

# CMC FORMULARY

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This publication was approved by the Correctional Managed Care Pharmacy & Therapeutics Committee that includes representatives from the Texas Department of Criminal Justice Health Services Division, the University of Texas Medical Branch Correctional Managed Care, and the Texas Tech University Health Sciences Center Office of Correctional Managed Health Care.

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**STATEWIDE POISON CENTER** 1-800-222-1222

## UNIT RESTRICTION LIST FOR FLOOR STOCK PURPOSES

<b>Dialysis Units:</b>	GC, E2, HP
<b>Emergency Dept (ED)</b>	0B, E2-RMF
<b>Female Units:</b>	BB, GC, GR, GV, HB, HT, LC, LJ, LM, LT, MV, N1, RL, SV, WM, XQ
<b>HCV Centers of Excellence:</b>	BX, GC, J3, ST, WM
<b>Hospice:</b>	JA, MI, GC-RMF
<b>Hospital Galveston:</b>	No restrictions. All medications administered from stock.
<b>Infirmaries:</b>	RMFs, AH, 0B, 0E, B2, CY, GV, J3, MI, ML, P1, P2, R3, ST, TL, TO
<b>Intake Facilities:</b>	0B, DB, DU, EN, ND, NE, NF, NH, RL, ISF facilities, SAFF facilities, State Jails
<b>ISF Facilities:</b>	GG, HM, NJ, RD, XQ
<b>Mobile MRI Hub Units:</b>	0B, AH, DA, E2-RMF, HP, LM, ML, P1, ST
<b>OB/GYN Clinics:</b>	GC, GV
<b>Optometry Clinic Units:</b>	AH, AJ, BC, CO, CV, DA, E2, GC, GV, HI, HJ, HP, HT, J2, J3, J4, JA, JM, LJ, LM, LT, ML, MV, NH, SV, TL, TO, WM, WY
<b>Orthopedic Clinic Units:</b>	0B, AH, DA, E2, GV
<b>Phototherapy Center:</b>	E2-RMF
<b>Psychiatric Inpatient Units:</b>	BC, CV, J4, JM, SV
<b>Regional Medical Facilities:</b>	BC, E2-RMF, GC-RMF, HP, JA, JM, RB
<b>SAFF Facilities:</b>	BB, E2, GV, JT, KY, LT, SO, SY, XQ
<b>State Jails:</b>	AJ, BH, BJ, BX, CL, FB, HF, HJ, LJ, LN, LT, RL, RZ, TI, WI, WM, WR
<b>Tattoo Removal Clinic Units:</b>	E2, MV
<b>Therapeutic Diversion Program Facilities:</b>	AH, CY, LM, TL
<b>Transient Facilities:</b>	0B, AJ, BJ, BX, CL, DA, DU, E2, EA, FB, FE, GR, GV, HJ, HV, JN, LJ, LN, LT, MI, ML, N1, N3, N4, N5, N6, NE, NF, NH, NJ, RB, RL, RZ, TH, TI, WI, WM
<b>Transient Facilities en route to HG:</b>	0B, DA, DU, E2, GR, HV, NF, NH, ML
<b>Wheelchair Units:</b>	BA, BJ, BY, DU, GL, HI, LM, N6, NF, Regional Medical Facilities, Infirmaries
<b>Wound Care Units:</b>	BC, E2-RMF, GC-RMF, JA, J3, JM, RB

ISF = Intermediate Sanction Facility

SAFF = Substance Abuse Felony Punishment

## CONVERSIONS AND CALCULATIONS

WEIGHT MEASURE	LIQUID MEASURE
1 kg (kilogram) = 1000 gm (grams) 1 gm = 1000 mg (milligrams) 1 mg = 1000 mcg or $\mu\text{g}$ (micrograms)  <b>METRIC=APOTHECARY</b> 60 mg or 65 mg = 1 gr (grain) 125 mg = 2 gr 200 mg = 3 gr 300 mg or 325 mg = 5 gr 600 mg or 650 mg = 10 gr 0.4 mg or 400 mcg = 1/150 gr 0.6 mg 600 mcg = 1/100 gr 15 gm = $\frac{1}{2}$ oz 30 gm = 1 oz 60 gm = 2 oz 240 gm = 8 oz = 1/2 lb. 480 gm = 16 oz = 1 lb. 1 kg = 2.2 lb. (pounds)	<b>METRIC=APOTHECARY</b> 1 mL (milliliter) = 1 cc 30 mL = 1 oz 15 mL = 1/2 oz 15 mL = 1 tablespoon (tbsp.) 5 mL = 1 teaspoon (tsp.) 2.5 mL = 1/2 tsp. 960 mL = 1 quart 1 L (liter) = 1000 mL (milliliters)

To convert from grams to milligrams multiply by 1000, milligrams to grams  $\div$  by 1000

To convert from kilograms to pounds multiply by 2.2, pound to kilograms  $\div$  by 2.2

To convert from grains to milligrams multiply by 60, milligrams to grains  $\div$  by 60

Formula for Calculating the Volume of a Solution Needed to Give a Certain Dose:

Solution Available: A mg / B mL, Dosage Necessary is C mg / ? mL

Formula: C x B then divide by A

Example: Solution available is 100 mg / 5 mL. Dose ordered is 60 mg.

What volume (mL) should be administered?  $60 \times 5 = 300$  divided by 100 = 3 mL

Formula for Calculating Drip Rate of IV Fluids:

$\frac{\text{total volume}}{\text{total hours}} = \text{mL/hr}$  Example:  $\frac{1000 \text{ mL}}{8 \text{ hr}} = 125 \text{ mL/hr}$

Formula for Calculating Drops (gtts) Per Minute (min):  $\frac{\text{mL/hr} \times \text{gtts/mL}}{60 \text{ min}} = \text{gtts/min}$

Example:  $\frac{125 \text{ mL/hr} \times 10 \text{ gtts/mL}}{60} = \frac{125 \times 10}{60} = \frac{1250}{60} = 20.8$  or 21 gtts/min

# **ORIENTATION GUIDE FOR HEALTH CARE PROVIDERS OF THE CORRECTIONAL MANAGED HEALTH CARE PROGRAM**

## **OVERVIEW**

The rising cost of health care in the Texas prisons prompted the 73rd Texas Legislature to enact Senate Bill 378 that established the Texas Correctional Managed Health Care program (CMHC). The Texas CMHC program represents a legislatively established partnership between the Texas Department of Criminal Justice (TDCJ), the Texas Tech University Health Sciences Center (TTUHSC) and the University of Texas Medical Branch at Galveston (UTMB). TTUHSC manages the care of the western 20% of the state and UTMB the remaining 80%. The partnership is governed by the Correctional Managed Health Care Committee (CMHCC) and is responsible for providing comprehensive health care services to all adult inmates incarcerated in Texas state prisons and state jails.

The mission of the CMHC program is to develop a statewide managed health care network to address three key goals:

- providing TDCJ inmates with timely access to care consistent with correctional standards;
- maintaining a quality of care that meets accepted standards of care; and,
- managing the costs of delivering comprehensive health care services to a growing and aging inmate population.

These goals can only be realized by promoting communication between the unit level primary care providers, specialty physicians, and tertiary, referral hospitals.

## **UNIT LEVEL HEALTH CARE**

Each prison in the state has a local, primary health care program. It consists of a team of physicians, physician assistants, advanced practice registered nurses, dentists, nurses, and assistants. These primary care providers (PCP) are responsible for providing care at the unit level. Health care services including medical, dental, and mental health are available at each unit.

All inmates have access to health care services. Each facility within TDCJ has written procedures which describe the process for inmates to gain access to the care needed to meet their medical, dental, and mental health needs.

Under the correctional health care program, inmates are provided with those health care services determined to be medically necessary. Consideration of medical necessity involves determinations that the service(s) to be provided are:

- appropriate and necessary for the symptoms, diagnosis, or treatment of the medical condition;
- provided for the diagnosis or direct care and treatment of the medical condition;
- within standards of good medical practice within the organized medical community;
- not primarily for convenience; and,
- the most appropriate provision or level of service which can be safely provided.

## **UTILIZATION REVIEW**

Referrals made by PCP for certain types of care (e.g., specialty clinics, procedures, surgery) require prior authorization through the utilization review process. Utilization management and review is a physician-driven system for making individual evaluations as to medical necessity. The review process entails consulting national accepted standards of care and comparing the individual circumstances of each case. Determinations made through the utilization management and review process may be appealed by the referring provider for additional review and decision in accordance with established procedures.

If the referral is appropriate, an appointment is scheduled, and the unit is informed. If a referral is redirected or deferred, an explanation and a recommended treatment alternative are given. Specialty telephone consultation may also be coordinated by the UR Nurses. For immediate or emergent admission, the unit physician should call the UR Nurse at 1-800-605-8165 (FAX 409-762-2765) for expedited approval.

## **SECURITY**

The goals of the unit level health facility and TDCJ are (1) to provide excellent, cost effective, and timely access to care and (2) to maintain complete security (65th Texas Legislature).

## **CMC FORMULARY & DISEASE MANAGEMENT GUIDELINES**

A standard statewide formulary is maintained by the Pharmacy and Therapeutics Committee and updated as needed and at least annually. This committee meets regularly to review the use of drugs within the health care system, evaluate agents on the Formulary and consider changes to the available medications. All medications prescribed for inmates must be listed in the Formulary unless specific medical necessity exists for authorizing a non-formulary medication. In such circumstances, a request for non-formulary approval will be processed and evaluated. Non-formulary determinations may be appealed by the referring provider for additional review and decision in accordance with established procedures.

In addition to the Formulary, the Pharmacy and Therapeutics Committee develops and maintains disease management guidelines that outline recommended treatment approaches for management of a variety of illnesses and chronic diseases. These guidelines are reviewed regularly and updated as necessary. Disease management guidelines focus on disease-based drug therapy and outline a recommended therapeutic approach to specific diseases. They are typically developed for high risk, high volume, or problem prone diseases encountered in the patient population. The goal is to improve patient outcomes and provide consistent, cost-effective care, which is based on national guidelines, current medical literature, and has been tailored to meet the specific needs of the patient population served.

Disease management guidelines are not meant to replace sound clinical judgment, nor are they intended to strictly apply to all patients.

## **DISCHARGE PLANNING & CONTINUITY OF CARE**

All patients will be switched to a CMC Formulary medication (if appropriate) at the time of discharge from subspecialty clinics and hospitals. A copy of the CMC Formulary is located at Hospital Galveston.

Non-formulary approval at the unit level is obtained by submitting a non-formulary request through Pearl EHR. If the unit provider disagrees with the clinical pharmacist's recommendation, approval may be requested from the Regional Medical Director. Non-formulary procedures for UTMB clinic/discharge patients can be found under subsection NON-FORMULARY APPROVAL PROCESS FOR DISCHARGE /CLINIC PATIENTS.

## **OVERVIEW OF HOSPITAL GALVESTON PROCESS**

Patients transferring from Hospital Galveston (HG) to Texas Department of Criminal Justice (TDCJ) units will have orders for all active medications entered into the Pearl EHR by the Hospital Galveston Pharmacy (Pharmacy Policy 10-50). Orders must be entered and will be filled for critical medications prior to the patient's departure. This will be done for all patients being discharged from the inpatient setting.

Medications will not be routinely entered into the Pearl EHR for outpatients. However, the HG practitioner may fax orders to the HG Pharmacy for any medication that is considered critical and that must be started immediately prior to the patient's return to his or her unit of assignment. Orders must be written on the TDCJ Discharge Prescription Fax Form and must specify drug, strength, route, frequency, and duration.

The Hospital Galveston pharmacy will dispense a 10-day supply of critical medications with no refills. Formulary medications will be supplied from facility unit stock. The HG pharmacists should use their professional judgment when determining if a medication is critical and should be sent with the patient.

The CMC Pharmacy and Therapeutics Committee will maintain the list of medications that have been deemed as critical. The list of critical medications is not inclusive. Critical medications are defined as:

- Anti-infectives – formulary and non-formulary agents
- Anti-platelets (e.g., clopidogrel, prasugrel, ticagrelor)
- Immunosuppressants – formulary and non-formulary agents
- Ophthalmic preparations – formulary and non-formulary agents
- Otic preparations – formulary and non-formulary agents
- Respiratory oral inhalers – formulary and non-formulary agents
- Sublingual nitroglycerin
- Non-formulary medications

All UTMB-CMC unit staff must be aware that the Pearl EHR or SMART must be checked when a patient is received from Hospital Galveston to check for critical discharge medication orders. Patients transported to the unit from HG should have a 10-day supply of critical medications sent with them upon discharge for continuity of patient care.

### **HG PHYSICIANS-ORDERING OF MEDICATION**

All discharge medication orders must be included in the discharge plan. Medication orders will be reviewed in EPIC for correct drug, strength, route, regimen, duration and type and frequency of any special monitoring. It is an option to submit a request using the electronic nonformulary medication request form for an advanced approval for non-formulary medications that will need to be continued at the unit level.

### **DISPENSING OF MEDICATION FROM HOSPITAL GALVESTON**

The Hospital Galveston pharmacist will enter orders for ALL medications ordered in EPIC or written on the TDCJ discharge prescription fax form (TDCJ-HG clinic /outpatient medication orders) to assure continuity of care and dispense a 10-day supply of critical medications only. The unit provider will be responsible for continuing the orders beyond the 10 days.

- Hospital Galveston pharmacists will screen all medication orders for appropriateness.
- Any orders active on the Pearl EHR prior to entering discharge medications **MUST BE VERIFIED** with the discharging provider if there is not an indication to “discontinue previous meds” in the patient’s discharge orders.
- The Therapeutic Interchange Policy (55-15) may be used by the HG pharmacy to substitute a formulary medication for a non-formulary medication that has been deemed as interchangeable by the CMC P&T Committee. Practitioners may override a therapeutic interchange by noting on the medication drug order “do not interchange.”
- Orders will be entered for 10 days if the medication needs to be continued for at least 10 days.
- The HG Pharmacy will type the number of days actually ordered by the HG physician in the special instructions field (e.g., take 1 tablet twice daily for **6 months**).
- All critical medications will be written as KOP except controlled substances, injectables, medications that require refrigeration, and TPN.
- The computer system will automatically append “HG” followed by the prescriber’s name in the special instructions field of the order (e.g., take 1 tablet twice daily for 30 days **HG Dr. Smith**).
- The HG Pharmacy will provide a 10-day supply of critical medications. One package/container will be supplied for medications that come in a package such as eye drops and inhalers.
- The HG Pharmacy will not dispense a medication that is not deemed critical.
- The HG Pharmacy will not dispense controlled substances.
- The HG Pharmacy will not dispense TPN. See policy 10-45 for details on TPN ordering process.
- Medications will be blister packed if possible and labeled with the patient label generated by the computer system.
- The HG Pharmacy will place filled orders in bags for distribution to patients.

### **NON-FORMULARY APPROVAL PROCESS FOR DISCHARGE/CLINIC PATIENTS**

It is an option to submit a request using the electronic nonformulary medication request form for an advanced approval for non-formulary medications that will need to be continued at the unit level. The link to the form is located on the UTMB TDCJ Hospital website under Links and Resources. The form is titled TDCJ Outpatient Non-Formulary Medication Request.

### **NON-FORMULARY APPROVAL PROCESS/UNIT LEVEL**

The unit practitioner is responsible for evaluating the patient and determining if the medication needs to be continued beyond 10 days. If the HG physician obtained advanced approval for a nonformulary medication, a copy of the approval will be in the EHR in the patient’s chart under Nonformulary Requests. If an approval was not obtained, the facility will submit a nonformulary request using the usual procedure.

### **MEDICATION NOT RECEIVED FROM HOSPITAL GALVESTON**

If the patient arrives at the unit **without non-formulary medications**, unit personnel should re-enter the orders for non-formulary medications into the EHR up to 10 days with no refills & **TYPE “HG SEND”** in the SPECIAL INSTRUCTIONS field. This will trigger the CMC pharmacist to allow an automatic 10-day approval of the non-formulary medication, and the order will be sent. This will also give providers additional time to assess the patient and request non-formulary approval for the continuation of therapy if needed.

If a patient arrives at the unit **without critical formulary medications**, floor stock may be used, or the order may be re-entered into the EHR if not available in stock to be dispensed from the CMC Pharmacy.

In an urgent situation when the medication is not immediately available and there is no acceptable formulary substitute, the provider should follow the medication procurement after hours process (Pharmacy Policy 10-40).

### **PAROLE AND DISCHARGE PATIENTS**

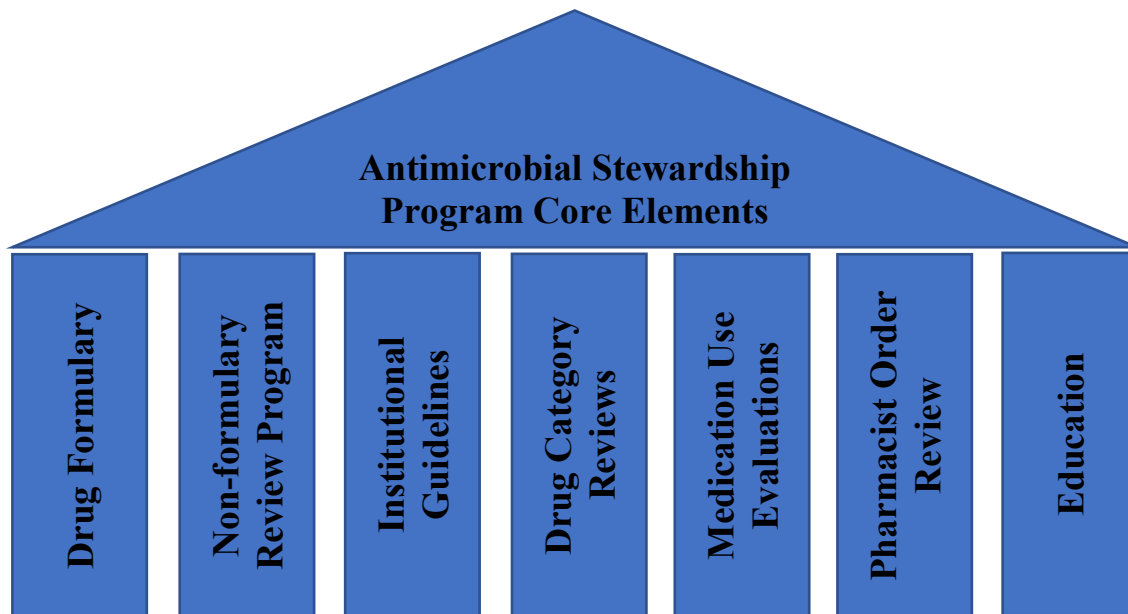
If a patient is to be directly discharged from HG, the HG pharmacist will dispense the appropriate medications per Pharmacy Policy 25-10.

### **SUMMARY**

This guide outlines the mission of the CMHC program and provides an overview of unit level care, utilization review and the Formulary. Compliance with the CMC Formulary is necessary to provide cost-effective care. Non-formulary medications will be approved as needed and the CMC Formulary will be continually updated by the Pharmacy and Therapeutics Committee with the goal of providing appropriate medical care.

## CORRECTIONAL MANAGED HEALTH CARE (CMHC) ANTIMICROBIAL STEWARDSHIP PROGRAM

The goal of the antimicrobial stewardship program is to improve how antimicrobial agents are used by promoting the appropriate use of antimicrobials, improving patient outcomes, reducing the risk of harm caused by unnecessary antimicrobial use, and combatting antibiotic resistance.



The core elements of CMHC’s antimicrobial stewardship program offer providers and other healthcare staff with a set of key tools to guide the use of antimicrobial use. These tools are evidence-based and anchored by best practices.

- **Drug Formulary:** Established formulary ensures optimal antimicrobial use, restricts use to specific indications through the use of prior authorization criteria, and limits broad spectrum antimicrobial use such as carbapenems and fluoroquinolones to regional medical facilities or emergency department. Other uses of broad-spectrum antimicrobial agents require non-formulary approval.
- **Non-formulary Review Program:** Use of non-formulary antimicrobial medications require review by a clinical pharmacist with experience and training in antimicrobial stewardship. Indication, dose, duration, culture and sensitivity, patient labs, comorbidities, and related guidelines and/or literature are considered during the review process.
- **Institutional guidelines for Evidence-based Empiric Use of Antimicrobials via Disease Management Guidelines and Infection Control Policy and Procedures:** Institutional disease management guidelines (DMGs) and Infection Control policy and procedures have been developed for the management of common conditions such as hepatitis B and C, HIV, sinusitis, skin and soft tissue infection, syphilis, and tuberculosis. Guidelines and policies are reviewed on an established cycle and guide providers on appropriate medication selection and duration of therapy.
- **Drug Category Reviews:** National clinical practice guidelines, medical literature, and efficacy of antimicrobial agents are reviewed periodically. The drug category reviews also include the

monitoring of antimicrobial prescribing patterns and review of new medications as well as their place in therapy. Findings are presented to the Joint Pharmacy and Therapeutics Committee and formulary changes are made when necessary.

- **Treatment Guideline and Policy Adherence Measured through Medication Use Evaluation (MUE):** Adherence to treatment guidelines and policies are measured periodically. MUE reports provide feedback on antimicrobial use and prescribing patterns to providers and other healthcare staff.
- **Pharmacist Order Review of Antimicrobial Use:** Pharmacists prospectively review medication orders to ensure that the right drug, dose, and duration are selected when antimicrobials are prescribed and make recommendations for changes when needed. For example, pharmacists review microbiology results (e.g., culture & sensitivity result) and prompt providers to tailor therapy as appropriate by de-escalating empiric therapy and narrowing coverage.
- **Education:** Education related to antimicrobial use, resistance, and opportunities for improving antimicrobial use are provided to providers and other healthcare staff. This may include information related to changes in institutional guidelines, policies, and the CMC Formulary and is communicated through the Pill Pass Newsletter, Pharmacy Clinical Practice Specialist education during regional provider meetings, and through Pharmacy Department email communications.

## SELECTED PHARMACY POLICIES AND PROCEDURES

(See Pharmacy Policy and Procedures Manual for full text)

### MEDICATION PROCUREMENT AFTER HOURS

(§10.40)

**PURPOSE:** To define guidelines for units to contact an on-call pharmacist to obtain medications or drug information during hours that the UTMB CMC Pharmacy is closed.

**POLICY:** Units must obtain authorization to purchase medications from an outside pharmacy from a UTMB CMC pharmacist during business hours or the On-call UTMB CMC Pharmacist after hours. Facilities may also contact the on-call pharmacist after hours to obtain drug information.

#### PROCEDURE:

- I. Contacting the Pharmacy
  - A. Units should call the Pharmacy and ask to speak to a pharmacist during normal business hours, which are 6:00 am to 6:00 pm Monday through Friday.
  - B. Units should call the On-Call Pharmacist when the Pharmacy is closed by calling 936-436-2093.
- II. In most instances, the UTMB CMC Pharmacy will not be able to supply same day or after-hours medication(s), since there is usually no way to ship the medication to the facility in need. Facility personnel may make arrangements to pick up a medication directly from the Pharmacy during business hours or after hours.
  - A. Controlled Substances: All controlled substances procured after hours should be submitted electronically to an outside pharmacy. The Regional Medical Directors have access to submitting electronic prescriptions to outside pharmacies and should be contacted when procurement after hours for a controlled substance is required.
- III. Procuring Medication from an Outside Pharmacy
  - A. Unit personnel should contact the prescriber or the facility's on-call provider to see if another medication may be substituted from stock.
  - B. If substitution is not possible, contact a Pharmacy representative as outlined above in section I.
    1. Authorization from a pharmacist is required to purchase medication from an outside pharmacy or borrow a medication from another CMC facility.
      - a. Under no circumstance should 340B medications be loaned to non-340B units.
    2. Unit personnel must provide the pharmacist with the information listed below:
      - a. Facility name
      - b. Facility contact person and telephone number
      - c. Patient name, number, allergies, and date of birth
      - d. Medication requested including strength, dosage form, quantity, and directions for use.
      - e. Indication (diagnosis) for medication
      - f. Rationale for urgent need
      - g. Texas Tech Unit - Source of purchase (i.e., outside pharmacy) including company name, contact person and telephone number
    3. The pharmacist will review the request and provide an alternative recommendation if applicable. If a formulary alternative is not available and the need is urgent as determined by a practitioner, the Pharmacist will authorize a purchase from an outside pharmacy.
    4. UTMB Sector
      - a. Pharmacist
        - i. Will complete the authorization form
        - ii. Will contact the approved outside pharmacy and verify that the medication is in stock.
        - iii. If the medication is available in stock, the Pharmacist will provide the pharmacy with the billing information.
        - iv. The Pharmacist will notify the unit that the medication is available and also provide the location of the pharmacy.
        - v. The Pharmacist will approve a 5-day supply or up to a 7-day supply of medication for holidays or holiday weekends. One package (e.g., eye drop, inhaler, bottle) may be approved for medications that come in unbreakable packaging.
      - b. Unit Personnel

- i. Unit personnel will call in or take a written prescription to the designated pharmacy and pick up the medication. An electronic prescription is required for controlled substances.
  - ii. Unit personnel will email a copy of the receipt to the Pharmacy on the next business day to [pharmacy@utmb.edu](mailto:pharmacy@utmb.edu). The email should be sent with attention "Pharmacy Accounting Department".
- C. The Pharmacist authorizing the purchase will provide the UTMB CMC Pharmacy Accounting Department with the purchasing information and reason for approval by completing the required authorization form and submitting the form on the next business day. Regarding a Texas Tech Sector facility, the Pharmacist will also notify the Chief of Managed Health Care Pharmacy Services.

## PHARMACY AND THERAPEUTICS COMMITTEE

(Abridged §05.05)

PURPOSE: The Pharmacy and Therapeutics Committee will develop and monitor the statewide formulary, drug use policies, treatment guidelines, and drug control measures used by facilities to ensure that safe, efficacious, and cost-effective therapies are used.

POLICY: The Pharmacy and Therapeutics (P&T) Committee will meet regularly to develop and maintain the statewide drug formulary, drug use policies, and disease management guidelines. The Committee will establish policy regarding the evaluation, selection, procurement, distribution, control, use, and other matters related to medications within the health care system. The Committee further serves to support educational efforts directed toward the health care staff on matters related to drugs and drug use which includes conducting periodic medication use evaluations to identify areas for improvement. All new and/or revised policies and procedures that have been approved by the P&T Committee and the University Medical Directors will require final approval by the TDCJ Director of Health Services.

