# GUAM Medicaid Formulary

**Mandatory Generic Plan.**

Brand name drugs with generic substitutes available are not covered

| ANTI-INFECTIVES | | | |
|---|---|---|---|
| Name | Strength/Unit | GPI | Comment |
| BICILLIN LA SUSPENSION /ML | 600000U/1ML | 0110002000E610 | Formulary |
| PENICILLIN VK POTASSIUM TAB | 500 MG | 01100040100315 | Formulary |
| PENICILLIN VK SUSPENSION/ML | 125MG/5ML | 01100040102105 | Formulary |
| PENICILLIN VK SUSPENSION/ML | 250MG/5ML | 01100040102110 | Formulary |
| AMOXICILLIN CAP | 250 MG | 01200010100105 | Formulary |
| AMOXICILLIN CAP | 500 MG | 01200010100110 | Formulary |
| AMOXICILLIN TAB | 500 MG | 01200010100303 | Formulary |
| AMOXICILLIN TAB | 875 MG | 01200010100315 | Formulary |
| AMOXICILLIN SUSP/PDR | 5ML/125MG | 01200010101910 | Formulary |
| AMOXICILLIN SUSP PDR/ML | 200MG/5ML | 01200010101913 | Formulary |
| AMOXICILLIN SUSP PDR/ML | 250MG/5ML | 01200010101915 | Formulary |
| AMOXICILLIN SUSP PDR/ML | 400MG/5ML | 01200010101924 | Formulary |
| AMPICILLIN CAP | 500 MG | 01200020200110 | Formulary |
| DICLOXACILLIN SODIUM CAP | 250 MG | 01300020100110 | Formulary |
| DICLOXACILLIN SODIUM CAP | 500 MG | 01300020100115 | Formulary |
| NAFCILLIN PDS IV /GM (HHS) | 1GM | 01300040102105 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| AMOXICILLIN/CLAVULANATE TAB | 250 MG-125 MG | 01990002200310 | Formulary |
| AMOXICILLIN/CLAVULANATE TAB | 500MG-125MG | 01990002200320 | Formulary |
| AMOXICILLIN/CLAVULANATE POTASSIUM TAB | 875-125MG | 01990002200340 | Formulary |
| AMOXICILLIN/CLAVULANATE POTASSIUM PDR SUSP /ML | 250MG-62.5MG | 01990002201920 | Formulary |
| AMOXICILLIN/CLAVULANATE POTASSIUM PDR/ML | 400MG-57MG | 01990002201935 | Formulary |
| AMOXICILLIN/CLAVULANATE POTASSIUM PDR ORAL /ML | 600/5-42.9/5ML | 01990002201960 | Formulary |
| AMOXICILLIN/CLAVULANATE POTASSIUM TER | 1000MG-62.5MG | 01990002207420 | Formulary |
| AMPICILLIN-SULBACTAM PDS IV /GM (HHS) | 1GM-0.5GM | 01990002252112 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| CEFADROXIL CAP | 500 MG | 02100010000105 | Formulary |
| CEFADROXIL SUSP | 250MG/5ML | 02100010001910 | Formulary |
| CEFADROXIL SUSP/ML | 500MG/5ML | 02100010001915 | Formulary |
| CEFAZOLIN PDS IV /GM (HHS) | 1GM | 02100015102115 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| CEPHALEXIN CAP (340B) | 250 MG | 02100020000105 | Formulary |
| CEPHALEXIN CAP | 500 MG | 02100020000110 | Formulary |
| CEPHALEXIN SUSP/ML | 125MG/5ML | 02100020001910 | Formulary |
| CEPHALEXIN SUSP/ML | 250MG/5ML | 02100020001915 | Formulary |
| CEFACLOR SUSP/ML | 250MG/5ML | 02200040001910 | Formulary |
| CEFPROZIL PDR | 125MG/5ML | 02200062001910 | Formulary |
| CEFPROZIL PDR /ML | 250MG/5ML | 02200062001920 | Formulary |
| CEFUROXIME AXETIL TAB | 250 MG | 02200065050310 | Formulary |
| CEFUROXIME AXETIL TAB | 500 MG | 02200065050315 | Formulary |
| CEFDINIR CAP | 300 MG | 02300040000120 | Formulary |
| CEFDINIR PDR / ML | 125MG/5ML | 02300040001920 | Formulary |
| CEFDINIR PDR/ ML | 250MG/5ML | 02300040001930 | Formulary |
| CEFTAZIDIME PDS IV /GM (HHS) | 1 GM | 02300080002110 | Formulary |
| CEFTRIAXONE PDS INJ /EA (HHS) | 250 MG | 02300090102105 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| CEFEPIME PDS IV /GM (HHS) | 1GM | 02400040102022 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| ERYTHROMYCIN STEARATE TAB | 250 MG | 03100005000305 | Formulary |
| ERYTHROMYCIN TAB | 500 MG | 03100005000310 | Formulary |
| ERYTHROMYCIN ETHYLSUCCINATE TAB | 400 MG | 03100030300305 | Formulary |
| ERYTHROMYCIN ETHYLSUCCINATE GRANULES PDR SUSP/ML | 200MG/5ML | 03100030301910 | Formulary |
| AZITHROMYCIN TAB | 250 MG | 03400010000320 | Formulary |
| AZITHROMYCIN TAB | 500 MG | 03400010000334 | Formulary |
| AZITHROMYCIN SUSP/ML | 100MG-5ML | 03400010001920 | Formulary |
| AZITHROMYCIN SUSP/ML | 200MG-5ML | 03400010001930 | Formulary |
| CLARITHROMYCIN TAB | 250 MG | 03500010000310 | Formulary |
| CLARITHROMYCIN TAB | 500 MG | 03500010000320 | Formulary |
| CLARITHROMYCIN SUSP | 125 MG/ML 50ML | 03500010001910 | Formulary |
| CLARITHROMYCIN SUSP | 250 MG/5 ML 50 | 03500010001920 | Formulary |
| DOXYCYCLINE MONOHYDRATE CAP | 100MG | 04000020000110 | Formulary |
| DOXYCYCLINE HYCLATE CAP | 50 MG | 04000020100105 | Formulary |
| DOXYCYCLINE HYCLATE CAP | 100 MG | 04000020100110 | Formulary |
| DOXYCYCLINE HYCLATE TAB | 100 MG | 04000020100310 | Formulary |
| MINOCYCLINE HCL/CAP | 100 MG | 04000040100110 | Formulary |
| TETRACYCLINE HCL CAP | 250 MG | 04000060100105 | Formulary |
| TETRACYCLINE HCL CAP | 500 MG | 04000060100110 | Formulary |
| CIPRO | 500 MG/5 ML | 05000020001930 | Formulary |
| CIPROFLOXACIN HYDROCHLORIDE TAB | 250 MG | 05000020100310 | Formulary |
| CIPROFLOXACIN HYDROCHLORIDE TAB | 500 MG | 05000020100315 | Formulary |
| CIPROFLOXACIN TAB | 750 MG | 05000020100320 | Formulary |
| CIPROFLOXACIN IV SOL./ML | 200MG/100ML | 05000020112024 | Formulary |
| CIPROFLOXACIN IV SOL./ ML | 400MG/200ML | 05000020112028 | Formulary |
| LEVOFLOXACIN TAB | 250 MG | 05000034000320 | Formulary |
| LEVOFLOXACIN TAB | 500 MG | 05000034000330 | Formulary |
| LEVOFLOXACIN TAB | 750 MG | 05000034000340 | Formulary |
| LEVOFLOXACIN SOL | 25MG/1ML | 05000034002050 | Formulary |
| GENTAMICIN SULFATE SOL INJ /ML (HHS) | 40MG/1ML | 07000020102045 | Formulary |
| NEOMYCIN SULFATE TAB | 500 MG | 07000040100305 | Formulary |
| TOBRAMYCIN SOL INHALATION | 300MG/5ML | 07000070002520 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| SULFADIAZINE TAB | 500 MG | 08000020000305 | Formulary |
| ETHAMBUTOL HCL TAB | 100 MG | 09000040100305 | Formulary |
| ETHAMBUTOL HCL TAB | 400 MG | 09000040100310 | Formulary |
| ISONIAZID (INH-TUBERCULOSIS) TABLET | 100 MG | 09000060000305 | Formulary |
| ISONIAZID (INH-TUBERCULOSIS) TABLET! | 300 MG | 09000060000310 | Formulary |
| ISONIAZID (INH-TUBERCULOSIS) SOL/ML | 50MG | 09000060001210 | Formulary |
| PYRAZINAMIDE TAB | 500MG | 09000070000310 | Formulary |
| RIFAMPIN CAPSULE | 150MG | 09000080000105 | Formulary |
| RIFAMPIN CAP | 300 MG | 09000080000110 | Formulary |
| PRIFTIN TAB | 150MG | 09000085000320 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |

| ANTIMYCROBACTERIAL AGENTS | | | |
|---|---|---|---|
| Name | Strength/Unit | GPI | Comment |
| GRISEOFULVIN TAB | 500 MG | 11000030100315 | Formulary |
| GRISEOFULVIN MICRO SUSPENSION | 125MG/5ML 120ML | 11000030101805 | Formulary |
| GRISEOFULVIN ULTRAMICROSIZE TAB | 250MG | 11000030200315 | Formulary |
| TERBINAFINE HCL TAB | 250 MG | 11000080100310 | Formulary |
| PENICILLIN VK POTASSIUM TAB | 250 MG | 1100040100310 | Formulary |
| KETOCONAZOLE TAB | 200 MG | 11404040000310 | Formulary |
| FLUCONAZOLE | 50 MG | 11407015000310 | Formulary |
| FLUCONAZOLE TAB | 100 MG | 11407015000320 | Formulary |
| FLUCONAZOLE TAB | 150 MG | 11407015000325 | Formulary |
| FLUCONAZOLE TAB | 200 MG | 11407015000330 | Formulary |
| FLUCONAZOLE SUSP/ML | 10 MG | 11407015001910 | Formulary |
| FLUCONAZOLE SUSP/ML | 40 MG | 11407015001940 | Formulary |
| ITRACONAZOLE CAP | 100 MG | 11407035000120 | Formulary |
| ITRACONAZOLE (ITZ) SOL | 10MG/1ML | 11407035002020 | Formulary |
| POSACONAZOLE | 100MG | 11407060000620 | Formulary |
| VORICONAZOLE TAB | 200 MG | 11407080000340 | Formulary |

| ANTIVIRALS | | | |
|---|---|---|---|
| Name | Strength/Unit | GPI | Comment |
| TIVICAY TAB | 50 MG | 12103015100320 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| ISENTRESS TAB | 400 MG | 12103060100320 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| ISENTRESS CTB | 100 MG | 12103060100540 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| REYATAZ CAP (B) | 300 MG | 12104515200150 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |

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| ANTIVIRALS | | | |
|---|---|---|---|
| Name | Strength/Unit | GPI | Comment |
| PREZISTA TAB | 600 MG | 12104520000325 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| PREZISTA TAB (HIV) | 800 MG | 12104520000350 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| RITONAVIR TAB | 100 MG | 12104560000320 | Formulary |
| ABACAVIR TAB | 300 MG | 12105005100320 | Formulary |
| LAMIVUDINE TAB (BRAND-EPIVIR) | 150 MG | 12106060000320 | Formulary |
| LAMIVUDINE TAB (BRAND-EPIVIR) | 300 MG | 12106060000330 | Formulary |
| LAMIVUDINE SOL/ML | 10MG/1ML | 12106060002020 | Formulary |
| ZIDOVUDINE CAP | 100 MG | 12108085000110 | Formulary |
| ZIDOVUDINE TAB (HIV) | 300 MG | 12108085000330 | Prior Authorization Required. Submit PA form and office notes |
| ZIDOVUDINE SYRUP/ML | 50MG | 12108085001210 | Formulary |
| RETROVIR | 10 MG/1 ML | 12108085002020 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| TENOFOVIR DISOPROXIL FUMARATE | 300 MG | 12108570100320 | Formulary |
| EFAVIRENZ | 600MG | 12109030000330 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| INTELENCE TAB (B) | 200 MG | 12109035000340 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| NEVIRAPINE TAB | 200 MG | 12109050000320 | Formulary |
| NEVIRAPINE SUSPENSION | 50MG/5ML | 12109050001820 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| ABACAVIR SULFATE- LAMIVUDINE | 600MG-300MG | 12109902200340 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| DESCOVY TABLET | 200MG-25MG | 12109902290320 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| EMTRICITABINE-TENOFOVIR DISOPROXIL FUMARATE TAB | 200 MG-300 MG | 12109902300320 | Prior Authorization Required. Submit PA form and office notes |
| LAMIVUDINE/ZIDOVUDINE TAB (NEGOTIATED PRICE-HIV) | 150MG/300MG | 12109902500320 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| KALETRA TAB (B) | 100MG-25MG | 12109902550310 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| KALETRA TAB (B) | 200MG-50MG | 12109902550320 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| TRIUMEQ (COMBO DRUG-ABACAVIR/DOLUTEGRAVIR/LAMIVUDINE) TAB (HIV) | 600MG-50MG-300M | 12109903150320 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| BIKTARVY TAB | 50MG-200MG-25MG | 12109903240330 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| EFAVIRENZ-EMTRICITABINE-TENOFOVIR DISOPROXIL FUMAR | 600-200-300MG | 12109903300320 | Formulary |
| COMPLERA TAB (HIV) | 200MG-25MG-300M | 12109903400320 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| GENVOYA 150-150-200MG-10 | 150, 200, 200MG | 12109904290315 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| STRIBILD TAB 150MG, 150MG, 200MG 300MG | 150, 200, 300MG | 12109904300320 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| VALGANCICLOVIR HCL TAB | 450MG | 12200066100320 | Formulary |
| VALGANCICLOVIR HYDROCHLORIDE PDS | 50MG/1ML | 12200066102120 | Formulary |
| ENTECAVIR TAB (NEGOTIATED PRICE-HIV) | .5 MG | 12352030000320 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| ENTECAVIR TAB (NEGOTIATED PRICE-HIV) | 1 MG | 12352030000330 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| LAMIVUDINE TAB (BRAND-EPIVIR) | 100 MG | 12352050000315 | Formulary |
| VEMLIDY TAB | 25 MG | 12352083200320 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| RIBAVIRIN CAP (HEP OFF-ISLAND SPECIALTY/ON-ISLAND) | 200 MG | 12353070000120 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| RIBAVIRIN TAB (HEP OFF-ISLAND SPECIALTY/ON-ISLAND) | 200 MG | 12353070000320 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| SOVALDI TAB (NEGOTIATED PRICE-HEP) | 400 MG | 12353080000320 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| LEDIPASVIR/SOFOSBUVIR (GENERIC) | 90 MG-400 MG | 12359902400320 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| SOFOSBUVIR-VELPATASVIR | 400-100MG | 12359902650330 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| ACYCLOVIR CAP | 200 MG | 12405010000110 | Formulary |
| ACYCLOVIR TAB | 400 MG | 12405010000320 | Formulary |
| ACYCLOVIR TAB | 800 MG | 12405010000330 | Formulary |
| ACYCLOVIR SUSP /ML | 200MG/5ML | 12405010001810 | Formulary |
| VALACYCLOVIR HCL TAB | 500 MG | 12405085100310 | Formulary |
| VALACYCLOVIR HCL TAB | 1GM | 12405085100320 | Formulary |
| OSELTAMIVIR PHOSPHATE CAP | 30 MG | 12504060200110 | Formulary |
| OSELTAMIVIR PHOSPHATE CAP | 45MG | 12504060200115 | Formulary |
| OSELTAMIVIR PHOSPHATE CAP | 75 MG | 12504060200120 | Formulary |
| OSELTAMIVIR PHOSPHATE PDR SUSP /ML | 6 MG | 12504060201910 | Formulary |
| MOLNUPIRAVIR CAP (DISPENSING FEE ONLY@OKA SUPERDRUG & ALL EXPRESSMED) | 200 MG | 12700046000120 | Formulary |
| PAXLOVID TAB RESTRICTED FOR PATIENTS WITH MEDICALLY NECESSARY (150MG;100MG DOSE PACK) | 150MG;100MG | 129900255B720 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |

| ANTIMALARIALS | | | |
|---|---|---|---|
| Name | Strength/Unit | GPI | Comment |
| HYDROXYCHLOROQUINE SULFATE TAB | 200 MG | 13000020100305 | Formulary |
| QUININE SULFATE CAP | 324 MG | 13000060100119 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |

| ANTIHELMINTICS | | | |
|---|---|---|---|
| Name | Strength/Unit | GPI | Comment |
| ALBENDAZOLE TABLET | 200MG | 15000002000320 | Formulary |
| IVERMECTIN TAB | 3 MG | 15000007000310 | Formulary |
| PRAZIQUANTEL TAB | 600 MG | 15000050000305 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |

| MISC. ANTIINFECTIVE AGENTS | | | |
|---|---|---|---|
| Name | Strength/Unit | GPI | Comment |
| METRONIDAZOLE TAB | 250 MG | 16000035000305 | Formulary |
| METRONIDAZOLE TAB | 500 MG | 16000035000310 | Formulary |
| XIFAXAN TAB | 550MG | 16000049000340 | Prior Authorization Required. Submit PA form and office notes |
| ERTAPENEM PDS INJ /GM (HHS) | 1GM | 16150030102130 | Formulary |
| PRIMAXIN IV (CANCER) PDS/MG | 500 MG/500MG | 16159902402120 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| CLINDAMYCIN HCL CAP | 150 MG | 16220020100110 | Formulary |
| CLINDAMYCIN HCL CAP | 300 MG | 16220020100120 | Formulary |
| CLINDAMYCIN PALMITATE HCL PDS ORAL /ML | 75MG/5ML | 16220020222120 | Formulary |
| LINEZOLID TAB | 600 MG | 16230040000330 | Formulary |
| DAPTOMYCIN PDS IV /EA (HHS) | 350MG | 16270030002130 | Prior Authorization Required. Submit PA form and office notes |
| CUBICIN IV PDS /EA | 500 MG | 16270030002140 | Prior Authorization Required. Submit PA form and office notes |
| VANCOMYCIN HCL CAP | 125 MG | 16280080100110 | Formulary |
| VANCOMYCIN HCL CAP | 250 MG | 16280080100120 | Formulary |
| VANCOMYCIN HCL PDS IV /EA | 500 MG | 16280080102110 | Formulary |
| VANCOMYCIN PDS IV /GM (HHS-ACQ W/NDC) | 1GM | 16280080102120 | Formulary |
| VANCOMYCIN HCL PDS IV /EA | 5 GM | 16280080102125 | Formulary |
| VANCOMYCIN HCL PDR | 250 MG/5 ML | 16280080102170 | Formulary |
| DAPSONE TABLET | 25 MG | 16300010000310 | Prior Authorization Required. Submit PA form and office notes |
| DAPSONE TABLET | 100 MG | 16300010000320 | Prior Authorization Required. Submit PA form and office notes |
| NITROFURANTOIN SUSPENSION/ML | 25 MG | 16800050001810 | Formulary |
| NITROFURANTOIN MACROCRYSTALS CAP | 25MG | 16800050100110 | Formulary |
| NITROFURANTOIN MACROCRYSTALS CAP | 50 MG | 16800050100115 | Formulary |
| NITROFURANTOIN MACROCRYSTALS CAP | 100 MG | 16800050100120 | Formulary |
| NITROFURANTOIN MONOHYDRATE MACRO CAP | 100 MG | 16800050150120 | Formulary |
| SULFAMETHOXAZOLE/TRIMETHOPRIM TAB | 400-80 MG | 16990002300310 | Formulary |
| SULFAMETHOXAZOLE/TRIMETHOPRIM TAB | 800-160 MG | 16990002300320 | Formulary |
| SULFAMETHOXAZOLE/TRIMETHOPRIM PED SUSPENSION | 200-40MG /5ML | 16990002301810 | Formulary |

| PASSIVE IMMUNIZING AND TREATMENT AGENTS | | | |
|---|---|---|---|
| Name | Strength/Unit | GPI | Comment |
| RHOGAM ULTRA-FILTERED PLUS SOL | 300 MCG | 1910005000E540 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |

| ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES | | | |
|---|---|---|---|
| Name | Strength/Unit | GPI | Comment |
| CARBOPLATIN SOL IV/ML | 10 MG | 21100015002030 | Formulary |
| CISPLATIN IV SOLN /ML (CANCER) | 1MG/1ML | 21100020002025 | Prior Authorization Required. Submit PA form and office notes |
| OXALIPLATIN INJ/VIAL (CANCER) | 100 MG/ | 21100028002130 | Prior Authorization Required. Submit PA form and office notes |
| CYCLOPHOSPHAMIDE CAP (CANCER) | 50 MG | 21101020000110 | Prior Authorization Required. Submit PA form and office notes |
| CYCLOPHOSPHAMIDE PDS IV/EA (CANCER) | 500 MG | 21101020002120 | Prior Authorization Required. Submit PA form and office notes |
| CYCLOPHOSPHAMIDE PDS IV/EA (CANCER) | 1GM | 21101020002125 | Prior Authorization Required. Submit PA form and office notes |
| CYCLOPHOSPHAMIDE PDS IV/EA | 2 GM | 21101020002130 | Prior Authorization Required. Submit PA form and office notes |
| TEMOZOLOMIDE (CANCER)/CAP | 5 MG | 21104070000110 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| TEMOZOLOMIDE (CANCER)/CAP | 100MG | 21104070000140 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| TEMOZOLOMIDE (CANCER) CAP | 250MG | 21104070000150 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| PERJETA SOLUTION (CANCER) VIAL/ML | 30MG/1 ML | 21170054002020 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| HERCEPTIN PDS IV (CANCER)/EA | 150MG | 21170070002110 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| BLEOMYCIN SULFATE PDS | 15 U/VIAL | 21200010102105 | Formulary |
| DOXORUBICIN HCL SOLN IV /ML | 2MG/1ML | 21200040102010 | Formulary |
| MITOMYCIN SOL IV/PDS/MG (CANCER) | 20 MG | 21200050002110 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |

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| ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES | | | |
|---|---|---|---|
| Name | Strength/Unit | GPI | Comment |
| CAPECITABINE TAB (CANCER) | 500 MG | 21300005000350 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| CYTARABINE INJ | 20 MG/ML | 21300010002011 | Formulary |
| CYTARABINE INJ | 100 MG | 21300010002040 | Formulary |
| FLUOROURACIL SOL IV /ML (CANCER) | 50MG/1ML | 21300030002020 | Prior Authorization Required. Submit PA form and office notes |
| GEMCITABINE HCL PDS IV (CANCER) | 200 MG | 21300034102020 | Prior Authorization Required. Submit PA form and office notes |
| GEMCITABINE HCL PDS IV (CANCER) | 1 GM | 21300034102040 | Prior Authorization Required. Submit PA form and office notes |
| MERCAPTOPURINE TAB (CANCER) | 50 MG | 21300040000305 | Prior Authorization Required. Submit PA form and office notes |
| METHOTREXATE SODIUM TAB (CANCER, ANTI RHEUMATIC) | 2.5 MG | 21300050100310 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| METHOTREXATE SODIUM INJ/ML | 25MG/1ML | 21300050102068 | Formulary |
| RITUXAN SOLN IV/ML (CANCER) | 10 MG/1ML | 21351860002040 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| ERBITUX INJ (CANCER)/ML | 2MG/1ML | 21360015002025 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| ERLOTINIB HYDROCHLORIDE | 100 MG | 21360025100330 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| BICALUTAMIDE | 50 MG | 21402420000320 | Formulary |
| TAMOXIFEN CITRATE TAB (CANCER) | 10 MG | 21402680100310 | Formulary |
| TAMOXIFEN CITRATE TAB (CANCER) | 20 MG | 21402680100320 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| ANASTROZOLE TAB (CANCER) | 1 MG | 21402810000310 | Formulary |
| EXEMESTANE TAB (CANCER) | 25MG | 21402835000320 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| LETROZOLE TAB (CANCER) | 2.5 MG | 21402860000320 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| MEGESTROL ACETATE TAB | 40 MG | 21404020100310 | Formulary |
| LUPRON DEPOT PI1 INJECTION (CANCER)/EA | 3.75 MG | 21405010106405 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| LUPRON DEPOT-PED IM PI1 (LEUPROLIDE ACETATE) | 7.5MG | 21405010106410 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| LUPRON DEPOT PI3 INJECTION (CANCER)/EA | 22.5 MG | 21405010156430 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| TRELSTAR PDR/ EA (CANCER) | 3.75 MG | 21405050201920 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| ABIRATERONE ACETATE TAB | 250MG | 21406010200320 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| DOCETAXEL SOLN IV/ML | 20 MG | 21500005002030 | Formulary |
| PACLITAXEL IV SOLUTION/ML (CANCER) | 6MG/ML 50 ML | 21500012001325 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| VINCRISTINE SULFATE SOLN IV/ML | 1 MG | 21500020102005 | Formulary |
| VINBLASTINE SULFATE SOLUTION/ML | 1 MG/1ML | 21500030102020 | Formulary |
| VINORELBINE TARTRATE/ML | 10 MG | 21500050802020 | Formulary |
| VERZENIO | 100 MG | 21531010000310 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| SPRYCEL TAB | 100 MG | 21531820000360 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| IMATINIB MESYLATE TAB (CANCER) | 100 MG | 21531835100320 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| IMATINIB MESYLATE TAB | 400 MG | 21531835100340 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| EVEROLIMUS TAB | 10MG | 21532530000330 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| SORAFENIB TOSYLATE TAB | 200MG | 21533060400320 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| INREBIC CAP | 100MG | 21537520200120 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| IRINOTECAN HCL SOLN IV /ML (CANCER) | 20 MG/1ML | 21550040102030 | Prior Authorization Required. Submit PA form and office notes |
| DACARBAZINE INJECTION | 200 MG | 21700020002110 | Formulary |
| HYDROXYUREA CAP (CANCER) | 500 MG | 21700030000105 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| LEUCOVORIN CALCIUM TAB (CANCER) | 5 MG | 21755040100310 | Prior Authorization Required. Submit PA form and office notes |
| LEUCOVORIN CALCIUM TAB (CANCER) | 10 MG | 21755040100325 | Prior Authorization Required. Submit PA form and office notes |
| LEUCOVORIN CALCIUM PDS/MG (CANCER) | 350 MG | 21755040102160 | Prior Authorization Required. Submit PA form and office notes |
| MESNA SOL IV (CANCER)/ML | 100MG/1ML | 21758050002010 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| CORTICOSTEROIDS | | | |
| Name | Strength/Unit | GPI | Comment |
| CORTISONE ACETATE | 25 MG | 22100015100310 | Formulary |
| DEXAMETHASONE TAB | 0.5 MG | 22100020000315 | Formulary |
| DEXAMETHASONE TAB | 0.75 MG | 22100020000320 | Formulary |
| DEXAMETHASONE TAB | 1 MG | 22100020000325 | Formulary |
| DEXAMETHASONE TAB | 2 MG | 22100020000335 | Formulary |
| DEXAMETHASONE TAB | 4 MG | 22100020000340 | Formulary |
| DEXAMETHASONE ELIXIR | 0.5MG/5ML | 22100020001005 | Formulary |
| DEXAMETHASONE INTENSOL SOLUTION/ML | 1 MG | 22100020001320 | Formulary |
| HYDROCORTISONE TAB | 5 MG | 22100025000303 | Formulary |
| HYDROCORTISONE TAB | 10 MG | 22100025000305 | Formulary |
| HYDROCORTISONE TAB | 20 MG | 22100025000310 | Formulary |
| SOLU-CORTEF INJECTION/PDS | 100 MG | 22100025402150 | Formulary |
| METHYLPREDNISOLONE TAB | 4 MG | 22100030000310 | Formulary |
| PREDNISOLONE SYRUP /ML | 15MG/5ML | 22100040002020 | Formulary |
| PREDNISOLONE SODIUM PHOSPHATE SYRUP/ML | 5MG/5ML | 22100040202040 | Formulary |
| PREDNISONE TABLET | 1 MG | 22100045000305 | Formulary |
| PREDNISONE TAB | 5 MG | 22100045000315 | Formulary |
| PREDNISONE TAB | 10 MG | 22100045000320 | Formulary |
| PREDNISONE TAB | 20 MG | 22100045000325 | Formulary |
| PREDNISONE TAB | 50MG | 22100045000335 | Formulary |
| PREDNISONE SOLUTION/ML | 5MG/5ML | 22100045002005 | Formulary |
| FLUDROCORTISONE ACETATE TAB | 0.1 MG | 22200030100305 | Formulary |
| ANDROGENS | | | |
| Name | Strength/Unit | GPI | Comment |
| DANAZOL | 200MG | 23100005000115 | Formulary |
| ANDROGEL (TESTOSTERONE) GEL | 1.62% | 23100030004050 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| ESTROGENS | | | |
| Name | Strength/Unit | GPI | Comment |
| PREMARIN TAB | 0.625 MG | 24000015000320 | Formulary |
| ESTRADIOL TAB | .5MG | 24000035000303 | Formulary |
| ESTRADIOL TAB | 1MG | 24000035000305 | Formulary |
| PREMPRO TAB | 0.3MG-1.5MG | 24993002040340 | Prior Authorization Required. Submit PA form and office notes |
| PREMPRO TAB | 0.45MG-1.5MG | 24993002040345 | Prior Authorization Required. Submit PA form and office notes |
| PREMPRO TAB | 0.625MG-2.5MG | 24993002040350 | Prior Authorization Required. Submit PA form and office notes |
| PREMPRO TAB | 0.625MG-5MG | 24993002040360 | Prior Authorization Required. Submit PA form and office notes |
| CONTRACEPTIVES | | | |
| Name | Strength/Unit | GPI | Comment |
| ERRIN TAB (B) | 0.35 MG | 25100010000305 | Formulary |
| MEDROXYPROGESTERONE ACETATE SUS | 150MG/1ML | 25150035101820 | Formulary |
| APRI (DESOGESTREL/ETHINYL ESTRADIOL;PLACEBO) | .15MG-.03MG;NA | 25990002100320 | Formulary |
| ETHINYL ESTRADIOL/LEVONORGESTREL;PLACEBO | 0.02MG-0.1MG;NA | 25990002400305 | Formulary |
| KURVELO TAB (ETHINYL ESTRADIOL/LEVONORGESTREL;PLACEBO) | 30MCG-0.15MG;NA | 25990002400310 | Formulary |
| NORTREL TAB | 35MCG/0.5MG | 25990002500310 | Formulary |
| NORTREL TAB | 35MCG-1MG | 25990002500320 | Formulary |
| ETHINYL ESTRADIOL - NORETHINDRONE ACETATE TAB | 1.5-30/20MCG-1M | 25990002600310 | Formulary |
| LOW-OGESTREL 28 | 30 MCG-0.3 MG; | 25990002900310 | Formulary |
| ETHINYL ESTRADIOL/NORGESTIMATE;ETHINYL ESTRADIOL TAB | .025-.18;.025MG | 25992002300310 | Formulary |
| ORTHO TRI-CYCLEN TAB | 35 MCG-0.18 MG; | 25992002300320 | Formulary |
| PROGESTINS | | | |
| Name | Strength/Unit | GPI | Comment |
| MEDROXYPROGESTERONE ACETATE TAB (MEDICAL JUSTIFICATION) | 2.5 MG | 26000020200305 | Formulary |
| MEDROXYPROGESTERONE ACETATE TAB (MEDICAL JUSTIFICATION) | 5 MG | 26000020200310 | Formulary |
| MEDROXYPROGESTERONE ACETATE TAB | 10 MG | 26000020200315 | Formulary |
| PROGESTERONE, MICRONIZED CAP | 100MG | 26000040000120 | Formulary |
| PROGESTERONE, MICRONIZED CAP | 200MG | 26000040000140 | Formulary |
| ANTIDIABETICS | | | |
| Name | Strength/Unit | GPI | Comment |
| INSULIN ASPART, RECOMBINANT | 100U/1ML | 27104002002022 | Formulary |
| INSULIN ASPART FLEXPEN(BLIND, SELF ADMIN@SCHOOL FOR CHIDREN) | 100U/1ML | 2710400200D220 | Formulary |
| INSULIN ASPART PENFILL | 100U/1ML | 2710400200E220 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| LANTUS SUBCUTANEOUS SOL | 100U/1ML | 27104003002020 | Formulary |
| BASAGLAR KWIKPEN SOL /ML (PS ,SHF) | 100U/1ML | 2710400300D220 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| INSULIN GLARGINE SOL | 100IU/1ML | 27104003902020 | Formulary |
| INSULIN GLARGINE PEN | 100U/1ML | 2710400390D220 | Formulary |

# GUAM Medicaid Formulary

**Mandatory Generic Plan.**

Brand name drugs with generic substitutes available are not covered

| ANTIDIABETICS | | | |
|---|---|---|---|
| Name | Strength/Unit | GPI | Comment |
| HUMALOG SOL INJ/ML | 100U/1ML | 27104005002022 | Formulary |
| HUMALOG KWIKPEN(BLIND,SELF-ADMIN@SCHOOL/DOSAGE@MONTH<VIAL) SUS/ML-GENERIC AVAILABLE | 100U/1ML | 2710400500D222 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| HUMULIN R SOL/ML | 100 U | 27104010002005 | Formulary |
| HUMULIN N (NPH) SUSP/ML | 100 U | 27104020001805 | Formulary |
| HUMULIN N (NPH) KWIKPEN /ML (BLIND, SELF-ADMIN@SCHOOL FOR CHILDREN) | 100U/1ML | 2710402000D320 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| INSULIN ASPART PROTAMINE 70U/IML 30U/1ML | 70U/1ML 30U/1ML | 27104070001820 | Formulary |
| HUMALOG MIX 75/25 SUSP/ML | 75U/1ML-25U/1ML | 27104080001820 | Formulary |
| HUMULIN 70/30 SUSP /ML | 70U/1ML-30U/1ML | 27104090001810 | Formulary |
| HUMULIN 70/30 KWIKPEN /ML | 70U/1ML-30U/1ML | 2710409000D320 | Formulary |
| TRULICITY SOL SUBCUTANEOUS/ML | 0.75MG/0.5ML | 27170015000520 | Prior Authorization Required. Submit PA form and office notes |
| TRULICITY SOL SUBCUTANEOUS/ML | 1.5MG/0.5ML | 2717001500D530 | Formulary |
| TRULICITY SOL SUBCUTANEOUS/ML | 3MG/0.5ML | 2717001500D540 | Formulary |
| TRULICITY SOL SUBCUTANEOUS/ML | 4.5MG/0.5ML | 2717001500D550 | Formulary |
| VICTOZA | 6 MG/1 ML | 2717005000D220 | Prior Authorization Required. Submit PA form and office notes |
| RYBELSUS TAB (SEMAGLUTIDE) | 3MG | 27170070000310 | Prior Authorization Required. Submit PA form and office notes |
| RYBELSUS TAB (SEMAGLUTIDE) | 7MG | 27170070000320 | Prior Authorization Required. Submit PA form and office notes |
| RYBELSUS TAB (SEMAGLUTIDE) | 14MG | 27170070000330 | Prior Authorization Required. Submit PA form and office notes |
| OZEMPIC 0.25MG-0.5MG/3ML DOSES | .25MG-.5MG/3ML | 2717007000D221 | Prior Authorization Required. Submit PA form and office notes |
| OZEMPIC 1MG/0.75ML DOSES | 4MG/3ML | 2717007000D222 | Prior Authorization Required. Submit PA form and office notes |
| OZEMPIC 0.25MG-0.5MG/1.5ML DOSES | .25-.5MG/1.5ML | 2717007000D225 | Prior Authorization Required. Submit PA form and office notes |
| GLIMEPIRIDE TAB | 1 MG | 27200027000310 | Formulary |
| GLIMEPIRIDE TAB | 2 MG | 27200027000320 | Formulary |
| GLIMEPIRIDE TAB | 4 MG | 27200027000340 | Formulary |
| GLIPIZIDE TAB | 5 MG | 27200030000305 | Formulary |
| GLIPIZIDE ER TAB | 10 MG | 27200030000310 | Formulary |
| GLIPIZIDE ER TAB | 2.5 MG | 27200030007505 | Formulary |
| GLIPIZIDE ER TAB | 5 MG | 27200030007510 | Formulary |
| GLYBURIDE TAB | 1.25MG | 27200040000305 | Formulary |
| GLYBURIDE TAB | 2.5 MG | 27200040000310 | Formulary |
| GLYBURIDE TAB | 5 MG | 27200040000315 | Formulary |
| GLYBURIDE MICRONIZED TAB | 3 MG | 27200040100320 | Formulary |
| GLYBURIDE MICRONIZED TAB | 6 MG | 27200040100340 | Formulary |
| METFORMIN HCL TAB | 500 MG | 27250050000320 | Formulary |
| METFORMIN HCL TAB | 850 MG | 27250050000340 | Formulary |
| METFORMIN HCL TAB | 1000 MG | 27250050000350 | Formulary |
| METFORMIN HCL TER | 500 MG | 27250050007520 | Formulary |
| METFORMIN HCL TER | 750 MG | 27250050007530 | Formulary |
| METFORMIN HCL TER | 1000MG | 27250050007570 | Formulary |
| NATEGLINIDE TAB | 120 MG | 27280040000330 | Formulary |
| REPAGLINIDE | 2 MG | 27280060000330 | Formulary |
| GLUCAGON EMERGENCY KIT PDS INJ /EA | 1 MG | 27300010106410 | Formulary |
| DIAZOXIDE SUS | 50MG/1ML | 27300020001810 | Formulary |
| ACARBOSE TAB | 25 MG | 27500010000310 | Formulary |
| ACARBOSE TAB | 50 MG | 27500010000320 | Formulary |
| ACARBOSE TAB | 100 MG | 27500010000340 | Formulary |
| TRADJENTA TAB | 5 MG | 27550050000320 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| JANUVIA TAB | 25MG | 27550070100320 | Formulary |
| JANUVIA TAB | 50MG | 27550070100330 | Formulary |
| JANUVIA TAB | 100MG | 27550070100340 | Formulary |
| PIOGLITAZONE HCL/TAB | 15 MG | 27607050100320 | Formulary |
| PIOGLITAZONE HCL TAB | 30 MG | 27607050100330 | Formulary |
| PIOGLITAZONE HCL TAB | 45MG | 27607050100340 | Formulary |
| INVOKANA TAB | 100 MG | 27700020000320 | Formulary |
| INVOKANA TAB | 300 MG | 27700020000330 | Formulary |
| DAPAGLIFLOZIN PROPANEDIOL TAB | 5MG | 27700040200310 | Formulary |
| DAPAGLIFLOZIN PROPANEDIOL TAB | 10MG | 27700040200320 | Formulary |
| JARDIANCE TAB | 10MG | 27700050000310 | Formulary |
| JARDIANCE TAB | 25MG | 27700050000320 | Formulary |
| JANUMET TAB | 500MG-50MG | 27992502700320 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| JANUMET XR TER | 500MG-50MG | 27992502707520 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| JANUMET XR TER | 1000MG-50MG | 27992502707530 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| JANUMET XR TER | 1000MG-100MG | 27992502707540 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| SYNJARDY | 12.5 MG-500 MG | 27996002400310 | Formulary |
| SYNJARDY | 5 MG-1000 MG | 27996002400315 | Formulary |
| SYNJARDY | 12.5 MG-1000 MG | 27996002400325 | Formulary |
| SYNJARDY XR | 5 MG-1000 MG | 27996002407530 | Formulary |
| SYNJARDY XR | 12.5 MG-1000 MG | 27996002407540 | Formulary |
| SYNJARDY XR | 25 MG-1000 MG | 27996002407560 | Formulary |
| GLIPIZIDE/METFORMIN HYDROCHLORIDE TAB | 50MG-500MG | 27997002350340 | Formulary |
| GLYBURIDE/METFORMIN HCL TAB | 2.5 MG-500 MG | 27997002400320 | Formulary |
| GLYBURIDE/METFORMIN HCL TAB | 5 MG-500 MG | 27997002400330 | Formulary |

