# APPENDIX TO RULE 4123-6-21.3
## Formulary List of Medications Covered by the Ohio Bureau of Workers' Compensation

| Drug Class Name | Drug Generic Name | Coverage restrictions or limitations for specific drugs or dosage forms are listed with the respective drugs below. |
|---|---|---|
| **Acne - Oral** | | |
| | Isotretinoin Cap 25 MG | |
| | Isotretinoin Cap 30 MG | |
| | Isotretinoin Cap 35 MG | |
| **ADHD - Amphetamines** | | |
| | Amphetamine-Dextroamphetamine Cap SR 24HR 5 MG | |
| | Amphetamine-Dextroamphetamine Cap SR 24HR 10 MG | |
| | Amphetamine-Dextroamphetamine Cap SR 24HR 15 MG | |
| | Amphetamine-Dextroamphetamine Cap SR 24HR 20 MG | |
| | Amphetamine-Dextroamphetamine Cap SR 24HR 25 MG | |
| | Amphetamine-Dextroamphetamine Cap SR 24HR 30 MG | |
| | Amphetamine-Dextroamphetamine Tab 5 MG | |
| | Amphetamine-Dextroamphetamine Tab 7.5 MG | |
| | Amphetamine-Dextroamphetamine Tab 10 MG | |
| | Amphetamine-Dextroamphetamine Tab 12.5 MG | |
| | Amphetamine-Dextroamphetamine Tab 15 MG | |
| | Amphetamine-Dextroamphetamine Tab 20 MG | |
| | Amphetamine-Dextroamphetamine Tab 30 MG | |
| | Dextroamphetamine Sulfate Cap SR 24HR 10 MG | |
| | Dextroamphetamine Sulfate Cap SR 24HR 15 MG | |
| | Dextroamphetamine Sulfate Tab 5 MG | |
| | Dextroamphetamine Sulfate Tab 10 MG | |
| | Lisdexamfetamine Dimesylate Cap 10 MG | |
| | Lisdexamfetamine Dimesylate Cap 20 MG | |
| | Lisdexamfetamine Dimesylate Cap 30 MG | |
| | Lisdexamfetamine Dimesylate Cap 40 MG | |
| | Lisdexamfetamine Dimesylate Cap 50 MG | |
| | Lisdexamfetamine Dimesylate Cap 60 MG | |
| | Lisdexamfetamine Dimesylate Cap 70 MG | |
| **ADHD - Stimulants - Misc** | | |
| | Armodafinil Tab 50 MG | |
| | Armodafinil Tab 150 MG | |
| | Armodafinil Tab 200 MG | |
| | Armodafinil Tab 250 MG | |
| | Dexmethylphenidate HCl Cap SR 24 HR 10 MG | |
| | Dexmethylphenidate HCl Cap SR 24 HR 15 MG | |
| | Dexmethylphenidate HCl Cap SR 24 HR 20 MG | |
| | Dexmethylphenidate HCl Cap SR 24 HR 30 MG | |
| | Methylphenidate HCl Cap CR 30 MG (CD) | |
| | Methylphenidate HCl Cap SR 24HR 10 MG (LA) | |
| | Methylphenidate HCl Cap SR 24HR 20 MG (LA) | |
| | Methylphenidate HCl Cap SR 24HR 30 MG (LA) | |
| | Methylphenidate HCl Cap SR 24HR 40 MG (LA) | |
| | Methylphenidate HCl Cap SR 24HR 60 MG (LA) | |
| | Methylphenidate HCl Tab 5 MG | |
| | Methylphenidate HCl Tab 10 MG | |
| | Methylphenidate HCl Tab 20 MG | |
| | Methylphenidate HCl Tab CR 10 MG | |
| | Methylphenidate HCl Tab CR 20 MG | |
| | Methylphenidate HCl Tab SA OSM 18 MG | |
| | Methylphenidate HCl Tab SA OSM 27 MG | |
| | Methylphenidate HCl Tab SA OSM 36 MG | |
| | Methylphenidate HCl Tab SA OSM 54 MG | |
| | Methylphenidate HCl Tab SR 24HR 18 MG | |
| | Methylphenidate HCl Tab SR 24HR 27 MG | |
| | Methylphenidate HCl Tab SR 24HR 36 MG | |

# APPENDIX TO RULE 4123-6-21.3
## Formulary List of Medications Covered by the Ohio Bureau of Workers' Compensation

| Drug Class Name | Drug Generic Name | Coverage restrictions or limitations for specific drugs or dosage forms are listed with the respective drugs below. |
|---|---|---|
| | Methylphenidate HCl Tab SR 24HR 54 MG | |
| | Modafinil Tab 100 MG | |
| | Modafinil Tab 200 MG | |
| **ADHD Agents** | | |
| | Atomoxetine HCl Cap 10 MG (Base Equiv) | |
| | Atomoxetine HCl Cap 18 MG (Base Equiv) | |
| | Atomoxetine HCl Cap 25 MG (Base Equiv) | |
| | Atomoxetine HCl Cap 40 MG (Base Equiv) | |
| | Atomoxetine HCl Cap 60 MG (Base Equiv) | |
| | Atomoxetine HCl Cap 80 MG (Base Equiv) | |
| | Atomoxetine HCl Cap 100 MG (Base Equiv) | |
| | Guanfacine HCl Tab SR 24HR 3 MG (Base Equiv) | |
| | Guanfacine HCl Tab SR 24HR 4 MG (Base Equiv) | |
| **Agents for Chemical Dependency** | | |
| | Acamprosate Calcium Tab Delayed Release 333 MG | |
| | Buprenorphine HCl SL Tab 2 MG (Base Equiv) | **Restricted to use for addiction treatment only. Claim must be allowed for addiction.** |
| | Buprenorphine HCl SL Tab 8 MG (Base Equiv) | **Restricted to use for addiction treatment only. Claim must be allowed for addiction.** |
| | Buprenorphine HCl-Naloxone HCl SL Film 2-0.5 MG (Base Equiv) | **Restricted to use for addiction treatment only. Claim must be allowed for addiction.** |
| | Buprenorphine HCl-Naloxone HCl SL Film 8-2 MG (Base Equiv) | **Restricted to use for addiction treatment only. Claim must be allowed for addiction.** |
| | Buprenorphine HCl-Naloxone HCl SL Tab 2-0.5 MG (Base Equiv) | **Restricted to use for addiction treatment only. Claim must be allowed for addiction.** |
| | Buprenorphine HCl-Naloxone HCl SL Tab 8-2 MG (Base Equiv) | **Restricted to use for addiction treatment only. Claim must be allowed for addiction.** |
| | Disulfiram Tab 250 MG | |
| | Disulfiram Tab 500 MG | |
| **Alternative Medicine** | | |
| | Glucosamine Sulfate Cap 500 MG | |
| | Glucosamine Sulfate Tab 500 MG | |
| | Glucosamine-Chondroitin Cap 500-400 MG | |
| | Glucosamine-Chondroitin Tab 500-400 MG | |
| | Glucosamine-Chondroitin Tab 750-600 MG | |
| | Lutein-Zeaxanthin Cap 6-0.24 MG | |
| | Lutein-Zeaxanthin Cap 20-0.8 MG | |
| | Lutein-Zeaxanthin Cap 20-1 MG | |
| | Lutein-Zeaxanthin Cap 25-5 MG | |
| | Lutein-Zeaxanthin Cap 45-1.8 MG | |
| | Melatonin Cap 5 MG | |
| | Melatonin Cap 10 MG | |
| | Melatonin Tab 300 MCG | |
| | Melatonin Tab 1 MG | |
| | Melatonin Tab 3 MG | |
| | Melatonin Tab 5 MG | |
| | Melatonin Tab 10 MG | |
| **Amyotrophic Lateral Sclerosis (ALS) Agents** | | |
| | Riluzole Tab 50 MG | |
| **Anabolic Steroids** | | |
| | Oxandrolone Tab 2.5 MG | |
| | Oxandrolone Tab 10 MG | |
| **Analgesic Combinations** | | |
| | Acetaminophen-Caffeine Tab 500-65 MG | |
| | Aspirin-Acetaminophen-Caffeine Tab 250-250-65 MG | |
| | Aspirin-APAP-Salicylamide-Caffeine Tab 500-250-150-32.5 MG | |
| | Aspirin-Caffeine Tab 400-32 MG | |

## APPENDIX TO RULE 4123-6-21.3
## Formulary List of Medications Covered by the Ohio Bureau of Workers' Compensation

| Drug Class Name | Drug Generic Name | Coverage restrictions or limitations for specific drugs or dosage forms are listed with the respective drugs below. |
|---|---|---|
| | Butalbital-Acetaminophen Tab 50-325 MG | **Reimbursement is restricted to combinations of Butalbital/APAP that contain 325mg of APAP.Reimbursement for this product shall not exceed 4 grams/day of APAP (12 tab) or 24 tab per calendar month and is restricted to only those claims that have the condition of headache specificed as a documented allowance in the claim.** |
| | Butalbital-Acetaminophen-Caffeine Cap 50-325-40 MG | **Reimbursement is restricted to combinations of Butalbital/caffeine/APAP that contain 325mg of APAP. Reimbursement for this product shall not exceed 4 grams/day of APAP (12 cap) or 24 cap per calendar month and is restricted to only those claims that have the condition of headache specificed as a documented allowance in the claim.** |
| | Butalbital-Acetaminophen-Caffeine Soln 50-325-40 MG/15ML | **Reimbursement is restricted to combinations of Butalbital/caffeine/APAP that contain 325mg of APAP. Reimbursement for this product shall not exceed 4 grams/day of APAP (184 ml) or 24 doses (360 ml) per calendar month and is restricted to only those claims that have the condition of headache specificed as a documented allowance in the claim.** |
| | Butalbital-Acetaminophen-Caffeine Tab 50-325-40 MG | **Reimbursement is restricted to combinations of Butalbital/caffeine/APAP that contain 325mg of APAP. Reimbursement for this product shall not exceed 4 grams/day of APAP (12 tab) or 24 tab per calendar month and is restricted to only those claims that have the condition of headache specificed as a documented allowance in the claim.** |
| | Butalbital-Aspirin-Caffeine Cap 50-325-40 MG | **Reimbursement for combinations of butalbital/aspirin/caffeine is restricted to 24 doses per calendar month and to only those claims that have the condition of headache specificed as a documented allowance in the claim.** |
| | Butalbital-Aspirin-Caffeine Tab 50-325-40 MG | **Reimbursement for combinations of butalbital/aspirin/caffeine is restricted to 24 doses per calendar month and to only those claims that have the condition of headache specificed as a documented allowance in the claim.** |
| | Meprobamate-Aspirin Tab 200-325 MG | |
| **Analgesics - Other** | | |
| | Acetaminophen Cap 500 MG | |
| | Acetaminophen Liquid 160 MG/5ML | |
| | Acetaminophen Liquid 167 MG/5ML | |
| | Acetaminophen Suppos 325 MG | |
| | Acetaminophen Suppos 650 MG | |
| | Acetaminophen Susp 160 MG/5ML | |
| | Acetaminophen Tab 325 MG | |
| | Acetaminophen Tab 500 MG | |
| **Analgesics - Peptide Channel Blockers** | | |
| | Ziconotide Acetate Intrathecal Inj 100 MCG/ML | **Requires previous approval of intrathecal pain pump.** |
| | Ziconotide Acetate Intrathecal Inj 500 MCG/20ML (25 MCG/ML) | **Requires previous approval of intrathecal pain pump.** |
| | Ziconotide Acetate Intrathecal Inj 500 MCG/5ML | **Requires previous approval of intrathecal pain pump.** |
| **Anaphylaxis Therapy Agents** | | |
| | Epinephrine Solution Auto-injector 0.15 MG/0.15ML (1:1000) | |
| | Epinephrine Solution Auto-injector 0.15 MG/0.3ML (1:2000) | |
| | Epinephrine Solution Auto-injector 0.3 MG/0.3ML (1:1000) | |
| **Androgens** | | **Coverage limited to only those claims that have allowed medical conditions involving the genitourinary or endocrine systems.** |
| | Methyltestosterone Cap 10 MG | **See Drug Class - Androgens restrictions above** |
| | Testosterone Cypionate IM Inj in Oil 100 MG/ML | **See Drug Class - Androgens restrictions above** |
| | Testosterone Cypionate IM Inj in Oil 200 MG/ML | **See Drug Class - Androgens restrictions above** |
| | Testosterone Enanthate IM Inj in Oil 200 MG/ML | **See Drug Class - Androgens restrictions above** |

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## Formulary List of Medications Covered by the Ohio Bureau of Workers' Compensation

| Drug Class Name | Drug Generic Name | Coverage restrictions or limitations for specific drugs or dosage forms are listed with the respective drugs below. |
|---|---|---|
| | Testosterone TD Gel 10MG/ACT (2%) | **See Drug Class - Androgens restrictions above** |
| | Testosterone TD Gel 12.5 MG/ACT (1%) | **See Drug Class - Androgens restrictions above** |
| | Testosterone TD Gel 20.25 MG/ACT (1.62%) | **See Drug Class - Androgens restrictions above** |
| | Testosterone TD Gel 25 MG/2.5GM (1%) | **See Drug Class - Androgens restrictions above** |
| | Testosterone TD Gel 50 MG/5GM (1%) | **See Drug Class - Androgens restrictions above** |
| | Testosterone TD Patch 24HR 2 MG/24HR | **See Drug Class - Androgens restrictions above** |
| | Testosterone TD Patch 24HR 4 MG/24HR | **See Drug Class - Androgens restrictions above** |
| | Testosterone TD Soln 30 MG/ACT | **See Drug Class - Androgens restrictions above** |
| **Antacids** | | |
| | Alum & Mag Hydroxide-Simethicone Chew Tab 200-200-20 MG | |
| | Alum & Mag Hydroxide-Simethicone Susp 200-200-20 MG/5ML | |
| | Alum & Mag Hydroxide-Simethicone Susp 400-400-40 MG/5ML | |
| | Aluminum & Magnesium Hydroxides Susp 500-500 MG/5ML | |
| | Aluminum Hydroxide-Magnesium Carbonate Chew Tab 160-105 MG | |
| | Aluminum Hydroxide-Magnesium Carbonate Susp 95-358 MG/15ML | |
| | Aluminum Hydroxide-Magnesium Trisilicate Chew Tab 80-14.2 MG | |
| | Aluminum Hydroxide-Magnesium Trisilicate Chew Tab 80-20 MG | |
| | Calcium Carbonate (Antacid) Chew Tab 500 MG | |
| | Calcium Carbonate (Antacid) Chew Tab 750 MG | |
| | Calcium Carbonate (Antacid) Chew Tab 1000 MG | |
| | Calcium Carbonate (Antacid) Tab 648 MG | |
| | Calcium Carbonate-Mag Hydroxide Chew Tab 550-110 MG | |
| | Calcium Carbonate-Mag Hydroxide Chew Tab 700-300 MG | |
| | Calcium Carbonate-Mag Hydroxide Chew Tab 1000-200 MG | |
| | Calcium Carbonate-Simethicone Chew Tab 750-80 MG | |
| | Calcium Carbonate-Simethicone Chew Tab 1000-60 MG | |
| | Magnesium Oxide Cap 140 MG (85 MG Elemental MG) | |
| | Magnesium Oxide Cap 500 MG | |
| | Magnesium Oxide Tab 400 MG | |
| | Sodium Bicarbonate Tab 325 MG | |
| | Sodium Bicarbonate Tab 650 MG | |
| | Sodium Bicarbonate-Citric Acid Effer Tab 1940-1000 MG | |
| **Anthelmintics** | | |
| | Mebendazole Chew Tab 100 MG | |
| **Antianginal Agents** | | |
| | Isosorbide Dinitrate Cap CR 40 MG | |
| | Isosorbide Dinitrate Tab 10 MG | |
| | Isosorbide Dinitrate Tab 20 MG | |
| | Isosorbide Dinitrate Tab CR 40 MG | |
| | Isosorbide Mononitrate Tab 20 MG | |
| | Isosorbide Mononitrate Tab SR 24HR 30 MG | |
| | Isosorbide Mononitrate Tab SR 24HR 60 MG | |
| | Isosorbide Mononitrate Tab SR 24HR 120 MG | |
| | Nitroglycerin Cap CR 9 MG | |
| | Nitroglycerin Oint 2% | |
| | Nitroglycerin SL Tab 0.3 MG | |
| | Nitroglycerin SL Tab 0.4 MG | |
| | Nitroglycerin TD Patch 24HR 0.1 MG/HR | |
| | Nitroglycerin TD Patch 24HR 0.2 MG/HR | |
| | Nitroglycerin TD Patch 24HR 0.3 MG/HR | |
| | Nitroglycerin TD Patch 24HR 0.4 MG/HR | |
| | Nitroglycerin TL Soln 0.4 MG/SPRAY (400 MCG/SPRAY) | |
| | Ranolazine Tab SR 12HR 500 MG | |
| | Ranolazine Tab SR 12HR 1000 MG | |

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## Formulary List of Medications Covered by the Ohio Bureau of Workers' Compensation

| Drug Class Name | Drug Generic Name | Coverage restrictions or limitations for specific drugs or dosage forms are listed with the respective drugs below. |
|---|---|---|
| **Antianxiety - Benzodiazepine** | | **Reimbursement is restricted to the maximum daily dose listed with each of the agents below. Reimbursement for all oral benzodiazepine anti-anxiety and anti-convulsant drug class agents will be limited to 60 days unless there is a psychological condition allowed in the claim.** |
| | Alprazolam Conc 1 MG/ML | **See Drug Class - Antianxiety - Benzodiazepine restrictions above. Maximum dose of four (4) milligrams per day** |
| | Alprazolam Orally Disintegrating Tab 0.25 MG | **Oral disintegrating dosage form is restricted to claims with an allowed condition that results in the inabiity to swallow or absorb oral medications. See Drug Class - Antianxiety - Benzodiazepine restrictions above. Maximum dose of four (4) milligrams per day** |
| | Alprazolam Orally Disintegrating Tab 0.5 MG | **Oral disintegrating dosage form is restricted to claims with an allowed condition that results in the inabiity to swallow or absorb oral medications. See Drug Class - Antianxiety - Benzodiazepine restrictions above. Maximum dose of four (4) milligrams per day** |
| | Alprazolam Orally Disintegrating Tab 1 MG | **Oral disintegrating dosage form is restricted to claims with an allowed condition that results in the inabiity to swallow or absorb oral medications. See Drug Class - Antianxiety - Benzodiazepine restrictions above. Maximum dose of four (4) milligrams per day** |
| | Alprazolam Orally Disintegrating Tab 2 MG | **Oral disintegrating dosage form is restricted to claims with an allowed condition that results in the inabiity to swallow or absorb oral medications. See Drug Class - Antianxiety - Benzodiazepine restrictions above. Maximum dose of four (4) milligrams per day** |
| | Alprazolam Tab 0.25 MG | **See Drug Class - Antianxiety - Benzodiazepine restrictions above. Maximum dose of four (4) milligrams per day** |
| | Alprazolam Tab 0.5 MG | **See Drug Class - Antianxiety - Benzodiazepine restrictions above. Maximum dose of four (4) milligrams per day** |
| | Alprazolam Tab 1 MG | **See Drug Class - Antianxiety - Benzodiazepine restrictions above. Maximum dose of four (4) milligrams per day** |
| | Alprazolam Tab 2 MG | **See Drug Class - Antianxiety - Benzodiazepine restrictions above. Maximum dose of four (4) milligrams per day** |
| | Alprazolam Tab SR 24HR 0.5 MG | **See Drug Class - Antianxiety - Benzodiazepine restrictions above. Maximum dose of four (4) milligrams per day** |
| | Alprazolam Tab SR 24HR 1 MG | **See Drug Class - Antianxiety - Benzodiazepine restrictions above. Maximum dose of four (4) milligrams per day** |
| | Alprazolam Tab SR 24HR 2 MG | **See Drug Class - Antianxiety - Benzodiazepine restrictions above. Maximum dose of four (4) milligrams per day** |
| | Alprazolam Tab SR 24HR 3 MG | **See Drug Class - Antianxiety - Benzodiazepine restrictions above. Maximum dose of four (4) milligrams per day** |
| | Chlordiazepoxide HCl Cap 5 MG | **See Drug Class - Antianxiety - Benzodiazepine restrictions above. Maximum dose of two hundred (200) milligrams per day** |
| | Chlordiazepoxide HCl Cap 10 MG | **See Drug Class - Antianxiety - Benzodiazepine restrictions above. Maximum dose of two hundred (200) milligrams per day** |
| | Chlordiazepoxide HCl Cap 25 MG | **See Drug Class - Antianxiety - Benzodiazepine restrictions above. Maximum dose of two hundred (200) milligrams per day** |
| | Clorazepate Dipotassium Tab 3.75 MG | **See Drug Class - Antianxiety - Benzodiazepine restrictions above. Maximum dose of eighty (80) milligrams per day** |

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|---|---|---|
| | Clorazepate Dipotassium Tab 7.5 MG | **See Drug Class - Antianxiety - Benzodiazepine restrictions above. Maximum dose of eighty (80) milligrams per day** |
| | Clorazepate Dipotassium Tab 15 MG | **See Drug Class - Antianxiety - Benzodiazepine restrictions above. Maximum dose of eighty (80) milligrams per day** |
| | Diazepam Conc 5 MG/ML | **See Drug Class - Antianxiety - Benzodiazepine restrictions above. Maximum dose of forty (40) milligrams per day** |
| | Diazepam Oral Soln 1 MG/ML | **See Drug Class - Antianxiety - Benzodiazepine restrictions above. Maximum dose of forty (40) milligrams per day** |
| | Diazepam Tab 2 MG | **See Drug Class - Antianxiety - Benzodiazepine restrictions above. Maximum dose of forty (40) milligrams per day** |
| | Diazepam Tab 5 MG | **See Drug Class - Antianxiety - Benzodiazepine restrictions above. Maximum dose of forty (40) milligrams per day** |
| | Diazepam Tab 10 MG | **See Drug Class - Antianxiety - Benzodiazepine restrictions above. Maximum dose of forty (40) milligrams per day** |
| | Lorazepam Conc 2 MG/ML | **See Drug Class - Antianxiety - Benzodiazepine restrictions above. Maximum dose of eight (8) milligrams per day** |
| | Lorazepam Tab 0.5 MG | **See Drug Class - Antianxiety - Benzodiazepine restrictions above. Maximum dose of eight (8) milligrams per day** |
| | Lorazepam Tab 1 MG | **See Drug Class - Antianxiety - Benzodiazepine restrictions above. Maximum dose of eight (8) milligrams per day** |
| | Lorazepam Tab 2 MG | **See Drug Class - Antianxiety - Benzodiazepine restrictions above. Maximum dose of eight (8) milligrams per day** |
| | Oxazepam Cap 10 MG | **See Drug Class - Antianxiety - Benzodiazepine restrictions above. Maximum dose of one hundred eighty (180) milligrams per day** |
| | Oxazepam Cap 15 MG | **See Drug Class - Antianxiety - Benzodiazepine restrictions above. Maximum dose of one hundred eighty (180) milligrams per day** |
| | Oxazepam Cap 30 MG | **See Drug Class - Antianxiety - Benzodiazepine restrictions above. Maximum dose of one hundred eighty (180) milligrams per day** |
| **Antianxiety Agents - Misc** | | |
| | Buspirone HCl Tab 5 MG | |
| | Buspirone HCl Tab 7.5 MG | |
| | Buspirone HCl Tab 10 MG | |
| | Buspirone HCl Tab 15 MG | |
| | Buspirone HCl Tab 30 MG | |
| | Hydroxyzine HCl Syrup 10 MG/5ML | |
| | Hydroxyzine HCl Tab 10 MG | |
| | Hydroxyzine HCl Tab 25 MG | |
| | Hydroxyzine HCl Tab 50 MG | |
| | Hydroxyzine Pamoate Cap 25 MG | |
| | Hydroxyzine Pamoate Cap 50 MG | |
| | Hydroxyzine Pamoate Cap 100 MG | |
| | Meprobamate Tab 200 MG | |
| | Meprobamate Tab 400 MG | |
| **Antiarrhythmics** | | |
| | Amiodarone HCl Tab 200 MG | |
| | Amiodarone HCl Tab 400 MG | |
| | Dofetilide Cap 125 MCG (0.125 MG) | |
| | Dofetilide Cap 250 MCG (0.25 MG) | |
| | Dofetilide Cap 500 MCG (0.5 MG) | |
| | Dronedarone HCl Tab 400 MG (Base Equivalent) | |
| | Flecainide Acetate Tab 50 MG | |
| | Flecainide Acetate Tab 100 MG | |
| | Flecainide Acetate Tab 150 MG | |
| | Mexiletine HCl Cap 150 MG | |
| | Mexiletine HCl Cap 200 MG | |

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| Drug Class Name | Drug Generic Name | Coverage restrictions or limitations for specific drugs or dosage forms are listed with the respective drugs below. |
|---|---|---|
| | Propafenone HCl Cap SR 12HR 225 MG | |
| | Propafenone HCl Cap SR 12HR 325 MG | |
| | Propafenone HCl Cap SR 12HR 425 MG | |
| | Propafenone HCl Tab 150 MG | |
| | Propafenone HCl Tab 225 MG | |
| | Propafenone HCl Tab 300 MG | |
| | Quinidine Gluconate Tab CR 324 MG | |
| | Quinidine Sulfate Tab CR 300 MG | |
| **Antibiotic - Aminoglycosides** | | |
| | Neomycin Sulfate Tab 500 MG | |
| | Tobramycin Inhal Cap 28 MG | |
| | Tobramycin Nebu Soln 300 MG/4ML | |
| | Tobramycin Nebu Soln 300 MG/5ML | |
| **Antibiotic - Cephalosporins - 1st Generation** | | |
| | Cefadroxil Cap 500 MG | |
| | Cefadroxil For Susp 500 MG/5ML | |
| | Cefadroxil Tab 1 GM | |
| | Cephalexin Cap 250 MG | |
| | Cephalexin Cap 500 MG | |
| | Cephalexin Cap 750 MG | |
| | Cephalexin For Susp 250 MG/5ML | |
| **Antibiotic - Cephalosporins - 2nd Generation** | | |
| | Cefaclor Cap 250 MG | |
| | Cefaclor Cap 500 MG | |
| | Cefprozil Tab 250 MG | |
| | Cefprozil Tab 500 MG | |
| | Cefuroxime Axetil For Susp 250 MG/5ML | |
| | Cefuroxime Axetil Tab 250 MG | |
| | Cefuroxime Axetil Tab 500 MG | |
| **Antibiotic - Cephalosporins - 3rd Generation** | | |
| | Cefdinir Cap 300 MG | |
| | Cefdinir For Susp 250 MG/5ML | |
| | Cefditoren Pivoxil Tab 200 MG (Base Equivalent) | |
| | Cefditoren Pivoxil Tab 400 MG (Base Equivalent) | |
| | Cefixime Cap 400 MG | |
| | Cefixime For Susp 500 MG/5ML | |
| | Cefixime Tab 400 MG | |
| | Cefpodoxime Proxetil Tab 100 MG | |
| | Cefpodoxime Proxetil Tab 200 MG | |
| | Ceftibuten Cap 400 MG | |
| | Ceftibuten For Susp 180 MG/5ML | |
| **Antibiotic - Fluoroquinolones** | | |
| | Ciprofloxacin For Oral Susp 500 MG/5ML (10%) (10 GM/100ML) | |
| | Ciprofloxacin HCl Tab 250 MG (Base Equiv) | |
| | Ciprofloxacin HCl Tab 500 MG (Base Equiv) | |
| | Ciprofloxacin HCl Tab 750 MG (Base Equiv) | |
| | Ciprofloxacin-Ciprofloxacin HCl Tab SR 24HR 500 MG (Base Eq) | |
| | Ciprofloxacin-Ciprofloxacin HCl Tab SR 24HR 1000 MG(Base Eq) | |
| | Gemifloxacin Mesylate Tab 320 MG (Base Equiv) | |
| | Levofloxacin Tab 250 MG | |
| | Levofloxacin Tab 500 MG | |
| | Levofloxacin Tab 750 MG | |
| | Moxifloxacin HCl Tab 400 MG (Base Equiv) | |
| | Norfloxacin Tab 400 MG | |
| | Ofloxacin Tab 300 MG | |
| | Ofloxacin Tab 400 MG | |
| **Antibiotic - Macrolides** | | |

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| Drug Class Name | Drug Generic Name | Coverage restrictions or limitations for specific drugs or dosage forms are listed with the respective drugs below. |
|---|---|---|
| | Azithromycin Extended Release For Oral Susp 2 GM | |
| | Azithromycin For Susp 100 MG/5ML | |
| | Azithromycin For Susp 200 MG/5ML | |
| | Azithromycin Powd Pack for Susp 1 GM | |
| | Azithromycin Tab 250 MG | |
| | Azithromycin Tab 500 MG | |
| | Clarithromycin Tab 250 MG | |
| | Clarithromycin Tab 500 MG | |
| | Clarithromycin Tab SR 24HR 500 MG | |
| | Erythromycin Ethylsuccinate For Susp 200 MG/5ML | |
| | Erythromycin Ethylsuccinate Tab 400 MG | |
| | Erythromycin Stearate Tab 250 MG | |
| | Erythromycin Tab 250 MG | |
| | Erythromycin Tab 500 MG | |
| | Erythromycin Tab Delayed Release 250 MG | |
| | Erythromycin Tab Delayed Release 333 MG | |
| | Erythromycin Tab Delayed Release 500 MG | |
| | Erythromycin w/ Delayed Release Particles Cap 250 MG | |
| **Antibiotic - Penicillins** | | |
| | Amoxicillin & K Clavulanate Chew Tab 400-57 MG | |
| | Amoxicillin & K Clavulanate For Susp 250-62.5 MG/5ML | |
| | Amoxicillin & K Clavulanate For Susp 400-57 MG/5ML | |
| | Amoxicillin & K Clavulanate For Susp 600-42.9 MG/5ML | |
| | Amoxicillin & K Clavulanate Tab 250-125 MG | |
| | Amoxicillin & K Clavulanate Tab 500-125 MG | |
| | Amoxicillin & K Clavulanate Tab 875-125 MG | |
| | Amoxicillin & K Clavulanate Tab SR 12HR 1000-62.5 MG | |
| | Amoxicillin (Trihydrate) Cap 250 MG | |
| | Amoxicillin (Trihydrate) Cap 500 MG | |
| | Amoxicillin (Trihydrate) Chew Tab 250 MG | |
| | Amoxicillin (Trihydrate) For Susp 250 MG/5ML | |
| | Amoxicillin (Trihydrate) For Susp 400 MG/5ML | |
| | Amoxicillin (Trihydrate) Tab 500 MG | |
| | Amoxicillin (Trihydrate) Tab 875 MG | |
| | Amoxicillin (Trihydrate) Tab SR 24HR 775 MG | |
| | Ampicillin Cap 250 MG | |
| | Ampicillin Cap 500 MG | |
| | Ampicillin For Susp 250 MG/5ML | |
| | Dicloxacillin Sodium Cap 250 MG | |
| | Dicloxacillin Sodium Cap 500 MG | |
| | Penicillin V Potassium For Soln 250 MG/5ML | |
| | Penicillin V Potassium Tab 250 MG | |
| | Penicillin V Potassium Tab 500 MG | |
| **Antibiotic -Tetracyclines** | | |
| | Demeclocycline HCl Tab 150 MG | |
| | Demeclocycline HCl Tab 300 MG | |
| | Doxycycline Calcium Syrup 50 MG/5ML | |
| | Doxycycline Hyclate Cap 50 MG | |
| | Doxycycline Hyclate Cap 100 MG | |
| | Doxycycline Hyclate Tab 20 MG | |
| | Doxycycline Hyclate Tab 100 MG | |
| | Doxycycline Hyclate Tab Delayed Release 50 MG | |
| | Doxycycline Hyclate Tab Delayed Release 75 MG | |
| | Doxycycline Hyclate Tab Delayed Release 100 MG | |
| | Doxycycline Hyclate Tab Delayed Release 150 MG | |
| | Doxycycline Hyclate Tab Delayed Release 200 MG | |
| | Doxycycline Monohydrate Cap 50 MG | |

## APPENDIX TO RULE 4123-6-21.3
## Formulary List of Medications Covered by the Ohio Bureau of Workers' Compensation

| Drug Class Name | Drug Generic Name | Coverage restrictions or limitations for specific drugs or dosage forms are listed with the respective drugs below. |
|---|---|---|
| | Doxycycline Monohydrate Cap 100 MG | |
| | Doxycycline Monohydrate Tab 50 MG | |
| | Doxycycline Monohydrate Tab 100 MG | |
| | Doxycycline Monohydrate Tab 150 MG | |
| | Minocycline HCl Cap 50 MG | |
| | Minocycline HCl Cap 75 MG | |
| | Minocycline HCl Cap 100 MG | |
| | Minocycline HCl Tab 100 MG | |
| | Minocycline HCl Tab SR 24HR 90 MG | |
| | Tetracycline HCl Cap 250 MG | |
| | Tetracycline HCl Cap 500 MG | |
| **Anti-Cataplectic Agents** | | |
| | Sodium Oxybate Oral Solution 500 MG/ML | |
| **Anticoagulants - Coumarin Anticoagulants** | | |
| | Warfarin Sodium Tab 1 MG | |
| | Warfarin Sodium Tab 2 MG | |
| | Warfarin Sodium Tab 2.5 MG | |
| | Warfarin Sodium Tab 3 MG | |
| | Warfarin Sodium Tab 4 MG | |
| | Warfarin Sodium Tab 5 MG | |
| | Warfarin Sodium Tab 6 MG | |
| | Warfarin Sodium Tab 7.5 MG | |
| | Warfarin Sodium Tab 10 MG | |
| **Anticoagulants - Direct Factor Xa Inhibitors** | | |
| | Apixaban Tab 2.5 MG | |
| | Apixaban Tab 5 MG | |
| | Edoxaban Tosylate Tab 15 MG (Base Equivalent) | |
| | Edoxaban Tosylate Tab 30 MG (Base Equivalent) | |
| | Edoxaban Tosylate Tab 60 MG (Base Equivalent) | |
| | Rivaroxaban Tab 10 MG | |
| | Rivaroxaban Tab 15 MG | |
| | Rivaroxaban Tab 20 MG | |
| | Rivaroxaban Tab Starter Therapy Pack 15 MG & 20 MG | |
| **Anticoagulants - Heparins and Heparinoid-Like Agents** | | |
| | Dalteparin Sodium Inj 2500 Unit/0.2ML | |
| | Dalteparin Sodium Inj 5000 Unit/0.2ML | |
| | Dalteparin Sodium Inj 7500 Unit/0.3ML | |
| | Dalteparin Sodium Inj 10000 Unit/ML | |
| | Dalteparin Sodium Inj 12500 Unit/0.5ML | |
| | Dalteparin Sodium Inj 15000 Unit/0.6ML | |
| | Dalteparin Sodium Inj 18000 Unit/0.72ML | |
| | Dalteparin Sodium Inj 25000 Unit/ML | |
| | Enoxaparin Sodium Inj 30 MG/0.3ML | |
| | Enoxaparin Sodium Inj 40 MG/0.4ML | |
| | Enoxaparin Sodium Inj 60 MG/0.6ML | |
| | Enoxaparin Sodium Inj 80 MG/0.8ML | |
| | Enoxaparin Sodium Inj 100 MG/ML | |
| | Enoxaparin Sodium Inj 120 MG/0.8ML | |
| | Enoxaparin Sodium Inj 150 MG/ML | |
| | Enoxaparin Sodium Inj 300 MG/3ML | |
| | Fondaparinux Sodium Subcutaneous Inj 2.5 MG/0.5ML | |
| | Fondaparinux Sodium Subcutaneous Inj 5 MG/0.4ML | |
| | Fondaparinux Sodium Subcutaneous Inj 7.5 MG/0.6ML | |
| | Fondaparinux Sodium Subcutaneous Inj 10 MG/0.8ML | |
| | Heparin Sodium (Porcine) Inj 5000 Unit/ML | |
| | Heparin Sodium (Porcine) PF Inj 5000 Unit/0.5ML | |