### PROCEDURE:

- I. The P&T Committee is a joint workgroup. Membership is multi-disciplinary and includes the following:
  - A. TDCJ Director of Health Services Division or designee
  - B. TDCJ Director of Office of Public Health or designee
  - C. University Medical Directors or designees
  - D. Texas Tech Regional Medical Directors or designees
  - E. Texas Tech Regional Medical Facility Director or designee
  - F. UTMB Chief Medical Officer or designee
  - G. UTMB Regional Medical Directors or designees
  - H. University Directors of Pharmacy or designees
  - I. University Assistant Directors of Pharmacy or designees
  - J. Appointed Members - The TDCJ Director of Health Services and each University Medical Director may appoint additional representatives to the Committee:
    1. Medical
    2. Psychiatry
    3. Dental
    4. Nursing
  - K. Other Appointments
    1. The Committee may add ex-officio, non-voting, representatives as deemed appropriate.
    2. The Committee may appoint working subcommittees to review and provide recommendations regarding a specific topic such as policies, medication delivery process or disease management guidelines.
    3. At a minimum, appointments must be reviewed when the current chairperson's term expires.
  - M. Committee Officers
    1. Chairperson
      - a. The Chair shall be appointed by the Joint Medical Director's Committee from the P&T Committee membership for a period not to exceed 2 years.
      - b. Individuals may serve no more than two (2) consecutive terms as chairperson.
      - c. The Chairperson shall serve as the Committee nonpartisan facilitator and will vote only when it is necessary to break a tie.
    2. Secretary - The Secretary shall be the Director of Pharmacy or designee.
- II. Meeting
  - A. The Committee shall meet bimonthly on the second Thursday of each month from 9:30AM until 12:00PM.
  - B. Subcommittees will meet prior to the Committee-at-Large from 8:30AM until 9:30AM.
  - C. Individual meetings may be held at other times agreed to by the Committee.
- III. Meeting Informational Materials
  - A. Agenda - The agenda will be defined by the Chairperson and Secretary. Agenda items may also be added by Committee vote.

B. Meeting Information

1. The Secretary will be responsible for coordinating the preparation of information for Committee deliberations to include minutes, monthly reports, medication use evaluations, policies, and other reports.
2. Meeting materials will be provided to members at least 7 days prior to each meeting to allow ample time for review.
3. Deliberations, discussions, and actions of the Committee will be disseminated in the form of minutes to members.
4. Committee decisions will be communicated to health care staff in the Pill Pass Newsletter, by email, and will be published on the Pharmacy's homepage.
5. Meeting materials and minutes should not be distributed and should be kept confidential in accordance with Vernon's Annotated Civil Statutes, Health & Safety Code, Chapters 161.032 and 161.033.

IV. Voting

- A. A quorum must be reached to vote on actions before the Committee. A quorum is defined as twelve voting members.
- B. Only members may vote on actions in front of the Committee. Ex-officio members and guests may not vote.
- C. Members must disclose all conflicts of interest prior to voting on an action before the Committee.
  1. Receipt of research funding, consulting fees or other funds from a manufacturer or vendor of a product under review for formulary inclusion or exclusion
  2. Income, honorarium for speaking, or gift from a manufacturer or vendor of a product under review for formulary inclusion or exclusion
  3. Financial interests (stocks, shares, investments, etc.) in a company or manufacturer of a product under review for formulary inclusion or exclusion

V. Function and Scope

- A. To serve in the evaluative, educational, policy development, maintenance, and review capacity in all matters pertaining to the use of drugs (including but not limited to, investigational drugs, treatment protocols, disease management guidelines, medication use evaluations, patient education materials, health care management, and the use of non-formulary medication).
- B. To develop and maintain the drug formulary.
- C. To develop and maintain the disease management guidelines.
- D. To establish and maintain drug use policies, procedures, and programs that help ensure medications are safe, efficacious, and cost-effective.
- E. To ensure policies support and meet accreditation standards.
- F. To establish or plan suitable educational programs for the organization's professional staff on matters related to drugs or drug use.
- G. To implement performance improvement activities related to prescribing, distribution, administration, and use of medications such as medication error reporting, adverse effect monitoring, and review of drug utilization and prescribing patterns.
- H. To establish a listing of medications that may be kept in stock.
- I. To initiate and direct medication use evaluation studies, review the results of such activities, and make appropriate recommendations to optimize drug use.
- J. To advise the pharmacy department in the implementation of effective drug distribution and control procedures.
- K. To disseminate information on its actions and approved recommendations to all organizational health care staff.
- L. To develop and/or review all patient education materials related to medication use.

VI. Formulary Maintenance

- A. The selection of items to be included in the Formulary shall be based on the following:
  1. Objective evaluation of a medication's relative therapeutic merits based on the medical literature, safety, and cost.
  2. Duplication of the same basic drug type, drug entity, or drug products will be avoided
  3. Generic equivalents will be utilized whenever possible.
- B. A tier-system will be used and includes the following categories:
  1. Formulary Agents – Medications listed in the CMC Formulary that may be prescribed for any patient at any facility.
  2. Restricted Agents – Medications that may be prescribed at specific facilities only. Restrictions will be

noted under individual medications in the CMC Formulary. All other uses require non-formulary approval.

3. Clinic Use Only Agents – Medications that may only be administered to patients one dose at a time while they are in clinic. They may not be prescribed to patients as individual orders to be dispensed by the Pharmacy.
4. Prior Authorization Agents – Medications that may be prescribed if specific clinical criteria are met. The prior authorization criteria must be met and included in the special instructions field of the medication order. All other uses require non-formulary approval.
5. Non-formulary Agents – Medications not included in the CMC Formulary. Approval must be obtained prior to their use (Pharmacy P&P 05-10).

VII. Policy Development

- A. The Correctional Managed Care Pharmacy Policy and Procedure Manual will be reviewed on an annual basis. A proportionate number of policies will be reviewed every other meeting.
- B. Policies and procedures may be reviewed and/or revised more frequently as deemed necessary by the Pharmacy and Therapeutics Committee.
- C. All new and/or revised policies and procedures that have been approved by the Pharmacy and Therapeutics Committee and the University Medical Directors will require final approval by the TDCJ Director of Health Services.

VIII. Medication Use Evaluations (MUEs)

- A. Medication use evaluations must be approved in advance by the P&T Committee prior to data collection.
- B. Data obtained through the MUE process is for internal use only for quality improvement and educational purposes unless otherwise approved.
- C. Outside publication of any TDCJ data requires IRB approval if applicable and approval by TDCJ Executive Services.

## REPRESENTATIVES OF PHARMACEUTICAL SUPPLIES AND RELATED COMPANIES

(§70.05)

PURPOSE: To define guidelines for pharmaceutical manufacturer and related supply representatives within Correctional Managed Care (CMC) facilities.

POLICY Healthcare staff and practitioners shall interact with vendors in a manner that meets ethical standards, protects patient confidentiality, does not interfere with the process of patient care, and encourages the appropriate, efficient, and cost-effective use of equipment, supplies, and pharmaceuticals within CMC facilities.

Industry Vendors who conduct business with CMC must do so in accordance with policy and procedure. Healthcare personnel must monitor industry vendors to ensure that they comply with these guidelines. Healthcare personnel must immediately report noncompliant vendors.

All personnel of the company which employs an industry vendor who violates any of the aforementioned policies may be denied access to CMC for a period of time determined by the CMC Pharmacy and Therapeutics Committee.

DEFINITION:

Industry Vendor - Means any sales representative or account executive and includes, but is not limited to, any sales representative, pharmaceutical representative, or equipment or device manufacturer representative.

PROCEDURES:

- I. Healthcare staff and practitioners shall interact with vendors in a manner that meets ethical standards, protects patient confidentiality, does not interfere with the process of patient care, and encourages the appropriate, efficient, and cost-effective use of equipment, supplies, and pharmaceuticals within CMC facilities.
  - A. Only medications or devices approved by the Pharmacy and Therapeutics Committee may be used within facilities.
  - B. Product samples may not be left by vendor representatives on facilities or at the Pharmacy (P&P 70-10).
  - C. Industry vendors are not permitted to bring drug samples, large bulky items, boxes, detailing materials, food, or other related items on to facilities.
- II. Industry Vendors who conduct business with CMC must do so in accordance with policy and procedure. Healthcare personnel must monitor industry vendors to ensure that they comply with these guidelines. Healthcare personnel must immediately report noncompliant vendors.
- III. All personnel of the company which employs an industry vendor who violates any of the aforementioned policies may be denied access to CMC for a period of time determined by the CMC Pharmacy and Therapeutics Committee.
- IV. Industry vendor contact- All contact with CMC practitioners by pharmaceutical representatives must be in compliance with PhRMA (Pharmaceutical Research and Manufacturers of America) Code and OIG (Office of Inspector General Compliance Program Guidance for Pharmaceutical Manufacturers) guidelines.
- V. Industry vendor appointments
  - A. Industry vendors must have an appointment prior to arrival at facilities, the Pharmacy, or the Medical Warehouse.
  - B. Industry vendors must sign in and obtain a visitor badge.
  - C. Visits are for the scheduled appointment only and do not provide authorization to visit other areas or meet with other staff.
- VI. Industry vendor access
  - A. Industry vendors may not have access to Protected Health Information (PHI) unless a business associate contract specifically delineates such access or patient authorization has been obtained.
  - B. Each agency reserves the right to limit the number of industry vendors that any single company has visiting a facility.
  - C. Industry vendors are not permitted inside facilities without permission from the TDCJ or University Medical Directors or their designee (see VII for designees). Industry vendors shall always be accompanied by authorized personnel.
  - D. Industry vendors are prohibited from entering patient care areas for promotional purposes.

- E. Industry vendors shall not attend programs or meetings in which specific patients are discussed or when quality assurance or risk management issues are presented.
  - F. Security
    - 1. Industry vendors must observe all security precautions on a facility being visited.
    - 2. Security precautions may vary depending on the facility.
    - 3. Representatives must have a driver's license with picture identification to enter a facility.
- VII. Educational Activities
- A. Exhibits by pharmaceutical representatives in association with continuing medical education (CME) programs must meet Standards to Ensure the Separation of Promotion from Education within the CME Activities of ACCME (Accreditation Council for Continuing Medical Education) standards.
  - B. Industry vendors who desire to provide educational material to facility-based healthcare personnel must contact the Regional or Chief Medical Officer (UTMB sector), Director of Mental Health Services or the Dental Director. The Regional or Chief Medical Officer, Director of Mental Health Services, or Dental Director will review all material for the accuracy and appropriateness of its content and will then make decisions about the proper forum for making the information available.
  - C. Industry vendors who desire to provide educational meetings with facility-based healthcare personnel must contact the Regional or Chief Medical Officer (UTMB sector) Director of Mental Health Services or Dental Director. The Regional or Chief Medical Officer, Director of Mental Health Services or Dental Director will review the meeting agenda and all material for the accuracy and appropriateness of its contents and will then make decisions about the proper forum for making the information available.
  - D. All decisions concerning educational needs, objectives, content, methods, evaluation, and speaker are made free of a commercial interest.
  - E. The lecturer must explicitly disclose all of his or her related financial relationships to the audience at the beginning of the educational activity. If an individual has no relevant financial relationship, the learners should be informed that no relevant financial relationship exists.
  - F. Attendees in the audience are not compensated or otherwise materially rewarded for attendance (e.g., through payment of travel expenses, lodging, honoraria, or personal expenses).
  - G. No gifts of any type are distributed to attendees or participants before, during, or after the meeting or lecture.
  - H. The content or format of an educational activity or its related materials must promote improvements of quality in health care and not a specific proprietary business purpose of a commercial interest.
- VIII. Formulary Inquiries
- A. Industry vendors should contact the Assistant Director of Pharmacy Clinical Programs regarding actions of the Pharmacy and Therapeutics Committee including information on the formulary status of new medications.
  - B. Industry vendors may not contact members of the Pharmacy and Therapeutics Committee regarding actions of the Committee, to influence the decision-making process, or to influence the approval process of medications.
  - C. Industry vendors may not request an addition to the Formulary or a formulary review.
- IX. Gifts and Travel
- A. UTMB CMC personnel may not accept any form of personal gift from industry or its representatives.
  - B. See applicable employer policy.

## **CRUSHING OF MEDICATIONS**

(§35.05)

**PURPOSE:** To define guidelines for the crushing of medications for administration to patients.

**POLICY:** A practitioner's order is required to crush an individual patient's medication(s).

**PROCEDURE:**

- I. Only medical personnel may initiate an order to crush medication.
  - A. A RN, in case of an emergency, may decide to allow a single dose of medication to be crushed. Proper documentation in the chart is required when the crushed medication is administered.
  - B. A practitioner may order a medication to be crushed for a patient with proper justification documented in the patient's medical record.
- II. Some medications cannot or should not be crushed (Attachment A: Tables 1 and 2).
  - A. Medications not suitable for crushing include:
    1. Medications surrounded by a protective coating (e.g., enteric coated).
    2. Medications formulated to provide delayed or continuous release of active ingredients. Many dosage forms can be identified by abbreviations such as TR (timed release), SA (sustained action), SR (sustained release), ER (extended release), CR (controlled release), LA (long acting), and XL or XR (extended release).
    3. Medications designed to be absorbed in the mouth or to have a local healing effect (e.g., lozenges, sublingual nitroglycerin).
    4. Medications that have an unpleasant taste (e.g., ibuprofen).
    5. Medications that may produce mucosal or gastrointestinal tract irritation (e.g., alendronate).
    6. Medications that meet National Institute for Occupational Safety and Health (NIOSH) hazardous drug criteria.
  - B. A physician or dentist may override all precautions and order all or any medication to be crushed for administration except for items included in Table 1 of Attachment A (This is not an all-inclusive list).
  - C. The Facility Medical Director may append Policy #35-05 and proclaim that specific medications should be crushed for all patients at the facility except those medications listed in Table 1 of Attachment A (This is not an all-inclusive list). Written documentation must be maintained and renewed at least annually.
  - D. If uncertain that a medication may be crushed, refer to medication package insert, drug reference, or contact Pharmacy.
- III. When medications are crushed for administration, care should be taken in selecting the substance to which the medication is added to prevent possible chemical alteration of the prescribed medication.
- IV. Crushed medication should be administered as soon as possible once it has been crushed and added to another substance.

**Table 1: Solid Dosage Forms that Cannot be Crushed, Opened, or Chewed**

<b>PRODUCT</b>	<b>DOSAGE</b>	<b>COMMENTS/REASON</b>
Alendronate (Fosamax®)	Tablet	Mucous Membrane Irritant
Aspirin (Ecotrin®, Enseals®)	Tablet	Enteric Coated
Aspirin/Dipyridamole (Aggrenox®)	Capsule	Extended Release
Bisacodyl (Dulcolax®, Correctol®)	Tablet <sup>1</sup>	Enteric Coated
Bupropion (Wellbutrin® SR, Wellbutrin® XL)	Tablet	Slow Release Extended Release
Chemotherapeutic agents	Oral Dosage Forms	See Pharmacy Policies 40-10 and 75-30
Clotrimazole (Mycelex® Troches)	Troches <sup>2</sup>	Troche
Dabigatran (Pradaxa®)	Capsule	75% Increase Bioavailability
Desvenlafaxine (Pristiq®, Khedezla®)	Tablet	Extended Release
Diltiazem (Dilacor® XR, Cardizem CD®)	Capsule	Extended Release
Divalproex Sodium (Depakote®, Depakote ER®)	Tablet	Enteric Coated, Extended Release, NIOSH Medication
Erythromycin (E-Mycin®, Ery-Tab®, E.E.S.®, Eryc®)	Tablet	Enteric Coated
Everolimus (Afinitor®, Zortress®)	Tablet	Amorphous Solid Dispersion, NIOSH Medication
Elbasvir/Grazoprevir (Zepatier®)	Tablet	Amorphous Solid Dispersion
Ferrous Sulfate (Feosol®)	Tablet	Enteric Coated
Fenofibrate (TriCor®, Triglide®)	Tablet	Nanocrystal Technology
Finasteride (Proscar®, Propecia®)	Tablet	Film Coated, Teratogenic, NIOSH Medication
Glecaprevir/Pibrentasvir (Mavyret®)	Tablet	Amorphous Solid Dispersion
Guanfacine ER (Intuniv®)	Tablet	Slow Release
Itraconazole (Tolsura®, Sporanox®, Onmel®)	Capsule	Amorphous Solid Dispersion
Levomilnacipran (Fetzima®)	Capsule	Extended Release
Lithium Carbonate (Lithobid®)	Tablet	Extended Release
Lopinavir/ritonavir 200mg/50mg (Kaletra®)	Tablet	Film Coated
Mesalamine (Asacol®, Lialda®)	Tablet	Enteric Coated
Methylphenidate (Ritalin® SR, Concerta®, Metadate® ER, Methylin® ER)	Tablet	Extended Release
Morphine Sulfate (MS Contin®)	Tablet	Extended Release
Mycophenolate (CellCept®, Myfortic®)	Capsule, Tablet	Mucous Membrane Irritant, Teratogenic, Enteric Coated Tablet, NIOSH Medication
Nifedipine (Adalat CC®, Procardia XL®)	Tablet	Extended Release
Nitroglycerin (Nitrostat® SL)	Tablet <sup>4</sup>	Sublingual
Olaparib (Lynparza®)	Tablet	Amorphous Solid Dispersion, NIOSH Medication
Paliperidone (Invega®)	Tablet	Extended Release
Pantoprazole (Protonix®)	Tablet	Enteric Coated
Pentoxifylline (Trental®)	Tablet	Extended Release
Phenytoin (Dilantin Kapseals®)	Capsule	Extended Release, NIOSH Medication
Posaconazole (Noxafil®)	Tablet	Amorphous Solid Dispersion, NIOSH Medication
Potassium Chloride/Gluconate (Klor-Con®, Klor-Con® M, K-Tab®)	Capsule	Extended Release
Ranolazine (Ranexa®)	Tablet	Extended Release
Regorafenib (Stivarga®)	Tablet	Amorphous Solid Dispersion, NIOSH Medication
Ritonavir (Norvir®)	Tablet	Decreased Bioavailability

<b>PRODUCT</b>	<b>DOSAGE</b>	<b>COMMENTS/REASON</b>
Sevelamer carbonate (Renvela®)	Tablet	Tablets expand in liquid if broken/crushed
Sofosbuvir (Epclusa®, Harvoni®)	Tablet	Amorphous Solid Dispersion
Sulfasalazine (Azulfidine® EN-tabs®)	Tablet	Enteric Coated
Tamsulosin (Flomax®)	Capsule	Slow Release
Valproic Acid (Depakene®)	Capsule	Slow Release, Mucous Membrane Irritant, NIOSH Medication
Venetoclax (Veneta®)	Tablet	Amorphous Solid Dispersion, NIOSH Medication

The recommendations are specific to the drug product listed by proprietary name. Other immediate release forms of the drugs listed may be available and can be crushed, opened, or chewed. (1) Antacids or milk may prematurely dissolve the coating of the tablets. (2) Troches are made to slowly dissolve in the mouth. (3) Tablet may be split, but do not chew or crush (4) Tablet is made to disintegrate under the tongue.

**Table 2: Solid Dosage Forms that Should not be Crushed, Opened or Chewed**

<b>PRODUCT</b>	<b>DOSAGE</b>	<b>COMMENTS/REASON</b>
Abacavir (Ziagen®)	Tablet	NIOSH Medication
Abacavir/Lamivudine (Epzicom®)	Tablet	NIOSH Medication
Ambrisentan (Letairis®)	Tablet	NIOSH Medication
Amphetamine/Dextroamphetamine (Adderall XR®)	Capsule <sup>1</sup>	Extended Release
Atomoxetine (Strattera®)	Capsule	Ocular Irritant
Azathioprine (Imuran®)	Tablet	NIOSH Medication
Cabergoline (Dostinex®)	Tablet	NIOSH Medication
Carbamazepine (Tegretol®)	Tablet	NIOSH Medication
Clonazepam (Klonopin®)	Tablet	NIOSH Medication
Colchicine (Colcrys®)	Tablet	NIOSH Medication
Cyclosporine (Neoral®)	Capsule	NIOSH Medication
Divalproex Sodium (Depakote Sprinkles®)	Capsule <sup>1</sup>	Extended Release, NIOSH Medication
Docusate Calcium/Sodium (Surfak®, Colace®)	Capsule <sup>2</sup>	Liquid Filled, Bad Taste
Dronedarone (Multaq®)	Tablet	NIOSH Medication
Duloxetine (Cymbalta®)	Capsule <sup>3</sup>	Enteric-Coated Pellets
Entecavir (Baraclude®)	Tablet	NIOSH Medication
Estradiol (Estrace®)	Tablet	NIOSH Medication
Etravirine (Intelence®)	Tablet <sup>4</sup>	Do not crush
Fluconazole (Diflucan®)	Tablet	NIOSH Medication
Ibuprofen (various)	Tablet	Bad Taste
Isosorbide Mononitrate (Imdur®)	Tablet <sup>5</sup>	Extended Release
Isotretinoin (Amnesteem®, Claravis®)	Capsule <sup>2</sup>	Mucous Membrane Irritant, Liquid Filled, NIOSH Medication
Lenalidomide (Revlimid®)	Capsule	Teratogenic Potential, NIOSH Medication
Levetiracetam (Keppra®)	Tablet	Bitter Taste
Lisdexamfetamine (Vyvanse®)	Capsule <sup>4</sup>	Extended Release
Medroxyprogesterone acetate (Provera®)	Tablet	NIOSH Medication
Mesalamine (Delzicol®)	Capsule <sup>1</sup>	Slow Release
Methimazole (Tapazole®)	Tablet	NIOSH Medication
Methylphenidate (Metadate CD®, Ritalin LA®)	Capsule <sup>1</sup>	Extended Release
Metoprolol Succinate (Toprol XL®)	Tablet <sup>5</sup>	Extended Release
Misoprostol (Cytotec®)	Tablet	NIOSH Medication
Nevirapine (Viramune®)	Tablet	NIOSH Medication
Nifedipine (Procardia®)	Capsule <sup>6</sup>	Liquid Filled
Omeprazole (Prilosec®)	Capsule <sup>1</sup>	Delayed Release
Oxcarbazepine (Trileptal®)	Tablet	NIOSH Medication
Pancrelipase (Creon®)	Capsule <sup>1</sup>	Enteric Coated
Paroxetine (Paxil®)	Tablet	NIOSH Medication
Propylthiouracil	Tablet	NIOSH Medication
Ribavirin (Ribasphere®)	Capsule	NIOSH Medication
Sirolimus (Rapamune®)	Tablet	NIOSH Medication
Spironolactone (Aldactone®)	Tablet	NIOSH Medication
Tacrolimus (Prograf®)	Capsule	NIOSH Medication
Theophylline (Theo-24®)	Capsule <sup>1</sup>	Extended Release
Tipranavir (Aptivus®)	Capsule	Liquid Filled, Taste
Topiramate (Topamax®)	Tablet	Bad Taste, NIOSH Medication
Venlafaxine (Effexor XR®)	Capsule <sup>1</sup>	Extended Release
Verapamil (Calan® SR, Isoptin® SR, Verelan® PM, Covera® HS)	Tablet <sup>5</sup> , Capsule <sup>1</sup>	Extended Release
Voriconazole (Vfend®)	Tablet	NIOSH Medication
Warfarin (Coumadin®)	Tablet	NIOSH Medication
Zidovudine (Retrovir®)	Tablet	NIOSH Medication

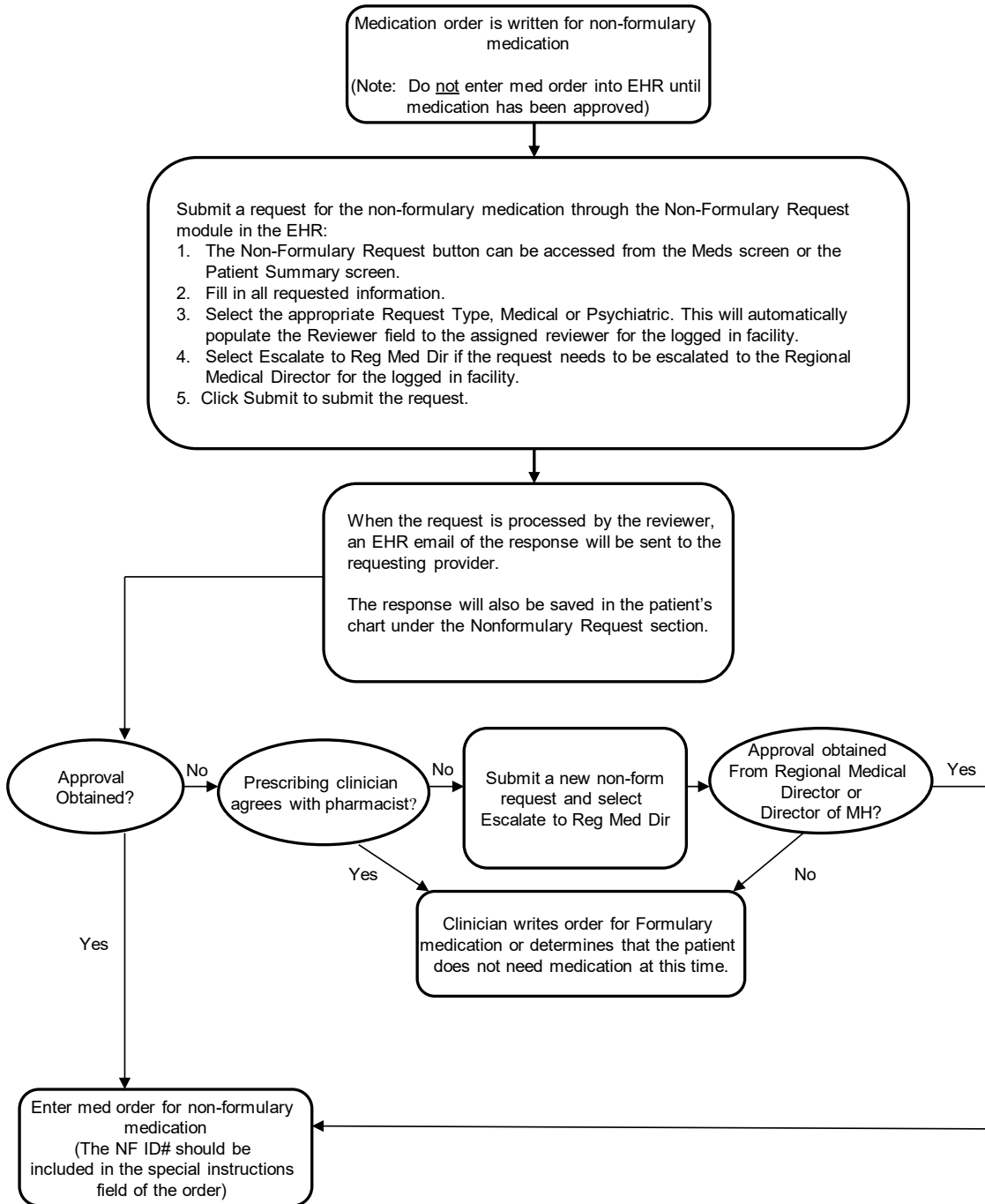
<b>PRODUCT</b>	<b>DOSAGE</b>	<b>COMMENTS/REASON</b>
Ziprasidone (Geodon®)	Capsule	NIOSH Medication
Zonisamide (Zonegran®)	Capsule	NIOSH Medication

These dosage forms may be crushed or opened at the physician's discretion. (1) Capsule may be opened, and the contents taken without crushing or chewing. Soft food such as applesauce or pudding may facilitate administration. (2) Contents of capsule may be removed for administration; incomplete recovery of content may result in decreased dosage being administered. (3) Capsule may be opened, and the contents may be mixed in applesauce or apple juice to facilitate administration. (4) If unable to swallow, tablet may be dispersed in a glass of water, stir well and drink immediately. Glass should be rinsed with water several times and each rinse completely swallowed to ensure entire dose is taken. (5) Tablet may be split, but do not chew or crush. (6) Administration of liquid from within capsule may result in partial sublingual absorption.

