

FORMULARY INSTRUCTIONS



At Child Health Plan *Plus* offered by Colorado Access, we want to make sure you get the prescription medications you need.

This is a list of medications covered by your plan. If a medication is not on the formulary list, it is not covered. Use this list to find out if your medication is covered. Medications are listed alphabetically. Updates are generally made at the first of each month.

Each prescription drug has been assigned a tier. Tiers determine what your copay will be. For example, tier one drugs are usually generic and cost the least, so copays for those drugs will be the lowest. A specialty or brand name drug that is more expensive will have a higher copay.

Tiers are listed to the right of the drug name, along with any special codes that apply. You can view an index explaining the codes at the bottom of each page.

If you have any questions, call us at 303-751-9021 or 888-214-1101 (toll free).

Search Tip:

You can search quickly and easily by clicking on the binoculars icon on your toolbar, or by using the command Control+Shift+F. This will display a search box for you to enter the name of the drug you want to find. If you're not sure about the spelling, you can start your search by typing just the first few letters of the drug name.

If you need this document in large print, Braille, or other formats or languages, or read aloud, or need a copy, call 800-511-5010. For TDD/TTY, call 888-803-4494. Call Monday to Friday, 8 a.m. to 5 p.m. The call is free.

Si necesita este documento en letra grande, Braille, otros formatos o idiomas, o se lea en voz alta, o necesita otra copia, llame al 800-511-5010. Para TDD/TTY, llame al 888-803-4494. Llame de lunes a viernes, de 8 a.m. a 5 p.m. La llamada es gratis.

Search Tip:

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

Colorado Access Child Health Plan Plus HMO Formulary

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
8-MOP CAP	-	2	DERMATOLOGICALS
abacavir soln (ZIAGEN equiv)	-	1	ANTIVIRALS
abacavir tab (ZIAGEN equiv)	-	1	ANTIVIRALS
abacavir/lamivudine tab (EPZICOM equiv)	-	1	ANTIVIRALS
abacavir/lamivudine/zidovudine tab (TRIZIVIR equiv)	-	1	ANTIVIRALS
ABILIFY DISCMELT (QL= 1 tab/day)	QL	2	ANTIPSYCHOTICS / ANTIMANIC AGENTS
ABILIFY SOLN	-	2	ANTIPSYCHOTICS / ANTIMANIC AGENTS
acamprosate calcium DR tab (CAMPRAL equiv)	-	1	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
acarbose tab (PRECOSE equiv)	-	1	ANTIDIABETICS
ACCU-CHEK AVIVA PLUS METER	OTC	\$0	MEDICAL DEVICES AND SUPPLIES
ACCU-CHEK AVIVA PLUS TEST STRIP	OTC	2	DIAGNOSTIC PRODUCTS
ACCU-CHEK GUIDE CARE METER	OTC	\$0	MEDICAL DEVICES AND SUPPLIES

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
ACCU-CHEK GUIDE ME KIT	OTC	\$0	MEDICAL DEVICES AND SUPPLIES
ACCU-CHEK GUIDE TEST STRIP	OTC	2	DIAGNOSTIC PRODUCTS
ACCU-CHEK NANO METER	OTC	\$0	MEDICAL DEVICES AND SUPPLIES
ACCU-CHEK SMARTVIEW TEST STRIP	OTC	2	DIAGNOSTIC PRODUCTS
ACCU-CHEK TEST STRIP	OTC	2	DIAGNOSTIC PRODUCTS
acebutolol cap (SECTRAL equiv)	-	1	BETA BLOCKERS
acetaminophen cap (TYLENOL equiv)	OTC	1	ANALGESICS - NONNARCOTIC
acetaminophen chew tab (TYLENOL equiv)	OTC	1	ANALGESICS - NONNARCOTIC
acetaminophen drops (TYLENOL equiv)	OTC	1	ANALGESICS - NONNARCOTIC
acetaminophen elixir (TYLENOL equiv)	OTC	1	ANALGESICS - NONNARCOTIC
acetaminophen liquid (TYLENOL equiv)	OTC	1	ANALGESICS - NONNARCOTIC
ACETAMINOPHEN SOLN	OTC	2	ANALGESICS - NONNARCOTIC
acetaminophen supp (TYLENOL equiv)	OTC	1	ANALGESICS - NONNARCOTIC
acetaminophen tab (TYLENOL equiv)	OTC	1	ANALGESICS - NONNARCOTIC

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
acetaminophen/codeine soln	-	1	ANALGESICS - OPIOID
acetaminophen/codeine tab (TYLENOL/CODEINE equiv)	-	1	ANALGESICS - OPIOID
acetazolamide ER cap (DIAMOX SEQUEL equiv)	-	1	DIURETICS
acetazolamide tab	-	1	DIURETICS
acetic acid otic soln (VOSOL equiv)	-	1	OTIC AGENTS
ACETIC ACID/ALUMINUM ACETATE OTIC SOLN	-	1	OTIC AGENTS
acetic acid/hydrocortisone otic soln (VOSOL HC equiv)	-	1	OTIC AGENTS
acetylcysteine soln (MUCOMYST equiv)	-	1	COUGH / COLD / ALLERGY
ACIDIC VAGINAL JELLY	-	2	VAGINAL PRODUCTS
acitretin cap (SORIATANE equiv)	-	1	DERMATOLOGICALS
ACTEMRA ACTPEN INJ (QL= 2 inj/28 days)	LMSP-PA-QL	2	ANALGESICS - ANTI-INFLAMMATORY
ACTEMRA SC INJ (QL= 2 inj/28 days)	LMSP-PA-QL	2	ANALGESICS - ANTI-INFLAMMATORY
ACTIMMUNE INJ (Only available through Walgreens 888-347-3416)	LD-PA	2	ANTINEOPLASTICS
acyclovir cap (ZOVIRAX equiv)	-	1	ANTIVIRALS
acyclovir oint (ZOVIRAX OINT equiv)	-	1	DERMATOLOGICALS
acyclovir susp (ZOVIRAX equiv)	-	1	ANTIVIRALS
acyclovir tab (ZOVIRAX equiv)	-	1	ANTIVIRALS
adapalene cream (DIFFERIN equiv)	-	1	DERMATOLOGICALS
adapalene gel (DIFFERIN equiv)	-	1	DERMATOLOGICALS

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
ADDERALL XR CAP (QL= 2 caps/day)	QL	1	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
ADDYI TAB	-	EX C	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
ADVAIR DISKUS INHALER	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ADVAIR HFA INHALER	-	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
AEROCHAMBER	OTC	2	MEDICAL DEVICES AND SUPPLIES
AFLURIA INJ (QL= 2 inj/8 months for members 9 years and younger; QL= 1 inj/8 months for members 10 years and older)	QL-VAC	\$0	VACCINES
AFLURIA INJ, FLUZONE INJ (QL= 2 inj/8 months for members 8 years and younger; QL= 1 inj/8 months for members 9 years and older)	QL-VAC	\$0	VACCINES
albuterol neb soln	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
albuterol sulfate ER tab (VOSPIRE ER equiv)	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
albuterol sulfate syrup	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
albuterol sulfate tab	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ALBUTEROL TAB ER	-	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
albuterol/ipratropium neb soln (DUONEB equiv)	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
alclometasone cream (ACLOVATE equiv)	-	1	DERMATOLOGICALS
alclometasone oint (ACLOVATE OINT equiv)	-	1	DERMATOLOGICALS
ALCOHOL SWABS	OTC	2	MEDICAL DEVICES AND SUPPLIES
alendronate tab (FOSAMAX equiv)	-	1	ENDOCRINE AND METABOLIC AGENTS - MISC.

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
ALENDRONATE TAB 40MG	-	2	ENDOCRINE AND METABOLIC AGENTS - MISC.
ALER-DRYL TAB	OTC	2	ANTIHISTAMINES
ALFERON-N INJ	LMSP	2	ANTINEOPLASTICS
alfuzosin SR tab (UROXATRAL equiv)	-	2	GENITOURINARY AGENTS - MISCELLANEOUS
ALINIA SUSP (QL= 60ml/3 days)	PA-QL	2	ANTI-INFECTIVE AGENTS MISC.
ALINIA TAB (QL= 6 tabs/3 days)	PA-QL	2	ANTI-INFECTIVE AGENTS MISC.
ALLEGRA TAB	OTC	2	ANTIHISTAMINES
allopurinol tab (ZYLOPRIM equiv)	-	1	GOUT AGENTS
ALOCRILOPHTH SOLN	-	2	OPHTHALMIC AGENTS
ALOMIDOPHTH SOLN	-	2	OPHTHALMIC AGENTS
alosetron tab (LOTRONEX equiv)	-	1	GASTROINTESTINAL AGENTS - MISC.
ALPHAGAN P OPTH SOLN 0.1%	-	2	OPHTHALMIC AGENTS
ALPHAGAN P OPTH SOLN 0.15%	-	2	OPHTHALMIC AGENTS
alprazolam ER tab (XANAX XR equiv)	-	2	ANTI-ANXIETY AGENTS
alprazolam ODT (NIRAVAM equiv)	-	2	ANTI-ANXIETY AGENTS
alprazolam tab (XANAX equiv)	-	1	ANTI-ANXIETY AGENTS
ALREXOPHTH SUSP	-	2	OPHTHALMIC AGENTS
ALTRENO LOTION	-	2	DERMATOLOGICALS

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
aluminum chloride soln (DRYSOL equiv)	-	1	DERMATOLOGICALS
amantadine syrup (SYMMETREL equiv)	-	1	ANTIPARKINSON AGENTS
ambrisentan tab (LETAIRIS equiv) (QL= 1 tab/day; Restricted to Cardiology or Pulmonology Specialist; Only available through Walgreens 888-347-3416)	LD-QL-RS	1	CARDIOVASCULAR AGENTS - MISC.
amethyst tab (LYBREL equiv)	-	1	CONTRACEPTIVES
amiloride tab (MIDAMOR equiv)	-	1	DIURETICS
amiloride/hydrochlorothiazide tab (MODURETIC equiv)	-	1	DIURETICS
aminocaproic acid soln (AMICAR equiv)	-	1	HEMOSTATICS
aminocaproic acid syrup (AMICAR equiv)	-	1	HEMOSTATICS
aminocaproic acid tab (AMICAR equiv)	-	1	HEMOSTATICS
aminophylline tab	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
amiodarone tab (CORDARONE equiv)	-	1	ANTIARRHYTHMICS
amitriptyline tab (ELAVIL equiv)	-	1	ANTIDEPRESSANTS
amlodipine tab (NORVASC equiv)	-	1	CALCIUM CHANNEL BLOCKERS
amlodipine/atorvastatin tab (CADUET equiv)	-	1	CARDIOVASCULAR AGENTS - MISC.
amlodipine/benazepril cap (LOTREL equiv)	-	1	ANTIHYPERTENSIVES
amlodipine/olmesartan tab (AZOR TAB equiv)	-	1	ANTIHYPERTENSIVES
amlodipine/valsartan tab (EXFORGE equiv)	-	1	ANTIHYPERTENSIVES

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
amlodipine/valsartan/hydrochlorothiazide tab (EXFORGE HCT equiv)	-	1	ANTIHYPERTENSIVES
ammonium lactate cream (LAC-HYDRIN equiv)	-	1	DERMATOLOGICALS
ammonium lactate lotion (LAC-HYDRIN equiv)	-	1	DERMATOLOGICALS
amnesteem cap, claravis cap, isotretinoin cap, myorisan cap, zenatane cap (ACCUTANE equiv)	-	1	DERMATOLOGICALS
AMOXAPINE TAB	-	1	ANTIDEPRESSANTS
amoxicillin cap (TRIMOX equiv)	-	1	PENICILLINS
AMOXICILLIN CHEW TAB	-	1	PENICILLINS
amoxicillin susp (TRIMOX equiv)	-	1	PENICILLINS
amoxicillin tab (AMOXIL equiv)	-	1	PENICILLINS
amoxicillin/clavulanate chew tab (AUGMENTIN equiv)	-	1	PENICILLINS
amoxicillin/clavulanate susp (AUGMENTIN ES equiv)	-	1	PENICILLINS
amoxicillin/clavulanate tab (AUGMENTIN equiv)	-	1	PENICILLINS
amphetamine/dextroamphetamine tab (ADDERALL equiv)	-	1	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
ampicillin cap (PRINCIPEN equiv)	-	1	PENICILLINS
ampicillin susp (PRINCIPEN equiv)	-	1	PENICILLINS
anagrelide cap (AGRYLIN equiv)	-	1	HEMATOLOGICAL AGENTS - MISC.

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
anastrozole tab (ARIMIDEX equiv)	-	1	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ANDRODERM PATCH (QL= 1 patch/day)	PA-QL	2	ANDROGENS-ANABOLIC
ANDROXY TAB	-	2	ANDROGENS-ANABOLIC
APHTHASOL PASTE	-	2	MOUTH / THROAT / DENTAL AGENTS
apraclonidine ophth soln (IOPIDINE equiv)	-	1	OPHTHALMIC AGENTS
aprepitant cap (EMEND equiv) (QL= 3 caps/fill)	QL	1	ANTIEMETICS
aprepitant pak (EMEND equiv) (QL= 3 caps/fill)	QL	1	ANTIEMETICS
APTIVUS CAP	-	2	ANTIVIRALS
APTIVUS SOLN	-	2	ANTIVIRALS
aripiprazole ODT (ABILIFY equiv) (QL= 1 tab/day)	QL	1	ANTIPSYCHOTICS / ANTIMANIC AGENTS
aripiprazole soln (ABILIFY equiv)	-	1	ANTIPSYCHOTICS / ANTIMANIC AGENTS
aripiprazole tab (ABILIFY equiv) (QL= 1 tab/day)	QL	1	ANTIPSYCHOTICS / ANTIMANIC AGENTS
armodafinil tab (NUVIGIL equiv) (QL= 1 tab/day)	PA-QL	1	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
ARMOUR THYROID TAB, NATURE THROID TAB	-	1	THYROID AGENTS

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
ARNUITY ELLIPTA INHALER (QL= 1 inhaler/30 days)	QL	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
artificial tears	OTC	1	OPHTHALMIC AGENTS
artificial tears (LIQUIFILM equiv)	OTC	1	OPHTHALMIC AGENTS
artificial tears ophth soln (AQUASITE equiv) (QL= 25ml/30 days)	OTC-QL	1	OPHTHALMIC AGENTS
ascorbic acid chew tab	OTC	1	VITAMINS
ascorbic acid tab	OTC	1	VITAMINS
ASMANEX HFA INHALER (QL= 1 inhaler/30 days)	QL	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ASMANEX INHALER (QL= 1 inhaler/30 days)	QL	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
aspirin chew tab 81mg	OTC	\$0	ANALGESICS - NONNARCOTIC
aspirin supp	OTC	1	ANALGESICS - NONNARCOTIC
aspirin tab 325mg	OTC	\$0	ANALGESICS - NONNARCOTIC
aspirin tab 81mg	OTC	\$0	ANALGESICS - NONNARCOTIC
aspirin/codeine tab	-	1	ANALGESICS - OPIOID

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
atazanavir cap (REYATAZ equiv)	-	1	ANTIVIRALS
atenolol tab (TENORMIN equiv)	-	1	BETA BLOCKERS
atenolol/chlorthalidone tab (TENORETIC equiv)	-	1	ANTIHYPERTENSIVES
atomoxetine cap (STRATTERA CAP equiv) (QL= 1 cap/day)	QL	1	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
atorvastatin tab 10mg (LIPITOR equiv) (QL= 1 tab/day)	QL	1	ANTIHYPERLIPIDEMICS
atorvastatin tab 20mg (LIPITOR equiv) (QL= 1 tab/day)	QL	1	ANTIHYPERLIPIDEMICS
atorvastatin tab 40mg (LIPITOR equiv)	-	1	ANTIHYPERLIPIDEMICS
atorvastatin tab 80mg (LIPITOR equiv)	-	1	ANTIHYPERLIPIDEMICS
atovaquone susp (MEPRON equiv)	-	1	ANTI-INFECTIVE AGENTS MISC.
ATRALIN GEL, RETIN-A GEL	-	2+p	DERMATOLOGICALS
ATRIPLA TAB	-	2	ANTIVIRALS
atropine ophth oint	-	1	OPHTHALMIC AGENTS
atropine ophth soln (ISOPTO ATROPINE equiv)	-	1	OPHTHALMIC AGENTS
AVANDAMET TAB	-	2	ANTIDIABETICS
AVANDARYL TAB	-	2	ANTIDIABETICS
AVANDIA TAB	-	2	ANTIDIABETICS

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
AVAR GEL	-	2	DERMATOLOGICALS
AVC VAGINAL CREAM	-	2	VAGINAL PRODUCTS
AVONEX INJ	LMSP	2	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
AVONEX INJ	LMSP	2	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
AXID AR TAB	OTC	2	ULCER DRUGS
AZASITE SOLN	-	2	OPHTHALMIC AGENTS
azathioprine tab (IMURAN equiv)	-	1	ASSORTED CLASSES
azelaic acid gel (FINACEA equiv)	-	1	DERMATOLOGICALS
azelastine nasal spray 0.1% (ASTELIN equiv) (QL= 1 bottle/month)	QL	1	NASAL AGENTS - SYSTEMIC AND TOPICAL
azelastine nasal spray 0.15% (ASTEPRO equiv) (QL= 1 bottle/month)	QL	1	NASAL AGENTS - SYSTEMIC AND TOPICAL
azelastine ophth soln (OPTIVAR equiv)	-	1	OPHTHALMIC AGENTS
azithromycin susp (ZITHROMAX equiv)	-	1	MACROLIDES
azithromycin tab (ZITHROMAX equiv)	-	1	MACROLIDES
bacitracin oint	OTC	1	DERMATOLOGICALS
BACITRACIN OPHTH OINT	-	2	OPHTHALMIC AGENTS
bacitracin/neomycin/polymyxin b ophth oint (NEOSPORIN equiv)	-	1	OPHTHALMIC AGENTS
bacitracin/polymyxin B oint (POLYSPORIN equiv)	OTC	1	DERMATOLOGICALS

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
bacitracin/polymyxin b ophth oint (POLYSPORIN equiv)	-	1	OPHTHALMIC AGENTS
bacitracin/polymyxin/neomycin/hydrocortisone ophtl oint (CORTISPORIN equiv)	-	1	OPHTHALMIC AGENTS
bacitracin/zinc oint	OTC	1	DERMATOLOGICALS
baclofen tab 10mg, 20mg	-	1	MUSCULOSKELETAL THERAPY AGENTS
balsalazide cap (COLAZAL equiv)	-	1	GASTROINTESTINAL AGENTS - MISC.
BANZEL SUSP (QL= 2400ml/30 days)	PA-QL	2	ANTICONSULTANTS
BANZEL TAB (QL= 8 tabs/day)	PA-QL	2	ANTICONSULTANTS
BAQSIMI NASAL POWDER (QL= 2 inhalations/fill)	QL	2	ANTIDIABETICS
B-D INSULIN SYRINGE	--OTC	1	MEDICAL DEVICES AND SUPPLIES
B-D PEN NEEDLE	OTC	1	MEDICAL DEVICES AND SUPPLIES
BELLADONNA ALKALOID/OPIUM SUPP	-	2	ULCER DRUGS
benazepril tab (LOTENSIN equiv)	-	1	ANTIHYPERTENSIVES
benazepril/hydrochlorothiazide tab (LOTENSIN HCT1 equiv)	-	1	ANTIHYPERTENSIVES
BENZNIDAZOLE TAB	PA	2	ANTHELMINTICS
benzocaine gel	OTC	1	MOUTH / THROAT / DENTAL AGENTS

	NC =Not Covered	generic =small letters	BRANDS =CAPITAL LETTERS
EXC	Plan Exclusion	INF	Infertility
LD	Limited Distribution	LMSD	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
benzocaine paste	OTC	1	MOUTH / THROAT / DENTAL AGENTS
benzonatate cap (TESSALON equiv)	-	1	COUGH / COLD / ALLERGY
benzoyl peroxide cream (NEOBENZ equiv)	OTC	1	DERMATOLOGICALS
benzoyl peroxide gel (OTC) (BENZAC equiv)	OTC	1	DERMATOLOGICALS
benzoyl peroxide liquid (BENZAC equiv)	OTC	1	DERMATOLOGICALS
benzoyl peroxide lotion (OTC) (TRIAZ equiv)	OTC	1	DERMATOLOGICALS
benztropine tab	-	1	ANTIPARKINSON AGENTS
BERINERT INJ (Only available through Walgreens 888-347-3416)	LD-PA	2	HEMATOLOGICAL AGENTS - MISC.
betamethasone augmented cream (DIPROLENE AF CREAM equiv)	-	1	DERMATOLOGICALS
betamethasone augmented gel	-	1	DERMATOLOGICALS
betamethasone augmented lotion (DIPROLENE LOTION equiv)	-	1	DERMATOLOGICALS
betamethasone augmented oint (DIPROLENE OINT equiv)	-	1	DERMATOLOGICALS
betamethasone dipropionate cream (DIPROSONE CREAM equiv)	-	1	DERMATOLOGICALS
betamethasone dipropionate lotion	-	1	DERMATOLOGICALS
betamethasone dipropionate oint (DIPROSONE OINT equiv)	-	1	DERMATOLOGICALS
betamethasone valerate cream	-	1	DERMATOLOGICALS
betamethasone valerate lotion	-	1	DERMATOLOGICALS

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
betamethasone valerate oint	-	1	DERMATOLOGICALS
BETASERON INJ (Step Therapy requires trial of 2 of the 3 products: AVONEX, REBIF, COPAXONE)	LMSP-ST	2	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
betaxolol ophth soln (BETOPTIC-S equiv)	-	1	OPHTHALMIC AGENTS
betaxolol tab (KERLONE equiv)	-	1	BETA BLOCKERS
bethanechol tab (URECHOLINE equiv)	-	1	URINARY ANTISPASMODICS
BETHKIS NEB SOLN	MSP	2	AMINOGLYCOSIDES
BETIMOL OPHTH SOLN	-	2	OPHTHALMIC AGENTS
BETOPTIC-S OPHTH SOLN	-	2	OPHTHALMIC AGENTS
bexarotene cap (TARGRETIN equiv) (Step Therapy requires trial of VALCHLOR)	LMSP-ST	1	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
bicalutamide tab (CASODEX equiv)	-	1	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
bimatoprost ophth soln (QL= 2.5ml/30 days)	QL	1	OPHTHALMIC AGENTS
bisoprolol tab (ZEBETA equiv)	-	1	BETA BLOCKERS
bisoprolol/hydrochlorothiazide tab (ZIAC equiv)	-	1	ANTIHYPERTENSIVES
BLEPHAMIDE OPHTH SOLN	-	2	OPHTHALMIC AGENTS
bosentan tab (TRACLEER equiv) (QL= 2 tabs/day; Restricted to Cardiology or Pulmonology Specialist; Only available through Walgreens 888-347-3416)	LD-QL-RS	1	CARDIOVASCULAR AGENTS - MISC.

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
BREO ELLIPTA INHALER	-	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
brimonidine ophth soln 0.15% (ALPHAGAN P 0.15% equiv)	-	2	OPHTHALMIC AGENTS
brimonidine ophth soln 0.2%	-	1	OPHTHALMIC AGENTS
bromocriptine cap (PARLODEL equiv)	-	1	ANTIPARKINSON AGENTS
bromocriptine tab (PARLODEL equiv)	-	1	ANTIPARKINSON AGENTS
budesonide inh susp (PULMICORT equiv)	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
budesonide SR cap (ENTOCORT EC equiv)	-	1	CORTICOSTEROIDS
BUFFERED ASPIRIN TAB	OTC	1	ANALGESICS - NONNARCOTIC
bufferin tab	OTC	1	ANALGESICS - NONNARCOTIC
bumetanide tab (BUMEX equiv)	-	1	DIURETICS
buprenorphine SL tab (SUBUTEX equiv)	-	1	ANALGESICS - OPIOID
buprenorphine/naloxone SL tab (SUBOXONE equiv)	-	1	ANALGESICS - OPIOID
bupropion ER tab (WELLBUTRIN equiv)	-	1	ANTIDEPRESSANTS
bupropion SR tab (ZYBAN equiv)	-	1	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
bupropion tab (WELLBUTRIN equiv)	-	1	ANTIDEPRESSANTS

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
bupropion XL tab (WELLBUTRIN XL equiv)	-	1	ANTIDEPRESSANTS
buspirone tab (BUSPAR equiv)	-	1	ANTI-ANXIETY AGENTS
butorphanol nasal spray (STADOL equiv) (QL= 1 bottle/30 days)	QL	1	ANALGESICS - OPIOID
BYDUREON BCISE AUTO INJ (QL= 4 inj/28 days)	QL	2	ANTIDIABETICS
BYDUREON INJ (QL= 4 inj/28 days)	QL	2	ANTIDIABETICS
BYDUREON PEN INJ (QL= 4 inj/28 days)	QL	2	ANTIDIABETICS
cabergoline tab (DOSTINEX equiv)	-	1	ENDOCRINE AND METABOLIC AGENTS - MISC.
caffeine citrate soln (CAFCIT equiv) (Only covered for members less than 1 year old)	-	2	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXICANTS
calcipotriene cream (DOVONEX CREAM equiv)	-	1	DERMATOLOGICALS
calcipotriene oint	-	1	DERMATOLOGICALS
calcipotriene soln (DOVONEX SOLN equiv)	-	1	DERMATOLOGICALS
calcitonin nasal spray (MIACALCIN equiv) (QL= 1 bottle/30 days)	QL	1	ENDOCRINE AND METABOLIC AGENTS - MISC.
calcitriol cap (ROCALTROL equiv)	-	1	ENDOCRINE AND METABOLIC AGENTS - MISC.

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
calcitriol soln (ROCALTROL equiv)	-	1	ENDOCRINE AND METABOLIC AGENTS - MISC.
calcium acetate cap (PHOSLO equiv)	-	1	GASTROINTESTINAL AGENTS - MISC.
calcium carbonate chew tab (TUMS equiv)	OTC	1	ANTACIDS
calcium carbonate susp	OTC	1	ANTACIDS
calcium carbonate tab	OTC	1	MINERALS & ELECTROLYTES
CALCIUM W/ VITAMIN D TAB	OTC	2	MINERALS & ELECTROLYTES
calcium w/vitamin D tab	OTC	1	MINERALS & ELECTROLYTES
CALIBRATION LIQUID	OTC	1	MEDICAL DEVICES AND SUPPLIES
capecitabine tab (XELODA equiv)	LMSP	1	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
captopril tab (CAPOTEN equiv)	-	1	ANTIHYPERTENSIVES
carbamazepine chew tab (TEGRETOL equiv)	-	1	ANTICONVULSANTS
carbamazepine ER cap (CARBATROL equiv)	-	2	ANTICONVULSANTS
carbamazepine ER tab (TEGRETOL XR equiv)	-	1	ANTICONVULSANTS
carbamazepine susp (TEGRETOL equiv)	-	1	ANTICONVULSANTS
carbamazepine tab (TEGRETOL equiv)	-	1	ANTICONVULSANTS
carbamide peroxide otic soln (DEBROX equiv)	OTC	1	OTIC AGENTS

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
carbidopa tab (LODOSYN equiv)	-	1	ANTIPARKINSON AGENTS
carbidopa/levodopa ER tab (SINEMET CR equiv)	-	1	ANTIPARKINSON AGENTS
carbidopa/levodopa ODT (PARCOPA equiv)	-	1	ANTIPARKINSON AGENTS
carbidopa/levodopa tab (SINEMET equiv)	-	1	ANTIPARKINSON AGENTS
CARBIDOPA/LEVODOPA/ENTACAPONE TAB (STALEVO equiv)	-	2	ANTIPARKINSON AGENTS
CARBINOXAMINE SOLN	-	1	ANTIHISTAMINES
carbinoxamine soln (PALGIC equiv)	-	1	ANTIHISTAMINES
CARBINOXAMINE TAB	-	1	ANTIHISTAMINES
carbinoxamine tab (PALGIC equiv)	-	1	ANTIHISTAMINES
carboplatin inj (PARAPLATIN equiv)	SP	1	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
carisoprodol tab (SOMA equiv)	-	1	MUSCULOSKELETAL THERAPY AGENTS
carteolol ophth soln (OCUPRESS equiv)	-	1	OPHTHALMIC AGENTS
carvedilol tab (COREG equiv)	-	1	BETA BLOCKERS
CAYSTON INH SOLN (Only available through Walgreens 888-347-3416)	LD-PA	2	ANTI-INFECTIVE AGENTS MISC.
cefaclor cap (CECLOR equiv)	-	1	CEPHALOSPORINS
cefadroxil cap (DURICEF equiv)	-	1	CEPHALOSPORINS
cefadroxil susp (DURICEF equiv)	-	1	CEPHALOSPORINS
cefadroxil tab (DURICEF equiv)	-	1	CEPHALOSPORINS
cefdinir cap (OMNICEF equiv)	-	1	CEPHALOSPORINS
cefdinir susp (OMNICEF equiv)	-	1	CEPHALOSPORINS

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
cefixime susp (SUPRAX equiv)	-	1	CEPHALOSPORINS
cefepime proxetil susp (VANTIN equiv)	-	1	CEPHALOSPORINS
cefepime proxetil tab (VANTIN equiv)	-	1	CEPHALOSPORINS
cefprozil susp (CEFZIL equiv)	-	1	CEPHALOSPORINS
cefprozil tab (CEFZIL equiv)	-	1	CEPHALOSPORINS
CEFTIN SUSP	-	2	CEPHALOSPORINS
cefuroxime susp (CEFTIN equiv)	-	1	CEPHALOSPORINS
cefuroxime tab (CEFTIN equiv)	-	1	CEPHALOSPORINS
celecoxib cap (CELEBREX equiv) (QL= 2 caps/day)	QL	1	ANALGESICS - ANTI-INFLAMMATORY
CELLCEPT CAP	-	2	ASSORTED CLASSES
CELLCEPT TAB	-	2	ASSORTED CLASSES
CELONTIN CAP	-	2	ANTICONVULSANTS
cephalexin cap (KEFLEX equiv)	-	1	CEPHALOSPORINS
cephalexin susp (KEFLEX equiv)	-	1	CEPHALOSPORINS
CEREZYME INJ	MSP-PA	2	HEMATOPOIETIC AGENTS
cetirizine syrup (ZYRTEC equiv) (QL= 300 ml/30 days)	OTC	1	ANTIHISTAMINES
cetirizine tab (ZYRTEC equiv) (QL= 1 tab/day)	OTC-QL	1	ANTIHISTAMINES
cetirizine/pseudoephedrine 12-hour tab (ZYRTEC equiv) (QL= 2 tabs/day)	OTC-QL	1	COUGH / COLD / ALLERGY
cevimeline cap (EVOXAC equiv)	-	1	MOUTH / THROAT / DENTAL AGENTS

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
CHANTIX PAK (Prior Authorization Required only if member is less than 16 years old)	PA	2	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
CHANTIX TAB (Prior Authorization Required only if member is less than 16 years old)	PA	2	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
CHEMET CAP	-	2	ANTIDOTES
chlordiazepoxide cap (LIBRIUM equiv)	-	1	ANTIANKXIETY AGENTS
CHLORDIAZEPOXIDE/AMITRIPTYLINE TAB	-	1	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
chlordiazepoxide/clidinium cap (LIBRAX equiv)	-	1	ULCER DRUGS
chlorhexidine gluconate soln (PERIDEX equiv)	-	1	MOUTH / THROAT / DENTAL AGENTS
chloroquine tab (ARALEN equiv)	-	1	ANTIMALARIALS
CHLOROTHIAZIDE TAB	-	1	DIURETICS
chlorothiazide tab (DIURIL equiv)	-	1	DIURETICS
chlorpheniramine ER cap	-	1	ANTIHISTAMINES
chlorpromazine tab (THORAZINE equiv)	-	1	ANTIPSYCHOTICS / ANTIMANIC AGENTS
chlorpropamide tab (DIABINESE equiv)	-	1	ANTIDIABETICS
CHLORTHALIDONE TAB	-	1	DIURETICS
chlorzoxazone tab 500mg	-	1	MUSCULOSKELETAL THERAPY AGENTS

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
cholecalciferol cap (VITAMIN D equiv)	OTC	1	VITAMINS
cholecalciferol tab (VITAMIN D equiv)	OTC	1	VITAMINS
cholestyramine lite powder (QUESTRAN LITE equiv)	-	1	ANTIHYPERLIPIDEMICS
cholestyramine lite powder pack (QUESTRAN LITE equiv)	-	1	ANTIHYPERLIPIDEMICS
cholestyramine powder (QUESTRAN equiv)	-	1	ANTIHYPERLIPIDEMICS
cholestyramine powder pack (QUESTRAN equiv)	-	1	ANTIHYPERLIPIDEMICS
CHOLINE MAGNESIUM TRISALICYLATE TAB	-	1	ANALGESICS - NONNARCOTIC
choline magnesium trisalicylate tab (TRILISATE equiv)	-	1	ANALGESICS - NONNARCOTIC
ciclopirox cream (LOPROX CREAM equiv)	-	1	DERMATOLOGICALS
ciclopirox gel (LOPROX GEL equiv)	-	1	DERMATOLOGICALS
ciclopirox shampoo (LOPROX SHAMPOO equiv)	-	1	DERMATOLOGICALS
ciclopirox topical susp (LOPROX SUSP equiv)	-	1	DERMATOLOGICALS
cilostazol tab (PLETAL equiv)	-	1	HEMATOLOGICAL AGENTS - MISC.
CIMDUO TAB	-	2	ANTIVIRALS
CIMETIDINE SOLN	-	1	ULCER DRUGS
cimetidine tab (TAGAMET equiv) (OTC covered only.)	OTC	1	ULCER DRUGS
CIMZIA INJ (QL= 2 inj/28 days)	LMSP-PA-QL	2	GASTROINTESTINAL AGENTS - MISC.

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
CIMZIA STARTER INJ KIT (QL= 1 kit/plan year)	LMSP-PA-QL	2	GASTROINTESTINAL AGENTS - MISC.
CINRYZE INJ (QL= 16 vials/28 days; Only available through CVS Specialty 800-237-2767)	LD-PA-QL	2	HEMATOLOGICAL AGENTS - MISC.
CIPRODEX OTIC SUSP	-	2	OTIC AGENTS
ciprofloxacin ophth soln (CILOXAN equiv)	-	1	OPHTHALMIC AGENTS
CIPROFLOXACIN OTIC SOLN	-	2	OTIC AGENTS
ciprofloxacin susp (CIPRO equiv)	-	1	FLUOROQUINOLONES
ciprofloxacin tab (CIPRO equiv)	-	1	FLUOROQUINOLONES
CISPLATIN INJ	-	1	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
cisplatin inj (PLATINOL AQ equiv)	-	1	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
citalopram soln (CELEXA equiv)	-	1	ANTIDEPRESSANTS
citalopram tab (CELEXA equiv)	-	1	ANTIDEPRESSANTS
CLARITHROMYC SUSP	-	2	MACROLIDES
clarithromycin ER tab (BIAXIN XL equiv)	-	1	MACROLIDES
clarithromycin susp (BIAXIN equiv)	-	1	MACROLIDES
clarithromycin tab (BIAXIN equiv)	-	1	MACROLIDES
clemastine tab 1.34mg (TAVIST equiv)	OTC	1	ANTIHISTAMINES
clindamycin cap (CLEOCIN equiv)	-	1	ANTI-INFECTIVE AGENTS MISC.
clindamycin gel (CLEOCIN GEL equiv)	-	1	DERMATOLOGICALS
clindamycin lotion (CLEOCIN- T equiv)	-	1	DERMATOLOGICALS

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
clindamycin pad (CLEOCIN-T equiv)	-	1	DERMATOLOGICALS
clindamycin soln (CLEOCIN equiv)	-	1	ANTI-INFECTIVE AGENTS MISC.
clindamycin topical soln (CLEOCIN-T equiv)	-	1	DERMATOLOGICALS
clindamycin vaginal cream (CLEOCIN equiv)	-	1	VAGINAL PRODUCTS
clindamycin/benzoyl peroxide gel (BENZA CLIN equiv)	-	1	DERMATOLOGICALS
clindamycin/benzoyl peroxide gel (DUAC GEL equiv)	-	1	DERMATOLOGICALS
CLINISTIX TEST STRIP	OTC	1	DIAGNOSTIC PRODUCTS
clobazam tab (ONFI equiv) (QL= 2 tabs/day)	QL	1	ANTICONVULSANTS
clobetasol foam	PA	1	DERMATOLOGICALS
clobetasol propionate cream (TEMOVATE equiv)	-	1	DERMATOLOGICALS
clobetasol propionate emollient cream (TEMOVATE E equiv)	-	1	DERMATOLOGICALS
clobetasol propionate gel (TEMOVATE GEL equiv)	-	1	DERMATOLOGICALS
clobetasol propionate oint (TEMOVATE equiv)	-	1	DERMATOLOGICALS
clobetasol propionate soln (TEMOVATE equiv)	-	1	DERMATOLOGICALS
clobetasol spray	PA	1	DERMATOLOGICALS
CLOBEX SPRAY	PA	2+p	DERMATOLOGICALS
clomipramine cap (ANAFRANIL equiv)	-	1	ANTIDEPRESSANTS
clonazepam ODT (KLONOPIN equiv)	-	1	ANTICONVULSANTS

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
clonazepam tab (KLONOPIN equiv)	-	1	ANTICONVULSANTS
clonidine ER tab (KAPVAY equiv) (QL= 2 tabs/day)	QL	2	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
clonidine patch (CATAPRES-TTS equiv)	-	1	ANTIHYPERTENSIVES
clonidine tab (CATAPRES equiv)	-	1	ANTIHYPERTENSIVES
clopidogrel tab 75mg (PLAVIX equiv)	-	1	HEMATOLOGICAL AGENTS - MISC.
clotrimazole cream (OTC) (LOTRIMIN AF equiv)	OTC	1	DERMATOLOGICALS
clotrimazole troches (MYCELEX TROCHES equiv)	-	1	MOUTH / THROAT / DENTAL AGENTS
clotrimazole vaginal cream (MYCELEX equiv)	OTC	1	VAGINAL PRODUCTS
clotrimazole/betamethasone cream (LORTRISONE CREAM equiv)	-	1	DERMATOLOGICALS
clotrimazole/betamethasone lotion (LORTRISONE LOTION equiv)	-	1	DERMATOLOGICALS
CLOZAPINE ODT	-	2	ANTIPSYCHOTICS / ANTIMANIC AGENTS
CLOZAPINE ODT 12.5MG	-	1	ANTIPSYCHOTICS / ANTIMANIC AGENTS
clozapine ODT 25mg, 100mg (CLOZAPINE, FAZACLO equiv)	-	1	ANTIPSYCHOTICS / ANTIMANIC AGENTS

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
CLOZAPINE ODT, FAZACLO ODT	-	2	ANTIPSYCHOTICS / ANTIMANIC AGENTS
clozapine tab (CLOZARIL equiv)	-	1	ANTIPSYCHOTICS / ANTIMANIC AGENTS
CODEINE SULFATE TAB	-	1	ANALGESICS - OPIOID
colchicine tab (COLCRYS equiv)	-	1	GOUT AGENTS
colchicine/probenecid tab (COL-BENEMID equiv)	-	1	GOUT AGENTS
colesevelam pack (WELCHOL equiv)	-	1	ANTIHYPERTENSIVES
colesevelam tab (WELCHOL equiv)	-	1	ANTIHYPERTENSIVES
colestipol granule (COLESTID equiv)	-	1	ANTIHYPERTENSIVES
colestipol powder packet (COLESTID equiv)	-	1	ANTIHYPERTENSIVES
colestipol tab (COLESTID equiv)	-	1	ANTIHYPERTENSIVES
COLY-MYCIN S OTIC SUSP	-	2	OTIC AGENTS
COMBIGAN OPHTH SOLN	-	2	OPHTHALMIC AGENTS
COMBIVENT RESPIMAT INHALER	-	2	ANTI-ASTHMATIC AND BRONCHODILATOR AGENTS
COMPLERA TAB	-	2	ANTIVIRALS
CONTRACEPTIVE GEL	OTC	\$0	VAGINAL PRODUCTS
CORLANOR SOLN	PA	2	CARDIOVASCULAR AGENTS - MISC.
CORLANOR TAB	PA	2	CARDIOVASCULAR AGENTS - MISC.
CORTISONE ACETATE TAB	-	2	CORTICOSTEROIDS

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
COSENTYX INJ (1-PACK) (QL= 1 inj/28 days)	LMSP-PA-QL	2	DERMATOLOGICALS
COSENTYX INJ (2-PACK) (QL= 2 fills (4 inj)/ year)	LMSP-PA-QL	2	DERMATOLOGICALS
CREON CAP	-	2	DIGESTIVE AIDS
CRIXIVAN CAP	-	2	ANTIVIRALS
cromolyn conc (GASTROCROM equiv)	-	2	GASTROINTESTINAL AGENTS - MISC.
cromolyn nasal spray (NASALCROM equiv)	OTC	1	NASAL AGENTS - SYSTEMIC AND TOPICAL
cromolyn ophth soln (CROLOM equiv)	-	1	OPHTHALMIC AGENTS
cryselle tab	-	1	CONTRACEPTIVES
cyanocobalamin inj	-	1	HEMATOPOIETIC AGENTS
cyclobenzaprine tab 10mg (FLEXERIL equiv)	-	1	MUSCULOSKELETAL THERAPY AGENTS
cyclobenzaprine tab 5mg (FLEXERIL equiv)	-	1	MUSCULOSKELETAL THERAPY AGENTS
CYCLOMYDRIL OPTH SOLN	-	2	OPHTHALMIC AGENTS
cyclopentolate ophth soln (CYCLOGYL equiv)	-	1	OPHTHALMIC AGENTS
cyclophosphamide cap	-	1	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
cyclophosphamide tab (CYTOXAN equiv)	-	1	ANTINEOPLASTICS
cyclosporine cap (SANDIMMUNE equiv)	-	1	ASSORTED CLASSES
cyclosporine modified cap (NEORAL equiv)	-	1	ASSORTED CLASSES
cyclosporine modified soln (NEORAL equiv)	-	1	ASSORTED CLASSES
cyproheptadine syrup	-	1	ANTIHISTAMINES

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
cyproheptadine tab	-	1	ANTIHISTAMINES
CYSTAGON CAP (Only available through CVS Specialty 800-238-7828)	LD	2	GENITOURINARY AGENTS - MISCELLANEOUS
CYSTARAN OPHTH SOLN (Only available through Walgreens 888-347-3416)	LD-PA	2	OPHTHALMIC AGENTS
CYTRA-3 SYRUP	-	1	GENITOURINARY AGENTS - MISCELLANEOUS
danazol cap (DANOCRINE equiv)	-	1	ANDROGENS-ANABOLIC
dantrolene cap (DANTRIUM equiv)	-	1	MUSCULOSKELETAL THERAPY AGENTS
dapsone tab	-	1	ANTI-INFECTIVE AGENTS MISC.
deferasirox tab (EXJADE equiv)	LMSP	1	ANTIDOTES AND SPECIFIC ANTAGONISTS
deferasirox tab 90mg, 360mg (JADENU equiv)	LMSP	1	ANTIDOTES AND SPECIFIC ANTAGONISTS
DENAVIR CREAM	-	2	DERMATOLOGICALS
DESCOVY TAB	PA	2	ANTIVIRALS
desipramine tab (NORPRAMIN equiv)	-	1	ANTIDEPRESSANTS
desmopressin acetate inj (DDAVP equiv)	-	1	ENDOCRINE AND METABOLIC AGENTS - MISC.

