)	-	1	ANTIPARKINSON AGENTS
selegiline tab (ELDEPRYL equiv) (QL=2 tabs/day)	QL	1	ANTIPARKINSON AGENTS
selenium sulfide shampoo 2.3%	-	1	DERMATOLOGICALS
SELZENTRY SOLN	-	2	ANTIVIRALS
SELZENTRY TAB 25MG	-	2	ANTIVIRALS
SELZENTRY TAB 75MG	-	2	ANTIVIRALS
SEMPREX-D CAP 8-60MG	-	2	COUGH / COLD / ALLERGY
SENNA LAXATIVE	-	1	LAXATIVES
senna tab	OTC	1	LAXATIVES

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
senna-s tab	OTC	1	LAXATIVES
SENOKOT S TAB	OTC	1	LAXATIVES
SERNIVO SPRAY	-	2	DERMATOLOGICALS
se-tan plus cap	-	1	HEMATOPOIETIC AGENTS
SEVELAMER HCL 400MG TAB	-	2	GASTROINTESTINAL AGENTS - MISC.
sevelamer hydrochloride tab (RENAGEL equiv)	-	1	GASTROINTESTINAL AGENTS - MISC.
sevelamer powder pak (RENVELA equiv)	-	1	GASTROINTESTINAL AGENTS - MISC.
sevelamer tab (RENVELA TAB equiv)	-	1	GASTROINTESTINAL AGENTS - MISC.
sevoflurane liquid	-	1	GENERAL ANESTHETICS
SHARPS CONTAINER	OTC	1	MEDICAL DEVICES AND SUPPLIES
SHINGRIX INJ (Covered for members age 18 or older; QL= 2 inj/lifetime)	QL-VAC	2	VACCINES
SIKLOS TAB	-	2	HEMATOPOIETIC AGENTS
SILAZONE-II KIT	-	2	DERMATOLOGICALS
sildenafil susp (REVATIO equiv) (QL= 224ml/30 days)	QL	3	CARDIOVASCULAR AGENTS - MISC.
sildenafil tab 20mg (REVATIO equiv) (QL= 3 tabs/day)	QL	1	CARDIOVASCULAR AGENTS - MISC.

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
silver nitrate applicator	-	1	DERMATOLOGICALS
silver nitrate soln	-	1	DERMATOLOGICALS
SILVER NITRATE SOLN	-	2	DERMATOLOGICALS
silver sulfadiazine cream (SILVADENE CREAM equiv)	-	1	DERMATOLOGICALS
simethicone chew tab	OTC	1	GASTROINTESTINAL AGENTS - MISC.
simethicone drops	OTC	1	GASTROINTESTINAL AGENTS - MISC.
simvastatin tab 5mg, 10mg, 20mg, 40mg (ZOCOR equiv) (QL= 1 tab/day)	QL	1	ANTIHYPERTENSIVES
simvastatin tab 80mg (ZOCOR equiv) (QL= 1 tab/day)	PA-QL	1	ANTIHYPERTENSIVES
sirolimus tab (RAPAMUNE equiv)	-	1	ASSORTED CLASSES
SITAVIG TAB	-	2	ANTIVIRALS
SIVEXTRO TAB (QL=6 tabs/fill)	QL	2	ANTI-INFECTION AGENTS MISC.
SKYLA IUD	-	2	CONTRACEPTIVES
SLYND TAB (QL=28 tabs/24 days)	QL	2	CONTRACEPTIVES
smz/tmp (DS) tab (BACTRIM DS equiv)	-	1	ANTI-INFECTION AGENTS MISC.
smz/tmp susp (BACTRIM, SEPTRA equiv)	-	1	ANTI-INFECTION AGENTS MISC.

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
sodium bicarbonate tab	OTC	1	ANTACIDS
sodium chloride drops	OTC	1	OPHTHALMIC AGENTS
sodium chloride neb soln (HYPER-SAL equiv)	-	1	COUGH / COLD / ALLERGY
sodium chloride oint	OTC	1	OPHTHALMIC AGENTS
sodium chloride tab	OTC	1	MINERALS & ELECTROLYTES
SODIUM CITRATE IN SODIUM CHLORIDE SOLN	-	1	MISCELLANEOUS THERAPEUTIC CLASSES
SODIUM CITRATE INJ	-	1	ANTICOAGULANTS
SODIUM CITRATE SOLN	-	1	ANTICOAGULANTS
sodium citrate/citric acid soln (BICITRA equiv)	OTC	1	GENITOURINARY AGENTS - MISCELLANEOUS
sodium fluoride chew tab (LURIDE equiv)	-	1	MINERALS & ELECTROLYTES
sodium fluoride cream (PREVIDENT equiv)	-	1	MOUTH / THROAT / DENTAL AGENTS
sodium fluoride gel (PREVIDENT equiv)	-	1	MOUTH / THROAT / DENTAL AGENTS
sodium fluoride paste (PREVIDENT equiv)	-	2	MOUTH / THROAT / DENTAL AGENTS
sodium fluoride soln (LURIDE equiv)	OTC	1	MINERALS & ELECTROLYTES

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
SODIUM FLUORIDE TAB	-	1	MINERALS & ELECTROLYTES
sodium fluoride/potassium nitrate paste (PREVIDENT equiv)	-	1	MOUTH / THROAT / DENTAL AGENTS
sodium phenylbutyrate powder (BUPHENYL equiv)	-	3	ENDOCRINE AND METABOLIC AGENTS - MISC.
sodium phenylbutyrate tab (BUPHENYL equiv)	-	3	ENDOCRINE AND METABOLIC AGENTS - MISC.
sodium sulfacetamide lotion (KLARON equiv)	-	1	DERMATOLOGICALS
sodium/potassium/magnesium soln (QL=2 fills/year	QL	1	LAXATIVES
SOFOSBUVIR/VELPATASVIR TAB (QL= 1 tab/day)	AMSP-QL	3	ANTIVIRALS
solifenacin tab (VESICARE equiv) (QL= 1 tab/day)	QL	1	URINARY ANTISPASMODICS
SOLOSEC GRANULES PACKET (QL= 2 packets/28 days)	QL	2	AMEBICIDES
SOLTAMAX SOLN (Step Therapy requires trial of tamoxifen tab)	ST	2	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
SOLU-CORTEF INJ	-	2	CORTICOSTEROIDS

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
SOMAVERT INJ (Only available through Accredo 877-826-7657 or Walgreens 888-347-3416)	LD-PA	4	ENDOCRINE AND METABOLIC AGENTS - MISC.
sorafenib tosylate tab	AMSP-PA	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
SORBITOL-MANNITOL SOLN	-	1	GENITOURINARY AGENTS - MISCELLANEOUS
sotalol AF tab (BETAPACE AF equiv)	-	1	BETA BLOCKERS
sotalol tab (BETAPACE equiv)	-	1	BETA BLOCKERS
SOTYLIZE SOLN	-	2	BETA BLOCKERS
SPIKEVAX INJ	VAC	2	VACCINES
SPIKEVAX INJ (QL=1 dose/24 days)	QL	2	VACCINES
SPIKEVAX INJ 50/0.5ML	VAC	2	VACCINES
SPINOSAD SUSP	-	1	DERMATOLOGICALS
SPIRIVA RESPIMAT INHALER 1.25MCG/ACT (QL= 1 inhaler/30 days)	QL	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
SPIRIVA RESPIMAT INHALER 2.5MCG/ACT (QL= 1 inhaler/30 days)	QL	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
spironolactone tab (ALDACTONE equiv)	-	1	DIURETICS
spironolactone/hydrochlorothiazide tab (ALDACTAZIDE equiv)	-	1	DIURETICS

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
sprintec 28 tab (ORTHO-CYCLEN equiv)	-	1	CONTRACEPTIVES
SPRITAM TAB	-	2	ANTICONSULSANTS
stavudine cap (ZERIT equiv) (QL= 2 caps/day)	QL	1	ANTIVIRALS
stavudine soln (ZERIT equiv) (QL= 2400ml/30 days)	QL	1	ANTIVIRALS
STEGLATRO TAB (QL= 2 tabs/day)	QL	2	ANTIDIABETICS
STEGLUJAN TAB (Step Therapy requires trial of metformin or metformin ER or metformin combinations)	ST	2	ANTIDIABETICS
STIVARGA TAB (QL= 84 tabs/28 days; Only available through Walgreens 888-347-3416)	LD-PA-QL	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
STRENSIQ INJ 18MG/.45ML (QL= 24 vials/28 days; Only available through PantherRx Pharmacy 855-726-8479)	LD-PA-QL	4	ENDOCRINE AND METABOLIC AGENTS - MISC.
STRENSIQ INJ 28MG/0.7ML (QL= 24 vials/28 days; Only available through PantherRx Pharmacy 855-726-8479)	LD-PA-QL	4	ENDOCRINE AND METABOLIC AGENTS - MISC.
STRENSIQ INJ 40 MG/ML (QL= 24 vials/28 days; Only available through PantherRx Pharmacy 855-726-8479)	LD-PA-QL	4	ENDOCRINE AND METABOLIC AGENTS - MISC.
STRENSIQ INJ 80MG/0.8ML (QL= 24 vials/28 days; Only available through PantherRx Pharmacy 855-726-8479)	LD-PA-QL	4	ENDOCRINE AND METABOLIC AGENTS - MISC.
STRIBILD TAB (QL= 1 tab/day)	QL	2	ANTIVIRALS

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier Category
STRIVERDI RESPIMAT INHALER (QL= 1 inhaler/30 days)	QL	2 ANTI-ASTHMATIC AND BRONCHODILATOR AGENTS
STRONG IODINE SOLN	-	1 MINERALS & ELECTROLYTES
SUBLOCADE INJ 100/0.5	-	4 ANALGESICS - OPIOID
SUBLOCADE INJ 300/1.5	-	4 ANALGESICS - OPIOID
SUBSYS SPRAY (QL= 4 sprays/day)	QL	2 ANALGESICS - OPIOID
sucralfate susp (CARAFATE equiv)	-	1 ULCER DRUGS / ANTISPASMODICS / ANTICHOLINERGICS
sucralfate tab (CARAFATE equiv)	-	1 ULCER DRUGS
SUFLAVE SOLN	-	2 LAXATIVES
SULFACETAMIDE SODIUM OPHTH OINT	-	1 OPHTHALMIC AGENTS
sulfacetamide sodium ophth soln (BLEPH-10 equiv)	-	1 OPHTHALMIC AGENTS
sulfacetamide sodium/prednisolone ophth soln (VASOCIDIN equiv)	-	1 OPHTHALMIC AGENTS
SULFACETAMIDE/PREDNISOLONE OPHTH SOLN	-	1 OPHTHALMIC AGENTS
sulfadiazine tab (QL=8 tabs/day)	QL	1 SULFONAMIDES
SULFAMYLON CREAM	-	2 DERMATOLOGICALS
SULFAMYLON PACK	-	2 DERMATOLOGICALS

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
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
sumatriptan nasal spray (IMITREX, SUMATRIPTAN equiv) (QL= 6 sprays/30 days; ST req trial of 2: naratriptan tab, rizatriptan tab/ODT, zolmitriptan tab, or sumatriptan tab)	QL-ST	1	MIGRAINE PRODUCTS
sumatriptan tab (IMITREX equiv) (QL= 9 tabs/30 days)	QL	1	MIGRAINE PRODUCTS
sumatriptan vial inj (IMITREX equiv) (QL=4 ml/30 days; ST req trial of 2: naratriptan tab, rizatriptan tab/ODT, zolmitriptan tab, or sumatriptan tab)	QL-ST	1	MIGRAINE PRODUCTS
sunitinib malate cap (QL= 28 caps/42 day)	AMSP-PA-QL	3	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
SUPERVITE LIQUID	-	2	MULTIVITAMINS
SUPRANE INHALATION SOLUTION	-	2	GENERAL ANESTHETICS
SUPRAX CAP	-	2	CEPHALOSPORINS
SUPRAX CHEW TAB	-	2	CEPHALOSPORINS
SUPRAX SUSP	-	2	CEPHALOSPORINS
SUPRAX TAB	-	2	CEPHALOSPORINS

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
SURVANTA INJ	-	2	RESPIRATORY AGENTS - MISC.
SYLATRON INJ (Only available through Walgreens 888-347-3416)	LD-PA	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
SYMAX DUOTAB	-	2	ULCER DRUGS
SYMDEKO TAB (QL= 2 tabs/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	4	RESPIRATORY AGENTS - MISC.
SYMJEPI INJ (QL= 2 inj/fill)	QL	1	VASOPRESSORS
SYMPAZAN ORAL FILM	-	2	ANTICONVULSANTS
SYMTUZA TAB	-	2	ANTIVIRALS
SYNAGIS INJ (QL=2 inj/28 days)	LMSP-PA-QL	4	PASSIVE IMMUNIZING AND TREATMENT AGENTS
SYNAGIS INJ (QL=2 inj/28 days)	LMSP-PA-QL	4	PASSIVE IMMUNIZING AND TREATMENT AGENTS
SYNALAR CREAM	-	2	DERMATOLOGICALS
SYNAREL NASAL SOLN	PA	4	ENDOCRINE AND METABOLIC AGENTS - MISC.
SYNDROS SOLN	-	2	ANTIEMETICS
SYNERA PATCH	-	2	DERMATOLOGICALS
SYNRIBO INJ (Only available through US Bioservices 888-518-7246)	LD-PA	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
TABLOID TAB (QL= 4 tabs/day)	QL	4	ANTINEOPLASTICS

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
tacrolimus cap (PROGRAF equiv)	-	1	ASSORTED CLASSES
tacrolimus oint (PROTOPIC OINT equiv)	-	1	DERMATOLOGICALS
tadalafil tab (CIALIS equiv) (QL=1 tab/day)	QL	1	CARDIOVASCULAR AGENTS - MISC.
tadalafil tab (PAH) (ADCIRCA equiv) (QL= 2 tabs/day)	QL	1	CARDIOVASCULAR AGENTS - MISC.
TAFINLAR CAP (QL= 4 caps/day)	AMSP-PA-QL	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
TAFINLAR TAB (QL=12 tabs/day)	LMSP-PA-QL	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
tafluprost preservative free (pf) ophth soln (QL=30 pouches/30 days)	QL	1	OPHTHALMIC AGENTS
TAMIFLU CAP 30MG (QL=28 caps/90 days)	QL	2	ANTIVIRALS
TAMIFLU CAP 45MG (QL=14 caps/90 days)	QL	2	ANTIVIRALS
TAMIFLU CAP 75MG (QL=14 caps/90 days)	QL	2	ANTIVIRALS
TAMIFLU SUSP (QL=120ml/fill)	QL	2	ANTIVIRALS
tamoxifen tab (NOLVADEX equiv)	-	1	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
tamsulosin cap (FLOMAX equiv)	-	1	GENITOURINARY AGENTS - MISCELLANEOUS
TARON FORTE CAP	-	1	HEMATOPOIETIC AGENTS
TASIGNA CAP (QL=2 caps/day)	AMSP-PA-QL	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
tasimelteon capsule	AMSP-PA	3	HYPNOTICS / SEDATIVES SLEEP DISORDER AGENTS
tazarotene cream 0.1% (TAZORAC equiv) (QL= 360g/30 days)	QL	1	DERMATOLOGICALS
TEKTURNA HCT TAB	-	2	ANTIHYPERTENSIVES
telmisartan tab (MICARDIS equiv)	-	1	ANTIHYPERTENSIVES
temazepam cap 15mg (RESTORIL equiv)	-	1	HYPNOTICS / SEDATIVES SLEEP DISORDER AGENTS
temazepam cap 30mg (RESTORIL equiv)	-	1	HYPNOTICS / SEDATIVES SLEEP DISORDER AGENTS
temozolomide cap (TEMODAR equiv)	AMSP	3	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
tenofovir disoproxil fumarate tab (VIREAD equiv) (QL= 1 tab/day)	QL	1	ANTIVIRALS
terazosin cap (HYTRIN equiv)	-	1	ANTIHYPERTENSIVES
terbinafine tab (LAMISIL equiv) (QL=1 tab/day)	QL	1	ANTIFUNGALS
terbutaline sulfate tab (BRETHINE equiv)	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
terconazole cream 0.4% (TERAZOL equiv) (QL=45 gm/fill)	QL	1	VAGINAL PRODUCTS
TERCONAZOLE CREAM 0.8%	-	1	VAGINAL PRODUCTS
terconazole cream 0.8% (TERAZOL equiv) (QL=20 gm/fill)	QL	1	VAGINAL AND RELATED PRODUCTS
terconazole supp (TERAZOL equiv) (QL=3 supps/fil	QL	1	VAGINAL PRODUCTS
teriflunomide tab (QL= 1 tab/day)	AMSP-QL	3	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
TERIPARATIDE INJ (QL= 2.48ml/28 days)	AMSP-PA-QL	4	ENDOCRINE AND METABOLIC AGENTS - MISC.
TESTOPEL IMPLANT PELLETS 75MG	-	2	ANDROGENS-ANABOLIC
testosterone cypionate inj (QL = 4 vials/28 days)	QL	1	ANDROGENS-ANABOLIC
testosterone cypionate inj (QL= 1 vial/28 days)	QL	1	ANDROGENS-ANABOLIC
testosterone cypionate inj (QL= 4 vials/28 days)	QL	1	ANDROGENS-ANABOLIC
testosterone cypionate inj (QL=1 vial/28 days)	QL	1	ANDROGENS-ANABOLIC
testosterone cypionate inj (DEPO-TESTOSTERONE equiv) (QL= 1 vial/28 days)	PA-QL	1	ANDROGENS-ANABOLIC
testosterone enanthate inj	-	1	ANDROGENS-ANABOLIC
TESTOSTERONE ENANTHATE INJ (QL= 5mL/28 days)	QL	1	ANDROGENS-ANABOLIC

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
testosterone gel 1% 25mg (ANDROGEL equiv) (QL=2.5 gm/day)	PA-QL	1	ANDROGENS-ANABOLIC
testosterone gel pump 1.62% (ANDROGEL equiv) (QL=150 gm/30 days)	PA-QL	1	ANDROGENS-ANABOLIC
TETANUS/DIPHTHERIA TOXOID INJ	VAC	2	TOXOIDS
tetrabenazine tab (XENAZINE equiv)	-	1	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
tetracycline cap	-	1	TETRACYCLINES
THALOMID CAP (Only available through Walgreen 888-347-3416)	LD	4	ASSORTED CLASSES
theanine cap	OTC	1	NUTRIENTS
THEO-24 CAP	-	2	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

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
THEOPHYLLINE ER TAB (QL= 1 tab/day)	QL	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
theophylline soln	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
thioridazine hcl tab (QL= 8 tabs/day)	QL	1	ANTIPSYCHOTICS / ANTIMANIC AGENTS
THROMBI-GEL PAD	-	1	HEMOSTATICS
THROMBI-PAD	-	1	HEMOSTATICS
THYROLAR TAB	-	2	THYROID AGENTS
tiagabine tab 12mg (GABITRIL equiv) (QL= 4 tabs/day)	QL	1	ANTICONVULSANTS
tiagabine tab 16mg (GABITRIL equiv) (QL= 3 tabs/day)	QL	1	ANTICONVULSANTS
tiagabine tab 2mg (GABITRIL equiv) (QL= 4 tabs/day)	QL	1	ANTICONVULSANTS
tiagabine tab 4mg (GABITRIL equiv) (QL= 4 tabs/day)	QL	1	ANTICONVULSANTS
TICANASE PAK	-	2	NASAL AGENTS - SYSTEMIC AND TOPICAL
TICLOPIDINE TAB	-	3	HEMATOLOGICAL AGENTS - MISC.

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
timolol maleate ophth soln 0.25% (TIMOPTIC equiv)	-	1	OPHTHALMIC AGENTS
timolol maleate ophth soln 0.5% (TIMOPTIC equiv)	-	1	OPHTHALMIC AGENTS
timolol maleate tab (BLOCADREN equiv)	-	1	BETA BLOCKERS
tinidazole tab (TINDAMAX equiv)	-	1	ANTI-INFECTIVE AGENTS MISC.
tiopronin dr tab (QL= 8 tabs/day)	AMSP-PA-QL	3	GENITOURINARY AGENTS - MISCELLANEOUS
tiopronin tab (Only available through Eversana 636-519-2400; QL=8 tabs/day)	LD-PA-QL	3	GENITOURINARY AGENTS - MISCELLANEOUS
tiotropium bromide cap inhaler (QL= 1 cap/day; For use with Handihaler device)	QL	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
TIROSINT CAP 125MCG	-	2	THYROID AGENTS
TIROSINT CAP 137MCG	-	2	THYROID AGENTS
TIVICAY PD TAB (QL= 180 tabs/30 days)	QL	2	ANTIVIRALS
TIVICAY TAB (QL=2 tabs/day)	QL	2	ANTIVIRALS
TIZANIDINE COMFORT KIT	-	2	MUSCULOSKELETAL THERAPY AGENTS
tizanidine tab (ZANAFLEX equiv)	-	1	MUSCULOSKELETAL THERAPY AGENTS
TOBI PODHALER (QL= 1 inhaler/56 days)	AMSP-PA-QL	4	AMINOGLYCOSIDES
TOBRADEX OPHTH OINT	-	2	OPHTHALMIC AGENTS

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
tobramycin neb soln (BETHKIS equiv) (QL= 280ml/30 days)	AMSP-PA-QL	3	AMINOGLYCOSIDES
tobramycin neb soln (TOBI equiv) (QL= 280ml/30 days)	AMSP-PA-QL	3	AMINOGLYCOSIDES
tobramycin ophth soln (TOBREX equiv)	-	1	OPHTHALMIC AGENTS
tobramycin/dexamethasone ophth soln (TOBRADEX equiv)	-	1	OPHTHALMIC AGENTS
TOBREX OPTH OINT	-	2	OPHTHALMIC AGENTS
tolazamide tab (TOLINASE equiv)	-	1	ANTIDIABETICS
TOLBUTAMIDE TAB	-	2	ANTIDIABETICS
tolmetin cap (TOLECTIN DS equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
tolnaftate cream	OTC	1	DERMATOLOGICALS
TOLSURA CAP	-	2	ANTIFUNGALS
tolvaptan tab (SAMSCA equiv) (QL= 1 tab/day; Onl available through Walgreens 888-347-3416)	LD-PA-QL	3	ENDOCRINE AND METABOLIC AGENTS - MISC.
topiramate ER cap 150mg (QUDEXY equiv) (QL= 2 caps/day)	QL	1	ANTICONVULSANTS
topiramate ER cap 200mg (QUDEXY equiv) (QL= 2 caps/day)	QL	1	ANTICONVULSANTS
topiramate sprinkle cap (TOPAMAX equiv)	-	1	ANTICONVULSANTS
topiramate tab (TOPAMAX equiv)	-	1	ANTICONVULSANTS

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
toremifene tab (FARESTON equiv)	-	1	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
torsemide tab (DEMADEX equiv)	-	1	DIURETICS
TRACHEOSTOMY CARE KIT	-	1	MEDICAL DEVICES AND SUPPLIES
TRAMADOL ER CAP (QL=1 cap/day)	QL	1	ANALGESICS - OPIOID
tramadol ER tab (RYZOLT equiv) (QL= 1 tab/day; Step Therapy requires trial of tramadol tab)	QL-ST	1	ANALGESICS - OPIOID
tramadol ER tab 100mg (ULTRAM ER equiv) (QL= 1 tab/day; Step Therapy requires trial of tramadol tab)	QL-ST	1	ANALGESICS - OPIOID
tramadol ER tab 200mg (ULTRAM ER equiv) (QL= 1 tab/day; Step Therapy requires trial of tramadol tab)	QL-ST	1	ANALGESICS - OPIOID
tramadol ER tab 300mg (ULTRAM ER equiv) (QL= 1 tab/day; Step Therapy requires trial of tramadol tab)	QL-ST	1	ANALGESICS - OPIOID
tramadol tab (ULTRAM equiv)	-	1	ANALGESICS - OPIOID
tramadol tab 100mg (QL= 4 tabs/day)	QL	1	ANALGESICS - OPIOID
tramadol/acetaminophen tab (ULTRACET equiv) (QL= 6 tabs/day)	QL	1	ANALGESICS - OPIOID
trandolapril tab (MAVIK equiv)	-	1	ANTIHYPERTENSIVES
trandolapril/verapamil ER tab (TARKA equiv)	-	1	ANTIHYPERTENSIVES

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
tranexamic acid tab (LYSTEDA equiv) (QL= 6 tabs/day 30 tabs/28 days)	QL	1	HEMOSTATICS
travoprost ophth soln (TRAVATAN Z equiv) (Step Therapy requires trial of latanoprost ophth soln)	ST	1	OPHTHALMIC AGENTS
TRECATOR TAB	-	2	ANTIMYCOBACTERIAL AGENTS
TRELEGY ELLIPTA INHALER (QL= 1 inhaler/30 days)	QL	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
treprostinil inj (REMODULIN equiv) (Only available through Accredo 800-803-2523)	LD-PA	3	CARDIOVASCULAR AGENTS - MISC.
tretinoin cap (VESANOID equiv)	-	1	ANTINEOPLASTICS
tretinoin cream (RETIN-A CREAM equiv) (QL= 360g/30 days, Step therapy requires trial of adapalene gel, followed by tretinoin cream 0.025%)	QL-ST	1	DERMATOLOGICALS
tretinoin cream 0.025% (QL= 360g/30 days, Step therapy requires trial of adapalene gel)	QL-ST	1	DERMATOLOGICALS
tretinoin gel (RETIN-A GEL equiv) (QL= 360g/30 days, Step therapy requires trial of adapalene gel, followed by tretinoin cream 0.025%)	QL-ST	1	DERMATOLOGICALS
tretinoin gel 0.03% (QL= 360g/30 days, Step therapy requires trial of adapalene gel, followed by tretinoin cream 0.025%)	QL-ST	1	DERMATOLOGICALS

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
TRETIN-X CREAM	-	2	DERMATOLOGICALS
TRETIN-X KIT	-	2	DERMATOLOGICALS
TREXALL TAB	-	2	ANTINEOPLASTICS
triamcinolone acetonide oint (TRIANEX equiv) (Step Therapy requires trial of triamcinolone acetonide oint 0.025% or 0.1%)	ST	1	DERMATOLOGICALS
triamcinolone acetonide oint 0.025% (TRIANEX equiv)	-	1	DERMATOLOGICALS
triamcinolone acetonide oint 0.1% (TRIANEX equiv)	-	1	DERMATOLOGICALS
triamcinolone acetonide oint 0.5% (TRIANEX equiv)	-	1	DERMATOLOGICALS
triamcinolone cream	-	1	DERMATOLOGICALS
triamcinolone in orabase paste (KENALOG/ORABASE equiv)	-	1	MOUTH / THROAT / DENTAL AGENTS
triamcinolone lotion	-	1	DERMATOLOGICALS
triamcinolone OTC nasal spray (NASACORT equiv)	OTC	1	NASAL AGENTS - SYSTEMIC AND TOPICAL
triamterene cap (DYRENIUM equiv) (Step Therapy requires trial of amiloride or spironolactone)	ST	1	DIURETICS
triamterene/hydrochlorothiazide cap (DYAZIDE equiv)	-	1	DIURETICS
TRIAMTERENE/HYDROCHLOROTHIAZIDE CAP 50-25mg	-	1	DIURETICS

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
triamterene/hydrochlorothiazide tab (MAXZIDE equiv)	-	1	DIURETICS
TRIANEX OINT	-	1	DERMATOLOGICALS
TRI-CHLOR SOLN	-	2	DERMATOLOGICALS
trientine cap 250mg (ST req trial of generic penicillamine tab)	ST	1	MISCELLANEOUS THERAPEUTIC CLASSES
TRIFLURIDINE OPHTH SOLN	-	1	OPHTHALMIC AGENTS
trifluridine ophth soln (VIROPTIC equiv)	-	1	OPHTHALMIC AGENTS
trigels-f forte cap	OTC	1	HEMATOPOIETIC AGENTS
TRIGLIDE TAB	-	2	ANTIHYPERLIPIDEMICS
trihexyphenidyl elixir (ARTANE equiv)	-	1	ANTIPARKINSON AND RELATED THERAPY AGENTS
TRIHEXYPHENIDYL SOLN (QL=946ml/28 days)	QL	1	ANTIPARKINSON AND RELATED THERAPY AGENTS
trihexyphenidyl tab (ARTANE equiv)	-	1	ANTIPARKINSON AGENTS
tri-legest tab (ESTROSTEP FE equiv)	-	1	CONTRACEPTIVES
TRI-LUMA CREAM	-	2	DERMATOLOGICALS
trilyte soln (NULYTELY equiv) (QL= 2 fills/calendar year)	QL	1	LAXATIVES
trimethobenzamide cap (TIGAN equiv)	-	1	ANTIEMETICS

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
trimethoprim tab (PROLOPRIM equiv)	-	1	ANTI-INFECTIVE AGENTS MISC.
TRIMETHOPRIM TAB	-	2	ANTI-INFECTIVE AGENTS MISC.
triple antibiotic oint	OTC	1	DERMATOLOGICALS
TRIPLE DYE SWAB	-	1	ANTISEPTICS & DISINFECTANTS
tri-sprintec tab (ORTHO TRI-CYCLEN (LO) equiv)	-	1	CONTRACEPTIVES
TRIUMEQ PD TAB (QL=6 tabs/day)	QL	2	ANTIVIRALS
TRIUMEQ TAB	-	2	ANTIVIRALS
TRI-VI-FLOR DROPS	-	2	MULTIVITAMINS
tri-vitamin with fluoride drops	-	1	MULTIVITAMINS
tropicamide ophth soln (MYDRIACYL equiv)	-	1	OPHTHALMIC AGENTS
TRULICITY INJ (QL= 4 pens/28 days)	QL-RDX	2	ANTIDIABETICS
TRUMENBA INJ	VAC	2	VACCINES
TRUSKIN SHEET	-	2	DERMATOLOGICALS
tussin dm syrup	OTC	1	COUGH / COLD / ALLERGY
TUXARIN ER TAB (QL= 20 tabs/day)	QL	2	COUGH / COLD / ALLERGY
TWINRIX INJ	VAC	1	VACCINES
TWINRIX INJ	VAC	2	VACCINES
TWIRLA PATCH	-	2	CONTRACEPTIVES
TYBLUME TAB	-	2	CONTRACEPTIVES

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
TYBOST TAB	-	2	ANTIVIRALS
TYENNE INJ (QL = 1.8mL/28 days)	AMSP-PA-QL	4	ANALGESICS - ANTI-INFLAMMATORY
TYMLOS INJ (QL= 1.56ml/28 days)	AMSP-PA-QL	4	ENDOCRINE AND METABOLIC AGENTS - MISC.
TYPHIM VI INJ	--VAC	2	VACCINES
ULESFIA LOTION	-	2	DERMATOLOGICALS
ultrasound gel	-	1	DIAGNOSTIC PRODUCTS
ULTRAVATE LOTION	-	2	DERMATOLOGICALS
umecta mouss aer (HYDRO 40 equiv)	-	1	DERMATOLOGICALS
UNISOM SLEEPGELS 50MG	OTC	1	HYPNOTICS / SEDATIVES SLEEP DISORDER AGENTS
UPTRAVI TAB (Only available through Accredo 877-826-7657)	LD-PA	4	CARDIOVASCULAR AGENTS - MISC.
UPTRAVI THERAPY PACK (Only available through Accredo 877-826-7657)	LD-PA	4	CARDIOVASCULAR AGENTS - MISC.
URAMAXIN FOAM	-	2	DERMATOLOGICALS
UREA NAIL KIT	-	1	DERMATOLOGICALS
uretron d-s tab	-	2	ANTI-INFECTIVE AGENTS MISC.

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
URIMAR-T TAB	-	1	ANTI-INFECTIVE AGENTS MISC.
UROQID #2 TAB	-	2	URINARY ANTI-INFECTIVES
ursodiol cap (ACTIGALL equiv)	-	1	GASTROINTESTINAL AGENTS - MISC.
ursodiol tab (URSO (FORTE) equiv)	-	1	GASTROINTESTINAL AGENTS - MISC.
UTA cap	-	1	ANTI-INFECTIVE AGENTS MISC.
valacyclovir tab (VALTREX equiv)	-	1	ANTIVIRALS
valganciclovir soln (VALCYTE equiv)	-	1	ANTIVIRALS
valganciclovir tab (VALCYTE equiv)	-	1	ANTIVIRALS
VALSARTAN SOLN (QL = 2400 mL/30 days)	QL	2	ANTIHYPERTENSIVES
valsartan tab (DIOVAN equiv)	-	1	ANTIHYPERTENSIVES
valsartan/hydrochlorothiazide tab (DIOVAN HCT equiv)	-	1	ANTIHYPERTENSIVES
vancomycin cap 125mg (VANCOCIN equiv) (QL= 56 caps/30 days)	QL	1	ANTI-INFECTIVE AGENTS MISC.
vancomycin cap 250mg (VANCOCIN equiv) (QL= 112 caps/30 days)	QL	1	ANTI-INFECTIVE AGENTS MISC.
vancomycin inj	-	1	ANTI-INFECTIVE AGENTS MISC.

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
VANCOMYCIN INJ 500MG	-	1	ANTI-INFECTIVE AGENTS MISC.
VANCOMYCIN SOLN	-	1	ANTI-INFECTIVE AGENTS MISC.
VANDAZOLE GEL 0.75% (Step therapy requires trial of metronidazole tab or clindamycin cap/oral soln; QL 1 package/30 days)	QL-ST	2	VAGINAL AND RELATED PRODUCTS
varenicline tartrate tab	SMKG	1	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
varenicline tartrate tab start pack	SMKG	1	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
VARIVAX INJ	VAC	2	VACCINES
VARUBI TAB	-	2	ANTIEMETICS
VAXCHORA SUSP	VAC	2	VACCINES
VAXELIS INJ	VAC	2	TOXOIDS
VAXNEUVANCE INJ	VAC	2	VACCINES
VECAMYL TAB	-	2	ANTIHYPERTENSIVES
VELIVET PAK	-	2	CONTRACEPTIVES
velivet tab (CYCLESSA equiv)	-	1	CONTRACEPTIVES
VEMLIDY TAB (QL= 1 tab/day)	AMSP-QL	4	ANTIVIRALS

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
VENCLEXTA STARTER PACK (Only available through OPTUM - 877-445-6874)	LD-PA	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
VENCLEXTA TAB (Only available through OPTUM 877-445-6874)	LD-PA	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
VENELEX OINT	-	2	DERMATOLOGICALS
verapamil SR tab (CALAN SR, ISOPTIN SR equiv)	-	1	CALCIUM CHANNEL BLOCKERS
verapamil tab (CALAN equiv)	-	1	CALCIUM CHANNEL BLOCKERS
VERDESO FOAM	-	2	DERMATOLOGICALS
VIBRAMYCIN SYRUP	-	2	TETRACYCLINES
VICTOZA INJ (QL= 9ml/30 days)	QL-RDX	2	ANTIDIABETICS
vienva tab, lessina tab, kurvelo tab (ALESSE equiv)	-	1	CONTRACEPTIVES
VINATE II TAB	-	1	MULTIVITAMINS
VINATE ONE	-	1	MULTIVITAMINS
violele tab, kariva tab (MIRCETTE equiv)	-	1	CONTRACEPTIVES
VIRACEPT POWDER	-	3	ANTIVIRALS
VIRACEPT TAB	-	2	ANTIVIRALS
VIREAD POWDER	-	2	ANTIVIRALS
VIRTUSSIN DAC SYRUP	OTC	1	COUGH / COLD / ALLERGY
vision formula tab	OTC	1	MULTIVITAMINS
VIT 3 CAP	-	1	HEMATOPOIETIC AGENTS

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
VITAFOL-OB+DHA PACK	-	1	MULTIVITAMINS
VITAL-D RX TAB	-	1	MULTIVITAMINS
VITAMEDMD ONE RX CAP	-	2	MULTIVITAMINS
vitamin b complex cap	OTC	1	MULTIVITAMINS
vitamin b-12 er tab	OTC	1	HEMATOPOIETIC AGENTS
vitamin b-12 tab 1000mcg	OTC	1	HEMATOPOIETIC AGENTS
vitamin b-12 tab 500mcg	OTC	1	HEMATOPOIETIC AGENTS
VITAMIN C CHEW TAB	OTC	1	MULTIVITAMINS
vitamin c chew tab 500mg	OTC	1	VITAMINS
vitamin D cap (RX strength only)	-	1	VITAMINS
vitamin e cap	OTC	1	VITAMINS
vitamin e cap 400unit	OTC	1	VITAMINS
VITA-RESPA TAB	OTC	1	DIETARY PRODUCTS / DIETARY MANAGEMENT PRODUCTS
VIVA DHA CAP	-	1	MULTIVITAMINS
VIVITROL INJ	AMSP	4	ANTIDOTES
voriconazole susp (VFEND equiv) (QL=15ml/day)	QL	1	ANTIFUNGALS
voriconazole tab (VFEND equiv) (QL=3 tabs/day)	QL	1	ANTIFUNGALS
VTOL SOLN	-	1	ANALGESICS - NONNARCOTIC
warfarin tab (COUMADIN equiv)	-	1	ANTICOAGULANTS

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
WINRHO SDF INJ	-	2	PASSIVE IMMUNIZING AND TREATMENT AGENTS
WYNZORA CREAM (QL=420 gm/28 days, Step therapy requires trial of 2 topicals: calcipotriene, betamethasone, AMCCINONIDE, fluocinonide, triamcinolone.)	QL-ST	2	DERMATOLOGICALS
XALKORI CAP (QL=6 caps/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
XARELTO STARTER PACK (QL= 1 pack/30 days)	QL	2	ANTICOAGULANTS
XARELTO SUSP (QL=10ml/day)	QL	2	ANTICOAGULANTS
XARELTO TAB (QL= 60 tabs/30 days)	QL	2	ANTICOAGULANTS
XARELTO TAB 10MG (QL= 30 tabs/30 days)	QL	2	ANTICOAGULANTS
XARELTO TAB 15MG (QL= 60 tabs/30 days)	QL	2	ANTICOAGULANTS
XARELTO TAB 20MG (QL=30 tabs/30 days)	QL	2	ANTICOAGULANTS
XEMBIFY INJ (Only available through OPTUM - 877-445-6874)	LD	2	PASSIVE IMMUNIZING AND TREATMENT AGENTS
XEPI CREAM	-	2	DERMATOLOGICALS
XIFAXAN TAB 200MG (QL= 9 tabs/3 days)	PA-QL	2	ANTI-INFECTIVE AGENTS MISC.
XIFAXAN TAB 550MG (QL= 2 tabs/day)	PA-QL	2	ANTI-INFECTIVE AGENTS MISC.
XIMINO CAP	-	2	TETRACYCLINES

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
XOLAIR 150MG/ML INJ (QL= 1 inj/28 days)	AMSP-QL	4	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
XOLAIR 300MG/2ML INJ (QL= 1 inj/28 days)	AMSP-QL	4	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
XOLAIR 75MG/0.5ML INJ (QL= 1 inj/28 days)	AMSP-QL	4	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
XOLAIR INJ (QL= 1 inj/28 days)	AMSP-QL	4	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
XOLAIR INJ 150MG/ML (QL= 1 inj/28 days)	AMSP-QL	4	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
XOLAIR INJ 300MG/2ML (QL= 1 inj/28 days)	AMSP-QL	4	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
XOLAIR INJ 75MG/0.5ML (QL= 1 inj/28 days)	AMSP-QL	4	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
XOLEGEL	-	2	DERMATOLOGICALS
XRYLIDERM KIT	-	1	DERMATOLOGICALS

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
XULANE PATCH	-	1	CONTRACEPTIVES
YONSA TAB	-	2	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
YOSPRALA ER TAB	-	2	HEMATOLOGICAL AGENTS - MISC.
YUPELRI SOLN	-	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
zafemy patch (XULANE equiv)	-	1	CONTRACEPTIVES
zafirlukast tab (ACCOLATE equiv)	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
zaleplon cap (SONATA equiv) (QL= 2 caps/day)	QL	1	HYPNOTICS / SEDATIVES SLEEP DISORDER AGENTS
ZARXIO INJ (QL=14 syringes/28 days)	AMSP-QL	4	HEMATOPOIETIC AGENTS
ZARXIO INJ 480/0.8 (QL= 14 syringes/28days)	AMSP-QL	4	HEMATOPOIETIC AGENTS
ZEJULA CAP (QL= 30 caps/30 days; Only available through OPTUM - 877-445-6874)	LD-PA-QL	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ZEJULA TAB (QL= 1 tab/day; Only available through OPTUM - 877-445-6874)	LD-PA-QL	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ZELAPAR ODT	-	2	ANTIPARKINSON AGENTS

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier Category
zenzedi tab 10mg (DEXEDRINE equiv) (QL= 3 tabs/day)	QL	1 ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
zephrex-d tab 30mg (QL= 240 tabs/30 days)	OTC-QL	1 NASAL AGENTS - SYSTEMIC AND TOPICAL
ZERVIAE OPTH SOLN (QL= 30 single use containers/30 days)	QL	2 OPHTHALMIC AGENTS
ZETONNA NASAL SPRAY (QL= 1 bottle/30 days)	QL	2 NASAL AGENTS - SYSTEMIC AND TOPICAL
zidovudine cap (RETROVIR equiv) (QL= 6 caps/day)	QL	1 ANTIVIRALS
zidovudine syrup (RETROVIR equiv) (QL= 1920ml/30 days)	QL	1 ANTIVIRALS
zidovudine tab (RETROVIR equiv) (QL= 2 tabs/day)	QL	1 ANTIVIRALS
zinc cap	OTC	1 MINERALS & ELECTROLYTES
zinc oxide oint 20%	OTC	1 DERMATOLOGICALS
ZIRGAN OPTH GEL	-	2 OPHTHALMIC AGENTS
ZITHRANOL SHAMPOO	-	2 DERMATOLOGICALS
ZITHROMAX POWDER PACK	-	2 MACROLIDES
ZOLINZA CAP	PA	2 ANTINEOPLASTICS
zolmitriptan tab (ZOMIG equiv) (QL= 9 tabs/30 days)	QL	1 MIGRAINE PRODUCTS

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
zolpidem ER tab (AMBIEN CR equiv) (QL= 1 tab/day; Step Therapy requires trial of zolpidem tab)	QL-ST	1	HYPNOTICS / SEDATIVES SLEEP DISORDER AGENTS
zolpidem er tab 6.25mg (QL= 2 tabs/day)	QL	1	HYPNOTICS / SEDATIVES SLEEP DISORDER AGENTS
zolpidem tab 10 MG (AMBIEN equiv) (QL=1 tab/day)	QL	1	HYPNOTICS / SEDATIVES SLEEP DISORDER AGENTS
zolpidem tab 5 MG (AMBIEN equiv) (QL=2 tabs/day)	QL	1	HYPNOTICS / SEDATIVES SLEEP DISORDER AGENTS
ZOLPIMIST SPRAY (QL= 1 bottle/30 days)	QL	2	HYPNOTICS / SEDATIVES SLEEP DISORDER AGENTS
ZOMACTON INJ	AMSP-PA	4	ENDOCRINE AND METABOLIC AGENTS - MISC.
zonisamide cap (ZONEGRAN equiv)	-	1	ANTICONVULSANTS
ZORVOLEX CAP	-	2	ANALGESICS - ANTI-INFLAMMATORY
ZTLIDO PATCH	-	2	DERMATOLOGICALS
ZUBSOLV SL TAB	-	2	ANALGESICS - OPIOID

NC =Not Covered		generic =small letters		BRANDS =CAPITAL LETTERS	
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC		Plan Exclusion	
LD	Limited Distribution	LMSP		Lumicera Mandatory Specialty Pharmacy Program	
OTC	Over-the-Counter	PA		Prior Authorization	
QL	Quantity Limit	RDX		Restricted to Diagnosis	
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.

