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

Drug Class Name	Drug Generic Name	Coverage restrictions or limitations for specific drugs or dosage forms are listed with the respective drugs below.
	Hydromorphone HCl Tab ER 24HR Deter Products	**Prior authorization is required to show documented allergic reaction to or clinical failure of, as defined in OAC 4213-6-21(J)(1) and (J)(2), Oxycodone ER or Fentanyl transdermal. Reimbursement shall not exceed one tablet per day. Prior authorization is required for reimbursment of doses above this limit. Claims in which this dose limitation was exceeded prior to January 1, 2017, will be limited to the last quantity prescribed before that date. Coverage will not be permitted for this product concurrenty with any other sustained release opioid. Sustained release opioids will not be covered in the post-operative period unless routinely prescribed pre-operatively.**
	Hydromorphone HCl Tab ER 24HR Deter 8 MG	**See Hydromorphone HCl Tab ER 24HR Deter Products restrictions above**
	Hydromorphone HCl Tab ER 24HR Deter 12 MG	**See Hydromorphone HCl Tab ER 24HR Deter Products restrictions above**
	Hydromorphone HCl Tab ER 24HR Deter 16 MG	**See Hydromorphone HCl Tab ER 24HR Deter Products restrictions above**
	Hydromorphone HCl Tab ER 24HR Deter 32 MG	**See Hydromorphone HCl Tab ER 24HR Deter Products restrictions above**
	Methadone Products	**All oral forms of methadone shall be considered to be long acting opioids and will be subject to the formulary limitations of sustained release drug formulations. Initial coverage of oral methadone requires documentation of a 12 lead electrocardiogram within the previous 6 months. Ongoing coverage of oral methadone requires the documentation of an annual 12 lead eclectocardiogram. Oral methadone will be eligible for reimbursement only after documentation of allergic reaction to or clinical failure of, as defined in OAC 4123-6-21(J)(1) and (J)(2), sustained release forms of morphine or hydrocodone. Prior Authorization is required. Reimbursement for this product may not exceed a maximum dose of 90 mg per day. Claims in which this dose limitation was exceeded prior to January 1, 2017, will be limited to the last quantity prescribed before that date. Coverage will not be permitted for this product concurrently with any other sustained release opioid . Sustained release opioids will not be covered in the post-operative period unless routinely prescribed pre-operatively.**
	Methadone HCl Tab 5 MG	**See Methadone Products Restrictions above**
	Methadone HCl Tab 10 MG	**See Methadone Products Restrictions above**
	Methadone HCl Soln 5 MG/5ML	**See Methadone Products Restrictions above**
	Methadone HCl Soln 10 MG/5ML	**See Methadone Products Restrictions above**
	Morphine Sulfate Tab ER Products	**Reimbursement shall be restricted to not exceed 3 tablets per day for doses less than 200 mg per tablet and 2 tablets per day for doses of 200 mg per tablet. Prior Authorization is required for reimbursement for any doses above this level. Coverage will not be permitted for this product concurrently with any other sustained release opioid. Sustained release opioids will not be covered in the post-operative period unless routinely prescribed pre-operatively.**
	Morphine Sulfate Tab ER 15 MG	**See Morphine Sulfate Tab ER Products restrictions above**
	Morphine Sulfate Tab ER 30 MG	**See Morphine Sulfate Tab ER Products restrictions above**
	Morphine Sulfate Tab ER 60 MG	**See Morphine Sulfate Tab ER Products restrictions above**
	Morphine Sulfate Tab ER 100 MG	**See Morphine Sulfate Tab ER Products restrictions above**
	Morphine Sulfate Tab ER 200 MG	**See Morphine Sulfate Tab ER Products restrictions above**
	Morphine-Naltrexone Cap ER Products	**Reimbursement for this product shall not exceed 2 capsules per day. Coverage will not be permitted for this product concurrently with any other sustained release opioid. Sustained release opioids will not be covered in the post-operative period unless routinely prescribed pre-operatively.**
	Morphine-Naltrexone Cap ER 20-0.8 MG	**See Morphine-Naltrexone Cap ER Products restrictions above**
	Morphine-Naltrexone Cap ER 30-1.2 MG	**See Morphine-Naltrexone Cap ER Products restrictions above**
	Morphine-Naltrexone Cap ER 50-2 MG	**See Morphine-Naltrexone Cap ER Products restrictions above**
	Morphine-Naltrexone Cap ER 60-2.4 MG	**See Morphine-Naltrexone Cap ER Products restrictions above**
	Morphine-Naltrexone Cap ER 80-3.2 MG	**See Morphine-Naltrexone Cap ER Products restrictions above**
	Morphine-Naltrexone Cap ER 100-4 MG	**See Morphine-Naltrexone Cap ER Products restrictions above**
	Oxycodone HCl Tab ER 12HR Deter Products	**Sustained release forms of Oxycodone are eligible for reimbursement only after documentation of treatment with an immediate release form of oxycodone for at least 60 days or allergic reaction to or clinical failure of, as defined in OAC 4123-6-21(J)(1) and (J)(2), sustained release forms of morphine or hydrocodone. Prior Authorization is required. Reimbursement for all strengths of this product shall not exceed every eight hours or 3 doses per day. A Prior Authorization is required for reimbursement for any doses above these levels. Coverage will not be permitted for this product concurrently with any other sustained release opioid. Sustained release opioids will not be covered in the post-operative period unless routinely prescribed pre-operatively.**

