



## CMDP Preferred Drug List

- Generic Drugs Are Preferred Over Brand Name Drugs Unless Specified as Brand Only
- Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List Are Available Through Prior Authorization

Effective Date: 10/1/2019

Drug Class/Drug Name	Reference Brand Name	Brand Only / Generic Notes	Preferred Drug Status	PA Type	Step Therapy Requirements	Quantity Limit	QL Days
<b>ADHD/ANTI-NARCOLEPSY</b>							
<b>AMPHETAMINES</b>							
AMPHETAMINE SUSPENSION EXTENDED RELEASE	DYANAVEL XR		Preferred Drug	PA Required for Ages < 6 years		240.00	30.00
AMPHETAMINE-DEXTROAMPHETAMINE CAPSULE 24-HOUR	ADDERALL XR	Brand Only	Preferred Drug	PA Required for Ages < 6 years		30.00	30.00
AMPHETAMINE-DEXTROAMPHETAMINE TABLETS	ADDERALL	Brand and Generic	Preferred Drug	PA Required for Ages < 6 years		60.00	30.00
DEXTROAMPHETAMINE SULFATE TABLETS	VARIOUS		Preferred Drug	PA Required for Ages < 6 years		60.00	30.00
LISDEXAMFETAMINE DIMESYLATE CAPSULES	VYVANSE	Brand Only	Preferred Drug	PA Required for Ages < 6 years		30.00	30.00
LISDEXAMFETAMINE DIMESYLATE CHEWABLE TABLETS	VYVANSE CHEWABLES	Brand Only	Preferred Drug	PA Required for Ages < 6 years		30.00	30.00
<b>STIMULANTS</b>							
DEXMETHYLPHENIDATE HCL CAPSULE 24-HOUR	FOCALIN XR	Brand Only	Preferred Drug	PA Required for Ages < 6 years		60.00	30.00
DEXMETHYLPHENIDATE HCL TABLETS	FOCALIN		Preferred Drug	PA Required for Ages < 6 years		60.00	30.00
METHYLPHENIDATE HCL CHEWABLE TABLETS	METHYLIN	Brand Only	Preferred Drug	PA Required for Ages < 6 years		90.00	30.00
METHYLPHENIDATE HCL CHEWABLE TABLETS EXTENDED RELEASE	QUILLICHEW ER	Brand Only	Preferred Drug	PA Required for Ages < 6 years		30.00	30.00
METHYLPHENIDATE HCL CAPSULE 24-HOUR	RITALIN LA /APTENSIO XR	Brand Only	Preferred Drug	PA Required for Ages < 6 years		30.00	30.00
METHYLPHENIDATE HCL CAPSULE 24-HOUR	VARIOUS		Preferred Drug	PA Required for Ages < 6 years		30.00	30.00
METHYLPHENIDATE HCL CAPSULE CONTROLLED RELEASE	VARIOUS		Preferred Drug	PA Required for Ages < 6 years		30.00	30.00
METHYLPHENIDATE PATCH	DAYTRANA	Brand Only	Preferred Drug	PA Required for Ages < 6 years		30.00	30.00
METHYLPHENIDATE HCL SOLUTION	METHYLIN	Brand Only	Preferred Drug	PA Required for Ages < 6 years		300.00	30.00
METHYLPHENIDATE HCL SUSPENSION	QUILLIVANT XR	Brand Only	Preferred Drug	PA Required for Ages < 6 years		150.00	30.00
METHYLPHENIDATE HCL TABLETS	VARIOUS		Preferred Drug	PA Required for Ages < 6 years		90.00	30.00
METHYLPHENIDATE HCL TABLET CONTROLLED RELEASE	CONCERTA ONLY	Brand Only	Preferred Drug	PA Required for Ages < 6 years		60.00	30.00
<b>MISCELLANEOUS AGENTS</b>							
ATOMOXETINE HCL CAPSULES	VARIOUS		Preferred Drug	PA Required for Ages < 6 years		30.00	30.00
<b>CENTRAL ALPHA-AGONISTS</b>							
CLONIDINE HCL TABLETS	CATAPRES			PA Required for Ages < 6 years			
CLONIDINE HCL TD PATCH WEEKLY	CATAPRES PATCHES			PA Required for Ages < 6 years		4	28
CLONIDINE HCL (ADHD) TABLET 12-HOUR	CLONIDINE ER			PA Required for Ages < 6 years		120.00	30.00
GUANFACINE HCL (ADHD) TABLET 24-HOUR	GUANFACINE ER		Preferred Drug	PA Required for Ages < 6 years		30.00	30.00
GUANFACINE HCL TABLETS	TENEX			PA Required for Ages < 6 years			
<b>AMINOGLYCOSIDES</b>							
<b>AMINOGLYCOSIDES</b>							
NEOMYCIN SULFATE TABLETS	NEOMYCIN SULFATE						
PAROMOMYCIN SULFATE CAPSULES	PAROMOMYCIN SULFATE						
TOBRAMYCIN NEBULIZED	KITABIS AND BETHKIS		Preferred Drug	PA Required			
<b>ANALGESICS - ANTI-INFLAMMATORY</b>							
<b>ANTIRHEUMATIC ANTIMETABOLITES</b>							
METHOTREXATE SODIUM (ANTIRHEUMATIC) TABLETS	RHEUMATREX						
<b>ANTIRHEUMATIC - ENZYME INHIBITORS</b>							
TOFACITINIB CITRATE	XELJANZ IMMEDIATE RELEASE ONLY	Brand Only	Preferred Drug	PA Required			
<b>ANTI-TNF-ALPHA - MONOCLONAL ANTIBODIES</b>							
ADALIMUMAB	HUMIRA		Preferred Drug	PA Required			
<b>NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (NSAIDS)</b>							
CELECOXIB CAPSULES	CELEBREX						
DICLOFENAC SODIUM TABLET 24-HOUR	VOLTAREN-XR					30.00	30.00
DICLOFENAC SODIUM TABLET ENTERIC COATED	DICLOFENAC SODIUM DR						
DICLOFENAC TABLET ENTERIC COATED	DICLOFENAC SODIUM EC						
ETODOLAC CAPSULES	ETODOLAC						
ETODOLAC TABLETS	ETODOLAC						
ETODOLAC TABLET 24-HOUR	ETODOLAC ER						
FENOPROFEN CALCIUM CAPSULES	NALFON						
FENOPROFEN CALCIUM TABLETS	FENOPROFEN CALCIUM						
FLURBIPROFEN TABLETS	FLURBIPROFEN						



## CMDP Preferred Drug List

- Generic Drugs Are Preferred Over Brand Name Drugs Unless Specified as Brand Only
- Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List Are Available Through Prior Authorization

Effective Date: 10/1/2019

Drug Class/Drug Name	Reference Brand Name	Brand Only / Generic Notes	Preferred Drug Status	PA Type	Step Therapy Requirements	Quantity Limit	QL Days
IBUPROFEN CAPSULES	ADVIL						
IBUPROFEN CHEWABLE TABLETS	CHILDRENS MOTRIN						
IBUPROFEN SUSPENSION	CHILDRENS MOTRIN						
IBUPROFEN TABLETS	ADVIL JUNIOR STRENGTH						
INDOMETHACIN CAPSULES	TIVORBEX						
INDOMETHACIN CAPSULE CONTROLLED RELEASE	INDOMETHACIN CR						
INDOMETHACIN SUPPOSITORY	INDOCIN						
INDOMETHACIN SUSPENSION	INDOCIN						
KETOROLAC TROMETHAMINE TABLETS	KETOROLAC TROMETHAMINE					20.00	30.00
MEFENAMIC ACID CAPSULES	PONSTEL						
MELOXICAM SUSPENSION	MOBIC						
MELOXICAM TABLETS	MOBIC						
NABUMETONE TABLETS	NABUMETONE						
NAPROXEN SODIUM	ALEVE						
NAPROXEN SODIUM TABLETS	ANAPROX						
NAPROXEN SUSPENSION	NAPROSYN						
NAPROXEN TABLETS	NAPROSYN						
NAPROXEN TABLET ENTERIC COATED	EC-NAPROSYN						
OXAPROZIN TABLETS	DAYPRO						
PIROXICAM CAPSULES	FELDENE						
SULINDAC TABLETS	SULINDAC						
<b>PHOSPHODIESTERASE 4 (PDE4) INHIBITORS</b>							
APREMILAST	OTEZLA	Brand Only	Preferred Drug	PA Required			
<b>PYRIMIDINE SYNTHESIS INHIBITORS</b>							
LEFLUNOMIDE TABLETS	ARAVA						
<b>SOLUBLE TUMOR NECROSIS FACTOR RECEPTOR AGENTS</b>							
ETANERCEPT	ENBREL		Preferred Drug	PA Required			
<b>ANALGESICS - NONNARCOTIC</b>							
<b>ANALGESIC COMBINATIONS</b>							
BUTALBITAL-ACETAMINOPHEN-CAFFEINE TABLETS	VARIOIUS					120.00	30.00
BUTALBITAL-ASPIRIN-CAFFEINE TABLETS	VARIOUS					120.00	30.00
<b>ANALGESICS OTHER</b>							
ACETAMINOPHEN CAPSULES	ACETAMINOPHEN						
ACETAMINOPHEN CHEWABLE TABLETS	CHILDRENS MEDI-TABLETS						
ACETAMINOPHEN ELIXIR	MEDI-TABLETS CHILDRENS						
ACETAMINOPHEN LIQUID	LITTLE REMEDIES FOR FEVERS FEVER/PAIN RELIEVER CHILDRENS						
ACETAMINOPHEN SOLUTION	ACETAMINOPHEN						
ACETAMINOPHEN SUPPOSITORY	FEVERALL INFANTS						
ACETAMINOPHEN SUSPENSION	TYLENOL INFANTS						
ACETAMINOPHEN SYRUP	TRIAMINIC FEVER REDUCER PAIN RELIEVER CHILDRENS						
ACETAMINOPHEN TABLETS	MEDI-TABLETS						
ACETAMINOPHEN TABLET CONTROLLED RELEASE	TYLENOL 8 HOUR						
ACETAMINOPHEN ORALLY DISPERSABLE TABLET	MAPAP CHILDRENS						
<b>SALICYLATES</b>							
ASPIRIN CHEWABLE TABLETS	ST JOSEPH ADULT						
ASPIRIN SUPPOSITORY	ASPIRIN						
ASPIRIN TABLETS	ASPIRIN						
ASPIRIN ORALLY DISPERSABLE TABLET	ADULT ASPIRIN LOW STRENGTH						
ASPIRIN TABLET ENTERIC COATED	1/2HALFPRIN						
ASPIRIN TABLET EFFERVESCENT	MEDI-SELTZER						
DIFLUNISAL TABLETS	DIFLUNISAL						



## CMDP Preferred Drug List

• Generic Drugs Are Preferred Over Brand Name Drugs Unless Specified as Brand Only

• Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List Are Available Through Prior Authorization

Effective Date: 10/1/2019

Drug Class/Drug Name	Reference Brand Name	Brand Only / Generic Notes	Preferred Drug Status	PA Type	Step Therapy Requirements	Quantity Limit	QL Days
SALSALATE TABLETS	DISALCID						
<b>ANALGESICS - OPIOID</b>							
<b>LONG-ACTING OPIOID AGONISTS</b>							
FENTANYL PATCH 72-HOUR 12mcg, 25mcg, 50mcg, 75mcg & 100mcg	DURAGESIC 12mcg, 25mcg, 50mcg, 75mcg & 100mcg		Preferred Drug	PA Required			
MORPHINE-NALTREXONE CAPSULE CONTROLLED RELEASE	EMBEDA		Preferred Drug	PA Required			
MORPHINE SULFATE TABLET CONTROLLED RELEASE	MS CONTIN		Preferred Drug	PA Required			
OXYCODONE CAPSULE ER 12-HOUR ABUSE-DETERRENT	XTAMPZA ER		Preferred Drug	PA Required			
TRAMADOL HCL ER TABLET 24-HOUR	TRAMADOL HCL ER		Preferred Drug	PA Required			
<b>SHORT-ACTING OPIOID AGONISTS</b>							
HYDROMORPHONE HCL LIQUID	DILAUDID			PA Required for > 2 Different Short Acting Opioid Medications in a 30-day time period.			
HYDROMORPHONE HCL SUPPOSITORY	HYDROMORPHONE HCL			PA Required for > 2 Different Short Acting Opioid Medications in a 30-day time period.			
HYDROMORPHONE HCL TABLETS	DILAUDID			PA Required for > 2 Different Short Acting Opioid Medications in a 30-day time period.			
MEPERIDINE HCL TABLETS	DEMEROL			PA Required for > 2 Different Short Acting Opioid Medications in a 30-day time period.			
MORPHINE SULFATE SOLUTION	MORPHINE SULFATE			PA Required for > 2 Different Short Acting Opioid Medications in a 30-day time period.			
MORPHINE SULFATE SUPPOSITORY	MORPHINE SULFATE			PA Required for > 2 Different Short Acting Opioid Medications in a 30-day time period.			
MORPHINE SULFATE TABLETS	MORPHINE SULFATE			PA Required for > 2 Different Short Acting Opioid Medications in a 30-day time period.			
OXYCODONE HCL CAPSULES	OXYCODONE HCL			PA Required for > 2 Different Short Acting Opioid Medications in a 30-day time period.			
OXYCODONE HCL CONCENTRATE	OXYCODONE HCL			PA Required for > 2 Different Short Acting Opioid Medications in a 30-day time period.			
OXYCODONE HCL SOLUTION	OXYCODONE HCL			PA Required for > 2 Different Short Acting Opioid Medications in a 30-day time period.			
OXYCODONE HCL TABLETS	ROXICODONE			PA Required for > 2 Different Short Acting Opioid Medications in a 30-day time period.			
TRAMADOL HCL TABLETS	ULTRAM			PA Required for > 2 Different Short Acting Opioid Medications in a 30-day time period.			
<b>OPIOID COMBINATIONS</b>							
ACETAMINOPHEN W/ CODEINE SOLUTION	ACETAMINOPHEN/CODEINE			PA Required for > 2 Different Short Acting Opioid Medications in a 30-day time period.			
ACETAMINOPHEN W/ CODEINE TABLETS	ACETAMINOPHEN/CODEINE			PA Required for > 2 Different Short Acting Opioid Medications in a 30-day time period.			



## CMDP Preferred Drug List

• Generic Drugs Are Preferred Over Brand Name Drugs Unless Specified as Brand Only

• Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List Are Available Through Prior Authorization

Effective Date: 10/1/2019

Drug Class/Drug Name	Reference Brand Name	Brand Only / Generic Notes	Preferred Drug Status	PA Type	Step Therapy Requirements	Quantity Limit	QL Days
BUTALBITAL-ACETAMINOPHEN-CAFFEINE W/ CODEINE CAPSULES	FIORICET/CODEINE			PA Required for > 2 Different Short Acting Opioid Medications in a 30-day time period.			
BUTALBITAL-ASPIRIN-CAFFEINE W/COD CAPSULES	ASCOMP/CODEINE			PA Required for > 2 Different Short Acting Opioid Medications in a 30-day time period.			
HYDROCODONE-ACETAMINOPHEN CAPSULES	HYDROGESIC			PA Required for > 2 Different Short Acting Opioid Medications in a 30-day time period.			
HYDROCODONE-ACETAMINOPHEN SOLUTION	HYCET			PA Required for > 2 Different Short Acting Opioid Medications in a 30-day time period.			
HYDROCODONE-ACETAMINOPHEN TABLETS	VERDROCET			PA Required for > 2 Different Short Acting Opioid Medications in a 30-day time period.			
HYDROCODONE-IBUPROFEN TABLETS	REPREXAIN			PA Required for > 2 Different Short Acting Opioid Medications in a 30-day time period.			
OXYCODONE W/ ACETAMINOPHEN CAPSULES	OXYCODONE/ACETAMINOPHEN			PA Required for > 2 Different Short Acting Opioid Medications in a 30-day time period.			
OXYCODONE W/ ACETAMINOPHEN SOLUTION	ROXICET			PA Required for > 2 Different Short Acting Opioid Medications in a 30-day time period.			
OXYCODONE W/ ACETAMINOPHEN TABLETS	ENDOCET			PA Required for > 2 Different Short Acting Opioid Medications in a 30-day time period.			
OXYCODONE-IBUPROFEN TABLETS	OXYCODONE/IBUPROFEN			PA Required for > 2 Different Short Acting Opioid Medications in a 30-day time period.			
<b>OPIOID PARTIAL AGONISTS</b>							
BUPRENORPHINE VARIOUS	VARIOUS			PA Required unless the member is pregnant- the prescriber must note the following ICD-10 codes on the prescription: 1. O09.91- Supervision of high risk pregnancy, 1st Trimester. 2. O09.92- Supervision of high risk pregnancy, 2nd Trimester. 3. O09.93- Supervision of high risk pregnancy, 3rd Trimester. 4. O09.91- Supervision of high risk pregnancy- use for Postpartum Nursing Mothers. <b>The first digit of the diagnosis code is the Letter - O and the second is a Zero - 0</b>			
BUPRENORPHINE PATCH WEEKLY	BUTRANS	Brand Only	Preferred Drug	PA Required			
BUPRENORPHINE SOLUTION PREFILLED SYRINGE	SUBLOCADE		Preferred Drug	PA Required			
BUPRENORPHINE HCL-NALOXONE HCL DIHYDRATE FILM	SUBOXONE FILM	Brand Only	Preferred Drug				
BUPRENORPHINE HCL-NALOXONE HCL DIHYDRATE SUBLINGUAL	BUPRENORPHINE HCL-NALOXONE HCL DIHYDRATE	GENERIC FORMULATIONS ONLY	Preferred Drug				



## CMDP Preferred Drug List

- Generic Drugs Are Preferred Over Brand Name Drugs Unless Specified as Brand Only
- Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List Are Available Through Prior Authorization

Effective Date: 10/1/2019

Drug Class/Drug Name	Reference Brand Name	Brand Only / Generic Notes	Preferred Drug Status	PA Type	Step Therapy Requirements	Quantity Limit	QL Days
<b>METHADONE</b>	VARIOUS			Only available at an Opioid Treatment Program (OTP) provider.			
<b>ANDROGENS-ANABOLIC</b>							
<b>ANDROGENS**</b>							
DANAZOL CAPSULES	DANAZOL						
FLUOXYMESTERONE TABLETS	ANDROXY						
TESTOSTERONE CYPIONATE KIT	TESTONE CIK			PA Required			
TESTOSTERONE CYPIONATE SOLUTION	DEPO-TESTOSTERONE			PA Required			
TESTOSTERONE ENANTHATE SOLUTION	TESTOSTERONE ENANTHATE			PA Required			
TESTOSTERONE GEL	ANDROGEL			PA Required			
TESTOSTERONE PATCH 24-HOUR	ANDRODERM			PA Required			
TESTOSTERONE SOLUTION	AXIRON			PA Required			
<b>ANORECTAL AGENTS</b>							
<b>INTRARECTAL STEROIDS</b>							
HYDROCORTISONE (INTRARECTAL) ENEMA	COLOCORT						
HYDROCORTISONE ACETATE (INTRARECTAL) FOAM	CORTIFOAM						
<b>RECTAL STEROIDS</b>							
HYDROCORTISONE (RECTAL) CREAM	PROCTOCORT						
<b>ANTACIDS</b>							
<b>ANTACIDS - CALCIUM SALTS</b>							
CALCIUM CARBONATE (ANTACID) CHEWABLE TABLETS	CHILDRENS MYLANTA UPSET STOMACH RELIEF						
CALCIUM CARBONATE (ANTACID) TABLETS	CALCIUM CARBONATE						
<b>ANTACID COMBINATIONS</b>							
ALUM & MAG HYDROX-SIMETHICONE SUSPENSION	ANTACID FAST ACTING						
<b>ANTACIDS - MAGNESIUM SALTS</b>							
MAGNESIUM OXIDE TABLETS	MAGNESIUM OXIDE						
<b>ANTHELMINTICS</b>							
<b>ANTHELMINTICS</b>							
ALBENDAZOLE TABLETS	ALBENZA			PA Required			
IVERMECTIN TABLETS	STROMECTOL			PA Required			
PRAZIQUANTEL TABLETS	BILTRICIDE						
<b>ANTIANGINAL AGENTS</b>							
<b>ANTIANGINALS-OTHER</b>							
RANOLAZINE TABLET 12-HOUR	RANEXA			PA Required			
<b>NITRATES</b>							
ISOSORBIDE DINITRATE CAPSULE CONTROLLED RELEASE	DILATRATE SR						
ISOSORBIDE DINITRATE SUBLINGUAL	ISOSORBIDE DINITRATE						
ISOSORBIDE DINITRATE TABLETS	ISORDIL TITRADOSE						
ISOSORBIDE DINITRATE TABLET CONTROLLED RELEASE	ISOSORBIDE DINITRATE ER						
ISOSORBIDE MONONITRATE TABLETS	ISOSORBIDE MONONITRATE						
ISOSORBIDE MONONITRATE TABLET 24-HOUR	IMDUR						
NITROGLYCERIN CAPSULE CONTROLLED RELEASE	NITRO-TIME						
NITROGLYCERIN OINTMENT	NITRO-BID						
NITROGLYCERIN PATCH 24-HOUR	NITRO-DUR						
NITROGLYCERIN SUBLINGUAL	NITROSTAT						
<b>ANTIANKXIETY AGENTS</b>							
<b>ANTIANKXIETY AGENTS - MISC.</b>							
HYDROXYZINE HCL SYRUP	ATARAX SYRUP					300.00	30.00
HYDROXYZINE HCL TABLETS	ATARAX TABLETS					240.00	30.00
HYDROXYZINE PAMOATE CAPSULES	VISTARIL					120.00	30.00
BUSPIRONE HCL TAB 5 MG	BUSPIRONE HCL			PA Required for > 1 Anxiolytic Medication in a 30-day time period.		120.00	30.00



## CMDP Preferred Drug List

• Generic Drugs Are Preferred Over Brand Name Drugs Unless Specified as Brand Only

• Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List Are Available Through Prior Authorization

Effective Date: 10/1/2019

Drug Class/Drug Name	Reference Brand Name	Brand Only / Generic Notes	Preferred Drug Status	PA Type	Step Therapy Requirements	Quantity Limit	QL Days
BUSPIRONE HCL TAB 7.5 MG	BUSPIRONE HCL			PA Required for > 1 Anxiolytic Medication in a 30-day time period.		120.00	30.00
BUSPIRONE HCL TAB 10 MG	BUSPIRONE HCL			PA Required for > 1 Anxiolytic Medication in a 30-day time period.		120.00	30.00
BUSPIRONE HCL TAB 15 MG	BUSPIRONE HCL			PA Required for > 1 Anxiolytic Medication in a 30-day time period.		120.00	30.00
BUSPIRONE HCL TAB 30 MG	BUSPIRONE HCL			PA Required for > 1 Anxiolytic Medication in a 30-day time period.		60.00	30.00
<b>BENZODIAZEPINES</b>							
ALPRAZOLAM CONC 1 MG/ML	ALPRAZOLAM INTENSOL			PA Required for > 1 Anxiolytic Medication in a 30-day time period.		60.00	15.00
ALPRAZOLAM ORALLY DISINTEGRATING TAB 0.25 MG	VARIOUS			PA Required for > 1 Anxiolytic Medication in a 30-day time period.		120.00	30.00
ALPRAZOLAM ORALLY DISINTEGRATING TAB 0.5 MG	VARIOUS			PA Required for > 1 Anxiolytic Medication in a 30-day time period.		120.00	30.00
ALPRAZOLAM ORALLY DISINTEGRATING TAB 1 MG	VARIOUS			PA Required for > 1 Anxiolytic Medication in a 30-day time period.		120.00	30.00
ALPRAZOLAM ORALLY DISINTEGRATING TAB 2 MG	VARIOUS			PA Required for > 1 Anxiolytic Medication in a 30-day time period.		60.00	30.00
ALPRAZOLAM TAB 0.25 MG	VARIOUS			PA Required for > 1 Anxiolytic Medication in a 30-day time period.		120.00	30.00
ALPRAZOLAM TAB 0.5 MG	VARIOUS			PA Required for > 1 Anxiolytic Medication in a 30-day time period.		120.00	30.00
ALPRAZOLAM TAB 1 MG	VARIOUS			PA Required for > 1 Anxiolytic Medication in a 30-day time period.		120.00	30.00
ALPRAZOLAM TAB 2 MG	VARIOUS			PA Required for > 1 Anxiolytic Medication in a 30-day time period.		60.00	30.00
ALPRAZOLAM TAB SR 24HR 0.5 MG	VARIOUS			PA Required for > 1 Anxiolytic Medication in a 30-day time period.		30.00	30.00
ALPRAZOLAM TAB SR 24HR 1 MG	VARIOUS			PA Required for > 1 Anxiolytic Medication in a 30-day time period.		30.00	30.00
ALPRAZOLAM TAB SR 24HR 2 MG	VARIOUS			PA Required for > 1 Anxiolytic Medication in a 30-day time period.		30.00	30.00
ALPRAZOLAM TAB SR 24HR 3 MG	VARIOUS			PA Required for > 1 Anxiolytic Medication in a 30-day time period.		30.00	30.00
CHLORDIAZEPOXIDE HCL CAP 10 MG	VARIOUS			PA Required for > 1 Anxiolytic Medication in a 30-day time period.		60.00	30.00
CHLORDIAZEPOXIDE HCL CAP 25 MG	VARIOUS			PA Required for > 1 Anxiolytic Medication in a 30-day time period.		60.00	30.00
CHLORDIAZEPOXIDE HCL CAP 5 MG	VARIOUS			PA Required for > 1 Anxiolytic Medication in a 30-day time period.		60.00	30.00
CLONAZEPAM 0.5 MG	Klonopin			PA Required for > 1 Anxiolytic Medication in a 30-day time period.		120.00	30.00
CLONAZEPAM 1.0 MG	Klonopin			PA Required for > 1 Anxiolytic Medication in a 30-day time period.		120.00	30.00
CLONAZEPAM 2 MG	Klonopin			PA Required for > 1 Anxiolytic Medication in a 30-day time period.		60.00	30.00
CLONAZEPAM ODT 0.125MG	VARIOUS			PA Required for > 1 Anxiolytic Medication in a 30-day time period.		120.00	30.00
CLONAZEPAM ODT 0.25MG	VARIOUS			PA Required for > 1 Anxiolytic Medication in a 30-day time period.		120.00	30.00
CLONAZEPAM ODT 0.5 MG	VARIOUS			PA Required for > 1 Anxiolytic Medication in a 30-day time period.		120.00	30.00



## CMDP Preferred Drug List

• Generic Drugs Are Preferred Over Brand Name Drugs Unless Specified as Brand Only

• Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List Are Available Through Prior Authorization

