

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE OCTOBER 1, 2021

- Generic Drugs Are Preferred Over Brand Name Drugs Unless The Drug Is Specified As BRAND ONLY
- Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List May Be Available Through Prior Authorization

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	Prior Authorization Type	Step Therapy Requirements	Quantity Limit (QL)	QL Days
ADHD/ANTI-NARCOLEPSY							
Amphetamines							
AMPHETAMINE-DEXTROAMPHETAMINE CAPSULE 24-HOUR	ADDERALL XR	BRAND ONLY	PREFERRED DRUG	PA Required for Ages < 6 years of age		30	30
AMPHETAMINE-DEXTROAMPHETAMINE TABLETS	ADDERALL	Brand & Generic	PREFERRED DRUG	PA Required for Ages < 6 years of age		60	30
DEXTROAMPHETAMINE SULFATE TABLETS	VARIOUS		PREFERRED DRUG	PA Required for Ages < 6 years of age		60	30
LISDEXAMFETAMINE DIMESYLATE CAPSULES	VYVANSE	BRAND ONLY	PREFERRED DRUG	PA Required for Ages < 6 years of age		30	30
Stimulants							
DEXMETHYLPHENIDATE HCL CAPSULE 24-HOUR	FOCALIN XR	BRAND ONLY	PREFERRED DRUG	PA Required for Ages < 6 years of age		60	30
DEXMETHYLPHENIDATE HCL TABLETS	VARIOUS		PREFERRED DRUG	PA Required for Ages < 6 years of age		60	30
METHYLPHENIDATE HCL CHEWABLE TABLETS	METHYLIN		PREFERRED DRUG	PA Required for Ages < 6 years of age		90	30
METHYLPHENIDATE HCL CAPSULE 24-HOUR	RITALIN LA 10MG	BRAND ONLY	PREFERRED DRUG	PA Required for Ages < 6 years of age		30	30
METHYLPHENIDATE HCL CAPSULE CONTROLLED RELEASE CD	VARIOUS		PREFERRED DRUG	PA Required for Ages < 6 years of age		30	30
METHYLPHENIDATE PATCH	DAYTRANA	BRAND ONLY	PREFERRED DRUG	PA Required for Ages < 6 years of age		30	30
METHYLPHENIDATE HCL SOLUTION	METHYLIN	BRAND ONLY	PREFERRED DRUG	PA Required for Ages < 6 years of age		300	30
METHYLPHENIDATE HCL TABLETS	VARIOUS		PREFERRED DRUG	PA Required for Ages < 6 years of age		90	30
METHYLPHENIDATE HCL TABLET EXTENDED RELEASE	RITALIN LA	BRAND ONLY	PREFERRED DRUG	PA Required for Ages < 6 years of age		60	30
METHYLPHENIDATE HCL TABLET CONTROLLED RELEASE	CONCERTA	BRAND ONLY	PREFERRED DRUG	PA Required for Ages < 6 years of age		60	30
Miscellaneous Agents							
ATOMOXETINE HCL CAPSULES	VARIOUS		PREFERRED DRUG	PA Required for Ages < 6 years of age		30	30
Central Alpha-Agonists							
clonidine hcl	Catapres			PA Required for Ages < 6 years of age			
clonidine hcl transdermal patch	Catapres Patches			PA Required for Ages < 6 years of age		4	28
CLONIDINE HCL (ADHD) TABLET 12-HOUR	Clonidine ER		PREFERRED DRUG	PA Required for Ages < 6 years of age		120	30
GUANFACINE HCL (ADHD) TABLET 24-HOUR	GUANFACINE ER		PREFERRED DRUG	PA Required for Ages < 6 years of age		30	30
guanfacine hcl	Tenex			PA Required for Ages < 6 years of age			
AMINOGLYCOSIDES							
AMINOGLYCOSIDES							
NEOMYCIN SULFATE TABLETS	NEOMYCIN SULFATE						
INHALED ANTIBIOTICS							

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE OCTOBER 1, 2021

- Generic Drugs Are Preferred Over Brand Name Drugs Unless The Drug Is Specified As BRAND ONLY
- Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List May Be Available Through Prior Authorization

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	Prior Authorization Type	Step Therapy Requirements	Quantity Limit (QL)	QL Days
TOBRAMYCIN NEBULIZED	BETHKIS	BRAND ONLY	PREFERRED DRUG	PA Required			
TOBRAMYCIN NEBULIZED	KITABIS	BRAND ONLY	PREFERRED DRUG	PA Required			
ANALGESICS - ANTI-INFLAMMATORY							
ANTIRHEUMATIC ANTIMETABOLITES							
METHOTREXATE SODIUM TABLETS	RHEUMATREX						
NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (NSAIDS)							
CELECOXIB CAPSULES	CELEBREX			PA Required			
DICLOFENAC SODIUM TABLET 24-HOUR	VOLTAREN-XR						
DICLOFENAC SODIUM TABLET ENTERIC COATED	VOLTAREN						
ETODOLAC CAPSULES	VARIOUS						
ETODOLAC TABLETS	VARIOUS						
FENOPROFEN CALCIUM CAPSULES	NALFON						
FENOPROFEN CALCIUM TABLETS	FENOPROFEN CALCIUM						
FLURBIPROFEN TABLETS	FLURBIPROFEN						
IBUPROFEN CAPSULES	ADVIL						
IBUPROFEN CHEWABLE TABLETS	CHILDRENS MOTRIN						
IBUPROFEN SUSPENSION	CHILDRENS MOTRIN						
IBUPROFEN TABLETS	ADVIL						
INDOMETHACIN CAPSULES	VARIOUS						
INDOMETHACIN CAPSULE CONTROLLED RELEASE	INDOMETHACIN CR						
INDOMETHACIN SUPPOSITORY	INDOCIN						
INDOMETHACIN SUSPENSION	INDOCIN						
KETOPROFEN CAPSULES	ORUDIS						
KETOROLAC TROMETHAMINE TABLETS	KETOROLAC TROMETHAMINE					20	30
MELOXICAM SUSPENSION	MOBIC						
MELOXICAM TABLETS	MOBIC						
NABUMETONE TABLETS	NABUMETONE						
NAPROXEN SODIUM TABLETS	ALEVE. ANAPROX						
NAPROXEN SUSPENSION	NAPROSYN						
NAPROXEN TABLETS	NAPROSYN						

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE OCTOBER 1, 2021

- Generic Drugs Are Preferred Over Brand Name Drugs Unless The Drug Is Specified As BRAND ONLY
- Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List May Be Available Through Prior Authorization

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	Prior Authorization Type	Step Therapy Requirements	Quantity Limit (QL)	QL Days
OXAPROZIN TABLETS	DAYPRO						
PIROXICAM CAPSULES	FELDENE						
SULINDAC TABLETS	SULINDAC						
PYRIMIDINE SYNTHESIS INHIBITORS							
LEFLUNOMIDE TABLETS	ARAVA						
CYTOKINE & CAM ANTAGONIST AGENTS							
ADALIMUMAB	HUMIRA	BRAND ONLY	PREFERRED DRUG	PA Required			
APREMILAST	OTEZLA	BRAND ONLY	PREFERRED DRUG	PA Required			
ETANERCEPT	ENBREL	BRAND ONLY	PREFERRED DRUG	PA Required			
TOFACITINIB CITRATE	XELJANZ IMMEDIATE RELEASE ONLY	BRAND ONLY	PREFERRED DRUG	PA Required			
ANALGESICS - NONNARCOTIC							
ANALGESIC COMBINATIONS							
BUTALBITAL-ACETAMINOPHEN-CAFFEINE TABLETS	VARIOUS					120	30
BUTALBITAL-ASPIRIN-CAFFEINE TABLETS	VARIOUS					120	30
ANALGESICS OTHER							
ACETAMINOPHEN CAPSULES	VARIOUS						
ACETAMINOPHEN CHEWABLE TABLETS	VARIOUS						
ACETAMINOPHEN ELIXIR	VARIOUS						
ACETAMINOPHEN LIQUID	VARIOUS						
ACETAMINOPHEN SUPPOSITORY	FEVERALL INFANTS						
ACETAMINOPHEN SUSPENSION	TYLENOL INFANTS						
SALICYLATES							
ASPIRIN CHEWABLE TABLETS	VARIOUS						
ASPIRIN SUPPOSITORY	VARIOUS						
ASPIRIN TABLETS	VARIOUS						
DIFLUNISAL TABLETS	DIFLUNISAL						
SALSALATE TABLETS	DISALCID						
ANALGESICS - OPIOID							
LONG-ACTING OPIOID AGONISTS							

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE OCTOBER 1, 2021

- Generic Drugs Are Preferred Over Brand Name Drugs Unless The Drug Is Specified As BRAND ONLY
- Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List May Be Available Through Prior Authorization

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	Prior Authorization Type	Step Therapy Requirements	Quantity Limit (QL)	QL Days
FENTANYL PATCH 72-HOUR 12mcg, 25mcg, 50mcg, 75mcg & 100mcg	DURAGESIC 12mcg, 25mcg, 50mcg, 75mcg & 100mcg		PREFERRED DRUG	PA Required			
MORPHINE-NALTREXONE CAPSULE CONTROLLED RELEASE	EMBEDA	BRAND ONLY	PREFERRED DRUG	PA Required			
MORPHINE SULFATE TABLET CONTROLLED RELEASE	VARIOUS		PREFERRED DRUG	PA Required			
OXYCODONE HCL TABLET 12-HOUR ABUSE DETERRANT	XTAMPZA ER	BRAND ONLY	PREFERRED DRUG	PA Required			
TRAMADOL HCL TABLETS ER	ULTRAM ER		PREFERRED DRUG	PA Required			
BUPRENORPHINE PATCH WEEKLY	BUTRANS	BRAND ONLY	PREFERRED DRUG	PA Required			
SHORT-ACTING OPIOID AGONISTS							
HYDROMORPHONE HCL LIQUID	DILAUDID			PA Required for > 2 Short Acting Opioid Medications in a 30-day time period.			
HYDROMORPHONE HCL SUPPOSITORY	HYDROMORPHONE HCL			PA Required for > 2 Short Acting Opioid Medications in a 30-day time period.			
HYDROMORPHONE HCL TABLETS	DILAUDID			PA Required for > 2 Short Acting Opioid Medications in a 30-day time period.			
MEPERIDINE HCL TABLETS	DEMEROL			PA Required for > 2 Short Acting Opioid Medications in a 30-day time period.			
MORPHINE SULFATE SOLUTION	MORPHINE SULFATE			PA Required for > 2 Short Acting Opioid Medications in a 30-day time period.			
MORPHINE SULFATE SUPPOSITORY	MORPHINE SULFATE			PA Required for > 2 Short Acting Opioid Medications in a 30-day time period.			
MORPHINE SULFATE TABLETS	MORPHINE SULFATE			PA Required for > 2 Short Acting Opioid Medications in a 30-day time period.			
OXYCODONE HCL CAPSULES	OXYCODONE HCL			PA Required for > 2 Short Acting Opioid Medications in a 30-day time period.			
OXYCODONE HCL CONCENTRATE	OXYCODONE HCL			PA Required for > 2 Short Acting Opioid Medications in a 30-day time period.			
OXYCODONE HCL SOLUTION	OXYCODONE HCL			PA Required for > 2 Short Acting Opioid Medications in a 30-day time period.			
OXYCODONE HCL TABLETS	ROXICODONE			PA Required for > 2 Short Acting Opioid Medications in a 30-day time period.			

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE OCTOBER 1, 2021

- Generic Drugs Are Preferred Over Brand Name Drugs Unless The Drug Is Specified As BRAND ONLY
- Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List May Be Available Through Prior Authorization

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	Prior Authorization Type	Step Therapy Requirements	Quantity Limit (QL)	QL Days
TRAMADOL HCL TABLETS	ULTRAM			PA Required for > 2 Short Acting Opioid Medications in a 30-day time period.			
OPIOID COMBINATIONS							
ACETAMINOPHEN W/ CODEINE SOLUTION	ACETAMINOPHEN/CODEINE			PA Required for > 2 Short Acting Opioid Medications in a 30-day time period.			
ACETAMINOPHEN W/ CODEINE TABLETS	ACETAMINOPHEN/CODEINE			PA Required for > 2 Short Acting Opioid Medications in a 30-day time period.			
BUTALBITAL-ACETAMINOPHEN-CAFFEINE W/ CODEINE CAPSULES	FIORICET/CODEINE			PA Required for > 2 Short Acting Opioid Medications in a 30-day time period.			
BUTALBITAL-ASPIRIN-CAFFEINE W/COD CAPSULES	ASCOMP/CODEINE			PA Required for > 2 Short Acting Opioid Medications in a 30-day time period.			
HYDROCODONE-ACETAMINOPHEN CAPSULES	HYDROGESIC			PA Required for > 2 Short Acting Opioid Medications in a 30-day time period.			
HYDROCODONE-ACETAMINOPHEN SOLUTION	HYCET			PA Required for > 2 Short Acting Opioid Medications in a 30-day time period.			
HYDROCODONE-ACETAMINOPHEN TABLETS	VERDROCET			PA Required for > 2 Short Acting Opioid Medications in a 30-day time period.			
HYDROCODONE-IBUPROFEN TABLETS	REPREXAIN			PA Required for > 2 Short Acting Opioid Medications in a 30-day time period.			
OXYCODONE W/ ACETAMINOPHEN CAPSULES	OXYCODONE/ ACETAMINOPHEN			PA Required for > 2 Short Acting Opioid Medications in a 30-day time period.			
OXYCODONE W/ ACETAMINOPHEN SOLUTION	ROXICET			PA Required for > 2 Short Acting Opioid Medications in a 30-day time period.			
OXYCODONE W/ ACETAMINOPHEN TABLETS	ENDOCET			PA Required for > 2 Short Acting Opioid Medications in a 30-day time period.			
OXYCODONE-IBUPROFEN TABLETS	OXYCODONE/IBUPROFEN			PA Required for > 2 Short Acting Opioid Medications in a 30-day time period.			
ANTIDOTES							
OPIOID ANTAGONISTS							
NALOXONE HCL SOLUTION + SYRINGE	NALOXONE HCL + SYRINGE		PREFERRED DRUG				

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE OCTOBER 1, 2021

- Generic Drugs Are Preferred Over Brand Name Drugs Unless The Drug Is Specified As BRAND ONLY
- Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List May Be Available Through Prior Authorization

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	Prior Authorization Type	Step Therapy Requirements	Quantity Limit (QL)	QL Days
NALOXONE HCL NASAL SPRAY	NARCAN NASAL SPRAY		PREFERRED DRUG				
NALTREXONE HCL TABLETS	NALTREXONE HCL		PREFERRED DRUG				
NALTREXONE SUSPENSION	VIVITROL		PREFERRED DRUG				
OPIOID AGONISTS							
BUPRENORPHINE	VARIOUS			PA Required unless the member is pregnant or nursing. The prescriber must note the following ICD-10 codes on the prescription: 1. 009.91- Supervision of high risk pregnancy, 1st Trimester. 2. 009.92- Supervision of high risk pregnancy, 2nd Trimester. 3. 009.93- Supervision of high risk pregnancy, 3rd Trimester. 4. 009.91- Supervision of high risk pregnancy-use for Postpartum Nursing Mothers. The first digit of the diagnosis code is the Letter - O and the second is a Zero - 0			
BUPRENORPHINE HCL-NALOXONE HCL DIHYDRATE FILM	SUBOXONE FILM	BRAND ONLY	PREFERRED DRUG				
BUPRENORPHINE HCL-NALOXONE HCL DIHYDRATE ORALLY DISINTEGRATING TABLETS	VARIOUS	GENERIC FORMULATIONS ONLY	PREFERRED DRUG				
BUPRENORPHINE EXTENDED RELEASE INJECTION	SUBLOCADE	BRAND ONLY	PREFERRED DRUG	PA Required			
METHADONE	VARIOUS			Only available at an Opioid Treatment Program (OTP) provider.			
MISCELLANEOUS AGENTS							
ACAMPROSATE	VARIOUS						
DISULFIRAM	ANTABUSE						
ANDROGENS-ANABOLIC							

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE OCTOBER 1, 2021

- Generic Drugs Are Preferred Over Brand Name Drugs Unless The Drug Is Specified As BRAND ONLY
- Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List May Be Available Through Prior Authorization

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	Prior Authorization Type	Step Therapy Requirements	Quantity Limit (QL)	QL Days
ANDROGENS							
DANAZOL CAPSULES	DANAZOL						
TESTOSTERONE CYPIONATE SOLUTION	DEPO-TESTOSTERONE			PA Required			
TESTOSTERONE ENANTHATE SOLUTION	TESTOSTERONE ENANTHATE			PA Required			
TESTOSTERONE GEL	ANDROGEL	BRAND ONLY	PREFERRED DRUG	PA Required			
TESTOSTERONE PATCH	ANDRODERM			PA Required			
ANORECTAL AGENTS							
INTRARECTAL STEROIDS							
HYDROCORTISONE (INTRARECTAL) ENEMA	COLOCORT						
HYDROCORTISONE ACETATE (INTRARECTAL) FOAM	CORTIFOAM						
RECTAL STEROIDS							
HYDROCORTISONE (RECTAL) CREAM	PROCTOCORT						
ANTHELMINTICS							
ANTHELMINTICS							
ALBENDAZOLE TABLETS	ALBENZA			PA Required			
IVERMECTIN TABLETS	STROMEKTOL			PA Required			
PRAZIQUANTEL TABLETS	BILTRICIDE						
ANTIANGINAL AGENTS							
ANTIANGINALS-OTHER							
RANOLAZINE TABLET 12-HOUR	RANEXA			PA Required			
NITRATES							
ISOSORBIDE DINITRATE CAPSULE CONTROLLED RELEASE	DILATRATE SR						
ISOSORBIDE DINITRATE SUBLINGUAL	ISOSORBIDE DINITRATE						
ISOSORBIDE DINITRATE TABLETS	ISORDIL TITRADOSE						
ISOSORBIDE DINITRATE TABLET CONTROLLED RELEASE	ISOSORBIDE DINITRATE ER						
ISOSORBIDE MONONITRATE TABLETS	ISOSORBIDE MONONITRATE						
ISOSORBIDE MONONITRATE TABLET 24-HOUR	IMDUR						
NITROGLYCERIN CAPSULE CONTROLLED RELEASE	NITRO-TIME						
NITROGLYCERIN OINTMENT	NITRO-BID						
NITROGLYCERIN PATCH 24-HOUR	NITRO-DUR						

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE OCTOBER 1, 2021

<ul style="list-style-type: none"> • Generic Drugs Are Preferred Over Brand Name Drugs Unless The Drug Is Specified As BRAND ONLY • Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List May Be Available Through Prior Authorization 							
Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	Prior Authorization Type	Step Therapy Requirements	Quantity Limit (QL)	QL Days
NITROGLYCERIN SUBLINGUAL	NITROSTAT						
ANTI-ANXIETY AGENTS							
ANTI-ANXIETY AGENTS - MISC.							
BUSPIRONE HCL TAB 5 MG	BUSPIRONE HCL			PA Required for Ages < 6 years. PA Required for > 1 Anxiolytic Medication in a 30-day time period.		120	30
BUSPIRONE HCL TAB 7.5 MG	BUSPIRONE HCL			PA Required for Ages < 6 years. PA Required for > 1 Anxiolytic Medication in a 30-day time period.		120	30
BUSPIRONE HCL TAB 10 MG	BUSPIRONE HCL			PA Required for Ages < 6 years. PA Required for > 1 Anxiolytic Medication in a 30-day time period.		120	30
BUSPIRONE HCL TAB 15 MG	BUSPIRONE HCL			PA Required for Ages < 6 years. PA Required for > 1 Anxiolytic Medication in a 30-day time period.		120	30
BUSPIRONE HCL TAB 30 MG	BUSPIRONE HCL			PA Required for Ages < 6 years. PA Required for > 1 Anxiolytic Medication in a 30-day time period.		60	30
HYDROXYZINE HCL SYRUP	HYDROXYZINE SYRUP					300	30
HYDROXYZINE HCL TABLETS	HYDROXYZINE TABLETS					240	30
HYDROXYZINE PAMOATE CAPSULES	VISTARIL					120	30
BENZODIAZEPINES							
ALPRAZOLAM CONC 1 MG/ML	ALPRAZOLAM INTENSOL			PA Required for Ages < 6 years. PA Required for > 1 Anxiolytic Medication in a 30-day time period.		60	15
ALPRAZOLAM ORALLY DISINTEGRATING TAB 0.25 MG	VARIOUS			PA Required for Ages < 6 years. PA Required for > 1 Anxiolytic Medication in a 30-day time period.		120	30
ALPRAZOLAM ORALLY DISINTEGRATING TAB 0.5 MG	VARIOUS			PA Required for Ages < 6 years. PA Required for > 1 Anxiolytic Medication in a 30-day time period.		120	30

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE OCTOBER 1, 2021

- Generic Drugs Are Preferred Over Brand Name Drugs Unless The Drug Is Specified As BRAND ONLY
- Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List May Be Available Through Prior Authorization