| THYROID AGENTS | | | |
|---|---|---|---|
| Name | Strength/Unit | GPI | Comment |
| LEVOTHYROXINE SODIUM COMPOUNDED | 25MCG/ML | 28100010100110 | Formulary |
| TIROSINT SGL | 112 MCG | 28100010100135 | Formulary |
| TIROSINT SOL | 137 MCG | 28100010100145 | Prior Authorization Required. Submit PA form and office notes |
| TIROSINT SOL | 150 MCG | 28100010100150 | Formulary |
| TIROSINT | 175 MCG | 28100010100155 | Formulary |
| LEVOTHYROXINE SODIUM TAB | 25 MCG | 28100010100305 | Formulary |
| LEVOTHYROXINE SODIUM TAB | 50 MCG | 28100010100310 | Formulary |
| LEVOTHYROXINE SODIUM TAB | 75 MCG | 28100010100315 | Formulary |
| LEVOTHYROXINE SODIUM TAB | 88 MCG | 28100010100317 | Formulary |
| LEVOTHYROXINE SODIUM TAB | 100 MCG | 28100010100320 | Formulary |
| LEVOTHYROXINE SODIUM TAB | 112 MCG | 28100010100322 | Formulary |
| LEVOTHYROXINE SODIUM TAB | 125 MCG | 28100010100325 | Formulary |
| LEVOTHYROXINE SODIUM TAB | 137 MCG | 28100010100327 | Formulary |
| LEVOTHYROXINE SODIUM TAB | 150 MCG | 28100010100330 | Formulary |
| LEVOTHYROXINE SODIUM TABLET | 175 MCG | 28100010100335 | Formulary |
| LEVOTHYROXINE SODIUM TAB | 200 MCG | 28100010100340 | Formulary |
| LEVOTHYROXINE SODIUM TAB | 300 MCG | 28100010100345 | Formulary |
| LIOTHYRONINE SODIUM TAB | 5MCG | 28100020100305 | Formulary |
| ARMOUR THYROID TAB | 15 MG | 28100050000305 | Formulary |
| ARMOUR THYROID TAB | 30 MG | 28100050000310 | Formulary |
| ARMOUR THYROID TAB | 60 MG | 28100050000315 | Formulary |
| ARMOUR THYROID TAB | 120 MG | 28100050000325 | Formulary |
| METHIMAZOLE TAB | 5 MG | 28300010000305 | Formulary |
| METHIMAZOLE TAB | 10 MG | 28300010000310 | Formulary |
| PROPYLTHIOURACIL TAB | 50 MG | 28300020000310 | Formulary |

| OXYTOCICS | | | |
|---|---|---|---|
| Name | Strength/Unit | GPI | Comment |
| METHYLERGONOVINE MALEATE TAB | 0.2 MG | 29000020100305 | Formulary |

| ENDOCRINE AND METABOLIC AGENTS - MISC. | | | |
|---|---|---|---|
| Name | Strength/Unit | GPI | Comment |
| ALENDRONATE SODIUM TAB | 5 MG | 30042010100305 | Formulary |
| ALENDRONATE SODIUM TAB | 10 MG | 30042010100310 | Formulary |
| ALENDRONATE SODIUM TAB | 35 MG | 30042010100335 | Formulary |
| ALENDRONATE SODIUM TAB | 70 MG | 30042010100370 | Formulary |
| IBANDRONATE SODIUM TAB | 150MG | 30042048100360 | Formulary |
| PAMIDRONATE DISODIUM PDS IV /EA (CANCER) | 30 MG | 30042060102006 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |

# GUAM Medicaid Formulary

**Mandatory Generic Plan.**

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| ENDOCRINE AND METABOLIC AGENTS - MISC. | | | |
|---|---|---|---|
| Name | Strength/Unit | GPI | Comment |
| RISEDRONATE SODIUM TAB (BRAND-ACTONEL) | 5 MG | 30042065100305 | Formulary |
| RISEDRONATE SODIUM (BRAND-ACTONEL) TAB | 35MG | 30042065100330 | Formulary |
| ZOLEDRONIC ACID NOVAPLUS SOL IV (CANCER)/ML | 4MG/5ML | 30042090001320 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| PROLIA SOL SQ | 60MG/1ML | 3004453000E520 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| RALOXIFENE HYDROCHLORIDE AVPAK TAB | 60 MG | 30053060100320 | Formulary |
| LUPRON DEPOT-PED IM PI1 (LEUPROLIDE ACETATE) | 15 MG | 30080050106440 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| GENOTROPIN PDS /EA | 5.8 MG | 3010002000E159 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| OMNITROPE | 5 MG/1.5 ML | 3010002000E210 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| SANDOSTATIN LAR DEPOT PDR IM | 10MG | 30170070106410 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| SANDOSTATIN LAR DEPOT/PDR | 20 MG | 30170070106420 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| SANDOSTATIN LAR DEPOT/MG | 30 MG | 30170070106430 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| DESMOPRESSIN ACETATE TAB | 0.1MG | 30201010100310 | Formulary |
| DESMOPRESSIN ACETATE TAB | 0.2 MG | 30201010100320 | Formulary |
| DESMOPRESSIN ACETATE NASAL SPRAY /ML | 0.01MG | 30201010122010 | Formulary |
| CABERGOLINE TAB | 0.5 MG | 30402020000320 | Formulary |
| CALCITRIOL SGL (ESRD, HYPOTHYROIDISM & HYPERTHYROIDISM) | 0.25 MCG | 30905030000105 | |
| CALCITRIOL SGL | 0.5 MCG | 30905030000110 | Formulary |
| CALCITRIOL SYRUP/ML | 1 MCG | 30905030002050 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| PARICALCITOL SGL (NEGOTIATED PRICE-FRES) | 1MCG | 30905070000110 | Formulary |
| PARICALCITOL SGL (NEGOTIATED PRICE-FRES) | 2 MCG | 30905070000120 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| CINACALCET HYDROCHLORIDE TAB (NEGOTIATED PRICE-FRES) | 30MG | 30905225100320 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| CINACALCET HYDROCHLORIDE TAB (NEGOTIATED PRICE-FRES) | 60MG | 30905225100330 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| CINACALCET HYDROCHLORIDE TAB (NEGOTIATED PRICE-FRES) | 90MG | 30905225100340 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| RAVICTI SOL | 1.1GM/1ML | 30908030000920 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| CARDIOTONICS | | | |
| Name | Strength/Unit | GPI | Comment |
| DIGOXIN TAB | 0.125 MG | 31200010000305 | Formulary |
| DIGOXIN TAB | 0.25 MG | 31200010000310 | Formulary |
| DIGOXIN LIQ ELIXIR | .05MG/ML 60ML | 31200010002040 | Formulary |
| ANTIANGINAL AGENTS | | | |
| Name | Strength/Unit | GPI | Comment |
| ISOSORBIDE DINITRATE TAB | 5 MG | 32100020000305 | Formulary |
| ISOSORBIDE DINITRATE TAB | 10 MG | 32100020000310 | Formulary |
| ISOSORBIDE DINITRATE TAB | 20 MG | 32100020000315 | Formulary |
| ISOSORBIDE DINITRATE TAB | 30 MG | 32100020000320 | Formulary |
| ISOSORBIDE MONONITRATE TAB | 10 MG | 32100025000310 | Formulary |
| ISOSORBIDE MONONITRATE TAB | 20 MG | 32100025000320 | Formulary |
| ISOSORBIDE MONONITRATE ER TAB | 30 MG | 32100025007520 | Formulary |
| ISOSORBIDE MONONITRATE ER TAB | 60 MG | 32100025007530 | Formulary |
| NITROGLYCERIN TAB | 0.4 MG | 32100030000715 | Formulary |
| NITRO-BID TRANSDERMAL OINTMENT /GM | 2% | 32100030004205 | Formulary |
| NITROGLYCERIN/PATCH | 0.2 MG/HR | 32100030008520 | Formulary |
| RANOLAZINE TER | 500 MG | 32200040007420 | Formulary |
| BETA BLOCKERS | | | |
| Name | Strength/Unit | GPI | Comment |
| NADOLOL TAB | 40 MG | 33100010000305 | Formulary |
| NADOLOL TAB | 80 MG | 33100010000310 | Formulary |
| PROPRANOLOL HCL TAB | 10 MG | 33100040100305 | Formulary |
| PROPRANOLOL HCL TAB | 20 MG | 33100040100310 | Formulary |
| PROPRANOLOL HCL TAB | 40 MG | 33100040100315 | Formulary |
| PROPRANOLOL HCL SOLUTION /ML | 20MG/5ML | 33100040102050 | Formulary |
| PROPRANOLOL HCL CER | 60 MG | 33100040107025 | Formulary |
| PROPRANOLOL HCL CER | 80 MG | 33100040107030 | Formulary |
| PROPRANOLOL HCL CER | 160MG | 33100040107040 | Formulary |
| SOTALOL HYDROCHLORIDE AF TAB | 80 MG | 33100045100310 | Formulary |
| ATENOLOL TAB | 25 MG | 33200020000303 | Formulary |
| ATENOLOL TAB | 50 MG | 33200020000305 | Formulary |
| ATENOLOL TAB | 100 MG | 33200020000310 | Formulary |
| BISOPROLOL FUMARATE TAB | 5 MG | 33200022100310 | Formulary |
| BISOPROLOL FUMARATE | 10 MG | 33200022100320 | Formulary |
| METOPROLOL SUCCINATE TER | 25 MG | 33200030057510 | Formulary |
| METOPROLOL SUCCINATE TER | 50 MG | 33200030057520 | Formulary |
| METOPROLOL SUCCINATE TER | 100 MG | 33200030057530 | Formulary |
| METOPROLOL SUCCINATE TER | 200 MG | 33200030057540 | Formulary |
| METOPROLOL TARTRATE TAB | 25 MG | 33200030100305 | Formulary |
| METOPROLOL TARTRATE TAB | 50 MG | 33200030100310 | Formulary |
| METOPROLOL TARTRATE /TAB | 100 MG | 33200030100315 | Formulary |
| NEBIVOLOL HYDROCHLORIDE TAB | 5MG | 33200040100320 | Formulary |
| CARVEDILOL TAB | 3.125 MG | 33300007000305 | Formulary |
| CARVEDILOL TAB | 6.25 MG | 33300007000310 | Formulary |
| CARVEDILOL TAB | 12.5 MG | 33300007000320 | Formulary |
| CARVEDILOL TAB | 25 MG | 33300007000330 | Formulary |
| LABETALOL HYDROCHLORIDE TAB | 100 MG | 33300010100305 | Formulary |
| LABETALOL HYDROCHLORIDE TAB | 200 MG | 33300010100310 | Formulary |
| LABETALOL HYDROCHLORIDE TAB | 300 MG | 33300010100315 | Formulary |
| CALCIUM CHANNEL BLOCKERS | | | |
| Name | Strength/Unit | GPI | Comment |
| AMLODIPINE BESYLATE TAB | 2.5 MG | 34000003100320 | Formulary |
| AMLODIPINE BESYLATE TAB | 5 MG | 34000003100330 | Formulary |
| AMLODIPINE BESYLATE TAB | 10 MG | 34000003100340 | Formulary |
| DILTIAZEM HCL TAB | 30 MG | 34000010100305 | Formulary |
| DILTIAZEM HCL TAB | 60 MG | 34000010100310 | Formulary |
| DILTIAZEM HCL TAB | 90 MG | 34000010100315 | Formulary |
| DILTIAZEM HCL TAB | 120 MG | 34000010100320 | Formulary |
| DILTIAZEM HCL ER CAP | 120 MG | 34000010107020 | Formulary |
| DILTIAZEM HCL ER CAP | 180 MG | 34000010117030 | Formulary |
| DILTIAZEM HCL ER CAP | 240 MG | 34000010117040 | Formulary |
| DILTIAZEM HCL ER CAP | 300 MG | 34000010127050 | Formulary |
| DILTIAZEM HCL ER CAP | 360 MG | 34000010127060 | Formulary |
| FELODIPINE TER | 2.5 MG | 34000013007505 | Formulary |
| FELODIPINE TER | 5 MG | 34000013007510 | Formulary |
| FELODIPINE TER | 10 MG | 34000013007520 | Formulary |
| NIFEDIPINE SGL | 10 MG | 34000020000105 | Formulary |
| NIFEDIPINE SGL | 20 MG | 34000020000110 | Formulary |
| NIFEDIPINE TER | 30 MG | 34000020007530 | Formulary |
| NIFEDIPINE TER | 60 MG | 34000020007540 | Formulary |
| NIFEDIPINE TER | 90 MG | 34000020007550 | Formulary |
| VERAPAMIL HCL TAB | 40 MG | 34000030100303 | Formulary |
| VERAPAMIL HCL TAB | 80 MG | 34000030100305 | Formulary |
| CALAN TAB | 120MG | 34000030100310 | Formulary |
| VERAPAMIL HCL TER | 120 MG | 34000030100410 | Formulary |
| VERAPAMIL HCL TER | 180 MG | 34000030100415 | Formulary |
| VERAPAMIL HCL TER | 240 MG | 34000030100420 | Formulary |
| VERAPAMIL HCL CER | 120 MG | 34000030107020 | Formulary |
| VERAPAMIL HCL CER | 180 MG. | 34000030107025 | Formulary |
| VERAPAMIL HCL CER | 240 MG | 34000030107035 | Formulary |
| ANTIARRHYTHMICS | | | |
| Name | Strength/Unit | GPI | Comment |
| DISOPYRAMIDE PHOSPHATE CAP | 150 MG | 35100010100110 | Formulary |