Effective Date: 10/1/2019

Drug Class/Drug Name	Reference Brand Name	Brand Only / Generic Notes	Preferred Drug Status	PA Type	Step Therapy Requirements	Quantity Limit	QL Days
CLONAZEPAM ODT 1MG	VARIOUS			PA Required for > 1 Anxiolytic Medication in a 30-day time period.		120.00	30.00
CLONAZEPAM ODT 2MG	VARIOUS			PA Required for > 1 Anxiolytic Medication in a 30-day time period.		60.00	30.00
CLORAZEPATE DIPOTASSIUM TAB 15 MG	VARIOUS			PA Required for > 1 Anxiolytic Medication in a 30-day time period.		60.00	30.00
CLORAZEPATE DIPOTASSIUM TAB 3.75 MG	VARIOUS			PA Required for > 1 Anxiolytic Medication in a 30-day time period.		120.00	30.00
CLORAZEPATE DIPOTASSIUM TAB 7.5 MG	VARIOUS			PA Required for > 1 Anxiolytic Medication in a 30-day time period.		120.00	30.00
DIAZEPAM CONC 5 MG/ML	DIAZEPAM INTENSOL			PA Required for > 1 Anxiolytic Medication in a 30-day time period.		60.00	30.00
DIAZEPAM SOLN 1 MG/ML	VARIOUS			PA Required for > 1 Anxiolytic Medication in a 30-day time period.		300.00	30.00
DIAZEPAM TAB 10 MG	VARIOUS			PA Required for > 1 Anxiolytic Medication in a 30-day time period.		120.00	30.00
DIAZEPAM TAB 2 MG	VARIOUS			PA Required for > 1 Anxiolytic Medication in a 30-day time period.		120.00	30.00
DIAZEPAM TAB 5 MG	VARIOUS			PA Required for > 1 Anxiolytic Medication in a 30-day time period.		120.00	30.00
LORAZEPAM CONC 2 MG/ML	LORAZEPAM INTENSOL			PA Required for > 1 Anxiolytic Medication in a 30-day time period.		60.00	30.00
LORAZEPAM TAB 0.5 MG	VARIOUS			PA Required for > 1 Anxiolytic Medication in a 30-day time period.		120.00	30.00
LORAZEPAM TAB 1 MG	VARIOUS			PA Required for > 1 Anxiolytic Medication in a 30-day time period.		120.00	30.00
LORAZEPAM TAB 2 MG	VARIOUS			PA Required for > 1 Anxiolytic Medication in a 30-day time period.		60.00	30.00
OXAZEPAM CAP 10 MG	VARIOUS			PA Required for > 1 Anxiolytic Medication in a 30-day time period.		60.00	30.00
OXAZEPAM CAP 15 MG	VARIOUS			PA Required for > 1 Anxiolytic Medication in a 30-day time period.		60.00	30.00
OXAZEPAM CAP 30 MG	VARIOUS			PA Required for > 1 Anxiolytic Medication in a 30-day time period.		60.00	30.00
<b>ANTIARRHYTHMICS</b>							
<b>ANTIARRHYTHMICS TYPE I-A</b>							
DISOPYRAMIDE PHOSPHATE CAPSULES	NORPACE						
DISOPYRAMIDE PHOSPHATE CAPSULE 12-HOUR	NORPACE CR						
QUINIDINE GLUCONATE TABLET CONTROLLED RELEASE	QUINIDINE GLUCONATE CR						
QUINIDINE SULFATE TABLETS	QUINIDINE SULFATE						
QUINIDINE SULFATE TABLET CONTROLLED RELEASE	QUINIDINE SULFATE ER						
<b>ANTIARRHYTHMICS TYPE I-B</b>							
MEXILETINE HCL CAPSULES	MEXILETINE HCL						
<b>ANTIARRHYTHMICS TYPE I-C</b>							
FLECAINIDE ACETATE TABLETS	TAMBOCOR						
PROPafenone HCL CAPSULE 12-HOUR	RYTHMOL SR						
PROPafenone HCL TABLETS	RYTHMOL						
<b>ANTIARRHYTHMICS TYPE III</b>							
AMIODARONE HCL TABLETS 100MG & 200MG	PACERONE						
DOFETILIDE CAPSULES	TIKOSYN			PA Required			
DRONEDARONE HCL TABLETS	MULTAQ			PA Required			
<b>ANTIASTHMATIC AND BRONCHODILATOR AGENTS</b>							
<b>ANTI-INFLAMMATORY AGENTS</b>							



## CMDP Preferred Drug List

• Generic Drugs Are Preferred Over Brand Name Drugs Unless Specified as Brand Only

• Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List Are Available Through Prior Authorization

Effective Date: 10/1/2019

Drug Class/Drug Name	Reference Brand Name	Brand Only / Generic Notes	Preferred Drug Status	PA Type	Step Therapy Requirements	Quantity Limit	QL Days
CROMOLYN SODIUM NEBULIZED	CROMOLYN SODIUM						
<b>BRONCHODILATORS - ANTICHOLINERGICS</b>							
ACLDINIUM BROMIDE AEROSOL SOLUTION	TUDORZA PRESSAIR		Preferred Drug				
IPRATROPIUM BROMIDE HFA AEROSOL SOLUTION	ATROVENT HFA		Preferred Drug				
IPRATROPIUM BROMIDE SOLUTION	IPRATROPIUM BROMIDE		Preferred Drug				
TIOTROPIUM BROMIDE MONOHYDRATE CAPSULES	SPIRIVA HANDIHALER		Preferred Drug				
<b>LEUKOTRIENE MODULATORS</b>							
MONTELUKAST SODIUM CHEWABLE TABLETS	SINGULAIR					30.00	30.00
MONTELUKAST SODIUM GRANULES	SINGULAIR			PA Required for > 4 Years of Age			
MONTELUKAST SODIUM TABLETS	SINGULAIR					30.00	30.00
<b>STEROID INHALANTS</b>							
BUDESONIDE (INHALATION) SUSPENSION 0.25MG/2ML, 0.5MG/2ML	PULMICORT	Brand Only	Preferred Drug		PA Required for > 4 Years of Age		
BUDESONIDE (INHALATION) SUSPENSION 1MG/2ML	PULMICORT		Preferred Drug		PA Required for > 4 Years of Age		
BUDESONIDE (INHALATION) AEROSOL POWDER	PULMICORT FLEXHALER		Preferred Drug				
FLUTICASON PROPRIONATE HFA AERO	FLOVENT HFA		Preferred Drug				
MOMETASONE FUROATE (INHALATION) AEPB	ASMANEX TWISTHALER		Preferred Drug				
<b>SYMPATHOMIMETICS</b>							
ALBUTEROL SULFATE TABLETS	ALBUTEROL SULFATE						
ALBUTEROL SULFATE TABLET 12-HOUR	ALBUTEROL SULFATE ER						
ALBUTEROL SULFATE INHALER	ProAir	Brand Only	Preferred Drug Only ProAir				
ALBUTEROL SULFATE NEBULIZED	ALBUTEROL SULFATE						
ALBUTEROL SULFATE SYRUP	ALBUTEROL SULFATE						
BUDESONIDE-FORMOTEROL FUMARATE DIHYDRATE INHALER	SYMBICORT		Preferred Drug		Step Therapy		
					Patient must have tried one steroid inhaler: Beclomethasone Dipropionate, Budesonide, Fluticasone Propionate, or Mometasone		
FLUTICASON-SALMETEROL INHALER	ADVAIR HFA		Preferred Drug		Step Therapy		
					Patient must have tried one steroid inhaler: Beclomethasone Dipropionate, Budesonide, Fluticasone Propionate, or Mometasone		
GLYCOPYRROLATE-FORMOTEROL FUMARATE AEROSOL SOLUTION	BEVESPI AEROSPHERE		Preferred Drug		PA Required	1.00	30.00
IPRATROPIUM-ALBUTEROL INHALER	COMBIVENT		Preferred Drug				
IPRATROPIUM-ALBUTEROL AEROSOL SOLUTION	COMBIVENT RESPIMAT		Preferred Drug				
IPRATROPIUM-ALBUTEROL SOLUTION	DUONEB		Preferred Drug				
LEVALBUTEROL HCL NEBULIZED	XOPENEX				PA Required for > 4 Years of Age		
MOMETASONE FUROATE-FORMOTEROL FUMARATE DIHYDRATE INHALER	DULERA		Preferred Drug		Step Therapy		
					Patient must have tried one steroid inhaler: Beclomethasone Dipropionate, Budesonide, Fluticasone Propionate, or Mometasone		
SALMETEROL XINAFOATE INHALER BREATH ACTIVATED	SEREVENT DISKUS		Preferred Drug		PA Required		
TIOTROPIUM BROMIDE-OLODATEROL HCL AEROSOL SOLUTION	STIOLTO RESPIMAT		Preferred Drug		PA Required	1.00	30.00
<b>XANTHINES</b>							
THEOPHYLLINE CAPSULE 24-HOUR	THEO-24						
THEOPHYLLINE ELIXIR	ELIXIROPHYLLIN						
THEOPHYLLINE SOLUTION	THEOPHYLLINE						
THEOPHYLLINE TABLET 12-HOUR	THEOCHRON						
THEOPHYLLINE TABLET 24-HOUR	THEOPHYLLINE ER						
<b>ANTICOAGULANTS</b>							
<b>COUMARIN ANTICOAGULANTS</b>							
WARFARIN SODIUM TABLETS	COUMADIN						
<b>DIRECT FACTOR XA INHIBITORS</b>							
APIXABAN TABLETS	ELIQUIS	Brand Only	Preferred Drug			60.00	30.00





## CMDP Preferred Drug List

• Generic Drugs Are Preferred Over Brand Name Drugs Unless Specified as Brand Only

• Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List Are Available Through Prior Authorization

Effective Date: 10/1/2019

Drug Class/Drug Name	Reference Brand Name	Brand Only / Generic Notes	Preferred Drug Status	PA Type	Step Therapy Requirements	Quantity Limit	QL Days
APIXABAN TABLETS STARTER PACK	ELIQUIS STARTER PACK	Brand Only	Preferred Drug			74.00	365.00
RIVAROXABAN TABLETS	XARELTO	Brand Only	Preferred Drug			60.00	30.00
RIVAROXABAN TABLETS THERAPY PACK	XARELTO STARTER PACK	Brand Only	Preferred Drug			51.00	30.00
<b>HEPARINS AND HEPARINOID-LIKE AGENTS</b>							
ENOXAPARIN SODIUM INJ 100 MG/ML	VARIOUS		Preferred Drug			60.00	30.00
ENOXAPARIN SODIUM INJ 120 MG/0.8ML	VARIOUS		Preferred Drug			60.00	30.00
ENOXAPARIN SODIUM INJ 150 MG/ML	VARIOUS		Preferred Drug			60.00	30.00
ENOXAPARIN SODIUM INJ 30 MG/0.3ML	VARIOUS		Preferred Drug			60.00	30.00
ENOXAPARIN SODIUM INJ 300 MG/3ML	VARIOUS		Preferred Drug			60.00	30.00
ENOXAPARIN SODIUM INJ 40 MG/0.4ML	VARIOUS		Preferred Drug			60.00	30.00
ENOXAPARIN SODIUM INJ 60 MG/0.6ML	VARIOUS		Preferred Drug			60.00	30.00
ENOXAPARIN SODIUM INJ 80 MG/0.8ML	VARIOUS		Preferred Drug			60.00	30.00
HEPARIN (PORCINE) IN SODIUM CHLORIDE SOLUTION	HEPARIN SODIUM/NACL 0.9%						
HEPARIN SOD (PORCINE) IN D5W SOLUTION	HEPARIN SODIUM/D5W						
HEPARIN SODIUM (PORCINE) LOCK FLUSH & NACL LOCK FLUSH KIT	HEPARIN SODIUM LOCK FLUSH						
HEPARIN SODIUM (PORCINE) LOCK FLUSH SOLUTION	HEPARIN LOCK FLUSH						
<b>THROMBIN INHIBITORS</b>							
DABIGATRAN ETEXILATE MESYLATE CAPSULES	PRADAXA	Brand Only	Preferred Drug			60.00	30.00
<b>ANTICONVULSANTS</b>							
<b>ANTICONVULSANTS - BENZODIAZEPINES</b>							
CLOBAZAM SUSPENSION	ONFI			PA Required			
CLOBAZAM TABLETS	ONFI			PA Required			
CLONAZEPAM TAB 0.5 MG	KLONOPIN			PA Required for > 1 Anxiolytic Medication in a 30-day time period.		120.00	30.00
CLONAZEPAM TAB 1 MG	KLONOPIN			PA Required for > 1 Anxiolytic Medication in a 30-day time period.		120.00	30.00
CLONAZEPAM TAB 2 MG	KLONOPIN			PA Required for > 1 Anxiolytic Medication in a 30-day time period.		60.00	30.00
CLONAZEPAM ORALLY DISINTEGRATING TAB 0.125 MG	VARIOUS			PA Required for > 1 Anxiolytic Medication in a 30-day time period.		120.00	30.00
CLONAZEPAM ORALLY DISINTEGRATING TAB 0.25 MG	VARIOUS			PA Required for > 1 Anxiolytic Medication in a 30-day time period.		120.00	30.00
CLONAZEPAM ORALLY DISINTEGRATING TAB 0.5 MG	VARIOUS			PA Required for > 1 Anxiolytic Medication in a 30-day time period.		120.00	30.00
CLONAZEPAM ORALLY DISINTEGRATING TAB 1 MG	VARIOUS			PA Required for > 1 Anxiolytic Medication in a 30-day time period.		120.00	30.00
CLONAZEPAM ORALLY DISINTEGRATING TAB 2 MG	VARIOUS			PA Required for > 1 Anxiolytic Medication in a 30-day time period.		60.00	30.00
DIAZEPAM RECTAL GEL DELIVERY SYSTEM 10 MG	DIASTAT					2.00	30.00
DIAZEPAM RECTAL GEL DELIVERY SYSTEM 2.5 MG	DIASTAT					2.00	30.00
DIAZEPAM RECTAL GEL DELIVERY SYSTEM 20 MG	DIASTAT					2.00	30.00
<b>ANTICONVULSANTS - MISC.</b>							
CARBAMAZEPINE (ANTIPSYCHOTIC) CAPSULE 12-HOUR	EQUETRO						
CARBAMAZEPINE CHEWABLE TABLETS	CARBAMAZEPINE						
CARBAMAZEPINE CAPSULE 12-HOUR	CARBATROL						
CARBAMAZEPINE SUSPENSION	TEGRETOL						
CARBAMAZEPINE TABLETS	EPITOL						
CARBAMAZEPINE TABLET 12-HOUR	TEGRETOL-XR						
EZOGBINE TABLETS	POTIGA			PA Required			
GABAPENTIN CAPSULES	NEURONTIN						
GABAPENTIN SOLUTION	NEURONTIN						
GABAPENTIN TABLETS	NEURONTIN						
GABAPENTIN (ONCE-DAILY) TABLETS	GRALISE			PA Required			



## CMDP Preferred Drug List

- Generic Drugs Are Preferred Over Brand Name Drugs Unless Specified as Brand Only
- Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List Are Available Through Prior Authorization

Effective Date: 10/1/2019

Drug Class/Drug Name	Reference Brand Name	Brand Only / Generic Notes	Preferred Drug Status	PA Type	Step Therapy Requirements	Quantity Limit	QL Days
GABAPENTIN ENACARBIL TABLET CONTROLLED RELEASE	HORIZANT			PA Required			
LACOSAMIDE SOLUTION	VIMPAT			PA Required			
LACOSAMIDE TABLETS	VIMPAT			PA Required			
LAMOTRIGINE CHEWABLE TABLETS	LAMICTAL						
LAMOTRIGINE KIT	LAMICTAL STARTER/TAKING VALPROATE						
LAMOTRIGINE TABLETS	LAMICTAL						
LAMOTRIGINE TABLET 24-HOUR	LAMICTAL XR						
LAMOTRIGINE ORALLY DISPERSABLE TABLET	LAMICTAL ODT						
LEVETIRACETAM SOLUTION	KEPPRA						
LEVETIRACETAM TABLETS	KEPPRA						
LEVETIRACETAM TABLET 24-HOUR	KEPPRA XR						
OXCARBAZEPINE SUSPENSION	TRILEPTAL						
OXCARBAZEPINE TABLETS	TRILEPTAL						
OXCARBAZEPINE TABLET 24-HOUR	OXTELLAR XR						
PREGABALIN CAPSULES (25MG, 50MG, 75MG, 100MG, 150MG, 200MG)	LYRICA					90.00	30.00
PREGABALIN CAPSULES (225MG, 300MG)	LYRICA					60.00	30.00
PREGABALIN SOLUTION	LYRICA					900.00	30.00
PRIMIDONE TABLETS	MYSOLINE						
RUFINAMIDE SUSPENSION	BANZEL			PA Required			
RUFINAMIDE TABLETS	BANZEL			PA Required			
TOPIRAMATE CAPSULE 24-HOUR	TROKENDI XR						
TOPIRAMATE SPRINKLE CAPSULES	TOPAMAX SPRINKLE						
TOPIRAMATE TABLETS	TOPAMAX						
ZONISAMIDE CAPSULES	ZONEGRAN						
<b>CARBAMATES</b>							
FELBAMATE SUSPENSION	FELBATOL						
FELBAMATE TABLETS	FELBATOL						
<b>GABA MODULATORS</b>							
TIAGABINE HCL TABLETS	GABITRIL			PA Required			
<b>HYDANTOINS</b>							
PHENYTOIN CHEWABLE TABLETS	DILANTIN INFATABLETS						
PHENYTOIN SODIUM EXTENDED CAPSULES	DILANTIN						
PHENYTOIN SUSPENSION	DILANTIN-125						
<b>SUCCINIMIDES</b>							
ETHOSUXIMIDE CAPSULES	ZARONTIN						
ETHOSUXIMIDE SOLUTION	ZARONTIN						
<b>VALPROIC ACID</b>							
DIVALPROEX SODIUM SPRINKLE CAPSULES	DEPAKOTE SPRINKLES						
DIVALPROEX SODIUM TABLET 24-HOUR	DEPAKOTE ER						
DIVALPROEX SODIUM TABLET ENTERIC COATED	DEPAKOTE						
VALPROATE SODIUM SYRUP	DEPAKENE						
VALPROIC ACID CAPSULES	DEPAKENE						
VALPROIC ACID CAPSULE DELAYED RELEASE	STAVZOR						
<b>ANTIDEPRESSANTS</b>							
<b>ALPHA-2 RECEPTOR ANTAGONISTS (TETRACYCLICS)</b>							
MIRTAZAPINE TABLETS	REMERON			PA Required for Ages < 6 years		30.00	30.00
MIRTAZAPINE ORALLY DISPERSABLE TABLET	REMERON SOLTAB			PA Required for Ages < 6 years		30.00	30.00
<b>NOREPINEPHRINE AND DOPAMINE REUPTAKE INHIBITORS (NDRIS)</b>							
BUPROPION HCL TABLETS	WELLBUTRIN			PA Required for Ages < 6 years		120.00	30.00
BUPROPION HCL TABLET 12-HOUR	BUDEPRION SR			PA Required for Ages < 6 years		60.00	30.00
BUPROPION HCL TABLET 24-HOUR	WELLBUTRIN XL			PA Required for Ages < 6 years		30.00	30.00
<b>SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIS)</b>							



## CMDP Preferred Drug List

- Generic Drugs Are Preferred Over Brand Name Drugs Unless Specified as Brand Only
- Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List Are Available Through Prior Authorization

Effective Date: 10/1/2019

Drug Class/Drug Name	Reference Brand Name	Brand Only / Generic Notes	Preferred Drug Status	PA Type	Step Therapy Requirements	Quantity Limit	QL Days
CITALOPRAM HYDROBROMIDE SOLUTION	CELEXA			PA Required for Ages < 6 years and for > the age of 12 years of age		600.00	30.00
CITALOPRAM HYDROBROMIDE TABLETS 10MG	CELEXA			PA Required for Ages < 6 years		60.00	30.00
CITALOPRAM HYDROBROMIDE TABLETS 20MG	CELEXA			PA Required for Ages < 6 years		30.00	30.00
CITALOPRAM HYDROBROMIDE TABLETS 40MG	CELEXA			PA Required for Ages < 6 years		30.00	30.00
ESCITALOPRAM OXALATE TABLETS 5MG	LEXAPRO			PA Required for Ages < 6 years		60.00	30.00
ESCITALOPRAM OXALATE TABLETS 10MG	LEXAPRO			PA Required for Ages < 6 years		30.00	30.00
ESCITALOPRAM OXALATE TABLETS 20MG	LEXAPRO			PA Required for Ages < 6 years		30.00	30.00
FLUOXETINE HCL CAPSULES ONLY 10MG	PROZAC			PA Required for Ages < 6 years		60.00	30.00
FLUOXETINE HCL CAPSULES ONLY 20MG	PROZAC			PA Required for Ages < 6 years		120.00	30.00
FLUOXETINE HCL CAPSULES ONLY 40MG	PROZAC			PA Required for Ages < 6 years		60.00	30.00
FLUOXETINE HCL SOLUTION	FLUOXETINE HCL			PA Required for Ages < 6 years and for > the age of 12 years of age		600.00	30.00
FLUVOXAMINE MALEATE TABLETS 25MG	LUVOX			PA Required for Ages < 6 years		60.00	30.00
FLUVOXAMINE MALEATE TABLETS 50MG	LUVOX			PA Required for Ages < 6 years		180.00	30.00
FLUVOXAMINE MALEATE TABLETS 100MG	LUVOX			PA Required for Ages < 6 years		90.00	30.00
PAROXETINE HCL TABLETS 10MG	PAXIL			PA Required for Ages < 6 years		30.00	30.00
PAROXETINE HCL TABLETS 20MG	PAXIL			PA Required for Ages < 6 years		30.00	30.00
PAROXETINE HCL TABLETS 30MG	PAXIL			PA Required for Ages < 6 years		30.00	30.00
PAROXETINE HCL TABLETS 40MG	PAXIL			PA Required for Ages < 6 years		45.00	30.00
SERTRALINE HCL CONCENTRATE	ZOLOFT			PA Required for Ages < 6 years and for > the age of 12 years of age		300.00	30.00
SERTRALINE HCL TABLETS 25MG	ZOLOFT			PA Required for Ages < 6 years		90.00	30.00
SERTRALINE HCL TABLETS 50MG	ZOLOFT			PA Required for Ages < 6 years		120.00	30.00
SERTRALINE HCL TABLETS 100MG	ZOLOFT			PA Required for Ages < 6 years		60.00	30.00
<b>SEROTONIN MODULATORS</b>							
TRAZODONE HCL TABLETS 50MG	TRAZODONE HCL			PA Required for Ages < 6 years		90.00	30.00
TRAZODONE HCL TABLETS 100MG	TRAZODONE HCL			PA Required for Ages < 6 years		120.00	30.00
TRAZODONE HCL TABLETS 150MG	TRAZODONE HCL			PA Required for Ages < 6 years		60.00	30.00
TRAZODONE HCL TABLETS 300MG	TRAZODONE HCL			PA Required for Ages < 6 years		30.00	30.00
<b>SEROTONIN-NOREPINEPHRINE REUPTAKE INHIBITORS (SNRI)</b>							
DULOXETINE HCL CAPSULE DELAYED RELEASE 20MG	CYMBALTA			PA Required for Ages < 6 years		120.00	30.00
DULOXETINE HCL CAPSULE DELAYED RELEASE 30MG	CYMBALTA			PA Required for Ages < 6 years		120.00	30.00
DULOXETINE HCL CAPSULE DELAYED RELEASE 60MG	CYMBALTA			PA Required for Ages < 6 years		60.00	30.00
VENLAFAXINE HCL CONTROLLED RELEASE - CAPSULES ONLY 37.5MG	EFFEXOR XR			PA Required for Ages < 6 years		90.00	30.00
VENLAFAXINE HCL CONTROLLED RELEASE - CAPSULES ONLY 75MG	EFFEXOR XR			PA Required for Ages < 6 years		90.00	30.00
VENLAFAXINE HCL CONTROLLED RELEASE - CAPSULES ONLY 150MG	EFFEXOR XR			PA Required for Ages < 6 years		30.00	30.00
VENLAFAXINE HCL TABLETS - IMMEDIATE RELEASE ONLY 25MG- TABLETS ONLY	VENLAFAXINE HCL			PA Required for Ages < 6 years		120.00	30.00
VENLAFAXINE HCL TABLETS - IMMEDIATE RELEASE ONLY 37.5MG- TABLETS ONLY	VENLAFAXINE HCL			PA Required for Ages < 6 years		90.00	30.00
VENLAFAXINE HCL TABLETS - IMMEDIATE RELEASE ONLY 50MG- TABLETS ONLY	VENLAFAXINE HCL			PA Required for Ages < 6 years		90.00	30.00
VENLAFAXINE HCL TABLETS - IMMEDIATE RELEASE ONLY 75MG- TABLETS ONLY	VENLAFAXINE HCL			PA Required for Ages < 6 years		150.00	30.00
VENLAFAXINE HCL TABLETS - IMMEDIATE RELEASE ONLY 100MG- TABLETS ONLY	VENLAFAXINE HCL			PA Required for Ages < 6 years		90.00	30.00
<b>TRICYCLIC AGENTS</b>							
AMITRIPTYLINE HCL TABLETS	AMITRIPTYLINE HCL			PA Required for Ages < 6 years			
AMOXAPINE TABLETS	VARIOUS			PA Required for ages < 6 years			
CLOMIPRAMINE HCL CAPSULES	ANAFRANIL			PA Required for Ages < 6 years			
DESIPRAMINE HCL TABLETS	NORPRAMIN			PA Required for Ages < 6 years			
DOXEPIN HCL CAPSULES	DOXEPIN HCL			PA Required for Ages < 6 years		90.00	30.00



## CMDP Preferred Drug List

- Generic Drugs Are Preferred Over Brand Name Drugs Unless Specified as Brand Only
- Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List Are Available Through Prior Authorization

Effective Date: 10/1/2019

Drug Class/Drug Name	Reference Brand Name	Brand Only / Generic Notes	Preferred Drug Status	PA Type	Step Therapy Requirements	Quantity Limit	QL Days
DOXEPIN HCL CONCENTRATE	DOXEPIN HCL			PA Required for Ages < 6 years		180.00	30.00
IMIPRAMINE HCL TABLETS	TOFRANIL			PA Required for Ages < 6 years			
IMIPRAMINE PAMOATE CAPSULES	TOFRANIL-PM			PA Required for Ages < 6 years		30.00	30.00
NORTRIPTYLINE HCL CAPSULES	PAMELOR			PA Required for Ages < 6 years			
NORTRIPTYLINE HCL SOLUTION	NORTRIPTYLINE HCL			PA Required for Ages < 6 years			
PROTRIPTYLINE HCL TABLETS	VIVACTIL			PA Required for Ages < 6 years			
TRIMIPRAMINE MALEATE	SURMONTIL			PA Required for Ages < 6 years			
<b>ANTIDIABETICS</b>							
<b>ALPHA-GLUCOSIDASE INHIBITORS</b>							
ACARBOSE TABLETS	PRECOSE						
<b>ANTIDIABETIC - AMYLIN ANALOGS</b>							
PRAMLINTIDE ACETATE SOLUTION PEN INJECTION	SYMLINPEN 60		Preferred Drug	PA Required			
<b>ANTIDIABETIC COMBINATIONS</b>							
EMPAGLIFLOZIN-LINAGLIPTIN TABLETS	GLYXAMBI		Preferred Drug	PA Required			
GLYBURIDE-METFORMIN HCL TABLETS	GLYBURIDE/METFORMIN HCL						
PIOGLITAZONE HCL-METFORMIN HCL TABLETS	ACTOPLUS MET						
PIOGLITAZONE HCL-METFORMIN HCL TABLET 24-HOUR	ACTOPLUS MET XR						
SITAGLIPTIN-METFORMIN HCL TABLETS	JANUMET		Preferred Drug	PA Required			
SITAGLIPTIN-METFORMIN HCL TABLET 24-HOUR	JANUMET XR		Preferred Drug	PA Required			
<b>BIGUANIDES</b>							
METFORMIN HCL TABLETS	GLUCOPHAGE						
METFORMIN HCL TABLET 24-HOUR (GENERIC OF GLUCOPHAGE XR ONLY- 500MG & 750MG)	GENERIC OF GLUCOPHAGE XR ONLY- 500MG & 750MG			PA Required for Osmotic and Modified Release Products			
<b>DIABETIC OTHER</b>							
GLUCAGON (RDNA) KIT	GLUCAGON EMERGENCY KIT					1.00	30.00
GLUCAGON HCL (RDNA) SOLUTION	GLUCAGON HYPOKIT					1.00	30.00
MIFEPRISTONE (HYPERGLYCEMIA) TABLETS	KORLYM			PA Required			
<b>DIPEPTIDYL PEPTIDASE-4 (DPP-4) INHIBITORS</b>							
ALOGLIPTIN BENZOATE TABLETS	NESINA						
LINAGLIPTIN TABLETS	TRADJENTA		Preferred Drug	PA Required			
LINAGLIPTIN-METFORMIN HCL TABLETS	JENTADUETO		Preferred Drug	PA Required			
LIRAGLUTIDE SOLUTION PEN INJECTION	VICTOZA		Preferred Drug	PA Required			
SAXAGLIPTIN HCL TABLETS	ONGLYZA		Preferred Drug	PA Required			
SAXAGLIPTIN-METFORMIN HCL TABLETS	KOMBIGLYZE XR		Preferred Drug	PA Required			
SITAGLIPTIN PHOSPHATE TABLETS	JANUVIA		Preferred Drug	PA Required			
<b>INCRETIN MIMETIC AGENTS (GLP-1 RECEPTOR AGONISTS)</b>							
EXENATIDE SOLUTION PEN INJECTION	BYETTA		Preferred Drug	PA Required			
EXENATIDE PEN	BYDUREON		Preferred Drug	PA Required			
EXENATIDE SUSPENSION EXTENDED RELEASE	BYDUREON		Preferred Drug	PA Required			
<b>INSULIN SENSITIZING AGENTS</b>							
PIOGLITAZONE HCL TABLETS	ACTOS						
<b>INSULIN</b>							
INSULIN ASPART SOLUTION	NOVOLOG		Preferred Drug				
INSULIN ASPART SOCT	NOVOLOG PENFILL		Preferred Drug				
INSULIN ASPART SOLUTION PEN INJECTION	NOVOLOG FLEXPEN		Preferred Drug				
INSULIN ASPART PROTAMINE & ASPART (HUMAN) SUSPENSION (70/30)	NOVOLOG MIX 70/30						
INSULIN ASPART PROTAMINE & ASPART (HUMAN) SUSPENSION PEN INJECTION (70/30)	NOVOLOG MIX 70/30 PREFILLED FLEXPEN						
INSULIN DETEMIR SOLUTION	LEVEMIR		Preferred Drug				
INSULIN DETEMIR SOLUTION PEN INJECTION	LEVEMIR FLEXPEN		Preferred Drug				
INSULIN GLARGINE SOLUTION	LANTUS		Preferred Drug				
INSULIN GLARGINE SOLUTION PEN INJECTION	LANTUS SOLOSTAR		Preferred Drug				