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	Prior Authorization Type	Step Therapy Requirements	Quantity Limit (QL)	QL Days
ALPRAZOLAM ORALLY DISINTEGRATING TAB 1 MG	VARIOUS			PA Required for Ages < 6 years. PA Required for > 1 Anxiolytic Medication in a 30-day time period.		120	30
ALPRAZOLAM ORALLY DISINTEGRATING TAB 2 MG	VARIOUS			PA Required for Ages < 6 years. PA Required for > 1 Anxiolytic Medication in a 30-day time period.		60	30
ALPRAZOLAM TAB 0.25 MG	VARIOUS			PA Required for Ages < 6 years. PA Required for > 1 Anxiolytic Medication in a 30-day time period.		120	30
ALPRAZOLAM TAB 0.5 MG	VARIOUS			PA Required for Ages < 6 years. PA Required for > 1 Anxiolytic Medication in a 30-day time period.		120	30
ALPRAZOLAM TAB 1 MG	VARIOUS			PA Required for Ages < 6 years. PA Required for > 1 Anxiolytic Medication in a 30-day time period.		120	30
ALPRAZOLAM TAB 2 MG	VARIOUS			PA Required for Ages < 6 years. PA Required for > 1 Anxiolytic Medication in a 30-day time period.		60	30
ALPRAZOLAM TAB SR 24HR 0.5 MG	VARIOUS			PA Required for Ages < 6 years. PA Required for > 1 Anxiolytic Medication in a 30-day time period.		30	30
ALPRAZOLAM TAB SR 24HR 1 MG	VARIOUS			PA Required for Ages < 6 years. PA Required for > 1 Anxiolytic Medication in a 30-day time period.		30	30
ALPRAZOLAM TAB SR 24HR 2 MG	VARIOUS			PA Required for Ages < 6 years. PA Required for > 1 Anxiolytic Medication in a 30-day time period.		30	30
ALPRAZOLAM TAB SR 24HR 3 MG	VARIOUS			PA Required for Ages < 6 years. PA Required for > 1 Anxiolytic Medication in a 30-day time period.		30	30

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE OCTOBER 1, 2021

- Generic Drugs Are Preferred Over Brand Name Drugs Unless The Drug Is Specified As BRAND ONLY
- Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List May Be Available Through Prior Authorization

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

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE OCTOBER 1, 2021

- Generic Drugs Are Preferred Over Brand Name Drugs Unless The Drug Is Specified As BRAND ONLY
- Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List May Be Available Through Prior Authorization

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	Prior Authorization Type	Step Therapy Requirements	Quantity Limit (QL)	QL Days
CLONAZEPAM ODT 2MG	VARIOUS			PA Required for Ages < 6 years. PA Required for > 1 Anxiolytic Medication in a 30-day time period.		60	30
CLORAZEPATE DIPOTASSIUM TAB 15 MG	VARIOUS			PA Required for Ages < 6 years. PA Required for > 1 Anxiolytic Medication in a 30-day time period.		60	30
CLORAZEPATE DIPOTASSIUM TAB 3.75 MG	VARIOUS			PA Required for Ages < 6 years. PA Required for > 1 Anxiolytic Medication in a 30-day time period.		120	30
CLORAZEPATE DIPOTASSIUM TAB 7.5 MG	VARIOUS			PA Required for Ages < 6 years. PA Required for > 1 Anxiolytic Medication in a 30-day time period.		120	30
DIAZEPAM CONC 5 MG/ML	DIAZEPAM INTENSOL			PA Required for Ages < 6 years. PA Required for > 1 Anxiolytic Medication in a 30-day time period.		60	30
DIAZEPAM SOLN 1 MG/ML	VARIOUS			PA Required for Ages < 6 years. PA Required for > 1 Anxiolytic Medication in a 30-day time period.		300	30
DIAZEPAM TAB 10 MG	VARIOUS			PA Required for Ages < 6 years. PA Required for > 1 Anxiolytic Medication in a 30-day time period.		120	30
DIAZEPAM TAB 2 MG	VARIOUS			PA Required for Ages < 6 years. PA Required for > 1 Anxiolytic Medication in a 30-day time period.		120	30
DIAZEPAM TAB 5 MG	VARIOUS			PA Required for Ages < 6 years. PA Required for > 1 Anxiolytic Medication in a 30-day time period.		120	30
LORAZEPAM CONC 2 MG/ML	LORAZEPAM INTENSOL			PA Required for Ages < 6 years. PA Required for > 1 Anxiolytic Medication in a 30-day time period.		60	30

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE OCTOBER 1, 2021

- Generic Drugs Are Preferred Over Brand Name Drugs Unless The Drug Is Specified As BRAND ONLY
- Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List May Be Available Through Prior Authorization

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	Prior Authorization Type	Step Therapy Requirements	Quantity Limit (QL)	QL Days
LORAZEPAM TAB 0.5 MG	VARIOUS			PA Required for Ages < 6 years. PA Required for > 1 Anxiolytic Medication in a 30-day time period.		120	30
LORAZEPAM TAB 1 MG	VARIOUS			PA Required for Ages < 6 years. PA Required for > 1 Anxiolytic Medication in a 30-day time period.		120	30
LORAZEPAM TAB 2 MG	VARIOUS			PA Required for Ages < 6 years. PA Required for > 1 Anxiolytic Medication in a 30-day time period.		60	30
OXAZEPAM CAP 10 MG	VARIOUS			PA Required for Ages < 6 years. PA Required for > 1 Anxiolytic Medication in a 30-day time period.		60	30
OXAZEPAM CAP 15 MG	VARIOUS			PA Required for Ages < 6 years. PA Required for > 1 Anxiolytic Medication in a 30-day time period.		60	30
OXAZEPAM CAP 30 MG	VARIOUS			PA Required for Ages < 6 years. PA Required for > 1 Anxiolytic Medication in a 30-day time period.		60	30
ANTIARRHYTHMICS							
ANTIARRHYTHMICS TYPE I-A							
DISOPYRAMIDE PHOSPHATE CAPSULES	NORPACE						
DISOPYRAMIDE PHOSPHATE CAPSULE 12-HOUR	NORPACE CR						
QUINIDINE GLUCONATE TABLET CONTROLLED RELEASE	QUINIDINE GLUCONATE CR						
QUINIDINE SULFATE TABLETS	QUINIDINE SULFATE						
QUINIDINE SULFATE TABLET CONTROLLED RELEASE	QUINIDINE SULFATE ER						
ANTIARRHYTHMICS TYPE I-B							
MEXILETINE HCL CAPSULES	MEXILETINE HCL						
ANTIARRHYTHMICS TYPE I-C							
FLECAINIDE ACETATE TABLETS	TAMBOCOR						
PROPAFENONE HCL CAPSULE 12-HOUR	RYTHMOL SR						

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE OCTOBER 1, 2021

- Generic Drugs Are Preferred Over Brand Name Drugs Unless The Drug Is Specified As BRAND ONLY
- Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List May Be Available Through Prior Authorization

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	Prior Authorization Type	Step Therapy Requirements	Quantity Limit (QL)	QL Days
PROPAFENONE HCL TABLETS	RYTHMOL						
ANTIARRHYTHMICS TYPE III							
AMIODARONE HCL TABLETS 100MG & 200MG	PACERONE						
DOFETILIDE CAPSULES	TIKOSYN			PA Required			
DRONEDARONE HCL TABLETS	MULTAQ			PA Required			
ANTIASTHMATIC AND BRONCHODILATOR AGENTS							
ANTI-INFLAMMATORY AGENTS							
CROMOLYN SODIUM NEBULIZER	CROMOLYN SODIUM						
BRONCHODILATORS - ANTICHOLINERGICS							
ACLIDINIUM BROMIDE	TUDORZA PRESSAIR		PREFERRED DRUG				
IPRATROPIUM BROMIDE HFA AEROSOL	ATROVENT HFA		PREFERRED DRUG				
IPRATROPIUM BROMIDE SOLUTION	IPRATROPIUM BROMIDE		PREFERRED DRUG				
TIOTROPIUM BROMIDE MONOHYDRATE CAPSULES	SPIRIVA HANDIHALER		PREFERRED DRUG				
LEUKOTRIENE MODULATORS							
MONTELUKAST SODIUM CHEWABLE TABLETS	SINGULAIR		PREFERRED DRUG			30	30
MONTELUKAST SODIUM GRANULES	SINGULAIR			PA IS NOT Required for < 4 Years of Age		30	30
MONTELUKAST SODIUM TABLETS	SINGULAIR		PREFERRED DRUG			30	30
STEROID INHALANTS							
BUDESONIDE (INHALATION) SUSPENSION 0.25MG, 0.50MG & 1.0MG	PULMICORT	VARIOUS	PREFERRED DRUG	PA IS NOT Required for < 4 Years of Age			
BUDESONIDE INHALATION POWDER	PULMICORT FLEXHALER	BRAND ONLY	PREFERRED DRUG				
FLUTICASONE PROPIONATE HFA AERO	FLOVENT HFA	BRAND ONLY	PREFERRED DRUG				
FLUTICASONE PROPIONATE ORAL INHALATION	FLOVENT DISKUS	BRAND ONLY	PREFERRED DRUG				
MOMETASONE FUROATE (INHALATION) AEPB	ASMANEX TWISTHALER		PREFERRED DRUG				
SYMPATHOMIMETICS							
ALBUTEROL SULFATE AEROSOL	PROAIR HFA- BRAND ONLY	BRAND Only	PREFERRED DRUG	PROAIR IS THE ONLY PREFERRED ALBUTEROL INHALER ON THE AHCCCS DRUG LIST.			
ALBUTEROL SULFATE NEBULIZED	ALBUTEROL SULFATE		PREFERRED DRUG				
ALBUTEROL SULFATE SYRUP	ALBUTEROL SULFATE		PREFERRED DRUG				

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE OCTOBER 1, 2021

- Generic Drugs Are Preferred Over Brand Name Drugs Unless The Drug Is Specified As BRAND ONLY
- Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List May Be Available Through Prior Authorization

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	Prior Authorization Type	Step Therapy Requirements	Quantity Limit (QL)	QL Days
BUDESONIDE-FORMOTEROL FUMARATE DIHYDRATE AEROSOL	SYMBICORT	BRAND ONLY	PREFERRED DRUG	Step Therapy	Patient must have tried one steroid inhaler: Beclomethasone Dipropionate, Budesonide, Fluticasone Propionate, or Mometasone		
FLUTICASONE-SALMETEROL ORAL INHALATION	ADVAIR DISKUS	BRAND ONLY	PREFERRED DRUG	Step Therapy	Patient must have tried one steroid inhaler: Beclomethasone Dipropionate, Budesonide, Fluticasone Propionate, or Mometasone		
FLUTICASONE-SALMETEROL AEROSOL	ADVAIR HFA	BRAND ONLY	PREFERRED DRUG	Step Therapy	Patient must have tried one steroid inhaler: Beclomethasone Dipropionate, Budesonide, Fluticasone Propionate, or Mometasone		

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE OCTOBER 1, 2021

- Generic Drugs Are Preferred Over Brand Name Drugs Unless The Drug Is Specified As BRAND ONLY
- Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List May Be Available Through Prior Authorization

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	Prior Authorization Type	Step Therapy Requirements	Quantity Limit (QL)	QL Days
MOMETASONE FUROATE-FORMOTEROL FUMARATE DIHYDRATE AEROSOL	DULERA	BRAND ONLY	PREFERRED DRUG	Step Therapy	Patient must have tried one steroid inhaler: Beclomethasone Dipropionate, Budesonide, Fluticasone Propionate, or Mometasone		
IPRATROPIUM-ALBUTEROL AEROSOL	COMBIVENT RESPIMAT		PREFERRED DRUG				
IPRATROPIUM-ALBUTEROL SOLUTION	DUONEB		PREFERRED DRUG				
SALMETEROL XINAFOATE AEROSOL POWDER BREATH ACTIVATED	SEREVENT DISKUS		PREFERRED DRUG	PA Required			
SALMETEROL XINAFOATE AEROSOL POWDER BREATH ACTIVATED	SEREVENT DISKUS		PREFERRED DRUG	PA Required			
TIOTROPIUM BROMIDE-OLODATEROL HCL AEROSOL SOLUTION	STIOLTO RESPIMAT		PREFERRED DRUG	PA Required		1	30
UMECLIDINIUM-VILANTEROL AEROSOL POWDER	ANORO ELLIPTA		PREFERRED DRUG	PA Required		1	30
ANTICOAGULANTS							
COUMARIN ANTICOAGULANTS							
WARFARIN SODIUM TABLETS	VARIOUS		PREFERRED DRUG				
DIRECT FACTOR XA INHIBITORS							
APIXABAN TABLETS	ELIQUIS	BRAND ONLY	PREFERRED DRUG			60	30
APIXABAN TABLETS STARTER PACK	ELIQUIS STARTER PACK	BRAND ONLY	PREFERRED DRUG			74	365
RIVAROXABAN TABLETS	XARELTO	BRAND ONLY	PREFERRED DRUG			60	30
RIVAROXABAN TABLETS	XARELTO DOSE PACK	BRAND ONLY	PREFERRED DRUG			51	30
HEPARINS AND HEPARINOID-LIKE AGENTS							
ENOXAPARIN SODIUM INJ 100 MG/ML	VARIOUS VIAL OR SYRINGE		PREFERRED DRUG			60	30
ENOXAPARIN SODIUM INJ 120 MG/0.8ML	VARIOUS VIAL OR SYRINGE		PREFERRED DRUG			60	30
ENOXAPARIN SODIUM INJ 150 MG/ML	VARIOUS VIAL OR SYRINGE		PREFERRED DRUG			60	30
ENOXAPARIN SODIUM INJ 30 MG/0.3ML	VARIOUS VIAL OR SYRINGE		PREFERRED DRUG			60	30
ENOXAPARIN SODIUM INJ 300 MG/3ML	VARIOUS VIAL OR SYRINGE		PREFERRED DRUG			60	30
ENOXAPARIN SODIUM INJ 40 MG/0.4ML	VARIOUS VIAL OR SYRINGE		PREFERRED DRUG			60	30
ENOXAPARIN SODIUM INJ 60 MG/0.6ML	VARIOUS VIAL OR SYRINGE		PREFERRED DRUG			60	30

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE OCTOBER 1, 2021

- Generic Drugs Are Preferred Over Brand Name Drugs Unless The Drug Is Specified As BRAND ONLY
- Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List May Be Available Through Prior Authorization

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	Prior Authorization Type	Step Therapy Requirements	Quantity Limit (QL)	QL Days
ENOXAPARIN SODIUM INJ 80 MG/0.8ML	VARIOUS VIAL OR SYRINGE		PREFERRED DRUG			60	30
HEPARIN (PORCINE) IN SODIUM CHLORIDE SOLUTION	HEPARIN SODIUM/NACL 0.9%						
HEPARIN SOD (PORCINE) IN D5W SOLUTION	HEPARIN SODIUM/D5W						
HEPARIN SODIUM (PORCINE) LOCK FLUSH & NACL LOCK FLUSH KIT	HEPARIN SODIUM LOCK FLUSH						
HEPARIN SODIUM (PORCINE) LOCK FLUSH SOLUTION	HEPARIN LOCK FLUSH						
THROMBIN INHIBITORS							
DABIGATRAN ETEXILATE MESYLATE CAPSULES	PRADAXA	BRAND ONLY	PREFERRED DRUG			60	30
ANTICONVULSANTS							
ANTICONVULSANTS - BENZODIAZEPINES							
CLOBAZAM SUSPENSION	ONFI			PA Required			
CLOBAZAM TABLETS	ONFI			PA Required			
CLONAZEPAM TAB 0.5 MG	KLONOPIN			PA Required for Ages < 6 years. PA Required for > 1 Anxiolytic Medication in a 30-day time period.		120	30
CLONAZEPAM TAB 1 MG	KLONOPIN			PA Required for Ages < 6 years. PA Required for > 1 Anxiolytic Medication in a 30-day time period.		120	30
CLONAZEPAM TAB 2 MG	KLONOPIN			PA Required for Ages < 6 years. PA Required for > 1 Anxiolytic Medication in a 30-day time period.		60	30
CLONAZEPAM ORALLY DISINTEGRATING TAB 0.125 MG	CLONAZEPAM ODT			PA Required for Ages < 6 years. PA Required for > 1 Anxiolytic Medication in a 30-day time period.		120	30
CLONAZEPAM ORALLY DISINTEGRATING TAB 0.25 MG	CLONAZEPAM ODT			PA Required for Ages < 6 years. PA Required for > 1 Anxiolytic Medication in a 30-day time period.		120	30
CLONAZEPAM ORALLY DISINTEGRATING TAB 0.5 MG	CLONAZEPAM ODT			PA Required for Ages < 6 years. PA Required for > 1 Anxiolytic Medication in a 30-day time period.		120	30

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE OCTOBER 1, 2021

- Generic Drugs Are Preferred Over Brand Name Drugs Unless The Drug Is Specified As BRAND ONLY
- Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List May Be Available Through Prior Authorization

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	Prior Authorization Type	Step Therapy Requirements	Quantity Limit (QL)	QL Days
CLONAZEPAM ORALLY DISINTEGRATING TAB 1 MG	CLONAZEPAM ODT			PA Required for Ages < 6 years. PA Required for > 1 Anxiolytic Medication in a 30-day time period.		120	30
CLONAZEPAM ORALLY DISINTEGRATING TAB 2 MG	CLONAZEPAM ODT			PA Required for Ages < 6 years. PA Required for > 1 Anxiolytic Medication in a 30-day time period.		60	30
DIAZEPAM RECTAL GEL DELIVERY SYSTEM 10 MG	DIASAT					2	30
DIAZEPAM RECTAL GEL DELIVERY SYSTEM 2.5 MG	DIASAT					2	30
DIAZEPAM RECTAL GEL DELIVERY SYSTEM 20 MG	DIASAT					2	30
ANTICONVULSANTS - MISC.							
CARBAMAZEPINE CHEWABLE TABLETS	CARBAMAZEPINE						
CARBAMAZEPINE CAPSULE 12-HOUR	CARBATROL						
CARBAMAZEPINE SUSPENSION	TEGRETOL						
CARBAMAZEPINE TABLETS	EPITOL						
CARBAMAZEPINE CAPSULE 12-HOUR	EQUETRO						
CARBAMAZEPINE TABLET 12-HOUR	TEGRETOL-XR						
GABAPENTIN CAPSULES	NEURONTIN						
GABAPENTIN SOLUTION	NEURONTIN						
GABAPENTIN	GRALISE			PA Required			
GABAPENTIN TABLETS	NEURONTIN						
GABAPENTIN	HORIZANT			PA Required			
LACOSAMIDE SOLUTION	VIMPAT			PA Required			
LACOSAMIDE TABLETS	VIMPAT			PA Required			
LAMOTRIGINE CHEWABLE TABLETS	LAMICTAL CHEWABLE						
LAMOTRIGINE TABLETS	LAMICTAL						
LAMOTRIGINE TABLET 24-HOUR	LAMICTAL XR						
LAMOTRIGINE ORALLY DISINTEGRATING TABLETS	LAMICTAL ODT						
LEVETIRACETAM SOLUTION	KEPPRA						
LEVETIRACETAM TABLETS	KEPPRA						
LEVETIRACETAM TABLET 24-HOUR	KEPPRA XR						

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE OCTOBER 1, 2021

- Generic Drugs Are Preferred Over Brand Name Drugs Unless The Drug Is Specified As BRAND ONLY
- Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List May Be Available Through Prior Authorization

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	Prior Authorization Type	Step Therapy Requirements	Quantity Limit (QL)	QL Days
OXCARBAZEPINE SUSPENSION	TRILEPTAL						
OXCARBAZEPINE TABLETS	TRILEPTAL						
PREGABALIN CAPSULES	LYRICA			PA Required			
PREGABALIN SOLUTION	LYRICA			PA Required			
PRIMIDONE TABLETS	MYSOLINE						
RUFINAMIDE SUSPENSION	BANZEL			PA Required			
RUFINAMIDE TABLETS	BANZEL			PA Required			
TOPIRAMATE SPRINKLE CAPSULES	TOPAMAX SPRINKLES						
TOPIRAMATE TABLETS	TOPAMAX						
ZONISAMIDE CAPSULES	ZONEGRAN						
CARBAMATES							
FELBAMATE SUSPENSION	FELBATOL						
FELBAMATE TABLETS	FELBATOL						
GABA MODULATORS							
TIAGABINE HCL TABLETS	GABITRIL			PA Required			
HYDANTOINS							
PHENYTOIN CHEWABLE TABLETS	DILANTIN INFATABLETS						
PHENYTOIN SODIUM EXTENDED CAPSULES	DILANTIN						
PHENYTOIN SUSPENSION	DILANTIN-125						
SUCCINIMIDES							
ETHOSUXIMIDE CAPSULES	ZARONTIN						
ETHOSUXIMIDE SOLUTION	ZARONTIN						
VALPROIC ACID							
DIVALPROEX SODIUM SPRINKLE CAPSULES	DEPAKOTE SPRINKLES						
DIVALPROEX SODIUM TABLET 24-HOUR	DEPAKOTE ER						
DIVALPROEX SODIUM TABLET ENTERIC COATED	DEPAKOTE						
VALPROATE SODIUM SYRUP	DEPAKENE+B252						
VALPROIC ACID CAPSULES	DEPAKENE						
ANTIDEPRESSANTS							
ALPHA-2 RECEPTOR ANTAGONISTS (TETRACYCLICS)							

