

# 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 1/1/2024

Drug Name	Special Code	Tier	Category
PRAMOSONE CREAM 1-1%	-	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
ABRYSVO INJ	VAC	\$0	VACCINES
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
ACCU-CHEK GUIDE ME KIT	OTC	\$0	MEDICAL DEVICES AND SUPPLIES
ACCU-CHEK GUIDE TEST STRIP	OTC	2	DIAGNOSTIC PRODUCTS

	<b>NC</b> =Not Covered	<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier Category
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
acetaminophen/codeine soln	-	1 ANALGESICS - OPIOID
acetaminophen/codeine tab (TYLENOL/CODEINE 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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier	Category
ACETASOL HC OTIC SOLN	-	1	OTIC AGENTS
acetazolamide ER cap (DIAMOX SEQUEL equiv)	-	1	DIURETICS
acetazolamide tab	-	1	DIURETICS
acetic acid otic soln (VOSOL equiv)	-	1	OTIC AGENTS
ACETIC ACID/ALUMINUM ACETATE OTIC SOLN	-	1	OTIC AGENTS
acetic acid/hydrocortisone otic soln (VOSOL HC equiv)	-	1	OTIC AGENTS
acetylcysteine soln (MUCOMYST equiv)	-	1	COUGH / COLD / ALLERGY
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
ACTHAR GEL INJ (QL= 4 vials/fill; Only available through Accredo 800-803-2523 or Walgreens 888-347-3416)	LD-PA-QL	2	ENDOCRINE AND METABOLIC AGENTS - MISC.
ACTHIB INJ, HIBERIX INJ	VAC	\$0	VACCINES
ACTIMMUNE INJ (Only available through Accredo 800-803-2523 or Walgreens 888-347-3416)	LD-PA	2	ANTINEOPLASTICS
acyclovir cap (ZOVIRAX equiv)	-	1	ANTIVIRALS
acyclovir cream 5%	-	2	DERMATOLOGICALS
acyclovir oint (ZOVIRAX OINT equiv)	-	1	DERMATOLOGICALS
acyclovir susp (ZOVIRAX equiv)	-	1	ANTIVIRALS
acyclovir tab (ZOVIRAX equiv)	-	1	ANTIVIRALS

	<b>NC</b> =Not Covered	<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month fo first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier	Category
ADALIMUMAB-ADAZ INJ (QL= 2 inj/28 days)	LMSP-PA-QL	2	ANALGESICS - ANTI-INFLAMMATORY
ADALIMUMAB-ADAZ PFS INJ (QL= 2 inj/28 days)	LMSP-PA-QL	2	ANALGESICS - ANTI-INFLAMMATORY
ADALIMUMAB-FKJP AUTO-INJECTOR KIT (QL= 2 inj/28 days)	LMSP-PA-QL	2	ANALGESICS - ANTI-INFLAMMATORY
ADALIMUMAB-FKJP PFS KIT 20 MG/0.4ML (QL= 2 inj/28 days)	LMSP-PA-QL	2	ANALGESICS - ANTI-INFLAMMATORY
ADALIMUMAB-FKJP PFS KIT 40 MG/0.8ML (QL= 2 inj/28 days)	LMSP-PA-QL	2	ANALGESICS - ANTI-INFLAMMATORY
adapalene cream (DIFFERIN equiv)	-	1	DERMATOLOGICALS
adapalene gel (DIFFERIN equiv)	-	1	DERMATOLOGICALS
adapalene/benzoyl peroxide gel 0.1-2.5% (EPIDUO equiv)	-	1	DERMATOLOGICALS
ADBRY INJ (QL= 4 inj/28 days)	LMSP-PA-QL	2	DERMATOLOGICALS
ADVAIR DISKUS INHALER	-	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ADVAIR HFA INHALER	-	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
AEROCHAMBER	OTC	2	MEDICAL DEVICES AND SUPPLIES

	<b>NC</b> =Not Covered	<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier Category
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= 1 inj/28 days for members 6 months and older)	QL-VAC	\$0 VACCINES
AIMOVIG INJ (QL= 1 pack/28 days)	PA-QL	2 MIGRAINE PRODUCTS
AJOVY INJ (QL= 1 pack/28 days)	PA-QL	2 MIGRAINE PRODUCTS
albuterol HFA inhaler (PROAIR, PROVENTIL equiv) (QL= 2 inhalers/30 days)	QL	1 ANTI-ASTHMATIC AND BRONCHODILATOR AGENTS
albuterol neb soln	-	1 ANTI-ASTHMATIC AND BRONCHODILATOR AGENTS
ALBUTEROL NEBULIZER SOLN	-	1 ANTI-ASTHMATIC AND BRONCHODILATOR AGENTS
albuterol sulfate syrup	-	1 ANTI-ASTHMATIC AND BRONCHODILATOR AGENTS
albuterol sulfate tab	-	1 ANTI-ASTHMATIC 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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier	Category
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.
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.
allopurinol tab (ZYLOPRIM equiv)	-	1	GOUT AGENTS
ALOCRILOPHTH SOLN	-	2	OPHTHALMIC AGENTS

	<b>NC</b> =Not Covered	<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier Category
ALOMIDE OPHTH SOLN	-	2 OPTHALMIC AGENTS
alose tron tab (LOTRONEX equiv)	-	1 GASTROINTESTINAL AGENTS - MISC.
ALPHAGAN P OPHTH SOLN 0.15%	-	2 OPTHALMIC 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
ALREX OPHTH SUSP	-	2 OPTHALMIC AGENTS
ALTRENO LOTION	-	2 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 Lumicera 855-847-3553)	LD-QL-RS	1 CARDIOVASCULAR AGENTS - MISC.
amethyst tab (LYBREL equiv)	-	\$0 CONTRACEPTIVES
amiloride tab (MIDAMOR equiv)	-	1 DIURETICS
AMILORIDE/HCTZ TAB	-	1 DIURETICS
amiloride/hydrochlorothiazide tab (MODURETIC equiv)	-	1 DIURETICS
aminocaproic acid soln (AMICAR equiv)	-	1 HEMOSTATICS
aminocaproic acid tab (AMICAR equiv)	-	1 HEMOSTATICS
amiodarone tab (CORDARONE equiv)	-	1 ANTIARRHYTHMICS
amitriptyline tab (ELAVIL equiv)	-	1 ANTIDEPRESSANTS
amlodipine tab (NORVASC equiv)	-	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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier	Category
amlodipine/benazepril cap (LOTREL equiv)	-	1	ANTIHYPERTENSIVES
amlodipine/olmesartan tab (AZOR TAB equiv)	-	1	ANTIHYPERTENSIVES
amlodipine/valsartan tab (EXFORGE equiv)	-	1	ANTIHYPERTENSIVES
ammonium lactate cream (LAC-HYDRIN equiv)	OTC	1	DERMATOLOGICALS
ammonium lactate lotion (LAC-HYDRIN equiv)	OTC	1	DERMATOLOGICALS
amnesteem cap, claravis cap, isotretinoin cap, myorisan cap, zenatane cap (AC CUTANE equiv)	-	1	DERMATOLOGICALS
amoxapine tab (AMOXAPINE equiv)	-	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 susp (AUGMENTIN ES equiv)	-	1	PENICILLINS
amoxicillin/clavulanate tab (AUGMENTIN equiv)	-	1	PENICILLINS
amphetamine/dextroamphetamine ER cap (ADDERALL XR equiv) (QL= 2 caps/day)	QL	1	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
amphetamine/dextroamphetamine tab (ADDERALL equiv)	-	1	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
ampicillin cap (AMPICILLIN equiv)	-	1	PENICILLINS

	<b>NC</b> =Not Covered	<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier	Category
anagrelide cap (AGRYLIN equiv)	-	1	HEMATOLOGICAL AGENTS - MISC.
anastrozole tab (ARIMIDEX equiv)	-	1	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ANDRODERM PATCH (QL= 1 patch/day)	PA-QL	2	ANDROGENS-ANABOLIC
ANNOVERA RING (QL= 1 ring/year)	QL	\$0	CONTRACEPTIVES
apraclonidine ophth soln (IOPIDINE equiv)	-	1	OPHTHALMIC AGENTS
APRACLONIDINE OPHTH SOLN	-	2	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 soln (ABILIFY equiv)	-	1	ANTIPSYCHOTICS / ANTIMANIC AGENTS
aripiprazole tab (ABILIFY equiv)	-	1	ANTIPSYCHOTICS / ANTIMANIC AGENTS
armodafinil tab (NUVIGIL equiv) (QL= 1 tab/day)	QL	1	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
ARMOUR THYROID TAB, NATURE THROID TAB	-	1	THYROID AGENTS
ARNUITY ELLIPTA INHALER (QL= 1 inhaler/30 days)	QL	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS

	<b>NC</b> =Not Covered	<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier	Category
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
asenapine maleate SL tab (SAPHRIS equiv) (QL= 2 tabs/day)	QL	1	ANTIPSYCHOTICS / ANTIMANIC AGENTS
ashlyna tab, daysee tab (SEASONALE, SEASONIQUE equiv)	-	\$0	CONTRACEPTIVES
ASMANEX HFA INHALER (QL= 1 inhaler/30 days)	QL	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ASMANEX INHALER (QL= 1 inhaler/30 days)	QL	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
aspirin chew tab 81mg	OTC	\$0	ANALGESICS - NONNARCOTIC
aspirin supp	OTC	1	ANALGESICS - NONNARCOTIC
aspirin tab 325mg	OTC	\$0	ANALGESICS - NONNARCOTIC
aspirin/codeine tab	-	1	ANALGESICS - OPIOID

	<b>NC</b> =Not Covered	<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier Category
ASTAMED MYO CAP	-	EX C DIETARY PRODUCTS / DIETARY MANAGEMENT PRODUCTS
atazanavir cap (REYATAZ equiv)	-	1 ANTIVIRALS
atenolol tab (TENORMIN equiv)	-	1 BETA BLOCKERS
atenolol/chlorthalidone tab (TENORETIC equiv)	-	1 ANTIHYPERTENSIVES
atomoxetine cap (STRATTERA equiv) (QL= 2 caps/day)	QL	1 ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
ATORVALIQ SUSP (Covered for members age 9 years and older; and patients that are unable to swallow tablets)	PA	2 ANTIHYPERLIPIDEMICS
atorvastatin tab (LIPITOR equiv)	-	1 ANTIHYPERLIPIDEMICS
atovaquone susp (MEPRON equiv)	-	1 ANTI-INFECTIVE AGENTS MISC.
ATRALIN GEL, RETIN-A GEL	-	2+p DERMATOLOGICALS enal ty
atropine ophth oint	-	1 OPHTHALMIC AGENTS
atropine ophth soln (ISOPTO ATROPINE equiv)	-	1 OPHTHALMIC AGENTS
ATROPINE SUL SOLN 1% OPHTH	-	1 OPHTHALMIC AGENTS
ATROPINE SULFATE OPHTH OINT	-	1 OPHTHALMIC AGENTS

	<b>NC</b> =Not Covered	<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month fo first 3 months	SMKG	Smoking Cessation
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 1/1/2024**

<b>Drug Name</b>	<b>Special Code</b>	<b>Tier</b>	<b>Category</b>
AUSTEDO XR TAB (QL= 2 tabs/day)	LMSP-PA-QL	2	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
AVAR GEL	-	2	DERMATOLOGICALS
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

	<b>NC</b> =Not Covered	<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024

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 intrathecal inj (BACLOFEN equiv) (Members age 9 or older require Prior Authorization)	PA	1	MUSCULOSKELETAL THERAPY AGENTS
BACLOFEN SUSP (Prior Authorization Required for members age 9 or older)	PA	2	MUSCULOSKELETAL THERAPY AGENTS
baclofen tab (BACLOFEN equiv)	-	1	MUSCULOSKELETAL THERAPY AGENTS
BALCOLTRA TAB	-	\$0	CONTRACEPTIVES
balsalazide cap (COLAZAL equiv)	-	1	GASTROINTESTINAL AGENTS - MISC.
BANZEL SUSP	PA	2+p enal ty	ANTICONVULSANTS
BAQSIMI NASAL POWDER (QL= 2 inhalations/fill)	QL	2	ANTIDIABETICS
BARACLUDE SOLN (Prior Authorization Required for members age 9 or older)	PA	2	ANTIVIRALS
BCG INJ	VAC	EX C	VACCINES
B-D INSULIN SYRINGE	--OTC	1	MEDICAL DEVICES AND SUPPLIES

	<b>NC</b> =Not Covered	<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier	Category
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 HCT equiv)	-	1	ANTIHYPERTENSIVES
BENZNIDAZOLE TAB (Restricted to Infectious Disease Specialist)	RS	2	ANTHELMINTICS
benzocaine gel	OTC	1	MOUTH / THROAT / DENTAL AGENTS
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
BENZPHETAMINE TAB	-	EX C	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
benztropine tab	-	1	ANTIPARKINSON AGENTS
BERINERT INJ (Only available through Accredo 800-803-2523)	LD-PA	2	HEMATOLOGICAL AGENTS - MISC.

	<b>NC</b> =Not Covered	<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier	Category
betamethasone augmented cream (DIPROLENE AF CREAM equiv)	-	1	DERMATOLOGICALS
betamethasone augmented gel	-	1	DERMATOLOGICALS
betamethasone augmented oint (DIPROLENE OINT equiv)	-	1	DERMATOLOGICALS
betamethasone dipropionate cream (DIPROSONE CREAM equiv)	-	1	DERMATOLOGICALS
betamethasone dipropionate lotion	-	1	DERMATOLOGICALS
betamethasone valerate cream	-	1	DERMATOLOGICALS
betamethasone valerate lotion	-	1	DERMATOLOGICALS
betamethasone valerate oint	-	1	DERMATOLOGICALS
BETAXOLOL OPTH SOLN	-	1	OPHTHALMIC AGENTS
betaxolol ophth soln (BETOPTIC-S equiv)	-	1	OPHTHALMIC AGENTS
betaxolol tab (KERLONE equiv)	-	1	BETA BLOCKERS
bethanechol tab (URECHOLINE equiv)	-	1	URINARY ANTISPASMODICS
BETIMOL OPTH SOLN	-	2	OPHTHALMIC AGENTS
BETOPTIC-S OPTH SOLN	-	2	OPHTHALMIC AGENTS
bexarotene cap (TARGRETIN equiv)	LMSP-PA	2	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
bexarotene gel (TARGRETIN equiv)	LMSP-PA	1	DERMATOLOGICALS
BEXSERO INJ	VAC	\$0	VACCINES
BEYFORTUS INJ	VAC	\$0	PASSIVE IMMUNIZING AND TREATMENT AGENTS

	<b>NC</b> =Not Covered	<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier	Category
bicalutamide tab (CASODEX equiv)	-	1	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
BIKTARVY TAB	-	2	ANTIVIRALS
bimatoprost ophth soln (QL= 2.5ml/30 days)	QL	1	OPHTHALMIC AGENTS
bimatoprost ophth soln	QL--	EX C	DERMATOLOGICALS
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 Lumicera 855-847-3553)	LD-QL-RS	1	CARDIOVASCULAR AGENTS - MISC.
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
brimonidine tartrate ophth soln 0.1% (ALPHAGAN equiv)	-	1	OPHTHALMIC AGENTS
brimonidine/timolol ophth soln (COMBIGAN OPHTH SOLN equiv)	-	1	OPHTHALMIC AGENTS
bromocriptine cap (PARLODEL equiv)	-	1	ANTIPARKINSON AGENTS
bromocriptine tab (PARLODEL equiv)	-	1	ANTIPARKINSON AGENTS

	<b>NC</b> =Not Covered	<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024**

<b>Drug Name</b>	<b>Special Code</b>	<b>Tier Category</b>	
budesonide inh susp (PULMICORT equiv)	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
budesonide SR cap (ENTOCORT EC equiv)	-	1	CORTICOSTEROIDS
budesonide/formoterol inhaler (SYMBICORT equiv)	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
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)	-	\$0	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
bupropion tab (WELLBUTRIN equiv)	-	1	ANTIDEPRESSANTS
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

	<b>NC =Not Covered</b>	<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier	Category
BYDUREON BCISE AUTO INJ (QL= 4 inj/28 days; Diagnosis Restricted – Type 2 Diabetes (E11))	QL-RDX	2	ANTIDIABETICS
BYDUREON INJ (QL= 4 inj/28 days; Diagnosis Restricted – Type 2 Diabetes (E11))	QL-RDX	2	ANTIDIABETICS
BYDUREON PEN INJ (QL= 4 inj/28 days; Diagnosis Restricted – Type 2 Diabetes (E11))	QL-RDX	2	ANTIDIABETICS
BYLVAY CAP 1200MCG (QL= 5 caps/day; Only available through PantheRx Pharmacy 855-726-8479)	LD-PA-QL	2	GASTROINTESTINAL AGENTS - MISC.
BYLVAY CAP 400MCG (QL= 15 caps/day; Only available through PantheRx Pharmacy 855-726-8479)	LD-PA-QL	2	GASTROINTESTINAL AGENTS - MISC.
BYLVAY SPRINKLE CAP 200MCG (QL= 8 caps/day; Only available through PantheRx Pharmacy 855-726-8479)	LD-PA-QL	2	GASTROINTESTINAL AGENTS - MISC.
BYLVAY SPRINKLE CAP 600MCG (QL= 4 caps/day; Only available through PantheRx Pharmacy 855-726-8479)	LD-PA-QL	2	GASTROINTESTINAL AGENTS - MISC.
cabergoline tab (DOSTINEX equiv)	-	1	ENDOCRINE AND METABOLIC AGENTS - MISC.
CABOMETYX TAB (QL= 1 tab/day)	PA-QL	2	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES

	<b>NC</b> =Not Covered	<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier Category
caffeine citrate soln (CAFCIT equiv) (Only covered for members less than 1 year old)	-	2 ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
calcipotriene cream (DOVONEX CREAM equiv)	-	1 DERMATOLOGICALS
calcipotriene oint	-	1 DERMATOLOGICALS
calcipotriene soln (DOVONEX SOLN equiv)	-	1 DERMATOLOGICALS
calcitonin inj (MIACALCIN equiv)	LMSP	1 ENDOCRINE AND METABOLIC AGENTS - MISC.
calcitriol cap (ROCALTROL equiv)	-	1 ENDOCRINE AND METABOLIC AGENTS - MISC.
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

	<b>NC</b> =Not Covered	<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier	Category
calcium w/vitamin D tab	OTC	1	MINERALS & ELECTROLYTES
CALIBRATION LIQUID	OTC	1	MEDICAL DEVICES AND SUPPLIES
CAMZYOS CAP (QL= 1 cap/day; Only available through Accredo 800-803-2523 or Walgreens 888-347-3416)	LD-PA-QL	2	CARDIOVASCULAR AGENTS - MISC.
candesartan tab (ATACAND equiv)	-	1	ANTIHYPERTENSIVES
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
carbidopa tab (LODOSYN equiv)	-	1	ANTIPARKINSON AGENTS
carbidopa/levodopa ER tab (SINEMET CR equiv)	-	1	ANTIPARKINSON AGENTS
CARBIDOPA/LEVODOPA ODT	-	1	ANTIPARKINSON AND RELATED THERAPY AGENTS
carbidopa/levodopa ODT (PARCOPA equiv)	-	1	ANTIPARKINSON AGENTS
carbidopa/levodopa tab (SINEMET equiv)	-	1	ANTIPARKINSON AGENTS

	<b>NC</b> =Not Covered	<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier	Category
CARBIDOPA/LEVODOPA/ENTACAPONE TAB (STALEVO equiv)	-	2	ANTIPARKINSON AGENTS
carbidopa-levodopa-entacapone tab (STALEVO equiv)	-	1	ANTIPARKINSON AND RELATED THERAPY AGENTS
CARBINOXAMINE SOLN	-	1	ANTIHISTAMINES
carbinoxamine tab (PALGIC equiv)	-	1	ANTIHISTAMINES
carboplatin inj (PARAPLATIN equiv)	MSP	1	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
CARETOUCH MIS	OTC	1	MEDICAL DEVICES AND SUPPLIES
carglumic acid tab (CARBAGLU equiv) (Only available through AnovoRx 844-288-5007)	LD-PA	2	ENDOCRINE AND METABOLIC AGENTS - MISC.
carisoprodol tab (SOMA equiv)	-	1	MUSCULOSKELETAL THERAPY AGENTS
CAROSPIR SUSP	-	2+p enal ty	DIURETICS
carteolol ophth soln (OCUPRESS equiv)	-	1	OPHTHALMIC AGENTS
carvedilol tab (COREG equiv)	-	1	BETA BLOCKERS
CAYSTON INH SOLN (Restricted to Infectious Disease or Pulmonology Specialist; Only available through Walgreens 888-347-3416)	LD-RS	2	ANTI-INFECTIVE AGENTS - MISC.

	<b>NC</b> =Not Covered	<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024**

<b>Drug Name</b>	<b>Special Code</b>	<b>Tier Category</b>
CEFACLOR CAP	-	1 CEPHALOSPORINS
cefaclor cap (CECLOR equiv)	-	1 CEPHALOSPORINS
cefadroxil cap (DURICEF equiv)	-	1 CEPHALOSPORINS
cefadroxil susp (DURICEF equiv)	-	1 CEPHALOSPORINS
CEFADROXIL TAB	-	1 CEPHALOSPORINS
cefadroxil tab (DURICEF equiv)	-	1 CEPHALOSPORINS
cefdinir cap (OMNICEF equiv)	-	1 CEPHALOSPORINS
cefdinir susp (OMNICEF equiv)	-	1 CEPHALOSPORINS
cefixime susp (SUPRAX equiv)	-	1 CEPHALOSPORINS
cefpodoxime proxetil susp (VANTIN equiv)	-	1 CEPHALOSPORINS
cefpodoxime proxetil tab (VANTIN equiv)	-	1 CEPHALOSPORINS
cefprozil susp (CEFZIL equiv)	-	1 CEPHALOSPORINS
cefprozil tab (CEFZIL equiv)	-	1 CEPHALOSPORINS
cefuroxime tab (CEFTIN equiv)	-	1 CEPHALOSPORINS
CELEBREX CAP	-	2+p ANALGESICS - enalANTI-INFLAMMATORY ty
celecoxib cap (CELEBREX equiv)	-	1 ANALGESICS - ANTI-INFLAMMATORY
CELLCEPT CAP	-	2 ASSORTED CLASSES
CELLCEPT TAB	-	2 ASSORTED CLASSES
cephalexin cap (KEFLEX equiv)	-	1 CEPHALOSPORINS
cephalexin susp (KEFLEX equiv)	-	1 CEPHALOSPORINS
CEREZYME INJ	MSP-PA	2 HEMATOPOIETIC AGENTS

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month fo first 3 months	SMKG	Smoking Cessation
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 1/1/2024**

<b>Drug Name</b>	<b>Special Code</b>	<b>Tier</b>	<b>Category</b>
cetirizine syrup (ZYRTEC equiv) (QL= 10ml/day)	OTC-QL	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
cetrorelix acetate for inj kit (CETROTIDE equiv)	INF	EX C	ENDOCRINE AND METABOLIC AGENTS - MISC.
CETROTIDE KIT	INF	EX C	ENDOCRINE AND METABOLIC AGENTS - MISC.
cevimeline cap (EVOXAC equiv)	-	1	MOUTH / THROAT / DENTAL AGENTS
CHEMET CAP	-	2	ANTIDOTES
chlordiazepoxide cap (LIBRIUM equiv)	-	1	ANTI-ANXIETY AGENTS
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
chlorpromazine tab (THORAZINE equiv)	-	1	ANTIPSYCHOTICS / ANTIMANIC AGENTS
chlorthalidone tab	-	1	DIURETICS

	<b>NC</b> =Not Covered	<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier	Category
chlorzoxazone tab 500mg	-	1	MUSCULOSKELETAL THERAPY AGENTS
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
CIBINQO TAB (QL= 1 tab/day)	LMSP-PA-QL	2	DERMATOLOGICALS
ciclopirox cream (LOPROX CREAM equiv)	-	1	DERMATOLOGICALS
ciclopirox gel (LOPROX GEL equiv)	-	1	DERMATOLOGICALS
ciclopirox nail soln (PENLAC equiv)	-	1	DERMATOLOGICALS
ciclopirox shampoo (LOPROX SHAMPOO equiv)	-	1	DERMATOLOGICALS
ciclopirox topical susp (LOPROX SUSP equiv)	-	1	DERMATOLOGICALS
cilostazol tab (PLETAL equiv)	-	1	HEMATOLOGICAL AGENTS - MISC.
CIMDUO TAB	-	2	ANTIVIRALS
CIMETIDINE SOLN	-	1	ULCER DRUGS / ANTISPASMODICS / ANTICHOLINERGICS
cimetidine soln (CIMETIDINE equiv)	-	1	ULCER DRUGS
cimetidine tab (TAGAMET equiv)	OTC	1	ULCER DRUGS

	<b>NC</b> =Not Covered	<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier	Category
CIMZIA INJ (QL= 2 inj/28 days)	LMSP-PA-QL	2	GASTROINTESTINAL AGENTS - MISC.
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 Accredo 800-803-2523)	LD-PA-QL	2	HEMATOLOGICAL AGENTS - MISC.
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
ciprofloxacin/dexamethasone otic susp (CIPRODEX equiv)	-	1	OTIC AGENTS
CISPLATIN INJ	-	1	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
cisplatin inj (PLATINOL AQ equiv)	-	1	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
CISPLATIN INJ 50MG/50ML	-	1	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
citalopram soln (CELEXA equiv)	-	1	ANTIDEPRESSANTS
citalopram tab (CELEXA equiv)	-	1	ANTIDEPRESSANTS
CLARITHROMYCIN SUSP	-	2	MACROLIDES
clarithromycin ER tab (BIAXIN XL equiv)	-	1	MACROLIDES
clarithromycin tab (BIAXIN equiv)	-	1	MACROLIDES
CLARITIN CHEW TAB	OTC	2	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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier	Category
CLEMASTINE TAB 1.34MG	OTC	1	ANTI-HISTAMINES
clemastine tab 1.34mg (TAVIST equiv)	OTC	1	ANTI-HISTAMINES
CLEOCIN-T GEL	-	2+p	DERMATOLOGICALS
		enal	
		ty	
clindamycin cap (CLEOCIN equiv)	-	1	ANTI-INFECTIVE AGENTS MISC.
clindamycin gel (CLEOCIN GEL equiv)	-	1	DERMATOLOGICALS
clindamycin lotion (CLEOCIN- T equiv)	-	1	DERMATOLOGICALS
clindamycin pad (CLEOCIN-T equiv)	-	1	DERMATOLOGICALS
clindamycin soln (CLEOCIN equiv)	-	1	ANTI-INFECTIVE AGENTS MISC.
clindamycin topical soln (CLEOCIN-T equiv)	-	1	DERMATOLOGICALS
clindamycin vaginal cream (CLEOCIN equiv) (QL=1 tube/fill)	QL	1	VAGINAL PRODUCTS
clindamycin/benzoyl peroxide gel (BENZACLIN equiv)	-	1	DERMATOLOGICALS
clindamycin/benzoyl peroxide gel (DUAC GEL equiv)	-	1	DERMATOLOGICALS
CLINISTIX TEST STRIP	OTC	1	DIAGNOSTIC PRODUCTS
clobazam susp (ONFI equiv) (Members age 9 or older require Prior Authorization)	PA	2	ANTICONVULSANTS
clobazam tab (ONFI equiv)	-	1	ANTICONVULSANTS
clobetasol foam	PA	1	DERMATOLOGICALS

	<b>NC</b> =Not Covered	<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024**

<b>Drug Name</b>	<b>Special Code</b>	<b>Tier</b>	<b>Category</b>
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 shampoo (CLOBEX SHAMPOO equiv)	PA	1	DERMATOLOGICALS
clobetasol spray	PA	1	DERMATOLOGICALS
CLOBEX SPRAY	PA	2+p	DERMATOLOGICALS
		enal	
		ty	
CLOMID TAB	INF	EX	ENDOCRINE AND
		C	METABOLIC AGENTS -
			MISC.
CLOMIPHENE TAB	INF	EX	ENDOCRINE AND
		C	METABOLIC AGENTS -
			MISC.
clomipramine cap (ANAFRANIL equiv)	-	1	ANTIDEPRESSANTS
clonazepam ODT (KLONOPIN equiv)	-	1	ANTICONVULSANTS
clonazepam tab (KLONOPIN equiv)	-	1	ANTICONVULSANTS
clonidine ER tab (KAPVAY equiv)	-	2	ADHD /
			ANTI-NARCOLEPSY /
			ANTI-OBESITY /
			ANOREXIANTS

	<b>NC</b> =Not Covered	<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier	Category
clonidine patch (CATAPRES-TTS equiv)	-	1	ANTIHYPERTENSIVES
clonidine tab (CATAPRES equiv)	-	1	ANTIHYPERTENSIVES
clopidogrel tab 75mg (PLAVIX equiv)	-	1	HEMATOLOGICAL AGENTS - MISC.
clotrimazole cream (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
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	ANTIHYPERLIPIDEMICS
colesevelam tab (WELCHOL equiv)	-	1	ANTIHYPERLIPIDEMICS
colestipol granule (COLESTID equiv)	-	1	ANTIHYPERLIPIDEMICS
colestipol powder packet (COLESTID equiv)	-	1	ANTIHYPERLIPIDEMICS
colestipol tab (COLESTID equiv)	-	1	ANTIHYPERLIPIDEMICS
COLY-MYCIN S OTIC SUSP	-	2	OTIC AGENTS
COMBIGAN OPHTH SOLN	-	2+p	OPHTHALMIC AGENTS
		enalty	

	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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier Category
COMBIVENT RESPIMAT INHALER	-	2 ANTI-ASTHMATIC AND BRONCHODILATOR AGENTS
COMIRNATY INJ (QL= 1 dose/17 days)	QL-VAC	\$0 VACCINES
COMIRNATY INJ 30MCG/0.3ML (QL= 1 dose/17 days)	QL-VAC	\$0 VACCINES
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
COVID-19 TEST (QL= 8 tests/30 days)	OTC-QL	\$0 DIAGNOSTIC PRODUCTS
COVID-19 VACCINE BIVALENT BOOSTER INJ (MODERNA) (QL= 1 inj/fill)	QL-VAC	\$0 VACCINES
COVID-19 VACCINE BIVALENT BOOSTER INJ (PFIZER) (QL= 1 inj/fill)	QL-VAC	\$0 VACCINES
COVID-19 VACCINE BIVALENT BOOSTER INJ 5-11Y (PFIZER) (QL= 1 inj/fill)	QL-VAC	\$0 VACCINES
COVID-19 VACCINE BIVALENT BOOSTER INJ 6M-4Y (PFIZER) (QL= 1 inj/fill)	QL-VAC	\$0 VACCINES
COVID-19 VACCINE BIVALENT BOOSTER INJ 6M-5Y (MODERNA) (QL= 1 inj/fill)	QL-VAC	\$0 VACCINES

	<b>NC</b> =Not Covered	<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024**

<b>Drug Name</b>	<b>Special Code</b>	<b>Tier Category</b>
COVID-19 VACCINE INJ (JANSSEN) (QL= 1 dose/45 days)	QL-VAC	\$0 VACCINES
COVID-19 VACCINE INJ (NOVAVAX) (QL= 1 dose/17 days)	QL-VAC	\$0 VACCINES
COVID-19 VACCINE INJ 5-11Y (PFIZER) (QL= 1 dose/17 days)	QL-VAC	\$0 VACCINES
COVID-19 VACCINE INJ 6M-11Y (MODERNA) (QL= 1 dose/24 days)	QL-VAC	\$0 VACCINES
COVID-19 VACCINE INJ 6M-4Y (PFIZER) (QL= 1 dose/17 days)	QL-VAC	\$0 VACCINES
CREON CAP	-	2 DIGESTIVE AIDS
CRESTOR TAB	-	2+p ANTIHYPERLIPIDEMICS enal ty
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
CROMOLYN SODIUM OPHTH SOLN	-	1 OPHTHALMIC AGENTS
cryselle tab	-	\$0 CONTRACEPTIVES
CUE COVID-19 INJ TEST CARTRIDGE	OTC	EX DIAGNOSTIC PRODUCTS C

	<b>NC =Not Covered</b>	<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier Category
CUE HEALTH MONITOR	OTC	EX DIAGNOSTIC PRODUCTS C
CUVITRU INJ	MSP-PA	2 PASSIVE IMMUNIZING AGENTS
cyanocobalamin inj	-	1 HEMATOPOIETIC AGENTS
cyclobenzaprine tab 10mg (FLEXERIL equiv)	-	1 MUSCULOSKELETAL THERAPY AGENTS
cyclobenzaprine tab 5mg (FLEXERIL equiv)	-	1 MUSCULOSKELETAL THERAPY AGENTS
CYCLOMYDRIL OPHTH SOLN	-	2 OPHTHALMIC AGENTS
cyclopentolate ophth soln (CYCLOGYL equiv)	-	1 OPHTHALMIC AGENTS
cyclophosphamide cap	-	1 ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
CYCLOPHOSPHAMIDE TAB	-	2 ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
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
cyproheptadine tab	-	1 ANTIHISTAMINES
CYSTADROPS SOLN (QL = 4 bottles/28 days; Restricted to Ophthalmology Specialist; Only available through Anovo Specialty Pharmacy 844-288-5007)	LD-QL-RS	2 OPHTHALMIC AGENTS

	<b>NC</b> =Not Covered	<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier	Category
CYSTAGON CAP (Only available through CVS Specialty 800-238-7828)	LD	2	GENITOURINARY AGENTS - MISCELLANEOUS
CYSTARAN OPHTH SOLN (QL= 4 bottles/28 days Restricted to Ophthalmology or Optometry Specialist Only available through Walgreens 888-347-3416)	LD-QL-RS	2	OPHTHALMIC AGENTS
CYTRA K CRYSTALS	-	1	GENITOURINARY AGENTS - MISCELLANEOUS
CYTRA-3 SYRUP	-	1	GENITOURINARY AGENTS - MISCELLANEOUS
dabigatran etexilate mesylate cap (PRADAXA equiv)	-	2	ANTICOAGULANTS
danazol cap (DANOCRINE equiv)	-	1	ANDROGENS-ANABOLIC
dantrolene cap (DANTRIUM equiv)	-	1	MUSCULOSKELETAL THERAPY AGENTS
dapsone tab	-	1	ANTI-INFECTIVE AGENTS MISC.
DAPTACEL INJ, INFANRIX INJ	VAC	\$0	TOXOIDS
darunavir tab (PREZISTA equiv)	-	1	ANTIVIRALS
DAYBUE SOLN (QL= 8 bottles/30 days; Only available through AnovoRx 844-288-5007)	LD-PA-QL	2	NEUROMUSCULAR AGENTS
DDAVP INJ	-	2+p	ENDOCRINE AND METABOLIC AGENTS - MISC.

	<b>NC</b> =Not Covered	<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier	Category
deferasirox granules packet (JADENU equiv)	LMSP	1	ANTIDOTES AND SPECIFIC ANTAGONISTS
deferasirox tab (EXJADE equiv)	LMSP	1	ANTIDOTES AND SPECIFIC ANTAGONISTS
deferasirox tab 180mg (JADENU equiv)	-	1	ANTIDOTES AND SPECIFIC ANTAGONISTS
deferasirox tab 90mg, 360mg (JADENU equiv)	LMSP	1	ANTIDOTES AND SPECIFIC ANTAGONISTS
deferiprone tab (FERRIPROX equiv) (Only available through Lumicera 855-847-3553)	LD-PA	1	ANTIDOTES AND SPECIFIC ANTAGONISTS
DELSTRIGO TAB	-	2	ANTIVIRALS
DENG VAXIA SUSP	VAC	\$0	VACCINES
DEPLIN CAP	-	EX C	DIETARY PRODUCTS / DIETARY MANAGEMENT PRODUCTS
DEPO-PROVERA INJ	-	\$0	CONTRACEPTIVES
DESCOVY TAB	-	\$0	ANTIVIRALS
desipramine tab (NORPRAMIN equiv)	-	1	ANTIDEPRESSANTS
desmopressin acetate inj (DDAVP equiv)	-	1	ENDOCRINE AND METABOLIC AGENTS - MISC.
desmopressin acetate nasal spray (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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier	Category
desmopressin acetate tab (DDAVP equiv)	-	1	ENDOCRINE AND METABOLIC AGENTS - MISC.
DESOGEN TAB	-	\$0	CONTRACEPTIVES
desonide cream (DESOWEN equiv)	-	2	DERMATOLOGICALS
desonide oint (DESOWEN equiv)	-	2	DERMATOLOGICALS
desoximetasone cream (DESOXIMETASONE equiv)	-	2	DERMATOLOGICALS
desoximetasone oint (TOPICORT equiv)	-	1	DERMATOLOGICALS
DEXAMETHASONE CONC	-	1	CORTICOSTEROIDS
dexamethasone elixir	-	1	CORTICOSTEROIDS
dexamethasone sodium phosphate inj	-	1	CORTICOSTEROIDS
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
dexmethylphenidate tab (FOCALIN equiv)	-	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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier	Category
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
DIACOMIT CAP	PA	2	ANTICONVULSANTS
DIACOMIT POWDER PACK	PA	2	ANTICONVULSANTS
DIALYVITE TAB	-	1	MULTIVITAMINS
dialyvite tab (NEPHRO-VITE equiv)	--OTC	1	MULTIVITAMINS
DIALYVITE/ZINC TAB	-	1	MULTIVITAMINS
DIAPHRAGM	-	2	MEDICAL DEVICES AND SUPPLIES
diazepam conc (VALIUM equiv)	-	1	ANTI-ANXIETY AGENTS
diazepam oral soln 5mg/5ml (DIAZEPAM equiv)	-	1	ANTI-ANXIETY AGENTS
diazepam tab (VALIUM equiv)	-	1	ANTI-ANXIETY AGENTS
diclofenac gel (SOLARAZE equiv) (QL= 300gm/30 days)	QL	1	DERMATOLOGICALS
diclofenac gel 1% (VOLTAREN equiv) (QL= 5 tubes/fill)	QL	1	DERMATOLOGICALS

	<b>NC</b> =Not Covered	<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier Category
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
DIETHYLPROPION ER TAB	-	EX ADHD / C ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
diethylpropion tab	-	EX ADHD / C ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
DIFFERIN OTC GEL 0.1%	OTC	1 DERMATOLOGICALS

	<b>NC</b> =Not Covered	<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month fo first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier	Category
DIFICID SUSP (QL= 136 mL/fill; Step Therapy requires trial of vancomycin cap, FIRST-VANCOMYCIN SOLN, or FIRVANQ SOLN)	QL-ST	2	MACROLIDES
DIFICID TAB (QL= 20 tabs/fill; Step Therapy requires trial of vancomycin cap, FIRST-VANCOMYCIN SOLN, or FIRVANQ SOLN)	QL-ST	2	MACROLIDES
diflunisal tab (DOLOBID equiv)	-	1	ANALGESICS - NONNARCOTIC
difluprednate ophth emulsion (DUREZOL equiv)	-	1	OPHTHALMIC AGENTS
digoxin soln (LANOXIN equiv)	-	1	CARDIOTONICS
DIGOXIN SOLN 0.05MG/ML	-	1	CARDIOTONICS
digoxin tab (LANOXIN equiv)	-	1	CARDIOTONICS
DILANTIN CAP 30MG	-	2	ANTICONVULSANTS
diltiazem ER cap (CARDIZEM CD equiv)	-	1	CALCIUM CHANNEL BLOCKERS
diltiazem ER cap (CARDIZEM SR equiv)	-	1	CALCIUM CHANNEL BLOCKERS
diltiazem ER cap (DILACOR XR equiv)	-	1	CALCIUM CHANNEL BLOCKERS
diltiazem ER cap (TIAZAC equiv)	-	1	CALCIUM CHANNEL BLOCKERS
diltiazem ER tab (CARDIZEM LA equiv)	-	1	CALCIUM CHANNEL BLOCKERS

	<b>NC</b> =Not Covered	<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier	Category
diltiazem tab (CARDIZEM equiv)	-	1	CALCIUM CHANNEL BLOCKERS
dimethyl fumarate DR cap (TECFIDERA equiv)	LMSP	1	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
dimethyl fumarate DR starter pack (TECFIDERA STARTER PACK equiv)	LMSP	1	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
diphenhydramine cap (OTC only)	OTC	1	HYPNOTICS / SEDATIVES SLEEP DISORDER AGENTS
diphenhydramine cap (BENADRYL equiv) (OTC only)	OTC	1	ANTIHISTAMINES
diphenhydramine cap 50mg (BENADRYL equiv) (Only 50mg covered)	-	1	ANTIHISTAMINES
DIPHENHYDRAMINE LIQUID	OTC	1	ANTIHISTAMINES
diphenhydramine liquid (BENADRYL equiv)	OTC	1	ANTIHISTAMINES
diphenhydramine tab (BENADRYL equiv)	OTC	1	ANTIHISTAMINES
diphenhydramine tab (NYTOL equiv)	OTC	1	HYPNOTICS / SEDATIVES SLEEP DISORDER AGENTS
DIPHENOXYLATE/ATROPINE LIQUID	-	2	ANTIDIARRHEAL / PROBIOTIC AGENTS
diphenoxylate/atropine tab (LOMOTIL equiv)	-	1	ANTIDIARRHEALS

	<b>NC</b> =Not Covered	<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier Category
DIPHTHERIA/TETANUS TOXOID (PEDIATRIC) INJ	VAC	\$0 TOXOIDS
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
DOCUSATE SYRUP	OTC	1 LAXATIVES
dofetilide cap (TIKOSYN equiv)	-	1 ANTIARRHYTHMICS
dorzolamide ophth soln (TRUSOPT equiv)	-	1 OPHTHALMIC AGENTS
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

