

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 4/1/2024

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
ABRYSSVO 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

	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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2024

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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2024

Drug Name	Special Code	Tier	Category
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

	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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2024

Drug Name	Special Code	Tier	Category
ADALIMUMAB-ADAZ INJ (HYRIMOZ equiv) (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 (HULIC equiv) (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

	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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2024

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	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
albuterol neb soln	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ALBUTEROL NEBULIZER SOLN	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
albuterol sulfate syrup	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
albuterol sulfate tab	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS

	NC =Not Covered	generic =small letters	BRANDS =CAPITAL LETTERS
EXC	Plan Exclusion	INF	Infertility
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of 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 4/1/2024

Drug Name	Special Code	Tier	Category
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	NASAL AGENTS - SYSTEMIC AND TOPICAL
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
ALOMIDE OPHTH SOLN	-	2	OPHTHALMIC AGENTS
alosetron tab (LOTRONEX equiv)	-	1	GASTROINTESTINAL AGENTS - MISC.

	NC =Not Covered	generic =small letters	BRANDS =CAPITAL LETTERS
EXC	Plan Exclusion	INF	Infertility
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of 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 4/1/2024

Drug Name	Special Code	Tier	Category
ALPHAGAN P OPHTH SOLN 0.15%	-	2	OPHTHALMIC AGENTS
alprazolam ER tab (XANAX XR equiv)	-	2	ANTIANKXIETY AGENTS
alprazolam ODT (NIRAVAM equiv)	-	2	ANTIANKXIETY AGENTS
alprazolam tab (XANAX equiv)	-	1	ANTIANKXIETY AGENTS
ALREX OPHTH SUSP	-	2	OPHTHALMIC AGENTS
ALTRENO LOTION	-	2	DERMATOLOGICALS
amantadine syrup (SYMMETREL equiv)	-	1	ANTIPARKINSON AGENTS
ambrisentan tab (LETAIRIS equiv) (QL= 1 tab/day; Only available through Lumicera 855-847-3553)	LD-PA-QL	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
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

	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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2024

Drug Name	Special Code	Tier	Category
ammonium lactate lotion (LAC-HYDRIN equiv)	OTC	1	DERMATOLOGICALS
amnestem cap, claravis cap, isotretinoin cap, myorisan cap, zenatane cap (ACCUTANE 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
anagrelide cap (AGRYLIN equiv)	-	1	HEMATOLOGICAL AGENTS - MISC.
anastrozole tab (ARIMIDEX equiv)	-	1	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 for first 3 months	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of 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 4/1/2024

Drug Name	Special Code	Tier	Category
ANDRODERM PATCH (QL= 1 patch/day)	PA-QL	2	ANDROGENS-ANABOLIC
ANNOVERA RING (QL= 1 ring/year)	QL	\$0	CONTRACEPTIVES
APAP/CODEINE SOLN	-	1	ANALGESICS - OPIOID
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
artificial tears	OTC	1	OPHTHALMIC AGENTS
artificial tears (LIQUIFILM equiv)	OTC	1	OPHTHALMIC AGENTS

	NC =Not Covered	generic =small letters	BRANDS =CAPITAL LETTERS
EXC	Plan Exclusion	INF	Infertility
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month fo first 3 months	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of 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 4/1/2024

Drug Name	Special Code	Tier	Category
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
ASTAMED MYO CAP	-	EX C	DIETARY PRODUCTS / DIETARY MANAGEMENT PRODUCTS

	NC =Not Covered	generic =small letters	BRANDS =CAPITAL LETTERS
EXC	Plan Exclusion	INF	Infertility
LD	Limited Distribution	LMSD	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of 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 4/1/2024

Drug Name	Special Code	Tier	Category
atazanavir cap (REYATAZ equiv)	-	1	ANTIVIRALS
atenolol tab (TENORMIN equiv)	-	1	BETA BLOCKERS
atenolol/chlorthalidone tab (TENORETIC equiv)	-	1	ANTIHYPERTENSIVES
atomoxetine cap (STRATTERA 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
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
AUSTEDO XR TAB (QL= 2 tabs/day)	LMSP-PA-QL	2	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
AVAR GEL	-	2	DERMATOLOGICALS

	NC =Not Covered	generic =small letters	BRANDS =CAPITAL LETTERS
EXC	Plan Exclusion	INF	Infertility
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of 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 4/1/2024

Drug Name	Special Code	Tier	Category
AVONEX INJ	LMSP	2	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
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
bacitracin/polymyxin b ophth oint (POLYSPORIN equiv)	-	1	OPHTHALMIC AGENTS
bacitracin/polymyxin/neomycin/hydrocortisone ophth oint (CORTISPORIN equiv)	-	1	OPHTHALMIC AGENTS
bacitracin/zinc oint	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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2024

Drug Name	Special Code	Tier Category
BACLOFEN ORAL SOLN 5 MG/5ML	-	2+p MUSCULOSKELETAL en al THERAPY AGENTS ty
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 ANTICONVULSANTS en al ty
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 VACCINES C
B-D INSULIN SYRINGE	--OTC	1 MEDICAL DEVICES AND SUPPLIES
B-D PEN NEEDLE	OTC	1 MEDICAL DEVICES AND SUPPLIES
BELLADONNA ALKALOID/OPIUM SUPP	-	2 ULCER DRUGS
benazepril tab (LOTENSIN equiv)	-	1 ANTIHYPERTENSIVES

	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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2024

Drug Name	Special Code	Tier	Category
benazepril/hydrochlorothiazide tab (LOTENSIN HC1 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.
betamethasone augmented cream (DIPROLENE AF CREAM equiv)	-	1	DERMATOLOGICALS
betamethasone augmented gel	-	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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2024

Drug Name	Special Code	Tier	Category
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 OPHTH 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 OPHTH SOLN	-	2	OPHTHALMIC AGENTS
BETOPTIC-S OPHTH SOLN	-	2	OPHTHALMIC AGENTS
bexarotene cap (TARGRETIN equiv)	PA-SP	1	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
bicalutamide tab (CASODEX equiv)	-	1	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
BIKTARVY 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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2024

Drug Name	Special Code	Tier	Category
bimatoprost ophth soln (QL= 2.5ml/30 days)	QL	1	OPHTHALMIC AGENTS
bimatoprost ophth soln	QL--	EX	DERMATOLOGICALS
		C	
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
budesonide inh susp (PULMICORT equiv)	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS

	NC =Not Covered	generic =small letters	BRANDS =CAPITAL LETTERS
EXC	Plan Exclusion	INF	Infertility
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month fo first 3 months	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of 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 4/1/2024

Drug Name	Special Code	Tier	Category
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
bupirone tab (BUSPAR equiv)	-	1	ANTIANKIETY AGENTS
butorphanol nasal spray (STADOL equiv) (QL= 1 bottle/30 days)	QL	1	ANALGESICS - OPIOID
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

	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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2024

Drug Name	Special Code	Tier	Category
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
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

	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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2024

Drug Name	Special Code	Tier	Category
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	MINERALS & ELECTROLYTES
calcium carbonate tab	OTC	1	MINERALS & ELECTROLYTES
CALCIUM W/ VITAMIN D TAB	OTC	2	MINERALS & ELECTROLYTES
calcium w/vitamin D tab	OTC	1	MINERALS & ELECTROLYTES
CALIBRATION LIQUID	OTC	1	MEDICAL DEVICES AND SUPPLIES

	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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2024

Drug Name	Special Code	Tier	Category
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
CARBIDOPA/LEVODOPA/ENTACAPONE TAB (STALEVO equiv)	-	2	ANTIPARKINSON 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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2024

Drug Name	Special Code	Tier	Category
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	1	ENDOCRINE AND METABOLIC AGENTS - MISC.
carisoprodol tab (SOMA equiv)	-	1	MUSCULOSKELETAL THERAPY AGENTS
CAROSPIR SUSP	-	2+p	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.
CEFACLOR CAP	-	1	CEPHALOSPORINS
cefaclor cap (CECLOR equiv)	-	1	CEPHALOSPORINS

	NC =Not Covered	generic =small letters	BRANDS =CAPITAL LETTERS
EXC	Plan Exclusion	INF	Infertility
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of 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 4/1/2024

Drug Name	Special Code	Tier	Category
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 - enantiomericANTI-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
cetirizine syrup (ZYRTEC equiv) (QL= 10ml/day)	OTC-QL	1	ANTIHISTAMINES
cetirizine tab (ZYRTEC equiv) (QL= 1 tab/day)	OTC-QL	1	ANTIHISTAMINES

	NC =Not Covered	generic =small letters	BRANDS =CAPITAL LETTERS
EXC	Plan Exclusion	INF	Infertility
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month fo first 3 months	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of 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 4/1/2024

Drug Name	Special Code	Tier	Category
cetirizine/pseudoephedrine 12-hour tab (ZYRTEC equiv) (QL= 2 tabs/day)	OTC-QL	1	COUGH / COLD / ALLERGY
cetorelix acetate for inj kit (CETROTIDE equiv)	INF	EX	ENDOCRINE AND METABOLIC AGENTS - MISC.
CETROTIDE KIT	INF	EX	ENDOCRINE AND METABOLIC AGENTS - MISC.
cevimeline cap (EVOXAC equiv)	-	1	MOUTH / THROAT / DENTAL AGENTS
CHEMET CAP	-	2	ANTIDOTES
chlordiazepoxide cap (LIBRIUM equiv)	-	1	ANTIANSIETY 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
chlorzoxazone tab 500mg	-	1	MUSCULOSKELETAL THERAPY AGENTS
cholecalciferol cap (VITAMIN D equiv)	OTC	1	VITAMINS

	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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2024

Drug Name	Special Code	Tier	Category
cholecalciferol tab (VITAMIN D equiv)	OTC	1	VITAMINS
cholestyramine lite powder (QUESTRAN LITE equiv)	-	1	ANTIHYPERSLIPIDEMICS
cholestyramine lite powder pack (QUESTRAN LITE equiv)	-	1	ANTIHYPERSLIPIDEMICS
cholestyramine powder (QUESTRAN equiv)	-	1	ANTIHYPERSLIPIDEMICS
cholestyramine powder pack (QUESTRAN equiv)	-	1	ANTIHYPERSLIPIDEMICS
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
CIMZIA INJ (QL= 2 inj/28 days)	LMSP-PA-QL	2	GASTROINTESTINAL AGENTS - MISC.

	NC =Not Covered	generic =small letters	BRANDS =CAPITAL LETTERS
EXC	Plan Exclusion	INF	Infertility
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of 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 4/1/2024

Drug Name	Special Code	Tier	Category
CIMZIA STARTER INJ KIT (QL= 1 kit/plan year)	LMSP-PA-QL	2	GASTROINTESTINAL AGENTS - MISC.
CINRYZE INJ (QL= 16 vials/28 days; Only available through 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
CLARITHROMYC SUSP	-	2	MACROLIDES
clarithromycin ER tab (BIAXIN XL equiv)	-	1	MACROLIDES
clarithromycin tab (BIAXIN equiv)	-	1	MACROLIDES
CLARITIN CHEW TAB	OTC	2	ANTIHISTAMINES
CLEMASTINE TAB 1.34MG	OTC	1	ANTIHISTAMINES
clemastine tab 1.34mg (TAVIST equiv)	OTC	1	ANTIHISTAMINES

	NC =Not Covered	generic =small letters	BRANDS =CAPITAL LETTERS
EXC	Plan Exclusion	INF	Infertility
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of 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 4/1/2024

Drug Name	Special Code	Tier	Category
CLEOCIN-T GEL	-	2+p	DERMATOLOGICALS
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
CLINDESSE VAGINAL CREAM (QL= 1 applicator/fill)	QL	2	VAGINAL AND RELATED PRODUCTS
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 (OLUX equiv)	-	1	DERMATOLOGICALS

	NC =Not Covered	generic =small letters	BRANDS =CAPITAL LETTERS
EXC	Plan Exclusion	INF	Infertility
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of 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 4/1/2024

Drug Name	Special Code	Tier	Category
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 equiv)	-	1	DERMATOLOGICALS
clobetasol spray	PA	1	DERMATOLOGICALS
CLOBEX SPRAY	PA	2+p	DERMATOLOGICALS
CLOMID TAB	INF	EX	ENDOCRINE AND METABOLIC AGENTS - MISC.
CLOMIPHENE TAB	INF	EX	ENDOCRINE AND 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

	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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2024

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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2024

Drug Name	Special Code	Tier	Category
COMBIVENT RESPIMAT INHALER	-	2	ANTIASTHMATIC 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

	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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2024

Drug Name	Special Code	Tier Category
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

	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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2024

Drug Name	Special Code	Tier	Category
CUE HEALTH MONITOR	OTC	EX	DIAGNOSTIC PRODUCTS
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
cyclosporine ophth emulsion (RESTASIS equiv) (QL= 60 vials/30 days; Restricted to Ophthalmology or Optometry Specialist)	QL-RS	1	OPHTHALMIC AGENTS
cyproheptadine syrup	-	1	ANTIHISTAMINES
cyproheptadine tab	-	1	ANTIHISTAMINES

	NC =Not Covered	generic =small letters	BRANDS =CAPITAL LETTERS
EXC	Plan Exclusion	INF	Infertility
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of 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 4/1/2024

Drug Name	Special Code	Tier	Category
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
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

	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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2024

Drug Name	Special Code	Tier	Category
deferasirox granules packet (JADENU equiv)	LMSP	1	ANTIDOTES AND SPECIFIC ANTAGONISTS
deferasirox tab (JADENU equiv)	LMSP	1	ANTIDOTES AND SPECIFIC ANTAGONISTS
deferasirox tab for oral susp (EXJADE 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
DENGVAZIA 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 nasal spray (DDAVP equiv)	-	1	ENDOCRINE AND METABOLIC AGENTS - MISC.
desmopressin acetate tab (DDAVP equiv)	-	1	ENDOCRINE AND METABOLIC AGENTS - MISC.
DESOGEN TAB	-	\$0	CONTRACEPTIVES
desonide cream (DESOWEN equiv)	-	2	DERMATOLOGICALS

	NC =Not Covered	generic =small letters	BRANDS =CAPITAL LETTERS
EXC	Plan Exclusion	INF	Infertility
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of 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 4/1/2024

Drug Name	Special Code	Tier	Category
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
dextroamphetamine ER cap (DEXEDRINE 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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2024

Drug Name	Special Code	Tier	Category
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 rectal gel (QL= 2 packs/fill)	QL	2	ANTICONVULSANTS
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
diclofenac potassium tab (CATAFLAM equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY

	NC =Not Covered	generic =small letters	BRANDS =CAPITAL LETTERS
EXC	Plan Exclusion	INF	Infertility
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of 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 4/1/2024

Drug Name	Special Code	Tier	Category
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
DIFICID SUSP (QL= 136 mL/fill; Step Therapy requires trial of vancomycin cap, FIRST-VANCOMYCIN SOLN, or FIRVANQ SOLN)	QL-ST	2	MACROLIDES

	NC =Not Covered	generic =small letters	BRANDS =CAPITAL LETTERS
EXC	Plan Exclusion	INF	Infertility
LD	Limited Distribution	LMS	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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2024

Drug Name	Special Code	Tier	Category
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
diltiazem tab (CARDIZEM 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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2024

Drug Name	Special Code	Tier	Category
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	HYPNOTICS / SEDATIVES SLEEP DISORDER AGENTS
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
DIPHTHERIA/TETANUS TOXOID (PEDIATRIC) INJ	VAC	\$0	TOXOIDS

	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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2024

Drug Name	Special Code	Tier	Category
dipyridamole tab (PERSANTINE equiv)	-	1	HEMATOLOGICAL AGENTS - MISC.
disopyramide cap (NORPACE equiv)	-	1	ANTIARRHYTHMICS
disulfiram tab (ANTABUSE equiv)	-	1	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
DIURIL SUSP	-	2	DIURETICS
divalproex ER tab (DEPAKOTE ER equiv)	-	1	ANTICONSULTANTS
divalproex sodium DR tab (DEPAKOTE equiv)	-	1	ANTICONSULTANTS
divalproex sprinkle cap (DEPAKOTE equiv)	-	1	ANTICONSULTANTS
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
doxepin cap (SINEQUAN equiv)	-	1	ANTIDEPRESSANTS
doxepin conc (SINEQUAN equiv)	-	1	ANTIDEPRESSANTS

	NC =Not Covered	generic =small letters	BRANDS =CAPITAL LETTERS
EXC	Plan Exclusion	INF	Infertility
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of 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 4/1/2024

Drug Name	Special Code	Tier	Category
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
econazole cream (SPECTAZOLE equiv)	-	1	DERMATOLOGICALS
EDURANT 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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2024

Drug Name	Special Code	Tier	Category
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	ANTIASTHMATIC 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
EMPAVELI INJ (QL= 160ml/28 days; Only available through PantheRx 855-726-8479)	LD-PA-QL	2	HEMATOLOGICAL AGENTS - MISC.

	NC =Not Covered	generic =small letters	BRANDS =CAPITAL LETTERS
EXC	Plan Exclusion	INF	Infertility
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of 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 4/1/2024

Drug Name	Special Code	Tier	Category
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
enpresse tab (TRI-LEVELLEN equiv)	-	\$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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2024

Drug Name	Special Code	Tier	Category
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
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
erythromycin DR cap (ERYC equiv)	-	2	MACROLIDES

	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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2024

Drug Name	Special Code	Tier	Category
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
estradiol patch (VIVELLE-DOT equiv)	-	1	ESTROGENS

	NC =Not Covered	generic =small letters	BRANDS =CAPITAL LETTERS
EXC	Plan Exclusion	INF	Infertility
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of 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 4/1/2024

Drug Name	Special Code	Tier	Category
estradiol tab (ESTRACE equiv)	-	1	ESTROGENS
estradiol valerate inj (DELESTROGEN equiv) (QL= 5ml/fill)	PA-QL	1	ESTROGENS
estradiol/norethindrone tab (ACTIVELLA 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 (EDECIN equiv)	-	1	DIURETICS
ethambutol tab (MYAMBUTOL equiv)	-	1	ANTIMYCOBACTERIAL AGENTS
ethosuximide cap (ZARONTIN equiv)	-	1	ANTICONVULSANTS
ethosuximide soln (ZARONTIN equiv)	-	1	ANTICONVULSANTS
etodolac cap (LODINE equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
etodolac ER tab (LODINE XL equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
etodolac tab	-	1	ANALGESICS - ANTI-INFLAMMATORY
ETOPOSIDE CAP	LMSP	1	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
etravirine tab (INTELENCE 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 fo first 3 months	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of 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 4/1/2024

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)	PA	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
EXTAVIA INJ	LMSP	2	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
EZALLOR SPRINKLE CAP (Prior Authorization Required for members age 9 or older)	PA	2	ANTHYPERLIPIDEMICS
ezetimibe tab (ZETIA equiv)	-	1	ANTHYPERLIPIDEMICS
FALESSA KIT	-	\$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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2024

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	ANTIHYPERTENSIVES
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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2024

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

	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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2024

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

	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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2024

Drug Name	Special Code	Tier Category
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 ACET CREAM	-	1 DERMATOLOGICALS
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

	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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2024

Drug Name	Special Code	Tier	Category
fluocinonide cream 0.1% (VANOS CREAM equiv)	-	1	DERMATOLOGICALS
fluocinonide emollient cream	-	1	DERMATOLOGICALS
fluocinonide gel	-	1	DERMATOLOGICALS
fluocinonide oint	-	1	DERMATOLOGICALS
fluocinonide soln	-	1	DERMATOLOGICALS
FLUORABON SOLN	-	2	MINERALS & ELECTROLYTES
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
fluorouracil soln (FLUOROURACIL equiv)	-	1	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

	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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2024

Drug Name	Special Code	Tier	Category
flurbiprofen tab (ANSAID equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
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 nasal spray (FLONASE equiv)	-	1	NASAL AGENTS - SYSTEMIC AND TOPICAL
fluticasone propionate cream (CUTIVATE equiv)	-	1	DERMATOLOGICALS
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

	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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2024

Drug Name	Special Code	Tier	Category
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
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

	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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2024

Drug Name	Special Code	Tier	Category
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
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

	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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2024

Drug Name	Special Code	Tier	Category
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 OPHTH OINT	-	1	OPHTHALMIC AGENTS
gentamicin ophth soln (GARAMYCIN equiv)	-	1	OPHTHALMIC AGENTS
gentamicin sulfate cream	-	1	DERMATOLOGICALS
gentamicin sulfate oint	-	1	DERMATOLOGICALS
genteal ophth oint	OTC	1	OPHTHALMIC AGENTS
GENVOYA TAB	PA	2	ANTIVIRALS
gianvi tab, ocella tab (YASMIN, YAZ equiv)	-	\$0	CONTRACEPTIVES
GILENYA CAP 0.25MG	LMSP-PA	2	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
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

	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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2024

Drug Name	Special Code	Tier	Category
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 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
GLUCAGON KIT (QL= 2 inj/fill, 1 fill/30 days)	QL	1	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
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

	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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2024

Drug Name	Special Code	Tier	Category
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
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

	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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2024

Drug Name	Special Code	Tier	Category
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
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, INSULIN LISPRO MIX KWIKPEN	-	2	ANTIDIABETICS
HUMALOG PEN INJ	-	2	ANTIDIABETICS
HUMIRA INJ 10MG (QL= 2 syringes/28 days)	LMSP-PA-QL	2	ANALGESICS - ANTI-INFLAMMATORY

	NC =Not Covered	generic =small letters	BRANDS =CAPITAL LETTERS
EXC	Plan Exclusion	INF	Infertility
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of 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 4/1/2024

Drug Name	Special Code	Tier	Category
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 PACK (QL= 1 pack/fill, 1 fill/plan year)	LMSP-PA-QL	2	ANALGESICS - ANTI-INFLAMMATORY
HUMIRA PEN INJ 40MG (QL= 2 pens/28 days)	LMSP-PA-QL	2	ANALGESICS - ANTI-INFLAMMATORY
HUMULIN 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

	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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2024

Drug Name	Special Code	Tier	Category
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
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

	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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2024

