

AHCCCS ACUTE - LONG TERM CARE DRUG LIST

• Generic Drugs Are Preferred Over Brand Name Drugs Unless The Drug Is Specified As BRAND ONLY				Drug List Effective Date: October 1, 2024			
• Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List May Be Available Through Prior Authorization							
Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	PA Status	Step Therapy Requirements	Quantity Limit (QL)	QL Days
<b>ADHD/ANTI-NARCOLEPSY</b>							
<b>Amphetamines</b>							
AMPHETAMINE-DEXTROAMPHETAMINE CAPSULE 24-HOUR	ADDERALL XR		PREFERRED DRUG	PA REQUIRED for Ages < 6 years of age		30	30
AMPHETAMINE-DEXTROAMPHETAMINE TABLETS	ADDERALL	BRAND & GENERIC	PREFERRED DRUG	PA REQUIRED for Ages < 6 years of age		60	30
DEXTROAMPHETAMINE SULFATE TABLETS	VARIOUS		PREFERRED DRUG	PA REQUIRED for Ages < 6 years of age		60	30
LISDEXAMFETAMINE DIMESYLATE CAPSULES	VYVANSE	BRAND ONLY	PREFERRED DRUG	PA REQUIRED for Ages < 6 years of age		30	30
<b>Stimulants</b>							
DEXMETHYLPHENIDATE HCL CAPSULE 24-HOUR	FOCALIN XR		PREFERRED DRUG	PA REQUIRED for Ages < 6 years of age		60	30
DEXMETHYLPHENIDATE HCL TABLETS	VARIOUS		PREFERRED DRUG	PA REQUIRED for Ages < 6 years of age		60	30
METHYLPHENIDATE HCL CHEWABLE TABLETS	METHYLIN		PREFERRED DRUG	PA REQUIRED for Ages < 6 years of age		90	30
METHYLPHENIDATE HCL CAPSULE 24-HOUR	RITALIN LA 10MG	BRAND ONLY	PREFERRED DRUG	PA REQUIRED for Ages < 6 years of age		30	30
METHYLPHENIDATE HCL CAPSULE CONTROLLED RELEASE CD	VARIOUS		PREFERRED DRUG	PA REQUIRED for Ages < 6 years of age		30	30
METHYLPHENIDATE PATCH	DAYTRANA	BRAND ONLY	PREFERRED DRUG	PA REQUIRED for Ages < 6 years of age		30	30
METHYLPHENIDATE HCL SOLUTION	METHYLIN	BRAND ONLY	PREFERRED DRUG	PA REQUIRED for Ages < 6 years of age		300	30
METHYLPHENIDATE HCL TABLETS	VARIOUS		PREFERRED DRUG	PA REQUIRED for Ages < 6 years of age		90	30
METHYLPHENIDATE HCL TABLET EXTENDED RELEASE	RITALIN LA	BRAND ONLY	PREFERRED DRUG	PA REQUIRED for Ages < 6 years of age		60	30
METHYLPHENIDATE HCL TABLET CONTROLLED RELEASE	CONCERTA	BRAND ONLY	PREFERRED DRUG	PA REQUIRED for Ages < 6 years of age		60	30
<b>Miscellaneous Agents</b>							
ATOMOXETINE HCL CAPSULES	VARIOUS		PREFERRED DRUG	PA REQUIRED for Ages < 6 years of age		30	30
<b>Central Alpha-Agonists</b>							
CLONIDINE HCL	Catapres			PA REQUIRED for Ages < 6 years of age			
CLONIDINE HCL TRANSDERMAL PATCH	Catapres Patches			PA REQUIRED for Ages < 6 years of age		4	28
CLONIDINE HCL (ADHD) TABLET 12-HOUR	Clonidine ER		PREFERRED DRUG	PA REQUIRED for Ages < 6 years of age		120	30
GUANFACINE HCL (ADHD) TABLET 24-HOUR	GUANFACINE ER		PREFERRED DRUG	PA REQUIRED for Ages < 6 years of age		30	30
GUANFACINE HCL	Tenex			PA REQUIRED for Ages < 6 years of age			
<b>AMINOGLYCOSIDES</b>							
<b>AMINOGLYCOSIDES</b>							
NEOMYCIN SULFATE TABLETS	NEOMYCIN SULFATE						
<b>INHALED ANTIBIOTICS</b>							
PAROMOMYCIN SULFATE CAPSULE	HUMATIN			Not covered through AHCCCS. Please contact Waylis Pharmaceuticals for the patient assistance program. Toll Free Number: 1-800-689-0255			
TOBRAMYCIN NEBULIZED	BETHKIS	BRAND ONLY	PREFERRED DRUG	PA REQUIRED			
TOBRAMYCIN NEBULIZED	KITABIS	BRAND ONLY	PREFERRED DRUG	PA REQUIRED			
<b>ANALGESICS - ANTI-INFLAMMATORY</b>							
<b>ANTIRHEUMATIC ANTIMETABOLITES</b>							
METHOTREXATE SODIUM TABLETS	RHEUMATREX						
<b>NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (NSAIDS)</b>							
CELECOXIB CAPSULES	CELEBREX			PA REQUIRED		60	30
DICLOFENAC SODIUM TABLET 24-HOUR	VOLTAREN-XR						
DICLOFENAC SODIUM TABLET ENTERIC COATED	VOLTAREN						
ETODOLAC CAPSULES	VARIOUS						
ETODOLAC TABLETS	VARIOUS						
FENOPROFEN CALCIUM CAPSULES	NALFON						
FENOPROFEN CALCIUM TABLETS	FENOPROFEN CALCIUM						
FLURBIPROFEN TABLETS	FLURBIPROFEN						
IBUPROFEN CAPSULES	ADVIL						
IBUPROFEN CHEWABLE TABLETS	CHILDRENS MOTRIN						
IBUPROFEN SUSPENSION	CHILDRENS MOTRIN						

AHCCCS ACUTE - LONG TERM CARE DRUG LIST

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	PA Status	Step Therapy Requirements	Quantity Limit (QL)	QL Days
IBUPROFEN TABLETS	ADVIL						
INDOMETHACIN CAPSULES	VARIOUS						
INDOMETHACIN CAPSULE CONTROLLED RELEASE	INDOMETHACIN CR						
INDOMETHACIN SUPPOSITORY	INDOCIN						
INDOMETHACIN SUSPENSION	INDOCIN						
KETOPROFEN CAPSULES	ORUDIS						
KETOROLAC TROMETHAMINE TABLETS	KETOROLAC TROMETHAMINE					20	30
MELOXICAM SUSPENSION	MOBIC						
MELOXICAM TABLETS	MOBIC						
NABUMETONE TABLETS	NABUMETONE						
NAPROXEN SODIUM TABLETS	ALEVE. ANAPROX						
NAPROXEN SUSPENSION	NAPROSYN						
NAPROXEN TABLETS	NAPROSYN						
OXAPROZIN TABLETS	DAYPRO						
PIROXICAM CAPSULES	FELDENE						
SULINDAC TABLETS	SULINDAC						
<b>PYRIMIDINE SYNTHESIS INHIBITORS</b>							
LEFLUNOMIDE TABLETS	ARAVA						
<b>SELECTIVE COSTIMULATION MODULATORS</b>							
ABATACEPT CLICKJECT OR SYRINGE	ORENCIA		PREFERRED DRUG	PA REQUIRED			
<b>CYTOKINE &amp; CAM ANTAGONIST AGENTS</b>							
ADALIMUMAB-ADBM AUTO-INJECTOR KIT	UNBRANDED ADALIMUMAD-ADBM		Preferred Drug	PA Required			
ADALIMUMAB-ADBM PREFILLED SYRINGE KIT	UNBRANDED ADALIMUMAD-ADBM		Preferred Drug	PA Required			
ADALIMUMAB-BWWD SOLN AUTO-INJ	HADLIMA PUSH		Preferred Drug	PA Required			
ADALIMUMAB-BWWD SOLN PREF SYR	HADLIMA		Preferred Drug	PA Required			
ADALIMUMAB-RYVK AUTO-INJECTOR KIT	SIMLANDI		Preferred Drug	PA Required			
APREMILAST	OTEZLA	BRAND ONLY	PREFERRED DRUG	PA REQUIRED			
ETANERCEPT	ENBREL	BRAND ONLY	PREFERRED DRUG	PA REQUIRED			
TOFACITINIB CITRATE	XELJANZ IMMEDIATE RELEASE ONLY	BRAND ONLY	PREFERRED DRUG	PA REQUIRED			
TOFACITINIB CITRATE TABLET ER 24HR	XELJANZ XR	Brand Only	Preferred Drug	PA Required			
<b>ANALGESICS - NONNARCOTIC</b>							
<b>ANALGESIC COMBINATIONS</b>							
BUTALBITAL-ACETAMINOPHEN-CAFFEINE TABLETS	VARIOUS					120	30
BUTALBITAL-ASPIRIN-CAFFEINE TABLETS	VARIOUS					120	30
<b>ANALGESICS OTHER</b>							
ACETAMINOPHEN CAPSULES	VARIOUS						
ACETAMINOPHEN CHEWABLE TABLETS	VARIOUS						
ACETAMINOPHEN ELIXIR	VARIOUS						
ACETAMINOPHEN LIQUID	VARIOUS						
ACETAMINOPHEN SUPPOSITORY	FEVERALL INFANTS						
ACETAMINOPHEN SUSPENSION	TYLENOL INFANTS						
<b>SALICYLATES</b>							
ASPIRIN CHEWABLE TABLETS	VARIOUS						
ASPIRIN SUPPOSITORY	VARIOUS						
ASPIRIN TABLETS	VARIOUS						
DIFLUNISAL TABLETS	DIFLUNISAL						
SALSALATE TABLETS	DISALCID						
<b>ANALGESICS - OPIOID</b>							
<b>LONG-ACTING OPIOID AGONISTS</b>							
FENTANYL PATCH 72-HOUR 12mcg, 25mcg, 50mcg, 75mcg & 100mcg	DURAGESIC 12mcg, 25mcg, 50mcg, 75mcg & 100mcg		PREFERRED DRUG	PA REQUIRED			

AHCCCS ACUTE - LONG TERM CARE DRUG LIST

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	PA Status	Step Therapy Requirements	Quantity Limit (QL)	QL Days
MORPHINE-NALTREXONE CAPSULE CONTROLLED RELEASE RELEASE	EMBEDA	BRAND ONLY	PREFERRED DRUG	PA REQUIRED			
MORPHINE SULFATE TABLET CONTROLLED RELEASE	VARIOUS		PREFERRED DRUG	PA REQUIRED			
OXYCODONE HCL TABLET 12-HOUR ABUSE DETERRANT	XTAMPZA ER	BRAND ONLY	PREFERRED DRUG	PA REQUIRED			
TRAMADOL HCL TABLETS ER	ULTRAM ER		PREFERRED DRUG	PA REQUIRED			
BUPRENORPHINE PATCH WEEKLY	BUTRANS	BRAND ONLY	PREFERRED DRUG	PA REQUIRED			
<b>SHORT-ACTING OPIOID AGONISTS</b>							
HYDROMORPHONE HCL LIQUID	DILAUDID			PA REQUIRED for > 2 Short Acting Opioid Medications in a 30-day time period.			
HYDROMORPHONE HCL SUPPOSITORY	HYDROMORPHONE HCL			PA REQUIRED for > 2 Short Acting Opioid Medications in a 30-day time period.			
HYDROMORPHONE HCL TABLETS	DILAUDID			PA REQUIRED for > 2 Short Acting Opioid Medications in a 30-day time period.			
MEPERIDINE HCL TABLETS	DEMEROL			PA REQUIRED for > 2 Short Acting Opioid Medications in a 30-day time period.			
MORPHINE SULFATE SOLUTION	MORPHINE SULFATE			PA REQUIRED for > 2 Short Acting Opioid Medications in a 30-day time period.			
MORPHINE SULFATE SUPPOSITORY	MORPHINE SULFATE			PA REQUIRED for > 2 Short Acting Opioid Medications in a 30-day time period.			
MORPHINE SULFATE TABLETS	MORPHINE SULFATE			PA REQUIRED for > 2 Short Acting Opioid Medications in a 30-day time period.			
OXYCODONE HCL CAPSULES	OXYCODONE HCL			PA REQUIRED for > 2 Short Acting Opioid Medications in a 30-day time period.			
OXYCODONE HCL CONCENTRATE	OXYCODONE HCL			PA REQUIRED for > 2 Short Acting Opioid Medications in a 30-day time period.			
OXYCODONE HCL SOLUTION	OXYCODONE HCL			PA REQUIRED for > 2 Short Acting Opioid Medications in a 30-day time period.			
OXYCODONE HCL TABLETS	ROXICODONE			PA REQUIRED for > 2 Short Acting Opioid Medications in a 30-day time period.			
TRAMADOL HCL TABLETS 50MG & 100MG	ULTRAM			PA REQUIRED for > 2 Short Acting Opioid Medications in a 30-day time period.			
<b>OPIOID COMBINATIONS</b>							
ACETAMINOPHEN W/ CODEINE SOLUTION	ACETAMINOPHEN/CODEINE			PA REQUIRED for > 2 Short Acting Opioid Medications in a 30-day time period.			
ACETAMINOPHEN W/ CODEINE TABLETS	ACETAMINOPHEN/CODEINE			PA REQUIRED for > 2 Short Acting Opioid Medications in a 30-day time period.			
BUTALBITAL-ACETAMINOPHEN-CAFFEINE W/ CODEINE CAPSULES	FIORICET/CODEINE			PA REQUIRED for > 2 Short Acting Opioid Medications in a 30-day time period.			
BUTALBITAL-ASPIRIN-CAFFEINE W/COD CAPSULES	ASCOMP/CODEINE			PA REQUIRED for > 2 Short Acting Opioid Medications in a 30-day time period.			
HYDROCODONE-ACETAMINOPHEN CAPSULES	HYDROGESIC			PA REQUIRED for > 2 Short Acting Opioid Medications in a 30-day time period.			
HYDROCODONE-ACETAMINOPHEN SOLUTION	HYCET			PA REQUIRED for > 2 Short Acting Opioid Medications in a 30-day time period.			
HYDROCODONE-ACETAMINOPHEN TABLETS	VERDROCET			PA REQUIRED for > 2 Short Acting Opioid Medications in a 30-day time period.			
HYDROCODONE-IBUPROFEN TABLETS	REPREXAIN			PA REQUIRED for > 2 Short Acting Opioid Medications in a 30-day time period.			
OXYCODONE W/ ACETAMINOPHEN CAPSULES	OXYCODONE/ ACETAMINOPHEN			PA REQUIRED for > 2 Short Acting Opioid Medications in a 30-day time period.			
OXYCODONE W/ ACETAMINOPHEN SOLUTION	ROXICET			PA REQUIRED for > 2 Short Acting Opioid Medications in a 30-day time period.			
OXYCODONE W/ ACETAMINOPHEN TABLETS	ENDOCET			PA REQUIRED for > 2 Short Acting Opioid Medications in a 30-day time period.			

AHCCCS ACUTE - LONG TERM CARE DRUG LIST

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	PA Status	Step Therapy Requirements	Quantity Limit (QL)	QL Days
OXYCODONE-IBUPROFEN TABLETS	OXYCODONE/IBUPROFEN			PA REQUIRED for > 2 Short Acting Opioid Medications in a 30-day time period.			
<b>ANTIDOTES</b>							
<b>OPIOID ANTAGONISTS</b>							
NALOXONE HCL SOLUTION + SYRINGE	NALOXONE HCL + SYRINGE		PREFERRED DRUG				
NALOXONE HCL NASAL SPRAY	NARCAN NASAL SPRAY	Over-the-Counter & Prescription Only	PREFERRED DRUG			2	1
NALOXONE HCL NASAL SPRAY 8mg	KLOXXADO NASAL SPRAY		PREFERRED DRUG			2	1
NALTREXONE HCL TABLETS	NALTREXONE HCL		PREFERRED DRUG				
NALTREXONE SUSPENSION	VIVITROL		PREFERRED DRUG				
<b>OPIOID AGONISTS</b>							
BUPRENORPHINE	VARIOUS			PA REQUIRED unless the member is pregnant or nursing. The prescriber must note the following ICD-10 codes on the prescription: 1. 009.91- Supervision of high risk pregnancy, 1st Trimester. 2. 009.92- Supervision of high risk pregnancy, 2nd Trimester. 3. 009.93- Supervision of high risk pregnancy, 3rd Trimester. 4. 009.91- Supervision of high risk pregnancy- use for Postpartum Nursing Mothers. The first digit of the diagnosis code is the Letter - O and the second is a Zero - 0			
BUPRENORPHINE HCL-NALOXONE HCL DIHYDRATE FILM	SUBOXONE FILM	BRAND ONLY	PREFERRED DRUG				
BUPRENORPHINE HCL-NALOXONE HCL DIHYDRATE ORALLY DISINTEGRATING TABLETS	VARIOUS	GENERIC FORMULATIONS ONLY	PREFERRED DRUG				
BUPRENORPHINE EXTENDED RELEASE INJECTION	SUBLOCADE	BRAND ONLY	PREFERRED DRUG	PA REQUIRED			
BUPRENORPHINE SOLN PREF SYR	BRIXADI		Preferred Drug	PA Required - if approved the prescriber must buy and bill a medical claim for the drug			
METHADONE	VARIOUS			Only available at an Opioid Treatment Program (OTP) provider.			
<b>MISCELLANEOUS AGENTS</b>							
ACAMPROSATE	VARIOUS						
DISULFIRAM	ANTABUSE						
<b>ANDROGENS-ANABOLIC</b>							
<b>ANDROGENS</b>							
DANAZOL CAPSULES	DANAZOL						
TESTOSTERONE CYPIONATE SOLUTION	DEPO-TESTOSTERONE			PA REQUIRED			
TESTOSTERONE ENANTHATE SOLUTION	TESTOSTERONE ENANTHATE			PA REQUIRED			
TESTOSTERONE GEL (1.62% - PUMP BOTTLE)	ANDROGEL/TESTOSTERONE (AG)		PREFERRED DRUG	PA REQUIRED			
TESTOSTERONE PATCH	ANDRODERM			PA REQUIRED			
<b>ANORECTAL AGENTS</b>							
<b>INTRARECTAL STEROIDS</b>							
HYDROCORTISONE (INTRARECTAL) ENEMA	COLOCORT						
HYDROCORTISONE ACETATE (INTRARECTAL) FOAM	CORTIFOAM						
<b>RECTAL STEROIDS</b>							
HYDROCORTISONE (RECTAL) CREAM	PROCTOCORT						
<b>ANTHELMINTICS</b>							
<b>ANTHELMINTICS</b>							

AHCCCS ACUTE - LONG TERM CARE DRUG LIST

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	PA Status	Step Therapy Requirements	Quantity Limit (QL)	QL Days
ALBENDAZOLE TABLETS	ALBENZA			PA REQUIRED			
IVERMECTIN TABLETS	STROMEKTOL			PA REQUIRED			
PRAZIQUANTEL TABLETS	BILTRICIDE						
<b>ANTIANGINAL AGENTS</b>							
<b>ANTIANGINALS-OTHER</b>							
RANOLAZINE TABLET 12-HOUR	RANEXA			PA REQUIRED			
<b>NITRATES</b>							
ISOSORBIDE DINITRATE CAPSULE CONTROLLED RELEASE	DILATRATE SR						
ISOSORBIDE DINITRATE SUBLINGUAL	ISOSORBIDE DINITRATE						
ISOSORBIDE DINITRATE TABLETS	ISORDIL TITRADOSE						
ISOSORBIDE DINITRATE TABLET CONTROLLED RELEASE	ISOSORBIDE DINITRATE ER						
ISOSORBIDE MONONITRATE TABLETS	ISOSORBIDE MONONITRATE						
ISOSORBIDE MONONITRATE TABLET 24-HOUR	IMDUR						
NITROGLYCERIN CAPSULE CONTROLLED RELEASE	NITRO-TIME						
NITROGLYCERIN OINTMENT	NITRO-BID						
NITROGLYCERIN PATCH 24-HOUR	NITRO-DUR						
NITROGLYCERIN SUBLINGUAL	NITROSTAT						
<b>ANTIANGINAL AGENTS</b>							
<b>ANTIANGINALS-OTHER</b>							
BUSPIRONE HCL TAB 5 MG	BUSPIRONE HCL			PA REQUIRED for Ages < 6 years. PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		120	30
BUSPIRONE HCL TAB 7.5 MG	BUSPIRONE HCL			PA REQUIRED for Ages < 6 years. PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		120	30
BUSPIRONE HCL TAB 10 MG	BUSPIRONE HCL			PA REQUIRED for Ages < 6 years. PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		120	30
BUSPIRONE HCL TAB 15 MG	BUSPIRONE HCL			PA REQUIRED for Ages < 6 years. PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		120	30
BUSPIRONE HCL TAB 30 MG	BUSPIRONE HCL			PA REQUIRED for Ages < 6 years. PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		60	30
HYDROXYZINE HCL SYRUP	HYDROXYZINE SYRUP					300	30
HYDROXYZINE HCL TABLETS	HYDROXYZINE TABLETS					240	30
HYDROXYZINE PAMOATE CAPSULES	VISTARIL					120	30
<b>BENZODIAZEPINES</b>							
ALPRAZOLAM CONC 1 MG/ML	ALPRAZOLAM INTENSOL			PA REQUIRED for Ages < 6 years. PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		60	15
ALPRAZOLAM ORALLY DISINTEGRATING TAB 0.25 MG	VARIOUS			PA REQUIRED for Ages < 6 years. PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		120	30
ALPRAZOLAM ORALLY DISINTEGRATING TAB 0.5 MG	VARIOUS			PA REQUIRED for Ages < 6 years. PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		120	30
ALPRAZOLAM ORALLY DISINTEGRATING TAB 1 MG	VARIOUS			PA REQUIRED for Ages < 6 years. PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		120	30
ALPRAZOLAM ORALLY DISINTEGRATING TAB 2 MG	VARIOUS			PA REQUIRED for Ages < 6 years. PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		60	30

