

Medication Class Name	Medication Generic Name	Allowed Condition Needed	Reimbursement restrictions or limitations for specific medications or dosage forms are listed with the respective medications below.
Acne Products	Isotretinoin Cap 25 MG	✓	
	Isotretinoin Cap 30 MG	✓	
	Isotretinoin Cap 35 MG	✓	
	Benzoyl Peroxide Liq 5%		
	Benzoyl Peroxide Liq 10%		
	Benzoyl Peroxide Gel 5%		
	Benzoyl Peroxide Gel 10%		
	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 Cleanser 10-5%	✓	
	Sulfacetamide Sodium w/ Sulfur Cream 10-5%	✓	
	Sulfacetamide Sodium w/ Sulfur Emulsion 10-1%	✓	
	Sulfacetamide Sodium w/ Sulfur Foam 10-5%	✓	
	Sulfacetamide Sodium w/ Sulfur Lotion 10-5%	✓	
	Sulfacetamide Sodium-Sulfur in Urea Emulsion 10-4%	✓	
Psychostimulants (ADHD)	ALL psychostimulants (amphetamines, stimulants, and ADHD agents)		Will only be considered for reimbursement for allowed conditions in the claim related to post-concussion syndrome or concussion, as defined in OAC 4123-6-34.
Amphetamines	Amphetamine-Dextroamphetamine Cap ER 24HR 5 MG	✓	
	Amphetamine-Dextroamphetamine Cap ER 24HR 10 MG	✓	
	Amphetamine-Dextroamphetamine Cap ER 24HR 15 MG	✓	
	Amphetamine-Dextroamphetamine Cap ER 24HR 20 MG	✓	
	Amphetamine-Dextroamphetamine Cap ER 24HR 25 MG	✓	
	Amphetamine-Dextroamphetamine Cap ER 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 ER 24HR 10 MG	✓	
	Dextroamphetamine Sulfate Cap ER 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	✓	
Stimulants – Misc.	Armodafinil Tab 50 MG	✓	
	Armodafinil Tab 150 MG	✓	
	Armodafinil Tab 200 MG	✓	
	Armodafinil Tab 250 MG	✓	
	Dexmethylphenidate HCl Cap ER 24 HR 10 MG	✓	
	Dexmethylphenidate HCl Cap ER 24 HR 15 MG	✓	
	Dexmethylphenidate HCl Cap ER 24 HR 20 MG	✓	
	Dexmethylphenidate HCl Cap ER 24 HR 30 MG	✓	
	Methylphenidate HCl Cap ER 30 MG (CD)	✓	
	Methylphenidate HCl Cap ER 24HR 10 MG (LA)	✓	
	Methylphenidate HCl Cap ER 24HR 20 MG (LA)	✓	
	Methylphenidate HCl Cap ER 24HR 30 MG (LA)	✓	
	Methylphenidate HCl Cap ER 24HR 40 MG (LA)	✓	
	Methylphenidate HCl Cap ER 24HR 60 MG (LA)	✓	
	Methylphenidate HCl Tab 5 MG	✓	
	Methylphenidate HCl Tab 10 MG	✓	
	Methylphenidate HCl Tab 20 MG	✓	
	Methylphenidate HCl Tab ER 10 MG	✓	
	Methylphenidate HCl Tab ER 20 MG	✓	
	Methylphenidate HCl Tab ER 24HR 18 MG	✓	
	Methylphenidate HCl Tab ER 24HR 27 MG	✓	
	Methylphenidate HCl Tab ER 24HR 36 MG	✓	
	Methylphenidate HCl Tab ER 24HR 54 MG	✓	
	Methylphenidate HCl Tab ER Osmotic Release 18 MG	✓	
	Methylphenidate HCl Tab ER Osmotic Release 27 MG	✓	
	Methylphenidate HCl Tab ER Osmotic Release 36 MG	✓	
	Methylphenidate HCl Tab ER Osmotic Release 54 MG	✓	
	Methylphenidate HCl Tab ER Osmotic Release 72 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 ER 24HR 3 MG (Base Equiv)	✓	
	Guanfacine HCl Tab ER 24HR 4 MG (Base Equiv)	✓	
Agents for Chemical	Acamprosate Calcium Tab Delayed Release 333 MG	✓	

APPENDIX TO RULE 4123-6-21.3

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

Medication Class Name	Medication Generic Name	Allowed Condition Needed	Reimbursement restrictions or limitations for specific medications or dosage forms are listed with the respective medications below.
Dependency	Disulfiram Tab 250 MG Disulfiram Tab 500 MG		
Agents for Opioid Use Disorder	Buprenorphine-Naloxone SL Tab 2-0.5 MG Buprenorphine-Naloxone SL Tab 8-2 MG Buprenorphine HCl-Naloxone HCl SL Film 2-0.5 MG Buprenorphine HCl-Naloxone HCl SL Film 8-2 MG	✓ ✓ ✓ ✓	May be reimbursed in claims with an allowed condition of opioid use disorder or as part of approved treatment under OAC 4123-6-21.8. Reimbursement is limited to two (2) tablets or films per day.
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-Caffeine Tab 400-32 MG Aspirin-Caffeine-Butalbital Tab 325-40-50 MG Butalbital-Acetaminophen Tab 50-325 MG Butalbital-Acetaminophen-Caffeine Cap 50-325-40 MG Butalbital-Acetaminophen-Caffeine Soln 50-325-40 MG/15ML Butalbital-Acetaminophen-Caffeine Tab 50-325-40 MG Butalbital-Aspirin-Caffeine Cap 50-325-40 MG	 ✓ ✓ ✓ ✓ ✓ ✓	Reimbursement is limited to four (4) grams of acetaminophen per day or 24 doses per 30 days and to claims in which headache is related to an allowed condition in the claim.
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 Ziconotide Acetate Intrathecal Inj 500 MCG/20ML (25 MCG/ML) Ziconotide Acetate Intrathecal Inj 500 MCG/5ML		May be considered for reimbursement upon submission of a prior authorization request and history of 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	Methyltestosterone Cap 10 MG Testosterone Cypionate IM Inj in Oil 100 MG/ML Testosterone Cypionate IM Inj in Oil 200 MG/ML Testosterone Enanthate IM or Subcutaneous Inj in Oil 200 MG/ML Testosterone Enanthate IM Inj in Oil 200 MG/ML Testosterone TD Gel 10MG/ACT (2%) Testosterone TD Gel 12.5 MG/ACT (1%) Testosterone TD Gel 20.25 MG/ACT (1.62%) Testosterone TD Gel 25 MG/2.5GM (1%) Testosterone TD Gel 50 MG/5GM (1%) Testosterone TD Patch 24HR 2 MG/24HR Testosterone TD Patch 24HR 4 MG/24HR Testosterone TD Soln 30 MG/ACT	✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓	Reimbursement is limited to claims that have allowed medical conditions involving the genitourinary or endocrine systems.
Antacids	Aluminum & Magnesium Hydroxides Susp 200-200MG/5ML Alum & Mag Hydroxide-Simethicone Susp 200-200-20 MG/5ML Alum & Mag Hydroxide-Simethicone Susp 400-400-40 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		

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

Medication Class Name	Medication Generic Name	Allowed Condition Needed	Reimbursement restrictions or limitations for specific medications or dosage forms are listed with the respective medications below.
	Calcium Carbonate (Antacid) Tab 648 MG		
	Calcium Carbonate-Mag Hydroxide Chew Tab 550-110 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 Mononitrate Tab 20 MG	✓	
	Isosorbide Mononitrate Tab ER 24HR 30 MG	✓	
	Isosorbide Mononitrate Tab ER 24HR 60 MG	✓	
	Isosorbide Mononitrate Tab ER 24HR 120 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 ER 12HR 500 MG	✓	
	Ranolazine Tab ER 12HR 1000 MG	✓	
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	✓	
	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	✓	
	Propafenone HCl Cap ER 12HR 225 MG	✓	
	Propafenone HCl Cap ER 12HR 325 MG	✓	
	Propafenone HCl Cap ER 12HR 425 MG	✓	
	Propafenone HCl Tab 150 MG	✓	
	Propafenone HCl Tab 225 MG	✓	
	Propafenone HCl Tab 300 MG	✓	
	Quinidine Gluconate Tab ER 324 MG	✓	
Antibiotic – Aminoglycosides	Neomycin Sulfate Tab 500 MG	✓	
	Tobramycin Inhal Cap 28 MG	✓	
	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 Tab 250 MG	✓	
	Cefuroxime Axetil Tab 500 MG	✓	
Antibiotic –Cephalosporins - 3rd Generation	Cefdinir Cap 300 MG	✓	
	Cefdinir For Susp 250 MG/5ML	✓	
	Cefixime Cap 400 MG	✓	
	Cefixime For Susp 500 MG/5ML	✓	
	Cefpodoxime Proxetil Tab 100 MG	✓	
	Cefpodoxime Proxetil Tab 200 MG	✓	
Antibiotic – Fluoroquinolones	Ciprofloxacin For Oral Susp 500 MG/5ML (10%) (10 GM/100ML)	✓	
	Ciprofloxacin HCl Tab 250 MG	✓	

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

Medication Class Name	Medication Generic Name	Allowed Condition Needed	Reimbursement restrictions or limitations for specific medications or dosage forms are listed with the respective medications below.
	Ciprofloxacin HCl Tab 500 MG	✓	
	Ciprofloxacin HCl Tab 750 MG	✓	
	Levofloxacin Tab 250 MG	✓	
	Levofloxacin Tab 500 MG	✓	
	Levofloxacin Tab 750 MG	✓	
	Moxifloxacin HCl Tab 400 MG	✓	
	Ofloxacin Tab 300 MG	✓	
	Ofloxacin Tab 400 MG	✓	
Antibiotic – Macrolides	Azithromycin Susp 100 MG/5ML	✓	
	Azithromycin 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 ER 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 ER 12HR 1000-62.5 MG	✓	
	Amoxicillin (Trihydrate) Cap 250 MG	✓	
	Amoxicillin (Trihydrate) Cap 500 MG	✓	
	Amoxicillin (Trihydrate) Chew Tab 250 MG	✓	
	Amoxicillin (Trihydrate) Susp 250 MG/5ML	✓	
	Amoxicillin (Trihydrate) Susp 400 MG/5ML	✓	
	Amoxicillin (Trihydrate) Tab 500 MG	✓	
	Amoxicillin (Trihydrate) Tab 875 MG	✓	
	Ampicillin Cap 500 MG	✓	
	Dicloxacillin Sodium Cap 250 MG	✓	
	Dicloxacillin Sodium Cap 500 MG	✓	
	Penicillin V Potassium 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	✓	
	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	✓	
	Tetracycline HCl Cap 250 MG	✓	
	Tetracycline HCl Cap 500 MG	✓	
Anti-Cataleptic 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	✓	After 30 days of use, may be considered for reimbursement upon submission of a prior authorization request that reflects use for an allowed condition in the claim.
	Apixaban Tab 5 MG	✓	
	Apixaban Tab Starter Pack 5 MG	✓	
	Edoxaban Tosylate Tab 15 MG (Base Equiv)	✓	
	Edoxaban Tosylate Tab 30 MG (Base Equiv)	✓	
	Edoxaban Tosylate Tab 60 MG (Base Equiv)	✓	
	Rivaroxaban Tab 2.5 MG	✓	
	Rivaroxaban Tab 10 MG	✓	
	Rivaroxaban Tab 15 MG	✓	
	Rivaroxaban Tab 20 MG	✓	

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

Medication Class Name	Medication Generic Name	Allowed Condition Needed	Reimbursement restrictions or limitations for specific medications or dosage forms are listed with the respective medications below.
Anticoagulants – Heparins and Heparinoid-Like Agents	Rivaroxaban Tab Starter Therapy Pack 15 MG & 20 MG	✓	
	Dalteparin Sodium Subcutaneous Soln 95000 Unit/3.8ML	✓	
	Dalteparin Sodium Soln Prefilled Syr 2500 Unit/0.2ML	✓	
	Dalteparin Sodium Soln Prefilled Syr 5000 Unit/0.2ML	✓	
	Dalteparin Sodium Soln Prefilled Syr 7500 Unit/0.3ML	✓	
	Dalteparin Sodium Soln Prefilled Syr 10000 Unit/ML	✓	
	Dalteparin Sodium Soln Prefilled Syr 12500 Unit/0.5ML	✓	
	Dalteparin Sodium Soln Prefilled Syr 15000 Unit/0.6ML	✓	
	Dalteparin Sodium Soln Prefilled Syr 18000 Unit/0.72ML	✓	
	Enoxaparin Sodium Inj 300 MG/3ML		
	Enoxaparin Sodium Inj Soln Pref Syr 30 MG/0.3ML		
	Enoxaparin Sodium Inj Soln Pref Syr 40 MG/0.4ML		
	Enoxaparin Sodium Inj Soln Pref Syr 60 MG/0.6ML		
	Enoxaparin Sodium Inj Soln Pref Syr 80 MG/0.8ML		
	Enoxaparin Sodium Inj Soln Pref Syr 100 MG/ML		
	Enoxaparin Sodium Inj Soln Pref Syr 120 MG/0.8ML		
	Enoxaparin Sodium Inj Soln Pref Syr 150 MG/ML		
	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		
	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)	✓	After 30 days of use, may be considered for reimbursement upon submission of a prior authorization request that reflects use for an allowed condition in the claim.
	Dabigatran Etexilate Mesylate Cap 110 MG (Etexilate Base Eq)	✓	
	Dabigatran Etexilate Mesylate Cap 150 MG (Etexilate Base Eq)	✓	
Anticonvulsants – Carbamates	Felbamate Tab 600 MG		
Anticonvulsants – GABA Modulators	Tiagabine HCl Tab 2 MG	✓	Reimbursement is limited to claims in which the injured worker has an allowed condition of seizure disorder.
	Tiagabine HCl Tab 4 MG	✓	
	Tiagabine HCl Tab 12 MG	✓	
	Tiagabine HCl Tab 16 MG	✓	
Anticonvulsants – Hydantoins	Phenytoin Chew Tab 50 MG		Reimbursement for chewable dosage form is limited to claims with an allowed condition that results in the inability to swallow or absorb oral medications.
	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.	Brivaracetam 10 MG		May be considered for reimbursement upon submission of a prior authorization request that reflects a trial and inadequate response to at least one anticonvulsant at optimal dosing within the past 180 days and the injured worker has an allowed condition of seizure disorder.
	Brivaracetam 25 MG		
	Brivaracetam 50 MG		
	Brivaracetam 75 MG		
	Brivaracetam 100 MG		
	Carbamazepine Cap ER 12HR 100 MG		
	Carbamazepine Cap ER 12HR 200 MG		
	Carbamazepine Cap ER 12HR 300 MG		
	Carbamazepine Chew Tab 100 MG		Reimbursement for chewable dosage form is limited to claims with an allowed condition that results in the inability to swallow or absorb oral medications.
	Carbamazepine Susp 100 MG/5ML		
	Carbamazepine Tab 200 MG		
	Carbamazepine Tab ER 12HR 100 MG		
	Carbamazepine Tab ER 12HR 200 MG		
	Carbamazepine Tab ER 12HR 400 MG		
	Gabapentin Cap 100 MG		Reimbursement is limited to 3,600 MG/day. Coverage of all gabapentin products is restricted to a single form at any one time.
	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 25 MG		Reimbursement for oral disintegrating dosage form is limited to claims with an allowed condition that results in the inability to swallow or absorb oral medications.
	Lamotrigine Orally Disintegrating Tab 50 MG		
	Lamotrigine Orally Disintegrating Tab 100 MG		
	Lamotrigine Orally Disintegrating Tab 200 MG		
	Lamotrigine Tab 25 MG		
	Lamotrigine Tab 100 MG		
	Lamotrigine Tab 150 MG		
	Lamotrigine Tab 200 MG		
	Lamotrigine Tab 35 X 25 MG Starter Kit		Starter kit may be reimbursed upon submission of a prior authorization request with documented medical justification for starter kit in lieu of individual dosage strengths.
	Lamotrigine Tab 25 MG (42) & 100 MG (7) Starter Kit		
	Lamotrigine Tab 84 X 25 MG & 14 X 100 MG Starter Kit		
	Lamotrigine Tab ER 24HR 25 (14) & 50 MG (14) & 100 MG(7) Kit		
	Lamotrigine Tab ER 24HR 50 MG		
	Lamotrigine Tab ER 24HR 100 MG		

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

Medication Class Name	Medication Generic Name	Allowed Condition Needed	Reimbursement restrictions or limitations for specific medications or dosage forms are listed with the respective medications below.
	Lamotrigine Tab ER 24HR 200 MG		
	Lamotrigine Tab ER 24HR 250 MG		
	Levetiracetam Oral Soln 100 MG/ML		
	Levetiracetam Tab 250 MG		
	Levetiracetam Tab 500 MG		
	Levetiracetam Tab 750 MG		
	Levetiracetam Tab 1000 MG		
	Levetiracetam Tab ER 24HR 500 MG		
	Levetiracetam Tab ER 24HR 750 MG		
	Oxcarbazepine Tab 150 MG		
	Oxcarbazepine Tab 300 MG		
	Oxcarbazepine Tab 600 MG		
	Pregabalin Cap 25 MG		Reimbursement is limited to 600 MG per day.
	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		
	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 ER 24 HR 250 MG		
	Divalproex Sodium Tab ER 24 HR 500 MG		
	Valproate Sodium Oral Soln 250 MG/5ML		
	Valproic Acid Cap 250 MG		
Antidementia Agents	Donepezil Hydrochloride Tab 5 MG	✓	
	Donepezil Hydrochloride Tab 10 MG	✓	
	Donepezil Hydrochloride Tab 23 MG	✓	
	Galantamine Hydrobromide Cap ER 24HR 8 MG	✓	
	Galantamine Hydrobromide Cap ER 24HR 16 MG	✓	
	Galantamine Hydrobromide Tab 4 MG	✓	
	Galantamine Hydrobromide Tab 8 MG	✓	
	Galantamine Hydrobromide Tab 12 MG	✓	
	Memantine HCl Cap ER 24HR 7 MG	✓	
	Memantine HCl Cap ER 24HR 14 MG	✓	
	Memantine HCl Cap ER 24HR 21 MG	✓	
	Memantine HCl Cap ER 24HR 28 MG	✓	
	Memantine HCl Cap ER 24HR 7 MG & 14 MG & 21 MG & 28 MG Pack	✓	
	Memantine HCl Tab 5 MG	✓	
	Memantine HCl Tab 10 MG	✓	
	Memantine HCl Tab 28 X 5 MG & 21 x 10 MG 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 15 MG		Reimbursement for oral disintegrating dosage form is limited to claims with an allowed condition that results in the inability to swallow or absorb oral medications.
	Mirtazapine Orally Disintegrating Tab 30 MG		
	Mirtazapine Orally Disintegrating Tab 45 MG		
	Mirtazapine Tab 7.5 MG		
	Mirtazapine Tab 15 MG		
	Mirtazapine Tab 30 MG		
	Mirtazapine Tab 45 MG		
Antidepressants – Misc.	Bupropion HCl Tab 75 MG		
	Bupropion HCl Tab 100 MG		
	Bupropion HCl Tab ER 12HR 100 MG		
	Bupropion HCl Tab ER 12HR 150 MG		
	Bupropion HCl Tab ER 12HR 200 MG		
	Bupropion HCl Tab ER 24HR 150 MG		
	Bupropion HCl Tab ER 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 –	Citalopram Hydrobromide Oral Soln 10 MG/5ML		