# GUAM Medicaid Formulary

**Mandatory Generic Plan.**

Brand name drugs with generic substitutes available are not covered

| ANTIARRHYTHMICS | | | |
|---|---|---|---|
| Name | Strength/Unit | GPI | Comment |
| MEXILETINE HYDROCHLORIDE CAPSULE | 200MG | 35200025100110 | Formulary |
| FLECAINIDE ACETATE | 50 MG | 35300010100303 | Formulary |
| PROPAFENONE HYDROCHLORIDE | 15O MG | 35300050000320 | Formulary |
| AMIODARONE HCL TAB | 100 MG | 35400005000303 | Formulary |
| AMIODARONE HCL TAB | 200 MG | 35400005000305 | Formulary |
| ANTIHYPERTENSIVES | | | |
| Name | Strength/Unit | GPI | Comment |
| BENAZEPRIL HCL TAB | 10 MG | 36100005100320 | Formulary |
| BENAZEPRIL HCL TAB | 20 MG | 36100005100330 | Formulary |
| BENAZEPRIL HCL TAB | 40 MG | 36100005100340 | Formulary |
| CAPTOPRIL TAB | 12.5 MG | 36100010000305 | Formulary |
| CAPTOPRIL TAB | 25 MG | 36100010000310 | Formulary |
| CAPTOPRIL TAB | 50 MG | 36100010000315 | Formulary |
| ENALAPRIL MALEATE TAB | 2.5 MG | 36100020100303 | Formulary |
| ENALAPRIL MALEATE TAB | 5 MG | 36100020100305 | Formulary |
| ENALAPRIL MALEATE TAB | 10 MG | 36100020100310 | Formulary |
| ENALAPRIL MALEATE TAB | 20 MG | 36100020100315 | Formulary |
| ENALAPRIL MALEATE SOL | 1MG/1ML | 36100020102020 | Formulary |
| FOSINOPRIL SODIUM TAB | 10 MG | 36100027100310 | Formulary |
| LISINOPRIL TAB | 2.5 MG | 36100030000303 | Formulary |
| LISINOPRIL TAB | 5 MG | 36100030000305 | Formulary |
| LISINOPRIL TAB | 10 MG | 36100030000310 | Formulary |
| LISINOPRIL TAB | 20 MG | 36100030000315 | Formulary |
| LISINOPRIL TAB | 30 MG | 36100030000324 | Formulary |
| LISINOPRIL TAB | 40 MG | 36100030000330 | Formulary |
| QUINAPRIL HCL TAB | 20 MG | 36100040100320 | Formulary |
| QUINAPRIL HCL TAB | 40 MG | 36100040100340 | Formulary |
| RAMIPRIL CAP | 10 MG | 36100050000140 | Formulary |
| CANDESARTAN CILEXETIL | 4 MG | 36150020100310 | Formulary |
| CANDESARTAN CILEXETIL | 8 MG | 36150020100320 | Formulary |
| CANDESARTAN CILEXETIL | 16 MG | 36150020100330 | Formulary |
| CANDESARTAN CILEXETIL | 32 MG | 36150020100340 | Formulary |
| IRBESARTAN TAB | 75 MG | 36150030000310 | Formulary |
| IRBESARTAN TAB | 150 MG | 36150030000320 | Formulary |
| IRBESARTAN TAB | 300 MG | 36150030000340 | Formulary |
| LOSARTAN POTASSIUM TAB | 25 MG | 36150040200320 | Formulary |
| LOSARTAN POTASSIUM TAB | 50 MG | 36150040200330 | Formulary |
| LOSARTAN POTASSIUM TAB | 100 MG | 36150040200340 | Formulary |
| OLMESARTAN MEDOXOMIL TAB | 5MG | 36150055200320 | Formulary |
| OLMESARTAN MEDOXOMIL TAB | 20MG | 36150055200340 | Formulary |
| OLMESARTAN MEDOXOMIL TAB | 40MG | 36150055200360 | Formulary |
| TELMISARTAN TAB | 20 MG | 36150070000310 | Formulary |
| TELMISARTAN TAB | 40 MG | 36150070000320 | Formulary |
| TELMISARTAN TAB | 80 MG | 36150070000340 | Formulary |
| VALSARTAN TAB | 40MG | 36150080000310 | Formulary |
| VALSARTAN TAB (BRAND-DIOVAN) | 80MG | 36150080000320 | Formulary |
| VALSARTAN TAB (BRAND-DIOVAN) | 160 MG | 36150080000330 | Formulary |
| VALSARTAN TAB (BRAND-DIOVAN) | 320 MG | 36150080000340 | Formulary |
| CLONIDINE HCL TAB | 0.1 MG | 36201010100305 | Formulary |
| CLONIDINE HCL TAB | 0.2 MG | 36201010100310 | Formulary |
| CLONIDINE HCL TAB | 0.3 MG | 36201010100315 | Formulary |
| GUANFACINE HCL TAB | 1 MG | 36201025100320 | Formulary |
| GUANFACINE HCL TAB | 2 MG | 36201025100330 | Formulary |
| METHYLDOPA TAB | 250 MG | 36201030000310 | Formulary |
| METHYLDOPA TAB | 500 MG | 36201030000315 | Formulary |
| DOXAZOSIN MESYLATE TAB | 1 MG | 36202005100310 | Formulary |
| DOXAZOSIN MESYLATE TAB | 2 MG | 36202005100320 | Formulary |
| DOXAZOSIN MESYLATE TAB | 4 MG | 36202005100330 | Formulary |
| DOXAZOSIN MESYLATE TAB | 8 MG | 36202005100340 | Formulary |
| PRAZOSIN HCL CAP | 1 MG | 36202030100105 | Formulary |
| PRAZOSIN HCL CAP | 2 MG | 36202030100110 | Formulary |
| PRAZOSIN HCL CAP | 5 MG | 36202030100115 | Formulary |
| TERAZOSIN HCL CAP | 1 MG | 36202040100105 | Formulary |
| TERAZOSIN HCL CAP | 2 MG | 36202040100110 | Formulary |
| TERAZOSIN HCL CAP | 5 MG | 36202040100115 | Formulary |
| TERAZOSIN HCL CAP | 10 MG | 36202040100120 | Formulary |
| HYDRALAZINE HCL TAB | 10 MG | 36400010100305 | Formulary |
| HYDRALAZINE HCL TAB! | 25 MG | 36400010100310 | Formulary |
| HYDRALAZINE HCL TAB | 50 MG | 36400010100315 | Formulary |
| HYDRALAZINE HCL TAB | 100 MG | 36400010100320 | Formulary |
| MINOXIDIL TAB | 2.5 MG | 36400020000305 | Formulary |
| MINOXIDIL TAB | 10 MG | 36400020000310 | Formulary |
| AMLODIPINE BESYLATE/BENAZEPRIL HCL CAP | 5-10MG | 36991502200130 | Formulary |
| AMLODIPINE BESYLATE-BENAZEPRIL HCL CAP | 5-20 MG | 36991502200140 | Formulary |
| AMLODIPINE BESYLATE / BENAZEPRIL HCL CAP | 10MG-20MG | 36991502200150 | Formulary |
| LISINOPRIL/HCTZ TAB | 12.5-10 MG | 36991802550305 | Formulary |
| HYDROCHLOROTHIAZIDE-LISINOPRIL TAB | 12.5MG-20MG | 36991802550310 | Formulary |
| HYDROCHLOROTHIAZIDE/LISINOPRIL TAB | 25MG-20MG | 36991802550320 | Formulary |
| HCTZ/BISOPROLOL FUMARATE TAB | 6.25-5 MG | 36992002130320 | Formulary |
| HCTZ/BISOPROLOL FUMARATE TAB | 10 MG-6.25 MG | 36992002130330 | Formulary |
| LOSARTAN POTASSIUM-HYDROCHLOROTHIAZIDE | 12.5-50 MG | 36994002450320 | Formulary |
| LOSARTAN POTASSIUM-HCTZ TAB | 12.5-100 MG | 36994002450325 | Formulary |
| LOSARTAN POTASSIUM-HCTZ TAB | 25-100 MG | 36994002450340 | Formulary |
| VALSARTAN/HYDROCHLOROTHIAZIDE TAB | 12.5-80 MG | 36994002700320 | Formulary |
| VALSARTAN/HYDROCHLOROTHIAZIDE TAB | 12.5-160 MG | 36994002700340 | Formulary |
| VALSARTAN/HYDROCHLOROTHIAZIDE TAB | 25-160 MG | 36994002700350 | Formulary |
| VALSARTAN/HYDROCHLOROTHIAZIDE TAB | 12.5-320 MG | 36994002700360 | Formulary |
| VALSARTAN/HYDROCHLOROTHIAZIDE TAB | 25-320MG | 36994002700370 | Formulary |
| DIURETICS | | | |
| Name | Strength/Unit | GPI | Comment |
| ACETAZOLAMIDE TAB | 250 MG | 37100010000310 | Formulary |
| ACETAZOLAMIDE ER CAP | 500 MG | 37100010006920 | Formulary |
| METHAZOLAMIDE TABLET | 50 MG | 37100030000305 | Formulary |
| BUMETANIDE TAB | 0.5MG | 37200010000305 | Formulary |
| BUMETANIDE TAB | 1 MG | 37200010000310 | Formulary |
| BUMETANIDE TAB | 2 MG | 37200010000315 | Formulary |
| FUROSEMIDE TAB | 20 MG | 37200030000305 | Formulary |
| FUROSEMIDE TAB | 40 MG | 37200030000310 | Formulary |
| FUROSEMIDE TAB | 80 MG | 37200030000315 | Formulary |
| FUROSEMIDE ORAL SOLN/ML | 10MG | 37200030002050 | Formulary |
| TORSEMIDE TAB | 5 MG | 37200080000310 | Formulary |
| TORSEMIDE TAB | 10 MG | 37200080000320 | Formulary |
| TORSEMIDE TAB | 20 MG | 37200080000330 | Formulary |
| AMILORIDE HCL TAB | 5MG | 37500010100305 | Formulary |
| SPIRONOLACTONE TAB | 25 MG | 37500020000305 | Formulary |
| SPIRONOLACTONE TAB | 50 MG | 37500020000310 | Formulary |
| SPIRONOLACTONE TAB | 100 MG | 37500020000315 | Formulary |
| DIURIL SUSPENSION | 250MG/5ML | 37600020001805 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| CHLORTHALIDONE TAB | 25 MG | 37600025000305 | Formulary |

# GUAM Medicaid Formulary

**Mandatory Generic Plan.**

Brand name drugs with generic substitutes available are not covered

| Name | Strength/Unit | GPI | Comment |
|---|---|---|---|
| **DIURETICS** | | | |
| CHLORTHALIDONE TAB | 50 MG | 37600025000310 | Formulary |
| HYDROCHLOROTHIAZIDE CAP | 12.5 MG | 37600040000110 | Formulary |
| HYDROCHLOROTHIAZIDE TAB | 12.5 MG | 37600040000303 | Formulary |
| HYDROCHLOROTHIAZIDE TAB | 25 MG | 37600040000305 | Formulary |
| HYDROCHLOROTHIAZIDE TAB | 50 MG | 37600040000310 | Formulary |
| METOLAZONE TAB | 2.5 MG | 37600060000305 | Formulary |
| METOLAZONE TAB | 5 MG | 37600060000310 | Formulary |
| HYDROCHLOROTHIAZIDE/TRIAMTERENE CAP | 25MG-37.5MG | 37990002300105 | Formulary |
| TRIAMTERENE/HCTZ TAB | 25 MG-37.5 MG | 37990002300315 | Formulary |
| TRIAMTERENE/HCTZ TAB | 50-75 MG | 37990002300330 | Formulary |
| **VASOPRESSORS** | | | |
| Name | Strength/Unit | GPI | Comment |
| MIDODRINE HCL TAB | 2.5 MG | 38000083100320 | Formulary |
| MIDODRINE HCL/TAB | 5 MG | 38000083100330 | Formulary |
| MIDODRINE HCL/TAB | 10 MG | 38000083100340 | Formulary |
| EPINEPHRINE JR AUTO-INJECTOR / EA | 0.15MG/0.3ML | 3890004000D520 | Formulary |
| EPINEPHRINE AUTO-INJECTOR / EA | 0.3MG/0.3ML | 3890004000D540 | Formulary |
| **ANTIHYPERLIPIDEMICS** | | | |
| Name | Strength/Unit | GPI | Comment |
| CHOLESTYRAMINE PDR LIGHT/GM | 4 GM/5.7GM | 39100010002905 | Formulary |
| COLESTIPOL HCL TAB | 1 GM | 39100020100320 | Formulary |
| COLESTIPOL HCL PDR (IN GRANULES) | 5 GM/1 PACKET | 39100020103010 | Formulary |
| FENOFIBRATE TAB! | 48 MG | 39200025000310 | Formulary |
| FENOFIBRATE TAB | 54 MG | 39200025000312 | Formulary |
| FENOFIBRATE TAB | 145 MG | 39200025000323 | Formulary |
| FENOFIBRATE TAB | 160 MG | 39200025000325 | Formulary |
| GEMFIBROZIL TAB | 600 MG | 39200030000310 | Formulary |
| EZETIMIBE TAB | 10 MG | 39300030000320 | Formulary |
| REPATHA SOL/ML | 140MG | 3935002000D520 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| REPATHA SOL/ML | 120MG | 3935002000E230 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| ATORVASTATIN CALCIUM TAB | 10 MG | 39400010100310 | Formulary |
| ATORVASTATIN CALCIUM TAB | 20 MG | 39400010100320 | Formulary |
| ATORVASTATIN CALCIUM TAB | 40 MG | 39400010100330 | Formulary |
| ATORVASTATIN CALCIUM TAB | 80 MG | 39400010100350 | Formulary |
| LOVASTATIN TAB | 10 MG | 39400050000305 | Formulary |
| LOVASTATIN TAB | 20 MG | 39400050000310 | Formulary |
| LOVASTATIN TAB | 40 MG | 39400050000320 | Formulary |
| ROSUVASTATIN CALCIUM TAB | 5 MG | 39400060100305 | Formulary |
| ROSUVASTATIN CALCIUM TAB | 10 MG | 39400060100310 | Formulary |
| ROSUVASTATIN CALCIUM TAB | 20 MG | 39400060100320 | Formulary |
| ROSUVASTATIN CALCIUM TAB | 40 MG | 39400060100340 | Formulary |
| PRAVASTATIN SODIUM TAB | 10 MG | 39400065100320 | Formulary |
| PRAVASTATIN SODIUM TAB | 20 MG | 39400065100330 | Formulary |
| PRAVASTATIN SODIUM TAB | 40 MG | 39400065100340 | Formulary |
| PRAVASTATIN SODIUM TAB | 80 MG | 39400065100360 | Formulary |
| SIMVASTATIN TAB | 5 MG | 39400075000310 | Formulary |
| SIMVASTATIN TAB | 10 MG | 39400075000320 | Formulary |
| SIMVASTATIN TAB | 20 MG | 39400075000330 | Formulary |
| SIMVASTATIN TAB | 40 MG | 39400075000340 | Formulary |
| SIMVASTATIN TAB | 80 MG | 39400075000360 | Formulary |
| NIACIN TER | 1000 MG | 39450050000470 | Formulary |
| OMEGA-3 FATTY ACIDS SGL | 1GM | 39500045200130 | Formulary |
| EZETIMIBE/SIMVASTATIN TAB | 10MG-10MG | 39994002300320 | Formulary |
| EZETIMIBE/SIMVASTATIN TAB | 10 MG - 20 MG | 39994002300330 | Formulary |
| EZETIMIBE-SIMVASTATIN | 10 MG-40 MG | 39994002300340 | Formulary |
| EZETIMIBE/SIMVASTATIN TAB | 10 MG-80 MG | 39994002300350 | Formulary |
| **CARDIOVASCULAR AGENTS - MISC.** | | | |
| Name | Strength/Unit | GPI | Comment |
| SILDENAFIL TAB | 20 MG | 40143060100320 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| SILDENAFIL CITRATE PDR | 10MG/1ML | 40143060101920 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| TADLIQ SUS/ML | 20MG/5ML | 40143080001820 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| AMBRISENTAN TAB | 5MG | 40160007000310 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| BOSENTAN | 62.5MG | 40160015000320 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| SILDENAFIL | 100 MG | 40304070100330 | Prior Authorization Required. Submit PA form and office notes |
| TADALAFIL TAB | 20MG | 40304080000320 | Formulary |
| CORLANOR TAB (IVABRADINE) | 5MG | 40700035100320 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| ENTRESTO TAB | 24MG-26MG | 40992002600320 | Formulary |
| ENTRESTO TAB | 49MG-51MG | 40992002600330 | Formulary |
| ENTRESTO TAB | 97MG-103MG | 40992002600340 | Formulary |
| **ANTIHISTAMINES** | | | |
| Name | Strength/Unit | GPI | Comment |
| DIPHENHYDRAMINE HCL CAP | 25 MG | 41200030100105 | Formulary |
| DIPHENHYDRAMINE HCL CAP | 50 MG | 41200030100110 | Formulary |
| DIPHENHYDRAMINE HYDROCHLORIDE TAB | 25 MG | 41200030100305 | Formulary |
| DIPHENHYDRAMINE HCL | 50 MG/1 ML | 41200030102010 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| PROMETHAZINE HCL TAB | 12.5 MG | 41400020100305 | Formulary |
| PROMETHAZINE HCL TAB | 25 MG | 41400020100310 | Formulary |
| PROMETHAZINE HCL SYRUP/ML | 6.25MG/5ML | 41400020102060 | Formulary |
| PROMETHAZINE HCL SUPPOSITORY/EA | 12.5 MG | 41400020105205 | Formulary |
| PROMETHAZINE HCL SUPPOSITORY/EA | 25 MG | 41400020105210 | Formulary |
| CYPROHEPTADINE HCL TABS | 4 MG | 41500020100305 | Formulary |
| CYPROHEPTADINE HCL SYRUP/ML | 2 MG/ 5 ML | 41500020101210 | Formulary |
| FEXOFENADINE HCL TAB | 60 MG | 41550024100320 | Formulary |
| FEXOFENADINE HCL TAB | 180 MG | 41550024100350 | Formulary |
| **NASAL AGENTS - SYSTEMIC AND TOPICAL** | | | |
| Name | Strength/Unit | GPI | Comment |
| BUDESONIDE SPRAY/ ML | .032MG/1ACT | 42200015001810 | Formulary |
| FLUTICASONE PROPIONATE NASAL SPRAY /ML | 0.05MG/1ACT | 42200032301810 | Formulary |
| AZELASTINE HCL NASAL SPRAY | 137MCG/1 ACT | 42401015102020 | Formulary |
| **COUGH/COLD/ALLERGY** | | | |
| Name | Strength/Unit | GPI | Comment |
| BENZONATATE SGL | 100 MG | 43102010000105 | Formulary |
| BENZONATATE SGL | 200 MG | 43102010000110 | Formulary |
| BIOTUSSIN DAC LIQ /ML | 10MG/5ML | 43200010000910 | Formulary |
| SODIUM CHLORIDE INH SOLN/ML | 0.9% | 43400010002520 | Formulary |
| CETIRIZINE HCL-PSEUDOEPHEDRINE HCL TER | 5MG-120MG | 43993002277420 | Formulary |
| PROMETHAZINE HCL-CODEINE PHOSPHATE SYR /ML | 10MG/5ML/6.25ML | 43995202341210 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| DEXTROMETHORPHAN/PROMETHAZINE (DM HYDROBROM/PROMETHAZINE HCL) SYR ORAL/ ML | 15/5-6.25/5ML | 43995702301210 | Formulary |
| CODEINE PHOSPHATE/GUAIFENESIN SOL | 10MG/100MG-5ML | 43997002282020 | Formulary |
| **ANTIASTHMATIC AND BRONCHODILATOR AGENTS** | | | |
| Name | Strength/Unit | GPI | Comment |
| IPRATROPIUM BROMIDE INHAL SOLN/ML | 0.02% 2.5ML | 44100030102020 | Formulary |
| ATROVENT HFA SOL /GM | 0.017MG/1ACT | 44100030123420 | Formulary |
| SPIRIVA INHALATION CAP/EA | 18 MCG | 44100080100120 | Formulary |
| SPIRIVA RESPIMAT SPR/GM 4GM | 1.25MCG/1ACT | 44100080103410 | Step Therapy: Must have tried one month of generic Spiriva Handihaler |
| SPIRIVA RESPIMAT SPR | 2.5MCG/1ACT | 44100080103420 | Step Therapy: Must have tried one month of generic Spiriva Handihaler |
| ALBUTEROL SULFATE TAB | 2 MG | 44201010100305 | Formulary |
| ALBUTEROL SULFATE TAB | 4 MG | 44201010100310 | Formulary |
| ALBUTEROL SYRUP / ML | 2MG/5ML | 44201010101205 | Formulary |

