



Maryland HealthChoice Preferred Drug List

Effective: 06/03/2025

This is a list of preferred outpatient and self-administered drugs (the “PDL”) for HealthChoice members of Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (“Kaiser Permanente”). Your doctor will choose from the drugs on the PDL when prescribing medicine for you to take doctor’s office or infusion center.

The PDL is selected by our plan in consultation with a team of health care providers and represents prescription therapies believed to be a necessary part of a quality treatment program.

The PDL does not provide detailed information on your HealthChoice coverage. For additional information regarding your pharmacy benefits, please call Member Services at **855-249-5019, 866-513-0008 TTY** from 7:30 a.m. to 5:30 p.m., Monday through Friday, except holidays.

Generic name, brand name, and non-preferred medications

There are both brand name and generic drugs on the PDL. In most cases, your doctor must prescribe a generic drug if one is available. Generic drugs have the same active ingredient as the brand name drug, but they usually cost less. The U.S. Food and Drug Administration (FDA) approves generic drugs to be as safe and effective as brand name drugs.

Brand name drugs are made and sold by the drug company that originally researched and developed the drug. Because these drugs are usually patented, no one else can make the drug for a time, and the company that developed the drug may charge a high price for it. When the patent on a brand name drug expires, other drug companies may then make and sell the FDA-approved generic version of the drug. This lowers the cost for the drug.

Your doctor must get our prior approval before he or she prescribes a brand name drug when there is a generic drug available, and for any drug not listed on the PDL. Generally, Kaiser Permanente will only approve a request for a non-preferred drug if your prescribing doctor considers the drug to be medically necessary. If a non-preferred drug is not medically necessary, but you want the non-preferred drug, you will be responsible for paying the full cost of the drug.

Drug Efficacy Study Implementation (DESI) drugs

DESI drugs were first marketed between 1938 and 1962 were approved as safe but required no showing of effectiveness for FDA approval. Beginning 1962, all new drugs were required to be both safe and effective before marketed. Kaiser Permanente does not pay for DESI classified drugs and identical, similar, or related to DESI products.

Maryland Medicaid Fee-For-Service Preferred Drug List

The Maryland Department of Health (MDH) is responsible for managing drug coverage for most of the medications used for behavioral health purposes, and substance abuse deterrents. Please refer to the Maryland Medicaid Fee-For-Service Preferred Drug List for information on covered drugs at

[https://health.maryland.gov/mmcp/pap/docs/PDL%201.1.2023%20-Updated 3.06.2023.pdf](https://health.maryland.gov/mmcp/pap/docs/PDL%201.1.2023%20-Updated%203.06.2023.pdf)

How to use the Kaiser Permanente Preferred Drug List document

Drugs available in generic form are listed by their generic name. Unless the drug has multiple branded names, drugs available only in brand name are in **BOLD AND ALL CAPITAL** letters. You can search the Kaiser Permanente Preferred Drug by using the “FIND” function in Adobe Reader (CTRL + F), or by the therapeutic drug category.

All dosages and strengths for a drug may not be in the Kaiser Permanente Preferred Drug List. Some drugs are available in more than one dosage form (example: tablet and injectable).

Please remember that this list will be updated on a monthly basis. Any drug not found on this list or in later updates is a non-preferred drug.

The Kaiser Permanente Preferred Drug List is also available online through **Formulary Navigator** at <https://client.formularynavigator.com/Search.aspx?siteCode=9388942695>

Restrictions on medication coverage

Some covered drugs may have additional requirements or limits on coverage.

Requirements and limits may include:

- **Limited Distribution**= some types of drugs aren't given to all pharmacies to sell. A drug that is a limited distribution drug may only be available at one or a limited number of pharmacies.
- **Prior Authorization** = for some drugs, Kaiser Permanente will cover the medication if certain criteria are met. To obtain additional information regarding drugs that require Prior Authorization and the Prior Authorization Process, please contact Member Services at **855-249-5019, 866-513-0008 TTY** from 7:30 a.m. to 5:30 p.m., Monday through Friday, except holidays.
- **Quantity Limit** = for certain drugs, Kaiser Permanente limits the amount of medication dispensed to a certain quantity per copay. Please see section below for additional information

Please Note: This document (including the list of preferred drugs) is not intended to be a substitute for the knowledge, expertise, skill, and judgment of the medical provider in his or her choice of prescription drugs. It in no way implies that any member should not receive specific drugs based on the recommendation of a provider. This document does not constitute medical advice: the treating provider is responsible for medical advice and treatment of members. Kaiser Permanente assumes no responsibility for the actions or omissions of any medical provider based on reliance, in whole or in part, on the information contained herein. The medical provider should consult the drug manufacturer's product literature or standard references for more detailed information.

Your HealthChoice benefits determine what is covered for you.

Kaiser Permanente may add or remove drugs from the PDL during the year without prior notice to members, for example if a generic of a brand name drug becomes available or a drug is removed from the market for safety reasons. This list is not all-inclusive, nor does it imply a guarantee of coverage. Please call Member Services at 855-249-5019, 866-513-0008 TTY from 7:30 a.m. to 5:30 p.m., Monday through Friday, if you have any questions on your drug coverage.

Key:

LD = A drug that may be subject limited distribution.

PA = A drug that needs prior authorization.

QL = A drug that has a quantity limit or is limited to a specific day supply.