AHCCCS ACUTE - LONG TERM CARE DRUG LIST

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	PA Status	Step Therapy Requirements	Quantity Limit (QL)	QL Days
ALPRAZOLAM TAB 0.25 MG	VARIOUS			PA REQUIRED for Ages < 6 years. PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		120	30
ALPRAZOLAM TAB 0.5 MG	VARIOUS			PA REQUIRED for Ages < 6 years. PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		120	30
ALPRAZOLAM TAB 1 MG	VARIOUS			PA REQUIRED for Ages < 6 years. PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		120	30
ALPRAZOLAM TAB 2 MG	VARIOUS			PA REQUIRED for Ages < 6 years. PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		60	30
ALPRAZOLAM TAB SR 24HR 0.5 MG	VARIOUS			PA REQUIRED for Ages < 6 years. PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		30	30
ALPRAZOLAM TAB SR 24HR 1 MG	VARIOUS			PA REQUIRED for Ages < 6 years. PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		30	30
ALPRAZOLAM TAB SR 24HR 2 MG	VARIOUS			PA REQUIRED for Ages < 6 years. PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		30	30
ALPRAZOLAM TAB SR 24HR 3 MG	VARIOUS			PA REQUIRED for Ages < 6 years. PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		30	30
CHLORDIAZEPOXIDE HCL CAP 10 MG	VARIOUS			PA REQUIRED for Ages < 6 years. PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		60	30
CHLORDIAZEPOXIDE HCL CAP 25 MG	VARIOUS			PA REQUIRED for Ages < 6 years. PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		60	30
CHLORDIAZEPOXIDE HCL CAP 5 MG	VARIOUS			PA REQUIRED for Ages < 6 years. PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		60	30
CLONAZEPAM 0.5 MG	VARIOUS			PA REQUIRED for Ages < 6 years. PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		120	30
CLONAZEPAM 1.0 MG	VARIOUS			PA REQUIRED for Ages < 6 years. PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		120	30
CLONAZEPAM 2 MG	VARIOUS			PA REQUIRED for Ages < 6 years. PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		60	30
CLONAZEPAM ODT 0.125MG	VARIOUS			PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		120	30
CLONAZEPAM ODT 0.25MG	VARIOUS			PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		120	30
CLONAZEPAM ODT 0.5 MG	VARIOUS			PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		120	30
CLONAZEPAM ODT 1MG	VARIOUS			PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		120	30
CLONAZEPAM ODT 2MG	VARIOUS			PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		60	30

AHCCCS ACUTE - LONG TERM CARE DRUG LIST

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	PA Status	Step Therapy Requirements	Quantity Limit (QL)	QL Days
CLORAZEPATE DIPOTASSIUM TAB 15 MG	VARIOUS			PA REQUIRED for Ages < 6 years. PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		60	30
CLORAZEPATE DIPOTASSIUM TAB 3.75 MG	VARIOUS			PA REQUIRED for Ages < 6 years. PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		120	30
CLORAZEPATE DIPOTASSIUM TAB 7.5 MG	VARIOUS			PA REQUIRED for Ages < 6 years. PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		120	30
DIAZEPAM CONC 5 MG/ML	DIAZEPAM INTENSOL			PA REQUIRED for Ages < 6 years. PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		60	30
DIAZEPAM SOLN 1 MG/ML	VARIOUS			PA REQUIRED for Ages < 6 years. PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		300	30
DIAZEPAM TAB 10 MG	VARIOUS			PA REQUIRED for Ages < 6 years. PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		120	30
DIAZEPAM TAB 2 MG	VARIOUS			PA REQUIRED for Ages < 6 years. PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		120	30
DIAZEPAM TAB 5 MG	VARIOUS			PA REQUIRED for Ages < 6 years. PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		120	30
LORAZEPAM CONC 2 MG/ML	LORAZEPAM INTENSOL			PA REQUIRED for Ages < 6 years. PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		60	30
LORAZEPAM TAB 0.5 MG	VARIOUS			PA REQUIRED for Ages < 6 years. PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		120	30
LORAZEPAM TAB 1 MG	VARIOUS			PA REQUIRED for Ages < 6 years. PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		120	30
LORAZEPAM TAB 2 MG	VARIOUS			PA REQUIRED for Ages < 6 years. PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		60	30
OXAZEPAM CAP 10 MG	VARIOUS			PA REQUIRED for Ages < 6 years. PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		60	30
OXAZEPAM CAP 15 MG	VARIOUS			PA REQUIRED for Ages < 6 years. PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		60	30
OXAZEPAM CAP 30 MG	VARIOUS			PA REQUIRED for Ages < 6 years. PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		60	30
<b>ANTIARRHYTHMICS</b>							
<b>ANTIARRHYTHMICS TYPE I-A</b>							
DISOPYRAMIDE PHOSPHATE CAPSULES	NORPACE						
DISOPYRAMIDE PHOSPHATE CAPSULE 12-HOUR	NORPACE CR						
QUINIDINE GLUCONATE TABLET CONTROLLED RELEASE	QUINIDINE GLUCONATE CR						
QUINIDINE SULFATE TABLETS	QUINIDINE SULFATE						
QUINIDINE SULFATE TABLET CONTROLLED RELEASE	QUINIDINE SULFATE ER						
<b>ANTIARRHYTHMICS TYPE I-B</b>							
MEXILETINE HCL CAPSULES	MEXILETINE HCL						

AHCCCS ACUTE - LONG TERM CARE DRUG LIST

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	PA Status	Step Therapy Requirements	Quantity Limit (QL)	QL Days
<b>ANTIARRHYTHMICS TYPE I-C</b>							
FLECAINIDE ACETATE TABLETS	TAMBOCOR						
PROPafenone HCL CAPSULE 12-HOUR	RYTHMOL SR						
PROPafenone HCL TABLETS	RYTHMOL						
<b>ANTIARRHYTHMICS TYPE III</b>							
AMIODARONE HCL TABLETS 100MG & 200MG	PACERONE						
DOFETILIDE CAPSULES	TIKOSYN			PA REQUIRED			
DRONEDARONE HCL TABLETS	MULTAQ			PA REQUIRED			
<b>ANTIASTHMATIC AND BRONCHODILATOR AGENTS</b>							
<b>ANTI-INFLAMMATORY AGENTS</b>							
CROMOLYN SODIUM NEBULIZER	CROMOLYN SODIUM						
<b>BRONCHODILATORS - ANTICHOLINERGICS</b>							
ACLIDINIUM BROMIDE	TUDORZA PRESSAIR		PREFERRED DRUG				
IPRATROPIUM BROMIDE HFA AEROSOL	ATROVENT HFA		PREFERRED DRUG				
IPRATROPIUM BROMIDE SOLUTION	IPRATROPIUM BROMIDE		PREFERRED DRUG				
TIOTROPIUM BROMIDE MONOHYDRATE AEROSOL SOLUTION	SPIRIVA RESPIMAT		PREFERRED DRUG				
TIOTROPIUM BROMIDE MONOHYDRATE CAPSULES	SPIRIVA HANDHALER	BRAND ONLY	PREFERRED DRUG				
<b>LEUKOTRIENE MODULATORS</b>							
MONTELUKAST SODIUM CHEWABLE TABLETS	SINGULAIR		PREFERRED DRUG			30	30
MONTELUKAST SODIUM GRANULES	SINGULAIR			PA IS NOT REQUIRED for < 4 Years of Age		30	30
MONTELUKAST SODIUM TABLETS	SINGULAIR		PREFERRED DRUG			30	30
<b>STEROID INHALANTS</b>							
BECLOMETHASONE DIPROPIONATE	QVAR REDHALER	BRAND ONLY	PREFERRED DRUG				
BUDESONIDE (INHALATION) SUSPENSION 0.25MG, 0.50MG & 1.0MG	PULMICORT	VARIOUS	PREFERRED DRUG				
BUDESONIDE INHALATION POWDER	PULMICORT FLEXHALER	BRAND ONLY	PREFERRED DRUG				
FLUTICASONE FUROATE	ARNUITY ELLIPTA	BRAND ONLY	PREFERRED DRUG				
FLUTICASONE PROPIONATE HFA AERO	VARIOUS	AUTHORIZED GENERIC ONLY	PREFERRED DRUG				
FLUTICASONE PROPIONATE ORAL INHALATION	VARIOUS	AUTHORIZED GENERIC ONLY	PREFERRED DRUG				
MOMETASONE FUROATE HFA	ASMANEX HFA	BRAND ONLY	PREFERRED DRUG				
MOMETASONE FUROATE (INHALATION) AEPB	ASMANEX TWISTHALER	BRAND ONLY	PREFERRED DRUG				
<b>SYMPATHOMIMETICS</b>							
ALBUTEROL SULFATE INHALER	ALBUTEROL HFA (PROVENTIL) (AG) (INHALATION)	NDC 00254100752 NDC 00781729685	Preferred Albuterol NDCs				
ALBUTEROL SULFATE INHALER	ALBUTEROL HFA (PROVENTIL) (INHALATION)	NDC 00054074287 NDC 69097014260 NDC 72572001401 NDC 76282067942	Preferred Albuterol NDCs				
ALBUTEROL SULFATE INHALER	ALBUTEROL HFA (PROAIR) (AG) (INHALATION)	NDC 00093317431	Preferred Albuterol NDCs				
ALBUTEROL SULFATE INHALER	ALBUTEROL HFA (PROAIR) (INHALATION)	NDC 45802008801 NDC 68180096301	Preferred Albuterol NDCs				
ALBUTEROL SULFATE INHALER	ALBUTEROL HFA (VENTOLIN) (AG) (INHALATION)	NDC 66993001968	Preferred Albuterol NDCs				
ALBUTEROL SULFATE NEBULIZED	ALBUTEROL SULFATE		PREFERRED DRUG				
ALBUTEROL SULFATE SYRUP	ALBUTEROL SULFATE		PREFERRED DRUG				
BUDESONIDE-FORMOTEROL FUMARATE DIHYDRATE AEROSOL	SYMBICORT	BRAND ONLY	PREFERRED DRUG				
FLUTICASONE-SALMETEROL ORAL INHALATION	ADVAIR DISKUS/AIRDUO	BRAND ONLY	PREFERRED DRUG				
FLUTICASONE-SALMETEROL AEROSOL	ADVAIR HFA	BRAND ONLY	PREFERRED DRUG				
MOMETASONE FUROATE-FORMOTEROL FUMARATE DIHYDRATE AEROSOL	DULERA	BRAND ONLY	PREFERRED DRUG				
IPRATROPIUM-ALBUTEROL AEROSOL	COMBIVENT RESPIMAT		PREFERRED DRUG				



AHCCCS ACUTE - LONG TERM CARE DRUG LIST

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	PA Status	Step Therapy Requirements	Quantity Limit (QL)	QL Days
IPRATROPIUM-ALBUTEROL SOLUTION	DUONEB		PREFERRED DRUG				
SALMETEROL XINAFOATE AEROSOL POWDER BREATH ACTIVATED	SEREVENT DISKUS		PREFERRED DRUG	PA REQUIRED			
SALMETEROL XINAFOATE AEROSOL POWDER BREATH ACTIVATED	SEREVENT DISKUS		PREFERRED DRUG	PA REQUIRED			
TIOTROPIUM BROMIDE-OLODATEROL HCL AEROSOL SOLUTION	STIOLTO RESPIMAT		PREFERRED DRUG	PA REQUIRED		1	30
UMECLIDINIUM-VILANTEROL AEROSOL POWDER	ANORO ELLIPTA		PREFERRED DRUG	PA REQUIRED		1	30
<b>ANTICOAGULANTS</b>							
<b>COUMARIN ANTICOAGULANTS</b>							
WARFARIN SODIUM TABLETS	VARIOUS		PREFERRED DRUG				
<b>DIRECT FACTOR XA INHIBITORS</b>							
APIXABAN TABLETS	ELIQUIS	BRAND ONLY	PREFERRED DRUG			60	30
APIXABAN TABLETS STARTER PACK	ELIQUIS STARTER PACK	BRAND ONLY	PREFERRED DRUG			74	365
RIVAROXABAN TABLETS	XARELTO	BRAND ONLY	PREFERRED DRUG			60	30
RIVAROXABAN TABLETS	XARELTO DOSE PACK	BRAND ONLY	PREFERRED DRUG			51	30
<b>HEPARINS AND HEPARINOID-LIKE AGENTS</b>							
ENOXAPARIN SODIUM INJ 100 MG/ML	VARIOUS VIAL OR SYRINGE		PREFERRED DRUG			60	30
ENOXAPARIN SODIUM INJ 120 MG/0.8ML	VARIOUS VIAL OR SYRINGE		PREFERRED DRUG			60	30
ENOXAPARIN SODIUM INJ 150 MG/ML	VARIOUS VIAL OR SYRINGE		PREFERRED DRUG			60	30
ENOXAPARIN SODIUM INJ 30 MG/0.3ML	VARIOUS VIAL OR SYRINGE		PREFERRED DRUG			60	30
ENOXAPARIN SODIUM INJ 300 MG/3ML	VARIOUS VIAL OR SYRINGE		PREFERRED DRUG			60	30
ENOXAPARIN SODIUM INJ 40 MG/0.4ML	VARIOUS VIAL OR SYRINGE		PREFERRED DRUG			60	30
ENOXAPARIN SODIUM INJ 60 MG/0.6ML	VARIOUS VIAL OR SYRINGE		PREFERRED DRUG			60	30
ENOXAPARIN SODIUM INJ 80 MG/0.8ML	VARIOUS VIAL OR SYRINGE		PREFERRED DRUG			60	30
HEPARIN (PORCINE) IN SODIUM CHLORIDE SOLUTION	HEPARIN SODIUM/NACL 0.9%						
HEPARIN SOD (PORCINE) IN D5W SOLUTION	HEPARIN SODIUM/D5W						
HEPARIN SODIUM (PORCINE) LOCK FLUSH & NACL LOCK FLUSH KIT	HEPARIN SODIUM LOCK FLUSH						
HEPARIN SODIUM (PORCINE) LOCK FLUSH SOLUTION	HEPARIN LOCK FLUSH						
<b>THROMBIN INHIBITORS</b>							
DABIGATRAN ETEXILATE MESYLATE CAPSULES	PRADAXA	BRAND ONLY	PREFERRED DRUG			60	30
<b>ANTICONVULSANTS</b>							
<b>AMPA GLUTAMATE RECEPTOR ANTAGONISTS**</b>							
PERAMPANEL TABLET	FYCOMPA			PA Required			
PERAMPANEL SUSPENSION	FYCOMPA			PA Required			
<b>ANTICONVULSANTS - BENZODIAZEPINES</b>							
CLOBAZAM SUSPENSION	ONFI			PA REQUIRED			
CLOBAZAM TABLETS	ONFI			PA REQUIRED			
CLONAZEPAM TAB 0.5 MG	KLONOPIN			PA REQUIRED for Ages < 6 years. PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		120	30
CLONAZEPAM TAB 1 MG	KLONOPIN			PA REQUIRED for Ages < 6 years. PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		120	30
CLONAZEPAM TAB 2 MG	KLONOPIN			PA REQUIRED for Ages < 6 years. PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		60	30
CLONAZEPAM ORALLY DISINTEGRATING TAB 0.125 MG	CLONAZEPAM ODT			PA REQUIRED for Ages < 6 years. PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		120	30
CLONAZEPAM ORALLY DISINTEGRATING TAB 0.25 MG	CLONAZEPAM ODT			PA REQUIRED for Ages < 6 years. PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		120	30

AHCCCS ACUTE - LONG TERM CARE DRUG LIST

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	PA Status	Step Therapy Requirements	Quantity Limit (QL)	QL Days
CLONAZEPAM ORALLY DISINTEGRATING TAB 0.5 MG	CLONAZEPAM ODT			PA REQUIRED for Ages < 6 years. PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		120	30
CLONAZEPAM ORALLY DISINTEGRATING TAB 1 MG	CLONAZEPAM ODT			PA REQUIRED for Ages < 6 years. PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		120	30
CLONAZEPAM ORALLY DISINTEGRATING TAB 2 MG	CLONAZEPAM ODT			PA REQUIRED for Ages < 6 years. PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		60	30
DIAZEPAM (ANTICONVULSANT) GEL	DIASAT PEDIATRIC					2	30
DIAZEPAM (ANTICONVULSANT) LIQUID	VALTOCO					2	30
DIAZEPAM (ANTICONVULSANT) LIQD THER PACK	VALTOCO					2	30
MIDAZOLAM (ANTICONVULSANT) SOLUTION	NAYZILAM					2	30
<b>ANTICONVULSANTS - MISC.</b>							
CANNABIDIOL SOLUTION	EPIDIOLEX			PA Required			
CARBAMAZEPINE TABLET CHEWABLE	CARBAMAZEPINE						
CARBAMAZEPINE CAPSULE ER 12 HR	CARBATROL						
CARBAMAZEPINE SUSPENSION	TEGRETOL						
CARBAMAZEPINE TABLET	EPITOL						
CARBAMAZEPINE TABLET ER 12HR	TEGRETOL-XR						
GABAPENTIN CAPSULE	NEURONTIN						
GABAPENTIN SOLUTION	NEURONTIN						
GABAPENTIN TABLET	NEURONTIN						
LACOSAMIDE SOLUTION	VIMPAT			PA Required			
LACOSAMIDE TABLET	VIMPAT			PA Required			
LAMOTRIGINE TABLET CHEWABLE	LAMICTAL CHEWABLE DISPERSIBLE						
LAMOTRIGINE TABLET	SUBVENITE						
LAMOTRIGINE TABLET ER 24HR	LAMICTAL XR						
LAMOTRIGINE TABLET DISINTEGRATING	LAMICTAL ODT						
LEVETIRACETAM SOLUTION	KEPPRA						
LEVETIRACETAM TABLET	ROWEEPRA						
LEVETIRACETAM TABLET ER 24HR	KEPPRA XR						
OXCARBAZEPINE SUSPENSION	TRILEPTAL	BRAND ONLY					
OXCARBAZEPINE TABLET	TRILEPTAL						
PREGABALIN CAPSULE (25MG, 50MG, 75MG, 100MG, 150MG, 200MG)	LYRICA					90.00	30.00
PREGABALIN CAPSULE (225MG, 300MG)	LYRICA					60.00	30.00
PREGABALIN SOLUTION	LYRICA					900	30
PRIMIDONE TABLET (20MG, 250MG)	MYSOLINE						
RUFINAMIDE SUSPENSION	BANZEL	BRAND ONLY		PA Required			
RUFINAMIDE TABLET	BANZEL			PA Required			
TOPIRAMATE CAPSULE ER 24 HR	TROKENDI XR	BRAND ONLY		PA Required			
TOPIRAMATE CAPSULE SPRINKLE	TOPAMAX SPRINKLE						
TOPIRAMATE CP24 SPRINKLE	QUDEXY XR			PA Required			
TOPIRAMATE TABLET	TOPAMAX						
ZONISAMIDE CAPSULE	ZONEGRAN						
<b>CARBAMATES**</b>							
CENOAMATE TABLET	XCOPRI			PA Required			
CENOAMATE TAB THER PACK	XCOPRI			PA Required			
FELBAMATE SUSPENSION	FELBATOL						
FELBAMATE TABLET	FELBATOL						
<b>GABA MODULATORS**</b>							
TIAGABINE HCL TABLET	GABITRIL			PA Required			

AHCCCS ACUTE - LONG TERM CARE DRUG LIST

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	PA Status	Step Therapy Requirements	Quantity Limit (QL)	QL Days
<b>HYDANTOINS**</b>							
PHENYTOIN TABLET CHEWABLE	DILANTIN CHEWABLES						
PHENYTOIN SODIUM EXTENDED CAPSULE	DILANTIN/PHENYTEK ER						
PHENYTOIN SUSPENSION	DILANTIN-125						
<b>SUCCINIMIDES**</b>							
ETHOSUXIMIDE CAPSULE	ZARONTIN						
ETHOSUXIMIDE SOLUTION	ZARONTIN						
METHSUXIMIDE CAPSULE	CELONTIN	BRAND ONLY					
<b>VALPROIC ACID**</b>							
DIVALPROEX SODIUM CAP DR SPRINKLE	DEPAKOTE SPRINKLES						
DIVALPROEX SODIUM TABLET ER 24HR	DEPAKOTE ER						
DIVALPROEX SODIUM TABLET ENTERIC COATED	DEPAKOTE						
VALPROATE SODIUM SOLUTION	VALPROATE SODIUM						
VALPROIC ACID CAPSULE	VALPROIC ACID						
<b>ANTIDEPRESSANTS</b>							
<b>ALPHA-2 RECEPTOR ANTAGONISTS (TETRACYCLICS)</b>							
MIRTAZAPINE TABLETS	MIRTAZAPINE			PA REQUIRED for Ages < 6 years of age		30	30
MIRTAZAPINE ORALLY DISINTEGRATING TABLETS	REMERON SOLTAB			PA REQUIRED for Ages < 6 years of age		30	30
<b>GABA RECEPTOR MODULATOR - NEUROACTIVE STEROID**</b>							
ZURANOLONE CAPSULE	ZURZUVAE			PA Required			
<b>N-METHYL-D-ASPARTATE (NMDA) RECEPTOR ANTAGONIST</b>							
ESKETAMINE HYDROCHLORIDE	SPRAVATO			PA REQUIRED			
<b>Norepinephrine and Dopamine Reuptake Inhibitors (NDRIs)</b>							
BUPROPION HCL TABLETS	WELLBUTRIN			PA REQUIRED for Ages < 6 years of age		120	30
BUPROPION HCL TABLET 12-HOUR	BUDEPRION SR			PA REQUIRED for Ages < 6 years of age		60	30
BUPROPION HCL TABLET 24-HOUR (150MG & 300MG)	WELLBUTRIN XL			PA REQUIRED for Ages < 6 years of age		30	30
<b>SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIS)</b>							
CITALOPRAM HYDROBROMIDE SOLUTION	CELEXA			PA REQUIRED for Ages < 6 years of age and greater than 12 years of age		600	30
CITALOPRAM HYDROBROMIDE TABLETS	CELEXA			PA REQUIRED for Ages < 6 years of age		10mg: 60 20mg: 30 40mg: 30	30 30 30
ESCITALOPRAM OXALATE TABLETS	LEXAPRO			PA REQUIRED for Ages < 6 years of age		5mg: 60 10mg: 30 20mg: 30	30 30 30
FLUOXETINE HCL CAPSULES ONLY	PROZAC			PA REQUIRED for Ages < 6 years of age		10mg: 60 20mg: 120 40mg: 60	30 30 30
FLUOXETINE HCL SOLUTION	PROZAC			PA REQUIRED for Ages < 6 years of age and greater than 12 years of age		600	30
FLUOXETINE HCL TABLETS - WEEKLY	PROZAC WEEKLY			PA REQUIRED			
FLUVOXAMINE MALEATE TABLETS	LUVOX			PA REQUIRED for Ages < 6 years of age		25mg: 60 50mg: 180 100mg: 90	30 30 30
PAROXETINE HCL TABLETS	PAXIL			PA REQUIRED for Ages < 6 years of age		10mg: 30 20mg: 30 30mg: 30 40mg: 45	30 30 30 30
SERTRALINE HCL CONCENTRATE	ZOLOFT			PA REQUIRED for Ages < 6 years of age and greater than 12 years of age		300	30
SERTRALINE HCL TABLETS	ZOLOFT			PA REQUIRED for Ages < 6 years of age		25mg: 90 50mg: 120 100mg: 60	30 30 30

