

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE JANUARY 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 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
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

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE JANUARY 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 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
CLONAZEPAM ODT 2MG	VARIOUS			PA Required for Ages < 6 years. PA Required for > 1 Anxiolytic Medication in a 30-day time period.		60	30

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE JANUARY 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
CLORAZEPATE DIPOTASSIUM TAB 15 MG	VARIOUS			PA Required for Ages < 6 years. PA Required for > 1 Anxiolytic Medication in a 30-day time period.		60	30
CLORAZEPATE DIPOTASSIUM TAB 3.75 MG	VARIOUS			PA Required for Ages < 6 years. PA Required for > 1 Anxiolytic Medication in a 30-day time period.		120	30
CLORAZEPATE DIPOTASSIUM TAB 7.5 MG	VARIOUS			PA Required for Ages < 6 years. PA Required for > 1 Anxiolytic Medication in a 30-day time period.		120	30
DIAZEPAM CONC 5 MG/ML	DIAZEPAM INTENSOL			PA Required for Ages < 6 years. PA Required for > 1 Anxiolytic Medication in a 30-day time period.		60	30
DIAZEPAM SOLN 1 MG/ML	VARIOUS			PA Required for Ages < 6 years. PA Required for > 1 Anxiolytic Medication in a 30-day time period.		300	30
DIAZEPAM TAB 10 MG	VARIOUS			PA Required for Ages < 6 years. PA Required for > 1 Anxiolytic Medication in a 30-day time period.		120	30
DIAZEPAM TAB 2 MG	VARIOUS			PA Required for Ages < 6 years. PA Required for > 1 Anxiolytic Medication in a 30-day time period.		120	30
DIAZEPAM TAB 5 MG	VARIOUS			PA Required for Ages < 6 years. PA Required for > 1 Anxiolytic Medication in a 30-day time period.		120	30
LORAZEPAM CONC 2 MG/ML	LORAZEPAM INTENSOL			PA Required for Ages < 6 years. PA Required for > 1 Anxiolytic Medication in a 30-day time period.		60	30
LORAZEPAM TAB 0.5 MG	VARIOUS			PA Required for Ages < 6 years. PA Required for > 1 Anxiolytic Medication in a 30-day time period.		120	30

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE JANUARY 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 JANUARY 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			
GLYCOPYRROLATE-FORMOTEROL FUMARATE AEROSOL SOLUTION	BEVESPI AEROSPHERE		PREFERRED DRUG	PA Required			
TIOTROPIUM BROMIDE-OLODATEROL HCL AEROSOL SOLUTION	STIOLTO RESPIMAT		PREFERRED DRUG	PA Required			
SALMETEROL XINAFOATE AEROSOL POWDER BREATH ACTIVATED	SEREVENT DISKUS		PREFERRED DRUG	PA Required			
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
ENOXAPARIN SODIUM INJ 80 MG/0.8ML	VARIOUS VIAL OR SYRINGE		PREFERRED DRUG			60	30

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE JANUARY 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
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
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

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE JANUARY 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 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						
OXCARBAZEPINE SUSPENSION	TRILEPTAL						
OXCARBAZEPINE TABLETS	TRILEPTAL						
PREGABALIN CAPSULES	LYRICA			PA Required			
PREGABALIN SOLUTION	LYRICA			PA Required			

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE JANUARY 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
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)							
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			

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE JANUARY 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
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	30
						20mg: 30	30
						40mg: 30	30
ESCITALOPRAM OXALATE TABLETS	LEXAPRO			PA Required for Ages < 6 years of age		5mg: 60	30
						10mg: 30	30
						20mg: 30	30
FLUOXETINE HCL CAPSULES ONLY	PROZAC			PA Required for Ages < 6 years of age		10mg: 60	30
						20mg: 120	30
						40mg: 60	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	30
						50mg: 180	30
						100mg: 90	30
PAROXETINE HCL TABLETS	PAXIL			PA Required for Ages < 6 years of age		10mg: 30	30
						20mg: 30	30
						30mg: 30	30
						40mg: 45	30
SERTRALINE HCL CONCENTRATE	ZOLOFT			PA Required for Ages < 6 years of age and greater than 12 years of age		300	30
SERTRALINE HCL TABLETS	ZOLOFT			PA Required for Ages < 6 years of age		25mg: 90	30
						50mg: 120	30
						100mg: 60	30
SEROTONIN MODULATORS							