Drug Name	Special Code	Tier	Category
hydroquinone cream (LUSTRA equiv)	-	EX	DERMATOLOGICALS C
hydroxychloroquine tab (PLAQUENIL equiv)	-	1	ANTIMALARIALS
hydroxyurea cap (HYDREA equiv)	-	1	ANTINEOPLASTICS
hydroxyzine pamoate cap (VISTARIL equiv)	-	1	ANTI-ANXIETY AGENTS
hydroxyzine syrup (ATARAX equiv)	-	1	ANTI-ANXIETY AGENTS
hydroxyzine tab (ATARAX equiv)	-	1	ANTI-ANXIETY AGENTS
HYFTOR GEL (QL= 10 grams/30 days)	PA-QL	2	DERMATOLOGICALS
hyoscyamine sulfate CR tab (LEVBIID 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
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

	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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2024

Drug Name	Special Code	Tier	Category
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.
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
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

	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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2024

Drug Name	Special Code	Tier	Category
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 GLARGINE SOLN PEN-INJ	-	2	ANTIDIABETICS
INSULIN LISPRO INJ (HUMALOG equiv)	-	1	ANTIDIABETICS
INSULIN LISPRO JR KWIKPEN INJ	-	2	ANTIDIABETICS
INSULIN LISPRO KWIKPEN INJ	-	2	ANTIDIABETICS
INTELENCE TAB	-	2	ANTIVIRALS
INVIRASE CAP	-	2	ANTIVIRALS
INVIRASE TAB	-	2	ANTIVIRALS
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

	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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2024

Drug Name	Special Code	Tier	Category
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 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
ISOXSUPRINE TAB	-	1	CARDIOVASCULAR AGENTS - MISC.
isradipine cap (DYNACIRC equiv)	-	1	CALCIUM CHANNEL BLOCKERS
ISTALOL OPHTH SOLN	-	2	OPHTHALMIC AGENTS
itraconazole cap (SPORANOX equiv)	PA	1	ANTIFUNGALS
ivermectin tab (STROMEKTOL equiv)	PA	1	ANTHELMINTICS
JAKAFI TAB	PA	2	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
JANUMET XR TAB	-	2	ANTIDIABETICS

	NC =Not Covered	generic =small letters	BRANDS =CAPITAL LETTERS
EXC	Plan Exclusion	INF	Infertility
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of 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 4/1/2024

Drug Name	Special Code	Tier	Category
JARDIANCE TAB (QL= 1 tab/day)	QL	2	ANTIDIABETICS
JAYPIRCA TAB (QL= 2 tabs/day)	LMS-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	ANTIVIRALS
KALYDECO PAK (QL= 2 packets/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	2	RESPIRATORY AGENTS - MISC.
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 / ANTI-NARCOLEPSY / 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

	NC =Not Covered	generic =small letters	BRANDS =CAPITAL LETTERS
EXC	Plan Exclusion	INF	Infertility
LD	Limited Distribution	LMS-PA-QL	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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2024

Drug Name	Special Code	Tier	Category
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
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 PEF SYRINGE, QUADRACEL PEF SYRINGE	VAC	\$0	TOXOIDS
KITABIS PAK NEB SOLN (Only available through Walgreens 888-347-3416)	LD	2	AMINOGLYCOSIDES

	NC =Not Covered	generic =small letters	BRANDS =CAPITAL LETTERS
EXC	Plan Exclusion	INF	Infertility
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of 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 4/1/2024

Drug Name	Special Code	Tier	Category
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	ANTIEMETICS enal
labetalol tab (NORMODYNE equiv)	-	1	BETA BLOCKERS
lacosamide iv inj (VIMPAT equiv) (QL= 1200 units/30 days)	QL	1	ANTICONVULSANTS
lacosamide oral solution (VIMPAT equiv) (QL= 1200ml/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

	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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2024

Drug Name	Special Code	Tier	Category
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
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 / ANTIMANIC AGENTS
layolis FE tab, wymzya FE tab (FEMCON FE equiv)	-	\$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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2024

Drug Name	Special Code	Tier	Category
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
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 OPHTH SOLN	-	1	OPHTHALMIC AGENTS
levobunolol ophth soln (BETAGAN equiv)	-	1	OPHTHALMIC AGENTS

	NC =Not Covered	generic =small letters	BRANDS =CAPITAL LETTERS
EXC	Plan Exclusion	INF	Infertility
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of 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 4/1/2024

Drug Name	Special Code	Tier	Category
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 OPHTH SOLN 0.5%	-	1	OPHTHALMIC AGENTS
levofloxacin soln (LEVAQUIN equiv)	-	1	FLUOROQUINOLONES
levofloxacin tab (LEVAQUIN equiv)	-	1	FLUOROQUINOLONES
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

	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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2024

Drug Name	Special Code	Tier	Category
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
lidocaine/prilocaine cream (EMLA equiv)	-	1	DERMATOLOGICALS
LIKMEZ SUSP (Prior Authorization Required for members age 9 or older)	PA	2	ANTI-INFECTIVE AGENTS MISC.
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

	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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2024

Drug Name	Special Code	Tier	Category
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
LITFULO CAP	-	EX	DERMATOLOGICALS
lithium carbonate cap (ESKALITH ER equiv)	-	1	ANTIPSYCHOTICS / ANTIMANIC AGENTS
lithium carbonate ER tab (LITHOBID equiv)	-	1	ANTIPSYCHOTICS / ANTIMANIC AGENTS
lithium carbonate tab	-	1	ANTIPSYCHOTICS / ANTIMANIC AGENTS
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

	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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2024

Drug Name	Special Code	Tier Category
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
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

	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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2024

Drug Name	Special Code	Tier	Category
LOTEMAX OPHTH GEL	-	2	OPHTHALMIC AGENTS
LOTEMAX OPHTH 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	ANTIHYPERSLIPIDEMICS
loxapine cap (LOXITANE equiv)	-	1	ANTIPSYCHOTICS / ANTIMANIC AGENTS
LUMIGAN OPHTH 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	ANTICONVULSANTS enal ty
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

	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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2024

Drug Name	Special Code	Tier	Category
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
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.

	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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2024

Drug Name	Special Code	Tier	Category
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 SOLN	PA	2	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
mercaptopurine tab (PURINETHOL equiv)	-	1	ANTINEOPLASTICS
mesalamine DR tab (LIALDA equiv)	-	1	GASTROINTESTINAL AGENTS - MISC.
mesalamine enema (ROWASA equiv)	-	1	GASTROINTESTINAL AGENTS - MISC.

	NC =Not Covered	generic =small letters	BRANDS =CAPITAL LETTERS
EXC	Plan Exclusion	INF	Infertility
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month fo first 3 months	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of 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 4/1/2024

Drug Name	Special Code	Tier	Category
mesna inj (MESNEX equiv)	-	1	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
MESNEX TAB	LMSP	2	ANTINEOPLASTICS
METANX CAP	-	EX C	DIETARY PRODUCTS / DIETARY MANAGEMENT PRODUCTS
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.
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

	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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2024

Drug Name	Special Code	Tier	Category
methscopolamine tab (PAMINE equiv)	-	1	ULCER DRUGS
methsuximide cap (CELONTIN equiv)	-	1	ANTICONVULSANTS
METHYLDOPA TAB	-	1	ANTIHYPERTENSIVES
methyl dopa tab (ALDOMET equiv)	-	1	ANTIHYPERTENSIVES
methylergonovine tab (METHERGINE equiv) (QL= 28 tabs/fill; 1 fill/365 days)	QL	2	OXYTOCICS
methylphenidate CD cap (METADATE CD equiv)	-	1	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
methylphenidate ER tab	-	1	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
METHYLPHENIDATE ER TAB (QL= 1 tab/day)	--QL	2	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
methylphenidate soln (METHYLIN 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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2024

Drug Name	Special Code	Tier	Category
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 OPHTH SOLN	-	2	OPHTHALMIC AGENTS
metoclopramide soln (REGLAN equiv)	-	1	GASTROINTESTINAL AGENTS - MISC.
metoclopramide tab (REGLAN equiv)	-	1	GASTROINTESTINAL AGENTS - MISC.
metolazone tab (ZAROXOLYN equiv)	-	1	DIURETICS
metoprolol ER tab (TOPROL XL equiv)	-	1	BETA BLOCKERS
metoprolol tab (LOPRESSOR equiv)	-	1	BETA BLOCKERS
metoprolol/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.

	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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2024

Drug Name	Special Code	Tier	Category
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
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

	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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2024

Drug Name	Special Code	Tier Category
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
modafinil tab (PROVIGIL equiv) (QL= 2 tabs/day)	QL	1 ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
moexipril tab (UNIVASC 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

	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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2024

Drug Name	Special Code	Tier	Category
montelukast chew tab (SINGULAIR equiv)	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
montelukast tab (SINGULAIR equiv)	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
MORPHINE SULF SOLN 10MG/5ML	-	1	ANALGESICS - OPIOID
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
moxifloxacin ophth soln (VIGAMOX OPHTH SOLN equiv)	-	1	OPHTHALMIC AGENTS
moxifloxacin tab (AVELOX equiv)	-	1	FLUOROQUINOLONES
MULTIGEN FOLIC TAB	-	1	HEMATOPOIETIC AGENTS
MULTIGEN PLUS TAB	-	1	HEMATOPOIETIC AGENTS
MULTIGEN TAB	-	1	HEMATOPOIETIC AGENTS
multiple vitamin liquid	OTC	1	MULTIVITAMINS
MULTIVITAMIN/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

	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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2024

Drug Name	Special Code	Tier	Category
mupirocin oint (BACTROBAN OINT equiv)	-	1	DERMATOLOGICALS
mycophenolate DR tab (MYFORTIC equiv)	-	1	ASSORTED CLASSES
mycophenolate mofetil cap (CELLCEPT equiv)	-	1	ASSORTED CLASSES
mycophenolate mofetil susp (CELLCEPT SUSP equiv)	-	1	ASSORTED CLASSES
mycophenolate mofetil tab (CELLCEPT equiv)	-	1	ASSORTED CLASSES
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
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

	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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2024

Drug Name	Special Code	Tier	Category
naproxen sodium tab 220mg (ALEVE equiv)	OTC	1	ANALGESICS - ANTI-INFLAMMATORY
naproxen tab (NAPROSYN equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
naratriptan tab (AMERGE equiv) (QL= 9 tabs/30 days; 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
NEFAZODONE TAB	-	1	ANTIDEPRESSANTS
nefazodone tab 50mg, 250mg	-	1	ANTIDEPRESSANTS
neomycin tab	-	1	AMINOGLYCOSIDES
neomycin/bacitracin/polymyxin oint (NEOSPORIN equiv)	OTC	1	DERMATOLOGICALS
NEOMYCIN/POLYMIXIN/GRAMICIDIN OPHTH SOLN	-	1	OPHTHALMIC AGENTS
neomycin/polymixin/hydrocortisone otic soln (CORTISPORIN equiv)	-	1	OTIC AGENTS
neomycin/polymixin/hydrocortisone otic susp (CORTISPORIN equiv)	-	1	OTIC AGENTS

	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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2024

Drug Name	Special Code	Tier	Category
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
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

	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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2024

Drug Name	Special Code	Tier	Category
NEXLETOL TAB (QL= 1 tab/day)	PA-QL	2	ANTIHYPERSLIPIDEMICS
NEXLIZET TAB (QL= 1 tab/day)	PA-QL	2	ANTIHYPERSLIPIDEMICS
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	ANTIHYPERSLIPIDEMICS
niacin tab	OTC	1	VITAMINS
niacinamide tab	OTC	1	VITAMINS
NIASPAN ER TAB	-	2+p	ANTIHYPERSLIPIDEMICS 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.

	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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2024

Drug Name	Special Code	Tier	Category
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
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

	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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2024

Drug Name	Special Code	Tier	Category
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
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

	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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2024

Drug Name	Special Code	Tier	Category
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
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

	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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2024

Drug Name	Special Code	Tier	Category
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
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

	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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2024

Drug Name	Special Code	Tier	Category
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
OLUMIANT TAB (QL= 1 tab/day)	LMSP-PA-QL	2	ANALGESICS - ANTI-INFLAMMATORY
OLUX FOAM	PA	2+p	DERMATOLOGICALS
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
OMNITROPE INJ	LMSP-PA	2	ENDOCRINE AND METABOLIC AGENTS - MISC.
ondansetron ODT (ZOFTRAN equiv)	-	1	ANTIEMETICS
ondansetron soln (ZOFTRAN equiv)	-	1	ANTIEMETICS
ONDANSETRON TAB	-	1	ANTIEMETICS
ondansetron tab (ZOFTRAN equiv)	-	1	ANTIEMETICS

	NC =Not Covered	generic =small letters	BRANDS =CAPITAL LETTERS
EXC	Plan Exclusion	INF	Infertility
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of 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 4/1/2024

Drug Name	Special Code	Tier	Category
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
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

	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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2024

Drug Name	Special Code	Tier	Category
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
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.

	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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2024

Drug Name	Special Code	Tier	Category
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
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

	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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2024

Drug Name	Special Code	Tier	Category
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
OZEMPIC INJ (QL= 1 pack/28 days; Diagnosis Restricted – Type 2 Diabetes (E11))	QL-RDX	2	ANTIDIABETICS
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

	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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2024

Drug Name	Special Code	Tier	Category
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
pediatric multiple vitamins/fluoride chew tab	-	1	MULTIVITAMINS
pediatric multiple vitamins/fluoride soln	-	1	MULTIVITAMINS
pediatric multiple vitamins/fluoride/iron soln	-	1	MULTIVITAMINS
pediatric multivitamin (VITALETS equiv)	OTC	1	MULTIVITAMINS
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

	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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2024

Drug Name	Special Code	Tier	Category
pentoxifylline ER tab (TRENTAL equiv)	-	1	HEMATOLOGICAL AGENTS - MISC.
PERINDOPRIL TAB	-	1	ANTIHYPERTENSIVES
perindopril tab (ACEON equiv)	-	1	ANTIHYPERTENSIVES
permethrin cream (ELIMITE equiv) (QL= 60gm/30 days)	QL	1	DERMATOLOGICALS
permethrin lotion	OTC	1	DERMATOLOGICALS
perphenazine tab (TRILAFON equiv)	-	1	ANTIPSYCHOTICS / ANTIMANIC AGENTS
PERPHENAZINE/ AMITRIPTYLINE TAB	-	1	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
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

	NC =Not Covered	generic =small letters	BRANDS =CAPITAL LETTERS
EXC	Plan Exclusion	INF	Infertility
LD	Limited Distribution	LMSD	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of 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 4/1/2024

Drug Name	Special Code	Tier Category
PHENDIMETRAZINE ER TAB	-	EX ADHD / C ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
phendimetrazine tab (BONTRIL PDM equiv)	-	EX ADHD / C 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

	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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2024

Drug Name	Special Code	Tier	Category
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
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
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

	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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2024

Drug Name	Special Code	Tier	Category
PODOFILOX SOLN	-	1	DERMATOLOGICALS
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

	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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2024

Drug Name	Special Code	Tier	Category
potassium chloride soln	-	2	MINERALS & ELECTROLYTES
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
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

	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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2024

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 cap 225mg (LYRICA equiv) (QL= 2 caps/day)	QL	1	ANTICONVULSANTS
pregabalin cap 300mg (LYRICA equiv) (QL= 2 caps/day)	QL	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

	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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2024

Drug Name	Special Code	Tier	Category
PRENATAL VITAMIN (OTC only)	OTC	2	MULTIVITAMINS
PREVACID CAP	-	2	ULCER DRUGS / ANTISPASMODICS / ANTICHOLINERGICS
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
PRIFTIN TAB	-	2	ANTIMYCOBACTERIAL AGENTS
PRILOSEC OTC DR TAB (QL= 2 caps/day)	OTC-QL	1	ULCER DRUGS
primidone tab (MYSOLINE equiv)	-	1	ANTICONVULSANTS
PRIMSOL SOLN	-	2	ANTI-INFECTIVE AGENTS MISC.
probenecid tab (BENEMID equiv)	-	1	GOUT AGENTS

	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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2024

Drug Name	Special Code	Tier	Category
prochlorperazine supp (COMPAZINE equiv)	-	1	ANTIPSYCHOTICS / ANTIMANIC AGENTS
prochlorperazine tab (COMPAZINE equiv)	-	1	ANTIPSYCHOTICS / ANTIMANIC AGENTS
PROCTOFOAM HC FOAM	-	2	ANORECTAL AGENTS
proctosol HC cream (ANUSOL HC equiv)	-	1	ANORECTAL AGENTS
progesterone cap (PROMETRIUM equiv)	-	1	PROGESTINS
progesterone oil inj	-	1	PROGESTINS
PROGRAF CAP	-	2	ASSORTED CLASSES
PROMACTA POWDER (QL= 1 packet/day)	LMSP-PA-QL	2	HEMATOPOIETIC AGENTS
PROMACTA TAB 12.5MG, 25MG (QL= 1 tab/day)	LMSP-PA-QL	2	HEMATOPOIETIC AGENTS
PROMACTA TAB 50MG (QL= 2 tabs/day)	LMSP-PA-QL	2	HEMATOPOIETIC AGENTS
PROMACTA TAB 75MG (QL= 2 tabs/day)	LMSP-PA-QL	2	HEMATOPOIETIC AGENTS
promethazine DM syrup	-	1	COUGH / COLD / ALLERGY
promethazine supp (PHENERGAN equiv)	-	1	ANTI-HISTAMINES
promethazine syrup	-	1	ANTI-HISTAMINES
promethazine tab (PHENERGAN equiv)	-	1	ANTI-HISTAMINES
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

	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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2024

Drug Name	Special Code	Tier	Category
PROMETHEGAN SUPP	-	1	ANTI-HISTAMINES
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
propranolol tab (INDERAL equiv)	-	1	BETA BLOCKERS
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

	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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2024

Drug Name	Special Code	Tier	Category
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.
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

	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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2024

Drug Name	Special Code	Tier	Category
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.
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

	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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2024

Drug Name	Special Code	Tier	Category
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	DERMATOLOGICALS
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	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

	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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2024

Drug Name	Special Code	Tier	Category
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
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.
RIVIVE SPRAY	OTC	1	ANTIDOTES AND SPECIFIC ANTAGONISTS
rizatriptan ODT (MAXALT equiv) (QL= 12 tabs/30 days)	QL	1	MIGRAINE PRODUCTS

	NC =Not Covered	generic =small letters	BRANDS =CAPITAL LETTERS
EXC	Plan Exclusion	INF	Infertility
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of 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 4/1/2024

Drug Name	Special Code	Tier	Category
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	ANTIHYPERLIPIDEMICS
ROTARIX SUSP	VAC	\$0	VACCINES
ROTATEQ INJ	VAC	\$0	VACCINES
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

	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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2024

Drug Name	Special Code	Tier	Category
SANDIMMUNE SOLN 100MG/ML	-	2	ASSORTED CLASSES
SAVELLA PAK	-	2	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
SAVELLA TAB	-	2	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
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
SEMGLEE INJ, INSULIN GLARGINE-YFGN INJ	-	2	ANTIDIABETICS
SEMGLEE PEN, INSULIN GLARGINE-YFGN PEN	-	2	ANTIDIABETICS

	NC =Not Covered	generic =small letters	BRANDS =CAPITAL LETTERS
EXC	Plan Exclusion	INF	Infertility
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of 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 4/1/2024

Drug Name	Special Code	Tier	Category
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
sertraline tab (ZOLOFT equiv)	-	1	ANTIDEPRESSANTS
sevelamer powder pak (RENVELA PAK equiv)	-	1	GASTROINTESTINAL AGENTS - MISC.
sevelamer tab (RENVELA TAB equiv)	-	1	GASTROINTESTINAL AGENTS - MISC.
SHINGRIX INJ (Covered for members age 19 years 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

	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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2024

Drug Name	Special Code	Tier	Category
SIMPONI INJ 100MG	PA	2	ANALGESICS - ANTI-INFLAMMATORY
simvastatin tab (ZOCOR equiv) (80mg is Not Covered)	-	1	ANTIHYPERTENSIVES
sirolimus soln (RAPAMUNE equiv)	-	1	MISCELLANEOUS THERAPEUTIC CLASSES
sirolimus tab (RAPAMUNE equiv)	-	1	ASSORTED CLASSES
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.

	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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2024

Drug Name	Special Code	Tier	Category
smz/tmp susp (BACTRIM, SEPTRA equiv)	-	1	ANTI-INFECTIVE AGENTS MISC.
sodium bicarbonate tab	OTC	1	ANTACIDS
sodium chloride neb soln (HYPER-SAL equiv)	OTC	1	COUGH / COLD / ALLERGY
sodium citrate/citric acid soln (BICITRA equiv)	-	1	GENITOURINARY AGENTS - MISCELLANEOUS
sodium fluoride chew tab (LURIDE equiv)	-	\$0	MINERALS & ELECTROLYTES
sodium fluoride cream (PREVIDENT 5000 PLUS equiv)	-	1	MOUTH / THROAT / DENTAL AGENTS
sodium fluoride gel (PREVIDENT equiv)	-	1	MOUTH / THROAT / DENTAL AGENTS
sodium fluoride 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

	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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2024

Drug Name	Special Code	Tier	Category
sodium phenylbutyrate powder (BUPHENYL equiv)	PA	1	ENDOCRINE AND METABOLIC AGENTS - MISC.
sodium phenylbutyrate tab (BUPHENYL equiv)	PA	1	ENDOCRINE AND METABOLIC AGENTS - MISC.
sodium polystyrene powder (KAYEXALATE equiv)	-	1	ASSORTED CLASSES
sodium polystyrene susp (SPS equiv)	-	1	ASSORTED CLASSES
sodium sulfacetamide lotion (KLARON equiv)	-	1	DERMATOLOGICALS
sodium sulfacetamide wash (OVACE WASH equiv)	-	1	DERMATOLOGICALS
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.