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE OCTOBER 1, 2021

<ul style="list-style-type: none"> • Generic Drugs Are Preferred Over Brand Name Drugs Unless The Drug Is Specified As BRAND ONLY • Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List May Be Available Through Prior Authorization 							
Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	Prior Authorization Type	Step Therapy Requirements	Quantity Limit (QL)	QL Days
MIRTAZAPINE TABLETS	MIRTAZAPINE			PA Required for Ages < 6 years of age		30	30
MIRTAZAPINE ORALLY DISINTEGRATING TABLETS	REMERON SOLTAB			PA Required for Ages < 6 years of age		30	30
N-METHYL-D-ASPARTATE (NMDA) RECEPTOR ANTAGONIST							
ESKETAMINE HYDROCHLORIDE	SPRAVATO			PA Required			
Norepinephrine and Dopamine Reuptake Inhibitors (NDRIs)							
BUPROPION HCL TABLETS	WELLBUTRIN			PA Required for Ages < 6 years of age		120	30
BUPROPION HCL TABLET 12-HOUR	BUDEPRION SR			PA Required for Ages < 6 years of age		60	30
BUPROPION HCL TABLET 24-HOUR (150MG & 300MG)	WELLBUTRIN XL			PA Required for Ages < 6 years of age		30	30
SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIS)							
CITALOPRAM HYDROBROMIDE SOLUTION	CELEXA			PA Required for Ages < 6 years of age and greater than 12 years of age		600	30
CITALOPRAM HYDROBROMIDE TABLETS	CELEXA			PA Required for Ages < 6 years of age		10mg: 60 20mg: 30 40mg: 30	30 30 30
ESCITALOPRAM OXALATE TABLETS	LEXAPRO			PA Required for Ages < 6 years of age		5mg: 60 10mg: 30 20mg: 30	30 30 30
FLUOXETINE HCL CAPSULES ONLY	PROZAC			PA Required for Ages < 6 years of age		10mg: 60 20mg: 120 40mg: 60	30 30 30
FLUOXETINE HCL SOLUTION	PROZAC			PA Required for Ages < 6 years of age and greater than 12 years of age		600	30
FLUOXETINE HCL TABLETS - WEEKLY	PROZAC WEEKLY			PA Required			
FLUVOXAMINE MALEATE TABLETS	LUVOX			PA Required for Ages < 6 years of age		25mg: 60 50mg: 180 100mg: 90	30 30 30
PAROXETINE HCL TABLETS	PAXIL			PA Required for Ages < 6 years of age		10mg: 30 20mg: 30 30mg: 30 40mg: 45	30 30 30 30

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE OCTOBER 1, 2021

<ul style="list-style-type: none"> • Generic Drugs Are Preferred Over Brand Name Drugs Unless The Drug Is Specified As BRAND ONLY • Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List May Be Available Through Prior Authorization 							
Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	Prior Authorization Type	Step Therapy Requirements	Quantity Limit (QL)	QL Days
SERTRALINE HCL CONCENTRATE	ZOLOFT			PA Required for Ages < 6 years of age and greater than 12 years of age		300	30
SERTRALINE HCL TABLETS	ZOLOFT			PA Required for Ages < 6 years of age		25mg: 90 50mg: 120 100mg: 60	30 30 30
SEROTONIN MODULATORS							
TRAZODONE HCL TABLETS	TRAZODONE HCL			PA Required for Ages < 6 years of age		50mg:90 100mg:120 150mg: 60 300mg 30	30 30 30 30
SEROTONIN-NOREPINEPHRINE REUPTAKE INHIBITORS (SNRI)							
DULOXETINE HCL CAPSULE DELAYED RELEASE 20MG, 30MG & 60MG	CYMBALTA 20MG, 30MG & 60MG			PA Required for Ages < 6 years of age		20mg: 120 30mg: 120 60mg: 60	30 30 30
VENLAFAXINE HCL CAPSULE CONTROLLED RELEASE	EFFEXOR XR			PA Required for Ages < 6 years of age		37.5mg: 90 75mg: 90 150mg: 30	30 30 30
VENLAFAXINE HCL TABLETS - IMMEDIATE RELEASE ONLY	VENLAFAXINE HCL			PA Required for Ages < 6 years of age		25mg: 120 37.5mg: 90 50mg: 90 75mg: 150 100mg: 90	30 30 30 30 30
TRICYCLIC AGENTS							
AMITRIPTYLINE HCL TABLETS	AMITRIPTYLINE HCL			PA Required for Ages < 6 years of age			
AMOXAPINE TABLETS	VARIOUS			PA Required for Ages < 6 years of age			
CLOMIPRAMINE HCL CAPSULES	ANAFRANIL			PA Required for Ages < 6 years of age			
DESIPRAMINE HCL TABLETS	NORPRAMIN			PA Required for Ages < 6 years of age			
DOXEPIN HCL CAPSULES	DOXEPIN HCL			PA Required for Ages < 6 years of age		90	30
DOXEPIN HCL CONCENTRATE	DOXEPIN HCL			PA Required for Ages < 6 years of age		180	30
IMIPRAMINE PAMOATE CAPSULES	TORFRANIL-PM			PA Required for Ages < 6 years of age		30	30
IMIPRAMINE HCL TABLETS	TOFRANIL			PA Required for Ages < 6 years of age			

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE OCTOBER 1, 2021

- Generic Drugs Are Preferred Over Brand Name Drugs Unless The Drug Is Specified As BRAND ONLY
- Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List May Be Available Through Prior Authorization

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	Prior Authorization Type	Step Therapy Requirements	Quantity Limit (QL)	QL Days
MAPROTIline HCL	VARIOUS			PA Required for Ages < 6 years of age			
NORTRIPTYLINE HCL CAPSULES	PAMELOR			PA Required for Ages < 6 years of age			
NORTRIPTYLINE HCL SOLUTION	NORTRIPTYLINE HCL			PA Required for Ages < 6 years of age			
PROTRIPTYLINE HCL TABLETS	VIVACTIL			PA Required for Ages < 6 years of age			
TRIMIPRAMINE MALEATE	SURMONTIL			PA Required for Ages < 6 years of age			
ANTIDIABETICS							
ALPHA-GLUCOSIDASE INHIBITORS							
ACARBOSE TABLETS	PRECOSE						
ANTIDIABETIC - AMLYN ANALOGS							
PRAMLINTIDE ACETATE SOLUTION PEN INJECTION	SYMLINPEN 60		PREFERRED DRUG	PA Required			
ANTIDIABETIC COMBINATIONS							
ALOGLIPTIN-METFORMIN HCL TABLETS	KAZANO	BRAND ONLY	PREFERRED DRUG				
ALOGLIPTIN-PIOGLITAZONE TABLETS	OSENI	BRAND ONLY	PREFERRED DRUG				
CANAGLIFLOZIN-METFORMIN HCL	INVOKAMET	BRAND ONLY	PREFERRED DRUG	PA Required			
DAPAGLIFLOZIN - METFORMIN	XIDUO XR	BRAND ONLY	PREFERRED DRUG	PA Required			
EMPAGLIFLOZIN-LINAGLIPTIN TABLETS	GLYXAMBI	BRAND ONLY	PREFERRED DRUG	PA Required			
EMPAGLIFLOZIN-LINAGLIPTIN-METFORMIN	TRIJARDY XR	BRAND ONLY	PREFERRED DRUG	PA Required			
EMPAGLIFLOZIN-METFORMIN HCL	SYNJARDY	BRAND ONLY	PREFERRED DRUG	PA Required			
GLYBURIDE-METFORMIN HCL TABLETS	GLYBURIDE/METFORMIN HCL						
LINAGLIPTIN-METFORMIN HCL TABLETS	JENTADUETO	BRAND ONLY	PREFERRED DRUG	PA Required			
LINAGLIPTIN-METFORMIN HCL TABLET 24-HOUR	JENTADUETO XR	BRAND ONLY	PREFERRED DRUG				
PIOGLITAZONE HCL-METFORMIN HCL TABLETS	ACTOPLUS MET						
PIOGLITAZONE HCL-METFORMIN HCL TABLET 24-HOUR	ACTOPLUS MET XR						
SAXAGLIPTIN-METFORMIN HCL TABLETS	KOMBIGLYZE XR	BRAND ONLY	PREFERRED DRUG	PA Required			
SITAGLIPTIN-METFORMIN HCL TABLETS	JANUMET	BRAND ONLY	PREFERRED DRUG	PA Required			
SITAGLIPTIN-METFORMIN HCL TABLET 24-HOUR	JANUMET XR	BRAND ONLY	PREFERRED DRUG	PA Required			
BIGUANIDES							
METFORMIN HCL TABLETS	GLUCOPHAGE						
METFORMIN HCL TABLET 24-HOUR (GENERIC OF GLUCOPHAGE XR ONLY- 500MG & 750MG)	Various			PA Required for Osmotic and Modified Release Products			
DIABETIC OTHER							

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE OCTOBER 1, 2021

- Generic Drugs Are Preferred Over Brand Name Drugs Unless The Drug Is Specified As BRAND ONLY
- Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List May Be Available Through Prior Authorization

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	Prior Authorization Type	Step Therapy Requirements	Quantity Limit (QL)	QL Days
DIAZOXIDE SUSPENSION	PROGLYCEM	BRAND ONLY					
GLUCAGON (RDNA) KIT	GLUCAGON EMERGENCY KIT	BRAND ONLY BY LILLY	PREFERRED DRUG			1.00	30.00
GLUCAGON HCL (RDNA) SOLUTION	GLUCAGEN HYPOKIT		PREFERRED DRUG			1.00	30.00
DIPEPTIDYL PEPTIDASE-4 (DPP-4) INHIBITORS							
ALOGLIPTIN BENZOATE TABLETS	NESINA	BRAND ONLY	PREFERRED DRUG	PA Required			
LINAGLIPTIN TABLETS	TRADJENTA	BRAND ONLY	PREFERRED DRUG	PA Required			
SAXAGLIPTIN HCL TABLETS	ONGLYZA	BRAND ONLY	PREFERRED DRUG	PA Required			
SAXAGLIPTIN-METFORMIN HCL TABLETS	KOMBIGLYZE XR	BRAND ONLY	PREFERRED DRUG	PA Required			
SITAGLIPTIN PHOSPHATE TABLETS	JANUVIA	BRAND ONLY	PREFERRED DRUG	PA Required			
INCRETIN MIMETIC AGENTS (GLP-1 RECEPTOR AGONISTS)							
DULAGLUTIDE SOLUTION PEN-INJECTION	TRULICITY		PREFERRED DRUG	PA Required			
EXENATIDE SOLUTION PEN INJECTION	BYETTA		PREFERRED DRUG	PA Required			
LIRAGLUTIDE SOLUTION PEN INJECTION	VICTOZA		PREFERRED DRUG	PA Required			
DIABETIC MISCELLANEOUS AGENT							
PRAMLINTIDE	SYMLIN PEN		PREFERRED DRUG	PA Required			
INSULIN SENSITIZING AGENTS							
PIOGLITAZONE HCL TABLETS	ACTOS						
INSULIN							
INSULIN ASPART	NOVOLOG	Authorized Generic Only	PREFERRED DRUG				
INSULIN ASPART	NOVOLOG PENFILL	Authorized Generic Only	PREFERRED DRUG				
INSULIN ASPART	NOVOLOG FLEXPEN	Authorized Generic Only	PREFERRED DRUG				
INSULIN ASPART PROTAMINE SUSPENSION & INSULIN ASPART	NOVOLOG MIX 70/30	Authorized Generic Only	PREFERRED DRUG				
INSULIN ASPART PROTAMINE SUSPENSION & INSULIN ASPART	NOVOLOG MIX 70/30 FLEXPEN	Authorized Generic Only	PREFERRED DRUG				
INSULIN DETEMIR SOLUTION	LEVEMIR	BRAND ONLY	PREFERRED DRUG				

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE OCTOBER 1, 2021

- Generic Drugs Are Preferred Over Brand Name Drugs Unless The Drug Is Specified As BRAND ONLY
- Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List May Be Available Through Prior Authorization

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	Prior Authorization Type	Step Therapy Requirements	Quantity Limit (QL)	QL Days
INSULIN DETEMIR SUSPENSION	LEVEMIR FLEXPEN	BRAND ONLY	PREFERRED DRUG				
INSULIN GLARGINE SOLUTION	LANTUS	BRAND ONLY	PREFERRED DRUG				
INSULIN GLARGINE SUSPENSION	LANTUS SOLOSTAR	BRAND ONLY	PREFERRED DRUG				
INSULIN LISPRO (HUMAN) SOLUTION	HUMALOG	Authorized Generic Only	PREFERRED DRUG				
INSULIN LISPRO PROTAMINE & LISPRO (HUMAN) SUSPENSION (75-25)	HUMALOG MIX 75/25	Authorized Generic Only	PREFERRED DRUG				
INSULIN LISPRO (HUMAN) SOLUTION PEN INJECTION 100/ML	HUMALOG JUNIOR KWIKPEN	Authorized Generic Only	PREFERRED DRUG				
INSULIN LISPRO (HUMAN) SOLUTION PEN INJECTION 100/ML	HUMALOG KWIKPEN	Authorized Generic Only	PREFERRED DRUG				
INSULIN LISPRO PROTAMINE & LISPRO (HUMAN) SUSPENSION PEN INJECTION (75-25)	HUMALOG MIX 75/25 KWIKPEN	Authorized Generic Only	PREFERRED DRUG				
INSULIN LISPRO PROTAMINE & LISPRO (HUMAN) SUSPENSION PEN INJECTION (50-50)	HUMALOG MIX 50/50 KWIKPEN	Brand Only	PREFERRED DRUG				
INSULIN NPH (HUMAN) (ISOPHANE) SUSPENSION	HUMULIN N	BRAND ONLY	PREFERRED DRUG				
INSULIN REGULAR (HUMAN) SOLUTION PEN INJECTION	HUMULIN N KWIKPEN	BRAND ONLY	PREFERRED DRUG				
INSULIN NPH (HUMAN) (ISOPHANE) SUSPENSION	NOVOLIN N	BRAND ONLY	PREFERRED DRUG				
INSULIN NPH ISOPHANE & REG (HUMAN) SUSPENSION	HUMULIN 70/30	BRAND ONLY	PREFERRED DRUG				
INSULIN NPH ISOPHANE & REG (HUMAN) SUSPENSION	HUMULIN 70/30 KWIKPEN	BRAND ONLY	PREFERRED DRUG				
INSULIN REGULAR (HUMAN) SOLUTION	HUMULIN R U-100	BRAND ONLY	PREFERRED DRUG				
INSULIN REGULAR (HUMAN) SOLUTION	NOVOLIN R	BRAND ONLY	PREFERRED DRUG				
INSULIN REGULAR (HUMAN) SOLUTION	HUMULIN R U-500 (CONCENTRATED)	BRAND ONLY	PREFERRED DRUG	PA REQUIRED			
INSULIN REGULAR (HUMAN) PEN	HUMULIN R U-500 PEN (CONCENTRATED)	BRAND ONLY	PREFERRED DRUG	PA REQUIRED			
MEGLITINIDE ANALOGUES							
NATEGLINIDE TABLETS	STARLIX						
REPAGLINIDE TABLETS	PRANDIN						
SGLT2S							
DAPAGLIFLOZIN PROPANEDIOL	FARXIGA		PREFERRED DRUG	PA Required			

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE OCTOBER 1, 2021

- Generic Drugs Are Preferred Over Brand Name Drugs Unless The Drug Is Specified As BRAND ONLY
- Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List May Be Available Through Prior Authorization

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	Prior Authorization Type	Step Therapy Requirements	Quantity Limit (QL)	QL Days
CANAGLIFLOZIN	INVOKANA		PREFERRED DRUG	PA Required			
EMPAGLIFLOZIN	JARDIANCE		PREFERRED DRUG	PA Required			
SULFONYLUREAS							
GLIMEPIRIDE TABLETS	AMARYL						
GLIPIZIDE TABLETS	GLUCOTROL						
GLIPIZIDE TABLET 24-HOUR	GLUCATROL XL						
GLYBURIDE MICRONIZED TABLETS	GLYNASE						
GLYBURIDE TABLETS	DIABETA						
ANTIDIARRHEALS							
ANTIPERISTALTIC AGENTS							
DIPHENOXYLATE W/ ATROPINE LIQUID	DIPHENOXYLATE/ATROPINE						
DIPHENOXYLATE W/ ATROPINE TABLETS	LOMOTIL						
LOPERAMIDE HCL CAPSULES	LOPERAMIDE HCL						
LOPERAMIDE HCL CHEWABLE TABLETS	IMODIUM A-D						
LOPERAMIDE HCL LIQUID	LOPERAMIDE HCL						
LOPERAMIDE HCL SUSPENSION	IMODIUM A-D						
LOPERAMIDE HCL TABLETS	IMODIUM A-D						
ANTIDOTES							
OPIOID ANTAGONISTS							
NALOXONE HCL SOLUTION + SYRINGE	NALOXONE HCL + SYRINGE		PREFERRED DRUG				
NALOXONE HCL NASAL SPRAY	NARCAN NASAL SPRAY		PREFERRED DRUG				
ANTIEMETICS							
5-HT3 RECEPTOR ANTAGONISTS							
DOLASETRON MESYLATE TABLETS	ANZEMET			PA Required			
GRANISETRON HCL SOLUTION	VARIOUS			PA Required			
GRANISETRON HCL TABLETS	VARIOUS			PA Required			
ONDANSETRON HCL TABLETS	ZOFRAN			PA Required for tablets > 8mg		30	30
ANTIEMETICS MISC.							
PROCHLORPERAZINE MALEATE TABLETS	COMPAZINE						
PROCHLORPERAZINE SUPPOSITORY	COMPAZINE						

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE OCTOBER 1, 2021

- Generic Drugs Are Preferred Over Brand Name Drugs Unless The Drug Is Specified As BRAND ONLY
- Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List May Be Available Through Prior Authorization

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	Prior Authorization Type	Step Therapy Requirements	Quantity Limit (QL)	QL Days
SUBSTANCE P/NEUROKININ 1 (NK1) RECEPTOR ANTAGONIST							
APREPITANT CAPSULES	EMEND					6	21
ANTIFUNGALS							
ANTIFUNGAL ORAL AGENTS							
CLOTRIMAZOLE TROCHE	VARIOUS						
GRISEOFULVIN SUSPENSION	VARIOUS						
GRISEOFULVIN MICROSIZED TABLETS	GRIFULVIN V						
NYSTATIN SUSPENSION	NYSTATIN						
NYSTATIN TABLETS	NYSTATIN						
TERBINAFINE HCL TABLETS	LAMISIL					90	365
IMIDAZOLE-RELATED ANTIFUNGALS							
FLUCONAZOLE SUSPENSION	DIFLUCAN					600	30
FLUCONAZOLE TABLETS	DIFLUCAN					60	30
ANTIHISTAMINES							
ANTIHISTAMINES - ALKYLAMINES							
BROMPHENIRAMINE MALEATE	J-TAN PD						
CHLORPHENIRAMINE MALEATE	CHLORPHENIRAMINE MALEATE						
DEXCHLORPHENIRAMINE MALEATE SYRUP	DEXCHLORPHENIRAMINE MALEATE						
ANTIHISTAMINES - ETHANOLAMINES							
CLEMASTINE FUMARATE SYRUP	CLEMASTINE FUMARATE						
CLEMASTINE FUMARATE TABLETS	CLEMASTINE FUMARATE						
DIPHENHYDRAMINE HCL CAPSULES	VARIOUS						
DIPHENHYDRAMINE HCL CHEWABLE TABLETS	VARIOUS						
DIPHENHYDRAMINE HCL ELIXIR	VARIOUS						
DIPHENHYDRAMINE HCL LIQUID	VARIOUS						
DIPHENHYDRAMINE HCL SOLUTION	VARIOUS						
DIPHENHYDRAMINE HCL SUSPENSION	VARIOUS						
DIPHENHYDRAMINE HCL SYRUP	VARIOUS						
DIPHENHYDRAMINE HCL TABLETS	VARIOUS						
ANTIHISTAMINES - NON-SEDATING							

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE OCTOBER 1, 2021

- Generic Drugs Are Preferred Over Brand Name Drugs Unless The Drug Is Specified As BRAND ONLY
- Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List May Be Available Through Prior Authorization

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	Prior Authorization Type	Step Therapy Requirements	Quantity Limit (QL)	QL Days
CETIRIZINE HCL CAPSULES	ZYRTEC ALLERGY					30	30
CETIRIZINE HCL CHEWABLE TABLETS	VARIOUS					30	30
CETIRIZINE HCL SYRUP	VARIOUS					150	30
CETIRIZINE HCL TABLETS	VARIOUS					30	30
CETIRIZINE HCL ORALLY DISINTEGRATING TABLETS	ZYRTEC ALLERGY					30	30
FEXOFENADINE HCL SUSPENSION	ALLEGRA ALLERGY CHILDRENS					150	30
FEXOFENADINE HCL TABLETS	ALLEGRA ALLERGY CHILDRENS					30	30
FEXOFENADINE HCL ORALLY DISINTEGRATING TABLETS	ALLEGRA ALLERGY CHILDRENS					30	30
LORATADINE CAPSULES	CLARITIN					30	30
LORATADINE CHEWABLE TABLETS	CLARITIN					30	30
LORATADINE SYRUP	CLARITIN					150	30
LORATADINE TABLETS	ALAVERT					30	30
LORATADINE ORALLY DISINTEGRATING TABLETS	CLARITIN REDITABS					30	30
ANTIHISTAMINES - PHENOTHIAZINES							
PROMETHAZINE HCL SUPPOSITORY	PHENERGAN						
PROMETHAZINE HCL TABLETS	PROMETHAZINE HCL						
ANTIHISTAMINES - PIPERIDINES							
CYPROHEPTADINE HCL SYRUP	CYPROHEPTADINE HCL						
CYPROHEPTADINE HCL TABLETS	CYPROHEPTADINE HCL						
ANTHYPERLIPIDEMICS							
BILE ACID SEQUESTRANTS							
CHOLESTYRAMINE LIGHT PACKETS	PREVALITE						
CHOLESTYRAMINE LIGHT POWDER	PREVALITE						
CHOLESTYRAMINE PACKETS	QUESTRAN						
CHOLESTYRAMINE POWDER	QUESTRAN						
COLESTIPOL HCL TABLETS	COLESTID						
FIBRIC ACID DERIVATIVES							
FENOFIBRATE MICRONIZED CAPSULES 67MG, 134MG & 200MG	VARIOUS						
FENOFIBRATE TABLETS 48MG, 54MG, 145MG & 160MG	VARIOUS						
FENOFIBRIC ACID TABLETS	FIBRICOR						

