

**Texas Association of Counties HDHP Formulary
Category/Class**

Last Updated* 11/1/2018

DrugName	Special Code	Tier
ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS		
AMPHETAMINES		
amphetamine/dextroamphetamine tab (ADDERALL equiv)	-	1
dextroamphetamine tab (DEXEDRINE equiv)	-	1
amphetamine/dextroamphetamine ER cap (ADDERALL XR equiv)	-	2
dextroamphetamine ER cap (DEXEDRINE equiv)	-	2
VYVANSE CAP	-	2
VYVANSE CHEW TAB	-	2
ADDERALL XR CAP	-	3
dextroamphetamine soln (PROCENTRA equiv)	-	3
ADZENYS XR TAB	-	NC
amphetamine tab (EVEKEO equiv)	-	NC
DYANAVEL XR SUSP, ADZENYS ER SUSP	-	NC
EVEKEO TAB	-	NC
methamphetamine tab (DESOXYN equiv)	-	NC
MYDAYIS CAP	-	NC
ZENZEDI TAB	-	NC
zenzedi tab 5mg (DEXEDRINE equiv)	-	NC
ANALECTICS		
caffeine citrate soln (CAFCIT equiv) (Only covered for members less than 1 year old)	-	2
CAFCIT INJ	-	NC
ANOREXIANTS NON-AMPHETAMINE		
LOMAIRA TAB	-	NC
ANTI-OBESITY AGENTS		
BELVIQ XR TAB	-	NC
ATTENTION-DEFICIT/HYPERACTIVITY DISORDER (ADHD) AGENTS		
guanfacine ER tab (INTUNIV equiv)	-	1
atomoxetine cap (STRATTERA CAP equiv)	-	3
clonidine ER tab (KAPVAY equiv)	-	NC
KAPVAY TAB	-	NC
STRATTERA CAP	-	NC
STIMULANTS - MISC.		
dexamethylphenidate tab (FOCALIN equiv)	-	1
methylphenidate ER tab 10mg, 20mg (RITALIN equiv)	-	1
methylphenidate tab (RITALIN equiv)	-	1
armodafinil tab (NUVIGIL equiv) (QL= 1 tab/day)	PA-QL	2
methylphenidate CD cap (METADATE CD equiv)	-	2
methylphenidate ER cap (RITALIN LA equiv)	-	2
METHYLPHENIDATE ER TAB	-	2
methylphenidate ER tab (CONCERTA equiv)	-	2
methylphenidate soln (METHYLIN equiv)	-	2
modafinil tab (PROVIGIL equiv) (QL= 2 tabs/day)	PA-QL	2
methylphenidate chew tab (METHYLIN equiv)	-	3
RITALIN SR TAB 20MG	-	3
APTENSIO XR CAP	-	NC
CONCERTA TAB	-	NC
COTEMPLA XR ODT	-	NC

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

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

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

**Texas Association of Counties HDHP Formulary
Category/Class**

Last Updated* 11/1/2018

DrugName	Special Code	Tier
ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS Cont.		
DAYTRANA PATCH	-	NC
dexamethylphenidate ER cap (FOCALIN XR equiv)	-	NC
FOCALIN XR CAP	-	NC
methylphenidate ER tab 72mg	-	NC
QUILLICHEW ER TAB	-	NC
QUILLIVANT XR SUSP	-	NC
ALLERGENIC EXTRACTS/BIOLOGICALS MISC		
ALLERGENIC EXTRACTS		
ODACTRA SL TAB	PA	3
ALTERNATIVE MEDICINES		
ALTERNATIVE MEDICINE - R'S		
RESERVAPAK SYRUP	-	NC
AMEBICIDES		
AMEBICIDES		
SOLOSEC GRANULES PACKET (QL= 1 packet/fill)	PA-QL	3
YODOXIN TAB	-	3
AMINOGLYCOSIDES		
AMINOGLYCOSIDES		
neomycin tab	-	1
TOBI PODHALER (Restricted to Infectious Disease or Pulmonology Specialist)	MSP-RS	2
tobramycin neb soln (TOBI equiv) (Restricted to Infectious Disease or Pulmonology Specialist)	LMSP-RS	2
paromomycin cap (HUMATIN equiv)	-	3
ARIKAYCE SUSP	-	NC
BETHKIS NEB SOLN	-	NC
KITABIS PAK NEB SOLN	-	NC
ANALGESICS - ANTI-INFLAMMATORY		
ANTIRHEUMATIC - ENZYME INHIBITORS		
OLUMIANT TAB	-	NC
XELJANZ TAB	-	NC
XELJANZ XR TAB	-	NC
ANTIRHEUMATIC ANTIMETABOLITES		
RHEUMATREX TAB	-	3
ANTI-TNF-ALPHA - MONOCLONAL ANTIBODIES		
HUMIRA INJ 10MG (QL= 2 syringes/28 days)	PA-QL-SP	2
HUMIRA INJ 20MG (QL= 2 syringes/28 days)	PA-QL-SP	2
HUMIRA INJ 40MG (QL= 2 syringes/28 days)	PA-QL-SP	2
HUMIRA INJ CROHNS/UC/HIDRADENITIS STARTER PACK (QL= 1 pack/fill, 1 fill/plan year)	PA-QL-SP	2
HUMIRA INJ PEDIATRIC CROHNS STARTER PACK (QL= 1 pack/fill, 1 fill/plan year)	PA-QL-SP	2
HUMIRA INJ PSORIASIS/UVEITIS STARTER PACK (QL= 1 pack/fill, 1 fill/plan year)	PA-QL-SP	2
HUMIRA PEN INJ 40MG (QL= 2 pens/28 days)	PA-QL-SP	2
SIMPONI ARIA INJ	-	NC
SIMPONI SC INJ	-	NC
GOLD COMPOUNDS		
RIDAURA CAP	-	2

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

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

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

**Texas Association of Counties HDHP Formulary
Category/Class**

Last Updated* 11/1/2018

DrugName	Special Code	Tier
ANALGESICS - ANTI-INFLAMMATORY Cont.		
INTERLEUKIN-1 RECEPTOR ANTAGONIST (IL-1RA)		
KINERET INJ (QL= 1 inj/day; Only available through Rx Crossroads: 1-866-547-0644)	LD-PA-QL	2
INTERLEUKIN-6 RECEPTOR INHIBITORS		
ACTEMRA SC INJ (QL= 2 inj/28 days)	LMSP-PA-QL	2
KEVZARA INJ (QL= 2 inj/28 days)	LMSP-PA-QL	2
NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (NSAIDS)		
diclofenac potassium tab (CATAFLAM equiv)	-	1
diclofenac sodium EC tab (VOLTAREN equiv)	-	1
diclofenac sodium XR tab (VOLTAREN XR equiv)	-	1
etodolac cap (LODINE equiv)	-	1
etodolac tab	-	1
flurbiprofen tab (ANSAID equiv)	-	1
ibuprofen susp (Rx ONLY) (ADVIL, MOTRIN equiv)	-	1
ibuprofen tab	-	1
ibuprofen tab (RX only)	-	1
indomethacin cap (INDOCIN equiv)	-	1
indomethacin CR cap (INDOCIN SR equiv)	-	1
KETOPROFEN CAP	-	1
ketoprofen cap (ORUDIS equiv)	-	1
ketorolac tab (TORADOL equiv) (QL= 20 tabs/5 days)	QL	1
meloxicam tab (MOBIC equiv)	-	1
nabumetone tab (RELAFEN equiv)	-	1
naproxen EC tab (NAPROSYN EC equiv)	-	1
naproxen susp (NAPROSYN equiv)	-	1
naproxen tab (NAPROSYN equiv)	-	1
sulindac tab (CLINORIL equiv)	-	1
celecoxib cap (CELEBREX equiv) (QL= 2 caps/day)	QL	2
INDOCIN SUPP	-	2
INDOCIN SUSP	-	2
naproxen sodium tab (ANAPROX equiv)	-	2
NAPROXEN SUSP	-	2
oxaprozin tab (DAYPRO equiv)	-	2
piroxicam cap (FELDENE equiv)	-	2
diclofenac/misoprostol DR tab (ARTHROTEC equiv)	-	3
etodolac ER tab (LODINE XL equiv)	-	3
fenoprofen calcium tab	-	3
FENOPROFEN CAP	-	3
KETOPROFEN ER CAP	-	3
mefenamic acid cap (PONSTEL equiv)	-	3
TOLMETIN CAP	-	3
tolmetin cap (TOLECTIN DS equiv)	-	3
TOLMETIN TAB	-	3
DUEXIS TAB	-	NC
KETOROLAC INJ	-	NC
ketorolac inj (TORADOL equiv)	-	NC
MECLOFENAMATE CAP	-	NC

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

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

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

**Texas Association of Counties HDHP Formulary
Category/Class**

Last Updated* 11/1/2018

DrugName	Special Code	Tier
ANALGESICS - ANTI-INFLAMMATORY Cont.		
MELOXICAM COMFORT KIT	-	NC
NAPRELAN CR TAB	-	NC
NAPRELAN CR TAB 375MG, 750MG	-	NC
naproxen sodium CR tab (NAPRELAN CR equiv)	-	NC
SPRIX NASAL SPRAY	-	NC
VIMOVO TAB	-	NC
VIVLODEX CAP	-	NC
ZORVOLEX CAP	-	NC
PHOSPHODIESTERASE 4 (PDE4) INHIBITORS		
OTEZLA STARTER PACK (QL= 1 pack/28 days)	LMSP-PA-QL	2
OTEZLA TAB (QL= 2 tabs/day)	LMSP-PA-QL	2
PYRIMIDINE SYNTHESIS INHIBITORS		
leflunomide tab (ARAVA equiv)	-	1
SELECTIVE COSTIMULATION MODULATORS		
ORENCIA CLICK INJ (QL= 4 inj/28 days)	LMSP-PA-QL	2
ORENCIA SC INJ 125MG/ML (QL= 4 inj/28 days)	LMSP-PA-QL	2
ORENCIA SC INJ 50MG/0.4ML (QL= 4 inj/28 days)	LMSP-PA-QL	2
ORENCIA SC INJ 87.5MG/0.7ML (QL= 4 inj/28 days)	LMSP-PA-QL	2
SOLUBLE TUMOR NECROSIS FACTOR RECEPTOR AGENTS		
ENBREL INJ 25MG (QL= 8 inj/28 days)	LMSP-PA-QL	2
ENBREL INJ 50MG (QL= 4 inj/28 days)	LMSP-PA-QL	2
ENBREL MINI INJ (QL= 4 inj/28 days)	LMSP-PA-QL	2
ENBREL SURECLICK INJ 50MG (QL= 4 inj/28 days)	LMSP-PA-QL	2
ANALGESICS - NONNARCOTIC		
ANALGESIC COMBINATIONS		
BUTAL/APAP CAP	-	NC
butalbital/acetaminophen/cafeine tab (FIORICET equiv)	-	NC
BUTALBITAL/ASPIRIN/CAFFEINE TAB	-	NC
DOLGIC PLUS TAB	-	NC
ESGIC TAB	-	NC
FIORICET CAP	-	NC
FIORINAL CAP	-	NC
SALICYLATES		
ASPIRIN CHEW TAB 75MG (Covered for males age 45-79 and females age 55-79)	OTC	\$0
aspirin chew tab 81mg (Covered for males age 45-79; Covered for females (no age restriction))	OTC	\$0
aspirin ec tab 325mg (Covered for males age 45-79 and females age 55-79)	OTC	\$0
aspirin ec tab 81mg (Covered for males age 45-79; Covered for females (no age restriction))	OTC	\$0
aspirin tab 325mg (Covered for males age 45-79 and females age 55-79)	OTC	\$0
aspirin tab 81mg (Covered for males age 45-79; Covered for females (no age restriction))	OTC	\$0
CHOLINE MAGNESIUM TRISALICYLATE TAB	-	1
choline magnesium trisalicylate tab (TRILISATE equiv)	-	1
diflunisal tab (DOLOBID equiv)	-	1
salsalate tab (DISALCID equiv)	-	2
ZORPRIN TAB	-	3

ANALGESICS - OPIOID

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

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

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

**Texas Association of Counties HDHP Formulary
Category/Class**

Last Updated* 11/1/2018

DrugName	Special Code	Tier
ANALGESICS - OPIOID Cont.		
OPIOID AGONISTS		
codeine sulfate tab	-	1
HYDROMORPHONE SUPP	-	1
hydromorphone tab (DILAUDID equiv)	-	1
meperidine tab (DEMEROL equiv)	-	1
methadone soln	-	1
methadone tab (DOLOPHINE equiv)	-	1
methadose tab	-	1
morphine sulfate ER tab (MS CONTIN equiv)	-	1
morphine sulfate soln	-	1
morphine sulfate tab	-	1
oxycodone cap (OXYIR equiv)	-	1
oxycodone tab (ROXICODONE equiv)	-	1
tramadol tab (ULTRAM equiv)	-	1
fentanyl citrate lollipop (ACTIQ equiv) (QL= 120 lozenges/30 days)	PA-QL	2
fentanyl patch (DURAGESIC equiv)	-	2
HYSINGLA ER TAB (QL= 1 tab/day)	QL	2
LEVORPHANOL TAB	-	2
morphine sulfate supp	-	2
NUCYNTA ER TAB (QL= 2 tabs/day)	QL	2
oxycodone conc (ROXICODONE equiv)	-	2
oxycodone soln (ROXICODONE equiv)	-	2
XTAMPZA ER CAP (QL= 120 caps/30 days)	QL	2
ABSTRAL SL TAB (QL= 120 tabs/30 days)	PA-QL	3
CODEINE SULFATE SOLN	-	3
FENTORA TAB (QL= 120 tabs/30 days)	PA-QL	3
LAZANDA NASAL SPRAY (QL= 15 bottles/30 days)	PA-QL	3
NUCYNTA TAB	-	3
tramadol ER tab (ULTRAM ER equiv)	-	3
ARYMO ER TAB	-	NC
AVINZA CAP	-	NC
EMBEDA CAP	-	NC
EXALGO TAB	-	NC
fentanyl patch 37.5mg, 62.5mg, 87.5mg (FENTANYL equiv)	-	NC
hydromorphone ER tab (EXALGO equiv)	-	NC
KADIAN CAP	-	NC
MORPHABOND TAB	-	NC
MORPHINE SULFATE ER BEAD CAP	-	NC
morphine sulfate ER cap (KADIAN equiv)	-	NC
OPANA ER TAB (CRUSH RESISTANT)	-	NC
OPANA TAB	-	NC
OXYCODONE ER TAB, OXYCONTIN CR TAB	-	NC
OXYCONTIN CR TAB	-	NC
OXYMORPHONE ER TAB	-	NC
oxymorphone tab (OPANA equiv)	-	NC
RYBIX ODT	-	NC
SUBSYS SPRAY	-	NC

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

INF Infertility	LD Limited Distribution	LMSP Lumicera Mandatory Specialty Pharmacy Program	BRANDS =CAPITAL LETTERS
MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter	PA Prior Authorization	Limited to two 15 day fills per month for first 3 months
QL Quantity Limit	RS Restricted to Specialist	SF Step Therapy	
SMKG Smoking Cessation	SP Available through Specialty Pharmacy Program		
VAC Vaccine Program	¢ RxCENTS		

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

**Texas Association of Counties HDHP Formulary
Category/Class**

Last Updated* 11/1/2018

DrugName	Special Code	Tier
ANALGESICS - OPIOID Cont.		
TRAMADOL ER CAP	-	NC
ZOHYDRO ER CAP	-	NC
OPIOID COMBINATIONS		
acetaminophen/codeine soln	-	1
acetaminophen/codeine tab (TYLENOL/CODEINE equiv)	-	1
aspirin/codeine tab	-	1
hydrocodone/acetaminophen cap (LORCET equiv)	-	1
hydrocodone/acetaminophen soln (HYCET, LORTAB equiv)	-	1
hydrocodone/acetaminophen tab (LORTAB equiv)	-	1
oxycodone/acetaminophen cap (TYLOX equiv)	-	1
oxycodone/acetaminophen tab (PERCOCET equiv)	-	1
oxycodone/aspirin tab (PERCODAN equiv)	-	1
pentazocine/acetaminophen tab (TALACEN equiv)	-	1
ACETAMINOPHEN/CAFFEINE/DIHYDROCODEINE TAB	-	2
acetaminophen/caffeine/dihydrocodeine tab (PANLOR SS equiv)	-	2
OXYCODONE/ACETAMINOPHEN SOLN	-	2
ACETAMINOPHEN/CAFFEINE/DIHYDROCODEINE CAP	-	3
CAPITAL/CODEINE SUSP	-	3
hydrocodone/acetaminophen tab 2.5-325mg (NORCO equiv)	-	3
hydrocodone/ibuprofen tab (VICOPROFEN equiv)	-	3
LORTAB ELIXIR	-	3
oxycodone/ibuprofen tab (COMBUNOX equiv)	-	3
tramadol/acetaminophen tab (ULTRACET equiv)	-	3
FIORICET/CODEINE CAP	-	NC
FIORINAL/CODEINE CAP	-	NC
hydrocodone/acetaminophen tab 10mg-300mg (XODOL equiv)	-	NC
hydrocodone/acetaminophen tab 5mg-300mg (XODOL equiv)	-	NC
hydrocodone/acetaminophen tab 7.5mg-300mg (XODOL equiv)	-	NC
VERDROCET TAB 2.5MG-325MG	-	NC
XARTEMIS XR TAB	-	NC
XODOL TAB 10MG-300MG	-	NC
XODOL TAB 5MG-300MG	-	NC
XODOL TAB 7.5MG-300MG	-	NC
OPIOID PARTIAL AGONISTS		
BUNAVAIL FILM, SUBOXONE SL FILM	-	2
butorphanol nasal spray (STADOL equiv) (QL= 1 bottle/fill, 2 fills/30 days)	QL	2
ZUBSOLV SL TAB	-	2
BUPRENORPHINE PATCH, BUTRANS PATCH (QL= 4 patches/28 days)	QL	3
pentazocine/naloxone tab (TALWIN NX equiv)	-	3
BELBUCA FILM	-	NC
buprenorphine SL tab (SUBUTEX equiv)	-	NC
buprenorphine/naloxone sl film (SUBOXONE equiv)	-	NC
buprenorphine/naloxone SL tab (SUBOXONE equiv)	-	NC
SUBLOCADE INJ	-	NC
SUBOXONE SL TAB	-	NC
ANDROGENS-ANABOLIC		

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

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

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

**Texas Association of Counties HDHP Formulary
Category/Class**

Last Updated* 11/1/2018

DrugName	Special Code	Tier
ANDROGENS-ANABOLIC Cont.		
ANABOLIC STEROIDS		
oxandrolone tab (OXANDRIN equiv)	-	1
ANDROGENS		
testosterone cypionate inj (DEPO-TESTOSTERONE equiv)	-	1
testosterone gel 1% 25mg (ANDROGEL equiv) (QL= 1 packet/day)	PA-QL	1
testosterone gel 1% 50mg (ANDROGEL equiv) (QL= 2 packets/day)	PA-QL	1
testosterone gel 1% pump (ANDROGEL equiv) (QL= 4 bottles/30 days)	PA-QL	1
ANDROXY TAB	-	2
danazol cap (DANOCRINE equiv)	-	2
ANDRODERM PATCH	-	NC
ANDROGEL 1% 50MG	-	NC
ANDROID CAP, TESTRED CAP	-	NC
AXIRON SOLN	-	NC
DEPO-TESTOSTERONE INJ	-	NC
FORTESTA GEL, TESTOSTERONE GEL	-	NC
METHITEST TAB	-	NC
METHYLTESTOSTERONE CAP	-	NC
NATESTO NASAL GEL	-	NC
TESTIM GEL	-	NC
TESTOSTERONE GEL 1% 25MG	-	NC
TESTOSTERONE GEL 1% 50MG	-	NC
testosterone gel 1.62% 1.25gm (ANDROGEL equiv)	-	NC
testosterone gel 1.62% 2.5gm (ANDROGEL equiv)	-	NC
TESTOSTERONE GEL PUMP	-	NC
testosterone gel pump 1.62% (ANDROGEL equiv)	-	NC
TESTOSTERONE GEL, VOGELXO GEL	-	NC
testosterone soln (AXIRON equiv)	-	NC
VOGELXO PUMP	-	NC
ANORECTAL AGENTS		
INTRARECTAL STEROIDS		
hydrocortisone enema (CORTENEMA equiv)	-	2
CORTIFOAM	-	3
UCERIS RECTAL FOAM	PA	3
RECTAL COMBINATIONS		
pramoxine/hydrocortisone cream (ANALPRAM HC equiv)	-	1
pramoxine/hydrocortisone cream kit (ANALPRAM-HC equiv)	-	1
lidocaine/hydrocortisone cream (ANAMANTLE equiv)	-	2
PROCTOFOAM HC FOAM	-	2
ANALPRAM-E KIT	-	3
RECTAL STEROIDS		
proctosol HC cream (ANUSOL HC equiv)	-	1
hydrocortisone supp (ANUSOL HC equiv)	-	2
ANTHELMINTICS		
ANTHELMINTICS		
BENZNIDAZOLE TAB	PA	2

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

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

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

**Texas Association of Counties HDHP Formulary
Category/Class**

Last Updated* 11/1/2018

DrugName	Special Code	Tier
ANTHELMINTICS Cont.		
ivermectin tab (STROMECTOL equiv)	-	2
praziquantel tab (BILTRICIDE equiv)	-	2
BILTRICIDE TAB	-	3
albendazole tab (ALBENZA equiv)	-	NC
ALBENZA TAB	-	NC
EMVERM TAB	-	NC

ANTIANGINAL AGENTS

ANTIANGINALS-OTHER		
RANEXA TAB	-	2
NITRATES		
isosorbide dinitrate ER tab (ISOCHRON equiv)	-	1
isosorbide dinitrate SL tab	-	1
isosorbide dinitrate tab (ISORDIL equiv)	-	1
isosorbide mononitrate ER tab (IMDUR equiv)	-	1
isosorbide mononitrate tab (MONOKET equiv)	-	1
nitroglycerin patch (NITRO-DUR equiv)	-	1
nitroglycerin SL tab (NITROSTAT equiv)	-	1
nitroglycerin SR cap	-	1
NITRO-DUR PATCH 0.3MG/HR, 0.8MG/HR	-	2
ISOSORBIDE DINITRATE TAB 30MG, 40MG	-	3
NITRO-BID OINT	-	3
nitroglycerin lingual spray (NITROLINGUAL equiv)	-	3
NITROMIST SPRAY	-	3
GONITRO POWDER	-	NC

ANTIANGIETY AGENTS

ANTIANGIETY AGENTS - MISC.		
buspirone tab (BUSPAR equiv)	-	1
hydroxyzine pamoate cap (VISTARIL equiv)	-	1
hydroxyzine syrup (ATARAX equiv)	-	1
hydroxyzine tab (ATARAX equiv)	-	1
meprobamate tab (MILTOWN equiv)	-	1
buspirone tab 30mg (BUSPAR equiv)	-	NC

BENZODIAZEPINES		
alprazolam tab (XANAX equiv)	-	1
chlordiazepoxide cap (LIBRIUM equiv)	-	1
diazepam conc (VALIUM equiv)	-	1
DIAZEPAM SOLN	-	1
diazepam tab (VALIUM equiv)	-	1
lorazepam conc (ATIVAN equiv)	-	1
lorazepam tab (ATIVAN equiv)	-	1
OXAZEPAM CAP	-	1
oxazepam cap (SERAX equiv)	-	1
clorazepate tab (TRANXENE-T equiv)	-	2
alprazolam ER tab (XANAX XR equiv)	-	3
alprazolam ODT (NIRAVAM equiv)	-	3

ANTIARRHYTHMICS

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

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

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

**Texas Association of Counties HDHP Formulary
Category/Class**

Last Updated* 11/1/2018

DrugName	Special Code	Tier
ANTIARRHYTHMICS TYPE I-A		
disopyramide cap (NORPACE equiv)	-	1
quinidine sulfate tab	-	1
disopyramide ER cap (NORPACE CR equiv)	-	2
NORPACE CR CAP	-	2
quinidine gluconate CR tab	-	2
QUINIDINE SULFATE ER TAB	-	3
ANTIARRHYTHMICS TYPE I-B		
mexiletine cap (MEXITIL equiv)	-	2
ANTIARRHYTHMICS TYPE I-C		
flecainide tab (TAMBOCOR equiv)	-	1
propafenone tab (RYTHMOL equiv)	-	1
propafenone ER cap (RYTHMOL SR equiv)	-	2
ANTIARRHYTHMICS TYPE III		
amiodarone tab (CORDARONE equiv)	-	1
dofetilide cap (TIKOSYN equiv)	-	2
MULTAQ TAB	-	2
ANTIASTHMATIC AND BRONCHODILATOR AGENTS		
ANTIASTHMATIC - MONOCLONAL ANTIBODIES		
DUPIXENT SOLN	-	NC
ANTI-INFLAMMATORY AGENTS		
cromolyn neb soln (INTAL equiv)	-	1
BRONCHODILATORS - ANTICHOLINERGICS		
ipratropium neb soln (ATROVENT equiv)	-	1
ATROVENT HFA INHALER	-	2
INCRUSE ELLIPTA INHALER	-	2
LONHALA MAGNAIR SOLN (Step Therapy requires trial of INCRUSE ELLIPTA INHALER)	ST	2
SPIRIVA RESPIMAT INHALER 1.25MCG/ACT (QL= 1 inhaler/30 days; Step Therapy requires trial of ADVAIR, BREO, DULERA, or FLUTICASONE/SALMETEROL)	QL-ST	2
SEEBRI NEOHALER CAP	-	NC
SPIRIVA HANDIHALER	-	NC
SPIRIVA RESPIMAT INHALER 2.5MCG/ACT	-	NC
TUDORZA PRESSAIR INHALER	-	NC
LEUKOTRIENE MODULATORS		
montelukast chew tab (SINGULAIR equiv)	-	1
montelukast tab (SINGULAIR equiv)	-	1
montelukast granule pack (SINGULAIR equiv)	-	2
zafirlukast tab (ACCOLATE equiv)	-	3
zileuton ER tab (ZYFLO CR equiv)	-	3
ZYFLO TAB	-	3
SELECTIVE PHOSPHODIESTERASE 4 (PDE4) INHIBITORS		
DALIRESP TAB	-	NC
STEROID INHALANTS		
ARNUITY ELLIPTA INHALER	-	1
ASMANEX HFA INHALER	-	1
ASMANEX INHALER	-	1

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

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

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

**Texas Association of Counties HDHP Formulary
Category/Class**

Last Updated* 11/1/2018

DrugName	Special Code	Tier
ANTIASTHMATIC AND BRONCHODILATOR AGENTS Cont.		
budesonide inh susp (PULMICORT equiv)	-	1
FLOVENT DISKUS INHALER	-	1
FLOVENT HFA INHALER	-	1
AEROSPAN HFA INHALER	-	NC
ALVESCO INHALER	-	NC
ARMONAIR RESPICLICK	-	NC
PULMICORT FLEXHALER	-	NC
QVAR INHALER	-	NC
QVAR REDIHALER	-	NC
SYMPATHOMIMETICS		
albuterol neb soln 0.083% (PROVENTIL equiv)	-	1
albuterol neb soln 0.5% (VENTOLIN equiv)	-	1
albuterol sulfate ER tab (VOSPIRE ER equiv)	-	1
albuterol sulfate syrup	-	1
albuterol sulfate tab	-	1
albuterol/ipratropium neb soln (DUONEB equiv)	-	1
FLUTICASONE/SALMETEROL INHALER	-	1
METAPROTERENOL SYRUP	-	1
terbutaline sulfate tab (BRETHINE equiv)	-	1
ADVAIR DISKUS INHALER	-	2
ADVAIR HFA INHALER	-	2
ALBUTEROL TAB ER	-	2
ANORO ELLIPTA INHALER	-	2
BREO ELLIPTA INHALER	-	2
COMBIVENT INHALER	-	2
COMBIVENT RESPIMAT INHALER	-	2
DULERA INHALER	-	2
FORADIL AEROLIZER	-	2
SEREVENT DISKUS INHALER	-	2
STIOLTO INHALER	-	2
TRELEGY ELLIPTA INHALER	-	2
VENTOLIN HFA INHALER (QL= 2 inhalers/30 days)	QL	2
albuterol neb soln 0.63mg (ACCUNEB equiv)	-	3
albuterol neb soln 1.25mg (ACCUNEB equiv)	-	3
BROVANA NEB SOLN	-	3
levalbuterol neb soln (XOPENEX equiv)	-	3
METAPROTERENOL TAB	-	3
PERFOROMIST NEB SOLN	-	3
STRIVERDI RESPIMAT INHALER (QL= 1 inhaler/30 days)	QL	3
AIRDUO RESPICLICK	-	NC
BEVESPI AEROSPHERE INHALER	-	NC
LEVALBUTEROL INHALER, XOPENEX HFA INHALER	-	NC
PROAIR HFA INHALER	-	NC
PROVENTIL HFA INHALER	-	NC
SYMBICORT INHALER	-	NC
UTIBRON NEOHALER CAP	-	NC

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

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

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

**Texas Association of Counties HDHP Formulary
Category/Class**

Last Updated* 11/1/2018

DrugName	Special Code	Tier
ANTIASTHMATIC AND BRONCHODILATOR AGENTS Cont.		
XANTHINES		
aminophylline tab	-	1
theophylline CR tab (QUIBRON-T equiv)	-	1
theophylline ER tab (UNIPHYL equiv)	-	1
theophylline soln	-	1
ELIXOPHYLLIN ELIXIR	-	2
LUFYLLIN TAB	-	3
ANTICOAGULANTS		
COUMARIN ANTICOAGULANTS		
warfarin tab (COUMADIN equiv)	-	1
DIRECT FACTOR XA INHIBITORS		
ELIQUIS TAB	-	2
XARELTO STARTER PACK	-	2
XARELTO TAB	-	2
BEVYXXA CAP	-	NC
SAVAYSA TAB	-	NC
XARELTO TAB 2.5MG	-	NC
HEPARINS AND HEPARINOID-LIKE AGENTS		
enoxaparin inj (LOVENOX equiv) (QL= 17 days supply)	QL	2
fondaparinux inj (ARIXTRA equiv)	PA	2
FRAGMIN INJ	-	3
THROMBIN INHIBITORS		
PRADAXA CAP	-	2
ANTICONVULSANTS		
AMPA GLUTAMATE RECEPTOR ANTAGONISTS		
FYCOMPA TAB	-	NC
FYCOMPA SUSP	-	NC
ANTICONVULSANTS - BENZODIAZEPINES		
clobazam tab (ONFI equiv)	PA	1
clonazepam tab (KLONOPIN equiv)	-	1
clonazepam ODT (KLONOPIN equiv)	-	3
DIASTAT RECTAL GEL, DIAZEPAM RECTAL GEL	-	3
clobazam susp (ONFI equiv)	-	NC
ONFI SUSP	-	NC
ONFI TAB	-	NC
ANTICONVULSANTS - MISC.		
carbamazepine chew tab (TEGRETOL equiv)	-	1
carbamazepine susp (TEGRETOL equiv)	-	1
carbamazepine tab (TEGRETOL equiv)	-	1
gabapentin cap (NEURONTIN equiv)	-	1
gabapentin tab (NEURONTIN equiv)	-	1
lamotrigine chew tab (LAMICTAL equiv)	-	1
lamotrigine tab (LAMICTAL equiv)	-	1
levetiracetam ER tab (KEPPRA XR equiv)	-	1
levetiracetam soln (KEPPRA equiv)	-	1
Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.		
INF Infertility MSP Mandatory Specialty Pharmacy Program QL Quantity Limit SMKG Smoking Cessation VAC Vaccine Program	LD Limited Distribution OTC Over-the-Counter RS Restricted to Specialist SP Available through Specialty Pharmacy Program ¢ RxCENTS	generic =small letters LMSP Lumicera Mandatory Specialty Pharmacy Program PA Prior Authorization SF Limited to two 15 day fills per month for first 3 months ST Step Therapy

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

**Texas Association of Counties HDHP Formulary
Category/Class**

Last Updated* 11/1/2018

DrugName	Special Code	Tier
ANTICONVULSANTS Cont.		
levetiracetam tab (KEPPRA equiv)	-	1
oxcarbazepine susp (TRILEPTAL equiv)	-	1
oxcarbazepine tab (TRILEPTAL equiv)	-	1
primidone tab (MYSOLINE equiv)	-	1
topiramate sprinkle cap (TOPAMAX equiv)	-	1
topiramate tab (TOPAMAX equiv)	-	1
zonisamide cap (ZONEGRAN equiv)	-	1
BANZEL SUSP	-	2
BANZEL TAB	-	2
carbamazepine ER cap (CARBATROL equiv)	-	2
carbamazepine ER tab (TEGRETOL XR equiv)	-	2
gabapentin soln (NEURONTIN equiv)	-	2
LAMICTAL CHEW TAB 2MG	-	2
LYRICA CAP	-	2
LYRICA SOLN	-	2
POTIGA TAB (QL= 3 tabs/day)	QL	2
VIMPAT SOLN	-	2
VIMPAT TAB (QL= 2 tabs/day)	QL	2
LAMICTAL ODT KIT, LAMICTAL XR KIT	-	3
lamotrigine ER tab (LAMICTAL XR equiv)	-	3
lamotrigine ODT (LAMICTAL equiv)	-	3
lamotrigine ODT kit (LAMICTAL ODT KIT equiv)	-	3
APTIOM TAB	-	NC
BRIVIACT INJ 50MG/5ML	-	NC
BRIVIACT SOLN 10MG/ML	-	NC
BRIVIACT TAB	-	NC
EPIDIOLEX SOLN	-	NC
QUDEXY XR CAP, TOPIRAMATE ER CAP	-	NC
SPRITAM TAB	-	NC
TROKENDI XR CAP	-	NC
CARBAMATES		
felbamate susp (FELBATOL equiv)	-	2
felbamate tab (FELBATOL equiv)	-	2
FELBATOL TAB	-	2
GABA MODULATORS		
SABRIL TAB (Only available through Walgreens 888-347-3416)	LD-PA	2
tiagabine tab (GABITRIL equiv)	-	2
vigabatrin powder pack (SABRIL POWDER equiv) (Only available through Walgreens 888-347-3416)	LD-PA	2
HYDANTOINS		
phenytoin cap (DILANTIN equiv)	-	1
phenytoin susp (DILANTIN equiv)	-	1
DILANTIN CAP 30MG	-	2
PEGANONE TAB	-	2
phenytoin chew tab (DILANTIN equiv)	-	2
SUCCINIMIDES		
ethosuximide soln (ZARONTIN equiv)	-	1