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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier Category
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 50mg, 100mg (MONODOX equiv)	-	1 TETRACYCLINES
doxycycline monohydrate tab (ADOXA equiv)	-	1 TETRACYCLINES
doxycycline susp (VIBRAMYCIN equiv)	-	1 TETRACYCLINES
D-PENAMINE TAB	-	2 ASSORTED CLASSES
drospirenone/ethinyl estradiol/levomefolate tab (BEYAZ equiv)	-	\$0 CONTRACEPTIVES
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 PEN INJ (QL= 2 inj/28 days)	LMSP-PA-QL	2 DERMATOLOGICALS
dutasteride cap (AVODART equiv)	-	1 GENITOURINARY AGENTS - MISCELLANEOUS

	<b>NC</b> =Not Covered	<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier Category
econazole cream (SPECTAZOLE equiv)	-	1 DERMATOLOGICALS
EDURANT TAB	-	2 ANTIVIRALS
EFAVIRENZ CAP	-	1 ANTIVIRALS
efavirenz tab (SUSTIVA equiv)	-	1 ANTIVIRALS
efavirenz/emtricitabine/tenofovir df tab (ATRIPLA equiv)	-	1 ANTIVIRALS
efavirenz/lamivudine/tenofovir df (lo) tab (SYMFI (LO) equiv)	-	1 ANTIVIRALS
EGRIFTA INJ	-	EX C ENDOCRINE AND METABOLIC AGENTS - MISC.
ELIGEN B12 TAB	-	EX C DIETARY PRODUCTS / DIETARY MANAGEMENT PRODUCTS
ELIXOPHYLLIN ELIXIR	-	2 ANTI-ASTHMATIC AND BRONCHODILATOR AGENTS
ELLA TAB	-	\$0 CONTRACEPTIVES
ELMIRON CAP	-	2 GENITOURINARY AGENTS - MISCELLANEOUS
EMCYT CAP	-	2 ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
EMGALITY INJ (QL= 1 inj/28 days)	PA-QL	2 MIGRAINE PRODUCTS
EMGALITY INJ 100MG/ML (QL= 3 inj/fill, 6 fills/yea	PA-QL	2 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		
RDX	Restricted to Diagnosis	RS	Restricted to Specialist		
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation		
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 1/1/2024

Drug Name	Special Code	Tier	Category
EMPAVELI INJ (QL= 160ml/28 days; Only available through PantheRx 855-726-8479)	LD-PA-QL	2	HEMATOLOGICAL AGENTS - MISC.
emtricitabine cap (EMTRIVA equiv)	-	1	ANTIVIRALS
emtricitabine/tenofovir disoproxil fumarate tab (TRUVADA equiv)	-	\$0	ANTIVIRALS
EMTRIVA CAP	-	2+p	ANTIVIRALS
EMTRIVA SOLN	-	2	ANTIVIRALS
enalapril maleate for oral solution (Prior Authorization Required for members age 9 or older)	PA	1	ANTIHYPERTENSIVES
enalapril tab (VASOTEC equiv)	-	1	ANTIHYPERTENSIVES
enalapril/hydrochlorothiazide tab (VASERETIC equiv)	-	1	ANTIHYPERTENSIVES
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
ENDARI POWDER PACK (QL= 6 packets/day)	LMSP-PA-QL	2	HEMATOPOIETIC AGENTS
enoxaparin inj (LOVENOX equiv)	-	1	ANTICOAGULANTS

	<b>NC</b> =Not Covered	<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier Category
enpresse tab (TRI-LEVELLEN equiv)	-	\$0 CONTRACEPTIVES
ENSPRYNG INJ (QL= 1 inj/28 days)	LMSP-PA-QL	2 MISCELLANEOUS THERAPEUTIC CLASSES
entacapone tab (COMTAN equiv)	-	2 ANTIPARKINSON AGENTS
epaned (Prior Authorization Required for members age 9 or older)	PA	2+p ANTIHYPERTENSIVES enal ty
EPCLUSA 200-50MG	PA	2 ANTIVIRALS
EPCLUSA 400-100MG	PA	2 ANTIVIRALS
EPIDIOLEX SOLN (Only available through Lumicera 855-847-3553)	LD-PA	2 ANTICONVULSANTS
EPIFOAM AEROSOL	-	2 DERMATOLOGICALS
epinastine ophth soln (ELESTAT equiv)	-	1 OPHTHALMIC AGENTS
epinephrine inj	-	1 VASOPRESSORS
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
EPRONTIA SOLN	PA	2 ANTICONVULSANTS
EQUETRO CAP	-	2 ANTIPSYCHOTICS / ANTIMANIC AGENTS
ERWINAZE INJ	-	2 ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ERY PAD	-	2 DERMATOLOGICALS

	<b>NC</b> =Not Covered	<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024**

<b>Drug Name</b>	<b>Special Code</b>	<b>Tier</b>	<b>Category</b>
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 tab (ERY-TAB equiv)	-	1	MACROLIDES
escitalopram soln (LEXAPRO equiv) (QL= 600 units/30 days)	QL	2	ANTIDEPRESSANTS
escitalopram tab 10mg (LEXAPRO equiv) (QL= 1.5 tabs/day)	QL	1	ANTIDEPRESSANTS
escitalopram tab 20mg (LEXAPRO equiv) (QL= 1 tab/day)	QL	1	ANTIDEPRESSANTS
escitalopram tab 5mg (LEXAPRO equiv) (QL= 3 tabs/day)	QL	1	ANTIDEPRESSANTS
esomeprazole cap (NEXIUM equiv)	OTC	1	ULCER DRUGS
estazolam tab (PROSOM equiv)	-	1	HYPNOTICS / SEDATIVES SLEEP DISORDER AGENTS
esterified estrogens/methyltestosterone tab (ESTRATEST equiv)	-	1	ESTROGENS
estradiol patch (CLIMARA equiv)	-	1	ESTROGENS

	<b>NC</b> =Not Covered	<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier	Category
estradiol patch (VIVELLE-DOT equiv)	-	1	ESTROGENS
estradiol tab (ESTRACE equiv)	-	1	ESTROGENS
estradiol valerate inj (DELESTROGEN equiv) (QL= 5ml/fill)	PA-QL	1	ESTROGENS
estradiol/norethindrone tab (ACTIVEVELLA equiv)	-	1	ESTROGENS
ESTRING (3 copays per Rx)	-	2	VAGINAL PRODUCTS
ESTROSTEP FE TAB	-	\$0	CONTRACEPTIVES
eszopiclone tab (LUNESTA equiv) (QL= 1 tab/day)	QL	1	HYPNOTICS / SEDATIVES SLEEP DISORDER AGENTS
ethacrynic tab (EDECRIN 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
etravirine tab (INTELENCE equiv)	-	1	ANTIVIRALS

	<b>NC</b> =Not Covered	<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier Category
EULEXIN CAP	-	2 ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
everolimus tab (AFINITOR equiv) (QL= 1 tab/day)	LMSP-PA-QL	1 ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
everolimus tab (ZORTRESS equiv)	LMSP-PA-QL	1 MISCELLANEOUS THERAPEUTIC CLASSES
everolimus tab 5mg (AFINITOR equiv) (QL= 1 tab/day)	LMSP-PA-QL	1 ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
everolimus tab for oral susp (AFINITOR DISPERZ equiv) (QL= 1 tab/day)	LMSP-PA-QL	1 ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
EVOTAZ TAB	-	2 ANTIVIRALS
EVRYSDI SOLN (QL= 6.67ml/day; Only available through Accredo 800-803-2523)	LD-PA-QL	2 NEUROMUSCULAR AGENTS
EXALGO TAB	-	2+p ANALGESICS - OPIOID enal ty
EXKIVITY CAP (QL= 4 caps/day; Only available through Biologics 800-850-4306)	LD-PA-QL	2 ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
EXTAVIA INJ	LMSP	2 PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
ezetimibe tab (ZETIA equiv)	-	1 ANTIHYPERLIPIDEMICS
FALESSA KIT	-	\$0 CONTRACEPTIVES

	<b>NC</b> =Not Covered	<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier Category
FALESSA TAB	-	EX C DIETARY PRODUCTS / DIETARY MANAGEMENT PRODUCTS
famciclovir tab (FAMVIR equiv)	-	1 ANTIVIRALS
famotidine susp (PEPCID equiv)	-	1 ULCER DRUGS
famotidine tab (PEPCID equiv)	OTC	1 ULCER DRUGS
FANAPT TAB (QL= 2 tabs/day)	PA-QL	2 ANTIPSYCHOTICS / ANTIMANIC AGENTS
FANAPT TITRATION PACK	PA	2 ANTIPSYCHOTICS / ANTIMANIC AGENTS
FARXIGA TAB (QL= 1 tab/day)	QL	2 ANTIDIABETICS
FASENRA PEN INJ (QL= 1 inj/56 days; Only available through Accredo 800-803-2523 or Walgreens 888-347-3416)	LD-PA-QL	2 ANTIASTHMATIC AND BRONCHODILATOR AGENTS
felbamate susp (FELBATOL equiv)	-	1 ANTICONVULSANTS
felbamate tab (FELBATOL equiv)	-	2 ANTICONVULSANTS
felodipine ER tab (PLENDIL equiv)	-	1 CALCIUM CHANNEL BLOCKERS
FEMALE CONDOMS	OTC	\$0 MEDICAL DEVICES AND SUPPLIES
FEMCON FE CHEW TAB	-	\$0 CONTRACEPTIVES
fenofibric acid DR cap (TRILIPIX equiv)	-	1 ANTIHYPERLIPIDEMICS
fentanyl patch (DURAGESIC equiv)	-	1 ANALGESICS - OPIOID
ferrex 150 forte cap	-	1 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		
RDX	Restricted to Diagnosis	RS	Restricted to Specialist		
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation		
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 1/1/2024

Drug Name	Special Code	Tier	Category
FERRIPROX SOLN (Only available through Ferriprox Total Care 866-758-7071)	LD-PA	2	ANTIDOTES
ferrous sulfate soln (FER-IN-SOL equiv)	OTC	1	HEMATOPOIETIC AGENTS
fesoterodine fumarate ER tab (TOVIAZ equiv)	-	1	URINARY ANTISPASMODICS
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
FILSPARI TAB (QL= 1 tab/day; Only available through Accredo 800-803-2523)	LD-PA-QL	2	GENITOURINARY AGENTS - MISCELLANEOUS
FINACEA FOAM	-	2	DERMATOLOGICALS
finasteride tab (PROSCAR equiv)	-	1	GENITOURINARY AGENTS - MISCELLANEOUS
finasteride tab (PROPECIA equiv)	-	EX C	DERMATOLOGICALS
fingolimod hcl cap 0.5mg (GILENYA equiv)	LMSP	1	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
FINTEPLA SOLN (QL= 12ml/day; Only available through Anovo Specialty Pharmacy 844-288-5007)	LD-PA-QL	2	ANTICONVULSANTS

	<b>NC</b> =Not Covered	<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier	Category
FIRDAPSE TAB (Only available through AnovoRx 844-288-5007)	LD-PA	2	ANTIMYASTHENIC / CHOLINERGIC AGENTS
FIRST OMEPRAZOLE SUSP	-	2	ULCER DRUGS
FIRVANQ SOLN	-	1	ANTI-INFECTIVE AGENTS MISC.
FIRVANQ SOLN 50MG/ML	-	1	ANTI-INFECTIVE AGENTS MISC.
flecainide tab (TAMBOCOR equiv)	-	1	ANTIARRHYTHMICS
FLEQSUVY SUSP (Prior Authorization Required for members age 9 or older)	PA	2	MUSCULOSKELETAL THERAPY AGENTS
FLINTSTONES COMPLETE CHEW	OTC	1	MULTIVITAMINS
FLOLIPID SUSP (Members age 9 or older require Prior Authorization)	PA	2	ANTHYPERLIPIDEMICS
FLONASE SENSIMIST NASAL SPRAY	OTC	2	NASAL AGENTS - SYSTEMIC AND TOPICAL
FLORIVA PLUS DROPS	-	2	MULTIVITAMINS
FLOVENT HFA INHALER	-	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
FLUBLOK QUAD PF INJ (QL= 1 inj/28 days for members 18 years and older)	QL-VAC	\$0	VACCINES
FLUCELVAX QUAD INJ (QL= 1 inj/28 days for members aged 6 months and older)	QL-VAC	\$0	VACCINES

	<b>NC</b> =Not Covered	<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024**

<b>Drug Name</b>	<b>Special Code</b>	<b>Tier Category</b>
FLUCELVAX QUAD INJ (QL= 2 inj/8 months for members 4 years through 8 years; QL= 1 inj/8 months for members 9 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
FLUDARABINE INJ	-	1 ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
FLUDARABINE INJ	-	2+p ANTINEOPLASTICS AND enalADJUNCTIVE THERAPIES ty
fludrocortisone tab (FLORINEF equiv)	-	1 CORTICOSTEROIDS
FLULAVAL QUAD INJ, FLUZONE QUAD INJ (QL= 1 inj/28 days for members 6 months and older)	QL-VAC	\$0 VACCINES
FLUMIST QUADRIVALENT NASAL SUSP (QL= 1 inj/28 days for members 2 years and older)	QL-VAC	\$0 VACCINES
flunisolide nasal soln	-	1 NASAL AGENTS - SYSTEMIC AND TOPICAL
fluocinolone acetonide cream	-	1 DERMATOLOGICALS
fluocinolone acetonide oint	-	1 DERMATOLOGICALS
fluocinolone acetonide soln	-	1 DERMATOLOGICALS
fluocinolone otic oil (DERMOTIC equiv)	-	1 OTIC AGENTS
fluocinonide cream 0.05% (LIDEX equiv)	-	1 DERMATOLOGICALS
fluocinonide cream 0.1% (VANOS CREAM equiv)	-	1 DERMATOLOGICALS

<b>NC</b> =Not Covered	<b>generic</b> =small letters	<b>BRANDS</b> =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	
RDX Restricted to Diagnosis	RS Restricted to Specialist	
SF Limited to two 15 day fills per month fo first 3 months	SMKG Smoking Cessation	
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 1/1/2024**

<b>Drug Name</b>	<b>Special Code</b>	<b>Tier</b>	<b>Category</b>
fluocinonide emollient cream	-	1	DERMATOLOGICALS
fluocinonide gel	-	1	DERMATOLOGICALS
fluocinonide oint	-	1	DERMATOLOGICALS
fluocinonide soln	-	1	DERMATOLOGICALS
FLUORABON SOLN	-	2	MINERALS & ELECTROLYTES
FLUORIDEX SENSITIVITY PASTE	-	1	MOUTH / THROAT / DENTAL AGENTS
fluorometholone ophth soln (FML LIQUIFILM equiv)	-	1	OPHTHALMIC AGENTS
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
fluphenazine tab (PROLIXIN equiv)	-	1	ANTIPSYCHOTICS / ANTIMANIC AGENTS
FLURAZEPAM CAP	-	2	HYPNOTICS / SEDATIVES SLEEP DISORDER AGENTS
FLURBIPROFEN TAB	-	1	ANALGESICS - ANTI-INFLAMMATORY
flurbiprofen tab (ANSAID equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY

	<b>NC</b> =Not Covered	<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month fo first 3 months	SMKG	Smoking Cessation
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 1/1/2024**

<b>Drug Name</b>	<b>Special Code</b>	<b>Tier Category</b>
flutamide cap (EULEXIN equiv)	-	1 ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
FLUTAMIDE CAP	-	2 ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
FLUTICASONE DISKUS INHALER	-	2 ANTIASTHMATIC AND BRONCHODILATOR AGENTS
FLUTICASONE HFA INHALER	-	2 ANTIASTHMATIC AND BRONCHODILATOR AGENTS
FLUTICASONE HFA INHALER 110 MCG/ACT	-	2 ANTIASTHMATIC AND BRONCHODILATOR AGENTS
FLUTICASONE HFA INHALER 220MCG/ACT	-	2 ANTIASTHMATIC AND BRONCHODILATOR AGENTS
FLUTICASONE HFA INHALER 44 MCG/ACT	-	2 ANTIASTHMATIC AND BRONCHODILATOR AGENTS
fluticasone nasal spray (FLONASE equiv)	-	1 NASAL AGENTS - SYSTEMIC AND TOPICAL
fluticasone propionate cream (CUTIVATE equiv)	-	1 DERMATOLOGICALS

	<b>NC</b> =Not Covered	<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024**

<b>Drug Name</b>	<b>Special Code</b>	<b>Tier</b>	<b>Category</b>
FLUTICASONE PROPIONATE DISKUS INHALER 100MCG/ACT	-	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
FLUTICASONE PROPIONATE DISKUS INHALER 250MCG/ACT	-	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
FLUTICASONE PROPIONATE DISKUS INHALER 50MCG/ACT	-	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
fluticasone propionate oint (CUTIVATE equiv)	-	1	DERMATOLOGICALS
fluticasone/salmeterol inhaler, wixela inhaler (ADVAIR equiv)	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
FLUTICASONE-SALMETEROL INHALER 113-14 MCG/ACT	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
FLUTICASONE-SALMETEROL INHALER 232-14 MCG/ACT	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
FLUTICASONE-SALMETEROL INHALER 55-14 MCG/ACT	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
fluvoxamine ER cap (LUVOX CR equiv)	-	1	ANTIDEPRESSANTS
fluvoxamine tab (LUVOX equiv)	-	1	ANTIDEPRESSANTS

	<b>NC</b> =Not Covered	<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier Category
FLUZONE/FLUARIX QUAD INJ (QL= 1 inj/28 days for members aged 6 months 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	-	\$0 HEMATOPOIETIC AGENTS
folic acid tab 400mcg	OTC	\$0 HEMATOPOIETIC AGENTS
folic acid tab 800mcg	OTC	\$0 HEMATOPOIETIC AGENTS
fosamprenavir tab (LEXIVA equiv)	-	1 ANTIVIRALS
fosinopril tab (MONOPRIL equiv)	-	1 ANTIHYPERTENSIVES
fosinopril/hydrochlorothiazide tab (MONOPRIL HCT equiv)	-	1 ANTIHYPERTENSIVES
FRAGMIN INJ	-	2 ANTICOAGULANTS
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) (QL= 9 caps/day)	QL	1 ANTICONVULSANTS
gabapentin cap 100mg (NEURONTIN equiv) (QL= 9 caps/day)	QL	1 ANTICONVULSANTS
gabapentin soln (NEURONTIN equiv) (QL= 72 mls/day)	QL	1 ANTICONVULSANTS

	<b>NC</b> =Not Covered	<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier	Category
gabapentin tab 600mg (NEURONTIN equiv) (QL= 6 tabs/day)	QL	1	ANTICONVULSANTS
gabapentin tab 800mg (NEURONTIN equiv) (QL= 4.5 tabs/day)	QL	1	ANTICONVULSANTS
GALZIN CAP	-	2	MINERALS & ELECTROLYTES
GARDASIL 9 INJ	VAC	\$0	VACCINES
gatifloxacin ophth soln (ZYMAXID equiv)	-	1	OPHTHALMIC AGENTS
GAVRETO CAP (QL= 4 caps/day; Only available through Lumicera 855-847-3553)	LD-PA-QL	2	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
gemfibrozil tab (LOPID equiv)	-	1	ANTIHYPERTENSIVES
GENOTROPIN INJ	LMSP-PA	2	ENDOCRINE AND METABOLIC AGENTS - MISC.
GENTAK OPTH OINT	-	1	OPHTHALMIC AGENTS
gentamicin ophth soln (GARAMYCIN equiv)	-	1	OPHTHALMIC AGENTS
gentamicin sulfate cream	-	1	DERMATOLOGICALS
gentamicin sulfate oint	-	1	DERMATOLOGICALS
gentle ophth oint	OTC	1	OPHTHALMIC AGENTS
GENVOYA TAB	PA	2	ANTIVIRALS
gianvi tab, ocella tab (YASMIN, YAZ equiv)	-	\$0	CONTRACEPTIVES
GILENYA CAP 0.25MG	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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024**

<b>Drug Name</b>	<b>Special Code</b>	<b>Tier</b>	<b>Category</b>
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
GLOPERBA SOLN (Prior Authorization Required for members age 9 or older)	PA	2	GOUT AGENTS
GLUCAGEN HYPOKIT INJ	-	2	ANTIDIABETICS
GLUCAGEN INJ	-	2	DIAGNOSTIC PRODUCTS
glucagon (rdna) for inj kit (GLUCAGON equiv) (QL= 2 inj/fill, 1 fill/30 days)	QL	1	ANTIDIABETICS
GLUCAGON DIAGNOSTIC INJ (QL= 2 inj/fill, 1 fill/30 days)	QL	2	DIAGNOSTIC PRODUCTS
GLUCAGON EMR INJ (QL= 2 inj/fill)	QL	2	ANTIDIABETICS
GLUCAGON INJ KIT (QL= 2 inj/fill)	QL	2	ANTIDIABETICS
GLUCOSE CHEW TAB	OTC	2	ANTIDIABETICS
glucose chew tab (GNP GLUCOSE CHEW equiv)	OTC	2	ANTIDIABETICS
glucose gel	OTC	1	ANTIDIABETICS
GLYBURID MCR TAB	-	1	ANTIDIABETICS
glyburide tab (MICRONASE equiv)	-	1	ANTIDIABETICS

	<b>NC</b> =Not Covered	<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024**

<b>Drug Name</b>	<b>Special Code</b>	<b>Tier</b>	<b>Category</b>
glyburide/metformin tab (GLUCOVANCE equiv)	-	1	ANTIDIABETICS
glycerin supp (GLYCERIN equiv)	OTC	1	LAXATIVES
glycopyrrolate tab (ROBINUL equiv)	-	1	ULCER DRUGS
GLYGEST PAK	-	EX C	DIETARY PRODUCTS / DIETARY MANAGEMENT PRODUCTS
GOLYTELY SOLN	-	1	LAXATIVES
granisetron tab (KYTRIL equiv) (QL= 14 tabs/fill, 1 fill/30 days)	QL	1	ANTIEMETICS
griseofulvin micro tab (GRIFULVIN V equiv)	-	1	ANTIFUNGALS
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 INJ (QL= 2 inj/fill)	QL	2	ANTIDIABETICS
GVOKE INJ KIT (QL= 2 inj/fill)	QL	2	ANTIDIABETICS

	<b>NC</b> =Not Covered	<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier	Category
GVOKE PFS INJ (QL= 2 inj/fill)	QL	2	ANTIDIABETICS
HADLIMA INJ (QL= 2 inj/28 days)	LMSP-PA-QL	2	ANALGESICS - ANTI-INFLAMMATORY
HADLIMA INJ 40MG/0.8ML (QL= 2 inj/28 days)	LMSP-PA-QL	2	ANALGESICS - ANTI-INFLAMMATORY
HADLIMA PUSH INJ (QL= 2 inj/28 days)	LMSP-PA-QL	2	ANALGESICS - ANTI-INFLAMMATORY
HADLIMA PUSH INJ 40MG/0.8ML (QL= 2 inj/28 days)	LMSP-PA-QL	2	ANALGESICS - ANTI-INFLAMMATORY
HAEGARDA INJ (Only available through Accredo 800-803-2523)	LD-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.
heparin flush	-	1	ANTICOAGULANTS
HEXALEN CAP	-	2	ANTINEOPLASTICS
HIZENTRA INJ	MSP-PA	2	PASSIVE IMMUNIZING AGENTS

	<b>NC</b> =Not Covered	<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier	Category
HOMATROPINE OPHTH SOLN	-	2	OPHTHALMIC AGENTS
HUMALOG JR KWIKPEN INJ	-	2	ANTIDIABETICS
HUMALOG KWIKPEN INJ	-	2	ANTIDIABETICS
HUMALOG MIX INJ	-	2	ANTIDIABETICS
HUMALOG MIX KWIKPEN INJ	-	2	ANTIDIABETICS
HUMALOG PEN INJ	-	2	ANTIDIABETICS
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 80MG (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 PEDIATRIC UC STARTER PACK (QL= 1 pack/fill, 1 fill/plan year)	LMSP-PA-QL	2	ANALGESICS - ANTI-INFLAMMATORY
HUMIRA INJ PSORIASIS/UVEITIS STARTER PACI (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

	<b>NC</b> =Not Covered	<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month fo first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier	Category
HUMULIN MIX INJ	OTC	2	ANTIDIABETICS
HUMULIN MIX PEN INJ	OTC	2	ANTIDIABETICS
HUMULIN N INJ	OTC	2	ANTIDIABETICS
HUMULIN N PEN INJ	OTC	2	ANTIDIABETICS
HUMULIN R INJ	OTC	2	ANTIDIABETICS
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
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 lotion 2% (ALA SCALP equiv)	-	1	DERMATOLOGICALS
hydrocortisone oint	OTC	1	DERMATOLOGICALS

	<b>NC</b> =Not Covered	<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier	Category
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 tab (DILAUDID equiv)	-	1	ANALGESICS - OPIOID
hydroquinone cream (LUSTRA equiv)	-	EX C	DERMATOLOGICALS
hydroxychloroquine tab (PLAQUENIL equiv)	-	1	ANTIMALARIALS
hydroxyurea cap (HYDREA equiv)	-	1	ANTINEOPLASTICS
hydroxyzine pamoate cap (VISTARIL equiv)	-	1	ANTIANKXIETY AGENTS
hydroxyzine syrup (ATARAX equiv)	-	1	ANTIANKXIETY AGENTS
hydroxyzine tab (ATARAX equiv)	-	1	ANTIANKXIETY AGENTS
HYFTOR GEL (QL= 10 grams/30 days)	PA-QL	2	DERMATOLOGICALS
hyoscyamine sulfate CR tab (LEVVID equiv)	-	1	ULCER DRUGS
hyoscyamine sulfate elixir (LEVSIN equiv)	-	1	ULCER DRUGS
hyoscyamine sulfate ODT (ANASPAZ equiv)	-	1	ULCER DRUGS
hyoscyamine sulfate SL tab (LEVSIN equiv)	-	1	ULCER DRUGS
hyoscyamine sulfate soln (LEVSIN equiv)	-	1	ULCER DRUGS
hyoscyamine tab (LEVSIN equiv)	-	1	ULCER DRUGS
HYQVIA INJ	MSP-PA	2	PASSIVE IMMUNIZING AGENTS

	<b>NC</b> =Not Covered	<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier	Category
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
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
IMBRUVICA SUSP (QL= 6ml/day; Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-QL	2	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
IMBRUVICA TAB 420MG, 560MG (QL= 1 tab/day; Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-QL	2	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES

	<b>NC</b> =Not Covered	<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month fo first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier	Category
IMCIVREE INJ (QL= 1 inj/day; Only available through PantherRx Pharmacy 855-726-8479)	LD-PA-QL	2	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
imipramine pamoate cap (TOFRANIL PM equiv)	-	1	ANTIDEPRESSANTS
imipramine tab (TOFRANIL equiv)	-	1	ANTIDEPRESSANTS
imiquimod cream (ALDARA equiv)	-	1	DERMATOLOGICALS
IMOVAX INJ	VAC	EX C	VACCINES
INCRELEX INJ (Only available through Accredo 800-803-2523 or Walgreens 888-347-3416)	LD	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 LISPRO INJ	-	1	ANTIDIABETICS
INTELENCE TAB	-	2	ANTIVIRALS
INVEGA INJ	PA	2	ANTIPSYCHOTICS / ANTIMANIC AGENTS
INVIRASE CAP	-	2	ANTIVIRALS
INVIRASE TAB	-	2	ANTIVIRALS

	<b>NC</b> =Not Covered	<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier	Category
iodoquinol/hydrocortisone cream 1% (VYTONE equiv)	-	1	DERMATOLOGICALS
IOPIDINE OPHTH SOLN	-	2	OPHTHALMIC AGENTS
IPOL INJ	VAC	\$0	VACCINES
ipratropium neb soln (ATROVENT equiv)	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
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)	-	\$0	CONTRACEPTIVES
isoniazid syrup (ISONIAZID equiv)	-	1	ANTIMYCOBACTERIAL AGENTS
isoniazid tab	-	1	ANTIMYCOBACTERIAL AGENTS
ISOPTO CARBACHOL OPHTH SOLN	-	2	OPHTHALMIC 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	-	1	ANTIANGINAL AGENTS
isosorbide mononitrate tab (MONOKET equiv)	-	1	ANTIANGINAL AGENTS

	<b>NC</b> =Not Covered	<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier	Category
isoxsuprine tab	-	1	CARDIOVASCULAR AGENTS - MISC.
isradipine cap (DYNACIRC equiv)	-	1	CALCIUM CHANNEL BLOCKERS
ISTALOL OPTH SOLN	-	2	OPHTHALMIC AGENTS
itraconazole cap (SPORANOX equiv)	PA	1	ANTIFUNGALS
ivermectin tab (STROMECTOL equiv)	PA	1	ANTHELMINTICS
JAKAFI TAB	PA	2	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
JANUMET XR TAB	-	2	ANTIDIABETICS
JARDIANCE TAB (QL= 1 tab/day)	QL	2	ANTIDIABETICS
JAYPIRCA TAB (QL= 2 tabs/day)	LMSP-PA-QL	2	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
jinteli tab (FEMHRT equiv)	-	1	ESTROGENS
JOENJA TAB (QL= 2 tabs/day; Only available through PantherRx Pharmacy 855-726-8479)	LD-PA-QL	2	MISCELLANEOUS THERAPEUTIC CLASSES
JYLAMVO SOLN, XATMEP SOLN (Prior Authorization Required for members age 9 or older)	PA	2	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
KALETRA TAB	-	2+p enal ty	ANTIVIRALS
KALYDECO PAK (QL= 2 packets/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	2	RESPIRATORY AGENTS - MISC.

	<b>NC</b> =Not Covered	<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier Category
KALYDECO TAB (QL= 2 tabs/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	2 RESPIRATORY AGENTS - MISC.
KAPVAY TAB	-	2+p ADHD / enalANTI-NARCOLEPSY / ty ANTI-OBESITY / ANOREXIANTS
KATERZIA SUSP (Prior Authorization Required for members age 9 or older)	PA	2 CALCIUM CHANNEL BLOCKERS
kelnor tab (DEMULEN equiv)	-	\$0 CONTRACEPTIVES
KESIMPTA INJ	LMSP	2 PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
ketoconazole cream (NIZORAL CREAM equiv)	-	1 DERMATOLOGICALS
ketoconazole shampoo (NIZORAL SHAMPOO equiv)	-	1 DERMATOLOGICALS
ketoconazole tab (NIZORAL equiv)	-	1 ANTIFUNGALS
KETO-DIASTIX TEST STRIP	OTC	1 DIAGNOSTIC PRODUCTS
ketorolac ophth soln (ACULAR (LS) equiv)	-	1 OPHTHALMIC AGENTS
ketorolac tab (TORADOL equiv) (QL= 20 tabs/5 days)	QL	1 ANALGESICS - ANTI-INFLAMMATORY
KETOSTIX	OTC	1 DIAGNOSTIC PRODUCTS
ketotifen ophth soln (ZADITOR equiv) (OTC covered only)	OTC	1 OPHTHALMIC AGENTS

	<b>NC</b> =Not Covered	<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier	Category
KEVZARA INJ (QL= 2 inj/28 days)	LMSP-PA-QL	2	ANALGESICS - ANTI-INFLAMMATORY
KINERET INJ (QL= 1 inj/day; Only available through Biologics 800-850-4306)	LD-PA-QL	2	ANALGESICS - ANTI-INFLAMMATORY
KINRIX INJ, QUADRACEL DTAP-IPV INJ	VAC	\$0	TOXOIDS
KINRIX PREF SYRINGE, QUADRACEL PREF SYRINGE	VAC	\$0	TOXOIDS
KITABIS PAK NEB SOLN (Only available through Walgreens 888-347-3416)	LD	2	AMINOGLYCOSIDES
KLOXXADO NASAL SPRAY	-	2	ANTIDOTES AND SPECIFIC ANTAGONISTS
KOSELUGO CAP (QL= 4 caps/day; Only available through Onco360 877-662-6633)	LD-PA-QL	2	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
KOSELUGO CAP 10MG (QL= 8 caps/day; Only available through Onco360 877-662-6633)	LD-PA-QL	2	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
K-PHOS TAB	-	2	MINERALS & ELECTROLYTES
K-TAB	-	1	MINERALS & ELECTROLYTES
KYTRIL TAB (QL= 14 tabs/fill, 1 fill/30 days)	QL	2+p enal ty	ANTIEMETICS
labetalol tab (NORMODYNE equiv)	-	1	BETA BLOCKERS

	<b>NC</b> =Not Covered	<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier	Category
lacosamide iv inj (VIMPAT equiv) (QL= 1200 units/30 days)	QL	1	ANTICONVULSANTS
lacosamide oral solution (VIMPAT equiv) (QL= 600ml/30days)	QL	1	ANTICONVULSANTS
lacosamide tab (VIMPAT equiv)	-	1	ANTICONVULSANTS
LACTIC ACID LOTION	-	1	DERMATOLOGICALS
lactulose soln	-	1	LAXATIVES
LAGEVRIO CAP (EUA) (QL= 40 caps/fill)	QL	\$0	ANTIVIRALS
LAGEVRIO CAP 200MG (QL= 40 caps/fill)	QL	2	ANTIVIRALS
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
LANCETS	OTC	1	MEDICAL DEVICES AND SUPPLIES
lansoprazole cap (PREVACID equiv)	OTC	1	ULCER DRUGS

	<b>NC</b> =Not Covered	<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier Category
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
latanoprost ophth soln (XALATAN equiv) (QL= 2.5ml/30 days)	QL	1 OPHTHALMIC AGENTS
LATUDA TAB (QL= 1 tab/day)	QL	2+p ANTIPSYCHOTICS / enalANTIMANIC AGENTS ty
layolis FE tab, wymzya FE tab (FEMCON FE equiv)	-	\$0 CONTRACEPTIVES
LEDIPASVIR/SOFOSBUVIR TAB (QL= 1 tab/day)	LMSP-PA-QL	2 ANTIVIRALS
leflunomide tab (ARAVA equiv)	-	1 ANALGESICS - ANTI-INFLAMMATORY
lenalidomide cap (REVLIMID equiv) (QL= 1 cap/day; Restricted to Oncology or Hematology Specialist; Only available through Walgreens 888-347-3416)	LD-QL-RS	1 MISCELLANEOUS THERAPEUTIC CLASSES
letrozole tab (FEMARA equiv)	-	1 ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
leucovorin tab	-	1 ANTINEOPLASTICS
LEUKERAN TAB	-	2 ANTINEOPLASTICS

	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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier	Category
LEVALBUTEROL INHALER, XOPENEX HFA INHALER (QL= 2 inhalers/fill, 2 fills/30 days; Step Therapy requires trial of Ventolin HFA)	QL-ST	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
levalbuterol neb soln (XOPENEX equiv)	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
LEVEMIR FLEXTOUCH INJ	-	2	ANTIDIABETICS
LEVEMIR INJ	-	2	ANTIDIABETICS
levetiracetam ER tab (KEPPRA XR equiv)	-	1	ANTICONVULSANTS
levetiracetam soln (KEPPRA equiv)	-	1	ANTICONVULSANTS
levetiracetam tab (KEPPRA equiv)	-	1	ANTICONVULSANTS
LEVOBUNOLOL OPTH 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 OPTH SOLN 0.5%	-	1	OPHTHALMIC AGENTS
levofloxacin soln (LEVAQUIN equiv)	-	1	FLUOROQUINOLONES
LEVOFLOXACIN SOLN 25MG/ML	-	1	FLUOROQUINOLONES
levofloxacin tab (LEVAQUIN equiv)	-	1	FLUOROQUINOLONES

	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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier Category
levonorgestrel tab (PLAN B equiv)	OTC	\$0 CONTRACEPTIVES
levonorgestrel-ethinyl estradiol-fe tab (BALCOLTRA equiv)	-	\$0 CONTRACEPTIVES
levothyroxine tab (SYNTHROID equiv)	-	1 THYROID AGENTS
LEXIVA SUSP	-	2 ANTIVIRALS
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 (GLYDO equiv)	-	1 DERMATOLOGICALS
lidocaine gel (XYLOCAINE equiv)	-	1 DERMATOLOGICALS
LIDOCAINE GEL	-	2 DERMATOLOGICALS
lidocaine oint (QL= 107gm/30 days)	QL	1 DERMATOLOGICALS
lidocaine soln (XYLOCAINE equiv)	-	1 DERMATOLOGICALS
lidocaine viscous soln (XYLOCAINE HCL (MOUTH-THROAT) equiv)	-	1 MOUTH / THROAT / DENTAL AGENTS
lidocaine/hydrocortisone cream (ANAMANTLE equiv)	-	1 ANORECTAL AGENTS

	<b>NC</b> =Not Covered	<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier	Category
lidocaine/prilocaine cream (EMLA equiv)	-	1	DERMATOLOGICALS
LINDANE SHAMPOO	-	1	DERMATOLOGICALS
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.
LINZESS CAP (QL= 1 cap/day)	PA-QL	2	GASTROINTESTINAL AGENTS - MISC.
liothyronine tab (CYTOMEL equiv)	-	1	THYROID AGENTS
lisdexamfetamine dimesylate cap (VYVANSE equiv)	-	1	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
lisdexamfetamine dimesylate chew tab (VYVANSE equiv)	-	1	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
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

	<b>NC</b> =Not Covered	<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier Category
lithium carbonate tab	-	1 ANTIPSYCHOTICS / ANTIMANIC AGENTS
LIVMARLI SOLN (QL= 90ml/30 days; Only available through Eversana 866-849-4481)	LD-PA-QL	2 GASTROINTESTINAL AGENTS - MISC.
LIVTENCITY TAB (QL= 4 tabs/day; Only available through Biologics 800-850-4306)	LD-PA-QL	2 ANTIVIRALS
L-METHYLFOLATE TAB	-	EX DIETARY PRODUCTS / C DIETARY MANAGEMENT PRODUCTS
LO LOESTRIN TAB	-	\$0 CONTRACEPTIVES
LOKELMA PAK	PA	2 MISCELLANEOUS THERAPEUTIC CLASSES
LOMAIRA TAB	-	EX ADHD / C ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
lopinavir/ritonavir soln (KALETRA equiv)	-	1 ANTIVIRALS
lopinavir/ritonavir tab (KALETRA equiv)	-	1 ANTIVIRALS
loratadine chew tab (CLARITIN equiv)	OTC	1 ANTIHISTAMINES
loratadine ODT (CLARITIN equiv)	OTC	1 ANTIHISTAMINES
loratadine syrup (CLARITIN equiv) (QL= 10ml/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

	<b>NC</b> =Not Covered	<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier	Category
loratadine/pseudoephedrine 24-hour tab (CLARITIN-D equiv)	OTC	1	COUGH / COLD / ALLERGY
lorazepam conc (ATIVAN equiv)	-	1	ANTIANXIETY AGENTS
lorazepam tab (ATIVAN equiv)	-	1	ANTIANXIETY AGENTS
losartan tab (COZAAR equiv)	-	1	ANTIHYPERTENSIVES
losartan/hydrochlorothiazide tab (HYZAAR equiv)	-	1	ANTIHYPERTENSIVES
LOTEMAX OPTH GEL	-	2	OPHTHALMIC AGENTS
LOTEMAX OPTH OINT	-	2	OPHTHALMIC AGENTS
loteprednol etabonate ophth gel (LOTEMAX equiv)	-	1	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 OPTH SOLN (QL= 2.5ml/30 days)	QL	2	OPHTHALMIC AGENTS
lurasidone hcl tab (LATUDA equiv)	-	1	ANTIPSYCHOTICS / ANTIMANIC AGENTS
LUVIRA CAP	-	EX C	DIETARY PRODUCTS / DIETARY MANAGEMENT PRODUCTS
LYRICA CAP (QL= 3 caps/day)	QL	2+p enal ty	ANTICONVULSANTS

	<b>NC</b> =Not Covered	<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month fo first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier Category
LYRICA CAP 225MG (QL= 2 caps/day)	QL	2+p ANTICONVULSANTS enal ty
LYSODREN TAB (Only available through Walgreen 888-347-3416)	LD	2 ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
LYUMJEV INJ	-	2 ANTIDIABETICS
LYUMJEV KWIKPEN INJ	-	2 ANTIDIABETICS
LYVISPAH GRANULE PACKET (Members age 9 or older require Prior Authorization)	PA	2 MUSCULOSKELETAL THERAPY AGENTS
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
MALE CONDOMS	OTC	\$0 MEDICAL DEVICES AND SUPPLIES
MAPROTILINE TAB	-	1 ANTIDEPRESSANTS
maraviroc tab (SELZENTRY equiv)	-	1 ANTIVIRALS
MARPLAN TAB	-	2 ANTIDEPRESSANTS
MATULANE CAP	-	2 ANTINEOPLASTICS
MAVENCLAD THERAPY PAK (Only available through Walgreens 888-347-3416)	LD	2 PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
MAVYRET PAK (QL= 5 packs/day)	LMSP-PA-QL	2 ANTIVIRALS
MAVYRET TAB (QL= 3 tabs/day)	LMSP-PA-QL	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		
RDX	Restricted to Diagnosis	RS	Restricted to Specialist		
SF	Limited to two 15 day fills per month fo first 3 months	SMKG	Smoking Cessation		
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 1/1/2024**

<b>Drug Name</b>	<b>Special Code</b>	<b>Tier</b>	<b>Category</b>
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	\$0	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
MEKINIST TAB 0.5MG (QL= 3 tabs/day)	MSP-PA-QL	2	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
MEKINIST TAB 2MG (QL= 1 tab/day)	MSP-PA-QL	2	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
meloxicam tab (MOBIC equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
MENACTRA INJ	VAC	\$0	VACCINES

	<b>NC</b> =Not Covered	<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier	Category
mercaptopurine 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
METANX CAP	-	EX C	DIETARY PRODUCTS / DIETARY MANAGEMENT PRODUCTS
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	ANTI-INFECTIVE AGENTS MISC.
methenamine mandelate tab	-	1	ANTI-INFECTIVE AGENTS MISC.

