

# Tribute 2019 Formulary

## Step Therapy Criteria

### ANTIDEPRESSANTS

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#### Products Affected

##### Step 2:

- *bupropion hcl er (xl) tablet extended release 24 hour 450 mg oral*
- PEXEVA TABLET 20 MG ORAL
- PEXEVA TABLET 30 MG ORAL
- PEXEVA TABLET 10 MG ORAL
- PEXEVA TABLET 40 MG ORAL

#### Details

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Criteria	
	Claim will pay automatically for Pexeva or bupropion XL 450mg (generic Forfivo XL) if enrollee has a paid claim for at least a 1 days supply of any 2 generic formulary antidepressants OR Paxil oral suspension OR Marplan in the past 365 days. Otherwise, Pexeva or bupropion XL 450mg (generic Forfivo XL) requires a step therapy exception request indicating: (1) history of inadequate treatment response with any 2 generic formulary antidepressants, OR Paxil oral suspension OR Marplan, OR (2) history of adverse event with any 2 generic formulary antidepressants OR Paxil oral suspension OR Marplan, OR (3) any 2 generic formulary antidepressants OR Paxil oral suspension OR Marplan are contraindicated.

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# Tribute 2019 Formulary

## Step Therapy Criteria

### CELECOXIB

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#### Products Affected

##### Step 2:

- *celecoxib capsule 100 mg oral*
- *celecoxib capsule 200 mg oral*
- *celecoxib capsule 400 mg oral*
- *celecoxib capsule 50 mg oral*

#### Details

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<b>Criteria</b>	Claim will pay automatically for Celecoxib if enrollee has a paid claim for at least a 1 days supply of any generic oral formulary NSAID in the past 365 days. Otherwise, Celecoxib requires a step therapy exception request indicating: (1) history of inadequate treatment response with any generic oral formulary NSAID, OR (2) history of adverse event with any generic oral formulary NSAID, OR (3) any generic oral formulary NSAID is contraindicated.
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# Tribute 2019 Formulary

## Step Therapy Criteria

### COPD

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#### Products Affected

##### Step 2:

- TRELEGY ELLIPTA AEROSOL POWDER BREATH ACTIVATED 100-62.5-25 MCG/INH INHALATION

#### Details

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<b>Criteria</b>	Claim will pay automatically for Trelegy if enrollee has a paid claim for at least a one day supply of any step level 1 agent (Spiriva, Serevent, Advair, Breo, or Stiolto). Otherwise, Trelegy requires a step therapy exception request indicating: (1) history of inadequate treatment response with step 1 agent, OR (2) history of adverse event with step 1 agent, OR (3) step 1 agent is contraindicated.
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# Tribute 2019 Formulary Step Therapy Criteria

## DHE

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### Products Affected

#### Step 2:

- *dihydroergotamine mesylate solution 4 mg/ml nasal*

### Details

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Criteria	Claim will pay automatically for DHE if enrollee has a paid claim for at least a 1 days supply of any generic formulary serotonin (5-HT) 1b/1d receptor agonist (i.e. triptan) in the past 365 days. Otherwise, DHE requires a step therapy exception request indicating: (1) history of inadequate treatment response with any generic formulary triptan, OR (2) history of adverse event with any generic formulary triptan, OR (3) any generic formulary triptan is contraindicated.
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# Tribute 2019 Formulary

## Step Therapy Criteria

### DIFICID

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#### Products Affected

##### Step 2:

- DIFICID TABLET 200 MG ORAL

#### Details

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Criteria	
	Claim will pay automatically for Dificid if enrollee has a paid claim for at least a 1 days supply of Vancomycin in the past 120 days. Otherwise, Dificid requires a step therapy exception request indicating: (1) history of inadequate treatment response with Vancomycin, OR (2) history of adverse event with Vancomycin, OR (3) Vancomycin is contraindicated.