# APPENDIX TO RULE 4123-6-21.3
## Formulary List of Medications Covered by the Ohio Bureau of Workers' Compensation

| Drug Class Name | Drug Generic Name | Coverage restrictions or limitations for specific drugs or dosage forms are listed with the respective drugs below. |
|---|---|---|
| | Heparin Sodium (Porcine) Inj 10000 Unit/ML | |
| | Heparin Sodium (Porcine) Inj 20000 Unit/ML | |
| **Anticoagulants - Thrombin Inhibitors** | | |
| | Dabigatran Etexilate Mesylate Cap 75 MG (Etexilate Base Eq) | |
| | Dabigatran Etexilate Mesylate Cap 110 MG (Etexilate Base Eq) | |
| | Dabigatran Etexilate Mesylate Cap 150 MG (Etexilate Base Eq) | |
| **Anticonvulsants - Benzodiazepines** | | |
| | Clonazepam Products | **Benzodiazepine drug class restrictions apply. Maximum dose of four (4) milligrams per day. Reimbursement for all benzodiazepine anti-anxiety and anti-convulsant drug class agents will be limited to 60 days unless there is a psychological condition allowed in the claim.** |
| | Clonazepam Orally Disintegrating Tab 0.125 MG | **See Clonazepam Products restrictions above. Oral disintegrating dosage form is restricted to claims with an allowed condition that results in the inabiity to swallow or absorb oral medications. Maximum dose of 4 milligrams per day.** |
| | Clonazepam Orally Disintegrating Tab 0.25 MG | **See Clonazepam Products restrictions above. Oral disintegrating dosage form is restricted to claims with an allowed condition that results in the inabiity to swallow or absorb oral medications. Maximum dose of 4 milligrams per day.** |
| | Clonazepam Orally Disintegrating Tab 0.5 MG | **See Clonazepam Products restrictions above. Oral disintegrating dosage form is restricted to claims with an allowed condition that results in the inabiity to swallow or absorb oral medications. Maximum dose of 4 milligrams per day.** |
| | Clonazepam Orally Disintegrating Tab 1 MG | **See Clonazepam Products restrictions above. Oral disintegrating dosage form is restricted to claims with an allowed condition that results in the inabiity to swallow or absorb oral medications. Maximum dose of 4 milligrams per day.** |
| | Clonazepam Orally Disintegrating Tab 2 MG | **See Clonazepam Products restrictions above. Oral disintegrating dosage form is restricted to claims with an allowed condition that results in the inabiity to swallow or absorb oral medications.Maximum dose of 4 milligrams per day.** |
| | Clonazepam Tab 0.5 MG | **See Clonazepam Products restrictions above. Maximum dose of 4 milligrams per day.** |
| | Clonazepam Tab 1 MG | **See Clonazepam Products restrictions above. Maximum dose of 4 milligrams per day.** |
| | Clonazepam Tab 2 MG | **See Clonazepam Products restrictions above. Maximum dose of 4 milligrams per day.** |
| | Diazepam Rectal Gel Delivery System 10 MG | |
| | Diazepam Rectal Gel Delivery System 20 MG | |
| **Anticonvulsants - Carbamates** | | |
| | Felbamate Tab 600 MG | |
| **Anticonvulsants - GABA Modulators** | | |
| | Tiagabine HCl Tab 2 MG | |
| | Tiagabine HCl Tab 4 MG | |
| | Tiagabine HCl Tab 12 MG | |
| | Tiagabine HCl Tab 16 MG | |
| **Anticonvulsants - Hydantoins** | | |
| | Phenytoin Chew Tab 50 MG | |
| | Phenytoin Sodium Extended Cap 30 MG | |
| | Phenytoin Sodium Extended Cap 100 MG | |
| | Phenytoin Sodium Extended Cap 200 MG | |
| | Phenytoin Sodium Extended Cap 300 MG | |
| | Phenytoin Susp 125 MG/5ML | |
| **Anticonvulsants - Misc** | | |

## APPENDIX TO RULE 4123-6-21.3
## Formulary List of Medications Covered by the Ohio Bureau of Workers' Compensation

| Drug Class Name | Drug Generic Name | Coverage restrictions or limitations for specific drugs or dosage forms are listed with the respective drugs below. |
|---|---|---|
| | Carbamazepine Cap SR 12HR 100 MG | |
| | Carbamazepine Cap SR 12HR 200 MG | |
| | Carbamazepine Cap SR 12HR 300 MG | |
| | Carbamazepine Chew Tab 100 MG | |
| | Carbamazepine Susp 100 MG/5ML | |
| | Carbamazepine Tab 200 MG | |
| | Carbamazepine Tab SR 12HR 100 MG | |
| | Carbamazepine Tab SR 12HR 200 MG | |
| | Carbamazepine Tab SR 12HR 400 MG | |
| | Gabapentin Cap 100 MG | |
| | Gabapentin Cap 300 MG | |
| | Gabapentin Cap 400 MG | |
| | Gabapentin Oral Soln 250 MG/5ML | |
| | Gabapentin Tab 600 MG | |
| | Gabapentin Tab 800 MG | |
| | Lacosamide Tab 50 MG | |
| | Lacosamide Tab 100 MG | |
| | Lacosamide Tab 150 MG | |
| | Lacosamide Tab 200 MG | |
| | Lamotrigine Orally Disintegrating Tab Products | **Oral disintegrating dosage form is restricted to claims with an allowed condition that results in the inabiity to swallow or absorb oral medications** |
| | Lamotrigine Orally Disintegrating Tab 25 MG | **See Lamotrigine ODT Products restrictions above** |
| | Lamotrigine Orally Disintegrating Tab 50 MG | **See Lamotrigine ODT Products restrictions above** |
| | Lamotrigine Orally Disintegrating Tab 100 MG | **See Lamotrigine ODT Products restrictions above** |
| | Lamotrigine Orally Disintegrating Tab 200 MG | **See Lamotrigine ODT Products restrictions above** |
| | Lamotrigine Tab 25 MG | |
| | Lamotrigine Tab 100 MG | |
| | Lamotrigine Tab 150 MG | |
| | Lamotrigine Tab 200 MG | |
| | Lamotrigine Tab 25 MG (35) Starter Kit | |
| | Lamotrigine Tab 25 MG (42) & 100 MG (7) Starter Kit | |
| | Lamotrigine Tab 25 MG (84) & 100 MG (14) Starter Kit | |
| | Lamotrigine Tab SR 24HR 50 MG | |
| | Lamotrigine Tab SR 24HR 100 MG | |
| | Lamotrigine Tab SR 24HR 200 MG | |
| | Lamotrigine Tab SR 24HR 250 MG | |
| | Lamotrigine Tab SR 24HR 25 (14) & 50 MG (14) & 100 MG(7) Kit | |
| | Levetiracetam Oral Soln 100 MG/ML | |
| | Levetiracetam Tab 250 MG | |
| | Levetiracetam Tab 500 MG | |
| | Levetiracetam Tab 750 MG | |
| | Levetiracetam Tab 1000 MG | |
| | Levetiracetam Tab SR 24HR 500 MG | |
| | Levetiracetam Tab SR 24HR 750 MG | |
| | Oxcarbazepine Tab 150 MG | |
| | Oxcarbazepine Tab 300 MG | |
| | Oxcarbazepine Tab 600 MG | |
| | Pregabalin Cap 25 MG | |
| | Pregabalin Cap 50 MG | |
| | Pregabalin Cap 75 MG | |
| | Pregabalin Cap 100 MG | |
| | Pregabalin Cap 150 MG | |
| | Pregabalin Cap 200 MG | |
| | Pregabalin Cap 225 MG | |
| | Pregabalin Cap 300 MG | |
| | Primidone Tab 50 MG | |
| | Primidone Tab 250 MG | |

## APPENDIX TO RULE 4123-6-21.3
## Formulary List of Medications Covered by the Ohio Bureau of Workers' Compensation

| Drug Class Name | Drug Generic Name | Coverage restrictions or limitations for specific drugs or dosage forms are listed with the respective drugs below. |
|---|---|---|
| | Topiramate Sprinkle Cap 15 MG | |
| | Topiramate Sprinkle Cap 25 MG | |
| | Topiramate Tab 25 MG | |
| | Topiramate Tab 50 MG | |
| | Topiramate Tab 100 MG | |
| | Topiramate Tab 200 MG | |
| | Zonisamide Cap 25 MG | |
| | Zonisamide Cap 50 MG | |
| | Zonisamide Cap 100 MG | |
| **Anticonvulsants - Succinimides** | | |
| | Ethosuximide Cap 250 MG | |
| **Anticonvulsants - Valproic Acid** | | |
| | Divalproex Sodium Cap Delayed Release Sprinkle 125 MG | |
| | Divalproex Sodium Tab Delayed Release 125 MG | |
| | Divalproex Sodium Tab Delayed Release 250 MG | |
| | Divalproex Sodium Tab Delayed Release 500 MG | |
| | Divalproex Sodium Tab SR 24 HR 250 MG | |
| | Divalproex Sodium Tab SR 24 HR 500 MG | |
| | Valproate Sodium Syrup 250 MG/5ML (Base Equiv) | |
| | Valproic Acid Cap 250 MG | |
| | Valproic Acid Cap Delayed Release 250 MG | |
| | Valproic Acid Cap Delayed Release 500 MG | |
| **Antidementia Agents** | | |
| | Donepezil Hydrochloride Tab 5 MG | |
| | Donepezil Hydrochloride Tab 10 MG | |
| | Donepezil Hydrochloride Tab 23 MG | |
| | Galantamine Hydrobromide Cap SR 24HR 8 MG | |
| | Galantamine Hydrobromide Cap SR 24HR 16 MG | |
| | Galantamine Hydrobromide Tab 4 MG | |
| | Galantamine Hydrobromide Tab 8 MG | |
| | Galantamine Hydrobromide Tab 12 MG | |
| | Memantine HCl Cap SR 24HR 7 MG | |
| | Memantine HCl Cap SR 24HR 14 MG | |
| | Memantine HCl Cap SR 24HR 21 MG | |
| | Memantine HCl Cap SR 24HR 28 MG | |
| | Memantine HCl Cap SR 24HR 7 MG & 14 MG & 21 MG & 28 MG Pack | |
| | Memantine HCl Tab 5 MG | |
| | Memantine HCl Tab 10 MG | |
| | Memantine HCl Tab 5 MG (28) & 10 MG (21) Titration Pak | |
| | Rivastigmine Tartrate Cap 3 MG | |
| | Rivastigmine Tartrate Cap 4.5 MG | |
| | Rivastigmine Tartrate Cap 6 MG | |
| | Rivastigmine TD Patch 24HR 4.6 MG/24HR | |
| | Rivastigmine TD Patch 24HR 9.5 MG/24HR | |
| **Antidepressants - Alpha-2 Receptor Antagonists (Tetracyclics)** | | |
| | Mirtazapine Orally Disintegrating Tab Products | **Oral disintegrating dosage form is restricted to claims with an allowed condition that results in the inabiity to swallow or absorb oral medications** |
| | Mirtazapine Orally Disintegrating Tab 15 MG | **See Mirtazapine ODT Products restrictions above** |
| | Mirtazapine Orally Disintegrating Tab 30 MG | **See Mirtazapine ODT Products restrictions above** |
| | Mirtazapine Orally Disintegrating Tab 45 MG | **See Mirtazapine ODT Products restrictions above** |
| | Mirtazapine Tab 7.5 MG | |
| | Mirtazapine Tab 15 MG | |
| | Mirtazapine Tab 30 MG | |

## APPENDIX TO RULE 4123-6-21.3
## Formulary List of Medications Covered by the Ohio Bureau of Workers' Compensation

| Drug Class Name | Drug Generic Name | Coverage restrictions or limitations for specific drugs or dosage forms are listed with the respective drugs below. |
|---|---|---|
| | Mirtazapine Tab 45 MG | |
| **Antidepressants - Misc** | | |
| | Bupropion HCl Tab 75 MG | |
| | Bupropion HCl Tab 100 MG | |
| | Bupropion HCl Tab SR 12HR 100 MG | |
| | Bupropion HCl Tab SR 12HR 150 MG | |
| | Bupropion HCl Tab SR 12HR 200 MG | |
| | Bupropion HCl Tab SR 24HR 150 MG | |
| | Bupropion HCl Tab SR 24HR 300 MG | |
| | Maprotiline HCl Tab 25 MG | |
| | Maprotiline HCl Tab 50 MG | |
| | Maprotiline HCl Tab 75 MG | |
| **Antidepressants - Monoamine Oxidase Inhibitors (MAOIs)** | | |
| | Phenelzine Sulfate Tab 15 MG | |
| | Selegiline TD Patch 24HR 6 MG/24HR | |
| | Selegiline TD Patch 24HR 9 MG/24HR | |
| | Selegiline TD Patch 24HR 12 MG/24HR | |
| | Tranylcypromine Sulfate Tab 10 MG | |
| **Antidepressants - Selective Serotonin Reuptake Inhibitors (SSRIs)** | | |
| | Citalopram Hydrobromide Oral Soln 10 MG/5ML | |
| | Citalopram Hydrobromide Tab 10 MG (Base Equiv) | |
| | Citalopram Hydrobromide Tab 20 MG (Base Equiv) | |
| | Citalopram Hydrobromide Tab 40 MG (Base Equiv) | |
| | Escitalopram Oxalate Soln 5 MG/5ML (Base Equiv) | |
| | Escitalopram Oxalate Tab 5 MG (Base Equiv) | |
| | Escitalopram Oxalate Tab 10 MG (Base Equiv) | |
| | Escitalopram Oxalate Tab 20 MG (Base Equiv) | |
| | Fluoxetine HCl Cap 10 MG | |
| | Fluoxetine HCl Cap 20 MG | |
| | Fluoxetine HCl Cap 40 MG | |
| | Fluoxetine HCl Cap Delayed Release 90 MG | |
| | Fluoxetine HCl Solution 20 MG/5ML | |
| | Fluoxetine HCl Tab 10 MG | |
| | Fluoxetine HCl Tab 20 MG | |
| | Fluvoxamine Maleate Cap SR 24HR 100 MG | |
| | Fluvoxamine Maleate Cap SR 24HR 150 MG | |
| | Fluvoxamine Maleate Tab 25 MG | |
| | Fluvoxamine Maleate Tab 50 MG | |
| | Fluvoxamine Maleate Tab 100 MG | |
| | Paroxetine HCl Oral Susp 10 MG/5ML (Base Equiv) | |
| | Paroxetine HCl Tab 10 MG | |
| | Paroxetine HCl Tab 20 MG | |
| | Paroxetine HCl Tab 30 MG | |
| | Paroxetine HCl Tab 40 MG | |
| | Paroxetine HCl Tab SR 24HR 12.5 MG | |
| | Paroxetine HCl Tab SR 24HR 25 MG | |
| | Paroxetine HCl Tab SR 24HR 37.5 MG | |
| | Paroxetine Mesylate Tab 10 MG (Base Equiv) | |
| | Paroxetine Mesylate Tab 20 MG (Base Equiv) | |
| | Paroxetine Mesylate Tab 30 MG (Base Equiv) | |
| | Paroxetine Mesylate Tab 40 MG (Base Equiv) | |
| | Sertraline HCl Oral Conc 20 MG/ML | |
| | Sertraline HCl Tab 25 MG | |
| | Sertraline HCl Tab 50 MG | |
| | Sertraline HCl Tab 100 MG | |

## APPENDIX TO RULE 4123-6-21.3
## Formulary List of Medications Covered by the Ohio Bureau of Workers' Compensation

| Drug Class Name | Drug Generic Name | Coverage restrictions or limitations for specific drugs or dosage forms are listed with the respective drugs below. |
|---|---|---|
| **Antidepressants - Serotonin Modulators** | | |
| | Nefazodone HCl Tab 50 MG | |
| | Nefazodone HCl Tab 100 MG | |
| | Nefazodone HCl Tab 150 MG | |
| | Nefazodone HCl Tab 200 MG | |
| | Nefazodone HCl Tab 250 MG | |
| | Trazodone HCl Tab 50 MG | |
| | Trazodone HCl Tab 100 MG | |
| | Trazodone HCl Tab 150 MG | |
| | Trazodone HCl Tab 300 MG | |
| | Trazodone HCl Tab SR 24HR 150 MG | |
| | Trazodone HCl Tab SR 24HR 300 MG | |
| | Vilazodone HCl Tab 10 MG | |
| | Vilazodone HCl Tab 20 MG | |
| | Vilazodone HCl Tab 40 MG | |
| | Vilazodone HCl Tab Starter Kit 10 (7) & 20 (23) MG | |
| | Vilazodone HCl Tab Starter Kit 10 (7) & 20 (7) & 40 (16) MG | |
| **Antidepressants - Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)** | | |
| | Desvenlafaxine Fumarate Tab SR 24HR 50 MG (Base Equiv) | |
| | Desvenlafaxine Fumarate Tab SR 24HR 100 MG (Base Equiv) | |
| | Desvenlafaxine Succinate Tab SR 24HR 25 MG (Base Equiv) | |
| | Desvenlafaxine Succinate Tab SR 24HR 50 MG (Base Equiv) | |
| | Desvenlafaxine Succinate Tab SR 24HR 100 MG (Base Equiv) | |
| | Desvenlafaxine Tab SR 24HR 50 MG | |
| | Desvenlafaxine Tab SR 24HR 100 MG | |
| | Duloxetine HCl Enteric Coated Pellets Cap 20 MG | |
| | Duloxetine HCl Enteric Coated Pellets Cap 30 MG | |
| | Duloxetine HCl Enteric Coated Pellets Cap 60 MG | |
| | Venlafaxine HCl Cap SR 24HR 37.5 MG (Base Equivalent) | |
| | Venlafaxine HCl Cap SR 24HR 75 MG (Base Equivalent) | |
| | Venlafaxine HCl Cap SR 24HR 150 MG (Base Equivalent) | |
| | Venlafaxine HCl Tab 25 MG | |
| | Venlafaxine HCl Tab 37.5 MG | |
| | Venlafaxine HCl Tab 50 MG | |
| | Venlafaxine HCl Tab 75 MG | |
| | Venlafaxine HCl Tab 100 MG | |
| | Venlafaxine HCl Tab SR 24HR 37.5 MG (Base Equivalent) | |
| | Venlafaxine HCl Tab SR 24HR 75 MG (Base Equivalent) | |
| | Venlafaxine HCl Tab SR 24HR 150 MG (Base Equivalent) | |
| | Venlafaxine HCl Tab SR 24HR 225 MG (Base Equivalent) | |
| **Antidepressants - Tricyclic Agents** | | |
| | Amitriptyline HCl Tab 10 MG | |
| | Amitriptyline HCl Tab 25 MG | |
| | Amitriptyline HCl Tab 50 MG | |
| | Amitriptyline HCl Tab 75 MG | |
| | Amitriptyline HCl Tab 100 MG | |
| | Amitriptyline HCl Tab 150 MG | |
| | Amoxapine Tab 25 MG | |
| | Amoxapine Tab 50 MG | |
| | Amoxapine Tab 100 MG | |
| | Amoxapine Tab 150 MG | |
| | Clomipramine HCl Cap 25 MG | |
| | Clomipramine HCl Cap 50 MG | |
| | Clomipramine HCl Cap 75 MG | |
| | Desipramine HCl Tab 10 MG | |
| | Desipramine HCl Tab 25 MG | |

## APPENDIX TO RULE 4123-6-21.3
## Formulary List of Medications Covered by the Ohio Bureau of Workers' Compensation

| Drug Class Name | Drug Generic Name | Coverage restrictions or limitations for specific drugs or dosage forms are listed with the respective drugs below. |
|---|---|---|
| | Desipramine HCl Tab 50 MG | |
| | Desipramine HCl Tab 75 MG | |
| | Desipramine HCl Tab 100 MG | |
| | Desipramine HCl Tab 150 MG | |
| | Doxepin HCl Cap 10 MG | |
| | Doxepin HCl Cap 25 MG | |
| | Doxepin HCl Cap 50 MG | |
| | Doxepin HCl Cap 75 MG | |
| | Doxepin HCl Cap 100 MG | |
| | Doxepin HCl Cap 150 MG | |
| | Doxepin HCl Conc 10 MG/ML | |
| | Imipramine HCl Tab 10 MG | |
| | Imipramine HCl Tab 25 MG | |
| | Imipramine HCl Tab 50 MG | |
| | Imipramine Pamoate Cap 75 MG | |
| | Imipramine Pamoate Cap 100 MG | |
| | Imipramine Pamoate Cap 125 MG | |
| | Imipramine Pamoate Cap 150 MG | |
| | Nortriptyline HCl Cap 10 MG | |
| | Nortriptyline HCl Cap 25 MG | |
| | Nortriptyline HCl Cap 50 MG | |
| | Nortriptyline HCl Cap 75 MG | |
| | Nortriptyline HCl Soln 10 MG/5ML | |
| | Protriptyline HCl Tab 5 MG | |
| | Protriptyline HCl Tab 10 MG | |
| | Trimipramine Maleate Cap 25 MG | |
| | Trimipramine Maleate Cap 50 MG | |
| | Trimipramine Maleate Cap 100 MG | |
| **Antidiabetic - Alpha-Glucosidase Inhibitors** | | |
| | Acarbose Tab 25 MG | |
| **Antidiabetic - Amylin Analogs** | | |
| | Pramlintide Acetate Pen-inj 1500 MCG/1.5ML (1000 MCG/ML) | |
| | Pramlintide Acetate Pen-inj 2700 MCG/2.7ML (1000 MCG/ML) | |
| **Antidiabetic - Biguanides** | | |
| | Metformin HCl Tab 500 MG | |
| | Metformin HCl Tab 850 MG | |
| | Metformin HCl Tab 1000 MG | |
| | Metformin HCl Tab SR 24HR 500 MG | |
| **Antidiabetic - Diabetic Other** | | |
| | Glucagon (rDNA) For Inj Kit 1 MG | |
| | Glucose Gel 40% | |
| **Antidiabetic - Dipeptidyl Peptidase-4 (DPP-4) Inhibitors** | | |
| | Sitagliptin Phosphate Tab 25 MG (Base Equiv) | |
| | Sitagliptin Phosphate Tab 50 MG (Base Equiv) | |
| | Sitagliptin Phosphate Tab 100 MG (Base Equiv) | |
| **Antidiabetic - Incretin Mimetic Agents (GLP-1 Receptor Agonists)** | | |
| | Exenatide For Inj Extended Release Susp 2 MG | |
| | Exenatide Soln Pen-injector 5 MCG/0.02ML | |
| | Exenatide Soln Pen-injector 10 MCG/0.04ML | |
| | Liraglutide Soln Pen-injector 18 MG/3ML (6 MG/ML) | |
| **Antidiabetic - Insulin** | | **All strengths and formulations of injectable insulin are covered for appropriate conditions allowed in the claim** |
| | Insulin Aspart Inj 100 Unit/ML | |
| | Insulin Aspart Prot & Aspart (Human) Inj 100 Unit/ML (70-30) | |

## APPENDIX TO RULE 4123-6-21.3
## Formulary List of Medications Covered by the Ohio Bureau of Workers' Compensation

| Drug Class Name | Drug Generic Name | Coverage restrictions or limitations for specific drugs or dosage forms are listed with the respective drugs below. |
|---|---|---|
| | Insulin Aspart Prot & Aspart Sus Pen-inj 100 Unit/ML (70-30) | |
| | Insulin Aspart Soln Cartridge 100 Unit/ML | |
| | Insulin Aspart Soln Pen-injector 100 Unit/ML | |
| | Insulin Degludec Soln Pen-Injector 100 Unit/ML | |
| | Insulin Degludec Soln Pen-Injector 200 Unit/ML | |
| | Insulin Detemir Inj 100 Unit/ML | |
| | Insulin Detemir Soln Pen-injector 100 Unit/ML | |
| | Insulin Glargine Inj 100 Unit/ML | |
| | Insulin Glargine Soln Pen-Injector 100 Unit/ML | |
| | Insulin Glargine Soln Pen-Injector 300 Unit/ML | |
| | Insulin Glulisine Inj 100 Unit/ML | |
| | Insulin Glulisine Soln Pen-Injector Inj 100 Unit/ML | |
| | Insulin Lispro (Human) Inj 100 Unit/ML | |
| | Insulin Lispro (Human) Soln Cartridge 100 Unit/ML | |
| | Insulin Lispro (Human) Soln Pen-injector 100 Unit/ML | |
| | Insulin Lispro (Human) Soln Pen-injector 200 Unit/ML | |
| | Insulin Lispro Prot & Lispro (Human) Inj 100 Unit/ML (50-50) | |
| | Insulin Lispro Prot & Lispro (Human) Inj 100 Unit/ML (75-25) | |
| | Insulin Lispro Prot & Lispro Sus Pen-inj 100 Unit/ML (50-50) | |
| | Insulin Lispro Prot & Lispro Sus Pen-inj 100 Unit/ML (75-25) | |
| | Insulin NPH & Regular Susp Pen-Inj 100 Unit/ML (70-30) | |
| | Insulin NPH (Human) (Isophane) Inj 100 Unit/ML | |
| | Insulin NPH (Human) (Isophane) Susp Pen-injector 100 Unit/ML | |
| | Insulin NPH Isophane & Regular Human Inj 100 Unit/ML (70-30) | |
| | Insulin Regular (Human) Inj 100 Unit/ML | |
| | Insulin Regular (Human) Inj 500 Unit/ML | |
| | Insulin Regular (Human) Soln Pen-Injector 500 Unit/ML | |
| **Antidiabetic - Insulin Sensitizing Agents** | | |
| | Pioglitazone HCl Tab 15 MG (Base Equiv) | |
| | Pioglitazone HCl Tab 30 MG (Base Equiv) | |
| | Pioglitazone HCl Tab 45 MG (Base Equiv) | |
| | Rosiglitazone Maleate Tab 4 MG (Base Equiv) | |
| | Rosiglitazone Maleate Tab 8 MG (Base Equiv) | |
| **Antidiabetic - Meglitinide Analogues** | | |
| | Nateglinide Tab 120 MG | |
| | Repaglinide Tab 0.5 MG | |
| | Repaglinide Tab 1 MG | |
| | Repaglinide Tab 2 MG | |
| **Antidiabetic - Sulfonylurea** | | |
| | Glimepiride Tab 1 MG | |
| | Glimepiride Tab 2 MG | |
| | Glimepiride Tab 4 MG | |
| | Glipizide Tab 5 MG | |
| | Glipizide Tab 10 MG | |
| | Glipizide Tab SR 24HR 2.5 MG | |
| | Glipizide Tab SR 24HR 5 MG | |
| | Glipizide Tab SR 24HR 10 MG | |
| | Glyburide Micronized Tab 3 MG | |
| | Glyburide Tab 2.5 MG | |
| | Glyburide Tab 5 MG | |
| **Antidiabetic Combinations** | | |
| | Glyburide-Metformin Tab 2.5-500 MG | |
| | Glyburide-Metformin Tab 5-500 MG | |
| | Pioglitazone HCl-Metformin HCl Tab 15-500 MG | |
| | Pioglitazone HCl-Metformin HCl Tab 15-850 MG | |
| | Rosiglitazone Maleate-Glimepiride Tab 4-4 MG | |
| | Rosiglitazone Maleate-Metformin HCl Tab 2-500 MG | |

# APPENDIX TO RULE 4123-6-21.3
## Formulary List of Medications Covered by the Ohio Bureau of Workers' Compensation

| Drug Class Name | Drug Generic Name | Coverage restrictions or limitations for specific drugs or dosage forms are listed with the respective drugs below. |
|---|---|---|
| | Rosiglitazone Maleate-Metformin HCl Tab 4-500 MG | |
| | Sitagliptin-Metformin HCl Tab 50-500 MG | |
| | Sitagliptin-Metformin HCl Tab 50-1000 MG | |
| **Antidiarrheal Agents - Misc** | | |
| | Bismuth Subsalicylate Chew Tab 262 MG | |
| | Bismuth Subsalicylate Susp 262 MG/15ML | |
| | Bismuth Subsalicylate Tab 262 MG | |
| | Lactobacillus - Packet | |
| | Lactobacillus Cap | |
| | Lactobacillus Chew Tab | |
| | Lactobacillus Rhamnosus (GG) Cap | |
| | Lactobacillus Tab | |
| | Probiotic Product - Cap | |
| | Saccharomyces boulardii Cap 250 MG | |
| **Antidotes - Chelating Agents** | | |
| | Succimer Cap 100 MG | |
| **Antiemetics** | | |
| | Aprepitant Capsule 80 MG | |
| | Aprepitant Capsule Therapy Pack 80 & 125 MG | |
| | Dimenhydrinate Chew Tab 25 MG | |
| | Dimenhydrinate Chew Tab 50 MG | |
| | Dimenhydrinate Tab 50 MG | |
| | Dronabinol Cap 2.5 MG | |
| | Dronabinol Cap 5 MG | |
| | Dronabinol Cap 10 MG | |
| | Granisetron HCl Tab 1 MG | |
| | Meclizine HCl Chew Tab 25 MG | |
| | Meclizine HCl Tab 12.5 MG | |
| | Meclizine HCl Tab 25 MG | |
| | Meclizine HCl Tab 50 MG | |
| | Ondansetron HCl Oral Soln 4 MG/5ML | |
| | Ondansetron HCl Tab 4 MG | |
| | Ondansetron HCl Tab 8 MG | |
| | Ondansetron Orally Disintegrating Tab Products | **Oral disintegrating dosage form is restricted to claims with an allowed condition that results in the inabiity to swallow or absorb oral medications** |
| | Ondansetron Orally Disintegrating Tab 4 MG | **See Ondansetron ODT Products restrictions above** |
| | Ondansetron Orally Disintegrating Tab 8 MG | **See Ondansetron ODT Products restrictions above** |
| | Scopolamine TD Patch 72HR 1 MG/3DAYS | |
| | Trimethobenzamide HCl Cap 300 MG | |
| **Antifungals** | | |
| | Fluconazole For Susp 40 MG/ML | |
| | Fluconazole Tab 50 MG | |
| | Fluconazole Tab 100 MG | |
| | Fluconazole Tab 150 MG | |
| | Fluconazole Tab 200 MG | |
| | Griseofulvin Microsize Susp 125 MG/5ML | |
| | Griseofulvin Microsize Tab 500 MG | |
| | Griseofulvin Ultramicrosize Tab 250 MG | |
| | Itraconazole Cap 100 MG | |
| | Itraconazole Oral Soln 10 MG/ML | |
| | Ketoconazole Tab 200 MG | |
| | Nystatin Tab 500000 Unit | |
| | Posaconazole Susp 40 MG/ML | |
| | Posaconazole Tab Delayed Release 100 MG | |
| | Terbinafine HCl Tab 250 MG | |

# APPENDIX TO RULE 4123-6-21.3
## Formulary List of Medications Covered by the Ohio Bureau of Workers' Compensation

| Drug Class Name | Drug Generic Name | Coverage restrictions or limitations for specific drugs or dosage forms are listed with the respective drugs below. |
|---|---|---|
| | Voriconazole Tab 200 MG | |
| **Antihistamines** | | |
| | Carbinoxamine Maleate Tab 4 MG | |
| | Cetirizine HCl Oral Soln 1 MG/ML (5 MG/5ML) | |
| | Cetirizine HCl Tab 5 MG | |
| | Cetirizine HCl Tab 10 MG | |
| | Chlorpheniramine Maleate Tab 4 MG | |
| | Clemastine Fumarate Tab 2.68 MG | |
| | Cyproheptadine HCl Tab 4 MG | |
| | Desloratadine Tab 5 MG | |
| | Diphenhydramine HCl Cap 25 MG | |
| | Diphenhydramine HCl Cap 50 MG | |
| | Diphenhydramine HCl Liquid 12.5 MG/5ML | |
| | Diphenhydramine HCl Tab 25 MG | |
| | Fexofenadine HCl Tab 60 MG | |
| | Fexofenadine HCl Tab 180 MG | |
| | Levocetirizine Dihydrochloride Tab 5 MG | |
| | Loratadine Syrup 5 MG/5ML | |
| | Loratadine Tab 10 MG | |
| | Promethazine HCl Suppos 12.5 MG | |
| | Promethazine HCl Suppos 25 MG | |
| | Promethazine HCl Suppos 50 MG | |
| | Promethazine HCl Syrup 6.25 MG/5ML | |
| | Promethazine HCl Tab 12.5 MG | |
| | Promethazine HCl Tab 25 MG | |
| | Promethazine HCl Tab 50 MG | |
| **Antihyperlipidemics - Bile Acid Sequestrants** | | |
| | Cholestyramine Light Powder 4 GM/DOSE | |
| | Cholestyramine Light Powder Packets 4 GM | |
| | Cholestyramine Powder 4 GM/DOSE | |
| | Cholestyramine Powder Packets 4 GM | |
| | Colesevelam HCl Packet For Susp 3.75 GM | |
| | Colesevelam HCl Tab 625 MG | |
| | Colestipol HCl Granule Packets 5 GM | |
| | Colestipol HCl Tab 1 GM | |
| **Antihyperlipidemics - Combinations** | | |
| | Ezetimibe-Simvastatin Tab 10-10 MG | |
| | Ezetimibe-Simvastatin Tab 10-20 MG | |
| | Ezetimibe-Simvastatin Tab 10-40 MG | |
| | Ezetimibe-Simvastatin Tab 10-80 MG | |
| **Antihyperlipidemics - Fibric Acid Derivatives** | | |
| | Choline Fenofibrate Cap DR 45 MG (Fenofibric Acid Equiv) | |
| | Choline Fenofibrate Cap DR 135 MG (Fenofibric Acid Equiv) | |
| | Fenofibrate Cap 150 MG | |
| | Fenofibrate Micronized Cap 130 MG | |
| | Fenofibrate Micronized Cap 134 MG | |
| | Fenofibrate Micronized Cap 200 MG | |
| | Fenofibrate Tab 48 MG | |
| | Fenofibrate Tab 54 MG | |
| | Fenofibrate Tab 120 MG | |
| | Fenofibrate Tab 145 MG | |
| | Fenofibrate Tab 160 MG | |
| | Gemfibrozil Tab 600 MG | |
| **Antihyperlipidemics - HMG CoA Reductase Inhibitors** | | |
| | Atorvastatin Calcium Tab 10 MG (Base Equivalent) | |
| | Atorvastatin Calcium Tab 20 MG (Base Equivalent) | |

## APPENDIX TO RULE 4123-6-21.3
## Formulary List of Medications Covered by the Ohio Bureau of Workers' Compensation

| Drug Class Name | Drug Generic Name | Coverage restrictions or limitations for specific drugs or dosage forms are listed with the respective drugs below. |
|---|---|---|
| | Atorvastatin Calcium Tab 40 MG (Base Equivalent) | |
| | Atorvastatin Calcium Tab 80 MG (Base Equivalent) | |
| | Fluvastatin Sodium Tab SR 24 HR 80 MG | |
| | Lovastatin Tab 10 MG | |
| | Lovastatin Tab 20 MG | |
| | Lovastatin Tab 40 MG | |
| | Lovastatin Tab SR 24HR 60 MG | |
| | Niacin-Lovastatin Tab SR 24HR 1000-20 MG | |
| | Niacin-Simvastatin Tab SR 24HR 500-20 MG | |
| | Niacin-Simvastatin Tab SR 24HR 500-40 MG | |
| | Niacin-Simvastatin Tab SR 24HR 1000-20 MG | |
| | Niacin-Simvastatin Tab SR 24HR 1000-40 MG | |
| | Pitavastatin Calcium Tab 1 MG (Base Equiv) | |
| | Pitavastatin Calcium Tab 2 MG (Base Equiv) | |
| | Pitavastatin Calcium Tab 4 MG (Base Equiv) | |
| | Pravastatin Sodium Tab 10 MG | |
| | Pravastatin Sodium Tab 20 MG | |
| | Pravastatin Sodium Tab 40 MG | |
| | Pravastatin Sodium Tab 80 MG | |
| | Rosuvastatin Calcium Tab 5 MG | |
| | Rosuvastatin Calcium Tab 10 MG | |
| | Rosuvastatin Calcium Tab 20 MG | |
| | Rosuvastatin Calcium Tab 40 MG | |
| | Simvastatin Tab 5 MG | |
| | Simvastatin Tab 10 MG | |
| | Simvastatin Tab 20 MG | |
| | Simvastatin Tab 40 MG | |
| | Simvastatin Tab 80 MG | |
| **Antihyperlipidemics - Intestinal Cholesterol Absorption Inhibitors** | | |
| | Ezetimibe Tab 10 MG | |
| **Antihyperlipidemics - Lecithin** | | |
| | Lecithin Cap 1200 MG | |
| | Lecithin Chew Tab 1000 MG | |
| **Antihyperlipidemics - Misc** | | |
| | Omega-3-acid Ethyl Esters Cap 1 GM | |
| **Antihyperlipidemics - Nicotinic Acid Derivatives** | | **All strengths of oral dosage forms are covered for allowed conditions** |
| | Niacin Tab CR 500 MG (Antihyperlipidemic) | |
| | Niacin Tab CR 750 MG (Antihyperlipidemic) | |
| | Niacin Tab CR 1000 MG (Antihyperlipidemic) | |
| **Antihyperlipidemics - Omega-3 Fatty Acids** | | |
| | Omega-3 Fatty Acids Cap 183.33 MG** | |
| | Omega-3 Fatty Acids Cap 150 MG** | |
| | Omega-3 Fatty Acids Cap 180 MG** | |
| | Omega-3 Fatty Acids Cap 554 MG** | |
| | Omega-3 Fatty Acids Cap 645 MG** | |
| | Omega-3 Fatty Acids Cap 875 MG** | |
| | Omega-3 Fatty Acids Cap 900 MG** | |
| | Omega-3 Fatty Acids Cap 1000 MG** | |
| | Omega-3 Fatty Acids Cap 1200 MG** | |
| | Omega-3 Fatty Acids Cap Delayed Release 332.5 MG** | |
| | Omega-3 Fatty Acids Cap Delayed Release 350 MG** | |
| | Omega-3 Fatty Acids Cap Delayed Release 500 MG** | |
| | Omega-3 Fatty Acids Cap Delayed Release 600 MG** | |
| | Omega-3 Fatty Acids Cap Delayed Release 1400 MG** | |
| | Omega-3 Fatty Acids Chew Tab 240 MG** | |