	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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2024

Drug Name	Special Code	Tier	Category
SOHONOS CAP 1.5MG (QL= 56 caps/28 days; Only available through CVS Specialty 800-238-7828	LD-PA-QL	2	MUSCULOSKELETAL THERAPY AGENTS
SOHONOS CAP 10MG (QL= 56 caps/28 days; Only available through CVS Specialty 800-238-7828	LD-PA-QL	2	MUSCULOSKELETAL THERAPY AGENTS
SOHONOS CAP 1MG (QL= 28 caps/28 days; Only available through CVS Specialty 800-238-7828)	LD-PA-QL	2	MUSCULOSKELETAL THERAPY AGENTS
SOHONOS CAP 2.5MG (QL= 28 caps/28 days; Only available through CVS Specialty 800-238-7828	LD-PA-QL	2	MUSCULOSKELETAL THERAPY AGENTS
SOHONOS CAP 5MG (QL= 28 caps/28 days; Only available through CVS Specialty 800-238-7828)	LD-PA-QL	2	MUSCULOSKELETAL THERAPY AGENTS
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
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

	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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2024

Drug Name	Special Code	Tier	Category
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
STELARA INJ (QL= 1 inj/84 days)	LMSP-PA-QL	2	DERMATOLOGICALS

	NC =Not Covered	generic =small letters	BRANDS =CAPITAL LETTERS
EXC	Plan Exclusion	INF	Infertility
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of 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 4/1/2024

Drug Name	Special Code	Tier	Category
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
sucralfate susp (CARAFATE equiv)	-	1	ULCER DRUGS / ANTISPASMODICS / ANTICHOLINERGICS
sucralfate tab (CARAFATE equiv)	-	1	ULCER DRUGS
sulfacetamide sodium ophth soln (BLEPH-10 equiv)	-	1	OPHTHALMIC AGENTS
sulfacetamide sodium/prednisolone ophth soln (VASOCIDIN equiv)	-	1	OPHTHALMIC AGENTS
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

	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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2024

Drug Name	Special Code	Tier Category
SUMADAN WASH 9-4.5%	-	2+p DERMATOLOGICALS enalty
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 enalty
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

	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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2024

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
TAFINLAR TAB	PA	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

	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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2024

Drug Name	Special Code	Tier	Category
TAVNEOS CAP (QL= 6 caps/day; Only available through PantheRx 855-726-8479)	LD-PA-QL	2	HEMATOLOGICAL AGENTS - MISC.
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

	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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2024

Drug Name	Special Code	Tier Category	
terconazole supp (TERAZOL equiv)	-	1	VAGINAL PRODUCTS
testosterone cypionate inj (DEPO-TESTOSTERONE equiv)	PA	1	ANDROGENS-ANABOLIC
TESTOSTERONE ENANTHATE INJ	PA	1	ANDROGENS-ANABOLIC
testosterone enanthate inj (DELATESTRYL INJ. equiv)	PA	1	ANDROGENS-ANABOLIC
TESTOSTERONE 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

	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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2024

Drug Name	Special Code	Tier	Category
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
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
timolol maleate ophth gel (TIMOPTIC-XE equiv)	-	1	OPHTHALMIC AGENTS
timolol maleate ophth soln (TIMOPTIC equiv)	-	1	OPHTHALMIC AGENTS

	NC =Not Covered	generic =small letters	BRANDS =CAPITAL LETTERS
EXC	Plan Exclusion	INF	Infertility
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of 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 4/1/2024

Drug Name	Special Code	Tier	Category
timolol maleate ophth soln 0.5% (ISTALOL equiv)	-	1	OPHTHALMIC AGENTS
timolol maleate tab (BLOCADREN equiv)	-	1	BETA BLOCKERS
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
tolmetin cap (TOLECTIN DS equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY

	NC =Not Covered	generic =small letters	BRANDS =CAPITAL LETTERS
EXC	Plan Exclusion	INF	Infertility
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of 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 4/1/2024

Drug Name	Special Code	Tier Category
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 ANTICONVULSANTS
topiramate tab (TOPAMAX equiv)	-	1 ANTICONVULSANTS
topotecan inj (HYCAMTIN equiv)	-	1 ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
toremifene tab (FARESTON equiv)	-	1 ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
toremide tab (DEMADEX equiv)	-	1 DIURETICS
TOUJEO SOLOSTAR INJ	-	2 ANTIDIABETICS
TOVIAZ TAB	-	2+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
TRAMADOL HCL ER TAB	-	1 ANALGESICS - OPIOID
tramadol tab (ULTRAM equiv)	-	1 ANALGESICS - OPIOID

EXC	NC =Not Covered	generic =small letters	BRANDS =CAPITAL LETTERS
LD	Plan Exclusion	INF	Infertility
MSP	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
PA	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
RDX	Prior Authorization	QL	Quantity Limit
SF	Restricted to Diagnosis	RS	Restricted to Specialist
SP	Limited to two 15 day fills per month fo first 3 months	SMKG	Smoking Cessation
VAC	Available through Specialty Pharmacy Program	ST	Step Therapy
	Vaccine Program		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of 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 4/1/2024

Drug Name	Special Code	Tier	Category
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
triamcinolone OTC nasal spray (NASACORT equiv) (QL= 2 bottles/fill)	OTC-QL	1	NASAL AGENTS - SYSTEMIC AND TOPICAL

	NC =Not Covered	generic =small letters	BRANDS =CAPITAL LETTERS
EXC	Plan Exclusion	INF	Infertility
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of 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 4/1/2024

Drug Name	Special Code	Tier	Category
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 OPHTH 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.
TRIKAFTA THERAPY PACK (QL= 2 packets/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	2	RESPIRATORY 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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2024

Drug Name	Special Code	Tier	Category
tri-legest tab (ESTROSTEP FE equiv)	-	\$0	CONTRACEPTIVES
TRI-LUMA CREAM	-	EX	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
TYVASO DPI POWDER (QL= 4 cartridges/day; Only available through Accredo 800-803-2523)	LD-PA-QL	2	CARDIOVASCULAR AGENTS - MISC.

	NC =Not Covered	generic =small letters	BRANDS =CAPITAL LETTERS
EXC	Plan Exclusion	INF	Infertility
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of 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 4/1/2024

Drug Name	Special Code	Tier	Category
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 0.6 MG/ML (Only available through Accredo 800-803-2523)	LD-PA	2	CARDIOVASCULAR AGENTS - MISC.
UBRELVY TAB (QL= 10 tabs/30 days, 6 fills/year)	PA-QL	2	MIGRAINE PRODUCTS
UPNEEQ SOLN	-	EX	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
valganciclovir tab (VALCYTE equiv)	-	1	ANTIVIRALS
valproic acid cap (DEPAKENE equiv)	-	1	ANTICONVULSANTS

	NC =Not Covered	generic =small letters	BRANDS =CAPITAL LETTERS
EXC	Plan Exclusion	INF	Infertility
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of 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 4/1/2024

Drug Name	Special Code	Tier	Category
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.
VANFLYTA TAB (QL= 1 tab/day; Only available through Onco360 877-662-6633 or Biologics 800-850-4306)	LD-PA-QL	2	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
VANFLYTA TAB 26.5MG (QL= 2 tabs/day; Only available through Onco360 877-662-6633 or Biologics 800-850-4306)	LD-PA-QL	2	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
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.

	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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2024

Drug Name	Special Code	Tier	Category
VARIVAX INJ	VAC	\$0	VACCINES
VAXNEUVANCE INJ	VAC	EX	VACCINES
		C	
VELIVET PAK	-	\$0	CONTRACEPTIVES
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	-	2	CALCIUM CHANNEL BLOCKERS
verapamil SR tab (CALAN SR, ISOPTIN SR equiv)	-	1	CALCIUM CHANNEL BLOCKERS
verapamil tab (CALAN 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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2024

Drug Name	Special Code	Tier	Category
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
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 D3 TAB	OTC	1	VITAMINS

	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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2024

Drug Name	Special Code	Tier	Category
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
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.
VYVANSE CAP	-	2+p	ADHD / enalANTI-NARCOLEPSY / ty ANTI-OBESITY / ANOREXIANTS
warfarin tab (COUMADIN equiv)	-	1	ANTICOAGULANTS

	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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2024

Drug Name	Special Code	Tier Category
WEGOVY INJ	-	EX ADHD / C ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
WEGOVY INJ 1.7MG/0.75ML	-	EX ADHD / C ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
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
XACIATO GEL (QL= 1 applicator/fill)	QL	2 VAGINAL AND RELATED PRODUCTS
XALKORI CAP (QL= 2 caps/day)	MSP-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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2024

Drug Name	Special Code	Tier	Category
XAQUIL XR TAB	-	EX C	DIETARY PRODUCTS / DIETARY MANAGEMENT PRODUCTS
XARELTO SUSP	-	2	ANTICOAGULANTS
XARELTO TAB	-	2	ANTICOAGULANTS
XDEMVIY DROP (QL= 1 bottle/42 days (1 bottle= 10ml); Only available through CVS Specialty 800-238-7828 or Walgreens 888-347-3416)	LD-PA-QL	2	OPHTHALMIC AGENTS
XELJANZ SOLN (QL= 10 ml/day)	PA-QL	2	ANALGESICS - ANTI-INFLAMMATORY
XELJANZ TAB (QL= 2 tabs/day)	PA-QL	2	ANALGESICS - ANTI-INFLAMMATORY
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 (QL= 2 tabs/day)	QL	2	ANTIDIABETICS
XIGDUO XR TAB 10-1000MG (QL= 1 tab/day)	QL	2	ANTIDIABETICS

	NC =Not Covered	generic =small letters	BRANDS =CAPITAL LETTERS
EXC	Plan Exclusion	INF	Infertility
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month fo first 3 months	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of 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 4/1/2024

Drug Name	Special Code	Tier Category	
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
XOLAIR SYRINGE (QL= 2 inj/28 days)	LMSP-PA-QL	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
XOLAIR SYRINGE 150MG/ML (QL= 2 inj/28 days)	LMSP-PA-QL	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
XULTOPHY INJ (QL= 15ml/30 days)	QL	2	ANTIDIABETICS
XYZBAC TAB	-	EX C	DIETARY PRODUCTS / DIETARY MANAGEMENT PRODUCTS
YAZ TAB, YASMIN 28 TAB	-	\$0	CONTRACEPTIVES
zafemy patch (XULANE equiv)	-	\$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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2024

Drug Name	Special Code	Tier	Category
zafirlukast tab (ACCOLATE equiv)	-	1	ANTIASTHMATIC 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.
ZEPOSIA STARTER PACK	LMSP-PA	2	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
zidovudine cap (RETROVIR equiv)	-	1	ANTIVIRALS
zidovudine syrup (RETROVIR 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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Alphabetical Index

Last Updated 4/1/2024

Drug Name	Special Code	Tier	Category
zidovudine tab (RETROVIR equiv)	-	1	ANTIVIRALS
ZIMHI SOLN	-	2	ANTIDOTES AND SPECIFIC ANTAGONISTS
ziprasidone cap (GEODON equiv)	-	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
ZYRTEC CHILD CHEW TAB	OTC	EX C	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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 4/1/2024

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

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	LMSF	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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 4/1/2024

DrugName	Special Code	Tier
ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS Cont.		
WEGOVY INJ 2.4MG/0.75ML	-	EXC
XENICAL CAP	-	EXC
ZEPBOUND INJ	-	EXC
ATTENTION-DEFICIT/HYPERACTIVITY DISORDER (ADHD) AGENTS		
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
STIMULANTS - MISC.		
armodafinil tab (NUVIGIL equiv) (QL= 1 tab/day)	QL	1
dexamethylphenidate ER cap (FOCALIN XR equiv) (QL= 1 cap/day)	QL	1
dexamethylphenidate tab (FOCALIN equiv)	-	1
methylphenidate CD cap (METADATE CD equiv)	-	1
methylphenidate ER tab	-	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
ALLERGENIC EXTRACTS/BIOLOGICALS MISC		
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.

	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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 4/1/2024

DrugName	Special Code	Tier
ALLERGENIC EXTRACTS/BIOLOGICALS MISC Cont.		
PALFORZIA SPRINKLE CAP (Only available through Walgreens 888-347-3416)	LD-PA	2
AMINOGLYCOSIDES		
AMINOGLYCOSIDES		
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
ANALGESICS - ANTI-INFLAMMATORY		
ANTIRHEUMATIC - ENZYME INHIBITORS		
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
ANTI-TNF-ALPHA - MONOCLONAL ANTIBODIES		
ADALIMUMAB-ADAZ INJ (HYRIMOZ equiv) (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 (HULIO equiv) (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.

	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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 4/1/2024

DrugName	Special Code	Tier
ANALGESICS - ANTI-INFLAMMATORY Cont.		
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/UEVITIS 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
GOLD COMPOUNDS		
RIDAURA CAP	-	2
INTERLEUKIN-1 RECEPTOR ANTAGONIST (IL-1RA)		
KINERET INJ (QL= 1 inj/day; Only available through Biologics 800-850-4306)	LD-PA-QL	2
INTERLEUKIN-6 RECEPTOR INHIBITORS		
ACTEMRA ACTPEN INJ (QL= 2 inj/28 days)	LMSP-PA-QL	2
ACTEMRA SC INJ (QL= 2 inj/28 days)	LMSP-PA-QL	2
KEVZARA INJ (QL= 2 inj/28 days)	LMSP-PA-QL	2
NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (NSAIDS)		

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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 4/1/2024

DrugName	Special Code	Tier
ANALGESICS - ANTI-INFLAMMATORY Cont.		
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.

	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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 4/1/2024

DrugName	Special Code	Tier
ANALGESICS - ANTI-INFLAMMATORY Cont.		
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
PHOSPHODIESTERASE 4 (PDE4) INHIBITORS		
OTEZLA STARTER PACK (QL= 1 pack/28 days)	LMSP-PA-QL	2
OTEZLA TAB (QL= 2 tabs/day)	LMSP-PA-QL	2
PYRIMIDINE SYNTHESIS INHIBITORS		
leflunomide tab (ARAVA equiv)	-	1
SELECTIVE COSTIMULATION MODULATORS		
ORENCIA CLICK INJ (QL= 4 inj/28 days)	LMSP-PA-QL	2
ORENCIA SC INJ 125MG/ML (QL= 4 inj/28 days)	LMSP-PA-QL	2
ORENCIA SC INJ 50MG/0.4ML (QL= 4 inj/28 days)	LMSP-PA-QL	2
ORENCIA SC INJ 87.5MG/0.7ML (QL= 4 inj/28 days)	LMSP-PA-QL	2
SOLUBLE TUMOR NECROSIS FACTOR RECEPTOR AGENTS		
ENBREL INJ 25MG (QL= 8 inj/28 days)	LMSP-PA-QL	2
ENBREL INJ 50MG (QL= 4 inj/28 days)	LMSP-PA-QL	2
ENBREL MINI INJ (QL= 4 inj/28 days)	LMSP-PA-QL	2

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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 4/1/2024

DrugName	Special Code	Tier
ANALGESICS - ANTI-INFLAMMATORY Cont.		
ENBREL SURECLICK INJ 50MG (QL= 4 inj/28 days)	LMSP-PA-QL	2
ANALGESICS - NONNARCOTIC		
ANALGESICS OTHER		
acetaminophen cap (TYLENOL equiv)	OTC	1
acetaminophen chew tab (TYLENOL equiv)	OTC	1
acetaminophen drops (TYLENOL equiv)	OTC	1
acetaminophen elixir (TYLENOL equiv)	OTC	1
acetaminophen liquid (TYLENOL equiv)	OTC	1
acetaminophen supp (TYLENOL equiv)	OTC	1
acetaminophen tab (TYLENOL equiv)	OTC	1
ACETAMINOPHEN SOLN	OTC	2
SALICYLATES		
aspirin chew tab 81mg	OTC	\$0
aspirin tab 325mg	OTC	\$0
aspirin supp	OTC	1
BUFFERED ASPIRIN TAB	OTC	1
bufferin tab	OTC	1
diflunisal tab (DOLOBID equiv)	-	1
salsalate tab (DISALCID equiv)	-	1
ANALGESICS - OPIOID		
OPIOID AGONISTS		
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.

	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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 4/1/2024

DrugName	Special Code	Tier
ANALGESICS - OPIOID Cont.		
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 SULF SOLN 10MG/5ML	-	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

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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 4/1/2024

DrugName	Special Code	Tier
ANALGESICS - OPIOID Cont.		
OXYCONTIN CR TAB (QL= 120 tabs/30 days)	QL	2+penalty
OPIOID COMBINATIONS		
acetaminophen/codeine soln	-	1
acetaminophen/codeine tab (TYLENOL/CODEINE equiv)	-	1
APAP/CODEINE SOLN	-	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
OPIOID PARTIAL AGONISTS		
buprenorphine SL tab (SUBUTEX equiv)	-	1
buprenorphine/naloxone SL tab (SUBOXONE equiv)	-	1
butorphanol nasal spray (STADOL equiv) (QL= 1 bottle/30 days)	QL	1

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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 4/1/2024

DrugName	Special Code	Tier
ANALGESICS - OPIOID Cont.		
ZUBSOLV SL TAB	-	2
ANDROGENS-ANABOLIC		
ANDROGENS		
danazol cap (DANOCRINE equiv)	-	1
testosterone cypionate inj (DEPO-TESTOSTERONE equiv)	PA	1
TESTOSTERONE ENANTHATE INJ	PA	1
testosterone enanthate inj (DELATESTRYL INJ. equiv)	PA	1
TESTOSTERONE 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
ANORECTAL AGENTS		
INTRARECTAL STEROIDS		
hydrocortisone enema (CORTENEMA equiv)	-	1
RECTAL COMBINATIONS		
lidocaine/hydrocortisone cream (ANAMANTLE equiv)	-	1
pramoxine/hydrocortisone cream (ANALPRAM HC equiv)	-	1

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

	NC =Not Covered	generic =small letters	BRANDS =CAPITAL LETTERS
EXC	Plan Exclusion	INF	Infertility
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course 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* 4/1/2024

DrugName	Special Code	Tier
ANORECTAL AGENTS Cont.		
PROCTOFOAM HC FOAM	-	2
RECTAL STEROIDS		
proctosol HC cream (ANUSOL HC equiv)	-	1
hydrocortisone supp (ANUSOL HC equiv)	-	2
ANTACIDS		
ANTACIDS - BICARBONATE		
sodium bicarbonate tab	OTC	1
ANTACIDS - CALCIUM SALTS		
calcium carbonate chew tab (TUMS equiv)	OTC	1
calcium carbonate susp	OTC	1
ANTHELMINTICS		
ANTHELMINTICS		
ivermectin tab (STROMECTOL equiv)	PA	1
BENZNIDAZOLE TAB (Restricted to Infectious Disease Specialist)	RS	2
ANTIANGINAL AGENTS		
NITRATES		
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

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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 4/1/2024

DrugName	Special Code	Tier
ANTIANGINAL AGENTS Cont.		
nitroglycerin SL tab (NITROSTAT equiv)	-	1
NITRO-DUR PATCH 0.3MG/HR, 0.8MG/HR	-	2
ANTIAXIETY AGENTS		
ANTIAXIETY AGENTS - MISC.		
bupirone tab (BUSPAR equiv)	-	1
hydroxyzine pamoate cap (VISTARIL equiv)	-	1
hydroxyzine syrup (ATARAX equiv)	-	1
hydroxyzine tab (ATARAX equiv)	-	1
BENZODIAZEPINES		
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
ANTIARRHYTHMICS		
ANTIARRHYTHMICS TYPE I-A		
disopyramide cap (NORPACE 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.