# Tribute 2019 Formulary

## Step Therapy Criteria

### ESA

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#### Products Affected

##### Step 2:

- ARANESP (ALBUMIN FREE)  
SOLUTION 100 MCG/ML INJECTION
- ARANESP (ALBUMIN FREE)  
SOLUTION 200 MCG/ML INJECTION
- ARANESP (ALBUMIN FREE)  
SOLUTION 25 MCG/ML INJECTION
- ARANESP (ALBUMIN FREE)  
SOLUTION 300 MCG/ML INJECTION
- ARANESP (ALBUMIN FREE)  
SOLUTION 40 MCG/ML INJECTION
- ARANESP (ALBUMIN FREE)  
SOLUTION 60 MCG/ML INJECTION
- ARANESP (ALBUMIN FREE)  
SOLUTION PREFILLED SYRINGE 10  
MCG/0.4ML INJECTION
- ARANESP (ALBUMIN FREE)  
SOLUTION PREFILLED SYRINGE 100  
MCG/0.5ML INJECTION
- ARANESP (ALBUMIN FREE)  
SOLUTION PREFILLED SYRINGE 150  
MCG/0.3ML INJECTION
- ARANESP (ALBUMIN FREE)  
SOLUTION PREFILLED SYRINGE 200  
MCG/0.4ML INJECTION
- ARANESP (ALBUMIN FREE)  
SOLUTION PREFILLED SYRINGE 25  
MCG/0.42ML INJECTION
- ARANESP (ALBUMIN FREE)  
SOLUTION PREFILLED SYRINGE 300  
MCG/0.6ML INJECTION
- ARANESP (ALBUMIN FREE)  
SOLUTION PREFILLED SYRINGE 40  
MCG/0.4ML INJECTION
- ARANESP (ALBUMIN FREE)  
SOLUTION PREFILLED SYRINGE 500  
MCG/ML INJECTION
- ARANESP (ALBUMIN FREE)  
SOLUTION PREFILLED SYRINGE 60  
MCG/0.3ML INJECTION
- EPOGEN SOLUTION 10000 UNIT/ML  
INJECTION
- EPOGEN SOLUTION 2000 UNIT/ML  
INJECTION
- EPOGEN SOLUTION 20000 UNIT/ML  
INJECTION
- EPOGEN SOLUTION 3000 UNIT/ML  
INJECTION
- EPOGEN SOLUTION 4000 UNIT/ML  
INJECTION

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# Tribute 2019 Formulary

## Step Therapy Criteria

### Details

<b>Criteria</b>	CLAIM WILL PAY AUTOMATICALLY FOR ARANESP OR EPOGEN IF ENROLLEE HAS A PAID CLAIM FOR AT LEAST A 1 DAYS SUPPLY OF PROCRIT OR RETACRIT IN THE PAST 365 DAYS. OTHERWISE, ARANESP OR EPOGEN REQUIRES A STEP THERAPY EXCEPTION REQUEST INDICATING: (1) HISTORY OF INADEQUATE TREATMENT RESPONSE WITH PROCRIT OR RETACRIT, OR (2) HISTORY OF ADVERSE EVENT WITH PROCRIT OR RETACRIT, OR (3) PROCRIT OR RETACRIT IS CONTRAINDICATED.
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# Tribute 2019 Formulary Step Therapy Criteria

## LIVALO

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### Products Affected

#### Step 2:

- LIVALO TABLET 1 MG ORAL
- LIVALO TABLET 2 MG ORAL
- LIVALO TABLET 4 MG ORAL

### Details

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<b>Criteria</b>	Claim will pay automatically for Livalo if enrollee has a paid claim for at least a 1 days supply of any generic formulary statin in the past 365 days. Otherwise, Livalo requires a step therapy exception request indicating: (1) history of inadequate treatment response with any generic formulary statin, OR (2) history of adverse event with any generic formulary statin, OR (3) any generic formulary statin is contraindicated.
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# Tribute 2019 Formulary

## Step Therapy Criteria

### NEUPRO

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#### Products Affected

##### Step 2:

- NEUPRO PATCH 24 HOUR 1 MG/24HR TRANSDERMAL
- NEUPRO PATCH 24 HOUR 2 MG/24HR TRANSDERMAL
- NEUPRO PATCH 24 HOUR 3 MG/24HR TRANSDERMAL
- NEUPRO PATCH 24 HOUR 4 MG/24HR TRANSDERMAL
- NEUPRO PATCH 24 HOUR 6 MG/24HR TRANSDERMAL
- NEUPRO PATCH 24 HOUR 8 MG/24HR TRANSDERMAL