# NONFORMULARY MEDICATIONS

(§05.10)

(SOPs>Pearl SOPs>Non-Formulary Request-Overview-Management)  
(Training Videos folder on Desktop>Pearl Training>Non-Formulary Module-Overview)



## MEDICATION STATUS

Listings of brand name products are for reference only. The least expensive generic equivalent will be utilized whenever possible. Use outside specific restrictions or prior authorization criteria requires non-formulary approval. Medications are classified into different statuses for use and management purposes. The different medication statuses are listed below.

1. Formulary Agents – Medications listed in the CMC Formulary that may be prescribed for any patient at any facility.
2. Restricted Agents – Medications that may be prescribed at specific facilities only (e.g., dialysis unit). Restrictions are noted under individual medications in the alphabetical listing by generic name in the CMC Formulary. All other uses require non-formulary approval. Restricted agents are designated in the EHR and PRS with an exclamation point (!) after the medication name.
3. Clinic Use Only Agents – Medications that may only be administered to patients one dose at a time while they are in clinic. They may not be prescribed to patients as individual orders to be dispensed by the Pharmacy or issued KOP by facility staff.
4. Prior Authorization Agents – Medications that may be prescribed if specific clinical criteria are met (see table on next page or alphabetical listing by generic name for drug-specific criteria). The prior authorization criteria must be met and included in the special instructions field of the medication order. All other uses require non-formulary approval. Prior authorization agents are designated in the EHR and PRS with an asterisk (\*) after the medication name.
5. Non-formulary Agents – Medications not included in the CMC Formulary. Approval must be obtained from a clinical pharmacist prior to their use (see P&P 05-10 for complete details). Non-formulary agents are designated in the EHR and PRS with a pound sign (#) after the medication name.

## KOP ELIGIBILITY

The KOP (Keep-On-Person) eligibility of medications is determined by the Pharmacy and Therapeutics Committee (P&P 50-05). Medications that meet any of the criteria listed below are generally excluded from the KOP program.

1. Potential for abuse or misuse (e.g., controlled substances, carbamazepine, gabapentin, bupropion, muscle relaxants, anticholinergics, antispasmodics)
2. Medications ordered DOT
3. Medications that require refrigeration
4. Medications that may be misused as weapons (e.g., medications in glass containers)
5. Injections (e.g., insulin)
6. Antipsychotics
7. Lithium
8. Warfarin
9. Oral or topical chemotherapy
10. Drugs that must be closely monitored (e.g., TB medications, transplant medications, drugs for dementia, HCV medications)
11. Caustic or harmful agents (e.g., podofilox)
12. Orders for half (1/2) tablets not split by Pharmacy
13. Clinic use only items (e.g., local anesthetics)
14. Liquid medications that only come in large bulk bottles (e.g., 473 ml bottle)

## USE CRITERIA FOR PRIOR AUTHORIZATION AND RESTRICTED AGENTS

Prior Authorization Agent / Restricted Agent	Criteria (Should be typed in Special Instructions field)
Absorbase (Eucerin®)	RMF or Dialysis
Acetaminophen/Codeine (Tylenol 3®)	Restricted to 10 days. Minimum of 30 days between orders without non-formulary approval.
Adenosine (Adenocard®) inj	RMF, ED, or EMS
Albumin, Human (Plasbumin-25®)	RMF for paracentesis
Albuterol (Ventolin®) nebulizer solution	KOP USE template-Issued Nebulizer Machine.
Alteplase (Cathflo Activase®)	Dialysis for catheter restoration
Amiodarone (Cordarone®) inj	EMS or RMF
Amiodarone (Nexterone®)	RMF
Aquaphor (Petrolatum)	Tattoo removal
Aspirin chew tab	Crash cart, SDO protocol, and ED
Atomoxetine (Strattera®)	TJJD only. Prior authorization criteria must be met and include <b>ADHD plus:</b> <ul style="list-style-type: none"> <li>• Treatment failure on adequate dose and trial of both formulary stimulants</li> <li>• Intolerance to both formulary stimulants</li> <li>• Contraindication to both formulary stimulants</li> <li>• Significant history of substance abuse</li> <li>• Co-morbid anxiety disorder</li> </ul>
Azithromycin (Zithromax®)	<ul style="list-style-type: none"> <li>• HIV+ dosed 1200 milligrams q week for MAC primary prophylaxis when CD4 &lt; 50</li> <li>• Pregnant patients-treatment of chlamydia dosed 1200mg x 1 dose</li> </ul>
Baclofen (Lioresal®)	<ul style="list-style-type: none"> <li>• Spinal cord injury</li> <li>• Multiple Sclerosis</li> <li>• Muscular dystrophy</li> <li>• Spastic hemiplegia</li> <li>• Amyotrophic lateral sclerosis</li> <li>• Cerebral palsy</li> </ul>
Benzotropine 1 mg/mL, 2 mL SDV	Restricted to Psychiatric inpatient facilities <ul style="list-style-type: none"> <li>• Patients with acute dystonia who fail to respond to diphenhydramine injection</li> </ul>
Barium Sulfate (Readi-Cat2®)	Mobile CT unit
Bictegravir-Emtricitabine-Tenofovir (Biktarvy®)	Patient on Biktarvy at intake
Birth control (Cryselle®, Nortrel®)	Females
Cefepime (Maxipime®)	RMF (inpatient use only), ED, or TJJD patient
Ceftriaxone (Rocephin®)	<ul style="list-style-type: none"> <li>• 500 mg – 500 mg IM x 1 dose for GC (gonorrhea) (If chlamydia has not been excluded, use with Doxycycline 100 mg BID x 7d. In pregnancy use with prior authorization azithromycin 1200 mg (2 tablets of 600 mg) x 1 dose.)</li> <li>• 1 gram – RMF (inpatient use only), Infirmity unit (inpatient use only), and TJJD</li> </ul>
Chlordiazepoxide (Librium®)	Restricted to benzodiazepine discontinuation
Ciprofloxacin eye drop (Ciloxan®)	Post-cataract surgery or ocular procedure
Ciprofloxacin tablet (Cipro®)	RMF (inpatient use only) or ED

Prior Authorization Agent / Restricted Agent	Criteria (Should be typed in Special Instructions field)
Clonidine (Catapres®)	<ul style="list-style-type: none"> <li>• Management of opioid withdrawal</li> <li>• Intake to taper</li> <li>• ED</li> </ul>
Collagenase (Santyl®)	<ul style="list-style-type: none"> <li>• TH (Telehealth) Wound care clinic</li> <li>• RMFs and Infirmaries</li> </ul>
Dental Anesthetics (Articaine, Benzocaine, Lido/Epi, Lido/Prilo, Mepivacaine, Prilo/Epi)	<ul style="list-style-type: none"> <li>• UTMB Dental</li> </ul>
Dextrose 10% Water 1000 mL (D10W)	Restricted to Beto, Estelle RMF, Jester 3, Michael, Montford RMF, Stiles and Young RMF for use until TPN is available.
Diazepam (Valium®)	<ul style="list-style-type: none"> <li>• Spinal Cord Injury</li> <li>• Multiple Sclerosis</li> <li>• Muscular Dystrophy</li> <li>• Spastic Hemiplegia</li> <li>• Amyotrophic Lateral Sclerosis</li> <li>• Cerebral Palsy</li> </ul>
Diltiazem SDV (Cardizem®)	ED
Elvitegravir – Cobicistat – Emtricitabine – Tenofovir (Genvoya®)	Patient on Genvoya or Stribild at intake
Epinephrine (Epipen®)	EMS, TJJJ emergency boxes, and Mobile MRI units.
Epoetin Alfa (Epogen®)	Dialysis
Estradiol (Estrace®, Depo-Estradiol®)	GD-gender dysphoria patients (new intake and GD clinic)
Estrogens (Premarin®)	Females
Ethyl Chloride Spray	Ortho Clinic
Ferric Subsulfate (Monsels®)	OB/GYN services at GC or GV
Finasteride (Proscar®)	GD-gender dysphoria patients (new intake and GD clinic)
Fluconazole (Diflucan®)	<ul style="list-style-type: none"> <li>• 150 mg – single dose for vaginal candidiasis</li> <li>• 100 mg &amp; 200 mg – HIV-positive patients, for treatment or prevention of opportunistic infections</li> </ul>
Flumazenil (Romazicon®)	Emergency use only
Gadobenate (Multihance®)	Mobile MRI units
Gadoteridol (Prohance®)	Mobile MRI units
Guaifenesin/DM (Robitussin DM®)	<ul style="list-style-type: none"> <li>• B14.52 cough</li> <li>• ED</li> </ul>
Heparin	1,000 U/mL – 30 mL: Dialysis
Hepatitis A Vaccine (Vaqta®)	<p>Patient is not immune (P&amp;P B-14.07) plus one of the following:</p> <ul style="list-style-type: none"> <li>• HIV</li> <li>• Chronic hepatitis C</li> <li>• Chronic hepatitis B</li> <li>• ESLD</li> <li>• NAFLD</li> <li>• Clotting factor disorders</li> </ul>
Hepatitis B vaccine (Recombivax HB®)	<p>Patient is not immune (P&amp;P B-14.07) plus one of the following:</p> <ul style="list-style-type: none"> <li>• Chronic hepatitis C</li> <li>• HIV (double dose - 20mcg)</li> <li>• Post-exposure prophylaxis</li> <li>• Sexual exposure</li> <li>• Job assignment that includes the handling of medical waste</li> <li>• ESLD</li> <li>• Chronic liver disease</li> <li>• Current or recent injection drug use</li> <li>• &lt;19 years old without documentation of series completion (lab work not required)</li> </ul>

Prior Authorization Agent / Restricted Agent	Criteria (Should be typed in Special Instructions field)
Hepatitis B Vaccine, Dialysis formulation (Recombivax HB®)	Patient is not immune (P&P B-14.07) plus patient is on dialysis
Human Papillomavirus Vaccine– HPV (Gardasil 9®)	Females ages 9 through 26 with no previous vaccination.
Hydralazine SDV (Apresoline®)	ED
Imipramine (Tofranil®)	TJJD for enuresis
Iopamidol (Isovue-370®)	Mobile CT unit
Ipratropium bromide (Atrovent®) neb sol	KOP USE template-Issued Nebulizer Machine.
Iron sucrose (Venofer®)	Dialysis
Isosorbide Dinitrate (Isordil®)	Heart failure
Ketorolac SDV (Toradol®)	ED
Labetalol injection	EMS and ED use only for treatment of HTN emergencies per protocol
Levetiracetam (Keppra®) Inj	ED
Lidocaine	<ul style="list-style-type: none"> <li>• 2% jelly – emergency use only</li> <li>• 5% ointment – OB/GYN services at GC or GV</li> <li>• 0.4%/D5W 500 mL bag– restricted to EMS</li> </ul>
Lisdexamfetamine (Vyvanse®)	TJJD only. Prior authorization criteria must be met and include: <ul style="list-style-type: none"> <li>• Failed treatment with Methylphenidate and Adderall.</li> </ul>
Lorazepam (Ativan®)	Injection <ul style="list-style-type: none"> <li>• Treatment of acute seizures uncontrolled by other measures.</li> <li>• Short-term treatment of agitation at inpatient psychiatric facilities.</li> <li>• ED</li> </ul> 0.5mg Tablet <ul style="list-style-type: none"> <li>• Mobile MRI</li> </ul>
Medroxyprogesterone (Provera®, Depo-Provera®)	<ul style="list-style-type: none"> <li>• Females</li> <li>• GD-gender dysphoria patients (new intake and GD clinic)</li> </ul>
Meningococcal Vaccine (Menquadfi®)	Anatomic or functional asplenia or HIV+ with no history of prior immunization or require a booster
Meropenem Inj (Merrem®)	RMF (inpatient use only) or ED
Methocarbamol (Robaxin®)	One 7-day supply/injury; min. 30 days between orders
Methylprednisolone acetate 80mg/1ml	Ortho Clinic
Metoclopramide SDV (Reglan®)	ED
Miconazole vaginal cream (Monistat-7®)	Females
Measles, Mumps, Rubella Vaccine (M-M-R®-II)	<ul style="list-style-type: none"> <li>• &lt;19 years old without documentation of series completion</li> <li>• Born after 1956 &amp; did not attend public school in Texas</li> <li>• Immigrants that have not completed the series</li> </ul>
Morphine sulfate (MS Contin®)	<ul style="list-style-type: none"> <li>• Elixir and extended-release tablets – RMF inpatient or Hospice (may not exceed 10-day supply)</li> <li>• Injection – one-time orders for pain associated with acute trauma or severe medical condition</li> </ul>
Multivitamin	<ul style="list-style-type: none"> <li>• HIV-positive + CD4 count &lt; 100 + <u>not</u> on enteral feeding</li> <li>• TH (Telehealth) Wound care clinic</li> </ul>
Nitroglycerin topical ointment (Nitrobid®)	Clinic use only for short term relief of angina
Norepinephrine/NS	ED
Pantoprazole SDV (Protonix®)	ED
Paricalcitol (Zemplar®)	Dialysis
Penicillin G Benzathine (Bicillin LA®)	Syphilis
Petrolatum (Vaseline®)	Phototherapy at E2

<b>Prior Authorization Agent / Restricted Agent</b>	<b>Criteria (Should be typed in Special Instructions field)</b>
Phenylephrine eye drop (Altafrin®)	Optometry Clinic
Phenytoin (Dilantin®)	<ul style="list-style-type: none"> <li>• Oral suspension restricted to RMFs</li> <li>• Injection restricted to Emergency Medical Services (EMS).</li> </ul>
Polio Vaccine (Ipol®)	Patients <19 years old
Potassium Chloride injection	Infirmery, RMF, or ED
Prenatal vitamins	Pregnancy
Renal Vitamin (Nephro-Vite®)	Dialysis
Ribavirin (Ribasphere®)	<ul style="list-style-type: none"> <li>• Virology/Genotype/Treatment experience/Cirrhosis class</li> </ul>
Rilpivirine (Edurant®)	Patient on Edurant ,Complera, Odefsey, or Juluca at intake.
Sevelamer (Renvela®)	<ul style="list-style-type: none"> <li>• Chronic kidney disease</li> <li>• Dialysis</li> </ul>
Sofosbuvir/Velpatasvir 400-100mg (Epclusa®)	<ul style="list-style-type: none"> <li>• Virology/Genotype/Treatment experience/Cirrhosis class</li> </ul>
Surgical lubricant (Surgilube®) 4.25 oz tube	RMF
Tenecteplase (TNKase®)	ED
Terbutaline injection (Brethine®)	Female patients at CYMF (GC) and Crain (GV)
Testosterone (Depo-Testosterone®)	GD-gender dysphoria patients (new intake and GD clinic)
Tetanus-Diphtheria-Acellular Pertussis TdaP (Boostrix®)	<ul style="list-style-type: none"> <li>• Pregnancy</li> <li>• Td booster indicated and not previously vaccinated with TdaP</li> </ul>
Tropicamide eye drop (Mydracyl®)	<ul style="list-style-type: none"> <li>• Optometry Clinic</li> </ul>
Ulipristal (Ella®)	Female unit/patient for emergency contraception
Varicella Vaccine (Varivax®)	<ul style="list-style-type: none"> <li>• &lt; 19 years old without documentation of previous disease or immunization (lab work not required)</li> <li>• Post-exposure prophylaxis with approval from Office of Public Health</li> <li>• HIV positive patients without documented immunity and CD4 count &gt; 200</li> </ul>
Vitamin C	<ul style="list-style-type: none"> <li>• TH (Telehealth) Wound care clinic</li> </ul>
Zinc Sulfate	<ul style="list-style-type: none"> <li>• TH (Telehealth) Wound care clinic</li> </ul>

## EMERGENCY DEPARTMENT (ED) STOCK LIST

Label Name	Brand Name	Generic Name
ADENOSINE 6MG/2ML VIAL	ADENOCARD 6MG/2ML VIAL	ADENOSINE
AMIODARONE 50MG/ML 3ML VIAL	CORDARONE 150MG/3ML VIAL	AMIODARONE HCL
AMOXIC/CLV 1000-62.5MG ER TAB	AUGMENTIN XR	AMOXICILLIN/CLAVULANATE
CEFEPIME 2 GRAM VIAL	MAXIPIME	CEFEPIME HCL
DILTIAZEM 5MG/ML 10ML SDV	CARDIZEM 5MG/ML 10ML SDV	DILTIAZEM HCL
ENOXAPARIN 40MG/0.4ML SYR	LOVENOX 40MG/0.4ML SYRINGE	ENOXAPARIN SODIUM
FAMOTIDINE 20MG/2ML SDV	PEPCID IV 20MG/2ML SDV	FAMOTIDINE
GUAIFEN/DM 400/20MG TAB 30	ROBITUSSIN DM	GUAIFENESIN/DEXTROMETHORPH
HYDRALAZINE 20MG/ML 1ML SDV	APRESOLINE 20MG/ML 1ML SDV	HYDRALAZINE HCL
KCL 20MEQ/D5W 1000ML BAG	KCL 20MEQ/D5W 1000ML BAG	POTASSIUM CHLORIDE/D5W
KETOROLAC 30MG/ML 1ML SDV	TORADOL 30MG/ML 1ML SDV	KETOROLAC TROMETHAMINE
LABETALOL HCL 5MG/ML 40ML VL	LABETALOL HCL 5MG/ML 40ML VL	LABETALOL HCL
LEVETIRACETAM 500MG/100ML BG	KEPPRA BAG	LEVETIRACETAM BAG
MAGNESIUM OXIDE 400MG TABLET	MAG-OX	MAGNESIUM OXIDE
MEROPENEM IV 1GM INJ 30ML VL	MERREM IV	MEROPENEM
METOCLOPRAMIDE 5MG/ML 2ML SDV	REGLAN 5MG/ML 2ML	METOCLOPRAMIDE HCL
NEXTERONE 360MG/200ML BAG	AMIODARONE IN DEXTROSE	NEXTERONE 360MG/200ML BAG
NOREPINEPHRINE/NS 4MG/250ML	NOREPINEPHRINE/NS 4MG/250ML	NOREPINEPHRINE/NORM SALINE
PROTONIX IV 40MG SDV	PROTONIX IV 40MG SDV	PANTOPRAZOLE SODIUM
SIMETHICONE 80MG CHEW TAB 100s	MYLICON	SIMETHICONE
TNKase 50MG KIT	TNKase 50MG KIT	TENECTEPLASE

## IV SOLUTION ADMIXTURE SYSTEMS

There are two admixture systems available for use. Advantages of the admixture systems include reduced risk for contamination, elimination of needles in the preparation of IV admixtures, reduced chance for errors, and greater convenience. Disadvantages include increased storage space requirements, decreased dosing flexibility, and not all antibiotics may be used with the systems.

The Mini-Bag Plus Admixture System is designed to be used with single dose powdered medications that are contained in standard 20 mm vials and need reconstitution prior to admixture with an IV solution. The Vial-Mate Adaptor is designed to connect a powdered drug contained in a standard 20 mm vial to a 250 mL IV solution bag. The Vial-Mate Adaptor should be reserved for use with medications that cannot be used with the Mini-Bag Plus Admixture System (i.e., the drug needs to be prepared in a 250 mL bag).

System	Antibiotics That May Be Used with System
Mini-Bag Plus Admixture System <ul style="list-style-type: none"> <li>• Mini-Bag Plus 0.9% NaCl 100 mL bag</li> <li>• Mini-Bag Plus D5W 100 mL bag</li> </ul>	Ampicillin (NS only) Cefazolin Ceftazidime* Ceftriaxone** Meropenem ** Nafcillin Oxacillin* Penicillin G Potassium
Mini-Bag Vial-Mate Adaptor	Doxycycline* Erythromycin Lactobionate* Vancomycin

NS=normal saline

\*Non-formulary approval required

\*\*Restricted to Regional Medical Facilities; otherwise, non-formulary approval required.

Antibiotics that cannot be used with the admixture systems include amphotericin, clindamycin, gentamicin, and sulfamethoxazole/trimethoprim.

In addition, clindamycin 900 mg in 50 mL D5 and metronidazole 500 mg in 100 mL NS are available in premixed bags.

## PRODUCT INFORMATION

3TC see LAMIVUDINE

**ABACAVIR** (Max 11 refills)

ZIAGEN®

300 MG TABLET (\$0.32)

**ABACAVIR/LAMIVUDINE** (Max 11 refills)

EPZICOM

600 MG/300 MG TABLET (\$0.95)

ABILIFY® see ARIPIPIRAZOLE

**ABSORBASE**

EUCERIN®

16 OZ CREAM (\$3.50)

(Note: Restricted to regional medical facilities and dialysis centers. All other uses require non-formulary approval.)

**ACETAMINOPHEN**

APAP, TYLENOL®

325 MG TABLET UD (500/BOX) (\$0.02/UD)

325 MG TABLET 100s (\$4.92/BOX)

650 MG SUPPOSITORY (\$0.35/SUPP)

650 MG/20.3 ML UD SOLUTION (\$1.74/UD)

(Note: UD tablets, suppositories, and UD solution take from stock. 325mg box of 100 is sent per patient order for 90D template. 1 box of 100 tablets to last 90 days. No refills allowed.)

**ACETAMINOPHEN/CODEINE - CIII**

TYLENOL® #3

APAP 300 MG/CODEINE 30 MG TABLET – CIII (\$0.42)

(Note: May not be given KOP. Non-formulary approval required for use > 10 days. A minimum 30-day period between orders is required for use beyond 10 days without a non-formulary approval. Take from stock. May only be ordered by a physician or DEA registered midlevel provider.)

**ACETAZOLAMIDE** (Max 11 refills)

DIAMOX®

250 MG TABLET (\$0.33)

**ACLIDINIUM BROMIDE** (Max 11 refills)

TUDORZA PRESSAIR®

ORAL INHALER 400MCG/DOSE - 60 DOSES (\$253.55)

ACTIDOSE-AQUA® see CHARCOAL, ACTIVATED

ACULAR® see KETOROLAC

ADENOCARD® see ADENOSINE

**ADENOSINE**

ADENOCARD®

6 MG/2 ML VIAL (\$6.65)

(Note: Clinic use only. Take from stock. May not be given KOP. Restricted to RMFs, ED, and EMS only.)

ADDERALL® see AMPHETAMINE SALTS

ADDERALL XR® see AMPHETAMINE SALTS

ADRENALIN see EPINEPHRINE

**ALBUMIN, HUMAN**

PLASBUMIN-25®

25% INJECTION – 100 ML (\$70.00)

(Note: Restricted to regional medical facilities as floor stock for use in paracentesis. Clinic use only. All other uses require non-formulary approval. May not be given KOP.)

**ALBUTEROL**

VENTOLIN® (Clinic use-No refills, KOP use-max 11 refills)  
0.083% NEBULIZER SOLUTION – 3 ML UD 25/BOX (\$3.75/BOX)

(Note: CLINIC USE template-Take from stock. Clinic use only.  
KOP USE template-Prior Authorization criteria must be met and noted in special instructions field. Criteria is issued nebulizer machine. Must be ordered KOP and orders may not exceed 25 days.)

PROVENTIL-HFA® (Max 1 refill)  
METERED DOSE INHALER 90MCG/ACTUATION 200 ACTUATIONS (\$9.98)

ALCAINE® OPTH SOLN see PROPARACAINE OPH SOL

ALDACTONE® see SPIRONOLACTONE

**ALLOPURINOL** (Max 11 refills)

ZYLOPRIM®  
100 MG (\$0.06), 300 MG (\$0.10) TABLET

ALPHAGAN® see BRIMONIDINE

ALTAFRIN® see PHENYLEPHRINE

**ALTEPLASE**

(t-PA, CATHFLO ACTIVASE®)  
1 MG/1 ML – 2 ML VIAL (\$155.84)

(Note: Clinic use only. Take from stock. May not be given KOP. Use and floor stock restricted to dialysis centers for catheter restoration.)

ALVESCO® see CICLESONIDE

**AMANTADINE HCL** (Max 11 refills)

SYMMETREL®  
100 MG CAPSULE (\$0.06)  
(Note: Non-formulary approval required for TJJD facilities.)

**AMINO ACID/ELECTROLYTES/CALCIUM IN D20W**

CLINIMIX E®  
4.25/5 2L (\$78.31), 5/15 1L (\$44.02), 5/15 2L (\$83.96), 5/20 1L (\$44.38), 5/20 2L (\$85.25)  
(Note: Non-formulary approval required for stock and patient orders. Non-form stock restricted to 0B, E2-RMF, GC-RMF, HP, J3, MI, and ST for TPN. Take from stock. Clinic use only. May not be given KOP.)

**AMIODARONE**

CORDARONE®  
200 MG TABLET (\$0.12) (Max 11 refills)  
50 MG/ML INJECTION – 3 ML VIAL (\$1.12) (No refills)  
(Note: Injection for clinic use only, should be taken from stock, may not be given KOP, and restricted to EMS and regional medical facilities.)

**AMIODARONE IN D5W**

NEXTERONE®  
360 MG/200 ML INJECTION – 200 ML BAG (\$461.40)  
(Note: Clinic use only. Take from stock. May not be given KOP. Restricted to regional medical facilities. Infusion rate 1mg/min, over 6 hours with in-line filter.)

**AMLODIPINE** (Max 11 refills)

NORVASC®  
5 MG (\$0.01), 10 MG (\$0.01) TABLET

**AMOXICILLIN**

AMOXIL®  
250 MG (\$0.04), 500 MG (\$0.06) CAPSULE

**AMOXICILLIN/CLAVULANATE**

AUGMENTIN®  
875-125 MG TABLET (\$0.15)  
(Note: Allowed as floor stock for TDCJ. Non-formulary approval still required for use.)

AUGMENTIN XR®  
1000-62.5 MG ER TABLET (\$6.16)  
(Note: Allowed as floor stock at ED. May be used without non-formulary approval for ED patients.)

AMOXIL® see AMOXICILLIN

AMPHETAMINE/DEXTROAMPHETAMINE see AMPHETAMINE SALTS

**AMPHETAMINE SALTS - CII**

ADDERALL®

5 MG (\$0.31), 10 MG (\$0.34) TABLET

ADDERALL XR®

10 MG (\$0.68) 20 MG (\$0.70), 30 MG (\$0.68) EXTENDED-RELEASE CAPSULE

(Note: May not be given KOP. Restricted to TJJD only. Take from stock TJJD institutions only. May only be ordered by a physician.)

**AMPICILLIN**

OMNIPEN-N®

500 MG INJECTION, IM OR IV (\$1.09)

IV Preparation Standard:

< 3 gm in 100 mL NS ONLY over 40 minutes.