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
desmopressin acetate nasal spray (DDAVP equiv)	-	1	ENDOCRINE AND METABOLIC AGENTS - MISC.
desmopressin acetate tab (DDAVP equiv)	-	1	ENDOCRINE AND METABOLIC AGENTS - MISC.
desmopressin nasal soln (DDAVP equiv)	-	1	ENDOCRINE AND METABOLIC AGENTS - MISC.
desonide cream (DESOWEN equiv)	-	2	DERMATOLOGICALS
desonide oint (DESOWEN equiv)	-	2	DERMATOLOGICALS
desoximetasone cream (DESOXIMETASONE equiv)	-	2	DERMATOLOGICALS
desoximetasone gel (TOPICORT equiv)	-	1	DERMATOLOGICALS
desoximetasone oint (TOPICORT equiv)	-	1	DERMATOLOGICALS
DEXAMETHASONE CONC	-	1	CORTICOSTEROIDS
dexamethasone elixir	-	1	CORTICOSTEROIDS
dexamethasone ophth soln	-	1	OPHTHALMIC AGENTS
DEXAMETHASONE SOLN	-	1	CORTICOSTEROIDS
dexamethasone tab (DECADRON equiv)	-	1	CORTICOSTEROIDS
dexmethylphenidate ER cap (FOCALIN XR equiv) (QL= 1 cap/day)	QL	1	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
dexmethylphenidate tab (FOCALIN equiv)	-	1	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
dextroamphetamine ER cap (DEXEDRINE equiv)	-	1	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
dextroamphetamine tab (DEXEDRINE equiv)	-	1	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
dextromethorphan/guaifenesin syrup 10-100mg (ROBITUSSIN equiv)	OTC	1	COUGH / COLD / ALLERGY
DIALYVITE TAB	-	1	MULTIVITAMINS
dialyvite tab (NEPHRO-VITE equiv)	--OTC	1	MULTIVITAMINS
DIALYVITE/ZINC TAB	-	1	MULTIVITAMINS
DIAPHRAGM	-	2	MEDICAL DEVICES AND SUPPLIES
DIASTAT RECTAL GEL, DIAZEPAM RECTAL GEL	-	2	ANTICONVULSANTS
diazepam conc (VALIUM equiv)	-	1	ANTI-ANXIETY AGENTS
DIAZEPAM SOLN	-	1	ANTI-ANXIETY AGENTS
diazepam tab (VALIUM equiv)	-	1	ANTI-ANXIETY AGENTS

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
diclofenac gel (SOLARAZE equiv) (QL= 300gm/30 days)	PA-QL	1	DERMATOLOGICALS
diclofenac gel 1% (VOLTAREN equiv) (QL= 5 tubes/fill)	QL	1	DERMATOLOGICALS
diclofenac potassium tab (CATAFLAM equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
diclofenac sodium EC tab (VOLTAREN equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
diclofenac sodium ophth soln (VOLTAREN equiv)	-	1	OPHTHALMIC AGENTS
diclofenac sodium XR tab (VOLTAREN XR equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
dicloxacillin cap (DYNAPEN equiv)	-	1	PENICILLINS
dicyclomine cap (BENTYL equiv)	-	1	ULCER DRUGS
dicyclomine soln (BENTYL equiv)	-	1	ULCER DRUGS
dicyclomine tab (BENTYL equiv)	-	1	ULCER DRUGS
didanosine DR cap (VIDEX EC equiv)	-	1	ANTIVIRALS
DIDANOSINE DR CAP, VIDEX EC CAP	-	1	ANTIVIRALS
DIFICID TAB (QL= 20 tabs/fill; Step Therapy requires trial of vancomycin cap, vancomycin soln, o FIRVANQ SOLN)	QL-ST	2	MACROLIDES
diflunisal tab (DOLOBID equiv)	-	1	ANALGESICS - NONNARCOTIC
DIGOXIN SOLN	-	1	CARDIOTONICS
digoxin soln (LANOXIN equiv)	-	1	CARDIOTONICS

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
digoxin tab (LANOXIN equiv)	-	1	CARDIOTONICS
DILANTIN CAP 30MG	-	2	ANTICONVULSANTS
DILTIAZEM CAP	-	1	CALCIUM CHANNEL BLOCKERS
diltiazem ER cap (CARDIZEM CD equiv)	-	1	CALCIUM CHANNEL BLOCKERS
diltiazem ER cap (CARDIZEM SR equiv)	-	1	CALCIUM CHANNEL BLOCKERS
diltiazem ER cap (DILACOR XR equiv)	-	1	CALCIUM CHANNEL BLOCKERS
diltiazem ER cap (TIAZAC equiv)	-	1	CALCIUM CHANNEL BLOCKERS
diltiazem ER tab (CARDIZEM LA equiv)	-	1	CALCIUM CHANNEL BLOCKERS
diltiazem tab (CARDIZEM equiv)	-	1	CALCIUM CHANNEL BLOCKERS
diphenhydramine cap (OTC only)	OTC	1	HYPNOTICS / SEDATIVES SLEEP DISORDER AGENTS
diphenhydramine cap (BENADRYL equiv) (OTC only)	OTC	1	ANTIHISTAMINES
diphenhydramine elixir (OTC only)	OTC	1	ANTIHISTAMINES
diphenhydramine liquid (BENADRYL equiv)	OTC	1	ANTIHISTAMINES
diphenhydramine tab (BENADRYL equiv)	OTC	1	ANTIHISTAMINES

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
diphenhydramine tab (NYTOL equiv)	OTC	1	HYPNOTICS / SEDATIVES SLEEP DISORDER AGENTS
DIPHENOXYLATE/ATROPINE LIQUID	-	1	ANTIDIARRHEAL / PROBIOTIC AGENTS
diphenoxylate/atropine tab (LOMOTIL equiv)	-	1	ANTIDIARRHEALS
dipyridamole tab (PERSANTINE equiv)	-	1	HEMATOLOGICAL AGENTS - MISC.
disopyramide cap (NORPACE equiv)	-	1	ANTIARRHYTHMICS
disopyramide ER cap (NORPACE CR equiv)	-	1	ANTIARRHYTHMICS
disulfiram tab (ANTABUSE equiv)	-	1	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
DIURIL SUSP	-	2	DIURETICS
divalproex ER tab (DEPAKOTE ER equiv)	-	1	ANTICONVULSANTS
divalproex sodium DR tab (DEPAKOTE equiv)	-	1	ANTICONVULSANTS
divalproex sprinkle cap (DEPAKOTE equiv)	-	1	ANTICONVULSANTS
docusate calcium cap (KAOPECTATE equiv)	OTC	1	LAXATIVES
docusate sodium cap (COLACE equiv)	OTC	1	LAXATIVES
docusate sodium liquid (COLACE equiv)	OTC	1	LAXATIVES
docusate sodium syrup (COLACE equiv)	OTC	1	LAXATIVES
docusate sodium tab (COLACE equiv)	OTC	1	LAXATIVES
dofetilide cap (TIKOSYN equiv)	-	1	ANTIARRHYTHMICS
dorzolamide ophth soln (TRUSOPT equiv)	-	1	OPHTHALMIC AGENTS

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
dorzolamide/timolol (pf) ophth soln (COSOPT equiv)	-	1	OPHTHALMIC AGENTS
DORZOLAMIDE/TIMOLOL OPHTH SOLN	-	2	OPHTHALMIC AGENTS
DOVATO TAB	-	2	ANTIVIRALS
doxazosin tab (CARDURA equiv)	-	1	ANTIHYPERTENSIVES
DOXEPIN CAP	-	1	ANTIDEPRESSANTS
doxepin cap (SINEQUAN equiv)	-	1	ANTIDEPRESSANTS
doxepin conc (SINEQUAN equiv)	-	1	ANTIDEPRESSANTS
doxercalciferol cap (HECTOROL equiv)	-	1	ENDOCRINE AND METABOLIC AGENTS - MISC.
doxycycline hyclate cap (VIBRAMYCIN equiv)	-	1	TETRACYCLINES
doxycycline hyclate tab (VIBRATAB equiv)	-	1	TETRACYCLINES
doxycycline monohydrate cap (MONODOX equiv)	-	1	TETRACYCLINES
doxycycline monohydrate tab (ADOXA equiv)	-	1	TETRACYCLINES
doxycycline susp (VIBRAMYCIN equiv)	-	1	TETRACYCLINES
D-PENAMINE TAB	-	2	ASSORTED CLASSES
DROXIA CAP	-	2	HEMATOPOIETIC AGENTS
DRYSOL SOLN	-	1	DERMATOLOGICALS
DULERA INHALER	-	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
duloxetine EC cap (CYMBALTA equiv)	-	1	ANTIDEPRESSANTS
DUPIXENT INJ (QL= 2 inj/ 28 days)	LMSP-PA-QL	2	DERMATOLOGICALS
DUPIXENT INJ (QL= 2 inj/28 days)	LMSP-PA-QL	2	DERMATOLOGICALS

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
DUREZOL OPHTH EMULSION	-	2	OPHTHALMIC AGENTS
dutasteride cap (AVODART equiv)	-	1	GENITOURINARY AGENTS - MISCELLANEOUS
econazole cream (SPECTAZOLE equiv)	-	1	DERMATOLOGICALS
EDURANT TAB	-	2	ANTIVIRALS
efavirenz cap (SUSTIVA equiv)	-	1	ANTIVIRALS
efavirenz tab (SUSTIVA equiv)	-	1	ANTIVIRALS
EGRIFTA INJ	-	EX C	ENDOCRINE AND METABOLIC AGENTS - MISC.
ELIXOPHYLLIN ELIXIR	-	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ELLA TAB (QL= 1 tab/28 days)	QL	2	CONTRACEPTIVES
ELMIRON CAP	-	2	GENITOURINARY AGENTS - MISCELLANEOUS
EMCYT CAP	-	2	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
EMTRIVA CAP	-	2	ANTIVIRALS
EMTRIVA SOLN	-	2	ANTIVIRALS
enalapril tab (VASOTEC equiv)	-	1	ANTIHYPERTENSIVES
enalapril/hydrochlorothiazide tab (VASERETIC equiv)	-	1	ANTIHYPERTENSIVES

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
ENBREL INJ 25MG (QL= 8 inj/28 days)	LMSP-PA-QL	2	ANALGESICS - ANTI-INFLAMMATORY
ENBREL INJ 50MG (QL= 4 inj/28 days)	LMSP-PA-QL	2	ANALGESICS - ANTI-INFLAMMATORY
ENBREL MINI INJ (QL= 4 inj/28 days)	LMSP-PA-QL	2	ANALGESICS - ANTI-INFLAMMATORY
ENBREL SURECLICK INJ 50MG (QL= 4 inj/28 days)	LMSP-PA-QL	2	ANALGESICS - ANTI-INFLAMMATORY
enoxaparin inj (LOVENOX equiv)	-	1	ANTICOAGULANTS
enpresse tab (TRI-LEVELLEN equiv)	-	1	CONTRACEPTIVES
entacapone tab (COMTAN equiv)	-	2	ANTIPARKINSON AGENTS
EPIDIOLEX SOLN (Only available through Walgreens 888-347-3416)	LD-PA	2	ANTICONVULSANTS
EPIFOAM AEROSOL	-	2	DERMATOLOGICALS
epinastine ophth soln (ELESTAT equiv)	-	1	OPHTHALMIC AGENTS
epinephrine inj	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
epinephrine pen inj 0.15mg, 0.3mg (EPIPEN (JR) equiv) (QL= 2 inj/fill)	QL	1	VASOPRESSORS
EPIVIR HBV SOLN	-	2	ANTIVIRALS
eplerenone tab (INSPRA equiv)	-	1	ANTIHYPERTENSIVES
EQUETRO CAP	-	2	ANTIPSYCHOTICS / ANTIMANIC AGENTS

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
ERWINAZE INJ	-	2	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ERY PAD	-	1	DERMATOLOGICALS
erythromycin DR cap (ERYC equiv)	-	2	MACROLIDES
ERYTHROMYCIN EC CAP	-	2	MACROLIDES
erythromycin ethylsuccinate susp (ERYPED equiv)	-	1	MACROLIDES
ERYTHROMYCIN ETHYLSUCCINATE TAB	-	2	MACROLIDES
erythromycin gel	-	1	DERMATOLOGICALS
erythromycin ophth oint	-	1	OPHTHALMIC AGENTS
erythromycin pad	-	1	DERMATOLOGICALS
erythromycin soln	-	1	DERMATOLOGICALS
erythromycin stearate tab	-	2	MACROLIDES
erythromycin tab (ERY-TAB equiv)	-	1	MACROLIDES
erythromycin/sulfisoxazole susp (PEDIAZOLE equiv)	-	1	ANTI-INFECTIVE AGENTS MISC.
escitalopram soln (LEXAPRO equiv) (QL= 600 units/30 days)	QL	2	ANTIDEPRESSANTS
escitalopram tab (LEXAPRO equiv) (QL= 1 tab/day)	QL	1	ANTIDEPRESSANTS
estazolam tab (PROSOM equiv)	-	1	HYPNOTICS / SEDATIVES SLEEP DISORDER AGENTS
esterified estrogens/methyltestosterone tab (ESTRATEST equiv)	-	1	ESTROGENS
estradiol patch (CLIMARA equiv)	-	1	ESTROGENS

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
estradiol patch (VIVELLE-DOT equiv)	-	1	ESTROGENS
estradiol tab (ESTRACE equiv)	-	1	ESTROGENS
estradiol/norethindrone tab (ACTIVELLA equiv)	-	1	ESTROGENS
ESTRING (3 copays per Rx)	-	2	VAGINAL PRODUCTS
ESTROPIPATE TAB	-	1	ESTROGENS
estropipate tab (OGEN equiv)	-	1	ESTROGENS
eszopiclone tab (LUNESTA equiv) (QL= 1 tab/day)	QL	1	HYPNOTICS / SEDATIVES SLEEP DISORDER AGENTS
ethacrynic tab (EDECIN equiv)	-	1	DIURETICS
ethambutol tab (MYAMBUTOL equiv)	-	1	ANTIMYCOBACTERIAL AGENTS
ethosuximide cap (ZARONTIN equiv)	-	1	ANTICONVULSANTS
ethosuximide soln (ZARONTIN equiv)	-	1	ANTICONVULSANTS
etodolac cap (LODINE equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
etodolac ER tab (LODINE XL equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
etodolac tab	-	1	ANALGESICS - ANTI-INFLAMMATORY
ETOPOSIDE CAP	LMSP	1	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
EURAX CREAM	-	2	DERMATOLOGICALS

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
everolimus tab (AFINITOR equiv) (QL= 1 tab/day)	LMSP-PA-QL	1	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
everolimus tab 0.25mg, 0.5mg, 0.75mg (ZORTRESS equiv)	PA	1	MISCELLANEOUS THERAPEUTIC CLASSES
EVOTAZ TAB	-	2	ANTIVIRALS
exemestane tab (AROMASIN equiv)	-	1	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
EXTAVIA INJ	LMSP	2	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
ezetimibe tab (ZETIA equiv)	-	1	ANTHYPERLIPIDEMICS
famciclovir tab (FAMVIR equiv)	-	1	ANTIVIRALS
famotidine susp (PEPCID equiv)	-	1	ULCER DRUGS
famotidine tab (PEPCID equiv) (OTC covered only.)	OTC	1	ULCER DRUGS
FANAPT TAB	PA	2	ANTIPSYCHOTICS / ANTIMANIC AGENTS
FANAPT TITRATION PACK	PA	2	ANTIPSYCHOTICS / ANTIMANIC AGENTS
FASENRA PEN INJ (QL= 1 inj/56 days)	LMSP-PA-QL	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
felbamate susp (FELBATOL equiv)	-	1	ANTICONVULSANTS
felbamate tab (FELBATOL equiv)	-	2	ANTICONVULSANTS

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
felodipine ER tab (PLENDIL equiv)	-	1	CALCIUM CHANNEL BLOCKERS
FEMALE CONDOMS	OTC	\$0	MEDICAL DEVICES AND SUPPLIES
fenofibric acid DR cap (TRILIPIX equiv)	-	1	ANTIHYPERTENSIVES
fentanyl patch (DURAGESIC equiv)	-	1	ANALGESICS - OPIOID
ferrex 150 forte cap	-	1	HEMATOPOIETIC AGENTS
ferrex 150 forte cap (NIFEREX 150 FORTE equiv)	-	1	HEMATOPOIETIC AGENTS
FERRIPROX SOLN (Only available through Ferriprox Total Care 866-758-7071)	LD-PA	2	ANTIDOTES
FERRIPROX TAB (Only available through Ferriprox Total Care 866-758-7071)	LD-PA	2	ANTIDOTES
ferrous sulfate soln (FER-IN-SOL equiv)	OTC	\$0	HEMATOPOIETIC AGENTS
fexofenadine susp (ALLEGRA equiv)	OTC	1	ANTIHISTAMINES
fexofenadine tab (ALLEGRA equiv)	OTC	1	ANTIHISTAMINES
fexofenadine/pseudoephedrine 12-hour tab (ALLEGRA-D 12 hour equiv)	OTC	1	COUGH / COLD / ALLERGY
fexofenadine/pseudoephedrine 24-hour tab (ALLEGRA-D equiv)	OTC	1	COUGH / COLD / ALLERGY
FIASP FLEXTOUCH INJ	-	2	ANTIDIABETICS
FIASP INJ	-	2	ANTIDIABETICS
FINACEA FOAM	-	2	DERMATOLOGICALS
FINACEA PLUS KIT	-	2	DERMATOLOGICALS

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
finasteride tab (PROSCAR equiv)	-	1	GENITOURINARY AGENTS - MISCELLANEOUS
finasteride tab (PROPECIA equiv)	-	EX C	DERMATOLOGICALS
FIRST ATENOLOL SOLN	-	2	BETA BLOCKERS
FIRST METOPROLOL ORAL SOLN	-	2	BETA BLOCKERS
FIRST OMEPRAZOLE SUSP	-	2	ULCER DRUGS
FIRST-VANCOMYCIN SOLN	-	1	ANTI-INFECTIVE AGENTS MISC.
flecainide tab (TAMBOCOR equiv)	-	1	ANTIARRHYTHMICS
FLORIVA PLUS DROPS	-	2	MULTIVITAMINS
FLOVENT DISKUS INHALER	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
FLOVENT HFA INHALER	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
FLUBLOK INJ (QL= 1 inj/8 months for members 18 years and older)	QL-VAC	\$0	VACCINES
FLUBLOK QUAD PF INJ (QL= 2 inj/8 months for members 8 years and young; QL= 1 inj/8 months for members 9 years and older)	QL-VAC	\$0	VACCINES

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier Category
FLUCELVAX INJ (QL= 2 inj/8 months for members 8 years and younger; QL= 1 inj/8 months for members 9 years and older)	QL-VAC	\$0 VACCINES
FLUCELVAX QUAD INJ (QL= 2 inj/8 months for members 8 years and younger; QL= 1 inj/8 months for members 9 years and older)	QL-VAC	\$0 VACCINES
FLUCELVAX QUAD INJ (QL= 2 inj/8 months for members 9 years and younger; QL= 1 inj/8 months for members 10 years and older)	QL-VAC	\$0 VACCINES
fluconazole susp (DIFLUCAN equiv)	-	1 ANTIFUNGALS
fluconazole tab (DIFLUCAN equiv)	-	1 ANTIFUNGALS
flucytosine cap (ANCOBON equiv)	-	1 ANTIFUNGALS
fludrocortisone tab (FLORINEF equiv)	-	1 CORTICOSTEROIDS
FLULAVAL QUAD INJ, FLUZONE QUAD INJ (QL= 2 inj/8 months for members 8 years and younger; QL= 1 inj/8 months for members 9 years and older)	QL-VAC	\$0 VACCINES
FLUMIST QUADRIVALENT NASAL SUSP (QL= 2 inj/8 months for members 8 years and younger; QL= 1 inj/8 months for members 9 years and older)	QL-VAC	\$0 VACCINES
FLUNISOLIDE NASAL SPRAY	-	1 NASAL AGENTS - SYSTEMIC AND TOPICAL
fluocinolone acetonide cream	-	1 DERMATOLOGICALS
fluocinolone acetonide oil (DERMA-SMOOTH/FS equiv)	-	1 DERMATOLOGICALS

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
fluocinolone acetonide oint	-	1	DERMATOLOGICALS
fluocinolone acetonide soln	-	1	DERMATOLOGICALS
fluocinolone otic oil (DERMOTIC equiv)	-	1	OTIC AGENTS
fluocinonide cream 0.05% (LIDEX equiv)	-	1	DERMATOLOGICALS
fluocinonide emollient cream	-	1	DERMATOLOGICALS
fluocinonide gel	-	1	DERMATOLOGICALS
fluocinonide oint	-	1	DERMATOLOGICALS
fluocinonide soln	-	1	DERMATOLOGICALS
FLUORABON SOLN	-	2	MINERALS & ELECTROLYTES
FLUOR-A-DAY CHEW TAB	-	1	MINERALS & ELECTROLYTES
fluorometholone ophth soln (FML LIQUIFILM equiv)	-	1	OPHTHALMIC AGENTS
FLUOROPLEX CREAM	-	2	DERMATOLOGICALS
fluorouracil cream (EFUDEX CREAM equiv)	-	1	DERMATOLOGICALS
FLUOROURACIL CREAM 0.5%	-	2	DERMATOLOGICALS
fluoxetine cap (PROZAC equiv)	-	1	ANTIDEPRESSANTS
fluoxetine soln (PROZAC equiv)	-	1	ANTIDEPRESSANTS
fluoxetine tab (PROZAC equiv)	-	1	ANTIDEPRESSANTS
fluoxetine tab 60mg	-	1	ANTIDEPRESSANTS
FLUPHENAZINE TAB	-	1	ANTIPSYCHOTICS / ANTIMANIC AGENTS
fluphenazine tab (PROLIXIN equiv)	-	1	ANTIPSYCHOTICS / ANTIMANIC AGENTS

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier Category
FLURAZEPAM CAP	-	1 HYPNOTICS / SEDATIVES SLEEP DISORDER AGENTS
flurbiprofen tab (ANSAID equiv)	-	1 ANALGESICS - ANTI-INFLAMMATORY
flutamide cap (EULEXIN equiv)	-	1 ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
fluticasone nasal spray (FLONASE equiv)	-	1 NASAL AGENTS - SYSTEMIC AND TOPICAL
fluticasone propionate cream (CUTIVATE equiv)	-	1 DERMATOLOGICALS
fluticasone propionate oint (CUTIVATE equiv)	-	1 DERMATOLOGICALS
FLUTICASONE/SALMETEROL INHALER	-	1 ANTI-ASTHMATIC AND BRONCHODILATOR AGENTS
FLUVIRIN INJ (QL= 2 inj/8 months for members 8 years and younger; QL= 1 inj/8 months for members 9 years and older)	QL-VAC	\$0 VACCINES
FLUVIRIN INJ (QL= 2 inj/8 months for members 9 years and younger; QL= 1 inj/8 months for members 10 years and older)	QL-VAC	\$0 VACCINES
FLUVIRIN PF INJ (QL= 2 inj/8 months for members 8 years and younger; QL= 1 inj/8 months for members 9 years and older)	QL-VAC	\$0 VACCINES
fluvoxamine ER cap (LUVOX CR equiv)	-	1 ANTIDEPRESSANTS

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
fluvoxamine tab (LUVOX equiv)	-	1	ANTIDEPRESSANTS
FLUZONE INTRADERMAL INJ (QL= 1 inj/8 month: for members 18 years and older)	QL-VAC	\$0	VACCINES
FLUZONE QUADRIVALENT INJ (QL= 2 inj/8 months for members 9 years and younger; QL= 1 inj/8 months for members 10 years and older)	QL-VAC	\$0	VACCINES
FLUZONE/FLUARIX QUAD INJ (QL= 2 inj/8 month for members 8 years and younger; QL= 1 inj/8 months for members 9 years and older)	QL-VAC	\$0	VACCINES
FML FORTE OPHTH SUSP	-	2	OPHTHALMIC AGENTS
FOLBEE PLUS CZ TAB	-	1	MULTIVITAMINS
folbee tab	-	1	HEMATOPOIETIC AGENTS
folic acid tab 1mg	-	1	HEMATOPOIETIC AGENTS
fosamprenavir tab (LEXIVA equiv)	-	1	ANTIVIRALS
fosinopril tab (MONOPRIL equiv)	-	1	ANTIHYPERTENSIVES
fosinopril/hydrochlorothiazide tab (MONOPRIL HCT equiv)	-	1	ANTIHYPERTENSIVES
FOSRENOL POWDER PACK	-	2	GASTROINTESTINAL AGENTS - MISC.
FRAGMIN INJ	-	2	ANTICOAGULANTS
FREESTYLE FREEDOM LITE METER	OTC	\$0	MEDICAL DEVICES AND SUPPLIES
FREESTYLE INSULINX METER	OTC	\$0	MEDICAL DEVICES AND SUPPLIES

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
FREESTYLE INSULINX TEST STRIP	OTC	2	DIAGNOSTIC PRODUCTS
FREESTYLE LITE METER	OTC	\$0	MEDICAL DEVICES AND SUPPLIES
FREESTYLE LITE TEST STRIP	OTC	2	DIAGNOSTIC PRODUCTS
FREESTYLE PRECISION NEO METER	OTC	\$0	MEDICAL DEVICES AND SUPPLIES
FREESTYLE PRECISION NEO TEST STRIP	OTC	2	DIAGNOSTIC PRODUCTS
FREESTYLE TEST STRIP	OTC	2	DIAGNOSTIC PRODUCTS
FULPHILA INJ	PA	2	HEMATOPOIETIC AGENTS
FUROSEMIDE SOLN	-	1	DIURETICS
furosemide soln (LASIX equiv)	-	1	DIURETICS
furosemide tab (LASIX equiv)	-	1	DIURETICS
FUZEON INJ	LMSP	2	ANTIVIRALS
gabapentin cap (NEURONTIN equiv)	-	1	ANTICONVULSANTS
gabapentin soln (NEURONTIN equiv)	-	1	ANTICONVULSANTS
gabapentin tab (NEURONTIN equiv)	-	1	ANTICONVULSANTS
galantamine ER cap (RAZADYNE ER equiv)	-	1	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
GALANTAMINE SOLN	-	1	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
galantamine tab (RAZADYNE equiv)	-	1	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
GALZIN CAP	-	2	MINERALS & ELECTROLYTES
GANCICLOVIR CAP	-	2	ANTIVIRALS
gatifloxacin ophth soln (ZYMAXID equiv)	-	1	OPHTHALMIC AGENTS
gemfibrozil tab (LOPID equiv)	-	1	ANTIHYPERLIPIDEMICS
GENOTROPIN INJ	LMSP-PA	2	ENDOCRINE AND METABOLIC AGENTS - MISC.
GENTAK OPHTH OINT	-	1	OPHTHALMIC AGENTS
gentamicin ophth oint (GARAMYCIN equiv)	-	1	OPHTHALMIC AGENTS
gentamicin ophth soln (GARAMYCIN equiv)	-	1	OPHTHALMIC AGENTS
gentamicin sulfate cream	-	1	DERMATOLOGICALS
gentamicin sulfate oint	-	1	DERMATOLOGICALS
genteal ophth oint	OTC	1	OPHTHALMIC AGENTS
GENVOYA TAB	PA	2	ANTIVIRALS
gianvi tab, ocella tab (YASMIN, YAZ equiv)	-	1	CONTRACEPTIVES
GILENYA CAP	LMSP-PA	2	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
glatiramer inj (COPAXONE equiv)	LMSP	1	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
GLEOSTINE/LOMUSTINE CAP	-	2	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
glimepiride tab (AMARYL equiv)	-	1	ANTIDIABETICS
glipizide ER tab (GLUCOTROL XL equiv)	-	1	ANTIDIABETICS
glipizide tab (GLUCOTROL equiv)	-	1	ANTIDIABETICS
glipizide/metformin tab (METAGLIP equiv)	-	1	ANTIDIABETICS
GLUCAGEN HYPOKIT INJ	-	2	ANTIDIABETICS
GLUCAGEN INJ	-	2	DIAGNOSTIC PRODUCTS
GLUCAGON DIAGNOSTIC INJ (QL= 2 inj/fill, 1 fill/30 days)	QL	2	DIAGNOSTIC PRODUCTS
GLUCAGON INJ KIT (QL= 2 inj/fill, 1 fill/30 days)	QL	2	ANTIDIABETICS
GLUCOSE CHEW TAB	OTC	2	ANTIDIABETICS
glucose gel	OTC	1	ANTIDIABETICS
glyburide micronized tab (GLYNASE equiv)	-	1	ANTIDIABETICS
glyburide tab (MICRONASE equiv)	-	1	ANTIDIABETICS
glyburide/metformin tab (GLUCOVANCE equiv)	-	1	ANTIDIABETICS
glycerin supp (GLYCERIN equiv)	OTC	1	LAXATIVES
glycopyrrolate tab (ROBINUL equiv)	-	1	ULCER DRUGS
granisetron tab (KYTRIL equiv) (QL= 14 tabs/fill, 1 fill/30 days)	QL	1	ANTIEMETICS
griseofulvin micro tab (GRIFULVIN V equiv)	-	1	ANTIFUNGALS

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
griseofulvin susp (GRIFULVIN equiv)	-	1	ANTIFUNGALS
griseofulvin tab (GRIS-PEG equiv)	-	1	ANTIFUNGALS
guaifenesin ER tab (MUCINEX equiv)	OTC	1	COUGH / COLD / ALLERGY
guaifenesin syrup 100mg/5ml (ROBITUSSIN equiv)	OTC	1	COUGH / COLD / ALLERGY
GUAIFENESIN/CODEINE SYRUP (QL= 240ml/fill)	OTC-QL	1	COUGH / COLD / ALLERGY
guaifenesin/codeine syrup (TUSSI-ORGANIDIN-S equiv) (QL= 240ml/fill)	OTC-QL	1	COUGH / COLD / ALLERGY
guanfacine ER tab (INTUNIV equiv) (QL= 1 tab/day)	QL	1	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
guanfacine IR tab (TENEX equiv)	-	1	ANTIHYPERTENSIVES
GVOKE PFS INJ (QL= 2 inj/fill)	QL	2	ANTIDIABETICS
HAEGARDA INJ	MSP-PA	2	HEMATOLOGICAL AGENTS - MISC.
halobetasol propionate cream (ULTRAVATE equiv)	-	1	DERMATOLOGICALS
halobetasol propionate oint (ULTRAVATE equiv)	-	1	DERMATOLOGICALS
haloperidol lactate conc (HALDOL equiv)	-	1	ANTIPSYCHOTICS / ANTIMANIC AGENTS
haloperidol tab (HALDOL equiv)	-	1	ANTIPSYCHOTICS / ANTIMANIC AGENTS
HARVONI TAB (QL= 1 tab/ day)	LMSP-PA-QL	2	ANTIVIRALS
HEMLIBRA INJ	LMSP-PA	2	HEMATOLOGICAL AGENTS - MISC.

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
heparin flush	-	1	ANTICOAGULANTS
HEXALEN CAP	-	2	ANTINEOPLASTICS
homatropine ophth soln (ISOPTO HOMATROPINE equiv)	-	1	OPHTHALMIC AGENTS
HOMATROPINE OPHTH SOLN	-	2	OPHTHALMIC AGENTS
HUMIRA INJ 10MG (QL= 2 syringes/28 days)	LMSP-PA-QL	2	ANALGESICS - ANTI-INFLAMMATORY
HUMIRA INJ 20MG (QL= 2 syringes/28 days)	LMSP-PA-QL	2	ANALGESICS - ANTI-INFLAMMATORY
HUMIRA INJ 40MG (QL= 2 syringes/28 days)	LMSP-PA-QL	2	ANALGESICS - ANTI-INFLAMMATORY
HUMIRA INJ CROHNS/UC/HIDRADENITIS STARTER PACK (QL= 1 pack/fill, 1 fill/plan year)	LMSP-PA-QL	2	ANALGESICS - ANTI-INFLAMMATORY
HUMIRA INJ PEDIATRIC CROHNS STARTER PACK (QL= 1 pack/fill, 1 fill/plan year)	LMSP-PA-QL	2	ANALGESICS - ANTI-INFLAMMATORY
HUMIRA INJ PSORIASIS/UVEITIS STARTER PACK (QL= 1 pack/fill, 1 fill/plan year)	LMSP-PA-QL	2	ANALGESICS - ANTI-INFLAMMATORY
HUMIRA PEN INJ 40MG (QL= 2 pens/28 days)	LMSP-PA-QL	2	ANALGESICS - ANTI-INFLAMMATORY
HUMULIN R INJ U-500	-	2	ANTIDIABETICS
HYCAMTIN CAP	LMSP-PA	2	ANTINEOPLASTICS
hydralazine tab (APRESOLINE equiv)	-	1	ANTIHYPERTENSIVES
hydrochlorothiazide cap (MICROZIDE equiv)	-	1	DIURETICS
hydrochlorothiazide tab (HYDRODIURIL equiv)	-	1	DIURETICS

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
hydrocodone/acetaminophen cap (LORCET equiv)	-	1	ANALGESICS - OPIOID
hydrocodone/acetaminophen soln (HYCET, LORTAB equiv)	-	1	ANALGESICS - OPIOID
hydrocodone/acetaminophen tab (LORTAB equiv)	-	1	ANALGESICS - OPIOID
hydrocodone/chlorpheniramine/pseudoephedrine liquid (ZUTRIPRO equiv) (QL= 120ml/fill, 2 fills/month)	QL	1	COUGH / COLD / ALLERGY
hydrocodone/homatropine syrup (HYCODAN equiv)	-	1	COUGH / COLD / ALLERGY
hydrocodone/ibuprofen tab (VICOPROFEN equiv)	-	1	ANALGESICS - OPIOID
hydrocortisone cream	OTC	1	DERMATOLOGICALS
hydrocortisone enema (CORTENEMA equiv)	-	1	ANORECTAL AGENTS
hydrocortisone lotion (HYTONE equiv)	-	1	DERMATOLOGICALS
hydrocortisone oint	OTC	1	DERMATOLOGICALS
hydrocortisone pramoxine cream (PRAMOSONE equiv)	-	1	DERMATOLOGICALS
hydrocortisone supp (ANUSOL HC equiv)	-	2	ANORECTAL AGENTS
hydrocortisone tab (CORTEF equiv)	-	1	CORTICOSTEROIDS
hydromorphone ER tab (EXALGO equiv)	-	1	ANALGESICS - OPIOID
hydromorphone liquid (DILAUDID-5 LIQUID equiv)	-	1	ANALGESICS - OPIOID
HYDROMORPHONE SUPP	-	1	ANALGESICS - OPIOID
hydromorphone tab (DILAUDID equiv)	-	1	ANALGESICS - OPIOID
hydroquinone cream (LUSTRA equiv)	-	EX	DERMATOLOGICALS
hydroxychloroquine tab (PLAQUENIL equiv)	-	1	ANTIMALARIALS

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
hydroxyprogesterone inj (MAKENA equiv)	MSP-PA	1	PROGESTINS
hydroxyurea cap (HYDREA equiv)	-	1	ANTINEOPLASTICS
hydroxyzine pamoate cap (VISTARIL equiv)	-	1	ANTI-ANXIETY AGENTS
hydroxyzine syrup (ATARAX equiv)	-	1	ANTI-ANXIETY AGENTS
hydroxyzine tab (ATARAX equiv)	-	1	ANTI-ANXIETY AGENTS
hyoscyamine sulfate CR tab (LEVBID equiv)	-	1	ULCER DRUGS
hyoscyamine sulfate elixir (LEVSIN equiv)	-	1	ULCER DRUGS
hyoscyamine sulfate ODT (ANASPAZ equiv)	-	1	ULCER DRUGS
hyoscyamine sulfate SL tab (LEVSIN equiv)	-	1	ULCER DRUGS
hyoscyamine sulfate soln (LEVSIN equiv)	-	1	ULCER DRUGS
hyoscyamine sulfate SR cap (LEVSINEX equiv)	-	1	ULCER DRUGS
hyoscyamine tab (LEVSIN equiv)	-	1	URINARY ANTISPASMODICS
ibuprofen cap 200mg	OTC	1	ANALGESICS - ANTI-INFLAMMATORY
ibuprofen chew tab (ADVIL equiv)	OTC	1	ANALGESICS - ANTI-INFLAMMATORY
ibuprofen susp	-	1	ANALGESICS - ANTI-INFLAMMATORY
ibuprofen tab	-	1	ANALGESICS - ANTI-INFLAMMATORY
ibuprofen tab (Rx only)	-	1	ANALGESICS - ANTI-INFLAMMATORY

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
ibuprofen tab 100mg (ADVIL equiv)	OTC	1	ANALGESICS - ANTI-INFLAMMATORY
ibuprofen tab 200mg (ADVIL equiv)	OTC	1	ANALGESICS - ANTI-INFLAMMATORY
icatibant inj (FIRAZYR equiv)	LMSP-PA	1	HEMATOLOGICAL AGENTS - MISC.
imatinib tab (GLEEVEC equiv)	LMSP	1	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
imipramine pamoate cap (TOFRANIL PM equiv)	-	1	ANTIDEPRESSANTS
imipramine tab (TOFRANIL equiv)	-	1	ANTIDEPRESSANTS
imiquimod cream (ALDARA equiv)	-	1	DERMATOLOGICALS
IMPLANON IMPLANT, NEXPLANON IMPLANT	-	\$0	CONTRACEPTIVES
INCRELEX INJ	MSP	2	ENDOCRINE AND METABOLIC AGENTS - MISC.
indapamide tab (LOZOL equiv)	-	1	DIURETICS
indomethacin cap (INDOCIN equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
indomethacin CR cap (INDOCIN SR equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
INSULIN ASPART FLEXPEN INJ (NOVOLOG equiv)	-	1	ANTIDIABETICS
INSULIN ASPART INJ (NOVOLOG equiv)	-	1	ANTIDIABETICS

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
INSULIN ASPART MIX FLEXPEN INJ (NOVOLOG equiv)	-	2	ANTIDIABETICS
INSULIN ASPART MIX INJ (NOVOLOG equiv)	-	2	ANTIDIABETICS
INSULIN ASPART PENFILL INJ (NOVOLOG equiv)	-	1	ANTIDIABETICS
INTELENCE TAB	-	2	ANTIVIRALS
INVEGA INJ	PA	2	ANTIPSYCHOTICS / ANTIMANIC AGENTS
INVIRASE CAP	-	2	ANTIVIRALS
INVIRASE TAB	-	2	ANTIVIRALS
iodoquinol/hydrocortisone cream 1% (VYTONE equiv)	-	1	DERMATOLOGICALS
IOPIDINE OPHTH SOLN 1%	-	2	OPHTHALMIC AGENTS
ipratropium neb soln (ATROVENT equiv)	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
irbesartan tab (AVAPRO equiv)	-	2	ANTIHYPERTENSIVES
irbesartan/hydrochlorothiazide tab (AVALIDE equiv)	-	1	ANTIHYPERTENSIVES
iron complex cap 150mg	OTC	1	HEMATOPOIETIC AGENTS
ISENTRESS (HD) TAB	-	2	ANTIVIRALS
ISENTRESS CHEW TAB	-	2	ANTIVIRALS
ISENTRESS POWDER PACK	-	2	ANTIVIRALS
isibloom tab, enskyce tab, apri tab (DESOGEN equiv)	-	1	CONTRACEPTIVES

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
ISONIAZID SYRUP	-	1	ANTIMYCOBACTERIAL AGENTS
isoniazid tab	-	1	ANTIMYCOBACTERIAL AGENTS
ISOPTO CARBACHOL OPHTH SOLN	-	2	OPHTHALMIC AGENTS
ISOPTO HYOSCINE OPHTH SOLN	-	2	OPHTHALMIC AGENTS
isosorbide dinitrate ER tab (ISOCHRON equiv)	-	1	ANTIANGINAL AGENTS
isosorbide dinitrate SL tab	-	1	ANTIANGINAL AGENTS
isosorbide dinitrate tab (ISORDIL equiv)	-	1	ANTIANGINAL AGENTS
isosorbide mononitrate ER tab (IMDUR equiv)	-	1	ANTIANGINAL AGENTS
isosorbide mononitrate tab (MONOKET equiv)	-	1	ANTIANGINAL AGENTS
isoxsuprine tab	-	1	CARDIOVASCULAR AGENTS - MISC.
isradipine cap (DYNACIRC equiv)	-	1	CALCIUM CHANNEL BLOCKERS
ISTALOL OPHTH SOLN	-	2	OPHTHALMIC AGENTS
itraconazole cap (SPORANOX equiv)	PA	1	ANTIFUNGALS
ivermectin tab (STROMEKTOL equiv)	-	1	ANTHELMINTICS
JADENU SPRINKLE	LMSP	2	ANTIDOTES AND SPECIFIC ANTAGONISTS
JANUMET XR TAB	-	2	ANTIDIABETICS
jinteli tab (FEMHRT equiv)	-	1	ESTROGENS
junel FE tab (LOESTRIN FE equiv)	-	1	CONTRACEPTIVES
junel tab (LOESTRIN equiv)	-	1	CONTRACEPTIVES

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
KALETRA TAB	-	2	ANTIVIRALS
KALYDECO PAK (QL= 2 packets/day; Only available through Maxor Pharmacy 800-658-6046 or Walgreens 888-347-3416)	LD-PA-QL	2	RESPIRATORY AGENTS - MISC.
KALYDECO TAB (QL= 2 tabs/day; Only available through Maxor Pharmacy 800-658-6046 or Walgreens 888-347-3416)	LD-PA-QL	2	RESPIRATORY AGENTS - MISC.
kelnor tab (DEMULEN equiv)	-	1	CONTRACEPTIVES
ketoconazole cream (NIZORAL CREAM equiv)	-	1	DERMATOLOGICALS
ketoconazole shampoo (NIZORAL SHAMPOO equiv)	-	1	DERMATOLOGICALS
ketoconazole tab (NIZORAL equiv)	-	1	ANTIFUNGALS
KETO-DIASTIX TEST STRIP	OTC	1	DIAGNOSTIC PRODUCTS
ketorolac ophth soln (ACULAR (LS) equiv)	-	1	OPHTHALMIC AGENTS
ketorolac tab (TORADOL equiv) (QL= 20 tabs/5 days)	QL	1	ANALGESICS - ANTI-INFLAMMATORY
KETOSTIX	OTC	1	DIAGNOSTIC PRODUCTS
ketotifen ophth soln (ZADITOR equiv) (QL= 2 bottles/30 days)	OTC-QL	1	OPHTHALMIC AGENTS
KEVZARA INJ (QL= 2 inj/28 days)	LMSP-PA-QL	2	ANALGESICS - ANTI-INFLAMMATORY
KINERET INJ (Only available through Biologics 800-850-4306)	LD-PA	2	ANALGESICS - ANTI-INFLAMMATORY
KITABIS PAK NEB SOLN	MSP	2	AMINOGLYCOSIDES