	<b>NC</b> =Not Covered	<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier Category
methimazole tab (TAPAZOLE equiv)	-	1 THYROID AGENTS
methocarbamol tab (ROBAXIN equiv)	-	1 MUSCULOSKELETAL THERAPY AGENTS
METHOTREXATE INJ	-	1 ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
methotrexate tab (TREXALL equiv)	-	1 ANTINEOPLASTICS
methoxsalen cap (OXSORALEN ULTRA equiv)	-	1 DERMATOLOGICALS
METHOXSALEN CAP	-	2 DERMATOLOGICALS
methscopolamine tab (PAMINE equiv)	-	1 ULCER DRUGS
methsuximide cap (CELONTIN equiv)	-	1 ANTICONVULSANTS
METHYLDOPA TAB	-	1 ANTIHYPERTENSIVES
methylodopa 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

	<b>NC</b> =Not Covered	<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier	Category
methylphenidate ER tab (QL= 1 tab/day)	--QL	1	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
METHYLPHENIDATE ER TAB (QL= 1 tab/day)	--QL	2	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
methylprednisolone sod succinate inj (SOLU-MEDROL equiv)	-	1	CORTICOSTEROIDS
METIPRANOLOL OPTH SOLN	-	2	OPHTHALMIC AGENTS
metoclopramide soln (REGLAN equiv)	-	1	GASTROINTESTINAL AGENTS - MISC.

	<b>NC</b> =Not Covered	<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier Category
metoclopramide tab (REGLAN equiv)	-	1 GASTROINTESTINAL AGENTS - MISC.
metolazone tab (ZAROXOLYN equiv)	-	1 DIURETICS
metoprolol ER tab (TOPROL XL equiv)	-	1 BETA BLOCKERS
metoprolol tab (LOPRESSOR equiv)	-	1 BETA BLOCKERS
metoprolol/hydrochlorothiazide tab (LOPRESSOR HCT equiv)	-	1 ANTIHYPERTENSIVES
metronidazole cream (METROCREAM equiv)	-	1 DERMATOLOGICALS
metronidazole gel (METROGEL equiv)	-	1 DERMATOLOGICALS
metronidazole gel 0.75% (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 hcl cap	-	1 ANTIARRHYTHMICS
miconazole 7 supp (MONISTAT equiv)	OTC	1 VAGINAL PRODUCTS
miconazole cream (MICATIN equiv)	OTC	1 DERMATOLOGICALS
miconazole nitrate aerosol (MICATIN equiv)	OTC	1 DERMATOLOGICALS
miconazole nitrate powder (MICATIN equiv)	OTC	1 DERMATOLOGICALS
miconazole vaginal cream (MONISTAT equiv)	OTC	1 VAGINAL PRODUCTS
miconazole vaginal kit (MONISTAT equiv)	OTC	1 VAGINAL PRODUCTS
midazolam inj (MIDAZOLAM equiv) (Restricted to Neurology Specialist)	RS	1 HYPNOTICS / SEDATIVES SLEEP DISORDER AGENTS

	<b>NC</b> =Not Covered	<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier Category
midodrine tab (PROAMATINE equiv)	-	1 VASOPRESSORS
mifepristone tab (MIFIPREX equiv)	-	1 ENDOCRINE AND METABOLIC AGENTS - MISC.
miglustat cap (ZAVESCA equiv) (Only available through Accredo 800-803-2523)	LD-PA	1 HEMATOPOIETIC AGENTS
milk of magnesium	OTC	1 LAXATIVES
MINASTRIN CHEW TAB	-	\$0 CONTRACEPTIVES
minocycline cap (MINOCIN equiv)	-	1 TETRACYCLINES
minocycline tab (DYNACIN equiv)	-	1 TETRACYCLINES
minoxidil tab (LONITEN equiv)	-	1 ANTIHYPERTENSIVES
MIRALAX PACKET	OTC	2+p LAXATIVES enal ty
MIRALAX POWDER	OTC	2+p LAXATIVES enal ty
MIRCETTE TAB	-	\$0 CONTRACEPTIVES
MIRENA IUD	-	\$0 CONTRACEPTIVES
mirtazapine ODT (REMERON equiv)	-	1 ANTIDEPRESSANTS
mirtazapine tab (REMERON equiv)	-	1 ANTIDEPRESSANTS
misoprostol tab (CYTOTEC equiv)	-	1 ULCER DRUGS
M-M-R II INJ	VAC	\$0 VACCINES

	<b>NC</b> =Not Covered	<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier	Category
modafinil tab (PROVIGIL equiv) (QL= 2 tabs/day)	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
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
MOUNJARO INJ (QL= 4 inj/28 days; Diagnosis Restricted – Type 2 Diabetes (E11))	QL-RDX	2	ANTIDIABETICS

	<b>NC</b> =Not Covered	<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month fo first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier	Category
moxifloxacin ophth soln (VIGAMOX OPTH 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/FLOURIDE CHEW 0.25MG	-	1	MULTIVITAMINS
MULTIVITAMIN/FLOURIDE CHEW 1MG	-	1	MULTIVITAMINS
MULTIVITAMIN/FLUORIDE CHEW TAB	-	1	MULTIVITAMINS
multivitamin/minerals tab (STROVITE equiv)	-	1	MULTIVITAMINS
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
MYFEMBREE TAB (QL= 1 tab/day)	PA-QL	2	ESTROGENS
MYLERAN TAB	LMSP	2	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
nabumetone tab (RELAFEN equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
nadolol tab (CORGARD equiv)	-	1	BETA BLOCKERS
naftifine cream (NAFTIN equiv)	-	1	DERMATOLOGICALS

	<b>NC</b> =Not Covered	<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month fo first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier	Category
naloxone hcl nasal spray (NARCAN equiv)	OTC	1	ANTIDOTES AND SPECIFIC ANTAGONISTS
naloxone prefilled inj	-	1	ANTIDOTES AND SPECIFIC ANTAGONISTS
NALOXONE PREFILLED INJ	-	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
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; Step Therapy requires a trial of rizatriptan or sumatriptan)	QL-ST	1	MIGRAINE PRODUCTS
NARCAN NASAL SPRAY	OTC	1	ANTIDOTES AND SPECIFIC ANTAGONISTS
NASACORT OTC NASAL SPRAY (QL= 2 bottles/fill)	OTC-QL	1	NASAL AGENTS - SYSTEMIC AND TOPICAL
NATAZIA TAB	-	\$0	CONTRACEPTIVES
NEBUSAL NEB SOLN	-	2	COUGH / COLD / ALLERGY

	<b>NC</b> =Not Covered	<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier Category
NEFAZODONE TAB	-	1 ANTIDEPRESSANTS
nefazodone tab 50mg, 250mg	-	1 ANTIDEPRESSANTS
neomycin tab	-	1 AMINOGLYCOSIDES
neomycin/bacitracin/polymyxin oint (NEOSPORIN equiv)	OTC	1 DERMATOLOGICALS
NEOMYCIN/POLYMYXIN/GRAMICIDIN OPHTH SOLN	-	1 OPHTHALMIC AGENTS
neomycin/polymixin/hydrocortisone otic soln (CORTISPORIN equiv)	-	1 OTIC AGENTS
neomycin/polymixin/hydrocortisone otic susp (CORTISPORIN equiv)	-	1 OTIC AGENTS
neomycin/polymyxin/dexamethasone ophth oint (MAXITROL equiv)	-	1 OPHTHALMIC AGENTS
neomycin/polymyxin/dexamethasone ophth soln (MAXITROL equiv)	-	1 OPHTHALMIC AGENTS
NEOMYCIN/POLYMYXIN/HYDROCORTISONE OPHTH SOLN	-	1 OPHTHALMIC AGENTS
NEORAL SOLN	-	2 ASSORTED CLASSES
NEPHRON FA TAB	-	2 HEMATOPOIETIC AGENTS
NEURONTIN SOLN (QL= 72 mls/day)	QL	2+p ANTICONVULSANTS enal ty

	<b>NC</b> =Not Covered	<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024**

<b>Drug Name</b>	<b>Special Code</b>	<b>Tier Category</b>
NEURONTIN TAB 600MG (QL= 6 tabs/day)	QL	2+p ANTICONVULSANTS enal ty
NEURONTIN TAB 800MG (QL= 4.5 tabs/day)	QL	2+p ANTICONVULSANTS enal ty
NEVIRAPINE ER TAB	-	1 ANTIVIRALS
nevirapine ER tab (VIRAMUNE XR equiv)	-	1 ANTIVIRALS
NEVIRAPINE SUSP	-	1 ANTIVIRALS
nevirapine tab (VIRAMUNE equiv)	-	1 ANTIVIRALS
NEXIUM 24HR TAB	OTC	2+p ULCER DRUGS / enalANTISPASMODICS / ty ANTICHOLINERGICS
NEXLETOL TAB (QL= 1 tab/day)	PA-QL	2 ANTIHYPERLIPIDEMICS
NEXLIZET TAB (QL= 1 tab/day)	PA-QL	2 ANTIHYPERLIPIDEMICS
NEXPLANON IMPLANT	-	\$0 CONTRACEPTIVES
NEXTSTELLIS TAB	-	\$0 CONTRACEPTIVES
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

	<b>NC =Not Covered</b>	<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month fo first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier Category
NIASPAN ER TAB	-	2+p ANTIHYPERLIPIDEMICS enal ty
NICOTINE KIT (QL= 1 patch/day; Limited to 3 months per calendar year)	OTC-QL	\$0 PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
nicotine patch (NICODERM equiv) (QL= 1 patch/day; Limited to 3 months per calendar year)	OTC-QL-SMKG	\$0 PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
NICOTROL INHALER	-	\$0 PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
NICOTROL NASAL SPRAY	-	\$0 PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
nifedipine cap (PROCARDIA equiv)	-	1 CALCIUM CHANNEL BLOCKERS
nifedipine ER tab (ADALAT CC equiv)	-	1 CALCIUM CHANNEL BLOCKERS
nilutamide tab (NILANDRON equiv)	LMSP	1 ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
nimodipine cap (NIMOTOP equiv)	-	1 CALCIUM CHANNEL BLOCKERS

	<b>NC</b> =Not Covered	<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier	Category
NINLARO CAP (Only available through Diplomat 877-977-9118, Walgreens 888-347-3416, Walmart Specialty 877-453-4566)	LD-PA	2	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
nitazoxanide tab (ALINIA equiv) (QL= 6 tabs/3 days)	PA-QL	1	ANTI-INFECTIVE AGENTS MISC.
NITRO-DUR PATCH 0.3MG/HR, 0.8MG/HR	-	2	ANTIANGINAL AGENTS
nitrofurantoin macrocrystals cap (MACRODANTIN equiv)	-	1	ANTI-INFECTIVE AGENTS MISC.
nitrofurantoin macrocrystals cap 25mg (MACRODANTIN equiv)	-	1	ANTI-INFECTIVE AGENTS MISC.
nitrofurantoin monohydrate cap (MACROBID equiv)	-	1	ANTI-INFECTIVE AGENTS MISC.
nitrofurantoin susp (FURADANTIN equiv)	PA	1	ANTI-INFECTIVE AGENTS MISC.
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
NIVESTYM INJ	LMSP	2	HEMATOPOIETIC AGENTS
NIZATIDINE CAP	-	2	ULCER DRUGS / ANTISPASMODICS / ANTICHOLINERGICS
nizatidine cap (AXID equiv)	-	2	ULCER DRUGS
NIZORAL A-D SHAMPOO	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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024**

<b>Drug Name</b>	<b>Special Code</b>	<b>Tier</b>	<b>Category</b>
nizoral a-d shampoo (NIZORAL equiv)	OTC	1	DERMATOLOGICALS
norethindrone ace-ethinyl estradiol-fe cap (TAYTULLA equiv)	-	\$0	CONTRACEPTIVES
norethindrone acetate/ethinyl estradiol FE chew tab (MINASTRIN equiv)	-	\$0	CONTRACEPTIVES
norethindrone acetate/ethinyl estradiol tab (LOESTRIN equiv)	-	\$0	CONTRACEPTIVES
norethindrone tab (NORA-QD equiv)	-	\$0	CONTRACEPTIVES
norethindrone tab (AYGESTIN equiv)	-	1	PROGESTINS
norethindrone/ethinyl estradiol FE tab (LOESTRIN FE equiv)	-	\$0	CONTRACEPTIVES
NORLIQVA ORAL SOLN 1MG/ML (Members age 9 or older require Prior Authorization)	PA	2	CALCIUM CHANNEL BLOCKERS
NORPACE CR CAP	-	2	ANTIARRHYTHMICS
NOR-QD TAB	-	\$0	CONTRACEPTIVES
nortrel 7/7/7 tab, pirmella 7/7/7 tab (TRI-NORINYL equiv)	-	\$0	CONTRACEPTIVES
nortrel tab (OVCON 35 equiv)	-	\$0	CONTRACEPTIVES
nortriptyline cap (PAMELOR equiv)	-	1	ANTIDEPRESSANTS
nortriptyline oral soln (NORTRIPTYLINE equiv)	-	1	ANTIDEPRESSANTS
NORVIR CAP	-	2	ANTIVIRALS
NORVIR POWDER PACK	-	2	ANTIVIRALS
NORVIR SOLN	-	2	ANTIVIRALS

	<b>NC =Not Covered</b>	<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024**

<b>Drug Name</b>	<b>Special Code</b>	<b>Tier</b>	<b>Category</b>
NOVOFINE PEN NEEDLE	OTC	1	MEDICAL DEVICES AND SUPPLIES
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	-	\$0	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/triamcinolone cream	-	1	DERMATOLOGICALS
nystatin/triamcinolone oint	-	1	DERMATOLOGICALS
NYVEPRIA INJ	LMSP	2	HEMATOPOIETIC AGENTS

	<b>NC =Not Covered</b>	<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier	Category
octreotide inj (SANDOSTATIN equiv)	LMSP	1	ENDOCRINE AND METABOLIC AGENTS - MISC.
OCTREOTIDE INJ 100MCG	LMSP	1	ENDOCRINE AND METABOLIC AGENTS - MISC.
ofloxacin ophth soln (OCUFLOX equiv)	-	1	OPHTHALMIC AGENTS
ofloxacin otic soln (FLOXIN equiv)	-	1	OTIC AGENTS
ofloxacin tab (FLOXIN equiv)	-	1	FLUOROQUINOLONES
olanzapine tab (ZYPREXA equiv)	-	1	ANTIPSYCHOTICS / ANTIMANIC AGENTS
olanzapine/fluoxetine cap (SYMBYAX equiv)	-	1	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
OLLIZAC POWDER	-	EX C	DIETARY PRODUCTS / DIETARY MANAGEMENT PRODUCTS
olmesartan tab (BENICAR equiv)	-	1	ANTIHYPERTENSIVES
olmesartan/hydrochlorothiazide tab (BENICAR HCT equiv)	-	1	ANTIHYPERTENSIVES
olopatadine ophth soln 0.1% (PATANOL equiv)	OTC	1	OPHTHALMIC AGENTS
olopatadine ophth soln 0.2% (PATADAY equiv) (QL= 2.5ml/30 days)	OTC-QL	1	OPHTHALMIC AGENTS

	<b>NC</b> =Not Covered	<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier Category
OLUMIANT TAB (QL= 1 tab/day)	LMSP-PA-QL	2 ANALGESICS - ANTI-INFLAMMATORY
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
omeprazole tab	OTC	1 ULCER DRUGS / ANTISPASMODICS / ANTICHOLINERGICS
ondansetron ODT (ZOFTRAN equiv)	-	1 ANTIEMETICS
ondansetron soln (ZOFTRAN equiv)	-	1 ANTIEMETICS
ONDANSETRON TAB	-	1 ANTIEMETICS
ondansetron tab (ZOFTRAN equiv)	-	1 ANTIEMETICS
ONETOUCH METER	OTC	\$0 MEDICAL DEVICES AND SUPPLIES
ONETOUCH TEST STRIP	OTC	2 DIAGNOSTIC PRODUCTS
ONETOUCH VERIO FLEX METER	OTC	\$0 MEDICAL DEVICES AND SUPPLIES
ONETOUCH VERIO IQ METER	OTC	\$0 MEDICAL DEVICES AND SUPPLIES
ONETOUCH VERIO METER	OTC	\$0 MEDICAL DEVICES AND SUPPLIES

	<b>NC</b> =Not Covered	<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month fo first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier Category
ONETOUCH VERIO REFLECT METER	OTC	\$0 MEDICAL DEVICES AND SUPPLIES
ONETOUCH VERIO TEST STRIP	OTC	2 DIAGNOSTIC PRODUCTS
opium tincture	-	1 ANTIDIARRHEALS
OPSUMIT TAB (QL= 1 tab/day; Only available through Accredo 800-803-2523)	LD-PA-QL	2 CARDIOVASCULAR AGENTS - MISC.
OPZELURA CREAM (QL= 12 tubes/year)	PA-QL	2 DERMATOLOGICALS
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 Walgreens 888-347-3416)	LD-PA-QL	2 RESPIRATORY AGENTS - MISC.
ORKAMBI TAB (QL= 4 tabs/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	2 RESPIRATORY AGENTS - MISC.
orphenadrine citrate ER tab (NORFLEX equiv)	-	1 MUSCULOSKELETAL THERAPY AGENTS

	<b>NC</b> =Not Covered	<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier Category
ORTHO TRI-CYCLEN (LO) TAB	-	\$0 CONTRACEPTIVES
ORTHO-CYCLEN TAB	-	\$0 CONTRACEPTIVES
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
OVCON 35 TAB	-	\$0 CONTRACEPTIVES
OVIDREL INJ	INF	EX C ENDOCRINE AND METABOLIC AGENTS - MISC.
oxaprozin tab (DAYPRO equiv)	-	1 ANALGESICS - ANTI-INFLAMMATORY
OXBRYTA TAB (QL= 3 tabs/day; Only available through Accredo 800-803-2523)	LD-PA-QL	2 HEMATOPOIETIC AGENTS
OXBRYTA TAB FOR ORAL SUSP (QL= 5 tabs/day Only available through Accredo 800-803-2523)	LD-PA-QL	2 HEMATOPOIETIC AGENTS
oxcarbazepine susp (TRILEPTAL equiv)	-	1 ANTICONVULSANTS
oxcarbazepine tab (TRILEPTAL equiv)	-	1 ANTICONVULSANTS

	<b>NC</b> =Not Covered	<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier	Category
OXERVATE OPHTH SOLN (QL= 8 kits/affected eye/lifetime; Only available through Accredo 800-803-2523)	LD-PA-QL	2	OPHTHALMIC AGENTS
oxybutynin ER tab (DITROPAN XL equiv)	-	1	URINARY ANTISPASMODICS
oxybutynin syrup	-	1	URINARY ANTISPASMODICS
oxybutynin tab (DITROPAN equiv)	-	1	URINARY ANTISPASMODICS
oxycodone cap (OXYIR equiv)	-	1	ANALGESICS - OPIOID
oxycodone conc (ROXICODONE equiv)	-	1	ANALGESICS - OPIOID
OXYCODONE ER TAB (QL= 120 tabs/30 days)	QL	2	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/ibuprofen tab (COMBUNOX equiv)	-	1	ANALGESICS - OPIOID
OXYCONTIN CR TAB (QL= 60 tabs/30 days)	QL	2	ANALGESICS - OPIOID
OXYCONTIN CR TAB (QL= 120 tabs/30 days)	QL	2+p	ANALGESICS - OPIOID
		en	
		ty	

	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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier Category
OZEMPIC INJ (QL= 1 pack/28 days; Diagnosis Restricted – Type 2 Diabetes (E11))	QL-RDX	2 ANTIDIABETICS
OZOBAX SOLN, BACLOFEN SOLN	-	2+p MUSCULOSKELETAL enal THERAPY AGENTS ty
PALFORZIA POWDER PACK (Only available through Walgreens 888-347-3416)	LD-PA	2 ALLERGENIC EXTRACTS / BIOLOGICALS MISC
PALFORZIA SPRINKLE CAP (Only available through Walgreens 888-347-3416)	LD-PA	2 ALLERGENIC EXTRACTS / BIOLOGICALS MISC
paliperidone ER tab (INVEGA equiv)	-	1 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 (HUMATIN equiv)	-	1 AMINOGLYCOSIDES
paroxetine ER tab (PAXIL CR equiv)	-	1 ANTIDEPRESSANTS
paroxetine tab (PAXIL equiv)	-	1 ANTIDEPRESSANTS
PAXLOVID TAB 150-100MG (QL= 20 tabs/fill)	QL	2 ANTIVIRALS
PAXLOVID TAB 300-100MG (QL= 30 tabs/fill)	QL	2 ANTIVIRALS
PEAK FLOW METER	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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month fo first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier	Category
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 (VITALETTS equiv)	OTC	1	MULTIVITAMINS
PEDVAXHIB INJ	VAC	\$0	VACCINES
peg 3350/electrolytes soln (GOLYTELY/COLYTE equiv)	-	1	LAXATIVES
peg 3350/electrolytes soln (NULYTELY 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 tab (VEETIDS equiv)	-	1	PENICILLINS
PENTACEL INJ	VAC	\$0	TOXOIDS
pentamidine neb soln (NEBUPENT equiv)	-	1	ANTI-INFECTIVE AGENTS - MISC.
PENTASA CR CAP 250MG	-	2	GASTROINTESTINAL AGENTS - MISC.
pentazocine/acetaminophen tab (TALACEN equiv)	-	1	ANALGESICS - OPIOID
pentoxifylline ER tab (TRENTAL equiv)	-	1	HEMATOLOGICAL AGENTS - MISC.
PERINDOPRIL TAB	-	1	ANTIHYPERTENSIVES
perindopril tab (ACEON equiv)	-	1	ANTIHYPERTENSIVES

	<b>NC</b> =Not Covered	<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier	Category
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.
PHEBURANE ORAL PELLETS (Only available through Accredo 800-803-2523; Step Therapy requires trial of sodium phenylbutyrate)	LD-ST	2	ENDOCRINE AND METABOLIC AGENTS - MISC.
phenazopyridine tab (PYRIDIUM equiv)	-	1	GENITOURINARY AGENTS - MISCELLANEOUS
phenazopyridine tab 95mg (AZO equiv)	OTC	1	GENITOURINARY AGENTS - MISCELLANEOUS
phenazopyridine tab 97.5mg (AZO equiv)	OTC	1	GENITOURINARY AGENTS - MISCELLANEOUS
phenazopyridine tab 99.5mg (AZO equiv)	OTC	1	GENITOURINARY AGENTS - MISCELLANEOUS
PHENDIMETRAZINE ER TAB	-	EX C	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS

	<b>NC</b> =Not Covered	<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024**

<b>Drug Name</b>	<b>Special Code</b>	<b>Tier Category</b>
phendimetrazine tab (BONTRIL PDM equiv)	-	EX C ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
PHENELZINE SULFATE TAB	-	1 ANTIDEPRESSANTS
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
phenytoin susp (DILANTIN equiv)	-	1 ANTICONVULSANTS
PHEXXI GEL	-	\$0 VAGINAL AND RELATED PRODUCTS
phospha 250 neutral tab (K-PHOS NEUTRAL equiv)	-	1 MINERALS & ELECTROLYTES
phytonadione tab (MEPHYTON equiv)	-	1 VITAMINS
PIFELTRO TAB	-	2 ANTIVIRALS
pilocarpine ophth soln (ISOPTO CARPINE equiv)	-	1 OPHTHALMIC AGENTS

	<b>NC =Not Covered</b>	<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier Category
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
PLAN B TAB	OTC	\$0 CONTRACEPTIVES
PLENITY CAP	-	EX C ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
PNEUMOVAX INJ (QL= 1 inj/lifetime for members 2 years and older)	QL-VAC	\$0 VACCINES
PODIAPN CAP	-	EX C DIETARY PRODUCTS / DIETARY MANAGEMENT PRODUCTS
PODOCON SOLN	-	2 DERMATOLOGICALS
PODOFILOX SOLN	-	1 DERMATOLOGICALS

	<b>NC</b> =Not Covered	<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024**

<b>Drug Name</b>	<b>Special Code</b>	<b>Tier</b>	<b>Category</b>
podofilox soln (CONDYLOX equiv)	-	1	DERMATOLOGICALS
polyethylene glycol 3350 powder (MIRALAX equiv)	OTC	1	LAXATIVES
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
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

	<b>NC</b> =Not Covered	<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month fo first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier	Category
POTASSIUM CHLORIDE TAB ER	-	1	MINERALS & ELECTROLYTES
potassium citrate CR tab (UROKIT-K TAB equiv)	-	1	GENITOURINARY AGENTS - MISCELLANEOUS
potassium citrate/citric acid powder pack (POLYCITRA equiv)	-	1	GENITOURINARY AGENTS - MISCELLANEOUS
potassium citrate/citric acid soln (POLYCITRA-K equiv)	-	1	GENITOURINARY AGENTS - MISCELLANEOUS
potassium iodide oral soln (SSKI equiv)	-	1	COUGH / COLD / ALLERGY
potassium phosphate monobasic tab (K-PHOS equiv)	-	1	MINERALS & ELECTROLYTES
PRADAXA CAP 110MG (Covered for members age 8 years or older)	-	2	ANTICOAGULANTS
pramipexole ER tab (MIRAPEX ER equiv)	-	1	ANTIPARKINSON AGENTS
pramipexole tab (MIRAPEX equiv)	-	1	ANTIPARKINSON AGENTS
PRAMOSONE E CREAM	-	2	DERMATOLOGICALS
pramoxine/hydrocortisone cream (ANALPRAM HC equiv)	-	1	ANORECTAL AGENTS
PRASCION RA CREAM	-	2	DERMATOLOGICALS
pravastatin tab (PRAVACHOL equiv)	-	1	ANTIHYPERTENSIVES
prazosin cap (MINIPRESS equiv)	-	1	ANTIHYPERTENSIVES
PRECISION XTRA KETONE TEST STRIP	OTC	2	DIAGNOSTIC PRODUCTS
PRED MILD OPHTH SOLN	-	2	OPHTHALMIC AGENTS
PRED-G OPHTH SOLN	-	2	OPHTHALMIC AGENTS

	<b>NC</b> =Not Covered	<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier	Category
PREDNICARBATE CREAM	-	2	DERMATOLOGICALS
PREDNICARBATE OIN	-	2	DERMATOLOGICALS
prednisolone ODT (ORAPRED equiv)	-	1	CORTICOSTEROIDS
PREDNISOLONE ODT TAB	-	2	CORTICOSTEROIDS
PREDNISOLONE OPHTH SUSP	-	1	OPHTHALMIC AGENTS
PREDNISOLONE SODIUM PHOSPHATE OPHTH SOLN	-	1	OPHTHALMIC AGENTS
prednisolone soln	-	1	CORTICOSTEROIDS
prednisolone soln (PEDIAPRED equiv)	-	1	CORTICOSTEROIDS
PREDNISON SOLN	-	1	CORTICOSTEROIDS
prednisone tab (DELTASONE equiv)	-	1	CORTICOSTEROIDS
pregabalin cap (LYRICA equiv)	-	1	ANTICONVULSANTS
pregabalin soln (LYRICA equiv)	-	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 CAP	-	2	ULCER DRUGS / ANTISPASMODICS / ANTICHOLINERGICS

	<b>NC</b> =Not Covered	<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier Category
PREVACID OTC CAP (QL= 2 caps/day)	OTC-QL	2 ULCER DRUGS
PREVIDENT PASTE	-	2 MOUTH / THROAT / DENTAL AGENTS
PREVNAR 13 INJ (QL= 4 inj/year for members 6 weeks old through 5 years; QL= 1 inj/lifetime for members 6 years and older)	QL-VAC	\$0 VACCINES
PREVNAR 20 INJ	VAC	\$0 VACCINES
PREZCOBIX TAB	-	2 ANTIVIRALS
PREZISTA SUSP	-	2 ANTIVIRALS
PREZISTA TAB	-	2 ANTIVIRALS
PREZISTA TAB	-	2+p ANTIVIRALS enal ty
PRIFTIN TAB	-	2 ANTIMYCOBACTERIAL AGENTS
PRIOSEC 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

	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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024**

<b>Drug Name</b>	<b>Special Code</b>	<b>Tier</b>	<b>Category</b>
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
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 oral soln 20mg/5ml (PROPRANOLOL equiv)	-	1	BETA BLOCKERS
PROPRANOLOL SOLN	-	1	BETA BLOCKERS

	<b>NC</b> =Not Covered	<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024**

<b>Drug Name</b>	<b>Special Code</b>	<b>Tier</b>	<b>Category</b>
propranolol tab (INDERAL equiv)	-	1	BETA BLOCKERS
PROPRANOLOL/HYDROCHLOROTHIAZIDE TAB	-	1	ANTIHYPERTENSIVES
propylthiouracil tab	-	1	THYROID AGENTS
PROQUAD INJ	VAC	\$0	VACCINES
protriptyline tab (VIVACTIL equiv)	-	1	ANTIDEPRESSANTS
pseudoephedrine 12hr tab (SUDAFED equiv)	OTC	1	NASAL AGENTS - SYSTEMIC AND TOPICAL
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.
PURIXAN SUSP (Covered for members age 9 years and older; and patients that are unable to swallow tablets)	PA	2	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
pyrazinamide tab	-	1	ANTIMYCOBACTERIAL AGENTS
pyridostigmine CR tab (MESTINON equiv)	-	1	ANTIMYASTHENIC / CHOLINERGIC AGENTS
pyridostigmine tab (MESTINON equiv)	-	1	ANTIMYASTHENIC / CHOLINERGIC AGENTS
PYRUKYND TAB (QL= 2 tabs/day; Only available through Biologics 800-850-4306)	LD-PA-QL	2	HEMATOLOGICAL AGENTS - MISC.

	<b>NC</b> =Not Covered	<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier	Category
PYRUKYND TAPER PACK (QL= 1 tab/day; Only available through Biologics 800-850-4306)	LD-PA-QL	2	HEMATOLOGICAL AGENTS - MISC.
QBRELIS SOLN (Prior Authorization Required for members age 9 or older)	PA	2	ANTIHYPERTENSIVES
QELBREE ER CAP (QL= 2 caps/day)	PA-QL	2	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
quetiapine tab (SEROQUEL equiv)	-	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/HCTZ TAB	-	1	ANTIHYPERTENSIVES
quinapril/hydrochlorothiazide tab (ACCURETIC equiv)	-	1	ANTIHYPERTENSIVES
quinidine gluconate CR tab	-	1	ANTIARRHYTHMICS
quinidine sulfate tab	-	1	ANTIARRHYTHMICS
RABAVERT INJ	VAC	EX C	VACCINES
rabeprazole EC tab (ACIPHEX equiv)	-	1	ULCER DRUGS
raloxifene tab (EVISTA 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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024**

<b>Drug Name</b>	<b>Special Code</b>	<b>Tier</b>	<b>Category</b>
ramipril cap (ALTACE equiv)	-	1	ANTIHYPERTENSIVES
RAVICTI LIQUID (Step Therapy requires trial of sodium phenylbutyrate and Pheburane Oral Pellets)	ST	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	-	2	HEMATOPOIETIC AGENTS
RETEVMO CAP (QL= 4 caps/day)	LMSP-PA-QL-SF	2	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
RETIN-A CREAM	-	2+p enal ty	DERMATOLOGICALS

	<b>NC =Not Covered</b>	<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier	Category
REVLIMID CAP (QL= 1 cap/day; Only available through Walgreens 888-347-3416; Restricted to Oncology or Hematology Specialist)	LD-QL-RS	2	MISCELLANEOUS THERAPEUTIC CLASSES
REYATAZ POWDER PACK	-	2	ANTIVIRALS
REZUROCK TAB (QL= 1 tab/day; Only available through Lumicera 855-847-3553)	LD-PA-QL	2	MISCELLANEOUS THERAPEUTIC CLASSES
RHOFADE CREAM	-	EX C	DERMATOLOGICALS
RIBAVIRIN CAP	LMSP	1	ANTIVIRALS
ribavirin cap (REBETOL equiv)	LMSP	1	ANTIVIRALS
RIBAVIRIN TAB	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
RINVOQ ER TAB (QL= 1 tab/day)	LMSP-PA-QL	2	ANALGESICS - ANTI-INFLAMMATORY
RISPERDAL INJ	PA	2	ANTIPSYCHOTICS / ANTIMANIC AGENTS

	<b>NC</b> =Not Covered	<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier	Category
risperidone microspheres inj (RISPERDAL equiv)	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
risperidone tab (RISPERDAL equiv)	-	1	ANTIPSYCHOTICS / ANTIMANIC AGENTS
ritonavir tab (NORVIR equiv)	-	1	ANTIVIRALS
rivastigmine cap (EXELON equiv)	-	1	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
rizatriptan ODT (MAXALT equiv) (QL= 12 tabs/30 days)	QL	1	MIGRAINE PRODUCTS
rizatriptan tab (MAXALT equiv) (QL= 12 tabs/30 days)	QL	1	MIGRAINE PRODUCTS
ropinirole ER tab (REQUIP XL equiv)	-	1	ANTIPARKINSON AGENTS
ropinirole tab (REQUIP equiv)	-	1	ANTIPARKINSON AGENTS
rosuvastatin tab (CRESTOR equiv)	-	1	ANTIHYPERTENSIVES
ROTARIX SUSP	VAC	\$0	VACCINES
ROTATEQ INJ	VAC	\$0	VACCINES

	<b>NC</b> =Not Covered	<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024**

<b>Drug Name</b>	<b>Special Code</b>	<b>Tier</b>	<b>Category</b>
ROZLYTREK CAP (QL= 3 caps/day)	LMSP-PA-QL	2	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
RUCONEST INJ (Only available through Accredo 800-803-2523)	LD-PA	2	HEMATOLOGICAL AGENTS - MISC.
rufinamide susp (BANZEL equiv)	PA	1	ANTICONVULSANTS
rufinamide tab (BANZEL equiv) (QL= 8 tabs/day)	PA-QL	1	ANTICONVULSANTS
RYBELSUS TAB (QL=1 tab/day; Diagnosis Restricted – Type 2 Diabetes (E11))	QL-RDX	2	ANTIDIABETICS
SAFYRAL TAB	-	\$0	CONTRACEPTIVES
salicylic acid liquid 17%	OTC	1	DERMATOLOGICALS
salicylic acid pads 40%	OTC	1	DERMATOLOGICALS
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
SANDIMMUNE CAP	-	2	ASSORTED CLASSES
SANDIMMUNE SOLN 100MG/ML	-	2	ASSORTED CLASSES
SAVELLA PAK	-	2	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
SAVELLA TAB	-	2	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.

	<b>NC</b> =Not Covered	<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier Category
scopolamine patch (TRANSDERM-SCOP equiv) (Covered for members age 18 or older)	-	1 ANTIEMETICS
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	OTC	1 DERMATOLOGICALS
selenium sulfide lotion 2.5% (SELSUN equiv)	-	1 DERMATOLOGICALS
selenium sulfide shampoo (SELSEB equiv)	-	1 DERMATOLOGICALS
SELZENTRY SOLN	-	2 ANTIVIRALS
SELZENTRY TAB	-	2 ANTIVIRALS
SELZENTRY TAB	-	2+p ANTIVIRALS enal ty
SEMGLEE INJ, INSULIN GLARGINE-YFGN INJ	-	2 ANTIDIABETICS
SEMGLEE PEN, INSULIN GLARGINE-YFGN PEN	-	2 ANTIDIABETICS
senna cap (SENOKOT equiv)	OTC	1 LAXATIVES
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

	<b>NC</b> =Not Covered	<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month fo first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier	Category
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.
SHINGRIX INJ (Covered for members age 19 year: or older)	VAC	\$0	VACCINES
sildenafil susp (REVATIO equiv) (Members age 9 or older require Prior Authorization)	PA	2	CARDIOVASCULAR 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
SIMPONI AUTO-INJECTOR 100MG	PA	2	ANALGESICS - ANTI-INFLAMMATORY
SIMPONI INJ 100MG	PA	2	ANALGESICS - ANTI-INFLAMMATORY
simvastatin tab (ZOCOR equiv) (80mg is Not Covered)	-	1	ANTHYPERLIPIDEMICS
sirolimus soln (RAPAMUNE equiv)	-	1	MISCELLANEOUS THERAPEUTIC CLASSES
sirolimus tab (RAPAMUNE equiv)	-	1	ASSORTED CLASSES

	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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024**

<b>Drug Name</b>	<b>Special Code</b>	<b>Tier</b>	<b>Category</b>
SIRTURO TAB (Restricted to Infectious Disease or Pulmonary Specialist)	RS	2	ANTIMYCOBACTERIAL AGENTS
SKYCLARYS CAP (QL= 3 caps/day; Only available through Biologics 800-850-4306)	LD-PA-QL	2	NEUROMUSCULAR AGENTS
SKYRIZI INJ 150MG/ML (QL= 1 inj/84 days)	LMSP-PA-QL	2	DERMATOLOGICALS
SKYRIZI INJ 180 MG/1.2ML	LMSP-PA-QL	2	GASTROINTESTINAL AGENTS - MISC.
SKYRIZI INJ 360MG/2.4ML	LMSP-PA-QL	2	GASTROINTESTINAL AGENTS - MISC.
SKYRIZI INJ 75MG/0.83ML (QL= 2 inj/84 days)	LMSP-PA-QL	2	DERMATOLOGICALS
SKYTROFA INJ	LMSP-PA	2	ENDOCRINE AND METABOLIC AGENTS - MISC.
SLYND TAB	-	\$0	CONTRACEPTIVES
smz/tmp (DS) tab (BACTRIM DS equiv)	-	1	ANTI-INFECTIVE AGENTS MISC.
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)	-	\$0	MINERALS & ELECTROLYTES

	<b>NC</b> =Not Covered	<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024**

<b>Drug Name</b>	<b>Special Code</b>	<b>Tier</b>	<b>Category</b>
sodium fluoride cream (PREVIDENT 5000 PLUS equiv)	-	1	MOUTH / THROAT / DENTAL AGENTS
sodium fluoride gel (PREVIDENT equiv)	-	1	MOUTH / THROAT / DENTAL AGENTS
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)	-	\$0	MINERALS & ELECTROLYTES
SODIUM FLUORIDE TAB	-	\$0	MINERALS & ELECTROLYTES
sodium fluoride/potassium nitrate paste (PREVIDENT equiv)	-	1	MOUTH / THROAT / DENTAL AGENTS
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 lotion (KLARON equiv)	-	1	DERMATOLOGICALS
sodium sulfacetamide wash (OVACE WASH equiv)	-	1	DERMATOLOGICALS

	<b>NC =Not Covered</b>	<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier	Category
sodium sulfacetamide/sulfur cleanser 10-5% (SUMAXIN equiv)	-	1	DERMATOLOGICALS
sodium sulfacetamide/sulfur cleanser 9-4.5% (SUMADAN WASH equiv)	-	1	DERMATOLOGICALS
sodium sulfacetamide/sulfur emulsion (ROSULA equiv)	-	1	DERMATOLOGICALS
sodium sulfacetamide/sulfur foam (CLARIFOAM EF equiv)	-	1	DERMATOLOGICALS
sodium sulfacetamide/sulfur gel (ROSULA equiv)	-	1	DERMATOLOGICALS
SOFOSBUVIR/VELPATASVIR TAB 400-100MG (QL= 1 tab/day)	PA-QL	1	ANTIVIRALS
SOGROYA INJ	LMSP-PA	2	ENDOCRINE AND METABOLIC AGENTS - MISC.
solifenacin tab (VESICARE equiv)	-	1	URINARY ANTISPASMODICS
SOLU-CORTEF INJ (QL= 1 vial/fill)	QL	2	CORTICOSTEROIDS
SOLU-CORTEF INJ 100MG (QL= 2 vials/fill)	QL	2	CORTICOSTEROIDS
SOLU-MEDROL INJ 2GM	-	2	CORTICOSTEROIDS
SOMAVERT INJ (Only available through Accredo 800-803-2523 or Walgreens 888-347-3416)	LD-PA	2	ENDOCRINE AND METABOLIC AGENTS - MISC.
sotalol AF tab (BETAPACE AF equiv)	-	1	BETA BLOCKERS
sotalol tab (BETAPACE equiv)	-	1	BETA BLOCKERS

	<b>NC</b> =Not Covered	<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier	Category
SOTYLIZE SOLN 5MG/ML (Prior Authorization Required for members age 9 or older)	PA	2	BETA BLOCKERS
SPIKEVAX INJ (QL= 1 dose/24 days)	QL-VAC	\$0	VACCINES
SPIKEVAX INJ 50MCG/0.5ML (QL= 1 dose/24 days)	QL-VAC	\$0	VACCINES
SPIRIVA RESPIMAT INHALER 1.25MCG/ACT (QL= 1 inhaler/30 days; Step Therapy requires trial of ADVAIR, BREO, DULERA, or FLUTICASONE/SALMETEROL)	QL-ST	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
spironolactone susp (CAROSPIR equiv) (Prior Authorization required for members age 9 or older)	PA	2	DIURETICS
spironolactone tab (ALDACTONE equiv)	-	1	DIURETICS
spironolactone/hydrochlorothiazide tab (ALDACTAZIDE equiv)	-	1	DIURETICS
sprintec 28 tab (ORTHO-CYCLEN equiv)	-	\$0	CONTRACEPTIVES
SPRYCEL TAB	LMSP-PA	2	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
SPS SUSP	-	1	MISCELLANEOUS THERAPEUTIC CLASSES
SSKI ORAL SOLN	-	2+p	COUGH / COLD / ALLERGY
STAVUDINE CAP	-	1	ANTIVIRALS
stavudine cap (ZERIT equiv)	-	1	ANTIVIRALS

	<b>NC</b> =Not Covered	<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier	Category
STELARA INJ (QL= 1 inj/84 days)	LMSP-PA-QL	2	DERMATOLOGICALS
STIMATE NASAL SOLN	-	2	ENDOCRINE AND METABOLIC AGENTS - MISC.
STIOLTO INHALER	-	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
STRIBILD TAB (QL= 1 tab/day)	QL	2	ANTIVIRALS
sucalfate susp (CARAFATE equiv)	-	1	ULCER DRUGS / ANTISPASMODICS / ANTICHOLINERGICS
sucalfate 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
sulfacetamide sodium/sulfur cream 10-5% (PLEXION SCT equiv)	-	1	DERMATOLOGICALS
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

	<b>NC</b> =Not Covered	<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024**

<b>Drug Name</b>	<b>Special Code</b>	<b>Tier Category</b>
SUMADAN WASH 9-4.5%	-	2+p DERMATOLOGICALS enal ty
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
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
sunitinib malate cap (SUTENT equiv)	LMSP-PA	1 ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
SYMDEKO TAB (QL= 2 tabs/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	2 RESPIRATORY AGENTS - MISC.
SYMFI (LO) TAB	-	2+p ANTIVIRALS enal ty
SYMJEPI INJ (QL= 2 inj/fill)	QL	2 VASOPRESSORS
SYNAGIS INJ	LMSP-PA	2 PASSIVE IMMUNIZING AGENTS
SYNJARDY TAB (QL= 2 tabs/day)	QL	2 ANTIDIABETICS
SYNJARDY XR TAB 10-1000MG, 25-1000MG (QL= 1 tab/day)	QL	2 ANTIDIABETICS

	<b>NC</b> =Not Covered	<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month fo first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier	Category
SYNJARDY XR TAB 5-1000MG, 12.5-1000MG (QL= 2 tabs/day)	QL	2	ANTIDIABETICS
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.
TADLIQ SUSP (Prior Authorization Required for members age 9 or older)	PA	2	CARDIOVASCULAR AGENTS - MISC.
TAFINLAR CAP (QL= 4 tabs/day)	MSP-PA-QL	2	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
TAKHZYRO INJ (QL= 2 inj/28 days; Only available through Accredo 800-803-2523)	LD-PA-QL	2	HEMATOLOGICAL AGENTS - MISC.
TAKHZYRO INJ 150MG/ML (QL= 2 inj/28 days; On available through Accredo 800-803-2523)	LD-PA-QL	2	HEMATOLOGICAL AGENTS - MISC.
TALTZ INJ (QL= 1 inj/28 days)	LMSP-PA-QL	2	DERMATOLOGICALS
tamoxifen tab (NOLVADEX equiv)	-	1	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
tamsulosin cap (FLOMAX equiv)	-	1	GENITOURINARY AGENTS - MISCELLANEOUS
TASIGNA CAP	LMSP-PA	2	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
TAVNEOS CAP (QL= 6 caps/day; Only available through PantheRx 855-726-8479)	LD-PA-QL	2	HEMATOLOGICAL AGENTS - MISC.