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE JANUARY 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
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			
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							

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE JANUARY 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
ACARBOSE TABLETS	PRECOSE						
ANTIDIABETIC - AMLYN ANALOGS							
PRAMLINTIDE ACETATE SOLUTION PEN INJECTION	SYMLINPEN 60		PREFERRED DRUG	PA Required			
ANTIDIABETIC COMBINATIONS							
GLYBURIDE-METFORMIN HCL TABLETS	GLUCOVANCE						
PIOGLITAZONE HCL-METFORMIN HCL TABLETS	ACTOPLUS MET						
PIOGLITAZONE HCL-METFORMIN HCL TABLET 24-HOUR	ACTOPLUS MET XR						
SITAGLIPTIN-METFORMIN HCL TABLETS	JANUMET		PREFERRED DRUG	PA Required			
LINAGLIPTIN - METFORMIN TABLETS	JENTADUETO		PREFERRED DRUG	PA Required			
SITAGLIPTIN-METFORMIN HCL TABLET 24-HOUR	JANUMET XR		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							
GLUCAGON (RDNA) KIT	GLUCAGON EMERGENCY KIT					1	30
DIPEPTIDYL PEPTIDASE-4 (DPP-4) INHIBITORS							
LINAGLIPTIN TABLETS	TRADJENTA		PREFERRED DRUG	PA Required			
EMPAGLIFLOZIN-LINAGLIPTIN TABLETS	GLYXAMBI		PREFERRED DRUG	PA Required			
SAXAGLIPTIN HCL TABLETS	ONGLYZA		PREFERRED DRUG	PA Required			
SAXAGLIPTIN-METFORMIN HCL TABLETS	KOMBIGLYZE XR		PREFERRED DRUG	PA Required			
SITAGLIPTIN PHOSPHATE TABLETS	JANUVIA		PREFERRED DRUG	PA Required			
INCRETIN MIMETIC AGENTS (GLP-1 RECEPTOR AGONISTS)							
EXENATIDE SOLUTION PEN INJECTION	BYETTA		PREFERRED DRUG	PA Required			
EXENATIDE PEN	BYDUREON		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							

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE JANUARY 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 ASPART	NOVOLOG	BRAND ONLY	PREFERRED DRUG				
INSULIN ASPART	NOVOLOG PENFILL	BRAND ONLY	PREFERRED DRUG				
INSULIN ASPART	NOVOLOG FLEXPEN	BRAND ONLY	PREFERRED DRUG				
INSULIN ASPART PROTAMINE SUSPENSION & INSULIN ASPART	NOVOLOG MIX 70/30	BRAND ONLY	PREFERRED DRUG				
INSULIN ASPART PROTAMINE SUSPENSION & INSULIN ASPART	NOVOLOG MIX 70/30 FLEXPEN	BRAND ONLY	PREFERRED DRUG				
INSULIN DETEMIR SOLUTION	LEVEMIR	BRAND ONLY	PREFERRED DRUG				
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	BRAND ONLY	PREFERRED DRUG				
INSULIN LISPRO (HUMAN) SUSPENSION	HUMALOG KWIKPEN	BRAND ONLY	PREFERRED DRUG				
INSULIN LISPRO (HUMAN) SOLUTION PEN INJECTION 100/ML	HUMALOG JUNIOR KWIKPEN	BRAND ONLY	PREFERRED DRUG				
INSULIN LISPRO PROTAMINE & LISPRO (HUMAN) SUSPENSION	HUMALOG MIX 50/50	BRAND ONLY	PREFERRED DRUG				
INSULIN LISPRO PROTAMINE & LISPRO (HUMAN) SUSPENSION	HUMALOG MIX 50/50 KWIKPEN	BRAND ONLY	PREFERRED DRUG				
INSULIN LISPRO PROTAMINE & LISPRO (HUMAN) SUSPENSION	HUMALOG MIX 75/25	BRAND ONLY	PREFERRED DRUG				
INSULIN LISPRO PROTAMINE & LISPRO (HUMAN) SUSPENSION	HUMALOG MIX 75/25 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							

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE JANUARY 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
DAPAGLIFLOZIN PROPANEDIOL	FARXIGA		PREFERRED DRUG	PA Required			
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	ZOFTRAN			PA Required for tablets > 8mg		30	30
ANTIEMETICS MISC.							
PROCHLORPERAZINE MALEATE TABLETS	COMPАЗINE						
PROCHLORPERAZINE SUPPOSITORY	COMPАЗINE						