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

INF Infertility	LD Limited Distribution	LMSP Lumicera Mandatory Specialty Pharmacy Program
MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter	PA Prior Authorization
QL Quantity Limit	RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months
SMKG Smoking Cessation	SP Available through Specialty Pharmacy Program	ST Step Therapy
VAC Vaccine Program	¢ RxCENTS	

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

**Texas Association of Counties HDHP Formulary
Category/Class**

Last Updated* 11/1/2018

DrugName	Special Code	Tier
ANTICONVULSANTS Cont.		
CELONTIN CAP	-	2
ethosuximide cap (ZARONTIN equiv)	-	2
VALPROIC ACID		
divalproex ER tab (DEPAKOTE ER equiv)	-	1
divalproex sodium DR tab (DEPAKOTE equiv)	-	1
divalproex sprinkle cap (DEPAKOTE equiv)	-	1
valproic acid cap (DEPAKENE equiv)	-	1
valproic acid syrup (DEPAKENE equiv)	-	1
DEPACON INJ	-	NC
STAVZOR CAP	-	NC
valproate inj (DEPACON equiv)	-	NC
ANTIDEPRESSANTS		
ALPHA-2 RECEPTOR ANTAGONISTS (TETRACYCLICS)		
mirtazapine ODT (REMERON equiv)	-	1
mirtazapine tab (REMERON equiv)	-	1
ANTIDEPRESSANTS - MISC.		
bupropion ER tab (WELLBUTRIN equiv)	-	1
bupropion tab (WELLBUTRIN equiv)	-	1
bupropion XL tab (WELLBUTRIN XL equiv)	-	1
MAPROTILINE TAB (Step therapy requires trial of two formulary covered generic antidepressants in the previous 180 days)	ST	3
APLENZIN TAB	-	NC
FORFIVO XL TAB	-	NC
MONOAMINE OXIDASE INHIBITORS (MAOIS)		
phenelzine tab (NARDIL equiv)	-	1
tranylcypromine tab (PARNATE equiv)	-	2
EMSAM PATCH (Step therapy requires trial of two formulary covered generic antidepressants in the previous 180 days)	ST	3
MARPLAN TAB (Step therapy requires trial of two formulary covered generic antidepressants in the previous 180 days)	ST	3
SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIS)		
citalopram soln (CELEXA equiv)	-	1
citalopram tab (CELEXA equiv)	-	1
escitalopram tab (LEXAPRO equiv)	-	1
fluoxetine cap (PROZAC equiv)	-	1
fluoxetine soln (PROZAC equiv)	-	1
fluoxetine tab (PROZAC equiv)	-	1
fluvoxamine tab (LUVOX equiv)	-	1
paroxetine tab (PAXIL equiv)	-	1
sertraline conc (ZOLOFT equiv)	-	1
sertraline tab (ZOLOFT equiv)	-	1
escitalopram soln (LEXAPRO equiv)	-	2
fluvoxamine ER cap (LUVOX CR equiv) (Step Therapy requires trial of citalopram, escitalopram, sertraline, fluoxetine, fluvoxamine or paroxetine)	ST	2
paroxetine ER tab (PAXIL CR equiv)	-	2
PAXIL SUSP (Step therapy requires trial of two formulary covered generic antidepressants in the previous 180 days)	ST	3
FLUOXETINE TAB 60MG	-	NC
fluoxetine weekly cap (PROZAC equiv)	-	NC

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

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

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

**Texas Association of Counties HDHP Formulary
Category/Class**

Last Updated* 11/1/2018

DrugName	Special Code	Tier
ANTIDEPRESSANTS Cont.		
PEXEVA TAB	-	NC
PROZAC SOLN	-	NC
PROZAC TAB	-	NC
PROZAC WEEKLY CAP	-	NC
SEROTONIN MODULATORS		
nefazodone tab 50mg, 250mg	-	1
trazodone tab (DESYREL equiv)	-	1
NEFAZODONE TAB (Step therapy requires trial of two formulary covered generic antidepressants in the previous 180 days)	ST	3
OLEPTRO TAB	-	NC
trazodone tab 300mg (DESYREL equiv)	-	NC
TRINTELLIX TAB	-	NC
VIIBRYD STARTER KIT	-	NC
SEROTONIN-NOREPINEPHRINE REUPTAKE INHIBITORS (SNRIS)		
duloxetine EC cap (CYMBALTA equiv)	-	1
venlafaxine ER cap (EFFEXOR XR equiv)	-	1
venlafaxine tab (EFFEXOR equiv)	-	1
desvenlafaxine ER tab (PRISTIQ equiv)	-	2
CYMBALTA CAP	-	NC
DESVENLAFAXINE ER TAB	-	NC
duloxetine cap 40mg (IRENKA equiv)	-	NC
FETZIMA CAP	-	NC
FETZIMA TITRATION PACK	-	NC
KHEDEZLA ER TAB	-	NC
VENLAFAXINE ER TAB	-	NC
TRICYCLIC AGENTS		
amitriptyline tab (ELAVIL equiv)	-	1
AMOXAPINE TAB (Step therapy requires trial of two formulary covered generic antidepressants in the previous 180 days)	ST	1
doxepin cap (SINEQUAN equiv)	-	1
doxepin conc (SINEQUAN equiv)	-	1
imipramine tab (TOFRANIL equiv)	-	1
nortriptyline cap (PAMELOR equiv)	-	1
nortriptyline oral soln (NORTRIPTYLINE equiv)	-	1
NORTRIPTYLINE SOLN	-	1
desipramine tab (NORPRAMIN equiv)	-	2
clomipramine cap (ANAFRANIL equiv)	-	3
imipramine pamoate cap (TOFRANIL PM equiv)	-	3
protriptyline tab (VIVACTIL equiv)	-	3
trimipramine cap (SURMONTIL equiv)	-	3
ANTIDIABETICS		
ALPHA-GLUCOSIDASE INHIBITORS		
acarbose tab (PRECOSE equiv)	-	1
miglitol tab (GLYSET equiv)	-	3
ANTIDIABETIC - AMYLIN ANALOGS		
SYMLINPEN INJ	-	NC

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

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

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

**Texas Association of Counties HDHP Formulary
Category/Class**

Last Updated* 11/1/2018

DrugName	Special Code	Tier
ANTIDIABETICS Cont.		
ANTIDIABETIC COMBINATIONS		
glipizide/metformin tab (METAGLIP equiv)	-	1
glyburide/metformin tab (GLUCOVANCE equiv)	-	1
AVANDAMET TAB	-	2
AVANDARYL TAB	-	2
GLYXAMBI TAB (QL= 1 tab/day)	QL	2
JANUMET TAB (QL= 2 tabs/day)	QL	2
JANUMET XR TAB (QL= 2 tabs/day)	QL	2
JENTADUETO TAB (QL= 2 tabs/day)	QL	2
JENTADUETO XR TAB (QL= 2 tabs/day)	QL	2
SYNJARDY TAB (QL= 2 tabs/day)	QL	2
SYNJARDY XR TAB 10-1000MG, 25-1000MG (QL= 1 tab/day)	QL	2
SYNJARDY XR TAB 5-1000MG, 12.5-1000MG (QL= 2 tabs/day)	QL	2
XIGDUO XR TAB 2.5-1000MG, 5-1000MG (QL= 2 tabs/day)	QL	2
XIGDUO XR TAB 5-500MG, 10-500MG, 10-1000MG (QL= 1 tab/day)	QL	2
XULTOPHY INJ (QL= 15ml/30 days)	PA-QL	2
ACTOPLUS MET XR TAB	-	3
ACTOPLUS MET TAB	-	NC
ALOGLIPTIN/METFORMIN TAB, KAZANO TAB	-	NC
ALOGLIPTIN/PIOGLITAZONE TAB, OSENI TAB	-	NC
DUETACT TAB	-	NC
INVOKAMET TAB	-	NC
INVOKAMET XR TAB	-	NC
KOMBIGLYZE XR TAB	-	NC
pioglitazone/glimepiride tab (DUETACT equiv)	-	NC
pioglitazone/metformin tab (ACTOPLUS MET equiv)	-	NC
PRANDIMET TAB	-	NC
QTERN TAB	-	NC
REPAGLINIDE TAB	-	NC
SEGLUROMET TAB	-	NC
SOLIQUA INJ	-	NC
STEGLUJAN TAB	-	NC
BIGUANIDES		
metformin ER tab (GLUCOPHAGE XR equiv)	-	1
metformin tab (GLUCOPHAGE equiv)	-	1
RIOMET SOLN, METFORMIN SOLN	-	3
FORTAMET TAB	-	NC
GLUMETZA TAB 1000MG	-	NC
GLUMETZA TAB 500MG	-	NC
metformin ER osmotic tab (FORTAMET equiv)	-	NC
metformin ER osmotic tab (GLUMETZA equiv)	-	NC
DIABETIC OTHER		
GLUCAGEN HYPOKIT INJ	-	2
GLUCAGON INJ KIT	-	2
KORLYM TAB (Only available through Korlym SPARK program 855-4Korlym (855-456-7596))	LD-PA	2
PROGLYCEM SUSP	-	3

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

INF Infertility	LD Limited Distribution	LMSP Lumicera Mandatory Specialty Pharmacy Program
MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter	PA Prior Authorization
QL Quantity Limit	RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months
SMKG Smoking Cessation	SP Available through Specialty Pharmacy Program	ST Step Therapy
VAC Vaccine Program	¢ RxCENTS	

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

**Texas Association of Counties HDHP Formulary
Category/Class**

Last Updated* 11/1/2018

DrugName	Special Code	Tier
ANTIDIABETICS Cont.		
DIPEPTIDYL PEPTIDASE-4 (DPP-4) INHIBITORS		
JANUVIA TAB (QL= 1 tab/day)	QL-¢	2
TRADJENTA TAB (QL= 1 tab/day)	QL	2
ALOGLIPTIN TAB, NESINA TAB	-	NC
ONGLYZA TAB	-	NC
DOPAMINE RECEPTOR AGONISTS - ANTIDIABETIC		
CYCLOSET TAB	-	3
INCRETIN MIMETIC AGENTS (GLP-1 RECEPTOR AGONISTS)		
BYDUREON BCISE AUTO INJ (QL= 4 inj/28 days)	QL	2
BYDUREON INJ (QL= 4 inj/28 days)	QL	2
BYDUREON PEN INJ (QL= 4 inj/28 days)	QL	2
OZEMPIC INJ (QL= 1 pack/28 days)	QL	2
VICTOZA INJ (QL= 9ml/30 days)	QL	2
BYETTA INJ (QL= 1 pen/30 days)	QL	3
TRULICITY INJ (QL= 4 pens/28 days)	QL	3
ADLYXIN INJ	-	NC
TANZEUM INJ	-	NC
INSULIN		
HUMULIN R INJ U-500	-	2
HUMULIN R U-500 KWIKPEN INJ	-	2
LANTUS INJ	-	2
LANTUS SOLOSTAR INJ	-	2
LEVEMIR FLEXTOUCH INJ	-	2
LEVEMIR INJ	-	2
NOVOLIN INJ	OTC	2
NOVOLOG FLEXPEN INJ, FIASP FLEXTOUCH INJ	-	2
NOVOLOG INJ, FIASP INJ	-	2
NOVOLOG MIX FLEXPEN INJ	-	2
NOVOLOG MIX INJ	-	2
NOVOLOG PENFILL INJ	-	2
TOUJEO MAX SOLOSTAR INJ	-	2
TOUJEO SOLOSTAR INJ	-	2
TRESIBA INJ	-	2
APIDRA INJ	-	NC
APIDRA SOLOSTAR INJ	-	NC
BASAGLAR INJ	-	NC
HUMALOG INJ, ADMELOG INJ	-	NC
HUMALOG KWIKPEN INJ, ADMELOG SOLOSTAR INJ	-	NC
HUMALOG MIX INJ	-	NC
HUMALOG MIX KWIKPEN INJ	-	NC
HUMALOG PEN INJ	-	NC
HUMULIN MIX INJ	OTC	NC
HUMULIN MIX PEN INJ	OTC	NC
HUMULIN N INJ	OTC	NC
HUMULIN N PEN INJ	OTC	NC
HUMULIN R INJ	OTC	NC

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

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

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

**Texas Association of Counties HDHP Formulary
Category/Class**

Last Updated* 11/1/2018

DrugName	Special Code	Tier
ANTIDIABETICS Cont.		
INSULIN SENSITIZING AGENTS		
pioglitazone tab (ACTOS equiv)	-	1
AVANDIA TAB	-	2
MEGLITINIDE ANALOGUES		
repaglinide tab (PRANDIN equiv)	-	1
nateglinide tab (STARLIX equiv)	-	3
SODIUM-GLUCOSE CO-TRANSPORTER 2 (SGLT2) INHIBITORS		
FARXIGA TAB (QL= 1 tab/day)	QL	2
JARDIANCE TAB (QL= 1 tab/day)	QL	2
INVOKANA TAB	-	NC
STEGLATRO TAB	-	NC
SULFONYLUREAS		
chlorpropamide tab (DIABINESE equiv)	-	1
glimepiride tab (AMARYL equiv)	-	1
glipizide ER tab (GLUCOTROL XL equiv)	-	1
glipizide tab (GLUCOTROL equiv)	-	1
glyburide micronized tab (GLYNASE equiv)	-	1
glyburide tab (MICRONASE equiv)	-	1
tolazamide tab (TOLINASE equiv)	-	1
TOLBUTAMIDE TAB	-	2
ANTIDIARRHEALS		
ANTIDIARRHEAL - CHLORIDE CHANNEL ANTAGONISTS		
MYTESI TAB	-	NC
ANTIDIARRHEAL AGENTS - MISC.		
REZYST CHEW TAB	-	NC
VSL #3 CAP	-	NC
ANTIDIARRHEAL COMBINATIONS		
EVIVO LIQUID	-	NC
ANTIPERISTALTIC AGENTS		
diphenoxylate/atropine liquid (LOMOTIL equiv)	-	1
diphenoxylate/atropine tab (LOMOTIL equiv)	-	1
opium tincture	-	3
loperamide cap (IMODIUM equiv)	-	NC
PAREGORIC TINCTURE	-	NC
ANTIDOTES		
ANTIDOTES		
VISTOGARD PAK	-	NC
ANTIDOTES - CHELATING AGENTS		
CHEMET CAP	-	2
EXJADE TAB	MSP	2
FERRIPROX SOLN (Only available through Ferriprox Total Care 866-758-7071)	LD-PA	2
FERRIPROX TAB (Only available through Ferriprox Total Care 866-758-7071)	LD-PA	2
JADENU TAB	LMSP	2
OPIOID ANTAGONISTS		

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

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

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

**Texas Association of Counties HDHP Formulary
Category/Class**

Last Updated* 11/1/2018

DrugName	Special Code	Tier
ANTIDOTES Cont.		
naltrexone tab (REVIA equiv)	-	1
NARCAN NASAL SPRAY (QL= 2 sprays/fill)	QL	2
EVZIO INJ	-	NC
VIVITROL INJ	-	NC

ANTIDOTES AND SPECIFIC ANTAGONISTS

ANTIDOTES - CHELATING AGENTS

JADENU SPRINKLE	LMSP	2
-----------------	------	---

ANTIDOTES AND SPECIFIC ANTAGONISTS

CETYLEV TAB	-	NC
-------------	---	----

OPIOID ANTAGONISTS

NALOXONE PREFILLED INJ (QL= 2 inj/fill)	QL	2
naloxone inj	-	NC

ANTIEMETICS

5-HT3 RECEPTOR ANTAGONISTS

granisetron tab (KYTRIL equiv) (QL= 9 tabs/fill)	QL	1
ondansetron ODT (ZOFTRAN equiv)	-	1
ondansetron soln (ZOFTRAN equiv)	-	1
ondansetron tab (ZOFTRAN equiv)	-	1
ANZEMET TAB (QL= 9 tabs/fill)	QL	3
GRANISOL SOLN (QL= 60ml/fill)	QL	3
SANCUSO PATCH (QL= 4 patches/fill)	QL	3
SUSTOL INJ	-	NC
ZUPLENZ SL FILM	-	NC

ANTIEMETICS - ANTICHOLINERGIC

maldemar tab (SCOPACE equiv)	-	1
meclizine tab (ANTIVERT equiv) (Rx Only)	-	1
trimethobenzamide cap (TIGAN equiv)	-	1
scopolamine patch (TRANSDERM-SCOP equiv)	-	3
TRANSDERM-SCOP PATCH	-	3
meclizine chew tab (BONINE equiv)	OTC	NC

ANTIEMETICS - MISCELLANEOUS

AKYNZEO CAP (QL= 1 cap/fill; Restricted to Oncology or Hematology Specialist)	QL-RS	2
dronabinol cap (MARINOL equiv)	PA	2
CESAMET CAP	-	3
DICLEGIS TAB	-	NC
SYNDROS SOLN	-	NC

SUBSTANCE P/NEUROKININ 1 (NK1) RECEPTOR ANTAGONISTS

aprepitant cap (EMEND equiv) (QL= 3 caps/fill; Restricted to Oncology or Hematology Specialist)	QL-RS	2
aprepitant pak (EMEND equiv) (QL= 3 caps/fill; Restricted to Oncology or Hematology Specialist)	QL-RS	2
VARUBI TAB (QL= 2 tabs/day; Restricted to Oncology or Hematology Specialist)	QL-RS	2
EMEND SUSP	-	NC

ANTIFUNGALS

ANTIFUNGALS

nystatin powder	-	1
nystatin tab	-	1

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

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

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

**Texas Association of Counties HDHP Formulary
Category/Class**

Last Updated* 11/1/2018

DrugName	Special Code	Tier
ANTIFUNGALS Cont.		
terbinafine tab (LAMISIL equiv)	-	1
flucytosine cap (ANCOBON equiv)	-	2
griseofulvin micro tab (GRIFULVIN V equiv)	-	2
griseofulvin susp (GRIFULVIN equiv)	-	2
griseofulvin tab (GRIS-PEG equiv)	-	2
IMIDAZOLE-RELATED ANTIFUNGALS		
fluconazole susp (DIFLUCAN equiv)	-	1
fluconazole tab (DIFLUCAN equiv)	-	1
ketoconazole tab (NIZORAL equiv)	-	1
itraconazole cap (SPORANOX equiv)	PA	2
NOXAFIL SUSP	-	2
NOXAFIL TAB	-	2
voriconazole susp (VFEND equiv) (Restricted to Infectious Disease Specialist)	RS	2
voriconazole tab (VFEND equiv) (Restricted to Infectious Disease Specialist)	RS	2
itraconazole soln (SPORANOX equiv)	PA	3
SPORANOX SOLN	PA	3
CRESEMBA CAP	-	NC
ANTIHISTAMINES		
ANTIHISTAMINES - ALKYLAMINES		
chlorpheniramine ER cap	-	1
ANTIHISTAMINES - ETHANOLAMINES		
diphenhydramine cap 50mg (BENADRYL equiv) (Only 50mg covered)	-	1
carbinoxamine soln (PALGIC equiv)	-	3
carbinoxamine tab (PALGIC equiv)	-	3
carbinoxane maleate tab 6mg (RYVENT equiv)	-	NC
KARBINAL ER SUSP	-	NC
ANTIHISTAMINES - NON-SEDATING		
cetirizine cap (ZYRTEC equiv)	OTC	1
cetirizine syrup (ZYRTEC equiv)	OTC	1
cetirizine tab (ZYRTEC equiv)	OTC	1
fexofenadine susp (ALLEGRA equiv)	OTC	1
fexofenadine tab (ALLEGRA equiv)	OTC	1
loratadine cap (CLARITIN equiv)	OTC	1
loratadine syrup (CLARITIN equiv)	OTC	1
loratadine tab (CLARITIN equiv)	OTC	1
ALLEGRA ODT	OTC	NC
ALLEGRA SUSP	OTC	NC
ALLEGRA TAB	OTC	NC
CLARINEX REDITAB	-	NC
CLARINEX SYRUP	-	NC
CLARINEX TAB	-	NC
CLARITIN CAP	OTC	NC
DESLORATADINE ODT	-	NC
desloratadine tab (CLARINEX equiv)	-	NC
levocetirizine soln (XYZAL equiv)	-	NC
levocetirizine tab (XYZAL equiv)	-	NC
Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.		
INF Infertility MSP Mandatory Specialty Pharmacy Program QL Quantity Limit SMKG Smoking Cessation VAC Vaccine Program	LD Limited Distribution OTC Over-the-Counter RS Restricted to Specialist SP Available through Specialty Pharmacy Program ¢ RxCENTS	generic =small letters LMSP Lumicera Mandatory Specialty Pharmacy Program PA Prior Authorization SF Limited to two 15 day fills per month for first 3 months ST Step Therapy BRANDS =CAPITAL LETTERS

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

**Texas Association of Counties HDHP Formulary
Category/Class**

Last Updated* 11/1/2018

DrugName	Special Code	Tier
ANTIHISTAMINES Cont.		
XYZAL SOLN	-	NC
XYZAL TAB	-	NC
ANTIHISTAMINES - PHENOTHIAZINES		
promethazine syrup	-	1
promethazine tab (PHENERGAN equiv)	-	1
promethazine supp (PHENERGAN equiv)	-	2
ANTIHISTAMINES - PIPERIDINES		
cyproheptadine syrup	-	1
cyproheptadine tab	-	1
ANTIHYPERLIPIDEMICS		
ANTIHYPERLIPIDEMICS - COMBINATIONS		
ezetimibe/simvastatin tab (VYTORIN equiv) (QL= 1 tab/day (10-80mg is Not Covered))	QL	3
ezetimibe/simvastatin tab 10-80mg (VYTORIN equiv) (This strength excluded from coverage)	-	NC
LIPTRUZET TAB	-	NC
ANTIHYPERLIPIDEMICS - MISC.		
omega-3-acid ethyl esters cap (LOVAZA equiv)	-	2
KYNAMRO INJ	-	NC
VASCEPA CAP	-	NC
BILE ACID SEQUESTRANTS		
cholestyramine lite powder (QUESTRAN LITE equiv)	-	1
cholestyramine lite powder pack (QUESTRAN LITE equiv)	-	1
cholestyramine powder (QUESTRAN equiv)	-	1
cholestyramine powder pack (QUESTRAN equiv)	-	1
colesevelam tab (WELCHOL equiv)	-	1
colestipol tab (COLESTID equiv)	-	1
colesevelam pack (WELCHOL equiv)	-	2
colestipol granule (COLESTID equiv)	-	3
colestipol powder packet (COLESTID equiv)	-	3
WELCHOL PACK	-	3
WELCHOL TAB	-	3
FIBRIC ACID DERIVATIVES		
fenofibrate cap 67mg, 134mg, 200mg (ANTARA equiv)	-	1
fenofibrate tab 48mg, 54mg, 145mg, 160mg (TRICOR equiv)	-	1
fenofibric acid DR cap (TRILIPIX equiv)	-	1
gemfibrozil tab (LOPID equiv)	-	1
FENOFIBRIC TAB, FIBRICOR TAB	-	3
ANTARA CAP, LOFIBRA CAP	-	NC
fenofibrate cap 43mg, 130mg (ANTARA equiv)	-	NC
FENOFIBRATE CAP, LIPOFEN CAP 50MG, 150MG	-	NC
fenofibrate tab 40mg, 120mg (FENOGLIDE equiv)	-	NC
LOFIBRA TAB, TRIGLIDE TAB	-	NC
TRIGLIDE TAB	-	NC
TRILIPIX CAP	-	NC
HMG COA REDUCTASE INHIBITORS		
atorvastatin tab 10mg (LIPITOR equiv)	-	\$0

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

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

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

**Texas Association of Counties HDHP Formulary
Category/Class**

Last Updated* 11/1/2018

DrugName	Special Code	Tier
ANTIHYPERTENSIVES Cont.		
atorvastatin tab 20mg (LIPITOR equiv)	-	\$0
lovastatin tab (MEVACOR equiv)	-	\$0
pravastatin tab (PRAVACHOL equiv)	-	\$0
rosuvastatin tab 10mg (CRESTOR equiv) (QL= 1 tab/day)	QL	\$0
rosuvastatin tab 5mg (CRESTOR equiv) (QL= 1 tab/day)	QL	\$0
simvastatin tab (ZOCOR equiv) (80mg is Not Covered)	-	\$0
atorvastatin tab 40mg (LIPITOR equiv)	-	1
atorvastatin tab 80mg (LIPITOR equiv)	-	1
rosuvastatin tab 20mg (CRESTOR equiv) (QL= 1.5 tabs/day)	QL	1
rosuvastatin tab 40mg (CRESTOR equiv) (QL= 1 tab/day)	QL	1
fluvastatin cap (LESCOL equiv)	-	2
LIVALO TAB (Step Therapy requires trial of atorvastatin, fluvastatin, lovastatin, pravastatin, rosuvastatin, or simvastatin)	ST	3
ADVICOR TAB	-	NC
ALTOPREV TAB	-	NC
FLOLIPID SUSP	-	NC
fluvastatin ER tab (LESCOL XL equiv)	-	NC
LESCOL XL TAB	-	NC
SIMCOR TAB	-	NC
simvastatin tab 80mg (ZOCOR equiv)	-	NC
ZOCOR TAB 80MG	-	NC
ZYPITAMAG TAB	-	NC
INTESTINAL CHOLESTEROL ABSORPTION INHIBITORS		
ezetimibe tab (ZETIA equiv)	-	1
ZETIA TAB	-	NC
MICROSOMAL TRIGLYCERIDE TRANSFER PROTEIN (MTP) INHIBITORS		
JUXTAPID CAP	-	NC
NICOTINIC ACID DERIVATIVES		
niacin ER tab (NIASPAN equiv)	-	1
NIACOR TAB	-	NC
NIASPAN ER TAB	-	NC
PROPROTEIN CONVERTASE SUBTILISIN/KEXIN TYPE 9 INHIBITORS		
PRALUENT INJ (QL= 2 inj/28 days)	LMSP-PA-QL	2
REPATHA INJ (QL= 2 inj/28 days)	LMSP-PA-QL	2
REPATHA PUSHTRONEX INJ (QL= 1 inj/28 days)	LMSP-PA-QL	2
ANTIHYPERTENSIVES		
ACE INHIBITORS		
benazepril tab (LOTENSIN equiv)	-	1
enalapril tab (VASOTEC equiv)	-	1
fosinopril tab (MONOPRIL equiv)	-	1
lisinopril tab (PRINIVIL/ZESTRIL equiv)	-	1
moexipril tab (UNIVASC equiv)	-	1
perindopril tab (ACEON equiv)	-	1
quinapril tab (ACCUPRIL equiv)	-	1
ramipril cap (ALTACE equiv)	-	1
trandolapril tab (MAVIK equiv)	-	1
captopril tab (CAPOTEN equiv)	-	2
Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.		
INF Infertility MSP Mandatory Specialty Pharmacy Program QL Quantity Limit SMKG Smoking Cessation VAC Vaccine Program	LD Limited Distribution OTC Over-the-Counter RS Restricted to Specialist SP Available through Specialty Pharmacy Program ¢ RxCENTS	generic =small letters LMSP Lumicera Mandatory Specialty Pharmacy Program PA Prior Authorization SF Limited to two 15 day fills per month for first 3 months ST Step Therapy BRANDS =CAPITAL LETTERS

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

**Texas Association of Counties HDHP Formulary
Category/Class**

Last Updated* 11/1/2018

DrugName	Special Code	Tier
ANTIHYPERTENSIVES Cont.		
EPANED PREMIXED SOLN	PA	3
EPANED SOLN	PA	3
QBRELIS SOLN	PA	3
AGENTS FOR PHEOCHROMOCYTOMA		
phenoxybenzamine cap (DIBENZYLIN equiv)	-	2
ANGIOTENSIN II RECEPTOR ANTAGONISTS		
irbesartan tab (AVAPRO equiv)	-	1
losartan tab (COZAAR equiv)	-	1
olmesartan tab (BENICAR equiv)	-	1
valsartan tab (DIOVAN equiv)	-	1
telmisartan tab (MICARDIS equiv)	-	2
ATACAND TAB	-	NC
candesartan tab (ATACAND equiv)	-	NC
EDARBI TAB	-	NC
EPROSARTAN TAB	-	NC
ANTIADRENERGIC ANTIHYPERTENSIVES		
clonidine tab (CATAPRES equiv)	-	1
doxazosin tab (CARDURA equiv)	-	1
guanfacine IR tab (TENEX equiv)	-	1
methyldopa tab (ALDOMET equiv)	-	1
prazosin cap (MINIPRESS equiv)	-	1
terazosin cap (HYTRIN equiv)	-	1
clonidine patch (CATAPRES-TTS equiv)	-	2
CATAPRES-TTS PATCH	-	3
GUANABENZ TAB	-	3
NEXICLON XR SUSP	-	3
NEXICLON XR TAB	-	3
RESERPINE TAB	-	3
ANTIHYPERTENSIVE COMBINATIONS		
amlodipine/benazepril cap (LOTREL equiv)	-	1
atenolol/chlorthalidone tab (TENORETIC equiv)	-	1
benazepril/hydrochlorothiazide tab (LOTENSIN HCT equiv)	-	1
bisoprolol/hydrochlorothiazide tab (ZIAC equiv)	-	1
enalapril/hydrochlorothiazide tab (VASERETIC equiv)	-	1
fosinopril/hydrochlorothiazide tab (MONOPRIL HCT equiv)	-	1
irbesartan/hydrochlorothiazide tab (AVALIDE equiv)	-	1
lisinopril/hydrochlorothiazide tab (ZESTORETIC equiv)	-	1
losartan/hydrochlorothiazide tab (HYZAAR equiv)	-	1
methyldopa/hydrochlorothiazide tab (ALDORIL equiv)	-	1
moexipril/hydrochlorothiazide tab (UNIRETIC equiv)	-	1
olmesartan/hydrochlorothiazide tab (BENICAR HCT equiv)	-	1
propranolol/hydrochlorothiazide tab (INDERIDE equiv)	-	1
quinapril/hydrochlorothiazide tab (ACCURETIC equiv)	-	1
valsartan/hydrochlorothiazide tab (DIOVAN HCT equiv)	-	1
amlodipine/olmesartan tab (AZOR equiv)	-	2
amlodipine/valsartan tab (EXFORGE equiv)	-	2

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

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

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

**Texas Association of Counties HDHP Formulary
Category/Class**

Last Updated* 11/1/2018

DrugName	Special Code	Tier
ANTIHYPERTENSIVES Cont.		
amlodipine/valsartan/hydrochlorothiazide tab (EXFORGE HCT equiv)	-	2
captopril/hydrochlorothiazide tab (CAPOZIDE equiv)	-	2
metoprolol/hydrochlorothiazide tab (LOPRESSOR HCT equiv)	-	2
AMTURNIDE TAB	-	3
CORZIDE TAB 80-5MG	-	3
nadolol/bendroflumethiazide tab (CORZIDE equiv)	-	3
TARKA TAB	-	3
TEKAMLO TAB	-	3
TEKTURNA HCT TAB	-	3
trandolapril/verapamil ER tab (TARKA equiv)	-	3
VALTURNA TAB	-	3
BYVALSON TAB	-	NC
candesartan/hydrochlorothiazide tab (ATACAND HCT equiv)	-	NC
DUTOPROL TAB	-	NC
EDARBYCLOR TAB	-	NC
MICARDIS HCT TAB	-	NC
olmesartan/amlodipine/hydrochlorothiazide tab (TRIBENZOR equiv)	-	NC
PRESTALIA TAB	-	NC
telmisartan/amlodipine tab (TWINSTA equiv)	-	NC
telmisartan/hydrochlorothiazide tab (MICARDIS HCT equiv)	-	NC
TEVETEN HCT TAB	-	NC
TRIBENZOR TAB	-	NC
DIRECT RENIN INHIBITORS		
TEKTURNA TAB	¢	3
SELECTIVE ALDOSTERONE RECEPTOR ANTAGONISTS (SARAS)		
eplerenone tab (INSPIRA equiv)	¢	3
VASODILATORS		
hydralazine tab (APRESOLINE equiv)	-	1
minoxidil tab (LONITEN equiv)	-	1
ANTI-INFECTIVE AGENTS - MISC.		
ANTI-INFECTIVE AGENTS - MISC.		
metronidazole cap (FLAGYL equiv)	-	1
metronidazole tab (FLAGYL equiv)	-	1
trimethoprim tab (PROLOPRIM equiv)	-	1
NEBUPENT NEB SOLN	-	2
FIRST METRONIDAZOLE SUSP	-	3
FLAGYL ER TAB	-	3
PRIMSOL SOLN	-	3
tinidazole tab (TINDAMAX equiv)	-	3
XIFAXAN TAB 200MG (QL= 9 tabs/3 days)	QL	3
XIFAXAN TAB 550MG (QL= 2 tabs/day; Quantities up to 3 tabs/day for the treatment of IBS-D allowed via PA)	PA-QL	3
colistimethate sodium inj (COLY-MYCIN M equiv)	-	NC
IMPAVIDO CAP	-	NC
ANTI-INFECTIVE MISC. - COMBINATIONS		
erythromycin/sulfisoxazole susp (PEDIAZOLE equiv)	-	1
smz/tmp (DS) tab (BACTRIM DS equiv)	-	1