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier Category
KLOR-CON M15 TAB	-	2 MINERALS & ELECTROLYTES
K-PHOS TAB	-	2 MINERALS & ELECTROLYTES
K-TAB	-	1 MINERALS & ELECTROLYTES
KYTRIL TAB (QL= 14 tabs/fill, 1 fill/30 days)	QL	2+p ANTIEMETICS enal ty
labetalol tab (NORMODYNE equiv)	-	1 BETA BLOCKERS
lactulose soln	-	1 LAXATIVES
LAMICTAL CHEW TAB 2MG	-	2 ANTICONVULSANTS
lamivudine soln (EPIVIR equiv)	-	1 ANTIVIRALS
lamivudine tab (EPIVIR equiv)	-	2 ANTIVIRALS
lamivudine tab 100mg (EPIVIR HBV equiv)	-	2 ANTIVIRALS
lamivudine/zidovudine tab (COMBIVIR equiv)	-	1 ANTIVIRALS
lamotrigine chew tab (LAMICTAL equiv)	-	1 ANTICONVULSANTS
lamotrigine ER tab (LAMICTAL XR equiv)	-	2 ANTICONVULSANTS
lamotrigine ODT (LAMICTAL equiv)	-	1 ANTICONVULSANTS
lamotrigine ODT kit (LAMICTAL ODT KIT equiv)	-	1 ANTICONVULSANTS
lamotrigine tab (LAMICTAL equiv)	-	1 ANTICONVULSANTS
LANCET KIT	OTC	1 MEDICAL DEVICES AND SUPPLIES

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
LANCETS	OTC	1	MEDICAL DEVICES AND SUPPLIES
lansoprazole cap 15mg (PREVACID equiv) (QL= 2 caps/day)	OTC-QL	1	ULCER DRUGS
lansoprazole odt (PREVACID SOLUTAB equiv) (QL= 2 tabs/day)	QL	1	ULCER DRUGS / ANTISPASMODICS / ANTICHOLINERGICS
lansoprazole/amoxicillin/clarithromycin kit (PREVPAC equiv)	-	1	ULCER DRUGS
LANTUS INJ	-	2	ANTIDIABETICS
LANTUS SOLOSTAR INJ	-	2	ANTIDIABETICS
latanoprost ophth soln (XALATAN equiv) (QL= 2.5ml/30 days)	QL	1	OPHTHALMIC AGENTS
LATUDA TAB (QL= 1 tab/day; Step Therapy requires trial of quetiapine)	QL-ST	2	ANTIPSYCHOTICS / ANTIMANIC AGENTS
LEDIPASVIR/SOFOSBUVIR TAB (QL= 1 tab/ day)	LMSP-PA-QL	2	ANTIVIRALS
leflunomide tab (ARAVA equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
letrozole tab (FEMARA equiv)	-	1	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
leucovorin tab	-	1	ANTINEOPLASTICS
LEUKERAN TAB	-	2	ANTINEOPLASTICS
LEUKINE INJ	LMSP-PA	2	HEMATOPOIETIC AGENTS

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
levalbuterol neb soln (XOPENEX equiv) (Step Therapy requires trial of albuterol neb)	ST	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
LEVEMIR FLEXTOUCH INJ	-	2	ANTIDIABETICS
LEVEMIR INJ	-	2	ANTIDIABETICS
levetiracetam soln (KEPPRA equiv)	-	1	ANTICONVULSANTS
levetiracetam tab (KEPPRA equiv)	-	1	ANTICONVULSANTS
LEVOBUNOLOL OPHTH SOLN	-	1	OPHTHALMIC AGENTS
levobunolol ophth soln (BETAGAN equiv)	-	1	OPHTHALMIC AGENTS
levocarnitine soln (CARNITOR equiv)	-	1	ENDOCRINE AND METABOLIC AGENTS - MISC.
levocarnitine tab (CARNITOR equiv)	-	1	ENDOCRINE AND METABOLIC AGENTS - MISC.
levofloxacin ophth soln (QUIXIN equiv)	-	1	OPHTHALMIC AGENTS
levofloxacin soln (LEVAQUIN equiv)	-	1	FLUOROQUINOLONES
levofloxacin tab (LEVAQUIN equiv)	-	1	FLUOROQUINOLONES
levonorgestrel tab (PLAN B equiv)	OTC	1	CONTRACEPTIVES
LEVONORGESTREL TAB 0.75MG	-	2	CONTRACEPTIVES
LEVORPHANOL TAB	-	1	ANALGESICS - OPIOID
levorphanol tab (LEVORPHANOL equiv)	-	1	ANALGESICS - OPIOID
levothyroxine tab (SYNTHROID equiv)	-	1	THYROID AGENTS
LEXIVA SUSP	-	2	ANTIVIRALS

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
lice aerosol (QL= 150ml/7 days, Limited to 2 fills/year)	OTC-QL	1	DERMATOLOGICALS
lice cream rinse (NIX equiv) (QL= 59ml/7 days, Limited to 2 fills/year)	OTC-QL	1	DERMATOLOGICALS
lice treatment kit (RID equiv)	OTC	1	DERMATOLOGICALS
lice treatment liquid (RID equiv) (QL= 120ml/7 days, Limited to 2 fills/year)	OTC-QL	1	DERMATOLOGICALS
lice treatment shampoo (PRONTO equiv) (QL= 120ml/7 days, Limited to 2 fills/year)	OTC-QL	1	DERMATOLOGICALS
lidocaine cream 3% (LIDAMANTLE equiv)	-	1	DERMATOLOGICALS
LIDOCAINE GEL	-	1	DERMATOLOGICALS
lidocaine gel (GLYDO equiv)	-	1	DERMATOLOGICALS
lidocaine gel (XYLOCAINE equiv)	-	1	DERMATOLOGICALS
lidocaine oint (QL= 107gm/30 days)	QL	1	DERMATOLOGICALS
LIDOCAINE ORAL SOLN 4%	-	2	MOUTH / THROAT / DENTAL AGENTS
lidocaine soln (XYLOCAINE equiv)	-	1	DERMATOLOGICALS
lidocaine viscous soln	-	1	MOUTH / THROAT / DENTAL AGENTS
lidocaine/hydrocortisone cream (ANAMANTLE equiv)	-	1	ANORECTAL AGENTS
lidocaine/prilocaine cream (EMLA equiv)	-	1	DERMATOLOGICALS
lindane lotion	-	1	DERMATOLOGICALS
LINDANE SHAMPOO	-	1	DERMATOLOGICALS

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
linezolid susp (Restricted to Infectious Disease Specialist)	RS	1	ANTI-INFECTIVE AGENTS MISC.
linezolid tab (ZYVOX equiv) (Restricted to Infectious Disease Specialist)	RS	1	ANTI-INFECTIVE AGENTS MISC.
liothyronine tab (CYTOMEL equiv)	-	1	THYROID AGENTS
lisinopril tab (PRINIVIL/ZESTRIL equiv)	-	1	ANTIHYPERTENSIVES
lisinopril/hydrochlorothiazide tab (ZESTORETIC equiv)	-	1	ANTIHYPERTENSIVES
lithium carbonate cap (ESKALITH ER equiv)	-	1	ANTIPSYCHOTICS / ANTIMANIC AGENTS
lithium carbonate ER tab (LITHOBID equiv)	-	1	ANTIPSYCHOTICS / ANTIMANIC AGENTS
lithium carbonate tab	-	1	ANTIPSYCHOTICS / ANTIMANIC AGENTS
lithium citrate soln	-	1	ANTIPSYCHOTICS / ANTIMANIC AGENTS
lopinavir/ritonavir soln (KALETRA equiv)	-	1	ANTIVIRALS
loratadine chew tab (CLARITIN equiv)	OTC	1	ANTIHISTAMINES
loratadine ODT (CLARITIN equiv)	OTC	1	ANTIHISTAMINES
loratadine syrup (CLARITIN equiv) (QL= 250ml/30 day)	OTC-QL	1	ANTIHISTAMINES
loratadine tab (CLARITIN equiv) (QL= 1 tab/day)	OTC-QL	1	ANTIHISTAMINES
loratadine/pseudoephedrine 12-hour tab (CLARITIN-D equiv)	OTC	1	COUGH / COLD / ALLERGY

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
loratadine/pseudoephedrine 24-hour tab (CLARITIN-D equiv)	OTC	1	COUGH / COLD / ALLERGY
lorazepam conc (ATIVAN equiv)	-	1	ANTIANKXIETY AGENTS
lorazepam tab (ATIVAN equiv)	-	1	ANTIANKXIETY AGENTS
losartan tab (COZAAR equiv)	-	1	ANTIHYPERTENSIVES
losartan/hydrochlorothiazide tab (HYZAAR equiv)	-	1	ANTIHYPERTENSIVES
LOTEMAX OPHTH GEL	-	2	OPHTHALMIC AGENTS
LOTEMAX OPHTH OINT	-	2	OPHTHALMIC AGENTS
loteprednol ophth susp (LOTEMAX equiv)	-	1	OPHTHALMIC AGENTS
lovastatin tab (MEVACOR equiv)	-	1	ANTIHYPERLIPIDEMICS
loxapine cap (LOXITANE equiv)	-	1	ANTIPSYCHOTICS / ANTIMANIC AGENTS
LUMIGAN OPHTH SOLN (QL= 2.5ml/30 days)	QL	2	OPHTHALMIC AGENTS
LUVOX CR CAP	-	2+p	ANTIDEPRESSANTS
LYSODREN TAB (Only available through Direct Success 732-919-1234)	LD	2	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
mafenide acetate soln packet (SULFAMYLON equiv)	-	2	DERMATOLOGICALS
malathion lotion (OVIDE equiv) (QL= 1 bottle/30 days; Limited to 2 fills/year)	QL	1	DERMATOLOGICALS
maldemar tab (SCOPACE equiv)	-	1	ANTIEMETICS
MAPROTILINE TAB	-	1	ANTIDEPRESSANTS

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
MARPLAN TAB	-	2	ANTIDEPRESSANTS
MATULANE CAP	-	2	ANTINEOPLASTICS
MAVYRET TAB (QL= 3 tabs/day)	LMSP-PA-QL	2	ANTIVIRALS
MAXIDEX OPHTH SOLN	-	2	OPHTHALMIC AGENTS
MAYZENT TAB	LMSP	2	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
MAYZENT TAB STARTER PACK	LMSP	2	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
meclizine chew tab (BONINE equiv)	OTC	1	ANTIEMETICS
meclizine tab (ANTIVERT equiv)	OTC	1	ANTIEMETICS
medroxyprogesterone inj (DEPO-PROVERA equiv) (QL= 1 inj/90 days)	QL	1	CONTRACEPTIVES
medroxyprogesterone tab (PROVERA equiv)	-	1	PROGESTINS
megestrol ES susp (MEGACE ES equiv)	-	1	PROGESTINS
megestrol susp (MEGACE equiv)	-	1	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
megestrol tab (MEGACE equiv)	-	1	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
meloxicam tab (MOBIC equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
MEPERIDINE TAB	-	1	ANALGESICS - OPIOID
meperidine tab (DEMEROL equiv)	-	1	ANALGESICS - OPIOID

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
mercaptapurine tab (PURINETHOL equiv)	-	1	ANTINEOPLASTICS
mesalamine DR tab (LIALDA equiv)	-	1	GASTROINTESTINAL AGENTS - MISC.
mesalamine enema (ROWASA equiv)	-	1	GASTROINTESTINAL AGENTS - MISC.
mesna inj (MESNEX equiv)	-	1	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
MESNEX TAB	LMSP	2	ANTINEOPLASTICS
METAPROTERENOL SYRUP	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
metformin ER tab (GLUCOPHAGE XR equiv)	-	1	ANTIDIABETICS
metformin tab (GLUCOPHAGE equiv)	-	1	ANTIDIABETICS
methadone soln	-	1	ANALGESICS - OPIOID
methadone tab (DOLOPHINE equiv)	-	1	ANALGESICS - OPIOID
methadose tab	-	1	ANALGESICS - OPIOID
methazolamide tab (NEPTAZANE equiv)	-	1	DIURETICS
methenamine hippurate tab (HIPREX equiv)	-	1	URINARY ANTI-INFECTIVES
methenamine mandelate tab	-	1	URINARY ANTI-INFECTIVES
methimazole tab (TAPAZOLE equiv)	-	1	THYROID AGENTS
methocarbamol tab (ROBAXIN equiv)	-	1	MUSCULOSKELETAL THERAPY AGENTS

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
METHOTREXATE INJ	-	1	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
methotrexate tab (Trexall equiv)	-	1	ANTINEOPLASTICS
methoxsalen cap (Oxsoralen Ultra equiv)	-	1	DERMATOLOGICALS
methscopolamine tab (Pamine equiv)	-	1	ULCER DRUGS
METHYCLOTHIAZIDE TAB	-	1	DIURETICS
methyldopa tab (Aldomet equiv)	-	1	ANTIHYPERTENSIVES
METHYLDOPA/HYDROCHLOROTHIAZIDE TAB	-	1	ANTIHYPERTENSIVES
methylergonovine tab (Methergine equiv) (QL= 28 tabs/fill; 1 fill/365 days)	QL	2	OXYTOCICS
methylphenidate CD cap (Metadate CD equiv)	-	1	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
methylphenidate ER tab	-	1	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
methylphenidate ER tab (QL= 1 tab/day)	--QL	1	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
METHYLPHENIDATE ER TAB (QL= 1 tab/day)	--QL	2	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
methylphenidate ER tab 36mg (QL= 2 tabs/day)	-	1	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
methylphenidate soln (METHYLIN equiv)	-	1	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
methylphenidate tab (RITALIN equiv)	-	1	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
methylprednisolone dose pack (MEDROL equiv)	-	1	CORTICOSTEROIDS
methylprednisolone tab (MEDROL equiv)	-	1	CORTICOSTEROIDS
METIPRANOLOL OPHTH SOLN	-	2	OPHTHALMIC AGENTS
metoclopramide soln (REGLAN equiv)	-	1	GASTROINTESTINAL AGENTS - MISC.
metoclopramide tab (REGLAN equiv)	-	1	GASTROINTESTINAL AGENTS - MISC.
metolazone tab (ZAROXOLYN equiv)	-	1	DIURETICS

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
metoprolol ER tab (TOPROL XL equiv)	-	1	BETA BLOCKERS
metoprolol tab (LOPRESSOR equiv)	-	1	BETA BLOCKERS
METOPROLOL/HYDROCHLOROTHIAZIDE TAB	-	1	ANTIHYPERTENSIVES
metoprolol/hydrochlorothiazide tab (LOPRESSOR HCT equiv)	-	1	ANTIHYPERTENSIVES
metronidazole cap (FLAGYL equiv)	-	1	ANTI-INFECTIVE AGENTS MISC.
metronidazole cream (METROCREAM equiv)	-	1	DERMATOLOGICALS
metronidazole gel (METROGEL equiv)	-	1	DERMATOLOGICALS
metronidazole lotion (METROLOTION equiv)	-	1	DERMATOLOGICALS
metronidazole tab (FLAGYL equiv)	-	1	ANTI-INFECTIVE AGENTS MISC.
metronidazole vaginal gel (METROGEL equiv)	-	1	VAGINAL PRODUCTS
MEXILETINE CAP	-	2	ANTIARRHYTHMICS
MIACALCIN INJ	LMSP	2	ENDOCRINE AND METABOLIC AGENTS - MISC.
MIACALCIN NASAL SPRAY (QL= 1 bottle/30 days	QL	2	ENDOCRINE AND METABOLIC AGENTS - MISC.
mibelas chew tab (MINASTRIN equiv)	-	1	CONTRACEPTIVES
miconazole 7 supp (MONISTAT equiv)	OTC	1	VAGINAL PRODUCTS
miconazole cream (MICATIN equiv)	OTC	1	DERMATOLOGICALS
miconazole nitrate aerosol (MICATIN equiv)	OTC	1	DERMATOLOGICALS

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
miconazole nitrate powder (MICATIN equiv)	OTC	1	DERMATOLOGICALS
MICONAZOLE NITRATE SPRAY	OTC	2	DERMATOLOGICALS
miconazole vaginal cream (MONISTAT equiv)	OTC	1	VAGINAL PRODUCTS
miconazole vaginal kit (MONISTAT equiv)	OTC	1	VAGINAL PRODUCTS
midodrine tab (PROAMATINE equiv)	-	1	VASOPRESSORS
MIGERGOT SUPP	-	2	MIGRAINE PRODUCTS
miglitol tab (GLYSET equiv)	-	1	ANTIDIABETICS
miglustat cap (ZAVESCA equiv) (Only available through Accredo 888-773-7376)	LD-PA	1	HEMATOPOIETIC AGENTS
milk of magnesium	OTC	1	LAXATIVES
minocycline cap (MINOCIN equiv)	-	1	TETRACYCLINES
minocycline tab (DYNACIN equiv)	-	1	TETRACYCLINES
minoxidil tab (LONITEN equiv)	-	1	ANTIHYPERTENSIVES
MIRENA IUD	-	\$0	CONTRACEPTIVES
mirtazapine ODT (REMERON equiv)	-	1	ANTIDEPRESSANTS
mirtazapine tab (REMERON equiv)	-	1	ANTIDEPRESSANTS
misoprostol tab (CYTOTEC equiv)	-	1	ULCER DRUGS
modafinil tab (PROVIGIL equiv) (QL= 2 tabs/day)	PA-QL	1	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
moexipril tab (UNIVASC equiv)	-	1	ANTIHYPERTENSIVES
MOEXIPRIL/HYDROCHLOROTHIAZIDE TAB	-	1	ANTIHYPERTENSIVES
moexipril/hydrochlorothiazide tab (UNIRETIC equiv)	-	1	ANTIHYPERTENSIVES

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
mometasone cream (ELOCON equiv)	-	1	DERMATOLOGICALS
mometasone nasal spray (NASONEX equiv)	-	1	NASAL AGENTS - SYSTEMIC AND TOPICAL
mometasone oint (ELOCON equiv)	-	1	DERMATOLOGICALS
mometasone soln (ELOCON equiv)	-	1	DERMATOLOGICALS
montelukast chew tab (SINGULAIR equiv)	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
montelukast tab (SINGULAIR equiv)	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
morphine sulfate ER tab (MS CONTIN equiv)	-	1	ANALGESICS - OPIOID
morphine sulfate soln	-	1	ANALGESICS - OPIOID
MORPHINE SULFATE SUPP	-	1	ANALGESICS - OPIOID
MORPHINE SULFATE TAB	-	1	ANALGESICS - OPIOID
MOVIPREP SOLN (QL= 1 bottle/fill)	QL	2	LAXATIVES
moxifloxacin ophth soln (VIGAMOX OPHTH SOLN equiv)	-	1	OPHTHALMIC AGENTS
moxifloxacin tab (AVELOX equiv)	-	1	FLUOROQUINOLONES
MULTIGEN FOLIC TAB	-	1	HEMATOPOIETIC AGENTS
MULTIGEN PLUS TAB	-	1	HEMATOPOIETIC AGENTS
MULTIGEN TAB	-	1	HEMATOPOIETIC AGENTS
multiple vitamin liquid	OTC	1	MULTIVITAMINS
multivitamin/minerals tab (STROVITE equiv)	-	1	MULTIVITAMINS

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
mupirocin oint (BACTROBAN OINT equiv)	-	1	DERMATOLOGICALS
mycophenolate DR tab (MYFORTIC equiv)	-	1	ASSORTED CLASSES
mycophenolate mofetil cap (CELLCEPT equiv)	-	1	ASSORTED CLASSES
mycophenolate mofetil susp (CELLCEPT SUSP equiv)	-	1	ASSORTED CLASSES
mycophenolate mofetil tab (CELLCEPT equiv)	-	1	ASSORTED CLASSES
MYLERAN TAB	LMSP	2	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
nabumetone tab (RELAFEN equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
nadolol tab (CORGARD equiv)	-	1	BETA BLOCKERS
nadolol/bendroflumethiazide tab (CORZIDE equiv)	-	1	ANTIHYPERTENSIVES
naftifine cream (NAFTIN equiv)	-	1	DERMATOLOGICALS
naloxone inj	-	1	ANTIDOTES AND SPECIFIC ANTAGONISTS
naloxone prefilled inj (QL= 2 inj/fill)	QL	1	ANTIDOTES AND SPECIFIC ANTAGONISTS
NALOXONE PREFILLED INJ (QL= 2 inj/fill)	QL	2	ANTIDOTES AND SPECIFIC ANTAGONISTS
naltrexone tab (REVIA equiv)	-	1	ANTIDOTES
naproxen EC tab (NAPROSYN EC equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
naproxen sodium tab (ANAPROX equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
naproxen sodium tab 220mg (ALEVE equiv)	OTC	1	ANALGESICS - ANTI-INFLAMMATORY
naproxen tab (NAPROSYN equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
naratriptan tab (AMERGE equiv) (QL= 9 tabs/30 days)	QL	1	MIGRAINE PRODUCTS
NARCAN NASAL SPRAY	-	2	ANTIDOTES
nateglinide tab (STARLIX equiv)	-	1	ANTIDIABETICS
NEBUSAL NEB SOLN	-	2	COUGH / COLD / ALLERGY
NECON TAB	-	1	CONTRACEPTIVES
NEFAZODONE TAB	-	1	ANTIDEPRESSANTS
nefazodone tab 50mg, 250mg	-	1	ANTIDEPRESSANTS
neomycin tab	-	1	AMINOGLYCOSIDES
neomycin/bacitracin/polymyxin oint (NEOSPORIN equiv)	OTC	1	DERMATOLOGICALS
NEOMYCIN/POLYMIXIN/GRAMICIDIN OPHTH SOLN	-	1	OPHTHALMIC AGENTS
neomycin/polymixin/hydrocortisone otic soln (CORTISPORIN equiv)	-	1	OTIC AGENTS
neomycin/polymixin/hydrocortisone otic susp (CORTISPORIN equiv)	-	1	OTIC AGENTS
neomycin/polymyxin/dexamethasone ophth oint (MAXITROL equiv)	-	1	OPHTHALMIC AGENTS

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
neomycin/polymyxin/dexamethasone ophth soln (MAXITROL equiv)	-	1	OPHTHALMIC AGENTS
NEOMYCIN/POLYMYXIN/HYDROCORTISONE OPHTH SOLN	-	1	OPHTHALMIC AGENTS
NEORAL SOLN	-	2	ASSORTED CLASSES
NEPHRON FA TAB	-	2	HEMATOPOIETIC AGENTS
NEVIRAPINE ER TAB	-	1	ANTIVIRALS
nevirapine ER tab (VIRAMUNE XR equiv)	-	1	ANTIVIRALS
nevirapine susp (VIRAMUNE equiv)	-	1	ANTIVIRALS
NEVIRAPINE SUSP (VIRAMUNE equiv)	-	2	ANTIVIRALS
nevirapine tab (VIRAMUNE equiv)	-	1	ANTIVIRALS
niacin cap	OTC	1	VITAMINS
niacin CR tab (SLO-NIACIN equiv)	OTC	1	VITAMINS
niacin ER tab (NIASPAN equiv)	-	1	ANTIHYPERLIPIDEMICS
niacin tab	OTC	1	VITAMINS
niacinamide tab	OTC	1	VITAMINS
nicotine patch (NICODERM equiv) (QL= 1 patch/day, Limited to 3 months per calendar year)	OTC-QL-SMKG	1	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
NICOTROL INHALER	-	2	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
NICOTROL NASAL SPRAY	-	2	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
nifedipine cap (PROCARDIA equiv)	-	1	CALCIUM CHANNEL BLOCKERS
nifedipine ER tab (ADALAT CC equiv)	-	1	CALCIUM CHANNEL BLOCKERS
nilutamide tab (NILANDRON equiv)	LMSP	1	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
nimodipine cap (NIMOTOP equiv)	-	1	CALCIUM CHANNEL BLOCKERS
NITRO-DUR PATCH 0.3MG/HR, 0.8MG/HR	-	2	ANTIANGINAL AGENTS
nitrofurantoin macrocrystals cap (MACRODANTIN equiv)	-	1	URINARY ANTI-INFECTIVES
nitrofurantoin macrocrystals cap 25mg (MACRODANTIN equiv)	-	1	URINARY ANTI-INFECTIVES
nitrofurantoin monohydrate cap (MACROBID equiv)	-	1	URINARY ANTI-INFECTIVES
nitrofurantoin susp (FURADANTIN equiv)	-	1	URINARY ANTI-INFECTIVES
NITROGLYCERIN ER CAP	-	1	ANTIANGINAL AGENTS
nitroglycerin lingual spray (NITROLINGUAL equiv)	-	1	ANTIANGINAL AGENTS
nitroglycerin patch (NITRO-DUR equiv)	-	1	ANTIANGINAL AGENTS
nitroglycerin SL tab (NITROSTAT equiv)	-	1	ANTIANGINAL AGENTS

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
NIVESTYM INJ	LMSP	2	HEMATOPOIETIC AGENTS
NIZATIDINE CAP	-	2	ULCER DRUGS / ANTISPASMODICS / ANTICHOLINERGICS
nizatidine cap (AXID equiv)	-	2	ULCER DRUGS
norethindrone tab (AYGESTIN equiv)	-	1	PROGESTINS
norethindrone tab (NORA-QD equiv)	-	1	CONTRACEPTIVES
NORPACE CR CAP	-	2	ANTIARRHYTHMICS
nortrel 7/7/7 tab, pirmella 7/7/7 tab (TRI-NORINYL equiv)	-	1	CONTRACEPTIVES
nortrel tab (OVCON 35 equiv)	-	1	CONTRACEPTIVES
nortriptyline cap (PAMELOR equiv)	-	1	ANTIDEPRESSANTS
nortriptyline oral soln (NORTRIPTYLINE equiv)	-	1	ANTIDEPRESSANTS
NORTRIPTYLINE SOLN	-	1	ANTIDEPRESSANTS
NORVIR CAP	-	2	ANTIVIRALS
NORVIR POWDER PACK	-	2	ANTIVIRALS
NORVIR SOLN	-	2	ANTIVIRALS
NOVOFINE PEN NEEDLE	OTC	1	MEDICAL DEVICES AND SUPPLIES
NOVOLIN 70/30 FLEXPEN INJ	OTC	2	ANTIDIABETICS
NOVOLIN INJ	OTC	2	ANTIDIABETICS
NOVOLIN N FLEXPEN INJ	OTC	2	ANTIDIABETICS
NOVOLOG FLEXPEN INJ	-	1	ANTIDIABETICS
NOVOLOG INJ	-	1	ANTIDIABETICS

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
NOVOLOG MIX FLEXPEN INJ	-	2	ANTIDIABETICS
NOVOLOG MIX INJ	-	2	ANTIDIABETICS
NOVOLOG PENFILL INJ	-	1	ANTIDIABETICS
NOVOTWIST PEN NEEDLE	OTC	1	MEDICAL DEVICES AND SUPPLIES
NOVOTWIST/NOVOFINE PEN NEEDLE	OTC	1	MEDICAL DEVICES AND SUPPLIES
np thyroid tab (ARMOUR THYROID, NATURE THROID equiv)	-	1	THYROID AGENTS
NUCALA INJ (QL= 1 inj/28 days)	LMSP-PA-QL	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
NUVARING	-	1	CONTRACEPTIVES
nystatin cream (MYCOSTATIN CREAM equiv)	-	1	DERMATOLOGICALS
nystatin oint	-	1	DERMATOLOGICALS
nystatin powder	-	1	ANTIFUNGALS
nystatin susp	-	1	MOUTH / THROAT / DENTAL AGENTS
nystatin tab	-	1	ANTIFUNGALS
nystatin topical powder	-	1	DERMATOLOGICALS
NYSTATIN VAGINAL TAB	-	1	VAGINAL PRODUCTS
octreotide inj (SANDOSTATIN equiv)	LMSP	1	ENDOCRINE AND METABOLIC AGENTS - MISC.

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
ofloxacin ophth soln (OCUFLOX equiv)	-	1	OPHTHALMIC AGENTS
ofloxacin otic soln (FLOXIN equiv)	-	1	OTIC AGENTS
ofloxacin tab (FLOXIN equiv)	-	1	FLUOROQUINOLONES
olanzapine ODT (ZYPREXA equiv) (QL= 1 tab/day)	QL	2	ANTIPSYCHOTICS / ANTIMANIC AGENTS
olanzapine tab (ZYPREXA equiv) (QL= 1 tab/day)	QL	1	ANTIPSYCHOTICS / ANTIMANIC AGENTS
olanzapine tab 10mg (ZYPREXA equiv) (QL= 2 tabs/day)	QL	2	ANTIPSYCHOTICS / ANTIMANIC AGENTS
olanzapine/fluoxetine cap (SYMBYAX equiv)	-	1	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
olmesartan tab (BENICAR equiv)	-	1	ANTIHYPERTENSIVES
olmesartan/hydrochlorothiazide tab (BENICAR HCT equiv)	-	1	ANTIHYPERTENSIVES
olopatadine ophth soln 0.1% (PATANOL equiv)	-	1	OPHTHALMIC AGENTS
olopatadine ophth soln 0.2% (PATADAY equiv) (QL= 2.5ml/30 days)	QL	1	OPHTHALMIC AGENTS
OLUX FOAM	PA	2+p	DERMATOLOGICALS enal ty
omega-3-acid ethyl esters cap (LOVAZA equiv)	-	1	ANTIHYPERLIPIDEMICS
omeprazole DR cap (PRILOSEC equiv)	-	1	ULCER DRUGS
ondansetron ODT (ZOFTRAN equiv)	-	1	ANTIEMETICS

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
ondansetron soln (ZOFTRAN equiv)	-	1	ANTIEMETICS
ONDANSETRON TAB	-	1	ANTIEMETICS
ondansetron tab (ZOFTRAN equiv)	-	1	ANTIEMETICS
opium tincture	-	1	ANTIDIARRHEALS
OPSUMIT TAB (QL= 1 tab/day; Only available through CVS Specialty 800-237-2767)	LD-PA-QL	2	CARDIOVASCULAR AGENTS - MISC.
ORACIT SOLN	-	1	GENITOURINARY AGENTS - MISCELLANEOUS
ORENCIA CLICK INJ (QL= 4 inj/28 days)	LMSP-PA-QL	2	ANALGESICS - ANTI-INFLAMMATORY
ORENCIA SC INJ 125MG/ML (QL= 4 inj/28 days)	LMSP-PA-QL	2	ANALGESICS - ANTI-INFLAMMATORY
ORENCIA SC INJ 50MG/0.4ML (QL= 4 inj/28 days)	LMSP-PA-QL	2	ANALGESICS - ANTI-INFLAMMATORY
ORENCIA SC INJ 87.5MG/0.7ML (QL= 4 inj/28 days)	LMSP-PA-QL	2	ANALGESICS - ANTI-INFLAMMATORY
ORKAMBI GRANULES PACKET (QL= 2 packets/day; Only available through Maxor Pharmac 800-658-6046 or Walgreens 888-347-3416)	LD-PA-QL	2	RESPIRATORY AGENTS - MISC.
ORKAMBI TAB (QL= 4 tabs/day; Only available through Maxor Pharmacy 800-658-6046 or Walgreens 888-347-3416)	LD-PA-QL	2	RESPIRATORY AGENTS - MISC.
orphenadrine citrate ER tab (NORFLEX equiv)	-	1	MUSCULOSKELETAL THERAPY AGENTS

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
orphenadrine/aspirin/caffeine tab (NORGESIC FORTE equiv)	-	1	MUSCULOSKELETAL THERAPY AGENTS
oseltamivir cap (TAMIFLU equiv) (QL= 10 caps/fill)	QL	1	ANTIVIRALS
oseltamivir cap 30mg (TAMIFLU equiv) (QL= 20 caps/fill)	QL	1	ANTIVIRALS
oseltamivir susp (TAMIFLU equiv) (QL= 250ml/fill)	QL	1	ANTIVIRALS
OTEZLA STARTER PACK (QL= 1 pack/28 days)	LMSP-PA-QL	2	ANALGESICS - ANTI-INFLAMMATORY
OTEZLA TAB (QL= 2 tabs/day)	LMSP-PA-QL	2	ANALGESICS - ANTI-INFLAMMATORY
oxandrolone tab (OXANDRIN equiv)	-	1	ANDROGENS-ANABOLIC
oxaprozin tab (DAYPRO equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
oxcarbazepine susp (TRILEPTAL equiv)	-	1	ANTICONVULSANTS
oxcarbazepine tab (TRILEPTAL equiv)	-	1	ANTICONVULSANTS
OXERVATE OPHTH SOLN (QL= 8 kits/affected eye/lifetime; Only available through Accredo 888-773-7376)	LD-PA-QL	2	OPHTHALMIC AGENTS
oxiconazole nitrate cream (OXISTAT equiv)	-	1	DERMATOLOGICALS
oxybutynin ER tab (DITROPAN XL equiv)	-	1	URINARY ANTISPASMODICS
oxybutynin syrup	-	1	URINARY ANTISPASMODICS

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
oxybutynin tab (DITROPAN equiv)	-	1	URINARY ANTISPASMODICS
oxycodone cap (OXYIR equiv)	-	1	ANALGESICS - OPIOID
oxycodone conc (ROXICODONE equiv)	-	1	ANALGESICS - OPIOID
oxycodone soln (ROXICODONE equiv)	-	1	ANALGESICS - OPIOID
oxycodone tab (ROXICODONE equiv)	-	1	ANALGESICS - OPIOID
oxycodone/acetaminophen cap (TYLOX equiv)	-	1	ANALGESICS - OPIOID
OXYCODONE/ACETAMINOPHEN SOLN	-	1	ANALGESICS - OPIOID
oxycodone/acetaminophen tab (PERCOCET equiv)	-	1	ANALGESICS - OPIOID
OXYCODONE/ASPIRIN TAB	-	1	ANALGESICS - OPIOID
oxycodone/aspirin tab (PERCODAN equiv)	-	1	ANALGESICS - OPIOID
oxycodone/ibuprofen tab (COMBUNOX equiv)	-	1	ANALGESICS - OPIOID
OXYCONTIN CR TAB (QL= 120 tabs/30 days)	QL	2	ANALGESICS - OPIOID
OZEMPIC INJ (QL= 1 pack/28 days)	QL	2	ANTIDIABETICS
paliperidone ER tab (INVEGA equiv) (Step Therapy requires trial of risperidone, GEODON, olanzapine or SEROQUEL)	ST	2	ANTIPSYCHOTICS / ANTIMANIC AGENTS
PANCREAZE CAP	-	2	DIGESTIVE AIDS
pantoprazole EC tab (PROTONIX equiv)	-	1	ULCER DRUGS
PARAGARD IUD	-	\$0	CONTRACEPTIVES
paricalcitol cap (ZEMPLAR equiv)	-	1	ENDOCRINE AND METABOLIC AGENTS - MISC.
PAROMOMYCIN CAP	-	1	AMINOGLYCOSIDES

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
paromomycin cap (HUMATIN equiv)	-	1	AMINOGLYCOSIDES
paroxetine ER tab (PAXIL CR equiv)	-	1	ANTIDEPRESSANTS
paroxetine tab (PAXIL equiv)	-	1	ANTIDEPRESSANTS
PEAK FLOW METER	OTC	1	MEDICAL DEVICES AND SUPPLIES
pediatric multiple vitamins/fluoride chew tab	-	1	MULTIVITAMINS
pediatric multiple vitamins/fluoride soln	-	1	MULTIVITAMINS
pediatric multiple vitamins/fluoride/iron soln	-	1	MULTIVITAMINS
pediatric multivitamin (VITALETS equiv)	OTC	1	MULTIVITAMINS
peg 3350/electrolytes soln (GOLYTELY/COLYTE equiv)	-	1	LAXATIVES
PEGANONE TAB	-	2	ANTICONVULSANTS
PEGASYS INJ	LMSP	2	ANTIVIRALS
PEG-INTRON INJ	LMSP	2	ANTIVIRALS
penicillamine tab (DEPEN TITRATAB equiv)	-	1	MISCELLANEOUS THERAPEUTIC CLASSES
penicillin vk soln (VEETIDS equiv)	-	1	PENICILLINS
penicillin vk tab (VEETIDS equiv)	-	1	PENICILLINS
pentamidine neb soln (NEBUPENT equiv)	-	1	ANTI-INFECTIVE AGENTS MISC.
PENTASA CAP	-	2	GASTROINTESTINAL AGENTS - MISC.
pentazocine/acetaminophen tab (TALACEN equiv)	-	1	ANALGESICS - OPIOID

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
pentoxifylline ER tab (TRENTAL equiv)	-	1	HEMATOLOGICAL AGENTS - MISC.
perindopril tab (ACEON equiv)	-	1	ANTIHYPERTENSIVES
permethrin cream (ELIMITE equiv) (QL= 60gm/30 days)	QL	1	DERMATOLOGICALS
permethrin lotion	OTC	1	DERMATOLOGICALS
perphenazine tab (TRILAFON equiv)	-	1	ANTIPSYCHOTICS / ANTIMANIC AGENTS
PERPHENAZINE/ AMITRIPTYLINE TAB	-	1	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
phenazopyridine tab (PYRIDIUM equiv)	-	1	GENITOURINARY AGENTS - MISCELLANEOUS
phenelzine tab (NARDIL equiv)	-	1	ANTIDEPRESSANTS
phenobarbital elixir	-	1	HYPNOTICS / SEDATIVES SLEEP DISORDER AGENTS
phenobarbital tab	-	1	HYPNOTICS / SEDATIVES SLEEP DISORDER AGENTS
phenoxybenzamine cap (DIBENZYLINE equiv)	-	1	ANTIHYPERTENSIVES
phenylephrine ophth soln (MYDFRIN equiv)	-	1	OPHTHALMIC AGENTS
phenytoin cap (DILANTIN equiv)	-	1	ANTICONVULSANTS
phenytoin chew tab (DILANTIN equiv)	-	1	ANTICONVULSANTS

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
phenytoin susp (DILANTIN equiv)	-	1	ANTICONVULSANTS
phospha 250 neutral tab (K-PHOS NEUTRAL equiv)	-	1	MINERALS & ELECTROLYTES
PHOSPHOLINE OPHTH SOLN	-	2	OPHTHALMIC AGENTS
phytonadione tab (MEPHYTON equiv)	-	1	VITAMINS
pilocarpine ophth soln (ISOPTO CARPINE equiv)	-	1	OPHTHALMIC AGENTS
pilocarpine tab (SALAGEN equiv)	-	1	MOUTH / THROAT / DENTAL AGENTS
pimecrolimus cream (ELIDEL equiv) (Covered for members 2 years or older; Step Therapy requires trial of tacrolimus oint)	ST	1	DERMATOLOGICALS
PIMOZIDE TAB	-	2	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
pindolol tab (VISKEN equiv)	-	1	BETA BLOCKERS
pioglitazone tab (ACTOS TAB equiv)	-	1	ANTIDIABETICS
piroxicam cap (FELDENE equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
PNEUMOVAX INJ (QL= 1 inj/lifetime for members 2 years and older)	QL-VAC	\$0	VACCINES
PODOCON SOLN	-	2	DERMATOLOGICALS
podofilox soln (CONDYLOX equiv)	-	1	DERMATOLOGICALS
polyethylene glycol 3350 powder (MIRALAX equiv)	OTC	1	LAXATIVES

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
POLYETHYLENE GLYCOL 8000 GRANULES	-	2	PHARMACEUTICAL ADJUVANTS
polymyxin b/trimethoprim ophth soln (POLYTRIM equiv)	-	1	OPHTHALMIC AGENTS
POLY-VI-FLOR SUSP	-	2	MULTIVITAMINS
POT/CHLORIDE EFFER TAB	-	1	MINERALS & ELECTROLYTES
POTABA POWDER PACKET	-	2	VITAMINS
POTABA TAB	-	2	VITAMINS
potassium bicarbonate effer tab (K-LYTE equiv)	-	1	MINERALS & ELECTROLYTES
potassium chloride effer tab (K-LYTE/CL equiv)	-	1	MINERALS & ELECTROLYTES
potassium chloride ER cap (MICRO-K equiv)	-	1	MINERALS & ELECTROLYTES
potassium chloride ER tab (K-TAB equiv)	-	1	MINERALS & ELECTROLYTES
potassium chloride micro tab (K-DUR equiv)	-	1	MINERALS & ELECTROLYTES
potassium chloride powder packet (KLOR-CON equiv)	-	2	MINERALS & ELECTROLYTES
potassium chloride soln	-	2	MINERALS & ELECTROLYTES

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
potassium citrate CR tab (UROCIT-K TAB equiv)	-	1	GENITOURINARY AGENTS - MISCELLANEOUS
potassium citrate/citric acid powder pack (POLYCITRA equiv)	-	1	GENITOURINARY AGENTS - MISCELLANEOUS
potassium citrate/citric acid soln (POLYCITRA-K equiv)	-	1	GENITOURINARY AGENTS - MISCELLANEOUS
pramipexole ER tab (MIRAPEX ER equiv)	-	1	ANTIPARKINSON AGENTS
pramipexole tab (MIRAPEX equiv)	-	1	ANTIPARKINSON AGENTS
PRAMOSONE E CREAM	-	2	DERMATOLOGICALS
PRAMOSONE OINT	-	2	DERMATOLOGICALS
pramoxine/hydrocortisone cream (ANALPRAM HC equiv)	-	1	ANORECTAL AGENTS
pramoxine/hydrocortisone cream kit (ANALPRAM-HC equiv)	-	1	ANORECTAL AGENTS
PRASCION RA CREAM	-	2	DERMATOLOGICALS
pravastatin tab (PRAVACHOL equiv)	-	1	ANTIHYPERLIPIDEMICS
prazosin cap (MINIPRESS equiv)	-	1	ANTIHYPERTENSIVES
PRECISION XTRA KETONE TEST STRIP	OTC	2	DIAGNOSTIC PRODUCTS
PRECISION XTRA METER	OTC	\$0	MEDICAL DEVICES AND SUPPLIES
PRECISION XTRA TEST STRIP	OTC	2	DIAGNOSTIC PRODUCTS
PRED MILD OPHTH SOLN	-	2	OPHTHALMIC AGENTS
PRED-G OPHTH SOLN	-	2	OPHTHALMIC AGENTS
PREDNICARBATE CREAM	-	2	DERMATOLOGICALS