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE JANUARY 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 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							
ANTIMETABOLITES							
MERCAPTOPYRINE TABLETS	PURINETHOL						
METHOTREXATE SODIUM TABLETS	METHOTREXATE						
ANTINEOPLASTIC - HORMONAL AND RELATED AGENTS							
ANASTROZOLE TABLETS	ARIMIDEX			PA Required			

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE JANUARY 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
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			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			
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			

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE JANUARY 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
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						
PRAMIPEXOLE DIHYDROCHLORIDE TABLETS	MIRAPEX						
ROPINIROLE HYDROCHLORIDE TABLETS	REQUIP						
ANTIPSYCHOTICS/ANTIMANIC AGENTS							
ANTIMANIC AGENTS							

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE JANUARY 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
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.			
ANTIPSYCHOTICS							
ANTIPSYCHOTICS - SECOND GENERATION - ATYPICAL ORAL AGENTS							

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE JANUARY 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 TABLETS	ABILIFY		PREFERRED DRUG	PA Required for Ages < 6 years Prior Authorization is not required for ages 6 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.		30	30
CLOZAPINE ORALLY DISPERSABLE TABLET	FAZACLO		PREFERRED DRUG	PA Required for Ages < 18 years Prior Authorization is not required for ages 18 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.		150	30
CLOZAPINE TABLETS	CLOZARIL		PREFERRED DRUG	PA Required for Ages < 18 years Prior Authorization is not required for ages 18 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.		150	30
LURASIDONE HCL TABS	LATUDA		PREFERRED DRUG	PA Required for Ages < 6 years Prior Authorization is not required for ages 6 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.		30	30
OLANZAPINE ORALLY DISPERSABLE TABLET	ZYPREXA ZYDIS		PREFERRED DRUG	PA Required for Ages < 6 years Prior Authorization is not required for ages 6 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.		5mg: 60 10mg: 60 15MG: 30 20mg: 30	30 30 30 30

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE JANUARY 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 TABLETS	ZYPREXA		PREFERRED DRUG	PA Required for Ages < 6 years Prior Authorization is not required for ages 6 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.		30	30
QUETIAPINE FUMARATE TABLETS	SEROQUEL		PREFERRED DRUG	PA Required for Ages < 6 years Prior Authorization is not required for ages 6 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.		60	30
RISPERIDONE ORALLY DISPERSABLE TABLET	RISPERIDONE ODT		PREFERRED DRUG	PA Required for Ages < 6 years Prior Authorization is not required for ages 6 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.		60	30
RISPERIDONE ORAL SOLUTION	RISPERDAL		PREFERRED DRUG	PA Required for Ages < 6 years Prior Authorization is not required for ages 6 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.		240	30
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

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE JANUARY 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
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							
ARIPIPIRAZOLE 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
ARIPIPIRAZOLE 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
ARIPIPIRAZOLE 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

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE JANUARY 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
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
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	30
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 JANUARY 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.			
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.			

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE JANUARY 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
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.			
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.			

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE JANUARY 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
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.			
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

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE JANUARY 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
DARUNAVIR ETHANOLATE SUSPENSION	PREZISTA						
DARUNAVIR ETHANOLATE TABLETS	PREZISTA						
DARUNAVIR-COBIKISTAT 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						
ELVITEGRAVIR-COBIKISTAT-EMTRICITABINE-TENOFOVIR TABLETS	STRIBILD						
ELVITEGRAVIR-COBIKISTAT-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					
ENFUVIRTIDE 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			

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE JANUARY 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
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						
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			

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE JANUARY 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
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			
SOFOSBUVIR/VELPATASVIR	EPCLUSA	AUTHORIZED GENERIC BRAND 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	(IV)	BRAND ONLY	PREFERRED DRUG	PA REQUIRED			
IMMUNE GLOBULIN	FLEBOGFAMMA DIF (IV)	BRAND ONLY	PREFERRED DRUG	PA REQUIRED			
IMMUNE GLOBULIN	GAMASTAN S/D (IM)	BRAND ONLY	PREFERRED DRUG	PA REQUIRED			
IMMUNE GLOBULIN	GAMMAGARD LIQUID (INJ)	BRAND ONLY	PREFERRED DRUG	PA REQUIRED			
IMMUNE GLOBULIN	GAMMAGARD S-D LIQUID (INJ)	BRAND ONLY	PREFERRED DRUG	PA REQUIRED			