For more information about our preferred drug list, you may contact Member Services at 855-249-5019, 866-513-0008 TTY. Representatives are available from 7:30 a.m. until 5:30 p.m., Monday through Friday, except holidays

Quantity limit list

Please Note: This is not meant to be a list of all the drugs on the formulary. All forms of a drug may not be covered. Drugs are listed by their brand names for ease of use, but the limits apply to the generic drugs as well. Quantity limits are “per fill” unless noted as per day, per month, or per year. Limits apply to all strengths and generic equivalents, unless otherwise noted. This list was correct when printed but may have changed.

DRUG NAME	LIMIT
Acetaminophen w/ codeine oral solution	1000ml per 30 days
Actemra	30 days per fill
Actimmune	30 days per fill
Aimovig	1 syringe per 30 days
Amerge	9 tabs per 30 days
Amjevita	60 days per fill
Ajovy	1 syringe per 30 days
Apokyn	30 days per fill
Aranesp	30 days per fill
Arcalyst	30 days per fill
Arixtra	30 days per fill
Auvi-Q	2 pens per 30 days
Avonex	30 days per fill
Avonex Pen	30 days per fill
Axert	12 tabs per 30 days
Belbuca	30 days per fill
Benlysta	30 days per fill
Betaseron	30 days per fill
Butorphanol	30 days per fill
Butrans	30 days per fill
Bynfezia	30 days per fill
Cibinqo	30 days per fill
Cimzia	30 days per fill
Codeine containing products	180 per 30 days
Codeine oral solution	1000mL per 30 days
Copaxone	30 days per fill
Cosentyx inj	30 days per fill
Cutaquig	30 days per fill

DRUG NAME	LIMIT
Cuvitru	30 days per fill
Cyanocobalamin Inj	30 days per fill
Daklinza	28 days per fill
DDAVP	30 days per fill
Delatestryl	30 days per fill
Delestrogen	30 days per fill
Depo-Estradiol	30 days per fill
Depo-Testosterone	30 days per fill
D.H.E. 45	30 days per fill
Dupixent	30 days per fill
Egrifta	30 days per fill
Dihydrocodeine containing	180 per 30 days
Emgality	2 pens/syr per 30 days
Enbrel	60 days per fill
Enoxaparin	30 days per fill
Enspryng	30 days per fill
Entyvio	30 days per fill
Epclusa	28 days per fill
Epipen, Epipen JR	2 pens per 30 days
Epogen	30 days per fill
Etonogestrel-Ethinyl Estradiol	4 rings per fill
Fasenra	60 days per fill
Fentanyl	10 patches per 30 days
Filspari	30 days per fill
Firazyr	30 days per fill
Fluticasone-Salmeterol Diskus	30 days per fill

DRUG NAME		LIMIT
Folic Acid inj		30 days per fill
Forteo		30 days per fill
Fragmin		30 days per fill
Frova		9 tabs per 30 days
Fulphila		30 days per fill
Fuzeon		30 days per fill
Gammaked		30 days per fill
Gamunex C		30 days per fill
Gattex		30 days per fill
Genotropin		30 days per fill
Glatopa		30 days per fill
Glucose Test Strips		300 per 30 days
Granix		30 days per fill
Haegarda		30 days per fill
Harvoni		28 days per fill
Heparin		30 days per fill
Hemlibra		30 days per fill
Hizentra		30 days per fill
HP Acthar		30 days per fill
Humatrope		30 days per fill
Humira		60 days per fill
Hydrocodone containing products		180 per 30 days
Hydrocodone/ acetaminophen oral sol		2750 ml per 30 days
	Hydromorphone 2mg	180 per 30 days
	4mg	168 per 30 days
	8mg	84 per 30 days
Hydromorphone oral liquid 1mg/ml		675 ml per 30 days
Hydroxyprogesterone caproate		30 days per fill
Hyftor		30g per 30 days
HyQvia		30 days per fill
Imitrex		9 tabs per 30 days
Imitrex Inj		5 boxes per 30 days
Imitrex Nasal		2 boxes per 30 days

DRUG NAME		LIMIT
Increlex		30 days per fill
Intron A		30 days per fill
Isotretinoin		30 days per fill
Iprivask		30 days per fill
Kesimpta		30 days per fill
Kevzara		30 days per fill
Kineret		30 days per fill
Kynamro		30 days per fill
Latex Condoms		12 condoms per fill
Lenvima		30 tabs per 30 days
LEUKINE		30 days per fill
Leuprolide Acetate		30 days per fill
Levorphanol		30 days per fill
Livtency		30 days per fill
Lupkynis		6 caps per day & 30 days per fill
Mavyret		28 days per fill
Maxalt		12 tabs per 30 days
Maxalt MLT		12 tabs per 30 days
Meperidine		30 days per fill
Meperidine oral solution 50mg/5ml		2700ml per 30 days
Methadone		30 days per fill
Mircera		30 days per fill
Micalcin		30 days per fill
Migranal		1 package per 30 days
Morphine containing prod		30 days per fill
Myalept		30 days per fill
Myfembree		30 days per fill
Natpara		30 days per fill

DRUG NAME		LIMIT
Neulasta		30 days per fill
Neumega		30 days per fill
Neupogen		30 days per fill
Nivestym		30 days per fill
Norditropin		30 days per fill
Nucala		30 days per fill
Nurtec ODT		16 tabs per 30 days
Nutropin		30 days per fill
Nyvepria		30 days per fill
Olysio		28 days per fill
Omnitrope		30 days per fill
OmvoH		30 days per fill
Onetouch Verio		1 meter per year
Opzelura		60-gram tube per week
Orencia		30 days per fill
Oseltamivir		10-day supply per fill
Otezla		30 days per fill
Otrexup		30 days per fill
Oxycodone containing products < 15mg		180 per 30 days
Oxycodone	15mg	120 per 30 days
	20mg	90 per 30 days
	30mg	60 per 30 days
Oxycodone oral concentrate 20mg/ml		90ml per 30 days
Oxycodone oral solution 5mg/ml		1800ml per 30 days
Oxycodone acetaminophen oral solution 5-325mg/5ml		1800ml per 30 days
Oxymorphone 10mg		90 per 30 days