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE OCTOBER 1, 2021

- Generic Drugs Are Preferred Over Brand Name Drugs Unless The Drug Is Specified As BRAND ONLY
- Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List May Be Available Through Prior Authorization

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	Prior Authorization Type	Step Therapy Requirements	Quantity Limit (QL)	QL Days
GEMFIBROZIL TABLETS	LOPID						
HMG COA REDUCTASE INHIBITORS							
ATORVASTATIN CALCIUM TABLETS	LIPITOR		PREFERRED DRUG			30	30
LOVASTATIN TABLETS	MEVACOR		PREFERRED DRUG			30	30
PRAVASTATIN SODIUM TABLETS	PRAVACOL		PREFERRED DRUG			30	30
ROUVASTATIN TABLETS	CRESTOR		PREFERRED DRUG			30	30
SIMVASTATIN TABLETS	ZOCOR		PREFERRED DRUG			30	30
INTESTINAL CHOLESTEROL ABSORPTION INHIBITORS							
EZETIMIBE TABLETS	ZETIA		PREFERRED DRUG	PA Required			
NICOTINIC ACID DERIVATIVES							
NIACIN CAPSULE CONTROLLED RELEASE	VARIOUS						
NIACIN TABLET CONTROLLED RELEASE	VARIOUS						
MISC. NUTRITIONAL SUBSTANCES							
OMEGA-3 FATTY ACIDS CAPSULES	FISH OIL						
OMEGA-3 FATTY ACIDS CAPSULE DELAYED RELEASE	FISH OIL						
ANTIHYPERTENSIVES							
ACE INHIBITORS							
BENAZEPRIL HCL TABLETS	BENAZEPRIL HCL						
CAPTOPRIL TABLETS	CAPTOPRIL						
ENALAPRIL MALEATE SOLUTION	EPANED						
ENALAPRIL MALEATE TABLETS	VASOTEC						
FOSINOPRIL SODIUM TABLETS	FOSINOPRIL SODIUM						
LISINOPRIL TABLETS	ZESTRIL						
MOEXIPRIL HCL TABLETS	UNIVASC						
PERINDOPRIL ERBUMINE TABLETS	ACEON						
QUINAPRIL HCL TABLETS	ACCUPRIL						
RAMIPRIL CAPSULES	ALTACE						
TRANDOLAPRIL TABLETS	MAVIK						
ANGIOTENSIN II RECEPTOR ANTAGONISTS							
IRBESARTAN TABLETS	AVAPRO						

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE OCTOBER 1, 2021

- Generic Drugs Are Preferred Over Brand Name Drugs Unless The Drug Is Specified As BRAND ONLY
- Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List May Be Available Through Prior Authorization

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	Prior Authorization Type	Step Therapy Requirements	Quantity Limit (QL)	QL Days
LOSARTAN POTASSIUM TABLETS	COZAAR						
VALSARTAN TABLETS	DIOVAN						
ANTIADRENERGIC ANTIHYPERTENSIVES							
CLONIDINE HCL PATCH-WEEKLY	CATAPRES-TTS-1			PA Required for Ages < 6 years of age		4	28
CLONIDINE HCL TABLETS	CATAPRES						
CLONIDINE HCL (ADHD) TABLET 12-HOUR	CLONIDINE ER			PA Required for Ages < 6 years of age		120	30
DOXAZOSIN MESYLATE TABLETS	CARDURA						
GUANFACINE HCL TABLETS	TENEX						
GUANFACINE HCL (ADHD) TABLET 24-HOUR	GUANFACINE ER		PREFERRED DRUG	PA Required for Ages < 6 years of age		30	30
METHYLDOPA TABLETS	METHYLDOPA						
PRAZOSIN HCL CAPSULES	MINIPRESS						
TERAZOSIN HCL CAPSULES	TERAZOSIN HCL						
ANTIHYPERTENSIVE COMBINATIONS							
ATENOLOL & CHLORTHALIDONE TABLETS	VARIOUS						
CAPTAPRIL & HYDROCHLOROTHIAZIDE TABLETS	CAPTAPRIL/ HYDROCHLOROTHIAZIDE						
ENALAPRIL MALEATE & HYDROCHLOROTHIAZIDE TABLETS	ENALAPRIL MALEATE/ HYDROCHLOROTHIAZIDE						
FOSINOPRIL SODIUM & HYDROCHLOROTHIAZIDE TABLETS	FOSINOPRIL SODIUM/ HYDROCHLOROTHIAZIDE						
LISINAPRIL & HYDROCHLOROTHIAZIDE TABLETS	ZESTORETIC						
LOSARTAN POTASSIUM & HYDROCHLOROTHIAZIDE TABLETS	HYZAAR						
MOEXIPRIL - HYDROCHLOROTHIAZIDE TABLETS	UNIRETIC						
QUINAPRIL - HYDROCHLOROTHIAZIDE TABLETS	ACCURETIC						
VALSARTAN - HYDROCHLOROTHIAZIDE TABLETS	DIOVAN HCT						
SELECTIVE ALDOSTERONE RECEPTOR ANTAGONISTS (SARAS)							
EPLERENONE TABLETS	INSPIRA			PA Required			
VASODILATORS							
HYDRALAZINE HCL TABLETS	HYDRALAZINE HCL						
MINOXIDIL TABLETS	MINOXIDIL						
ANTI-INFECTIVE AGENTS - MISCELLANEOUS							

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE OCTOBER 1, 2021

- Generic Drugs Are Preferred Over Brand Name Drugs Unless The Drug Is Specified As BRAND ONLY
- Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List May Be Available Through Prior Authorization

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	Prior Authorization Type	Step Therapy Requirements	Quantity Limit (QL)	QL Days
ANTI-INFECTIVE AGENTS - MISC.							
VANCOMYCIN HCL CAPSULES	VANCOCIN HCL			PA Required			
VANCOMYCIN HCL SOLUTION	Available through a compounding pharmacy			PA Required			
ANTI-INFECTIVE MISC. - COMBINATIONS							
ERYTHROMYCIN-SULFISOXAZOLE SUSPENSION	E.S.P.						
SULFAMETHOXAZOLE-TRIMETHOPRIM SUSPENSION	SULFATRIM PEDIATRIC						
SULFAMETHOXAZOLE-TRIMETHOPRIM TABLETS	BACTRIM						
LEPROSTATICS							
DAPSONE TABLETS	DAPSONE						
OXAZOLIDINONES							
LINEZOLID SUSPENSION	ZYVOX			PA Required			
LINEZOLID TABLETS	ZYVOX			PA Required			
ANTIMALARIALS							
ANTIMALARIAL COMBINATIONS							
ARTEMETHER-LUMEFANTRINE TABLETS	COARTEM						
ATOVAQUONE-PROGUANIL HCL TABLETS	MALARONE						
ANTIMALARIALS							
CHLOROQUINE PHOSPHATE TABLETS	CHLOROQUINE PHOSPHATE						
HYDROXYCHLOROQUINE SULFATE TABLETS	PLAQUENIL						
PRIMAQUINE PHOSPHATE TABLETS	PRIMAQUINE PHOSPHATE						
QUININE SULFATE CAPSULES	QUALAQUIN						
ANTIMYCOBACTERIAL AGENTS							
ETHAMBUTOL HCL TABLETS	MYAMBUTOL						
ISONIAZID SYRUP	ISONIAZID						
ISONIAZID TABLETS	ISONIAZID						
PYRAZINAMIDE TABLETS	PYRAZINAMIDE						
RIFAMPIN CAPSULES	RIFADIN						
ONCOLOGY -FEDERALLY REIMBURSABLE ANTINEOPLASTIC AGENTS,NOT LISTED BELOW, ARE AVAILABLE THROUGH PRIOR AUTHORIZATION							
ALKYLATING AGENTS							

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE OCTOBER 1, 2021

- Generic Drugs Are Preferred Over Brand Name Drugs Unless The Drug Is Specified As BRAND ONLY
- Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List May Be Available Through Prior Authorization

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	Prior Authorization Type	Step Therapy Requirements	Quantity Limit (QL)	QL Days
MELPHALAN TABLETS	ALKERAN	BRAND ONLY		PA Required			
ANTIMETABOLITES							
MERCAPTOPYRINE TABLETS	PURINETHOL						
METHOTREXATE SODIUM TABLETS	METHOTREXATE						
ANTINEOPLASTIC - HORMONAL AND RELATED AGENTS							
ANASTROZOLE TABLETS	ARIMIDEX			PA Required			
EXEMESTANE TABLETS	AROMASIN			PA Required			
FLUTAMIDE CAPSULES	FLUTAMIDE						
LEUPROLIDE ACETATE (3 MONTH) KIT	LUPRON DEPOT			PA Required			
LEUPROLIDE ACETATE (4 MONTH) KIT	LUPRON DEPOT			PA Required			
LEUPROLIDE ACETATE KIT	LUPRON DEPOT			PA Required			
TAMOXIFEN CITRATE TABLETS	TAMOXIFEN CITRATE						
TOREMIFENE CITRATE TABLETS	FARESTON			PA Required			
ANTINEOPLASTIC ENZYME INHIBITORS							
AXITINIB TABLETS	INLYTA			PA Required			
CRIZOTINIB CAPSULES	XALKORI			PA Required			
ERLOTINIB HCL TABLETS	TARCEVA			PA Required			
EVEROLIMUS TABLETS	AFINITOR			PA Required			
EVEROLIMUS SOLUBLE TABLET	AFINITOR DISPERZ			PA Required			
GEFITINIB TABLETS	IRESSA			PA Required			
IBRUTINIB CAPSULES	IMBRUVICA			PA Required			
IMATINIB MESYLATE TABLETS	GLEEVEC	BRAND ONLY		PA Required			
LAPATINIB DITOSYLATE TABLETS	TYKERB			PA Required			
NILOTINIB HCL CAPSULES	TASIGNA			PA Required			
PAZOPANIB HCL TABLETS	VOTRIENT			PA Required			
PONATINIB HCL TABLETS	ICLUSIG			PA Required			
RUXOLITINIB PHOSPHATE TABLETS	JAKAFI			PA Required			
SORAFENIB TOSYLATE TABLETS	NEXAVAR			PA Required			
SUNITINIB MALATE CAPSULES	SUTENT			PA Required			
VANDETANIB TABLETS	CAPRELSA			PA Required			

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE OCTOBER 1, 2021

- Generic Drugs Are Preferred Over Brand Name Drugs Unless The Drug Is Specified As BRAND ONLY
- Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List May Be Available Through Prior Authorization

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	Prior Authorization Type	Step Therapy Requirements	Quantity Limit (QL)	QL Days
VEMURAFENIB TABLETS	ZELBORAF			PA Required			
VORINOSTAT CAPSULES	ZOLINZA			PA Required			
ANTINEOPLASTICS - MISC.							
BEXAROTENE CAPSULES	TARGRETIN			PA Required			
HYDROXYUREA CAPSULES	HYDREA						
INTERFERON ALFA-2B SOLUTION	INTRON A			PA Required			
INTERFERON ALFA-2B SOLUTION	INTRON A			PA Required			
INTERFERON ALFA-N3 SOLUTION	ALFERON N			PA Required			
INTERFERON GAMMA-1B SOLUTION	ACTIMMUNE			PA Required			
PEGINTERFERON ALFA-2B (ANTINEOPLASTIC) KIT	SYLATRON			PA Required			
PROCARBAZINE HCL CAPSULES	MATULANE						
TRETINOIN (CHEMOTHERAPY) CAPSULES	TRETINOIN			PA Required For > 26 Years of Age			
CHEMOTHERAPY RESCUE/ANTIDOTE AGENTS							
LEUCOVORIN CALCIUM TABLETS	LEUCOVORIN CALCIUM			PA Required			
MITOTIC INHIBITORS							
ETOPOSIDE CAPSULES	ETOPOSIDE			PA Required			
ANTIPARKINSON AGENTS							
ANTIPARKINSON ANTICHOLINERGICS							
BENZTROPINE MESYLATE TABLETS	BENZTROPINE MESYLATE						
TRIHEXYPHENIDYL HCL ELIXIR	TRIHEXYPHENIDYL HCL						
TRIHEXYPHENIDYL HCL TABLETS	TRIHEXYPHENIDYL HCL						
ANTIPARKINSON COMT INHIBITORS							
ENTACAPONE TABLETS	COMTAN						
ANTIPARKINSON DOPAMINERGICS							
AMANTADINE HCL CAPSULES	AMANTADINE HCL						
AMANTADINE HCL SYRUP	AMANTADINE HCL						
BROMOCRIPTINE MESYLATE CAPSULES	PARLODEL						
BROMOCRIPTINE MESYLATE TABLETS	PARLODEL						
CARBIDOPA-LEVODOPA TABLETS	SINEMET						
CARBIDOPA-LEVODOPA ER TABLETS	VARIOUS						

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE OCTOBER 1, 2021

<ul style="list-style-type: none"> • Generic Drugs Are Preferred Over Brand Name Drugs Unless The Drug Is Specified As BRAND ONLY • Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List May Be Available Through Prior Authorization 							
Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	Prior Authorization Type	Step Therapy Requirements	Quantity Limit (QL)	QL Days
PRAMIPEXOLE DIHYDROCHLORIDE TABLETS	MIRAPEX						
ROPINIROLE HYDROCHLORIDE TABLETS	REQUIP						
ANTIPSYCHOTICS/ANTIMANIC AGENTS							
ANTIMANIC AGENTS							
LITHIUM CARBONATE CAPSULES	LITHIUM CARBONATE			PA Required for Ages < 6 years Prior Authorization is not required for ages 6 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.			
LITHIUM CARBONATE TABLETS	LITHIUM CARBONATE			PA Required for Ages < 6 years Prior Authorization is not required for ages 6 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.			
LITHIUM CARBONATE TABLET CONTROLLED RELEASE	LITHOBID			PA Required for Ages < 6 years Prior Authorization is not required for ages 6 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.			
LITHIUM SOLUTION	LITHIUM			PA Required for Ages < 6 years Prior Authorization is not required for ages 6 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.			

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE OCTOBER 1, 2021

- Generic Drugs Are Preferred Over Brand Name Drugs Unless The Drug Is Specified As BRAND ONLY
- Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List May Be Available Through Prior Authorization

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	Prior Authorization Type	Step Therapy Requirements	Quantity Limit (QL)	QL Days
ANTIPSYCHOTICS							
ANTIPSYCHOTICS - SECOND GENERATION - ATYPICAL ORAL AGENTS							
ARIPIPIRAZOLE TABLETS	ABILIFY		PREFERRED DRUG	PA Required for Ages < 6 years Prior Authorization is not required for ages 6 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.		30	30
CLOZAPINE ORALLY DISPERSABLE TABLET	FAZACLO		PREFERRED DRUG	PA Required for Ages < 18 years Prior Authorization is not required for ages 18 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.		150	30
CLOZAPINE TABLETS	CLOZARIL		PREFERRED DRUG	PA Required for Ages < 18 years Prior Authorization is not required for ages 18 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.		150	30
LURASIDONE HCL TABS	LATUDA		PREFERRED DRUG	PA Required for Ages < 6 years Prior Authorization is not required for ages 6 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.		30	30

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE OCTOBER 1, 2021

- Generic Drugs Are Preferred Over Brand Name Drugs Unless The Drug Is Specified As BRAND ONLY
- Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List May Be Available Through Prior Authorization

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	Prior Authorization Type	Step Therapy Requirements	Quantity Limit (QL)	QL Days
OLANZAPINE ORALLY DISPERSABLE TABLET	ZYPREXA ZYDIS		PREFERRED DRUG	PA Required for Ages < 6 years Prior Authorization is not required for ages 6 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.		5mg: 60 10mg: 60 15MG: 30 20mg: 30	30 30 30 30
OLANZAPINE TABLETS	ZYPREXA		PREFERRED DRUG	PA Required for Ages < 6 years Prior Authorization is not required for ages 6 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.		30	30
QUETIAPINE FUMARATE TABLETS	SEROQUEL		PREFERRED DRUG	PA Required for Ages < 6 years Prior Authorization is not required for ages 6 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.		60	30
RISPERIDONE ORALLY DISPERSABLE TABLET	RISPERIDONE ODT		PREFERRED DRUG	PA Required for Ages < 6 years Prior Authorization is not required for ages 6 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.		60	30

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE OCTOBER 1, 2021

- Generic Drugs Are Preferred Over Brand Name Drugs Unless The Drug Is Specified As BRAND ONLY
- Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List May Be Available Through Prior Authorization

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	Prior Authorization Type	Step Therapy Requirements	Quantity Limit (QL)	QL Days
RISPERIDONE ORAL SOLUTION	RISPERDAL		PREFERRED DRUG	PA Required for Ages < 6 years Prior Authorization is not required for ages 6 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.		240	30
RISPERIDONE TABLETS	RISPERDAL		PREFERRED DRUG	PA Required for Ages < 6 years Prior Authorization is not required for ages 6 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.		60	30
ZIPRASIDONE HCL CAPSULES	GEODON		PREFERRED DRUG	PA Required for Ages < 6 years Prior Authorization is not required for ages 6 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.		60	30
ANTIPSYCHOTICS - SECOND GENERATION - ATYPICAL LONG ACTING INJECTABLES							
ARIPIPRAZOLE LAUROXIL	ARISTADA INITIO		PREFERRED DRUG	PA Required for Ages < 18 years Prior Authorization is not required for ages 18 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.		2	365

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE OCTOBER 1, 2021

- Generic Drugs Are Preferred Over Brand Name Drugs Unless The Drug Is Specified As BRAND ONLY
- Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List May Be Available Through Prior Authorization

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	Prior Authorization Type	Step Therapy Requirements	Quantity Limit (QL)	QL Days
ARIPIRAZOLE LAUROXIL	ARISTADA		PREFERRED DRUG	PA Required for Ages < 18 years Prior Authorization is not required for ages 18 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.		1	30
ARIPIRAZOLE SUSPENSION	ABILIFY MAINTENA		PREFERRED DRUG	PA Required for Ages < 18 years Prior Authorization is not required for ages 18 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.		1	30
PALIPERIDONE PALMITATE SUSPENSION	INVEGA SUSTENNA		PREFERRED DRUG	PA Required for Ages < 18 years Prior Authorization is not required for ages 18 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.		1	30
PALIPERIDONE PALMITATE SUSPENSION	INVEGA TRINZA		PREFERRED DRUG	PA Required for Ages < 18 years Prior Authorization is not required for ages 18 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.		1	90

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE OCTOBER 1, 2021

- Generic Drugs Are Preferred Over Brand Name Drugs Unless The Drug Is Specified As BRAND ONLY
- Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List May Be Available Through Prior Authorization

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	Prior Authorization Type	Step Therapy Requirements	Quantity Limit (QL)	QL Days
RISPERIDONE MICROSPHERES SUSPENSION	RISPERDAL CONSTA		PREFERRED DRUG	PA Required for Ages < 18 years Prior Authorization is not required for ages 18 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.		2	28
RISPERIDONE PREFILLED SYRINGE	PERSERIS		PREFERRED DRUG	PA Required for Ages < 18 years Prior Authorization is not required for ages 18 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.		2	28
ANTIPSYCHOTICS - FIRST GENERATION -TYPICAL ORAL AGENTS							
CHLORPROMAZINE HCL SOLUTION	VARIOUS			PA Required for Ages < 6 years Prior Authorization is not required for ages 6 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.			
CHLORPROMAZINE HCL TABLETS	VARIOUS			PA Required for Ages < 6 years Prior Authorization is not required for ages 6 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.			

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE OCTOBER 1, 2021

- Generic Drugs Are Preferred Over Brand Name Drugs Unless The Drug Is Specified As BRAND ONLY
- Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List May Be Available Through Prior Authorization

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	Prior Authorization Type	Step Therapy Requirements	Quantity Limit (QL)	QL Days
FLUPHENAZINE HCL CONCENTRATE	VARIOUS			PA Required for Ages < 6 years Prior Authorization is not required for ages 6 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.			
FLUPHENAZINE HCL ELIXIR	VARIOUS			PA Required for Ages < 6 years Prior Authorization is not required for ages 6 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.			
FLUPHENAZINE HCL TABLETS	VARIOUS			PA Required for Ages < 6 years Prior Authorization is not required for ages 6 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.			
HALOPERIDOL LACTATE CONCENTRATE	VARIOUS			PA Required for Ages < 6 years Prior Authorization is not required for ages 6 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.			