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

Drug Class Name	Drug Generic Name	Coverage restrictions or limitations for specific drugs or dosage forms are listed with the respective drugs below.
	Oxycodone HCl Tab ER 12HR Deter 10 MG	**See Oxycodone HCl Tab ER 12HR Deter Products restrictions above**
	Oxycodone HCl Tab ER 12HR Deter 15 MG	**See Oxycodone HCl Tab ER 12HR Deter Products restrictions above**
	Oxycodone HCl Tab ER 12HR Deter 20 MG	**See Oxycodone HCl Tab ER 12HR Deter Products restrictions above**
	Oxycodone HCl Tab ER 12HR Deter 30 MG	**See Oxycodone HCl Tab ER 12HR Deter Products restrictions above**
	Oxycodone HCl Tab ER 12HR Deter 40 MG	**See Oxycodone HCl Tab ER 12HR Deter Products restrictions above**
	Oxycodone HCl Tab ER 12HR Deter 60 MG	**See Oxycodone HCl Tab ER 12HR Deter Products restrictions above**
	Oxycodone HCl Tab ER 12HR Deter 80 MG	**See Oxycodone HCl Tab ER 12HR Deter Products restrictions above**
	Oxymorphone HCl Tab ER 12HR Products	**Prior authorization is required showing documentation of allergic reaction to or clinical failure of, as defined in OAC 4123-6-21(J)(1) and (J)(2),Oxycodone ER or Fentanyl transdermal. Reimbursement shall not exceed two tablets per day. Claims in which this dose limitation was exceeded prior to January 1, 2017, will be limited to the last quantity prescribed before that date. Coverage will not be permitted for this product concurrenty with any other sustained release opioid. Sustained release opioids will not be covered in the post-operative period unless routinely prescribed pre-operatively.**
	Oxymorphone HCl Tab ER 12HR 5 MG	**See Oxymorphone HCl Tab ER 12HR Products restrictions above**
	Oxymorphone HCl Tab ER 12HR 7.5 MG	**See Oxymorphone HCl Tab ER 12HR Products restrictions above**
	Oxymorphone HCl Tab ER 12HR 10 MG	**See Oxymorphone HCl Tab ER 12HR Products restrictions above**
	Oxymorphone HCl Tab ER 12HR 15 MG	**See Oxymorphone HCl Tab ER 12HR Products restrictions above**
	Oxymorphone HCl Tab ER 12HR 20 MG	**See Oxymorphone HCl Tab ER 12HR Products restrictions above**
	Oxymorphone HCl Tab ER 12HR 30 MG	**See Oxymorphone HCl Tab ER 12HR Products restrictions above**
	Oxymorphone HCl Tab ER 12HR 40 MG	**See Oxymorphone HCl Tab ER 12HR Products restrictions above**
	Tapentadol HCl Tab ER 12HR Products	**Reimbursement shall not exceed 500 mg per day. Coverage will not be permitted for this product concurrently with any other sustained release opioid or immediate release tapentadol products. Sustained release opioids will not be covered in the post-operative period unless routinely prescribed pre-operatively.**
	Tapentadol HCl Tab ER 12HR 50 MG	**See Tapentadol HCl Tab ER 12HR Products restrictions above**
	Tapentadol HCl Tab ER 12HR 100 MG	**See Tapentadol HCl Tab ER 12HR Products restrictions above**
	Tapentadol HCl Tab ER 12HR 150 MG	**See Tapentadol HCl Tab ER 12HR Products restrictions above**
	Tapentadol HCl Tab ER 12HR 200 MG	**See Tapentadol HCl Tab ER 12HR Products restrictions above**
	Tapentadol HCl Tab ER 12HR 250 MG	**See Tapentadol HCl Tab ER 12HR Products restrictions above**
	Tramadol HCl Tab ER 24HR Products	**Reimbursement for this product shall not exceed 300 mg per day. Coverage will not be permitted for this product concurrently with any other sustained release opioid. Sustained release opioids will not be covered in the post-operative period unless routinely prescribed pre-operatively.**
	Tramadol HCl Tab ER 24HR 100 MG	**See Tramadol HCl Tab ER 24HR Products restrictions above**
	Tramadol HCl Tab ER 24HR 200 MG	**See Tramadol HCl Tab ER 24HR Products restrictions above**
	Tramadol HCl Tab ER 24HR 300 MG	**See Tramadol HCl Tab ER 24HR Products restrictions above**
	Tramadol HCl Tab ER 24HR Biphasic Release 100 MG	**See Tramadol HCl Tab ER 24HR Products restrictions above**
	Tramadol HCl Tab ER 24HR Biphasic Release 200 MG	**See Tramadol HCl Tab ER 24HR Products restrictions above**
	Tramadol HCl Tab ER 24HR Biphasic Release 300 MG	**See Tramadol HCl Tab ER 24HR Products restrictions above**
Opioid Antagonists		
	Naloxone HCl Nasal Spray 4 MG/0.1ML	**Reimbursement is restricted to only those claims in which a prior authorization or prescription history look-back has documented that BWC is currently or has recently been reimbursing for opioid drugs.**
	Naltrexone HCl Tab 50 MG	**Reimbursement is restricted to only those claims in which a prior authorization has documented that BWC is currently reimbursing for opioid drugs.**
Opioid Combinations		**Immediate Release Opioid Dose Formulations Restrictions:** **(1) initial coverage of any immediate release opioid in an opioid naive IW will be limited to 7 days of coverage or 30 doses, whichever is less; a PA may be obtained to exceed these limitations for post-operative situations.** **(2) Concurrent use of more than one immediate release opioid agent will not be covered without a Prior Authorization.** **(3) A quantity limit of 6 doses per day for any immediate release opioid will be implemented in all claims. Daily doses above this level may be reimbursed with prior authorization upon submission of documentation that supports clinical failure, as defined in OAC 4123-6-21(J)(2), of a lower daily dose. Claims in which this quantity limit was exceeded prior to January 1, 2017 will be limited to the last quantity prescribed before that date.**