#### Details

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<b>Criteria</b>	Claim will pay automatically for neupro if enrollee has a paid claim for at least a 1 days supply of pramipexole or ropinirole in the past 365 days. Otherwise, neupro requires a step therapy exception request indicating: (1) history of inadequate treatment response with pramipexole or ropinirole, OR (2) history of adverse event with pramipexole or ropinirole, OR (3) pramipexole or ropinirole is contraindicated.
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# Tribute 2019 Formulary

## Step Therapy Criteria

### PPI

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#### Products Affected

##### Step 2:

- DEXILANT CAPSULE DELAYED RELEASE 30 MG ORAL
- DEXILANT CAPSULE DELAYED RELEASE 60 MG ORAL

#### Details

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Criteria	Claim will pay automatically for Dexilant if enrollee has a paid claim for at least a 1 days supply of any 1 of the following: omeprazole (Rx), lansoprazole (Rx), or pantoprazole in the past 365 days. Otherwise, Dexilant requires a step therapy exception request indicating: (1) history of inadequate treatment response with any 1 of the following: omeprazole (Rx), lansoprazole (Rx), or pantoprazole OR (2) history of adverse event with any 1 of the following: omeprazole (Rx), lansoprazole (Rx), or pantoprazole, OR (3) any 1 of the following: omeprazole (Rx), lansoprazole (Rx), or pantoprazole are contraindicated.

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# Tribute 2019 Formulary

## Step Therapy Criteria

### PRADAXA

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#### Products Affected

##### Step 2:

- PRADAXA CAPSULE 110 MG ORAL
- PRADAXA CAPSULE 75 MG ORAL
- PRADAXA CAPSULE 150 MG ORAL

#### Details

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Criteria	CLAIM WILL PAY AUTOMATICALLY FOR Pradaxa IF ENROLLEE HAS A PAID CLAIM FOR AT LEAST A 1 DAYS SUPPLY OF Xarelto or Eliquis IN THE PAST 365 DAYS. OTHERWISE, Pradaxa REQUIRES A STEP THERAPY EXCEPTION REQUEST INDICATING: (1) HISTORY OF INADEQUATE TREATMENT RESPONSE WITH Xarelto or Eliquis, OR (2) HISTORY OF ADVERSE EVENT WITH Xarelto or Eliquis, OR (3) Xarelto or Eliquis IS CONTRAINDICATED.
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# Tribute 2019 Formulary

## Step Therapy Criteria

### PROLIA

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#### Products Affected

##### Step 2:

- PROLIA SOLUTION 60 MG/ML  
SUBCUTANEOUS
- PROLIA SOLUTION PREFILLED  
SYRINGE 60 MG/ML  
SUBCUTANEOUS

#### Details

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<b>Criteria</b>	Claim will pay automatically for Prolia if enrollee has a paid claim for at least a 1 days supply of any formulary bisphosphonate in the past 180 days. Otherwise, Prolia requires a step therapy exception request indicating: (1) history of inadequate treatment response with any formulary bisphosphonate, OR (2) history of adverse event with any formulary bisphosphonate, OR (3) any formulary bisphosphonate is contraindicated. For osteoporosis prophylaxis in men at high risk for bone fractures after receiving androgen deprivation therapy for nonmetastatic prostate cancer and in women at high risk for bone fractures after receiving adjuvant aromatase inhibitor therapy for breast cancer, Prolia will be approved.
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# Tribute 2019 Formulary

## Step Therapy Criteria

### RYTARY

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#### Products Affected

##### Step 2:

- RYTARY CAPSULE EXTENDED RELEASE 23.75-95 MG ORAL
- RYTARY CAPSULE EXTENDED RELEASE 36.25-145 MG ORAL
- RYTARY CAPSULE EXTENDED RELEASE 48.75-195 MG ORAL
- RYTARY CAPSULE EXTENDED RELEASE 61.25-245 MG ORAL