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE OCTOBER 1, 2021

- Generic Drugs Are Preferred Over Brand Name Drugs Unless The Drug Is Specified As BRAND ONLY
- Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List May Be Available Through Prior Authorization

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	Prior Authorization Type	Step Therapy Requirements	Quantity Limit (QL)	QL Days
HALOPERIDOL TABLETS	VARIOUS			PA Required for Ages < 6 years Prior Authorization is not required for ages 6 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.			
LOXAPINE SUCCINATE CAPSULES	LOXITANE			PA Required for Ages < 6 years Prior Authorization is not required for ages 6 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.			
PERPHENAZINE TABLETS	VARIOUS			PA Required for Ages < 6 years Prior Authorization is not required for ages 6 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.			
PIMOZIDE	ORAP			PA Required for Ages < 12 years Prior Authorization is not required for ages 6 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.			

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE OCTOBER 1, 2021

<ul style="list-style-type: none"> • Generic Drugs Are Preferred Over Brand Name Drugs Unless The Drug Is Specified As BRAND ONLY • Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List May Be Available Through Prior Authorization 							
Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	Prior Authorization Type	Step Therapy Requirements	Quantity Limit (QL)	QL Days
THIORIDAZINE HCL TABLETS	VARIOUS			PA Required for Ages < 6 years Prior Authorization is not required for ages 6 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.			
THIOTHIXENE CAPSULES	VARIOUS			PA Required for Ages < 6 years Prior Authorization is not required for ages 6 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.			
TRIFLUOPERAZINE HCL TABLETS	VARIOUS			PA Required for Ages < 6 years Prior Authorization is not required for ages 6 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.			
ANTIPSYCHOTICS - FIRST GENERATION -TYPICAL -LONG ACTING INJECTIONS							
FLUPHENAZINE DECANOATE SOLUTION	FLUPHENAZINE DECANOATE			PA Required for Ages < 18 years Prior Authorization is not required for ages 18 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.			

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE OCTOBER 1, 2021

- Generic Drugs Are Preferred Over Brand Name Drugs Unless The Drug Is Specified As BRAND ONLY
- Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List May Be Available Through Prior Authorization

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	Prior Authorization Type	Step Therapy Requirements	Quantity Limit (QL)	QL Days
HALOPERIDOL DECANOATE SOLUTION	HALDOL DECANOATE 50			PA Required for Ages < 18 years Prior Authorization is not required for ages 18 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.			
ANTIVIRALS							
ANTIRETROVIRALS							
ABACAVIR SULFATE SOLUTION	ZIAGEN						
ABACAVIR SULFATE TABLETS	ZIAGEN						
ABACAVIR SULFATE-LAMIVUDINE TABLETS	EPZICOM						
ABACAVIR SULFATE-LAMIVUDINE-ZIDOVUDINE TABLETS	TRIZIVIR						
ABACAVIR-DOLUTEGRAVIR-LAMIVUDINE TABLETS	TRIUMEQ						
ATAZANAVIR SULFATE CAPSULES	REYATAZ						
ATAZANAVIR SULFATE PACK	REYATAZ						
ATAZANAVIR SULFATE-COBICISTAT TABLETS	EVOTAZ						
BICTEGRAVIR-EMTRICITABINE-TENOFOVIR ALAFENAMIDE FUMARATE TABLETS	BIKTARVY					30	30
COBICISTAT TABLETS	TYBOST					30	30
DARUNAVIR ETHANOLATE SUSPENSION	PREZISTA						
DARUNAVIR ETHANOLATE TABLETS	PREZISTA						
DARUNAVIR-COBICISTAT TABLETS	PREZCOBIX						
DELAVIRDINE MESYLATE TABLETS	RESCRIPTOR						
DIDANOSINE CAPSULE DELAYED RELEASE	VIDEX EC						
DIDANOSINE SOLUTION	VIDEX PEDIATRIC						
DOLUTEGRAVIR SODIUM TABLETS	TIVICAY						
DORAVIRINE TABLETS	PIFELTRO						
EFAVIRENZ CAPSULES	SUSTIVA						
EFAVIRENZ TABLETS	SUSTIVA						
EFAVIRENZ-EMTRICITABINE-TENOFOVIR DISOPROXIL FUMARATE TABLETS	ATRIPLA	BRAND ONLY					
ELVITEGRAVIR TABLETS	VITEKTA						

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE OCTOBER 1, 2021

- Generic Drugs Are Preferred Over Brand Name Drugs Unless The Drug Is Specified As BRAND ONLY
- Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List May Be Available Through Prior Authorization

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	Prior Authorization Type	Step Therapy Requirements	Quantity Limit (QL)	QL Days
ELVITEGRAVIR-COBIICISTAT-EMTRICITABINE-TENOFOVIR TABLETS	STRIBILD						
ELVITEGRAVIR-COBIICISTAT-EMTRICITABINE-TENOFOVIR ALAFENAMIDE TABLETS	GENVOYA						
EMTRICITABINE CAPSULES	EMTRIVA						
EMTRICITABINE SOLUTION	EMTRIVA						
EMTRICITABINE-RILPIVIRINE-TENOFOVIR ALAFENAMIDE FUMARATE TABLETS	ODEFSEY						
EMTRICITABINE-RILPIVIRINE-TENOFOVIR DISOPROXIL FUMARATE TABLETS	COMPLERA						
EMTRICITABINE-TENOFOVIR ALAFENAMIDE FUMARATE TABLETS	DESCOVY						
EMTRICITABINE-TENOFOVIR DISOPROXIL FUMARATE TABLETS	TRUVADA	BRAND ONLY					
ENFUVRTIDE SOLUTION	FUZEON			PA Required		1	30
ETRAVIRINE TABLETS	INTELENCE						
FOSAMPRENAVIR CALCIUM SUSPENSION	LEXIVA						
FOSAMPRENAVIR CALCIUM TABLETS	LEXIVA						
INDINAVIR SULFATE CAPSULES	CRIXIVAN						
LAMIVUDINE SOLUTION	EPIVIR						
LAMIVUDINE TABLETS	EPIVIR						
LAMIVUDINE-ZIDOVUDINE TABLETS	COMBIVIR						
LOPINAVIR-RITONAVIR SOLUTION	KALETRA						
LOPINAVIR-RITONAVIR TABLETS	KALETRA						
MARAVIROC TABLETS	SELZENTRY			PA Required			
NELFINAVIR MESYLATE TABLETS	VIRACEPT						
NEVIRAPINE SUSPENSION	VIRAMUNE						
NEVIRAPINE TABLETS	VIRAMUNE						
NEVIRAPINE TABLET 24-HOUR	VIRAMUNE XR						
RALTEGRAVIR POTASSIUM CHEWABLE TABLETS	ISENTRESS						
RALTEGRAVIR POTASSIUM PACK	ISENTRESS						
RALTEGRAVIR POTASSIUM TABLETS	ISENTRESS						
RILPIVIRINE HCL TABLETS	EDURANT						
RITONAVIR CAPSULES	NORVIR						
RITONAVIR SOLUTION	NORVIR						
RITONAVIR TABLETS	NORVIR						

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE OCTOBER 1, 2021

- Generic Drugs Are Preferred Over Brand Name Drugs Unless The Drug Is Specified As BRAND ONLY
- Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List May Be Available Through Prior Authorization

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	Prior Authorization Type	Step Therapy Requirements	Quantity Limit (QL)	QL Days
SAQUINAVIR MESYLATE CAPSULES	INVIRASE						
SAQUINAVIR MESYLATE TABLETS	INVIRASE						
STAVUDINE CAPSULES	ZERIT						
STAVUDINE SOLUTION	ZERIT						
TENOFOVIR DISOPROXIL FUMARATE POWDER	VIREAD						
TENOFOVIR DISOPROXIL FUMARATE TABLETS	VIREAD						
TIPRANAVIR CAPSULES	APTIVUS						
TIPRANAVIR SOLUTION	APTIVUS						
ZIDOVUDINE CAPSULES	RETROVIR						
ZIDOVUDINE SYRUP	RETROVIR						
ZIDOVUDINE TABLETS	ZIDOVUDINE						
CMV AGENTS							
CIDOFOVIR IV	VISTIDE			PA Required			
FOSCARENT SODIUM	FOSCAVIR			PA Required			
GANCICLOVIR SODIUM	CYTOVENE			PA Required			
VALGANCICLOVIR HCL SOLUTION	VALCYTE			PA Required			
VALGANCICLOVIR HCL TABLETS	VALCYTE			PA Required			
HEPATITIS B AGENTS							
ADEFOVIR DIPIVOXIL TABLETS	HEPSERA			PA Required			
ENTECAVIR SOLUTION	BARACLUDE			PA Required			
ENTECAVIR TABLETS	BARACLUDE			PA Required			
LAMIVUDINE (HBV) SOLUTION	EPIVIR HBV						
LAMIVUDINE (HBV) TABLETS	EPIVIR HBV						
TELBIVUDINE TABLETS	TYZEKA			PA Required			
HEPATITIS C AGENTS							
GLECAPREVIR-PIBRENTASVIR TABLETS	MAVYRET		PREFERRED DRUG	PA Required			
PEGINTERFERON ALFA-2A SOLUTION	PEGASYS		PREFERRED DRUG	PA Required			
PEGINTERFERON ALFA-2B KIT	PEGINTRON		PREFERRED DRUG	PA Required			
RIBAVIRIN (HEPATITIS C) CAPSULES	VARIOUS		PREFERRED DRUG	PA Required			
RIBAVIRIN (HEPATITIS C) TABLETS	VARIOUS		PREFERRED DRUG	PA Required			

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE OCTOBER 1, 2021

- Generic Drugs Are Preferred Over Brand Name Drugs Unless The Drug Is Specified As BRAND ONLY
- Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List May Be Available Through Prior Authorization

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	Prior Authorization Type	Step Therapy Requirements	Quantity Limit (QL)	QL Days
SOFOSBUVIR/VELPATASVIR	EPCLUSA	AUTHORIZED GENERIC ONLY	PREFERRED DRUG	PA Required			
HERPES AGENTS							
ACYCLOVIR SUSPENSION	ZOVIRAX						
ACYCLOVIR TABLETS	ZOVIRAX						
FAMCICLOVIR TABLETS	FAMVIR			PA Required			
VALACYCLOVIR HCL TABLETS	VALTREX			PA Required			
INFLUENZA AGENTS							
OSELTAMIVIR PHOSPHATE CAPSULES	TAMIFLU					20	270
OSELTAMIVIR PHOSPHATE SUSPENSION	TAMIFLU						
RIMANTADINE HYDROCHLORIDE TABLETS	FLUMADINE						
ZANAMIVIR AEROSOL POWDER BREATH ACTIVATED	RELENZA DISKHALER					40	270
ASSORTED CLASSES							
BLOOD PRODUCTS - IMMUNE GLOBULINS							
IMMUNE GLOBULIN	BIVIGAM (IV)	BRAND ONLY	PREFERRED DRUG	PA REQUIRED			
IMMUNE GLOBULIN	FLEBOGFAMMA DIF (IV)	BRAND ONLY	PREFERRED DRUG	PA REQUIRED			
IMMUNE GLOBULIN	GAMMAGARD LIQUID (INJ)	BRAND ONLY	PREFERRED DRUG	PA REQUIRED			
IMMUNE GLOBULIN	GAMMAKED (INJ)	BRAND ONLY	PREFERRED DRUG	PA Required			
IMMUNE GLOBULIN	GAMUNEX-C (INJ)	BRAND ONLY	PREFERRED DRUG	PA REQUIRED			
IMMUNE GLOBULIN	HIZENTRA (SUBQ)	BRAND ONLY	PREFERRED DRUG	PA REQUIRED			
IMMUNE GLOBULIN	PRIVIGEN (IV)	BRAND ONLY	PREFERRED DRUG	PA Required			
CHELATING AGENTS							
PENICILLAMINE CAPSULES	CUPRIMINE						
IMMUNOMODULATORS							
LENALIDOMIDE CAPSULES	REVLIMID			PA Required			
THALIDOMIDE CAPSULES	THALOMID			PA Required			
IMMUNOSUPPRESSIVE AGENTS							
AZATHIOPRINE TABLETS	IMURAN						
CYCLOSPORINE CAPSULES	SANDIMMUNE						

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE OCTOBER 1, 2021

- Generic Drugs Are Preferred Over Brand Name Drugs Unless The Drug Is Specified As BRAND ONLY
- Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List May Be Available Through Prior Authorization

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	Prior Authorization Type	Step Therapy Requirements	Quantity Limit (QL)	QL Days
CYCLOSPORINE MODIFIED (FOR MICROEMULSION) CAPSULES	GENGRAF						
CYCLOSPORINE MODIFIED (FOR MICROEMULSION) SOLUTION	GENGRAF						
CYCLOSPORINE SOLUTION	SANDIMMUNE						
EVEROLIMUS (IMMUNOSUPPRESSANT) TABLETS	ZORTRESS			PA Required			
MYCOPHENOLATE MOFETIL CAPSULES	CELLCEPT						
MYCOPHENOLATE MOFETIL SUSPENSION	CELLCEPT						
MYCOPHENOLATE MOFETIL TABLETS	CELLCEPT						
SIROLIMUS SOLUTION	RAPAMUNE						
SIROLIMUS TABLETS	RAPAMUNE						
TACROLIMUS CAPSULES	HECORIA						
TACROLIMUS CAPSULE CONTROLLED RELEASE	ASTAGRAF XL						
POTASSIUM REMOVING RESINS							
SODIUM POLYSTYRENE SULFONATE POWDER	KAYEXALATE						
SODIUM POLYSTYRENE SULFONATE SUSPENSION	KIONEX						
BETA BLOCKERS							
ALPHA-BETA BLOCKERS							
CARVEDILOL TABLETS	COREG						
LABETALOL HCL TABLETS	TRANDATE						
BETA BLOCKERS CARDIO-SELECTIVE							
ATENOLOL TABLETS	TENORMIN						
ATENOLOL/CHLORTHALIDONE	VARIOUS						
BISOPRODOL	VARIOUS						
BISOPRODOL/HCTZ	VARIOUS						
METOPROLOL TARTRATE TABLETS	VARIOUS						
METOPROLOL SUCCINATE TABLET XL 24-HOUR	VARIOUS						
METOPROLOL TARTRATE/HCTZ	VARIOUS						
BETA BLOCKERS NON-SELECTIVE							
NADOLOL	VARIOUS			PA NOT REQUIRED FOR CHILDREN AND ADOLESCENTS UNDER 19 YEARS OF AGE			
PROPRANOLOL HCL CAPSULE ER CONTROLLED RELEASE	VARIOUS						
PROPRANOLOL HCL SOLUTION	VARIOUS						

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE OCTOBER 1, 2021

- Generic Drugs Are Preferred Over Brand Name Drugs Unless The Drug Is Specified As BRAND ONLY
- Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List May Be Available Through Prior Authorization

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	Prior Authorization Type	Step Therapy Requirements	Quantity Limit (QL)	QL Days
PROPRANOLOL HCL TABLETS	VARIOUS						
PROPRANOLOL / HCTZ	VARIOUS						
SOTALOL HCL TABLETS	BETAPACE						
CALCIUM CHANNEL BLOCKERS							
CALCIUM CHANNEL BLOCKERS							
AMLODIPINE BESYLATE	VARIOUS					30	30
DILTIAZEM CAPSULE ER	VARIOUS						
DILTIAZEM TABLETS	VARIOUS						
FELODIPINE TABLET ER 24-HOUR	VARIOUS					30	30
NIFEDIPINE IR CAPSULES	VARIOUS						
NIFEDIPINE TABLET ER 24-HOUR	VARIOUS					30	30
VERAPAMIL HCL CAPSULE SR	VARIOUS					30	30
VERAPAMIL HCL TABLETS	VARIOUS						
VERAPAMIL HCL TABLET CONTROLLED RELEASE	VARIOUS					30	30
CARDIOTONICS							
CARDIAC GLYCOSIDES							
DIGOXIN SOLUTION	DIGOXIN						
DIGOXIN TABLETS	LANOXIN						
CARDIOVASCULAR AGENTS - MISC.							
ANGIOTENSTIN RECEPTOR NEPRILYSIN INHIBITOR							
SACUBITRIL / VALSARTAN	ENTRESTO			PA Required			
PULMONARY HYPERTENSION - ENDOTHELIN RECEPTOR ANTAG							
AMBRISENTAN TABLETS	LETAIRIS	BRAND ONLY	PREFERRED DRUG	PA Required			
BOSENTAN TABLETS	TRACLEER	BRAND ONLY	PREFERRED DRUG	PA Required			
PULMONARY HYPERTENSION - PHOSPHODIESTERASE INHIBIT							
SILDENAFIL CITRATE (PULMONARY HYPERTENSION) SUSPENSION	REVATIO	BRAND ONLY	PREFERRED DRUG	PA Required FOR > 12 YEARS OF AGE			
SILDENAFIL CITRATE (PULMONARY HYPERTENSION) TABLETS	VARIOUS		PREFERRED DRUG	PA Required			
TADALAFIL (PULMONARY HYPERTENSION) TABLETS	ADCIRCA	BRAND ONLY	PREFERRED DRUG	PA Required			
CEPHALOSPORINS							
CEPHALOSPORINS - 1ST GENERATION							
CEFADROXIL CAPSULES	CEFADROXIL						

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE OCTOBER 1, 2021

- Generic Drugs Are Preferred Over Brand Name Drugs Unless The Drug Is Specified As BRAND ONLY
- Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List May Be Available Through Prior Authorization

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	Prior Authorization Type	Step Therapy Requirements	Quantity Limit (QL)	QL Days
CEFADROXIL SUSPENSION	CEFADROXIL						
CEFADROXIL TABLETS	CEFADROXIL						
CEPHALEXIN CAPSULES	KEFLEX						
CEPHALEXIN SUSPENSION	CEPHALEXIN						
CEPHALEXIN TABLETS	CEPHALEXIN						
CEPHALOSPORINS - 2ND GENERATION							
CEFACLOR CAPSULES	CEFACLOR						
CEFACLOR SUSPENSION	CEFACLOR						
CEFPROZIL SUSPENSION	CEFPROZIL						
CEFPROZIL TABLETS	CEFPROZIL						
CEFUROXIME AXETIL SUSPENSION	CEFTIN						
CEFUROXIME AXETIL TABLETS	CEFTIN						
CEPHALOSPORINS - 3RD GENERATION							
CEFDINIR CAPSULES	CEFDINIR						
CEFDINIR SUSPENSION	CEFDINIR						
CEFIXIME CAPSULES	SUPRAX					1	30
CEFIXIME CHEWABLE TABLETS	SUPRAX					1	30
CEFIXIME SUSPENSION	SUPRAX					1	30
CEFIXIME TABLETS	SUPRAX					1	30
CEFPODOXIME PROXETIL SUSPENSION	CEFPODOXIME PROXETIL						
CEFPODOXIME PROXETIL TABLETS	CEFPODOXIME PROXETIL						
CONTRACEPTION							
COMBINATION CONTRACEPTIVES - ORAL							
DESOGESTREL & ETHINYL ESTRADIOL TABLETS	APRI						
DESOGESTREL-ETHINYL ESTRADIOL (BIPHASIC) TABLETS	AZURETTE						
DESOGESTREL-ETHINYL ESTRADIOL (TRIPHASIC) TABLETS	CAZIAN						
DROSPIRENONE-ETHINYL ESTRADIOL TABLETS	OCELLA						
ETHYNODIOL DIACET & ETHINYL ESTRADIOL TABLETS	KELNOR 1/35						
LEVONORGESTREL & ETHINYL ESTRADIOL TABLETS	AUBRA						
LEVONORGESTREL-ETHINYL ESTRADIOL (TRIPHASIC) TABLETS	ENPRESSE-28						

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE OCTOBER 1, 2021

- Generic Drugs Are Preferred Over Brand Name Drugs Unless The Drug Is Specified As BRAND ONLY
- Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List May Be Available Through Prior Authorization

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	Prior Authorization Type	Step Therapy Requirements	Quantity Limit (QL)	QL Days
LEVONORGESTREL-ETHINYL ESTRADIOL (91-DAY) TABLETS	AMETHIA LO						
LEVONORGESTREL & ETHINYL ESTRADIOL (CONTINUOUS) TABLETS	AMETHYST						
NORETHINDRONE ACE & ETHINYL ESTRADIOL-FE TABLETS	JUNEL FE						
NORETHINDRONE ACE & ETHINYL ESTRADIOL-FE CHEWABLES	MELODETTA 24 FE						
NORETHINDRONE & ETH ESTRADIOL TABLETS	BALZIVA						
NORETHINDRONE & MESTRANOL TABLETS	NECON 1/50-28						
NORETHINDRONE ACET & ETH ESTRA TABLETS	GILDESS 1/20						
NORETHINDRONE ACETATE-ETHINYL ESTRADIOL-FE TABLETS	ESTROSTEP FE						
NORETHIN ACET & ESTRAD-FE TABLETS	LOESTRIN FE TAB 1/20						
NORETHINDRONE-ETH ESTRADIOL (BIPHASIC) TABLETS	NECON 10/11-28						
NORETHINDRONE-ETH ESTRADIOL (TRIPHASIC) TABLETS	CYCLAFEM 7/7/7						
NORETHINDRONE & ETHINYL ESTRADIOL-FE CHEWABLES	KAITLIB FE						
NORGESTIMATE-ETHINYL ESTRADIOL (TRIPHASIC) TABLETS	ORTHO TRI-CYCLEN						
NORGESTIMATE-ETHINYL ESTRADIOL TABLETS	ESTARYLLA						
NORGESTREL & ETHINYL ESTRADIOL TABLETS	CRYSELLE-28						
COMBINATION CONTRACEPTIVES - VAGINAL							
ETONOGESTREL-ETHINYL ESTRADIOL RING	NUVARING	BRAND ONLY					
COPPER CONTRACEPTIVES - IUD							
COPPER (IUD)	PARAGARD			Buy and Bill Under Medical Benefit			
EMERGENCY CONTRACEPTIVES							
LEVONORGESTREL (EMERGENCY OC) TABLETS	PLAN B ONE-STEP OTC		PREFERRED DRUG				
LEVONORGESTREL (EMERGENCY OC) TABLETS	AFTERA OTC		PREFERRED DRUG				
LEVONORGESTREL (EMERGENCY OC) TABLETS	LEVONORGESTREL OTC		PREFERRED DRUG				
LEVONORGESTREL (EMERGENCY OC) TABLETS	MY CHOICE OTC		PREFERRED DRUG				