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

Drug Class Name	Drug Generic Name	Coverage restrictions or limitations for specific drugs or dosage forms are listed with the respective drugs below.
	Acetaminophen w/ Codeine Products	**Reimbursement for oral solid dosage forms of Codeine/Acetaminophen (APAP) is restricted to products that contain 300 mg of APAP. Reimbursement for this product will be limited to 6 doses per day for all covered forms of this product. Daily doses above this level may be reimbursed with prior authorization upon submission of documentation that supports clinical failure, as defined in OAC 4123-6-21(J)(2), of a lower daily dose. Claims in which this quantity limit was exceeded prior to January 1, 2017 will be limited to the last quantity prescribed before that date. Prior Authorization will be required in all claims for reimbursement of concurrent use of this product with any other immediate release opioid. See also "Immediate Release Opioid Dose Formulation Restrictions" for additional restrictions for opioid naive IW.**
	Acetaminophen w/ Codeine Soln 120-12 MG/5ML	**See Acetaminophen w/ Codeine Product Restrictions Above**
	Acetaminophen w/ Codeine Tab 300-15 MG	**See Acetaminophen w/ Codeine Product Restrictions Above**
	Acetaminophen w/ Codeine Tab 300-30 MG	**See Acetaminophen w/ Codeine Product Restrictions Above**
	Acetaminophen w/ Codeine Tab 300-60 MG	**See Acetaminophen w/ Codeine Product Restrictions Above**
	Aspirin-Caffeine-Dihydrocodeine Cap 356.4-30-16 MG	**Initial coverage in an opioid naive IW will be limited to 7 days of coverage or 30 doses, whichever is less; a PA may be obtained to exceed these limitations for post-operative situations.**
	Butalbital-Acetaminophen-Caff w/ COD Cap 50-325-40-30 MG	**Reimbursement is restricted to combinations of Butalbital/codeine/caffeine/APAP that contain 325 mg of APAP. Reimbursement for this product shall not exceed 4 grams/day of APAP (12 cap) or 24 cap per calendar month and is restricted to only those claims that have the condition of headache specificed as a documented allowance in the claim.**
	Butalbital-Aspirin-Caff w/ Codeine Cap 50-325-40-30 MG	**Reimbursement for this product shall not exceed 24 cap per calendar month and is restricted to only those claims that have the condition of headache specificed as a documented allowance in the claim.**
	Hydrocodone-Acetaminophen Tab Products	**Reimbursement is restricted to combinations of Hydrocodone/Acetaminophen (APAP) that contain 325 mg of APAP. Effective January 1, 2017 reimbursement for this product will be limited to 6 doses per day for all covered forms of this product. Daily doses above this level may be reimbursed with prior authorization upon submission of documentation that supports clinical failure, as defined in OAC 4123-6-21(J)(2), of a lower daily dose. Claims in which this quantity limit was exceeded prior to January 1, 2017 will be limited to the last quantity prescribed before that date. Effective January 1, 2017 Prior Authorization will be required in all claims for reimbursement of concurrent use of this product with any other immediate release opioid. See also "Immediate Release Opioid Dose Formulation Restrictions" for additional restrictions for opioid naive IW.**
	Hydrocodone-Acetaminophen Tab 5-325 MG	**See Hydrocodone-Acetaminophen Tab Products restrictions above**
	Hydrocodone-Acetaminophen Tab 7.5-325 MG	**See Hydrocodone-Acetaminophen Tab Products restrictions above**
	Hydrocodone-Acetaminophen Tab 10-325 MG	**See Hydrocodone-Acetaminophen Tab Products restrictions above**
	Hydrocodone-Acetaminophen Soln 7.5-325 MG/15ML	**Reimbursement for these products shall not exceed 180 ml/ day (4 grams/day of APAP). Initial coverage in an opioid naive IW will be limited to 7 days of coverage; a PA may be obtained to exceed these limitations for post-operative situations.**
	Hydrocodone-Acetaminophen Soln 10-325 MG/15ML	**Reimbursement for these products shall not exceed 180 ml/ day (4 grams/day of APAP). Initial coverage in an opioid naive IW will be limited to 7 days of coverage; a PA may be obtained to exceed these limitations for post-operative situations.**
	Hydrocodone-Ibuprofen Tab Products	**Reimbursement for these products shall not exceed more than five tablets per day. Initial coverage in an opioid naive IW will be limited to 7 days of coverage or 30 doses, whichever is less; a PA may be obtained to exceed these limitations for post-operative situations.**
	Hydrocodone-Ibuprofen Tab 2.5-200 MG	**See Hydrocodone-Ibuprofen Tab Products restrictions above**
	Hydrocodone-Ibuprofen Tab 5-200 MG	**See Hydrocodone-Ibuprofen Tab Products restrictions above**
	Hydrocodone-Ibuprofen Tab 7.5-200 MG	**See Hydrocodone-Ibuprofen Tab Products restrictions above**
	Hydrocodone-Ibuprofen Tab 10-200 MG	**See Hydrocodone-Ibuprofen Tab Products restrictions above**