## CMDP Preferred Drug List

- Generic Drugs Are Preferred Over Brand Name Drugs Unless Specified as Brand Only
- Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List Are Available Through Prior Authorization

Effective Date: 10/1/2019

Drug Class/Drug Name	Reference Brand Name	Brand Only / Generic Notes	Preferred Drug Status	PA Type	Step Therapy Requirements	Quantity Limit	QL Days
INSULIN LISPRO (HUMAN) SOLUTION	HUMALOG		Preferred Drug				
INSULIN LISPRO PROTAMINE & LISPRO (HUMAN) SUSPENSION (75-25)	HUMALOG MIX 75/25		Preferred Drug				
INSULIN LISPRO PROTAMINE & LISPRO (HUMAN) SUSPENSION (50-50)	HUMALOG MIX 50/50		Preferred Drug				
INSULIN LISPRO (HUMAN) SOLUTION PEN INJECTION 100/ML	HUMALOG KWIKPEN		Preferred Drug				
INSULIN LISPRO PROTAMINE & LISPRO (HUMAN) SUSPENSION PEN INJECTION (75-25)	HUMALOG MIX 75/25 KWIKPEN		Preferred Drug				
INSULIN LISPRO PROTAMINE & LISPRO (HUMAN) SUSPENSION PEN INJECTION (50-50)	HUMALOG MIX 50/50 KWIKPEN		Preferred Drug				
INSULIN NPH (HUMAN) (ISOPHANE) SUSPENSION	HUMULIN N		Preferred Drug				
INSULIN NPH (HUMAN) (ISOPHANE) SUSPENSION	NOVOLIN N		Preferred Drug				
INSULIN NPH ISOPHANE & REG (HUMAN) SUSPENSION	HUMULIN 70/30		Preferred Drug				
INSULIN NPH ISOPHANE & REG (HUMAN) SUSPENSION	NOVOLIN 70/30		Preferred Drug				
INSULIN REGULAR (HUMAN) SOLUTION	HUMULIN R		Preferred Drug				
INSULIN REGULAR (HUMAN) SOLUTION	NOVOLIN R		Preferred Drug				
INSULIN REGULAR (HUMAN) SOLUTION	HUMULIN R U-500 (CONCENTRATED)		Preferred Drug	PA Required			
INSULIN REGULAR (HUMAN) SOLUTION PEN INJECTION	HUMULIN R U-500 KWIKPEN		Preferred Drug	PA Required			
<b>MEGLITINIDE ANALOGUES</b>							
NATEGLINIDE TABLETS	STARLIX						
REPAGLINIDE TABLETS	PRANDIN						
<b>SGLT2S</b>							
DAPAGLIFLOZIN PROPRANEDIOL	FARXIGA		Preferred Drug	PA Required			
CANAGLIFLOZIN	INVOKANA		Preferred Drug	PA Required			
EMPAGLIFLOZIN	JARDIANCE		Preferred Drug	PA Required			
<b>SULFONYLUREAS</b>							
CHLORPROPAMIDE TABLETS	CHLORPROPAMIDE						
GLIMEPIRIDE TABLETS	AMARYL						
GLIPIZIDE TABLETS	GLUCOTROL						
GLIPIZIDE TABLET 24-HOUR	GLIPIZIDE XL						
GLYBURIDE MICRONIZED TABLETS	GLYNASE						
GLYBURIDE TABLETS	DIABETA						
TOLAZAMIDE TABLETS	TOLAZAMIDE						
TOLBUTAMIDE TABLETS	TOLBUTAMIDE						
<b>ANTIDIARRHEALS</b>							
<b>ANTIPERISTALTIC AGENTS</b>							
DIPHENOXYLATE W/ ATROPINE LIQUID	DIPHENOXYLATE/ATROPINE						
DIPHENOXYLATE W/ ATROPINE TABLETS	LOMOTIL						
LOPERAMIDE HCL CAPSULES	LOPERAMIDE HCL						
LOPERAMIDE HCL CHEWABLE TABLETS	IMODIUM A-D						
LOPERAMIDE HCL LIQUID	LOPERAMIDE HCL						
LOPERAMIDE HCL SUSPENSION	IMODIUM A-D						
LOPERAMIDE HCL TABLETS	IMODIUM A-D						
<b>ANTIDOTES</b>							
<b>OPIOID ANTAGONISTS</b>							
NALOXONE HCL SOLUTION + SYRINGE	NALOXONE HCL + SYRINGE		Preferred Drug				
NALOXONE HCL NASAL SPRAY	NARCAN NASAL SPRAY		Preferred Drug				
NALTREXONE HCL TABLETS	NALTREXONE HCL		Preferred Drug				
NALTREXONE SUSPENSION	VIVITROL		Preferred Drug				
<b>ANTIEMETICS</b>							
<b>5-HT3 RECEPTOR ANTAGONISTS</b>							
DOLASETRON MESYLATE TABLETS	ANZEMET			PA Required			
GRANISETRON HCL SOLUTION	GRANISOL			PA Required			
GRANISETRON HCL TABLETS	GRANISETRON HCL			PA Required			
ONDANSETRON HCL SOLUTION	ZOFRAN					150.00	30.00



## CMDP Preferred Drug List

• Generic Drugs Are Preferred Over Brand Name Drugs Unless Specified as Brand Only

• Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List Are Available Through Prior Authorization

Effective Date: 10/1/2019

Drug Class/Drug Name	Reference Brand Name	Brand Only / Generic Notes	Preferred Drug Status	PA Type	Step Therapy Requirements	Quantity Limit	QL Days
ONDANSETRON HCL TABLETS	ZOFRAN					30.00	30.00
ONDANSETRON ORALLY DISPERSABLE TABLET	ZOFRAN ODT					30.00	30.00
<b>ANTIEMETICS - ANTICHOLINERGIC</b>							
MECLIZINE HCL CHEWABLE TABLETS	MECLIZINE HCL						
MECLIZINE HCL TABLETS	MECLIZINE HCL						
TRIMETHOBENZAMIDE HCL CAPSULES	TIGAN						
TRIMETHOBENZAMIDE HCL SOLUTION	TIGAN						
<b>ANTIEMETICS - MISCELLANEOUS</b>							
DRONABINOL CAPSULES	MARINOL			PA Required			
PROCHLORPERAZINE MALEATE TABLETS	COMPAZINE						
PROCHLORPERAZINE SUPPOSITORY	COMPAZINE						
<b>SUBSTANCE P/NEUROKININ 1 (NK1) RECEPTOR ANTAGONIST</b>							
APREPITANT CAPSULES	EMEND					6.00	21.00
<b>ANTIFUNGALS</b>							
<b>ANTIFUNGAL ORAL AGENTS</b>							
CLOTRIMAZOLE TROCHE	VARIOUS						
GRISEOFULVIN SUSPENSION	VARIOUS						
GRISEOFULVIN MICROSIZE TABLETS	GRIFULVIN V						
NYSTATIN SUSPENSION	NYSTATIN						
NYSTATIN TABLETS	NYSTATIN						
TERBINAFINE HCL TABLETS	LAMISIL					90.00	365.00
<b>IMIDAZOLE-RELATED ANTIFUNGALS</b>							
FLUCONAZOLE SUSPENSION	DIFLUCAN					600.00	30.00
FLUCONAZOLE TABLETS	DIFLUCAN					60.00	30.00
<b>ANTIHISTAMINES</b>							
<b>ANTI HISTAMINES - ALKYLAMINES</b>							
BROMPHENIRAMINE MALEATE	J-TAN PD						
CHLORPHENIRAMINE MALEATE TABLETS	CHLORPHENIRAMINE MALEATE						
DEXCHLORPHENIRAMINE MALEATE SYRUP	DEXCHLORPHENIRAMINE MALEATE						
<b>ANTI HISTAMINES - ETHANOLAMINES</b>							
CLEMASTINE FUMARATE SYRUP	CLEMASTINE FUMARATE						
CLEMASTINE FUMARATE TABLETS	CLEMASTINE FUMARATE						
DIPHENHYDRAMINE HCL CAPSULES	BANOPHEN						
DIPHENHYDRAMINE HCL CHEWABLE TABLETS	BENADRYL ALLERGY CHILDRENS						
DIPHENHYDRAMINE HCL ELIXIR	MEDI-PHEDRYL						
DIPHENHYDRAMINE HCL LIQUID	BANOPHEN						
DIPHENHYDRAMINE HCL SOLUTION	DIPHENHYDRAMINE HCL						
DIPHENHYDRAMINE HCL STRP	TRIAMINIC COUGH & RUNNY NOSE						
DIPHENHYDRAMINE HCL SUSPENSION	DICOPANOL FUSEPAQ						
DIPHENHYDRAMINE HCL SYRUP	ALTARYL						
DIPHENHYDRAMINE HCL TABLETS	ALKA-SELTZER PLUS ALLERGY FAST RELIEF FORMULA						
DIPHENHYDRAMINE HCL ORALLY DISPERSABLE TABLET	WAL-DRYL ALLERGY RELIEF CHILDRENS						
<b>ANTI HISTAMINES - NON-SEDATING</b>							
CETIRIZINE HCL CAPSULES	ZYRTEC ALLERGY					30.00	30.00
CETIRIZINE HCL CHEWABLE TABLETS	WAL-ZYR CHILDRENS					30.00	30.00
CETIRIZINE HCL SYRUP	ALL DAY ALLERGY CHILDRENS					150.00	30.00
CETIRIZINE HCL TABLETS	CETIRIZINE HCL					30.00	30.00
CETIRIZINE HCL ORALLY DISPERSABLE TABLET	ZYRTEC ALLERGY					30.00	30.00
FEXOFENADINE HCL SUSPENSION	ALLEGRA ALLERGY CHILDRENS					150.00	30.00
FEXOFENADINE HCL TABLETS	ALLEGRA ALLERGY CHILDRENS					30.00	30.00
FEXOFENADINE HCL ORALLY DISPERSABLE TABLET	ALLEGRA ALLERGY CHILDRENS					30.00	30.00
LORATADINE CAPSULES	CLARITIN					30.00	30.00



## CMDP Preferred Drug List

- Generic Drugs Are Preferred Over Brand Name Drugs Unless Specified as Brand Only
- Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List Are Available Through Prior Authorization

Effective Date: 10/1/2019

Drug Class/Drug Name	Reference Brand Name	Brand Only / Generic Notes	Preferred Drug Status	PA Type	Step Therapy Requirements	Quantity Limit	QL Days
LORATADINE CHEWABLE TABLETS	CLARITIN					30.00	30.00
LORATADINE SYRUP	CLARITIN					150.00	30.00
LORATADINE TABLETS	ALAVERT					30.00	30.00
LORATADINE ORALLY DISPERSABLE TABLET	CLARITIN REDITABLETS					30.00	30.00
<b>ANTIHISTAMINES - PHENOTHIAZINES</b>							
PROMETHAZINE HCL SOLUTION	PROMETHAZINE HCL						
PROMETHAZINE HCL SUPPOSITORY	PHENADOZ						
PROMETHAZINE HCL TABLETS	PROMETHAZINE HCL						
<b>ANTIHISTAMINES - PIPERIDINES</b>							
CYPROHEPTADINE HCL SYRUP	CYPROHEPTADINE HCL						
CYPROHEPTADINE HCL TABLETS	CYPROHEPTADINE HCL						
<b>ANTIHYPERTENSIVES</b>							
<b>BILE ACID SEQUESTRANTS</b>							
CHOLESTYRAMINE LIGHT PACK	PREVALITE						
CHOLESTYRAMINE LIGHT POWDER	PREVALITE						
CHOLESTYRAMINE PACK	QUESTRAN						
CHOLESTYRAMINE POWDER	QUESTRAN						
COLESTIPOL HCL GRANULES	COLESTID						
COLESTIPOL HCL PACK	COLESTID						
COLESTIPOL HCL TABLETS	COLESTID						
<b>FIBRIC ACID DERIVATIVES</b>							
FENOFIBRATE MICRONIZED CAPSULES 67MG, 134MG & 200MG	VARIOUS						
FENOFIBRATE TABLETS 48MG, 54MG, 145MG & 160MG	VARIOUS						
FENOFIBRIC ACID TABLETS	FIBRICOR						
GEMFIBROZIL TABLETS	LOPID						
<b>HMG COA REDUCTASE INHIBITORS</b>							
ATORVASTATIN CALCIUM TABLETS	LIPITOR					30.00	30.00
FLUVASTATIN SODIUM CAPSULES	LESCOL					30.00	30.00
FLUVASTATIN SODIUM TABLET 24-HOUR	LESCOL XL					30.00	30.00
LOVASTATIN TABLETS	LOVASTATIN					30.00	30.00
PRAVASTATIN SODIUM TABLETS	PRAVASTATIN SODIUM					30.00	30.00
ROSUVASTATIN CALCIUM TABLETS	CRESTOR					30.00	30.00
SIMVASTATIN TABLETS	ZOCOR					30.00	30.00
<b>INTESTINAL CHOLESTEROL ABSORPTION INHIBITORS</b>							
EZETIMIBE TABLETS	ZETIA			PA Required			
<b>NICOTINIC ACID DERIVATIVES</b>							
NIACIN (ANTIHYPERTENSIVE) TABLETS (250MG, 500MG, & 750MG)	NIACIN CR						
<b>ANTIHYPERTENSIVES</b>							
<b>ACE INHIBITORS</b>							
BENAZEPRIL HCL TABLETS	BENAZEPRIL HCL						
CAPTAPRIL TABLETS	CAPTAPRIL						
ENALAPRIL MALEATE SOLUTION	EPANED						
ENALAPRIL MALEATE TABLETS	VASOTEC						
FOSINOPRIL SODIUM TABLETS	FOSINOPRIL SODIUM						
LISINAPRIL TABLETS	ZESTRIL						
MOEXIPRIL HCL TABLETS	UNIVASC						
PERINDOPRIL ERBUMINE TABLETS	PERINDOPRIL ERBUMINE						
QUINAPRIL HCL TABLETS	ACCUPRIL						
RAMIPRIL CAPSULES	ALTACE						
TRANDOLAPRIL TABLETS	MAVIK						
<b>ANGIOTENSIN II RECEPTOR ANTAGONISTS</b>							
CANDESARTAN CILEXETIL TABLETS	ATACAND			Step Therapy	Patient must have tried Losartan, Irbesartan		



## CMDP Preferred Drug List

- Generic Drugs Are Preferred Over Brand Name Drugs Unless Specified as Brand Only
- Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List Are Available Through Prior Authorization

Effective Date: 10/1/2019

Drug Class/Drug Name	Reference Brand Name	Brand Only / Generic Notes	Preferred Drug Status	PA Type	Step Therapy Requirements	Quantity Limit	QL Days
IRBESARTAN TABLETS	AVAPRO						
LOSARTAN POTASSIUM TABLETS	COZAAR						
OLMESARTAN MEDOXOMIL TABLETS	BENICAR				Patient must have tried Irbesartan & Losartan		
VALSARTAN TABLETS	DIOVAN			<b>Step Therapy</b>			
<b>ANTIADRENERGIC ANTIHYPERTENSIVES</b>							
CLONIDINE HCL PATCH WEEKLY	CATAPRES-TTS					4.00	28.00
CLONIDINE HCL TABLETS	CATAPRES						
DOXAZOSIN MESYLATE TABLETS	CARDURA						
GUANFACINE HCL TABLETS	TENEX						
METHYLDOPA TABLETS	METHYLDOPA						
PRAZOSIN HCL CAPSULES	MINIPRESS						
TERAZOSIN HCL CAPSULES	TERAZOSIN HCL						
<b>ANTIHYPERTENSIVE COMBINATIONS</b>							
ATENOLOL & CHLORTHALIDONE TABLETS	VARIOUS						
BISOPROLOL & HYDROCHLOROTHIAZIDE TABLETS	ZIAC						
CAPTAPRIL & HYDROCHLOROTHIAZIDE TABLETS	CAPTAPRIL/HYDROCHLOROTHIAZIDE						
ENALAPRIL MALEATE & HYDROCHLOROTHIAZIDE TABLETS	ENALAPRIL MALEATE/HYDROCHLOROTHIAZIDE						
FOSINOPRIL SODIUM & HYDROCHLOROTHIAZIDE TABLETS	FOSINOPRIL SODIUM/HYDROCHLOROTHIAZIDE						
LISINAPRIL & HYDROCHLOROTHIAZIDE TABLETS	ZESTORETIC						
LOSARTAN POTASSIUM & HYDROCHLOROTHIAZIDE TABLETS	HYZAAR						
METOPROLOL & HYDROCHLOROTHIAZIDE TABLETS	LOPRESSOR HCT						
MOEXIPRIL-HYDROCHLOROTHIAZIDE TABLETS	UNIRETIC						
NADOLOL & BENDROFLUMETHIAZIDE TABLETS	CORZIDE						
OLMESARTAN MEDOXOMIL-HYDROCHLOROTHIAZIDE TABLETS	BENICAR HCT						
PROPRANOLOL & HYDROCHLOROTHIAZIDE TABLETS	PROPRANOLOL/HYDROCHLOROTHIAZIDE						
QUINAPRIL-HYDROCHLOROTHIAZIDE TABLETS	ACCURETIC						
VALSARTAN-HYDROCHLOROTHIAZIDE TABLETS	DIOVAN HCT						
<b>DIRECT RENIN INHIBITORS</b>							
ALISKIREN FUMARATE TABLETS	TEKURNA						
<b>SELECTIVE ALDOSTERONE RECEPTOR ANTAGONISTS (SARAS)</b>							
EPLERENONE TABLETS	INSpra						
<b>VASODILATORS</b>							
HYDRALAZINE HCL TABLETS	HYDRALAZINE HCL						
MINOXIDIL TABLETS	MINOXIDIL						
<b>ANTI-INFECTIVE AGENTS - MISC.</b>							
<b>ANTI-INFECTIVE AGENTS - MISC.</b>							
METRONIDAZOLE CAPSULES	FLAGYL						
METRONIDAZOLE TABLETS	FLAGYL						
RIFAXIMIN TABLETS	XIFAXAN						
TRIMETHOPRIM TABLETS	TRIMETHOPRIM						
VANCOMYCIN HCL CAPSULES	VANCOcin HCL						
VANCOMYCIN HCL SOLUTION	FIRST-VANCOMYCIN 25						
<b>ANTI-INFECTIVE MISC. - COMBINATIONS</b>							
ERYTHROMYCIN-SULFISOXAZOLE SUSPENSION	E.S.P.						
SULFAMETHOXAZOLE-TRIMETHOPRIM SUSPENSION	SULFATRIM PEDIATRIC						
SULFAMETHOXAZOLE-TRIMETHOPRIM TABLETS	BACTRIM						
<b>LEPROSTATICS</b>							
DAPSONE TABLETS	DAPSONE						
<b>LINCOSAMIDES</b>							
CLINDAMYCIN HCL CAPSULES	CLEOCIN						





## CMDP Preferred Drug List

- Generic Drugs Are Preferred Over Brand Name Drugs Unless Specified as Brand Only
- Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List Are Available Through Prior Authorization

Effective Date: 10/1/2019

Drug Class/Drug Name	Reference Brand Name	Brand Only / Generic Notes	Preferred Drug Status	PA Type	Step Therapy Requirements	Quantity Limit	QL Days
CLINDAMYCIN PALMITATE HYDROCHLORIDE SOLUTION	CLEOCIN PEDIATRIC GRANULES						
<b>OXAZOLIDINONES</b>							
LINEZOLID SUSPENSION	ZYVOX			PA Required			
LINEZOLID TABLETS	ZYVOX			PA Required			
<b>ANTIMALARIALS</b>							
<b>ANTIMALARIAL COMBINATIONS</b>							
ARTEMETHER-LUMEFANTRINE TABLETS	COARTEM						
ATOVAQUONE-PROGUANIL HCL TABLETS	MALARONE						
<b>ANTIMALARIALS</b>							
CHLOROQUINE PHOSPHATE TABLETS	CHLOROQUINE PHOSPHATE						
HYDROXYCHLOROQUINE SULFATE TABLETS	PLAQUENIL						
PRIMAQUINE PHOSPHATE TABLETS	PRIMAQUINE PHOSPHATE						
PYRIMETHAMINE TABLETS	DARAPRIM						
QUININE SULFATE CAPSULES	QUALAQUIN						
<b>ANTIMYASTHENIC/CHOLINERGIC AGENTS</b>							
<b>ANTIMYASTHENIC/CHOLINERGIC AGENTS</b>							
PYRIDOSTIGMINE BROMIDE SYRUP	MESTINON						
PYRIDOSTIGMINE BROMIDE TABLETS	MESTINON						
PYRIDOSTIGMINE BROMIDE TABLET CONTROLLED RELEASE	MESTINON TIMESPAN						
<b>ANTIMYCOBACTERIAL AGENTS</b>							
<b>ANTI TB COMBINATIONS</b>							
ISONIAZID & RIFAMPIN CAPSULES	RIFAMATE						
<b>ANTIMYCOBACTERIAL AGENTS</b>							
ETHAMBUTOL HCL TABLETS	MYAMBUTOL						
ISONIAZID SYRUP	ISONIAZID						
ISONIAZID TABLETS	ISONIAZID						
PYRAZINAMIDE TABLETS	PYRAZINAMIDE						
RIFAMPIN CAPSULES	RIFADIN						
<b>ONCOLOGY -FEDERALLY REIMBURSABLE ANTINEOPLASTIC AGENTS,NOT LISTED BELOW, ARE AVAILABLE THROUGH PRIOR AUTHORIZATION</b>							
<b>ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES</b>							
<b>ALKYLATING AGENTS</b>							
ALTRETAMINE CAPSULES	HEXALEN			PA Required			
CHLORAMBUCIL TABLETS	LEUKERAN						
CYCLOPHOSPHAMIDE CAPSULES	CYCLOPHOSPHAMIDE						
CYCLOPHOSPHAMIDE TABLETS	CYCLOPHOSPHAMIDE						
LOMUSTINE CAPSULES	CEENU						
TEMOZOLOMIDE CAPSULES	TEMODAR			PA Required			
<b>ANTIMETABOLITES</b>							
MERCAPTOPYRINE TABLETS	VARIOUS						
METHOTREXATE SODIUM TABLETS	METHOTREXATE						
THIOGUANINE TABLETS	TABLOID						
<b>ANTINEOPLASTIC - HEDGEHOG PATHWAY INHIBITORS</b>							
VISMODEGIB CAPSULES	ERIVEDGE			PA Required			
<b>ANTINEOPLASTIC - HORMONAL AND RELATED AGENTS</b>							
ABIRATERONE ACETATE TABLETS	ZYTIGA			PA Required			
ANASTROZOLE TABLETS	ARIMIDEX			PA Required			
BICALUTAMIDE TABLETS	CASODEX						
DEGARELIXIR ACETATE SOLUTION	FIRMAGON			PA Required			
ESTRAMUSTINE PHOSPHATE SODIUM CAPSULES	EMCYT			PA Required			
EXEMESTANE TABLETS	AROMASIN			PA Required			



## CMDP Preferred Drug List

- Generic Drugs Are Preferred Over Brand Name Drugs Unless Specified as Brand Only
- Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List Are Available Through Prior Authorization

Effective Date: 10/1/2019

Drug Class/Drug Name	Reference Brand Name	Brand Only / Generic Notes	Preferred Drug Status	PA Type	Step Therapy Requirements	Quantity Limit	QL Days
FLUTAMIDE CAPSULES	FLUTAMIDE						
LETROZOLE TABLETS	FEMARA			PA Required			
LEUPROLIDE ACETATE (3 MONTH) KIT	LUPRON DEPOT			PA Required			
LEUPROLIDE ACETATE (4 MONTH) KIT	LUPRON DEPOT			PA Required			
LEUPROLIDE ACETATE (6 MONTH) KIT	ELIGARD			PA Required			
LEUPROLIDE ACETATE KIT	LUPRON DEPOT			PA Required			
MEGESTROL ACETATE SUSPENSION	MEGACE ORAL						
MEGESTROL ACETATE TABLETS	MEGESTROL ACETATE						
MITOTANE TABLETS	LYSODREN						
NILUTAMIDE TABLETS	NILANDRON					60.00	30.00
TAMOXIFEN CITRATE SOLUTION	SOLTAMOX						
TAMOXIFEN CITRATE TABLETS	TAMOXIFEN CITRATE						
TOREMIFENE CITRATE TABLETS	FARESTON			PA Required			
<b>ANTINEOPLASTIC ENZYME INHIBITORS</b>							
ALECTINIB HCL CAPSULES	ALECENSA			PA Required			
AXITINIB TABLETS	INLYTA			PA Required			
COBIMETINIB FUMARATE TABLETS	COTELLIC			PA Required			
CRIZOTINIB CAPSULES	XALKORI			PA Required			
DASATINIB TABLETS	SPRYCEL			PA Required			
ERLOTINIB HCL TABLETS	TARCEVA			PA Required			
EVEROLIMUS TABLETS	AFINITOR			PA Required			
EVEROLIMUS TBSO	AFINITOR DISPERZ			PA Required			
GEFITINIB TABLETS	IRESSA			PA Required			
IBRUTINIB CAPSULES	IMBRUVICA			PA Required			
IMATINIB MESYLATE TABLETS	GLEEVEC	BRAND PREFERRED	BRAND PREFERRED	PA Required			
IBRUTINIB TABLETS	IMBRUVICA			PA Required			
LAPATINIB DITOSYLATE TABLETS	TYKERB			PA Required			
IXAZOMIB CITRATE CAPSULES	NINLARO			PA Required			
NILOTINIB HCL CAPSULES	TASIGNA			PA Required			
PAZOPANIB HCL TABLETS	VOTRIENT			PA Required			
PONATINIB HCL TABLETS	ICLUSIG			PA Required			
RUXOLITINIB PHOSPHATE TABLETS	JAKAFI			PA Required			
SORAFENIB TOSYLATE TABLETS	NEXAVAR			PA Required			
SUNITINIB MALATE CAPSULES	SUTENT			PA Required			
VANDETANIB TABLETS	CAPRELSA			PA Required			
VEMURAFENIB TABLETS	ZELBORAF			PA Required			
VORINOSTAT CAPSULES	ZOLINZA			PA Required			
<b>ANTINEOPLASTICS MISC.</b>							
BEXAROTENE CAPSULES	TARGRETIN			PA Required			
HYDROXYUREA CAPSULES	HYDREA						
INTERFERON ALFA-2B SOLUTION	INTRON A			PA Required			
INTERFERON ALFA-2B SOLUTION	INTRON A			PA Required			
INTERFERON ALFA-N3 SOLUTION	ALFERON N			PA Required			
INTERFERON GAMMA-1B SOLUTION	ACTIMMUNE			PA Required			
PEGINTERFERON ALFA-2B (ANTINEOPLASTIC) KIT	SYLATRON			PA Required			
PROCARBAZINE HCL CAPSULES	MATULANE						
TRETINOIN (CHEMOTHERAPY) CAPSULES	TRETINOIN			PA Required For > 26 Years of Age			
<b>CHEMOTHERAPY RESCUE/ANTIDOTE AGENTS</b>							
LEUCOVORIN CALCIUM TABLETS	LEUCOVORIN CALCIUM						
<b>MITOTIC INHIBITORS</b>							
ETOPOSIDE CAPSULES	ETOPOSIDE						
<b>ANTIPARKINSON AGENTS</b>							
<b>ANTIPARKINSON ADJUVANTS</b>							