	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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 4/1/2024

DrugName	Special Code	Tier
ANTIARRHYTHMICS Cont.		
NORPACE CR CAP	-	2
ANTIARRHYTHMICS TYPE I-B		
mexiletine hcl cap	-	1
ANTIARRHYTHMICS TYPE I-C		
flecainide tab (TAMBOCOR equiv)	-	1
propafenone tab (RYTHMOL equiv)	-	1
ANTIARRHYTHMICS TYPE III		
amiodarone tab (CORDARONE equiv)	-	1
dofetilide cap (TIKOSYN equiv)	-	1
ANTIASTHMATIC AND BRONCHODILATOR AGENTS		
ANTIASTHMATIC - MONOCLONAL ANTIBODIES		
FASENRA PEN INJ (QL= 1 inj/56 days; 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
XOLAIR SYRINGE (QL= 2 inj/28 days)	LMSP-PA-QL	2
XOLAIR SYRINGE 150MG/ML (QL= 2 inj/28 days)	LMSP-PA-QL	2
BRONCHODILATORS - ANTICHOLINERGICS		
ipratropium neb soln (ATROVENT equiv)	-	1
SPIRIVA RESPIMAT INHALER 1.25MCG/ACT (QL= 1 inhaler/30 days; Step Therapy requires trial of ADVAIR, BREO, DULERA, or FLUTICASONE/SALMETEROL)	QL-ST	2
LEUKOTRIENE MODULATORS		
montelukast chew tab (SINGULAIR equiv)	-	1

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

	NC =Not Covered	generic =small letters	BRANDS =CAPITAL LETTERS
EXC	Plan Exclusion	INF	Infertility
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course 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* 4/1/2024

DrugName	Special Code	Tier
ANTIASTHMATIC AND BRONCHODILATOR AGENTS Cont.		
montelukast tab (SINGULAIR equiv)	-	1
zafirlukast tab (ACCOLATE equiv)	-	1
STEROID INHALANTS		
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 PROPIONATE DISKUS INHALER 100MCG/ACT	-	2
FLUTICASONE PROPIONATE DISKUS INHALER 250MCG/ACT	-	2
FLUTICASONE PROPIONATE DISKUS INHALER 50MCG/ACT	-	2
SYMPATHOMIMETICS		
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
epinephrine inj	-	1

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

	NC =Not Covered	generic =small letters	BRANDS =CAPITAL LETTERS
EXC	Plan Exclusion	INF	Infertility
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course 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* 4/1/2024

DrugName	Special Code	Tier
ANTIASTHMATIC AND BRONCHODILATOR AGENTS Cont.		
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
terbutaline sulfate tab (BRETHINE equiv)	-	1
VENTOLIN HFA INHALER (QL= 2 inhalers/30 days)	QL	1
ADVAIR DISKUS INHALER	-	2
ADVAIR HFA INHALER	-	2
BREO ELLIPTA INHALER	-	2
COMBIVENT RESPIMAT INHALER	-	2
DULERA INHALER	-	2
SEREVENT DISKUS INHALER	-	2
STIOLTO INHALER	-	2
TRELEGY ELLIPTA INHALER	-	2
XANTHINES		
theophylline er tab (THEOPHYLLINE ER equiv)	-	1
theophylline ER tab (UNIPHYL equiv)	-	1
theophylline soln	-	1
ELIXOPHYLLIN ELIXIR	-	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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 4/1/2024

DrugName	Special Code	Tier
ANTIASTHMATIC AND BRONCHODILATOR AGENTS Cont.		
THEOPHYLLINE TAB ER	-	2
ANTICOAGULANTS		
COUMARIN ANTICOAGULANTS		
warfarin tab (COUMADIN equiv)	-	1
DIRECT FACTOR XA INHIBITORS		
XARELTO SUSP	-	2
XARELTO TAB	-	2
HEPARINS AND HEPARINOID-LIKE AGENTS		
enoxaparin inj (LOVENOX equiv)	-	1
heparin flush	-	1
FRAGMIN INJ	-	2
THROMBIN INHIBITORS		
dabigatran etexilate mesylate cap (PRADAXA equiv)	-	2
ANTICONSULSANTS		
ANTICONSULSANTS - BENZODIAZEPINES		
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
diazepam rectal gel (QL= 2 packs/fill)	QL	2
ANTICONSULSANTS - MISC.		
carbamazepine chew tab (TEGRETOL equiv)	-	1
carbamazepine ER tab (TEGRETOL XR equiv)	-	1

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

	NC =Not Covered	generic =small letters	BRANDS =CAPITAL LETTERS
EXC	Plan Exclusion	INF	Infertility
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course 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* 4/1/2024

DrugName	Special Code	Tier
ANTICONVULSANTS Cont.		
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= 1200ml/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
pregabalin cap (LYRICA equiv)	-	1
pregabalin cap 225mg (LYRICA equiv) (QL= 2 caps/day)	QL	1
pregabalin cap 300mg (LYRICA equiv) (QL= 2 caps/day)	QL	1

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

	NC =Not Covered	generic =small letters	BRANDS =CAPITAL LETTERS
EXC	Plan Exclusion	INF	Infertility
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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 4/1/2024

DrugName	Special Code	Tier
ANTICONVULSANTS Cont.		
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
LYRICA CAP 225MG (QL= 2 caps/day)	QL	2+penalty

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

	NC =Not Covered	generic =small letters	BRANDS =CAPITAL LETTERS
EXC	Plan Exclusion	INF	Infertility
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course 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* 4/1/2024

DrugName	Special Code	Tier
ANTICONVULSANTS Cont.		
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
CARBAMATES		
felbamate susp (FELBATOL equiv)	-	1
felbamate tab (FELBATOL equiv)	-	2
GABA MODULATORS		
tiagabine tab (GABITRIL equiv)	-	1
vigabatrin powder pack (SABRIL POWDER equiv) (Only available through 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
HYDANTOINS		
phenytoin cap (DILANTIN equiv)	-	1
phenytoin chew tab (DILANTIN equiv)	-	1
phenytoin susp (DILANTIN equiv)	-	1

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

	NC =Not Covered	generic =small letters	BRANDS =CAPITAL LETTERS
EXC	Plan Exclusion	INF	Infertility
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course 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* 4/1/2024

DrugName	Special Code	Tier
ANTICONVULSANTS Cont.		
DILANTIN CAP 30MG	-	2
PEGANONE TAB	-	2
SUCCINIMIDES		
ethosuximide cap (ZARONTIN equiv)	-	1
ethosuximide soln (ZARONTIN equiv)	-	1
methsuximide cap (CELONTIN equiv)	-	1
VALPROIC ACID		
divalproex ER tab (DEPAKOTE ER equiv)	-	1
divalproex sodium DR tab (DEPAKOTE equiv)	-	1
divalproex sprinkle cap (DEPAKOTE equiv)	-	1
valproic acid cap (DEPAKENE equiv)	-	1
valproic acid syrup (DEPAKENE equiv)	-	1
ANTIDEPRESSANTS		
ALPHA-2 RECEPTOR ANTAGONISTS (TETRACYCLICS)		
mirtazapine ODT (REMERON equiv)	-	1
mirtazapine tab (REMERON equiv)	-	1
ANTIDEPRESSANTS - MISC.		
bupropion ER tab (WELLBUTRIN equiv)	-	1
bupropion tab (WELLBUTRIN equiv)	-	1
bupropion XL tab (WELLBUTRIN XL equiv)	-	1
MAPROTILINE TAB	-	1
MONOAMINE OXIDASE INHIBITORS (MAOIS)		
PHENELZINE SULFATE TAB	-	1

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

	NC =Not Covered	generic =small letters	BRANDS =CAPITAL LETTERS
EXC	Plan Exclusion	INF	Infertility
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course 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* 4/1/2024

DrugName	Special Code	Tier
ANTIDEPRESSANTS Cont.		
phenelzine tab (NARDIL equiv)	-	1
tranylcypromine tab (PARNATE equiv)	-	1
MARPLAN TAB	-	2
SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIS)		
citalopram soln (CELEXA equiv)	-	1
citalopram tab (CELEXA equiv)	-	1
escitalopram tab 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
SEROTONIN MODULATORS		
NEFAZODONE TAB	-	1
nefazodone tab 50mg, 250mg	-	1

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

	NC =Not Covered	generic =small letters	BRANDS =CAPITAL LETTERS
EXC	Plan Exclusion	INF	Infertility
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course 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* 4/1/2024

DrugName	Special Code	Tier
ANTIDEPRESSANTS Cont.		
trazodone tab (DESYREL equiv)	-	1
SEROTONIN-NOREPINEPHRINE REUPTAKE INHIBITORS (SNRIS)		
duloxetine EC cap (CYMBALTA equiv)	-	1
venlafaxine ER cap (EFFEXOR XR equiv) (PA Required only if member is less than 12 years old)	PA	1
venlafaxine tab (EFFEXOR equiv) (PA Required only if member is 12 years or younger)	PA	1
TRICYCLIC AGENTS		
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		
acarbose tab (PRECOSE equiv)	-	1
ANTIDIABETIC COMBINATIONS		

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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 4/1/2024

DrugName	Special Code	Tier
ANTIDIABETICS Cont.		
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 (QL= 2 tabs/day)	QL	2
XIGDUO XR TAB 10-1000MG (QL= 1 tab/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
BIGUANIDES		
metformin ER tab (GLUCOPHAGE XR equiv)	-	1
metformin tab (GLUCOPHAGE equiv)	-	1
DIABETIC OTHER		
GLUCAGON KIT (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.

	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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 4/1/2024

DrugName	Special Code	Tier
ANTIDIABETICS Cont.		
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
INCRETIN MIMETIC AGENTS		
OZEMPIC INJ (QL= 1 pack/28 days; Diagnosis Restricted – Type 2 Diabetes (E11))	QL-RDX	2
INCRETIN MIMETIC AGENTS (GLP-1 RECEPTOR AGONISTS)		
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
INSULIN		
INSULIN LISPRO INJ (HUMALOG equiv)	-	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.

	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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 4/1/2024

DrugName	Special Code	Tier
ANTIDIABETICS Cont.		
HUMALOG MIX KWIKPEN, INSULIN LISPRO MIX KWIKPEN	-	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
INSULIN GLARGINE SOLN PEN-INJ	-	2
INSULIN LISPRO JR KWIKPEN INJ	-	2
INSULIN LISPRO KWIKPEN INJ	-	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
INSULIN SENSITIZING AGENTS		
pioglitazone tab (ACTOS TAB equiv)	-	1

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

NC =Not Covered	generic =small letters	BRANDS =CAPITAL LETTERS
EXC	Plan Exclusion	INF Infertility
LD	Limited Distribution	LMS 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
SP	Available through Specialty Pharmacy Program	ST Step Therapy
VAC	Vaccine Program	

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 4/1/2024

DrugName	Special Code	Tier
ANTIDIABETICS Cont.		
MEGLITINIDE ANALOGUES		
repaglinide tab (PRANDIN equiv)	-	1
SODIUM-GLUCOSE CO-TRANSPORTER 2 (SGLT2) INHIBITORS		
FARXIGA TAB (QL= 1 tab/day)	QL	2
JARDIANCE TAB (QL= 1 tab/day)	QL	2
SULFONYLUREAS		
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
ANTIDIARRHEAL/PROBIOTIC AGENTS		
ANTIPERISTALTIC AGENTS		
DIPHENOXYLATE/ATROPINE LIQUID	-	2
ANTIDIARRHEALS		
ANTIPERISTALTIC AGENTS		
diphenoxylate/atropine tab (LOMOTIL equiv)	-	1
opium tincture	-	1
ANTIDOTES		
ANTIDOTES - CHELATING AGENTS		
CHEMET CAP	-	2

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

	NC =Not Covered	generic =small letters	BRANDS =CAPITAL LETTERS
EXC	Plan Exclusion	INF	Infertility
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course 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* 4/1/2024

DrugName	Special Code	Tier
ANTIDOTES Cont.		
FERRIPROX SOLN (Only available through Ferriprox Total Care 866-758-7071)	LD-PA	2
OPIOID ANTAGONISTS		
naltrexone tab (REVIA equiv)	-	1
ANTIDOTES AND SPECIFIC ANTAGONISTS		
ANTIDOTES - CHELATING AGENTS		
deferasirox granules packet (JADENU equiv)	LMSp	1
deferasirox tab (JADENU equiv)	LMSp	1
deferasirox tab for oral susp (EXJADE equiv)	LMSp	1
deferiprone tab (FERRIPROX equiv) (Only available through Lumicera 855-847-355)	LD-PA	1
OPIOID ANTAGONISTS		
naloxone hcl nasal spray (NARCAN equiv)	OTC	1
naloxone prefilled inj	-	1
NARCAN NASAL SPRAY	OTC	1
RIVIVE SPRAY	OTC	1
KLOXXADO NASAL SPRAY	-	2
NALOXONE PREFILLED INJ	-	2
ZIMHI SOLN	-	2
ANTIEMETICS		
5-HT3 RECEPTOR ANTAGONISTS		
granisetron tab (KYTRIL equiv) (QL= 14 tabs/fill, 1 fill/30 days)	QL	1
ondansetron ODT (ZOFTRAN equiv)	-	1
ondansetron soln (ZOFTRAN equiv)	-	1
ONDANSETRON TAB	-	1

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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 4/1/2024

DrugName	Special Code	Tier
ANTIEMETICS Cont.		
ondansetron tab (ZOFTRAN equiv)	-	1
KYTRIL TAB (QL= 14 tabs/fill, 1 fill/30 days)	QL	2+penalty
ANTIEMETICS - ANTICHOLINERGIC		
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
SUBSTANCE P/NEUROKININ 1 (NK1) RECEPTOR ANTAGONISTS		
aprepitant cap (EMEND equiv) (QL= 3 caps/fill)	QL	1
aprepitant pak (EMEND equiv) (QL= 3 caps/fill)	QL	1
ANTIFUNGALS		
ANTIFUNGALS		
flucytosine cap (ANCOBON equiv)	-	1
griseofulvin micro tab (GRIFULVIN V equiv)	-	1
griseofulvin susp (GRIFULVIN equiv)	-	1
griseofulvin tab (GRIS-PEG equiv)	-	1
nystatin powder	-	1
nystatin tab	-	1
terbinafine tab (LAMISIL equiv)	-	1
IMIDAZOLE-RELATED ANTIFUNGALS		
fluconazole susp (DIFLUCAN equiv)	-	1

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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 4/1/2024

DrugName	Special Code	Tier
ANTIFUNGALS Cont.		
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
voriconazole tab (VFEND equiv) (Restricted to Infectious Disease Specialist)	RS	2
ANTIHISTAMINES		
ANTIHISTAMINES - ETHANOLAMINES		
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
ANTIHISTAMINES - NON-SEDATING		
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

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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 4/1/2024

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

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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 4/1/2024

DrugName	Special Code	Tier
ANTIHYPERLIPIDEMICS Cont.		
cholestyramine lite powder (QUESTRAN LITE equiv)	-	1
cholestyramine lite powder pack (QUESTRAN LITE equiv)	-	1
cholestyramine powder (QUESTRAN equiv)	-	1
cholestyramine powder pack (QUESTRAN equiv)	-	1
colesevelam pack (WELCHOL equiv)	-	1
colesevelam tab (WELCHOL equiv)	-	1
colestipol granule (COLESTID equiv)	-	1
colestipol powder packet (COLESTID equiv)	-	1
colestipol tab (COLESTID equiv)	-	1
WELCHOL PACK	-	2+penalty
WELCHOL TAB	-	2+penalty
FIBRIC ACID DERIVATIVES		
fenofibric acid DR cap (TRILIPIX equiv)	-	1
gemfibrozil tab (LOPID equiv)	-	1
HMG COA REDUCTASE INHIBITORS		
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

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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 4/1/2024

DrugName	Special Code	Tier
ANTHYPERLIPIDEMICS Cont.		
ATORVALIQ SUSP (Covered for members age 9 years and older; and patients that are unable to swallow tablets)	PA	2
EZALLOR SPRINKLE CAP (Prior Authorization Required for members age 9 or older)	PA	2
FLOLIPID SUSP (Members age 9 or older require Prior Authorization)	PA	2
CRESTOR TAB	-	2+penalty
INTESTINAL CHOLESTEROL ABSORPTION INHIBITORS		
ezetimibe tab (ZETIA equiv)	-	1
NICOTINIC ACID DERIVATIVES		
niacin ER tab (NIASPAN equiv)	-	1
NIASPAN ER TAB	-	2+penalty
PROTEIN CONVERTASE SUBTILISIN/KEXIN TYPE 9 INHIBITORS		
REPATHA INJ (QL= 2 inj/28 days)	PA-QL	2
REPATHA PUSHTRONEX INJ (QL= 1 inj/28 days)	PA-QL	2
ANTHYPERTENSIVES		
ACE INHIBITORS		
benazepril tab (LOTENSIN equiv)	-	1
captopril tab (CAPOTEN equiv)	-	1
enalapril maleate for oral solution (Prior Authorization Required for members age 9 or older)	PA	1
enalapril tab (VASOTEC equiv)	-	1

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

	NC =Not Covered	generic =small letters	BRANDS =CAPITAL LETTERS
EXC	Plan Exclusion	INF	Infertility
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course 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* 4/1/2024

DrugName	Special Code	Tier
ANTIHYPERTENSIVES Cont.		
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
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

AGENTS FOR PHEOCHROMOCYTOMA

phenoxybenzamine cap (DIBENZYLINE equiv)	-	1
--	---	---

ANGIOTENSIN II RECEPTOR ANTAGONISTS

candesartan tab (ATACAND equiv)	-	1
losartan tab (COZAAR equiv)	-	1
olmesartan tab (BENICAR equiv)	-	1
valsartan tab (DIOVAN equiv)	-	1

ANTIADRENERGIC ANTIHYPERTENSIVES

clonidine patch (CATAPRES-TTS equiv)	-	1
clonidine tab (CATAPRES equiv)	-	1
doxazosin tab (CARDURA equiv)	-	1
guanfacine IR tab (TENEX equiv)	-	1

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

	NC =Not Covered	generic =small letters	BRANDS =CAPITAL LETTERS
EXC	Plan Exclusion	INF	Infertility
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course 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* 4/1/2024

DrugName	Special Code	Tier
ANTIHYPERTENSIVES Cont.		
METHYLDOPA TAB	-	1
methyldopa tab (ALDOMET equiv)	-	1
prazosin cap (MINIPRESS equiv)	-	1
terazosin cap (HYTRIN equiv)	-	1
ANTIHYPERTENSIVE COMBINATIONS		
amlodipine/benazepril cap (LOTREL equiv)	-	1
amlodipine/olmesartan tab (AZOR TAB equiv)	-	1
amlodipine/valsartan tab (EXFORGE equiv)	-	1
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
metoprolol/hydrochlorothiazide tab (LOPRESSOR HCT equiv)	-	1
olmesartan/hydrochlorothiazide tab (BENICAR HCT equiv)	-	1
QUINAPRIL/HCTZ TAB	-	1
quinapril/hydrochlorothiazide tab (ACCURETIC equiv)	-	1
valsartan/hydrochlorothiazide tab (DIOVAN HCT equiv)	-	1
SELECTIVE ALDOSTERONE RECEPTOR ANTAGONISTS (SARAS)		

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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 4/1/2024

DrugName	Special Code	Tier
ANTIHYPERTENSIVES Cont.		
eplerenone tab (INSPRA equiv)	-	1
VASODILATORS		
hydralazine tab (APRESOLINE equiv)	-	1
minoxidil tab (LONITEN equiv)	-	1
ANTI-INFECTIVE AGENTS - MISC.		
ANTI-INFECTIVE AGENTS - MISC.		
metronidazole tab (FLAGYL equiv)	-	1
pentamidine neb soln (NEBUPENT equiv)	-	1
tinidazole tab (TINDAMAX equiv)	-	1
TRIMETHOPRIM TAB	-	1
trimethoprim tab (PROLOPRIM equiv)	-	1
LIKMEZ SUSP (Prior Authorization Required for members age 9 or older)	PA	2
PRIMSOL SOLN	-	2
ANTI-INFECTIVE MISC. - COMBINATIONS		
smz/tmp (DS) tab (BACTRIM DS equiv)	-	1
smz/tmp susp (BACTRIM, SEPTRA equiv)	-	1
ANTIPROTOZOAL AGENTS		
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
GLYCOPEPTIDES		
FIRVANQ SOLN	-	1
FIRVANQ SOLN 50MG/ML	-	1

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

	NC =Not Covered	generic =small letters	BRANDS =CAPITAL LETTERS
EXC	Plan Exclusion	INF	Infertility
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course 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* 4/1/2024

DrugName	Special Code	Tier
ANTI-INFECTIVE AGENTS - MISC. Cont.		
vancomycin cap (VANCOGIN equiv) (QL= 56 caps/fill)	QL	2
LEPROSTATICS		
dapsone tab	-	1
LINCOSAMIDES		
clindamycin cap (CLEOCIN equiv)	-	1
clindamycin soln (CLEOCIN equiv)	-	1
MONOBACTAMS		
CAYSTON INH SOLN (Restricted to Infectious Disease or Pulmonology Specialist; Only available through Walgreens 888-347-3416)	LD-RS	2
OXAZOLIDINONES		
linezolid susp (Restricted to Infectious Disease Specialist)	RS	1
linezolid tab (ZYVOX equiv) (Restricted to Infectious Disease Specialist)	RS	1
PLEUROMUTILINS		
XENLETA TAB	PA	2
URINARY ANTI-INFECTIVES		
methenamine hippurate tab (HIPREX equiv)	-	1
methenamine mandelate tab	-	1
nitrofurantoin macrocrystals cap (MACRODANTIN equiv)	-	1
nitrofurantoin macrocrystals cap 25mg (MACRODANTIN equiv)	-	1
nitrofurantoin monohydrate cap (MACROBID equiv)	-	1
nitrofurantoin susp (FURADANTIN equiv)	PA	1
ANTIMALARIALS		
ANTIMALARIALS		

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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 4/1/2024

DrugName	Special Code	Tier
ANTIMALARIALS Cont.		
chloroquine tab (ARALEN equiv)	-	1
hydroxychloroquine tab (PLAQUENIL equiv)	-	1
ANTIMYASTHENIC/CHOLINERGIC AGENTS		
ANTIMYASTHENIC/CHOLINERGIC AGENTS		
pyridostigmine CR tab (MESTINON equiv)	-	1
pyridostigmine tab (MESTINON equiv)	-	1
FIRDAPSE TAB (Only available through AnovoRx 844-288-5007)	LD-PA	2
ANTIMYCOBACTERIAL AGENTS		
ANTI TB COMBINATIONS		
RIFAMATE CAP	-	2
ANTIMYCOBACTERIAL AGENTS		
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
ANTINEOPLASTICS		
ALKYLATING AGENTS		
HEXALEN CAP	-	2
ANTIMETABOLITES		

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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 4/1/2024

DrugName	Special Code	Tier
ANTINEOPLASTICS Cont.		
mercaptapurine tab (PURINETHOL equiv)	-	1
methotrexate tab (TREXALL equiv)	-	1
TABLOID TAB	-	2
ANTINEOPLASTIC ENZYME INHIBITORS		
ZOLINZA CAP	LMSP-PA	2
ANTINEOPLASTICS MISC.		
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
CHEMOTHERAPY RESCUE/ANTIDOTE AGENTS		
leucovorin tab	-	1
MESNEX TAB	LMSP	2
TOPOISOMERASE I INHIBITORS		
HYCAMTIN CAP	LMSP-PA	2
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES		
ALKYLATING AGENTS		
carboplatin inj (PARAPLATIN equiv)	MSP	1
CISPLATIN INJ	-	1
cisplatin inj (PLATINOL AQ equiv)	-	1
CISPLATIN INJ 50MG/50ML	-	1

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

	NC =Not Covered	generic =small letters	BRANDS =CAPITAL LETTERS
EXC	Plan Exclusion	INF	Infertility
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course 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* 4/1/2024

DrugName	Special Code	Tier
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES Cont.		
cyclophosphamide cap	-	1
temozolomide cap (TEMODAR equiv)	LMSP	1
CYCLOPHOSPHAMIDE TAB	-	2
GLEOSTINE/LOMUSTINE CAP	-	2
MYLERAN TAB	LMSP	2
ANTIMETABOLITES		
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 - 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

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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 4/1/2024

DrugName	Special Code	Tier
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES Cont.		
tamoxifen tab (NOLVADEX equiv)	-	1
toremifene tab (FARESTON equiv)	-	1
EMCYT CAP	-	2
EULEXIN CAP	-	2
FLUTAMIDE CAP	-	2
LYSODREN TAB (Only available through Walgreens 888-347-3416)	LD	2
ANTINEOPLASTIC - HYPOXIA-INDUCIBLE FACTOR INHIBITORS		
WELIREG TAB (QL= 3 tabs/day; Only available through Biologics 800-850-4306)	LD-PA-QL	2
ANTINEOPLASTIC ENZYME INHIBITORS		
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
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

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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 4/1/2024