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

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	Oxycodone w/ Acetaminophen Tab Products	**Reimbursement is restricted to combinations of Oxycodone/Acetaminophen (APAP) that contain 325 mg of APAP. Reimbursement for this product will be limited to 6 doses per day for all covered forms of this product. Daily doses above this level may be reimbursed with prior authorization upon submission of documentation that supports clinical failure, as defined in OAC 4123-6-21(J)(2), of a lower daily dose. Claims in which this quantity limit was exceeded prior to January 1, 2017 will be limited to the last quantity prescribed before that date. Prior Authorization will be required in all claims for reimbursement of concurrent use of this product with any other immediate release opioid. See also "Immediate Release Opioid Dose Formulation Restrictions" for additional restrictions for opioid naive IW.**
	Oxycodone w/ Acetaminophen Tab 2.5-325 MG	**See Oxycodone w/ Acetaminophen Tab Products restrictions above**
	Oxycodone w/ Acetaminophen Tab 5-325 MG	**See Oxycodone w/ Acetaminophen Tab Products restrictions above**
	Oxycodone w/ Acetaminophen Tab 7.5-325 MG	**See Oxycodone w/ Acetaminophen Tab Products restrictions above**
	Oxycodone w/ Acetaminophen Tab 10-325 MG	**See Oxycodone w/ Acetaminophen Tab Products restrictions above**
	Oxycodone w/ Acetaminophen Soln 5-325 MG/5ML	**Reimbursement for these products shall not exceed 60 mls/ day (4 grams/day of APAP). Initial coverage in an opioid naive IW will be limited to 7 days of coverage; a PA may be obtained to exceed these limitations for post-operative situations.**
	Oxycodone-Aspirin Tab 4.8355-325 MG	**Reimbursement for this product will be limited to 6 doses per day. Daily doses above this level may be reimbursed with prior authorization upon submission of documentation that supports clinical failure, as defined in OAC 4123-6-21(J)(2), of a lower daily dose. Claims in which this quantity limit was exceeded prior to January 1, 2017 will be limited to the last quantity prescribed before that date. Prior Authorization will be required in all claims for reimbursement of concurrent use of this product with any other immediate release opioid. See also "Immediate Release Opioid Dose Formulation Restrictions" for additional restrictions for opioid naive IW.**
	Oxycodone-Ibuprofen Tab 5-400 MG	**Reimbursement for these products shall not exceed more than four doses per day or continue for longer that seven days.**
	Tramadol-Acetaminophen Tab 37.5-325 MG	**Reimbursement is restricted to only those combinations of Tramadol/Acetaminophen (APAP) that contain 325 mg of APAP. Reimbursement for this product will be limited to 6 doses per day. Daily doses above this level may be reimbursed with prior authorization upon submission of documentation that supports clinical failure, as defined in OAC 4123-6-21(J)(2), of a lower daily dose. Claims in which this quantity limit was exceeded prior to January 1, 2017 will be limited to the last quantity prescribed before that date. Prior Authorization will be required in all claims for reimbursement of concurrent use of this product with any other immediate release opioid. See also "Immediate Release Opioid Dose Formulation Restrictions" for additional restrictions for opioid naive IW.**
Opioid Partial Agonists - Immediate Release		
	Butorphanol Tartrate Nasal Soln 10 MG/ML	
	Pentazocine w/ Naloxone Tab 50-0.5 MG	
Opioid Partial Agonists - Sustained Release		
	Buprenorphine TD Patch Products	**Coverage is limited to a maximum quantity of 4 patches of any strength per 28 days. The maximum daily dose covered for this product is 20 mcg/day. Coverage of this product is limited to only those claims with a daily Morphine Equivalent Dose (MED) requirement of 90 mg or less. Coverage will not be permitted for this product concurrently with any other sustained release opioid.**
	Buprenorphine TD Patch Weekly 5 MCG/HR	**See Buprenorphine TD Patch Product restrictions above**
	Buprenorphine TD Patch Weekly 7.5 MCG/HR	**See Buprenorphine TD Patch Product restrictions above**
	Buprenorphine TD Patch Weekly 10 MCG/HR	**See Buprenorphine TD Patch Product restrictions above**
	Buprenorphine TD Patch Weekly 15 MCG/HR	**See Buprenorphine TD Patch Product restrictions above**
	Buprenorphine TD Patch Weekly 20 MCG/HR	**See Buprenorphine TD Patch Product restrictions above**
Otic Agents - Misc		
	Acetic Acid Otic Soln 2%	
	Antipyrine-Benzocaine Otic Soln 54-14 MG/ML (5.4-1.4%)	
	Antipyrine-Benzocaine-Polycosanol Otic Sol 5.4-1.4-0.0097%	
	Cresyl Acetate Otic Soln 25%	
	Pramoxine-HC-Chloroxylenol Otic Soln 10-10-1 MG/ML	
Otic Anti-infective/Steroid		