## CMDP Preferred Drug List

• Generic Drugs Are Preferred Over Brand Name Drugs Unless Specified as Brand Only

• Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List Are Available Through Prior Authorization

Effective Date: 10/1/2019

Drug Class/Drug Name	Reference Brand Name	Brand Only / Generic Notes	Preferred Drug Status	PA Type	Step Therapy Requirements	Quantity Limit	QL Days
CARBIDOPA TABLETS	LODOSYN						
<b>ANTIPARKINSON ANTICHOLINERGICS</b>							
BENZTROPINE MESYLATE TABLETS	BENZTROPINE MESYLATE						
BENZTROPINE MESYLATE SOLUTION	COGENTIN						
TRIHEXYPHENIDYL HCL ELIXIR	TRIHEXYPHENIDYL HCL						
TRIHEXYPHENIDYL HCL TABLETS	TRIHEXYPHENIDYL HCL						
<b>ANTIPARKINSON COMT INHIBITORS</b>							
ENTACAPONE TABLETS	COMTAN						
<b>ANTIPARKINSON DOPAMINERGICS</b>							
AMANTADINE HCL CAPSULES	AMANTADINE HCL						
AMANTADINE HCL SYRUP	AMANTADINE HCL						
AMANTADINE HCL TABLETS	AMANTADINE HCL						
BROMOCRIPTINE MESYLATE CAPSULES	PARLODEL						
BROMOCRIPTINE MESYLATE TABLETS	PARLODEL						
CARBIDOPA-LEVODOPA TABLETS	SINEMET						
CARBIDOPA-LEVODOPA TABLET CONTROLLED RELEASE	SINEMET CR						
CARBIDOPA-LEVODOPA ORALLY DISPERSABLE TABLET	PARCOPA						
CARBIDOPA-LEVODOPA-ENTACAPONE TABLETS	STALEVO 50						
PRAMIPEXOLE DIHYDROCHLORIDE TABLETS	MIRAPEX						
PRAMIPEXOLE DIHYDROCHLORIDE TABLET 24-HOUR	MIRAPEX ER						
ROPINIROLE HYDROCHLORIDE TABLETS	REQUIP						
ROPINIROLE HYDROCHLORIDE TABLET 24-HOUR	REQUIP XL						
<b>ANTIPARKINSON MONOAMINE OXIDASE INHIBITORS</b>							
SELEGILINE HCL CAPSULES	ELDEPRYL						
SELEGILINE HCL TABLETS	SELEGILINE HCL						
SELEGILINE HCL ORALLY DISPERSABLE TABLET	ZELAPAR						
<b>ANTIPSYCHOTICS/ANTIMANIC AGENTS</b>							
<b>ANTIMANIC AGENTS</b>							
LITHIUM CARBONATE CAPSULES	LITHIUM CARBONATE				Prior Authorization is not required when prescribed by a psychiatric clinician, a behavioral pediatrician or other prescribers as approved by the FFS Administration		
LITHIUM CARBONATE POWDER	LITHIUM CARBONATE				Prior Authorization is not required when prescribed by a psychiatric clinician, a behavioral pediatrician or other prescribers as approved by the FFS Administration		
LITHIUM CARBONATE TABLETS	LITHIUM CARBONATE				Prior Authorization is not required when prescribed by a psychiatric clinician, a behavioral pediatrician or other prescribers as approved by the FFS Administration		
LITHIUM CARBONATE TABLET CONTROLLED RELEASE	LITHOBID				Prior Authorization is not required when prescribed by a psychiatric clinician, a behavioral pediatrician or other prescribers as approved by the FFS Administration		
LITHIUM SOLUTION	LITHIUM				Prior Authorization is not required when prescribed by a psychiatric clinician, a behavioral pediatrician or other prescribers as approved by the FFS Administration		



## CMDP Preferred Drug List

• Generic Drugs Are Preferred Over Brand Name Drugs Unless Specified as Brand Only		Effective Date: 10/1/2019						
• Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List Are Available Through Prior Authorization								
Drug Class/Drug Name	Reference Brand Name	Brand Only / Generic Notes	Preferred Drug Status	PA Type	Step Therapy Requirements	Quantity Limit	QL Days	
<b>ANTIPSYCHOTICS - SECOND GENERATION - ATYPICAL ORAL AGENTS</b>								
ARIPIPIRAZOLE TABLETS	ABILIFY		Preferred Drug	PA Required for < 6 years of age, Prior Authorization is not required when prescribed by a psychiatric clinician, a behavioral pediatrician or other prescribers as approved by the FFS Administration.		30.00	30.00	
CLOZAPINE ORALLY DISPERSABLE TABLET	FAZACLO		Preferred Drug	PA Required for Ages < 18 years Prior Authorization is not required when prescribed by a psychiatric clinician, a behavioral pediatrician or other prescribers as approved by the FFS Administration.		150.00	30.00	
CLOZAPINE TABLETS	CLOZARIL		Preferred Drug	PA Required for Ages < 18 years Prior Authorization is not required when prescribed by a psychiatric clinician, a behavioral pediatrician or other prescribers as approved by the FFS Administration.		150.00	30.00	
LURASIDONE HCL TABS	LATUDA		Preferred Drug	PA Required for < 6 years of age, Prior Authorization is not required when prescribed by a psychiatric clinician, a behavioral pediatrician or other prescribers as approved by the FFS Administration.		30.00	30.00	
OLANZAPINE ORALLY DISPERSABLE TABLET 5MG	ZYPREXA ZYDIS		Preferred Drug	PA Required for < 6 years of age, Prior Authorization is not required when prescribed by a psychiatric clinician, a behavioral pediatrician or other prescribers as approved by the FFS Administration.		60.00	30.00	
OLANZAPINE ORALLY DISPERSABLE TABLET 10MG	ZYPREXA ZYDIS		Preferred Drug	PA Required for < 6 years of age, Prior Authorization is not required when prescribed by a psychiatric clinician, a behavioral pediatrician or other prescribers as approved by the FFS Administration.		60.00	30.00	
OLANZAPINE ORALLY DISPERSABLE TABLET 15MG	ZYPREXA ZYDIS		Preferred Drug	PA Required for < 6 years of age, Prior Authorization is not required when prescribed by a psychiatric clinician, a behavioral pediatrician or other prescribers as approved by the FFS Administration.		30.00	30.00	
OLANZAPINE ORALLY DISPERSABLE TABLET 20MG	ZYPREXA ZYDIS		Preferred Drug	PA Required for < 6 years of age, Prior Authorization is not required when prescribed by a psychiatric clinician, a behavioral pediatrician or other prescribers as approved by the FFS Administration.		30.00	30.00	



## CMDP Preferred Drug List

<ul style="list-style-type: none"> <li>• Generic Drugs Are Preferred Over Brand Name Drugs Unless Specified as Brand Only</li> <li>• Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List Are Available Through Prior Authorization</li> </ul>							
							Effective Date: 10/1/2019
Drug Class/Drug Name	Reference Brand Name	Brand Only / Generic Notes	Preferred Drug Status	PA Type	Step Therapy Requirements	Quantity Limit	QL Days
OLANZAPINE TABLETS	ZYPREXA		Preferred Drug	PA Required for < 6 years of age, Prior Authorization is not required when prescribed by a psychiatric clinician, a behavioral pediatrician or other prescribers as approved by the FFS Administration.		30.00	30.00
QUETIAPINE FUMARATE TABLETS	SEROQUEL		Preferred Drug	PA Required for < 6 years of age, Prior Authorization is not required when prescribed by a psychiatric clinician, a behavioral pediatrician or other prescribers as approved by the FFS Administration.		60.00	30.00
RISPERIDONE ORALLY DISPERSABLE TABLET	RISPERIDONE ODT		Preferred Drug	PA Required for < 6 years of age, Prior Authorization is not required when prescribed by a psychiatric clinician, a behavioral pediatrician or other prescribers as approved by the FFS Administration.		60.00	30.00
RISPERIDONE ORAL SOLUTION	RISPERDAL		Preferred Drug	PA Required for < 6 years of age, Prior Authorization is not required when prescribed by a psychiatric clinician, a behavioral pediatrician or other prescribers as approved by the FFS Administration.		240.00	30.00
RISPERIDONE TABLETS	RISPERDAL		Preferred Drug	PA Required for < 6 years of age, Prior Authorization is not required when prescribed by a psychiatric clinician, a behavioral pediatrician or other prescribers as approved by the FFS Administration.		60.00	30.00
ZIPRASIDONE HCL CAPSULES	GEODON		Preferred Drug	PA Required for < 6 years of age, Prior Authorization is not required when prescribed by a psychiatric clinician, a behavioral pediatrician or other prescribers as approved by the FFS Administration.		60.00	30.00
<b>ANTIPSYCHOTICS - SECOND GENERATION - ATYPICAL LONG ACTING INJECTABLES</b>							
ARIPIPIRAZOLE LAUROXIL	ARISTADA		Preferred Drug	PA Required for < 18 years of age, Prior Authorization is not required when prescribed by a psychiatric clinician, a behavioral pediatrician or other prescribers as approved by the FFS Administration.		1.00	30.00
ARIPIPIRAZOLE LAUROXIL PREFILLED SYRINGE	ARISTADA INITIO		Preferred Drug	PA Required for Ages < 18 years Prior Authorization is not required when prescribed by a psychiatric clinician, a behavioral pediatrician or other prescribers as approved by the FFS Administration.		2.00	365.00



## CMDP Preferred Drug List

• Generic Drugs Are Preferred Over Brand Name Drugs Unless Specified as Brand Only

• Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List Are Available Through Prior Authorization

Effective Date: 10/1/2019

Drug Class/Drug Name	Reference Brand Name	Brand Only / Generic Notes	Preferred Drug Status	PA Type	Step Therapy Requirements	Quantity Limit	QL Days
ARIPIRAZOLE SUSPENSION	ABILIFY MAINTENA		Preferred Drug	PA Required for < 18 years of age, Prior Authorization is not required when prescribed by a psychiatric clinician, a behavioral pediatrician or other prescribers as approved by the FFS Administration.		1.00	30.00
PALIPERIDONE PALMITATE SUSPENSION	INVEGA SUSTENNA		Preferred Drug	PA Required for < 18 years of age, Prior Authorization is not required when prescribed by a psychiatric clinician, a behavioral pediatrician or other prescribers as approved by the FFS Administration.		1.00	30.00
PALIPERIDONE PALMITATE SUSPENSION	INVEGA TRINZA		Preferred Drug	PA Required for < 18 years of age, Prior Authorization is not required when prescribed by a psychiatric clinician, a behavioral pediatrician or other prescribers as approved by the FFS Administration.		1.00	84.00
RISPERIDONE MICROSPHERES SUSPENSION	RISPERDAL CONSTA		Preferred Drug	PA Required for < 18 years of age, Prior Authorization is not required when prescribed by a psychiatric clinician, a behavioral pediatrician or other prescribers as approved by the FFS Administration.		2.00	30.00
<b>ANTIPSYCHOTICS - FIRST GENERATION - TYPICAL ORAL AGENTS</b>							
CHLORPROMAZINE HCL SOLUTION	VARIOUS			PA Required for < 6 years of age, Prior Authorization is not required when prescribed by a psychiatric clinician, a behavioral pediatrician or other prescribers as approved by the FFS Administration.			
CHLORPROMAZINE HCL TABLETS	VARIOUS			PA Required for < 6 years of age, Prior Authorization is not required when prescribed by a psychiatric clinician, a behavioral pediatrician or other prescribers as approved by the FFS Administration.			
FLUPHENAZINE HCL CONCENTRATE	VARIOUS			PA Required for < 6 years of age, Prior Authorization is not required when prescribed by a psychiatric clinician, a behavioral pediatrician or other prescribers as approved by the FFS Administration.			
FLUPHENAZINE HCL ELIXIR	VARIOUS			PA Required for < 6 years of age, Prior Authorization is not required when prescribed by a psychiatric clinician, a behavioral pediatrician or other prescribers as approved by the FFS Administration.			



## CMDP Preferred Drug List

• Generic Drugs Are Preferred Over Brand Name Drugs Unless Specified as Brand Only

• Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List Are Available Through Prior Authorization

Effective Date: 10/1/2019

Drug Class/Drug Name	Reference Brand Name	Brand Only / Generic Notes	Preferred Drug Status	PA Type	Step Therapy Requirements	Quantity Limit	QL Days
FLUPHENAZINE HCL TABLETS	VARIOUS			PA Required for < 6 years of age, Prior Authorization is not required when prescribed by a psychiatric clinician, a behavioral pediatrician or other prescribers as approved by the FFS Administration.			
HALOPERIDOL LACTATE CONCENTRATE	VARIOUS			PA Required for < 6 years of age, Prior Authorization is not required when prescribed by a psychiatric clinician, a behavioral pediatrician or other prescribers as approved by the FFS Administration.			
HALOPERIDOL TABLETS	VARIOUS			PA Required for < 6 years of age, Prior Authorization is not required when prescribed by a psychiatric clinician, a behavioral pediatrician or other prescribers as approved by the FFS Administration.			
LOXAPINE SUCCINATE CAPSULES	LOXITANE			PA Required for < 6 years of age, Prior Authorization is not required when prescribed by a psychiatric clinician, a behavioral pediatrician or other prescribers as approved by the FFS Administration.			
PERPHENAZINE TABLETS	VARIOUS			PA Required for < 6 years of age, Prior Authorization is not required when prescribed by a psychiatric clinician, a behavioral pediatrician or other prescribers as approved by the FFS Administration.			
PIMOZIDE	ORAP			PA Required for < 6 years of age, Prior Authorization is not required when prescribed by a psychiatric clinician, a behavioral pediatrician or other prescribers as approved by the FFS Administration.			
THIORIDAZINE HCL TABLETS	VARIOUS			PA Required for < 6 years of age. Prior Authorization is not required when prescribed by a psychiatric clinician, a behavioral pediatrician or other prescribers as approved by the FFS Administration.			
THIOTHIXENE CAPSULES	VARIOUS			PA Required for < 12 years of age. Prior Authorization is not required when prescribed by a psychiatric clinician, a behavioral pediatrician or other prescribers as approved by the FFS Administration.			



## CMDP Preferred Drug List

- Generic Drugs Are Preferred Over Brand Name Drugs Unless Specified as Brand Only
- Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List Are Available Through Prior Authorization

Effective Date: 10/1/2019

Drug Class/Drug Name	Reference Brand Name	Brand Only / Generic Notes	Preferred Drug Status	PA Type	Step Therapy Requirements	Quantity Limit	QL Days
TRIFLUOPERAZINE HCL TABLETS	VARIOUS			PA Required for < 6 years of age. Prior Authorization is not required when prescribed by a psychiatric clinician, a behavioral pediatrician or other prescribers as approved by the FFS Administration.			
<b>ANTIPSYCHOTICS - FIRST GENERATION -TYPICAL -LONG ACTING INJECTIONS</b>							
FLUPHENAZINE DECANOATE SOLUTION	FLUPHENAZINE DECANOATE			PA Required for < 18 years of age, Prior Authorization is not required when prescribed by a psychiatric clinician, a behavioral pediatrician or other prescribers as approved by the FFS Administration.			
HALOPERIDOL DECANOATE SOLUTION	HALDOL DECANOATE 50			PA Required for < 18 years of age, Prior Authorization is not required when prescribed by a psychiatric clinician, a behavioral pediatrician or other prescribers as approved by the FFS Administration.			
<b>ANTIVIRALS</b>							
<b>ANTIRETROVIRALS</b>							
ABACAVIR SULFATE SOLUTION	ZIAGEN						
ABACAVIR SULFATE TABLETS	ZIAGEN						
ABACAVIR SULFATE-LAMIVUDINE TABLETS	EPZICOM						
ABACAVIR SULFATE-LAMIVUDINE-ZIDOVUDINE TABLETS	TRIZIVIR						
ABACAVIR-DOLUTEGRAVIR-LAMIVUDINE TABLETS	TRIUMEQ						
ATAZANAVIR SULFATE CAPSULES	REYATAZ						
ATAZANAVIR SULFATE PACK	REYATAZ						
ATAZANAVIR SULFATE-COBICISTAT TABLETS	EVOTAZ						
BICTEGRAVIR-EMTRICITABINE-TENOFOVIR ALAFENAMIDE FUMARATE TABLETS	BIKTARVY					30.00	30.00
COBICISTAT TABLETS	TYBOST					30.00	30.00
DARUNAVIR ETHANOLATE SUSPENSION	PREZISTA						
DARUNAVIR ETHANOLATE TABLETS	PREZISTA						
DARUNAVIR-COBICISTAT TABLETS	PREZCOBIX						
DELAVIRDINE MESYLATE TABLETS	RESCRIPTOR						
DIDANOSINE CAPSULE DELAYED RELEASE	VIDEX EC						
DIDANOSINE SOLUTION	VIDEX PEDIATRIC						
DOLUTEGRAVIR SODIUM TABLETS	TIVICAY						
DORAVIRINE TABLETS	PIFELTRO						
EFAVIRENZ CAPSULES	SUSTIVA						
EFAVIRENZ TABLETS	SUSTIVA						
EFAVIRENZ-EMTRICITABINE-TENOFOVIR DISOPROXIL FUMARATE TABLETS	ATRIPLA						
ELVITEGRAVIR TABLETS	VITEKTA						
ELVITEGRAVIR-COBICISTAT-EMTRICITABINE-TENOFOVIR TABLETS	STRIBILD						
ELVITEGRAVIR-COBICISTAT-EMTRICITABINE-TENOFOVIR ALAFENAMIDE TABLETS	GENVOYA					30.00	30.00
EMTRICITABINE CAPSULES	EMTRIVA						
EMTRICITABINE SOLUTION	EMTRIVA						
EMTRICITABINE-RILPIVIRINE-TENOFOVIR ALAFENAMIDE FUMARATE TABLETS	ODEFSEY					30.00	30.00
EMTRICITABINE-RILPIVIRINE-TENOFOVIR DISOPROXIL FUMARATE TABLETS	COMPLERA						
EMTRICITABINE-TENOFOVIR ALAFENAMIDE FUMARATE TABLETS	DESCOVY					30.00	30.00





## CMDP Preferred Drug List

- Generic Drugs Are Preferred Over Brand Name Drugs Unless Specified as Brand Only
- Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List Are Available Through Prior Authorization

Effective Date: 10/1/2019

Drug Class/Drug Name	Reference Brand Name	Brand Only / Generic Notes	Preferred Drug Status	PA Type	Step Therapy Requirements	Quantity Limit	QL Days
EMTRICITABINE-TENOFOVIR DISOPROXIL FUMARATE TABLETS	TRUVADA						
ENFUVRTIDE SOLUTION	FUZEON			PA Required		1.00	30.00
ETRAVIRINE TABLETS	INTELENCE						
FOSAMPRENAVIR CALCIUM SUSPENSION	LEXIVA						
FOSAMPRENAVIR CALCIUM TABLETS	LEXIVA						
INDINAVIR SULFATE CAPSULES	CRIXIVAN						
LAMIVUDINE SOLUTION	EPIVIR						
LAMIVUDINE TABLETS	EPIVIR						
LAMIVUDINE-ZIDOVUDINE TABLETS	COMBIVIR						
LOPINAVIR-RITONAVIR SOLUTION	KALETRA						
LOPINAVIR-RITONAVIR TABLETS	KALETRA						
MARAVIROC TABLETS	SELZENTRY			PA Required			
NELFINAVIR MESYLATE TABLETS	VIRACEPT						
NEVIRAPINE SUSPENSION	VIRAMUNE						
NEVIRAPINE TABLETS	VIRAMUNE						
NEVIRAPINE TABLET 24-HOUR	VIRAMUNE XR						
RALTEGRAVIR POTASSIUM CHEWABLE TABLETS	ISENTRESS						
RALTEGRAVIR POTASSIUM PACK	ISENTRESS						
RALTEGRAVIR POTASSIUM TABLETS	ISENTRESS						
RILPIVIRINE HCL TABLETS	EDURANT						
RITONAVIR CAPSULES	NORVIR						
RITONAVIR SOLUTION	NORVIR						
RITONAVIR TABLETS	NORVIR						
SAQUINAVIR MESYLATE CAPSULES	INVIRASE						
SAQUINAVIR MESYLATE TABLETS	INVIRASE						
STAVUDINE CAPSULES	ZERIT						
STAVUDINE SOLUTION	ZERIT						
TENOFOVIR DISOPROXIL FUMARATE POWDER	VIREAD						
TENOFOVIR DISOPROXIL FUMARATE TABLETS	VIREAD						
TIPRANAVIR CAPSULES	APTIVUS						
TIPRANAVIR SOLUTION	APTIVUS						
ZIDOVUDINE CAPSULES	RETROVIR						
ZIDOVUDINE SYRUP	RETROVIR						
ZIDOVUDINE TABLETS	ZIDOVUDINE						
<b>CMV AGENTS</b>							
VALGANCICLOVIR HCL SOLUTION	VALCYTE			PA Required			
VALGANCICLOVIR HCL TABLETS	VALCYTE			PA Required			
<b>HEPATITIS AGENTS</b>							
ADEFOVIR DIPIVOXIL TABLETS	HEPSERA			PA Required			
ENTECAVIR SOLUTION	BARACLUDE			PA Required			
ENTECAVIR TABLETS	BARACLUDE			PA Required			
GLECAPREVIR-PIBRENTASVIR TABLETS	MAVYRET		Preferred Drug	PA Required			
LAMIVUDINE (HBV) SOLUTION	EPIVIR HBV						
LAMIVUDINE (HBV) TABLETS	EPIVIR HBV						
PEGINTERFERON ALFA-2A SOLUTION	PEGASYS		Preferred Drug	PA Required			
PEGINTERFERON ALFA-2B KIT	PEGINTRON		Preferred Drug	PA Required			
RIBAVIRIN (HEPATITIS C) CAPSULES	VARIOUS		Preferred Drug	PA Required			
RIBAVIRIN (HEPATITIS C) TABLETS	VARIOUS		Preferred Drug	PA Required			
SOFOSBUVIR-VELPATASVIR TABLETS	EPCLUSA	AUTHORIZED GENERIC ONLY	Preferred Drug	PA Required			
TELBIVUDINE TABLETS	TYZEKA			PA Required			
<b>HERPES AGENTS</b>							
ACYCLOVIR SUSPENSION	ZOVIRAX						



## CMDP Preferred Drug List

• Generic Drugs Are Preferred Over Brand Name Drugs Unless Specified as Brand Only

• Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List Are Available Through Prior Authorization

Effective Date: 10/1/2019

Drug Class/Drug Name	Reference Brand Name	Brand Only / Generic Notes	Preferred Drug Status	PA Type	Step Therapy Requirements	Quantity Limit	QL Days
ACYCLOVIR TABLETS	ZOVIRAX						
FAMCICLOVIR TABLETS	FAMVIR						
VALACYCLOVIR HCL TABLETS	VALTREX			PA Required			
<b>INFLUENZA AGENTS</b>							
OSELTAMIVIR PHOSPHATE CAPSULES	TAMIFLU					20.00	270.00
OSELTAMIVIR PHOSPHATE SUSPENSION	TAMIFLU						
RIMANTADINE HYDROCHLORIDE TABLETS	FLUMADINE						
ZANAMIVIR AEPB	RELENZA DISKHALER					40.00	270.00
<b>ASSORTED CLASSES</b>							
<b>BLOOD PRODUCTS - IMMUNE GLOBULINS</b>							
IMMUNE GLOBULIN	BIVIGAM (IV)	BRAND ONLY	PREFERRED DRUG	PA REQUIRED			
IMMUNE GLOBULIN	CARIMUNE NF NANOFILTERED (IV)	BRAND ONLY	PREFERRED DRUG	PA REQUIRED			
IMMUNE GLOBULIN	FLEBOGFAMMA DIF (IV)	BRAND ONLY	PREFERRED DRUG	PA REQUIRED			
IMMUNE GLOBULIN	GAMASTAN S/D (IM)	BRAND ONLY	PREFERRED DRUG	PA REQUIRED			
IMMUNE GLOBULIN	GAMMAGARD LIQUID (INJ)	BRAND ONLY	PREFERRED DRUG	PA REQUIRED			
IMMUNE GLOBULIN	GAMMAGARD S-D LIQUID (INJ)	BRAND ONLY	PREFERRED DRUG	PA REQUIRED			
IMMUNE GLOBULIN	GAMUNEX-C (INJ)	BRAND ONLY	PREFERRED DRUG	PA REQUIRED			
IMMUNE GLOBULIN	HIZENTRAL (SUBQ)	BRAND ONLY	PREFERRED DRUG	PA REQUIRED			
<b>CHELATING AGENTS</b>							
PENICILLAMINE CAPSULES	CUPRIMINE						
<b>IMMUNOMODULATORS</b>							
LENALIDOMIDE CAPSULES	REVLIMID			PA Required			
THALIDOMIDE CAPSULES	THALOMID			PA Required			
<b>IMMUNOSUPPRESSIVE AGENTS</b>							
AZATHIOPRINE TABLETS	IMURAN						
CYCLOSPORINE CAPSULES	SANDIMMUNE						
CYCLOSPORINE MODIFIED (FOR MICROEMULSION) CAPSULES	GENGRAF						
CYCLOSPORINE MODIFIED (FOR MICROEMULSION) SOLUTION	GENGRAF						
CYCLOSPORINE SOLUTION	SANDIMMUNE						
EVEROLIMUS (IMMUNOSUPPRESSANT) TABLETS	ZORTRESS			PA Required			
MYCOPHENOLATE MOFETIL CAPSULES	CELLCEPT						
MYCOPHENOLATE MOFETIL SUSPENSION	CELLCEPT						
MYCOPHENOLATE MOFETIL TABLETS	CELLCEPT						
SIROLIMUS SOLUTION	RAPAMUNE						
SIROLIMUS TABLETS	RAPAMUNE						
TACROLIMUS CAPSULES	HECORIA						
TACROLIMUS CAPSULE 24-HOUR	ASTAGRAF XL						
<b>POTASSIUM REMOVING RESINS</b>							
SODIUM POLYSTYRENE SULFONATE POWDER	KAYEXALATE						
SODIUM POLYSTYRENE SULFONATE SUSPENSION	KIONEX						
<b>BETA BLOCKERS</b>							
<b>ALPHA-BETA BLOCKERS</b>							
CARVEDILOL TABLETS	COREG						
LABETALOL HCL TABLETS	TRANDATE						
<b>BETA BLOCKERS CARDIO-SELECTIVE</b>							
ATENOLOL TABLETS	TENORMIN						
BISOPROLOL FUMARATE TABLETS	ZEBETA						
METOPROLOL SUCCINATE TABLET 24-HOUR	TOPROL XL						
METOPROLOL TARTRATE TABLETS	METOPROLOL TARTRATE						
<b>BETA BLOCKERS NON-SELECTIVE</b>							
NADOLOL TABLETS	CORGARD						
PROPRANOLOL HCL CAPSULE 24-HOUR	INDERAL LA						
PROPRANOLOL HCL SOLUTION	PROPRANOLOL HCL						