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

Medication Class Name	Medication Generic Name	Allowed Condition Needed	Reimbursement restrictions or limitations for specific medications or dosage forms are listed with the respective medications below.
Selective Serotonin Reuptake Inhibitors (SSRIs)	Citalopram Hydrobromide Tab 10 MG		
	Citalopram Hydrobromide Tab 20 MG		
	Citalopram Hydrobromide Tab 40 MG		
	Escitalopram Oxalate Soln 5 MG/5ML		
	Escitalopram Oxalate Tab 5 MG		
	Escitalopram Oxalate Tab 10 MG		
	Escitalopram Oxalate Tab 20 MG		
	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		
	Fluvoxamine Maleate Cap ER 24HR 100 MG		
	Fluvoxamine Maleate Cap ER 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		
	Paroxetine HCl Tab 10 MG		
	Paroxetine HCl Tab 20 MG		
	Paroxetine HCl Tab 30 MG		
	Paroxetine HCl Tab 40 MG		
	Paroxetine HCl Tab ER 24HR 12.5 MG		
	Paroxetine HCl Tab ER 24HR 25 MG		
	Paroxetine HCl Tab ER 24HR 37.5 MG		
	Sertraline HCl Oral Concentrate for Solution 20 MG/ML		
	Sertraline HCl Tab 25 MG		
	Sertraline HCl Tab 50 MG		
	Sertraline HCl Tab 100 MG		
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		
	Vilazodone HCl Tab 10 MG	✓	
Antidepressants – Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)	Vilazodone HCl Tab 20 MG	✓	
	Vilazodone HCl Tab 40 MG	✓	
	Vilazodone HCl Tab Starter Kit 10 (7) & 20 (23) MG	✓	
	Desvenlafaxine Succinate Tab ER 24HR 25 MG		
	Desvenlafaxine Succinate Tab ER 24HR 50 MG		
	Desvenlafaxine Succinate Tab ER 24HR 100 MG		
	Desvenlafaxine Tab ER 24HR 50 MG		
	Desvenlafaxine Tab ER 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 ER 24HR 37.5 MG		
	Venlafaxine HCl Cap ER 24HR 75 MG		
	Venlafaxine HCl Cap ER 24HR 150 MG		
	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 ER 24HR 37.5 MG		
Antidepressants – Tricyclic Agents	Venlafaxine HCl Tab ER 24HR 75 MG		
	Venlafaxine HCl Tab ER 24HR 150 MG		
	Venlafaxine HCl Tab ER 24HR 225 MG		
	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		
	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		

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

Medication Class Name	Medication Generic Name	Allowed Condition Needed	Reimbursement restrictions or limitations for specific medications or dosage forms are listed with the respective medications below.
	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	✓	
	Acarbose Tab 50 MG	✓	
	Acarbose Tab 100 MG	✓	
	Miglitol Tab 25 MG	✓	
	Miglitol Tab 50 MG	✓	
	Miglitol Tab 100 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 ER 24HR 500 MG	✓	
	Metformin HCl Tab ER 24HR 750 MG	✓	
Antidiabetic – Diabetic Other	Glucagon (rDNA) For Inj Kit 1 MG	✓	
	Glucagon HCl (rDNA) For Inj 1 MG	✓	
	Glucose Chew Tab 1 GM	✓	
	Glucose Chew Tab 4 GM	✓	
	Glucose Chew Tab 5 GM	✓	
	Glucose Gel 15 GM/32 ML	✓	
	Glucose Gel 15 GM/33GM	✓	
	Glucose Gel 40%	✓	
	Glucose Gel 77.4%	✓	
	Glucose Oral Liquid 15 GM/59ML	✓	
	Glucose Oral Liquid 15 GM/60ML	✓	
Antidiabetic – Dipeptidyl Peptidase-4 (DPP-4) Inhibitors	Alogliptin Benzoate Tab 6.25 MG	✓	
	Alogliptin Benzoate Tab 12.5 MG	✓	
	Alogliptin Benzoate Tab 25 MG	✓	
	Linagliptin Tab 5 MG	✓	
	Saxagliptin HCl Tab 2.5 MG	✓	
	Saxagliptin HCl Tab 5 MG	✓	
	Sitagliptin Phosphate Tab 25 MG	✓	
	Sitagliptin Phosphate Tab 50 MG	✓	
	Sitagliptin Phosphate Tab 100 MG	✓	
Antidiabetic – Incretin Mimetic Agents (GLP-1 Receptor Agonists)	Dulaglutide Soln Pen-injector 0.75 MG/0.5ML	✓	
	Dulaglutide Soln Pen-injector 1.5 MG/0.5ML	✓	Reimbursement limited to two (2) ML per 28 days.
	Dulaglutide Soln Pen-injector 3 MG/0.5ML	✓	
	Dulaglutide Soln Pen-injector 4.5 MG/0.5ML	✓	
	Exenatide Extended Release for Susp Pen-injector 2 MG	✓	
	Exenatide Extended Release Susp Auto-Injector 2 MG/0.85ML	✓	
	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)	✓	
	Semaglutide Tab 3 MG	✓	
	Semaglutide Tab 7 MG	✓	
	Semaglutide Tab 14 MG	✓	
	Semaglutide Soln Pen-Inj 0.25 or 0.5 MG/Dose (2 MG/1.5ML)	✓	
	Semaglutide Soln Pen-Inj 0.25 or 0.5 MG/Dose (2 MG/3ML)	✓	
	Semaglutide Soln Pen-Inj 1 MG/Dose (2 MG/1.5ML)	✓	
	Semaglutide Soln Pen-inj 1 MG/DOSE (4 MG/3ML)	✓	
	Semaglutide Soln Pen-inj 2 MG/DOSE (8 MG/3ML)	✓	
Antidiabetic – Incretin Mimetic Agents (GIP & GLP-1 Receptor Agonists)	Tirzepatide Soln Pen-injector 2.5 MG/0.5ML	✓	
	Tirzepatide Soln Pen-injector 5 MG/0.5ML	✓	
	Tirzepatide Soln Pen-injector 7.5 MG/0.5ML	✓	
	Tirzepatide Soln Pen-injector 10 MG/0.5ML	✓	
	Tirzepatide Soln Pen-injector 12.5 MG/0.5ML	✓	
	Tirzepatide Soln Pen-injector 15 MG/0.5ML	✓	
Antidiabetic – Insulin	Insulin Aspart (with Niacinamide) Inj 100 Unit/ML	✓	
	Insulin Aspart (with Niacinamide) Sol Pen-inj 100 Unit/ML	✓	
	Insulin Aspart Inj 100 Unit/ML	✓	
	Insulin Aspart Prot & Aspart (Human) Inj 100 Unit/ML (70-30)	✓	
	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	✓	

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

Medication Class Name	Medication Generic Name	Allowed Condition Needed	Reimbursement restrictions or limitations for specific medications or dosage forms are listed with the respective medications below.
	Insulin Degludec Soln Pen-Injector 100 Unit/ML	✓	
	Insulin Degludec Soln Pen-Injector 200 Unit/ML	✓	
	Insulin Glargine Inj 100 Unit/ML	✓	
	Insulin Glargine Soln Pen-Injector 100 Unit/ML	✓	
	Insulin Glargine Soln Pen-Injector 300 Unit/ML (1 Unit Dial)	✓	
	Insulin Glargine Soln Pen-Injector 300 Unit/ML (2 Unit Dial)	✓	
	Insulin Glulisine Inj 100 Unit/ML	✓	
	Insulin Glulisine Soln Pen-Injector Inj 100 Unit/ML	✓	
	Insulin Lispro Inj Soln 100 Unit/ML	✓	
	Insulin Lispro Soln Cartridge 100 Unit/ML	✓	
	Insulin Lispro Soln Pen-injector 200 Unit/ML	✓	
	Insulin Lispro Prot & Lispro 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 Lispro Protamine & Lispro Inj 100 Unit/ML (50-50)	✓	
	Insulin Lispro Sol Pen-injector 100 Unit/ML (1 Unit Dial)	✓	
	Insulin Lispro Soln Pen-injector 100 Unit/ML (0.5 Unit Dial)	✓	
	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)	✓	
Antidiabetic – Meglitinide Analogues	Nateglinide Tab 60 MG	✓	
	Nateglinide Tab 120 MG	✓	
	Repaglinide Tab 0.5 MG	✓	
	Repaglinide Tab 1 MG	✓	
	Repaglinide Tab 2 MG	✓	
Antidiabetic – Sodium-Glucose Co-transporter 2 (SGLT2) Inhibitors	Bexagliflozin Tab 20 MG	✓	
	Canagliflozin Tab 100 MG	✓	
	Canagliflozin Tab 300 MG	✓	
	Dapagliflozin Propanediol Tab 5 MG (Base Equivalent)	✓	
	Dapagliflozin Propanediol Tab 10 MG (Base Equivalent)	✓	
	Empagliflozin Tab 10 MG	✓	
	Empagliflozin Tab 25 MG	✓	
	Ertugliflozin L-Pyroglutamic Acid Tab 5 MG (Base Equiv)	✓	
Antidiabetic – Sulfonylurea	Ertugliflozin L-Pyroglutamic Acid Tab 15 MG (Base Equiv)	✓	
	Glimepiride Tab 1 MG	✓	
	Glimepiride Tab 2 MG	✓	
	Glimepiride Tab 4 MG	✓	
	Glipizide Tab 5 MG	✓	
	Glipizide Tab 10 MG	✓	
	Glipizide Tab ER 24HR 2.5 MG	✓	
	Glipizide Tab ER 24HR 5 MG	✓	
	Glipizide Tab ER 24HR 10 MG	✓	
	Glyburide Micronized Tab 1.5 MG	✓	
	Glyburide Micronized Tab 3 MG	✓	
	Glyburide Micronized Tab 6 MG	✓	
	Glyburide Tab 1.25 MG	✓	
	Glyburide Tab 2.5 MG	✓	
	Glyburide Tab 5 MG	✓	
Antidiabetic – Thiazolidinediones (TZDs)	Pioglitazone HCl Tab 15 MG (Base Equiv)	✓	
	Pioglitazone HCl Tab 30 MG (Base Equiv)	✓	
	Pioglitazone HCl Tab 45 MG (Base Equiv)	✓	
Antidiarrheal Agents - Misc	Bismuth Subsalicylate Chew Tab 262 MG	✓	
	Bismuth Subsalicylate Susp 262 MG/15ML	✓	
	Bismuth Subsalicylate Tab 262 MG	✓	
	Lactobacillus - Packet		May be considered for reimbursement upon submission of a prior authorization request with documented medical justification.
	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		May be considered for reimbursement upon submission of a prior authorization request that reflects an allowed condition of chemotherapy induced nausea and vomiting, or a previous trial and inadequate response with at least one (1) antiemetic.
	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	✓	

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

Medication Class Name	Medication Generic Name	Allowed Condition Needed	Reimbursement restrictions or limitations for specific medications or dosage forms are listed with the respective medications below.
	Meclizine HCl Tab 25 MG	✓	
	Ondansetron Orally Disintegrating Tab 4 MG		
	Ondansetron Orally Disintegrating Tab 8 MG		
	Ondansetron HCl Tab 4 MG		
	Ondansetron HCl Tab 8 MG		
	Ondansetron HCl Oral Soln 4 MG/5ML	✓	
	Scopolamine TD Patch 72HR 1 MG/3DAYS	✓	
	Trimethobenzamide HCl Cap 300 MG	✓	
Antifungals	Fluconazole 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	✓	
	Isavuconazonium 186 MG		May be considered for reimbursement upon submission of a prior authorization request that reflects treatment for a fungal infection related to an allowed condition in the claim and documented inadequate response of another agent in this class within the past 120 days.
	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	✓	
	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 Oral Soln 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	✓	
	Choline Fenofibrate Cap DR 135 MG	✓	
	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)	✓	
	Atorvastatin Calcium Tab 40 MG (Base Equivalent)	✓	
	Atorvastatin Calcium Tab 80 MG (Base Equivalent)	✓	
	Fluvastatin Sodium Tab ER 24 HR 80 MG (Base Equivalent)	✓	
	Lovastatin Tab 10 MG	✓	
	Lovastatin Tab 20 MG	✓	
	Lovastatin Tab 40 MG	✓	
	Lovastatin Tab ER 24HR 60 MG	✓	

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

Medication Class Name	Medication Generic Name	Allowed Condition Needed	Reimbursement restrictions or limitations for specific medications or dosage forms are listed with the respective medications below.
	Pitavastatin Calcium Tab 1 MG	✓	
	Pitavastatin Calcium Tab 2 MG	✓	
	Pitavastatin Calcium Tab 4 MG	✓	
	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	✓	
Antihyperlipidemic – Intestinal Cholesterol Absorption Inhibitors	Ezetimibe Tab 10 MG	✓	
Antihyperlipidemic – Lecithin	Lecithin Cap 1200 MG		May be considered for reimbursement upon submission of a prior authorization request with documented medical justification.
	Lecithin Chew Tab 1000 MG		
Antihyperlipidemic – Misc.	Omega-3-acid Ethyl Esters Cap 1 GM	✓	
Antihyperlipidemic – Nicotinic Acid Derivatives	Niacin Tab ER 500 MG (Antihyperlipidemic)	✓	
	Niacin Tab ER 750 MG (Antihyperlipidemic)	✓	
	Niacin Tab ER 1000 MG (Antihyperlipidemic)	✓	
Antihyperlipidemic – Omega-3 Fatty Acids	Omega-3 Fatty Acids Cap 183.33 MG		May be considered for reimbursement upon submission of a prior authorization request with documented medical justification.
	Omega-3 Fatty Acids Cap 150 MG	✓	
	Omega-3 Fatty Acids Cap 180 MG		May be considered for reimbursement upon submission of a prior authorization request with documented medical justification.
	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 1000 MG	✓	
	Omega-3 Fatty Acids Cap 1200 MG	✓	
	Omega-3 Fatty Acids Cap Delayed Release 332.5 MG		May be considered for reimbursement upon submission of a prior authorization request with documented medical justification.
	Omega-3 Fatty Acids Cap Delayed Release 350 MG		
	Omega-3 Fatty Acids Cap Delayed Release 600 MG		
	Omega-3 Fatty Acids Cap Delayed Release 1400 MG		
Antihyperlipidemic – PCSK9 Inhibitors	Alirocumab Subcutaneous Soln Pen-injector 75 MG/ML		May be considered for reimbursement upon submission of a prior authorization request that reflects atherosclerotic cardiovascular disease as an allowed condition and LDL ≥ 70 MG/dL despite maximally tolerated statin plus ezetimibe therapy for at least 90 days within the past 180 days.
	Alirocumab Subcutaneous Soln Pen-injector 150 MG/ML		
Antihypertensive Combinations	Aliskiren-Hydrochlorothiazide Tab 150-12.5 MG	✓	
	Aliskiren-Hydrochlorothiazide Tab 300-12.5 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	✓	
	Candesartan Cilexetil-Hydrochlorothiazide Tab 32-25 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	✓	

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

Medication Class Name	Medication Generic Name	Allowed Condition Needed	Reimbursement restrictions or limitations for specific medications or dosage forms are listed with the respective medications below.
	Losartan Potassium & Hydrochlorothiazide Tab 100-25 MG	✓	
	Metoprolol & Hydrochlorothiazide Tab 50-25 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 ER 2-240 MG	✓	
	Trandolapril-Verapamil HCl Tab ER 4-240 MG	✓	
	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	✓	
Antihypertensive – 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	✓	
	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	✓	

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

Medication Class Name	Medication Generic Name	Allowed Condition Needed	Reimbursement restrictions or limitations for specific medications or dosage forms are listed with the respective medications below.
	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 (Base Equivalent)	✓	
	Terazosin HCl Cap 2 MG (Base Equivalent)	✓	
	Terazosin HCl Cap 5 MG (Base Equivalent)	✓	
Antihypertensive – Direct Renin Inhibitors	Aliskiren Fumarate Tab 150 MG (Base Equivalent)	✓	
	Aliskiren Fumarate Tab 300 MG (Base Equivalent)	✓	
Antihypertensive – Selective Aldosterone Receptor Antagonists	Eplerenone Tab 25 MG	✓	
	Eplerenone Tab 50 MG	✓	
Antihypertensive – 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 Susp 100 MG/5ML	✓	
	Linezolid Tab 600 MG	✓	
	Metronidazole Cap 375 MG	✓	
	Metronidazole Tab 250 MG	✓	
	Metronidazole Tab 500 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	✓	
	Tinidazole Tab 500 MG	✓	
	Trimethoprim Tab 100 MG	✓	
	Vancomycin HCl Cap 125 MG (Base Equiv)	✓	
	Vancomycin HCl Cap 250 MG (Base Equiv)	✓	
Antimalarial	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 ER 300 MG	✓	
	Lithium Carbonate Tab ER 450 MG	✓	
Antimyasthenic/Cholinergic Agents	Lithium Oral Solution 8 mEq/5ML	✓	
	Pyridostigmine Bromide Tab 60 MG	✓	
Antimycobacterial Agents	Pyridostigmine Bromide Tab ER 180 MG	✓	
	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 – (Cancer Agents)	Antineoplastic drugs prescribed per OAC 4123-6-21.3(F)(2).	✓	
Antiparkinson Agents	Amantadine HCl Cap 100 MG	✓	
	Amantadine HCl Tab 100 MG	✓	
	Benzotropine Mesylate Tab 0.5 MG	✓	
	Benzotropine Mesylate Tab 1 MG	✓	
	Benzotropine Mesylate Tab 2 MG	✓	
	Bromocriptine Mesylate Cap 5 MG (Base Equivalent)	✓	
	Carbidopa & Levodopa Tab 10-100 MG	✓	
	Carbidopa & Levodopa Tab 25-100 MG	✓	
	Carbidopa & Levodopa Tab 25-250 MG	✓	
	Carbidopa & Levodopa Tab ER 25-100 MG	✓	
	Carbidopa & Levodopa Tab ER 50-200 MG	✓	
	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 ER 24HR 0.375 MG	✓	
	Pramipexole Dihydrochloride Tab ER 24HR 0.75 MG	✓	
	Pramipexole Dihydrochloride Tab ER 24HR 1.5 MG	✓	
	Rasagiline Mesylate Tab 1 MG (Base Equiv)	✓	
	Ropinirole Hydrochloride Tab 0.25 MG	✓	
	Ropinirole Hydrochloride Tab 0.5 MG	✓	