AHCCCS ACUTE - LONG TERM CARE DRUG LIST

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	PA Status	Step Therapy Requirements	Quantity Limit (QL)	QL Days
<b>SEROTONIN MODULATORS</b>							
TRAZODONE HCL TABLETS	TRAZODONE HCL			PA REQUIRED for Ages < 6 years of age		50mg:90 100mg:120 150mg: 60 300mg 30	30 30 30 30
<b>SEROTONIN-NOREPINEPHRINE REUPTAKE INHIBITORS (SNRI)</b>							
DULOXETINE HCL CAPSULE DELAYED RELEASE 20MG, 30MG & 60MG	CYMBALTA 20MG, 30MG & 60MG			PA REQUIRED for Ages < 6 years of age		20mg: 120 30mg: 120 60mg: 60	30 30 30
VENLAFAXINE HCL CAPSULE CONTROLLED RELEASE	EFFEXOR XR			PA REQUIRED for Ages < 6 years of age		37.5mg: 90 75mg: 90 150mg: 30	30 30 30
VENLAFAXINE HCL TABLETS - IMMEDIATE RELEASE ONLY	VENLAFAXINE HCL			PA REQUIRED for Ages < 6 years of age		25mg: 120 37.5mg: 90 50mg: 90 75mg: 150 100mg: 90	30 30 30 30 30
<b>TRICYCLIC AGENTS</b>							
AMITRIPTYLINE HCL TABLETS	AMITRIPTYLINE HCL			PA REQUIRED for Ages < 6 years of age			
AMOXAPINE TABLETS	VARIOUS			PA REQUIRED for Ages < 6 years of age			
CLOMIPRAMINE HCL CAPSULES	ANAFRANIL			PA REQUIRED for Ages < 6 years of age			
DESIPRAMINE HCL TABLETS	NORPRAMIN			PA REQUIRED for Ages < 6 years of age			
DOXEPIN HCL CAPSULES	DOXEPIN HCL			PA REQUIRED for Ages < 6 years of age		90	30
DOXEPIN HCL CONCENTRATE	DOXEPIN HCL			PA REQUIRED for Ages < 6 years of age		180	30
IMIPRAMINE PAMOATE CAPSULES	TORFRANIL-PM			PA REQUIRED for Ages < 6 years of age		30	30
IMIPRAMINE HCL TABLETS	TOFRANIL			PA REQUIRED for Ages < 6 years of age			
MAPROTILINE HCL	VARIOUS			PA REQUIRED for Ages < 6 years of age			
NORTRIPTYLINE HCL CAPSULES	PAMELOR			PA REQUIRED for Ages < 6 years of age			
NORTRIPTYLINE HCL SOLUTION	NORTRIPTYLINE HCL			PA REQUIRED for Ages < 6 years of age			
PROTRIPTYLINE HCL TABLETS	VIVACTIL			PA REQUIRED for Ages < 6 years of age			
TRIMIPRAMINE MALEATE	SURMONTIL			PA REQUIRED for Ages < 6 years of age			
<b>ANTIDIABETICS</b>							
<b>ALPHA-GLUCOSIDASE INHIBITORS</b>							
ACARBOSE TABLETS	PRECOSE						
<b>ANTIDIABETIC - AMLYN ANALOGS</b>							
PRAMLINTIDE ACETATE SOLUTION PEN INJECTION	SYMLINPEN 60		PREFERRED DRUG	PA REQUIRED			
<b>ANTIDIABETIC COMBINATIONS</b>							
ALOGLIPTIN-METFORMIN HCL TABLETS	KAZANO		PREFERRED DRUG		STEP THROUGH METFORMIN		
ALOGLIPTIN-PIOGLITAZONE TABLETS	OSENI		PREFERRED DRUG		STEP THROUGH METFORMIN		
CANAGLIFLOZIN-METFORMIN HCL	INVOKAMET	BRAND ONLY	PREFERRED DRUG		STEP THROUGH METFORMIN		
DAPAGLIFLOZIN - METFORMIN	XIDUO XR	BRAND ONLY	PREFERRED DRUG		STEP THROUGH METFORMIN		
EMPAGLIFLOZIN-LINAGLIPTIN-METFORMIN	TRIJARDY XR	BRAND ONLY	PREFERRED DRUG		STEP THROUGH METFORMIN		
EMPAGLIFLOZIN-METFORMIN HCL	SYNJARDY	BRAND ONLY	PREFERRED DRUG		STEP THROUGH METFORMIN		
GLYBURIDE-METFORMIN HCL TABLETS	GLYBURIDE/METFORMIN HCL						
LINAGLIPTIN-METFORMIN HCL TABLETS	JENTADUETO	BRAND ONLY	PREFERRED DRUG		STEP THROUGH METFORMIN		
LINAGLIPTIN-METFORMIN HCL TABLET 24-HOUR	JENTADUETO XR	BRAND ONLY	PREFERRED DRUG		STEP THROUGH METFORMIN		
PIOGLITAZONE HCL-METFORMIN HCL TABLETS	ACTOPLUS MET						
PIOGLITAZONE HCL-METFORMIN HCL TABLET 24-HOUR	ACTOPLUS MET XR						
SITAGLIPTIN-METFORMIN HCL TABLETS	JANUMET	BRAND ONLY	PREFERRED DRUG		STEP THROUGH METFORMIN		
SITAGLIPTIN-METFORMIN HCL TABLET 24-HOUR	JANUMET XR	BRAND ONLY	PREFERRED DRUG		STEP THROUGH METFORMIN		
<b>BIGUANIDES</b>							
METFORMIN HCL TABLETS	GLUCOPHAGE						

AHCCCS ACUTE - LONG TERM CARE DRUG LIST

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	PA Status	Step Therapy Requirements	Quantity Limit (QL)	QL Days
METFORMIN HCL TABLET 24-HOUR (GENERIC OF GLUCOPHAGE XR ONLY-500MG & 750MG)	Various			PA REQUIRED for Osmotic and Modified Release Products			
<b>DIABETIC OTHER</b>							
DASIGLUCAGON HCL SOLN AUTO-INJ	ZEGALOGUE		PREFERRED DRUG			1	30
DIAZOXIDE SUSPENSION	PROGLYCEM	BRAND ONLY					
GLUCAGON HCL (RDNA) SOLUTION	GLUCAGEN HYPOKIT		PREFERRED DRUG			2	30
GLUCAGON SOLUTION AUTOINJECTOR - ADULT	GVOKE HYPO		PREFERRED DRUG			1	30
GLUCAGON SOLUTION AUTOINJECTOR - PEDIATRIC	GVOKE HYPO		PREFERRED DRUG			1	30
GLUCAGON SOLUTION	GVOKE KIT		PREFERRED DRUG			1	30
GLUCAGON SOLN PREF SYR	GVOKE PFS		PREFERRED DRUG			1	30
<b>DIPEPTIDYL PEPTIDASE-4 (DPP-4) INHIBITORS</b>							
ALOGLIPTIN BENZOATE TABLETS	NESINA		PREFERRED DRUG		STEP THROUGH METFORMIN		
LINAGLIPTIN TABLETS	TRADJENTA	BRAND ONLY	PREFERRED DRUG		STEP THROUGH METFORMIN		
SITAGLIPTIN PHOSPHATE TABLETS	JANUVIA	BRAND ONLY	PREFERRED DRUG		STEP THROUGH METFORMIN		
<b>INCRETIN MIMETIC AGENTS (GLP-1 RECEPTOR AGONISTS)</b>							
DULAGLUTIDE SOLUTION PEN-INJECTION	TRULICITY		PREFERRED DRUG	PA REQUIRED			
EXENATIDE SOLUTION PEN INJECTION	BYETTA		PREFERRED DRUG	PA REQUIRED			
LIRAGLUTIDE SOLUTION PEN INJECTION	VICTOZA		PREFERRED DRUG	PA REQUIRED			
<b>DIABETIC MISCELLANEOUS AGENT</b>							
PRAMLINTIDE	SYMLIN PEN		PREFERRED DRUG	PA REQUIRED			
<b>INSULIN SENSITIZING AGENTS</b>							
INSULIN DEGLUDEC SOLUTION	TRESIBA						
INSULIN DEGLUDEC SOLN PEN-INJ	TRESIBA						
PIOGLITAZONE HCL TABLETS	ACTOS						
<b>INSULIN</b>							
INSULIN LISPRO (HUMAN) SOLUTION	HUMALOG	Authorized Generic Only	PREFERRED DRUG				
INSULIN LISPRO (HUMAN) SOLUTION CARTRIDGE	HUMALOG	BRAND ONLY	PREFERRED DRUG				
INSULIN LISPRO (HUMAN) SOLUTION PEN INJECTION 100/ML	HUMALOG JUNIOR KWIKPEN	Authorized Generic Only	PREFERRED DRUG				
INSULIN LISPRO (HUMAN) SOLUTION PEN INJECTION 100/ML	HUMALOG KWIKPEN	Authorized Generic Only	PREFERRED DRUG				
INSULIN LISPRO PROTAMINE & LISPRO (HUMAN) SUSPENSION PEN INJECTION (50-50)	HUMALOG MIX 50/50 KWIKPEN	Brand Only	PREFERRED DRUG				
INSULIN LISPRO PROTAMINE & LISPRO SUSPENSION (75-25)	HUMALOG MIX 75/25	Brand Only	PREFERRED DRUG				
INSULIN LISPRO PROTAMINE & LISPRO (HUMAN) SUSPENSION PEN INJECTION (75-25)	HUMALOG MIX 75/25 KWIKPEN	Authorized Generic Only	PREFERRED DRUG				
INSULIN NPH ISOPHANE & REG (HUMAN) SUSPENSION	HUMULIN 70/30	BRAND ONLY	PREFERRED DRUG				
INSULIN NPH ISOPHANE & REG (HUMAN) SUSPENSION	HUMULIN 70/30 KWIKPEN	BRAND ONLY	PREFERRED DRUG				
INSULIN NPH (HUMAN) (ISOPHANE) SUSPENSION	HUMULIN N	BRAND ONLY	PREFERRED DRUG				
INSULIN REGULAR (HUMAN) SOLUTION PEN INJECTION	HUMULIN N KWIKPEN	BRAND ONLY	PREFERRED DRUG				
INSULIN REGULAR (HUMAN) SOLUTION	HUMULIN R U-100	BRAND ONLY	PREFERRED DRUG				
INSULIN REGULAR (HUMAN) SOLUTION	HUMULIN R U-500 (CONCENTRATED)	BRAND ONLY	PREFERRED DRUG	PA REQUIRED			
INSULIN REGULAR (HUMAN) SOLUTION PEN-INJECTION	HUMULIN R U-500 KWIKPEN	BRAND ONLY	PREFERRED DRUG	PA REQUIRED			
INSULIN GLARGINE SOLUTION	LANTUS	BRAND ONLY	PREFERRED DRUG				
INSULIN GLARGINE SUSPENSION	LANTUS SOLOSTAR	BRAND ONLY	PREFERRED DRUG				
INSULIN NPH ISOPHANE & REG (HUMAN) SUSPENSION	NOVOLIN 70/30	BRAND ONLY	PREFERRED DRUG				
INSULIN NPH (HUMAN) (ISOPHANE) SUSPENSION	NOVOLIN N	BRAND ONLY	PREFERRED DRUG				
INSULIN REGULAR (HUMAN) SOLUTION	NOVOLIN R	BRAND ONLY	PREFERRED DRUG				
INSULIN ASPART SOLUTION	NOVOLOG	Authorized Generic Only	PREFERRED DRUG				

AHCCCS ACUTE - LONG TERM CARE DRUG LIST

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	PA Status	Step Therapy Requirements	Quantity Limit (QL)	QL Days
INSULIN ASPART SOLUTION PEN-INJECTION	NOVOLOG FLEXPEN	Authorized Generic Only	PREFERRED DRUG				
INSULIN ASPART PROTAMINE & ASPART (HUMAN) SUSPENSION (70/30)	NOVOLOG MIX 70/30	Authorized Generic Only	PREFERRED DRUG				
INSULIN ASPART PROTAMINE & ASPART (HUMAN) SUSPENSION PEN INJECTION (70/30)	NOVOLOG MIX 70/30 FLEXPEN	Authorized Generic Only	PREFERRED DRUG				
INSULIN ASPART SOLUTION CARTRIDGE	NOVOLOG PENFILL	Authorized Generic Only	PREFERRED DRUG				
<b>MEGLITINIDE ANALOGUES</b>							
NATEGLINIDE TABLETS	STARLIX						
REPAGLINIDE TABLETS	PRANDIN						
<b>SGLT2S</b>							
DAPAGLIFLOZIN PROPANEDIOL	FARXIGA		PREFERRED DRUG		STEP THROUGH METFORMIN		
CANAGLIFLOZIN	INVOKANA		PREFERRED DRUG		STEP THROUGH METFORMIN		
EMPAGLIFLOZIN	JARDIANCE		PREFERRED DRUG		STEP THROUGH METFORMIN		
<b>SULFONYLUREAS</b>							
GLIMEPIRIDE TABLETS (1MG, 2MG, 4MG)	AMARYL						
GLIPIZIDE TABLETS	GLUCOTROL						
GLIPIZIDE TABLET 24-HOUR	GLUCATROL XL						
GLYBURIDE MICRONIZED TABLETS	GLYNASE						
GLYBURIDE TABLETS	DIABETA						
<b>ANTIDIARRHEALS</b>							
<b>ANTIPERISTALTIC AGENTS</b>							
DIPHENOXYLATE W/ ATROPINE LIQUID	DIPHENOXYLATE/ATROPINE						
DIPHENOXYLATE W/ ATROPINE TABLETS	LOMOTIL						
LOPERAMIDE HCL CAPSULES	LOPERAMIDE HCL						
LOPERAMIDE HCL CHEWABLE TABLETS	IMODIUM A-D						
LOPERAMIDE HCL LIQUID	LOPERAMIDE HCL						
LOPERAMIDE HCL SUSPENSION	IMODIUM A-D						
LOPERAMIDE HCL TABLETS	IMODIUM A-D						
<b>ANTIDOTES</b>							
<b>OPIOID ANTAGONISTS</b>							
NALOXONE HCL SOLUTION + SYRINGE	NALOXONE HCL + SYRINGE		PREFERRED DRUG				
NALOXONE	KLOXXADO	BRAND ONLY	PREFERRED DRUG				
NALOXONE HCL NASAL SPRAY	NARCAN NASAL SPRAY/REXTOVY NASAL SPRAY	BRAND ONLY	PREFERRED DRUG			2	1
<b>ANTIEMETICS</b>							
<b>5-HT3 RECEPTOR ANTAGONISTS</b>							
DOLASETRON MESYLATE TABLETS	ANZEMET			PA REQUIRED			
GRANISETRON HCL SOLUTION	VARIOUS			PA REQUIRED			
GRANISETRON HCL TABLETS	VARIOUS			PA REQUIRED			
ONDANSETRON SOLUTION	VARIOUS			PA REQUIRED for tablets > 8mg Per Dose		300	30
ONDANSETRON HCL ODT TABLETS	VARIOUS			PA REQUIRED for tablets > 8mg Per Dose		60	30
ONDANSETRON HCL TABLETS	VARIOUS			PA REQUIRED for tablets > 8mg per Dose		60	30
<b>ANTIEMETICS MISC.</b>							
PROCHLORPERAZINE MALEATE TABLETS	COMPAZINE						
PROCHLORPERAZINE SUPPOSITORY	COMPAZINE						
<b>SUBSTANCE P/NEUROKININ 1 (NK1) RECEPTOR ANTAGONIST</b>							
APREPITANT CAPSULES	EMEND					6	21
<b>ANTIFUNGALS</b>							
<b>ANTIFUNGAL ORAL AGENTS</b>							
CLOTRIMAZOLE TROCHE	VARIOUS						

AHCCCS ACUTE - LONG TERM CARE DRUG LIST

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	PA Status	Step Therapy Requirements	Quantity Limit (QL)	QL Days
GRISEOFULVIN SUSPENSION	VARIOUS						
GRISEOFULVIN MICROSIZED TABLETS	GRIFULVIN V						
NYSTATIN SUSPENSION	NYSTATIN						
NYSTATIN TABLETS	NYSTATIN						
TERBINAFINE HCL TABLETS	LAMISIL					90	365
<b>IMIDAZOLE-RELATED ANTIFUNGALS</b>							
FLUCONAZOLE SUSPENSION	DIFLUCAN					600	30
FLUCONAZOLE TABLETS	DIFLUCAN					60	30
VORICONAZOLE SUSPENSION	VFEND	Brand Only		PA Required			
<b>ANTIHISTAMINES</b>							
<b>ANTIHISTAMINES - ALKYLAMINES</b>							
BROMPHENIRAMINE MALEATE	J-TAN PD						
CHLORPHENIRAMINE MALEATE	CHLORPHENIRAMINE MALEATE						
DEXCHLORPHENIRAMINE MALEATE SYRUP	DEXCHLORPHENIRAMINE MALEATE						
<b>ANTIHISTAMINES - ETHANOLAMINES</b>							
CLEMASTINE FUMARATE SYRUP	CLEMASTINE FUMARATE						
CLEMASTINE FUMARATE TABLETS	CLEMASTINE FUMARATE						
DIPHENHYDRAMINE HCL CAPSULES	VARIOUS						
DIPHENHYDRAMINE HCL CHEWABLE TABLETS	VARIOUS						
DIPHENHYDRAMINE HCL ELIXIR	VARIOUS						
DIPHENHYDRAMINE HCL LIQUID	VARIOUS						
DIPHENHYDRAMINE HCL SOLUTION	VARIOUS						
DIPHENHYDRAMINE HCL SUSPENSION	VARIOUS						
DIPHENHYDRAMINE HCL SYRUP	VARIOUS						
DIPHENHYDRAMINE HCL TABLETS	VARIOUS						
<b>ANTIHISTAMINES - NON-SEDATING</b>							
CETIRIZINE HCL CAPSULES	ZYRTEC ALLERGY					30	30
CETIRIZINE HCL CHEWABLE TABLETS	VARIOUS					30	30
CETIRIZINE HCL SYRUP	VARIOUS					150	30
CETIRIZINE HCL TABLETS	VARIOUS					30	30
CETIRIZINE HCL ORALLY DISINTEGRATING TABLETS	ZYRTEC ALLERGY					30	30
FEXOFENADINE HCL TABLET DISINTEGRATING (60mg)	WAL-FEX ALLERGY 12 HOUR					60	30
FEXOFENADINE HCL TABLET DISINTEGRATING (180mg)	WAL-FEX ALLERGY 12 HOUR					30	30
FEXOFENADINE HCL SUSPENSION	ALLEGRA ALLERGY CHILDRENS					150	30
FEXOFENADINE HCL TABLETS	ALLEGRA ALLERGY CHILDRENS					30	30
FEXOFENADINE HCL ORALLY DISINTEGRATING TABLETS	ALLEGRA ALLERGY CHILDRENS					30	30
LORATADINE CAPSULES	CLARITIN					30	30
LORATADINE CHEWABLE TABLETS	CLARITIN					30	30
LORATADINE SYRUP	CLARITIN					150	30
LORATADINE TABLETS	ALAVERT					30	30
LORATADINE ORALLY DISINTEGRATING TABLETS	CLARITIN REDITABS					30	30
<b>ANTIHISTAMINES - PHENOTHIAZINES</b>							
PROMETHAZINE HCL SUPPOSITORY	PHENERGAN						
PROMETHAZINE HCL TABLETS	PROMETHAZINE HCL						
<b>ANTIHISTAMINES - PIPERIDINES</b>							
CYPROHEPTADINE HCL SYRUP	CYPROHEPTADINE HCL						
CYPROHEPTADINE HCL TABLETS	CYPROHEPTADINE HCL						
<b>ANTIHYPOLIPIDEMICS</b>							
<b>BILE ACID SEQUESTRANTS</b>							
CHOLESTYRAMINE LIGHT PACKETS	PREVALITE						
CHOLESTYRAMINE LIGHT POWDER	PREVALITE						