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
prednicarbate cream (DERMATOP equiv)	-	2	DERMATOLOGICALS
PREDNICARBATE OIN	-	2	DERMATOLOGICALS
prednisolone ODT (ORAPRED equiv)	-	1	CORTICOSTEROIDS
PREDNISOLONE OPHTH SUSP	-	1	OPHTHALMIC AGENTS
PREDNISOLONE SODIUM PHOSPHATE OPHTH SOLN	-	1	OPHTHALMIC AGENTS
prednisolone soln (PEDIAPRED equiv)	-	1	CORTICOSTEROIDS
PREDNISOLONE SYRUP	-	1	CORTICOSTEROIDS
prednisolone syrup (PRELONE equiv)	-	1	CORTICOSTEROIDS
PREDNISON SOLN	-	1	CORTICOSTEROIDS
prednisone tab (DELTASONE equiv)	-	1	CORTICOSTEROIDS
pregabalin cap (LYRICA equiv)	PA	1	ANTICONVULSANTS
pregabalin soln (LYRICA equiv)	PA	1	ANTICONVULSANTS
PREMARIN TAB	-	2	ESTROGENS
PREMARIN VAGINAL CREAM	-	2	VAGINAL PRODUCTS
PREMPHASE TAB, PREMPRO TAB	-	2	ESTROGENS
PRENATABS RX TAB	-	1	MULTIVITAMINS
PRENATAL 19 TAB	-	1	MULTIVITAMINS
prenatal vitamin	OTC	1	MULTIVITAMINS
PRENATAL VITAMIN	OTC	2	MULTIVITAMINS
PRENATAL VITAMIN (OTC only)	OTC	2	MULTIVITAMINS
PREVACID OTC CAP (QL= 2 caps/day)	OTC-QL	2	ULCER DRUGS
PREVIDENT PASTE	-	2	MOUTH / THROAT / DENTAL AGENTS

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
PREVNAR 13 INJ (QL= 2 inj/8 months for member: 9 years and younger; QL= 1 inj/8 months for members 10 years and older)	QL-VAC	\$0	VACCINES
PREZCOBIX TAB	-	2	ANTIVIRALS
PREZISTA SUSP	-	2	ANTIVIRALS
PREZISTA TAB	-	2	ANTIVIRALS
PRIFTIN TAB	-	2	ANTIMYCOBACTERIAL AGENTS
PRILOSEC OTC DR TAB (QL= 2 caps/day)	OTC-QL	1	ULCER DRUGS
primidone tab (MYSOLINE equiv)	-	1	ANTICONVULSANTS
PRIMSOL SOLN	-	2	ANTI-INFECTIVE AGENTS MISC.
probenecid tab (BENEMID equiv)	-	1	GOUT AGENTS
prochlorperazine supp (COMPAZINE equiv)	-	1	ANTIPSYCHOTICS / ANTIMANIC AGENTS
prochlorperazine tab (COMPAZINE equiv)	-	1	ANTIPSYCHOTICS / ANTIMANIC AGENTS
PROCTOFOAM HC FOAM	-	2	ANORECTAL AGENTS
proctosol HC cream (ANUSOL HC equiv)	-	1	ANORECTAL AGENTS
progesterone cap (PROMETRIUM equiv)	-	1	PROGESTINS
progesterone oil inj	-	1	PROGESTINS
PROGRAF CAP	-	2	ASSORTED CLASSES
promethazine DM syrup	-	1	COUGH / COLD / ALLERGY
promethazine supp (PHENERGAN equiv)	-	1	ANTIHISTAMINES

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
promethazine syrup	-	1	ANTIHISTAMINES
promethazine tab (PHENERGAN equiv)	-	1	ANTIHISTAMINES
PROMETHAZINE VC SYRUP	-	1	COUGH / COLD / ALLERGY
promethazine VC syrup (PHENERGAN VC equiv)	-	1	COUGH / COLD / ALLERGY
PROMETHAZINE VC/CODEINE SYRUP	-	1	COUGH / COLD / ALLERGY
promethazine VC/codeine syrup (PHENERGAN VC/CODEINE equiv)	-	1	COUGH / COLD / ALLERGY
promethazine/codeine syrup (PHENERGAN/CODEINE equiv)	-	1	COUGH / COLD / ALLERGY
PROMETHEGAN SUPP	-	1	ANTIHISTAMINES
propafenone tab (RYTHMOL equiv)	-	1	ANTIARRHYTHMICS
PROPANTHELINE TAB	-	2	ULCER DRUGS
proparacaine ophth soln (ALCAINE equiv)	-	1	OPHTHALMIC AGENTS
propranolol ER cap (INDERAL LA equiv)	-	1	BETA BLOCKERS
PROPRANOLOL SOLN	-	1	BETA BLOCKERS
propranolol tab (INDERAL equiv)	-	1	BETA BLOCKERS
PROPRANOLOL/HYDROCHLOROTHIAZIDE TAB	-	1	ANTIHYPERTENSIVES
propylthiouracil tab	-	1	THYROID AGENTS
PROSTIGMIN TAB	-	2	ANTIMYASTHENIC / CHOLINERGIC AGENTS
protriptyline tab (VIVACTIL equiv)	-	1	ANTIDEPRESSANTS
pseudoephedrine 12hr tab (SUDAFED equiv)	OTC	1	NASAL AGENTS - SYSTEMIC AND TOPICAL

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
pseudoephedrine tab (SUDAFED equiv)	OTC	1	NASAL AGENTS - SYSTEMIC AND TOPICAL
pseudopseudoephedrine liquid (SUDAFED equiv)	OTC	1	NASAL AGENTS - SYSTEMIC AND TOPICAL
PULMOZYME INH SOLN	LMSP	2	RESPIRATORY AGENTS - MISC.
pyrazinamide tab	-	1	ANTIMYCOBACTERIAL AGENTS
pyridostigmine CR tab (MESTINON equiv)	-	1	ANTIMYASTHENIC / CHOLINERGIC AGENTS
pyridostigmine tab (MESTINON equiv)	-	1	ANTIMYASTHENIC / CHOLINERGIC AGENTS
quetiapine tab (SEROQUEL equiv) (QL= 3 tabs/day)	QL	1	ANTIPSYCHOTICS / ANTIMANIC AGENTS
quetiapine XR tab (SEROQUEL XR equiv) (QL= 2 tabs/day)	QL	1	ANTIPSYCHOTICS / ANTIMANIC AGENTS
quinapril tab (ACCUPRIL equiv)	-	1	ANTIHYPERTENSIVES
quinapril/hydrochlorothiazide tab (ACCURETIC equiv)	-	1	ANTIHYPERTENSIVES
quinidine gluconate CR tab	-	1	ANTIARRHYTHMICS
quinidine sulfate tab	-	1	ANTIARRHYTHMICS
rabeprazole EC tab (ACIPHEX equiv)	-	1	ULCER DRUGS

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
raloxifene tab (EVISTA equiv)	-	1	ENDOCRINE AND METABOLIC AGENTS - MISC.
ramipril cap (ALTACE equiv)	-	1	ANTIHYPERTENSIVES
RAVICTI LIQUID	-	2	ENDOCRINE AND METABOLIC AGENTS - MISC.
REBETOL SOLN	LMSP	2	ANTIVIRALS
REBIF INJ	LMSP	2	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
REGRANEX GEL (QL= 30gm/fill)	QL	2	DERMATOLOGICALS
RELENZA DISKHALER (QL= 1 inhaler/fill)	QL	2	ANTIVIRALS
renaphro cap (NEPHROCAP equiv)	-	1	MULTIVITAMINS
RENOVA CREAM	-	EX C	DERMATOLOGICALS
repaglinide tab (PRANDIN equiv)	-	1	ANTIDIABETICS
REPATHA INJ (QL= 2 inj/28 days)	PA-QL	2	ANTIHYPERLIPIDEMICS
REPATHA PUSHTRONEX INJ (QL= 1 inj/28 days)	PA-QL	2	ANTIHYPERLIPIDEMICS
RESCRIPTOR TAB	-	2	ANTIVIRALS
RETACRIT INJ	PA	2	HEMATOPOIETIC AGENTS
RETIN-A CREAM	-	2+p enal ty	DERMATOLOGICALS

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
REVLIMID CAP (QL= 1 cap/day; Restricted to Oncology or Hematology Specialist)	MSP-QL-RS	2	ASSORTED CLASSES
REYATAZ POWDER PACK	-	2	ANTIVIRALS
ribavirin cap (REBETOL equiv)	LMSP	1	ANTIVIRALS
ribavirin tab (COPEGUS equiv)	LMSP	1	ANTIVIRALS
RIDAURA CAP	-	2	ANALGESICS - ANTI-INFLAMMATORY
rifabutin cap (MYCOBUTIN equiv)	-	1	ANTIMYCOBACTERIAL AGENTS
RIFAMATE CAP	-	2	ANTIMYCOBACTERIAL AGENTS
rifampin cap (RIFADIN equiv)	-	1	ANTIMYCOBACTERIAL AGENTS
RIMANTADINE TAB	-	1	ANTIVIRALS
RINVOQ ER TAB (QL= 1 tab/day)	LMSP-PA-QL	2	ANALGESICS - ANTI-INFLAMMATORY
RISPERDAL INJ	PA	2	ANTIPSYCHOTICS / ANTIMANIC AGENTS
risperidone ODT (RISPERDAL M equiv)	-	1	ANTIPSYCHOTICS / ANTIMANIC AGENTS
RISPERIDONE ODT	-	2	ANTIPSYCHOTICS / ANTIMANIC AGENTS
risperidone soln (RISPERDAL equiv)	-	1	ANTIPSYCHOTICS / ANTIMANIC AGENTS

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
risperidone tab (RISPERDAL equiv)	-	1	ANTIPSYCHOTICS / ANTIMANIC AGENTS
ritonavir tab (NORVIR equiv)	-	1	ANTIVIRALS
rivastigmine cap (EXELON equiv)	-	1	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
rivastigmine patch (EXELON equiv)	-	1	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
rizatriptan ODT (MAXALT equiv) (QL= 12 tabs/30 days)	QL	1	MIGRAINE PRODUCTS
rizatriptan tab (MAXALT equiv) (QL= 12 tabs/30 days)	QL	1	MIGRAINE PRODUCTS
ropinirole ER tab (REQUIP XL equiv)	-	1	ANTIPARKINSON AGENTS
ropinirole tab (REQUIP equiv)	-	1	ANTIPARKINSON AGENTS
RUCONEST INJ (Only available through CVS Specialty 800-237-2767)	LD-PA	2	HEMATOLOGICAL AGENTS - MISC.
RUZURGI TAB (Only available through PantheRx Pharmacy 855-726-8479)	LD-PA	2	ANTIMYASTHENIC / CHOLINERGIC AGENTS
salicylic acid shampoo (SALEX equiv)	-	1	DERMATOLOGICALS
saline nasal spray (OCEAN equiv)	OTC	1	NASAL AGENTS - SYSTEMIC AND TOPICAL
salsalate tab (DISALCID equiv)	-	1	ANALGESICS - NONNARCOTIC

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
SANDIMMUNE CAP	-	2	ASSORTED CLASSES
SANDIMMUNE SOLN 100MG/ML	-	2	ASSORTED CLASSES
SANDOSTATIN INJ	LMSP	2	ENDOCRINE AND METABOLIC AGENTS - MISC.
SAPHRIS SL TAB	PA	2	ANTIPSYCHOTICS / ANTIMANIC AGENTS
SAVELLA PAK	-	2	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
SAVELLA TAB	-	2	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
seb-prev cream (OVACE CREAM equiv)	-	1	DERMATOLOGICALS
SECONAL CAP	-	2	HYPNOTICS / SEDATIVES SLEEP DISORDER AGENTS
selegiline cap (ELDEPRYL equiv)	-	1	ANTIPARKINSON AGENTS
selegiline tab (ELDEPRYL equiv)	-	1	ANTIPARKINSON AGENTS
selenium sulfide lotion	-	1	DERMATOLOGICALS
selenium sulfide shampoo (SELSEB equiv)	-	1	DERMATOLOGICALS
SELZENTRY SOLN	-	2	ANTIVIRALS
SELZENTRY TAB	-	2	ANTIVIRALS
senna cap (SENOKOT equiv)	OTC	1	LAXATIVES

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
senna syrup (SENOKOT equiv)	OTC	1	LAXATIVES
senna tab (SENOKOT equiv)	OTC	1	LAXATIVES
SEREVENT DISKUS INHALER	-	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
sertraline conc (ZOLOFT equiv)	-	1	ANTIDEPRESSANTS
sertraline tab (ZOLOFT equiv)	-	1	ANTIDEPRESSANTS
sevelamer powder pak (REVELA PAK equiv)	-	1	GASTROINTESTINAL AGENTS - MISC.
sevelamer tab (REVELA TAB equiv)	-	1	GASTROINTESTINAL AGENTS - MISC.
sildenafil tab 20mg (REVATIO equiv)	PA	1	CARDIOVASCULAR AGENTS - MISC.
SILPHEN COUGH SYRUP	OTC	1	ANTIHISTAMINES
silver sulfadiazine cream (SILVADENE CREAM equiv)	-	1	DERMATOLOGICALS
simvastatin tab (ZOCOR equiv) (80mg is Not Covered)	-	1	ANTIHYPERLIPIDEMICS
sirolimus soln (RAPAMUNE equiv)	-	1	MISCELLANEOUS THERAPEUTIC CLASSES
sirolimus tab (RAPAMUNE equiv)	-	1	ASSORTED CLASSES
SKYRIZI INJ (QL= 2 inj/84 days)	LMSP-PA-QL	2	DERMATOLOGICALS
smz/tmp (DS) tab (BACTRIM DS equiv)	-	1	ANTI-INFECTIVE AGENTS MISC.

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
smz/tmp susp (BACTRIM, SEPTRA equiv)	-	1	ANTI-INFECTIVE AGENTS MISC.
sodium bicarbonate tab	OTC	1	ANTACIDS
sodium chloride neb soln (HYPER-SAL equiv)	OTC	1	COUGH / COLD / ALLERGY
sodium citrate/citric acid soln (BICITRA equiv)	-	1	GENITOURINARY AGENTS - MISCELLANEOUS
sodium fluoride chew tab (LURIDE equiv)	-	1	MINERALS & ELECTROLYTES
sodium fluoride cream (PREVIDENT 5000 PLUS equiv)	-	1	MOUTH / THROAT / DENTAL AGENTS
sodium fluoride gel (PREVIDENT equiv)	-	1	MOUTH / THROAT / DENTAL AGENTS
SODIUM FLUORIDE LOZENGE	-	1	MINERALS & ELECTROLYTES
sodium fluoride paste (PREVIDENT equiv)	-	1	MOUTH / THROAT / DENTAL AGENTS
sodium fluoride rinse (PREVIDENT equiv)	-	1	MOUTH / THROAT / DENTAL AGENTS
sodium fluoride soln (LURIDE SOLN. equiv)	-	1	MINERALS & ELECTROLYTES
SODIUM FLUORIDE TAB	-	1	MINERALS & ELECTROLYTES
sodium fluoride/potassium nitrate paste (PREVIDENT equiv)	-	1	MOUTH / THROAT / DENTAL AGENTS

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
sodium phenylbutyrate powder (BUPHENYL equiv)	PA	1	ENDOCRINE AND METABOLIC AGENTS - MISC.
sodium phenylbutyrate tab (BUPHENYL equiv)	PA	1	ENDOCRINE AND METABOLIC AGENTS - MISC.
sodium polystyrene powder (KAYEXALATE equiv)	-	1	ASSORTED CLASSES
sodium polystyrene susp (SPS equiv)	-	1	ASSORTED CLASSES
sodium sulfacetamide gel (OVACE PLUS equiv)	-	1	DERMATOLOGICALS
sodium sulfacetamide lotion (KLARON equiv)	-	1	DERMATOLOGICALS
sodium sulfacetamide shampoo (OVACE equiv)	-	1	DERMATOLOGICALS
sodium sulfacetamide wash (OVACE WASH equiv)	-	1	DERMATOLOGICALS
sodium sulfacetamide/sulfur cream (PLEXION SCT equiv)	-	1	DERMATOLOGICALS
sodium sulfacetamide/sulfur emulsion (ROSULA equiv)	-	1	DERMATOLOGICALS
sodium sulfacetamide/sulfur foam (CLARIFOAM EF equiv)	-	1	DERMATOLOGICALS
sodium sulfacetamide/sulfur gel (ROSULA equiv)	-	1	DERMATOLOGICALS
sodium sulfacetamide/sulfur wash (SUMAXIN WASH equiv)	-	1	DERMATOLOGICALS
sodium sulfacetamide/urea pad (ROSULA equiv)	-	1	DERMATOLOGICALS
solifenacin tab (VESICARE equiv)	-	1	URINARY ANTISPASMODICS

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
SOMAVERT INJ (Only available through Walgreen: 888-347-3416)	LD-PA	2	ENDOCRINE AND METABOLIC AGENTS - MISC.
SORIATANE CK KIT	-	2	DERMATOLOGICALS
sotalol AF tab (BETAPACE AF equiv)	-	1	BETA BLOCKERS
sotalol tab (BETAPACE equiv)	-	1	BETA BLOCKERS
SOVALDI TAB (QL= 1 tab/day)	LMSP-PA-QL	2	ANTIVIRALS
SPIRIVA RESPIMAT INHALER 1.25MCG/ACT (QL= 1 inhaler/30 days; Step Therapy requires trial c ADVAIR, BREO, DULERA, or FLUTICASONE/SALMETEROL)	QL-ST	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
spironolactone tab (ALDACTONE equiv)	-	1	DIURETICS
spironolactone/hydrochlorothiazide tab (ALDACTAZIDE equiv)	-	1	DIURETICS
sprintec 28 tab (ORTHO-CYCLEN equiv)	-	1	CONTRACEPTIVES
SPRYCEL TAB	LMSP-PA	2	ANTINEOPLASTICS
SSKI SOLN	-	2	COUGH / COLD / ALLERGY
stavudine cap (ZERIT equiv)	-	1	ANTIVIRALS
stavudine soln (ZERIT equiv)	-	1	ANTIVIRALS
STELARA INJ (QL= 1 inj/84 days)	LMSP-PA-QL	2	DERMATOLOGICALS
STIMATE NASAL SOLN	-	2	ENDOCRINE AND METABOLIC AGENTS - MISC.

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
STIOLTO INHALER	-	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
STRIBILD TAB (QL= 1 tab/day)	QL	2	ANTIVIRALS
sucralfate susp (CARAFATE equiv)	-	1	ULCER DRUGS / ANTISPASMODICS / ANTICHOLINERGICS
sucralfate tab (CARAFATE equiv)	-	1	ULCER DRUGS
sulfacetamide sodium ophth soln (BLEPH-10 equiv)	-	1	OPHTHALMIC AGENTS
sulfacetamide sodium/prednisolone ophth soln (VASOCIDIN equiv)	-	1	OPHTHALMIC AGENTS
SULFADIAZINE TAB	-	1	SULFONAMIDES
SULFAMYLON CREAM	-	2	DERMATOLOGICALS
sulfasalazine EC tab (AZULFIDINE equiv)	-	1	GASTROINTESTINAL AGENTS - MISC.
sulfasalazine tab (AZULFIDINE equiv)	-	1	GASTROINTESTINAL AGENTS - MISC.
sulindac tab (CLINORIL equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
sumatriptan inj (QL= 6 inj/30 days)	QL	1	MIGRAINE PRODUCTS
SUMATRIPTAN INJ 6MG/0.5ML (QL= 6 inj/30 days)	QL	2	MIGRAINE PRODUCTS
sumatriptan nasal spray (IMITREX, SUMATRIPTAN equiv) (QL= 6 sprays/fill, 2 fills/30 days)	QL	1	MIGRAINE PRODUCTS

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
sumatriptan tab (IMITREX equiv) (QL= 9 tabs/30 days)	QL	1	MIGRAINE PRODUCTS
sumatriptan vial inj (IMITREX equiv) (QL= 5 inj/fill, 2 fills/30 days)	QL	1	MIGRAINE PRODUCTS
SUTENT CAP	MSP-PA	2	ANTINEOPLASTICS
SYMDEKO TAB (QL= 2 tabs/day; Only available through Maxor Pharmacy 800-658-6046 or Walgreens 888-347-3416)	LD-PA-QL	2	RESPIRATORY AGENTS - MISC.
SYMFI (LO) TAB	-	2	ANTIVIRALS
SYMJEPI INJ (QL= 2 inj/fill)	QL	2	VASOPRESSORS
SYNAGIS INJ (Available through Avella Specialty Pharmacy 877-470-7603)	MSP-PA	2	PASSIVE IMMUNIZING AGENTS
TABLOID TAB	-	2	ANTINEOPLASTICS
tacrolimus cap (PROGRAF equiv)	-	1	ASSORTED CLASSES
tacrolimus oint (PROTOPIC OINT equiv)	-	1	DERMATOLOGICALS
tadalafil tab (PAH) (ADCIRCA equiv)	LMSP-PA	1	CARDIOVASCULAR AGENTS - MISC.
TAKHZYRO INJ (QL= 2 inj/28 days; Only available through CVS Specialty 800-237-2767)	LD-PA-QL	2	HEMATOLOGICAL AGENTS - MISC.
tamoxifen tab (NOLVADEX equiv)	-	1	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
tamsulosin cap (FLOMAX equiv)	-	1	GENITOURINARY AGENTS - MISCELLANEOUS

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
TARGRETIN GEL (Step Therapy requires trial of VALCHLOR GEL)	LMSP-ST	2	DERMATOLOGICALS
TASIGNA CAP	LMSP-PA	2	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
tazarotene cream 0.1% (TAZORAC equiv)	-	2	DERMATOLOGICALS
TAZORAC CREAM 0.05%	-	2	DERMATOLOGICALS
telmisartan tab (MICARDIS equiv)	-	1	ANTIHYPERTENSIVES
temazepam cap 15mg (RESTORIL equiv)	-	1	HYPNOTICS / SEDATIVES SLEEP DISORDER AGENTS
temazepam cap 30mg (RESTORIL equiv)	-	1	HYPNOTICS / SEDATIVES SLEEP DISORDER AGENTS
temozolomide cap (TEMODAR equiv)	LMSP	1	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
tenofovir disoproxil fumarate tab (VIREAD equiv)	-	1	ANTIVIRALS
terazosin cap (HYTRIN equiv)	-	1	ANTIHYPERTENSIVES
terbinafine cream (LAMISIL AT equiv)	OTC	1	DERMATOLOGICALS
terbinafine tab (LAMISIL equiv)	-	1	ANTIFUNGALS
terbutaline sulfate tab (BRETHINE equiv)	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
terconazole cream (TERAZOL equiv)	-	1	VAGINAL PRODUCTS
TERCONAZOLE CREAM 0.8%	-	1	VAGINAL PRODUCTS

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier Category	
terconazole supp (TERAZOL equiv)	-	1	VAGINAL PRODUCTS
testosterone cypionate inj (DEPO-TESTOSTERONE equiv)	PA	1	ANDROGENS-ANABOLIC
TESTOSTERONE ENANTHATE INJ	PA	1	ANDROGENS-ANABOLIC
testosterone enanthate inj (DELATESTRYL INJ. equiv)	PA	1	ANDROGENS-ANABOLIC
testosterone gel 1% 25mg (ANDROGEL equiv) (QL= 1 packet/day)	PA-QL	1	ANDROGENS-ANABOLIC
TESTOSTERONE GEL 1% 25MG (QL= 1 packet/day)	PA-QL	2	ANDROGENS-ANABOLIC
testosterone gel 1% 50mg (ANDROGEL equiv) (QL= 2 packets/day)	PA-QL	1	ANDROGENS-ANABOLIC
TESTOSTERONE GEL 1% 50MG (QL= 2 packets/day)	PA-QL	2	ANDROGENS-ANABOLIC
testosterone gel 1% pump (ANDROGEL equiv) (QL= 4 bottles/30 days)	PA-QL	1	ANDROGENS-ANABOLIC
testosterone gel 1.62% 1.25gm (ANDROGEL equiv) (QL= 1 packet/day)	PA-QL	1	ANDROGENS-ANABOLIC
testosterone gel 1.62% 2.5gm (ANDROGEL equiv) (QL= 2 packets/day)	PA-QL	1	ANDROGENS-ANABOLIC
TESTOSTERONE GEL PUMP (QL= 4 bottles/30 days)	PA-QL	2	ANDROGENS-ANABOLIC
testosterone gel pump 1.62% (ANDROGEL equiv) (QL= 2 bottles/30 days)	PA-QL	1	ANDROGENS-ANABOLIC

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
tetracycline cap	-	1	TETRACYCLINES
THALOMID CAP	MSP-PA	2	ASSORTED CLASSES
THEOCHRON TAB	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
theophylline CR tab (QUIBRON-T equiv)	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
theophylline ER tab (UNIPHYL equiv)	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
theophylline soln	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
thioridazine tab (MELLARIL equiv)	-	1	ANTIPSYCHOTICS / ANTIMANIC AGENTS
thiothixene cap (NAVANE equiv)	-	1	ANTIPSYCHOTICS / ANTIMANIC AGENTS
THYROLAR TAB	-	2	THYROID AGENTS
tiagabine tab (GABITRIL equiv)	-	1	ANTICONVULSANTS
ticlopidine tab (TICLID equiv)	-	1	HEMATOLOGICAL AGENTS - MISC.
timolol maleate ophth gel (TIMOPTIC-XE equiv)	-	1	OPHTHALMIC AGENTS
timolol maleate ophth soln (TIMOPTIC equiv)	-	1	OPHTHALMIC AGENTS

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
timolol maleate ophth soln 0.5% (ISTALOL equiv)	-	1	OPHTHALMIC AGENTS
timolol maleate tab (BLOCADREN equiv)	-	1	BETA BLOCKERS
TIMOLOL OPHTH GEL SOLN	-	2	OPHTHALMIC AGENTS
tinidazole tab (TINDAMAX equiv)	-	2	ANTI-INFECTIVE AGENTS MISC.
tizanidine cap (ZANAFLEX equiv)	-	1	MUSCULOSKELETAL THERAPY AGENTS
tizanidine tab (ZANAFLEX equiv)	-	1	MUSCULOSKELETAL THERAPY AGENTS
tobramycin neb soln (TOBI equiv) (Restricted to Infectious Disease or Pulmonology Specialist)	LMSR-RS	1	AMINOGLYCOSIDES
tobramycin ophth soln (TOBEX equiv)	-	1	OPHTHALMIC AGENTS
tobramycin/dexamethasone ophth soln (TOBRADEX equiv)	-	1	OPHTHALMIC AGENTS
TODAY SPONGE	OTC	\$0	VAGINAL PRODUCTS
TOLAZAMIDE TAB	-	1	ANTIDIABETICS
TOLBUTAMIDE TAB	-	2	ANTIDIABETICS
tolmetin cap (TOLECTIN DS equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
tolnaftate aerosol (TINACTIN equiv)	OTC	1	DERMATOLOGICALS
tolnaftate cream (TINACTIN equiv)	OTC	1	DERMATOLOGICALS
tolnaftate powder (TINACTIN equiv)	OTC	1	DERMATOLOGICALS
tolnaftate soln (TINACTIN equiv)	OTC	1	DERMATOLOGICALS

	NC =Not Covered	generic =small letters	BRANDS =CAPITAL LETTERS
EXC	Plan Exclusion	INF	Infertility
LD	Limited Distribution	LMSR	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
tolterodine SR cap (DETROL LA equiv)	-	1	URINARY ANTISPASMODICS
tolterodine tab (DETROL equiv)	-	1	URINARY ANTISPASMODICS
topiramate sprinkle cap (TOPAMAX equiv)	-	1	ANTICONVULSANTS
topiramate tab (TOPAMAX equiv)	-	1	ANTICONVULSANTS
topotecan inj (HYCAMTIN equiv)	-	1	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
toremifene tab (FARESTON equiv)	-	1	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
toremide tab (DEMADEX equiv)	-	1	DIURETICS
TOUJEO SOLOSTAR INJ	-	2	ANTIDIABETICS
TOVIAZ TAB	-	2	URINARY ANTISPASMODICS
TRACLEER TAB 32MG (Only available through Walgreens 888-347-3416)	LD-PA	2	CARDIOVASCULAR AGENTS - MISC.
tramadol ER tab (ULTRAM ER equiv)	-	1	ANALGESICS - OPIOID
tramadol tab (ULTRAM equiv)	-	1	ANALGESICS - OPIOID
tramadol/acetaminophen tab (ULTRACET equiv)	-	1	ANALGESICS - OPIOID
trandolapril tab (MAVIK equiv)	-	1	ANTIHYPERTENSIVES
tranexamic acid tab (LYSTEDA equiv) (QL= 1 tab/day; Step Therapy requires trial of 1 generic NSAID)	QL-ST	2	HEMOSTATICS
tranylcypromine tab (PARNATE equiv)	-	1	ANTIDEPRESSANTS

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
travoprost ophth soln (TRAVATAN Z equiv) (QL= 5ml/30 days)	QL	1	OPHTHALMIC AGENTS
trazodone tab (DESYREL equiv)	-	1	ANTIDEPRESSANTS
TRELEGY ELLIPTA INHALER	-	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
TRESIBA FLEXTOUCH INJ	-	2	ANTIDIABETICS
TRESIBA INJ	-	2	ANTIDIABETICS
tretinoin cap (VESANOID equiv)	LMSP	1	ANTINEOPLASTICS
tretinoin cream	-	1	DERMATOLOGICALS
tretinoin gel (RETIN-A GEL equiv)	-	1	DERMATOLOGICALS
triamcinolone cream	-	1	DERMATOLOGICALS
triamcinolone in orabase paste (KENALOG/ORABASE equiv)	-	1	MOUTH / THROAT / DENTAL AGENTS
triamcinolone lotion	-	1	DERMATOLOGICALS
triamcinolone nasal spray (NASACORT equiv)	-	2	NASAL AGENTS - SYSTEMIC AND TOPICAL
triamcinolone oint	-	1	DERMATOLOGICALS
triamcinolone OTC nasal spray (NASACORT equiv) (QL= 2 bottles/fill)	OTC-QL	1	NASAL AGENTS - SYSTEMIC AND TOPICAL
triamcinolone spray (KENALOG equiv)	-	1	DERMATOLOGICALS
triamterene/hydrochlorothiazide cap (DYAZIDE equiv)	-	1	DIURETICS

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
TRIAMTERENE/HYDROCHLOROTHIAZIDE CAP 50-25mg	-	2	DIURETICS
triamterene/hydrochlorothiazide tab (MAXZIDE equiv)	-	1	DIURETICS
triazolam tab (HALCION equiv)	-	1	HYPNOTICS / SEDATIVES SLEEP DISORDER AGENTS
tricitrates soln (POLYCITRA-LC equiv)	-	1	GENITOURINARY AGENTS - MISCELLANEOUS
tricon cap (TRINSICON equiv)	-	1	HEMATOPOIETIC AGENTS
trifluoperazine tab (STELAZINE equiv)	-	1	ANTIPSYCHOTICS / ANTIMANIC AGENTS
TRIFLURIDINE OPHTH SOLN	-	1	OPHTHALMIC AGENTS
trifluridine ophth soln (VIROPTIC equiv)	-	1	OPHTHALMIC AGENTS
trihexyphenidyl elixir (ARTANE equiv)	-	1	ANTIPARKINSON AND RELATED THERAPY AGENTS
trihexyphenidyl tab (ARTANE equiv)	-	1	ANTIPARKINSON AGENTS
tri-legest tab (ESTROSTEP FE equiv)	-	1	CONTRACEPTIVES
TRI-LUMA CREAM	-	EX C	DERMATOLOGICALS
trilyte soln (NULYTELY equiv)	-	1	LAXATIVES
trimethobenzamide cap (TIGAN equiv)	-	1	ANTIEMETICS

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
trimethoprim tab (PROLOPRIM equiv)	-	1	ANTI-INFECTIVE AGENTS MISC.
tri-sprintec tab (ORTHO TRI-CYCLEN (LO) equiv)	-	1	CONTRACEPTIVES
TRIUMEQ TAB (QL= 1 tab/day)	QL	2	ANTIVIRALS
TRI-VI-FLOR SUSP	-	2	MULTIVITAMINS
tropicamide ophth soln (MYDRIACYL equiv)	-	1	OPHTHALMIC AGENTS
TRUVADA TAB (QL= 1 tab/day)	QL	2	ANTIVIRALS
tussigon tab (HYCODAN equiv)	-	1	COUGH / COLD / ALLERGY
TYBOST TAB	-	2	ANTIVIRALS
TYVASO INH SOLN (Only available through Accredo 888-773-7376)	LD-PA	2	CARDIOVASCULAR AGENTS - MISC.
U-CORT CREAM	-	2	DERMATOLOGICALS
ursodiol cap (ACTIGALL equiv)	-	1	GASTROINTESTINAL AGENTS - MISC.
ursodiol tab (URSO (FORTE) equiv)	-	1	GASTROINTESTINAL AGENTS - MISC.
valacyclovir tab (VALTREX equiv)	-	1	ANTIVIRALS
VALCHLOR GEL (QL= 4 tubes/30 days; Only available through Avella (877) 546-5779)	LD-PA-QL	2	DERMATOLOGICALS
valganciclovir soln (VALCYTE equiv)	-	1	ANTIVIRALS
valganciclovir tab (VALCYTE equiv)	-	1	ANTIVIRALS
valproic acid cap (DEPAKENE equiv)	-	1	ANTICONVULSANTS
valproic acid syrup (DEPAKENE equiv)	-	1	ANTICONVULSANTS
valsartan tab (DIOVAN equiv)	-	1	ANTIHYPERTENSIVES

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
valsartan/hydrochlorothiazide tab (DIOVAN HCT equiv)	-	1	ANTIHYPERTENSIVES
VANCOMYCIN SOLN	-	1	ANTI-INFECTIVE AGENTS MISC.
VANIQA CREAM	-	EX C	DERMATOLOGICALS
vcf vaginal gel (CONCEPTROL equiv)	OTC	\$0	VAGINAL PRODUCTS
velivet tab (CYCLESSA equiv)	-	1	CONTRACEPTIVES
venlafaxine ER cap (EFFEXOR XR equiv) (PA Required only if member is less than 18 years old)	PA	1	ANTIDEPRESSANTS
venlafaxine tab (EFFEXOR equiv) (PA Required only if member is less than 18 years old)	PA	1	ANTIDEPRESSANTS
VENTAVIS INH SOLN (Only available through Accredo 888-773-7376)	LD-PA	2	CARDIOVASCULAR AGENTS - MISC.
VENTOLIN HFA INHALER (QL= 2 inhalers/30 days)	QL	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
VERAPAMIL CAP 100MG	-	1	CALCIUM CHANNEL BLOCKERS
VERAPAMIL ER CAP 200MG	-	1	CALCIUM CHANNEL BLOCKERS
VERAPAMIL ER CAP 300MG	-	1	CALCIUM CHANNEL BLOCKERS

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
verapamil SR cap (VERELAN equiv)	-	1	CALCIUM CHANNEL BLOCKERS
VERAPAMIL SR CAP 360mg	-	1	CALCIUM CHANNEL BLOCKERS
verapamil SR tab (CALAN SR, ISOPTIN SR equiv)	-	1	CALCIUM CHANNEL BLOCKERS
verapamil tab (CALAN equiv)	-	1	CALCIUM CHANNEL BLOCKERS
VEXOL OPHTH SUSP	-	2	OPHTHALMIC AGENTS
V-GO INJ KIT (QL= 1 kit/day)	QL	2	MEDICAL DEVICES AND SUPPLIES
VICTOZA INJ (QL= 9ml/30 days)	QL	2	ANTIDIABETICS
VIDEX SOLN	-	2	ANTIVIRALS
vienva tab, lessina tab, kurvelo tab (ALESSE equiv)	-	1	CONTRACEPTIVES
vigabatrin powder pack (SABRIL POWDER equiv) (Only available through Walgreens 888-347-3416)	LD-PA	1	ANTICONVULSANTS
vigabatrin tab (SABRIL equiv) (Only available through Walgreens 888-347-3416)	LD-PA	1	ANTICONVULSANTS
VIMPAT INJ (QL= 1200 units/30 days)	QL	2	ANTICONVULSANTS
VIMPAT SOLN (QL= 600ml/30days)	QL	2	ANTICONVULSANTS
VIMPAT TAB (QL= 2 tabs/day; Step Therapy requires trial of carbamazepine, divalproex, lamotrigine or topiramate)	QL-ST	2	ANTICONVULSANTS
violele tab, kariva tab (MIRCETTE equiv)	-	1	CONTRACEPTIVES

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
VIRACEPT POWDER	-	2	ANTIVIRALS
VIRACEPT TAB	-	2	ANTIVIRALS
VIREAD TAB	-	2	ANTIVIRALS
VITAMIN C TAB	OTC	1	VITAMINS
vitamin D cap (RX strength only)	-	1	VITAMINS
vitamin D cap 400unit	OTC	\$0	VITAMINS
vitamin E liquid	OTC	1	DERMATOLOGICALS
VITEKTA TAB	-	2	ANTIVIRALS
VITRAKVI CAP 100MG (QL= 2 caps/day; Only available through US Bioservices 888-518-7246)	LD-PA-QL	2	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
VITRAKVI CAP 25MG (QL= 6 caps/day; Only available through US Bioservices 888-518-7246)	LD-PA-QL	2	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
VITRAKVI SOLN (QL= 10ml/day; Only available through US Bioservices 888-518-7246)	LD-PA-QL	2	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
VYLEESI INJ	-	EX C	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
VYVANSE CAP	-	2	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
VYVANSE CHEW TAB	-	2	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
warfarin tab (COUMADIN equiv)	-	1	ANTICOAGULANTS
XENICAL CAP	-	EX C	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
XOFLUZA TAB (QL= 2 tabs/fill; Covered for members 12 years of age or older)	QL	2	ANTIVIRALS
XULANE PATCH	-	1	CONTRACEPTIVES
zafirlukast tab (ACCOLATE equiv)	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
zaleplon cap (SONATA equiv)	-	1	HYPNOTICS / SEDATIVES SLEEP DISORDER AGENTS
ZARXIO INJ	LMSP	2	HEMATOPOIETIC AGENTS
zidovudine cap (RETROVIR equiv)	-	1	ANTIVIRALS
zidovudine syrup (RETROVIR equiv)	-	1	ANTIVIRALS
zidovudine tab (RETROVIR equiv)	-	1	ANTIVIRALS
ZIEXTENZO INJ	MSP	2	HEMATOPOIETIC AGENTS

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

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 6/1/2020

Drug Name	Special Code	Tier	Category
zinc sulfate cap	-	1	MINERALS & ELECTROLYTES
ziprasidone cap (GEODON equiv) (QL= 2 caps/day)	QL	1	ANTIPSYCHOTICS / ANTIMANIC AGENTS
ZIRGAN OPHTH GEL	-	2	OPHTHALMIC AGENTS
ZITHROMAX POWDER PACK	-	1	MACROLIDES
ZOLINZA CAP	LMSP-PA	2	ANTINEOPLASTICS
zonisamide cap (ZONEGRAN equiv)	-	1	ANTICONVULSANTS
ZORTRESS TAB 1MG	PA	2	ASSORTED CLASSES
ZUBSOLV SL TAB	-	2	ANALGESICS - OPIOID
ZYLET OPHTH SUSP (QL= 5ml/fill (10ml bottle is Not Covered))	QL	2	OPHTHALMIC AGENTS

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

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 6/1/2020

DrugName	Special Code	Tier
ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS		
AMPHETAMINES		
ADDERALL XR CAP (QL= 2 caps/day)	QL	1
amphetamine/dextroamphetamine tab (ADDERALL equiv)	-	1
dextroamphetamine ER cap (DEXEDRINE equiv)	-	1
dextroamphetamine tab (DEXEDRINE equiv)	-	1
VYVANSE CAP	-	2
VYVANSE CHEW TAB	-	2
ANALEPTICS		
caffeine citrate soln (CAFCIT equiv) (Only covered for members less than 1 year old)	-	2
ANTI-OBESITY AGENTS		
XENICAL CAP	-	EXC
ATTENTION-DEFICIT/HYPERACTIVITY DISORDER (ADHD) AGENTS		
atomoxetine cap (STRATTERA CAP equiv) (QL= 1 cap/day)	QL	1
guanfacine ER tab (INTUNIV equiv) (QL= 1 tab/day)	QL	1
clonidine ER tab (KAPVAY equiv) (QL= 2 tabs/day)	QL	2
STIMULANTS - MISC.		
armodafinil tab (NUVIGIL equiv) (QL= 1 tab/day)	PA-QL	1
dexmethylphenidate ER cap (FOCALIN XR equiv) (QL= 1 cap/day)	QL	1
dexmethylphenidate tab (FOCALIN equiv)	-	1
methylphenidate CD cap (METADATE CD equiv)	-	1
methylphenidate ER tab	-	1
methylphenidate ER tab (QL= 1 tab/day)	--QL	1
methylphenidate ER tab 36mg (QL= 2 tabs/day)	-	1

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

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

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 6/1/2020

DrugName	Special Code	Tier
ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS Cont.		
methylphenidate soln (METHYLIN equiv)	-	1
methylphenidate tab (RITALIN equiv)	-	1
modafinil tab (PROVIGIL equiv) (QL= 2 tabs/day)	PA-QL	1
METHYLPHENIDATE ER TAB (QL= 1 tab/day)	QL	2
AMINOGLYCOSIDES		
AMINOGLYCOSIDES		
neomycin tab	-	1
PAROMOMYCIN CAP	-	1
paromomycin cap (HUMATIN equiv)	-	1
tobramycin neb soln (TOBI equiv) (Restricted to Infectious Disease or Pulmonology Specialist)	LMSP-RS	1
BETHKIS NEB SOLN	MSP	2
KITABIS PAK NEB SOLN	MSP	2
ANALGESICS - ANTI-INFLAMMATORY		
ANTIRHEUMATIC - ENZYME INHIBITORS		
RINVOQ ER TAB (QL= 1 tab/day)	LMSP-PA-QL	2
ANTI-TNF-ALPHA - MONOCLONAL ANTIBODIES		
HUMIRA INJ 10MG (QL= 2 syringes/28 days)	LMSP-PA-QL	2
HUMIRA INJ 20MG (QL= 2 syringes/28 days)	LMSP-PA-QL	2
HUMIRA INJ 40MG (QL= 2 syringes/28 days)	LMSP-PA-QL	2
HUMIRA INJ CROHNS/UC/HIDRADENITIS STARTER PACK (QL= 1 pack/fill, 1 fill/plan year)	LMSP-PA-QL	2
HUMIRA INJ PEDIATRIC CROHNS STARTER PACK (QL= 1 pack/fill, 1 fill/plan year)	LMSP-PA-QL	2