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

Medication Class Name	Medication Generic Name	Allowed Condition Needed	Reimbursement restrictions or limitations for specific medications or dosage forms are listed with the respective medications below.
	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 ER 24HR 2 MG	✓	
	Ropinirole Hydrochloride Tab ER 24HR 4 MG	✓	
	Ropinirole Hydrochloride Tab ER 24HR 6 MG	✓	
	Ropinirole Hydrochloride Tab ER 24HR 8 MG	✓	
	Ropinirole Hydrochloride Tab ER 24HR 12 MG	✓	
	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	✓	
Antipsoriatics	Acitretin Cap 25 MG	✓	
	Calcipotriene Cream 0.005%	✓	
	Calcipotriene Soln 0.005% (50 MCG/ML)	✓	
	Tazarotene Cream 0.1%	✓	
Antipsychotics	ALL antipsychotic agents		Except as noted for specific agents below, these restrictions apply to all antipsychotic agents: - May be reimbursed in claims with an allowed condition of schizophrenia, bipolar disorder, or psychosis. - Documentation of Abnormal Involuntary Movement Scale (AIMS) testing is required at initial antipsychotic prescribing and every six (6) months thereafter for ongoing use of all antipsychotic medications. - Concurrent use of multiple antipsychotics will not be approved.
Antipsychotics – Benzisoxazoles	Paliperidone Tab ER 24HR 1.5 MG	✓	
	Paliperidone Tab ER 24HR 3 MG	✓	
	Paliperidone Tab ER 24HR 6 MG	✓	
	Paliperidone Tab ER 24HR 9 MG	✓	
	Risperidone Orally Disintegrating Tab 0.25 MG		Reimbursement for oral disintegrating dosage form is limited to claims with an allowed condition that results in the inability to swallow or absorb oral medications.
	Risperidone Orally Disintegrating Tab 0.5 MG		
	Risperidone Orally Disintegrating Tab 1 MG		
	Risperidone Orally Disintegrating Tab 2 MG		
	Risperidone Orally Disintegrating Tab 3 MG		
	Risperidone Orally Disintegrating Tab 4 MG		
	Risperidone Soln 1 MG/ML	✓	
	Risperidone Tab 0.25 MG	✓	
	Risperidone Tab 0.5 MG	✓	
	Risperidone Tab 1 MG	✓	
	Risperidone Tab 2 MG	✓	
	Risperidone Tab 3 MG	✓	
	Risperidone Tab 4 MG	✓	
Antipsychotics – Butyrophenones	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	✓	
Antipsychotics – Dibenzapines	Asenapine Maleate SL Tab 2.5 MG		Reimbursement for sublingual dosage form is limited to claims with an allowed condition that results in the inability to swallow or absorb oral medications.
	Asenapine Maleate SL Tab 5 MG		
	Asenapine Maleate SL Tab 10 MG		
	Clozapine Orally Disintegrating Tab 12.5 MG		Reimbursement for oral disintegrating dosage form is limited to claims with an allowed condition that results in the inability to swallow or absorb oral medications.
	Clozapine Orally Disintegrating Tab 25 MG		
	Clozapine Orally Disintegrating Tab 100 MG		
	Clozapine Orally Disintegrating Tab 150 MG		
	Clozapine Orally Disintegrating Tab 200 MG		
	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 5 MG		May be considered for reimbursement for augmentation of antidepressant therapy upon submission of a prior authorization request that reflects:
	Olanzapine Orally Disintegrating Tab 10 MG		
	Olanzapine Orally Disintegrating Tab 15 MG		
	Olanzapine Orally Disintegrating Tab 20 MG		
	Olanzapine Tab 2.5 MG	✓	- Olanzapine is being used in combination with fluoxetine, and - The injured worker has an allowed condition of major depressive disorder or dysthymic disorder, and - A minimum of a 90-day trial and documented inadequate response or intolerance to at least two antidepressants of different classes within the past 240 days.
	Olanzapine Tab 5 MG	✓	
	Olanzapine Tab 7.5 MG	✓	
	Olanzapine Tab 10 MG	✓	
	Olanzapine Tab 15 MG	✓	
	Olanzapine Tab 20 MG	✓	Reimbursement for oral disintegrating dosage form is limited to claims with an allowed condition that results in the inability to swallow or absorb oral medications.
	Quetiapine Fumarate Tab 25 MG	✓	Immediate release formulation may be reimbursed in claims with an allowed condition of schizophrenia, bipolar disorder, or psychosis.
	Quetiapine Fumarate Tab 50 MG	✓	
	Quetiapine Fumarate Tab 100 MG	✓	

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

Medication Class Name	Medication Generic Name	Allowed Condition Needed	Reimbursement restrictions or limitations for specific medications or dosage forms are listed with the respective medications below.
	Quetiapine Fumarate Tab 200 MG	✓	May be considered for reimbursement for augmentation of antidepressant therapy upon submission of a prior authorization request that reflects: - Quetiapine ER is being used in combination with an antidepressant, and - The injured worker has an allowed condition of major depressive disorder or dysthymic disorder, and - A minimum of a 90-day trial and documented inadequate response or intolerance to at least two antidepressants of different classes within the past 240 days.
	Quetiapine Fumarate Tab 300 MG	✓	
	Quetiapine Fumarate Tab 400 MG	✓	
	Quetiapine Fumarate Tab ER 24HR 50 MG	✓	
	Quetiapine Fumarate Tab ER 24HR 150 MG	✓	
	Quetiapine Fumarate Tab ER 24HR 200 MG	✓	
	Quetiapine Fumarate Tab ER 24HR 300 MG	✓	
Antipsychotics – Dihydroindolones	Quetiapine Fumarate Tab ER 24HR 400 MG	✓	
	Molindone HCl Tab 5 MG	✓	
	Molindone HCl Tab 10 MG	✓	
Antipsychotics – Misc.	Molindone HCl Tab 25 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 (Base Equivalent)	✓	
	Trifluoperazine HCl Tab 2 MG (Base Equivalent)	✓	
	Trifluoperazine HCl Tab 5 MG (Base Equivalent)	✓	
	Trifluoperazine HCl Tab 10 MG (Base Equivalent)	✓	
Antipsychotics – Quinolone Derivatives	Aripiprazole Oral Solution 1 MG/ML	✓	May be considered for reimbursement for augmentation of antidepressant therapy upon submission of a prior authorization request that reflects: - Aripiprazole is being used in combination with an antidepressant - The injured worker has an allowed condition of major depressive disorder or dysthymic disorder, and - A minimum of a 90-day trial and documented inadequate response or intolerance to at least two antidepressants of different classes within the past 240 days. Reimbursement for oral disintegrating dosage form is limited to claims with an allowed condition that results in the inability to swallow or absorb oral medications.
	Aripiprazole Orally Disintegrating Tab 10 MG		
	Aripiprazole Orally Disintegrating Tab 15 MG		
	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	✓	
	Thiothixene Cap 5 MG	✓	
	Thiothixene Cap 10 MG	✓	
Antiretroviral	Antiretroviral drugs prescribed per OAC 4123-6-21.3(F)(3).	✓	
Antirheumatic – Anti-TNF-alpha – Monoclonal Antibodies	Adalimumab Pen-Injector Kit 40 MG/0.4ML	✓	May be considered for reimbursement upon submission of a prior authorization request. Reimbursement will only be considered in claims with an allowed condition of rheumatoid arthritis .
	Adalimumab Pen-injector Kit 40 MG/0.8ML	✓	
	Adalimumab Prefilled Syringe Kit 40 MG/0.4ML	✓	
	Adalimumab Prefilled Syringe Kit 40 MG/0.8ML	✓	
	Certolizumab Pegol For Inj Kit 2x200 MG		
	Certolizumab Pegol Prefilled Syringe Kit 2x200 MG/ML		
	Certolizumab Pegol Prefilled Syringe Kit 6x200 MG/ML		
	Golimumab Subcutaneous Soln Auto-injector 50 MG/0.5ML		
	Golimumab Subcutaneous Soln Auto-injector 100 MG/0.5ML		
	Golimumab Subcutaneous Soln Prefilled Syringe 50 MG/0.5ML		
	Golimumab Subcutaneous Soln Prefilled Syringe 100 MG/0.5ML		
	Baricitinib Tab 1 MG		
Antirheumatic –			May be considered for reimbursement upon submission of a prior

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

Medication Class Name	Medication Generic Name	Allowed Condition Needed	Reimbursement restrictions or limitations for specific medications or dosage forms are listed with the respective medications below.
Enzyme Inhibitors	Baricitinib Tab 2 MG		authorization request. Reimbursement will only be considered in claims with an allowed condition of rheumatoid arthritis.
	Tofacitinib Citrate 5 MG		
	Tofacitinib Citrate 10 MG		
	Tofacitinib Citrate Tab ER 24HR 11 MG		
	Tofacitinib Citrate Tab ER 24HR 22 MG		
	Upadacitinib Tab ER 24HR 15 MG		
Antirheumatic – Pyrimidine Synthesis Inhibitors	Leflunomide Tab 10 MG	✓	
	Leflunomide Tab 20 MG	✓	
Antirheumatic – Selective Costimulation Modulator	Abatacept Subcutaneous Soln Auto-Injector 125 MG/ML		May be considered for reimbursement upon submission of a prior authorization request. Reimbursement will only be considered in claims with an allowed condition of rheumatoid arthritis.
	Abatacept Subcutaneous Soln Prefilled Syringe 50 MG/0.4ML		
	Abatacept Subcutaneous Soln Prefilled Syringe 87.5 MG/0.7ML		
	Abatacept Subcutaneous Soln Prefilled Syringe 125 MG/ML		
Antirheumatic 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	✓	
	Etanercept Subcutaneous Solution Cartridge 50 MG/ML	✓	
Antiseptics & Disinfectants	Cadexomer Iodine Gel 0.9%		May be considered for reimbursement upon submission of a prior authorization request with documented medical justification.
	Chlorhexidine Gluconate Liquid 4%		
	Chlorhexidine Gluconate Soln 4%		
	Sodium Hypochlorite Soln 0.125% (Quarter Strength)	✓	
	Sodium Hypochlorite Soln 0.25% (Half Strength)	✓	
	Sodium Hypochlorite Soln 0.5%	✓	
	Formaldehyde Solution 10%		
	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	✓	
	Hydrocodone Bitart-Homatropine Methylbromide Tab 5-1.5 MG	✓	
	Hydrocodone Bitart-Homatropine Methylbrom Soln 5-1.5 MG/5ML	✓	
Benzodiazepines – Antianxiety	All Benzodiazepine products		For all oral benzodiazepines, excluding clobazam, after 30 days of use, may be considered for reimbursement upon submission of a prior authorization request that reflects a minimum of a 90-day trial and documented inadequate response to at least two (2) SSRIs and/or SNRIs within the past 180 days. Reimbursement for all oral benzodiazepines is limited to one (1) product per month.
	Alprazolam Products		Effective August 1, 2017, alprazolam products were removed from the outpatient medication formulary. Claims in which alprazolam was reimbursed prior to August 1, 2017 and has been continuously reimbursed since then may continue to be reimbursed, but reimbursement is limited to the daily dose that was last covered or lower.
	Chlordiazepoxide HCl Cap 5 MG		Reimbursement is limited to 100 MG per day.
	Chlordiazepoxide HCl Cap 10 MG		
	Chlordiazepoxide HCl Cap 25 MG		
	Clorazepate Dipotassium Tab 3.75 MG		Reimbursement is limited to 80 MG per day.
	Clorazepate Dipotassium Tab 7.5 MG		
	Clorazepate Dipotassium Tab 15 MG		
	Diazepam Conc 5 MG/ML		Reimbursement is limited to 40 MG per day.
	Diazepam Oral Soln 1 MG/ML		
	Diazepam Tab 2 MG		
	Diazepam Tab 5 MG		
	Diazepam Tab 10 MG		Reimbursement is limited to 8 MG per day.
	Lorazepam Conc 2 MG/ML		
	Lorazepam Tab 0.5 MG		
	Lorazepam Tab 1 MG		
	Lorazepam Tab 2 MG		Reimbursement is limited to 120 MG per day.
	Oxazepam Cap 10 MG		
	Oxazepam Cap 15 MG		
	Oxazepam Cap 30 MG		
Benzodiazepines – Anticonvulsants	Clobazam Tab 10 MG		May be considered for reimbursement upon submission of a prior authorization request that reflects a minimum of a 60-day trial and documented inadequate response to at least two (2) first line anticonvulsants within the past 180 days and the injured worker has an allowed condition of seizure disorder.
	Clobazam Tab 20 MG		
	Clonazepam Orally Disintegrating Tab 0.125 MG		Reimbursement for oral disintegrating dosage form is limited to claims with an allowed condition that results in the inability to swallow or absorb oral medications. Reimbursement is limited to four (4) MG per day.
	Clonazepam Orally Disintegrating Tab 0.25 MG		
	Clonazepam Orally Disintegrating Tab 0.5 MG		
	Clonazepam Orally Disintegrating Tab 1 MG		

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

Medication Class Name	Medication Generic Name	Allowed Condition Needed	Reimbursement restrictions or limitations for specific medications or dosage forms are listed with the respective medications below.
	Clonazepam Orally Disintegrating Tab 2 MG		Reimbursement is limited to four (4) MG per day.
	Clonazepam Tab 0.5 MG		
	Clonazepam Tab 1 MG		
	Clonazepam Tab 2 MG		
	Diazepam Rectal Gel Delivery System 10 MG		
	Diazepam Rectal Gel Delivery System 20 MG		
	Midazolam HCl Inj 5 MG/ML		
	Midazolam Nasal Spray Soln 5 MG/0.1 ML		May be considered for reimbursement upon submission of a prior authorization request in which all of the following are documented: frequent seizure activity that is related to allowed condition(s) in the claim, the injured worker is concurrently receiving maintenance anticonvulsant medication, and the injured worker is unable to administer generic injectable midazolam intranasally. Reimbursement is limited to one (1) package every 30 days.
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 ER 24HR 10 MG	✓	
	Carvedilol Phosphate Cap ER 24HR 20 MG	✓	
	Carvedilol Phosphate Cap ER 24HR 40 MG	✓	
	Carvedilol Phosphate Cap ER 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 ER 24HR 25 MG (Tartrate Equiv)	✓	
	Metoprolol Succinate Tab ER 24HR 50 MG (Tartrate Equiv)	✓	
	Metoprolol Succinate Tab ER 24HR 100 MG (Tartrate Equiv)	✓	
	Metoprolol Succinate Tab ER 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 ER 24HR 60 MG	✓	
	Propranolol HCl Cap ER 24HR 80 MG	✓	
	Propranolol HCl Cap ER 24HR 120 MG	✓	
	Propranolol HCl Cap ER 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	✓	
C1 Esterase Inhibitors	C1 Esterase Inhibitor (Human) for Subcutaneous Inj 2000 Unit	✓	May be considered for reimbursement upon submission of a prior authorization request that reflects an allowed condition of angioedema. Initial approval will be no greater than six (6) months, and subsequent requests may be considered if there is a documented positive response to therapy demonstrated by a reduction in angioedema attacks.
	C1 Esterase Inhibitor (Human) for Subcutaneous Inj 3000 Unit	✓	
Calcium Channel Blockers	Amlodipine Besylate Tab 2.5 MG (Base Equivalent)	✓	
	Amlodipine Besylate Tab 5 MG (Base Equivalent)	✓	
	Amlodipine Besylate Tab 10 MG (Base Equivalent)	✓	
	Diltiazem HCl Cap ER 24HR 120 MG	✓	
	Diltiazem HCl Cap ER 24HR 180 MG	✓	
	Diltiazem HCl Cap ER 24HR 240 MG	✓	
	Diltiazem HCl Coated Beads Cap ER 24HR 120 MG	✓	
	Diltiazem HCl Coated Beads Cap ER 24HR 180 MG	✓	
	Diltiazem HCl Coated Beads Cap ER 24HR 240 MG	✓	
	Diltiazem HCl Coated Beads Cap ER 24HR 300 MG	✓	
	Diltiazem HCl Coated Beads Cap ER 24HR 360 MG	✓	
	Diltiazem HCl Tab ER 24HR 240 MG	✓	
	Diltiazem HCl Tab ER 24HR 360 MG	✓	
	Diltiazem HCl Extended Release Beads Cap ER 24HR 180 MG	✓	

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

Medication Class Name	Medication Generic Name	Allowed Condition Needed	Reimbursement restrictions or limitations for specific medications or dosage forms are listed with the respective medications below.
	Diltiazem HCl Extended Release Beads Cap ER 24HR 240 MG	✓	
	Diltiazem HCl Extended Release Beads Cap ER 24HR 300 MG	✓	
	Diltiazem HCl Extended Release Beads Cap ER 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 ER 24HR 5 MG	✓	
	Felodipine Tab ER 24HR 10 MG	✓	
	Nicardipine HCl Cap 20 MG	✓	
	Nifedipine Cap 10 MG	✓	
	Nifedipine Cap 20 MG	✓	
	Nifedipine Tab ER 24HR 30 MG	✓	
	Nifedipine Tab ER 24HR 60 MG	✓	
	Nifedipine Tab ER 24HR 90 MG	✓	
	Nifedipine Tab ER 24HR Osmotic Release 30 MG	✓	
	Nifedipine Tab ER 24HR Osmotic Release 60 MG	✓	
	Nifedipine Tab ER 24HR Osmotic Release 90 MG	✓	
	Nisoldipine Tab ER 24HR 20 MG	✓	
	Nisoldipine Tab ER 24HR 25.5 MG	✓	
	Verapamil HCl Cap ER 24HR 120 MG	✓	
	Verapamil HCl Cap ER 24HR 180 MG	✓	
	Verapamil HCl Cap ER 24HR 240 MG	✓	
	Verapamil HCl Tab 40 MG	✓	
	Verapamil HCl Tab 80 MG	✓	
	Verapamil HCl Tab 120 MG	✓	
	Verapamil HCl Tab ER 120 MG	✓	
	Verapamil HCl Tab ER 180 MG	✓	
	Verapamil HCl Tab ER 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	✓	
	Sacubitril-Valsartan Tab 24-26 MG	✓	
	Sacubitril-Valsartan Tab 49-51 MG	✓	
Chelating Agents	Penicillamine Cap 250 MG	✓	
	Penicillamine Tab 250 MG	✓	
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	✓	
	Cyanocobalamin SL Tab 500 MCG	✓	
	Cyanocobalamin SL Tab 1000 MCG	✓	
	Cyanocobalamin SL Tab 2500 MCG	✓	
	Cyanocobalamin SL Tab 3000 MCG	✓	
	Cyanocobalamin SL Tab 5000 MCG	✓	
	Cyanocobalamin SL Tab 6000 MCG	✓	
	Cyanocobalamin Inj 1000 MCG/ML	✓	
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 Elixir 1-2.5MG/5ML		
	Cetirizine-Pseudoephedrine Tab ER 12HR 5-120 MG	✓	
	Chlorpheniramine-DM Tab 4-30 MG		May be considered for reimbursement upon submission of a prior authorization request with documented medical justification.
	Dextromethorphan-Doxylamine-APAP Liquid 10-6.25-325 MG/15ML		
	Dextromethorphan-Guaifenesin Liquid 10-100 MG/5ML	✓	
	Dextromethorphan-Guaifenesin Liquid 10-187 MG/5ML		May be considered for reimbursement upon submission of a prior authorization request with documented medical justification.
	Dextromethorphan-Guaifenesin Liquid 10-200 MG/5ML	✓	
	Dextromethorphan-Guaifenesin Liquid 5-100 MG/5ML	✓	
	Dextromethorphan-Guaifenesin Liquid 5-50 MG/ML	✓	
	Dextromethorphan-Guaifenesin Liquid 20-200 MG/20ML		May be considered for reimbursement upon submission of a prior authorization request with documented medical justification.
	Dextromethorphan-Guaifenesin Syrup 10-100 MG/5ML	✓	
	Diphenhydramine-Acetaminophen Tab 12.5-325 MG	✓	