AHCCCS ACUTE - LONG TERM CARE DRUG LIST

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	PA Status	Step Therapy Requirements	Quantity Limit (QL)	QL Days
CHOLESTYRAMINE PACKETS	QUESTRAN						
CHOLESTYRAMINE POWDER	QUESTRAN						
COLESTIPOL HCL TABLETS	COLESTID						
<b>FIBRIC ACID DERIVATIVES</b>							
FENOFIBRATE MICRONIZED CAPSULES 67MG, 134MG & 200MG	VARIOUS						
FENOFIBRATE TABLETS 48MG, 54MG, 145MG & 160MG	VARIOUS						
FENOFIBRIC ACID TABLETS	FIBRICOR						
GEMFIBROZIL TABLETS	LOPID						
<b>HMG COA REDUCTASE INHIBITORS</b>							
ATORVASTATIN CALCIUM TABLETS	LIPITOR		PREFERRED DRUG			30	30
LOVASTATIN TABLETS	MEVACOR		PREFERRED DRUG			30	30
PRAVASTATIN SODIUM TABLETS	PRAVACOL		PREFERRED DRUG			30	30
ROUVASTATIN TABLETS	CRESTOR		PREFERRED DRUG			30	30
SIMVASTATIN TABLETS	ZOCOR		PREFERRED DRUG			30	30
<b>INTESTINAL CHOLESTEROL ABSORPTION INHIBITORS</b>							
EZETIMIBE TABLETS	ZETIA		PREFERRED DRUG	PA REQUIRED			
<b>NICOTINIC ACID DERIVATIVES</b>							
NIACIN CAPSULE CONTROLLED RELEASE	VARIOUS						
NIACIN TABLET CONTROLLED RELEASE	VARIOUS						
<b>MISC. NUTRITIONAL SUBSTANCES</b>							
OMEGA-3 FATTY ACIDS CAPSULES	FISH OIL						
OMEGA-3 FATTY ACIDS CAPSULE DELAYED RELEASE	FISH OIL						
<b>ANTIHYPERTENSIVES</b>							
<b>ACE INHIBITORS</b>							
BENAZEPRIL HCL TABLETS	BENAZEPRIL HCL						
CAPTAPRIL TABLETS	CAPTAPRIL						
ENALAPRIL MALEATE SOLUTION	EPANED						
ENALAPRIL MALEATE TABLETS	VASOTEC						
FOSINOPRIL SODIUM TABLETS	FOSINOPRIL SODIUM						
LISINOPRIL TABLETS	ZESTRIL						
MOEXIPRIL HCL TABLETS	UNIVASC						
PERINDOPRIL ERBUMINE TABLETS	ACEON						
QUINAPRIL HCL TABLETS	ACCUPRIL						
RAMIPRIL CAPSULES	ALTACE						
TRANDOLAPRIL TABLETS	MAVIK						
<b>ANGIOTENSIN II RECEPTOR ANTAGONISTS</b>							
IRBESARTAN TABLETS	AVAPRO						
LOSARTAN POTASSIUM TABLETS	COZAAR						
VALSARTAN SOLUTION	VALSARETAN			PA Required for > 7 Years Old			
VALSARTAN TABLETS	DIOVAN						
<b>ANTIADRENERGIC ANTIHYPERTENSIVES</b>							
CLONIDINE HCL PATCH-WEEKLY	CATAPRES-TTS-1			PA REQUIRED for Ages < 6 years of age		4	28
CLONIDINE HCL TABLETS	CATAPRES						
CLONIDINE HCL (ADHD) TABLET 12-HOUR	CLONIDINE ER			PA REQUIRED for Ages < 6 years of age		120	30
DOXAZOSIN MESYLATE TABLETS	CARDURA						
GUANFACINE HCL TABLETS	TENEX						
<b>GUANFACINE HCL (ADHD) TABLET 24-HOUR</b>	<b>GUANFACINE ER</b>		<b>PREFERRED DRUG</b>	<b>PA REQUIRED for Ages &lt; 6 years of age</b>		<b>30</b>	<b>30</b>
METHYLDOPA TABLETS	METHYLDOPA						
PRAZOSIN HCL CAPSULES	MINIPRESS						
TERAZOSIN HCL CAPSULES	TERAZOSIN HCL						
<b>ANTIHYPERTENSIVE COMBINATIONS</b>							



AHCCCS ACUTE - LONG TERM CARE DRUG LIST

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	PA Status	Step Therapy Requirements	Quantity Limit (QL)	QL Days
ATENOLOL & CHLORTHALIDONE TABLETS	VARIOUS						
CAPTAPRIL & HYDROCHLOROTHIAZIDE TABLETS	CAPTAPRIL/ HYDROCHLOROTHIAZIDE						
ENALAPRIL MALEATE & HYDROCHLOROTHIAZIDE TABLETS	ENALAPRIL MALEATE/ HYDROCHLOROTHIAZIDE						
FOSINOPRIL SODIUM & HYDROCHLOROTHIAZIDE TABLETS	FOSINOPRIL SODIUM/ HYDROCHLOROTHIAZIDE						
LISINAPRIL & HYDROCHLOROTHIAZIDE TABLETS	ZESTORETIC						
LOSARTAN POTASSIUM & HYDROCHLOROTHIAZIDE TABLETS	HYZAAR						
MOEXIPRIL - HYDROCHLOROTHIAZIDE TABLETS	UNIRETIC						
QUINAPRIL - HYDROCHLOROTHIAZIDE TABLETS	ACCURETIC						
VALSARTAN - HYDROCHLOROTHIAZIDE TABLETS	DIOVAN HCT						
<b>SELECTIVE ALDOSTERONE RECEPTOR ANTAGONISTS (SARAS)</b>							
EPLERENONE TABLETS	INSPIRA			PA REQUIRED			
<b>VASODILATORS</b>							
HYDRALAZINE HCL TABLETS	HYDRALAZINE HCL						
MINOXIDIL TABLETS	MINOXIDIL						
<b>ANTI-INFECTIVE AGENTS - MISC.</b>							
<b>ANTI-INFECTIVE AGENTS - MISC.</b>							
METRONIDAZOLE TABLETS	FLAGYL						
METRONIDAZOLE SUSPENSION	LIKMEZ			PA NOT REQUIRED FOR < 10 YEARS OF AGE			
RIFAXIMIN TABLETS	XIFAXAN						
TINIDAZOLE	VARIOUS						
TRIMETHOPRIM TABLETS	TRIMETHOPRIM						
VANCOMYCIN HCL CAPSULES	VANCOCIN HCL			PA Required			
VANCOMYCIN HCL SOLUTION RECONSTITUTED	FIRVANQ (ORAL)	BRAND ONLY					
<b>ANTI-INFECTIVE MISC. - COMBINATIONS</b>							
ERYTHROMYCIN-SULFISOXAZOLE SUSPENSION	E.S.P.						
SULFAMETHOXAZOLE-TRIMETHOPRIM SUSPENSION	SULFATRIM PEDIATRIC						
SULFAMETHOXAZOLE-TRIMETHOPRIM TABLETS	BACTRIM						
<b>LEPROSTATICS</b>							
DAPSONE TABLETS	DAPSONE						
<b>OXAZOLIDINONES</b>							
LINEZOLID SUSPENSION	ZYVOX			PA REQUIRED			
LINEZOLID TABLETS	ZYVOX			PA REQUIRED			
<b>ANTIMALARIALS</b>							
<b>ANTIMALARIAL COMBINATIONS</b>							
ARTEMETHER-LUMEFANTRINE TABLETS	COARTEM						
ATOVAQUONE-PROGUANIL HCL TABLETS	MALARONE						
<b>ANTIMALARIALS</b>							
CHLOROQUINE PHOSPHATE TABLETS	CHLOROQUINE PHOSPHATE						
HYDROXYCHLOROQUINE SULFATE TABLETS	PLAQUENIL						
PRIMAQUINE PHOSPHATE TABLETS	PRIMAQUINE PHOSPHATE						
QUININE SULFATE CAPSULES	QUALAQUIN						
<b>ANTIMYCOBACTERIAL AGENTS</b>							
ETHAMBUTOL HCL TABLETS	MYAMBUTOL						
ISONIAZID SYRUP	ISONIAZID						
ISONIAZID TABLETS	ISONIAZID						
PYRAZINAMIDE TABLETS	PYRAZINAMIDE						
RIFAMPIN CAPSULES	RIFADIN						

AHCCCS ACUTE - LONG TERM CARE DRUG LIST

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	PA Status	Step Therapy Requirements	Quantity Limit (QL)	QL Days
<b>ONCOLOGY -FEDERALLY REIMBURSABLE ANTINEOPLASTIC AGENTS,NOT LISTED BELOW, ARE AVAILABLE THROUGH PRIOR AUTHORIZATION</b>							
<b>ALKYLATING AGENTS</b>							
MELPHALAN TABLETS	ALKERAN			Not covered through AHCCCS. Please contact Waylis Pharmaceuticals for the patient assistance program. Toll Free Number: 1-800-689-0255			
<b>ANTIMETABOLITES</b>							
MERCAPTOPYRINE TABLETS	PURINETHOL						
METHOTREXATE SODIUM TABLETS	METHOTREXATE						
<b>ANTINEOPLASTIC - ANTIBODIES</b>							
RITUXIMAB-ABBS	TRUXIMA			PA REQUIRED			
RITUXIMAB-PVVR	RUXIENCE			PA REQUIRED			
<b>ANTINEOPLASTIC - ANGIOGENESIS INHIBITORS</b>							
BEVACIZUMAB-AWWB INJECTION	MVASI			PA REQUIRED			
BEVACIZUMAB-BVZR INJECTION	ZIRABEV			PA REQUIRED			
<b>ANTINEOPLASTIC - ANTI-HER2 AGENTS</b>							
TRASTUZUMAB-ANNS SOLUTION	KANJINTI			PA REQUIRED			
TRASTUZUMAB-ANNS INJECTION	KANJINTI			PA REQUIRED			
TRASTUZUMAB-DKST INJECTION	OGIVRI			PA REQUIRED			
TRASTUZUMAB-PKRB INJECTION	HERZUMA			PA REQUIRED			
TRASTUZUMAB-QYYP INJECTION	TRAZIMERA			PA REQUIRED			
<b>ANTINEOPLASTIC - HORMONAL AND RELATED AGENTS</b>							
ANASTROZOLE TABLETS	ARIMIDEX			PA REQUIRED			
EXEMESTANE TABLETS	AROMASIN			PA REQUIRED			
FLUTAMIDE CAPSULE	EULEXIN			Not covered through AHCCCS. Please contact Waylis Pharmaceuticals for the patient assistance program. Toll Free Number: 1-800-689-0255			
LEUPROLIDE ACETATE (3 MONTH) KIT	LUPRON DEPOT			PA REQUIRED			
LEUPROLIDE ACETATE (4 MONTH) KIT	LUPRON DEPOT			PA REQUIRED			
LEUPROLIDE ACETATE KIT	LUPRON DEPOT			PA REQUIRED			
TAMOXIFEN CITRATE TABLETS	TAMOXIFEN CITRATE						
TOREMIFENE CITRATE TABLETS	FARESTON			PA REQUIRED			
<b>ANTINEOPLASTIC ENZYME INHIBITORS</b>							
AXITINIB TABLETS	INLYTA			PA REQUIRED			
CRIZOTINIB CAPSULES	XALKORI			PA REQUIRED			
CRIZOTINIB CAPSULE SPRINKLE	XALKORI			PA REQUIRED			
DASATINIB TABLETS	SPRYCEL			PA REQUIRED			
ERLOTINIB HCL TABLETS	TARCEVA			PA REQUIRED			
EVEROLIMUS SOLUBLE TABLET	AFINITOR DISPERZ			PA REQUIRED			
GEFITINIB TABLETS	IRESSA			PA REQUIRED			
IBRUTINIB CAPSULES	IMBRUVICA			PA REQUIRED			
IBRUTINIB SUSPENSION	IMBRUVICA			PA REQUIRED			
IMATINIB MESYLATE TABLETS	GLEEVEC			PA REQUIRED			
LAPATINIB DITOSYLATE TABLETS	TYKERB			PA REQUIRED			
NILOTINIB HCL CAPSULES	TASIGNA			PA REQUIRED			
PAZOPANIB HCL TABLETS	VOTRIENT			PA REQUIRED			
PONATINIB HCL TABLETS	ICLUSIG			PA REQUIRED			
RUXOLITINIB PHOSPHATE TABLETS	JAKAFI			PA REQUIRED			
SORAFENIB TOSYLATE TABLETS	NEXAVAR			PA REQUIRED			

AHCCCS ACUTE - LONG TERM CARE DRUG LIST

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	PA Status	Step Therapy Requirements	Quantity Limit (QL)	QL Days
SUNITINIB MALATE CAPSULES	SUTENT			PA REQUIRED			
VANDETANIB TABLETS	CAPRELSA			PA REQUIRED			
VEMURAFENIB TABLETS	ZELBORAF			PA REQUIRED			
VORINOSTAT CAPSULES	ZOLINZA			PA REQUIRED			
<b>ANTINEOPLASTICS - MISC.</b>							
BEXAROTENE CAPSULES	TARGRETIN			PA REQUIRED			
HYDROXYUREA CAPSULES	HYDREA						
INTERFERON ALFA-2B SOLUTION	INTRON A			PA REQUIRED			
INTERFERON ALFA-2B SOLUTION	INTRON A			PA REQUIRED			
INTERFERON ALFA-N3 SOLUTION	ALFERON N			PA REQUIRED			
INTERFERON GAMMA-1B SOLUTION	ACTIMMUNE			PA REQUIRED			
PEGINTERFERON ALFA-2B (ANTINEOPLASTIC) KIT	SYLATRON			PA REQUIRED			
PROCARBAZINE HCL CAPSULES	MATULANE						
TRETINOIN (CHEMOTHERAPY) CAPSULES	TRETINOIN			PA REQUIRED For > 26 Years of Age			
<b>CHEMOTHERAPY RESCUE/ANTIDOTE AGENTS</b>							
LEUCOVORIN CALCIUM TABLETS	LEUCOVORIN CALCIUM			PA REQUIRED			
<b>MITOTIC INHIBITORS</b>							
ETOPOSIDE CAPSULES	ETOPOSIDE			PA REQUIRED			
<b>ANTIPARKINSON AGENTS</b>							
<b>ANTIPARKINSON ANTICHOLINERGICS</b>							
BENZTROPINE MESYLATE TABLETS	BENZTROPINE MESYLATE						
TRIHEXYPHENIDYL HCL ELIXIR	TRIHEXYPHENIDYL HCL						
TRIHEXYPHENIDYL HCL TABLETS	TRIHEXYPHENIDYL HCL						
<b>ANTIPARKINSON COMT INHIBITORS</b>							
ENTACAPONE TABLETS	COMTAN						
<b>ANTIPARKINSON DOPAMINERGICS</b>							
AMANTADINE HCL CAPSULES	AMANTADINE HCL						
AMANTADINE HCL SYRUP	AMANTADINE HCL						
BROMOCRIPTINE MESYLATE CAPSULES	PARLODEL						
BROMOCRIPTINE MESYLATE TABLETS	PARLODEL						
CARBIDOPA-LEVODOPA TABLETS	SINEMET						
CARBIDOPA-LEVODOPA ER TABLETS	VARIOUS						
PRAMIPEXOLE DIHYDROCHLORIDE TABLETS	MIRAPEX						
ROPINIROLE HYDROCHLORIDE TABLETS	REQUIP						
<b>ANTIPSYCHOTICS/ANTIMANIC AGENTS</b>							
<b>ANTIMANIC AGENTS</b>							
LITHIUM CARBONATE CAPSULES	LITHIUM CARBONATE			PA REQUIRED for Ages < 6 years Prior Authorization is not REQUIRED for ages 6 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.			
LITHIUM CARBONATE TABLETS	LITHIUM CARBONATE			PA REQUIRED for Ages < 6 years Prior Authorization is not REQUIRED for ages 6 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.			
LITHIUM CARBONATE TABLET CONTROLLED RELEASE	LITHOBID			PA REQUIRED for Ages < 6 years Prior Authorization is not REQUIRED for ages 6 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.			

AHCCCS ACUTE - LONG TERM CARE DRUG LIST

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	PA Status	Step Therapy Requirements	Quantity Limit (QL)	QL Days
LITHIUM SOLUTION	LITHIUM			PA REQUIRED for Ages < 6 years Prior Authorization is not REQUIRED for ages 6 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.			
<b>ANTIPSYCHOTICS</b>							
<b>ANTIPSYCHOTICS - SECOND GENERATION - ATYPICAL ORAL AGENTS</b>							
ARIPIRAZOLE TABLETS	ABILIFY		PREFERRED DRUG	PA REQUIRED for Ages < 6 years Prior Authorization is not REQUIRED for ages 6 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.		30	30
CLOZAPINE ORALLY DISPERSABLE TABLET	FAZACLO		PREFERRED DRUG	PA REQUIRED for Ages < 18 years Prior Authorization is not REQUIRED for ages 18 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.		150	30
CLOZAPINE TABLETS	CLOZARIL		PREFERRED DRUG	PA REQUIRED for Ages < 18 years Prior Authorization is not REQUIRED for ages 18 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.		150	30
LURASIDONE HCL TABS	LATUDA		PREFERRED DRUG	PA REQUIRED for Ages < 6 years Prior Authorization is not REQUIRED for ages 6 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.		30	30
OLANZAPINE ORALLY DISPERSABLE TABLET	ZYPREXA ZYDIS		PREFERRED DRUG	PA REQUIRED for Ages < 6 years Prior Authorization is not REQUIRED for ages 6 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.		5mg: 60 10mg: 60 15MG: 30 20mg: 30	30 30 30 30
OLANZAPINE TABLETS	ZYPREXA		PREFERRED DRUG	PA REQUIRED for Ages < 6 years Prior Authorization is not REQUIRED for ages 6 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.		30	30
QUETIAPINE FUMARATE TABLETS	SEROQUEL		PREFERRED DRUG	PA REQUIRED for Ages < 6 years Prior Authorization is not REQUIRED for ages 6 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.		60	30
RISPERIDONE ORALLY DISPERSABLE TABLET	RISPERIDONE ODT		PREFERRED DRUG	PA REQUIRED for Ages < 6 years Prior Authorization is not REQUIRED for ages 6 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.		60	30
RISPERIDONE ORAL SOLUTION	RISPERDAL		PREFERRED DRUG	PA REQUIRED for Ages < 6 years Prior Authorization is not REQUIRED for ages 6 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.		240	30

AHCCCS ACUTE - LONG TERM CARE DRUG LIST

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	PA Status	Step Therapy Requirements	Quantity Limit (QL)	QL Days
RISPERIDONE TABLETS	RISPERDAL		PREFERRED DRUG	PA REQUIRED for Ages < 6 years Prior Authorization is not REQUIRED for ages 6 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.		60	30
ZIPRASIDONE HCL CAPSULES	GEODON		PREFERRED DRUG	PA REQUIRED for Ages < 6 years Prior Authorization is not REQUIRED for ages 6 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.		60	30
<b>ANTIPSYCHOTICS - SECOND GENERATION - ATYPICAL LONG ACTING INJECTABLES</b>							
ARIPIRAZOLE LAUROXIL	ARISTADA INITIO		PREFERRED DRUG	PA REQUIRED for Ages < 18 years Prior Authorization is not REQUIRED for ages 18 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.		2	365
ARIPIRAZOLE LAUROXIL	ARISTADA		PREFERRED DRUG	PA REQUIRED for Ages < 18 years Prior Authorization is not REQUIRED for ages 18 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.		1	30
ARIPIRAZOLE SUSPENSION	ABILIFY MAINTENA		PREFERRED DRUG	PA REQUIRED for Ages < 18 years Prior Authorization is not REQUIRED for ages 18 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.		1	30
ARIPIRAZOLE SUSPENSION	ABILIFY ASIMTUFI		PREFERRED DRUG	PA REQUIRED for Ages < 18 years Prior Authorization is not REQUIRED for ages 18 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.		1	60
PALIPERIDONE PALMITATE SUSPENSION	INVEGA HAFYE		PREFERRED DRUG	PA REQUIRED for Ages < 18 years Prior Authorization is not REQUIRED for ages 18 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.		1	170
PALIPERIDONE PALMITATE SUSPENSION	INVEGA SUSTENNA		PREFERRED DRUG	PA REQUIRED for Ages < 18 years Prior Authorization is not REQUIRED for ages 18 years and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.		1	30
PALIPERIDONE PALMITATE SUSPENSION	INVEGA TRINZA		PREFERRED DRUG	PA REQUIRED for Ages < 18 years Prior Authorization is not REQUIRED for ages 18 years and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.		1	90
RISPERIDONE MICROSPPHERES SUSPENSION	RISPERDAL CONSTA	BRAND ONLY	PREFERRED DRUG	PA REQUIRED for Ages < 18 years Prior Authorization is not REQUIRED for ages 18 years and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.		2	28

AHCCCS ACUTE - LONG TERM CARE DRUG LIST

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	PA Status	Step Therapy Requirements	Quantity Limit (QL)	QL Days
RISPERIDONE PREFILLED SYRINGE	PERSERIS		PREFERRED DRUG	PA REQUIRED for Ages < 18 years Prior Authorization is not REQUIRED for ages 18 years and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.		2	28
<b>ANTIPSYCHOTICS - FIRST GENERATION -TYPICAL ORAL AGENTS</b>							
CHLORPROMAZINE HCL SOLUTION	VARIOUS			PA REQUIRED for Ages < 6 years Prior Authorization is not REQUIRED for ages 6 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.			
CHLORPROMAZINE HCL TABLETS	VARIOUS			PA REQUIRED for Ages < 6 years Prior Authorization is not REQUIRED for ages 6 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.			
FLUPHENAZINE HCL CONCENTRATE	VARIOUS			PA REQUIRED for Ages < 6 years Prior Authorization is not REQUIRED for ages 6 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.			
FLUPHENAZINE HCL ELIXIR	VARIOUS			PA REQUIRED for Ages < 6 years Prior Authorization is not REQUIRED for ages 6 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.			
FLUPHENAZINE HCL TABLETS	VARIOUS			PA REQUIRED for Ages < 6 years Prior Authorization is not REQUIRED for ages 6 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.			
HALOPERIDOL LACTATE CONCENTRATE	VARIOUS			PA REQUIRED for Ages < 12 years Prior Authorization is not REQUIRED for ages 6 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.			
HALOPERIDOL TABLETS	VARIOUS			PA REQUIRED for Ages < 12 years Prior Authorization is not REQUIRED for ages 6 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.			
LOXAPINE SUCCINATE CAPSULES	LOXITANE			PA REQUIRED for Ages < 12 years Prior Authorization is not REQUIRED for ages 6 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.			
MOLINDONE	VARIOUS			PA REQUIRED for Ages < 12 years Prior Authorization is not REQUIRED for ages 6 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.			