EOCCO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2025

Drug Name	Special Code	Tier	Category
ZYCLARA CREAM 2.5%	-	2	DERMATOLOGICALS
ZYFLO TAB	-	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ZYLET OPHTH SUSP	-	2	OPHTHALMIC AGENTS
ZYPITAMAG TAB (QL= 1 tab/day)	QL	2	ANTIHYPERLIPIDEMICS
ZYRTEC CHEW TAB (QL= 1 tab/day)	OTC-QL	1	ANTIHISTAMINES

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS		
AMPHETAMINES		
amphetamine/dextroamphetamine ER cap (ADDERALL XR equiv) (QL=2 caps/day)	QL	1
amphetamine/dextroamphetamine tab 10mg (QL=180 tabs/30 days)	QL	1
amphetamine/dextroamphetamine tab 12.5mg (QL=150 tabs/30 days)	QL	1
amphetamine/dextroamphetamine tab 15mg (QL=120 tabs/30 days)	QL	1
amphetamine/dextroamphetamine tab 20mg (QL=90 tabs/30 days)	QL	1
amphetamine/dextroamphetamine tab 30mg (QL=60 tabs/30 days)	QL	1
amphetamine/dextroamphetamine tab 5mg (QL=360 tabs/30 days)	QL	1
amphetamine/dextroamphetamine tab 7.5mg (QL=240 tabs/30 days)	QL	1
dextroamphetamine 5mg tab (QL= 9 tabs/day)	QL	1
dextroamphetamine ER cap 10mg (DEXEDRINE equiv) (QL= 4 caps/day)	QL	1
dextroamphetamine ER cap 15mg (QL= 4 caps/day)	QL	1
dextroamphetamine ER cap 5mg (DEXEDRINE equiv) (QL= 2 caps/day)	QL	1
dextroamphetamine tab 10mg (QL= 6 tabs/day)	QL	1
zenzedi tab 10mg (DEXEDRINE equiv) (QL= 3 tabs/day)	QL	1
ANALEPTICS		
caffeine citrate soln (CAFCIT equiv)	-	1
STIMULANTS - MISC.		
dexmethylphenidate ER cap (FOCALIN XR equiv) (QL=1 cap/day)	QL	1
dexmethylphenidate ER cap 10mg (QL=60 caps/30 days)	QL	1
dexmethylphenidate ER cap 15mg (QL=60 caps/30 days)	QL	1

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS Cont.		
dexmethylphenidate ER cap 20mg (QL=60 caps/30 days)	QL	1
dexmethylphenidate ER cap 5mg (QL=60 caps/30 days)	QL	1
dexmethylphenidate tab (FOCALIN equiv) (QL= 2 tabs/day)	QL	1
methylphenidate CD cap (METADATE CD equiv) (QL= 1 cap/day)	QL	1
methylphenidate chew tab (METHYLIN equiv) (QL= 3 tabs/day)	QL	1
methylphenidate ER cap 10mg (QL=60 caps/30 days)	QL	1
methylphenidate ER cap 10mg (RITALIN LA equiv) (QL= 1 cap/day)	QL	1
methylphenidate ER cap 20mg (QL= 2 caps/day)	QL	1
methylphenidate ER cap 20mg (QL=60 caps/30 days)	QL	1
methylphenidate ER cap 30mg (QL=60 caps/30 days)	QL	1
methylphenidate ER cap 30mg (RITALIN LA equiv) (QL= 2 caps/day)	QL	1
methylphenidate ER cap 40mg (RITALIN LA equiv) (QL= 1 cap/day)	QL	1
methylphenidate ER cap 60mg (RITALIN LA equiv) (QL= 1 cap/day)	QL	1
methylphenidate ER tab (QL= 1 tab/day)	QL	1
methylphenidate ER tab 10mg (QL= 3 tabs/day)	QL	1
methylphenidate ER tab 18mg (QL=60 tabs/30 days)	QL	1
methylphenidate ER tab 20mg (QL= 3 tabs/day)	QL	1
METHYLPHENIDATE ER TAB 27MG (QL=60 tabs/30 days)	QL	1
methylphenidate ER tab 36mg (QL=60 tabs/30 days)	QL	1
methylphenidate soln 10mg/5ml (QL= 900ml/30 days)	QL	1
methylphenidate soln 5mg/5ml (METHYLIN equiv) (QL= 1800ml/30 days)	QL	1

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS Cont.		
methylphenidate tab (RITALIN equiv) (QL= 3 tabs/day)	QL	1
COTEMPLA XR ODT 25.9MG	-	2
COTEMPLA XR ODT 8.6MG	-	2
JORNAY PM CAP (QL=1 cap/day)	QL	2
QUILLICHEW ER TAB (QL= 1 tab/day)	QL	2
QUILLICHEW ER TAB 20MG (QL=3 tabs/day)	QL	2
QUILLICHEW ER TAB 30MG (QL=2 tabs/day)	QL	2
QUILLIVANT XR SUSP	-	2
ALLERGENIC EXTRACTS/BIOLOGICALS MISC		
ALLERGENIC EXTRACTS		
ODACTRA SL TAB (QL= 30 tabs/30 days)	QL	2
ORALAIR SL TAB	-	2
ALTERNATIVE MEDICINES		
ALTERNATIVE MEDICINE - M'S		
melatonin tab 3mg	OTC	1
ALTERNATIVE MEDICINE COMBINATIONS		
MELATONIN TAB	OTC	1
AMEBICIDES		
AMEBICIDES		
SOLOSEC GRANULES PACKET (QL= 2 packets/28 days)	QL	2
AMINOGLYCOSIDES		

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
AMINOGLYCOSIDES Cont.		
AMINOGLYCOSIDES		
neomycin tab	-	1
tobramycin neb soln (BETHKIS equiv) (QL= 280ml/30 days)	AMSP-PA-QL	3
tobramycin neb soln (TOBI equiv) (QL= 280ml/30 days)	AMSP-PA-QL	3
TOBI PODHALER (QL= 1 inhaler/56 days)	AMSP-PA-QL	4
ANALGESICS - ANTI-INFLAMMATORY		
ANTI-TNF-ALPHA - MONOCLONAL ANTIBODIES		
ADALIMU-ADAZ INJ 80/0.8ML (QL=2 inj/28days)	AMSP-QL	4
ADALIMUMAB-ADAZ INJ (QL= 2 syringes/28 days)	AMSP-PA-QL	4
ADALIMUMAB-ADAZ PEN INJ (QL=2 pens/28 days)	AMSP-PA-QL	4
HADLIMA INJ (QL= 2 syringes/28 days)	AMSP-PA-QL	4
HADLIMA PUSH INJ 40/0.4ML (QL= 2 inj/28 days)	AMSP-PA-QL	4
HADLIMA PUSH INJ 40/0.8ML (QL= 2 inj/28 days)	AMSP-PA-QL	4
HADLIMA PUSHTOUCH INJ (QL= 2 inj/28 days)	AMSP-PA-QL	4
INTERLEUKIN-6 RECEPTOR INHIBITORS		
TYENNE INJ (QL = 1.8mL/28 days)	AMSP-PA-QL	4
NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (NSAIDS)		
celecoxib cap (CELEBREX equiv) (QL= 2 caps/day)	QL	1
celecoxib cap 400mg (QL= 2 caps/day; Step therapy requires trial of celecoxib 50mg, celecoxib 100mg, OR celecoxib 200mg.)	QL-ST	1
diclofenac potassium tab (CATAFLAM equiv)	-	1

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
ANALGESICS - ANTI-INFLAMMATORY Cont.		
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
FLURBIPROFEN TAB	-	1
flurbiprofen tab (ANSAID equiv)	-	1
ibuprofen cap	OTC	1
ibuprofen chew tab	-	1
ibuprofen susp (ADVIL, MOTRIN equiv)	OTC	1
ibuprofen tab	OTC	1
ibuprofen tab 100mg	-	1
indomethacin cap (INDOCIN equiv)	-	1
indomethacin CR cap (INDOCIN SR equiv)	-	1
KETOPROFEN CAP	-	1
ketorolac tab (TORADOL equiv) (QL= 20 tabs/30 days)	QL	1
meloxicam cap (VIVLODEX equiv) (QL= 1 cap/day; Step Therapy requires trial of meloxicam, aspirin, naproxen, diclofenac, ketoprofen, oxaprozin, sulindac, or tolmeti	QL-ST	1
meloxicam tab (MOBIC equiv)	-	1
nabumetone tab (RELAFEN equiv)	-	1

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
ANALGESICS - ANTI-INFLAMMATORY Cont.		
naproxen EC tab (NAPROSYN EC equiv)	-	1
naproxen sodium tab (ANAPROX equiv)	OTC	1
NAPROXEN SUSP	-	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 (TOLECTIN DS equiv)	-	1
COMFORT PAC-NAPROXEN KIT	-	2
INDOCIN SUPP	-	2
NUDROXIPAK I-800 KIT	-	2
RELAFEN DS TAB (QL= 2 tabs/day)	QL	2
ZORVOLEX CAP	-	2
PYRIMIDINE SYNTHESIS INHIBITORS		
leflunomide tab (ARAVA equiv)	-	1
SOLUBLE TUMOR NECROSIS FACTOR RECEPTOR AGENTS		
ENBREL INJ (QL= 8 inj/28 days)	AMSP-PA-QL	4
ENBREL INJ 25MG (QL= 8 inj/28 days)	AMSP-PA-QL	4
ENBREL INJ 50MG (QL= 4 inj/28 days)	AMSP-PA-QL	4
ENBREL MINI INJ (QL=4 inj/28 days)	AMSP-PA-QL	4

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
ANALGESICS - ANTI-INFLAMMATORY Cont.		
ENBREL SURECLICK INJ 50MG (QL= 4 inj/28 days)	AMSP-PA-QL	4
ANALGESICS - NONNARCOTIC		
ANALGESIC COMBINATIONS		
butalbital/acetaminophen tab (PHRENILIN equiv) (QL= 6 tabs/day)	QL	1
butalbital/acetaminophen/caffeine cap (FIORICET equiv) (QL=6 caps/day)	QL	1
butalbital/acetaminophen/caffeine soln	-	1
butalbital/acetaminophen/caffeine tab (FIORICET equiv)	-	1
butalbital/aspirin/caffeine cap (FIORINAL equiv)	-	1
BUTALBITAL/ASPIRIN/CAFFEINE TAB	-	1
migraine relief tab	OTC	1
VTOL SOLN	-	1
ANALGESICS OTHER		
acetaminophen chew tab 80mg	OTC	1
acetaminophen elixir	OTC	1
acetaminophen er tab	OTC	1
acetaminophen soln	OTC	1
acetaminophen susp	OTC	1
acetaminophen tab	OTC	1
FEVERALL SUPP 325MG	OTC	1
FEVERALL SUPP	OTC	2
SALICYLATES		

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
ANALGESICS - NONNARCOTIC Cont.		
aspirin chew tab 81mg (Covered for males age 45-79; Covered for females (no age restriction))	OTC	1
aspirin ec tab 325mg (Covered for males age 45-79 and females age 55-79)	OTC	1
aspirin ec tab 81mg (Covered for males age 45-79; Covered for females (no age restriction))	OTC	1
aspirin tab 325mg (Covered for males age 45-79 and females age 55-79)	OTC	1
buffered aspirin tab	OTC	1
BUFFERIN TAB 325MG	OTC	1
CHOLINE MAGNESIUM TRISALICYLATE TAB	-	1
choline/mag salicylate liquid	-	1
diflunisal tab (DOLOBID equiv)	-	1
ECOTRIN EC TAB 325MG	OTC	1
salsalate tab (DISALCID equiv)	-	1
ANALGESICS - OPIOID		
OPIOID AGONISTS		
CODEINE SULFATE SOLN	-	1
CODEINE SULFATE TAB	-	1
FENTANYL BUCCAL TAB (QL= 3 tabs/day)	QL	1
fentanyl patch (DURAGESIC equiv) (QL=15 patches/30 days; Step Therapy require: trial of morphine sulfate ER tab)	QL-ST	1
hydromorphone liquid (DILAUDID equiv)	-	1

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
ANALGESICS - OPIOID Cont.		
HYDROMORPHONE SUPP	-	1
hydromorphone tab (DILAUDID equiv)	-	1
MEPERIDINE SOLN	-	1
METHADONE SOLN	-	1
methadone soln (QL= 4 ml/day)	--QL	1
METHADONE SOLN 10MG/5ML (QL= 20ml/day)	QL	1
METHADONE SOLN 5MG/5ML (QL= 40ml/day)	QL	1
methadone tab 10mg (DOLOPHINE equiv) (QL= 4 tabs/day)	QL	1
methadone tab 5mg (DOLOPHINE equiv) (QL= 8 tabs/day)	QL	1
methadose tab (QL= 1 tab/day)	QL	1
morphine sulfate ER cap 100mg (QL= 2 caps/day)	QL	1
morphine sulfate ER cap 10mg (KADIAN equiv) (QL= 2 caps/day)	QL	1
morphine sulfate ER cap 30mg (QL= 2 caps/day)	QL	1
morphine sulfate ER tab (MS CONTIN equiv) (QL= 3 tabs/day)	QL	1
morphine sulfate oral soln	-	1
morphine sulfate oral soln 20mg/5ml	-	1
morphine sulfate soln	-	1
MORPHINE SULFATE SUPP	-	1
morphine sulfate tab	-	1
oxycodone cap (OXYIR equiv) (QL= 16 caps/day)	QL	1
oxycodone conc (ROXICODONE equiv) (QL= 240 syringes/30 days)	QL	1

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
ANALGESICS - OPIOID Cont.		
OXYCODONE ER TAB 10MG (QL= 2 tabs/day; Step Therapy requires trial of morphine sulfate ER tab)	QL-ST	1
OXYCODONE ER TAB 15MG (QL= 2 tabs/day; Step Therapy requires trial of morphine sulfate ER tab)	QL-ST	1
OXYCODONE ER TAB 20MG (QL= 2 tabs/day; Step Therapy requires trial of morphine sulfate ER tab)	QL-ST	1
OXYCODONE ER TAB 30MG (QL= 2 tabs/day; Step Therapy requires trial of morphine sulfate ER tab)	QL-ST	1
OXYCODONE ER TAB 40MG (QL= 2 tabs/day; Step Therapy requires trial of morphine sulfate ER tab)	QL-ST	1
OXYCODONE ER TAB 60MG (QL= 2 tabs/day; Step Therapy requires trial of morphine sulfate ER tab)	QL-ST	1
OXYCODONE ER TAB 80MG (QL= 4 tabs/day; Step Therapy requires trial of morphine sulfate ER tab)	QL-ST	1
oxycodone soln (ROXICODONE equiv) (QL= 2400ml/30 days)	QL	1
oxycodone tab 10mg (ROXICODONE equiv) (QL= 8 tabs/day)	QL	1
oxycodone tab 15mg (ROXICODONE equiv) (QL= 5.34 tabs/day)	QL	1
oxycodone tab 20mg (ROXICODONE equiv) (QL= 4 tabs/day)	QL	1
oxycodone tab 30mg (ROXICODONE equiv) (QL= 2 tabs/day)	QL	1
oxycodone tab 5mg (ROXICODONE equiv) (QL= 16 tabs/day)	QL	1

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
ANALGESICS - OPIOID Cont.		
OXYCONTIN ER 10MG TAB (QL= 2 tabs/day; Step Therapy requires trial of morphine sulfate ER tab)	QL-ST	1
OXYCONTIN ER 20MG TAB (QL= 2 tabs/day; Step Therapy requires trial of morphine sulfate ER tab)	QL-ST	1
OXYCONTIN ER 40MG TAB (QL= 2 tabs/day; Step Therapy requires trial of morphine sulfate ER tab)	QL-ST	1
oxymorphone ER tab 30mg (OPANA ER equiv) (QL= 4 tabs/day)	QL	1
oxymorphone ER tab 40mg (OPANA ER equiv) (QL= 4 tabs/day)	QL	1
oxymorphone tab (OPANA equiv)	-	1
TRAMADOL ER CAP (QL=1 cap/day)	QL	1
tramadol ER tab (RYZOLT equiv) (QL= 1 tab/day; Step Therapy requires trial of tramadol tab)	QL-ST	1
tramadol ER tab 100mg (ULTRAM ER equiv) (QL= 1 tab/day; Step Therapy requires trial of tramadol tab)	QL-ST	1
tramadol ER tab 200mg (ULTRAM ER equiv) (QL= 1 tab/day; Step Therapy requires trial of tramadol tab)	QL-ST	1
tramadol ER tab 300mg (ULTRAM ER equiv) (QL= 1 tab/day; Step Therapy requires trial of tramadol tab)	QL-ST	1
tramadol tab (ULTRAM equiv)	-	1
tramadol tab 100mg (QL= 4 tabs/day)	QL	1
DSUVIA SL TAB	-	2

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
ANALGESICS - OPIOID Cont.		
FENTANYL CITRATE LOLLIPOP (QL= 120 lozenges/30 days)	QL	2
FENTORA TAB (QL= 3 tabs/day)	QL	2
LAZANDA NASAL SPRAY	-	2
MORPHINE SULFATE SOLN	-	2
MORPHINE SULFATE SOLN 20MG/5ML	-	2
NUCYNTA ER TAB (QL= 2 tabs/day)	QL	2
NUCYNTA TAB	-	2
OXAYDO TAB, ROXYBOND TAB	-	2
SUBSYS SPRAY (QL= 4 sprays/day)	QL	2
OPIOID COMBINATIONS		
acetaminophen/codeine tab (TYLENOL/CODEINE equiv) (QL= 12 tabs/day)	QL	1
acetaminophen/codeine tab 300mg/60mg (TYLENOL/CODEINE equiv) (QL= 6 tabs/day)	QL	1
APAP/CODEINE SOLN (QL=990ml/30 days)	QL	1
BENZHYDROCODONE-ACETAMINOPHEN TAB (QL= 12 tabs/day)	QL	1
butalbital/acetaminophen/caffeine/codeine cap (FIORICET/CODEINE equiv) (QL= 6 caps/day)	QL	1
butalbital/aspirin/caffeine/codeine cap (FIORINAL/CODEINE equiv) dvorah tab	-	1
hydrocodone/acetaminophen soln (HYCET, LORTAB equiv) (QL= 90ml/day)	QL	1
hydrocodone/acetaminophen tab 10-325mg (QL= 12 tabs/day)	QL	1

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
ANALGESICS - OPIOID Cont.		
hydrocodone/acetaminophen tab 2.5-325mg (NORCO equiv) (QL= 12 tabs/day)	QL	1
hydrocodone/acetaminophen tab 5-325mg (QL= 12 tabs/day)	QL	1
hydrocodone/acetaminophen tab 7.5mg-325mg (QL= 12 tabs/day)	QL	1
hydrocodone/ibuprofen tab (VICOPROFEN equiv)	-	1
oxycodone/acetaminophen tab 10-325mg (PERCOCET equiv) (QL= 12 tabs/day)	QL	1
oxycodone/acetaminophen tab 2.5-325mg (PERCOCET equiv) (QL= 12 tabs/day)	QL	1
oxycodone/acetaminophen tab 5-325mg (PERCOCET equiv) (QL= 12 tabs/day)	QL	1
oxycodone/acetaminophen tab 7.5-325mg (PERCOCET equiv) (QL= 12 tabs/day)	QL	1
OXYCODONE/ASPIRIN TAB	-	1
OXYCODONE/IBUPROFEN TAB	-	1
oxycodone/ibuprofen tab (COMBUNOX equiv)	-	1
REPREXAIN TAB (QL=5 tabs/day)	QL	1
tramadol/acetaminophen tab (ULTRACET equiv) (QL= 6 tabs/day)	QL	1
OPIOID PARTIAL AGONISTS		
buprenorphine patch (BUTRANS equiv)	-	1
buprenorphine SL tab (SUBUTEX equiv)	-	1
buprenorphine/naloxone sl film	-	1
buprenorphine/naloxone SL tab (SUBOXONE equiv)	-	1
butorphanol nasal spray (QL= 1 bottle/15 days; 2 fills/30 days)	QL	1
pentazocine/naloxone tab (TALWIN NX equiv)	-	1
BUNAVAIL FILM	-	2

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
ANALGESICS - OPIOID Cont.		
ZUBSOLV SL TAB	-	2
BRIXADI SOLN	-	4
SUBLOCADE INJ 100/0.5	-	4
SUBLOCADE INJ 300/1.5	-	4
ANDROGENS-ANABOLIC		
ANDROGENS		
danazol cap (DANOCRINE equiv) (QL= 4 caps/day)	QL	1
depo-testosterone inj (QL=1 vial/28 days)	QL	1
testosterone cypionate inj (QL = 4 vials/28 days)	QL	1
testosterone cypionate inj (QL= 1 vial/28 days)	QL	1
testosterone cypionate inj (QL= 4 vials/28 days)	QL	1
testosterone cypionate inj (QL=1 vial/28 days)	QL	1
testosterone cypionate inj (DEPO-TESTOSTERONE equiv) (QL= 1 vial/28 days)	QL-PA	1
testosterone enanthate inj	-	1
TESTOSTERONE ENANTHATE INJ (QL= 5mL/28 days)	--QL	1
testosterone gel 1% 25mg (ANDROGEL equiv) (QL=2.5 gm/day)	PA-QL	1
testosterone gel pump 1.62% (ANDROGEL equiv) (QL=150 gm/30 days)	PA-QL	1
DEPO-TESTOSTERONE INJ (QL= 4 vials/28 days)	PA-QL	2
DEPO-TESTOSTERONE INJ (QL=1 vial/28 days)	PA-QL	2
methyltestosterone cap (QL= 150 caps/30 days)	PA-QL	2
NATESTO NASAL GEL (QL=3 bottles/30 days)	PA-QL	2

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
ANDROGENS-ANABOLIC Cont.		
TESTOPEL IMPLANT PELLETS 75MG	-	2
ANORECTAL AGENTS		
INTRARECTAL STEROIDS		
hydrocortisone enema (CORTENEMA equiv)	-	1
CORTIFOAM	-	2
RECTAL COMBINATIONS		
lidocaine/hydrocortisone cream (ANAMANTLE equiv)	-	1
ANALPRAM HC LOTION	-	2
ANALPRAM-E KIT	-	2
PROCTOFOAM HC FOAM	-	2
RECTAL STEROIDS		
hydrocortisone supp (ANUSOL HC equiv)	-	1
proctosol HC cream (ANUSOL HC equiv)	OTC	1
ANTACIDS		
ANTACID COMBINATIONS		
antacid susp	OTC	1
ANTACIDS - BICARBONATE		
sodium bicarbonate tab	OTC	1
ANTACIDS - CALCIUM SALTS		
antacid chew tab	OTC	1
ANTACIDS - MAGNESIUM SALTS		

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
ANTACIDS Cont.		
magnesium oxide tab	OTC	1
ANTHELMINTICS		
ANTHELMINTICS		
albendazole tab (ALBENZA equiv)	-	1
BENZNIDAZOLE TAB (QL= 360 tabs/365 days)	QL	1
ivermectin tab (STROMEKTOL equiv)	-	1
praziquantel tab (BILTRICIDE equiv)	-	1
EGATEN TAB	-	2
EMVERM TAB	-	2
ANTIANGINAL AGENTS		
ANTIANGINALS-OTHER		
ranolazine tab (RANEXA equiv) (QL=4 tabs/day)	QL	1
ASPRUZYO SPRINKLE GRANULES (QL= 2 packets/day; Step Therpay requires trial of ranolazine ER tab)	QL-ST	2
NITRATES		
ISOSORBIDE DINITRATE ER TAB	-	1
isosorbide dinitrate tab 5mg (ISORDIL equiv)	-	1
isosorbide mononitrate ER tab (IMDUR equiv)	-	1
ISOSORBIDE MONONITRATE TAB	-	1
isosorbide mononitrate tab (MONOKET equiv)	-	1
NITROGLYCERIN ER CAP	-	1

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
ANTIANGINAL AGENTS Cont.		
nitroglycerin patch (NITRO-DUR equiv)	-	1
nitroglycerin SL tab (NITROSTAT equiv)	-	1
GONITRO POWDER	-	2
NITRO-BID OINT	-	2
NITRO-DUR PATCH 0.3MG/HR, 0.8MG/HR	-	2
ANTIANXIETY AGENTS		
ANTIANXIETY AGENTS - MISC.		
hydroxyzine pamoate cap (VISTARIL equiv)	-	1
HYDROXYZINE PAMOATE CAP 100MG	-	1
hydroxyzine syrup (ATARAX equiv)	-	1
hydroxyzine tab (ATARAX equiv)	-	1
ANTIARRHYTHMICS		
ANTIARRHYTHMICS TYPE I-A		
disopyramide cap (NORPACE equiv)	-	1
quinidine sulfate tab (QL=8 tabs/day)	QL	1
NORPACE CR CAP	-	2
QUINIDINE SULFATE TAB 200MG (QL= 8 tabs/day)	QL	2
QUINIDINE SULFATE TAB 300MG (QL= 5 tabs/day)	QL	2
ANTIARRHYTHMICS TYPE I-B		
mexiletine hcl cap	-	1
ANTIARRHYTHMICS TYPE I-C		

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
ANTIARRHYTHMICS Cont.		
flecainide tab (TAMBOCOR equiv)	-	1
propafenone er cap 325mg	-	1
propafenone tab (RYTHMOL equiv)	-	1
ANTIARRHYTHMICS TYPE III		
amiodarone tab (CORDARONE equiv)	-	1
dofetilide cap 500mcg	-	1
MULTAQ TAB	-	2
ANTIASTHMATIC AND BRONCHODILATOR AGENTS		
ANTIASTHMATIC - MONOCLONAL ANTIBODIES		
NUCALA INJ (QL= 1 inj/28 days)	AMSP-PA-QL	4
NUCALA INJ (QL=1 inj/28 days)	AMSP-PA-QL	4
XOLAIR 150MG/ML INJ (QL= 1 inj/28 days)	AMSP-QL	4
XOLAIR 300MG/2ML INJ (QL= 1 inj/28 days)	AMSP-QL	4
XOLAIR 75MG/0.5ML INJ (QL= 1 inj/28 days)	AMSP-QL	4
XOLAIR INJ (QL= 1 inj/28 days)	AMSP-QL	4
XOLAIR INJ 150MG/ML (QL= 1 inj/28 days)	AMSP-QL	4
XOLAIR INJ 300MG/2ML (QL= 1 inj/28 days)	AMSP-QL	4
XOLAIR INJ 75MG/0.5ML (QL= 1 inj/28 days)	AMSP-QL	4
ANTI-INFLAMMATORY AGENTS		
cromolyn neb soln (INTAL equiv)	-	1
BRONCHODILATORS - ANTICHOLINERGICS		

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
ANTIASTHMATIC AND BRONCHODILATOR AGENTS Cont.		
ipratropium neb soln (ATROVENT equiv)	-	1
tiotropium bromide cap inhaler (QL= 1 cap/day; For use with Handihaler device)	QL	1
ATROVENT HFA INHALER (QL = 2 inhalers (25.8g)/30 days)	QL	2
INCRUSE ELLIPTA INHALER (QL= 1 inhaler/30 days)	QL	2
SPIRIVA RESPIMAT INHALER 1.25MCG/ACT (QL= 1 inhaler/30 days)	QL	2
SPIRIVA RESPIMAT INHALER 2.5MCG/ACT (QL= 1 inhaler/30 days)	QL	2
YUPELRI SOLN	-	2
LEUKOTRIENE MODULATORS		
montelukast chew tab (SINGULAIR equiv)	-	1
montelukast tab (SINGULAIR equiv)	-	1
zafirlukast tab (ACCOLATE equiv)	-	1
ZYFLO TAB	-	2
SELECTIVE PHOSPHODIESTERASE 4 (PDE4) INHIBITORS		
roflumilast tab (QL=1 tab/day)	PA-QL	1
STEROID INHALANTS		
budesonide inh susp (PULMICORT equiv) (QL= 120 units/30 days)	QL	1
ASMANEX HFA INHALER (QL= 1 inhaler/30 days)	QL	2
ASMANEX INHALER (QL= 1 inhaler/30 days)	QL	2
FLUTICASONE DISKUS INHALER (QL=2 inhalers/30 days)	QL	2
SYMPATHOMIMETICS		
ALBUTEROL HFA INHALER (QL= 2 inhalers/30 days)	QL	1

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
ANTIASTHMATIC AND BRONCHODILATOR AGENTS Cont.		
albuterol HFA inhaler (PROAIR equiv)	QL--	1
albuterol HFA inhaler (PROVENTIL equiv) (QL= 2 inhalers/30 days)	QL--	1
ALBUTEROL NEB SOLN	-	1
albuterol sulfate ER tab (VOSPIRE ER equiv)	-	1
albuterol sulfate syrup	-	1
albuterol sulfate tab	-	1
albuterol/ipratropium neb soln (DUONEB equiv)	-	1
BREYNA AER 160/4.5 (Step Therapy requires trial of fluticasone/salmeterol or wixela and Dulera.)	QL-ST	1
BREYNA AER 80/4.5 (Step Therapy requires trial of fluticasone/salmeterol or wixela and Dulera.)	QL-ST	1
ephedrine hcl tab (QL= 12 tablets/day)	OTC-QL	1
FLUTICASONE/SALMETEROL INHALER (QL= 1 inhaler/30 days)	QL	1
fluticasone/salmeterol inhaler, wixela inhaler (ADVAIR equiv) (QL= 1 inhaler/30 days)	QL	1
LEVALBUTEROL INHALER (QL= 2 inhalers/fill, 2 fills/30 days; Step Therapy requires trial of albuterol hfa inhaler)	QL-ST	1
levalbuterol neb soln (XOPENEX equiv) (QL= 96 vials/30 days; Step Therapy requires trial of albuterol neb soln)	QL-ST	1
terbutaline sulfate tab (BRETHINE equiv)	-	1
ANORO ELLIPTA INHALER (QL= 1 inhaler/30 days)	QL	2
ARCAPTA NEOHALER	-	2

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
ANTIASTHMATIC AND BRONCHODILATOR AGENTS Cont.		
COMBIVENT RESPIMAT INHALER (QL= 2 inhalers/30 days)	QL	2
DULERA INHALER (QL= 1 inhaler/30 days)	QL	2
DULERA INHALER (QL=1 inhaler/30 days)	QL	2
STRIVERDI RESPIMAT INHALER (QL= 1 inhaler/30 days)	QL	2
TRELEGY ELLIPTA INHALER (QL= 1 inhaler/30 days)	QL	2
XANTHINES		
ELIXOPHYLLIN ELIXIR	-	1
theophylline CR tab (QUIBRON-T equiv)	-	1
theophylline ER tab (UNIPHYL equiv)	-	1
theophylline soln	-	1
THEO-24 CAP	-	2
THEOPHYLLINE ER TAB (QL= 1 tab/day)	QL	2
ANTICOAGULANTS		
ANTICOAGULANTS - MISC.		
ANTICOAGULANT SODIUM CITRATE INJ	-	1
SODIUM CITRATE INJ	-	1
COUMARIN ANTICOAGULANTS		
warfarin tab (COUMADIN equiv)	-	1
DIRECT FACTOR XA INHIBITORS		
ELIQUIS STARTER PACK (QL= 1 pack /30 days)	QL	2
ELIQUIS TAB 2.5MG (QL= 2 tabs/1 day)	QL	2

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
ANTICOAGULANTS Cont.		
ELIQUIS TAB 5MG (QL= 74 tabs/30 days)	QL	2
SAVAYSA TAB (QL= 1 tab/day)	QL	2
XARELTO STARTER PACK (QL= 1 pack/30 days)	QL	2
XARELTO SUSP (QL=10ml/day)	QL	2
XARELTO TAB (QL= 60 tabs/30 days)	QL	2
XARELTO TAB 10MG (QL= 30 tabs/30 days)	QL	2
XARELTO TAB 15MG (QL= 60 tabs/30 days)	QL	2
XARELTO TAB 20MG (QL=30 tabs/30 days)	QL	2
HEPARINS AND HEPARINOID-LIKE AGENTS		
enoxaparin inj 100mg (LOVENOX equiv)	-	1
enoxaparin inj 120mg (LOVENOX equiv)	-	1
enoxaparin inj 150mg (LOVENOX equiv)	-	1
enoxaparin inj 300mg (LOVENOX equiv)	-	1
enoxaparin inj 30mg (LOVENOX equiv)	-	1
enoxaparin inj 40mg (LOVENOX equiv)	-	1
enoxaparin inj 60mg (LOVENOX equiv)	-	1
enoxaparin inj 80mg (LOVENOX equiv)	-	1
fondaparinux inj 10mg/0.8ml (ARIXTRA equiv)	-	1
fondaparinux inj 2.5mg/0.5ml (ARIXTRA equiv)	-	1
fondaparinux inj 5mg/0.4ml (ARIXTRA equiv)	-	1
fondaparinux inj 7.5mg/0.6ml (ARIXTRA equiv)	-	1

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
ANTICOAGULANTS Cont.		
heparin porcine inj	-	1
IN VITRO/LOCK ANTICOAGULANTS		
CITRATE PHOSPHATE DEXTROSE SOLN	-	1
SODIUM CITRATE SOLN	-	1
THROMBIN INHIBITORS		
dabigatran etexilate mesylate cap (QL= 2 caps/day)	QL	1
ANTICONVULSANTS		
AMPA GLUTAMATE RECEPTOR ANTAGONISTS		
FYCOMPA TAB	-	2
FYCOMPA SUSP	-	2
ANTICONVULSANTS - BENZODIAZEPINES		
clobazam susp (ONFI equiv) (QL= 16ml/day)	QL	1
clobazam tab (ONFI equiv)	-	1
clobazam tab 10mg	QL	1
clonazepam ODT (KLONOPIN equiv)	-	1
clonazepam tab (KLONOPIN equiv)	-	1
diazepam rectal gel (QL= 1 kit/30 days)	QL	1
DIAZEPAM RECTAL GEL (QL= 1 unit/30 days)	QL	1
DIAZEPAM RECTAL GEL (QL= 1 kit/30 days)	QL	2
NAYZILAM SPRAY (QL = 4 doses/fill, 5 fills/month)	QL	2
SYMPAZAN ORAL FILM	-	2

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
ANTICONVULSANTS Cont.		
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	-	1
gabapentin tab (NEURONTIN equiv)	-	1
lacosamide oral solution (QL= 1200ml/30 days)	QL	1
lacosamide tab (QL=2 tabs/day)	QL	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
pregabalin cap	-	1
pregabalin soln (LYRICA equiv) (QL= 30ml/day)	QL	1
PRIMIDONE TAB (QL=4 tabs/day)	QL	1
primidone tab (MYSOLINE equiv)	QL--	1
topiramate ER cap 150mg (QUDEXY equiv) (QL= 2 caps/day)	QL	1

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
ANTICONVULSANTS Cont.		
topiramate ER cap 200mg (QUDEXY equiv) (QL= 2 caps/day)	QL	1
topiramate sprinkle cap (TOPAMAX equiv)	-	1
topiramate tab (TOPAMAX equiv)	-	1
zonisamide cap (ZONEGRAN equiv)	-	1
APTiom TAB (QL= 60 tabs/30 days)	QL	2
SPRITAM TAB	-	2
CARBAMATES		
felbamate susp (FELBATOL equiv) (QL= 30ml/day)	QL	1
felbamate tab 400mg (FELBATOL equiv) (QL= 9 tabs/day)	QL	1
felbamate tab 600mg (FELBATOL equiv) (QL= 6 tabs/day)	QL	1
GABA MODULATORS		
tiagabine tab 12mg (GABITRIL equiv) (QL= 4 tabs/day)	QL	1
tiagabine tab 16mg (GABITRIL equiv) (QL= 3 tabs/day)	QL	1
tiagabine tab 2mg (GABITRIL equiv) (QL= 4 tabs/day)	QL	1
tiagabine tab 4mg (GABITRIL equiv) (QL= 4 tabs/day)	QL	1
HYDANTOINS		
phenytoin cap (DILANTIN equiv)	-	1
phenytoin chew tab (DILANTIN equiv)	-	1
phenytoin susp (DILANTIN equiv)	-	1
DILANTIN CAP 30MG	-	2
PEGANONE TAB	-	2

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
ANTICONVULSANTS Cont.		
SUCCINIMIDES		
ethosuximide cap (ZARONTIN equiv)	-	1
ethosuximide soln (ZARONTIN equiv)	-	1
ANTIDIABETICS		
ALPHA-GLUCOSIDASE INHIBITORS		
acarbose tab (PRECOSE equiv) (QL=3 tabs/day)	QL	1
ANTIDIABETIC COMBINATIONS		
glipizide/metformin tab (METAGLIP equiv)	-	1
glyburide/metformin tab (GLUCOVANCE equiv)	-	1
pioglitazone/metformin tab (ACTOPLUS MET equiv) (QL= 3 tabs/day)	QL	1
ALOGLIPTIN/METFORMIN TAB (QL = 1 tab/day)	QL	2
ALOGLIPTIN/PIOGLITAZONE TAB (QL = 1 tab/day)	QL	2
DAPAGLIFLOZIN-METFORMIN ER TAB 10-1000 MG (QL = 1 tab/day)	QL	2
DAPAGLIFLOZIN-METFORMIN ER TAB 5-1000 MG (QL = 2 tabs/day)	QL	2
GLYXAMBI TAB (Step Therapy requires trial of metformin or metformin ER or metformin combinations)	ST	2
QTERN TAB (Step Therapy requires trial of metformin or metformin ER or metformin combinations)	ST	2
SEGLUROMET TAB (QL= 2 tabs/day)	QL	2
SEGLUROMET TAB 2.5-500MG (QL= 4 tabs/day)	QL	2