#### Details

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Criteria	CLAIM WILL PAY AUTOMATICALLY FOR RYTARY IF ENROLLEE HAS A PAID CLAIM FOR AT LEAST A 1 DAYS SUPPLY OF ANY COMBINATION CARBIDOPA/LEVODOPA PRODUCT IN THE PAST 365 DAYS. OTHERWISE, RYTARY REQUIRES A STEP THERAPY EXCEPTION REQUEST INDICATING: (1) HISTORY OF INADEQUATE TREATMENT RESPONSE WITH ANY COMBINATION CARBIDOPA/LEVODOPA PRODUCT, OR (2) HISTORY OF ADVERSE EVENT WITH ANY COMBINATION CARBIDOPA/LEVODOPA PRODUCT, OR (3) ANY COMBINATION CARBIDOPA/LEVODOPA PRODUCT IS CONTRAINDICATED.
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# Tribute 2019 Formulary

## Step Therapy Criteria

### SGLT2

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#### Products Affected

##### Step 2:

- INVOKAMET TABLET 150-1000 MG ORAL
- INVOKAMET TABLET 150-500 MG ORAL
- INVOKAMET TABLET 50-1000 MG ORAL
- INVOKAMET TABLET 50-500 MG ORAL
- INVOKAMET XR TABLET EXTENDED RELEASE 24 HOUR 150-1000 MG ORAL
- INVOKAMET XR TABLET EXTENDED RELEASE 24 HOUR 150-500 MG ORAL
- INVOKAMET XR TABLET EXTENDED RELEASE 24 HOUR 50-1000 MG ORAL
- INVOKAMET XR TABLET EXTENDED RELEASE 24 HOUR 50-500 MG ORAL
- INVOKANA TABLET 100 MG ORAL
- INVOKANA TABLET 300 MG ORAL
- JARDIANCE TABLET 10 MG ORAL
- JARDIANCE TABLET 25 MG ORAL
- SYNJARDY TABLET 12.5-1000 MG ORAL
- SYNJARDY TABLET 12.5-500 MG ORAL
- SYNJARDY TABLET 5-1000 MG ORAL
- SYNJARDY TABLET 5-500 MG ORAL
- SYNJARDY XR TABLET EXTENDED RELEASE 24 HOUR 10-1000 MG ORAL
- SYNJARDY XR TABLET EXTENDED RELEASE 24 HOUR 12.5-1000 MG ORAL
- SYNJARDY XR TABLET EXTENDED RELEASE 24 HOUR 25-1000 MG ORAL
- SYNJARDY XR TABLET EXTENDED RELEASE 24 HOUR 5-1000 MG ORAL

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# Tribute 2019 Formulary Step Therapy Criteria

## Details

<b>Criteria</b>	CLAIM WILL PAY AUTOMATICALLY FOR INVOKANA, INVOKAMET IR/XR, JARDIANCE, OR SYNJARDY IR/XR IF ENROLLEE HAS A PAID CLAIM FOR AT LEAST A 1 DAYS SUPPLY OF GENERIC METFORMIN OR A COMBINATION GENERIC METFORMIN PRODUCT IN THE PAST 365 DAYS. OTHERWISE, INVOKANA, INVOKAMET IR/XR, JARDIANCE, OR SYNJARDY IR/XR REQUIRES A STEP THERAPY EXCEPTION REQUEST INDICATING: (1) HISTORY OF INADEQUATE TREATMENT RESPONSE WITH GENERIC METFORMIN OR A COMBINATION GENERIC METFORMIN PRODUCT, OR (2) HISTORY OF ADVERSE EVENT WITH GENERIC METFORMIN OR A COMBINATION GENERIC METFORMIN PRODUCT, OR (3) GENERIC METFORMIN OR A COMBINATION GENERIC METFORMIN PRODUCT IS CONTRAINDICATED.
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# Tribute 2019 Formulary