	<b>NC</b> =Not Covered	<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month fo first 3 months	SMKG	Smoking Cessation
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 1/1/2024**

<b>Drug Name</b>	<b>Special Code</b>	<b>Tier</b>	<b>Category</b>
TAYTULLA CAP	-	\$0	CONTRACEPTIVES
tazarotene cream 0.1% (TAZORAC equiv)	-	2	DERMATOLOGICALS
TAZORAC CREAM 0.05%	-	2	DERMATOLOGICALS
TAZVERIK TAB (QL= 8 tabs/day; Only available through Onco360 877-662-6633)	LD-PA-QL	2	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
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
terconazole supp (TERAZOL equiv)	-	1	VAGINAL PRODUCTS

	<b>NC =Not Covered</b>	<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024**

<b>Drug Name</b>	<b>Special Code</b>	<b>Tier</b>	<b>Category</b>
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 ENANTHATE INJ 200MG/ML	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% 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	2	ANDROGENS-ANABOLIC
testosterone gel 1.62% 2.5gm (ANDROGEL equiv) (QL= 2 packets/day)	PA-QL	2	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
tetracycline cap	-	1	TETRACYCLINES

	<b>NC =Not Covered</b>	<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month fo first 3 months	SMKG	Smoking Cessation
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 1/1/2024**

<b>Drug Name</b>	<b>Special Code</b>	<b>Tier</b>	<b>Category</b>
TEZSPIRE INJ (QL= 1 pen/28 days)	PA-QL	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
THALOMID CAP	MSP-PA	2	ASSORTED CLASSES
theophylline er tab (THEOPHYLLINE ER equiv)	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
theophylline ER tab (UNIPHYL equiv)	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
theophylline soln	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
THEOPHYLLINE TAB ER	-	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
THIOLA EC TAB	LMSP-PA	2	GENITOURINARY AGENTS - MISCELLANEOUS
thioridazine tab (MELLARIL equiv)	-	1	ANTIPSYCHOTICS / ANTIMANIC AGENTS
thiothixene cap (NAVANE equiv)	-	1	ANTIPSYCHOTICS / ANTIMANIC AGENTS
THYROLAR TAB	-	2	THYROID AGENTS
tiagabine tab (GABITRIL equiv)	-	1	ANTICONVULSANTS

	<b>NC</b> =Not Covered	<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier	Category
timolol maleate ophth gel (TIMOPTIC-XE equiv)	-	1	OPHTHALMIC AGENTS
timolol maleate ophth soln (TIMOPTIC equiv)	-	1	OPHTHALMIC AGENTS
timolol maleate ophth soln 0.5% (ISTALOL equiv)	-	1	OPHTHALMIC AGENTS
timolol maleate tab (BLOCADREN equiv)	-	1	BETA BLOCKERS
tinidazole tab (TINDAMAX equiv)	-	1	ANTI-INFECTIVE AGENTS MISC.
tiopronin tab (THIOLA equiv)	LMSP-PA	1	GENITOURINARY AGENTS - MISCELLANEOUS
TIROSINT-SOL (Prior Authorization Required for members age 9 or older)	PA	2	THYROID AGENTS
TIVICAY PD TAB	-	2	ANTIVIRALS
TIVICAY TAB	-	2	ANTIVIRALS
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)	LMSP-RS	1	AMINOGLYCOSIDES
tobramycin ophth soln (TOBREX 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

	<b>NC</b> =Not Covered	<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier	Category
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
tolterodine SR cap (DETROL LA equiv)	-	1	URINARY ANTISPASMODICS
tolterodine tab (DETROL equiv)	-	1	URINARY ANTISPASMODICS
topiramate sprinkle cap (TOPAMAX equiv)	-	1	ANTICONSULSANTS
topiramate tab (TOPAMAX equiv)	-	1	ANTICONSULSANTS
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+p	URINARY enalANTISPASMODICS ty
TRACLEER TAB 32MG (Only available through Accredo 800-803-2523)	LD-PA	2	CARDIOVASCULAR AGENTS - MISC.
tramadol ER tab (ULTRAM ER equiv)	-	1	ANALGESICS - OPIOID

	<b>NC</b> =Not Covered	<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier	Category
TRAMADOL HCL ER TAB	-	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	2	HEMOSTATICS
tranylcypromine tab (PARNATE equiv)	-	1	ANTIDEPRESSANTS
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
TREMFYA	PA	2	DERMATOLOGICALS
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 oint	-	1	DERMATOLOGICALS

	<b>NC</b> =Not Covered	<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier	Category
triamcinolone OTC nasal spray (NASACORT equiv) (QL= 2 bottles/fill)	OTC-QL	1	NASAL AGENTS - SYSTEMIC AND TOPICAL
triamterene/hydrochlorothiazide cap (DYAZIDE equiv)	-	1	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 OPTH SOLN	-	1	OPHTHALMIC AGENTS
trihexyphenidyl elixir (ARTANE equiv)	-	1	ANTIPARKINSON AND RELATED THERAPY AGENTS
TRIHEXYPHENIDYL SOLN	-	1	ANTIPARKINSON AND RELATED THERAPY AGENTS
trihexyphenidyl tab (ARTANE equiv)	-	1	ANTIPARKINSON AGENTS
TRIKAFTA TAB (QL= 84 tabs/28 days; Only available through Walgreens 888-347-3416)	LD-PA-QL	2	RESPIRATORY AGENTS - MISC.

	<b>NC</b> =Not Covered	<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month fo first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier	Category
TRIKAFTA THERAPY PACK (QL= 2 packets/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	2	RESPIRATORY AGENTS - MISC.
tri-legest tab (ESTROSTEP FE equiv)	-	\$0	CONTRACEPTIVES
TRI-LUMA CREAM	-	EX C	DERMATOLOGICALS
trimethobenzamide cap (TIGAN equiv)	-	1	ANTIEMETICS
TRIMETHOPRIM TAB	-	1	ANTI-INFECTIVE AGENTS MISC.
trimethoprim tab (PROLOPRIM equiv)	-	1	ANTI-INFECTIVE AGENTS MISC.
TRI-NORINYL TAB	-	\$0	CONTRACEPTIVES
tri-sprintec tab (ORTHO TRI-CYCLEN (LO) equiv)	-	\$0	CONTRACEPTIVES
TRIUMEQ PD TAB (QL= 1 tab/day)	QL	2	ANTIVIRALS
TRIUMEQ TAB (QL= 1 tab/day)	QL	2	ANTIVIRALS
TRI-VI-FLOR SUSP	-	2	MULTIVITAMINS
TRIZIVIR TAB	-	2	ANTIVIRALS
tropicamide ophth soln (MYDRIACYL equiv)	-	1	OPHTHALMIC AGENTS
TRULICITY INJ (Diagnosis Restricted – Type 2 Diabetes (E11))	RDX	2	ANTIDIABETICS
tussigon tab (HYCODAN equiv)	-	1	COUGH / COLD / ALLERGY
TWIRLA PATCH	-	\$0	CONTRACEPTIVES
TYBLUME TAB	-	\$0	CONTRACEPTIVES
TYBOST TAB	-	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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier	Category
TYVASO DPI POWDER (QL= 4 cartridges/day; Only available through Accredo 800-803-2523)	LD-PA-QL	2	CARDIOVASCULAR AGENTS - MISC.
TYVASO DPI POWDER MAINTENANCE KIT 32-48MCG (QL= 224 cartridges/28 days; Only available through Accredo 800-803-2523)	LD-PA-QL	2	CARDIOVASCULAR AGENTS - MISC.
TYVASO DPI POWDER TITRATION KIT 16-32-48MCG (QL= 252 cartridges/28 days; Only available through Accredo 800-803-2523)	LD-PA-QL	2	CARDIOVASCULAR AGENTS - MISC.
TYVASO DPI POWDER TITRATION KIT 16-32MCG (QL= 196 cartridges/28 days; Only available through Accredo 800-803-2523)	LD-PA-QL	2	CARDIOVASCULAR AGENTS - MISC.
TYVASO INH SOLN (Only available through Accredo 800-803-2523)	LD-PA	2	CARDIOVASCULAR AGENTS - MISC.
UPNEEQ SOLN	-	EXC	OPHTHALMIC AGENTS
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 Optum Pharmacy 877-445-6874)	LD-PA-QL	2	DERMATOLOGICALS
valganciclovir soln (VALCYTE equiv)	-	1	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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier	Category
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
valsartan/hydrochlorothiazide tab (DIOVAN HCT equiv)	-	1	ANTIHYPERTENSIVES
vancomycin cap (VANCOCIN equiv) (QL= 56 caps/fill)	QL	2	ANTI-INFECTIVE AGENTS MISC.
VANIQA CREAM	-	EX C	DERMATOLOGICALS
VARENICLINE TAB (Prior Authorization Required only if member is less than 16 years old)	PA	\$0	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
varenicline tartrate tab (VARENICLINE equiv) (Prior Authorization Required only if member is less than 1 years old)	PA	\$0	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
varenicline tartrate tab starter pack (VARENICLINE PAK equiv) (Limited to 180 days/plan year; Prior Authorization Required only if member is less than 1 years old)	PA-QL-SMKG	\$0	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
VARIVAX INJ	VAC	\$0	VACCINES
VAXNEUVANCE INJ	VAC	EX C	VACCINES
VELIVET PAK	-	\$0	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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier Category
velivet tab (CYCLESSA equiv)	-	\$0 CONTRACEPTIVES
VELTASSA POWDER	PA	2 ASSORTED CLASSES
VEMLIDY TAB	-	2 ANTIVIRALS
venlafaxine ER cap (EFFEXOR XR equiv) (PA Required only if member is less than 12 years old)	PA	1 ANTIDEPRESSANTS
venlafaxine tab (EFFEXOR equiv) (PA Required only if member is 12 years or younger)	PA	1 ANTIDEPRESSANTS
VENTAVIS INH SOLN (Only available through Accredo 800-803-2523)	LD-PA	2 CARDIOVASCULAR AGENTS - MISC.
VENTOLIN HFA INHALER (QL= 2 inhalers/30 days	QL	1 ANTIASTHMATIC AND BRONCHODILATOR AGENTS
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
VICTOZA INJ (QL= 9ml/30 days; Diagnosis Restricted – Type 2 Diabetes (E11))	QL-RDX	2 ANTIDIABETICS
VIDEX SOLN	-	2 ANTIVIRALS
vienva tab, lessina tab, kurvelo tab (ALESSE equiv)	-	\$0 CONTRACEPTIVES

	<b>NC</b> =Not Covered	<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier Category
vigabatrin powder pack (SABRIL POWDER equiv) (Only available through Lumicera 855-847-3553)	LD-PA	1 ANTICONVULSANTS
vigabatrin tab (SABRIL equiv) (Only available through Lumicera 855-847-3553)	LD-PA	1 ANTICONVULSANTS
vigadrone powder pack (Only available through PantheRx 855-726-8479)	LD-PA	1 ANTICONVULSANTS
VIJOICE TAB (QL= 1 tab/day)	MSP-PA-QL	2 MISCELLANEOUS THERAPEUTIC CLASSES
VIMPAT INJ (QL= 1200 units/30 days)	QL	2+p ANTICONVULSANTS enal ty
VIMPAT TAB	-	2+p ANTICONVULSANTS enal ty
violele tab, kariva tab (MIRCETTE equiv)	-	\$0 CONTRACEPTIVES
VIRACEPT TAB	-	2 ANTIVIRALS
VIREAD TAB	-	2 ANTIVIRALS
VITAMIN C TAB	OTC	1 VITAMINS
vitamin D cap (RX strength only)	-	1 VITAMINS
vitamin E liquid	OTC	1 DERMATOLOGICALS
VITRAKVI CAP 100MG (QL= 2 caps/day; Only available through Accredo 800-803-2523)	LD-PA-QL	2 ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
VITRAKVI CAP 25MG (QL= 6 caps/day; Only available through Accredo 800-803-2523)	LD-PA-QL	2 ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES

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		
RDX	Restricted to Diagnosis	RS	Restricted to Specialist		
SF	Limited to two 15 day fills per month fo first 3 months	SMKG	Smoking Cessation		
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 1/1/2024**

<b>Drug Name</b>	<b>Special Code</b>	<b>Tier Category</b>
VITRAKVI SOLN (QL= 10ml/day; Only available through Accredo 800-803-2523)	LD-PA-QL	2 ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
VOCABRIA TAB	-	\$0 ANTIVIRALS
VONJO CAP (QL= 4 caps/day; Only available through Biologics 800-850-4306)	LD-PA-QL	2 ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
voriconazole susp (VFEND equiv) (Restricted to Infectious Disease Specialist)	RS	2 ANTIFUNGALS
voriconazole tab (VFEND equiv) (Restricted to Infectious Disease Specialist)	RS	2 ANTIFUNGALS
VOWST CAP (QL= 12 caps/fill; Only available through Orsini 800-410-8575)	LD-PA-QL	2 GASTROINTESTINAL AGENTS - MISC.
VOXZOGO INJ (QL= 1 vial/day; Only available through Accredo 888-773-7376)	LD-PA-QL	2 ENDOCRINE AND METABOLIC AGENTS - MISC.
warfarin tab (COUMADIN equiv)	-	1 ANTICOAGULANTS
WEGOVY INJ	-	EX C ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
WEGOVY INJ 1.7MG/0.75ML	-	EX C ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS

	<b>NC =Not Covered</b>	<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024**

<b>Drug Name</b>	<b>Special Code</b>	<b>Tier Category</b>
WEGOVY INJ 2.4MG/0.75ML	-	EX ADHD / C ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
WELCHOL PACK	-	2+p ANTIHYPERLIPIDEMICS enal ty
WELCHOL TAB	-	2+p ANTIHYPERLIPIDEMICS enal ty
WELIREG TAB (QL= 3 tabs/day; Only available through Biologics 800-850-4306)	LD-PA-QL	2 ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
XALKORI CAP (QL= 2 caps/day)	MSP-PA-QL	2 ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
XAQUIL XR TAB	-	EX DIETARY PRODUCTS / C DIETARY MANAGEMENT PRODUCTS
XARELTO SUSP	-	2 ANTICOAGULANTS
XARELTO TAB	-	2 ANTICOAGULANTS
XELJANZ SOLN (QL= 10 ml/day)	PA-QL	2 ANALGESICS - ANTI-INFLAMMATORY
XELJANZ TAB (QL= 2 tabs/day)	PA-QL	2 ANALGESICS - ANTI-INFLAMMATORY

	<b>NC</b> =Not Covered	<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month fo first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier	Category
XELJANZ XR TAB (QL= 1 tab/day)	PA-QL	2	ANALGESICS - ANTI-INFLAMMATORY
XEMBIFY INJ (Only available through Diplomat Pharmacy 877-977-9118)	LD-PA	2	PASSIVE IMMUNIZING AND TREATMENT AGENTS
XENICAL CAP	-	EX C	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
XENLETA TAB	PA	2	ANTI-INFECTIVE AGENTS MISC.
XIGDUO XR TAB 2.5-1000MG, 5-1000MG (QL= 2 tabs/day)	QL	2	ANTIDIABETICS
XIGDUO XR TAB 5-500MG, 10-500MG, 10-1000MG (QL= 1 tab/day)	QL	2	ANTIDIABETICS
XOFLUZA TAB (QL= 2 tabs/fill; Covered for members 12 years of age or older)	QL	2	ANTIVIRALS
XOFLUZA TAB THERAPY PACK 40MG (QL= 1 tab/fill; Covered for members 12 years of age or older)	QL	2	ANTIVIRALS
XOFLUZA TAB THERAPY PACK 80MG (QL= 1 tab/fill; Covered for members 12 years of age or older)	QL	2	ANTIVIRALS
XULTOPHY INJ (QL= 15ml/30 days)	QL	2	ANTIDIABETICS

	<b>NC</b> =Not Covered	<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier Category
XYZBAC TAB	-	EX C DIETARY PRODUCTS / DIETARY MANAGEMENT PRODUCTS
YAZ TAB, YASMIN 28 TAB	-	\$0 CONTRACEPTIVES
zafemy patch (XULANE equiv)	-	\$0 CONTRACEPTIVES
zafirlukast tab (ACCOLATE equiv)	-	1 ANTI-ASTHMATIC AND BRONCHODILATOR AGENTS
zaleplon cap (SONATA equiv) (QL= 1 cap/day)	QL	1 HYPNOTICS / SEDATIVES SLEEP DISORDER AGENTS
ZARXIO INJ	LMSP	2 HEMATOPOIETIC AGENTS
ZAVZPRET NASAL SPRAY (QL= 6 units/fill; 60 units/365 days)	PA-QL	2 MIGRAINE PRODUCTS
ZEGALOGUE INJ (QL= 2 inj/fill)	QL	2 ANTIDIABETICS
ZEJULA CAP (QL= 3 caps/day; Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-QL	2 ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ZEPBOUND INJ	-	EX C ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
ZEPOSIA CAP	LMSP-PA	2 PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.

	<b>NC</b> =Not Covered	<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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 1/1/2024

Drug Name	Special Code	Tier	Category
ZEPOSIA STARTER PACK	LMSP-PA	2	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
zidovudine cap (RETROVIR equiv)	-	1	ANTIVIRALS
zidovudine syrup (RETROVIR equiv)	-	1	ANTIVIRALS
zidovudine tab (RETROVIR equiv)	-	1	ANTIVIRALS
ZIMHI SOLN	-	2	ANTIDOTES AND SPECIFIC ANTAGONISTS
ziprasidone cap (GEODON equiv) (QL= 2 caps/day)	QL	1	ANTIPSYCHOTICS / ANTIMANIC AGENTS
ZIRGAN OPHTH GEL	-	2	OPHTHALMIC AGENTS
ZITHROMAX POWDER PACK	-	1	MACROLIDES
ZOKINVY CAP (QL= 4 caps/day; Only available through CVS Specialty 800-237-2767)	LD-PA-QL	2	MISCELLANEOUS THERAPEUTIC CLASSES
ZOLINZA CAP	LMSP-PA	2	ANTINEOPLASTICS
ZONISADE SUSP (Prior Authorization Required for members age 9 or older)	PA	2	ANTICONVULSANTS
zonisamide cap (ZONEGRAN equiv)	-	1	ANTICONVULSANTS
ZORYVE CREAM (QL= 60 grams/30 days)	PA-QL	2	DERMATOLOGICALS
ZTALMY SUSP (QL= 1100ml/30 days; Only available through Orsini 800-410-8575)	LD-PA-QL	2	ANTICONVULSANTS
ZUBSOLV SL TAB	-	2	ANALGESICS - OPIOID
ZYLET OPHTH SUSP (QL= 5ml/fill (10ml bottle is Not Covered))	QL	2	OPHTHALMIC AGENTS

	<b>NC</b> =Not Covered	<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS</b>		
<b>AMPHETAMINES</b>		
amphetamine/dextroamphetamine ER cap (ADDERALL XR equiv) (QL= 2 caps/day	QL	1
amphetamine/dextroamphetamine tab (ADDERALL equiv)	-	1
dextroamphetamine ER cap (DEXEDRINE equiv)	-	1
dextroamphetamine tab (DEXEDRINE equiv)	-	1
lisdexamfetamine dimesylate cap (VYVANSE equiv)	-	1
lisdexamfetamine dimesylate chew tab (VYVANSE equiv)	-	1
<b>ANALEPTICS</b>		
caffeine citrate soln (CAFCIT equiv) (Only covered for members less than 1 year old	-	2
<b>ANOREXIANTS NON-AMPHETAMINE</b>		
BENZPHETAMINE TAB	-	EXC
DIETHYLPROPION ER TAB	-	EXC
diethylpropion tab	-	EXC
LOMAIRA TAB	-	EXC
PHENDIMETRAZINE ER TAB	-	EXC
phendimetrazine tab (BONTRIL PDM equiv)	-	EXC
PLENITY CAP	-	EXC
<b>ANTI-OBESITY AGENTS</b>		
IMCIVREE INJ (QL= 1 inj/day; Only available through PantherRx Pharmacy 855-726-8479)	LD-PA-QL	2
WEGOVY INJ	-	EXC
WEGOVY INJ 1.7MG/0.75ML	-	EXC
WEGOVY INJ 2.4MG/0.75ML	-	EXC

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS Cont.</b>		
XENICAL CAP	-	EXC
ZEPBOUND INJ	-	EXC
<b>ATTENTION-DEFICIT/HYPERACTIVITY DISORDER (ADHD) AGENTS</b>		
atomoxetine cap (STRATTERA equiv) (QL= 2 caps/day)	QL	1
guanfacine ER tab (INTUNIV equiv) (QL= 1 tab/day)	QL	1
clonidine ER tab (KAPVAY equiv)	-	2
QELBREE ER CAP (QL= 2 caps/day)	PA-QL	2
KAPVAY TAB	-	2+penalty
<b>STIMULANTS - MISC.</b>		
armodafinil tab (NUVIGIL equiv) (QL= 1 tab/day)	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 soln (METHYLIN equiv)	-	1
methylphenidate tab (RITALIN equiv)	-	1
modafinil tab (PROVIGIL equiv) (QL= 2 tabs/day)	QL	1
METHYLPHENIDATE ER TAB (QL= 1 tab/day)	QL	2
<b>ALLERGENIC EXTRACTS/BIOLOGICALS MISC</b>		

## ALLERGENIC EXTRACTS

PALFORZIA POWDER PACK (Only available through Walgreens 888-347-3416) LD-PA 2

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>ALLERGENIC EXTRACTS/BIOLOGICALS MISC Cont.</b>		
PALFORZIA SPRINKLE CAP (Only available through Walgreens 888-347-3416)	LD-PA	2
<b>AMINOGLYCOSIDES</b>		
<b>AMINOGLYCOSIDES</b>		
neomycin tab	-	1
paromomycin cap (HUMATIN equiv)	-	1
tobramycin neb soln (TOBI equiv) (Restricted to Infectious Disease or Pulmonology Specialist)	LMSP-RS	1
KITABIS PAK NEB SOLN (Only available through Walgreens 888-347-3416)	LD	2
<b>ANALGESICS - ANTI-INFLAMMATORY</b>		
<b>ANTIRHEUMATIC - ENZYME INHIBITORS</b>		
OLUMIANT TAB (QL= 1 tab/day)	LMSP-PA-QL	2
RINVOQ ER TAB (QL= 1 tab/day)	LMSP-PA-QL	2
XELJANZ SOLN (QL= 10 ml/day)	PA-QL	2
XELJANZ TAB (QL= 2 tabs/day)	PA-QL	2
XELJANZ XR TAB (QL= 1 tab/day)	PA-QL	2
<b>ANTI-TNF-ALPHA - MONOCLONAL ANTIBODIES</b>		
ADALIMUMAB-ADAZ INJ (QL= 2 inj/28 days)	LMSP-PA-QL	2
ADALIMUMAB-ADAZ PFS INJ (QL= 2 inj/28 days)	LMSP-PA-QL	2
ADALIMUMAB-FKJP AUTO-INJECTOR KIT (QL= 2 inj/28 days)	LMSP-PA-QL	2
ADALIMUMAB-FKJP PFS KIT 20 MG/0.4ML (QL= 2 inj/28 days)	LMSP-PA-QL	2
ADALIMUMAB-FKJP PFS KIT 40 MG/0.8ML (QL= 2 inj/28 days)	LMSP-PA-QL	2
HADLIMA INJ (QL= 2 inj/28 days)	LMSP-PA-QL	2
HADLIMA INJ 40MG/0.8ML (QL= 2 inj/28 days)	LMSP-PA-QL	2

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>ANALGESICS - ANTI-INFLAMMATORY Cont.</b>		
HADLIMA PUSH INJ (QL= 2 inj/28 days)	LMSP-PA-QL	2
HADLIMA PUSH INJ 40MG/0.8ML (QL= 2 inj/28 days)	LMSP-PA-QL	2
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 80MG (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
HUMIRA INJ PEDIATRIC UC STARTER PACK (QL= 1 pack/fill, 1 fill/plan year)	LMSP-PA-QL	2
HUMIRA INJ PSORIASIS/UEITIS 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
SIMPONI AUTO-INJECTOR 100MG	PA	2
SIMPONI INJ 100MG	PA	2
<b>GOLD COMPOUNDS</b>		
RIDAURA CAP	-	2
<b>INTERLEUKIN-1 RECEPTOR ANTAGONIST (IL-1RA)</b>		
KINERET INJ (QL= 1 inj/day; Only available through Biologics 800-850-4306)	LD-PA-QL	2
<b>INTERLEUKIN-6 RECEPTOR INHIBITORS</b>		
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
<b>NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (NSAIDS)</b>		

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>ANALGESICS - ANTI-INFLAMMATORY Cont.</b>		
celecoxib cap (CELEBREX equiv)	-	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	-	1
flurbiprofen tab (ANSAID equiv)	-	1
ibuprofen cap 200mg	OTC	1
ibuprofen chew tab (ADVIL equiv)	OTC	1
ibuprofen susp	-	1
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

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>ANALGESICS - ANTI-INFLAMMATORY Cont.</b>		
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
CELEBREX CAP	-	2+penalty
<b>PHOSPHODIESTERASE 4 (PDE4) INHIBITORS</b>		
OTEZLA STARTER PACK (QL= 1 pack/28 days)	LMSP-PA-QL	2
OTEZLA TAB (QL= 2 tabs/day)	LMSP-PA-QL	2
<b>PYRIMIDINE SYNTHESIS INHIBITORS</b>		
leflunomide tab (ARAVA equiv)	-	1
<b>SELECTIVE COSTIMULATION MODULATORS</b>		
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
<b>SOLUBLE TUMOR NECROSIS FACTOR RECEPTOR AGENTS</b>		
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

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>ANALGESICS - ANTI-INFLAMMATORY Cont.</b>		
ENBREL SURECLICK INJ 50MG (QL= 4 inj/28 days)	LMSP-PA-QL	2
<b>ANALGESICS - NONNARCOTIC</b>		
<b>ANALGESICS OTHER</b>		
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
<b>SALICYLATES</b>		
aspirin chew tab 81mg	OTC	\$0
aspirin tab 325mg	OTC	\$0
aspirin supp	OTC	1
BUFFERED ASPIRIN TAB	OTC	1
bufferin tab	OTC	1
diflunisal tab (DOLOBID equiv)	-	1
salsalate tab (DISALCID equiv)	-	1
<b>ANALGESICS - OPIOID</b>		
<b>OPIOID AGONISTS</b>		
CODEINE SULFATE TAB	-	1
fentanyl patch (DURAGESIC equiv)	-	1

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>ANALGESICS - OPIOID Cont.</b>		
hydromorphone ER tab (EXALGO equiv)	-	1
hydromorphone liquid (DILAUDID-5 LIQUID equiv)	-	1
hydromorphone tab (DILAUDID equiv)	-	1
methadone soln	-	1
methadone tab (DOLOPHINE equiv)	-	1
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 HCL ER TAB	-	1
tramadol tab (ULTRAM equiv)	-	1
OXYCODONE ER TAB (QL= 120 tabs/30 days)	QL	2
OXYCONTIN CR TAB (QL= 60 tabs/30 days)	QL	2
EXALGO TAB	-	2+penalty
OXYCONTIN CR TAB (QL= 120 tabs/30 days)	QL	2+penalty

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>ANALGESICS - OPIOID Cont.</b>		
<b>OPIOID COMBINATIONS</b>		
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
oxycodone/acetaminophen tab (PERCOCET equiv)	-	1
OXYCODONE/ASPIRIN TAB	-	1
oxycodone/ibuprofen tab (COMBUNOX equiv)	-	1
pentazocine/acetaminophen tab (TALACEN equiv)	-	1
tramadol/acetaminophen tab (ULTRACET equiv)	-	1
<b>OPIOID PARTIAL AGONISTS</b>		
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
<b>ANDROGENS-ANABOLIC</b>		
<b>ANDROGENS</b>		

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>ANDROGENS-ANABOLIC Cont.</b>		
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 ENANTHATE INJ 200MG/ML	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
testosterone gel pump 1.62% (ANDROGEL equiv) (QL= 2 bottles/30 days)	PA-QL	1
ANDRODERM PATCH (QL= 1 patch/day)	PA-QL	2
TESTOSTERONE GEL 1% 25MG (QL= 1 packet/day)	PA-QL	2
testosterone gel 1.62% 1.25gm (ANDROGEL equiv) (QL= 1 packet/day)	PA-QL	2
testosterone gel 1.62% 2.5gm (ANDROGEL equiv) (QL= 2 packets/day)	PA-QL	2
TESTOSTERONE GEL PUMP (QL= 4 bottles/30 days)	PA-QL	2
<b>ANORECTAL AGENTS</b>		
<b>INTRARECTAL STEROIDS</b>		
hydrocortisone enema (CORTENEMA equiv)	-	1
<b>RECTAL COMBINATIONS</b>		
lidocaine/hydrocortisone cream (ANAMANTLE equiv)	-	1
pramoxine/hydrocortisone cream (ANALPRAM HC equiv)	-	1
PROCTOFOAM HC FOAM	-	2
<b>RECTAL STEROIDS</b>		

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>ANORECTAL AGENTS Cont.</b>		
proctosol HC cream (ANUSOL HC equiv)	-	1
hydrocortisone supp (ANUSOL HC equiv)	-	2
<b>ANTACIDS</b>		
<b>ANTACIDS - BICARBONATE</b>		
sodium bicarbonate tab	OTC	1
<b>ANTACIDS - CALCIUM SALTS</b>		
calcium carbonate chew tab (TUMS equiv)	OTC	1
calcium carbonate susp	OTC	1
<b>ANTHELMINTICS</b>		
<b>ANTHELMINTICS</b>		
ivermectin tab (STROMECTOL equiv)	PA	1
BENZNIDAZOLE TAB (Restricted to Infectious Disease Specialist)	RS	2
<b>ANTIANGINAL AGENTS</b>		
<b>NITRATES</b>		
isosorbide dinitrate SL tab	-	1
isosorbide dinitrate tab (ISORDIL equiv)	-	1
isosorbide mononitrate ER tab (IMDUR equiv)	-	1
ISOSORBIDE MONONITRATE TAB	-	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

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>ANTIANGINAL AGENTS Cont.</b>		
NITRO-DUR PATCH 0.3MG/HR, 0.8MG/HR	-	2
<b>ANTIANXIETY AGENTS</b>		
<b>ANTIANXIETY AGENTS - MISC.</b>		
bupirone tab (BUSPAR equiv)	-	1
hydroxyzine pamoate cap (VISTARIL equiv)	-	1
hydroxyzine syrup (ATARAX equiv)	-	1
hydroxyzine tab (ATARAX equiv)	-	1
<b>BENZODIAZEPINES</b>		
alprazolam tab (XANAX equiv)	-	1
chlordiazepoxide cap (LIBRIUM equiv)	-	1
diazepam conc (VALIUM equiv)	-	1
diazepam oral soln 5mg/5ml (DIAZEPAM equiv)	-	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
<b>ANTIARRHYTHMICS</b>		
<b>ANTIARRHYTHMICS TYPE I-A</b>		
disopyramide cap (NORPACE equiv)	-	1
disopyramide ER cap (NORPACE CR equiv)	-	1
quinidine gluconate CR tab	-	1
quinidine sulfate tab	-	1

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>ANTIARRHYTHMICS Cont.</b>		
NORPACE CR CAP	-	2
<b>ANTIARRHYTHMICS TYPE I-B</b>		
mexiletine hcl cap	-	1
<b>ANTIARRHYTHMICS TYPE I-C</b>		
flecainide tab (TAMBOCOR equiv)	-	1
propafenone tab (RYTHMOL equiv)	-	1
<b>ANTIARRHYTHMICS TYPE III</b>		
amiodarone tab (CORDARONE equiv)	-	1
dofetilide cap (TIKOSYN equiv)	-	1
<b>ANTIASTHMATIC AND BRONCHODILATOR AGENTS</b>		
<b>ANTIASTHMATIC - MONOCLONAL ANTIBODIES</b>		
FASENRA PEN INJ (QL= 1 inj/56 days; Only available through Accredo 800-803-2523 or Walgreens 888-347-3416)	LD-PA-QL	2
NUCALA INJ (QL= 1 inj/28 days)	LMSP-PA-QL	2
TEZSPIRE INJ (QL= 1 pen/28 days)	PA-QL	2
<b>BRONCHODILATORS - ANTICHOLINERGICS</b>		
ipratropium neb soln (ATROVENT equiv)	-	1
SPIRIVA RESPIMAT INHALER 1.25MCG/ACT (QL= 1 inhaler/30 days; Step Therapy requires trial of ADVAIR, BREO, DULERA, or FLUTICASONE/SALMETEROL)	QL-ST	2
<b>LEUKOTRIENE MODULATORS</b>		
montelukast chew tab (SINGULAIR equiv)	-	1
montelukast tab (SINGULAIR equiv)	-	1
zafirlukast tab (ACCOLATE equiv)	-	1

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>ANTIASTHMATIC AND BRONCHODILATOR AGENTS Cont.</b>		
<b>STEROID INHALANTS</b>		
budesonide inh susp (PULMICORT equiv)	-	1
ARNUITY ELLIPTA INHALER (QL= 1 inhaler/30 days)	QL	2
ASMANEX HFA INHALER (QL= 1 inhaler/30 days)	QL	2
ASMANEX INHALER (QL= 1 inhaler/30 days)	QL	2
FLOVENT HFA INHALER	-	2
FLUTICASONE DISKUS INHALER	-	2
FLUTICASONE HFA INHALER	-	2
FLUTICASONE HFA INHALER 110 MCG/ACT	-	2
FLUTICASONE HFA INHALER 220MCG/ACT	-	2
FLUTICASONE HFA INHALER 44 MCG/ACT	-	2
FLUTICASONE PROPIONATE DISKUS INHALER 100MCG/ACT	-	2
FLUTICASONE PROPIONATE DISKUS INHALER 250MCG/ACT	-	2
FLUTICASONE PROPIONATE DISKUS INHALER 50MCG/ACT	-	2
<b>SYMPATHOMIMETICS</b>		
albuterol HFA inhaler (PROAIR, PROVENTIL equiv) (QL= 2 inhalers/30 days)	QL	1
albuterol neb soln	-	1
ALBUTEROL NEBULIZER SOLN	-	1
albuterol sulfate syrup	-	1
albuterol sulfate tab	-	1
albuterol/ipratropium neb soln (DUONEB equiv)	-	1
budesonide/formoterol inhaler (SYMBICORT equiv)	-	1

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>ANTIASTHMATIC AND BRONCHODILATOR AGENTS Cont.</b>		
epinephrine inj	-	1
fluticasone/salmeterol inhaler, wixela inhaler (ADVAIR equiv)	-	1
FLUTICASONE-SALMETEROL INHALER 113-14 MCG/ACT	-	1
FLUTICASONE-SALMETEROL INHALER 232-14 MCG/ACT	-	1
FLUTICASONE-SALMETEROL INHALER 55-14 MCG/ACT	-	1
LEVALBUTEROL INHALER, XOPENEX HFA INHALER (QL= 2 inhalers/fill, 2 fills/30 days; Step Therapy requires trial of Ventolin HFA)	QL-ST	1
levalbuterol neb soln (XOPENEX equiv)	-	1
METAPROTERENOL SYRUP	-	1
terbutaline sulfate tab (BRETHINE equiv)	-	1
VENTOLIN HFA INHALER (QL= 2 inhalers/30 days)	QL	1
ADVAIR DISKUS INHALER	-	2
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
<b>XANTHINES</b>		
theophylline er tab (THEOPHYLLINE ER equiv)	-	1

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>ANTIASTHMATIC AND BRONCHODILATOR AGENTS Cont.</b>		
theophylline ER tab (UNIPHYL equiv)	-	1
theophylline soln	-	1
ELIXOPHYLLIN ELIXIR	-	2
THEOPHYLLINE TAB ER	-	2
<b>ANTICOAGULANTS</b>		
<b>COUMARIN ANTICOAGULANTS</b>		
warfarin tab (COUMADIN equiv)	-	1
<b>DIRECT FACTOR XA INHIBITORS</b>		
XARELTO SUSP	-	2
XARELTO TAB	-	2
<b>HEPARINS AND HEPARINOID-LIKE AGENTS</b>		
enoxaparin inj (LOVENOX equiv)	-	1
heparin flush	-	1
FRAGMIN INJ	-	2
<b>THROMBIN INHIBITORS</b>		
dabigatran etexilate mesylate cap (PRADAXA equiv)	-	2
PRADAXA CAP 110MG (Covered for members age 8 years or older)	-	2
<b>ANTICONVULSANTS</b>		
<b>ANTICONVULSANTS - BENZODIAZEPINES</b>		
clobazam tab (ONFI equiv)	-	1
clonazepam ODT (KLONOPIN equiv)	-	1
clonazepam tab (KLONOPIN equiv)	-	1
clobazam susp (ONFI equiv) (Members age 9 or older require Prior Authorization)	PA	2

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>ANTICONVULSANTS Cont.</b>		
<b>ANTICONVULSANTS - MISC.</b>		
carbamazepine chew tab (TEGRETOL equiv)	-	1
carbamazepine ER tab (TEGRETOL XR equiv)	-	1
carbamazepine susp (TEGRETOL equiv)	-	1
carbamazepine tab (TEGRETOL equiv)	-	1
gabapentin cap (NEURONTIN equiv) (QL= 9 caps/day)	QL	1
gabapentin cap 100mg (NEURONTIN equiv) (QL= 9 caps/day)	QL	1
gabapentin soln (NEURONTIN equiv) (QL= 72 mls/day)	QL	1
gabapentin tab 600mg (NEURONTIN equiv) (QL= 6 tabs/day)	QL	1
gabapentin tab 800mg (NEURONTIN equiv) (QL= 4.5 tabs/day)	QL	1
lacosamide iv inj (VIMPAT equiv) (QL= 1200 units/30 days)	QL	1
lacosamide oral solution (VIMPAT equiv) (QL= 600ml/30days)	QL	1
lacosamide tab (VIMPAT 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 ER tab (KEPPRA XR equiv)	-	1
levetiracetam soln (KEPPRA equiv)	-	1
levetiracetam tab (KEPPRA equiv)	-	1
oxcarbazepine susp (TRILEPTAL equiv)	-	1
oxcarbazepine tab (TRILEPTAL equiv)	-	1

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>ANTICONVULSANTS Cont.</b>		
pregabalin cap (LYRICA equiv)	-	1
pregabalin soln (LYRICA equiv)	-	1
primidone tab (MYSOLINE equiv)	-	1
rufinamide susp (BANZEL equiv)	PA	1
rufinamide tab (BANZEL equiv) (QL= 8 tabs/day)	PA-QL	1
topiramate sprinkle cap (TOPAMAX equiv)	-	1
topiramate tab (TOPAMAX equiv)	-	1
zonisamide cap (ZONEGRAN equiv)	-	1
carbamazepine ER cap (CARBATROL equiv)	-	2
DIACOMIT CAP	PA	2
DIACOMIT POWDER PACK	PA	2
EPIDIOLEX SOLN (Only available through Lumicera 855-847-3553)	LD-PA	2
EPRONTIA SOLN	PA	2
FINTEPLA SOLN (QL= 12ml/day; Only available through Anovo Specialty Pharmac 844-288-5007)	LD-PA-QL	2
lamotrigine ER tab (LAMICTAL XR equiv)	-	2
ZONISADE SUSP (Prior Authorization Required for members age 9 or older)	PA	2
ZTALMY SUSP (QL= 1100ml/30 days; Only available through Orsini 800-410-8575)	LD-PA-QL	2
BANZEL SUSP	PA	2+penalty
LYRICA CAP (QL= 3 caps/day)	QL	2+penalty