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

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

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

**Texas Association of Counties HDHP Formulary
Category/Class**

Last Updated* 11/1/2018

DrugName	Special Code	Tier
ANTI-INFECTIVE AGENTS - MISC. Cont.		
smz/tmp susp (BACTRIM, SEPTRA equiv)	-	1
ANTIPROTOZOAL AGENTS		
ALINIA SUSP (QL= 60ml/3 days)	PA-QL	2
ALINIA TAB (QL= 6 tabs/3 days)	PA-QL	2
atovaquone susp (MEPRON equiv)	-	2
GLYCOPEPTIDES		
FIRVANQ SOLN	-	1
VANCOMYCIN SOLN KIT	-	1
vancomycin cap (VANCOCIN equiv) (QL= 56 caps/fill; Step Therapy requires trial of vancomycin soln or FIRVANQ SOLN)	QL-ST	2
VANCOMYCIN INJ	-	NC
KETOLIDES		
KETEK TAB	-	3
LEPROSTATICS		
dapsone tab	-	1
LINCOSAMIDES		
clindamycin cap (CLEOCIN equiv)	-	1
clindamycin soln (CLEOCIN equiv)	-	3
MONOBACTAMS		
CAYSTON INH SOLN (Restricted to Infectious Disease or Pulmonology Specialist; Only available through Walgreens 888-347-3416)	LD-RS	2
OXAZOLIDINONES		
linezolid susp (ZYVOX equiv) (Restricted to Infectious Disease Specialist)	RS	2
linezolid tab (ZYVOX equiv) (Restricted to Infectious Disease Specialist)	RS	2
SIVEXTRO TAB (QL= 6 tabs/fill; Restricted to Infectious Disease Specialist)	QL-RS	2
ANTIMALARIALS		
ANTIMALARIAL COMBINATIONS		
atovaquone/proguanil tab (MALARONE equiv)	-	2
MALARONE TAB	-	2
FANSIDAR TAB	-	3
ANTIMALARIALS		
chloroquine tab (ARALEN equiv)	-	1
hydroxychloroquine tab (PLAQUENIL equiv)	-	1
DARAPRIM TAB (QL= 3 tabs/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	2
MEFLOQUINE TAB	-	2
mefloquine tab (LARIAM equiv)	-	2
PRIMAQUINE TAB	-	2
QUALAQUIN CAP	-	NC
quinine sulfate cap (QUALAQUIN equiv)	-	NC
ANTIMYASTHENIC/CHOLINERGIC AGENTS		
ANTIMYASTHENIC/CHOLINERGIC AGENTS		
pyridostigmine tab (MESTINON equiv)	-	1
PROSTIGMIN TAB	-	2
pyridostigmine CR tab (MESTINON equiv)	-	2
MESTINON SYRUP	-	3

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

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

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

**Texas Association of Counties HDHP Formulary
Category/Class**

Last Updated* 11/1/2018

DrugName	Special Code	Tier
ANTIMYCOBACTERIAL AGENTS		
ANTI TB COMBINATIONS		
RIFAMATE CAP	-	2
ANTIMYCOBACTERIAL AGENTS		
ISONIAZID SYRUP	-	1
isoniazid tab	-	1
pyrazinamide tab	-	1
ethambutol tab (MYAMBUTOL equiv)	-	2
PRIFTIN TAB	-	2
rifabutin cap (MYCOBUTIN equiv)	-	2
rifampin cap (RIFADIN equiv)	-	2
CYCLOSERINE CAP	-	NC
SIRTURO TAB	-	NC
ANTINEOPLASTICS		
ANTINEOPLASTICS MISC.		
tretinoin cap (VESANOID equiv)	LMSP	2
MITOTIC INHIBITORS		
etoposide cap (VEPESID equiv)	LMSP	2
TOPOISOMERASE I INHIBITORS		
HYCAMTIN CAP	LMSP-PA	2
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES		
ALKYLATING AGENTS		
AFINITOR TAB (QL= 1 tab/day)	LMSP-PA-QL-SF	2
CEENU CAP	-	2
cyclophosphamide cap	-	2
cyclophosphamide tab (CYTOXAN equiv)	-	2
GLEOSTINE/LOMUSTINE CAP	-	2
HEXALEN CAP	-	2
LEUKERAN TAB	-	2
melphalan tab (ALKERAN equiv)	-	2
MYLERAN TAB	LMSP	2
temozolomide cap (TEMODAR equiv)	LMSP	2
ANTIMETABOLITES		
methotrexate inj	-	1
methotrexate tab (TREXALL equiv)	-	1
capecitabine tab (XELODA equiv)	LMSP	2
mercaptopurine tab (PURINETHOL equiv)	-	2
METHOTREXATE INJ	-	2
TABLOID TAB	-	2
PURIXAN SUSP	-	NC
XATMEP SOLN	-	NC
ANTINEOPLASTIC - ANTIBODIES		
GAZYVA INJ	-	NC
ANTINEOPLASTIC - BCL-2 INHIBITORS		
VENCLEXTA STARTER PACK (Only available through Diplomat Pharmacy 877-977-9118)	LD-PA	2
VENCLEXTA TAB (Only available through Diplomat Pharmacy 877-977-9118)	LD-PA	2
Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.		

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

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

**Texas Association of Counties HDHP Formulary
Category/Class**

Last Updated* 11/1/2018

DrugName	Special Code	Tier															
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES Cont.																	
ANTINEOPLASTIC - HEDGEHOG PATHWAY INHIBITORS																	
ERIVEDGE CAP	MSP-PA-SF	2															
ODOMZO CAP	LMSP-PA-SF	2															
ANTINEOPLASTIC - HORMONAL AND RELATED AGENTS																	
tamoxifen tab (NOLVADEX equiv) (Covered at \$0 for women 35 years or older; All other members covered at generic copay)	-	\$0															
anastrozole tab (ARIMIDEX equiv)	-	1															
bicalutamide tab (CASODEX equiv)	-	1															
letrozole tab (FEMARA equiv)	-	1															
megestrol susp (MEGACE equiv)	-	1															
megestrol tab (MEGACE equiv)	-	1															
EMCYT CAP	-	2															
exemestane tab (AROMASIN equiv)	-	2															
FARESTON TAB	-	2															
flutamide cap (EULEXIN equiv)	-	2															
LYSODREN TAB (Only available through Direct Success 732-919-1234)	LD	2															
nilutamide tab (NILANDRON equiv)	LMSP	2															
XTANDI CAP (QL= 4 caps/day)	MSP-PA-QL-SF	2															
ZYTIGA TAB 250MG (QL= 4 tabs/day)	LMSP-PA-QL-SF	2															
ZYTIGA TAB 500MG (QL= 2 tabs/day)	LMSP-PA-QL-SF	2															
ERLEADA TAB	-	NC															
HYDROXYPROGESTERONE CAPROATE INJ	-	NC															
YONSA TAB	-	NC															
ANTINEOPLASTIC - IMMUNOMODULATORS																	
POMALYST CAP	-	NC															
ANTINEOPLASTIC COMBINATIONS																	
KISQALI PAK (QL= 91 tabs/28 days)	LMSP-PA-QL	2															
LONSURF TAB (Only available through Walgreens 888-347-3416)	LD-PA	2															
ANTINEOPLASTIC ENZYME INHIBITORS																	
AFINITOR DISPERZ (QL= 1 tab/day)	LMSP-PA-QL-SF	2															
ALECENSA CAP (QL= 8 caps/day)	MSP-PA-QL	2															
ALUNBRIG TAB 30MG (QL= 4 tabs/day; Only available through Biologics 800-850-4306)	LD-PA-QL-SF	2															
ALUNBRIG TAB 90MG, 180MG (QL= 1 tab/day; Only available through Biologics 800-850-4306)	LD-PA-QL-SF	2															
BOSULIF TAB	MSP-PA-SF	2															
CABOMETYX TAB (QL= 1 tab/day)	MSP-PA-QL-SF	2															
CALQUENCE CAP (QL= 2 caps/day; Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-QL-SF	2															
CAPRELSA TAB (Only available through Biologics 800-850-4306)	LD-PA	2															
COMETRIQ KIT (Only available through Diplomat Pharmacy 877-977-9118)	LD-PA	2															
COTELLIC TAB (QL= 3 tabs/day)	MSP-PA-QL	2															
FARYDAK CAP (QL= 6 caps/21 days)	MSP-PA-QL	2															
GILOTRIF TAB (QL= 1 tab/day; Only available through Accredo 888-773-7376)	LD-PA-QL	2															
IBRANCE CAP (QL= 21 caps/28 days)	MSP-PA-QL	2															
ICLUSIG TAB (Only available through Biologics 800-850-4306)	LD-PA-SF	2															
IDHIFA TAB (QL= 1 tab/day)	MSP-PA-QL	2															
imatinib tab (GLEEVEC equiv)	LMSP-PA-SF	2															
IMBRUVICA CAP 140MG (QL= 3 caps/day; Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-QL	2															
Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.																	
<table border="0" style="width: 100%;"> <tr> <td style="width: 33%;">INF Infertility</td> <td style="width: 33%;">LD Limited Distribution</td> <td style="width: 33%;">LMSP Lumicera Mandatory Specialty Pharmacy Program</td> </tr> <tr> <td>MSP Mandatory Specialty Pharmacy Program</td> <td>OTC Over-the-Counter</td> <td>PA Prior Authorization</td> </tr> <tr> <td>QL Quantity Limit</td> <td>RS Restricted to Specialist</td> <td>SF Limited to two 15 day fills per month for first 3 months</td> </tr> <tr> <td>SMKG Smoking Cessation</td> <td>SP Available through Specialty Pharmacy Program</td> <td>ST Step Therapy</td> </tr> <tr> <td>VAC Vaccine Program</td> <td>¢ RxCENTS</td> <td></td> </tr> </table>	INF Infertility	LD Limited Distribution	LMSP Lumicera Mandatory Specialty Pharmacy Program	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter	PA Prior Authorization	QL Quantity Limit	RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation	SP Available through Specialty Pharmacy Program	ST Step Therapy	VAC Vaccine Program	¢ RxCENTS			
INF Infertility	LD Limited Distribution	LMSP Lumicera Mandatory Specialty Pharmacy Program															
MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter	PA Prior Authorization															
QL Quantity Limit	RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months															
SMKG Smoking Cessation	SP Available through Specialty Pharmacy Program	ST Step Therapy															
VAC Vaccine Program	¢ RxCENTS																

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

**Texas Association of Counties HDHP Formulary
Category/Class**

Last Updated* 11/1/2018

DrugName	Special Code	Tier						
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES Cont.								
IMBRUVICA CAP 70MG (QL= 1 cap/day; Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-QL	2						
IMBRUVICA TAB (QL= 1 tab/day; Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-QL	2						
INLYTA TAB (QL= 8 tabs/day)	MSP-PA-QL-SF	2						
IRESSA TAB (Only available through Diplomat Pharmacy 877-977-9118)	LD-PA	2						
JAKAFI TAB (QL= 2 tabs/day)	MSP-PA-QL	2						
KISQALI TAB (QL= 63 tabs/28 days)	LMSP-PA-QL	2						
LENVIMA CAP (QL= 3 caps/day; Only available through Accredo 888-773-7376)	LD-PA-QL	2						
LYNPARZA CAP (Only available through Biologics 800-850-4306, QL= 16 caps/day)	LD-PA-QL-SF	2						
LYNPARZA TAB (Only available through Biologics 800-850-4306, QL= 4 tabs/day)	LD-PA-QL-SF	2						
MEKINIST TAB	LMSP-PA	2						
NERLYNX TAB (QL= 6 tabs/day; Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-QL-SF	2						
NEXAVAR TAB	MSP-PA-SF	2						
NINLARO CAP	MSP-PA	2						
RUBRACA TAB (QL= 4 tabs/day; Only available through Avella Pharmacy (877) 546-5779)	LD-PA-QL-SF	2						
RYDAPT CAP	LMSP-PA	2						
SPRYCEL TAB	LMSP-PA-SF	2						
STIVARGA TAB (QL= 4 tabs/day)	MSP-PA-QL-SF	2						
SUTENT CAP	MSP-PA-SF	2						
TAFINLAR CAP (QL= 4 caps/day)	LMSP-PA-QL-SF	2						
TAGRISSO TAB (QL= 1 tab/day; Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-QL-SF	2						
TARCEVA TAB	LMSP-PA-SF	2						
TASIGNA CAP	LMSP-PA-SF	2						
TYKERB TAB	LMSP-PA	2						
VERZENIO TAB (QL= 2 tabs/day)	MSP-PA-QL-SF	2						
VOTRIENT TAB	LMSP-PA-SF	2						
XALKORI CAP (QL= 2 caps/day)	MSP-PA-QL-SF	2						
ZEJULA CAP (QL= 3 caps/day; Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-QL-SF	2						
ZELBORAF TAB	MSP-PA-SF	2						
ZOLINZA CAP	LMSP-PA-SF	2						
ZYDELIG TAB (Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-SF	2						
ZYKADIA CAP (QL= 3 caps/day)	LMSP-PA-QL-SF	2						
ALUNBRIG PAK	-	NC						
BRAFTOVI CAP	-	NC						
COPIKTRA CAP	-	NC						
MEKTOVI TAB	-	NC						
TALZENNA CAP	-	NC						
TIBSOVO TAB	-	NC						
VIZIMPRO TAB	-	NC						
ANTINEOPLASTICS MISC.								
hydroxyurea cap (HYDREA equiv)	-	1						
ACTIMMUNE INJ (Only available through Walgreens 888-347-3416)	LD-PA	2						
ALFERON-N INJ	LMSP	2						
bexarotene cap (TARGRETIN equiv)	LMSP-PA-SF	2						
INTRON-A INJ	MSP	2						
MATULANE CAP	-	2						
SYLATRON INJ	MSP-PA	3						
PROLEUKIN INJ	-	NC						
Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.								
<table border="0" style="width: 100%;"> <tr> <td style="width: 33%;"> NC =Not Covered INF Infertility MSP Mandatory Specialty Pharmacy Program QL Quantity Limit SMKG Smoking Cessation VAC Vaccine Program </td> <td style="width: 33%;"> LD Limited Distribution OTC Over-the-Counter RS Restricted to Specialist SP Available through Specialty Pharmacy Program ¢ RxCENTS </td> <td style="width: 33%;"> generic =small letters LMSP Lumicera Mandatory Specialty Pharmacy Program PA Prior Authorization SF Limited to two 15 day fills per month for first 3 months ST Step Therapy </td> </tr> <tr> <td colspan="3"> BRANDS =CAPITAL LETTERS </td> </tr> </table>			NC =Not Covered INF Infertility MSP Mandatory Specialty Pharmacy Program QL Quantity Limit SMKG Smoking Cessation VAC Vaccine Program	LD Limited Distribution OTC Over-the-Counter RS Restricted to Specialist SP Available through Specialty Pharmacy Program ¢ RxCENTS	generic =small letters LMSP Lumicera Mandatory Specialty Pharmacy Program PA Prior Authorization SF Limited to two 15 day fills per month for first 3 months ST Step Therapy	BRANDS =CAPITAL LETTERS		
NC =Not Covered INF Infertility MSP Mandatory Specialty Pharmacy Program QL Quantity Limit SMKG Smoking Cessation VAC Vaccine Program	LD Limited Distribution OTC Over-the-Counter RS Restricted to Specialist SP Available through Specialty Pharmacy Program ¢ RxCENTS	generic =small letters LMSP Lumicera Mandatory Specialty Pharmacy Program PA Prior Authorization SF Limited to two 15 day fills per month for first 3 months ST Step Therapy						
BRANDS =CAPITAL LETTERS								

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

**Texas Association of Counties HDHP Formulary
Category/Class**

Last Updated* 11/1/2018

DrugName	Special Code	Tier
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES Cont.		
SYNRIBO INJ	-	NC
CHEMOTHERAPY RESCUE/ANTIDOTE AGENTS		
leucovorin tab	-	1
MESNEX TAB	LMSP	2
ANTIPARKINSON AGENTS		
ANTIPARKINSON ADJUVANTS		
carbidopa tab (LODOSYN equiv)	-	2
ANTIPARKINSON ANTICHOLINERGICS		
benztropine tab	-	1
trihexyphenidyl elixir (ARTANE equiv)	-	1
trihexyphenidyl tab (ARTANE equiv)	-	1
ANTIPARKINSON COMT INHIBITORS		
entacapone tab (COMTAN equiv)	-	2
tolcapone tab (TASMAR equiv)	-	3
ANTIPARKINSON DOPAMINERGICS		
amantadine cap (SYMMETREL equiv)	-	1
amantadine syrup (SYMMETREL equiv)	-	1
carbidopa/levodopa ER tab (SINEMET CR equiv)	-	1
carbidopa/levodopa ODT (PARCOPA equiv)	-	1
carbidopa/levodopa tab (SINEMET equiv)	-	1
pramipexole tab (MIRAPEX equiv)	-	1
ropinirole tab (REQUIP equiv)	-	1
amantadine tab	-	2
APOKYN INJ (Only available through CVS Specialty 800-237-2767)	LD	2
bromocriptine cap (PARLODEL equiv)	-	2
bromocriptine tab (PARLODEL equiv)	-	2
CARBIDOPA/LEVODOPA/ENTACAPONE TAB (STALEVO equiv)	-	2
NEUPRO PATCH	-	3
pramipexole ER tab (MIRAPEX ER equiv)	-	3
ropinirole ER tab (REQUIP XL equiv)	-	3
DUOPA ENTERAL SUSP	-	NC
GOCOVRI CAP	-	NC
MIRAPEX ER TAB	-	NC
RYTARY CAP	-	NC
ANTIPARKINSON MONOAMINE OXIDASE INHIBITORS		
selegiline cap (ELDEPRYL equiv)	-	1
selegiline tab (ELDEPRYL equiv)	-	1
rasagiline tab (AZILECT equiv)	¢	2
XADAGO TAB (QL= 1 tab/day)	PA-QL	3
ZELAPAR ODT	-	3

ANTIPARKINSON AND RELATED THERAPY AGENTS

ANTIPARKINSON DOPAMINERGICS		
OSMOLEX ER TAB	-	NC

ANTIPSYCHOTICS/ANTIMANIC AGENTS

ANTIMANIC AGENTS																	
Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.																	
<table style="width: 100%; border: none;"> <tr> <td style="width: 33%;">INF Infertility</td> <td style="width: 33%;">LD Limited Distribution</td> <td style="width: 33%;">LMSP Lumicera Mandatory Specialty Pharmacy Program</td> </tr> <tr> <td>MSP Mandatory Specialty Pharmacy Program</td> <td>OTC Over-the-Counter</td> <td>PA Prior Authorization</td> </tr> <tr> <td>QL Quantity Limit</td> <td>RS Restricted to Specialist</td> <td>SF Limited to two 15 day fills per month for first 3 months</td> </tr> <tr> <td>SMKG Smoking Cessation</td> <td>SP Available through Specialty Pharmacy Program</td> <td>ST Step Therapy</td> </tr> <tr> <td>VAC Vaccine Program</td> <td>¢ RxCENTS</td> <td></td> </tr> </table>	INF Infertility	LD Limited Distribution	LMSP Lumicera Mandatory Specialty Pharmacy Program	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter	PA Prior Authorization	QL Quantity Limit	RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation	SP Available through Specialty Pharmacy Program	ST Step Therapy	VAC Vaccine Program	¢ RxCENTS			
INF Infertility	LD Limited Distribution	LMSP Lumicera Mandatory Specialty Pharmacy Program															
MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter	PA Prior Authorization															
QL Quantity Limit	RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months															
SMKG Smoking Cessation	SP Available through Specialty Pharmacy Program	ST Step Therapy															
VAC Vaccine Program	¢ RxCENTS																

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

**Texas Association of Counties HDHP Formulary
Category/Class**

Last Updated* 11/1/2018

DrugName	Special Code	Tier
ANTIPSYCHOTICS/ANTIMANIC AGENTS Cont.		
lithium carbonate cap (ESKALITH ER equiv)	-	1
lithium carbonate ER tab (LITHOBID equiv)	-	1
lithium carbonate tab	-	1
lithium citrate soln	-	1
ANTIPSYCHOTICS - MISC.		
ziprasidone cap (GEODON equiv)	-	1
EQUETRO CAP	-	2
LATUDA TAB (QL= 1 tab/day; Step Therapy requires trial of quetiapine)	QL-ST	2
NUPLAZID CAP	-	NC
NUPLAZID TAB	-	NC
VRAYLAR CAP	-	NC
VRAYLAR PACK	-	NC
BENZISOXAZOLES		
risperidone soln (RISPERDAL equiv)	-	1
risperidone tab (RISPERDAL equiv)	-	1
paliperidone ER tab (INVEGA equiv)	PA	2
RISPERIDONE ODT	-	2
risperidone ODT (RISPERDAL M equiv)	-	2
FANAPT TAB (QL= 2 tabs/day)	PA-QL	3
FANAPT TITRATION PACK (QL= 1 pack/plan year)	PA-QL	3
INVEGA INJ	-	NC
BUTYROPHENONES		
haloperidol lactate conc (HALDOL equiv)	-	1
haloperidol tab (HALDOL equiv)	-	1
DIBENZAPINES		
loxapine cap (LOXITANE equiv)	-	1
olanzapine tab (ZYPREXA equiv)	-	1
quetiapine tab (SEROQUEL equiv)	-	1
clozapine ODT 12.5mg, 25mg, 100mg (CLOZAPINE, FAZACLO equiv)	-	2
CLOZAPINE ODT, FAZACLO ODT	-	2
clozapine tab (CLOZARIL equiv)	-	2
olanzapine ODT (ZYPREXA equiv)	-	2
quetiapine XR tab (SEROQUEL XR equiv)	-	2
SAPHRIS SL TAB (QL= 2 tabs/day)	PA-QL	3
ADASUVE INHALER	-	NC
SEROQUEL TAB	-	NC
SEROQUEL XR TAB	-	NC
VERSACLOZ SUSP	-	NC
PHENOTHIAZINES		
chlorpromazine tab (THORAZINE equiv)	-	1
fluphenazine tab (PROLIXIN equiv)	-	1
perphenazine tab (TRILAFON equiv)	-	1
prochlorperazine supp (COMPAZINE equiv)	-	1
prochlorperazine tab (COMPAZINE equiv)	-	1
thioridazine tab (MELLARIL equiv)	-	1
trifluoperazine tab (STELAZINE equiv)	-	1

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

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

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

**Texas Association of Counties HDHP Formulary
Category/Class**

Last Updated* 11/1/2018

DrugName	Special Code	Tier
ANTIPSYCHOTICS/ANTIMANIC AGENTS Cont.		
QUINOLINONE DERIVATIVES		
aripiprazole tab (ABILIFY equiv)	-	1
ABILIFY DISCMELT (QL= 2 tabs/day)	PA-QL	3
ABILIFY SOLN	PA	3
aripiprazole ODT (ABILIFY equiv) (QL= 2 tabs/day)	PA-QL	3
aripiprazole soln (ABILIFY equiv)	PA	3
ABILIFY TAB	-	NC
REXULTI TAB	-	NC
THIOXANTHENES		
thiothixene cap (NAVANE equiv)	-	1
ANTISEPTICS & DISINFECTANTS		
CHLORINE ANTISEPTICS		
PHISOHEX LIQUID	-	3
IODINE ANTISEPTICS		
IODOFLEX PAD	-	NC
ANTIVIRALS		
ANTIRETROVIRALS		
nevirapine tab (VIRAMUNE equiv)	-	1
abacavir soln (ZIAGEN equiv)	-	2
abacavir tab (ZIAGEN equiv)	-	2
abacavir/lamivudine tab (EPZICOM equiv)	-	2
abacavir/lamivudine/zidovudine tab (TRIZIVIR equiv)	-	2
APTIVUS CAP	-	2
APTIVUS SOLN	-	2
atazanavir cap (REYATAZ equiv)	-	2
ATRIPLA TAB	-	2
BIKTARVY TAB	-	2
CIMDUO TAB	-	2
COMPLERA TAB	-	2
CRIXIVAN CAP	-	2
DESCOVY TAB	PA	2
didanosine DR cap (VIDEX EC equiv)	-	2
EDURANT TAB	-	2
efavirenz cap (SUSTIVA equiv)	-	2
efavirenz tab (SUSTIVA equiv)	-	2
EMTRIVA CAP	-	2
EMTRIVA SOLN	-	2
EVOTAZ TAB	-	2
fosamprenavir tab (LEXIVA equiv)	-	2
FUZEON INJ	LMSP	2
GENVOYA TAB	-	2
INTELENCE TAB	-	2
INVIRASE CAP	-	2
INVIRASE TAB	-	2
ISENTRESS (HD) TAB	-	2

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

INF Infertility	LD Limited Distribution	LMSP Lumicera Mandatory Specialty Pharmacy Program
MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter	PA Prior Authorization
QL Quantity Limit	RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months
SMKG Smoking Cessation	SP Available through Specialty Pharmacy Program	ST Step Therapy
VAC Vaccine Program	¢ RxCENTS	

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

**Texas Association of Counties HDHP Formulary
Category/Class**

Last Updated* 11/1/2018

DrugName	Special Code	Tier
ANTIVIRALS Cont.		
ISENTRESS CHEW TAB	-	2
ISENTRESS POWDER PACK	-	2
JULUCA TAB	-	2
KALETRA TAB	-	2
lamivudine soln (EPIVIR equiv)	-	2
lamivudine tab (EPIVIR equiv)	-	2
lamivudine/zidovudine tab (COMBIVIR equiv)	-	2
LEXIVA SUSP	-	2
lopinavir/ritonavir soln (KALETRA equiv)	-	2
nevirapine ER tab (VIRAMUNE XR equiv) (Step Therapy requires trial of nevirapine)	ST	2
NEVIRAPINE SUSP (VIRAMUNE equiv)	-	2
NORVIR CAP	-	2
NORVIR POWDER PACK	-	2
NORVIR SOLN	-	2
ODEFSEY TAB	-	2
PREZCOBIX TAB	-	2
PREZISTA SUSP	-	2
PREZISTA TAB	-	2
RESCRIPTOR TAB	-	2
REYATAZ POWDER PACK	-	2
ritonavir tab (NORVIR equiv)	-	2
SELZENTRY SOLN	-	2
SELZENTRY TAB	-	2
stavudine cap (ZERIT equiv)	-	2
stavudine soln (ZERIT equiv)	-	2
STRIBILD TAB	-	2
SYMFI (LO) TAB	-	2
SYMTUZA TAB	-	2
tenofovir disoproxil fumarate tab (VIREAD equiv)	-	2
TIVICAY TAB (QL= 2 tabs/day)	QL	2
TRIUMEQ TAB	-	2
TRUVADA TAB	PA	2
VIDEX EC CAP 125MG	-	2
VIDEX SOLN	-	2
VIRACEPT POWDER	-	2
VIRACEPT TAB	-	2
VIREAD TAB	-	2
VITEKTA TAB	-	2
zidovudine cap (RETROVIR equiv)	-	2
zidovudine syrup (RETROVIR equiv)	-	2
zidovudine tab (RETROVIR equiv)	-	2
SUSTIVA TAB	-	3
ZERIT SOLN	-	3
DELSTRIGO TAB	-	NC
PIFELTRO TAB	-	NC
TYBOST TAB	-	NC

CMV AGENTS

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

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

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

**Texas Association of Counties HDHP Formulary
Category/Class**

Last Updated* 11/1/2018

DrugName	Special Code	Tier
ANTIVIRALS Cont.		
GANCICLOVIR CAP	-	2
valganciclovir soln (VALCYTE equiv)	-	2
valganciclovir tab (VALCYTE equiv)	-	2
PREVYMIS TAB	-	NC
HEPATITIS AGENTS		
adefovir dipivoxil tab (HEPSERA equiv)	LMSP	2
entecavir tab (BARACLUDE equiv) (QL= 1 tab/day)	QL	2
EPCLUSA TAB (QL= 1 tab/day)	LMSP-PA-QL	2
EPIVIR HBV SOLN	-	2
HARVONI TAB (QL= 1 tab/day)	LMSP-PA-QL	2
INFERGEN INJ	LMSP	2
lamivudine tab 100mg (EPIVIR HBV equiv)	-	2
MAVYRET TAB (QL= 3 tabs/day)	LMSP-PA-QL	2
PEGASYS INJ	LMSP-PA	2
PEGASYS INJ KIT	LMSP-PA	2
PEG-INTRON INJ	LMSP	2
REBETOL SOLN	LMSP	2
RIBATAB	LMSP	2
ribavirin cap (REBETOL equiv)	LMSP	2
ribavirin tab (COPEGUS equiv)	LMSP	2
VEMLIDY TAB	-	2
VOSEVI TAB (QL= 1 tab/day)	LMSP-PA-QL	2
DAKLINZA TAB	-	NC
INCIVEK TAB	-	NC
OLYSIO CAP	-	NC
RIBAPAK TAB	-	NC
SOVALDI TAB	-	NC
TECHNIVIE TAB	-	NC
TYZEKA TAB	-	NC
VICTRELIS CAP	-	NC
VIEKIRA XR TAB	-	NC
ZEPATIER TAB	-	NC
HERPES AGENTS		
acyclovir cap (ZOVIRAX equiv)	-	1
acyclovir susp (ZOVIRAX equiv)	-	1
acyclovir tab (ZOVIRAX equiv)	-	1
valacyclovir tab (VALTREX equiv)	-	1
famciclovir tab (FAMVIR equiv)	-	3
SITAVIG TAB	-	NC
INFLUENZA AGENTS		
rimantadine tab (FLUMADINE equiv)	-	1
oseltamivir cap (TAMIFLU equiv) (QL= 10 caps/fill)	QL	2
oseltamivir cap 30mg (TAMIFLU equiv) (QL= 20 caps/fill)	QL	2
oseltamivir susp (TAMIFLU equiv) (QL= 250ml/fill)	QL	2
RELENZA DISKHALER (QL= 1 inhaler/fill)	QL	2
XOFLUZA TAB	-	NC

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

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

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

**Texas Association of Counties HDHP Formulary
Category/Class**

Last Updated* 11/1/2018

DrugName	Special Code	Tier
ANTIVIRALS Cont.		
RESPIRATORY SYNCYTIAL VIRUS (RSV) AGENTS		
ribavirin inh soln (VIRAZOLE equiv)	-	NC
ASSORTED CLASSES		
CHELATING AGENTS		
DEPEN TITRATAB	-	2
CUPRIMINE CAP	-	NC
IMMUNOMODULATORS		
REVLIMID CAP (QL= 1 cap/day)	MSP-PA-QL	2
THALOMID CAP	MSP-PA	2
IMMUNOSUPPRESSIVE AGENTS		
azathioprine tab (IMURAN equiv)	-	1
mycophenolate mofetil cap (CELLCEPT equiv)	-	1
mycophenolate mofetil tab (CELLCEPT equiv)	-	1
cyclosporine cap (SANDIMMUNE equiv)	-	2
cyclosporine modified cap (NEORAL equiv)	-	2
cyclosporine modified soln (NEORAL equiv)	-	2
mycophenolate DR tab (MYFORTIC equiv)	-	2
mycophenolate mofetil susp (CELLCEPT SUSP equiv)	-	2
RAPAMUNE SOLN	-	2
SANDIMMUNE SOLN 100MG/ML	-	2
sirolimus tab (RAPAMUNE equiv)	-	2
tacrolimus cap (PROGRAF equiv)	-	2
ZORTRESS TAB	PA	2
AZASAN TAB	-	3
ENVARUSUS XR TAB	-	NC
POTASSIUM REMOVING RESINS		
sodium polystyrene susp (SPS equiv)	-	1
sodium polystyrene powder (KAYEXALATE equiv)	-	2
VELTASSA POWDER	PA	2
BETA BLOCKERS		
ALPHA-BETA BLOCKERS		
carvedilol tab (COREG equiv)	-	1
labetalol tab (NORMODYNE equiv)	-	1
carvedilol phosphate ER cap (COREG CR equiv)	-	NC
COREG CR CAP	-	NC
BETA BLOCKERS CARDIO-SELECTIVE		
acebutolol cap (SECTRAL equiv)	-	1
atenolol tab (TENORMIN equiv)	-	1
betaxolol tab (KERLONE equiv)	-	1
bisoprolol tab (ZEBETA equiv)	-	1
metoprolol ER tab (TOPROL XL equiv)	-	1
metoprolol tab (LOPRESSOR equiv)	-	1
BYSTOLIC TAB	¢	2
KAPSPARGO CAP	-	NC
METOPROLOL TARTRATE TAB 37.5MG, 75MG	-	NC

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

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

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

**Texas Association of Counties HDHP Formulary
Category/Class**

Last Updated* 11/1/2018

DrugName	Special Code	Tier
----------	--------------	------

BETA BLOCKERS Cont.