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

Medication Class Name	Medication Generic Name	Allowed Condition Needed	Reimbursement restrictions or limitations for specific medications or dosage forms are listed with the respective medications below.
	Fexofenadine-Pseudoephedrine Tab ER 12HR 60-120 MG	✓	
	Fexofenadine-Pseudoephedrine Tab ER 24HR 180-240 MG	✓	
	Guaifenesin-Codeine Soln 100-10 MG/5ML	✓	
	Hydrocod Polst-Chlorphen Polst Cap ER 12HR 10-8 MG	✓	
	Hydrocod Polst-Chlorphen Polst ER Susp 10-8 MG/5ML	✓	
	Loratadine & Pseudoephedrine Tab ER 12HR 5-120 MG	✓	
	Loratadine & Pseudoephedrine Tab ER 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		May be considered for reimbursement upon submission of a prior authorization request with documented medical justification.
	Phenylephrine w/ DM-GG Tab 10-15-400 MG		
	Phenylephrine w/ DM-GG Tab 5-10-200 MG	✓	
	Phenylephrine-Chlorphen-DM Liquid 10-4-10 MG/5ML		May be considered for reimbursement upon submission of a prior authorization request with documented medical justification.
	Phenylephrine-Chlorphen-DM Tab 10-4-10 MG		
	Phenylephrine-Promethazine-Codeine Syrup 5-6.25-10 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 Soln 30-10-100 MG/5ML	✓	
	Pseudoephedrine w/ DM-GG Tab 60-15-400 MG		May be considered for reimbursement upon submission of a prior authorization request with documented medical justification.
	Pseudoephedrine w/ DM-GG Tab 60-20-380 MG		
	Pseudoephedrine-Guaifenesin Tab ER 12HR 120-1200 MG	✓	
	Pseudoephedrine-Guaifenesin Tab ER 12HR 60-600 MG	✓	
Cystic Fibrosis Agents	Dornase Alfa Inhal Soln 1 MG/ML	✓	
Pulmonary Fibrosis Agents	Nintedanib Esylate Cap 100 MG (Base Equivalent)		May be considered for reimbursement upon submission of a prior authorization request that reflects the injured worker is being treated for interstitial lung disease related to an allowed condition in the claim and includes documentation of clinical signs of progression (defined as Forced Vital Capacity (FVC) decline with worsening symptoms or imaging) within the past year and an FVC greater than or equal to forty percent of predicted.
	Nintedanib Esylate Cap 150 MG (Base Equivalent)		
Cytomegalovirus (CMV) Agents	Valganciclovir HCI Tab 450 MG	✓	
Diabetic Supplies	Alcohol, Rubbing 70%	✓	
	Alcohol Sheets	✓	
	Alcohol Swabs	✓	
	Lancet Devices	✓	
	Lancets Misc.	✓	
	Lancets	✓	
Diagnostic Test	Glucose Blood Test Strip	✓	
Dietary Management Products	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		May be considered for reimbursement upon submission of a prior authorization request with documented medical justification.
	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		
	Folic Acid-Pyridoxine-Cyanocobalamin Tab 2.5-25-2 MG		
Digestive Enzymes	Lactase Tab 3000 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 10000-32000-42000 Unit	✓	
	Pancrelipase (Lip-Prot-Amyl) DR Cap 10500-35500-61500 Unit	✓	
	Pancrelipase (Lip-Prot-Amyl) DR Cap 12000-38000-60000 Unit	✓	
	Pancrelipase (Lip-Prot-Amyl) DR Cap 15000-47000-63000 Unit	✓	
	Pancrelipase (Lip-Prot-Amyl) DR Cap 16000-57500-60500 Unit	✓	
	Pancrelipase (Lip-Prot-Amyl) DR Cap 16800-56800-98400 Unit	✓	
	Pancrelipase (Lip-Prot-Amyl) DR Cap 20000-63000-84000 Unit	✓	
	Pancrelipase (Lip-Prot-Amyl) DR Cap 24000-76000-120000 Unit	✓	
	Pancrelipase (Lip-Prot-Amyl) DR Cap 25000-79000-105000 Unit	✓	
	Pancrelipase (Lip-Prot-Amyl) DR Cap 36000-114000-180000 Unit	✓	
	Pancrelipase (Lip-Prot-Amyl) DR Cap 40000-126000-168000 Unit	✓	
	Pancrelipase (Lip-Prot-Amyl) Tab 10440-39150-39150 Unit	✓	
	Pancrelipase (Lip-Prot-Amyl) Tab 20880-78300-78300 Unit	✓	

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

Medication Class Name	Medication Generic Name	Allowed Condition Needed	Reimbursement restrictions or limitations for specific medications or dosage forms are listed with the respective medications below.
Diuretics	Acetazolamide Cap ER 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	✓	
	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	✓	
Endocrine – Bone Density Regulators	Alendronate Sodium Oral Soln 70 MG/75ML	✓	
	Alendronate Sodium Tab 5 MG	✓	
	Alendronate Sodium Tab 35 MG	✓	
	Alendronate Sodium Tab 70 MG	✓	
	Alendronate Sodium-Cholecalciferol Tab 70-2800 MG-Unit	✓	
	Calcitonin (Salmon) Nasal Soln 200 Unit/ACT	✓	
	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 620 MCG/2.48 ML	✓	
Endocrine – Corticotropin	Corticotropin Inj Gel 80 Unit/ML	✓	
Endocrine – Growth Hormones	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	✓	
	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 Tab 200 MG	✓	
	Guaifenesin Tab 400 MG	✓	
	Guaifenesin Tab ER 12HR 600 MG	✓	
	Guaifenesin Tab ER 12HR 1200 MG	✓	
Fertility Regulators	Clomiphene Citrate Tab 50 MG		May be considered for reimbursement upon submission of a prior authorization request. Reimbursement is limited to claims in which low testosterone is related to an allowed condition in the claim.
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	✓	

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

Medication Class Name	Medication Generic Name	Allowed Condition Needed	Reimbursement restrictions or limitations for specific medications or dosage forms are listed with the respective medications below.
G.I. Agent – Gastrointestinal Chloride Channel Activators	Lubiprostone Cap 8 MCG		May be considered for reimbursement upon submission of a prior authorization request that reflects: a diagnosis of opioid induced constipation, defined as fewer than three (3) bowel movements per week or two (2) consecutive days without a bowel movement; the injured worker has received opioid prescriptions reimbursed by BWC for at least eight (8) consecutive weeks immediately prior to the request; the opioid prescription(s) are ongoing; and office notes document previous failed therapy with at least two (2) osmotic (PEG 3350, etc.) or stimulant (bisacodyl, senna, etc.) laxatives. Reimbursement is limited to two (2) capsules per day.
	Lubiprostone Cap 24 MCG		
G.I. Agent – Gastrointestinal Stimulants	Metoclopramide HCl Soln 5 MG/5ML (10 MG/10ML) (Base Equiv)	✓	
	Metoclopramide HCl Tab 5 MG (Base Equivalent)	✓	
	Metoclopramide HCl Tab 10 MG (Base Equivalent)	✓	
G.I. Agent – Inflammatory Bowel Agents	Balsalazide Disodium Cap 750 MG	✓	
	Mesalamine Cap ER 500 MG	✓	
	Mesalamine Cap DR 400 MG	✓	
	Mesalamine Enema 4 GM	✓	
	Mesalamine Suppos 1000 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	Naldemedine Tosylate Tab 0.2 MG		May be considered for reimbursement upon submission of a prior authorization request that reflects: a diagnosis of opioid induced constipation, defined as fewer than three (3) bowel movements per week or two (2) consecutive days without a bowel movement; the injured worker has received opioid prescriptions reimbursed by BWC for at least eight (8) consecutive weeks immediately prior to the request; the opioid prescription(s) are ongoing; and office notes document previous failed therapy with at least two osmotic (PEG 3350, etc.) or stimulant (bisacodyl, senna, etc.) laxatives. Reimbursement is limited to one (1) tablet per day.
	Naloxegol Oxalate Tab 12.5 MG		
	Naloxegol Oxalate Tab 25 MG		
Genitourinary – Alkalinizers	Potassium Citrate Tab ER 5 MEQ (540 MG)	✓	
	Potassium Citrate Tab ER 10 MEQ (1080 MG)	✓	
Genitourinary Irrigants	Acetic Acid Irrigation Soln 0.25%	✓	
	Sodium Chloride Irrigation Soln 0.9%		
	*Citric Acid-Gluconolactone-Magnesium Carbonate 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)		
	Hydrocortisone Tab 5 MG		
	Hydrocortisone Tab 10 MG		
	Hydrocortisone Tab 20 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		
	Prednisolone Sodium Phosphate Oral Soln 25 MG/5ML (Base Eq)		
	Prednisolone Soln 15 MG/5ML		
	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)		
	Prednisone Tab Therapy Pack 5 MG (48)		
	Prednisone Tab Therapy Pack 10 MG (21)		
	Prednisone Tab Therapy Pack 10 MG (48)		
Gout Agents	Allopurinol Tab 100 MG	✓	
	Allopurinol Tab 300 MG	✓	
	Colchicine Cap 0.6 MG	✓	
	Colchicine Tab 0.6 MG	✓	

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

Medication Class Name	Medication Generic Name	Allowed Condition Needed	Reimbursement restrictions or limitations for specific medications or dosage forms are listed with the respective medications below.
	Febuxostat Tab 40 MG	✓	
	Febuxostat Tab 80 MG	✓	
Hematopoietic Agents – Folic Acid/Folates	Folic Acid Tab 800 MCG	✓	
	Folic Acid Tab 1 MG	✓	
Hematopoietic Agents – Iron	Carbonyl Iron Tab 45 MG (Elemental Iron)	✓	
	Ferrous Gluconate Tab 239 MG (27 MG Fe Equivalent)	✓	
	Ferrous Gluconate Tab 324 MG (38 MG Elemental Iron)	✓	
	Ferrous Sulfate Dried Tab ER 160 MG (50 MG Fe Equivalent)	✓	
	Ferrous Sulfate Soln 220 MG/5ML (44 MG/5ML Elemental Fe)	✓	
	Ferrous Sulfate Soln 300 MG/5ML (60 MG/5ML Elemental Fe)	✓	
	Ferrous Sulfate Tab 325 MG (65 MG Elemental Fe)	✓	
	Ferrous Sulfate Tab ER 142 MG (45 MG Fe Equivalent)	✓	
	Ferrous Sulfate Tab ER 143 MG (45 MG Fe Equivalent)	✓	
	Ferrous Sulfate Tab ER 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 Asparto Gly-Succ Ac-C-Threonic Ac-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		May be considered for reimbursement upon submission of a prior authorization request with documented medical justification.
Hematorheologic Agents	Pentoxifylline Tab ER 400 MG	✓	
Hemostatics – Systemic	Aminocaproic Acid Oral Soln 0.25 GM/ML		
	Aminocaproic Acid Tab 500 MG		
	Aminocaproic Acid Tab 1000 MG		
Hepatitis Agents	Elbasvir-Grazoprevir Tab 50-100 MG	✓	
	Glecaprevir-Pibrentasvir Tab 100-40 MG	✓	
	Ledipasvir-Sofosbuvir Tab 90-400 MG	✓	
	Peginterferon alfa-2a Soln Auto-Injector 180 MCG/0.5ML	✓	
	Peginterferon alfa-2a Soln Prefilled Syr 180 MCG/0.5ML	✓	
	Peginterferon alfa-2b For Inj Kit 50 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	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	Eszopiclone Tab 1 MG		
	Eszopiclone Tab 2 MG		
	Eszopiclone Tab 3 MG		
	Temazepam Cap 15 MG		
	Temazepam Cap 30 MG		
	Zaleplon Cap 5 MG		
	Zaleplon Cap 10 MG		
	Zolpidem Tartrate Tab 5 MG		
	Zolpidem Tartrate Tab 10 MG		
	Zolpidem Tartrate Tab ER 6.25 MG		
	Zolpidem Tartrate Tab ER 12.5 MG		
Immunomodulators	Lenalidomide Caps 2.5 MG	✓	
	Lenalidomide Cap 5 MG	✓	
	Lenalidomide Cap 10 MG	✓	

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

Medication Class Name	Medication Generic Name	Allowed Condition Needed	Reimbursement restrictions or limitations for specific medications or dosage forms are listed with the respective medications below.
Immunosuppressive Agents	Lenalidomide Cap 20 MG	✓	
	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	✓	
	Everolimus Tab 1 MG	✓	
	Mycophenolate Mofetil Cap 250 MG	✓	
	Mycophenolate Mofetil Tab 500 MG	✓	
	Mycophenolate Mofetil For Oral Susp 200 MG/ML		
	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 ER 24HR 0.75 MG	✓	
	Tacrolimus Tab ER 24HR 1 MG	✓	
	Tacrolimus Tab ER 24HR 4 MG	✓	
Impotence Agents	ALL impotence agents		Reimbursement for impotence medications is limited to one (1) product per month.
	Alprostadil For Inj 20 MCG	✓	Reimbursement is limited to six (6) units per 30 days.
	Alprostadil For Inj Kit 10 MCG	✓	
	Alprostadil For Inj Kit 20 MCG	✓	
	Alprostadil For Inj Kit 40 MCG	✓	
	Alprostadil Urethral Pellet 250 MCG	✓	Reimbursement is limited to six (6) pellet per 30 days.
	Alprostadil Urethral Pellet 500 MCG	✓	
	Alprostadil Urethral Pellet 1000 MCG	✓	
	Sildenafil Citrate Tab 25 MG	✓	Reimbursement is limited to six (6) tablets per 30 days.
	Sildenafil Citrate Tab 50 MG	✓	
	Sildenafil Citrate Tab 100 MG	✓	Reimbursement is limited to 30 tablets per 30 days.
	Tadalafil Tab 2.5 MG	✓	
	Tadalafil Tab 5 MG	✓	Reimbursement is limited to six (6) tablets per 30 days.
	Tadalafil Tab 10 MG	✓	
	Tadalafil Tab 20 MG	✓	Reimbursement is limited to six (6) tablets per 30 days.
	Vardenafil HCl Tab 5 MG	✓	
	Vardenafil HCl Tab 10 MG	✓	
	Vardenafil HCl Tab 20 MG	✓	
Influenza Agents	Oseltamivir Phosphate Cap 75 MG	✓	
	Zanamivir Aero Powder Breath Activated 5 MG/BLISTER	✓	
Insulin Administration Supplies	Insulin Pen Needles	✓	
	Insulin Syringes	✓	
	Insulin Syringe/Needles	✓	
Interstitial Cystitis Agents	Pentosan Polysulfate Sodium Caps 100 MG	✓	
Irrigation Solutions	Water For Irrigation, Sterile Irrigation Soln		
Laxative – Combinations	Bisacodyl Tab & PEG 3350-KCl-Sod Bicarb-NaCl For Soln Kit		May be considered for reimbursement upon submission of a prior authorization request with documented medical justification.
	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-NaCl-Na Sulfate-Na Ascorbate-C For Soln 100 GM		
	PEG 3350-KCl-Sod Bicarb-NaCl For Soln 420 GM		
	Sod Sulfate-Pot Sulf-Mg Sulf Oral Sol 17.5-3.13-1.6 GM/177ML		
	Psyllium w/ Calcium Capsule		
	Sennosides-Docusate Sodium Tab 8.6-50 MG		
Laxatives – Bulk	Calcium Polycarbophil Tab 625 MG		
	Cellulose Powder		
	Methylcellulose Powder Laxative		
	Methylcellulose Tab 500 MG		
	Psyllium Cap 0.36 GM		
	Psyllium Cap 0.52 GM		
	Psyllium Powder 27%		
	Psyllium Powder 28.3%		
	Psyllium Powder 30.9%		
	Psyllium Powder 33%		
	Psyllium Powder 48.57%		
	Psyllium Powder 49%		
	Psyllium Powder 51.7%		
	Psyllium Powder 52.3%		
	Psyllium Powder 58.6%		
	Psyllium Powder Packet 28%		
	Psyllium Powder Packet 51.7%		
	Psyllium Powder Packet 58.12%		
	Psyllium Powder Packet 58.6%		

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

Medication Class Name	Medication Generic Name	Allowed Condition Needed	Reimbursement restrictions or limitations for specific medications or dosage forms are listed with the respective medications below.
	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 Enema Adult 5.4 GM/Average Delivered Dose		
	Glycerin Suppos 2 GM		
	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 17 GM		
	Polyethylene Glycol 3350 Oral Powder 17 GM/SCOOP		
	Sorbitol Oral Solution 70%		
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		
	Sennosides Cap 8.6 MG		
	Sennosides Syrup 8.8 MG/5ML		
	Sennosides Tab 15 MG		
	Sennosides Tab 17.2 MG		
	Sennosides Tab 25 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		
Liquid Vehicles	Sorbitol Solution (Bulk)		May be reimbursed with documented approval of intrathecal pain pump.
	Water For Injection		
	Water For IV Injection		
Migraine Products – calcitonin gene-related peptide (CGRP) receptor antagonists	ALL CGRP products		May be considered for reimbursement upon submission of a prior authorization request. Reimbursement is limited to claims in which migraine headaches are related to an allowed condition in the claim. Reimbursement will not be approved for duplicate therapy with other CGRP antagonists. CGRP products for acute treatment: Reimbursement will be considered for individuals who have a documented inadequate response to at least two (2) triptan medications, or if the injured worker has a contraindication for triptans. CGRP products for prophylaxis : Reimbursement will be considered for individuals who have a minimum of a 90-day trial and documented inadequate response to at least one (1) medication from three (3) of the four (4) following different classes within the past 180 days: 1) Topiramate, sodium valproate, divalproex sodium 2) Amitriptyline, nortriptyline 3) Venlafaxine, duloxetine 4) Atenolol, metoprolol, nadolol, propranolol, timolol. The initial reimbursement may be for up to three (3) months. Subsequent approvals may be granted if there is a documented positive response to therapy demonstrated by a reduction in migraines AND there is documented improvement in function.
	Atogepant Tab 10 MG		Reimbursement is limited to one (1) tablet per day.
	Atogepant Tab 30 MG		
	Atogepant Tab 60 MG		
	Rimegepant 75 MG ODT		Reimbursement is limited to 18 tablets per 30 days.
	Ubrogepant 50 MG		Reimbursement is limited to 16 tablets per 30 days.
	Ubrogepant 100 MG		
	Erenumab-aooe Injection 70 MG/ML		
	Erenumab-aooe Injection 140 MG/ML		
	Fremanezumab-vfrm Injection 225 MG/ 1.5 ML		
	Galcanezumab-gnlm Injection 100 MG/ML		
	Galcanezumab-gnlm Injection 120 MG/ML		
Migraine Products – Misc.	Dihydroergotamine Mesylate Nasal Spray 4 MG/ML	✓	
	Ergotamine w/ Caffeine Tab 1-100 MG	✓	
Migraine Products – Serotonin Agonists	ALL Triptan migraine products		Reimbursement for triptan migraine medications is limited to one (1) product per month.
	Almotriptan Malate Tab 12.5 MG	✓	Reimbursement is limited to 12 tablets per 30 days.
	Eletriptan Hydrobromide Tab 20 MG	✓	Reimbursement is limited to six (6) tablets per 30 days.
	Eletriptan Hydrobromide Tab 40 MG	✓	Reimbursement is limited to six (6) tablets per 30 days.
	Frovatriptan Succinate Tab 2.5 MG	✓	Reimbursement is limited to nine (9) tablets per 30 days.
	Lasmiditan 50 MG		May be considered for reimbursement upon submission of a prior authorization request that reflects the injured worker has not received an adequate response from use of at least one triptan medication, or if the injured worker has a contraindication to triptans. Reimbursement is