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
ANTIDIABETICS Cont.		
STEGLUJAN TAB (Step Therapy requires trial of metformin or metformin ER or metformin combinations)	ST	2
BIGUANIDES		
metformin ER osmotic tab (FORTAMET equiv)	-	1
metformin ER tab (GLUCOPHAGE XR equiv)	-	1
metformin tab (GLUCOPHAGE equiv)	-	1
DIABETIC OTHER		
diazoxide susp (PROGLYCEM equiv) (QL=336 ml/30 days)	QL	1
glucagon (rdna) for inj kit (QL = 2 inj/fill, 2 fill/month)	QL	1
GLUCOSE CHEW TAB	OTC	1
glucose gel packet	OTC	1
INSTA-GLUCOSE GEL	OTC	1
BAQSIMI NASAL POWDER	-	2
GLUCAGON INJ KIT	-	2
GVOKE INJ	-	2
GVOKE INJ KIT (QL=2 vials/fill, 2 fills/30 days)	QL	2
GVOKE PFS INJ	-	2
mifepristone tab (QL = 4 tabs/day)	AMSP-PA-QL	3
DIPEPTIDYL PEPTIDASE-4 (DPP-4) INHIBITORS		
ALOGLIPTIN TAB (QL = 1 tab/day)	QL	2
INCRETIN MIMETIC AGENTS		

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
ANTIDIABETICS Cont.		
liraglutide soln pen-injector	QL-RDX	1
TRULICITY INJ (QL= 4 pens/28 days)	QL-RDX	2
VICTOZA INJ (QL= 9ml/30 days)	QL-RDX	2
INSULIN		
INSULIN ASPART FLEXPEN INJ (NOVOLOG equiv) (QL= 60ml/30 days)	QL	1
INSULIN ASPART INJ (NOVOLOG equiv) (QL= 60ml/30 days)	QL	1
INSULIN ASPART MIX FLEXPEN INJ (NOVOLOG equiv) (QL= 60ml/30 days)	QL	1
INSULIN ASPART MIX INJ (NOVOLOG equiv) (QL= 60ml/30 days)	QL	1
INSULIN ASPART PENFILL INJ (NOVOLOG equiv) (QL= 60ml/30 days)	QL	1
INSULIN LISPRO INJ (QL= 60ml/30 days)	QL	1
INSULIN LISPRO KWIKPEN INJ (JUNIOR) (QL= 60ml/30 days)	QL	1
INSULIN LISPRO PROTAMINE INJ (QL= 60ml/30 days)	QL	1
NOVOLIN R INJ 100 UNIT (QL= 60ml/30 days)	OTC-QL	1
ADMELOG INJ (QL= 60ml/30 days)	QL	2
ADMELOG SOLOSTAR INJ (QL= 60ml/30 days)	QL	2
AFREZZA INH POWDER	--PA	2
HUMALOG MIX 50-50 KWIKPEN (QL= 60ml/30 days)	QL	2
HUMALOG MIX INJ (QL= 60ml/30 days)	QL	2
HUMULIN MIX INJ (QL= 60ml/30 days)	OTC-QL	2
HUMULIN MIX PEN INJ (QL= 60ml/30 days)	OTC-QL	2
HUMULIN N INJ (QL= 60ml/30 days)	OTC-QL	2

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
ANTIDIABETICS Cont.		
HUMULIN N PEN INJ (QL= 60ml/30 days)	OTC-QL	2
HUMULIN R INJ (QL= 60ml/30days)	OTC-QL	2
HUMULIN R INJ U-500 (QL= 40ml/30 days)	QL	2
HUMULIN R U-500 KWIKPEN INJ (QL= 24ml/30 days)	QL	2
INSULIN GLARGINE INJ (QL= 60ml/30 days)	QL	2
INSULIN GLARGINE, SEMGLEE INJ (QL= 60ml/30 days)	QL	2
INSULIN GLARGINE-YFGN (QL= 60ml/30 days)	QL	2
NOVOLIN 70/30 FLEXPEN INJ (QL= 60ml/30 days)	OTC-QL	2
NOVOLIN 70/30 INJ (QL= 60ml/30 days)	QL	2
NOVOLIN N FLEXPEN INJ (QL=60ml/30 days)	QL	2
NOVOLIN N INJ (QL= 60ml/30 days)	QL	2
NOVOLIN N RELION INJ (QL= 60ml/30 days)	OTC-QL	2
NOVOLIN R FLEXPEN INJ (QL= 60ml/30 days)	QL	2
NOVOLIN R INJ (QL= 60ml/30 days)	QL	2
NOVOLIN RELION INJ 70/30 (QL= 60mls/30 days)	OTC-QL	2
NOVOLIN VIAL (QL= 60ml/30 days)	OTC-QL	2
INSULIN SENSITIZING AGENTS		
pioglitazone tab (ACTOS equiv) (QL= 1 tab/day)	QL	1
AVANDIA TAB	-	2
MEGLITINIDE ANALOGUES		
nateglinide tab (STARLIX equiv)	-	1

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
ANTIDIABETICS Cont.		
repaglinide tab (PRANDIN equiv) (Step Therapy requires trial of metformin or metformin ER)	ST	1
SODIUM-GLUCOSE CO-TRANSPORTER 2 (SGLT2) INHIBITORS		
DAPAGLIFLOZIN TAB 10MG (QL = 1 tab/day)	QL	2
DAPAGLIFLOZIN TAB 5MG (QL = 1 tab/day)	QL	2
STEGLATRO TAB (QL= 2 tabs/day)	QL	2
SULFONYLUREAS		
glimepiride tab (AMARYL equiv)	-	1
glipizide ER tab (GLUCOTROL XL equiv)	-	1
glipizide tab (GLUCOTROL equiv)	-	1
GLYBURIDE MICRONIZED TAB	-	1
glyburide tab (MICRONASE equiv)	-	1
tolazamide tab (TOLINASE equiv)	-	1
TOLBUTAMIDE TAB	-	2
ANTIDIARRHEAL/PROBIOTIC AGENTS		
ANTIDIARRHEAL/PROBIOTIC AGENTS - MISC.		
pink bismuth susp	OTC	1
ANTIPERISTALTIC AGENTS		
DIPHENOXYLATE/ATROPINE LIQUID	-	1
ANTIDIARRHEALS		
ANTIDIARRHEAL - CHLORIDE CHANNEL ANTAGONISTS		

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
ANTIDIARRHEALS Cont.		
MYTESI TAB (QL= 2 tabs/day)	QL	2
ANTIDIARRHEAL AGENTS - MISC.		
pink bismuth chew tab	OTC	1
ANTIDIARRHEAL COMBINATIONS		
RESTORA RX CAP	-	2
ANTIPERISTALTIC AGENTS		
diphenoxylate/atropine tab (LOMOTIL equiv)	-	1
loperamide cap (IMODIUM equiv)	-	1
MOTOFEN TAB	-	2
PAREGORIC TINCTURE	-	2
ANTIDOTES		
ANTIDOTES		
RADIOGARDASE CAP	-	2
ANTIDOTES - CHELATING AGENTS		
CHEMET CAP	-	2
OPIOID ANTAGONISTS		
naltrexone tab (REVIA equiv)	-	1
KLOXXADO SPRAY, RIVIVE SPRAY	OTC	2
VIVITROL INJ	AMSP	4
ANTIDOTES AND SPECIFIC ANTAGONISTS		
ANTIDOTES - CHELATING AGENTS		

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
ANTIDOTES AND SPECIFIC ANTAGONISTS Cont.		
deferasirox tab (EXJADE equiv)	AMSP	3
deferasirox tab (JADENU equiv)	AMSP	3
deferiprone tab (FERRIPROX equiv) (Only available through Lumicera 855-847-355	LD-PA	3
deferasirox granules packet (JADENU equiv)	AMSP-PA	4
OPIOID ANTAGONISTS		
NALOXONE HCL SOLN 0.4MG/ML (QL = 2 mL/fill, 2 fills/30 days)	QL	1
naloxone inj	-	1
naloxone nasal spray	OTC	1
naloxone prefilled inj	-	1
NARCAN NASAL SPRAY	OTC	1
OPVEE NASAL SPRAY	-	2
REXTOVY SPRAY	-	2
ANTIEMETICS		
5-HT3 RECEPTOR ANTAGONISTS		
granisetron tab (KYTRIL equiv) (QL= 1 tab/15 days; Step therapy requires trial of ondansetron)	QL-ST	1
ondansetron inj (QL= 24mL/fill, 1 fill/15 days)	QL	1
ondansetron ODT 4 MG (ZOFRAN equiv) (QL=6 tabs/day)	QL	1
ondansetron ODT 8 MG (ZOFRAN equiv) (QL=3 tabs/day)	QL	1
ondansetron soln 4 MG/5 ML (ZOFRAN equiv) (QL= 5ml/day)	QL	1
ondansetron tab 4 MG (ZOFRAN equiv) (QL=6 tabs/day)	QL	1

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
ANTIEMETICS Cont.		
ondansetron tab 8 MG (ZOFTRAN equiv) (QL=90 tabs/30 days)	QL	1
SANCUSO PATCH	-	2
ANTIEMETICS - ANTICHOLINERGIC		
meclizine tab (ANTIVERT equiv)	-	1
scopolamine patch (TRANSDERM-SCOP equiv) (QL= 10 patches/30 days)	QL	1
trimethobenzamide cap (TIGAN equiv)	-	1
ANTIEMETICS - MISCELLANEOUS		
doxylamine/pyridoxine dr tab (DICLEGIS equiv) (QL= 120 tabs/30 days)	QL	1
dronabinol cap (MARINOL equiv)	-	1
AKYNZEO CAP (Step Therapy requires trial of aprepitant, granisetron, or ondansetron)	ST	2
CESAMET CAP (QL= 1 cap/day)	QL	2
SYNDROS SOLN	-	2
SUBSTANCE P/NEUROKININ 1 (NK1) RECEPTOR ANTAGONISTS		
aprepitant cap 125mg (EMEND equiv) (QL= 1 cap/21 days)	QL	1
aprepitant cap 40mg (EMEND equiv) (QL= 1 cap/28 days)	QL	1
VARUBI TAB	-	2
ANTIFUNGALS		
ANTIFUNGALS		
flucytosine cap (ANCOBON equiv)	-	1
griseofulvin susp (GRIFULVIN equiv)	-	1

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
ANTIFUNGALS Cont.		
nystatin tab	-	1
terbinafine tab (LAMISIL equiv) (QL=1 tab/day)	QL	1
IMIDAZOLE-RELATED ANTIFUNGALS		
fluconazole susp (DIFLUCAN equiv)	-	1
fluconazole tab (DIFLUCAN equiv)	-	1
itraconazole cap (SPORANOX equiv)	-	1
itraconazole soln (SPORANOX equiv)	-	1
ketoconazole tab (NIZORAL equiv)	-	1
voriconazole susp (VFEND equiv) (QL=15ml/day)	QL	1
voriconazole tab (VFEND equiv) (QL=3 tabs/day)	QL	1
TOLSURA CAP	-	2
ANTIHISTAMINES		
ANTIHISTAMINES - ALKYLAMINES		
chlorpheniramine ER cap	-	1
chlorpheniramine tab	OTC	1
DEXCHLORPHENIRAMINE SYRUP	-	1
ANTIHISTAMINES - ETHANOLAMINES		
CARBINOXAMINE SOLN (QL=40ml/day)	QL	1
carbinoxamine soln (PALGIC equiv)	QL--	1
carbinoxamine tab (PALGIC equiv) (QL=240 tabs/30 days)	QL	1
diphenhydramine cap	OTC	1

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
ANTIHISTAMINES Cont.		
diphenhydramine chew tab	OTC	1
diphenhydramine liquid	--OTC	1
diphenhydramine ODT	OTC	1
diphenhydramine tab	OTC	1
DIPHENHYDRAMINE ELIXIR	-	2
ANTIHISTAMINES - NON-SEDATING		
cetirizine chew tab (ZYRTEC equiv) (QL=1 tab/day)	OTC-QL	1
cetirizine hcl orally disintegrating tab (QL = 1 tab/day)	OTC-QL	1
cetirizine syrup (ZYRTEC equiv)	OTC	1
cetirizine tab (ZYRTEC equiv)	OTC	1
desloratadine tab (CLARINEX equiv) (QL= 1 tab/day)	QL	1
fexofenadine tab 180mg (QL=1 tab/day)	OTC-QL	1
levocetirizine soln (XYZAL equiv) (QL= 10ml/day)	QL	1
loratadine ODT (CLARITIN equiv)	OTC	1
loratadine syrup (CLARITIN equiv)	OTC	1
loratadine tab (CLARITIN equiv)	OTC	1
ZYRTEC CHEW TAB (QL= 1 tab/day)	OTC-QL	1
ANTIHISTAMINES - PHENOTHIAZINES		
promethazine supp (PHENERGAN equiv)	-	1
promethazine syrup 6.25 mg/5ml	-	1
promethazine tab (PHENERGAN equiv)	-	1

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
ANTIHISTAMINES Cont.		
PROMETHEGAN SUPP	-	1
ANTIHISTAMINES - PIPERIDINES		
cyproheptadine syrup	-	1
cyproheptadine tab	-	1
ANTHYPERLIPIDEMICS		
ANTHYPERLIPIDEMICS - COMBINATIONS		
ezetimibe/simvastatin tab (VYTORIN equiv)	QL	1
ANTHYPERLIPIDEMICS - MISC.		
icosapent ethyl cap 0.5gm (QL=2 caps/day)	QL	1
icosapent ethyl cap 1gm (VASCEPA equiv) (QL= 4 caps/day)	QL	1
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
colesevelam tab (WELCHOL equiv)	-	1
colestipol granule (COLESTID equiv)	-	1
colestipol powder packet (COLESTID equiv)	-	1
colestipol tab (COLESTID equiv)	-	1
FIBRIC ACID DERIVATIVES		
FENOFIBRATE CAP	-	1

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
ANTIHYPERTENSIVES Cont.		
fenofibrate cap 43mg, 130mg (ANTARA equiv)	-	1
fenofibrate cap 67mg, 134mg, 200mg (LOFIBRA equiv)	-	1
fenofibrate tab 40mg, 120mg (FENOGLIDE equiv)	-	1
fenofibrate tab 48mg, 54mg, 145mg, 160mg (TRICOR equiv)	-	1
fenofibric acid DR cap (TRILIPIX equiv)	-	1
FENOFIBRIC TAB	-	1
gemfibrozil tab (LOPID equiv)	-	1
TRIGLIDE TAB	-	2
HMG COA REDUCTASE INHIBITORS		
atorvastatin tab (LIPITOR equiv) (QL= 1 tab/day)	QL	1
atorvastatin tab 10mg (QL= 60 tabs/30 days)	QL	1
atorvastatin tab 20mg (QL= 60 tabs/30 days)	QL	1
atorvastatin tab 40mg (QL= 60 tabs/30 days)	QL	1
lovastatin tab (MEVACOR equiv) (QL= 2 tabs/day)	QL	1
pravastatin tab (PRAVACHOL equiv) (QL= 1 tab/day)	QL	1
rosuvastatin tab (CRESTOR equiv) (QL= 1 tab/day)	QL	1
simvastatin tab 5mg, 10mg, 20mg, 40mg (ZOCOR equiv) (QL= 1 tab/day)	QL	1
simvastatin tab 80mg (ZOCOR equiv) (QL= 1 tab/day)	PA-QL	1
ALTOPREV TAB	-	2
ZYPITAMAG TAB (QL= 1 tab/day)	QL	2
INTESTINAL CHOLESTEROL ABSORPTION INHIBITORS		

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
ANTHYPERLIPIDEMICS Cont.		
ezetimibe tab (ZETIA equiv) (QL= 1 tab/day)	QL	1
NICOTINIC ACID DERIVATIVES		
niacin ER tab (NIASPAN equiv) (QL= 2 tabs/day)	QL	1
NIACOR TAB	-	1
PROTEIN CONVERTASE SUBTILISIN/KEXIN TYPE 9 INHIBITORS		
REPATHA INJ (QL= 2 inj/28 days)	PA-QL	2
REPATHA PUSHTRONEX INJ (QL= 1 inj/28 days)	PA-QL	2
ANTHYPERTENSIVES		
ACE INHIBITORS		
benazepril tab (LOTENSIN 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
AGENTS FOR PHEOCHROMOCYTOMA		
metirosine cap (DEMSEER equiv) (QL= 448 caps/28 days)	PA-QL	3
ANGIOTENSIN II RECEPTOR ANTAGONISTS		

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
ANTIHYPERTENSIVES Cont.		
candesartan tab (ATACAND equiv) (Step Therapy requires trial of 2: irbesartan, irbesartan/hctz. losartan, or losartan/hctz)	ST	1
irbesartan tab (AVAPRO equiv)	-	1
losartan tab (COZAAR equiv)	-	1
olmesartan tab (BENICAR equiv)	-	1
telmisartan tab (MICARDIS equiv)	-	1
valsartan tab (DIOVAN equiv)	-	1
EDARBI TAB	-	2
VALSARTAN SOLN (QL = 2400 mL/30 days)	QL	2
ANTIADRENERGIC ANTIHYPERTENSIVES		
clonidine patch (CATAPRES-TTS equiv) (QL=1 patch/7 days)	QL	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
METHYLDOPA TAB	-	2
ANTIHYPERTENSIVE COMBINATIONS		
amlodipine/benazepril cap (LOTREL equiv)	-	1
amlodipine/olmesartan tab (AZOR TAB equiv)	-	1

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
ANTIHYPERTENSIVES Cont.		
amlodipine/valsartan tab (EXFORGE 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) (Step Therapy requires trial of 2: irbesartan, irbesartan/hctz. losartan, or losartan/hctz)	ST	1
CAPTOPRIL/HYDROCHLOROTHIAZIDE TAB (Step Therapy requires trial of HCTZ/benazepril, enalapril, fosinopril, lisinopril, moexipril, or quinapril)	ST	1
captopril/hydrochlorothiazide tab (CAPOZIDE equiv)	ST--	1
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
nadolol/bendroflumethiazide tab (CORZIDE equiv)	-	1
olmesartan/amlodipine/hydrochlorothiazide tab (TRIBENZOR TAB equiv) (QL=1 tab/day)	QL	1
olmesartan/hydrochlorothiazide tab (BENICAR HCT equiv)	-	1
propranolol/hydrochlorothiazide tab (INDERIDE equiv)	-	1

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
ANTIHYPERTENSIVES Cont.		
quinapril/hydrochlorothiazide tab (ACCURETIC equiv)	-	1
trandolapril/verapamil ER tab (TARKA equiv)	-	1
valsartan/hydrochlorothiazide tab (DIOVAN HCT equiv)	-	1
EDARBYCLOR TAB	-	2
PRESTALIA TAB	-	2
TEKTURN HCT TAB	-	2
ANTIHYPERTENSIVES - MISC.		
VECAMYL TAB	-	2
SELECTIVE ALDOSTERONE RECEPTOR ANTAGONISTS (SARAS)		
eplerenone tab (INSPIRA equiv) (QL= 2 tabs/day)	QL	1
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
pentamidine neb soln (NEBUPENT equiv) (QL=1 vial/month)	QL	1
tinidazole tab (TINDAMAX equiv)	-	1
trimethoprim tab (PROLOPRIM equiv)	-	1
AEMCOLO TAB	-	2

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
ANTI-INFECTIVE AGENTS - MISC. Cont.		
LIKMEZ SUSP (QL = 210 mL/14 days)	QL	2
PRIMSOL SOLN	-	2
TRIMETHOPRIM TAB	-	2
XIFAXAN TAB 200MG (QL= 9 tabs/3 days)	PA-QL	2
XIFAXAN TAB 550MG (QL= 2 tabs/day)	PA-QL	2
IMPAVIDO CAP	AMSP-PA	4
ANTI-INFECTIVE MISC. - COMBINATIONS		
smz/tmp (DS) tab (BACTRIM DS equiv)	-	1
smz/tmp susp (BACTRIM, SEPTRA equiv)	-	1
URIMAR-T TAB	-	1
UTA cap	-	1
uretron d-s tab	-	2
ANTIPROTOZOAL AGENTS		
atovaquone susp (MEPRON equiv)	-	1
LAMPIT TAB	-	2
GLYCOPEPTIDES		
vancomycin cap 125mg (VANCOCIN equiv) (QL= 56 caps/30 days)	QL	1
vancomycin cap 250mg (VANCOCIN equiv) (QL= 112 caps/30 days)	QL	1
vancomycin inj	-	1
VANCOMYCIN INJ 500MG	-	1
VANCOMYCIN SOLN	-	1

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
ANTI-INFECTIVE AGENTS - MISC. Cont.		
LEPROSTATICS		
dapsone tab	-	1
LINCOSAMIDES		
clindamycin cap (CLEOCIN equiv)	-	1
clindamycin soln (CLEOCIN equiv)	-	1
OXAZOLIDINONES		
linezolid susp	-	1
SIVEXTRO TAB (QL=6 tabs/fill)	QL	2
URINARY ANTI-INFECTIVES		
fosfomycin tromethamine powder pack (MONUROL equiv)	-	1
methenamine mandelate tab	-	1
nitrofurantoin macrocrystals cap (MACRODANTIN equiv)	-	1
nitrofurantoin monohydrate cap (MACROBID equiv)	-	1
nitrofurantoin susp (FURADANTIN equiv)	-	1
ANTIMALARIALS		
ANTIMALARIAL COMBINATIONS		
atovaquone/proguanil tab (MALARONE equiv)	-	1
COARTEM TAB	-	2
ANTIMALARIALS		
chloroquine tab (ARALEN equiv)	-	1
hydroxychloroquine tab (PLAQUENIL equiv)	-	1

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
ANTIMALARIALS Cont.		
mefloquine tab (LARIAM equiv)	-	1
quinine sulfate cap (QUALAQUIN equiv)	-	1
PRIMAQUINE TAB	-	2
primaquine tab (PRIMAQUINE equiv)	-	2
ANTIMYASTHENIC/CHOLINERGIC AGENTS		
ANTIMYASTHENIC/CHOLINERGIC AGENTS		
GUANIDINE TAB	-	1
pyridostigmine CR tab (MESTINON equiv)	-	1
pyridostigmine tab (MESTINON equiv)	-	1
ANTIMYCOBACTERIAL AGENTS		
ANTI TB COMBINATIONS		
RIFAMATE CAP	-	2
RIFATER TAB	-	2
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
PASER GRANULE	-	2

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
ANTIMYCOBACTERIAL AGENTS Cont.		
PRIFTIN TAB	-	2
TRECATOR TAB	-	2
ANTINEOPLASTICS		
ALKYLATING AGENTS		
cyclophosphamide tab (CYTOXAN equiv)	-	1
MYLERAN TAB	AMSP	4
ANTIMETABOLITES		
mercaptopurine tab (PURINETHOL equiv)	-	1
methotrexate tab (TREXALL equiv)	-	1
TREXALL TAB	-	2
TABLOID TAB (QL= 4 tabs/day)	QL	4
ANTINEOPLASTIC ENZYME INHIBITORS		
ZOLINZA CAP	PA	2
ANTINEOPLASTICS MISC.		
hydroxyurea cap (HYDREA equiv)	-	1
tretinoin cap (VESANOID equiv)	-	1
ACTIMMUNE INJ (Only available through Accredo 877-826-7657 or Walgreens 888-347-3416)	LD-PA	4
INTRON-A INJ	AMSP	4
MATULANE CAP (Only available through Walgreens 888-347-3416)	LD	4
CHEMOTHERAPY RESCUE/ANTIDOTE AGENTS		

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
ANTINEOPLASTICS Cont.		
leucovorin tab	-	1
MITOTIC INHIBITORS		
etoposide cap (VEPESID equiv)	-	3
TOPOISOMERASE I INHIBITORS		
HYCAMTIN CAP	-	2
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES		
ALKYLATING AGENTS		
cyclophosphamide cap	-	1
CYCLOPHOSPHAMIDE TAB	-	1
temozolomide cap (TEMODAR equiv)	AMSP	3
MELPHALAN TAB	AMSP	4
ANTIMETABOLITES		
METHOTREXATE INJ	-	1
capecitabine tab (XELODA equiv)	AMSP	3
mercaptopurine susp	AMSP	3
ONUREG TAB	PA	4
ANTINEOPLASTIC - ANGIOGENESIS INHIBITORS		
INLYTA TAB (QL= 4 tabs/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	4
INLYTA TAB 1MG (QL= 8 tabs/day; Only available through Walgreens 888-347-341	LD-PA-QL	4
LENVIMA CAP (QL= 3 caps/day; Only available through OPTUM - 877-445-6874)	LD-PA-QL	4
ANTINEOPLASTIC - BCL-2 INHIBITORS		

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES Cont.		
VENCLEXTA STARTER PACK (Only available through OPTUM - 877-445-6874)	LD-PA	4
VENCLEXTA TAB (Only available through OPTUM - 877-445-6874)	LD-PA	4
ANTINEOPLASTIC - EGFR INHIBITORS		
erlotinib tab 100mg (TARCEVA equiv)	AMSP	3
erlotinib tab 150mg (TARCEVA equiv)	AMSP	3
erlotinib tab 25mg (TARCEVA equiv) (QL = 3 tabs/day)	AMSP-QL	3
gefitinib tab (QL=1 tab/day)	AMSP-PA-QL	3
ANTINEOPLASTIC - HORMONAL AND RELATED AGENTS		
anastrozole tab (ARIMIDEX equiv)	-	1
bicalutamide tab (CASODEX equiv)	-	1
exemestane tab (AROMASIN equiv) (QL=1 tab/day)	QL	1
flutamide cap (EULEXIN equiv)	-	1
letrozole tab (FEMARA equiv)	-	1
megestrol susp (MEGACE equiv)	-	1
megestrol tab (MEGACE equiv)	-	1
tamoxifen tab (NOLVADEX equiv)	-	1
toremifene tab (FARESTON equiv)	-	1
SOLTAMAX SOLN (Step Therapy requires trial of tamoxifen tab)	ST	2
YONSA TAB	-	2
abiraterone acetate tab 500mg (ZYTIGA equiv) (QL= 2 tabs/day)	AMSP-PA-QL	3
abiraterone tab 250mg (ZYTIGA equiv)	AMSP	3

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES Cont.		
HYDROXYPROGESTERONE CAPROATE INJ (QL=1 vial/35 days)	AMSP-PA-QL	3
leuprolide inj (LUPRON equiv)	PA	3
nilutamide tab (NILANDRON equiv) (QL= 2 tabs/day)	AMSP-QL	3
EMCYT CAP	-	4
ERLEADA TAB (QL= 4 tabs/day)	AMSP-PA-QL	4
ERLEADA TAB 240MG (QL= 1 tab/day)	AMSP-PA-QL	4
LUPRON DEPOT INJ	AMSP-PA	4
ANTINEOPLASTIC - IMMUNOMODULATORS		
POMALYST CAP (QL= 21 caps/28 days; Only available through Walgreens 888-347-3416)	LD-PA-QL	4
ANTINEOPLASTIC COMBINATIONS		
LONSURF TAB (QL= 80 tabs/28 days; Only available through OPTUM - 877-445-6874 or Walgreens 888-347-3416)	LD-PA-QL	4
ANTINEOPLASTIC ENZYME INHIBITORS		
everolimus tab (AFINITOR equiv) (QL=1 tab/day)	AMSP-PA-QL	1
dasatinib tab	AMSP-PA	3
everolimus tab for oral susp (QL=1 tab/day)	AMSP-PA-QL	3
imatinib tab 100mg (GLEEVEC equiv)	AMSP	3
imatinib tab 400mg (GLEEVEC equiv)	AMSP	3
lapatinib ditosylate tab (TYKERB equiv)	AMSP-PA	3
pazopanib hcl tab (QL = 120 tabs/30 days)	AMSP-PA-QL	3

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES Cont.		
sunitinib malate cap (QL= 28 caps/42 day)	AMSP-PA-QL	3
ALECENSA CAP (QL=8 caps/day)	AMSP-PA-QL	4
BOSULIF CAP (QL=5 caps/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	4
BOSULIF TAB (Only available through Walgreens 888-347-3416)	LD-PA	4
CALQUENCE CAP (QL=2 caps/day)	AMSP-PA-QL	4
CALQUENCE TAB (QL=2 tabs/day)	AMSP-PA-QL	4
ICLUSIG TAB (QL= 30 tabs/30 days; Only available through AcariaHealth 1-800-511-5144)	LD-PA-QL	4
IMBRUVICA CAP 140MG (QL=4 caps/day; Only available through OPTUM - 877-445-6874)	LD-PA-QL	4
IMBRUVICA CAP 70MG (QL=1 cap/day; Only available through OPTUM - 877-445-6874)	LD-PA-QL	4
IMBRUVICA SUSP (QL=216 ml/30 days; Only available through OPTUM - 877-445-6874)	LD-PA-QL	4
IMBRUVICA TAB (QL=1 tab/day; Only available through OPTUM - 877-445-6874)	LD-PA-QL	4
MEKINIST SOLN (QL=40 ml/day)	LMSP-PA-QL	4
MEKINIST TAB 0.5MG (QL= 3 tabs/day)	AMSP-PA-QL	4
MEKINIST TAB 2MG (QL= 1 tab/day)	AMSP-PA-QL	4
RUBRACA TAB (QL= 4 tabs/day; Only available through OPTUM - 877-445-6874)	LD-PA-QL	4
RYDAPT CAP	AMSP-PA	4
sorafenib tosylate tab	AMSP-PA	4

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES Cont.		
STIVARGA TAB (QL= 84 tabs/28 days; Only available through Walgreens 888-347-3416)	LD-PA-QL	4
TAFINLAR CAP (QL= 4 caps/day)	AMSP-PA-QL	4
TAFINLAR TAB (QL=12 tabs/day)	LMSP-PA-QL	4
TASIGNA CAP (QL=2 caps/day)	AMSP-PA-QL	4
XALKORI CAP (QL=6 caps/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	4
ZEJULA CAP (QL= 30 caps/30 days; Only available through OPTUM - 877-445-6874)	LD-PA-QL	4
ZEJULA TAB (QL= 1 tab/day; Only available through OPTUM - 877-445-6874)	LD-PA-QL	4
ANTINEOPLASTICS MISC.		
SYLATRON INJ (Only available through Walgreens 888-347-3416)	LD-PA	4
SYNRIBO INJ (Only available through US Bioservices 888-518-7246)	LD-PA	4
CHEMOTHERAPY RESCUE/ANTIDOTE/PROTECTIVE AGENTS		
mesna tab	AMSP	3
MITOTIC INHIBITORS		
ETOPOSIDE CAP (QL= 20 caps/30 days)	QL	3
ANTIPARKINSON AGENTS		
ANTIPARKINSON ADJUVANTS		
carbidopa tab (LODOSYN equiv)	-	1
ANTIPARKINSON ANTICHOLINERGICS		
benztropine tab	-	1

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
ANTIPARKINSON AGENTS Cont.		
trihexyphenidyl tab (ARTANE equiv)	-	1
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) (QL= 1 tab/day)	QL	1
pramipexole tab (MIRAPEX equiv)	-	1
ropinirole ER tab (REQUIP XL equiv) (Step Therapy requires trial of ropinirole)	ST	1
ropinirole tab (REQUIP equiv)	-	1
ANTIPARKINSON MONOAMINE OXIDASE INHIBITORS		
rasagiline tab (AZILECT equiv) (QL= 1 tab/day)	QL	1
selegiline cap (ELDEPRYL equiv)	-	1
selegiline tab (ELDEPRYL equiv) (QL=2 tabs/day)	QL	1
ZELAPAR ODT	-	2
ANTIPARKINSON AND RELATED THERAPY AGENTS		
ANTIPARKINSON ANTICHOLINERGICS		

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
ANTIPARKINSON AND RELATED THERAPY AGENTS Cont.		
trihexyphenidyl elixir (ARTANE equiv)	-	1
TRIHEXYPHENIDYL SOLN (QL=946ml/28 days)	QL	1
ANTIPARKINSON DOPAMINERGICS		
CARBIDOPA/LEVODOPA ODT	-	1
carbidopa-levodopa-entacapone tab 12.5-50-200 mg (QL= 8 tabs/day)	QL	1
carbidopa-levodopa-entacapone tab 18.75-75-200 mg (QL= 8 tabs/day)	QL	1
carbidopa-levodopa-entacapone tab 25-100-200 mg (QL= 8 tabs/day)	QL	1
carbidopa-levodopa-entacapone tab 31.25-125-200 mg (QL= 8 tabs/day)	QL	1
carbidopa-levodopa-entacapone tab 37.5-150-200 mg (QL= 8 tabs/day)	QL	1
carbidopa-levodopa-entacapone tab 50-200-200 mg (QL= 6 tabs/day)	QL	1
OSMOLEX ER TAB	-	2
apomorphine inj (QL= 54ml/30 days; Only available through Caremark/CVS Special	LD-QL	3
800-237-2767)		
KYNMOBI FILM (QL= 150 films/30 days. Only available through Ardon 855-425-4085)	AMSP-QL	4
KYNMOBI TITRATION KIT (Only available through Ardon 855-425-4085)	AMSP-PA	4
ANTIPSYCHOTICS/ANTIMANIC AGENTS		
PHENOTHIAZINES		
prochlorperazine supp (COMPAZINE equiv)	-	1
prochlorperazine tab (COMPAZINE equiv)	-	1
thioridazine hcl tab (QL= 8 tabs/day)	QL	1
ANTISEPTICS & DISINFECTANTS		

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
ANTISEPTICS & DISINFECTANTS Cont.		
ANTISEPTICS & DISINFECTANTS		
hydrogen peroxide soln	-	1
TRIPLE DYE SWAB	-	1
CHLORINE ANTISEPTICS		
betasept liquid	OTC	1
IODINE ANTISEPTICS		
IODINE SOLN	-	1
povidone-iodine oint	-	1
IODOFLEX PAD	-	2
ANTIVIRALS		
ANTIRETROVIRALS		
abacavir soln (ZIAGEN equiv) (QL= 960ml/30 days)	QL	1
abacavir tab (ZIAGEN equiv) (QL= 2 tabs/day)	QL	1
abacavir/lamivudine tab (EPZICOM equiv) (QL= 1 tab/day)	QL	1
abacavir/lamivudine/zidovudine tab (TRIZIVIR equiv) (QL= 2 tabs/day)	QL	1
atazanavir cap 150mg (REYATAZ equiv) (QL= 2 caps/day)	QL	1
atazanavir cap 200mg (REYATAZ equiv) (QL= 2 caps/day)	QL	1
atazanavir cap 300mg (REYATAZ equiv) (QL= 1 cap/day)	QL	1
darunavir tab (QL= 1 tab/day)	QL	1
darunavir tab (QL=2 tabs/day)	QL	1
didanosine DR cap (VIDEX EC equiv) (QL= 1 cap/day)	QL	1

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
ANTIVIRALS Cont.		
EFAVIRENZ CAP	-	1
efavirenz tab (SUSTIVA equiv)	-	1
efavirenz/emtricitabine/tenofovir df tab (ATRIPLA equiv) (QL= 1 tab/day)	QL	1
efavirenz/lamivudine/tenofovir df (lo) tab (SYMFI (LO) equiv) (QL= 1 tab/day)	QL	1
emtricitabine cap (EMTRIVA equiv) (QL= 1 cap/day)	QL	1
emtricitabine/tenofovir disoproxil fumarate tab (TRUVADA equiv) (QL= 1 tab/day)	QL	1
etravirine tab 100mg (QL=4 tabs/day)	QL	1
etravirine tab 200mg (QL=2 tabs/day)	QL	1
fosamprenavir tab (LEXIVA equiv) (QL= 4 tabs/day)	QL	1
lamivudine soln (EPIVIR equiv) (QL= 960ml/30 days)	QL	1
lamivudine tab 150mg (EPIVIR equiv) (QL= 2 tabs/day)	QL	1
lamivudine tab 300mg (EPIVIR equiv) (QL= 1 tab/day)	QL	1
lamivudine/zidovudine tab (COMBIVIR equiv) (QL= 2 tabs/day)	QL	1
lopinavir/ritonavir soln (KALETRA equiv) (QL= 480ml/30 days)	QL	1
lopinavir-ritonavir tab 100-25mg (QL=2 tabs/day)	QL	1
lopinavir-ritonavir tab 200-50mg (QL=4 tabs/day)	QL	1
maraviroc tab 150mg (QL=2 tabs/day)	QL	1
maraviroc tab 300mg (QL=4 tabs/day)	QL	1
NEVIRAPINE ER TAB (QL= 1 tab/day)	QL	1
nevirapine ER tab (VIRAMUNE XR equiv) (QL= 1 tab/day)	QL	1
NEVIRAPINE SUSP (VIRAMUNE equiv)	-	1

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
ANTIVIRALS Cont.		
nevirapine tab (VIRAMUNE equiv) (QL= 2 tabs/day)	QL	1
ritonavir tab (NORVIR equiv) (QL= 12 tabs/30 days)	QL	1
stavudine cap (ZERIT equiv) (QL= 2 caps/day)	QL	1
stavudine soln (ZERIT equiv) (QL= 2400ml/30 days)	QL	1
tenofovir disoproxil fumarate tab (VIREAD equiv) (QL= 1 tab/day)	QL	1
zidovudine cap (RETROVIR equiv) (QL= 6 caps/day)	QL	1
zidovudine syrup (RETROVIR equiv) (QL= 1920ml/30 days)	QL	1
zidovudine tab (RETROVIR equiv) (QL= 2 tabs/day)	QL	1
APTIVUS CAP	-	2
APTIVUS SOLN	-	2
BIKTARVY TAB	-	2
BIKTARVY TAB 30-120-15MG (QL=1 tab/day)	QL	2
CIMDUO TAB (QL= 1 tab/day)	QL	2
COMPLERA TAB (QL= 1 tab/day)	QL	2
CRIXIVAN CAP	-	2
DELSTRIGO TAB	-	2
DESCOVY TAB (QL= 1 tab/day)	PA-QL	2
EDURANT TAB	-	2
EMTRIVA SOLN	-	2
EVOTAZ TAB	-	2
GENVOYA TAB	-	2

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
ANTIVIRALS Cont.		
INTELENCE TAB	-	2
INTELENCE TAB 25MG	-	2
INVIRASE TAB	-	2
ISENTRESS (HD) TAB	-	2
ISENTRESS CHEW TAB	-	2
ISENTRESS POWDER PACK	-	2
JULUCA TAB	-	2
LEXIVA SUSP	-	2
NEVIRAPINE SUSP (QL=1200 ml/30 days)	QL	2
NORVIR POWDER PACK	-	2
NORVIR SOLN	-	2
ODEFSEY TAB	-	2
PIFELTRO TAB	-	2
PREZCOBIX TAB	-	2
PREZISTA SUSP	-	2
PREZISTA TAB	-	2
PREZISTA TAB 150MG	-	2
PREZISTA TAB 300MG	-	2
PREZISTA TAB 400MG	-	2
PREZISTA TAB 75MG	-	2
RESCRIPTOR TAB 200MG	-	2

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
ANTIVIRALS Cont.		
REYATAZ POWDER PACK	-	2
SELZENTRY SOLN	-	2
SELZENTRY TAB 25MG	-	2
SELZENTRY TAB 75MG	-	2
STRIBILD TAB (QL= 1 tab/day)	QL	2
SYMITUZA TAB	-	2
TIVICAY PD TAB (QL= 180 tabs/30 days)	QL	2
TIVICAY TAB (QL=2 tabs/day)	QL	2
TRIUMEQ PD TAB (QL=6 tabs/day)	QL	2
TRIUMEQ TAB	-	2
TYBOST TAB	-	2
VIRACEPT TAB	-	2
VIREAD POWDER	-	2
VIRACEPT POWDER	-	3
ANTIVIRAL COMBINATIONS		
PAXLOVID TAB 150-100 (QL= 20 tabs/5 days; 20 tabs/fill; Covered for members age 12 years or older)	QL	2
PAXLOVID TAB 300-100 (QL= 30 tabs/5 days; 30 tabs/fill; Covered for members age 12 years or older)	QL	2
CMV AGENTS		
valganciclovir soln (VALCYTE equiv)	-	1