DrugName	Special Code	Tier
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES Cont.		
KOSELUGO CAP 10MG (QL= 8 caps/day; Only available through Onco360 877-662-6633)	LD-PA-QL	2
MEKINIST SOLN	PA	2
MEKINIST TAB 0.5MG (QL= 3 tabs/day)	MSP-PA-QL	2
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
TAFINLAR TAB	PA	2
TASIGNA CAP	LMSP-PA	2
TAZVERIK TAB (QL= 8 tabs/day; Only available through Onco360 877-662-6633)	LD-PA-QL	2
VANFLYTA TAB (QL= 1 tab/day; Only available through Onco360 877-662-6633 or Biologics 800-850-4306)	LD-PA-QL	2
VANFLYTA TAB 26.5MG (QL= 2 tabs/day; Only available through Onco360 877-662-6633 or Biologics 800-850-4306)	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

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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 4/1/2024

DrugName	Special Code	Tier
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES Cont.		
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)	PA-SP	1
CHEMOTHERAPY RESCUE/ANTIDOTE AGENTS		
mesna inj (MESNEX equiv)	-	1
MITOTIC INHIBITORS		
ETOPOSIDE CAP	LMSP	1
TOPOISOMERASE I INHIBITORS		
topotecan inj (HYCAMTIN equiv)	-	1
ANTIPARKINSON AGENTS		
ANTIPARKINSON ADJUVANTS		
carbidopa tab (LODOSYN equiv)	-	1
ANTIPARKINSON ANTICHOLINERGICS		
benztropine tab	-	1
trihexyphenidyl tab (ARTANE equiv)	-	1
ANTIPARKINSON COMT INHIBITORS		
entacapone tab (COMTAN equiv)	-	2

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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 4/1/2024

DrugName	Special Code	Tier
ANTIPARKINSON AGENTS Cont.		
ANTIPARKINSON DOPAMINERGICS		
amantadine syrup (SYMMETREL equiv)	-	1
bromocriptine cap (PARLODEL equiv)	-	1
bromocriptine tab (PARLODEL equiv)	-	1
carbidopa/levodopa ER tab (SINEMET CR equiv)	-	1
carbidopa/levodopa ODT (PARCOPA equiv)	-	1
carbidopa/levodopa tab (SINEMET equiv)	-	1
pramipexole ER tab (MIRAPEX ER equiv)	-	1
pramipexole tab (MIRAPEX equiv)	-	1
ropinirole ER tab (REQUIP XL equiv)	-	1
ropinirole tab (REQUIP equiv)	-	1
CARBIDOPA/LEVODOPA/ENTACAPONE TAB (STALEVO equiv)	-	2
ANTIPARKINSON MONOAMINE OXIDASE INHIBITORS		
selegiline cap (ELDEPRYL equiv)	-	1
selegiline tab (ELDEPRYL equiv)	-	1
ANTIPARKINSON AND RELATED THERAPY AGENTS		
ANTIPARKINSON ANTICHOLINERGICS		
trihexyphenidyl elixir (ARTANE equiv)	-	1
TRIHEXYPHENIDYL SOLN	-	1
ANTIPARKINSON DOPAMINERGICS		
CARBIDOPA/LEVODOPA ODT	-	1
carbidopa-levodopa-entacapone tab (STALEVO equiv)	-	1
ANTIPSYCHOTICS/ANTIMANIC AGENTS		

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

	NC =Not Covered	generic =small letters	BRANDS =CAPITAL LETTERS
EXC	Plan Exclusion	INF	Infertility
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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 4/1/2024

DrugName	Special Code	Tier
ANTIPSYCHOTICS/ANTIMANIC AGENTS Cont.		
ANTIMANIC AGENTS		
lithium carbonate cap (ESKALITH ER equiv)	-	1
lithium carbonate ER tab (LITHOBID equiv)	-	1
lithium carbonate tab	-	1
ANTIPSYCHOTICS - MISC.		
lurasidone hcl tab (LATUDA equiv)	-	1
ziprasidone cap (GEODON equiv)	-	1
EQUETRO CAP	-	2
LATUDA TAB (QL= 1 tab/day)	QL	2+penalty
BENZISOXAZOLES		
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
RISPERDAL INJ	PA	2
risperidone microspheres inj (RISPERDAL equiv)	PA	2
RISPERIDONE ODT	-	2
BUTYROPHENONES		
haloperidol lactate conc (HALDOL equiv)	-	1
haloperidol tab (HALDOL equiv)	-	1

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

	NC =Not Covered	generic =small letters	BRANDS =CAPITAL LETTERS
EXC	Plan Exclusion	INF	Infertility
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course 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* 4/1/2024

DrugName	Special Code	Tier
ANTIPSYCHOTICS/ANTIMANIC AGENTS Cont.		
DIBENZAPINES		
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
PHENOTHIAZINES		
chlorpromazine tab (THORAZINE equiv)	-	1
fluphenazine tab (PROLIXIN equiv)	-	1
perphenazine tab (TRILAFON equiv)	-	1
prochlorperazine supp (COMPAZINE equiv)	-	1
prochlorperazine tab (COMPAZINE equiv)	-	1
thioridazine tab (MELLARIL equiv)	-	1
trifluoperazine tab (STELAZINE equiv)	-	1
QUINOLINONE DERIVATIVES		
aripiprazole soln (ABILIFY equiv)	-	1
aripiprazole tab (ABILIFY equiv)	-	1
THIOXANTHENES		
thiothixene cap (NAVANE equiv)	-	1

ANTIVIRALS

ANTIRETROVIRALS		
DESCOVY TAB	-	\$0

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

	NC =Not Covered	generic =small letters	BRANDS =CAPITAL LETTERS
EXC	Plan Exclusion	INF	Infertility
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course 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* 4/1/2024

DrugName	Special Code	Tier
ANTIVIRALS Cont.		
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
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

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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 4/1/2024

DrugName	Special Code	Tier
ANTIVIRALS Cont.		
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
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

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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 4/1/2024

DrugName	Special Code	Tier
ANTIVIRALS Cont.		
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
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

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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 4/1/2024

DrugName	Special Code	Tier
ANTIVIRALS Cont.		
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
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
ANTIVIRAL COMBINATIONS		
PAXLOVID TAB 150-100MG (QL= 20 tabs/fill)	QL	2
PAXLOVID TAB 300-100MG (QL= 30 tabs/fill)	QL	2
CMV AGENTS		

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

	NC =Not Covered	generic =small letters	BRANDS =CAPITAL LETTERS
EXC	Plan Exclusion	INF	Infertility
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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 4/1/2024

DrugName	Special Code	Tier
ANTIVIRALS Cont.		
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
HEPATITIS AGENTS		
RIBAVIRIN CAP	LMSP	1
ribavirin cap (REBETOL equiv)	LMSP	1
RIBAVIRIN TAB	LMSP	1
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
HERPES AGENTS		

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

	NC =Not Covered	generic =small letters	BRANDS =CAPITAL LETTERS
EXC	Plan Exclusion	INF	Infertility
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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 4/1/2024

DrugName	Special Code	Tier
ANTIVIRALS Cont.		
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
INFLUENZA AGENTS		
oseltamivir cap (TAMIFLU equiv) (QL= 10 caps/fill)	QL	1
oseltamivir cap 30mg (TAMIFLU equiv) (QL= 20 caps/fill)	QL	1
oseltamivir susp (TAMIFLU equiv) (QL= 250ml/fill)	QL	1
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
MISC. ANTIVIRALS		
LAGEVRIO CAP (EUA) (QL= 40 caps/fill)	QL	\$0
LAGEVRIO CAP 200MG (QL= 40 caps/fill)	QL	2
ASSORTED CLASSES		
CHELATING AGENTS		
D-PENAMINE TAB	-	2
IMMUNOMODULATORS		
THALOMID CAP	MSP-PA	2

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

	NC =Not Covered	generic =small letters	BRANDS =CAPITAL LETTERS
EXC	Plan Exclusion	INF	Infertility
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course 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* 4/1/2024

DrugName	Special Code	Tier
ASSORTED CLASSES Cont.		
IMMUNOSUPPRESSIVE AGENTS		
azathioprine tab (IMURAN equiv)	-	1
cyclosporine cap (SANDIMMUNE equiv)	-	1
cyclosporine modified cap (NEORAL equiv)	-	1
cyclosporine modified soln (NEORAL equiv)	-	1
mycophenolate DR tab (MYFORTIC equiv)	-	1
mycophenolate mofetil cap (CELLCEPT equiv)	-	1
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
POTASSIUM REMOVING RESINS		
sodium polystyrene powder (KAYEXALATE equiv)	-	1
sodium polystyrene susp (SPS equiv)	-	1
VELTASSA POWDER	PA	2
BETA BLOCKERS		

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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 4/1/2024

DrugName	Special Code	Tier
BETA BLOCKERS Cont.		
ALPHA-BETA BLOCKERS		
carvedilol tab (COREG equiv)	-	1
labetalol tab (NORMODYNE equiv)	-	1
BETA BLOCKERS CARDIO-SELECTIVE		
acebutolol cap (SECTRAL equiv)	-	1
atenolol tab (TENORMIN equiv)	-	1
betaxolol tab (KERLONE equiv)	-	1
bisoprolol tab (ZEBETA equiv)	-	1
metoprolol ER tab (TOPROL XL equiv)	-	1
metoprolol tab (LOPRESSOR equiv)	-	1
BETA BLOCKERS NON-SELECTIVE		
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

CALCIUM CHANNEL BLOCKERS

CALCIUM CHANNEL BLOCKERS

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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 4/1/2024

DrugName	Special Code	Tier
CALCIUM CHANNEL BLOCKERS Cont.		
amlodipine tab (NORVASC equiv)	-	1
diltiazem ER cap (CARDIZEM CD equiv)	-	1
diltiazem ER cap (CARDIZEM SR equiv)	-	1
diltiazem ER cap (DILACOR XR equiv)	-	1
diltiazem ER cap (TIAZAC equiv)	-	1
diltiazem ER tab (CARDIZEM LA equiv)	-	1
diltiazem tab (CARDIZEM equiv)	-	1
felodipine ER tab (PLENDIL equiv)	-	1
isradipine cap (DYNACIRC equiv)	-	1
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 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
VERAPAMIL SR CAP 360mg	-	2
CARDIOTONICS		
CARDIAC GLYCOSIDES		
digoxin soln (LANOXIN equiv)	-	1

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

	NC =Not Covered	generic =small letters	BRANDS =CAPITAL LETTERS
EXC	Plan Exclusion	INF	Infertility
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course 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* 4/1/2024

DrugName	Special Code	Tier
CARDIOTONICS Cont.		
DIGOXIN SOLN 0.05MG/ML	-	1
digoxin tab (LANOXIN equiv)	-	1
CARDIOVASCULAR AGENTS - MISC.		
CARDIAC MYOSIN INHIBITORS		
CAMZYOS CAP (QL= 1 cap/day; Only available through Accredo 800-803-2523 or Walgreens 888-347-3416)	LD-PA-QL	2
PERIPHERAL VASODILATORS		
isoxsuprine tab	-	1
PROSTAGLANDIN VASODILATORS		
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 0.6 MG/ML (Only available through Accredo 800-803-2523)	LD-PA	2
VENTAVIS INH SOLN (Only available through Accredo 800-803-2523)	LD-PA	2
PULMONARY HYPERTENSION - ENDOTHELIN RECEPTOR ANTAGONISTS		
ambrisentan tab (LETAIRIS equiv) (QL= 1 tab/day; Only available through Lumicera 855-847-3553)	LD-PA-QL	1

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

	NC =Not Covered	generic =small letters	BRANDS =CAPITAL LETTERS
EXC	Plan Exclusion	INF	Infertility
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course 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* 4/1/2024

DrugName	Special Code	Tier
CARDIOVASCULAR AGENTS - MISC. Cont.		
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
PULMONARY HYPERTENSION - PHOSPHODIESTERASE INHIBITORS		
sildenafil tab 20mg (REVATIO equiv)	PA	1
tadalafil tab (PAH) (ADCIRCA equiv)	LMSP-PA	1
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
SINUS NODE INHIBITORS		
CORLANOR SOLN	PA	2
CORLANOR TAB	PA	2
CEPHALOSPORINS		
CEPHALOSPORINS - 1ST GENERATION		
cefadroxil cap (DURICEF equiv)	-	1
cefadroxil susp (DURICEF equiv)	-	1
CEFADROXIL TAB	-	1
cefadroxil tab (DURICEF equiv)	-	1
cephalexin cap (KEFLEX equiv)	-	1
cephalexin susp (KEFLEX equiv)	-	1
CEPHALOSPORINS - 2ND GENERATION		
CEFACLOR CAP	-	1
cefaclor cap (CECLOR equiv)	-	1

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

	NC =Not Covered	generic =small letters	BRANDS =CAPITAL LETTERS
EXC	Plan Exclusion	INF	Infertility
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course 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* 4/1/2024

DrugName	Special Code	Tier
CEPHALOSPORINS Cont.		
cefprozil susp (CEFZIL equiv)	-	1
cefprozil tab (CEFZIL equiv)	-	1
cefuroxime tab (CEFTIN equiv)	-	1
CEPHALOSPORINS - 3RD GENERATION		
cefdinir cap (OMNICEF equiv)	-	1
cefdinir susp (OMNICEF equiv)	-	1
cefixime susp (SUPRAX equiv)	-	1
cefpodoxime proxetil susp (VANTIN equiv)	-	1
cefpodoxime proxetil tab (VANTIN equiv)	-	1
CONTRACEPTIVES		
COMBINATION CONTRACEPTIVES - ORAL		
amethyst tab (LYBREL equiv)	-	\$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

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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 4/1/2024

DrugName	Special Code	Tier
CONTRACEPTIVES Cont.		
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
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

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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 4/1/2024

DrugName	Special Code	Tier
CONTRACEPTIVES Cont.		
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
viorele tab, kariva tab (MIRCETTE equiv)	-	\$0
YAZ TAB, YASMIN 28 TAB	-	\$0
COMBINATION CONTRACEPTIVES - TRANSDERMAL		
TWIRLA PATCH	-	\$0
zafemy patch (XULANE equiv)	-	\$0
COMBINATION CONTRACEPTIVES - VAGINAL		
ANNOVERA RING (QL= 1 ring/year)	QL	\$0
NUVARING	-	\$0
COPPER CONTRACEPTIVES - IUD		
PARAGARD IUD	-	\$0
EMERGENCY CONTRACEPTIVES		
ELLA TAB	-	\$0
levonorgestrel tab (PLAN B equiv)	OTC	\$0
PLAN B TAB	OTC	\$0
PROGESTIN CONTRACEPTIVES - IMPLANTS		
NEXPLANON IMPLANT	-	\$0
PROGESTIN CONTRACEPTIVES - INJECTABLE		

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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 4/1/2024

DrugName	Special Code	Tier
CONTRACEPTIVES Cont.		
DEPO-PROVERA INJ	-	\$0
medroxyprogesterone inj (DEPO-PROVERA equiv) (QL= 1 inj/90 days)	QL	\$0
PROGESTIN CONTRACEPTIVES - IUD		
MIRENA IUD	-	\$0
PROGESTIN CONTRACEPTIVES - ORAL		
norethindrone tab (NORA-QD equiv)	-	\$0
NOR-QD TAB	-	\$0
SLYND TAB	-	\$0
CORTICOSTEROIDS		
GLUCOCORTICOSTEROIDS		
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

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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 4/1/2024

DrugName	Special Code	Tier
CORTICOSTEROIDS Cont.		
prednisolone soln (PEDIAPRED equiv)	-	1
PREDNISON 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
SOLU-MEDROL INJ 2GM	-	2
MINERALOCORTICIDS		
fludrocortisone tab (FLORINEF equiv)	-	1
COUGH/COLD/ALLERGY		
ANTITUSSIVES		
benzonatate cap (TESSALON equiv)	-	1
hydrocodone/homatropine syrup (HYCODAN equiv)	-	1
tussigon tab (HYCODAN equiv)	-	1
COUGH/COLD/ALLERGY COMBINATIONS		
cetirizine/pseudoephedrine 12-hour tab (ZYRTEC equiv) (QL= 2 tabs/day)	OTC-QL	1
dextromethorphan/guaifenesin syrup 10-100mg (ROBITUSSIN equiv)	OTC	1
fexofenadine/pseudoephedrine 12-hour tab (ALLEGRA-D 12 hour equiv)	OTC	1
fexofenadine/pseudoephedrine 24-hour tab (ALLEGRA-D equiv)	OTC	1
GUAIFENESIN/CODEINE SYRUP (QL= 240ml/fill)	OTC-QL	1
guaifenesin/codeine syrup (TUSSI-ORGANIDIN-S equiv) (QL= 240ml/fill)	OTC-QL	1

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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 4/1/2024

DrugName	Special Code	Tier
COUGH/COLD/ALLERGY Cont.		
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
promethazine VC/codeine syrup (PHENERGAN VC/CODEINE equiv)	-	1
promethazine/codeine syrup (PHENERGAN/CODEINE equiv)	-	1
EXPECTORANTS		
guaifenesin ER tab (MUCINEX equiv)	OTC	1
guaifenesin syrup 100mg/5ml (ROBITUSSIN equiv)	OTC	1
potassium iodide oral soln (SSKI equiv)	-	1
SSKI ORAL SOLN	-	2+penalty
MISC. RESPIRATORY INHALANTS		
sodium chloride neb soln (HYPER-SAL equiv)	OTC	1
NEBUSAL NEB SOLN	-	2
MUCOLYTICS		
acetylcysteine soln (MUCOMYST equiv)	-	1
DERMATOLOGICALS		
ACNE PRODUCTS		

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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 4/1/2024

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
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 (ACCUTANE equiv)	-	1
benzoyl peroxide cream (NEOBENZ equiv)	OTC	1
benzoyl peroxide gel (OTC) (BENZAC equiv)	OTC	1
benzoyl peroxide liquid (BENZAC equiv)	OTC	1
benzoyl peroxide lotion (OTC) (TRIAZ equiv)	OTC	1
clindamycin gel (CLEOCIN GEL equiv)	-	1
clindamycin lotion (CLEOCIN- T equiv)	-	1
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

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

	NC =Not Covered	generic =small letters	BRANDS =CAPITAL LETTERS
EXC	Plan Exclusion	INF	Infertility
LD	Limited Distribution	LMSPP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course 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* 4/1/2024

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
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
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

AGENTS FOR WRINKLES/LIPOATROPHY/OTHER AESTHETIC USES

RENOVA CREAM	-	EXC
--------------	---	-----

ANTIBIOTICS - TOPICAL

bacitracin oint	OTC	1
bacitracin/polymyxin B oint (POLYSPORIN equiv)	OTC	1

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

	NC =Not Covered	generic =small letters	BRANDS =CAPITAL LETTERS
EXC	Plan Exclusion	INF	Infertility
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course 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* 4/1/2024

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
bacitracin/zinc oint	OTC	1
gentamicin sulfate cream	-	1
gentamicin sulfate oint	-	1
mupirocin oint (BACTROBAN OINT equiv)	-	1
neomycin/bacitracin/polymyxin oint (NEOSPORIN equiv)	OTC	1
ANTIFUNGALS - TOPICAL		
ciclopirox cream (LOPROX CREAM equiv)	-	1
ciclopirox gel (LOPROX GEL equiv)	-	1
ciclopirox 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% (VYTONNE 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

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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 4/1/2024

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
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
tolnaftate cream (TINACTIN equiv)	OTC	1
tolnaftate powder (TINACTIN equiv)	OTC	1
tolnaftate soln (TINACTIN equiv)	OTC	1
ANTI-INFLAMMATORY AGENTS - TOPICAL		
diclofenac gel 1% (VOLTAREN equiv) (QL= 5 tubes/fill)	QL	1
ANTINEOPLASTIC OR PREMALIGNANT LESION AGENTS - TOPICAL		
bexarotene gel (TARGRETIN equiv)	LMSP-PA	1
diclofenac gel (SOLARAZE equiv) (QL= 300gm/30 days)	QL	1
fluorouracil cream (EFUDEX CREAM equiv)	-	1
fluorouracil soln (FLUOROURACIL 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
ANTIPSORIATICS		

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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 4/1/2024

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
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
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
ANTISEBORRHEIC PRODUCTS		
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
ANTIVIRALS - TOPICAL		
acyclovir oint (ZOVIRAX OINT equiv)	-	1
acyclovir cream 5%	-	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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 4/1/2024

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
BURN PRODUCTS		
silver sulfadiazine cream (SILVADENE CREAM equiv)	-	1
mafenide acetate soln packet (SULFAMYLON equiv)	-	2
SULFAMYLON CREAM	-	2
CORTICOSTEROIDS - TOPICAL		
alclometasone cream (ACLOVATE equiv)	-	1
alclometasone oint (ACLOVATE OINT equiv)	-	1
betamethasone augmented cream (DIPROLENE AF CREAM equiv)	-	1
betamethasone augmented gel	-	1
betamethasone augmented 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 (OLUX equiv)	-	1
clobetasol propionate cream (TEMOVATE equiv)	-	1
clobetasol propionate emollient cream (TEMOVATE E equiv)	-	1
clobetasol propionate gel (TEMOVATE GEL equiv)	-	1
clobetasol propionate oint (TEMOVATE equiv)	-	1
clobetasol propionate soln (TEMOVATE equiv)	-	1
clobetasol shampoo (CLOBEX equiv)	-	1

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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 4/1/2024

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
clobetasol spray	PA	1
desoximetasone oint (TOPICORT equiv)	-	1
FLUOCINOLONE ACET CREAM	-	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
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

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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 4/1/2024

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
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
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

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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 4/1/2024

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
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
LITFULO CAP	-	EXC
HAIR REDUCTION AGENTS		
VANIQA CREAM	-	EXC
IMMUNOMODULATING AGENTS - TOPICAL		
imiquimod cream (ALDARA equiv)	-	1
IMMUNOSUPPRESSIVE AGENTS - TOPICAL		
pimecrolimus cream (ELIDEL equiv) (Covered for members 2 years or older; Step Therapy requires trial of tacrolimus oint)	ST	1
tacrolimus oint (PROTOPIC OINT equiv)	-	1
HYFTOR GEL (QL= 10 grams/30 days)	PA-QL	2
KERATOLYTIC/ANTIMITOTIC AGENTS		
PODOFILOX SOLN	-	1
podofilox soln (CONDYLOX equiv)	-	1
salicylic acid liquid 17%	OTC	1
salicylic acid pads 40%	OTC	1