# APPENDIX TO RULE 4123-6-21.3
## Formulary List of Medications Covered by the Ohio Bureau of Workers' Compensation

| Drug Class Name | Drug Generic Name | Coverage restrictions or limitations for specific drugs or dosage forms are listed with the respective drugs below. |
|---|---|---|
| **Antihyperlipidemics - PCSK9 Inhibitors** | | |
| | Alirocumab Subcutaneous Soln Pen-injector 75 MG/ML | |
| | Alirocumab Subcutaneous Soln Pen-injector 150 MG/ML | |
| | Alirocumab Subcutaneous Soln Prefilled Syringe 75 MG/ML | |
| | Alirocumab Subcutaneous Soln Prefilled Syringe 150 MG/ML | |
| **Antihypertensive Combinations** | | |
| | Aliskiren-Hydrochlorothiazide Tab 150-12.5 MG | |
| | Aliskiren-Hydrochlorothiazide Tab 300-12.5 MG | |
| | Aliskiren-Valsartan Tab 150-160 MG | |
| | Aliskiren-Valsartan Tab 300-320 MG | |
| | Amlodipine Besylate-Benazepril HCl Cap 2.5-10 MG | |
| | Amlodipine Besylate-Benazepril HCl Cap 5-10 MG | |
| | Amlodipine Besylate-Benazepril HCl Cap 5-20 MG | |
| | Amlodipine Besylate-Benazepril HCl Cap 5-40 MG | |
| | Amlodipine Besylate-Benazepril HCl Cap 10-20 MG | |
| | Amlodipine Besylate-Benazepril HCl Cap 10-40 MG | |
| | Amlodipine Besylate-Olmesartan Medoxomil Tab 5-20 MG | |
| | Amlodipine Besylate-Olmesartan Medoxomil Tab 10-20 MG | |
| | Amlodipine Besylate-Olmesartan Medoxomil Tab 10-40 MG | |
| | Amlodipine Besylate-Valsartan Tab 5-160 MG | |
| | Amlodipine Besylate-Valsartan Tab 10-160 MG | |
| | Amlodipine Besylate-Valsartan Tab 10-320 MG | |
| | Amlodipine-Valsartan-Hydrochlorothiazide Tab 5-160-12.5 MG | |
| | Amlodipine-Valsartan-Hydrochlorothiazide Tab 5-160-25 MG | |
| | Amlodipine-Valsartan-Hydrochlorothiazide Tab 10-160-12.5 MG | |
| | Amlodipine-Valsartan-Hydrochlorothiazide Tab 10-320-25 MG | |
| | Atenolol & Chlorthalidone Tab 50-25 MG | |
| | Atenolol & Chlorthalidone Tab 100-25 MG | |
| | Bisoprolol & Hydrochlorothiazide Tab 2.5-6.25 MG | |
| | Bisoprolol & Hydrochlorothiazide Tab 5-6.25 MG | |
| | Bisoprolol & Hydrochlorothiazide Tab 10-6.25 MG | |
| | Candesartan Cilexetil-Hydrochlorothiazide Tab 16-12.5 MG | |
| | Candesartan Cilexetil-Hydrochlorothiazide Tab 32-12.5 MG | |
| | Enalapril Maleate & Hydrochlorothiazide Tab 10-25 MG | |
| | Irbesartan-Hydrochlorothiazide Tab 150-12.5 MG | |
| | Irbesartan-Hydrochlorothiazide Tab 300-12.5 MG | |
| | Lisinopril & Hydrochlorothiazide Tab 10-12.5 MG | |
| | Lisinopril & Hydrochlorothiazide Tab 20-12.5 MG | |
| | Lisinopril & Hydrochlorothiazide Tab 20-25 MG | |
| | Losartan Potassium & Hydrochlorothiazide Tab 50-12.5 MG | |
| | Losartan Potassium & Hydrochlorothiazide Tab 100-12.5 MG | |
| | Losartan Potassium & Hydrochlorothiazide Tab 100-25 MG | |
| | Metoprolol & Hydrochlorothiazide Tab 50-25 MG | |
| | Moexipril-Hydrochlorothiazide Tab 15-25 MG | |
| | Olmesartan Medoxomil-Hydrochlorothiazide Tab 20-12.5 MG | |
| | Olmesartan Medoxomil-Hydrochlorothiazide Tab 40-12.5 MG | |
| | Olmesartan Medoxomil-Hydrochlorothiazide Tab 40-25 MG | |
| | Olmesartan-Amlodipine-Hydrochlorothiazide Tab 20-5-12.5 MG | |
| | Olmesartan-Amlodipine-Hydrochlorothiazide Tab 40-5-12.5 MG | |
| | Olmesartan-Amlodipine-Hydrochlorothiazide Tab 40-5-25 MG | |
| | Olmesartan-Amlodipine-Hydrochlorothiazide Tab 40-10-25 MG | |
| | Quinapril-Hydrochlorothiazide Tab 20-12.5 MG | |
| | Quinapril-Hydrochlorothiazide Tab 20-25 MG | |
| | Telmisartan-Amlodipine Tab 40-5 MG | |
| | Telmisartan-Amlodipine Tab 80-10 MG | |
| | Trandolapril-Verapamil HCl Tab CR 2-240 MG | |
| | Trandolapril-Verapamil HCl Tab CR 4-240 MG | |

## APPENDIX TO RULE 4123-6-21.3
## Formulary List of Medications Covered by the Ohio Bureau of Workers' Compensation

| Drug Class Name | Drug Generic Name | Coverage restrictions or limitations for specific drugs or dosage forms are listed with the respective drugs below. |
|---|---|---|
| | Valsartan-Hydrochlorothiazide Tab 80-12.5 MG | |
| | Valsartan-Hydrochlorothiazide Tab 160-12.5 MG | |
| | Valsartan-Hydrochlorothiazide Tab 160-25 MG | |
| | Valsartan-Hydrochlorothiazide Tab 320-12.5 MG | |
| | Valsartan-Hydrochlorothiazide Tab 320-25 MG | |
| **Antihypertensives - ACE Inhibitors** | | |
| | Benazepril HCl Tab 5 MG | |
| | Benazepril HCl Tab 10 MG | |
| | Benazepril HCl Tab 20 MG | |
| | Benazepril HCl Tab 40 MG | |
| | Captopril Tab 12.5 MG | |
| | Captopril Tab 25 MG | |
| | Captopril Tab 50 MG | |
| | Captopril Tab 100 MG | |
| | Enalapril Maleate Tab 2.5 MG | |
| | Enalapril Maleate Tab 5 MG | |
| | Enalapril Maleate Tab 10 MG | |
| | Enalapril Maleate Tab 20 MG | |
| | Fosinopril Sodium Tab 10 MG | |
| | Fosinopril Sodium Tab 20 MG | |
| | Lisinopril Tab 2.5 MG | |
| | Lisinopril Tab 5 MG | |
| | Lisinopril Tab 10 MG | |
| | Lisinopril Tab 20 MG | |
| | Lisinopril Tab 30 MG | |
| | Lisinopril Tab 40 MG | |
| | Moexipril HCl Tab 15 MG | |
| | Quinapril HCl Tab 5 MG | |
| | Quinapril HCl Tab 10 MG | |
| | Quinapril HCl Tab 20 MG | |
| | Quinapril HCl Tab 40 MG | |
| | Ramipril Cap 1.25 MG | |
| | Ramipril Cap 2.5 MG | |
| | Ramipril Cap 5 MG | |
| | Ramipril Cap 10 MG | |
| | Trandolapril Tab 1 MG | |
| | Trandolapril Tab 2 MG | |
| **Antihypertensives - Agents for Pheochromocytoma** | | |
| | Phenoxybenzamine HCl Cap 10 MG | |
| **Antihypertensives - Angiotensin II Receptor Antagonists** | | |
| | Candesartan Cilexetil Tab 8 MG | |
| | Candesartan Cilexetil Tab 16 MG | |
| | Candesartan Cilexetil Tab 32 MG | |
| | Irbesartan Tab 75 MG | |
| | Irbesartan Tab 150 MG | |
| | Irbesartan Tab 300 MG | |
| | Losartan Potassium Tab 25 MG | |
| | Losartan Potassium Tab 50 MG | |
| | Losartan Potassium Tab 100 MG | |
| | Olmesartan Medoxomil Tab 5 MG | |
| | Olmesartan Medoxomil Tab 20 MG | |
| | Olmesartan Medoxomil Tab 40 MG | |
| | Telmisartan Tab 80 MG | |
| | Valsartan Tab 40 MG | |

## APPENDIX TO RULE 4123-6-21.3
## Formulary List of Medications Covered by the Ohio Bureau of Workers' Compensation

| Drug Class Name | Drug Generic Name | Coverage restrictions or limitations for specific drugs or dosage forms are listed with the respective drugs below. |
|---|---|---|
| | Valsartan Tab 80 MG | |
| | Valsartan Tab 160 MG | |
| | Valsartan Tab 320 MG | |
| **Antihypertensives - Antiadrenergic Antihypertensives** | | |
| | Clonidine HCl Tab 0.1 MG | |
| | Clonidine HCl Tab 0.2 MG | |
| | Clonidine HCl Tab 0.3 MG | |
| | Clonidine HCl TD Patch Weekly 0.1 MG/24HR | |
| | Clonidine HCl TD Patch Weekly 0.2 MG/24HR | |
| | Clonidine HCl TD Patch Weekly 0.3 MG/24HR | |
| | Doxazosin Mesylate Tab 1 MG | |
| | Doxazosin Mesylate Tab 2 MG | |
| | Doxazosin Mesylate Tab 4 MG | |
| | Doxazosin Mesylate Tab 8 MG | |
| | Guanfacine HCl Tab 1 MG | |
| | Guanfacine HCl Tab 2 MG | |
| | Prazosin HCl Cap 1 MG | |
| | Prazosin HCl Cap 2 MG | |
| | Prazosin HCl Cap 5 MG | |
| | Terazosin HCl Cap 1 MG | |
| | Terazosin HCl Cap 2 MG | |
| | Terazosin HCl Cap 5 MG | |
| | Terazosin HCl Cap 10 MG | |
| **Antihypertensives - Direct Renin Inhibitors** | | |
| | Aliskiren Fumarate Tab 150 MG (Base Equivalent) | |
| | Aliskiren Fumarate Tab 300 MG (Base Equivalent) | |
| **Antihypertensives - Selective Aldosterone Receptor Antagonists (SARAs)** | | |
| | Eplerenone Tab 25 MG | |
| | Eplerenone Tab 50 MG | |
| **Antihypertensives - Vasodilators** | | |
| | Hydralazine HCl Tab 10 MG | |
| | Hydralazine HCl Tab 25 MG | |
| | Hydralazine HCl Tab 50 MG | |
| | Hydralazine HCl Tab 100 MG | |
| | Minoxidil Tab 2.5 MG | |
| | Minoxidil Tab 10 MG | |
| **Anti-infective Agents - Misc** | | |
| | Atovaquone Susp 750 MG/5ML | |
| | Clindamycin HCl Cap 150 MG | |
| | Clindamycin HCl Cap 300 MG | |
| | Clindamycin Palmitate HCl For Soln 75 MG/5ML (Base Equiv) | |
| | Dapsone Tab 25 MG | |
| | Dapsone Tab 100 MG | |
| | Linezolid For Susp 100 MG/5ML | |
| | Linezolid Tab 600 MG | |
| | Metronidazole Cap 375 MG | |
| | Metronidazole Tab 250 MG | |
| | Metronidazole Tab 500 MG | |
| | Metronidazole Tab SR 24HR 750 MG | |
| | Nitazoxanide Tab 500 MG | |
| | Rifaximin Tab 200 MG | |
| | Rifaximin Tab 550 MG | |
| | Sulfamethoxazole-Trimethoprim Susp 200-40 MG/5ML | |
| | Sulfamethoxazole-Trimethoprim Tab 400-80 MG | |
| | Sulfamethoxazole-Trimethoprim Tab 800-160 MG | |

## APPENDIX TO RULE 4123-6-21.3
## Formulary List of Medications Covered by the Ohio Bureau of Workers' Compensation

| Drug Class Name | Drug Generic Name | Coverage restrictions or limitations for specific drugs or dosage forms are listed with the respective drugs below. |
|---|---|---|
| | Telithromycin Tab 400 MG | |
| | Tinidazole Tab 500 MG | |
| | Trimethoprim Tab 100 MG | |
| | Vancomycin HCl Cap 125 MG | |
| | Vancomycin HCl Cap 250 MG | |
| **Antimalarials** | | |
| | Atovaquone-Proguanil HCl Tab 250-100 MG | |
| | Chloroquine Phosphate Tab 250 MG | |
| | Hydroxychloroquine Sulfate Tab 200 MG | |
| | Mefloquine HCl Tab 250 MG | |
| | Quinine Sulfate Cap 324 MG | |
| **Antimanic Agents** | | |
| | Lithium Carbonate Cap 150 MG | |
| | Lithium Carbonate Cap 300 MG | |
| | Lithium Carbonate Cap 600 MG | |
| | Lithium Carbonate Tab 300 MG | |
| | Lithium Carbonate Tab CR 300 MG | |
| | Lithium Carbonate Tab CR 450 MG | |
| | Lithium Oral Solution 8 mEq/5ML | |
| **Antimyasthenic/Cholinergic Agents** | | |
| | Pyridostigmine Bromide Tab 60 MG | |
| | Pyridostigmine Bromide Tab CR 180 MG | |
| **Antimycobacterial Agents** | | |
| | Ethambutol HCl Tab 100 MG | |
| | Ethambutol HCl Tab 400 MG | |
| | Isoniazid Tab 300 MG | |
| | Pyrazinamide Tab 500 MG | |
| | Rifampin Cap 150 MG | |
| | Rifampin Cap 300 MG | |
| **Antineoplastic - Alkylating Agents** | | |
| | Cyclophosphamide Cap 25 MG | |
| | Cyclophosphamide Cap 50 MG | |
| | Cyclophosphamide Tab 50 MG | |
| **Antineoplastic - Antimetabolites** | | |
| | Capecitabine Tab 500 MG | |
| | Methotrexate Sodium Tab 2.5 MG (Base Equiv) | |
| **Antineoplastic - Hormonal and Related Agents** | | |
| | Anastrozole Tab 1 MG | |
| | Exemestane Tab 25 MG | |
| | Letrozole Tab 2.5 MG | |
| | Megestrol Acetate Susp 40 MG/ML | |
| | Megestrol Acetate Tab 20 MG | |
| | Megestrol Acetate Tab 40 MG | |
| | Tamoxifen Citrate Tab 20 MG (Base Equivalent) | |
| **Antiparkinson Agents** | | |
| | Amantadine HCl Cap 100 MG | |
| | Amantadine HCl Syrup 50 MG/5ML | |
| | Amantadine HCl Tab 100 MG | |
| | Benztropine Mesylate Tab 0.5 MG | |
| | Benztropine Mesylate Tab 1 MG | |
| | Benztropine Mesylate Tab 2 MG | |
| | Bromocriptine Mesylate Cap 5 MG | |
| | Carbidopa & Levodopa Tab 10-100 MG | |
| | Carbidopa & Levodopa Tab 25-100 MG | |
| | Carbidopa & Levodopa Tab 25-250 MG | |
| | Carbidopa & Levodopa Tab CR 25-100 MG | |
| | Carbidopa & Levodopa Tab CR 50-200 MG | |

# APPENDIX TO RULE 4123-6-21.3
## Formulary List of Medications Covered by the Ohio Bureau of Workers' Compensation

| Drug Class Name | Drug Generic Name | Coverage restrictions or limitations for specific drugs or dosage forms are listed with the respective drugs below. |
|---|---|---|
| | Entacapone Tab 200 MG | |
| | Pramipexole Dihydrochloride Tab 0.125 MG | |
| | Pramipexole Dihydrochloride Tab 0.25 MG | |
| | Pramipexole Dihydrochloride Tab 0.5 MG | |
| | Pramipexole Dihydrochloride Tab 1 MG | |
| | Pramipexole Dihydrochloride Tab 1.5 MG | |
| | Pramipexole Dihydrochloride Tab SR 24HR 0.375 MG | |
| | Pramipexole Dihydrochloride Tab SR 24HR 0.75 MG | |
| | Pramipexole Dihydrochloride Tab SR 24HR 1.5 MG | |
| | Rasagiline Mesylate Tab 1 MG (Base Equiv) | |
| | Ropinirole Hydrochloride Tab 0.25 MG | |
| | Ropinirole Hydrochloride Tab 0.5 MG | |
| | Ropinirole Hydrochloride Tab 1 MG | |
| | Ropinirole Hydrochloride Tab 2 MG | |
| | Ropinirole Hydrochloride Tab 3 MG | |
| | Ropinirole Hydrochloride Tab 4 MG | |
| | Ropinirole Hydrochloride Tab 5 MG | |
| | Ropinirole Hydrochloride Tab SR 24HR 2 MG (Base Equivalent) | |
| | Ropinirole Hydrochloride Tab SR 24HR 4 MG (Base Equivalent) | |
| | Ropinirole Hydrochloride Tab SR 24HR 6 MG (Base Equivalent) | |
| | Ropinirole Hydrochloride Tab SR 24HR 8 MG (Base Equivalent) | |
| | Ropinirole Hydrochloride Tab SR 24HR 12 MG (Base Equivalent) | |
| | Trihexyphenidyl HCl Tab 2 MG | |
| | Trihexyphenidyl HCl Tab 5 MG | |
| **Antiperistaltic Agents** | | |
| | Difenoxin w/ Atropine Tab 1-0.025 MG | |
| | Diphenoxylate w/ Atropine Liq 2.5-0.025 MG/5ML | |
| | Diphenoxylate w/ Atropine Tab 2.5-0.025 MG | |
| | Loperamide HCl Cap 2 MG | |
| | Loperamide HCl Liq 1 MG/5ML (0.2 MG/ML) | |
| | Loperamide HCl Tab 2 MG | |
| | Paregoric Tincture 2 MG/5ML | |
| **Antipsoriatics - Oral** | | |
| | Acitretin Cap 25 MG | |
| **Antipsychotics - Benzisoxazoles** | | |
| | Haloperidol Lactate Oral Conc 2 MG/ML | |
| | Haloperidol Tab 0.5 MG | |
| | Haloperidol Tab 1 MG | |
| | Haloperidol Tab 2 MG | |
| | Haloperidol Tab 5 MG | |
| | Haloperidol Tab 10 MG | |
| | Haloperidol Tab 20 MG | |
| | Paliperidone Tab SR 24HR 1.5 MG | |
| | Paliperidone Tab SR 24HR 3 MG | |
| | Paliperidone Tab SR 24HR 6 MG | |
| | Paliperidone Tab SR 24HR 9 MG | |
| | Risperidone Orally Disintegrating Tab Products | **Oral disintegrating dosage form is restricted to claims with an allowed condition that results in the inabiity to swallow or absorb oral medications** |
| | Risperidone Orally Disintegrating Tab 0.25 MG | **See Risperidone ODT Products restrictions above** |
| | Risperidone Orally Disintegrating Tab 0.5 MG | **See Risperidone ODT Products restrictions above** |
| | Risperidone Orally Disintegrating Tab 1 MG | **See Risperidone ODT Products restrictions above** |
| | Risperidone Orally Disintegrating Tab 2 MG | **See Risperidone ODT Products restrictions above** |
| | Risperidone Orally Disintegrating Tab 3 MG | **See Risperidone ODT Products restrictions above** |
| | Risperidone Orally Disintegrating Tab 4 MG | **See Risperidone ODT Products restrictions above** |
| | Risperidone Soln 1 MG/ML | |
| | Risperidone Tab 0.25 MG | |

## APPENDIX TO RULE 4123-6-21.3
## Formulary List of Medications Covered by the Ohio Bureau of Workers' Compensation

| Drug Class Name | Drug Generic Name | Coverage restrictions or limitations for specific drugs or dosage forms are listed with the respective drugs below. |
|---|---|---|
| | Risperidone Tab 0.5 MG | |
| | Risperidone Tab 1 MG | |
| | Risperidone Tab 2 MG | |
| | Risperidone Tab 3 MG | |
| | Risperidone Tab 4 MG | |
| **Antipsychotics - Dibenzapines** | | |
| | Asenapine Maleate SL Tab Products | **Sublingual dosage form is restricted to claims with an allowed condition that results in the inability to swallow or absorb oral medications** |
| | Asenapine Maleate SL Tab 2.5 MG (Base Equiv) | **See Asenapine Maleate SL Tab Products restrictions above** |
| | Asenapine Maleate SL Tab 5 MG (Base Equiv) | **See Asenapine Maleate SL Tab Products restrictions above** |
| | Asenapine Maleate SL Tab 10 MG (Base Equiv) | **See Asenapine Maleate SL Tab Products restrictions above** |
| | Clozapine Orally Disintegrating Tab Products | **Oral disintegrating dosage form is restricted to claims with an allowed condition that results in the inabiity to swallow or absorb oral medications** |
| | Clozapine Orally Disintegrating Tab 12.5 MG | **See Clozapine ODT Products restrictions above** |
| | Clozapine Orally Disintegrating Tab 25 MG | **See Clozapine ODT Products restrictions above** |
| | Clozapine Orally Disintegrating Tab 100 MG | **See Clozapine ODT Products restrictions above** |
| | Clozapine Orally Disintegrating Tab 150 MG | **See Clozapine ODT Products restrictions above** |
| | Clozapine Orally Disintegrating Tab 200 MG | **See Clozapine ODT Products restrictions above** |
| | Clozapine Tab 25 MG | |
| | Clozapine Tab 50 MG | |
| | Clozapine Tab 100 MG | |
| | Clozapine Tab 200 MG | |
| | Loxapine Succinate Cap 5 MG | |
| | Loxapine Succinate Cap 10 MG | |
| | Loxapine Succinate Cap 25 MG | |
| | Loxapine Succinate Cap 50 MG | |
| | Olanzapine Orally Disintegrating Tab Products | **Oral disintegrating dosage form is restricted to claims with an allowed condition that results in the inabiity to swallow or absorb oral medications** |
| | Olanzapine Orally Disintegrating Tab 5 MG | **See Olanzapine ODT Products restrictions above** |
| | Olanzapine Orally Disintegrating Tab 10 MG | **See Olanzapine ODT Products restrictions above** |
| | Olanzapine Orally Disintegrating Tab 15 MG | **See Olanzapine ODT Products restrictions above** |
| | Olanzapine Orally Disintegrating Tab 20 MG | **See Olanzapine ODT Products restrictions above** |
| | Olanzapine Tab 2.5 MG | |
| | Olanzapine Tab 5 MG | |
| | Olanzapine Tab 7.5 MG | |
| | Olanzapine Tab 10 MG | |
| | Olanzapine Tab 15 MG | |
| | Olanzapine Tab 20 MG | |
| | Quetiapine Fumarate Tab 25 MG | |
| | Quetiapine Fumarate Tab 50 MG | |
| | Quetiapine Fumarate Tab 100 MG | |
| | Quetiapine Fumarate Tab 200 MG | |
| | Quetiapine Fumarate Tab 300 MG | |
| | Quetiapine Fumarate Tab 400 MG | |
| | Quetiapine Fumarate Tab SR 24HR 50 MG | |
| | Quetiapine Fumarate Tab SR 24HR 150 MG | |
| | Quetiapine Fumarate Tab SR 24HR 200 MG | |
| | Quetiapine Fumarate Tab SR 24HR 300 MG | |
| | Quetiapine Fumarate Tab SR 24HR 400 MG | |
| **Antipsychotics - Dihydroindolones** | | |
| | Molindone HCl Tab 5 MG | |
| | Molindone HCl Tab 10 MG | |
| | Molindone HCl Tab 25 MG | |

## APPENDIX TO RULE 4123-6-21.3
## Formulary List of Medications Covered by the Ohio Bureau of Workers' Compensation

| Drug Class Name | Drug Generic Name | Coverage restrictions or limitations for specific drugs or dosage forms are listed with the respective drugs below. |
|---|---|---|
| **Antipsychotics - Misc** | | |
| | Carbamazepine (Antipsychotic) Cap SR 12HR 100 MG | |
| | Carbamazepine (Antipsychotic) Cap SR 12HR 200 MG | |
| | Carbamazepine (Antipsychotic) Cap SR 12HR 300 MG | |
| | Lurasidone HCl Tab 20 MG | |
| | Lurasidone HCl Tab 40 MG | |
| | Lurasidone HCl Tab 60 MG | |
| | Lurasidone HCl Tab 80 MG | |
| | Lurasidone HCl Tab 120 MG | |
| | Ziprasidone HCl Cap 20 MG | |
| | Ziprasidone HCl Cap 40 MG | |
| | Ziprasidone HCl Cap 60 MG | |
| | Ziprasidone HCl Cap 80 MG | |
| **Antipsychotics - Phenothiazines** | | |
| | Chlorpromazine HCl Tab 10 MG | |
| | Chlorpromazine HCl Tab 25 MG | |
| | Chlorpromazine HCl Tab 50 MG | |
| | Chlorpromazine HCl Tab 100 MG | |
| | Chlorpromazine HCl Tab 200 MG | |
| | Fluphenazine HCl Elixir 2.5 MG/5ML | |
| | Fluphenazine HCl Oral Conc 5 MG/ML | |
| | Fluphenazine HCl Tab 1 MG | |
| | Fluphenazine HCl Tab 2.5 MG | |
| | Fluphenazine HCl Tab 5 MG | |
| | Fluphenazine HCl Tab 10 MG | |
| | Perphenazine Tab 2 MG | |
| | Perphenazine Tab 4 MG | |
| | Perphenazine Tab 8 MG | |
| | Perphenazine Tab 16 MG | |
| | Prochlorperazine Maleate Tab 5 MG (Base Equivalent) | |
| | Prochlorperazine Maleate Tab 10 MG (Base Equivalent) | |
| | Prochlorperazine Suppos 25 MG | |
| | Thioridazine HCl Tab 10 MG | |
| | Thioridazine HCl Tab 25 MG | |
| | Thioridazine HCl Tab 50 MG | |
| | Thioridazine HCl Tab 100 MG | |
| | Trifluoperazine HCl Tab 1 MG | |
| | Trifluoperazine HCl Tab 2 MG | |
| | Trifluoperazine HCl Tab 5 MG | |
| | Trifluoperazine HCl Tab 10 MG | |
| **Antipsychotics - Quinolinone Derivatives** | | |
| | Aripiprazole Oral Solution 1 MG/ML | |
| | Aripiprazole Orally Disintegrating Tab Products | **Oral disintegrating dosage form is restricted to claims with an allowed condition that results in the inabiity to swallow or absorb oral medications** |
| | Aripiprazole Orally Disintegrating Tab 10 MG | **See Aripiprazole ODT Products restrictions above** |
| | Aripiprazole Orally Disintegrating Tab 15 MG | **See Aripiprazole ODT Products restrictions above** |
| | Aripiprazole Tab 2 MG | |
| | Aripiprazole Tab 5 MG | |
| | Aripiprazole Tab 10 MG | |
| | Aripiprazole Tab 15 MG | |
| | Aripiprazole Tab 20 MG | |
| | Aripiprazole Tab 30 MG | |
| **Antipsychotics - Thioxanthenes** | | |
| | Thiothixene Cap 1 MG | |
| | Thiothixene Cap 2 MG | |

## APPENDIX TO RULE 4123-6-21.3
## Formulary List of Medications Covered by the Ohio Bureau of Workers' Compensation

| Drug Class Name | Drug Generic Name | Coverage restrictions or limitations for specific drugs or dosage forms are listed with the respective drugs below. |
|---|---|---|
| | Thiothixene Cap 5 MG | |
| | Thiothixene Cap 10 MG | |
| **Antiretrovirals** | | |
| | Abacavir Sulfate-Lamivudine Tab 600-300 MG | |
| | Atazanavir Sulfate Cap 150 MG (Base Equiv) | |
| | Atazanavir Sulfate Cap 200 MG (Base Equiv) | |
| | Atazanavir Sulfate Cap 300 MG (Base Equiv) | |
| | Atazanavir Sulfate Oral Powder Packet 50 MG (Base Equiv) | |
| | Efavirenz Cap 50 MG | |
| | Efavirenz Cap 200 MG | |
| | Efavirenz Tab 600 MG | |
| | Efavirenz-Emtricitabine-Tenofovir DF Tab 600-200-300 MG | |
| | Emtricitabine-Tenofovir Disoproxil Fumarate Tab 200-300 MG | |
| | Indinavir Sulfate Cap 200 MG | |
| | Indinavir Sulfate Cap 400 MG | |
| | Lamivudine Oral Soln 10 MG/ML | |
| | Lamivudine Tab 150 MG | |
| | Lamivudine Tab 300 MG | |
| | Lamivudine-Zidovudine Tab 150-300 MG | |
| | Lopinavir-Ritonavir Soln 400-100 MG/5ML (80-20 MG/ML) | |
| | Lopinavir-Ritonavir Tab 100-25 MG | |
| | Lopinavir-Ritonavir Tab 200-50 MG | |
| | Nelfinavir Mesylate Tab 250 MG | |
| | Nelfinavir Mesylate Tab 625 MG | |
| | Raltegravir Potassium Chew Tab 25 MG (Base Equiv) | |
| | Raltegravir Potassium Chew Tab 100 MG (Base Equiv) | |
| | Raltegravir Potassium Packet For Susp 100 MG (Base Equiv) | |
| | Raltegravir Potassium Tab 400 MG (Base Equiv) | |
| | Ritonavir Cap 100 MG | |
| | Ritonavir Oral Soln 80 MG/ML | |
| | Ritonavir Tab 100 MG | |
| | Tenofovir Disoproxil Fumarate Oral Powder 40 MG/GM | |
| | Tenofovir Disoproxil Fumarate Tab 150 MG | |
| | Tenofovir Disoproxil Fumarate Tab 200 MG | |
| | Tenofovir Disoproxil Fumarate Tab 250 MG | |
| | Tenofovir Disoproxil Fumarate Tab 300 MG | |
| | Zidovudine Cap 100 MG | |
| | Zidovudine Syrup 10 MG/ML | |
| | Zidovudine Tab 300 MG | |
| **Antiseptics & Disinfectants** | | |
| | Cadexomer Iodine Gel 0.9% | |
| | Chlorhexidine Gluconate Liquid 4% | |
| | Chlorhexidine Gluconate Soln 4% | |
| | Dakin's Solution 0.125% (Quarter Strength) | |
| | Dakin's Solution 0.25% (Half Strength) | |
| | Dakin's Solution 0.5% | |
| | Formaldehyde Solution 10% | |
| | Hexachlorophene Liq 3% | |
| | Hydrogen Peroxide Soln 3% | |
| | Povidone-Iodine Oint 10% | |
| | Povidone-Iodine Soln 7.5% | |
| | Povidone-Iodine Soln 10% | |
| | Povidone-Iodine Swabs 10% | |
| **Antitussives** | | |
| | Benzonatate Cap 100 MG | |
| | Benzonatate Cap 200 MG | |
| | Dextromethorphan Polistirex Extended Release Susp 30 MG/5ML | |

## APPENDIX TO RULE 4123-6-21.3
## Formulary List of Medications Covered by the Ohio Bureau of Workers' Compensation

| Drug Class Name | Drug Generic Name | Coverage restrictions or limitations for specific drugs or dosage forms are listed with the respective drugs below. |
|---|---|---|
| | Hydrocodone w/ Homatropine Syrup 5-1.5 MG/5ML | |
| | Hydrocodone w/ Homatropine Tab 5-1.5 MG | |
| **Beta Blockers** | | |
| | Acebutolol HCl Cap 200 MG | |
| | Acebutolol HCl Cap 400 MG | |
| | Atenolol Tab 25 MG | |
| | Atenolol Tab 50 MG | |
| | Atenolol Tab 100 MG | |
| | Bisoprolol Fumarate Tab 5 MG | |
| | Bisoprolol Fumarate Tab 10 MG | |
| | Carvedilol Phosphate Cap SR 24HR 10 MG | |
| | Carvedilol Phosphate Cap SR 24HR 20 MG | |
| | Carvedilol Phosphate Cap SR 24HR 40 MG | |
| | Carvedilol Phosphate Cap SR 24HR 80 MG | |
| | Carvedilol Tab 3.125 MG | |
| | Carvedilol Tab 6.25 MG | |
| | Carvedilol Tab 12.5 MG | |
| | Carvedilol Tab 25 MG | |
| | Labetalol HCl Tab 100 MG | |
| | Labetalol HCl Tab 200 MG | |
| | Labetalol HCl Tab 300 MG | |
| | Metoprolol Succinate Tab SR 24HR 25 MG (Tartrate Equiv) | |
| | Metoprolol Succinate Tab SR 24HR 50 MG (Tartrate Equiv) | |
| | Metoprolol Succinate Tab SR 24HR 100 MG (Tartrate Equiv) | |
| | Metoprolol Succinate Tab SR 24HR 200 MG (Tartrate Equiv) | |
| | Metoprolol Tartrate Tab 25 MG | |
| | Metoprolol Tartrate Tab 50 MG | |
| | Metoprolol Tartrate Tab 100 MG | |
| | Nadolol Tab 20 MG | |
| | Nadolol Tab 40 MG | |
| | Nadolol Tab 80 MG | |
| | Nebivolol HCl Tab 2.5 MG (Base Equivalent) | |
| | Nebivolol HCl Tab 5 MG (Base Equivalent) | |
| | Nebivolol HCl Tab 10 MG (Base Equivalent) | |
| | Nebivolol HCl Tab 20 MG (Base Equivalent) | |
| | Pindolol Tab 5 MG | |
| | Pindolol Tab 10 MG | |
| | Propranolol HCl Cap SR 24HR 60 MG | |
| | Propranolol HCl Cap SR 24HR 80 MG | |
| | Propranolol HCl Cap SR 24HR 120 MG | |
| | Propranolol HCl Cap SR 24HR 160 MG | |
| | Propranolol HCl Tab 10 MG | |
| | Propranolol HCl Tab 20 MG | |
| | Propranolol HCl Tab 40 MG | |
| | Propranolol HCl Tab 60 MG | |
| | Propranolol HCl Tab 80 MG | |
| | Sotalol HCl (AFIB/AFL) Tab 80 MG | |
| | Sotalol HCl Tab 80 MG | |
| | Sotalol HCl Tab 120 MG | |
| | Sotalol HCl Tab 160 MG | |
| | Timolol Maleate Tab 10 MG | |
| **Calcium Channel Blockers** | | |
| | Amlodipine Besylate Tab 2.5 MG | |
| | Amlodipine Besylate Tab 5 MG | |
| | Amlodipine Besylate Tab 10 MG | |
| | Diltiazem HCl Cap SR 24HR 120 MG | |
| | Diltiazem HCl Cap SR 24HR 180 MG | |