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
ANTIVIRALS Cont.		
valganciclovir tab (VALCYTE equiv)	-	1
HEPATITIS AGENTS		
lamivudine tab 100mg (EPIVIR HBV equiv) (QL= 1 tab/day)	AMSP	1
adefovir dipivoxil tab (HEPSERA equiv) (QL= 1 tab/day)	AMSP	3
entecavir tab (BARACLUDE equiv) (QL= 1 tab/day)	QL	3
RIBAVIRIN CAP	-	3
RIBAVIRIN TAB	AMSP	3
SOFOSBUVIR/VELPATASVIR TAB (QL= 1 tab/day)	AMSP-QL	3
BARACLUDE SOLN	AMSP	4
EPIVIR HBV SOLN	AMSP	4
MAVYRET PAK (QL=5 packets/day)	AMSP-PA-QL	4
MAVYRET TAB (QL= 3 tabs/day)	AMSP-QL	4
PEGASYS INJ (QL=2 inj/28 days)	PA-QL	4
VEMLIDY TAB (QL= 1 tab/day)	AMSP-QL	4
HERPES AGENTS		
acyclovir cap (ZOVIRAX equiv)	-	1
acyclovir susp (ZOVIRAX equiv)	-	1
acyclovir tab (ZOVIRAX equiv)	-	1
famciclovir tab 125mg (FAMVIR equiv) (QL= 2 tabs/day)	QL	1
famciclovir tab 250mg (FAMVIR equiv) (QL= 30 tabs/10 days)	QL	1
famciclovir tab 500mg (FAMVIR equiv) (QL= 42 tabs/fill, 2 fills/month)	QL	1

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
ANTIVIRALS Cont.		
valacyclovir tab (VALTREX equiv)	-	1
SITAVIG TAB	-	2
INFLUENZA AGENTS		
oseltamivir cap 30mg (TAMIFLU equiv) (QL= 28 caps/90 days, 1 fill/120 days)	QL	1
oseltamivir cap 45mg (TAMIFLU equiv) (QL= 14 caps/90 days, 1 fill/120 days)	QL	1
oseltamivir cap 75mg (TAMIFLU equiv) (QL= 14 caps/90 days, 1 fill/120 days)	QL	1
oseltamivir susp (TAMIFLU equiv) (QL= 120ml/10 days, 1 fill/120 days)	QL	1
RIMANTADINE TAB	-	1
RELENZA DISKHALER (QL= 1 inhaler/fill, 1 fill/month)	QL	2
TAMIFLU CAP 30MG (QL=28 caps/90 days)	QL	2
TAMIFLU CAP 45MG (QL=14 caps/90 days)	QL	2
TAMIFLU CAP 75MG (QL=14 caps/90 days)	QL	2
TAMIFLU SUSP (QL=120ml/fill)	QL	2
MISC. ANTIVIRALS		
LAGEVRIO CAP (EUA) (QL=40 caps/fill)	QL	1
LAGEVRIO CAP (QL=40 caps/5 days, 40 caps/fill; Covered for members age 18 years or older)	QL	2
ASSORTED CLASSES		
IMMUNOMODULATORS		
THALOMID CAP (Only available through Walgreens 888-347-3416)	LD	4
IMMUNOSUPPRESSIVE AGENTS		

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
ASSORTED CLASSES Cont.		
azathioprine tab (IMURAN equiv)	-	1
cyclosporine cap (SANDIMMUNE equiv)	-	1
cyclosporine modified cap (NEORAL equiv)	-	1
cyclosporine modified soln (NEORAL equiv)	-	1
mycophenolate DR tab (MYFORTIC equiv)	-	1
mycophenolate mofetil cap (CELLCEPT equiv)	-	1
mycophenolate mofetil susp (CELLCEPT SUSP equiv)	-	1
mycophenolate mofetil tab (CELLCEPT equiv)	-	1
sirolimus tab (RAPAMUNE equiv)	-	1
tacrolimus cap (PROGRAF equiv)	-	1
ENVARUSUS XR TAB	-	2
SANDIMMUNE SOLN 100MG/ML	-	2
BETA BLOCKERS		
ALPHA-BETA BLOCKERS		
carvedilol tab (COREG equiv)	-	1
labetalol tab (NORMODYNE equiv)	-	1
BETA BLOCKERS CARDIO-SELECTIVE		
acebutolol cap (SECTRAL equiv)	-	1
atenolol tab (TENORMIN equiv)	-	1
betaxolol tab (KERLONE equiv)	-	1
bisoprolol tab (ZEBETA equiv)	-	1

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
BETA BLOCKERS Cont.		
metoprolol ER tab (TOPROL XL equiv)	-	1
metoprolol tab (LOPRESSOR equiv)	-	1
nebivolol tab (QL=1 tab/day)	QL	1
KAPSPARGO CAP	-	2
BETA BLOCKERS NON-SELECTIVE		
nadolol tab (CORCARD equiv)	-	1
pindolol tab (VISKEN equiv)	-	1
propranolol ER cap (INDERAL LA equiv)	-	1
PROPRANOLOL SOLN	-	1
PROPRANOLOL SOLN 20MG/5ML	-	1
propranolol tab (INDERAL equiv)	-	1
sotalol AF tab (BETAPACE AF equiv)	-	1
sotalol tab (BETAPACE equiv)	-	1
timolol maleate tab (BLOCADREN equiv)	-	1
HEMANGEOL SOLN	-	2
INDERAL XL CAP, INNOPRAN XL CAP	-	2
LEVATOL TAB	-	2
SOTYLIZE SOLN	-	2
BIOLOGICALS MISC		
ALLERGENIC EXTRACTS		
GRASSTK SL TAB (QL= 30 tabs/30 days)	QL	2

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
BIOLOGICALS MISC Cont.		
ORALAIR SL TAB (QL= 30 tabs/30 days)	QL	2
RAGWITEK SL TAB (QL= 30 tabs/30 days)	QL	2
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	-	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
verapamil SR tab (CALAN SR, ISOPTIN SR equiv)	-	1
verapamil tab (CALAN equiv)	-	1
CARDIOTONICS		
CARDIAC GLYCOSIDES		
digoxin tab (LANOXIN equiv) (QL=1 tab/day)	QL	1

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
CARDIOTONICS Cont.		
digoxin soln (LANOXIN equiv)	-	2
CARDIOVASCULAR AGENTS - MISC.		
CARDIOVASCULAR AGENTS MISC. - COMBINATIONS		
isosorbide dinitrate-hydralazine tab (QL=6 tabs/day)	QL	1
ENTRESTO CAP (QL= 8 caps/day)	QL	2
ENTRESTO TAB (QL= 2 tabs/day)	QL	2
IMPOTENCE AGENTS		
tadalafil tab (CIALIS equiv) (QL=1 tab/day)	QL	1
PERIPHERAL VASODILATORS		
isoxsuprine tab	-	1
ISOXSUPRINE TAB (QL=4 tabs/day)	QL	2
PROSTAGLANDIN VASODILATORS		
treprostinil inj (REMODULIN equiv) (Only available through Accredo 800-803-2523)	LD-PA	3
PULMONARY HYPERTENSION - ENDOTHELIN RECEPTOR ANTAGONISTS		
ambrisentan tab (LETAIRIS equiv) (Only available through Ardon 855-425-4085)	AMSP-PA	3
bosentan tab (TRACLEER equiv) (Only available through Lumicera 855-847-3553)	LD-PA	3
OPSUMIT TAB (Only available through Accredo 877-826-7657)	LD-PA	4
PULMONARY HYPERTENSION - PHOSPHODIESTERASE INHIBITORS		
sildenafil tab 20mg (REVATIO equiv) (QL= 3 tabs/day)	QL	1
tadalafil tab (PAH) (ADCIRCA equiv) (QL= 2 tabs/day)	QL	1
sildenafil susp (REVATIO equiv) (QL= 224ml/30 days)	QL	3

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
CARDIOVASCULAR AGENTS - MISC. Cont.		
PULMONARY HYPERTENSION - PROSTACYCLIN RECEPTOR AGONIST		
UPTRAVI TAB (Only available through Accredo 877-826-7657)	LD-PA	4
UPTRAVI THERAPY PACK (Only available through Accredo 877-826-7657)	LD-PA	4
SINUS NODE INHIBITORS		
CORLANOR SOLN (QL=15 ml/day)	QL	2
CORLANOR TAB (QL = 60 tabs/30 days)	QL	2
ivabradine hcl tab (QL = 60 tabs/30 days)	QL	3
CEPHALOSPORINS		
CEPHALOSPORINS - 1ST GENERATION		
cefadroxil cap (DURICEF equiv)	-	1
cefadroxil susp (DURICEF equiv)	-	1
CEFADROXIL TAB	-	1
cefadroxil tab (DURICEF equiv)	-	1
cephalexin cap (KEFLEX equiv)	-	1
cephalexin susp (KEFLEX equiv)	-	1
cephalexin tab	-	1
CEPHALOSPORINS - 2ND GENERATION		
CEFACLOR CAP	-	1
cefaclor cap (CECLOR equiv)	-	1
CEFACLOR ER TAB	-	1
CEFACLOR SUSP	-	1

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
CEPHALOSPORINS Cont.		
cefaclor susp (CEFACLOR equiv)	-	1
cefprozil susp (CEFZIL equiv)	-	1
cefprozil tab (CEFZIL equiv)	-	1
cefuroxime susp (CEFTIN equiv)	-	1
cefuroxime tab (CEFTIN equiv)	-	1
CEPHALOSPORINS - 3RD GENERATION		
cefdinir cap (OMNICEF equiv)	-	1
cefdinir susp (OMNICEF equiv)	-	1
CEFDITOREN TAB	-	1
cefixime cap (SUPRAX equiv)	-	1
cefixime susp (SUPRAX equiv)	-	1
CEFPODOXIME PROXETIL SUSP	-	1
cefpodoxime proxetil tab (VANTIN equiv)	-	1
SUPRAX CAP	-	2
SUPRAX CHEW TAB	-	2
SUPRAX SUSP	-	2
SUPRAX TAB	-	2
CHEMICALS		
BULK CHEMICALS - I'S		
IODINE SOLN	OTC	1
CONTRACEPTIVES		

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
CONTRACEPTIVES Cont.		
COMBINATION CONTRACEPTIVES - ORAL		
amethyst tab (LYBREL equiv)	-	1
ashlyna tab, daysee tab (SEASONALE, SEASONIQUE equiv)	-	1
camrese lo tab, lojaimiess tab (QL= 91 tabs/91 days)	QL	1
cryselle tab	-	1
drospirenone/ethinyl estradiol/levomefolate tab (BEYAZ equiv)	-	1
enpresse tab (TRI-LEVELLEN equiv)	-	1
FEMLYV TAB (QL=28 tabs/24 days)	QL	1
gianvi tab, ocella tab (YASMIN, YAZ equiv)	-	1
isibloom tab, enskyce tab, apri tab (DESOGEN equiv)	-	1
junel FE tab (LOESTRIN FE equiv)	-	1
junel tab (LOESTRIN equiv)	-	1
kelnor tab (DEMULEN equiv)	-	1
layolis FE tab (FEMCON FE equiv)	-	1
levonorgestrel-ethinyl estradiol-fe tab	-	1
mibelas chew tab (MINASTRIN equiv)	-	1
norethindrone ace-ethinyl estradiol-fe cap 1 mg-20 mcg (24) (TAYTULLA equiv)	-	1
nortrel 7/7/7 tab, pirmella 7/7/7 tab (TRI-NORINYL equiv)	-	1
nortrel tab (OVCON 35 equiv)	-	1
sprintec 28 tab (ORTHO-CYCLEN equiv)	-	1
tri-legest tab (ESTROSTEP FE equiv)	-	1

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
CONTRACEPTIVES Cont.		
tri-sprintec tab (ORTHO TRI-CYCLEN (LO) equiv)	-	1
velivet tab (CYCLESSA equiv)	-	1
vienva tab, lessina tab, kurvelo tab (ALESSE equiv)	-	1
viorele tab, kariva tab (MIRCETTE equiv)	-	1
DROSPIRENONE/ETHINYL ESTRADIOL/LEVOMEFOLATE TAB, SAFYRAL TAB	-	2
LO LOESTRIN TAB	-	2
NATAZIA TAB	-	2
NEXTSTELLIS TAB (QL=28 tabs/24 days)	QL	2
OGESTREL TAB	-	2
TYBLUME TAB	-	2
VELIVET PAK	-	2
COMBINATION CONTRACEPTIVES - TRANSDERMAL		
XULANE PATCH	-	1
zafemy patch (XULANE equiv)	-	1
TWIRLA PATCH	-	2
COMBINATION CONTRACEPTIVES - VAGINAL		
eluryng vaginal ring (NUVARING equiv) (QL=1 ring/21 days)	QL	1
ANNOVERA RING (QL=1 ring/273 days)	QL	2
COPPER CONTRACEPTIVES - IUD		
PARAGARD IUD	-	2
EMERGENCY CONTRACEPTIVES		

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
CONTRACEPTIVES Cont.		
levonorgestrel tab (PLAN B equiv)	OTC	1
ELLA TAB	-	2
PROGESTIN CONTRACEPTIVES - IMPLANTS		
IMPLANON IMPLANT, NEXPLANON IMPLANT	-	2
NEXPLANON IMPLANT	-	2
PROGESTIN CONTRACEPTIVES - INJECTABLE		
medroxyprogesterone inj (DEPO-PROVERA equiv) (QL= 1 inj/84 days)	QL	1
DEPO-PROVERA SC INJ 104MG (QL= 1 inj/84 days)	QL	2
PROGESTIN CONTRACEPTIVES - IUD		
KYLEENA IUD	-	2
MIRENA IUD	-	2
SKYLA IUD	-	2
PROGESTIN CONTRACEPTIVES - ORAL		
norethindrone tab (NORA-QD equiv)	-	1
OPILL TAB	OTC	2
SLYND TAB (QL=28 tabs/24 days)	QL	2
CORTICOSTEROIDS		
GLUCOCORTICOSTEROIDS		
budesonide ER tab (UCERIS equiv)	-	1
budesonide SR cap (ENTOCORT EC equiv)	-	1
dexamethasone elixir	-	1

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
CORTICOSTEROIDS Cont.		
dexamethasone pak (DEXPAK equiv)	-	1
DEXAMETHASONE SOLN	-	1
dexamethasone tab (DECADRON equiv)	-	1
hydrocortisone sodium succinate pf for inj	-	1
hydrocortisone tab (CORTEF equiv)	-	1
methylprednisolone dose pack (MEDROL equiv)	-	1
methylprednisolone tab (MEDROL equiv)	-	1
PREDNISOLONE SOLN	-	1
prednisolone soln (PEDIAPRED equiv)	-	1
prednisolone syrup	-	1
prednisone pack	-	1
PREDNISON SOLN	-	1
prednisone tab (DELTASONE equiv)	-	1
CORTISONE ACETATE TAB	-	2
DEXAMETHASONE CONC	-	2
DEXAMETHASONE TAB (QL=8 tabs/30 days)	QL	2
DXEVO 11-DAY PAK	-	2
EOHILIA SUSP (Step therapy requires trial of budesonide vials)	RDX-ST	2
MEDROL TAB	-	2
MILLIPRED DP PAK	-	2
MILLIPRED TAB	-	2

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
CORTICOSTEROIDS Cont.		
PREDNISONE CONC	-	2
RAYOS TAB	-	2
SOLU-CORTEF INJ	-	2
ALKINDI SPRINKLE CAP	PA	4
MINERALOCORTICIDS		
fludrocortisone tab (FLORINEF equiv)	-	1
COUGH/COLD/ALLERGY		
ANTITUSSIVES		
BENZONATATE CAP (QL= 3 caps/day)	QL	1
benzonatate cap (TESSALON equiv)	QL--	1
COUGH/COLD/ALLERGY COMBINATIONS		
fexofenadine/pseudoephedrine 24-hour tab (ALLEGRA-D equiv) (QL=1 tab/day)	QL	1
guaifenesin dac syrup	-	1
HYD POL/CPM SUSP (QL=10ml/day)	QL	1
hydrocodone/chlorpheniramine/pseudoephedrine liquid (ZUTRIPRO equiv)	-	1
neo-tuss liquid	OTC	1
PROMETHAZINE VC /CODEINE SYRUP	-	1
PROMETHAZINE VC SYRUP	-	1
PROMETHAZINE VC SYRUP (QL= 30 mL/day)	--QL	1
promethazine VC syrup (PHENERGAN VC equiv)	--QL	1
tussin dm syrup	OTC	1

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
COUGH/COLD/ALLERGY Cont.		
VIRTUSSIN DAC SYRUP	OTC	1
CLARINEX-D 12 HOUR	-	2
LORTUSS EX LIQUID	-	2
MAXI-TUSS CD LIQUID	OTC	2
NINJACOF-XG LIQUID (QL=473 ml/month)	OTC-QL	2
SEMPREX-D CAP 8-60MG	-	2
TUXARIN ER TAB (QL= 20 tabs/day)	QL	2
EXPECTORANTS		
guaifenesin tab (ALLFEN JR equiv)	-	1
potassium iodide oral soln (QL=90 ml/30 days)	QL	1
MISC. RESPIRATORY INHALANTS		
sodium chloride neb soln (HYPER-SAL equiv)	-	1
MUCOLYTICS		
acetylcysteine soln (MUCOMYST equiv)	-	1
DERMATOLOGICALS		
ACNE PRODUCTS		
adapalene cream (DIFFERIN equiv) (Step Therapy requires trial of adapalene gel, followed by tretinoin cream 0.025%.)	ST	1
adapalene gel (DIFFERIN equiv) (QL= 360g/30 days)	QL	1
ADAPALENE SOLN (QL= 360 mL/30 days; Step therapy requires adapalene gel)	QL-ST	1

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
amneesteem cap, claravis cap, isotretinoin cap, myorisan cap, zenatane cap (ACCUTANE equiv)	-	1
benzoyl peroxide gel (QL= 360g/30 days)	OTC-QL	1
BPO GEL 8%	-	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 1-5% (QL= 360g/30 days)	QL	1
erythromycin gel	-	1
erythromycin pad	-	1
erythromycin soln	-	1
sodium sulfacetamide lotion (KLARON equiv)	-	1
tretinoin cream (RETIN-A CREAM equiv) (QL= 360g/30 days, Step therapy requires trial of adapalene gel, followed by tretinoin cream 0.025%)	QL-ST	1
tretinoin cream 0.025% (QL= 360g/30 days, Step therapy requires trial of adapalene gel)	QL-ST	1
tretinoin gel (RETIN-A GEL equiv) (QL= 360g/30 days, Step therapy requires trial of adapalene gel, followed by tretinoin cream 0.025%)	QL-ST	1
tretinoin gel 0.03% (QL= 360g/30 days, Step therapy requires trial of adapalene gel followed by tretinoin cream 0.025%)	QL-ST	1

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
ACNOMEL CREAM (QL= 360g/30 days)	OTC-QL	2
BENZAC WASH (QL= 360g/30 days)	QL	2
BENZOYL PEROXIDE LOTION (QL= 360g/30 days)	OTC-QL	2
BENZOYL PEROXIDE WASH (QL= 360g/30 days)	QL	2
ERY PAD (Step therapy requires trial of topical clindamycin or erythromycin gel/sol)	QL-ST	2
INOVA KIT	-	2
LIQUIMAT LOTION (QL= 360g/30 days)	OTC-QL	2
NEUAC KIT	-	2
RIAX FOAM (QL= 360g/30 days)	OTC-QL	2
TRETIN-X CREAM	-	2
TRETIN-X KIT	-	2
ANALGESICS - TOPICAL		
NEURAPTINE CREAM KIT	-	2
ANTIBIOTICS - TOPICAL		
bacitracin oint	OTC	1
bacitracin zinc oint	OTC	1
gentamicin sulfate cream	-	1
gentamicin sulfate oint	-	1
mupirocin cream (BACTROBAN CREAM equiv)	-	1
mupirocin oint (BACTROBAN OINT equiv)	-	1
triple antibiotic oint	OTC	1

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
ALTABAX OINT	-	2
CENTANY AT KIT	-	2
CORTISPORIN CREAM	-	2
CORTISPORIN OINT	-	2
NEO-SYNALAR CREAM	-	2
NEO-SYNALAR KIT	-	2
XEPI CREAM	-	2
ANTIFUNGALS - TOPICAL		
butenafine cream	OTC	1
ciclopirox cream (LOPROX CREAM equiv)	-	1
ciclopirox gel (LOPROX GEL equiv)	-	1
ciclopirox shampoo (LOPROX SHAMPOO equiv)	-	1
ciclopirox topical susp (LOPROX SUSP equiv)	-	1
clotrimazole cream (LOTRIMIN AF CREAM equiv)	OTC	1
clotrimazole soln	OTC	1
clotrimazole/betamethasone cream (LORTRISONE CREAM equiv)	-	1
CLOTRIMAZOLE/BETAMETHASONE LOTION	-	1
clotrimazole/betamethasone lotion (LOTRISONE LOTION equiv)	-	1
econazole cream (SPECTAZOLE equiv)	-	1
iodoquinol/hydrocortisone cream 1% (VYTONE equiv)	-	1
iodoquinol/hydrocortisone/aloe polysaccharide gel (ALCORTIN A equiv)	-	1

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
ketoconazole cream (NIZORAL CREAM equiv)	-	1
ketoconazole shampoo	-	1
MICATIN CREAM 2%	OTC	1
miconazole cream	OTC	1
naftifine gel (NAFTIN equiv)	-	1
nystatin cream (MYCOSTATIN CREAM equiv)	-	1
nystatin oint	-	1
nystatin topical powder	-	1
nystatin/triamcinolone cream	-	1
nystatin/triamcinolone oint	-	1
tolnaftate cream	OTC	1
ALCORTIN A GEL	-	2
ALOQUIN GEL	-	2
ECOZA FOAM	-	2
ERTACZO CREAM	-	2
EXODERM LOTION	-	2
LOPROX KIT	-	2
OXISTAT LOTION	-	2
XOLEGEL	-	2
ANTI-INFLAMMATORY AGENTS - TOPICAL		
diclofenac gel 1% (VOLTAREN equiv) (QL=400grams/30 days)	QL	1

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
diclofenac soln 1.5% (PENNSAID equiv)	-	1
DERMACINRX LEXITRAL PAK	-	2
diclofenac/capsaicin kit	-	2
ANTINEOPLASTIC OR PREMALIGNANT LESION AGENTS - TOPICAL		
diclofenac gel (SOLARAZE equiv)	-	1
fluorouracil cream (EFUDEX CREAM equiv)	-	1
fluorouracil soln	-	1
FLUOROPLEX CREAM	-	2
PANRETIN GEL	-	2
PICATO GEL	-	2
bexarotene gel	AMSP-PA	3
ANTIPSORIATICS		
calcipotriene cream (DOVONEX CREAM equiv)	-	1
calcipotriene oint	-	1
CALCIPOTRIENE SOLN	-	1
calcipotriene soln (DOVONEX SOLN equiv)	-	1
methoxsalen cap (OXSORALEN ULTRA equiv)	-	1
tazarotene cream 0.1% (TAZORAC equiv) (QL= 360g/30 days)	QL	1
ZITHRANOL SHAMPOO	-	2
COSENTYX INJ (QL = 1 inj/28 days)	AMSP-PA-QL	4
COSENTYX INJ (1-PACK) (QL=1 inj/28 days)	AMSP-PA-QL	4

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
COSENTYX INJ (2-PACK) (QL=2 inj/56 days)	AMSP-PA-QL	4
ANTISEBORRHEIC PRODUCTS		
selenium sulfide shampoo 2.3%	-	1
ANTIVIRALS - TOPICAL		
acyclovir oint (ZOVIRAX OINT equiv)	-	1
BURN PRODUCTS		
mafenide acetate soln packet (SULFAMYLON equiv)	-	1
silver sulfadiazine cream (SILVADENE CREAM equiv)	-	1
SULFAMYLON CREAM	-	2
SULFAMYLON PACK	-	2
CAUTERIZING AGENTS		
silver nitrate applicator	-	1
silver nitrate soln	-	1
SILVER NITRATE SOLN	-	2
TRI-CHLOR SOLN	-	2
CORTICOSTEROIDS - TOPICAL		
alclometasone cream (ACLOVATE equiv)	-	1
ALCLOMETASONE OINT	-	1
alclometasone oint (ACLOVATE OINT equiv)	-	1
AMCINONIDE CREAM 0.1%	-	1
AMCINONIDE LOTION	-	1

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
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
clobetasol E foam (OLUX E equiv)	-	1
clobetasol foam (OLUX equiv)	-	1
clobetasol lotion (CLOBEX equiv)	-	1
clobetasol propionate cream (TEMOVATE equiv)	-	1
clobetasol propionate emollient cream (TEMOVATE E equiv)	-	1
clobetasol propionate gel (TEMOVATE GEL equiv)	-	1
clobetasol propionate oint (TEMOVATE equiv)	-	1
clobetasol propionate soln (TEMOVATE equiv)	-	1
clobetasol shampoo (CLOBEX equiv)	-	1
clobetasol spray (CLOBEX equiv)	-	1
desonate gel	-	1

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
desonide cream	-	1
desonide lotion	-	1
desonide oint	-	1
desoximetasone cream (TOPICORT CREAM equiv)	-	1
desoximetasone gel (TOPICORT equiv)	-	1
desoximetasone oint (TOPICORT equiv)	-	1
fluocinolone acetonide cream	-	1
fluocinolone acetonide oil (QL=119ml/30 days)	QL	1
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
fluticasone propionate cream (CUTIVATE equiv)	-	1
fluticasone propionate oint (CUTIVATE equiv)	-	1
halcinonide cream (HALOG equiv) (Step Therapy requires trial of 2 High potency corticosteroids)	ST	1
halobetasol propionate cream (ULTRAVATE equiv)	-	1
halobetasol propionate oint (ULTRAVATE equiv)	-	1

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
halonate pac kit (ULTRAVATE KIT equiv)	-	1
HC BUTYRATE CREAM	-	1
HC BUTYRATE SOLN	-	1
hydrocortisone butyrate cream (LOCOID equiv)	-	1
hydrocortisone butyrate lipocream (LOCOID equiv)	-	1
HYDROCORTISONE BUTYRATE OINT	-	1
hydrocortisone butyrate oint (LOCOID equiv)	-	1
hydrocortisone butyrate soln (LOCOID equiv)	-	1
hydrocortisone cream (PROCTOCORT equiv)	OTC	1
hydrocortisone lotion 2.5%	-	1
hydrocortisone oint	OTC	1
hydrocortisone pramoxine cream (PRAMOSONE equiv)	-	1
hydrocortisone valerate cream	-	1
hydrocortisone valerate oint (WESTCORT equiv)	-	1
LOCOID LIPOCREAM	-	1
mometasone cream (ELOCON equiv)	-	1
mometasone oint (ELOCON equiv)	-	1
mometasone soln (ELOCON equiv)	-	1
PREDNICARBATE CREAM	-	1
prednicarbate cream (DERMATOP equiv)	-	1
PREDNICARBATE OIN	-	1

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
triamcinolone acetonide oint (TRIANEX equiv) (Step Therapy requires trial of triamcinolone acetonide oint 0.025% or 0.1%)	ST	1
triamcinolone acetonide oint 0.025% (TRIANEX equiv)	-	1
triamcinolone acetonide oint 0.1% (TRIANEX equiv)	-	1
triamcinolone acetonide oint 0.5% (TRIANEX equiv)	-	1
triamcinolone cream	-	1
triamcinolone lotion	-	1
TRIANEX OINT	-	1
APEXICON E CREAM (PSORCON E equiv)	-	2
BRYHALI LOTION	-	2
CAPEX SHAMPOO	-	2
CLODAN KIT	-	2
CORDRAN TAPE	-	2
CORTANE-B LOTION	-	2
DESONATE GEL	-	2
DUOBRII LOTION (QL=1 tube/30 days; Step Therapy requires trial of a high potency topical steroid)	QL-ST	2
ENSTILAR FOAM	-	2
EPIFOAM AEROSOL	-	2
FLUOVIX PAK	-	2
HALOG OINT	-	2

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
IMPOYZ CREAM	-	2
PANDEL CREAM	-	2
PRAMOSONE CREAM 1-1%	-	2
PRAMOSONE LOTION	-	2
PRAMOSONE OINT	-	2
SCALACORT DK KIT	-	2
SERNIVO SPRAY	-	2
SILAZONE-II KIT	-	2
SYNALAR CREAM	-	2
ULTRAVATE LOTION	-	2
VERDESO FOAM	-	2
WYNZORA CREAM (QL=420 gm/28 days, Step therapy requires trial of 2 topicals: calcipotriene, betamethasone, AMCINONIDE, fluocinonide, triamcinolone.)	QL-ST	2
ECZEMA AGENTS		
DUPIXENT INJ (QL= 2 inj/28 days)	AMSP-PA-QL	4
DUPIXENT INJ (QL=2 inj/28 days)	AMSP-PA-QL	4
DUPIXENT PEN INJ (QL= 2 inj/28 days)	AMSP-PA-QL	4
EMOLLIENT/KERATOLYTIC AGENTS		
umecta mouss aer (HYDRO 40 equiv)	-	1
UREA NAIL KIT	-	1
URAMAXIN FOAM	-	2

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
EMOLLIENTS		
ammonium lactate cream (LAC-HYDRIN equiv)	OTC	1
ENZYMES - TOPICAL		
SANTYL OINT	-	2
IMMUNOMODULATING AGENTS - TOPICAL		
imiquimod cream 5% (ALDARA equiv) (QL= 24gm/30 days)	QL	1
ZYCLARA CREAM 2.5%	-	2
IMMUNOSUPPRESSIVE AGENTS - TOPICAL		
tacrolimus oint (PROTOPIC OINT equiv)	-	1
KERATOLYTIC/ANTIMITOTIC AGENTS		
PODOCON SOLN	-	1
podofilox soln (CONDYLOX equiv)	-	1
SALICYLIC ACID LOTION 6%	-	1
BENSAL HP OINT	-	2
KERALYT SCALP KIT	-	2
PODOFILOX SOLN (QL= 0.5mL/day)	QL	2
SALIMEZ FORTE CREAM 10%	-	2
SALVAX DUO PLUS KIT	-	2
LOCAL ANESTHETICS - TOPICAL		
capsaicin cream 0.025%	OTC	1
ETHYL CHLORIDE SPRAY	-	1

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
L.E.T. GEL	-	1
lidocaine soln (XYLOCAINE equiv)	-	1
lidocaine/prilocaine cream (EMLA equiv)	-	1
lidocaine/prilocaine cream kit	-	1
LIDO-EP-TETR SOLN	-	1
XRYLIDERM KIT	-	1
ANASTIA LOTION	-	2
CETACAINE ANESTHETIC LIQUID	-	2
CETACAINE SPRAY	-	2
lidopac kit	-	2
LIDOPIN CREAM	-	2
LIDOTREX GEL	-	2
LIDOVEX CREAM	-	2
PAIN EASE MIST SPRAY	-	2
SYNERA PATCH	-	2
ZTLIDO PATCH	-	2
MISC. DERMATOLOGICAL PRODUCTS		
EPICERAM EMULSION	-	2
NEOSALUS FOAM	-	2
MISC. TOPICAL		
zinc oxide oint 20%	OTC	1

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
HYCLODEX SOLN	-	2
PROSILK GEL	-	2
PIGMENTING-DEPIGMENTING AGENTS		
TRI-LUMA CREAM	-	2
ROSACEA AGENTS		
azelaic acid gel (FINACEA equiv) (QL= 360 g/30 days; Step therapy requires adapalene gel OR topical clindamycin)	QL-ST	1
ivermectin cream (SOOLANTRA equiv) (QL= 45gm/30 days)	QL	1
metronidazole gel (METROGEL equiv)	-	1
metronidazole lotion (METROLOTION equiv)	-	1
NORITATE CREAM	-	2
SCABICIDES & PEDICULICIDES		
LINDANE LOTION	-	1
malathion lotion (OVIDE equiv)	-	1
permethrin cream (ELIMITE CREAM equiv)	-	1
permethrin liquid	OTC	1
SPINOSAD SUSP	-	1
EURAX CREAM	-	2
EURAX LOTION	-	2
ULESFIA LOTION	-	2
SCAR TREATMENT PRODUCTS		

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
SCARCIN GEL	-	2
WOUND CARE PRODUCTS		
BIAFINE EMULSION	-	1
MASTISOL LIQUID	-	1
APLIGRAF DISK	-	2
BIONECT CREAM	-	2
DERMAGRAFT SHEET	-	2
GRAFIX CORE SHEET	-	2
LUXAMEND CREAM	-	2
REGENECARE GEL	-	2
REGRANEX GEL	-	2
TRUSKIN SHEET	-	2
VENELEX OINT	-	2
DIAGNOSTIC PRODUCTS		
DIAGNOSTIC PRODUCTS, MISC.		
FREESTYLE LITE TEST STRIP (QL= 300 test strips/30 days)	OTC-QL	1
ultrasound gel	-	1
DIAGNOSTIC TESTS		
COVID-19 HOME COLLECTION TEST KIT (QL= 8 kits/30 days)	OTC-QL	1
COVID-19 TEST SPECIMEN COLLECTION KIT (Q= 8 kits/30 days)	OTC-QL	1
CUE HEALTH MONITOR (QL=1 kit/year)	OTC-QL	1

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
DIAGNOSTIC PRODUCTS Cont.		
CVS DIGITAL TEST PREGNANCY	-	1
FREESTYLE INSULINX TEST STRIP (QL= 300 test strips/30 days)	OTC-QL	1
FREESTYLE PRECISION NEO TEST STRIP (QL= 300 test strips/30 days)	OTC-QL	1
FREESTYLE TEST STRIP (QL= 300 test strips/30 days)	OTC-QL	1
FREESTYLE TEST STRIPS (QL= 300 strips/30 days)	OTC-QL	1
hemoglobin test	-	1
PRECISION XTRA KETONE TEST STRIP (QL=300 strips/30 days)	OTC-QL	1
PRECISION XTRA TEST STRIP (QL= 300 test strips/30 days)	OTC-QL	1
DIETARY PRODUCTS/DIETARY MANAGEMENT PRODUCTS		
DIETARY MANAGEMENT PRODUCTS		
folbic tab	-	1
VITA-RESPA TAB	OTC	1
MACUZIN CAP	-	2
NUTRITIONAL SUPPLEMENTS		
SALMON OIL-1000 CAP	OTC	1
DIGESTIVE AIDS		
DIGESTIVE ENZYMES		
CREON CAP	-	2
DIURETICS		
CARBONIC ANHYDRASE INHIBITORS		
acetazolamide ER cap (DIAMOX SEQUEL equiv)	-	1

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
DIURETICS Cont.		
acetazolamide tab	-	1
dichlorphenamide tab (QL= 4 tabs/day)	AMSP-PA-QL	3
DIURETIC COMBINATIONS		
AMILORIDE/HYDROCHLOROTHIAZIDE TAB	-	1
amiloride/hydrochlorothiazide tab (MODURETIC equiv)	-	1
spironolactone/hydrochlorothiazide tab (ALDACTAZIDE equiv)	-	1
triamterene/hydrochlorothiazide cap (DYAZIDE equiv)	-	1
TRIAMTERENE/HYDROCHLOROTHIAZIDE CAP 50-25mg	-	1
triamterene/hydrochlorothiazide tab (MAXZIDE equiv)	-	1
ALDACTAZIDE TAB 50-50MG	-	2
LOOP DIURETICS		
bumetanide tab (BUMEX equiv)	-	1
FUROSEMIDE SOLN	-	1
furosemide soln (LASIX equiv)	-	1
furosemide tab (LASIX equiv)	-	1
torsemide tab (DEMADEX equiv)	-	1
POTASSIUM SPARING DIURETICS		
amiloride tab (MIDAMOR equiv)	-	1
spironolactone tab (ALDACTONE equiv)	-	1
triamterene cap (DYRENIUM equiv) (Step Therapy requires trial of amiloride or spironolactone)	ST	1

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
DIURETICS Cont.		
THIAZIDES AND THIAZIDE-LIKE DIURETICS		
CHLOROTHIAZIDE TAB	-	1
chlorothiazide tab (DIURIL equiv)	-	1
chlorthalidone tab	-	1
hydrochlorothiazide cap (MICROZIDE equiv)	-	1
hydrochlorothiazide tab (HYDRODIURIL equiv)	-	1
indapamide tab (LOZOL equiv)	-	1
metolazone tab (ZAROXOLYN equiv)	-	1
DIURIL SUSP	-	2
METHYCLOTHIAZIDE TAB	-	2
ENDOCRINE AND METABOLIC AGENTS - MISC.		
BONE DENSITY REGULATORS		
alendronate sodium oral soln (FOSAMAX equiv) (QL=300 ml/28 days)	QL	1
alendronate tab (FOSAMAX equiv)	-	1
calcitonin nasal spray (MIACALCIN equiv)	-	1
ibandronate tab 150mg (BONIVA equiv) (QL=1 tab/28 days)	QL	1
risedronate tab 30mg (ACTONEL equiv) (QL= 1 tab/day)	QL	1
risedronate tab 35mg (ACTONEL equiv) (QL= 4 tabs/28 days)	QL	1
risedronate tab 5mg (ACTONEL equiv) (QL= 1 tab/day)	QL	1
ALENDRONATE TAB 40MG	-	2
BINOSTO TAB (QL= 4 tabs/28 days)	QL	2

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
ENDOCRINE AND METABOLIC AGENTS - MISC. Cont.		
FOSAMAX+D TAB (QL= 4 tabs/28 days)	QL	2
TERIPARATIDE INJ (QL= 2.48ml/28 days)	AMSP-PA-QL	4
TYMLOS INJ (QL= 1.56ml/28 days)	AMSP-PA-QL	4
GROWTH HORMONE RECEPTOR ANTAGONISTS		
SOMAVERT INJ (Only available through Accredo 877-826-7657 or Walgreens 888-347-3416)	LD-PA	4
GROWTH HORMONES		
NORDITROPIN FLEXPOR INJ	AMSP-PA	4
ZOMACTON INJ	AMSP-PA	4
HORMONE RECEPTOR MODULATORS		
raloxifene tab (EVISTA equiv) (QL= 1 tab/day)	QL	1
INSULIN-LIKE GROWTH FACTORS (SOMATOMEDINS)		
INCRELEX INJ (Only available through AnovoRx 844-288-5007)	LD-PA	4
LHRH/GNRH AGONIST ANALOG PITUITARY SUPPRESSANTS		
SYNAREL NASAL SOLN	PA	4
METABOLIC MODIFIERS		
calcitriol cap (ROCALTRON equiv)	-	1
calcitriol soln (CALCITRIOL equiv)	-	1
levocarnitine soln (CARNITOR equiv)	-	1
levocarnitine tab (CARNITOR equiv)	-	1
paricalcitol cap (ZEMPLAR equiv)	-	1

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
ENDOCRINE AND METABOLIC AGENTS - MISC. Cont.		
RAYALDEE CAP (QL= 1 cap/day)	QL	2
betaine powder for oral solution (QL=540 grams/30 days; Only available through Walgreens 888-347-3416)	LD-QL	3
carglumic acid tab (Only available through AnovoRx 844-288-5007)	LD-PA	3
javygtor pak 100mg	LMSP-PA	3
javygtor powder 500mg	LMSP-PA	3
javygtor tab 100mg	LMSP-PA	3
nitisinone cap (ORFADIN equiv)	LMSP-PA	3
sapropterin dihydrochloride powder packet (KUVAN equiv)	AMSP-PA	3
sapropterin dihydrochloride soluble tab (KUVAN equiv)	AMSP-PA	3
sodium phenylbutyrate powder (BUPHENYL equiv)	-	3
sodium phenylbutyrate tab (BUPHENYL equiv)	-	3
CYSTADANE POWDER (QL=540 grams/30 days; Only available through AnovoRx 844-288-5007)	LD-QL	4
STRENSIQ INJ 18MG/.45ML (QL= 24 vials/28 days; Only available through PantherRx Pharmacy 855-726-8479)	LD-PA-QL	4
STRENSIQ INJ 28MG/0.7ML (QL= 24 vials/28 days; Only available through PantherRx Pharmacy 855-726-8479)	LD-PA-QL	4
STRENSIQ INJ 40 MG/ML (QL= 24 vials/28 days; Only available through PantherR Pharmacy 855-726-8479)	LD-PA-QL	4