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

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

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 6/1/2020

DrugName	Special Code	Tier
ANALGESICS - ANTI-INFLAMMATORY Cont.		
HUMIRA INJ PSORIASIS/UVEITIS STARTER PACK (QL= 1 pack/fill, 1 fill/plan year)	LMSP-PA-QL	2
HUMIRA PEN INJ 40MG (QL= 2 pens/28 days)	LMSP-PA-QL	2
GOLD COMPOUNDS		
RIDAURA CAP	-	2
INTERLEUKIN-1 RECEPTOR ANTAGONIST (IL-1RA)		
KINERET INJ (Only available through Biologics 800-850-4306)	LD-PA	2
INTERLEUKIN-6 RECEPTOR INHIBITORS		
ACTEMRA ACTPEN INJ (QL= 2 inj/28 days)	LMSP-PA-QL	2
ACTEMRA SC INJ (QL= 2 inj/28 days)	LMSP-PA-QL	2
KEVZARA INJ (QL= 2 inj/28 days)	LMSP-PA-QL	2
NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (NSAIDS)		
celecoxib cap (CELEBREX equiv) (QL= 2 caps/day)	QL	1
diclofenac potassium tab (CATAFLAM equiv)	-	1
diclofenac sodium EC tab (VOLTAREN equiv)	-	1
diclofenac sodium XR tab (VOLTAREN XR equiv)	-	1
etodolac cap (LODINE equiv)	-	1
etodolac ER tab (LODINE XL equiv)	-	1
etodolac tab	-	1
flurbiprofen tab (ANSAID equiv)	-	1
ibuprofen cap 200mg	OTC	1
ibuprofen chew tab (ADVIL equiv)	OTC	1
ibuprofen susp	-	1

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

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

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 6/1/2020

DrugName	Special Code	Tier
ANALGESICS - ANTI-INFLAMMATORY Cont.		
ibuprofen tab	-	1
ibuprofen tab (Rx only)	-	1
ibuprofen tab 100mg (ADVIL equiv)	OTC	1
ibuprofen tab 200mg (ADVIL equiv)	OTC	1
indomethacin cap (INDOCIN equiv)	-	1
indomethacin CR cap (INDOCIN SR equiv)	-	1
ketorolac tab (TORADOL equiv) (QL= 20 tabs/5 days)	QL	1
meloxicam tab (MOBIC equiv)	-	1
nabumetone tab (RELAFEN equiv)	-	1
naproxen EC tab (NAPROSYN EC equiv)	-	1
naproxen sodium tab (ANAPROX equiv)	-	1
naproxen sodium tab 220mg (ALEVE equiv)	OTC	1
naproxen tab (NAPROSYN equiv)	-	1
oxaprozin tab (DAYPRO equiv)	-	1
piroxicam cap (FELDENE equiv)	-	1
sulindac tab (CLINORIL equiv)	-	1
tolmetin cap (TOLECTIN DS equiv)	-	1
PHOSPHODIESTERASE 4 (PDE4) INHIBITORS		
OTEZLA STARTER PACK (QL= 1 pack/28 days)	LMSP-PA-QL	2
OTEZLA TAB (QL= 2 tabs/day)	LMSP-PA-QL	2
PYRIMIDINE SYNTHESIS INHIBITORS		
leflunomide tab (ARAVA equiv)	-	1

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

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

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 6/1/2020

DrugName	Special Code	Tier
ANALGESICS - ANTI-INFLAMMATORY Cont.		
SELECTIVE COSTIMULATION MODULATORS		
ORENCIA CLICK INJ (QL= 4 inj/28 days)	LMSP-PA-QL	2
ORENCIA SC INJ 125MG/ML (QL= 4 inj/28 days)	LMSP-PA-QL	2
ORENCIA SC INJ 50MG/0.4ML (QL= 4 inj/28 days)	LMSP-PA-QL	2
ORENCIA SC INJ 87.5MG/0.7ML (QL= 4 inj/28 days)	LMSP-PA-QL	2
SOLUBLE TUMOR NECROSIS FACTOR RECEPTOR AGENTS		
ENBREL INJ 25MG (QL= 8 inj/28 days)	LMSP-PA-QL	2
ENBREL INJ 50MG (QL= 4 inj/28 days)	LMSP-PA-QL	2
ENBREL MINI INJ (QL= 4 inj/28 days)	LMSP-PA-QL	2
ENBREL SURECLICK INJ 50MG (QL= 4 inj/28 days)	LMSP-PA-QL	2
ANALGESICS - NONNARCOTIC		
ANALGESICS OTHER		
acetaminophen cap (TYLENOL equiv)	OTC	1
acetaminophen chew tab (TYLENOL equiv)	OTC	1
acetaminophen drops (TYLENOL equiv)	OTC	1
acetaminophen elixir (TYLENOL equiv)	OTC	1
acetaminophen liquid (TYLENOL equiv)	OTC	1
acetaminophen supp (TYLENOL equiv)	OTC	1
acetaminophen tab (TYLENOL equiv)	OTC	1
ACETAMINOPHEN SOLN	OTC	2
SALICYLATES		
aspirin chew tab 81mg	OTC	\$0
aspirin tab 325mg	OTC	\$0

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

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

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 6/1/2020

DrugName	Special Code	Tier
ANALGESICS - NONNARCOTIC Cont.		
aspirin tab 81mg	OTC	\$0
aspirin supp	OTC	1
BUFFERED ASPIRIN TAB	OTC	1
bufferin tab	OTC	1
CHOLINE MAGNESIUM TRISALICYLATE TAB	-	1
choline magnesium trisalicylate tab (TRILISATE equiv)	-	1
diflunisal tab (DOLOBID equiv)	-	1
salsalate tab (DISALCID equiv)	-	1
ANALGESICS - OPIOID		
OPIOID AGONISTS		
CODEINE SULFATE TAB	-	1
fentanyl patch (DURAGESIC equiv)	-	1
hydromorphone ER tab (EXALGO equiv)	-	1
hydromorphone liquid (DILAUDID-5 LIQUID equiv)	-	1
HYDROMORPHONE SUPP	-	1
hydromorphone tab (DILAUDID equiv)	-	1
LEVORPHANOL TAB	-	1
levorphanol tab (LEVORPHANOL equiv)	-	1
MEPERIDINE TAB	-	1
meperidine tab (DEMEROL equiv)	-	1
methadone soln	-	1
methadone tab (DOLOPHINE equiv)	-	1

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

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

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 6/1/2020

DrugName	Special Code	Tier
ANALGESICS - OPIOID Cont.		
methadose tab	-	1
morphine sulfate ER tab (MS CONTIN equiv)	-	1
morphine sulfate soln	-	1
MORPHINE SULFATE SUPP	-	1
morphine sulfate tab	-	1
oxycodone cap (OXYIR equiv)	-	1
oxycodone conc (ROXICODONE equiv)	-	1
oxycodone soln (ROXICODONE equiv)	-	1
oxycodone tab (ROXICODONE equiv)	-	1
tramadol ER tab (ULTRAM ER equiv)	-	1
tramadol tab (ULTRAM equiv)	-	1
OXYCONTIN CR TAB (QL= 120 tabs/30 days)	QL	2
OPIOID COMBINATIONS		
acetaminophen/codeine soln	-	1
acetaminophen/codeine tab (TYLENOL/CODEINE equiv)	-	1
aspirin/codeine tab	-	1
hydrocodone/acetaminophen cap (LORCET equiv)	-	1
hydrocodone/acetaminophen soln (HYCET, LORTAB equiv)	-	1
hydrocodone/acetaminophen tab (LORTAB equiv)	-	1
hydrocodone/ibuprofen tab (VICOPROFEN equiv)	-	1
oxycodone/acetaminophen cap (TYLOX equiv)	-	1
OXYCODONE/ACETAMINOPHEN SOLN	-	1

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

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

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 6/1/2020

DrugName	Special Code	Tier
ANALGESICS - OPIOID Cont.		
oxycodone/acetaminophen tab (PERCOCET equiv)	-	1
OXYCODONE/ASPIRIN TAB	-	1
oxycodone/aspirin tab (PERCODAN equiv)	-	1
oxycodone/ibuprofen tab (COMBUNOX equiv)	-	1
pentazocine/acetaminophen tab (TALACEN equiv)	-	1
tramadol/acetaminophen tab (ULTRACET equiv)	-	1
OPIOID PARTIAL AGONISTS		
buprenorphine SL tab (SUBUTEX equiv)	-	1
buprenorphine/naloxone SL tab (SUBOXONE equiv)	-	1
butorphanol nasal spray (STADOL equiv) (QL= 1 bottle/30 days)	QL	1
ZUBSOLV SL TAB	-	2
ANDROGENS-ANABOLIC		
ANABOLIC STEROIDS		
oxandrolone tab (OXANDRIN equiv)	-	1
ANDROGENS		
danazol cap (DANOCRINE equiv)	-	1
testosterone cypionate inj (DEPO-TESTOSTERONE equiv)	PA	1
TESTOSTERONE ENANTHATE INJ	PA	1
testosterone enanthate inj (DELATESTRYL INJ. equiv)	PA	1
testosterone gel 1% 25mg (ANDROGEL equiv) (QL= 1 packet/day)	PA-QL	1
testosterone gel 1% 50mg (ANDROGEL equiv) (QL= 2 packets/day)	PA-QL	1
testosterone gel 1% pump (ANDROGEL equiv) (QL= 4 bottles/30 days)	PA-QL	1

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

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

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 6/1/2020

DrugName	Special Code	Tier
ANDROGENS-ANABOLIC Cont.		
testosterone gel 1.62% 1.25gm (ANDROGEL equiv) (QL= 1 packet/day)	PA-QL	1
testosterone gel 1.62% 2.5gm (ANDROGEL equiv) (QL= 2 packets/day)	PA-QL	1
testosterone gel pump 1.62% (ANDROGEL equiv) (QL= 2 bottles/30 days)	PA-QL	1
ANDRODERM PATCH (QL= 1 patch/day)	PA-QL	2
ANDROXY TAB	-	2
TESTOSTERONE GEL 1% 25MG (QL= 1 packet/day)	PA-QL	2
TESTOSTERONE GEL 1% 50MG (QL= 2 packets/day)	PA-QL	2
TESTOSTERONE GEL PUMP (QL= 4 bottles/30 days)	PA-QL	2
ANORECTAL AGENTS		
INTRARECTAL STEROIDS		
hydrocortisone enema (CORTENEMA equiv)	-	1
RECTAL COMBINATIONS		
lidocaine/hydrocortisone cream (ANAMANTLE equiv)	-	1
pramoxine/hydrocortisone cream (ANALPRAM HC equiv)	-	1
pramoxine/hydrocortisone cream kit (ANALPRAM-HC equiv)	-	1
PROCTOFOAM HC FOAM	-	2
RECTAL STEROIDS		
proctosol HC cream (ANUSOL HC equiv)	-	1
hydrocortisone supp (ANUSOL HC equiv)	-	2
ANTACIDS		
ANTACIDS - BICARBONATE		
sodium bicarbonate tab	OTC	1
ANTACIDS - CALCIUM SALTS		

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

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

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 6/1/2020

DrugName	Special Code	Tier
ANTACIDS Cont.		
calcium carbonate chew tab (TUMS equiv)	OTC	1
calcium carbonate susp	OTC	1
ANTHELMINTICS		
ANTHELMINTICS		
ivermectin tab (STROMECTOL equiv)	-	1
BENZNIDAZOLE TAB	PA	2
ANTIANGINAL AGENTS		
NITRATES		
isosorbide dinitrate ER tab (ISOCHRON equiv)	-	1
isosorbide dinitrate SL tab	-	1
isosorbide dinitrate tab (ISORDIL equiv)	-	1
isosorbide mononitrate ER tab (IMDUR equiv)	-	1
isosorbide mononitrate tab (MONOKET equiv)	-	1
NITROGLYCERIN ER CAP	-	1
nitroglycerin lingual spray (NITROLINGUAL equiv)	-	1
nitroglycerin patch (NITRO-DUR equiv)	-	1
nitroglycerin SL tab (NITROSTAT equiv)	-	1
NITRO-DUR PATCH 0.3MG/HR, 0.8MG/HR	-	2
ANTIAXIETY AGENTS		
ANTIAXIETY AGENTS - MISC.		
bupirone tab (BUSPAR equiv)	-	1
hydroxyzine pamoate cap (VISTARIL equiv)	-	1
hydroxyzine syrup (ATARAX equiv)	-	1

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

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

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 6/1/2020

DrugName	Special Code	Tier
ANTIANSXIETY AGENTS Cont.		
hydroxyzine tab (ATARAX equiv)	-	1
BENZODIAZEPINES		
alprazolam tab (XANAX equiv)	-	1
chlordiazepoxide cap (LIBRIUM equiv)	-	1
diazepam conc (VALIUM equiv)	-	1
DIAZEPAM SOLN	-	1
diazepam tab (VALIUM equiv)	-	1
lorazepam conc (ATIVAN equiv)	-	1
lorazepam tab (ATIVAN equiv)	-	1
alprazolam ER tab (XANAX XR equiv)	-	2
alprazolam ODT (NIRAVAM equiv)	-	2
ANTIARRHYTHMICS		
ANTIARRHYTHMICS TYPE I-A		
disopyramide cap (NORPACE equiv)	-	1
disopyramide ER cap (NORPACE CR equiv)	-	1
quinidine gluconate CR tab	-	1
quinidine sulfate tab	-	1
NORPACE CR CAP	-	2
ANTIARRHYTHMICS TYPE I-B		
MEXILETINE CAP	-	2
ANTIARRHYTHMICS TYPE I-C		
flecainide tab (TAMBOCOR equiv)	-	1
propafenone tab (RYTHMOL equiv)	-	1

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

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

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 6/1/2020

DrugName	Special Code	Tier
ANTIARRHYTHMICS Cont.		
ANTIARRHYTHMICS TYPE III		
amiodarone tab (CORDARONE equiv)	-	1
dofetilide cap (TIKOSYN equiv)	-	1
ANTIASTHMATIC AND BRONCHODILATOR AGENTS		
ANTIASTHMATIC - MONOCLONAL ANTIBODIES		
FASENRA PEN INJ (QL= 1 inj/56 days)	LMSP-PA-QL	2
NUCALA INJ (QL= 1 inj/28 days)	LMSP-PA-QL	2
BRONCHODILATORS - ANTICHOLINERGICS		
ipratropium neb soln (ATROVENT equiv)	-	1
SPIRIVA RESPIMAT INHALER 1.25MCG/ACT (QL= 1 inhaler/30 days; Step Thera requires trial of ADVAIR, BREO, DULERA, or FLUTICASONE/SALMETEROL)	QL-ST	2
LEUKOTRIENE MODULATORS		
montelukast chew tab (SINGULAIR equiv)	-	1
montelukast tab (SINGULAIR equiv)	-	1
zafirlukast tab (ACCOLATE equiv)	-	1
STEROID INHALANTS		
ARNUITY ELLIPTA INHALER (QL= 1 inhaler/30 days)	QL	1
ASMANEX HFA INHALER (QL= 1 inhaler/30 days)	QL	1
ASMANEX INHALER (QL= 1 inhaler/30 days)	QL	1
budesonide inh susp (PULMICORT equiv)	-	1
FLOVENT DISKUS INHALER	-	1
FLOVENT HFA INHALER	-	1
SYMPATHOMIMETICS		

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

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

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 6/1/2020

DrugName	Special Code	Tier
ANTIASTHMATIC AND BRONCHODILATOR AGENTS Cont.		
ADVAIR DISKUS INHALER	-	1
albuterol neb soln	-	1
albuterol sulfate ER tab (VOSPIRE ER equiv)	-	1
albuterol sulfate syrup	-	1
albuterol sulfate tab	-	1
albuterol/ipratropium neb soln (DUONEB equiv)	-	1
epinephrine inj	-	1
FLUTICASONE/SALMETEROL INHALER	-	1
levalbuterol neb soln (XOPENEX equiv) (Step Therapy requires trial of albuterol net)	ST	1
METAPROTERENOL SYRUP	-	1
terbutaline sulfate tab (BRETHINE equiv)	-	1
VENTOLIN HFA INHALER (QL= 2 inhalers/30 days)	QL	1
ADVAIR HFA INHALER	-	2
ALBUTEROL TAB ER	-	2
BREO ELLIPTA INHALER	-	2
COMBIVENT RESPIMAT INHALER	-	2
DULERA INHALER	-	2
SEREVENT DISKUS INHALER	-	2
STIOLTO INHALER	-	2
TRELEGY ELLIPTA INHALER	-	2
XANTHINES		
aminophylline tab	-	1

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

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

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 6/1/2020

DrugName	Special Code	Tier
ANTIASTHMATIC AND BRONCHODILATOR AGENTS Cont.		
THEOCHRON TAB	-	1
theophylline CR tab (QUIBRON-T equiv)	-	1
theophylline ER tab (UNIPHYL equiv)	-	1
theophylline soln	-	1
ELIXOPHYLLIN ELIXIR	-	2
ANTICOAGULANTS		
COUMARIN ANTICOAGULANTS		
warfarin tab (COUMADIN equiv)	-	1
HEPARINS AND HEPARINOID-LIKE AGENTS		
enoxaparin inj (LOVENOX equiv)	-	1
heparin flush	-	1
FRAGMIN INJ	-	2
ANTICONVULSANTS		
ANTICONVULSANTS - BENZODIAZEPINES		
clobazam tab (ONFI equiv) (QL= 2 tabs/day)	QL	1
clonazepam ODT (KLONOPIN equiv)	-	1
clonazepam tab (KLONOPIN equiv)	-	1
DIASTAT RECTAL GEL, DIAZEPAM RECTAL GEL	-	2
ANTICONVULSANTS - MISC.		
carbamazepine chew tab (TEGRETOL equiv)	-	1
carbamazepine ER tab (TEGRETOL XR equiv)	-	1
carbamazepine susp (TEGRETOL equiv)	-	1
carbamazepine tab (TEGRETOL equiv)	-	1

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

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

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 6/1/2020

DrugName	Special Code	Tier
ANTICONVULSANTS Cont.		
gabapentin cap (NEURONTIN equiv)	-	1
gabapentin soln (NEURONTIN equiv)	-	1
gabapentin tab (NEURONTIN equiv)	-	1
lamotrigine chew tab (LAMICTAL equiv)	-	1
lamotrigine ODT (LAMICTAL equiv)	-	1
lamotrigine ODT kit (LAMICTAL ODT KIT equiv)	-	1
lamotrigine tab (LAMICTAL equiv)	-	1
levetiracetam soln (KEPPRA equiv)	-	1
levetiracetam tab (KEPPRA equiv)	-	1
oxcarbazepine susp (TRILEPTAL equiv)	-	1
oxcarbazepine tab (TRILEPTAL equiv)	-	1
pregabalin cap (LYRICA equiv)	PA	1
pregabalin soln (LYRICA equiv)	PA	1
primidone tab (MYSOLINE equiv)	-	1
topiramate sprinkle cap (TOPAMAX equiv)	-	1
topiramate tab (TOPAMAX equiv)	-	1
zonisamide cap (ZONEGRAN equiv)	-	1
BANZEL SUSP (QL= 2400ml/30 days)	PA-QL	2
BANZEL TAB (QL= 8 tabs/day)	PA-QL	2
carbamazepine ER cap (CARBATROL equiv)	-	2
EPIDIOLEX SOLN (Only available through Walgreens 888-347-3416)	LD-PA	2
LAMICTAL CHEW TAB 2MG	-	2

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

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

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 6/1/2020

DrugName	Special Code	Tier
ANTICONVULSANTS Cont.		
lamotrigine ER tab (LAMICTAL XR equiv)	-	2
VIMPAT INJ (QL= 1200 units/30 days)	QL	2
VIMPAT SOLN (QL= 600ml/30days)	QL	2
VIMPAT TAB (QL= 2 tabs/day; Step Therapy requires trial of carbamazepine, divalproex, lamotrigine or topiramate)	QL-ST	2
CARBAMATES		
felbamate susp (FELBATOL equiv)	-	1
felbamate tab (FELBATOL equiv)	-	2
GABA MODULATORS		
tiagabine tab (GABITRIL equiv)	-	1
vigabatrin powder pack (SABRIL POWDER equiv) (Only available through Walgreen 888-347-3416)	LD-PA	1
vigabatrin tab (SABRIL equiv) (Only available through Walgreens 888-347-3416)	LD-PA	1
HYDANTOINS		
phenytoin cap (DILANTIN equiv)	-	1
phenytoin chew tab (DILANTIN equiv)	-	1
phenytoin susp (DILANTIN equiv)	-	1
DILANTIN CAP 30MG	-	2
PEGANONE TAB	-	2
SUCCINIMIDES		
ethosuximide cap (ZARONTIN equiv)	-	1
ethosuximide soln (ZARONTIN equiv)	-	1
CELONTIN CAP	-	2

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

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

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 6/1/2020

DrugName	Special Code	Tier
ANTICONVULSANTS Cont.		
VALPROIC ACID		
divalproex ER tab (DEPAKOTE ER equiv)	-	1
divalproex sodium DR tab (DEPAKOTE equiv)	-	1
divalproex sprinkle cap (DEPAKOTE equiv)	-	1
valproic acid cap (DEPAKENE equiv)	-	1
valproic acid syrup (DEPAKENE equiv)	-	1
ANTIDEPRESSANTS		
ALPHA-2 RECEPTOR ANTAGONISTS (TETRACYCLICS)		
mirtazapine ODT (REMERON equiv)	-	1
mirtazapine tab (REMERON equiv)	-	1
ANTIDEPRESSANTS - MISC.		
bupropion ER tab (WELLBUTRIN equiv)	-	1
bupropion tab (WELLBUTRIN equiv)	-	1
bupropion XL tab (WELLBUTRIN XL equiv)	-	1
MAPROTILINE TAB	-	1
MONOAMINE OXIDASE INHIBITORS (MAOIS)		
phenelzine tab (NARDIL equiv)	-	1
tranylcypromine tab (PARNATE equiv)	-	1
MARPLAN TAB	-	2
SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIS)		
citalopram soln (CELEXA equiv)	-	1
citalopram tab (CELEXA equiv)	-	1
escitalopram tab (LEXAPRO equiv) (QL= 1 tab/day)	QL	1

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

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

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 6/1/2020

DrugName	Special Code	Tier
ANTIDEPRESSANTS Cont.		
fluoxetine cap (PROZAC equiv)	-	1
fluoxetine soln (PROZAC equiv)	-	1
fluoxetine tab (PROZAC equiv)	-	1
FLUOXETINE TAB 60MG	-	1
fluvoxamine ER cap (LUVOX CR equiv)	-	1
fluvoxamine tab (LUVOX equiv)	-	1
paroxetine ER tab (PAXIL CR equiv)	-	1
paroxetine tab (PAXIL equiv)	-	1
sertraline conc (ZOLOFT equiv)	-	1
sertraline tab (ZOLOFT equiv)	-	1
escitalopram soln (LEXAPRO equiv) (QL= 600 units/30 days)	QL	2
LUVOX CR CAP	-	2+penalty

SEROTONIN MODULATORS

NEFAZODONE TAB	-	1
nefazodone tab 50mg, 250mg	-	1
trazodone tab (DESYREL equiv)	-	1

SEROTONIN-NOREPINEPHRINE REUPTAKE INHIBITORS (SNRIS)

duloxetine EC cap (CYMBALTA equiv)	-	1
venlafaxine ER cap (EFFEXOR XR equiv) (PA Required only if member is less than 18 years old)	PA	1
venlafaxine tab (EFFEXOR equiv) (PA Required only if member is less than 18 year old)	PA	1

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

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

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 6/1/2020

DrugName	Special Code	Tier
ANTIDEPRESSANTS Cont.		
TRICYCLIC AGENTS		
amitriptyline tab (ELAVIL equiv)	-	1
AMOXAPINE TAB	-	1
clomipramine cap (ANAFRANIL equiv)	-	1
desipramine tab (NORPRAMIN equiv)	-	1
DOXEPIN CAP	-	1
doxepin cap (SINEQUAN equiv)	-	1
doxepin conc (SINEQUAN equiv)	-	1
imipramine pamoate cap (TOFRANIL PM equiv)	-	1
imipramine tab (TOFRANIL equiv)	-	1
nortriptyline cap (PAMELOR equiv)	-	1
nortriptyline oral soln (NORTRIPTYLINE equiv)	-	1
NORTRIPTYLINE SOLN	-	1
protriptyline tab (VIVACTIL equiv)	-	1
ANTIDIABETICS		
ALPHA-GLUCOSIDASE INHIBITORS		
acarbose tab (PRECOSE equiv)	-	1
miglitol tab (GLYSET equiv)	-	1
ANTIDIABETIC COMBINATIONS		
glipizide/metformin tab (METAGLIP equiv)	-	1
glyburide/metformin tab (GLUCOVANCE equiv)	-	1
AVANDAMET TAB	-	2

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

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

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 6/1/2020

DrugName	Special Code	Tier
ANTIDIABETICS Cont.		
AVANDARYL TAB	-	2
JANUMET XR TAB	-	2
BIGUANIDES		
metformin ER tab (GLUCOPHAGE XR equiv)	-	1
metformin tab (GLUCOPHAGE equiv)	-	1
DIABETIC OTHER		
glucose gel	OTC	1
BAQSIMI NASAL POWDER (QL= 2 inhalations/fill)	QL	2
GLUCAGEN HYPOKIT INJ	-	2
GLUCAGON INJ KIT (QL= 2 inj/fill, 1 fill/30 days)	QL	2
GLUCOSE CHEW TAB	OTC	2
GVOKE PFS INJ (QL= 2 inj/fill)	QL	2
INCRETIN MIMETIC AGENTS (GLP-1 RECEPTOR AGONISTS)		
BYDUREON BCISE AUTO INJ (QL= 4 inj/28 days)	QL	2
BYDUREON INJ (QL= 4 inj/28 days)	QL	2
BYDUREON PEN INJ (QL= 4 inj/28 days)	QL	2
OZEMPIC INJ (QL= 1 pack/28 days)	QL	2
VICTOZA INJ (QL= 9ml/30 days)	QL	2
INSULIN		
INSULIN ASPART FLEXPEN INJ (NOVOLOG equiv)	-	1
INSULIN ASPART INJ (NOVOLOG equiv)	-	1
INSULIN ASPART PENFILL INJ (NOVOLOG equiv)	-	1

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

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

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 6/1/2020

DrugName	Special Code	Tier
ANTIDIABETICS Cont.		
NOVOLOG FLEXPEN INJ	-	1
NOVOLOG INJ	-	1
NOVOLOG PENFILL INJ	-	1
FIASP FLEXTOUCH INJ	-	2
FIASP INJ	-	2
HUMULIN R INJ U-500	-	2
INSULIN ASPART MIX FLEXPEN INJ (NOVOLOG equiv)	-	2
INSULIN ASPART MIX INJ (NOVOLOG equiv)	-	2
LANTUS INJ	-	2
LANTUS SOLOSTAR INJ	-	2
LEVEMIR FLEXTOUCH INJ	-	2
LEVEMIR INJ	-	2
NOVOLIN 70/30 FLEXPEN INJ	OTC	2
NOVOLIN INJ	OTC	2
NOVOLIN N FLEXPEN INJ	OTC	2
NOVOLOG MIX FLEXPEN INJ	-	2
NOVOLOG MIX INJ	-	2
TOUJEO SOLOSTAR INJ	-	2
TRESIBA FLEXTOUCH INJ	-	2
TRESIBA INJ	-	2
INSULIN SENSITIZING AGENTS		
pioglitazone tab (ACTOS TAB equiv)	-	1

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

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

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 6/1/2020

DrugName	Special Code	Tier
ANTIDIABETICS Cont.		
AVANDIA TAB	-	2
MEGLITINIDE ANALOGUES		
nateglinide tab (STARLIX equiv)	-	1
repaglinide tab (PRANDIN equiv)	-	1
SULFONYLUREAS		
chlorpropamide tab (DIABINESE equiv)	-	1
glimepiride tab (AMARYL equiv)	-	1
glipizide ER tab (GLUCOTROL XL equiv)	-	1
glipizide tab (GLUCOTROL equiv)	-	1
glyburide micronized tab (GLYNASE equiv)	-	1
glyburide tab (MICRONASE equiv)	-	1
TOLAZAMIDE TAB	-	1
TOLBUTAMIDE TAB	-	2
ANTIDIARRHEAL/PROBIOTIC AGENTS		
ANTIPERISTALTIC AGENTS		
DIPHENOXYLATE/ATROPINE LIQUID	-	1
ANTIDIARRHEALS		
ANTIPERISTALTIC AGENTS		
diphenoxylate/atropine tab (LOMOTIL equiv)	-	1
opium tincture	-	1
ANTIDOTES		
ANTIDOTES - CHELATING AGENTS		
CHEMET CAP	-	2

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

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

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 6/1/2020

DrugName	Special Code	Tier
ANTIDOTES Cont.		
FERRIPROX SOLN (Only available through Ferriprox Total Care 866-758-7071)	LD-PA	2
FERRIPROX TAB (Only available through Ferriprox Total Care 866-758-7071)	LD-PA	2
OPIOID ANTAGONISTS		
naltrexone tab (REVIA equiv)	-	1
NARCAN NASAL SPRAY	-	2
ANTIDOTES AND SPECIFIC ANTAGONISTS		
ANTIDOTES - CHELATING AGENTS		
deferasirox tab (EXJADE equiv)	LMSP	1
deferasirox tab 90mg, 360mg (JADENU equiv)	LMSP	1
JADENU SPRINKLE	LMSP	2
OPIOID ANTAGONISTS		
naloxone inj	-	1
naloxone prefilled inj (QL= 2 inj/fill)	QL	1
NALOXONE PREFILLED INJ (QL= 2 inj/fill)	QL	2
ANTIEMETICS		
5-HT3 RECEPTOR ANTAGONISTS		
granisetron tab (KYTRIL equiv) (QL= 14 tabs/fill, 1 fill/30 days)	QL	1
ondansetron ODT (ZOFTRAN equiv)	-	1
ondansetron soln (ZOFTRAN equiv)	-	1
ONDANSETRON TAB	-	1
ondansetron tab (ZOFTRAN equiv)	-	1
KYTRIL TAB (QL= 14 tabs/fill, 1 fill/30 days)	QL	2+penalty

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

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

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 6/1/2020

DrugName	Special Code	Tier
ANTIEMETICS Cont.		
ANTIEMETICS - ANTICHOLINERGIC		
maldemar tab (SCOPACE equiv)	-	1
meclizine chew tab (BONINE equiv)	OTC	1
meclizine tab (ANTIVERT equiv)	OTC	1
trimethobenzamide cap (TIGAN equiv)	-	1
SUBSTANCE P/NEUROKININ 1 (NK1) RECEPTOR ANTAGONISTS		
aprepitant cap (EMEND equiv) (QL= 3 caps/fill)	QL	1
aprepitant pak (EMEND equiv) (QL= 3 caps/fill)	QL	1
ANTIFUNGALS		
ANTIFUNGALS		
flucytosine cap (ANCOBON equiv)	-	1
griseofulvin micro tab (GRIFULVIN V equiv)	-	1
griseofulvin susp (GRIFULVIN equiv)	-	1
griseofulvin tab (GRIS-PEG equiv)	-	1
nystatin powder	-	1
nystatin tab	-	1
terbinafine tab (LAMISIL equiv)	-	1
IMIDAZOLE-RELATED ANTIFUNGALS		
fluconazole susp (DIFLUCAN equiv)	-	1
fluconazole tab (DIFLUCAN equiv)	-	1
itraconazole cap (SPORANOX equiv)	PA	1
ketoconazole tab (NIZORAL equiv)	-	1
ANTIHISTAMINES		

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

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

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 6/1/2020

DrugName	Special Code	Tier
ANTIHISTAMINES Cont.		
ANTIHISTAMINES - ALKYLAMINES		
chlorpheniramine ER cap	-	1
ANTIHISTAMINES - ETHANOLAMINES		
CARBINOXAMINE SOLN	-	1
carbinoxamine soln (PALGIC equiv)	-	1
CARBINOXAMINE TAB	-	1
carbinoxamine tab (PALGIC equiv)	-	1
clemastine tab 1.34mg (TAVIST equiv)	OTC	1
diphenhydramine cap (BENADRYL equiv) (OTC only)	OTC	1
diphenhydramine elixir (OTC only)	OTC	1
diphenhydramine liquid (BENADRYL equiv)	OTC	1
diphenhydramine tab (BENADRYL equiv)	OTC	1
SILPHEN COUGH SYRUP	OTC	1
ALER-DRYL TAB	OTC	2
ANTIHISTAMINES - NON-SEDATING		
cetirizine syrup (ZYRTEC equiv) (QL= 300 ml/30 days)	OTC	1
cetirizine tab (ZYRTEC equiv) (QL= 1 tab/day)	OTC-QL	1
fexofenadine susp (ALLEGRA equiv)	OTC	1
fexofenadine tab (ALLEGRA equiv)	OTC	1
loratadine chew tab (CLARITIN equiv)	OTC	1
loratadine ODT (CLARITIN equiv)	OTC	1
loratadine syrup (CLARITIN equiv) (QL= 250ml/30 day)	OTC-QL	1

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

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

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 6/1/2020

DrugName	Special Code	Tier
ANTIHISTAMINES Cont.		
loratadine tab (CLARITIN equiv) (QL= 1 tab/day)	OTC-QL	1
ALLEGRA TAB	OTC	2
ANTIHISTAMINES - PHENOTHIAZINES		
promethazine supp (PHENERGAN equiv)	-	1
promethazine syrup	-	1
promethazine tab (PHENERGAN equiv)	-	1
PROMETHEGAN SUPP	-	1
ANTIHISTAMINES - PIPERIDINES		
cyproheptadine syrup	-	1
cyproheptadine tab	-	1
ANTIHYPERLIPIDEMICS		
ANTIHYPERLIPIDEMICS - MISC.		
omega-3-acid ethyl esters cap (LOVAZA equiv)	-	1
BILE ACID SEQUESTRANTS		
cholestyramine lite powder (QUESTRAN LITE equiv)	-	1
cholestyramine lite powder pack (QUESTRAN LITE equiv)	-	1
cholestyramine powder (QUESTRAN equiv)	-	1
cholestyramine powder pack (QUESTRAN equiv)	-	1
colesevelam pack (WELCHOL equiv)	-	1
colesevelam tab (WELCHOL equiv)	-	1
colestipol granule (COLESTID equiv)	-	1
colestipol powder packet (COLESTID equiv)	-	1
colestipol tab (COLESTID equiv)	-	1

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

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

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 6/1/2020

DrugName	Special Code	Tier
ANTIHYPERTENSIVES Cont.		
FIBRIC ACID DERIVATIVES		
fenofibric acid DR cap (TRILIPIX equiv)	-	1
gemfibrozil tab (LOPID equiv)	-	1
HMG COA REDUCTASE INHIBITORS		
atorvastatin tab 10mg (LIPITOR equiv) (QL= 1 tab/day)	QL	1
atorvastatin tab 20mg (LIPITOR equiv) (QL= 1 tab/day)	QL	1
atorvastatin tab 40mg (LIPITOR equiv)	-	1
atorvastatin tab 80mg (LIPITOR equiv)	-	1
lovastatin tab (MEVACOR equiv)	-	1
pravastatin tab (PRAVACHOL equiv)	-	1
simvastatin tab (ZOCOR equiv) (80mg is Not Covered)	-	1
INTESTINAL CHOLESTEROL ABSORPTION INHIBITORS		
ezetimibe tab (ZETIA equiv)	-	1
NICOTINIC ACID DERIVATIVES		
niacin ER tab (NIASPAN equiv)	-	1
PROPROTEIN CONVERTASE SUBTILISIN/KEXIN TYPE 9 INHIBITORS		
REPATHA INJ (QL= 2 inj/28 days)	PA-QL	2
REPATHA PUSHTRONEX INJ (QL= 1 inj/28 days)	PA-QL	2
ANTIHYPERTENSIVES		
ACE INHIBITORS		
benazepril tab (LOTENSIN equiv)	-	1
captopril tab (CAPOTEN equiv)	-	1
enalapril tab (VASOTEC equiv)	-	1

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

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

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 6/1/2020

DrugName	Special Code	Tier
ANTIHYPERTENSIVES Cont.		
fosinopril tab (MONOPRIL equiv)	-	1
lisinopril tab (PRINIVIL/ZESTRIL equiv)	-	1
moexipril tab (UNIVASC equiv)	-	1
perindopril tab (ACEON equiv)	-	1
quinapril tab (ACCUPRIL equiv)	-	1
ramipril cap (ALTACE equiv)	-	1
trandolapril tab (MAVIK equiv)	-	1
AGENTS FOR PHEOCHROMOCYTOMA		
phenoxybenzamine cap (DIBENZYLINE equiv)	-	1
ANGIOTENSIN II RECEPTOR ANTAGONISTS		
losartan tab (COZAAR equiv)	-	1
olmesartan tab (BENICAR equiv)	-	1
telmisartan tab (MICARDIS equiv)	-	1
valsartan tab (DIOVAN equiv)	-	1
irbesartan tab (AVAPRO equiv)	-	2
ANTIADRENERGIC ANTIHYPERTENSIVES		
clonidine patch (CATAPRES-TTS equiv)	-	1
clonidine tab (CATAPRES equiv)	-	1
doxazosin tab (CARDURA equiv)	-	1
guanfacine IR tab (TENEX equiv)	-	1
methyldopa tab (ALDOMET equiv)	-	1
prazosin cap (MINIPRESS equiv)	-	1

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

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

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 6/1/2020

DrugName	Special Code	Tier
ANTIHYPERTENSIVES Cont.		
terazosin cap (HYTRIN equiv)	-	1
ANTIHYPERTENSIVE COMBINATIONS		
amlodipine/benazepril cap (LOTREL equiv)	-	1
amlodipine/olmesartan tab (AZOR TAB equiv)	-	1
amlodipine/valsartan tab (EXFORGE equiv)	-	1
amlodipine/valsartan/hydrochlorothiazide tab (EXFORGE HCT equiv)	-	1
atenolol/chlorthalidone tab (TENORETIC equiv)	-	1
benazepril/hydrochlorothiazide tab (LOTENSIN HCT equiv)	-	1
bisoprolol/hydrochlorothiazide tab (ZIAC equiv)	-	1
enalapril/hydrochlorothiazide tab (VASERETIC equiv)	-	1
fosinopril/hydrochlorothiazide tab (MONOPRIL HCT equiv)	-	1
irbesartan/hydrochlorothiazide tab (AVALIDE equiv)	-	1
lisinopril/hydrochlorothiazide tab (ZESTORETIC equiv)	-	1
losartan/hydrochlorothiazide tab (HYZAAR equiv)	-	1
METHYLDOPA/HYDROCHLOROTHIAZIDE TAB	-	1
METOPROLOL/HYDROCHLOROTHIAZIDE TAB	-	1
metoprolol/hydrochlorothiazide tab (LOPRESSOR HCT equiv)	-	1
MOEXIPRIL/HYDROCHLOROTHIAZIDE TAB	-	1
moexipril/hydrochlorothiazide tab (UNIRETIC equiv)	-	1
nadolol/bendroflumethiazide tab (CORZIDE equiv)	-	1
olmesartan/hydrochlorothiazide tab (BENICAR HCT equiv)	-	1
PROPRANOLOL/HYDROCHLOROTHIAZIDE TAB	-	1

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

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

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 6/1/2020

DrugName	Special Code	Tier
ANTIHYPERTENSIVES Cont.		
quinapril/hydrochlorothiazide tab (ACCURETIC equiv)	-	1
valsartan/hydrochlorothiazide tab (DIOVAN HCT equiv)	-	1
SELECTIVE ALDOSTERONE RECEPTOR ANTAGONISTS (SARAS)		
eplerenone tab (INSPRA equiv)	-	1
VASODILATORS		
hydralazine tab (APRESOLINE equiv)	-	1
minoxidil tab (LONITEN equiv)	-	1
ANTI-INFECTIVE AGENTS - MISC.		
ANTI-INFECTIVE AGENTS - MISC.		
metronidazole cap (FLAGYL equiv)	-	1
metronidazole tab (FLAGYL equiv)	-	1
pentamidine neb soln (NEBUPENT equiv)	-	1
trimethoprim tab (PROLOPRIM equiv)	-	1
PRIMSOL SOLN	-	2
tinidazole tab (TINDAMAX equiv)	-	2
ANTI-INFECTIVE MISC. - COMBINATIONS		
erythromycin/sulfisoxazole susp (PEDIAZOLE equiv)	-	1
smz/tmp (DS) tab (BACTRIM DS equiv)	-	1
smz/tmp susp (BACTRIM, SEPTRA equiv)	-	1
ANTIPROTOZOAL AGENTS		
atovaquone susp (MEPRON equiv)	-	1
ALINIA SUSP (QL= 60ml/3 days)	PA-QL	2
ALINIA TAB (QL= 6 tabs/3 days)	PA-QL	2

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

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

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 6/1/2020

DrugName	Special Code	Tier
ANTI-INFECTIVE AGENTS - MISC. Cont.		
GLYCOPEPTIDES		
FIRST-VANCOMYCIN SOLN	-	1
VANCOMYCIN SOLN	-	1
LEPROSTATICS		
dapsone tab	-	1
LINCOSAMIDES		
clindamycin cap (CLEOCIN equiv)	-	1
clindamycin soln (CLEOCIN equiv)	-	1
MONOBACTAMS		
CAYSTON INH SOLN (Only available through Walgreens 888-347-3416)	LD-PA	2
OXAZOLIDINONES		
linezolid susp (Restricted to Infectious Disease Specialist)	RS	1
linezolid tab (ZYVOX equiv) (Restricted to Infectious Disease Specialist)	RS	1
ANTIMALARIALS		
ANTIMALARIALS		
chloroquine tab (ARALEN equiv)	-	1
hydroxychloroquine tab (PLAQUENIL equiv)	-	1
ANTIMYASTHENIC/CHOLINERGIC AGENTS		
ANTIMYASTHENIC/CHOLINERGIC AGENTS		
pyridostigmine CR tab (MESTINON equiv)	-	1
pyridostigmine tab (MESTINON equiv)	-	1
PROSTIGMIN TAB	-	2
RUZURGI TAB (Only available through PantheRx Pharmacy 855-726-8479)	LD-PA	2