## APPENDIX TO RULE 4123-6-21.3
## Formulary List of Medications Covered by the Ohio Bureau of Workers' Compensation

| Drug Class Name | Drug Generic Name | Coverage restrictions or limitations for specific drugs or dosage forms are listed with the respective drugs below. |
|---|---|---|
| | Diltiazem HCl Cap SR 24HR 240 MG | |
| | Diltiazem HCl Coated Beads Cap SR 24HR 120 MG | |
| | Diltiazem HCl Coated Beads Cap SR 24HR 180 MG | |
| | Diltiazem HCl Coated Beads Cap SR 24HR 240 MG | |
| | Diltiazem HCl Coated Beads Cap SR 24HR 300 MG | |
| | Diltiazem HCl Coated Beads Cap SR 24HR 360 MG | |
| | Diltiazem HCl Coated Beads Tab SR 24HR 240 MG | |
| | Diltiazem HCl Coated Beads Tab SR 24HR 360 MG | |
| | Diltiazem HCl Extended Release Beads Cap SR 24HR 180 MG | |
| | Diltiazem HCl Extended Release Beads Cap SR 24HR 240 MG | |
| | Diltiazem HCl Extended Release Beads Cap SR 24HR 300 MG | |
| | Diltiazem HCl Extended Release Beads Cap SR 24HR 360 MG | |
| | Diltiazem HCl Tab 30 MG | |
| | Diltiazem HCl Tab 60 MG | |
| | Diltiazem HCl Tab 90 MG | |
| | Diltiazem HCl Tab 120 MG | |
| | Felodipine Tab SR 24HR 5 MG | |
| | Felodipine Tab SR 24HR 10 MG | |
| | Isradipine Tab SR 24HR 5 MG | |
| | Isradipine Tab SR 24HR 10 MG | |
| | Nicardipine HCl Cap 20 MG | |
| | Nicardipine HCl Cap SR 12HR 60 MG | |
| | Nifedipine Cap 10 MG | |
| | Nifedipine Cap 20 MG | |
| | Nifedipine Tab SR 24HR 30 MG | |
| | Nifedipine Tab SR 24HR 60 MG | |
| | Nifedipine Tab SR 24HR 90 MG | |
| | Nifedipine Tab SR 24HR Osmotic Release 30 MG | |
| | Nifedipine Tab SR 24HR Osmotic Release 60 MG | |
| | Nifedipine Tab SR 24HR Osmotic Release 90 MG | |
| | Nisoldipine Tab SR 24HR 20 MG | |
| | Nisoldipine Tab SR 24HR 25.5 MG | |
| | Verapamil HCl Cap SR 24HR 120 MG | |
| | Verapamil HCl Cap SR 24HR 180 MG | |
| | Verapamil HCl Cap SR 24HR 240 MG | |
| | Verapamil HCl Tab 40 MG | |
| | Verapamil HCl Tab 80 MG | |
| | Verapamil HCl Tab 120 MG | |
| | Verapamil HCl Tab CR 120 MG | |
| | Verapamil HCl Tab CR 180 MG | |
| | Verapamil HCl Tab CR 240 MG | |
| **Cardiac Glycosides** | | |
| | Digoxin Tab 125 MCG (0.125 MG) | |
| | Digoxin Tab 250 MCG (0.25 MG) | |
| **Cardiovascular Agents Misc. - Combinations** | | |
| | Amlodipine Besylate-Atorvastatin Calcium Tab 5-10 MG | |
| | Amlodipine Besylate-Atorvastatin Calcium Tab 5-20 MG | |
| | Amlodipine Besylate-Atorvastatin Calcium Tab 5-40 MG | |
| | Amlodipine Besylate-Atorvastatin Calcium Tab 5-80 MG | |
| | Amlodipine Besylate-Atorvastatin Calcium Tab 10-10 MG | |
| | Amlodipine Besylate-Atorvastatin Calcium Tab 10-20 MG | |
| | Amlodipine Besylate-Atorvastatin Calcium Tab 10-40 MG | |
| | Amlodipine Besylate-Atorvastatin Calcium Tab 10-80 MG | |
| | Isosorbide Dinitrate-Hydralazine HCl Tab 20-37.5 MG | |
| **Chelating Agents** | | |
| | Penicillamine Cap 250 MG | |
| | Penicillamine Tab 250 MG | |

# APPENDIX TO RULE 4123-6-21.3
## Formulary List of Medications Covered by the Ohio Bureau of Workers' Compensation

| Drug Class Name | Drug Generic Name | Coverage restrictions or limitations for specific drugs or dosage forms are listed with the respective drugs below. |
|---|---|---|
| **Chemical** | | |
| | Alcohol, Rubbing 70% | |
| **Combination Psychotherapeutics** | | |
| | Chlordiazepoxide-Amitriptyline Tab 5-12.5 MG | |
| | Chlordiazepoxide-Amitriptyline Tab 10-25 MG | |
| | Olanzapine-Fluoxetine HCl Cap 3-25 MG | |
| | Olanzapine-Fluoxetine HCl Cap 6-25 MG | |
| | Olanzapine-Fluoxetine HCl Cap 6-50 MG | |
| | Olanzapine-Fluoxetine HCl Cap 12-25 MG | |
| | Olanzapine-Fluoxetine HCl Cap 12-50 MG | |
| | Perphenazine-Amitriptyline Tab 2-10 MG | |
| | Perphenazine-Amitriptyline Tab 2-25 MG | |
| | Perphenazine-Amitriptyline Tab 4-10 MG | |
| | Perphenazine-Amitriptyline Tab 4-25 MG | |
| | Perphenazine-Amitriptyline Tab 4-50 MG | |
| **Cough/Cold/Allergy Combinations** | | |
| | Brompheniramine & Phenylephrine Syrup 1-2.5 MG/5ML | |
| | Cetirizine-Pseudoephedrine Tab SR 12HR 5-120 MG | |
| | Chlorpheniramine-DM Tab 4-30 MG | |
| | Desloratadine & Pseudoephedrine Tab SR 24HR 5-240 MG | |
| | Dextromethorphan-Guaifenesin Liquid 10-100 MG/5ML | |
| | Dextromethorphan-Guaifenesin Liquid 10-187 MG/5ML | |
| | Dextromethorphan-Guaifenesin Liquid 10-200 MG/5ML | |
| | Dextromethorphan-Guaifenesin Liquid 20-400 MG/5ML | |
| | Dextromethorphan-Guaifenesin Liquid 5-100 MG/5ML | |
| | Dextromethorphan-Guaifenesin Liquid 5-50 MG/ML | |
| | Dextromethorphan-Guaifenesin Syrup 10-100 MG/5ML | |
| | Diphenhydramine-Acetaminophen Tab 12.5-325 MG | |
| | Fexofenadine-Pseudoephedrine Tab SR 12HR 60-120 MG | |
| | Fexofenadine-Pseudoephedrine Tab SR 24HR 180-240 MG | |
| | Guaifenesin-Codeine Liquid 300-10 MG/5ML | |
| | Guaifenesin-Codeine Soln 100-10 MG/5ML | |
| | Hydrocod Polst-Chlorphen Polst Cap SR 12HR 10-8 MG | |
| | Hydrocod Polst-Chlorphen Polst ER Susp 10-8 MG/5ML | |
| | Loratadine & Pseudoephedrine Tab SR 12HR 5-120 MG | |
| | Loratadine & Pseudoephedrine Tab SR 24HR 10-240 MG | |
| | Phenylephrine w/ Acetaminophen Tab 5-325 MG | |
| | Phenylephrine w/ DM-GG Liqd 10-18-200 MG/15ML | |
| | Phenylephrine w/ DM-GG Liqd 2.5-5-100 MG/ML | |
| | Phenylephrine w/ DM-GG Liqd 5-10-100 MG/5ML | |
| | Phenylephrine w/ DM-GG Liquid 10-15-350 MG/5ML | |
| | Phenylephrine w/ DM-GG Tab 10-15-395 MG | |
| | Phenylephrine w/ DM-GG Tab 10-15-400 MG | |
| | Phenylephrine w/ DM-GG Tab 5-10-200 MG | |
| | Phenylephrine-Chlorphen-DM Liquid 10-2-15 MG/5ML | |
| | Phenylephrine-Chlorphen-DM Liquid 10-4-10 MG/5ML | |
| | Phenylephrine-Chlorphen-DM Liquid 6-2-15 MG/5ML | |
| | Phenylephrine-Chlorphen-DM Syrup 10-4-20 MG/5ML | |
| | Phenylephrine-Chlorphen-DM Tab 10-4-10 MG | |
| | Phenylephrine-Promethazine w/ Codeine Syrup 5-6.25-10 MG/5ML | |
| | Phenylephrine-Pyrilamine w/ Codeine Syrup 5-8.33-9 MG/5ML | |
| | Phenylephrine-Pyrilamine-DM Syrup 5-8.33-10 MG/5ML | |
| | Promethazine & Phenylephrine Syrup 6.25-5 MG/5ML | |
| | Promethazine w/ Codeine Syrup 6.25-10 MG/5ML | |
| | Promethazine-DM Syrup 6.25-15 MG/5ML | |
| | Pseudoephed-Bromphen-DM Syrup 30-2-10 MG/5ML | |
| | Pseudoephedrine w/ COD-GG Liquid 30-10-100 MG/5ML | |

# APPENDIX TO RULE 4123-6-21.3
## Formulary List of Medications Covered by the Ohio Bureau of Workers' Compensation

| Drug Class Name | Drug Generic Name | Coverage restrictions or limitations for specific drugs or dosage forms are listed with the respective drugs below. |
|---|---|---|
| | Pseudoephedrine w/ COD-GG Soln 30-10-100 MG/5ML | |
| | Pseudoephedrine w/ DM-GG Tab 30-30-400 MG | |
| | Pseudoephedrine w/ DM-GG Tab 60-15-400 MG | |
| | Pseudoephedrine w/ DM-GG Tab 60-20-380 MG | |
| | Pseudoephedrine-Guaifenesin Tab SR 12HR 120-1200 MG | |
| | Pseudoephedrine-Guaifenesin Tab SR 12HR 60-600 MG | |
| **Cystic Fibrosis Agents** | | |
| | Dornase Alfa Inhal Soln 1 MG/ML | |
| **Cytomegalovirus (CMV) Agents** | | |
| | Valganciclovir HCl Tab 450 MG (Base Equivalent) | |
| **Diabetic Supplies** | | |
| | Alcohol Swabs*** | |
| | Lancet Devices*** | |
| | Lancets Misc.*** | |
| | Lancets*** | |
| **Diagnostic Test** | | |
| | Glucose Blood Test Strip | |
| **Dietary Management Products - L-Methylfolate** | | **All combinations and strengths of oral dosage forms are covered for allowed conditions** |
| | L-Methylfolate Tab 7.5 MG** | |
| | L-Methylfolate Tab 15 MG** | |
| | L-Methylfolate w/ Vit B12-Vit B6-Vit B2 Tab 6-1-50-5 MG*** | |
| | L-Methylfolate w/ Vit B6-Vit B12 Tab 3-35-2 MG*** | |
| | L-Methylfolate w/ Vit B6-Vit B12 Tab 3-43.75-2.72 MG*** | |
| | L-Methylfolate-Algae Cap 15-90.314 MG*** | |
| | L-Methylfolate-Algae-Vit B12-B6 Cap 3-90.314-2-35 MG*** | |
| | L-Methylfolate-Methylcobalamin-Acetylcyst Tab 6-2-600 MG*** | |
| **Dietary Management Products - Misc** | | |
| | Folic Acid-Pyridoxine-Cyanocobalamin Tab 2.5-25-2 MG | |
| **Digestive Enzymes** | | **All oral formulations of pancreatic enzymes are covered for allowed conditions** |
| | Lactase Tab 3000 Unit | |
| | Pancrelipase (Lip-Prot-Amyl) DR Cap 3000-10000-16000 Unit | |
| | Pancrelipase (Lip-Prot-Amyl) DR Cap 6000-19000-30000 Unit | |
| | Pancrelipase (Lip-Prot-Amyl) DR Cap 8000-28750-30250 Unit | |
| | Pancrelipase (Lip-Prot-Amyl) DR Cap 10500-25000-43750 Unit | |
| | Pancrelipase (Lip-Prot-Amyl) DR Cap 12000-38000-60000 Unit | |
| | Pancrelipase (Lip-Prot-Amyl) DR Cap 13800-27600-27600 Unit | |
| | Pancrelipase (Lip-Prot-Amyl) DR Cap 16000-57500-60500 Unit | |
| | Pancrelipase (Lip-Prot-Amyl) DR Cap 16800-40000-70000 Unit | |
| | Pancrelipase (Lip-Prot-Amyl) DR Cap 20000-68000-109000 Unit | |
| | Pancrelipase (Lip-Prot-Amyl) DR Cap 20700-41400-41400 Unit | |
| | Pancrelipase (Lip-Prot-Amyl) DR Cap 23000-46000-46000 Unit | |
| | Pancrelipase (Lip-Prot-Amyl) DR Cap 24000-76000-120000 Unit | |
| | Pancrelipase (Lip-Prot-Amyl) DR Cap 25000-85000-136000 Unit | |
| | Pancrelipase (Lip-Prot-Amyl) DR Cap 36000-114000-180000 Unit | |
| | Pancrelipase (Lip-Prot-Amyl) DR Cap 40000-136000-218000 Unit | |
| | Pancrelipase (Lip-Prot-Amyl) Tab 10440-39150-39150 Unit | |
| | Pancrelipase (Lip-Prot-Amyl) Tab 20880-78300-78300 Unit | |
| **Diuretics** | | |
| | Acetazolamide Cap SR 12HR 500 MG | |
| | Acetazolamide Tab 125 MG | |
| | Acetazolamide Tab 250 MG | |
| | Amiloride & Hydrochlorothiazide Tab 5-50 MG | |
| | Amiloride HCl Tab 5 MG | |
| | Bumetanide Tab 0.5 MG | |
| | Bumetanide Tab 1 MG | |

## APPENDIX TO RULE 4123-6-21.3
## Formulary List of Medications Covered by the Ohio Bureau of Workers' Compensation

| Drug Class Name | Drug Generic Name | Coverage restrictions or limitations for specific drugs or dosage forms are listed with the respective drugs below. |
|---|---|---|
| | Bumetanide Tab 2 MG | |
| | Chlorthalidone Tab 25 MG | |
| | Chlorthalidone Tab 50 MG | |
| | Furosemide Oral Soln 10 MG/ML | |
| | Furosemide Tab 20 MG | |
| | Furosemide Tab 40 MG | |
| | Furosemide Tab 80 MG | |
| | Hydrochlorothiazide Cap 12.5 MG | |
| | Hydrochlorothiazide Tab 25 MG | |
| | Hydrochlorothiazide Tab 50 MG | |
| | Indapamide Tab 1.25 MG | |
| | Methazolamide Tab 25 MG | |
| | Methazolamide Tab 50 MG | |
| | Metolazone Tab 2.5 MG | |
| | Metolazone Tab 5 MG | |
| | Spironolactone Tab 25 MG | |
| | Spironolactone Tab 50 MG | |
| | Spironolactone Tab 100 MG | |
| | Torsemide Tab 10 MG | |
| | Torsemide Tab 20 MG | |
| | Torsemide Tab 100 MG | |
| | Triamterene & Hydrochlorothiazide Cap 37.5-25 MG | |
| | Triamterene & Hydrochlorothiazide Tab 37.5-25 MG | |
| | Triamterene & Hydrochlorothiazide Tab 75-50 MG | |
| **Electrolytes - Potassium** | | **All potassium salts and oral dosage forms are covered for allowed conditions** |
| | Potassium Bicarbonate Effer Tab 25 mEq | |
| | Potassium Chloride Cap CR 8 mEq | |
| | Potassium Chloride Cap CR 10 mEq | |
| | Potassium Chloride Microencapsulated Crys CR Tab 10 mEq | |
| | Potassium Chloride Microencapsulated Crys CR Tab 20 mEq | |
| | Potassium Chloride Oral Soln 10% (20 MEQ/15ML) | |
| | Potassium Chloride Powder Packet 20 mEq | |
| | Potassium Chloride Tab CR 8 mEq (600 MG) | |
| | Potassium Chloride Tab CR 10 mEq | |
| | Potassium Chloride Tab CR 20 mEq (1500 MG) | |
| | Potassium Gluconate Tab 80 MG (Elemental Potassium) | |
| | Potassium Gluconate Tab 550 MG (90 MG Equiv K) | |
| **Endocrine - Bone Density Regulators** | | |
| | Alendronate Sodium Oral Soln 70 MG/75ML | |
| | Alendronate Sodium Tab 5 MG | |
| | Alendronate Sodium Tab 35 MG | |
| | Alendronate Sodium Tab 40 MG | |
| | Alendronate Sodium Tab 70 MG | |
| | Alendronate Sodium-Cholecalciferol Tab 70-2800 MG-Unit | |
| | Calcitonin (Salmon) Nasal Soln 200 Unit/ACT | |
| | Etidronate Disodium Tab 200 MG | |
| | Etidronate Disodium Tab 400 MG | |
| | Ibandronate Sodium Tab 150 MG (Base Equivalent) | |
| | Risedronate Sodium Tab 30 MG | |
| | Risedronate Sodium Tab 35 MG | |
| | Risedronate Sodium Tab 150 MG | |
| | Risedronate Sodium Tab Delayed Release 35 MG | |
| | Teriparatide (Recombinant) Inj 600 MCG/2.4ML | |
| **Endocrine - Corticotropin** | | |
| | Corticotropin Inj Gel 80 Unit/ML | |
| **Endocrine - Growth Hormones** | | |

## APPENDIX TO RULE 4123-6-21.3
## Formulary List of Medications Covered by the Ohio Bureau of Workers' Compensation

| Drug Class Name | Drug Generic Name | Coverage restrictions or limitations for specific drugs or dosage forms are listed with the respective drugs below. |
|---|---|---|
| | Somatropin For Inj 6 MG (18 Unit) | |
| **Endocrine - Hormone Receptor Modulators** | | |
| | Raloxifene HCl Tab 60 MG | |
| **Endocrine - Metabolic Modifiers** | | |
| | Calcitriol Cap 0.25 MCG | |
| | Calcitriol Cap 0.5 MCG | |
| | Cinacalcet HCl Tab 30 MG (Base Equiv) | |
| | Doxercalciferol Cap 0.5 MCG | |
| | Doxercalciferol Cap 2.5 MCG | |
| | Paricalcitol Cap 1 MCG | |
| | Paricalcitol Cap 2 MCG | |
| **Endocrine - Posterior Pituitary Hormones** | | |
| | Desmopressin Acetate Inj 4 MCG/ML | |
| | Desmopressin Acetate Nasal Soln 0.01% (Refrigerated) | |
| | Desmopressin Acetate Nasal Spray Soln 0.01% | |
| | Desmopressin Acetate Nasal Spray Soln 0.01% (Refrigerated) | |
| | Desmopressin Acetate Tab 0.1 MG | |
| | Desmopressin Acetate Tab 0.2 MG | |
| **Estrogens** | | |
| | Estradiol Tab 0.5 MG | |
| **Expectorants** | | |
| | Guaifenesin Liquid 100 MG/5ML | |
| | Guaifenesin Syrup 100 MG/5ML | |
| | Guaifenesin Tab 200 MG | |
| | Guaifenesin Tab 400 MG | |
| | Guaifenesin Tab SR 12HR 600 MG | |
| | Guaifenesin Tab SR 12HR 1200 MG | |
| **Fibromyalgia Agents** | | |
| | Milnacipran HCl Tab 12.5 MG | |
| | Milnacipran HCl Tab 25 MG | |
| | Milnacipran HCl Tab 50 MG | |
| | Milnacipran HCl Tab 100 MG | |
| | Milnacipran HCl Tab 12.5 MG (5) & 25 MG (8) & 50 MG (42) Pak | |
| **G.I. Agent - Antiflatulents** | | |
| | Simethicone Cap 125 MG | |
| | Simethicone Cap 180 MG | |
| | Simethicone Chew Tab 80 MG | |
| | Simethicone Chew Tab 125 MG | |
| | Simethicone Susp 40 MG/0.6ML | |
| **G.I. Agent - Gallstone Solubilizing Agents** | | |
| | Ursodiol Cap 300 MG | |
| **G.I. Agent - Gastrointestinal Chloride Channel Activators** | | |
| | Lubiprostone Cap 8 MCG | |
| | Lubiprostone Cap 24 MCG | |
| **G.I. Agent - Gastrointestinal Stimulants** | | |
| | Metoclopramide HCl Soln 5 MG/5ML (10 MG/10ML) | |
| | Metoclopramide HCl Tab 5 MG | |
| | Metoclopramide HCl Tab 10 MG | |
| **G.I. Agent - Inflammatory Bowel Agents** | | |
| | Balsalazide Disodium Cap 750 MG | |
| | Balsalazide Disodium Tab 1.1 GM | |
| | Mesalamine Cap CR 500 MG | |
| | Mesalamine Cap DR 400 MG | |
| | Mesalamine Enema 4 GM | |
| | Mesalamine Suppos 1000 MG | |

## APPENDIX TO RULE 4123-6-21.3
## Formulary List of Medications Covered by the Ohio Bureau of Workers' Compensation

| Drug Class Name | Drug Generic Name | Coverage restrictions or limitations for specific drugs or dosage forms are listed with the respective drugs below. |
|---|---|---|
| | Mesalamine Tab Delayed Release 400 MG | |
| | Mesalamine Tab Delayed Release 800 MG | |
| | Mesalamine Tab Delayed Release 1.2 GM | |
| | Olsalazine Sodium Cap 250 MG | |
| | Sulfasalazine Tab 500 MG | |
| | Sulfasalazine Tab Delayed Release 500 MG | |
| **G.I. Agent - Intestinal Acidifiers** | | |
| | Lactulose (Encephalopathy) Solution 10 GM/15ML | |
| **G.I. Agent - Peripheral Opioid Receptor Antagonists** | | |
| | Methylnaltrexone Bromide Inj 8 MG/0.4ML (20 MG/ML) | **Reimbursement limited to claims in which a prior authorization has documented a diagnosis of opioid induced constipation; defined as fewer than 3 bowel movements per week or 2 consecutive days without a bowel movement. Patient must have received opioid prescriptions reimbursed by BWC for at least 8 weeks at a dose of 40 mg or greater Morphine Equivalent Dose/day. Office notes must document previous failed therapy with at least two separate trials of prescribed stool softener/stimulant laxative or other laxative classes. Reimbursement is limited to one vial or syringe per day.** |
| | Methylnaltrexone Bromide Inj 12 MG/0.6ML (20 MG/ML) | **Reimbursement limited to claims in which a prior authorization has documented a diagnosis of opioid induced constipation; defined as fewer than 3 bowel movements per week or 2 consecutive days without a bowel movement. Patient must have received opioid prescriptions reimbursed by BWC for at least 8 weeks at a dose of 40 mg or greater Morphine Equivalent Dose/day. Office notes must document previous failed therapy with at least two separate trials of prescribed stool softener/stimulant laxative or other laxative classes. Reimbursement is limited to one vial or syringe per day.** |
| | Naloxegol Oxalate Tab 12.5 MG (Base Equivalent) | **Reimbursement limited to claims in which a prior authorization has documented a diagnosis of opioid induced constipation; defined as fewer than 3 bowel movements per week or 2 consecutive days without a bowel movement. Patient must have received opioid prescriptions reimbursed by BWC for at least 8 weeks at a dose of 40 mg or greater Morphine Equivalent Dose/day. Office notes must document previous failed therapy with at least two separate trials of prescribed stool softener/stimulant laxative or other laxative classes. Reimbursement is limited to one vial or syringe per day.** |
| | Naloxegol Oxalate Tab 25 MG (Base Equivalent) | **Reimbursement limited to claims in which a prior authorization has documented a diagnosis of opioid induced constipation; defined as fewer than 3 bowel movements per week or 2 consecutive days without a bowel movement. Patient must have received opioid prescriptions reimbursed by BWC for at least 8 weeks at a dose of 40 mg or greater Morphine Equivalent Dose/day. Office notes must document previous failed therapy with at least two separate trials of prescribed stool softener/stimulant laxative or other laxative classes. Reimbursement is limited to one vial or syringe per day.** |

# APPENDIX TO RULE 4123-6-21.3
## Formulary List of Medications Covered by the Ohio Bureau of Workers' Compensation

| Drug Class Name | Drug Generic Name | Coverage restrictions or limitations for specific drugs or dosage forms are listed with the respective drugs below. |
|---|---|---|
| **Genitourinary - Alkalinizers** | | |
| | Potassium Citrate & Citric Acid Soln 1100-334 MG/5ML | |
| | Potassium Citrate Tab CR 5 MEQ (540 MG) | |
| | Potassium Citrate Tab CR 10 MEQ (1080 MG) | |
| **Genitourinary Irrigants** | | |
| | Acetic Acid Irrigation Soln 0.25% | |
| | Citric Acid & D-Gluconic Acid Soln | |
| **Glucocorticosteroids** | | |
| | Cortisone Acetate Tab 25 MG | |
| | Dexamethasone Conc 1 MG/ML | |
| | Dexamethasone Elixir 0.5 MG/5ML | |
| | Dexamethasone Soln 0.5 MG/5ML | |
| | Dexamethasone Tab 0.5 MG | |
| | Dexamethasone Tab 0.75 MG | |
| | Dexamethasone Tab 1 MG | |
| | Dexamethasone Tab 1.5 MG | |
| | Dexamethasone Tab 2 MG | |
| | Dexamethasone Tab 4 MG | |
| | Dexamethasone Tab 6 MG | |
| | Dexamethasone Tab Therapy Pack 1.5 MG (21) | |
| | Dexamethasone Tab Therapy Pack 1.5 MG (35) | |
| | Dexamethasone Tab Therapy Pack 1.5 MG (51) | |
| | Dexamethasone Sod Phosphate Preservative Free Inj 10 MG/ML | |
| | Dexamethasone Sodium Phosphate Inj 4 MG/ML | |
| | Dexamethasone Sodium Phosphate Inj 10 MG/ML | |
| | Dexamethasone Sodium Phosphate Inj 20 MG/5ML | |
| | Dexamethasone Sodium Phosphate Inj 120 MG/30ML | |
| | Dexamethasone Sodium Phosphate Inj 100 MG/10ML | |
| | Hydrocortisone Tab 5 MG | |
| | Hydrocortisone Tab 10 MG | |
| | Hydrocortisone Tab 20 MG | |
| | Methylprednisolone Acetate Inj Susp 40 MG/ML | |
| | Methylprednisolone Acetate Inj Susp 80 MG/ML | |
| | Methylprednisolone Acetate PF Inj Susp 40 MG/ML | |
| | Methylprednisolone Acetate PF Inj Susp 80 MG/ML | |
| | Methylprednisolone Sodium Succinate For Inj 125 MG | |
| | Methylprednisolone Tab 2 MG | |
| | Methylprednisolone Tab 4 MG | |
| | Methylprednisolone Tab 8 MG | |
| | Methylprednisolone Tab 16 MG | |
| | Methylprednisolone Tab 32 MG | |
| | Methylprednisolone Tab Therapy Pack 4 MG (21) | |
| | Prednisolone Sod Phosph Oral Soln 6.7 MG/5ML (5 MG/5ML Base) | |
| | Prednisolone Sod Phosphate Oral Soln 15 MG/5ML (Base Equiv) | |
| | Prednisolone Sodium Phosphate Oral Soln 25 MG/5ML (Base Eq) | |
| | Prednisolone Syrup 15 MG/5ML (USP Solution Equivalent) | |
| | Prednisolone Tab 5 MG | |
| | Prednisolone Tab Therapy Pack 5 MG (21) | |
| | Prednisolone Tab Therapy Pack 5 MG (48) | |
| | Prednisone Oral Soln 5 MG/5ML | |
| | Prednisone Tab 1 MG | |
| | Prednisone Tab 2.5 MG | |
| | Prednisone Tab 5 MG | |
| | Prednisone Tab 10 MG | |
| | Prednisone Tab 20 MG | |
| | Prednisone Tab 50 MG | |
| | Prednisone Tab Therapy Pack 5 MG (21) | |

# APPENDIX TO RULE 4123-6-21.3
## Formulary List of Medications Covered by the Ohio Bureau of Workers' Compensation

| Drug Class Name | Drug Generic Name | Coverage restrictions or limitations for specific drugs or dosage forms are listed with the respective drugs below. |
|---|---|---|
| | Prednisone Tab Therapy Pack 5 MG (48) | |
| | Prednisone Tab Therapy Pack 10 MG (21) | |
| | Prednisone Tab Therapy Pack 10 MG (48) | |
| | Triamcinolone Acetonide Inj Susp 40 MG/ML | |
| **Gout Agents** | | |
| | Allopurinol Tab 100 MG | |
| | Allopurinol Tab 300 MG | |
| | Colchicine Cap 0.6 MG | |
| | Colchicine Tab 0.6 MG | |
| | Febuxostat Tab 40 MG | |
| | Febuxostat Tab 80 MG | |
| **Hematopoietic Agents - Cobalamins** | | |
| | Cyanocobalamin Cap 1000 MCG | |
| | Cyanocobalamin Cap 3000 MCG | |
| | Cyanocobalamin Cap 5000 MCG | |
| | Cyanocobalamin Tab 500 MCG | |
| | Cyanocobalamin Tab 1000 MCG | |
| | Cyanocobalamin Tab 2500 MCG | |
| **Hematopoietic Agents - Folic Acid/Folates** | | |
| | Folic Acid Tab 800 MCG | |
| | Folic Acid Tab 1 MG | |
| **Hematopoietic Agents - Iron** | | **All iron salts and oral dosage forms are covered for allowed conditions** |
| | Carbonyl Iron Tab 45 MG (Elemental Iron) | |
| | Ferrous Fumarate Tab CR 50 MG (Fe Equivalent) | |
| | Ferrous Gluconate Tab 324 MG (38 MG Elemental Iron) | |
| | Ferrous Sulfate Dried Tab CR 160 MG (50 MG Fe Equivalent) | |
| | Ferrous Sulfate Elixir 220 MG/5ML (44 MG/5ML Elemental Fe) | |
| | Ferrous Sulfate Syrup 300 MG/5ML (60 MG/5ML Elemental Fe) | |
| | Ferrous Sulfate Tab 325 MG (65 MG Elemental Fe) | |
| | Ferrous Sulfate Tab CR 142 MG (45 MG Fe Equivalent) | |
| | Ferrous Sulfate Tab CR 143 MG (45 MG Fe Equivalent) | |
| | Ferrous Sulfate Tab CR 47.5 MG (Elemental Fe) | |
| | Ferrous Sulfate Tab EC 324 MG (65 MG Fe Equivalent) | |
| | Ferrous Sulfate Tab EC 325 MG (65 MG Fe Equivalent) | |
| | Polysaccharide Iron Complex Cap 150 MG (Iron Equivalent) | |
| | Polysaccharide Iron Complex Cap 391.3 MG (180 MG Elem Fe) | |
| **Hematopoietic Growth Factors** | | |
| | Darbepoetin Alfa Soln Prefilled Syringe 10 MCG/0.4ML | |
| | Darbepoetin Alfa Soln Prefilled Syringe 60 MCG/0.3ML | |
| | Epoetin Alfa Inj 40000 Unit/ML | |
| | Filgrastim Soln Prefilled Syringe 300 MCG/0.5ML | |
| | Filgrastim-sndz Soln Prefilled Syringe 300 MCG/0.5ML | |
| | Filgrastim-sndz Soln Prefilled Syringe 480 MCG/0.8ML | |
| | Pegfilgrastim Soln Prefilled Syringe 6 MG/0.6ML | |
| | Pegfilgrastim Soln Prefilled Syringe Kit 6 MG/0.6ML | |
| **Hematopoietic Mixtures** | | |
| | Fe Asp Gly-Fe Polysacch-Succ Ac-C-Threon Ac-B12-FA Cap*** | |
| | Fe Asp Gly-Fe Polysacc-Succ Ac-C-Threon Ac Cap*** | |
| | Fe Asparto Gly-Succ Acd-C-Threonic Acd-B12-Des Stom Tab*** | |
| | Fe Fumarate w/ B12-Vit C-FA-IFC Cap 110-0.015-75-0.5-240 MG | |
| | Folic Acid-Vitamin B6-Vitamin B12 Tab 2.2-25-1 MG | |
| | Iron Polysacch Complex-Vit B12-FA Cap 150-0.025-1 MG | |
| **Hematorheologic Agents** | | |
| | Pentoxifylline Tab CR 400 MG | |
| **Hemostatics - Systemic** | | |

## APPENDIX TO RULE 4123-6-21.3
## Formulary List of Medications Covered by the Ohio Bureau of Workers' Compensation

| Drug Class Name | Drug Generic Name | Coverage restrictions or limitations for specific drugs or dosage forms are listed with the respective drugs below. |
|---|---|---|
| | Aminocaproic Acid Oral Soln 0.25 GM/ML | |
| | Aminocaproic Acid Syrup 25% | |
| | Aminocaproic Acid Tab 500 MG | |
| | Aminocaproic Acid Tab 1000 MG | |
| **Hepatitis Agents** | | |
| | Daclatasvir Dihydrochloride Tab 30 MG (Base Equivalent) | |
| | Daclatasvir Dihydrochloride Tab 60 MG (Base Equivalent) | |
| | Daclatasvir Dihydrochloride Tab 90 MG (Base Equivalent) | |
| | Elbasvir-Grazoprevir Tab 50-100 MG | |
| | Ledipasvir-Sofosbuvir Tab 90-400 MG | |
| | Peginterferon alfa-2a Inj 135 MCG/0.5ML | |
| | Peginterferon alfa-2a Inj 180 MCG/0.5ML | |
| | Peginterferon alfa-2a Inj Kit 180 MCG/0.5ML | |
| | Peginterferon alfa-2b For Inj Kit 50 MCG/0.5ML | |
| | Peginterferon alfa-2b For Inj Kit 80 MCG/0.5ML | |
| | Ribavirin Cap 200 MG | |
| | Ribavirin Tab 200 MG | |
| | Sofosbuvir Tab 400 MG | |
| | Sofosbuvir-Velpatasvir Tab 400-100 MG | |
| **Herpes Agents** | | |
| | Acyclovir Cap 200 MG | |
| | Acyclovir Susp 200 MG/5ML | |
| | Acyclovir Tab 400 MG | |
| | Acyclovir Tab 800 MG | |
| | Famciclovir Tab 125 MG | |
| | Famciclovir Tab 250 MG | |
| | Famciclovir Tab 500 MG | |
| | Valacyclovir HCl Tab 500 MG | |
| | Valacyclovir HCl Tab 1 GM | |
| **Hypnotics - Antihistamine** | | |
| | Diphenhydramine-Acetaminophen Tab 25-500 MG (sleep) | |
| | Ibuprofen-Diphenhydramine Citrate Tab 200-38 MG | |
| **Hypnotics - Barbiturate** | | |
| | Butabarbital Sodium Tab 30 MG | |
| | Phenobarbital Elixir 20 MG/5ML | |
| | Phenobarbital Tab 15 MG | |
| | Phenobarbital Tab 16.2 MG | |
| | Phenobarbital Tab 30 MG | |
| | Phenobarbital Tab 32.4 MG | |
| | Phenobarbital Tab 60 MG | |
| | Phenobarbital Tab 64.8 MG | |
| | Phenobarbital Tab 97.2 MG | |
| **Hypnotics - Non-Barbiturate** | | **Reimbursement is restricted to only the following drugs in this class: Zolpidem Immediate Release and Continuous release tablets, Temazepam capsules, Zaleplon capsules and Eszopiclone tablets.** |
| | Eszopiclone Tab 1 MG | |
| | Eszopiclone Tab 2 MG | |
| | Eszopiclone Tab 3 MG | |
| | Temazepam Cap 7.5 MG | |
| | Temazepam Cap 15 MG | |
| | Temazepam Cap 22.5 MG | |
| | Temazepam Cap 30 MG | |
| | Zaleplon Cap 5 MG | |
| | Zaleplon Cap 10 MG | |
| | Zolpidem Tartrate Tab 5 MG | |