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
ENDOCRINE AND METABOLIC AGENTS - MISC. Cont.		
STRENSIQ INJ 80MG/0.8ML (QL= 24 vials/28 days; Only available through PantherRx Pharmacy 855-726-8479)	LD-PA-QL	4
POSTERIOR PITUITARY HORMONES		
desmopressin acetate nasal spray (DDAVP equiv)	-	1
desmopressin acetate tab (DDAVP equiv)	-	1
NOCDURNA SL TAB	-	2
NOCTIVA EMULSION SPRAY	-	2
PROGESTERONE RECEPTOR ANTAGONISTS		
mifepristone tab (MIFEPREX equiv)	-	1
PROLACTIN INHIBITORS		
cabergoline tab (DOSTINEX equiv) (QL=16 tabs/30 days)	QL	1
SOMATOSTATIC AGENTS		
OCTREOTIDE INJ	AMSP-PA	3
octreotide inj (SANDOSTATIN equiv)	AMSP-PA	3
VASOPRESSIN RECEPTOR ANTAGONISTS		
tolvaptan tab (SAMSCA equiv) (QL= 1 tab/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	3
JYNARQUE PAK (QL= 2 tabs/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	4
JYNARQUE TAB 15MG (QL= 2 tabs/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	4
ESTROGENS		

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
ESTROGENS Cont.		
ESTROGEN COMBINATIONS		
esterified estrogens/methyltestosterone tab (ESTRATEST equiv)	-	1
estradiol/norethindrone tab (ACTIVELLA equiv)	-	1
jinteli tab (FEMHRT equiv)	-	1
ANGELIQ TAB	-	2
DUAVEE TAB	-	2
PREFEST TAB	-	2
PREMPHASE TAB, PREMPRO TAB	-	2
ESTROGENS		
estradiol patch (CLIMARA equiv) (QL= 4 patches/28 days)	QL	1
estradiol patch (VIVELLE-DOT equiv) (QL= 8 patches/28 days)	QL	1
estradiol tab (ESTRACE equiv)	-	1
estradiol valerate inj	-	1
EVAMIST SPRAY	-	2
MENEST TAB	-	2
MENOSTAR PATCH	-	2
PREMARIN TAB	-	2
FLUOROQUINOLONES		
FLUOROQUINOLONES		
CIPRO SUSP	-	1
CIPROFLOXACIN 100MG TAB	-	1

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
FLUOROQUINOLONES Cont.		
ciprofloxacin for oral susp 5gm/100ml	-	1
ciprofloxacin susp (CIPRO equiv)	-	1
ciprofloxacin tab 250mg, 500mg, 750mg (CIPRO equiv)	-	1
levofloxacin oral soln 25mg/ml	-	1
LEVOFLOXACIN SOLN	-	1
levofloxacin tab (LEVAQUIN equiv)	-	1
moxifloxacin tab (AVELOX equiv)	-	1
OFLOXACIN TAB	-	1
ofloxacin tab (FLOXIN equiv)	-	1
BAXDELA TAB (QL= 28 tabs/14 day)	QL	2
FACTIVE TAB (QL= 7 tabs/30 days)	QL	2
GASTROINTESTINAL AGENTS - MISC.		
ANTIFLATULENTS		
simethicone chew tab	OTC	1
simethicone drops	OTC	1
FARNESOID X RECEPTOR (FXR) AGONISTS		
OCALIVA TAB (Only available through Accredo 877-826-7657 or Walgreens 888-347-3416)	LD-PA	4
GALLSTONE SOLUBILIZING AGENTS		
ursodiol cap (ACTIGALL equiv)	-	1
ursodiol tab (URSO (FORTE) equiv)	-	1

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
GASTROINTESTINAL AGENTS - MISC. Cont.		
GASTROINTESTINAL CHLORIDE CHANNEL ACTIVATORS		
lubiprostone cap (QL=2 caps/day)	QL	1
GASTROINTESTINAL STIMULANTS		
metoclopramide soln (REGLAN equiv)	-	1
metoclopramide tab (REGLAN equiv)	-	1
INFLAMMATORY BOWEL AGENTS		
balsalazide cap (COLAZAL equiv)	-	1
mesalamine DR cap (DELZICOL equiv) (QL= 6 caps/day)	QL	1
MESALAMINE DR TAB	-	1
mesalamine DR tab 1.2 GM (LIALDA equiv) (QL 120 tabs/30 days)	QL	1
mesalamine enema (ROWASA equiv) (QL= 60mL/day)	QL	1
mesalamine ER cap (APRISO equiv) (QL= 8 caps/day)	QL	1
mesalamine supp (CANASA equiv) (QL= 1 supp/day)	QL	1
sulfasalazine EC tab (AZULFIDINE equiv)	-	1
sulfasalazine tab (AZULFIDINE equiv)	-	1
DIPENTUM CAP	-	2
INTESTINAL ACIDIFIERS		
lactulose soln	-	1
IRRITABLE BOWEL SYNDROME (IBS) AGENTS		
alosetron tab (LOTRONEX equiv)	-	1
PHOSPHATE BINDER AGENTS		

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
GASTROINTESTINAL AGENTS - MISC. Cont.		
calcium acetate cap (PHOSLO equiv)	-	1
calcium acetate tab (ELIPHOS equiv)	-	1
lanthanum carbonate chew tab 1000mg (QL=3 tabs/day; Step Therapy requires trial of sevelamer carbonate tab or sevelamer HCL tab)	QL-ST	1
lanthanum carbonate chew tab 500mg (QL=5 tabs/day; Step Therapy requires trial sevelamer carbonate tab or sevelamer HCL tab)	QL-ST	1
lanthanum carbonate chew tab 750mg (QL=3 tabs/day; Step Therapy requires trial sevelamer carbonate tab or sevelamer HCL tab)	QL-ST	1
sevelamer hydrochloride tab (RENAGEL equiv)	-	1
sevelamer powder pak (RENVELA equiv)	-	1
sevelamer tab (RENVELA TAB equiv)	-	1
PHOSLYRA SOLN	-	2
SEVELAMER HCL 400MG TAB	-	2
GENERAL ANESTHETICS		
VOLATILE ANESTHETICS		
desflurane liquid	-	1
isoflurane liquid	-	1
sevoflurane liquid	-	1
SUPRANE INHALATION SOLUTION	-	2
GENITOURINARY AGENTS - MISCELLANEOUS		
ALKALINIZERS		

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
GENITOURINARY AGENTS - MISCELLANEOUS Cont.		
CYTRA-3 SYRUP	OTC	1
potassium citrate CR tab (UROCIT-K TAB equiv)	-	1
potassium citrate/citric acid soln (POLYCITRA-K equiv)	-	1
sodium citrate/citric acid soln (BICITRA equiv)	OTC	1
ORACIT SOLN	-	2
CYTRA K CRYSTALS	-	3
GENITOURINARY IRRIGANTS		
SORBITOL-MANNITOL SOLN	-	1
INTERSTITIAL CYSTITIS AGENTS		
ELMIRON CAP (QL= 3 caps/day; ST requires trial of hydroxyzine)	QL-ST	2
PROSTATIC HYPERTROPHY AGENTS		
alfuzosin SR tab (UROXATRAL equiv)	-	1
dutasteride cap (AVODART equiv)	-	1
finasteride tab (PROSCAR equiv)	-	1
tamsulosin cap (FLOMAX equiv)	-	1
CARDURA XL TAB	-	2
URINARY ANALGESICS		
phenazopyridine tab 100mg	-	1
phenazopyridine tab 200mg	-	1
URINARY STONE AGENTS		
LITHOSTAT TAB	-	2

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
GENITOURINARY AGENTS - MISCELLANEOUS Cont.		
tiopronin dr tab (QL= 8 tabs/day)	AMSP-PA-QL	3
tiopronin tab (Only available through Eversana 636-519-2400; QL=8 tabs/day)	LD-PA-QL	3
GOUT AGENTS		
GOUT AGENT COMBINATIONS		
colchicine/probenecid tab (COL-BENEMID equiv)	-	1
GOUT AGENTS		
allopurinol tab (ZYLOPRIM equiv)	-	1
colchicine tab (COLCRYS equiv) (QL= 4 tabs/day)	QL	1
febuxostat tab (ULORIC equiv) (QL=1 tab/day)	QL	1
GLOPERBA SOLN (QL= 300ml/30 days)	QL	2
URICOSURICS		
probenecid tab (BENEMID equiv)	-	1
HEMATOLOGICAL AGENTS - MISC.		
ANTIHEMOPHILIC PRODUCTS		
ADVATE INJ 1000UNIT	AMSP-PA	4
ADVATE INJ 1500UNIT	AMSP-PA	4
ADVATE INJ 2000UNIT	AMSP-PA	4
ADVATE INJ 250UNIT	AMSP-PA	4
ADVATE INJ 3000UNIT	AMSP-PA	4
ADVATE INJ 4000UNIT	AMSP-PA	4
ADVATE INJ 500UNIT	AMSP-PA	4

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
HEMATOLOGICAL AGENTS - MISC. Cont.		
ALPROLIX INJ (Only available through Accredo 800-803-2523)	LD-PA	4
BENEFIX KIT	AMSP-PA	4
ELOCTATE INJ	AMSP-PA	4
HEMLIBRA INJ	AMSP-PA	4
HUMATE-P INJ	AMSP-PA	4
KOATE INJ	AMSP-PA	4
OBIZUR INJ (Only available through Caremark/CVS Specialty 800-237-2767)	LD-PA	4
PROFILNINE INJ	AMSP-PA	4
BRADYKININ B2 RECEPTOR ANTAGONISTS		
icatibant inj (QL=36 ml/30 days; Only available through Accredo 877-826-7657)	LD-PA-QL	3
icatibant inj (FIRAZYR equiv) (QL=36 ml/30 days)	LD-PA-QL-AM SP	3
HEMATORHEOLOGIC AGENTS		
pentoxifylline ER tab (TRENTAL equiv)	-	1
PLATELET AGGREGATION INHIBITORS		
anagrelide cap (AGRYLIN equiv)	-	1
cilostazol tab (PLETAL equiv)	-	1
clopidogrel tab 300mg (PLAVIX equiv) (QL= 4 tabs/30 days)	QL	1
clopidogrel tab 75mg (PLAVIX equiv)	-	1
dipyridamole tab (PERSANTINE equiv)	-	1
prasugrel tab (EFFIENT equiv) (QL=1 tab/day)	QL	1

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
HEMATOLOGICAL AGENTS - MISC. Cont.		
DURLAZA CAP	-	2
YOSPRALA ER TAB	-	2
TICLOPIDINE TAB	-	3
HEMATOPOIETIC AGENTS		
AGENTS FOR GAUCHER DISEASE		
miglustat cap (ZAVESCA equiv) (QL= 3 caps/day; Only available through Accredo 877-826-7657)	LD-PA-QL	3
CERDELGA CAP (QL= 1 cap/day; Only available through Accredo 877-826-7657)	LD-PA-QL	4
AGENTS FOR SICKLE CELL ANEMIA		
DROXIA CAP	-	2
SIKLOS TAB	-	2
AGENTS FOR SICKLE CELL DISEASE		
glutamine (sickle cell) powder pack (Step Therapy requires trial of hydroxyurea cap QL = 6 packets/day)	AMSP-QL-ST	3
COBALAMINS		
B-12 DOTS TAB	OTC	1
cyanocobalamin inj	-	1
vitamin b-12 er tab	OTC	1
vitamin b-12 tab 1000mcg	OTC	1
vitamin b-12 tab 500mcg	OTC	1
FOLIC ACID/FOLATES		

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
HEMATOPOIETIC AGENTS Cont.		
folic acid cap	OTC	1
folic acid tab 1mg	-	1
folic acid tab 800mcg (Covered for females only)	OTC	1
HEMATOPOIETIC GROWTH FACTORS		
ARANESP INJ (QL=4 syringes/30 days)	AMSP-PA-QL	4
ARANESP INJ (QL=4 vials/30 days)	AMSP-PA-QL	4
FULPHILA INJ (QL= 2 syringes/28 days)	AMSP-QL	4
MULPLETA TAB (QL= 7 tabs/fill, 3 fills/365 days; Only available through Lumicera 855-847-3553)	LMSP-PA-QL	4
NYVEPRIA INJ (QL=2 inj/28 days)	AMSP-QL	4
PROMACTA TAB	AMSP-PA-QL	4
RETACRIT INJ (QL= 12 vials/30 days)	AMSP-PA-QL	4
RETACRIT INJ (QL= 4 vials/30 days)	AMSP-PA-QL	4
ZARXIO INJ (QL=14 syringes/28 days)	AMSP-QL	4
ZARXIO INJ 480/0.8 (QL= 14 syringes/28days)	AMSP-QL	4
HEMATOPOIETIC MIXTURES		
abaneu sl tab	-	1
BIFERARX TAB	-	1
corvita 150 tab	-	1
ferocon cap	-	1
FERRAPLUS 90 TAB	-	1

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
HEMATOPOIETIC AGENTS Cont.		
ferrocite plus tab	-	1
folbee tab	OTC	1
FOLIVANE-PLUS CAP	-	1
HEMATOGEN FA CAP	-	1
ICAR-C PLUS TAB	-	1
iferex 150 forte cap	-	1
INTEGRA F CAP	-	1
iron 100 plus tab	OTC	1
IRON POLYSACCH/THREONIC ACID/B12/FA CAP	OTC	1
MTX SUPPORT TAB	OTC	1
MULTIGEN FOLIC TAB	-	1
MULTIGEN PLUS TAB	-	1
NEURIN-SL TAB	-	1
se-tan plus cap	-	1
TARON FORTE CAP	-	1
trigels-f forte cap	OTC	1
VIT 3 CAP	-	1
ACTIVE FE TAB	-	2
ANIMI-3 CAP	-	2
CENTRATEX CAP	-	2
DERMACINRX PUREFOLIX TAB	-	2

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
HEMATOPOIETIC AGENTS Cont.		
FERIVA 21-7 TAB	-	2
FUSION PLUS CAP	-	2
HEMATINIC PL TAB VITAMIN	-	2
HEMATRON-AF TAB	-	2
IROSPAN 24/6 PACK	-	2
PROFERRIN TAB	OTC	2
IRON		
FEOSOL TAB	OTC	1
FERROUS SULFATE LIQUID	OTC	1
ferrous sulfate soln	OTC	1
iron tab	OTC	1
poly-iron cap	OTC	1
HEMOSTATICS		
HEMOSTATICS - SYSTEMIC		
aminocaproic acid soln (AMICAR equiv)	-	1
tranexamic acid tab (LYSTEDA equiv) (QL= 6 tabs/day 30 tabs/28 days)	QL	1
HEMOSTATICS - TOPICAL		
MONSEL'S SOLN	-	1
THROMBI-GEL PAD	-	1
THROMBI-PAD	-	1
ARTISS INJ	-	2

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
HEMOSTATICS Cont.		
ASTRINGYN SOLN	-	2
AVITENE POWDER	-	2
AVITENE SHEET	-	2
ENDO-AVITENE SHEET	-	2
GELFOAM SPONGE	-	2
RECOTHROM INJ	-	2
HYPNOTICS		
ANTI-HISTAMINE HYPNOTICS		
diphenhydramine tab	OTC	1
HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS		
ANTI-HISTAMINE HYPNOTICS		
diphenhydramine cap	OTC	1
diphenhydramine ODT	OTC	1
diphenhydramine/acetaminophen tab	OTC	1
UNISOM SLEEPGELS 50MG	OTC	1
BARBITURATE HYPNOTICS		
phenobarbital tab	-	1
SECONAL CAP	-	2
NON-BARBITURATE HYPNOTICS		
estazolam tab (PROSOM equiv)	-	1
midazolam hcl syrup	-	1

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS Cont.		
MIDAZOLAM INJ	-	1
midazolam inj (MIDAZOLAM equiv)	-	1
temazepam cap 15mg (RESTORIL equiv)	-	1
temazepam cap 30mg (RESTORIL equiv)	-	1
zaleplon cap (SONATA equiv) (QL= 2 caps/day)	QL	1
zolpidem ER tab (AMBIEN CR equiv) (QL= 1 tab/day; Step Therapy requires trial of zolpidem tab)	QL-ST	1
zolpidem er tab 6.25mg (QL= 2 tabs/day)	QL	1
zolpidem tab 10 MG (AMBIEN equiv) (QL=1 tab/day)	QL	1
zolpidem tab 5 MG (AMBIEN equiv) (QL=2 tabs/day)	QL	1
ZOLPIMIST SPRAY (QL= 1 bottle/30 days)	QL	2
SELECTIVE MELATONIN RECEPTOR AGONISTS		
tasimelteon capsule	AMSP-PA	3
LAXATIVES		
BULK LAXATIVES		
fiber cap	OTC	1
fiber therapy powder	OTC	1
fiber therapy tab	OTC	1
LAXATIVE COMBINATIONS		
GAVILYTE-C SOLN	-	1
peg 3350/electrolytes soln (COLYTE equiv) (QL= 2 fills/calendar year)	QL	1

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
LAXATIVES Cont.		
senna-s tab	OTC	1
SENOKOT S TAB	OTC	1
sodium/potassium/magnesium soln (QL=2 fills/year)	QL	1
trilyte soln (NULYTELY equiv) (QL= 2 fills/calendar year)	QL	1
SUFLAVE SOLN	-	2
LAXATIVES - MISCELLANEOUS		
glycerin supp	OTC	1
lactulose soln	-	1
polyethylene glycol 3350 powder (MIRALAX equiv)	OTC	1
polyethylene glycol packet (MIRALAX equiv)	OTC	1
GIALAX KIT	-	2
SALINE LAXATIVES		
magnesium citrate soln	OTC	1
milk of magnesia susp	OTC	1
saline enema	OTC	1
OSMOPREP TAB	-	2
STIMULANT LAXATIVES		
bisacodyl supp	OTC	1
bisacodyl tab	OTC	1
SENNALAXATIVE	-	1
senna tab	OTC	1

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
LAXATIVES Cont.		
SURFACTANT LAXATIVES		
docusate cap	OTC	1
docusate liquid	OTC	1
docusate syrup	OTC	1
MACROLIDES		
AZITHROMYCIN		
azithromycin susp (ZITHROMAX equiv)	-	1
azithromycin tab (ZITHROMAX equiv)	-	1
ZITHROMAX POWDER PACK	-	2
CLARITHROMYCIN		
CLARITHROMYC SUSP	-	1
clarithromycin ER tab (BIAXIN XL equiv)	-	1
clarithromycin susp (BIAXIN equiv)	-	1
clarithromycin tab (BIAXIN equiv)	-	1
ERYTHROMYCINS		
E.E.S. TAB	-	1
ERYTHROCIN TAB	-	1
erythromycin DR cap (ERYC equiv)	-	1
erythromycin ethylsuccinate susp (ERYPED equiv)	-	1
erythromycin ethylsuccinate tab	-	1
erythromycin stearate tab	-	1

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
MACROLIDES Cont.		
erythromycin tab (ERY-TAB equiv)	-	1
erythromycin tab (ERYTHROMYCIN equiv) (all forms except PCE)	-	1
ERYTHROMYCIN DR CAP	-	2
ERYTHROMYCIN EC CAP	-	2
FIDAXOMICIN		
DIFICID SUSP (QL= 136 mL/10 days)	QL	2
DIFICID TAB (QL=20 tabs/10 days)	QL	2
MEDICAL DEVICES		
BANDAGES-DRESSINGS-TAPE		
PROVENT	-	1
MEDICAL DEVICES AND SUPPLIES		
BLOOD PRESSURE DEVICES		
BLOOD PRESSURE MONITOR	-	1
CONCEPTION ASSISTANCE SUPPLIES		
CONCEPTION KIT	-	1
CONTRACEPTIVES		
DIAPHRAGM	-	1
FEMALE CONDOMS	OTC	1
MALE CONDOMS	OTC	1
DIABETIC SUPPLIES		
CALIBRATION LIQUID	OTC	1

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
MEDICAL DEVICES AND SUPPLIES Cont.		
LANCET DEVICE	OTC	1
LANCET KIT	OTC	1
LANCET MISC	OTC	1
LANCETS	OTC	1
PUMP SUPPLIES	OTC	1
DEXCOM G6 RECEIVER (QL= 1 receiver/year)	PA-QL	2
DEXCOM G6 SENSOR (QL= 3 sensors/30 days)	PA-QL	2
DEXCOM G6 TRANSMITTER (QL= 4 transmitters/365 days)	PA-QL	2
DEXCOM G7 RECEIVER (QL=1 receiver/year)	PA-QL	2
DEXCOM G7 SENSOR (QL=3 sensors/30 days)	PA-QL	2
FREE LIBRE 3-PLUS SENSOR (QL = 2 sensors/30 days)	PA-QL	2
FREESTYLE LIBRE 2 (QL= 2 sensors/28 days)	PA-QL	2
FREESTYLE LIBRE 2 RECEIVER (QL= 1 receiver/year)	PA-QL	2
FREESTYLE LIBRE 2-PLUS SENSOR (QL= 2 sensors/30 days)	PA-QL	2
FREESTYLE LIBRE 3 READER (QL = 1 receiver/1 year)	PA-QL	2
FREESTYLE LIBRE KIT 3 SENSOR (QL= 2 sensors/28 days)	PA-QL	2
FREESTYLE LIBRE RECEIVER (QL= 1 receiver/year)	PA-QL	2
FREESTYLE LIBRE SENSOR (10-DAY) (QL= 3 sensors/30 days)	PA-QL	2
FREESTYLE LIBRE SENSOR (14-DAY) (QL= 2 sensors/28 days)	PA-QL	2
OMNIPOD 5 G6 INTRO KIT (QL= 1 kit/year)	QL	2
OMNIPOD 5 G6 MIS PODS (QL= 15 pods/30 days)	QL	2

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
MEDICAL DEVICES AND SUPPLIES Cont.		
OMNIPOD 5 G6 PODS MISC (QL= 15 pods/30 days)	QL	2
OMNIPOD 5 G7 KIT INTRO (QL= 1 kit/year)	QL	2
OMNIPOD 5 G7 MIS PODS (QL= 15 pods/30 days)	QL	2
OMNIPOD 5 INTRO KIT (QL= 1 kit/year)	QL	2
OMNIPOD 5 PACK PODS (QL = 15 pods/30 days)	QL	2
OMNIPOD 5 PACK PODS (QL= 15 pods/30 days)	QL	2
OMNIPOD DASH INTRO KIT (QL= 1 kit/year)	QL	2
OMNIPOD DASH PODS (QL= 15 pods/30 days)	QL	2
OMNIPOD GO KIT 20UNT/DY (QL= 10 pods/month)	QL	2
OMNIPOD GO KIT 30UNT/DY (QL= 10 pods/month)	QL	2
OMNIPOD GO KIT 40UNT/DY (QL= 10 pods/month)	QL	2
OMNIPOD GO KIT (QL= 10 pods/month)	QL	2
OMNIPOD STARTER KIT (QL= 1 kit/year)	QL	2
GI-GU OSTOMY & IRRIGATION SUPPLIES		
EXU-DRY BANDAGE	-	2
IMPOTENCE AIDS		
RAPPORT VACUUM THERAPY KIT	-	1
PARENTERAL THERAPY SUPPLIES		
ACCU-CHEK TENDER	-	1
HYPODERMIC NEEDLES	OTC	1
INSUFLON	-	1

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
MEDICAL DEVICES AND SUPPLIES Cont.		
LANCETS	OTC	1
PUMP SUPPLIES	OTC	1
SAFETYGLIDE SYRINGE	OTC	1
SHARPS CONTAINER	OTC	1
BD INSULIN SYRINGES	--OTC	2
BD PEN NEEDLES	OTC	2
RESPIRATORY THERAPY SUPPLIES		
TRACHEOSTOMY CARE KIT	-	1
AEROCHAMBER (QL= 1 device/365 days)	OTC-QL	2
MIGRAINE PRODUCTS		
CALCITONIN GENE-RELATED PEPTIDE (CGRP) RECEPTOR ANTAG		
AJOVY INJ (QL= 1 inj/28 days)	PA-QL	2
MIGRAINE COMBINATIONS		
MIGERGOT SUPP	-	2
ACETAMINOPHEN/ISOMETHEPTENE/DICHLORAL CAP	-	3
MIGRAINE PRODUCTS - MONOCLONAL ANTIBODIES		
AJOVY INJ (QL= 1 inj/28 days)	PA-QL	2
EMGALITY INJ (QL= 1 inj/28 days)	PA-QL	2
SEROTONIN AGONISTS		
naratriptan tab (AMERGE equiv) (QL= 9 tabs/30 days)	QL	1
rizatriptan ODT (MAXALT equiv) (QL= 12 tabs/30 days)	QL	1

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
MIGRAINE PRODUCTS Cont.		
rizatriptan tab (MAXALT equiv) (QL= 12 tabs/30 days)	QL	1
sumatriptan nasal spray (IMITREX, SUMATRIPTAN equiv) (QL= 6 sprays/30 days; ST req trial of 2: naratriptan tab, rizatriptan tab/ODT, zolmitriptan tab, or sumatriptan tab)	QL-ST	1
sumatriptan tab (IMITREX equiv) (QL= 9 tabs/30 days)	QL	1
sumatriptan vial inj (IMITREX equiv) (QL=4 ml/30 days; ST req trial of 2: naratriptan tab, rizatriptan tab/ODT, zolmitriptan tab, or sumatriptan tab)	QL-ST	1
zolmitriptan tab (ZOMIG equiv) (QL= 9 tabs/30 days)	QL	1
MINERALS & ELECTROLYTES		
CALCIUM		
calcium carbonate tab	OTC	1
CALCIUM CITRATE TAB 200MG	OTC	1
calcium citrate/vitamin d3 tab	OTC	1
calcium citrate/vitamin d3 tab 315mg/200unit	OTC	1
calcium/vitamin d3 tab	OTC	1
calcium/vitamin d3 tab 600mg/200unit	OTC	1
calcium/vitamin d3 tab 600mg/400unit	OTC	1
calcium/vitamin d3 tab 600mg/800unit	OTC	1
CITRACAL MAXIMUM TAB	OTC	1
ELECTROLYTE MIXTURES		
oral electrolyte soln	OTC	1
FLUORIDE		

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
MINERALS & ELECTROLYTES Cont.		
sodium fluoride chew tab (LURIDE equiv)	-	1
sodium fluoride soln (LURIDE equiv)	OTC	1
SODIUM FLUORIDE TAB	-	1
FLORIVA DROPS	-	2
FLURA-DROPS	-	2
IODINE PRODUCTS		
STRONG IODINE SOLN	-	1
MAGNESIUM		
MAG 64 TAB	OTC	1
magnesium chloride dr tab	OTC	1
MAGNESIUM OXIDE CHEW TAB	OTC	1
magnesium oxide tab	OTC	1
magnesium oxide tab 400mg	OTC	1
magnesium tab 400mg	OTC	1
PHOSPHATE		
potassium phosphate monobasic tab (QL=8 tabs/day)	QL	1
POTASSIUM		
potassium chloride ER cap (MICRO-K equiv)	-	1
POTASSIUM CHLORIDE ER TAB	-	1
potassium chloride ER tab (K-TAB equiv)	-	1
potassium chloride micro tab (K-DUR equiv)	-	1

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
MINERALS & ELECTROLYTES Cont.		
potassium chloride powder packet (KLOR-CON equiv)	-	1
potassium chloride soln	-	1
EFFER-K TAB	-	2
POT/CHLORIDE EFFER TAB	-	2
SODIUM		
sodium chloride tab	OTC	1
ZINC		
zinc cap	OTC	1
GALZIN CAP	-	2
MISCELLANEOUS THERAPEUTIC CLASSES		
CHELATING AGENTS		
penicillamine tab (DEPEN TITRATAB equiv) (QL= 480 tabs/30 days)	QL	1
trientine cap 250mg (ST req trial of generic penicillamine tab)	ST	1
CONTINUOUS RENAL REPLACEMENT THERAPY (CRRT) SOLUTIONS		
SODIUM CITRATE IN SODIUM CHLORIDE SOLN	-	1
DIGITAL THERAPY		
DIGITAL THERAPY APPLICATION - SLEEP (QL=1 membership/lifetime)	OTC-PA-QL	2
IMMUNOMODULATORS		
lenalidomide cap (QL= 1 cap/day; Only available through Onco360 877-662-6633)	LD-PA-QL	3
IMMUNOSUPPRESSIVE AGENTS		
everolimus tab (ZORTRESS equiv) (QL=2 tabs/day)	QL	1

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
MISCELLANEOUS THERAPEUTIC CLASSES Cont.		
ASTAGRAF XL CAP	-	2
MYHIBBIN SUSP	-	2
PROGRAF PACKET	-	2
POTASSIUM REMOVING AGENTS		
LOKELMA PAK (QL=1 pak/day; Step Therapy requires trial of 1 diuretic: chlorothiazide, chlorthalidone, bumetanide, hydrochlorothiazide, torsemide, indapamide, furosemide, ethacrynic acid, metolazone, chlorothiazide or hydrochlorothiazide)	QL-ST	2
MOUTH/THROAT/DENTAL AGENTS		
ANESTHETICS TOPICAL ORAL		
LIDOCAINE ORAL SOLN 4%	-	1
ANTI-INFECTIVES - THROAT		
clotrimazole troches (MYCELEX TROCHES equiv)	-	1
nystatin susp	-	1
ANTISEPTICS - MOUTH/THROAT		
chlorhexidine gluconate soln (PERIDEX equiv)	-	1
DEBACTEROL SOLN	-	2
DENTAL PRODUCTS		
sodium fluoride cream (PREVIDENT equiv)	-	1
sodium fluoride gel (PREVIDENT equiv)	-	1
sodium fluoride/potassium nitrate paste (PREVIDENT equiv)	-	1

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
MOUTH/THROAT/DENTAL AGENTS Cont.		
PREVIDENT GEL (Excluded for members age 19 years and older)	-	2
sodium fluoride paste (PREVIDENT equiv)	-	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
GELCLAIR GEL	-	2
NUMOISYN LOZENGE	-	2
ORAMAGICRX MOUTHWASH	-	2
MULTIVITAMINS		
B-COMPLEX VITAMINS		
vitamin b complex cap	OTC	1
B-COMPLEX W/ FOLIC ACID		
dailyvite tab	OTC	1
DIALYVITE 800 WITH IRON TAB	OTC	1
DIALYVITE TAB	-	1
FOLBEE PLUS CZ TAB	-	1
folbee plus tab	-	1
mynephron cap	OTC	1
NEPHPLEX RX TAB	-	1

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
MULTIVITAMINS Cont.		
VITAL-D RX TAB	-	1
vitamin b complex cap	OTC	1
DIALYVITE 5000 TAB	-	2
SUPERVITE LIQUID	-	2
BIOFLAVONOID PRODUCTS		
VITAMIN C CHEW TAB	OTC	1
MULTIPLE VITAMINS W/ IRON		
multi vitamin with iron tab	OTC	1
MULTIPLE VITAMINS W/ MINERALS		
MVW COMPLETE MULTIVITAMIN CAP	OTC	1
vision formula tab	OTC	1
CORVITE TAB	-	2
FORTAVIT CAP	-	2
NICADAN TAB	-	2
NICAZEL TAB	-	2
REQ49 PLUS TAB	-	2
MULTIVITAMINS		
daily multi vitamin tab	OTC	1
ONE-A-DAY MENS TAB	OTC	1
PED MULTI VITAMINS W/FL & FE		
multivitamin/flouride/iron drops	OTC	1

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
MULTIVITAMINS Cont.		
POLY-VI-FLOR WITH IRON DROPS	-	2
PED MV W/ FLUORIDE		
ADC/FLUORIDE DROP	-	1
FLORIVA PLUS DROPS	-	1
pediatric multiple vitamins/fluoride soln	OTC	1
tri-vitamin with fluoride drops	-	1
POLY-VI-FLOR DROPS	-	2
QUFLORA PEDIATRIC CHEW TAB	-	2
TRI-VI-FLOR DROPS	-	2
PEDIATRIC MULTIPLE VITAMINS		
POLY-VI-SOL DROPS	OTC	1
poly-vita drops	OTC	2
PEDIATRIC MULTIPLE VITAMINS & MINERALS W/ FLUORIDE		
FLORIVA CHEW TAB	-	2
PEDIATRIC VITAMINS		
pedia tri-vite drops	OTC	1
PRENATAL VITAMINS		
O-CAL PRENATAL TAB	-	1
PNV-SELECT TAB	-	1
PRENATABS RX TAB	-	1
PRENATAL 19 CHEW TAB	-	1

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
MULTIVITAMINS Cont.		
PRENATAL 19 TAB	OTC	1
PRENATAL VITAMINS (NON-PREFERRED)	-	1
VINATE II TAB	-	1
VINATE ONE	-	1
VITAFOL-OB+DHA PACK	-	1
VIVA DHA CAP	-	1
CITRANATAL RX TAB	-	2
COMPLETE NATAL DHA PACK	-	2
DUET DHA 400 PACK	-	2
NEXA PLUS CAP	-	2
OB COMPLETE TAB	-	2
OBSTETRIX EC TAB	-	2
PREFERAOB ONE CAP	-	2
PRENATA CHEW TAB	-	2
PRENATAL VITAMINS (NON-PREFERRED)	-	2
PRENATAL VITAMINS (PRENATAL PLUS, PREPLUS, PRENAPLUS)	OTC	2
PRENATE DHA CAP	-	2
PRENATE ENHANCE CAP	-	2
PRENATE RESTORE CAP	-	2
VITAMEDMD ONE RX CAP	-	2
SPECIALTY VITAMINS PRODUCTS		

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
MULTIVITAMINS Cont.		
multivitamin tab	OTC	1
MUSCULOSKELETAL THERAPY AGENTS		
CENTRAL MUSCLE RELAXANTS		
baclofen tab (BACLOFEN equiv)	-	1
BACLOFEN TAB 5MG	-	1
carisoprodol tab (SOMA equiv) (Step Therapy requires trial of 2: cyclobenzaprine, tizanidine, methocarbamol, or orphenadrine ER)	ST	1
chlorzoxazone tab 250mg (QL=4 tabs/day)	QL	1
chlorzoxazone tab 500mg	-	1
cyclobenzaprine tab (FLEXERIL equiv)	-	1
methocarbamol tab (ROBAXIN equiv)	-	1
orphenadrine citrate ER tab (NORFLEX equiv)	-	1
tizanidine tab (ZANAFLEX equiv)	-	1
MUSCLE RELAXANT COMBINATIONS		
CARISOPRODOL/ASPIRIN TAB	-	1
carisoprodol/aspirin tab (SOMA COMPOUND equiv)	-	1
CARISOPRODOL/ASPIRIN/CODEINE TAB	-	1
TIZANIDINE COMFORT KIT	-	2
NASAL AGENTS - SYSTEMIC AND TOPICAL		
NASAL AGENTS - MISC.		
OCEAN NASAL SPRAY 0.65%	OTC	1

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
NASAL AGENTS - SYSTEMIC AND TOPICAL Cont.		
saline nasal spray	OTC	1
TICANASE PAK	-	2
NASAL STEROIDS		
fluticasone nasal spray (FLONASE equiv) (QL= 16gm/30 days)	QL	1
triamcinolone OTC nasal spray (NASACORT equiv)	OTC	1
BECONASE AQ NASAL SPRAY (QL= 1 bottle/15 days; 2 fills/month)	QL	2
QNASL CHILDRENS NASAL SPRAY	-	2
ZETONNA NASAL SPRAY (QL= 1 bottle/30 days)	QL	2
SYMPATHOMIMETIC DECONGESTANTS		
cvs nasal decongestant cap (QL=240 caps/30 days)	QL	1
epinephrine hcl nasal soln (ADRENALIN equiv)	-	1
pseudoephedrine ER tab 120mg (QL= 2 tabs/day)	QL	1
pseudoephedrine tab 30mg (QL= 8 tabs/day)	QL	1
pseudoephedrine tab 60mg (QL= 4 tabs/day)	QL	1
zephrex-d tab 30mg (QL= 240 tabs/30 days)	OTC-QL	1
NEUROMUSCULAR AGENTS		
ALS AGENTS		
riluzole tab (RILUTEK equiv) (QL=2 tabs/day)	AMSP-QL	3
EXSERVAN FILM (Only available through PantherRx Pharmacy 855-726-8479; QL=60 films/30 days)	LD-PA-QL	4
NUTRIENTS		

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
NUTRIENTS Cont.		
LIPOTROPICS		
LIPOCHOL PLUS TAB	OTC	2
MISC. NUTRITIONAL SUBSTANCES		
CARDIOVID PLUS CAP	-	1
fish oil cap	OTC	1
fish oil dr cap	OTC	1
prenatal dha cap	OTC	1
PROTEINS		
theanine cap	OTC	1
OPHTHALMIC AGENTS		
ARTIFICIAL TEARS AND LUBRICANTS		
artificial tear drops	OTC	1
artificial tears	OTC	1
artificial tears soln	-	1
LACRISERT INSERT	-	2
lubricant eye oint	OTC	2
REFRESH CLASSIC DROPS	OTC	2
REFRESH OPHTH GEL 1%	OTC	2
BETA-BLOCKERS - OPHTHALMIC		
betaxolol ophth soln (BETOPTIC-S equiv)	-	1
CARTEOLOL OPHTH SOLN	-	1

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
OPHTHALMIC AGENTS Cont.		
carteolol ophth soln (OCUPRESS equiv)	-	1
dorzolamide/timolol (pf) ophth soln (Step Therapy requires trial of dorzolamide/timol ophth soln)	ST	1
dorzolamide/timolol ophth soln (COSOPT equiv)	-	1
LEVOBUNOLOL OPTH SOLN	-	1
levobunolol ophth soln (BETAGAN equiv)	-	1
METIPRANOLOL OPTH SOLN	-	1
timolol maleate ophth soln 0.25% (TIMOPTIC equiv)	-	1
timolol maleate ophth soln 0.5% (TIMOPTIC equiv)	-	1
CONTACT LENS SOLUTIONS		
RENU REWETTING DROPS	-	1
CYCLOPLEGIC MYDRIATICS		
atropine ophth oint	-	1
ATROPINE OPTH SOLN	-	1
atropine ophth soln (ISOPTO ATROPINE equiv) (QL=1 bottle/30 days)	--QL	1
cyclopentolate ophth soln (CYCLOGYL equiv)	-	1
homatropine ophth soln (ISOPTO HOMATROPINE equiv)	-	1
phenylephrine ophth soln (MYDFRIN equiv)	-	1
tropicamide ophth soln (MYDRIACYL equiv)	-	1
CYCLOMYDRIL OPTH SOLN	-	2
MIOTICS		

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
OPHTHALMIC AGENTS Cont.		
pilocarpine ophth soln (ISOPTO CARPINE equiv)	-	1
OPHTHALMIC ADRENERGIC AGENTS		
brimonidine ophth soln 0.15% (ALPHAGAN P 0.15% equiv) (Step Therapy requires trial of brimonidine ophth soln 0.2%)	ST	1
brimonidine ophth soln 0.2% (ALPHAGAN equiv)	-	1
OPHTHALMIC ANTI-INFECTIVES		
BACITRACIN OPHTH OINT	-	1
bacitracin/neomycin/polymyxin b ophth oint (NEOSPORIN equiv)	-	1
bacitracin/polymyxin b ophth oint (POLYSPORIN equiv)	-	1
BLEPH-10 OPHTH SOLN	-	1
ciprofloxacin ophth soln (CILOXAN equiv)	-	1
erythromycin ophth oint	-	1
gatifloxacin ophth soln (ZYMAXID equiv)	-	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) (QL=3 ml/7 days; Step therapy requires trial of ciprofloxacin ophth soln, levofloxacin ophth soln, or ofloxacin ophth soln)	QL-ST	1
NEOMYCIN/POLYMIXIN/GRAMICIDIN OPHTH SOLN	-	1