DRUG NAME	LIMIT
Palynzig	30 days per fill
Pegasys	30 days per fill
Pegasys Proclick	30 days per fill
Pentazocine containing	30 days per fill
Pentazocine-naloxone 50mg-0.5mg	147 per 30 days
Plaquenil	30 days per fill
Plegridy	30 days per fill
Plegridy Pen	30 days per fill
Praluent	30 days per fill
Procrit	34 days per fill
Qulipta	30 days per fill
Rasuvo	30 days per fill
Rebif	30 days per fill
Rebif Rebidose	30 days per fill
Reditrex	30 days per fill
Relenza	1 pack per fill
Relistor	30 days per fill
Relpax	12 tabs per 30 days
Repatha	30 days per fill
Restasis	60 single use vials per 30 days
Retacrit	30 days per fill
Reyvow	8 tabs per 30 days
Rinvoq	30 days per fill
Saizen	30 days per fill
Samsca 30 mg	30 days per fill
Samsca 15 mg	30 days per fill
Sandostatin	30 days per fill
Serostim	30 days per fill
Signifor	30 days per fill
Siliq	30 days per fill
Simponi	30 days per fill

DRUG NAME		LIMIT
Skyrizi		30 days per fill
Skytrofa		8 cart per 28 days
Sogroya		4 pens per 28 days
Somavert		30 days per fill
Sovaldi		28 days per fill
Strensiq		30 days per fill
Sumavel		5 boxes per 30 days
Sylatron		30 days per fill
Symjepi		2 pens per 30 days
Synribo		30 days per fill
Takhzyro		30 days per fill
Taltz		30 days per fill
Tapentadol	50mg	135 per 30 days
	75mg	90 per 30 days
	100mg	67.5 per 30 days
TARPEYO		4 caps per day & 30 days per fill
Technivie		28 days per fill
Tegsedi		30 days per fill
Teriparatide		30 days per fill
Tolvaptan		30 days per fill
Tramadol	200mg	135 per 30 days
	300mg	90 per 30 days
Tramadol containing products < 200 mg		180 per 30 days
Tremfya		34 days per fill
Treximet		9 tabs per 30 days
Tymlos		30 days per fill
Tyrvaya		30 days per fill

DRUG NAME	LIMIT
Ubrelvy	8 tabs per 30 days
Udenyca	30 days per fill
Veozah	30 days per fill
Viberzi	30 days per fill
Viekira	28 days per fill
Vonjo	30 days per fill
Vosevi	28 days per fill
Xdemvy	1 bottle per year
Xembify	30 days per fill
Xgeva	30 days per fill
Xifaxan 200 mg	18 tabs per 365 days
Xiidra	60 prefilled vials per 30 days
Xyosted	30 days per fill
Zavzpret	6 Nasal Sprays/ 30 days
Zarxio	30 days per fill
Zepatier	28 days per fill
Zinbryta	30 days per fill
Zomacton	30 days per fill
Zomig	12 tabs per 30 days
Zomig MLT	12 tabs per 30 days
Zomig Nasal	12 units per 30 days
Zorbtive	30 days per fill

DRUG NAME	REQUIREMENTS AND LIMITS
ANTI-HISTAMINE DRUGS	
Cyproheptadine HCl	
Promethazine HCL	
ANTI-INFECTIVE AGENTS	
Anthelmintics	
Albendazole	
Antibacterials	
Amoxicillin	
Amoxicillin & Pot Clavulanate	
Ampicillin	
Azithromycin	
Cefaclor	
Cefdinir	
Cefixime	
Cefuroxime Axetil	
Cephalexin	
Ciprofloxacin	
Clarithromycin	
Clindamycin	
Clindamycin Palmitate HCL	
Dicloxacillin Sodium	
Doxycycline Monohydrate	
Doxycycline Hyclate	
Erythromycin Base	
Erythromycin Ethylsuccinate Susp	
Erythromycin-Sulfisoxazole	
Levofloxacin	
Linezolid	
Minocycline HCL	
Neomycin Sulfate	
Penicillin V Potassium	
Sulfadiazine	
Sulfasalazine	

DRUG NAME	REQUIREMENTS AND LIMITS
Sulfamethoxazole-Trimethoprim	
Tobramycin Neb	
Vancomycin HCL	
ZYVOX	
Antifungals	
Fluconazole	
Griseofulvin Microsize Susp	
Itraconazole	
Ketoconazole	
Nystatin	
Terbinafine	
Voriconazole	
Antimycobacterials	
Dapsone	
Ethambutol HCL	
Isoniazid	
PRETOMANID	
Pyrazinamide	
Rifabutin	
Rifampin	
Antiprotozoals	
Atovaquone	
Atovaquone-Proguanil HCL	
Chloroquine Phosphate	
COARTEM	
Hydroxychloroquine Sulfate	
KRINTAFEL	
LIKMEZ	
Mefloquine HCL	
Metronidazole	
NEBUPENT INH	
Primaquine Phosphate	
Antivirals	
Abacavir	
Abacavir-Lamivudine	

LEGEND

- Brand-name drugs are in bold type and all capital letters
- For drugs not indicated in bold, generic drugs will be dispensed as the formulary agent