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE OCTOBER 1, 2021

- Generic Drugs Are Preferred Over Brand Name Drugs Unless The Drug Is Specified As BRAND ONLY
- Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List May Be Available Through Prior Authorization

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	Prior Authorization Type	Step Therapy Requirements	Quantity Limit (QL)	QL Days
LEVONORGESTREL (EMERGENCY OC) TABLETS	MY WAY OTC		PREFERRED DRUG				
LEVONORGESTREL (EMERGENCY OC) TABLETS	NEW DAY OTC		PREFERRED DRUG				
LEVONORGESTREL (EMERGENCY OC) TABLETS	OPTION 2 OTC		PREFERRED DRUG				
LEVONORGESTREL (EMERGENCY OC) TABLETS	TAKE ACTION OTC		PREFERRED DRUG				
PROGESTINS							
HYDROXYPROGESTERONE CAPROATE OIL	MAKENA 250 MG/ML	BRAND ONLY	PREFERRED DRUG	PA Required			
HYDROXYPROGESTERONE CAPROATE SOLUTION AUTOINJECTOR	MAKENA AUTO INJECTOR	BRAND ONLY	PREFERRED DRUG	PA Required			
MEDROXYPROGESTERONE ACETATE TABLETS	PROVERA		PREFERRED DRUG				
PROGESTERONE MICRONIZED CAPSULES	PROMETRIUM		PREFERRED DRUG				
PROGESTIN CONTRACEPTIVES - IMPLANTS							
ETONOGESTREL IMPLANT	NEXPLANON		PREFERRED DRUG				
PROGESTIN CONTRACEPTIVES - INJECTABLE							
MEDROXYPROGESTERONE ACETATE (CONTRACEPTIVE) SUSPENSION	CONTRACEPTIVE						
PROGESTIN CONTRACEPTIVES - IUD							
LEVONORGESTREL (IUD)	LILETTA			Buy and Bill Under Medical Benefit			
LEVONORGESTREL (IUD)	SKYLA			Buy and Bill Under Medical Benefit			
LEVONORGESTREL (IUD)	MIRENA			Buy and Bill Under Medical Benefit			
LEVONORGESTREL (IUD)	KYLEENA			Buy and Bill Under Medical Benefit			
PROGESTIN CONTRACEPTIVES - ORAL							

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE OCTOBER 1, 2021

- Generic Drugs Are Preferred Over Brand Name Drugs Unless The Drug Is Specified As BRAND ONLY
- Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List May Be Available Through Prior Authorization

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	Prior Authorization Type	Step Therapy Requirements	Quantity Limit (QL)	QL Days
NORETHINDRONE (CONTRACEPTIVE) TABLETS	CAMILA						
PROGESTIN CONTRACEPTIVES - TRANSDERMAL							
NORELGESTROMIN-ETHINYL ESTRADIOL PATCH WEEKLY	XULANE						
CORTICOSTEROIDS							
GLUCOCORTICOSTEROIDS							
DEXAMETHASONE CONCENTRATE	DEXAMETHASONE INTENSOL						
DEXAMETHASONE ELIXIR	VARIOUS						
DEXAMETHASONE SOLUTION	DEXAMETHASONE						
DEXAMETHASONE TABLETS	DEXAMETHASONE						
HYDROCORTISONE SOD SUCCINATE SOLUTION (INJECTABLE)	A-HYDROCORT			PA Required			
METHYLPREDNISOLONE ACETATE SUSPENSION (INJECTABLE)	DEPO-MEDROL			PA Required			
METHYLPREDNISOLONE SOD SUCC SOLUTION (INJECTABLE)	A-METHAPRED			PA Required			
METHYLPREDNISOLONE TABLETS	MEDROL						
PREDNISOLONE SODIUM PHOSPHATE SOLUTION	ORAPRED						
PREDNISOLONE SODIUM PHOSPHATE ORALLY DISINTEGRATING TABLETS	ORAPRED ODT						
PREDNISOLONE SYRUP	PRELONE						
PREDNISOLONE TABLETS	VARIOUS						
PREDNISONE CONCENTRATE	PREDNISONE INTENSOL						
PREDNISONE SOLUTION	PREDNISONE						
PREDNISONE TABLETS	PREDNISONE						
TRIAMCINOLONE ACETONIDE SUSPENSION (INJECTABLE)	KENALOG-10			PA Required			
TRIAMCINOLONE DIACETATE SUSPENSION (INJECTABLE)	TRIAMCINOLONE			PA Required			
TRIAMCINOLONE HEXACETONIDE SUSPENSION (INJECTABLE)	ARISTOSPAN INTRALESIONAL & INTRA-ARTICULAR			PA Required			
MINERALOCORTICOIDS							
FLUDROCORTISONE ACETATE TABLETS	FLORINEF						
COUGH/COLD/ALLERGY							
ANTITUSSIVES							
BENZONATATE CAPSULES	TESSALON PERLES						
HYDROCODONE W/ HOMATROPINE SYRUP	VARIOUS			PA Required for < 18 years of age		240	12
HYDROCODONE W/ HOMATROPINE TABLETS	VARIOUS			PA Required for < 18 years of age			

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE OCTOBER 1, 2021

- Generic Drugs Are Preferred Over Brand Name Drugs Unless The Drug Is Specified As BRAND ONLY
- Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List May Be Available Through Prior Authorization

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	Prior Authorization Type	Step Therapy Requirements	Quantity Limit (QL)	QL Days
COUGH/COLD/ALLERGY COMBINATIONS							
BROMPHENIRAMINE & PSEUDOEPHEDRINE LIQUID	VARIOUS						
BROMPHENIRAMINE & PSEUDOEPHEDRINE TABLET 12-HOUR	VARIOUS						
BROMPHENIRAMINE-DEXTROMETHORPHAN-PHENYLEPHRINE LIQUID/TABLETS	VARIOUS						
CETIRIZINE-PSEUDOEPHEDRINE TABLET 12-HOUR	VARIOUS					30	30
CHLORPHENIRAMINE & PSEUDOEPHEDRINE CHEWABLE TABLETS	VARIOUS						
CHLORPHENIRAMINE & PSEUDOEPHEDRINE LIQUID	VARIOUS					480	30
CHLORPHENIRAMINE & PSEUDOEPHEDRINE SOLUTION	VARIOUS					480	30
CHLORPHENIRAMINE & PSEUDOEPHEDRINE SYRUP	VARIOUS					480	30
CHLORPHENIRAMINE & PSEUDOEPHEDRINE TABLETS	VARIOUS						
DEXTROMETHORPHAN-GUAIFENESIN TABLET	VARIOUS						
DEXTROMETHORPHAN-GUAIFENESIN LIQUID	VARIOUS					480	30
DEXTROMETHORPHAN-GUAIFENESIN TABLET 12-HOUR	MUCINEX DM						
FEXOFENADINE-PSEUDOEPHEDRINE TABLET 12-HOUR	VARIOUS					30	30
FEXOFENADINE-PSEUDOEPHEDRINE TABLET 24-HOUR	VARIOUS					30	30
GUAIFENESIN-CODEINE SYRUP	ROBITUSSIN AC			PA Required for < 18 years of age		240	12
LORATADINE & PSEUDOEPHEDRINE TABLET 12-HOUR	ALAVERT ALLERGY/SINUS					30	30
LORATADINE & PSEUDOEPHEDRINE TABLET 24-HOUR	CLARITIN-D 24 HOUR					30	30
PHENYLEPHRINE W/ DEXTROMETHORPHAN-GUAIFENESIN CAPSULES	VARIOUS						
PHENYLEPHRINE W/ DEXTROMETHORPHAN-GUAIFENESIN LIQUID	ROBITUSSIN CHILDRENS COUGH & COLD CF					480	30
PHENYLEPHRINE W/ DEXTROMETHORPHAN-GUAIFENESIN SYRUP	VARIOUS					480	30
PHENYLEPHRINE W/ DEXTROMETHORPHAN-GUAIFENESIN TABLETS	VARIOUS						
PHENYLEPHRINE W/ DEXTROMETHORPHAN-GUAIFENESIN TABLET 12-HOUR	VARIOUS						
PHENYLEPHRINE-BROMPHENIRAMINE-DEXTROMETHORPHAN ELIXIR	VARIOUS					480	30
PHENYLEPHRINE-BROMPHENIRAMINE-DEXTROMETHORPHAN LIQUID	DIMETAPP DEXTROMETHORPHAN COLD & COUGH					480	30
PHENYLEPHRINE-BROMPHENIRAMINE-DEXTROMETHORPHAN SYRUP	VARIOUS					480	30
PHENYLEPHRINE-CHLORPHENIRAMINE-DEXTROMETHORPHAN LIQUID	VARIOUS					480	30
PHENYLEPHRINE-CHLORPHENIRAMINE-DEXTROMETHORPHAN DROPS	VARIOUS			PA Required for < 6 years age			

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE OCTOBER 1, 2021

- Generic Drugs Are Preferred Over Brand Name Drugs Unless The Drug Is Specified As BRAND ONLY
- Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List May Be Available Through Prior Authorization

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	Prior Authorization Type	Step Therapy Requirements	Quantity Limit (QL)	QL Days
PHENYLEPHRINE-CHLORPHENIRAMINE-DEXTROMETHORPHAN SYRUP	VARIOUS					480	30
PHENYLEPHRINE-CHLORPHENIRAMINE-DEXTROMETHORPHAN TABLETS	VARIOUS						
PHENYLEPHRINE-GUAIFENESIN CAPSULES	VARIOUS						
PHENYLEPHRINE-GUAIFENESIN LIQUID	TRIAMINIC CHEST/ NASAL CONGESTION					480	30
PHENYLEPHRINE-GUAIFENESIN SYRUP	TRIAMINIC CHEST & NASAL CONGESTION					480	30
PHENYLEPHRINE-GUAIFENESIN TABLETS	VARIOUS						
PROMETHAZINE & PHENYLEPHRINE SYRUP	PROMETHAZINE/ PHENYLEPHRINE					480	30
PROMETHAZINE W/CODEINE SYRUP	PROMETHAZINE/CODEINE			PA Required for < 18 years of age		240	12
PROMETHAZINE-DEXTROMETHORPHAN SYRUP	PROMETHAZINE/ DEXTROMETHORPHAN					480	30
PSEUDOEPHEDRINE W/ CODEINE-GUAIFENESIN SYRUP	VARIOUS			PA Required for < 18 years of age		240	12
EXPECTORANTS							
GUAIFENESIN LIQUID	VARIOUS					480	30
GUAIFENESIN SYRUP	VARIOUS					480	30
GUAIFENESIN TABLETS	VARIOUS						
GUAIFENESIN TABLET 12-HOUR	VARIOUS						
DERMATOLOGICALS							
ACNE PRODUCTS							
BENZOYL PEROXIDE WASH 5% & 10%	VARIOUS						
BENZOYL PEROXIDE CLEANSER 6%	NEUTROGENA ON-THE-SPOT ACNE TREATMENT						
BENZOYL PEROXIDE GEL	BENZOYL PEROXIDE						
BENZOYL PEROXIDE LIQUID	PANOXYL						
BENZOYL PEROXIDE LOTION	BP CLEANSING LOTION						
BENZOYL PEROXIDE-ERYTHROMYCIN PACK	BENZAMYCINPAK						
CLINDAMYCIN PHOSPHATE (TOPICAL) GEL	CLEOCIN-T						
CLINDAMYCIN PHOSPHATE (TOPICAL) LOTION	CLEOCIN-T						
CLINDAMYCIN PHOSPHATE (TOPICAL) SOLUTION	CLEOCIN-T						
CLINDAMYCIN PHOSPHATE (TOPICAL) SWAB	CLEOCIN-T						

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE OCTOBER 1, 2021

- Generic Drugs Are Preferred Over Brand Name Drugs Unless The Drug Is Specified As BRAND ONLY
- Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List May Be Available Through Prior Authorization

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	Prior Authorization Type	Step Therapy Requirements	Quantity Limit (QL)	QL Days
CLINDAMYCIN PHOSPHATE-BENZOYL PEROXIDE (REFRIGERATE)	CLINDAMY/BEN						
ERYTHROMYCIN (ACNE AID) SOLUTION	ERYTHROMYCIN						
ISOTRETINOIN CAPSULES	ABSORICA			PA Required			
TRETINOIN CREAM	RETIN-A	BRAND ONLY		PA Required For > 26 Years of Age			
TRETINOIN GEL	RETIN-A	BRAND ONLY		PA Required For > 26 Years of Age			
ANTIBIOTICS - TOPICAL							
BACITRACIN OINTMENT	BACIGUENT						
BACITRACIN ZINC OINTMENT	BACITRACIN						
BACITRACIN-POLYMYXIN B OINTMENT	POLYSPORIN						
BACITRACIN-POLYMYXIN-NEOMYCIN HC OINTMENT	CORTISPORIN						
GENTAMICIN SULFATE CREAM	GENTAMICIN SULFATE						
GENTAMICIN SULFATE OINTMENT	GENTAMICIN SULFATE						
MUPIROCIN CALCIUM CREAM	BACTROBAN						
MUPIROCIN OINTMENT	BACTROBAN						
NEOMYCIN-BACITRACIN-POLYMYXIN OINTMENT	NEOSPORIN						
ANTIFUNGALS - TOPICAL							
BUTENAFINE	LOTRIMIN ULTRA						
CICLOPROX CREAM	VARIOUS						
CICLOPROX SOLUTION	VARIOUS						
CLOTRIMAZOLE CREAM (RX & OTC)	LOTRIMIN						
CLOTRIMAZOLE OINTMENT	LOTRIMIN						
CLOTRIMAZOLE SOLUTION (OTC)	VARIOUS						
CLOTRIMAZOLE W/ BETAMETHASONE CREAM	LOTRISONE						
KETOCONAZOLE CREAM	VARIOUS						
KETOCONAZOLE SHAMPOO	VARIOUS						
MICONAZOLE NITRATE CREAM	VARIOUS						
MICONAZOLE NITRATE POWDER	VARIOUS						
NYSTATIN CREAM	VARIOUS						
NYSTATIN OINTMENT	VARIOUS						
NYSTATIN POWDER	VARIOUS						

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE OCTOBER 1, 2021

- Generic Drugs Are Preferred Over Brand Name Drugs Unless The Drug Is Specified As BRAND ONLY
- Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List May Be Available Through Prior Authorization

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	Prior Authorization Type	Step Therapy Requirements	Quantity Limit (QL)	QL Days
TOLNAFTATE AERO POWDER	VARIOUS						
TOLNAFTATE CREAM	VARIOUS						
TOLNAFTATE POWDER	VARIOUS						
TERBINAFINE CREAM	VARIOUS						
ANTIHISTAMINES-TOPICAL							
DIPHENHYDRAMINE HCL CREAM	ANTI-ITCH MAXIMUM STRENGTH						
DIPHENHYDRAMINE HCL GEL	BENADRYL ITCH STOPPING						
DIPHENHYDRAMINE HCL SOLUTION	BENADRYL MAXIMUM STRENGTH						
ANTISEBORRHEIC TOPICAL PRODUCTS							
SELENIUM SULFIDE LOTION	SELSUN SHAMPOO						
ANTIVIRALS - TOPICAL							
DOCOSANOL 10% CREAM	ABREVA		PREFERRED DRUG			15GM	30
ACYCLOVIR OINTMENT	ZOVIRAX		PREFERRED DRUG				
BURN PRODUCTS							
SILVER SULFADIAZINE CREAM	SILVADENE						
CORTICOSTEROIDS - TOPICAL LOW POTENCY							
FLUOCINOLONE ACETONIDE	DERMA-SMOOTH FS	BRAND ONLY					
HYDROCORTISONE CREAM	VARIOUS						
HYDROCORTISONE GEL	VARIOUS						
HYDROCORTISONE LOTION	VARIOUS						
HYDROCORTISONE OINTMENT	VARIOUS						
FLUOCINOLONE 0.01% OIL	VARIOUS						
CORTICOSTEROIDS - TOPICAL MEDIUM POTENCY							
FLUTICASONE PROPIONATE CREAM	VARIOUS						
FLUTICASONE PROPIONATE OINTMENT	VARIOUS						
MOMETASONE FUROATE CREAM	VARIOUS						
MOMETASONE FUROATE OINTMENT	VARIOUS						
MOMETASONE FUROATE SOLUTION	VARIOUS						
CORTICOSTEROIDS - TOPICAL HIGH POTENCY							
BETAMETHASONE DIPROPIONATE LOTION	VARIOUS						

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE OCTOBER 1, 2021

- Generic Drugs Are Preferred Over Brand Name Drugs Unless The Drug Is Specified As BRAND ONLY
- Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List May Be Available Through Prior Authorization

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	Prior Authorization Type	Step Therapy Requirements	Quantity Limit (QL)	QL Days
BETAMETHASONE DIPROPIONATE/PROPYLENE GLYC. CREAM	VARIOUS						
BETAMETHASONE VALERATE CREAM	VARIOUS						
BETAMETHASONE VALERATE LOTION	VARIOUS						
BETAMETHASONE VALERATE SOLUTION	VARIOUS						
FLUOCINONIDE CREAM	VARIOUS						
FLUOCINONIDE OINTMENT	VARIOUS						
FLUOCINONIDE SOLUTION	VARIOUS						
TRIAMCINOLONE ACETONIDE CREAM	VARIOUS						
TRIAMCINOLONE ACETONIDE LOTION	VARIOUS						
TRIAMCINOLONE ACETONIDE OINTMENT	VARIOUS						
CORTICOSTEROIDS - TOPICAL VERY HIGH POTENCY							
CLOBETASOL PROPIONATE CREAM	VARIOUS					100	30
CLOBETASOL PROPIONATE EMOLLIENT	VARIOUS					100	30
CLOBETASOL PROPIONATE GEL	VARIOUS					118	30
CLOBETASOL PROPIONATE OINTMENT	VARIOUS					100	30
CLOBETASOL PROPIONATE SOLUTION	VARIOUS					100	30
HALOBETASOL PROPIONATE CREAM	VARIOUS					100	30
HALOBETASOL PROPIONATE OINTMENT	VARIOUS					100	30
KERATOLYTIC/ANTIMITOTIC AGENTS							
SALICYLIC ACID CREAM	SALACYN						
SALICYLIC ACID FOAM	SALVAX						
SALICYLIC ACID GEL	KERALYT						
SALICYLIC ACID LIQUID	VIRASAL						
SALICYLIC ACID LOTION	SALACYN						
SALICYLIC ACID SHAMPOO	SALEX						
SALICYLIC ACID SOLUTION	VARIOUS						
LOCAL ANESTHETICS - TOPICAL							
LIDOCAINE CREAM 4%	ASPERCREME W/LIDOCAINE						
LIDOCAINE HCL GEL 2%	GLYDO						
LIDOCAINE HCL LOTION	LIDOCAINE HCL			PA Required			

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE OCTOBER 1, 2021

- Generic Drugs Are Preferred Over Brand Name Drugs Unless The Drug Is Specified As BRAND ONLY
- Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List May Be Available Through Prior Authorization

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	Prior Authorization Type	Step Therapy Requirements	Quantity Limit (QL)	QL Days
LIDOCAINE OINTMENT	LIDOCAINE			PA Required			
LIDOCAINE PATCH	LIDODERM			PA Required			
LIDOCAINE HCL SOLUTION	VARIOUS						
LIDOCAINE-PRILOCAINE CREAM	EMLA						
TOPICAL - MISC.							
ALUMINUM CHLORIDE SOLUTION	DRYSOL						
ROSACEA TOPICAL AGENTS							
METRONIDAZOLE CREAM 0.75%	METROCREAM						
METRONIDAZOLE GEL 0.75%	METROGEL						
METRONIDAZOLE LOTION	METROLOTION						
SCABICIDES & PEDICULICIDES TOPICAL AGENTS+A1106							
CROTAMITON CREAM	EURAX						
CROTAMITON LOTION	EURAX						
IVERMECTIN LOTION	SKLICE			PA Required			
PERMETHRIN CREAM	ACTICIN						
PERMETHRIN 1%, 5%	NIX, ELIMITE						
PERMETHRIN LIQUID	NIX CREME RINSE						
PYRETHRINS-PIPERONYL BUTOXIDE GEL	A-200						
PYRETHRINS-PIPERONYL BUTOXIDE LIQUID	BARC						
PYRETHRINS-PIPERONYL BUTOXIDE SHAMPOO	LICIDE						
SPINOSAD SUSPENSION	NATROBA			PA Required			
DIAGNOSTIC PRODUCTS							
DIAGNOSTIC TESTS							
BLOOD GLUCOSE MONITORS & STRIPS	VARIOUS						
DIGESTIVE AIDS							
DIGESTIVE ENZYMES							
LIPASE-PROTEASE-AMYLASE CAPSULE DELAYED RELEASE	CREON	BRAND ONLY	PREFERRED DRUG			500	30
LIPASE-PROTEASE-AMYLASE CAPSULE DELAYED RELEASE	ZENPEP	BRAND ONLY	PREFERRED DRUG			500	30
LIPASE-PROTEASE-AMYLASE CAPSULE DELAYED RELEASE 5000 UNITS	PANCRELIPASE 5000 UNITS		PREFERRED DRUG			300	30
DIURETICS							