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
OPHTHALMIC AGENTS Cont.		
ofloxacin ophth soln (OCUFLOX equiv)	-	1
polymyxin b/trimethoprim ophth soln (POLYTRIM equiv)	-	1
SULFACETAMIDE SODIUM OPHTH OINT	-	1
sulfacetamide sodium ophth soln (BLEPH-10 equiv)	-	1
tobramycin ophth soln (TOBREX equiv)	-	1
TRIFLURIDINE OPHTH SOLN	-	1
trifluridine ophth soln (VIROPTIC equiv)	-	1
AZASITE SOLN	-	2
CILOXAN OPHTH OINT	-	2
MITOSOL KIT	-	2
NATACYN OPHTH SUSP (QL=45 ml/30 days)	QL	2
TOBREX OPHTH OINT	-	2
ZIRGAN OPHTH GEL	-	2
OPHTHALMIC IMMUNOMODULATORS		
cyclosporine ophth emulsion (QL=60 vials/30 days)	QL	1
OPHTHALMIC LOCAL ANESTHETICS		
ALCAINE OPHTH SOLN	-	1
proparacaine ophth soln (ALCAINE equiv)	-	1
AKTEN OPHTH GEL	-	2
OPHTHALMIC STEROIDS		
bacitracin/polymyxin/neomycin/hydrocortisone ophth oint (CORTISPORIN equiv)	-	1

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
OPHTHALMIC AGENTS Cont.		
DEXAMETHASONE OPHTH SOLN	-	1
fluorometholone ophth soln (FML LIQUIFILM equiv)	-	1
loteprednol etabonate ophth gel (LOTEMAX equiv) (QL= 5 grams/28 days)	QL	1
neomycin/polymyxin/dexamethasone ophth oint (MAXITROL equiv)	-	1
neomycin/polymyxin/dexamethasone ophth soln (MAXITROL equiv)	-	1
NEOMYCIN/POLYMYXIN/HYDROCORTISONE OPHTH SOLN	-	1
prednisolone acetate ophth susp	-	1
PREDNISOLONE OPHTH SUSP	-	1
PREDNISOLONE SODIUM PHOSPHATE OPHTH SOLN	-	1
PREDNISOLONE-GATIFLOXACIN-BROMFENAC SUSP	-	1
sulfacetamide sodium/prednisolone ophth soln (VASOCIDIN equiv)	-	1
SULFACETAMIDE/PREDNISOLONE OPHTH SOLN	-	1
tobramycin/dexamethasone ophth soln (TOBRADEX equiv)	-	1
BLEPHAMIDE OPHTH SOLN	-	2
BLEPHAMIDE S.O.P. OPHTH OINT	-	2
FLAREX OPHTH SUSP	-	2
FML FORTE OPHTH SUSP	-	2
FML S.O.P. OPHTH OINT	-	2
LOTEMAX OPHTH OINT	-	2
MAXIDEX OPHTH SOLN	-	2
PRED MILD OPHTH SOLN	-	2

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
OPHTHALMIC AGENTS Cont.		
PRED-G OPTH SOLN	-	2
PRED-G S.O.P OPTH OINTMENT	-	2
TOBRADEX OPTH OINT	-	2
ZYLET OPTH SUSP	-	2
OPHTHALMIC SURGICAL AIDS		
GELFILM	-	2
OPHTHALMICS - MISC.		
altafluor benox ophth soln	-	1
azelastine ophth soln (OPTIVAR equiv)	-	1
brinzolamide ophth susp (AZOPT equiv) (Step Therapy requires trial of dorzolamide 2% ophth soln)	ST	1
CROMOLYN OPTH SOLN	-	1
diclofenac sodium ophth soln (VOLTAREN equiv)	-	1
dorzolamide ophth soln (TRUSOPT equiv)	-	1
fluorescein/proparacaine ophth soln	-	1
ketorolac ophth soln .05% (ACULAR (LS) equiv)	-	1
ketorolac ophth soln .4% (ACULAR (LS) equiv)	-	1
MURO-128 OINT 5%	OTC	1
olopatadine ophth soln 0.1% (PATANOL equiv)	-	1
sodium chloride drops	OTC	1
sodium chloride oint	OTC	1

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
OPHTHALMIC AGENTS Cont.		
ACUVAIL OPTH SOLN	-	2
ALOCRIL OPTH SOLN	-	2
ALOMIDE OPTH SOLN	-	2
LASTACFT OPTH SOLN	-	2
NEVANAC OPTH SUSP, ILEVRO OPTH SUSP	-	2
PAREMYD DROPS	-	2
PAZEO OPTH SOLN	-	2
ZERVIAE OPTH SOLN (QL= 30 single use containers/30 days)	QL	2
PROSTAGLANDINS - OPHTHALMIC		
bimatoprost ophth soln (Step Therapy requires trial of latanoprost ophth soln; QL=2.5ml/25 days)	QL-ST	1
latanoprost ophth soln (XALATAN equiv)	-	1
tafluprost preservative free (pf) ophth soln (QL=30 pouches/30 days)	QL	1
travoprost ophth soln (TRAVATAN Z equiv) (Step Therapy requires trial of latanoprost ophth soln)	ST	1
LATANOPROST OPTH SOLN (QL=30 single use containers/30 days; Step therapy requires trial of latanoprost ophth soln)	QL-ST	2
OTIC AGENTS		
OTIC AGENTS - MISCELLANEOUS		
acetic acid otic soln (VOSOL equiv)	-	1
DEBROX OTIC SOLN	OTC	1

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
OTIC AGENTS Cont.		
ear wax removal drops	OTC	1
OTIC ANTI-INFECTIVES		
ciprofloxacin hcl otic soln	-	1
ofloxacin otic soln (FLOXIN equiv)	-	1
OTIC COMBINATIONS		
CIPROFLOXACIN/FLUOCINOLONE OTIC SOLN (QL= 1 bottle/7 days)	QL	1
neomycin/polymixin/hydrocortisone otic soln (CORTISPORIN equiv)	-	1
neomycin/polymixin/hydrocortisone otic susp (CORTISPORIN equiv)	-	1
ANTIPYRINE/BENZOCAINE OTIC SOLN 1.4-5.5%	-	2
CIPRO HC OTIC SUSP	-	2
OXYTOCICS		
ABORTIFACIENTS/AGENTS FOR CERVICAL RIPENING		
CERVIDIL INSERTS	-	2
PREPIDIL GEL	-	2
PROSTIN E2 SUPP	-	2
OXYTOCICS		
methylergonovine tab (METHERGINE equiv)	-	1
PASSIVE IMMUNIZING AGENTS		
IMMUNE SERUMS		
HIZENTRA INJ (Only available through Emerging Health 971-290-2010)	LD	2
HYPERRHO S-D INJ	-	2

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
PASSIVE IMMUNIZING AGENTS Cont.		
HYPERTET S-D INJ	-	2
PASSIVE IMMUNIZING AGENTS - COMBINATIONS		
HYQVIA INJ (Only available through Walgreens 888-347-3416)	LD-PA	2
PASSIVE IMMUNIZING AND TREATMENT AGENTS		
IMMUNE SERUMS		
CUTAQUIG INJ (QL= 576ml/28 days; Only available through Caremark/CVS Specialty 800-237-2767)	LD-PA-QL	2
GAMASTAN INJ	-	2
GAMMAGARD LIQUID INJ (QL= 690ml/28 days)	PA-QL	2
GAMUNEX-C INJ (QL= 960ml/28 days)	PA-QL	2
HIZENTRA INJ (Only available through Emerging Health 971-290-2010)	LD	2
HYPERHEP B INJ	-	2
KEDRAB INJ	-	2
NABI-HB INJ	-	2
WINRHO SDF INJ	-	2
XEMBIFY INJ (Only available through OPTUM - 877-445-6874)	LD	2
MONOCLONAL ANTIBODIES		
SYNAGIS INJ (QL=2 inj/28 days)	LMSP-PA-QL	4
SYNAGIS INJ (QL=2 inj/28 days)	LMSP-PA-QL	4
PENICILLINS		
AMINOPENICILLINS		

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
PENICILLINS Cont.		
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 (PRINCIPEN equiv)	-	1
ampicillin susp	-	1
MOXATAG TAB	-	2
NATURAL PENICILLINS		
penicillin g potassium inj	-	1
PENICILLIN VK SOLN	-	1
penicillin vk tab (VEETIDS equiv)	-	1
PENICILLIN COMBINATIONS		
AMOXICILLIN/CLAVULANATE CHEW TAB	-	1
amoxicillin/clavulanate chew tab (AUGMENTIN equiv)	-	1
AMOXICILLIN/CLAVULANATE ER TAB	-	1
amoxicillin/clavulanate susp (AUGMENTIN ES equiv)	-	1
amoxicillin/clavulanate tab (AUGMENTIN equiv)	-	1
PENICILLINASE-RESISTANT PENICILLINS		
dicloxacillin cap (DYNAPEN equiv)	-	1
PROGESTINS		

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
PROGESTINS Cont.		
PROGESTINS		
medroxyprogesterone tab (PROVERA equiv)	-	1
megestrol ES susp (MEGACE ES equiv)	-	1
MEGESTROL SUSP	-	1
norethindrone tab (AYGESTIN equiv)	-	1
progesterone cap (PROMETRIUM equiv)	-	1
hydroxyprogesterone inj (QL=4 vials/28 days)	AMSP-PA-QL	3
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.		
AGENTS FOR CHEMICAL DEPENDENCY		
disulfiram tab (ANTABUSE equiv)	-	1
lofexidine tab (QL= 224 tablets/fill; 1 fill/month)	QL	1
ANTIDEMENTIA AGENTS		
donepezil ODT (ARICEPT equiv)	-	1
donepezil tab 10mg (ARICEPT equiv) (QL=60 tabs/30 days)	QL	1
donepezil tab 23mg (ARICEPT equiv) (QL=1 tab/day)	QL	1
donepezil tab 5mg (ARICEPT equiv) (QL=60 tabs/30 days)	QL	1
galantamine ER cap (RAZADYNE ER equiv) (QL= 1 cap/day)	QL	1
GALANTAMINE SOLN	-	1
galantamine tab (RAZADYNE equiv) (QL= 2 tabs/day)	QL	1
memantine ER cap (NAMENDA XR equiv) (QL= 1 cap/day; Step Therapy requires trial of memantine tab)	QL-ST	1

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. Cont.		
memantine tab	-	1
rivastigmine cap (EXELON equiv)	-	1
NAMENDA XR TITRATION PACK (QL= 28 caps/28 days, Step Therapy requires tri: of memantine tab)	QL-ST	2
NAMZARIC CAP	-	2
NAMZARIC STARTER PACK	-	2
MOVEMENT DISORDER DRUG THERAPY		
tetrabenazine tab (XENAZINE equiv)	-	1
MULTIPLE SCLEROSIS AGENTS		
dalfampridine ER tab (AMPYRA equiv)	AMSP-PA	3
dimethyl fumarate DR cap (TECFIDERA equiv) (QL= 2 caps/day)	AMSP-QL	3
dimethyl fumarate DR starter pack (TECFIDERA STARTER PACK equiv) (QL= 2 caps/day)	AMSP-QL	3
fingolimod hcl cap 0.5mg (QL=1 cap/day)	AMSP-QL	3
glatiramer inj 20mg/ml (COPAXONE equiv) (QL= 30 syringes (30ml)/30 days)	AMSP-QL	3
glatiramer inj 40mg/ml (QL= 12 syringes (12ml)/28 days)	AMSP-QL	3
teriflunomide tab (QL= 1 tab/day)	AMSP-QL	3
AVONEX INJ (QL=1 inj/28 days)	AMSP-QL	4
PREMENSTRUAL DYSPHORIC DISORDER (PMDD) AGENTS		
FLUOXETINE CAP (PMDD)	-	2
PSEUDOBULBAR AFFECT (PBA) AGENTS		

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. Cont.		
NUDEXTA CAP (QL= 2 caps/day; Step therapy requires trial of 1 SSRI AND 1 TCA)	QL-ST	2
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.		
ERGOLOID MESYLATES TAB	-	1
ergoloid mesylates tab (HYDERGINE equiv)	-	1
RESTLESS LEG SYNDROME (RLS) AGENTS		
HORIZANT TAB (QL= 30 tabs/30 days)	PA-QL	2
HORIZANT TAB 600MG (QL= 60 tabs/30 days)	PA-QL	2
SMOKING DETERRENTS		
bupropion SR tab (ZYBAN equiv)	SMKG	1
nicotine gum (NICORETTE equiv)	OTC-SMKG	1
nicotine lozenge (COMMIT equiv)	OTC-SMKG	1
nicotine patch (NICODERM equiv)	OTC-SMKG	1
varenicline tartrate tab	SMKG	1
varenicline tartrate tab start pack	SMKG	1
CHANTIX PAK (Limited to 180 days/plan year)	QL-SMKG	2
CHANTIX TAB	SMKG	2
NICOTROL INHALER	SMKG	2
NICOTROL NASAL SPRAY	SMKG	2
RESPIRATORY AGENTS - MISC.		
CYSTIC FIBROSIS AGENTS		

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
RESPIRATORY AGENTS - MISC. Cont.		
KALYDECO PAK (Only available through Walgreens 888-347-3416)	LD-PA	4
KALYDECO PAK (QL=2 packets/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	4
KALYDECO PAK 13.4MG (QL=2 packets/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	4
KALYDECO TAB (QL= 2 tabs/day; Only available through Walgreens 888-347-3416)	LD-QL	4
ORKAMBI GRANULES PACKET (QL= 2 packets/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	4
ORKAMBI TAB (Only available through Walgreens 888-347-3416)	LD-PA	4
PULMOZYME INH SOLN (QL= 30 ampules/30 days)	AMSP-QL-RDX	4
SYMDEKO TAB (QL= 2 tabs/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	4
PULMONARY FIBROSIS AGENTS		
pirfenidone cap (QL=3 caps/day)	AMSP-PA-QL	3
PIRFENIDONE TAB (QL=4 tabs/day; Only available through Lumicera 855-847-3555)	LD-PA-QL	3
pirfenidone tab 267mg (QL=9 tabs/day)	AMSP-PA-QL	3
pirfenidone tab 801mg (QL=3 tabs/day)	AMSP-PA-QL	3
RESPIRATORY AGENTS - MISC.		
CUROSURF INJ	-	2
INFASURF INJ	-	2
SURVANTA INJ	-	2
SULFONAMIDES		

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
SULFONAMIDES Cont.		
SULFONAMIDES		
sulfadiazine tab (QL=8 tabs/day)	QL	1
TETRACYCLINES		
TETRACYCLINE COMBINATIONS		
AVIDOXY DK KIT	-	2
BENZODOX PAK	-	2
TETRACYCLINES		
demeclocycline tab (DECLOMYCIN equiv)	-	1
doxycycline hyclate cap 100mg	-	1
doxycycline hyclate cap 50mg	-	1
doxycycline hyclate DR tab 100mg (DORYX equiv) (QL= 2 tabs/day)	QL	1
doxycycline hyclate tab 100mg	-	1
doxycycline hyclate tab 20mg	-	1
doxycycline monohydrate cap (MONODOX equiv) (QL= 2 caps/day)	QL	1
doxycycline monohydrate tab (ADOXA equiv) (QL= 2 tabs/day)	QL	1
doxycycline susp (VIBRAMYCIN equiv)	-	1
minocycline cap (MINOCIN equiv)	-	1
minocycline er tab 65mg	-	1
minocycline tab (DYNACIN equiv)	-	1
tetracycline cap	-	1
DORYX MPC TAB 120MG	-	2

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
TETRACYCLINES Cont.		
VIBRAMYCIN SYRUP	-	2
XIMINO CAP	-	2
THYROID AGENTS		
ANTITHYROID AGENTS		
methimazole tab (TAPAZOLE equiv)	-	1
propylthiouracil tab	-	1
THYROID HORMONES		
levothyroxine tab (SYNTHROID equiv)	-	1
liothyronine tab (CYTOMEL equiv)	-	1
THYROLAR TAB	-	2
TIROSINT CAP 125MCG	-	2
TIROSINT CAP 137MCG	-	2
TOXOIDS		
TOXOID COMBINATIONS		
ADACEL/BOOSTRIX INJ	VAC	2
DAPTACEL DTAP INJ	VAC	2
DIPHThERIA-TETANUS TOXOIDS-PED INJ	-	2
KINRIX INJ	-	2
PEDIARIX INJ	-	2
PENTACEL INJ	-	2
TETANUS/DIPHThERIA TOXOID INJ	VAC	2

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
TOXOIDS Cont.		
VAXELIS INJ	VAC	2
ULCER DRUGS		
ANTISPASMODICS		
b-donna tab (DONNATAL equiv) (QL= 8 tabs/day)	QL	1
BELLADONNA ALKALOID/OPIUM SUPP	-	1
chlordiazepoxide/clidinium cap (LIBRAX equiv)	-	1
dicyclomine cap (BENTYL equiv)	-	1
dicyclomine soln (BENTYL equiv)	-	1
dicyclomine tab (BENTYL equiv)	-	1
glycopyrrolate tab (ROBINUL equiv)	-	1
hyoscyamine sulfate CR tab (LEVVID 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 tab (LEVSIN equiv)	-	1
methscopolamine tab (PAMINE equiv)	-	1
pb-belladonna elixir (DONNATAL equiv) (QL= 1200ml/30 days)	QL	1
DONNATAL ELIXIR	-	2
DONNATAL TAB	-	2
PROPANTHELINE TAB	-	2

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
ULCER DRUGS Cont.		
SYMAX DUOTAB	-	2
H-2 ANTAGONISTS		
cimetidine tab (TAGAMET equiv)	OTC	1
famotidine susp (PEPCID equiv)	-	1
famotidine tab (PEPCID equiv)	OTC	1
nizatidine cap (AXID equiv)	-	1
MISC. ANTI-ULCER		
sucralfate tab (CARAFATE equiv)	-	1
PROTON PUMP INHIBITORS		
ESOMEPRAZOLE STRONTIUM CAP	-	1
omeprazole DR cap (PRILOSEC equiv) (QL=1 cap/day)	QL	1
OMEPRAZOLE DR TAB (QL= 2 tabs/day)	QL	1
omeprazole magnesium delayed release tab (PRILOSEC OTC equiv) (QL= 1 tab/day)	OTC-QL	1
pantoprazole EC tab (PROTONIX equiv) (QL=2 tabs/day)	QL	1
ACIPHEX SPRINKLE CAP	-	2
ESOMEPRAZOLE-EZS KIT	-	2
ULCER DRUGS - PROSTAGLANDINS		
misoprostol tab (CYTOTEC equiv)	-	1
ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS		
ANTISPASMODICS		

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS Cont.		
glycopyrrolate oral soln (QL=9 ml/day)	QL	1
H-2 ANTAGONISTS		
NIZATIDINE CAP	-	1
MISC. ANTI-ULCER		
sucralfate susp (CARAFATE equiv)	-	1
PROTON PUMP INHIBITORS		
esomeprazole DR granule pack (NEXIUM equiv) (QL=1 pack/day)	QL	1
omeprazole dr cap	OTC	1
omeprazole tab (QL=2 tabs/day)	OTC-QL	1
pantoprazole packet (QL=1 packet/day)	QL	1
ACIPHEX SPRINKLE CAP (QL= 1 cap/day)	QL	2
ULCER THERAPY COMBINATIONS		
bismuth-metronidazole-tetracycline cap (QL=120 tabs/10 days)	QL	1
lansoprazole/amoxicillin/clarithromycin kit (PREVPAC equiv)	-	1
URINARY ANTI-INFECTIVES		
URINARY ANTI-INFECTIVE COMBINATIONS		
UROQID #2 TAB	-	2
URINARY ANTISPASMODICS		
URINARY ANTISPASMODIC - ANTIMUSCARINICS (ANTICHOLINERGIC)		
oxybutynin ER tab (DITROPAN XL equiv)	-	1
oxybutynin ER tab 10 MG (DITROPAN XL equiv) (QL=2 tabs/day)	QL	1

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
URINARY ANTISPASMODICS Cont.		
oxybutynin ER tab 5 MG (DITROPAN XL equiv) (QL=1 tab/day)	QL	1
oxybutynin syrup (QL=20ml/day)	QL	1
oxybutynin tab (DITROPAN equiv) (QL=4 tabs/day)	QL	1
solifenacin tab (VESICARE equiv) (QL= 1 tab/day)	QL	1
GELNIQUE	-	2
GELNIQUE (QL= 30 packets/30 days)	--QL	2
OXYTROL PATCH (QL= 1 patch/3 days)	QL	2
URINARY ANTISPASMODICS - CHOLINERGIC AGONISTS		
bethanechol tab (URECHOLINE equiv)	-	1
VACCINES		
BACTERIAL VACCINES		
ACTHIB INJ	-	2
BCG VACCINE INJ	-	2
BEXSERO INJ	VAC	2
BIOTHRAX INJ	-	2
CAPVAXIVE INJ (QL= 0.5 mL/fill; Covered for ages 19 years and older)	QL-VAC	2
MENACTRA INJ	VAC	2
MENHIBRIX INJ	VAC	2
MENOMUNE INJ	VAC	2
MENQUADFI INJ	VAC	2
MENVEO INJ	VAC	2

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
VACCINES Cont.		
MENVEO SOLN	VAC	2
PEDVAXHIB INJ	-	2
PENBRAYA INJ (Covered for members age 10-25 years)	-	2
PNEUMOVAX INJ	VAC	2
PREVNAR 13 INJ	VAC	2
PREVNAR 20 INJ	VAC	2
TRUMENBA INJ	VAC	2
TYPHIM VI INJ	--VAC	2
VAXCHORA SUSP	VAC	2
VAXNEUVANCE INJ	VAC	2
VIRAL VACCINES		
HEPLISAV-B INJ	VAC	1
TWINRIX INJ	VAC	1
ABRYSVO INJ (QL= 1 inj/day, 1 fill/lifetime, Covered for ages over 60 and weeks 32-36 of pregnancy)	QL-VAC	2
ACAM2000 INJ	-	2
AFLURIA INJ (QL = 0.5mL/fill)	QL-VAC	2
AFLURIA INJ, FLUZONE INJ	VAC	2
AREXVY INJ (QL= 1 inj/day, 1 fill/lifetime, Covered for members 60 years of age and older)	QL-VAC	2
CERVARIX INJ	VAC	2

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
VACCINES Cont.		
COMIRNATY INJ	VAC	2
COVID-19 VACCINE INJ	VAC	2
COVID-19 VACCINE INJ 6M-11Y (MODERNA)	VAC	2
ENGRIX-B INJ, RECOMBIVAX-HB INJ	VAC	2
EZ FLU SHOT KIT	VAC	2
EZ FLU SHOT PF KIT	VAC	2
EZ FLU SHOT QUAD KIT	VAC	2
FLUAD INJ	VAC	2
FLUBLOK INJ	VAC	2
FLUBLOK INJ (QL = 0.5mL/fill)	VAC-QL	2
FLUCELVAX INJ (QL = 0.5mL/fill)	QL-VAC	2
FLUCELVAX INJ (QL= 0.5ml/fill)	QL-VAC	2
FLUMIST NASAL (QL= 1 dose/fill; Limited to members aged 2 to 49 years old)	QL-VAC	2
FLUVIRIN INJ	VAC	2
FLUVIRIN PF INJ	VAC	2
FLUZONE HIGH DOSE PF INJ	VAC	2
FLUZONE INTRADERMAL INJ	VAC	2
FLUZONE QUAD INJ	VAC	2
GARDASIL 9 INJ	VAC	2
GARDASIL INJ	VAC	2
HAVRIX INJ, VAQTA INJ	VAC	2

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
VACCINES Cont.		
HEPLISAV-B INJ	VAC	2
IMOVAX RABIES VACCINE INJ	-	2
IPOL VACCINE INJ	-	2
JYNNEOS INJ	-	2
M-M-R II INJ	VAC	2
MRESVIA INJ (QL= 0.5 mL/fill; Covered for ages 60 years and older)	QL-VAC	2
NOVAVAX INJ	VAC	2
PRIORIX INJ	VAC	2
PROQUAD INJ	-	2
RABAVERT INJ	-	2
ROTARIX INJ	-	2
ROTATEQ INJ	-	2
SHINGRIX INJ (Covered for members age 18 or older; QL= 2 inj/lifetime)	QL-VAC	2
SPIKEVAX INJ	VAC	2
SPIKEVAX INJ (QL=1 dose/24 days)	VAC-QL	2
SPIKEVAX INJ 50/0.5ML	VAC	2
TWINRIX INJ	VAC	2
VARIVAX INJ	VAC	2
VAGINAL AND RELATED PRODUCTS		

VAGINAL ANTI-INFECTIVES

miconazole nitrate kit	OTC	1
------------------------	-----	---

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
VAGINAL AND RELATED PRODUCTS Cont.		
terconazole cream 0.8% (TERAZOL equiv) (QL=20 gm/fill)	QL	1
MONISTAT 3 COMBO PACK	OTC	2
VANDAZOLE GEL 0.75% (Step therapy requires trial of metronidazole tab or clindamycin cap/oral soln; QL 1 package/30 days)	QL-ST	2
VAGINAL ANTI-INFLAMMATORY AGENTS		
hydrocortisone cream (PROCTOCORT equiv)	OTC	1
MONISTAT SOOTHING CARE CREAM 1%	OTC	1
VAGINAL CONTRACEPTIVE - PH MODULATORS		
PHEXXI GEL	-	2
VAGINAL PRODUCTS		
MISCELLANEOUS VAGINAL PRODUCTS		
PRO-CEPTION FERTILITY PAK	-	1
FEM PH GEL	-	2
VAGINAL ANTI-INFECTIVES		
clindamycin vaginal cream (CLEOCIN equiv) (QL= 1 tube/fill)	QL	1
clotrimazole vaginal cream	OTC	1
metronidazole vaginal gel (METROGEL equiv)	-	1
MICONAZOLE 3 SUPP 200MG	-	1
miconazole nitrate cream	OTC	1
miconazole nitrate vaginal supp	OTC	1
terconazole cream 0.4% (TERAZOL equiv) (QL=45 gm/fill)	QL	1

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
VAGINAL PRODUCTS Cont.		
TERCONAZOLE CREAM 0.8%	-	1
terconazole supp (TERAZOL equiv) (QL=3 supps/fill)	QL	1
CLEOCIN VAGINAL SUPP	-	2
CLINDESSE VAGINAL CREAM	-	2
GYNAZOLE CREAM	-	2
NUVESSA VAGINAL GEL	-	2
VAGINAL ESTROGENS		
estradiol cream (ESTRACE equiv)	-	1
estradiol vaginal tab, yuvafem vaginal tab (VAGIFEM equiv)	-	1
FEMRING (3 copays per Rx)	-	2
VAGINAL PROGESTINS		
CRINONE GEL	-	2
VASOPRESSORS		
ANAPHYLAXIS THERAPY AGENTS		
epinephrine inj	-	1
EPINEPHRINE INJ 0.15MG (QL= 2 inj/fill)	QL	1
EPINEPHRINE INJ 0.3MG (QL= 2 inj/fill)	QL	1
epinephrine pen inj 0.15mg (1-Pack) (QL= 2 inj/fill)	QL	1
epinephrine pen inj 0.15mg, 0.3mg (EPIPEN (JR) equiv) (QL= 2 inj/fill)	QL	1
epinephrine pen inj 0.3mg (1-Pack) (QL= 2 inj/fill)	QL	1
SYMJEPI INJ (QL= 2 inj/fill)	QL	1

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Category/Class
Last Updated* 4/1/2025

DrugName	Special Code	Tier
VASOPRESSORS Cont.		
AUVI-Q INJ (QL=2 inj/fill)	QL	2
AUVI-Q INJ 0.15MG (QL=2 inj/30 days)	QL	2
NEFFY SPRAY (QL=2 inj/fill)	QL	2
VITAMINS		
OIL SOLUBLE VITAMINS		
phytonadione tab (MEPHYTON equiv)	OTC	1
vitamin D cap (RX strength only)	-	1
vitamin e cap	OTC	1
vitamin e cap 400unit	OTC	1
WATER SOLUBLE VITAMINS		
niacin er tab	OTC	1
pyridoxine tab	OTC	1
vitamin c chew tab 500mg	OTC	1
POTABA TAB	-	2

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

NC =Not Covered		generic =small letters	BRANDS =CAPITAL LETTERS
AMSP	Ardon Mandatory Specialty Pharmacy Program	EXC	Plan Exclusion
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis
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.

EOCCO Formulary
Prior Authorization Drug List
Last Updated* 4/1/2025

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

Drug Name	Tier # for Drug Copay (if prior auth is approved)
abiraterone acetate tab 500mg	3
ACTIMMUNE INJ	4
ADALIMUMAB-ADAZ INJ	4
ADALIMUMAB-ADAZ PEN INJ	4
ADVATE INJ 1000UNIT	4
ADVATE INJ 1500UNIT	4
ADVATE INJ 2000UNIT	4
ADVATE INJ 250UNIT	4
ADVATE INJ 3000UNIT	4
ADVATE INJ 4000UNIT	4
ADVATE INJ 500UNIT	4
AFREZZA INH POWDER	2
AJOVY INJ	2
ALECENSA CAP	4
ALKINDI SPRINKLE CAP	4
ALPROLIX INJ	4
ambrisentan tab	3
ARANESP INJ	4
BENEFIX KIT	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.

EOCCO Formulary cont.
Prior Authorization Drug List
Last Updated* 4/1/2025

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.

Drug Name	Tier # for Drug Copay (if prior auth is approved)
bexarotene gel	3
bosentan tab	3
BOSULIF CAP	4
BOSULIF TAB	4
CALQUENCE CAP	4
CALQUENCE TAB	4
carglumic acid tab	3
CERDELGA CAP	4
COSENTYX INJ	4
COSENTYX INJ (1-PACK)	4
COSENTYX INJ (2-PACK)	4
CUTAQUIG INJ	2
dalfampridine ER tab	3
dasatinib tab	3
deferasirox granules packet	4
deferiprone tab	3
DEPO-TESTOSTERONE INJ	2
DESCOVY TAB	2
DEXCOM G6 RECEIVER	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.

EOCCO Formulary cont.
Prior Authorization Drug List
Last Updated* 4/1/2025

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

Drug Name	Tier # for Drug Copay (if prior auth is approved)
DEXCOM G6 SENSOR	2
DEXCOM G6 TRANSMITTER	2
DEXCOM G7 RECEIVER	2
DEXCOM G7 SENSOR	2
dichlorphenamide tab	3
DIGITAL THERAPY APPLICATION - SLEEP	2
DUPIXENT INJ	4
DUPIXENT PEN INJ	4
ELOCTATE INJ	4
EMGALITY INJ	2
ENBREL INJ	4
ENBREL INJ 25MG	4
ENBREL INJ 50MG	4
ENBREL MINI INJ	4
ENBREL SURECLICK INJ 50MG	4
ERLEADA TAB	4
ERLEADA TAB 240MG	4
everolimus tab	1
everolimus tab for oral susp	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.

EOCCO Formulary cont.
Prior Authorization Drug List
Last Updated* 4/1/2025

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

Drug Name	Tier # for Drug Copay (if prior auth is approved)
EXSERVAN FILM	4
FREE LIBRE 3-PLUS SENSOR	2
FREESTYLE LIBRE 2	2
FREESTYLE LIBRE 2 RECEIVER	2
FREESTYLE LIBRE 2-PLUS SENSOR	2
FREESTYLE LIBRE 3 READER	2
FREESTYLE LIBRE KIT 3 SENSOR	2
FREESTYLE LIBRE RECEIVER	2
FREESTYLE LIBRE SENSOR (10-DAY)	2
FREESTYLE LIBRE SENSOR (14-DAY)	2
GAMMAGARD LIQUID INJ	2
GAMUNEX-C INJ	2
gefitinib tab	3
HADLIMA INJ	4
HADLIMA PUSH INJ 40/0.4ML	4
HADLIMA PUSH INJ 40/0.8ML	4
HADLIMA PUSHTOUCH INJ	4
HEMLIBRA INJ	4
HORIZANT TAB	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.

EOCCO Formulary cont.
Prior Authorization Drug List
Last Updated* 4/1/2025

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

Drug Name	Tier # for Drug Copay (if prior auth is approved)
HORIZANT TAB 600MG	2
HUMATE-P INJ	4
HYDROXYPROGESTERONE CAPROATE INJ	3
hydroxyprogesterone inj	3
HYQVIA INJ	2
icatibant inj	3
ICLUSIG TAB	4
IMBRUVICA CAP 140MG	4
IMBRUVICA CAP 70MG	4
IMBRUVICA SUSP	4
IMBRUVICA TAB	4
IMPAVIDO CAP	4
INCRELEX INJ	4
INLYTA TAB	4
INLYTA TAB 1MG	4
javygtor pak 100mg	3
javygtor powder 500mg	3
javygtor tab 100mg	3
JYNARQUE PAK	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.

EOCCO Formulary cont.
Prior Authorization Drug List
Last Updated* 4/1/2025

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

Drug Name	Tier # for Drug Copay (if prior auth is approved)
JYNARQUE TAB 15MG	4
KALYDECO PAK	4
KALYDECO PAK 13.4MG	4
KOATE INJ	4
KYNMOBI TITRATION KIT	4
lapatinib ditosylate tab	3
lenalidomide cap	3
LENVIMA CAP	4
leuprolide inj	3
LONSURF TAB	4
LUPRON DEPOT INJ	4
MAVYRET PAK	4
MEKINIST SOLN	4
MEKINIST TAB 0.5MG	4
MEKINIST TAB 2MG	4
methyltestosterone cap	2
metyrosine cap	3
mifepristone tab	3
miglustat cap	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.

EOCCO Formulary cont.
Prior Authorization Drug List
Last Updated* 4/1/2025

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.

Drug Name	Tier # for Drug Copay (if prior auth is approved)
MULPLETA TAB	4
NATESTO NASAL GEL	2
nitisinone cap	3
NORDITROPIN FLEXPON INJ	4
NUCALA INJ	4
OBIZUR INJ	4
OCALIVA TAB	4
OCTREOTIDE INJ	3
ONUREG TAB	4
OPSUMIT TAB	4
ORKAMBI GRANULES PACKET	4
ORKAMBI TAB	4
pazopanib hcl tab	3
PEGASYS INJ	4
pirfenidone cap	3
PIRFENIDONE TAB	3
pirfenidone tab 267mg	3
pirfenidone tab 801mg	3
POMALYST CAP	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.

EOCCO Formulary cont.
Prior Authorization Drug List
Last Updated* 4/1/2025

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

Drug Name	Tier # for Drug Copay (if prior auth is approved)
PROFILNINE INJ	4
PROMACTA TAB	4
REPATHA INJ	2
REPATHA PUSHTRONEX INJ	2
RETACRIT INJ	4
roflumilast tab	1
RUBRACA TAB	4
RYDAPT CAP	4
sapropterin dihydrochloride powder packet	3
sapropterin dihydrochloride soluble tab	3
simvastatin tab 80mg	1
SOMAVERT INJ	4
sorafenib tosylate tab	4
STIVARGA TAB	4
STRENSIQ INJ 18MG/.45ML	4
STRENSIQ INJ 28MG/0.7ML	4
STRENSIQ INJ 40 MG/ML	4
STRENSIQ INJ 80MG/0.8ML	4
sunitinib malate cap	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.

EOCCO Formulary cont.
Prior Authorization Drug List
Last Updated* 4/1/2025

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

Drug Name	Tier # for Drug Copay (if prior auth is approved)
SYLATRON INJ	4
SYMDEKO TAB	4
SYNAGIS INJ	4
SYNAGIS INJ	4
SYNAREL NASAL SOLN	4
SYNRIBO INJ	4
TAFINLAR CAP	4
TAFINLAR TAB	4
TASIGNA CAP	4
tasimelteon capsule	3
TERIPARATIDE INJ	4
testosterone cypionate inj	1
testosterone gel 1% 25mg	1
testosterone gel pump 1.62%	1
tiopronin dr tab	3
tiopronin tab	3
TOBI PODHALER	4
tobramycin neb soln	3
tolvaptan tab	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.

EOCCO Formulary cont.
Prior Authorization Drug List
Last Updated* 4/1/2025

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

Drug Name	Tier # for Drug Copay (if prior auth is approved)
treprostinil inj	3
TYENNE INJ	4
TYMLOS INJ	4
UPTRAVI TAB	4
UPTRAVI THERAPY PACK	4
VENCLEXTA STARTER PACK	4
VENCLEXTA TAB	4
XALKORI CAP	4
XIFAXAN TAB 200MG	2
XIFAXAN TAB 550MG	2
ZEJULA CAP	4
ZEJULA TAB	4
ZOLINZA CAP	2
ZOMACTON 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.

EOCCO Formulary
Last Updated* 4/1/2025
Over-the-Counter (OTC)

- The following OTC drugs are a covered benefit with a prescription

Over-the-Counter (OTC) Medications

acetaminophen chew tab 80mg	acetaminophen elixir	acetaminophen er tab	acetaminophen soln
acetaminophen susp	acetaminophen tab	ACNOMEL CREAM	AEROCHAMBER
ammonium lactate cream	antacid chew tab	antacid susp	artificial tear drops
artificial tears	aspirin chew tab 81mg	aspirin ec tab 325mg	aspirin ec tab 81mg
aspirin tab 325mg	B-12 DOTS TAB	bacitracin oint	bacitracin zinc oint
BD INSULIN SYRINGES	BD PEN NEEDLES	benzoyl peroxide gel	BENZOYL PEROXIDE LOTION
betasept liquid	bisacodyl supp	bisacodyl tab	buffered aspirin tab
BUFFERIN TAB 325MG	butenafine cream	calcium carbonate tab	CALCIUM CITRATE TAB 200MG
calcium citrate/vitamin d3 tab	calcium citrate/vitamin d3 tab 315mg/200unit	calcium/vitamin d3 tab	calcium/vitamin d3 tab 600mg/200unit
calcium/vitamin d3 tab 600mg/400unit	calcium/vitamin d3 tab 600mg/800unit	CALIBRATION LIQUID	capsaicin cream 0.025%
cetirizine chew tab	cetirizine hcl orally disintegrating tab	cetirizine syrup	cetirizine tab
chlorpheniramine tab	cimetidine tab	CITRACAL MAXIMUM TAB	clotrimazole cream
clotrimazole soln			

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.

clotrimazole vaginal cream	COVID-19 HOME COLLECTION TEST KIT	COVID-19 TEST SPECIMEN COLLECTION KIT	CUE HEALTH MONITOR
CYTRA-3 SYRUP DIALYVITE 800 WITH IRON TAB diphenhydramine liquid	daily multi vitamin tab DIGITAL THERAPY APPLICATION - SLEEP diphenhydramine ODT	dailyvite tab diphenhydramine cap diphenhydramine tab	DEBROX OTIC SOLN diphenhydramine chew tab diphenhydramine/acetaminophen tab ear wax removal drops FEMALE CONDOMS
docusate cap ECOTRIN EC TAB 325MG FEOSOL TAB	docusate liquid ephedrine hcl tab	DOCUSATE SYRUP famotidine tab	FEVERALL SUPP
FEVERALL SUPP 325MG fiber therapy tab folic acid cap	FERROUS SULFATE LIQUID fexofenadine tab 180mg	ferrous sulfate soln fiber cap	fiber therapy powder
fish oil cap folic acid tab 800mcg	fish oil cap folic acid tab 800mcg	fish oil dr cap FREESTYLE INSULINX TEST STRIP FREESTYLE TEST STRIPS	folbee tab FREESTYLE LITE TEST STRIP GLUCOSE CHEW TAB
FREESTYLE PRECISION NEO TEST STRIP glucose gel packet HUMULIN N INJ hydrocortisone oint	FREESTYLE TEST STRIP glycerin supp HUMULIN N PEN INJ HYPODERMIC NEEDLES	HUMULIN MIX INJ HUMULIN R INJ ibuprofen cap	HUMULIN MIX PEN INJ hydrocortisone cream ibuprofen susp
ibuprofen tab IRON POLYSACCH/THREONIC ACID/B12/FA CAP	INSTA-GLUCOSE GEL iron tab	IODINE SOLN KLOXXADO SPRAY, RIVIVE SPRAY	iron 100 plus tab LANCET DEVICE

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.