- Limited Distribution—LD
- Prior Authorization—PA
- Quantity Limits—QL

DRUG NAME	REQUIREMENTS AND LIMITS
Abacavir-Lamivudine-Zidovudine	
Adefovir Dipivoxil	
Amantadine HCL	
APTIVUS	
Atazanavir	
BIKTARVY	
CABENUVA	
CIMDUO	
COMPLERA	
CRIXIVAN	
Darunavir	
DELSTRIGO	
DESCOVY	
Didanosine	
DOVATO	
EDURANT	
Efavirenz	
Emtricitabine-tenofovir disoproxil fumarate	
Efavirenz-emtricitabine-tenofovir disoproxil fumarate	
Emtricitabine	
Entecavir	
Etravirine	
EVOTAZ	QL
Fosamprenavir	
FUZEON	
GENVOYA	
INVIRASE	
ISENTRESS	
JULUCA	
Lamivudine	
Lamivudine-Zidovudine	
Ledipasvir-Sofosbuvir	
LEXIVA	
LIVTENCITY	QL
Lopinavir-Ritonavir	

DRUG NAME	REQUIREMENTS AND LIMITS
Maraviroc	
MAVYRET	QL, PA
Nevirapine	
NORVIR	
ODEFSEY	
Oseltamivir	QL
PEGASYS	QL
PEGASYS PROCLICK	QL
PIFELTRO	
RELENZA	QL
PREVYMIS	
PREZCOBIX	
RESCRIPTOR	
REYATAZ	
Ribavirin	
Rimantadine HCL	
RITONAVIR	
Sofosbuvir-Velpatasvir	PA
Stavudine	
STRIBILD	
SYMFI	
SYMFI Lo	
SYMTUZA	
TECHNIVIE	QL, PA
Tenofovir	
TIVICAY	
TRIUMEQ	
Valacyclovir	
Valganciclovir	
VIDEX	
VIEKIRA	QL
VIRACEPT	
VOSEVI	QL, PA
ZEPATIER	QL, PA
Zidovudine	

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DRUG NAME	REQUIREMENTS AND LIMITS
Urinary Anti-Infectives	
Fosfomycin tromethamine	
Methenamine Hippurate	
Nitrofurantoin	
Nitrofurantoin Macrocrystals	
Nitrofurantoin monohyd macro	
Trimethoprim	
ANTINEOPLASTIC AGENTS	
Antineoplastic Agents	
Abiraterone	
ALECENSA	
ALUNBRIG	
Anastrozole	
Bicalutamide	
BRUKINSA	
CABOMETYX	
Capecitabine	
CAPRELSA	LD
COMETRIQ	
COTELLIC	
Cyclophosphamide	PA
Dasatinib	
EMCYT	
Erlotinib	
Etoposide	
Everolimus	
Exemestane	
Flutamide	
Gefitinib	
GLEOSTINE	
HYCAMTIN	
Hydroxyurea	
IBRANCE	
Imatinib Mesylate	

DRUG NAME	REQUIREMENTS AND LIMITS
INLYTA	
JAKAFI	
KISQALI	
Lapatinib ditosylate	
Lenalidomide	LD
LENVIMA	QL
Letrozole	
LEUKERAN	
Lomustine	
LONSURF	
LUPRON	QL
LUPRON DEPOT	QL
LUPRON DEPOT-PED	QL
LYNPARZA	
LYSODREN	
Megestrol Acetate	
MEKINIST	
Melphalan	
Mercaptopurine	
Methotrexate sodium	
MYLERAN	
NINLARO	
ODOMZO	
Pazopanib HCL	
POMALYST	
Procarbazine HCL	
RYDAPT	
Sorafenib	
STIVARGA	
Sunitinib	
TABLOID	
TAFINLAR	
TAGRISSO	
Tamoxifen Citrate	PA
TASIGNA	
Temozolomide	
Tretinoin (Chemotherapy)	

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- Limited Distribution—LD
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 - Quantity Limits—QL

DRUG NAME	REQUIREMENTS AND LIMITS
VENCLEXTA	
VERZENIO	
XTANDI	
ZEJULA	
ZELBORAF	
ZOLINZA	
ZYKADIA	
AUTONOMIC DRUGS	
Anticholinergic Agents	
Atropine injection	
Dicyclomine HCL	
Ipratropium Bromide	
Spiriva	
STIOLTO RESPIMAT	

Autonomic Drugs, Miscellaneous	
Ergoloid Mesylates	
Phenoxybenzamine	
Parasympathomimetic Agents (Cholinergic)	
Bethanechol Chloride	
Donepezil HCL	
Galantamine Hydrobromide	
Neostigmine Bromide	
Pilocarpine HCL (ORAL)	
Pyridostigmine Bromide	
Skeletal Muscle Relaxants	
Baclofen	
Cyclobenzaprine HCL	
Dantrolene Sodium	
Methocarbamol	
Sympathomimetic (Adrenergic) Agents	
Albuterol	

DRUG NAME	REQUIREMENTS AND LIMITS
AUVI-Q	
Epinephrine HCl	QL
EPIPEN	QL
Fluticasone-salmeterol	QL
Ipratropium-albuterol	
Midodrine	
SEREVENT DISKUS	
STRIVERDI	
Tamsulosin HCL	
Terbutaline Sulfate	
BLOOD FORMATION, COAGULATION, THROMBOSIS	
Coagulants and Anticoagulants	
Anagrelide HCL	
Aminocaproic Acid	
BRILINTA	
Aspirin-Dipyridamole	
Cilostazol	
Clopidogrel	
Dabigatran Etexilate Mesylate	
Dipyridamole	
Enoxaparin	QL
HEMLIBRA	QL, PA
KOVALTRY	
Pentoxifylline	
Prasugrel	
Tranexamic acid	
Warfarin Sodium	
XARELTO	
Hematopoietic Agents	
ALVAIZ	
GRANIX	QL
LEUKINE	QL
PROCRIT/EPOGEN	QL
PROMACTA	