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

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	Ciprofloxacin-Dexamethasone Otic Susp 0.3-0.1%	
	Ciprofloxacin-Hydrocortisone Otic Susp 0.2-1%	
	Neomycin-Colistin-HC-Thonzonium Otic Susp 3.3-3-10-0.5 MG/ML	
	Neomycin-Polymyxin-HC Otic Soln 1%	
	Neomycin-Polymyxin-HC Otic Susp 3.5 MG/ML-10000 Unit/ML-1%	
Otic Anti-infectives		
	Ofloxacin Otic Soln 0.3%	
Otic Steroids		
	Fluocinolone Acetonide (Otic) Oil 0.01%	
	Hydrocortisone w/ Acetic Acid Otic Soln 1-2%	
Oxytocics		
	Methylergonovine Maleate Tab 0.2 MG	
Phosphate Binder Agents		
	Calcium Acetate (Phosphate Binder) Cap 667 MG (169 MG Ca)	
	Lanthanum Carbonate Chew Tab 750 MG (Elemental)	
	Lanthanum Carbonate Chew Tab 1000 MG (Elemental)	
	Lanthanum Carbonate Oral Powder Pack 750 MG (Elemental)	
	Lanthanum Carbonate Oral Powder Pack 1000 MG (Elemental)	
	Sevelamer Carbonate Packet 2.4 GM	
	Sevelamer Carbonate Tab 800 MG	
	Sevelamer HCl Tab 800 MG	
Platelet Aggregation Inhibitors		
	Aspirin-Dipyridamole Cap ER 12HR 25-200 MG	
	Cilostazol Tab 50 MG	
	Cilostazol Tab 100 MG	
	Clopidogrel Bisulfate Tab 75 MG (Base Equiv)	
	Dipyridamole Tab 25 MG	
	Dipyridamole Tab 50 MG	
	Dipyridamole Tab 75 MG	
	Prasugrel HCl Tab 10 MG (Base Equiv)	
Postherpetic Neuralgia (PHN) Agents		
	Gabapentin (Once-Daily) Tab 300 MG	**Gabapentin Sustained Release product class restriction:** **Coverage of Gabapentin Sustained Release products requires a Prior Authorization that reflects a 30 day trial and documented clinical failure (as defined in O.A.C. 4123-6-21 (J) (2) of the immediate release form of gabapentin. Coverage of all gabapentin products is restricted to a single form at any one time.**
	Gabapentin (Once-Daily) Tab 600 MG	**Gabapentin Sustained Release product class restriction:** **Coverage of Gabapentin Sustained Release products requires a Prior Authorization that reflects a 30 day trial and documented clinical failure (as defined in O.A.C. 4123-6-21 (J) (2) of the immediate release form of gabapentin. Coverage of all gabapentin products is restricted to a single form at any one time.**
Potassium Removing Agents		
	Sodium Polystyrene Sulfonate Oral Susp 15 GM/60ML	
	Sodium Polystyrene Sulfonate Powder**	
Progestins		
	Medroxyprogesterone Acetate Tab 10 MG	
	Megestrol Acetate Susp 625 MG/5ML	
Prostatic Hypertrophy Agents		
	Alfuzosin HCl Tab ER 24HR 10 MG	
	Dutasteride Cap 0.5 MG	
	Dutasteride-Tamsulosin HCl Cap 0.5-0.4 MG	
	Finasteride Tab 5 MG	
	Silodosin Cap 4 MG	
	Silodosin Cap 8 MG	
	Tamsulosin HCl Cap 0.4 MG	
Pseudobulbar Affect (PBA) Agents		
	Dextromethorphan HBr-Quinidine Sulfate Cap 20-10 MG	
Pulmonary Hypertension - Endothelin Receptor Antagonists		

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

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	Ambrisentan Tab 10 MG	
Pulmonary Hypertension - Phosphodiesterase Inhibitors		
	Sildenafil Citrate Tab 20 MG	
Pyrimidine Synthesis Inhibitors		
	Leflunomide Tab 10 MG	
	Leflunomide Tab 20 MG	
Rectal - Intrarectal Steroids		
	Hydrocortisone Enema 100 MG/60ML	
Rectal - Local Anesthetics		
	Dibucaine Rectal Ointment 1%	
	Hydrocortisone Acetate w/ Pramoxine Rectal Cream 1-1%	
	Hydrocortisone Acetate w/ Pramoxine Rectal Cream 2.5-1%	
	Hydrocortisone Acetate w/ Pramoxine Rectal Foam 1-1%	
	Lidocaine Anorectal Cream 5%	
	Lidocaine Anorectal Gel 5%	
	Lidocaine-Hydrocortisone Acetate Rectal Cream 3-0.5%	
	Phenylephrine-Shark Liver Oil-MO-Pet Oint 0.25-3-14-71.9%	
	Phenyleph-Shark Liver Oil-Cocoa Butter Suppos 0.25-3-85.5%	
	Pramoxine HCl Rectal Foam 1%	
	Pramox-PE-Glycerin-Petrolatum Rectal Cream 1-0.25-14.4-15%	
Rectal - Steroids		
	Hydrocortisone Acetate Suppos 25 MG	
	Hydrocortisone Acetate Suppos 30 MG	
	Hydrocortisone Rectal Cream 1%	
	Hydrocortisone Rectal Cream 2.5%	
Respiratory - Antiasthmatic - Monoclonal Antibodies		
	Omalizumab For Inj 150 MG	
Respiratory - Anticholinergics		
	Aclidinium Bromide Aerosol Powd Breath Activated 400 MCG/ACT	
	Glycopyrrolate Inhal Cap 15.6 MCG	
	Ipratropium Bromide HFA Inhal Aerosol 17 MCG/ACT	
	Ipratropium Bromide Inhal Soln 0.02%	
	Tiotropium Bromide Monohydrate Inhal Aerosol 1.25 MCG/ACT	
	Tiotropium Bromide Monohydrate Inhal Aerosol 2.5 MCG/ACT	
	Tiotropium Bromide Monohydrate Inhal Cap 18 MCG (Base Equiv)	
	Umeclidinium Br Aero Powd Breath Act 62.5 MCG/INH (Base Eq)	
Respiratory - Anti-Inflammatory Agents		
	Cromolyn Sodium Soln Nebu 20 MG/2ML	
Respiratory - Leukotriene Modulators		
	Montelukast Sodium Chew Tab 5 MG (Base Equiv)	
	Montelukast Sodium Tab 10 MG (Base Equiv)	
	Zafirlukast Tab 20 MG	
	Zileuton Tab ER 12HR 600 MG	
Respiratory - Selective Phosphodiesterase 4 (PDE4) Inhibitors		
	Roflumilast Tab 500 MCG	
Respiratory - Steroid Inhalants		
	Beclomethasone Diprop Inhal Aero Soln 40 MCG/ACT (50/Valve)	
	Beclomethasone Diprop Inhal Aero Soln 80 MCG/ACT (100/Valve)	
	Budesonide Inhal Aero Powd 90 MCG/ACT (Breath Activated)	
	Budesonide Inhal Aero Powd 180 MCG/ACT (Breath Activated)	
	Budesonide Inhalation Susp 0.25 MG/2ML	
	Budesonide Inhalation Susp 0.5 MG/2ML	
	Budesonide Inhalation Susp 1 MG/2ML	
	Ciclesonide Inhal Aerosol 80 MCG/ACT	
	Ciclesonide Inhal Aerosol 160 MCG/ACT	
	Flunisolide HFA Inhal Aerosol 80 MCG/ACT	
	Fluticasone Furoate Aerosol Powder Breath Activ 100 MCG/ACT	