LANCET KIT LIPOCHOL PLUS TAB loratadine tab	LANCET MISC LIQUIMAT LOTION lubricant eye oint	LANCETS loratadine ODT MAG 64 TAB	levonorgestrel tab loratadine syrup magnesium chloride dr tab
magnesium citrate soln	MAGNESIUM OXIDE CHEW TAB	magnesium oxide tab	magnesium oxide tab 400mg
magnesium tab 400mg melatonin tab 3mg miconazole nitrate kit	MALE CONDOMS MICATIN CREAM 2% miconazole nitrate vaginal supp	MAXI-TUSS CD LIQUID miconazole cream migraine relief tab	MELATONIN TAB miconazole nitrate cream milk of magnesia susp
MONISTAT 3 COMBO PACK multivitamin tab	MONISTAT SOOTHING CARE CREAM 1% multivitamin/fluoride/iron drops	MTX SUPPORT TAB MURO-128 OINT 5%	multi vitamin with iron tab MVW COMPLETE MULTIVITAMIN CAP
mynephron cap neo-tuss liquid nicotine patch	naloxone nasal spray niacin er tab NINJACOF-XG LIQUID	naproxen sodium tab nicotine gum NOVOLIN 70/30 FLEXPEN INJ	NARCAN NASAL SPRAY nicotine lozenge NOVOLIN N RELION INJ
NOVOLIN R INJ 100 UNIT omeprazole dr cap	NOVOLIN RELION INJ 70/30 omeprazole magnesium delayed release tab	NOVOLIN VIAL omeprazole tab	OCEAN NASAL SPRAY 0.65% ONE-A-DAY MENS TAB
OPILL TAB	oral electrolyte soln	pedia tri-vite drops	pediatric multiple vitamins/fluoride soln
permethrin liquid polyethylene glycol 3350 powder poly-vita drops	phytonadione tab polyethylene glycol packe	pink bismuth chew tab poly-iron cap	pink bismuth susp POLY-VI-SOL DROPS

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.

PRECISION XTRA KETONE TEST STRIP	PRECISION XTRA TEST STRIP	PRENATAL 19 TAB	prenatal dha cap
PRENATAL VITAMINS (PRENATAL PLUS, PREPLUS, PRENAPLUS)	proctosol HC cream	PROFERRIN TAB	PUMP SUPPLIES
pyridoxine tab	REFRESH CLASSIC DROPS	REFRESH OPHTH GEL 1%	RIAX FOAM
SAFETYGLIDE SYRINGE	saline enema	saline nasal spray	SALMON OIL-1000 CAP
senna tab	senna-s tab	SENOKOT S TAB	SHARPS CONTAINER
simethicone chew tab	simethicone drops	sodium bicarbonate tab	sodium chloride drops
sodium chloride oint	sodium chloride tab	sodium citrate/citric acid soln	sodium fluoride soln
theanine cap	tolnaftate cream	triamcinolone OTC nasal spray	trigels-f forte cap
triple antibiotic oint	tussin dm syrup	UNISOM SLEEPGELS 50MG	VIRTUSSIN DAC SYRUP
vision formula tab	vitamin b complex cap	vitamin b-12 er tab	vitamin b-12 tab 1000mcg
vitamin b-12 tab 500mcg	VITAMIN C CHEW TAB	vitamin c chew tab 500mcg	vitamin e cap
vitamin e cap 400unit	VITA-RESPA TAB	zephrex-d tab 30mg	zinc cap
zinc oxide oint 20%	ZYRTEC CHEW 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.

EOCCO Formulary
Last Updated* 4/1/2025

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

abiraterone acetate tab 500mg	abiraterone tab 250mg	ACTIMMUNE INJ	ADALIMU-ADAZ INJ 80/0.8ML
ADALIMUMAB-ADAZ INJ	ADALIMUMAB-ADAZ PEN INJ	adefovir dipivoxil tab	ADVATE INJ 1000UNIT
ADVATE INJ 1500UNIT	ADVATE INJ 2000UNIT	ADVATE INJ 250UNIT	ADVATE INJ 3000UNIT
ADVATE INJ 4000UNIT	ADVATE INJ 500UNIT	ALECENSA CAP	ALPROLIX INJ
ambrisentan tab	apomorphine inj	ARANESP INJ	AVONEX INJ
BARACLUDE SOLN	BENEFIX KIT	betaine powder for oral solution	bexarotene gel
bosentan tab	BOSULIF CAP	BOSULIF TAB	CALQUENCE CAP
CALQUENCE TAB	capecitabine tab	carglumic acid tab	CERDELGA CAP
COSENTYX INJ	COSENTYX INJ (1-PACK)	COSENTYX INJ (2-PACK)	CUTAQUIG INJ
CYSTADANE POWDER	dalfampridine ER tab	dasatinib tab	deferasirox granules packet
deferasirox tab	deferiprone tab	dichlorphenamide tab	dimethyl fumarate DR cap

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.

dimethyl fumarate DR starter pack	DUPIXENT INJ	DUPIXENT PEN INJ	ELOCTATE INJ
ENBREL INJ	ENBREL INJ 25MG	ENBREL INJ 50MG	ENBREL MINI INJ
ENBREL SURECLICK INJ	EPIVIR HBV SOLN 50MG	ERLEADA TAB	ERLEADA TAB 240MG
erlotinib tab 100mg	erlotinib tab 150mg	erlotinib tab 25mg	everolimus tab
everolimus tab for oral susp	EXSERVAN FILM	fingolimod hcl cap 0.5mg	FULPHILA INJ
gefitinib tab	glatiramer inj 20mg/ml	glatiramer inj 40mg/ml	glutamine (sickle cell) powder pack
HADLIMA INJ	HADLIMA PUSH INJ 40/0.4ML	HADLIMA PUSH INJ 40/0.8ML	HADLIMA PUSHTOUCH INJ
HEMLIBRA INJ	HIZENTRA INJ	HUMATE-P INJ	HYDROXYPROGESTERONE CAPROATE INJ
hydroxyprogesterone inj	HYQVIA INJ	icatibant inj	ICLUSIG TAB
imatinib tab 100mg	imatinib tab 400mg	IMBRUVICA CAP 140MG	IMBRUVICA CAP 70MG
IMBRUVICA SUSP	IMBRUVICA TAB	IMPAVIDO CAP	INCRELEX INJ
INLYTA TAB	INLYTA TAB 1MG	INTRON-A INJ	javygtor pak 100mg
javygtor powder 500mg	javygtor tab 100mg	JYNARQUE PAK	JYNARQUE TAB 15MG
KALYDECO PAK	KALYDECO PAK 13.4MG	KALYDECO TAB	KOATE INJ
KYNMOBI FILM	KYNMOBI TITRATION KIT	lamivudine tab 100mg	lapatinib ditosylate tab
lenalidomide cap	LENVIMA CAP	LONSURF TAB	LUPRON DEPOT INJ
MATULANE CAP	MAVYRET PAK	MAVYRET TAB	MEKINIST SOLN
MEKINIST TAB 0.5MG	MEKINIST TAB 2MG	MELPHALAN TAB	mercaptopurine susp
mesna tab	mifepristone tab	miglustat cap	MULPLETA TAB
MYLERAN TAB	nilutamide tab	nitisinone cap	NORDITROPIN FLEXPEN INJ
NUCALA INJ	NYVEPRIA INJ	OBIZUR INJ	OCALIVA 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.

OCTREOTIDE INJ	OPSUMIT TAB	ORKAMBI GRANULES PACKET	ORKAMBI TAB
pazopanib hcl tab	pirfenidone cap	PIRFENIDONE TAB	pirfenidone tab 267mg
pirfenidone tab 801mg	POMALYST CAP	PROFILNINE INJ	PROMACTA TAB
PULMOZYME INH SOLN	RETACRIT INJ	RIBAVIRIN TAB	riluzole tab
RUBRACA TAB	RYDAPT CAP	sapropterin dihydrochloride powder packet	sapropterin dihydrochloride soluble tat
SOFOSBUVIR/VELPATA SVIR TAB	SOMAVERT INJ	sorafenib tosylate tab	STIVARGA TAB
STRENSIQ INJ 18MG/.45ML	STRENSIQ INJ 28MG/0.7ML	STRENSIQ INJ 40 MG/ML	STRENSIQ INJ 80MG/0.8ML
sunitinib malate cap	SYLATRON INJ	SYMDEKO TAB	SYNAGIS INJ
SYNAGIS INJ	SYNRIBO INJ	TAFINLAR CAP	TAFINLAR TAB
TASIGNA CAP	tasimelteon capsule	temozolomide cap	teriflunomide tab
TERIPARATIDE INJ	THALOMID CAP	tiopronin dr tab	tiopronin tab
TOBI PODHALER	tobramycin neb soln	tolvaptan tab	treprostinil inj
TYENNE INJ	TYMLOS INJ	UPTRAVI TAB	UPTRAVI THERAPY PACK
VEMLIDY TAB	VENCLEXTA STARTER PACK	VENCLEXTA TAB	VIVITROL INJ
XALKORI CAP	XEMBIFY INJ	XOLAIR 150MG/ML INJ	XOLAIR 300MG/2ML INJ
XOLAIR 75MG/0.5ML INJ	XOLAIR INJ	XOLAIR INJ 150MG/ML	XOLAIR INJ 300MG/2ML
XOLAIR INJ 75MG/0.5ML	ZARXIO INJ	ZARXIO INJ 480/0.8	ZEJULA CAP
ZEJULA TAB	ZOMACTON INJ		

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.

EOCCO Formulary
Last Updated* 4/1/2025
Step Therapy (ST)

- The following drugs are covered on the formulary with a Step Therapy.

Step Therapy (ST) Medications

Drug Name	Step Therapy Requirements
adapalene cream	Step Therapy requires trial of adapalene gel, followed by tretinoin cream 0.025%.
ADAPALENE SOLN	QL= 360 mL/30 days; Step therapy requires adapalene gel
AKYNZEO CAP	Step Therapy requires trial of aprepitant, granisetron, or ondansetron
ASPRUZYO SPRINKLE GRANULES	QL= 2 packets/day; Step Therapy requires trial of ranolazine ER tab
azelaic acid gel	QL= 360 g/30 days; Step therapy requires adapalene gel OR topical clindamycin
bimatoprost ophth soln	Step Therapy requires trial of latanoprost ophth soln; QL=2.5ml/25 days
BREYNA AER 160/4.5	Step Therapy requires trial of fluticasone/salmeterol or wixela and Duler
BREYNA AER 80/4.5	Step Therapy requires trial of fluticasone/salmeterol or wixela and Duler
brimonidine ophth soln 0.15%	Step Therapy requires trial of brimonidine ophth soln 0.2%
brinzolamide ophth susp	Step Therapy requires trial of dorzolamide 2% ophth soln
candesartan tab	Step Therapy requires trial of 2: irbesartan, irbesartan/hctz. losartan, or losartan/hctz
candesartan/hydrochlorothiazide tab	Step Therapy requires trial of 2: irbesartan, irbesartan/hctz. losartan, or losartan/hctz
CAPTOPRIL/HYDROCHLOROTHIAZIDE TAB	Step Therapy requires trial of HCTZ/benazepril, enalapril, fosinopril, lisinopril, moexipril, or quinapril

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.

EOCCO Formulary Cont.**Last Updated* 4/1/2025****Step Therapy (ST)**

- The following drugs are covered on the formulary with a Step Therapy.

Step Therapy (ST) Medications

Drug Name	Step Therapy Requirements
carisoprodol tab	Step Therapy requires trial of 2: cyclobenzaprine, tizanidine, methocarbamol, or orphenadrine ER
celecoxib cap 400mg	QL= 2 caps/day; Step therapy requires trial of celecoxib 50mg, celecoxib 100mg, OR celecoxib 200mg.
dorzolamide/timolol (pf) ophth soln DUOBRII LOTION	Step Therapy requires trial of dorzolamide/timolol ophth soln QL=1 tube/30 days; Step Therapy requires trial of a high potency topical steroid
ELMIRON CAP	QL= 3 caps/day; ST requires trial of hydroxyzine
EOHILIA SUSP	Step therapy requires trial of budesonide vials
ERY PAD	Step therapy requires trial of topical clindamycin or erythromycin gel/solution
fentanyl patch	QL=15 patches/30 days; Step Therapy requires trial of morphine sulfate ER tab
glutamine (sickle cell) powder pack GLYXAMBI TAB	Step Therapy requires trial of hydroxyurea cap; QL = 6 packets/day Step Therapy requires trial of metformin or metformin ER or metformin combinations
granisetron tab	QL= 1 tab/15 days; Step therapy requires trial of ondansetron
halcinonide cream	Step Therapy requires trial of 2 High potency corticosteroids
lanthanum carbonate chew tab 1000mg	QL=3 tabs/day; Step Therapy requires trial of sevelamer carbonate tab sevelamer HCL 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.

EOCCO Formulary Cont.**Last Updated* 4/1/2025****Step Therapy (ST)**

- The following drugs are covered on the formulary with a Step Therapy.

Step Therapy (ST) Medications

Drug Name	Step Therapy Requirements
lanthanum carbonate chew tab 500mg	QL=5 tabs/day; Step Therapy requires trial of sevelamer carbonate tab sevelamer HCL tab
lanthanum carbonate chew tab 750mg	QL=3 tabs/day; Step Therapy requires trial of sevelamer carbonate tab sevelamer HCL tab
LATANOPROST OPTH SOLN	QL=30 single use containers/30 days; Step therapy requires trial of latanoprost opth soln
LEVALBUTEROL INHALER	QL= 2 inhalers/fill, 2 fills/30 days; Step Therapy requires trial of albuterol hfa inhaler
levalbuterol neb soln	QL= 96 vials/30 days; Step Therapy requires trial of albuterol neb soln
LOKELMA PAK	QL=1 pak/day; Step Therapy requires trial of 1 diuretic: chlorothiazide, chlorthalidone, bumetanide, hydrochlorothiazide, torsemide, indapamide, furosemide, ethacrynic acid, metolazone, chlorothiazide or hydrochlorothiazide
meloxicam cap	QL= 1 cap/day; Step Therapy requires trial of meloxicam, aspirin, naproxen, diclofenac, ketoprofen, oxaprozin, sulindac, or tolmetin
memantine ER cap	QL= 1 cap/day; Step Therapy requires trial of memantine tab
moxifloxacin ophth soln	QL=3 ml/7 days; Step therapy requires trial of ciprofloxacin ophth soln, levofloxacin ophth soln, or ofloxacin ophth soln
NAMENDA XR TITRATION PACK	QL= 28 caps/28 days, Step Therapy requires trial of memantine 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.

EOCCO Formulary Cont.**Last Updated* 4/1/2025****Step Therapy (ST)**

- The following drugs are covered on the formulary with a Step Therapy.

Step Therapy (ST) Medications

Drug Name	Step Therapy Requirements
NUEDEXTA CAP	QL= 2 caps/day; Step therapy requires trial of 1 SSRI AND 1 TCA
OXYCODONE ER TAB 10MG	QL= 2 tabs/day; Step Therapy requires trial of morphine sulfate ER tab
OXYCODONE ER TAB 15MG	QL= 2 tabs/day; Step Therapy requires trial of morphine sulfate ER tab
OXYCODONE ER TAB 20MG	QL= 2 tabs/day; Step Therapy requires trial of morphine sulfate ER tab
OXYCODONE ER TAB 30MG	QL= 2 tabs/day; Step Therapy requires trial of morphine sulfate ER tab
OXYCODONE ER TAB 40MG	QL= 2 tabs/day; Step Therapy requires trial of morphine sulfate ER tab
OXYCODONE ER TAB 60MG	QL= 2 tabs/day; Step Therapy requires trial of morphine sulfate ER tab
OXYCODONE ER TAB 80MG	QL= 4 tabs/day; Step Therapy requires trial of morphine sulfate ER tab
OXYCONTIN ER 10MG TAB	QL= 2 tabs/day; Step Therapy requires trial of morphine sulfate ER tab
OXYCONTIN ER 20MG TAB	QL= 2 tabs/day; Step Therapy requires trial of morphine sulfate ER tab
OXYCONTIN ER 40MG TAB	QL= 2 tabs/day; Step Therapy requires trial of morphine sulfate ER tab
QTERN TAB	Step Therapy requires trial of metformin or metformin ER or metformin combinations
repaglinide tab	Step Therapy requires trial of metformin or metformin ER
ropinirole ER tab	Step Therapy requires trial of ropinirole
SOLTAMAX SOLN	Step Therapy requires trial of tamoxifen tab
STEGLUJAN TAB	Step Therapy requires trial of metformin or metformin ER or metformin combinations

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.

EOCCO Formulary Cont.**Last Updated* 4/1/2025****Step Therapy (ST)**

- The following drugs are covered on the formulary with a Step Therapy.

Step Therapy (ST) Medications

Drug Name	Step Therapy Requirements
sumatriptan nasal spray	QL= 6 sprays/30 days; ST req trial of 2: naratriptan tab, rizatriptan tab/ODT, zolmitriptan tab, or sumatriptan tab
sumatriptan vial inj	QL=4 ml/30 days; ST req trial of 2: naratriptan tab, rizatriptan tab/ODT, zolmitriptan tab, or sumatriptan tab
tramadol ER tab	QL= 1 tab/day; Step Therapy requires trial of tramadol tab
tramadol ER tab 100mg	QL= 1 tab/day; Step Therapy requires trial of tramadol tab
tramadol ER tab 200mg	QL= 1 tab/day; Step Therapy requires trial of tramadol tab
tramadol ER tab 300mg	QL= 1 tab/day; Step Therapy requires trial of tramadol tab
travoprost ophth soln	Step Therapy requires trial of latanoprost ophth soln
tretinoin cream	QL= 360g/30 days, Step therapy requires trial of adapalene gel, followed by tretinoin cream 0.025%
tretinoin cream 0.025%	QL= 360g/30 days, Step therapy requires trial of adapalene gel
tretinoin gel	QL= 360g/30 days, Step therapy requires trial of adapalene gel, followed by tretinoin cream 0.025%
tretinoin gel 0.03%	QL= 360g/30 days, Step therapy requires trial of adapalene gel, followed by tretinoin cream 0.025%
triamcinolone acetonide oint	Step Therapy requires trial of triamcinolone acetonide oint 0.025% or 0.1%
triamterene cap	Step Therapy requires trial of amiloride or spironolactone

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.

EOCCO Formulary Cont.**Last Updated* 4/1/2025****Step Therapy (ST)**

- The following drugs are covered on the formulary with a Step Therapy.

Step Therapy (ST) Medications

Drug Name	Step Therapy Requirements
trientine cap 250mg	ST req trial of generic penicillamine tab
VANDAZOLE GEL 0.75%	Step therapy requires trial of metronidazole tab or clindamycin cap/oral soln; QL 1 package/30 days
WYNZORA CREAM	QL=420 gm/28 days, Step therapy requires trial of 2 topicals: calcipotriene, betamethasone, AMCINONIDE, fluocinonide, triamcinolone.
zolpidem ER tab	QL= 1 tab/day; Step Therapy requires trial of zolpidem 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.

EOCCO Formulary
Smoking Cessation Agents
Last Updated* 4/1/2025

Drug Name	Tier # for Drug Copay
BUPROPION SR TAB	1
CHANTIX PAK(Limited to180 days/plan year)	2
CHANTIX TAB	2
NICOTINE GUM	1
NICOTINE LOZENGE	1
NICOTINE PATCH	1
NICOTROL INHALER	2
NICOTROL NASAL SPRAY	2
VARENICLINE TARTRATE TAB	1
VARENICLINE TARTRATE TAB START PACK	1

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.

EOCCO Formulary
Last Updated* 4/1/2025

Quantity Limit (QL)

- The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
abacavir soln	QL= 960ml/30 days
abacavir tab	QL= 2 tabs/day
abacavir/lamivudine tab	QL= 1 tab/day
abacavir/lamivudine/zidovudine tab	QL= 2 tabs/day
abiraterone acetate tab 500mg	QL= 2 tabs/day
ABRYSVO INJ	QL= 1 inj/day, 1 fill/lifetime, Covered for ages over 60 and weeks 32-36 of pregnancy
acarbose tab	QL=3 tabs/day
acetaminophen/codeine tab	QL= 12 tabs/day
acetaminophen/codeine tab 300mg/60mg	QL= 6 tabs/day
ACIPHEX SPRINKLE CAP	QL= 1 cap/day
ACNOMEL CREAM	QL= 360g/30 days
ADALIMU-ADAZ INJ 80/0.8ML	QL=2 inj/28days
ADALIMUMAB-ADAZ INJ	QL= 2 syringes/28 days
ADALIMUMAB-ADAZ PEN INJ	QL=2 pens/28 days
adapalene gel	QL= 360g/30 days
ADAPALENE SOLN	QL= 360 mL/30 days; Step therapy requires adapalene gel
ADMELOG INJ	QL= 60ml/30 days
ADMELOG SOLOSTAR INJ	QL= 60ml/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.

EOCCO Formulary Cont.**Last Updated* 4/1/2025****Quantity Limit (QL)**

- The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
AEROCHAMBER	QL= 1 device/365 days
AFLURIA INJ	QL = 0.5mL/fill
AJOVY INJ	QL= 1 inj/28 days
ALBUTEROL HFA INHALER	QL= 2 inhalers/30 days
ALECENSA CAP	QL=8 caps/day
alendronate sodium oral soln	QL=300 ml/28 days
ALOGLIPTIN TAB	QL = 1 tab/day
ALOGLIPTIN/METFORMIN TAB	QL = 1 tab/day
ALOGLIPTIN/PIOGLITAZONE TAB	QL = 1 tab/day
amphetamine/dextroamphetamine ER cap	QL=2 caps/day
amphetamine/dextroamphetamine tab 10mg	QL=180 tabs/30 days
amphetamine/dextroamphetamine tab 12.5mg	QL=150 tabs/30 days
amphetamine/dextroamphetamine tab 15mg	QL=120 tabs/30 days
amphetamine/dextroamphetamine tab 20mg	QL=90 tabs/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.

EOCCO Formulary Cont.**Last Updated* 4/1/2025****Quantity Limit (QL)**

- The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
amphetamine/dextroamphetamine tab 30mg	QL=60 tabs/30 days
amphetamine/dextroamphetamine tab 5mg	QL=360 tabs/30 days
amphetamine/dextroamphetamine tab 7.5mg	QL=240 tabs/30 days
ANNOVERA RING	QL=1 ring/273 days
ANORO ELLIPTA INHALER	QL= 1 inhaler/30 days
APAP/CODEINE SOLN	QL=990ml/30 days
apomorphine inj	QL= 54ml/30 days; Only available through Caremark/CVS Specialty 800-237-2767
aprepitant cap 125mg	QL= 1 cap/21 days
aprepitant cap 40mg	QL= 1 cap/28 days
APTOM TAB	QL= 60 tabs/30 days
ARANESP INJ	QL=4 syringes/30 days
AREXVY INJ	QL= 1 inj/day, 1 fill/lifetime, Covered for members 60 years of age and older
ASMANEX HFA INHALER	QL= 1 inhaler/30 days
ASMANEX INHALER	QL= 1 inhaler/30 days
ASPRUZYO SPRINKLE GRANULES	QL= 2 packets/day; Step Therapy requires trial of ranolazine ER 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.

EOCCO Formulary Cont.**Last Updated* 4/1/2025****Quantity Limit (QL)**

- The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
atazanavir cap 150mg	QL= 2 caps/day
atazanavir cap 200mg	QL= 2 caps/day
atazanavir cap 300mg	QL= 1 cap/day
atorvastatin tab	QL= 1 tab/day
atorvastatin tab 10mg	QL= 60 tabs/30 days
atorvastatin tab 20mg	QL= 60 tabs/30 days
atorvastatin tab 40mg	QL= 60 tabs/30 days
atropine ophth soln	QL=1 bottle/30 days
ATROVENT HFA INHALER	QL = 2 inhalers (25.8g)/30 days
AUVI-Q INJ	QL=2 inj/fill
AUVI-Q INJ 0.15MG	QL=2 inj/30 days
AVONEX INJ	QL=1 inj/28 days
azelaic acid gel	QL= 360 g/30 days; Step therapy requires adapalene gel OR topical clindamycin
BAXDELA TAB	QL= 28 tabs/14 day
b-donna tab	QL= 8 tabs/day
BECONASE AQ NASAL SPRAY	QL= 1 bottle/15 days; 2 fills/month
BENZAC WASH	QL= 360g/30 days
BENZHYDROCODONE-ACETAMINOPHEN TAB	QL= 12 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.

EOCCO Formulary Cont.**Last Updated* 4/1/2025****Quantity Limit (QL)**

- The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
BENZNIDAZOLE TAB	QL= 360 tabs/365 days
BENZONATATE CAP	QL= 3 caps/day
benzoyl peroxide gel	QL= 360g/30 days
BENZOYL PEROXIDE LOTION	QL= 360g/30 days
BENZOYL PEROXIDE WASH	QL= 360g/30 days
betaine powder for oral solution	QL=540 grams/30 days; Only available through Walgreens 888-347-3416
BIKTARVY TAB 30-120-15MG	QL=1 tab/day
bimatoprost ophth soln	Step Therapy requires trial of latanoprost ophth soln; QL=2.5ml/25 days
BINOSTO TAB	QL= 4 tabs/28 days
bismuth-metronidazole-tetracycline cap	QL=120 tabs/10 days
BOSULIF CAP	QL=5 caps/day; Only available through Walgreens 888-347-3416
BREYNA AER 160/4.5	Step Therapy requires trial of fluticasone/salmeterol or wixela and Dulera.
BREYNA AER 80/4.5	Step Therapy requires trial of fluticasone/salmeterol or wixela and Dulera.
budesonide inh susp	QL= 120 units/30 days
butalbital/acetaminophen tab	QL= 6 tabs/day
butalbital/acetaminophen/caffeine cap	QL=6 caps/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.

EOCCO Formulary Cont.**Last Updated* 4/1/2025****Quantity Limit (QL)**

- The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
butalbital/acetaminophen/caffeine/codeine cap	QL= 6 caps/day
butorphanol nasal spray	QL= 1 bottle/15 days; 2 fills/30 days
cabergoline tab	QL=16 tabs/30 days
CALQUENCE CAP	QL=2 caps/day
CALQUENCE TAB	QL=2 tabs/day
camrese lo tab, lojaimiess tab	QL= 91 tabs/91 days
CAPVAXIVE INJ	QL= 0.5 mL/fill; Covered for ages 19 years and older
carbidopa-levodopa-entacapone tab 12.5-50-200 mg	QL= 8 tabs/day
carbidopa-levodopa-entacapone tab 18.75-75-200 mg	QL= 8 tabs/day
carbidopa-levodopa-entacapone tab 25-100-200 mg	QL= 8 tabs/day
carbidopa-levodopa-entacapone tab 31.25-125-200 mg	QL= 8 tabs/day
carbidopa-levodopa-entacapone tab 37.5-150-200 mg	QL= 8 tabs/day
carbidopa-levodopa-entacapone tab 50-200-200 mg	QL= 6 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.

EOCCO Formulary Cont.**Last Updated* 4/1/2025****Quantity Limit (QL)**

- The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
CARBINOXAMINE SOLN	QL=40ml/day
carbinoxamine tab	QL=240 tabs/30 days
celecoxib cap	QL= 2 caps/day
celecoxib cap 400mg	QL= 2 caps/day; Step therapy requires trial of celecoxib 50mg, celecoxib 100mg, OR celecoxib 200mg.
CERDELGA CAP	QL= 1 cap/day; Only available through Accredo 877-826-7657
CESAMET CAP	QL= 1 cap/day
cetirizine chew tab	QL=1 tab/day
cetirizine hcl orally disintegrating tab	QL = 1 tab/day
CHANTIX PAK	Limited to 180 days/plan year
chlorzoxazone tab 250mg	QL=4 tabs/day
CIMDUO TAB	QL= 1 tab/day
CIPROFLOXACIN/FLUOCINOLONE OTIC SOLN	QL= 1 bottle/7 days
clindamycin vaginal cream	QL= 1 tube/fill
clindamycin/benzoyl peroxide gel 1-5%	QL= 360g/30 days
clobazam susp	QL= 16ml/day
clobazam tab 10mg	
clonidine patch	QL=1 patch/7 days
clopidogrel tab 300mg	QL= 4 tabs/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.

EOCCO Formulary Cont.**Last Updated* 4/1/2025****Quantity Limit (QL)**

- The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
colchicine tab	QL= 4 tabs/day
COMBIVENT RESPIMAT INHALER	QL= 2 inhalers/30 days
COMPLERA TAB	QL= 1 tab/day
CORLANOR SOLN	QL=15 ml/day
CORLANOR TAB	QL = 60 tabs/30 days
COSENTYX INJ	QL = 1 inj/28 days
COSENTYX INJ (1-PACK)	QL=1 inj/28 days
COSENTYX INJ (2-PACK)	QL=2 inj/56 days
COVID-19 HOME COLLECTION TEST KIT	QL= 8 kits/30 days
COVID-19 TEST SPECIMEN COLLECTION KIT	Q= 8 kits/30 days
CUE HEALTH MONITOR	QL=1 kit/year
CUTAQUIG INJ	QL= 576ml/28 days; Only available through Caremark/CVS Specialty 800-237-2767
cvs nasal decongestant cap	QL=240 caps/30 days
cyclosporine ophth emulsion	QL=60 vials/30 days
CYSTADANE POWDER	QL=540 grams/30 days; Only available through AnovoRx 844-288-5007
dabigatran etexilate mesylate cap	QL= 2 caps/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.

EOCCO Formulary Cont.**Last Updated* 4/1/2025****Quantity Limit (QL)**

- The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
danazol cap	QL= 4 caps/day
DAPAGLIFLOZIN TAB 10MG	QL = 1 tab/day
DAPAGLIFLOZIN TAB 5MG	QL = 1 tab/day
DAPAGLIFLOZIN-METFORMIN ER TAIQL = 1 tab/day 10-1000 MG	
DAPAGLIFLOZIN-METFORMIN ER TAIQL = 2 tabs/day 5-1000 MG	
darunavir tab	QL= 1 tab/day
DEPO-PROVERA SC INJ 104MG	QL= 1 inj/84 days
DEPO-TESTOSTERONE INJ	QL= 4 vials/28 days
DESCOVY TAB	QL= 1 tab/day
desloratadine tab	QL= 1 tab/day
DEXAMETHASONE TAB	QL=8 tabs/30 days
DEXCOM G6 RECEIVER	QL= 1 receiver/year
DEXCOM G6 SENSOR	QL= 3 sensors/30 days
DEXCOM G6 TRANSMITTER	QL= 4 transmitters/365 days
DEXCOM G7 RECEIVER	QL=1 receiver/year
DEXCOM G7 SENSOR	QL=3 sensors/30 days
dexmethylphenidate ER cap	QL=1 cap/day
dexmethylphenidate ER cap 10mg	QL=60 caps/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.

EOCCO Formulary Cont.**Last Updated* 4/1/2025****Quantity Limit (QL)**

- The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
dexmethylphenidate ER cap 15mg	QL=60 caps/30 days
dexmethylphenidate ER cap 20mg	QL=60 caps/30 days
dexmethylphenidate ER cap 5mg	QL=60 caps/30 days
dexmethylphenidate tab	QL= 2 tabs/day
dextroamphetamine 5mg tab	QL= 9 tabs/day
dextroamphetamine ER cap 10mg	QL= 4 caps/day
dextroamphetamine ER cap 15mg	QL= 4 caps/day
dextroamphetamine ER cap 5mg	QL= 2 caps/day
dextroamphetamine tab 10mg	QL= 6 tabs/day
DIAZEPAM RECTAL GEL	QL= 1 kit/30 days
diazoxide susp	QL=336 ml/30 days
dichlorphenamide tab	QL= 4 tabs/day
diclofenac gel 1%	QL=400grams/30 days
didanosine DR cap	QL= 1 cap/day
DIFICID SUSP	QL= 136 mL/10 days
DIFICID TAB	QL=20 tabs/10 days
DIGITAL THERAPY APPLICATION - SLEEP	QL=1 membership/lifetime
digoxin tab	QL=1 tab/day
dimethyl fumarate DR cap	QL= 2 caps/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.

EOCCO Formulary Cont.**Last Updated* 4/1/2025****Quantity Limit (QL)**

- The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
dimethyl fumarate DR starter pack	QL= 2 caps/day
donepezil tab 10mg	QL=60 tabs/30 days
donepezil tab 23mg	QL=1 tab/day
donepezil tab 5mg	QL=60 tabs/30 days
doxycycline hyclate DR tab 100mg	QL= 2 tabs/day
doxycycline monohydrate cap	QL= 2 caps/day
doxycycline monohydrate tab	QL= 2 tabs/day
doxylamine/pyridoxine dr tab	QL= 120 tabs/30 days
DULERA INHALER	QL= 1 inhaler/30 days
DUOBRII LOTION	QL=1 tube/30 days; Step Therapy requires trial of a high potency topical steroid
DUPIXENT INJ	QL= 2 inj/28 days
DUPIXENT PEN INJ	QL= 2 inj/28 days
efavirenz/emtricitabine/tenofovir df tab	QL= 1 tab/day
efavirenz/lamivudine/tenofovir df (lo) tab	QL= 1 tab/day
ELIQUIS STARTER PACK	QL= 1 pack /30 days
ELIQUIS TAB 2.5MG	QL= 2 tabs/1 day
ELIQUIS TAB 5MG	QL= 74 tabs/30 days
ELMIRON CAP	QL= 3 caps/day; ST requires trial of hydroxyzine
eluryng vaginal ring	QL=1 ring/21 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.

EOCCO Formulary Cont.**Last Updated* 4/1/2025****Quantity Limit (QL)**

- The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
EMGALITY INJ	QL= 1 inj/28 days
emtricitabine cap	QL= 1 cap/day
emtricitabine/tenofovir disoproxil fumarate tab	QL= 1 tab/day
ENBREL INJ	QL= 8 inj/28 days
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
entecavir tab	QL= 1 tab/day
ENTRESTO CAP	QL= 8 caps/day
ENTRESTO TAB	QL= 2 tabs/day
ephedrine hcl tab	QL= 12 tablets/day
EPINEPHRINE INJ 0.15MG	QL= 2 inj/fill
EPINEPHRINE INJ 0.3MG	QL= 2 inj/fill
epinephrine pen inj 0.15mg (1-Pack)	QL= 2 inj/fill
epinephrine pen inj 0.15mg, 0.3mg	QL= 2 inj/fill
epinephrine pen inj 0.3mg (1-Pack)	QL= 2 inj/fill
eplerenone tab	QL= 2 tabs/day
ERLEADA TAB	QL= 4 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.

EOCCO Formulary Cont.**Last Updated* 4/1/2025****Quantity Limit (QL)**

- The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
ERLEADA TAB 240MG	QL= 1 tab/day
erlotinib tab 25mg	QL = 3 tabs/day
ERY PAD	Step therapy requires trial of topical clindamycin or erythromycin gel/soln
esomeprazole DR granule pack	QL=1 pack/day
estradiol patch	QL= 8 patches/28 days
ETOPOSIDE CAP	QL= 20 caps/30 days
etravirine tab 100mg	QL=4 tabs/day
etravirine tab 200mg	QL=2 tabs/day
everolimus tab	QL=2 tabs/day
everolimus tab for oral susp	QL=1 tab/day
exemestane tab	QL=1 tab/day
EXSERVAN FILM	Only available through PantherRx Pharmacy 855-726-8479; QL=60 films/30 days
ezetimibe tab	QL= 1 tab/day
ezetimibe/simvastatin tab	
FACTIVE TAB	QL= 7 tabs/30 days
famciclovir tab 125mg	QL= 2 tabs/day
famciclovir tab 250mg	QL= 30 tabs/10 days
famciclovir tab 500mg	QL= 42 tabs/fill, 2 fills/month

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.

EOCCO Formulary Cont.**Last Updated* 4/1/2025****Quantity Limit (QL)**

- The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
febuxostat tab	QL=1 tab/day
felbamate susp	QL= 30ml/day
felbamate tab 400mg	QL= 9 tabs/day
felbamate tab 600mg	QL= 6 tabs/day
FEMLYV TAB	QL=28 tabs/24 days
FENTANYL BUCCAL TAB	QL= 3 tabs/day
FENTANYL CITRATE LOLLIPOP	QL= 120 lozenges/30 days
fentanyl patch	QL=15 patches/30 days; Step Therapy requires trial of morphine sulfate ER tab
FENTORA TAB	QL= 3 tabs/day
fexofenadine tab 180mg	QL=1 tab/day
fexofenadine/pseudoephedrine 24-hour tab	QL=1 tab/day
fingolimod hcl cap 0.5mg	QL=1 cap/day
FLUBLOK INJ	QL = 0.5mL/fill
FLUCELVAX INJ	QL = 0.5mL/fill
FLUMIST NASAL	QL= 1 dose/fill; Limited to members aged 2 to 49 years old
fluocinolone acetonide oil	QL=119ml/30 days
FLUTICASONE DISKUS INHALER	QL=2 inhalers/30 days
fluticasone nasal spray	QL= 16gm/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.

EOCCO Formulary Cont.**Last Updated* 4/1/2025****Quantity Limit (QL)**

- The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
FLUTICASONE/SALMETEROL INHALER	QL= 1 inhaler/30 days
fluticasone/salmeterol inhaler, wixela inhaler	QL= 1 inhaler/30 days
FOSAMAX+D TAB	QL= 4 tabs/28 days
fosamprenavir tab	QL= 4 tabs/day
FREE LIBRE 3-PLUS SENSOR	QL = 2 sensors/30 days
FREESTYLE INSULINX TEST STRIP	QL= 300 test strips/30 days
FREESTYLE LIBRE 2	QL= 2 sensors/28 days
FREESTYLE LIBRE 2 RECEIVER	QL= 1 receiver/year
FREESTYLE LIBRE 2-PLUS SENSOR	QL= 2 sensors/30 days
FREESTYLE LIBRE 3 READER	QL = 1 receiver/1 year
FREESTYLE LIBRE KIT 3 SENSOR	QL= 2 sensors/28 days
FREESTYLE LIBRE RECEIVER	QL= 1 receiver/year
FREESTYLE LIBRE SENSOR (10-DAY)	QL= 3 sensors/30 days
FREESTYLE LIBRE SENSOR (14-DAY)	QL= 2 sensors/28 days
FREESTYLE LITE TEST STRIP	QL= 300 test strips/30 days
FREESTYLE PRECISION NEO TEST STRIP	QL= 300 test strips/30 days
FREESTYLE TEST STRIP	QL= 300 test strips/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.

EOCCO Formulary Cont.**Last Updated* 4/1/2025****Quantity Limit (QL)**

- The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
FREESTYLE TEST STRIPS	QL= 300 strips/30 days
FULPHILA INJ	QL= 2 syringes/28 days
galantamine ER cap	QL= 1 cap/day
galantamine tab	QL= 2 tabs/day
GAMMAGARD LIQUID INJ	QL= 690ml/28 days
GAMUNEX-C INJ	QL= 960ml/28 days
gefitinib tab	QL=1 tab/day
GELNIQUE	QL= 30 packets/30 days
glatiramer inj 20mg/ml	QL= 30 syringes (30ml)/30 days
glatiramer inj 40mg/ml	QL= 12 syringes (12ml)/28 days
GLOPERBA SOLN	QL= 300ml/30 days
glucagon (rdna) for inj kit	QL = 2 inj/fill, 2 fill/month
glutamine (sickle cell) powder pack	Step Therapy requires trial of hydroxyurea cap; QL = 6 packets/day
glycopyrrolate oral soln	QL=9 ml/day
granisetron tab	QL= 1 tab/15 days; Step therapy requires trial of ondansetron
GRASTEK SL TAB	QL= 30 tabs/30 days
GVOKE INJ KIT	QL=2 vials/fill, 2 fills/30 days
HADLIMA INJ	QL= 2 syringes/28 days
HADLIMA PUSH INJ 40/0.4ML	QL= 2 inj/28 days
HADLIMA PUSH INJ 40/0.8ML	QL= 2 inj/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.

EOCCO Formulary Cont.**Last Updated* 4/1/2025****Quantity Limit (QL)**

- The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
HADLIMA PUSHTOUCH INJ	QL= 2 inj/28 days
HORIZANT TAB	QL= 30 tabs/30 days
HORIZANT TAB 600MG	QL= 60 tabs/30 days
HUMALOG MIX 50-50 KWIKPEN	QL= 60ml/30 days
HUMALOG MIX INJ	QL= 60ml/30 days
HUMULIN MIX INJ	QL= 60ml/30 days
HUMULIN MIX PEN INJ	QL= 60ml/30 days
HUMULIN N INJ	QL= 60ml/30 days
HUMULIN N PEN INJ	QL= 60ml/30 days
HUMULIN R INJ	QL= 60ml/30days
HUMULIN R INJ U-500	QL= 40ml/30 days
HUMULIN R U-500 KWIKPEN INJ	QL= 24ml/30 days
HYD POL/CPM SUSP	QL=10ml/day
hydrocodone/acetaminophen soln	QL= 90ml/day
hydrocodone/acetaminophen tab 10-325mg	QL= 12 tabs/day
hydrocodone/acetaminophen tab 2.5-325mg	QL= 12 tabs/day
hydrocodone/acetaminophen tab 5-325mg	QL= 12 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.