(Note: Clinic use only. Take from stock. May not be given KOP.)

ANCEF® see CEFAZOLIN

ANTACID see CALCIUM CARBONATE

**ANTIHEMOPHILIC FACTOR (HUMAN)** (Max 2 refills)

KOATE® (FACTOR VIII)

1000 (+/-) UNITS VIAL (\$540.00)

(Note: Floor stock and administration restricted to J3 and ST. Designated as a Local Control and therefore must be kept and inventoried as a controlled substance (Pharmacy Policies 20-05, 20-10, 20-15). Non-formulary approval is still required prior to use. Take from stock. May not be given KOP.)

ANTIVERT® see MECLIZINE HCL

ANU-MED® SUPPOSITORY see HEMORRHOIDAL SUPPOSITORY

ANUSOL-HC SUPP® see HYDROCORTISONE HEMORRHOIDAL SUPPOSITORY

APRESOLINE® see HYDRALAZINE

AQUAPHOR® see PETROLATUM

**ARIPIPIRAZOLE** (Max 11 refills)

ABILIFY®

2 MG (\$0.02), 5 MG (\$0.02), 10 MG (\$0.03), 15 MG (\$0.07), 20 MG (\$0.20), 30 MG (\$0.26)  
TABLET

(Note: May not be given KOP. Floor stock for TJJD: 5mg & 15mg. Floor stock for TDCJ: 10mg & 15mg.)

**ARTICAINE/EPINEPHRINE**

ORABLOC®, ARTICADENT®

4% / 1:100,000 CARTRIDGE (50/BOX) (\$40.50/BOX)

(Note: Restricted to UTMB dental services. Clinic use only. Take from stock. May not be given KOP.)

ARTIFICIAL TEARS SOLUTION see POLYVINYL/POVIDONE

ARZOL® see SILVER NITRATE

**ASPIRIN**

BAYER® ASPIRIN (No refills)

81 MG CHEWABLE TABLET (\$0.09)

(Note: Take from stock. Restricted to crash cart, SDO protocol, and ED use only.)

ECOTRIN® (Max 11 refills)

81 MG (\$0.01), 325 MG (\$0.02) ENTERIC-COATED TABLET

**ATAZANAVIR** (Max 11 refills)

REYATAZ®

200 MG (\$1.16), 300 MG (\$3.22) CAPSULE

ATIVAN® see LORAZEPAM

**ATOMOXETINE** (Max 11 refills)

STRATTERA®

25 MG (\$1.52), 40 MG (\$1.65), 60 MG (\$1.94), 80 MG (\$2.18), 100 MG (\$2.18) CAPSULE

(Note: May not be given KOP. Restricted to TJJD. Prior authorization must be met and noted in the special instructions field for use without non-formulary approval. Criteria include:

- a. ADHD and failure on adequate dose and trial of both formulary stimulants.
- b. ADHD and intolerance to both formulary stimulants.
- c. ADHD and contraindication to use of both formulary stimulants.
- d. ADHD and significant history of substance abuse.
- e. ADHD and co-morbid anxiety disorder.

10mg and 25mg available in stock to prevent delays in therapy. Non-form still required for all other uses.)

**ATORVASTATIN** (Max 11 refills)

LIPITOR®

10 MG (\$0.02), 20 MG (\$0.02), 40 MG (\$0.03), 80 MG (\$0.04) TABLET

**ATROPINE SULFATE**

ATROPINE

0.1 MG/ML INJECTION – 10 ML SYRINGE (\$9.46) (No refills)

(Note: Clinic use only. Take from stock. May not be given KOP.)

ISOPTO ATROPINE®

1% OPHTH SOLUTION – 15 ML (\$58.22) (Max 11 refills)

ATROVENT see IPRATROPIUM BROMIDE

AUGMENTIN® see AMOXICILLIN/CLAVULANATE

AVLOSULFON® see DAPSONE

**AZATHIOPRINE** (Max 11 refills)

IMURAN®

50 MG TABLET (\$0.15)

(Note: May not be given KOP.)

**AZITHROMYCIN** (Max 11 refills)

ZITHROMAX®

600 MG TABLET (\$0.75)

(Note: There are two ordering templates in the EHR for azithromycin including one for HIV MAC prophylaxis which has 11 allowable refills and one for CT (pregnant women with chlamydia) which has no allowable refills. Prior authorization criteria must be met and noted in the special instructions field for use without a non-formulary approval. Criteria include:

- a. HIV patients dosed 1200 milligrams q week for MAC primary prophylaxis when CD4 count < 50. Treatment should be continued for CD4 count of 50 to 100 and discontinued when the CD4 is >100 for ≥ 3 months.
- b. Pregnancy - 1200 milligrams x 1 dose for chlamydia)

AZT see ZIDOVUDINE

AZULFIDINE® see SULFASALAZINE

B-1, VITAMIN see THIAMINE HCL

B-6, VITAMIN see PYRIDOXINE HCL

B-12, VITAMIN see CYANOCOBALAMIN

**BACITRACIN/POLYMYXIN**

POLYSPORIN®, DOUBLE ANTIBIOTIC OINTMENT

TOPICAL OINTMENT – 15 GM TUBE (\$4.77)

POLYSPORIN®

OPHTHALMIC OINTMENT - 3.5 GM TUBE (\$9.11)

**BACLOFEN (Max 11 refills)**

LIORESAL®

10 MG (\$0.08), 20 MG (\$0.06) TABLET

(Note: May not be given KOP. Prior Authorization criteria must be met and noted in the special instructions field for use without non-formulary approval. Criteria include:

- a. Spinal cord injury
- b. Multiple sclerosis
- c. Muscular dystrophy
- d. Spastic hemiplegia
- e. Amyotrophic lateral sclerosis
- f. Cerebral palsy

10mg available in stock to prevent delays in therapy. Non-formulary approval is still required for all other uses.)

BACTRIM® see SULFAMETHOXAZOLE/TRIMETHOPRIM

BARACLUDE® see ENTECAVIR

**BARIUM SULFATE**

READI-CAT2®

2% O/SUSP 450 ML (\$4.63)

(Note: Imaging contrast agent. Restricted to mobile CT unit. Clinic use only. Take from stock.)

BAYER® ASPIRIN see ASPIRIN

BENADRYL® see DIPHENHYDRAMINE

BENZAC® see BENZOYL PEROXIDE

**BENZOCAINE**

ZILACTIN-B®

10% ORAL GEL – 7 GM (\$4.93)

HURRICAIN®

20% ORAL GEL – 1 OZ BTL (\$7.99)

(Note: 20% restricted to UTMB dental services. Clinic use only. Take from stock. May not be given KOP.)

**BENZOYL PEROXIDE (Max 3 refills)**

BENZAC®

10% GEL – 60 GM (\$13.01)

(Note: Orders are to be given a 90-day expiration date.)

**BENZTROPINE MESYLATE**

COGENTIN®

0.5 MG (\$0.05), 1 MG (\$0.07), 2 MG (\$0.13) TABLET (Max refills: TDCJ-5, TJJJ-2)

(Note: May not be given KOP.)

1 MG/ML, 2 ML SDV (\$24.41) (No refills)

(Note: Clinic use only. Take from stock. May not be given KOP. Floor stock and use restricted to psychiatric inpatient facilities (BC, CV, J4, JM, SV). Prior authorization criteria must be met and noted in the special instructions field for use without non-formulary approval. Criteria include: patients with acute dystonia who fail to respond to diphenhydramine injection.

BETAPACE® see SOTALOL

BICILLIN-LA® see PENICILLIN G BENZATHINE

**BICTEGRAVIR/EMTRICITABINE/TENOFOVIR ALA (Max 11 refills)**

BIKTARVY®

50 MG/200 MG/25 MG TABLET (\$133.27)

(Note: Prior authorization criteria must be met and noted in special instructions field for use without a non-formulary approval. Criteria include: Patient on Biktarvy at intake.)

BIKTARVY® see BICTEGRAVIR/EMTRICITABINE/TENOFOVIR ALA

**BISACODYL**

DULCOLAX®

5 MG TABLET (\$0.02)

10 MG SUPPOSITORY (\$0.24)

(Note: Take from stock.)

**BISMUTH SUBSALICYLATE**

PEPTO BISMOL®

262 MG CHEWABLE TABLET (\$0.09)

(Note: Take from stock.)

**BODY LOTION**

DERMALUBE, LUBRIDERM, LUBRISOFT, THERA DERM®  
LOTION (\$1.68)

(Note: May be supplied as a different size depending on product availability. Take from stock.)

BOOSTRIX® see TETANUS/DIPHThERIA/ACELLULAR PERTUSSIS (TDaP)

BRETHINE® see TERBUTALINE SULFATE

**BRIMONIDINE (Max 11 refills)**

ALPHAGAN®  
0.2% OPHTHALMIC SOLUTION -10 ML (\$3.12)

**BROMOCRIPTINE MESYLATE (Max 11 refills)**

PARLODEL®  
2.5 MG TABLET (\$0.79)

(Note: May not be used post-partum to inhibit lactation.)

**BUPIVACAINE HCL**

MARCAINE®  
0.25% INJECTION – 10 ML VIAL (\$1.72)  
0.5% INJECTION – 10 ML VIAL (\$1.95)

(Note: Clinic use only. Take from stock. May not be given KOP.)

**BUPRENORPHINE**

SUBUTEX®  
2 MG SUBLINGUAL TABLET (\$3.25)

(Note: May not be given KOP. Floor stock allowed at select intake units (0B, BX, FB, GC, LJ, ND, NE, NJ, RZ, SY, and WM) for tapering/pregnancy. Nonformulary approval required for use.)

**CALAMINE LOTION**

LOTION – 6 OZ (\$1.93)

(Note: Take from stock.)

CALAN® SR see VERAPAMIL HCL

CALAN® see VERAPAMIL HCL

**CALCITRIOL (Max 11 refills)**

ROCALTROL®  
0.25 MCG CAPSULE (\$0.07)

**CALCIUM CARBONATE**

OS-CAL® (Max 11 refills)  
500 MG ELEMENTAL CALCIUM/1.25 GM CARBONATE SALT TAB (\$0.03)

TUMS® (Max 2 refills)  
500 MG CALCIUM CARBONATE CHEW TAB 150s (\$1.80/BTL)

ANTACID®  
420 MG CHEW TABLET – 500/BOX (\$10.00)

(Note: For nursing protocol use only. No refills allowed.)

**CALCIUM CARBONATE/VITAMIN D (Max 11 refills)**

600 MG ELEMENTAL CALCIUM/400 IU VITAMIN D TABLET (\$0.01)

**CALCIUM GLUCONATE**

10% INJECTION – 10 ML VIAL (\$9.23)  
(94 MG CALCIUM GLUCONATE EACH VIAL)

(Note: Clinic use only. Take from stock. May not be given KOP.)

**CALCIUM POLYCARBOPHIL (Max 5 refills)**

FIBERCON®, FIBER LAXATIVE  
625 MG TABLET (\$0.06)

(Note: Dispensed in increments of 60. Floor stock restricted to TJJD.)

CALMOSEPTINE® see ZINC OXIDE/MENTHOL

**CARBAMAZEPINE (Max 11 refills)**

TEGRETOL®  
200 MG TABLET (\$0.05)  
SUSPENSION 100 MG/5 ML – 450 ML (\$178.84)

(Note: May not be given KOP. Suspension is take from stock for TDCJ UTMB. Use cautiously in patients of Asian descent. See seizure pathway for complete details.)

**CARBAMIDE PEROXIDE**

DEBROX®

6.5% OTIC SOLUTION – 15 ML (\$0.92)

(Note: Clinic use only, should be taken from stock, and may not be given KOP.)

**CARBIDOPA/LEVODOPA (Max 11 refills)**

SINEMET® 25-250

CARBIDOPA 25 MG/LEVODOPA 250 MG TABLET (\$0.08)

CARDIZEM® see DILTIAZEM

**CARVEDILOL (Max 11 refills)**

COREG®

3.125 MG (\$0.02), 6.25 MG (\$0.02), 12.5 MG (\$0.02), 25 MG (\$0.04) TABLET

CATAPRES® see CLONIDINE HCL

CATHFLO ACTIVASE® see ALTEPLASE

**CEFAZOLIN SODIUM**

ANCEF®

1 GM INJECTION – 10 ML VIAL (\$0.87)

Preparation Standard:

< 2 gm in 100mL D<sub>5</sub>W over 30-60 minutes.

(Note: Clinic use only. Take from stock. May not be given KOP.)

**CEFEPIME**

MAXIPIME®

2 GM INJECTION (\$8.11)

(Note: Clinic use only. Take from stock for RMFs, ED, and TJJD only. May not be given KOP. Restricted to regional medical facilities (inpatient use only), ED, and TJJD. Should **not** be used as single injectable dose followed by oral therapy.)**CEFTRIAZONE**

ROCEPHIN®

500 MG INJECTION (\$0.83)

(Note: Clinic use only. May not be given KOP. Prior authorization criteria must be met and noted in the special instructions field for use. Criteria is: Treatment of GC (gonorrhea). If chlamydia has not been excluded, use with doxycycline 100 mg BID x 7d. In pregnant patients with chlamydia, use with prior authorization azithromycin 1200 mg (2 tablets of 600 mg) x 1 dose.)

1 GM INJECTION (\$0.94)

(Note: Clinic use only. Take from stock for RMFs, infirmaries, and TJJD only. May not be given KOP. Restricted to regional medical facilities (inpatient use only), infirmary units (inpatient use only), and TJJD.)

CELLCEPT® see MYCOPHENOLATE MOFETIL

**CEPHALEXIN**

KEFLEX®

500 MG CAPSULE (\$0.08)

**CETIRIZINE (Max 2 refills)**

Zyrtec®

10 MG TABLET (\$0.02)

**CHARCOAL**

ACTIDOSE® -AQUA

50 GM ACTIVATED CHARCOAL SUSP 240 ML (\$17.67)

(Note: Clinic use only. Take from stock. May not be given KOP.)

**CHLORDIAZEPOXIDE - CIV**

LIBRIUM®

10 MG (\$0.46), 25 MG (\$0.49) CAPSULE

(Note: May not be given KOP. Take from stock. Restricted to benzodiazepine discontinuation. Take from stock. May only be ordered by a physician or a DEA registered midlevel provider.)

**CHLORHEXIDINE GLUCONATE**

PERIDEX®

0.12% ORAL RINSE – 16 OZ (\$2.55)

(Note: Restricted to floor stock.)

**CHOLECALCIFEROL (Max 11 refills)**

VITAMIN D-3

1000 IU TABLET (\$0.01)

**CICLESONIDE HFA** (Max 11 refills)

ALVESCO®

HFA ORAL INHALER 60 ACUTATIONS 80 MCG (\$54.40), 160 MCG (\$54.40)

(Note: 80mcg: 1 inhaler will last 30 days at 1 puff BID. If needing 2 puffs (total dose 160mcg) enter order for the 160mcg inhaler.

160mcg: 1 inhaler will last 30 days at 1 puff BID. 1 inhaler will last 15 days at 2 puffs BID. Enter order for 30 day and Pharmacy will send 2 inhalers per month.

Drug interaction with protease inhibitors and cobicistat. For these patients seek non-formulary approval for QVAR 80 mcg RediHaler.)

CILOXAN® see CIPROFLOXACIN

CIPRO® see CIPROFLOXACIN

**CIPROFLOXACIN**

CILOXAN®

0.3% OPHTHALMIC SOLUTION – 5 ML (\$6.90)

(Note: Prior authorization criteria must be met and noted in the special instructions field for use without a non-formulary approval. Criteria include: post-cataract surgery or ocular procedures. Floor stock restricted to Montford.)

CIPRO®

500 MG TABLET (\$0.13)

(Note: Use restricted to regional medical facilities (inpatient use only) and ED. Available as floor stock to prevent delays in therapy. Not recommended for GC or gram-positive infections including *S. aureus*. Non-formulary approval still required for use at facilities other than RMFs.)

CITANEST FORTE® see PRILOCAINE/EPINEPHRINE

CLARITIN® see LORATADINE

CLEOCIN®, CLEOCIN-T® see CLINDAMYCIN

**CLINDAMYCIN HCL**

CLEOCIN®

150 MG CAPSULE (\$0.07)

**CLINDAMYCIN PHOSPHATE**

CLEOCIN®, CLEOCIN-T®

1% TOPICAL SOLUTION – 60 ML (\$4.94)

(Note: Topical solution is restricted to TJJD facilities and may not be given KOP.)

150 MG/ML – 6 ML VIAL (\$4.16)

IV Preparation Standard:

> 600 mg in 100mL D<sub>5</sub>W over 60 minutes. Maximum rate of infusion 30 mg/minute.

900 MG/50 ML D<sub>5</sub>W PREMIX (\$13.32)

(Note: Injection is clinic use only. Take from stock. May not be given KOP.)

CLINIMIX E® see AMINO ACID/ELECTROLYTES/CALCIUM IN D20W

**CLONIDINE HCL**

CATAPRES®

0.1 MG TABLET (\$0.03)

(Note: Clinic use only for management of withdrawal symptoms from opioid discontinuation or in ED. Take from stock. May not be given KOP. A 30-day supply may be ordered for intake patients without a non-formulary approval to facilitate tapering off the medication and conversion to a formulary agent. Providers must type "intake" in the special instructions field. All other uses require non-formulary approval.)

**CLOPIDOGREL** (Max 11 refills)

PLAVIX®

75 MG TABLET (\$0.04)

**CLOTRIMAZOLE**

LOTRIMIN®

1% TOPICAL SOLUTION – 10 ML (\$13.87)

1% CREAM – 15 GM TUBE (\$3.29)

MYCELEX®

10 MG TROCHE, 70/BOTTLE (\$17.47/BOTTLE)

**CLOZAPINE** (Max 11 refills)

CLOZARIL®

25 MG (\$0.78), 100 MG (\$2.01) TABLET

(Note: May not be given KOP. Non-formulary approval is required for use. Floor stock restricted to BC, CV, J4, JM, SV.)

CLOZARIL® see CLOZAPINE

**COAL TAR**

DHS TAR, PC-TAR®  
0.5% SHAMPOO – 8.5 OZ (\$2.42)  
(Note: Should be ordered for 1 bottle to last 90 days.)

COGENTIN® see BENZTROPINE MESYLATE

COLACE® see DOCUSATE SODIUM

**COLLAGENASE**

SANTYL®  
250 UNITS/GM – 30 GM OINTMENT (\$309.53)  
(Note: Clinic use only. Use and floor stock restricted to Infirmaries and RMFs. Take from stock for infirmaries and RMFs. May not be given KOP. For all other units, prior authorization criteria must be met and noted in special instructions field for use without non-formulary approval. Criteria include: TH (Telehealth) Wound care clinic.)

COMPAZINE® see PROCHLORPERAZINE

COMPOUND W® see SALICYLIC ACID

CONCERTA® see METHYLPHENIDATE

CONDYLOX® see PODOFILOX

CORDARONE® see AMIODARONE

COREG® see CARVEDILOL

CORTISPORIN® see NEOMYCIN/POLYMYXIN/BACITRACIN/HYDROCORTISONE

CORTISPORIN® OTIC see NEOMYCIN/POLYMYXIN/HYDROCORTISONE

COUMADIN® see WARFARIN SODIUM

**COVID VACCINE**

SPIKEVAX®  
50 MCG / 0.5 ML - SINGLE DOSE VIAL (\$138.79)  
(Note: Given through the Immunization Module as SDO-Standing Delegated Order. Clinic use only. Take from stock. May not be given KOP. Follow Infection Control P&P B-14.52)

COZAAR® see LOSARTAN

CREON 12® see PANCRELIPASE

CRYSELLE® see NORGESTREL/ETHINYL ESTRADIOL

**CYANOCOBALAMIN, VITAMIN B-12 (Max 11 refills)**

1000 MCG TABLET (\$0.02)  
1000 MCG/ML INJECTION – 1 ML VIAL (\$1.90)  
(Note: Injection for clinic use only, should be taken from stock, and may not be given KOP.)

CYCLOGYL® see CYCLOPENTOLATE HCL

**CYLCOPENTOLATE HCL**

CYCLOGYL®  
1% OPHTHALMIC SOLUTION – 15 ML (\$9.67)

**CYCLOSPORINE, MODIFIED (Max 11 refills)**

NEORAL®  
25 MG (\$0.53), 100 MG (\$4.29) CAPSULE  
(Note: May not be given KOP.)

CYMBALTA® see DULOXETINE

D-T TOXOIDS see TETANUS & DIPHTHERIA TOXOIDS

DACRIOSE® see OPHTHALMIC IRRIGATING SOLUTION

**DAPSONE** (Max 11 refills)  
AVLOSULFON®  
100 MG TABLET (\$1.13)

DARAPRIM® see PYRIMETHAMINE

**DARUNAVIR** (Max 11 refills)  
PREZISTA®  
600 MG (\$1.45), 800 MG (\$2.06) TABLET  
(Note: The 600 mg is dosed BID and the 800 mg is dosed QD.)

DDAVP see DESMOPRESSIN

DEBROX® see CARBAMIDE PEROXIDE

DECADRON® see DEXAMETHASONE

DELTASONE® see PREDNISONE

DEPAKOTE® see DIVALPROEX SODIUM

DEPO-MEDROL® see METHYLPREDNISOLONE ACETATE

DEPO-ESTRADIOL® see ESTRADIOL CYPIONATE

DEPO-PROVERA® see MEDROXYPROGESTERONE

DEPO-TESTOSTERONE® see TESTOSTERONE

**DESMOPRESSIN** (Max 5 refills)  
DDAVP®  
0.2 MG TABLET (\$0.43)  
(Note: Restricted to TJJD use only.)

DESYREL® see TRAZODONE HCL

**DEXAMETHASONE**  
DECADRON®  
4 MG/ML – 1 ML VIAL (\$0.71) (No refills)  
(Note: Clinic use only. Take from stock. May not be given KOP).  
4 MG TABLET (\$0.05) (Max 11 refills)  
(Note: Tablet allowed as floor stock at RMFs only. Non-formulary approval still required for use.)

DEXTROAMPHETAMINE/AMPHETAMINE see AMPHETAMINE SALTS

**DEXTROSE**  
DEXTROSE 5% in WATER INJECTION  
100 ML (\$2.31), 250 ML, (\$3.80), 500 ML (\$3.97), 1000 ML (\$4.94)  
DEXTROSE 5% in WATER INJECTION MINI-BAG – 100 ML (\$5.68)  
DEXTROSE 5% in NS INJECTION – 500 ML (\$4.63) 1000 ML (\$5.03)  
DEXTROSE 5% in 1/4 NS INJECTION – 1000 ML (\$6.09)  
DEXTROSE 5% in 1/2 NS INJECTION – 1000 ML (\$2.82)  
DEXTROSE 5% LACTATED RINGERS – 1000 ML (\$5.29)  
DEXTROSE 10% in WATER INJECTION – 1000 ML (\$7.40)  
DEXTROSE 50% INJECTION SYRINGE – 50 ML (\$18.66)  
(Note: Clinic use only. Take from stock. May not be given KOP. D10W 1000 mL restricted to facilities that provide skilled nursing care, convalescent care or hospice (0B, E2-RMF, GC-RMF, HP, J3, MI, ST) for use until TPN is available.)  
  
DEXTROSE GLUCOSE ORAL GEL 15GM/POUCH – 6/BOX  
TRUEPLUS® 6/BOX (\$1.38/packet)  
(Note: Clinic use only. Take from stock. May not be given KOP.)

DIAMOX® see ACETAZOLAMIDE

**DIAZEPAM - CIV** (Max 5 refills)

VALIUM®

5 MG TABLET (\$0.07)

(Note: May not be given KOP. Take from stock. May only be ordered by a physician or DEA registered midlevel provider. Prior authorization must be met and noted in the special instructions field for use without non-formulary approval. Criteria include:

- a. Spinal cord injury
- b. Multiple sclerosis
- c. Muscular dystrophy
- d. Spastic hemiplegia
- e. Amyotrophic lateral sclerosis
- f. Cerebral palsy)

**DICLOXACILLIN SODIUM**

DYNAPEN®

250 MG (\$0.59), 500 MG (\$0.89) CAPSULE

DIFLUCAN® see FLUCONAZOLE

DILACOR® XR see DILTIAZEM

DILANTIN® see PHENYTOIN SODIUM

**DILTIAZEM**

CARDIZEM®

60 MG (\$0.15), 90 MG (\$0.08) TABLET (Max 11 refills)

5 MG/ML INJECTION - 10 ML SDV (\$5.20) (No refills)

(Note: Injection use and stock restricted to ED. Take from stock for ED.)

DILACOR® XR (extended release once-daily dosage form)

180 MG (\$0.34), 240 MG (\$0.60) EXTENDED-RELEASE CAPSULE (Max 11 refills)

**DIPHENHYDRAMINE HCL**

BENADRYL®

25 MG (\$0.02), 50 MG CAPSULE (\$0.02) (Max refills: TDCJ-5, TJJJ-2)

ELIXIR 12.5 MG/5 ML – 4 OZ (\$1.24) (No refills)

50 MG/ML INJECTION – 1 ML VIAL (\$0.97) (No refills)

(Note: Injection for clinic use only, should be taken from stock, and may not be given KOP.)

DIPHThERIA/TETANUS TOXOIDS see TETANUS & DIPHTHERIA TOXOIDS

**DIVALPROEX SODIUM DR** (Max 11 refills)

DEPAKOTE DR®

250 MG (\$0.06), 500 MG (\$0.11) DELAYED RELEASE TABLET

**DOCUSATE SODIUM** (Max 5 refills)

COLACE®

100 MG CAPSULE (\$0.04)

**DOLUTEGRAVIR** (Max 11 refills)

TIVICAY®

50 MG TABLET (\$75.57)

**DOPAMINE**

DOPAMINE 400 MG IN 5% DEXTROSE 250 ML (\$12.47)

(Note: Clinic use only. Take from stock. May not be given KOP.)

**DORZOLAMIDE**

TRUSOPT®

2% OPHTHALMIC SOLUTION – 10 ML (\$9.83)

DOUBLE ANTIBIOTIC OINTMENT see BACITRACIN/POLYMYXIN B

**DOXYCYCLINE**

VIBRAMYCIN®

100 MG TABLET (\$0.06)

(Note: Dosed 100 mg twice daily x 7 days for treatment of chlamydia.)

D-T TOXOIDS see see TETANUS & DIPHTHERIA TOXOIDS

DULCOLAX® see BISACODYL

**DULOXETINE** (Max 11 refills)  
 CYMBALTA®  
 30 MG (\$0.06), 60 MG (\$0.06) DELAYED-RELEASE CAPSULE

DUOFILM® see SALICYLIC ACID

DURAGESIC® see FENTANYL

DYAZIDE® see TRIAMTERENE/HCTZ

DYNAPEN® see DICLOXACILLIN SODIUM

ECOTRIN® see ASPIRIN, ENTERIC-COATED

EDURANT® see RILPIVIRINE

**EFAVIRENZ** (Max 11 refills)  
 SUSTIVA®  
 600 MG TABLET (\$0.43)

EFFEXOR® XR see VENLAFAXINE HCL

**ELECTROLYTE ORAL SOLUTION**  
 GOLYTELY®  
 PEG 3350 & ELECTROLYTE SOLUTION - 4 LITER BOTTLE (\$22.97)  
 (Note: Clinic use only. Take from stock. May not be given KOP.)