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

	NC =Not Covered	generic =small letters	BRANDS =CAPITAL LETTERS
EXC	Plan Exclusion	INF	Infertility
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course 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* 4/1/2024

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
salicylic acid shampoo (SALEX equiv)	-	1
PODOCON SOLN	-	2
LOCAL ANESTHETICS - TOPICAL		
lidocaine cream 3% (LIDAMANTLE equiv)	-	1
lidocaine gel (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
MISC. TOPICAL		
DRYSOL SOLN	-	1
PIGMENTING-DEPIGMENTING AGENTS		
hydroquinone cream (LUSTRA equiv)	-	EXC
TRI-LUMA CREAM	-	EXC
ROSACEA AGENTS		
azelaic acid gel (FINACEA equiv)	-	1
metronidazole cream (METROCREAM equiv)	-	1
metronidazole gel (METROGEL equiv)	-	1
metronidazole gel 0.75% (METROGEL equiv)	-	1
metronidazole lotion (METROLOTION equiv)	-	1
FINACEA FOAM	-	2

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

	NC =Not Covered	generic =small letters	BRANDS =CAPITAL LETTERS
EXC	Plan Exclusion	INF	Infertility
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course 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* 4/1/2024

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
RHOFADE CREAM	-	EXC
SCABICIDES & PEDICULICIDES		
lice aerosol (QL= 150ml/7 days, Limited to 2 fills/year)	OTC-QL	1
lice cream rinse (NIX equiv) (QL= 59ml/7 days, Limited to 2 fills/year)	OTC-QL	1
lice treatment kit (RID equiv)	OTC	1
lice treatment liquid (RID equiv) (QL= 120ml/7 days, Limited to 2 fills/year)	OTC-QL	1
lice treatment shampoo (PRONTO equiv) (QL= 120ml/7 days, Limited to 2 fills/year)	OTC-QL	1
LINDANE 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
WOUND CARE PRODUCTS		
REGRANEX GEL (QL= 30gm/fill)	QL	2
DIAGNOSTIC PRODUCTS		
DIAGNOSTIC DRUGS		
GLUCAGEN INJ	-	2
GLUCAGON DIAGNOSTIC INJ (QL= 2 inj/fill, 1 fill/30 days)	QL	2
DIAGNOSTIC TESTS		
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

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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 4/1/2024

DrugName	Special Code	Tier
DIAGNOSTIC PRODUCTS Cont.		
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
DIETARY PRODUCTS/DIETARY MANAGEMENT PRODUCTS		
DIETARY MANAGEMENT PRODUCTS		
ASTAMED MYO CAP	-	EXC
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

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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 4/1/2024

DrugName	Special Code	Tier
DIGESTIVE AIDS		
DIGESTIVE ENZYMES		
CREON CAP	-	2
PANCREAZE CAP	-	2
DIURETICS		
CARBONIC ANHYDRASE INHIBITORS		
acetazolamide ER cap (DIAMOX SEQUEL equiv)	-	1
acetazolamide tab	-	1
methazolamide tab (NEPTAZANE equiv)	-	1
DIURETIC COMBINATIONS		
AMILORIDE/HCTZ TAB	-	1
amiloride/hydrochlorothiazide tab (MODURETIC equiv)	-	1
spironolactone/hydrochlorothiazide tab (ALDACTAZIDE equiv)	-	1
triamterene/hydrochlorothiazide cap (DYAZIDE equiv)	-	1
triamterene/hydrochlorothiazide tab (MAXZIDE equiv)	-	1
LOOP DIURETICS		
bumetanide tab (BUMEX equiv)	-	1
ethacrynic tab (EDECIN equiv)	-	1
FUROSEMIDE SOLN	-	1
furosemide soln (LASIX equiv)	-	1
furosemide tab (LASIX equiv)	-	1
toremide tab (DEMADEX equiv)	-	1
POTASSIUM SPARING DIURETICS		
amiloride tab (MIDAMOR equiv)	-	1

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

	NC =Not Covered	generic =small letters	BRANDS =CAPITAL LETTERS
EXC	Plan Exclusion	INF	Infertility
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course 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* 4/1/2024

DrugName	Special Code	Tier
DIURETICS Cont.		
spironolactone tab (ALDACTONE equiv)	-	1
spironolactone susp (CAROSPIR equiv) (Prior Authorization required for members age 9 or older)	PA	2
CAROSPIR SUSP	-	2+penalty
THIAZIDES AND THIAZIDE-LIKE DIURETICS		
CHLOROTHIAZIDE TAB	-	1
chlorothiazide tab (DIURIL equiv)	-	1
chlorthalidone tab	-	1
hydrochlorothiazide cap (MICROZIDE equiv)	-	1
hydrochlorothiazide tab (HYDRODIURIL equiv)	-	1
indapamide tab (LOZOL equiv)	-	1
metolazone tab (ZAROXOLYN equiv)	-	1
DIURIL SUSP	-	2
ENDOCRINE AND METABOLIC AGENTS - MISC.		
BONE DENSITY REGULATORS		
alendronate tab (FOSAMAX equiv)	-	1
calcitonin inj (MIACALCIN equiv)	LMSP	1
ALENDRONATE TAB 40MG	-	2
CORTICOTROPIN		
ACTHAR GEL INJ (QL= 4 vials/fill; Only available through Accredo 800-803-2523 or Walgreens 888-347-3416)	LD-PA-QL	2
FERTILITY REGULATORS		

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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 4/1/2024

DrugName	Special Code	Tier
ENDOCRINE AND METABOLIC AGENTS - MISC. Cont.		
CLOMID TAB	INF	EXC
CLOMIPHENE TAB	INF	EXC
OVIDREL INJ	INF	EXC
GNRH/LHRH ANTAGONISTS		
cetorelix acetate for inj kit (CETROTIDE equiv)	INF	EXC
CETROTIDE KIT	INF	EXC
GROWTH HORMONE RECEPTOR ANTAGONISTS		
SOMAVERT INJ (Only available through Accredo 800-803-2523 or Walgreens 888-347-3416)	LD-PA	2
GROWTH HORMONE RELEASING HORMONES (GHRH)		
EGRIFTA INJ	-	EXC
GROWTH HORMONES		
GENOTROPIN INJ	LMSP-PA	2
OMNITROPE INJ	LMSP-PA	2
SKYTROFA INJ	LMSP-PA	2
SOGROYA INJ	LMSP-PA	2
HORMONE RECEPTOR MODULATORS		
raloxifene tab (EVISTA equiv)	-	1
INSULIN-LIKE GROWTH FACTORS (SOMATOMEDINS)		
INCRELEX INJ (Only available through Accredo 800-803-2523 or Walgreens 888-347-3416)	LD	2
METABOLIC MODIFIERS		
calcitriol cap (ROCALTROL equiv)	-	1

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

	NC =Not Covered	generic =small letters	BRANDS =CAPITAL LETTERS
EXC	Plan Exclusion	INF	Infertility
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course 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* 4/1/2024

DrugName	Special Code	Tier
ENDOCRINE AND METABOLIC AGENTS - MISC. Cont.		
calcitriol soln (ROCALTROL equiv)	-	1
carglumic acid tab (CARBAGLU equiv) (Only available through AnovoRx 844-288-5007)	LD-PA	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
PHEBURANE ORAL PELLETS (Only available through Accredo 800-803-2523; Ste Therapy requires trial of sodium phenylbutyrate)	LD-ST	2
RAVICTI LIQUID (Step Therapy requires trial of sodium phenylbutyrate and Pheburane Oral Pellets)	ST	2

NATRIURETIC PEPTIDES

VOXZOGO INJ (QL= 1 vial/day; Only available through Accredo 888-773-7376)	LD-PA-QL	2
---	----------	---

POSTERIOR PITUITARY HORMONES

desmopressin acetate nasal spray (DDAVP equiv)	-	1
desmopressin acetate tab (DDAVP equiv)	-	1
STIMATE NASAL SOLN	-	2

PROGESTERONE RECEPTOR ANTAGONISTS

mifepristone tab (MIFIPREX equiv)	-	1
-----------------------------------	---	---

PROLACTIN INHIBITORS

cabergoline tab (DOSTINEX equiv)	-	1
----------------------------------	---	---

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

	NC =Not Covered	generic =small letters	BRANDS =CAPITAL LETTERS
EXC	Plan Exclusion	INF	Infertility
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course 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* 4/1/2024

DrugName	Special Code	Tier
ENDOCRINE AND METABOLIC AGENTS - MISC. Cont.		
SOMATOSTATIC AGENTS		
octreotide inj (SANDOSTATIN equiv)	LMSP	1
OCTREOTIDE INJ 100MCG	LMSP	1
ESTROGENS		
ESTROGEN COMBINATIONS		
esterified estrogens/methyltestosterone tab (ESTRATEST equiv)	-	1
estradiol/norethindrone tab (ACTIVELLA equiv)	-	1
jinteli tab (FEMHRT equiv)	-	1
MYFEMBREE TAB (QL= 1 tab/day)	PA-QL	2
PREMPHASE TAB, PREMPRO TAB	-	2
ESTROGENS		
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
FLUOROQUINOLONES		
FLUOROQUINOLONES		
ciprofloxacin susp (CIPRO equiv)	-	1
ciprofloxacin tab (CIPRO equiv)	-	1
levofloxacin soln (LEVAQUIN equiv)	-	1
levofloxacin tab (LEVAQUIN equiv)	-	1
moxifloxacin tab (AVELOX equiv)	-	1

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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 4/1/2024

DrugName	Special Code	Tier
FLUOROQUINOLONES Cont.		
ofloxacin tab (FLOXIN equiv)	-	1
GASTROINTESTINAL AGENTS - MISC.		
GALLSTONE SOLUBILIZING AGENTS		
ursodiol cap (ACTIGALL equiv)	-	1
ursodiol tab (URSO (FORTE) equiv)	-	1
GASTROINTESTINAL ANTIALLERGY AGENTS		
cromolyn conc (GASTROCROM equiv)	-	2
GASTROINTESTINAL STIMULANTS		
metoclopramide soln (REGLAN equiv)	-	1
metoclopramide tab (REGLAN equiv)	-	1
ILEAL BILE ACID TRANSPORTER (IBAT) INHIBITORS		
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
INFLAMMATORY BOWEL AGENTS		
balsalazide cap (COLAZAL equiv)	-	1

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

	NC =Not Covered	generic =small letters	BRANDS =CAPITAL LETTERS
EXC	Plan Exclusion	INF	Infertility
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course 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* 4/1/2024

DrugName	Special Code	Tier
GASTROINTESTINAL AGENTS - MISC. Cont.		
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
SKYRIZI INJ 180 MG/1.2ML	LMSP-PA-QL	2
SKYRIZI INJ 360MG/2.4ML	LMSP-PA-QL	2
INTESTINAL ACIDIFIERS		
lactulose soln	-	1
IRRITABLE BOWEL SYNDROME (IBS) AGENTS		
alosetron tab (LOTROXEX equiv)	-	1
LINZESS CAP (QL= 1 cap/day)	PA-QL	2
LIVE FECAL MICROBIOTA		
VOWST CAP (QL= 12 caps/fill; Only available through Orsini 800-410-8575)	LD-PA-QL	2
PHOSPHATE BINDER AGENTS		
calcium acetate cap (PHOSLO equiv)	-	1
sevelamer powder pak (RENVELA PAK equiv)	-	1
sevelamer tab (RENVELA TAB equiv)	-	1
GENITOURINARY AGENTS - MISCELLANEOUS		
ALKALINIZERS		
CYTRA K CRYSTALS	-	1

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

	NC =Not Covered	generic =small letters	BRANDS =CAPITAL LETTERS
EXC	Plan Exclusion	INF	Infertility
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course 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* 4/1/2024

DrugName	Special Code	Tier
GENITOURINARY AGENTS - MISCELLANEOUS Cont.		
CYTRA-3 SYRUP	-	1
ORACIT SOLN	-	1
potassium citrate CR tab (UROKIT-K TAB equiv)	-	1
potassium citrate/citric acid powder pack (POLYCITRA equiv)	-	1
potassium citrate/citric acid soln (POLYCITRA-K equiv)	-	1
sodium citrate/citric acid soln (BICITRA equiv)	-	1
tricitrates soln (POLYCITRA-LC equiv)	-	1
CYSTINOSIS AGENTS		
CYSTAGON CAP (Only available through CVS Specialty 800-238-7828)	LD	2
IGA NEPHROPATHY (IGAN) AGENTS		
FILSPARI TAB (QL= 1 tab/day; Only available through Accredo 800-803-2523)	LD-PA-QL	2
INTERSTITIAL CYSTITIS AGENTS		
ELMIRON CAP	-	2
PROSTATIC HYPERTROPHY AGENTS		
dutasteride cap (AVODART equiv)	-	1
finasteride tab (PROSCAR equiv)	-	1
tamsulosin cap (FLOMAX equiv)	-	1
alfuzosin SR tab (UROXATRAL equiv)	-	2
URINARY ANALGESICS		
phenazopyridine tab (PYRIDIUM equiv)	-	1
phenazopyridine tab 95mg (AZO equiv)	OTC	1
phenazopyridine tab 97.5mg (AZO equiv)	OTC	1
phenazopyridine tab 99.5mg (AZO equiv)	OTC	1

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

	NC =Not Covered	generic =small letters	BRANDS =CAPITAL LETTERS
EXC	Plan Exclusion	INF	Infertility
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course 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* 4/1/2024

DrugName	Special Code	Tier
GENITOURINARY AGENTS - MISCELLANEOUS Cont.		
URINARY STONE AGENTS		
tiopronin tab (THIOLA equiv)	LMSP-PA	1
GOUT AGENTS		
GOUT AGENT COMBINATIONS		
colchicine/probenecid tab (COL-BENEMID equiv)	-	1
GOUT AGENTS		
allopurinol tab (ZYLOPRIM equiv)	-	1
colchicine tab (COLCRYS equiv)	-	1
GLOPERBA SOLN (Prior Authorization Required for members age 9 or older)	PA	2
URICOSURICS		
probenecid tab (BENEMID equiv)	-	1
HEMATOLOGICAL AGENTS - MISC.		
ANTIHEMOPHILIC PRODUCTS		
HEMLIBRA INJ	LMSP-PA	2
BRADYKININ B2 RECEPTOR ANTAGONISTS		
icatibant inj (FIRAZYR equiv)	LMSP-PA	1
COMPLEMENT INHIBITORS		
BERINERT INJ (Only available through 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 855-726-847)	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

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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 4/1/2024

DrugName	Special Code	Tier
HEMATOLOGICAL AGENTS - MISC. Cont.		
HEMATORHEOLOGIC AGENTS		
pentoxifylline ER tab (TRENTAL equiv)	-	1
PLASMA KALLIKREIN INHIBITORS		
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
PLATELET AGGREGATION INHIBITORS		
anagrelide cap (AGRYLIN equiv)	-	1
cilostazol tab (PLETAL equiv)	-	1
clopidogrel tab 75mg (PLAVIX equiv)	-	1
dipyridamole tab (PERSANTINE equiv)	-	1
PYRUVATE KINASE ACTIVATORS		
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

HEMATOPOIETIC AGENTS

AGENTS FOR GAUCHER DISEASE		
miglustat cap (ZAVESCA equiv) (Only available through Accredo 800-803-2523)	LD-PA	1
CEREZYME INJ	MSP-PA	2
AGENTS FOR SICKLE CELL ANEMIA		
DROXIA CAP	-	2
OXBRYTA TAB (QL= 3 tabs/day; Only available through Accredo 800-803-2523)	LD-PA-QL	2
AGENTS FOR SICKLE CELL DISEASE		

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

	NC =Not Covered	generic =small letters	BRANDS =CAPITAL LETTERS
EXC	Plan Exclusion	INF	Infertility
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course 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* 4/1/2024

DrugName	Special Code	Tier
HEMATOPOIETIC AGENTS Cont.		
ENDARI POWDER PACK (QL= 6 packets/day)	LMSP-PA-QL	2
OXBRYTA TAB FOR ORAL SUSP (QL= 5 tabs/day; Only available through Accredited Pharmacies 800-803-2523)	LD-PA-QL	2
COBALAMINS		
cyanocobalamin inj	-	1
FOLIC ACID/FOLATES		
folic acid tab 1mg	-	\$0
folic acid tab 400mcg	OTC	\$0
folic acid tab 800mcg	OTC	\$0
HEMATOPOIETIC GROWTH FACTORS		
FULPHILA INJ	PA	2
NIVESTYM INJ	LMSP	2
NYVEPRIA INJ	LMSP	2
PROMACTA POWDER (QL= 1 packet/day)	LMSP-PA-QL	2
PROMACTA TAB 12.5MG, 25MG (QL= 1 tab/day)	LMSP-PA-QL	2
PROMACTA TAB 50MG (QL= 2 tabs/day)	LMSP-PA-QL	2
PROMACTA TAB 75MG (QL= 2 tabs/day)	LMSP-PA-QL	2
RETACRIT INJ	-	2
ZARXIO INJ	LMSP	2
HEMATOPOIETIC MIXTURES		
ferrex 150 forte cap	-	1
folbee tab	-	1
MULTIGEN FOLIC TAB	-	1

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

	NC =Not Covered	generic =small letters	BRANDS =CAPITAL LETTERS
EXC	Plan Exclusion	INF	Infertility
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course 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* 4/1/2024

DrugName	Special Code	Tier
HEMATOPOIETIC AGENTS Cont.		
MULTIGEN PLUS TAB	-	1
MULTIGEN TAB	-	1
tricon cap (TRINSICON equiv)	-	1
NEPHRON FA TAB	-	2
IRON		
ferrous sulfate soln (FER-IN-SOL equiv)	OTC	1
iron complex cap 150mg	OTC	1
HEMOSTATICS		
HEMOSTATICS - SYSTEMIC		
aminocaproic acid soln (AMICAR equiv)	-	1
aminocaproic acid tab (AMICAR equiv)	-	1
tranexamic acid tab (LYSTEDA equiv)	QL	2
HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS		
ANTIHISTAMINE HYPNOTICS		
diphenhydramine cap (OTC only)	OTC	1
diphenhydramine cap 50mg (BENADRYL equiv) (Only 50mg covered)	-	1
diphenhydramine tab (NYTOL equiv)	OTC	1
BARBITURATE HYPNOTICS		
phenobarbital elixir	-	1
phenobarbital tab	-	1
SECONAL CAP	-	2
NON-BARBITURATE HYPNOTICS		
estazolam tab (PROSOM equiv)	-	1

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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 4/1/2024

DrugName	Special Code	Tier
HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS Cont.		
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
LAXATIVES		
LAXATIVE COMBINATIONS		
GOLYTELY SOLN	-	1
peg 3350/electrolytes soln (GOLYTELY/COLYTE equiv)	-	1
peg 3350/electrolytes soln (NULYTELY equiv)	-	1
LAXATIVES - MISCELLANEOUS		
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
SALINE LAXATIVES		
milk of magnesium	OTC	1
STIMULANT LAXATIVES		

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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 4/1/2024

DrugName	Special Code	Tier
LAXATIVES Cont.		
senna cap (SENOKOT equiv)	OTC	1
senna syrup (SENOKOT equiv)	OTC	1
senna tab (SENOKOT equiv)	OTC	1
SURFACTANT LAXATIVES		
docusate calcium cap (KAOPECTATE equiv)	OTC	1
docusate sodium cap (COLACE equiv)	OTC	1
docusate sodium liquid (COLACE equiv)	OTC	1
docusate sodium syrup (COLACE equiv)	OTC	1
docusate sodium tab (COLACE equiv)	OTC	1
DOCUSATE SYRUP	OTC	1
MACROLIDES		
AZITHROMYCIN		
azithromycin susp (ZITHROMAX equiv)	-	1
azithromycin tab (ZITHROMAX equiv)	-	1
ZITHROMAX POWDER PACK	-	1
CLARITHROMYCIN		
clarithromycin ER tab (BIAXIN XL equiv)	-	1
clarithromycin tab (BIAXIN equiv)	-	1
CLARITHROMYC SUSP	-	2
ERYTHROMYCINS		
erythromycin ethylsuccinate susp (ERYPED equiv)	-	1
erythromycin tab (ERY-TAB equiv)	-	1
erythromycin DR cap (ERYC equiv)	-	2

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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 4/1/2024

DrugName	Special Code	Tier
MACROLIDES Cont.		
ERYTHROMYCIN EC CAP	-	2
ERYTHROMYCIN ETHYLSUCCINATE TAB	-	2
FIDAXOMICIN		
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
MEDICAL DEVICES AND SUPPLIES		
CONTRACEPTIVES		
FEMALE CONDOMS	OTC	\$0
MALE CONDOMS	OTC	\$0
DIAPHRAGM	-	2
DIABETIC SUPPLIES		
ACCU-CHEK AVIVA PLUS METER	OTC	\$0
ACCU-CHEK GUIDE CARE METER	OTC	\$0
ACCU-CHEK GUIDE ME KIT	OTC	\$0
ACCU-CHEK NANO METER	OTC	\$0
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

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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 4/1/2024

DrugName	Special Code	Tier
MEDICAL DEVICES AND SUPPLIES Cont.		
LANCET KIT	OTC	1
LANCETS	OTC	1
MISC. DEVICES		
ALCOHOL SWABS	OTC	2
PARENTERAL THERAPY SUPPLIES		
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
NOVOTWIST/NOVOFINE PEN NEEDLE	OTC	1
RESPIRATORY THERAPY SUPPLIES		
PEAK FLOW METER	OTC	1
AEROCHAMBER	OTC	2
MIGRAINE PRODUCTS		
CALCITONIN GENE-RELATED PEPTIDE (CGRP) RECEPTOR ANTAG		
UBRELVY TAB (QL= 10 tabs/30 days, 6 fills/year)	PA-QL	2
ZAVZPRET NASAL SPRAY (QL= 6 units/fill; 60 units/365 days)	PA-QL	2
MIGRAINE PRODUCTS - MONOCLONAL ANTIBODIES		
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

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	LMSF	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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 4/1/2024