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- Limited Distribution—LD
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- Quantity Limits—QL

DRUG NAME	REQUIREMENTS AND LIMITS
CARDIOVASCULAR DRUGS	
Alpha-Adrenergic Blocking Agents	
Doxazosin	
Terazosin HCL	
Antilipemic Agents	
Atorvastatin Calcium	
Cholestyramine	
Cholestyramine Light	
Colestipol	
Fenofibrate 54mg, 160mg	
Gemfibrozil	
Lovastatin	
Niacin	
Pravastatin 20mg, 40mg, 80mg	
Rosuvastatin	
Simvastatin 10mg, 20mg, 40mg,80mg	
Beta-Adrenergic Blocking Agents	
Atenolol/Chlorthalidone	
Atenolol HCL	
Bisoprolol/ Hydrochlorothiazide	
Bisoprolol Fumarate	
Carvedilol	
Labetalol HCL	
Metoprolol Succinate	
Metoprolol Tartrate	
Propranolol HCL	
Sotalol HCL	
Calcium-Channel Blocking Agents	
Amlodipine Besylate	
Amiodarone HCL	
Diltiazem HCL	
Nifedipine	

DRUG NAME	REQUIREMENTS AND LIMITS
Verapamil HCL	
Cardiac Drugs	
Digoxin	
Disopyramide Phosphate	
Dofetilide	
Flecainide Acetate	
Mexiletine HCL	
Propafenone HCL	
Quinidine Gluconate	
Quinidine Sulfate	
Quinidine Sulfate ER	
Hypotensive Agents	
Acetazolamide	
Clonidine HCL	
Clonidine HCL ER	
Guanfacine HCL	
Hydralazine HCL	
Methazolamide	
Methyldopa	
Minoxidil	
Renin-Angiotensin-Aldosterone System Inhibitors	
Captopril	
Enalapril Maleate	
ENTRESTO	
Irbesartan	
Irbesartan/Hydrochlorothiazide	
Lisinopril	
Lisinopril/Hydrochlorothiazide	
Losartan Potassium	
Losartan Potassium/HCTZ	
Olmesartan-Medoxomil	
Olmesartan-Medoxomil/HCTZ	
Spironolactone	

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DRUG NAME	REQUIREMENTS AND LIMITS
Spironolactone/Hydrochlorothiazide	
Valsartan	
Valsartan/ Hydrochlorothiazide	
Vasodilating Agents	
ADEMPAS	LD, PA
Isosorbide Dinitrate	
Isosorbide Mononitrate	
Nitroglycerin Patch	
Nitroglycerin	
Papaverine HCL	
Sildenafil Citrate	
CENTRAL NERVOUS SYSTEM AGENTS	
Analgesics and Antipyretics	
Acetaminophen/Codeine	QL, PA
Codeine Phosphate	QL, PA
Codeine Sulfate	QL, PA
Diclofenac Sodium	
Etodolac	
Fentanyl	QL, PA
Hydrocodone/ Acetaminophen	QL, PA
Hydromorphone HCL	QL, PA
Ibuprofen	
Indomethacin	
Meloxicam	
Meperidine HCL	QL, PA
Methadone HCL	QL, PA

DRUG NAME	REQUIREMENTS AND LIMITS
Morphine Sulfate	QL, PA
Nabumetone	
Naproxen	
Oxycodone HCL	QL, PA
Oxycodone/Acetaminophen	QL, PA
Sulindac	
Tramadol HCL	QL
Antimigraine Agents	
AJOVY	QL
Naratriptan HCL	QL
Rizatriptan Benzoate ODT	QL
Sumatriptan	QL
Central Nervous System Agents, Miscellaneous	
Cabergoline	
Carbidopa	
Carbidopa/Levodopa, ER	
CELONTIN	
KYNMOBI	
Entacapone	
Memantine	
Pramipexole Dihydrochloride	
Riluzole	
Ropinirole HCL	
Selegiline	
ELECTROLYTIC, CALORIC, AND WATER BALANCE	
Acidifying and Alkalinizing Agents	
Potassium & Sodium Acid Phosphates	
Potassium Citrate (Alkalinizer)	
Sodium Citrate & Citric Acid	

LEGEND

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- Limited Distribution—LD
- Prior Authorization—PA
- Quantity Limits—QL

DRUG NAME	REQUIREMENTS AND LIMITS
Ammonia Detoxicants	
Lactulose	
Diuretics	
Amiloride HCL	
Amiloride/ Hydrochlorothiazide	
Chlorothiazide	
Chlorthalidone	
Furosemide	
Hydrochlorothiazide	
Indapamide	
Metolazone	
Torsemide	
Triamterene/ Hydrochlorothiazide	
Ion-Removing Agents	
Lanthanum	
Sevelamer	
Irrigating Solutions	
DIANEAL	
EXTRANEAL	
Replacement Preparations	
Calcium Acetate	
ELIPHOS	
LOKELMA	
PHOSLYRA	
Potassium Phosphate Dibasic/Monobasic	
Potassium Bicarbonate	
Potassium Chloride	
Potassium Phosphate Monobasic	
Uricosuric Agents	
Probenecid	