# GUAM Medicaid Formulary

**Mandatory Generic Plan.**

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| Name | Strength/Unit | GPI | Comment |
|---|---|---|---|
| **ANTIASTHMATIC AND BRONCHODILATOR AGENTS** | | | |
| ALBUTEROL SULFATE INH SOL / ML | 0.083% | 44201010102515 | Formulary |
| ALBUTEROL SULFATE INH SOL / ML | 0.5% | 44201010102520 | Formulary |
| ALBUTEROL SULFATE SOL (INHALATION) | 0.63 MG/3ML | 44201010102555 | Formulary |
| ALBUTEROL SULFATE SOL | 1.25MG/3ML | 44201010102560 | Formulary |
| ALBUTEROL SULFATE HFA 18GM INH SUS ARO /GM | .09MG/1ACT | 44201010103410 | Formulary |
| PROAIR HFA 8.5 SUS/GM (MEDICARE D) | 0.09MG/1ACT | 44201010108020 | Prior Authorization Required. Submit PA form and office notes |
| LEVALBUTEROL HCL INHALATION SOLN/3ML | 0.31MG | 44201045102510 | Formulary |
| LEVALBUTEROL HCL INHALATION SOLN/3ML | 0.63MG/3ML | 44201045102520 | Formulary |
| LEVALBUTEROL TARTRATE 15GM | 0.045MG/1 ACTUA | 44201045503220 | Formulary |
| TERBUTALINE SO4 TAB | 2.5 MG | 44201060200305 | Formulary |
| IPRATROPIUM BROMIDE/ALBUTEROL SULFA SOL/ ML | 3MG-0.5 MG/3 ML | 44209902012015 | Formulary |
| COMBIVENT RESPIMAT SPRAY /GM | 100MCG | 44209902013420 | Formulary |
| BUDESONIDE-FORMOTEROL FUMARATE AER(INHALATION)/GM | 80MCG/1ACT-4.5 | 44209902413220 | Formulary |
| BUDESONIDE-FORMOTEROL FUMARATE AER(INHALATION)/GM | 160MCG/1ACT-4.5 | 44209902413240 | Formulary |
| FLUTICASONE PROPIONATE/SALMETEROL XINAFOATE INH | 45MCG/1AC-21MCG | 44209902703250 | Formulary |
| ADVAIR HFA 115/21 | 115MCG/1ACT-21M | 44209902703260 | Step Therapy: Must have tried one month of generic Advair Diskus |
| FLUTICASONE PROPIONATE/SALMETEROL INHAL DISKUS/EA | .1MG/.05MG | 44209902708020 | Formulary |
| FLUTICASONE PROPIONATE/SALMETEROL XINAFOATE INHAL DISKUS/EA | .25MG/.05MG | 44209902708030 | Formulary |
| FLUTICASONE PROPIONATE/SALMETEROL INHAL DISKUS/EA | .5MG/.05MG | 44209902708040 | Formulary |
| BREO ELLIPTA POWDER INHALATION | 100MCG/1ACT-25M | 44209902758020 | Prior Authorization Required. Submit PA form and office notes |
| BREO ELLIPTA POWDER INH | 200MCG/25M | 44209902758030 | Prior Authorization Required. Submit PA form and office notes |
| STIOLTO RESPIMAT SPR INHALATION | 2.5MCG/1ACT-2.5 | 44209902923420 | Prior Authorization Required. Submit PA form and office notes |
| ANORO ELLIPTA POWDER INHALATION | 62.5MCG/1ACT-25 | 44209902958020 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| TRELEGY ELLIPTA POWDER INHALATION/EA | 100MCG/1AC-62.5 | 44209903408020 | Formulary |
| TRELEGY ELLIPTA POWDER INHALATION/EA | 200MCG/1AC-62.5 | 44209903408040 | Formulary |
| THEOPHYLLINE T12 TAB | 100 MG | 44300040007420 | Formulary |
| THEOPHYLLINE TER | 300 MG | 44300040007440 | Formulary |
| QVAR REDIHALER | 0.04 MG/1 ACTUA | 44400010128120 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| QVAR REDIHALER | 0.08 MG/1 ACTUA | 44400010128140 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| BUDESONIDE SUS(INHALATION)/ML | 0.25MG/2ML | 44400015001830 | Formulary |
| BUDESONIDE SUS(INHALATION)/ML | 0.5MG/2ML | 44400015001840 | Formulary |
| BUDESONIDE SUS(INHALATION)/ML | 1MG/2ML | 44400015001850 | Formulary |
| PULMICORT FLEXHALER POW (INHALATION) | 90MCG/1ACTUATIO | 44400015008009 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| PULMICORT FLEXHALER POW (INHALATION) | 180MCG/1ACTUATI | 44400015008018 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| FLOVENT DISKUS INH | 250MCG/1ACTUATI | 44400033208030 | Step Therapy: Must have tried one month of generic Flovent HFA |
| FLOVENT HFA INH/GM | .044MG/AC | 44400033223220 | Formulary |
| FLOVENT HFA INH /GM | 0.11MG/ACT 12GM | 44400033223230 | Formulary |
| FLOVENT HFA INH /GM | 0.22MG/ACT 12GM | 44400033223240 | Formulary |
| DALIRESP TABLET | 250 MG | 44450065000310 | Prior Authorization Required. Submit PA form and office notes |
| DALIRESP TABLET | 500 MG | 44450065000320 | Prior Authorization Required. Submit PA form and office notes |
| MONTELUKAST SODIUM TAB | 10 MG | 44505050100330 | Formulary |
| MONTELUKAST SODIUM CTB | 4 MG | 44505050100516 | Formulary |
| MONTELUKAST SODIUM CTB | 5 MG | 44505050100520 | Formulary |
| ZAFIRLUKAST TAB | 10MG | 44505080000310 | Formulary |
| ZAFIRLUKAST TAB | 20MG | 44505080000320 | Formulary |
| XOLAIR PDS /EA | 150MG | 44603060002120 | Specialty Drug; Prior Authorization Required. Submit PA form and office notes |
| **LAXATIVES** | | | |
| BISACODYL ECT | 5 MG | 46200010000610 | Formulary |
| LACTULOSE SOLUTION/ML | 10 GM | 46600020002010 | Formulary |
| POLYETHYLENE GLYCOL 3350 PDS/GM | 17 GM/1 DOSE | 46600033002910 | Formulary |
| PEG ELECTROLYTE LAVAGE SOLUTION | 236-2.97-6.74-5 | 46992005302130 | Formulary |
| **ANTIDIARRHEAL/PROBIOTIC AGENTS** | | | |
| ATROPINE SULFATE/DIPHENOXYLATE HCL TAB | 0.025MG-2.5MG | 47100010100310 | Formulary |
| **ANTACIDS** | | | |
| SODIUM BICARBONATE TAB | 650MG | 48200010000325 | Formulary |
| MAGNESIUM OXIDE | 400MG | 48400020000310 | Formulary |
| **ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS** | | | |
| ATROPINE IV SOL /ML | 0.4MG/1ML | 49101010102022 | Formulary |
| GLYCOPYRROLATE TAB | 1 MG | 49102030000310 | Formulary |
| DICYCLOMINE HCL CAP | 10 MG | 49103010100105 | Formulary |
| DICYCLOMINE HCL TAB | 20 MG | 49103010100305 | Formulary |
| CIMETIDINE TAB | 300 MG | 49200010000310 | Formulary |
| CIMETIDINE TAB | 400 MG | 49200010000315 | Formulary |
| FAMOTIDINE TAB | 20 MG | 49200030000320 | Formulary |
| FAMOTIDINE TAB | 40MG | 49200030000340 | Formulary |
| FAMOTIDINE PDR/ML | 40 MG | 49200030001920 | Formulary |
| MISOPROSTOL TAB | 200 MCG | 49250030000320 | Formulary |
| ESOMEPRAZOLE MAGNESIUM ECC | 20 MG | 49270025106520 | Formulary |
| ESOMEPRAZOLE MAGNESIUM (BRAND-NEXIUM) CAP | 40 MG | 49270025106540 | Formulary |
| LANSOPRAZOLE ECC | 30 MG | 49270040006520 | Formulary |
| OMEPRAZOLE EC/CAP | 10 MG | 49270060006510 | Formulary |
| OMEPRAZOLE EC/CAP* | 20 MG | 49270060006520 | Formulary |
| OMEPRAZOLE ECC | 40 MG | 49270060006530 | Formulary |
| PRILOSEC (OMEPRAZOLE MAGNESIUM) | 10MG/1PACKET | 49270060103030 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| PANTOPRAZOLE SODIUM/TAB | 20 MG | 49270070100610 | Formulary |
| PANTOPRAZOLE SODIUM/TAB | 40 MG | 49270070100620 | Formulary |
| RABEPRAZOLE SODIUM EC TAB | 20 MG | 49270076100620 | Formulary |
| SUCRALFATE TAB | 1 GM | 49300010000305 | Formulary |
| SUCRALFATE SUSPENSION | 1GM/10ML | 49300010001820 | Formulary |
| **ANTIEMETICS** | | | |
| ONDANSETRON ODT | 4 MG | 50250065007220 | Formulary |
| ONDANSETRON ODT | 8 MG | 50250065007240 | Formulary |
| ONDANSETRON HCL/TAB (#04262017) | 4 MG | 50250065050310 | Formulary |
| ONDANSETRON HCL TAB | 8 MG | 50250065050320 | Formulary |
| ONDANSETRON SOLUTION 5ML | 4MG/5ML | 50250065052070 | Formulary |
| DRONABINOL SGL | 5 MG | 50300030000115 | Formulary |
| **DIGESTIVE AIDS** | | | |
| CREON ECC ORAL /EA | 6K-12K-38K U | 51200024006705 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| CREON ECC ORAL /EA (CS) | 18-36-114KS | 51200024006780 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| **GASTROINTESTINAL AGENTS - MISC.** | | | |
| URSODIOL CAP | 300 MG | 52100040000120 | Formulary |
| URSODIOL TAB | 250 MG | 52100040000325 | Formulary |
| METOCLOPRAMIDE HCL TAB | 5 MG | 52300020100303 | Formulary |
| METOCLOPRAMIDE HCL TAB | 10 MG | 52300020100305 | Formulary |
| METOCLOPRAMIDE SOL ORAL/ML | 5 MG / 5 ML | 52300020102013 | Formulary |
| MESALAMINE ECC | 400MG | 52500030006530 | Formulary |
| SULFASALAZINE TAB | 500 MG | 52500060000310 | Formulary |
| CIMZIA | 200 MG/1 ML | 52505020010F840 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| REMICADE PDS | 100 MG | 52505040002120 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| LINZESS CAP | 145MCG | 52557050000120 | Prior Authorization Required. Submit PA form and office notes |
| LINZESS CAP | 290MCG | 52557050000140 | Prior Authorization Required. Submit PA form and office notes |
| CALCIUM ACETATE CAP (NEGOTIATED PRICE-FRES) | 667 MG | 52800020100120 | Prior Authorization Required. Submit PA form and office notes |

# GUAM Medicaid Formulary

**Mandatory Generic Plan.**

Brand name drugs with generic substitutes available are not covered

| GASTROINTESTINAL AGENTS - MISC. | | | |
|---|---|---|---|
| Name | Strength/Unit | GPI | Comment |
| CALCIUM ACETATE TAB (NEGOTIATED PRICE-FRES) | 667MG | 52800020100320 | Prior Authorization Required. Submit PA form and office notes |
| AURYXIA TAB (NEGOTIATED PRICE-FRES) | 1GM=210MG | 52800030100320 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| LANTHANUM CARBONATE CHW TAB (NEGOTIATED PRICE-FRES) | 500MG | 52800045200540 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| LANTHANUM CARBONATE CHW TAB (NEGOTIATED PRICE-FRES) | 750 MG | 52800045200550 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| LANTHANUM CARBONATE CHW TAB (NEGOTIATED PRICE-FRES) | 1000MG | 52800045200560 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| FOSRENOL ORAL POWDER PACKET (NEGOTIATED PRICE-FRES) | 750 MG | 52800045203030 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| FOSRENOL ORAL POWDER PACKET (NEGOTIATED PRICE-FRES) | 1000 MG | 52800045203040 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| RENVELA TAB/MG (USRC); GENERIC AVAILABLE 5149 | 800 MG | 52800070050340 | Prior Authorization Required. Submit PA form and office notes |
| SEVELAMER CARBONATE PDR ORAL/EA (NEGOTIATED PRICE-FRES) | 0.8GM/1PKG | 52800070053020 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| SEVELAMER CARBONATE PDR ORAL/EA (NEGOTIATED PRICE-FRES) | 2.4GM/1PKG | 52800070053040 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| RENAGEL TAB (NEGOTIATED PRICE-FRES) | 800MG | 52800070100340 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| VELPHORO CTB | 500MG | 52800080100520 | Prior Authorization Required. Submit PA form and office notes |
| URINARY ANTISPASMODICS | | | |
| Name | Strength/Unit | GPI | Comment |
| OXYBUTYNIN CHLORIDE/TAB | 5 MG | 54100045200330 | Formulary |
| OXYBUTYNIN ER/TAB | 5 MG | 54100045207520 | Formulary |
| OXYBUTYNIN ER/TAB | 10 MG | 54100045207530 | Formulary |
| SOLIFENACIN SUCCINATE TAB | 5MG | 54100055200320 | Formulary |
| SOLIFENACIN SUCCINATE TAB | 10MG | 54100055200330 | Formulary |
| TOLTERODINE TARTRATE TAB | 2 MG | 54100060200330 | Formulary |
| TROSPIUM CHLORIDE TAB | 20MG | 54100065200320 | |
| MIRABEGRON TER | 25 MG | 54200050007520 | Formulary |
| MIRABEGRON TER | 50 MG | 54200050007530 | Formulary |
| BETHANECHOL CHLORIDE TAB (PT: TA) | 50 MG | 54300010100340 | Formulary |
| VAGINAL AND RELATED PRODUCTS | | | |
| Name | Strength/Unit | GPI | Comment |
| CLINDAMYCIN PHOSPHATE VAGINAL CREAM/GM | 2% | 55100018103720 | Formulary |
| METRONIDAZOLE VAGINAL GEL/GM 70GM | 0.75% | 55100035004020 | Formulary |
| PREMARIN VAGINAL CREAM/GM 30GM | .625 MG | 55350025003710 | Formulary |
| FIRST-PROGESTERONE VGS100 EA | 100MG/EA | 55370060005210 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| GENITOURINARY AGENTS - MISCELLANEOUS | | | |
| Name | Strength/Unit | GPI | Comment |
| CITRIC ACID/SODIUM CITRATE | 334M/5ML500M5ML | 56202020002010 | Formulary |
| TRICITRATES ORAL SOLUTION / ML | 334MG/5ML-550 | 56202030102020 | Formulary |
| PHENAZOPYRIDINE HCL/TAB | 100 MG | 56300010100305 | Formulary |
| PHENAZOPYRIDINE HCL/TAB | 200 MG | 56300010100310 | Formulary |
| NEOMYCIN&POLYMYXIN B SULF SOL URINARY BLADDER /ML | 40MG/200000U | 56701002102000 | Formulary |
| DUTASTERIDE SGL | 0.5 MG | 56851020000120 | Formulary |
| FINASTERIDE TAB | 5 MG | 56851030000320 | Formulary |
| ALFUZOSIN HYDROCHLORIDE TER | 10 MG | 56852010107530 | Formulary |
| TAMSULOSIN HCL CAP | 0.4 MG | 56852070100110 | Formulary |
| ANTIANXIETY AGENTS | | | |
| Name | Strength/Unit | GPI | Comment |
| ALPRAZOLAM TAB | 0.25 MG | 57100010000305 | Formulary |
| ALPRAZOLAM TAB | 0.5 MG | 57100010000310 | Formulary |
| ALPRAZOLAM TAB | 1 MG | 57100010000315 | Formulary |
| ALPRAZOLAM TAB | 2 MG | 57100010000320 | Formulary |
| CHLORDIAZEPOXIDE HCL CAP | 5 MG | 57100020100105 | Formulary |
| CHLORDIAZEPOXIDE HCL CAP | 10 MG | 57100020100110 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| CHLORDIAZEPOXIDE HCL CAP | 25 MG | 57100020100115 | Formulary |
| DIAZEPAM TAB | 2 MG | 57100040000305 | Formulary |
| DIAZEPAM TAB | 5 MG | 57100040000310 | Formulary |
| DIAZEPAM TAB | 10 MG | 57100040000315 | Formulary |
| LORAZEPAM TAB (ATIVAN) | 0.5 MG | 57100060000305 | |
| LORAZEPAM TAB (ATIVAN) | 1 MG | 57100060000310 | |
| LORAZEPAM TAB (ATIVAN) | 2 MG | 57100060000315 | |
| LORAZEPAM | 2 MG/1 ML | 57100060001320 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| BUSPIRONE HCL TAB | 5 MG | 57200005100310 | Formulary |
| BUSPIRONE HCL TAB | 10 MG | 57200005100320 | Formulary |
| BUSPIRONE HCL TAB | 15 MG | 57200005100330 | Formulary |
| HYDROXYZINE HCL TAB | 10 MG | 57200040100305 | Formulary |
| HYDROXYZINE HCL TAB | 25 MG | 57200040100310 | Formulary |
| HYDROXYZINE HCL TAB | 50 MG | 57200040100315 | Formulary |
| HYDROXYZINE HCL SYRUP/ML | 10MG/5ML | 57200040101210 | Formulary |
| HYDROXYZINE PAMOATE CAP | 25 MG | 57200040200105 | Formulary |
| HYDROXYZINE PAMOATE CAP | 50 MG | 57200040200110 | Formulary |
| ANTIDEPRESSANTS | | | |
| Name | Strength/Unit | GPI | Comment |
| MIRTAZAPINE TAB | 15MG | 58030050000315 | Formulary |
| MIRTAZAPINE TAB | 30MG | 58030050000330 | Formulary |
| TRAZODONE HCL TAB | 50 MG | 58120080100305 | Formulary |
| TRAZODONE HCL TAB | 100 MG | 58120080100310 | Formulary |
| TRINTELLIX TABLET | 5 MG | 58120093100310 | Prior Authorization Required. Submit PA form and office notes |
| TRINTELLIX TABLET | 10MG | 58120093100320 | Prior Authorization Required. Submit PA form and office notes |
| TRINTELLIX TABLET | 20MG | 58120093100340 | Prior Authorization Required. Submit PA form and office notes |
| CITALOPRAM HYDROBROMIDE TAB | 10 MG | 58160020100310 | Formulary |
| CITALOPRAM HYDROBROMIDE TAB | 20 MG | 58160020100320 | Formulary |
| CITALOPRAM HYDROBROMIDE TAB | 40 MG | 58160020100340 | Formulary |
| ESCITALOPRAM OXALATE TAB | 5 MG | 58160034100310 | Formulary |
| ESCITALOPRAM TAB | 10MG | 58160034100320 | Formulary |
| ESCITALOPRAM | 20 MG | 58160034100330 | Formulary |
| FLUOXETINE HCL CAP | 10 MG | 58160040000110 | Formulary |
| FLUOXETINE HCL CAP | 20 MG | 58160040000120 | Formulary |
| FLUOXETINE HCL CAP | 40 MG | 58160040000140 | Formulary |
| FLUOXETINE HCL SOLN/ML | 20MG | 58160040002020 | Formulary |
| PAROXETINE HCL/TAB | 10 MG | 58160060000310 | Formulary |
| PAROXETINE HCL/TAB | 20 MG | 58160060000320 | Formulary |
| PAROXETINE HCL/TAB | 30 MG | 58160060000330 | Formulary |
| PAROXETINE HCL/TAB | 40 MG | 58160060000340 | Formulary |
| SERTRALINE HCL TAB | 25 MG | 58160070100305 | Formulary |
| SERTRALINE HCL TAB (BR EQUIVALENT ZOLOFT) | 50 MG | 58160070100310 | Formulary |
| SERTRALINE HCL TAB | 100 MG | 58160070100320 | Formulary |
| DULOXETINE HCL ECC (ANTIDEPRESSANT) | 20 MG | 58180025106720 | Formulary |
| DULOXETINE HCL ECC (ANTIDEPRESSANT) | 30MG | 58180025106730 | Formulary |
| DULOXETINE HCL ECC (ANTIDEPRESSANT) | 60MG | 58180025106750 | Formulary |
| VENLAFAXINE HCL TAB | 25MG | 58180090100320 | Formulary |
| VENLAFAXINE HCL TAB | 37.5MG | 58180090100340 | Formulary |
| VENLAFAXINE HCL TAB | 50MG | 58180090100350 | Formulary |
| VENLAFAXINE HCL TAB | 75 MG | 58180090100360 | Formulary |
| VENLAFAXINE HCL TAB | 100MG | 58180090100370 | Formulary |
| VENLAFAXINE TER | 37.5 MG | 58180090107020 | Formulary |
| VENLAFAXINE ER | 75 MG | 58180090107030 | Formulary |
| AMITRIPTYLINE HCL TAB | 10 MG | 58200010100305 | Formulary |
| AMITRIPTYLINE HCL TAB | 25 MG | 58200010100310 | Formulary |
| AMITRIPTYLINE HCL TAB (BR ELAVIL) | 50 MG | 58200010100315 | Formulary |
| AMITRIPTYLINE HCL TAB | 100 MG | 58200010100325 | Formulary |
| CLOMIPRAMINE HCL | 50MG | 58200025100130 | Formulary |
| DOXEPIN HCL CAP | 10 MG | 58200040100105 | Formulary |
| DOXEPIN HCL CAP | 25 MG | 58200040100110 | Formulary |