BETA BLOCKERS NON-SELECTIVE

pindolol tab (VISKEN equiv)	-	1
propranolol ER cap (INDERAL LA equiv)	-	1
PROPRANOLOL SOLN	-	1
propranolol tab (INDERAL equiv)	-	1
sotalol AF tab (BETAPACE AF equiv)	-	1
sotalol tab (BETAPACE equiv)	-	1
timolol maleate tab (BLOCADREN equiv)	-	1
nadolol tab (CORGARD equiv)	-	2
LEVATOL TAB	-	3
HEMANGEOL SOLN	-	NC
INNOPRAN XL CAP	-	NC
SOTYLIZE SOLN	-	NC

BIOLOGICALS MISC

ALLERGENIC EXTRACTS

GRASTEK SL TAB	-	NC
ORALAIR SL TAB	-	NC
RAGWITEK SL TAB	-	NC

CALCIUM CHANNEL BLOCKERS

CALCIUM CHANNEL BLOCKERS

amlodipine tab (NORVASC equiv)	-	1
diltiazem ER cap (CARDIZEM CD equiv)	-	1
diltiazem ER cap (CARDIZEM SR equiv)	-	1
diltiazem ER cap (DILACOR XR equiv)	-	1
diltiazem ER cap (TIAZAC equiv)	-	1
diltiazem tab (CARDIZEM equiv)	-	1
isradipine cap (DYNACIRC equiv)	-	1
nicardipine cap (CARDENE equiv)	-	1
nifedipine cap (PROCARDIA equiv)	-	1
nifedipine ER tab (ADALAT CC equiv)	-	1
verapamil SR cap (VERELAN SR equiv)	-	1
VERAPAMIL SR CAP 360mg	-	1
verapamil SR tab (CALAN SR, ISOPTIN SR equiv)	-	1
verapamil tab (CALAN equiv)	-	1
diltiazem ER tab (CARDIZEM LA equiv)	-	2
nisoldipine ER tab (SULAR equiv)	-	2
CARDENE SR CAP	-	3
COVERA-HS TAB	-	3
DYNACIRC CR TAB	-	3
felodipine ER tab (PLENDIL equiv)	-	3
nimodipine cap (NIMOTOP equiv)	-	3
verapamil SR cap (VERELAN PM equiv)	-	3
VERELAN SR CAP 360mg	-	3

CARDIOTONICS

CARDIAC GLYCOSIDES

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

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

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

**Texas Association of Counties HDHP Formulary
Category/Class**

Last Updated* 11/1/2018

DrugName	Special Code	Tier
CARDIOTONICS Cont.		
digoxin soln (LANOXIN equiv)	-	1
digoxin tab (LANOXIN equiv)	-	1
LANOXIN INJ	-	NC
LANOXIN TAB 0.0625MG, 0.1875MG	-	NC
CARDIOVASCULAR AGENTS - MISC.		
CARDIOVASCULAR AGENTS MISC. - COMBINATIONS		
amlodipine/atorvastatin tab (CADUET equiv)	-	2
ENTRESTO TAB (QL= 2 tabs/day)	PA-QL	2
PERIPHERAL VASODILATORS		
isoxsuprine tab	-	3
PROSTAGLANDIN VASODILATORS		
TYVASO INH SOLN (QL= 1 ampule/day; Only available through Accredo 888-773-7376)	LD-PA-QL	2
VENTAVIS INH SOLN (QL= 9 ampules/day; Only available through Accredo 888-773-7376)	LD-PA-QL	2
ORENITRAM TAB	-	NC
PULMONARY HYPERTENSION - ENDOTHELIN RECEPTOR ANTAGONISTS		
LETAIRIS TAB (QL= 1 tab/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	2
OPSUMIT TAB (QL= 1 tab/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	2
TRACLEER TAB 32MG (QL=4 tabs/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	2
TRACLEER TAB 62.5MG, 125MG (QL= 2 tabs/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	2
PULMONARY HYPERTENSION - PHOSPHODIESTERASE INHIBITORS		
sildenafil tab 20mg (REVATIO equiv)	PA	1
tadalafil tab (PAH) (ADCIRCA equiv)	LMSP-PA	2
REVATIO SUSP	-	NC
PULMONARY HYPERTENSION - PROSTACYCLIN RECEPTOR AGONIST		
UPTRAVI TAB (QL= 2 tabs/day; Only available through Accredo 888-773-7376)	LD-PA-QL	2
PULMONARY HYPERTENSION - SOL GUANYLATE CYCLASE STIMULATOR		
ADEMPAS TAB (QL= 3 tabs/day; Only available through Accredo 888-773-7376)	LD-PA-QL	2
SINUS NODE INHIBITORS		
CORLANOR TAB	PA	3
CEPHALOSPORINS		
CEPHALOSPORINS - 1ST GENERATION		
cefadroxil cap (DURICEF equiv)	-	1
cefadroxil susp (DURICEF equiv)	-	1
cefadroxil tab (DURICEF equiv)	-	1
cephalexin cap (KEFLEX equiv)	-	1
cephalexin susp (KEFLEX equiv)	-	1
CEPHALEXIN TAB	-	NC
DAXBIA CAP	-	NC
CEPHALOSPORINS - 2ND GENERATION		
cefuroxime susp (CEFTIN equiv)	-	1
cefuroxime tab (CEFTIN equiv)	-	1
cefprozil susp (CEFZIL equiv)	-	2
cefprozil tab (CEFZIL equiv)	-	2
cefaclor cap (CECLOR equiv)	-	3

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

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

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

**Texas Association of Counties HDHP Formulary
Category/Class**

Last Updated* 11/1/2018

DrugName	Special Code	Tier
CEPHALOSPORINS Cont.		
CEFACLOR ER TAB	-	3
CEFACLOR SUSP	-	3
CEPHALOSPORINS - 3RD GENERATION		
cefdinir cap (OMNICEF equiv)	-	2
cefdinir susp (OMNICEF equiv)	-	2
CEDAX CAP	-	3
CEDAX SUSP	-	3
CEFDITOREN TAB	-	3
cefixime susp (SUPRAX equiv)	-	3
cefpodoxime proxetil susp (VANTIN equiv)	-	3
cefpodoxime proxetil tab (VANTIN equiv)	-	3
SPECTRACEF TAB	-	3
SUPRAX CAP	-	3
SUPRAX CHEW TAB	-	3
SUPRAX SUSP 500MG/5ML	-	3
SUPRAX TAB	-	3
CONTRACEPTIVES		
COMBINATION CONTRACEPTIVES - ORAL		
amethyst tab (LYBREL equiv)	-	\$0
apri tab (DESOGEN equiv)	-	\$0
aranelle tab (TRI-NORINYL equiv)	-	\$0
aviane tab (ALESSE equiv)	-	\$0
cesia tab (CYCLESSA equiv)	-	\$0
cryselle tab	-	\$0
enpresse tab (TRI-LEVELLEN equiv)	-	\$0
gianvi tab, ocella tab (YASMIN, YAZ equiv)	-	\$0
jollesa tab, amethia tab (SEASONALE, SEASONIQUE equiv)	-	\$0
junel FE tab (LOESTRIN FE equiv)	-	\$0
junel tab (LOESTRIN equiv)	-	\$0
kariva tab (MIRCETTE equiv)	-	\$0
kelnor tab (DEMULEN equiv)	-	\$0
mononessa tab (ORTHO-CYCLEN equiv)	-	\$0
necon tab (ORTHO-NOVUM equiv)	-	\$0
necon tab 1-50 (NORYNIL equiv)	-	\$0
nortrel tab (OVCON 35 equiv)	-	\$0
tri-legest tab (ESTROSTEP FE equiv)	-	\$0
tri-nessa (LO) tab (ORTHO TRI-CYCLEN (LO) equiv)	-	\$0
wymzya FE tab (FEMCON FE equiv)	-	\$0
LO LOESTRIN TAB	-	3
LO MINASTRIN 24 FE CHEW TAB	-	3
LOESTRIN 24 FE TAB	-	3
mibelas chew tab (MINASTRIN equiv)	-	3
NATAZIA TAB	-	3
YASMIN TAB	-	3
YAZ TAB	-	3
BALCOLTRA TAB	-	NC

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

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

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

**Texas Association of Counties HDHP Formulary
Category/Class**

Last Updated* 11/1/2018

DrugName	Special Code	Tier															
CONTRACEPTIVES Cont.																	
BEYAZ TAB	-	NC															
FALESSA KIT	-	NC															
rajani tab (BEYAZ equiv)	-	NC															
TAYTULLA CAP	-	NC															
tydemy tab (SAFYRAL equiv)	-	NC															
COMBINATION CONTRACEPTIVES - TRANSDERMAL																	
XULANE PATCH	-	\$0															
COMBINATION CONTRACEPTIVES - VAGINAL																	
NUVARING	-	\$0															
COPPER CONTRACEPTIVES - IUD (NEW)																	
PARAGARD IUD	-	\$0															
EMERGENCY CONTRACEPTIVES																	
ELLA TAB	-	\$0															
levonorgestrel tab (PLAN B equiv)	OTC	\$0															
LEVONORGESTREL TAB 0.75MG	-	\$0															
PLAN B TAB	OTC	\$0															
PROGESTIN CONTRACEPTIVES - IMPLANTS																	
IMPLANON IMPLANT, NEXPLANON IMPLANT	-	\$0															
PROGESTIN CONTRACEPTIVES - INJECTABLE																	
DEPO-PROVERA SC INJ 104MG (QL= 1 inj/90 days)	QL	\$0															
medroxyprogesterone inj (DEPO-PROVERA equiv) (QL= 1 inj/90 days)	QL	\$0															
DEPO-PROVERA INJ	-	NC															
PROGESTIN CONTRACEPTIVES - IUD																	
MIRENA IUD	-	\$0															
PROGESTIN CONTRACEPTIVES - ORAL																	
norethindrone tab (NORA-QD equiv)	-	\$0															
CORTICOSTEROIDS																	
GLUCOCORTICOSTEROIDS																	
DEXAMETHASONE CONC	-	1															
dexamethasone elixir	-	1															
dexamethasone soln	-	1															
dexamethasone tab (DECADRON equiv)	-	1															
hydrocortisone tab (CORTEF equiv)	-	1															
methylprednisolone dose pack (MEDROL equiv)	-	1															
methylprednisolone tab (MEDROL equiv)	-	1															
prednisolone soln (PEDIAPRED equiv)	-	1															
PREDNISOLONE SYRUP	-	1															
prednisolone syrup (PRELONE equiv)	-	1															
PREDNISON SOLN	-	1															
PREDNISON TAB	-	1															
prednisone tab (DELTASONE equiv)	-	1															
budesonide SR cap (ENTOCORT EC equiv) (Step Therapy requires trial of APRISO, LIALDA, or sulfasalazine)	ST	2															
CORTISONE ACETATE TAB	-	2															
prednisolone ODT (ORAPRED equiv)	-	2															
PREDNISON PAK	-	2															
Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.																	
<table border="0" style="width: 100%;"> <tr> <td style="width: 33%;">INF Infertility</td> <td style="width: 33%;">LD Limited Distribution</td> <td style="width: 33%;">LMSP Lumicera Mandatory Specialty Pharmacy Program</td> </tr> <tr> <td>MSP Mandatory Specialty Pharmacy Program</td> <td>OTC Over-the-Counter</td> <td>PA Prior Authorization</td> </tr> <tr> <td>QL Quantity Limit</td> <td>RS Restricted to Specialist</td> <td>SF Limited to two 15 day fills per month for first 3 months</td> </tr> <tr> <td>SMKG Smoking Cessation</td> <td>SP Available through Specialty Pharmacy Program</td> <td>ST Step Therapy</td> </tr> <tr> <td>VAC Vaccine Program</td> <td>¢ RxCENTS</td> <td></td> </tr> </table>	INF Infertility	LD Limited Distribution	LMSP Lumicera Mandatory Specialty Pharmacy Program	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter	PA Prior Authorization	QL Quantity Limit	RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation	SP Available through Specialty Pharmacy Program	ST Step Therapy	VAC Vaccine Program	¢ RxCENTS			
INF Infertility	LD Limited Distribution	LMSP Lumicera Mandatory Specialty Pharmacy Program															
MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter	PA Prior Authorization															
QL Quantity Limit	RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months															
SMKG Smoking Cessation	SP Available through Specialty Pharmacy Program	ST Step Therapy															
VAC Vaccine Program	¢ RxCENTS																

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

**Texas Association of Counties HDHP Formulary
Category/Class**

Last Updated* 11/1/2018

DrugName	Special Code	Tier
CORTICOSTEROIDS Cont.		
budesonide ER tab (UCERIS equiv) (QL=1 tab/day)	PA-QL	3
DEXPAK TAB	-	3
MILLIPRED DP PAK	-	3
MILLIPRED TAB	-	3
dexamethasone pak (DEXPAK equiv)	-	NC
EMFLAZA SUSP	-	NC
EMFLAZA TAB	-	NC
FLO-PRED SUSP	-	NC
LIDOLOG KIT	-	NC
PREDNISONE/DIPHENHYDRAMINE KIT	-	NC
RAYOS TAB	-	NC
MINERALOCORTICIDS		
fludrocortisone tab (FLORINEF equiv)	-	1
COUGH/COLD/ALLERGY		
ANTITUSSIVES		
benzonatate cap (TESSALON equiv)	-	1
hydrocodone/homatropine syrup (HYCODAN equiv)	-	1
benzonatate cap 150mg (ZONATUSS equiv)	-	NC
ZONATUSS CAP 150MG	-	NC
COUGH/COLD/ALLERGY COMBINATIONS		
cetirizine/pseudoephedrine 12-hour tab (ZYRTEC equiv)	OTC	1
feofenadine/pseudoephedrine 24-hour tab (ALLEGRA-D equiv)	OTC	1
GUAIFENESIN/CODEINE SYRUP (QL= 240ml/fill)	OTC-QL	1
guaifenesin/codeine syrup (TUSSI-ORGANIDIN-S equiv) (QL= 240ml/fill)	OTC-QL	1
loratadine/pseudoephedrine 12-hour tab (CLARITIN-D equiv)	OTC	1
promethazine VC syrup (PHENERGAN VC equiv)	-	1
promethazine VC/codeine syrup (PHENERGAN VC/CODEINE equiv)	-	1
promethazine/codeine syrup (PHENERGAN/CODEINE equiv)	-	1
hydrocodone/chlorpheniramine CR susp (TUSSIONEX equiv) (QL= 120ml/fill; 2 fills/30 days)	QL	3
NEOTUSS PLUS LIQUID	-	3
promethazine DM syrup	-	3
TUSSI-ORGANI SYRUP (QL= 240ml/fill)	QL	3
ALLEGRA-D 12-HOUR TAB	OTC	NC
ALLEGRA-D 24-HOUR TAB	OTC	NC
ALLEGRA-D TAB	OTC	NC
CLARINEX-D TAB	-	NC
DECON-A LIQUID	OTC	NC
DURAVENT PE TAB	-	NC
HDC DM SYRUP	-	NC
HYCOFENIX SOLN	-	NC
MUCINEX LIQUID	-	NC
POLY-TUSSIN DM SYRUP	-	NC
TUSSICAPS	-	NC
TUSSIONEX SUSP	-	NC
TUSSI-PRES LIQUID	-	NC
TUZISTRA XR SUSP	-	NC

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

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

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

**Texas Association of Counties HDHP Formulary
Category/Class**

Last Updated* 11/1/2018

DrugName	Special Code	Tier
COUGH/COLD/ALLERGY Cont.		
ZUTRIPRO LIQUID	-	NC
EXPECTORANTS		
SSKI SOLN	-	2
GUAIFENESEN SYRUP	-	NC
guaifenesin tab (ALLFEN JR equiv)	-	NC
MUCINEX TAB	-	NC
MISC. RESPIRATORY INHALANTS		
sodium chloride neb soln (HYPER-SAL equiv)	-	1
NEBUSAL NEB SOLN	-	2
MUCOLYTICS		
acetylcysteine soln (MUCOMYST equiv)	-	1
DERMATOLOGICALS		
ACNE PRODUCTS		
clindamycin gel (CLEOCIN GEL equiv)	-	1
clindamycin lotion (CLEOCIN- T equiv)	-	1
clindamycin pad (CLEOCIN-T equiv)	-	1
clindamycin topical soln (CLEOCIN-T equiv)	-	1
erythromycin gel	-	1
erythromycin pad	-	1
erythromycin soln	-	1
sodium sulfacetamide/sulfur lotion (SULFACET R equiv)	-	1
adapalene cream (DIFFERIN equiv) (Acne Only – members age 35 or older require Prior Authorization)	PA	2
adapalene gel (DIFFERIN equiv) (Acne Only – members age 35 or older require Prior Authorization)	PA	2
ADAPALENE LOTION (DIFFERIN equiv) (Acne Only – members age 35 or older require Prior Authorization)	PA	2
adapalene/benzoyl peroxide gel 0.1-2.5% (EPIDUO equiv) (Acne Only – members age 35 or older require Prior Authorization)	PA	2
AVAR GEL	-	2
EPIDUO FORTE GEL (Acne Only – members age 35 or older require Prior Authorization)	PA	2
isotretinoin cap (ACUTANE equiv)	-	2
PRASCION RA CREAM	-	2
sodium sulfacetamide/sulfur cream (PLEXION SCT equiv)	-	2
sodium sulfacetamide/sulfur emulsion (ROSAC WASH equiv)	-	2
sodium sulfacetamide/sulfur emulsion (ROSULA equiv)	-	2
sodium sulfacetamide/sulfur gel (ROSULA equiv)	-	2
SODIUM SULFACETAMIDE/SULFUR LOTION	-	2
sodium sulfacetamide/sulfur pad (PLEXION CLEANSING CLOTH equiv)	-	2
sodium sulfacetamide/sulfur wash (SUMAXIN equiv)	-	2
tretinoin cream (Acne Only – members age 35 or older require Prior Authorization)	PA	2
tretinoin gel (Acne Only – members age 35 or older require Prior Authorization)	-	2
tretinoin gel (RETIN-A GEL equiv) (Acne Only – members age 35 or older require Prior Authorization)	--PA	2
AVAR AEROSOL FOAM	-	3
AZELEX CREAM	PA	3
clindamycin/benzoyl peroxide gel (BENZA CLIN equiv)	-	3
clindamycin/benzoyl peroxide gel (DUAC GEL equiv)	-	3
CLINDAMYCIN/BENZOYL PEROXIDE GEL, ACANYA GEL	-	3
EPIDUO GEL 0.1-2.5%	PA	3

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

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

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

**Texas Association of Counties HDHP Formulary
Category/Class**

Last Updated* 11/1/2018

DrugName	Special Code	Tier															
DERMATOLOGICALS Cont.																	
ONEXTON GEL	-	3															
RETIN-A MICRO GEL 0.04%, 0.1% (Acne Only – members age 35 or older require Prior Authorization)	PA	3															
sodium sulfacetamide lotion (KLARON equiv)	-	3															
sodium sulfacetamide/sulfur foam (CLARIFOAM EF equiv)	-	3															
SODIUM SULFACETAMIDE/SULFUR SUSP	-	3															
sodium sulfacetamide/sulfur susp (SUMAXIN equiv)	-	3															
ABSORICA CAP	-	NC															
ACZONE GEL 7.5%	-	NC															
ALTRENO LOTION	-	NC															
AVAR PAD	-	NC															
BENZAC WASH	-	NC															
BENZOYL PEROXIDE CREAM	OTC	NC															
BENZOYL PEROXIDE/HYDROCORTISONE LOTION	-	NC															
benzoyl peroxide/hydrocortisone lotion (VANOXIDE-HC equiv)	-	NC															
CLINDACIN KIT	-	NC															
CLINDAGEL	-	NC															
clindamycin foam (EVOCLIN equiv)	-	NC															
clindamycin/tretinoin gel (ZIANA equiv)	-	NC															
dapsone gel (ACZONE equiv)	-	NC															
DIFFERIN OTC GEL 0.1%	OTC	NC															
DUAC CS KIT	-	NC															
EVOCLIN FOAM	-	NC															
FABIOR AEROSOL FOAM	-	NC															
RETIN-A MICRO GEL 0.08%, 0.06%	-	NC															
ROSULA WASH	-	NC															
sodium sulfacetamide/sunscreen kit (SUMADEN XLT equiv)	-	NC															
SUMADAN KIT	-	NC															
SUMADEN XLT KIT	-	NC															
TRETIN-X CREAM	-	NC															
VELTIN GEL	-	NC															
ZIANA GEL	-	NC															
AGENTS FOR EXTERNAL GENITAL AND PERIANAL WARTS																	
VEREGEN OINT	-	NC															
AGENTS FOR WRINKLES/LIPOATROPHY/OTHER AESTHETIC USES																	
KYBELLA INJ	-	NC															
RENOVA CREAM	-	NC															
ANALGESICS - TOPICAL																	
BACLOFEN CREAM COMPOUND KIT	-	NC															
TRAMADOL COMPOUND KIT	-	NC															
ANTIBIOTICS - TOPICAL																	
gentamicin sulfate cream	-	1															
gentamicin sulfate oint	-	1															
mupirocin oint (BACTROBAN OINT equiv)	-	1															
ALTABAX OINT	-	3															
CENTANY OINT	-	3															
CORTISPORIN CREAM	-	3															
Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.																	
<table border="0" style="width: 100%;"> <tr> <td style="width: 33%;">INF Infertility</td> <td style="width: 33%;">LD Limited Distribution</td> <td style="width: 33%;">LMSP Lumicera Mandatory Specialty Pharmacy Program</td> </tr> <tr> <td>MSP Mandatory Specialty Pharmacy Program</td> <td>OTC Over-the-Counter</td> <td>PA Prior Authorization</td> </tr> <tr> <td>QL Quantity Limit</td> <td>RS Restricted to Specialist</td> <td>SF Limited to two 15 day fills per month for first 3 months</td> </tr> <tr> <td>SMKG Smoking Cessation</td> <td>SP Available through Specialty Pharmacy Program</td> <td>ST Step Therapy</td> </tr> <tr> <td>VAC Vaccine Program</td> <td>¢ RxCENTS</td> <td></td> </tr> </table>	INF Infertility	LD Limited Distribution	LMSP Lumicera Mandatory Specialty Pharmacy Program	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter	PA Prior Authorization	QL Quantity Limit	RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation	SP Available through Specialty Pharmacy Program	ST Step Therapy	VAC Vaccine Program	¢ RxCENTS			
INF Infertility	LD Limited Distribution	LMSP Lumicera Mandatory Specialty Pharmacy Program															
MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter	PA Prior Authorization															
QL Quantity Limit	RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months															
SMKG Smoking Cessation	SP Available through Specialty Pharmacy Program	ST Step Therapy															
VAC Vaccine Program	¢ RxCENTS																

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

**Texas Association of Counties HDHP Formulary
Category/Class**

Last Updated* 11/1/2018

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
CORTISPORIN OINT	-	3
BACTROBAN CREAM	-	NC
mupirocin cream (BACTROBAN equiv)	-	NC
NEO-SYNALAR CREAM	-	NC
XEPI CREAM	-	NC
ANTIFUNGALS - TOPICAL		
ciclopirox cream (LOPROX CREAM equiv)	-	1
ciclopirox gel (LOPROX GEL equiv)	-	1
ciclopirox nail soln (PENLAC equiv)	-	1
ciclopirox topical susp (LOPROX SUSP equiv)	-	1
clotrimazole/betamethasone cream (LORTRISONE CREAM equiv)	-	1
ketoconazole cream (NIZORAL CREAM equiv)	-	1
ketoconazole shampoo (NIZORAL SHAMPOO equiv)	-	1
nystatin cream (MYCOSTATIN CREAM equiv)	-	1
nystatin oint	-	1
nystatin topical powder	-	1
ciclopirox shampoo (LOPROX SHAMPOO equiv)	-	2
clotrimazole/betamethasone lotion (LOTRISONE LOTION equiv)	-	2
econazole cream (SPECTAZOLE equiv)	-	3
ERTACZO CREAM	-	3
EXELDERM CREAM	-	3
EXELDERM SOLN	-	3
iodoquinol/hydrocortisone cream 1% (VYTONE equiv)	-	3
MENTAX CREAM	-	3
naftifine cream (NAFTIN equiv)	-	3
NAFTIN GEL	-	3
oxiconazole nitrate cream (OXISTAT equiv)	-	3
OXISTAT LOTION	-	3
ALCORTIN A GEL (iodoquinol/hydrocortisone/aloe polysaccharide gel equiv)	-	NC
ALOQUIN GEL	-	NC
CICLODAN KIT	-	NC
clotrimazole cream (LOTRIMIN AF CREAM equiv)	-	NC
ECOZA FOAM	-	NC
iodoquinol/hydrocortisone cream 1.9-1% (VYTONE equiv)	-	NC
iodoquinol/hydrocortisone/aloe polysaccharide gel (ALCORTIN A equiv)	-	NC
JUBLIA SOLN	-	NC
KERYDIN SOLN	-	NC
LOTRIMIN AF CREAM	-	NC
LULICONAZOLE CREAM, LUZU CREAM	-	NC
NAFTIN GEL 2%	-	NC
nystatin/triamcinolone cream	-	NC
nystatin/triamcinolone oint	-	NC
PENLAC SOLN	-	NC
VYTONE CREAM 1.9-1%	-	NC
XOLEGEL	-	NC
ANTI-INFLAMMATORY AGENTS - TOPICAL		

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

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

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

**Texas Association of Counties HDHP Formulary
Category/Class**

Last Updated* 11/1/2018

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
diclofenac gel 1% (VOLTAREN equiv) (QL= 5 tubes/fill)	QL	2
FLECTOR PATCH (QL= 30 patches/fill)	QL	3
diclofenac soln 1.5% (PENNSAID equiv)	-	NC
DICLOPR KIT	-	NC
DST PLUS PAK KIT	-	NC
NAPROXEN CREAM COMPOUND KIT	-	NC
PENNSAID SOLN	-	NC
PENNSAID SOLN 1.5%	-	NC
REXAPHENAC CREAM	-	NC
VOPAC 5 CREAM	-	NC
VOPAC CREAM	-	NC
VOPAC GB CREAM	-	NC
ANTINEOPLASTIC OR PREMALIGNANT LESION AGENTS - TOPICAL		
fluorouracil cream (EFUDEX CREAM equiv)	-	1
FLUOROPLEX CREAM	-	2
FLUOROURACIL SOLN	-	2
TARGRETIN GEL	LMSP	2
VALCHLOR GEL (QL= 4 tubes/30 days; Only available through Accredo 888-773-7376)	LD-PA-QL	2
diclofenac gel (SOLARAZE equiv) (QL= 300gm/30 days)	PA-QL	3
CARAC CREAM	-	NC
FLUORAC CREAM	-	NC
FLUOROURACIL CREAM 0.5%	-	NC
PICATO GEL	-	NC
ANTIPRURITICS - TOPICAL		
DOXEPIN CREAM, PRUDOXIN CREAM, ZONALON CREAM	-	NC
ANTIPSORIATICS		
8-MOP CAP	-	2
acitretin cap (SORIATANE equiv)	-	2
calcipotriene cream (DOVONEX CREAM equiv)	-	2
calcipotriene oint	-	2
calcipotriene soln (DOVONEX SOLN equiv)	-	2
COSENTYX INJ (1-PACK) (QL= 1 inj/28 days)	LMSP-PA-QL	2
COSENTYX INJ (2-PACK) (QL= 2 inj/28 days)	LMSP-PA-QL	2
methoxsalen cap (OXSORALEN ULTRA equiv)	-	2
SORIATANE CK KIT	-	2
SORILUX FOAM	-	3
VECTICAL OINT	-	3
SILIQ INJ	-	NC
STELARA INJ	-	NC
TALTZ INJ	-	NC
tazarotene cream (TAZORAC equiv)	-	NC
TAZORAC CREAM	-	NC
TAZORAC GEL	-	NC
TREMFYA INJ	-	NC
ANTISEBORRHEIC PRODUCTS		
selenium sulfide lotion	-	1

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

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

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

**Texas Association of Counties HDHP Formulary
Category/Class**

Last Updated* 11/1/2018

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
selenium sulfide shampoo (SELSEB equiv)	-	2
sodium sulfacetamide wash (OVACE WASH equiv)	-	2
OVACE PLUS CREAM	-	3
seb-prev cream (OVACE CREAM equiv)	-	3
sodium sulfacetamide gel (OVACE PLUS equiv)	-	3
sodium sulfacetamide shampoo (OVACE equiv)	-	3
sodium sulfacetamide/urea pad (ROSULA equiv)	-	3
ESKATA SOLN	-	NC
OVACE PLUS LOTION	-	NC
OVACE PLUS FOAM	-	NC
selenium sulfide shampoo 2.3% (SELRX equiv)	-	NC
ANTIVIRALS - TOPICAL		
acyclovir oint (ZOVIRAX OINT equiv)	-	2
DENAVIR CREAM	-	2
XERESE CREAM	-	3
ZOVIRAX CREAM	-	3
ZOVIRAX OINT	-	NC
BURN PRODUCTS		
silver sulfadiazine cream (SILVADENE CREAM equiv)	-	1
SULFAMYLON CREAM	-	2
CORTICOSTEROIDS - TOPICAL		
betamethasone augmented cream (DIPROLENE AF CREAM equiv)	-	1
BETAMETHASONE AUGMENTED GEL	-	1
betamethasone augmented lotion (DIPROLENE LOTION equiv)	-	1
betamethasone augmented oint (DIPROLENE OINT equiv)	-	1
betamethasone dipropionate cream (DIPROSONE CREAM equiv)	-	1
betamethasone dipropionate lotion	-	1
betamethasone dipropionate oint (DIPROSONE OINT equiv)	-	1
betamethasone valerate cream	-	1
betamethasone valerate lotion	-	1
betamethasone valerate oint	-	1
desoximetasone cream (TOPICORT CREAM equiv)	-	1
fluocinolone acetonide cream	-	1
fluocinolone acetonide oint	-	1
fluocinolone acetonide soln	-	1
fluocinonide cream 0.05% (LIDEX equiv)	-	1
fluocinonide emollient cream	-	1
fluocinonide gel	-	1
fluocinonide oint	-	1
fluocinonide soln	-	1
fluticasone propionate cream (CUTIVATE equiv)	-	1
fluticasone propionate oint (CUTIVATE equiv)	-	1
hydrocortisone cream (PROCTOCORT equiv)	-	1
hydrocortisone lotion (HYTONE equiv)	-	1
hydrocortisone oint	-	1
mometasone cream (ELOCON equiv)	-	1

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

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

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

**Texas Association of Counties HDHP Formulary
Category/Class**

Last Updated* 11/1/2018

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
mometasone oint (ELOCON equiv)	-	1
mometasone soln (ELOCON equiv)	-	1
PREDNICARBATE CREAM	-	1
prednicarbate cream (DERMATOP equiv)	-	1
PREDNICARBATE OIN	-	1
triamcinolone cream	-	1
triamcinolone lotion	-	1
triamcinolone oint	-	1
ALA SCALP LOTION	-	2
alclometasone cream (ACLOVATE equiv)	-	2
alclometasone oint (ACLOVATE OINT equiv)	-	2
clobetasol propionate cream (TEMOVATE equiv)	PA	2
clobetasol propionate emollient cream (TEMOVATE E equiv)	PA	2
clobetasol propionate gel (TEMOVATE GEL equiv)	PA	2
clobetasol propionate oint (TEMOVATE equiv)	PA	2
desoximetasone gel (TOPICORT equiv)	-	2
desoximetasone oint (TOPICORT equiv)	-	2
EPIFOAM AEROSOL	-	2
halobetasol propionate cream (ULTRAVATE equiv)	-	2
halobetasol propionate oint (ULTRAVATE equiv)	-	2
hydrocortisone pramoxine cream (PRAMOSONE equiv)	-	2
PRAMOSONE CREAM	-	2
PRAMOSONE E CREAM	-	2
PRAMOSONE OINT	-	2
U-CORT CREAM	-	2
calcipotriene/betamethasone oint (TACLONEX equiv)	-	3
CAPEX SHAMPOO	-	3
clobetasol foam (OLUX equiv)	PA	3
clobetasol lotion (CLOBEX equiv)	PA	3
clobetasol propionate soln (TEMOVATE equiv)	PA	3
clobetasol shampoo (CLOBEX equiv)	PA	3
clobetasol spray (CLOBEX equiv)	PA	3
CLOCORTOLONE CREAM, CLODERM CREAM	-	3
CORDRAN TAPE	-	3
fluocinolone acetonide oil (DERMA-SMOOTH/FS equiv)	-	3
flurandrenolide cream (CORDRAN equiv)	-	3
flurandrenolide lotion (CORDRAN equiv)	-	3
PANDEL CREAM	-	3
PRAMOSONE LOTION	-	3
TACLONEX SCALP SUSP	-	3
TOPICORT GEL	-	3
TOPICORT OINT	-	3
triamcinolone spray (KENALOG equiv)	-	3
ULTRAVATE LOTION	-	3
VERDESO FOAM	-	3
AMCINONIDE CREAM 0.1%	-	NC
AMCINONIDE LOTION	-	NC

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

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

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

**Texas Association of Counties HDHP Formulary
Category/Class**

Last Updated* 11/1/2018

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
AMCINONIDE OINT	-	NC
APEXICON E CREAM (PSORCON E equiv)	-	NC
betamethasone valerate foam (LUXIQ equiv)	-	NC
clobetasol E foam (OLUX E equiv)	-	NC
CORDRAN CREAM	-	NC
CUTIVATE LOTION	-	NC
DERMACINRX KIT	-	NC
DESONATE GEL	-	NC
desonide cream (DESOWEN equiv)	-	NC
desonide lotion (DESOWEN equiv)	-	NC
desonide oint (DESOWEN equiv)	-	NC
DESOWEN CREAM	-	NC
DESOWEN CREAM KIT	-	NC
DESOWEN LOTION	-	NC
DESOWEN LOTION KIT	-	NC
DESOWEN OINT	-	NC
DESOWEN OINT KIT	-	NC
DIFLORASONE CREAM	-	NC
diflorasone oint	-	NC
ENSTILAR FOAM	-	NC
fluocinonide cream 0.1% (VANOS CREAM equiv)	-	NC
fluticasone propionate lotion (CUTIVATE equiv)	-	NC
HALOG CREAM	-	NC
HALOG OINT	-	NC
halonate pac kit (ULTRAVATE KIT equiv)	-	NC
HC-LIDOCAINE CREAM	-	NC
hydrocortisone butyrate cream (LOCOID equiv)	-	NC
hydrocortisone butyrate lipocream (LOCOID equiv)	-	NC
hydrocortisone butyrate oint (LOCOID equiv)	-	NC
hydrocortisone butyrate soln (LOCOID equiv)	-	NC
hydrocortisone lotion (LOCOID equiv)	-	NC
hydrocortisone valerate cream (WESTCORT equiv)	-	NC
hydrocortisone valerate oint (WESTCORT equiv)	-	NC
IMPOYZ CREAM	-	NC
lidocaine/hydrocortisone cream	-	NC
LOCOID CREAM	-	NC
LOCOID LIPOCREAM	-	NC
LOCOID OINT	-	NC
LOCOID SOLN	-	NC
LUXIQ FOAM	-	NC
MEXPAROX HC CREAM	-	NC
MICORT-HC CREAM	-	NC
NOVACORT GEL	-	NC
OLUX E FOAM	-	NC
paramox hc gel (NOVACORT GEL equiv)	-	NC
SERNIVO SPRAY	-	NC
SILALITE PAK MIS	-	NC