## CMDP Preferred Drug List

- Generic Drugs Are Preferred Over Brand Name Drugs Unless Specified as Brand Only
- Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List Are Available Through Prior Authorization

Effective Date: 10/1/2019

Drug Class/Drug Name	Reference Brand Name	Brand Only / Generic Notes	Preferred Drug Status	PA Type	Step Therapy Requirements	Quantity Limit	QL Days
PROPRANOLOL HCL TABLETS	PROPRANOLOL HCL						
SOTALOL AF TABLETS	SOTALOL HCL (AF)						
SOTALOL HCL SOLUTION	SOTALOL HYDROCHLORIDE						
SOTALOL HCL TABLETS	BETAPACE						
<b>CALCIUM CHANNEL BLOCKERS</b>							
<b>CALCIUM CHANNEL BLOCKERS</b>							
AMLODIPINE BESYLATE TABLETS	NORVASC					30.00	30.00
DILTIAZEM HCL COATED BEADS CAPSULE 24-HOUR	CARDIZEM CD						
DILTIAZEM HCL CAPSULE 12-HOUR	DILTIAZEM HCL ER						
DILTIAZEM HCL CAPSULE 24-HOUR	DILTIAZEM HCL ER						
DILTIAZEM HCL EXTENDED RELEASE BEADS CAPSULE 24-HOUR	TAZTIA XT						
DILTIAZEM HCL TABLETS	CARDIZEM						
FELODIPINE TABLET 24-HOUR	FELODIPINE ER						
NIFEDIPINE CAPSULES	PROCARDIA						
NIFEDIPINE TABLET 24-HOUR	ADALAT CC					30.00	30.00
NIMODIPINE CAPSULES	NIMODIPINE						
VERAPAMIL HCL CAPSULE 24-HOUR	VERELAN PM					30.00	30.00
VERAPAMIL HCL TABLETS	VERAPAMIL HCL						
VERAPAMIL HCL TABLET CONTROLLED RELEASE	CALAN SR					30.00	30.00
<b>CARDIOTONICS</b>							
<b>CARDIAC GLYCOSIDES</b>							
DIGOXIN SOLUTION	DIGOXIN						
DIGOXIN TABLETS	LANOXIN						
<b>CARDIOVASCULAR AGENTS - MISC.</b>							
<b>CARDIOVASCULAR AGENTS MISC. - COMBINATIONS</b>							
SACUBITRIL-VALSARTAN TABS	ENTRESTO			PA Required			
<b>PULMONARY HYPERTENSION - ENDOTHELIN RECEPTOR ANTAGONIST</b>							
AMBRISENTAN TABLETS	LETAIRIS	BRAND ONLY	PREFERRED DRUG	PA Required			
BOSENTAN TABLETS	TRACLEER	BRAND ONLY	PREFERRED DRUG	PA Required			
<b>PULMONARY HYPERTENSION - PHOSPHODIESTERASE INHIBITOR</b>							
SILDENAFIL CITRATE (PULMONARY HYPERTENSION) SUSPENSION	REVATIO SUSPENSION	BRAND ONLY	PREFERRED FOR UNDER THE AGE OF 12	PA Required FOR > 12 YEARS OF AGE			
SILDENAFIL CITRATE (PULMONARY HYPERTENSION) TABLETS	VARIOIUS		PREFERRED DRUG	PA Required			
TADALAFIL (PULMONARY HYPERTENSION) TABLETS	ADCIRCA	BRAND ONLY	PREFERRED DRUG	PA Required			
<b>CEPHALOSPORINS</b>							
<b>CEPHALOSPORINS - 1ST GENERATION</b>							
CEFADROXIL CAPSULES	CEFADROXIL						
CEFADROXIL SUSPENSION	CEFADROXIL						
CEFADROXIL TABLETS	CEFADROXIL						
CEPHALEXIN CAPSULES	KEFLEX						
CEPHALEXIN SUSPENSION	CEPHALEXIN						
CEPHALEXIN TABLETS	CEPHALEXIN						
<b>CEPHALOSPORINS - 2ND GENERATION</b>							
CEFACLOR CAPSULES	CEFACLOR						
CEFACLOR SUSPENSION	CEFACLOR						
CEFPROZIL SUSPENSION	CEFPROZIL						
CEFPROZIL TABLETS	CEFPROZIL						
CEFUROXIME AXETIL SUSPENSION	CEFTIN						
CEFUROXIME AXETIL TABLETS	CEFTIN						
<b>CEPHALOSPORINS - 3RD GENERATION</b>							
CEFDINIR CAPSULES	CEFDINIR						
CEFDINIR SUSPENSION	CEFDINIR						



## CMDP Preferred Drug List

• Generic Drugs Are Preferred Over Brand Name Drugs Unless Specified as Brand Only

• Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List Are Available Through Prior Authorization

Effective Date: 10/1/2019

Drug Class/Drug Name	Reference Brand Name	Brand Only / Generic Notes	Preferred Drug Status	PA Type	Step Therapy Requirements	Quantity Limit	QL Days
CEFIXIME CAPSULES	SUPRAX					1.00	30.00
CEFIXIME CHEWABLE TABLETS	SUPRAX					1.00	30.00
CEFIXIME SUSPENSION	SUPRAX					1.00	30.00
CEFIXIME TABLETS	SUPRAX					1.00	30.00
CEFPODOXIME PROXETIL SUSPENSION	CEFPODOXIME PROXETIL						
CEFPODOXIME PROXETIL TABLETS	CEFPODOXIME PROXETIL						
<b>CONTRACEPTIVES</b>							
<b>COMBINATION CONTRACEPTIVES - ORAL</b>							
DESOGESTREL & ETHINYL ESTRADIOL TABLETS	APRI						
DESOGESTREL-ETHINYL ESTRADIOL (BIPHASIC) TABLETS	AZURETTE						
DESOGESTREL-ETHINYL ESTRADIOL (TRIPHASIC) TABLETS	CAZIAN						
DROSPIRENONE-ETHINYL ESTRADIOL TABLETS	OCELLA						
ETHYNODIOL DIACET & ETH ESTRAD TABLETS	KELNOR 1/35						
LEVONORGESTREL & ETH ESTRADIOL TABLETS	AUBRA						
LEVONORGESTREL-ETH ESTRADIOL (TRIPHASIC) TABLETS	ENPRESSE-28						
LEVONORGESTREL-ETHINYL ESTRADIOL (91-DAY) TABLETS	AMETHIA LO						
NORETHINDRONE ACE & ETHINYL ESTRADIOL-FE TABLETS	JUNEL FE						
NORETHINDRONE & ETH ESTRADIOL TABLETS	BALZIVA						
NORETHINDRONE & MESTRANOL TABLETS	NECON 1/50-28						
NORETHINDRONE ACET & ETH ESTRA TABLETS	GILDESS 1/20						
NORETHINDRONE ACETATE-ETHINYL ESTRADIOL-FE TABLETS	ESTROSTEP FE						
NORETHINDRONE-ETH ESTRADIOL (BIPHASIC) TABLETS	NECON 10/11-28						
NORETHINDRONE-ETH ESTRADIOL (TRIPHASIC) TABLETS	CYCLAFEM 7/7/7						
NORGESTIMATE-ETHINYL ESTRADIOL (TRIPHASIC) TABLETS	ORTHO TRI-CYCLEN						
NORGESTIMATE-ETHINYL ESTRADIOL TABLETS	ESTARYLLA						
NORGESTREL & ETHINYL ESTRADIOL TABLETS	CRYSSELLE-28						
<b>COMBINATION CONTRACEPTIVES - VAGINAL</b>							
ETONOGESTREL-ETHINYL ESTRADIOL RING	NUVARING						
<b>EMERGENCY CONTRACEPTIVES</b>							
LEVONORGESTREL (EMERGENCY OC) TABLETS	PLAN B						
<b>PROGESTIN CONTRACEPTIVES - INJECTION/INJECTABLE</b>							
MEDROXYPROGESTERONE ACETATE (CONTRACEPTIVE) SUSPENSION	DEPO-PROVERA CONTRACEPTIVE						
<b>PROGESTIN CONTRACEPTIVES - ORAL</b>							
NORETHINDRONE (CONTRACEPTIVE) TABLETS	CAMILA						
<b>CORTICOSTEROIDS</b>							
<b>GLUCOCORTICOSTEROIDS</b>							
CORTISONE ACETATE TABLETS	CORTISONE ACETATE						
DEXAMETHASONE CONCENTRATE	DEXAMETHASONE INTENSOL						
DEXAMETHASONE ELIXIR	BAYCADRON						
DEXAMETHASONE SOLUTION	DEXAMETHASONE						
DEXAMETHASONE TABLETS	DEXAMETHASONE						
HYDROCORTISONE SOD SUCCINATE SOLUTION	A-HYDROCORT				Prior Authorization Required		
METHYLPREDNISOLONE ACETATE SUSPENSION	DEPO-MEDROL				Prior Authorization Required		
METHYLPREDNISOLONE SOD SUCC SOLUTION	A-METHAPRED				Prior Authorization Required		
METHYLPREDNISOLONE TABLETS	MEDROL						
PREDNISOLONE ACETATE SUSPENSION	FLO-PRED						
PREDNISOLONE SODIUM PHOSPHATE SOLUTION	ORAPRED						
PREDNISOLONE SODIUM PHOSPHATE ORALLY DISPERSABLE TABLET	ORAPRED ODT						
PREDNISOLONE SYRUP	PRELONE						
PREDNISOLONE TABLETS	MILLIPRED						
PREDNISONE CONCENTRATE	PREDNISONE INTENSOL						
PREDNISONE SOLUTION	PREDNISONE						
PREDNISONE TABLETS	PREDNISONE						



## CMDP Preferred Drug List

• Generic Drugs Are Preferred Over Brand Name Drugs Unless Specified as Brand Only

• Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List Are Available Through Prior Authorization

Effective Date: 10/1/2019

Drug Class/Drug Name	Reference Brand Name	Brand Only / Generic Notes	Preferred Drug Status	PA Type	Step Therapy Requirements	Quantity Limit	QL Days
PREDNISONE TABLET ENTERIC COATED	RAYOS						
TRIAMCINOLONE ACETONIDE SUSPENSION	KENALOG-10			Prior Authorization Required			
TRIAMCINOLONE DIACETATE SUSPENSION	TRIAMCINOLONE			Prior Authorization Required			
<b>MINERALOCORTICOIDS</b>							
FLUDROCORTISONE ACETATE TABLETS	FLUDROCORTISONE ACETATE						
<b>COUGH/COLD/ALLERGY</b>							
<b>ANTITUSSIVES</b>							
BENZONATATE CAPSULES	TESSALON PERLES						
HYDROCODONE W/ HOMETROPINE SYRUP	HYDROCODONE BITARTRATE/HOMATROPINE			PA Required for < 18 years of age		240.00	12.00
HYDROCODONE W/ HOMETROPINE TABLETS	METHYLBROMIDE TUSSIGON			PA Required for < 18 years of age			
<b>COUGH/COLD/ALLERGY COMBINATIONS</b>							
BROMPHENIRAMINE & PSEUDOEPH	J-TAN D PD						
BROMPHENIRAMINE & PSEUDOEPH TABLET 12-HOUR	BPM PSEUDO						
CETIRIZINE-PSEUDOEPHEDRINE TABLET 12-HOUR	KLS ALLER-TEC D					30.00	30.00
CHLORPHENIRAMINE & PSEUDOEPH CHEWABLE TABLETS	DICEL						
CHLORPHENIRAMINE & PSEUDOEPH LIQUID	LOHIST-D						
CHLORPHENIRAMINE & PSEUDOEPH SOLUTION	NEUTRAHIST						
CHLORPHENIRAMINE & PSEUDOEPH SYRUP	EQ TRIACTING COLD/ALLERGY						
CHLORPHENIRAMINE & PSEUDOEPH TABLETS	SUDOGEST SINUS & ALLERGY						
CHLORPHENIRAMINE W/ CODEINE LIQUID	CODAR AR			PA Required for < 18 years of age		240.00	12.00
DEXTROMETHORPHAN-GUAIFENESIN	BRONCOTRON						
DEXTROMETHORPHAN-GUAIFENESIN LIQUID	NORTUSS-EX						
DEXTROMETHORPHAN-GUAIFENESIN TABLET 12-HOUR	MUCINEX DM						
DIPHENHYDRAMINE-PHENYLEPHRINE-ACETAMINOPHEN LIQUID	THERAFLU WARMING RELIEF FLU & SORE THROAT						
DIPHENHYDRAMINE-PHENYLEPHRINE-ACETAMINOPHEN PACK	MUCINEX FAST-MAX NIGHT TIME COLD & FLU						
DIPHENHYDRAMINE-PHENYLEPHRINE-ACETAMINOPHEN SUSPENSION	TYLENOL CHILDRENS PLUS COLD & ALLERGY						
DIPHENHYDRAMINE-PHENYLEPHRINE-ACETAMINOPHEN TABLETS	BENADRYL ALLERGY & COLD						
FEXOFENADINE-PSEUDOEPHEDRINE TABLET 12-HOUR	ALLEGRA-D 12 HOUR ALLERGY & CONGESTION					30.00	30.00
FEXOFENADINE-PSEUDOEPHEDRINE TABLET 24-HOUR	ALLEGRA-D 24 HOUR ALLERGY & CONGESTION					30.00	30.00
GUAIFENESIN-CODEINE	M-CLEAR			PA Required for < 18 years of age		240.00	12.00
GUAIFENESIN-CODEINE LIQUID	DEX-TUSS			PA Required for < 18 years of age		240.00	12.00
LORATADINE & PSEUDOEPHEDRINE TABLET 12-HOUR	ALAVERT ALLERGY/SINUS					30.00	30.00
LORATADINE & PSEUDOEPHEDRINE TABLET 24-HOUR	CLARITIN-D 24 HOUR					30.00	30.00
PHENYLEPHRINE W/ DM-GG CAPSULES	GILTUSS TR						
PHENYLEPHRINE W/ DM-GG LIQUID	ROBITUSSIN CHILDRENS COUGH & COLD CF						
PHENYLEPHRINE W/ DM-GG SUSPENSION	BRONCOTRON-D						
PHENYLEPHRINE W/ DM-GG SYRUP	DESPEC DM						
PHENYLEPHRINE W/ DM-GG TABLETS	MUCINEX FAST-MAX SEVERE CONGESTION & COUGH						
PHENYLEPHRINE W/ DM-GG TABLET 12-HOUR	GILTUSS TR						
PHENYLEPHRINE-BROMPHENIRAMINE W/ CODEINE	POLY-TUSSIN AC			PA Required for < 18 years of age		240.00	12.00
PHENYLEPHRINE-BROMPHENIRAMINE-DM ELIXIR	DIMAPHEN DM COLD & COUGH					480.00	30.00
PHENYLEPHRINE-BROMPHENIRAMINE-DM LIQUID	DIMETAPP DM COLD & COUGH					480.00	30.00
PHENYLEPHRINE-BROMPHENIRAMINE-DM SYRUP	BPM-DM-PHEN					480.00	30.00
PHENYLEPHRINE-CHLORPHEN-DM LIQUID	GENCONTUSS			PA Required			
PHENYLEPHRINE-CHLORPHEN-DM SOLUTION	FATHER JOHNS MEDICINE PLUS			PA Required			
PHENYLEPHRINE-CHLORPHEN-DM SYRUP	BALAMINE DM						
PHENYLEPHRINE-CHLORPHEN-DM TABLETS	PHENABID DM			PA Required			
PHENYLEPHRINE-GUAIFENESIN CAPSULES	DECONEX						
PHENYLEPHRINE-GUAIFENESIN LIQUID	TRIAMINIC CHEST/NASAL CONGESTION						
PHENYLEPHRINE-GUAIFENESIN SYRUP	TRIAMINIC CHEST & NASAL CONGESTION						



## CMDP Preferred Drug List

• Generic Drugs Are Preferred Over Brand Name Drugs Unless Specified as Brand Only

• Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List Are Available Through Prior Authorization

Effective Date: 10/1/2019

Drug Class/Drug Name	Reference Brand Name	Brand Only / Generic Notes	Preferred Drug Status	PA Type	Step Therapy Requirements	Quantity Limit	QL Days
PHENYLEPHRINE-GUAIFENESIN TABLETS	LIQUIBID PD-R						
PROMETHAZINE & PHENYLEPHRINE SYRUP	PROMETHAZINE/PHENYLEPHRINE						
PROMETHAZINE W/CODEINE SYRUP	PROMETHAZINE/CODEINE			PA Required for < 18 years of age		240.00	12.00
PROMETHAZINE-DM SYRUP	PROMETHAZINE/DEXTROMETHORPHAN						
PSEUDOEPHEDRINE W/ CODEINE-GG	SUTTAR-2					240.00	12.00
PSEUDOEPHEDRINE-BROMPHENIRAMINE-CODEINE LIQUID	CPB WC			PA Required for < 18 years of age		240.00	12.00
PSEUDOEPHEDRINE-GUAIFENESIN CAPSULES	RESPIRE-30						
PSEUDOEPHEDRINE-GUAIFENESIN LIQUID	TUSNEL PEDIATRIC						
PSEUDOEPHEDRINE-GUAIFENESIN SYRUP	ALTARUSSIN-PE						
PSEUDOEPHEDRINE-GUAIFENESIN TABLETS	AMBI 40PSE/400GFN						
PSEUDOEPHEDRINE-GUAIFENESIN TABLET 12-HOUR	MUCINEX D						
<b>EXPECTORANTS</b>							
GUAIFENESIN LIQUID	HERBAL EXPEC						
GUAIFENESIN PACK	MUCINEX FOR KIDS						
GUAIFENESIN SOLUTION	TRIACTIN CHEST CONGESTION						
GUAIFENESIN SYRUP	DIABETIC TUSSIN EX						
GUAIFENESIN TABLETS	GUAIFENESIN						
GUAIFENESIN TABLET 12-HOUR	EQ MUCUS ER						
<b>MISC. RESPIRATORY INHALANTS</b>							
SODIUM CHLORIDE (INHALANT) NEBULIZED	SODIUM CHLORIDE						
<b>DERMATOLOGICALS</b>							
<b>ACNE PRODUCTS</b>							
ADAPALENE CREAM	DIFFERIN			PA Required For > 26 Years of Age			
ADAPALENE GEL	DIFFERIN			PA Required For > 26 Years of Age			
ADAPALENE LOTION	DIFFERIN			PA Required For > 26 Years of Age			
AZELAIC ACID (ACNE) CREAM	AZELEX			PA Required For > 26 Years of Age			
BENZOYL PEROXIDE BAR	PANOXYL						
BENZOYL PEROXIDE CREAM	NEUTROGENA ON-THE-SPOT ACNE TREATMENT						
BENZOYL PEROXIDE FOAM	BENZEFOAM						
BENZOYL PEROXIDE GEL	BENZOYL PEROXIDE						
BENZOYL PEROXIDE LIQUID	PANOXYL						
BENZOYL PEROXIDE LOTION	BP CLEANSING LOTION						
BENZOYL PEROXIDE SOLUTION	EFFACLAR DUO						
BENZOYL PEROXIDE-ERYTHROMYCIN GEL	BENZAMYCIN						
BENZOYL PEROXIDE-ERYTHROMYCIN PACK	BENZAMYCINPAK						
CLINDAMYCIN PHOSPHATE (TOPICAL) FOAM	EVOCLIN						
CLINDAMYCIN PHOSPHATE (TOPICAL) GEL	CLEOCIN-T						
CLINDAMYCIN PHOSPHATE (TOPICAL) LOTION	CLEOCIN-T						
CLINDAMYCIN PHOSPHATE (TOPICAL) SOLUTION	CLEOCIN-T						
CLINDAMYCIN PHOSPHATE (TOPICAL) SWAB	CLEOCIN-T						
CLINDAMYCIN PHOSPHATE-BENZOYL PEROXIDE GEL	BENZACLIN						
ERYTHROMYCIN (ACNE AID) GEL	ERYGEL						
ERYTHROMYCIN (ACNE AID) OINTMENT	AKNE-MYCIN						
ERYTHROMYCIN (ACNE AID) PADS	ERYTHROMYCIN						
ERYTHROMYCIN (ACNE AID) SOLUTION	ERYTHROMYCIN						
ISOTRETINOIN CAPSULES	ABSORICA			PA Required			
SULFACETAMIDE SODIUM (ACNE) LOTION	KLARON						
TRETINOIN CREAM	VARIOUS			PA Required For > 26 Years of Age			
TRETINOIN GEL	VARIOUS			PA Required For > 26 Years of Age			
<b>ANTIBIOTICS - TOPICAL</b>							
BACITRACIN (TOPICAL) OINTMENT	BACIGUENT						
BACITRACIN ZINC OINTMENT	BACITRACIN						



## CMDP Preferred Drug List

- Generic Drugs Are Preferred Over Brand Name Drugs Unless Specified as Brand Only
- Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List Are Available Through Prior Authorization

Effective Date: 10/1/2019

Drug Class/Drug Name	Reference Brand Name	Brand Only / Generic Notes	Preferred Drug Status	PA Type	Step Therapy Requirements	Quantity Limit	QL Days
BACITRACIN-POLYMYXIN B OINTMENT	POLYSPORIN						
BACITRACIN-POLYMYXIN-NEOMYCIN HC OINTMENT	CORTISPORIN						
GENTAMICIN SULFATE (TOPICAL) CREAM	GENTAMICIN SULFATE						
GENTAMICIN SULFATE (TOPICAL) OINTMENT	GENTAMICIN SULFATE						
MUPIROCIIN CALCIUM (TOPICAL) CREAM	BACTROBAN						
MUPIROCIIN OINTMENT	BACTROBAN						
NEOMYCIN-BACITRACIN-POLYMYXIN OINTMENT	LANABIOTIC						
<b>ANTIFUNGALS - TOPICAL</b>							
BUTENAFINE	LOTRIMIN ULTRA		PREFERRED BRAND				
CICLOPROX CREAM	VARIOUS						
CICLOPROX SOLUTION	VARIOUS						
CICLOPROX SUSPENSION	VARIOUS						
CLOTRIMAZOLE CREAM (RX & OTC)	LOTRIMIN						
CLOTRIMAZOLE OINTMENT	LOTRIMIN						
CLOTRIMAZOLE SOLUTION ( RX & OTC)	VARIOUS						
CLOTRIMAZOLE W/ BETAMETHASONE CREAM	LOTRISONE						
KETOCONAZOLE CREAM	VARIOUS						
KETOCONAZOLE SHAMPOO	VARIOUS						
MICONAZOLE NITRATE CREAM	VARIOUS						
MICONAZOLE NITRATE LIQUID/SPRAY	VARIOUS						
MICONAZOLE NITRATE OINTMENT	VARIOUS						
MICONAZOLE NITRATE POWDER	VARIOUS						
NYSTATIN CREAM	VARIOUS						
NYSTATIN OINTMENT	VARIOUS						
NYSTATIN POWDER	NYAMYC						
TOLNAFTATE AERO POWDER	VARIOUS						
TOLNAFTATE CREAM	VARIOUS						
TOLNAFTATE POWDER	VARIOUS						
TOLNAFTATE SPRAY	VARIOUS						
TERBINAFINE CREAM	VARIOUS						
<b>ANTIHISTAMINES-TOPICAL</b>							
DIPHENHYDRAMINE HCL (TOPICAL) CREAM	ANTI-ITCH MAXIMUM STRENGTH						
DIPHENHYDRAMINE HCL (TOPICAL) GEL	BENADRYL ITCH STOPPING						
DIPHENHYDRAMINE HCL (TOPICAL) SOLUTION	BENADRYL MAXIMUM STRENGTH						
DICLOFENAC SODIUM (TOPICAL) GEL	VOLTAREN	BRAND ONLY				100 GM	300.00
<b>ANTINEOPLASTIC OR PREMALIGNANT LESION AGENTS - TOP</b>							
BEXAROTENE (TOPICAL) GEL	TARGETIN						
FLUOROURACIL (TOPICAL) CREAM	CARAC						
FLUOROURACIL (TOPICAL) SOLUTION	FLUOROURACIL						
<b>ANTIPSORIATICS</b>							
ACITRETIN CAPSULES	SORIATANE						
ANTHRALIN CREAM	DRITHO-CREME HP						
CALCIPOTRIENE CREAM	DOVONEX						
CALCIPOTRIENE FOAM	SORILUX						
CALCIPOTRIENE OINTMENT	CALCITRENE						
CALCIPOTRIENE SOLUTION	CALCIPOTRIENE						
METHOXSALEN RAPID CAPSULES	OXSORALEN ULTRA						
TAZAROTENE CREAM	TAZORAC			PA Required			
TAZAROTENE GEL	TAZORAC			PA Required			
<b>ANTISEBORRHEIC PRODUCTS</b>							
SELENIUM SULFIDE LOTION	SELSUN SHAMPOO						
<b>ANTIVIRALS - TOPICAL</b>							
DOCOSANOL CREAM	ABREVA						



## CMDP Preferred Drug List

- Generic Drugs Are Preferred Over Brand Name Drugs Unless Specified as Brand Only
- Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List Are Available Through Prior Authorization