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

Medication Class Name	Medication Generic Name	Allowed Condition Needed	Reimbursement restrictions or limitations for specific medications or dosage forms are listed with the respective medications below.
	Lasmiditan 100 MG		limited to claims in which migraine headaches are related to an allowed condition in the claim. Reimbursement is limited to four (4) tablets per 30 days.
	Naratriptan HCl Tab 2.5 MG	✓	Reimbursement is limited to nine (9) tablets per 30 days.
	Rizatriptan Benzoate Oral Disintegrating Tab 5 MG (Base Eq)		Reimbursement is limited to 12 tablets per 30 days. Reimbursement for oral disintegrating dosage form is limited to claims with an allowed condition that results in the inability to swallow or absorb oral medications
	Rizatriptan Benzoate Oral Disintegrating Tab 10 MG (Base Eq)		Reimbursement is limited to 12 tablets per 30 days. Reimbursement for oral disintegrating dosage form is limited to claims with an allowed condition that results in the inability to swallow or absorb oral medications
	Rizatriptan Benzoate Tab 5 MG	✓	Reimbursement is limited to 12 tablets per 30 days.
	Rizatriptan Benzoate Tab 10 MG	✓	Reimbursement is limited to 12 tablets per 30 days.
	Sumatriptan Nasal Spray 5 MG/ACT	✓	Reimbursement is limited to 12 units per 30 days.
	Sumatriptan Nasal Spray 20 MG/ACT	✓	Reimbursement is limited to six (6) units per 30 days.
	Sumatriptan Succinate Inj 6 MG/0.5ML	✓	Reimbursement is limited to 10 units per 30 days.
	Sumatriptan Succinate Solution Auto-injector 4 MG/0.5ML	✓	Reimbursement is limited to eight (8) units per 30 days.
	Sumatriptan Succinate Solution Auto-injector 6 MG/0.5ML	✓	Reimbursement is limited to 10 units per 30 days.
	Sumatriptan Succinate Solution Cartridge 4 MG/0.5ML	✓	Reimbursement is limited to eight (8) units per 30 days.
	Sumatriptan Succinate Solution Cartridge 6 MG/0.5ML	✓	Reimbursement is limited to 10 units per 30 days.
	Sumatriptan Succinate Solution Prefilled Syringe 6 MG/0.5ML	✓	Reimbursement is limited to 10 units per 30 days.
	Sumatriptan Succinate Tab 25 MG	✓	Reimbursement is limited to 18 tablets per 30 days.
	Sumatriptan Succinate Tab 50 MG	✓	Reimbursement is limited to nine (9) tablets per 30 days.
	Sumatriptan Succinate Tab 100 MG	✓	Reimbursement is limited to nine (9) tablets per 30 days.
	Zolmitriptan Nasal Spray 2.5 MG/Spray Unit	✓	Reimbursement is limited to 12 units per 30 days.
	Zolmitriptan Nasal Spray 5 MG/Spray Unit	✓	Reimbursement is limited to 12 units per 30 days.
	Zolmitriptan Orally Disintegrating Tab 2.5 MG		Reimbursement is limited to 12 tablets per 30 days. Reimbursement for oral disintegrating dosage form is limited to claims with an allowed condition that results in the inability to swallow or absorb oral medications
	Zolmitriptan Orally Disintegrating Tab 5 MG		Reimbursement is limited to six (6) tablets per 30 days. Reimbursement for oral disintegrating dosage form is limited to claims with an allowed condition that results in the inability to swallow or absorb oral medications
	Zolmitriptan Tab 2.5 MG	✓	Reimbursement is limited to 12 tablets per 30 days.
	Zolmitriptan Tab 5 MG	✓	Reimbursement is limited to six (6) tablets per 30 days.
Mineralocorticoids	Fludrocortisone Acetate Tab 0.1 MG	✓	
Minerals & Electrolytes – Calcium	Calcium & Phosphorus w/ Vit D Chew Tab 200 MG-96.6 MG-200 Unt		May be considered for reimbursement upon submission of a prior authorization request with documented medical justification.
	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 Tab 1250 MG (500 MG Elemental Ca)	✓	
	Calcium Carbonate Tab 1500 MG (600 MG Elemental Ca)	✓	
	Calcium Carbonate Tab 600 MG	✓	
	Calcium Carbonate Chew Tab 1250 MG (500 MG Elemental Ca)	✓	
	Calcium Carb-Cholecalciferol Cap 600 MG-2.5 MCG (100 Unit)	✓	
	Calcium Carb-Cholecalciferol Cap 600 MG-10 MCG (400 Unit)		May be considered for reimbursement upon submission of a prior authorization request with documented medical justification.
	Calcium Carb-Cholecalciferol Cap 600 MG-62.5 MCG (2500 Unit)		
	Calcium Carb-Cholecalciferol Chew Tab 500 MG-2.5 MCG (100 Unit)	✓	
	Calcium Carb-Cholecalciferol Chew Tab 600 MG-10 MCG (400 Unit)	✓	
	Calcium Carb-Cholecalciferol Chew Tab 600 MG-20 MCG (800 Unit)		May be considered for reimbursement upon submission of a prior authorization request with documented medical justification.
	Calcium Carb-Cholecalciferol Liquid 500-10 MCG (400 MG-UNIT)/5ML		
	Calcium Carb-Cholecalciferol Tab 250 MG-3.125 MCG (125 Unit)	✓	
	Calcium Carb-Cholecalciferol Tab 500 MG-5 MCG (200 Unit)	✓	
	Calcium Carb-Cholecalciferol Tab 500 MG-10 MCG (400 Unit)	✓	
	Calcium Carb-Cholecalciferol Tab 500 MG-15 MCG (600 Unit)	✓	
	Calcium Carb-Cholecalciferol Tab 600 MG-5 MCG (200 Unit)	✓	

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

Medication Class Name	Medication Generic Name	Allowed Condition Needed	Reimbursement restrictions or limitations for specific medications or dosage forms are listed with the respective medications below.
	Calcium Carb-Cholecalciferol Tab 600 MG-10 MCG (400 Unit)	✓	
	Calcium Carb-Cholecalciferol Tab 600 MG-20 MCG (800 Unit)	✓	
	Calcium Carbonate-Ergocalciferol Tab 500MG-5 MCG (200 Unit)	✓	
	Calcium Carbonate-Vitamin D Tab 250 MG-3.125 MCG (125 Unit)	✓	
	Calcium Carbonate-Vitamin D Tab 500 MG-5 MCG (200 Unit)	✓	
	Calcium Carbonate-Vitamin D Tab 600 MG-3.125 MCG (125 Unit)	✓	
	Calcium Carbonate-Vitamin D Tab 600 MG-5 MCG (200 Unit)	✓	
	Calcium Carbonate-Vitamin D Tab 600 MG-10 MCG (400 Unit)	✓	
	Calcium Carb-Vit D w/ Minerals Chew Tab 600 MG-800 Unit		May be considered for reimbursement upon submission of a prior authorization request with documented medical justification.
	Calcium Carb-Vit D w/ Minerals Tabs 600 MG-800 Unit		
	Calcium Citrate Cap 150 MG	✓	
	Calcium Cit Malate-Cholecalciferol Tab 250 MG-2.5 MCG (100 Unit)		May be considered for reimbursement upon submission of a prior authorization request with documented medical justification.
	Calcium Citrate Tab 333 MG (Elemental Ca)		
	Calcium Citrate Tab 950 MG (200 MG Elemental Ca)	✓	
	Calcium Citrate-Vitamin D Liquid 1000-0.01 MG(400 Unit)/30ML		May be considered for reimbursement upon submission of a prior authorization request with documented medical justification.
	Calcium Citrate-Vit D-Vit K w/ Minerals Tabs 200 MG		
	Calcium Cit-Vitamin D Chew Tab 500 MG-8.325 MCG (333 Unit)		
	Calcium Cit-Vitamin D Chew Tab 500 MG-12.5 MCG (500 Unit)		
	Calcium Cit-Vit D Tab 200 MG-6.25 MCG (250 Unit) (Elem Ca)	✓	
	Calcium Cit-Vitamin D Tab 250 MG-5 MCG (200 Unit) (Elem Ca)	✓	
	Calcium Phos-Cholecalciferol Chew Tab 200 MG-5 MCG (200 Unit)		May be considered for reimbursement upon submission of a prior authorization request with documented medical justification.
	Calcium Phos-Cholecalciferol Chew Tab 250 MG-2.5 MCG (100 Unit)		
	Calcium Phosp-Cholecalciferol Chew Tab 250 MG-10 MCG (400 Unit)		
	Calcium Phos-Cholecalciferol Chew Tab 250 MG-12.5 MCG (500 Unit)	✓	
	Calcium w/ Magnesium Cap 70-83 MG		May be considered for reimbursement upon submission of a prior authorization request with documented medical justification.
	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 & K Tab 500 MG-200 Unit-90 MCG		
	Calcium w/ Vitamin D & K Tab 600 MG-1000 Unit-90 MCG		
	Calcium-Vitamin D Tab 600 MG-5 MCG (200 Unit)	✓	
	Calcium-Cholecalciferol Tab 200 MG-6.25 MCG (250 Unit)	✓	
	Calcium-Cholecalciferol Tab 500 MG-5 MCG (200 Unit)	✓	
	Calcium-Ergocalciferol Tab 250 MG-2.5 MCG (100 Unit)	✓	
	Calcium-Ergocalciferol Tab 500 MG-5 MCG (200 Unit)	✓	
	Calcium-Magnesium w/ Vit D Tab ER 24HR 600 MG-40 MG-500 Unit		May be considered for reimbursement upon submission of a prior authorization request with documented medical justification.
	Calcium-Magnesium w/ Vitamin D Chew Tab 300MG-20MG-200 Unit		
	Calcium-Magnesium w/ Vitamin D Tab 300 MG-150 MG-400 Unit		
	Calcium-Magnesium W/ Vitamin D Wafer 250 MG-125 MG-200 UNIT		May be considered for reimbursement upon submission of a prior authorization request with documented medical justification.
	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 & Electrolytes Iodine Products	Potassium Iodide Oral Soln 1 GM/ML	✓	
Minerals & Electrolytes – Magnesium	*Specialty Vitamin Product Tab**		May be considered for reimbursement upon submission of a prior authorization request with documented medical justification.
	Magnesium Bisglycinate Tab 100 MG (Elemental Mg)		
	Magnesium Cap 125 MG		
	Magnesium Cap 400 MG		
	Magnesium Carbonate Oral Powder 250 MG/GM (Elemental Mg)		
	Magnesium Chewable Tab 200 MG		
	Magnesium Tab 250 MG		
	Magnesium Citrate Cap 125 MG (Elemental Mg)		
	Magnesium Citrate Tab 100 MG		
	Magnesium Citrate Tab 200 MG (Elemental 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		

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

Medication Class Name	Medication Generic Name	Allowed Condition Needed	Reimbursement restrictions or limitations for specific medications or dosage forms are listed with the respective medications below.
	Magnesium Gluconate Tab 500 MG (27 MG Elemental Mg)		
	Magnesium Lactate Tab ER 84 MG (Elemental Mg) (7 MEQ)		
	Magnesium Malate Tab 1250 MG (141.7 MG Magnesium Equivalent)		
	Magnesium Oral Powder		
	Magnesium Oxide Cap 400 MG (Elemental Mg) (Mg Supplement)		
	Magnesium Oxide Powder (Mg Supplement)		
	Magnesium Tab 400 MG		
	Magnesium Chloride Tab DR 64 MG (Elemental Mg)	✓	
	Magnesium Oxide Tab 250 MG (Mg Supplement)	✓	
	Magnesium Oxide Tab 400 MG (240 MG Elemental Mg)	✓	
Minerals & Electrolytes – Mineral Combinations	Multiple Minerals w/ Vitamins Liquid		May be considered for reimbursement upon submission of a prior authorization request with documented medical justification.
Minerals & Electrolytes – Potassium	Potassium Bicarbonate Effer Tab 25 mEq	✓	
	Potassium Chloride Cap ER 8 mEq	✓	
	Potassium Chloride Cap ER 10 mEq	✓	
	Potassium Chloride Microencapsulated Crys ER Tab 10 mEq	✓	
	Potassium Chloride Microencapsulated Crys ER Tab 20 mEq	✓	
	Potassium Chloride Oral Soln 10% (20 MEQ/15ML)	✓	
	Potassium Chloride Powder Packet 20 mEq	✓	
	Potassium Chloride Tab ER 8 mEq (600 MG)	✓	
	Potassium Chloride Tab ER 10 mEq	✓	
	Potassium Chloride Tab ER 20 mEq (1500 MG)	✓	
	Potassium Gluconate Tab 80 MG (Elemental Potassium)	✓	
	Potassium Gluconate Tab 550 MG (90 MG Equiv K)	✓	
Minerals & Electrolytes– Sodium	Sodium Chloride Tab 1 GM	✓	
	Sodium Chloride Inj 0.9%		
Minerals & Electrolytes– Zinc	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		May be considered for reimbursement upon submission of a prior authorization request with documented medical justification.
	Zinc Tab 50 MG	✓	
Mouth/Throat – Anesthetics Topical Oral	Benzocaine Dental Gel 20%		May be considered for reimbursement upon submission of a prior authorization request with documented medical justification.
	Benzocaine Dental Paste 20%		
	Benzocaine Dental Soln 20%		
	Benzocaine-Menthol Lozenge 15-3.6 MG		
	Benzocaine-Menthol Lozenge 15-4 MG		
	Benzocaine Mouth/Throat Aerosol 20%		
Mouth/Throat – Anti-infectives	Lidocaine HCl Viscous Soln 2%	✓	
	Clotrimazole Troche 10 MG	✓	
	Hydrogen Peroxide Soln 1.5%		
Mouth/Throat – Antiseptics	Nystatin Susp 100000 Unit/ML	✓	
	Chlorhexidine Gluconate Soln 0.12%	✓	
	Phenol Liquid 1.4%		May be considered for reimbursement upon submission of a prior authorization request with documented medical justification.
Mouth/Throat – Dental Products	Sodium Fluoride Cream 1.1%	✓	
	Sodium Fluoride Gel 1.1% (0.5% F)	✓	
	Stannous Fluoride Paste 0.454%		May be considered for reimbursement upon submission of a prior authorization request with documented medical justification.
Mouth/Throat – Lozenge	Menthol Lozenge 5.4 MG		May be considered for reimbursement upon submission of a prior authorization request with documented medical justification.
Mouth/Throat – Steroids	Triamcinolone Acetonide Dental Paste 0.1%	✓	
Mouth/Throat – Throat Products – Misc.	Artificial Saliva – Solution		
	Cevimeline HCl Cap 30 MG	✓	
	Misc Throat Products – Liquid		
	Pilocarpine HCl Tab 5 MG	✓	
	Pilocarpine HCl Tab 7.5 MG	✓	
	Povidone-Sodium Hyaluronate-Glycyrrhetic Acid Gel		
Movement Disorder Drug Therapy	Deutetrabenazine Tab 6 MG		May be considered for reimbursement upon submission of a prior authorization request that reflects an allowed condition of tardive dyskinesia and baseline Abnormal Involuntary Movement Scale (AIMS) test. Each reimbursement is limited to 12 weeks. Documentation of new AIMS testing is required for all subsequent renewals.
	Deutetrabenazine Tab 9 MG		
	Deutetrabenazine Tab 12 MG		
	Tetrabenazine Tab 12.5 MG		
	Tetrabenazine Tab 25 MG		
	Valbenazine Tosylate Cap 40 MG		
	Valbenazine Tosylate Cap 60 MG		
	Valbenazine Tosylate Cap 80 MG		
	Valbenazine Tosylate Cap 40-80 MG		
Mucolytics	Acetylcysteine Inhal Soln 10%	✓	
	Acetylcysteine Inhal Soln 20%	✓	
Multiple Sclerosis Agents	Fingolimod HCl Cap 0.5 MG	✓	
	Glatiramer Acetate Soln Prefilled Syringe 20 MG/ML	✓	
	Glatiramer Acetate Soln Prefilled Syringe 40 MG/ML	✓	
	Interferon Beta-1a IM Auto-Injector Kit 30 MCG/0.5ML	✓	
	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)	✓	
	Teriflunomide Tab 7 MG	✓	
	Teriflunomide Tab 14 MG	✓	

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

Medication Class Name	Medication Generic Name	Allowed Condition Needed	Reimbursement restrictions or limitations for specific medications or dosage forms are listed with the respective medications below.
Muscle Relaxants	ALL muscle relaxant products		After 90 days of use, may be considered for reimbursement upon submission of a prior authorization request that reflects use for an allowed condition in the claim. Prior authorization is not needed for baclofen or dantrolene. A prior authorization request may be submitted to request reimbursement of more than one (1) muscle relaxant.
	Baclofen Tab 5 MG		Reimbursement is limited to 80 MG per day. A prior authorization request may be submitted to request up to 120 MG per day.
	Baclofen Tab 10 MG		
	Baclofen Tab 20 MG		
	Chlorzoxazone Tab 500 MG		Reimbursement is limited to 2000 MG per day.
	Cyclobenzaprine HCl Tab 5 MG		Reimbursement is limited to 30 MG per day.
	Cyclobenzaprine HCl Tab 7.5 MG		
	Cyclobenzaprine HCl Tab 10 MG		
	Dantrolene Sodium Cap 25 MG		Reimbursement is limited to 200 MG per day.
	Dantrolene Sodium Cap 50 MG		
	Dantrolene Sodium Cap 100 MG		
	Metaxalone Tab 800 MG		May be considered for reimbursement upon submission of a prior authorization request that reflects a minimum of a 14-day trial and documented inadequate response of another covered muscle relaxant (excluding baclofen and dantrolene) within the past 6 months. Reimbursement is limited to 3200 MG per day.
	Methocarbamol Tab 500 MG		Reimbursement is limited to 6000 MG per day.
	Methocarbamol Tab 750 MG		
	Orphenadrine Citrate Tab ER 12HR 100 MG		Reimbursement is limited to 200 MG per day.
	Tizanidine HCl Cap 2 MG		Reimbursement is limited to 24 MG per day.
	Tizanidine HCl Cap 4 MG		
	Tizanidine HCl Cap 6 MG		
	Tizanidine HCl Tab 2 MG		
	Tizanidine HCl Tab 4 MG		
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 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	✓	
	Mometasone Furoate Nasal Susp 50 MCG/ACT	✓	
	Triamcinolone Acetonide Nasal Aerosol Suspension 55 MCG/ACT	✓	
Nonsteroidal Anti-inflammatory Agents (NSAIDs)	Celecoxib Cap 50 MG		Reimbursement is limited to 400 MG per day.
	Celecoxib Cap 100 MG		
	Celecoxib Cap 200 MG		
	Celecoxib Cap 400 MG		
	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 ER 24HR 100 MG		
	Etodolac Cap 200 MG		
	Etodolac Cap 300 MG		
	Etodolac Tab 400 MG		
	Etodolac Tab 500 MG		
	Etodolac Tab ER 24HR 400 MG		
	Etodolac Tab ER 24HR 500 MG		
	Etodolac Tab ER 24HR 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 ER 75 MG		
	Ketorolac Tromethamine Tab 10 MG		Reimbursement is limited to 20 tablets or a five (5)-day supply, whichever is less, during a rolling 12-month period.
	Ketorolac Tromethamine Inj 15 MG/ML		
	Ketorolac Tromethamine Inj 30 MG/ML		
	Ketorolac Tromethamine IM Inj 60 MG/2ML		
	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		