# APPENDIX TO RULE 4123-6-21.3
## Formulary List of Medications Covered by the Ohio Bureau of Workers' Compensation

| Drug Class Name | Drug Generic Name | Coverage restrictions or limitations for specific drugs or dosage forms are listed with the respective drugs below. |
|---|---|---|
| | Zolpidem Tartrate Tab 10 MG | |
| | Zolpidem Tartrate Tab CR 6.25 MG | |
| | Zolpidem Tartrate Tab CR 12.5 MG | |
| **Immunomodulators** | | |
| | Lenalidomide Caps 2.5 MG | |
| | Lenalidomide Cap 5 MG | |
| | Lenalidomide Cap 10 MG | |
| | Lenalidomide Cap 20 MG | |
| **Immunosuppressive Agents** | | |
| | Azathioprine Tab 50 MG | |
| | Cyclosporine Cap 100 MG | |
| | Cyclosporine Modified Cap 25 MG | |
| | Cyclosporine Modified Cap 100 MG | |
| | Cyclosporine Modified Oral Soln 100 MG/ML | |
| | Cyclosporine Oral Soln 100 MG/ML | |
| | Everolimus Tab 0.25 MG | |
| | Everolimus Tab 0.5 MG | |
| | Everolimus Tab 0.75 MG | |
| | Mycophenolate Mofetil Cap 250 MG | |
| | Mycophenolate Mofetil Tab 500 MG | |
| | Mycophenolate Sodium Tab DR 180 MG (Mycophenolic Acid Equiv) | |
| | Mycophenolate Sodium Tab DR 360 MG (Mycophenolic Acid Equiv) | |
| | Sirolimus Oral Soln 1 MG/ML | |
| | Sirolimus Tab 0.5 MG | |
| | Sirolimus Tab 1 MG | |
| | Sirolimus Tab 2 MG | |
| | Tacrolimus Cap 0.5 MG | |
| | Tacrolimus Cap 1 MG | |
| | Tacrolimus Cap 5 MG | |
| | Tacrolimus Tab SR 24HR 0.75 MG | |
| | Tacrolimus Tab SR 24HR 1 MG | |
| | Tacrolimus Tab SR 24HR 4 MG | |
| **Impotence Agents** | | |
| | Alprostadil For Inj 20 MCG | **Max 6 units per 30 Days** |
| | Alprostadil For Inj Kit 10 MCG | **Max 6 units per 30 Days** |
| | Alprostadil For Inj Kit 20 MCG | **Max 6 units per 30 Days** |
| | Alprostadil For Inj Kit 40 MCG | **Max 6 units per 30 Days** |
| | Alprostadil Urethral Pellet 250 MCG | **Max 6 pellet per 30 Days** |
| | Alprostadil Urethral Pellet 500 MCG | **Max 6 pellet per 30 Days** |
| | Alprostadil Urethral Pellet 1000 MCG | **Max 6 pellet per 30 Days** |
| | Sildenafil Citrate Tab 25 MG | **Max 6 tab per 30 Days** |
| | Sildenafil Citrate Tab 50 MG | **Max 6 tab per 30 Days** |
| | Sildenafil Citrate Tab 100 MG | **Max 6 tab per 30 Days** |
| | Tadalafil Tab 2.5 MG | **Max 30 tab per 30 Days** |
| | Tadalafil Tab 5 MG | **Max 30 tab per 30 Days** |
| | Tadalafil Tab 10 MG | **Max 6 tab per 30 Days** |
| | Tadalafil Tab 20 MG | **Max 6 tab per 30 Days** |
| | Vardenafil HCl Tab 5 MG | **Max 6 tab per 30 Days** |
| | Vardenafil HCl Tab 10 MG | **Max 6 tab per 30 Days** |
| | Vardenafil HCl Tab 20 MG | **Max 6 tab per 30 Days** |
| **Influenza Agents** | | |
| | Oseltamivir Phosphate Cap 75 MG (Base Equiv) | |
| | Zanamivir Aero Powder Breath Activated 5 MG/BLISTER | |
| **Insulin Administration Supplies** | | |
| | Insulin Pen Needle 29 G X 5 MM (3/16") | |
| | Insulin Pen Needle 29 G X 8 MM (5/16") | |

## APPENDIX TO RULE 4123-6-21.3
## Formulary List of Medications Covered by the Ohio Bureau of Workers' Compensation

| Drug Class Name | Drug Generic Name | Coverage restrictions or limitations for specific drugs or dosage forms are listed with the respective drugs below. |
|---|---|---|
| | Insulin Pen Needle 29 G X 12 MM (1/2") | |
| | Insulin Pen Needle 29 G X 12.7 MM | |
| | Insulin Pen Needle 29 G X 13 MM (1/2") | |
| | Insulin Pen Needle 30 G X 5 MM (3/16") | |
| | Insulin Pen Needle 30 G X 8 MM (1/3" or 5/16") | |
| | Insulin Pen Needle 31 G X 4 MM (1/6") | |
| | Insulin Pen Needle 31 G X 5 MM (3/16") | |
| | Insulin Pen Needle 31 G X 6 MM (1/4") | |
| | Insulin Pen Needle 31 G X 8 MM (1/3" or 5/16") | |
| | Insulin Pen Needle 32 G X 4 MM (5/32") | |
| | Insulin Pen Needle 32 G X 5 MM (1/5" or 3/16") | |
| | Insulin Pen Needle 32 G X 6 MM (1/4") | |
| | Insulin Pen Needle 32 G X 8 MM | |
| | Insulin Pen Needle 33 G X 4 MM (5/32") | |
| | Insulin Pen Needle 33 G X 5 MM (1/5" or 3/16") | |
| | Insulin Pen Needle 33 G X 6 MM (1/4") | |
| | Insulin Pen Needle 33 G X 8 MM (1/3" or 5/16") | |
| | Insulin Syringe (Disp) U-100 0.3 ML | |
| | Insulin Syringe (Disp) U-100 1/2 ML | |
| | Insulin Syringe (Disp) U-100 1 ML | |
| | Insulin Syringe/Needle U-40 1 ML 25 x 5/8" | |
| | Insulin Syringe/Needle U-100 0.3 ML 28 x 1/2" | |
| | Insulin Syringe/Needle U-100 0.3 ML 29 G | |
| | Insulin Syringe/Needle U-100 0.3 ML 29 x 1" | |
| | Insulin Syringe/Needle U-100 0.3 ML 29 x 1/2" | |
| | Insulin Syringe/Needle U-100 0.3 ML 29 x 7/16" | |
| | Insulin Syringe/Needle U-100 0.3 ML 30 G | |
| | Insulin Syringe/Needle U-100 0.3 ML 30 x 1/2" | |
| | Insulin Syringe/Needle U-100 0.3 ML 30 x 3/8" | |
| | Insulin Syringe/Needle U-100 0.3 ML 30 x 5/16" | |
| | Insulin Syringe/Needle U-100 0.3 ML 30 x 7/16" | |
| | Insulin Syringe/Needle U-100 0.3 ML 31 x 1/4" (6 MM) | |
| | Insulin Syringe/Needle U-100 0.3 ML 31 x 15/64" | |
| | Insulin Syringe/Needle U-100 0.3 ML 31 x 3/8" | |
| | Insulin Syringe/Needle U-100 0.3 ML 31 x 5/16" | |
| | Insulin Syringe/Needle U-100 0.5 ML 31 x 1/4" (6 MM) | |
| | Insulin Syringe/Needle U-100 1 ML 25 x 1" | |
| | Insulin Syringe/Needle U-100 1 ML 25 x 5/8" | |
| | Insulin Syringe/Needle U-100 1 ML 26 x 1/2" | |
| | Insulin Syringe/Needle U-100 1 ML 27 x 1/2" | |
| | Insulin Syringe/Needle U-100 1 ML 27 x 5/8" | |
| | Insulin Syringe/Needle U-100 1 ML 28 x 1/2" | |
| | Insulin Syringe/Needle U-100 1 ML 28 x 5/16" | |
| | Insulin Syringe/Needle U-100 1 ML 29 G | |
| | Insulin Syringe/Needle U-100 1 ML 29 x 1/2" | |
| | Insulin Syringe/Needle U-100 1 ML 29 x 5/16" | |
| | Insulin Syringe/Needle U-100 1 ML 29 x 7/16" | |
| | Insulin Syringe/Needle U-100 1 ML 30 G | |
| | Insulin Syringe/Needle U-100 1 ML 30 x 1/2" | |
| | Insulin Syringe/Needle U-100 1 ML 30 x 3/8" | |
| | Insulin Syringe/Needle U-100 1 ML 30 x 5/16" | |
| | Insulin Syringe/Needle U-100 1 ML 30 x 7/16" | |
| | Insulin Syringe/Needle U-100 1 ML 31 x 1/4" (6 MM) | |
| | Insulin Syringe/Needle U-100 1 ML 31 x 15/64" | |
| | Insulin Syringe/Needle U-100 1 ML 31 x 3/8" | |
| | Insulin Syringe/Needle U-100 1 ML 31 x 5/16" | |
| | Insulin Syringe/Needle U-100 1/2 ML 27 x 1/2" | |

## APPENDIX TO RULE 4123-6-21.3
## Formulary List of Medications Covered by the Ohio Bureau of Workers' Compensation

| Drug Class Name | Drug Generic Name | Coverage restrictions or limitations for specific drugs or dosage forms are listed with the respective drugs below. |
|---|---|---|
| | Insulin Syringe/Needle U-100 1/2 ML 28 x 1/2" | |
| | Insulin Syringe/Needle U-100 1/2 ML 28 x 5/16" | |
| | Insulin Syringe/Needle U-100 1/2 ML 29 G | |
| | Insulin Syringe/Needle U-100 1/2 ML 29 x 1/2" | |
| | Insulin Syringe/Needle U-100 1/2 ML 29 x 5/16" | |
| | Insulin Syringe/Needle U-100 1/2 ML 29 x 7/16" | |
| | Insulin Syringe/Needle U-100 1/2 ML 30 G | |
| | Insulin Syringe/Needle U-100 1/2 ML 30 x 1/2" | |
| | Insulin Syringe/Needle U-100 1/2 ML 30 x 3/8" | |
| | Insulin Syringe/Needle U-100 1/2 ML 30 x 5/16" | |
| | Insulin Syringe/Needle U-100 1/2 ML 30 x 7/16" | |
| | Insulin Syringe/Needle U-100 1/2 ML 31 x 15/64" | |
| | Insulin Syringe/Needle U-100 1/2 ML 31 x 3/8" | |
| | Insulin Syringe/Needle U-100 1/2 ML 31 x 5/16" | |
| | Insulin Syringe/Needle U-100 2 ML 27.5 x 5/8" | |
| | Insulin Syringe/Needle U-100 2 ML 29 x 1/2" | |
| **Interstitial Cystitis Agents** | | |
| | Pentosan Polysulfate Sodium Caps 100 MG | |
| **Iodine Products** | | |
| | Potassium Iodide Soln 1 GM/ML | |
| **Laxatives** | | **All laxatives are covered. All bowel prep products are covered for allowed conditions.** |
| **Laxative Combinations** | | |
| | Bisacodyl Tab & PEG 3350-KCl-Sod Bicarb-NaCl For Soln Kit | |
| | PEG 3350-KCl-Na Bicarb-NaCl-Na Sulfate For Soln 236 GM | |
| | PEG 3350-KCl-Na Bicarb-NaCl-Na Sulfate For Soln 240 GM | |
| | PEG 3350-KCl-Na Bicarb-NaCl-Na Sulfate Packet 227.1 GM | |
| | PEG 3350-KCl-NaCl-Na Sulfate-Na Ascorbate-C For Soln 100 GM | |
| | PEG 3350-KCl-Sod Bicarb-NaCl For Soln 420 GM | |
| | Psyllium w/ Calcium Capsule | |
| | Sennosides-Docusate Sodium Tab 8.6-50 MG | |
| | Sodium Sulfate-Potassium Sulfate-Magnesium Sulfate Oral Soln | |
| **Laxatives - Bulk** | | |
| | Calcium Polycarbophil Tab 625 MG | |
| | Cellulose Powder | |
| | Methylcellulose Powder Laxative | |
| | Methylcellulose Tab 500 MG | |
| | Psyllium Cap 0.52 GM | |
| | Psyllium Powder 28.3% | |
| | Psyllium Powder 30.9% | |
| | Psyllium Powder 33% | |
| | Psyllium Powder 48.57% | |
| | Psyllium Powder 49% | |
| | Psyllium Powder 52.3% | |
| | Psyllium Powder 58.6% | |
| | Psyllium Powder Packet 28% | |
| | Psyllium Powder Packet 58.12% | |
| | Psyllium Powder Packet 58.6% | |
| | Psyllium Powder Packet 60.3% | |
| | Wheat Dextrin Oral Powder** | |
| | Wheat Dextrin Packet** | |
| **Laxatives - Lubricant** | | |
| | Mineral Oil | |
| | Mineral Oil Emul 50% | |
| | Mineral Oil Enema | |
| **Laxatives - Miscellaneous** | | |
| | Glycerin Suppos 2 GM | |

## APPENDIX TO RULE 4123-6-21.3
## Formulary List of Medications Covered by the Ohio Bureau of Workers' Compensation

| Drug Class Name | Drug Generic Name | Coverage restrictions or limitations for specific drugs or dosage forms are listed with the respective drugs below. |
|---|---|---|
| | Glycerin Suppos 2.1 GM | |
| | Glycerin Suppos 80.7% | |
| | Lactulose Oral Crystal Packet 10 GM | |
| | Lactulose Oral Crystal Packet 20 GM | |
| | Lactulose Solution 10 GM/15ML | |
| | Polyethylene Glycol 3350 Oral Packet | |
| | Polyethylene Glycol 3350 Oral Powder | |
| | Sorbitol Oral Solution 70% | |
| | Sorbitol Solution (Bulk) | |
| **Laxatives - Saline** | | |
| | Magnesium Citrate Soln | |
| | Magnesium Hydroxide Susp 400 MG/5ML | |
| | Sod Phos Mono-Sod Phos Di Tabs 1.102-0.398 GM(1.5GM Na Phos) | |
| | Sodium Phosphates - Enema*** | |
| **Laxatives - Stimulant** | | |
| | Bisacodyl Enema 10 MG/30ML | |
| | Bisacodyl Suppos 10 MG | |
| | Bisacodyl Tab Delayed Release 5 MG | |
| | Senna Tab** | |
| | Sennosides Cap 8.6 MG | |
| | Sennosides Syrup 8.8 MG/5ML | |
| | Sennosides Tab 15 MG | |
| | Sennosides Tab 17.2 MG | |
| | Sennosides Tab 25 MG | |
| | Sennosides Tab 8.6 MG | |
| **Laxatives - Surfactant** | | |
| | Benzocaine-Docusate Sodium Rectal Enema 20-283 MG | |
| | Docusate Calcium Cap 240 MG | |
| | Docusate Sodium Cap 50 MG | |
| | Docusate Sodium Cap 100 MG | |
| | Docusate Sodium Cap 250 MG | |
| | Docusate Sodium Enema 283 MG | |
| | Docusate Sodium Liquid 150 MG/15ML | |
| | Docusate Sodium Syrup 60 MG/15ML | |
| **Migraine Products - Misc** | | |
| | Dihydroergotamine Mesylate Nasal Spray 4 MG/ML | |
| | Ergotamine w/ Caffeine Tab 1-100 MG | |
| | Isometheptene-Dichloral-Acetaminophen Cap 65-100-325 MG | |
| **Migraine Products - Serotonin Agonist/NSAID** | | |
| | Sumatriptan-Naproxen Sodium Tab 85-500 MG | **Max 9 tab per 30 days** |
| **Migraine Products - Serotonin Agonists** | | |
| | Almotriptan Malate Tab 12.5 MG | **Max 12 tab per 30 days** |
| | Eletriptan Hydrobromide Tab 20 MG (Base Equivalent) | **Max 6 tab per 30 days** |
| | Eletriptan Hydrobromide Tab 40 MG (Base Equivalent) | **Max 6 tab per 30 days** |
| | Frovatriptan Succinate Tab 2.5 MG (Base Equivalent) | **Max 9 tab per 30 days** |
| | Naratriptan HCl Tab 2.5 MG (Base Equiv) | **Max 9 tab per 30 days** |
| | Rizatriptan Benzoate Oral Disintegrating Tab 5 MG (Base Eq) | **Max 12 tab per 30 days<br>Oral disintegrating dosage form is restricted to claims with an allowed condition that results in the inabiity to swallow or absorb oral medications** |
| | Rizatriptan Benzoate Oral Disintegrating Tab 10 MG (Base Eq) | **Max 12 tab per 30 days<br>Oral disintegrating dosage form is restricted to claims with an allowed condition that results in the inabiity to swallow or absorb oral medications** |
| | Rizatriptan Benzoate Tab 5 MG (Base Equivalent) | **Max 12 tab per 30 days** |
| | Rizatriptan Benzoate Tab 10 MG (Base Equivalent) | **Max 12 tab per 30 days** |

## APPENDIX TO RULE 4123-6-21.3
## Formulary List of Medications Covered by the Ohio Bureau of Workers' Compensation

| Drug Class Name | Drug Generic Name | Coverage restrictions or limitations for specific drugs or dosage forms are listed with the respective drugs below. |
|---|---|---|
| | Sumatriptan Nasal Spray 5 MG/ACT | **Max 12 units per 30 days** |
| | Sumatriptan Nasal Spray 20 MG/ACT | **Max 6 units per 30 days** |
| | Sumatriptan Succinate Inj 4 MG/0.5ML | **Max 8 units per 30 days** |
| | Sumatriptan Succinate Inj 6 MG/0.5ML | **Max 10 units per 30 days** |
| | Sumatriptan Succinate Solution Auto-injector 4 MG/0.5ML | **Max 8 units per 30 days** |
| | Sumatriptan Succinate Solution Auto-injector 6 MG/0.5ML | **Max 10 units per 30 days** |
| | Sumatriptan Succinate Solution Cartridge 4 MG/0.5ML | **Max 8 units per 30 days** |
| | Sumatriptan Succinate Solution Cartridge 6 MG/0.5ML | **Max 10 units per 30 days** |
| | Sumatriptan Succinate Solution Jet-injector 4 MG/0.5ML | **Max 8 units per 30 days** |
| | Sumatriptan Succinate Solution Jet-injector 6 MG/0.5ML | **Max 10 units per 30 days** |
| | Sumatriptan Succinate Solution Prefilled Syringe 6 MG/0.5ML | **Max 10 units per 30 days** |
| | Sumatriptan Succinate Tab 25 MG | **Max 18 tab per 30 days** |
| | Sumatriptan Succinate Tab 50 MG | **Max 9 tab per 30 days** |
| | Sumatriptan Succinate Tab 100 MG | **Max 9 tab per 30 days** |
| | Zolmitriptan Nasal Spray 2.5 MG/Spray Unit | **Max 12 units per 30 days** |
| | Zolmitriptan Nasal Spray 5 MG/Spray Unit | **Max 12 units per 30 days** |
| | Zolmitriptan Orally Disintegrating Tab 2.5 MG | **Max 12 tab per 30 days**<br>**Oral disintegrating dosage form is restricted to claims with an allowed condition that results in the inabiity to swallow or absorb oral medications** |
| | Zolmitriptan Orally Disintegrating Tab 5 MG | **Max 6 tab per 30 days**<br>**Oral disintegrating dosage form is restricted to claims with an allowed condition that results in the inabiity to swallow or absorb oral medications** |
| | Zolmitriptan Tab 2.5 MG | **Max 12 tab per 30 days** |
| | Zolmitriptan Tab 5 MG | **Max 6 tab per 30 days** |
| **Mineralocorticoids** | | |
| | Fludrocortisone Acetate Tab 0.1 MG | |
| **Minerals - Calcium** | | **All calcium salts and oral dosage forms are covered for allowed conditions** |
| | Calcium & Phosphorus w/ Vit D Chew Tab 100 MG-50 MG-100 Unit | |
| | Calcium & Phosphorus w/ Vit D Chew Tab 200 MG-96.6 MG-200 Unt | |
| | Calcium & Phosphorus w/ Vit D Chew Tab 250 MG-100 MG-500 Unt | |
| | Calcium & Phosphorus w/ Vit D Chew Tab 250 MG-115 MG-250 Unt | |
| | Calcium & Phosphorus w/ Vit D Chew Tab 250 MG-107 MG-500 Unt | |
| | Calcium & Phosphorus w/ Vit D Chew Tab 250 MG-135 MG-200 Unt | |
| | Calcium Acetate Tab 668 MG (169 MG Elemental Ca) | |
| | Calcium Cap 250 MG | |
| | Calcium Carb-Magnesium Oxide-Vit C Tab 400-116.7-166.7 MG | |
| | Calcium Carbonate Chewable Wafer 500 MG (200 MG Calcium) | |
| | Calcium Carbonate Susp 1250 MG/5ML (500 MG/5ML Elemental Ca) | |
| | Calcium Carbonate Tab 1250 MG (500 MG Elemental Ca) | |
| | Calcium Carbonate Tab 600 MG | |
| | Calcium Carbonate-Cholecalciferol Cap 600 MG-100 Unit | |
| | Calcium Carbonate-Cholecalciferol Cap 600 MG-400 Unit | |
| | Calcium Carbonate-Cholecalciferol Chew Tab 500 MG-100 Unit | |
| | Calcium Carbonate-Cholecalciferol Chew Tab 600 MG-400 Unit | |
| | Calcium Carbonate-Cholecalciferol Chew Tab 600 MG-800 Unit | |
| | Calcium Carbonate-Cholecalciferol Liquid 500-400 MG-UNIT/5ML | |
| | Calcium Carbonate-Cholecalciferol Tab 250 MG-125 Unit | |
| | Calcium Carbonate-Cholecalciferol Tab 500 MG-200 Unit | |
| | Calcium Carbonate-Cholecalciferol Tab 500 MG-400 Unit | |
| | Calcium Carbonate-Cholecalciferol Tab 500 MG-600 Unit | |
| | Calcium Carbonate-Cholecalciferol Tab 600 MG-200 Unit | |
| | Calcium Carbonate-Cholecalciferol Tab 600 MG-400 Unit | |

## APPENDIX TO RULE 4123-6-21.3
## Formulary List of Medications Covered by the Ohio Bureau of Workers' Compensation

| Drug Class Name | Drug Generic Name | Coverage restrictions or limitations for specific drugs or dosage forms are listed with the respective drugs below. |
|---|---|---|
| | Calcium Carbonate-Cholecalciferol Tab 600 MG-800 Unit | |
| | Calcium Carbonate-Cholecalciferol Tab 90 MG-400 Unit | |
| | Calcium Carbonate-Ergocalciferol Tab 500MG-200 Unit | |
| | Calcium Carbonate-Vitamin D Tab 250 MG-125 Unit | |
| | Calcium Carbonate-Vitamin D Tab 500 MG-200 Unit | |
| | Calcium Carbonate-Vitamin D Tab 500 MG-400 Unit | |
| | Calcium Carbonate-Vitamin D Tab 600 MG-125 Unit | |
| | Calcium Carbonate-Vitamin D Tab 600 MG-200 Unit | |
| | Calcium Carbonate-Vitamin D Tab 600 MG-400 Unit | |
| | Calcium Carb-Vit D w/ Minerals Chew Tab 600 MG-800 Unit*** | |
| | Calcium Carb-Vit D w/ Minerals Tabs 600 MG-800 Unit*** | |
| | Calcium Citrate Cap 150 MG | |
| | Calcium Citrate Malate-Cholecalciferol Tab 250 MG-100 Unit | |
| | Calcium Citrate Tab 200 MG | |
| | Calcium Citrate Tab 950 MG (200 MG Elemental Ca) | |
| | Calcium Citrate-Vit D Liqd 1000 MG/30ML-400 Unit/30ML | |
| | Calcium Citrate-Vit D-Vit K w/ Minerals Tabs 200 MG*** | |
| | Calcium Citrate-Vitamin D Chew Tab 500 MG-500 Unit | |
| | Calcium Citrate-Vitamin D Tab 200 MG-250 Unit (Elemental Ca) | |
| | Calcium Citrate-Vitamin D Tab 250 MG-200 Unit (Elemental Ca) | |
| | Calcium Gluconate Tab 500 MG | |
| | Calcium Lactate Tab 648 MG (84 MG Elemental Ca) | |
| | Calcium Phosphate-Cholecalciferol Chew Tab 200 MG-200 Unit | |
| | Calcium Phosphate-Cholecalciferol Chew Tab 250 MG-100 Unit | |
| | Calcium Phosphate-Cholecalciferol Chew Tab 250 MG-400 Unit | |
| | Calcium Phosphate-Cholecalciferol Tab 115 MG-2000 Unit | |
| | Calcium w/ Magnesium Cap 70-83 MG | |
| | Calcium w/ Magnesium Tab 166.67-83.33 MG | |
| | Calcium w/ Magnesium Tab 200-50 MG | |
| | Calcium w/ Vitamin D & K Chew Tab 500 MG-1000 Unit-40 MCG | |
| | Calcium w/ Vitamin D Tab 500 MG-125 Unit | |
| | Calcium w/ Vitamin D Tab 600 MG-200 Unit | |
| | Calcium-Cholecalciferol Tab 200 MG-250 Unit | |
| | Calcium-Cholecalciferol Tab 500 MG-200 Unit | |
| | Calcium-Ergocalciferol Tab 250 MG-100 Unit | |
| | Calcium-Ergocalciferol Tab 500 MG-200 Unit | |
| | Calcium-Magnesium w/ Vit D Tab SR 24HR 600 MG-40 MG-500 Unit | |
| | Calcium-Magnesium w/ Vitamin D Chew Tab 300MG-20MG-200 Unit | |
| | Calcium-Magnesium W/ Vitamin D Wafer 250 MG-125 MG-200 UNIT | |
| | Calcium-Phosphorus-D-Mag Tab 333.3MG-80MG-133.3Unt-133.3MG | |
| | Calc-Phosphorus-Vit D-Mag Tab 600 MG-280 MG-500 Unit-50 MG | |
| | Oyster Shell Calcium Tab 500 MG | |
| **Minerals - Magnesium** | | **All magnesium salts and oral dosage forms are covered for allowed conditions** |
| | Magnesium Cap 400 MG | |
| | Magnesium Carbonate Oral Powder 250 MG/GM (Elemental Mg) | |
| | Magnesium Chloride Tab CR 535 MG (64 MG Elemental Mg) | |
| | Magnesium Chloride-Calcium Tab DR 64-106 MG (Base Equiv) | |
| | Magnesium Citrate Cap 125 MG (Elemental Mg) | |
| | Magnesium Citrate Tab 100 MG | |
| | Magnesium Cl-Ca Carbonate Tab DR 71.5-119 MG (Elemental) | |
| | Magnesium Gluconate Tab 27.5 MG (Elemental Mg) | |
| | Magnesium Gluconate Tab 500 MG | |
| | Magnesium Gluconate Tab 500 MG (27 MG Elemental Mg) | |
| | Magnesium Lactate Tab CR 84 MG (Elemental Mg) (7 MEQ) | |
| | Magnesium Oxide Cap 400 MG (Elemental Mg) (Mg Supplement) | |
| | Magnesium Oxide Powder (Mg Supplement)** | |

## APPENDIX TO RULE 4123-6-21.3
## Formulary List of Medications Covered by the Ohio Bureau of Workers' Compensation

| Drug Class Name | Drug Generic Name | Coverage restrictions or limitations for specific drugs or dosage forms are listed with the respective drugs below. |
|---|---|---|
| | Magnesium Oxide Tab 250 MG (Mg Supplement) | |
| | Magnesium Oxide Tab 400 MG (240 MG Elemental Mg) | |
| | Magnesium Oxide Tab 400 MG (241.3 MG Elemental Mg) | |
| | Magnesium Tab 250 MG | |
| | Magnesium Tab 400 MG | |
| **Minerals - Mineral Combinations** | | |
| | Multiple Minerals w/ Vitamins Liquid** | |
| **Minerals - Zinc** | | **All zinc salts and oral dosage forms are covered for allowed conditions** |
| | Zinc Gluconate Tab 50 MG (Elemental Zn) | |
| | Zinc Sulfate Cap 220 MG (50 MG Elemental Zn) | |
| | Zinc Sulfate Tab 220 MG (50 MG Zinc Equivalent) | |
| | Zinc Tab 22.5 MG | |
| | Zinc Tab 50 MG | |
| **Mouth/Throat - Anesthetics Topical Oral** | | |
| | Benzocaine Dental Gel 20% | |
| | Benzocaine Dental Paste 20% | |
| | Benzocaine Dental Soln 20% | |
| | Benzocaine-Menthol Lozenge 15-3.6 MG | |
| | Benzocaine-Menthol Lozenge 15-4 MG | |
| | Lidocaine HCl Viscous Soln 2% | |
| **Mouth/Throat - Anti-infectives** | | |
| | Clotrimazole Troche 10 MG | |
| | Hydrogen Peroxide Soln 1.5% | |
| | Nystatin Susp 100000 Unit/ML | |
| **Mouth/Throat - Antiseptics** | | |
| | Chlorhexidine Gluconate Soln 0.12% | |
| | Phenol Liquid 1.4% | |
| **Mouth/Throat - Dental Products** | | **All combinations and strengths of oral dosage forms are covered for allowed conditions** |
| | Sodium Fluoride Cream 1.1% | |
| | Sodium Fluoride Gel 1.1% (0.5% F) | |
| | Stannous Fluoride Paste 0.454% | |
| **Mouth/Throat - Lozenge** | | |
| | Menthol Lozenge 5.4 MG | |
| **Mouth/Throat - Steroids** | | |
| | Triamcinolone Acetonide Dental Paste 0.1% | |
| **Mouth/Throat - Throat Products - Misc** | | |
| | Artificial Saliva - Aero Soln*** | |
| | Cevimeline HCl Cap 30 MG | |
| | Misc Throat Products - Liquid** | |
| | Pilocarpine HCl Tab 5 MG | |
| | Pilocarpine HCl Tab 7.5 MG | |
| | Povidone-Sodium Hyaluronate-Glycyrrhetinic Acid Gel*** | |
| **Movement Disorder Drug Therapy** | | |
| | Tetrabenazine Tab 12.5 MG | |
| | Tetrabenazine Tab 25 MG | |
| **Mucolytics** | | |
| | Acetylcysteine Inhal Soln 10% | |
| | Acetylcysteine Inhal Soln 20% | |
| **Multiple Sclerosis Agents** | | |
| | Fingolimod HCl Cap 0.5 MG (Base Equiv) | |
| | Glatiramer Acetate Soln Prefilled Syringe 20 MG/ML | |
| | Glatiramer Acetate Soln Prefilled Syringe 40 MG/ML | |
| | Interferon Beta-1a For IM Inj Kit 30MCG (33MCG(6.6 MU)/Vial) | |
| | Interferon Beta-1a IM Auto-Injector Kit 30 MCG/0.5ML | |

# APPENDIX TO RULE 4123-6-21.3
## Formulary List of Medications Covered by the Ohio Bureau of Workers' Compensation

| Drug Class Name | Drug Generic Name | Coverage restrictions or limitations for specific drugs or dosage forms are listed with the respective drugs below. |
|---|---|---|
| | Interferon Beta-1a IM Prefilled Syringe Kit 30 MCG/0.5ML | |
| | Interferon Beta-1a Soln Auto-inj 44 MCG/0.5ML (24MU/ML) | |
| | Interferon Beta-1a Soln Pref Syr 44 MCG/0.5ML (24MU/ML) | |
| **Muscle Relaxants** | | **90 days lifetime supply combined all Muscle Relaxants (excludes all baclofen and dantrolene and tizanidine prescribed for spasticity) plus one additional 30 days per rolling 365 days when requested via PA. Additional one year of coverage may be requested by PA for treatment of muscle spasms during recovery from spinal surgery or spinal device implantation and for adjunctive treatment of pain.** |
| | Baclofen Tab 10 MG | |
| | Baclofen Tab 20 MG | |
| | Chlorzoxazone Tab 500 MG | **See Drug Class - Muscle Relaxants restrictions above** |
| | Cyclobenzaprine HCl Tab 5 MG | **See Drug Class - Muscle Relaxants restrictions above** |
| | Cyclobenzaprine HCl Tab 7.5 MG | **See Drug Class - Muscle Relaxants restrictions above** |
| | Cyclobenzaprine HCl Tab 10 MG | **See Drug Class - Muscle Relaxants restrictions above** |
| | Dantrolene Sodium Cap 25 MG | |
| | Dantrolene Sodium Cap 50 MG | |
| | Dantrolene Sodium Cap 100 MG | |
| | Metaxalone Tab 800 MG | **Covered ONLY after a 14 day trial of another covered skeletal muscle relaxant which resulted in a therapeutic failure or clinically documented drug specific side effects. Then all class rules apply - See Drug Class - Muscle Relaxant restrictions above.** |
| | Methocarbamol Tab 500 MG | **See Drug Class - Muscle Relaxants restrictions above** |
| | Methocarbamol Tab 750 MG | **See Drug Class - Muscle Relaxants restrictions above** |
| | Orphenadrine Citrate Tab SR 12HR 100 MG | **See Drug Class - Muscle Relaxants restrictions above** |
| | Tizanidine Products | **Tizanidine is subject to the Drug Class - Muscle Relaxant class restrictions above, unless a PA is submitted for documented conditions of spasticity in the claim -** |
| | Tizanidine HCl Cap 2 MG (Base Equivalent) | **See Tizanidine Products restrictions above** |
| | Tizanidine HCl Cap 4 MG (Base Equivalent) | **See Tizanidine Products restrictions above** |
| | Tizanidine HCl Cap 6 MG (Base Equivalent) | **See Tizanidine Products restrictions above** |
| | Tizanidine HCl Tab 2 MG (Base Equivalent) | **See Tizanidine Products restrictions above** |
| | Tizanidine HCl Tab 4 MG (Base Equivalent) | **See Tizanidine Products restrictions above** |
| **Nasal Agents - Misc** | | |
| | Saline Nasal Spray 0.65% | |
| **Nasal Antiallergy** | | |
| | Azelastine HCl Nasal Spray 0.1% (137 MCG/SPRAY) | |
| | Azelastine HCl Nasal Spray 0.15% (205.5 MCG/SPRAY) | |
| | Cromolyn Sodium Nasal Aerosol Soln 5.2 MG/ACT (4%) | |
| | Olopatadine HCl Nasal Soln 0.6% | |
| **Nasal Anticholinergics** | | |
| | Ipratropium Bromide Nasal Soln 0.03% (21 MCG/SPRAY) | |
| | Ipratropium Bromide Nasal Soln 0.06% (42 MCG/SPRAY) | |
| **Nasal Anti-infectives** | | |
| | Mupirocin Calcium Nasal Oint 2% | |
| **Nasal Steroids** | | |
| | Beclomethasone Dipropionate Monohyd Nasal Susp 42 MCG/SPRAY | |
| | Budesonide Nasal Susp 32 MCG/ACT | |
| | Ciclesonide Nasal Susp 50 MCG/ACT | |
| | Flunisolide Nasal Soln 25 MCG/ACT (0.025%) | |
| | Fluticasone Furoate Nasal Susp 27.5 MCG/SPRAY | |
| | Fluticasone Propionate Nasal Susp 50 MCG/ACT | |

## APPENDIX TO RULE 4123-6-21.3
## Formulary List of Medications Covered by the Ohio Bureau of Workers' Compensation

| Drug Class Name | Drug Generic Name | Coverage restrictions or limitations for specific drugs or dosage forms are listed with the respective drugs below. |
|---|---|---|
| | Mometasone Furoate Nasal Susp 50 MCG/ACT | |
| | Triamcinolone Acetonide Nasal Aerosol Suspension 55 MCG/ACT | |
| **Neprilysin Inhib (ARNI)-Angiotensin II Recept Antag Comb** | | |
| | Sacubitril-Valsartan Tab 24-26 MG | |
| | Sacubitril-Valsartan Tab 49-51 MG | |
| | Sacubitril-Valsartan Tab 97-103 MG | |
| **Nonsteroidal Anti-inflammatory Agents (NSAIDs)** | | |
| | Celecoxib Cap 50 MG | **Max 400 mg (8 cap) per day** |
| | Celecoxib Cap 100 MG | **Max 400 mg (4 cap) per day** |
| | Celecoxib Cap 200 MG | **Max 400 mg (2 cap) per day** |
| | Celecoxib Cap 400 MG | **Max 400 mg (1 cap) per day** |
| | Diclofenac Potassium Tab 50 MG | |
| | Diclofenac Sodium Tab Delayed Release 25 MG | |
| | Diclofenac Sodium Tab Delayed Release 50 MG | |
| | Diclofenac Sodium Tab Delayed Release 75 MG | |
| | Diclofenac Sodium Tab SR 24HR 100 MG | |
| | Etodolac Cap 200 MG | |
| | Etodolac Cap 300 MG | |
| | Etodolac Tab 400 MG | |
| | Etodolac Tab 500 MG | |
| | Etodolac Tab SR 24HR 400 MG | |
| | Etodolac Tab SR 24HR 500 MG | |
| | Etodolac Tab SR 24HR 600 MG | |
| | Fenoprofen Calcium Cap 200 MG | |
| | Fenoprofen Calcium Cap 400 MG | |
| | Fenoprofen Calcium Tab 600 MG | |
| | Flurbiprofen Tab 50 MG | |
| | Flurbiprofen Tab 100 MG | |
| | Ibuprofen Cap 200 MG | |
| | Ibuprofen Susp 100 MG/5ML | |
| | Ibuprofen Tab 200 MG | |
| | Ibuprofen Tab 400 MG | |
| | Ibuprofen Tab 600 MG | |
| | Ibuprofen Tab 800 MG | |
| | Indomethacin Cap 25 MG | |
| | Indomethacin Cap 50 MG | |
| | Indomethacin Cap CR 75 MG | |
| | Ketoprofen Cap 50 MG | |
| | Ketoprofen Cap 75 MG | |
| | Ketoprofen Cap SR 24HR 200 MG | |
| | Ketorolac Tromethamine Tab 10 MG | **Quantity shall not exceed 20 units or a 5 day supply, whichever is less, during a rolling 12 month period.** |
| | Meclofenamate Sodium Cap 50 MG | |
| | Meclofenamate Sodium Cap 100 MG | |
| | Meloxicam Susp 7.5 MG/5ML | |
| | Meloxicam Tab 7.5 MG | |
| | Meloxicam Tab 15 MG | |
| | Nabumetone Tab 500 MG | |
| | Nabumetone Tab 750 MG | |
| | Naproxen Sodium Tab 220 MG | |
| | Naproxen Sodium Tab 275 MG | |
| | Naproxen Sodium Tab 550 MG | |
| | Naproxen Susp 125 MG/5ML | |
| | Naproxen Tab 250 MG | |
| | Naproxen Tab 375 MG | |