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE JANUARY 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
IMMUNE GLOBULIN	GAMUNEX-C (INJ)	BRAND ONLY	PREFERRED DRUG	PA REQUIRED			
IMMUNE GLOBULIN	HIZENTRAL (SUBQ)	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						
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						

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE JANUARY 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
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						
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							

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE JANUARY 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
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						
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							

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE JANUARY 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
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						
LEVONORGESTREL-ETHINYL ESTRADIOL (91-DAY) TABLETS	AMETHIA LO						
LEVONORGESTREL & ETHINYL ESTRADIOL (CONTINUOUS) TABLETS	AMETHYST						
NORETHINDRONE ACE & ETHINYL ESTRADIOL-FE TABLETS	JUNEL FE						
NORETHINDRONE ACE & ETHINYL ESTRADIOL-FE CHEWABLES	MELODETTA 24 FE						
NORETHINDRONE & ETH ESTRADIOL TABLETS	BALZIVA						
NORETHINDRONE & MESTRANOL TABLETS	NECON 1/50-28						
NORETHINDRONE ACET & ETH ESTRA TABLETS	GILDESS 1/20						
NORETHINDRONE ACETATE-ETHINYL ESTRADIOL-FE TABLETS	ESTROSTEP FE						
NORETHIN ACET & ESTRAD-FE TABLETS	LOESTRIN FE TAB 1/20						
NORETHINDRONE-ETH ESTRADIOL (BIPHASIC) TABLETS	NECON 10/11-28						
NORETHINDRONE-ETH ESTRADIOL (TRIPHASIC) TABLETS	CYCLAFEM 7/7/7						
NORETHINDRONE & ETHINYL ESTRADIOL-FE CHEWABLES	KAITLIB FE						
NORGESTIMATE-ETHINYL ESTRADIOL (TRIPHASIC) TABLETS	ORTHO TRI-CYCLEN						
NORGESTIMATE-ETHINYL ESTRADIOL TABLETS	ESTARYLLA						
NORGESTREL & ETHINYL ESTRADIOL TABLETS	CRYSSELLE-28						
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						
LEVONORGESTREL (EMERGENCY OC) TABLETS	AFTERA OTC						

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE JANUARY 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	LEVONORGESTREL OTC						
LEVONORGESTREL (EMERGENCY OC) TABLETS	MY CHOICE OTC						
LEVONORGESTREL (EMERGENCY OC) TABLETS	MY WAY OTC						
LEVONORGESTREL (EMERGENCY OC) TABLETS	NEW DAY OTC						
LEVONORGESTREL (EMERGENCY OC) TABLETS	OPTION 2 OTC						
LEVONORGESTREL (EMERGENCY OC) TABLETS	TAKE ACTION OTC						
PROGESTIN CONTRACEPTIVES - IMPLANTS							
ETONOGESTREL IMPLANT	NEXPLANON	PREFERRED					
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							
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						

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE JANUARY 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
PREDNISOLONE SODIUM PHOSPHATE SOLUTION	ORAPRED						
PREDNISOLONE SODIUM PHOSPHATE ORALLY DISINTEGRATING TABLETS	ORAPRED ODT						
PREDNISOLONE SYRUP	PRELONE						
PREDNISOLONE TABLETS	VARIOUS						
PREDNISON CONCENTRATE	PREDNISON INTENSOL						
PREDNISON SOLUTION	PREDNISON						
PREDNISON TABLETS	PREDNISON						
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/ HOMETROPINE SYRUP	VARIOUS			PA Required for < 18 years of age		240	12
HYDROCODONE W/ HOMETROPINE TABLETS	VARIOUS			PA Required for < 18 years of age			
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						