ELIMITE® see PERMETHRIN

ELLA® see ULIPRISTAL

ELOCON® see MOMETASONE FUROATE

**ELVITEGRAVIR/COBICISTAT/EMTRICITABINE/TENOFOVIR** (Max 11 refills)  
 GENVOYA®  
 150 MG/150 MG/200 MG/10 MG TABLET (\$137.02)  
 (Note: Prior authorization criteria must be met and noted in the special instructions field for use without a non-formulary approval. Criteria include: Patient on Genvoya or Stribild at intake.)

**EMTRICITABINE/TENOFOVIR** (Max 11 refills)  
 TRUVADA®  
 200 MG/300 MG TABLET (\$0.46)

**ENOXAPARIN** (Max 11 refills)  
 LOVENOX®  
 40 MG/0.4ML (\$2.49), 100 MG/ML (\$6.16), 150 MG/ML (\$10.62) SYRINGES  
 (Note: May not be given KOP. Floor stock allowed at RMFs, Infirmaries, ED, and transient units en route to HG (0B, DU, DA, DU, E2, GR, HV, ML, ND, NF and NH) Nonformulary approval required for use. 40MG/0.4ML may be used without non-form approval for ED patients.)

**ENTECAVIR** (Max 11 refills)  
 BARACLUDE®  
 0.5 MG (\$0.25), 1 MG (\$0.71) TABLET  
 (Note: Non-formulary approval required by HCV group from Pharmacy at [utmbcmc.pharmacy@utmb.edu](mailto:utmbcmc.pharmacy@utmb.edu) for UTMB units and assigned clinical pharmacist for TTUHSC units.)

**ENTERAL FEEDING/NUTRITION**  
 OSMOLITE® 1.0, 1.2, or 1.5 CAL  
 8 OZ ARC (\$1.28)  
 (Note: Take from stock. Enteral feeding formulation may be therapeutically interchanged if unavailable. No refills allowed except dialysis may order a maximum of 5 refills.)

ENULOSE® see LACTULOSE

EPCLUSA® see SOFOSBUVIR/VELPATASVIR

**EPINEPHRINE HCL**

ADRENALIN®

1 MG/1 ML INJECTION – 1 ML VIAL (\$13.65)

0.1 MG/1 ML INJECTION – 10 ML SYRINGE (\$12.67)

EPIPEN®

0.3 MG/0.3 ML INJECTION – 2 SYRINGES/PK (\$50.00/SYR)

(Note: Clinic use only. Take from stock. May not be given KOP. EpiPen restricted to EMS, TJJJ institutions for emergency boxes, and MRI mobile units. Non-formulary approval required for patient orders at TDCJ.)

EPIPEN® see EPINEPHRINE

EPIVIR® see LAMIVUDINE

**EPOETIN ALFA (Max 2 refills)**

EPOGEN®

10,000 UNIT/ML INJECTION – 2 ML MDV (\$323.31)

(Note: Clinic use only. Take from stock. May not be given KOP. Restricted to dialysis units as floor stock. Prior authorization criteria must be met and noted in the special instructions field for use without non-formulary approval. Criteria include: Dialysis.)

EPOGEN® see EPOETIN ALFA

EPZICOM® see ABACAVIR/LAMIVUDINE

**ERYTHROMYCIN BASE**

ERYTHROMYCIN DR®

250 MG CAPSULE (\$4.43)

**ERYTHROMYCIN**

ILOTYCIN®

0.5% OPHTHALMIC OINTMENT - 3.5 GM (\$7.77)

**ESCITALOPRAM (Max 11 refills)**

LEXAPRO®

5 MG (\$0.04), 10 MG (\$0.03), 20 MG (\$0.07) TABLET

(Note: Use and stock of 5mg restricted to TJJJ. Floor stock of 10mg restricted to TDCJ.)

ESKALITH® see LITHIUM CARBONATE

ESTRACE® see ESTRADIOL

**ESTRADIOL (Max 11 refills)**

ESTRACE®

1 MG (\$0.08), 2 MG (\$0.05) TABLET

(Note: Prior authorization criteria must be met and noted in special instructions field for use without a non-formulary approval. Criteria include: GD (gender dysphoria patients-new intake on hormone therapy or gender dysphoria clinic))

**ESTRADIOL CYPIONATE (Max 11 refills)**

DEPO-ESTRADIOL®

5 MG/ML INJECTION – 5 ML MDV (\$228.86)

(Note: May not be given KOP. Injection for clinic use only and should be taken from stock for TDCJ units only. Prior authorization criteria must be met and noted in special instructions field for use without a non-formulary approval. Criteria include: GD (gender dysphoria patients) - new intake on hormone therapy or gender dysphoria clinic.)

**ESTROGENS, BIRTH CONTROL**

see NORETHINDRONE / ETHINYL ESTRADIOL (ORTHO-NOVUM®, NORTREL®)

see NORGESTREL / ETHINYL ESTRADIOL (CRYSSELLE®, LO-OVRAL®)

**ESTROGENS, CONJUGATED**

PREMARIN®

0.625 MG (\$4.86), 1.25 MG (\$6.52) TABLET (Max 11 refills)

(Note: Restricted to use in female patients only.)

**ESTROGENS, CONJUGATED, VAGINAL** (Max 11 refills)

PREMARIN VAGINAL CREAM®  
0.625 MG/GRAM – 30 GRAM TUBE (\$323.10)  
(Note: Restricted to use in female patients only.)

**ETHAMBUTOL HCL** (Max 11 refills)

MYAMBUTOL®  
400 MG TABLET (\$0.40)  
(Note: May not be given KOP. Treatment of active TB should be DOT.)

**ETHYL CHLORIDE**

TOPICAL ANESTHETIC SPRAY 3.9 OZ (\$25.68)  
(Note: Restricted to Orthopedic Clinic use only. Take from stock for orthopedic clinic facilities.)

EUCERIN® see ABSORBASE

**EZETIMIBE** (Max 11 refills)

ZETIA®  
10 MG TABLET (\$0.17)

FACTOR VIII see ANTIHEMOPHILIC FACTOR (HUMAN)

**FAMOTIDINE** (Max 11 refills)

PEPCID®  
20 MG TABLET (\$0.01) (Max 11 refills)  
PEPCID® IV  
20 MG/2 ML SDV (\$0.79)

(Note: Non-formulary approval required for stock and patient order. Non-form stock restricted to 0B, E2-RMF, GC-RMF, HP, J3, MI, and ST for TPN. Take from stock. Clinic use only. May not be given KOP. Use and stock allowed without non-form approval at ED.)

**FAT EMULSIONS**

INTRALIPID®  
20% FAT EMULSIONS 250 ML (\$44.63), 500 ML (\$39.44)  
(Note: Non-formulary approval required for stock and patient order. Non-form stock restricted to 0B, E2-RMF, GC-RMF, HP, J3, MI, and ST for TPN. Take from stock. Clinic use only. May not be given KOP.)

**FENOFIBRATE** (Max 11 refills)

TRICOR®  
48 MG (\$0.05), 145 MG (\$0.07) TABLET

**FENTANYL- CII**

DURAGESIC®  
25 MCG/HR (\$4.51), 100 MCG/HR (\$12.41) PATCH  
(Note: Floor stock restricted to RMFs and hospice facilities. May not be given KOP. May only be ordered by a physician. Non-formulary approval is required prior to use.)

FEOSOL® see FERROUS SULFATE

**FERRIC SUBSULFATE**

MONSELS®  
PASTE 8ML SUV 12/BOX (\$179.50/BOX)  
(Note: Use and stock restricted to GC and GV for OB/GYN services. Clinic use only. Take from stock. May not be given KOP.)

**FERROUS SULFATE** (Max 11 refills)

FEOSOL®  
325 MG TABLET (\$0.01)

FIBERCON®, FIBER LAXATIVE see CALCIUM POLYCARBOPHIL

**FILGRASTIM** (Max 11 refills)

NIVESTYM®  
300 MCG/0.5 ML - PFS (\$200.71), 480 MCG/0.8 ML PFS (\$321.15)  
(Note: Clinic use only. May not be given KOP. Allowed as floor stock at E2 and GC only. Non-formulary approval still required for use.)

**FINASTERIDE** (Max 11 refills)

PROSCAR®  
5 MG TABLET (\$0.05)

Note: (Prior authorization criteria must be met and noted in special instructions field for use without a non-formulary approval. Criteria include: GD (gender dysphoria patients-new intake on hormone therapy or gender dysphoria clinic.))

FLEETS PHOSPHO SODA® see SODIUM PHOSPHATE ORAL SOLUTION

FLAGYL® see METRONIDAZOLE

FLOMAX® see TAMSULOSIN

**FLUCONAZOLE** (Max 11 refills)

DIFLUCAN®

100 MG (\$0.20), 150 MG (\$0.18), 200 MG (\$0.15) TABLET

(Note: Prior authorization must be met and noted in the special instructions field for use without non-formulary approval. Criteria include:

- a. 100 mg and 200 mg tablets restricted to treatment of HIV-related opportunistic infections.
- b. 150 mg tablets restricted to single dose therapy for vaginal candidiasis. Floor stock restricted to TJJD.)

**FLUMAZENIL**

ROMAZICON®

0.1 MG/ML IV INJECTION – 5 ML VIAL (\$3.35)

(Note: Restricted to emergency use only. Clinic use only. Take from stock. May not be given KOP.)

**FLUOCINONIDE**

LIDEX®

0.05% OINTMENT – 15 GM (\$5.65)

0.05% CREAM – 15 GM (\$5.17)

FLUORETS® see FLUORESCEIN SODIUM STRIPS

**FLUORESCEIN SODIUM STRIPS**

FLUORETS®, BIO-GLO®, FUL-GLO®

1 MG OPTHALMIC STRIPS – 100/BOX (\$0.22 each strip)

(Note: Clinic use only. Take from stock. May not be given KOP.)

**FLUOROMETHOLONE**

FML®

0.1% OPTHALMIC SUSPENSION – 5 ML (\$71.40)

**FLUOXETINE** (Max 11 refills)

PROZAC®

10 MG (\$0.05), 20 MG (\$0.02) CAPSULE

(Note: Use and stock of 10 mg restricted to TJJD only.)

**FLUPHENAZINE HCL** (Max 11 refills)

PROLIXIN®

2.5 MG (\$0.29), 5 MG (\$0.13), 10 MG (\$0.41) TABLET

2.5 MG/ML INJECTION – 10 ML VIAL (\$177.08)

(Note: May not be given KOP. Injection for clinic use only and should be taken from stock.)

**FLUPHENAZINE DECANOATE** (Max 11 refills)

PROLIXIN D®

25 MG/ML INJECTION – 5 ML VIAL (\$45.64)

(Note: Clinic use only, should be taken from stock and may not be given KOP.)

FML® see FLUOROMETHOLONE

**FOLIC ACID** (Max 11 refills)

FOLVITE®

1 MG TABLET (\$0.02)

FOLINIC ACID see LEUCOVORIN CALCIUM

FOLVITE® see FOLIC ACID

**FOSAMPRENAVIR** (Max 11 refills)

LEXIVA®

700 MG TABLET (\$9.86)

**FUROSEMIDE**

LASIX®

20 MG (\$0.02), 40 MG (\$0.02) TABLET (Max 11 refills)

10 MG/ML INJECTION – 4 ML VIAL (\$0.76) (No refills)

(Note: Injection for clinic use only, should be taken from stock and may not be given KOP.)

**GADOBENATE**

MULTIHANCE®

10 ML (\$17.08), 15 ML (\$25.18), 20 ML (\$33.57)

(Note: Imaging contrast agent. Restricted to mobile MRI unit. Clinic use only. Take from stock.)

**GADOTERIDOL**

PROHANCE®

10 ML (\$14.36), 15 ML (\$28.44), 20 ML (\$52.53)

(Note: Imaging contrast agent. Restricted to mobile MRI unit. Clinic use only. Take from stock.)

GARDASIL 9® see HUMAN PAPILLOMAVIRUS

GEL-KAM® see STANNOUS FLUORIDE

GENOPTIC® see GENTAMICIN

**GENTAMICIN**

GARAMYCIN®, GENOPTIC®

0.3% OPHTHALMIC SOLUTION – 5 ML (\$4.93)

GENTAMICIN

40 MG/ML INJECTION – 2 ML VIAL (\$3.04)

IV Preparation Standard:

In 100mL D<sub>5</sub>W over 60 minutes

(Note: Injection for clinic use only, should be taken from stock, and may not be given KOP.)

GENVOYA® see ELVITEGRAVIR/COBICISTAT/EMTRICITABINE/TENOFOVIR

GEODON® see ZIPRASIDONE

**GLIPIZIDE (Max 11 refills)**

GLUCOTROL®

5 MG (\$0.02), 10 MG (\$0.03) TABLET

GLUCAGEN® see GLUCAGON

**GLUCAGON**

GLUCAGEN®

1 MG HYPOKIT (\$257.97)

(Note: Clinic use only. Take from stock. May not be given KOP.)

GLUCOTROL® see GLIPIZIDE

GLUCOPHAGE® see METFORMIN

GLUCOSE GEL see DEXTROSE (TRUEPLUS®)

GLYDO® see LIDOCAINE HCL

GOLYTELY® see ELECTROLYTE ORAL SOLUTION

**GUAIFENESIN/DEXTROMETHORPHAN**

ROBITUSSIN DM

400 MG/20 MG TABLET, 30/BOTTLE (\$5.00/BOTTLE)

(Note: Prior authorization required and must be noted in special instructions. Criteria include: B14.52 cough or ED. No refills allowed. Limit of one bottle of 30 per order. Duration may not exceed 5 days. Stock restricted to ED.)

**GUANFACINE (Max 11 refills)**

TENEX®

1 MG (\$0.05), 2 MG (\$0.07) TABLET

**GUANFACINE ER (Max 11 refills)**

INTUNIV ER®

1 MG (\$0.02), 2 MG (\$0.03), 3 MG (\$0.03), 4 MG (\$0.02) EXTENDED-RELEASE TABLET

(Note: May not be given KOP. Restricted to TJJD use only.)

HALDOL® see HALOPERIDOL, HALOPERIDOL LACTATE

HALDOL D® see HALOPERIDOL DECANOATE

**HALOPERIDOL (Max 11 refills)**

HALDOL®

1 MG (\$0.07), 5 MG (\$0.11), 10 MG (\$0.10) TABLET

(Note: May not be given KOP.)

**HALOPERIDOL LACTATE**

HALDOL®

2 MG/ML ORAL CONCENTRATE – 120 ML (\$21.70) (Max 11 refills)

5 MG/ML INJECTION – 1 ML VIAL (\$0.77) (No refills)

(Note: May not be given KOP. Injection for clinic use only and should be taken from stock.)

**HALOPERIDOL DECANOATE (Max 11 refills)**

HALDOL D®

100 MG/ML INJECTION – 1 ML SDV (\$6.23)

100 MG/ML INJECTION – 5 ML MDV (\$27.58)

(Note: May not be given KOP. Injection for clinic use only and should be taken from stock. 5 ML MDV restricted to psychiatric inpatient facilities (BC, CV, J4, JM, SV) and facilities with Therapeutic Diversion Programs (AH, CY, LM, TL))

**HEMORRHOIDAL CREAM**

PREPARATION H®

MAXIMUM STRENGTH CREAM 51 GM (\$2.23) (Max 11 Refills)

(Note: Contains pramoxine HCL 1% and phenylephrine 0.25%)

**HEMORRHOIDAL SUPPOSITORY**

ANU-MED®

SUPPOSITORY - 12/BOX (\$0.21 EACH) (No refills)

(Note: Take from stock. Contains phenylephrine HCL 0.25% as active ingredients.)

HEMORRHOIDAL-HC RECTAL SUPPOSITORY see HYDROCORTISONE

HEP-LOCK® see HEPARIN SODIUM

**HEPARIN SODIUM**

HEP-LOCK®

100 U/ML – 3 ML SYRINGE (\$0.55)

HEPARIN

1,000 U/ML – 30 ML VIAL (\$3.27)

5,000 U/ML – 1 ML VIAL (\$2.76)

(Note: Clinic use only. Take from stock. May not be given KOP. 1,000 U/ML-30 ML restricted to dialysis centers.)

**HEPATITIS A VACCINE, INACTIVATED (Max 1 refill)**

VAQTA®

50 UNITS / ML – 1 ML SYR (\$57.49)

(Note: May not be given KOP. Restricted from floor stock. Order for 180 days to be given at 0 and 6 months. Prior authorization criteria must be met and noted in the special instructions field for use without non-formulary approval. Criteria include: patient is not immune (P&P B-14.07) plus one of the following

- a. HIV
- b. Chronic hepatitis C
- c. Chronic hepatitis B
- d. End stage liver disease
- e. NAFLD
- f. Clotting factor disorders)

**HEPATITIS B VACCINE, RECOMBINANT (Max 2 refills)**

RECOMBIVAX HB®

10 MCG/ML – 1 ML SYRINGE (\$45.83)

(Note: Clinic use only. Restricted from floor stock. May not be given KOP. Order for 60 days with 2 refills to be given at 0, 2, & 4 months. The Pharmacy will send each dose as an individual patient medication order. Prior authorization criteria must be met and noted in the special instructions field for use without non-formulary approval. Criteria include: patient is not immune (P&P B-14.07) plus one of the following

- a. Chronic hepatitis C
- b. HIV (double dose - 20mcg)
- c. Inmates who are subject to a blood borne exposure as outlined in Infection Control Policy B-14.06 (post-exposure prophylaxis)
- d. Sexual exposure
- e. Inmate workers in job classifications that have potential for occupational exposure as outlined in Correctional Managed Healthcare Policy B-14.4
- f. End stage liver disease
- g. Chronic liver disease
- h. Current or recent injection drug use
- i. <19 years old without documentation of series completion (lab work not required)

**HEPATITIS B VACCINE, RECOMBINANT, DIALYSIS FORMULATION (Max 2 refills)**

RECOMBIVAX HB®

40 MCG/ML – 1 ML SDV (\$102.76)

(Note: Clinic use only. Restricted from floor stock. May not be given KOP. Order for 60 days with 2 refills to be given at 0, 2, & 4 months. The Pharmacy will send each dose as an individual patient medication order. Prior authorization criteria must be met and noted in the special instructions field for use without non-formulary approval. Criteria include: patient is not immune (P&P B-14.07) plus patient is on dialysis.)

**HUMAN PAPILLOMAVIRUS VACCINE (HPV) (Max 2 refills)**

GARDASIL 9®

0.5 ML SINGLE DOSE VIAL (\$270.65)

(Note: Clinic use only. Restricted from floor stock. May not be given KOP. Order for 90 days with 2 refills to be given at 0, 3 and 6 months. The Pharmacy will send each dose as an individual patient medication order. Prior authorization criteria must be met and noted in the special instructions field for use without non-formulary approval. Criteria include: Female patient age 9 through 26 and has not been previously vaccinated.)

HURRICAIN® see BENZOCAINE

**HYDRALAZINE**

APRESOLINE®

25 MG (\$0.02), 50 MG (\$0.02) TABLET (Max 11 refills)

20 MG/ML INJECTION - 1 ML SDV (\$13.83) (No refills)

(Note: Injection use and stock restricted to ED. Take from stock for ED.)

**HYDROCHLOROTHIAZIDE (Max 11 refills)**

HYDRODIURIL®

12.5 MG CAPSULE (\$0.02)

25 MG (\$0.01), 50 MG (\$0.02) TABLET

**HYDROCORTISONE**

ANUSOL-HC®

25 MG HEMORRHOIDAL-HC RECTAL SUPPOSITORY–12/BOX (\$0.48 EACH)

HYTONE®

1% CREAM – 30 GM (\$1.48), U/D PACKET (\$0.08)

(Note: U/D Packet restricted to nurse protocol. Take from stock.)

**HYDROCORTISONE SODIUM SUCCINATE**

SOLU-CORTEF®

100 MG INJECTION – 2 ML VIAL (\$22.10)

250 MG INJECTION – 2 ML VIAL (\$40.98)

IV Preparation Standard:

50-100 mg in 100 mL D<sub>5</sub>W over 40 minutes

>100 mg in 250 mL D<sub>5</sub>W over 60 minutes.

(Note: Clinic use only. Take from stock. May not be given KOP.)

HYDRODIURIL® see HYDROCHLOROTHIAZIDE

**HYDROXYZINE PAMOATE (Max 2 refills)**

VISTARIL®

25 MG (\$0.06), 50 MG (\$0.07) CAPSULE

(Note: Restricted to TJJD only.)

HYTONE® see HYDROCORTISONE CREAM

HYTRIN® see TERAZOSIN

**IBUPROFEN (Max 2 refills)**

MOTRIN®

200 MG (\$0.04), 400 MG (\$0.02), 600 MG (\$0.03), 800 MG (\$0.04) TABLET

(Note: The 200 mg tablets should be taken from stock, no refills allowed and restricted to Texas Tech TDCJ facilities and TJJD facilities. 30D and 90D templates for 1 card of 30 to last 30 and 90 days. Stock of the 400 mg is restricted to UTMB TDCJ facilities.)

IMDUR® see ISOSORBIDE MONONITRATE

**IMIPRAMINE HCL (Max 11 refills)**

TOFRANIL®

25 MG (\$0.19), 50 MG (\$0.29) TABLET

(Note: May not be given KOP. Restricted to TJJD for treatment of enuresis.)

IMODIUM® see LOPERAMIDE HCL

IMURAN® see AZATHIOPRINE

INDERAL® see PROPRANOLOL

**INFLIXIMAB** (Max 5 refills)

RENFLEXIS®

100 MG IV INJECTION (\$453.80)

(Note: Floor stock and administration restricted to RMFs. Designated as a Local Control and therefore must be kept and inventoried as a controlled substance (Pharmacy Policies 20-05, 20-10, 20-15). Non-formulary approval is still required prior to use. Take from stock. May not be given KOP.)

**INFLUENZA VIRUS VACCINE**

AFLURIA®, FLUCELVAX®, FLUVIRIN®

45 MCG / 0.5 ML - 0.5 ML SYR (\$14.98)

(Note: Given through the Immunization Module as SDO-Standing Delegated Order. Clinic use only. Take from stock. May not be given KOP. Seasonally available. Follow Infection Control P&P B-14.51.

a. ≥ 50 years old

b. Certain chronic diseases (heart disease, asthma, COPD, diabetes, renal disease, hepatic disease, neurologic disease, asplenic, and hematologic disease)

c. Immunocompromising diseases (HIV, most cancers, ESRD, sickle cell, medications)

d. Pregnancy during the influenza season

e. < 18 years old and on chronic aspirin therapy

f. Morbidly obese BMI ≥ 40)

INFUVITE® see MULTIVITAMIN

INH see ISONIAZID

**INSULIN GLARGINE** (Max 11 refills)

LANTUS®

100U/ML 10 ML VIAL (\$62.65)

(Note: Clinic use only. Take from stock. May not be given KOP. Once opened, must be discarded after 28 days if stored refrigerated or at room temperature.)

**INSULIN, HUMAN** (Max 11 refills)

NOVOLIN®

NPH 100 UNITS/ML – 10 ML VIAL (\$44.44)

REGULAR 100 UNITS/ML – 10 ML VIAL (\$44.44)

(Note: Clinic use only. Take from stock. May not be given KOP. Once opened, must be discarded after 30 days if stored refrigerated or at room temperature.)

INTRALIPID® see FAT EMULSIONS

INTUNIV ER® see GUANFACINE ER

**IOPAMIDOL**

ISOVUE-370®

100 ML (\$13.72)

(Note: Imaging contrast agent. Restricted to mobile CT unit. Clinic use only. Take from stock.)

**IPRATROPIUM BROMIDE**

ATROVENT® (Clinic use - No refills, KOP use - max 11 refills)

0.02% NEBULIZER SOLUTION - 2.5 ML UD 25/BOX (\$4.25/BOX)

(Note: CLINIC USE template -Take from stock. Clinic use only.

KOP USE template - Prior Authorization criteria must be met and noted in special instructions field. Criteria is issued nebulizer machine. Must be ordered KOP and orders may not exceed 25 days.)

**IRON SUCROSE** (Max 11 refills)

VENOFER®

20 MG/ML – 5 ML SINGLE DOSE VIAL (\$34.86)

(Note: Clinic use only. Take from stock. May not be given KOP. Restricted to dialysis centers. All other uses require non-formulary approval. Non-formulary use restricted to RMFs.)

ISENTRESS® see RALTEGRAVIR

**ISONIAZID** (Max 11 refills)

NYDRAZID®, INH

300 MG TABLET (\$3.09)

(Note: May not be given KOP. Take from stock for TDCJ. Should be dosed DOT for treatment of latent TB once weekly with rifapentine (Priftin®) and for twice weekly dosing. Treatment of active TB should also be DOT.)

ISOPTO ATROPINE® see ATROPINE SULFATE

ISORDIL® see ISOSORBIDE DINITRATE

**ISOSORBIDE DINITRATE** (Max 11 refills)

ISORDIL®

10 MG (\$0.53), 20 MG (\$0.29)

(Note : Prior authorization criteria must be met and noted in the special instructions field for use without non-formulary approval. Criteria is: Heart Failure. Should be used in combination with hydralazine. 10 mg available in stock to prevent delays in therapy. Non-formulary approval is still required for all other uses.)

**ISOSORBIDE MONONITRATE** (Max 11 refills)

ISMN, IMDUR®

30 MG (\$0.08), 60 MG (\$0.12) EXTENDED RELEASE TABLET

ISOVUE® see IOPAMIDOL

KALETRA® see LOPINAVIR/RITONAVIR

KAYEXALATE® see POLYSTYRENE SODIUM SULFONATE

K-DUR® see POTASSIUM CHLORIDE

KCL see POTASSIUM CHLORIDE

KEFLEX® see CEPHALEXIN

KENALOG® see TRIAMCINOLONE

KENALOG IN ORABASE® see TRIAMCINOLONE DENTAL PASTE

KEPPRA® see LEVETIRACETAM

**KETOROLAC**

ACULAR®

0.5% OPHTHALMIC SOLUTION – 5 ML (\$8.70)

TORADOL®

30 MG/ML INJECTION - 1 ML SDV (\$0.62)

(Note: Use and stock restricted to ED. Take from stock for ED.)

KOATE® see ANTIHEMOPHILIC FACTOR (HUMAN)

KYLEENA® see LEVONORGESTREL

**LABETALOL**

NORMODYNE®

5 MG/ML – 40 ML MDV (\$2.73)

(Note: Restricted to EMS and ED for treatment of HTN emergencies per protocol.)

**LACTATED RINGERS**

INJECTION 1000 ML (\$3.04)

(Note: Clinic use only. Take from stock. May not be given KOP.)