## Step Therapy Criteria

### TOPICAL AGENTS

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#### Products Affected

##### Step 2:

- CONDYLOX GEL 0.5 % EXTERNAL

#### Details

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<b>Criteria</b>	Claim will pay automatically for Condylox if enrollee has a paid claim for at least a 1 days supply of Podofilox in the past 365 days. Otherwise, Condylox requires a step therapy exception request indicating: (1) history of inadequate treatment response with podofilox OR (2) history of adverse event with podofilox OR (3) podofilox is contraindicated.
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# Tribute 2019 Formulary

## Step Therapy Criteria

### TOPICAL ANTI-INFLAMMATORY

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#### Products Affected

##### Step 2:

- EUCRISA OINTMENT 2 % EXTERNAL
- *pimecrolimus cream 1 % external*
- *tacrolimus ointment 0.03 % external*
- *tacrolimus ointment 0.1 % external*

#### Details

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Criteria	
	Claim will pay automatically for pimecrolimus, Eucrisa, or Tacrolimus External if enrollee has a paid claim for at least a 1 days supply of any formulary topical corticosteroid in the past 365 days. Otherwise, pimecrolimus, Eucrisa, or Tacrolimus External requires a step therapy exception request indicating: (1) history of inadequate treatment response with any formulary topical corticosteroid, OR (2) history of adverse event with any formulary topical corticosteroid, OR (3) any formulary topical corticosteroid is contraindicated.

# Tribute 2019 Formulary

## Step Therapy Criteria

### UCERIS

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#### Products Affected

##### Step 2:

- *budesonide er tablet extended release 24 hour 9 mg oral*
- UCERIS FOAM 2 MG/ACT RECTAL

#### Details

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Criteria	Claim will pay automatically for Budesonide ER 9mg or Uceris Rectal Foam if enrollee has a paid claim for at least a 1 days supply of any formulary corticosteroid used to treat ulcerative colitis in the past 365 days. Otherwise, Budesonide ER 9mg or Uceris Rectal Foam requires a step therapy exception request indicating: (1) history of inadequate treatment response with any formulary corticosteroid used to treat ulcerative colitis, OR (2) history of adverse event with any formulary corticosteroid used to treat ulcerative colitis, OR (3) any formulary corticosteroid used to treat ulcerative colitis is contraindicated.
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# Tribute 2019 Formulary

## Step Therapy Criteria

### ULORIC

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#### Products Affected

##### Step 2:

- *febuxostat tablet 40 mg oral*
- *febuxostat tablet 80 mg oral*
- ULORIC TABLET 40 MG ORAL
- ULORIC TABLET 80 MG ORAL

#### Details

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<b>Criteria</b>	Claim will pay automatically for Uloric or Febuxostat if enrollee has a paid claim for at least a 1 days supply of Allopurinol in the past 365 days. Otherwise, Uloric or Febuxostat require a step therapy exception request indicating: (1) history of inadequate treatment response with Allopurinol, OR (2) history of adverse event with Allopurinol, OR (3) Allopurinol is contraindicated.
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# Tribute 2019 Formulary

## Step Therapy Criteria

### ZYFLO

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#### Products Affected

##### Step 2:

- *zileuton er tablet extended release 12 hour 600 mg oral* • ZYFLO TABLET 600 MG ORAL

#### Details

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Criteria	CLAIM WILL PAY AUTOMATICALLY FOR Zileuton IF ENROLLEE HAS A PAID CLAIM FOR AT LEAST A 1 DAYS SUPPLY OF Montelukast or Zafirlukast IN THE PAST 365 DAYS. OTHERWISE, Zileuton REQUIRES A STEP THERAPY EXCEPTION REQUEST INDICATING: (1) HISTORY OF INADEQUATE TREATMENT RESPONSE WITH Montelukast or Zafirlukast, OR (2) HISTORY OF ADVERSE EVENT WITH Montelukast or Zafirlukast, OR (3) Montelukast or Zafirlukast IS CONTRAINDICATED.
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# Tribute 2019 Formulary