AHCCCS ACUTE - LONG TERM CARE DRUG LIST

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	PA Status	Step Therapy Requirements	Quantity Limit (QL)	QL Days
PERPHENAZINE TABLETS	VARIOUS			PA REQUIRED for Ages < 12 years Prior Authorization is not REQUIRED for ages 6 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.			
PIMOZIDE	ORAP			PA REQUIRED for Ages < 12 years Prior Authorization is not REQUIRED for ages 6 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.			
THIORIDAZINE HCL TABLETS	VARIOUS			PA REQUIRED for Ages < 12 years Prior Authorization is not REQUIRED for ages 6 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.			
THIOTHIXENE CAPSULES	VARIOUS			PA REQUIRED for Ages < 12 years Prior Authorization is not REQUIRED for ages 6 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.			
TRIFLUOPERAZINE HCL TABLETS	VARIOUS			PA REQUIRED for Ages < 12 years Prior Authorization is not REQUIRED for ages 6 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.			
<b>ANTIPSYCHOTICS - FIRST GENERATION -TYPICAL -LONG ACTING INJECTIONS</b>							
FLUPHENAZINE DECANOATE SOLUTION	FLUPHENAZINE DECANOATE			PA REQUIRED for Ages < 18 years Prior Authorization is not REQUIRED for ages 18 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.			
HALOPERIDOL DECANOATE SOLUTION	HALDOL DECANOATE 50			PA REQUIRED for Ages < 18 years Prior Authorization is not REQUIRED for ages 18 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.			
<b>ANTIVIRALS</b>							
<b>ANTIRETROVIRALS</b>							
ABACAVIR SULFATE SOLUTION	ZIAGEN		Preferred Drug				
ABACAVIR SULFATE TABLETS	ZIAGEN		Preferred Drug				
ABACAVIR SULFATE-LAMIVUDINE TABLETS	EPZICOM		Preferred Drug				
ABACAVIR SULFATE-LAMIVUDINE-ZIDOVUDINE TABLETS	TRIZIVIR		Preferred Drug				
ABACAVIR-DOLUTEGRAVIR-LAMIVUDINE TABLETS	TRIUMEQ		Preferred Drug			30	30
ABACAVIR-DOLUTEGRAVIR-LAMIVUDINE SUSPENSION	TRIUMEQ PD		Preferred Drug			180	30
ABACAVIR-DOLUTEGRAVIR-LAMIVUDINE TABLETS	TRIUMEQ		Preferred Drug				
ATAZANAVIR SULFATE CAPSULES	REYATAZ		Preferred Drug				
ATAZANAVIR SULFATE POWDER PACK	REYATAZ		Preferred Drug				
ATAZANAVIR SULFATE-COBICISTAT TABLETS	EVOTAZ		Preferred Drug				
BICTEGRAVIR-EMTRICITABINE-TENOFOVIR ALAFENAMIDE FUMARATE TABLETS	BIKTARVY		Preferred Drug			30	30
COBICISTAT TABLETS	TYBOST		Preferred Drug			30	30
DARUNAVIR ETHANOLATE SUSPENSION	PREZISTA		Preferred Drug				
DARUNAVIR ETHANOLATE TABLETS	PREZISTA		Preferred Drug				

AHCCCS ACUTE - LONG TERM CARE DRUG LIST

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	PA Status	Step Therapy Requirements	Quantity Limit (QL)	QL Days
DARUNAVIR-COBICISTAT TABLETS	PREZCOBIX		Preferred Drug				
DARUNAVIR-COBICISTAT-EMTRICITABINE-TENOFOVIR ALAFENAMIDE TABLETS	SYMTUZA		Preferred Drug				
DELAVIRDINE MESYLATE TABLETS	RESCRIPTOR						
DOLUTEGRAVIR SODIUM TABLETS	TIVICAY		Preferred Drug				
DOLUTEGRAVIR SODIUM SOLUBLE TABLETS	TIVICAY PD		Preferred Drug				
DOLUTEGRAVIR SODIUM-LAMIVUDINE TABLETS	DOVATO		Preferred Drug				
DOLUTEGRAVIR SODIUM-RILPIVIRINE HCL TABLETS	JULUCA		Preferred Drug				
DORAVIRINE-LAMIVUDINE-TENOFOVIR DISOPROXIL FUMARATE TABLETS	DELSTRIGO		Preferred Drug				
DORAVIRINE TABLETS	PIFELTRO		Preferred Drug				
EFAVIRENZ CAPSULES	SUSTIVA		Preferred Drug				
EFAVIRENZ TABLETS	SUSTIVA		Preferred Drug				
EFAVIRENZ-LAMIVUDINE-TENOFOVIR DISOPROXIL FUMARATE TABLETS	SYMFI	Brand Only	Preferred Drug			30	30
EFAVIRENZ-LAMIVUDINE-TENOFOVIR DISOPROXIL FUMARATE TABLETS	SYMFI LO	Brand Only	Preferred Drug			30	30
ELVITEGRAVIR TABLETS	VITEKTA						
ELVITEGRAVIR-COBICISTAT-EMTRICITABINE-TENOFOVIR TABLETS	STRIBILD		Preferred Drug				
ELVITEGRAVIR-COBICISTAT-EMTRICITABINE-TENOFOVIR ALAFENAMIDE TABLETS	GENVOYA		Preferred Drug			30	30
EMTRICITABINE CAPSULES	EMTRIVA		Preferred Drug				
EMTRICITABINE SOLUTION	EMTRIVA		Preferred Drug				
EMTRICITABINE-RILPIVIRINE-TENOFOVIR ALAFENAMIDE FUMARATE TABLETS	ODEFSEY		Preferred Drug			30	30
EMTRICITABINE-RILPIVIRINE-TENOFOVIR DISOPROXIL FUMARATE TABLETS	COMPLERA		Preferred Drug				
EMTRICITABINE-TENOFOVIR ALAFENAMIDE FUMARATE TABLETS	DESCOVY		Preferred Drug			30	30
<b>EMTRICITABINE-TENOFOVIR DISOPROXIL FUMARATE TABLETS</b>	<b>TRUVADA</b>	Brand Only	Preferred Drug				
ENFUVRTIDE SOLUTION	FUZEON		Preferred Drug	PA REQUIRED		1	30
FOSAMPRENAVIR CALCIUM SUSPENSION	LEXIVA		Preferred Drug				
FOSAMPRENAVIR CALCIUM TABLETS	LEXIVA		Preferred Drug				
INDINAVIR SULFATE CAPSULES	CRIXIVAN						
LAMIVUDINE SOLUTION	EPIVIR		Preferred Drug				
LAMIVUDINE TABLETS	EPIVIR		Preferred Drug				
LAMIVUDINE-ZIDOVUDINE TABLETS	COMBIVIR		Preferred Drug				
LOPINAVIR-RITONAVIR SOLUTION	KALETRA		Preferred Drug				
LOPINAVIR-RITONAVIR TABLETS	KALETRA		Preferred Drug				
<b>MARAVIROC TABLETS</b>	<b>SELZENTRY</b>	Brand Only	Preferred Drug	PA REQUIRED			
NEVIRAPINE SUSPENSION	VIRAMUNE		Preferred Drug				
NEVIRAPINE TABLETS	VIRAMUNE		Preferred Drug				
NEVIRAPINE TABLET 24-HOUR	VIRAMUNE XR		Preferred Drug				
RALTEGRAVIR POTASSIUM CHEWABLE TABLETS	ISENTRESS		Preferred Drug				
RALTEGRAVIR POTASSIUM PACK	ISENTRESS		Preferred Drug				
RALTEGRAVIR POTASSIUM TABLETS	ISENTRESS		Preferred Drug				
RILPIVIRINE HCL TABLET	EDURANT		Preferred Drug				
RITONAVIR CAPSULES	NORVIR		Preferred Drug				
RITONAVIR SOLUTION	NORVIR		Preferred Drug				
RITONAVIR TABLETS	NORVIR		Preferred Drug				
RITONAVIR POWDER	NORVIR		Preferred Drug				
TENOFOVIR DISOPROXIL FUMARATE POWDER	VIREAD		Preferred Drug				
ZIDOVUDINE CAPSULES	RETROVIR		Preferred Drug				



AHCCCS ACUTE - LONG TERM CARE DRUG LIST

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	PA Status	Step Therapy Requirements	Quantity Limit (QL)	QL Days
ZIDOVUDINE SYRUP	RETROVIR		Preferred Drug				
ZIDOVUDINE TABLETS	ZIDOVUDINE		Preferred Drug				
<b>CMV AGENTS</b>							
CIDOFOVIR IV	VISTIDE			PA REQUIRED			
FOSCARENT SODIUM	FOSCAVIR			PA REQUIRED			
GANCICLOVIR SODIUM	CYTOVENE			PA REQUIRED			
MARIBAVIR TABLETS	LIVTENCITY			PA REQUIRED			
VALGANCICLOVIR HCL SOLUTION	VALCYTE			PA REQUIRED			
VALGANCICLOVIR HCL TABLETS	VALCYTE			PA REQUIRED			
<b>HEPATITIS B AGENTS</b>							
ADEFOVIR DIPIVOXIL TABLETS	HEPSERA			PA REQUIRED			
ENTECAVIR SOLUTION	BARACLUDE			PA REQUIRED			
ENTECAVIR TABLETS	BARACLUDE			PA REQUIRED			
LAMIVUDINE (HBV) SOLUTION	EPIVIR HBV						
LAMIVUDINE (HBV) TABLETS	EPIVIR HBV						
TELBIVUDINE TABLETS	TYZEKA			PA REQUIRED			
<b>HEPATITIS C AGENTS</b>							
GLECAPREVIR-PIBRENTASVIR TABLETS	MAVYRET		Preferred Drug	PA Required if member has been treated previously with Direct-Acting Antiviral (DAA) Hep C Regimens in the past.		168	Lifetime
GLECAPREVIR-PIBRENTASVIR PACKETS	MAVYRET		Preferred Drug	PA Required if member has been treated previously with Direct-Acting Antiviral (DAA) Hep C Regimens in the past.		280	Lifetime
PEGINTERFERON ALFA-2A SOLUTION	PEGASYS		PREFERRED DRUG	PA REQUIRED			
PEGINTERFERON ALFA-2B KIT	PEGINTRON		PREFERRED DRUG	PA REQUIRED			
RIBAVIRIN (HEPATITIS C) CAPSULES	VARIOUS		PREFERRED DRUG	PA REQUIRED			
RIBAVIRIN (HEPATITIS C) TABLETS	VARIOUS		PREFERRED DRUG	PA REQUIRED			
SOFOSBUVIR-VELPATASVIR TABLETS	EPLUSA	AUTHORIZED GENERIC ONLY	Preferred Drug	PA Required if member has been treated previously with Direct-Acting Antiviral (DAA) Hep C Regimens in the past.		168	Lifetime
<b>HERPES AGENTS</b>							
ACYCLOVIR SUSPENSION	ZOVIRAX						
ACYCLOVIR TABLETS	ZOVIRAX						
FAMCICLOVIR TABLETS	FAMVIR			PA REQUIRED			
VALACYCLOVIR HCL TABLETS	VALTREX			PA REQUIRED			
<b>INFLUENZA AGENTS</b>							
OSELTAMIVIR PHOSPHATE CAPSULES	TAMIFLU					20	270
OSELTAMIVIR PHOSPHATE SUSPENSION	TAMIFLU						
RIMANTADINE HYDROCHLORIDE TABLETS	FLUMADINE						
ZANAMIVIR AEROSOL POWDER BREATH ACTIVATED	RELENZA DISKHALER					40	270
<b>MISC. ANTIVIRALS</b>							
MOLNUPIRAVIR CAPSULES	LAGEVRIO			Minimum Patient Age of 18 Years		80	365
NIRMATRELVIR-RITONAVIR	PAXLOVID			Minimum Patient Age of 12 Years		60	365
REMDESIVIR SOLUTION	VEKLURY						
REMDESIVIR FOR SOLUTION	VEKLURY						
<b>ASSORTED CLASSES</b>							
<b>BLOOD PRODUCTS - IMMUNE GLOBULINS</b>							
IMMUNE GLOBULIN	BIVIGAM (IV)	BRAND ONLY	PREFERRED DRUG	PA REQUIRED			
IMMUNE GLOBULIN	FLEBOGFAMMA DIF (IV)	BRAND ONLY	PREFERRED DRUG	PA REQUIRED			
IMMUNE GLOBULIN	GAMMAGARD LIQUID (INJ)	BRAND ONLY	PREFERRED DRUG	PA REQUIRED			
IMMUNE GLOBULIN	GAMMAKED (INJ)	BRAND ONLY	PREFERRED DRUG	PA REQUIRED			
IMMUNE GLOBULIN	GAMUNEX-C (INJ)	BRAND ONLY	PREFERRED DRUG	PA REQUIRED			

AHCCCS ACUTE - LONG TERM CARE DRUG LIST

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	PA Status	Step Therapy Requirements	Quantity Limit (QL)	QL Days
IMMUNE GLOBULIN	HIZENTRA (SUBQ)	BRAND ONLY	PREFERRED DRUG	PA REQUIRED			
IMMUNE GLOBULIN	OCTAGAM (IV)	BRAND ONLY	PREFERRED DRUG	PA REQUIRED			
IMMUNE GLOBULIN	PRIVIGEN (IV)	BRAND ONLY	PREFERRED DRUG	PA REQUIRED			
IMMUNE GLOBULIN	XEMBIFY (SUBQ)	BRAND ONLY	PREFERRED DRUG	PA REQUIRED			
<b>CHELATING AGENTS</b>							
PENICILLAMINE CAPSULES	CUPRIMINE						
<b>IMMUNOMODULATORS</b>							
LENALIDOMIDE CAPSULES	REVLIMID			PA REQUIRED			
THALIDOMIDE CAPSULES	THALOMID			PA REQUIRED			
<b>IMMUNOSUPPRESSIVE AGENTS</b>							
AZATHIOPRINE TABLETS	IMURAN						
CYCLOSPORINE CAPSULES	SANDIMMUNE						
CYCLOSPORINE MODIFIED (FOR MICROEMULSION) CAPSULES	GENGRAF						
CYCLOSPORINE MODIFIED (FOR MICROEMULSION) SOLUTION	GENGRAF						
CYCLOSPORINE SOLUTION	SANDIMMUNE						
EVEROLIMUS (IMMUNOSUPPRESSANT) TABLETS	ZORTRESS			PA REQUIRED			
MYCOPHENOLATE MOFETIL CAPSULES	CELLCEPT						
MYCOPHENOLATE MOFETIL SUSPENSION	CELLCEPT						
MYCOPHENOLATE MOFETIL TABLETS	CELLCEPT						
SIROLIMUS SOLUTION	RAPAMUNE						
SIROLIMUS TABLETS	RAPAMUNE						
TACROLIMUS CAPSULES	HECORIA						
TACROLIMUS CAPSULE CONTROLLED RELEASE	ASTAGRAF XL						
<b>ROCK2 INHIBITORS</b>							
BELUMOSUDIL MESYLATE	REZUROCK			PA REQUIRED			
<b>POTASSIUM REMOVING RESINS</b>							
SODIUM POLYSTYRENE SULFONATE POWDER	KAYEXALATE						
SODIUM POLYSTYRENE SULFONATE SUSPENSION	KIONEX						
<b>BETA BLOCKERS</b>							
<b>ALPHA-BETA BLOCKERS</b>							
CARVEDILOL TABLETS	COREG		Preferred Drug				
LABETALOL HCL TABLETS	TRANDATE		Preferred Drug				
<b>BETA BLOCKERS CARDIO-SELECTIVE</b>							
ATENOLOL TABLETS	TENORMIN		Preferred Drug				
ATENOLOL/CHLORTHALIDONE	VARIOUS		Preferred Drug				
BISOPRODOL	VARIOUS		Preferred Drug				
BISOPRODOL/HCTZ	VARIOUS		Preferred Drug				
METOPROLOL TARTRATE TABLETS	VARIOUS		Preferred Drug				
METOPROLOL SUCCINATE TABLET XL 24-HOUR	VARIOUS		Preferred Drug				
METOPROLOL TARTRATE/HCTZ	VARIOUS		Preferred Drug				
<b>BETA BLOCKERS NON-SELECTIVE</b>							
NADOLOL	VARIOUS		Preferred Drug	PA NOT REQUIRED FOR CHILDREN AND ADOLESCENTS UNDER 19 YEARS OF AGE			
PROPRANOLOL HCL CAPSULE ER CONTROLLED RELEASE	VARIOUS		Preferred Drug				
PROPRANOLOL HCL SOLUTION	VARIOUS		Preferred Drug				
PROPRANOLOL HCL TABLETS	VARIOUS		Preferred Drug				
PROPRANOLOL / HCTZ	VARIOUS		Preferred Drug				
SOTALOL HCL TABLETS	BETAPACE		Preferred Drug				
<b>CALCIUM CHANNEL BLOCKERS</b>							
<b>CALCIUM CHANNEL BLOCKERS</b>							
AMLODIPINE BESYLATE	VARIOUS		Preferred Drug			30	30

AHCCCS ACUTE - LONG TERM CARE DRUG LIST

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	PA Status	Step Therapy Requirements	Quantity Limit (QL)	QL Days
AMLODIPINE BENZOATE SUSPENSION	KATERZIA		Preferred Drug	PA Required for > 7 Years Old		300	30
DILTIAZEM CAPSULE ER	VARIOUS		Preferred Drug				
DILTIAZEM TABLETS	VARIOUS		Preferred Drug				
FELODIPINE TABLET ER 24-HOUR	VARIOUS		Preferred Drug			30	30
NIFEDIPINE IR CAPSULES	VARIOUS		Preferred Drug				
NIFEDIPINE TABLET ER 24-HOUR	VARIOUS		Preferred Drug			30	30
VERAPAMIL HCL CAPSULE SR	VARIOUS		Preferred Drug			30	30
VERAPAMIL HCL TABLETS	VARIOUS		Preferred Drug				
VERAPAMIL HCL TABLET CONTROLLED RELEASE	VARIOUS		Preferred Drug			30	30
<b>CARDIOTONICS</b>							
<b>CARDIAC GLYCOSIDES</b>							
DIGOXIN SOLUTION	DIGOXIN						
DIGOXIN TABLETS	LANOXIN						
<b>CARDIOVASCULAR AGENTS - MISC.</b>							
<b>ANGIOTENSTIN RECEPTOR NEPRILYSIN INHIBITOR</b>							
SACUBITRIL / VALSARTAN	ENTRESTO			PA REQUIRED			
SACUBITRIL-VALSARTAN CAPSULE SPRINKLE	ENTRESTO SPRINKLE			PA REQUIRED			
<b>PULMONARY HYPERTENSION - ENDOTHELIN RECEPTOR ANTAG</b>							
AMBRISENTAN TABLETS	LETAIRIS		PREFERRED DRUG	PA REQUIRED			
BOSENTAN TABLETS	TRACLEER		PREFERRED DRUG	PA REQUIRED			
<b>PULMONARY HYPERTENSION - PHOSPHODIESTERASE INHIBIT</b>							
SILDENAFIL CITRATE (PULMONARY HYPERTENSION) SUSPENSION	LIQREV		PREFERRED DRUG	PA REQUIRED FOR > 12 YEARS OF AGE			
SILDENAFIL CITRATE (PULMONARY HYPERTENSION) SUSPENSION RECONSTITUTED	REVATIO		Preferred for Under the Age of 12	PA Required For > 12 Year of Age			
SILDENAFIL CITRATE (PULMONARY HYPERTENSION) TABLETS	VARIOUS		PREFERRED DRUG	PA REQUIRED			
TADALAFIL (PULMONARY HYPERTENSION) TABLETS	ADCIRCA		PREFERRED DRUG	PA REQUIRED			
<b>PROSTAGLANDIN VASODILATORS**</b>							
TREPROSTINIL DIOLAMINE TABLET ER	ORENITRAM			PA Required			
TREPROSTINIL DIOLAMINE TBER THER PACK	ORENITRAM			PA Required			
<b>CEPHALOSPORINS</b>							
<b>CEPHALOSPORINS - 1ST GENERATION</b>							
CEFADROXIL CAPSULES	CEFADROXIL						
CEFADROXIL SUSPENSION	CEFADROXIL						
CEFADROXIL TABLETS	CEFADROXIL						
CEPHALEXIN CAPSULES	KEFLEX						
CEPHALEXIN SUSPENSION	CEPHALEXIN						
CEPHALEXIN TABLETS	CEPHALEXIN						
<b>CEPHALOSPORINS - 2ND GENERATION</b>							
CEFACLOR CAPSULES	CEFACLOR						
CEFACLOR SUSPENSION	CEFACLOR						
CEFPROZIL SUSPENSION	CEFPROZIL						
CEFPROZIL TABLETS	CEFPROZIL						
CEFUROXIME AXETIL SUSPENSION	CEFTIN						
CEFUROXIME AXETIL TABLETS	CEFTIN						
<b>CEPHALOSPORINS - 3RD GENERATION</b>							
CEFDINIR CAPSULES	CEFDINIR						
CEFDINIR SUSPENSION	CEFDINIR						
CEFIXIME CAPSULES	SUPRAX					1	30
CEFIXIME CHEWABLE TABLETS	SUPRAX					1	30
CEFIXIME SUSPENSION	SUPRAX					1	30
CEFIXIME TABLETS	SUPRAX					1	30