## APPENDIX TO RULE 4123-6-21.3
## Formulary List of Medications Covered by the Ohio Bureau of Workers' Compensation

| Drug Class Name | Drug Generic Name | Coverage restrictions or limitations for specific drugs or dosage forms are listed with the respective drugs below. |
|---|---|---|
| | Naproxen Tab 500 MG | |
| | Naproxen Tab EC 375 MG | |
| | Naproxen Tab EC 500 MG | |
| | Oxaprozin Tab 600 MG | |
| | Piroxicam Cap 10 MG | |
| | Piroxicam Cap 20 MG | |
| | Sulindac Tab 150 MG | |
| | Sulindac Tab 200 MG | |
| | Tolmetin Sodium Cap 400 MG | |
| | Tolmetin Sodium Tab 200 MG | |
| | Tolmetin Sodium Tab 600 MG | |
| **Ophthalmic Adrenergic Agents** | | |
| | Apraclonidine HCl Ophth Soln 0.5% (Base Equivalent) | |
| | Brimonidine Tartrate Ophth Soln 0.1% | |
| | Brimonidine Tartrate Ophth Soln 0.15% | |
| | Brimonidine Tartrate Ophth Soln 0.2% | |
| | Cyclosporine (Ophth) Emulsion 0.05% | |
| **Ophthalmic Anti-infectives** | | |
| | Azithromycin Ophth Soln 1% | |
| | Bacitracin Ophth Oint 500 Unit/GM | |
| | Bacitracin-Polymyxin B Ophth Oint | |
| | Besifloxacin HCl Ophth Susp 0.6% (Base Equiv) | |
| | Ciprofloxacin HCl Ophth Oint 0.3% | |
| | Ciprofloxacin HCl Ophth Soln 0.3% | |
| | Erythromycin Ophth Oint 5 MG/GM | |
| | Ganciclovir Ophth Gel 0.15% | |
| | Gatifloxacin Ophth Soln 0.5% | |
| | Gentamicin Sulfate Ophth Oint 0.3% | |
| | Gentamicin Sulfate Ophth Soln 0.3% | |
| | Levofloxacin Ophth Soln 0.5% | |
| | Moxifloxacin HCl Ophth Soln 0.5% (Base Eq) (2 Times Daily) | |
| | Moxifloxacin HCl Ophth Soln 0.5% (Base Equiv) | |
| | Natamycin Ophth Susp 5% | |
| | Neomycin-Bacitrac Zn-Polymyx 5(3.5)MG-400Unt-10000Unt Op Oin | |
| | Neomycin-Polymy-Gramicid Op Sol 1.75-10000-0.025MG-UNT-MG/ML | |
| | Ofloxacin Ophth Soln 0.3% | |
| | Polymyxin B-Trimethoprim Ophth Soln 10000 Unit/ML-0.1% | |
| | Sulfacetamide Sodium Ophth Soln 10% | |
| | Tobramycin Ophth Oint 0.3% | |
| | Tobramycin Ophth Soln 0.3% | |
| | Trifluridine Ophth Soln 1% | |
| **Ophthalmic Artificial Tears and Lubricants** | | |
| | Artificial Tear Ophth Gel*** | |
| | Artificial Tear Ophth Insert*** | |
| | Artificial Tear Ophth Ointment*** | |
| | Artificial Tear Ophth Solution*** | |
| | Carboxymethylcell-Glycerin-Polysorb 80 Ophth Soln 0.5-1-0.5% | |
| | Carboxymethylcellulose Sodium Ophth Gel 1% | |
| | Carboxymethylcellulose Sodium Ophth Liquid 0.7% | |
| | Carboxymethylcellulose Sodium Ophth Soln 0.25% | |
| | Carboxymethylcellulose Sodium Ophth Soln 0.5% | |
| | Carboxymethylcellulose Sodium Ophth Soln 1% | |
| | Carboxymethylcellulose-Glycerin Ophth Gel 1-0.9% | |
| | Carboxymethylcellulose-Glycerin Ophth Soln 0.5-0.9% | |
| | Carboxymethylcellulose-Hypromellose Gel 0.25-0.3% | |
| | Glycerin-Hypromellose-PEG 400 Ophth Soln 0.2-0.2-1% | |
| | Glycerin-Hypromellose-PEG 400 Ophth Soln 0.2-0.36-1% | |

# APPENDIX TO RULE 4123-6-21.3
## Formulary List of Medications Covered by the Ohio Bureau of Workers' Compensation

| Drug Class Name | Drug Generic Name | Coverage restrictions or limitations for specific drugs or dosage forms are listed with the respective drugs below. |
|---|---|---|
| | Hypromellose Ophth Gel 0.3% | |
| | Hypromellose Ophth Soln 0.2% | |
| | Hypromellose Ophth Soln 0.3% | |
| | Hypromellose Ophth Soln 0.4% | |
| | Hypromellose Ophth Soln 0.5% | |
| | Light Mineral Oil-Mineral Oil Ophth Emulsion 0.5-0.5% | |
| | Polyethylene Glycol-Polyvinyl Alcohol Ophth Soln 1-1% | |
| | Polyethylene Glycol-Propylene Glycol Ophth Gel 0.4-0.3% | |
| | Polyethylene Glycol-Propylene Glycol Ophth Soln 0.4-0.3% | |
| | Polysorbate 80 Ophth Soln 1% | |
| | Polyvinyl Alcohol Ophth Soln 1.4% | |
| | Polyvinyl Alcohol-Povidone Ophth Soln 1.4-0.6% | |
| | Polyvinyl Alcohol-Povidone Ophth Soln 2.7-2% | |
| | Polyvinyl Alcohol-Povidone Ophth Soln 5-6 MG/ML (0.5-0.6%) | |
| | Propylene Glycol Ophth Soln 0.6% | |
| | Propylene Glycol-Glycerin Ophth Soln 0.6-0.6% | |
| | Propylene Glycol-Glycerin Ophth Soln 1-0.3% | |
| | White Petrolatum-Mineral Oil Ophth Ointment*** | |
| **Ophthalmic Beta-blockers** | | |
| | Betaxolol HCl Ophth Susp 0.25% | |
| | Brimonidine Tartrate-Timolol Maleate Ophth Soln 0.2-0.5% | |
| | Carteolol HCl Ophth Soln 1% | |
| | Dorzolamide HCl-Timolol Maleate Ophth Sol 22.3-6.8 MG/ML PF | |
| | Dorzolamide HCl-Timolol Maleate Ophth Soln 22.3-6.8 MG/ML | |
| | Levobunolol HCl Ophth Soln 0.25% | |
| | Levobunolol HCl Ophth Soln 0.5% | |
| | Timolol Maleate Ophth Gel Forming Soln 0.25% | |
| | Timolol Maleate Ophth Gel Forming Soln 0.5% | |
| | Timolol Maleate Ophth Soln 0.25% | |
| | Timolol Maleate Ophth Soln 0.5% | |
| | Timolol Maleate Ophth Soln 0.5% (Once-Daily) | |
| | Timolol Maleate Preservative Free Ophth Soln 0.25% | |
| | Timolol Maleate Preservative Free Ophth Soln 0.5% | |
| | Timolol Ophth Soln 0.25% | |
| | Timolol Ophth Soln 0.5% | |
| **Ophthalmic Cycloplegic Mydriatics** | | |
| | Atropine Sulfate Ophth Oint 1% | |
| | Atropine Sulfate Ophth Soln 1% | |
| | Cyclopentolate HCl Ophth Soln 1% | |
| | Cyclopentolate HCl Ophth Soln 2% | |
| | Homatropine HBr Ophth Soln 2% | |
| | Homatropine HBr Ophth Soln 5% | |
| | Scopolamine HBr Ophth Soln 0.25% | |
| **Ophthalmic Decongestants** | | |
| | Naphazoline w/ Pheniramine Ophth Soln 0.025-0.3% | |
| **Ophthalmic Miotics** | | |
| | Carbachol Ophth Soln 1.5% | |
| | Pilocarpine HCl Ophth Soln 1% | |
| | Pilocarpine HCl Ophth Soln 2% | |
| | Pilocarpine HCl Ophth Soln 4% | |
| **Ophthalmic Prostaglandins** | | |
| | Bimatoprost Ophth Soln 0.01% | |
| | Bimatoprost Ophth Soln 0.03% | |
| | Latanoprost Ophth Soln 0.005% | |
| | Travoprost Ophth Soln 0.004% | |
| | Travoprost Ophth Soln 0.004% (Benzalkonium Free) (BAK Free) | |
| **Ophthalmic Steroids** | | |

## APPENDIX TO RULE 4123-6-21.3
## Formulary List of Medications Covered by the Ohio Bureau of Workers' Compensation

| Drug Class Name | Drug Generic Name | Coverage restrictions or limitations for specific drugs or dosage forms are listed with the respective drugs below. |
|---|---|---|
| | Bacitracin-Polymyxin-Neomycin-HC Ophth Oint 1% | |
| | Dexamethasone Ophth Susp 0.1% | |
| | Dexamethasone Sodium Phosphate Ophth Soln 0.1% | |
| | Difluprednate Ophth Emulsion 0.05% | |
| | Fluorometholone Acetate Ophth Susp 0.1% | |
| | Fluorometholone Ophth Oint 0.1% | |
| | Fluorometholone Ophth Susp 0.1% | |
| | Fluorometholone Ophth Susp 0.25% | |
| | Gentamicin-Prednisolone Ace Ophth Susp 0.3-1% | |
| | Loteprednol Etabonate Ophth Gel 0.5% | |
| | Loteprednol Etabonate Ophth Oint 0.5% | |
| | Loteprednol Etabonate Ophth Susp 0.2% | |
| | Loteprednol Etabonate Ophth Susp 0.5% | |
| | Loteprednol Etabonate-Tobramycin Ophth Susp 0.5-0.3% | |
| | Neomycin-Polymyxin-Dexamethasone Ophth Oint 0.1% | |
| | Neomycin-Polymyxin-Dexamethasone Ophth Susp 0.1% | |
| | Neomycin-Polymyxin-HC Ophth Susp | |
| | Prednisolone Acetate Ophth Susp 0.12% | |
| | Prednisolone Acetate Ophth Susp 1% | |
| | Prednisolone Sodium Phosphate Ophth Soln 1% | |
| | Rimexolone Ophth Susp 1% | |
| | Sulfacetamide Sodium-Prednisolone Ophth Oint 10-0.2% | |
| | Sulfacetamide Sodium-Prednisolone Ophth Soln 10-0.23(0.25)% | |
| | Sulfacetamide Sodium-Prednisolone Ophth Susp 10-0.2% | |
| | Tobramycin-Dexamethasone Ophth Oint 0.3-0.1% | |
| | Tobramycin-Dexamethasone Ophth Susp 0.3-0.05% | |
| | Tobramycin-Dexamethasone Ophth Susp 0.3-0.1% | |
| **Ophthalmics - Misc** | | |
| | Azelastine HCl Ophth Soln 0.05% | |
| | Brinzolamide Ophth Susp 1% | |
| | Bromfenac Sodium Ophth Soln 0.07% (Base Equivalent) | |
| | Bromfenac Sodium Ophth Soln 0.09% (Base Equiv) (Once-Daily) | |
| | Bromfenac Sodium Ophth Soln 0.09% (Base Equivalent) | |
| | Cromolyn Sodium Ophth Soln 4% | |
| | Diclofenac Sodium Ophth Soln 0.1% | |
| | Dorzolamide HCl Ophth Soln 2% | |
| | Epinastine HCl Ophth Soln 0.05% | |
| | Flurbiprofen Sodium Ophth Soln 0.03% | |
| | Ketorolac Tromethamine Ophth Soln 0.4% | |
| | Ketorolac Tromethamine Ophth Soln 0.45% | |
| | Ketorolac Tromethamine Ophth Soln 0.5% | |
| | Ketotifen Fumarate Ophth Soln 0.025% (Base Equiv) | |
| | Nepafenac Ophth Susp 0.1% | |
| | Olopatadine HCl Ophth Soln 0.1% (Base Equivalent) | |
| | Olopatadine HCl Ophth Soln 0.2% (Base Equivalent) | |
| | Sodium Chloride Hypertonic Ophth Oint 5% | |
| | Sodium Chloride Hypertonic Ophth Soln 2% | |
| | Sodium Chloride Hypertonic Ophth Soln 5% | |
| | Tyloxapol Ophth Soln 0.25% | |

## APPENDIX TO RULE 4123-6-21.3
## Formulary List of Medications Covered by the Ohio Bureau of Workers' Compensation

| Drug Class Name | Drug Generic Name | Coverage restrictions or limitations for specific drugs or dosage forms are listed with the respective drugs below. |
|---|---|---|
| Opioid Agonists - Immediate Release | | **Immediate Release Opioid Dose Formulations Restrictions:** **Effective January 1, 2017 the following limitations will be effective; initial coverage of any immediate release opioid in an opioid naive IW will be limited to 7 days of coverage or 30 doses, whichever is less; a PA may be obtained to exceed these limitations for post-operative situations. Concurrent use of more than one immediate release opioid agent will not be covered without a Prior Authorization. A quantity limit of 6 doses per day for any immediate release opioid will be implemented in all claims. Daily doses above this level may be reimbursed with prior authorization upon submission of documentation that supports clinical failure, as defined in OAC 4123-6-21(J)(2), of a lower daily dose. Claims in which this quantity limit was exceeded prior to January 1, 2017 will be limited to the last quantity prescribed before that date.** |
| | Codeine Sulfate Tab Products | **Effective January 1, 2017 reimbursement for this product will be limited to 6 doses per day for all covered forms of this product. Daily doses above this level may be reimbursed with prior authorization upon submission of documentation that supports clinical failure, as defined in OAC 4123-6-21(J)(2), of a lower daily dose. Claims in which this quantity limit was exceeded prior to January 1, 2017 will be limited to the last quantity prescribed before that date. Effective January 1, 2017 Prior Authorization will be required in all claims for reimbursement of concurrent use of this product with any other immediate release opioid. See also "Immediate Release Opioid Dose Formulation Restrictions" for additional restrictions for opioid naive IW.** |
| | Codeine Sulfate Tab 15 MG | **See Codeine Sulfate Tab Products restrictions above** |
| | Codeine Sulfate Tab 30 MG | **See Codeine Sulfate Tab Products restrictions above** |
| | Codeine Sulfate Tab 60 MG | **See Codeine Sulfate Tab Products restrictions above** |
| | Fentanyl Citrate Buccal Tab Products | **Claim must be allowed for neoplasm or malignancy for reimbursement.** |
| | Fentanyl Citrate Buccal Tab 100 MCG (Base Equiv) | **See Fentanyl Citrate Buccal Tab Products restrictions above** |
| | Fentanyl Citrate Buccal Tab 200 MCG (Base Equiv) | **See Fentanyl Citrate Buccal Tab Products restrictions above** |
| | Fentanyl Citrate Buccal Tab 400 MCG (Base Equiv) | **See Fentanyl Citrate Buccal Tab Products restrictions above** |
| | Fentanyl Citrate Buccal Tab 600 MCG (Base Equiv) | **See Fentanyl Citrate Buccal Tab Products restrictions above** |
| | Fentanyl Citrate Buccal Tab 800 MCG (Base Equiv) | **See Fentanyl Citrate Buccal Tab Products restrictions above** |
| | Fentanyl Citrate Lozenge Products | **Claim must be allowed for neoplasm or malignancy for reimbursement.** |
| | Fentanyl Citrate Lozenge on a Handle 200 MCG | **See Fentanyl Citrate Lozenge Products restrictions above** |
| | Fentanyl Citrate Lozenge on a Handle 400 MCG | **See Fentanyl Citrate Lozenge Products restrictions above** |
| | Fentanyl Citrate Lozenge on a Handle 600 MCG | **See Fentanyl Citrate Lozenge Products restrictions above** |
| | Fentanyl Citrate Lozenge on a Handle 800 MCG | **See Fentanyl Citrate Lozenge Products restrictions above** |
| | Fentanyl Citrate Lozenge on a Handle 1200 MCG | **See Fentanyl Citrate Lozenge Products restrictions above** |
| | Fentanyl Citrate Lozenge on a Handle 1600 MCG | **See Fentanyl Citrate Lozenge Products restrictions above** |
| | Hydromorphone HCl Liqd 1 MG/ML | **Initial coverage in an opioid naive IW will be limited to 7 days of coverage; a PA may be obtained to exceed these limitations for post-operative situations** |
| | Hydromorphone HCl Suppos 3 MG | **Initial coverage in an opioid naive IW will be limited to 7 days of coverage or 30 doses, whichever is less; a PA may be obtained to exceed these limitations for post-operative situations.** |

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## Formulary List of Medications Covered by the Ohio Bureau of Workers' Compensation

| Drug Class Name | Drug Generic Name | Coverage restrictions or limitations for specific drugs or dosage forms are listed with the respective drugs below. |
|---|---|---|
| | Hydromorphone HCl Tab Products | **Effective January 1, 2017 reimbursement for this product will be limited to 6 doses per day for all covered forms of this product. Daily doses above this level may be reimbursed with prior authorization upon submission of documentation that supports clinical failure, as defined in OAC 4123-6-21(J)(2), of a lower daily dose. Claims in which this quantity limit was exceeded prior to January 1, 2017 will be limited to the last quantity prescribed before that date. Effective January 1, 2017 Prior Authorization will be required in all claims for reimbursement of concurrent use of this product with any other immediate release opioid. See also "Immediate Release Opioid Dose Formulation Restrictions" for additional restrictions for opioid naive IW.** |
| | Hydromorphone HCl Tab 2 MG | **See Hydromorphone HCl Tab Products restrictions above** |
| | Hydromorphone HCl Tab 4 MG | **See Hydromorphone HCl Tab Products restrictions above** |
| | Hydromorphone HCl Tab 8 MG | **See Hydromorphone HCl Tab Products restrictions above** |
| | Levorphanol Tartrate Tab 2 MG | **Effective January 1, 2017 Levorphanol will be removed from the formulary and reimbursement for all dosage forms of Levorphanol will be discontinued. Reimbursment will continue for any claim in which Levorphanol was being covered as of January 1, 2017.** |
| | Meperidine HCl Oral Soln 50 MG/5ML | **Initial coverage in an opioid naive IW will be limited to 7 days of coverage; a PA may be obtained to exceed these limitations for post-operative situations.** |
| | Meperidine HCl Tab Products | **Effective January 1, 2017 reimbursement for this product will be limited to 6 doses per day for all covered forms of this product. Daily doses above this level may be reimbursed with prior authorization upon submission of documentation that supports clinical failure, as defined in OAC 4123-6-21(J)(2), of a lower daily dose. Claims in which this quantity limit was exceeded prior to January 1, 2017 will be limited to the last quantity prescribed before that date. Effective January 1, 2017 Prior Authorization will be required in all claims for reimbursement of concurrent use of this product with any other immediate release opioid. See also "Immediate Release Opioid Dose Formulation Restrictions" for additional restrictions for opioid naive IW.** |
| | Meperidine HCl Tab 50 MG | **See Meperidine HCl Tab Products restrictions above** |
| | Meperidine HCl Tab 100 MG | **See Meperidine HCl Tab Products restrictions above** |
| | Morphine Sulfate Oral Soln Products | **Effective January 1, 2017, reimbursement shall be restricted to not exceed a total dose of 400 mg per day. Daily doses above this level may be reimbursed with prior authorization upon submission of documentation that supports clinical failure, as defined in OAC 4123-6-21(J)(2), of a lower daily dose. Claims in which this quantity limit was exceeded prior to January 1, 2017 will be limited to the last quantity prescribed before that date. Effective January 1, 2017 Prior Authorization will be required in all claims for reimbursement of concurrent use of this product with any other immediate release opioid. See also "Immediate Release Opioid Dose Formulation Restrictions" for additional restrictions for opioid naive IW.** |
| | Morphine Sulfate Oral Soln 10 MG/5ML | **See Morphine Sulfate Oral Soln Products restrictions above** |
| | Morphine Sulfate Oral Soln 20 MG/5ML | **See Morphine Sulfate Oral Soln Products restrictions above** |
| | Morphine Sulfate Oral Soln 100 MG/5ML (20 MG/ML) | **See Morphine Sulfate Oral Soln Products restrictions above** |

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## Formulary List of Medications Covered by the Ohio Bureau of Workers' Compensation

| Drug Class Name | Drug Generic Name | Coverage restrictions or limitations for specific drugs or dosage forms are listed with the respective drugs below. |
|---|---|---|
| | Morphine Sulfate Tab (IR) Products | **Effective January 1, 2017 reimbursement for this product will be limited to 6 doses per day for all covered forms of this product. Daily doses above this level may be reimbursed with prior authorization upon submission of documentation that supports clinical failure, as defined in OAC 4123-6-21(J)(2), of a lower daily dose. Claims in which this quantity limit was exceeded prior to January 1, 2017 will be limited to the last quantity prescribed before that date. Effective January 1, 2017 Prior Authorization will be required in all claims for reimbursement of concurrent use of this product with any other immediate release opioid. See also "Immediate Release Opioid Dose Formulation Restrictions" for additional restrictions for opioid naive IW.** |
| | Morphine Sulfate Tab 15 MG | **See Morphine Sulfate Tab (IR) Products restrictions above** |
| | Morphine Sulfate Tab 30 MG | **See Morphine Sulfate Tab (IR) Products restrictions above** |
| | Oxycodone HCl Cap 5 MG | **Effective January 1, 2017 reimbursement for this product will be limited to 6 doses per day for all covered forms of this product. Daily doses above this level may be reimbursed with prior authorization upon submission of documentation that supports clinical failure, as defined in OAC 4123-6-21(J)(2), of a lower daily dose. Claims in which this quantity limit was exceeded prior to January 1, 2017 will be limited to the last quantity prescribed before that date. Effective January 1, 2017 Prior Authorization will be required in all claims for reimbursement of concurrent use of this product with any other immediate release opioid. See also "Immediate Release Opioid Dose Formulation Restrictions" for additional restrictions for opioid naive IW.** |
| | Oxycodone HCl Conc 100 MG/5ML (20 MG/ML) | **Initial coverage in an opioid naive IW will be limited to 7 days of coverage; a PA may be obtained to exceed these limitations for post-operative situations.** |
| | Oxycodone HCl Soln 5 MG/5ML | **Initial coverage in an opioid naive IW will be limited to 7 days of coverage; a PA may be obtained to exceed these limitations for post-operative situations.** |
| | Oxycodone HCl Tab (IR) Products | **Effective January 1, 2017 reimbursement for this product will be limited to 6 doses per day for all covered forms of this product. Daily doses above this level may be reimbursed with prior authorization upon submission of documentation that supports clinical failure, as defined in OAC 4123-6-21(J)(2), of a lower daily dose. Claims in which this quantity limit was exceeded prior to January 1, 2017 will be limited to the last quantity prescribed before that date. Effective January 1, 2017 Prior Authorization will be required in all claims for reimbursement of concurrent use of this product with any other immediate release opioid. See also "Immediate Release Opioid Dose Formulation Restrictions" for additional restrictions for opioid naive IW.** |
| | Oxycodone HCl Tab 5 MG | **See Oxycodone HCl Tab (IR) Products restrictions above** |
| | Oxycodone HCl Tab 10 MG | **See Oxycodone HCl Tab (IR) Products restrictions above** |
| | Oxycodone HCl Tab 15 MG | **See Oxycodone HCl Tab (IR) Products restrictions above** |
| | Oxycodone HCl Tab 20 MG | **See Oxycodone HCl Tab (IR) Products restrictions above** |
| | Oxycodone HCl Tab 30 MG | **See Oxycodone HCl Tab (IR) Products restrictions above** |

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| Drug Class Name | Drug Generic Name | Coverage restrictions or limitations for specific drugs or dosage forms are listed with the respective drugs below. |
|---|---|---|
| | Oxymorphone HCl Tab (IR) Products | **Effective January 1, 2017 reimbursement for this product will be limited to 6 doses per day for all covered forms of this product. Daily doses above this level may be reimbursed with prior authorization upon submission of documentation that supports clinical failure, as defined in OAC 4123-6-21(J)(2), of a lower daily dose. Claims in which this quantity limit was exceeded prior to January 1, 2017 will be limited to the last quantity prescribed before that date. Effective January 1, 2017 Prior Authorization will be required in all claims for reimbursement of concurrent use of this product with any other immediate release opioid. See also "Immediate Release Opioid Dose Formulation Restrictions" for additional restrictions for opioid naive IW.** |
| | Oxymorphone HCl Tab 5 MG | **See Oxymorphone HCl Tab (IR) Products restrictions above** |
| | Oxymorphone HCl Tab 10 MG | **See Oxymorphone HCl Tab (IR) Products restrictions above** |
| | Tapentadol HCl Tab (IR) Products | **Reimbursement for this product shall not exceed 600 mg per day. Coverage will not be permitted for this product concurrently with any other immediate release opioid product or sustained release tapentadol products. See also "Immediate Release Opioid Dose Formulation Restrictions" for additional restrictions for opioid naive IW.** |
| | Tapentadol HCl Tab 50 MG | **See Tapentadol HCl Tab (IR) Products restrictions above** |
| | Tapentadol HCl Tab 75 MG | **See Tapentadol HCl Tab (IR) Products restrictions above** |
| | Tapentadol HCl Tab 100 MG | **See Tapentadol HCl Tab (IR) Products restrictions above** |
| | Tramadol HCl Orally Disintegrating Tab 50 MG | **The oral disintegrating dosage form is restricted to claims with an an allowed condition that results in the inability to swallow or absorb oral medications. Prior Authorization is required. Reimbursement for this product shall not exceed 8 tablets (400 mg) per day. Coverage will not be permitted for this product concurrently with any other immediate release opioid. See also "Immediate Release Opioid Dose Formulation Restrictions" for additional restrictions for opioid naive IW.** |
| | Tramadol HCl Tab 50 MG | **Reimbursement for this product shall not exceed 8 tablets (400 mg) per day. Coverage will not be permitted for this product concurrently with any other immediate release opioid. See also "Immediate Release Opioid Dose Formulation Restrictions" for additional restrictions for opioid naive IW.** |
| **Opioid Agonists - Sustained Release** | | **Sustained Release Opioid Dosage Form Class Restrictions:<br>Effective January 1, 2017; coverage will not be permitted for concurrent treatment with multiple sustained release opioids (Including methadone); concurrent use of any sustained release opioid, oral or transdermal, with any parenteral pain management medications (e.g. IM, SC, IV, IT analgesic medications) will not be covered.; sustained release opioids will not be covered in post operative conditions unless the injured worker was being treated with the sustained release drug prior to surgery.** |

## APPENDIX TO RULE 4123-6-21.3
## Formulary List of Medications Covered by the Ohio Bureau of Workers' Compensation

| Drug Class Name | Drug Generic Name | Coverage restrictions or limitations for specific drugs or dosage forms are listed with the respective drugs below. |
|---|---|---|
| | Fentanyl TD Patch Products | **Effective January 1, 2017, prior authorization is required to show documented allergic reaction to or clinical failure of, as defined in OAC 4213-6-21(J)(1) and (J)(2), morphine sulfate sustained release tablets, Embeda or Hysingla ER or a documented inability to swallow or absorb oral medications. Reimbursement restricted to not more than 1 patch every 72 hours dosing frequency. Dosing at every 48 hours may be reimbursed upon submission of documentation that supports clinical failure of a 72 hours dosing interval and evidence of an escalation of the dose before a reduction in frequency. Coverage will not be permitted for this product concurrently with any other sustained release opioid. Sustained release opioids will not be covered in the post-operative period unless routinely prescribed pre-operatively.** |
| | Fentanyl TD Patch 72HR 12 MCG/HR | **See Fentanyl TD Patch Products restrictions above** |
| | Fentanyl TD Patch 72HR 25 MCG/HR | **See Fentanyl TD Patch Products restrictions above** |
| | Fentanyl TD Patch 72HR 50 MCG/HR | **See Fentanyl TD Patch Products restrictions above** |
| | Fentanyl TD Patch 72HR 75 MCG/HR | **See Fentanyl TD Patch Products restrictions above** |
| | Fentanyl TD Patch 72HR 100 MCG/HR | **See Fentanyl TD Patch Products restrictions above** |
| | Hydrocodone Bitartrate Tab ER 24HR Deter Products | **Effective December 1, 2015 Hysingla ER® will be eligible for reimbursement as a first tier sustained release opioid. Reimbursement for all strengths of this product shall not exceed one tablet per day of any strength or combination of strengths. Coverage will not be permitted for this product concurrenty with any other sustained release opioid. Sustained release opioids will not be covered in the post-operative period unless routinely prescribed pre-operatively.** |
| | Hydrocodone Bitartrate Tab ER 24HR Deter 20 MG | **See Hydrocodone Bitartrate Tab ER 24HR Deter Products restrictions above** |
| | Hydrocodone Bitartrate Tab ER 24HR Deter 30 MG | **See Hydrocodone Bitartrate Tab ER 24HR Deter Products restrictions above** |
| | Hydrocodone Bitartrate Tab ER 24HR Deter 40 MG | **See Hydrocodone Bitartrate Tab ER 24HR Deter Products restrictions above** |
| | Hydrocodone Bitartrate Tab ER 24HR Deter 60 MG | **See Hydrocodone Bitartrate Tab ER 24HR Deter Products restrictions above** |
| | Hydrocodone Bitartrate Tab ER 24HR Deter 80 MG | **See Hydrocodone Bitartrate Tab ER 24HR Deter Products restrictions above** |
| | Hydrocodone Bitartrate Tab ER 24HR Deter 100 MG | **See Hydrocodone Bitartrate Tab ER 24HR Deter Products restrictions above** |
| | Hydrocodone Bitartrate Tab ER 24HR Deter 120 MG | **See Hydrocodone Bitartrate Tab ER 24HR Deter Products restrictions above** |
| | Hydromorphone HCl Tab ER 24HR Deter Products | **Effective January 1, 2017, for any claim in which this drug was not currently being reimbursed, prior authorization is required to show documented allergic reaction to or clinical failure of, as defined in OAC 4213-6-21(J)(1) and (J)(2), Oxycodone ER or Fentanyl transdermal. Reimbursement shall not exceed one tablet per day. Prior authorization is required for reimbursment of doses above this limit. Claims in which this dose limitation was exceeded prior to January 1, 2017, will be limited to the last quantity prescribed before that date. Coverage will not be permitted for this product concurrenty with any other sustained release opioid. Sustained release opioids will not be covered in the post-operative period unless routinely prescribed pre-operatively.** |

## APPENDIX TO RULE 4123-6-21.3
## Formulary List of Medications Covered by the Ohio Bureau of Workers' Compensation

| Drug Class Name | Drug Generic Name | Coverage restrictions or limitations for specific drugs or dosage forms are listed with the respective drugs below. |
|---|---|---|
| | Hydromorphone HCl Tab ER 24HR Deter 8 MG | **See Hydromorphone HCl Tab ER 24HR Deter Products restrictions above** |
| | Hydromorphone HCl Tab ER 24HR Deter 12 MG | **See Hydromorphone HCl Tab ER 24HR Deter Products restrictions above** |
| | Hydromorphone HCl Tab ER 24HR Deter 16 MG | **See Hydromorphone HCl Tab ER 24HR Deter Products restrictions above** |
| | Hydromorphone HCl Tab ER 24HR Deter 32 MG | **See Hydromorphone HCl Tab ER 24HR Deter Products restrictions above** |
| | Methadone Products | **Effective January 1, 2017 all oral forms of methadone shall be considered to be long acting opioids and will be subject to the formulary limitations of sustained release drug formulations. Initial coverage of oral methadone requires documentation of a 12 lead electrocardiogram within the previous 6 months. Ongoing coverage of oral methadone requires the documentation of an annual 12 lead eclectocardiogram. Oral methadone will be eligible for reimbursement only after documentation of allergic reaction to or clinical failure of, as defined in OAC 4123-6-21(J)(1) and (J)(2), sustained release forms of morphine or hydrocodone. Prior Authorization is required. Reimbursement for this product may not exceed a maximum dose of 90 mg per day. Claims in which this dose limitation was exceeded prior to January 1, 2017, will be limited to the last quantity prescribed before that date. Coverage will not be permitted for this product concurrently with any other sustained release opioid . Sustained release opioids will not be covered in the post-operative period unless routinely prescribed pre-operatively.** |
| | Methadone HCl Tab 5 MG | **See Methadone Products Restrictions above** |
| | Methadone HCl Tab 10 MG | **See Methadone Products Restrictions above** |
| | Methadone HCl Soln 5 MG/5ML | **See Methadone Products Restrictions above** |
| | Methadone HCl Soln 10 MG/5ML | **See Methadone Products Restrictions above** |
| | Morphine Sulfate Tab CR Products | **Effective January 1, 2017, reimbursement shall be restricted to not exceed 3 tablets per day for doses less than 200 mg per tablet and 2 tablets per day for doses of 200 mg per tablet. Prior Authorization is required for reimbursement for any doses above this level. Coverage will not be permitted for this product concurrently with any other sustained release opioid. Sustained release opioids will not be covered in the post-operative period unless routinely prescribed pre-operatively.** |
| | Morphine Sulfate Tab CR 15 MG | **See Morphine Sulfate Tab CR Products restrictions above** |
| | Morphine Sulfate Tab CR 30 MG | **See Morphine Sulfate Tab CR Products restrictions above** |
| | Morphine Sulfate Tab CR 60 MG | **See Morphine Sulfate Tab CR Products restrictions above** |
| | Morphine Sulfate Tab CR 100 MG | **See Morphine Sulfate Tab CR Products restrictions above** |
| | Morphine Sulfate Tab CR 200 MG | **See Morphine Sulfate Tab CR Products restrictions above** |
| | Morphine-Naltrexone Cap CR Products | **Reimbursement for this product shall not exceed 2 capsules per day. Coverage will not be permitted for this product concurrently with any other sustained release opioid. Sustained release opioids will not be covered in the post-operative period unless routinely prescribed pre-operatively.** |
| | Morphine-Naltrexone Cap CR 20-0.8 MG | **See Morphine-Naltrexone Cap CR Products restrictions above** |
| | Morphine-Naltrexone Cap CR 30-1.2 MG | **See Morphine-Naltrexone Cap CR Products restrictions above** |
| | Morphine-Naltrexone Cap CR 50-2 MG | **See Morphine-Naltrexone Cap CR Products restrictions above** |
| | Morphine-Naltrexone Cap CR 60-2.4 MG | **See Morphine-Naltrexone Cap CR Products restrictions above** |
| | Morphine-Naltrexone Cap CR 80-3.2 MG | **See Morphine-Naltrexone Cap CR Products restrictions above** |