Effective Date: 10/1/2019

Drug Class/Drug Name	Reference Brand Name	Brand Only / Generic Notes	Preferred Drug Status	PA Type	Step Therapy Requirements	Quantity Limit	QL Days
ACYCLOVIR OINTMENT	ZOVIRAX					15GM	30.00
<b>BURN PRODUCTS</b>							
SILVER SULFADIAZINE CREAM	SILVADENE						
<b>CORTICOSTEROIDS - TOPICAL LOW POTENCY</b>							
HYDROCORTISONE CREAM	VARIOUS						
HYDROCORTISONE GEL	VARIOUS						
HYDROCORTISONE KIT	VARIOUS						
HYDROCORTISONE LOTION	VARIOUS						
HYDROCORTISONE OINTMENT	VARIOUS						
HYDROCORTISONE ACETATE CREAM 0.5%	VARIOUS						
FLUOCINOLONE 0.01% OIL	VARIOUS						
<b>CORTICOSTEROIDS - TOPICAL MEDIUM POTENCY</b>							
FLUTICASON PROPIONATE CREAM	VARIOUS						
FLUTICASON PROPIONATE OINTMENT	VARIOUS						
MOMETASONE FUROATE CREAM	VARIOUS						
MOMETASONE FUROATE OINTMENT	VARIOUS						
MOMETASONE FUROATE SOLUTION	VARIOUS						
<b>CORTICOSTEROIDS - TOPICAL HIGH POTENCY</b>							
BETAMETHASONE DIPROPIONATE LOTION	VARIOUS						
BETAMETHASONE DIPROPIONATE/PROPYLENE GLYC. CREAM	VARIOUS						
BETAMETHASONE VALERATE CREAM	VARIOUS						
BETAMETHASONE VALERATE LOTION	VARIOUS						
BETAMETHASONE VALERATE OINTMENT	VARIOUS						
FLUOCINONIDE CREAM	VARIOUS						
FLUOCINONIDE OINTMENT	VARIOUS						
FLUOCINONIDE SOLUTION	VARIOUS						
TRIAMCINOLONE ACETONIDE CREAM	VARIOUS						
TRIAMCINOLONE ACETONIDE LOTION	VARIOUS						
TRIAMCINOLONE ACETONIDE OINTMENT	VARIOUS						
<b>CORTICOSTEROIDS - TOPICAL VERY HIGH POTENCY</b>							
CLOBETASOL PROPIONATE CREAM	VARIOUS					100	30
CLOBETASOL PROPIONATE EMOLLIENT	VARIOUS					100	30
CLOBETASOL PROPIONATE GEL	VARIOUS					118	30
CLOBETASOL PROPIONATE OINTMENT	VARIOUS					100	30
CLOBETASOL PROPIONATE SOLUTION	VARIOUS					100	30
HALOBETASOL PROPIONATE CREAM	VARIOUS					100	30
HALOBETASOL PROPIONATE OINTMENT	VARIOUS					100	30
<b>EMOLLIENTS</b>							
LACTIC ACID (AMMONIUM LACTATE) CREAM	NOBLE MYSTIQUE EMU-LAC						
LACTIC ACID (AMMONIUM LACTATE) FOAM	PRO:12 MOUSSE AL12						
LACTIC ACID (AMMONIUM LACTATE) LOTION	GERI-HYDROLAC 5						
<b>IMMUNOSUPPRESSIVE AGENTS - TOPICAL</b>							
PIMECROLIMUS CREAM	ELIDEL						
TACROLIMUS (TOPICAL) OINTMENT	PROTOPIC			PA Required			
VITAMINS A & D (TOPICAL) OINTMENT	CURAD VITAMIN A & D						
<b>KERATOLYTIC/ANTIMITOTIC AGENTS</b>							
SALICYLIC ACID CREAM	SALACYN						
SALICYLIC ACID FOAM	SALVAX						
SALICYLIC ACID GEL	KERALYT						
SALICYLIC ACID KIT	KERALYT SCALP						
SALICYLIC ACID LIQUID	VIRASAL						
SALICYLIC ACID LOTION	SALACYN						
SALICYLIC ACID SHAMPOO	SALEX						





## CMDP Preferred Drug List

- Generic Drugs Are Preferred Over Brand Name Drugs Unless Specified as Brand Only
- Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List Are Available Through Prior Authorization

Effective Date: 10/1/2019

Drug Class/Drug Name	Reference Brand Name	Brand Only / Generic Notes	Preferred Drug Status	PA Type	Step Therapy Requirements	Quantity Limit	QL Days
SALICYLIC ACID SOLUTION	SALICYLIC ACID						
<b>LOCAL ANESTHETICS - TOPICAL</b>							
LIDOCAINE CREAM 4%	ASPERCREME W/LIDOCAINE						
LIDOCAINE HCL GEL 2%	GLYDO						
LIDOCAINE HCL LOTION	LIDOCAINE HCL						
LIDOCAINE OINTMENT	LIDOCAINE			PA Required			
LIDOCAINE PATCH	LIDODERM			PA Required			
LIDOCAINE-PRILOCAINE CREAM	EMLA						
<b>MISC. TOPICAL</b>							
ALUMINUM CHLORIDE SOLUTION	DRYSOL						
ZINC OXIDE (TOPICAL) OINTMENT	ZINC OXIDE						
ZINC OXIDE (TOPICAL) PASTE	ZINC OXIDE						
<b>PIGMENTING-DEPIGMENTING AGENTS</b>							
METHOXSALEN (TOPICAL) LOTION	OXSORALEN						
<b>ROSACEA AGENTS</b>							
METRONIDAZOLE (TOPICAL) CREAM 0.75%	METROCREAM						
METRONIDAZOLE (TOPICAL) GEL 0.75%	ROSDAN						
METRONIDAZOLE (TOPICAL) LOTION	METROLOTION						
<b>SCABICIDES &amp; PEDICULICIDES</b>							
CROTAMITON CREAM	EURAX						
CROTAMITON LOTION	EURAX						
IVERMECTIN (PEDICULICIDE) LOTION	SKLICE			PA Required			
LINDANE LOTION	LINDANE			PA Required			
LINDANE SHAMPOO	LINDANE			PA Required			
MALATHION LOTION	OVIDE						
PERMETHRIN 1%, 5%	NIX, ELIMITE						
PERMETHRIN CREAM	ACTICIN						
PERMETHRIN LIQUID	NIX CREME RINSE						
PERMETHRIN LOTION	LICE TREATMENT						
PYRETHRINS-PIPERONYL BUTOXIDE GEL	A-200						
PYRETHRINS-PIPERONYL BUTOXIDE KIT	PRONTO						
PYRETHRINS-PIPERONYL BUTOXIDE LIQUID	BARC						
PYRETHRINS-PIPERONYL BUTOXIDE SHAMPOO	LICIDE						
SPINOSAD SUSPENSION	NATROBA			PA Required			
<b>WOUND CARE PRODUCTS</b>							
BECAPLERMIN GEL	REGANEX			PA Required			
<b>DIAGNOSTIC PRODUCTS</b>							
<b>DIAGNOSTIC TESTS</b>							
GLUCOSE BLOOD STRIPS	TRUETRACK AND ACCU-CHEK AVIVA					200.00	30.00
<b>DIGESTIVE AIDS</b>							
<b>DIGESTIVE ENZYMES</b>							
LIPASE-PROTEASE-AMYLASE CAPSULE DELAYED RELEASE	CREON	Brand Only	Preferred Drug			300.00	30.00
LIPASE-PROTEASE-AMYLASE CAPSULE DELAYED RELEASE	ZENPEP	Brand Only	Preferred Drug			300.00	30.00
LIPASE-PROTEASE-AMYLASE CAPSULE DELAYED RELEASE 5000 UNITS	PANCRELIPASE 5000 UNITS		Preferred Drug			300.00	30.00
SACROSIDASE SOLUTION	SUCRAID			PA Required			
<b>DIURETICS</b>							
<b>CARBONIC ANHYDRASE INHIBITORS</b>							
ACETAZOLAMIDE CAPSULE 12-HOUR	DIAMOX						
ACETAZOLAMIDE TABLETS	ACETAZOLAMIDE						
METHAZOLAMIDE TABLETS	NEPTAZANE						
<b>DIURETIC COMBINATIONS</b>							
SPIRONOLACTONE & HYDROCHLOROTHIAZIDE TABLETS	ALDACTAZIDE						
TRIAMTERENE & HYDROCHLOROTHIAZIDE CAPSULES	DYAZIDE						



## CMDP Preferred Drug List

- Generic Drugs Are Preferred Over Brand Name Drugs Unless Specified as Brand Only
- Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List Are Available Through Prior Authorization

Effective Date: 10/1/2019

Drug Class/Drug Name	Reference Brand Name	Brand Only / Generic Notes	Preferred Drug Status	PA Type	Step Therapy Requirements	Quantity Limit	QL Days
TRIAMTERENE & HYDROCHLOROTHIAZIDE TABLETS	MAXZIDE-25						
<b>LOOP DIURETICS</b>							
BUMETANIDE TABLETS	BUMETANIDE						
FUROSEMIDE SOLUTION	FUROSEMIDE						
FUROSEMIDE TABLETS	LASIX						
TORSEMIDE TABLETS	DEMADEX						
<b>POTASSIUM SPARING DIURETICS</b>							
AMILORIDE HCL TABLETS	AMILORIDE HCL						
SPIRONOLACTONE TABLETS	ALDACTONE						
TRIAMTERENE CAPSULES	DYRENIUM						
<b>THIAZIDES AND THIAZIDE-LIKE DIURETICS</b>							
CHLOROTHIAZIDE SUSPENSION	DIURIL						
CHLOROTHIAZIDE TABLETS	CHLOROTHIAZIDE						
CHLORTHALIDONE TABLETS	CHLORTHALIDONE						
HYDROCHLOROTHIAZIDE 12.5MG CAPSULES	VARIOUS						
HYDROCHLOROTHIAZIDE TABLETS 25MG & 50MG	HYDROCHLOROTHIAZIDE						
INDAPAMIDE TABLETS	INDAPAMIDE						
METHYLCLOTHIAZIDE TABLETS	METHYLCLOTHIAZIDE						
METOLAZONE TABLETS	ZAROXOLYN						
<b>ENDOCRINE AND METABOLIC AGENTS - MISC.</b>							
<b>BONE DENSITY REGULATORS</b>							
ALENDRONATE SODIUM SOLUTION	ALENDRONATE SODIUM			PA Required			
ALENDRONATE SODIUM TABLETS	ALENDRONATE SODIUM					30.00	30.00
CALCITONIN (SALMON) SOLUTION	FORTICAL						
RALOXIFENE TABLETS	VARIOUS						
<b>GROWTH HORMONE RECEPTOR ANTAGONISTS</b>							
PEGVISOMANT SOLUTION	SOMAVERT			PA Required			
<b>GROWTH HORMONES</b>							
SOMATROPIN SOLUTION	NORDITROPIN	Brand Only	Preferred Drug	PA Required			
SOMATROPIN SOLUTION	GENOTROPIN	Brand Only	Preferred Drug	PA Required			
<b>HORMONE RECEPTOR MODULATORS</b>							
RALOXIFENE HCL TABLETS	EVISTA					30.00	30.00
<b>INSULIN-LIKE GROWTH FACTORS (SOMATOMEDINS)</b>							
MECASERMIN SOLUTION	INCRELEX			PA Required			
<b>LHRH/GNRH AGONIST ANALOG PITUITARY SUPPOSITORYSSANTS</b>							
LEUPROLIDE ACETATE (CPP) (3 MONTH) KIT	LUPRON DEPOT-PED			PA Required			
LEUPROLIDE ACETATE (CPP) KIT	LUPRON DEPOT-PED			PA Required			
NAFARELIN ACETATE SOLUTION	SYNAREL			PA Required			
<b>METABOLIC MODIFIERS</b>							
CALCITRIOL CAPSULES	ROCALTROL						
CALCITRIOL SOLUTION	ROCALTROL						
CINACALCET HCL TABLETS	SENSIPAR			PA Required			
IDURSULFASE SOLUTION	ELAPRASE			PA Required			
LEVOCARNITINE (METABOLIC MODIFIERS) SOLUTION	CARNITOR			PA Required			
LEVOCARNITINE (METABOLIC MODIFIERS) TABLETS	CARNITOR			PA Required			
<b>POSTERIOR PITUITARY HORMONES</b>							
DESMOPRESSIN ACETATE REFRIGERATED SOLUTION	DDAVP						
DESMOPRESSIN ACETATE SOLUTION	STIMATE						
DESMOPRESSIN ACETATE SPRAY REFRIGERATED SOLUTION	DESMOPRESSIN ACETATE						
DESMOPRESSIN ACETATE SPRAY SOLUTION	DDAVP						
DESMOPRESSIN ACETATE TABLETS	DDAVP						
<b>PROLACTIN INHIBITORS</b>							
CABERGOLINE TABLETS	CABERGOLINE			PA Required			



## CMDP Preferred Drug List

- Generic Drugs Are Preferred Over Brand Name Drugs Unless Specified as Brand Only
- Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List Are Available Through Prior Authorization

Effective Date: 10/1/2019

Drug Class/Drug Name	Reference Brand Name	Brand Only / Generic Notes	Preferred Drug Status	PA Type	Step Therapy Requirements	Quantity Limit	QL Days
<b>SOMATOSTATIC AGENTS</b>							
LANREOTIDE ACETATE SOLUTION	SOMATULINE DEPOT			PA Required			
OCTREOTIDE ACETATE KIT	SANDOSTATIN LAR DEPOT			PA Required			
OCTREOTIDE ACETATE SOLUTION	SANDOSTATIN			PA Required			
<b>ESTROGENS</b>							
<b>ESTROGEN COMBINATIONS</b>							
CONJUGATED ESTROGENS-MEDROXYPROGESTERONE ACETATE TABLETS	PREMPRO						
ESTERIFIED ESTROGENS & METHYLTESTOSTERONE TABLETS	COVARYX HS						
ESTRADIOL & NORETHINDRONE ACETATE PATCH TWICE WEEKLY	COMBIPATCH						
ESTRADIOL & NORETHINDRONE ACETATE TABLETS	ACTIVELLA						
ESTRADIOL-LEVONORGESTREL PATCH WEEKLY	CLIMARA PRO						
NORETHINDRONE ACETATE-ETHINYL ESTRADIOL TABLETS	FEMHRT LOW DOSE						
<b>ESTROGENS</b>							
ESTERIFIED ESTROGENS TABLETS	MENEST						
ESTRADIOL PATCH TWICE WEEKLY	ALORA						
ESTRADIOL PATCH WEEKLY	MENOSTAR						
ESTRADIOL TABLETS	ESTRACE						
ESTROGENS, CONJUGATED SYNTHETIC A TABLETS	CENESTIN						
ESTROGENS, CONJUGATED TABLETS	PREMARIN						
ESTROPIPATE TABLETS	ORTHO-EST						
<b>FLUOROQUINOLONES</b>							
<b>FLUOROQUINOLONES</b>							
CIPROFLOXACIN HCL TABLETS	CIPROFLOXACIN HCL						
LEVOFLOXACIN SOLUTION	LEVAQUIN						
LEVOFLOXACIN TABLETS	LEVAQUIN						
OFLOXACIN TABLETS	OFLOXACIN						
<b>GASTROINTESTINAL AGENTS - MISC.</b>							
<b>GALLSTONE SOLUBILIZING AGENTS</b>							
URSODIOL CAPSULES	ACTIGALL						
URSODIOL TABLETS	URSO 250						
<b>GASTROINTESTINAL ANTIALLERGY AGENTS</b>							
CROMOLYN SODIUM (MASTOCYTOSIS) CONCENTRATE	GASTROCROM						
<b>GASTROINTESTINAL CHLORIDE CHANNEL ACTIVATORS</b>							
LUBIPROSTONE CAPSULES	AMITIZA			PA Required			
<b>GASTROINTESTINAL STIMULANTS</b>							
METOCLOPRAMIDE HCL SOLUTION	METOCLOPRAMIDE HCL						
METOCLOPRAMIDE HCL TABLETS	REGLAN						
METOCLOPRAMIDE HCL ORALLY DISPERSABLE TABLET	METOZOLV ODT						
<b>INFLAMMATORY BOWEL AGENTS</b>							
BALSALAZIDE DISODIUM CAPSULES	COLAZAL					270.00	30.00
BALSALAZIDE DISODIUM TABLETS	GIAZO					270.00	30.00
MESALAMINE CAPSULE CONTROLLED RELEASE	PENTASA					270.00	30.00
MESALAMINE ENEMA	MESALAMINE					240.00	30.00
MESALAMINE TABLET ENTERIC COATED	ASACOL HD					120.00	30.00
OLSALAZINE SODIUM CAPSULES	DIPENTUM					120.00	30.00
SULFASALAZINE TABLETS	AZULFIDINE					240.00	30.00
SULFASALAZINE TABLET ENTERIC COATED	AZULFIDINE EN-TABLETS					240.00	30.00
<b>INTESTINAL ACIDIFIERS</b>							
LACTULOSE (ENCEPHALOPATHY) SOLUTION	LACTULOSE						
<b>IRRITABLE BOWEL SYNDROME (IBS) AGENTS</b>							
ALOSETRON HCL TABLETS	LOTRONEX			PA Required			
LINALOTIDE CAPSULES	LINZESS			PA Required			
<b>PHOSPHATE BINDER AGENTS</b>							



## CMDP Preferred Drug List

- Generic Drugs Are Preferred Over Brand Name Drugs Unless Specified as Brand Only
- Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List Are Available Through Prior Authorization

Effective Date: 10/1/2019

Drug Class/Drug Name	Reference Brand Name	Brand Only / Generic Notes	Preferred Drug Status	PA Type	Step Therapy Requirements	Quantity Limit	QL Days
CALCIUM ACETATE (PHOSPHATE BINDER) CAPSULES	CALCIUM ACETATE						
CALCIUM ACETATE (PHOSPHATE BINDER) TABLETS	CALCIUM ACETATE						
<b>SEVELAMER CARBONATE TABLETS</b>	<b>REVELA</b>	<b>Brand Only</b>					
<b>SEVELAMER HCL TABLETS</b>	<b>RENAGEL</b>	<b>Brand Only</b>					
<b>GENITOURINARY AGENTS - MISCELLANEOUS</b>							
<b>ACIDIFIERS</b>							
POTASSIUM & SODIUM ACID PHOSPHATES TABLETS	K-PHOS NO 2						
<b>ALKALINIZERS</b>							
POT & SOD CITRATES W/CITRIC AC SOLUTION	POTASSIUM CITRATE/SODIUM CITRATE/CITRIC ACID						
POT & SOD CITRATES W/CITRIC AC SYRUP	CYTRA-3						
POTASSIUM CITRATE (ALKALINIZER) TABLET CONTROLLED RELEASE	UROCIT-K 5						
POTASSIUM CITRATE-CITRIC ACID PACK	TARON-CRYSTALS						
POTASSIUM CITRATE-CITRIC ACID SOLUTION	POTASSIUM CITRATE/CITRIC ACID						
SODIUM CITRATE & CITRIC ACID SOLUTION	SHOHL'S SOLUTION MODIFIED						
<b>INTERSTITIAL CYSTITIS AGENTS</b>							
PENTOSAN POLYSULFATE SODIUM CAPSULES	ELMIRON			<b>PA Required</b>			
<b>PROSTATIC HYPERTROPHY AGENTS</b>							
ALFUZOSIN HCL TABLET 24-HOUR	VARIOUS						
DOXAZOSIN MESYLATE TABLETS	VARIOUS						
DUTASTERIDE CAPS	VARIOUS						
FINASTERIDE TABLETS	PROSCAR						
TAMSULOSIN HCL CAPSULES	FLOMAX						
TERAZOSIN HCL CAPSULES	VARIOUS						
<b>URINARY ANALGESICS</b>							
PHENAZOPYRIDINE HCL	BARIDIUM						
PHENAZOPYRIDINE HCL TABLETS	PYRIDIUM						
<b>GOUT AGENTS</b>							
<b>GOUT AGENT COMBINATIONS</b>							
COLCHICINE W/ PROBENECID TABLETS	PROBENECID/COLCHICINE						
<b>GOUT AGENTS</b>							
ALLOPURINOL TABLETS	ZYLOPRIM						
COLCHICINE TABLETS	COLCRYS			<b>PA Required</b>			
FEBUXOSTAT TABLETS	ULORIC					30.00	30.00
<b>URICOSURICS</b>							
PROBENECID TABLETS	PROBENECID						
<b>HEMATOLOGICAL AGENTS - MISC.</b>							
<b>HEMATORHEOLOGIC AGENTS</b>							
PENTOXIFYLLINE TABLET CONTROLLED RELEASE	TRENTAL						
<b>PLATELET AGGREGATION INHIBITORS</b>							
ANAGRELIDE HCL CAPSULES	AGRYLIN						
CILOSTAZOL TABLETS	PLETAL						
CLOPIDOGREL BISULFATE TABLETS	PLAVIX						
DIPYRIDAMOLE TABLETS	PERSANTINE						
TICAGRELOR TABLETS	BRILINTA						
TICLOPIDINE HCL TABLETS	TICLOPIDINE HCL						
<b>GASTROINTESTINAL AGENTS - MISCELLANEOUS</b>							
<b>ANTIFLATULENTS</b>							
SIMETHICONE SUSPENSION	CVS INFANTS GAS RELIEF						
<b>HEMATOPOIETIC AGENTS</b>							
<b>AGENTS FOR GAUCHER DISEASE</b>							
ELIGLUSTAT TARTRATE	CARDELA (oral)			<b>PA Required</b>			
IMIGLUCERASE SOLUTION	CEREZYME 400 IU (IV)			<b>PA Required</b>			



## CMDP Preferred Drug List

• Generic Drugs Are Preferred Over Brand Name Drugs Unless Specified as Brand Only

• Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List Are Available Through Prior Authorization

Effective Date: 10/1/2019

Drug Class/Drug Name	Reference Brand Name	Brand Only / Generic Notes	Preferred Drug Status	PA Type	Step Therapy Requirements	Quantity Limit	QL Days
TALIGLUCERASE ALFA	ELELYSO (IV)			PA Required			
MIGLUSTAT	MIGLUSTAT (AG) (oral)			PA Required			
VELAGLUCERASE ALFA	VPRIB 400 IU			PA Required			
<b>FOLIC ACID/FOLATES</b>							
FOLIC ACID CAPSULES	FA-8						
FOLIC ACID TABLETS	FOLIC ACID						
<b>HEMATOPOIETIC GROWTH FACTORS</b>							
ELTROMBOPAG OLAMINE TABLETS	PROMACTA	BRAND ONLY	PREFERRED DRUG	PA Required			
EPOETIN ALFA-EPBX SOLUTION	RETACRIT	BRAND ONLY	PREFERRED DRUG	PA Required			
FILGRASTIM SOLUTION	NEUPOGEN VIAL & DISPOSABLE SYRINGE	BRAND ONLY	PREFERRED DRUG	PA Required			
PEGFILGRASTIM SOLUTION	UDENYCA	BRAND ONLY	PREFERRED DRUG	PA Required			
PEGFILGRASTIM- JMDB SOLUTION	FULPHILIA	BRAND ONLY	PREFERRED DRUG	PA Required			
ROMIPLOSTIM	NPLATE	BRAND ONLY	PREFERRED DRUG	PA Required			
<b>HEMATOPOIETIC MIXTURES</b>							
FE FUMARATE-VITAMIN C-VITAMIN B12-FOLIC ACID CAPSULES	HEMATOGEN FA						
FERROUS FUMARATE W/ B12-VIT C-FA-IFC CAPSULES	TRICON						
FERROUS FUMARATE W/ FA-DSS-B COMPLEX-VIT C TABLETS	NEPHRON FA						
FOLATE-VITAMIN B12-INTRINSIC FACTOR TABLETS	INTRINSI B12/FOLATE						
IRON COMBINATIONS	CORVITE 150						
IRON COMBINATIONS CAPSULES	HEMATOGEN						
IRON COMBINATIONS ELIXIR	HEMOCYTE-F						
<b>IRON</b>							
FERROUS FUMARATE CAPSULES	HIGH POTENCY IRON						
FERROUS FUMARATE TABLETS	FEMIRON						
FERROUS FUMARATE TABLET CONTROLLED RELEASE	IRON						
FERROUS GLUCONATE TABLETS	FERATE						
FERROUS SULFATE DRIED TABLETS	FEOSOL						
FERROUS SULFATE DRIED TABLET CONTROLLED RELEASE	EQ SLOW-RELEASE IRON						
FERROUS SULFATE ELIXIR	FEROSUL						
FERROUS SULFATE LIQUID	SPATONE PUR-ABSORB IRON						
FERROUS SULFATE SOLUTION	BPROTECTED PEDIA IRON						
FERROUS SULFATE SYRUP	FERROUS SULFATE						
FERROUS SULFATE TABLETS	FERROUS SULFATE						
FERROUS SULFATE TABLET CONTROLLED RELEASE	FERROUS SULFATE						
FERROUS SULFATE TABLET ENTERIC COATED	FERROUS SULFATE						
<b>HEMOSTATICS</b>							
<b>HEMOSTATICS - SYSTEMIC</b>							
AMINOCAPROIC ACID SYRUP	AMICAR						
AMINOCAPROIC ACID TABLETS	AMICAR						
<b>HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENT</b>							
<b>ANTIHISTAMINE HYPNOTICS</b>							
DIPHENHYDRAMINE HCL (SLEEP) CAPSULES	CVS NIGHTTIME SLEEP AID						
DIPHENHYDRAMINE HCL (SLEEP) TABLET	NIGHTTIME SLEEP-AID						
DIPHENHYDRAMINE HCL (SLEEP) LIQUID	ZZZQUIL						
DIPHENHYDRAMINE HCL (SLEEP) TABLET DISPERSIBLE	WAL-SOM						
<b>BARBITURATE HYPNOTICS</b>							
PHENOBARBITAL SOLUTION	PHENOBARBITAL						
PHENOBARBITAL TABLETS	PHENOBARBITAL						
<b>NON-BARBITURATE HYPNOTICS</b>							
TEMAZEPAM CAPSULES 15MG & 30MG	RESTORIL			PA Required for > 1 Hypnotic		30.00	30.00
ZOLPIDEM TARTRATE TABLETS 5MG	AMBIEN			PA Required for > 1 Hypnotic		60.00	30.00
ZOLPIDEM TARTRATE TABLETS 10MG	AMBIEN			PA Required for > 1 Hypnotic		30.00	30.00
<b>SELECTIVE MELATONIN RECEPTOR AGONISTS</b>							



## CMDP Preferred Drug List

- Generic Drugs Are Preferred Over Brand Name Drugs Unless Specified as Brand Only
- Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List Are Available Through Prior Authorization

Effective Date: 10/1/2019

Drug Class/Drug Name	Reference Brand Name	Brand Only / Generic Notes	Preferred Drug Status	PA Type	Step Therapy Requirements	Quantity Limit	QL Days
RAMELTEON TABLETS	ROZEREM				Patient must have tried Temazepam and Zolpidem		
<b>HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENT</b>							
<b>ANTIHISTAMINE HYPNOTICS</b>							
DOXYLAMINE SUCCINATE (SLEEP) TABLETS	RA NIGHT SLEEP AID						
<b>LAXATIVES</b>							
<b>BULK LAXATIVES</b>							
FIBER CAPSULES	ADVANCED FIBER COMPLEX/ACIDOPHILUS						
FIBER TABLETS	FIBER COMPLETE						
FIBER CHEWABLES	EQ FIBER SUPPLEMENT						
FIBER LIQDID	LIQUAFIBER						
FIBER POWDER	SOLFIBER						
METHYLCELLULOSE (LAXATIVE) TABLETS	MIRAFIBER						
METHYLCELLULOSE (LAXATIVE) POWDER	CITRUCEL FIBER LAXATIVE						
METHYLCELLULOSE (LAXATIVE) PACKETS	CITRUCEL FIBER LAXATIVE						
PSYLLIUM CAPSULES	NAT-RUL PSYLLIUM SEED HUSKS						
PSYLLIUM PACK	METAMUCIL SMOOTH TEXTURE						
PSYLLIUM POWDER	KONSYL						
PSYLLIUM SUBLINGUAL	METAMUCIL						
<b>LAXATIVE COMBINATIONS</b>							
PEG 3350-KCL-SOD BICARB-SOD CHLORIDE-SOD SULFATE SOLUTION	COLYTE-FLAVOR PACKS						
PEG 3350-POTASSIUM CHLORIDE-SOD BICARBONATE-SOD CHLORIDE SOLUTION	GAVILYTE-N/FLAVOR PACK						
SENNOSIDES-DOCUSATE SODIUM TABLETS	SENNA-S						
<b>LAXATIVES - MISCELLANEOUS</b>							
GLYCERIN (LAXATIVE) SUPPOSITORIES	GLYCERIN CHILDREN						
LACTULOSE PACK	KRISTALOSE						
LACTULOSE SOLUTION	LACTULOSE						
POLYETHYLENE GLYCOL 3350 PACK	CLEARLAX						
POLYETHYLENE GLYCOL 3350 POWDER	CLEARLAX						
<b>SALINE LAXATIVES</b>							
MAGNESIUM CITRATE SOLNTION	CITROMA						
MAGNESIUM OXIDE (LAXATIVE) TABLETS	PHILLIPS						
SODIUM PHOSPHATES ENEMA	GNP ENEMA						
<b>STIMULANT LAXATIVES</b>							
BISACODYL ENEMA	FLEET BISACODYL						
BISACODYL KIT	DULCOLAX BOWEL PREP KIT						
BISACODYL POWDER	BISACODYL						
BISACODYL SUPPOSITORY	BISAC-EVAC						
BISACODYL TABLET ENTERIC COATED	ALOPHEN						
CASCARA SAGRADA CAPSULES	CASCARA SAGRADA						
CASCARA SAGRADA TABLETS	CASCARA SAGRADA						
CASCARA SAGRADA EXTRACT	CASCARA SAGRADA						
SENNA SYRP	SENNA						
SENNA MISC	CORRECTOL HERBAL TEA						
SENNA LEAV	SENNA LEAVES						
SENNOSIDES CAPSULES	RA SENNA						
SENNOSIDES TABLETS	SENNA-LAX						
SENNOSIDES CHEWABLES	RA LAXATIVE						
SENNOSIDES LIQUID	AGORAL MAXIMUM STRENGTH						
SENNOSIDES SYRUP	SENNA-GRX						
<b>SURFACTANT LAXATIVES</b>							
DOCUSATE SODIUM CAPSULES	COLACE						