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DRUG NAME	REQUIREMENTS AND LIMITS
ENZYMES	
Enzymes	
PULMOZYME SOL	
VPRIV	
EYE, EAR, NOSE, AND THROAT (EENT) PREPARATIONS	
Antiallergic Agents	
Azelastine HCL	
Cromolyn Sodium (OP)	
Olopatadine (OP)	
Anti-Infectives	
Bacitracin (OP)	
Bacitracin/Polymyxin B (OP)	
Ciprofloxacin (OP)	
Erythromycin (OP)	
Gentamicin Sulfate (OP)	
Moxifloxacin	
NATACYN	
Ofloxacin (OP)	
Polymyxin B/Trimethoprim	
Tobramycin Sulfate (OP)	
Trifluridine	
Anti-Inflammatory Agents	
Bacitracin/Polymyxin/ Neomycin/HC	
Bromfenac Sodium (OP)	
CEQUA	
Ciprofloxacin-Dexamethasone	
COLY-MYCIN S OTIC	

- Limited Distribution—LD
- Prior Authorization—PA
- Quantity Limits—QL

DRUG NAME	REQUIREMENTS AND LIMITS
Cyclosporine (OP)	QL
Dexamethasone Sodium Phosphate (OP)	
Diclofenac Sodium (OP)	
Fluorometholone (OP)	
Flunisolide	
Flurbiprofen (OP)	
Fluticasone Propionate	
Hydrocortisone/Acetic Acid (OTIC)	
Ketorolac Tromethamine	
Neomycin/Polymyxin/Dexameth	
Neomycin/Polymyxin/HC	
PRED-G	
Prednisolone Acetate	
Prednisolone Sodium Phosphate	
Sulfacetamide Sodium/Prednisolone	
Tobramycin/Dexamethasone	
EENT Drugs, Miscellaneous	
Acetic Acid (OTIC)	
Acetic Acid/Aluminum Acetate	
Brimonidine Tartrate	
Carbachol (OP)	
Dorzolamide	
Dorzolamide/Timolol	
Latanoprost	
Levobunolol HCL	
Timolol (OP)	
Local Anesthetics	

DRUG NAME	REQUIREMENTS AND LIMITS
Lidocaine HCL	
Proparacaine HCL	
Tetracaine HCL	
Mydriatics	
Atropine Sulfate	
CYCLOMYDRIL	
Homatropine HBR	
Tropicamide	
Vasoconstrictors	
Phenylephrine HCL (OP)	
GASTROINTESTINAL DRUGS	
Antidiarrhea Agents	
Diphenoxylate/Atropine	
Antiemetics	
AKYNZEO	
Aprepitant	
Dronabinol	
Granisetron HCL	
Ondansetron HCL	
Prochlorperazine	
Scopolamine	
TRANSDERM-SCOP	
Anti-Inflammatory Agents	
Balsalazide Disodium	
Mesalamine	
PENTASA	
Antiulcer Agents and Acid Suppressants	
Famotidine	
Misoprostol	
Omeprazole	
Pantoprazole	
Sucralfate	

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DRUG NAME	REQUIREMENTS AND LIMITS
Digestants	
CREON	
GAVILYTE-C	
Pancrelipase	
ZENPEP	
GI Drugs, Miscellaneous	
AMITIZA	
Metoclopramide HCL	
PEG3350-KCL-Sodium Bicarb-Sodium Chloride-Sodium Sulfate	
Ursodiol	
HEAVY METAL ANTAGONISTS	
Heavy Metal Antagonists	
Deferasirox	
Penicillamine	
HORMONES AND SYNTHETIC SUBSTITUTES	
Adrenals	
ALVESCO	
ASMANEX	
BREZTRI	
Budesonide	
Budesonide-Formoterol Fumarate Dihydrate	
Cortisone Acetate	
Dexamethasone Sodium Phosphate	
Fludrocortisone Acetate	
Hydrocortisone	
Methylprednisolone	
MILLIPRED	
Prednisolone	
Prednisolone Sodium Phos	
Prednisone	

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DRUG NAME	REQUIREMENTS AND LIMITS
Androgens	
Danocrine	
Testosterone	QL
Contraceptives	
Desogestrel/Ethinyl Estradiol	
Drospirenone/Ethinyl Estradiol	
ELLA	
Etonogestrel-ethinyl estradiol	
Ethinodiol Diacetate/Ethinyl Estradiol	
Levonorgestrel/Ethinyl Estradiol	
Levonorgestrel/Ethinyl Estradiol (Triphasic)	
NEXPLANON	
Norethindrone	
Norethindrone/Ethinyl Estradiol	
Norethindrone Acetate/ Ethinyl Estradiol	
Norethindrone/Ethinyl Estradiol (Triphasic)	
Norgestimate/Ethinyl Estradiol (Mono & Triphasic)	
OPIII	
PLAN B ONE-STEP	
Xulane	
Diabetic Agents	
Acarbose	
BAQSIMI ONE PACK	
Diazoxide	
Glipizide	
GLUCAGON EMERGENCY 1MG VL KIT 1 ML	
HUMALOG vial; KwikPen 100u/ml	
HUMULIN N 70/30	

- Limited Distribution—LD
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- Quantity Limits—QL

DRUG NAME	REQUIREMENTS AND LIMITS
HUMULIN N	
HUMULIN R VIAL	
HUMULIN R U-500	
INSULIN DEGLUDEC FLEXTOUCH	
INSULIN GLARGINE-YFGN	
Insulin syringes/needles	
JARDIANCE	
Liraglutide	PA
Metformin HCL	
Metformin ER	
Pioglitazone HCL	
Sitagliptin	
Estrogens and Antiestrogens	
CLIMARA	
Estradiol	
Raloxifene	
YUVAFEM	
IUD	
MIRENA	
Parathyroid	
Calcitonin	QL
Pituitary	
Desmopressin Acetate	
Progestins	
Medroxyprogesterone Acetate	
Norethindrone Acetate	
Progesterone Micronized	
Somatotropin Agonist and Antagonist	
OMNITROPE	PA, QL
Thyroid and Antithyroid Agents	
Levothyroxine Sodium	
Liothyronine Sodium	