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

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	Fluticasone Furoate Aerosol Powder Breath Activ 200 MCG/ACT	
	Fluticasone Propionate Aer Pow BA 50 MCG/BLISTER	
	Fluticasone Propionate Aer Pow BA 100 MCG/BLISTER	
	Fluticasone Propionate Aer Pow BA 250 MCG/BLISTER	
	Fluticasone Propionate Aer Pow BA 55 MCG/ACT	
	Fluticasone Propionate Aer Pow BA 113 MCG/ACT	
	Fluticasone Propionate Aer Pow BA 232 MCG/ACT	
	Fluticasone Propionate HFA Inhal Aero 44 MCG/ACT (50/Valve)	
	Fluticasone Propionate HFA Inhal Aer 110 MCG/ACT (125/Valve)	
	Fluticasone Propionate HFA Inhal Aer 220 MCG/ACT (250/Valve)	
	Mometasone Furoate Inhal Aerosol Suspension 100 MCG/ACT	
	Mometasone Furoate Inhal Aerosol Suspension 200 MCG/ACT	
	Mometasone Furoate Inhal Powd 110 MCG/INH (Breath Activated)	
	Mometasone Furoate Inhal Powd 220 MCG/INH (Breath Activated)	
Respiratory - Sympathomimetics		
	Albuterol Sulfate Aer Pow BA 108 MCG/ACT (90 MCG Base Equiv)	
	Albuterol Sulfate Inhal Aero 108 MCG/ACT (90MCG Base Equiv)	
	Albuterol Sulfate Soln Nebu 0.083% (2.5 MG/3ML)	
	Albuterol Sulfate Soln Nebu 0.5% (5 MG/ML)	
	Albuterol Sulfate Soln Nebu 0.63 MG/3ML (Base Equiv)	
	Albuterol Sulfate Soln Nebu 1.25 MG/3ML (Base Equiv)	
	Albuterol Sulfate Syrup 2 MG/5ML	
	Albuterol Sulfate Tab 2 MG	
	Albuterol Sulfate Tab 4 MG	
	Albuterol Sulfate Tab ER 12HR 4 MG	
	Albuterol Sulfate Tab ER 12HR 8 MG	
	Arformoterol Tartrate Soln Nebu 15 MCG/2ML (Base Equiv)	
	Budesonide-Formoterol Fumarate Dihyd Aerosol 80-4.5 MCG/ACT	
	Budesonide-Formoterol Fumarate Dihyd Aerosol 160-4.5 MCG/ACT	
	Fluticasone Furoate-Vilanterol Aero Powd BA 100-25 MCG/INH	
	Fluticasone Furoate-Vilanterol Aero Powd BA 200-25 MCG/INH	
	Fluticasone-Salmeterol Aer Powder BA 55-14 MCG/ACT	
	Fluticasone-Salmeterol Aer Powder BA 113-14 MCG/ACT	
	Fluticasone-Salmeterol Aer Powder BA 100-50 MCG/DOSE	
	Fluticasone-Salmeterol Aer Powder BA 232-14 MCG/ACT	
	Fluticasone-Salmeterol Aer Powder BA 250-50 MCG/DOSE	
	Fluticasone-Salmeterol Aer Powder BA 500-50 MCG/DOSE	
	Fluticasone-Salmeterol Inhal Aerosol 45-21 MCG/ACT	
	Fluticasone-Salmeterol Inhal Aerosol 115-21 MCG/ACT	
	Fluticasone-Salmeterol Inhal Aerosol 230-21 MCG/ACT	
	Fluticasone-Umeclidinium-Vilanterol AEPB 100-62.5-25 MCG/INH	
	Formoterol Fumarate Inhal Cap 12 MCG	
	Formoterol Fumarate Soln Nebu 20 MCG/2ML	
	Glycopyrrolate-Formoterol Fumarate Aerosol 9-4.8 MCG/ACT	
	Indacaterol-Glycopyrrolate Inhal Cap 27.5-15.6 MCG	
	Indacaterol Maleate Inhal Powder Cap 75 MCG (Base Equiv)	
	Ipratropium-Albuterol Aerosol 18-103 MCG/ACT (20-120MCG/ACT)	
	Ipratropium-Albuterol Inhal Aerosol Soln 20-100 MCG/ACT	
	Ipratropium-Albuterol Nebu Soln 0.5-2.5(3) MG/3ML	
	Levalbuterol HCl Soln Nebu 0.31 MG/3ML (Base Equiv)	
	Levalbuterol HCl Soln Nebu 0.63 MG/3ML (Base Equiv)	
	Levalbuterol HCl Soln Nebu 1.25 MG/3ML (Base Equiv)	
	Levalbuterol HCl Soln Nebu Conc 1.25 MG/0.5ML (Base Equiv)	
	Levalbuterol Tartrate Inhal Aerosol 45 MCG/ACT (Base Equiv)	
	Metaproterenol Sulfate Tab 10 MG	
	Metaproterenol Sulfate Tab 20 MG	
	Mometasone Furoate-Formoterol Fumarate Aerosol 100-5 MCG/ACT	
	Mometasone Furoate-Formoterol Fumarate Aerosol 200-5 MCG/ACT	
	Olodaterol HCl Inhal Aerosol Soln 2.5 MCG/ACT (Base Equiv)	
	Pirbuterol Acetate Breath Activated Inhal Aerosol 200MCG/INH	