# GUAM Medicaid Formulary

**Mandatory Generic Plan.**

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| ANTIDEPRESSANTS | | | |
|---|---|---|---|
| Name | Strength/Unit | GPI | Comment |
| IMIPRAMINE HCL TAB | 10 MG | 58200050100305 | Formulary |
| IMIPRAMINE HCL TAB | 25 MG | 58200050100310 | Formulary |
| IMIPRAMINE HCL TAB | 50 MG | 58200050100315 | Formulary |
| NORTRIPTYLINE HCL CAP | 10 MG | 58200060100105 | Formulary |
| NORTRIPTYLINE HCL CAP | 25 MG | 58200060100110 | Formulary |
| NORTRIPTYLINE HCL CAP | 50 MG | 58200060100115 | Formulary |
| NORTRIPTYLINE HCL CAP | 75 MG | 58200060100120 | Formulary |
| BUPROPION HCL TAB | 75 MG | 58300040100305 | Formulary |
| BUPROPION HCL TAB | 100 MG | 58300040100310 | Formulary |
| BUPROPION HCL T12 (TAB FOR EXTENDED RELEASE FOR 12 HOURS) | 150 MG | 58300040107430 | Formulary |
| BUPROPION HCL XL T24 TAB | 150 MG | 58300040107520 | Formulary |
| BUPROPION HCL ER T24 | 300MG | 58300040107530 | Formulary |
| ANTIPSYCHOTICS/ANTIMANIC AGENTS | | | |
| Name | Strength/Unit | GPI | Comment |
| RISPERIDONE TAB | 0.25 MG | 59070070000303 | Formulary |
| RISPERIDONE TAB | 0.5 MG | 59070070000306 | Formulary |
| RISPERIDONE TAB | 1 MG | 59070070000310 | Formulary |
| RISPERIDONE TAB | 2 MG | 59070070000320 | Formulary |
| RISPERIDONE TAB | 3 MG | 59070070000330 | Formulary |
| RISPERIDONE TAB | 4MG | 59070070000340 | Formulary |
| RISPERDAL CONSTA GER/ EA | 25MG | 5907007010G220 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| RISPERDAL CONSTA GER/ EA | 50MG | 5907007010G240 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| HALOPERIDOL TAB | 0.5 MG | 59100010100305 | Formulary |
| HALOPERIDOL TAB ( BR: HALDOL) | 1 MG | 59100010100310 | Formulary |
| HALOPERIDOL TAB | 2 MG | 59100010100315 | Formulary |
| HALOPERIDOL TAB (BR EQUIVALENT HALDOL) | 5 MG | 59100010100320 | Formulary |
| HALOPERIDOL TAB | 10 MG | 59100010100325 | Formulary |
| HALOPERIDOL LACTATE | 5 MG/1 ML | 59100010202005 | Formulary |
| HALOPERIDOL DECANOATE 50 | 50 MG/1 ML | 59100010302010 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| HALDOL DECANOATE OIL INTRAMUSCULAR (SCHIZOPHRENIA)/ML | 100MG/1ML | 59100010302020 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| QUETIAPINE FUMARATE TAB | 25 MG | 59153070100310 | Formulary |
| QUETIAPINE FUMARATE TAB | 50 MG | 59153070100314 | Formulary |
| QUETIAPINE FUMARATE TAB | 100 MG | 59153070100320 | Formulary |
| QUETIAPINE FUMARATE TAB | 200 MG | 59153070100330 | Formulary |
| QUETIAPINE FUMARATE TAB | 300 MG | 59153070100340 | Formulary |
| OLANZAPINE TAB | 2.5 MG | 59157060000305 | Formulary |
| OLANZAPINE TAB | 5 MG | 59157060000310 | Formulary |
| OLANZAPINE TAB | 7.5 MG | 59157060000315 | Formulary |
| OLANZAPINE TAB | 10 MG | 59157060000320 | Formulary |
| OLANZAPINE TAB | 15 MG | 59157060000330 | Formulary |
| OLANZAPINE TAB -BR ZYPREXA | 20 MG | 59157060000340 | Formulary |
| CHLORPROMAZINE HCL TAB (THORAZINE) | 25 MG | 59200015100310 | Formulary |
| CHLORPROMAZINE HCL TAB | 50 MG | 59200015100315 | Formulary |
| CHLORPROMAZINE HCL TAB | 100 MG | 59200015100320 | Formulary |
| FLUPHENAZINE HCL TAB | 2.5 MG | 59200025100310 | Formulary |
| FLUPHENAZINE HCL TAB | 5 MG | 59200025100315 | Formulary |
| FLUPHENAZINE HCL TAB | 10 MG | 59200025100320 | Formulary |
| FLUPHENAZINE DECANOATE OIL | 25MG/1ML | 59200025302005 | Formulary |
| PROCHLORPERAZINE MALEATE TAB | 5 MG | 59200055100305 | Formulary |
| PROCHLORPERAZINE MALEATE TAB | 10 MG | 59200055100310 | Formulary |
| THIORIDAZINE HCL TAB | 50 MG | 59200080100320 | Formulary |
| TRIFLUOPERAZINE HCL TAB | 2 MG | 59200085100310 | Formulary |
| TRIFLUOPERAZINE HCL TAB | 10 MG | 59200085100320 | Formulary |
| ARIPIPRAZOLE TAB | 2 MG | 59250015000305 | Formulary |
| ARIPIPRAZOLE TAB | 5 MG | 59250015000310 | Formulary |
| ARIPIPRAZOLE TAB | 10 MG | 59250015000320 | Formulary |
| ARIPIPRAZOLE TAB | 15 MG | 59250015000330 | Formulary |
| ARIPIPRAZOLE TAB | 20 MG | 59250015000340 | Formulary |
| ARIPIPRAZOLE TAB | 30 MG | 59250015000350 | Formulary |
| ABILIFY MAINTENA DUAL-CHAMBERED SYRINGE GER IM | 300MG | 5925001500E430 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| VRAYLAR CAP | 1.5MG | 59400018100120 | Prior Authorization Required. Submit PA form and office notes |
| LATUDA TAB | 20MG | 59400023100310 | |
| LATUDA TAB | 40MG | 59400023100320 | Formulary |
| LURASIDONE HCL TAB | 80 MG | 59400023100340 | Formulary |
| ZIPRASIDONE HCL CAP | 80 MG | 59400085100150 | Formulary |
| LITHIUM CARBONATE CAP | 150 MG | 59500010100103 | Formulary |
| LITHIUM CARBONATE CAP | 300 MG | 59500010100105 | Formulary |
| LITHIUM CARBONATE TER | 300 MG | 59500010100305 | Formulary |
| HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS | | | |
| Name | Strength/Unit | GPI | Comment |
| PHENOBARBITAL TAB | 30 MG | 60100060000315 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| PHENOBARBITAL TAB | 32.4 MG | 60100060000317 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| PHENOBARBITAL TAB | 64.8 MG | 60100060000322 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| PHENOBARBITAL ELIXIR /ML | 20MG/5ML | 60100060001010 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| FLURAZEPAM HCL CAP | 15 MG | 60201010100105 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| FLURAZEPAM HCL CAP | 30 MG | 60201010100110 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| MIDAZOLAM HCL SYRUP/ML | 2 MG | 60201025101220 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| TEMAZEPAM CAP | 7.5 MG | 60201030000103 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| TEMAZEPAM CAP | 15 MG | 60201030000105 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| TRIAZOLAM TAB | 0.125 MG | 60201040000305 | Formulary |
| TRIAZOLAM TAB | 0.25 MG | 60201040000310 | Formulary |
| ESZOPICLONE TAB | 3MG | 60204035000340 | Formulary |
| ZALEPLON CAP | 5MG | 60204070000120 | Formulary |
| ZALEPLON CAPSULE | 10 MG | 60204070000130 | Formulary |
| ZOLPIDEM TARTRATE TAB | 5 MG | 60204080100310 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| ZOLPIDEM TARTRATE TAB (BRAND-AMBIEN)/MG | 10 MG | 60204080100315 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| ZOLPIDEM TARTRATE TER | 12.5 MG | 60204080100420 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| RAMELTEON | 8 MG | 60250060000320 | Formulary |
| BELSOMRA | 10MG | 60500070000310 | Prior Authorization Required. Submit PA form and office notes |
| ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS | | | |
| Name | Strength/Unit | GPI | Comment |
| AMPHETAMINE SALT COMBO TAB | 7.5MG | 61109902100307 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| AMPHETAMINE SALT COMBO TAB | 10 MG | 61109902100310 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| AMPHETAMINE SALT COMBO TAB | 20 MG | 61109902100320 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| MIXED AMPHETAMINE SALT CER | 10 MG | 61109902107010 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| AMPHETAMINE SALT COMBINATION | 15 MG | 61109902107015 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| ADDERALL XR (B) CAP | 20 MG | 61109902107020 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| MIXED AMPHETAMINE SALT CER | 30 MG | 61109902107030 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| GUANFACINE HCL TER | 1 MG | 61353030107520 | Formulary |
| GUANFACINE ER TAB (BRAND-INTUNIV) | 4 MG | 61353030107550 | Formulary |
| ATOMOXETINE HCL CAP | 18MG | 61354015100118 | Formulary |
| ATOMOXETINE HCL CAP | 25MG | 61354015100125 | Formulary |
| ATOMOXETINE HCL | 40MG | 61354015100140 | Formulary |
| ATOMOXETINE HCL CAP | 60MG | 61354015100160 | Formulary |
| ATOMOXETINE HCL CAP | 100MG | 61354015100180 | Formulary |
| METHYLPHENIDATE HCL TAB | 5 MG | 61400020100305 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| METHYLPHENIDATE HCL TAB | 10 MG | 61400020100310 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| METHYLPHENIDATE HCL TAB | 20 MG | 61400020100315 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| METHYLPHENIDATE HCL ER TAB | 10MG | 61400020100403 | Formulary |

# GUAM Medicaid Formulary

**Mandatory Generic Plan.**

Brand name drugs with generic substitutes available are not covered

| ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS | | | |
|---|---|---|---|
| Name | Strength/Unit | GPI | Comment |
| METHYLPHENIDATE HCL TER | 20 MG | 61400020100405 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| METHYLPHENIDATE HCL TER | 18 MG | 61400020100460 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| METHYLPHENIDATE HCL TER | 27 MG | 61400020100465 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| METHYLPHENIDATE HCL TER (BR:CONCERTA) | 36 MG | 61400020100470 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| METHYLPHENIDATE HCL TER | 54 MG | 61400020100480 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| MODAFINIL TAB | 100MG | 61400024000310 | Formulary |
| PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. | | | |
| Name | Strength/Unit | GPI | Comment |
| DONEPEZIL HCL TAB | 5 MG | 62051025100310 | Formulary |
| DONEPEZIL HCL TAB | 10 MG | 62051025100320 | Formulary |
| DONEPEZIL HCL TAB | 23MG | 62051025100330 | Formulary |
| RIVASTIGMINE TARTRATE CAP | 1.5MG | 62051040200110 | Formulary |
| MEMANTINE (BRAND-NAMENDA) | 5MG | 62053550100320 | Formulary |
| MEMANTINE (BRAND-NAMENDA) | 10MG | 62053550100330 | Formulary |
| CHANTIX TAB | 0.5 MG | 62100080200320 | Formulary |
| CHANTIX TAB | 1 MG | 62100080200330 | Formulary |
| TETRABENAZINE | 25 MG | 62380070000320 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| GLATIRAMER ACETATE SOL SUBCUTANEOUS | 20MG/1ML | 6240003010E520 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| GLATIRAMER ACETATE SOL SUBCUTANEOUS | 40MG/1ML | 6240003010E540 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| AVONEX IM KIT /EA (MULTIPLE SCLEROSIS) | 30MCG/.5ML | 6240306045F830 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| ANALGESICS - NonNarcotic | | | |
| Name | Strength/Unit | GPI | Comment |
| ASPIRIN ECT | 325 MG | 64100010000315 | Formulary |
| ASPIRIN LOW ECT (CARDIAC) | 81 MG | 64100010000510 | Formulary |
| ENTERIC COATED ASA | 325 MG | 64100010000605 | Formulary |
| ACETAMINOPHEN-BUTALBITAL-CAFFEINE CAP | 300MG-50MG-40MG | 64991003100108 | Formulary |
| BUTALBITAL-ACETAMINOPHEN-CAFFEINE TAB | 325MG/50MG/40MG | 64991003100110 | Formulary |
| BUTALBITAL-ASPIRIN-CAFFEINE TAB | 325-50-40 MG | 64991003100310 | Formulary |
| BUTALBITAL-ASPIRIN-CAFFEINE CAP | 325 MG-50 MG-40 | 64991003300120 | Formulary |
| ANALGESICS - OPIOID | | | |
| Name | Strength/Unit | GPI | Comment |
| FENTANYL TRANSDERMAL (TDM) SYSTEM (PATCHES) | 12 MCG/1HR | 65100025008610 | Formulary |
| FENTANYL TDM /EA | 25 MCG/1HR | 65100025008620 | Prior Authorization Required. Submit PA form and office notes |
| FENTANYL TDM /EA | 50 MCG/1HR | 65100025008630 | Prior Authorization Required. Submit PA form and office notes |
| FENTANYL TDM /EA | 75 MCG/1HR | 65100025008640 | Prior Authorization Required. Submit PA form and office notes |
| FENTANYL TDM /EA | 100 MCG/1HR | 65100025008650 | Prior Authorization Required. Submit PA form and office notes |
| HYDROMORPHONE HCL TAB | 2 MG | 65100035100310 | Prior Authorization Required. Submit PA form and office notes |
| HYDROMORPHONE HCL TAB | 4 MG | 65100035100320 | Formulary |
| HYDROMORPHONE HCL SOL/ML | 1 MG | 65100035100920 | Formulary |
| MORPHINE SULFATE TAB | 15 MG | 65100055100310 | Prior Authorization Required. Submit PA form and office notes |
| MORPHINE SULFATE IMMEDIATE RELEASE TABLET | 30 MG | 65100055100315 | Formulary |
| MORPHINE SULFATE TER | 30 MG | 65100055100432 | Prior Authorization Required. Submit PA form and office notes |
| MORPHINE SULFATE TER | 60 MG | 65100055100445 | Formulary |
| MORPHINE SULFATE 5ML | 20MG/1ML | 65100055102090 | Formulary |
| OXYCODONE HCL TAB | 5 MG | 65100075100310 | Prior Authorization Required. Submit PA form and office notes |
| OXYCODONE HCL TAB | 10 MG | 65100075100320 | Prior Authorization Required. Submit PA form and office notes |
| OXYCODONE HCL TABLET | 20 MG | 65100075100330 | Prior Authorization Required. Submit PA form and office notes |
| OXYCODONE HCL SOL | 5MG/5ML | 65100075102005 | Prior Authorization Required. Submit PA form and office notes |
| OXYCODONE HCL TER | 20 MG | 6510007510A720 | Prior Authorization Required. Submit PA form and office notes |
| TRAMADOL HCL TAB | 50 MG | 65100095100320 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| OXYCODONE HCL-ACETAMINOPHEN TAB | 325-5MG | 65990002200310 | Prior Authorization Required. Submit PA form and office notes |
| OXYCODONE HCL-ACETAMINOPHEN TAB | 325-7.5MG | 65990002200327 | Prior Authorization Required. Submit PA form and office notes |
| OXYCODONE HCL-ACETAMINOPHEN TAB | 325-10MG | 65990002200335 | Prior Authorization Required. Submit PA form and office notes |
| ACETAMINOPHEN-CODEINE PHOSPHATE TAB | 300MG-30MG | 65991002050315 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| ACETAMINOPHEN/CODEINE PHOSPHATE TAB | 300MG-60MG | 65991002050320 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| ACETAMINOPHEN-CODEINE PHOSPHATE SOL/ML | 120MG/5ML/12MG | 65991002052020 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| BUTALBITAL-APAP-CAFFEINE-CODEINE CAP | 325-50-40-30MG | 65991004100115 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| ACETAMINOPHEN-HYDROCODONE BITARTRATE TAB | 325-10 MG | 65991702100305 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| HYDROCODONE BITARTRATE-ACETAMINOPHEN TAB | 300-5MG | 65991702100309 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| HYDROCODONE BITARTRATE-ACETAMINOPHEN TAB | 300-7.5MG | 65991702100322 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| ACETAMINOPHEN/HYDROCODONE BITARTRATE TAB | 325MG-5MG | 65991702100356 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| ANALGESICS - ANTI-INFLAMMATORY | | | |
| Name | Strength/Unit | GPI | Comment |
| DICLOFENAC SODIUM EC TAB | 50 MG | 66100007100330 | Formulary |
| DICLOFENAC SODIUM EC TAB | 75 MG | 66100007200630 | Formulary |
| IBUPROFEN TAB | 400 MG | 66100020000320 | Formulary |
| IBUPROFEN TAB | 600 MG | 66100020000330 | Formulary |
| IBUPROFEN TAB | 800 MG | 66100020000340 | Formulary |
| INDOMETHACIN CAP | 25 MG | 66100030000105 | Formulary |
| INDOMETHACIN CAP | 50 MG | 66100030000110 | Formulary |
| INDOMETHACIN CAP ER | 75 MG | 66100030000205 | Formulary |
| KETOROLAC TROMETHAMINE TAB | 10 MG | 66100037100320 | Formulary |
| MELOXICAM TAB (340B) | 7.5 MG | 66100052000320 | Formulary |
| MELOXICAM TAB | 15 MG | 66100052000330 | Formulary |
| NAPROXEN TAB | 250 MG | 66100060000305 | Formulary |
| NAPROXEN TAB | 375 MG | 66100060000310 | Formulary |
| NAPROXEN TAB | 500 MG | 66100060000315 | Formulary |
| NAPROXEN SODIUM TAB | 550 MG | 66100060100310 | Formulary |
| PIROXICAM CAP | 10 MG | 66100070000105 | Formulary |
| PIROXICAM CAP | 20 MG | 66100070000110 | Formulary |
| CELECOXIB CAP (BRAND-CELEBREX) | 100MG | 66100525000120 | Formulary |
| CELECOXIB CAP (BRAND-CELEBREX) | 200MG | 66100525000130 | Formulary |
| HUMIRA SUB KIT OR SOL / EA VIAL | 40MG/.8ML | 6627001500F520 | Prior Authorization Required. Submit PA form and office notes |
| HUMIRA SOL SUBCUTANEOUS / EA VIAL | 40MG/.4ML | 6627001500F530 | Prior Authorization Required. Submit PA form and office notes |
| HUMIRA PEN STARTER PACK, 80MG/0.8ML | 80MG/0.8ML | 6627001500F540 | Prior Authorization Required. Submit PA form and office notes |
| HUMIRA PEN PSORIASIS/UVEITIS STARTER PACK,40MG/0.4ML;80MG/0.8ML | 40/0.4;80/0.8 | 6627001500F550 | Prior Authorization Required. Submit PA form and office notes |
| HUMIRA SOL SUBCUTANEOUS / EA VIAL | 20MG/.2ML | 6627001500F809 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| LEFLUNOMIDE TAB | 20MG | 66280050000320 | Formulary |
| ENBREL SOL SQ | 25MG/0.5ML | 66290030002015 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| ENBREL SOL SQ | 50MG/1ML | 66290030000D530 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| ORENCIA INJ. PDS IV | 250MG | 66400010002120 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| ACTEMRA ACTPEN (TOCILIZUMAB) | 162 MG/0.9ML | 66500070000D520 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| XELJANZ | 5 MG | 66603065100320 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| XELJANZ XR | 11 MG | 66603065107530 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| XELJANZ XR | 22 MG | 66603065107550 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| RINVOQ (UPADACITINIB) TER | 15MG | 66603072007520 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| RINVOQ (UPADACITINIB) TER | 30MG | 66603072007530 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| RINVOQ (UPADACITINIB) TER | 45MG | 66603072007540 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| OTEZLA TAB | 30MG | 66700015000330 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| OTEZLA STARTER PACK /TAB | 10MG;20MG;30MG | 6670001500B720 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| MIGRAINE PRODUCTS | | | |
| Name | Strength/Unit | GPI | Comment |
| SUMATRIPTAN SUCCINATE TAB | 25 MG | 67406070100305 | Formulary |
| SUMATRIPTAN SUCCINATE TAB | 50 MG | 67406070100310 | Formulary |
| SUMATRIPTAN SUCCINATE TAB | 100 MG | 67406070100320 | Formulary |
| UBRELVY TABLET | 50 MG | 67701080000320 | Prior Authorization Required. Submit PA form and office notes |
| UBRELVY TABLET | 100 MG | 67701080000340 | Prior Authorization Required. Submit PA form and office notes |
| AJOVY SOL | 225MG/1.5ML | 6770203020D520 | Prior Authorization Required. Submit PA form and office notes |