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE JANUARY 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
FEXOFENADINE-PSEUDOEPHEDRINE TABLET 12-HOUR	VARIOUS					30	30
FEXOFENADINE-PSEUDOEPHEDRINE TABLET 24-HOUR	VARIOUS					30	30
GUAIFENESIN-CODEINE SYRUP	ROBITUSSIN AC			PA Required for < 18 years of age		240	12
LORATADINE & PSEUDOEPHEDRINE TABLET 12-HOUR	ALAVERT ALLERGY/SINUS					30	30
LORATADINE & PSEUDOEPHEDRINE TABLET 24-HOUR	CLARITIN-D 24 HOUR					30	30
PHENYLEPHRINE W/ DEXTROMETHORPHAN-GUAIFENESIN CAPSULES	VARIOUS						
PHENYLEPHRINE W/ DEXTROMETHORPHAN-GUAIFENESIN LIQUID	ROBITUSSIN CHILDRENS COUGH & COLD CF					480	30
PHENYLEPHRINE W/ DEXTROMETHORPHAN-GUAIFENESIN SYRUP	VARIOUS					480	30
PHENYLEPHRINE W/ DEXTROMETHORPHAN-GUAIFENESIN TABLETS	VARIOUS						
PHENYLEPHRINE W/ DEXTROMETHORPHAN-GUAIFENESIN TABLET 12-HOUR	VARIOUS						
PHENYLEPHRINE-BROMPHENIRAMINE-DEXTROMETHORPHAN ELIXIR	VARIOUS					480	30
PHENYLEPHRINE-BROMPHENIRAMINE-DEXTROMETHORPHAN LIQUID	DIMETAPP DEXTROMETHORPHAN COLD & COUGH					480	30
PHENYLEPHRINE-BROMPHENIRAMINE-DEXTROMETHORPHAN SYRUP	VARIOUS					480	30
PHENYLEPHRINE-CHLORPHENIRAMINE-DEXTROMETHORPHAN LIQUID	VARIOUS					480	30
PHENYLEPHRINE-CHLORPHENIRAMINE-DEXTROMETHORPHAN DROPS	VARIOUS			PA Required for < 6 years age			
PHENYLEPHRINE-CHLORPHENIRAMINE-DEXTROMETHORPHAN SYRUP	VARIOUS					480	30
PHENYLEPHRINE-CHLORPHENIRAMINE-DEXTROMETHORPHAN TABLETS	VARIOUS						
PHENYLEPHRINE-GUAIFENESIN CAPSULES	VARIOUS						
PHENYLEPHRINE-GUAIFENESIN LIQUID	TRIAMINIC CHEST/ NASAL CONGESTION					480	30
PHENYLEPHRINE-GUAIFENESIN SYRUP	TRIAMINIC CHEST & NASAL CONGESTION					480	30
PHENYLEPHRINE-GUAIFENESIN TABLETS	VARIOUS						
PROMETHAZINE & PHENYLEPHRINE SYRUP	PROMETHAZINE/ PHENYLEPHRINE					480	30
PROMETHAZINE W/CODEINE SYRUP	PROMETHAZINE/CODEINE			PA Required for < 18 years of age		240	12
PROMETHAZINE-DEXTROMETHORPHAN SYRUP	PROMETHAZINE/ DEXTROMETHORPHAN					480	30
PSEUDOEPHEDRINE W/ CODEINE-GUAIFENESIN SYRUP	VARIOUS			PA Required for < 18 years of age		240	12
EXPECTORANTS							
GUAIFENESIN LIQUID	VARIOUS					480	30

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE JANUARY 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
GUAIFENESIN SYRUP	VARIOUS					480	30
GUAIFENESIN TABLETS	VARIOUS						
GUAIFENESIN TABLET 12-HOUR	VARIOUS						
DERMATOLOGICALS							
ACNE PRODUCTS							
BENZOYL PEROXIDE WASH 55 & 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						
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						

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE JANUARY 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
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						
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					15GM	30
ACYCLOVIR OINTMENT	ZOVIRAX						
BURN PRODUCTS							
SILVER SULFADIAZINE CREAM	SILVADENE						
CORTICOSTEROIDS - TOPICAL LOW POTENCY							

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE JANUARY 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
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						
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

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE JANUARY 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
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		
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						

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE JANUARY 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
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							
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						

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE JANUARY 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
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						
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						

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE JANUARY 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
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						
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 CAPSULES	COLAZAL					270	30

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE JANUARY 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
BALSALAZIDE DISODIUM TABLETS	GIAZO					270	30
INFLIXIMAB-ABDA	RENFLEXIS			PA Required			
BUDESONIDE CAPSULES	ENTOCORT EC						
MESALAMINE CAPSULE CONTROLLED RELEASE	PENTASA					270	30
MESALAMINE ENEMA	MESALAMINE					30	30
MESALAMINE TABLET ENTERIC COATED	ASACOL HD					120	30
OLSALAZINE SODIUM CAPSULES	DIPENTUM					120	30
SULFASALAZINE TABLETS	AZULFIDINE					240	30
SULFASALAZINE TABLET ENTERIC COATED	AZULFIDINE EN-TABLETS					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						
GOUT AGENTS							
GOUT AGENTS							
ALLOPURINOL TABLETS	ZYLOPRIM						
COLCHICINE TABLETS	VARIOUS						