DrugName	Special Code	Tier
MIGRAINE PRODUCTS Cont.		
SEROTONIN AGONISTS		
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
MINERALS & ELECTROLYTES		
CALCIUM		
calcium carbonate susp	OTC	1
calcium carbonate tab	OTC	1
calcium w/vitamin D tab	OTC	1
CALCIUM W/ VITAMIN D TAB	OTC	2
FLUORIDE		
sodium fluoride chew tab (LURIDE equiv)	-	\$0
sodium fluoride soln (LURIDE SOLN. equiv)	-	\$0
SODIUM FLUORIDE TAB	-	\$0
FLUORABON SOLN	-	2
PHOSPHATE		

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 fo first 3 months	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course 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* 4/1/2024

DrugName	Special Code	Tier
MINERALS & ELECTROLYTES Cont.		
phospha 250 neutral tab (K-PHOS NEUTRAL equiv)	-	1
potassium phosphate monobasic tab (K-PHOS equiv)	-	1
K-PHOS TAB	-	2
POTASSIUM		
K-TAB	-	1
POT/CHLORIDE EFFER TAB	-	1
potassium bicarbonate effer tab (K-LYTE equiv)	-	1
potassium chloride effer tab (K-LYTE/CL equiv)	-	1
potassium chloride ER cap (MICRO-K equiv)	-	1
potassium chloride ER tab (K-TAB equiv)	-	1
potassium chloride micro tab (K-DUR equiv)	-	1
POTASSIUM CHLORIDE TAB ER	-	1
potassium chloride powder packet (KLOR-CON equiv)	-	2
potassium chloride soln	-	2
ZINC		
GALZIN CAP	-	2
MISCELLANEOUS THERAPEUTIC CLASSES		
CHELATING AGENTS		
penicillamine tab (DEPEN TITRATAB equiv)	-	1
IMMUNOMODULATORS		
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

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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 4/1/2024

DrugName	Special Code	Tier
MISCELLANEOUS THERAPEUTIC CLASSES Cont.		
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
IMMUNOSUPPRESSIVE AGENTS		
everolimus tab (ZORTRESS equiv)	PA	1
sirolimus soln (RAPAMUNE equiv)	-	1
ENSPRYNG INJ (QL= 1 inj/28 days)	LMSP-PA-QL	2
PIK3CA-RELATED OVERGROWTH SPECTRUM (PROS) AGENTS		
VIJOICE TAB (QL= 1 tab/day)	MSP-PA-QL	2
POTASSIUM REMOVING AGENTS		
SPS SUSP	-	1
LOKELMA PAK	PA	2
PROGERIA TREATMENT AGENTS		
ZOKINVY CAP (QL= 4 caps/day; Only available through CVS Specialty 800-237-2767)	LD-PA-QL	2
MOUTH/THROAT/DENTAL AGENTS		
ANESTHETICS TOPICAL ORAL		
benzocaine gel	OTC	1
benzocaine paste	OTC	1
lidocaine viscous soln (XYLOCAINE HCL (MOUTH-THROAT) equiv)	-	1
ANTI-INFECTIVES - THROAT		

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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 4/1/2024

DrugName	Special Code	Tier
MOUTH/THROAT/DENTAL AGENTS Cont.		
clotrimazole troches (MYCELEX TROCHES equiv)	-	1
nystatin susp	-	1
ANTISEPTICS - MOUTH/THROAT		
chlorhexidine gluconate soln (PERIDEX equiv)	-	1
DENTAL PRODUCTS		
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
STEROIDS - MOUTH/THROAT		
triamcinolone in orabase paste (KENALOG/ORABASE equiv)	-	1
THROAT PRODUCTS - MISC.		
cevimeline cap (EVOXAC equiv)	-	1
pilocarpine tab (SALAGEN equiv)	-	1
MULTIVITAMINS		
B-COMPLEX W/ FOLIC ACID		
DIALYVITE TAB	-	1
dialyvite tab (NEPHRO-VITE equiv)	--OTC	1
DIALYVITE/ZINC TAB	-	1
FOLBEE PLUS CZ TAB	-	1

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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 4/1/2024

DrugName	Special Code	Tier
MULTIVITAMINS Cont.		
renaphro cap (NEPHROCAP equiv)	-	1
MULTIPLE VITAMINS W/ MINERALS		
multivitamin/minerals tab (STROVITE equiv)	-	1
MULTIVITAMINS		
multiple vitamin liquid	OTC	1
PED MULTI VITAMINS W/FL & FE		
pediatric multiple vitamins/fluoride/iron soln	-	1
POLY-VI-FLOR SUSP	-	2
PED MULTIPLE VITAMINS W/ MINERALS		
pediatric multivitamin (VITALETS equiv)	OTC	1
PED MV W/ FLUORIDE		
MULTIVITAMIN/FLOURIDE CHEW 0.25MG	-	1
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
PED MV W/ IRON		
FLINTSTONES COMPLETE CHEW	OTC	1
pediatric multivitamin (VITALETS equiv)	OTC	1
PRENATAL VITAMINS		
PRENATABS RX TAB	-	1

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

	NC =Not Covered	generic =small letters	BRANDS =CAPITAL LETTERS
EXC	Plan Exclusion	INF	Infertility
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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 4/1/2024

DrugName	Special Code	Tier
MULTIVITAMINS Cont.		
PRENATAL 19 TAB	-	1
prenatal vitamin	OTC	1
PRENATAL VITAMIN	OTC	2
PRENATAL VITAMIN (OTC only)	OTC	2
MUSCULOSKELETAL THERAPY AGENTS		
CENTRAL MUSCLE RELAXANTS		
baclofen tab (BACLOFEN equiv)	-	1
carisoprodol tab (SOMA equiv)	-	1
chlorzoxazone tab 500mg	-	1
cyclobenzaprine tab 10mg (FLEXERIL equiv)	-	1
cyclobenzaprine tab 5mg (FLEXERIL equiv)	-	1
methocarbamol tab (ROBAXIN equiv)	-	1
orphenadrine citrate ER tab (NORFLEX equiv)	-	1
tizanidine cap (ZANAFLEX equiv)	-	1
tizanidine tab (ZANAFLEX equiv)	-	1
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
BACLOFEN ORAL SOLN 5 MG/5ML	-	2+penalty

DIRECT MUSCLE RELAXANTS

dantrolene cap (DANTRIUM equiv)	-	1
---------------------------------	---	---

FIBRODYSPLASIA OSSIFICANS PROGRESSIVA (FOP) AGENTS

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

	NC =Not Covered	generic =small letters	BRANDS =CAPITAL LETTERS
EXC	Plan Exclusion	INF	Infertility
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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 4/1/2024

DrugName	Special Code	Tier
MUSCULOSKELETAL THERAPY AGENTS Cont.		
SOHONOS CAP 1.5MG (QL= 56 caps/28 days; Only available through CVS Specialty 800-238-7828)	LD-PA-QL	2
SOHONOS CAP 10MG (QL= 56 caps/28 days; Only available through CVS Specialty 800-238-7828)	LD-PA-QL	2
SOHONOS CAP 1MG (QL= 28 caps/28 days; Only available through CVS Specialty 800-238-7828)	LD-PA-QL	2
SOHONOS CAP 2.5MG (QL= 28 caps/28 days; Only available through CVS Specialty 800-238-7828)	LD-PA-QL	2
SOHONOS CAP 5MG (QL= 28 caps/28 days; Only available through CVS Specialty 800-238-7828)	LD-PA-QL	2
NASAL AGENTS - SYSTEMIC AND TOPICAL		
NASAL AGENTS - MISC.		
saline nasal spray (OCEAN equiv)	OTC	1
ALCOHOL SWABS	OTC	2
NASAL ANTIALLERGY		
azelastine nasal spray 0.1% (ASTELIN equiv) (QL= 1 bottle/month)	QL	1
azelastine nasal spray 0.15% (ASTEPRO equiv) (QL= 1 bottle/month)	QL	1
cromolyn nasal spray (NASALCROM equiv)	OTC	1
NASAL STEROIDS		
flunisolide nasal soln	-	1
fluticasone nasal spray (FLONASE equiv)	-	1
mometasone nasal spray (NASONEX equiv)	-	1
NASACORT OTC NASAL SPRAY (QL= 2 bottles/fill)	OTC-QL	1

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

	NC =Not Covered	generic =small letters	BRANDS =CAPITAL LETTERS
EXC	Plan Exclusion	INF	Infertility
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course 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* 4/1/2024

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

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

	NC =Not Covered	generic =small letters	BRANDS =CAPITAL LETTERS
EXC	Plan Exclusion	INF	Infertility
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course 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* 4/1/2024

DrugName	Special Code	Tier
OPHTHALMIC AGENTS Cont.		
brimonidine/timolol ophth soln (COMBIGAN OPHTH SOLN equiv)	-	1
carteolol ophth soln (OCUPRESS equiv)	-	1
dorzolamide/timolol (pf) ophth soln (COSOPT equiv)	-	1
LEVOBUNOLOL OPHTH SOLN	-	1
levobunolol ophth soln (BETAGAN equiv)	-	1
timolol maleate ophth gel (TIMOPTIC-XE equiv)	-	1
timolol maleate ophth soln (TIMOPTIC equiv)	-	1
timolol maleate ophth soln 0.5% (ISTALOL equiv)	-	1
BETIMOL OPHTH SOLN	-	2
BETOPTIC-S OPHTH SOLN	-	2
DORZOLAMIDE/TIMOLOL OPHTH SOLN	-	2
ISTALOL OPHTH SOLN	-	2
METIPRANOLOL OPHTH SOLN	-	2
COMBIGAN OPHTH SOLN	-	2+penalty
CYCLOPLEGIC MYDRIATICS		
atropine ophth oint	-	1
atropine ophth soln (ISOPTO ATROPINE equiv)	-	1
ATROPINE SUL SOLN 1% OPHTH	-	1
ATROPINE SULFATE OPHTH OINT	-	1
cyclopentolate ophth soln (CYCLOGYL equiv)	-	1
phenylephrine ophth soln (MYDFRIN equiv)	-	1

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

	NC =Not Covered	generic =small letters	BRANDS =CAPITAL LETTERS
EXC	Plan Exclusion	INF	Infertility
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course 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* 4/1/2024

DrugName	Special Code	Tier
OPHTHALMIC AGENTS Cont.		
tropicamide ophth soln (MYDRIACYL equiv)	-	1
CYCLOMYDRIL OPHTH SOLN	-	2
HOMATROPINE OPHTH SOLN	-	2
MIOTICS		
pilocarpine ophth soln (ISOPTO CARPINE equiv)	-	1
ISOPTO CARBACHOL OPHTH SOLN	-	2
OPHTHALMIC ADRENERGIC AGENTS		
apraclonidine ophth soln (IOPIDINE equiv)	-	1
brimonidine ophth soln 0.2%	-	1
brimonidine tartrate ophth soln 0.1% (ALPHAGAN equiv)	-	1
ALPHAGAN P OPHTH SOLN 0.15%	-	2
APRACLONIDINE OPHTH SOLN	-	2
brimonidine ophth soln 0.15% (ALPHAGAN P 0.15% equiv)	-	2
IOPIDINE OPHTH SOLN	-	2
OPHTHALMIC ANTI-INFECTIVES		
bacitracin/neomycin/polymyxin b ophth oint (NEOSPORIN equiv)	-	1
bacitracin/polymyxin b ophth oint (POLYSPORIN equiv)	-	1
ciprofloxacin ophth soln (CILOXAN equiv)	-	1
erythromycin ophth oint	-	1
gatifloxacin ophth soln (ZYMAXID equiv)	-	1
GENTAK OPHTH OINT	-	1
gentamicin ophth soln (GARAMYCIN equiv)	-	1

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

	NC =Not Covered	generic =small letters	BRANDS =CAPITAL LETTERS
EXC	Plan Exclusion	INF	Infertility
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course 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* 4/1/2024

DrugName	Special Code	Tier
OPHTHALMIC AGENTS Cont.		
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
XDEMVIY DROP (QL= 1 bottle/42 days (1 bottle= 10ml); Only available through CV Specialty 800-238-7828 or Walgreens 888-347-3416)	LD-PA-QL	2
ZIRGAN OPHTH GEL	-	2

OPHTHALMIC IMMUNOMODULATORS

cyclosporine ophth emulsion (RESTASIS equiv) (QL= 60 vials/30 days; Restricted to Ophthalmology or Optometry Specialist)	QL-RS	1
--	-------	---

OPHTHALMIC LOCAL ANESTHETICS

proparacaine ophth soln (ALCAINE equiv)	-	1
---	---	---

OPHTHALMIC NERVE GROWTH FACTORS

OXERVATE OPHTH SOLN (QL= 8 kits/affected eye/lifetime; Only available through Accredo 800-803-2523)	LD-PA-QL	2
---	----------	---

OPHTHALMIC STEROIDS

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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 4/1/2024

DrugName	Special Code	Tier
OPHTHALMIC AGENTS Cont.		
bacitracin/polymyxin/neomycin/hydrocortisone ophth oint (CORTISPORIN equiv)	-	1
difluprednate ophth emulsion (DUREZOL equiv)	-	1
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
OPHTHALMICS - MISC.		

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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 4/1/2024

DrugName	Special Code	Tier
OPHTHALMIC AGENTS Cont.		
azelastine ophth soln (OPTIVAR equiv)	-	1
cromolyn ophth soln (CROLOM equiv)	-	1
CROMOLYN SODIUM OPHTH 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
ALOMIDOPHTH 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 OPHTH 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
PROSTAGLANDINS - OPHTHALMIC		
bimatoprost ophth soln (QL= 2.5ml/30 days)	QL	1
latanoprost ophth soln (XALATAN equiv) (QL= 2.5ml/30 days)	QL	1
travoprost ophth soln (TRAVATAN Z equiv) (QL= 5ml/30 days)	QL	1
LUMIGAN OPHTH SOLN (QL= 2.5ml/30 days)	QL	2

OTIC AGENTS

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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 4/1/2024

DrugName	Special Code	Tier
OTIC AGENTS Cont.		
OTIC AGENTS - MISCELLANEOUS		
acetic acid otic soln (VOSOL equiv)	-	1
ACETIC ACID/ALUMINUM ACETATE OTIC SOLN	-	1
carbamide peroxide otic soln (DEBROX equiv)	OTC	1
OTIC ANTI-INFECTIVES		
ofloxacin otic soln (FLOXIN equiv)	-	1
CIPROFLOXACIN OTIC SOLN	-	2
OTIC COMBINATIONS		
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
OTIC STEROIDS		
acetic acid/hydrocortisone otic soln (VOSOL HC equiv)	-	1
fluocinolone otic oil (DERMOTIC equiv)	-	1
OXYTOCICS		
OXYTOCICS		
methylergonovine tab (METHERGINE equiv) (QL= 28 tabs/fill; 1 fill/365 days)	QL	2
PASSIVE IMMUNIZING AGENTS		
IMMUNE SERUMS		
CUVITRU INJ	MSP-PA	2
HIZENTRA INJ	MSP-PA	2
MONOCLONAL ANTIBODIES		

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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 4/1/2024

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

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

	NC =Not Covered	generic =small letters	BRANDS =CAPITAL LETTERS
EXC	Plan Exclusion	INF	Infertility
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course 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* 4/1/2024

DrugName	Special Code	Tier
PHARMACEUTICAL ADJUVANTS		
SEMI SOLID VEHICLES		
POLYETHYLENE GLYCOL 8000 GRANULES	-	2
PROGESTINS		
PROGESTINS		
medroxyprogesterone tab (PROVERA equiv)	-	1
megestrol ES susp (MEGACE ES equiv)	-	1
norethindrone tab (AYGESTIN equiv)	-	1
progesterone cap (PROMETRIUM equiv)	-	1
progesterone oil inj	-	1
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.		
AGENTS FOR CHEMICAL DEPENDENCY		
acamprosate calcium DR tab (CAMPRAL equiv)	-	1
disulfiram tab (ANTABUSE equiv)	-	1
ANTIDEMENTIA AGENTS		
rivastigmine cap (EXELON equiv)	-	1
COMBINATION PSYCHOTHERAPEUTICS		
olanzapine/fluoxetine cap (SYMBYAX equiv)	-	1
PERPHENAZINE/ AMITRIPTYLINE TAB	-	1
FIBROMYALGIA AGENTS		
SAVELLA PAK	-	2
SAVELLA TAB	-	2
MOVEMENT DISORDER DRUG THERAPY		
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.

	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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 4/1/2024

DrugName	Special Code	Tier
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. Cont.		
MULTIPLE SCLEROSIS AGENTS		
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
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.		
PIMOZIDE TAB	-	2
SMOKING DETERRENTS		
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.

	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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 4/1/2024

DrugName	Special Code	Tier
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. Cont.		
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
RESPIRATORY AGENTS - MISC.		
CYSTIC FIBROSIS AGENTS		
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
TETRACYCLINES		

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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 4/1/2024

DrugName	Special Code	Tier
TETRACYCLINES Cont.		
TETRACYCLINES		
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
THYROID AGENTS		
ANTITHYROID AGENTS		
methimazole tab (TAPAZOLE equiv)	-	1
propylthiouracil tab	-	1
THYROID HORMONES		
ARMOUR THYROID TAB, NATURE THROID TAB	-	1
levothyroxine tab (SYNTHROID equiv)	-	1
liothyronine tab (CYTOMEL equiv)	-	1
np thyroid tab (ARMOUR THYROID, NATURE THROID equiv)	-	1
THYROLAR TAB	-	2
TIROSINT-SOL (Prior Authorization Required for members age 9 or older)	PA	2

TOXOIDS

TOXOID COMBINATIONS		
DAPTACEL INJ, INFANRIX INJ	VAC	\$0

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

	NC =Not Covered	generic =small letters	BRANDS =CAPITAL LETTERS
EXC	Plan Exclusion	INF	Infertility
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course 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* 4/1/2024

DrugName	Special Code	Tier
TOXOIDS Cont.		
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
ULCER DRUGS		
ANTISPASMODICS		
chlordiazepoxide/clidinium cap (LIBRAX equiv)	-	1
dicyclomine cap (BENTYL equiv)	-	1
dicyclomine soln (BENTYL equiv)	-	1
dicyclomine tab (BENTYL equiv)	-	1
glycopyrrolate tab (ROBINUL equiv)	-	1
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
H-2 ANTAGONISTS		
cimetidine soln (CIMETIDINE equiv)	-	1

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

	NC =Not Covered	generic =small letters	BRANDS =CAPITAL LETTERS
EXC	Plan Exclusion	INF	Infertility
LD	Limited Distribution	LMSF	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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 4/1/2024

DrugName	Special Code	Tier
ULCER DRUGS Cont.		
cimetidine tab (TAGAMET equiv)	OTC	1
famotidine susp (PEPCID equiv)	-	1
famotidine tab (PEPCID equiv)	OTC	1
nizatidine cap (AXID equiv)	-	2
MISC. ANTI-ULCER		
sucralfate tab (CARAFATE equiv)	-	1
PROTON PUMP INHIBITORS		
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
ULCER DRUGS - PROSTAGLANDINS		
misoprostol tab (CYTOTEC equiv)	-	1
ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS		
H-2 ANTAGONISTS		
CIMETIDINE SOLN	-	1
NIZATIDINE CAP	-	2
MISC. ANTI-ULCER		

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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 4/1/2024

DrugName	Special Code	Tier
ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS Cont.		
sucralfate susp (CARAFATE equiv)	-	1
PROTON PUMP INHIBITORS		
lansoprazole odt (PREVACID SOLUTAB equiv) (QL= 2 tabs/day)	QL	1
omeprazole tab	OTC	1
PREVACID CAP	-	2
NEXIUM 24HR TAB	OTC	2+penalty
URINARY ANTISPASMODICS		
URINARY ANTISPASMODIC - ANTIMUSCARINICS (ANTICHOLINERGIC)		
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
URINARY ANTISPASMODICS - CHOLINERGIC AGONISTS		
bethanechol tab (URECHOLINE equiv)	-	1
VACCINES		
BACTERIAL VACCINES		
ACTHIB INJ, HIBERIX INJ	VAC	\$0

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

	NC =Not Covered	generic =small letters	BRANDS =CAPITAL LETTERS
EXC	Plan Exclusion	INF	Infertility
LD	Limited Distribution	LMSF	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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 4/1/2024

DrugName	Special Code	Tier
VACCINES Cont.		
BXSERO 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
VIRAL VACCINES		
ABRYSVO 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
COVID-19 VACCINE INJ (JANSSEN) (QL= 1 dose/45 days)	QL-VAC	\$0

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

	NC =Not Covered	generic =small letters	BRANDS =CAPITAL LETTERS
EXC	Plan Exclusion	INF	Infertility
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course 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* 4/1/2024

DrugName	Special Code	Tier
VACCINES Cont.		
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
DENGVAXIA 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 QUADRIVALENT 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 an older)	QL-VAC	\$0
GARDASIL 9 INJ	VAC	\$0
IPOL 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
SPIKEVAX INJ (QL= 1 dose/24 days)	QL-VAC	\$0

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

	NC =Not Covered	generic =small letters	BRANDS =CAPITAL LETTERS
EXC	Plan Exclusion	INF	Infertility
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month fo first 3 months	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course 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* 4/1/2024

DrugName	Special Code	Tier
VACCINES Cont.		
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
VAGINAL AND RELATED PRODUCTS		
VAGINAL ANTI-INFECTIVES		
CLINDESSE VAGINAL CREAM (QL= 1 applicator/fill)	QL	2
XACIATO GEL (QL= 1 applicator/fill)	QL	2
VAGINAL CONTRACEPTIVE - PH MODULATORS		
PHEXXI GEL	-	\$0
VAGINAL PRODUCTS		
SPERMICIDES		
CONTRACEPTIVE GEL	OTC	\$0
TODAY SPONGE	OTC	\$0
VAGINAL ANTI-INFECTIVES		
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

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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary