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>ANTICONVULSANTS Cont.</b>		
LYRICA CAP 225MG (QL= 2 caps/day)	QL	2+penalty
NEURONTIN SOLN (QL= 72 mls/day)	QL	2+penalty
NEURONTIN TAB 600MG (QL= 6 tabs/day)	QL	2+penalty
NEURONTIN TAB 800MG (QL= 4.5 tabs/day)	QL	2+penalty
VIMPAT INJ (QL= 1200 units/30 days)	QL	2+penalty
VIMPAT TAB	-	2+penalty
<b>CARBAMATES</b>		
felbamate susp (FELBATOL equiv)	-	1
felbamate tab (FELBATOL equiv)	-	2
<b>GABA MODULATORS</b>		
tiagabine tab (GABITRIL equiv)	-	1
vigabatrin powder pack (SABRIL POWDER equiv) (Only available through Lumicera 855-847-3553)	LD-PA	1
vigabatrin tab (SABRIL equiv) (Only available through Lumicera 855-847-3553)	LD-PA	1
vigadrone powder pack (Only available through PantheRx 855-726-8479)	LD-PA	1
<b>HYDANTOINS</b>		
phenytoin cap (DILANTIN equiv)	-	1

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>ANTICONVULSANTS Cont.</b>		
phenytoin chew tab (DILANTIN equiv)	-	1
phenytoin susp (DILANTIN equiv)	-	1
DILANTIN CAP 30MG	-	2
PEGANONE TAB	-	2
<b>SUCCINIMIDES</b>		
ethosuximide cap (ZARONTIN equiv)	-	1
ethosuximide soln (ZARONTIN equiv)	-	1
methsuximide cap (CELONTIN equiv)	-	1
<b>VALPROIC ACID</b>		
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
<b>ANTIDEPRESSANTS</b>		
<b>ALPHA-2 RECEPTOR ANTAGONISTS (TETRACYCLICS)</b>		
mirtazapine ODT (REMERON equiv)	-	1
mirtazapine tab (REMERON equiv)	-	1
<b>ANTIDEPRESSANTS - MISC.</b>		
bupropion ER tab (WELLBUTRIN equiv)	-	1
bupropion tab (WELLBUTRIN equiv)	-	1
bupropion XL tab (WELLBUTRIN XL equiv)	-	1
MAPROTILINE TAB	-	1

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>ANTIDEPRESSANTS Cont.</b>		
<b>MONOAMINE OXIDASE INHIBITORS (MAOIS)</b>		
PHENELZINE SULFATE TAB	-	1
phenelzine tab (NARDIL equiv)	-	1
tranylcypromine tab (PARNATE equiv)	-	1
MARPLAN TAB	-	2
<b>SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIS)</b>		
citalopram soln (CELEXA equiv)	-	1
citalopram tab (CELEXA equiv)	-	1
escitalopram tab 10mg (LEXAPRO equiv) (QL= 1.5 tabs/day)	QL	1
escitalopram tab 20mg (LEXAPRO equiv) (QL= 1 tab/day)	QL	1
escitalopram tab 5mg (LEXAPRO equiv) (QL= 3 tabs/day)	QL	1
fluoxetine cap (PROZAC equiv)	-	1
fluoxetine soln (PROZAC equiv)	-	1
fluoxetine tab (PROZAC equiv)	-	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
<b>SEROTONIN MODULATORS</b>		

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>ANTIDEPRESSANTS Cont.</b>		
NEFAZODONE TAB	-	1
nefazodone tab 50mg, 250mg	-	1
trazodone tab (DESYREL equiv)	-	1
<b>SEROTONIN-NOREPINEPHRINE REUPTAKE INHIBITORS (SNRIS)</b>		
duloxetine EC cap (CYMBALTA equiv)	-	1
venlafaxine ER cap (EFFEXOR XR equiv) (PA Required only if member is less than 12 years old)	PA	1
venlafaxine tab (EFFEXOR equiv) (PA Required only if member is 12 years or younger)	PA	1
<b>TRICYCLIC AGENTS</b>		
amitriptyline tab (ELAVIL equiv)	-	1
amoxapine tab (AMOXAPINE equiv)	-	1
clomipramine cap (ANAFRANIL equiv)	-	1
desipramine tab (NORPRAMIN equiv)	-	1
doxepin cap (SINEQUAN equiv)	-	1
doxepin conc (SINEQUAN equiv)	-	1
imipramine pamoate cap (TOFRANIL PM equiv)	-	1
imipramine tab (TOFRANIL equiv)	-	1
nortriptyline cap (PAMELOR equiv)	-	1
nortriptyline oral soln (NORTRIPTYLINE equiv)	-	1
protriptyline tab (VIVACTIL equiv)	-	1

## ANTIDIABETICS

### ALPHA-GLUCOSIDASE INHIBITORS

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>ANTIDIABETICS Cont.</b>		
acarbose tab (PRECOSE equiv)	-	1
<b>ANTIDIABETIC COMBINATIONS</b>		
glipizide/metformin tab (METAGLIP equiv)	-	1
glyburide/metformin tab (GLUCOVANCE equiv)	-	1
JANUMET XR TAB	-	2
SYNJARDY TAB (QL= 2 tabs/day)	QL	2
SYNJARDY XR TAB 10-1000MG, 25-1000MG (QL= 1 tab/day)	QL	2
SYNJARDY XR TAB 5-1000MG, 12.5-1000MG (QL= 2 tabs/day)	QL	2
XIGDUO XR TAB 2.5-1000MG, 5-1000MG (QL= 2 tabs/day)	QL	2
XIGDUO XR TAB 5-500MG, 10-500MG, 10-1000MG (QL= 1 tab/day)	QL	2
XULTOPHY INJ (QL= 15ml/30 days)	QL	2
<b>BIGUANIDES</b>		
metformin ER tab (GLUCOPHAGE XR equiv)	-	1
metformin tab (GLUCOPHAGE equiv)	-	1
<b>DIABETIC OTHER</b>		
glucagon (rdna) for inj kit (GLUCAGON equiv) (QL= 2 inj/fill, 1 fill/30 days)	QL	1
glucose gel	OTC	1
BAQSIMI NASAL POWDER (QL= 2 inhalations/fill)	QL	2
GLUCAGEN HYPOKIT INJ	-	2
GLUCAGON EMR INJ (QL= 2 inj/fill)	QL	2
GLUCAGON INJ KIT (QL= 2 inj/fill)	QL	2
GLUCOSE CHEW TAB	OTC	2

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>ANTIDIABETICS Cont.</b>		
glucose chew tab (GNP GLUCOSE CHEW equiv)	OTC	2
GVOKE INJ (QL= 2 inj/fill)	QL	2
GVOKE INJ KIT (QL= 2 inj/fill)	QL	2
GVOKE PFS INJ (QL= 2 inj/fill)	QL	2
ZEGALOGUE INJ (QL= 2 inj/fill)	QL	2
<b>INCRETIN MIMETIC AGENTS</b>		
OZEMPIC INJ (QL= 1 pack/28 days; Diagnosis Restricted – Type 2 Diabetes (E11))	QL-RDX	2
<b>INCRETIN MIMETIC AGENTS (GLP-1 RECEPTOR AGONISTS)</b>		
BYDUREON BCISE AUTO INJ (QL= 4 inj/28 days; Diagnosis Restricted – Type 2 Diabetes (E11))	QL-RDX	2
BYDUREON INJ (QL= 4 inj/28 days; Diagnosis Restricted – Type 2 Diabetes (E11))	QL-RDX	2
BYDUREON PEN INJ (QL= 4 inj/28 days; Diagnosis Restricted – Type 2 Diabetes (E11))	QL-RDX	2
MOUNJARO INJ (QL= 4 inj/28 days; Diagnosis Restricted – Type 2 Diabetes (E11))	QL-RDX	2
OZEMPIC INJ (QL= 1 pack/28 days; Diagnosis Restricted – Type 2 Diabetes (E11))	QL-RDX	2
RYBELSUS TAB (QL=1 tab/day; Diagnosis Restricted – Type 2 Diabetes (E11))	QL-RDX	2
TRULICITY INJ (Diagnosis Restricted – Type 2 Diabetes (E11))	RDX	2
VICTOZA INJ (QL= 9ml/30 days; Diagnosis Restricted – Type 2 Diabetes (E11))	QL-RDX	2
<b>INSULIN</b>		
INSULIN LISPRO INJ	-	1
HUMALOG JR KWIKPEN INJ	-	2
HUMALOG KWIKPEN INJ	-	2
HUMALOG MIX INJ	-	2

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>ANTIDIABETICS Cont.</b>		
HUMALOG MIX KWIKPEN INJ	-	2
HUMALOG PEN INJ	-	2
HUMULIN MIX INJ	OTC	2
HUMULIN MIX PEN INJ	OTC	2
HUMULIN N INJ	OTC	2
HUMULIN N PEN INJ	OTC	2
HUMULIN R INJ	OTC	2
HUMULIN R INJ U-500	-	2
LEVEMIR FLEXTOUCH INJ	-	2
LEVEMIR INJ	-	2
LYUMJEV INJ	-	2
LYUMJEV KWIKPEN INJ	-	2
SEMGLEE INJ, INSULIN GLARGINE-YFGN INJ	-	2
SEMGLEE PEN, INSULIN GLARGINE-YFGN PEN	-	2
TOUJEO SOLOSTAR INJ	-	2
TRESIBA FLEXTOUCH INJ	-	2
TRESIBA INJ	-	2
<b>INSULIN SENSITIZING AGENTS</b>		
pioglitazone tab (ACTOS TAB equiv)	-	1
<b>MEGLITINIDE ANALOGUES</b>		
repaglinide tab (PRANDIN equiv)	-	1
<b>SODIUM-GLUCOSE CO-TRANSPORTER 2 (SGLT2) INHIBITORS</b>		

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>ANTIDIABETICS Cont.</b>		
FARXIGA TAB (QL= 1 tab/day)	QL	2
JARDIANCE TAB (QL= 1 tab/day)	QL	2
<b>SULFONYLUREAS</b>		
glimepiride tab (AMARYL equiv)	-	1
glipizide ER tab (GLUCOTROL XL equiv)	-	1
glipizide tab (GLUCOTROL equiv)	-	1
GLYBURID MCR TAB	-	1
glyburide tab (MICRONASE equiv)	-	1
TOLAZAMIDE TAB	-	1
TOLBUTAMIDE TAB	-	2
<b>ANTIDIARRHEAL/PROBIOTIC AGENTS</b>		
<b>ANTIPERISTALTIC AGENTS</b>		
DIPHENOXYLATE/ATROPINE LIQUID	-	2
<b>ANTIDIARRHEALS</b>		
<b>ANTIPERISTALTIC AGENTS</b>		
diphenoxylate/atropine tab (LOMOTIL equiv)	-	1
opium tincture	-	1
<b>ANTIDOTES</b>		
<b>ANTIDOTES - CHELATING AGENTS</b>		
CHEMET CAP	-	2
FERRIPROX SOLN (Only available through Ferriprox Total Care 866-758-7071)	LD-PA	2
<b>OPIOID ANTAGONISTS</b>		
naltrexone tab (REVIA equiv)	-	1

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>ANTIDOTES AND SPECIFIC ANTAGONISTS</b>		
<b>ANTIDOTES - CHELATING AGENTS</b>		
deferasirox granules packet (JADENU equiv)	LMSP	1
deferasirox tab (EXJADE equiv)	LMSP	1
deferasirox tab 180mg (JADENU equiv)	-	1
deferasirox tab 90mg, 360mg (JADENU equiv)	LMSP	1
deferiprone tab (FERRIPROX equiv) (Only available through Lumicera 855-847-355	LD-PA	1
<b>OPIOID ANTAGONISTS</b>		
naloxone hcl nasal spray (NARCAN equiv)	OTC	1
naloxone prefilled inj	-	1
NARCAN NASAL SPRAY	OTC	1
KLOXXADO NASAL SPRAY	-	2
NALOXONE PREFILLED INJ	-	2
ZIMHI SOLN	-	2
<b>ANTIEMETICS</b>		
<b>5-HT3 RECEPTOR ANTAGONISTS</b>		
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

### ANTIEMETICS - ANTICHOLINERGIC

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>ANTIEMETICS Cont.</b>		
meclizine chew tab (BONINE equiv)	OTC	1
meclizine tab (ANTIVERT equiv)	OTC	1
scopolamine patch (TRANSDERM-SCOP equiv) (Covered for members age 18 or older)	-	1
trimethobenzamide cap (TIGAN equiv)	-	1
<b>SUBSTANCE P/NEUROKININ 1 (NK1) RECEPTOR ANTAGONISTS</b>		
aprepitant cap (EMEND equiv) (QL= 3 caps/fill)	QL	1
aprepitant pak (EMEND equiv) (QL= 3 caps/fill)	QL	1
<b>ANTIFUNGALS</b>		
<b>ANTIFUNGALS</b>		
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
<b>IMIDAZOLE-RELATED ANTIFUNGALS</b>		
fluconazole susp (DIFLUCAN equiv)	-	1
fluconazole tab (DIFLUCAN equiv)	-	1
itraconazole cap (SPORANOX equiv)	PA	1
ketoconazole tab (NIZORAL equiv)	-	1
voriconazole susp (VFEND equiv) (Restricted to Infectious Disease Specialist)	RS	2

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>ANTIFUNGALS Cont.</b>		
voriconazole tab (VFEND equiv) (Restricted to Infectious Disease Specialist)	RS	2
<b>ANTIHISTAMINES</b>		
<b>ANTIHISTAMINES - ETHANOLAMINES</b>		
CARBINOXAMINE SOLN	-	1
carbinoxamine tab (PALGIC equiv)	-	1
CLEMASTINE TAB 1.34MG	OTC	1
clemastine tab 1.34mg (TAVIST equiv)	OTC	1
diphenhydramine cap (BENADRYL equiv) (OTC only)	OTC	1
diphenhydramine cap 50mg (BENADRYL equiv) (Only 50mg covered)	-	1
DIPHENHYDRAMINE LIQUID	OTC	1
diphenhydramine liquid (BENADRYL equiv)	OTC	1
diphenhydramine tab (BENADRYL equiv)	OTC	1
SILPHEN COUGH SYRUP	OTC	1
ALER-DRYL TAB	OTC	2
<b>ANTIHISTAMINES - NON-SEDATING</b>		
cetirizine syrup (ZYRTEC equiv) (QL= 10ml/day)	OTC-QL	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= 10ml/day)	OTC-QL	1

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>ANTI-HISTAMINES Cont.</b>		
loratadine tab (CLARITIN equiv) (QL= 1 tab/day)	OTC-QL	1
CLARITIN CHEW TAB	OTC	2
<b>ANTI-HISTAMINES - PHENOTHIAZINES</b>		
promethazine supp (PHENERGAN equiv)	-	1
promethazine syrup	-	1
promethazine tab (PHENERGAN equiv)	-	1
PROMETHEGAN SUPP	-	1
<b>ANTI-HISTAMINES - PIPERIDINES</b>		
cyproheptadine syrup	-	1
cyproheptadine tab	-	1
<b>ANTI-HYPERLIPIDEMICS</b>		
<b>ADENOSINE TRIPHOSPHATE-CITRATE LYASE (ACL) INHIBITORS</b>		
NEXLETOL TAB (QL= 1 tab/day)	PA-QL	2
<b>ANTI-HYPERLIPIDEMICS - COMBINATIONS</b>		
NEXLIZET TAB (QL= 1 tab/day)	PA-QL	2
<b>ANTI-HYPERLIPIDEMICS - MISC.</b>		
omega-3-acid ethyl esters cap (LOVAZA equiv)	-	1
<b>BILE ACID SEQUESTRANTS</b>		
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

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>ANTIHYPERLIPIDEMICS Cont.</b>		
colesevelam tab (WELCHOL equiv)	-	1
colestipol granule (COLESTID equiv)	-	1
colestipol powder packet (COLESTID equiv)	-	1
colestipol tab (COLESTID equiv)	-	1
WELCHOL PACK	-	2+penalty
WELCHOL TAB	-	2+penalty
<b>FIBRIC ACID DERIVATIVES</b>		
fenofibric acid DR cap (TRILIPIX equiv)	-	1
gemfibrozil tab (LOPID equiv)	-	1
<b>HMG COA REDUCTASE INHIBITORS</b>		
atorvastatin tab (LIPITOR equiv)	-	1
lovastatin tab (MEVACOR equiv)	-	1
pravastatin tab (PRAVACHOL equiv)	-	1
rosuvastatin tab (CRESTOR equiv)	-	1
simvastatin tab (ZOCOR equiv) (80mg is Not Covered)	-	1
ATORVALIQ SUSP (Covered for members age 9 years and older; and patients that are unable to swallow tablets)	PA	2
FLOLIPID SUSP (Members age 9 or older require Prior Authorization)	PA	2
CRESTOR TAB	-	2+penalty

## INTESTINAL CHOLESTEROL ABSORPTION INHIBITORS

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>ANTIHYPERLIPIDEMICS Cont.</b>		
ezetimibe tab (ZETIA equiv)	-	1
<b>NICOTINIC ACID DERIVATIVES</b>		
niacin ER tab (NIASPAN equiv)	-	1
NIASPAN ER TAB	-	2+penalty
<b>PROTEIN CONVERTASE SUBTILISIN/KEXIN TYPE 9 INHIBITORS</b>		
REPATHA INJ (QL= 2 inj/28 days)	PA-QL	2
REPATHA PUSHTRONEX INJ (QL= 1 inj/28 days)	PA-QL	2
<b>ANTIHYPERTENSIVES</b>		
<b>ACE INHIBITORS</b>		
benazepril tab (LOTENSIN equiv)	-	1
captopril tab (CAPOTEN equiv)	-	1
enalapril maleate for oral solution (Prior Authorization Required for members age 9 older)	PA	1
enalapril tab (VASOTEC equiv)	-	1
fosinopril tab (MONOPRIL equiv)	-	1
lisinopril tab (PRINIVIL/ZESTRIL equiv)	-	1
moexipril tab (UNIVASC equiv)	-	1
PERINDOPRIL TAB	-	1
perindopril tab (ACEON equiv)	-	1
quinapril tab (ACCUPRIL equiv)	-	1
ramipril cap (ALTACE equiv)	-	1
trandolapril tab (MAVIK equiv)	-	1

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>ANTIHYPERTENSIVES Cont.</b>		
QBRELIS SOLN (Prior Authorization Required for members age 9 or older)	PA	2
epaned (Prior Authorization Required for members age 9 or older)	PA	2+penalty
<b>AGENTS FOR PHEOCHROMOCYTOMA</b>		
phenoxybenzamine cap (DIBENZYLIN equiv)	-	1
<b>ANGIOTENSIN II RECEPTOR ANTAGONISTS</b>		
candesartan tab (ATACAND equiv)	-	1
losartan tab (COZAAR equiv)	-	1
olmesartan tab (BENICAR equiv)	-	1
valsartan tab (DIOVAN equiv)	-	1
<b>ANTIADRENERGIC ANTIHYPERTENSIVES</b>		
clonidine patch (CATAPRES-TTS equiv)	-	1
clonidine tab (CATAPRES equiv)	-	1
doxazosin tab (CARDURA equiv)	-	1
guanfacine IR tab (TENEX equiv)	-	1
METHYLDOPA TAB	-	1
methyldopa tab (ALDOMET equiv)	-	1
prazosin cap (MINIPRESS equiv)	-	1
terazosin cap (HYTRIN equiv)	-	1
<b>ANTIHYPERTENSIVE COMBINATIONS</b>		
amlodipine/benazepril cap (LOTREL equiv)	-	1
amlodipine/olmesartan tab (AZOR TAB equiv)	-	1
amlodipine/valsartan tab (EXFORGE equiv)	-	1

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>ANTIHYPERTENSIVES Cont.</b>		
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 (LOPRESSOR HCT equiv)	-	1
MOEXIPRIL/HYDROCHLOROTHIAZIDE TAB	-	1
moexipril/hydrochlorothiazide tab (UNIRETIC equiv)	-	1
olmesartan/hydrochlorothiazide tab (BENICAR HCT equiv)	-	1
PROPRANOLOL/HYDROCHLOROTHIAZIDE TAB	-	1
QUINAPRIL/HCTZ TAB	-	1
quinapril/hydrochlorothiazide tab (ACCURETIC equiv)	-	1
valsartan/hydrochlorothiazide tab (DIOVAN HCT equiv)	-	1
<b>SELECTIVE ALDOSTERONE RECEPTOR ANTAGONISTS (SARAS)</b>		
eplerenone tab (INSPRA equiv)	-	1
<b>VASODILATORS</b>		
hydralazine tab (APRESOLINE equiv)	-	1
minoxidil tab (LONITEN equiv)	-	1

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>ANTI-INFECTIVE AGENTS - MISC.</b>		
<b>ANTI-INFECTIVE AGENTS - MISC.</b>		
metronidazole tab (FLAGYL equiv)	-	1
pentamidine neb soln (NEBUPENT equiv)	-	1
tinidazole tab (TINDAMAX equiv)	-	1
TRIMETHOPRIM TAB	-	1
trimethoprim tab (PROLOPRIM equiv)	-	1
PRIMSOL SOLN	-	2
<b>ANTI-INFECTIVE MISC. - COMBINATIONS</b>		
smz/tmp (DS) tab (BACTRIM DS equiv)	-	1
smz/tmp susp (BACTRIM, SEPTRA equiv)	-	1
<b>ANTIPROTOZOAL AGENTS</b>		
atovaquone susp (MEPRON equiv)	-	1
nitazoxanide tab (ALINIA equiv) (QL= 6 tabs/3 days)	PA-QL	1
ALINIA SUSP (QL= 60ml/3 days)	PA-QL	2
<b>GLYCOPEPTIDES</b>		
FIRVANQ SOLN	-	1
FIRVANQ SOLN 50MG/ML	-	1
vancomycin cap (VANCOCIN equiv) (QL= 56 caps/fill)	QL	2
<b>LEPROSTATICS</b>		
dapsone tab	-	1
<b>LINCOSAMIDES</b>		
clindamycin cap (CLEOCIN equiv)	-	1
clindamycin soln (CLEOCIN equiv)	-	1

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>ANTI-INFECTIVE AGENTS - MISC. Cont.</b>		
<b>MONOBACTAMS</b>		
CAYSTON INH SOLN (Restricted to Infectious Disease or Pulmonology Specialist; Only available through Walgreens 888-347-3416)	LD-RS	2
<b>OXAZOLIDINONES</b>		
linezolid susp (Restricted to Infectious Disease Specialist)	RS	1
linezolid tab (ZYVOX equiv) (Restricted to Infectious Disease Specialist)	RS	1
<b>PLEUROMUTILINS</b>		
XENLETA TAB	PA	2
<b>URINARY ANTI-INFECTIVES</b>		
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
nitrofurantoin susp (FURADANTIN equiv)	PA	1
<b>ANTIMALARIALS</b>		
<b>ANTIMALARIALS</b>		
chloroquine tab (ARALEN equiv)	-	1
hydroxychloroquine tab (PLAQUENIL equiv)	-	1
<b>ANTIMYASTHENIC/CHOLINERGIC AGENTS</b>		
<b>ANTIMYASTHENIC/CHOLINERGIC AGENTS</b>		
pyridostigmine CR tab (MESTINON equiv)	-	1
pyridostigmine tab (MESTINON equiv)	-	1

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>ANTIMYASTHENIC/CHOLINERGIC AGENTS Cont.</b>		
FIRDAPSE TAB (Only available through AnovoRx 844-288-5007)	LD-PA	2
<b>ANTIMYCOBACTERIAL AGENTS</b>		
<b>ANTI TB COMBINATIONS</b>		
RIFAMATE CAP	-	2
<b>ANTIMYCOBACTERIAL AGENTS</b>		
ethambutol tab (MYAMBUTOL equiv)	-	1
isoniazid syrup (ISONIAZID equiv)	-	1
ISONIAZID TAB	-	1
pyrazinamide tab	-	1
rifabutin cap (MYCOBUTIN equiv)	-	1
rifampin cap (RIFADIN equiv)	-	1
PRIFTIN TAB	-	2
SIRTURO TAB (Restricted to Infectious Disease or Pulmonary Specialist)	RS	2
<b>ANTINEOPLASTICS</b>		
<b>ALKYLATING AGENTS</b>		
HEXALEN CAP	-	2
LEUKERAN TAB	-	2
<b>ANTIMETABOLITES</b>		
mercaptopurine tab (PURINETHOL equiv)	-	1
methotrexate tab (TREXALL equiv)	-	1
TABLOID TAB	-	2
<b>ANTINEOPLASTIC ENZYME INHIBITORS</b>		
ZOLINZA CAP	LMSP-PA	2

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>ANTINEOPLASTICS Cont.</b>		
<b>ANTINEOPLASTICS MISC.</b>		
hydroxyurea cap (HYDREA equiv)	-	1
tretinoin cap (VESANOID equiv)	LMSP	1
ACTIMMUNE INJ (Only available through Accredo 800-803-2523 or Walgreens 888-347-3416)	LD-PA	2
ALFERON-N INJ	LMSP	2
MATULANE CAP	-	2
<b>CHEMOTHERAPY RESCUE/ANTIDOTE AGENTS</b>		
leucovorin tab	-	1
MESNEX TAB	LMSP	2
<b>TOPOISOMERASE I INHIBITORS</b>		
HYCAMTIN CAP	LMSP-PA	2
<b>ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES</b>		
<b>ALKYLATING AGENTS</b>		
carboplatin inj (PARAPLATIN equiv)	MSP	1
CISPLATIN INJ	-	1
cisplatin inj (PLATINOL AQ equiv)	-	1
CISPLATIN INJ 50MG/50ML	-	1
cyclophosphamide cap	-	1
temozolomide cap (TEMODAR equiv)	LMSP	1
CYCLOPHOSPHAMIDE TAB	-	2
GLEOSTINE/LOMUSTINE CAP	-	2
MYLERAN TAB	LMSP	2

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES Cont.</b>		
<b>ANTIMETABOLITES</b>		
capecitabine tab (XELODA equiv)	LMSP	1
FLUDARABINE INJ	-	1
METHOTREXATE INJ	-	1
JYLAMVO SOLN, XATMEP SOLN (Prior Authorization Required for members age 9 or older)	PA	2
PURIXAN SUSP (Covered for members age 9 years and older; and patients that are unable to swallow tablets)	PA	2
FLUDARABINE INJ	-	2+penalty

## ANTINEOPLASTIC - EGFR INHIBITORS

EXKIVITY CAP (QL= 4 caps/day; Only available through Biologics 800-850-4306)	LD-PA-QL	2
--	----------	---

## ANTINEOPLASTIC - HORMONAL AND RELATED AGENTS

anastrozole tab (ARIMIDEX equiv)	-	1
bicalutamide tab (CASODEX 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

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES Cont.</b>		
EULEXIN CAP	-	2
FLUTAMIDE CAP	-	2
LYSODREN TAB (Only available through Walgreens 888-347-3416)	LD	2
<b>ANTINEOPLASTIC - HYPOXIA-INDUCIBLE FACTOR INHIBITORS</b>		
WELIREG TAB (QL= 3 tabs/day; Only available through Biologics 800-850-4306)	LD-PA-QL	2
<b>ANTINEOPLASTIC ENZYME INHIBITORS</b>		
everolimus tab (AFINITOR equiv) (QL= 1 tab/day)	LMSP-PA-QL	1
everolimus tab 5mg (AFINITOR equiv) (QL= 1 tab/day)	LMSP-PA-QL	1
everolimus tab for oral susp (AFINITOR DISPERZ equiv) (QL= 1 tab/day)	LMSP-PA-QL	1
imatinib tab (GLEEVEC equiv)	LMSP	1
sunitinib malate cap (SUTENT equiv)	LMSP-PA	1
CABOMETYX TAB (QL= 1 tab/day)	PA-QL	2
GAVRETO CAP (QL= 4 caps/day; Only available through Lumicera 855-847-3553)	LD-PA-QL	2
IMBRUVICA SUSP (QL= 6ml/day; Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-QL	2
IMBRUVICA TAB 420MG, 560MG (QL= 1 tab/day; Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-QL	2
JAKAFI TAB	PA	2
JAYPIRCA TAB (QL= 2 tabs/day)	LMSP-PA-QL	2
KOSELUGO CAP (QL= 4 caps/day; Only available through Onco360 877-662-6633)	LD-PA-QL	2
KOSELUGO CAP 10MG (QL= 8 caps/day; Only available through Onco360 877-662-6633)	LD-PA-QL	2
MEKINIST TAB 0.5MG (QL= 3 tabs/day)	MSP-PA-QL	2

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES Cont.</b>		
MEKINIST TAB 2MG (QL= 1 tab/day)	MSP-PA-QL	2
NINLARO CAP (Only available through Diplomat 877-977-9118, Walgreens 888-347-3416, Walmart Specialty 877-453-4566)	LD-PA	2
RETEVMO CAP (QL= 4 caps/day)	LMSP-PA-QL-S F	2
ROZLYTREK CAP (QL= 3 caps/day)	LMSP-PA-QL	2
SPRYCEL TAB	LMSP-PA	2
TAFINLAR CAP (QL= 4 tabs/day)	MSP-PA-QL	2
TASIGNA CAP	LMSP-PA	2
TAZVERIK TAB (QL= 8 tabs/day; Only available through Onco360 877-662-6633)	LD-PA-QL	2
VITRAKVI CAP 100MG (QL= 2 caps/day; Only available through Accredo 800-803-2523)	LD-PA-QL	2
VITRAKVI CAP 25MG (QL= 6 caps/day; Only available through Accredo 800-803-2523)	LD-PA-QL	2
VITRAKVI SOLN (QL= 10ml/day; Only available through Accredo 800-803-2523)	LD-PA-QL	2
VONJO CAP (QL= 4 caps/day; Only available through Biologics 800-850-4306)	LD-PA-QL	2
XALKORI CAP (QL= 2 caps/day)	MSP-PA-QL	2
ZEJULA CAP (QL= 3 caps/day; Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-QL	2

### ANTINEOPLASTIC ENZYMES

ERWINAZE INJ	-	2
--------------	---	---

### ANTINEOPLASTICS MISC.

bexarotene cap (TARGRETIN equiv)	LMSP-PA	2
----------------------------------	---------	---

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES Cont.</b>		
<b>CHEMOTHERAPY RESCUE/ANTIDOTE AGENTS</b>		
mesna inj (MESNEX equiv)	-	1
<b>MITOTIC INHIBITORS</b>		
ETOPOSIDE CAP	LMSP	1
<b>TOPOISOMERASE I INHIBITORS</b>		
topotecan inj (HYCAMTIN equiv)	-	1
<b>ANTIPARKINSON AGENTS</b>		
<b>ANTIPARKINSON ADJUVANTS</b>		
carbidopa tab (LODOSYN equiv)	-	1
<b>ANTIPARKINSON ANTICHOLINERGICS</b>		
benztropine tab	-	1
trihexyphenidyl tab (ARTANE equiv)	-	1
<b>ANTIPARKINSON COMT INHIBITORS</b>		
entacapone tab (COMTAN equiv)	-	2
<b>ANTIPARKINSON DOPAMINERGICS</b>		
amantadine syrup (SYMMETREL equiv)	-	1
bromocriptine cap (PARLODEL equiv)	-	1
bromocriptine tab (PARLODEL equiv)	-	1
carbidopa/levodopa ER tab (SINEMET CR equiv)	-	1
carbidopa/levodopa ODT (PARCOPA equiv)	-	1
carbidopa/levodopa tab (SINEMET equiv)	-	1
pramipexole ER tab (MIRAPEX ER equiv)	-	1
pramipexole tab (MIRAPEX equiv)	-	1

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>ANTIPARKINSON AGENTS Cont.</b>		
ropinirole ER tab (REQUIP XL equiv)	-	1
ropinirole tab (REQUIP equiv)	-	1
CARBIDOPA/LEVODOPA/ENTACAPONE TAB (STALEVO equiv)	-	2
<b>ANTIPARKINSON MONOAMINE OXIDASE INHIBITORS</b>		
selegiline cap (ELDEPRYL equiv)	-	1
selegiline tab (ELDEPRYL equiv)	-	1
<b>ANTIPARKINSON AND RELATED THERAPY AGENTS</b>		
<b>ANTIPARKINSON ANTICHOLINERGICS</b>		
trihexyphenidyl elixir (ARTANE equiv)	-	1
TRIHEXYPHENIDYL SOLN	-	1
<b>ANTIPARKINSON DOPAMINERGICS</b>		
CARBIDOPA/LEVODOPA ODT	-	1
carbidopa-levodopa-entacapone tab (STALEVO equiv)	-	1
<b>ANTIPSYCHOTICS/ANTIMANIC AGENTS</b>		
<b>ANTIMANIC AGENTS</b>		
lithium carbonate cap (ESKALITH ER equiv)	-	1
lithium carbonate ER tab (LITHOBID equiv)	-	1
lithium carbonate tab	-	1
<b>ANTIPSYCHOTICS - MISC.</b>		
lurasidone hcl tab (LATUDA equiv)	-	1
ziprasidone cap (GEODON equiv) (QL= 2 caps/day)	QL	1
EQUETRO CAP	-	2

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>ANTIPSYCHOTICS/ANTIMANIC AGENTS Cont.</b>		
LATUDA TAB (QL= 1 tab/day)	QL	2+penalty
<b>BENZISOXAZOLES</b>		
paliperidone ER tab (INVEGA equiv)	-	1
risperidone ODT (RISPERDAL M equiv)	-	1
risperidone soln (RISPERDAL equiv)	-	1
risperidone tab (RISPERDAL equiv)	-	1
FANAPT TAB (QL= 2 tabs/day)	PA-QL	2
FANAPT TITRATION PACK	PA	2
INVEGA INJ	PA	2
RISPERDAL INJ	PA	2
risperidone microspheres inj (RISPERDAL equiv)	PA	2
RISPERIDONE ODT	-	2
<b>BUTYROPHENONES</b>		
haloperidol lactate conc (HALDOL equiv)	-	1
haloperidol tab (HALDOL equiv)	-	1
<b>DIBENZAPINES</b>		
asenapine maleate SL tab (SAPHRIS equiv) (QL= 2 tabs/day)	QL	1
clozapine tab (CLOZARIL equiv)	-	1
loxapine cap (LOXITANE equiv)	-	1
olanzapine tab (ZYPREXA equiv)	-	1
quetiapine tab (SEROQUEL equiv)	-	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.

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>ANTIPSYCHOTICS/ANTIMANIC AGENTS Cont.</b>		
<b>PHENOTHIAZINES</b>		
chlorpromazine tab (THORAZINE equiv)	-	1
fluphenazine tab (PROLIXIN equiv)	-	1
perphenazine tab (TRILAFON equiv)	-	1
prochlorperazine supp (COMPAZINE equiv)	-	1
prochlorperazine tab (COMPAZINE equiv)	-	1
thioridazine tab (MELLARIL equiv)	-	1
trifluoperazine tab (STELAZINE equiv)	-	1
<b>QUINOLINONE DERIVATIVES</b>		
aripiprazole soln (ABILIFY equiv)	-	1
aripiprazole tab (ABILIFY equiv)	-	1
<b>THIOXANTHENES</b>		
thiothixene cap (NAVANE equiv)	-	1
<b>ANTIVIRALS</b>		
<b>ANTIRETROVIRALS</b>		
DESCOVY TAB	-	\$0
emtricitabine/tenofovir disoproxil fumarate tab (TRUVADA equiv)	-	\$0
VOCABRIA TAB	-	\$0
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

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>ANTIVIRALS Cont.</b>		
darunavir tab (PREZISTA equiv)	-	1
didanosine DR cap (VIDEX EC equiv)	-	1
DIDANOSINE DR CAP, VIDEX EC CAP	-	1
EFAVIRENZ CAP	-	1
efavirenz tab (SUSTIVA equiv)	-	1
efavirenz/emtricitabine/tenofovir df tab (ATRIPLA equiv)	-	1
efavirenz/lamivudine/tenofovir df (lo) tab (SYMFI (LO) equiv)	-	1
emtricitabine cap (EMTRIVA equiv)	-	1
etravirine tab (INTELENCE equiv)	-	1
fosamprenavir tab (LEXIVA equiv)	-	1
lamivudine soln (EPIVIR equiv)	-	1
lamivudine/zidovudine tab (COMBIVIR equiv)	-	1
lopinavir/ritonavir soln (KALETRA equiv)	-	1
lopinavir/ritonavir tab (KALETRA equiv)	-	1
maraviroc tab (SELZENTRY equiv)	-	1
NEVIRAPINE ER TAB	-	1
nevirapine ER tab (VIRAMUNE XR equiv)	-	1
NEVIRAPINE SUSP	-	1
nevirapine tab (VIRAMUNE equiv)	-	1
ritonavir tab (NORVIR equiv)	-	1
STAVUDINE CAP	-	1
stavudine cap (ZERIT equiv)	-	1

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

<b>NC</b> =Not Covered		<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>ANTIVIRALS Cont.</b>		
tenofovir disoproxil fumarate tab (VIREAD equiv)	-	1
zidovudine cap (RETROVIR equiv)	-	1
zidovudine syrup (RETROVIR equiv)	-	1
zidovudine tab (RETROVIR equiv)	-	1
APTIVUS CAP	-	2
APTIVUS SOLN	-	2
BIKTARVY TAB	-	2
CIMDUO TAB	-	2
COMPLERA TAB	-	2
CRIXIVAN CAP	-	2
DELSTRIGO TAB	-	2
DOVATO TAB	-	2
EDURANT TAB	-	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.

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>ANTIVIRALS Cont.</b>		
ISENTRESS POWDER PACK	-	2
lamivudine tab (EPIVIR equiv)	-	2
LEXIVA SUSP	-	2
NORVIR CAP	-	2
NORVIR POWDER PACK	-	2
NORVIR SOLN	-	2
PIFELTRO TAB	-	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
TIVICAY PD TAB	-	2
TIVICAY TAB	-	2
TRIUMEQ PD TAB (QL= 1 tab/day)	QL	2
TRIUMEQ TAB (QL= 1 tab/day)	QL	2
TRIZIVIR TAB	-	2
TYBOST TAB	-	2
VIDEX SOLN	-	2

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>ANTIVIRALS Cont.</b>		
VIRACEPT TAB	-	2
VIREAD TAB	-	2
EMTRIVA CAP	-	2+penalty
KALETRA TAB	-	2+penalty
PREZISTA TAB	-	2+penalty
SELZENTRY TAB	-	2+penalty
SYMFI (LO) TAB	-	2+penalty
<b>ANTIVIRAL COMBINATIONS</b>		
PAXLOVID TAB 150-100MG (QL= 20 tabs/fill)	QL	2
PAXLOVID TAB 300-100MG (QL= 30 tabs/fill)	QL	2
<b>CMV AGENTS</b>		
valganciclovir soln (VALCYTE equiv)	-	1
valganciclovir tab (VALCYTE equiv)	-	1
LIVTENCITY TAB (QL= 4 tabs/day; Only available through Biologics 800-850-4306)	LD-PA-QL	2
<b>HEPATITIS AGENTS</b>		
RIBAVIRIN CAP	LMSP	1
ribavirin cap (REBETOL equiv)	LMSP	1
RIBAVIRIN TAB	LMSP	1

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>ANTIVIRALS Cont.</b>		
SOFOSBUVIR/VELPATASVIR TAB 400-100MG (QL= 1 tab/day)	PA-QL	1
BARACLUDE SOLN (Prior Authorization Required for members age 9 or older)	PA	2
EPCLUSA 200-50MG	PA	2
EPCLUSA 400-100MG	PA	2
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 PAK (QL= 5 packs/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
VEMLIDY TAB	-	2
<b>HERPES AGENTS</b>		
acyclovir cap (ZOVIRAX equiv)	-	1
acyclovir susp (ZOVIRAX equiv)	-	1
acyclovir tab (ZOVIRAX equiv)	-	1
famciclovir tab (FAMVIR equiv)	-	1
valacyclovir tab (VALTREX equiv)	-	1
<b>INFLUENZA AGENTS</b>		
oseltamivir cap (TAMIFLU equiv) (QL= 10 caps/fill)	QL	1

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>ANTIVIRALS Cont.</b>		
oseltamivir cap 30mg (TAMIFLU equiv) (QL= 20 caps/fill)	QL	1
oseltamivir susp (TAMIFLU equiv) (QL= 250ml/fill)	QL	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
XOFLUZA TAB THERAPY PACK 40MG (QL= 1 tab/fill; Covered for members 12 years of age or older)	QL	2
XOFLUZA TAB THERAPY PACK 80MG (QL= 1 tab/fill; Covered for members 12 years of age or older)	QL	2
<b>MISC. ANTIVIRALS</b>		
LAGEVRIO CAP (EUA) (QL= 40 caps/fill)	QL	\$0
LAGEVRIO CAP 200MG (QL= 40 caps/fill)	QL	2
<b>ASSORTED CLASSES</b>		
<b>CHELATING AGENTS</b>		
D-PENAMINE TAB	-	2
<b>IMMUNOMODULATORS</b>		
THALOMID CAP	MSP-PA	2
<b>IMMUNOSUPPRESSIVE AGENTS</b>		
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.

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>ASSORTED CLASSES Cont.</b>		
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
<b>POTASSIUM REMOVING RESINS</b>		
sodium polystyrene powder (KAYEXALATE equiv)	-	1
sodium polystyrene susp (SPS equiv)	-	1
VELTASSA POWDER	PA	2
<b>BETA BLOCKERS</b>		
<b>ALPHA-BETA BLOCKERS</b>		
carvedilol tab (COREG equiv)	-	1
labetalol tab (NORMODYNE equiv)	-	1
<b>BETA BLOCKERS CARDIO-SELECTIVE</b>		
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.