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

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

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

**Texas Association of Counties HDHP Formulary
Category/Class**

Last Updated* 11/1/2018

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
TRIANEX OINT	-	NC
ULTRAVATE PAC KIT	-	NC
VANOS CREAM	-	NC
WESTCORT OINT	-	NC
ECZEMA AGENTS		
DUPIXENT INJ (QL= 2 inj/ 28 days)	LMSP-PA-QL	2
EMOLLIENT/KERATOLYTIC AGENTS		
CARMOL LOTION	-	NC
KERAFOAM	-	NC
KERALAC CREAM	-	NC
UMECTA EMULSION	-	NC
UMECTA PD EMULSION	-	NC
UMECTA SUSP	-	NC
URAMAXIN CREAM	-	NC
URAMAXIN GEL	-	NC
urea cream	-	NC
urea emulsion	-	NC
urea gel (URAMAXIN equiv)	-	NC
UREA LOTION	-	NC
urea lotion (KERALAC LOTION equiv)	-	NC
UREA NAIL KIT	-	NC
UREA SUSP	-	NC
urea susp 40% (UMECTA equiv)	-	NC
EMOLLIENTS		
ammonium lactate cream (LAC-HYDRIN equiv)	-	1
ammonium lactate lotion (LAC-HYDRIN equiv)	-	1
ENZYMES - TOPICAL		
SANTYL OINT (QL= 90gm/30 days)	QL	2
vasolex oint (XENADERM equiv)	-	NC
XENADERM OINT	-	NC
HAIR GROWTH AGENTS		
finasteride tab (PROPECIA equiv)	-	NC
HAIR REDUCTION AGENTS		
VANIQA CREAM	-	NC
IMMUNOMODULATING AGENTS - TOPICAL		
imiquimod cream (ALDARA equiv)	-	2
ZYCLARA CREAM	-	NC
IMMUNOSUPPRESSIVE AGENTS - TOPICAL		
ELIDEL CREAM	-	2
tacrolimus oint (PROTOPIC OINT equiv)	-	2
KERATOLYTIC/ANTIMITOTIC AGENTS		
PODOCON SOLN	-	2
podofilox soln (CONDYLOX equiv)	-	2
salicylic acid shampoo (SALEX equiv)	-	2
CONDYLOX GEL	-	3

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

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

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

**Texas Association of Counties HDHP Formulary
Category/Class**

Last Updated* 11/1/2018

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
SALIMEZ FORTE CREAM	-	NC
XALIX SOL	-	NC
LOCAL ANESTHETICS - TOPICAL		
lidocaine cream 3% (LIDAMANTLE equiv)	-	1
lidocaine gel (XYLOCAINE equiv)	-	1
lidocaine soln (XYLOCAINE equiv)	-	1
lidocaine/prilocaine cream (EMLA equiv)	-	1
lidocaine patch (LIDODERM equiv) (QL= 3 patches/day)	QL	3
ADAZIN CREAM	-	NC
ANASTIA LOTION	-	NC
capsaicin/menthol topical patch (SINELEE equiv)	-	NC
LIDOCAINE CREAM	-	NC
lidocaine cream 3.88% (LIDOTRAL CREAM equiv)	-	NC
lidocaine lotion	-	NC
lidocaine oint	-	NC
LIDOCIN GEL	-	NC
LIDOTRAL CREAM (lidocaine cream equiv)	-	NC
LIDOTREX GEL	-	NC
MEDI-PATCH W/LIDOCAINE PATCH	-	NC
PROZENA PAD	-	NC
SILVERA PAD	-	NC
SOLAICE PATCH	-	NC
SYNVEXIA TC CREAM	-	NC
WPR PLUS	-	NC
MISC. DERMATOLOGICAL PRODUCTS		
NEOSALUS FOAM	-	NC
MISC. TOPICAL		
aluminum chloride soln (DRYSOL equiv)	-	1
DRYSOL SOLN	-	1
HYCLODEX SOLN	-	NC
QBREXZA PAD	-	NC
PHOSPHODIESTERASE 4 (PDE4) INHIBITORS - TOPICAL		
EUCRISA OINT	-	NC
PIGMENTING-DEPIGMENTING AGENTS		
hydroquinone cream (LUSTRA equiv)	-	NC
TRI-LUMA CREAM	-	NC
ROSACEA AGENTS		
metronidazole lotion (METROLOTION equiv)	-	1
FINACEA FOAM	-	2
FINACEA GEL	-	2
FINACEA PLUS KIT	-	2
metronidazole cream (METROCREAM equiv)	-	2
metronidazole gel (METROGEL equiv)	-	2
DOXYCYCLINE CAP, ORACEA CAP	-	NC
MIRVASO GEL	-	NC
NORITATE CREAM	-	NC

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

INF Infertility	LD Limited Distribution	LMSP Lumicera Mandatory Specialty Pharmacy Program
MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter	PA Prior Authorization
QL Quantity Limit	RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months
SMKG Smoking Cessation	SP Available through Specialty Pharmacy Program	ST Step Therapy
VAC Vaccine Program	¢ RxCENTS	

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

**Texas Association of Counties HDHP Formulary
Category/Class**

Last Updated* 11/1/2018

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
RHOFADE CREAM	-	NC
ROSADAN KIT	-	NC
SCABICIDES & PEDICULICIDES		
permethrin cream (ELIMITE CREAM equiv)	-	1
EURAX CREAM	-	2
SPINOSAD SUSP (QL= 1 bottle/fill)	QL	2
crotamiton lotion (EURAX equiv)	-	3
lindane lotion	-	3
lindane shampoo	-	3
malathion lotion (OVIDE equiv) (QL= 2 bottles/fill)	QL	3
NATROBA SUSP (QL= 1 bottle/fill)	QL	3
SKLICE LOTION (QL= 1 tube/fill)	PA-QL	3
ULESFIA LOTION (QL= 4 bottles/fill)	QL	3
SCAR TREATMENT PRODUCTS		
SCARCIN GEL	-	NC
scarcin gel (SCARCIN equiv)	-	NC
SCARCIN LIQUID ROLL-ON	-	NC
SILIPAC KIT	-	NC
WOUND CARE PRODUCTS		
REGRANEX GEL (QL= 30gm/fill)	QL	2
BIAFINE EMULSION	-	NC
DIAGNOSTIC PRODUCTS		
DIAGNOSTIC DRUGS		
GLUCAGEN INJ	-	2
GLUCAGON DIAGNOSTIC INJ	-	NC
MACRILEN PACK	-	NC
DIAGNOSTIC PRODUCTS, MISC.		
FREESTYLE LITE TEST STRIP	OTC	2
DIAGNOSTIC TESTS		
CLINISTIX TEST STRIP	OTC	1
KETO-DIASTIX TEST STRIP	OTC	1
KETOSTIX	OTC	1
ACCU-CHEK AVIVA PLUS TEST STRIP	OTC	2
ACCU-CHEK GUIDE TEST STRIP	OTC	2
ACCU-CHEK SMARTVIEW TEST STRIP	OTC	2
ACCU-CHEK TEST STRIP	OTC	2
FREESTYLE INSULINX TEST STRIP	OTC	2
FREESTYLE PRECISION NEO TEST STRIP	OTC	2
FREESTYLE TEST STRIP	OTC	2
PRECISION XTRA TEST STRIP	OTC	2
TEST STRIP (all other test strips)	OTC	NC
RADIOGRAPHIC CONTRAST MEDIA		
OMNIPAQUE SOLN	-	NC

DIETARY PRODUCTS/DIETARY MANAGEMENT PRODUCTS

DIETARY MANAGEMENT PRODUCTS

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

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

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

**Texas Association of Counties HDHP Formulary
Category/Class**

Last Updated* 11/1/2018

DrugName	Special Code	Tier
DIETARY PRODUCTS/DIETARY MANAGEMENT PRODUCTS Cont.		
ASTAMED MYO CAP	-	NC
DEPLIN CAP	-	NC
ELIGEN B12 TAB	-	NC
FALESSA TAB	-	NC
GLYGEST PAK	-	NC
L-METHYLFOLATE TAB	-	NC
METANX CAP	-	NC
OLLIZAC POWDER	-	NC
PODIAPN CAP	-	NC
XAQUIL XR TAB	-	NC
XYZBAC TAB	-	NC
DIGESTIVE AIDS		
DIGESTIVE ENZYMES		
CREON CAP	-	2
PANCREAZE CAP, PERTZYE CAP, ULTRESA CAP, ZENPEP CAP	-	NC
PANCRELIPASE CAP	-	NC
SUCRAID SOLN	-	NC
DIURETICS		
CARBONIC ANHYDRASE INHIBITORS		
acetazolamide ER cap (DIAMOX SEQUEL equiv)	-	2
acetazolamide tab	-	2
methazolamide tab (NEPTAZANE equiv)	-	2
KEVEYIS TAB	-	NC
DIURETIC COMBINATIONS		
amiloride/hydrochlorothiazide tab (MODURETIC equiv)	-	1
spironolactone/hydrochlorothiazide tab (ALDACTAZIDE equiv)	-	1
triamterene/hydrochlorothiazide cap (DYAZIDE equiv)	-	1
triamterene/hydrochlorothiazide tab (MAXZIDE equiv)	-	1
TRIAMTERENE/HYDROCHLOROTHIAZIDE CAP 50-25mg	-	2
LOOP DIURETICS		
bumetanide tab (BUMEX equiv)	-	1
FUROSEMIDE SOLN	-	1
furosemide soln (LASIX equiv)	-	1
furosemide tab (LASIX equiv)	-	1
torsemide tab (DEMADEX equiv)	-	1
ethacrynic tab (EDECIN equiv)	-	2
POTASSIUM SPARING DIURETICS		
amiloride tab (MIDAMOR equiv)	-	1
spironolactone tab (ALDACTONE equiv)	-	1
DYRENIUM CAP	-	2
CAROSPIR SUSP	-	NC
THIAZIDES AND THIAZIDE-LIKE DIURETICS		
chlorothiazide tab (DIURIL equiv)	-	1
CHLOROTHIAZIDE TAB 250MG	-	1
CHLORTHALIDONE TAB	-	1

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

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

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

**Texas Association of Counties HDHP Formulary
Category/Class**

Last Updated* 11/1/2018

DrugName	Special Code	Tier
DIURETICS Cont.		
hydrochlorothiazide cap (MICROZIDE equiv)	-	1
hydrochlorothiazide tab (HYDRODIURIL equiv)	-	1
indapamide tab (LOZOL equiv)	-	1
METHYCLOTHIAZIDE TAB	-	1
metolazone tab (ZAROXOLYN equiv)	-	1
DIURIL SUSP	-	2
ENDOCRINE AND METABOLIC AGENTS - MISC.		
BONE DENSITY REGULATORS		
alendronate tab (FOSAMAX equiv)	-	1
ibandronate tab 150mg (BONIVA equiv) (QL= 1 tab/30 days)	QL	1
ALENDRONATE TAB 40MG	-	2
calcitonin nasal spray (MIACALCIN equiv)	-	2
FORTICAL NASAL SPRAY	-	2
NATPARA INJ (Only available through Walgreens 888-347-3416)	LD-PA	2
risedronate tab (ACTONEL equiv)	-	2
TYMLOS INJ	LMSP-PA	2
FOSAMAX+D TAB	-	3
risedronate DR tab (ATELVIA equiv) (Step Therapy requires trial of alendronate)	ST	3
SKELID TAB	-	3
CALCIUM REGULATORS - MISC.		
FORTEO INJ	LMSP-PA	2
MIACALCIN INJ	LMSP	2
ALENDRONATE SOLN	-	3
etidronate disodium tab 200mg (DIDRONEL equiv)	-	3
CORTICOTROPIN		
ACTHAR HP GEL INJ	MSP-PA	3
GNRH/LHRH ANTAGONISTS		
ORLISSA TAB	-	NC
GROWTH HORMONE RECEPTOR ANTAGONISTS		
SOMAVERT INJ (Only available through Walgreens 888-347-3416)	LD-PA	2
GROWTH HORMONE RELEASING HORMONES (GHRH)		
EGRIFTA INJ	-	NC
GROWTH HORMONES		
GENOTROPIN INJ	LMSP-PA	2
HUMATROPE INJ, ZOMACTON INJ	-	NC
NORDITROPIN INJ, NUTROPIN AQ INJ, OMNITROPE INJ	-	NC
SAIZEN INJ, SEROSTIM INJ, ZORBTIVE INJ	-	NC
HORMONE RECEPTOR MODULATORS		
raloxifene tab (EVISTA equiv) (Covered at \$0 for women 35 years or older; All other members covered at generic copay)	-	\$0
OSPHENA TAB	-	NC
INSULIN-LIKE GROWTH FACTORS (SOMATOMEDINS)		
INCRELEX INJ	MSP	2
LHRH/GNRH AGONIST ANALOG PITUITARY SUPPRESSANTS		
SYNAREL NASAL SOLN	-	2

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

INF Infertility	LD Limited Distribution	LMSP Lumicera Mandatory Specialty Pharmacy Program
MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter	PA Prior Authorization
QL Quantity Limit	RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months
SMKG Smoking Cessation	SP Available through Specialty Pharmacy Program	ST Step Therapy
VAC Vaccine Program	¢ RxCENTS	

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

**Texas Association of Counties HDHP Formulary
Category/Class**

Last Updated* 11/1/2018

DrugName	Special Code	Tier
ENDOCRINE AND METABOLIC AGENTS - MISC. Cont.		
METABOLIC MODIFIERS		
calcitriol cap (ROCALTROL equiv)	-	1
CALCITRIOL INJ	LMSP	1
calcitriol inj (CALCIJEX equiv)	LMSP	1
calcitriol soln (ROCALTROL equiv)	-	1
levocarnitine soln (CARNITOR equiv)	-	1
levocarnitine tab (CARNITOR equiv)	-	1
doxercalciferol cap (HECTOROL equiv)	-	2
KUVAN POWDER PACK (Only available through Walgreens 888-347-3416)	LD-PA	2
KUVAN TAB (Only available through Walgreens 888-347-3416)	LD-PA	2
paricalcitol cap (ZEMPLAR equiv)	-	2
SENSIPAR TAB	-	2
sodium phenylbutyrate powder (BUPHENYL equiv)	-	2
sodium phenylbutyrate tab (BUPHENYL equiv)	-	2
STRENSIQ INJ (Only available through PantherRx Pharmacy 855-726-8479)	LD-PA	2
CARBAGLU TAB	-	NC
GALAFOLD CAP	-	NC
MYALEPT INJ	-	NC
NITYR TAB	-	NC
ORFADIN CAP	-	NC
ORFADIN SUSP	-	NC
PALYNZIQ INJ	-	NC
RAVICTI LIQUID	-	NC
RAYALDEE CAP	-	NC
XURIDEN POWDER	-	NC
POSTERIOR PITUITARY HORMONES		
desmopressin acetate inj (DDAVP equiv)	-	2
desmopressin acetate tab (DDAVP equiv)	-	2
desmopressin nasal soln (DDAVP equiv)	-	2
STIMATE NASAL SOLN	-	2
DDAVP NASAL SOLN	-	3
NOCDURNA SL TAB	-	NC
NOCTIVA EMULSION SPRAY	-	NC
PROLACTIN INHIBITORS		
cabergoline tab (DOSTINEX equiv)	-	1
SOMATOSTATIC AGENTS		
octreotide inj (SANDOSTATIN equiv)	LMSP	2
SANDOSTATIN INJ	LMSP	2
SIGNIFOR INJ (QL= 2 vials/day; Only available through Accredo 888-773-7376)	LD-PA-QL	2
SANDOSTATIN LAR INJ KIT	-	NC
SIGNIFOR LAR INJ	-	NC
SOMATULINE INJ	-	NC
VASOPRESSIN RECEPTOR ANTAGONISTS		
JYNARQUE PAK (QL= 2 tabs/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	2

ESTROGENS

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

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

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

**Texas Association of Counties HDHP Formulary
Category/Class**

Last Updated* 11/1/2018

DrugName	Special Code	Tier
ESTROGENS Cont.		
ESTROGEN COMBINATIONS		
esterified estrogens/methyltestosterone tab (ESTRATEST equiv)	-	1
jinteli tab (FEMHRT equiv)	-	2
PREMPHASE TAB, PREMPRO TAB	-	2
estradiol/norethindrone tab (ACTIVEVELLA equiv)	-	3
ANGELIQ TAB	-	NC
CLIMARA PRO PATCH	-	NC
COMBIPATCH	-	NC
FEMHRT TAB	-	NC
ORTHO-PREFEST TAB	-	NC
ESTROGENS		
estradiol patch (CLIMARA equiv)	-	1
estradiol tab (ESTRACE equiv)	-	1
ESTROPIPATE TAB	-	1
estropipate tab (OGEN equiv)	-	1
estradiol patch (VIVELLE-DOT equiv)	-	2
PREMARIN TAB	-	2
CENESTIN TAB	-	3
ALORA PATCH	-	NC
DIVIGEL GEL, ELESTRIN GEL	-	NC
ENJUVIA TAB	-	NC
ESTRASORB EMULSION	-	NC
ESTRATAB	-	NC
EVAMIST SPRAY	-	NC
MENOSTAR PATCH	-	NC
VIVELLE-DOT PATCH	-	NC
FLUOROQUINOLONES		
FLUOROQUINOLONES		
ciprofloxacin tab (CIPRO equiv)	-	1
levofloxacin soln (LEVAQUIN equiv)	-	1
levofloxacin tab (LEVAQUIN equiv)	-	1
ofloxacin tab (FLOXIN equiv)	-	1
BAXDELA TAB (QL= 2 tabs/day; Restricted to Infectious Disease Specialist)	QL-RS	2
ciprofloxacin susp (CIPRO equiv)	-	2
moxifloxacin tab (AVELOX equiv)	-	2
CIPRO SUSP 5%	-	3
CIPROFLOXACIN 100MG TAB	-	3
ciprofloxacin ER tab (CIPRO XR equiv)	-	3
NOROXIN TAB	-	3
FACTIVE TAB	-	NC
PROQUIN XR TAB	-	NC
GASTROINTESTINAL AGENTS - MISC.		
AGENTS FOR CHRONIC IDIOPATHIC CONSTIPATION (CIC)		
TRULANCE TAB	-	NC
BILE ACID SYNTHESIS DISORDER AGENTS		

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

INF Infertility	LD Limited Distribution	LMSP Lumicera Mandatory Specialty Pharmacy Program
MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter	PA Prior Authorization
QL Quantity Limit	RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months
SMKG Smoking Cessation	SP Available through Specialty Pharmacy Program	ST Step Therapy
VAC Vaccine Program	¢ RxCENTS	

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

**Texas Association of Counties HDHP Formulary
Category/Class**

Last Updated* 11/1/2018

DrugName	Special Code	Tier
GASTROINTESTINAL AGENTS - MISC. Cont.		
CHOLBAM CAP (Only available through Dohmen LSS 844-246-5226)	LD-PA	2
FARNESOID X RECEPTOR (FXR) AGONISTS		
OCALIVA TAB (QL= 1 tab/day; Only available through Walgreens 888-347-3416)	LD-PA-QL-SF-¢	2
GALLSTONE SOLUBILIZING AGENTS		
ursodiol cap (ACTIGALL equiv)	-	1
ursodiol tab (URSO (FORTE) equiv)	-	1
GASTROINTESTINAL ANTIALLERGY AGENTS		
cromolyn conc (GASTROCROM equiv)	-	2
GASTROINTESTINAL CHLORIDE CHANNEL ACTIVATORS		
AMITIZA CAP	-	NC
GASTROINTESTINAL STIMULANTS		
metoclopramide soln (REGLAN equiv)	-	1
metoclopramide tab (REGLAN equiv)	-	1
METOZOLV ODT	-	NC
INFLAMMATORY BOWEL AGENTS		
balsalazide cap (COLAZAL equiv)	-	1
sulfasalazine EC tab (AZULFIDINE equiv)	-	1
sulfasalazine tab (AZULFIDINE equiv)	-	1
APRISO CAP	-	2
CANASA SUPP	-	2
CIMZIA INJ (QL= 2 inj/28 days)	LMSP-PA-QL	2
CIMZIA STARTER INJ KIT (QL= 1 kit/plan year)	LMSP-PA-QL	2
mesalamine DR tab (LIALDA equiv)	-	2
mesalamine enema (ROWASA equiv)	-	2
DIPENTUM CAP	-	3
LIALDA TAB	-	3
ASACOL HD TAB, MESALAMINE TAB	-	NC
DELZICOL CAP	-	NC
PENTASA CAP	-	NC
ROWASA KIT	-	NC
INTESTINAL ACIDIFIERS		
lactulose soln	-	1
IRRITABLE BOWEL SYNDROME (IBS) AGENTS		
LINZESS CAP	PA	2
alosetron tab (LOTROXEX equiv)	-	3
VIBERZI TAB	-	NC
PERIPHERAL OPIOID RECEPTOR ANTAGONISTS		
MOVANTIK TAB	PA	2
SYMPROIC TAB	PA	2
RELISTOR INJ	-	NC
RELISTOR INJ KIT	-	NC
RELISTOR TAB	-	NC
PHOSPHATE BINDER AGENTS		
calcium acetate cap (PHOSLO equiv)	-	1
FOSRENOL POWDER PACK	-	2

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

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

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

**Texas Association of Counties HDHP Formulary
Category/Class**

Last Updated* 11/1/2018

DrugName	Special Code	Tier
GASTROINTESTINAL AGENTS - MISC. Cont.		
lanthanum carbonate chew tab (FOSRENOL equiv)	-	2
PHOSLYRA SOLN	-	2
SEVELAMER CARBONATE TAB	-	2
sevelamer powder pak (RENVELA equiv)	-	2
sevelamer tab (RENVELA TAB equiv)	-	2
FOSRENOL CHEW TAB	-	3
RENVELA TAB	-	3
AURYXIA TAB	-	NC
RENAGEL TAB	-	NC
VELPHORO CHEW TAB	-	NC
SHORT BOWEL SYNDROME (SBS) AGENTS		
GATTEX KIT	-	NC
TRYPTOPHAN HYDROXYLASE INHIBITORS		
XERMELO TAB	-	NC
GENITOURINARY AGENTS - MISCELLANEOUS		
ALKALINIZERS		
CYTRA-3 SYRUP	-	1
K/NA CITRATE SOLN CITRIC ACID	-	1
ORACIT SOLN	-	1
potassium citrate/citric acid powder pack (POLYCITRA equiv)	-	1
potassium citrate/citric acid soln (POLYCITRA-K equiv)	-	1
sodium citrate/citric acid soln (BICITRA equiv)	-	1
tricitrates soln (POLYCITRA-LC equiv)	-	1
potassium citrate CR tab (UROCIT-K TAB equiv)	-	2
CYSTINOSIS AGENTS		
CYSTAGON CAP (Only available through CVS Specialty 800-238-7828)	LD-PA	2
PROCYSBI CAP	-	NC
INTERSTITIAL CYSTITIS AGENTS		
ELMIRON CAP	-	2
PROSTATIC HYPERTROPHY AGENTS		
alfuzosin SR tab (UROXATRAL equiv)	-	1
finasteride tab (PROSCAR equiv)	-	1
tamsulosin cap (FLOMAX equiv)	-	1
dutasteride cap (AVODART equiv)	-	2
dutasteride/tamsulosin cap (JALYN equiv)	-	2
CARDURA XL TAB	-	NC
RAPAFLO CAP	-	NC
URINARY ANALGESICS		
phenazopyridine tab (PYRIDIDIUM equiv)	-	1
URINARY STONE AGENTS		
LITHOSTAT TAB	-	3
THIOLA TAB	-	NC

GOUT AGENTS

GOUT AGENT COMBINATIONS		
colchicine/probenecid tab (COL-BENEMID equiv)	-	1

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

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

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

**Texas Association of Counties HDHP Formulary
Category/Class**

Last Updated* 11/1/2018

DrugName	Special Code	Tier
GOUT AGENTS Cont.		
DUZALLO TAB	-	NC
GOUT AGENTS		
allopurinol tab (ZYLOPRIM equiv)	-	1
MITIGARE CAP	-	2
ULORIC TAB (Step Therapy requires trial of allopurinol)	ST-¢	2
COLCHICINE CAP	-	NC
COLCHICINE TAB, COLCRYS TAB	-	NC
ZURAMPIC TAB	-	NC
URICOSURICS		
probenecid tab (BENEMID equiv)	-	1
HEMATOLOGICAL AGENTS - MISC.		
ANTIHEMOPHILIC PRODUCTS		
ADVATE INJ	MSP-PA	3
ADYNOVATE INJ	MSP-PA	3
AFSTYLA KIT	MSP-PA	3
ALPHANATE/HEMOFIL/KOATE INJ	MSP-PA	3
ALPHANINE SD/MONONINE INJ	MSP-PA	3
ALPROLIX INJ	MSP-PA	3
BEBULIN/PROFILNINE INJ	MSP-PA	3
BENEFIX INJ	MSP-PA	3
BENEFIX/RIXUBIS INJ	MSP-PA	3
COAGADEX INJ	MSP-PA	3
CORIFACT INJ	MSP-PA	3
ELOCTATE INJ	MSP-PA	3
FEIBA INJ	MSP-PA	3
HELIXATE/KOGENATE INJ	MSP-PA	3
HEMLIBRA INJ	MSP-PA	3
HUMATE-P/WILATE INJ	MSP-PA	3
IDELVION SOLN	MSP-PA	3
MONOCLATE-P INJ	MSP-PA	3
NOVOSEVEN RT INJ	MSP-PA	3
REBINYN SOLN	MSP-PA	3
RECOMBINATE INJ	MSP-PA	3
TRETEN INJ	MSP-PA	3
VONVEDI INJ	MSP-PA	3
XYNTHA INJ	MSP-PA	3
BRADYKININ B2 RECEPTOR ANTAGONISTS		
FIRAZYR INJ	-	NC
COMPLEMENT INHIBITORS		
BERINERT INJ	-	NC
CINRYZE INJ	-	NC
HAEGARDA INJ	-	NC
RUCONEST INJ	-	NC
HEMATAOLOGIC - TYROSINE KINASE INHIBITORS		
TAVALISSE TAB	-	NC

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

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

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

**Texas Association of Counties HDHP Formulary
Category/Class**

Last Updated* 11/1/2018

DrugName	Special Code	Tier
HEMATOLOGICAL AGENTS - MISC. Cont.		
HEMATORHEOLOGIC AGENTS		
pentoxifylline ER tab (TRENTAL equiv)	-	1
PLASMA KALLIKREIN INHIBITORS		
TAKHZYRO INJ	-	NC
PLASMA PROTEINS		
THROMBAT III INJ	MSP-PA	3
PLATELET AGGREGATION INHIBITORS		
anagrelide cap (AGRYLIN equiv)	-	1
cilostazol tab (PLETAL equiv)	-	1
clopidogrel tab 75mg (PLAVIX equiv)	-	1
dipyridamole tab (PERSANTINE equiv)	-	1
prasugrel tab (EFFIENT equiv)	-	1
ticlopidine tab (TICLID equiv)	-	1
aspirin/dipyridamole cap (AGGRENEX equiv)	-	2
BRILINTA TAB (Restricted to Cardiology Specialist)	RS	3
ZONTIVITY TAB (Restricted to Cardiology Specialist)	RS	3
CLOPIDOGREL THERAPY PACK	-	NC
PLAVIX TAB 300MG	-	NC
YOSPRALA TAB	-	NC
HEMATOPOIETIC AGENTS		
AGENTS FOR GAUCHER DISEASE		
miglustat cap (ZAVESCA equiv) (Only available through Accredo 888-773-7376)	LD-PA	2
CERDELGA CAP	-	NC
AGENTS FOR SICKLE CELL ANEMIA		
DROXIA CAP	-	2
ENDARI POWDER PACK	-	NC
SIKLOS TAB	-	NC
COBALAMINS		
cyanocobalamin inj	-	1
NASCOBAL NASAL SPRAY	-	3
CALOMIST NASAL SPRAY	-	NC
FOLIC ACID/FOLATES		
folic acid tab 1mg (Covered at \$0 for females only; All other members covered at generic copay)	-	\$0
folic acid tab 400mcg (Covered for females only)	OTC	\$0
folic acid tab 800mcg (Covered for females only)	OTC	\$0
HEMATOPOIETIC GROWTH FACTORS		
EPOGEN INJ	-	2
FULPHILA INJ	LMSP	2
GRANIX INJ	LMSP	2
LEUKINE INJ	LMSP-PA	2
NEUMEGA INJ	LMSP	2
PROCRIT INJ	-	2
PROMACTA TAB	LMSP-PA	2
RETACRIT INJ	-	2
ZARXIO INJ	LMSP	2
Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.		
INF Infertility MSP Mandatory Specialty Pharmacy Program QL Quantity Limit SMKG Smoking Cessation VAC Vaccine Program	LD Limited Distribution OTC Over-the-Counter RS Restricted to Specialist SP Available through Specialty Pharmacy Program ¢ RxCENTS	generic =small letters LMSP Lumicera Mandatory Specialty Pharmacy Program PA Prior Authorization SF Limited to two 15 day fills per month for first 3 months ST Step Therapy

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

**Texas Association of Counties HDHP Formulary
Category/Class**

Last Updated* 11/1/2018

DrugName	Special Code	Tier
HEMATOPOIETIC AGENTS Cont.		
ARANESP INJ	-	NC
DOPTELET TAB	-	NC
MIRCERA INJ	-	NC
MULPLETA TAB	-	NC
NEULASTA INJ	-	NC
NEUPOGEN INJ	-	NC
NIVESTYM INJ	-	NC
HEMATOPOIETIC MIXTURES		
ferrex 150 forte cap	-	1
ferrex 150 forte cap (NIFEREX 150 FORTE equiv)	-	1
folbee tab	-	1
multigen folic tab (CHROMAGEN FA equiv)	-	1
multigen plus tab (CHROMAGEN FORTE equiv)	-	1
multigen tab (CHROMAGEN equiv)	-	1
tricon cap (TRINSICON equiv)	-	1
NEPHRON FA TAB	-	2
BIFERARX TAB	-	NC
B-SERENE PAD	-	NC
CYFOLEX CAP	-	NC
PUREFOLIX TAB	-	NC
IRON		
ferrous sulfate elixir (Covered for members 1 year or younger)	OTC	\$0
FERROUS SULFATE LIQUID (Covered for members 1 year or younger)	OTC	\$0
ferrous sulfate soln (Covered for members 1 year or younger)	OTC	\$0
FERROUS SULFATE SYRUP (Covered for members 1 year or younger)	OTC	\$0
IRON SUSP (Covered for members 1 year or younger)	OTC	\$0
HEMOSTATICS		
HEMOSTATICS - SYSTEMIC		
aminocaproic acid syrup (AMICAR equiv)	-	1
aminocaproic acid tab (AMICAR equiv)	-	1
AMICAR SOLN	-	2
AMICAR TAB	-	2
tranexamic acid tab (LYSTEDA equiv)	-	2
AMICAR SYRUP	-	3
AMINOCAPROIC ACID TAB	-	3
HYPNOTICS		
NON-BARBITURATE HYPNOTICS		
zolpidem tab (AMBIEN equiv) (QL= 1 tab/day)	QL	1
OREXIN RECEPTOR ANTAGONISTS		
BELSOMRA TAB	-	NC
HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS		
BARBITURATE HYPNOTICS		
phenobarbital elixir	-	1
phenobarbital tab	-	1
SECONAL CAP	-	2

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

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

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

**Texas Association of Counties HDHP Formulary
Category/Class**

Last Updated* 11/1/2018

DrugName	Special Code	Tier
HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS Cont.		
BUTISOL ELIXIR	-	3
BUTISOL TAB	-	3
HYPNOTICS - TRICYCLIC AGENTS		
SILENOR TAB	-	NC
NON-BARBITURATE HYPNOTICS		
estazolam tab (PROSOM equiv)	-	1
eszopiclone tab (LUNESTA equiv) (QL= 1 tab/day)	QL	1
FLURAZEPAM CAP	-	1
temazepam cap 15mg (RESTORIL equiv)	-	1
temazepam cap 30mg (RESTORIL equiv)	-	1
triazolam tab (HALCION equiv)	-	1
zaleplon cap (SONATA equiv)	-	1
SOMNOTE CAP	-	3
temazepam cap 22.5mg (RESTORIL equiv)	-	3
temazepam cap 7.5mg (RESTORIL equiv)	-	3
AMBIEN CR TAB	-	NC
DORAL TAB	-	NC
EDLUAR SL TAB	-	NC
INTERMEZZO SL TAB	-	NC
zolpidem ER tab (AMBIEN CR equiv)	-	NC
zolpidem tartrate SL tab (INTERMEZZO equiv)	-	NC
ZOLPIMIST SPRAY	-	NC
SELECTIVE MELATONIN RECEPTOR AGONISTS		
HETLIOZ CAP	-	NC
ROZEREM TAB	-	NC
LAXATIVES		
LAXATIVE COMBINATIONS		
peg 3350/electrolytes soln (COLYTE equiv) (Covered at \$0 for members 50-75 years-Limited to 2 fills/calendar year; All other members covered at generic copay)	QL	\$0
trilyte soln (NULYTELY equiv) (Covered at \$0 for members 50-75 years, all other members covered at generic copay; Limited to 2 fills/calendar year)	QL	\$0
CLENPIQ SOLN	-	2
gavilyte-h kit	-	NC
GOLYTELY SOLN	-	NC
HALFLYTELY BOWEL PREP KIT	-	NC
MOVIPREP SOLN	-	NC
NULYTELY SOLN	-	NC
PLENVU SOLN	-	NC
SUCLEAR KIT	-	NC
SUPREP SOLN	-	NC
LAXATIVES - MISCELLANEOUS		
lactulose soln	-	1
KRISTALOSE PACKET	-	3
lactulose pack (KRISTALOSE equiv)	-	3
GIALAX KIT	-	NC
MIRALAX PACKET	-	NC