Category/Class

Last Updated* 4/1/2024

DrugName	Special Code	Tier
VAGINAL PRODUCTS Cont.		
terconazole supp (TERAZOL equiv)	-	1
VAGINAL ESTROGENS		
ESTRING (3 copays per Rx)	-	2
PREMARIN VAGINAL CREAM	-	2
VASOPRESSORS		
ANAPHYLAXIS THERAPY AGENTS		
epinephrine pen inj 0.15mg, 0.3mg (EPIPEN (JR) equiv) (QL= 2 inj/fill)	QL	1
VASOPRESSORS		
EPINEPHRINE INJ	-	1
midodrine tab (PROAMATINE equiv)	-	1
VITAMINS		
OIL SOLUBLE VITAMINS		
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
VITAMIN D3 TAB	OTC	1
WATER SOLUBLE VITAMINS		
ascorbic acid chew tab	OTC	1
ascorbic acid tab	OTC	1
niacin cap	OTC	1
niacin CR tab (SLO-NIACIN equiv)	OTC	1
niacin tab	OTC	1

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

	NC =Not Covered	generic =small letters	BRANDS =CAPITAL LETTERS
EXC	Plan Exclusion	INF	Infertility
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course 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* 4/1/2024

DrugName	Special Code	Tier
VITAMINS Cont.		
niacinamide tab	OTC	1
VITAMIN C TAB	OTC	1
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
SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program		

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

Colorado Access Child Health Plan Plus HMO Formulary

Prior Authorization Drug List

Last Updated* 4/1/2024

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

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
ambrisentan tab	1
ANDRODERM PATCH	2
ATORVALIQ SUSP	2
AUSTEDO XR TAB	2
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* 4/1/2024

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

<u>Drug Name</u>	<u>Tier # for Drug Copay (if prior auth is approved)</u>
bexarotene cap	1
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	1
CEREZYME INJ	2
CIBINQO TAB	2
CIMZIA INJ	2
CIMZIA STARTER INJ KIT	2
CINRYZE INJ	2
clobazam susp	2
clobetasol spray	1
CLOBEX SPRAY	2+penalty
CORLANOR SOLN	2
CORLANOR TAB	2
CUVITRU INJ	2
DAYBUE 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* 4/1/2024

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

Drug Name	Tier # for Drug Copay (if prior auth is approved)
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
EPRONTIA SOLN	2
estradiol valerate inj	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* 4/1/2024

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

Drug Name	Tier # for Drug Copay (if prior auth is approved)
everolimus tab	1
everolimus tab (ZORTRESS equiv)	1
everolimus tab 5mg	1
everolimus tab for oral susp	1
EVRYSOI SOLN	2
EZALLOR SPRINKLE 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
GLOPERBA 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* 4/1/2024

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

Drug Name	Tier # for Drug Copay (if prior auth is approved)
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/UVEITIS STARTER PACK	2
HUMIRA PEN INJ 40MG	2
HYCAMTIN CAP	2
HYFTOR GEL	2
HYQVIA 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* 4/1/2024

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

Drug Name	Tier # for Drug Copay (if prior auth is approved)
icatibant inj	1
IMBRUVICA SUSP	2
IMBRUVICA TAB 420MG, 560MG	2
IMCIVREE 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
LIKMEZ SUSP	2
LINZESS CAP	2
LIVMARLI 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* 4/1/2024

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

<u>Drug Name</u>	<u>Tier # for Drug Copay (if prior auth is approved)</u>
LIVTENCITY TAB	2
LOKELMA PAK	2
LYVISPAH GRANULE PACKET	2
MAVYRET PAK	2
MAVYRET TAB	2
MEKINIST SOLN	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
OMNITROPE INJ	2
OPSUMIT 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* 4/1/2024

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

Drug Name	Tier # for Drug Copay (if prior auth is approved)
OPZELURA CREAM	2
ORENCIA CLICK INJ	2
ORENCIA SC INJ 125MG/ML	2
ORENCIA SC INJ 50MG/0.4ML	2
ORENCIA SC INJ 87.5MG/0.7ML	2
ORKAMBI GRANULES PACKET	2
ORKAMBI TAB	2
OTEZLA STARTER PACK	2
OTEZLA TAB	2
OXBRYTA TAB	2
OXBRYTA TAB FOR ORAL SUSP	2
OXERVATE OPHTH SOLN	2
PALFORZIA POWDER PACK	2
PALFORZIA SPRINKLE CAP	2
PROMACTA POWDER	2
PROMACTA TAB 12.5MG, 25MG	2
PROMACTA TAB 50MG	2
PROMACTA TAB 75MG	2
PURIXAN SUSP	2
PYRUKYND TAB	2
PYRUKYND TAPER PACK	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* 4/1/2024

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

<u>Drug Name</u>	<u>Tier # for Drug Copay (if prior auth is approved)</u>
QBRELIS SOLN	2
QELBREE ER CAP	2
REPATHA INJ	2
REPATHA PUSHTRONEX INJ	2
RETEVMO CAP	2
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

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of 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* 4/1/2024

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

Drug Name	Tier # for Drug Copay (if prior auth is approved)
SKYRIZI INJ 75MG/0.83ML	2
SKYTROFA INJ	2
sodium phenylbutyrate powder	1
sodium phenylbutyrate tab	1
SOFOSBUVIR/VELPATASVIR TAB 400-100MG	1
SOGROYA INJ	2
SOHONOS CAP 1.5MG	2
SOHONOS CAP 10MG	2
SOHONOS CAP 1MG	2
SOHONOS CAP 2.5MG	2
SOHONOS CAP 5MG	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

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of 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* 4/1/2024

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

<u>Drug Name</u>	<u>Tier # for Drug Copay (if prior auth is approved)</u>
TAFINLAR CAP	2
TAFINLAR TAB	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
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
tiopronin tab	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* 4/1/2024

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

Drug Name	Tier # for Drug Copay (if prior auth is approved)
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
TYVASO DPI POWDER TITRATION KIT 16-32MCG	2
TYVASO INH SOLN 0.6 MG/ML	2
UBRELVY TAB	2
VALCHLOR GEL	2
VANFLYTA TAB	2
VANFLYTA TAB 26.5MG	2
VARENICLINE TAB	\$0
varenicline tartrate tab	\$0
varenicline tartrate tab starter pack	\$0
VELTASSA POWDER	2
venlafaxine ER cap	1

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

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

Colorado Access Child Health Plan Plus HMO Formulary cont.

Prior Authorization Drug List

Last Updated* 4/1/2024

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

<u>Drug Name</u>	<u>Tier # for Drug Copay (if prior auth is approved)</u>
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
XALKORI CAP	2
XDEMZY DROP	2
XELJANZ SOLN	2
XELJANZ TAB	2
XELJANZ XR TAB	2
XEMBIFY INJ	2
XENLETA TAB	2
XOLAIR SYRINGE	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* 4/1/2024

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

Drug Name	Tier # for Drug Copay (if prior auth is approved)
XOLAIR SYRINGE 150MG/ML	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* 4/1/2024

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
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	cetirizine/pseudoephedrine 12-hour tab

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

cholecalciferol cap CLEMASTINE TAB 1.34MG CONTRACEPTIVE GEL	cholecalciferol tab CLINISTIX TEST STRIP COVID-19 TEST	cimetidine tab clotrimazole cream cromolyn nasal spray	CLARITIN CHEW TAB clotrimazole vaginal cream dextromethorphan/guaifer esin syrup 10-100mg diphenhydramine liquid
dialyvite tab	DIFFERIN OTC GEL 0.1%	diphenhydramine cap	docusate sodium liquid
diphenhydramine tab docusate sodium syrup famotidine tab fexofenadine tab	docusate calcium cap docusate sodium tab FEMALE CONDOMS fexofenadine/pseudoephe drine 12-hour tab folic acid tab 400mcg	docusate sodium cap DOCUSATE SYRUP ferrous sulfate soln fexofenadine/pseudoephe drine 24-hour tab folic acid tab 800mcg	docusate sodium liquid esomeprazole cap fexofenadine susp FLINTSTONES COMPLETE CHEW gental ophth oint
FLONASE SENSIMIST NASAL SPRAY GLUCOSE CHEW TAB guaifenesin syrup 100mg/5ml HUMULIN N INJ hydrocortisone oint ibuprofen tab 200mg	glucose gel GUAIFENESIN/CODEINE SYRUP HUMULIN N PEN INJ ibuprofen cap 200mg iron complex cap 150mg	glycerin supp HUMULIN MIX INJ HUMULIN R INJ ibuprofen chew tab KETO-DIASTIX TEST STRIP LANCETS lice aerosol lice treatment shampoo loratadine tab	guaifenesin ER tab HUMULIN MIX PEN INJ hydrocortisone cream ibuprofen tab 100mg KETOSTIX
ketotifen ophth soln lansoprazole cap 15mg lice treatment kit loratadine ODT	LANCET KIT levonorgestrel tab lice treatment liquid loratadine syrup	LANCETS lice aerosol lice treatment shampoo loratadine tab	lansoprazole cap lice cream rinse loratadine chew tab loratadine/pseudoephedri ne 12-hour tab meclizine tab
loratadine/pseudoephedri ne 24-hour tab miconazole 7 supp	MALE CONDOMS miconazole cream	meclizine chew tab miconazole nitrate aeroso	miconazole nitrate powde

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety 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 vaginal cream MIRALAX POWDER	miconazole vaginal kit multiple vitamin liquid	milk of magnesium naloxone hcl nasal spray	MIRALAX PACKET naproxen sodium tab 220mg NEXIUM 24HR TAB
NARCAN NASAL SPRAY	NASACORT OTC NASAL SPRAY	neomycin/bacitracin/poly myxin oint niacin tab	niacinamide tab NOVOFINE PEN NEEDLE
niacin cap NICOTINE KIT	niacin CR tab nicotine patch	NIZORAL A-D SHAMPOO	NOVOFINE PEN NEEDLE
NOVOTWIST PEN NEEDLE	NOVOTWIST/NOVOFINE PEN NEEDLE	olopatadine ophth soln 0.1%	olopatadine ophth soln 0.2%
omeprazole tab	ONETOUCH METER	ONETOUCH TEST STRIP	ONETOUCH VERIO FLEX METER
ONETOUCH VERIO IQ METER PEAK FLOW METER	ONETOUCH VERIO METER pediatric multivitamin	ONETOUCH VERIO REFLECT METER permethrin lotion	ONETOUCH VERIO TEST STRIP phenazopyridine tab 95mg
phenazopyridine tab 97.5mg PRECISION XTRA KETONE TEST STRIP	phenazopyridine tab 99.5mg PRENATAL VITAMIN	PLAN B TAB PREVACID OTC CAP	polyethylene glycol 3350 powder PRILOSEC OTC DR TAB
pseudoephedrine 12hr tab	pseudoephedrine tab	pseudopseudoephedrine liquid	RIVIVE SPRAY
salicylic acid liquid 17% senna cap	salicylic acid pads 40% senna syrup	saline nasal spray senna tab	selenium sulfide lotion SILPHEN COUGH SYRUP
sodium bicarbonate tab tolnaftate aerosol triamcinolone OTC nasal spray	sodium chloride neb soln tolnaftate cream VITAMIN C TAB	terbinafine cream tolnaftate powder VITAMIN D3 TAB	TODAY SPONGE tolnaftate soln vitamin E liquid

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

Colorado Access Child Health Plan Plus HMO Formulary

Last Updated* 4/1/2024

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 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 OPHTH SOLN
DAYBUE SOLN	deferasirox granules packet	deferasirox tab	deferasirox tab for oral susp
deferiprone tab	dimethyl fumarate DR cap	dimethyl fumarate DR starter pack	DUPIXENT 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.

DUPIXENT PEN INJ	EMPAVELI INJ	ENBREL INJ 25MG	ENBREL INJ 50MG
ENBREL MINI INJ	ENBREL SURECLICK INJ	ENDARI POWDER PACK	ENSPRYNG INJ
EPIDIOLEX SOLN	ETOPOSIDE CAP	everolimus tab	everolimus tab 5mg
everolimus tab for oral susp	EVRYSDI SOLN	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	HUMIRA INJ PEDIATRIC
		CROHNS/UC/HIDRADENI TIS STARTER PACK	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	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/SOFOSBUV IR TAB	lenalidomide cap	LIVMARLI SOLN	LIVTENCITY TAB
LYSODREN TAB	MAVENCLAD THERAPY PAK	MAVYRET PAK	MAVYRET TAB
MAYZENT 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.

MAYZENT TAB STARTER PACK	MEKINIST TAB 0.5MG	MEKINIST TAB 2MG	MESNEX TAB
miglustat cap	MYLERAN TAB	nilutamide tab	NINLARO CAP
NIVESTYM INJ	NUCALA INJ	NYVEPRIA INJ	octreotide inj
OCTREOTIDE INJ 100MCG	OLUMIANT TAB	OMNITROPE INJ	OPSUMIT TAB
ORENCIA CLICK INJ	ORENCIA SC INJ 125MG/ML	ORENCIA SC INJ 50MG/0.4ML	ORENCIA SC INJ 87.5MG/0.7ML
ORKAMBI GRANULES PACKET	ORKAMBI TAB	OTEZLA STARTER PACK	OTEZLA TAB
OXBRYTA TAB	OXBRYTA TAB FOR ORAL SUSP	OXERVATE OPHTH SOLN	PALFORZIA POWDER PACK
PALFORZIA SPRINKLE CAP	PEGASYS INJ	PEG-INTRON INJ	PHEBURANE ORAL PELLETS
PROMACTA POWDER	PROMACTA TAB 12.5MG, 25MG	PROMACTA TAB 50MG	PROMACTA TAB 75MG
PULMOZYME INH SOLN	PYRUKYND TAB	PYRUKYND TAPER PACK	REBETOL SOLN
REBIF INJ	RETEVMO CAP	REVLIMID CAP	REZUROCK TAB
RIBAVIRIN CAP	RIBAVIRIN TAB	RINVOQ ER TAB	ROZLYTREK CAP
RUCONEST INJ	SKYCLARYS CAP	SKYRIZI INJ 150MG/ML	SKYRIZI INJ 180 MG/1.2ML
SKYRIZI INJ 360MG/2.4M	SKYRIZI INJ 75MG/0.83M	SKYTROFA INJ	SOGROYA INJ
SOHONOS CAP 1.5MG	SOHONOS CAP 10MG	SOHONOS CAP 1MG	SOHONOS CAP 2.5MG
SOHONOS CAP 5MG	SOMAVERT INJ	SPRYCEL TAB	STELARA INJ
sunitinib malate cap	SYMDEKO TAB	SYNAGIS INJ	tadalafil tab (PAH)
TAFINLAR CAP	TAKHZYRO INJ	TAKHZYRO INJ 150MG/ML	TALTZ INJ
TASIGNA CAP	TAVNEOS CAP	TAZVERIK TAB	temozolomide cap

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

THALOMID CAP	tiopronin tab	tobramycin neb soln	TRACLEER TAB 32MG
tretinoin cap	TRIKAFTA TAB	TRIKAFTA THERAPY PACK	TYVASO DPI POWDER
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 0.6 MG/ML
VALCHLOR GEL	VANFLYTA TAB	VANFLYTA TAB 26.5MG	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
XDEMVY DROP	XEMBIFY INJ	XOLAIR SYRINGE	XOLAIR SYRINGE 150MG/ML
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* 4/1/2024

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 O 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* 4/1/2024

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* 4/1/2024

Drug Name	Tier # for Drug Copay
cetorelix 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* 4/1/2024

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; 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* 4/1/2024

Quantity Limit (QL)

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

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
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* 4/1/2024

Quantity Limit (QL)

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

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
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
CLINDESSE VAGINAL CREAM	QL= 1 applicator/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* 4/1/2024

Quantity Limit (QL)

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

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
COMIRNATY INJ	QL= 1 dose/17 days
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

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of 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* 4/1/2024****Quantity Limit (QL)**

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

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
cyclosporine ophth emulsion	QL= 60 vials/30 days; Restricted to Ophthalmology or Optometry Specialist
CYSTADROPS SOLN	QL = 4 bottles/28 days; Restricted to Ophthalmology Specialist; Only available through Anovo Specialty Pharmacy 844-288-5007
CYSTARAN OPHTH 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
dexamethylphenidate ER cap	QL= 1 cap/day
diazepam rectal gel	QL= 2 packs/fill
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

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of 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* 4/1/2024****Quantity Limit (QL)**

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

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
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
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
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

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of 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* 4/1/2024

Quantity Limit (QL)

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

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
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
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 DIAGNOSTIC INJ	QL= 2 inj/fill, 1 fill/30 days
GLUCAGON EMR INJ	QL= 2 inj/fill
GLUCAGON INJ KIT	QL= 2 inj/fill
GLUCAGON KIT	QL= 2 inj/fill, 1 fill/30 days
granisetron tab	QL= 14 tabs/fill, 1 fill/30 days
GUAIFENESIN/CODEINE SYRUP	QL= 240ml/fill
guanfacine ER tab	QL= 1 tab/day
GVOKE INJ	QL= 2 inj/fill
GVOKE INJ KIT	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* 4/1/2024

Quantity Limit (QL)

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

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
GVOKE PFS INJ	QL= 2 inj/fill
HADLIMA INJ	QL= 2 inj/28 days
HADLIMA INJ 40MG/0.8ML	QL= 2 inj/28 days
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/UVEITIS STARTER PACK	QL= 1 pack/fill, 1 fill/plan year
HUMIRA PEN INJ 40MG	QL= 2 pens/28 days
hydrocodone/chlorpheniramine/pseudoephedrine liquid	QL= 120ml/fill, 2 fills/month

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of 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* 4/1/2024

Quantity Limit (QL)

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

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
HYFTOR GEL	QL= 10 grams/30 days
IMBRUVICA SUSP	QL= 6ml/day; Only available through Diplomat Pharmacy 877-977-9118
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= 1200ml/30days
LAGEVRIO CAP (EUA)	QL= 40 caps/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* 4/1/2024

Quantity Limit (QL)

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

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
LAGEVRIO CAP 200MG	QL= 40 caps/fill
lansoprazole cap 15mg	QL= 2 caps/day
lansoprazole odt	QL= 2 tabs/day
latanoprost ophth soln	QL= 2.5ml/30 days
LATUDA TAB	QL= 1 tab/day
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
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 OPHTH SOLN	QL= 2.5ml/30 days
LYRICA CAP	QL= 3 caps/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* 4/1/2024

Quantity Limit (QL)

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

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
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
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

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of 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* 4/1/2024

Quantity Limit (QL)

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

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
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
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

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of 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* 4/1/2024

Quantity Limit (QL)

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

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
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= 60 tabs/30 days
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
pregabalin cap 225mg	QL= 2 caps/day
pregabalin cap 300mg	QL= 2 caps/day
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
PROMACTA POWDER	QL= 1 packet/day
PROMACTA TAB 12.5MG, 25MG	QL= 1 tab/day
PROMACTA TAB 50MG	QL= 2 tabs/day
PROMACTA TAB 75MG	QL= 2 tabs/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

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of 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* 4/1/2024

Quantity Limit (QL)

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

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
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
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

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of 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* 4/1/2024****Quantity Limit (QL)**

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

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
SOHONOS CAP 1.5MG	QL= 56 caps/28 days; Only available through CVS Specialty 800-238-7828
SOHONOS CAP 10MG	QL= 56 caps/28 days; Only available through CVS Specialty 800-238-7828
SOHONOS CAP 1MG	QL= 28 caps/28 days; Only available through CVS Specialty 800-238-7828
SOHONOS CAP 2.5MG	QL= 28 caps/28 days; Only available through CVS Specialty 800-238-7828
SOHONOS CAP 5MG	QL= 28 caps/28 days; Only available through CVS Specialty 800-238-7828
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, BREQ DULERA, or FLUTICASONE/SALMETEROL
STELARA INJ	QL= 1 inj/84 days
STRIBILD TAB	QL= 1 tab/day
sumatriptan inj	QL= 6 inj/30 days
SUMATRIPTAN INJ 6MG/0.5ML	QL= 6 inj/30 days
sumatriptan nasal spray	QL= 6 sprays/fill, 2 fills/30 days
sumatriptan tab	QL= 9 tabs/30 days

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of 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* 4/1/2024

Quantity Limit (QL)

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

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
sumatriptan vial inj	QL= 5 inj/fill, 2 fills/30 days
SYMDEKO TAB	QL= 2 tabs/day; Only available through Walgreens 888-347-3416
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
testosterone gel pump 1.62%	QL= 2 bottles/30 days
TEZSPIRE INJ	QL= 1 pen/28 days
tranexamic acid 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.

Colorado Access Child Health Plan Plus HMO Formulary Cont.

Last Updated* 4/1/2024

Quantity Limit (QL)

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

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
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 KI 16-32-48MCG	QL= 252 cartridges/28 days; Only available through Accredo 800-803-2523
TYVASO DPI POWDER TITRATION KI 16-32MCG	QL= 196 cartridges/28 days; Only available through Accredo 800-803-2523
UBRELVY TAB	QL= 10 tabs/30 days, 6 fills/year
VALCHLOR GEL	QL= 4 tubes/30 days; Only available through Optum Pharmacy 877-445-6874
vancomycin cap	QL= 56 caps/fill
VANFLYTA TAB	QL= 1 tab/day; Only available through Onco360 877-662-6633 or Biologics 800-850-4306
VANFLYTA TAB 26.5MG	QL= 2 tabs/day; Only available through Onco360 877-662-6633 or Biologics 800-850-4306

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of 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* 4/1/2024

Quantity Limit (QL)

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

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
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
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
XACIATO GEL	QL= 1 applicator/fill
XALKORI CAP	QL= 2 caps/day
XDEMVIY DROP	QL= 1 bottle/42 days (1 bottle= 10ml); Only available through CVS Specialty 800-238-7828 or Walgreens 888-347-3416
XELJANZ SOLN	QL= 10 ml/day
XELJANZ TAB	QL= 2 tabs/day
XELJANZ XR TAB	QL= 1 tab/day
XIGDUO XR TAB	QL= 2 tabs/day
XIGDUO XR TAB 10-1000MG	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* 4/1/2024

Quantity Limit (QL)

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

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
XIGDUO XR TAB 2.5-1000MG, 5-1000MG	QL= 2 tabs/day
XIGDUO XR TAB 5-500MG, 10-500MG	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
XOLAIR SYRINGE	QL= 2 inj/28 days
XOLAIR SYRINGE 150MG/ML	QL= 2 inj/28 days
XULTOPHY INJ	QL= 15ml/30 days
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
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.