# APPENDIX TO RULE 4123-6-21.3
## Formulary List of Medications Covered by the Ohio Bureau of Workers' Compensation

| Drug Class Name | Drug Generic Name | Coverage restrictions or limitations for specific drugs or dosage forms are listed with the respective drugs below. |
|---|---|---|
| | Morphine-Naltrexone Cap CR 100-4 MG | **See Morphine-Naltrexone Cap CR Products restrictions above** |
| | Oxycodone HCl Tab ER 12HR Deter Products | **Effective January 1, 2017, sustained release forms of Oxycodone are eligible for reimbursement only after documentation of treatment with an immediate release form of oxycodone for at least 60 days or allergic reaction to or clinical failure of, as defined in OAC 4123-6-21(J)(1) and (J)(2), sustained release forms of morphine or hydrocodone. Prior Authorization is required. Reimbursement for all strengths of this product shall not exceed every eight hours or 3 doses per day. A Prior Authorization is required for reimbursement for any doses above these levels. Coverage will not be permitted for this product concurrently with any other sustained release opioid. Sustained release opioids will not be covered in the post-operative period unless routinely prescribed pre-operatively.** |
| | Oxycodone HCl Tab ER 12HR Deter 10 MG | **See Oxycodone HCl Tab ER 12HR Deter Products restrictions above** |
| | Oxycodone HCl Tab ER 12HR Deter 15 MG | **See Oxycodone HCl Tab ER 12HR Deter Products restrictions above** |
| | Oxycodone HCl Tab ER 12HR Deter 20 MG | **See Oxycodone HCl Tab ER 12HR Deter Products restrictions above** |
| | Oxycodone HCl Tab ER 12HR Deter 30 MG | **See Oxycodone HCl Tab ER 12HR Deter Products restrictions above** |
| | Oxycodone HCl Tab ER 12HR Deter 40 MG | **See Oxycodone HCl Tab ER 12HR Deter Products restrictions above** |
| | Oxycodone HCl Tab ER 12HR Deter 60 MG | **See Oxycodone HCl Tab ER 12HR Deter Products restrictions above** |
| | Oxycodone HCl Tab ER 12HR Deter 80 MG | **See Oxycodone HCl Tab ER 12HR Deter Products restrictions above** |
| | Oxymorphone HCl Tab SR 12HR Products | **Effective January 1, 2017 for any claim in which this drug was not currently being reimbursed, prior authorization is required showing documentation of allergic reaction to or clinical failure of, as defined in OAC 4123-6-21(J)(1) and (J)(2),Oxycodone ER or Fentanyl transdermal. Reimbursement shall not exceed two tablets per day. Claims in which this dose limitation was exceeded prior to January 1, 2017, will be limited to the last quantity prescribed before that date. Coverage will not be permitted for this product concurrenty with any other sustained release opioid. Sustained release opioids will not be covered in the post-operative period unless routinely prescribed pre-operatively.** |
| | Oxymorphone HCl Tab SR 12HR 5 MG | **See Oxymorphone HCl Tab SR 12HR Products restrictions above** |
| | Oxymorphone HCl Tab SR 12HR 7.5 MG | **See Oxymorphone HCl Tab SR 12HR Products restrictions above** |
| | Oxymorphone HCl Tab SR 12HR 10 MG | **See Oxymorphone HCl Tab SR 12HR Products restrictions above** |
| | Oxymorphone HCl Tab SR 12HR 15 MG | **See Oxymorphone HCl Tab SR 12HR Products restrictions above** |
| | Oxymorphone HCl Tab SR 12HR 20 MG | **See Oxymorphone HCl Tab SR 12HR Products restrictions above** |
| | Oxymorphone HCl Tab SR 12HR 30 MG | **See Oxymorphone HCl Tab SR 12HR Products restrictions above** |
| | Oxymorphone HCl Tab SR 12HR 40 MG | **See Oxymorphone HCl Tab SR 12HR Products restrictions above** |
| | Oxymorphone HCl Tab ER 12HR Deter Products | **Effective January 1, 2017 for any claim in which this drug was not currently being reimbursed, prior authorization is required showing documentation of allergic reaction to or clinical failure of, as defined in OAC 4123-6-21(J)(1) and (J)(2), Oxycodone ER or Fentanyl transdermal. Reimbursement shall not exceed two tablets per day. Claims in which this dose limitation was exceeded prior to January 1, 2017, will be limited to the last quantity prescribed before that date. Coverage will not be permitted for this product concurrenty with any other sustained release opioid. Sustained release opioids will not be covered in the post-operative period unless routinely prescribed pre-operatively.** |
| | Oxymorphone HCl Tab ER 12HR Deter 5 MG | **See Oxymorphone HCl Tab ER 12HR Deter Products restrictions above** |
| | Oxymorphone HCl Tab ER 12HR Deter 7.5 MG | **See Oxymorphone HCl Tab ER 12HR Deter Products restrictions above** |
| | Oxymorphone HCl Tab ER 12HR Deter 10 MG | **See Oxymorphone HCl Tab ER 12HR Deter Products restrictions above** |
| | Oxymorphone HCl Tab ER 12HR Deter 15 MG | **See Oxymorphone HCl Tab ER 12HR Deter Products restrictions above** |

## APPENDIX TO RULE 4123-6-21.3
## Formulary List of Medications Covered by the Ohio Bureau of Workers' Compensation

| Drug Class Name | Drug Generic Name | Coverage restrictions or limitations for specific drugs or dosage forms are listed with the respective drugs below. |
|---|---|---|
| | Oxymorphone HCl Tab ER 12HR Deter 20 MG | **See Oxymorphone HCl Tab ER 12HR Deter Products restrictions above** |
| | Oxymorphone HCl Tab ER 12HR Deter 30 MG | **See Oxymorphone HCl Tab ER 12HR Deter Products restrictions above** |
| | Oxymorphone HCl Tab ER 12HR Deter 40 MG | **See Oxymorphone HCl Tab ER 12HR Deter Products restrictions above** |
| | Tapentadol HCl Tab SR 12HR Products | **Reimbursement shall not exceed 500 mg per day. Coverage will not be permitted for this product concurrently with any other sustained release opioid or immediate release tapentadol products. Sustained release opioids will not be covered in the post-operative period unless routinely prescribed pre-operatively.** |
| | Tapentadol HCl Tab SR 12HR 50 MG | **See Tapentadol HCl Tab SR 12HR Products restrictions above** |
| | Tapentadol HCl Tab SR 12HR 100 MG | **See Tapentadol HCl Tab SR 12HR Products restrictions above** |
| | Tapentadol HCl Tab SR 12HR 150 MG | **See Tapentadol HCl Tab SR 12HR Products restrictions above** |
| | Tapentadol HCl Tab SR 12HR 200 MG | **See Tapentadol HCl Tab SR 12HR Products restrictions above** |
| | Tapentadol HCl Tab SR 12HR 250 MG | **See Tapentadol HCl Tab SR 12HR Products restrictions above** |
| | Tramadol HCl Tab SR 24HR Products | **Reimbursement for this product shall not exceed 300 mg per day. Coverage will not be permitted for this product concurrently with any other sustained release opioid. Sustained release opioids will not be covered in the post-operative period unless routinely prescribed pre-operatively.** |
| | Tramadol HCl Tab SR 24HR 100 MG | **See Tramadol HCl Tab SR 24HR Products restrictions above** |
| | Tramadol HCl Tab SR 24HR 200 MG | **See Tramadol HCl Tab SR 24HR Products restrictions above** |
| | Tramadol HCl Tab SR 24HR 300 MG | **See Tramadol HCl Tab SR 24HR Products restrictions above** |
| | Tramadol HCl Tab SR 24HR Biphasic Release 100 MG | **See Tramadol HCl Tab SR 24HR Products restrictions above** |
| | Tramadol HCl Tab SR 24HR Biphasic Release 200 MG | **See Tramadol HCl Tab SR 24HR Products restrictions above** |
| | Tramadol HCl Tab SR 24HR Biphasic Release 300 MG | **See Tramadol HCl Tab SR 24HR Products restrictions above** |
| **Opioid Antagonists** | | |
| | Naloxone HCl Nasal Spray 4 MG/0.1ML | **Covered effective January 1, 2017. Reimbursement is restricted to only those claims in which a prior authorization has documented that BWC is currently reimbursing for opioid drugs.** |
| | Naloxone HCl Solution Auto-injector 0.4 MG/0.4ML | **Effective January 1, 2017 prescriptions for Naloxone HCL Solution Auto-injector will no longer be eligible for reimbursement.** |
| | Naltrexone HCl Tab 50 MG | **Reimbursement is restricted to only those claims in which a prior authorization has documented that BWC is currently reimbursing for opioid drugs.** |
| **Opioid Combinations** | | **Immediate Release Opioid Dose Formulation Restrictions:**<br>**Effective January 1, 2017 the following limitations will be effective; initial coverage of any immediate release opioid in an opioid naive IW will be limited to 7 days of coverage or 30 doses, whichever is <u>less;</u> a PA may be obtained to exceed these limitations for post-operative situations. Concurrent use of more than one immediate release opioid agent will not be covered without a Prior Authorization. A quantity limit of 6 doses per day for any immediate release opioid, will be implemented in all claims. Daily doses above this level may be reimbursed with prior authorization upon submission of documentation that supports clinical failure, as defined in OAC 4123-6-21(J)(2), of a lower daily dose. Claims in which this dose limitation was exceeded prior to January 1, 2017, will be limited to the last quantity prescribed before that date.** |

## APPENDIX TO RULE 4123-6-21.3
## Formulary List of Medications Covered by the Ohio Bureau of Workers' Compensation

| Drug Class Name | Drug Generic Name | Coverage restrictions or limitations for specific drugs or dosage forms are listed with the respective drugs below. |
|---|---|---|
| | Acetaminophen w/ Codeine Products | **Reimbursement for oral solid dosage forms of Codeine/Acetaminophen (APAP) is restricted to products that contain 300 mg of APAP. Effective January 1, 2017 reimbursement for this product will be limited to 6 doses per day for all covered forms of this product. Daily doses above this level may be reimbursed with prior authorization upon submission of documentation that supports clinical failure, as defined in OAC 4123-6-21(J)(2), of a lower daily dose. Claims in which this quantity limit was exceeded prior to January 1, 2017 will be limited to the last quantity prescribed before that date. Effective January 1, 2017 Prior Authorization will be required in all claims for reimbursement of concurrent use of this product with any other immediate release opioid. See also "Immediate Release Opioid Dose Formulation Restrictions" for additional restrictions for opioid naive IW.** |
| | Acetaminophen w/ Codeine Soln 120-12 MG/5ML | **See Acetaminophen w/ Codeine Product Restrictions Above** |
| | Acetaminophen w/ Codeine Tab 300-15 MG | **See Acetaminophen w/ Codeine Product Restrictions Above** |
| | Acetaminophen w/ Codeine Tab 300-30 MG | **See Acetaminophen w/ Codeine Product Restrictions Above** |
| | Acetaminophen w/ Codeine Tab 300-60 MG | **See Acetaminophen w/ Codeine Product Restrictions Above** |
| | Aspirin-Caffeine-Dihydrocodeine Cap 356.4-30-16 MG | **Initial coverage in an opioid naive IW will be limited to 7 days of coverage or 30 doses, whichever is less; a PA may be obtained to exceed these limitations for post-operative situations.** |
| | Butalbital-Acetaminophen-Caff w/ COD Cap 50-325-40-30 MG | **Reimbursement is restricted to combinations of Butalbital/codeine/caffeine/APAP that contain 325mg of APAP. Reimbursement for this product shall not exceed 4 grams/day of APAP (12 cap) or 24 cap per calendar month and is restricted to only those claims that have the condition of headache specificed as a documented allowance in the claim.** |
| | Butalbital-Aspirin-Caff w/ Codeine Cap 50-325-40-30 MG | **Reimbursement for this product shall not exceed 24 cap per calendar month and is restricted to only those claims that have the condition of headache specificed as a documented allowance in the claim.** |
| | Hydrocodone-Acetaminophen Tab Products | **Reimbursement is restricted to combinations of Hydrocodone/Acetaminophen (APAP) that contain 325mg of APAP. Effective January 1, 2017 reimbursement for this product will be limited to 6 doses per day for all covered forms of this product. Daily doses above this level may be reimbursed with prior authorization upon submission of documentation that supports clinical failure, as defined in OAC 4123-6-21(J)(2), of a lower daily dose. Claims in which this quantity limit was exceeded prior to January 1, 2017 will be limited to the last quantity prescribed before that date. Effective January 1, 2017 Prior Authorization will be required in all claims for reimbursement of concurrent use of this product with any other immediate release opioid. See also "Immediate Release Opioid Dose Formulation Restrictions" for additional restrictions for opioid naive IW.** |
| | Hydrocodone-Acetaminophen Tab 5-325 MG | **See Hydrocodone-Acetaminophen Tab Products restrictions above** |
| | Hydrocodone-Acetaminophen Tab 7.5-325 MG | **See Hydrocodone-Acetaminophen Tab Products restrictions above** |
| | Hydrocodone-Acetaminophen Tab 10-325 MG | **See Hydrocodone-Acetaminophen Tab Products restrictions above** |
| | Hydrocodone-Acetaminophen Soln 7.5-325 MG/15ML | **Reimbursement for these products shall not exceed 180 ml/ day (4 grams/day of APAP). Initial coverage in an opioid naive IW will be limited to 7 days of coverage; a PA may be obtained to exceed these limitations for post-operative situations.** |

## APPENDIX TO RULE 4123-6-21.3
## Formulary List of Medications Covered by the Ohio Bureau of Workers' Compensation

| Drug Class Name | Drug Generic Name | Coverage restrictions or limitations for specific drugs or dosage forms are listed with the respective drugs below. |
|---|---|---|
| | Hydrocodone-Acetaminophen Soln 10-325 MG/15ML | **Reimbursement for these products shall not exceed 180 ml/ day (4 grams/day of APAP). Initial coverage in an opioid naive IW will be limited to 7 days of coverage; a PA may be obtained to exceed these limitations for post-operative situations.** |
| | Hydrocodone-Ibuprofen Tab Products | **Reimbursement for these products shall not exceed more than five tablets per day. Initial coverage in an opioid naive IW will be limited to 7 days of coverage or 30 doses, whichever is less; a PA may be obtained to exceed these limitations for post-operative situations.** |
| | Hydrocodone-Ibuprofen Tab 2.5-200 MG | **See Hydrocodone-Ibuprofen Tab Products restrictions above** |
| | Hydrocodone-Ibuprofen Tab 5-200 MG | **See Hydrocodone-Ibuprofen Tab Products restrictions above** |
| | Hydrocodone-Ibuprofen Tab 7.5-200 MG | **See Hydrocodone-Ibuprofen Tab Products restrictions above** |
| | Hydrocodone-Ibuprofen Tab 10-200 MG | **See Hydrocodone-Ibuprofen Tab Products restrictions above** |
| | Oxycodone w/ Acetaminophen Tab Products | **Reimbursement is restricted to combinations of Oxycodone/Acetaminophen (APAP) that contain 325 mg of APAP. Effective January 1, 2017 reimbursement for this product will be limited to 6 doses per day for all covered forms of this product. Daily doses above this level may be reimbursed with prior authorization upon submission of documentation that supports clinical failure, as defined in OAC 4123-6-21(J)(2), of a lower daily dose. Claims in which this quantity limit was exceeded prior to January 1, 2017 will be limited to the last quantity prescribed before that date. Effective January 1, 2017 Prior Authorization will be required in all claims for reimbursement of concurrent use of this product with any other immediate release opioid. See also "Immediate Release Opioid Dose Formulation Restrictions" for additional restrictions for opioid naive IW.** |
| | Oxycodone w/ Acetaminophen Tab 2.5-325 MG | **See Oxycodone w/ Acetaminophen Tab Products restrictions above** |
| | Oxycodone w/ Acetaminophen Tab 5-325 MG | **See Oxycodone w/ Acetaminophen Tab Products restrictions above** |
| | Oxycodone w/ Acetaminophen Tab 7.5-325 MG | **See Oxycodone w/ Acetaminophen Tab Products restrictions above** |
| | Oxycodone w/ Acetaminophen Tab 10-325 MG | **See Oxycodone w/ Acetaminophen Tab Products restrictions above** |
| | Oxycodone w/ Acetaminophen Soln 5-325 MG/5ML | **Reimbursement for these products shall not exceed 60 mls/ day (4 grams/day of APAP). Initial coverage in an opioid naive IW will be limited to 7 days of coverage; a PA may be obtained to exceed these limitations for post-operative situations.** |
| | Oxycodone-Aspirin Tab 4.8355-325 MG | **Effective January 1, 2017 reimbursement for this product will be limited to 6 doses per day for all covered forms of this product. Daily doses above this level may be reimbursed with prior authorization upon submission of documentation that supports clinical failure, as defined in OAC 4123-6-21(J)(2), of a lower daily dose. Claims in which this quantity limit was exceeded prior to January 1, 2017 will be limited to the last quantity prescribed before that date. Effective January 1, 2017 Prior Authorization will be required in all claims for reimbursement of concurrent use of this product with any other immediate release opioid. See also "Immediate Release Opioid Dose Formulation Restrictions" for additional restrictions for opioid naive IW.** |
| | Oxycodone-Ibuprofen Tab 5-400 MG | **Reimbursement for these products shall not exceed more than four doses per day or continue for longer that seven days.** |

## APPENDIX TO RULE 4123-6-21.3
## Formulary List of Medications Covered by the Ohio Bureau of Workers' Compensation

| Drug Class Name | Drug Generic Name | Coverage restrictions or limitations for specific drugs or dosage forms are listed with the respective drugs below. |
|---|---|---|
| | Tramadol-Acetaminophen Tab 37.5-325 MG | **Reimbursement is restricted to only those combinations of Tramadol/Acetaminophen (APAP) that contain 325 mg of APAP. Effective January 1, 2017 reimbursement for this product will be limited to 6 doses per day for all covered forms of this product. Daily doses above this level may be reimbursed with prior authorization upon submission of documentation that supports clinical failure, as defined in OAC 4123-6-21(J)(2), of a lower daily dose. Claims in which this quantity limit was exceeded prior to January 1, 2017 will be limited to the last quantity prescribed before that date. Effective January 1, 2017 Prior Authorization will be required in all claims for reimbursement of concurrent use of this product with any other immediate release opioid. See also "Immediate Release Opioid Dose Formulation Restrictions" for additional restrictions for opioid naive IW.** |
| **Opioid Partial Agonists - Immediate Release** | | |
| | Butorphanol Tartrate Nasal Soln 10 MG/ML | |
| | Pentazocine w/ Naloxone Tab 50-0.5 MG | |
| **Opioid Partial Agonists - Sustained Release** | | |
| | Buprenorphine TD Patch Products | **Effective January 1, 2017 for all claims, coverage is limited to a maximum quantity of 4 patches of any strength per 28 days. The maximum daily dose covered for this product is 20 mcg/day. Coverage of this product is limited to only those claims with a daily Morphine Equivalent Dose (MED) requirement of 90 mg or less. Coverage will not be permitted for this product concurrently with any other sustained release opioid.** |
| | Buprenorphine TD Patch Weekly 5 MCG/HR | **See Buprenorphine TD Patch Product restrictions above** |
| | Buprenorphine TD Patch Weekly 7.5 MCG/HR | **See Buprenorphine TD Patch Product restrictions above** |
| | Buprenorphine TD Patch Weekly 10 MCG/HR | **See Buprenorphine TD Patch Product restrictions above** |
| | Buprenorphine TD Patch Weekly 15 MCG/HR | **See Buprenorphine TD Patch Product restrictions above** |
| | Buprenorphine TD Patch Weekly 20 MCG/HR | **See Buprenorphine TD Patch Product restrictions above** |
| **Otic Agents - Misc** | | |
| | Acetic Acid Otic Soln 2% | |
| | Antipyrine-Benzocaine Otic Soln 54-14 MG/ML (5.4-1.4%) | |
| | Antipyrine-Benzocaine-Polycosanol Otic Sol 5.4-1.4-0.0097%* | |
| | Cresyl Acetate Otic Soln 25% | |
| | Pramoxine-HC-Chloroxylenol Otic Soln 10-10-1 MG/ML | |
| **Otic Anti-infective/Steroid** | | |
| | Ciprofloxacin-Dexamethasone Otic Susp 0.3-0.1% | |
| | Ciprofloxacin-Hydrocortisone Otic Susp 0.2-1% | |
| | Neomycin-Colistin-HC-Thonzonium Otic Susp 3.3-3-10-0.5 MG/ML | |
| | Neomycin-Polymyxin-HC Otic Soln 1% | |
| | Neomycin-Polymyxin-HC Otic Susp 3.5 MG/ML-10000 Unit/ML-1% | |
| **Otic Anti-infectives** | | |
| | Ofloxacin Otic Soln 0.3% | |
| **Otic Steroids** | | |
| | Fluocinolone Acetonide (Otic) Oil 0.01% | |
| | Hydrocortisone w/ Acetic Acid Otic Soln 1-2% | |
| **Oxytocics** | | |
| | Methylergonovine Maleate Tab 0.2 MG | |
| **Phosphate Binder Agents** | | |
| | Calcium Acetate (Phosphate Binder) Cap 667 MG (169 MG Ca) | |
| | Lanthanum Carbonate Chew Tab 750 MG (Elemental) | |
| | Lanthanum Carbonate Chew Tab 1000 MG (Elemental) | |
| | Lanthanum Carbonate Oral Powder Pack 750 MG (Elemental) | |

## APPENDIX TO RULE 4123-6-21.3
## Formulary List of Medications Covered by the Ohio Bureau of Workers' Compensation

| Drug Class Name | Drug Generic Name | Coverage restrictions or limitations for specific drugs or dosage forms are listed with the respective drugs below. |
|---|---|---|
| | Lanthanum Carbonate Oral Powder Pack 1000 MG (Elemental) | |
| | Sevelamer Carbonate Packet 2.4 GM | |
| | Sevelamer Carbonate Tab 800 MG | |
| | Sevelamer HCl Tab 800 MG | |
| **Platelet Aggregation Inhibitors** | | |
| | Aspirin-Dipyridamole Cap SR 12HR 25-200 MG | |
| | Cilostazol Tab 50 MG | |
| | Cilostazol Tab 100 MG | |
| | Clopidogrel Bisulfate Tab 75 MG (Base Equiv) | |
| | Dipyridamole Tab 25 MG | |
| | Dipyridamole Tab 50 MG | |
| | Dipyridamole Tab 75 MG | |
| | Prasugrel HCl Tab 10 MG (Base Equiv) | |
| **Postherpetic Neuralgia (PHN) Agents** | | |
| | Gabapentin (Once-Daily) Tab 300 MG | **Gabapentin Sustained Release product class restriction: Coverage of Gabapentin Sustained Release products requires a Prior Authorization that reflects a 30 day trail and documented clinical failure (as defined in O.A.C. 4123-6-21 (J) (2) of the immediate release form of gabapentin. Coverage of all gabapentin products is restricted to a single form at any one time.** |
| | Gabapentin (Once-Daily) Tab 600 MG | **Gabapentin Sustained Release product class restriction: Coverage of Gabapentin Sustained Release products requires a Prior Authorization that reflects a 30 day trail and documented clinical failure (as defined in O.A.C. 4123-6-21 (J) (2) of the immediate release form of gabapentin. Coverage of all gabapentin products is restricted to a single form at any one time.** |
| **Potassium Removing Agents** | | |
| | Sodium Polystyrene Sulfonate Oral Susp 15 GM/60ML | |
| | Sodium Polystyrene Sulfonate Powder** | |
| **Progestins** | | |
| | Medroxyprogesterone Acetate Tab 10 MG | |
| | Megestrol Acetate Susp 625 MG/5ML | |
| **Prostatic Hypertrophy Agents** | | |
| | Alfuzosin HCl Tab SR 24HR 10 MG | |
| | Dutasteride Cap 0.5 MG | |
| | Dutasteride-Tamsulosin HCl Cap 0.5-0.4 MG | |
| | Finasteride Tab 5 MG | |
| | Silodosin Cap 4 MG | |
| | Silodosin Cap 8 MG | |
| | Tamsulosin HCl Cap 0.4 MG | |
| **Pseudobulbar Affect (PBA) Agents** | | |
| | Dextromethorphan HBr-Quinidine Sulfate Cap 20-10 MG | |
| **Pulmonary Hypertension - Endothelin Receptor Antagonists** | | |
| | Ambrisentan Tab 10 MG | |
| **Pulmonary Hypertension - Phosphodiesterase Inhibitors** | | |
| | Sildenafil Citrate Tab 20 MG | |
| **Pyrimidine Synthesis Inhibitors** | | |
| | Leflunomide Tab 10 MG | |
| | Leflunomide Tab 20 MG | |
| **Rectal - Intrarectal Steroids** | | |
| | Hydrocortisone Enema 100 MG/60ML | |
| **Rectal - Local Anesthetics** | | |
| | Dibucaine Rectal Ointment 1% | |
| | Hydrocortisone Acetate w/ Pramoxine Rectal Cream 1-1% | |

# APPENDIX TO RULE 4123-6-21.3
## Formulary List of Medications Covered by the Ohio Bureau of Workers' Compensation

| Drug Class Name | Drug Generic Name | Coverage restrictions or limitations for specific drugs or dosage forms are listed with the respective drugs below. |
|---|---|---|
| | Hydrocortisone Acetate w/ Pramoxine Rectal Cream 2.5-1% | |
| | Hydrocortisone Acetate w/ Pramoxine Rectal Foam 1-1% | |
| | Lidocaine Anorectal Cream 5% | |
| | Lidocaine Anorectal Gel 5% | |
| | Lidocaine-Hydrocortisone Acetate Rectal Cream 3-0.5% | |
| | Phenylephrine-Shark Liver Oil-MO-Pet Oint 0.25-3-14-71.9% | |
| | Phenyleph-Shark Liver Oil-Cocoa Butter Suppos 0.25-3-85.5% | |
| | Pramoxine HCl Rectal Foam 1% | |
| | Pramox-PE-Glycerin-Petrolatum Rectal Cream 1-0.25-14.4-15% | |
| **Rectal - Steroids** | | |
| | Hydrocortisone Acetate Suppos 25 MG | |
| | Hydrocortisone Acetate Suppos 30 MG | |
| | Hydrocortisone Rectal Cream 1% | |
| | Hydrocortisone Rectal Cream 2.5% | |
| **Respiratory - Antiasthmatic - Monoclonal Antibodies** | | |
| | Omalizumab For Inj 150 MG | |
| **Respiratory - Anticholinergics** | | |
| | Ipratropium Bromide HFA Inhal Aerosol 17 MCG/ACT | |
| | Ipratropium Bromide Inhal Soln 0.02% | |
| | Tiotropium Bromide Monohydrate Inhal Aerosol 1.25 MCG/ACT | |
| | Tiotropium Bromide Monohydrate Inhal Aerosol 2.5 MCG/ACT | |
| | Tiotropium Bromide Monohydrate Inhal Cap 18 MCG (Base Equiv) | |
| **Respiratory - Anti-Inflammatory Agents** | | |
| | Cromolyn Sodium Soln Nebu 20 MG/2ML | |
| **Respiratory - Leukotriene Modulators** | | |
| | Montelukast Sodium Chew Tab 5 MG (Base Equiv) | |
| | Montelukast Sodium Tab 10 MG (Base Equiv) | |
| | Zafirlukast Tab 20 MG | |
| | Zileuton Tab SR 12HR 600 MG | |
| **Respiratory - Selective Phosphodiesterase 4 (PDE4) Inhibitors** | | |
| | Roflumilast Tab 500 MCG | |
| **Respiratory - Steroid Inhalants** | | |
| | Beclomethasone Diprop Inhal Aero Soln 40 MCG/ACT (50/Valve) | |
| | Beclomethasone Diprop Inhal Aero Soln 80 MCG/ACT (100/Valve) | |
| | Budesonide Inhal Aero Powd 90 MCG/ACT (Breath Activated) | |
| | Budesonide Inhal Aero Powd 180 MCG/ACT (Breath Activated) | |
| | Budesonide Inhalation Susp 0.25 MG/2ML | |
| | Budesonide Inhalation Susp 0.5 MG/2ML | |
| | Budesonide Inhalation Susp 1 MG/2ML | |
| | Fluticasone Propionate Aer Pow BA 50 MCG/BLISTER | |
| | Fluticasone Propionate Aer Pow BA 100 MCG/BLISTER | |
| | Fluticasone Propionate HFA Inhal Aero 44 MCG/ACT (50/Valve) | |
| | Fluticasone Propionate HFA Inhal Aer 110 MCG/ACT (125/Valve) | |
| | Fluticasone Propionate HFA Inhal Aer 220 MCG/ACT (250/Valve) | |
| | Mometasone Furoate Inhal Aerosol Suspension 100 MCG/ACT | |
| | Mometasone Furoate Inhal Aerosol Suspension 200 MCG/ACT | |
| | Mometasone Furoate Inhal Powd 110 MCG/INH (Breath Activated) | |
| | Mometasone Furoate Inhal Powd 220 MCG/INH (Breath Activated) | |
| **Respiratory - Sympathomimetics** | | |
| | Albuterol Sulfate Aer Pow BA 108 MCG/ACT (90 MCG Base Equiv) | |
| | Albuterol Sulfate Inhal Aero 108 MCG/ACT (90MCG Base Equiv) | |
| | Albuterol Sulfate Soln Nebu 0.083% (2.5 MG/3ML) | |
| | Albuterol Sulfate Soln Nebu 0.5% (5 MG/ML) | |
| | Albuterol Sulfate Soln Nebu 0.63 MG/3ML (Base Equiv) | |
| | Albuterol Sulfate Soln Nebu 1.25 MG/3ML (Base Equiv) | |

## APPENDIX TO RULE 4123-6-21.3
## Formulary List of Medications Covered by the Ohio Bureau of Workers' Compensation

| Drug Class Name | Drug Generic Name | Coverage restrictions or limitations for specific drugs or dosage forms are listed with the respective drugs below. |
|---|---|---|
| | Albuterol Sulfate Syrup 2 MG/5ML | |
| | Albuterol Sulfate Tab 2 MG | |
| | Albuterol Sulfate Tab 4 MG | |
| | Albuterol Sulfate Tab SR 12HR 4 MG | |
| | Albuterol Sulfate Tab SR 12HR 8 MG | |
| | Arformoterol Tartrate Soln Nebu 15 MCG/2ML (Base Equiv) | |
| | Budesonide-Formoterol Fumarate Dihyd Aerosol 80-4.5 MCG/ACT | |
| | Budesonide-Formoterol Fumarate Dihyd Aerosol 160-4.5 MCG/ACT | |
| | Fluticasone-Salmeterol Aer Powder BA 100-50 MCG/DOSE | |
| | Fluticasone-Salmeterol Aer Powder BA 250-50 MCG/DOSE | |
| | Fluticasone-Salmeterol Aer Powder BA 500-50 MCG/DOSE | |
| | Fluticasone-Salmeterol Inhal Aerosol 45-21 MCG/ACT | |
| | Fluticasone-Salmeterol Inhal Aerosol 115-21 MCG/ACT | |
| | Fluticasone-Salmeterol Inhal Aerosol 230-21 MCG/ACT | |
| | Formoterol Fumarate Inhal Cap 12 MCG | |
| | Formoterol Fumarate Soln Nebu 20 MCG/2ML | |
| | Ipratropium-Albuterol Aerosol 18-103 MCG/ACT (20-120MCG/ACT) | |
| | Ipratropium-Albuterol Inhal Aerosol Soln 20-100 MCG/ACT | |
| | Ipratropium-Albuterol Nebu Soln 0.5-2.5(3) MG/3ML | |
| | Levalbuterol HCl Soln Nebu 0.31 MG/3ML (Base Equiv) | |
| | Levalbuterol HCl Soln Nebu 0.63 MG/3ML (Base Equiv) | |
| | Levalbuterol HCl Soln Nebu 1.25 MG/3ML (Base Equiv) | |
| | Levalbuterol HCl Soln Nebu Conc 1.25 MG/0.5ML (Base Equiv) | |
| | Levalbuterol Tartrate Inhal Aerosol 45 MCG/ACT (Base Equiv) | |
| | Metaproterenol Sulfate Tab 10 MG | |
| | Metaproterenol Sulfate Tab 20 MG | |
| | Mometasone Furoate-Formoterol Fumarate Aerosol 100-5 MCG/ACT | |
| | Mometasone Furoate-Formoterol Fumarate Aerosol 200-5 MCG/ACT | |
| | Pirbuterol Acetate Breath Activated Inhal Aerosol 200MCG/INH | |
| | Salmeterol Xinafoate Aer Pow BA 50 MCG/DOSE (Base Equiv) | |
| | Terbutaline Sulfate Tab 2.5 MG | |
| | Terbutaline Sulfate Tab 5 MG | |
| **Respiratory - Xanthines** | | |
| | Theophylline Cap SR 24HR 100 MG | |
| | Theophylline Cap SR 24HR 200 MG | |
| | Theophylline Cap SR 24HR 300 MG | |
| | Theophylline Cap SR 24HR 400 MG | |
| | Theophylline Tab SR 12HR 100 MG | |
| | Theophylline Tab SR 12HR 200 MG | |
| | Theophylline Tab SR 12HR 300 MG | |
| | Theophylline Tab SR 24HR 400 MG | |
| | Theophylline Tab SR 24HR 600 MG | |
| **Respiratory Inhalants - Misc** | | |
| | Camphor-Eucalyptus-Menthol - Oint*** | |
| | Sodium Chloride Aero Soln 0.9% | |
| | Sodium Chloride Soln Nebu 0.9% | |
| **Restless Leg Syndrome (RLS) Agents** | | |
| | Gabapentin Enacarbil Tab CR 300 MG | **Gabapentin Sustained Release product class restriction: Coverage of Gabapentin Sustained Release products requires a Prior Authorization that reflects a 30 day trail and documented clinical failure (as defined in O.A.C. 4123-6-21 (J) (2) of the immediate release form of gabapentin. Coverage of all gabapentin products is restricted to a single form at any one time.** |

# APPENDIX TO RULE 4123-6-21.3
## Formulary List of Medications Covered by the Ohio Bureau of Workers' Compensation

| Drug Class Name | Drug Generic Name | Coverage restrictions or limitations for specific drugs or dosage forms are listed with the respective drugs below. |
|---|---|---|
| | Gabapentin Enacarbil Tab CR 600 MG | **Gabapentin Sustained Release product class restriction: Coverage of Gabapentin Sustained Release products requires a Prior Authorization that reflects a 30 day trail and documented clinical failure (as defined in O.A.C. 4123-6-21 (J) (2) of the immediate release form of gabapentin. Coverage of all gabapentin products is restricted to a single form at any one time.** |
| **Rosacea Agents - Oral** | | |
| | Doxycycline (Rosacea) Cap Delayed Release 40 MG | |
| **Salicylates** | | |
| | Aspirin Buffered (Ca Carb-Mg Carb-Mg Ox) Tab 325 MG | |
| | Aspirin Buffered (Ca Carb-Mg Carb-Mg Ox) Tab 500 MG | |
| | Aspirin Chew Tab 81 MG | |
| | Aspirin Tab 81 MG | |
| | Aspirin Tab 325 MG | |
| | Aspirin Tab 500 MG | |
| | Aspirin Tab Delayed Release 81 MG | |
| | Aspirin Tab Delayed Release 325 MG | |
| | Aspirin Tab Delayed Release 500 MG | |
| | Aspirin-Al Hydro-Mg Hydro-Ca Carb Tab 500-33-33-237 MG | |
| | Aspirin-Al Hydro-Mg Hydro-Ca Carb Tab 325 MG*** | |
| | Choline & Magnesium Salicylates Tab 1000 MG | |
| | Choline & Magnesium Salicylates Tab 500 MG | |
| | Choline & Magnesium Salicylates Tab 750 MG | |
| | Diflunisal Tab 500 MG | |
| | Salsalate Tab 500 MG | |
| | Salsalate Tab 750 MG | |
| **Sympathomimetic Decongestants** | | |
| | Oxymetazoline HCl Nasal Soln 0.05% | |
| | Phenylephrine HCl Tab 10 MG | |
| | Pseudoephedrine HCl Syrup 30 MG/5ML | |
| | Pseudoephedrine HCl Tab 30 MG | |
| | Pseudoephedrine HCl Tab 60 MG | |
| | Pseudoephedrine HCl Tab SR 12HR 120 MG | |
| | Pseudoephedrine HCl Tab SR 24HR 240 MG | |
| **Thyroid Hormones** | | |
| | Levothyroxine Sodium Tab 25 MCG | |
| | Levothyroxine Sodium Tab 50 MCG | |
| | Levothyroxine Sodium Tab 75 MCG | |
| | Levothyroxine Sodium Tab 88 MCG | |
| | Levothyroxine Sodium Tab 100 MCG | |
| | Levothyroxine Sodium Tab 112 MCG | |
| | Levothyroxine Sodium Tab 125 MCG | |
| | Levothyroxine Sodium Tab 137 MCG | |
| | Levothyroxine Sodium Tab 150 MCG | |
| | Levothyroxine Sodium Tab 175 MCG | |
| | Levothyroxine Sodium Tab 200 MCG | |
| | Levothyroxine Sodium Tab 300 MCG | |
| | Liothyronine Sodium Tab 5 MCG | |
| | Liothyronine Sodium Tab 25 MCG | |
| | Liothyronine Sodium Tab 50 MCG | |
| | Thyroid Tab 30 MG (1/2 Grain) | |
| | Thyroid Tab 60 MG (1 Grain) | |
| | Thyroid Tab 81.25 MG | |
| | Thyroid Tab 90 MG (1 1/2 Grain) | |
| | Thyroid Tab 113.75 MG | |
| | Thyroid Tab 162.5 MG (2 1/2 Grain) | |
| | Thyroid Tab 146.25 MG | |