# GUAM Medicaid Formulary

**Mandatory Generic Plan.**

Brand name drugs with generic substitutes available are not covered

| GOUT AGENTS | | | |
|---|---|---|---|
| Name | Strength/Unit | GPI | Comment |
| ALLOPURINOL TAB | 100 MG | 68000010000305 | Formulary |
| ALLOPURINOL TAB | 300 MG | 68000010000310 | Formulary |
| COLCHICINE TAB (BRAND-COLCRYS) | 0.6 MG | 68000020000310 | Formulary |
| FEBUXOSTAT TAB | 40 MG | 68000030000320 | Formulary |
| FEBUXOSTAT TAB | 80MG | 68000030000330 | Formulary |
| PROBENECID TAB | 500 MG | 68100010000310 | Formulary |
| LOCAL ANESTHETICS-Parenteral | | | |
| Name | Strength/Unit | GPI | Comment |
| LIDOCAINE HCL SOLN INJEC /ML | 2% | 69100040102020 | Formulary |
| ANTICONVULSANTS | | | |
| Name | Strength/Unit | GPI | Comment |
| CLOBAZAM SUS ORAL | 2.5MG/1ML | 72100007001830 | Formulary |
| CLONAZEPAM TAB | 0.5 MG | 72100010000305 | Formulary |
| CLONAZEPAM TAB | 1 MG | 72100010000310 | Formulary |
| CLONAZEPAM TAB | 2 MG | 72100010000315 | Formulary |
| CLONAZEPAM ODT TAB | .25MG | 72100010007215 | Formulary |
| DIASTAT PEDIATRIC | 2.5MG | 72100030004030 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| DIASTAT ACUDIAL GEL (B) | 10 MG | 72100030004040 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| DIASTAT ACUDIAL GEL (B) | 20 MG | 72100030004060 | Formulary |
| PHENYTOIN CHEWABLE INFATAB (BRAND-DILANTIN)/CTB | 50 MG | 72200030000505 | Formulary |
| PHENYTOIN ORAL SUSPENSION/ ML | 125MG/5ML | 72200030001810 | Formulary |
| DILANTIN CER | 100 MG | 72200030200110 | |
| DIVALPROEX SODIUM | 125 MG | 72500010100605 | Formulary |
| DIVALPROEX SODIUM TAB | 250 MG | 72500010100610 | Formulary |
| DIVALPROEX SODIUM | 500 MG | 72500010100615 | Formulary |
| DIVALPROEX SODIUM TCP (USE 6000992) | 250 MG | 72500010107520 | Formulary |
| DIVALPROEX SODIUM ER TAB | 500 MG | 72500010107530 | Formulary |
| DIVALPROEX SODIUM | 125 MG | 72500010107H120 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| VALPROIC ACID SYRUP | 250 MG/5 ML | 72500020102060 | Formulary |
| VALPROIC ACID SGL | 250 MG | 72500030000105 | Formulary |
| CARBAMAZEPINE TAB | 200 MG | 72600020000305 | Formulary |
| CARBAMAZEPINE CTB | 100 MG | 72600020000505 | Formulary |
| CARBAMAZEPINE SUSP | 100MG/5ML 450ML | 72600020001810 | Formulary |
| CARBAMAZEPINE XR TAB | 200 MG | 72600020006920 | Formulary |
| CARBAMAZEPINE ER CAP | 300 MG | 72600020006930 | Formulary |
| CARBAMAZEPINE TER TAB | 400 MG | 72600020007440 | Formulary |
| GABAPENTIN CAP | 100 MG | 72600030000110 | Formulary |
| GABAPENTIN CAP | 300 MG | 72600030000130 | Formulary |
| GABAPENTIN CAP | 400 MG | 72600030000140 | Formulary |
| GABAPENTIN TAB | 600 MG | 72600030000330 | Formulary |
| GABAPENTIN TAB | 800 MG | 72600030000340 | Formulary |
| GABAPENTIN SOL | 250MG/5ML | 72600030002020 | Formulary |
| LACOSAMIDE TAB | 50MG | 72600036000320 | Formulary |
| LACOSAMIDE TAB | 100MG | 72600036000330 | Formulary |
| VIMPAT TAB | 200MG | 72600036000350 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| LAMOTRIGINE TAB | 25 MG | 72600040000310 | Formulary |
| LAMOTRIGINE TAB | 100 MG | 72600040000330 | Formulary |
| LAMOTRIGINE TAB | 200 MG | 72600040000340 | Formulary |
| LAMOTRIGINE CTB | 25MG | 72600040000520 | Formulary |
| LAMOTRIGINE ODT | 25 MG | 72600040007225 | Formulary |
| LAMOTRIGINE ODT | 50 MG | 72600040007230 | Formulary |
| LAMOTRIGINE ODT | 100 MG | 72600040007240 | Formulary |
| LAMOTRIGINE ODT | 200 MG | 72600040007250 | Formulary |
| LEVETIRACETAM TAB | 250 MG | 72600043000320 | Formulary |
| LEVETIRACETAM TAB | 500 MG | 72600043000330 | Formulary |
| LEVETIRACETAM TAB | 750 MG | 72600043000340 | Formulary |
| LEVETIRACETAM ORAL SOLN/ML | 100MG | 72600043002020 | Formulary |
| KEPPRA TER | 500 MG | 72600043007520 | Formulary |
| KEPPRA TER | 750 MG | 72600043007530 | Formulary |
| OXCARBAZEPINE TAB | 300 MG | 72600046000320 | Formulary |
| OXCARBAZEPINE SUSPENSION 250ML | 300MG/5ML | 72600046001820 | Formulary |
| PREGABALIN CAP | 25 MG | 72600057000110 | Formulary |
| PREGABALIN CAP | 50 MG | 72600057000115 | Formulary |
| PREGABALIN CAP | 75 MG | 72600057000120 | Formulary |
| PREGABALIN CAP | 100 MG | 72600057000125 | Formulary |
| PREGABALIN CAP | 150 MG | 72600057000135 | Formulary |
| PREGABALIN CAP | 200MG | 72600057000145 | Formulary |
| PREGABALIN CAP | 300 MG | 72600057000160 | Formulary |
| PRIMIDONE TAB | 50 MG | 72600060000305 | Formulary |
| PRIMIDONE TAB | 250 MG | 72600060000310 | Formulary |
| TOPIRAMATE TAB | 25 MG | 72600075000310 | Formulary |
| TOPIRAMATE TAB | 50 MG | 72600075000320 | Formulary |
| TOPIRAMATE TAB | 100 MG | 72600075000330 | Formulary |
| TOPIRAMATE TAB | 200 MG | 72600075000340 | Formulary |
| TOPIRAMATE CAP | 15 MG | 72600075006820 | Formulary |
| TOPAMAX CAP (SPRINKLE) (B) | 25 MG | 72600075006830 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| ZONISAMIDE CAP | 100MG | 72600090000120 | Formulary |
| ANTIPARKINSON AND RELATED THERAPY AGENTS | | | |
| Name | Strength/Unit | GPI | Comment |
| BENZTROPINE MESYLATE TAB | 0.5 MG | 73100010100305 | Formulary |
| BENZTROPINE MESYLATE TAB | 1 MG | 73100010100310 | Formulary |
| BENZTROPINE MESYLATE TAB (COGENTIN) | 2MG | 73100010100315 | Formulary |
| TRIHEXYPHENIDYL HCL TAB | 2 MG | 73100070100310 | Formulary |
| TRIHEXYPHENIDYL HCL TAB | 5 MG | 73100070100320 | Formulary |
| AMANTADINE HCL CAP | 100 MG | 73200010100105 | Formulary |
| AMANTADINE HCL TAB | 100 MG | 73200010100310 | Formulary |
| BROMOCRIPTINE MESYLATE (NOT FOR AMENORRHEA, GALACTORRHEA, HYPERPROLACTENEMIA &NEUROLEPTIC M | 2.5 MG TAB | 73200020100305 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| PRAMIPEXOLE DIHYDROCHLORIDE TAB | 0.125 MG | 73203060100305 | Formulary |
| PRAMIPEXOLE DIHYDROCHLORIDE TAB | 0.25 MG | 73203060100310 | Formulary |
| PRAMIPEXOLE DIHYDROCHLORIDE TAB | 0.5MG | 73203060100315 | Formulary |
| PRAMIPEXOLE DIHYDROCHLORIDE TAB | 1 MG | 73203060100320 | Formulary |
| PRAMIPEXOLE DIHYDROCHLORIDE TER | 0.375 | 73203060107520 | Formulary |
| PRAMIPEXOLE DIHYDROCHLORIDE TER | 0.75 | 73203060107530 | Formulary |
| PRAMIPEXOLE DIHYDROCHLORIDE TER | 1.5 MG | 73203060107540 | Formulary |
| PRAMIPEXOLE DIHYDROCHLORIDE TER | 2.25 MG | 73203060107545 | Formulary |
| PRAMIPEXOLE DIHYDROCHLORIDE TER | 3 MG | 73203060107550 | Formulary |
| PRAMIPEXOLE DIHYDROCHLORIDE TER | 4.5 MG | 73203060107560 | Formulary |
| ROPINIROLE HCL TAB | 0.25 MG | 73203070100310 | Formulary |
| ROPINIROLE HCL TAB | 0.5MG | 73203070100315 | Formulary |
| ROPINIROLE HCL TAB | 1MG | 73203070100320 | Formulary |
| ROPINIROLE HCL TAB | 2MG | 73203070100330 | Formulary |
| ROPINIROLE HCL TAB | 3MG | 73203070100337 | Formulary |
| ROPINIROLE HCL TAB | 4MG | 73203070100344 | Formulary |
| ROPINIROLE HCL TAB | 5MG | 73203070100350 | Formulary |
| CARBIDOPA/LEVODOPA TAB | 10 MG-100 MG | 73209902100310 | Formulary |
| CARBIDOPA/LEVODOPA TAB | 25 MG-100 MG | 73209902100320 | Formulary |
| CARBIDOPA/LEVODOPA TAB | 25 MG-250 MG | 73209902100330 | Formulary |

# GUAM Medicaid Formulary

**Mandatory Generic Plan.**

Brand name drugs with generic substitutes available are not covered

| MUSCULOSKELETAL THERAPY AGENTS | | | |
|---|---|---|---|
| Name | Strength/Unit | GPI | Comment |
| CARBIDOPA/LEVODOPA TER | 25MG-100MG | 73209902100410 | Formulary |
| CARBIDOPA/LEVODOPA TER | 50MG-200MG | 73209902100420 | Formulary |
| BACLOFEN TAB | 10 MG | 75100010000305 | Formulary |
| BACLOFEN TAB | 20 MG | 75100010000310 | Formulary |
| CARISOPRODOL TAB | 350 MG | 75100020000305 | Formulary |
| CHLORZOXAZONE TAB | 500 MG | 75100040000310 | Formulary |
| CYCLOBENZAPRINE HCL TAB | 5 MG | 75100050100303 | Formulary |
| CYCLOBENZAPRINE HCL TAB | 10 MG | 75100050100305 | Formulary |
| METHOCARBAMOL TAB | 500 MG | 75100070000305 | Formulary |
| METHOCARBAMOL TAB | 750 MG | 75100070000310 | Formulary |
| TIZANIDINE HCL TAB | 4 MG | 75100090100320 | Formulary |
| SYNVISC ONE SOL | 8MG/1ML | 7580004000E560 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| EUFLEXXA SOL | 10 MG | 7580007010E520 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| ANTIMYASTHENIC/CHOLINERGIC AGENTS | | | |
| Name | Strength/Unit | GPI | Comment |
| PYRIDOSTIGMINE BROMIDE TAB | 60 MG | 76000050100305 | Formulary |
| VITAMINS | | | |
| Name | Strength/Unit | GPI | Comment |
| NIACIN TER TAB | 500 MG | 77103010000450 | Formulary |
| VITAMIN D (ERGOCALCIFEROL) SGL | 50000IU | 77202030000110 | Formulary |
| VITAMIN D3 CAP (CHOLECALCIFEROL) | 50000IU | 77202032000140 | Formulary |
| MULTIVITAMINS | | | |
| Name | Strength/Unit | GPI | Comment |
| RENAL CAPS (VIT C/BIOTIN/CA PANTOTHENATE/VIT B12/FOLIC ACID) | 100MG-0.15MG-5M | 78133000000130 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| RENA-VITE (VIT C/BIOTIN/CAPANTOTHENATE/VITB12/FOLIC ACID) | 60MG0.3MG10MG0. | 78133000000325 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| RENA-VITE RX (VIT C/BIOTIN/CA PANTOTHENATE/VIT B12/FOLIC ACID) | 60MG0.3MG10MG0. | 78133000000330 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| MULTIVITAMIN CHILDREN'S CHEW TAB (EPSDT) | 60MG-.0045-.3 | 78410000000500 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| MULTIVITAMIN W/FLUORIDE CHEW TAB (EPSDT) | 60MG-400I/.25MG | 78441000000505 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| MULTIVITAMIN W/FLUORIDE CHEW TAB (EPSDT) | 60MG-400I/.5MG | 78441000000510 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| MULTIVITAMIN W/FLUORIDE CHEW TAB (EPSDT) | 60MG-400I/1MG | 78441000000520 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| MULTIVITAMIN W/FLUORIDE DROPS SUS ORAL /ML (EPSDT) | 35MG-400/.25MG | 78441000002005 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| MULTIVITAMIN W/FLUORIDE DROPS SUS ORAL /ML (EPSDT) | 35MG-400/.5MG | 78441000002010 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| MULTIVITAMIN W/FLUORIDE & IRON DROPS SOL ORAL /ML (EPSDT) | 35MG-.25-10/.5 | 78450000002008 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| PRENATAL VITAMIN TAB (PREGNANT) | 100-200-.004-0 | 78512015000322 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| PRENATAL PLUS VITAMIN TAB (PREGNANT) | 120-200-400IU-2 | 78512015000324 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| MINERALS & ELECTROLYTES | | | |
| Name | Strength/Unit | GPI | Comment |
| SODIUM BICARBONATE SOL | 8.4 % | 79050020002025 | Formulary |
| SODIUM FLUORIDE CTB (340B) | 0.5MG | 79300020000310 | Formulary |
| LUDENT FLUORIDE CTB | 0.25 MG | 79300020000505 | Formulary |
| LUDENT FLUORIDE CHEWABLE TABLET | 1 MG | 79300020000515 | Formulary |
| SODIUM FLUORIDE SOLN | 0.5MG/ML 50 ML | 79300020002050 | Formulary |
| PHOSPHORUS/POTASSIUM/SODIUM | 250MG/1P-280MG1 | 79600030003012 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| POTASSIUM CHLORIDE ER TAB | 10 MEQ | 79700030000210 | Formulary |
| POTASSIUM CHLORIDE ER TAB | 20 MEQ | 79700030000445 | Formulary |
| POTASSIUM CHLORIDE SOLN IV /ML | 20MEQ/100ML | 79700030002060 | Formulary |
| HEMATOPOIETIC AGENTS | | | |
| Name | Strength/Unit | GPI | Comment |
| CYANOCOBALAMIN SOL | 1000MCG/1ML | 82100010002015 | Formulary |
| FOLIC ACID TAB | 1 MG | 82200010000315 | Formulary |
| FERROUS SULFATE TAB (MEDICAL JUSTIFICATION) | 325 MG | 82300010000332 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| FERROUS SULFATE LIQ ELIXIR /ML | 220MG/5ML | 82300010002030 | Formulary |
| EPOGEN INJ (CHRONIC RENAL FAILURE; ESRD, HIV AND CANCER RELATED ANEMIA) SOL/ ML | 2000U/1ML | 82401020002010 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| EPOGEN INJ (CHRONIC RENAL FAILURE; ESRD, HIV AND CANCER RELATED ANEMIA) SOL /ML | 4,000U/1ML | 82401020002020 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| EPOGEN INJ (CHRONIC RENAL FAILURE; ESRD, HIV AND CANCER RELATED ANEMIA) SOL /ML | 10,000U/ML | 82401020002040 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| EPOGEN INJ (CHRONIC RENAL FAILURE; ESRD, HIV AND CANCER RELATED ANEMIA) SOL /ML | 20,000U/1ML | 82401020002050 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| RETACRIT SOL | 4000U/1ML | 82401020042020 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| RETACRIT SOL | 10000U/1ML | 82401020042040 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| RETACRIT SOL | 20000U/1ML | 82401020042050 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| NEUPOGEN SOL / ML | 300MCG/1ML | 82401520002010 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| GRANIX SOL SQ | 300MCG/0.5ML | 82401520070E530 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| NEULASTA SOL/.1ML (CANCER) | 6 MG/0.6 ML | 82401570000E520 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| PROMACTA TAB | 12.5 MG | 82405030100310 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| PROMACTA TAB (MAXIMUM 60 UNITS BASED ON MD RX) | 25 MG | 82405030100320 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| PROMACTA TAB | 50 MG | 82405030100330 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| PROMACTA TAB | 75 MG | 82405030100340 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| ANTICOAGULANTS | | | |
| Name | Strength/Unit | GPI | Comment |
| ENOXAPARIN SODIUM SOL SQ/ML | 30MG/0.3ML | 8310102010E520 | Formulary |
| ENOXAPARIN SODIUM SOL SQ/ML | 60MG/0.6ML | 8310102010E530 | Formulary |
| ENOXAPARIN SODIUM SOL SQ/ML | 80MG/0.8ML | 8310102010E535 | Formulary |
| ENOXAPARIN SODIUM SOL SQ/ML | 100MG/1ML | 8310102010E540 | Formulary |
| ENOXAPARIN SODIUM SOL SQ/ML | 120MG/0.8ML | 8310102010E560 | Formulary |
| ENOXAPARIN SODIUM SOL SQ/ML | 150MG/1ML | 8310102010E565 | Formulary |
| WARFARIN SODIUM TAB | 1 MG | 83200030200303 | Formulary |
| WARFARIN SODIUM TAB | 2 MG | 83200030200305 | Formulary |
| WARFARIN SODIUM TAB | 2.5 MG | 83200030200310 | Formulary |
| WARFARIN SODIUM TAB | 3 MG | 83200030200311 | Formulary |
| WARFARIN SODIUM TAB | 4 MG | 83200030200313 | Formulary |
| WARFARIN SODIUM TAB | 5 MG | 83200030200315 | Formulary |
| WARFARIN SODIUM TAB | 6 MG | 83200030200317 | Formulary |
| WARFARIN SODIUM TAB | 7.5 MG | 83200030200320 | Formulary |
| WARFARIN SODIUM TAB | 10 MG | 83200030200325 | Formulary |
| PRADAXA CAP | 75 MG | 83337030200120 | Formulary |
| PRADAXA CAP | 110 MG | 83337030200130 | Formulary |
| PRADAXA CAP | 150 MG | 83337030200140 | Formulary |
| ELIQUIS TAB | 2.5 MG TAB | 83370010000320 | Formulary |
| ELIQUIS TAB | 5 MG | 83370010000330 | Formulary |
| XARELTO TAB | 2.5 MG | 83370060000310 | Formulary |
| XARELTO TAB | 10MG | 83370060000320 | Formulary |
| XARELTO TAB | 15MG | 83370060000330 | Formulary |
| XARELTO TAB | 20MG | 83370060000340 | Formulary |
| XARELTO PDR | 1MG/1ML | 83370060001920 | Formulary |
| XARELTO STARTER PACK | 15 MG; 20 MG | 833706000B720 | Formulary |
| HEMOSTATICS | | | |
| Name | Strength/Unit | GPI | Comment |
| AMICAR TAB (NEGOTIATED PRICE-HEMO) | 500 MG | 84100010000305 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| TRANEXAMIC ACID TAB (SEVERE BLEEDING) | 650MG | 84100040000320 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| HEMATOLOGICAL AGENTS - MISC. | | | |
| Name | Strength/Unit | GPI | Comment |
| RECOMBINATE PDS IV / EA (NEGOTIATED PRICE-HEMO) | 1 IU | 85100010202115 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| NUWIQ PDS IV /EA (NEGOTIATED PRICE-HEMO) | 1IU | 85100010222120 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| ADVATE IV (NEGOTIATED PRICE-HEMO) | 1 IU | 85100010252140 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| NOVOEIGHT PDS IV /EA (NEGOTIATED PRICE-HEMO) | 1IU | 85100010332140 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| HUMATE-P PDS IV /EA (NEGOTIATED PRICE-HEMO) | 1 IU-1 IU | 85100015102144 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| WILATE PDS IV /EA (NEGOTIATED PRICE-HEMO) | 1IU-1IU | 85100015106430 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| FEIBA NF PDS /EA (NEGOTIATED PRICE-HEMO) | 1 IU | 85100020002130 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| DIPYRIDAMOLE TAB | 25 MG | 85150030000310 | Formulary |
| DIPYRIDAMOLE TAB | 50 MG | 85150030000320 | Formulary |