## CMDP Preferred Drug List

• Generic Drugs Are Preferred Over Brand Name Drugs Unless Specified as Brand Only

• Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List Are Available Through Prior Authorization

Effective Date: 10/1/2019

Drug Class/Drug Name	Reference Brand Name	Brand Only / Generic Notes	Preferred Drug Status	PA Type	Step Therapy Requirements	Quantity Limit	QL Days
DOCUSATE SODIUM ENEMA	DOCUSOL KIDS						
DOCUSATE SODIUM LIQUID	PEDIA-LAX						
DOCUSATE SODIUM SYRUP	DIOCTO						
DOCUSATE SODIUM TABLETS	DOK						
<b>MACROLIDES</b>							
<b>AZITHROMYCIN</b>							
AZITHROMYCIN PACK	ZITHROMAX						
AZITHROMYCIN SUSPENSION	ZITHROMAX						
AZITHROMYCIN TABLETS	ZITHROMAX						
<b>CLARITHROMYCIN</b>							
CLARITHROMYCIN SUSPENSION	CLARITHROMYCIN						
CLARITHROMYCIN TABLETS	BIAXIN						
CLARITHROMYCIN TABLET 24-HOUR	BIAXIN XL						
<b>ERYTHROMYCIN PRODUCTS REQUIRE PRIOR AUTHORIZATION</b>							
<b>FIDAXOMICIN</b>							
FIDAXOMICIN TABLETS	DIFICID			PA Required			
<b>MEDICAL DEVICES</b>							
<b>CONTRACEPTIVES</b>							
CONDOMS - FEMALE MISC	FC FEMALE CONDOM					30.00	30.00
CONDOMS - MALE MISC	LIFESTYLES ASSORTED COLORS					30.00	30.00
CONDOMS LATEX LUBRICATED - MALE MISC	ATLAS COLORED LUBRICATED CONDOM					30.00	30.00
CONDOMS LATEX NON-LUBRICATED - MALE MISC	ATLAS COLORED CONDOM/SPERMICIDE					30.00	30.00
CONDOMS NON-LATEX NON-LUBRICATED - MALE MISC	TROJAN NATURALAMB					30.00	30.00
DIAPHRAGM ARC-SPRING DPRH	CAYA					1.00	365.00
DIAPHRAGM COIL SPRING KIT	ORTHO DIAPHRAGM COIL SPRING KIT 50					1.00	365.00
DIAPHRAGM FLAT SPRING KIT	ORTHO DIAPHRAGM FLAT SPRING KIT 55					1.00	365.00
DIAPHRAGM WIDE SEAL DPRH	WIDE-SEAL SILICONE DIAPHRAGM KIT 60					1.00	365.00
DIAPHRAGMS DPRH	OMNIFLEX DIAPHRAGM					1.00	365.00
<b>DIABETIC SUPPLIES</b>							
BLOOD GLUCOSE CALIBRATION LIQUID	ACCU-CHEK ACTIVE GLUCOSE CONTROL SOLUTION						
BLOOD GLUCOSE MONITORING SUPPLIES DEVICE	TRUETRACK MIS BLD GLC						
BLOOD GLUCOSE MONITORING SUPPLIES KIT	TRUETRACK KIT SYSTEM						
LANCET DEVICES MISC	ACCU-CHEK SOFTCLIX LANCETDEVICECE						
LANCETS MISC	1ST CHOICE LANCETS SUPER THIN						
LANCETS MISC. KIT	ACCU-CHEK FASTCLIX LANCETDEVICECE KIT						
LANCETS MISC. MISC	AUTOLET PLATFORMS						
<b>MISC. DEVICES</b>							
ALCOHOL SWABS PADS	ALCOH-GLOVE CONTOURED WIPE						
<b>PARENTERAL THERAPY SUPPLIES</b>							
INSULIN PEN NEEDLE MISC	BD AUTOSHIELD 29G X 3/16"						
INSULIN SYRINGE/NEEDLE U-100 MISC	RELION INSULIN SYRINGE/U-100/0.3ML/29G						
INSULIN SYRINGE/NEEDLE U-40 MISC	BD INSULIN SYRINGE U-40/1ML/25G X 5/8"						
INSULIN SYRINGES (DISPOSABLE) MISC	KMART VALU PLUS INSULIN SYRINGE/0.3ML/30G						
SYRINGE/NEEDLE (DISP) 1 ML	MONOJECT MAGELLAN SYRINGE/SAFETY NEEDLE/1ML/23G X 1"						
SYRINGE/NEEDLE (DISP) 1 ML MISC	MONOJECT LIFESHIELD BLUNTCANNULA/REG LUER SYR/1ML/18G X 1"						
<b>RESPIRATORY THERAPY SUPPLIES</b>							
PEAK FLOW METER W/INHALER ASSIST DEVICE KIT	AEROGEAR ASTHMA ACTION					2.00	365.00
RESPIRATORY THERAPY DEVICE	AEROBIKA						
RESPIRATORY THERAPY KIT	AIRS DISPOSABLE NEBULIZER						



## CMDP Preferred Drug List

- Generic Drugs Are Preferred Over Brand Name Drugs Unless Specified as Brand Only
- Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List Are Available Through Prior Authorization

Effective Date: 10/1/2019

Drug Class/Drug Name	Reference Brand Name	Brand Only / Generic Notes	Preferred Drug Status	PA Type	Step Therapy Requirements	Quantity Limit	QL Days
RESPIRATORY THERAPY MISC	ACE AEROSOL CLOUD ENHANCER					2.00	365.00
SPACER/AEROSOL-HOLDING CHAMBER - MASKS MISC	MASK VORTEX/BABY WHIRL DUCKLING						
SPACER/AEROSOL-HOLDING CHAMBERS DEVICE	AEROCHAMBER MINI CHAMBER					2.00	365.00
SPACER/AEROSOL-HOLDING CHAMBERS MISC	AEROCHAMBER MINI CHAMBER						
<b>MIGRAINE PRODUCTS</b>							
<b>MIGRAINE COMBINATIONS</b>							
ERGOTAMINE W/ CAFFEINE SUPPOSITORY	MIGERGOT					12.00	30.00
ERGOTAMINE W/ CAFFEINE TABLETS	CAFERGOT					40.00	30.00
<b>MIGRAINE PRODUCTS - MONOCLONAL ANTIBODIES</b>							
ERENUMAB-AOOE SOLUTION AUTOINJECTOR	AIMOVIG		Preferred Drug	PA Required			
GALCANEZUMAB-GNLM SOLUTION AUTOINJECTOR / PREFILLED SYRINGE / PEN	EMGALITY		Preferred Drug	PA Required			
<b>SEROTONIN AGONISTS</b>							
NARATRIPTAN HCL TABLETS	AMERGE					9.00	30.00
RIZATRIPTAN BENZOATE TABLETS	MAXALT					9.00	30.00
RIZATRIPTAN BENZOATE ORALLY DISPERSABLE TABLET	MAXALT-MLT					9.00	30.00
SUMATRIPTAN SOLUTION NASAL SPRAY	IMITREX SPRAY					6.00	30.00
SUMATRIPTAN SUCCINATE SOLUTION INJECTION	IMITREX					2.00	30.00
SUMATRIPTAN SUCCINATE SOLUTION AUTO-INJECTION	IMITREX STATDOSE SYSTEM					2.00	30.00
SUMATRIPTAN SUCCINATE SOLUTION CARTRIDGE	IMITREX STATDOSE REFILL					2.00	30.00
SUMATRIPTAN SUCCINATE TABLETS	IMITREX					9.00	30.00
ZOLMITRIPTAN TABLETS	ZOMIG					9.00	30.00
ZOLMITRIPTAN ORALLY DISPERSABLE TABLET	ZOMIG ZMT					9.00	30.00
<b>MINERALS &amp; ELECTROLYTES</b>							
<b>CALCIUM</b>							
CALCIUM LACTATE CAPSULES	CAL-LAC						
CALCIUM LACTATE TABLETS	CALCIUM LACTATE						
<b>FLUORIDE</b>							
SODIUM FLUORIDE CHEWABLE TABLETS	LUIDENT						
SODIUM FLUORIDE LOZG	LOZI-FLUR						
SODIUM FLUORIDE SOLUTION	FLUOR-A-DAY						
SODIUM FLUORIDE TABLETS	SODIUM FLUORIDE						
<b>MAGNESIUM</b>							
MAGNESIUM OXIDE (MG SUPPLEMENT) CAPSULES	MAGNESIUM						
MAGNESIUM OXIDE (MG SUPPLEMENT) TABLETS	MAG-200						
<b>POTASSIUM</b>							
POTASSIUM BICARB & CHLORIDE TABLET EFFERVESCENT	EFFERVESCENT POTASSIUM/CHLORIDE						
POTASSIUM BICARBONATE TABLET EFFERVESCENT	EFFER-K						
POTASSIUM BICARBONATE-CITRIC ACID TABLET EFFERVESCENT	EFFER-K						
POTASSIUM CHLORIDE CAPSULE CONTROLLED RELEASE	KLOR-CON SPRINKLE						
POTASSIUM CHLORIDE LIQUID	K-SOL						
POTASSIUM CHLORIDE MICRO ENCAPSULESULATED CRYSTALS CONTROLLED RELEASE	KLOR-CON M10						
POTASSIUM CHLORIDE PACK	KLOR-CON						
POTASSIUM CHLORIDE TABLET CONTROLLED RELEASE	KLOR-CON 8						
<b>SODIUM</b>							
SODIUM CHLORIDE FLUSH SOLUTION	NORMAL SALINE FLUSH						
<b>MOUTH/THROAT/DENTAL AGENTS</b>							
<b>ANTISEPTICS - MOUTH/THROAT</b>							
CHLORHEXIDINE GLUCONATE (MOUTH-THROAT) SOLUTION	PAROEX						
<b>STERIODS - MOUTH/THROAT</b>							
TRIAMCINOLONE ACETONIDE (MOUTH) PASTE	ORALONE					10.00	30.00
<b>ANESTHETICS TOPICAL ORAL</b>							





## CMDP Preferred Drug List

• Generic Drugs Are Preferred Over Brand Name Drugs Unless Specified as Brand Only

• Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List Are Available Through Prior Authorization

Effective Date: 10/1/2019

Drug Class/Drug Name	Reference Brand Name	Brand Only / Generic Notes	Preferred Drug Status	PA Type	Step Therapy Requirements	Quantity Limit	QL Days
LIDOCAINE HCL (MOUTH-THROAT) SOLUTION	LIDOCAINE VISCOUS						
<b>THROAT PRODUCTS - MISC.</b>							
ARTIFICIAL SALIVA KIT	ORAL RELIEF FOR DRY MOUTH& DISCOMFORT						
ARTIFICIAL SALIVA LOZENGE	ACT DRY MOUTH						
ARTIFICIAL SALIVA SOLUTION	BIOTENE MOISTURIZING MOUTH SPRAY						
<b>MULTIVITAMINS</b>							
<b>B-COMPLEX VITAMINS</b>							
B-COMPLEX VITAMINS	B-COMPLEX						
<b>B-COMPLEX W/ C</b>							
B COMPLEX W/ C CAPSULES	B COMPLEX/VITAMIN C						
B COMPLEX W/ C TABLETS	B COMPLEX/C						
B COMPLEX W/ C TABLET CONTROLLED RELEASE	B-COMPLEX +C						
<b>B-COMPLEX W/ FOLIC ACID</b>							
B COMPLEX W/ C-BIOTIN-E-FOLIC ACID & IRON CARBONYL MISC	RENATABLETS WITH IRON						
B-COMPLEX W/ C & FOLIC ACID	MILCO-B-FORTE						
B-COMPLEX W/ C & FOLIC ACID CAPSULES	NEPHROCAPSULES						
B-COMPLEX W/ C & FOLIC ACID TABLETS	DIALYVITE						
B-COMPLEX W/ C-BIOTIN-D-ZINC & FOLIC ACID TABLETS	VITAL-D RX						
B-COMPLEX W/ LYSINE-MIN-FE & FOLIC ACID LIQUID	NUTRIVIT						
B-COMPLEX W/ LYSINE-ZN & FOLIC ACID LIQUID	SUPERVITE						
<b>IRON W/ VITAMINS</b>							
IRON W/ VITAMINS TABLETS	GERITOL COMPLETE					30.00	30.00
<b>MULTIPLE VITAMINS W/ IRON</b>							
MULTIPLE VITAMINS W/ IRON TABLETS	MULTIPLE VITAMINS/IRON						
<b>MULTIPLE VITAMINS W/ MINERALS</b>							
MULTIPLE VITAMINS W/ MINERALS CAPSULES	VARIOUS					30.00	30.00
MULTIPLE VITAMINS W/ MINERALS CHEWABLE TABLETS	VARIOUS					30.00	30.00
MULTIPLE VITAMINS W/ MINERALS LIQUID	VARIOUS					30.00	30.00
MULTIPLE VITAMINS W/ MINERALS TABLETS	VARIOUS					30.00	30.00
<b>PEDIATRIC MULTIPLE VITAMINS</b>							
PEDIATRIC MULTIPLE VITAMIN W/ C SOLUTION	POLY-VITE DROPS						
<b>PED MULTIPLE VITAMINS W/ MINERALS</b>							
PEDIATRIC MULTIPLE VITAMIN W/ MINERALS & C CHEWABLES	CHILDRENS CHEWABLE GUMMIES						
<b>PED MV W/ IRON</b>							
PEDIATRIC MULTIPLE VITAMINS W/ IRON SOLUTION	POLY-VITE SOL /IRON						
<b>PED MULTI VITAMINS W/FL &amp; FE</b>							
PEDIATRIC VITAMINS ACD FLUORIDE & IRON SOLUTION	TRI-VIT/FLUORIDE/IRON						
<b>PED MV W/ FLUORIDE</b>							
PEDIATRIC MULTIVITAMINS W/FL CHEWABLE TABLETS	MVC-FLUORIDE					30.00	30.00
PEDIATRIC MULTIVITAMINS W/FL SOLUTION	QUFLORA PEDIATRIC						
PEDIATRIC MULTIVITAMINS W/FL SUSPENSION	POLY-VI-FLOR						
PEDIATRIC VITAMINS ACD W/ FLUORIDE SOLUTION	TRIPLE-VITAMIN/FLUORIDE						
<b>PRENATAL VITAMINS</b>							
PRENATAL MULTIVIT-MIN W/FE-FA TABS	PRE-NATAL FORMULA					30.00	30.00
PRENATAL MV & MIN W/FE FUMARATE-FA-DHA MISC	VITAFOL-OB+DHA					30.00	30.00
PRENATAL MV & MIN W/FE POLYSACCHARIDE COMPLEX-FA-DHA CAPS	VITAFOL-ONE					30.00	30.00
PRENATAL MV & MIN W/FE POLYSACCHARIDE COMPLEX-FA-DHA MISC	SELECT-OB+DHA					30.00	30.00
PRENATAL VIT W/ DOCUSATE-FE FUMARATE-FOLIC ACID TABS	PNV FERROUS FUMARATE/DOCUSATE/FOLIC ACID					30.00	30.00
PRENATAL VIT W/ FE BISGLYCINATE CHELATE-FOLIC ACID TABS	VINATE AZ EXTRA					30.00	30.00
PRENATAL VIT W/ FE FUM-IRON POLYSACCH COMPLEX -FA-OMEGA 3 CAPS	CONCEPT DHA					30.00	30.00
PRENATAL VIT W/ FERROUS FUMARATE-FA-OMEGA 3 FATTY ACIDS CAPS	VIVA DHA					30.00	30.00
PRENATAL VIT W/ FERROUS FUMARATE-FOLIC ACID CHEW	COMPLETENATE					30.00	30.00



## CMDP Preferred Drug List

• Generic Drugs Are Preferred Over Brand Name Drugs Unless Specified as Brand Only

• Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List Are Available Through Prior Authorization

Effective Date: 10/1/2019

Drug Class/Drug Name	Reference Brand Name	Brand Only / Generic Notes	Preferred Drug Status	PA Type	Step Therapy Requirements	Quantity Limit	QL Days
PRENATAL VIT W/ FERROUS FUMARATE-FOLIC ACID TABS	M-VIT					30.00	30.00
PRENATAL VIT W/ FERROUS FUMARATE-L METHYLFOLATE-FOLIC ACID TABS	ZATEAN-PN					30.00	30.00
PRENATAL VIT W/ IRON CARBONYL-FE ASPART GLYC-FA-OMEGA 3 CAPS	FOLCAPS OMEGA 3					30.00	30.00
PRENATAL VIT W/ IRON CARBONYL-FOLIC ACID TABS	PRENATABS RX					30.00	30.00
PRENATAL VIT W/ SELENIUM-FE FUMARATE-FOLIC ACID TABS	VINATE M					30.00	30.00
PRENATAL W/O VIT A W/ FE FUMARATE-DSS-FA-DHA CAPS	PRENEXA					30.00	30.00
PRENATAL WITHOUT A VIT W/ FE FUMARATE-FOLIC ACID CHEW	VINATE CARE					30.00	30.00
PRENATAL WITHOUT A VIT W/ FE FUM-IRON POLYSACCH COMPLEX -FA CAPS	CONCEPT OB					30.00	30.00
PRENATAL WITHOUT VIT A W/ FE CARBONYL-FE GLUC-DOCUSATE-FA TABS	CITRANATAL RX					30.00	30.00
<b>MUSCULOSKELETAL THERAPY AGENTS</b>							
<b>CENTRAL MUSCLE RELAXANTS</b>							
BACLOFEN TABLETS	BACLOFEN						
CYCLOBENZAPRINE HCL TABLETS 5MG & 10MG ONLY	FLEXERIL						
METAXALONE TABLETS	METAXALONE						
METHOCARBAMOL TABLETS	ROBAXIN						
ORPHENADRINE CITRATE TABLET 12-HOUR	ORPHENADRINE CITRATE CR						
TIZANIDINE HCL - 2mg and 4mg TABLETS ONLY	TIZANIDINE HCL						
<b>DIRECT MUSCLE RELAXANTS</b>							
DANTROLENE SODIUM CAPSULES	DANTRIUM						
<b>NASAL AGENTS - SYSTEMIC AND TOPICAL</b>							
<b>NASAL AGENTS - MISCELLANEOUS</b>							
SALINE NASAL SPRAY	SALINE NASAL SPRAY						
<b>NASAL ANTIALLERGY</b>							
AZELASTINE HCL SOLUTION 0.10%	ASTELIN						
<b>NASAL ANTICHOLINERGICS</b>							
IPRATROPIUM BROMIDE (NASAL) SOLUTION	ATROVENT						
<b>NASAL STEROIDS</b>							
FLUNISOLIDE (NASAL) SOLUTION	FLUNISOLIDE						
FLUTICASON PROPRIONATE (NASAL) SUSPENSION	FLOINASE						
MOMETASON FUROATE (NASAL) SUSPENSION	NASONEX						
<b>SYMPATHOMIMETIC DECONGESTANTS</b>							
PSEUDOEPHEDRINE HCL GEL	ELIXIRSURE CONGESTION						
PSEUDOEPHEDRINE HCL LIQUID	SUDAFED CHILDRENS						
PSEUDOEPHEDRINE HCL SYRUP	PSEUDOEPHEDRINE						
PSEUDOEPHEDRINE HCL TABLETS	SHOPKO NASAL DECONGESTANTMAXIMUM STRENGTH						
PSEUDOEPHEDRINE HCL TABLET 12-HOUR	SHOPKO NASAL DECONGESTANT						
PSEUDOEPHEDRINE HCL TABLET 24-HOUR	SUDAFED 24 HOUR						
<b>OPHTHALMIC AGENTS</b>							
<b>ARTIFICIAL TEARS AND LUBRICANTS</b>							
ARTIFICIAL TEAR GEL GEL	VARIOUS						
ARTIFICIAL TEAR OINTMENT	VARIOUS						
ARTIFICIAL TEAR SOLUTION SOLUTION	VARIOUS						
CARBOXYMETHYLCELLULOSE-GLYCERIN SOLUTION	VARIOUS						
CARBOXYMETHYLCELLULOSE-HYPROMELLOSE GEL	VARIOUS						
CARBOXYMETHYLCELLULOSE SODIUM (OPHTH) SOUTION	VARIOUS						
CARBOXYMETHYLCELLULOSE SODIUM (OPHTH) GEL	VARIOUS						
HYPROMELLOSE (GONIOSCOPIC) SOLUTION	VARIOUS						
POLYETHYLENE GLYCOL 400 (OPHTH) GEL	VARIOUS						
POLYETHYLENE GLYCOL 400 (OPHTH) SOLUTION	VARIOUS						
POLYETHYLENE GLYCOL-PROPYLENE GLYCOL (OPHTH) SOLUTION	VARIOUS						
POLYSORBATE 80 (OPHTH) SOLUTION	VARIOUS						
POLYVINYL ALCOHOL SOLUTION	VARIOUS						



## CMDP Preferred Drug List

- Generic Drugs Are Preferred Over Brand Name Drugs Unless Specified as Brand Only
- Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List Are Available Through Prior Authorization

Effective Date: 10/1/2019

Drug Class/Drug Name	Reference Brand Name	Brand Only / Generic Notes	Preferred Drug Status	PA Type	Step Therapy Requirements	Quantity Limit	QL Days
<b>BETA-BLOCKERS - OPHTHALMIC</b>							
BETAXOLOL HCL (OPHTH) SOLUTION	BETAXOLOL HCL						
BETAXOLOL HCL (OPHTH) SUSPENSION	BETOPTIC-S						
BRIMONIDINE TARTRATE-TIMOLOL MALEATE SOLUTION	COMBIGAN						
CARTEOLOL HCL (OPHTH) SOLUTION	CARTEOLOL HCL						
DORZOLAMIDE HCL-TIMOLOL MALEATE SOLUTION	COSOPT						
LEVOBUNOLOL HCL SOLUTION	LEVOBUNOLOL HCL						
METIPRANOLOL SOLUTION	METIPRANOLOL						
TIMOLOL MALEATE (OPHTH) DROPS	TIMOPTIC-XE						
TIMOLOL MALEATE (OPHTH) SOLUTION	TIMOPTIC						
TIMOLOL SOLUTION	BETIMOL						
<b>CYCLOPLEGIC MYDRIATICS</b>							
ATROPINE SULFATE (OPHTHALMIC) OINTMENT	ATROPINE SULFATE						
ATROPINE SULFATE (OPHTHALMIC) SOLUTION	ISOPTO ATROPINE						
CYCLOPENTOLATE HCL SOLUTION	CYCLOGYL						
HOMATROPINE HBR SOLUTION	ISOPTO HOMATROPINE						
TROPICAMIDE SOLUTION	TROPICAMIDE						
<b>MIOTICS</b>							
PILOCARPINE HCL GEL	PILOPINE HS						
PILOCARPINE HCL SOLUTION	ISOPTO CARPINE						
<b>OPHTHALMIC ADRENERGIC AGENTS</b>							
APRACLONIDINE HCL SOLUTION	IOPIDINE						
BRIMONIDINE TARTRATE SOLUTION	ALPHAGAN P						
<b>OPHTHALMIC ANTI-INFECTIVES</b>							
BACITRACIN (OPHTHALMIC) OINTMENT	BACITRACIN					3.50	7.00
BACITRACIN-POLYMYXIN B (OPHTH) OINTMENT	POLYCIN						
CIPROFLOXACIN HCL (OPHTH) OINTMENT	CILOXAN						
CIPROFLOXACIN HCL (OPHTH) SOLUTION	CILOXAN						
ERYTHROMYCIN (OPHTH) OINTMENT	ILOTYCIN						
GENTAMICIN SULFATE (OPHTH) OINTMENT	GARAMYCIN						
GENTAMICIN SULFATE (OPHTH) SOLUTION	GARAMYCIN						
MOXIFLOXACIN HCL (OPHTH) SOLUTION	VIGAMOX						
NATAMYCIN SUSPENSION	NATACYN						
NEOMYCIN-BACITRACIN ZN-POLYMYXIN OINTMENT	NEO-POLYCIN						
NEOMYCIN-POLYMYXIN-GRAMICIDIN SOLUTION	NEOSPORIN						
OFLOXACIN (OPHTH) SOLUTION	OCUFLOX						
POLYMYXIN B-TRIMETHOPRIM SOLUTION	POLYTRIM						
SULFACETAMIDE SODIUM (OPHTH) OINTMENT	SULFACETAMIDE SODIUM						
SULFACETAMIDE SODIUM (OPHTH) SOLUTION	BLEPH-10						
TOBRAMYCIN (OPHTH) OINTMENT	TOBREX					3.50	7.00
TOBRAMYCIN (OPHTH) SOLUTION	TOBREX						
TRIFLURIDINE SOLUTION	VIROPTIC						
<b>OPHTHALMIC DECONGESTANTS</b>							
HYPROMELLOSE-GLYCERIN-NAPHAZOLINE SOLUTION	CLEAR EYES FOR DRY EYES PLUS REDNESS RELIEF						
HYPROMELLOSE-NAPHAZOLINE-POLYSORBATE 80-ZINC SULFATE SOLUTION	CLEAR EYES COMPLETE 7 SYMPTOM RELIEF						
NAPHAZOLINE HCL SOLUTION	VASOCLEAR						
NAPHAZOLINE W/ PHENIRAMINE SOLUTION	NAPHCN-A						
NAPHAZOLINE W/ ZINC SULFATE SOLUTION	VASOCLEAR A						
NAPHAZOLINE-GLYCERIN SOLUTION	CLEAR EYES REDNESS RELIEF						
NAPHAZOLINE-GLYCERIN-ZINC SULFATE SOLUTION	CLEAR EYES SEASONAL RELIEF						
NAPHAZOLINE-HYPROMELLOSE SOLUTION	CVS MAXIMUM REDNESS RELIEF						
NAPHAZOLINE-POLYETHYLENE GLYCOL 300 SOLUTION	CVS REDNESS RELIEF						



## CMDP Preferred Drug List

• Generic Drugs Are Preferred Over Brand Name Drugs Unless Specified as Brand Only

• Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List Are Available Through Prior Authorization