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE OCTOBER 1, 2021

- Generic Drugs Are Preferred Over Brand Name Drugs Unless The Drug Is Specified As BRAND ONLY
- Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List May Be Available Through Prior Authorization

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	Prior Authorization Type	Step Therapy Requirements	Quantity Limit (QL)	QL Days
CARBONIC ANHYDRASE INHIBITORS							
ACETAZOLAMIDE CAPSULE 12-HOUR	DIAMOX						
ACETAZOLAMIDE TABLETS	ACETAZOLAMIDE						
METHAZOLAMIDE TABLETS	NEPTAZANE						
DIURETIC COMBINATIONS							
SPIRONOLACTONE & HYDROCHLOROTHIAZIDE TABLETS	ALDACTAZIDE						
TRIAMTERENE & HYDROCHLOROTHIAZIDE CAPSULES	DYAZIDE						
TRIAMTERENE & HYDROCHLOROTHIAZIDE TABLETS	MAXZIDE-25						
LOOP DIURETICS							
BUMETANIDE TABLETS	BUMETANIDE						
FUROSEMIDE SOLUTION	FUROSEMIDE						
FUROSEMIDE TABLETS	LASIX						
TORSEMIDE TABLETS	DEMADEX						
POTASSIUM SPARING DIURETICS							
SPIRONOLACTONE TABLETS	ALDACTONE						
THIAZIDES AND THIAZIDE-LIKE DIURETICS							
CHLOROTHIAZIDE SUSPENSION	DIURIL						
CHLOROTHIAZIDE TABLETS	CHLOROTHIAZIDE						
CHLORTHALIDONE TABLETS	CHLORTHALIDONE						
HYDROCHLOROTHIAZIDE CAPSULES 12.5MG	VARIOUS						
HYDROCHLOROTHIAZIDE TABLETS 25MG & 50MG	HYDROCHLOROTHIAZIDE						
INDAPAMIDE TABLETS	INDAPAMIDE						
METOLAZONE TABLETS	ZAROXOLYN						
ENDOCRINE AND METABOLIC AGENTS - MISC.							
BONE DENSITY REGULATORS							
ALENDRONATE SODIUM SOLUTION	ALENDRONATE SODIUM						
ALENDRONATE SODIUM TABLETS	ALENDRONATE SODIUM						
CALCITONIN (SALMON) SOLUTION	FORTICAL						
DENOSUMAB	PROLIA				PA Required		
IBANDRONATE SODIUM	BONIVA						

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE OCTOBER 1, 2021

- Generic Drugs Are Preferred Over Brand Name Drugs Unless The Drug Is Specified As BRAND ONLY
- Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List May Be Available Through Prior Authorization

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	Prior Authorization Type	Step Therapy Requirements	Quantity Limit (QL)	QL Days
RALOXIFENE TABLETS	VARIOUS						
TERIPARATIDE (RECOMBINANT)	FORTEO			PA Required			
GROWTH HORMONES							
SOMATROPIN SOLUTION	NORDITROPIN	BRAND ONLY	PREFERRED DRUG	PA Required			
SOMATROPIN SOLUTION	GENOTROPIN	BRAND ONLY	PREFERRED DRUG	PA Required			
HORMONE RECEPTOR MODULATORS							
RALOXIFENE HCL TABLETS	EVISTA						
INSULIN-LIKE GROWTH FACTORS (SOMATOMEDINS)							
MECASERMIN SOLUTION	INCRELEX			PA Required			
LHRH/GNRH AGONIST ANALOG PITUITARY SUPPRESSANTS							
LEUPROLIDE ACETATE (CPP) (3 MONTH) KIT	LUPRON DEPOT-PED			PA Required			
LEUPROLIDE ACETATE (CPP) KIT	LUPRON DEPOT-PED			PA Required			
METABOLIC MODIFIERS							
CINACALCET HCL TABLETS	SENSIPAR			PA Required			
IDURSULFASE SOLUTION	ELAPRASE			PA Required			
POSTERIOR PITUITARY HORMONES							
DESMOPRESSIN ACETATE REFRIGERATED SOLUTION	VARIOUS						
DESMOPRESSIN ACETATE SOLUTION	VARIOUS						
DESMOPRESSIN ACETATE SPRAY REFRIGERATED SOLUTION	VARIOUS						
DESMOPRESSIN ACETATE SPRAY SOLUTION	VARIOUS						
DESMOPRESSIN ACETATE TABLETS	VARIOUS			PA Required			
ESTROGENS							
ESTROGEN COMBINATIONS							
CONJUGATED ESTROGENS-MEDROXYPROGESTERONE ACETATE TABLETS	PREMPRO						
ESTRADIOL-LEVONORGESTREL PATCH-WEEKLY	CLIMARA PATCH						
ESTROGENS							
ESTERIFIED ESTROGENS TABLETS	MENEST						
ESTRADIOL PATCH-TWICE WEEKLY	ALORA						
ESTRADIOL PATCH-WEEKLY	MENOSTAR						
ESTRADIOL TABLETS	ESTRACE						

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE OCTOBER 1, 2021

- Generic Drugs Are Preferred Over Brand Name Drugs Unless The Drug Is Specified As BRAND ONLY
- Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List May Be Available Through Prior Authorization

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	Prior Authorization Type	Step Therapy Requirements	Quantity Limit (QL)	QL Days
ESTROGENS, CONJUGATED SYNTHETIC A TABLETS	CENESTIN						
ESTROGENS, CONJUGATED TABLETS	PREMARIN						
ESTROPIPATE TABLETS	ORTHO-EST						
FLUOROQUINOLONES							
FLUOROQUINOLONES							
CIPROFLOXACIN HCL TABLETS	CIPROFLOXACIN HCL						
LEVOFLOXACIN SOLUTION	LEVAQUIN						
LEVOFLOXACIN TABLETS	LEVAQUIN						
OFLOXACIN TABLETS	OFLOXACIN						
GASTROINTESTINAL AGENTS - MISC.							
GALLSTONE SOLUBILIZING AGENTS							
URSODIOL CAPSULES	ACTIGALL						
URSODIOL TABLETS	URSO 250						
GASTROINTESTINAL CHLORIDE CHANNEL ACTIVATORS							
LUBIPROSTONE CAPSULES	AMITIZA			PA Required			
GASTROINTESTINAL STIMULANTS							
METOCLOPRAMIDE HCL SOLUTION	VARIOUS						
METOCLOPRAMIDE HCL TABLETS	VARIOUS						
METOCLOPRAMIDE HCL ORALLY DISINTEGRATING TABLETS	VARIOUS						
INFLAMMATORY BOWEL AGENTS							
BALSALAZIDE DISODIUM TABLETS	GIAZO		PREFERRED DRUG			270	30
INFLIXIMAB-ABDA	AVSOLA	BRAND ONLY	PREFERRED DRUG	PA Required			
BUDESONIDE CAPSULES	ENTOCORT EC		PREFERRED DRUG				
MESALAMINE CAPSULE CONTROLLED RELEASE	PENTASA		PREFERRED DRUG			270	30
MESALAMINE CAPSULE DELAYED RELEASE	DELZICOL	BRAND ONLY	PREFERRED DRUG			180	30

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE OCTOBER 1, 2021

- Generic Drugs Are Preferred Over Brand Name Drugs Unless The Drug Is Specified As BRAND ONLY
- Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List May Be Available Through Prior Authorization

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	Prior Authorization Type	Step Therapy Requirements	Quantity Limit (QL)	QL Days
MESALAMINE CAPSULE 24-HOUR	APRISO	BRAND ONLY	PREFERRED DRUG			120	30
MESALAMINE ENEMA	SFROWASA	BRAND ONLY	PREFERRED DRUG			30	30
MESALAMINE TABLET ENTERIC COATED	LIALDA	BRAND ONLY	PREFERRED DRUG			120	30
MESALAMINE SUPPOSITORY	CANASA	BRAND ONLY	PREFERRED DRUG			30	30
SULFASALAZINE TABLETS	AZULFIDINE		PREFERRED DRUG			240	30
SULFASALAZINE TABLET ENTERIC COATED	AZULFIDINE EN-TABLETS		PREFERRED DRUG			240	30
IRRITABLE BOWEL SYNDROME (IBS) AGENTS							
LINACLOTIDE CAPSULES	LINZESS			PA Required			
PHOSPHATE BINDER AGENTS							
CALCIUM ACETATE TABLETS	VARIOUS		PREFERRED DRUG				
CALCIUM ACETATE CAPSULES	VARIOUS		PREFERRED DRUG				
SEVELAMER CARBONATE	REVELA	VARIOUS	PREFERRED DRUG				
GENITOURINARY AGENTS - MISC.							
INTERSTITIAL CYSTITIS AGENTS							
PENTOSAN POLYSULFATE SODIUM CAPSULES	ELMIRON			PA Required			
PROSTATIC HYPERTROPHY AGENTS							
ALFUZOSIN ER	VARIOUS						
DOXAZOSIN MESYLATE	VARIOUS						
DUTASTERIDE	VARIOUS						
FINASTERIDE	PROSCAR						
TAMSULOSIN HCL	FLOMAX						
TERAZOSIN	VARIOUS						
URINARY ANALGESICS							
PHENAZOPYRIDINE HCL TABLETS	PYRIDIUM						

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE OCTOBER 1, 2021

- Generic Drugs Are Preferred Over Brand Name Drugs Unless The Drug Is Specified As BRAND ONLY
- Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List May Be Available Through Prior Authorization

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	Prior Authorization Type	Step Therapy Requirements	Quantity Limit (QL)	QL Days
GOUT AGENTS							
GOUT AGENTS							
ALLOPURINOL TABLETS	ZYLOPRIM						
COLCHICINE TABLETS	VARIOUS						
FEBUXOSTAT TABLETS	ULORIC			PA Required			
URICOSURICS							
PROBENECID TABLETS	PROBENECID						
HEMATOLOGICAL AGENTS - MISC.							
PLATELET AGGREGATION INHIBITORS							
CILOSTAZOL TABLETS	PLETAL						
CLOPIDOGREL BISULFATE TABLETS	PLAVIX						
DIPYRIDAMOLE TABLETS	PERSANTINE						
TICAGRELOR TABLETS	BRILINTA			PA Required			
HEMATOPOIETIC AGENTS							
AGENTS FOR GAUCHER DISEASE							
ELIGLUSTAT TARTRATE	CERDELGA (oral)	BRAND ONLY		PA Required			
IMIGLUCERASE SOLUTION	CEREZYME 400 IU (IV)	BRAND ONLY		PA Required			
TALIGLUCERASE ALFA	ELELYSO (IV)	BRAND ONLY		PA Required			
MIGLUSTAT	MIGLUSTAT (AG) (oral)	BRAND ONLY		PA Required			
VELAGLUCERASE ALFA	VPRIV 400 IU	BRAND ONLY		PA Required			
HEMATOPOIETIC GROWTH FACTORS							
ELTROMBOPAG OLAMINE TABLETS	PROMACTA	BRAND ONLY	PREFERRED DRUG	PA Required			
EPOETIN ALFA SOLUTION	RETACRIT	BRAND ONLY	PREFERRED DRUG	PA Required			
FILGRASTIM DISPOSABLE SYRINGE	NEUPOGEN	BRAND ONLY	PREFERRED DRUG	PA Required			
FILGRASTIM SOLUTION	NEUPOGEN	BRAND ONLY	PREFERRED DRUG	PA Required			
FILGRASTIM-AAF SOLUTION PREFILLED SYRINGE	NIVESTYM	BRAND ONLY	PREFERRED DRUG	PA Required			
PEGFILGRASTIM -JMDB PREFILLED SYRINGE	FULPHILA	BRAND ONLY	PREFERRED DRUG	PA Required			
PEGFILGRASTIM-APGF SOLUTION PREFILLED SYRINGE	NYVEPRIA	BRAND ONLY	PREFERRED DRUG	PA Required			
PEGFILGRASTIM PREFILLED SYRINGE	UNDENYCA	BRAND ONLY	PREFERRED DRUG	PA Required			
ROMIPOSTIM	NPLATE	BRAND ONLY	PREFERRED DRUG	PA Required			

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE OCTOBER 1, 2021

- Generic Drugs Are Preferred Over Brand Name Drugs Unless The Drug Is Specified As BRAND ONLY
- Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List May Be Available Through Prior Authorization

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	Prior Authorization Type	Step Therapy Requirements	Quantity Limit (QL)	QL Days
HEMOSTATICS							
HEMOSTATICS - SYSTEMIC							
AMINOCAPROIC ACID SYRUP	AMICAR						
AMINOCAPROIC ACID TABLETS	AMICAR						
HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENT							
BARBITURATE HYPNOTICS							
PHENOBARBITAL SOLUTION	PHENOBARBITAL						
PHENOBARBITAL TABLETS	PHENOBARBITAL						
NON-BARBITURATE HYPNOTICS							
ESZOPICLONE	LUNESTA	VARIOUS	PREFERRED DRUG	PA Required for Ages <6 years PA Required for > 1 Hypnotic Drug		30	30
TEMAZEPAM CAPSULES 15MG & 30MG	RESTORIL		PREFERRED DRUG	PA Required for Ages <6 years PA Required for > 1 Hypnotic Drug		30	30
ZOLPIDEM TARTRATE TABLETS 5MG	AMBIEN		PREFERRED DRUG	PA Required for Ages <6 years PA Required for > 1 Hypnotic Drug		60	30
ZOLPIDEM TARTRATE TABLETS 10MG	AMBIEN		PREFERRED DRUG	PA Required for Ages <6 years PA Required for > 1 Hypnotic Drug		30	30
SELECTIVE MELATONIN RECEPTOR AGONISTS							
RAMELTEON TABLETS	ROZEREM	BRAND ONLY	PREFERRED DRUG	PA Required for < 6 years of age	Patient must have tried two preferred agents.	30	30
LAXATIVES							
LAXATIVE COMBINATIONS							
PEG 3350-KCL-SOD BICARB-SOD CHLORIDE-SOD SULFATE SOLUTION	COLYTE						
LAXATIVES - MISC.							
LACTULOSE SOLUTION	LACTULOSE						
MACROLIDES							
AZITHROMYCIN							

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE OCTOBER 1, 2021

- Generic Drugs Are Preferred Over Brand Name Drugs Unless The Drug Is Specified As BRAND ONLY
- Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List May Be Available Through Prior Authorization

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	Prior Authorization Type	Step Therapy Requirements	Quantity Limit (QL)	QL Days
AZITHROMYCIN PACKETS	ZITHROMAX						
AZITHROMYCIN SUSPENSION	ZITHROMAX						
AZITHROMYCIN TABLETS	ZITHROMAX						
CLARITHROMYCIN							
CLARITHROMYCIN SUSPENSION	CLARITHROMYCIN						
CLARITHROMYCIN TABLETS	BIAXIN						
CLARITHROMYCIN TABLET 24-HOUR	BIAXIN XL						
MEDICAL DEVICES							
CONTRACEPTIVES							
CONDOMS - FEMALE MISC.	FC FEMALE CONDOM						
CONDOMS - MALE MISC.	LIFESTYLES ASSORTED COLORS						
DIAPHRAGM ARC-SPRING DPRH	CAYA						
DIAPHRAGM COIL SPRING KIT	ORTHO DIAPHRAGM COIL SPRING KIT 50						
DIAPHRAGM FLAT SPRING KIT	ORTHO DIAPHRAGM FLAT SPRING KIT 55						
DIAPHRAGM WIDE SEAL DPRH	WIDE-SEAL SILICONE DIAPHRAGM KIT 60						
DIAPHRAGMS - OTHER+A1294	OMNIFLEX DIAPHRAGM						
DIABETIC SUPPLIES							
BLOOD GLUCOSE MONITORING KIT W/ DEVICE	VARIOUS						
BLOOD GLUCOSE MONITORING DEVICES	VARIOUS						
LANCET DEVICES MISC.	VARIOUS						
LANCETS MISC.	VARIOUS						
DEVICES - MISC.							
ALCOHOL SWABS PADS	ALCOH-GLOVE CONTOURED WIPE						
RESPIRATORY THERAPY SUPPLIES							
SPACER/AEROSOL-HOLDING CHAMBER SUPPLIES - MASKS	MASK VORTEX/ BABY WHIRL DUCKLING					2	365
SPACER/AEROSOL-HOLDING CHAMBERS DEVICE	AEROCHAMBER MINI AEROCHAMBER					2	365

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE OCTOBER 1, 2021

<ul style="list-style-type: none"> • Generic Drugs Are Preferred Over Brand Name Drugs Unless The Drug Is Specified As BRAND ONLY • Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List May Be Available Through Prior Authorization 							
Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	Prior Authorization Type	Step Therapy Requirements	Quantity Limit (QL)	QL Days
MIGRAINE PRODUCTS							
MIGRAINE COMBINATIONS							
ERGOTAMINE W/ CAFFEINE SUPPOSITORY	MIGERGOT					12	30
ERGOTAMINE W/ CAFFEINE TABLETS	CAFERGOT					40	30
MIGRAINE PRODUCTS - MONOCLONAL ANTIBODIES							
GALCANEZUMAB-GNLM SOLUTION AUTOINJECTOR / PREFILLED SYRINGE / PEN	EMGALITY		PREFERRED DRUG	PA Required		1.00	30.00
CALCITONIN GENE-RELATED PEPTIDE (CGRP) RECEPTOR ANTAGONIST							
ERENUMAB-AOOE SOLUTION AUTOINJECTOR	AIMOVIG		PREFERRED DRUG	PA Required		1.00	30.00
FREMANEZUMAB-VFRM SOLUTION AUTOINJECTOR	AJOVY		PREFERRED DRUG	PA Required		1.00	30.00
UBROGEPANT TABLETS	UBRELVY		PREFERRED DRUG	PA Required		8.00	30.00
SEROTONIN AGONISTS							
NARATRIPTAN HCL TABLETS	AMERGE		PREFERRED DRUG			9	30
RIZATRIPTAN BENZOATE ORALLY DISPERSABLE TABLET	MAXALT-MLT		PREFERRED DRUG			9	30
RIZATRIPTAN BENZOATE TABLETS	MAXALT		PREFERRED DRUG			9	30
SUMATRIPTAN NASAL SPRAY	IMITREX	BRAND ONLY	PREFERRED DRUG			6	30
SUMATRIPTAN SUCCINATE SUBCUTANEOUS SOLUTION AUTO INJECTION	IMITREX		PREFERRED DRUG			2	30
SUMATRIPTAN SUCCINATE SUBCUTANEOUS SOLUTION CARTRIDGE	IMITREX		PREFERRED DRUG			2	30
SUMATRIPTAN SUCCINATE TABLETS	IMITREX		PREFERRED DRUG			9	30
ZOLMITRIPTAN NASAL SPRAY	ZOMIG	BRAND ONLY	PREFERRED DRUG			6	30
ZOLMITRIPTAN ORALLY DISPERSABLE TABLET	ZOMIG ZMT		PREFERRED DRUG			9	30
ZOLMITRIPTAN TABLETS	ZOMIG		PREFERRED DRUG			9	30
MINERALS & ELECTROLYTES							
SODIUM FLUORIDE CHEWABLE TABLETS	LUDENT						
SODIUM FLUORIDE LOZG	LOZI-FLUR						

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE OCTOBER 1, 2021

- Generic Drugs Are Preferred Over Brand Name Drugs Unless The Drug Is Specified As BRAND ONLY
- Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List May Be Available Through Prior Authorization

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	Prior Authorization Type	Step Therapy Requirements	Quantity Limit (QL)	QL Days
SODIUM FLUORIDE SOLUTION	FLUOR-A-DAY						
SODIUM FLUORIDE TABLETS	SODIUM FLUORIDE						
MOUTH/THROAT/DENTAL AGENTS							
ANTI-INFECTIVES - THROAT							
CLOTRIMAZOLE TROC	CLOTRIMAZOLE						
STEROIDS - MOUTH/THROAT							
TRIAMCINOLONE ACETONIDE ORAL PASTE	ORALONE						
MULTIVITAMINS							
PRENATAL VITAMINS							
PRENATAL MULTIVITAMINS WITH OR WITHOUT MINERALS W/ FOLATE	VARIOUS						
PRENATAL MULTIVITAMINES WITH MINERAL W/FE-FA	VARIOUS						
MUSCULOSKELETAL THERAPY AGENTS							
CENTRAL MUSCLE RELAXANTS							
BACLOFEN TABLETS	BACLOFEN						
CYCLOBENZAPRINE HCL TABLETS 5MG & 10MG	FLEXERIL			PA Required for dosages other than 5mg and 10mg tablets			
METHOCARBAMOL TABLETS	ROBAXIN						
TIZANIDINE HCL TABLETS - 2MG & 4MG ONLY	TIZANIDINE HCL						
DIRECT MUSCLE RELAXANTS							
DANTROLENE SODIUM CAPSULES	DANTRIUM						
NASAL AGENTS - SYSTEMIC AND TOPICAL							
NASAL ANTIALLERGY							
AZELASTINE HCL SOLUTION 0.10%	ASTELIN						
NASAL ANTICHOLINERGICS							
IPRATROPIUM BROMIDE SOLUTION	ATROVENT						
NASAL STEROIDS							
FLUNISOLIDE SOLUTION	FLUNISOLIDE						
FLUTICASONE PROPIONATE SUSPENSION	FLONASE						
TRIAMCINOLONE ACETONIDE	NASACORT AQ						
SYMPATHOMIMETIC DECONGESTANTS							