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

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

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 6/1/2020

DrugName	Special Code	Tier
ANTIMYCOBACTERIAL AGENTS		
ANTI TB COMBINATIONS		
RIFAMATE CAP	-	2
ANTIMYCOBACTERIAL AGENTS		
ethambutol tab (MYAMBUTOL equiv)	-	1
ISONIAZID SYRUP	-	1
isoniazid tab	-	1
pyrazinamide tab	-	1
rifabutin cap (MYCOBUTIN equiv)	-	1
rifampin cap (RIFADIN equiv)	-	1
PRIFTIN TAB	-	2
ANTINEOPLASTICS		
ALKYLATING AGENTS		
cyclophosphamide tab (CYTOXAN equiv)	-	1
HEXALEN CAP	-	2
LEUKERAN TAB	-	2
ANTIMETABOLITES		
mercaptapurine tab (PURINETHOL equiv)	-	1
methotrexate tab (TREXALL equiv)	-	1
TABLOID TAB	-	2
ANTINEOPLASTIC ENZYME INHIBITORS		
SPRYCEL TAB	LMSP-PA	2
SUTENT CAP	MSP-PA	2
ZOLINZA CAP	LMSP-PA	2

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

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

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 6/1/2020

DrugName	Special Code	Tier
ANTINEOPLASTICS Cont.		
ANTINEOPLASTICS MISC.		
hydroxyurea cap (HYDREA equiv)	-	1
tretinoin cap (VESANOID equiv)	LMSP	1
ACTIMMUNE INJ (Only available through Walgreens 888-347-3416)	LD-PA	2
ALFERON-N INJ	LMSP	2
MATULANE CAP	-	2
CHEMOTHERAPY RESCUE/ANTIDOTE AGENTS		
leucovorin tab	-	1
MESNEX TAB	LMSP	2
TOPOISOMERASE I INHIBITORS		
HYCAMTIN CAP	LMSP-PA	2
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES		
ALKYLATING AGENTS		
carboplatin inj (PARAPLATIN equiv)	SP	1
CISPLATIN INJ	-	1
cisplatin inj (PLATINOL AQ equiv)	-	1
cyclophosphamide cap	-	1
temozolomide cap (TEMODAR equiv)	LMSP	1
GLEOSTINE/LOMUSTINE CAP	-	2
MYLERAN TAB	LMSP	2
ANTIMETABOLITES		
capecitabine tab (XELODA equiv)	LMSP	1
METHOTREXATE INJ	-	1

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

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

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 6/1/2020

DrugName	Special Code	Tier
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES Cont.		
ANTINEOPLASTIC - HORMONAL AND RELATED AGENTS		
anastrozole tab (ARIMIDEX equiv)	-	1
bicalutamide tab (CASODEX equiv)	-	1
exemestane tab (AROMASIN equiv)	-	1
flutamide cap (EULEXIN equiv)	-	1
letrozole tab (FEMARA equiv)	-	1
megestrol susp (MEGACE equiv)	-	1
megestrol tab (MEGACE equiv)	-	1
nilutamide tab (NILANDRON equiv)	LMSP	1
tamoxifen tab (NOLVADEX equiv)	-	1
toremifene tab (FARESTON equiv)	-	1
EMCYT CAP	-	2
LYSODREN TAB (Only available through Direct Success 732-919-1234)	LD	2
ANTINEOPLASTIC ENZYME INHIBITORS		
everolimus tab (AFINITOR equiv) (QL= 1 tab/day)	LMSP-PA-QL	1
imatinib tab (GLEEVEC equiv)	LMSP	1
TASIGNA CAP	LMSP-PA	2
VITRAKVI CAP 100MG (QL= 2 caps/day; Only available through US Bioservices 888-518-7246)	LD-PA-QL	2
VITRAKVI CAP 25MG (QL= 6 caps/day; Only available through US Bioservices 888-518-7246)	LD-PA-QL	2
VITRAKVI SOLN (QL= 10ml/day; Only available through US Bioservices 888-518-7246)	LD-PA-QL	2

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

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

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 6/1/2020

DrugName	Special Code	Tier
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES Cont.		
ANTINEOPLASTIC ENZYMES		
ERWINAZE INJ	-	2
ANTINEOPLASTICS MISC.		
bexarotene cap (TARGRETIN equiv) (Step Therapy requires trial of VALCHLOR)	LMSP-ST	1
CHEMOTHERAPY RESCUE/ANTIDOTE AGENTS		
mesna inj (MESNEX equiv)	-	1
MITOTIC INHIBITORS		
ETOPOSIDE CAP	LMSP	1
TOPOISOMERASE I INHIBITORS		
topotecan inj (HYCAMTIN equiv)	-	1
ANTIPARKINSON AGENTS		
ANTIPARKINSON ADJUVANTS		
carbidopa tab (LODOSYN equiv)	-	1
ANTIPARKINSON ANTICHOLINERGICS		
benztropine tab	-	1
trihexyphenidyl tab (ARTANE equiv)	-	1
ANTIPARKINSON COMT INHIBITORS		
entacapone tab (COMTAN equiv)	-	2
ANTIPARKINSON DOPAMINERGICS		
amantadine syrup (SYMMETREL equiv)	-	1
bromocriptine cap (PARLODEL equiv)	-	1
bromocriptine tab (PARLODEL equiv)	-	1
carbidopa/levodopa ER tab (SINEMET CR equiv)	-	1

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

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

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 6/1/2020

DrugName	Special Code	Tier
ANTIPARKINSON AGENTS Cont.		
carbidopa/levodopa ODT (PARCOPA equiv)	-	1
carbidopa/levodopa tab (SINEMET equiv)	-	1
pramipexole ER tab (MIRAPEX ER equiv)	-	1
pramipexole tab (MIRAPEX equiv)	-	1
ropinirole ER tab (REQUIP XL equiv)	-	1
ropinirole tab (REQUIP equiv)	-	1
CARBIDOPA/LEVODOPA/ENTACAPONE TAB (STALEVO equiv)	-	2
ANTIPARKINSON MONOAMINE OXIDASE INHIBITORS		
selegiline cap (ELDEPRYL equiv)	-	1
selegiline tab (ELDEPRYL equiv)	-	1
ANTIPARKINSON AND RELATED THERAPY AGENTS		
ANTIPARKINSON ANTICHOLINERGICS		
trihexyphenidyl elixir (ARTANE equiv)	-	1
ANTIPSYCHOTICS/ANTIMANIC AGENTS		
ANTIMANIC AGENTS		
lithium carbonate cap (ESKALITH ER equiv)	-	1
lithium carbonate ER tab (LITHOBID equiv)	-	1
lithium carbonate tab	-	1
LITHIUM CITRATE SOLN	-	1
ANTIPSYCHOTICS - MISC.		
ziprasidone cap (GEODON equiv) (QL= 2 caps/day)	QL	1
EQUETRO CAP	-	2
LATUDA TAB (QL= 1 tab/day; Step Therapy requires trial of quetiapine)	QL-ST	2

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

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

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 6/1/2020

DrugName	Special Code	Tier
ANTIPSYCHOTICS/ANTIMANIC AGENTS Cont.		
BENZISOXAZOLES		
risperidone ODT (RISPERDAL M equiv)	-	1
risperidone soln (RISPERDAL equiv)	-	1
risperidone tab (RISPERDAL equiv)	-	1
FANAPT TAB	PA	2
FANAPT TITRATION PACK	PA	2
INVEGA INJ	PA	2
paliperidone ER tab (INVEGA equiv) (Step Therapy requires trial of risperidone, GEODON, olanzapine or SEROQUEL)	ST	2
RISPERDAL INJ	PA	2
RISPERIDONE ODT	-	2
BUTYROPHENONES		
haloperidol lactate conc (HALDOL equiv)	-	1
haloperidol tab (HALDOL equiv)	-	1
DIBENZAPINES		
CLOZAPINE ODT 12.5MG	-	1
clozapine ODT 25mg, 100mg (CLOZAPINE, FAZACLO equiv)	-	1
clozapine tab (CLOZARIL equiv)	-	1
loxapine cap (LOXITANE equiv)	-	1
olanzapine tab (ZYPREXA equiv) (QL= 1 tab/day)	QL	1
quetiapine tab (SEROQUEL equiv) (QL= 3 tabs/day)	QL	1
quetiapine XR tab (SEROQUEL XR equiv) (QL= 2 tabs/day)	QL	1

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

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

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 6/1/2020

DrugName	Special Code	Tier
ANTIPSYCHOTICS/ANTIMANIC AGENTS Cont.		
CLOZAPINE ODT	-	2
CLOZAPINE ODT, FAZACLO ODT	-	2
olanzapine ODT (ZYPREXA equiv) (QL= 1 tab/day)	QL	2
olanzapine tab 10mg (ZYPREXA equiv) (QL= 2 tabs/day)	QL	2
SAPHRIS SL TAB	PA	2
PHENOTHIAZINES		
chlorpromazine tab (THORAZINE equiv)	-	1
FLUPHENAZINE TAB	-	1
fluphenazine tab (PROLIXIN equiv)	-	1
perphenazine tab (TRILAFON equiv)	-	1
prochlorperazine supp (COMPAZINE equiv)	-	1
prochlorperazine tab (COMPAZINE equiv)	-	1
thioridazine tab (MELLARIL equiv)	-	1
trifluoperazine tab (STELAZINE equiv)	-	1
QUINOLINONE DERIVATIVES		
aripiprazole ODT (ABILIFY equiv) (QL= 1 tab/day)	QL	1
aripiprazole soln (ABILIFY equiv)	-	1
aripiprazole tab (ABILIFY equiv) (QL= 1 tab/day)	QL	1
ABILIFY DISCMELT (QL= 1 tab/day)	QL	2
ABILIFY SOLN	-	2
THIOXANTHENES		
thiothixene cap (NAVANE equiv)	-	1

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

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

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 6/1/2020

DrugName	Special Code	Tier
ANTIVIRALS		
ANTIRETROVIRALS		
abacavir soln (ZIAGEN equiv)	-	1
abacavir tab (ZIAGEN equiv)	-	1
abacavir/lamivudine tab (EPZICOM equiv)	-	1
abacavir/lamivudine/zidovudine tab (TRIZIVIR equiv)	-	1
atazanavir cap (REYATAZ equiv)	-	1
didanosine DR cap (VIDEX EC equiv)	-	1
DIDANOSINE DR CAP, VIDEX EC CAP	-	1
efavirenz cap (SUSTIVA equiv)	-	1
efavirenz tab (SUSTIVA equiv)	-	1
fosamprenavir tab (LEXIVA equiv)	-	1
lamivudine soln (EPIVIR equiv)	-	1
lamivudine/zidovudine tab (COMBIVIR equiv)	-	1
lopinavir/ritonavir soln (KALETRA equiv)	-	1
NEVIRAPINE ER TAB	-	1
nevirapine ER tab (VIRAMUNE XR equiv)	-	1
nevirapine susp (VIRAMUNE equiv)	-	1
nevirapine tab (VIRAMUNE equiv)	-	1
ritonavir tab (NORVIR equiv)	-	1
stavudine cap (ZERIT equiv)	-	1
stavudine soln (ZERIT equiv)	-	1
tenofovir disoproxil fumarate tab (VIREAD equiv)	-	1

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

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

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 6/1/2020

DrugName	Special Code	Tier
ANTIVIRALS Cont.		
zidovudine cap (RETROVIR equiv)	-	1
zidovudine syrup (RETROVIR equiv)	-	1
zidovudine tab (RETROVIR equiv)	-	1
APTIVUS CAP	-	2
APTIVUS SOLN	-	2
ATRIPLA TAB	-	2
CIMDUO TAB	-	2
COMPLERA TAB	-	2
CRIXIVAN CAP	-	2
DESCOVY TAB	PA	2
DOVATO TAB	-	2
EDURANT TAB	-	2
EMTRIVA CAP	-	2
EMTRIVA SOLN	-	2
EVOTAZ TAB	-	2
FUZEON INJ	LMSP	2
GENVOYA TAB	PA	2
INTELENCE TAB	-	2
INVIRASE CAP	-	2
INVIRASE TAB	-	2
ISENTRESS (HD) TAB	-	2
ISENTRESS CHEW TAB	-	2

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

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

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 6/1/2020

DrugName	Special Code	Tier
ANTIVIRALS Cont.		
ISENTRESS POWDER PACK	-	2
KALETRA TAB	-	2
lamivudine tab (EPIVIR equiv)	-	2
LEXIVA SUSP	-	2
NEVIRAPINE SUSP (VIRAMUNE equiv)	-	2
NORVIR CAP	-	2
NORVIR POWDER PACK	-	2
NORVIR SOLN	-	2
PREZCOBIX TAB	-	2
PREZISTA SUSP	-	2
PREZISTA TAB	-	2
RESCRIPTOR TAB	-	2
REYATAZ POWDER PACK	-	2
SELZENTRY SOLN	-	2
SELZENTRY TAB	-	2
STRIBILD TAB (QL= 1 tab/day)	QL	2
SYMFI (LO) TAB	-	2
TRIUMEQ TAB (QL= 1 tab/day)	QL	2
TRUVADA TAB (QL= 1 tab/day)	QL	2
TYBOST TAB	-	2
VIDEX SOLN	-	2
VIRACEPT POWDER	-	2

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

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

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 6/1/2020

DrugName	Special Code	Tier
ANTIVIRALS Cont.		
VIRACEPT TAB	-	2
VIREAD TAB	-	2
VITEKTA TAB	-	2
CMV AGENTS		
valganciclovir soln (VALCYTE equiv)	-	1
valganciclovir tab (VALCYTE equiv)	-	1
GANCICLOVIR CAP	-	2
HEPATITIS AGENTS		
ribavirin cap (REBETOL equiv)	LMSP	1
ribavirin tab (COPEGUS equiv)	LMSP	1
EPIVIR HBV SOLN	-	2
HARVONI TAB (QL= 1 tab/ day)	LMSP-PA-QL	2
lamivudine tab 100mg (EPIVIR HBV equiv)	-	2
LEDIPASVIR/SOFOSBUVIR TAB (QL= 1 tab/ day)	LMSP-PA-QL	2
MAVYRET TAB (QL= 3 tabs/day)	LMSP-PA-QL	2
PEGASYS INJ	LMSP	2
PEG-INTRON INJ	LMSP	2
REBETOL SOLN	LMSP	2
SOVALDI TAB (QL= 1 tab/day)	LMSP-PA-QL	2
HERPES AGENTS		
acyclovir cap (ZOVIRAX equiv)	-	1
acyclovir susp (ZOVIRAX equiv)	-	1

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

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

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 6/1/2020

DrugName	Special Code	Tier
ANTIVIRALS Cont.		
acyclovir tab (ZOVIRAX equiv)	-	1
famciclovir tab (FAMVIR equiv)	-	1
valacyclovir tab (VALTREX equiv)	-	1
INFLUENZA AGENTS		
oseltamivir cap (TAMIFLU equiv) (QL= 10 caps/fill)	QL	1
oseltamivir cap 30mg (TAMIFLU equiv) (QL= 20 caps/fill)	QL	1
oseltamivir susp (TAMIFLU equiv) (QL= 250ml/fill)	QL	1
RIMANTADINE TAB	-	1
RELENZA DISKHALER (QL= 1 inhaler/fill)	QL	2
XOFLUZA TAB (QL= 2 tabs/fill; Covered for members 12 years of age or older)	QL	2

ASSORTED CLASSES

CHELATING AGENTS

D-PENAMINE TAB	-	2
----------------	---	---

IMMUNOMODULATORS

REVLIMID CAP (QL= 1 cap/day; Restricted to Oncology or Hematology Specialist)	MSP-QL-RS	2
THALOMID CAP	MSP-PA	2

IMMUNOSUPPRESSIVE AGENTS

azathioprine tab (IMURAN equiv)	-	1
cyclosporine cap (SANDIMMUNE equiv)	-	1
cyclosporine modified cap (NEORAL equiv)	-	1
cyclosporine modified soln (NEORAL equiv)	-	1
mycophenolate DR tab (MYFORTIC equiv)	-	1
mycophenolate mofetil cap (CELLCEPT equiv)	-	1

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

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

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 6/1/2020

DrugName	Special Code	Tier
ASSORTED CLASSES Cont.		
mycophenolate mofetil susp (CELLCEPT SUSP equiv)	-	1
mycophenolate mofetil tab (CELLCEPT equiv)	-	1
sirolimus tab (RAPAMUNE equiv)	-	1
tacrolimus cap (PROGRAF equiv)	-	1
CELLCEPT CAP	-	2
CELLCEPT TAB	-	2
NEORAL SOLN	-	2
PROGRAF CAP	-	2
SANDIMMUNE CAP	-	2
SANDIMMUNE SOLN 100MG/ML	-	2
ZORTRESS TAB 1MG	PA	2
POTASSIUM REMOVING RESINS		
sodium polystyrene powder (KAYEXALATE equiv)	-	1
sodium polystyrene susp (SPS equiv)	-	1
BETA BLOCKERS		
ALPHA-BETA BLOCKERS		
carvedilol tab (COREG equiv)	-	1
labetalol tab (NORMODYNE equiv)	-	1
BETA BLOCKERS CARDIO-SELECTIVE		
acebutolol cap (SECTRAL equiv)	-	1
atenolol tab (TENORMIN equiv)	-	1
betaxolol tab (KERLONE equiv)	-	1

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

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

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 6/1/2020

DrugName	Special Code	Tier
BETA BLOCKERS Cont.		
bisoprolol tab (ZEBETA equiv)	-	1
metoprolol ER tab (TOPROL XL equiv)	-	1
metoprolol tab (LOPRESSOR equiv)	-	1
FIRST ATENOLOL SOLN	-	2
FIRST METOPROLOL ORAL SOLN	-	2
BETA BLOCKERS NON-SELECTIVE		
nadolol tab (CORGARD equiv)	-	1
pindolol tab (VISKEN equiv)	-	1
propranolol ER cap (INDERAL LA equiv)	-	1
PROPRANOLOL SOLN	-	1
propranolol tab (INDERAL equiv)	-	1
sotalol AF tab (BETAPACE AF equiv)	-	1
sotalol tab (BETAPACE equiv)	-	1
timolol maleate tab (BLOCADREN equiv)	-	1
CALCIUM CHANNEL BLOCKERS		
CALCIUM CHANNEL BLOCKERS		
amlodipine tab (NORVASC equiv)	-	1
DILTIAZEM CAP	-	1
diltiazem ER cap (CARDIZEM CD equiv)	-	1
diltiazem ER cap (CARDIZEM SR equiv)	-	1
diltiazem ER cap (DILACOR XR equiv)	-	1
diltiazem ER cap (TIAZAC equiv)	-	1

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

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

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 6/1/2020

DrugName	Special Code	Tier
CALCIUM CHANNEL BLOCKERS Cont.		
diltiazem ER tab (CARDIZEM LA equiv)	-	1
diltiazem tab (CARDIZEM equiv)	-	1
felodipine ER tab (PLENDIL equiv)	-	1
isradipine cap (DYNACIRC equiv)	-	1
nifedipine cap (PROCARDIA equiv)	-	1
nifedipine ER tab (ADALAT CC equiv)	-	1
nimodipine cap (NIMOTOP equiv)	-	1
VERAPAMIL CAP 100MG	-	1
VERAPAMIL ER CAP 200MG	-	1
VERAPAMIL ER CAP 300MG	-	1
verapamil SR cap (VERELAN equiv)	-	1
VERAPAMIL SR CAP 360mg	-	1
verapamil SR tab (CALAN SR, ISOPTIN SR equiv)	-	1
verapamil tab (CALAN equiv)	-	1
CARDIOTONICS		
CARDIAC GLYCOSIDES		
DIGOXIN SOLN	-	1
digoxin soln (LANOXIN equiv)	-	1
digoxin tab (LANOXIN equiv)	-	1
CARDIOVASCULAR AGENTS - MISC.		
CARDIOVASCULAR AGENTS MISC. - COMBINATIONS		
amlodipine/atorvastatin tab (CADUET equiv)	-	1

PERIPHERAL VASODILATORS

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

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

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 6/1/2020

DrugName	Special Code	Tier
CARDIOVASCULAR AGENTS - MISC. Cont.		
isoxsuprine tab	-	1
PROSTAGLANDIN VASODILATORS		
TYVASO INH SOLN (Only available through Accredo 888-773-7376)	LD-PA	2
VENTAVIS INH SOLN (Only available through Accredo 888-773-7376)	LD-PA	2
PULMONARY HYPERTENSION - ENDOTHELIN RECEPTOR ANTAGONISTS		
ambrisentan tab (LETAIRIS equiv) (QL= 1 tab/day; Restricted to Cardiology or Pulmonology Specialist; Only available through Walgreens 888-347-3416)	LD-QL-RS	1
bosentan tab (TRACLEER equiv) (QL= 2 tabs/day; Restricted to Cardiology or Pulmonology Specialist; Only available through Walgreens 888-347-3416)	LD-QL-RS	1
OPSUMIT TAB (QL= 1 tab/day; Only available through CVS Specialty 800-237-276)	LD-PA-QL	2
TRACLEER TAB 32MG (Only available through Walgreens 888-347-3416)	LD-PA	2
PULMONARY HYPERTENSION - PHOSPHODIESTERASE INHIBITORS		
sildenafil tab 20mg (REVATIO equiv)	PA	1
tadalafil tab (PAH) (ADCIRCA equiv)	LMSP-PA	1
SINUS NODE INHIBITORS		
CORLANOR SOLN	PA	2
CORLANOR TAB	PA	2
CEPHALOSPORINS		
CEPHALOSPORINS - 1ST GENERATION		
cefadroxil cap (DURICEF equiv)	-	1
cefadroxil susp (DURICEF equiv)	-	1
cefadroxil tab (DURICEF equiv)	-	1
cephalexin cap (KEFLEX equiv)	-	1

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

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

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 6/1/2020

DrugName	Special Code	Tier
CEPHALOSPORINS Cont.		
cephalexin susp (KEFLEX equiv)	-	1
CEPHALOSPORINS - 2ND GENERATION		
cefaclor cap (CECLOR equiv)	-	1
cefprozil susp (CEFZIL equiv)	-	1
cefprozil tab (CEFZIL equiv)	-	1
cefuroxime susp (CEFTIN equiv)	-	1
cefuroxime tab (CEFTIN equiv)	-	1
CEFTIN SUSP	-	2
CEPHALOSPORINS - 3RD GENERATION		
cefdinir cap (OMNICEF equiv)	-	1
cefdinir susp (OMNICEF equiv)	-	1
cefixime susp (SUPRAX equiv)	-	1
cefpodoxime proxetil susp (VANTIN equiv)	-	1
cefpodoxime proxetil tab (VANTIN equiv)	-	1
CONTRACEPTIVES		
COMBINATION CONTRACEPTIVES - ORAL		
amethyst tab (LYBREL equiv)	-	1
cryselle tab	-	1
enpresse tab (TRI-LEVELLEN equiv)	-	1
gianvi tab, ocella tab (YASMIN, YAZ equiv)	-	1
isibloom tab, enskyce tab, apri tab (DESOGEN equiv)	-	1
junel FE tab (LOESTRIN FE equiv)	-	1

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

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

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 6/1/2020

DrugName	Special Code	Tier
CONTRACEPTIVES Cont.		
junel tab (LOESTRIN equiv)	-	1
kelnor tab (DEMULEN equiv)	-	1
mibelas chew tab (MINASTRIN equiv)	-	1
NECON TAB	-	1
nortrel 7/7/7 tab, pirmella 7/7/7 tab (TRI-NORINYL equiv)	-	1
nortrel tab (OVCON 35 equiv)	-	1
sprintec 28 tab (ORTHO-CYCLEN equiv)	-	1
tri-legest tab (ESTROSTEP FE equiv)	-	1
tri-sprintec tab (ORTHO TRI-CYCLEN (LO) equiv)	-	1
velivet tab (CYCLESSA equiv)	-	1
vienva tab, lessina tab, kurvelo tab (ALESSE equiv)	-	1
viorele tab, kariva tab (MIRCETTE equiv)	-	1
COMBINATION CONTRACEPTIVES - TRANSDERMAL		
XULANE PATCH	-	1
COMBINATION CONTRACEPTIVES - VAGINAL		
NUVARING	-	1
COPPER CONTRACEPTIVES - IUD		
PARAGARD IUD	-	\$0
EMERGENCY CONTRACEPTIVES		
levonorgestrel tab (PLAN B equiv)	OTC	1
ELLA TAB (QL= 1 tab/28 days)	QL	2
LEVONORGESTREL TAB 0.75MG	-	2
PROGESTIN CONTRACEPTIVES - IMPLANTS		

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

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

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 6/1/2020

DrugName	Special Code	Tier
CONTRACEPTIVES Cont.		
IMPLANON IMPLANT, NEXPLANON IMPLANT	-	\$0
PROGESTIN CONTRACEPTIVES - INJECTABLE		
medroxyprogesterone inj (DEPO-PROVERA equiv) (QL= 1 inj/90 days)	QL	1
PROGESTIN CONTRACEPTIVES - IUD		
MIRENA IUD	-	\$0
PROGESTIN CONTRACEPTIVES - ORAL		
norethindrone tab (NORA-QD equiv)	-	1
CORTICOSTEROIDS		
GLUCOCORTICOSTEROIDS		
budesonide SR cap (ENTOCORT EC equiv)	-	1
DEXAMETHASONE CONC	-	1
dexamethasone elixir	-	1
DEXAMETHASONE SOLN	-	1
dexamethasone tab (DECADRON equiv)	-	1
hydrocortisone tab (CORTEF equiv)	-	1
methylprednisolone dose pack (MEDROL equiv)	-	1
methylprednisolone tab (MEDROL equiv)	-	1
prednisolone ODT (ORAPRED equiv)	-	1
prednisolone soln (PEDIAPRED equiv)	-	1
PREDNISOLONE SYRUP	-	1
prednisolone syrup (PRELONE equiv)	-	1
PREDNISON SOLN	-	1
prednisone tab (DELTASONE equiv)	-	1

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

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

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 6/1/2020

DrugName	Special Code	Tier
CORTICOSTEROIDS Cont.		
CORTISONE ACETATE TAB	-	2
MINERALOCORTICIDS		
fludrocortisone tab (FLORINEF equiv)	-	1
COUGH/COLD/ALLERGY		
ANTITUSSIVES		
benzonatate cap (TESSALON equiv)	-	1
hydrocodone/homatropine syrup (HYCODAN equiv)	-	1
tussigon tab (HYCODAN equiv)	-	1
COUGH/COLD/ALLERGY COMBINATIONS		
cetirizine/pseudoephedrine 12-hour tab (ZYRTEC equiv) (QL= 2 tabs/day)	OTC-QL	1
dextromethorphan/guaifenesin syrup 10-100mg (ROBITUSSIN equiv)	OTC	1
fexofenadine/pseudoephedrine 12-hour tab (ALLEGRA-D 12 hour equiv)	OTC	1
fexofenadine/pseudoephedrine 24-hour tab (ALLEGRA-D equiv)	OTC	1
GUAIFENESIN/CODEINE SYRUP (QL= 240ml/fill)	OTC-QL	1
guaifenesin/codeine syrup (TUSSI-ORGANIDIN-S equiv) (QL= 240ml/fill)	OTC-QL	1
hydrocodone/chlorpheniramine/pseudoephedrine liquid (ZUTRIPRO equiv) (QL= 120ml/fill, 2 fills/month)	QL	1
loratadine/pseudoephedrine 12-hour tab (CLARITIN-D equiv)	OTC	1
loratadine/pseudoephedrine 24-hour tab (CLARITIN-D equiv)	OTC	1
promethazine DM syrup	-	1
PROMETHAZINE VC SYRUP	-	1
promethazine VC syrup (PHENERGAN VC equiv)	-	1
PROMETHAZINE VC/CODEINE SYRUP	-	1

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

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

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 6/1/2020

DrugName	Special Code	Tier
COUGH/COLD/ALLERGY Cont.		
promethazine VC/codeine syrup (PHENERGAN VC/CODEINE equiv)	-	1
promethazine/codeine syrup (PHENERGAN/CODEINE equiv)	-	1
EXPECTORANTS		
guaifenesin ER tab (MUCINEX equiv)	OTC	1
guaifenesin syrup 100mg/5ml (ROBITUSSIN equiv)	OTC	1
SSKI SOLN	-	2
MISC. RESPIRATORY INHALANTS		
sodium chloride neb soln (HYPER-SAL equiv)	OTC	1
NEBUSAL NEB SOLN	-	2
MUCOLYTICS		
acetylcysteine soln (MUCOMYST equiv)	-	1
DERMATOLOGICALS		
ACNE PRODUCTS		
adapalene cream (DIFFERIN equiv)	-	1
adapalene gel (DIFFERIN equiv)	-	1
amnestem cap, claravis cap, isotretinoin cap, myorisan cap, zenatane cap (ACCUTANE equiv)	-	1
benzoyl peroxide cream (NEOBENZ equiv)	OTC	1
benzoyl peroxide gel (OTC) (BENZAC equiv)	OTC	1
benzoyl peroxide liquid (BENZAC equiv)	OTC	1
benzoyl peroxide lotion (OTC) (TRIAZ equiv)	OTC	1
clindamycin gel (CLEOCIN GEL equiv)	-	1
clindamycin lotion (CLEOCIN- T equiv)	-	1

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

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

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 6/1/2020

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
clindamycin pad (CLEOCIN-T equiv)	-	1
clindamycin topical soln (CLEOCIN-T equiv)	-	1
clindamycin/benzoyl peroxide gel (BENZACLIN equiv)	-	1
clindamycin/benzoyl peroxide gel (DUAC GEL equiv)	-	1
ERY PAD	-	1
erythromycin gel	-	1
erythromycin pad	-	1
erythromycin soln	-	1
sodium sulfacetamide lotion (KLARON equiv)	-	1
sodium sulfacetamide/sulfur cream (PLEXION SCT equiv)	-	1
sodium sulfacetamide/sulfur emulsion (ROSULA equiv)	-	1
sodium sulfacetamide/sulfur foam (CLARIFOAM EF equiv)	-	1
sodium sulfacetamide/sulfur gel (ROSULA equiv)	-	1
sodium sulfacetamide/sulfur wash (SUMAXIN WASH equiv)	-	1
tretinoin cream	-	1
tretinoin gel (RETIN-A GEL equiv)	-	1
ALTRENO LOTION	-	2
AVAR GEL	-	2
PRASCION RA CREAM	-	2
ATRALIN GEL, RETIN-A GEL	-	2+penalty
RETIN-A CREAM	-	2+penalty

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

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

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 6/1/2020

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
AGENTS FOR WRINKLES/LIPOATROPHY/OTHER AESTHETIC USES		
RENOVA CREAM	-	EXC
ANTIBIOTICS - TOPICAL		
bacitracin oint	OTC	1
bacitracin/polymyxin B oint (POLYSPORIN equiv)	OTC	1
bacitracin/zinc oint	OTC	1
gentamicin sulfate cream	-	1
gentamicin sulfate oint	-	1
mupirocin oint (BACTROBAN OINT equiv)	-	1
neomycin/bacitracin/polymyxin oint (NEOSPORIN equiv)	OTC	1
ANTIFUNGALS - TOPICAL		
ciclopirox cream (LOPROX CREAM equiv)	-	1
ciclopirox gel (LOPROX GEL equiv)	-	1
ciclopirox shampoo (LOPROX SHAMPOO equiv)	-	1
ciclopirox topical susp (LOPROX SUSP equiv)	-	1
clotrimazole cream (OTC) (LOTRIMIN AF equiv)	OTC	1
clotrimazole/betamethasone cream (LORTRISONE CREAM equiv)	-	1
clotrimazole/betamethasone lotion (LOTRISONE LOTION equiv)	-	1
econazole cream (SPECTAZOLE equiv)	-	1
iodoquinol/hydrocortisone cream 1% (VYTONE equiv)	-	1
ketoconazole cream (NIZORAL CREAM equiv)	-	1
ketoconazole shampoo (NIZORAL SHAMPOO equiv)	-	1

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

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

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 6/1/2020

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
miconazole cream (MICATIN equiv)	OTC	1
miconazole nitrate aerosol (MICATIN equiv)	OTC	1
miconazole nitrate powder (MICATIN equiv)	OTC	1
naftifine cream (NAFTIN equiv)	-	1
nystatin cream (MYCOSTATIN CREAM equiv)	-	1
nystatin oint	-	1
nystatin topical powder	-	1
oxiconazole nitrate cream (OXISTAT equiv)	-	1
terbinafine cream (LAMISIL AT equiv)	OTC	1
tolnaftate aerosol (TINACTIN equiv)	OTC	1
tolnaftate cream (TINACTIN equiv)	OTC	1
tolnaftate powder (TINACTIN equiv)	OTC	1
tolnaftate soln (TINACTIN equiv)	OTC	1
MICONAZOLE NITRATE SPRAY	OTC	2
ANTI-INFLAMMATORY AGENTS - TOPICAL		
diclofenac gel 1% (VOLTAREN equiv) (QL= 5 tubes/fill)	QL	1
ANTINEOPLASTIC OR PREMALIGNANT LESION AGENTS - TOPICAL		
diclofenac gel (SOLARAZE equiv) (QL= 300gm/30 days)	PA-QL	1
fluorouracil cream (EFUDEX CREAM equiv)	-	1
FLUOROPLEX CREAM	-	2
FLUOROURACIL CREAM 0.5%	-	2
TARGRETIN GEL (Step Therapy requires trial of VALCHLOR GEL)	LMSP-ST	2

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

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

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 6/1/2020

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
VALCHLOR GEL (QL= 4 tubes/30 days; Only available through Avella (877) 546-5779)	LD-PA-QL	2
ANTIPSORIATICS		
acitretin cap (SORIATANE equiv)	-	1
calcipotriene cream (DOVONEX CREAM equiv)	-	1
calcipotriene oint	-	1
calcipotriene soln (DOVONEX SOLN equiv)	-	1
methoxsalen cap (OXSORALEN ULTRA equiv)	-	1
8-MOP CAP	-	2
COSENTYX INJ (1-PACK) (QL= 1 inj/28 days)	LMSP-PA-QL	2
COSENTYX INJ (2-PACK) (QL= 2 fills (4 inj)/ year)	LMSP-PA-QL	2
SKYRIZI INJ (QL= 2 inj/84 days)	LMSP-PA-QL	2
SORIATANE CK KIT	-	2
STELARA INJ (QL= 1 inj/84 days)	LMSP-PA-QL	2
tazarotene cream 0.1% (TAZORAC equiv)	-	2
TAZORAC CREAM 0.05%	-	2
ANTISEBORRHEIC PRODUCTS		
seb-prev cream (OVACE CREAM equiv)	-	1
selenium sulfide lotion	-	1
selenium sulfide shampoo (SELSEB equiv)	-	1
sodium sulfacetamide gel (OVACE PLUS equiv)	-	1
sodium sulfacetamide shampoo (OVACE equiv)	-	1

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

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

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 6/1/2020

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
sodium sulfacetamide wash (OVACE WASH equiv)	-	1
sodium sulfacetamide/urea pad (ROSULA equiv)	-	1
ANTIVIRALS - TOPICAL		
acyclovir oint (ZOVIRAX OINT equiv)	-	1
DENAVIR CREAM	-	2
BURN PRODUCTS		
silver sulfadiazine cream (SILVADENE CREAM equiv)	-	1
mafenide acetate soln packet (SULFAMYLON equiv)	-	2
SULFAMYLON CREAM	-	2
CORTICOSTEROIDS - TOPICAL		
alclometasone cream (ACLOVATE equiv)	-	1
alclometasone oint (ACLOVATE OINT equiv)	-	1
betamethasone augmented cream (DIPROLENE AF CREAM equiv)	-	1
betamethasone augmented gel	-	1
betamethasone augmented lotion (DIPROLENE LOTION equiv)	-	1
betamethasone augmented oint (DIPROLENE OINT equiv)	-	1
betamethasone dipropionate cream (DIPROSONE CREAM equiv)	-	1
betamethasone dipropionate lotion	-	1
betamethasone dipropionate oint (DIPROSONE OINT equiv)	-	1
betamethasone valerate cream	-	1
betamethasone valerate lotion	-	1
betamethasone valerate oint	-	1

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

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

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 6/1/2020

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
clobetasol foam	PA	1
clobetasol propionate cream (TEMOVATE equiv)	-	1
clobetasol propionate emollient cream (TEMOVATE E equiv)	-	1
clobetasol propionate gel (TEMOVATE GEL equiv)	-	1
clobetasol propionate oint (TEMOVATE equiv)	-	1
clobetasol propionate soln (TEMOVATE equiv)	-	1
clobetasol spray	PA	1
desoximetasone gel (TOPICORT equiv)	-	1
desoximetasone oint (TOPICORT equiv)	-	1
fluocinolone acetonide cream	-	1
fluocinolone acetonide oil (DERMA-SMOOTH/FS equiv)	-	1
fluocinolone acetonide oint	-	1
fluocinolone acetonide soln	-	1
fluocinonide cream 0.05% (LIDEX equiv)	-	1
fluocinonide emollient cream	-	1
fluocinonide gel	-	1
fluocinonide oint	-	1
fluocinonide soln	-	1
fluticasone propionate cream (CUTIVATE equiv)	-	1
fluticasone propionate oint (CUTIVATE equiv)	-	1
halobetasol propionate cream (ULTRAVATE equiv)	-	1
halobetasol propionate oint (ULTRAVATE equiv)	-	1

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

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

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 6/1/2020

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
hydrocortisone cream	OTC	1
hydrocortisone lotion (HYTONE equiv)	-	1
hydrocortisone oint	OTC	1
hydrocortisone pramoxine cream (PRAMOSONE equiv)	-	1
mometasone cream (ELOCON equiv)	-	1
mometasone oint (ELOCON equiv)	-	1
mometasone soln (ELOCON equiv)	-	1
triamcinolone cream	-	1
triamcinolone lotion	-	1
triamcinolone oint	-	1
triamcinolone spray (KENALOG equiv)	-	1
desonide cream (DESOWEN equiv)	-	2
desonide oint (DESOWEN equiv)	-	2
desoximetasone cream (DESOXIMETASONE equiv)	-	2
EPIFOAM AEROSOL	-	2
PRAMOSONE E CREAM	-	2
PRAMOSONE OINT	-	2
PREDNICARBATE CREAM	-	2
prednicarbate cream (DERMATOP equiv)	-	2
PREDNICARBATE OIN	-	2
U-CORT CREAM	-	2

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

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

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 6/1/2020

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
CLOBEX SPRAY	PA	2+penalty
OLUX FOAM	PA	2+penalty
ECZEMA AGENTS		
DUPIXENT INJ (QL= 2 inj/ 28 days)	LMSP-PA-QL	2
DUPIXENT INJ (QL= 2 inj/28 days)	LMSP-PA-QL	2
EMOLLIENTS		
ammonium lactate cream (LAC-HYDRIN equiv)	-	1
ammonium lactate lotion (LAC-HYDRIN equiv)	-	1
vitamin E liquid	OTC	1
HAIR GROWTH AGENTS		
finasteride tab (PROPECIA equiv)	-	EXC
HAIR REDUCTION AGENTS		
VANIQA CREAM	-	EXC
IMMUNOMODULATING AGENTS - TOPICAL		
imiquimod cream (ALDARA equiv)	-	1
IMMUNOSUPPRESSIVE AGENTS - TOPICAL		
pimecrolimus cream (ELIDEL equiv) (Covered for members 2 years or older; Step Therapy requires trial of tacrolimus oint)	ST	1
tacrolimus oint (PROTOPIC OINT equiv)	-	1
KERATOLYTIC/ANTIMITOTIC AGENTS		
podofilox soln (CONDYLOX equiv)	-	1

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

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

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 6/1/2020

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
salicylic acid shampoo (SALEX equiv)	-	1
PODOCON SOLN	-	2
LOCAL ANESTHETICS - TOPICAL		
lidocaine cream 3% (LIDAMANTLE equiv)	-	1
LIDOCAINE GEL	-	1
lidocaine gel (GLYDO equiv)	-	1
lidocaine gel (XYLOCAINE equiv)	-	1
lidocaine oint (QL= 107gm/30 days)	QL	1
lidocaine soln (XYLOCAINE equiv)	-	1
lidocaine/prilocaine cream (EMLA equiv)	-	1
MISC. TOPICAL		
aluminum chloride soln (DRYSOL equiv)	-	1
DRYSOL SOLN	-	1
PIGMENTING-DEPIGMENTING AGENTS		
hydroquinone cream (LUSTRA equiv)	-	EXC
TRI-LUMA CREAM	-	EXC
ROSACEA AGENTS		
azelaic acid gel (FINACEA equiv)	-	1
metronidazole cream (METROCREAM equiv)	-	1
metronidazole gel (METROGEL equiv)	-	1
metronidazole lotion (METROLOTION equiv)	-	1
FINACEA FOAM	-	2

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

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

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 6/1/2020

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
FINACEA PLUS KIT	-	2
SCABICIDES & PEDICULICIDES		
lice aerosol (QL= 150ml/7 days, Limited to 2 fills/year)	OTC-QL	1
lice cream rinse (NIX equiv) (QL= 59ml/7 days, Limited to 2 fills/year)	OTC-QL	1
lice treatment kit (RID equiv)	OTC	1
lice treatment liquid (RID equiv) (QL= 120ml/7 days, Limited to 2 fills/year)	OTC-QL	1
lice treatment shampoo (PRONTO equiv) (QL= 120ml/7 days, Limited to 2 fills/year)	OTC-QL	1
lindane lotion	-	1
LINDANE SHAMPOO	-	1
malathion lotion (OVIDE equiv) (QL= 1 bottle/30 days; Limited to 2 fills/year)	QL	1
permethrin cream (ELIMITE equiv) (QL= 60gm/30 days)	QL	1
permethrin lotion	OTC	1
EURAX CREAM	-	2
WOUND CARE PRODUCTS		
REGRANEX GEL (QL= 30gm/fill)	QL	2
DIAGNOSTIC PRODUCTS		
DIAGNOSTIC DRUGS		
GLUCAGEN INJ	-	2
GLUCAGON DIAGNOSTIC INJ (QL= 2 inj/fill, 1 fill/30 days)	QL	2
DIAGNOSTIC PRODUCTS, MISC.		
FREESTYLE LITE TEST STRIP	OTC	2
DIAGNOSTIC TESTS		
CLINISTIX TEST STRIP	OTC	1

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

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

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 6/1/2020

DrugName	Special Code	Tier
DIAGNOSTIC PRODUCTS Cont.		
KETO-DIASTIX TEST STRIP	OTC	1
KETOSTIX	OTC	1
ACCU-CHEK AVIVA PLUS TEST STRIP	OTC	2
ACCU-CHEK GUIDE TEST STRIP	OTC	2
ACCU-CHEK SMARTVIEW TEST STRIP	OTC	2
ACCU-CHEK TEST STRIP	OTC	2
FREESTYLE INSULINX TEST STRIP	OTC	2
FREESTYLE PRECISION NEO TEST STRIP	OTC	2
FREESTYLE TEST STRIP	OTC	2
PRECISION XTRA KETONE TEST STRIP	OTC	2
PRECISION XTRA TEST STRIP	OTC	2
DIGESTIVE AIDS		
DIGESTIVE ENZYMES		
CREON CAP	-	2
PANCREAZE CAP	-	2
DIURETICS		
CARBONIC ANHYDRASE INHIBITORS		
acetazolamide ER cap (DIAMOX SEQUEL equiv)	-	1
acetazolamide tab	-	1
methazolamide tab (NEPTAZANE equiv)	-	1
DIURETIC COMBINATIONS		
amiloride/hydrochlorothiazide tab (MODURETIC equiv)	-	1
spironolactone/hydrochlorothiazide tab (ALDACTAZIDE equiv)	-	1