EOCCO Formulary Cont.**Last Updated* 4/1/2025****Quantity Limit (QL)**

- The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
hydrocodone/acetaminophen tab 7.5mg-325mg	QL= 12 tabs/day
HYDROXYPROGESTERONE CAPROATE INJ	QL=1 vial/35 days
hydroxyprogesterone inj	QL=4 vials/28 days
ibandronate tab 150mg	QL=1 tab/28 days
icatibant inj	QL=36 ml/30 days; Only available through Accredo 877-826-7657
ICLUSIG TAB	QL= 30 tabs/30 days; Only available through AcariaHealth 1-800-511-5144
icosapent ethyl cap 0.5gm	QL=2 caps/day
icosapent ethyl cap 1gm	QL= 4 caps/day
IMBRUVICA CAP 140MG	QL=4 caps/day; Only available through OPTUM - 877-445-6874
IMBRUVICA CAP 70MG	QL=1 cap/day; Only available through OPTUM - 877-445-6874
IMBRUVICA SUSP	QL=216 ml/30 days; Only available through OPTUM - 877-445-6874
IMBRUVICA TAB	QL=1 tab/day; Only available through OPTUM - 877-445-6874
imiquimod cream 5%	QL= 24gm/30 days
INCRUSE ELLIPTA INHALER	QL= 1 inhaler/30 days
INLYTA TAB	QL= 4 tabs/day; Only available through Walgreens 888-347-3416
INLYTA TAB 1MG	QL= 8 tabs/day; Only available through Walgreens 888-347-3416
INSULIN ASPART FLEXPEN INJ	QL= 60ml/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.

EOCCO Formulary Cont.**Last Updated* 4/1/2025****Quantity Limit (QL)**

- The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
INSULIN ASPART INJ	QL= 60ml/30 days
INSULIN ASPART MIX FLEXPEN INJ	QL= 60ml/30 days
INSULIN ASPART MIX INJ	QL= 60ml/30 days
INSULIN ASPART PENFILL INJ	QL= 60ml/30 days
INSULIN GLARGINE INJ	QL= 60ml/30 days
INSULIN GLARGINE, SEMGLEE INJ	QL= 60ml/30 days
INSULIN GLARGINE-YFGN	QL= 60ml/30 days
INSULIN LISPRO INJ	QL= 60ml/30 days
INSULIN LISPRO KWIKPEN INJ (JUNIOR)	QL= 60ml/30 days
INSULIN LISPRO PROTAMINE INJ	QL= 60ml/30 days
isosorbide dinitrate-hydralazine tab	QL=6 tabs/day
ISOXSUPRINE TAB	QL=4 tabs/day
ivabradine hcl tab	QL = 60 tabs/30 days
ivermectin cream	QL= 45gm/30 days
JORNAY PM CAP	QL=1 cap/day
JYNARQUE PAK	QL= 2 tabs/day; Only available through Walgreens 888-347-3416
JYNARQUE TAB 15MG	QL= 2 tabs/day; Only available through Walgreens 888-347-3416
KALYDECO PAK	QL=2 packets/day; Only available through Walgreens 888-347-3416
KALYDECO PAK 13.4MG	QL=2 packets/day; Only available through Walgreens 888-347-3416

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.

EOCCO Formulary Cont.**Last Updated* 4/1/2025****Quantity Limit (QL)**

- The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
KALYDECO TAB	QL= 2 tabs/day; Only available through Walgreens 888-347-3416
ketorolac tab	QL= 20 tabs/30 days
KYNMOBI FILM	QL= 150 films/30 days. Only available through Ardon 855-425-4085
lacosamide oral solution	QL= 1200ml/30 days
lacosamide tab	QL=2 tabs/day
LAGEVRIO CAP	QL=40 caps/5 days, 40 caps/fill; Covered for members age 18 years or older
LAGEVRIO CAP (EUA)	QL=40 caps/fill
lamivudine soln	QL= 960ml/30 days
lamivudine tab 150mg	QL= 2 tabs/day
lamivudine tab 300mg	QL= 1 tab/day
lamivudine/zidovudine tab	QL= 2 tabs/day
lanthanum carbonate chew tab 1000mg	QL=3 tabs/day; Step Therapy requires trial of sevelamer carbonate tab or sevelamer HCL tab
lanthanum carbonate chew tab 500mg	QL=5 tabs/day; Step Therapy requires trial of sevelamer carbonate tab or sevelamer HCL tab
lanthanum carbonate chew tab 750mg	QL=3 tabs/day; Step Therapy requires trial of sevelamer carbonate tab or sevelamer HCL tab
LATANOPROST OPHTH SOLN	QL=30 single use containers/30 days; Step therapy requires trial of latanoprost ophth soln

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.

EOCCO Formulary Cont.**Last Updated* 4/1/2025****Quantity Limit (QL)**

- The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
lenalidomide cap	QL= 1 cap/day; Only available through Onco360 877-662-6633
LENVIMA CAP	QL= 3 caps/day; Only available through OPTUM - 877-445-6874
LEVALBUTEROL INHALER	QL= 2 inhalers/fill, 2 fills/30 days; Step Therapy requires trial of albuterol hfa inhaler
levalbuterol neb soln	QL= 96 vials/30 days; Step Therapy requires trial of albuterol neb soln
levocetirizine soln	QL= 10ml/day
LIKMEZ SUSP	QL = 210 mL/14 days
LIQUIMAT LOTION	QL= 360g/30 days
liraglutide soln pen-injector	
lofexidine tab	QL= 224 tablets/fill; 1 fill/month
LOKELMA PAK	QL=1 pak/day; Step Therapy requires trial of 1 diuretic: chlorothiazide, chlorthalidone, bumetanide, hydrochlorothiazide, torsemide, indapamide, furosemide, ethacrynic acid, metolazone, chlorothiazide or hydrochlorothiazide
LONSURF TAB	QL= 80 tabs/28 days; Only available through OPTUM - 877-445-6874 or Walgreens 888-347-3416
lopinavir/ritonavir soln	QL= 480ml/30 days
lopinavir-ritonavir tab 100-25mg	QL=2 tabs/day
lopinavir-ritonavir tab 200-50mg	QL=4 tabs/day
loteprednol etabonate ophth gel	QL= 5 grams/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.

EOCCO Formulary Cont.**Last Updated* 4/1/2025****Quantity Limit (QL)**

- The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
lovastatin tab	QL= 2 tabs/day
lubiprostone cap	QL=2 caps/day
maraviroc tab 150mg	QL=2 tabs/day
maraviroc tab 300mg	QL=4 tabs/day
MAVYRET PAK	QL=5 packets/day
MAVYRET TAB	QL= 3 tabs/day
medroxyprogesterone inj	QL= 1 inj/84 days
MEKINIST SOLN	QL=40 ml/day
MEKINIST TAB 0.5MG	QL= 3 tabs/day
MEKINIST TAB 2MG	QL= 1 tab/day
meloxicam cap	QL= 1 cap/day; Step Therapy requires trial of meloxicam, aspirin, naproxen, diclofenac, ketoprofen, oxaprozin, sulindac, or tolmetin
memantine ER cap	QL= 1 cap/day; Step Therapy requires trial of memantine tab
mesalamine DR cap	QL= 6 caps/day
mesalamine DR tab 1.2 GM	QL 120 tabs/30 days
mesalamine enema	QL= 60mL/day
mesalamine ER cap	QL= 8 caps/day
mesalamine supp	QL= 1 supp/day
methadone soln	QL= 4 ml/day
METHADONE SOLN 10MG/5ML	QL= 20ml/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.

EOCCO Formulary Cont.**Last Updated* 4/1/2025****Quantity Limit (QL)**

- The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
METHADONE SOLN 5MG/5ML	QL= 40ml/day
methadone tab 10mg	QL= 4 tabs/day
methadone tab 5mg	QL= 8 tabs/day
methadose tab	QL= 1 tab/day
methylphenidate CD cap	QL= 1 cap/day
methylphenidate chew tab	QL= 3 tabs/day
methylphenidate ER cap 10mg	QL=60 caps/30 days
methylphenidate ER cap 20mg	QL= 2 caps/day
methylphenidate ER cap 30mg	QL= 2 caps/day
methylphenidate ER cap 40mg	QL= 1 cap/day
methylphenidate ER cap 60mg	QL= 1 cap/day
METHYLPHENIDATE ER TAB	QL= 1 tab/day
methylphenidate ER tab 10mg	QL= 3 tabs/day
methylphenidate ER tab 18mg	QL=60 tabs/30 days
methylphenidate ER tab 20mg	QL= 3 tabs/day
methylphenidate ER tab 27mg	QL=60 tabs/30 days
methylphenidate ER tab 36mg	QL=60 tabs/30 days
methylphenidate soln 10mg/5ml	QL= 900ml/30 days
methylphenidate soln 5mg/5ml	QL= 1800ml/30 days
methylphenidate tab	QL= 3 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.

EOCCO Formulary Cont.**Last Updated* 4/1/2025****Quantity Limit (QL)**

- The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
methyltestosterone cap	QL= 150 caps/30 days
metyrosine cap	QL= 448 caps/28 days
mifepristone tab	QL = 4 tabs/day
miglustat cap	QL= 3 caps/day; Only available through Accredo 877-826-7657
morphine sulfate ER cap 100mg	QL= 2 caps/day
morphine sulfate ER cap 10mg	QL= 2 caps/day
morphine sulfate ER cap 30mg	QL= 2 caps/day
morphine sulfate ER tab	QL= 3 tabs/day
moxifloxacin ophth soln	QL=3 ml/7 days; Step therapy requires trial of ciprofloxacin ophth soln levofloxacin ophth soln, or ofloxacin ophth soln
MRESVIA INJ	QL= 0.5 mL/fill; Covered for ages 60 years and older
MULPLETA TAB	QL= 7 tabs/fill, 3 fills/365 days; Only available through Lumicera 855-847-3553
MYTESI TAB	QL= 2 tabs/day
NALOXONE HCL SOLN 0.4MG/ML	QL = 2 mL/fill, 2 fills/30 days
NAMENDA XR TITRATION PACK	QL= 28 caps/28 days, Step Therapy requires trial of memantine tab
naratriptan tab	QL= 9 tabs/30 days
NATACYN OPTH SUSP	QL=45 ml/30 days
NATESTO NASAL GEL	QL=3 bottles/30 days
NAYZILAM SPRAY	QL = 4 doses/fill, 5 fills/month

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.

EOCCO Formulary Cont.**Last Updated* 4/1/2025****Quantity Limit (QL)**

- The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
nebivolol tab	QL=1 tab/day
NEFFY SPRAY	QL=2 inj/fill
NEVIRAPINE ER TAB	QL= 1 tab/day
NEVIRAPINE SUSP	QL=1200 ml/30 days
nevirapine tab	QL= 2 tabs/day
NEXTSTELLIS TAB	QL=28 tabs/24 days
niacin ER tab	QL= 2 tabs/day
nilutamide tab	QL= 2 tabs/day
NINJACOF-XG LIQUID	QL=473 ml/month
NOVOLIN 70/30 FLEXPEN INJ	QL= 60ml/30 days
NOVOLIN 70/30 INJ	QL= 60ml/30 days
NOVOLIN N FLEXPEN INJ	QL=60ml/30 days
NOVOLIN N INJ	QL= 60ml/30 days
NOVOLIN N RELION INJ	QL= 60ml/30 days
NOVOLIN R INJ 100 UNIT	QL = 60ml/30 days
NOVOLIN R FLEXPEN INJ	QL= 60ml/30 days
NOVOLIN R INJ	QL= 60ml/30 days
NOVOLIN RELION INJ 70/30	QL= 60mls/30 days
NOVOLIN VIAL	QL= 60ml/30 days
NUCALA INJ	QL=1 inj/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.

EOCCO Formulary Cont.**Last Updated* 4/1/2025****Quantity Limit (QL)**

- The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
NUCYNTA ER TAB	QL= 2 tabs/day
NUEDEXTA CAP	QL= 2 caps/day; Step therapy requires trial of 1 SSRI AND 1 TCA
NYVEPRIA INJ	QL=2 inj/28 days
ODACTRA SL TAB	QL= 30 tabs/30 days
olmesartan/amlodipine/hydrochlorothiazide tab	QL=1 tab/day
omeprazole DR cap	QL=1 cap/day
OMEPRAZOLE DR TAB	QL= 2 tabs/day
omeprazole magnesium delayed release tab	QL= 1 tab/day
omeprazole tab	QL=2 tabs/day
OMNIPOD 5 G6 INTRO KIT	QL= 1 kit/year
OMNIPOD 5 G6 MIS PODS	QL= 15 pods/30 days
OMNIPOD 5 G6 PODS MISC	QL= 15 pods/30 days
OMNIPOD 5 G7 KIT INTRO	QL= 1 kit/year
OMNIPOD 5 G7 MIS PODS	QL= 15 pods/30 days
OMNIPOD 5 INTRO KIT	QL= 1 kit/year
OMNIPOD 5 PACK PODS	QL= 15 pods/30 days
OMNIPOD DASH INTRO KIT	QL= 1 kit/year
OMNIPOD DASH PODS	QL= 15 pods/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.

EOCCO Formulary Cont.**Last Updated* 4/1/2025****Quantity Limit (QL)**

- The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
OMNIPOD GO KIT 20UNT/DY	QL= 10 pods/month
OMNIPOD GO KIT 30UNT/DY	QL= 10 pods/month
OMNIPOD GO KIT 40UNT/DY	QL= 10 pods/month
OMNIPOD GO KIT	QL= 10 pods/month
OMNIPOD STARTER KIT	QL= 1 kit/year
ondansetron inj	QL= 24mL/fill, 1 fill/15 days
ondansetron ODT 4 MG	QL=6 tabs/day
ondansetron ODT 8 MG	QL=3 tabs/day
ondansetron soln 4 MG/5 ML	QL= 5ml/day
ondansetron tab 4 MG	QL=6 tabs/day
ondansetron tab 8 MG	QL=90 tabs/30 days
ORALAIR SL TAB	QL= 30 tabs/30 days
ORKAMBI GRANULES PACKET	QL= 2 packets/day; Only available through Walgreens 888-347-3416
oseltamivir cap 30mg	QL= 28 caps/90 days, 1 fill/120 days
oseltamivir cap 45mg	QL= 14 caps/90 days, 1 fill/120 days
oseltamivir cap 75mg	QL= 14 caps/90 days, 1 fill/120 days
oseltamivir susp	QL= 120ml/10 days, 1 fill/120 days
oxybutynin ER tab 10 MG	QL=2 tabs/day
oxybutynin ER tab 5 MG	QL=1 tab/day
oxybutynin syrup	QL=20ml/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.

EOCCO Formulary Cont.**Last Updated* 4/1/2025****Quantity Limit (QL)**

- The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
oxybutynin tab	QL=4 tabs/day
oxycodone cap	QL= 16 caps/day
oxycodone conc	QL= 240 syringes/30 days
OXYCODONE ER TAB 10MG	QL= 2 tabs/day; Step Therapy requires trial of morphine sulfate ER ta
OXYCODONE ER TAB 15MG	QL= 2 tabs/day; Step Therapy requires trial of morphine sulfate ER ta
OXYCODONE ER TAB 20MG	QL= 2 tabs/day; Step Therapy requires trial of morphine sulfate ER ta
OXYCODONE ER TAB 30MG	QL= 2 tabs/day; Step Therapy requires trial of morphine sulfate ER ta
OXYCODONE ER TAB 40MG	QL= 2 tabs/day; Step Therapy requires trial of morphine sulfate ER ta
OXYCODONE ER TAB 60MG	QL= 2 tabs/day; Step Therapy requires trial of morphine sulfate ER ta
OXYCODONE ER TAB 80MG	QL= 4 tabs/day; Step Therapy requires trial of morphine sulfate ER ta
oxycodone soln	QL= 2400ml/30 days
oxycodone tab 10mg	QL= 8 tabs/day
oxycodone tab 15mg	QL= 5.34 tabs/day
oxycodone tab 20mg	QL= 4 tabs/day
oxycodone tab 30mg	QL= 2 tabs/day
oxycodone tab 5mg	QL= 16 tabs/day
oxycodone/acetaminophen tab 10-325mg	QL= 12 tabs/day
oxycodone/acetaminophen tab 2.5-325mg	QL= 12 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.

EOCCO Formulary Cont.**Last Updated* 4/1/2025****Quantity Limit (QL)**

- The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
oxycodone/acetaminophen tab 5-325mg	QL= 12 tabs/day
oxycodone/acetaminophen tab 7.5-325mg	QL= 12 tabs/day
OXYCONTIN ER 10MG TAB	QL= 2 tabs/day; Step Therapy requires trial of morphine sulfate ER tab
OXYCONTIN ER 20MG TAB	QL= 2 tabs/day; Step Therapy requires trial of morphine sulfate ER tab
OXYCONTIN ER 40MG TAB	QL= 2 tabs/day; Step Therapy requires trial of morphine sulfate ER tab
oxymorphone ER tab 30mg	QL= 4 tabs/day
oxymorphone ER tab 40mg	QL= 4 tabs/day
OXYTROL PATCH	QL= 1 patch/3 days
pantoprazole EC tab	QL=2 tabs/day
pantoprazole packet	QL=1 packet/day
PAXLOVID TAB 150-100	QL= 20 tabs/5 days; 20 tabs/fill; Covered for members age 12 years and older
PAXLOVID TAB 300-100	QL= 30 tabs/5 days; 30 tabs/fill; Covered for members age 12 years and older
pazopanib hcl tab	QL = 120 tabs/30 days
pb-belladonna elixir	QL= 1200ml/30 days
peg 3350/electrolytes soln	QL= 2 fills/calendar year
PEGASYS INJ	QL=2 inj/28 days
penicillamine tab	QL= 480 tabs/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.

EOCCO Formulary Cont.**Last Updated* 4/1/2025****Quantity Limit (QL)**

- The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
pentamidine neb soln	QL=1 vial/month
pioglitazone tab	QL= 1 tab/day
pioglitazone/metformin tab	QL= 3 tabs/day
pirfenidone cap	QL=3 caps/day
PIRFENIDONE TAB	QL=4 tabs/day; Only available through Lumicera 855-847-3553
pirfenidone tab 267mg	QL=9 tabs/day
pirfenidone tab 801mg	QL=3 tabs/day
PODOFILOX SOLN	QL= 0.5mL/day
POMALYST CAP	QL= 21 caps/28 days; Only available through Walgreens 888-347-3416
potassium iodide oral soln	QL=90 ml/30 days
potassium phosphate monobasic tab	QL=8 tabs/day
pramipexole ER tab	QL= 1 tab/day
prasugrel tab	QL=1 tab/day
pravastatin tab	QL= 1 tab/day
PRECISION XTRA KETONE TEST STRIP	QL=300 strips/30 days
PRECISION XTRA TEST STRIP	QL= 300 test strips/30 days
pregabalin soln	QL= 30ml/day
PRIMIDONE TAB	QL=4 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.

EOCCO Formulary Cont.**Last Updated* 4/1/2025****Quantity Limit (QL)**

- The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
PROMACTA TAB	
PROMETHAZINE VC SYRUP	QL= 30 mL/day
pseudoephedrine ER tab 120mg	QL= 2 tabs/day
pseudoephedrine tab 30mg	QL= 8 tabs/day
pseudoephedrine tab 60mg	QL= 4 tabs/day
PULMOZYME INH SOLN	QL= 30 ampules/30 days
QUILLICHEW ER TAB	QL= 1 tab/day
QUILLICHEW ER TAB 20MG	QL=3 tabs/day
QUILLICHEW ER TAB 30MG	QL=2 tabs/day
quinidine sulfate tab	QL=8 tabs/day
QUINIDINE SULFATE TAB 200MG	QL= 8 tabs/day
QUINIDINE SULFATE TAB 300MG	QL= 5 tabs/day
RAGWITEK SL TAB	QL= 30 tabs/30 days
raloxifene tab	QL= 1 tab/day
ranolazine tab	QL=4 tabs/day
rasagiline tab	QL= 1 tab/day
RAYALDEE CAP	QL= 1 cap/day
RELAFEN DS TAB	QL= 2 tabs/day
RELENZA DISKHALER	QL= 1 inhaler/fill, 1 fill/month
REPATHA INJ	QL= 2 inj/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.

EOCCO Formulary Cont.**Last Updated* 4/1/2025****Quantity Limit (QL)**

- The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
REPATHA PUSHTRONEX INJ	QL= 1 inj/28 days
REPREXAIN TAB	QL=5 tabs/day
RETACRIT INJ	QL= 4 vials/30 days
RIAX FOAM	QL= 360g/30 days
riluzole tab	QL=2 tabs/day
risedronate tab 30mg	QL= 1 tab/day
risedronate tab 35mg	QL= 4 tabs/28 days
risedronate tab 5mg	QL= 1 tab/day
ritonavir tab	QL= 12 tabs/30 days
rizatriptan ODT	QL= 12 tabs/30 days
rizatriptan tab	QL= 12 tabs/30 days
roflumilast tab	QL=1 tab/day
rosuvastatin tab	QL= 1 tab/day
RUBRACA TAB	QL= 4 tabs/day; Only available through OPTUM - 877-445-6874
SAVAYSA TAB	QL= 1 tab/day
scopolamine patch	QL= 10 patches/30 days
SEGLUROMET TAB	QL= 2 tabs/day
SEGLUROMET TAB 2.5-500MG	QL= 4 tabs/day
selegiline tab	QL=2 tabs/day
SHINGRIX INJ	Covered for members age 18 or older; QL= 2 inj/lifetime

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.

EOCCO Formulary Cont.**Last Updated* 4/1/2025****Quantity Limit (QL)**

- The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
sildenafil susp	QL= 224ml/30 days
sildenafil tab 20mg	QL= 3 tabs/day
simvastatin tab 5mg, 10mg, 20mg, 40mg	QL= 1 tab/day
simvastatin tab 80mg	QL= 1 tab/day
SIVEXTRO TAB	QL=6 tabs/fill
SLYND TAB	QL=28 tabs/24 days
sodium/potassium/magnesium soln	QL=2 fills/year
SOFOSBUVIR/VELPATASVIR TAB	QL= 1 tab/day
solifenacin tab	QL= 1 tab/day
SOLOSEC GRANULES PACKET	QL= 2 packets/28 days
SPIKEVAX INJ	QL=1 dose/24 days
SPIRIVA RESPIMAT INHALER 1.25MCG/ACT	QL= 1 inhaler/30 days
SPIRIVA RESPIMAT INHALER 2.5MCG/ACT	QL= 1 inhaler/30 days
stavudine cap	QL= 2 caps/day
stavudine soln	QL= 2400ml/30 days
STEGLATRO TAB	QL= 2 tabs/day
STIVARGA TAB	QL= 84 tabs/28 days; Only available through Walgreens 888-347-341

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.

EOCCO Formulary Cont.**Last Updated* 4/1/2025****Quantity Limit (QL)**

- The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
STRENSIQ INJ 18MG/.45ML	QL= 24 vials/28 days; Only available through PantherRx Pharmacy 855-726-8479
STRENSIQ INJ 28MG/0.7ML	QL= 24 vials/28 days; Only available through PantherRx Pharmacy 855-726-8479
STRENSIQ INJ 40 MG/ML	QL= 24 vials/28 days; Only available through PantherRx Pharmacy 855-726-8479
STRENSIQ INJ 80MG/0.8ML	QL= 24 vials/28 days; Only available through PantherRx Pharmacy 855-726-8479
STRIBILD TAB	QL= 1 tab/day
STRIVERDI RESPIMAT INHALER	QL= 1 inhaler/30 days
SUBSYS SPRAY	QL= 4 sprays/day
sulfadiazine tab	QL=8 tabs/day
sumatriptan nasal spray	QL= 6 sprays/30 days; ST req trial of 2: naratriptan tab, rizatriptan tab/ODT, zolmitriptan tab, or sumatriptan tab
sumatriptan tab	QL= 9 tabs/30 days
sumatriptan vial inj	QL=4 ml/30 days; ST req trial of 2: naratriptan tab, rizatriptan tab/ODT, zolmitriptan tab, or sumatriptan tab
sunitinib malate cap	QL= 28 caps/42 day
SYMDEKO TAB	QL= 2 tabs/day; Only available through Walgreens 888-347-3416
SYMJEPI INJ	QL= 2 inj/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.

EOCCO Formulary Cont.**Last Updated* 4/1/2025****Quantity Limit (QL)**

- The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
SYNAGIS INJ	QL=2 inj/28 days
SYNAGIS INJ	QL=2 inj/28 days
TABLOID TAB	QL= 4 tabs/day
tadalafil tab	QL=1 tab/day
tadalafil tab (PAH)	QL= 2 tabs/day
TAFINLAR CAP	QL= 4 caps/day
TAFINLAR TAB	QL=12 tabs/day
tafluprost preservative free (pf) ophth soln	QL=30 pouches/30 days
TAMIFLU CAP 30MG	QL=28 caps/90 days
TAMIFLU CAP 45MG	QL=14 caps/90 days
TAMIFLU CAP 75MG	QL=14 caps/90 days
TAMIFLU SUSP	QL=120ml/fill
TASIGNA CAP	QL=2 caps/day
tazarotene cream 0.1%	QL= 360g/30 days
tenofovir disoproxil fumarate tab	QL= 1 tab/day
terbinafine tab	QL=1 tab/day
terconazole cream 0.4%	QL=45 gm/fill
terconazole cream 0.8%	QL=20 gm/fill
terconazole supp	QL=3 supps/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.

EOCCO Formulary Cont.**Last Updated* 4/1/2025****Quantity Limit (QL)**

- The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
teriflunomide tab	QL= 1 tab/day
TERIPARATIDE INJ	QL= 2.48ml/28 days
testosterone cypionate inj	QL=1 vial/28 days
TESTOSTERONE ENANTHATE INJ	QL= 5mL/28 days
testosterone gel 1% 25mg	QL=2.5 gm/day
testosterone gel pump 1.62%	QL=150 gm/30 days
THEOPHYLLINE ER TAB	QL= 1 tab/day
thioridazine hcl tab	QL= 8 tabs/day
tiagabine tab 12mg	QL= 4 tabs/day
tiagabine tab 16mg	QL= 3 tabs/day
tiagabine tab 2mg	QL= 4 tabs/day
tiagabine tab 4mg	QL= 4 tabs/day
tiopronin dr tab	QL= 8 tabs/day
tiopronin tab	Only available through Eversana 636-519-2400; QL=8 tabs/day
tiotropium bromide cap inhaler	QL= 1 cap/day; For use with Handihaler device
TIVICAY PD TAB	QL= 180 tabs/30 days
TIVICAY TAB	QL=2 tabs/day
TOBI PODHALER	QL= 1 inhaler/56 days
tobramycin neb soln	QL= 280ml/30 days
tolvaptan tab	QL= 1 tab/day; Only available through Walgreens 888-347-3416

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.

EOCCO Formulary Cont.**Last Updated* 4/1/2025****Quantity Limit (QL)**

- The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
topiramate ER cap 150mg	QL= 2 caps/day
topiramate ER cap 200mg	QL= 2 caps/day
TRAMADOL ER CAP	QL=1 cap/day
tramadol ER tab	QL= 1 tab/day; Step Therapy requires trial of tramadol tab
tramadol ER tab 100mg	QL= 1 tab/day; Step Therapy requires trial of tramadol tab
tramadol ER tab 200mg	QL= 1 tab/day; Step Therapy requires trial of tramadol tab
tramadol ER tab 300mg	QL= 1 tab/day; Step Therapy requires trial of tramadol tab
tramadol tab 100mg	QL= 4 tabs/day
tramadol/acetaminophen tab	QL= 6 tabs/day
tranexamic acid tab	QL= 6 tabs/day 30 tabs/28 days
TRELEGY ELLIPTA INHALER	QL= 1 inhaler/30 days
tretinoin cream	QL= 360g/30 days, Step therapy requires trial of adapalene gel, followed by tretinoin cream 0.025%
tretinoin cream 0.025%	QL= 360g/30 days, Step therapy requires trial of adapalene gel
tretinoin gel	QL= 360g/30 days, Step therapy requires trial of adapalene gel, followed by tretinoin cream 0.025%
tretinoin gel 0.03%	QL= 360g/30 days, Step therapy requires trial of adapalene gel, followed by tretinoin cream 0.025%
TRIHEXYPHENIDYL SOLN	QL=946ml/28 days
trilyte soln	QL= 2 fills/calendar year

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.

EOCCO Formulary Cont.**Last Updated* 4/1/2025****Quantity Limit (QL)**

- The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
TRIUMEQ PD TAB	QL=6 tabs/day
TRULICITY INJ	QL= 4 pens/28 days
TUXARIN ER TAB	QL= 20 tabs/day
TYENNE INJ	QL = 1.8mL/28 days
TYMLOS INJ	QL= 1.56ml/28 days
VALSARTAN SOLN	QL = 2400 mL/30 days
vancomycin cap 125mg	QL= 56 caps/30 days
vancomycin cap 250mg	QL= 112 caps/30 days
VANDAZOLE GEL 0.75%	Step therapy requires trial of metronidazole tab or clindamycin cap/or soln; QL 1 package/30 days
VEMLIDY TAB	QL= 1 tab/day
VICTOZA INJ	QL= 9ml/30 days
voriconazole susp	QL=15ml/day
voriconazole tab	QL=3 tabs/day
WYNZORA CREAM	QL=420 gm/28 days, Step therapy requires trial of 2 topicals: calcipotriene, betamethasone, AMCINONIDE, fluocinonide, triamcinolone.
XALKORI CAP	QL=6 caps/day; Only available through Walgreens 888-347-3416
XARELTO STARTER PACK	QL= 1 pack/30 days
XARELTO SUSP	QL=10ml/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.

EOCCO Formulary Cont.**Last Updated* 4/1/2025****Quantity Limit (QL)**

- The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
XARELTO TAB	QL= 60 tabs/30 days
XARELTO TAB 10MG	QL= 30 tabs/30 days
XARELTO TAB 15MG	QL= 60 tabs/30 days
XARELTO TAB 20MG	QL=30 tabs/30 days
XIFAXAN TAB 200MG	QL= 9 tabs/3 days
XIFAXAN TAB 550MG	QL= 2 tabs/day
XOLAIR 150MG/ML INJ	QL= 1 inj/28 days
XOLAIR 300MG/2ML INJ	QL= 1 inj/28 days
XOLAIR 75MG/0.5ML INJ	QL= 1 inj/28 days
XOLAIR INJ	QL= 1 inj/28 days
XOLAIR INJ 150MG/ML	QL= 1 inj/28 days
XOLAIR INJ 300MG/2ML	QL= 1 inj/28 days
XOLAIR INJ 75MG/0.5ML	QL= 1 inj/28 days
zaleplon cap	QL= 2 caps/day
ZARXIO INJ	QL=14 syringes/28 days
ZARXIO INJ 480/0.8	QL= 14 syringes/28days
ZEJULA CAP	QL= 30 caps/30 days; Only available through OPTUM - 877-445-6874
ZEJULA TAB	QL= 1 tab/day; Only available through OPTUM - 877-445-6874
zenzedi tab 10mg	QL= 3 tabs/day
zephrex-d tab 30mg	QL= 240 tabs/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.

EOCCO Formulary Cont.**Last Updated* 4/1/2025****Quantity Limit (QL)**

- The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
ZERVIAE OPTH SOLN	QL= 30 single use containers/30 days
ZETONNA NASAL SPRAY	QL= 1 bottle/30 days
zidovudine cap	QL= 6 caps/day
zidovudine syrup	QL= 1920ml/30 days
zidovudine tab	QL= 2 tabs/day
zolmitriptan tab	QL= 9 tabs/30 days
zolpidem ER tab	QL= 1 tab/day; Step Therapy requires trial of zolpidem tab
zolpidem er tab 6.25mg	QL= 2 tabs/day
zolpidem tab 10 MG	QL=1 tab/day
zolpidem tab 5 MG	QL=2 tabs/day
ZOLPIMIST SPRAY	QL= 1 bottle/30 days
ZYPITAMAG TAB	QL= 1 tab/day
ZYRTEC CHEW 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.

Language access statement



English. You can get this document in other languages, large print, Braille or a format you prefer. You can also ask for an interpreter. This help is free. Call 800-342-0526 or TTY 711. We accept relay calls. You can get help from a certified and qualified health care interpreter.

Español (Spanish). Puede obtener este documento en otros idiomas, en letra grande, en braille o en el formato que usted prefiera. También puede recibir los servicios de un intérprete. Esta ayuda es gratuita. Llame al servicio de atención al cliente 800-342-0526 o TTY 711. Aceptamos todas las llamadas de retransmisión. Usted puede obtener ayuda de un intérprete certificado y calificado en atención de salud.

Русский (Russian). Вы можете получить это документ на другом языке, напечатанное крупным шрифтом, шрифтом Брайля или в предпочитаемом вами формате. Вы также можете запросить услуги устного переводчика. Эта помощь предоставляется бесплатно. Звоните по тел. 800-342-0526 или TTY 711. Мы принимаем звонки по линии трансляционной связи. Вы можете получить помощь от аккредитованного и квалифицированного медицинского переводчика.

Tiếng Việt (Vietnamese). Quý vị có thể nhận tài liệu này bằng một ngôn ngữ khác, theo định dạng chữ in lớn, chữ nổi Braille hoặc một định dạng khác theo ý muốn. Quý vị cũng có thể yêu cầu được thông dịch viên hỗ trợ. Sự trợ giúp này là miễn phí. Gọi 800-342-0526 hoặc TTY (Đường dây Dành cho Người Khiếm thính hoặc Khuyết tật về Phát âm) 711. Chúng tôi chấp nhận các cuộc gọi chuyển tiếp. Quý vị có thể nhận được sự giúp đỡ từ một thông dịch viên có chứng nhận và đủ tiêu chuẩn chuyên về chăm sóc sức khỏe.

العربية (Arabic). يمكنكم الحصول على هذا وثيقة بلغات أخرى، أو مطبوعة بخط كبير، أو مطبوعة على طريقة برايل أو حسب الصيغة المفضلة لديكم. كما يمكنكم طلب مترجم شفهي. إن هذه المساعدة مجانية. اتصلو على 800-342-0526 أو المبرقة الكاتبة TTY 711. نستقبل المكالمات المحولة. يمكنكم الحصول على المساعدة من مترجم معتمد ومؤهل في مجال الرعاية الصحية.

Somali. Waxaad heli kartaa warqadan oo ku qoran luqaddo kale, far waaweyn, farta dadka indhaha aan qabin wax ku akhriyaan ee Braille ama qaabka aad doorbidayso. Waxaad sidoo kale codsan kartaa turjubaan. Taageeradani waa lacag la'aan. Wac 800-342-0526 ama TTY 711. Waa aqbalnaa wicitaanada gudbinta. Waxaad caawimaad ka heli kartaa turjubaanka daryeelka caafimaadka oo xirfad leh isla markaana la aqoonsan yahay.

简体中文 (Simplified Chinese). 您可获取本文件的其他语言版、大字版、盲文版或您偏好的格式版本。您还可要求提供口译员服务。本帮助免费。致电 800-342-0526 或 TTY 711。我们会接听所有的转接来电。您可以从经过认证且合格的医疗口语翻译人员那里获得帮助。

繁體中文 (Traditional Chinese). 您可獲得本信息函的其他語言版本、大字版、盲文版或您偏好的格式。您也可申請口譯員。以上協助均為免費。請致電 800-342-0526 或聽障專線 711。我們接受所有傳譯電話。您可透過經認證的合格醫療保健口譯員取得協助。

한국어 (Korean). 이문서는 다른 언어, 큰 활자, 점자 또는 선호하는 형식으로 받아보실 수 있습니다. 통역사를 요청하실 수도 있습니다. 무료 지원해 드립니다. 800-342-0526 또는 TTY 711에 전화하십시오. 저희는 중계 전화를 받습니다. 공인 및 자격을 갖춘 의료서비스 전문 통역사의 도움을 받으실 수 있습니다.

Chuukic (Chuukese). En mi tongeni angei ei taropwe non pwan ew fosun fenu, mese watte mak, Braille ika pwan ew format ke mwochen. En mi tongeni pwan tingor emon chon chiaku Ei aninis ese fokkun pwan kamo. Kokori 800-342-0526 ika TTY 711. Kich mi etiwa ekkewe keken relay. En mi tongeni kopwe angei aninis seni emon mi certified ika qualified ren chon chiaku ren health care.

Українська (Ukrainian). Ви можете отримати цей довідник іншими мовами, крупним шрифтом, шрифтом Брайля або у форматі, якому ви надаєте перевагу. Ви також можете попросити надати послуги перекладача. Ця допомога є безкоштовною. Дзвоніть по номеру телефону 800-342-0526 або телетайпу 711. Ми приймаємо всі дзвінки, які на нас переводять. Ви можете отримати допомогу від сертифікованого та кваліфікованого медичного перекладача.

فارسی (Farsi). می‌توانید این نامه را به زبان‌های دیگر، درشت‌خط، بریل یا قالب ترجمه‌ای دیگری دریافت کنید. می‌توانید مترجم شفاهی نیز درخواست کنید. این کمک رایگان است. با 800-342-0526 یا TTY 711 تماس بگیرید. تماس‌های رله را می‌پذیریم. می‌توانید از یک مترجم شفاهی دارای گواهی و باکفایت در زمینه بهداشت و

Kiswahili (Swahili). Unaweza kupata herufi hii kwa lugha zingine, kwa herufi kubwa, kwa lugha ya maandishi kwa vipofu au namna yeyote unayopendelea. Unaweza pia kuomba mkalimani. Msaada huu ni wa bure. Piga 800-342-0526 au TTY 711. Tunakubali simu za kupitisha ujumbe. Unaweza pata usaidizi kutoka kwa mkalimani wa huduma ya afya aliyeidhinishwa na aliyehitimu.

မြန်မာဘာသာစကား (Burmese). ဤစာကို အချားဘာသာစကားများ၊ ပုံနှိပ်စာလုံးပုံစံ၊ မ်ကျမဋ္ဌားအကြံကု ဘေရးလု သို့မဟုတ် သင်္ဃိမိုးဝှက် သည့် ပုံစံပူဖင်း ရယူနိုင်ပါသည်။ သည့် စကားပြောနည်းလည်း တောင့်ဆံ့ နိုင်ပါသည်။ ဤအကူအညီသည် အခမဲ့ပူဖွယ်ပါသည်။ 800-342-0526 သို့မဟုတ် TTY 711 ကို ဖုန်းဆက်ပါ။ ထည့်သွင်းခံဆံ့မေးမားကို ကဖြေးပွဲပွဲလက် ပါသည်။ သည့် သင့်ဆုံးလက်တွဲအရည်အသွေးရှိသည့် ကံနား မာရေး စောင့်ပွဲကွဲး စကားပြောနည်းလည်း အကူအညီရယူနိုင်ပါသည်။

አማርኛ (Amharic). ይህንን ደብዳቤ በሌሎች ቋንቋዎች፣ በትልቅ ህትመት፣ በብሬይል ወይም እርሶ በሚመርጡት መልኩ ማግኘት ይቻላል። በተጨማሪም አስተርጓሚ መጠየቅም ይቻላል። ይህ ድጋፍ የሚሰጠው በነጻ ነው። ወደ 800-342-0526 ወይም TTY 711 ይደውሉ። የሪሌድ ጥሪዎችን እንቀበላለን። ፍቃድ ካለው እና ብቃት ካለው የጤና እንክብካቤ አስተርጓሚ ድጋፍ ማግኘት ይቻላል።

Română (Romanian). Puteți obține această scrisoare în alte limbi, cu scris cu litere majuscule, în Braille sau într-un format preferat. De asemenea, puteți solicita un interpret. Aceste servicii de asistență sunt gratuite. Sunați la 800-342-0526 sau TTY 711. Acceptăm apeluri adaptate persoanelor surdomute. Puteți obține ajutor din partea unui interpret de îngrijire medicală certificat și calificat.