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

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

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

Texas Association of Counties HDHP Formulary
Category/Class

Last Updated* 11/1/2018

DrugName	Special Code	Tier
LAXATIVES Cont.		
MIRALAX POWDER	-	NC
polyethylene glycol 3350 powder (MIRALAX equiv)	-	NC
SALINE LAXATIVES		
OSMOPREP TAB	-	3
VISICOL TAB	-	3
MACROLIDES		
AZITHROMYCIN		
azithromycin susp (ZITHROMAX equiv)	-	1
azithromycin tab (ZITHROMAX equiv)	-	1
ZITHROMAX POWDER PACK	-	3
ZMAX SUSP	-	3
CLARITHROMYCIN		
clarithromycin susp (BIAXIN equiv)	-	1
clarithromycin tab (BIAXIN equiv)	-	1
CLARITHROMYC SUSP	-	2
clarithromycin ER tab (BIAXIN XL equiv)	-	3
ERYTHROMYCINS		
erythromycin DR cap (ERYC equiv)	-	2
erythromycin ethylsuccinate susp (ERYPED equiv)	-	2
erythromycin stearate tab	-	2
erythromycin tab (ERYTHROMYCIN equiv) (all forms except PCE)	-	2
ERYPED SUSP	-	3
ERY-TAB	-	3
ERYTHROMYCIN ETHYLSUCCINATE TAB	-	3
PCE TAB	-	3
FIDAXOMICIN		
DIFICID TAB (QL= 20 tabs/fill; Step Therapy requires trial of vancomycin cap, vancomycin soln, or FIRVANQ SOLN)	QL-ST	2

MEDICAL DEVICES AND SUPPLIES

CONTRACEPTIVES		
CERVICAL CAP	-	\$0
DIAPHRAGM	-	\$0
FEMALE CONDOMS	OTC	\$0
DIABETIC SUPPLIES		
ACCU-CHECK GUIDE CARE METER	OTC	\$0
ACCU-CHEK AVIVA PLUS METER	OTC	\$0
ACCU-CHEK NANO METER	OTC	\$0
FREESTYLE FREEDOM LITE METER	OTC	\$0
FREESTYLE INSULINX METER	OTC	\$0
FREESTYLE LITE METER	OTC	\$0
FREESTYLE PRECISION NEO METER	OTC	\$0
PRECISION XTRA METER	OTC	\$0
CALIBRATION LIQUID	OTC	1
LANCET KIT	OTC	1
LANCETS	OTC	1
V-GO INJ KIT (QL= 1 kit/day)	QL	2

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

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

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

**Texas Association of Counties HDHP Formulary
Category/Class**

Last Updated* 11/1/2018

DrugName	Special Code	Tier
MEDICAL DEVICES AND SUPPLIES Cont.		
DEXCOM G6 RECEIVER (QL= 1 receiver/year)	PA-QL	3
DEXCOM G6 SENSOR (QL= 3 sensors/28 days)	PA-QL	3
DEXCOM G6 TRANSMITTER (QL= 1 transmitter/90 days)	PA-QL	3
FREESTYLE LIBRE RECEIVER (QL= 1 receiver/year)	PA-QL	3
FREESTYLE LIBRE SENSOR (10-DAY) (QL= 3 sensors/30 days)	PA-QL	3
FREESTYLE LIBRE SENSOR (14-DAY) (QL= 2 sensors/28 days)	PA-QL	3
DIABETIC METER (all other diabetic meters)	OTC	NC
MISC. DEVICES		
ALCOHOL SWABS	OTC	1
ORAL HYGIENE PRODUCTS		
HURRISEAL MIS SNAP	-	NC
PARENTERAL THERAPY SUPPLIES		
B-D INSULIN SYRINGE	--OTC	1
B-D PEN NEEDLE	OTC	1
NOVOFINE PEN NEEDLE	OTC	1
NOVOTWIST PEN NEEDLE	OTC	1
NOVOTWIST/NOVOFINE PEN NEEDLE	OTC	1
INSULIN SYRINGE	OTC	NC
PEN NEEDLE	OTC	NC
RESPIRATORY THERAPY SUPPLIES		
PEAK FLOW METER	OTC	1
AEROCHAMBER	OTC	2
MIGRAINE PRODUCTS		
MIGRAINE COMBINATIONS		
ISOMETHEPTENE/CAFFEINE/ACETAMINOPHEN TAB	-	2
isometheptene/caffeine/acetaminophen tab (PRODRIN equiv)	-	2
MIGERGOT SUPP	-	2
PRODRIN TAB	-	2
ergotamine/caffeine tab (CAFERGOT equiv)	-	3
ACETAMINOPHEN/ISOMETHEPTENE/DICHLORAL CAP	-	NC
acetaminophen/isometheptene/dichloral cap (MIDRIN equiv)	-	NC
sumatriptan/naproxen tab (TREXIMET equiv)	-	NC
TREXIMET TAB	-	NC
MIGRAINE PRODUCTS		
DIHYDROERGOTAMINE SPRAY, MIGRANAL SPRAY (QL= 8 sprays/fill, 2 fills/30 days)	QL	3
dihydroergotamine mesylate inj (D.H.E. equiv)	-	NC
MIGRAINE PRODUCTS - MONOCLONAL ANTIBODIES		
AIMOVIG INJ	-	NC
AJOVY INJ	-	NC
EMGALITY INJ	-	NC
MIGRAINE PRODUCTS - NSAIDS		
CAMBIA POWDER PACKET	-	NC
SEROTONIN AGONISTS		
rizatriptan ODT (MAXALT equiv) (QL= 12 tabs/fill, 3 fills/60 days)	QL	1
rizatriptan tab (MAXALT equiv) (QL= 12 tabs/fill, 3 fills/60 days)	QL	1

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

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

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

**Texas Association of Counties HDHP Formulary
Category/Class**

Last Updated* 11/1/2018

DrugName	Special Code	Tier
MIGRAINE PRODUCTS Cont.		
sumatriptan tab (IMITREX equiv) (QL= 9 tabs/fill, 2 fills/30 days)	QL	1
naratriptan tab (AMERGE equiv) (QL= 9 tabs/fill, 2 fills/30 days)	QL	2
sumatriptan inj (IMITREX equiv) (QL= 4 inj/fill, 2 fills/30 days)	QL	2
SUMATRIPTAN INJ 6MG/0.5ML (QL= 4 inj/fill, 2 fills/30 days)	QL	2
sumatriptan nasal spray (IMITREX, SUMATRIPTAN equiv) (QL= 6 sprays/fill, 2 fills/30 days)	QL	2
sumatriptan vial inj (IMITREX equiv) (QL= 5 inj/fill, 2 fills/30 days)	QL	2
zolmitriptan ODT (ZOMIG equiv) (QL= 9 tabs/fill, 2 fills/30 days)	QL	3
zolmitriptan tab (ZOMIG equiv) (QL= 9 tabs/fill, 2 fills/30 days)	QL	3
ZOMIG NASAL SPRAY (QL= 6 sprays/fill, 2 fills/30 days)	QL	3
almotriptan tab (AXERT equiv)	-	NC
ALSUMA INJ, ZEMBRACE SYMTOUCH INJ	-	NC
AXERT TAB	-	NC
eletriptan tab (RELPAK equiv)	-	NC
FROVA TAB	-	NC
frovatriptan tab (FROVA equiv)	-	NC
ONZETRA XSAIL	-	NC
RELPAK TAB	-	NC
SUMAVEL DOSEPRO INJ	-	NC
ZECUITY PAD	-	NC

MINERALS & ELECTROLYTES

FLUORIDE

FLUORABON SOLN (Covered at \$0 for members 5 years or younger; All other members covered at preferred brand copay)	-	\$0
sodium fluoride chew tab (LURIDE equiv) (Covered at \$0 for members 5 years or younger; All other members covered at generic copay)	-	\$0
SODIUM FLUORIDE LOZENGE (Covered at \$0 for members 5 years or younger; All other members covered at generic copay)	-	\$0
sodium fluoride soln (LURIDE equiv) (Covered at \$0 for members 5 years or younger; All other members covered at generic copay)	-	\$0
SODIUM FLUORIDE TAB (Covered at \$0 for members 5 years or younger; All other members covered at generic copay)	-	\$0
FLUOR-A-DAY CHEW TAB	-	1

PHOSPHATE

phospha 250 neutral tab (K-PHOS NEUTRAL equiv)	-	1
K-PHOS TAB	-	2

POTASSIUM

potassium bicarbonate effer tab (K-LYTE equiv)	-	1
potassium chloride effer tab (K-LYTE/CL equiv)	-	1
potassium chloride ER cap (MICRO-K equiv)	-	1
POTASSIUM CHLORIDE ER TAB	-	1
potassium chloride ER tab (KLOR-CON equiv)	-	1
potassium chloride micro tab (K-DUR equiv)	-	1
potassium chloride powder packet (KLOR-CON equiv)	-	1
potassium chloride soln	-	1
KLOR-CON M15 TAB	-	2
KLOR-CON POWDER PACKET 25MEQ	-	3

ZINC

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

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

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

**Texas Association of Counties HDHP Formulary
Category/Class**

Last Updated* 11/1/2018

DrugName	Special Code	Tier
MINERALS & ELECTROLYTES Cont.		
zinc sulfate cap	-	1
GALZIN CAP	-	2
MISCELLANEOUS THERAPEUTIC CLASSES		
CHELATING AGENTS		
trientine cap (SYPRINE equiv)	MSP-PA	2
IMMUNOSUPPRESSIVE AGENTS		
CYCLOSPORINE MODIFIED CAP	-	2
POTASSIUM REMOVING AGENTS		
LOKELMA PAK	-	NC
SYSTEMIC LUPUS ERYTHEMATOSUS AGENTS		
BENLYSTA AUTO-INJECTOR (QL= 4 inj/28 day)	LMSP-PA-QL	2
BENLYSTA INJ (QL= 4 inj/28 day)	LMSP-PA-QL	2
MOUTH/THROAT/DENTAL AGENTS		
ANESTHETICS TOPICAL ORAL		
lidocaine viscous soln	-	1
LIDOCAINE ORAL SOLN 4%	-	2
FIRST MOUTHWASH BLM	-	3
ANTIALLERGY AGENTS - MOUTH/THROAT		
APHTHASOL PASTE	-	2
ANTI-INFECTIVES - THROAT		
clotrimazole troches (MYCELEX TROCHES equiv)	-	1
nystatin susp	-	1
ORAVIG TAB	-	3
ANTISEPTICS - MOUTH/THROAT		
chlorhexidine gluconate soln (PERIDEX equiv)	-	1
DENTAL PRODUCTS		
PREVIDENT 5000 PLUS CREAM (Covered at \$0 for members 5 years or younger; All other members covered at preferred brand copay)	-	\$0
sodium fluoride cream (PREVIDENT equiv) (Covered at \$0 for members 5 years or younger; All other members covered at generic copay)	-	\$0
sodium fluoride gel (PREVIDENT equiv)	-	1
sodium fluoride paste (PREVIDENT equiv)	-	1
sodium fluoride rinse (PREVIDENT equiv)	-	1
sodium fluoride/potassium nitrate paste (PREVIDENT equiv)	-	1
PREVIDENT PASTE	-	2
PREVIDENT RINSE	-	2
STEROIDS - MOUTH/THROAT		
triamcinolone in orabase paste (KENALOG/ORABASE equiv)	-	1
THROAT PRODUCTS - MISC.		
pilocarpine tab (SALAGEN equiv)	-	1
cevimeline cap (EVOXAC equiv)	-	2
GELCLAIR GEL	-	NC
PROTHELIAL PASTE	-	NC

MULTIVITAMINS

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

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

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

**Texas Association of Counties HDHP Formulary
Category/Class**

Last Updated* 11/1/2018

DrugName	Special Code	Tier
MULTIVITAMINS Cont.		
B-COMPLEX W/ FOLIC ACID		
DIALYVITE TAB	-	1
dialyvite tab (NEPHRO-VITE equiv)	-	1
DIALYVITE/ZINC TAB	-	1
FOLBEE PLUS CZ TAB	-	1
renaphro cap (NEPHROCAP equiv)	-	1
FIBRIK CAP	-	NC
MULTIPLE VITAMINS & FLUORIDE-FOLIC ACID		
MULTIVITAMIN/FLUORIDE CHEW TAB	-	NC
MULTIPLE VITAMINS W/ MINERALS		
multivitamin/minerals tab (STROVITE equiv)	-	1
MULTIVITAMINS		
FOLIKA-V TAB	-	NC
PED MULTI VITAMINS W/FL & FE		
pediatric multiple vitamins/fluoride/iron soln	-	1
PED MV W/ FLUORIDE		
pediatric multiple vitamins/fluoride soln	-	1
FLORIVA PLUS DROPS	-	2
pediatric multiple vitamins/fluoride chew tab	-	3
QUFLORA PEDIATRIC CHEW TAB	-	3
PEDIATRIC MULTIPLE VITAMINS & MINERALS W/ FLUORIDE		
FLORIVA CHEW TAB	-	NC
PRENATAL VITAMINS		
PRENATAL VITAMINS (PRENATAL PLUS, PREPLUS, PRENAPLUS)	-	1
PRENATAL VITAMINS (NON-PREFERRED)	-	3
CITRANATAL CAP MEDLEY	-	NC
MUSCULOSKELETAL THERAPY AGENTS		
CENTRAL MUSCLE RELAXANTS		
baclofen tab 10mg, 20mg	-	1
carisoprodol tab (SOMA equiv)	-	1
CHLORZOXAZONE TAB 500MG	-	1
cyclobenzaprine tab 10mg (FLEXERIL equiv)	-	1
cyclobenzaprine tab 5mg (FLEXERIL equiv)	-	1
methocarbamol tab (ROBAXIN equiv)	-	1
orphenadrine citrate ER tab (NORFLEX equiv)	-	1
tizanidine tab (ZANAFLEX equiv)	-	1
cyclobenzaprine tab 7.5mg (FEXMID equiv)	-	3
metaxalone tab (SKELAXIN equiv)	-	3
METAXALONE TAB 400MG	-	3
tizanidine cap (ZANAFLEX equiv)	-	3
BACLOFEN TAB	-	NC
carisoprodol tab 250mg (SOMA equiv)	-	NC
CHLORZOXAZONE TAB 250MG, LORZONE TAB	-	NC
CYCLOBENZAPRINE COMPOUND KIT	-	NC
FIRST BACLOFEN SUSP KIT	-	NC
Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.		
INF Infertility MSP Mandatory Specialty Pharmacy Program QL Quantity Limit SMKG Smoking Cessation VAC Vaccine Program	LD Limited Distribution OTC Over-the-Counter RS Restricted to Specialist SP Available through Specialty Pharmacy Program ¢ RxCENTS	generic =small letters LMSP Lumicera Mandatory Specialty Pharmacy Program PA Prior Authorization SF Limited to two 15 day fills per month for first 3 months ST Step Therapy

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

**Texas Association of Counties HDHP Formulary
Category/Class**

Last Updated* 11/1/2018

DrugName	Special Code	Tier
MUSCULOSKELETAL THERAPY AGENTS Cont.		
SOMA TAB 250MG	-	NC
DIRECT MUSCLE RELAXANTS		
dantrolene cap (DANTRIUM equiv)	-	2
MUSCLE RELAXANT COMBINATIONS		
ORPHENADRINE/ASPIRIN/CAFFEINE TAB	-	3
orphenadrine/aspirin/caffeine tab (NORGESIC FORTE equiv)	-	3
carisoprodol/aspirin tab (SOMA COMPOUND equiv)	-	NC
carisoprodol/aspirin/codeine tab (SOMA COMPOUND/CODEINE equiv)	-	NC
LORVATUS PHARMAPAK KIT	-	NC
TIZANIDINE COMFORT KIT	-	NC
NASAL AGENTS - SYSTEMIC AND TOPICAL		
NASAL AGENT COMBINATIONS		
AZENASE PAK	-	NC
DYMISTA NASAL SPRAY	-	NC
NASAL AGENTS - MISC.		
ALZAIR NASAL SPRAY	-	NC
TICANASE PAK	-	NC
NASAL ANESTHETICS		
GOPRELTO SOLN	-	NC
NASAL ANTIALLERGY		
azelastine nasal spray 0.1% (ASTELIN equiv)	-	1
azelastine nasal spray 0.15% (ASTEPRO equiv)	-	2
olopatadine nasal spray (PATANASE equiv)	-	2
NASAL ANTICHOLINERGICS		
ipratropium nasal spray (ATROVENT equiv)	-	1
NASAL ANTI-INFECTIVES		
BACTROBAN NASAL OINT	-	3
NASAL STEROIDS		
fluticasone nasal spray (FLONASE equiv) (QL= 2 bottles/fill)	QL	1
FLUNISOLIDE NASAL SPRAY (QL= 2 bottles/fill)	QL	3
BECONASE AQ NASAL SPRAY	-	NC
budesonide nasal spray (RHINOCORT AQUA equiv)	-	NC
FLONASE NASAL SPRAY	-	NC
flunisolide nasal solution 0.025% (FLUNISOLIDE NASAL SPRAY 0.025% equiv)	-	NC
FLUNISOLIDE NASAL SPRAY 0.025%	-	NC
mometasone nasal spray (NASONEX equiv)	-	NC
NASACORT OTC NASAL SPRAY	OTC	NC
OMNARIS NASAL SPRAY	-	NC
QNASL NASAL SPRAY	-	NC
RHINOCORT AQUA NASAL SPRAY	-	NC
triamcinolone OTC nasal spray (NASACORT equiv)	OTC	NC
VERAMYST NASAL SPRAY	-	NC
XHANCE NASAL EXHALER	-	NC
ZETONNA NASAL SPRAY	-	NC

NEUROMUSCULAR AGENTS

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

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

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

**Texas Association of Counties HDHP Formulary
Category/Class**

Last Updated* 11/1/2018

DrugName	Special Code	Tier
NEUROMUSCULAR AGENTS Cont.		
ALS AGENTS		
riluzole tab (RILUTEK equiv)	-	2
TIGLUTIK SUSP	-	NC
NEUROMUSCULAR BLOCKING AGENT - NEUROTOXINS		
BOTOX INJ	LMSP-PA	3
DYSPOIN INJ	LMSP-PA	3
MYOBLOC INJ	MSP-PA	3
XEOMIN INJ	LMSP-PA	3
OPHTHALMIC AGENTS		
ARTIFICIAL TEARS AND LUBRICANTS		
LACRISERT OPHTH INSERT	-	2
BETA-BLOCKERS - OPHTHALMIC		
betaxolol ophth soln (BETOPTIC-S equiv)	-	1
CARTEOLOL OPHTH SOLN	-	1
carteolol ophth soln (OCUPRESS equiv)	-	1
dorzolamide/timolol (pf) ophth soln (COSOPT equiv)	-	1
levobunolol ophth soln (BETAGAN equiv)	-	1
timolol maleate ophth soln (TIMOPTIC equiv)	-	1
BETIMOL OPHTH SOLN	-	2
BETOPTIC-S OPHTH SOLN	-	2
COMBIGAN OPHTH SOLN	-	2
DORZOLAMIDE/TIMOLOL OPHTH SOLN	-	2
ISTALOL OPHTH SOLN	-	2
METIPRANOLOL OPHTH SOLN	-	2
timolol maleate ophth gel (TIMOPTIC-XE equiv)	-	2
timolol maleate ophth soln 0.5% (ISTALOL equiv)	-	2
TIMOLOL OPHTH GEL SOLN	-	2
TIMOPTIC OCUDOSE OPHTH SOLN	-	3
CYCLOPLEGIC MYDRIATICS		
atropine ophth oint	-	1
atropine ophth soln (ISOPTO ATROPINE equiv)	-	1
cyclopentolate ophth soln (CYCLOGYL equiv)	-	1
homatropine ophth soln (ISOPTO HOMATROPINE equiv)	-	1
tropicamide ophth soln (MYDRIACYL equiv)	-	1
CYCLOMYDRIL OPHTH SOLN	-	2
ISOPTO HOMATROPINE OPHTH SOLN 2%	-	2
ISOPTO HOMATROPINE OPHTH SOLN 5%	-	2
ISOPTO HYOSCINE OPHTH SOLN	-	2
MIOTICS		
pilocarpine ophth soln (ISOPTO CARPINE equiv)	-	1
ISOPTO CARBACHOL OPHTH SOLN	-	2
PHOSPHOLINE OPHTH SOLN	-	2
PILOPINE HS OPHTH GEL	-	3
OPHTHALMIC ADRENERGIC AGENTS		
brimonidine ophth soln 0.2%	-	1

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

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

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

**Texas Association of Counties HDHP Formulary
Category/Class**

Last Updated* 11/1/2018

DrugName	Special Code	Tier
OPHTHALMIC AGENTS Cont.		
ALPHAGAN P OPHTH SOLN 0.1%	-	2
apraclonidine ophth soln (IOPIDINE equiv)	-	2
brimonidine ophth soln 0.15% (ALPHAGAN P 0.15% equiv)	-	2
IOPIDINE OPHTH SOLN 1%	-	2
SIMBRINZA OPHTH SUSP	-	2
LUMIFY OPHTH SOLN 0.25%	-	NC
OPHTHALMIC ANTI-INFECTIVES		
bacitracin/neomycin/polymyxin b ophth oint (NEOSPORIN equiv)	-	1
bacitracin/polymyxin b ophth oint (POLYSPORIN equiv)	-	1
ciprofloxacin ophth soln (CILOXAN equiv)	-	1
erythromycin ophth oint	-	1
GENTAK OPHTH OINT	-	1
gentamicin ophth oint (GARAMYCIN equiv)	-	1
gentamicin ophth soln (GARAMYCIN equiv)	-	1
levofloxacin ophth soln (QUIXIN equiv)	-	1
moxifloxacin ophth soln (VIGAMOX OPHTH SOLN equiv)	-	1
neomycin/polymyxin b/gramicidin ophth soln (NEOSPORIN equiv)	-	1
ofloxacin ophth soln (OCUFLOX equiv)	-	1
polymyxin b/trimethoprim ophth soln (POLYTRIM equiv)	-	1
sulfacetamide sodium ophth soln (BLEPH-10 equiv)	-	1
tobramycin ophth soln (TOBREX equiv)	-	1
AZASITE SOLN	-	2
BACITRACIN OPHTH OINT	-	2
trifluridine ophth soln (VIROPTIC equiv)	-	2
ZIRGAN OPHTH GEL	-	2
CILOXAN OPHTH OINT	-	3
gatifloxacin ophth soln (ZYMAXID equiv)	-	3
TOBREX OPHTH OINT	-	3
VIGAMOX OPHTH SOLN	-	3
ZYMAXID OPHTH SOLN	-	3
BESIVANCE OPHTH SUSP	-	NC
MOXEZA OPHTH SOLN	-	NC
OPHTHALMIC DECONGESTANTS		
phenylephrine ophth soln (MYDFRIN equiv)	-	1
OPHTHALMIC IMMUNOMODULATORS		
RESTASIS OPHTH EMULSION	PA	2
OPHTHALMIC INTEGRIN ANTAGONISTS		
XIIDRA OPHTH SOLN	-	NC
OPHTHALMIC KINASE INHIBITORS		
RHOPRESSA OPHTH SOLN	-	NC
OPHTHALMIC LOCAL ANESTHETICS		
proparacaine ophth soln (ALCAINE equiv)	-	1
OPHTHALMIC PHOTOENHANCERS		
PHOTREXA OP KIT	-	NC
PHOTREXA VISCOUS OPHTH SOLN	-	NC

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

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

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

**Texas Association of Counties HDHP Formulary
Category/Class**

Last Updated* 11/1/2018

DrugName	Special Code	Tier
OPHTHALMIC AGENTS Cont.		
OPHTHALMIC STEROIDS		
bacitracin/polymyxin/neomycin/hydrocortisone ophth oint (CORTISPORIN equiv)	-	1
dexamethasone ophth soln	-	1
fluorometholone ophth soln (FML LIQUIFILM equiv)	-	1
neomycin/polymyxin/dexamethasone ophth oint (MAXITROL equiv)	-	1
neomycin/polymyxin/dexamethasone ophth soln (MAXITROL equiv)	-	1
neomycin/polymyxin/hydrocortisone ophth soln (CORTISPORIN equiv)	-	1
prednisolone ophth soln (PRED FORTE equiv)	-	1
sulfacetamide sodium/prednisolone ophth soln (VASOCIDIN equiv)	-	1
tobramycin/dexamethasone ophth soln (TOBRADEX equiv)	-	1
ALREX OPHTH SUSP, LOTEMAX OPHTH SUSP	-	2
BLEPHAMIDE OPHTH SOLN	-	2
DUREZOL OPHTH EMULSION	-	2
LOTEMAX OPHTH GEL	-	2
LOTEMAX OPHTH OINT	-	2
MAXIDEX OPHTH SOLN	-	2
PRED MILD OPHTH SOLN	-	2
PRED-G OPHTH SOLN	-	2
PREDNISOLONE SODIUM PHOSPHATE OPHTH SOLN	-	2
TOBRADEX OPHTH OINT	-	2
VEXOL OPHTH SUSP	-	2
ZYLET OPHTH SUSP (QL= 5ml/fill (10ml bottle is Not Covered))	QL	2
BLEPHAMIDE S.O.P. OPHTH OINT	-	3
FLAREX OPHTH SUSP	-	3
FML FORTE OPHTH SUSP	-	3
FML S.O.P. OPHTH OINT	-	3
TOBRADEX ST OPHTH SUSP	-	3
INVELTYS OPHTH SUSP	-	NC
PREDNISOLONE/MOXIFLOXACIN OPHTH SOLN	-	NC
PREDNISOLONE/MOXIFLOXACIN/BROMFENAC OPHTH SOLN	-	NC
PREDNISOLONE/MOXIFLOXACIN/KETOROLAC OPHTH SOLN	-	NC
OPHTHALMICS - MISC.		
azelastine ophth soln (OPTIVAR equiv)	-	1
cromolyn ophth soln (CROLOM equiv)	-	1
diclofenac sodium ophth soln (VOLTAREN equiv)	-	1
dorzolamide ophth soln (TRUSOPT equiv)	-	1
flurbiprofen ophth soln (OCUFEN equiv)	-	1
ketorolac ophth soln (ACULAR (LS) equiv)	-	1
ALAMAST OPHTH SOLN	-	2
ALOCRIAL OPHTH SOLN	-	2
ALOMIDE OPHTH SOLN	-	2
AZOPT OPHTH SUSP	-	2
bromfenac ophth soln (BROMDAY equiv)	-	2
BROMFENAC OPHTH SOLN 0.09% (ONCE DAILY)	-	2
CYSTARAN OPHTH SOLN (QL= 4 bottles/30 days; Only available through Walgreens 888-347-3416)	LD-PA-QL	2
ILEVRO OPHTH SUSP	-	2

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

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

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

**Texas Association of Counties HDHP Formulary
Category/Class**

Last Updated* 11/1/2018

DrugName	Special Code	Tier
OPHTHALMIC AGENTS Cont.		
NEVANAC OPHTH SUSP	-	2
olopatadine ophth soln 0.1% (PATANOL equiv)	-	2
PROLENSA OPHTH SOLN	-	2
ACUVAIL OPHTH SOLN	-	3
BEPREVE OPHTH SOLN	-	3
EMADINE OPHTH SOLN	-	3
epinastine ophth soln (ELESTAT equiv)	-	3
LASTACFT OPHTH SOLN (QL= 3ml/30 days)	QL	3
BROMSITE OPHTH SOLN	-	NC
ketotifen ophth soln (ZADITOR equiv)	OTC	NC
olopatadine ophth soln 0.2% (PATADAY equiv)	-	NC
PATADAY OPHTH SOLN	-	NC
PAZEO OPHTH SOLN 0.7%	-	NC
ZADITOR OPHTH SOLN	OTC	NC
PROSTAGLANDINS - OPHTHALMIC		
latanoprost ophth soln (XALATAN equiv) (QL= 2.5ml/30 days)	QL	1
bimatoprost ophth soln (QL= 2.5ml/30 days)	QL	2
LUMIGAN OPHTH SOLN (QL= 2.5ml/30 days)	QL	2
TRAVATAN Z OPHTH SOLN (QL= 2.5ml/30 days)	QL	2
VYZULTA SOLN	-	NC
ZIOPTAN OPHTH SOLN	-	NC
OTIC AGENTS		
OTIC AGENTS - MISCELLANEOUS		
acetic acid otic soln (VOSOL equiv)	-	1
ACETIC ACID/ALUMINUM ACETATE OTIC SOLN	-	1
OTIC ANTI-INFECTIVES		
CIPROFLOXACIN OTIC SOLN	-	2
ofloxacin otic soln (FLOXIN equiv)	-	3
OTIC COMBINATIONS		
neomycin/polymixin/hydrocortisone otic soln (CORTISPORIN equiv)	-	1
neomycin/polymixin/hydrocortisone otic susp (CORTISPORIN equiv)	-	1
CIPRODEX OTIC SUSP	-	2
COLY-MYCIN S OTIC SUSP	-	2
CIPRO HC OTIC SUSP	-	3
antipyrine/benzocaine otic soln (AURALGAN equiv)	-	NC
CORTANE-B AQUEOUS OTIC SOLN	-	NC
CORTANE-B OTIC SOLN	-	NC
otomax-HC otic soln (CORTANE-B equiv)	-	NC
OTOVEL OTIC SOLN	-	NC
OTOZIN OTIC DROPS	-	NC
pramoxine-HC AQ otic soln (CORTANE-B AQUEOUS equiv)	-	NC
OTIC STEROIDS		
acetic acid/hydrocortisone otic soln (VOSOL HC equiv)	-	1
fluocinolone otic oil (DERMOTIC equiv)	-	2
ACETASOL HC OTIC SOLN	-	3

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

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

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

**Texas Association of Counties HDHP Formulary
Category/Class**

Last Updated* 11/1/2018

DrugName	Special Code	Tier
----------	--------------	------

OXYTOCICS

OXYTOCICS

methylergonovine tab (METHERGINE equiv) (QL= 28 tabs/fill, 1 fill/365 days)	QL	2
---	----	---

PASSIVE IMMUNIZING AGENTS

IMMUNE SERUMS

BIVIGAM INJ	MSP-PA	3
CYTOGAM INJ	MSP-PA	3
GAMMAGARD SD INJ, CARIMUNE NF INJ	MSP-PA	3
HIZENTRA INJ, CUVITRU INJ	MSP-PA	3
OCTAGAM INJ, FLEBOGAMMA INJ, GAMMAPLEX INJ, PRIVIGEN INJ	MSP-PA	3

MONOCLONAL ANTIBODIES

SYNAGIS INJ	MSP-PA	3
-------------	--------	---

PASSIVE IMMUNIZING AGENTS - COMBINATIONS

HYQVIA INJ	MSP-PA	3
------------	--------	---

PASSIVE IMMUNIZING AND TREATMENT AGENTS

IMMUNE SERUMS

GAMASTAN INJ, GAMASTAN S/D INJ	MSP-PA	3
GAMUNEX-C INJ, GAMMAGARD INJ, GAMMAKED INJ	MSP-PA	3

PENICILLINS

AMINOPENICILLINS

amoxicillin cap (TRIMOX equiv)	-	1
amoxicillin chew tab (AMOXIL equiv)	-	1
AMOXICILLIN CHEW TAB 250MG	-	1
amoxicillin susp (TRIMOX equiv)	-	1
amoxicillin tab (AMOXIL equiv)	-	1
ampicillin cap (PRINCIPEN equiv)	-	1
ampicillin susp (PRINCIPEN equiv)	-	1
MOXATAG TAB	-	NC
MOXATAG TAB 775MG	-	NC

NATURAL PENICILLINS

penicillin vk soln (VEETIDS equiv)	-	1
penicillin vk tab (VEETIDS equiv)	-	1

PENICILLIN COMBINATIONS

amoxicillin/clavulanate chew tab (AUGMENTIN equiv)	-	1
amoxicillin/clavulanate susp (AUGMENTIN ES equiv)	-	1
amoxicillin/clavulanate tab (AUGMENTIN equiv)	-	1
amoxicillin/clavulanate ER tab (AUGMENTIN XR equiv)	-	3

PENICILLINASE-RESISTANT PENICILLINS

dicloxacillin cap (DYNAPEN equiv)	-	1
-----------------------------------	---	---

PHARMACEUTICAL ADJUVANTS

SEMI SOLID VEHICLES

POLYETHYLENE GLYCOL 8000 GRANULES	-	2
-----------------------------------	---	---

PROGESTINS

PROGESTINS

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

INF Infertility	LD generic =small letters Limited Distribution	LMSP Lumicera Mandatory Specialty Pharmacy Program
MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter	PA Prior Authorization
QL Quantity Limit	RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months
SMKG Smoking Cessation	SP Available through Specialty Pharmacy Program	ST Step Therapy
VAC Vaccine Program	¢ RxCENTS	