## Step Therapy Criteria

### Alphabetical Listing

#### A

ARANESP (ALBUMIN FREE)  
 SOLUTION 100 MCG/ML INJECTION  
 ..... 6, 9

ARANESP (ALBUMIN FREE)  
 SOLUTION 200 MCG/ML INJECTION  
 ..... 6, 9

ARANESP (ALBUMIN FREE)  
 SOLUTION 25 MCG/ML INJECTION 6,  
 9

ARANESP (ALBUMIN FREE)  
 SOLUTION 300 MCG/ML INJECTION  
 ..... 6, 9

ARANESP (ALBUMIN FREE)  
 SOLUTION 40 MCG/ML INJECTION 6,  
 9

ARANESP (ALBUMIN FREE)  
 SOLUTION 60 MCG/ML INJECTION 6,  
 9

ARANESP (ALBUMIN FREE)  
 SOLUTION PREFILLED SYRINGE 10  
 MCG/0.4ML INJECTION..... 6, 9

ARANESP (ALBUMIN FREE)  
 SOLUTION PREFILLED SYRINGE 100  
 MCG/0.5ML INJECTION..... 6, 9

ARANESP (ALBUMIN FREE)  
 SOLUTION PREFILLED SYRINGE 150  
 MCG/0.3ML INJECTION..... 6, 9

ARANESP (ALBUMIN FREE)  
 SOLUTION PREFILLED SYRINGE 200  
 MCG/0.4ML INJECTION..... 6, 9

ARANESP (ALBUMIN FREE)  
 SOLUTION PREFILLED SYRINGE 25  
 MCG/0.42ML INJECTION..... 6, 9

ARANESP (ALBUMIN FREE)  
 SOLUTION PREFILLED SYRINGE 300  
 MCG/0.6ML INJECTION..... 6, 9

ARANESP (ALBUMIN FREE)  
 SOLUTION PREFILLED SYRINGE 40  
 MCG/0.4ML INJECTION.....6, 9

ARANESP (ALBUMIN FREE)  
 SOLUTION PREFILLED SYRINGE 500  
 MCG/ML INJECTION.....6, 9

ARANESP (ALBUMIN FREE)  
 SOLUTION PREFILLED SYRINGE 60  
 MCG/0.3ML INJECTION .....6, 9

#### B

budesonide er tablet extended release 24  
 hour 9 mg oral .....26

bupropion hcl er (xl) tablet extended release  
 24 hour 450 mg oral .....1

#### C

celecoxib capsule 100 mg oral .....2

celecoxib capsule 200 mg oral .....2

celecoxib capsule 400 mg oral .....2

celecoxib capsule 50 mg oral .....2

CONDYLOX GEL 0.5 % EXTERNAL ...24

#### D

DEXILANT CAPSULE DELAYED  
 RELEASE 30 MG ORAL.....15

DEXILANT CAPSULE DELAYED  
 RELEASE 60 MG ORAL.....15

DIFICID TABLET 200 MG ORAL.....5

dihydroergotamine mesylate solution 4  
 mg/ml nasal .....4

#### E

EPOGEN SOLUTION 10000 UNIT/ML  
 INJECTION .....7, 9

EPOGEN SOLUTION 2000 UNIT/ML  
 INJECTION .....7, 9

EPOGEN SOLUTION 20000 UNIT/ML  
 INJECTION .....7, 9

EPOGEN SOLUTION 3000 UNIT/ML  
 INJECTION .....7, 9

EPOGEN SOLUTION 4000 UNIT/ML  
 INJECTION .....7, 9

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## Step Therapy Criteria

EUCRISA OINTMENT 2 % EXTERNAL  
..... 25

**F**

febuxostat tablet 40 mg oral ..... 27  
febuxostat tablet 80 mg oral ..... 27

**I**

INVOKAMET TABLET 150-1000 MG  
ORAL ..... 19, 21

INVOKAMET TABLET 150-500 MG  
ORAL ..... 19, 21

INVOKAMET TABLET 50-1000 MG  
ORAL ..... 19, 21

INVOKAMET TABLET 50-500 MG  
ORAL ..... 19, 21

INVOKAMET XR TABLET EXTENDED  