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

Medication Class Name	Medication Generic Name	Allowed Condition Needed	Reimbursement restrictions or limitations for specific medications or dosage forms are listed with the respective medications below.
	Naproxen Sodium Tab 550 MG		
	Naproxen Susp 125 MG/5ML		
	Naproxen Tab 250 MG		
	Naproxen Tab 375 MG		
	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		
Ophthalmic Adrenergic Agents	Apraclonidine HCl Ophth Soln 0.5%	✓	May be considered for reimbursement upon submission of a prior authorization request that reflects a documented allergic reaction, adverse event, or an inadequate response after a minimum of a 14-day trial of another agent in this class within the past 30 days.
	Brimonidine Tartrate Ophth Soln 0.025%		
	Brimonidine Tartrate Ophth Soln 0.1%		
	Brimonidine Tartrate Ophth Soln 0.15%		
	Brimonidine Tartrate Ophth Soln 0.2%	✓	
Ophthalmic – Antiallergic	Azelastine HCl Ophth Soln 0.05%	✓	
	Cromolyn Sodium Ophth Soln 4%	✓	
	Epinastine HCl Ophth Soln 0.05%	✓	
	Ketotifen Fumarate Ophth Soln 0.025%	✓	
	Ketotifen Fumarate Ophth Soln 0.035%	✓	
	Olopatadine HCl Ophth Soln 0.1%	✓	
	Olopatadine HCl Ophth Soln 0.2%	✓	
Ophthalmic Antibiotics	Azithromycin Ophth Soln 1%		
	Bacitracin Ophth Oint 500 Unit/GM		
	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		
	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% (2 Times Daily)		
	Moxifloxacin HCl Ophth Soln 0.5%		
	Ofloxacin Ophth Soln 0.3%		
	Tobramycin Ophth Oint 0.3%		
	Tobramycin Ophth Soln 0.3%		
Ophthalmic Antifungals	Natamycin Ophth Susp 5%		
Ophthalmic Anti-infective Combinations	Bacitracin-Polymyxin B Ophth Oint		
	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		
	Polymyxin B-Trimethoprim Ophth Soln 10000 Unit/ML-0.1%		
Ophthalmic Antivirals	Ganciclovir Ophth Gel 0.15%		
	Trifluridine Ophth Soln 1%		
Ophthalmic Artificial Tears and Lubricants	Artificial Tear Ophth Insert	✓	
	Artificial Tear Ophth Solution	✓	
	Carboxymethylcell-Glycerin-Polysorb 80 Ophth Soln 0.5-1-0.5%		
	Carboxymethylcell-Glyc-Polysorb 80 (PF) Ophth Sol 0.5-1-0.5%		
	Carboxymethylcellulose Sodium Ophth Gel 1%	✓	
	Carboxymethylcellulose Sodium (PF) Ophth Gel 1%	✓	
	Carboxymethylcellulose Sodium Ophth Liquid 0.7%	✓	
	Carboxymethylcellulose Sodium Ophth Soln 0.25%	✓	
	Carboxymethylcellulose Sodium (PF) Ophth Soln 0.25%	✓	
	Carboxymethylcellulose Sodium Ophth Soln 0.5%	✓	
	Carboxymethylcellulose Sodium (PF) 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-Glycerin (PF) Ophth Soln 0.5-0.9%	✓	
	Carboxymethylcellulose-Hypromellose Gel 0.25-0.3%		
	Dextran 70-Hypromellose (PF) Ophth Soln 0.1-0.3%	✓	
	Glycerin-Hypromellose-PEG 400 Ophth Soln 0.2-0.2-1%	✓	
	Hypromellose Ophth Gel 0.3%	✓	
	Hypromellose Ophth Soln 0.3%	✓	
	Hypromellose Ophth Soln 0.5%	✓	
	Light Mineral Oil-Mineral Oil Ophth Emulsion 0.5-0.5%		
	Polyethylene Glycol 400 Ophth Soln 1%	✓	
	Polyethylene Glycol-Propylene Glycol Ophth Gel 0.4-0.3%	✓	
	Polyethylene Glycol-Propylene Glycol Ophth Soln 0.4-0.3%	✓	
	Polyethylene Glycol-Propylene Glycol PF Op Soln 0.4-0.3%	✓	
	Polysorbate 80 (PF) Ophth Soln 1%		
	Polyvinyl Alcohol Ophth Soln 1.4%		
	Polyvinyl Alcohol-Povidone (PF) Ophth Soln 1.4-0.6%		

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

Medication Class Name	Medication Generic Name	Allowed Condition Needed	Reimbursement restrictions or limitations for specific medications or dosage forms are listed with the respective medications below.
	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%		May be considered for reimbursement upon submission of a prior authorization request that reflects a documented allergic reaction, adverse event, or an inadequate response after a minimum of a 14-day trial of another agent in this class within the past 30 days.
	Betaxolol HCl Ophth Soln 0.5%		
	Carteolol HCl Ophth Soln 1%	✓	
	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)		May be considered for reimbursement upon submission of a prior authorization request that reflects the injured worker is unable to use non-once daily formulation.
	Timolol Maleate Preservative Free Ophth Soln 0.25%		May be considered for reimbursement upon submission of a prior authorization request that reflects the injured worker is unable to use non-preservative free.
	Timolol Maleate Preservative Free Ophth Soln 0.5%		
	Timolol Ophth Soln 0.25%		May be considered for reimbursement upon submission of a prior authorization request that reflects a documented allergic reaction, adverse event, or an inadequate response after a minimum of a 14-day trial of another agent in this class within the past 30 days.
	Timolol Ophth Soln 0.5%		
Ophthalmic Beta-blocker Combinations	Brimonidine Tartrate-Timolol Maleate Ophth Soln 0.2-0.5%	✓	
	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	✓	
Ophthalmic Carbonic Anhydrase Inhibitors	Brinzolamide Ophth Susp 1%	✓	
	Dorzolamide HCl Ophth Soln 2%	✓	
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 5%	✓	
Ophthalmic Decongestants	Naphazoline w/ Pheniramine Ophth Soln 0.025-0.3%	✓	
Ophthalmic Hyperosmolar Products	Sodium Chloride Hypertonic Ophth Oint 5%	✓	
	Sodium Chloride Hypertonic Ophth Soln 2%	✓	
	Sodium Chloride Hypertonic Ophth Soln 5%	✓	
Ophthalmic Immunomodulators	Cyclosporine (Ophth) Emulsion 0.05%	✓	
Ophthalmic Integrin Antagonists	Lifitegrast Ophth Soln 5%	✓	
Ophthalmic Miotics	Pilocarpine HCl Ophth Soln 1%	✓	
	Pilocarpine HCl Ophth Soln 2%	✓	
	Pilocarpine HCl Ophth Soln 4%	✓	
Ophthalmic Nonsteroidal Anti-inflammatory	Bromfenac Sodium Ophth Soln 0.07%		
	Bromfenac Sodium Ophth Soln 0.09% (Once Daily)		
	Diclofenac Sodium Ophth Soln 0.1%		
	Flurbiprofen Sodium Ophth Soln 0.03%		
	Ketorolac Tromethamine Ophth Soln 0.4%		
	Ketorolac Tromethamine (PF) Ophth Soln 0.45%		
	Ketorolac Tromethamine Ophth Soln 0.5%		
	Nepafenac Ophth Susp 0.1%		
Ophthalmic Prostaglandins	Bimatoprost Ophth Soln 0.01%		May be considered for reimbursement upon submission of a prior authorization request that reflects a documented allergic reaction, adverse event, or an inadequate response after a minimum of a 14-day trial of another agent in this class within the past 30 days.
	Latanoprost Ophth Soln 0.005%	✓	
	Travoprost Ophth Soln 0.004% (Benzalkonium Free) (BAK Free)		May be considered for reimbursement upon submission of a prior authorization request that reflects the injured worker is unable to use non-BAK Free.
Ophthalmic Steroids	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%		
	Loteprednol Etabonate Ophth Gel 0.5%		
	Loteprednol Etabonate Ophth Oint 0.5%		
	Loteprednol Etabonate Ophth Susp 0.2%		
	Loteprednol Etabonate Ophth Susp 0.5%		
	Prednisolone Acetate Ophth Susp 0.12%		
	Prednisolone Acetate Ophth Susp 1%		
	Prednisolone Sodium Phosphate Ophth Soln 1%		
Ophthalmic Steroid Combinations	Bacitracin-Polymyxin-Neomycin-HC Ophth Oint 1%		
	Gentamicin-Prednisolone Ace Ophth Susp 0.3-1%		
	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		
	Sulfacetamide Sodium-Prednisolone Ophth Oint 10-0.2%		

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

Medication Class Name	Medication Generic Name	Allowed Condition Needed	Reimbursement restrictions or limitations for specific medications or dosage forms are listed with the respective medications below.
	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%		
Ophthalmic Sulfonamides	Sulfacetamide Sodium Ophth Soln 10%		
Opioid Agonists – Immediate Release	ALL Opioid Immediate Release products		Immediate Release Opioid Dose Formulations Restrictions: - Reimbursement of any immediate release opioid in an opioid naïve (no opioid use in the last 108 days) injured worker is limited to seven (7) days of coverage or 30 units, whichever is less. - Reimbursement limited to six (6) tablets per day for any immediate release opioid unless otherwise noted in this appendix. - Prior authorization (PA) may be submitted to request to exceed the initial coverage limitations for: post-operative situations, or, if the injured worker is not opioid naïve, as verified by a prescription drug monitoring program (PDMP). - PA may be submitted to request use of more than one immediate release opioid agent for post-operative situations only. - PA may be submitted to request use of two (2) different strengths of the same immediate release opioid agent. - Claims in which this quantity limit was exceeded prior to January 1, 2017 and has been continuously reimbursed since then may continue to be reimbursed, but reimbursement is limited to the last quantity prescribed before that date or lower.
	Butorphanol Tartrate Nasal Soln 10 MG/ML		May be considered for reimbursement upon submission of a prior authorization request that reflects a documented allergic reaction or inadequate response of nonopioid analgesics and opioid combination products.
	Codeine Sulfate Tab 15 MG		
	Codeine Sulfate Tab 30 MG		
	Codeine Sulfate Tab 60 MG		
	Fentanyl Citrate Buccal Tab 100 MCG		Reimbursement is limited to claims in which the injured worker has an allowed condition of cancer.
	Fentanyl Citrate Buccal Tab 200 MCG		
	Fentanyl Citrate Buccal Tab 400 MCG		
	Fentanyl Citrate Buccal Tab 600 MCG		
	Fentanyl Citrate Buccal Tab 800 MCG		
	Fentanyl Citrate Lozenge on a Handle 200 MCG		
	Fentanyl Citrate Lozenge on a Handle 400 MCG		
	Fentanyl Citrate Lozenge on a Handle 600 MCG		
	Fentanyl Citrate Lozenge on a Handle 800 MCG		
	Fentanyl Citrate Lozenge on a Handle 1200 MCG		
	Fentanyl Citrate Lozenge on a Handle 1600 MCG		
	Hydromorphone HCl Liqd 1 MG/ML		
	Hydromorphone HCl Suppos 3 MG		
	Hydromorphone HCl Tab 2 MG		
	Hydromorphone HCl Tab 4 MG		
	Hydromorphone HCl Tab 8 MG		
	Meperidine HCl Oral Soln 50 MG/5ML		
	Meperidine HCl Tab 50 MG		
	Morphine Sulfate Oral Soln 10 MG/5ML		Reimbursement is limited to 400 MG per day.
	Morphine Sulfate Oral Soln 20 MG/5ML		
	Morphine Sulfate Oral Soln 100 MG/5ML (20 MG/ML)		
	Morphine Sulfate Tab 15 MG		
	Morphine Sulfate Tab 30 MG		
	Oxycodone HCl Cap 5 MG		
	Oxycodone HCl Conc 100 MG/5ML (20 MG/ML)		
	Oxycodone HCl Soln 5 MG/5ML		
	Oxycodone HCl Tab 5 MG		
	Oxycodone HCl Tab 10 MG		
	Oxycodone HCl Tab 15 MG		
	Oxycodone HCl Tab 20 MG		
	Oxycodone HCl Tab 30 MG		
	Oxymorphone HCl Tab 5 MG		
	Oxymorphone HCl Tab 10 MG		
	Pentazocine w/ Naloxone Tab 50-0.5 MG		May be considered for reimbursement upon submission of a prior authorization request that reflects a documented allergic reaction or inadequate response of nonopioid analgesics and opioid combination products.
	Tapentadol HCl Tab 50 MG		Reimbursement is limited to 600 MG per day and will not be reimbursed concurrently with sustained release tapentadol products.
	Tapentadol HCl Tab 75 MG		
	Tapentadol HCl Tab 100 MG		
	Tramadol HCl Tab 50 MG		Reimbursement is limited to 400 MG per day.
Opioid Agonists – Sustained Release	ALL Opioid Sustained Release products		Sustained Release Opioid Dosage Form Class Restrictions: - Treatment with multiple sustained release opioids (including methadone) will not be covered. - Duplicate use of any sustained release opioid with any parenteral pain management medication(s) (e.g., IM, SC, IV, IT analgesic medications) will not be covered. - Treatment with sustained release opioids for post-operative conditions will not be covered unless the injured worker was being treated with the drug prior to surgery.
	Buprenorphine HCl Buccal Film 75 MCG		Tier 1 sustained release opioid.
	Buprenorphine HCl Buccal Film 150 MCG		Reimbursement is limited to two (2) films per day.

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

Medication Class Name	Medication Generic Name	Allowed Condition Needed	Reimbursement restrictions or limitations for specific medications or dosage forms are listed with the respective medications below.
	Buprenorphine HCl Buccal Film 300 MCG		- Will not be reimbursed concurrently with any other sustained release opioid or opioid partial agonist. - This product will not be covered in the post-operative period unless routinely prescribed pre-operatively.
	Buprenorphine HCl Buccal Film 450 MCG		
	Buprenorphine HCl Buccal Film 600 MCG		
	Buprenorphine HCl Buccal Film 750 MCG		
	Buprenorphine HCl Buccal Film 900 MCG		
	Buprenorphine TD Patch Weekly 5 MCG/HR		Tier 1 sustained release opioid. - Reimbursement is limited to a maximum quantity of four (4) patches per 28 days. - Reimbursement will not be permitted for this product concurrently with any other sustained release opioid or opioid partial agonist.
	Buprenorphine TD Patch Weekly 7.5 MCG/HR		
	Buprenorphine TD Patch Weekly 10 MCG/HR		
	Buprenorphine TD Patch Weekly 15 MCG/HR		
	Buprenorphine TD Patch Weekly 20 MCG/HR		
	Fentanyl TD Patch 72HR 12 MCG/HR		Tier 2 sustained release opioid. - Reimbursement restricted to 10 patches every 30 days (every 72-hour dosing). - PA may be submitted to show documented allergic reaction to or inadequate response to at least two (2) Tier 1 sustained release opioids or a documented inability to swallow or absorb oral medications. - PA may be submitted for 15 patches every 30 days (every 48-hour dosing) if documentation supports clinical failure of 10 patches every 30 days (72-hour dosing interval) and evidence of an escalation of the dose before a reduction in frequency. - PA may be submitted for concurrent use of the 12 MCG/HR and 25 MCG/HR patches.
	Fentanyl TD Patch 72HR 25 MCG/HR		
	Fentanyl TD Patch 72HR 50 MCG/HR		
	Fentanyl TD Patch 72HR 75 MCG/HR		
	Fentanyl TD Patch 72HR 100 MCG/HR		
	Hydrocodone Bitartrate Tab ER 24HR Deter 20 MG		Tier 1 sustained release opioid. Reimbursement is limited to one (1) tablet per day.
	Hydrocodone Bitartrate Tab ER 24HR Deter 30 MG		
	Hydrocodone Bitartrate Tab ER 24HR Deter 40 MG		
	Hydrocodone Bitartrate Tab ER 24HR Deter 60 MG		
	Hydrocodone Bitartrate Tab ER 24HR Deter 80 MG		
	Hydrocodone Bitartrate Tab ER 24HR Deter 100 MG		Tier 3 sustained release opioid. - Reimbursement is limited to one (1) tablet per day. - Prior authorization may be submitted to show documented allergic reaction to or inadequate response to at least two (2) Tier 2 sustained release opioids. - Claims in which this dose limitation was exceeded prior to January 1, 2017 and has been continuously reimbursed since then may continue to be reimbursed, but reimbursement is limited to the last quantity prescribed before that date or lower.
	Hydrocodone Bitartrate Tab ER 24HR Deter 120 MG		
	Hydromorphone HCl Tab ER 24HR Deter 8 MG		
	Hydromorphone HCl Tab ER 24HR Deter 12 MG		
	Hydromorphone HCl Tab ER 24HR Deter 16 MG		
	Hydromorphone HCl Tab ER 24HR Deter 32 MG		Tier 2 sustained release opioid. - All forms of methadone are considered sustained release opioids. - Reimbursement is limited to 90 MG per day. - PA may be submitted to show documented allergic reaction to or inadequate response to at least two (2) Tier 1 sustained release opioids.
	Methadone HCl Tab 5 MG		
	Methadone HCl Tab 10 MG		
	Methadone HCl Soln 5 MG/5ML		
	Methadone HCl Soln 10 MG/5ML		
	Morphine Sulfate Tab ER 15 MG		Tier 1 sustained release opioid Reimbursement is limited to three (3) tablets per day all strengths except 200 MG, which is limited to two (2) tablets per day. PA is required for reimbursement for any doses above this level.
	Morphine Sulfate Tab ER 30 MG		
	Morphine Sulfate Tab ER 60 MG		
	Morphine Sulfate Tab ER 100 MG		
	Morphine Sulfate Tab ER 200 MG		
	Oxycodone Cap ER 12hr Abuse-Deterrent 27 Mg		Tier 4 sustained release opioid. - Reimbursement is limited to two (2) tablets per day. - PA may be submitted to show documented allergic reaction to or inadequate response to at least two (2) Tier 3 sustained release opioids.
	Oxycodone Cap ER 12hr Abuse-Deterrent 13.5 Mg		
	Oxycodone Cap ER 12hr Abuse-Deterrent 9 Mg		
	Oxycodone Cap ER 12hr Abuse-Deterrent 36 Mg		
	Oxycodone Cap ER 12hr Abuse-Deterrent 18 Mg		
	Oxymorphone HCl Tab ER 12HR 5 MG		Tier 3 sustained release opioid - Reimbursement is limited to two (2) tablets per day. - Prior authorization may be submitted to show documentation of allergic reaction to or inadequate response to at least two (2) Tier 2. - Claims in which this dose limitation was exceeded prior to January 1, 2017 and has been continuously reimbursed since then may continue to be reimbursed, but reimbursement is limited to the last quantity prescribed before that date or lower.
	Oxymorphone HCl Tab ER 12HR 7.5 MG		
	Oxymorphone HCl Tab ER 12HR 10 MG		
	Oxymorphone HCl Tab ER 12HR 15 MG		
	Oxymorphone HCl Tab ER 12HR 20 MG		
	Oxymorphone HCl Tab ER 12HR 30 MG		
	Oxymorphone HCl Tab ER 12HR 40 MG		
	Tapentadol HCl Tab ER 12HR 50 MG		Tier 2 sustained release opioid - Reimbursement is limited to 500 MG per day. - Will not be reimbursed concurrently with immediate release tapentadol products. - PA may be submitted to show documented allergic reaction to or inadequate response to at least two (2) Tier 1 sustained release opioids.
	Tapentadol HCl Tab ER 12HR 100 MG		
	Tapentadol HCl Tab ER 12HR 150 MG		
	Tapentadol HCl Tab ER 12HR 200 MG		
	Tapentadol HCl Tab ER 12HR 250 MG		
	Tramadol HCl Tab ER 24HR 100 MG		Tier 1 sustained release opioid Reimbursement is limited to 300 MG per day.
	Tramadol HCl Tab ER 24HR 200 MG		
	Tramadol HCl Tab ER 24HR 300 MG		
	Tramadol HCl Tab ER 24HR Biphasic Release 100 MG		
	Tramadol HCl Tab ER 24HR Biphasic Release 200 MG		