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

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

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 6/1/2020

DrugName	Special Code	Tier
DIURETICS Cont.		
triamterene/hydrochlorothiazide cap (DYAZIDE equiv)	-	1
triamterene/hydrochlorothiazide tab (MAXZIDE equiv)	-	1
TRIAMTERENE/HYDROCHLOROTHIAZIDE CAP 50-25mg	-	2
LOOP DIURETICS		
bumetanide tab (BUMEX equiv)	-	1
ethacrynic tab (EDECIN equiv)	-	1
FUROSEMIDE SOLN	-	1
furosemide soln (LASIX equiv)	-	1
furosemide tab (LASIX equiv)	-	1
torseamide tab (DEMADEX equiv)	-	1
POTASSIUM SPARING DIURETICS		
amiloride tab (MIDAMOR equiv)	-	1
spironolactone tab (ALDACTONE equiv)	-	1
THIAZIDES AND THIAZIDE-LIKE DIURETICS		
CHLOROTHIAZIDE TAB	-	1
chlorothiazide tab (DIURIL equiv)	-	1
CHLORTHALIDONE TAB	-	1
hydrochlorothiazide cap (MICROZIDE equiv)	-	1
hydrochlorothiazide tab (HYDRODIURIL equiv)	-	1
indapamide tab (LOZOL equiv)	-	1
METHYCLOTHIAZIDE TAB	-	1
metolazone tab (ZAROXOLYN equiv)	-	1

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

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

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 6/1/2020

DrugName	Special Code	Tier
DIURETICS Cont.		
DIURIL SUSP	-	2
ENDOCRINE AND METABOLIC AGENTS - MISC.		
BONE DENSITY REGULATORS		
alendronate tab (FOSAMAX equiv)	-	1
calcitonin nasal spray (MIACALCIN equiv) (QL= 1 bottle/30 days)	QL	1
ALENDRONATE TAB 40MG	-	2
MIACALCIN INJ	LMSP	2
MIACALCIN NASAL SPRAY (QL= 1 bottle/30 days)	QL	2
GROWTH HORMONE RECEPTOR ANTAGONISTS		
SOMAVERT INJ (Only available through Walgreens 888-347-3416)	LD-PA	2
GROWTH HORMONE RELEASING HORMONES (GHRH)		
EGRIFTA INJ	-	EXC
GROWTH HORMONES		
GENOTROPIN INJ	LMSP-PA	2
HORMONE RECEPTOR MODULATORS		
raloxifene tab (EVISTA equiv)	-	1
INSULIN-LIKE GROWTH FACTORS (SOMATOMEDINS)		
INCRELEX INJ	MSP	2
METABOLIC MODIFIERS		
calcitriol cap (ROCALTROL equiv)	-	1
calcitriol soln (ROCALTROL equiv)	-	1
doxercalciferol cap (HECTOROL equiv)	-	1
levocarnitine soln (CARNITOR equiv)	-	1

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

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

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 6/1/2020

DrugName	Special Code	Tier
ENDOCRINE AND METABOLIC AGENTS - MISC. Cont.		
levocarnitine tab (CARNITOR equiv)	-	1
paricalcitol cap (ZEMPLAR equiv)	-	1
sodium phenylbutyrate powder (BUPHENYL equiv)	PA	1
sodium phenylbutyrate tab (BUPHENYL equiv)	PA	1
RAVICTI LIQUID	-	2
POSTERIOR PITUITARY HORMONES		
desmopressin acetate inj (DDAVP equiv)	-	1
desmopressin acetate nasal spray (DDAVP equiv)	-	1
desmopressin acetate tab (DDAVP equiv)	-	1
desmopressin nasal soln (DDAVP equiv)	-	1
STIMATE NASAL SOLN	-	2
PROLACTIN INHIBITORS		
cabergoline tab (DOSTINEX equiv)	-	1
SOMATOSTATIC AGENTS		
octreotide inj (SANDOSTATIN equiv)	LMSP	1
SANDOSTATIN INJ	LMSP	2
ESTROGENS		
ESTROGEN COMBINATIONS		
esterified estrogens/methyltestosterone tab (ESTRATEST equiv)	-	1
estradiol/norethindrone tab (ACTIVELLA equiv)	-	1
jinteli tab (FEMHRT equiv)	-	1
PREMPHASE TAB, PREMPRO TAB	-	2
ESTROGENS		

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

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

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 6/1/2020

DrugName	Special Code	Tier
ESTROGENS Cont.		
estradiol patch (CLIMARA equiv)	-	1
estradiol patch (VIVELLE-DOT equiv)	-	1
estradiol tab (ESTRACE equiv)	-	1
ESTROPIPATE TAB	-	1
estropipate tab (OGEN equiv)	-	1
PREMARIN TAB	-	2
FLUROQUINOLONES		
FLUROQUINOLONES		
ciprofloxacin susp (CIPRO equiv)	-	1
ciprofloxacin tab (CIPRO equiv)	-	1
levofloxacin soln (LEVAQUIN equiv)	-	1
levofloxacin tab (LEVAQUIN equiv)	-	1
moxifloxacin tab (AVELOX equiv)	-	1
ofloxacin tab (FLOXIN equiv)	-	1
GASTROINTESTINAL AGENTS - MISC.		
GALLSTONE SOLUBILIZING AGENTS		
ursodiol cap (ACTIGALL equiv)	-	1
ursodiol tab (URSO (FORTE) equiv)	-	1
GASTROINTESTINAL ANTIALLERGY AGENTS		
cromolyn conc (GASTROCROM equiv)	-	2
GASTROINTESTINAL STIMULANTS		
metoclopramide soln (REGLAN equiv)	-	1
metoclopramide tab (REGLAN equiv)	-	1

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

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

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 6/1/2020

DrugName	Special Code	Tier
GASTROINTESTINAL AGENTS - MISC. Cont.		
INFLAMMATORY BOWEL AGENTS		
balsalazide cap (COLAZAL equiv)	-	1
mesalamine DR tab (LIALDA equiv)	-	1
mesalamine enema (ROWASA equiv)	-	1
sulfasalazine EC tab (AZULFIDINE equiv)	-	1
sulfasalazine tab (AZULFIDINE equiv)	-	1
CIMZIA INJ (QL= 2 inj/28 days)	LMSP-PA-QL	2
CIMZIA STARTER INJ KIT (QL= 1 kit/plan year)	LMSP-PA-QL	2
PENTASA CAP	-	2
INTESTINAL ACIDIFIERS		
lactulose soln	-	1
IRRITABLE BOWEL SYNDROME (IBS) AGENTS		
alosetron tab (LOTROSEX equiv)	-	1
PHOSPHATE BINDER AGENTS		
calcium acetate cap (PHOSLO equiv)	-	1
sevelamer powder pak (RENVELA PAK equiv)	-	1
sevelamer tab (RENVELA TAB equiv)	-	1
FOSRENOL POWDER PACK	-	2
GENITOURINARY AGENTS - MISCELLANEOUS		
ALKALINIZERS		
CYTRA-3 SYRUP	-	1
ORACIT SOLN	-	1
potassium citrate CR tab (UROKIT-K TAB equiv)	-	1

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

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

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 6/1/2020

DrugName	Special Code	Tier
GENITOURINARY AGENTS - MISCELLANEOUS Cont.		
potassium citrate/citric acid powder pack (POLYCITRA equiv)	-	1
potassium citrate/citric acid soln (POLYCITRA-K equiv)	-	1
sodium citrate/citric acid soln (BICITRA equiv)	-	1
tricitrates soln (POLYCITRA-LC equiv)	-	1
CYSTINOSIS AGENTS		
CYSTAGON CAP (Only available through CVS Specialty 800-238-7828)	LD	2
INTERSTITIAL CYSTITIS AGENTS		
ELMIRON CAP	-	2
PROSTATIC HYPERTROPHY AGENTS		
dutasteride cap (AVODART equiv)	-	1
finasteride tab (PROSCAR equiv)	-	1
tamsulosin cap (FLOMAX equiv)	-	1
alfuzosin SR tab (UROXATRAL equiv)	-	2
URINARY ANALGESICS		
phenazopyridine tab (PYRIDIUM equiv)	-	1
GOUT AGENTS		
GOUT AGENT COMBINATIONS		
colchicine/probenecid tab (COL-BENEMID equiv)	-	1
GOUT AGENTS		
allopurinol tab (ZYLOPRIM equiv)	-	1
colchicine tab (COLCRYS equiv)	-	1
URICOSURICS		
probenecid tab (BENEMID equiv)	-	1

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

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

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 6/1/2020

DrugName	Special Code	Tier
HEMATOLOGICAL AGENTS - MISC.		
ANTIHEMOPHILIC PRODUCTS		
HEMLIBRA INJ	LMSP-PA	2
BRADYKININ B2 RECEPTOR ANTAGONISTS		
icatibant inj (FIRAZYR equiv)	LMSP-PA	1
COMPLEMENT INHIBITORS		
BERINERT INJ (Only available through Walgreens 888-347-3416)	LD-PA	2
CINRYZE INJ (QL= 16 vials/28 days; Only available through CVS Specialty 800-237-2767)	LD-PA-QL	2
HAEGARDA INJ	MSP-PA	2
RUCONEST INJ (Only available through CVS Specialty 800-237-2767)	LD-PA	2
HEMATORHEOLOGIC AGENTS		
pentoxifylline ER tab (TRENTAL equiv)	-	1
PLASMA KALLIKREIN INHIBITORS		
TAKHZYRO INJ (QL= 2 inj/28 days; Only available through CVS Specialty 800-237-2767)	LD-PA-QL	2
PLATELET AGGREGATION INHIBITORS		
anagrelide cap (AGRYLIN equiv)	-	1
cilostazol tab (PLETAL equiv)	-	1
clopidogrel tab 75mg (PLAVIX equiv)	-	1
dipyridamole tab (PERSANTINE equiv)	-	1
ticlopidine tab (TICLID equiv)	-	1
HEMATOPOIETIC AGENTS		
AGENTS FOR GAUCHER DISEASE		

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

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

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 6/1/2020

DrugName	Special Code	Tier
HEMATOPOIETIC AGENTS Cont.		
miglustat cap (ZAVESCA equiv) (Only available through Accredo 888-773-7376)	LD-PA	1
CEREZYME INJ	MSP-PA	2
AGENTS FOR SICKLE CELL ANEMIA		
DROXIA CAP	-	2
COBALAMINS		
cyanocobalamin inj	-	1
FOLIC ACID/FOLATES		
folic acid tab 1mg	-	1
HEMATOPOIETIC GROWTH FACTORS		
FULPHILA INJ	PA	2
LEUKINE INJ	LMSP-PA	2
NIVESTYM INJ	LMSP	2
RETACRIT INJ	PA	2
ZARXIO INJ	LMSP	2
ZIEXTENZO INJ	MSP	2
HEMATOPOIETIC MIXTURES		
ferrex 150 forte cap	-	1
ferrex 150 forte cap (NIFEREX 150 FORTE equiv)	-	1
folbee tab	-	1
MULTIGEN FOLIC TAB	-	1
MULTIGEN PLUS TAB	-	1
MULTIGEN TAB	-	1
tricon cap (TRINSICON equiv)	-	1

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

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

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 6/1/2020

DrugName	Special Code	Tier
HEMATOPOIETIC AGENTS Cont.		
NEPHRON FA TAB	-	2
IRON		
ferrous sulfate soln (FER-IN-SOL equiv)	OTC	\$0
iron complex cap 150mg	OTC	1
HEMOSTATICS		
HEMOSTATICS - SYSTEMIC		
aminocaproic acid soln (AMICAR equiv)	-	1
aminocaproic acid syrup (AMICAR equiv)	-	1
aminocaproic acid tab (AMICAR equiv)	-	1
tranexamic acid tab (LYSTEDA equiv) (QL= 1 tab/day; Step Therapy requires trial o generic NSAID)	QL-ST	2
HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS		
ANTI-HISTAMINE HYPNOTICS		
diphenhydramine cap (OTC only)	OTC	1
diphenhydramine tab (NYTOL equiv)	OTC	1
BARBITURATE HYPNOTICS		
phenobarbital elixir	-	1
phenobarbital tab	-	1
SECONAL CAP	-	2
NON-BARBITURATE HYPNOTICS		
estazolam tab (PROSOM equiv)	-	1
eszopiclone tab (LUNESTA equiv) (QL= 1 tab/day)	QL	1
FLURAZEPAM CAP	-	1

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

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

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 6/1/2020

DrugName	Special Code	Tier
HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS Cont.		
temazepam cap 15mg (RESTORIL equiv)	-	1
temazepam cap 30mg (RESTORIL equiv)	-	1
triazolam tab (HALCION equiv)	-	1
zaleplon cap (SONATA equiv)	-	1
LAXATIVES		
LAXATIVE COMBINATIONS		
peg 3350/electrolytes soln (GOLYTELY/COLYTE equiv)	-	1
trilyte soln (NULYTELY equiv)	-	1
MOVIPREP SOLN (QL= 1 bottle/fill)	QL	2
LAXATIVES - MISCELLANEOUS		
glycerin supp (GLYCERIN equiv)	OTC	1
lactulose soln	-	1
polyethylene glycol 3350 powder (MIRALAX equiv)	OTC	1
SALINE LAXATIVES		
milk of magnesium	OTC	1
STIMULANT LAXATIVES		
senna cap (SENOKOT equiv)	OTC	1
senna syrup (SENOKOT equiv)	OTC	1
senna tab (SENOKOT equiv)	OTC	1
SURFACTANT LAXATIVES		
docusate calcium cap (KAOPECTATE equiv)	OTC	1
docusate sodium cap (COLACE equiv)	OTC	1
docusate sodium liquid (COLACE equiv)	OTC	1

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

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

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 6/1/2020

DrugName	Special Code	Tier
LAXATIVES Cont.		
docusate sodium syrup (COLACE equiv)	OTC	1
docusate sodium tab (COLACE equiv)	OTC	1
MACROLIDES		
AZITHROMYCIN		
azithromycin susp (ZITHROMAX equiv)	-	1
azithromycin tab (ZITHROMAX equiv)	-	1
ZITHROMAX POWDER PACK	-	1
CLARITHROMYCIN		
clarithromycin ER tab (BIAXIN XL equiv)	-	1
clarithromycin susp (BIAXIN equiv)	-	1
clarithromycin tab (BIAXIN equiv)	-	1
CLARITHROMYC SUSP	-	2
ERYTHROMYCINS		
erythromycin ethylsuccinate susp (ERYPED equiv)	-	1
erythromycin tab (ERY-TAB equiv)	-	1
erythromycin DR cap (ERYC equiv)	-	2
ERYTHROMYCIN EC CAP	-	2
ERYTHROMYCIN ETHYLSUCCINATE TAB	-	2
erythromycin stearate tab	-	2
FIDAXOMICIN		
DIFICID TAB (QL= 20 tabs/fill; Step Therapy requires trial of vancomycin cap, vancomycin soln, or FIRVANQ SOLN)	QL-ST	2

MEDICAL DEVICES AND SUPPLIES

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

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

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 6/1/2020

DrugName	Special Code	Tier
MEDICAL DEVICES AND SUPPLIES Cont.		
CONTRACEPTIVES		
FEMALE CONDOMS	OTC	\$0
DIAPHRAGM	-	2
DIABETIC SUPPLIES		
ACCU-CHEK AVIVA PLUS METER	OTC	\$0
ACCU-CHEK GUIDE CARE METER	OTC	\$0
ACCU-CHEK GUIDE ME KIT	OTC	\$0
ACCU-CHEK NANO METER	OTC	\$0
FREESTYLE FREEDOM LITE METER	OTC	\$0
FREESTYLE INSULINX METER	OTC	\$0
FREESTYLE LITE METER	OTC	\$0
FREESTYLE PRECISION NEO METER	OTC	\$0
PRECISION XTRA METER	OTC	\$0
CALIBRATION LIQUID	OTC	1
LANCET KIT	OTC	1
LANCETS	OTC	1
V-GO INJ KIT (QL= 1 kit/day)	QL	2
MISC. DEVICES		
ALCOHOL SWABS	OTC	2
PARENTERAL THERAPY SUPPLIES		
B-D INSULIN SYRINGE	--OTC	1
B-D PEN NEEDLE	OTC	1

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

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

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 6/1/2020

DrugName	Special Code	Tier
MEDICAL DEVICES AND SUPPLIES Cont.		
NOVOFINE PEN NEEDLE	OTC	1
NOVOTWIST PEN NEEDLE	OTC	1
NOVOTWIST/NOVOFINE PEN NEEDLE	OTC	1
RESPIRATORY THERAPY SUPPLIES		
PEAK FLOW METER	OTC	1
AEROCHAMBER	OTC	2
MIGRAINE PRODUCTS		
MIGRAINE COMBINATIONS		
MIGERGOT SUPP	-	2
SEROTONIN AGONISTS		
naratriptan tab (AMERGE equiv) (QL= 9 tabs/30 days)	QL	1
rizatriptan ODT (MAXALT equiv) (QL= 12 tabs/30 days)	QL	1
rizatriptan tab (MAXALT equiv) (QL= 12 tabs/30 days)	QL	1
sumatriptan inj (QL= 6 inj/30 days)	QL	1
sumatriptan nasal spray (IMITREX, SUMATRIPTAN equiv) (QL= 6 sprays/fill, 2 fills/ days)	QL	1
sumatriptan tab (IMITREX equiv) (QL= 9 tabs/30 days)	QL	1
sumatriptan vial inj (IMITREX equiv) (QL= 5 inj/fill, 2 fills/30 days)	QL	1
SUMATRIPTAN INJ 6MG/0.5ML (QL= 6 inj/30 days)	QL	2
MINERALS & ELECTROLYTES		
CALCIUM		
calcium carbonate susp	OTC	1
calcium carbonate tab	OTC	1

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

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

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 6/1/2020

DrugName	Special Code	Tier
MINERALS & ELECTROLYTES Cont.		
calcium w/vitamin D tab	OTC	1
CALCIUM W/ VITAMIN D TAB	OTC	2
FLUORIDE		
FLUOR-A-DAY CHEW TAB	-	1
sodium fluoride chew tab (LURIDE equiv)	-	1
SODIUM FLUORIDE LOZENGE	-	1
sodium fluoride soln (LURIDE SOLN. equiv)	-	1
SODIUM FLUORIDE TAB	-	1
FLUORABON SOLN	-	2
PHOSPHATE		
phospha 250 neutral tab (K-PHOS NEUTRAL equiv)	-	1
K-PHOS TAB	-	2
POTASSIUM		
K-TAB	-	1
POT/CHLORIDE EFFER TAB	-	1
potassium bicarbonate effer tab (K-LYTE equiv)	-	1
potassium chloride effer tab (K-LYTE/CL equiv)	-	1
potassium chloride ER cap (MICRO-K equiv)	-	1
potassium chloride ER tab (K-TAB equiv)	-	1
potassium chloride micro tab (K-DUR equiv)	-	1
KLOR-CON M15 TAB	-	2
potassium chloride powder packet (KLOR-CON equiv)	-	2

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

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

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 6/1/2020

DrugName	Special Code	Tier
MINERALS & ELECTROLYTES Cont.		
potassium chloride soln	-	2
ZINC		
zinc sulfate cap	-	1
GALZIN CAP	-	2
MISCELLANEOUS THERAPEUTIC CLASSES		
CHELATING AGENTS		
penicillamine tab (DEPEN TITRATAB equiv)	-	1
IMMUNOSUPPRESSIVE AGENTS		
everolimus tab 0.25mg, 0.5mg, 0.75mg (ZORTRESS equiv)	PA	1
sirolimus soln (RAPAMUNE equiv)	-	1
MOUTH/THROAT/DENTAL AGENTS		
ANESTHETICS TOPICAL ORAL		
benzocaine gel	OTC	1
benzocaine paste	OTC	1
lidocaine viscous soln	-	1
LIDOCAINE ORAL SOLN 4%	-	2
ANTIALLERGY AGENTS - MOUTH/THROAT		
APHTHASOL PASTE	-	2
ANTI-INFECTIVES - THROAT		
clotrimazole troches (MYCELEX TROCHES equiv)	-	1
nystatin susp	-	1
ANTISEPTICS - MOUTH/THROAT		
chlorhexidine gluconate soln (PERIDEX equiv)	-	1

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

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

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 6/1/2020

DrugName	Special Code	Tier
MOUTH/THROAT/DENTAL AGENTS Cont.		
DENTAL PRODUCTS		
sodium fluoride cream (PREVIDENT 5000 PLUS equiv)	-	1
sodium fluoride gel (PREVIDENT equiv)	-	1
sodium fluoride paste (PREVIDENT equiv)	-	1
sodium fluoride rinse (PREVIDENT equiv)	-	1
sodium fluoride/potassium nitrate paste (PREVIDENT equiv)	-	1
PREVIDENT PASTE	-	2
STEROIDS - MOUTH/THROAT		
triamcinolone in orabase paste (KENALOG/ORABASE equiv)	-	1
THROAT PRODUCTS - MISC.		
cevimeline cap (EVOXAC equiv)	-	1
pilocarpine tab (SALAGEN equiv)	-	1
MULTIVITAMINS		
B-COMPLEX W/ FOLIC ACID		
DIALYVITE TAB	-	1
dialyvite tab (NEPHRO-VITE equiv)	--OTC	1
DIALYVITE/ZINC TAB	-	1
FOLBEE PLUS CZ TAB	-	1
renaphro cap (NEPHROCAP equiv)	-	1
MULTIPLE VITAMINS W/ MINERALS		
multivitamin/minerals tab (STROVITE equiv)	-	1
MULTIVITAMINS		
multiple vitamin liquid	OTC	1

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

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

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 6/1/2020

DrugName	Special Code	Tier
MULTIVITAMINS Cont.		
PED MULTI VITAMINS W/FL & FE		
pediatric multiple vitamins/fluoride/iron soln	-	1
POLY-VI-FLOR SUSP	-	2
PED MULTIPLE VITAMINS W/ MINERALS		
pediatric multivitamin (VITALETS equiv)	OTC	1
PED MV W/ FLUORIDE		
pediatric multiple vitamins/fluoride chew tab	-	1
pediatric multiple vitamins/fluoride soln	-	1
FLORIVA PLUS DROPS	-	2
TRI-VI-FLOR SUSP	-	2
PED MV W/ IRON		
pediatric multivitamin (VITALETS equiv)	OTC	1
PRENATAL VITAMINS		
PRENATABS RX TAB	-	1
PRENATAL 19 TAB	-	1
prenatal vitamin	OTC	1
PRENATAL VITAMIN	OTC	2
PRENATAL VITAMIN (OTC only)	OTC	2
MUSCULOSKELETAL THERAPY AGENTS		
CENTRAL MUSCLE RELAXANTS		
baclofen tab 10mg, 20mg	-	1
carisoprodol tab (SOMA equiv)	-	1
chlorzoxazone tab 500mg	-	1

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

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

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 6/1/2020

DrugName	Special Code	Tier
MUSCULOSKELETAL THERAPY AGENTS Cont.		
cyclobenzaprine tab 10mg (FLEXERIL equiv)	-	1
cyclobenzaprine tab 5mg (FLEXERIL equiv)	-	1
methocarbamol tab (ROBAXIN equiv)	-	1
orphenadrine citrate ER tab (NORFLEX equiv)	-	1
tizanidine cap (ZANAFLEX equiv)	-	1
tizanidine tab (ZANAFLEX equiv)	-	1
DIRECT MUSCLE RELAXANTS		
dantrolene cap (DANTRIUM equiv)	-	1
MUSCLE RELAXANT COMBINATIONS		
orphenadrine/aspirin/caffeine tab (NORGESIC FORTE equiv)	-	1
NASAL AGENTS - SYSTEMIC AND TOPICAL		
NASAL AGENTS - MISC.		
saline nasal spray (OCEAN equiv)	OTC	1
NASAL ANTIALLERGY		
azelastine nasal spray 0.1% (ASTELIN equiv) (QL= 1 bottle/month)	QL	1
azelastine nasal spray 0.15% (ASTEPRO equiv) (QL= 1 bottle/month)	QL	1
cromolyn nasal spray (NASALCROM equiv)	OTC	1
NASAL STEROIDS		
FLUNISOLIDE NASAL SPRAY	-	1
fluticasone nasal spray (FLONASE equiv)	-	1
mometasone nasal spray (NASONEX equiv)	-	1
triamcinolone OTC nasal spray (NASACORT equiv) (QL= 2 bottles/fill)	OTC-QL	1
triamcinolone nasal spray (NASACORT equiv)	-	2

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

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

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 6/1/2020

DrugName	Special Code	Tier
NASAL AGENTS - SYSTEMIC AND TOPICAL Cont.		
SYMPATHOMIMETIC DECONGESTANTS		
pseudoephedrine 12hr tab (SUDAFED equiv)	OTC	1
pseudoephedrine tab (SUDAFED equiv)	OTC	1
pseudopseudoephedrine liquid (SUDAFED equiv)	OTC	1
OPHTHALMIC AGENTS		
ARTIFICIAL TEARS AND LUBRICANTS		
artificial tears	OTC	1
artificial tears (LIQUIFILM equiv)	OTC	1
artificial tears ophth soln (AQUASITE equiv) (QL= 25ml/30 days)	OTC-QL	1
genteal ophth oint	OTC	1
BETA-BLOCKERS - OPHTHALMIC		
betaxolol ophth soln (BETOPTIC-S equiv)	-	1
carteolol ophth soln (OCUPRESS equiv)	-	1
dorzolamide/timolol (pf) ophth soln (COSOPT equiv)	-	1
LEVOBUNOLOL OPHTH SOLN	-	1
levobunolol ophth soln (BETAGAN equiv)	-	1
timolol maleate ophth gel (TIMOPTIC-XE equiv)	-	1
timolol maleate ophth soln (TIMOPTIC equiv)	-	1
timolol maleate ophth soln 0.5% (ISTALOL equiv)	-	1
BETIMOL OPHTH SOLN	-	2
BETOPTIC-S OPHTH SOLN	-	2
COMBIGAN OPHTH SOLN	-	2

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

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

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 6/1/2020

DrugName	Special Code	Tier
OPHTHALMIC AGENTS Cont.		
DORZOLAMIDE/TIMOLOL OPHTH SOLN	-	2
ISTALOL OPHTH SOLN	-	2
METIPRANOLOL OPHTH SOLN	-	2
TIMOLOL OPHTH GEL SOLN	-	2
CYCLOPLEGIC MYDRIATICS		
atropine ophth oint	-	1
atropine ophth soln (ISOPTO ATROPINE equiv)	-	1
cyclopentolate ophth soln (CYCLOGYL equiv)	-	1
homatropine ophth soln (ISOPTO HOMATROPINE equiv)	-	1
phenylephrine ophth soln (MYDFRIN equiv)	-	1
tropicamide ophth soln (MYDRIACYL equiv)	-	1
CYCLOMYDRIL OPHTH SOLN	-	2
HOMATROPINE OPHTH SOLN	-	2
ISOPTO HYOSCINE OPHTH SOLN	-	2
MIOTICS		
pilocarpine ophth soln (ISOPTO CARPINE equiv)	-	1
ISOPTO CARBACHOL OPHTH SOLN	-	2
PHOSPHOLINE OPHTH SOLN	-	2
OPHTHALMIC ADRENERGIC AGENTS		
apraclonidine ophth soln (IOPIDINE equiv)	-	1
brimonidine ophth soln 0.2%	-	1
ALPHAGAN P OPHTH SOLN 0.1%	-	2

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

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

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 6/1/2020

DrugName	Special Code	Tier
OPHTHALMIC AGENTS Cont.		
ALPHAGAN P OPHTH SOLN 0.15%	-	2
brimonidine ophth soln 0.15% (ALPHAGAN P 0.15% equiv)	-	2
IOPIDINE OPHTH SOLN 1%	-	2
OPHTHALMIC ANTI-INFECTIVES		
bacitracin/neomycin/polymyxin b ophth oint (NEOSPORIN equiv)	-	1
bacitracin/polymyxin b ophth oint (POLYSPORIN equiv)	-	1
ciprofloxacin ophth soln (CILOXAN equiv)	-	1
erythromycin ophth oint	-	1
gatifloxacin ophth soln (ZYMAXID equiv)	-	1
GENTAK OPHTH OINT	-	1
gentamicin ophth oint (GARAMYCIN equiv)	-	1
gentamicin ophth soln (GARAMYCIN equiv)	-	1
levofloxacin ophth soln (QUIXIN equiv)	-	1
moxifloxacin ophth soln (VIGAMOX OPHTH SOLN equiv)	-	1
NEOMYCIN/POLYMIXIN/GRAMICIDIN OPHTH SOLN	-	1
ofloxacin ophth soln (OCUFLOX equiv)	-	1
polymyxin b/trimethoprim ophth soln (POLYTRIM equiv)	-	1
sulfacetamide sodium ophth soln (BLEPH-10 equiv)	-	1
tobramycin ophth soln (TOBREX equiv)	-	1
TRIFLURIDINE OPHTH SOLN	-	1
trifluridine ophth soln (VIROPTIC equiv)	-	1
AZASITE SOLN	-	2

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

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

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 6/1/2020

DrugName	Special Code	Tier
OPHTHALMIC AGENTS Cont.		
BACITRACIN OPHTH OINT	-	2
ZIRGAN OPHTH GEL	-	2
OPHTHALMIC LOCAL ANESTHETICS		
proparacaine ophth soln (ALCAINE equiv)	-	1
OPHTHALMIC NERVE GROWTH FACTORS		
OXERVATE OPHTH SOLN (QL= 8 kits/affected eye/lifetime; Only available through Accredo 888-773-7376)	LD-PA-QL	2
OPHTHALMIC STEROIDS		
bacitracin/polymyxin/neomycin/hydrocortisone ophth oint (CORTISPORIN equiv)	-	1
dexamethasone ophth soln	-	1
fluorometholone ophth soln (FML LIQUIFILM equiv)	-	1
loteprednol ophth susp (LOTEMAX equiv)	-	1
neomycin/polymyxin/dexamethasone ophth oint (MAXITROL equiv)	-	1
neomycin/polymyxin/dexamethasone ophth soln (MAXITROL equiv)	-	1
NEOMYCIN/POLYMYXIN/HYDROCORTISONE OPHTH SOLN	-	1
PREDNISOLONE OPHTH SUSP	-	1
PREDNISOLONE SODIUM PHOSPHATE OPHTH SOLN	-	1
sulfacetamide sodium/prednisolone ophth soln (VASOCIDIN equiv)	-	1
tobramycin/dexamethasone ophth soln (TOBRADEX equiv)	-	1
ALREX OPHTH SUSP	-	2
BLEPHAMIDE OPHTH SOLN	-	2
DUREZOL OPHTH EMULSION	-	2

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

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

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 6/1/2020

DrugName	Special Code	Tier
OPHTHALMIC AGENTS Cont.		
FML FORTE OPHTH SUSP	-	2
LOTEMAX OPHTH GEL	-	2
LOTEMAX OPHTH OINT	-	2
MAXIDEX OPHTH SOLN	-	2
PRED MILD OPHTH SOLN	-	2
PRED-G OPHTH SOLN	-	2
VEXOL OPHTH SUSP	-	2
ZYLET OPHTH SUSP (QL= 5ml/fill (10ml bottle is Not Covered))	QL	2
OPHTHALMICS - MISC.		
azelastine ophth soln (OPTIVAR equiv)	-	1
cromolyn ophth soln (CROLOM equiv)	-	1
diclofenac sodium ophth soln (VOLTAREN equiv)	-	1
dorzolamide ophth soln (TRUSOPT equiv)	-	1
epinastine ophth soln (ELESTAT equiv)	-	1
ketorolac ophth soln (ACULAR (LS) equiv)	-	1
ketotifen ophth soln (ZADITOR equiv) (QL= 2 bottles/30 days)	OTC-QL	1
olopatadine ophth soln 0.1% (PATANOL equiv)	-	1
olopatadine ophth soln 0.2% (PATADAY equiv) (QL= 2.5ml/30 days)	QL	1
ALOCRIAL OPHTH SOLN	-	2
ALOMIDE OPHTH SOLN	-	2
CYSTARAN OPHTH SOLN (Only available through Walgreens 888-347-3416)	LD-PA	2
PROSTAGLANDINS - OPHTHALMIC		

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

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

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 6/1/2020

DrugName	Special Code	Tier
OPHTHALMIC AGENTS Cont.		
bimatoprost ophth soln (QL= 2.5ml/30 days)	QL	1
latanoprost ophth soln (XALATAN equiv) (QL= 2.5ml/30 days)	QL	1
travoprost ophth soln (TRAVATAN Z equiv) (QL= 5ml/30 days)	QL	1
LUMIGAN OPHTH SOLN (QL= 2.5ml/30 days)	QL	2
OTIC AGENTS		
OTIC AGENTS - MISCELLANEOUS		
acetic acid otic soln (VOSOL equiv)	-	1
ACETIC ACID/ALUMINUM ACETATE OTIC SOLN	-	1
carbamide peroxide otic soln (DEBROX equiv)	OTC	1
OTIC ANTI-INFECTIVES		
ofloxacin otic soln (FLOXIN equiv)	-	1
CIPROFLOXACIN OTIC SOLN	-	2
OTIC COMBINATIONS		
neomycin/polymixin/hydrocortisone otic soln (CORTISPORIN equiv)	-	1
neomycin/polymixin/hydrocortisone otic susp (CORTISPORIN equiv)	-	1
CIPRODEX OTIC SUSP	-	2
COLY-MYCIN S OTIC SUSP	-	2
OTIC STEROIDS		
acetic acid/hydrocortisone otic soln (VOSOL HC equiv)	-	1
fluocinolone otic oil (DERMOTIC equiv)	-	1
OXYTOCICS		
OXYTOCICS		
methylergonovine tab (METHERGINE equiv) (QL= 28 tabs/fill; 1 fill/365 days)	QL	2

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

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

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 6/1/2020

DrugName	Special Code	Tier
PASSIVE IMMUNIZING AGENTS		
MONOCLONAL ANTIBODIES		
SYNAGIS INJ (Available through Avella Specialty Pharmacy 877-470-7603)	MSP-PA	2
PENICILLINS		
AMINOPENICILLINS		
amoxicillin cap (TRIMOX equiv)	-	1
AMOXICILLIN CHEW TAB	-	1
amoxicillin susp (TRIMOX equiv)	-	1
amoxicillin tab (AMOXIL equiv)	-	1
ampicillin cap (PRINCIPEN equiv)	-	1
ampicillin susp (PRINCIPEN equiv)	-	1
NATURAL PENICILLINS		
penicillin vk soln (VEETIDS equiv)	-	1
penicillin vk tab (VEETIDS equiv)	-	1
PENICILLIN COMBINATIONS		
amoxicillin/clavulanate chew tab (AUGMENTIN equiv)	-	1
amoxicillin/clavulanate susp (AUGMENTIN ES equiv)	-	1
amoxicillin/clavulanate tab (AUGMENTIN equiv)	-	1
PENICILLINASE-RESISTANT PENICILLINS		
dicloxacillin cap (DYNAPEN equiv)	-	1
PHARMACEUTICAL ADJUVANTS		
SEMI SOLID VEHICLES		
POLYETHYLENE GLYCOL 8000 GRANULES	-	2
PROGESTINS		

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

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

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 6/1/2020

DrugName	Special Code	Tier
PROGESTINS Cont.		
PROGESTINS		
hydroxyprogesterone inj (MAKENA equiv)	MSP-PA	1
medroxyprogesterone tab (PROVERA equiv)	-	1
megestrol ES susp (MEGACE ES equiv)	-	1
norethindrone tab (AYGESTIN equiv)	-	1
progesterone cap (PROMETRIUM equiv)	-	1
progesterone oil inj	-	1
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.		
AGENTS FOR CHEMICAL DEPENDENCY		
acamprosate calcium DR tab (CAMPRAL equiv)	-	1
disulfiram tab (ANTABUSE equiv)	-	1
ANTIDEMENTIA AGENTS		
galantamine ER cap (RAZADYNE ER equiv)	-	1
GALANTAMINE SOLN	-	1
galantamine tab (RAZADYNE equiv)	-	1
rivastigmine cap (EXELON equiv)	-	1
rivastigmine patch (EXELON equiv)	-	1
COMBINATION PSYCHOTHERAPEUTICS		
CHLORDIAZEPOXIDE/AMITRIPTYLINE TAB	-	1
olanzapine/fluoxetine cap (SYMBYAX equiv)	-	1
PERPHENAZINE/ AMITRIPTYLINE TAB	-	1
FIBROMYALGIA AGENTS		
SAVELLA PAK	-	2

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

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

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 6/1/2020

DrugName	Special Code	Tier
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. Cont.		
SAVELLA TAB	-	2
HYPOACTIVE SEXUAL DESIRE DISORDER (HSDD) AGENTS		
ADDYI TAB	-	EXC
VYLEESI INJ	-	EXC
MULTIPLE SCLEROSIS AGENTS		
glatiramer inj (COPAXONE equiv)	LMSP	1
AVONEX INJ	LMSP	2
AVONEX INJ	LMSP	2
BETASERON INJ (Step Therapy requires trial of 2 of the 3 products: AVONEX, REBIF, COPAXONE)	LMSP-ST	2
EXTAVIA INJ	LMSP	2
GILENYA CAP	LMSP-PA	2
MAYZENT TAB	LMSP	2
MAYZENT TAB STARTER PACK	LMSP	2
REBIF INJ	LMSP	2
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.		
PIMOZIDE TAB	-	2
SMOKING DETERRENENTS		
bupropion SR tab (ZYBAN equiv)	-	1
nicotine patch (NICODERM equiv) (QL= 1 patch/day, Limited to 3 months per calendar year)	OTC-QL-SMKG	1
CHANTIX PAK (Prior Authorization Required only if member is less than 16 years old)	PA	2

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

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

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 6/1/2020

DrugName	Special Code	Tier
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. Cont.		
CHANTIX TAB (Prior Authorization Required only if member is less than 16 years o	PA	2
NICOTROL INHALER	-	2
NICOTROL NASAL SPRAY	-	2
RESPIRATORY AGENTS - MISC.		
CYSTIC FIBROSIS AGENTS		
KALYDECO PAK (QL= 2 packets/day; Only available through Maxor Pharmacy 800-658-6046 or Walgreens 888-347-3416)	LD-PA-QL	2
KALYDECO TAB (QL= 2 tabs/day; Only available through Maxor Pharmacy 800-658-6046 or Walgreens 888-347-3416)	LD-PA-QL	2
ORKAMBI GRANULES PACKET (QL= 2 packets/day; Only available through Maxc Pharmacy 800-658-6046 or Walgreens 888-347-3416)	LD-PA-QL	2
ORKAMBI TAB (QL= 4 tabs/day; Only available through Maxor Pharmacy 800-658-6046 or Walgreens 888-347-3416)	LD-PA-QL	2
PULMOZYME INH SOLN	LMSP	2
SYMDEKO TAB (QL= 2 tabs/day; Only available through Maxor Pharmacy 800-658-6046 or Walgreens 888-347-3416)	LD-PA-QL	2
SULFONAMIDES		
SULFONAMIDES		
SULFADIAZINE TAB	-	1
TETRACYCLINES		
TETRACYCLINES		
doxycycline hyclate cap (VIBRAMYCIN equiv)	-	1
doxycycline hyclate tab (VIBRATAB equiv)	-	1

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

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

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 6/1/2020

DrugName	Special Code	Tier
TETRACYCLINES Cont.		
doxycycline monohydrate cap (MONODOX equiv)	-	1
doxycycline monohydrate tab (ADOXA equiv)	-	1
doxycycline susp (VIBRAMYCIN equiv)	-	1
minocycline cap (MINOCIN equiv)	-	1
minocycline tab (DYNACIN equiv)	-	1
tetracycline cap	-	1
THYROID AGENTS		
ANTITHYROID AGENTS		
methimazole tab (TAPAZOLE equiv)	-	1
propylthiouracil tab	-	1
THYROID HORMONES		
ARMOUR THYROID TAB, NATURE THROID TAB	-	1
levothyroxine tab (SYNTHROID equiv)	-	1
liothyronine tab (CYTOMEL equiv)	-	1
np thyroid tab (ARMOUR THYROID, NATURE THROID equiv)	-	1
THYROLAR TAB	-	2
ULCER DRUGS		
ANTISPASMODICS		
chlordiazepoxide/clidinium cap (LIBRAX equiv)	-	1
dicyclomine cap (BENTYL equiv)	-	1
dicyclomine soln (BENTYL equiv)	-	1
dicyclomine tab (BENTYL equiv)	-	1
glycopyrrolate tab (ROBINUL equiv)	-	1

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

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

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 6/1/2020

DrugName	Special Code	Tier
ULCER DRUGS Cont.		
hyoscyamine sulfate CR tab (LEVBID equiv)	-	1
hyoscyamine sulfate elixir (LEVSIN equiv)	-	1
hyoscyamine sulfate ODT (ANASPAZ equiv)	-	1
hyoscyamine sulfate SL tab (LEVSIN equiv)	-	1
hyoscyamine sulfate soln (LEVSIN equiv)	-	1
hyoscyamine sulfate SR cap (LEVSINEX equiv)	-	1
hyoscyamine tab (LEVSIN equiv)	-	1
methscopolamine tab (PAMINE equiv)	-	1
BELLADONNA ALKALOID/OPIUM SUPP	-	2
PROPANTHELINE TAB	-	2
H-2 ANTAGONISTS		
CIMETIDINE SOLN	-	1
cimetidine tab (TAGAMET equiv) (OTC covered only.)	OTC	1
famotidine susp (PEPCID equiv)	-	1
famotidine tab (PEPCID equiv) (OTC covered only.)	OTC	1
AXID AR TAB	OTC	2
nizatidine cap (AXID equiv)	-	2
MISC. ANTI-ULCER		
sucralfate tab (CARAFATE equiv)	-	1
PROTON PUMP INHIBITORS		
lansoprazole cap 15mg (PREVACID equiv) (QL= 2 caps/day)	OTC-QL	1
omeprazole DR cap (PRILOSEC equiv)	-	1