Effective Date: 10/1/2019

Drug Class/Drug Name	Reference Brand Name	Brand Only / Generic Notes	Preferred Drug Status	PA Type	Step Therapy Requirements	Quantity Limit	QL Days
OXYMETAZOLINE HCL (OPHTH) SOLUTION	VISINE-LR						
PHENYLEPHRINE-POLYVINYL ALCOHOL SOLUTION	REFRESH REDNESS RELIEF						
TETRAHYDROZOLINE HCL (OPHTH) SOLUTION	ALTAZINE						
TETRAHYDROZOLINE W/ POLYETHYLENE GLYCOL SOLUTION	ADVANCED LUBRICANT						
TETRAHYDROZOLINE W/ ZINC SULFATE SOLUTION	VISINE-AC						
TETRAHYDROZOLINE-DEXTRAN-POLYETHYLENE GLYCOL-POVIDONE SOLUTION	VISINE ADVANCED RELIEF						
TETRAHYDROZOLINE-GLYCERIN-HYPROMELLOSE-PEG 400 SOLUTION	VISINE MAXIMUM REDNESS RELIEF						
TETRAHYDROZOLINE-GLYCERIN-HYPROMELLOSE-PEG 400-ZINC SULFATE SOLUTION	VISINE TOTALITY MULTI-SYMPTOM/HYDROBLEND						
TETRAHYDROZOLINE-POLYVINYL ALCOHOL-POVIDONE SOLUTION	CLEAR EYES TRIPLE ACTION RELIEF						
<b>OPHTHALMIC IMMUNOMODULATORS</b>							
CYCLOSPORINE (OPHTH) EMULSION	RESTASIS			PA Required			
<b>OPHTHALMIC STEROIDS</b>							
BACITRACIN-POLY-NEOMYCIN-HC OINTMENT	NEO-POLYCIN HC						
DEXAMETHASONE (OPHTH) SUSPENSION	MAXIDEX						
DEXAMETHASONE SODIUM PHOSPHATE (OPHTH) SOLUTION	DEXAMETHASONE SODIUM PHOSPHATE						
FLUOROMETHOLONE (OPHTH) OINTMENT	FML						
FLUOROMETHOLONE (OPHTH) SUSPENSION	FML LIQUIFILM						
GENTAMICIN-PREDNISOLONE ACETATE OINTMENT	PRED-G S.O.P.						
GENTAMICIN-PREDNISOLONE ACETATE SUSPENSION	PRED-G						
NEOMYCIN-POLYMY-DEXAMETH OINTMENT	MAXITROL						
NEOMYCIN-POLYMY-DEXAMETH SUSPENSION	MAXITROL						
NEOMYCIN-POLYMYXIN-HC (OPHTH) SUSPENSION	NEOMYCIN/POLYMYXIN/HYDROCORTISONE						
PREDNISOLONE ACETATE (OPHTH) SUSPENSION	PRED MILD						
PREDNISOLONE SODIUM PHOSPHATE (OPHTH) SOLUTION	PREDNISOLONE SODIUM PHOSPHATE						
SULFACETAMIDE SOD-PREDNISOLONE OINTMENT	BLEPHAMIDE S.O.P.						
SULFACETAMIDE SOD-PREDNISOLONE SOLUTION	SULFACETAMIDE SODIUM/PREDNISOLONE SODIUM PHOSPHATE						
SULFACETAMIDE SOD-PREDNISOLONE SUSPENSION	BLEPHAMIDE						
TOBRAMYCIN-DEXAMETHASONE OINTMENT	TOBRADEX					3.50	7.00
TOBRAMYCIN-DEXAMETHASONE SUSPENSION	TOBRADEX ST						
<b>OPHTHALMICS - MISC.</b>							
AZELASTINE HCL (OPHTH) SOLUTION	OPTIVAR						
BRINZOLAMIDE SUSPENSION	AZOPT			PA Required			
BROMFENAC SODIUM (OPHTH) SOLUTION	PROLENSA						
CROMOLYN SODIUM (OPHTH) SOLUTION	CROMOLYN SODIUM						
DICLOFENAC SODIUM (OPHTH) SOLUTION	DICLOFENAC SODIUM						
DORZOLAMIDE HCL SOLUTION	TRUSOPT						
EPINASTINE HCL (OPHTH) SOLUTION	ELESTAT						
FLURBIPROFEN SODIUM SOLUTION	OCUFEN						
KETOROLAC TROMETHAMINE (OPHTH) SOLUTION	ACULAR LS						
KETOTIFEN FUMARATE (OPHTH) SOLUTION	ALAWAY						
LODOXAMIDE TROMETHAMINE SOLUTION	ALOMIDE						
OLOPATADINE HCL SOLUTION	PATANOL						
SODIUM CHLORIDE HYPERTONIC SOLUTION	ALTACHLORE						
<b>PROSTAGLANDINS - OPHTHALMIC</b>							
LATANOPROST SOLUTION	XALATAN					2.50	30.00
TAFLUPROST SOLUTION	ZIOPATAN			PA Required			
TRAVOPROST SOLUTION	TRAVATAN Z			PA Required			
<b>OTIC AGENTS</b>							
<b>OTIC AGENTS - MISCELLANEOUS</b>							
ACETIC ACID (OTIC) SOLUTION	ACETIC ACID						



## CMDP Preferred Drug List

- Generic Drugs Are Preferred Over Brand Name Drugs Unless Specified as Brand Only
- Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List Are Available Through Prior Authorization

Effective Date: 10/1/2019

Drug Class/Drug Name	Reference Brand Name	Brand Only / Generic Notes	Preferred Drug Status	PA Type	Step Therapy Requirements	Quantity Limit	QL Days
<b>OTIC ANTI-INFECTIVES</b>							
CIPROFLOXACIN HCL (OTIC) SOLUTION	VARIOUS		PREFERRED DRUG				
<b>OTIC COMBINATIONS</b>							
CIPROFLOXACIN-DEXAMETHASONE	CIPRODEX	BRAND ONLY	PREFERRED BRAND				
NEOMYCIN-POLYMYXIN-HC (OTIC) SOLUTION	VARIOUS		PREFERRED BRAND				
NEOMYCIN-POLYMYXIN-HC (OTIC) SUSPENSION	VARIOUS		PREFERRED BRAND				
<b>OTIC STEROIDS</b>							
FLUOCINOLONE ACETONIDE (OTIC) OIL	DERMOTIC						
HYDROCORTISONE W/ACETIC ACID SOLUTION	ACETASOL HC						
<b>OXYTOCICS</b>							
<b>OXYTOCICS</b>							
METHYLERGONOVINE MALEATE TABLETS	METHERGINE						
<b>PASSIVE IMMUNIZING AGENTS</b>							
<b>MONOCLONAL ANTIBODIES</b>							
PALIVIZUMAB SOLUTION	SYNAGIS			PA Required - if approved the prescriber must buy and bill a medical claim for the drug			
<b>PENICILLINS</b>							
<b>AMINOPENICILLINS</b>							
AMOXICILLIN CAPSULES	AMOXICILLIN						
AMOXICILLIN CHEWABLE TABLETS	AMOXICILLIN						
AMOXICILLIN SUSPENSION	AMOXICILLIN						
AMOXICILLIN TABLETS	AMOXICILLIN						
AMOXICILLIN TABLET 24-HOUR	MOXATAG						
AMPICILLIN CAPSULES	AMPICILLIN						
AMPICILLIN SUSPENSION	AMPICILLIN						
<b>NATURAL PENICILLINS</b>							
PENICILLIN V POTASSIUM SOLUTION	PENICILLIN V POTASSIUM						
PENICILLIN V POTASSIUM TABLETS	PENICILLIN V POTASSIUM						
<b>PENICILLIN COMBINATIONS</b>							
AMOXICILLIN & POT CLAVULANATE CHEWABLE TABLETS	AUGMENTIN						
AMOXICILLIN & POT CLAVULANATE SUSPENSION	AUGMENTIN						
AMOXICILLIN & POT CLAVULANATE TABLETS	AMOXICILLIN/CLAVULANATE POTASSIUM						
AMOXICILLIN & POT CLAVULANATE TABLET 12-HOUR	AUGMENTIN XR						
<b>PENICILLINASE-RESISTANT PENICILLINS</b>							
DICLOXACILLIN SODIUM CAPSULES	DICLOXACILLIN SODIUM						
<b>PROGESTINS</b>							
<b>PROGESTINS</b>							
HYDROXYPROGESTERONE CAPROATE OIL	MAKENA 250 MG/ML	BRAND ONLY		PA Required			
HYDROXYPROGESTERONE CAPROATE SOLUTION AUTOINJECTOR	MAKENA AUTO INJECTOR	BRAND ONLY		PA Required			
MEDROXYPROGESTERONE ACETATE TABLETS	PROVERA						
NORETHINDRONE ACETATE TABLETS	AYGESTIN						
PROGESTERONE MICRONIZED CAPSULES	PROMETRIUM						
<b>PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENT</b>							
<b>AGENTS FOR CHEMICAL DEPENDENCY</b>							
ACAMPROSATE CALCIUM TABLET DELAYED RELEASE	VARIOUS						
DISULFIRAM TABLETS	VARIOUS						
<b>ANTIDEMENTIA AGENTS</b>							
DONEPEZIL HYDROCHLORIDE TABLETS	ARICEPT						
DONEPEZIL HYDROCHLORIDE ORALLY DISPERSABLE TABLET	ARICEPT ODT						
GALANTAMINE HYDROBROMIDE CAPSULE 24-HOUR	RAZADYNE ER			PA Required			
GALANTAMINE HYDROBROMIDE SOLUTION	RAZADYNE			PA Required			
GALANTAMINE HYDROBROMIDE TABLETS	RAZADYNE			PA Required			



## CMDP Preferred Drug List

• Generic Drugs Are Preferred Over Brand Name Drugs Unless Specified as Brand Only

• Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List Are Available Through Prior Authorization

Effective Date: 10/1/2019

Drug Class/Drug Name	Reference Brand Name	Brand Only / Generic Notes	Preferred Drug Status	PA Type	Step Therapy Requirements	Quantity Limit	QL Days
MEMANTINE HCL CAPSULE 24-HOUR	NAMENDA XR			PA Required			
MEMANTINE HCL SOLUTION	NAMENDA			PA Required			
MEMANTINE HCL TABLETS	NAMENDA			PA Required			
RIVASTIGMINE PATCH 24-HOUR	EXELON			PA Required			
RIVASTIGMINE TARTRATE CAPSULES	EXELON			PA Required			
RIVASTIGMINE TARTRATE SOLUTION	EXELON			PA Required			
<b>MULTIPLE SCLEROSIS AGENTS</b>							
FINGOLIMOD HCL CAPSULES	GILENYA			PA Required			
GLATIRAMER ACETATE 20MG	COPAXONE 20mg	BRAND ONLY	Preferred Drug	PA Required			
GLATIRAMER ACETATE 40MG	GLATOPA 40MG	BRAND ONLY	Preferred Drug	PA Required			
INTERFERON BETA-1A KIT	AVONEX			PA Required			
INTERFERON BETA-1A SOLUTION	REBIF REBIDOSE TITRATION PACK			PA Required			
INTERFERON BETA-1B KIT	BETASERON			PA Required			
<b>PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.</b>							
ERGOLOID MESYLATES TABLETS	ERGOLOID MESYLATES						
PIMOZIDE TABLETS	ORAP				Prior Authorization is required for < 12 years of age.		
<b>SMOKING DETERRENTS</b>							
BUPROPION HCL (SMOKING DETERRENT) TABLET 12-HOUR	BUPROBAN					168.00	180.00
NICOTINE INHALER	NICOTROL INHALER					1008.00	180.00
NICOTINE KIT	NICOTINE TRANSDERMAL SYSTEM					84.00	180.00
NICOTINE POLACRILEX GUM	KLS QUIT2					540.00	180.00
NICOTINE POLACRILEX LOZENGE	COMMIT					540.00	180.00
NICOTINE PATCH 24-HOUR	NICODERM CQ					84.00	180.00
NICOTINE SOLUTION	NICOTROL NS					120.00	180.00
VARENICLINE TARTRATE TABLETS	CHANTIX					168.00	180.00
<b>RESPIRATORY AGENTS - MISC.</b>							
<b>ALPHA-PROTEINASE INHIBITOR (HUMAN)</b>							
ALPHA1-PROTEINASE INHIBITOR (HUMAN) SOLUTION	ARALAST NP			PA Required			
<b>CYSTIC FIBROSIS AGENTS</b>							
DORNASE ALFA SOLUTION	PULMOZYME			PA Required			
IVACAFTOR PACK	KALYDECO			PA Required			
IVACAFTOR TABLETS	KALYDECO			PA Required			
<b>SULFONAMIDES</b>							
<b>SULFONAMIDES</b>							
SULFADIAZINE TABLETS	SULFADIAZINE						
<b>TOXOIDS</b>							
<b>TOXOID COMBINATIONS</b>							
DIPH-AC PERT-TET TOX AD-POLIO IPV-HAEMOPHIL B POLY VAC SUSPENSION	PENTACEL						
DIPH-TETANUS TOX AD-ACELL PERTUSSIS & POLIO VIRUS, IPV VAC SUSPENSION	KINRIX						
DIPH-TETANUS TOX-ACELL PERT-HEPATITIS B RECOMB-POLIO IPV VA SUSPENSION	PEDIARIX						
DIPHThERIA, ACELLULAR PERTUSSIS & TETANUS TOXOIDS SUSPENSION	INFANRIX						
DIPHThERIA-TETANUS TOXOIDS (DT) SUSPENSION	DIPHThERIA/TETANUS TOXOIDS ADSORBED PEDIATRIC						
TETANUS TOXOID-DIPHThERIA-ACELLULAR PERTUSSIS ADSORB (TDAP) SUSPENSION	BOOSTRIX						
TETANUS-DIPHThERIA TOXOIDS (TD) INJECTION	TETANUS/DIPHThERIA TOXOID-ADSORBED PUROGENATED ADULT						
TETANUS-DIPHThERIA TOXOIDS (TD) SUSPENSION	TETANUS/DIPHThERIA TOXOIDS-ADSORBED ADULT						
<b>TETRACYCLINES</b>							



## CMDP Preferred Drug List

- Generic Drugs Are Preferred Over Brand Name Drugs Unless Specified as Brand Only
- Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List Are Available Through Prior Authorization

Effective Date: 10/1/2019

Drug Class/Drug Name	Reference Brand Name	Brand Only / Generic Notes	Preferred Drug Status	PA Type	Step Therapy Requirements	Quantity Limit	QL Days
<b>TETRACYCLINES</b>							
DEMECLOXYCLINE HCL TABLETS	DEMECLOXYCLINE HCL			PA Required			
DOXYCYCLINE HYCLATE CAPSULES - 50MG AND 100MG CAPSULES ONLY	VARIOUS						
DOXYCYCLINE HYCLATE TABLETS - 20MG AND 100MG TABLETS ONLY	VARIOUS						
DOXYCYCLINE MONOHYDRATE - CAPSULES 50MG & 100MG ONLY	VARIOUS						
MINOCYCLINE HCL - 50MG, 75MG & 100MG CAPSULES ONLY	MINOCIN						
<b>THYROID AGENTS</b>							
<b>ANTITHYROID AGENTS</b>							
METHIMAZOLE TABLETS	TAPAZOLE						
PROPYLTHIOURACIL TABLETS	PROPYLTHIOURACIL						
<b>THYROID HORMONES</b>							
LEVOTHYROXINE SODIUM CAPSULES	TIROSINT					30.00	30.00
LEVOTHYROXINE SODIUM TABLETS	LEVO-T					30.00	30.00
LIOTHYRONINE SODIUM TABLETS	CYTOMEL					30.00	30.00
THYROID TABLETS	ARMOUR THYROID						
<b>ULCER DRUGS</b>							
<b>ANTISPASMODICS</b>							
DICYCLOMINE HCL CAPSULES	BENTYL						
DICYCLOMINE HCL SOLUTION	DICYCLOMINE HCL						
DICYCLOMINE HCL TABLETS	BENTYL						
GLYCOPYRROLATE SOLUTION	CUVPOSA						
GLYCOPYRROLATE TABLETS	ROBINUL						
HYOSCYAMINE SULFATE ELIXIR	HYOSCYAMINE SULFATE					120.00	30.00
HYOSCYAMINE SULFATE SOLUTION	HYOSCYAMINE SULFATE					120.00	30.00
HYOSCYAMINE SULFATE SUBLINGUAL	HYOMAX-SL					120.00	30.00
HYOSCYAMINE SULFATE TABLETS	LEVSIN					120.00	30.00
HYOSCYAMINE SULFATE TABLET 12-HOUR	LEVBID					120.00	30.00
HYOSCYAMINE SULFATE TABLET CONTROLLED RELEASE	SYMAX DUOTAB					120.00	30.00
HYOSCYAMINE SULFATE ORALLY DISPERSABLE TABLET	ANASPAZ					120.00	30.00
PROPANTHELINE BROMIDE TABLETS	PROPANTHELINE BROMIDE						
<b>H-2 ANTAGONISTS</b>							
FAMOTIDINE CHEWABLE TABLETS	PEPCID AC						
FAMOTIDINE SUSPENSION	PEPCID						
FAMOTIDINE TABLETS	PEPCID AC						
NIZATIDINE CAPSULES	NIZATIDINE						
NIZATIDINE SOLUTION	AXID						
RANITIDINE HCL CAPSULES	RANITIDINE HCL						
RANITIDINE HCL SUSPENSION	DEPRIZINE FUSEPAQ						
RANITIDINE HCL SYRUP	ZANTAC						
RANITIDINE HCL TABLETS	WAL-ZAN 75						
<b>MISC. ANTI-ULCER</b>							
SUCRALFATE TABLETS	CARAFATE						
<b>PROTON PUMP INHIBITORS</b>							
LANSOPRAZOLE CAPSULE DELAYED RELEASE	HEARTBURN RELIEF 24 HOUR					30.00	30.00
LANSOPRAZOLE ORALLY DISPERSABLE TABLET	PREVACID SOLUTAB					60.00	30.00
OMEPRAZOLE CAPSULE DELAYED RELEASE	PRILOSEC					60.00	30.00
OMEPRAZOLE MAGNESIUM CAPSULE DELAYED RELEASE	OMEPRAZOLE MAGNESIUM					60.00	30.00
OMEPRAZOLE MAGNESIUM TABLET ENTERIC COATED	PRILOSEC OTC					60.00	30.00
<b>ULCER DRUGS - PROSTAGLANDINS</b>							
MISOPROSTOL TABLETS	CYTOTEC						
<b>URINARY ANTI-INFECTIVES</b>							
<b>URINARY ANTI-INFECTIVES</b>							



## CMDP Preferred Drug List

- Generic Drugs Are Preferred Over Brand Name Drugs Unless Specified as Brand Only
- Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List Are Available Through Prior Authorization

Effective Date: 10/1/2019

Drug Class/Drug Name	Reference Brand Name	Brand Only / Generic Notes	Preferred Drug Status	PA Type	Step Therapy Requirements	Quantity Limit	QL Days
FOSFOMYCIN TROMETHAMINE PACK	MONUROL				Patient must have tried Cipro AND Macrobid		
NITROFURANTOIN MACROCRYSTAL CAPSULES	MACRODANTIN						
NITROFURANTOIN MONOHYD MACRO CAPSULES	MACROBID						
NITROFURANTOIN SUSPENSION	FURADANTIN						
<b>URINARY ANTISPASMODICS</b>							
<b>URINARY ANTISPASMODIC - ANTIMUSCARINICS (ANTICHOLI</b>							
OXYBUTYNIN CHLORIDE GEL	GELNIQUE						
OXYBUTYNIN CHLORIDE SYRUP	OXYBUTYNIN CHLORIDE						
OXYBUTYNIN CHLORIDE TABLETS	OXYBUTYNIN CHLORIDE						
OXYBUTYNIN CHLORIDE TABLET 24-HOUR	DITROPAN XL						
TOLTERODINE TARTRATE CAPSULE 24-HOUR	DETROL LA						
TOLTERODINE TARTRATE TABLETS	DETROL						
TROSPIMUM CHLORIDE CAPSULE 24-HOUR	SANCTURA XR						
TROSPIMUM CHLORIDE TABLETS	SANCTURA						
<b>URINARY ANTISPASMODICS - CHOLINERGIC AGONISTS</b>							
BETHANECHOL CHLORIDE TABLETS	URECHOLINE						
<b>URINARY ANTISPASMODICS - DIRECT MUSCLE RELAXANTS</b>							
FLAVOXATE HCL TABLETS	FLAVOXATE HCL						
<b>VAGINAL PRODUCTS</b>							
<b>SPERMICIDES</b>							
NONOXYNOL-9 FILM	VCF VAGINAL CONTRACEPTIVE FILM						
NONOXYNOL-9 FOAM	VCF VAGINAL CONTRACEPTIVE FOAM						
NONOXYNOL-9 GEL	SHUR-SEAL						
NONOXYNOL-9 MISC	TODAY SPONGE						
NONOXYNOL-9 SUPPOSITORY	ENCARE						
<b>VAGINAL ANTI-INFECTIVES</b>							
CLINDAMYCIN PHOSPHATE VAGINAL CREAM	CLEOCIN						
CLINDAMYCIN PHOSPHATE VAGINAL SUPPOSITORY	CLEOCIN						
CLOTRIMAZOLE VAGINAL CREAM	GYNE-LOTRIMIN						
METRONIDAZOLE VAGINAL GEL	METROGEL-VAGINAL						
MICONAZOLE NITRATE VAGINAL KIT	MONISTAT 3 COMBINATION PACK						
MICONAZOLE NITRATE VAGINAL SUPPOSITORY	MICONAZOLE 3						
SULFANILAMIDE VAGINAL CREAM	AVC						
TERCONAZOLE VAGINAL CREAM	TERAZOL 7						
TERCONAZOLE VAGINAL SUPPOSITORY	TERAZOL 3						
TIOCONAZOLE VAGINAL	MONISTAT 1-DAY						
<b>VAGINAL ESTROGENS</b>							
ESTRADIOL ACETATE VAGINAL RING	FEMRING			PA Required		1.00	30.00
ESTRADIOL VAGINAL CREAM	ESTRADIOL						
ESTRADIOL VAGINAL RING	ESTRING					1.00	90.00
ESTRADIOL VAGINAL TABLETS	VAGIFEM						
ESTROGENS, CONJUGATED VAGINAL CREAM	PREMARIN					1.00	30.00
<b>VAGINAL PROGESTINS</b>							
PROGESTERONE (VAGINAL) GEL	CRINONE			PA Required			
<b>VASOPRESSORS</b>							
<b>ANAPHYLAXIS THERAPY AGENTS</b>							
EPINEPHRINE SELF-INJECTABLE	EPINEPHRINE SELF-INJECTABLE (By Mylan)	Mylan Generic	Preferred Drug	PA Required for > 2 Per Month		2.00	30.00
EPINEPHRINE SELF-INJECTABLE	EPINEPHRINE SELF-INJECTABLE (By Mylan)	Mylan Generic	Preferred Drug	PA Required for > 2 Per Month		2.00	30.00
SYMJEPI SELF-INJECTABLE	EPINEPHRINE SELF-INJECTABLE		Preferred Drug	PA Required for > 2 Per Month		2.00	30.00
<b>VASOPRESSORS</b>							
MIDODRINE HCL TABLETS	MIDODRINE HCL						
<b>VACCINES</b>							





## CMDP Preferred Drug List

- Generic Drugs Are Preferred Over Brand Name Drugs Unless Specified as Brand Only
- Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List Are Available Through Prior Authorization

Effective Date: 10/1/2019

Drug Class/Drug Name	Reference Brand Name	Brand Only / Generic Notes	Preferred Drug Status	PA Type	Step Therapy Requirements	Quantity Limit	QL Days
<b>VIRAL VACCINES</b>							
HEPATITIS B VACCINE (RECOMB) INJECTION	ENGERIX-B						
HEPATITIS B VACCINE (RECOMB) SUSPENSION	RECOMBIVAX HB						
HUMAN PAPILOMAVIRUS (HPV) 9-VALENT RECOMBINANT VACCINE SUSPENSION	GARDASIL 9						
HUMAN PAPILOMAVIRUS (HPV) 9-VALENT RECOMBINANT VACCINE SUSPENSION PREFILLED SYRINGE	GARDASIL 9						
HUMAN PAPILOMAVIRUS (HPV) BIVALENT (TYPES 16, 18) RECOMB VA SUSPENSION	CERVARIX						
HUMAN PAPILOMAVIRUS (HPV) QUADRIVALENT RECOMBINANT VACCINE SUSPENSION	GARDASIL						
INFLUENZA VIRUS VACCINE RECOMBINANT HEMAGGLUTININ (HA) SOLUTION	FLUBLOK						
INFLUENZA VIRUS VACCINE SPLIT SUSPENSION	FLUZONE SPLIT						
INFLUENZA VIRUS VACCINE SPLIT HIGH-DOSE PRESERVATIVE FREE SUSPENSION PREFILLED SYRINGE	FLUZONE HIGH-DOSE PF						
INFLUENZA VIRUS VACCINE SPLIT PRESERVATIVE FREE SUSPENSION PREFILLED SYRINGE	FLUZONE PF						
INFLUENZA VIRUS VACCINE SPLIT QUADRIVALENT SUSPENSION	FLUZONE QUADRIVALENT						
INFLUENZA VIRUS VACCINE SPLIT QUADRIVALENT SUSPENSION PREFILLED SYRINGE	FLUZONE QUADRIVALENT						
INFLUENZA VIRUS VACCINE TISSUE-CULTURED SUBUNIT PSKT	MEDICAL PROVIDER EZ FLU SHOT						
INFLUENZA VIRUS VACCINE TISSUE-CULTURED SUBUNIT SUSPENSION PREFILLED SYRINGE	FLUCELVAX						
INFLUENZA VIRUS VACCINE TISSUE-CULTURED SUBUNIT QUADRIVALENT SUSPENSION PREFILLED SYRINGE	FLUCELVAX QUADRIVALENT						
INFLUENZA VIRUS VACCINE TYPES A & B PRESERVATIVE FREE PSKT	MEDICAL PROVIDER EZ FLU SHOT PF						
INFLUENZA VIRUS VACCINE TYPES A & B PRESERVATIVE FREE SUSPENSION PREFILLED SYRINGE	FLUVIRIN PF						
INFLUENZA VIRUS VACCINE TYPES A & B SURFACE ANTIGEN PSKT	MEDICAL PROVIDER SINGLE USE EZ FLU SHOT						
INFLUENZA VIRUS VACCINE TYPES A & B SURFACE ANTIGEN SUSPENSION	FLUVIRIN						
INFLUENZA VIRUS VACCINE TYPES A & B SURFACE ANTIGEN SUSPENSION PREFILLED SYRINGE	FLUVIRIN						
INFLUENZA VIRUS VACCINE TYPES A & B SURFACE ANTIGEN ADJUVAN SUSPENSION PREFILLED SYRINGE	FLUAD						
MEASLES, MUMPS & RUBELLA VIRUS VACCINES INJECTION	M-M-R II						
MEASLES-MUMPS-RUBELLA-VARICELLA VIRUS VACCINES INJECTION	PROQUAD						
PNEUMOCOCCAL 13-VALENT CONJUGATE VACCINE SUSPENSION	PREVNAR 13						
PNEUMOCOCCAL VAC POLYVALENT INJECTION	PNEUMOVAX 23/5 DOSE						
ZOSTER VACCINE LIVE SOLUTION RECONSTITUED	ZOSTAVAX						
<b>VITAMINS</b>							
<b>OIL SOLUBLE VITAMINS</b>							
ERGOCALCIFEROL CAPSULES	DRISDOL					12.00	30.00
VITAMIN E CAPSULES	VITAMIN E						
VITAMIN D DROPS 400UNIT	D-VI-SOL			PA Required for > 2 years of age			
<b>WATER SOLUBLE VITAMINS</b>							
NIACIN CAPSULE CONTROLLED RELEASE	NIACIN						
NIACIN TABLETS	NIACIN						
NIACIN TABLET CONTROLLED RELEASE	ENDUR-ACIN						
PYRIDOXINE HCL TABLETS	PYRIDOXINE HCL						
THIAMINE HCL TABLETS	VITAMIN B-1						