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

Drug Class Name	Drug Generic Name	Coverage restrictions or limitations for specific drugs or dosage forms are listed with the respective drugs below.
	Racepinephrine HCl Soln Nebu 2.25% (Base Equivalent)	
	Salmeterol Xinafoate Aer Pow BA 50 MCG/DOSE (Base Equiv)	
	Terbutaline Sulfate Tab 2.5 MG	
	Terbutaline Sulfate Tab 5 MG	
	Tiotropium Br-Olodaterol Inhal Aero Soln 2.5-2.5 MCG/ACT	
	Umeclidinium-Vilanterol Aero Powd BA 62.5-25 MCG/INH	
Respiratory - Xanthines		
	Theophylline Cap ER 24HR 100 MG	
	Theophylline Cap ER 24HR 200 MG	
	Theophylline Cap ER 24HR 300 MG	
	Theophylline Cap ER 24HR 400 MG	
	Theophylline Tab ER 12HR 100 MG	
	Theophylline Tab ER 12HR 200 MG	
	Theophylline Tab ER 12HR 300 MG	
	Theophylline Tab ER 24HR 400 MG	
	Theophylline Tab ER 24HR 600 MG	
Respiratory Inhalants - Misc		
	Camphor-Eucalyptus-Menthol - Oint	
	Sodium Chloride Aero Soln 0.9%	
	Sodium Chloride Soln Nebu 0.9%	
Restless Leg Syndrome (RLS) Agents		
	Gabapentin Enacarbil Tab ER 300 MG	**Gabapentin Extended Release product class restriction:** **Coverage of Gabapentin Extended Release products requires a Prior Authorization that reflects a 30 day trial and documented clinical failure (as defined in O.A.C. 4123-6-21 (J) (2) of the immediate release form of gabapentin. Coverage of all gabapentin products is restricted to a single form at any one time.**
	Gabapentin Enacarbil Tab ER 600 MG	**Gabapentin Extended Release product class restriction:** **Coverage of Gabapentin Extended Release products requires a Prior Authorization that reflects a 30 day trial and documented clinical failure (as defined in O.A.C. 4123-6-21 (J) (2) of the immediate release form of gabapentin. Coverage of all gabapentin products is restricted to a single form at any one time.**
Rosacea Agents - Oral		
	Doxycycline (Rosacea) Cap Delayed Release 40 MG	
Salicylates		
	Aspirin Buffered (Ca Carb-Mg Carb-Mg Ox) Tab 325 MG	
	Aspirin Buffered (Ca Carb-Mg Carb-Mg Ox) Tab 500 MG	
	Aspirin Chew Tab 81 MG	
	Aspirin Tab 81 MG	
	Aspirin Tab 325 MG	
	Aspirin Tab 500 MG	
	Aspirin Tab Delayed Release 81 MG	
	Aspirin Tab Delayed Release 325 MG	
	Aspirin Tab Delayed Release 500 MG	
	Aspirin-Al Hydro-Mg Hydro-Ca Carb Tab 500-33-33-237 MG	
	Aspirin-Al Hydro-Mg Hydro-Ca Carb Tab 325 MG	
	Choline & Magnesium Salicylates Tab 1000 MG	
	Choline & Magnesium Salicylates Tab 500 MG	
	Choline & Magnesium Salicylates Tab 750 MG	
	Diflunisal Tab 500 MG	
	Salsalate Tab 500 MG	
	Salsalate Tab 750 MG	
Sympathomimetic Decongestants		
	Oxymetazoline HCl Nasal Soln 0.05%	
	Phenylephrine HCl Tab 10 MG	
	Pseudoephedrine HCl Syrup 30 MG/5ML	
	Pseudoephedrine HCl Tab 30 MG	
	Pseudoephedrine HCl Tab 60 MG	
	Pseudoephedrine HCl Tab ER 12HR 120 MG	
	Pseudoephedrine HCl Tab ER 24HR 240 MG	
Thyroid Hormones		

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

Drug Class Name	Drug Generic Name	Coverage restrictions or limitations for specific drugs or dosage forms are listed with the respective drugs below.
	Levothyroxine Sodium Tab 25 MCG	
	Levothyroxine Sodium Tab 50 MCG	
	Levothyroxine Sodium Tab 75 MCG	
	Levothyroxine Sodium Tab 88 MCG	
	Levothyroxine Sodium Tab 100 MCG	
	Levothyroxine Sodium Tab 112 MCG	
	Levothyroxine Sodium Tab 125 MCG	
	Levothyroxine Sodium Tab 137 MCG	
	Levothyroxine Sodium Tab 150 MCG	
	Levothyroxine Sodium Tab 175 MCG	
	Levothyroxine Sodium Tab 200 MCG	
	Levothyroxine Sodium Tab 300 MCG	
	Liothyronine Sodium Tab 5 MCG	
	Liothyronine Sodium Tab 25 MCG	
	Liothyronine Sodium Tab 50 MCG	
	Thyroid Tab 30 MG (1/2 Grain)	
	Thyroid Tab 60 MG (1 Grain)	
	Thyroid Tab 81.25 MG	
	Thyroid Tab 90 MG (1 1/2 Grain)	
	Thyroid Tab 113.75 MG	
	Thyroid Tab 162.5 MG (2 1/2 Grain)	
	Thyroid Tab 146.25 MG	
TNF - Anti-TNF-alpha - Monoclonal Antibodies		
	Adalimumab Pen-injector Kit 40 MG/0.8ML	
	Adalimumab Prefilled Syringe Kit 40 MG/0.8ML	
TNF - Soluble Tumor Necrosis Factor Receptor Agents		
	Etanercept Subcutaneous Soln Prefilled Syringe 25 MG/0.5ML	
	Etanercept Subcutaneous Soln Prefilled Syringe 50 MG/ML	
	Etanercept Subcutaneous Solution Auto-injector 50 MG/ML	
	Etanercept Subcutaneous Solution Cartridge 50 MG/ML	
Topical - Acne Products		
	Benzoyl Peroxide-Erythromycin Gel 5-3%	
	Clindamycin Phosphate Foam 1%	
	Clindamycin Phosphate Gel 1%	
	Clindamycin Phosphate Lotion 1%	
	Clindamycin Phosphate Soln 1%	
	Clindamycin Phosphate Swab 1%	
	Erythromycin Gel 2%	
	Erythromycin Soln 2%	
	Sulfacetamide Sodium w/ Sulfur Cream 10-5%	
	Sulfacetamide Sodium w/ Sulfur Emulsion 10-1%	
	Sulfacetamide Sodium w/ Sulfur Emulsion 10-5%	
	Sulfacetamide Sodium w/ Sulfur Foam 10-5%	
	Sulfacetamide Sodium w/ Sulfur Lotion 10-5%	
	Sulfacetamide Sodium-Sulfur in Urea Emulsion 10-4%	
Topical - Agents for External Genital and Perianal Warts		
	Sinecatechins Oint 15%	
Topical - Analgesics		
	Menthol Areosol 10.5%	
	Menthol Aerosol Powder 1%	
	Menthol Cream 7.5%	
	Menthol Cream 16%	
	Menthol Gel 2%	
	Menthol Gel 2.5%	
	Menthol Gel 3.1%	
	Menthol Gel 3.5%	
	Menthol Gel 3.7%	
	Menthol Gel 4%	
	Menthol Gel 4.5%	