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>BETA BLOCKERS Cont.</b>		
bisoprolol tab (ZEBETA equiv)	-	1
metoprolol ER tab (TOPROL XL equiv)	-	1
metoprolol tab (LOPRESSOR equiv)	-	1
<b>BETA BLOCKERS NON-SELECTIVE</b>		
nadolol tab (CORGARD equiv)	-	1
pindolol tab (VISKEN equiv)	-	1
propranolol ER cap (INDERAL LA equiv)	-	1
propranolol oral soln 20mg/5ml (PROPRANOLOL 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
SOTYLIZE SOLN 5MG/ML (Prior Authorization Required for members age 9 or older)	PA	2
<b>CALCIUM CHANNEL BLOCKERS</b>		
<b>CALCIUM CHANNEL BLOCKERS</b>		
amlodipine tab (NORVASC equiv)	-	1
diltiazem ER cap (CARDIZEM CD equiv)	-	1
diltiazem ER cap (CARDIZEM SR equiv)	-	1
diltiazem ER cap (DILACOR XR equiv)	-	1
diltiazem ER cap (TIAZAC equiv)	-	1
diltiazem ER tab (CARDIZEM LA equiv)	-	1

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>CALCIUM CHANNEL BLOCKERS Cont.</b>		
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 SR cap (VERELAN equiv)	-	1
VERAPAMIL SR CAP 360mg	-	1
verapamil SR tab (CALAN SR, ISOPTIN SR equiv)	-	1
verapamil tab (CALAN equiv)	-	1
KATERZIA SUSP (Prior Authorization Required for members age 9 or older)	PA	2
NORLIQVA ORAL SOLN 1MG/ML (Members age 9 or older require Prior Authorization)	PA	2
<b>CARDIOTONICS</b>		
<b>CARDIAC GLYCOSIDES</b>		
digoxin soln (LANOXIN equiv)	-	1
DIGOXIN SOLN 0.05MG/ML	-	1
digoxin tab (LANOXIN equiv)	-	1
<b>CARDIOVASCULAR AGENTS - MISC.</b>		
<b>CARDIAC MYOSIN INHIBITORS</b>		
CAMZYOS CAP (QL= 1 cap/day; Only available through Accredo 800-803-2523 or Walgreens 888-347-3416)	LD-PA-QL	2
<b>PERIPHERAL VASODILATORS</b>		

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>CARDIOVASCULAR AGENTS - MISC. Cont.</b>		
isoxsuprine tab	-	1
<b>PROSTAGLANDIN VASODILATORS</b>		
TYVASO DPI POWDER (QL= 4 cartridges/day; Only available through Accredo 800-803-2523)	LD-PA-QL	2
TYVASO DPI POWDER MAINTENANCE KIT 32-48MCG (QL= 224 cartridges/28 days; Only available through Accredo 800-803-2523)	LD-PA-QL	2
TYVASO DPI POWDER TITRATION KIT 16-32-48MCG (QL= 252 cartridges/28 day Only available through Accredo 800-803-2523)	LD-PA-QL	2
TYVASO DPI POWDER TITRATION KIT 16-32MCG (QL= 196 cartridges/28 days; Only available through Accredo 800-803-2523)	LD-PA-QL	2
TYVASO INH SOLN (Only available through Accredo 800-803-2523)	LD-PA	2
VENTAVIS INH SOLN (Only available through Accredo 800-803-2523)	LD-PA	2
<b>PULMONARY HYPERTENSION - ENDOTHELIN RECEPTOR ANTAGONISTS</b>		
ambrisentan tab (LETAIRIS equiv) (QL= 1 tab/day; Restricted to Cardiology or Pulmonology Specialist; Only available through Lumicera 855-847-3553)	LD-QL-RS	1
bosentan tab (TRACLEER equiv) (QL= 2 tabs/day; Restricted to Cardiology or Pulmonology Specialist; Only available through Lumicera 855-847-3553)	LD-QL-RS	1
OPSUMIT TAB (QL= 1 tab/day; Only available through Accredo 800-803-2523)	LD-PA-QL	2
TRACLEER TAB 32MG (Only available through Accredo 800-803-2523)	LD-PA	2
<b>PULMONARY HYPERTENSION - PHOSPHODIESTERASE INHIBITORS</b>		
sildenafil tab 20mg (REVATIO equiv)	PA	1
tadalafil tab (PAH) (ADCIRCA equiv)	LMSP-PA	1

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>CARDIOVASCULAR AGENTS - MISC. Cont.</b>		
sildenafil susp (REVATIO equiv) (Members age 9 or older require Prior Authorization)	PA	2
TADLIQ SUSP (Prior Authorization Required for members age 9 or older)	PA	2
<b>SINUS NODE INHIBITORS</b>		
CORLANOR SOLN	PA	2
CORLANOR TAB	PA	2
<b>CEPHALOSPORINS</b>		
<b>CEPHALOSPORINS - 1ST GENERATION</b>		
cefadroxil cap (DURICEF equiv)	-	1
cefadroxil susp (DURICEF equiv)	-	1
CEFADROXIL TAB	-	1
cefadroxil tab (DURICEF equiv)	-	1
cephalexin cap (KEFLEX equiv)	-	1
cephalexin susp (KEFLEX equiv)	-	1
<b>CEPHALOSPORINS - 2ND GENERATION</b>		
CEFACLOX CAP	-	1
cefaclor cap (CECLOR equiv)	-	1
cefprozil susp (CEFZIL equiv)	-	1
cefprozil tab (CEFZIL equiv)	-	1
cefuroxime tab (CEFTIN equiv)	-	1
<b>CEPHALOSPORINS - 3RD GENERATION</b>		
cefdinir cap (OMNICEF equiv)	-	1
cefdinir susp (OMNICEF equiv)	-	1
cefixime susp (SUPRAX equiv)	-	1

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>CEPHALOSPORINS Cont.</b>		
cefepodoxime proxetil susp (VANTIN equiv)	-	1
cefepodoxime proxetil tab (VANTIN equiv)	-	1
<b>CONTRACEPTIVES</b>		
<b>COMBINATION CONTRACEPTIVES - ORAL</b>		
amethyst tab (LYBREL equiv)	-	\$0
ashlyna tab, daysee tab (SEASONALE, SEASONIQUE equiv)	-	\$0
BALCOLTRA TAB	-	\$0
cryselle tab	-	\$0
DESOGEN TAB	-	\$0
drospirenone/ethinyl estradiol/levomefolate tab (BEYAZ equiv)	-	\$0
enpresse tab (TRI-LEVELLEN equiv)	-	\$0
ESTROSTEP FE TAB	-	\$0
FALESSA KIT	-	\$0
FEMCON FE CHEW TAB	-	\$0
gianvi tab, ocella tab (YASMIN, YAZ equiv)	-	\$0
isibloom tab, enskyce tab, apri tab (DESOGEN equiv)	-	\$0
kelnor tab (DEMULEN equiv)	-	\$0
layolis FE tab, wymzya FE tab (FEMCON FE equiv)	-	\$0
levonorgestrel-ethinyl estradiol-fe tab (BALCOLTRA equiv)	-	\$0
LO LOESTRIN TAB	-	\$0
MINASTRIN CHEW TAB	-	\$0
MIRCETTE TAB	-	\$0

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>CONTRACEPTIVES Cont.</b>		
NATAZIA TAB	-	\$0
NEXTSTELLIS TAB	-	\$0
norethindrone ace-ethinyl estradiol-fe cap (TAYTULLA equiv)	-	\$0
norethindrone acetate/ethinyl estradiol FE chew tab (MINASTRIN equiv)	-	\$0
norethindrone acetate/ethinyl estradiol tab (LOESTRIN equiv)	-	\$0
norethindrone/ethinyl estradiol FE tab (LOESTRIN FE equiv)	-	\$0
nortrel 7/7/7 tab, pirmella 7/7/7 tab (TRI-NORINYL equiv)	-	\$0
nortrel tab (OVCON 35 equiv)	-	\$0
ORTHO TRI-CYCLEN (LO) TAB	-	\$0
ORTHO-CYCLEN TAB	-	\$0
OVCON 35 TAB	-	\$0
SAFYRAL TAB	-	\$0
sprintec 28 tab (ORTHO-CYCLEN equiv)	-	\$0
TAYTULLA CAP	-	\$0
tri-legest tab (ESTROSTEP FE equiv)	-	\$0
TRI-NORINYL TAB	-	\$0
tri-sprintec tab (ORTHO TRI-CYCLEN (LO) equiv)	-	\$0
TYBLUME TAB	-	\$0
VELIVET PAK	-	\$0
velivet tab (CYCLESSA equiv)	-	\$0
vienna tab, lessina tab, kurvelo tab (ALESSE equiv)	-	\$0
violele tab, kariva tab (MIRCETTE equiv)	-	\$0

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>CONTRACEPTIVES Cont.</b>		
YAZ TAB, YASMIN 28 TAB	-	\$0
<b>COMBINATION CONTRACEPTIVES - TRANSDERMAL</b>		
TWIRLA PATCH	-	\$0
zafemy patch (XULANE equiv)	-	\$0
<b>COMBINATION CONTRACEPTIVES - VAGINAL</b>		
ANNOVERA RING (QL= 1 ring/year)	QL	\$0
NUVARING	-	\$0
<b>COPPER CONTRACEPTIVES - IUD</b>		
PARAGARD IUD	-	\$0
<b>EMERGENCY CONTRACEPTIVES</b>		
ELLA TAB	-	\$0
levonorgestrel tab (PLAN B equiv)	OTC	\$0
PLAN B TAB	OTC	\$0
<b>PROGESTIN CONTRACEPTIVES - IMPLANTS</b>		
NEXPLANON IMPLANT	-	\$0
<b>PROGESTIN CONTRACEPTIVES - INJECTABLE</b>		
DEPO-PROVERA INJ	-	\$0
medroxyprogesterone inj (DEPO-PROVERA equiv) (QL= 1 inj/90 days)	QL	\$0
<b>PROGESTIN CONTRACEPTIVES - IUD</b>		
MIRENA IUD	-	\$0
<b>PROGESTIN CONTRACEPTIVES - ORAL</b>		
norethindrone tab (NORA-QD equiv)	-	\$0
NOR-QD TAB	-	\$0

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>CONTRACEPTIVES Cont.</b>		
SLYND TAB	-	\$0
<b>CORTICOSTEROIDS</b>		
<b>GLUCOCORTICOSTEROIDS</b>		
budesonide SR cap (ENTOCORT EC equiv)	-	1
DEXAMETHASONE CONC	-	1
dexamethasone elixir	-	1
dexamethasone sodium phosphate inj	-	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
methylprednisolone sod succinate inj (SOLU-MEDROL equiv)	-	1
prednisolone ODT (ORAPRED equiv)	-	1
prednisolone soln	-	1
prednisolone soln (PEDIAPRED equiv)	-	1
PREDNISONE SOLN	-	1
prednisone tab (DELTASONE equiv)	-	1
CORTISONE ACETATE TAB	-	2
PREDNISOLONE ODT TAB	-	2
SOLU-CORTEF INJ (QL= 1 vial/fill)	QL	2
SOLU-CORTEF INJ 100MG (QL= 2 vials/fill)	QL	2

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>CORTICOSTEROIDS Cont.</b>		
SOLU-MEDROL INJ 2GM	-	2
<b>MINERALOCORTICIDS</b>		
fludrocortisone tab (FLORINEF equiv)	-	1
<b>COUGH/COLD/ALLERGY</b>		
<b>ANTITUSSIVES</b>		
benzonatate cap (TESSALON equiv)	-	1
hydrocodone/homatropine syrup (HYCODAN equiv)	-	1
tussigon tab (HYCODAN equiv)	-	1
<b>COUGH/COLD/ALLERGY COMBINATIONS</b>		
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.

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>COUGH/COLD/ALLERGY Cont.</b>		
promethazine VC/codeine syrup (PHENERGAN VC/CODEINE equiv)	-	1
promethazine/codeine syrup (PHENERGAN/CODEINE equiv)	-	1
<b>EXPECTORANTS</b>		
guaifenesin ER tab (MUCINEX equiv)	OTC	1
guaifenesin syrup 100mg/5ml (ROBITUSSIN equiv)	OTC	1
potassium iodide oral soln (SSKI equiv)	-	1
SSKI ORAL SOLN	-	2+penalty
<b>MISC. RESPIRATORY INHALANTS</b>		
sodium chloride neb soln (HYPER-SAL equiv)	OTC	1
NEBUSAL NEB SOLN	-	2
<b>MUCOLYTICS</b>		
acetylcysteine soln (MUCOMYST equiv)	-	1
<b>DERMATOLOGICALS</b>		
<b>ACNE PRODUCTS</b>		
adapalene cream (DIFFERIN equiv)	-	1
adapalene gel (DIFFERIN equiv)	-	1
adapalene/benzoyl peroxide gel 0.1-2.5% (EPIDUO equiv)	-	1
amnestem cap, claravis cap, isotretinoin cap, myorisan cap, zenatane cap (ACUTANE equiv)	-	1
benzoyl peroxide cream (NEOBENZ equiv)	OTC	1
benzoyl peroxide gel (OTC) (BENZAC equiv)	OTC	1
benzoyl peroxide liquid (BENZAC equiv)	OTC	1

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>DERMATOLOGICALS Cont.</b>		
benzoyl peroxide lotion (OTC) (TRIAZ equiv)	OTC	1
clindamycin gel (CLEOCIN GEL equiv)	-	1
clindamycin lotion (CLEOCIN- T equiv)	-	1
clindamycin pad (CLEOCIN-T equiv)	-	1
clindamycin topical soln (CLEOCIN-T equiv)	-	1
clindamycin/benzoyl peroxide gel (BENZACLIN equiv)	-	1
clindamycin/benzoyl peroxide gel (DUAC GEL equiv)	-	1
DIFFERIN OTC GEL 0.1%	OTC	1
erythromycin gel	-	1
erythromycin pad	-	1
erythromycin soln	-	1
sodium sulfacetamide lotion (KLARON equiv)	-	1
sodium sulfacetamide/sulfur cleanser 10-5% (SUMAXIN equiv)	-	1
sodium sulfacetamide/sulfur cleanser 9-4.5% (SUMADAN WASH equiv)	-	1
sodium sulfacetamide/sulfur emulsion (ROSULA equiv)	-	1
sodium sulfacetamide/sulfur foam (CLARIFOAM EF equiv)	-	1
sodium sulfacetamide/sulfur gel (ROSULA equiv)	-	1
sulfacetamide sodium/sulfur cream 10-5% (PLEXION SCT equiv)	-	1
tretinoin cream	-	1
tretinoin gel (RETIN-A GEL equiv)	-	1
ALTRENO LOTION	-	2
AVAR GEL	-	2

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>DERMATOLOGICALS Cont.</b>		
ERY PAD	-	2
PRASCION RA CREAM	-	2
ATRALIN GEL, RETIN-A GEL	-	2+penalty
CLEOCIN-T GEL	-	2+penalty
RETIN-A CREAM	-	2+penalty
SUMADAN WASH 9-4.5%	-	2+penalty
<b>AGENTS FOR WRINKLES/LIPOATROPHY/OTHER AESTHETIC USES</b>		
RENOVA CREAM	-	EXC
<b>ANTIBIOTICS - TOPICAL</b>		
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
<b>ANTIFUNGALS - TOPICAL</b>		
ciclopirox cream (LOPROX CREAM equiv)	-	1
ciclopirox gel (LOPROX GEL equiv)	-	1

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>DERMATOLOGICALS Cont.</b>		
ciclopirox nail soln (PENLAC equiv)	-	1
ciclopirox shampoo (LOPROX SHAMPOO equiv)	-	1
ciclopirox topical susp (LOPROX SUSP equiv)	-	1
clotrimazole cream (LOTRIMIN AF equiv)	OTC	1
clotrimazole/betamethasone cream (LORTRISONE CREAM 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
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
NIZORAL A-D SHAMPOO	OTC	1
nizoral a-d shampoo (NIZORAL equiv)	OTC	1
nystatin cream (MYCOSTATIN CREAM equiv)	-	1
nystatin oint	-	1
nystatin topical powder	-	1
nystatin/triamcinolone cream	-	1
nystatin/triamcinolone oint	-	1
terbinafine cream (LAMISIL AT equiv)	OTC	1
tolnaftate aerosol (TINACTIN equiv)	OTC	1

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>DERMATOLOGICALS Cont.</b>		
tolnaftate cream (TINACTIN equiv)	OTC	1
tolnaftate powder (TINACTIN equiv)	OTC	1
tolnaftate soln (TINACTIN equiv)	OTC	1
<b>ANTI-INFLAMMATORY AGENTS - TOPICAL</b>		
diclofenac gel 1% (VOLTAREN equiv) (QL= 5 tubes/fill)	QL	1
<b>ANTINEOPLASTIC OR PREMALIGNANT LESION AGENTS - TOPICAL</b>		
bexarotene gel (TARGRETIN equiv)	LMSP-PA	1
diclofenac gel (SOLARAZE equiv) (QL= 300gm/30 days)	QL	1
fluorouracil cream (EFUDEX CREAM equiv)	-	1
FLUOROURACIL CREAM 0.5%	-	2
VALCHLOR GEL (QL= 4 tubes/30 days; Only available through Optum Pharmacy 877-445-6874)	LD-PA-QL	2
<b>ANTIPSORIATICS</b>		
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
METHOXSALEN CAP	-	2
SKYRIZI INJ 150MG/ML (QL= 1 inj/84 days)	LMSP-PA-QL	2
SKYRIZI INJ 75MG/0.83ML (QL= 2 inj/84 days)	LMSP-PA-QL	2
STELARA INJ (QL= 1 inj/84 days)	LMSP-PA-QL	2

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>DERMATOLOGICALS Cont.</b>		
TALTZ INJ (QL= 1 inj/28 days)	LMSP-PA-QL	2
tazarotene cream 0.1% (TAZORAC equiv)	-	2
TAZORAC CREAM 0.05%	-	2
TREMFYA	PA	2
ZORYVE CREAM (QL= 60 grams/30 days)	PA-QL	2
<b>ANTISEBORRHEIC PRODUCTS</b>		
selenium sulfide lotion	OTC	1
selenium sulfide lotion 2.5% (SELSUN equiv)	-	1
selenium sulfide shampoo (SELSEB equiv)	-	1
sodium sulfacetamide wash (OVACE WASH equiv)	-	1
<b>ANTIVIRALS - TOPICAL</b>		
acyclovir oint (ZOVIRAX OINT equiv)	-	1
acyclovir cream 5%	-	2
<b>BURN PRODUCTS</b>		
silver sulfadiazine cream (SILVADENE CREAM equiv)	-	1
mafenide acetate soln packet (SULFAMYLON equiv)	-	2
SULFAMYLON CREAM	-	2
<b>CORTICOSTEROIDS - TOPICAL</b>		
alclometasone cream (ACLOVATE equiv)	-	1
alclometasone oint (ACLOVATE OINT equiv)	-	1
betamethasone augmented cream (DIPROLENE AF CREAM equiv)	-	1
betamethasone augmented gel	-	1

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>DERMATOLOGICALS Cont.</b>		
betamethasone augmented oint (DIPROLENE OINT equiv)	-	1
betamethasone dipropionate cream (DIPROSONE CREAM equiv)	-	1
betamethasone dipropionate lotion	-	1
betamethasone valerate cream	-	1
betamethasone valerate lotion	-	1
betamethasone valerate oint	-	1
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 shampoo (CLOBEX SHAMPOO equiv)	PA	1
clobetasol spray	PA	1
desoximetasone oint (TOPICORT equiv)	-	1
fluocinolone acetonide cream	-	1
fluocinolone acetonide oint	-	1
fluocinolone acetonide soln	-	1
fluocinonide cream 0.05% (LIDEX equiv)	-	1
fluocinonide cream 0.1% (VANOS CREAM equiv)	-	1
fluocinonide emollient cream	-	1
fluocinonide gel	-	1

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>DERMATOLOGICALS Cont.</b>		
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
hydrocortisone cream	OTC	1
hydrocortisone lotion (HYTONE equiv)	-	1
hydrocortisone lotion 2% (ALA SCALP 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
PRAMOSONE CREAM 1-1%	-	2
desonide cream (DESOWEN equiv)	-	2
desonide oint (DESOWEN equiv)	-	2
desoximetasone cream (DESOXIMETASONE equiv)	-	2
EPIFOAM AEROSOL	-	2

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>DERMATOLOGICALS Cont.</b>		
PRAMOSONE E CREAM	-	2
PREDNICARBATE CREAM	-	2
PREDNICARBATE OIN	-	2
CLOBEX SPRAY	PA	2+penalty
OLUX FOAM	PA	2+penalty

### ECZEMA AGENTS

ADBRY INJ (QL= 4 inj/28 days)	LMSP-PA-QL	2
CIBINQO TAB (QL= 1 tab/day)	LMSP-PA-QL	2
DUPIXENT INJ (QL= 2 inj/28 days)	LMSP-PA-QL	2
DUPIXENT PEN INJ (QL= 2 inj/28 days)	LMSP-PA-QL	2
OPZELURA CREAM (QL= 12 tubes/year)	PA-QL	2

### EMOLLIENTS

ammonium lactate cream (LAC-HYDRIN equiv)	OTC	1
ammonium lactate lotion (LAC-HYDRIN equiv)	OTC	1
LACTIC ACID LOTION	-	1
vitamin E liquid	OTC	1

### HAIR GROWTH AGENTS

bimatoprost ophth soln	-	EXC
finasteride tab (PROPECIA equiv)	-	EXC

### HAIR REDUCTION AGENTS

VANIQA CREAM	-	EXC
--------------	---	-----

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>DERMATOLOGICALS Cont.</b>		
<b>IMMUNOMODULATING AGENTS - TOPICAL</b>		
imiquimod cream (ALDARA equiv)	-	1
<b>IMMUNOSUPPRESSIVE AGENTS - TOPICAL</b>		
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
HYFTOR GEL (QL= 10 grams/30 days)	PA-QL	2
<b>KERATOLYTIC/ANTIMITOTIC AGENTS</b>		
PODOFILOX SOLN	-	1
podofilox soln (CONDYLOX equiv)	-	1
salicylic acid liquid 17%	OTC	1
salicylic acid pads 40%	OTC	1
salicylic acid shampoo (SALEX equiv)	-	1
PODOCON SOLN	-	2
<b>LOCAL ANESTHETICS - TOPICAL</b>		
lidocaine cream 3% (LIDAMANTLE equiv)	-	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
LIDOCAINE GEL	-	2
<b>MISC. TOPICAL</b>		

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>DERMATOLOGICALS Cont.</b>		
DRYSOL SOLN	-	1
<b>PIGMENTING-DEPIGMENTING AGENTS</b>		
hydroquinone cream (LUSTRA equiv)	-	EXC
TRI-LUMA CREAM	-	EXC
<b>ROSACEA AGENTS</b>		
azelaic acid gel (FINACEA equiv)	-	1
metronidazole cream (METROCREAM equiv)	-	1
metronidazole gel (METROGEL equiv)	-	1
metronidazole gel 0.75% (METROGEL equiv)	-	1
metronidazole lotion (METROLOTION equiv)	-	1
FINACEA FOAM	-	2
RHOFADE CREAM	-	EXC
<b>SCABICIDES &amp; PEDICULICIDES</b>		
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 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

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>DERMATOLOGICALS Cont.</b>		
<b>WOUND CARE PRODUCTS</b>		
REGRANEX GEL (QL= 30gm/fill)	QL	2
<b>DIAGNOSTIC PRODUCTS</b>		
<b>DIAGNOSTIC DRUGS</b>		
GLUCAGEN INJ	-	2
GLUCAGON DIAGNOSTIC INJ (QL= 2 inj/fill, 1 fill/30 days)	QL	2
<b>DIAGNOSTIC TESTS</b>		
COVID-19 TEST (QL= 8 tests/30 days)	OTC-QL	\$0
CLINISTIX TEST STRIP	OTC	1
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
ONETOUCH TEST STRIP	OTC	2
ONETOUCH VERIO TEST STRIP	OTC	2
PRECISION XTRA KETONE TEST STRIP	OTC	2
CUE COVID-19 INJ TEST CARTRIDGE	OTC	EXC
CUE HEALTH MONITOR	OTC	EXC
<b>DIETARY PRODUCTS/DIETARY MANAGEMENT PRODUCTS</b>		
<b>DIETARY MANAGEMENT PRODUCTS</b>		
ASTAMED MYO CAP	-	EXC

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>DIETARY PRODUCTS/DIETARY MANAGEMENT PRODUCTS Cont.</b>		
DEPLIN CAP	-	EXC
ELIGEN B12 TAB	-	EXC
FALESSA TAB	-	EXC
GLYGEST PAK	-	EXC
L-METHYLFOLATE TAB	-	EXC
LUVIRA CAP	-	EXC
METANX CAP	-	EXC
OLLIZAC POWDER	-	EXC
PODIAPN CAP	-	EXC
XAQUIL XR TAB	-	EXC
XYZBAC TAB	-	EXC
<b>DIGESTIVE AIDS</b>		
<b>DIGESTIVE ENZYMES</b>		
CREON CAP	-	2
PANCREAZE CAP	-	2
<b>DIURETICS</b>		
<b>CARBONIC ANHYDRASE INHIBITORS</b>		
acetazolamide ER cap (DIAMOX SEQUEL equiv)	-	1
acetazolamide tab	-	1
methazolamide tab (NEPTAZANE equiv)	-	1
<b>DIURETIC COMBINATIONS</b>		
AMILORIDE/HCTZ TAB	-	1
amiloride/hydrochlorothiazide tab (MODURETIC equiv)	-	1

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>DIURETICS Cont.</b>		
spironolactone/hydrochlorothiazide tab (ALDACTAZIDE equiv)	-	1
triamterene/hydrochlorothiazide cap (DYAZIDE equiv)	-	1
triamterene/hydrochlorothiazide tab (MAXZIDE equiv)	-	1
<b>LOOP DIURETICS</b>		
bumetanide tab (BUMEX equiv)	-	1
ethacrynic tab (EDECRIN equiv)	-	1
FUROSEMIDE SOLN	-	1
furosemide soln (LASIX equiv)	-	1
furosemide tab (LASIX equiv)	-	1
torsemide tab (DEMADEX equiv)	-	1
<b>POTASSIUM SPARING DIURETICS</b>		
amiloride tab (MIDAMOR equiv)	-	1
spironolactone tab (ALDACTONE equiv)	-	1
spironolactone susp (CAROSPIR equiv) (Prior Authorization required for members age 9 or older)	PA	2
CAROSPIR SUSP	-	2+penalty
<b>THIAZIDES AND THIAZIDE-LIKE DIURETICS</b>		
CHLOROTHIAZIDE TAB	-	1
chlorothiazide tab (DIURIL equiv)	-	1
chlorthalidone tab	-	1
hydrochlorothiazide cap (MICROZIDE equiv)	-	1
hydrochlorothiazide tab (HYDRODIURIL equiv)	-	1

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>DIURETICS Cont.</b>		
indapamide tab (LOZOL equiv)	-	1
metolazone tab (ZAROXOLYN equiv)	-	1
DIURIL SUSP	-	2
<b>ENDOCRINE AND METABOLIC AGENTS - MISC.</b>		
<b>BONE DENSITY REGULATORS</b>		
alendronate tab (FOSAMAX equiv)	-	1
calcitonin inj (MIACALCIN equiv)	LMSP	1
ALENDRONATE TAB 40MG	-	2
<b>CORTICOTROPIN</b>		
ACTHAR GEL INJ (QL= 4 vials/fill; Only available through Accredo 800-803-2523 or Walgreens 888-347-3416)	LD-PA-QL	2
<b>FERTILITY REGULATORS</b>		
CLOMID TAB	INF	EXC
CLOMIPHENE TAB	INF	EXC
OVIDREL INJ	INF	EXC
<b>GNRH/LHRH ANTAGONISTS</b>		
cetrorelix acetate for inj kit (CETROTIDE equiv)	INF	EXC
CETROTIDE KIT	INF	EXC
<b>GROWTH HORMONE RECEPTOR ANTAGONISTS</b>		
SOMAVERT INJ (Only available through Accredo 800-803-2523 or Walgreens 888-347-3416)	LD-PA	2
<b>GROWTH HORMONE RELEASING HORMONES (GHRH)</b>		
EGRIFTA INJ	-	EXC

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>ENDOCRINE AND METABOLIC AGENTS - MISC. Cont.</b>		
<b>GROWTH HORMONES</b>		
GENOTROPIN INJ	LMSP-PA	2
SKYTROFA INJ	LMSP-PA	2
SOGROYA INJ	LMSP-PA	2
<b>HORMONE RECEPTOR MODULATORS</b>		
raloxifene tab (EVISTA equiv)	-	1
<b>INSULIN-LIKE GROWTH FACTORS (SOMATOMEDINS)</b>		
INCRELEX INJ (Only available through Accredo 800-803-2523 or Walgreens 888-347-3416)	LD	2
<b>METABOLIC MODIFIERS</b>		
calcitriol cap (ROCALtrol equiv)	-	1
calcitriol soln (ROCALtrol equiv)	-	1
doxercalciferol cap (HECTOROL equiv)	-	1
levocarnitine soln (CARNITOR equiv)	-	1
levocarnitine tab (CARNITOR equiv)	-	1
paricalcitol cap (ZEMPLAR equiv)	-	1
sodium phenylbutyrate powder (BUPHENYL equiv)	PA	1
sodium phenylbutyrate tab (BUPHENYL equiv)	PA	1
carglumic acid tab (CARBAGLU equiv) (Only available through AnovoRx 844-288-5007)	LD-PA	2
PHEBURANE ORAL PELLETS (Only available through Accredo 800-803-2523; Ste Therapy requires trial of sodium phenylbutyrate)	LD-ST	2

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>ENDOCRINE AND METABOLIC AGENTS - MISC. Cont.</b>		
RAVICTI LIQUID (Step Therapy requires trial of sodium phenylbutyrate and Pheburane Oral Pellets)	ST	2
<b>NATRIURETIC PEPTIDES</b>		
VOXZOGO INJ (QL= 1 vial/day; Only available through Accredo 888-773-7376)	LD-PA-QL	2
<b>POSTERIOR PITUITARY HORMONES</b>		
desmopressin acetate inj (DDAVP equiv)	-	1
desmopressin acetate nasal spray (DDAVP equiv)	-	1
desmopressin acetate tab (DDAVP equiv)	-	1
STIMATE NASAL SOLN	-	2
DDAVP INJ	-	2+pe nalty
<b>PROGESTERONE RECEPTOR ANTAGONISTS</b>		
mifepristone tab (MIFIPREX equiv)	-	1
<b>PROLACTIN INHIBITORS</b>		
cabergoline tab (DOSTINEX equiv)	-	1
<b>SOMATOSTATIC AGENTS</b>		
octreotide inj (SANDOSTATIN equiv)	LMSP	1
OCTREOTIDE INJ 100MCG	LMSP	1
<b>ESTROGENS</b>		
<b>ESTROGEN COMBINATIONS</b>		
esterified estrogens/methyltestosterone tab (ESTRATEST equiv)	-	1
estradiol/norethindrone tab (ACTIVEVELLA equiv)	-	1
jinteli tab (FEMHRT equiv)	-	1

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>ESTROGENS Cont.</b>		
MYFEMBREE TAB (QL= 1 tab/day)	PA-QL	2
PREMPHASE TAB, PREMPRO TAB	-	2
<b>ESTROGENS</b>		
estradiol patch (CLIMARA equiv)	-	1
estradiol patch (VIVELLE-DOT equiv)	-	1
estradiol tab (ESTRACE equiv)	-	1
estradiol valerate inj (DELESTROGEN equiv) (QL= 5ml/fill)	PA-QL	1
PREMARIN TAB	-	2
<b>FLUOROQUINOLONES</b>		
<b>FLUOROQUINOLONES</b>		
ciprofloxacin susp (CIPRO equiv)	-	1
ciprofloxacin tab (CIPRO equiv)	-	1
levofloxacin soln (LEVAQUIN equiv)	-	1
LEVOFLOXACIN SOLN 25MG/ML	-	1
levofloxacin tab (LEVAQUIN equiv)	-	1
moxifloxacin tab (AVELOX equiv)	-	1
ofloxacin tab (FLOXIN equiv)	-	1
<b>GASTROINTESTINAL AGENTS - MISC.</b>		
<b>GALLSTONE SOLUBILIZING AGENTS</b>		
ursodiol cap (ACTIGALL equiv)	-	1
ursodiol tab (URSO (FORTE) equiv)	-	1
<b>GASTROINTESTINAL ANTIALLERGY AGENTS</b>		
cromolyn conc (GASTROCROM equiv)	-	2

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>GASTROINTESTINAL AGENTS - MISC. Cont.</b>		
<b>GASTROINTESTINAL STIMULANTS</b>		
metoclopramide soln (REGLAN equiv)	-	1
metoclopramide tab (REGLAN equiv)	-	1
<b>ILEAL BILE ACID TRANSPORTER (IBAT) INHIBITORS</b>		
BYLVAY CAP 1200MCG (QL= 5 caps/day; Only available through PantheRx Pharmacy 855-726-8479)	LD-PA-QL	2
BYLVAY CAP 400MCG (QL= 15 caps/day; Only available through PantheRx Pharmacy 855-726-8479)	LD-PA-QL	2
BYLVAY SPRINKLE CAP 200MCG (QL= 8 caps/day; Only available through PantheRx Pharmacy 855-726-8479)	LD-PA-QL	2
BYLVAY SPRINKLE CAP 600MCG (QL= 4 caps/day; Only available through PantheRx Pharmacy 855-726-8479)	LD-PA-QL	2
LIVMARLI SOLN (QL= 90ml/30 days; Only available through Eversana 866-849-4481)	LD-PA-QL	2
<b>INFLAMMATORY BOWEL AGENTS</b>		
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 CR CAP 250MG	-	2

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>GASTROINTESTINAL AGENTS - MISC. Cont.</b>		
SKYRIZI INJ 180 MG/1.2ML	LMSP-PA-QL	2
SKYRIZI INJ 360MG/2.4ML	LMSP-PA-QL	2
<b>INTESTINAL ACIDIFIERS</b>		
lactulose soln	-	1
<b>IRRITABLE BOWEL SYNDROME (IBS) AGENTS</b>		
alosetron tab (LOTROXON equiv)	-	1
LINZESS CAP (QL= 1 cap/day)	PA-QL	2
<b>LIVE FECAL MICROBIOTA</b>		
VOWST CAP (QL= 12 caps/fill; Only available through Orsini 800-410-8575)	LD-PA-QL	2
<b>PHOSPHATE BINDER AGENTS</b>		
calcium acetate cap (PHOSLO equiv)	-	1
sevelamer powder pak (REVELA PAK equiv)	-	1
sevelamer tab (REVELA TAB equiv)	-	1
<b>GENITOURINARY AGENTS - MISCELLANEOUS</b>		
<b>ALKALINIZERS</b>		
CYTRA K CRYSTALS	-	1
CYTRA-3 SYRUP	-	1
ORACIT SOLN	-	1
potassium citrate CR tab (UROKIT-K TAB equiv)	-	1
potassium citrate/citric acid powder pack (POLYKITRA equiv)	-	1
potassium citrate/citric acid soln (POLYKITRA-K equiv)	-	1
sodium citrate/citric acid soln (BICITRA equiv)	-	1
tricitrates soln (POLYKITRA-LC equiv)	-	1

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>GENITOURINARY AGENTS - MISCELLANEOUS Cont.</b>		
<b>CYSTINOSIS AGENTS</b>		
CYSTAGON CAP (Only available through CVS Specialty 800-238-7828)	LD	2
<b>IGA NEPHROPATHY (IGAN) AGENTS</b>		
FILSPARI TAB (QL= 1 tab/day; Only available through Accredo 800-803-2523)	LD-PA-QL	2
<b>INTERSTITIAL CYSTITIS AGENTS</b>		
ELMIRON CAP	-	2
<b>PROSTATIC HYPERTROPHY AGENTS</b>		
dutasteride cap (AVODART equiv)	-	1
finasteride tab (PROSCAR equiv)	-	1
tamsulosin cap (FLOMAX equiv)	-	1
alfuzosin SR tab (UROXATRAL equiv)	-	2
<b>URINARY ANALGESICS</b>		
phenazopyridine tab (PYRIDIUM equiv)	-	1
phenazopyridine tab 95mg (AZO equiv)	OTC	1
phenazopyridine tab 97.5mg (AZO equiv)	OTC	1
phenazopyridine tab 99.5mg (AZO equiv)	OTC	1
<b>URINARY STONE AGENTS</b>		
tiopronin tab (THIOLA equiv)	LMSP-PA	1
THIOLA EC TAB	LMSP-PA	2
<b>GOUT AGENTS</b>		
<b>GOUT AGENT COMBINATIONS</b>		
colchicine/probenecid tab (COL-BENEMID equiv)	-	1

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>GOUT AGENTS Cont.</b>		
allopurinol tab (ZYLOPRIM equiv)	-	1
colchicine tab (COLCRYS equiv)	-	1
GLOPERBA SOLN (Prior Authorization Required for members age 9 or older)	PA	2
<b>URICOSURICS</b>		
probenecid tab (BENEMID equiv)	-	1
<b>HEMATOLOGICAL AGENTS - MISC.</b>		
<b>ANTIHEMOPHILIC PRODUCTS</b>		
HEMLIBRA INJ	LMSP-PA	2
<b>BRADYKININ B2 RECEPTOR ANTAGONISTS</b>		
icatibant inj (FIRAZYR equiv)	LMSP-PA	1
<b>COMPLEMENT INHIBITORS</b>		
BERINERT INJ (Only available through Accredo 800-803-2523)	LD-PA	2
CINRYZE INJ (QL= 16 vials/28 days; Only available through Accredo 800-803-2523)	LD-PA-QL	2
EMPAVELI INJ (QL= 160ml/28 days; Only available through PantheRx 855-726-8479)	LD-PA-QL	2
HAEGARDA INJ (Only available through Accredo 800-803-2523)	LD-PA	2
RUCONEST INJ (Only available through Accredo 800-803-2523)	LD-PA	2
TAVNEOS CAP (QL= 6 caps/day; Only available through PantheRx 855-726-8479)	LD-PA-QL	2
<b>HEMATORHEOLOGIC AGENTS</b>		
pentoxifylline ER tab (TRENTAL equiv)	-	1
<b>PLASMA KALLIKREIN INHIBITORS</b>		
TAKHZYRO INJ (QL= 2 inj/28 days; Only available through Accredo 800-803-2523)	LD-PA-QL	2
TAKHZYRO INJ 150MG/ML (QL= 2 inj/28 days; Only available through Accredo 800-803-2523)	LD-PA-QL	2

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>HEMATOLOGICAL AGENTS - MISC. Cont.</b>		
<b>PLATELET AGGREGATION INHIBITORS</b>		
anagrelide cap (AGRYLIN equiv)	-	1
cilostazol tab (PLETAL equiv)	-	1
clopidogrel tab 75mg (PLAVIX equiv)	-	1
dipyridamole tab (PERSANTINE equiv)	-	1
<b>PYRUVATE KINASE ACTIVATORS</b>		
PYRUKYND TAB (QL= 2 tabs/day; Only available through Biologics 800-850-4306)	LD-PA-QL	2
PYRUKYND TAPER PACK (QL= 1 tab/day; Only available through Biologics 800-850-4306)	LD-PA-QL	2
<b>HEMATOPOIETIC AGENTS</b>		
<b>AGENTS FOR GAUCHER DISEASE</b>		
miglustat cap (ZAVESCA equiv) (Only available through Accredo 800-803-2523)	LD-PA	1
CEREZYME INJ	MSP-PA	2
<b>AGENTS FOR SICKLE CELL ANEMIA</b>		
DROXIA CAP	-	2
OXBRYTA TAB (QL= 3 tabs/day; Only available through Accredo 800-803-2523)	LD-PA-QL	2
<b>AGENTS FOR SICKLE CELL DISEASE</b>		
ENDARI POWDER PACK (QL= 6 packets/day)	LMSP-PA-QL	2
OXBRYTA TAB FOR ORAL SUSP (QL= 5 tabs/day; Only available through Accredo 800-803-2523)	LD-PA-QL	2
<b>COBALAMINS</b>		
cyanocobalamin inj	-	1
<b>FOLIC ACID/FOLATES</b>		

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>HEMATOPOIETIC AGENTS Cont.</b>		
folic acid tab 1mg	-	\$0
folic acid tab 400mcg	OTC	\$0
folic acid tab 800mcg	OTC	\$0
<b>HEMATOPOIETIC GROWTH FACTORS</b>		
FULPHILA INJ	PA	2
NIVESTYM INJ	LMSP	2
NYVEPRIA INJ	LMSP	2
RETACRIT INJ	-	2
ZARXIO INJ	LMSP	2
<b>HEMATOPOIETIC MIXTURES</b>		
ferrex 150 forte cap	-	1
folbee tab	-	1
MULTIGEN FOLIC TAB	-	1
MULTIGEN PLUS TAB	-	1
MULTIGEN TAB	-	1
tricon cap (TRINSICON equiv)	-	1
NEPHRON FA TAB	-	2
<b>IRON</b>		
ferrous sulfate soln (FER-IN-SOL equiv)	OTC	1
iron complex cap 150mg	OTC	1

## HEMOSTATICS

### HEMOSTATICS - SYSTEMIC

aminocaproic acid soln (AMICAR equiv)	-	1
---------------------------------------	---	---

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>HEMOSTATICS Cont.</b>		
aminocaproic acid tab (AMICAR equiv)	-	1
tranexamic acid tab (LYSTEDA equiv)	QL	2
<b>HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS</b>		
<b>ANTI-HISTAMINE HYPNOTICS</b>		
diphenhydramine cap (OTC only)	OTC	1
diphenhydramine cap 50mg (BENADRYL equiv) (Only 50mg covered)	-	1
diphenhydramine tab (NYTOL equiv)	OTC	1
<b>BARBITURATE HYPNOTICS</b>		
phenobarbital elixir	-	1
phenobarbital tab	-	1
SECONAL CAP	-	2
<b>NON-BARBITURATE HYPNOTICS</b>		
estazolam tab (PROSOM equiv)	-	1
eszopiclone tab (LUNESTA equiv) (QL= 1 tab/day)	QL	1
midazolam inj (MIDAZOLAM equiv) (Restricted to Neurology Specialist)	RS	1
temazepam cap 15mg (RESTORIL equiv)	-	1
temazepam cap 30mg (RESTORIL equiv)	-	1
triazolam tab (HALCION equiv)	-	1
zaleplon cap (SONATA equiv) (QL= 1 cap/day)	QL	1
FLURAZEPAM CAP	-	2
<b>LAXATIVES</b>		
<b>LAXATIVE COMBINATIONS</b>		
GOLYTELY SOLN	-	1