AHCCCS ACUTE - LONG TERM CARE DRUG LIST

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	PA Status	Step Therapy Requirements	Quantity Limit (QL)	QL Days
CEFPODOXIME PROXETIL SUSPENSION	CEFPODOXIME PROXETIL						
CEFPODOXIME PROXETIL TABLETS	CEFPODOXIME PROXETIL						
<b>CONTRACEPTION</b>							
<b>COMBINATION CONTRACEPTIVES - ORAL</b>							
DESOGESTREL & ETHINYL ESTRADIOL TABLETS	APRI						
DESOGESTREL-ETHINYL ESTRADIOL (BIPHASIC) TABLETS	AZURETTE						
DESOGESTREL-ETHINYL ESTRADIOL (TRIPHASIC) TABLETS	CAZIAN						
DROSPIRENONE-ETHINYL ESTRADIOL TABLETS	OCELLA						
ETHYNODIOL DIACET & ETHINYL ESTRADIOL TABLETS	KELNOR 1/35						
LEVONORGESTREL & ETHINYL ESTRADIOL TABLETS	AUBRA						
LEVONORGESTREL-ETHINYL ESTRADIOL (TRIPHASIC) TABLETS	ENPRESSE-28						
LEVONORGESTREL-ETHINYL ESTRADIOL (91-DAY) TABLETS	AMETHIA LO						
LEVONORGESTREL & ETHINYL ESTRADIOL (CONTINUOUS) TABLETS	AMETHYST						
NORETHINDRONE ACE & ETHINYL ESTRADIOL-FE TABLETS	JUNEL FE						
NORETHINDRONE ACE & ETHINYL ESTRADIOL-FE CHEWABLES	MELODETTA 24 FE						
NORETHINDRONE & ETH ESTRADIOL TABLETS	BALZIVA						
NORETHINDRONE & MESTRANOL TABLETS	NECON 1/50-28						
NORETHINDRONE ACET & ETH ESTRA TABLETS	GILDESS 1/20						
NORETHINDRONE ACETATE-ETHINYL ESTRADIOL-FE TABLETS	ESTROSTEP FE						
NORETHIN ACET & ESTRAD-FE TABLETS	LOESTRIN FE TAB 1/20						
NORETHINDRONE-ETH ESTRADIOL (BIPHASIC) TABLETS	NECON 10/11-28						
NORETHINDRONE-ETH ESTRADIOL (TRIPHASIC) TABLETS	CYCLAFEM 7/7/7						
NORETHINDRONE & ETHINYL ESTRADIOL-FE CHEWABLES	KAITLIB FE						
NORGESTIMATE-ETHINYL ESTRADIOL (TRIPHASIC) TABLETS	ORTHO TRI-CYCLEN						
NORGESTIMATE-ETHINYL ESTRADIOL TABLETS	ESTARYLLA						
NORGESTREL & ETHINYL ESTRADIOL TABLETS	CRYSSELLE-28						
<b>COMBINATION CONTRACEPTIVES - VAGINAL</b>							
ETONOGESTREL-ETHINYL ESTRADIOL RING	NUVARING	<b>BRAND ONLY</b>					
<b>COPPER CONTRACEPTIVES - IUD</b>							
COPPER IUD	PARAGARD					1	999 Days
<b>EMERGENCY CONTRACEPTIVES</b>							
LEVONORGESTREL (EMERGENCY OC) TABLETS	PLAN B ONE-STEP OTC		<b>PREFERRED DRUG</b>				
LEVONORGESTREL (EMERGENCY OC) TABLETS	AFTERA OTC		<b>PREFERRED DRUG</b>				
LEVONORGESTREL (EMERGENCY OC) TABLETS	LEVONORGESTREL OTC		<b>PREFERRED DRUG</b>				
LEVONORGESTREL (EMERGENCY OC) TABLETS	MY CHOICE OTC		<b>PREFERRED DRUG</b>				
LEVONORGESTREL (EMERGENCY OC) TABLETS	MY WAY OTC		<b>PREFERRED DRUG</b>				
LEVONORGESTREL (EMERGENCY OC) TABLETS	NEW DAY OTC		<b>PREFERRED DRUG</b>				
LEVONORGESTREL (EMERGENCY OC) TABLETS	OPTION 2 OTC		<b>PREFERRED DRUG</b>				
LEVONORGESTREL (EMERGENCY OC) TABLETS	TAKE ACTION OTC		<b>PREFERRED DRUG</b>				
ULIPRISTAL ACETATE TABLETS	ELLA		<b>PREFERRED DRUG</b>			1	5
<b>PROGESTINS</b>							
MEDROXYPROGESTERONE ACETATE TABLETS	PROVERA		<b>PREFERRED DRUG</b>				
NORETHINDRONE ACETATE	AYGESTIN		<b>PREFERRED DRUG</b>				
PROGESTERONE MICRONIZED CAPSULES	PROMETRIUM		<b>PREFERRED DRUG</b>				
<b>PROGESTIN CONTRACEPTIVES - IMPLANTS</b>							
ETONOGESTREL IMPLANT	NEXPLANON					1	999 Days
<b>PROGESTIN CONTRACEPTIVES - INJECTABLE</b>							
MEDROXYPROGESTERONE ACETATE (CONTRACEPTIVE) SUSPENSION	DEPO-PROVERA CONTRACEPTIVE						
<b>PROGESTIN CONTRACEPTIVES - IUD</b>							

AHCCCS ACUTE - LONG TERM CARE DRUG LIST

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	PA Status	Step Therapy Requirements	Quantity Limit (QL)	QL Days
LEVONORGESTREL (IUD)	LILETTA					1	999 Days
LEVONORGESTREL (IUD)	SKYLA					1	730 Days
LEVONORGESTREL (IUD)	MIRENA					1	999 Days
LEVONORGESTREL (IUD)	KYLEENA					1	730 Days
<b>PROGESTIN CONTRACEPTIVES - ORAL</b>							
NORETHINDRONE (CONTRACEPTIVE) TABLETS	CAMILA						
NORGESTREL TABLET	OPILL						
<b>PROGESTIN CONTRACEPTIVES - TRANSDERMAL</b>							
NORELGESTROMIN-ETHINYL ESTRADIOL PATCH WEEKLY	XULANE						
<b>CORTICOSTEROIDS</b>							
<b>GLUCOCORTICOSTEROIDS</b>							
DEXAMETHASONE CONCENTRATE	DEXAMETHASONE INTENSOL						
DEXAMETHASONE ELIXIR	VARIOUS						
DEXAMETHASONE SOLUTION	DEXAMETHASONE						
DEXAMETHASONE TABLETS - ALL STRENGTHS EXCEPT 20MG	DEXAMETHASONE						
HYDROCORTISONE SOD SUCCINATE SOLUTION (INJECTABLE)	A-HYDROCORT				PA REQUIRED		
METHYLPREDNISOLONE ACETATE SUSPENSION (INJECTABLE)	DEPO-MEDROL				PA REQUIRED		
METHYLPREDNISOLONE SOD SUCC SOLUTION (INJECTABLE)	A-METHAPRED				PA REQUIRED		
METHYLPREDNISOLONE TABLETS	MEDROL						
PREDNISOLONE SODIUM PHOSPHATE SOLUTION	ORAPRED						
PREDNISOLONE SODIUM PHOSPHATE ORALLY DISINTEGRATING TABLETS	ORAPRED ODT						
PREDNISOLONE SYRUP	PRELONE						
PREDNISOLONE TABLETS	VARIOUS						
PREDNISONE CONCENTRATE	PREDNISONE INTENSOL						
PREDNISONE SOLUTION	PREDNISONE						
PREDNISONE TABLETS	PREDNISONE						
TRIAMCINOLONE ACETONIDE SUSPENSION (INJECTABLE)	KENALOG-10				PA REQUIRED		
TRIAMCINOLONE DIACETATE SUSPENSION (INJECTABLE)	TRIAMCINOLONE				PA REQUIRED		
TRIAMCINOLONE HEXACETONIDE SUSPENSION (INJECTABLE)	ARISTOSPAN INTRALESIONAL & INTRA-ARTICULAR				PA REQUIRED		
<b>MINERALOCORTICIDS</b>							
FLUDROCORTISONE ACETATE TABLETS	FLORINEF						
<b>NONSTEROIDAL MINERALOCORTICOID RECEPTOR ANTAGONIST</b>							
FINERENONE TABLETS	KERENDIA				PA REQUIRED		
<b>COUGH/COLD/ALLERGY</b>							
<b>ANTITUSSIVES</b>							
BENZONATATE CAPSULES	TESSALON PERLES						
HYDROCODONE W/ HOMATROPINE SYRUP	VARIOUS				PA REQUIRED for < 18 years of age	240	12
HYDROCODONE W/ HOMATROPINE TABLETS	VARIOUS				PA REQUIRED for < 18 years of age		
<b>COUGH/COLD/ALLERGY COMBINATIONS</b>							
BROMPHENIRAMINE & PSEUDOEPHEDRINE LIQUID	VARIOUS						
BROMPHENIRAMINE & PSEUDOEPHEDRINE TABLET 12-HOUR	VARIOUS						
BROMPHENIRAMINE-DEXTROMETHORPHAN-PHENYLEPHRINE LIQUID/TABLETS	VARIOUS						
CETIRIZINE-PSEUDOEPHEDRINE TABLET 12-HOUR	VARIOUS					30	30
CHLORPHENIRAMINE & PSEUDOEPHEDRINE CHEWABLE TABLETS	VARIOUS						
CHLORPHENIRAMINE & PSEUDOEPHEDRINE LIQUID	VARIOUS					480	30

AHCCCS ACUTE - LONG TERM CARE DRUG LIST

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	PA Status	Step Therapy Requirements	Quantity Limit (QL)	QL Days
CHLORPHENIRAMINE & PSEUDOEPHEDRINE SOLUTION	VARIOUS					480	30
CHLORPHENIRAMINE & PSEUDOEPHEDRINE SYRUP	VARIOUS					480	30
CHLORPHENIRAMINE & PSEUDOEPHEDRINE TABLETS	VARIOUS						
DEXTROMETHORPHAN-GUAIFENESIN TABLET	VARIOUS						
DEXTROMETHORPHAN-GUAIFENESIN LIQUID	VARIOUS					480	30
DEXTROMETHORPHAN-GUAIFENESIN TABLET 12-HOUR	MUCINEX DM						
FEXOFENADINE-PSEUDOEPHEDRINE TABLET 12-HOUR	VARIOUS					30	30
FEXOFENADINE-PSEUDOEPHEDRINE TABLET 24-HOUR	VARIOUS					30	30
GUAIFENESIN-CODEINE SYRUP	ROBITUSSIN AC			PA REQUIRED for < 18 years of age		240	12
LORATADINE & PSEUDOEPHEDRINE TABLET 12-HOUR	ALAVERT ALLERGY/SINUS					30	30
LORATADINE & PSEUDOEPHEDRINE TABLET 24-HOUR	CLARITIN-D 24 HOUR					30	30
PHENYLEPHRINE W/ DEXTROMETHORPHAN-GUAIFENESIN CAPSULES	VARIOUS						
PHENYLEPHRINE W/ DEXTROMETHORPHAN-GUAIFENESIN LIQUID	ROBITUSSIN CHILDRENS COUGH & COLD CF					480	30
PHENYLEPHRINE W/ DEXTROMETHORPHAN-GUAIFENESIN SYRUP	VARIOUS					480	30
PHENYLEPHRINE W/ DEXTROMETHORPHAN-GUAIFENESIN TABLETS	VARIOUS						
PHENYLEPHRINE W/ DEXTROMETHORPHAN-GUAIFENESIN TABLET 12-HOUR	VARIOUS						
PHENYLEPHRINE-BROMPHENIRAMINE-DEXTROMETHORPHAN ELIXIR	VARIOUS					480	30
PHENYLEPHRINE-BROMPHENIRAMINE-DEXTROMETHORPHAN LIQUID	DIMETAPP DEXTROMETHORPHAN COLD & COUGH					480	30
PHENYLEPHRINE-BROMPHENIRAMINE-DEXTROMETHORPHAN SYRUP	VARIOUS					480	30
PHENYLEPHRINE-CHLORPHENIRAMINE-DEXTROMETHORPHAN LIQUID	VARIOUS					480	30
PHENYLEPHRINE-CHLORPHENIRAMINE-DEXTROMETHORPHAN DROPS	VARIOUS			PA REQUIRED for < 6 years age			
PHENYLEPHRINE-CHLORPHENIRAMINE-DEXTROMETHORPHAN SYRUP	VARIOUS					480	30
PHENYLEPHRINE-CHLORPHENIRAMINE-DEXTROMETHORPHAN TABLETS	VARIOUS						
PHENYLEPHRINE-GUAIFENESIN CAPSULES	VARIOUS						
PHENYLEPHRINE-GUAIFENESIN LIQUID	TRIAMINIC CHEST/ NASAL CONGESTION					480	30
PHENYLEPHRINE-GUAIFENESIN SYRUP	TRIAMINIC CHEST & NASAL CONGESTION					480	30
PHENYLEPHRINE-GUAIFENESIN TABLETS	VARIOUS						
PROMETHAZINE & PHENYLEPHRINE SYRUP	PROMETHAZINE/ PHENYLEPHRINE					480	30
PROMETHAZINE W/CODEINE SYRUP	PROMETHAZINE/CODEINE			PA REQUIRED for < 18 years of age		240	12
PROMETHAZINE-DEXTROMETHORPHAN SYRUP	PROMETHAZINE/ DEXTROMETHORPHAN					480	30
PSEUDOEPHEDRINE W/ CODEINE-GUAIFENESIN SYRUP	VARIOUS			PA REQUIRED for < 18 years of age		240	12
<b>EXPECTORANTS</b>							
GUAIFENESIN LIQUID	VARIOUS					480	30
GUAIFENESIN SYRUP	VARIOUS					480	30
GUAIFENESIN TABLETS	VARIOUS						
GUAIFENESIN TABLET 12-HOUR	VARIOUS						
<b>DERMATOLOGICALS</b>							
<b>ACNE PRODUCTS</b>							
BENZOYL PEROXIDE WASH 5% & 10%	VARIOUS						
BENZOYL PEROXIDE CLEANSER 6%	NEUTROGENA ON-THE-SPOT ACNE TREATMENT						
BENZOYL PEROXIDE GEL	BENZOYL PEROXIDE						
BENZOYL PEROXIDE LIQUID	PANOXYL						

AHCCCS ACUTE - LONG TERM CARE DRUG LIST

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	PA Status	Step Therapy Requirements	Quantity Limit (QL)	QL Days
BENZOYL PEROXIDE LOTION	BP CLEANSING LOTION						
BENZOYL PEROXIDE-ERYTHROMYCIN PACK	BENZAMYCINPAK						
CLINDAMYCIN PHOSPHATE (TOPICAL) GEL	CLEOCIN-T						
CLINDAMYCIN PHOSPHATE (TOPICAL) LOTION	CLEOCIN-T						
CLINDAMYCIN PHOSPHATE (TOPICAL) SOLUTION	CLEOCIN-T						
CLINDAMYCIN PHOSPHATE (TOPICAL) SWAB	CLEOCIN-T						
CLINDAMYCIN PHOSPHATE-BENZOYL PEROXIDE (REFRIGERATE)	CLINDAMY/BEN						
ERYTHROMYCIN ACNE GEL	VARIOUS	NDCs: 45802096694, 45802096696, 63739005366, 63739005368					
ERYTHROMYCIN (ACNE AID) SOLUTION	ERYTHROMYCIN						
ISOTRETINOIN CAPSULES	ABSORICA			PA REQUIRED			
TRETINOIN CREAM	RETIN-A	BRAND ONLY		PA REQUIRED For > 26 Years of Age			
TRETINOIN GEL	RETIN-A	BRAND ONLY		PA REQUIRED For > 26 Years of Age			
<b>ANTIBIOTICS - TOPICAL</b>							
BACITRACIN OINTMENT	BACIGUENT						
BACITRACIN ZINC OINTMENT	BACITRACIN						
BACITRACIN-POLYMYXIN B OINTMENT	POLYSPORIN						
BACITRACIN-POLYMYXIN-NEOMYCIN HC OINTMENT	CORTISPORIN						
GENTAMICIN SULFATE CREAM	GENTAMICIN SULFATE						
GENTAMICIN SULFATE OINTMENT	GENTAMICIN SULFATE						
MUPIROCIN CALCIUM CREAM	BACTROBAN						
MUPIROCIN OINTMENT	BACTROBAN						
NEOMYCIN-BACITRACIN-POLYMYXIN OINTMENT	NEOSPORIN						
<b>ANTIFUNGALS - TOPICAL</b>							
BUTENAFINE	LOTRIMIN ULTRA						
CICLOPROX CREAM	VARIOUS	Preferred Drug					
CICLOPROX SOLUTION	VARIOUS	Preferred Drug					
CLOTRIMAZOLE CREAM (RX & OTC)	LOTRIMIN	Preferred Drug					
CLOTRIMAZOLE OINTMENT	LOTRIMIN						
CLOTRIMAZOLE TOPICAL SOLUTION	CLOTRIMAZOLE (RX ONLY)						
CLOTRIMAZOLE W/ BETAMETHASONE CREAM	LOTRISONE	Preferred Drug					
KETOCONAZOLE CREAM	VARIOUS	Preferred Drug					
KETOCONAZOLE SHAMPOO	VARIOUS	Preferred Drug					
MICONAZOLE NITRATE CREAM	VARIOUS	Preferred Drug					
MICONAZOLE NITRATE POWDER	VARIOUS	Preferred Drug					
NYSTATIN CREAM	VARIOUS	Preferred Drug					
NYSTATIN OINTMENT	VARIOUS	Preferred Drug					
NYSTATIN POWDER	VARIOUS	Preferred Drug					
TOLNAFTATE AERO POWDER	VARIOUS	Preferred Drug					
TOLNAFTATE CREAM	VARIOUS	Preferred Drug					
TOLNAFTATE POWDER	VARIOUS	Preferred Drug					
TERBINAFINE CREAM	VARIOUS	Preferred Drug					
<b>ANTIHISTAMINES-TOPICAL</b>							
DIPHENHYDRAMINE HCL CREAM	ANTI-ITCH MAXIMUM STRENGTH						
DIPHENHYDRAMINE HCL GEL	BENADRYL ITCH STOPPING						
DIPHENHYDRAMINE HCL SOLUTION	BENADRYL MAXIMUM STRENGTH						
<b>ANTISEBORRHEIC TOPICAL PRODUCTS</b>							
SELENIUM SULFIDE LOTION	SELSUN SHAMPOO						
<b>ANTIVIRALS - TOPICAL</b>							

AHCCCS ACUTE - LONG TERM CARE DRUG LIST

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	PA Status	Step Therapy Requirements	Quantity Limit (QL)	QL Days
DOCOSANOL 10% CREAM	ABREVA		PREFERRED DRUG			2GM	30
ACYCLOVIR OINTMENT	ZOVIRAX	BRAND ONLY	PREFERRED DRUG			15GM	30
ACYCLOVIR OINTMENT	ZOVIRAX		PREFERRED DRUG			15GM	30
<b>BURN PRODUCTS</b>							
SILVER SULFADIAZINE CREAM	SILVADENE						
<b>CORTICOSTEROIDS - TOPICAL LOW POTENCY</b>							
FLUOCINOLONE ACETONIDE	DERMA-SMOOTH FS	BRAND ONLY	PREFERRED DRUG				
FLUOCINOLONE ACETONIDE SOLUTION	SYNALAR						
HYDROCORTISONE CREAM	VARIOUS		PREFERRED DRUG				
HYDROCORTISONE GEL	VARIOUS		PREFERRED DRUG				
HYDROCORTISONE LOTION	VARIOUS		PREFERRED DRUG				
HYDROCORTISONE OINTMENT	VARIOUS		PREFERRED DRUG				
FLUOCINOLONE 0.01% OIL	VARIOUS		PREFERRED DRUG				
<b>CORTICOSTEROIDS - TOPICAL MEDIUM POTENCY</b>							
FLUTICASONE PROPIONATE CREAM	VARIOUS		PREFERRED DRUG				
FLUTICASONE PROPIONATE OINTMENT	VARIOUS		PREFERRED DRUG				
MOMETASONE FUROATE CREAM	VARIOUS		PREFERRED DRUG				
MOMETASONE FUROATE OINTMENT	VARIOUS		PREFERRED DRUG				
MOMETASONE FUROATE SOLUTION	VARIOUS		PREFERRED DRUG				
<b>CORTICOSTEROIDS - TOPICAL HIGH POTENCY</b>							
BETAMETHASONE DIPROPIONATE LOTION	VARIOUS		PREFERRED DRUG				
BETAMETHASONE DIPROPIONATE CREAM	VARIOUS		PREFERRED DRUG				
BETAMETHASONE DIPROPIONATE/PROPYLENE GLYC. CREAM	VARIOUS		PREFERRED DRUG				
BETAMETHASONE DIPROPIONATE (TOPICAL) OINTMENT	VARIOUS		PREFERRED DRUG				
BETAMETHASONE VALERATE CREAM	VARIOUS		PREFERRED DRUG				
BETAMETHASONE VALERATE LOTION	VARIOUS		PREFERRED DRUG				
BETAMETHASONE VALERATE SOLUTION	VARIOUS		PREFERRED DRUG				
FLUOCINONIDE CREAM	VARIOUS		PREFERRED DRUG				
FLUOCINONIDE OINTMENT	VARIOUS		PREFERRED DRUG				
FLUOCINONIDE SOLUTION	VARIOUS		PREFERRED DRUG				
TRIAMCINOLONE ACETONIDE CREAM	VARIOUS		PREFERRED DRUG				
TRIAMCINOLONE ACETONIDE LOTION	VARIOUS		PREFERRED DRUG				
TRIAMCINOLONE ACETONIDE OINTMENT	VARIOUS		PREFERRED DRUG				
<b>CORTICOSTEROIDS - TOPICAL VERY HIGH POTENCY</b>							
CLOBETASOL PROPIONATE CREAM	VARIOUS		PREFERRED DRUG			100	30
CLOBETASOL PROPIONATE EMOLLIENT	VARIOUS		PREFERRED DRUG			100	30
CLOBETASOL PROPIONATE GEL	VARIOUS		PREFERRED DRUG			118	30
CLOBETASOL PROPIONATE OINTMENT	VARIOUS		PREFERRED DRUG			100	30
CLOBETASOL PROPIONATE SHAMPOO	VARIOUS		PREFERRED DRUG			120	30
CLOBETASOL PROPIONATE SOLUTION	VARIOUS		PREFERRED DRUG			100	30
HALOBETASOL PROPIONATE CREAM	VARIOUS		PREFERRED DRUG			100	30
HALOBETASOL PROPIONATE OINTMENT	VARIOUS		PREFERRED DRUG			100	30
<b>STEROIDS - MOUTH/THROAT/DENTAL**</b>							
TRIAMCINOLONE ACETONIDE (MOUTH) PASTE	ORALONE DENTAL PASTE					10	30
<b>ECZEMA AGENTS</b>							
RUXOLITINIB PHOSPHATE (TOPICAL) CREAM	OPZELURA			PA Required			
TRALOKINUMAB-LDRM SOLN AUTO-INJ	ADBRY			PA Required			
TRALOKINUMAB-LDRM SOLN PREF SYR	ADBRY		PREFERRED DRUG	PA REQUIRED			
<b>ENZYMES - TOPICAL</b>							
TACROLIMUS (TOPICAL) OINTMENT	PROTOPIC		PREFERRED DRUG	PA REQUIRED			
<b>IMMUNOSUPPRESSIVE AGENTS - TOPICAL</b>							