RELEASE 24 HOUR 150-1000 MG

ORAL ..... 19, 21

INVOKAMET XR TABLET EXTENDED  
RELEASE 24 HOUR 150-500 MG

ORAL ..... 19, 21

INVOKAMET XR TABLET EXTENDED  
RELEASE 24 HOUR 50-1000 MG

ORAL ..... 19, 21

INVOKAMET XR TABLET EXTENDED  
RELEASE 24 HOUR 50-500 MG ORAL  
..... 19, 21

INVOKANA TABLET 100 MG ORAL.. 19,  
21

INVOKANA TABLET 300 MG ORAL.. 19,  
21

**J**

JARDIANCE TABLET 10 MG ORAL ... 19,  
21

JARDIANCE TABLET 25 MG ORAL ... 19,  
21

**L**

LIVALO TABLET 1 MG ORAL ..... 12  
LIVALO TABLET 2 MG ORAL ..... 12  
LIVALO TABLET 4 MG ORAL ..... 12

**N**

NEUPRO PATCH 24 HOUR 1 MG/24HR  
TRANSDERMAL..... 13, 14

NEUPRO PATCH 24 HOUR 2 MG/24HR  
TRANSDERMAL..... 13, 14

NEUPRO PATCH 24 HOUR 3 MG/24HR  
TRANSDERMAL..... 13, 14

NEUPRO PATCH 24 HOUR 4 MG/24HR  
TRANSDERMAL..... 13, 14

NEUPRO PATCH 24 HOUR 6 MG/24HR  
TRANSDERMAL..... 13, 14

NEUPRO PATCH 24 HOUR 8 MG/24HR  
TRANSDERMAL..... 13, 14

**P**

PEXEVA TABLET 10 MG ORAL ..... 1  
PEXEVA TABLET 20 MG ORAL ..... 1

PEXEVA TABLET 30 MG ORAL ..... 1  
PEXEVA TABLET 40 MG ORAL ..... 1

pimecrolimus cream 1 % external..... 25

PRADAXA CAPSULE 110 MG ORAL... 16  
PRADAXA CAPSULE 150 MG ORAL... 16

PRADAXA CAPSULE 75 MG ORAL..... 16

PROLIA SOLUTION 60 MG/ML  
SUBCUTANEOUS ..... 17

PROLIA SOLUTION PREFILLED  
SYRINGE 60 MG/ML  
SUBCUTANEOUS ..... 17

**R**

RYTARY CAPSULE EXTENDED  
RELEASE 23.75-95 MG ORAL..... 18

RYTARY CAPSULE EXTENDED  
RELEASE 36.25-145 MG ORAL..... 18

RYTARY CAPSULE EXTENDED  
RELEASE 48.75-195 MG ORAL..... 18

RYTARY CAPSULE EXTENDED  
RELEASE 61.25-245 MG ORAL..... 18

**S**

SYNJARDY TABLET 12.5-1000 MG  
ORAL ..... 19, 21

SYNJARDY TABLET 12.5-500 MG ORAL  
..... 19, 21

SYNJARDY TABLET 5-1000 MG ORAL  
..... 19, 21

SYNJARDY TABLET 5-500 MG ORAL 19,  
21

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SYNJARDY XR TABLET EXTENDED  
 RELEASE 24 HOUR 10-1000 MG  
 ORAL ..... 19, 21  
 SYNJARDY XR TABLET EXTENDED  
 RELEASE 24 HOUR 12.5-1000 MG  
 ORAL ..... 19, 21  
 SYNJARDY XR TABLET EXTENDED  
 RELEASE 24 HOUR 25-1000 MG  
 ORAL ..... 19, 21  
 SYNJARDY XR TABLET EXTENDED  
 RELEASE 24 HOUR 5-1000 MG ORAL  
 ..... 19, 21

**T**

tacrolimus ointment 0.03 % external .....25

tacrolimus ointment 0.1 % external.....25  
 TRELEGY ELLIPTA AEROSOL  
 POWDER BREATH ACTIVATED 100-  
 62.5-25 MCG/INH INHALATION .....3

**U**

UCERIS FOAM 2 MG/ACT RECTAL ....26  
 ULORIC TABLET 40 MG ORAL .....27  
 ULORIC TABLET 80 MG ORAL .....27

**Z**

zileuton er tablet extended release 12 hour  
 600 mg oral .....28  
 ZYFLO TABLET 600 MG ORAL .....28