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>LAXATIVES Cont.</b>		
peg 3350/electrolytes soln (GOLYTELY/COLYTE equiv)	-	1
peg 3350/electrolytes soln (NULYTELY equiv)	-	1
<b>LAXATIVES - MISCELLANEOUS</b>		
glycerin supp (GLYCERIN equiv)	OTC	1
lactulose soln	-	1
polyethylene glycol 3350 powder (MIRALAX equiv)	OTC	1
MIRALAX PACKET	OTC	2+penalty
MIRALAX POWDER	OTC	2+penalty
<b>SALINE LAXATIVES</b>		
milk of magnesium	OTC	1
<b>STIMULANT LAXATIVES</b>		
senna cap (SENOKOT equiv)	OTC	1
senna syrup (SENOKOT equiv)	OTC	1
senna tab (SENOKOT equiv)	OTC	1
<b>SURFACTANT LAXATIVES</b>		
docusate calcium cap (KAOPECTATE equiv)	OTC	1
docusate sodium cap (COLACE equiv)	OTC	1
docusate sodium liquid (COLACE equiv)	OTC	1
docusate sodium syrup (COLACE equiv)	OTC	1
docusate sodium tab (COLACE equiv)	OTC	1
DOCUSATE SYRUP	OTC	1

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>MACROLIDES</b>		
<b>AZITHROMYCIN</b>		
azithromycin susp (ZITHROMAX equiv)	-	1
azithromycin tab (ZITHROMAX equiv)	-	1
ZITHROMAX POWDER PACK	-	1
<b>CLARITHROMYCIN</b>		
clarithromycin ER tab (BIAXIN XL equiv)	-	1
clarithromycin tab (BIAXIN equiv)	-	1
CLARITHROMYC SUSP	-	2
<b>ERYTHROMYCINS</b>		
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
<b>FIDAXOMICIN</b>		
DIFICID SUSP (QL= 136 mL/fill; Step Therapy requires trial of vancomycin cap, FIRST-VANCOMYCIN SOLN, or FIRVANQ SOLN)	QL-ST	2
DIFICID TAB (QL= 20 tabs/fill; Step Therapy requires trial of vancomycin cap, FIRST-VANCOMYCIN SOLN, or FIRVANQ SOLN)	QL-ST	2
<b>MEDICAL DEVICES AND SUPPLIES</b>		
<b>CONTRACEPTIVES</b>		
FEMALE CONDOMS	OTC	\$0
MALE CONDOMS	OTC	\$0

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>MEDICAL DEVICES AND SUPPLIES Cont.</b>		
DIAPHRAGM	-	2
<b>DIABETIC SUPPLIES</b>		
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
ONETOUCH METER	OTC	\$0
ONETOUCH VERIO FLEX METER	OTC	\$0
ONETOUCH VERIO IQ METER	OTC	\$0
ONETOUCH VERIO METER	OTC	\$0
ONETOUCH VERIO REFLECT METER	OTC	\$0
CALIBRATION LIQUID	OTC	1
LANCET KIT	OTC	1
LANCETS	OTC	1
<b>MISC. DEVICES</b>		
ALCOHOL SWABS	OTC	2
<b>PARENTERAL THERAPY SUPPLIES</b>		
B-D INSULIN SYRINGE	--OTC	1
B-D PEN NEEDLE	OTC	1
CARETOUCH MIS	OTC	1
NOVOFINE PEN NEEDLE	OTC	1
NOVOTWIST PEN NEEDLE	OTC	1

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>MEDICAL DEVICES AND SUPPLIES Cont.</b>		
NOVOTWIST/NOVOFINE PEN NEEDLE	OTC	1
<b>RESPIRATORY THERAPY SUPPLIES</b>		
PEAK FLOW METER	OTC	1
AEROCHAMBER	OTC	2
<b>MIGRAINE PRODUCTS</b>		
<b>CALCITONIN GENE-RELATED PEPTIDE (CGRP) RECEPTOR ANTAG</b>		
ZAVZPRET NASAL SPRAY (QL= 6 units/fill; 60 units/365 days)	PA-QL	2
<b>MIGRAINE PRODUCTS - MONOCLONAL ANTIBODIES</b>		
AIMOVIG INJ (QL= 1 pack/28 days)	PA-QL	2
AJOVY INJ (QL= 1 pack/28 days)	PA-QL	2
EMGALITY INJ (QL= 1 inj/28 days)	PA-QL	2
EMGALITY INJ 100MG/ML (QL= 3 inj/fill, 6 fills/year)	PA-QL	2
<b>SEROTONIN AGONISTS</b>		
naratriptan tab (AMERGE equiv) (QL= 9 tabs/30 days; Step Therapy requires a trial rizatriptan or sumatriptan)	QL-ST	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

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month fo first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>MINERALS &amp; ELECTROLYTES</b>		
<b>CALCIUM</b>		
calcium carbonate susp	OTC	1
calcium carbonate tab	OTC	1
calcium w/vitamin D tab	OTC	1
CALCIUM W/ VITAMIN D TAB	OTC	2
<b>FLUORIDE</b>		
sodium fluoride chew tab (LURIDE equiv)	-	\$0
sodium fluoride soln (LURIDE SOLN. equiv)	-	\$0
SODIUM FLUORIDE TAB	-	\$0
FLUORABON SOLN	-	2
<b>PHOSPHATE</b>		
phospha 250 neutral tab (K-PHOS NEUTRAL equiv)	-	1
potassium phosphate monobasic tab (K-PHOS equiv)	-	1
K-PHOS TAB	-	2
<b>POTASSIUM</b>		
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

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>MINERALS &amp; ELECTROLYTES Cont.</b>		
POTASSIUM CHLORIDE TAB ER	-	1
potassium chloride powder packet (KLOR-CON equiv)	-	2
potassium chloride soln	-	2
<b>ZINC</b>		
GALZIN CAP	-	2
<b>MISCELLANEOUS THERAPEUTIC CLASSES</b>		
<b>CHELATING AGENTS</b>		
penicillamine tab (DEPEN TITRATAB equiv)	-	1
<b>IMMUNOMODULATORS</b>		
lenalidomide cap (REVLIMID equiv) (QL= 1 cap/day; Restricted to Oncology or Hematology Specialist; Only available through Walgreens 888-347-3416)	LD-QL-RS	1
JOENJA TAB (QL= 2 tabs/day; Only available through PantherRx Pharmacy 855-726-8479)	LD-PA-QL	2
REVLIMID CAP (QL= 1 cap/day; Only available through Walgreens 888-347-3416; Restricted to Oncology or Hematology Specialist)	LD-QL-RS	2
REZUROCK TAB (QL= 1 tab/day; Only available through Lumicera 855-847-3553)	LD-PA-QL	2
<b>IMMUNOSUPPRESSIVE AGENTS</b>		
everolimus tab (ZORTRESS equiv)	PA	1
sirolimus soln (RAPAMUNE equiv)	-	1
ENSPRYNG INJ (QL= 1 inj/28 days)	LMSP-PA-QL	2
<b>PIK3CA-RELATED OVERGROWTH SPECTRUM (PROS) AGENTS</b>		
VIJOICE TAB (QL= 1 tab/day)	MSP-PA-QL	2
<b>POTASSIUM REMOVING AGENTS</b>		

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>MISCELLANEOUS THERAPEUTIC CLASSES Cont.</b>		
SPS SUSP	-	1
LOKELMA PAK	PA	2
<b>PROGERIA TREATMENT AGENTS</b>		
ZOKINVY CAP (QL= 4 caps/day; Only available through CVS Specialty 800-237-2767)	LD-PA-QL	2
<b>MOUTH/THROAT/DENTAL AGENTS</b>		
<b>ANESTHETICS TOPICAL ORAL</b>		
benzocaine gel	OTC	1
benzocaine paste	OTC	1
lidocaine viscous soln (XYLOCAINE HCL (MOUTH-THROAT) equiv)	-	1
<b>ANTI-INFECTIVES - THROAT</b>		
clotrimazole troches (MYCELEX TROCHES equiv)	-	1
nystatin susp	-	1
<b>ANTISEPTICS - MOUTH/THROAT</b>		
chlorhexidine gluconate soln (PERIDEX equiv)	-	1
<b>DENTAL PRODUCTS</b>		
FLUORIDEX SENSITIVITY PASTE	-	1
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

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>MOUTH/THROAT/DENTAL AGENTS Cont.</b>		
<b>STERIODS - MOUTH/THROAT</b>		
triamcinolone in orabase paste (KENALOG/ORABASE equiv)	-	1
<b>THROAT PRODUCTS - MISC.</b>		
cevimeline cap (EVOXAC equiv)	-	1
pilocarpine tab (SALAGEN equiv)	-	1
<b>MULTIVITAMINS</b>		
<b>B-COMPLEX W/ FOLIC ACID</b>		
DIALYVITE TAB	-	1
dialyvite tab (NEPHRO-VITE equiv)	--OTC	1
DIALYVITE/ZINC TAB	-	1
FOLBEE PLUS CZ TAB	-	1
renaphro cap (NEPHROCAP equiv)	-	1
<b>MULTIPLE VITAMINS W/ MINERALS</b>		
multivitamin/minerals tab (STROVITE equiv)	-	1
<b>MULTIVITAMINS</b>		
multiple vitamin liquid	OTC	1
<b>PED MULTI VITAMINS W/FL &amp; FE</b>		
pediatric multiple vitamins/fluoride/iron soln	-	1
POLY-VI-FLOR SUSP	-	2
<b>PED MULTIPLE VITAMINS W/ MINERALS</b>		
pediatric multivitamin (VITALETS equiv)	OTC	1
<b>PED MV W/ FLUORIDE</b>		
MULTIVITAMIN/FLOURIDE CHEW 0.25MG	-	1

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>MULTIVITAMINS Cont.</b>		
MULTIVITAMIN/FLOURIDE CHEW 1MG	-	1
MULTIVITAMIN/FLUORIDE CHEW TAB	-	1
pediatric multiple vitamins/fluoride chew tab	-	1
pediatric multiple vitamins/fluoride soln	-	1
FLORIVA PLUS DROPS	-	2
TRI-VI-FLOR SUSP	-	2
<b>PED MV W/ IRON</b>		
FLINTSTONES COMPLETE CHEW	OTC	1
pediatric multivitamin (VITALETS equiv)	OTC	1
<b>PRENATAL VITAMINS</b>		
PRENATABS RX TAB	-	1
PRENATAL 19 TAB	-	1
prenatal vitamin	OTC	1
PRENATAL VITAMIN	OTC	2
PRENATAL VITAMIN (OTC only)	OTC	2
<b>MUSCULOSKELETAL THERAPY AGENTS</b>		
<b>CENTRAL MUSCLE RELAXANTS</b>		
baclofen intrathecal inj (BACLOFEN equiv) (Members age 9 or older require Prior Authorization)	PA	1
baclofen tab (BACLOFEN equiv)	-	1
carisoprodol tab (SOMA equiv)	-	1
chlorzoxazone tab 500mg	-	1
cyclobenzaprine tab 10mg (FLEXERIL equiv)	-	1

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>MUSCULOSKELETAL THERAPY AGENTS Cont.</b>		
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
BACLOFEN SUSP (Prior Authorization Required for members age 9 or older)	PA	2
FLEQSUVY SUSP (Prior Authorization Required for members age 9 or older)	PA	2
LYVISPAH GRANULE PACKET (Members age 9 or older require Prior Authorization)	PA	2
OZOBAX SOLN, BACLOFEN SOLN	-	2+penalty
<b>DIRECT MUSCLE RELAXANTS</b>		
dantrolene cap (DANTRIUM equiv)	-	1
<b>NASAL AGENTS - SYSTEMIC AND TOPICAL</b>		
<b>NASAL AGENTS - MISC.</b>		
saline nasal spray (OCEAN equiv)	OTC	1
ALCOHOL SWABS	OTC	2
<b>NASAL ANTIALLERGY</b>		
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
<b>NASAL STEROIDS</b>		
flunisolide nasal soln	-	1
fluticasone nasal spray (FLONASE equiv)	-	1

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>NASAL AGENTS - SYSTEMIC AND TOPICAL Cont.</b>		
mometasone nasal spray (NASONEX equiv)	-	1
NASACORT OTC NASAL SPRAY (QL= 2 bottles/fill)	OTC-QL	1
triamcinolone OTC nasal spray (NASACORT equiv) (QL= 2 bottles/fill)	OTC-QL	1
FLONASE SENSIMIST NASAL SPRAY	OTC	2
<b>SYMPATHOMIMETIC DECONGESTANTS</b>		
pseudoephedrine 12hr tab (SUDAFED equiv)	OTC	1
pseudoephedrine tab (SUDAFED equiv)	OTC	1
pseudopseudoephedrine liquid (SUDAFED equiv)	OTC	1
<b>NEUROMUSCULAR AGENTS</b>		
<b>FRIEDRICH'S ATAXIA AGENTS</b>		
SKYCLARYS CAP (QL= 3 caps/day; Only available through Biologics 800-850-430	LD-PA-QL	2
<b>RETT SYNDROME AGENTS</b>		
DAYBUE SOLN (QL= 8 bottles/30 days; Only available through AnovoRx 844-288-5007)	LD-PA-QL	2
<b>SPINAL MUSCULAR ATROPHY AGENTS (SMA)</b>		
EVRYSDI SOLN (QL= 6.67ml/day; Only available through Accredo 800-803-2523)	LD-PA-QL	2
<b>OPHTHALMIC AGENTS</b>		
<b>ARTIFICIAL TEARS AND LUBRICANTS</b>		
artificial tears	OTC	1
artificial tears (LIQUIFILM equiv)	OTC	1
artificial tears ophth soln (AQUASITE equiv) (QL= 25ml/30 days)	OTC-QL	1
gentle ophth oint	OTC	1
<b>BETA-BLOCKERS - OPHTHALMIC</b>		

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>OPHTHALMIC AGENTS Cont.</b>		
BETAXOLOL OPTH SOLN	-	1
betaxolol ophth soln (BETOPTIC-S equiv)	-	1
brimonidine/timolol ophth soln (COMBIGAN OPTH SOLN equiv)	-	1
carteolol ophth soln (OCUPRESS equiv)	-	1
dorzolamide/timolol (pf) ophth soln (COSOPT equiv)	-	1
LEVOBUNOLOL OPTH 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 OPTH SOLN	-	2
BETOPTIC-S OPTH SOLN	-	2
DORZOLAMIDE/TIMOLOL OPTH SOLN	-	2
ISTALOL OPTH SOLN	-	2
METIPRANOLOL OPTH SOLN	-	2
COMBIGAN OPTH SOLN	-	2+penalty
<b>CYCLOPLEGIC MYDRIATICS</b>		
atropine ophth oint	-	1
atropine ophth soln (ISOPTO ATROPINE equiv)	-	1
ATROPINE SUL SOLN 1% OPTH	-	1
ATROPINE SULFATE OPTH OINT	-	1

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>OPHTHALMIC AGENTS Cont.</b>		
cyclopentolate ophth soln (CYCLOGYL equiv)	-	1
phenylephrine ophth soln (MYDFRIN equiv)	-	1
tropicamide ophth soln (MYDRIACYL equiv)	-	1
CYCLOMYDRIL OPTH SOLN	-	2
HOMATROPINE OPTH SOLN	-	2
<b>MIOTICS</b>		
pilocarpine ophth soln (ISOPTO CARPINE equiv)	-	1
ISOPTO CARBACHOL OPTH SOLN	-	2
<b>OPHTHALMIC ADRENERGIC AGENTS</b>		
apraclonidine ophth soln (IOPIDINE equiv)	-	1
brimonidine ophth soln 0.2%	-	1
brimonidine tartrate ophth soln 0.1% (ALPHAGAN equiv)	-	1
ALPHAGAN P OPTH SOLN 0.15%	-	2
APRACLONIDINE OPTH SOLN	-	2
brimonidine ophth soln 0.15% (ALPHAGAN P 0.15% equiv)	-	2
IOPIDINE OPTH SOLN	-	2
<b>OPHTHALMIC ANTI-INFECTIVES</b>		
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

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>OPHTHALMIC AGENTS Cont.</b>		
GENTAK OPHTH OINT	-	1
gentamicin ophth soln (GARAMYCIN equiv)	-	1
levofloxacin ophth soln (QUIXIN equiv)	-	1
LEVOFLOXACIN OPHTH SOLN 0.5%	-	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
AZASITE SOLN	-	2
BACITRACIN OPHTH OINT	-	2
ZIRGAN OPHTH GEL	-	2
<b>OPHTHALMIC LOCAL ANESTHETICS</b>		
proparacaine ophth soln (ALCAINE equiv)	-	1
<b>OPHTHALMIC NERVE GROWTH FACTORS</b>		
OXERVATE OPHTH SOLN (QL= 8 kits/affected eye/lifetime; Only available through LD-PA-QL Accredito 800-803-2523)		2
<b>OPHTHALMIC STEROIDS</b>		
bacitracin/polymyxin/neomycin/hydrocortisone ophth oint (CORTISPORIN equiv)	-	1
difluprednate ophth emulsion (DUREZOL equiv)	-	1

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>OPHTHALMIC AGENTS Cont.</b>		
fluorometholone ophth soln (FML LIQUIFILM equiv)	-	1
loteprednol etabonate ophth gel (LOTEMAX 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
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
ZYLET OPHTH SUSP (QL= 5ml/fill (10ml bottle is Not Covered))	QL	2
<b>OPHTHALMICS - MISC.</b>		
azelastine ophth soln (OPTIVAR equiv)	-	1
cromolyn ophth soln (CROLOM equiv)	-	1

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>OPHTHALMIC AGENTS Cont.</b>		
CROMOLYN SODIUM OPTH SOLN	-	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) (OTC covered only)	OTC	1
olopatadine ophth soln 0.1% (PATANOL equiv)	OTC	1
olopatadine ophth soln 0.2% (PATADAY equiv) (QL= 2.5ml/30 days)	OTC-QL	1
ALOCRILOPHTH SOLN	-	2
ALOMIDE OPTH SOLN	-	2
CYSTADROPS SOLN (QL = 4 bottles/28 days; Restricted to Ophthalmology Specialist; Only available through Anovo Specialty Pharmacy 844-288-5007)	LD-QL-RS	2
CYSTARAN OPTH SOLN (QL= 4 bottles/28 days; Restricted to Ophthalmology or Optometry Specialist; Only available through Walgreens 888-347-3416)	LD-QL-RS	2
UPNEEQ SOLN	-	EXC
<b>PROSTAGLANDINS - OPTHALMIC</b>		
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 OPTH SOLN (QL= 2.5ml/30 days)	QL	2
<b>OTIC AGENTS</b>		
<b>OTIC AGENTS - MISCELLANEOUS</b>		
acetic acid otic soln (VOSOL equiv)	-	1

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>OTIC AGENTS Cont.</b>		
ACETIC ACID/ALUMINUM ACETATE OTIC SOLN	-	1
carbamide peroxide otic soln (DEBROX equiv)	OTC	1
<b>OTIC ANTI-INFECTIVES</b>		
ofloxacin otic soln (FLOXIN equiv)	-	1
CIPROFLOXACIN OTIC SOLN	-	2
<b>OTIC COMBINATIONS</b>		
ciprofloxacin/dexamethasone otic susp (CIPRODEX equiv)	-	1
neomycin/polymixin/hydrocortisone otic soln (CORTISPORIN equiv)	-	1
neomycin/polymixin/hydrocortisone otic susp (CORTISPORIN equiv)	-	1
COLY-MYCIN S OTIC SUSP	-	2
<b>OTIC STEROIDS</b>		
ACETASOL HC OTIC SOLN	-	1
acetic acid/hydrocortisone otic soln (VOSOL HC equiv)	-	1
fluocinolone otic oil (DERMOTIC equiv)	-	1
<b>OXYTOCICS</b>		
<b>OXYTOCICS</b>		
methylergonovine tab (METHERGINE equiv) (QL= 28 tabs/fill; 1 fill/365 days)	QL	2
<b>PASSIVE IMMUNIZING AGENTS</b>		
<b>IMMUNE SERUMS</b>		
CUVITRU INJ	MSP-PA	2
HIZENTRA INJ	MSP-PA	2
<b>MONOCLONAL ANTIBODIES</b>		
SYNAGIS INJ	LMSP-PA	2

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>PASSIVE IMMUNIZING AGENTS Cont.</b>		
<b>PASSIVE IMMUNIZING AGENTS - COMBINATIONS</b>		
HYQVIA INJ	MSP-PA	2
<b>PASSIVE IMMUNIZING AND TREATMENT AGENTS</b>		
<b>IMMUNE SERUMS</b>		
HIZENTRA INJ	MSP-PA	2
XEMBIFY INJ (Only available through Diplomat Pharmacy 877-977-9118)	LD-PA	2
<b>MONOCLONAL ANTIBODIES</b>		
BEYFORTUS INJ	VAC	\$0
<b>PENICILLINS</b>		
<b>AMINOPENICILLINS</b>		
amoxicillin cap (TRIMOX equiv)	-	1
AMOXICILLIN CHEW TAB	-	1
amoxicillin susp (TRIMOX equiv)	-	1
amoxicillin tab (AMOXIL equiv)	-	1
ampicillin cap (AMPICILLIN equiv)	-	1
<b>NATURAL PENICILLINS</b>		
penicillin vk tab (VEETIDS equiv)	-	1
<b>PENICILLIN COMBINATIONS</b>		
amoxicillin/clavulanate susp (AUGMENTIN ES equiv)	-	1
amoxicillin/clavulanate tab (AUGMENTIN equiv)	-	1
<b>PENICILLINASE-RESISTANT PENICILLINS</b>		
dicloxacillin cap (DYNAPEN equiv)	-	1
<b>PHARMACEUTICAL ADJUVANTS</b>		

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>PHARMACEUTICAL ADJUVANTS Cont.</b>		
<b>SEMI SOLID VEHICLES</b>		
POLYETHYLENE GLYCOL 8000 GRANULES	-	2
<b>PROGESTINS</b>		
<b>PROGESTINS</b>		
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
<b>PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.</b>		
<b>AGENTS FOR CHEMICAL DEPENDENCY</b>		
acamprosate calcium DR tab (CAMPRAL equiv)	-	1
disulfiram tab (ANTABUSE equiv)	-	1
<b>ANTIDEMENTIA AGENTS</b>		
rivastigmine cap (EXELON equiv)	-	1
<b>COMBINATION PSYCHOTHERAPEUTICS</b>		
olanzapine/fluoxetine cap (SYMBYAX equiv)	-	1
PERPHENAZINE/ AMITRIPTYLINE TAB	-	1
<b>FIBROMYALGIA AGENTS</b>		
SAVELLA PAK	-	2
SAVELLA TAB	-	2
<b>MOVEMENT DISORDER DRUG THERAPY</b>		
AUSTEDO XR TAB (QL= 2 tabs/day)	LMSP-PA-QL	2

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. Cont.</b>		
<b>MULTIPLE SCLEROSIS AGENTS</b>		
dimethyl fumarate DR cap (TECFIDERA equiv)	LMSP	1
dimethyl fumarate DR starter pack (TECFIDERA STARTER PACK equiv)	LMSP	1
fingolimod hcl cap 0.5mg (GILENYA equiv)	LMSP	1
glatiramer inj (COPAXONE equiv)	LMSP	1
AVONEX INJ	LMSP	2
EXTAVIA INJ	LMSP	2
GILENYA CAP 0.25MG	LMSP-PA	2
KESIMPTA INJ	LMSP	2
MAVENCLAD THERAPY PAK (Only available through Walgreens 888-347-3416)	LD	2
MAYZENT TAB	LMSP	2
MAYZENT TAB STARTER PACK	LMSP	2
REBIF INJ	LMSP	2
ZEPOSIA CAP	LMSP-PA	2
ZEPOSIA STARTER PACK	LMSP-PA	2
<b>PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.</b>		
PIMOZIDE TAB	-	2
<b>SMOKING DETERRENTS</b>		
bupropion SR tab (ZYBAN equiv)	-	\$0
NICOTINE KIT (QL= 1 patch/day; Limited to 3 months per calendar year)	OTC-QL	\$0
nicotine patch (NICODERM equiv) (QL= 1 patch/day; Limited to 3 months per calendar year)	OTC-QL-SMKG	\$0

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. Cont.</b>		
NICOTROL INHALER	-	\$0
NICOTROL NASAL SPRAY	-	\$0
VARENICLINE TAB (Prior Authorization Required only if member is less than 16 years old)	PA	\$0
varenicline tartrate tab (VARENICLINE equiv) (Prior Authorization Required only if member is less than 16 years old)	PA	\$0
varenicline tartrate tab starter pack (VARENICLINE PAK equiv) (Limited to 180 days/plan year; Prior Authorization Required only if member is less than 16 years old)	PA-QL-SMKG	\$0
<b>RESPIRATORY AGENTS - MISC.</b>		
<b>CYSTIC FIBROSIS AGENTS</b>		
KALYDECO PAK (QL= 2 packets/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	2
KALYDECO TAB (QL= 2 tabs/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	2
ORKAMBI GRANULES PACKET (QL= 2 packets/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	2
ORKAMBI TAB (QL= 4 tabs/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	2
PULMOZYME INH SOLN	LMSP	2
SYMDEKO TAB (QL= 2 tabs/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	2
TRIKAFTA TAB (QL= 84 tabs/28 days; Only available through Walgreens 888-347-3416)	LD-PA-QL	2
TRIKAFTA THERAPY PACK (QL= 2 packets/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	2
<b>TETRACYCLINES</b>		

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>TETRACYCLINES Cont.</b>		
<b>TETRACYCLINES</b>		
doxycycline hyclate cap (VIBRAMYCIN equiv)	-	1
doxycycline hyclate tab (VIBRATAB equiv)	-	1
doxycycline monohydrate cap 50mg, 100mg (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
<b>THYROID AGENTS</b>		
<b>ANTITHYROID AGENTS</b>		
methimazole tab (TAPAZOLE equiv)	-	1
propylthiouracil tab	-	1
<b>THYROID HORMONES</b>		
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
TIROSINT-SOL (Prior Authorization Required for members age 9 or older)	PA	2
<b>TOXOIDS</b>		
<b>TOXOID COMBINATIONS</b>		
DAPTACEL INJ, INFANRIX INJ	VAC	\$0

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>TOXOIDS Cont.</b>		
DIPHTHERIA/TETANUS TOXOID (PEDIATRIC) INJ	VAC	\$0
KINRIX INJ, QUADRACEL DTAP-IPV INJ	VAC	\$0
KINRIX PREF SYRINGE, QUADRACEL PREF SYRINGE	VAC	\$0
PENTACEL INJ	VAC	\$0
<b>ULCER DRUGS</b>		
<b>ANTISPASMODICS</b>		
chlordiazepoxide/clidinium cap (LIBRAX equiv)	-	1
dicyclomine cap (BENTYL equiv)	-	1
dicyclomine soln (BENTYL equiv)	-	1
dicyclomine tab (BENTYL equiv)	-	1
glycopyrrolate tab (ROBINUL equiv)	-	1
hyoscyamine sulfate CR tab (LEVVID equiv)	-	1
hyoscyamine sulfate elixir (LEVSIN equiv)	-	1
hyoscyamine sulfate ODT (ANASPAZ equiv)	-	1
hyoscyamine sulfate SL tab (LEVSIN equiv)	-	1
hyoscyamine sulfate soln (LEVSIN equiv)	-	1
hyoscyamine tab (LEVSIN equiv)	-	1
methscopolamine tab (PAMINE equiv)	-	1
BELLADONNA ALKALOID/OPIUM SUPP	-	2
PROPANTHELINE TAB	-	2
<b>H-2 ANTAGONISTS</b>		
cimetidine soln (CIMETIDINE equiv)	-	1

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>ULCER DRUGS Cont.</b>		
cimetidine tab (TAGAMET equiv)	OTC	1
famotidine susp (PEPCID equiv)	-	1
famotidine tab (PEPCID equiv)	OTC	1
AXID AR TAB	OTC	2
nizatidine cap (AXID equiv)	-	2
<b>MISC. ANTI-ULCER</b>		
sucralfate tab (CARAFATE equiv)	-	1
<b>PROTON PUMP INHIBITORS</b>		
esomeprazole cap (NEXIUM equiv)	OTC	1
lansoprazole cap (PREVACID equiv)	OTC	1
lansoprazole cap 15mg (PREVACID equiv) (QL= 2 caps/day)	OTC-QL	1
omeprazole DR cap (PRILOSEC equiv)	-	1
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
<b>ULCER DRUGS - PROSTAGLANDINS</b>		
misoprostol tab (CYTOTEC equiv)	-	1
<b>ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS</b>		
<b>H-2 ANTAGONISTS</b>		
CIMETIDINE SOLN	-	1
NIZATIDINE CAP	-	2

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS Cont.</b>		
<b>MISC. ANTI-ULCER</b>		
sucralfate susp (CARAFATE equiv)	-	1
<b>PROTON PUMP INHIBITORS</b>		
lansoprazole odt (PREVACID SOLUTAB equiv) (QL= 2 tabs/day)	QL	1
omeprazole tab	OTC	1
PREVACID CAP	-	2
NEXIUM 24HR TAB	OTC	2+penalty
<b>URINARY ANTISPASMODICS</b>		
<b>URINARY ANTISPASMODIC - ANTIMUSCARINICS (ANTICHOLINERGIC)</b>		
fesoterodine fumarate ER tab (TOVIAZ equiv)	-	1
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+penalty
<b>URINARY ANTISPASMODICS - CHOLINERGIC AGONISTS</b>		
bethanechol tab (URECHOLINE equiv)	-	1
<b>VACCINES</b>		
<b>BACTERIAL VACCINES</b>		

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>VACCINES Cont.</b>		
ACTHIB INJ, HIBERIX INJ	VAC	\$0
BEXSERO INJ	VAC	\$0
MENACTRA INJ	VAC	\$0
PEDVAXHIB INJ	VAC	\$0
PNEUMOVAX INJ (QL= 1 inj/lifetime for members 2 years and older)	QL-VAC	\$0
PREVNAR 13 INJ (QL= 4 inj/year for members 6 weeks old through 5 years; QL= 1 inj/lifetime for members 6 years and older)	QL-VAC	\$0
PREVNAR 20 INJ	VAC	\$0
BCG INJ	VAC	EXC
VAXNEUVANCE INJ	VAC	EXC
<b>VIRAL VACCINES</b>		
ABRYSSVO INJ	VAC	\$0
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
AFLURIA INJ, FLUZONE INJ (QL= 1 inj/28 days for members 6 months and older)	QL-VAC	\$0
COMIRNATY INJ (QL= 1 dose/17 days)	QL-VAC	\$0
COMIRNATY INJ 30MCG/0.3ML (QL= 1 dose/17 days)	QL-VAC	\$0
COVID-19 VACCINE BIVALENT BOOSTER INJ (MODERNA) (QL= 1 inj/fill)	QL-VAC	\$0
COVID-19 VACCINE BIVALENT BOOSTER INJ (PFIZER) (QL= 1 inj/fill)	QL-VAC	\$0
COVID-19 VACCINE BIVALENT BOOSTER INJ 5-11Y (PFIZER) (QL= 1 inj/fill)	QL-VAC	\$0
COVID-19 VACCINE BIVALENT BOOSTER INJ 6M-4Y (PFIZER) (QL= 1 inj/fill)	QL-VAC	\$0
COVID-19 VACCINE BIVALENT BOOSTER INJ 6M-5Y (MODERNA) (QL= 1 inj/fill)	QL-VAC	\$0

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>VACCINES Cont.</b>		
COVID-19 VACCINE INJ (JANSSEN) (QL= 1 dose/45 days)	QL-VAC	\$0
COVID-19 VACCINE INJ (NOVAVAX) (QL= 1 dose/17 days)	QL-VAC	\$0
COVID-19 VACCINE INJ 5-11Y (PFIZER) (QL= 1 dose/17 days)	QL-VAC	\$0
COVID-19 VACCINE INJ 6M-11Y (MODERNA) (QL= 1 dose/24 days)	QL-VAC	\$0
COVID-19 VACCINE INJ 6M-4Y (PFIZER) (QL= 1 dose/17 days)	QL-VAC	\$0
DENG VAXIA SUSP	VAC	\$0
FLUBLOK QUAD PF INJ (QL= 1 inj/28 days for members 18 years and older)	QL-VAC	\$0
FLUCELVAX QUAD INJ (QL= 1 inj/28 days for members aged 6 months and older)	QL-VAC	\$0
FLUCELVAX QUAD INJ (QL= 2 inj/8 months for members 4 years through 8 years; QL= 1 inj/8 months for members 9 years and older)	QL-VAC	\$0
FLULAVAL QUAD INJ, FLUZONE QUAD INJ (QL= 1 inj/28 days for members 6 months and older)	QL-VAC	\$0
FLUMIST QUAD RIVALENT NASAL SUSP (QL= 1 inj/28 days for members 2 years and older)	QL-VAC	\$0
FLUZONE/FLUARIX QUAD INJ (QL= 1 inj/28 days for members aged 6 months and older)	QL-VAC	\$0
GARDASIL 9 INJ	VAC	\$0
I POL INJ	VAC	\$0
M-M-R II INJ	VAC	\$0
PROQUAD INJ	VAC	\$0
ROTARIX SUSP	VAC	\$0
ROTATEQ INJ	VAC	\$0
SHINGRIX INJ (Covered for members age 19 years or older)	VAC	\$0

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

<b>NC</b> =Not Covered		<b>generic</b> =small letters	<b>BRANDS</b> =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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>VACCINES Cont.</b>		
SPIKEVAX INJ (QL= 1 dose/24 days)	QL-VAC	\$0
SPIKEVAX INJ 50MCG/0.5ML (QL= 1 dose/24 days)	QL-VAC	\$0
VARIVAX INJ	VAC	\$0
IMOVAX INJ	VAC	EXC
RABAVERT INJ	VAC	EXC
<b>VAGINAL AND RELATED PRODUCTS</b>		
<b>VAGINAL CONTRACEPTIVE - PH MODULATORS</b>		
PHEXXI GEL	-	\$0
<b>VAGINAL PRODUCTS</b>		
<b>SPERMICIDES</b>		
CONTRACEPTIVE GEL	OTC	\$0
TODAY SPONGE	OTC	\$0
<b>VAGINAL ANTI-INFECTIVES</b>		
clindamycin vaginal cream (CLEOCIN equiv) (QL=1 tube/fill)	QL	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
terconazole cream (TERAZOL equiv)	-	1
TERCONAZOLE CREAM 0.8%	-	1
terconazole supp (TERAZOL equiv)	-	1
<b>VAGINAL ESTROGENS</b>		

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
<b>VAGINAL PRODUCTS Cont.</b>		
ESTRING (3 copays per Rx)	-	2
PREMARIN VAGINAL CREAM	-	2
<b>VASOPRESSORS</b>		
<b>ANAPHYLAXIS THERAPY AGENTS</b>		
epinephrine pen inj 0.15mg, 0.3mg (EPIPEN (JR) equiv) (QL= 2 inj/fill)	QL	1
SYMJEPI INJ (QL= 2 inj/fill)	QL	2
<b>VASOPRESSORS</b>		
EPINEPHRINE INJ	-	1
midodrine tab (PROAMATINE equiv)	-	1
<b>VITAMINS</b>		
<b>OIL SOLUBLE VITAMINS</b>		
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
<b>WATER SOLUBLE VITAMINS</b>		
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
niacinamide tab	OTC	1
VITAMIN C TAB	OTC	1

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

<b>NC =Not Covered</b>		<b>generic =small letters</b>	<b>BRANDS =CAPITAL LETTERS</b>
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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

DrugName	Special Code	Tier
VITAMINS Cont.		
POTABA POWDER PACKET	-	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
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
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\* 1/1/2024

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

Drug Name	Tier # for Drug Copay (if prior auth is approved)
ACTEMRA ACTPEN INJ	2
ACTEMRA SC INJ	2
ACTHAR GEL INJ	2
ACTIMMUNE INJ	2
ADALIMUMAB-ADAZ INJ	2
ADALIMUMAB-ADAZ PFS INJ	2
ADALIMUMAB-FKJP AUTO-INJECTOR KIT	2
ADALIMUMAB-FKJP PFS KIT 20 MG/0.4ML	2
ADALIMUMAB-FKJP PFS KIT 40 MG/0.8ML	2
ADBRY INJ	2
AIMOVIG INJ	2
AJOVY INJ	2
ALINIA SUSP	2
ANDRODERM PATCH	2
ATORVALIQ SUSP	2
AUSTEDO XR TAB	2
baclofen intrathecal inj	1
BACLOFEN SUSP	2
BANZEL SUSP	2+penalty
BARACLUDE SOLN	2
BERINERT 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\* 1/1/2024**

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

<b>Drug Name</b>	<b>Tier # for Drug Copay (if prior auth is approved)</b>
bexarotene cap	2
bexarotene gel	1
BYLVAY CAP 1200MCG	2
BYLVAY CAP 400MCG	2
BYLVAY SPRINKLE CAP 200MCG	2
BYLVAY SPRINKLE CAP 600MCG	2
CABOMETYX TAB	2
CAMZYOS CAP	2
carglumic acid tab	2
CEREZYME INJ	2
CIBINQO TAB	2
CIMZIA INJ	2
CIMZIA STARTER INJ KIT	2
CINRYZE INJ	2
clobazam susp	2
clobetasol foam	1
clobetasol shampoo	1
clobetasol spray	1
CLOBEX SPRAY	2+penalty
CORLANOR SOLN	2
CORLANOR TAB	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\* 1/1/2024**

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

<b>Drug Name</b>	<b>Tier # for Drug Copay (if prior auth is approved)</b>
CUVITRU INJ	2
DAYBUE SOLN	2
deferiprone tab	1
DIACOMIT CAP	2
DIACOMIT POWDER PACK	2
DUPIXENT INJ	2
DUPIXENT PEN INJ	2
EMGALITY INJ	2
EMGALITY INJ 100MG/ML	2
EMPAVELI INJ	2
enalapril maleate for oral solution	1
ENBREL INJ 25MG	2
ENBREL INJ 50MG	2
ENBREL MINI INJ	2
ENBREL SURECLICK INJ 50MG	2
ENDARI POWDER PACK	2
ENSPRYNG INJ	2
epaned	2+penalty
EPCLUSA 200-50MG	2
EPCLUSA 400-100MG	2
EPIDIOLEX SOLN	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\* 1/1/2024**

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

<b>Drug Name</b>	<b>Tier # for Drug Copay (if prior auth is approved)</b>
EPRONTIA SOLN	2
estradiol valerate inj	1
everolimus tab	1
everolimus tab 5mg	1
everolimus tab for oral susp	1
EVRYSDI SOLN	2
EXKIVITY CAP	2
FANAPT TAB	2
FANAPT TITRATION PACK	2
FASENRA PEN INJ	2
FERRIPROX SOLN	2
FILSPARI TAB	2
FINTEPLA SOLN	2
FIRDAPSE TAB	2
FLEQSUVY SUSP	2
FLOLIPID SUSP	2
FULPHILA INJ	2
GAVRETO CAP	2
GENOTROPIN INJ	2
GENVOYA TAB	2
GILENYA CAP 0.25MG	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\* 1/1/2024**

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

<b>Drug Name</b>	<b>Tier # for Drug Copay (if prior auth is approved)</b>
GLOPERBA SOLN	2
HADLIMA INJ	2
HADLIMA INJ 40MG/0.8ML	2
HADLIMA PUSH INJ	2
HADLIMA PUSH INJ 40MG/0.8ML	2
HAEGARDA INJ	2
HARVONI TAB	2
HEMLIBRA INJ	2
HIZENTRA INJ	2
HUMIRA INJ 10MG	2
HUMIRA INJ 20MG	2
HUMIRA INJ 40MG	2
HUMIRA INJ 80MG	2
HUMIRA INJ CROHNS/UC/HIDRADENITIS STARTER PACK	2
HUMIRA INJ PEDIATRIC CROHNS STARTER PAC	2
HUMIRA INJ PEDIATRIC UC STARTER PACK	2
HUMIRA INJ PSORIASIS/UEVITIS STARTER PACK	2
HUMIRA PEN INJ 40MG	2
HYCAMTIN CAP	2
HYFTOR GEL	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\* 1/1/2024**

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

<b>Drug Name</b>	<b>Tier # for Drug Copay (if prior auth is approved)</b>
HYQVIA INJ	2
icatibant inj	1
IMBRUVICA SUSP	2
IMBRUVICA TAB 420MG, 560MG	2
IMCIVREE INJ	2
INVEGA INJ	2
itraconazole cap	1
ivermectin tab	1
JAKAFI TAB	2
JAYPIRCA TAB	2
JOENJA TAB	2
JYLAMVO SOLN, XATMEP SOLN	2
KALYDECO PAK	2
KALYDECO TAB	2
KATERZIA SUSP	2
KEVZARA INJ	2
KINERET INJ	2
KOSELUGO CAP	2
KOSELUGO CAP 10MG	2
LEDIPASVIR/SOFOSBUVIR TAB	2
LINZESS CAP	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\* 1/1/2024**

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

<b>Drug Name</b>	<b>Tier # for Drug Copay (if prior auth is approved)</b>
LIVMARLI SOLN	2
LIVTENCITY TAB	2
LOKELMA PAK	2
LYVISPAH GRANULE PACKET	2
MAVYRET PAK	2
MAVYRET TAB	2
MEKINIST TAB 0.5MG	2
MEKINIST TAB 2MG	2
miglustat cap	1
MYFEMBREE TAB	2
NEXLETOL TAB	2
NEXLIZET TAB	2
NINLARO CAP	2
nitazoxanide tab	1
nitrofurantoin susp	1
NORLIQVA ORAL SOLN 1MG/ML	2
NUCALA INJ	2
OLUMIANT TAB	2
OLUX FOAM	2+penalty
OPSUMIT TAB	2
OPZELURA CREAM	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\* 1/1/2024**