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

**Texas Association of Counties HDHP Formulary
Category/Class**

Last Updated* 11/1/2018

DrugName	Special Code	Tier
PROGESTINS Cont.		
medroxyprogesterone tab (PROVERA equiv)	-	1
norethindrone tab (AYGESTIN equiv)	-	1
progesterone cap (PROMETRIUM equiv)	-	2
megestrol ES susp (MEGACE ES equiv)	-	3
progesterone oil inj	-	NC
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.		
AGENTS FOR CHEMICAL DEPENDENCY		
disulfiram tab (ANTABUSE equiv)	-	1
acamprosate calcium DR tab (CAMPRAL equiv)	-	2
LUCEMYRA TAB	-	NC
ANTI-CATAPLECTIC AGENTS		
XYREM SOLN (QL= 540ml/30 days; Only available through Xyrem Central Pharmacy 866-997-3688)	LD-PA-QL	3
ANTIDEMENTIA AGENTS		
donepezil ODT (ARICEPT equiv) (QL= 1 tab/day)	QL	1
donepezil tab (ARICEPT equiv) (QL= 2 tabs/day)	QL	1
galantamine tab (RAZADYNE equiv)	¢	1
memantine tab (NAMENDA equiv)	-	1
rivastigmine cap (EXELON equiv)	-	1
donepezil tab 23mg (ARICEPT equiv) (QL= 1 tab/day; Step Therapy requires trial of donepezil 10mg)	QL-ST	2
EXELON SOLN	-	2
galantamine ER cap (RAZADYNE ER equiv)	-	2
GALANTAMINE SOLN	-	2
memantine ER cap (NAMENDA XR equiv)	-	2
memantine soln (NAMENDA equiv)	-	2
NAMENDA XR TITRATION PACK	-	2
NAMZARIC CAP (Step Therapy requires trial of donepezil and memantine)	ST	2
NAMZARIC STARTER PACK (Step Therapy requires trial of donepezil and memantine)	ST	2
rivastigmine patch (EXELON equiv)	-	2
NAMENDA XR CAP	-	NC
COMBINATION PSYCHOTHERAPEUTICS		
chlordiazepoxide/amitriptyline tab (LIMBITROL equiv)	-	1
PERPHENAZINE/ AMITRIPTYLINE TAB	-	1
olanzapine/fluoxetine cap (SYMBYAX equiv)	-	2
FIBROMYALGIA AGENTS		
SAVELLA PAK	-	2
SAVELLA TAB (QL= 2 tabs/day)	QL	2
HYPOACTIVE SEXUAL DESIRE DISORDER (HSDD) AGENTS		
ADDYI TAB	-	NC
MOVEMENT DISORDER DRUG THERAPY		
tetrabenazine tab (XENAZINE equiv)	LMSP-PA	2
AUSTEDO TAB	-	NC
INGREZZA CAP	-	NC
XENAZINE TAB	-	NC
MULTIPLE SCLEROSIS AGENTS		
AUBAGIO TAB	LMSP	2

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

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

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

**Texas Association of Counties HDHP Formulary
Category/Class**

Last Updated* 11/1/2018

DrugName	Special Code	Tier
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. Cont.		
AVONEX INJ	LMSP	2
dalfampridine ER tab (AMPYRA equiv) (QL= 2 tabs/day)	MSP-PA-QL	2
EXTAVIA INJ	LMSP	2
GILENYA CAP	LMSP	2
glatiramer inj (COPAXONE equiv)	LMSP	2
PLEGRIDY INJ	LMSP	2
PLEGRIDY PEN INJ	LMSP	2
REBIF INJ	LMSP	2
TECFIDERA CAP	LMSP	2
TECFIDERA STARTER PACK	LMSP	2
OCREVUS INJ	MSP-PA	3
BETASERON INJ	-	NC
ZINBRYTA INJ	-	NC
POSTHERPETIC NEURALGIA (PHN) AGENTS		
GRALISE TAB	-	NC
LYRICA CR TAB	-	NC
PREMENSTRUAL DYSPHORIC DISORDER (PMDD) AGENTS		
fluoxetine (pmdd) tab (SARAFEM equiv)	-	NC
FLUOXETINE CAP (PMDD)	-	NC
SARAFEM TAB	-	NC
PSEUDOBULBAR AFFECT (PBA) AGENTS		
NUEDEXTA CAP (QL= 2 caps/day)	PA-QL	2
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.		
pimozide tab (ORAP equiv)	-	2
ERGOLOID MESYLATES TAB	-	NC
ergoloid mesylates tab (HYDERGINE equiv)	-	NC
RESTLESS LEG SYNDROME (RLS) AGENTS		
HORIZANT TAB	-	NC
SMOKING DETERRENTS		
bupropion SR tab (ZYBAN equiv) (Limited to 180 days/plan year)	QL-SMKG	\$0
CHANTIX PAK (Limited to 180 days/plan year)	QL-SMKG	\$0
CHANTIX TAB (Limited to 180 days/plan year)	QL-SMKG	\$0
nicotine gum (NICORETTE equiv) (Limited to 180 days/plan year)	OTC-QL-SMKG	\$0
NICOTINE KIT	OTC-QL-SMKG	\$0
nicotine lozenge (COMMIT equiv) (Limited to 180 days/plan year)	OTC-QL-SMKG	\$0
nicotine patch (NICODERM equiv) (Limited to 180 days/plan year)	OTC-QL-SMKG	\$0
NICOTROL INHALER (Limited to 180 days/plan year)	QL-SMKG	\$0
NICOTROL NASAL SPRAY (Limited to 180 days/plan year)	QL-SMKG	\$0
TRANSTHYRETIN AMYLOIDOSIS AGENTS		
TEGSEDI INJ	-	NC
VASOMOTOR SYMPTOM AGENTS		
BRISDELLE CAP	-	NC
paroxetine cap (BRISDELLE equiv)	-	NC
RESPIRATORY AGENTS - MISC.		
CYSTIC FIBROSIS AGENTS		

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

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

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

**Texas Association of Counties HDHP Formulary
Category/Class**

Last Updated* 11/1/2018

DrugName	Special Code	Tier
RESPIRATORY AGENTS - MISC. Cont.		
KALYDECO PAK (QL= 2 packets/day)	MSP-PA-QL-SF	2
KALYDECO TAB (QL= 2 tabs/day)	MSP-PA-QL-SF	2
ORKAMBI GRANULES PACKET (QL= 2 packets/day)	MSP-PA-QL-SF	2
ORKAMBI TAB (QL= 4 tabs/day)	MSP-PA-QL-SF	2
PULMOZYME INH SOLN	LMSP	2
SYMDEKO TAB	-	NC
PULMONARY FIBROSIS AGENTS		
ESBRIET CAP (QL= 9 caps/day)	LMSP-PA-QL-SF	2
ESBRIET TAB 267MG (QL= 9 tabs/day)	LMSP-PA-QL-SF	2
ESBRIET TAB 801MG (QL= 3 tabs/day)	LMSP-PA-QL-SF	2
OFEV CAP (QL= 2 caps/day)	MSP-PA-QL-SF	2
SULFONAMIDES		
SULFONAMIDES		
SULFADIAZINE TAB	-	1
TETRACYCLINES		
TETRACYCLINES		
doxycycline hyclate cap (VIBRAMYCIN equiv)	-	1
doxycycline hyclate tab (VIBRATAB equiv)	-	1
doxycycline monohydrate cap 100mg (MONODOX equiv)	-	1
doxycycline monohydrate cap 50mg (MONODOX equiv)	-	1
doxycycline monohydrate tab (ADOXA equiv)	-	1
minocycline cap (MINOCIN equiv)	-	1
doxycycline susp (VIBRAMYCIN equiv)	-	2
minocycline tab (DYNACIN equiv)	-	2
demeclocycline tab (DECLOMYCIN equiv)	-	3
doxycycline hyclate DR tab (DORYX equiv)	-	3
doxycycline monohydrate cap 150mg (MONODOX equiv)	-	3
doxycycline monohydrate cap 75mg (MONODOX equiv)	-	3
ORAXYL CAP	-	3
tetracycline cap	-	3
VIBRAMYCIN SYRUP	-	3
ACTICLATE TAB 75MG, 150MG	-	NC
ADOXA PAK	-	NC
DORYX MPC TAB	-	NC
DORYX TAB 200MG	-	NC
doxycycline hyclate DR tab 200mg (DORYX equiv)	-	NC
doxycycline hyclate tab 75mg, 150mg	-	NC
doxycycline hyclate tab 75mg, 150mg (ACTICLATE equiv)	-	NC
doxycycline monohydrate tab 150mg (ADOXA equiv)	-	NC
minocycline ER tab (SOLODYN equiv)	-	NC
SOLODYN TAB	-	NC
TARGADOX TAB	-	NC
XIMINO CAP	-	NC
THYROID AGENTS		
ANTITHYROID AGENTS		

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

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

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

**Texas Association of Counties HDHP Formulary
Category/Class**

Last Updated* 11/1/2018

DrugName	Special Code	Tier
THYROID AGENTS Cont.		
methimazole tab (TAPAZOLE equiv)	-	1
propylthiouracil tab	-	1
THYROID HORMONES		
ARMOUR THYROID TAB, NATURE THROID TAB	-	1
levothyroxine tab (SYNTHROID equiv)	-	1
liothyronine tab (CYTOMEL equiv)	-	1
np thyroid tab (ARMOUR THYROID, NATURE THROID equiv)	-	1
THYROLAR TAB	-	2
SYNTHROID TAB	-	3
TIROSINT CAP	-	3
TOXOIDS		
TOXOID COMBINATIONS		
ADACEL/BOOSTRIX INJ	VAC	\$0
TETANUS/DIPHTHERIA TOXOID INJ	VAC	\$0
ULCER DRUGS		
ANTISPASMODICS		
dicyclomine cap (BENTYL equiv)	-	1
dicyclomine tab (BENTYL equiv)	-	1
hyoscyamine sulfate CR tab (LEVBID equiv)	-	1
hyoscyamine sulfate elixir (LEVSIN equiv)	-	1
hyoscyamine sulfate ODT (ANASPAZ equiv)	-	1
hyoscyamine sulfate SL tab (LEVSIN equiv)	-	1
hyoscyamine sulfate soln (LEVSIN equiv)	-	1
hyoscyamine sulfate SR cap (LEVSINEX equiv)	-	1
hyoscyamine tab (LEVSIN equiv)	-	1
BELLADONNA ALKALOID/OPIUM SUPP	-	2
chlordiazepoxide/clidinium cap (LIBRAX equiv)	-	2
dicyclomine soln (BENTYL equiv)	-	2
glycopyrrolate tab (ROBINUL equiv)	-	2
PROPANTHELINE TAB	-	2
CANTIL TAB	-	3
CUVPOSA SOLN	-	3
DONNATAL ELIXIR	-	3
methscopolamine tab (PAMINE equiv)	-	3
pb-belladonna elixir (DONNATAL equiv)	-	3
SYMAX DUOTAB	-	3
b-donna tab (DONNATAL equiv)	-	NC
DONNATAL EXTENTABS	-	NC
DONNATAL TAB	-	NC
H-2 ANTAGONISTS		
cimetidine tab (TAGAMET equiv)	-	1
famotidine tab (PEPCID equiv)	-	1
ranitidine cap (ZANTAC equiv)	-	1
ranitidine syrup (ZANTAC equiv)	-	1
ranitidine tab (Rx Only) (ZANTAC equiv)	-	1
famotidine susp (PEPCID equiv)	-	2
Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.		
INF Infertility MSP Mandatory Specialty Pharmacy Program QL Quantity Limit SMKG Smoking Cessation VAC Vaccine Program	LD Limited Distribution OTC Over-the-Counter RS Restricted to Specialist SP Available through Specialty Pharmacy Program ¢ RxCENTS	generic =small letters LMSP Lumicera Mandatory Specialty Pharmacy Program PA Prior Authorization SF Limited to two 15 day fills per month for first 3 months ST Step Therapy

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

**Texas Association of Counties HDHP Formulary
Category/Class**

Last Updated* 11/1/2018

DrugName	Special Code	Tier
ULCER DRUGS Cont.		
AXID CAP	-	NC
AXID SOLN	-	NC
CIMETIDINE SOLN	-	NC
nizatidine cap (AXID equiv)	-	NC
nizatidine soln (AXID equiv)	-	NC
PEPCID SUSP	-	NC
PEPCID TAB	-	NC
TAGAMET TAB	-	NC
ZANTAC CAP	-	NC
ZANTAC EFFER TAB	-	NC
ZANTAC SYRUP	-	NC
ZANTAC TAB	-	NC
MISC. ANTI-ULCER		
sucralfate tab (CARAFATE equiv)	-	1
CARAFATE SUSP	-	2
PROTON PUMP INHIBITORS		
lansoprazole cap (PREVACID equiv) (Rx Only)	-	1
omeprazole DR cap (PRILOSEC equiv)	-	1
pantoprazole EC tab (PROTONIX equiv)	-	1
FIRST OMEPRAZOLE SUSP	-	3
ACIPHEX SPRINKLE CAP	-	NC
DEXILANT CAP	-	NC
esomeprazole cap (NEXIUM equiv)	-	NC
ESOMEPRAZOLE STRONTIUM CAP	-	NC
lansoprazole odt (PREVACID SOLUTAB equiv)	-	NC
LANSOPRAZOLE SUSP	-	NC
NEXIUM 24HR TAB	-	NC
NEXIUM CAP	-	NC
NEXIUM GRANULE PACK	-	NC
OMEPRAZOLE TAB	OTC	NC
PREVACID OTC CAP	OTC	NC
PRILOSEC CAP	-	NC
PRILOSEC OTC DR TAB	-	NC
PROTONIX PAK	-	NC
rabeprazole EC tab (ACIPHEX equiv)	-	NC
ULCER DRUGS - PROSTAGLANDINS		
misoprostol tab (CYTOTEC equiv)	-	1
ULCER THERAPY COMBINATIONS		
lansoprazole/amoxicillin/clarithromycin kit (PREVPAC equiv)	-	3
PYLERA CAP	-	3
omeprazole/sodium bicarbonate cap (ZEGERID equiv)	-	NC
omeprazole/sodium bicarbonate powder pack (ZEGERID equiv)	-	NC
ZEGERID CAP	-	NC
ZEGERID CAP OTC	OTC	NC
ZEGERID POWDER PACK	-	NC

ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS

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

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

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

**Texas Association of Counties HDHP Formulary
Category/Class**

Last Updated* 11/1/2018

DrugName	Special Code	Tier
ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS Cont.		
ANTISPASMODICS		
GLYCATE TAB	-	NC
glycopyrrolate tab 1.5mg (GLYCATE equiv)	-	NC
URINARY ANTI-INFECTIVES		
URINARY ANTI-INFECTIVE COMBINATIONS		
UROQID #2 TAB	-	3
HYOPHEN TAB	-	NC
PROSED DS TAB	-	NC
UTA CAP	-	NC
URINARY ANTI-INFECTIVES		
methenamine mandelate tab	-	1
nitrofurantoin macrocrystals cap (MACRODANTIN equiv)	-	1
nitrofurantoin monohydrate cap (MACROBID equiv)	-	1
methenamine hippurate tab (HIPREX equiv)	-	2
nitrofurantoin susp (FURADANTIN equiv)	-	2
MONUROL GRANULE PACK	-	3
URINARY ANTISPASMODICS		
BETA-3 ADRENERGIC AGONISTS		
MYRBETRIQ TAB	-	2
URINARY ANTISPASMODIC - ANTIMUSCARINICS (ANTICHOLIN) (NEW)		
oxybutynin ER tab (DITROPAN XL equiv)	-	1
oxybutynin syrup	-	1
oxybutynin tab (DITROPAN equiv)	-	1
tolterodine tab (DETROL equiv)	¢	2
VESICARE TAB	¢	2
GELNIQUE	-	3
OXYTROL PATCH	PA	3
tropium chloride SR cap (SANCTURA XR equiv)	PA	3
tropium tab (SANCTURA equiv)	-	3
TOVIAZ TAB	-	NC
URINARY ANTISPASMODIC - ANTIMUSCARINICS (ANTICHOLINERGIC)		
tolterodine SR cap (DETROL LA equiv)	-	2
darifenacin SR tab (ENABLEX equiv)	-	NC
ENABLEX TAB	-	NC
URINARY ANTISPASMODICS		
hyoscyamine tab (LEVSIN equiv)	-	1
URINARY ANTISPASMODICS - CHOLINERGIC AGONISTS		
bethanechol tab (URECHOLINE equiv)	-	1
URINARY ANTISPASMODICS - DIRECT MUSCLE RELAXANTS (NEW)		
flavoxate tab (URISPAS equiv)	-	NC
VACCINES		
BACTERIAL VACCINES		
BEXSERO INJ	VAC	\$0
MENACTRA INJ	VAC	\$0

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

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

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

**Texas Association of Counties HDHP Formulary
Category/Class**

Last Updated* 11/1/2018

DrugName	Special Code	Tier
VACCINES Cont.		
MENHIBRIX INJ	VAC	\$0
MENOMUNE INJ	VAC	\$0
MENVEO INJ	VAC	\$0
PNEUMOVAX INJ	VAC	\$0
PREVNAR 13 INJ	VAC	\$0
TRUMENBA INJ	VAC	\$0
VIVOTIF CAP (QL= 4 caps/fill)	QL-VAC	\$0
VAXCHORA SUSP	-	NC
VIRAL VACCINES		
AFLURIA INJ	VAC	\$0
AFLURIA INJ, FLUZONE INJ	VAC	\$0
CERVARIX INJ	VAC	\$0
ENGERIX-B INJ	VAC	\$0
ENGERIX-B INJ, RECOMBIVAX-HB INJ	VAC	\$0
FLUAD INJ	VAC	\$0
FLUBLOK INJ	VAC	\$0
FLUBLOK QUAD PF INJ	VAC	\$0
FLUCELVAX INJ	VAC	\$0
FLUCELVAX QUAD INJ	VAC	\$0
FLULAVAL QUAD INJ, FLUZONE QUAD INJ	VAC	\$0
FLUVIRIN INJ	VAC	\$0
FLUVIRIN PF INJ	VAC	\$0
FLUZONE HIGH DOSE PF INJ	VAC	\$0
FLUZONE INTRADERMAL INJ	VAC	\$0
FLUZONE QUAD INJ	VAC	\$0
FLUZONE/FLUARIX QUAD INJ	VAC	\$0
GARDASIL 9 INJ	VAC	\$0
GARDASIL INJ	VAC	\$0
HAVRIX INJ, VAQTA INJ	VAC	\$0
HEPLISAV-B INJ	VAC	\$0
M-M-R II INJ	VAC	\$0
SHINGRIX INJ (Covered for members age 50 or older)	VAC	\$0
TWINRIX INJ	VAC	\$0
VARIVAX INJ	VAC	\$0
ZOSTAVAX INJ (Covered for members age 50 or older)	VAC	\$0
STAMARIL INJ	-	NC

VAGINAL PRODUCTS

MISCELLANEOUS VAGINAL PRODUCTS

ACIDIC VAGINAL JELLY	-	2
FEM PH GEL	-	3
INTRAROSA SUPP	-	NC

SPERMICIDES

CONTRACEPTIVE FILM	OTC	\$0
CONTRACEPTIVE FOAM	OTC	\$0
CONTRACEPTIVE GEL	OTC	\$0
CONTRACEPTIVE SUPP	OTC	\$0

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

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

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

**Texas Association of Counties HDHP Formulary
Category/Class**

Last Updated* 11/1/2018

DrugName	Special Code	Tier
VAGINAL PRODUCTS Cont.		
TODAY SPONGE	OTC	\$0
vcf vaginal gel (CONCEPTROL equiv)	OTC	\$0
VAGINAL ANTI-INFECTIVES		
clindamycin vaginal cream (CLEOCIN equiv)	-	1
metronidazole vaginal gel (METROGEL equiv)	-	1
NYSTATIN VAGINAL TAB	-	1
terconazole cream (TERAZOL equiv)	-	1
TERCONAZOLE CREAM 8%	-	1
terconazole supp (TERAZOL equiv)	-	1
AVC VAGINAL CREAM	-	2
CLEOCIN VAGINAL SUPP	-	3
CLINDESSE VAGINAL CREAM	-	3
VAGINAL ESTROGENS		
estradiol cream (ESTRACE equiv)	-	1
ESTRING (3 copays per Rx)	-	2
PREMARIN VAGINAL CREAM	-	2
FEMRING (3 copays per Rx)	-	3
estradiol vaginal tab, yuvafem vaginal tab (VAGIFEM equiv)	-	NC
IMVEXXY SUPP	-	NC
VAGIFEM TAB	-	NC
VAGINAL PROGESTINS		
CRINONE GEL	PA	2
ENDOMETRIN INSERT	PA	2
PROGESTERONE SUPP	PA	3
VASOPRESSORS		
ANAPHYLAXIS THERAPY AGENTS		
EPINEPHRINE PEN INJ 0.15MG (MYLAN) (QL= 2 inj/fill)	QL	2
EPINEPHRINE PEN INJ 0.3MG (MYLAN) (QL= 2 inj/fill)	QL	2
ADRENALCLICK INJ, EPINEPHRINE INJ	-	NC
AUVI-Q INJ, EPIPEN (JR) INJ	-	NC
NEUROGENIC ORTHOSTATIC HYPOTENSION (NOH) - AGENTS		
NORTHERA CAP	-	NC
VASOPRESSORS		
midodrine tab (PROAMATINE equiv)	-	1
VITAMINS		
OIL SOLUBLE VITAMINS		
vitamin D cap 1000unit (Covered for members 65 years or older)	OTC	\$0
vitamin D cap 400unit (Covered for members 65 years or older)	OTC	\$0
VITAMIN D TAB 400UNIT (Covered for members 65 years or older)	OTC	\$0
vitamin D cap (RX strength only)	-	1
phytonadione tab (MEPHYTON equiv)	-	2
ERGOCAL CAP	-	NC
WATER SOLUBLE VITAMINS		
POTABA POWDER PACKET	-	2
POTABA TAB	-	2

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

INF Infertility	LD generic =small letters Limited Distribution	LMSP BRANDS =CAPITAL LETTERS Lumicera Mandatory Specialty Pharmacy Program
MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter	PA Prior Authorization
QL Quantity Limit	RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months
SMKG Smoking Cessation	SP Available through Specialty Pharmacy Program	ST Step Therapy
VAC Vaccine Program	¢ RxCENTS	

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

**Texas Association of Counties HDHP Formulary
Category/Class**

Last Updated* 11/1/2018

DrugName	Special Code	Tier
VITAMINS Cont.		
niacin cap	OTC	NC
niacin CR tab (SLO-NIACIN equiv)	OTC	NC
niacin tab	OTC	NC
NIACIN TR TAB	OTC	NC
niacinamide tab	OTC	NC
SLO-NIACIN TAB	OTC	NC

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

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

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

Texas Association of Counties HDHP Formulary
Prior Authorization Drug List
Last Updated* 11/1/2018

Some products on the Formulary are only covered with a prior authorization approval. Drug products requiring prior authorization are listed below. The pharmacy will also alert members if the medication prescribed requires prior authorization. Please call Customer Service if you have further questions regarding prior authorizations.

Drug Name	Tier # for Drug Copay (if prior auth is approved)
ABILIFY DISCMELT	3
ABILIFY SOLN	3
ABSTRAL SL TAB	3
ACTEMRA SC INJ	2
ACTHAR HP GEL INJ	3
ACTIMMUNE INJ	2
adapalene cream	2
adapalene gel	2
ADAPALENE LOTION	2
adapalene/benzoyl peroxide gel 0.1-2.5%	2
ADEMPAS TAB	2
ADVATE INJ	3
ADYNOVATE INJ	3
AFINITOR DISPERZ	2
AFINITOR TAB	2
AFSTYLA KIT	3
ALECENSA CAP	2
ALINIA SUSP	2
ALINIA TAB	2
ALPHANATE/HEMOFIL/KOATE INJ	3
ALPHANINE SD/MONONINE INJ	3
ALPROLIX INJ	3
ALUNBRIG TAB 30MG	2
ALUNBRIG TAB 90MG, 180MG	2
aripiprazole ODT	3
aripiprazole soln	3
armodafinil tab	2
AZELEX CREAM	3
BEBULIN/PROFILNINE INJ	3
BENEFIX INJ	3
BENEFIX/RIXUBIS INJ	3
BENLYSTA AUTO-INJECTOR	2
BENLYSTA INJ	2
BENZNIDAZOLE TAB	2
bexarotene cap	2
BIVIGAM INJ	3
BOSULIF TAB	2
BOTOX INJ	3
budesonide ER tab	3
CABOMETYX TAB	2
CALQUENCE CAP	2
CAPRELSA TAB	2

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

Texas Association of Counties HDHP Formulary cont.
Prior Authorization Drug List
Last Updated* 11/1/2018

Some products on the Formulary are only covered with a prior authorization approval. Drug products requiring prior authorization are listed below. The pharmacy will also alert members if the medication prescribed requires prior authorization. Please call Customer Service if you have further questions regarding prior authorizations.

Drug Name	Tier # for Drug Copay (if prior auth is approved)
CHOLBAM CAP	2
CIMZIA INJ	2
CIMZIA STARTER INJ KIT	2
clobazam tab	1
clobetasol foam	3
clobetasol lotion	3
clobetasol propionate cream	2
clobetasol propionate emollient cream	2
clobetasol propionate gel	2
clobetasol propionate oint	2
clobetasol propionate soln	3
clobetasol shampoo	3
clobetasol spray	3
COAGADEX INJ	3
COMETRIQ KIT	2
CORIFACT INJ	3
CORLANOR TAB	3
COSENTYX INJ (1-PACK)	2
COSENTYX INJ (2-PACK)	2
COTELLIC TAB	2
CRINONE GEL	2
CYSTAGON CAP	2
CYSTARAN OPHTH SOLN	2
CYTOGAM INJ	3
dalfampridine ER tab	2
DARAPRIM TAB	2
DESCOVY TAB	2
DEXCOM G6 RECEIVER	3
DEXCOM G6 SENSOR	3
DEXCOM G6 TRANSMITTER	3
diclofenac gel	3
dronabinol cap	2
DUPIXENT INJ	2
DYSPORT INJ	3
ELOCTATE INJ	3
ENBREL INJ 25MG	2
ENBREL INJ 50MG	2
ENBREL MINI INJ	2
ENBREL SURECLICK INJ 50MG	2
ENDOMETRIN INSERT	2
ENTRESTO TAB	2
EPANED PREMIXED SOLN	3

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

Texas Association of Counties HDHP Formulary cont.
Prior Authorization Drug List
Last Updated* 11/1/2018

Some products on the Formulary are only covered with a prior authorization approval. Drug products requiring prior authorization are listed below. The pharmacy will also alert members if the medication prescribed requires prior authorization. Please call Customer Service if you have further questions regarding prior authorizations.

Drug Name	Tier # for Drug Copay (if prior auth is approved)
EPANED SOLN	3
EPCLUSA TAB	2
EPIDUO FORTE GEL	2
EPIDUO GEL 0.1-2.5%	3
ERIVEDGE CAP	2
ESBRIET CAP	2
ESBRIET TAB 267MG	2
ESBRIET TAB 801MG	2
FANAPT TAB	3
FANAPT TITRATION PACK	3
FARYDAK CAP	2
FEIBA INJ	3
fentanyl citrate lollipop	2
FENTORA TAB	3
FERRIPROX SOLN	2
FERRIPROX TAB	2
fondaparinux inj	2
FORTEO INJ	2
FREESTYLE LIBRE RECEIVER	3
FREESTYLE LIBRE SENSOR (10-DAY)	3
FREESTYLE LIBRE SENSOR (14-DAY)	3
GAMASTAN INJ, GAMASTAN S/D INJ	3
GAMMAGARD SD INJ, CARIMUNE NF INJ	3
GAMUNEX-C INJ, GAMMAGARD INJ, GAMMAKED INJ	3
GENOTROPIN INJ	2
GILOTRIF TAB	2
HARVONI TAB	2
HELIXATE/KOGENATE INJ	3
HEMLIBRA INJ	3
HIZENTRA INJ, CUVITRU INJ	3
HUMATE-P/WILATE INJ	3
HUMIRA INJ 10MG	2
HUMIRA INJ 20MG	2
HUMIRA INJ 40MG	2
HUMIRA INJ CROHNS/UC/HIDRADENITIS STARTER PACK	2
HUMIRA INJ PEDIATRIC CROHNS STARTER PACK	2
HUMIRA INJ PSORIASIS/UVEITIS STARTER PACK	2
HUMIRA PEN INJ 40MG	2
HYCAMTIN CAP	2
HYQVIA INJ	3
IBRANCE CAP	2
ICLUSIG TAB	2

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

Texas Association of Counties HDHP Formulary cont.
Prior Authorization Drug List
Last Updated* 11/1/2018

Some products on the Formulary are only covered with a prior authorization approval. Drug products requiring prior authorization are listed below. The pharmacy will also alert members if the medication prescribed requires prior authorization. Please call Customer Service if you have further questions regarding prior authorizations.

Drug Name	Tier # for Drug Copay (if prior auth is approved)
IDELVION SOLN	3
IDHIFA TAB	2
imatinib tab	2
IMBRUVICA CAP 140MG	2
IMBRUVICA CAP 70MG	2
IMBRUVICA TAB	2
INLYTA TAB	2
IRESSA TAB	2
itraconazole cap	2
itraconazole soln	3
JAKAFI TAB	2
JYNARQUE PAK	2
KALYDECO PAK	2
KALYDECO TAB	2
KEVZARA INJ	2
KINERET INJ	2
KISQALI PAK	2
KISQALI TAB	2
KORLYM TAB	2
KUVAN POWDER PACK	2
KUVAN TAB	2
LAZANDA NASAL SPRAY	3
LENVIMA CAP	2
LETAIRIS TAB	2
LEUKINE INJ	2
LINZESS CAP	2
LONSURF TAB	2
LYNPARZA CAP	2
LYNPARZA TAB	2
MAVYRET TAB	2
MEKINIST TAB	2
miglustat cap	2
modafinil tab	2
MONOCLATE-P INJ	3
MOVANTIK TAB	2
MYOBLOC INJ	3
NATPARA INJ	2
NERLYNX TAB	2
NEXAVAR TAB	2
NINLARO CAP	2
NOVOSEVEN RT INJ	3
NUDEXTA CAP	2

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

Texas Association of Counties HDHP Formulary cont.
Prior Authorization Drug List
Last Updated* 11/1/2018

Some products on the Formulary are only covered with a prior authorization approval. Drug products requiring prior authorization are listed below. The pharmacy will also alert members if the medication prescribed requires prior authorization. Please call Customer Service if you have further questions regarding prior authorizations.

Drug Name	Tier # for Drug Copay (if prior auth is approved)
OCALIVA TAB	2
OCREVUS INJ	3
OCTAGAM INJ, FLEBOGAMMA INJ, GAMMAPLEX INJ, PRIVIGEN INJ	3
ODACTRA SL TAB	3
ODOMZO CAP	2
OFEV CAP	2
OPSUMIT TAB	2
ORENCIA CLICK INJ	2
ORENCIA SC INJ 125MG/ML	2
ORENCIA SC INJ 50MG/0.4ML	2
ORENCIA SC INJ 87.5MG/0.7ML	2
ORKAMBI GRANULES PACKET	2
ORKAMBI TAB	2
OTEZLA STARTER PACK	2
OTEZLA TAB	2
OXYTROL PATCH	3
paliperidone ER tab	2
PEGASYS INJ	2
PEGASYS INJ KIT	2
PRALUENT INJ	2
PROGESTERONE SUPP	3
PROMACTA TAB	2
QBRELIS SOLN	3
REBINYN SOLN	3
RECOMBINATE INJ	3
REPATHA INJ	2
REPATHA PUSHTRONEX INJ	2
RESTASIS OPHTH EMULSION	2
RETIN-A MICRO GEL 0.04%, 0.1%	3
REVLIMID CAP	2
RUBRACA TAB	2
RYDAPT CAP	2
SABRIL TAB	2
SAPHRIS SL TAB	3
SIGNIFOR INJ	2
sildenafil tab 20mg	1
SKLICE LOTION	3
SOLOSEC GRANULES PACKET	3
SOMAVERT INJ	2
SPORANOX SOLN	3
SPRYCEL TAB	2

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

Texas Association of Counties HDHP Formulary cont.
Prior Authorization Drug List
Last Updated* 11/1/2018

Some products on the Formulary are only covered with a prior authorization approval. Drug products requiring prior authorization are listed below. The pharmacy will also alert members if the medication prescribed requires prior authorization. Please call Customer Service if you have further questions regarding prior authorizations.

Drug Name	Tier # for Drug Copay (if prior auth is approved)
STIVARGA TAB	2
STRENSIQ INJ	2
SUTENT CAP	2
SYLATRON INJ	3
SYMPROIC TAB	2
SYNAGIS INJ	3
tadalafil tab (PAH)	2
TAFINLAR CAP	2
TAGRISSO TAB	2
TARCEVA TAB	2
TASIGNA CAP	2
testosterone gel 1% 25mg	1
testosterone gel 1% 50mg	1
testosterone gel 1% pump	1
tetrabenazine tab	2
THALOMID CAP	2
THROMBAT III INJ	3
TRACLEER TAB 32MG	2
TRACLEER TAB 62.5MG, 125MG	2
tretinoin cream	2
tretinoin gel	2
TRETTEN INJ	3
trientine cap	2
tropium chloride SR cap	3
TRUVADA TAB	2
TYKERB TAB	2
TYMLOS INJ	2
TYVASO INH SOLN	2
UCERIS RECTAL FOAM	3
UPTRAVI TAB	2
VALCHLOR GEL	2
VELTASSA POWDER	2
VENCLEXTA STARTER PACK	2
VENCLEXTA TAB	2
VENTAVIS INH SOLN	2
VERZENIO TAB	2
vigabatrin powder pack	2
VONVEDI INJ	3
VOSEVI TAB	2
VOTRIENT TAB	2
XADAGO TAB	3
XALKORI CAP	2

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

Texas Association of Counties HDHP Formulary cont.
Prior Authorization Drug List
Last Updated* 11/1/2018

Some products on the Formulary are only covered with a prior authorization approval. Drug products requiring prior authorization are listed below. The pharmacy will also alert members if the medication prescribed requires prior authorization. Please call Customer Service if you have further questions regarding prior authorizations.