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

Drug Class Name	Drug Generic Name	Coverage restrictions or limitations for specific drugs or dosage forms are listed with the respective drugs below.
	Menthol Gel 5%	
	Menthol Gel 6%	
	Menthol Gel 7%	
	Menthol Gel 10%	
	Menthol Gel 16%	
	Menthol Liquid 2.5%	
	Menthol Liquid 3.1%	
	Menthol Liquid 3.5%	
	Menthol Liquid 3.7%	
	Menthol Liquid 8%	
	Menthol Liquid 10%	
	Menthol Liquid 10.4%	
	Menthol Liquid 16%	
	Menthol Lotion 0.1%	
	Menthol Lotion 7.5%	
	Menthol Lotion 8.5%	
	Menthol Pad 154 MG	
	Menthol Patch 5%	
	Menthol Patch 7.5%	
	Menthol Roll 7.5%	
	Menthol Sleeve 16%	
Topical - Antibiotics		
	Bacitracin Oint 500 Unit/GM	
	Bacitracin Zinc Oint 500 Unit/GM	
	Bacitracin-Polymyxin B Oint	
	Bacitracin-Polymyxin-Neomycin HC Oint 1%	
	Gentamicin Sulfate Cream 0.1%	
	Gentamicin Sulfate Oint 0.1%	
	Mupirocin Calcium Cream 2%	
	Mupirocin Oint 2%	
	Neomycin-Bacitracin-Polymyxin Oint	
	Neomycin-Bacitracin-Polymyxin-Pramoxine Oint 1%	
	Neomycin-Polymyxin w/ Pramoxine Cream 1%	
	Neomycin-Polymyxin-HC Crm 3.5 MG/GM-10000 UNT/GM-0.5%	
	Retapamulin Oint 1%	
Topical - Antifungals		
	Butenafine HCl Cream 1%	
	Ciclopirox Gel 0.77%	
	Ciclopirox Olamine Cream 0.77% (Base Equiv)	
	Ciclopirox Olamine Susp 0.77% (Base Equiv)	
	Ciclopirox Shampoo 1%	
	Ciclopirox Solution 8%	
	Clotrimazole Cream 1%	
	Clotrimazole Ointment 1%	
	Clotrimazole Soln 1%	
	Clotrimazole w/ Betamethasone Cream 1-0.05%	
	Clotrimazole w/ Betamethasone Lotion 1-0.05%	
	Econazole Nitrate Cream 1%	
	Gentian Violet Soln 1%	
	Iodoquinol-HC Cream 1%	
	Iodoquinol-Hydrocortisone-Aloe Polysaccharide Gel 1-2-1%	
	Ketoconazole Cream 2%	
	Ketoconazole Foam 2%	
	Ketoconazole Shampoo 2%	
	Miconazole Nitrate Cream 2%	
	Miconazole Nitrate Ointment 2%	
	Miconazole Nitrate Powder 2%	
	Miconazole Nitrate Soln 2%	
	Miconazole-Zinc Oxide-White Petrolatum Oint 0.25-15-81.35%	
	Naftifine HCl Cream 1%	

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

Drug Class Name	Drug Generic Name	Coverage restrictions or limitations for specific drugs or dosage forms are listed with the respective drugs below.
	Vitamins A & D Cap	
Vitamins - Water Soluble Vitamins		
	Ascorbic Acid Cap ER 500 MG	
	Ascorbic Acid Chew Tab 250 MG	
	Ascorbic Acid Chew Tab 500 MG	
	Ascorbic Acid Chew Tab 1000 MG	
	Ascorbic Acid Syrup 500 MG/5ML	
	Ascorbic Acid Tab 250 MG	
	Ascorbic Acid Tab 500 MG	
	Ascorbic Acid Tab 1000 MG	
	Ascorbic Acid Tab ER 500 MG	
	Ascorbic Acid Tab Disint 60 MG	
	Niacin Tab ER 250 MG	
	Niacin Tab ER 750 MG	
	Potassium Aminobenzoate Tab 500 MG	
	Pyridoxine HCl Tab 50 MG	
	Pyridoxine HCl Tab 100 MG	
	Riboflavin Tab 100 MG	
	Thiamine HCl Tab 50 MG	
	Thiamine HCl Tab 100 MG	
	Thiamine Mononitrate Tab 100 MG	