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE OCTOBER 1, 2021

- Generic Drugs Are Preferred Over Brand Name Drugs Unless The Drug Is Specified As BRAND ONLY
- Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List May Be Available Through Prior Authorization

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	Prior Authorization Type	Step Therapy Requirements	Quantity Limit (QL)	QL Days
PSEUDOEPHEDRINE HCL LIQUID	SUDAFED CHILDRENS						
PSEUDOEPHEDRINE HCL SYRUP	PSEUDOEPHEDRINE						
PSEUDOEPHEDRINE HCL TABLETS	SUDAFED						
PSEUDOEPHEDRINE HCL TABLET 12-HOUR	NASAL DECONGESTANT						
PSEUDOEPHEDRINE HCL TABLET 24-HOUR	SUDAFED 24 HOUR						
OPHTHALMIC AGENTS							
OPHTHALMIC - BETA-BLOCKERS							
BETAXOLOL HCL SOLUTION	BETAXOLOL HCL						
BETAXOLOL HCL SUSPENSION	BETOPTIC-S						
CARTEOLOL HCL SOLUTION	CARTEOLOL HCL						
DORZOLAMIDE HCL-TIMOLOL MALEATE SOLUTION	COSOPT						
LEVOBUNOLOL HCL SOLUTION	LEVOBUNOLOL HCL						
METIPRANOLOL SOLUTION	METIPRANOLOL						
TIMOLOL MALEATE SOLUTION	TIMOPTIC-XE						
TIMOLOL MALEATE SOLUTION	TIMOPTIC						
OPHTHALMIC - CYCLOPLEGIC MYDRIATICS							
ATROPINE SULFATE OINTMENT	ATROPINE SULFATE						
ATROPINE SULFATE SOLUTION	ISOPTO ATROPINE						
CYCLOPENTOLATE HCL SOLUTION	CYCLOGYL						
HOMATROPINE HBR SOLUTION	ISOPTO HOMATROPINE						
OPHTHALMIC - MIOTICS							
PILOCARPINE HCL GEL	PILOPINE HS						
PILOCARPINE HCL SOLUTION	ISOPTO CARPINE						
OPHTHALMIC - ANTI-INFECTIVES							
BACITRACIN OINTMENT	BACITRACIN					3.5GM	7
BACITRACIN-POLYMYXIN B OINTMENT	POLYCIN						
CIPROFLOXACIN HCL OINTMENT	CILOXAN						
CIPROFLOXACIN HCL SOLUTION	CILOXAN						
ERYTHROMYCIN OINTMENT	ILOTYCIN						
GENTAMICIN SULFATE OINTMENT	GARAMYCIN						

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE OCTOBER 1, 2021

- Generic Drugs Are Preferred Over Brand Name Drugs Unless The Drug Is Specified As BRAND ONLY
- Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List May Be Available Through Prior Authorization

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	Prior Authorization Type	Step Therapy Requirements	Quantity Limit (QL)	QL Days
GENTAMICIN SULFATE SOLUTION	GARAMYCIN						
MOXIFLOXACIN HCL SOLUTION	VIGAMOX						
NATAMYCIN SUSPENSION	NATACYN						
NEOMYCIN-BACITRACIN ZN-POLYMYXIN OINTMENT	NEO-POLYCIN						
NEOMYCIN-POLYMYXIN-GRAMICIDIN SOLUTION	NEOSPORIN						
OFLOXACIN SOLUTION	OCUFLOX						
POLYMYXIN B-TRIMETHOPRIM SOLUTION	POLYTRIM						
SULFACETAMIDE SODIUM OINTMENT	SULFACETAMIDE SODIUM						
SULFACETAMIDE SODIUM SOLUTION	BLEPH-10						
TOBRAMYCIN OINTMENT	TOBREX					3.5GM	7
TOBRAMYCIN SOLUTION	TOBREX						
TRIFLURIDINE SOLUTION	VIROPTIC						
OPHTHALMIC - DECONGESTANTS							
NAPHAZOLINE HCL SOLUTION	VASOCLEAR						
NAPHAZOLINE W/ PHENIRAMINE SOLUTION	NAPHCON-A						
OPHTHALMIC - IMMUNOMODULATORS							
CYCLOSPORINE EMULSION	RESTASIS			PA Required			
OPHTHALMIC - STEROIDS							
BACITRACIN-POLY-NEOMYCIN-HC OINTMENT	NEO-POLYCIN HC						
DEXAMETHASONE SUSPENSION	MAXIDEX						
DEXAMETHASONE SODIUM PHOSPHATE SOLUTION	DEXAMETHASONE SODIUM PHOSPHATE						
FLUOROMETHOLONE OINTMENT	FML						
FLUOROMETHOLONE SUSPENSION	FML LIQUIFILM						
GENTAMICIN-PREDNISOLONE ACETATE OINTMENT	PRED-G S.O.P.						
GENTAMICIN-PREDNISOLONE ACETATE SUSPENSION	PRED-G						
NEOMYCIN-POLYMY-DEXAMETH OINTMENT	MAXITROL						
NEOMYCIN-POLYMY-DEXAMETH SUSPENSION	MAXITROL						
PREDNISOLONE ACETATE SUSPENSION	PRED MILD						
PREDNISOLONE SODIUM PHOSPHATE SOLUTION	PREDNISOLONE SODIUM PHOSPHATE						

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE OCTOBER 1, 2021

- Generic Drugs Are Preferred Over Brand Name Drugs Unless The Drug Is Specified As BRAND ONLY
- Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List May Be Available Through Prior Authorization

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	Prior Authorization Type	Step Therapy Requirements	Quantity Limit (QL)	QL Days
SULFACETAMIDE SOD-PREDNISOLONE OINTMENT	BLEPHAMIDE S.O.P.						
SULFACETAMIDE SOD-PREDNISOLONE SOLUTION	SULFACETAMIDE SODIUM/PREDNISOLONE SODIUM PHOSPHATE						
SULFACETAMIDE SOD-PREDNISOLONE SUSPENSION	BLEPHAMIDE						
TOBRAMYCIN-DEXAMETHASONE OINTMENT	TOBRADEX						
TOBRAMYCIN-DEXAMETHASONE SUSPENSION	TOBRADEX ST						
OPHTHALMICS - MISC.							
BRINZOLAMIDE SUSPENSION	AZOPT			PA Required			
CROMOLYN SODIUM SOLUTION	CROMOLYN SODIUM						
DICLOFENAC SODIUM SOLUTION	DICLOFENAC SODIUM						
DORZOLAMIDE HCL SOLUTION	TRUSOPT						
FLURBIPROFEN SODIUM SOLUTION	OCUFEN						
KETOROLAC TROMETHAMINE SOLUTION	ACULAR LS						
KETOTIFEN FUMARATE SOLUTION	ALAWAY						
OPHTHALMIC - PROSTAGLANDINS							
LATANOPROST SOLUTION	XALATAN					2.5	30
TAFLUPROST SOLUTION	ZIOPATAN			PA Required			
TRAVOPROST SOLUTION	TRAVATAN Z			PA Required			
OTIC AGENTS							
OTIC AGENTS - MISCELLANEOUS							
ACETIC ACID SOLUTION	ACETIC ACID						
OTIC ANTI-INFECTIVES							
CIPROFLOXACIN SOLUTION	VARIOUS						
OFLOXACIN (OTIC) SOLUTION	VARIOUS						
OTIC COMBINATIONS							
ANTIPYRINE-BENZOCAINE SOLUTION	AURODEX						
ANTIPYRINE-BENZOCAINE-POLYCOSANOL SOLUTION	OTIC CARE						
CIPROFLOXACIN-DEXAMETHASONE	CIPRODEX	BRAND ONLY	PREFERRED DRUG				
NEOMYCIN-POLYMYXIN-HC SOLUTION	CORTISPORIN		PREFERRED DRUG				
NEOMYCIN-POLYMYXIN-HC SUSPENSION	NEO/POLYMYXIN/HC 5-10000-1		PREFERRED DRUG				

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE OCTOBER 1, 2021

- Generic Drugs Are Preferred Over Brand Name Drugs Unless The Drug Is Specified As BRAND ONLY
- Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List May Be Available Through Prior Authorization

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	Prior Authorization Type	Step Therapy Requirements	Quantity Limit (QL)	QL Days
OTIC STEROIDS							
HYDROCORTISONE W/ACETIC ACID SOLUTION	ACETASOL HC						
OXYTOCICS							
OXYTOCICS							
METHYLERGONOVINE MALEATE TABLETS	METHERGINE						
PASSIVE IMMUNIZING AGENTS							
MONOCLONAL ANTIBODIES							
PALIVIZUMAB SOLUTION	SYNAGIS			PA Required - if approved the prescriber may be required to buy and bill a medical claim for the drug			
PENICILLINS							
AMINOPENICILLINS							
AMOXICILLIN CAPSULES	AMOXICILLIN						
AMOXICILLIN CHEWABLE TABLETS	AMOXICILLIN						
AMOXICILLIN SUSPENSION	AMOXICILLIN						
AMOXICILLIN TABLETS	AMOXICILLIN						
AMPICILLIN CAPSULES	AMPICILLIN						
AMPICILLIN SUSPENSION	AMPICILLIN						
NATURAL PENICILLINS							
PENICILLIN V POTASSIUM SOLUTION	PENICILLIN V POTASSIUM						
PENICILLIN V POTASSIUM TABLETS	PENICILLIN V POTASSIUM						
PENICILLIN COMBINATIONS							
AMOXICILLIN & POT CLAVULANATE CHEWABLE TABLETS	AUGMENTIN						
AMOXICILLIN & POT CLAVULANATE SUSPENSION	AUGMENTIN						
AMOXICILLIN & POT CLAVULANATE TABLET 12-HOUR	AUGMENTIN XR						
PENICILLINASE-RESISTANT PENICILLINS							
DICLOXACILLIN SODIUM CAPSULES	DICLOXACILLIN SODIUM						
PROGESTINS							
PROGESTINS							
MEDROXYPROGESTERONE ACETATE TABLETS	PROVERA						

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE OCTOBER 1, 2021

- Generic Drugs Are Preferred Over Brand Name Drugs Unless The Drug Is Specified As BRAND ONLY
- Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List May Be Available Through Prior Authorization

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	Prior Authorization Type	Step Therapy Requirements	Quantity Limit (QL)	QL Days
NORETHINDRONE ACETATE TABLETS	AYGESTIN						
PROGESTERONE MICRONIZED CAPSULES	PROMETRIUM						
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENT							
ANTIDEMENTIA AGENTS							
DONEPEZIL HYDROCHLORIDE TABLETS	ARICEPT			PA Required			
DONEPEZIL HYDROCHLORIDE ORALLY DISINTEGRATING TABLETS	ARICEPT ODT			PA Required			
GALANTAMINE HYDROBROMIDE CAPSULE CONTROLLED RELEASE	RAZADYNE ER			PA Required			
GALANTAMINE HYDROBROMIDE SOLUTION	RAZADYNE			PA Required			
GALANTAMINE HYDROBROMIDE TABLETS	RAZADYNE			PA Required			
MEMANTINE HCL SOLUTION	NAMENDA			PA Required			
MEMANTINE HCL TABLETS	NAMENDA			PA Required			
RIVASTIGMINE PATCH	EXELON			PA Required			
RIVASTIGMINE TARTRATE CAPSULES	EXELON			PA Required			
RIVASTIGMINE TARTRATE SOLUTION	EXELON			PA Required			
MULTIPLE SCLEROSIS AGENTS							
FINGOLIMOD HCL CAPSULES	GILENYA			PA Required			
GLATIRAMER ACETATE 20MG	COPAXONE 20mg	BRAND ONLY	PREFERRED DRUG	PA Required			
GLATIRAMER ACETATE 40MG	GLATOPA 40MG	BRAND ONLY	PREFERRED DRUG	PA Required			
INTERFERON BETA-1A KIT	AVONEX			PA Required			
INTERFERON BETA-1A SOLUTION	REBIF REBIDOSE			PA Required			
INTERFERON BETA-1B KIT	BETASERON			PA Required			
SMOKING DETERRENTS							
BUPROPION HCL (SMOKING DETERRENT) TABLET 12-HOUR	BUPROBAN					84-day supply	180
NICOTINE INHA	NICOTROL INHALER					84-day supply	180
NICOTINE POLACRILEX GUM	NICORETTE GUM					84-day supply	180
NICOTINE POLACRILEX LOZENGE	COMMIT					84-day supply	180

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE OCTOBER 1, 2021

<ul style="list-style-type: none"> • Generic Drugs Are Preferred Over Brand Name Drugs Unless The Drug Is Specified As BRAND ONLY • Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List May Be Available Through Prior Authorization 							
Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	Prior Authorization Type	Step Therapy Requirements	Quantity Limit (QL)	QL Days
NICOTINE PATCH	NICODERM CQ					84-day supply	180
NICOTINE SOLUTION	NICOTROL NS					84-day supply	180
VARENICLINE TARTRATE TABLETS	CHANTIX					84-day supply	180
RESPIRATORY AGENTS - MISC.							
ALPHA-PROTEINASE INHIBITOR (HUMAN)							
ALPHA1-PROTEINASE INHIBITOR (HUMAN) SOLUTION	ARALAST NP			PA Required			
CYSTIC FIBROSIS AGENTS							
DORNASE ALFA SOLUTION	PULMOZYME			PA Required			
SULFONAMIDES							
SULFONAMIDES							
SULFADIAZINE TABLETS	SULFADIAZINE						
TETRACYCLINES							
TETRACYCLINES							
DEMECLOCYCLINE HCL TABLETS	DEMECLOCYCLINE HCL			PA Required			
DOXYCYCLINE HYCLATE CAPSULES - 50MG AND 100MG CAPSULES ONLY	VARIOUS						
DOXYCYCLINE HYCLATE TABLETS - 20MG AND 100MG TABLETS ONLY	VARIOUS						
DOXYCYCLINE MONOHYDRATE - CAPSULES 50MG & 100MG ONLY	VARIOUS						
MINOCYCLINE HCL - 50MG, 75MG & 100MG CAPSULES ONLY	MINOCIN						
THYROID AGENTS							
ANTITHYROID AGENTS							
METHIMAZOLE TABLETS	TAPAZOLE						
PROPYLTHIOURACIL TABLETS	PROPYLTHIOURACIL						
THYROID HORMONES							
LEVOTHYROXINE SODIUM TABLETS	LEVO-T						
LIOETHYRONINE SODIUM TABLETS	CYTOMEL						
THYROID TABLETS	ARMOUR THYROID						
ULCER DRUGS							
ANTISPASMODICS							

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE OCTOBER 1, 2021

- Generic Drugs Are Preferred Over Brand Name Drugs Unless The Drug Is Specified As BRAND ONLY
- Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List May Be Available Through Prior Authorization

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	Prior Authorization Type	Step Therapy Requirements	Quantity Limit (QL)	QL Days
DICYCLOMINE HCL CAPSULES	VARIOUS						
DICYCLOMINE HCL SOLUTION	VARIOUS						
DICYCLOMINE HCL TABLETS	VARIOUS						
GLYCOPYRROLATE SOLUTION	VARIOUS						
GLYCOPYRROLATE TABLETS	VARIOUS						
HYOSCYAMINE SULFATE ELIXIR	VARIOUS						
HYOSCYAMINE SULFATE SOLUTION	VARIOUS						
HYOSCYAMINE SULFATE SUBLINGUAL	VARIOUS						
HYOSCYAMINE SULFATE TABLETS	VARIOUS						
HYOSCYAMINE SULFATE TABLET 12-HOUR	VARIOUS						
HYOSCYAMINE SULFATE CONTROLLED RELEASE TABLET	VARIOUS						
HYOSCYAMINE SULFATE ORALLY DISINTEGRATING TABLETS	VARIOUS						
PROPANTHELINE BROMIDE TABLETS	VARIOUS						
H-2 ANTAGONISTS							
FAMOTIDINE CHEWABLE TABLETS	PEPCID AC						
FAMOTIDINE SUSPENSION	PEPCID						
FAMOTIDINE TABLETS	PEPCID AC						
RANITIDINE HCL CAPSULES	RANITIDINE HCL						
RANITIDINE HCL SUSPENSION	DEPRIZINE FUSEPAQ						
RANITIDINE HCL SYRUP	ZANTAC						
RANITIDINE HCL TABLETS	ZANTAC 75						
ANTI-ULCER - MISC.							
SUCRALFATE TABLETS	CARAFATE						
PROTON PUMP INHIBITORS							
ESOMEPRAZOLE MAGNESIUM PACKETS	NEXIUM		PREFERRED DRUG	PA Required for > 18 Years of Age		30.00	30.00
ESOMEPRAZOLE MAGNESIUM CAPSULE DELAYED RELEASE	NEXIUM		PREFERRED DRUG			60.00	30.00
LANSOPRAZOLE CAPSULE DELAYED RELEASE	VARIOUS		PREFERRED DRUG			60.00	30.00
LANSOPRAZOLE ORALLY DISPERSABLE TABLET (ODT)	PREVACID SOLUTAB		PREFERRED DRUG	PA Required for > 18 Years of Age		60.00	30.00
OMEPRAZOLE ORAL CAPSULES	VARIOUS		PREFERRED DRUG			60.00	30.00
PANTOPRAZOLE SODIUM PACKETS	PROTONIX		PREFERRED DRUG	PA Required for > 18 Years of Age		30.00	30.00

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE OCTOBER 1, 2021

- Generic Drugs Are Preferred Over Brand Name Drugs Unless The Drug Is Specified As BRAND ONLY
- Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List May Be Available Through Prior Authorization

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	Prior Authorization Type	Step Therapy Requirements	Quantity Limit (QL)	QL Days
PANTOPRAZOLE TABLETS	PROTONIX		PREFERRED DRUG			30.00	30.00
URINARY ANTISPASMODICS							
URINARY ANTISPASMODIC - ANTIMUSCARINICS (ANTICHOLI)							
FESOTERODINE FUMARATE	TOVIAZ	BRAND ONLY	PREFERRED DRUG				
OXYBUTYNIN CHLORIDE SYRUP	VARIOUS		PREFERRED DRUG				
OXYBUTYNIN CHLORIDE TABLETS	VARIOUS		PREFERRED DRUG				
OXYBUTYNIN CHLORIDE TABLET 24-HOUR	DITROPAN XL		PREFERRED DRUG				
TOLTERODINE TARTRATE CAPSULE CONTROLLED RELEASE	DETROL LA	BRAND ONLY	PREFERRED DRUG				
TOLTERODINE TARTRATE TABLETS	DETROL	BRAND ONLY	PREFERRED DRUG				
VAGINAL PRODUCTS							
SPERMICIDES							
NONOXYNOL-9 FOAM	VCF VAGINAL CONTRACEPTIVE FOAM						
NONOXYNOL-9 GEL	SHUR-SEAL						
VAGINAL ANTI-INFECTIVES							
CLINDAMYCIN PHOSPHATE VAGINAL CREAM	CLEOCIN						
CLINDAMYCIN PHOSPHATE VAGINAL SUPPOSITORY	CLEOCIN						
CLOTRIMAZOLE VAGINAL CREAM	GYNE-LOTRIMIN						
METRONIDAZOLE VAGINAL GEL	METROGEL-VAGINAL						
MICONAZOLE NITRATE VAGINAL	MONISTAT 3 COMBINATION PACKETS						
MICONAZOLE NITRATE VAGINAL SUPPOSITORY	MICONAZOLE 3						
SULFANILAMIDE VAGINAL CREAM	AVC						
VAGINAL ESTROGENS							
ESTRADIOL ACETATE VAGINAL RING	FEMRING			PA Required			
ESTRADIOL VAGINAL RING	ESTRING						
ESTRADIOL VAGINAL TABLETS	VAGIFEM						
ESTRADIOL VAGINAL CREAM 0.01%	ESTRACE CREAM						
ESTROGENS, CONJUGATED VAGINAL CREAM	PREMARIN VAGINAL CREAM			PA Required			
VASOPRESSORS							
ANAPHYLAXIS THERAPY AGENTS							

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE OCTOBER 1, 2021

- Generic Drugs Are Preferred Over Brand Name Drugs Unless The Drug Is Specified As BRAND ONLY
- Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List May Be Available Through Prior Authorization

Drug Class/Drug Name	Reference Brand Name	BRAND ONLY / Generic Notes	Preferred Drug Status	Prior Authorization Type	Step Therapy Requirements	Quantity Limit (QL)	QL Days
EPINEPHRINE SELF-INJECTABLE 0.15MG AND 0.30MG	EPINEPHRINE SELF-INJECTABLE (By Mylan)	Mylan Generic	PREFERRED DRUG	PA Required for > 2 Per Month		2.00	30.00