AHCCCS ACUTE - LONG TERM CARE DRUG LIST

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	PA Status	Step Therapy Requirements	Quantity Limit (QL)	QL Days
PIMECROLIMUS CREAM	ELIDEL			PA Required		60 GM	30
PIMECROLIMUS CREAM	VARIOUS		PREFERRED DRUG			60gm	30
<b>KERATOLYTIC/ANTIMITOTIC AGENTS</b>							
SALICYLIC ACID CREAM	SALACYN						
SALICYLIC ACID FOAM	SALVAX						
SALICYLIC ACID GEL	KERALYT						
SALICYLIC ACID LIQUID	VIRASAL						
SALICYLIC ACID LOTION	SALACYN						
SALICYLIC ACID SHAMPOO	SALEX						
SALICYLIC ACID SOLUTION	VARIOUS						
<b>LOCAL ANESTHETICS - TOPICAL</b>							
LIDOCAINE CREAM 4%	ASPERCREME W/LIDOCAINE						
LIDOCAINE HCL GEL 2%	GLYDO						
LIDOCAINE HCL LOTION	LIDOCAINE HCL			PA REQUIRED			
LIDOCAINE OINTMENT	LIDOCAINE			PA REQUIRED			
LIDOCAINE PATCH	LIDODERM			PA REQUIRED			
LIDOCAINE HCL SOLUTION	VARIOUS						
LIDOCAINE-PRILOCAINE CREAM	EMLA						
<b>TOPICAL - MISC.</b>							
ALUMINUM CHLORIDE SOLUTION	DRYSOL						
<b>PHOSPHODIESTERASE 4 (PDE4) INHIBITORS - TOPICAL</b>							
CRISABOROLE OINTMENT	EUCRISA		PREFERRED DRUG	PA REQUIRED			
<b>ROSACEA TOPICAL AGENTS</b>							
METRONIDAZOLE CREAM 0.75%	METROCREAM						
METRONIDAZOLE GEL 0.75%	METROGEL						
METRONIDAZOLE LOTION	METROLOTION						
<b>SCABICIDES &amp; PEDICULICIDES TOPICAL AGENTS+A1106</b>							
CROTAMITON CREAM	EURAX						
CROTAMITON LOTION	EURAX						
IVERMECTIN LOTION	SKLICE			PA REQUIRED			
PERMETHRIN CREAM	ACTICIN						
PERMETHRIN 1%, 5%	NIX, ELIMITE						
PERMETHRIN LIQUID	NIX CREME RINSE						
PYRETHRINS-PIPERONYL BUTOXIDE GEL	A-200						
PYRETHRINS-PIPERONYL BUTOXIDE LIQUID	BARC						
PYRETHRINS-PIPERONYL BUTOXIDE SHAMPOO	LICIDE						
SPINOSAD SUSPENSION	NATROBA			PA REQUIRED			
<b>DIAGNOSTIC PRODUCTS</b>							
<b>DIAGNOSTIC TESTS</b>							
BLOOD GLUCOSE MONITORS & STRIPS	VARIOUS						
<b>DIGESTIVE AIDS</b>							
<b>DIGESTIVE ENZYMES</b>							
LIPASE-PROTEASE-AMYLASE CAPSULE DELAYED RELEASE	CREON	BRAND ONLY	PREFERRED DRUG			500	30
LIPASE-PROTEASE-AMYLASE CAPSULE DELAYED RELEASE	ZENPEP	BRAND ONLY	PREFERRED DRUG			500	30
<b>DIURETICS</b>							
<b>CARBONIC ANHYDRASE INHIBITORS</b>							
ACETAZOLAMIDE CAPSULE 12-HOUR	DIAMOX						
ACETAZOLAMIDE TABLETS	ACETAZOLAMIDE						
METHAZOLAMIDE TABLETS	NEPTAZANE						
<b>DIURETIC COMBINATIONS</b>							
SPIRONOLACTONE & HYDROCHLOROTHIAZIDE TABLETS	ALDACTAZIDE						

AHCCCS ACUTE - LONG TERM CARE DRUG LIST

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	PA Status	Step Therapy Requirements	Quantity Limit (QL)	QL Days
TRIAMTERENE & HYDROCHLOROTHIAZIDE CAPSULES	DYAZIDE						
TRIAMTERENE & HYDROCHLOROTHIAZIDE TABLETS	MAXZIDE-25						
<b>LOOP DIURETICS</b>							
BUMETANIDE TABLETS	BUMETANIDE						
FUROSEMIDE SOLUTION	FUROSEMIDE						
FUROSEMIDE TABLETS	LASIX						
TORSEMIDE TABLETS	DEMADEX						
<b>POTASSIUM SPARING DIURETICS</b>							
SPIRONOLACTONE TABLETS	ALDACTONE						
<b>THIAZIDES AND THIAZIDE-LIKE DIURETICS</b>							
CHLOROTHIAZIDE SUSPENSION	DIURIL						
CHLOROTHIAZIDE TABLETS	CHLOROTHIAZIDE						
CHLORTHALIDONE TABLETS	CHLORTHALIDONE						
HYDROCHLOROTHIAZIDE CAPSULES 12.5MG	VARIOUS						
HYDROCHLOROTHIAZIDE TABLETS 25MG & 50MG	HYDROCHLOROTHIAZIDE						
INDAPAMIDE TABLETS	INDAPAMIDE						
METOLAZONE TABLETS	ZAROXOLYN						
<b>ENDOCRINE AND METABOLIC AGENTS - MISC.</b>							
<b>BONE DENSITY REGULATORS</b>							
ALENDRONATE SODIUM SOLUTION	ALENDRONATE SODIUM						
ALENDRONATE SODIUM TABLETS	ALENDRONATE SODIUM						
CALCITONIN (SALMON) SOLUTION	FORTICAL						
DENOSUMAB	PROLIA			PA REQUIRED			
IBANDRONATE SODIUM	BONIVA						
RALOXIFENE TABLETS	VARIOUS						
<b>TERIPARATIDE (RECOMBINANT)</b>	<b>FORTEO</b>	<b>BRAND ONLY</b>		PA REQUIRED			
<b>GROWTH HORMONES</b>							
<b>SOMATROPIN SOLUTION</b>	<b>NORDITROPIN</b>	<b>BRAND ONLY</b>	PREFERRED DRUG	PA REQUIRED			
<b>SOMATROPIN SOLUTION</b>	<b>GENOTROPIN</b>	<b>BRAND ONLY</b>	PREFERRED DRUG	PA REQUIRED			
<b>HORMONE RECEPTOR MODULATORS</b>							
RALOXIFENE HCL TABLETS	EVISTA						
<b>INSULIN-LIKE GROWTH FACTORS (SOMATOMEDINS)</b>							
MECASERMIN SOLUTION	INCRELEX			PA REQUIRED			
<b>LHRH/GNRH AGONIST ANALOG PITUITARY SUPPRESSANTS</b>							
LEUPROLIDE ACETATE (CPP) (3 MONTH) KIT	LUPRON DEPOT-PED			PA REQUIRED			
LEUPROLIDE ACETATE (CPP) KIT	LUPRON DEPOT-PED			PA REQUIRED			
<b>METABOLIC MODIFIERS</b>							
CINACALCET HCL TABLETS	SENSIPAR			PA REQUIRED			
IDURSULFASE SOLUTION	ELAPRASE			PA REQUIRED			
<b>POSTERIOR PITUITARY HORMONES</b>							
DESMOPRESSIN ACETATE REFRIGERATED SOLUTION	VARIOUS						
DESMOPRESSIN ACETATE SOLUTION	VARIOUS						
DESMOPRESSIN ACETATE SPRAY REFRIGERATED SOLUTION	VARIOUS						
DESMOPRESSIN ACETATE SPRAY SOLUTION	VARIOUS						
DESMOPRESSIN ACETATE TABLETS	VARIOUS			PA REQUIRED			
<b>ESTROGENS</b>							
<b>ESTROGEN COMBINATIONS</b>							
CONJUGATED ESTROGENS-MEDROXYPROGESTERONE ACETATE TABLETS	PREMPRO						
ESTRADIOL-LEVONORGESTREL PATCH-WEEKLY	CLIMARA PATCH						
<b>ESTROGENS</b>							

AHCCCS ACUTE - LONG TERM CARE DRUG LIST

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	PA Status	Step Therapy Requirements	Quantity Limit (QL)	QL Days
ESTERIFIED ESTROGENS TABLETS	MENEST						
ESTRADIOL PATCH-TWICE WEEKLY	ALORA						
ESTRADIOL PATCH-WEEKLY	MENOSTAR						
ESTRADIOL TABLETS	ESTRACE						
ESTROGENS, CONJUGATED SYNTHETIC A TABLETS	CENESTIN						
ESTROGENS, CONJUGATED TABLETS	PREMARIN						
ESTROPIPATE TABLETS	ORTHO-EST						
<b>FLUOROQUINOLONES</b>							
<b>FLUOROQUINOLONES</b>							
CIPROFLOXACIN HCL TABLETS	CIPROFLOXACIN HCL						
LEVOFLOXACIN SOLUTION	LEVAQUIN						
LEVOFLOXACIN TABLETS	LEVAQUIN						
OFLOXACIN TABLETS	OFLOXACIN						
<b>GASTROINTESTINAL AGENTS - MISC.</b>							
<b>GALLSTONE SOLUBILIZING AGENTS</b>							
URSODIOL CAPSULES	ACTIGALL						
URSODIOL TABLETS	URSO 250						
<b>GASTROINTESTINAL CHLORIDE CHANNEL ACTIVATORS</b>							
LUBIPROSTONE CAPSULES	AMITIZA			PA REQUIRED			
<b>GASTROINTESTINAL STIMULANTS</b>							
METOCLOPRAMIDE HCL SOLUTION	VARIOUS						
METOCLOPRAMIDE HCL TABLETS	VARIOUS						
METOCLOPRAMIDE HCL ORALLY DISINTEGRATING TABLETS	VARIOUS						
<b>INFLAMMATORY BOWEL AGENTS</b>							
BALSALAZIDE DISODIUM TABLETS	GIAZO		PREFERRED DRUG			270	30
<b>INFLIXIMAB</b>	<b>INFLIXIMAB</b>	<b>JANSSEN PRODUCT ONLY</b>	<b>PREFERRED DRUG</b>	<b>PA REQUIRED</b>			
BUDESONIDE CAPSULES	ENTOCORT EC		PREFERRED DRUG				
MESALAMINE CAPSULE CONTROLLED RELEASE	PENTASA	BRAND ONLY	PREFERRED DRUG			270	30
<b>MESALAMINE CAPSULE DELAYED RELEASE CAPSULE</b>	<b>DELZICOL</b>		<b>PREFERRED DRUG</b>			<b>180</b>	<b>30</b>
MESALAMINE CAPSULE DELAYED RELEASE TABLET	ASACOL HD		PREFERRED DRUG			180	30
MESALAMINE CAPSULE 24-HOUR	APRISO	BRAND ONLY	PREFERRED DRUG			120	30
MESALAMINE ENEMA	SFROWASA	BRAND ONLY	PREFERRED DRUG			30	30
MESALAMINE TABLET ENTERIC COATED	VARIOUS		PREFERRED DRUG			120	30
MESALAMINE SUPPOSITORY	CANASA	BRAND ONLY	PREFERRED DRUG			30	30
SULFASALAZINE TABLETS	AZULFIDINE		PREFERRED DRUG			240	30
SULFASALAZINE TABLET ENTERIC COATED	AZULFIDINE EN-TABLETS		PREFERRED DRUG			240	30
<b>IRRITABLE BOWEL SYNDROME (IBS) AGENTS</b>							
LINACLOTIDE CAPSULES	LINZESS			PA REQUIRED			
<b>PHOSPHATE BINDER AGENTS</b>							
CALCIUM ACETATE TABLETS	VARIOUS		PREFERRED DRUG				
CALCIUM ACETATE CAPSULES	VARIOUS		PREFERRED DRUG				
SEVELAMER CARBONATE TABLETS	REVELA	VARIOUS	PREFERRED DRUG				
<b>GENITOURINARY AGENTS - MISC.</b>							
<b>INTERSTITIAL CYSTITIS AGENTS</b>							
PENTOSAN POLYSULFATE SODIUM CAPSULES	ELMIRON			PA REQUIRED			
<b>PROSTATIC HYPERTROPHY AGENTS</b>							
ALFUZOSIN ER	VARIOUS		Preferred Drug				
DOXAZOSIN MESYLATE	VARIOUS		Preferred Drug				
DUTASTERIDE	VARIOUS		Preferred Drug				
FINASTERIDE	PROSCAR		Preferred Drug				

AHCCCS ACUTE - LONG TERM CARE DRUG LIST

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	PA Status	Step Therapy Requirements	Quantity Limit (QL)	QL Days
TAMSULOSIN HCL	FLOMAX		Preferred Drug				
TERAZOSIN	VARIOUS		Preferred Drug				
<b>URINARY ANALGESICS</b>							
PHENAZOPYRIDINE HCL TABLETS	PYRIDIUM						
<b>GOUT AGENTS</b>							
<b>GOUT AGENTS</b>							
ALLOPURINOL TABLETS	ZYLOPRIM						
COLCHICINE TABLETS	VARIOUS						
FEBUXOSTAT TABLETS	ULORIC			PA REQUIRED			
<b>URICOSURICS</b>							
PROBENECID TABLETS	PROBENECID						
<b>HEMATOLOGICAL AGENTS - MISC.</b>							
<b>PLATELET AGGREGATION INHIBITORS</b>							
CILOSTAZOL TABLETS	PLETAL						
CLOPIDOGREL BISULFATE TABLETS	PLAVIX						
DIPYRIDAMOLE TABLETS	PERSANTINE						
TICAGRELOR TABLETS	BRILINTA			PA REQUIRED			
<b>HEMATOPOIETIC AGENTS</b>							
<b>AGENTS FOR GAUCHER DISEASE</b>							
ELIGLUSTAT TARTRATE	CERDELGA (oral)	BRAND ONLY		PA REQUIRED			
IMIGLUCERASE SOLUTION	CEREZYME 400 IU (IV)	BRAND ONLY		PA REQUIRED			
TALIGLUCERASE ALFA	ELELYSO (IV)	BRAND ONLY		PA REQUIRED			
MIGLUSTAT	MIGLUSTAT (oral)	BRAND ONLY		PA REQUIRED			
VELAGLUCERASE ALFA	VPRIV 400 IU	BRAND ONLY		PA REQUIRED			
<b>HEMATOPOIETIC GROWTH FACTORS</b>							
ELTROMBOPAG OLAMINE TABLET	PROMACTA	Brand Only	Preferred Drug	PA Required			
EPOETIN ALFA SOLUTION	EPOGEN	Brand Only	Preferred Drug	PA Required			
EPOETIN ALFA-EPBX SOLUTION	RETACRIT	Brand Only	Preferred Drug	PA Required			
FILGRASTIM SOLUTION	NEUPOGEN	Brand Only	Preferred Drug	PA Required			
FILGRASTIM SOLN PREF SYR	NEUPOGEN	Brand Only	Preferred Drug	PA Required			
FILGRASTIM-AAFI SOLUTION	NIVESTYM	Brand Only	Preferred Drug	PA Required			
FILGRASTIM-AAFI SOLN PREF SYR	NIVESTYM	Brand Only	Preferred Drug	PA Required			
PEGFILGRASTIM-APGF SOLN PREF SYR	NYVEPRIA	Brand Only	Preferred Drug	PA Required			
PEGFILGRASTIM-BMEZ SOLN PREF SYR	ZIEXTENZO	Brand Only	Preferred Drug	PA Required			
PEGFILGRASTIM-CBQV SOLN AUTO-INJ	UDENYCA	Brand Only	Preferred Drug	PA Required			
PEGFILGRASTIM-PBBK SOLN PREF SYR	FYLNETRA	Brand Only	Preferred Drug	PA Required			
ROMIPLOSTIM SOLUTION RECONSTITUTED	NPLATE	Brand Only	Preferred Drug	PA Required			
<b>HEMOSTATICS</b>							
<b>HEMOSTATICS - SYSTEMIC</b>							
AMINOCAPROIC ACID SYRUP	AMICAR						
AMINOCAPROIC ACID TABLETS	AMICAR						
<b>HEREDITARY ANGIOEDEMA AGENTS</b>							
ICATIBANT ACETATE SOLUTION	VARIOUS		PREFERRED DRUG	PA REQUIRED			
C1 ESTERASE INHIBITOR (HUMAN) SOLUTION	BERINERT	BRAND ONLY	PREFERRED DRUG	PA REQUIRED			
C1 ESTERASE INHIBITOR (HUMAN) SOLUTION	CINRYZE	BRAND ONLY	PREFERRED DRUG	PA REQUIRED			
C1 ESTERASE INHIBITOR (HUMAN) SOLUTION	HAEGARDA	BRAND ONLY	PREFERRED DRUG	PA REQUIRED			
ECALLANTIDE SOLUTION	KALBITOR		PREFERRED DRUG	PA REQUIRED			
<b>HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENT</b>							
<b>BARBITURATE HYPNOTICS</b>							
PHENOBARBITAL SOLUTION	PHENOBARBITAL						
PHENOBARBITAL TABLETS	PHENOBARBITAL						



AHCCCS ACUTE - LONG TERM CARE DRUG LIST

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	PA Status	Step Therapy Requirements	Quantity Limit (QL)	QL Days
<b>MIGRAINE COMBINATIONS</b>							
ERGOTAMINE W/ CAFFEINE TABLETS	CAFERGOT					40	30
<b>MIGRAINE PRODUCTS - MONOCLONAL ANTIBODIES</b>							
DIHYDROERGOTAMINE MESYLATE SOLUTION	MIGRANAL					2	30
<b>CALCITONIN GENE-RELATED PEPTIDE (CGRP) RECEPTOR ANTAGONIST</b>							
ERENUMAB-AOOE SOLN AUTO-INJ	AMOVIG		Preferred Drug	PA Required		1	30
GALCANEZUMAB-GNLM SOLUTION AUTOINJECTOR / PREFILLED SYRINGE / PEN	EMGALITY		PREFERRED DRUG	PA REQUIRED		1	30
UBROGEPANT TABLETS	UBRELVY		PREFERRED DRUG	PA REQUIRED		10	30
<b>SEROTONIN AGONISTS</b>							
NARATRIPTAN HCL TABLETS	AMERGE		PREFERRED DRUG			9	30
RIZATRIPTAN BENZOATE ORALLY DISPERSABLE TABLET	MAXALT-MLT		PREFERRED DRUG			9	30
RIZATRIPTAN BENZOATE TABLETS	MAXALT		PREFERRED DRUG			9	30
SUMATRIPTAN NASAL SPRAY	VARIOUS		PREFERRED DRUG			6	30
SUMATRIPTAN SUCCINATE SUBCUTANEOUS SOLUTION AUTO INJECTION	IMITREX		PREFERRED DRUG			2	30
SUMATRIPTAN SUCCINATE SUBCUTANEOUS SOLUTION CARTRIDGE	IMITREX		PREFERRED DRUG			2	30
SUMATRIPTAN SUCCINATE TABLETS	IMITREX		PREFERRED DRUG			9	30
ZOLMITRIPTAN NASAL SPRAY	ZOMIG	BRAND ONLY	PREFERRED DRUG			6	30
ZOLMITRIPTAN SOLUTION	ZOMIG NASAL SPRAY	Brand Only	Preferred Drug			6	30
ZOLMITRIPTAN ORALLY DISPERSABLE TABLET	ZOMIG ZMT		PREFERRED DRUG			9	30
ZOLMITRIPTAN TABLETS	ZOMIG		PREFERRED DRUG			9	30
<b>MINERALS &amp; ELECTROLYTES</b>							
SODIUM FLUORIDE CHEWABLE TABLETS	LUDENT						
SODIUM FLUORIDE LOZG	LOZI-FLUR						
SODIUM FLUORIDE SOLUTION	FLUOR-A-DAY						
SODIUM FLUORIDE TABLETS	SODIUM FLUORIDE						
<b>MOUTH/THROAT/DENTAL AGENTS</b>							
<b>ANTI-INFECTIVES - THROAT</b>							
CLOTRIMAZOLE TROC	CLOTRIMAZOLE						
<b>STEROIDS - MOUTH/THROAT</b>							
TRIAMCINOLONE ACETONIDE ORAL PASTE	ORALONE						
<b>MULTIVITAMINS</b>							
<b>PRENATAL VITAMINS</b>							
PRENATAL MULTIVITAMINS WITH OR WITHOUT MINERALS W/ FOLATE	VARIOUS						
PRENATAL MULTIVITAMINES WITH MINERAL W/FE-FA	VARIOUS						
<b>MUSCULOSKELETAL THERAPY AGENTS</b>							
<b>CENTRAL MUSCLE RELAXANTS</b>							
BACLOFEN TABLET (5MG, 10MG, 20MG)	BACLOFEN						
CYCLOBENZAPRINE HCL TABLETS 5MG & 10MG	FLEXERIL			PA REQUIRED for dosages other than 5mg and 10mg tablets			
METHOCARBAMOL TABLETS	ROBAXIN						
TIZANIDINE HCL TABLETS - 2MG & 4MG ONLY	TIZANIDINE HCL						
<b>DIRECT MUSCLE RELAXANTS</b>							
DANTROLENE SODIUM CAPSULES	DANTRIUM						
<b>NASAL AGENTS - SYSTEMIC AND TOPICAL</b>							
<b>NASAL ANTIALLERGY</b>							
AZELASTINE HCL SOLUTION 0.10%	ASTELIN						
<b>NASAL ANTICHOLINERGICS</b>							
IPRATROPIUM BROMIDE SOLUTION	ATROVENT						