# APPENDIX TO RULE 4123-6-21.3
## Formulary List of Medications Covered by the Ohio Bureau of Workers' Compensation

| Drug Class Name | Drug Generic Name | Coverage restrictions or limitations for specific drugs or dosage forms are listed with the respective drugs below. |
|---|---|---|
| **TNF - Anti-TNF-alpha - Monoclonal Antibodies** | | |
| | Adalimumab Pen-injector Kit 40 MG/0.8ML | |
| | Adalimumab Prefilled Syringe Kit 40 MG/0.8ML | |
| **TNF - Soluble Tumor Necrosis Factor Receptor Agents** | | |
| | Etanercept Subcutaneous Soln Prefilled Syringe 25 MG/0.5ML | |
| | Etanercept Subcutaneous Soln Prefilled Syringe 50 MG/ML | |
| | Etanercept Subcutaneous Solution Auto-injector 50 MG/ML | |
| **Topical - Acne Products** | | |
| | Benzoyl Peroxide-Erythromycin Gel 5-3% | |
| | Clindamycin Phosphate Foam 1% | |
| | Clindamycin Phosphate Gel 1% | |
| | Clindamycin Phosphate Lotion 1% | |
| | Clindamycin Phosphate Soln 1% | |
| | Clindamycin Phosphate Swab 1% | |
| | Erythromycin Gel 2% | |
| | Erythromycin Soln 2% | |
| | Sulfacetamide Sodium w/ Sulfur Cream 10-5% | |
| | Sulfacetamide Sodium w/ Sulfur Emulsion 10-1% | |
| | Sulfacetamide Sodium w/ Sulfur Emulsion 10-5% | |
| | Sulfacetamide Sodium w/ Sulfur Foam 10-5% | |
| | Sulfacetamide Sodium w/ Sulfur Lotion 10-5% | |
| | Sulfacetamide Sodium-Sulfur in Urea Emulsion 10-4% | |
| **Topical - Agents for External Genital and Perianal Warts** | | |
| | Sinecatechins Oint 15% | |
| **Topical - Analgesics** | | |
| | Menthol Gel 2% | |
| | Menthol Gel 2.5% | |
| | Menthol Gel 3.5% | |
| | Menthol Gel 4% | |
| | Menthol Gel 16% | |
| | Menthol Liquid 3.1% | |
| | Menthol Pad 154 MG | |
| | Menthol Pad 5% | |
| **Topical - Antibiotics** | | |
| | Bacitracin Oint 500 Unit/GM | |
| | Bacitracin Zinc Oint 500 Unit/GM | |
| | Bacitracin-Polymyxin B Oint*** | |
| | Bacitracin-Polymyxin-Neomycin HC Oint 1% | |
| | Gentamicin Sulfate Cream 0.1% | |
| | Gentamicin Sulfate Oint 0.1% | |
| | Mupirocin Calcium Cream 2% | |
| | Mupirocin Oint 2% | |
| | Neomycin-Bacitracin-Polymyxin Oint*** | |
| | Neomycin-Bacitracin-Polymyxin-Pramoxine Oint 1% | |
| | Neomycin-Polymyxin w/ Pramoxine Cream 1% | |
| | Neomycin-Polymyxin-HC Crm 3.5 MG/GM-10000 UNT/GM-0.5% | |
| | Retapamulin Oint 1% | |
| **Topical - Antifungals** | | |
| | Butenafine HCl Cream 1% | |
| | Ciclopirox Gel 0.77% | |
| | Ciclopirox Olamine Cream 0.77% (Base Equiv) | |
| | Ciclopirox Olamine Susp 0.77% (Base Equiv) | |
| | Ciclopirox Shampoo 1% | |
| | Ciclopirox Solution 8% | |
| | Clotrimazole Cream 1% | |
| | Clotrimazole Ointment 1% | |

## APPENDIX TO RULE 4123-6-21.3
## Formulary List of Medications Covered by the Ohio Bureau of Workers' Compensation

| Drug Class Name | Drug Generic Name | Coverage restrictions or limitations for specific drugs or dosage forms are listed with the respective drugs below. |
|---|---|---|
| | Clotrimazole Soln 1% | |
| | Clotrimazole w/ Betamethasone Cream 1-0.05% | |
| | Clotrimazole w/ Betamethasone Lotion 1-0.05% | |
| | Econazole Nitrate Cream 1% | |
| | Gentian Violet Soln 1% | |
| | Iodoquinol-HC Cream 1% | |
| | Iodoquinol-Hydrocortisone-Aloe Polysaccharide Gel 1-2-1%*** | |
| | Ketoconazole Cream 2% | |
| | Ketoconazole Foam 2% | |
| | Ketoconazole Shampoo 2% | |
| | Miconazole Nitrate Cream 2% | |
| | Miconazole Nitrate Ointment 2% | |
| | Miconazole Nitrate Powder 2% | |
| | Miconazole Nitrate Soln 2% | |
| | Miconazole-Zinc Oxide-White Petrolatum Oint 0.25-15-81.35% | |
| | Naftifine HCl Cream 1% | |
| | Naftifine HCl Gel 1% | |
| | Nystatin Cream 100000 Unit/GM | |
| | Nystatin Oint 100000 Unit/GM | |
| | Nystatin Topical Powder** | |
| | Nystatin-Triamcinolone Cream 100000-0.1 Unit/GM-% | |
| | Nystatin-Triamcinolone Oint 100000-0.1 Unit/GM-% | |
| | Oxiconazole Nitrate Cream 1% | |
| | Oxiconazole Nitrate Lotion 1% | |
| | Sertaconazole Nitrate Cream 2% | |
| | Sulconazole Nitrate Cream 1% | |
| | Terbinafine HCl Cream 1% | |
| | Terbinafine HCl Soln 1% | |
| | Tolnaftate Aerosol Pow 1% | |
| | Tolnaftate Cream 1% | |
| | Tolnaftate Powder 1% | |
| | Tolnaftate Soln 1% | |
| **Topical - Antihistamines** | | |
| | Diphenhydramine HCl Cream 2% | |
| **Topical - Anti-inflammatory Agents** | | |
| | Diclofenac Sodium Gel 1% | |
| | Diclofenac Sodium Soln 1.5% | **Reimbursement will be provided only in claims with osteoarthritis of the knee as an allowed condition.** |
| **Topical - Antineoplastic or Premalignant Lesion Agents** | | |
| | Diclofenac Sodium (Actinic Keratosis) Gel 3% | **ONLY reimbursed in claims with Actinic Keratosis allowed.** |
| | Fluorouracil Cream 0.5% | |
| | Fluorouracil Cream 4% | |
| | Fluorouracil Cream 5% | |
| **Topical - Antipruritics** | | |
| | Camphor & Menthol Gel 0.2-3.5% | |
| | Camphor & Menthol Lotion 0.5-0.5% | |
| | Doxepin HCl Cream 5% | |
| **Topical - Antipsoriatics** | | |
| | Calcipotriene Cream 0.005% | |
| | Calcipotriene Soln 0.005% (50 MCG/ML) | |
| | Tazarotene Cream 0.1% | |
| **Topical - Antivirals** | | |
| | Acyclovir Cream 5% | |
| | Acyclovir Oint 5% | |
| | Penciclovir Cream 1% | |
| **Topical - Burn Products** | | |

## APPENDIX TO RULE 4123-6-21.3
## Formulary List of Medications Covered by the Ohio Bureau of Workers' Compensation

| Drug Class Name | Drug Generic Name | Coverage restrictions or limitations for specific drugs or dosage forms are listed with the respective drugs below. |
|---|---|---|
| | Mafenide Acetate Cream 85 MG/GM | |
| | Mafenide Acetate Packet For Topical Soln 5% (50 GM) | |
| | Silver Sulfadiazine Cream 1% | |
| **Topical - Cauterizing Agents** | | |
| | Silver Nitrate-Potassium Nitrate Applicator 75-25% | |
| **Topical - Corticosteroids** | | |
| | Alclometasone Dipropionate Cream 0.05% | |
| | Alclometasone Dipropionate Oint 0.05% | |
| | Amcinonide Cream 0.1% | |
| | Amcinonide Oint 0.1% | |
| | Betamethasone Dipropionate Augmented Cream 0.05% | |
| | Betamethasone Dipropionate Augmented Gel 0.05% | |
| | Betamethasone Dipropionate Augmented Lotion 0.05% | |
| | Betamethasone Dipropionate Augmented Oint 0.05% | |
| | Betamethasone Dipropionate Cream 0.05% | |
| | Betamethasone Dipropionate Lotion 0.05% | |
| | Betamethasone Dipropionate Oint 0.05% | |
| | Betamethasone Valerate Aerosol Foam 0.12% | |
| | Betamethasone Valerate Cream 0.1% | |
| | Betamethasone Valerate Lotion 0.1% | |
| | Betamethasone Valerate Oint 0.1% | |
| | Calcipotriene-Betamethasone Dipropionate Foam 0.005-0.064% | |
| | Calcipotriene-Betamethasone Dipropionate Oint 0.005-0.064% | |
| | Clobetasol Propionate Cream 0.05% | |
| | Clobetasol Propionate Emollient Base Cream 0.05% | |
| | Clobetasol Propionate Emulsion Foam 0.05% | |
| | Clobetasol Propionate Foam 0.05% | |
| | Clobetasol Propionate Gel 0.05% | |
| | Clobetasol Propionate Lotion 0.05% | |
| | Clobetasol Propionate Oint 0.05% | |
| | Clobetasol Propionate Shampoo 0.05% | |
| | Clobetasol Propionate Soln 0.05% | |
| | Clobetasol Propionate Spray 0.05% | |
| | Clocortolone Pivalate Cream 0.1% | |
| | Desonide Cream 0.05% | |
| | Desonide Foam 0.05% | |
| | Desonide Gel 0.05% | |
| | Desonide Lotion 0.05% | |
| | Desonide Oint 0.05% | |
| | Desoximetasone Cream 0.05% | |
| | Desoximetasone Cream 0.25% | |
| | Desoximetasone Gel 0.05% | |
| | Desoximetasone Oint 0.25% | |
| | Diflorasone Diacetate Cream 0.05% | |
| | Diflorasone Diacetate Emollient Base Cream 0.05% | |
| | Diflorasone Diacetate Oint 0.05% | |
| | Fluocinolone Acetonide Cream 0.01% | |
| | Fluocinolone Acetonide Cream 0.025% | |
| | Fluocinolone Acetonide Oil 0.01% (Body Oil) | |
| | Fluocinolone Acetonide Oil 0.01% (Scalp Oil) | |
| | Fluocinolone Acetonide Oint 0.025% | |
| | Fluocinolone Acetonide Shampoo 0.01% | |
| | Fluocinolone Acetonide Soln 0.01% | |
| | Fluocinonide Cream 0.05% | |
| | Fluocinonide Cream 0.1% | |
| | Fluocinonide Emulsified Base Cream 0.05% | |
| | Fluocinonide Gel 0.05% | |

## APPENDIX TO RULE 4123-6-21.3
## Formulary List of Medications Covered by the Ohio Bureau of Workers' Compensation

| Drug Class Name | Drug Generic Name | Coverage restrictions or limitations for specific drugs or dosage forms are listed with the respective drugs below. |
|---|---|---|
| | Fluocinonide Oint 0.05% | |
| | Fluocinonide Soln 0.05% | |
| | Flurandrenolide Cream 0.05% | |
| | Flurandrenolide Tape 4 MCG/SQCM | |
| | Fluticasone Propionate Cream 0.05% | |
| | Fluticasone Propionate Lotion 0.05% | |
| | Fluticasone Propionate Oint 0.005% | |
| | Halcinonide Cream 0.1% | |
| | Halcinonide Oint 0.1% | |
| | Halobetasol Propionate Cream 0.05% | |
| | Halobetasol Propionate Oint 0.05% | |
| | Hydrocortisone Butyrate Cream 0.1% | |
| | Hydrocortisone Butyrate Hydrophilic Lipo Base Cream 0.1% | |
| | Hydrocortisone Butyrate Lotion 0.1% | |
| | Hydrocortisone Butyrate Oint 0.1% | |
| | Hydrocortisone Butyrate Soln 0.1% | |
| | Hydrocortisone Cream 0.5% | |
| | Hydrocortisone Cream 1% | |
| | Hydrocortisone Cream 2.5% | |
| | Hydrocortisone Gel 1% | |
| | Hydrocortisone Lotion 1% | |
| | Hydrocortisone Lotion 2.5% | |
| | Hydrocortisone Oint 0.5% | |
| | Hydrocortisone Oint 1% | |
| | Hydrocortisone Oint 2.5% | |
| | Hydrocortisone Probutate Cream 0.1% | |
| | Hydrocortisone Valerate Cream 0.2% | |
| | Hydrocortisone Valerate Oint 0.2% | |
| | Hydrocortisone-Aloe Vera Cream 1% | |
| | Mometasone Furoate Cream 0.1% | |
| | Mometasone Furoate Oint 0.1% | |
| | Mometasone Furoate Solution 0.1% (Lotion) | |
| | Pramoxine-HC Cream 1-1% | |
| | Pramoxine-HC Lotion 1-2.5% | |
| | Pramoxine-HC Oint 1-2.5% | |
| | Prednicarbate Oint 0.1% | |
| | Triamcinolone Acetonide Aerosol Soln 0.147 MG/GM | |
| | Triamcinolone Acetonide Cream 0.025% | |
| | Triamcinolone Acetonide Cream 0.1% | |
| | Triamcinolone Acetonide Cream 0.5% | |
| | Triamcinolone Acetonide Lotion 0.025% | |
| | Triamcinolone Acetonide Lotion 0.1% | |
| | Triamcinolone Acetonide Oint 0.025% | |
| | Triamcinolone Acetonide Oint 0.05% | |
| | Triamcinolone Acetonide Oint 0.1% | |
| | Triamcinolone Acetonide Oint 0.5% | |
| **Topical - Emollient/Keratolytic Agents** | | |
| | Urea Lotion 10% | |
| | Urea-Hyaluronate Sodium Susp 40-0.3% | |
| **Topical - Emollients** | | |
| | Emollient - Cream** | |
| | Emollient - Lotion** | |
| | Emollient - Ointment** | |
| | Hyaluronate Sodium (Emollient) Gel 0.2% | |
| | Hyaluronate Sodium (Emollient) Lotion 0.1% | |
| | Lactic Acid (Ammonium Lactate) Cream 12% | |
| | Lactic Acid (Ammonium Lactate) Lotion 12% | |

## APPENDIX TO RULE 4123-6-21.3
## Formulary List of Medications Covered by the Ohio Bureau of Workers' Compensation

| Drug Class Name | Drug Generic Name | Coverage restrictions or limitations for specific drugs or dosage forms are listed with the respective drugs below. |
|---|---|---|
| | Lactic Acid (Ammonium Lactate) Lotion 5% | |
| | Vitamins A & D Cream** | |
| | Vitamins A & D Oint** | |
| **Topical - Enzymes** | | |
| | Collagenase Oint 250 Unit/GM | |
| | Trypsin w/ Castor Oil & Peruvian Balsam Gel | |
| | Trypsin w/ Castor Oil & Peruvian Balsam Oint | |
| | Trypsin w/ Castor Oil & Peruvian Balsam Spray | |
| **Topical - Hair Growth Agents (Eye Lash)** | | |
| | Bimatoprost Soln 0.03% | |
| **Topical - Immunomodulating Agents** | | |
| | Imiquimod Cream 3.75% | |
| | Imiquimod Cream 5% | |
| | Pimecrolimus Cream 1% | |
| | Tacrolimus Oint 0.1% | |
| **Topical - Keratolytic/Antimitotic Agents** | | |
| | Salicylic Acid & Benzoic Acid Oint 3-6% | |
| **Topical - Liniments** | | |
| | Capsaicin-Menthol-Methyl Salicylate Cream 0.025-1-12% | |
| | Capsaicin-Menthol-Methyl Salicylate Cream 0.035-10-25% | |
| | Capsaicin-Menthol-Methyl Salicylate Cream 0.035-6-30% | |
| | Capsicum Oleoresin Cream 0.025% | |
| | Capsicum Oleoresin Cream 0.075% | |
| | Liniments & Rubs - Cream** | |
| | Liniments & Rubs - Gel** | |
| | Liniments & Rubs - Lotion** | |
| | Liniments & Rubs - Pad** | |
| | Menthol-Camphor Lotion 16-4% | |
| | Menthol-Methyl Salicylate Cream*** | |
| | Menthol-Methyl Salicylate Ointment*** | |
| | Menthol-Methyl Salicylate Stick*** | |
| | Methyl Salicylate Liniment 10% | |
| | Methyl Salicylate Liquid** | |
| | Trolamine Salicylate Cream 10% | |
| | Trolamine Salicylate Lotion 10% | |
| **Topical - Local Anesthetics** | | |
| | Benzocaine Aerosol 10% | |
| | Butamben-Tetracaine-Benzocaine Aerosol Spray 2-2-14% | |
| | Capsaicin Cream 0.025% | |
| | Capsaicin Cream 0.035% | |
| | Capsaicin Cream 0.075% | |
| | Capsaicin Cream 0.1% | |
| | Capsaicin in Lidocaine Vehicle Cream 0.25% | |
| | Capsaicin Liquid 0.15% | |
| | Capsaicin Pad 0.025% | |
| | Dibucaine Oint 1% | |
| | Ethyl Chloride Aerosol Spray | |
| | Lidocaine Cream 4% | |
| | Lidocaine Gel 4% | |
| | Lidocaine HCl Cream 3% | |
| | Lidocaine HCl Gel 2% | |
| | Lidocaine HCl Lotion 3% | |
| | Lidocaine Oint 5% | |
| | Lidocaine Patch 5% | **ONLY reimbursed in claims with post herpetic neuralgia allowed.** |
| | Lidocaine-Prilocaine Cream 2.5-2.5% | |
| | Lidocaine-Tetracaine Topical Patch 70-70 MG | |
| | Pentafluoropropane-Tetrafluoroethane Aero Spray | |

# APPENDIX TO RULE 4123-6-21.3
## Formulary List of Medications Covered by the Ohio Bureau of Workers' Compensation

| Drug Class Name | Drug Generic Name | Coverage restrictions or limitations for specific drugs or dosage forms are listed with the respective drugs below. |
|---|---|---|
| | Pramoxine HCl Lotion 1% | |
| | Pramoxine-Benzyl Alcohol Gel 1-10% | |
| | Pramoxine-Zinc Acetate Lotion 1-0.1% | |
| **Topical - Misc** | | |
| | Aloe Vera Liquid** | |
| | Aloe Vera Lotion** | |
| | Aluminum Acetate Soln | |
| | Aluminum Chloride in Alcohol Solution 15% | |
| | Aluminum Chloride Soln 20% | |
| | Aluminum Hydroxide Oint | |
| | Benzoin Tincture | |
| | Dimethicone Cream 1% | |
| | Dimethicone-Petrolatum Cream 3-30% | |
| | Menthol-Zinc Oxide Oint 0.44-20.6% | |
| | Menthol-Zinc Oxide Oint 0.44-20.625% | |
| | Petrolatum-Zinc Oxide Oint 49-15% | |
| | Skin Protectants Misc - Cream*** | |
| | Skin Protectants Misc - Ointment*** | |
| | Skin Protectants Misc - Paste*** | |
| | Sodium Chloride External Soln 0.9% | |
| | Talc Topical Powder | |
| | Witch Hazel-Glycerin Cleansing Pads | |
| | Zinc Oxide Cream 13% | |
| | Zinc Oxide Cream 30.6% | |
| | Zinc Oxide Oint 12.8% | |
| | Zinc Oxide Oint 20% | |
| | Zinc Oxide Oint 40% | |
| **Topical - Misc Dermatological Products** | | |
| | Dermatological Products Misc - Cream** | |
| | Dermatological Products Misc - Emulsion** | |
| **Topical - Rosacea Agents** | | |
| | Metronidazole Cream 0.75% | |
| | Metronidazole Gel 0.75% | |
| | Metronidazole Gel 1% | |
| **Topical - Scabicides & Pediculicides** | | |
| | Crotamiton Cream 10% | |
| | Crotamiton Lotion 10% | |
| | Lindane Lotion 1% | |
| | Lindane Shampoo 1% | |
| | Malathion Lotion 0.5% | |
| | Permethrin Cream 5% | |
| | Permethrin Lotion 1% | |
| | Pyrethrins-Piperonyl Butoxide Liq 0.33-4% | |
| | Pyrethrins-Piperonyl Butoxide Shampoo 0.33-4% | |
| **Topical - Scar Treatment** | | |
| | Scar Treatment Products - Cream** | |
| | Scar Treatment Products - Gel** | |
| **Topical - Wound Care** | | |
| | Becaplermin Gel 0.01% | |
| | Hyaluronate Sodium Gel 0.2% | |
| | Lidocaine HCl-Collagen-Aloe Vera Gel 2% | |
| | Wound Cleansers - Liquid** | |
| | Wound Dressings - Emulsion*** | |
| | Wound Dressings - Gel*** | |
| **Ulcer Drugs - Antispasmodics** | | |
| | Belladonna Alkaloids & Opium Suppos 16.2-30 MG | |
| | Belladonna Alkaloids & Opium Suppos 16.2-60 MG | |

## APPENDIX TO RULE 4123-6-21.3
## Formulary List of Medications Covered by the Ohio Bureau of Workers' Compensation

| Drug Class Name | Drug Generic Name | Coverage restrictions or limitations for specific drugs or dosage forms are listed with the respective drugs below. |
|---|---|---|
| | Chlordiazepoxide HCl-Clidinium Bromide Cap 5-2.5 MG | |
| | Dicyclomine HCl Cap 10 MG | |
| | Dicyclomine HCl Oral Soln 10 MG/5ML | |
| | Dicyclomine HCl Tab 20 MG | |
| | Glycopyrrolate Tab 1 MG | |
| | Glycopyrrolate Tab 2 MG | |
| | Hyoscyamine Sulfate Elixir 0.125 MG/5ML | |
| | Hyoscyamine Sulfate Tab 0.125 MG | |
| | Hyoscyamine Sulfate Tab CR 0.375 MG (0.125 MG IR/0.25 MG CR) | |
| | Hyoscyamine Sulfate Tab Disp 0.125 MG | |
| | Hyoscyamine Sulfate Tab SL 0.125 MG | |
| | Hyoscyamine Sulfate Tab SR 12HR 0.375 MG | |
| | Methscopolamine Bromide Tab 2.5 MG | |
| | Methscopolamine Bromide Tab 5 MG | |
| | PB-Hyoscy-Atrop-Scopol Tab 16.2-0.1037-0.0194-0.0065 MG | |
| | PB-Hyoscy-Atrop-Scopol Tab CR 48.6-0.3111-0.0582-0.0195 MG | |
| | Propantheline Bromide Tab 15 MG | |
| **Ulcer Drugs - H-2 Antagonists** | | **H-2 Antagonist Drug Class Restictions:**<br>**Reimbursement for covered drugs in this class is only permitted when they are prescribed as gastrointestinal protectants during recurrent oral steroid or non-steroidal anti-inflammatory drug therapy or to treat an allowed condition that involves a gastrointestinal disorder such as ulcer or GERD (gastrointestinal esophageal reflux disease)** |
| | Famotidine Tab 10 MG | **See H-2 Antagonist Drug Class Restrictions** |
| | Famotidine Tab 20 MG | **See H-2 Antagonist Drug Class Restrictions** |
| | Famotidine Tab 40 MG | **See H-2 Antagonist Drug Class Restrictions** |
| | Ranitidine HCl Cap 150 MG | **See H-2 Antagonist Drug Class Restrictions** |
| | Ranitidine HCl Cap 300 MG | **See H-2 Antagonist Drug Class Restrictions** |
| | Ranitidine HCl Syrup 15 MG/ML (75 MG/5ML) | **See H-2 Antagonist Drug Class Restrictions** |
| | Ranitidine HCl Tab 75 MG | **See H-2 Antagonist Drug Class Restrictions** |
| | Ranitidine HCl Tab 150 MG | **See H-2 Antagonist Drug Class Restrictions** |
| | Ranitidine HCl Tab 300 MG | **See H-2 Antagonist Drug Class Restrictions** |
| **Ulcer Drugs - Misc** | | |
| | Amoxicillin Cap-Clarithro Tab-Lansopraz Cap DR Therapy Pack | |
| | Metronidaz Tab-Tetracyc Cap-Bis Subsal Chew Tab Therapy Pack | |
| | Sucralfate Susp 1 GM/10ML | |
| | Sucralfate Tab 1 GM | |
| **Ulcer Drugs - Prostaglandins** | | |
| | Misoprostol Tab 100 MCG | |
| | Misoprostol Tab 200 MCG | |

## APPENDIX TO RULE 4123-6-21.3
## Formulary List of Medications Covered by the Ohio Bureau of Workers' Compensation

| Drug Class Name | Drug Generic Name | Coverage restrictions or limitations for specific drugs or dosage forms are listed with the respective drugs below. |
|---|---|---|
| **Ulcer Drugs - Proton Pump Inhibitors** | | **Proton Pump Drug Class Restrictions: Reimbursement is restricted to only the following drugs in this class:<br>Prescription Strength Delayed Release Products: Omeprazole 10mg, 20mg, 40mg<br>Prescription Strength Dispersible Tablets: Prevacid Solutab (15mg, 30mg) Requires Prior Authorization to document inability to use the standard oral prduct.<br>Over the Counter (OTC) Products: Omeprazole OTC 20mg<br>Reimbursement for covered drugs in this class is only permitted when they are prescribed as gastrointestinal protectants during non-steroidal anti-inflammatory drug therapy or to treat an allowed condition that involves a gastrointestinal disorder such as ulcer or GERD (gastrointestinal esophageal reflux disease)** |
| | Lansoprazole Tab Delayed Release Orally Disintegrating 15 MG | **Prior Authorization required to document inability to use a formulary omeprazole oral product.<br>Reimbursement is only permitted when prescribed as a gastrointestinal protectant during non-steroidal anti-inflammatory drug therapy or to treat an allowed condition that involves a gastrointestinal disorder such as ulcer or GERD (gastrointestinal esophageal reflux disease).** |
| | Lansoprazole Tab Delayed Release Orally Disintegrating 30 MG | **Prior Authorization required to document inability to use a formulary omeprazole oral product.<br>Reimbursement is only permitted when prescribed as a gastrointestinal protectant during non-steroidal anti-inflammatory drug therapy or to treat an allowed condition that involves a gastrointestinal disorder such as ulcer or GERD (gastrointestinal esophageal reflux disease).** |
| | Omeprazole Cap Delayed Release 10 MG | **Reimbursement is only permitted when prescribed as a gastrointestinal protectant during non-steroidal anti-inflammatory drug therapy or to treat an allowed condition that involves a gastrointestinal disorder such as ulcer or GERD (gastrointestinal esophageal reflux disease)** |
| | Omeprazole Cap Delayed Release 20 MG | **Reimbursement is only permitted when prescribed as a gastrointestinal protectant during non-steroidal anti-inflammatory drug therapy or to treat an allowed condition that involves a gastrointestinal disorder such as ulcer or GERD (gastrointestinal esophageal reflux disease)** |
| | Omeprazole Cap Delayed Release 40 MG | **Reimbursement is only permitted when prescribed as a gastrointestinal protectant during non-steroidal anti-inflammatory drug therapy or to treat an allowed condition that involves a gastrointestinal disorder such as ulcer or GERD (gastrointestinal esophageal reflux disease)** |
| | Omeprazole Magnesium Delayed Release Tab 20 MG (Base Equiv) | **Reimbursement is only permitted when prescribed as a gastrointestinal protectant during non-steroidal anti-inflammatory drug therapy or to treat an allowed condition that involves a gastrointestinal disorder such as ulcer or GERD (gastrointestinal esophageal reflux disease)** |
| **Urinary Analgesics** | | |

## APPENDIX TO RULE 4123-6-21.3
## Formulary List of Medications Covered by the Ohio Bureau of Workers' Compensation

| Drug Class Name | Drug Generic Name | Coverage restrictions or limitations for specific drugs or dosage forms are listed with the respective drugs below. |
|---|---|---|
| | Phenazopyridine HCl Tab 100 MG | |
| | Phenazopyridine HCl Tab 200 MG | |
| **Urinary Anti-infectives** | | |
| | Fosfomycin Tromethamine Powd Pack 3 GM (Base Equivalent) | |
| | Methenamine Hippurate Tab 1 GM | |
| | Methenamine Mandelate Tab 1 GM | |
| | Methenamine-Hyosc-Meth Blue-Benz Acid-Phenyl Sal Tab 81.6MG | |
| | Methenamine-Hyosc-Meth Blue-Sod Phos-Phen Sal Cap 118 MG*** | |
| | Methenamine-Hyosc-Meth Blue-Sod Phos-Phen Sal Tab 81 MG*** | |
| | Methenamine-Hyos-Meth Blue-Sod Phos-Phen Sal Tab 81.6 MG*** | |
| | Nitrofurantoin Macrocrystalline Cap 100 MG | |
| | Nitrofurantoin Macrocrystalline Cap 50 MG | |
| | Nitrofurantoin Monohydrate Macrocrystalline Cap 100 MG | |
| **Urinary Antispasmodic** | | |
| | Bethanechol Chloride Tab 5 MG | |
| | Bethanechol Chloride Tab 10 MG | |
| | Bethanechol Chloride Tab 25 MG | |
| | Bethanechol Chloride Tab 50 MG | |
| | Darifenacin Hydrobromide Tab SR 24HR 7.5 MG (Base Equiv) | |
| | Darifenacin Hydrobromide Tab SR 24HR 15 MG (Base Equiv) | |
| | Fesoterodine Fumarate Tab SR 24HR 4 MG | |
| | Fesoterodine Fumarate Tab SR 24HR 8 MG | |
| | Flavoxate HCl Tab 100 MG | |
| | Mirabegron Tab SR 24 HR 25 MG | |
| | Mirabegron Tab SR 24 HR 50 MG | |
| | Oxybutynin Chloride Syrup 5 MG/5ML | |
| | Oxybutynin Chloride Tab 5 MG | |
| | Oxybutynin Chloride Tab SR 24HR 5 MG | |
| | Oxybutynin Chloride Tab SR 24HR 10 MG | |
| | Oxybutynin Chloride Tab SR 24HR 15 MG | |
| | Oxybutynin Chloride TD Gel 10% | |
| | Oxybutynin TD Patch Twice Weekly 3.9 MG/24HR | |
| | Solifenacin Succinate Tab 5 MG | |
| | Solifenacin Succinate Tab 10 MG | |
| | Tolterodine Tartrate Cap SR 24HR 2 MG | |
| | Tolterodine Tartrate Cap SR 24HR 4 MG | |
| | Tolterodine Tartrate Tab 1 MG | |
| | Tolterodine Tartrate Tab 2 MG | |
| | Trospium Chloride Cap SR 24HR 60 MG | |
| | Trospium Chloride Tab 20 MG | |
| **Urinary Stone Agents** | | |
| | Acetohydroxamic Acid Tab 250 MG | |
| **Vaccines** | | |
| | Zoster Vaccine Live For Inj 19400 Unit/0.65ML | |
| **Vaginal Anti-infectives** | | |
| | Metronidazole Vaginal Gel 0.75% | |
| | Miconazole Nitrate Vaginal Cream 2% | |
| | Miconazole Nitrate Vaginal Cream 4% (200 MG/5GM) | |
| | Terconazole Vaginal Cream 0.8% | |
| **Vaginal Estrogens** | | |
| | Estradiol Vaginal Cream 0.1 MG/GM | |
| | Estradiol Vaginal Tab 10 MCG | |
| **Vasopressors** | | |
| | Midodrine HCl Tab 2.5 MG | |
| | Midodrine HCl Tab 5 MG | |
| | Midodrine HCl Tab 10 MG | |

## APPENDIX TO RULE 4123-6-21.3
## Formulary List of Medications Covered by the Ohio Bureau of Workers' Compensation

| Drug Class Name | Drug Generic Name | Coverage restrictions or limitations for specific drugs or dosage forms are listed with the respective drugs below. |
|---|---|---|
| **Vitamins - B-Complex w/ C** | | **All combinations and strengths of oral dosage forms are covered for allowed conditions** |
| | B-Complex w/ C & E + Zn Tab*** | |
| | B-Complex w/ C Tab** | |
| **Vitamins - B-Complex w/ Folic Acid** | | |
| | B-Complex w/ C & Folic Acid Cap 1 MG*** | |
| | B-Complex w/ C & Folic Acid Tab 0.8 MG*** | |
| | B-Complex w/ C & Folic Acid Tab*** | |
| | B-Complex w/ C-Biotin-Vit E & Folic Acid Tab 0.4 MG*** | |
| | B-Complex w/Biotin & Folic Acid Tab CR*** | |
| **Vitamins - Multiple Vitamins w/ Iron** | | **All combinations and strengths of oral dosage forms are covered for allowed conditions** |
| | Multiple Vitamins w/ Iron Tab** | |
| **Vitamins - Multiple Vitamins w/ Minerals** | | **All combinations and strengths of oral dosage forms are covered for allowed conditions** |
| | Multiple Vitamins w/ Calcium Cap** | |
| | Multiple Vitamins w/ Calcium Chew Tab** | |
| | Multiple Vitamins w/ Calcium Tab** | |
| | Multiple Vitamins w/ Minerals & FA Cap 0.5 MG*** | |
| | Multiple Vitamins w/ Minerals Cap** | |
| | Multiple Vitamins w/ Minerals EC Tab** | |
| | Multiple Vitamins w/ Minerals Effer Tab** | |
| | Multiple Vitamins w/ Minerals Liquid** | |
| | Multiple Vitamins w/ Minerals Tab** | |
| **Vitamins - Multivitamins** | | |
| | Multiple Vitamin Liquid** | |
| | Multiple Vitamin Tab** | |
| **Vitamins - Oil Soluble Vitamins** | | |
| | Cholecalciferol Cap 400 Unit | |
| | Cholecalciferol Cap 1000 Unit | |
| | Cholecalciferol Cap 2000 Unit | |
| | Cholecalciferol Cap 5000 Unit | |
| | Cholecalciferol Cap 10000 Unit | |
| | Cholecalciferol Cap 50000 Unit | |
| | Cholecalciferol Chewable Wafer 50000 Unit | |
| | Cholecalciferol Tab 400 Unit | |
| | Cholecalciferol Tab 1000 Unit | |
| | Cholecalciferol Tab 2000 Unit | |
| | Cholecalciferol Tab 10000 Unit | |
| | Ergocalciferol Cap 50000 Unit | |
| | Ergocalciferol Soln 8000 Unit/ML | |
| | Ergocalciferol Tab 2000 Unit | |
| | Phytonadione Tab 5 MG | |
| | Vitamin A Tab 8000 Unit | |
| | Vitamin E Cap 1000 Unit | |
| **Vitamins - Vitamin Mixtures** | | |
| | Cholecalciferol-Vitamin C Cap 1000 Unit-500 MG | |
| | Niacinamide w/ Zn-Cu-Methylfolate Tab 750-25-1.5-0.5 MG*** | |
| | Niacinamide w/ Zn-Cu-Methylfol-Se-Cr Tab 750-27-2-0.5 MG*** | |
| | Vit C-Cholecalciferol-Rose Hips Cap 500 MG-1000 Unit-20 MG | |
| | Vitamin A-Vitamin D-Minerals Cap*** | |
| | Vitamin C-Vitamin D-Zinc Tab*** | |
| | Vitamin D & K Cap*** | |
| | Vitamins A & C Chew Tab*** | |
| | Vitamins A & D Cap*** | |
| **Vitamins - Water Soluble Vitamins** | | |
| | Ascorbic Acid Cap CR 500 MG | |

## APPENDIX TO RULE 4123-6-21.3
## Formulary List of Medications Covered by the Ohio Bureau of Workers' Compensation

| Drug Class Name | Drug Generic Name | Coverage restrictions or limitations for specific drugs or dosage forms are listed with the respective drugs below. |
|---|---|---|
| | Ascorbic Acid Chew Tab 250 MG | |
| | Ascorbic Acid Chew Tab 500 MG | |
| | Ascorbic Acid Chew Tab 1000 MG | |
| | Ascorbic Acid Syrup 500 MG/5ML | |
| | Ascorbic Acid Tab 250 MG | |
| | Ascorbic Acid Tab 500 MG | |
| | Ascorbic Acid Tab 1000 MG | |
| | Ascorbic Acid Tab CR 500 MG | |
| | Ascorbic Acid Tab Disp 60 MG | |
| | Niacin Tab CR 250 MG | |
| | Niacin Tab CR 750 MG | |
| | Potassium Aminobenzoate Tab 500 MG | |
| | Pyridoxine HCl Tab 50 MG | |
| | Pyridoxine HCl Tab 100 MG | |
| | Riboflavin Tab 100 MG | |
| | Thiamine HCl Tab 50 MG | |
| | Thiamine HCl Tab 100 MG | |
| | Thiamine Mononitrate Tab 100 MG | |