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

Medication Class Name	Medication Generic Name	Allowed Condition Needed	Reimbursement restrictions or limitations for specific medications or dosage forms are listed with the respective medications below.
	Tramadol HCl Tab ER 24HR Biphasic Release 300 MG		
Opioid Combinations	ALL Opioid combination products		Immediate Release Opioid Dose Formulations Restrictions: - Reimbursement of any immediate release opioid in an opioid naïve (no opioid use in the last 108 days) injured worker will be limited to seven (7) days of coverage or 30 doses, whichever is less. - Reimbursement is limited to six (6) doses per day for any immediate release opioid unless otherwise noted in this appendix. - Prior Authorization (PA) may be submitted to request to exceed the initial coverage limitations for: post-operative situations, or if the IW is not opioid naïve, as verified by a prescription drug monitoring program (PDMP). - PA may be submitted to request use of more than one (1) immediate release combination opioid agent for post-operative situations only. - Acetaminophen content may not exceed four (4) grams per day. - Claims in which this quantity limit was exceeded prior to January 1, 2017 and has been continuously reimbursed since then may continue to be reimbursed, but reimbursement is limited to the last quantity prescribed before that date or lower.
	Acetaminophen w/ Codeine Soln 120-12 MG/5ML		
	Acetaminophen w/ Codeine Tab 300-15 MG		
	Acetaminophen w/ Codeine Tab 300-30 MG		
	Acetaminophen w/ Codeine Tab 300-60 MG		
	Butalbital-Acetaminophen-Caff w/ COD Cap 50-325-40-30 MG	✓	Reimbursement is limited to four (4) grams of acetaminophen per day or 24 doses per 30 days and is restricted to only those claims in which headache is related to an allowed condition in the claim.
	Butalbital-Aspirin-Caff w/ Codeine Cap 50-325-40-30 MG	✓	
	Hydrocodone-Acetaminophen Tab 5-325 MG		
	Hydrocodone-Acetaminophen Tab 7.5-325 MG		
	Hydrocodone-Acetaminophen Tab 10-325 MG		
	Hydrocodone-Acetaminophen Soln 7.5-325 MG/15ML		Reimbursement is limited to 180 ML/ day (4 grams/day of acetaminophen).
	Hydrocodone-Acetaminophen Soln 10-325 MG/15ML		
	Hydrocodone-Ibuprofen Tab 5-200 MG		Reimbursement is limited to five (5) tablets per day.
	Hydrocodone-Ibuprofen Tab 7.5-200 MG		
	Hydrocodone-Ibuprofen Tab 10-200 MG		
	Oxycodone w/ Acetaminophen Tab 2.5-325 MG		
	Oxycodone w/ Acetaminophen Tab 5-325 MG		
	Oxycodone w/ Acetaminophen Tab 7.5-325 MG		
	Oxycodone w/ Acetaminophen Tab 10-325 MG		
	Oxycodone-Aspirin Tab 4.8355-325 MG		
	Tramadol-Acetaminophen Tab 37.5-325 MG		
Opioid Antagonists	Naloxone HCl Nasal Spray 4 MG/0.1ML		Reimbursement is limited to claims in which a prior authorization request or prescription history look-back has documented that BWC is currently or has recently been reimbursing for opioid drugs.
	Naltrexone HCl Tab 50 MG		Reimbursement is limited to claims with an allowed condition of opioid use disorder or as part of approved treatment under OAC 4123-6-21.8.
	Naltrexone IM Extended Release Susp 380 MG		Reimbursement is limited to claims with an allowed condition of opioid use disorder or as part of approved treatment under OAC 4123-6-21.8.
Otic Agents – Misc.	Acetic Acid Otic Soln 2%	✓	
Otic Combinations	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 500 MG (Elemental)	✓	
	Lanthanum Carbonate Chew Tab 750 MG (Elemental)	✓	
	Lanthanum Carbonate Chew Tab 1000 MG (Elemental)	✓	
	Lanthanum Carbonate Oral Powder Pack 750 MG (Elemental)	✓	
	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 ER 12HR 25-200 MG	✓	
	Cilostazol Tab 50 MG	✓	
	Cilostazol Tab 100 MG	✓	
	Clopidogrel Bisulfate Tab 75 MG (Base Equiv)	✓	
	Prasugrel HCl Tab 10 MG (Base Equiv)	✓	
	Ticagrelor Tab 90 MG	✓	
Postherpetic Neuralgia (PHN)/Neuropathic Pain Agents	Gabapentin (Once-Daily) Tab 300 MG		Gabapentin Extended-Release product class restriction: Gabapentin Extended-Release products may be considered for reimbursement upon submission of a prior authorization request that reflects a minimum of a 90-day trial and documented inadequate response of the immediate release form of gabapentin within the past 120 days.

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

Medication Class Name	Medication Generic Name	Allowed Condition Needed	Reimbursement restrictions or limitations for specific medications or dosage forms are listed with the respective medications below.
	Gabapentin (Once-Daily) Tab 600 MG		Coverage of all gabapentin products is restricted to a single form at any one time. Claims in which an extended-release gabapentin product was approved prior to February 1, 2023 and has been continuously reimbursed since then are not subject to the 90-day trial and failure of immediate release gabapentin. Reimbursement is limited to 1,800 MG/day.
Potassium Removing Agents	Sodium Polystyrene Sulfonate Oral Susp 15 GM/60ML	✓	
	Sodium Polystyrene Sulfonate Powder	✓	
Endocrine – Progestins	Medroxyprogesterone Acetate Tab 10 MG	✓	
	Megestrol Acetate Susp 625 MG/5ML	✓	
Prostatic Hypertrophy Agents	Alfuzosin HCl Tab ER 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	✓	
Rectal – Intrarectal Steroids	Hydrocortisone Enema 100 MG/60ML	✓	
Rectal – Local Anesthetics	Dibucaine Perianal Ointment 1%		
	Hydrocortisone Acetate w/ Pramoxine Perianal Cream 1-1%	✓	
	Hydrocortisone Acetate w/ Pramoxine Perianal Cream 2.5-1%	✓	
	Hydrocortisone Acetate w/ Pramoxine Perianal Foam 1-1%	✓	
	Lidocaine Anorectal Cream 5%		
	Lidocaine Anorectal Gel 5%		
	Lidocaine-Hydrocortisone Acetate Perianal Cream 3-0.5%	✓	
	Phenylephrine-Mineral Oil-Petrolatum Oint 0.25-14-71.9%		
	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 Perianal Foam 1%		
	Pramox-PE-Glycerin-Petrolatum Perianal Cream 1-0.25-14.4-15%		
Rectal – Steroids	Hydrocortisone Rectal Perianal 1%	✓	
	Hydrocortisone Rectal Perianal 2.5%	✓	
Respiratory – Antiasthmatic – Monoclonal Antibodies	Benralizumab Subcutaneous Soln Auto-injector 30 MG/ML		May be considered for reimbursement as add-on maintenance treatment upon submission of a prior authorization request that reflects: 1. Asthma as an allowed condition 2. Inadequate control of asthma after at least three (3) months of use of an inhaled corticosteroid plus a long-acting beta-agonist, or an inhaled corticosteroid plus a long-acting muscarinic antagonist 3. A peripheral eosinophil count greater than or equal to 300 cells/mcL in the past 12 months. Initial approval will be no greater than six (6) months, and subsequent requests may be considered if there is a documented decrease in exacerbations, improvement in pulmonary function tests, improvement in symptoms, or decrease in utilization of rescue medications.
	Benralizumab Subcutaneous Soln Prefilled Syringe 30 MG/ML		
	Omalizumab For Inj 150 MG		May be considered for reimbursement upon submission of a prior authorization request that reflects: 1. Asthma as an allowed condition 2. A positive skin test or specific IgE 3. Inadequate control of asthma after at least three (3) months of use of an inhaled corticosteroid Initial approval will be no greater than six (6) months, and subsequent requests may be considered if there is a documented decrease in exacerbations, improvement in pulmonary function tests, improvement in symptoms, or decrease in utilization of rescue medications.
	Dupilumab Subcutaneous Soln Pen-injector 300 MG/2ML		May be considered for reimbursement upon submission of a prior authorization request that reflects: 1. Asthma is an allowed condition 2. Inadequate control of asthma after at least three (3) months of use of an inhaled corticosteroid plus a long-acting beta-agonist, or an inhaled corticosteroid plus a long-acting muscarinic antagonist 3. A peripheral eosinophil count greater than or equal to 300 cells/mcL within the past 12 months. Initial approval will be no greater than six (6) months and subsequent requests may be considered if there is a documented decrease in exacerbations, improvement in pulmonary function tests, improvement in symptoms, or decrease in utilization of rescue medications.
	Dupilumab Subcutaneous Soln Prefilled Syringe 300 MG/2ML		
Respiratory – Anticholinergics	Acclidinium Bromide Aerosol Powd Breath Activated 400 MCG/ACT	✓	

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

Medication Class Name	Medication Generic Name	Allowed Condition Needed	Reimbursement restrictions or limitations for specific medications or dosage forms are listed with the respective medications below.
	Glycopyrrolate Inhal Cap 15.6 MCG	✓	
	Glycopyrrolate Inhal Solution 25 MCG/ML	✓	
	Ipratropium Bromide HFA Inhal Aerosol 17 MCG/ACT	✓	
	Ipratropium Bromide Inhal Soln 0.02%	✓	
	Tiotropium Bromide Monohydrate Inhal Aerosol 1.25 MCG/ACT		May be considered for reimbursement upon submission of a prior authorization request that reflects a documented allergic reaction, adverse event, or an inadequate response after a minimum of a 30-day trial of another agent in this class within the past 120 days.
	Tiotropium Bromide Monohydrate Inhal Aerosol 2.5 MCG/ACT		
	Tiotropium Bromide Monohydrate Inhal Cap 18 MCG		
Respiratory – Leukotriene Modulators	Umeclidinium Br Aero Powd Breath Act 62.5 MCG/INH	✓	
	Montelukast Sodium Chew Tab 5 MG	✓	
	Montelukast Sodium Tab 10 MG	✓	
	Zafirlukast Tab 20 MG	✓	
	Zileuton Tab ER 12HR 600 MG		May be considered for reimbursement upon submission of a prior authorization request that reflects a documented allergic reaction, adverse event, or an inadequate response after a minimum of a 60-day trial of another agent in this class within the past 120 days.
Respiratory – Selective Phosphodiesterase 4 (PDE4) Inhibitors	Roflumilast Tab 250 MCG	✓	
	Roflumilast Tab 500 MCG	✓	
Respiratory – Steroid Inhalants	Beclomethasone Diprop HFA Breath Act Inh Aer 40 MCG/ACT	✓	
	Beclomethasone Diprop HFA Breath Act Inh Aer 80 MCG/ACT	✓	
	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	✓	
	Ciclesonide Inhal Aerosol 80 MCG/ACT	✓	
	Ciclesonide Inhal Aerosol 160 MCG/ACT	✓	
	Fluticasone Furoate Aerosol Powder Breath Activ 100 MCG/ACT	✓	
	Fluticasone Furoate Aerosol Powder Breath Activ 200 MCG/ACT	✓	
	Fluticasone Propionate Aer Pow BA 50 MCG/BLISTER	✓	
	Fluticasone Propionate Aer Pow BA 100 MCG/BLISTER	✓	
	Fluticasone Propionate Aer Pow BA 250 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 50 MCG/ACT	✓	
	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)		May be considered for reimbursement upon submission of a prior authorization request that reflects a documented allergic reaction, adverse event, inability to use, or an inadequate response after a minimum of a 14-day trial of another agent in this class within the past 60 days.
	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	✓	
	Albuterol Sulfate Soln Nebu 1.25 MG/3ML	✓	
	Albuterol Sulfate Syrup 2 MG/5ML	✓	
	Albuterol Sulfate Tab 2 MG	✓	
	Albuterol Sulfate Tab 4 MG	✓	
	Albuterol Sulfate Tab ER 12HR 4 MG	✓	
	Albuterol Sulfate Tab ER 12HR 8 MG	✓	
	Arformoterol Tartrate Soln Nebu 15 MCG/2ML	✓	
	Budesonide-Formoterol Fumarate Dihyd Aerosol 80-4.5 MCG/ACT	✓	
	Budesonide-Formoterol Fumarate Dihyd Aerosol 160-4.5 MCG/ACT	✓	
	Fluticasone Furoate-Vilanterol Aero Powd BA 100-25 MCG/INH	✓	
	Fluticasone Furoate-Vilanterol Aero Powd BA 200-25 MCG/INH	✓	
	Fluticasone-Salmeterol Aer Powder BA 55-14 MCG/ACT	✓	
	Fluticasone-Salmeterol Aer Powder BA 113-14 MCG/ACT	✓	
	Fluticasone-Salmeterol Aer Powder BA 100-50 MCG/DOSE	✓	
	Fluticasone-Salmeterol Aer Powder BA 232-14 MCG/ACT	✓	

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

Medication Class Name	Medication Generic Name	Allowed Condition Needed	Reimbursement restrictions or limitations for specific medications or dosage forms are listed with the respective medications below.
	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	✓	
	Fluticasone-Umeclidinium-Vilanterol AEPB 100-62.5-25 MCG/INH		May be considered for reimbursement upon submission of a prior authorization that reflects a documented allergic reaction or inadequate response to at least two (2) other medications in this class other than short-acting beta agonist products.
	Fluticasone-Umeclidinium-Vilanterol AEPB 200-62.5-25 MCG/INH		
	Formoterol Fumarate Soln Nebu 20 MCG/2ML	✓	
	Glycopyrrolate-Formoterol Fumarate Aerosol 9-4.8 MCG/ACT	✓	
	Indacaterol-Glycopyrrolate Inhal Cap 27.5-15.6 MCG	✓	
	Indacaterol Maleate Inhal Powder Cap 75 MCG	✓	
	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	✓	
	Levalbuterol HCl Soln Nebu 0.63 MG/3ML	✓	
	Levalbuterol HCl Soln Nebu 1.25 MG/3ML	✓	
	Levalbuterol HCl Soln Nebu Conc 1.25 MG/0.5ML	✓	
	Levalbuterol Tartrate Inhal Aerosol 45 MCG/ACT	✓	
	Mometasone Furoate-Formoterol Fumarate Aerosol 100-5 MCG/ACT	✓	
	Mometasone Furoate-Formoterol Fumarate Aerosol 200-5 MCG/ACT	✓	
	Olodaterol HCl Inhal Aerosol Soln 2.5 MCG/ACT	✓	
	Racpinephrine HCl Soln Nebu 2.25%	✓	
	Salmeterol Xinafoate Aer Pow BA 50 MCG/DOSE	✓	
	Terbutaline Sulfate Tab 2.5 MG	✓	
	Terbutaline Sulfate Tab 5 MG	✓	
	Tiotropium Br-Olodaterol Inhal Aero Soln 2.5-2.5 MCG/ACT		May be considered for reimbursement upon submission of a prior authorization request that reflects a documented allergic reaction or inadequate response to at least one (1) other medication in this class other than short-acting beta agonist products.
	Umeclidinium-Vilanterol Aero Powd BA 62.5-25 MCG/INH		
Respiratory – Xanthines	Theophylline Cap ER 24HR 100 MG	✓	
	Theophylline Cap ER 24HR 200 MG	✓	
	Theophylline Cap ER 24HR 300 MG	✓	
	Theophylline Cap ER 24HR 400 MG	✓	
	Theophylline Tab ER 12HR 300 MG	✓	
	Theophylline Tab ER 24HR 400 MG	✓	
	Theophylline Tab ER 24HR 600 MG	✓	
Respiratory Inhalants – Misc.	Sodium Chloride Aero Soln 0.9%	✓	
	Sodium Chloride Soln Nebu 0.9%		
	Sodium Chloride Soln Nebu 3%		
Restless Leg Syndrome (RLS) Agents	Gabapentin Enacarbil Tab ER 300 MG		Gabapentin Extended-Release products may be considered for reimbursement upon submission of a prior authorization request that reflects a minimum of a 90-day trial and documented inadequate response of the immediate release form of gabapentin within the past 120 days. Coverage of all gabapentin products is restricted to a single form at any one time. Claims in which an extended-release gabapentin product was approved prior to February 1, 2023 and has been continuously reimbursed since then are not subject to the 90-day trial and failure of immediate release gabapentin. Reimbursement is limited to 1,200 MG/day.
	Gabapentin Enacarbil Tab ER 600 MG		
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 325 MG		
	Aspirin Tab 500 MG		
	Aspirin Tab Delayed Release 81 MG		
	Aspirin Tab Delayed Release 325 MG		
	Aspirin Tab Delayed Release 500 MG		
	Diflunisal Tab 500 MG		
	Salsalate Tab 500 MG		
	Salsalate Tab 750 MG		
Sympathomimetic Decongestants	Oxymetazoline HCl Nasal Gel 0.05%	✓	Reimbursement is limited to one (1) package per 30 days.
	Oxymetazoline HCl Nasal Soln 0.05%	✓	
	Phenylephrine HCl Tab 10 MG	✓	Reimbursement is limited to 60 MG per day.
	Pseudoephedrine HCl Tab 30 MG	✓	Reimbursement is limited to 240 MG per day.
	Pseudoephedrine HCl Tab 60 MG	✓	
	Pseudoephedrine HCl Tab ER 12HR 120 MG	✓	
	Pseudoephedrine HCl Tab ER 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	✓	

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

Medication Class Name	Medication Generic Name	Allowed Condition Needed	Reimbursement restrictions or limitations for specific medications or dosage forms are listed with the respective medications below.
Topical – Agents for External Genital and Perianal Warts	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 162.5 MG (2 1/2 Grain)	✓	
	Sinecatechins Oint 15%	✓	
Topical – Analgesics	Menthol Aerosol 10.5%		
	Menthol Aerosol Powder 1%		
	Menthol Cream 7.5%		
	Menthol Cream 16%		
	Menthol Gel 2%		
	Menthol Gel 2.5%		
	Menthol Gel 3.1%		
	Menthol Gel 3.5%		
	Menthol Gel 3.7%		
	Menthol Gel 4%		
	Menthol Gel 4.5%		
	Menthol Gel 5%		
	Menthol Gel 5.5%		
	Menthol Gel 6%		
	Menthol Gel 7%		
	Menthol Gel 10%		
	Menthol Gel 16%		
	Menthol Liquid 2.5%		
	Menthol Liquid 3.5%		
	Menthol Liquid 3.7%		
	Menthol Liquid 8%		
	Menthol Liquid 10%		
	Menthol Liquid 16%		
	Menthol Lotion 0.1%		
	Menthol Lotion 7.5%		
	Menthol Lotion 8.5%		
	Menthol Patch 5%		
	Menthol Patch 7.5%		
	Menthol Roll 7.5%		
	Menthol Sleeve 16%		
Topical – Antibiotics	Bacitracin Oint 500 Unit/GM		
	Bacitracin Zinc Oint 500 Unit/GM		
	Bacitracin-Polymyxin B Oint		
	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%		
	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%	✓	
	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%	✓	
	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 100000 Unit/GM	✓	
	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%	✓	
	Tolnaftate Aerosol Pow 1%	✓	