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

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

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 6/1/2020

DrugName	Special Code	Tier
ULCER DRUGS Cont.		
pantoprazole EC tab (PROTONIX equiv)	-	1
PRILOSEC OTC DR TAB (QL= 2 caps/day)	OTC-QL	1
rabeprazole EC tab (ACIPHEX equiv)	-	1
FIRST OMEPRAZOLE SUSP	-	2
PREVACID OTC CAP (QL= 2 caps/day)	OTC-QL	2
ULCER DRUGS - PROSTAGLANDINS		
misoprostol tab (CYTOTEC equiv)	-	1
ULCER THERAPY COMBINATIONS		
lansoprazole/amoxicillin/clarithromycin kit (PREVPAC equiv)	-	1
ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS		
H-2 ANTAGONISTS		
NIZATIDINE CAP	-	2
MISC. ANTI-ULCER		
sucralfate susp (CARAFATE equiv)	-	1
PROTON PUMP INHIBITORS		
lansoprazole odt (PREVACID SOLUTAB equiv) (QL= 2 tabs/day)	QL	1
URINARY ANTI-INFECTIVES		
URINARY ANTI-INFECTIVES		
methenamine hippurate tab (HIPREX equiv)	-	1
methenamine mandelate tab	-	1
nitrofurantoin macrocrystals cap (MACRODANTIN equiv)	-	1
nitrofurantoin macrocrystals cap 25mg (MACRODANTIN equiv)	-	1
nitrofurantoin monohydrate cap (MACROBID equiv)	-	1

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

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

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 6/1/2020

DrugName	Special Code	Tier
URINARY ANTI-INFECTIVES Cont.		
nitrofurantoin susp (FURADANTIN equiv)	-	1
URINARY ANTISPASMODICS		
URINARY ANTISPASMODIC - ANTIMUSCARINICS (ANTICHOLINERGIC)		
oxybutynin ER tab (DITROPAN XL equiv)	-	1
oxybutynin syrup	-	1
oxybutynin tab (DITROPAN equiv)	-	1
solifenacin tab (VESICARE equiv)	-	1
tolterodine SR cap (DETROL LA equiv)	-	1
tolterodine tab (DETROL equiv)	-	1
TOVIAZ TAB	-	2
URINARY ANTISPASMODICS		
hyoscyamine tab (LEVSIN equiv)	-	1
URINARY ANTISPASMODICS - CHOLINERGIC AGONISTS		
bethanechol tab (URECHOLINE equiv)	-	1
VACCINES		
BACTERIAL VACCINES		
PNEUMOVAX INJ (QL= 1 inj/lifetime for members 2 years and older)	QL-VAC	\$0
PREVNAR 13 INJ (QL= 2 inj/8 months for members 9 years and younger; QL= 1 inj/8 months for members 10 years and older)	QL-VAC	\$0
VIRAL VACCINES		
AFLURIA INJ (QL= 2 inj/8 months for members 9 years and younger; QL= 1 inj/8 months for members 10 years and older)	QL-VAC	\$0

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

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

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 6/1/2020

DrugName	Special Code	Tier
VACCINES Cont.		
AFLURIA INJ, FLUZONE INJ (QL= 2 inj/8 months for members 8 years and younger; QL= 1 inj/8 months for members 9 years and older)	QL-VAC	\$0
FLUBLOK INJ (QL= 1 inj/8 months for members 18 years and older)	QL-VAC	\$0
FLUBLOK QUAD PF INJ (QL= 2 inj/8 months for members 8 years and younger; QL= 1 inj/8 months for members 9 years and older)	QL-VAC	\$0
FLUCELVAX INJ (QL= 2 inj/8 months for members 8 years and younger; QL= 1 inj/8 months for members 9 years and older)	QL-VAC	\$0
FLUCELVAX QUAD INJ (QL= 2 inj/8 months for members 8 years and younger; QL= 1 inj/8 months for members 9 years and older)	QL-VAC	\$0
FLUCELVAX QUAD INJ (QL= 2 inj/8 months for members 9 years and younger; QL= 1 inj/8 months for members 10 years and older)	QL-VAC	\$0
FLULAVAL QUAD INJ, FLUZONE QUAD INJ (QL= 2 inj/8 months for members 8 years and younger; QL= 1 inj/8 months for members 9 years and older)	QL-VAC	\$0
FLUMIST QUADRIVALENT NASAL SUSP (QL= 2 inj/8 months for members 8 years and younger; QL= 1 inj/8 months for members 9 years and older)	QL-VAC	\$0
FLUVIRIN INJ (QL= 2 inj/8 months for members 8 years and younger; QL= 1 inj/8 months for members 9 years and older)	QL-VAC	\$0
FLUVIRIN INJ (QL= 2 inj/8 months for members 9 years and younger; QL= 1 inj/8 months for members 10 years and older)	QL-VAC	\$0
FLUVIRIN PF INJ (QL= 2 inj/8 months for members 8 years and younger; QL= 1 inj/8 months for members 9 years and older)	QL-VAC	\$0
FLUZONE INTRADERMAL INJ (QL= 1 inj/8 months for members 18 years and older)	QL-VAC	\$0

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

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

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 6/1/2020

DrugName	Special Code	Tier
VACCINES Cont.		
FLUZONE QUADRIVALENT INJ (QL= 2 inj/8 months for members 9 years and younger; QL= 1 inj/8 months for members 10 years and older)	QL-VAC	\$0
FLUZONE/FLUARIX QUAD INJ (QL= 2 inj/8 months for members 8 years and younger; QL= 1 inj/8 months for members 9 years and older)	QL-VAC	\$0
VAGINAL PRODUCTS		
MISCELLANEOUS VAGINAL PRODUCTS		
ACIDIC VAGINAL JELLY	-	2
SPERMICIDES		
CONTRACEPTIVE GEL	OTC	\$0
TODAY SPONGE	OTC	\$0
vcf vaginal gel (CONCEPTROL equiv)	OTC	\$0
VAGINAL ANTI-INFECTIVES		
clindamycin vaginal cream (CLEOCIN equiv)	-	1
clotrimazole vaginal cream (MYCELEX equiv)	OTC	1
metronidazole vaginal gel (METROGEL equiv)	-	1
miconazole 7 supp (MONISTAT equiv)	OTC	1
miconazole vaginal cream (MONISTAT equiv)	OTC	1
miconazole vaginal kit (MONISTAT equiv)	OTC	1
NYSTATIN VAGINAL TAB	-	1
terconazole cream (TERAZOL equiv)	-	1
TERCONAZOLE CREAM 0.8%	-	1
terconazole supp (TERAZOL equiv)	-	1
AVC VAGINAL CREAM	-	2

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

NC =Not Covered	generic =small letters	BRANDS =CAPITAL LETTERS
EXC	Plan Exclusion	INF Infertility
LD	Limited Distribution	LMSPP Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
PA	Prior Authorization	QL Quantity Limit
RS	Restricted to Specialist	SMKG Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST Step Therapy
VAC	Vaccine Program	

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 6/1/2020

DrugName	Special Code	Tier
VAGINAL PRODUCTS Cont.		
VAGINAL ESTROGENS		
ESTRING (3 copays per Rx)	-	2
PREMARIN VAGINAL CREAM	-	2
VASOPRESSORS		
ANAPHYLAXIS THERAPY AGENTS		
epinephrine pen inj 0.15mg, 0.3mg (EPIPEN (JR) equiv) (QL= 2 inj/fill)	QL	1
SYMJEPI INJ (QL= 2 inj/fill)	QL	2
VASOPRESSORS		
epinephrine inj	-	1
midodrine tab (PROAMATINE equiv)	-	1
VITAMINS		
OIL SOLUBLE VITAMINS		
vitamin D cap 400unit	OTC	\$0
cholecalciferol cap (VITAMIN D equiv)	OTC	1
cholecalciferol tab (VITAMIN D equiv)	OTC	1
phytonadione tab (MEPHYTON equiv)	-	1
vitamin D cap (RX strength only)	-	1
WATER SOLUBLE VITAMINS		
ascorbic acid chew tab	OTC	1
ascorbic acid tab	OTC	1
niacin cap	OTC	1
niacin CR tab (SLO-NIACIN equiv)	OTC	1
niacin tab	OTC	1

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

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

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 6/1/2020

DrugName	Special Code	Tier
VITAMINS Cont.		
niacinamide tab	OTC	1
VITAMIN C TAB	OTC	1
POTABA POWDER PACKET	-	2
POTABA TAB	-	2

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

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

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

Colorado Access Child Health Plan Plus HMO Formulary

Prior Authorization Drug List

Last Updated* 6/1/2020

Some products on the Formulary are only covered with a prior authorization approval. Drug products requiring prior authorization are listed below. The pharmacy will also alert members if the medication prescribed requires

Drug Name	Tier # for Drug Copay (if prior auth is approved)
ACTEMRA ACTPEN INJ	2
ACTEMRA SC INJ	2
ACTIMMUNE INJ	2
ALINIA SUSP	2
ALINIA TAB	2
ANDRODERM PATCH	2
armodafinil tab	1
BANZEL SUSP	2
BANZEL TAB	2
BENZNIDAZOLE TAB	2
BERINERT INJ	2
CAYSTON INH SOLN	2
CEREZYME INJ	2
CHANTIX PAK	2
CHANTIX TAB	2
CIMZIA INJ	2
CIMZIA STARTER INJ KIT	2
CINRYZE INJ	2
clobetasol foam	1
clobetasol spray	1
CLOBEX SPRAY	2+penalty

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.**

Products listed may not be all inclusive and are subject to change.

Colorado Access Child Health Plan Plus HMO Formulary cont.**Prior Authorization Drug List****Last Updated* 6/1/2020**

Some products on the Formulary are only covered with a prior authorization approval. Drug products requiring prior authorization are listed below. The pharmacy will also alert members if the medication prescribed requires

Drug Name	Tier # for Drug Copay (if prior auth is approved)
CORLANOR SOLN	2
CORLANOR TAB	2
COSENTYX INJ (1-PACK)	2
COSENTYX INJ (2-PACK)	2
CYSTARAN OPHTH SOLN	2
DESCOVY TAB	2
diclofenac gel	1
DUPIXENT INJ	2
ENBREL INJ 25MG	2
ENBREL INJ 50MG	2
ENBREL MINI INJ	2
ENBREL SURECLICK INJ 50MG	2
EPIDIOLEX SOLN	2
everolimus tab	1
everolimus tab 0.25mg, 0.5mg, 0.75mg	1
FANAPT TAB	2
FANAPT TITRATION PACK	2
FASENRA PEN INJ	2
FERRIPROX SOLN	2
FERRIPROX TAB	2
FULPHILA INJ	2

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.**

Products listed may not be all inclusive and are subject to change.

Colorado Access Child Health Plan Plus HMO Formulary cont.

Prior Authorization Drug List

Last Updated* 6/1/2020

Some products on the Formulary are only covered with a prior authorization approval. Drug products requiring prior authorization are listed below. The pharmacy will also alert members if the medication prescribed requires

Drug Name	Tier # for Drug Copay (if prior auth is approved)
GENOTROPIN INJ	2
GENVOYA TAB	2
GILENYA CAP	2
HAEGARDA INJ	2
HARVONI TAB	2
HEMLIBRA INJ	2
HUMIRA INJ 10MG	2
HUMIRA INJ 20MG	2
HUMIRA INJ 40MG	2
HUMIRA INJ CROHNS/UC/HIDRADENITIS STARTER PACK	2
HUMIRA INJ PEDIATRIC CROHNS STARTER PACK	2
HUMIRA INJ PSORIASIS/UVEITIS STARTER PACI	2
HUMIRA PEN INJ 40MG	2
HYCAMTIN CAP	2
hydroxyprogesterone inj	1
icatibant inj	1
INVEGA INJ	2
itraconazole cap	1
KALYDECO PAK	2

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.**

Products listed may not be all inclusive and are subject to change.

Colorado Access Child Health Plan Plus HMO Formulary cont.**Prior Authorization Drug List****Last Updated* 6/1/2020**

Some products on the Formulary are only covered with a prior authorization approval. Drug products requiring prior authorization are listed below. The pharmacy will also alert members if the medication prescribed requires

Drug Name	Tier # for Drug Copay (if prior auth is approved)
KALYDECO TAB	2
KEVZARA INJ	2
KINERET INJ	2
LEDIPASVIR/SOFOSBUVIR TAB	2
LEUKINE INJ	2
MAVYRET TAB	2
miglustat cap	1
modafinil tab	1
NUCALA INJ	2
OLUX FOAM	2+penalty
OPSUMIT TAB	2
ORENCIA CLICK INJ	2
ORENCIA SC INJ 125MG/ML	2
ORENCIA SC INJ 50MG/0.4ML	2
ORENCIA SC INJ 87.5MG/0.7ML	2
ORKAMBI GRANULES PACKET	2
ORKAMBI TAB	2
OTEZLA STARTER PACK	2
OTEZLA TAB	2
OXERVATE OPHTH SOLN	2
pregabalin cap	1

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.**

Products listed may not be all inclusive and are subject to change.

Colorado Access Child Health Plan Plus HMO Formulary cont.

Prior Authorization Drug List

Last Updated* 6/1/2020

Some products on the Formulary are only covered with a prior authorization approval. Drug products requiring prior authorization are listed below. The pharmacy will also alert members if the medication prescribed requires

Drug Name	Tier # for Drug Copay (if prior auth is approved)
pregabalin soln	1
REPATHA INJ	2
REPATHA PUSHTRONEX INJ	2
RETACRIT INJ	2
RINVOQ ER TAB	2
RISPERDAL INJ	2
RUCONEST INJ	2
RUZURGI TAB	2
SAPHRIS SL TAB	2
sildenafil tab 20mg	1
SKYRIZI INJ	2
sodium phenylbutyrate powder	1
sodium phenylbutyrate tab	1
SOMAVERT INJ	2
SOVALDI TAB	2
SPRYCEL TAB	2
STELARA INJ	2
SUTENT CAP	2
SYMDEKO TAB	2
SYNAGIS INJ	2
tadalafil tab (PAH)	1

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.**

Products listed may not be all inclusive and are subject to change.

Colorado Access Child Health Plan Plus HMO Formulary cont.

Prior Authorization Drug List

Last Updated* 6/1/2020

Some products on the Formulary are only covered with a prior authorization approval. Drug products requiring prior authorization are listed below. The pharmacy will also alert members if the medication prescribed requires

<u>Drug Name</u>	<u>Tier # for Drug Copay (if prior auth is approved)</u>
TAKHZYRO INJ	2
TASIGNA CAP	2
testosterone cypionate inj	1
testosterone enanthate inj	1
testosterone gel 1% 25mg	1
TESTOSTERONE GEL 1% 50MG	2
testosterone gel 1% pump	1
testosterone gel 1.62% 1.25gm	1
testosterone gel 1.62% 2.5gm	1
TESTOSTERONE GEL PUMP	2
testosterone gel pump 1.62%	1
THALOMID CAP	2
TRACLEER TAB 32MG	2
TYVASO INH SOLN	2
VALCHLOR GEL	2
venlafaxine ER cap	1
venlafaxine tab	1
VENTAVIS INH SOLN	2
vigabatrin powder pack	1
vigabatrin tab	1
VITRAKVI CAP 100MG	2

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.**

Products listed may not be all inclusive and are subject to change.

Colorado Access Child Health Plan Plus HMO Formulary cont.

Prior Authorization Drug List

Last Updated* 6/1/2020

Some products on the Formulary are only covered with a prior authorization approval. Drug products requiring prior authorization are listed below. The pharmacy will also alert members if the medication prescribed requires

Drug Name	Tier # for Drug Copay (if prior auth is approved)
VITRAKVI CAP 25MG	2
VITRAKVI SOLN	2
ZOLINZA CAP	2
ZORTRESS TAB 1MG	2

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

Colorado Access Child Health Plan Plus HMO Formulary

Last Updated* 6/1/2020

Over-the-Counter (OTC)

- The following OTC drugs are a covered benefit with a prescription

Over-the-Counter (OTC) Medications

ACCU-CHEK AVIVA PLUS METER	ACCU-CHEK AVIVA PLUS TEST STRIP	ACCU-CHEK GUIDE CARE METER	ACCU-CHEK GUIDE ME KIT
ACCU-CHEK GUIDE TEST STRIP	ACCU-CHEK NANO METER	ACCU-CHEK SMARTVIEW TEST STRIP	ACCU-CHEK TEST STRIP
acetaminophen cap	acetaminophen chew tab	acetaminophen drops	acetaminophen elixir
acetaminophen liquid	ACETAMINOPHEN SOLN	acetaminophen supp	acetaminophen tab
AEROCHAMBER	ALCOHOL SWABS	ALER-DRYL TAB	ALLEGRA TAB
artificial tears	artificial tears ophth soln	ascorbic acid chew tab	ascorbic acid tab
aspirin chew tab 81mg	aspirin supp	aspirin tab 325mg	aspirin tab 81mg
AXID AR TAB	bacitracin oint	bacitracin/polymyxin B oint	bacitracin/zinc oint
B-D INSULIN SYRINGE	B-D PEN NEEDLE	benzocaine gel	benzocaine paste
benzoyl peroxide cream	benzoyl peroxide gel (OTC)	benzoyl peroxide liquid	benzoyl peroxide lotion (OTC)
BUFFERED ASPIRIN TAB	bufferin tab	calcium carbonate chew tab	calcium carbonate susp
calcium carbonate tab	CALCIUM W/ VITAMIN D TAB	calcium w/vitamin D tab	CALIBRATION LIQUID
carbamide peroxide otic soln	cetirizine syrup	cetirizine tab	cetirizine/pseudoephedrine 12-hour tab

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

cholecalciferol cap CLINISTIX TEST STRIP	cholecalciferol tab clotrimazole cream (OTC)	cimetidine tab clotrimazole vaginal cream	clemastine tab 1.34mg CONTRACEPTIVE GEL
cromolyn nasal spray	dextromethorphan/guaifer esin syrup 10-100mg	dialyvite tab	diphenhydramine cap
diphenhydramine elixir	diphenhydramine liquid	diphenhydramine tab	docusate calcium cap
docusate sodium cap	docusate sodium liquid	docusate sodium syrup	docusate sodium tab
famotidine tab	FEMALE CONDOMS	ferrous sulfate soln	fexofenadine susp
fexofenadine tab	fexofenadine/pseudoephe drine 12-hour tab	fexofenadine/pseudoephe drine 24-hour tab	FREESTYLE FREEDOM LITE METER
FREESTYLE INSULINX METER	FREESTYLE INSULINX TEST STRIP	FREESTYLE LITE METER	FREESTYLE LITE TEST STRIP
FREESTYLE PRECISION NEO METER	FREESTYLE PRECISION NEO TEST STRIP	FREESTYLE TEST STRIP	genteal ophth oint
GLUCOSE CHEW TAB	glucose gel	glycerin supp	guaifenesin ER tab
guaifenesin syrup 100mg/5ml	GUAIFENESIN/CODEINE SYRUP	hydrocortisone cream	hydrocortisone oint
ibuprofen cap 200mg	ibuprofen chew tab	ibuprofen tab 100mg	ibuprofen tab 200mg
iron complex cap 150mg	KETO-DIASTIX TEST STRIP	KETOSTIX	ketotifen ophth soln
LANCET KIT	LANCETS	lansoprazole cap 15mg	levonorgestrel tab
lice aerosol	lice cream rinse	lice treatment kit	lice treatment liquid
lice treatment shampoo	loratadine chew tab	loratadine ODT	loratadine syrup
loratadine tab	loratadine/pseudoephedri ne 12-hour tab	loratadine/pseudoephedri ne 24-hour tab	meclizine chew tab
meclizine tab	miconazole 7 supp	miconazole cream	miconazole nitrate aeroso
miconazole nitrate powde	MICONAZOLE NITRATE SPRAY	miconazole vaginal cream	miconazole vaginal kit
milk of magnesium	multiple vitamin liquid		

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

naproxen sodium tab 220mg niacin tab	neomycin/bacitracin/poly myxin oint niacinamide tab	niacin cap nicotine patch	niacin CR tab NOVOFINE PEN NEEDLE NOVOTWIST PEN NEEDLE permethrin lotion
NOVOLIN 70/30 FLEXPEN INJ NOVOTWIST/NOVOFINE PEN NEEDLE	NOVOLIN INJ PEAK FLOW METER	NOVOLIN N FLEXPEN INJ pediatric multivitamin	
polyethylene glycol 3350 powder PRENATAL VITAMIN	PRECISION XTRA KETONE TEST STRIP PREVACID OTC CAP	PRECISION XTRA METER PRILOSEC OTC DR TAB	PRECISION XTRA TEST STRIP pseudoephedrine 12hr tab senna cap
pseudoephedrine tab senna syrup	pseudopseudoephedrine liquid senna tab	saline nasal spray SILPHEN COUGH SYRUP TODAY SPONGE	sodium bicarbonate tab tolnaftate aerosol triamcinolone OTC nasal spray vitamin E liquid
sodium chloride neb soln tolnaftate cream	terbinafine cream tolnaftate powder	tolnaftate soln	
vcf vaginal gel	VITAMIN C TAB	vitamin D cap 400unit	

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

Colorado Access Child Health Plan Plus HMO Formulary

Last Updated* 6/1/2020

Mandatory Specialty Pharmacy (MSP)

- Navitus utilizes a specialty pharmacy, experienced in handling specialty drugs, to coordinate personalized support for members impacted by chronic illnesses and complex diseases.
- Specialty drugs are only available for a one month supply due to their high cost and use.
- The following drugs are required to be filled through a Specialty Pharmacy provider.

Mandatory Specialty Pharmacy (MSP) Medications

ACTEMRA ACTPEN INJ	ACTEMRA SC INJ	ACTIMMUNE INJ	ALFERON-N INJ
ambrisentan tab	AVONEX INJ	AVONEX INJ	BERINERT INJ
BETASERON INJ	BETHKIS NEB SOLN	bexarotene cap	bosentan tab
capecitabine tab	CAYSTON INH SOLN	CEREZYME INJ	CIMZIA INJ
CIMZIA STARTER INJ KIT	CINRYZE INJ	COSENTYX INJ (1-PACK)	COSENTYX INJ (2-PACK)
CYSTAGON CAP	CYSTARAN OPHTH SOLN	deferasirox tab	deferasirox tab 90mg, 360mg
DUPIXENT INJ	ENBREL INJ 25MG	ENBREL INJ 50MG	ENBREL MINI INJ
ENBREL SURECLICK INJ	EPIDIOLEX SOLN 50MG	ETOPOSIDE CAP	everolimus tab
EXTAVIA INJ	FASENRA PEN INJ	FERRIPROX SOLN	FERRIPROX TAB
FUZEON INJ	GENOTROPIN INJ	GILENYA CAP	glatiramer inj
HAEGARDA INJ	HARVONI TAB	HEMLIBRA INJ	HUMIRA INJ 10MG
HUMIRA INJ 20MG	HUMIRA INJ 40MG	HUMIRA INJ	HUMIRA INJ PEDIATRIC
		CROHNS/UC/HIDRADENICROHNS STARTER TIS STARTER PACK	PACK

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

HUMIRA INJ PSORIASIS/UVEITIS STARTER PACK icatibant inj KALYDECO PAK KITABIS PAK NEB SOLN	HUMIRA PEN INJ 40MG imatinib tab KALYDECO TAB LEDIPASVIR/SOFOSBUV IR TAB MAYZENT TAB miglustat cap NUCALA INJ ORENCIA SC INJ 125MG/ML ORKAMBI TAB PEGASYS INJ REBIF INJ RINVOQ ER TAB SKYRIZI INJ STELARA INJ tadalafil tab (PAH) temozolomide cap tretinoin cap vigabatrin powder pack VITRAKVI SOLN	HYCAMTIN CAP INCRELEX INJ KEVZARA INJ LEUKINE INJ MAYZENT TAB STARTER PACK MYLERAN TAB octreotide inj ORENCIA SC INJ 50MG/0.4ML OTEZLA STARTER PACK PEG-INTRON INJ REVLIMID CAP RUCONEST INJ SOMAVERT INJ SUTENT CAP TAKHZYRO INJ THALOMID CAP TYVASO INH SOLN vigabatrin tab ZARXIO INJ	hydroxyprogesterone inj JADENU SPRINKLE KINERET INJ LYSODREN TAB MESNEX TAB nilutamide tab OPSUMIT TAB ORENCIA SC INJ 87.5MG/0.7ML OTEZLA TAB PULMOZYME INH SOLN ribavirin cap RUZURGI TAB SOVALDI TAB SYMDEKO TAB TARGRETIN GEL tobramycin neb soln VALCHLOR GEL VITRAKVI CAP 100MG ZIENTENZO INJ
MAVYRET TAB	MAYZENT TAB	MAYZENT TAB STARTER PACK	MESNEX TAB
MIACALCIN INJ NIVESTYM INJ ORENCIA CLICK INJ	ORENCIA SC INJ 125MG/ML	ORENCIA SC INJ 50MG/0.4ML	ORENCIA SC INJ 87.5MG/0.7ML
ORKAMBI GRANULES PACKET	ORKAMBI TAB	OTEZLA STARTER PACK	OTEZLA TAB
OXERVATE OPHTH SOLN	PEGASYS INJ	PEG-INTRON INJ	PULMOZYME INH SOLN
REBETOL SOLN ribavirin tab	REBIF INJ	REVLIMID CAP	ribavirin cap
SANDOSTATIN INJ	RINVOQ ER TAB	RUCONEST INJ	RUZURGI TAB
SPRYCEL TAB	SKYRIZI INJ	SOMAVERT INJ	SOVALDI TAB
SYNAGIS INJ	STELARA INJ	SUTENT CAP	SYMDEKO TAB
TASIGNA CAP	tadalafil tab (PAH)	TAKHZYRO INJ	TARGRETIN GEL
TRACLEER TAB 32MG	temozolomide cap	THALOMID CAP	tobramycin neb soln
VENTAVIS INH SOLN	tretinoin cap	TYVASO INH SOLN	VALCHLOR GEL
VITRAKVI CAP 25MG	vigabatrin powder pack	vigabatrin tab	VITRAKVI CAP 100MG
ZOLINZA CAP	VITRAKVI SOLN	ZARXIO INJ	ZIENTENZO INJ

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

Colorado Access Child Health Plan Plus HMO Formulary

Last Updated* 6/1/2020

Step Therapy (ST)

- The following drugs are covered on the formulary with a Step Therapy.

Step Therapy (ST) Medications

Drug Name	Step Therapy Requirements
BETASERON INJ	Step Therapy requires trial of 2 of the 3 products: AVONEX, REBIF, COPAXONE
bexarotene cap	Step Therapy requires trial of VALCHLOR
DIFICID TAB	QL= 20 tabs/fill; Step Therapy requires trial of vancomycin cap, vancomycin soln, or FIRVANQ SOLN
LATUDA TAB	QL= 1 tab/day; Step Therapy requires trial of quetiapine
levalbuterol neb soln	Step Therapy requires trial of albuterol neb
paliperidone ER tab	Step Therapy requires trial of risperidone, GEODON, olanzapine or SEROQUEL
pimecrolimus cream	Covered for members 2 years or older; Step Therapy requires trial of tacrolimus oint
SPIRIVA RESPIMAT INHALER 1.25MCG/ACT	QL= 1 inhaler/30 days; Step Therapy requires trial of ADVAIR, BREO, DULERA, or FLUTICASONE/SALMETEROL
TARGRETIN GEL	Step Therapy requires trial of VALCHLOR GEL
tranexamic acid tab	QL= 1 tab/day; Step Therapy requires trial of 1 generic NSAID
VIMPAT TAB	QL= 2 tabs/day; Step Therapy requires trial of carbamazepine, divalproex, lamotrigine or topiramate

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

Colorado Access Child Health Plan Plus HMO Formulary

Smoking Cessation Agents

Last Updated* 6/1/2020

Drug Name

Tier # for Drug Copay

nicotine patch(QL= 1 patch/day, Limited to 3 months per calendar year)

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

Colorado Access Child Health Plan Plus HMO Formulary

Last Updated* 6/1/2020

Quantity Limit (QL)

- The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
ABILIFY DISCMELT	QL= 1 tab/day
ACTEMRA ACTPEN INJ	QL= 2 inj/28 days
ACTEMRA SC INJ	QL= 2 inj/28 days
ADDERALL XR CAP	QL= 2 caps/day
AFLURIA INJ	QL= 2 inj/8 months for members 9 years and younger; QL= 1 inj/8 months for members 10 years and older
AFLURIA INJ, FLUZONE INJ	QL= 2 inj/8 months for members 8 years and younger; QL= 1 inj/8 months for members 9 years and older
ALINIA SUSP	QL= 60ml/3 days
ALINIA TAB	QL= 6 tabs/3 days
ambrisentan tab	QL= 1 tab/day; Restricted to Cardiology or Pulmonology Specialist; Only available through Walgreens 888-347-3416
ANDRODERM PATCH	QL= 1 patch/day
aprepitant cap	QL= 3 caps/fill
aprepitant pak	QL= 3 caps/fill
aripiprazole ODT	QL= 1 tab/day
aripiprazole tab	QL= 1 tab/day
armodafinil tab	QL= 1 tab/day
ARNUITY ELLIPTA INHALER	QL= 1 inhaler/30 days
artificial tears ophth soln	QL= 25ml/30 days
ASMANEX HFA INHALER	QL= 1 inhaler/30 days
ASMANEX INHALER	QL= 1 inhaler/30 days

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Last Updated* 6/1/2020

Quantity Limit (QL)

- The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
atomoxetine cap	QL= 1 cap/day
atorvastatin tab 10mg	QL= 1 tab/day
atorvastatin tab 20mg	QL= 1 tab/day
azelastine nasal spray 0.1%	QL= 1 bottle/month
azelastine nasal spray 0.15%	QL= 1 bottle/month
BANZEL SUSP	QL= 2400ml/30 days
BANZEL TAB	QL= 8 tabs/day
BAQSIMI NASAL POWDER	QL= 2 inhalations/fill
bimatoprost ophth soln	QL= 2.5ml/30 days
bosentan tab	QL= 2 tabs/day; Restricted to Cardiology or Pulmonology Specialist; Only available through Walgreens 888-347-3416
butorphanol nasal spray	QL= 1 bottle/30 days
BYDUREON BCISE AUTO INJ	QL= 4 inj/28 days
BYDUREON INJ	QL= 4 inj/28 days
BYDUREON PEN INJ	QL= 4 inj/28 days
calcitonin nasal spray	QL= 1 bottle/30 days
celecoxib cap	QL= 2 caps/day
cetirizine tab	QL= 1 tab/day
cetirizine/pseudoephedrine 12-hour tab	QL= 2 tabs/day
CIMZIA INJ	QL= 2 inj/28 days
CIMZIA STARTER INJ KIT	QL= 1 kit/plan year

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.**Last Updated* 6/1/2020****Quantity Limit (QL)**

- The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
CINRYZE INJ	QL= 16 vials/28 days; Only available through CVS Specialty 800-237-2767
clobazam tab	QL= 2 tabs/day
clonidine ER tab	QL= 2 tabs/day
COSENTYX INJ (1-PACK)	QL= 1 inj/28 days
COSENTYX INJ (2-PACK)	QL= 2 fills (4 inj)/ year
dexmethylphenidate ER cap	QL= 1 cap/day
diclofenac gel	QL= 300gm/30 days
diclofenac gel 1%	QL= 5 tubes/fill
DIFICID TAB	QL= 20 tabs/fill; Step Therapy requires trial of vancomycin cap, vancomycin soln, or FIRVANQ SOLN
DUPIXENT INJ	QL= 2 inj/28 days
ELLA TAB	QL= 1 tab/28 days
ENBREL INJ 25MG	QL= 8 inj/28 days
ENBREL INJ 50MG	QL= 4 inj/28 days
ENBREL MINI INJ	QL= 4 inj/28 days
ENBREL SURECLICK INJ 50MG	QL= 4 inj/28 days
epinephrine pen inj 0.15mg, 0.3mg	QL= 2 inj/fill
escitalopram soln	QL= 600 units/30 days
escitalopram tab	QL= 1 tab/day
eszopiclone tab	QL= 1 tab/day
everolimus tab	QL= 1 tab/day

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.**Last Updated* 6/1/2020****Quantity Limit (QL)**

- The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
FASENRA PEN INJ	QL= 1 inj/56 days
FLUBLOK INJ	QL= 1 inj/8 months for members 18 years and older
FLUBLOK QUAD PF INJ	QL= 2 inj/8 months for members 8 years and young; QL= 1 inj/8 mon for members 9 years and older
FLUCELVAX INJ	QL= 2 inj/8 months for members 8 years and younger; QL= 1 inj/8 months for members 9 years and older
FLUCELVAX QUAD INJ	QL= 2 inj/8 months for members 8 years and younger; QL= 1 inj/8 months for members 9 years and older
FLULAVAL QUAD INJ, FLUZONE QUAD INJ	QL= 2 inj/8 months for members 8 years and younger; QL= 1 inj/8 months for members 9 years and older
FLUMIST QUADRIVALENT NASAL SUSP	QL= 2 inj/8 months for members 8 years and younger; QL= 1 inj/8 months for members 9 years and older
FLUVIRIN INJ	QL= 2 inj/8 months for members 9 years and younger; QL= 1 inj/8 months for members 10 years and older
FLUVIRIN PF INJ	QL= 2 inj/8 months for members 8 years and younger; QL= 1 inj/8 months for members 9 years and older
FLUZONE INTRADERMAL INJ	QL= 1 inj/8 months for members 18 years and older
FLUZONE QUADRIVALENT INJ	QL= 2 inj/8 months for members 9 years and younger; QL= 1 inj/8 months for members 10 years and older
FLUZONE/FLUARIX QUAD INJ	QL= 2 inj/8 months for members 8 years and younger; QL= 1 inj/8 months for members 9 years and older
GLUCAGON DIAGNOSTIC INJ	QL= 2 inj/fill, 1 fill/30 days

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.**

Products listed may not be all inclusive and are subject to change.

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Last Updated* 6/1/2020

Quantity Limit (QL)

- The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
GLUCAGON INJ KIT	QL= 2 inj/fill, 1 fill/30 days
granisetron tab	QL= 14 tabs/fill, 1 fill/30 days
GUAIFENESIN/CODEINE SYRUP	QL= 240ml/fill
guanfacine ER tab	QL= 1 tab/day
GVOKE PFS INJ	QL= 2 inj/fill
HARVONI TAB	QL= 1 tab/ day
HUMIRA INJ 10MG	QL= 2 syringes/28 days
HUMIRA INJ 20MG	QL= 2 syringes/28 days
HUMIRA INJ 40MG	QL= 2 syringes/28 days
HUMIRA INJ	QL= 1 pack/fill, 1 fill/plan year
CROHNS/UC/HIDRADENITIS STARTER PACK	
HUMIRA INJ PEDIATRIC CROHNS STARTER PACK	QL= 1 pack/fill, 1 fill/plan year
HUMIRA INJ PSORIASIS/UVEITIS STARTER PACK	QL= 1 pack/fill, 1 fill/plan year
HUMIRA PEN INJ 40MG	QL= 2 pens/28 days
hydrocodone/chlorpheniramine/pseudoephedrine liquid	QL= 120ml/fill, 2 fills/month
KALYDECO PAK	QL= 2 packets/day; Only available through Maxor Pharmacy 800-658-6046 or Walgreens 888-347-3416

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Last Updated* 6/1/2020

Quantity Limit (QL)

- The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
KALYDECO TAB	QL= 2 tabs/day; Only available through Maxor Pharmacy 800-658-6046 or Walgreens 888-347-3416
ketorolac tab	QL= 20 tabs/5 days
ketotifen ophth soln	QL= 2 bottles/30 days
KEVZARA INJ	QL= 2 inj/28 days
KYTRIL TAB	QL= 14 tabs/fill, 1 fill/30 days
lansoprazole cap 15mg	QL= 2 caps/day
lansoprazole odt	QL= 2 tabs/day
latanoprost ophth soln	QL= 2.5ml/30 days
LATUDA TAB	QL= 1 tab/day; Step Therapy requires trial of quetiapine
LEDIPASVIR/SOFOSBUVIR TAB	QL= 1 tab/ day
lice aerosol	QL= 150ml/7 days, Limited to 2 fills/year
lice cream rinse	QL= 59ml/7 days, Limited to 2 fills/year
lice treatment liquid	QL= 120ml/7 days, Limited to 2 fills/year
lice treatment shampoo	QL= 120ml/7 days, Limited to 2 fills/year
lidocaine oint	QL= 107gm/30 days
loratadine syrup	QL= 250ml/30 day
loratadine tab	QL= 1 tab/day
LUMIGAN OPHTH SOLN	QL= 2.5ml/30 days
malathion lotion	QL= 1 bottle/30 days; Limited to 2 fills/year
MAVYRET TAB	QL= 3 tabs/day

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Last Updated* 6/1/2020

Quantity Limit (QL)

- The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
medroxyprogesterone inj	QL= 1 inj/90 days
methylergonovine tab	QL= 28 tabs/fill; 1 fill/365 days
METHYLPHENIDATE ER TAB	QL= 1 tab/day
MIACALCIN NASAL SPRAY	QL= 1 bottle/30 days
modafinil tab	QL= 2 tabs/day
MOVIPREP SOLN	QL= 1 bottle/fill
naloxone prefilled inj	QL= 2 inj/fill
naratriptan tab	QL= 9 tabs/30 days
nicotine patch	QL= 1 patch/day, Limited to 3 months per calendar year
NUCALA INJ	QL= 1 inj/28 days
olanzapine ODT	QL= 1 tab/day
olanzapine tab	QL= 1 tab/day
olanzapine tab 10mg	QL= 2 tabs/day
olopatadine ophth soln 0.2%	QL= 2.5ml/30 days
OPSUMIT TAB	QL= 1 tab/day; Only available through CVS Specialty 800-237-2767
ORENCIA CLICK INJ	QL= 4 inj/28 days
ORENCIA SC INJ 125MG/ML	QL= 4 inj/28 days
ORENCIA SC INJ 50MG/0.4ML	QL= 4 inj/28 days
ORENCIA SC INJ 87.5MG/0.7ML	QL= 4 inj/28 days
ORKAMBI GRANULES PACKET	QL= 2 packets/day; Only available through Maxor Pharmacy 800-658-6046 or Walgreens 888-347-3416

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.**Last Updated* 6/1/2020****Quantity Limit (QL)**

- The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
ORKAMBI TAB	QL= 4 tabs/day; Only available through Maxor Pharmacy 800-658-6046 or Walgreens 888-347-3416
oseltamivir cap	QL= 10 caps/fill
oseltamivir cap 30mg	QL= 20 caps/fill
oseltamivir susp	QL= 250ml/fill
OTEZLA STARTER PACK	QL= 1 pack/28 days
OTEZLA TAB	QL= 2 tabs/day
OXERVATE OPHTH SOLN	QL= 8 kits/affected eye/lifetime; Only available through Accredo 888-773-7376
OXYCONTIN CR TAB	QL= 120 tabs/30 days
OZEMPIC INJ	QL= 1 pack/28 days
permethrin cream	QL= 60gm/30 days
PNEUMOVAX INJ	QL= 1 inj/lifetime for members 2 years and older
PREVACID OTC CAP	QL= 2 caps/day
PREVNAR 13 INJ	QL= 2 inj/8 months for members 9 years and younger; QL= 1 inj/8 months for members 10 years and older
PRILOSEC OTC DR TAB	QL= 2 caps/day
quetiapine tab	QL= 3 tabs/day
quetiapine XR tab	QL= 2 tabs/day
REGRANEX GEL	QL= 30gm/fill
RELENZA DISKHALER	QL= 1 inhaler/fill
REPATHA INJ	QL= 2 inj/28 days

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Last Updated* 6/1/2020

Quantity Limit (QL)

- The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
REPATHA PUSHTRONEX INJ	QL= 1 inj/28 days
REVLIMID CAP	QL= 1 cap/day; Restricted to Oncology or Hematology Specialist
RINVOQ ER TAB	QL= 1 tab/day
rizatriptan ODT	QL= 12 tabs/30 days
rizatriptan tab	QL= 12 tabs/30 days
SKYRIZI INJ	QL= 2 inj/84 days
SOVALDI TAB	QL= 1 tab/day
SPIRIVA RESPIMAT INHALER 1.25MCG/ACT	QL= 1 inhaler/30 days; Step Therapy requires trial of ADVAIR, BREC DULERA, or FLUTICASONE/SALMETEROL
STELARA INJ	QL= 1 inj/84 days
STRIBILD TAB	QL= 1 tab/day
sumatriptan inj	QL= 6 inj/30 days
SUMATRIPTAN INJ 6MG/0.5ML	QL= 6 inj/30 days
sumatriptan nasal spray	QL= 6 sprays/fill, 2 fills/30 days
sumatriptan tab	QL= 9 tabs/30 days
sumatriptan vial inj	QL= 5 inj/fill, 2 fills/30 days
SYMDEKO TAB	QL= 2 tabs/day; Only available through Maxor Pharmacy 800-658-6046 or Walgreens 888-347-3416
SYMJEPI INJ	QL= 2 inj/fill
TAKHZYRO INJ	QL= 2 inj/28 days; Only available through CVS Specialty 800-237-2767
testosterone gel 1% 25mg	QL= 1 packet/day

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Last Updated* 6/1/2020

Quantity Limit (QL)

- The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
TESTOSTERONE GEL 1% 50MG	QL= 2 packets/day
testosterone gel 1% pump	QL= 4 bottles/30 days
testosterone gel 1.62% 1.25gm	QL= 1 packet/day
testosterone gel 1.62% 2.5gm	QL= 2 packets/day
TESTOSTERONE GEL PUMP	QL= 4 bottles/30 days
testosterone gel pump 1.62%	QL= 2 bottles/30 days
tranexamic acid tab	QL= 1 tab/day; Step Therapy requires trial of 1 generic NSAID
travoprost ophth soln	QL= 5ml/30 days
triamcinolone OTC nasal spray	QL= 2 bottles/fill
TRIUMEQ TAB	QL= 1 tab/day
TRUVADA TAB	QL= 1 tab/day
VALCHLOR GEL	QL= 4 tubes/30 days; Only available through Avella (877) 546-5779
VENTOLIN HFA INHALER	QL= 2 inhalers/30 days
V-GO INJ KIT	QL= 1 kit/day
VICTOZA INJ	QL= 9ml/30 days
VIMPAT INJ	QL= 1200 units/30 days
VIMPAT SOLN	QL= 600ml/30days
VIMPAT TAB	QL= 2 tabs/day; Step Therapy requires trial of carbamazepine, divalproex, lamotrigine or topiramate
VITRAKVI CAP 100MG	QL= 2 caps/day; Only available through US Bioservices 888-518-724
VITRAKVI CAP 25MG	QL= 6 caps/day; Only available through US Bioservices 888-518-724

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Last Updated* 6/1/2020

Quantity Limit (QL)

- The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
VITRAKVI SOLN	QL= 10ml/day; Only available through US Bioservices 888-518-7246
XOFLUZA TAB	QL= 2 tabs/fill; Covered for members 12 years of age or older
ziprasidone cap	QL= 2 caps/day
ZYLET OPHTH SUSP	QL= 5ml/fill (10ml bottle is Not Covered)

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