**LACTULOSE** (Max 11 refills)

ENULOSE®

10 GM/15 ML SYRUP – 473 ML (\$10.41)

(Note: Take from stock for TDCJ only.)

LAMICTAL® see LAMOTRIGINE

**LAMIVUDINE** (3TC) (Max 11 refills)

EPIVIR®

150 MG (\$0.24), 300 MG (\$0.72) TABLET

(Note: Use PEP template for post-exposure prophylaxis.)

**LAMOTRIGINE** (Max 11 refills)

LAMICTAL®

25 MG (\$0.03) TABLET

(Note: 25 mg allowed as floor stock at TJJJ intake facilities only. Non-formulary approval still required for use.)

LANTUS® see INSULIN GLARGINE

LASIX® see FUROSEMIDE

**LATANOPROST** (Max 11 refills)

XALATAN®

0.005% OPHTHALMIC SOLUTION - 2.5 ML (\$2.43)

(Note: Requires refrigeration prior to administration. It may be stored outside of the refrigerator for up to 30 days once given to the patient KOP.)

LATUDA® see LURASIDONE

LAVACOL® see ALCOHOL, ETHYL 70%

**LEUCOVORIN CALCIUM** (Max 11 refills)

WELLCOVORIN®, FOLINIC ACID

5 MG TABLET (\$1.06)

LEVAQUIN® see LEVOFLOXACIN

**LEVETIRACETAM**

KEPPRA®

500 MG (\$0.04), 1000 MG (\$0.15) TABLET (Max 11 refills)

500 MG/100 ML BAG (\$9.28) (No refills)

(Note: Injection use and stock restricted to ED. Take from stock for ED.)

LEVODOPA/CARBIDOPA see CARBIDOPA/LEVODOPA

**LEVOFLOXACIN**

LEVAQUIN®

750 MG TABLET (\$0.16)

(Note: Allowed as floor stock for TDCJ. Non-form approval still required for use.)

**LEVONORGESTREL** (Max 4 refills)

KYLEENA®

19.5 MG SYSTEM (\$1202.48)

(Note: Floor stock and use restricted to GC and GV. Non-formulary approval required for stock and patient order. Take from stock. Clinic use only. May not be given KOP.)

**LEVOTHYROXINE SODIUM** (Max 11 refills)

SYNTHROID®

0.025 MG (\$0.05), 0.05 MG (\$0.02), 0.075 MG (\$0.05), 0.1 MG (\$0.01), 0.15 MG (\$0.02) TABLET

LEXAPRO® see ESCITALOPRAM

LEXIVA® see FOSAMPRENAVIR

LIBRIUM® see CHLORDIAZEPOXIDE

LIDEX® see FLUOCINONIDE

**LIDOCAINE HCL**

XYLOCAINE®, GLYDO®

2% VISCOUS ORAL SOLUTION – 100 ML (\$9.03)

2% TOPICAL JELLY PFS - 6 ML (\$3.78)

5% OINTMENT – 1.25 OZ (\$6.64)

0.4%/D5W IV INJECTION – 500 ML (\$2.25)

1% LOCAL INJECTION (10 MG/ML) – 20 ML VIAL (\$0.97)

2% LOCAL INJECTION (20 MG/ML) – 20 ML VIAL (\$1.29)

(Note: Injection and 2% jelly for clinic use only and should be taken from stock. The 2% jelly restricted to emergency use only. Viscous solution may not be given KOP. The 5% ointment is restricted as floor stock to GC and GV for clinic use only by OBGYN services and may not be given KOP. The 0.4%/D5W 500 mL premix bags are restricted to EMS.)

**LIDOCAINE/EPINEPHRINE**

XYLOCAINE/EPINEPHRINE®

1% / 1:100,000 – 20 ML VIAL (\$5.15)

2% / 1:100,000 CARTRIDGE (50/BOX) (\$35.45/BOX)

(Note: Cartridges restricted to UTMB dental services. Clinic use only. Take from stock. May not be given KOP.)

**LIDOCAINE/PRILOCAINE**

ORAQIX®

2.5% / 2.5% GEL CARTRIDGE (20/BOX) (\$68.35/BOX)

(Note: Restricted to UTMB dental services. Clinic use only. Take from stock. May not be given KOP.)

LIORESAL® see BACLOFEN

LIPITOR® see ATORVASTATIN

**LISDEXAMFETAMINE - CII**

VYVANSE®

30 MG (\$12.60), 40 MG (\$12.60), 50 MG (\$12.60), 60 MG (\$12.60), 70 MG (\$12.60) CAPSULE

(Note: May not be given KOP. Restricted to TJJD use only. Take from stock TJJD institutions only. May only be ordered by a physician. Prior authorization criteria must be met and include: Failed treatment with Methylphenidate and Adderall.)

**LISINAPRIL (Max 11 refills)**

PRINIVIL®, ZESTRIL®

2.5 MG (\$0.01), 5 MG (\$0.01), 10 MG (\$0.01), 20 MG (\$0.02), 40 MG (\$0.04) TABLET

**LITHIUM CARBONATE (Max 11 refills)**

ESKALITH®

300 MG CAPSULE (\$0.07)

(Note: May not be given KOP.)

LO/OVRAL-28® see NORGESTREL/ETHINYL ESTRADIOL

LONITEN® see MINOXIDIL

**LOPERAMIDE HCL**

IMODIUM®

2 MG CAPSULE (\$0.07)

(Note: U/D tablets allowed for TJJD nurse protocol and HWH only.)

**LOPINA VIR/RITONAVIR (Max 11 refills)**

KALETRA®

200 MG/50 MG FILM-COATED TABLET (\$2.93)

(Note: Use PEP template for post-exposure prophylaxis.)

LOPRESSOR® see METOPROLOL TARTRATE

**LORATADINE (Max 2 refills)**

CLARITIN®

10 MG TABLET (\$0.03), U/D (\$0.25)

(Note: U/D take from stock and restricted to nursing protocol.)

**LORAZEPAM - CIV**

ATIVAN®

2 MG/ML INJECTION – 1 ML VIAL (\$1.18)

(Note: Clinic use only. Take from stock. May not be given KOP. May only be ordered by a physician or DEA registered midlevel provider. Requires refrigeration. Use restricted to: treatment of acute seizures uncontrolled by other measures; short-term treatment of agitation at inpatient psychiatric facilities or ED. All other uses require non-formulary approval.)

0.5 MG TABLET (\$0.04)

(Note: Clinic use only. Take from stock. May not be given KOP. Floor stock and use restricted to mobile MRI hub units for patients who have documented claustrophobia. Prior authorization criteria must be met and noted in the special instructions field. Criteria: Mobile MRI. Give 2 tabs 30-60 minutes before MRI. May re-dose with 1 tablet in 30 minutes if needed. May only be ordered by a physician or DEA registered midlevel provider.)

**LOSARTAN (Max 11 refills)**

COZAAR®

25 MG (\$0.03), 50 MG (\$0.17), 100 MG (\$0.05) TABLET

LOTRIMIN® see CLOTRIMAZOLE

LOVENOX® see ENOXAPARIN

**LUBRICANT EYE OINT (Max 11 refills)**

SOOTHE® LUBRICANT EYE OINT

OPHTHALMIC OINTMENT – 3.5GM (\$6.77)

**LUBRICANT, SURGICAL**

SURGILUBE®

4.25 OZ TUBE (\$2.41)

3 GM FOILPACK (\$0.15)

(Note: Clinic use only, take from stock, and may not be given KOP. Use and stock of the 4.25 oz is restricted to regional medical facilities.)

**LURASIDONE** (Max 11 refills)

LATUDA®

20 MG (\$0.16), 40 MG (\$0.50), 60 MG (\$0.61), 80 MG (\$0.35), 120 MG (\$0.77) TABLET  
(Note: May not be given KOP. 120mg restricted to TDCJ. Max dose for patients <18 yo is 80mg/day.)

MACROBID® see NITROFURANTOIN MONO

**MAGNESIUM CITRATE**

SOLUTION – 300 ML (\$1.43)

(Note: Clinic use only. Take from stock. May not be given KOP.)

**MAGNESIUM HYDROXIDE**

MILK OF MAGNESIA®

2400 MG/30 ML SUSPENSION – 30 ML UNIT DOSE (\$1.44)

(Note: Take from stock.)

MAG OX® see Magnesium Oxide

**MAGNESIUM OXIDE** (Max 11 refills)

MAG OX®

400 MG TABLET (\$0.07)

(Note: Stock restricted to ED.)

**MAGNESIUM SULFATE**

50% INJECTION (500 MG/ML) – 2 ML VIAL (\$1.12)

(Note: Clinic use only. Take from stock. May not be given KOP.)

MARCAINE® see BUPIVACAINE

MAXIPIME® see CEFEPIME

MAXITROL® see NEOMYCIN/POLYMYXIN/DEXAMETHASONE

**MEASLES/MUMPS/RUBELLA VACCINE, LIVE**

M-M-R®- II VACCINE

0.5 ML SC INJECTION (\$88.29)

(Note: Restricted from stock. May not be given KOP. Prior authorization criteria must be met and noted in the special instructions field for use without non-formulary approval. Criteria include:

- a. < 19 years old without documentation of completion
- b. Immigrants that have not completed the series
- c. Born after 1956 and did not attend public school in Texas.)

**MECLIZINE HCL** (Max 2 refills)

ANTIVERT®

25 MG TABLET (\$0.04)

MEDROL DOSEPAK® see METHYLPREDNISOLONE

**MEDROXYPROGESTERONE**

DEPO-PROVERA®

150 MG/ML INJECTION – 1 ML VIAL (\$31.22) (Max 3 refills)

PROVERA®

2.5 MG (\$0.10), 10 MG (\$0.25) TABLET (Max 11 refills)

(Note: Injection for clinic use only, should be taken from stock and may not be given KOP. For all dosage forms, prior authorization criteria must be met and noted in special instructions field for use without a non-formulary approval. Criteria include: female or GD (gender dysphoria patients-new intake on hormone therapy or gender dysphoria clinic.))

**MELATONIN** (Max 2 refills)

3 MG TABLET (\$0.05)

(Note: May not be given KOP. Restricted to TJJD only.)

**MELOXICAM** (Max 2 refills)

MOBIC®

7.5 MG (\$0.02), 15 MG (\$0.01) TABLET

(Note: 30D and 90D templates for 1 card of 30 to last 30 and 90 days.)

**MENINGOCOCCAL VACCINE, POLYSACCHARIDE** (Max 1 refill)

MENQUADFI

0.5 ML SDV (\$143.63)

(Note: Restricted from stock. May not be given KOP. Prior authorization criteria must be met and noted in the special instructions field for use without non-formulary approval. Criteria include: anatomic or functional asplenia or HIV+ with no history of prior immunization or require a booster. Primary series is 2 doses given 60 days apart (1 refill). A single booster dose is recommended every 5 years.)

MENQUADFI® see MENINGOCOCCAL VACCINE

**MENTHOLATUM RUB**

VICKS VAPORUB®

OINTMENT – 50 GM (\$4.11)

(Note: Clinic use only. Take from stock. May not be given KOP. Restricted to TJJD facilities.)

MEPHYTON® see PHYTONADIONE

**MEPIVACAINE**

3% CARTRIDGE (50/BOX) (\$42.29/BOX)

(Note: Restricted to UTMB dental services. Clinic use only. Take from stock. May not be given KOP.)

MERREM® see MEROPENEM

**MEROPENEM**

MERREM®

1 GM IV INJECTION – 30 ML VIAL (\$3.41)

IV Preparation Standard:

1gm in NS or D5W 100 ML over 30 minutes

(Note: Clinic use only. Take from stock for RMFs, infirmaries, and ED. May not be given KOP. Restricted to regional medical facilities and ED for inpatient use only. Non-formulary approval still required for use at non-RMFs or ED.)

**METFORMIN (Max 11 refills)**

GLUCOPHAGE®

500 MG (\$0.02), 1000 MG (\$0.02) TABLET

METHADOSE® see METHADONE

**METHADONE**

METHADOSE®

5 MG (\$0.28), 10 MG (\$0.32) TABLET

(Note: May not be given KOP. Floor stock allowed at select intake units (0B, BX, FB, GC, LJ, ND, NE, NJ, RZ, SY, and WM) for tapering/pregnancy. Nonformulary approval required for use.

**METHIMAZOLE (Max 11 refills)**

TAPAZOLE®

5 MG TABLET (\$0.04)

**METHOCARBAMOL**

ROBAXIN®

750 MG TABLET (\$0.04)

(Note: Tablets restricted to one 7-day supply per injury. A minimum 30-day period between orders is required. May not be given KOP.)

**METHYLPHENIDATE- CII**

CONCERTA®

18 MG (\$11.89), 27 MG (\$12.19), 36 MG (\$12.58), 54 MG (\$13.68) EXTENDED-RELEASE TABLET

RITALIN®

5 MG (\$0.16), 10 MG (\$0.26) TABLET

RITALIN LA®

10 MG (\$2.79), 20 MG (\$1.86), 30 MG (\$2.73), 40 MG (\$1.81) EXTENDED-RELEASE CAPSULE

(Note: May not be given KOP. Use and stock restricted to TJJD. May only be ordered by a physician.)

**METHYLPREDNISOLONE**

MEDROL DOSEPAK®

4 MG TABLET – 21 CT DOSEPACK (\$1.70)

(Note: For use when a short course of steroid treatment is indicated. Use as directed on dosepack, 6 day taper. Limit of 1 box of 21 tabs per order per policy.)

**METHYLPREDNISOLONE ACETATE**

DEPO-MEDROL®

80 MG/1 ML SDV (\$12.79)

(Note: Restricted to Orthopedic Clinic use only. Take from stock for orthopedic clinic facilities.)

**METHYLPREDNISOLONE SODIUM SUCCINATE**

SOLU-MEDROL®

125 MG INJECTION – 2 ML VIAL (\$9.60)

IV Preparation Standard:

3 gm in 100 mL D<sub>5</sub>W over 40 minutes.

(Note: Clinic use only. Take from stock. May not be given KOP.)

**METHYL SALICYLATE/MENTHOL**

MUSCLE RUB CREAM

85 GM TUBE (\$2.56)

(Note: May not be given KOP. Restricted to TJJD.)

**METOCLOPRAMIDE HCL**

REGLAN®

10 MG TABLET (\$0.03) (Max 2 refills)

5 MG/ML INJECTION - 2 ML SDV (\$0.90) (No refills)

(Note: Injection use and stock restricted to ED. Take from stock for ED.)

**METOLAZONE (Max 11 refills)**

ZAROXOLYN®

5 MG TABLET (\$0.33)

**METOPROLOL SUCCINATE**

TOPROL XL®

25 MG (\$0.03), 50 MG (\$0.03), 100 MG (\$0.05), 200 MG (\$0.10) EXTENDED-RELEASE TABLET

(Note: Extended-release formulation to be dosed once a day. May not be crushed or chewed.)

**METOPROLOL TARTRATE**

LOPRESSOR®

5 MG/5 ML INJECTION – 5 ML VIAL (\$0.66)

(Note: Clinic use only, should be taken from stock, and may not be given KOP.)

**METRONIDAZOLE HCL**

FLAGYL®

250 MG (\$0.10), 500 MG (\$0.06) TABLET

500 MG in NS READY-TO-USE 100ML BAG (\$2.25)

IV Preparation Standard: over 75 minutes, DO NOT REFRIGERATE, PROTECT FROM LIGHT.

(Note: Injection for clinic use only, should be taken from stock, and may not be given KOP.)

**MICONAZOLE**

MONISTAT-7®

VAGINAL CREAM 2% (100MG/APPLICATOR) WITH 7 APPLICATORS/BOX (\$4.76/BOX)

(Note: Restricted to female patients. Take from stock. Generally dosed 1 applicatorful inserted vaginally QHS x 7 days.)

SECURA AF®

2% CREAM 2 OZ (\$6.10)

(Note: Restricted to TDCJ UTMB facilities. Clinic use only. Take from stock. May not be given KOP. No refills allowed. For use per wound clinic and standing delegated order.)

MILK OF MAGNESIA see MAGNESIUM HYDROXIDE

**MINOXIDIL (Max 11 refills)**

LONITEN®

2.5 MG (\$0.07), 10 MG (\$0.05) TABLET

M-M-R®- II VACCINE see MEASLES/MUMPS/RUBELLA VACCINE, LIVE

MOBIC® see MELOXICAM

**MOMETASONE FUROATE**

ELOCON®

0.1% TOPICAL SOLUTION – 60 ML (\$16.94)

MONISTAT® see MICONAZOLE

MONSELS® see FERRIC SUBSULFATE

**MORPHINE SULFATE - CII**

4 MG/1 ML INJECTION-1 ML SDV (\$2.29)

10 MG/5 ML ELIXIR – 5 ML UNIT DOSE (\$1.10)

MS CONTIN®

15 MG (\$0.74), 30 MG (\$1.34) EXTENDED-RELEASE TABLET

(Note: Take from stock. May not be given KOP. May only be ordered by a physician. Elixir and extended-release tablets restricted to regional medical facilities and hospices for inpatient use only. Non-formulary approval is required for use &gt; 10 days. A minimum 30-day period between orders is required for use beyond 10 days without a non-formulary approval. Non-formulary approval is required for use at all other units. Elixir and ER 15mg tablets are allowed as floor stock at these transient facilities en route to HG: 0B, DA, DU, E2, GR, HV, ND, NF, NH, and ML.

Injection is restricted to one-time orders for pain associated with acute trauma or severe medical condition. All other uses require non-formulary approval.)

MOTRIN® see IBUPROFEN

MS-CONTIN® see MORPHINE SULFATE

MULTIHANCE® see GADOBENATE

**MULTIVITAMIN** (Max 11 refills, tablet)

M.V.I. ADULT™, INFUVITE®  
INJECTION – 10 ML VIAL (\$10.79)

(Note: Clinic use only. Take from stock. May not be given KOP.)

TABLET (\$0.02)

(Note: Prior authorization required for use of tablets. Prior authorization criteria must be met and noted in the special instructions field for use without non-formulary approval. Criteria include:

- a. HIV positive, CD4 count < 100 cells/mm<sup>3</sup> and not prescribed a nutritional supplement/enteral feeding.
- b. TH (Telehealth) Wound care clinic)

MURINE® see POLYVINYL/POVIDONE

MURO® 128 see SODIUM CHLORIDE OPHTHALMIC

MUSCLE RUB CREAM see METHYL SALICYLATE/MENTHOL

M.V.I. ADULT™ see MULTIVITAMIN

MYAMBUTOL® see ETHAMBUTOL HCL

MYCELEX® see CLOTRIMAZOLE

MYCOBUTIN® see RIFABUTIN

**MYCOPHENOLATE MOFETIL** (Max 11 refills)

CELLCEPT®  
250 MG CAPSULE (\$0.18)  
500 MG TABLET (\$0.45)

(Note: May not be given KOP.)

MYDRIACYL® see TROPICAMIDE

MYLICON® see SIMETHICONE

MYSOLINE® see PRIMIDONE

NAFCILL® see NAFCILLIN SODIUM

**NAFCILLIN**

NAFCILL®  
1 GM INJECTION VIAL (\$4.15)

IV Preparation Standard:

≤ 1 gm in 100 mL D<sub>5</sub>W over 30 minutes

> 1 gm in 100 mL D<sub>5</sub>W over 40 minutes.

(Note: Clinic use only. Take from stock. May not be given KOP.)

**NALOXONE HCL**

NARCAN®  
4 MG/0.1 ML SINGLE DOSE NASAL SPRAY 2 PACK - (\$30.74)

(Note: Clinic use only. Take from stock. May not be given KOP)

**NAPHAZOLINE/PHENIRAMINE**

OPCON-A®, NAPHCN-A®  
NAPHAZOLINE 0.025%/PHENIRAMINE 0.3% OPHTHALMIC SOLUTION – 15 ML (\$4.86)

NAPHCN-A® see NAPHAZOLINE/PHENIRAMINE

NAPROSYN® see NAPROXEN

**NAPROXEN** (Max 2 refills)

NAPROSYN®  
250 MG (\$0.05), 500 MG (\$0.04) TABLET

(Note: 30D and 90D templates for 1 card of 30 to last 30 and 90 days.)

NARCAN® see NALOXONE HCL

NASACORT AQ® see TRIAMCINOLONE NASAL SPRAY

NATALINS® FA see PRENATAL-FOLIC ACID

NAVANE® see THIOTHIXENE HCL

**NEOMYCIN/BACITRACIN/POLYMYXIN**

NEOSPORIN®, TRIPLE ANTIBIOTIC

OPHTHALMIC OINTMENT - 3.5 GM (\$20.74)

TOPICAL OINTMENT 1 GM PACKET (\$0.13)

(Note: 1 gm packet for clinic use only, should be taken from stock and may not be given KOP.)

**NEOMYCIN/BACITRACIN/POLYMYXIN/HYDROCORTISONE**

CORTISPORIN®

OPHTHALMIC OINTMENT - 3.5 GM (\$15.66)

**NEOMYCIN/POLYMYXIN/DEXAMETHASONE**

MAXITROL®

OPHTHALMIC SUSPENSION – 5 ML (\$6.02)

OPHTHALMIC OINTMENT - 3.5 GM (\$6.63)

**NEOMYCIN/POLYMYXIN/HYDROCORTISONE**

CORTISPORIN®

OTIC SUSPENSION – 10 ML (\$36.62)

**NEOMYCIN /POLYMYXIN/GRAMICIDIN**

NEOSPORIN®

OPHTHALMIC SOLUTION – 10 ML (\$45.54)

NEORAL® see CYCLOSPORINE

NEOSPORIN® see NEOMYCIN/POLYMYXIN/GRAMICIDIN  
see also NEOMYCIN/BACITRACIN/POLYMYXIN

NEPHRO-VITE® see VITAMIN B COMPLEX & VITAMIN C WITH FOLIC ACID

NIVESTYM® see FILGRASTIM

**NEVIRAPINE (Max 11 refills)**

VIRAMUNE®

200 MG TABLET (\$0.15)

NEXTERONE® see AMIODARONE IN D5W

NITRO-DUR® see NITROGLYCERIN

NITRO-BID® see NITROGLYCERIN

**NITROFURANTOIN MONO**

MACROBID®

100MG CAPSULE (\$0.30)

**NITROGLYCERIN**

NITROSTAT® (Max 1 refill)

0.4 MG SUBLINGUAL TABLET - 25 PER BOTTLE (\$1.79/BOTTLE)

(Note: Sublingual tablets should be ordered as 1 bottle to last 6 months.)

NITROBID®

2% TOPICAL OINTMENT – 60 GM (\$71.02) (No refills)

(Note: The ointment is restricted to clinic use only for short-term relief of angina, should be taken from stock and may not be given KOP.)

NITRO-DUR® (Max 11 refills)

0.2 MG/HR (\$0.62), 0.4 MG/HR (\$0.60) PATCH – 30 PATCHES PER BOX

(Note: The Pharmacy will add standardized directions to patches to allow for a nitrate-free interval to minimize tolerance that states "Apply in the morning for 12 hours and then remove in the evening" for 30 days, KOP.)

NITROSTAT® see NITROGLYCERIN

NIX® see PERMETHRIN

**NOREPINEPHRINE IN NS**

4 MG/250 ML (16 MCG/ML) BAG (\$34.50)

(Note: Use and stock restricted to ED. Take from stock for ED.)

**NORETHINDRONE/ETHINYL ESTRADIOL** (Max 11 refills)

ORTHO NOVUM®, NORTREL®  
1/35-28 TABLET (\$5.70)  
(Note: Restricted to female patients)

**NORGESTREL/ETHINYL ESTRADIOL** (Max 11 refills)

LO/OVRAL®, CRYSELLE®  
0.3/30-28 TABLET (\$21.70)  
(Note: Restricted to female patients.)

NORMAL SALINE see SODIUM CHLORIDE 0.9%

NORMODYNE® see LABETALOL

NORTREL® see NORETHINDRONE/ETHINYL ESTRADIOL

NORVASC® see AMLODIPINE

NORVIR® see RITONAVIR

NOVOLIN® see INSULIN, HUMAN

NYDRAZID® see ISONIAZID

OCEAN NASAL MIST® see SODIUM CHLORIDE

**OMEPRAZOLE** (Max 11 refills)

PRILOSEC®  
20 MG CAPSULE (\$0.03)  
(Note: Recommended treatment duration: H Pylori- 14 days; GERD/dyspepsia-trial 8 weeks and reassess (see Gastrointestinal Pathways DMG)).

OMNIPEN-N® see AMPICILLIN

**ONDANSETRON** (Max 2 refills)

ZOFRAN®  
4 MG TABLET (\$0.10)  
2 MG/ML – 2 ML VIAL (\$0.32)  
(Note: Injection for clinic use only, should be taken from stock, and may not be given KOP. There are 2 templates in EHR. Select IV-Ondansetron for intravenous administration, and IM-Ondansetron for intramuscular administration.)

OPCON-A® see NAPHAZOLINE/PHENIRAMINE

**OPHTHALMIC IRRIGATING SOLUTION**

DACRIOSE®  
IRRIGATING EYE WASH – 120 ML (\$3.30)

ORABLOC® see ARTICAINE/EPINEPHRINE

ORAQIX® see LIDOCAINE/PRILOCAINE

ORTHO-NOVUM® see NORETHINDRONE/ETHINYL ESTRADIOL

OS-CAL® see CALCIUM CARBONATE

**OSELTAMIVIR**

TAMIFLU®  
30 MG (\$0.33), 75 MG CAPSULE (\$2.40)  
(Note: 30MG for patients with renal insufficiency.)

OSMOLITE® see ENTERAL FEEDING/NUTRITION

**PANCRELIPASE** (Max 11 refills)

CREON 12®  
LIPASE 12,000 U/AMYLASE 38,000 U/PROTEASE 60,000 U PER CAPSULE (\$418.32/100 count bottle)

**PANTOPRAZOLE**

PROTONIX IV®  
40MG SDV (\$4.88)  
(Note: Use and stock restricted to ED. Take from stock for ED.)

**PARICALCITOL (Max 11 refills)**

ZEMPLAR®

2 MCG CAPSULE (\$1.91)

(Note: Restricted to dialysis units. Take from stock for dialysis units. All other uses require non-formulary approval.)

5 MCG/ML – 1 ML VIAL (\$2.28)

(Note: Clinic use only. Take from stock. May not be given KOP. Restricted to dialysis centers.)

PARLODEL® see BROMOCRIPTINE MALEATE

**PAROXETINE (Max 11 refills)**

PAXIL®

10 MG (\$0.11) TABLET

(Note: 10 mg allowed as floor stock at TJJ intake facilities only. Non-formulary approval still required for use.)

PAXIL® see PAROXETINE

PC-TAR® see COAL TAR

PEG 3350 see ELECTROLYTE ORAL SOLUTION

**PENICILLIN VK**

VEETIDS®

500 MG TABLET (\$0.08)

**PENICILLIN G BENZATHINE**

BICILLIN LA®

1.2 MU/2 ML SYRINGE (\$340.25)

(Note: Clinic use only. Take from stock. May not be given KOP. Prior authorization must be met and noted in the special instructions field for use without non-formulary approval. Criteria include: syphilis.)