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE JANUARY 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
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			
PEGFILGRASTIM -JMDB PREFILLED SYRINGE	FULPHILA	BRAND ONLY	PREFERRED DRUG	PA Required			
PEGFILGRASTIM PREFILLED SYRINGE	UNDENYCA	BRAND ONLY	PREFERRED DRUG	PA Required			
ROMIPLOSTIM	NPLATE	BRAND ONLY	PREFERRED DRUG	PA Required			
HEMOSTATICS							
HEMOSTATICS - SYSTEMIC							
AMINOCAPROIC ACID SYRUP	AMICAR						
AMINOCAPROIC ACID TABLETS	AMICAR						
HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENT							
BARBITURATE HYPNOTICS							
PHENOBARBITAL SOLUTION	PHENOBARBITAL						

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE JANUARY 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
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							
AZITHROMYCIN PACKETS	ZITHROMAX						
AZITHROMYCIN SUSPENSION	ZITHROMAX						
AZITHROMYCIN TABLETS	ZITHROMAX						
CLARITHROMYCIN							
CLARITHROMYCIN SUSPENSION	CLARITHROMYCIN						
CLARITHROMYCIN TABLETS	BIAXIN						
CLARITHROMYCIN TABLET 24-HOUR	BIAXIN XL						
MEDICAL DEVICES							

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE JANUARY 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
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
MIGRAINE PRODUCTS							
MIGRAINE COMBINATIONS							
ERGOTAMINE W/ CAFFEINE SUPPOSITORY	MIGERGOT					12	30
ERGOTAMINE W/ CAFFEINE TABLETS	CAFERGOT						
MIGRAINE PRODUCTS - MONOCLONAL ANTIBODIES							
FREMANEZUMAB-VFRM SOLUTION AUTOINJECTOR	AJOVY		Preferred Drug	PA Required		1.00	30.00
GALCANEZUMAB-GNLM SOLUTION AUTOINJECTOR / PREFILLED SYRINGE / PEN	EMGALITY		Preferred Drug	PA Required			

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE JANUARY 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
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						
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							

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE JANUARY 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
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						
FLUTICASON PROPIONATE SUSPENSION	FLOMASE						
TRIAMCINOLONE ACETONIDE	NASACORT AQ						
SYMPATHOMIMETIC DECONGESTANTS							
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						

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE JANUARY 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
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						
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	TOBEX					3.5GM	7
TOBRAMYCIN SOLUTION	TOBEX						
TRIFLURIDINE SOLUTION	VIROPTIC						
OPHTHALMIC - DECONGESTANTS							
NAPHAZOLINE HCL SOLUTION	VASOCLEAR						
NAPHAZOLINE W/ PHENIRAMINE SOLUTION	NAPHCON-A						

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE JANUARY 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
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						
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							

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE JANUARY 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
LATANOPROST SOLUTION	XALATAN					2.5	30
T AFLUPROST SOLUTION	ZIOPTAN			PA Required			
TRAVOPROST SOLUTION	TRAVATAN Z			PA Required			
OTIC AGENTS							
OTIC AGENTS - MISCELLANEOUS							
ACETIC ACID SOLUTION	ACETIC ACID						
OTIC ANTI-INFECTIVES							
CIPROFLOXACIN 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				
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						

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE JANUARY 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
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						
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			

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE JANUARY 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
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
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						

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE JANUARY 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
THYROID AGENTS							
ANTITHYROID AGENTS							
METHIMAZOLE TABLETS	TAPAZOLE						
PROPYLTHIOURACIL TABLETS	PROPYLTHIOURACIL						
THYROID HORMONES							
LEVOTHYROXINE SODIUM TABLETS	LEVO-T						
LIOTHYRONINE SODIUM TABLETS	CYTOMEL						
THYROID TABLETS	ARMOUR THYROID						
ULCER DRUGS							
ANTISPASMODICS							
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						

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE JANUARY 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-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
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						
CLOTTRIMAZOLE 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							

AHCCCS ACUTE - LONG TERM CARE DRUG LIST EFFECTIVE JANUARY 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
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							
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