Drug Name	Tier # for Drug Copay (if prior auth is approved)
XEOMIN INJ	3
XIFAXAN TAB 550MG	3
XTANDI CAP	2
XULTOPHY INJ	2
XYNTHA INJ	3
XYREM SOLN	3
ZEJULA CAP	2
ZELBORAF TAB	2
ZOLINZA CAP	2
ZORTRESS TAB	2
ZYDELIG TAB	2
ZYKADIA CAP	2
ZYTIGA TAB 250MG	2
ZYTIGA TAB 500MG	2

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

Texas Association of Counties HDHP Formulary
Last Updated* 11/1/2018
RxCents (Cost Savings Enabled by Tablet Splitting)

Tablet splitting helps control prescription drug benefit costs and can provide significant savings for members. Participation in the program is voluntary. Through this program, members pay up to one-half of their usual copayment on a select group of prescription drugs. Drugs included in this program are based on the following criteria:

- The drug product is on the formulary.
- The drug product is recognized as an appropriate product to split by the Pharmacy & Therapeutics Committee.
- The drug is flat priced (i.e. various strengths of the medication must be comparably priced).
- The medication must have once-daily dosing.

An example of the savings that can be realized through this program is illustrated below:

	Product & Strength	Quantity	Member Copay	Member Annual Savings
Without Tablet Splitting	Drug A 40 mg tab	30	\$15.00	
With Tablet Splitting	Drug A 80 mg tab	15	\$7.50	\$90

As the example illustrates, tablet splitting allows members to receive the same dose in a fewer number of tablets; thus, the overall

RxCents Program Medications

BYSTOLIC TAB	eplerenone tab	galantamine tab	JANUVIA TAB
OCALIVA TAB	rasagiline tab	TEKTURNA TAB	tolterodine tab
ULORIC TAB	VESICARE TAB		

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

Texas Association of Counties HDHP Formulary
Last Updated* 11/1/2018
Over-the-Counter (OTC)

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

Over-the-Counter (OTC) Medications

ACCU-CHECK GUIDE CARE METER	ACCU-CHEK AVIVA PLUS METER	ACCU-CHEK AVIVA PLUS TEST STRIP	ACCU-CHEK GUIDE TEST STRIP
ACCU-CHEK NANO METER	ACCU-CHEK SMARTVIEW TEST STRIP	ACCU-CHEK TEST STRIP	AEROCHAMBER
ALCOHOL SWABS	ASPIRIN CHEW TAB 75MG	aspirin chew tab 81mg	aspirin ec tab 325mg
aspirin ec tab 81mg	aspirin tab 325mg	aspirin tab 81mg	B-D INSULIN SYRINGE
B-D PEN NEEDLE	CALIBRATION LIQUID	cetirizine cap	cetirizine syrup
cetirizine tab	cetirizine/pseudoephedrine 12-hour tab	CLINISTIX TEST STRIP	CONTRACEPTIVE FILM
CONTRACEPTIVE FOAM	CONTRACEPTIVE GEL	CONTRACEPTIVE SUPP	FEMALE CONDOMS
ferrous sulfate elixir	FERROUS SULFATE LIQUIII	ferrous sulfate soln	FERROUS SULFATE SYRUP
fexofenadine susp	fexofenadine tab	fexofenadine/pseudoephedrine 24-hour tab	folic acid tab 400mcg
folic acid tab 800mcg	FREESTYLE FREEDOM LITE METER	FREESTYLE INSULINX METER	FREESTYLE INSULINX TEST STRIP
FREESTYLE LITE METER	FREESTYLE LITE TEST STRIP	FREESTYLE PRECISION NEO METER	FREESTYLE PRECISION NEO TEST STRIP
FREESTYLE TEST STRIP	guaifenesin/codeine syrup	IRON SUSP	KETO-DIASTIX TEST STRIP
KETOSTIX	LANCET KIT	LANCETS	levonorgestrel tab
loratadine cap	loratadine syrup	loratadine tab	loratadine/pseudoephedrine 12-hour tab
nicotine gum	NICOTINE KIT	nicotine lozenge	nicotine patch
NOVOFINE PEN NEEDLE	NOVOLIN INJ	NOVOTWIST PEN NEEDLE	NOVOTWIST/NOVOFINE PEN NEEDLE
PEAK FLOW METER	PLAN B TAB	PRECISION XTRA METER	PRECISION XTRA TEST STRIP
TODAY SPONGE	vcf vaginal gel	vitamin D cap 1000unit	vitamin D cap 400unit
VITAMIN D TAB 400UNIT			

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

Texas Association of Counties HDHP Formulary
Last Updated* 11/1/2018
Mandatory Specialty Pharmacy (MSP)

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

Mandatory Specialty Pharmacy (MSP) Medications

ACTEMRA SC INJ	ACTHAR HP GEL INJ	ACTIMMUNE INJ	adefovir dipivoxil tab
ADEMPAS TAB	ADVATE INJ	ADYNOVATE INJ	AFINITOR DISPERZ
AFINITOR TAB	AFSTYLA KIT	ALECENSA CAP	ALFERON-N INJ
ALPHANATE/HEMOPIL/KOFA TE INJ	ALPHANINE SD/MONONINE INJ	ALPROLIX INJ	ALUNBRIG TAB 30MG
ALUNBRIG TAB 90MG, 180MG	APOKYN INJ	AUBAGIO TAB	AVONEX INJ
BEBULIN/PROFILNINE INJ	BENEFIX INJ	BENEFIX/RIXUBIS INJ	BENLYSTA AUTO-INJECTOR
BENLYSTA INJ	bexarotene cap	BIVIGAM INJ	BOSULIF TAB
BOTOX INJ	CABOMETYX TAB	calcitriol inj	CALQUENCE CAP
capecitabine tab	CAPRELSA TAB	CAYSTON INH SOLN	CHOLBAM CAP
CIMZIA INJ	CIMZIA STARTER INJ KIT	COAGADEX INJ	COMETRIQ KIT
CORIFACT INJ	COSENTYX INJ (1-PACK)	COSENTYX INJ (2-PACK)	COTELLIC TAB
CYTAGON CAP	CYSTARAN OPHTH SOLN	CYTOGAM INJ	dalfampridine ER tab
DARAPRIM TAB	DUPIXENT INJ	DYSPORT INJ	ELOCTATE INJ
ENBREL INJ 25MG	ENBREL INJ 50MG	ENBREL MINI INJ	ENBREL SURECLICK INJ 50MG
EPCLUSA TAB	ERIVEDGE CAP	ESBRIET CAP	ESBRIET TAB 267MG
ESBRIET TAB 801MG	etoposide cap	EXJADE TAB	EXTAVIA INJ
FARYDAK CAP	FEIBA INJ	FERRIPROX SOLN	FERRIPROX TAB
FORTEO INJ	FULPHILA INJ	FUZEON INJ	GAMASTAN INJ, GAMASTAN S/D INJ
GAMMAGARD SD INJ, CARIMUNE NF INJ	GAMUNEX-C INJ, GAMMAGARD INJ, GAMMAKED INJ	GENOTROPIN INJ	GILENYA CAP
GILOTRIF TAB	glatiramer inj	GRANIX INJ	HARVONI TAB
HELIXATE/KOGENATE INJ	HEMLIBRA INJ	HIZENTRA INJ, CUVITRU IN	HUMATE-P/WILATE INJ
HYCAMTIN CAP	HYQVIA INJ	IBRANCE CAP	ICLUSIG TAB
IDELVION SOLN	IDHIFA TAB	imatinib tab	IMBRUVICA CAP 140MG
IMBRUVICA CAP 70MG	IMBRUVICA TAB	INCRELEX INJ	INFERGEN INJ
INLYTA TAB	INTRON-A INJ	IRESSA TAB	JADENU SPRINKLE
JADENU TAB	JAKAFI TAB	JYNARQUE PAK	KALYDECO PAK
KALYDECO TAB	KEVZARA INJ	KINERET INJ	KISQALI PAK
KISQALI TAB	KORLYM TAB	KUVAN POWDER PACK	KUVAN TAB
LENVIMA CAP	LETAIRIS TAB	LEUKINE INJ	LONSURF TAB
LYNPARZA CAP	LYNPARZA TAB	LYSODREN TAB	MAVYRET TAB
MEKINIST TAB	MESNEX TAB	MIACALCIN INJ	miglustat cap

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

MONOCLATE-P INJ NERLYNX TAB NINLARO CAP OCTAGAM INJ, FLEBOGAMMA INJ, GAMMAPLEX INJ, PRIVIGEN INJ OPSUMIT TAB	MYLERAN TAB NEUMEGA INJ NOVOSEVEN RT INJ octreotide inj	MYOBLOC INJ NEXAVAR TAB OCALIVA TAB ODOMZO CAP	NATPARA INJ nilutamide tab OCREVUS INJ OFEV CAP
ORENCIA SC INJ 87.5MG/0.7ML OTEZLA TAB PLEGRIDY INJ PULMOZYME INH SOLN RECOMBINATE INJ	ORENCIA CLICK INJ ORKAMBI GRANULES PACKET PEGASYS INJ PLEGRIDY PEN INJ REBETOL SOLN REPATHA INJ	ORENCIA SC INJ 125MG/ML ORKAMBI TAB PEGASYS INJ KIT PRALUENT INJ REBIF INJ REPATHA PUSHTRONEX INJ ribavirin tab SANDOSTATIN INJ STIVARGA TAB SYNAGIS INJ TARCEVA TAB TECFIDERA STARTER PACK THROMBAT III INJ TRACLEER TAB 62.5MG, 125MG TYKERB TAB VALCHLOR GEL	ORENCIA SC INJ 50MG/0.4ML OTEZLA STARTER PACK PEG-INTRON INJ PROMACTA TAB REBINYN SOLN REVLIMID CAP RUBRACA TAB SIGNIFOR INJ STRENSIQ INJ tadalafil tab (PAH) TARGRETIN GEL temozolomide cap TOBI PODHALER tretinoin cap TYMLOS INJ VENCLEXTA STARTER PACK vigabatrin powder pack XALKORI CAP XYREM SOLN ZOLINZA CAP ZYTIGA TAB 500MG
RIBATAB RYDAPT CAP SOMAVERT INJ SUTENT CAP TAFINLAR CAP TASIGNA CAP	ribavirin cap SABRIL TAB SPRYCEL TAB SYLATRON INJ TAGRISSO TAB TECFIDERA CAP	ribavirin tab SANDOSTATIN INJ STIVARGA TAB SYNAGIS INJ TARCEVA TAB TECFIDERA STARTER PACK THROMBAT III INJ TRACLEER TAB 62.5MG, 125MG TYKERB TAB VALCHLOR GEL	RUBRACA TAB SIGNIFOR INJ STRENSIQ INJ tadalafil tab (PAH) TARGRETIN GEL temozolomide cap TOBI PODHALER tretinoin cap TYMLOS INJ VENCLEXTA STARTER PACK vigabatrin powder pack XALKORI CAP XYREM SOLN ZOLINZA CAP ZYTIGA TAB 500MG
tetrabenazine tab tobramycin neb soln	THALOMID CAP TRACLEER TAB 32MG	THROMBAT III INJ TRACLEER TAB 62.5MG, 125MG TYKERB TAB VALCHLOR GEL	TOBI PODHALER tretinoin cap
TRETTEN INJ TYVASO INH SOLN	trientine cap UPTRAVI TAB	TYKERB TAB VALCHLOR GEL	TYMLOS INJ VENCLEXTA STARTER PACK
VENCLEXTA TAB VONVEDI INJ XEOMIN INJ ZARXIO INJ ZYDELIG TAB	VENTAVIS INH SOLN VOSEVI TAB XTANDI CAP ZEJULA CAP ZYKADIA CAP	VERZENIO TAB VOTRIENT TAB XYNTHA INJ ZELBORAF TAB ZYTIGA TAB 250MG	vigabatrin powder pack XALKORI CAP XYREM SOLN ZOLINZA CAP ZYTIGA TAB 500MG

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

Texas Association of Counties HDHP Formulary
Last Updated* 11/1/2018
Step Therapy (ST)

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

Step Therapy (ST) Medications

Drug Name	Step Therapy Requirements
AMOXAPINE TAB	Step therapy requires trial of two formulary covered generic antidepressants in the previous 180 days
budesonide SR cap	Step Therapy requires trial of APRISO, LIALDA, or sulfasalazine
DIFICID TAB	QL= 20 tabs/fill; Step Therapy requires trial of vancomycin cap, vancomycin soln, or FIRVANQ SOLN
donepezil tab 23mg	QL= 1 tab/day; Step Therapy requires trial of donepezil 10mg
EMSAM PATCH	Step therapy requires trial of two formulary covered generic antidepressants in the previous 180 days
fluvoxamine ER cap	Step Therapy requires trial of citalopram, escitalopram, sertraline, fluoxetine, fluvoxamine or paroxetine
LATUDA TAB	QL= 1 tab/day; Step Therapy requires trial of quetiapine
LIVALO TAB	Step Therapy requires trial of atorvastatin, fluvastatin, lovastatin, pravastatin, rosuvastatin, or simvastatin
LONHALA MAGNAIR SOLN	Step Therapy requires trial of INCRUSE ELLIPTA INHALER
MAPROTILINE TAB	Step therapy requires trial of two formulary covered generic antidepressants in the previous 180 days
MARPLAN TAB	Step therapy requires trial of two formulary covered generic antidepressants in the previous 180 days
NAMZARIC CAP	Step Therapy requires trial of donepezil and memantine
NAMZARIC STARTER PACK	Step Therapy requires trial of donepezil and memantine
NEFAZODONE TAB	Step therapy requires trial of two formulary covered generic antidepressants in the previous 180 days
nevirapine ER tab	Step Therapy requires trial of nevirapine
PAXIL SUSP	Step therapy requires trial of two formulary covered generic antidepressants in the previous 180 days
risedronate DR tab	Step Therapy requires trial of alendronate
SPIRIVA RESPIMAT INHALER 1.25MCG/ACT	QL= 1 inhaler/30 days; Step Therapy requires trial of ADVAIR, BREO, DULERA, or FLUTICASONE/SALMETEROL
ULORIC TAB	Step Therapy requires trial of allopurinol
vancomycin cap	QL= 56 caps/fill; Step Therapy requires trial of vancomycin soln or FIRVANQ SOLN

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

Texas Association of Counties HDHP Formulary
Smoking Cessation Agents
Last Updated* 11/1/2018

Drug Name	Tier # for Drug Copay
bupropion SR tab(Limited to 180 days/plan year)	\$0
CHANTIX PAK(Limited to 180 days/plan year)	\$0
CHANTIX TAB(Limited to 180 days/plan year)	\$0
nicotine gum(Limited to 180 days/plan year)	\$0
NICOTINE KIT	\$0
nicotine lozenge(Limited to 180 days/plan year)	\$0
nicotine patch(Limited to 180 days/plan year)	\$0
NICOTROL INHALER(Limited to 180 days/plan year)	\$0
NICOTROL NASAL SPRAY(Limited to 180 days/plan year)	\$0

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

Texas Association of Counties HDHP Formulary
Last Updated* 11/1/2018
Quantity Limit (QL)

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

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
ABILIFY DISCMELT	QL= 2 tabs/day
ABSTRAL SL TAB	QL= 120 tabs/30 days
ACTEMRA SC INJ	QL= 2 inj/28 days
ADEMPAS TAB	QL= 3 tabs/day; Only available through Accredo 888-773-7376
AFINITOR DISPERZ	QL= 1 tab/day
AFINITOR TAB	QL= 1 tab/day
AKYNZEO CAP	QL= 1 cap/fill; Restricted to Oncology or Hematology Specialist
ALECENSA CAP	QL= 8 caps/day
ALINIA SUSP	QL= 60ml/3 days
ALINIA TAB	QL= 6 tabs/3 days
ALUNBRIG TAB 30MG	QL= 4 tabs/day; Only available through Biologics 800-850-4306
ALUNBRIG TAB 90MG, 180MG	QL= 1 tab/day; Only available through Biologics 800-850-4306
ANZEMET TAB	QL= 9 tabs/fill
aprepitant cap	QL= 3 caps/fill; Restricted to Oncology or Hematology Specialist
aprepitant pak	QL= 3 caps/fill; Restricted to Oncology or Hematology Specialist
aripiprazole ODT	QL= 2 tabs/day
armodafinil tab	QL= 1 tab/day
BAXDELA TAB	QL= 2 tabs/day; Restricted to Infectious Disease Specialist
BENLYSTA AUTO-INJECTOR	QL= 4 inj/28 day
BENLYSTA INJ	QL= 4 inj/28 day
bimatoprost ophth soln	QL= 2.5ml/30 days
budesonide ER tab	QL=1 tab/day
BUPRENORPHINE PATCH, BUTRANS PATCH	QL= 4 patches/28 days
bupropion SR tab	Limited to 180 days/plan year
butorphanol nasal spray	QL= 1 bottle/fill, 2 fills/30 days
BYDUREON BCISE AUTO INJ	QL= 4 inj/28 days
BYDUREON INJ	QL= 4 inj/28 days
BYDUREON PEN INJ	QL= 4 inj/28 days
BYETTA INJ	QL= 1 pen/30 days
CABOMETYX TAB	QL= 1 tab/day
CALQUENCE CAP	QL= 2 caps/day; Only available through Diplomat Pharmacy 877-977-9118
celecoxib cap	QL= 2 caps/day
CHANTIX PAK	Limited to 180 days/plan year
CHANTIX TAB	Limited to 180 days/plan year
CIMZIA INJ	QL= 2 inj/28 days
CIMZIA STARTER INJ KIT	QL= 1 kit/plan year
COSENTYX INJ (1-PACK)	QL= 1 inj/28 days
COSENTYX INJ (2-PACK)	QL= 2 inj/28 days
COTELLIC TAB	QL= 3 tabs/day
CYSTARAN OPHTH SOLN	QL= 4 bottles/30 days; Only available through Walgreens 888-347-3416
dalfampridine ER tab	QL= 2 tabs/day
DARAPRIM TAB	QL= 3 tabs/day; Only available through Walgreens 888-347-3416

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

Texas Association of Counties HDHP Formulary Cont.
Last Updated* 11/1/2018
Quantity Limit (QL)

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

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
DEPO-PROVERA SC INJ 104MG	QL= 1 inj/90 days
DEXCOM G6 RECEIVER	QL= 1 receiver/year
DEXCOM G6 SENSOR	QL= 3 sensors/28 days
DEXCOM G6 TRANSMITTER	QL= 1 transmitter/90 days
diclofenac gel	QL= 300gm/30 days
diclofenac gel 1%	QL= 5 tubes/fill
DIFICID TAB	QL= 20 tabs/fill; Step Therapy requires trial of vancomycin cap, vancomycin soln, or FIRVANQ SOLN
DIHYDROERGOTAMINE SPRAY, MIGRANAL SPRAY	QL= 8 sprays/fill, 2 fills/30 days
donepezil ODT	QL= 1 tab/day
donepezil tab	QL= 2 tabs/day
donepezil tab 23mg	QL= 1 tab/day; Step Therapy requires trial of donepezil 10mg
DUPIXENT INJ	QL= 2 inj/ 28 days
ENBREL INJ 25MG	QL= 8 inj/28 days
ENBREL INJ 50MG	QL= 4 inj/28 days
ENBREL MINI INJ	QL= 4 inj/28 days
ENBREL SURECLICK INJ 50MG	QL= 4 inj/28 days
enoxaparin inj	QL= 17 days supply
entecavir tab	QL= 1 tab/day
ENTRESTO TAB	QL= 2 tabs/day
EPCLUSA TAB	QL= 1 tab/day
EPINEPHRINE PEN INJ 0.15MG (MYLAN)	QL= 2 inj/fill
EPINEPHRINE PEN INJ 0.3MG (MYLAN)	QL= 2 inj/fill
ESBRIET CAP	QL= 9 caps/day
ESBRIET TAB 267MG	QL= 9 tabs/day
ESBRIET TAB 801MG	QL= 3 tabs/day
eszopiclone tab	QL= 1 tab/day
ezetimibe/simvastatin tab	QL= 1 tab/day (10-80mg is Not Covered)
FANAPT TAB	QL= 2 tabs/day
FANAPT TITRATION PACK	QL= 1 pack/plan year
FARXIGA TAB	QL= 1 tab/day
FARYDAK CAP	QL= 6 caps/21 days
fentanyl citrate lollipop	QL= 120 lozenges/30 days
FENTORA TAB	QL= 120 tabs/30 days
FLECTOR PATCH	QL= 30 patches/fill
FLUNISOLIDE NASAL SPRAY	QL= 2 bottles/fill
fluticasone nasal spray	QL= 2 bottles/fill
FREESTYLE LIBRE RECEIVER	QL= 1 receiver/year
FREESTYLE LIBRE SENSOR (10-DAY)	QL= 3 sensors/30 days
FREESTYLE LIBRE SENSOR (14-DAY)	QL= 2 sensors/28 days
GILOTRIF TAB	QL= 1 tab/day; Only available through Accredo 888-773-7376
GLYXAMBI TAB	QL= 1 tab/day

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

Texas Association of Counties HDHP Formulary Cont.
Last Updated* 11/1/2018
Quantity Limit (QL)

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

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
granisetron tab	QL= 9 tabs/fill
GRANISOL SOLN	QL= 60ml/fill
guaifenesin/codeine syrup	QL= 240ml/fill
HARVONI TAB	QL= 1 tab/day
HUMIRA INJ 10MG	QL= 2 syringes/28 days
HUMIRA INJ 20MG	QL= 2 syringes/28 days
HUMIRA INJ 40MG	QL= 2 syringes/28 days
HUMIRA INJ CROHNS/UC/HIDRADENITIS STARTER PACK	QL= 1 pack/fill, 1 fill/plan year
HUMIRA INJ PEDIATRIC CROHNS STARTER PACK	QL= 1 pack/fill, 1 fill/plan year
HUMIRA INJ PSORIASIS/UVEITIS STARTER PACK	QL= 1 pack/fill, 1 fill/plan year
HUMIRA PEN INJ 40MG	QL= 2 pens/28 days
hydrocodone/chlorpheniramine CR susp	QL= 120ml/fill; 2 fills/30 days
HYSINGLA ER TAB	QL= 1 tab/day
ibandronate tab 150mg	QL= 1 tab/30 days
IBRANCE CAP	QL= 21 caps/28 days
IDHIFA TAB	QL= 1 tab/day
IMBRUVICA CAP 140MG	QL= 3 caps/day; Only available through Diplomat Pharmacy 877-977-9118
IMBRUVICA CAP 70MG	QL= 1 cap/day; Only available through Diplomat Pharmacy 877-977-9118
IMBRUVICA TAB	QL= 1 tab/day; Only available through Diplomat Pharmacy 877-977-9118
INLYTA TAB	QL= 8 tabs/day
JAKAFI TAB	QL= 2 tabs/day
JANUMET TAB	QL= 2 tabs/day
JANUMET XR TAB	QL= 2 tabs/day
JANUVIA TAB	QL= 1 tab/day
JARDIANCE TAB	QL= 1 tab/day
JENTADUETO TAB	QL= 2 tabs/day
JENTADUETO XR TAB	QL= 2 tabs/day
JYNARQUE PAK	QL= 2 tabs/day; Only available through Walgreens 888-347-3416
KALYDECO PAK	QL= 2 packets/day
KALYDECO TAB	QL= 2 tabs/day
ketorolac tab	QL= 20 tabs/5 days
KEVZARA INJ	QL= 2 inj/28 days
KINERET INJ	QL= 1 inj/day; Only available through Rx Crossroads: 1-866-547-0644
KISQALI PAK	QL= 91 tabs/28 days
KISQALI TAB	QL= 63 tabs/28 days
LASTACFT OPHTH SOLN	QL= 3ml/30 days
latanoprost ophth soln	QL= 2.5ml/30 days
LATUDA TAB	QL= 1 tab/day; Step Therapy requires trial of quetiapine
LAZANDA NASAL SPRAY	QL= 15 bottles/30 days
LENVIMA CAP	QL= 3 caps/day; Only available through Accredo 888-773-7376

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

Texas Association of Counties HDHP Formulary Cont.
Last Updated* 11/1/2018
Quantity Limit (QL)

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

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
LETAIRIS TAB	QL= 1 tab/day; Only available through Walgreens 888-347-3416
lidocaine patch	QL= 3 patches/day
LUMIGAN OPHTH SOLN	QL= 2.5ml/30 days
LYNPARZA CAP	Only available through Biologics 800-850-4306, QL= 16 caps/day
LYNPARZA TAB	Only available through Biologics 800-850-4306, QL= 4 tabs/day
malathion lotion	QL= 2 bottles/fill
MAVYRET TAB	QL= 3 tabs/day
medroxyprogesterone inj	QL= 1 inj/90 days
methylegonovine tab	QL= 28 tabs/fill, 1 fill/365 days
modafinil tab	QL= 2 tabs/day
NALOXONE PREFILLED INJ	QL= 2 inj/fill
naratriptan tab	QL= 9 tabs/fill, 2 fills/30 days
NARCAN NASAL SPRAY	QL= 2 sprays/fill
NATROBA SUSP	QL= 1 bottle/fill
NERLYNX TAB	QL= 6 tabs/day; Only available through Diplomat Pharmacy 877-977-9118
nicotine gum	Limited to 180 days/plan year
NICOTINE KIT	
nicotine lozenge	Limited to 180 days/plan year
nicotine patch	Limited to 180 days/plan year
NICOTROL INHALER	Limited to 180 days/plan year
NICOTROL NASAL SPRAY	Limited to 180 days/plan year
NUCYNTA ER TAB	QL= 2 tabs/day
NUDEXTA CAP	QL= 2 caps/day
OCALIVA TAB	QL= 1 tab/day; Only available through Walgreens 888-347-3416
OFEV CAP	QL= 2 caps/day
OPSUMIT TAB	QL= 1 tab/day; Only available through Walgreens 888-347-3416
ORENCIA CLICK INJ	QL= 4 inj/28 days
ORENCIA SC INJ 125MG/ML	QL= 4 inj/28 days
ORENCIA SC INJ 50MG/0.4ML	QL= 4 inj/28 days
ORENCIA SC INJ 87.5MG/0.7ML	QL= 4 inj/28 days
ORKAMBI GRANULES PACKET	QL= 2 packets/day
ORKAMBI TAB	QL= 4 tabs/day
oseltamivir cap	QL= 10 caps/fill
oseltamivir cap 30mg	QL= 20 caps/fill
oseltamivir susp	QL= 250ml/fill
OTEZLA STARTER PACK	QL= 1 pack/28 days
OTEZLA TAB	QL= 2 tabs/day
OZEMPIC INJ	QL= 1 pack/28 days
peg 3350/electrolytes soln	Covered at \$0 for members 50-75 years-Limited to 2 fills/calendar year; All other members covered at generic copay
POTIGA TAB	QL= 3 tabs/day
PRALUENT INJ	QL= 2 inj/28 days
REGANEX GEL	QL= 30gm/fill

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

Texas Association of Counties HDHP Formulary Cont.
Last Updated* 11/1/2018
Quantity Limit (QL)

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

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
RELENZA DISKHALER	QL= 1 inhaler/fill
REPATHA INJ	QL= 2 inj/28 days
REPATHA PUSHTRONEX INJ	QL= 1 inj/28 days
REVLIMID CAP	QL= 1 cap/day
rizatriptan ODT	QL= 12 tabs/fill, 3 fills/60 days
rizatriptan tab	QL= 12 tabs/fill, 3 fills/60 days
rosuvastatin tab 10mg	QL= 1 tab/day
rosuvastatin tab 20mg	QL= 1.5 tabs/day
rosuvastatin tab 40mg	QL= 1 tab/day
rosuvastatin tab 5mg	QL= 1 tab/day
RUBRACA TAB	QL= 4 tabs/day; Only available through Avella Pharmacy (877) 546-5779
SANCUSO PATCH	QL= 4 patches/fill
SANTYL OINT	QL= 90gm/30 days
SAPHRIS SL TAB	QL= 2 tabs/day
SAVELLA TAB	QL= 2 tabs/day
SIGNIFOR INJ	QL= 2 vials/day; Only available through Accredo 888-773-7376
SIVEXTRO TAB	QL= 6 tabs/fill; Restricted to Infectious Disease Specialist
SKLICE LOTION	QL= 1 tube/fill
SOLOSEC GRANULES PACKET	QL= 1 packet/fill
SPINOSAD SUSP	QL= 1 bottle/fill
SPIRIVA RESPIMAT INHALER 1.25MCG/ACT	QL= 1 inhaler/30 days; Step Therapy requires trial of ADVAIR, BREO, DULERA, or FLUTICASONE/SALMETEROL
STIVARGA TAB	QL= 4 tabs/day
STRIVERDI RESPIMAT INHALER	QL= 1 inhaler/30 days
sumatriptan inj	QL= 4 inj/fill, 2 fills/30 days
SUMATRIPTAN INJ 6MG/0.5ML	QL= 4 inj/fill, 2 fills/30 days
sumatriptan nasal spray	QL= 6 sprays/fill, 2 fills/30 days
sumatriptan tab	QL= 9 tabs/fill, 2 fills/30 days
sumatriptan vial inj	QL= 5 inj/fill, 2 fills/30 days
SYNJARDY TAB	QL= 2 tabs/day
SYNJARDY XR TAB 10-1000MG, 25-1000MG	QL= 1 tab/day
SYNJARDY XR TAB 5-1000MG, 12.5-1000MG	QL= 2 tabs/day
TAFINLAR CAP	QL= 4 caps/day
TAGRISSE TAB	QL= 1 tab/day; Only available through Diplomat Pharmacy 877-977-9118
testosterone gel 1% 25mg	QL= 1 packet/day
testosterone gel 1% 50mg	QL= 2 packets/day
testosterone gel 1% pump	QL= 4 bottles/30 days
TIVICAY TAB	QL= 2 tabs/day
TRACLEER TAB 32MG	QL=4 tabs/day; Only available through Walgreens 888-347-3416
TRACLEER TAB 62.5MG, 125MG	QL= 2 tabs/day; Only available through Walgreens 888-347-3416
TRADJENTA TAB	QL= 1 tab/day

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

Texas Association of Counties HDHP Formulary Cont.
Last Updated* 11/1/2018
Quantity Limit (QL)

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

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
TRAVATAN Z OPTH SOLN	QL= 2.5ml/30 days
trilyte soln	Covered at \$0 for members 50-75 years, all other members covered at generic copay Limited to 2 fills/calendar year
TRULICITY INJ	QL= 4 pens/28 days
TUSSI-ORGANI SYRUP	QL= 240ml/fill
TYVASO INH SOLN	QL= 1 ampule/day; Only available through Accredo 888-773-7376
ULESFIA LOTION	QL= 4 bottles/fill
UPTRAVI TAB	QL= 2 tabs/day; Only available through Accredo 888-773-7376
VALCHLOR GEL	QL= 4 tubes/30 days; Only available through Accredo 888-773-7376
vancomycin cap	QL= 56 caps/fill; Step Therapy requires trial of vancomycin soln or FIRVANQ SOLN
VARUBI TAB	QL= 2 tabs/day; Restricted to Oncology or Hematology Specialist
VENTAVIS INH SOLN	QL= 9 ampules/day; Only available through Accredo 888-773-7376
VENTOLIN HFA INHALER	QL= 2 inhalers/30 days
VERZENIO TAB	QL= 2 tabs/day
V-GO INJ KIT	QL= 1 kit/day
VICTOZA INJ	QL= 9ml/30 days
VIMPAT TAB	QL= 2 tabs/day
VIVOTIF CAP	QL= 4 caps/fill
VOSEVI TAB	QL= 1 tab/day
XADAGO TAB	QL= 1 tab/day
XALKORI CAP	QL= 2 caps/day
XIFAXAN TAB 200MG	QL= 9 tabs/3 days
XIFAXAN TAB 550MG	QL= 2 tabs/day; Quantities up to 3 tabs/day for the treatment of IBS-D allowed via PA
XIGDUO XR TAB 2.5-1000MG, 5-1000MG	QL= 2 tabs/day
XIGDUO XR TAB 5-500MG, 10-500MG, 10-1000MG	QL= 1 tab/day
XTAMPZA ER CAP	QL= 120 caps/30 days
XTANDI CAP	QL= 4 caps/day
XULTOPHY INJ	QL= 15ml/30 days
XYREM SOLN	QL= 540ml/30 days; Only available through Xyrem Central Pharmacy 866-997-3688
ZEJULA CAP	QL= 3 caps/day; Only available through Diplomat Pharmacy 877-977-9118
zolmitriptan ODT	QL= 9 tabs/fill, 2 fills/30 days
zolmitriptan tab	QL= 9 tabs/fill, 2 fills/30 days
zolpidem tab	QL= 1 tab/day
ZOMIG NASAL SPRAY	QL= 6 sprays/fill, 2 fills/30 days
ZYKADIA CAP	QL= 3 caps/day
ZYLET OPTH SUSP	QL= 5ml/fill (10ml bottle is Not Covered)
ZYTIGA TAB 250MG	QL= 4 tabs/day
ZYTIGA TAB 500MG	QL= 2 tabs/day

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