**PENICILLIN G POTASSIUM**

PFIZERPEN®

5 MU INJECTION VIAL (\$11.83)

IV Preparation Standard:

2 MU in 100 mL D<sub>5</sub>W over 20 minutes

>2 MU in 100 mL D<sub>5</sub>W over 40 minutes.

(Note: Clinic use only. Take from stock. May not be given KOP.)

PEPCID® see FAMOTIDINE

PEPTO-BISMOL® see BISMUTH SUBSALICYLATE

PERIDEX® see CHLORHEXIDINE GLUCONATE ORAL RINSE

**PERMETHRIN**

NIX®

1% LOTION – 2 OZ (\$8.21)

(Note: Take from stock.)

ELIMITE®

5% CREAM – 60 GM (\$11.71)

**PERPHENAZINE (Max 11 refills)**

TRILAFON®

4 MG (\$0.13), 8 MG (\$0.10), 16 MG (\$0.33) TABLET

(Note: May not be given KOP.)

**PETROLATUM**

VASELINE®

JELLY – 13 OZ (\$3.20)

(Note: Clinic use only. Take from stock. May not be given KOP. Restricted to phototherapy centers-E2.)

AQUAPHOR®

41% OINTMENT – 1.75 OZ (\$5.41)

(Note: Use and stock restricted to tattoo removal clinic at E2 and MV. Restricted criteria required for use without non-formulary approval. Criterion is: tattoo removal. Clinic use only. Take from stock.)

PFIZERPEN® see PENICILLIN G POTASSIUM

**PHENAZOPYRIDINE HCL**

PYRIDIUM®

200 MG TABLET (\$0.19)

PHENERGAN® see PROMETHAZINE HCL

**PHENYLEPHRINE HCL**

ALTAFRIN®

2.5% OPHTHALMIC SOLUTION 15 ML (\$78.83)

10% OPHTHALMIC SOLUTION 5 ML (\$35.04)

(Note: Restricted to Optometry Clinic use only for routine eye exams. Take from stock for optometry clinic facilities. All other uses require non-formulary approval. May not be given KOP.)

**PHENYTOIN (Max 11 refills)**

DILANTIN®

125 MG/5 ML SUSPENSION - 8OZ (\$20.16)

(Note: Use and floor stock restricted to regional medical facilities. May not be given KOP.)

**PHENYTOIN SODIUM**

DILANTIN®

100 MG EXTENDED-RELEASE CAPSULE (\$0.07) (Max 11 refills)

50 MG/ML INJECTION – 5 ML VIAL (\$1.27) (No refills)

(Note: May not be given KOP. Restricted to EMS use only. All other uses require non-formulary approval.)

PHOSPHATE ENEMA see SODIUM PHOSPHATE/SODIUM SALT

**PHYTONADIONE (VITAMIN K-1)**

MEPHYTON®

5 MG TABLET (\$36.88)

PLASBUMIN-25® see ALBUMIN, HUMAN

PLAVIX® see CLOPIDOGREL

**PNEUMOCOCCAL VACCINE (POLYVALENT)**

PREVNAR-20®

0.5 ML INJECTION - 0.5 ML PREFILLED SYRINGE (\$223.68)

(Note: Clinic use only. Take from stock. May not be given KOP. Follow Infection Control P&P B-14.07 and standing delegated order when selecting patients.

a. ≥ 65 years old

b. Patients with disease associated with increased risk (splenic dysfunction, anatomic asplenia, Hodgkin's disease, multiple myeloma, cirrhosis, alcoholism, NAFLD, renal failure, CSF leaks, diabetes mellitus, COPD, emphysema, heart disease)

c. Immunosuppressed patients (HIV positive, most cancers, sickle cell, and cochlear implants)

\*If patients do not meet criteria, a non-form approval is required. If non-form is approved, a patient specific order should be entered in the EHR.)

**PODOFILOX**

CONDYLOX®

0.5% TOPICAL SOLUTION - 3.5 ML (\$46.79)

(Note: Clinic use only. Take from stock. May not be given KOP.)

**POLIO VIRUS VACCINE, INACTIVATED**

IPOL®

0.5 ML INJECTION – 5 ML MDV – 10 DOSES/VIAL (\$268.25)

(Note: May not be given KOP. Prior authorization required for use. Criteria: patients < 19 years old. All other uses require non-formulary approval.)

**POLYMYXIN B/TRIMETHOPRIM**

POLYTRIM®

10,000 U/1 MG OPHTHALMIC SOLUTION – 10 ML (\$3.22)

POLYSPORIN® see BACITRACIN/POLYMYXIN B

**POLYSTYRENE SODIUM SULFONATE**

KAYEXALATE®

SUSPENSION 15 G/60 ML – 16 OZ (\$193.62)

(Note: May not be given KOP. Contains 65mEq Na, 15mEq of potassium exchange capacity per 60mL.)

POLYTRIM® see POLYMYXIN B/TRIMETHOPRIM

**POLYVINYL/POVIDONE** (Max 11 refills)

ARTIFICIAL TEARS, MURINE®

0.5%/0.6% OPHTHALMIC SOLUTION – 15 ML (\$1.43)

**POTASSIUM CHLORIDE**

K-DUR®, KCL

10 MEQ (\$0.09), 20MEQ (\$0.12) EXTENDED-RELEASE TABLET (Max 11 refills)

20 MEQ/1000 ML D<sub>5</sub>W INJECTION (\$7.21) (No refills)

20 MEQ/1000 ML 1/2NS D5W INJECTION (\$5.06) (No refills)

(Note: Injection for clinic use only, should be taken from stock, may not be given KOP, and restricted to infirmaries & regional medical facilities, and ED.)

PRAVACHOL® see PRAVASTATIN

**PRAVASTATIN** (Max 11 refills)

PRAVACHOL®

10 MG (\$0.03), 20 MG (\$0.03), 40 MG (\$0.08) TABLET

PRED FORTE® see PREDNISOLONE ACETATE

**PREDNISOLONE ACETATE**

PRED FORTE®

1% OPHTHALMIC SUSPENSION – 5 ML (\$16.73)

**PREDNISONE** (Max 11 refills 5 mg tablets only)

DELTASONE®

5 MG (\$0.13), 10 MG (\$0.13), 20 MG (\$0.16) TABLET

PREMARIN® see ESTROGENS, CONJUGATED

**PRENATAL-FOLIC ACID** (Max 11 refills)

NATALINS FA®

TABLET (\$0.11)

(Note: Contains 1 mg folic acid. Prior authorization criteria must be met and noted in the special instructions field to use without non-formulary approval. Criteria: pregnancy.)

PREPARATION H® CREAM see HEMORRHOIDAL

PREVNAR-20® see PNEUMOCOCCAL VACCINE

PREZISTA® see DARUNAVIR

PRIFTIN® see RIFAPENTINE

**PRILOCAINE/EPINEPHRINE**

CITANEST FORTE®

4% / 1:200,000 CARTRIDGE (50/BOX) (\$43.93/BOX)

(Note: Restricted to UTMB dental services. Clinic use only. Take from stock. May not be given KOP.)

PRILOSEC® see OMEPRAZOLE

**PRIMIDONE** (Max 11 refills)

MYSOLINE®

250 MG TABLET (\$0.31)

PRINIVIL® see LISINAPRIL

**PROCHLORPERAZINE**

COMPAZINE®

10 MG TABLET (\$0.41)

PROGRAF® see TACROLIMUS

PROHANCE® see GADOTERIDOL

PROLIXIN® see FLUPHENAZINE HCL

PROLIXIN D® see FLUPHENAZINE DECANOATE

**PROMETHAZINE HCL**

PHENERGAN®

25 MG TABLET (\$0.08)

25 MG SUPPOSITORY - 12/BOX (\$107.88/BOX)

**PROPARACAINE HCL**

ALCAINE®

0.5% OPHTHALMIC SOLUTION – 15 ML (\$29.18)

(Note: Clinic use only. Take from stock. May not be given KOP.)

**PROPRANOLOL HCL** (Max 11 refills)

INDERAL®

10 MG (\$0.07), 20 MG (\$0.04), 40 MG (\$0.04) TABLET

PROSCAR® see FINASTERIDE

**PROTAMINE SULFATE**

50 MG INJECTION – 5 ML VIAL (\$14.26)

(Note: Clinic use only. Take from stock. May not be given KOP.)

PROTONIX® see PANTOPRAZOLE

PROVENTIL-HFA® see ALBUTEROL

PROVERA® see MEDROXYPROGESTERONE

PROZAC® see FLUOXETINE

**PYRAZINAMIDE** (PZA) (Max 11 refills)

500 MG TABLET (\$3.48)

(Note: May not be given KOP. Treatment of active TB should be DOT.)

PYRIDIUM® see PHENAZOPYRIDINE

**PYRIDOXINE HCL** (VITAMIN B-6) (Max 11 refills)

50 MG TABLET (\$0.01)

PZA see PYRAZINAMIDE

**RALTEGRAVIR** (Max 11 refills)

ISENTRISS®

400 MG TABLET (\$33.85)

RAPAMUNE® see SIROLIMUS

READI-CAT2® see BARIUM SULFATE

RECOMBIVAX HB ® see HEPATITIS B VACCINE RECOMBINANT

REGLAN® see METOCLOPRAMIDE HCL

RENAL VITAMIN see VITAMIN B COMPLEX & VITAMIN C WITH FOLIC ACID

RENFLEXIS® see INFLIXIMAB

REVELA® see SEVELAMER

RETROVIR® see ZIDOVUDINE

REYATAZ® see ATAZANAVIR

**RHO(D) IMMUNE GLOBULIN**

RHOPHYLAC®, RHOGAM®

300 MCG SYRINGE (\$170.15)

(Note: Floor stock restricted to Carol Young. Non-formulary approval still required for use).

RHOGAM® see RHO(D) IMMUNE GLOBULIN

RHOPHYLAC® see RHO(D) IMMUNE GLOBULIN

RIBASPHERE® see RIBAVIRIN

**RIBAVIRIN** (Max 5 refills)

RIBASPHERE®

200 MG CAPSULE (\$1.23)

(Note: Floor stock is allowed at UTMB facilities. Prior authorization required for use. Prior auth criteria must be met and noted in special instructions. Criteria: Virology/Genotype/Treatment Experience/Cirrhosis Class. All other uses and use beyond 12 weeks require non-formulary approval. May not be given KOP.)

**RIFABUTIN** (Max 11 refills)

MYCOBUTIN®

150 MG CAPSULE (\$8.08)

(Note: May not be given KOP.)

RIFADIN® see RIFAMPIN

**RIFAMPIN** (Max 11 refills)

RIFADIN®

300 MG CAPSULE (\$1.81)

(Note: May not be given KOP. Treatment of active TB should be DOT.)

**RIFAPENTINE** (Max 2 refills)

PRIFTIN®

150 MG CAPSULE (\$4.58)

(Note: May not be given KOP. Take from stock for TDCJ. Treatment of latent TB with INH, once weekly dosing. Order DOT.)

**RILPIVIRINE** (Max 11 refills)

EDURANT®

25 MG TABLET (\$46.89)

(Note: Prior authorization criteria must be met and noted in the special instructions field for use without a non-formulary approval. Criteria include: Patient on Edurant, Complera, Odefsey, or Juluca at intake. Available in stock to prevent delays in therapy. Non-formulary approval is still required for all other uses.)

RINGERS INJECTION, LACTATED see LACTATED RINGERS

RISPERDAL® see RISPERIDONE

**RISPERIDONE** (Max 11 refills)

RISPERDAL®

0.5 MG (\$0.04), 1 MG (\$0.02), 2 MG (\$0.02), 3 MG (\$0.16), 4 MG (\$0.03) TABLET

(Note: May not be given KOP. Use and stock of 0.5mg restricted to TJJD. Floor stock of 1mg restricted to TDCJ.)

RITALIN® see METHYLPHENIDATE

RITALIN LA® see METHYLPHENIDATE

**RITONAVIR** (Max 11 refills)

NORVIR®

100 MG TABLET (\$1.46)

**RIVAROXABAN** (Max 11 refills)

XARELTO®

15 MG (\$18.38), 20 MG (\$18.38) TABLET

(Note: 20mg is the most commonly prescribed strength. For venous thromboembolism treatment: initial treatment is dosed as 15mg twice daily for 21 days, followed by 20mg once daily. 15mg indicated for patients with reduced renal function.)

ROBAXIN® see METHOCARBAMOL

ROBITUSSIN DM® see GUAIFENESIN/DEXTROMETHORPHAN

ROCALTROL® see CALCITRIOL

ROCEPHIN® see CEFTRIAXONE

ROMAZICON® see FLUMAZENIL

**SALICYLIC ACID**

COMPOUND W®, DUOFILM®

17% TOPICAL SOLUTION - 0.3 OZ (\$2.48)

(Note: Clinic use only. Take from stock. May not be given KOP.)

SALINE see SODIUM CHLORIDE

SANTYL® see COLLAGENASE

SECURA AF® see MICONAZOLE

**SELENIUM SULFIDE**

SELSUN®

2.5% SHAMPOO 4 OZ (\$9.42)

(Note: Orders should be written for 1 bottle to last 90 days.)

SELSUN® see SELENIUM SULFIDE

**SERTRALINE** (Max 11 refills)

ZOLOFT®

25 mg (\$0.05), 50 MG (\$0.03), 100 MG (\$0.04) TABLET

(Note: Use and floor stock of 25mg restricted to TJJJ only. Floor stock of 50mg restricted to TDCJ.)

**SEVELAMER CARBONATE** (Max 11 refills)

RENVELA®

800 MG TABLET (\$0.13)

(Note: Prior authorization required and must be noted in the special instructions field for use without non-formulary approval. Criteria include: chronic kidney disease or dialysis.)

SHINGRIX® see ZOSTER VACCINE

SILVADENE® see SILVER SULFADIAZINE

**SILVER NITRATE**

ARZOL®

75% APPLICATOR STICK, 100/BOX (\$34.13/BOX)

(Note: Clinic use only. Take from stock. May not be given KOP.)

**SILVER SULFADIAZINE**

SILVADENE®

1% CREAM – 50 GM (\$13.85), 400 GM (\$62.01)

(Note: 50 gm may be given KOP. 400 gm for clinic use only, should be taken from stock and may not be given KOP.)

**SIMETHICONE** (Max 3 refills)

MYLICON®

80 MG CHEWABLE TABLET, 100/BOTTLE (\$2.20/BOTTLE)

(Note: May be ordered PRN with a limit of 1 btl of 100 to be dispensed for 90-days. Stock restricted to ED.)

SINEMET® see CARBIDOPA/LEVODOPA

**SIROLIMUS** (Max 11 refills)

RAPAMUNE®

1 MG (\$6.96), 2 MG (\$6.96) TABLET

(Note: May not be given KOP.)

SMZ/TMP see SULFAMETHOXAZOLE/TRIMETHOPRIM

**SODIUM BICARBONATE**

SODIUM BICARBONATE

1 mEq/ML INJECTION (8.4%) – 50 ML SYRINGE (\$18.15)

(Note: Clinic use only. Take from stock. May not be given KOP.)

**SODIUM CHLORIDE**

0.45% INJECTION – 1000 ML (\$5.63)

0.9% INJECTION – 100 ML (\$2.46), 250 ML (\$5.15), 500 ML (\$3.54), 1000 ML (\$4.82)

0.9% MINI-BAG – 100 ML (\$5.68)

0.9% IRRIGATION SOLUTION – 250 ML (\$3.78)

0.9% BACTERIOSTATIC INJECTION – 30 ML VIAL (\$1.22)

0.9% PRESERVATIVE FREE INJ – 10 ML SYR (\$0.59)

0.9% NEB SOL – 3 ML UD 100/BOX (\$24.00/BOX)

OCEAN® (Max 2 refills)

NASAL SPRAY – 45 ML (\$0.75)

MURO 128® (Max 11 refills)

5% OPHTHALMIC SOLUTION – 15 ML (\$4.20)

5% OPHTHALMIC OINTMENT - 3.5 GM (\$15.47)

(Note: Injection, irrigating solution, bags, and nebulizer solution are for clinic use only, should be taken from stock and may not be given KOP.)

**SODIUM PHOSPHATE**

FLEET'S® ENEMA

ENEMA – 133 ML (\$0.89)

(Note: Take from stock.)

**SOFOSBUVIR/VELPATASVIR (Max 5 refills)**

EPCLUSA®

400 MG-100 MG TABLET (\$278.57)

(Note: The preferred Hepatitis C therapy. Prior authorization required for use. Prior auth criteria must be met and noted in special instructions. Criteria: Virology/Genotype/Treatment Experience/Cirrhosis Class. All other uses and use beyond 12 weeks require non-formulary approval. Floor stock is allowed at UTMB facilities. Floor stock is designated as a Local Control and therefore must be kept and inventoried as a controlled substance (Pharmacy Policies 20-05, 20-10, 20-15). May not be given KOP.)

**SOLIFENACIN (Max 11 refills)**

VESICARE®

5 MG (\$0.04), 10 MG (\$0.07)

SOLU-CORTEF® see HYDROCORTISONE SODIUM SUCCINATE

SOLU-MEDROL® see METHYLPREDNISOLONE SODIUM SUCCINATE

SOOTHE® LUBRICANT EYE OINT see LUBRICANT EYE OINT

**SOTALOL (Max 11 refills)**

BETAPACE®

80 MG (\$0.04), 120 MG (\$0.07), 160 MG (\$0.11) TABLET

SPIKEVAX® see COVID VACCINE

**SPIRONOLACTONE (Max 11 refills)**

ALDACTONE®

25 MG TABLET (\$0.03)

**STANNOUS FLUORIDE**

GEL-KAM®

0.4% GEL – 4.3 OZ (\$17.19)

STELAZINE® see TRIFLUOPERAZINE HCL

STRATTERA see ATOMOXETINE

SUBUTEX® see BUPRENORPHINE

SULAMYD® see SULFACETAMIDE SODIUM

**SULFACETAMIDE SODIUM**

SULAMYD®

10% OPHTHALMIC SOLUTION – 15 ML (\$22.29)

**SULFAMETHOXAZOLE/TRIMETHOPRIM**

BACTRIM® DS

SMZ 800 MG/TMP 160 MG DOUBLE STRENGTH TABLET (\$0.06) (Max 11 refills)

SMZ 800 MG/TMP 160 MG per 10 ML INJECTION – 10 ML MDV (\$11.56) (No refills)

IV Preparation Standard:

In D<sub>5</sub>W ONLY over 60-90 minutes.

(Note: Orders for IV Bactrim should be based on trimethoprim dosage. Injection for clinic use only, should be taken from stock, and may not be given KOP.)

**SULFASALAZINE (Max 11 refills)**

AZULFIDINE®

500 MG TABLET (\$0.17)

**SUNSCREEN**

SUNSCREEN

SPF 30 LOTION – 240 ML (\$5.02)

(Note: May be supplied as a different size depending on product availability. Take from stock.)

SURGILUBE® see LUBRICANT, SURGICAL

SUSTIVA® see EFAVIRENZ

SYMMETREL® see AMANTADINE HCL

SYNTHROID® see LEVOTHYROXINE SODIUM

**TACROLIMUS** (Max 11 refills)  
PROGRAF®  
0.5 MG (\$0.33), 1 MG (\$0.17), 5 MG (\$3.13) CAPSULE  
(Note: May not be given KOP.)

TAMIFLU® see OSELTAMIVIR

**TAMSULOSIN** (Max 11 refills)  
FLOMAX®  
0.4 MG CAPSULE (\$0.04)

TAPAZOLE® see METHIMAZOLE

Tdap see TETANUS/DIPHTHERIA/ACELLULAR PERTUSSIS

TDF see TENOFOVIR

TEGRETOL® see CARBAMAZEPINE

TENECTEPLASE  
TNKase®  
50 MG INJECTION KIT (\$8089.83)  
(Note: Use and stock restricted to ED. Take from stock for ED.)

TENEX® see GAUNFACINE

TENIVAC™ see TETANUS & DIPHTHERIA TOXOIDS

**TENOFOVIR** (TDF) (Max 11 Refills)  
VIREAD®  
300 MG TABLET (\$0.82)

**TERAZOSIN HCL** (Max 11 refills)  
HYTRIN®  
1 MG (\$0.06), 2 MG (\$0.04), 5 MG (\$0.05), 10 MG (\$0.07) CAPSULE

**TERBUTALINE SULFATE**  
BRETHINE®  
1 MG/ML INJECTION – 1 ML VIAL (\$1.44)  
(Note: Clinic use only. Take from stock. May not be given KOP. Use restricted to female patients at Carol Young (GC) and Crain (GV) facilities.)

**TESTOSTERONE** (Max 5 refills)  
DEPO-TESTOSTERONE®  
200 MG/ML INJECTION – 1 ML VIAL (\$10.14)  
(Note: May not be given KOP. Take from stock. May only be ordered by a physician or DEA registered midlevel provider. Prior authorization must be met and noted in the special instructions field for use without non-formulary approval. Criteria include: GD (gender dysphoria patients-new intake on hormone therapy or gender dysphoria clinic.))

**TETANUS/DIPHTHERIA TOXOIDS VACCINE**  
D-T TOXOIDS, TENIVAC™  
0.5 ML SINGLE DOSE VIAL (\$38.98)  
(Note: Clinic use only. Take from stock. May not be given KOP. Follow Infection Control P&P for selecting patients. Criteria include:  
a. < 19 years old without documentation of completion  
b. No history of prior immunization within the last 10 years  
c. Prophylaxis for wound management.)

**TETANUS/DIPHTHERIA/ACELLULAR PERTUSSIS (Tdap) VACCINE**  
BOOSTRIX®  
0.5 ML PREFILLED SYRINGE (\$44.99)  
(Note: May not be given KOP. Clinic use only. Prior authorization criteria must be met and noted in the special instructions field for use without non-formulary approval. Criteria include: pregnancy or Td booster indicated and not previously vaccinated with Tdap.)

THERA DERM® see BODY LOTION

**THIAMINE HCL** (VITAMIN B-1)  
100 MG TABLET (\$0.03) (Max 11 refills)  
100 MG/ML – 2 ML VIAL (\$9.16) (No refills)  
(Note: Injection for clinic use only, should be taken from stock, and may not be given KOP.)

**THIOTHIXENE** (Max 11 refills)

NAVANE®

2 MG (\$0.43), 5 MG (\$0.67), 10 MG (\$0.90) CAPSULE  
(Note: May not be given KOP.)

**TIMOLOL MALEATE** (Max 11 refills)

TIMOPTIC®

0.5% OPHTHALMIC SOLUTION – 5 ML (\$3.47)

TINACTIN® see TOLNAFTATE

TIVICAY® see DOLUTEGRAVIR

TNKase® see TENECTEPLASE

**TOBRAMYCIN**

TOBREX®

0.3% OPHTHALMIC SOLUTION – 5 ML (\$4.25)

TOFRANIL® see IMIPRAMINE HCL

**TOLNAFTATE**

TINACTIN®

1% CREAM – 15 GM (\$1.89)

TOPAMAX® see TOPIRAMATE

TOPICAL ANESTHETIC SPRAY see ETHYL CHLORIDE

**TOPIRAMATE** (Max 11 refills)

TOPAMAX®

25 MG (\$0.06) TABLET

(Note: 25 mg allowed as floor stock at TJD intake facilities only. Non-formulary approval still required for use.)

TORADOL® see KETOROLAC

t-PA (TISSUE-TYPE PLASMINOGEN ACTIVATOR) see ALTEPLASE

TOPROL XL® see METOPROLOL SUCCINATE

**TRACE ELEMENTS**

TRALEMENT®

1 ML SDV (\$21.79)

(Note: Zinc, Copper, Manganese, and Selenium. Non-formulary approval required for stock and patient order. Non-form stock restricted to 0B, E2-RMF, GC-RMF, HP, J3, MI, and ST for TPN. Take from stock. Clinic use only. May not be given KOP.)

TRALEMENT® see TRACE ELEMENTS

**TRAZODONE HCL** (Max 11 refills)

DESYREL®

50 MG (\$0.02), 100 MG (\$0.02) TABLET

**TRIAMCINOLONE**

KENALOG®

0.025% OINTMENT – 15 GM (\$3.90)

0.025% CREAM – 15 GM (\$2.37)

0.1% CREAM – 15 GM (\$2.42)

0.1% CREAM – 80 GM (\$2.71) (max 5 refills)

10 MG/ML INJECTION – 5 ML VIAL (\$10.89)

40 MG/ML INJECTION – 1 ML VIAL (\$5.35)

KENALOG IN ORABASE®

0.1% DENTAL PASTE – 5 GM (\$5.79)

(Note: Injection is for clinic use only, should be taken from stock and may not be given KOP.)

NASACORT AQ® (Max 2 refills)

NASAL SPRAY 55MCG/SPRAY 120 SPRAYS (\$10.66)

(Note: 1 bottle will last 60 days at 1 spray in each nostril daily. 1 bottle will last 30 days at 2 sprays in each nostril daily.)

**TRIAMTERENE/HYDROCHLOROTHIAZIDE** (Max 11 refills)

DYAZIDE®

TRIAMTERENE 37.5 MG/HCTZ 25 MG CAPSULE (\$0.04)

TRICOR® see FENOFIBRATE

**TRIFLUOPERAZINE HCL** (Max 11 refills)

STELAZINE®

2 MG (\$0.29), 5 MG (\$0.59), 10 MG (\$0.61) TABLET

(Note: May not be given KOP.)

**TRIFLURIDINE**

VIROPTIC®

1% OPHTHALMIC SOLUTION – 7.5 ML (\$124.42)

TRILAFON® see PERPHENAZINE

TRIMETHOPRIM/POLYMYXIN B see POLYMYXIN B/TRIMETHOPRIM

**TROPICAMIDE**

MYDRIACYL®

1% OPHTHALMIC SOLUTION – 15 ML (\$7.99)

(Note: Restricted to Optometry Clinic use only for routine eye exams. Take from stock for optometry clinic facilities. All other uses require non-formulary approval. May not be given KOP.)

TRUEPLUS® see DEXTROSE

TRUSOPT see DORZOLAMIDE

TRUVADA® see EMTRICITABINE/TENOFOVIR

**TUBERCULIN INJECTION** (PURIFIED PROTEIN DERIVATIVE)

PPD, APLISOL®

10 TESTS/1 ML INJECTION – 1 ML VIAL (\$106.59)

50 TESTS/5 ML INJECTION – 5 ML VIAL (\$415.24)

(Note: Given through the Immunization Module as SDO-Standing Delegated Order. Clinic use only. Take from stock. May not be given KOP.)