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

Medication Class Name	Medication Generic Name	Allowed Condition Needed	Reimbursement restrictions or limitations for specific medications or dosage forms are listed with the respective medications below.
	Tolnaftate Cream 1%	✓	
	Tolnaftate Powder 1%	✓	
	Tolnaftate Soln 1%	✓	
Topical – Antihistamines	Diphenhydramine HCl Cream 2%		
Topical – Anti-inflammatory Agents	Diclofenac Sodium Gel 1% (1.16% Diethylamine Equiv)		
	Diclofenac Sodium Soln 1.5%	✓	May be reimbursed in claims with osteoarthritis of the knee as an allowed condition.
	Diclofenac Epolamine Patch 1.3%		May be considered for reimbursement upon submission of a prior authorization request that reflects a contraindication, intolerance, or clinical failure to at least two (2) other non-steroidal anti-inflammatory drugs on the formulary. Reimbursement is limited to the first 12 weeks following the date of injury and may not exceed two (2) patches per day. Will not be reimbursed concurrently with other non-steroidal anti-inflammatory drugs.
Topical – Antineoplastic or Premalignant Lesion Agents	Diclofenac Sodium (Actinic Keratosis) Gel 3%	✓	May be reimbursed in claims with Actinic Keratosis as an allowed condition.
	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%		May be considered for reimbursement upon submission of a prior authorization request with documented medical justification.
Topical – Antivirals	Acyclovir Cream 5%	✓	
	Acyclovir Oint 5%	✓	
	Penciclovir Cream 1%	✓	
Topical – Burn Products	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 Very High Potency	Betamethasone Dipropionate Augmented Gel 0.05%	✓	Reimbursement is only permitted when prescribed for an allowed dermatological condition. Topical corticosteroids will not be approved for the treatment of pain.
	Betamethasone Dipropionate Augmented Lotion 0.05%	✓	
	Betamethasone Dipropionate Augmented Oint 0.05%	✓	
	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%	✓	
	Diflorasone Diacetate Oint 0.05%	✓	
	Fluocinonide Cream 0.1%	✓	
	Flurandrenolide Tape 4 MCG/SQCM	✓	
	Halobetasol Propionate Cream 0.05%	✓	
	Halobetasol Propionate Oint 0.05%	✓	
Topical – Corticosteroids High Potency	Amcinonide Cream 0.1%	✓	Reimbursement is only permitted when prescribed for an allowed dermatological condition. Topical corticosteroids will not be approved for the treatment of pain.
	Amcinonide Oint 0.1%	✓	
	Betamethasone Dipropionate Augmented Cream 0.05%	✓	
	Betamethasone Dipropionate Oint 0.05%	✓	
	Calcipotriene-Betamethasone Dipropionate Foam 0.005-0.064%	✓	
	Calcipotriene-Betamethasone Dipropionate Oint 0.005-0.064%	✓	
	Desoximetasone Cream 0.25%	✓	
	Desoximetasone Gel 0.05%	✓	
	Desoximetasone Oint 0.25%	✓	
	Diflorasone Diacetate Cream 0.05%	✓	
	Diflorasone Diacetate Emollient Base Cream 0.05%	✓	
	Fluocinonide Cream 0.05%	✓	
	Fluocinonide Gel 0.05%	✓	
	Fluocinonide Oint 0.05%	✓	
	Fluocinonide Soln 0.05%	✓	
	Halcinonide Cream 0.1%	✓	
	Halcinonide Oint 0.1%	✓	
	Mometasone Furoate Oint 0.1%	✓	
	Triamcinolone Acetonide Cream 0.5%	✓	
	Triamcinolone Acetonide Oint 0.5%	✓	
Topical – Corticosteroids Medium Potency	Betamethasone Dipropionate Cream 0.05%	✓	Reimbursement is only permitted when prescribed for an allowed dermatological condition. Topical corticosteroids will not be approved for the treatment of pain.
	Betamethasone Dipropionate Lotion 0.05%	✓	
	Betamethasone Valerate Aerosol Foam 0.12%	✓	
	Betamethasone Valerate Cream 0.1% (Base Equivalent)	✓	
	Betamethasone Valerate Lotion 0.1% (Base Equivalent)	✓	
	Betamethasone Valerate Oint 0.1% (Base Equivalent)	✓	
	Clocortolone Pivalate Cream 0.1%	✓	
	Desoximetasone Cream 0.05%	✓	
	Fluocinolone Acetonide Cream 0.025%	✓	
	Fluocinolone Acetonide Oint 0.025%	✓	
	Fluocinolone Acetonide Shampoo 0.01%	✓	
	Fluocinonide Emulsified Base Cream 0.05%	✓	
	Flurandrenolide Cream 0.05%	✓	
	Fluticasone Propionate Cream 0.05%	✓	
	Fluticasone Propionate Lotion 0.05%	✓	

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

Medication Class Name	Medication Generic Name	Allowed Condition Needed	Reimbursement restrictions or limitations for specific medications or dosage forms are listed with the respective medications below.
	Fluticasone Propionate Oint 0.005%	✓	
	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 Probutate Cream 0.1%	✓	
	Hydrocortisone Valerate Cream 0.2%	✓	
	Hydrocortisone Valerate Oint 0.2%	✓	
	Mometasone Furoate Cream 0.1%	✓	
	Prednicarbate Oint 0.1%	✓	
	Triamcinolone Acetonide Aerosol Soln 0.147 MG/GM	✓	
	Triamcinolone Acetonide Cream 0.025%	✓	
	Triamcinolone Acetonide Cream 0.1%	✓	
	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%	✓	
Topical – Corticosteroids Low Potency	Alclometasone Dipropionate Cream 0.05%	✓	Reimbursement is only permitted when prescribed for an allowed dermatological condition. Topical corticosteroids will not be approved for the treatment of pain.
	Alclometasone Dipropionate Oint 0.05%	✓	
	Desonide Cream 0.05%	✓	
	Desonide Foam 0.05%	✓	
	Desonide Gel 0.05%	✓	
	Desonide Lotion 0.05%	✓	
	Desonide Oint 0.05%	✓	
	Fluocinolone Acetonide Cream 0.01%	✓	
	Fluocinolone Acetonide Oil 0.01% (Body Oil)	✓	
	Fluocinolone Acetonide Oil 0.01% (Scalp Oil)	✓	
	Fluocinolone Acetonide Soln 0.01%	✓	
	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%	✓	
	Mometasone Furoate Solution 0.1% (Lotion)	✓	
Topical – Emollient/Keratolytic Agents	Urea Lotion 10%		
Topical – Emollients	Emollient - Cream		
	Emollient - Lotion		
	Emollient - Ointment		
	Lactic Acid (Ammonium Lactate) Cream 12%		
	Lactic Acid (Ammonium Lactate) Lotion 12%		
	Lactic Acid (Ammonium Lactate) Lotion 5%		
	Vitamins A & D Oint		
Topical – Enzymes	Collagenase Oint 250 Unit/GM	✓	
Topical – Immunomodulating Agents	Imiquimod Cream 3.75%	✓	
	Imiquimod Cream 5%	✓	
	Pimecrolimus Cream 1%	✓	
	Tacrolimus Oint 0.1%	✓	
	Tacrolimus (Topical) Soln 0.1%		
Topical – Liniments	*Camphor-Eucalyptus-Menthol - Oint***		
	Camphor-Menthol-Capsicum Topical Patch 80-24-16 MG		
	Camphor-Menthol-Methyl Salicylate Cream 3-5-15%		
	Camphor-Menthol-Methyl Salicylate Cream 4-10-30%		
	Camphor-Menthol-Methyl Salicylate Gel 0.2-4-8%		
	Camphor-Menthol-Methyl Salicylate Gel 3.1-16-10%		
	Camphor-Menthol-Methyl Salicylate Liquid 4-10-30%		
	Camphor-Menthol-Methyl Salicylate Ointment 4-10-30%		
	Camphor-Menthol-Methyl Salicylate Topical Patch 1.2-5.7-6.3%		
	Capsaicin-Menthol-Methyl Salicylate Cream 0.025-1-12%		
	Capsaicin-Menthol-Methyl Salicylate Cream 0.035-10-25%		
	Liniments & Rubs - Cream		
	Liniments & Rubs - Gel		
	Liniments & Rubs - Lotion		
	Menthol-Camphor Cream 10-11%		
	Menthol-Camphor Cream 11-11%		
	Menthol-Camphor Cream 16-11%		
	Menthol-Camphor Gel 3-3%		
	Menthol-Camphor Gel 3.5-0.8%		
	Menthol-Camphor Lotion 16-4%		
	Menthol-Camphor Ointment 5.1-5.1%		
	Menthol-Camphor Patch 70-230 MG		
	Menthol-Methyl Salicylate Cream		
	Menthol-Methyl Salicylate Gel		
	Menthol-Methyl Salicylate Liquid		
	Menthol-Methyl Salicylate Lotion		
	Menthol-Methyl Salicylate Ointment		
	Menthol-Methyl Salicylate Patch		

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

Medication Class Name	Medication Generic Name	Allowed Condition Needed	Reimbursement restrictions or limitations for specific medications or dosage forms are listed with the respective medications below.
	Menthol-Methyl Salicylate Stick		
	Methyl Salicylate Lotion 10%		
	Trolamine Salicylate Cream 10%		
	Trolamine Salicylate Lotion 10%		
Topical – Local Anesthetics	Capsaicin Cream 0.025%		
	Capsaicin Cream 0.033%		
	Capsaicin Cream 0.035%		
	Capsaicin Cream 0.075%		
	Capsaicin Cream 0.1%		
	Capsaicin in Lidocaine Vehicle Cream 0.25%		
	Capsaicin Liquid 0.15%		
	Capsaicin Lotion 0.035%		
	Capsaicin Patch 0.025%		
	Capsaicin-Menthol Gel 0.025-10%		
	Capsaicin-Menthol Topical Patch 0.05-5%		
	Dibucaine Oint 1%		
	Ethyl Chloride Aerosol Spray		
	Lidocaine Cream 3%	✓	
	Lidocaine Cream 4%		
	Lidocaine Gel 4%		
	Lidocaine HCl Solution 4%		
	Lidocaine HCl Cream 3%		
	Lidocaine HCl Cream 4%		
	Lidocaine HCl Gel 2%	✓	
	Lidocaine HCl Gel 2.5%		
	Lidocaine HCl Gel 4%		
	Lidocaine HCl Urethral/Mucosal Gel 2%	✓	
	Lidocaine HCl Urethral/Mucosal Gel Prefilled Syringe 2%	✓	
	Lidocaine Oint 5%		May be considered for reimbursement upon submission of a prior authorization request that reflects a minimum of a 14-day trial and documented inadequate response of a lidocaine 4% topical product within the past 30 days. Claims in which lidocaine 5% ointment was covered in the 60 days prior to 10/1/2017 and has been continuously reimbursed since then are not subject to the 14-day trial and failure of a lidocaine 4% topical product.
	Lidocaine Patch 4%		
	Lidocaine Patch 5%		May be considered for reimbursement upon submission of a prior authorization request that reflects a minimum of a 14-day trial and documented inadequate response of lidocaine patch 4% within the past 30 days. Reimbursement is limited to one (1) patch per day.
	Lidocaine-Prilocaine Cream 2.5-2.5%		
	Pentafluoropropane-Tetrafluoroethane Aero Spray		
	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 Soln 20%	✓	
	Aluminum Hydroxide Oint		
	Benzoin Tincture		
	Corn Starch Topical Powder		
	Dimethicone Cream 1%		
	Dimethicone-Petrolatum Cream 3-30%		
	Lanolin-Petrolatum Oint 15.5-53.4%		
	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 Oint 12.8%		
	Zinc Oxide Oint 20%		
	Zinc Oxide Oint 40%		
Topical – Misc. Dermatological Products	Dermatological Products Misc. - Cream		May be considered for reimbursement upon submission of a prior authorization request with documented medical justification.
	Dermatological Products Misc. - Emulsion		
Topical – Rosacea Agents	Metronidazole Cream 0.75%	✓	
	Metronidazole Gel 0.75%	✓	
	Metronidazole Gel 1%	✓	
Topical – Scabicides & Pediculicides	Crotamiton Lotion 10%	✓	
	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		May be considered for reimbursement upon submission of a prior authorization request with documented medical justification.
	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		

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

Medication Class Name	Medication Generic Name	Allowed Condition Needed	Reimbursement restrictions or limitations for specific medications or dosage forms are listed with the respective medications below.
	Silver - Gel		
Ulcer Drugs – Antispasmodics	Belladonna Alkaloids & Opium Suppos 16.2-30 MG	✓	
	Belladonna Alkaloids & Opium Suppos 16.2-60 MG	✓	
	Dicyclomine HCl Cap 10 MG	✓	
	Dicyclomine HCl Oral Soln 10 MG/5ML	✓	
	Dicyclomine HCl Tab 20 MG	✓	
	Glycopyrrolate Oral Soln 1 MG/5ML		
	Glycopyrrolate Tab 1 MG	✓	
	Glycopyrrolate Tab 2 MG	✓	
	Hyoscyamine Sulfate Tab ER 0.375 MG (0.125 MG IR/0.25 MG ER)	✓	
	Hyoscyamine Sulfate Tab ER 12HR 0.375 MG	✓	
	Methscopolamine Bromide Tab 2.5 MG	✓	
	Methscopolamine Bromide Tab 5 MG	✓	
	Propantheline Bromide Tab 15 MG	✓	
Ulcer Drugs – H-2 Antagonists	Famotidine Tab 10 MG	✓	Reimbursement is only permitted for treatment of an allowed condition that involves a gastrointestinal disorder such as ulcer or gastrointestinal esophageal reflux disease (GERD) or to prevent gastrointestinal bleeding during concurrent non-steroidal anti-inflammatory drug (NSAID), anticoagulant, or antiplatelet drug therapy.
	Famotidine Tab 20 MG	✓	
	Famotidine Tab 40 MG	✓	
Ulcer Drugs – Misc.	Amoxicil Cap & Clarithro Tab & Lansopraz Cap DR 500 & 500 & 30MG	✓	
	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	✓	
Ulcer Drugs – Proton Pump Inhibitors	Lansoprazole Cap Delayed Release 15 MG	✓	Reimbursement is only permitted for treatment of an allowed condition that involves a gastrointestinal disorder such as ulcer or gastrointestinal esophageal reflux disease (GERD) or to prevent gastrointestinal bleeding during concurrent non-steroidal anti-inflammatory drug (NSAID), anticoagulant, or antiplatelet drug therapy. Reimbursement is limited to two (2) doses per day. Reimbursement for oral disintegrating dosage form is limited to claims with an allowed condition that results in the inability to swallow or absorb oral medications.
	Lansoprazole Cap Delayed Release 30 MG	✓	
	Lansoprazole Tab Delayed Release Orally Disintegrating 15 MG		
	Lansoprazole Tab Delayed Release Orally Disintegrating 30 MG		
	Esomeprazole Magnesium Tab Delayed Release 20 MG	✓	
	Omeprazole Cap Delayed Release 10 MG	✓	
	Omeprazole Cap Delayed Release 20 MG	✓	
	Omeprazole Cap Delayed Release 40 MG	✓	
	Omeprazole Delayed Release Tab 20 MG	✓	
	Omeprazole Magnesium Delayed Release Tab 20 MG	✓	
	Pantoprazole Sodium EC Tab 20 MG	✓	
	Pantoprazole Sodium EC Tab 40 MG	✓	
Urinary Analgesics	Phenazopyridine HCl Tab 100 MG	✓	
	Phenazopyridine HCl Tab 200 MG	✓	
Urinary Anti-infectives	Fosfomycin Tromethamine Powd Pack 3 GM	✓	
	Methenamine Hippurate Tab 1 GM	✓	
	Methenamine Mandelate Tab 1 GM	✓	
	Methenamine-Hyosc-Meth Blue-Benz Acid-Phenyl Sal Tab 81.6MG	✓	
	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 ER 24HR 7.5 MG	✓	
	Darifenacin Hydrobromide Tab ER 24HR 15 MG	✓	
	Fesoterodine Fumarate Tab ER 24HR 4 MG	✓	
	Fesoterodine Fumarate Tab ER 24HR 8 MG	✓	
	Flavoxate HCl Tab 100 MG	✓	
	Mirabegron Tab ER 24 HR 25 MG	✓	
	Mirabegron Tab ER 24 HR 50 MG	✓	
	Oxybutynin Chloride Solution 5 MG/5ML	✓	
	Oxybutynin Chloride Tab 5 MG	✓	
	Oxybutynin Chloride Tab ER 24HR 5 MG	✓	
	Oxybutynin Chloride Tab ER 24HR 10 MG	✓	
	Oxybutynin Chloride Tab ER 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 ER 24HR 2 MG	✓	
	Tolterodine Tartrate Cap ER 24HR 4 MG	✓	
	Tolterodine Tartrate Tab 1 MG	✓	
	Tolterodine Tartrate Tab 2 MG	✓	
	Trospium Chloride Cap ER 24HR 60 MG	✓	
	Trospium Chloride Tab 20 MG	✓	
Urinary Stone Agents	Acetohydroxamic Acid Tab 250 MG	✓	
Vaccines	Zoster Vaccine Live for Subcutaneous Susp 19400 Unit/0.65ML	✓	
	Zoster Vaccine Recombinant Adjuvanted for IM Inj 50 MCG	✓	
Vaginal Anti-infectives	Metronidazole Vaginal Gel 0.75%	✓	

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

Medication Class Name	Medication Generic Name	Allowed Condition Needed	Reimbursement restrictions or limitations for specific medications or dosage forms are listed with the respective medications below.	
	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	✓		
Vitamins – B-Complex w/ C	B-Complex w/ C & E + Zn Tab		May be considered for reimbursement upon submission of a prior authorization request with documented medical justification.	
	B-Complex w/ C Tab			
Vitamins – B-Complex w/ Folic Acid	B-Complex w/ C & Folic Acid Cap 1 MG	✓	May be considered for reimbursement upon submission of a prior authorization request with documented medical justification.	
	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 ER			
Vitamins – Multiple Vitamins w/ Iron	Multiple Vitamins w/ Iron Tab	✓		
Vitamins – Multiple Vitamins w/ Minerals	Multiple Vitamins w/ Minerals Cap	✓		
	Multiple Vitamins w/ Minerals Tab	✓		
	Multiple Vitamins w/ Minerals Effer Tab		May be considered for reimbursement upon submission of a prior authorization request with documented medical justification.	
	Multiple Vitamins w/ Minerals Liquid			
Vitamins – Multiple Vitamins w/ Calcium	Multiple Vitamins w/ Calcium Cap		May be considered for reimbursement upon submission of a prior authorization request with documented medical justification.	
	Multiple Vitamins w/ Calcium Tab			
Vitamins – Multivitamins	Multiple Vitamin Liquid		May be considered for reimbursement upon submission of a prior authorization request with documented medical justification.	
	Multiple Vitamin Tab	✓		
Vitamins – Oil Soluble Vitamins	Cholecalciferol Cap 10 MCG (400 Unit)	✓		
	Cholecalciferol Cap 25 MCG (1000 Unit)	✓		
	Cholecalciferol Cap 50 MCG (2000 Unit)	✓		
	Cholecalciferol Cap 125 MCG (5000 Unit)	✓		
	Cholecalciferol Cap 250 MCG (10000 Unit)		May be considered for reimbursement upon submission of a prior authorization request with documented medical justification.	
	Cholecalciferol Cap 1.25 MG (50000 Unit)	✓		
	Cholecalciferol Chewable Wafer 1.25 MG (50000 Unit)		May be considered for reimbursement upon submission of a prior authorization request with documented medical justification.	
	Cholecalciferol Tab 10 MCG (400 Unit)	✓		
	Cholecalciferol Tab 25 MCG (1000 Unit)	✓		
	Cholecalciferol Tab 50 MCG (2000 Unit)	✓		
	Cholecalciferol Tab 250 MCG (10000 Unit)	✓		
	Cholecalciferol Tab 125 MCG (5000 Unit)	✓		
	Cholecalciferol Tab 1.25 MG (50000 Unit)			
	Ergocalciferol Cap 1.25 MG (50000 Unit)	✓		
	Ergocalciferol Soln 200 MCG/ML (8000 Unit/ML)	✓		
	Ergocalciferol Tab 50 MCG (2000 Unit)	✓		
	Phytonadione Tab 5 MG	✓		
	Vitamin A Tab 2400 MCG (8000 Unit)	✓		
	Vitamin E Cap 1,000 Unit	✓		
		Vitamin E Cap 450 MG (1000 Unit)	✓	
		Vitamin E Cap 670 MG (1000 Unit)	✓	
Vitamins – Vitamin Mixtures	Cholecalciferol-Vitamin C Cap 1000 Unit-500 MG		May be considered for reimbursement upon submission of a prior authorization request with documented medical justification.	
	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 ER 500 MG	✓		
	Ascorbic Acid Chew Tab 250 MG	✓		
	Ascorbic Acid Chew Tab 500 MG	✓		
	Ascorbic Acid Liquid 500 MG/5ML			
	Ascorbic Acid Tab 250 MG	✓		
	Ascorbic Acid Tab 500 MG	✓		
	Ascorbic Acid Tab 1000 MG	✓		
	Ascorbic Acid Tab ER 500 MG	✓		
	Ascorbic Acid Tab Disint 60 MG		Reimbursement for oral disintegrating dosage form is limited to claims with an allowed condition that results in the inability to swallow or absorb oral medications.	
	Niacin Tab ER 250 MG	✓		
	Niacin Tab ER 750 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	✓		