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

<b>Drug Name</b>	<b>Tier # for Drug Copay (if prior auth is approved)</b>
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
OXBRYTA TAB	2
OXBRYTA TAB FOR ORAL SUSP	2
OXERVATE OPTH SOLN	2
PALFORZIA POWDER PACK	2
PALFORZIA SPRINKLE CAP	2
PURIXAN SUSP	2
PYRUKYND TAB	2
PYRUKYND TAPER PACK	2
QBRELIS SOLN	2
QELBREE ER CAP	2
REPATHA INJ	2
REPATHA PUSHTRONEX INJ	2
RETEVMO CAP	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\* 1/1/2024**

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

<b>Drug Name</b>	<b>Tier # for Drug Copay (if prior auth is approved)</b>
REZUROCK TAB	2
RINVOQ ER TAB	2
RISPERDAL INJ	2
risperidone microspheres inj	2
ROZLYTREK CAP	2
RUCONEST INJ	2
rufinamide susp	1
rufinamide tab	1
sildenafil susp	2
sildenafil tab 20mg	1
SIMPONI AUTO-INJECTOR 100MG	2
SIMPONI INJ 100MG	2
SKYCLARYS CAP	2
SKYRIZI INJ 150MG/ML	2
SKYRIZI INJ 180 MG/1.2ML	2
SKYRIZI INJ 360MG/2.4ML	2
SKYRIZI INJ 75MG/0.83ML	2
SKYTROFA INJ	2
sodium phenylbutyrate powder	1
sodium phenylbutyrate tab	1
SOFOSBUVIR/VELPATASVIR TAB 400-100MG	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\* 1/1/2024**

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

<b>Drug Name</b>	<b>Tier # for Drug Copay (if prior auth is approved)</b>
SOGROYA INJ	2
SOMAVERT INJ	2
SOTYLIZE SOLN 5MG/ML	2
spironolactone susp	2
SPRYCEL TAB	2
STELARA INJ	2
sunitinib malate cap	1
SYMDEKO TAB	2
SYNAGIS INJ	2
tadalafil tab (PAH)	1
TADLIQ SUSP	2
TAFINLAR CAP	2
TAKHZYRO INJ	2
TAKHZYRO INJ 150MG/ML	2
TALTZ INJ	2
TASIGNA CAP	2
TAVNEOS CAP	2
TAZVERIK TAB	2
testosterone cypionate inj	1
TESTOSTERONE ENANTHATE INJ	1
TESTOSTERONE ENANTHATE INJ 200MG/ML	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\* 1/1/2024**

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

<b>Drug Name</b>	<b>Tier # for Drug Copay (if prior auth is approved)</b>
TESTOSTERONE GEL 1% 25MG	2
testosterone gel 1% 50mg	1
testosterone gel 1% pump	1
testosterone gel 1.62% 1.25gm	2
testosterone gel 1.62% 2.5gm	2
TESTOSTERONE GEL PUMP	2
testosterone gel pump 1.62%	1
TEZSPIRE INJ	2
THALOMID CAP	2
THIOLA EC TAB	2
tiopronin tab	1
TIROSINT-SOL	2
TRACLEER TAB 32MG	2
TREMFYA	2
TRIKAFTA TAB	2
TRIKAFTA THERAPY PACK	2
TYVASO DPI POWDER	2
TYVASO DPI POWDER MAINTENANCE KIT 32-48MCG	2
TYVASO DPI POWDER TITRATION KIT 16-32-48MCG	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\* 1/1/2024**

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

<b>Drug Name</b>	<b>Tier # for Drug Copay (if prior auth is approved)</b>
TYVASO DPI POWDER TITRATION KIT 16-32MCG	2
TYVASO INH SOLN	2
VALCHLOR GEL	2
VARENICLINE TAB	\$0
varenicline tartrate tab	\$0
varenicline tartrate tab starter pack	\$0
VELTASSA POWDER	2
venlafaxine ER cap	1
venlafaxine tab	1
VENTAVIS INH SOLN	2
vigabatrin powder pack	1
vigabatrin tab	1
vigadrone powder pack	1
VIJOICE TAB	2
VITRAKVI CAP 100MG	2
VITRAKVI CAP 25MG	2
VITRAKVI SOLN	2
VONJO CAP	2
VOWST CAP	2
VOXZOGO INJ	2
WELIREG TAB	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\* 1/1/2024**

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

<b>Drug Name</b>	<b>Tier # for Drug Copay (if prior auth is approved)</b>
XALKORI CAP	2
XELJANZ SOLN	2
XELJANZ TAB	2
XELJANZ XR TAB	2
XEMBIFY INJ	2
XENLETA TAB	2
ZAVZPRET NASAL SPRAY	2
ZEJULA CAP	2
ZEPOSIA CAP	2
ZEPOSIA STARTER PACK	2
ZOKINVY CAP	2
ZOLINZA CAP	2
ZONISADE SUSP	2
ZORYVE CREAM	2
ZTALMY SUSP	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\* 1/1/2024

### 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	ammonium lactate cream
ammonium lactate lotion	artificial tears	artificial tears ophth soln	ascorbic acid chew tab
ascorbic acid tab	aspirin chew tab 81mg	aspirin supp	aspirin tab 325mg
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	CARETOUCH MIS	cetirizine syrup	cetirizine 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.

cetirizine/pseudoephedrine 12-hour tab	cholecalciferol cap	cholecalciferol tab	cimetidine tab
CLARITIN CHEW TAB	CLEMASTINE TAB 1.34MG	CLINISTIX TEST STRIP	clotrimazole cream
clotrimazole vaginal cream	CONTRACEPTIVE GEL	COVID-19 TEST	cromolyn nasal spray
dextromethorphan/guaifenesin syrup 10-100mg	dialyvite tab	DIFFERIN OTC GEL 0.1%	diphenhydramine cap
diphenhydramine liquid	diphenhydramine tab	docusate calcium cap	docusate sodium cap
docusate sodium liquid	docusate sodium syrup	docusate sodium tab	DOCUSATE SYRUP
esomeprazole cap	famotidine tab	FEMALE CONDOMS	ferrous sulfate soln
fexofenadine susp	fexofenadine tab	fexofenadine/pseudoephedrine 12-hour tab	fexofenadine/pseudoephedrine 24-hour tab
FLINTSTONES COMPLETE CHEW	FLONASE SENSIMIST NASAL SPRAY	folic acid tab 400mcg	folic acid tab 800mcg
genteal ophth oint	GLUCOSE CHEW TAB	glucose gel	glycerin supp
guaifenesin ER tab	guaifenesin syrup 100mg/5ml	GUAIFENESIN/CODEINE SYRUP	HUMULIN MIX INJ
HUMULIN MIX PEN INJ	HUMULIN N INJ	HUMULIN N PEN INJ	HUMULIN R INJ
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	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/pseudoephedrine 12-hour tab	loratadine/pseudoephedrine 24-hour tab	MALE CONDOMS	meclizine chew tab
meclizine tab	miconazole 7 supp	miconazole cream	miconazole nitrate aerosol

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.

miconazole nitrate powder	miconazole vaginal cream	miconazole vaginal kit	milk of magnesium
MIRALAX PACKET	MIRALAX POWDER	multiple vitamin liquid	naloxone hcl nasal spray
naproxen sodium tab	NARCAN NASAL SPRAY	NASACORT OTC NASAL	neomycin/bacitracin/poly
220mg		SPRAY	myxin oint
NEXIUM 24HR TAB	niacin cap	niacin CR tab	niacin tab
niacinamide tab	NICOTINE KIT	nicotine patch	NIZORAL A-D SHAMPOO
NOVOFINE PEN	NOVOTWIST PEN	NOVOTWIST/NOVOFINE	olopatadine ophth soln
NEEDLE	NEEDLE	PEN NEEDLE	0.1%
olopatadine ophth soln	omeprazole tab	ONETOUCH METER	ONETOUCH TEST STRIP
0.2%			
ONETOUCH VERIO	ONETOUCH VERIO IQ	ONETOUCH VERIO	ONETOUCH VERIO
FLEX METER	METER	METER	REFLECT METER
ONETOUCH VERIO	PEAK FLOW METER	pediatric multivitamin	permethrin lotion
TEST STRIP			
phenazopyridine tab	phenazopyridine tab	phenazopyridine tab	PLAN B TAB
95mg	97.5mg	99.5mg	
polyethylene glycol 3350	PRECISION XTRA	PRENATAL VITAMIN	PREVACID OTC CAP
powder	KETONE TEST STRIP		
PRILOSEC OTC DR TAB	pseudoephedrine 12hr	pseudoephedrine tab	pseudopseudoephedrine
	tab		liquid
salicylic acid liquid 17%	salicylic acid pads 40%	saline nasal spray	selenium sulfide lotion
senna cap	senna syrup	senna tab	SILPHEN COUGH
			SYRUP
sodium bicarbonate tab	sodium chloride neb soln	terbinafine cream	TODAY SPONGE
tolnaftate aerosol	tolnaftate cream	tolnaftate powder	tolnaftate soln
triamcinolone OTC nasal	VITAMIN C TAB	vitamin E liquid	
spray			

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\* 1/1/2024

## 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	ACTHAR GEL INJ	ACTIMMUNE INJ
ADALIMUMAB-ADAZ INJ	ADALIMUMAB-ADAZ PFS INJ	ADALIMUMAB-FKJP AUTO-INJECTOR KIT	ADALIMUMAB-FKJP PFS KIT 20 MG/0.4ML
ADALIMUMAB-FKJP PFS KIT 40 MG/0.8ML	ADBRY INJ	ALFERON-N INJ	ambrisentan tab
AUSTEDO XR TAB	AVONEX INJ	BERINERT INJ	bexarotene cap
bexarotene gel	bosentan tab	BYLVAY CAP 1200MCG	BYLVAY CAP 400MCG
BYLVAY SPRINKLE CAP 200MCG	BYLVAY SPRINKLE CAP 600MCG	calcitonin inj	CAMZYOS CAP
capecitabine tab	carboplatin inj	carglumic acid tab	CAYSTON INH SOLN
CEREZYME INJ	CIBINQO TAB	CIMZIA INJ	CIMZIA STARTER INJ KIT
CINRYZE INJ	CUVITRU INJ	CYSTADROPS SOLN	CYSTAGON CAP
CYSTARAN OPTH SOLN	DAYBUE SOLN	deferasirox granules packet	deferasirox tab
deferasirox tab 90mg, 360mg	deferiprone tab	dimethyl fumarate DR cap	dimethyl fumarate DR starter pack
DUPIXENT INJ	DUPIXENT PEN INJ	EMPAVELI INJ	ENBREL INJ 25MG
ENBREL INJ 50MG	ENBREL MINI 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.

ENBREL SURECLICK INJ	ENDARI POWDER PACK	ENSPRYNG INJ	EPIDIOLEX SOLN
50MG			
ETOPOSIDE CAP	everolimus tab	everolimus tab 5mg	everolimus tab for oral susp
EVRYSDI SOLN	EXKIVITY CAP	EXTAVIA INJ	FASENRA PEN INJ
FERRIPROX SOLN	FILSPARI TAB	fingolimod hcl cap 0.5mg	FINTEPLA SOLN
FIRDAPSE TAB	FUZEON INJ	GAVRETO CAP	GENOTROPIN INJ
GILENYA CAP 0.25MG	glatiramer inj	HADLIMA INJ	HADLIMA INJ 40MG/0.8ML
HADLIMA PUSH INJ	HADLIMA PUSH INJ 40MG/0.8ML	HAEGARDA INJ	HARVONI TAB
HEMLIBRA INJ	HIZENTRA INJ	HUMIRA INJ 10MG	HUMIRA INJ 20MG
HUMIRA INJ 40MG	HUMIRA INJ 80MG	HUMIRA INJ CROHNS/UC/HIDRADENITIS STARTER PACK	HUMIRA INJ PEDIATRIC CROHNS STARTER PACK
HUMIRA INJ PEDIATRIC UC STARTER PACK	HUMIRA INJ PSORIASIS/UVEITIS STARTER PACK	HUMIRA PEN INJ 40MG	HYCAMTIN CAP
HYQVIA INJ	icatibant inj	imatinib tab	IMBRUVICA SUSP
IMBRUVICA TAB 420MG, 560MG	IMCIVREE INJ	INCRELEX INJ	JAYPIRCA TAB
JOENJA TAB	KALYDECO PAK	KALYDECO TAB	KESIMPTA INJ
KEVZARA INJ	KINERET INJ	KITABIS PAK NEB SOLN	KOSELUGO CAP
KOSELUGO CAP 10MG	LEDIPASVIR/SOFOSBUVIR TAB	lenalidomide cap	LIVMARLI SOLN
LIVTENCITY TAB	LYSODREN TAB	MAVENCLAD THERAPY PAK	MAVYRET PAK
MAVYRET TAB	MAYZENT TAB	MAYZENT TAB STARTER PACK	MEKINIST TAB 0.5MG

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.



MEKINIST TAB 2MG nilutamide tab NYVEPRIA INJ	MESNEX TAB NINLARO CAP octreotide inj	miglustat cap NIVESTYM INJ OCTREOTIDE INJ 100MCG	MYLERAN TAB NUCALA INJ OLUMIANT TAB
OPSUMIT TAB	ORENCIA CLICK INJ	ORENCIA SC INJ 125MG/ML	ORENCIA SC INJ 50MG/0.4ML
ORENCIA SC INJ 87.5MG/0.7ML OTEZLA TAB	ORKAMBI GRANULES PACKET OXBRYTA TAB	ORKAMBI TAB  OXBRYTA TAB FOR ORAL SUSP PEGASYS INJ	OTEZLA STARTER PACK  OXERVATE OPHTH SOLN PEG-INTRON INJ
PALFORZIA POWDER PACK PHEBURANE ORAL PELLETS REBETOL SOLN REZUROCK TAB ROZLYTREK CAP SKYRIZI INJ 180 MG/1.2ML SOGROYA INJ sunitinib malate cap TAFINLAR CAP	PALFORZIA SPRINKLE CAP PULMOZYME INH SOLN  REBIF INJ RIBAVIRIN CAP RUCONEST INJ SKYRIZI INJ 360MG/2.4M	PYRUKYND TAB  RETEVMO CAP RIBAVIRIN TAB SKYCLARYS CAP SKYRIZI INJ 75MG/0.83M	PYRUKYND TAPER PACK REVLIMID CAP RINVOQ ER TAB SKYRIZI INJ 150MG/ML SKYTROFA INJ
TASIGNA CAP THALOMID CAP TRACLEER TAB 32MG	SOMAVERT INJ SYMDEKO TAB TAKHZYRO INJ  TAVNEOS CAP THIOLA EC TAB tretinoin cap	SPRYCEL TAB SYNAGIS INJ TAKHZYRO INJ 150MG/ML TAZVERIK TAB tiopronin tab TRIKAFTA TAB	STELARA INJ tadalafil tab (PAH) TALTZ INJ  temozolomide cap tobramycin neb soln TRIKAFTA THERAPY PACK
TYVASO DPI POWDER			

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.

TYVASO DPI POWDER MAINTENANCE KIT 32-48MCG	TYVASO DPI POWDER TITRATION KIT 16-32-48MCG	TYVASO DPI POWDER TITRATION KIT 16-32MCG	TYVASO INH SOLN
VALCHLOR GEL	VENTAVIS INH SOLN	vigabatrin powder pack	vigabatrin tab
vigadrone powder pack	VIJOICE TAB	VITRAKVI CAP 100MG	VITRAKVI CAP 25MG
VITRAKVI SOLN	VONJO CAP	VOWST CAP	VOXZOGO INJ
WELIREG TAB	XALKORI CAP	XEMBIFY INJ	ZARXIO INJ
ZEJULA CAP	ZEPOSIA CAP	ZEPOSIA STARTER PACK	ZOKINVY CAP
ZOLINZA CAP	ZTALMY SUSP		

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\* 1/1/2024

### Step Therapy (ST)

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

#### Step Therapy (ST) Medications

Drug Name	Step Therapy Requirements
DIFICID SUSP	QL= 136 mL/fill; Step Therapy requires trial of vancomycin cap, FIRST-VANCOMYCIN SOLN, or FIRVANQ SOLN
DIFICID TAB	QL= 20 tabs/fill; Step Therapy requires trial of vancomycin cap, FIRST-VANCOMYCIN SOLN, or FIRVANQ SOLN
LEVALBUTEROL INHALER, XOPENEX HFA INHALER	QL= 2 inhalers/fill, 2 fills/30 days; Step Therapy requires trial of Ventolin HFA
naratriptan tab	QL= 9 tabs/30 days; Step Therapy requires a trial of rizatriptan or sumatriptan
PHEBURANE ORAL PELLETS	Only available through Accredo 800-803-2523; Step Therapy requires trial of sodium phenylbutyrate
pimecrolimus cream	Covered for members 2 years or older; Step Therapy requires trial of tacrolimus oint
RAVICTI LIQUID	Step Therapy requires trial of sodium phenylbutyrate and Pheburane Oral Pellets
SPIRIVA RESPIMAT INHALER 1.25MCG/ACT	QL= 1 inhaler/30 days; Step Therapy requires trial of ADVAIR, BREO, DULERA, or FLUTICASONE/SALMETEROL

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\* 1/1/2024

Drug Name	Tier # for Drug Copay
nicotine patch( QL= 1 patch/day; Limited to 3 months per calendar year)	\$0
varenicline tartrate tab starter pack( Limited to 180 days/plan year; Prior Authorization Required only if member is less than 16 years old)	\$0

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**

**Infertility Drug List**

**Last Updated\* 1/1/2024**

<b>Drug Name</b>	<b>Tier # for Drug Copay</b>
cetrorelix acetate for inj kit	EXC
CETROTIDE KIT	EXC
CLOMID TAB	EXC
CLOMIPHENE TAB	EXC
OVIDREL INJ	EXC

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\* 1/1/2024

## Quantity Limit (QL)

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

### Quantity Limit (QL) Medications

Drug Name	Quantity Limit
ACTEMRA ACTPEN INJ	QL= 2 inj/28 days
ACTEMRA SC INJ	QL= 2 inj/28 days
ACTHAR GEL INJ	QL= 4 vials/fill; Only available through Accredo 800-803-2523 or Walgreens 888-347-3416
ADALIMUMAB-ADAZ INJ	QL= 2 inj/28 days
ADALIMUMAB-ADAZ PFS INJ	QL= 2 inj/28 days
ADALIMUMAB-FKJP AUTO-INJECTOR KIT	QL= 2 inj/28 days
ADALIMUMAB-FKJP PFS KIT 20 MG/0.4ML	QL= 2 inj/28 days
ADALIMUMAB-FKJP PFS KIT 40 MG/0.8ML	QL= 2 inj/28 days
ADBRY INJ	QL= 4 inj/28 days
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= 1 inj/28 days for members 6 months and older
AIMOVIG INJ	QL= 1 pack/28 days
AJOVY INJ	QL= 1 pack/28 days
albuterol HFA inhaler	QL= 2 inhalers/30 days
ALINIA SUSP	QL= 60ml/3 days
ambrisentan tab	QL= 1 tab/day; Restricted to Cardiology or Pulmonology Specialist; Only available through Lumicera 855-847-3553

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\* 1/1/2024****Quantity Limit (QL)**

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

**Quantity Limit (QL) Medications**

<b>Drug Name</b>	<b>Quantity Limit</b>
amphetamine/dextroamphetamine ER cap	QL= 2 caps/day
ANDRODERM PATCH	QL= 1 patch/day
ANNOVERA RING	QL= 1 ring/year
aprepitant cap	QL= 3 caps/fill
aprepitant pak	QL= 3 caps/fill
armodafinil tab	QL= 1 tab/day
ARNUITY ELLIPTA INHALER	QL= 1 inhaler/30 days
artificial tears ophth soln	QL= 25ml/30 days
asenapine maleate SL tab	QL= 2 tabs/day
ASMANEX HFA INHALER	QL= 1 inhaler/30 days
ASMANEX INHALER	QL= 1 inhaler/30 days
atomoxetine cap	QL= 2 caps/day
AUSTEDO XR TAB	QL= 2 tabs/day
azelastine nasal spray 0.1%	QL= 1 bottle/month
azelastine nasal spray 0.15%	QL= 1 bottle/month
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 Lumicera 855-847-3553
butorphanol nasal spray	QL= 1 bottle/30 days
BYDUREON BCISE AUTO INJ	QL= 4 inj/28 days; Diagnosis Restricted – Type 2 Diabetes (E11)

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\* 1/1/2024****Quantity Limit (QL)**

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

**Quantity Limit (QL) Medications**

<b>Drug Name</b>	<b>Quantity Limit</b>
BYDUREON INJ	QL= 4 inj/28 days; Diagnosis Restricted – Type 2 Diabetes (E11)
BYDUREON PEN INJ	QL= 4 inj/28 days; Diagnosis Restricted – Type 2 Diabetes (E11)
BYLVAY CAP 1200MCG	QL= 5 caps/day; Only available through PantheRx Pharmacy 855-726-8479
BYLVAY CAP 400MCG	QL= 15 caps/day; Only available through PantheRx Pharmacy 855-726-8479
BYLVAY SPRINKLE CAP 200MCG	QL= 8 caps/day; Only available through PantheRx Pharmacy 855-726-8479
BYLVAY SPRINKLE CAP 600MCG	QL= 4 caps/day; Only available through PantheRx Pharmacy 855-726-8479
CABOMETYX TAB	QL= 1 tab/day
CAMZYOS CAP	QL= 1 cap/day; Only available through Accredo 800-803-2523 or Walgreens 888-347-3416
cetirizine syrup	QL= 10ml/day
cetirizine tab	QL= 1 tab/day
cetirizine/pseudoephedrine 12-hour tab	QL= 2 tabs/day
CIBINQO TAB	QL= 1 tab/day
CIMZIA INJ	QL= 2 inj/28 days
CIMZIA STARTER INJ KIT	QL= 1 kit/plan year
CINRYZE INJ	QL= 16 vials/28 days; Only available through Accredo 800-803-2523
clindamycin vaginal cream	QL=1 tube/fill
COMIRNATY INJ	QL= 1 dose/17 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\* 1/1/2024****Quantity Limit (QL)**

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

**Quantity Limit (QL) Medications**

<b>Drug Name</b>	<b>Quantity Limit</b>
COMIRNATY INJ 30MCG/0.3ML	QL= 1 dose/17 days
COVID-19 TEST	QL= 8 tests/30 days
COVID-19 VACCINE BIVALENT BOOSTER INJ (MODERNA)	QL= 1 inj/fill
COVID-19 VACCINE BIVALENT BOOSTER INJ (PFIZER)	QL= 1 inj/fill
COVID-19 VACCINE BIVALENT BOOSTER INJ 5-11Y (PFIZER)	QL= 1 inj/fill
COVID-19 VACCINE BIVALENT BOOSTER INJ 6M-4Y (PFIZER)	QL= 1 inj/fill
COVID-19 VACCINE BIVALENT BOOSTER INJ 6M-5Y (MODERNA)	QL= 1 inj/fill
COVID-19 VACCINE INJ (JANSSEN)	QL= 1 dose/45 days
COVID-19 VACCINE INJ (NOVAVAX)	QL= 1 dose/17 days
COVID-19 VACCINE INJ 5-11Y (PFIZER)	QL= 1 dose/17 days
COVID-19 VACCINE INJ 6M-11Y (MODERNA)	QL= 1 dose/24 days
COVID-19 VACCINE INJ 6M-4Y (PFIZER)	QL= 1 dose/17 days
CYSTADROPS SOLN	QL = 4 bottles/28 days; Restricted to Ophthalmology Specialist; Only available through Anovo Specialty Pharmacy 844-288-5007

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\* 1/1/2024****Quantity Limit (QL)**

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

**Quantity Limit (QL) Medications**

<b>Drug Name</b>	<b>Quantity Limit</b>
CYSTARAN OPTH SOLN	QL= 4 bottles/28 days; Restricted to Ophthalmology or Optometry Specialist; Only available through Walgreens 888-347-3416
DAYBUE SOLN	QL= 8 bottles/30 days; Only available through AnovoRx 844-288-500
dexmethylphenidate ER cap	QL= 1 cap/day
diclofenac gel	QL= 300gm/30 days
diclofenac gel 1%	QL= 5 tubes/fill
DIFICID SUSP	QL= 136 mL/fill; Step Therapy requires trial of vancomycin cap, FIRST-VANCOMYCIN SOLN, or FIRVANQ SOLN
DIFICID TAB	QL= 20 tabs/fill; Step Therapy requires trial of vancomycin cap, FIRST-VANCOMYCIN SOLN, or FIRVANQ SOLN
DUPIXENT INJ	QL= 2 inj/28 days
DUPIXENT PEN INJ	QL= 2 inj/28 days
EMGALITY INJ	QL= 1 inj/28 days
EMGALITY INJ 100MG/ML	QL= 3 inj/fill, 6 fills/year
EMPAVELI INJ	QL= 160ml/28 days; Only available through PantheRx 855-726-8479
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
ENDARI POWDER PACK	QL= 6 packets/day
ENSPRYNG INJ	QL= 1 inj/28 days
epinephrine pen inj 0.15mg, 0.3mg	QL= 2 inj/fill

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\* 1/1/2024****Quantity Limit (QL)**

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

**Quantity Limit (QL) Medications**

<b>Drug Name</b>	<b>Quantity Limit</b>
escitalopram soln	QL= 600 units/30 days
escitalopram tab 10mg	QL= 1.5 tabs/day
escitalopram tab 20mg	QL= 1 tab/day
escitalopram tab 5mg	QL= 3 tabs/day
estradiol valerate inj	QL= 5ml/fill
eszopiclone tab	QL= 1 tab/day
everolimus tab	QL= 1 tab/day
everolimus tab 5mg	QL= 1 tab/day
everolimus tab for oral susp	QL= 1 tab/day
EVRYSDI SOLN	QL= 6.67ml/day; Only available through Accredo 800-803-2523
EXKIVITY CAP	QL= 4 caps/day; Only available through Biologics 800-850-4306
FANAPT TAB	QL= 2 tabs/day
FARXIGA TAB	QL= 1 tab/day
FASENRA PEN INJ	QL= 1 inj/56 days; Only available through Accredo 800-803-2523 or Walgreens 888-347-3416
FILSPARI TAB	QL= 1 tab/day; Only available through Accredo 800-803-2523
FINTEPLA SOLN	QL= 12ml/day; Only available through Anovo Specialty Pharmacy 844-288-5007
FLUBLOK QUAD PF INJ	QL= 1 inj/28 days for members 18 years and older
FLUCELVAX QUAD INJ	QL= 1 inj/28 days for members aged 6 months and older
FLULAVAL QUAD INJ, FLUZONE QUAD INJ	QL= 1 inj/28 days for members 6 months and older

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\* 1/1/2024****Quantity Limit (QL)**

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

**Quantity Limit (QL) Medications**

<b>Drug Name</b>	<b>Quantity Limit</b>
FLUMIST QUADRIVALENT NASAL SUSP	QL= 1 inj/28 days for members 2 years and older
FLUZONE/FLUARIX QUAD INJ	QL= 1 inj/28 days for members aged 6 months and older
gabapentin cap	QL= 9 caps/day
gabapentin cap 100mg	QL= 9 caps/day
gabapentin soln	QL= 72 mls/day
gabapentin tab 600mg	QL= 6 tabs/day
gabapentin tab 800mg	QL= 4.5 tabs/day
GAVRETO CAP	QL= 4 caps/day; Only available through Lumicera 855-847-3553
glucagon (rdna) for inj kit	QL= 2 inj/fill, 1 fill/30 days
GLUCAGON DIAGNOSTIC INJ	QL= 2 inj/fill, 1 fill/30 days
GLUCAGON EMR INJ	QL= 2 inj/fill
GLUCAGON INJ KIT	QL= 2 inj/fill
granisetron tab	QL= 14 tabs/fill, 1 fill/30 days
guaifenesin/codeine syrup	QL= 240ml/fill
guanfacine ER tab	QL= 1 tab/day
GVOKE INJ	QL= 2 inj/fill
GVOKE INJ KIT	QL= 2 inj/fill
GVOKE PFS INJ	QL= 2 inj/fill
HADLIMA INJ	QL= 2 inj/28 days
HADLIMA INJ 40MG/0.8ML	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\* 1/1/2024****Quantity Limit (QL)**

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

**Quantity Limit (QL) Medications**

<b>Drug Name</b>	<b>Quantity Limit</b>
HADLIMA PUSH INJ	QL= 2 inj/28 days
HADLIMA PUSH INJ 40MG/0.8ML	QL= 2 inj/28 days
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 80MG	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 PEDIATRIC UC STARTER PACK	QL= 1 pack/fill, 1 fill/plan year
HUMIRA INJ PSORIASIS/UEVITIS 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
HYFTOR GEL	QL= 10 grams/30 days
IMBRUVICA SUSP	QL= 6ml/day; Only available through Diplomat Pharmacy 877-977-9118

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\* 1/1/2024****Quantity Limit (QL)**

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

**Quantity Limit (QL) Medications**

<b>Drug Name</b>	<b>Quantity Limit</b>
IMBRUVICA TAB 420MG, 560MG	QL= 1 tab/day; Only available through Diplomat Pharmacy 877-977-9118
IMCIVREE INJ	QL= 1 inj/day; Only available through PantherRx Pharmacy 855-726-8479
JARDIANCE TAB	QL= 1 tab/day
JAYPIRCA TAB	QL= 2 tabs/day
JOENJA TAB	QL= 2 tabs/day; Only available through PantherRx Pharmacy 855-726-8479
KALYDECO PAK	QL= 2 packets/day; Only available through Walgreens 888-347-3416
KALYDECO TAB	QL= 2 tabs/day; Only available through Walgreens 888-347-3416
ketorolac tab	QL= 20 tabs/5 days
KEVZARA INJ	QL= 2 inj/28 days
KINERET INJ	QL= 1 inj/day; Only available through Biologics 800-850-4306
KOSELUGO CAP	QL= 4 caps/day; Only available through Onco360 877-662-6633
KOSELUGO CAP 10MG	QL= 8 caps/day; Only available through Onco360 877-662-6633
KYTRIL TAB	QL= 14 tabs/fill, 1 fill/30 days
lacosamide iv inj	QL= 1200 units/30 days
lacosamide oral solution	QL= 600ml/30days
LAGEVRIO CAP (EUA)	QL= 40 caps/fill
LAGEVRIO CAP 200MG	QL= 40 caps/fill
lansoprazole cap 15mg	QL= 2 caps/day
lansoprazole odt	QL= 2 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\* 1/1/2024****Quantity Limit (QL)**

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

**Quantity Limit (QL) Medications**

<b>Drug Name</b>	<b>Quantity Limit</b>
latanoprost ophth soln	QL= 2.5ml/30 days
LATUDA TAB	QL= 1 tab/day
LEDIPASVIR/SOFOSBUVIR TAB	QL= 1 tab/day
lenalidomide cap	QL= 1 cap/day; Restricted to Oncology or Hematology Specialist; On available through Walgreens 888-347-3416
LEVALBUTEROL INHALER, XOPENEX HFA INHALER	QL= 2 inhalers/fill, 2 fills/30 days; Step Therapy requires trial of Ventol HFA
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
LINZESS CAP	QL= 1 cap/day
LIVMARLI SOLN	QL= 90ml/30 days; Only available through Eversana 866-849-4481
LIVTENCITY TAB	QL= 4 tabs/day; Only available through Biologics 800-850-4306
loratadine syrup	QL= 10ml/day
loratadine tab	QL= 1 tab/day
LUMIGAN OPTH SOLN	QL= 2.5ml/30 days
LYRICA CAP	QL= 3 caps/day
LYRICA CAP 225MG	QL= 2 caps/day
malathion lotion	QL= 1 bottle/30 days; Limited to 2 fills/year
MAVYRET PAK	QL= 5 packs/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\* 1/1/2024****Quantity Limit (QL)**

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

**Quantity Limit (QL) Medications**

<b>Drug Name</b>	<b>Quantity Limit</b>
MAVYRET TAB	QL= 3 tabs/day
medroxyprogesterone inj	QL= 1 inj/90 days
MEKINIST TAB 0.5MG	QL= 3 tabs/day
MEKINIST TAB 2MG	QL= 1 tab/day
methylergonovine tab	QL= 28 tabs/fill; 1 fill/365 days
methylphenidate ER tab	QL= 1 tab/day
modafinil tab	QL= 2 tabs/day
MOUNJARO INJ	QL= 4 inj/28 days; Diagnosis Restricted – Type 2 Diabetes (E11)
MYFEMBREE TAB	QL= 1 tab/day
naratriptan tab	QL= 9 tabs/30 days; Step Therapy requires a trial of rizatriptan or sumatriptan
NASACORT OTC NASAL SPRAY	QL= 2 bottles/fill
NEURONTIN SOLN	QL= 72 mls/day
NEURONTIN TAB 600MG	QL= 6 tabs/day
NEURONTIN TAB 800MG	QL= 4.5 tabs/day
NEXLETOL TAB	QL= 1 tab/day
NEXLIZET TAB	QL= 1 tab/day
NICOTINE KIT	QL= 1 patch/day; Limited to 3 months per calendar year
nicotine patch	QL= 1 patch/day; Limited to 3 months per calendar year
nitazoxanide tab	QL= 6 tabs/3 days
NUCALA INJ	QL= 1 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\* 1/1/2024****Quantity Limit (QL)**

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

**Quantity Limit (QL) Medications**

<b>Drug Name</b>	<b>Quantity Limit</b>
olopatadine ophth soln 0.2%	QL= 2.5ml/30 days
OLUMIANT TAB	QL= 1 tab/day
OPSUMIT TAB	QL= 1 tab/day; Only available through Accredo 800-803-2523
OPZELURA CREAM	QL= 12 tubes/year
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 Walgreens 888-347-3416
ORKAMBI TAB	QL= 4 tabs/day; Only available through 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
OXBRYTA TAB	QL= 3 tabs/day; Only available through Accredo 800-803-2523
OXBRYTA TAB FOR ORAL SUSP	QL= 5 tabs/day; Only available through Accredo 800-803-2523
OXERVATE OPHTH SOLN	QL= 8 kits/affected eye/lifetime; Only available through Accredo 800-803-2523
OXYCODONE ER TAB	QL= 120 tabs/30 days
OXYCONTIN CR TAB	QL= 120 tabs/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\* 1/1/2024****Quantity Limit (QL)**

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

**Quantity Limit (QL) Medications**

<b>Drug Name</b>	<b>Quantity Limit</b>
OZEMPIC INJ	QL= 1 pack/28 days; Diagnosis Restricted – Type 2 Diabetes (E11)
PAXLOVID TAB 150-100MG	QL= 20 tabs/fill
PAXLOVID TAB 300-100MG	QL= 30 tabs/fill
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= 4 inj/year for members 6 weeks old through 5 years; QL= 1 inj/lifetime for members 6 years and older
PRILOSEC OTC DR TAB	QL= 2 caps/day
PYRUKYND TAB	QL= 2 tabs/day; Only available through Biologics 800-850-4306
PYRUKYND TAPER PACK	QL= 1 tab/day; Only available through Biologics 800-850-4306
QELBREE ER CAP	QL= 2 caps/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
REPATHA PUSHTRONEX INJ	QL= 1 inj/28 days
RETEVMO CAP	QL= 4 caps/day
REVLIMID CAP	QL= 1 cap/day; Only available through Walgreens 888-347-3416; Restricted to Oncology or Hematology Specialist
REZUROCK TAB	QL= 1 tab/day; Only available through Lumicera 855-847-3553
RINVOQ ER 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\* 1/1/2024****Quantity Limit (QL)**

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

**Quantity Limit (QL) Medications**

<b>Drug Name</b>	<b>Quantity Limit</b>
rizatriptan ODT	QL= 12 tabs/30 days
rizatriptan tab	QL= 12 tabs/30 days
ROZLYTREK CAP	QL= 3 caps/day
rufinamide tab	QL= 8 tabs/day
RYBELSUS TAB	QL=1 tab/day; Diagnosis Restricted – Type 2 Diabetes (E11)
SKYCLARYS CAP	QL= 3 caps/day; Only available through Biologics 800-850-4306
SKYRIZI INJ 150MG/ML	QL= 1 inj/84 days
SKYRIZI INJ 180 MG/1.2ML	
SKYRIZI INJ 360MG/2.4ML	
SKYRIZI INJ 75MG/0.83ML	QL= 2 inj/84 days
SOFOSBUVIR/VELPATASVIR TAB 400-100MG	QL= 1 tab/day
SOLU-CORTEF INJ	QL= 1 vial/fill
SOLU-CORTEF INJ 100MG	QL= 2 vials/fill
SPIKEVAX INJ	QL= 1 dose/24 days
SPIKEVAX INJ 50MCG/0.5ML	QL= 1 dose/24 days
SPIRIVA RESPIMAT INHALER 1.25MCG/ACT	QL= 1 inhaler/30 days; Step Therapy requires trial of ADVAIR, BREO 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

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\* 1/1/2024****Quantity Limit (QL)**

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

**Quantity Limit (QL) Medications**

<b>Drug Name</b>	<b>Quantity Limit</b>
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 Walgreens 888-347-3416
SYMJEPI INJ	QL= 2 inj/fill
SYNJARDY TAB	QL= 2 tabs/day
SYNJARDY XR TAB 10-1000MG, 25-1000MG	QL= 1 tab/day
SYNJARDY XR TAB 5-1000MG, 12.5-1000MG	QL= 2 tabs/day
TAFINLAR CAP	QL= 4 tabs/day
TAKHZYRO INJ	QL= 2 inj/28 days; Only available through Accredo 800-803-2523
TAKHZYRO INJ 150MG/ML	QL= 2 inj/28 days; Only available through Accredo 800-803-2523
TALTZ INJ	QL= 1 inj/28 days
TAVNEOS CAP	QL= 6 caps/day; Only available through PantheRx 855-726-8479
TAZVERIK TAB	QL= 8 tabs/day; Only available through Onco360 877-662-6633
TESTOSTERONE GEL 1% 25MG	QL= 1 packet/day
testosterone gel 1% 50mg	QL= 2 packets/day
testosterone gel 1% pump	QL= 4 bottles/30 days
testosterone gel 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

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\* 1/1/2024****Quantity Limit (QL)**

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

**Quantity Limit (QL) Medications**

<b>Drug Name</b>	<b>Quantity Limit</b>
testosterone gel pump 1.62%	QL= 2 bottles/30 days
TEZSPIRE INJ	QL= 1 pen/28 days
tranexamic acid tab	
travoprost ophth soln	QL= 5ml/30 days
triamcinolone OTC nasal spray	QL= 2 bottles/fill
TRIKAFTA TAB	QL= 84 tabs/28 days; Only available through Walgreens 888-347-341
TRIKAFTA THERAPY PACK	QL= 2 packets/day; Only available through Walgreens 888-347-3416
TRIUMEQ PD TAB	QL= 1 tab/day
TRIUMEQ TAB	QL= 1 tab/day
TYVASO DPI POWDER	QL= 4 cartridges/day; Only available through Accredo 800-803-2523
TYVASO DPI POWDER MAINTENANCE KIT 32-48MCG	QL= 224 cartridges/28 days; Only available through Accredo 800-803-2523
TYVASO DPI POWDER TITRATION KIT 16-32-48MCG	QL= 252 cartridges/28 days; Only available through Accredo 800-803-2523
TYVASO DPI POWDER TITRATION KIT 16-32MCG	QL= 196 cartridges/28 days; Only available through Accredo 800-803-2523
VALCHLOR GEL	QL= 4 tubes/30 days; Only available through Optum Pharmacy 877-445-6874
vancomycin cap	QL= 56 caps/fill
varenicline tartrate tab starter pack	Limited to 180 days/plan year; Prior Authorization Required only if member is less than 16 years old
VENTOLIN HFA INHALER	QL= 2 inhalers/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\* 1/1/2024****Quantity Limit (QL)**

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

**Quantity Limit (QL) Medications**

<b>Drug Name</b>	<b>Quantity Limit</b>
VICTOZA INJ	QL= 9ml/30 days; Diagnosis Restricted – Type 2 Diabetes (E11)
VIJOICE TAB	QL= 1 tab/day
VIMPAT INJ	QL= 1200 units/30 days
VITRAKVI CAP 100MG	QL= 2 caps/day; Only available through Accredo 800-803-2523
VITRAKVI CAP 25MG	QL= 6 caps/day; Only available through Accredo 800-803-2523
VITRAKVI SOLN	QL= 10ml/day; Only available through Accredo 800-803-2523
VONJO CAP	QL= 4 caps/day; Only available through Biologics 800-850-4306
VOWST CAP	QL= 12 caps/fill; Only available through Orsini 800-410-8575
VOXZOGO INJ	QL= 1 vial/day; Only available through Accredo 888-773-7376
WELIREG TAB	QL= 3 tabs/day; Only available through Biologics 800-850-4306
XALKORI CAP	QL= 2 caps/day
XELJANZ SOLN	QL= 10 ml/day
XELJANZ TAB	QL= 2 tabs/day
XELJANZ XR TAB	QL= 1 tab/day
XIGDUO XR TAB 2.5-1000MG, 5-1000MG	QL= 2 tabs/day
XIGDUO XR TAB 5-500MG, 10-500MG 10-1000MG	QL= 1 tab/day
XOFLUZA TAB	QL= 2 tabs/fill; Covered for members 12 years of age or older
XOFLUZA TAB THERAPY PACK 40MG	QL= 1 tab/fill; Covered for members 12 years of age or older
XOFLUZA TAB THERAPY PACK 80MG	QL= 1 tab/fill; Covered for members 12 years of age or older
XULTOPHY INJ	QL= 15ml/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\* 1/1/2024****Quantity Limit (QL)**

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

**Quantity Limit (QL) Medications**

<b>Drug Name</b>	<b>Quantity Limit</b>
zaleplon cap	QL= 1 cap/day
ZAVZPRET NASAL SPRAY	QL= 6 units/fill; 60 units/365 days
ZEGALOGUE INJ	QL= 2 inj/fill
ZEJULA CAP	QL= 3 caps/day; Only available through Diplomat Pharmacy 877-977-9118
ziprasidone cap	QL= 2 caps/day
ZOKINVY CAP	QL= 4 caps/day; Only available through CVS Specialty 800-237-2767
ZORYVE CREAM	QL= 60 grams/30 days
ZTALMY SUSP	QL= 1100ml/30 days; Only available through Orsini 800-410-8575
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.