TUDORZA PRESSAIR® see ACLIDINIUM BROMIDE

TUMS® see CALCIUM CARBONATE

TYLENOL® see ACETAMINOPHEN

TYLENOL® W/CODEINE see ACETAMINOPHEN/CODEINE

TYLENOL #3® see ACETAMINOPHEN WITH CODEINE

**ULIPRISTAL**

ELLA®

30 MG TABLET (\$37.78)

(Restricted to female units for emergency contraceptive use in sexual assault as defined in Correctional Managed Healthcare Sexual Assault Policy G.57.1. All other uses require non-formulary approval. Take from stock. May not be given KOP. Designated as a Local Control and therefore must be kept and inventoried as a controlled substance (Pharmacy Policies 20-05, 20-10, 20-15).)

**VALACYCLOVIR**

VALTREX®

500 MG TABLET (\$0.32) (Max 11 refills)

1 GM TABLET (\$0.31) (No refills)

VALIUM® see DIAZEPAM

VALTREX® see VALACYCLOVIR

VANCOCIN® see VANCOMYCIN HCL

**VANCOMYCIN HCL**

VANCOBIN®

1 G INJECTION VIAL (\$2.16)

IV Preparation Standard:

<500 mg in 100 mL D<sub>5</sub>W over 60-90 minutes>500 mg in 250 mL D<sub>5</sub>W over 90-120 minutes.

(Note: Dose based on actual body weight. Most patients will need 15 mg/kg every 12 hours. Round to the nearest 250 milligrams. Consult pharmacy for obese patients. Medication should be ordered in milligrams. Draw trough 30 minutes before 4<sup>th</sup> dose. Monitor serum creatinine. Clinic use only. Take from stock. May not be given KOP.)

VAQTA® see HEPATITIS A VACCINE

**VARICELLA VACCINE (Max 1 refill)**

VARIVAX®

1350 PFU/0.5 ML – VIAL (\$173.89)

(Note: May not be given KOP. Restricted from floor stock. Order for 42 days with 1 refill to be administered at 0 and 6 weeks. (For HIV+ patients, order for 90 days with 1 refill to be administered at 0 and 3 months.) Prior authorization criteria must be met and noted in the special instructions field for use without non-formulary approval. Criteria include:

- Post-exposure prophylaxis with approval from the Office of Public Health
- < 19 years old without documentation of previous disease or immunization (lab work not required)
- HIV positive patients without documented immunity and CD4 > 200)

VARIVAX® see VARICELLA VACCINE

VASELINE® JELLY see PETROLATUM

VEETIDS® see PENICILLIN VK

**VENLAFAXINE HCL ER (Max 11 refills)**

EFFEXOR® XR

37.5 MG (\$0.07), 75 MG (\$0.06), 150 MG (\$0.10) EXTENDED-RELEASE CAPSULE

(Note: Extended-release formulation to be dosed once a day. May not be crushed or chewed.)

VENOFER® see IRON SUCROSE

**VERAPAMIL HCL**

CALAN®

80 MG (\$0.05), 120 MG (\$0.07) IMMEDIATE RELEASE TABLET (Max 11 refills)

2.5 MG/ML INJECTION – 2 ML VIAL (\$9.17) (No refills)

CALAN SR®

180 MG (\$0.19), 240 MG (\$0.18) SUSTAINED RELEASE CAPLET (Max 11 refills)

(Note: Injection for clinic use only, should be taken from stock, may not be given KOP.)

VESICARE® see SOLIFENACIN

VIBRAMYCIN® see DOXYCYCLINE

VICKS VAPORUB® see CAMPHOR/EUCALYPTUS/MENTHOL

VIRAMUNE® see NEVIRAPINE

VIREAD® see TENOFOVIR

VIROPTIC® see TRIFLURIDINE

VISTARIL® see HYDROXYZINE PAMOATE

VITAMIN B-1 see THIAMINE HCL

VITAMIN B-6 see PYRIDOXINE HCL

VITAMIN B-12 see CYANOCOBALAMIN

**VITAMIN B COMPLEX & VITAMIN C WITH FOLIC ACID (Max 11 refills)**

NEPHRO-VITE®, RENAL VITAMIN

TABLET (\$0.05)

(Note: Prior authorization required. The following prior authorization criteria must be met and noted in the special instructions field: dialysis. Floor stock restricted to dialysis.)

VITAMIN C (Max 11 refills)  
 250 MG (\$0.01), 500 MG (\$0.02) TABLET  
 (Prior authorization criteria must be met and noted in special instructions field for use without non-formulary approval. Criteria include: TH (Telehealth) Wound care clinic)

VITAMIN D-3 see CHOLECALCIFEROL

VITAMIN K-1 see PHYTONADIONE

VITAMIN, I.V. INFUSION see MULTIVITAMIN

VYVANSE® see LISDEXAMFETMAINE

**WARFARIN SODIUM** (Max 11 refills)  
 COUMADIN®  
 2.5 MG TABLET (\$0.09)  
 (Note: May not be given KOP.)

**WATER FOR INJECTION**  
 WATER FOR INJECTION, STERILE – 10 ML (\$3.14)  
 WATER FOR INJECTION, BACTERIOSTATIC – 30 ML (\$5.77)  
 (Note: Clinic use only. Take from stock. May not be given KOP.)

WELLCOVORIN® see LEUCOVORIN CALCIUM

XALATAN® see LATANOPROST

XARELTO® see RIVAROXABAN

XYLOCAINE® see LIDOCAINE HCL

XYLOCAINE/EPINEPHRINE® see LIDOCAINE/EPINEPHRINE

ZAROXOLYN® see METOLAZONE

ZDV see ZIDOVUDINE

ZEMPLAR® see PARICALCITOL

ZESTRIL® see LISINOPRIL

ZETIA® see EZETIMIBE

ZIAGEN® see ABACAVIR

**ZIDOVUDINE** (AZT, ZDV) (Max 11 refills)  
 RETROVIR®  
 300 MG TABLET (\$0.45)  
 (Note: Use PEP template for post-exposure prophylaxis.)

ZILACTIN-B® see BENZOCAINE

**ZINC SULFATE**  
 220 MG CAPSULE (\$0.03)  
 (Note: Prior authorization criteria must be met and noted in special instructions field for use without non-formulary approval. Criteria include: TH (Telehealth) Wound care clinic.)

**ZINC OXIDE/MENTHOL**  
 CALMOSEPTINE®  
 OINTMENT 3.5 GM PACKET (\$0.37)  
 (Note: Restricted to TDCJ UTMB facilities. Clinic use only. Take from stock. May not be given KOP. No refills allowed. For use per wound clinic and standing delegated order.)

**ZIPRASIDONE HCL** (Max 11 refills)  
 GEODON®  
 20 MG (\$0.18), 40 MG (\$0.11), 60 MG (\$0.17), 80 MG (\$0.13) CAPSULE  
 (Note: May not be given KOP. Use and floor stock of 20 mg restricted to TJJD. Floor stock for TDCJ: 20mg & 40mg)

**ZIPRASIDONE MESYLATE**  
 GEODON®  
 20 MG/ML – 1 ML VIAL (\$25.26)  
 (Note: Clinic use only. Take from stock. May not be given KOP. See the Acute Psychosis pathway for injection dosing recommendations.)

ZITHROMAX® see AZITHROMYCIN

ZOFRAN® see ONDANSETRON

**ZOSTER VACCINE, RECOMBINANT**

SHINGRIX®

2 VIAL KIT – 0.5ML RECONSTITUTED (\$210.12)

(Note: Clinic use only. Take from stock. May not be given KOP. Administered as a 2-dose series at 0 & 2 months. Follow Infection Control P&P B-14.07 and standing delegated order when selecting patients.

a. new intake and ≥50 year of age, or

b. new intake and patients ages 19-49 with hematopoietic cell transplant, hematologic malignancies, HIV infection, psoriasis, spondyloarthropathy, and rheumatoid arthritis.

\*If patients do not meet criteria, a non-form approval is required. If non-form is approved, a patient specific order should be entered in the EHR.)

ZYLOPRIM® see ALLOPURINOL

ZYRETC® see CETIRIZINE

## THERAPEUTIC CATEGORY INDEX

The following index provides a list of Formulary items grouped by therapeutic category according to the American Hospital Formulary Service (AHFS) classification system. The major drug classification appears in all capital letters followed by sub-classification when indicated. Major drug classes are listed below with the corresponding page number(s). Drugs may be listed in more than one therapeutic category.

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<b>VITAMINS</b> .....	84

- 04:00 **ANTI-HISTAMINES**
- 04:04 **First Generation Antihistamines**
- 04:04.04 **Ethanolamine Derivatives**  
diphenhydramine
- 04:04.12 **Phenothiazine Derivatives**  
promethazine
- 04:08 **Second Generation Antihistamines**  
cetirizine  
loratadine
- 08:00 **ANTI-INFECTIVES**
- 08:12 **Antibacterials**
- 08:12.02 **Aminoglycosides**  
gentamicin
- 08:12.06 **Cephalosporins**  
*1st Generation*  
cefazolin  
cephalexin
- 3rd Generation*  
cefepime  
ceftriaxone
- 08:12.07 **Miscellaneous  $\beta$ -Lactams**  
meropenem
- 08:12.12 **Macrolides**  
azithromycin  
erythromycin
- 08:12.16 **Penicillins**  
*Natural Penicillins*  
penicillin G benzathine  
penicillin G potassium  
penicillin VK
- Penicillinase-Resistant Penicillins*  
dicloxacillin  
nafcillin
- Aminopenicillins Penicillins*  
amoxicillin  
amoxicillin/clavulanate  
ampicillin
- 08:12.18 **Quinolones**  
ciprofloxacin  
levofloxacin
- 08:12.20 **Sulfonamides**  
sulfamethoxazole/trimethoprim  
sulfasalazine
- 08:12.24 **Tetracyclines**  
doxycycline
- 08:12.28 **Miscellaneous Antibacterials**  
clindamycin  
vancomycin
- 08:14 **Antifungals**
- 08:14.08 **Azoles**  
fluconazole

- 08:16 Antimycobacterial Agents**  
**08:16.04 Antituberculosis Agents**  
 ethambutol  
 isoniazid  
 pyrazinamide  
 rifabutin  
 rifampin  
 rifapentine
- 08:16.92 Miscellaneous Antimycobacterials**  
 dapsone
- 08:18 Antivirals**  
**08:18.04 Adamantanes**  
 amantadine
- 08:18.08 Antiretroviral Agents**  
*Integrase Inhibitor*  
 raltegravir
- Integrase Strand Transfer Inhibitor*  
 dolutegravir  
 elvitegravir/cobicistat/emtricitabine/tenofovir  
 bictegravir/emtricitabine/tenofovir
- Nucleoside reverse transcriptase inhibitors*  
 abacavir  
 abacavir/lamivudine  
 lamivudine  
 zidovudine
- Nucleotide reverse transcriptase inhibitors*  
 emtricitabine/tenofovir  
 tenofovir
- Non-nucleoside reverse transcriptase inhibitors*  
 efavirenz  
 nevirapine  
 rilpivirine
- Protease Inhibitors*  
 atazanavir  
 darunavir  
 fosamprenavir  
 lopinavir/ritonavir  
 ritonavir
- 08:18.28 Neuraminidase inhibitors**  
 oseltamivir
- 08:18.32 Nucleosides and Nucleotides**  
 entecavir  
 ribavirin  
 valacyclovir
- 08:18.40 HCV Antivirals**  
 sofosbuvir/velpatasvir
- 08:30 Antiprotozoals**  
**08:30.92 Miscellaneous**  
 metronidazole
- 08:36 Urinary Anti-Infectives**  
 nitrofurantoin mono

**12:00 AUTONOMIC DRUGS**

- 12:08 Anticholinergic Agents**  
**12:08.08 Antimuscarinic / Antispasmodics**  
 acridinium  
 atropine  
 ipratropium

- 12:12 **Sympathomimetic Agents**  
albuterol  
dopamine  
epinephrine  
norepinephrine  
terbutaline
- 12:16 **Sympatholytic Agents**  
12:16:04 **Selective Alpha-1 Adrenergic Blocking**  
Tamsulosin
- 12:20 **Skeletal Muscle Relaxants**  
baclofen  
methocarbamol
- 16:00 **BLOOD DERIVATIVES**  
albumin, human
- 20:00 **BLOOD FORMATION AND COAGULATION**
  - 20:04 **Antianemia Drugs**  
20:04.04 **Iron Preparations**  
ferrous sulfate  
iron sucrose
  - 20:12 **Antithrombotic Agents**  
20:12.04 **Anticoagulants**  
enoxaparin  
heparin  
rivaroxaban  
warfarin
  - 20:12.18 **Platelet-aggregation Inhibitors**  
clopidogrel
  - 20:12.20 **Thrombolytic Agents**  
alteplase  
tenecteplase
  - 20:16 **Hematopoietic Agents**  
epoetin alfa  
filgrastim-aafi
  - 20:28 **Antihemorrhagic Agents**  
20:28.08 **Antiheparin Agents**  
protamine
  - 20:28.16 **Hemostatic**  
antihemophilic factor VIII  
ferric subsulfate
- 24:00 **CARDIOVASCULAR DRUGS**
  - 24:04 **Cardiac Drugs**  
24:04.04 **Antiarrhythmic Agents**  
adenosine  
amiodarone
  - 24:06 **Antilipemic Agents**  
24:06.05 **Cholesterol Absorption Inhibitors**  
ezetimibe
  - 24:06.06 **Fibric Acid Derivative**  
fenofibrate
  - 24:06.08 **HMG-CoA Reductase Inhibitors (Statin)**  
atorvastatin  
pravastatin
  - 24:08 **Hypotensive Agents**  
24:08.16 **Central Alpha Agonists**  
clonidine  
guanfacine

- 24:08.20      **Direct Vasodilators**  
hydralazine  
minoxidil
- 24:12      **Vasodilating Agents**
- 24:12.08      **Nitrates and Nitrites**  
isosorbide dinitrate  
isosorbide mononitrate  
nitroglycerin
- 24:20      **Alpha-Adrenergic Blocking Agents**  
Terazosin
- 24:24      **Beta-Adrenergic Blocking Agents**  
carvedilol  
labetalol  
metoprolol  
propranolol  
sotalol
- 24:28      **Calcium-Channel Blocking Agents**
- 24:28.08      **Dihydropyridines**  
amlodipine
- 24:28.92      **Miscellaneous Calcium-Channel Blocking Agents**  
diltiazem  
verapamil
- 24:32      **Renin-Angiotensin-Aldosterone System Inhibitors**
- 24:32.04      **Angiotensin-Converting Enzyme Inhibitors**  
lisinopril
- 24:32.08      **Angiotensin II Receptor Antagonists**  
losartan
- 24:32.20      **Mineralcorticoid (Aldosterone) Receptor Antagonists**  
spironolactone
- 28:00      **CENTRAL NERVOUS SYSTEM AGENTS**
- 28:08      **Analgesics and Antipyretics**
- 28:08.04      **Nonsteroidal Anti-Inflammatory Agents**  
*Acetic Acids*  
ketorolac  
  
*Acetylated Salicylates*  
aspirin  
  
*Propionic Acids*  
ibuprofen  
naproxen  
  
*Oxicams*  
meloxicam
- 28:08.08      **Opiate Agonists**  
acetaminophen/codeine  
fentanyl  
methadone  
morphine
- 28:08.12      **Opiate Partial Agonists**  
buprenorphine
- 28:08.92      **Miscellaneous Analgesics & Antipyretics**  
acetaminophen
- 28:10      **Opiate Antagonists**  
naloxone
- 28:12      **Anticonvulsants**
- 28:12.04      **Barbiturates**  
primidone

- 28:12.12 Hydantoins**  
phenytoin
- 28:12.92 Miscellaneous Anticonvulsants**  
carbamazepine  
divalproex sodium DR  
lamotrigine  
levetiracetam  
magnesium sulfate  
topiramate
- 28:16 Psychotherapeutic Agents**  
**28:16.04 Antidepressants**  
*Selective Serotonin & Norepinephrine Reuptake Inhibitors*  
duloxetine  
venlafaxine
- Selective Serotonin Reuptake Inhibitors*  
escitalopram  
fluoxetine  
paroxetine  
sertraline
- Serotonin Modulators*  
trazodone
- Tricyclics and Other Norepinephrine Reuptake Inhibitors*  
imipramine
- 28:16.08 Antipsychotics**  
*Atypical Antipsychotics*  
aripiprazole  
clozapine  
lurasidone  
risperidone  
ziprasidone
- Typical Antipsychotics*  
fluphenazine  
haloperidol  
perphenazine  
thiothixene  
trifluoperazine
- 28:20 Anorexigenic Agents and Respiratory & Cerebral Stimulants**  
**28:20.04 Amphetamines**  
amphetamine salts  
lisdexamfetamine  
methylphenidate
- 28:20.92** methylphenidate ER
- 28:24 Anxiolytics, Sedatives, and Hypnotics**  
**28:24.08 Benzodiazepines**  
chlordiazepoxide  
diazepam  
lorazepam
- 28:24.92 Misc Anxiolytics, Sedatives, & Hypnotics**  
hydroxyzine
- 28:28 Antimanic Agents**  
lithium
- 28:36 Antiparkinsonian Agents**  
**28:36.04 Adamantines**  
Amantadine
- 28:36.08 Anticholinergic Agents**  
benztropine
- 28:36.16 Dopamine Precursors**  
carbidopa/levodopa

- 28:36.20      **Dopamine Receptor Agonists**  
Bromocriptine
- 28:92    **Central Nervous System Agents, Miscellaneous**  
atomoxetine  
flumazenil  
guanfacine ER
- 36:00    **DIAGNOSTIC AGENTS**
- 36:58    **Ocular**  
fluorescein strips
- 36:68    **Contrast**  
gadobenate  
gadoteridol
- 36:84    **Tuberculosis**  
tuberculin PPD
- 40:00    **ELECTROLYTIC, CALORIC & WATER BALANCE**
- 40:08    **Alkalinizing Agents**  
sodium bicarbonate
- 40:10    **Ammonia Detoxicants**  
lactulose
- 40:12    **Replacement Preparations**  
calcium carbonate  
calcium gluconate  
dextrose / lactated ringers  
potassium chloride  
ringers-lactated  
sodium chloride  
trace elements (zn/cu/mn/se)  
zinc sulfate
- 40:18    **Ion-removing Agents**
- 40:18.18    **Potassium-Removing Agents**  
polystyrene sodium sulfonate
- 40:18.19    **Phosphate-Removing Agents**  
sevelamer
- 40:20    **Caloric Agents**  
amino acid/electrolytes/calcium in D20W  
dextrose  
enteral feeding/enteral nutrition  
fat emulsions
- 40:28    **Diuretics**  
*Loop Diuretics*  
furosemide  
  
*Potassium-sparing diuretics*  
triamterene / hydrochlorothiazide  
  
*Thiazide Diuretics*  
hydrochlorothiazide  
  
*Thiazide-like Diuretics*  
metolazone
- 40:36    **Irrigating Solutions**  
sodium chloride
- 48:00    **RESPIRATORY TRACT AGENTS**
- 48:08    **Antitussive/48:16 Expectorant**  
Guaifenesin/Dextromethorphan
- 48:10    **Anti-Inflammatory Agents**
- 48:10:08    **Corticosteroids**  
Ciclesonide

**52:00 EYE, EAR, NOSE, & THROAT (EENT) PREPARATIONS**

**52:04 Anti-Infectives**

**52:04.04**

**Antibacterials**

bacitracin / polymyxin ophth  
ciprofloxacin ophth  
erythromycin ophth  
gentamicin ophth  
neomycin / polymyxin / bacitracin ophth  
neomycin / polymyxin / bacitracin / hydrocortisone ophth  
neomycin / polymyxin / dexamethasone ophth  
neomycin / polymyxin / gramicidin ophth  
neomycin / polymyxin / hydrocortisone otic  
polymyxin B / trimethoprim ophth  
sulfacetamide ophth  
tobramycin ophth

**52:04.20**

**Antivirals**

trifluridine ophth

**52:04.92**

**Miscellaneous Anti-Infectives**

carbamide peroxide otic  
chlorhexidine

**52:08 Anti-Inflammatory Agents**

**52:08:08**

**Corticosteroids**

prednisolone ophth  
fluorometholone ophth  
triamcinolone nasal

**52:08.20**

**Nonsteroidal Anti-inflammatory Agents**

ketorolac ophth

**52:16 Local Anesthetics**

benzocaine (orajel)  
lidocaine viscous  
proparacaine ophth

**52:24 Mydriatics**

atropine ophth  
cyclopentolate ophth  
tropicamide ophth

**52:32 Vasoconstrictors**

naphazoline / pheniramine ophth  
phenylephrine ophth

**52:40 Antiglaucoma agents**

**52:40.04**

**Alpha-Adrenergic Agonists**

brimonidine ophth

**52:40.08**

**Beta-Adrenergic Agents**

timolol ophth

**52:40.12**

**Carbonic Anhydrase Inhibitors**

acetazolamide  
dorzolamide ophth

**52:40.28**

**Prostaglandin Analogs**

latanoprost

**52:92 Miscellaneous EENT Drugs**

lubricant ophth oint  
ophthalmic irrigating solution  
polyvinyl/povidone ophth (artificial tears)  
sodium chloride nasal  
sodium chloride ophth

**56:00 GASTROINTESTINAL DRUGS**

**56:04 Antacids & Adsorbents**

calcium carbonate  
charcoal, activated  
magnesium oxide

- 56:08 Antidiarrheal Agents**  
bismuth subsalicylate  
loperamide
- 56:10 Antiflatulents**  
simethicone
- 56:12 Cathartics & Laxatives**  
*Bowel Evacuants*  
PEG-3350 / electrolytes
- Bulk-Forming Laxatives*  
calcium polycarbophil
- Saline Laxatives*  
magnesium citrate  
magnesium hydroxide  
sodium phosphate
- Stimulant Laxatives*  
bisacodyl
- Stool Softeners*  
docusate sodium
- 56:16 Digestants**  
lipase / protease / amylase (pancrelipase)
- 56:22 Antiemetics**
- 56:22.08 Antihistamines**  
meclizine  
prochlorperazine
- 56:22.20 5-HT3 Receptor Antagonists**  
ondansetron
- 56:28.12 H-2 Receptor Antagonists**  
Famotidine
- 56:28.36 Proton-pump Inhibitors**  
omeprazole  
pantoprazole
- 56:32 Prokinetic Agents**  
metoclopramide
- 68:00 HORMONES & SYNTHETIC SUBSTITUTES**
- 68:04 Adrenals**  
dexamethasone  
hydrocortisone  
methylprednisolone  
prednisone  
triamcinolone
- 68:08 Androgen**  
Testosterone
- 68:12 Contraceptives**  
levonorgestrel  
norethindrone / ethinyl estradiol  
norgestrel / ethinyl estradiol  
ulipristal
- 68:16 Estrogen**
- 68:16.04 Estrogens**  
conjugated estrogens  
estradiol
- 68:20 Antidiabetic Agents**
- 68:20.04 Biguanides**  
metformin

- 68:20.08      **Insulins**  
insulin, human - glargine  
insulin, human - NPH  
insulin, human - regular
    - 68:20.20      **Sulfonylureas**  
glipizide
  - 68:22      **Antihypoglycemic Agents**
    - 68:22.12      **Glycogenolytic Agents**  
glucagon
  - 68:28      **Pituitary**  
desmopressin
  - 68:32      **Progestins**  
medroxyprogesterone
  - 68:36      **Thyroid & Antithyroid Agents**
    - 68:36.04      **Thyroid Agents**  
levothyroxine
    - 68:36.08      **Antithyroid Agents**  
methimazole
- 72:00      **LOCAL ANESTHETICS**  
bupivacaine  
lidocaine
- 80:00      **SERUMS, TOXOIDS, & VACCINES**
  - 80:04      **Serums**  
rho(D) immune globulin
  - 80:08      **Toxoids**  
tetanus-diphtheria  
tetanus-diphtheria-acellular pertussis
  - 80:12      **Vaccines**  
COVID vaccine  
hepatitis A vaccine  
hepatitis B vaccine  
human papillomavirus vaccine  
influenza virus vaccine  
measles-mumps-rubella vaccine  
meningococcal polysaccharide vaccine  
pneumococcal polyvalent vaccine  
poliovirus vaccine, inactivated  
varicella vaccine  
zoster vaccine
- 84:00      **SKIN & MUCOUS MEMBRANE AGENTS**
  - 84:04      **Anti-Infectives**
    - 84:04.04      **Antibacterials**  
bacitracin / polymyxin  
clindamycin  
neomycin / polymyxin / bacitracin
    - 84:04.08      **Antifungals**  
clotrimazole  
miconazole  
tolnaftate
    - 84:04.12      **Scabicides & Pediculicides**  
permethrin
    - 84:04.92      **Miscellaneous Local Anti-Infectives**  
selenium sulfide  
silver sulfadiazine

- 84:06 Anti-Inflammatory Agents**  
 fluocinonide  
 hydrocortisone  
 mometasone furoate  
 triamcinolone  
 triamcinolone / orabase
- 84:08 Antipruritics & Local Anesthetics**  
 ethyl chloride  
 lidocaine  
 phenazopyridine
- 84:24 Emollients, Demulcents and Protectants**  
**84:24.04 Basic Lotions and Liniments**  
 calamine  
 body lotion  
 mentholatum rub
- 84:24.12 Basic Ointments and Protectants**  
 absorbbase  
 zinc oxide/menthol
- 84:28 Keratolytic Agents**  
 benzoyl peroxide  
 salicylic acid
- 84:32 Keratoplastic Agents**  
 coal tar
- 84:80 Sunscreen Agents**  
 sunscreen, SPF 30
- 84:92 Miscellaneous**  
 collagenase  
 lubricant, surgical  
 podofilox  
 phenylephrine suppositories (hemorrhoidal)  
 pramoxine/phenylephrine (hemorrhoidal)
- 86:00 SMOOTH MUSCLE RELAXANTS**  
**86:12 Genitourinary Smooth Muscle Relaxants**  
**86:12:04 Antimuscarinics**  
 Solifenacin
- 88:00 VITAMINS**  
**88:08 Vitamin B Complex**  
 cyanocobalamin  
 folic acid  
 pyridoxine  
 renal vitamin  
 thiamine
- 88:12 Vitamin C**
- 88:16 Vitamin D**  
 calcitriol  
 cholecalciferol (D<sub>3</sub>)  
 paricalcitol
- 88:24 Vitamin K**  
 phytonadione
- 88:28 Multivitamin Preparations**  
 multivitamin, IV infusion  
 multivitamin  
 prenatal-folic acid
- 92:00 MISCELLANEOUS THERAPEUTIC AGENTS**  
**92:08 5-Alpha Reductase Inhibitor**  
 Finasteride
- 92:12 Antidotes**  
 leucovorin

**92:16 Antigout Agents**  
allopurinol

**92:28 Cariostatic Agents**  
stannous fluoride

**92:36 Disease-modifying Antirheumatic Drugs**  
Infliximab-abda

**92:44 Immunosuppressive Agents**  
azathioprine  
cyclosporine  
mycophenolate mofetil  
sirolimus  
tacrolimus

**92:92 Other**  
melatonin

**96:00 PHARMACEUTICAL AIDS**  
petrolatum jelly