# GUAM Medicaid Formulary

**Mandatory Generic Plan.**

Brand name drugs with generic substitutes available are not covered

| HEMATOLOGICAL AGENTS - MISC. | | | |
|---|---|---|---|
| Name | Strength/Unit | GPI | Comment |
| DIPYRIDAMOLE TAB | 75 MG | 85150030000330 | Formulary |
| CILOSTAZOL TAB | 50 MG | 85155516000320 | Formulary |
| CILOSTAZOL TAB | 100 MG | 85155516000330 | Formulary |
| ANAGRELIDE HCL (CANCER) CAP | 0.5MG | 85156010100120 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| ANAGRELIDE HCL (CANCER) CAP | 1 MG CAP | 85156010100130 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| CLOPIDOGREL BISULFATE SULFATE TAB | 75 MG | 85158020100320 | Formulary |
| BRILINTA | 60 MG | 85158470000315 | Formulary |
| BRILINTA (TICAGRELOR) | 90 MG | 85158470000320 | Formulary |
| PENTOXIFYLLINE TER | 400 MG | 85200010000410 | Formulary |
| OPHTHALMIC AGENTS | | | |
| Name | Strength/Unit | GPI | Comment |
| AZASITE SOL OPHT / ML | 1% | 86101004002020 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| BACITRACIN OPHTHALMIC OINTMENT/GM; 3.5GM | 500U/1GM | 86101005004205 | Formulary |
| CIPROFLOXACIN HCL OPTH SOLN /ML | 0.3% | 86101023102010 | Formulary |
| ERYTHROMYCIN OPHTHALMIC OINT/GM | 5MG | 86101025004210 | Formulary |
| GENTAMICIN SULFATE OPHTH OINT/GM | 3MG/GM 3.5 GM | 86101030002005 | Formulary |
| MOXIFLOXACIN HCL SOL OPHTHALMIC SOLUTION /ML | 0.5 % | 86101038102020 | Formulary |
| OFLOXACIN OPHTHALMIC SOL 10ML | 0.3% | 86101047002020 | Formulary |
| TOBRAMYCIN SOL OPHTHALMIC | 0.3% | 86101070002005 | Formulary |
| SULFACETAMIDE SODIUM OPHTH SOLN | 10% 15 ML | 86102010102010 | Formulary |
| POLYMYXIN B/TMP SULFATE OPTHA SOLN/ML | 10000U | 86109902602020 | Formulary |
| TIMOLOL MALEATE OPHTH SOLN/ML | 0.5% | 86250030102010 | Formulary |
| DORZOLAMIDE/TIMOLOL OPHTH SOL /ML | 22.3MG-6-8MG/ML | 86259902202020 | Formulary |
| FLUOROMETHOLONE OPHTH SUSP/1ML | 0.1% 5 ML | 86300020001810 | Formulary |
| LOTEMAX (LOTEPREDNOL ETABONATE) OPHTHALMIC OIN / GM | 0.5% | 86300035101830 | Formulary |
| LOTEMAX (LOTEPREDNOL ETABONATE) OPHTHALMIC GEL /GM 5GM | 0.5% | 86300035104020 | Formulary |
| PREDNISOLONE ACETATE OPHTHALMIC SUSPENSION/ML | 1% | 86300050101815 | Formulary |
| PREDNISOLONE SODIUM PHOSP OP SOLN/ML | 1% | 86300050202015 | Formulary |
| TOBRAMYCIN/DEXAMETHASONE OPHTH SUSP/ ML | .1%-.3%/2.5,5, | 86309902801820 | Formulary |
| TOBRADEX OPHTH OINTMENT/ GM | 0.1-0.3%/ 3.5GM | 86309902804220 | Formulary |
| DEXAMETHASONE-NEO-POLYMXBSULF SUS OPTH /ML | 1-3.5-10000U | 86309903321810 | Formulary |
| NEOMYCIN&POLYMYXIN B SULF, BACITRN ZN & HC OIN OPHTH /GM | 400U-1%-3.5-100 | 86309904104220 | Formulary |
| LUMIGAN OPHTHALMIC SOLN/ML | 0.01% | 86330015002010 | Formulary |
| LATANOPROST OPHTH SOLN/ML | 0.005% | 86330050002020 | Formulary |
| TRAVOPROST SOLUTION | 0.004% | 86330070002025 | Formulary |
| ATROPINE SULFATE OPHTH SOL /ML | 1% | 86350010102010 | Formulary |
| ALPHAGAN P OPHTH SOL/ ML | 0.1% | 86602020102005 | Formulary |
| BRIMONIDINE TARTRATE OPTH SOL / ML | 0.15% | 86602020102007 | Formulary |
| BRIMONIDINE TARTRATE OPTH SOL /ML | 0.2% | 86602020102010 | Formulary |
| CYCLOSPORINE EMU OPHTHALMIC | 0.05% | 86720020001620 | Formulary |
| CROMOLYN SODIUM OPHTH SOLN/ML | 4% | 86802010102005 | Formulary |
| OLOPATADINE HCL OPHTHALMIC EYEDROP/ML 5ML | .1% | 86802065102020 | Formulary |
| KETOROLAC TROMETH OPHTH SOLN LS/ML | 0.4% 5 ML | 86805035102015 | Formulary |
| KETOROLAC TROMETHAMINE OPHTHALMIC SOLN/ML | 0.5% | 86805035102020 | Formulary |
| OTIC AGENTS | | | |
| Name | Strength/Unit | GPI | Comment |
| OFLOXACIN OTIC SOL 10ML | 0.3% | 87100060002010 | Formulary |
| ACETIC ACID OTIC SOL /ML | 2% | 87400010102010 | Formulary |
| CIPROFLOXACIN HCL/DEXAMETHASONE SUSP OTIC | 0.3%/0.1% | 87991002361820 | Formulary |
| CIPRO HC SUS OTIC/ML | 0.2%-1% | 87991002401820 | Formulary |
| HC/NEOMYCIN/ POLYMYXIN B SOL OTIC /ML | 1%-.35%-10000U | 87991003101807 | Formulary |
| MOUTH/THROAT/DENTAL AGENTS | | | |
| Name | Strength/Unit | GPI | Comment |
| NYSTATIN ORAL SUSPENSION | 100,000U/ML | 88100010001805 | Formulary |
| CHLORHEXIDINE GLUCONATE ORAL RINSE/ML | 0.12 % | 88150020102012 | Formulary |
| TRIAMCINOLONE ACETONIDE PASTE/GM; 5GM | 0.1% | 88250020104410 | Formulary |
| LIDOCAINE HCL VISCOUS | 2% SOL | 88350065102050 | Formulary |
| ANORECTAL AND RELATED PRODUCTS | | | |
| Name | Strength/Unit | GPI | Comment |
| PROCTOZONE-HC (HYDROCORTISONE) CREAM, RECTAL AND TOPICAL APPLICATION/GM 30GM | 2.5% | 89100010003720 | Formulary |
| PROCTOZONE-HC (HYDROCORTISONE) CREAM, RECTAL AND TOPICAL APPLICATION/GM 30GM | 2.5% | 89100010003720 | Formulary |
| HYDROCORTISONE ACETATE SUPPOSITORY | 25MG | 89100010105230 | Formulary |
| DERMATOLOGICALS | | | |
| Name | Strength/Unit | GPI | Comment |
| TRETINOIN CREAM/ GM; 45GM | 0.1% | 90050030003703 | Formulary |
| TRETINOIN CREAM/ GM; 20GM | 0.05% | 90050030003705 | Formulary |
| TRETINOIN CREAM/ GM; 20GM | 0.1% | 90050030003710 | Formulary |
| TRETINOIN GEL/ GM; 45GM | 0.01% | 90050030004005 | Formulary |
| TRETINOIN GEL/ GM; 45GM | 0.025% | 90050030004010 | Formulary |
| CLINDAMYCIN PHOSPHATE SOL - TOPICAL | 1% | 90051010102005 | Formulary |
| CLINDAMYCIN PHOSPHATE GEL/30GM (USE 3151) | 1% | 90051010104005 | Formulary |
| CLINDAMYCIN PHOSPHATE PAD | 1% | 90051010109420 | Formulary |
| METRONIDAZOLE CREAM /GM | 0.75% | 90060040003710 | Formulary |
| GENTAMICIN SULFATE CREAM/GM | 0.1% | 90100050103705 | Formulary |
| GENTAMICIN SULFATE OINTMENT/GM | 0.1% | 90100050104205 | Formulary |
| MUPIROCIN OINTMENT/GM 22GM | 2% | 90100065104210 | Formulary |
| MUPIROCIN CALCIUM CREAM/GM 30GM | 2% | 90100065203710 | Formulary |
| NAFTIN GEL | 1% | 90150078003710 | Formulary |
| NYSTATIN CREAM/GM | 100,000U | 90150080003710 | Formulary |
| NYSTATIN OINTMENT/GM | 100,000U | 90150080004215 | Formulary |
| CLOTRIMAZOLE CREAM/GM; 30GM | 1% | 90154020003705 | Formulary |
| ECONAZOLE NITRATE CREAM /GM | 1% | 90154035103705 | Formulary |
| KETOCONAZOLE CREAM 15GM | 2% | 90154045003710 | Formulary |
| KETOCONAZOLE SHAMPOO (SEVERE FUNGAL INFECTION, TINEA VERSICOLOR, ANDROGENIC ALOPECIA)/ML | 2% | 90154045004510 | Formulary |
| CLOTRIMAZOLE- BETAMETHASONE DIPROPRIONATE CREAM /GM; 45GM | 0.05%-1% | 90159902053710 | Formulary |
| NYSTATIN/TRIAMCINOLONE ACETONIDE CREAM/GM;15/30/60 | 100000U/GM-0.1% | 90159902253700 | Formulary |
| NYSTATIN/TRIAMCINOLONE ACETONIDE OINT/GM; 15GM | 100000U/0.1% | 90159902254200 | Formulary |
| DICLOFENAC SODIUM GEL (TOPICAL) | 1% | 90210030304020 | Formulary |
| CALCIPOTRIENE CREAM/GM | 0.005% | 90250025003710 | Formulary |
| CALCIPOTRIENE OINTMENT/GM | 0.005% | 90250025004210 | Formulary |
| STELARA SOL (SUBCUTANEOUS) - PRE-APPROVED FOR PT W/CO-INSURANCE | 45MG/0.5ML | 90250585002020 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| SELENIUM SULFIDE LOTION/ML | 2.5% 120 ML | 90300050004120 | Formulary |
| ACYCLOVIR CRE 5GM | 5% | 90350010003720 | Formulary |
| ACYCLOVIR OINTMENT/ GM 15GM/30GM | 5% | 90350010004205 | Formulary |
| FLUOROURACIL CREAM /GM (R.H),(J.L) 40GM | 5% | 90372030003730 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| SILVER SULFADIAZINE CREAM | 1% - 50 GM | 90450030003710 | Formulary |
| BETAMETHASONE DIPROPIONATE CREAM 15GM | 0.05% | 90550020003705 | Formulary |
| BETAMETHASONE DIPROPIONATE LOTION /ML | 0.05% | 90550020004105 | Formulary |
| BETAMETHASONE DIPROPIONATE OINT /GM | 0.05% | 90550020004205 | Formulary |
| BETAMETHASONE DIPROPIONATE CREAM 50GM | 0.05% | 90550020053705 | Formulary |
| BETAMETHASONE VALERATE CRM /GM | 0.1% | 90550020103710 | Formulary |
| BETAMETHASONE VALERATE LOTION /ML | 1% | 90550020104105 | Formulary |
| BETAMETHASONE VALERATE OINTMENT 15GM | 0.1% | 90550020104205 | Formulary |
| CLOBETASOL PROPIONATE SOLN/ML | 0.05% | 90550025102005 | Formulary |
| CLOBETASOL PROPIONATE CREAM /GM | 0.05% | 90550025103705 | Formulary |
| CLOBETASOL PROPIONATE OINT /GM | 0.05% | 90550025104205 | Formulary |
| DESONIDE CREAM/GM | 0.05% | 90550035003705 | Formulary |
| DESONIDE LOTION ML | 0.05% | 90550035004105 | Formulary |
| DESONIDE OINT/GM | 0.05% | 90550035004205 | Formulary |

# GUAM Medicaid Formulary

**Mandatory Generic Plan.**

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| DERMATOLOGICALS | | | |
|---|---|---|---|
| Name | Strength/Unit | GPI | Comment |
| FLUOCINOLONE ACETONIDE OIL | 0.01% | 90550055101714 | Formulary |
| FLUOCINOLONE ACETONIDE SOLN | 0.01% | 90550055102005 | Formulary |
| FLUOCINOLONE ACETONIDE CREAM/GM | 0.01% | 90550055103705 | Formulary |
| FLUOCINOLONE ACETONIDE OINT /GM | 0.025% | 90550055104205 | Formulary |
| FLUOCINONIDE TOPICAL SOLN/60ML | 0.05% | 90550060002005 | Formulary |
| FLUOCINONIDE CREAM/GM | 0.05% | 90550060003705 | Formulary |
| FLUOCINONIDE CREAM/GM | 0.1% | 90550060003710 | Formulary |
| FLUOCINONIDE OINT/GM 60GM | 0.05% | 90550060004205 | Formulary |
| FLUTICASONE PROPIONATE CREAM/GM | 0.05 % 30 GM | 90550068103710 | Formulary |
| HYDROCORTISONE CREAM/GM (20,28,28.35,30,453.60,454) | 2.5% | 90550075003725 | Formulary |
| HYDROCORTISONE OINTMENT/GM; (20GM, 28.35GM & 454GM) | 2.5% | 90550075004215 | Formulary |
| HYDROCORTISONE VALERATE CREAM /GM; 15GM | 0.2% | 90550075203705 | Formulary |
| HYDROCORTISONE VALERATE OINT/GM; 60GM | 0.2% | 90550075204205 | Formulary |
| MOMETASONE FUROATE CREAM/GM; 45GM | 0.1% | 90550082103710 | Formulary |
| MOMETASONE FUROATE OINTMENT 15GM | 0.1% | 90550082104210 | Formulary |
| TRIAMCINOLONE ACETONIDE CREAM/GRAM; 15GM | 0.025% | 90550085103705 | Formulary |
| TRIAMCINOLONE ACETONIDE CREAM/GM | 0.1% | 90550085103710 | Formulary |
| TRIAMCINOLONE ACETONIDE CREAM /GM | 0.5% 15 | 90550085103720 | Formulary |
| TRIAMCINOLONE ACETONIDE LOTION | .025% 60,... | 90550085104105 | Formulary |
| TRIAMCINOLONE ACETONIDE LOTION / ML | 0.1% 60 | 90550085104110 | Formulary |
| TRIAMCINOLONE ACETONIDE OINTMENT /GM | .025% 80,454 | 90550085104205 | Formulary |
| TRIAMCINOLONE ACETONIDE OINTMENT / GM | 0.1% 30,80,... | 90550085104210 | Formulary |
| TRIAMCINOLONE ACETONIDE OINTMENT / GM | 0.5% | 90550085104215 | Formulary |
| SANTYL OINTMENT 30 GRAM | 250 U/1 GM | 90700010004205 | Formulary |
| PIMECROLIMUS CREAM/GM | 1% | 90784060003720 | Formulary |
| TACROLIMUS OIN /GM | .1% & .03% | 90784075004210 | Formulary |
| LIDOCAINE TDM (PATCH) | 5% | 90850060005930 | Formulary |
| LIDOCAINE/PRILOCAINE CREAM/GM 30GM | 2.5% - 2.5% | 90859902903710 | Formulary |
| PERMETHRIN CREAM/GM 60GM | 5% | 90900035003720 | Formulary |
| ANTISEPTICS & DISINFECTANTS | | | |
| Name | Strength/Unit | GPI | Comment |
| IODOSORB GEL 10GM | 0.9% | 92200003004020 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| POVIDONE IODINE SOL | 10% | 92200040002015 | Formulary |
| ANTIDOTES AND SPECIFIC ANTAGONISTS | | | |
| Name | Strength/Unit | GPI | Comment |
| DEFERIPRONE TAB | 1000MG | 93100028000340 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| NALOXONE HCL NASAL SPRAY | 4MG/0.1ML | 93400020100920 | Formulary |
| CHEMICALS | | | |
| Name | Strength/Unit | GPI | Comment |
| ISOSORBIDE POW / GM | 1 GM | 96587845752900 | Formulary |
| MEDICAL DEVICES AND SUPPLIES | | | |
| Name | Strength/Unit | GPI | Comment |
| NOVOPEN ECHO INSULIN PEN (BLIND, SELF-ADMIN@SCHOOL FOR CHILDREN, OR DOSAGE@MONTH < FOR THE VIAL | DEVICE | 97051050126220 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| NOVOFINE 32GX6MM NEEDLES | NEEDLES | 97051050146368 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| PHARMACEUTICAL ADJUVANTS | | | |
| Name | Strength/Unit | GPI | Comment |
| CHERRY SYRUP | ML | 98402020001200 | Formulary |
| MISCELLANEOUS THERAPEUTIC CLASSES | | | |
| Name | Strength/Unit | GPI | Comment |
| CYCLOSPORINE CAP (RESTRICTED, NCB FOR ORGAN TRANSPLANT STATUS) | 100 MG | 99402020000140 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| CYCLOSPORINE SGL | 25 MG | 99402020300120 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| CYCLOSPORINE, MODIFIED SGL | 50MG | 99402020300130 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| MYCOPHENOLATE MOFETIL/CAP | 250 MG | 99403030100120 | Formulary |
| MYCOPHENOLATE MOFETIL/TAB | 500 MG | 99403030100330 | Formulary |
| MYCOPHENOLATE MOFETIL PDR | 200MG/1ML | 99403030101920 | Formulary |
| MYFORTIC TAB (NCB FOR KIDNEY TRANSPLANT STATUS) | 360 MG | 99403030300630 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| SIROLIMUS TAB | 1MG | 99404070000320 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| TACROLIMUS CAP (NCB FOR ORGAN TRANSPLANT STATUS) | 1 MG | 99404080000110 | Specialty Drug: Prior Authorization Required. Submit PA form and office notes |
| AZATHIOPRINE TAB | 50 MG | 99406010000305 | Formulary |
| SODIUM POLYSTYRENE SULFONATE SUS | 15 MG/60 ML | 99450010001805 | Formulary |
| LOKELMA PDR (NEGOTIATED PRICE-FRES) | 5GM/1PACKET | 99450020003020 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| LOKELMA PDR (NEGOTIATED PRICE-FRES) | 10GM/1 PACKET | 99450020003040 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| VELTASSA PDR ORAL / EA (NEGOTIATED PRICE-FRES) | 8.4 GM/ 1PKG | 99450060203020 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| VELTASSA PDR ORAL / EA (NEGOTIATED PRICE-FRES) | 16.8GM/PKG | 99450060203030 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |
| VELTASSA PDR ORAL / EA (NEGOTIATED PRICE-FRES) | 25.2GM/1PKG | 99450060203040 | Prior Authorization Required. Submit Prior Authorization Form with Diagnosis |