AHCCCS ACUTE - LONG TERM CARE DRUG LIST

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	PA Status	Step Therapy Requirements	Quantity Limit (QL)	QL Days
<b>NASAL STEROIDS</b>							
FLUNISOLIDE SOLUTION	FLUNISOLIDE						
FLUTICASONE PROPIONATE SUSPENSION	FLONASE						
TRIAMCINOLONE ACETONIDE	NASACORT AQ						
<b>SYMPATHOMIMETIC DECONGESTANTS</b>							
PSEUDOEPHEDRINE HCL LIQUID	SUDAFED CHILDRENS						
PSEUDOEPHEDRINE HCL SYRUP	PSEUDOEPHEDRINE						
PSEUDOEPHEDRINE HCL TABLETS	SUDAFED						
PSEUDOEPHEDRINE HCL TABLET 12-HOUR	NASAL DECONGESTANT						
PSEUDOEPHEDRINE HCL TABLET 24-HOUR	SUDAFED 24 HOUR						
<b>NEUROMUSCULAR AGENTS*</b>							
<b>FRIEDRICH'S ATAXIA AGENTS**</b>							
OMAVELOXOLONE CAPSULE	SKYCLARYS			PA Required			
<b>OPHTHALMIC AGENTS</b>							
<b>OPHTHALMIC - BETA-BLOCKERS</b>							
BETAXOLOL HCL SOLUTION	BETAXOLOL HCL						
BETAXOLOL HCL SUSPENSION	BETOPTIC-S						
CARTEOLOL HCL SOLUTION	CARTEOLOL HCL						
DORZOLAMIDE HCL-TIMOLOL MALEATE SOLUTION	COSOPT						
LEVOBUNOLOL HCL SOLUTION	LEVOBUNOLOL HCL						
METIPRANOLOL SOLUTION	METIPRANOLOL						
TIMOLOL MALEATE SOLUTION	TIMOPTIC-XE						
TIMOLOL MALEATE SOLUTION	TIMOPTIC						
<b>OPHTHALMIC - CYCLOPLEGIC MYDRIATICS</b>							
ATROPINE SULFATE OINTMENT	ATROPINE SULFATE						
ATROPINE SULFATE SOLUTION	ISOPTO ATROPINE						
CYCLOPENTOLATE HCL SOLUTION	CYCLOGYL						
HOMATROPINE HBR SOLUTION	ISOPTO HOMATROPINE						
<b>OPHTHALMIC - MIOTICS</b>							
PILOCARPINE HCL GEL	PILOPINE HS						
PILOCARPINE HCL SOLUTION	ISOPTO CARPINE						
<b>OPHTHALMIC - ANTI-INFECTIVES</b>							
BACITRACIN OINTMENT	BACITRACIN					3.5GM	7
BACITRACIN-POLYMYXIN B OINTMENT	POLYCIN						
CIPROFLOXACIN HCL OINTMENT	CILOXAN						
CIPROFLOXACIN HCL SOLUTION	CILOXAN						
ERYTHROMYCIN OINTMENT	ILOTYCIN						
GENTAMICIN SULFATE OINTMENT	GARAMYCIN						
GENTAMICIN SULFATE SOLUTION	GARAMYCIN						
MOXIFLOXACIN HCL SOLUTION	VIGAMOX						
NATAMYCIN SUSPENSION	NATACYN						
NEOMYCIN-BACITRACIN ZN-POLYMYXIN OINTMENT	NEO-POLYCIN						
NEOMYCIN-POLYMYXIN-GRAMICIDIN SOLUTION	NEOSPORIN						
OFLOXACIN SOLUTION	OCUFLOX						
POLYMYXIN B-TRIMETHOPRIM SOLUTION	POLYTRIM						
SULFACETAMIDE SODIUM OINTMENT	SULFACETAMIDE SODIUM						
SULFACETAMIDE SODIUM SOLUTION	BLEPH-10						
TOBRAMYCIN OINTMENT	TOBREX					3.5GM	7
TOBRAMYCIN SOLUTION	TOBREX						
TRIFLURIDINE SOLUTION	VIROPTIC						
<b>OPHTHALMIC - DECONGESTANTS</b>							

AHCCCS ACUTE - LONG TERM CARE DRUG LIST

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	PA Status	Step Therapy Requirements	Quantity Limit (QL)	QL Days
NAPHAZOLINE HCL SOLUTION	VASOCLEAR						
NAPHAZOLINE W/ PHENIRAMINE SOLUTION	NAPHCON-A						
<b>OPHTHALMIC - IMMUNOMODULATORS</b>							
CYCLOSPORINE EMULSION	RESTASIS			PA REQUIRED			
<b>OPHTHALMIC INTEGRIN ANTAGONISTS**</b>							
LIFITEGRAST SOLUTION	XIIDRA			PA Required			
<b>OPHTHALMIC - MISCELLANEOUS TOPICALS</b>							
EYELID CLEANSERS FOAM	OCUSOFT						
EYELID CLEANSERS PAD	OCUSOFT						
TEA TREE OIL	VARIOUS						
<b>OPHTHALMIC - STEROIDS</b>							
BACITRACIN-POLY-NEOMYCIN-HC OINTMENT	NEO-POLYCIN HC						
DEXAMETHASONE SUSPENSION	MAXIDEX						
DEXAMETHASONE SODIUM PHOSPHATE SOLUTION	DEXAMETHASONE SODIUM PHOSPHATE						
FLUOROMETHOLONE OINTMENT	FML						
FLUOROMETHOLONE SUSPENSION	FML LIQUIFILM						
GENTAMICIN-PREDNISOLONE ACETATE OINTMENT	PRED-G S.O.P.						
GENTAMICIN-PREDNISOLONE ACETATE SUSPENSION	PRED-G						
NEOMYCIN-POLYMY-DEXAMETH OINTMENT	MAXITROL						
NEOMYCIN-POLYMY-DEXAMETH SUSPENSION	MAXITROL						
PREDNISOLONE ACETATE SUSPENSION	PRED MILD						
PREDNISOLONE SODIUM PHOSPHATE SOLUTION	PREDNISOLONE SODIUM PHOSPHATE						
SULFACETAMIDE SOD-PREDNISOLONE OINTMENT	BLEPHAMIDE S.O.P.						
SULFACETAMIDE SOD-PREDNISOLONE SOLUTION	SULFACETAMIDE SODIUM/PREDNISOLONE SODIUM PHOSPHATE						
SULFACETAMIDE SOD-PREDNISOLONE SUSPENSION	BLEPHAMIDE						
TOBRAMYCIN-DEXAMETHASONE OINTMENT	TOBRADEX						
TOBRAMYCIN-DEXAMETHASONE SUSPENSION	TOBRADEX ST						
<b>OPHTHALMICS - MISC.</b>							
BRINZOLAMIDE SUSPENSION	AZOPT			PA REQUIRED			
CROMOLYN SODIUM SOLUTION	CROMOLYN SODIUM						
DICLOFENAC SODIUM SOLUTION	DICLOFENAC SODIUM						
DORZOLAMIDE HCL SOLUTION	TRUSOPT						
FLURBIPROFEN SODIUM SOLUTION	OCUFEN						
KETOROLAC TROMETHAMINE SOLUTION	ACULAR LS						
KETOTIFEN FUMARATE SOLUTION	ALAWAY						
<b>OPHTHALMIC - PROSTAGLANDINS</b>							
LATANOPROST SOLUTION	XALATAN					2.5	30
TAFLUPROST SOLUTION	ZIOPTAN			PA REQUIRED			
TRAVOPROST SOLUTION	TRAVATAN Z			PA REQUIRED			
<b>OTIC AGENTS</b>							
<b>OTIC AGENTS - MISCELLANEOUS</b>							
ACETIC ACID SOLUTION	ACETIC ACID						
<b>OTIC ANTI-INFECTIVES</b>							
CIPROFLOXACIN SOLUTION	VARIOUS						
OFLOXACIN (OTIC) SOLUTION	VARIOUS						
<b>OTIC COMBINATIONS</b>							
ANTIPYRINE-BENZOCAINE SOLUTION	AURODEX						
ANTIPYRINE-BENZOCAINE-POLYCOSANOL SOLUTION	OTIC CARE						



AHCCCS ACUTE - LONG TERM CARE DRUG LIST

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	PA Status	Step Therapy Requirements	Quantity Limit (QL)	QL Days
CIPROFLOXACIN-DEXAMETHASONE	VARIOUS		PREFERRED DRUG				
CIPROFLOXACIN /HYDROCORTISONE	CIPRO HC	BRAND ONLY	PREFERRED DRUG				
NEOMYCIN-POLYMYXIN-HC SOLUTION	CORTISPORIN		PREFERRED DRUG				
NEOMYCIN-POLYMYXIN-HC SUSPENSION	NEO/POLYMYXIN/HC 5-10000-1		PREFERRED DRUG				
<b>OTIC STEROIDS</b>							
HYDROCORTISONE W/ACETIC ACID SOLUTION	ACETASOL HC						
<b>OXYTOCICS</b>							
<b>OXYTOCICS</b>							
METHYLERGONOVINE MALEATE TABLETS	METHERGINE						
<b>PASSIVE IMMUNIZING AGENTS</b>							
<b>MONOCLONAL ANTIBODIES</b>							
PALIVIZUMAB SOLUTION	SYNAGIS			PA is not Required for children under the age of 2 years. Note: the prescriber must buy and bill a medical claim for the drug			
<b>PENICILLINS</b>							
<b>AMINOPENICILLINS</b>							
AMOXICILLIN CAPSULES	AMOXICILLIN						
AMOXICILLIN CHEWABLE TABLETS	AMOXICILLIN						
AMOXICILLIN SUSPENSION	AMOXICILLIN						
AMOXICILLIN TABLETS	AMOXICILLIN						
AMPICILLIN CAPSULES	AMPICILLIN						
AMPICILLIN SUSPENSION	AMPICILLIN						
<b>NATURAL PENICILLINS</b>							
PENICILLIN V POTASSIUM SOLUTION	PENICILLIN V POTASSIUM						
PENICILLIN V POTASSIUM TABLETS	PENICILLIN V POTASSIUM						
<b>PENICILLIN COMBINATIONS</b>							
AMOXICILLIN & POT CLAVULANATE CHEWABLE TABLETS	AUGMENTIN						
AMOXICILLIN & POT CLAVULANATE SUSPENSION	AUGMENTIN						
AMOXICILLIN & POT CLAVULANATE TABLET 12-HOUR	AUGMENTIN XR						
<b>PENICILLINASE-RESISTANT PENICILLINS</b>							
DICLOXACILLIN SODIUM CAPSULES	DICLOXACILLIN SODIUM						
<b>PROGESTINS</b>							
<b>PROGESTINS</b>							
MEDROXYPROGESTERONE ACETATE TABLETS	PROVERA						
PROGESTERONE MICRONIZED CAPSULES	PROMETRIUM						
<b>PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENT</b>							
<b>ANTIDEMENTIA AGENTS</b>							
DONEPEZIL HYDROCHLORIDE TABLETS	ARICEPT			PA REQUIRED			
DONEPEZIL HYDROCHLORIDE ORALLY DISINTEGRATING TABLETS	ARICEPT ODT			PA REQUIRED			
GALANTAMINE HYDROBROMIDE CAPSULE CONTROLLED RELEASE	RAZADYNE ER			PA REQUIRED			
GALANTAMINE HYDROBROMIDE SOLUTION	RAZADYNE			PA REQUIRED			
GALANTAMINE HYDROBROMIDE TABLETS	RAZADYNE			PA REQUIRED			
MEMANTINE HCL SOLUTION	NAMENDA			PA REQUIRED			
MEMANTINE HCL TABLETS	NAMENDA			PA REQUIRED			
RIVASTIGMINE PATCH	EXELON			PA REQUIRED			
RIVASTIGMINE TARTRATE CAPSULES	EXELON			PA REQUIRED			
RIVASTIGMINE TARTRATE SOLUTION	EXELON			PA REQUIRED			
<b>MOVEMENT DISORDERS</b>							
DEUTETRABENAZINE TABLET	AUSTEDO			PA REQUIRED		60	30
DEUTETRABENAZINE TAB THERAPY PACK	AUSTEDO PATIENT TITRATION KIT			PA REQUIRED		1 kit	28
DEUTETRABENAZINE TABLET ER 24HR	AUSTEDO XR			PA REQUIRED		30	30

AHCCCS ACUTE - LONG TERM CARE DRUG LIST

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	PA Status	Step Therapy Requirements	Quantity Limit (QL)	QL Days
DEUTETRABENAZINE TBER THERAPY PACK	AUSTEDO XR PATIENT TITRATION KIT			PA REQUIRED		1 kit	28
VALBENAZINE TOSYLATE CAPSULE	INGREZZA			PA REQUIRED		30	30
VALBENAZINE TOSYLATE CAPSULE SPRINKLE	INGREZZA			PA Required		30	30
VALBENAZINE TOSYLATE CAP THER PACK	INGREZZA			PA Required		1 kit	28
<b>MULTIPLE SCLEROSIS AGENTS</b>							
DIMETHYL FUMARATE CAPSULE DELAYED RELEASE	TECFIDERA			PA REQUIRED			
DALFAMPRIDINE TABLET ER 12HR	AMPYRA			PA REQUIRED			
FINGOLIMOD HCL CAPSULE	GILENYA			PA REQUIRED			
GLATIRAMER ACETATE SOLN PREF SYR	COPAXONE	BRAND ONLY		PA REQUIRED			
INTERFERON BETA-1A AUTO-INJECTOR KIT	AVONEX PEN			PA REQUIRED			
INTERFERON BETA-1A PREFILLED SYRINGE KIT	AVONEX			PA REQUIRED			
INTERFERON BETA-1A SOLN AUTO-INJ	REBIF REBIDOSE			PA REQUIRED			
INTERFERON BETA-1A SOLN PREF SYR	REBIF			PA REQUIRED			
NATALIZUMAB CONCENTRATE	TYSABRI			PA REQUIRED			
OCRELIZUMAB SOLUTION	OCREVUS			PA REQUIRED			
OFATUMUMAB (MS) SOLN AUTO-INJ	KESIMPTA			PA REQUIRED			
TERIFLUNOMIDE TABLET	AUBAGIO			PA REQUIRED			
FINGOLIMOD HCL CAPSULES	GILENYA			PA REQUIRED			
INTERFERON BETA-1A KIT	AVONEX			PA REQUIRED			
<b>SMOKING DETERRENTS</b>							
BUPROPION HCL (SMOKING DETERRENT) TABLET 12-HOUR	BUPROBAN					84-day supply	180
NICOTINE INHA	NICOTROL INHALER					84-day supply	180
NICOTINE POLACRILEX GUM	NICORETTE GUM					84-day supply	180
NICOTINE POLACRILEX LOZENGE	COMMIT					84-day supply	180
NICOTINE PATCH	NICODERM CQ					84-day supply	180
NICOTINE SOLUTION	NICOTROL NS					84-day supply	180
VARENICLINE TARTRATE TABLETS	CHANTIX					84-day supply	180
<b>RESPIRATORY AGENTS - MISC.</b>							
<b>ALPHA-PROTEINASE INHIBITOR (HUMAN)</b>							
ALPHA1-PROTEINASE INHIBITOR (HUMAN) SOLUTION	ARALAST NP			PA REQUIRED			
ALPHA1-PROTEINASE INHIBITOR (HUMAN) SOLUTION	PROLASTIN-C			PA REQUIRED			
<b>CYSTIC FIBROSIS AGENTS</b>							
DORNASE ALFA SOLUTION	PULMOZYME			PA REQUIRED			
<b>PULMONARY FIBROSIS AGENTS</b>							
PIRFENIDONE 267MG, 801MG	ESBRIET	Brand Only					
<b>SULFONAMIDES</b>							
<b>SULFONAMIDES</b>							
SULFADIAZINE TABLETS	SULFADIAZINE						
<b>TETRACYCLINES</b>							
<b>TETRACYCLINES</b>							
DEMECLOCYCLINE HCL TABLETS	DEMECLOCYCLINE HCL			PA REQUIRED			
DOXYCYCLINE HYCLATE CAPSULES - 50MG AND 100MG CAPSULES ONLY	VARIOUS						
DOXYCYCLINE HYCLATE TABLETS - 20MG AND 100MG TABLETS ONLY	VARIOUS						
DOXYCYCLINE MONOHYDRATE - CAPSULES 50MG & 100MG ONLY	VARIOUS						

AHCCCS ACUTE - LONG TERM CARE DRUG LIST

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	PA Status	Step Therapy Requirements	Quantity Limit (QL)	QL Days
MINOCYCLINE HCL - 50MG, 75MG & 100MG CAPSULES ONLY	MINOCIN						
<b>THYROID AGENTS</b>							
<b>ANTITHYROID AGENTS</b>							
METHIMAZOLE TABLETS	TAPAZOLE						
PROPYLTHIOURACIL TABLETS	PROPYLTHIOURACIL						
<b>THYROID HORMONES</b>							
LEVOthyroxine Sodium Tablets	LEVO-T						
LIOTHYRONINE SODIUM TABLETS	CYTOMEL						
THYROID TABLETS	ARMOUR THYROID						
<b>ULCER DRUGS</b>							
<b>ANTISPASMODICS</b>							
DICYCLOMINE HCL CAPSULES	VARIOUS						
DICYCLOMINE HCL SOLUTION	VARIOUS						
DICYCLOMINE HCL TABLETS	VARIOUS						
GLYCOPYRROLATE SOLUTION	VARIOUS						
GLYCOPYRROLATE TABLETS	VARIOUS						
HYOSCYAMINE SULFATE ELIXIR	VARIOUS						
HYOSCYAMINE SULFATE SOLUTION	VARIOUS						
HYOSCYAMINE SULFATE SUBLINGUAL	VARIOUS						
HYOSCYAMINE SULFATE TABLETS	VARIOUS						
HYOSCYAMINE SULFATE TABLET 12-HOUR	VARIOUS						
HYOSCYAMINE SULFATE CONTROLLED RELEASE TABLET	VARIOUS						
HYOSCYAMINE SULFATE ORALLY DISINTEGRATING TABLETS	VARIOUS						
PROPANTHELINE BROMIDE TABLETS	VARIOUS						
<b>H-2 ANTAGONISTS</b>							
FAMOTIDINE CHEWABLE TABLETS	PEPCID AC						
FAMOTIDINE SUSPENSION	PEPCID						
FAMOTIDINE TABLETS	PEPCID AC						
RANITIDINE HCL CAPSULES	RANITIDINE HCL						
RANITIDINE HCL SUSPENSION	DEPRIZINE FUSEPAQ						
RANITIDINE HCL SYRUP	ZANTAC						
RANITIDINE HCL TABLETS	ZANTAC 75						
<b>ANTI-ULCER - MISC.</b>							
SUCRALFATE TABLETS	CARAFATE						
<b>PROTON PUMP INHIBITORS</b>							
ESOMEPRAZOLE MAGNESIUM PACKETS	NEXIUM		PREFERRED DRUG	PA REQUIRED for > 18 Years of Age		30	30
LANSOPRAZOLE ORALLY DISPERSABLE TABLET (ODT)	PREVACID SOLUTAB		PREFERRED DRUG	PA REQUIRED for > 18 Years of Age		60	30
OMEPRAZOLE ORAL CAPSULES	VARIOUS		PREFERRED DRUG			60	30
PANTOPRAZOLE SODIUM PACKETS	PROTONIX		PREFERRED DRUG	PA REQUIRED for > 18 Years of Age		30	30
PANTOPRAZOLE TABLETS	PROTONIX		PREFERRED DRUG			30	30
<b>URINARY ANTISPASMODICS</b>							
<b>URINARY ANTISPASMODIC - ANTIMUSCARINICS (ANTICHOLI)</b>							
FESOTERODINE FUMARATE	TOVIAZ	BRAND ONLY	PREFERRED DRUG				
OXYBUTYNIN CHLORIDE SYRUP	VARIOUS		PREFERRED DRUG				
OXYBUTYNIN CHLORIDE 5MG TABLETS	VARIOUS		PREFERRED DRUG				
OXYBUTYNIN CHLORIDE TABLET 24-HOUR	DITROPAN XL		PREFERRED DRUG				
TOLTERODINE TARTRATE CAPSULE CONTROLLED RELEASE	DETROL LA	BRAND ONLY	PREFERRED DRUG				
TOLTERODINE TARTRATE TABLETS	DETROL	BRAND ONLY	PREFERRED DRUG				
<b>VAGINAL PRODUCTS</b>							
<b>SPERMICIDES</b>							

AHCCCS ACUTE - LONG TERM CARE DRUG LIST

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	PA Status	Step Therapy Requirements	Quantity Limit (QL)	QL Days
NONOXYNOL-9 FOAM	VCF VAGINAL CONTRACEPTIVE FOAM						
NONOXYNOL-9 GEL	SHUR-SEAL						
<b>VAGINAL ANTI-INFECTIVES</b>							
CLINDAMYCIN PHOSPHATE VAGINAL CREAM	CLEOCIN						
CLINDAMYCIN PHOSPHATE VAGINAL SUPPOSITORY	CLEOCIN						
CLOTRIMAZOLE VAGINAL CREAM	GYNE-LOTRIMIN						
METRONIDAZOLE VAGINAL GEL	METROGEL-VAGINAL						
MICONAZOLE NITRATE VAGINAL	MONISTAT 3 COMBINATION PACKETS						
MICONAZOLE NITRATE VAGINAL SUPPOSITORY	MICONAZOLE 3						
SULFANILAMIDE VAGINAL CREAM	AVC						
<b>VAGINAL ESTROGENS</b>							
ESTRADIOL ACETATE VAGINAL RING	FEMRING			PA REQUIRED			
ESTRADIOL VAGINAL RING	ESTRING						
ESTRADIOL VAGINAL TABLETS	VAGIFEM						
ESTRADIOL VAGINAL CREAM 0.01%	ESTRACE CREAM						
ESTROGENS, CONJUGATED VAGINAL CREAM	PREMARIN VAGINAL CREAM			PA REQUIRED			
<b>VASOPRESSORS</b>							
<b>ANAPHYLAXIS THERAPY AGENTS</b>							
EPINEPHRINE SELF-INJECTABLE 0.15MG AND 0.30MG	EPINEPHRINE SELF-INJECTABLE (By Mylan)	Mylan Generic	PREFERRED DRUG	PA REQUIRED for > 2 Per Month		2	30
COVID AT-HOME TEST KITS							
COVID AT-HOME TEST KITS		VARIOUS				2 TESTS	30