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DRUG NAME	REQUIREMENTS AND LIMITS
Methimazole	
Propylthiouracil	
MISCELLANEOUS THERAPEUTIC AGENTS	
Miscellaneous Therapeutic Agents	
Alendronate Sodium	
Allopurinol	
AMJEVITA	QL
Azathioprine	
BETASERON	QL
Bromocriptine Mesylate	
CERDELGA	LD
Cinacalcet	
Colchicine	
Cromolyn Sodium	
Dimethyl Fumarate	
Finasteride	
Fingolimod Hcl	
GENGRAF	
Glatiramer	QL
Icatibant	QL
Leflunomide	
Leucovorin Calcium	
LEVOCARNITINE (METABOLIC MODIFIERS)	
MESNEX	
Mycophenolate Mofetil	
ODACTRA	
ORENCIA	PA, QL
OTEZLA	PA, QL
SANDIMMUNE	
Sodium Fluoride	

- Limited Distribution—LD
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- Quantity Limits—QL

DRUG NAME	REQUIREMENTS AND LIMITS
Tacrolimus	
THALOMID	PA, LD
VOLUMEN	
XELJANZ	PA
Vitamins	
Folic Acid	
Iron Complex	
Phytonadione	
Pyridoxine HCL	
OXYTOCICS	
Oxytocics	
Methylergonovine Maleate	
RESPIRATORY TRACT AGENTS	
Anti-Inflammatory Agents	
Cromolyn Sodium	
FASENRA	PA, QL
Montelukast Sodium	
Antitussives	
Benzonatate	
Guaifenesin/Codeine	QL
Respiratory Agents, Miscellaneous	
Acetylcysteine	
Ambrisentan	LD
Bosentan	LD
Pirfenidone	LD
Sodium Chloride (Inhalant)	
SERUMS, TOXOIDS, AND VACCINES	
Vaccines	
COMIRNATY	
HIBERIX	
PRIORIX	

DRUG NAME	REQUIREMENTS AND LIMITS
SKIN AND MUCOUS MEMBRANE AGENTS	
Anti-Infectives (Skin and Mucous Membrane)	
Ciclopirox	
Clindamycin Phosphate	
Clotrimazole Troche	
Gentamicin Sulfate	
Ketoconazole	
Metronidazole	
Mupirocin	
Nystatin	
Salicylic Acid	
Selenium Sulfide	
Silver Nitrate/Potassium Nitrate	
Silver Sulfadiazine	
Anti-Inflammatory Agents (Skin and Mucous Membrane)	
Betamethasone Dipropionate	
Betamethasone Valerate	
Clobetasol Propionate	

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DRUG NAME	REQUIREMENTS AND LIMITS
Clobetasol Propionate	
Desoximetasone	
Diflorasone Diacetate	
Fluocinolone Acetonide	
Fluocinonide	
Hydrocortisone (Rectal)	
Hydrocortisone (Topical)	
Hydrocortisone Butyrate	
Hydrocortisone Valerate	
Mometasone Furoate	
Tacrolimus	
Triamcinolone Acetonide	
Cell Stimulants and Proliferants	
ALTRENO	
Tretinoin	
Skin and Mucous Membrane Agents, Miscellaneous	
Acitretin	
Adapalene	
Aluminum Chloride	
Azelaic acid	
Calcipotriene	
COSENTYX	PA, QL
Fluorouracil	
Imiquimod	
Isotretinoin	
Lidocaine HCL	
Lidocaine/Prilocaine	
Methoxsalen	

DRUG NAME	REQUIREMENTS AND LIMITS
PHISOHEX LIQ	
Podofilox	
SANTYL	
SMOOTH MUSCLE RELAXANTS	
Smooth Muscle Relaxants	
Aminophylline	
Darifenacin	
Mirabegron	PA
Oxybutynin Chloride	
Oxybutynin Chloride XL	
Solifenacin Succinate	
Theophylline	
Trospium	
VASODILATING AGENTS	
Miscellaneous Therapeutic Agents	
Tadalafil	PA
VITAMINS	
Vitamins	
Calcitriol	
Pediatric Multivitamins/ Fluoride	
Pediatric Multivitamins/ Fluoride/Iron	
Pediatric Multivitamins ACD/ Fluoride	
Pediatric Multivitamins ACD/ Fluoride/Iron	
Prenatal Vitamins	

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Over-the-counter drug coverage

Along with prescription benefits, Kaiser Permanente covers the following over-the-counter medications with a written or verbal prescription from a provider.

DRUG NAME	REQUIREMENTS AND LIMITS
ANALGESICS	
Aspirin	
Aspirin Buffered	
ANTI-HISTAMINES	
Cetirizine HCL	
Fexofenadine HCL	
Loratadine	
CONTRACEPTIVES	
Latex Condoms (covered with or without a prescription)	QL
Levonorgestrel (covered with or without a prescription)	
Nonoxynol-9	
IRON SUPPLEMENTS	
Ferrous Sulfate	

DRUG NAME	REQUIREMENTS AND LIMITS
NASAL PREPARATIONS	
NASACORT ALLERGY	
PEDIATRIC ELECTROLYTE SOLUTION	
Oral Electrolytes	
SUPPLEMENTS/VITAMINS	
Ergocalciferol Solution	
Multivitamins/Iron	
Multivitamins/Minerals	
Vitamin D	

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Nondiscrimination Statement

It is the policy of Kaiser Foundation Health Plan of the Mid-Atlantic, Inc. (Kaiser Health Plan) not to discriminate on the basis of race, color, national origin, sex, age or disability. Kaiser Health Plan has adopted an internal grievance procedure providing for prompt and equitable resolution of complaints alleging any action prohibited by Section 1557 of the Affordable Care Act (42 U.S.C. 18116) and its implementing regulations at 45 CFR part 92, issued by the U.S. Department of Health and Human Services. Section 1557 prohibits discrimination on the basis of race, color, national origin, sex, age or disability in certain health programs and activities. Section 1557 and its implementing regulations may be examined in the office of Kaiser Civil Rights Coordinator, 2101 East Jefferson Street, Rockville, MD 20852, telephone number: 1-800-777- 7902, who has been designated to coordinate the efforts of the Kaiser Health Plan to comply with Section 1557.

Any person who believes someone has been subjected to discrimination on the basis of race, color, national origin, sex, age or disability may file a grievance under this procedure. It is against the law for Kaiser Health Plan to retaliate against anyone who opposes discrimination, files a grievance, or participates in the investigation of a grievance.

Procedure:

- Grievances must be submitted to the Section 1557 Coordinator within (60 days) of the date the person filing the grievance becomes aware of the alleged discriminatory action.
- A complaint must be in writing, containing the name and address of the person filing it. The complaint must state the problem or action alleged to be discriminatory and the remedy or relief sought.
- The Section 1557 Coordinator (or her/his designee) shall conduct an investigation of the complaint. This investigation may be informal, but it will be thorough, affording all interested persons an opportunity to submit evidence relevant to the complaint. The Section 1557 Coordinator will maintain the files and records of Kaiser Health Plan relating to such grievances. To the extent possible, and in accordance with applicable law, the Section 1557 Coordinator will take appropriate steps to preserve the confidentiality of files and records relating to grievances and will share them only with those who have a need to know.
- The Section 1557 Coordinator will issue a written decision on the grievance, based on a preponderance of the evidence, no later than 30 days after its filing, including a notice to the complainant of their right to pursue further administrative or legal remedies.

The availability and use of this grievance procedure does not prevent a person from pursuing other legal or administrative remedies, including filing a complaint of discrimination on the basis of race, color, national origin, sex, age or disability in court or with the U.S. Department of Health and Human Services, Office for Civil Rights. A person can file a complaint of

discrimination electronically through the Office for Civil Rights Complaint Portal, which is available at: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201. Toll free#: 800-368-1019 TDD: 800-537-7697

Complaint forms are available at: <http://www.hhs.gov/ocr/office/file/index.html>. Such complaints must be filed within 180 days of the date of the alleged discrimination.

Kaiser Health Plan will make appropriate arrangements to ensure that individuals with disabilities and individuals with limited English proficiency are provided auxiliary aids and services or language assistance services, respectively, if needed to participate in this grievance process. Such arrangements may include, but are not limited to, providing qualified interpreters, providing taped cassettes of material for individuals with low vision, or assuring a barrier-free location for the proceedings. The Section 1557 Coordinator will be responsible for such arrangements.

Language Accessibility Statement

Interpreter Services Are Available for Free

ATTENTION: *If you speak [language], language assistance services, free of charge, are available to you. Call 855-249-5019 (TTY: 711).*

Español/Spanish

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 855-249-5019 (TTY: 711).

አማርኛ/Amharic

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጅተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 855-249-5019 (መስማት ለተሳናቸው: 711)፡

العربية/Arabic

رقم (855-249-5019 ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم

-هاتف الصم والبكم: 117)

Bàsòò-wùdù-po-nyò /Bassa

Dè dɛ nià kɛ dyédé gbo: ɔ jũ ké m̩ [Bàsò ò -wùdù-po-nyò] jũ ní, nií, à wuɖu kà kò dò po-poò bɛ in m̩ gbo kpáa. Dá 855-249-5019 (TTY: 711).

中文/Chinese

注意: 如果您使用繁體中文, 您可以免費獲得語言援助服務。請致電855-249-5019 (TTY: 711)。

فارسی/Farsi

855-249-5019 توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما بگيريد تماس ((TTY: 711)) با. باشد می فر

Français/French

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 855-249-5019 (ATS: 711).

ગુજરાતી/Gujarati

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે.

ફોન કરો

855-249-5019 (TTY: 711).

kreyòl ayisyen/Haitian Creole

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele - **855-249-5019** (TTY: 711).

Igbo

Ntị: Ọ bụrụ na asụ Ibo, asụsụ aka ọasụ n'efu, defu, aka. Call **855-249-5019** (TTY: 711).

한국어/Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **855-249-5019** (TTY: 711).)번으로 전화해 주십시오.

Português/Portuguese

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para **855-249-5019** (TTY: 711).

Русский/Russian

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **855-249-5019** (телетайп: 711).

Tagalog

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **855-249-5019** (TTY: 711).

اردو/Urdu

خدمات مفت میں دستیاب ہیں۔ کال خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی

کریں۔ **(855-249-5019)** (TTY: 711).

Tiếng Việt/Vietnamese

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **855-249-5019** (TTY: 711).

Yorùbá/Yoruba

AKIYESI: Bi o ba nsọ èdè Yorùbú ọfẹ ni iranlọwọ lori èdè wa fun yin o. E pe ẹrọ-ibanisọrọ yi 1- **855-249-5019** (TTY: 711).