



MASSACHUSETTS

Blue Cross Blue Shield of Massachusetts is an Independent
Licensee of the Blue Cross and Blue Shield Association

Policy 727 Quality Care Dosing (QCD) Guidelines

Drug Product	Maximum Quantity Per RX
*Abstral [®] ^{PA} 0.1, 0.2, 0.3, 0.4, 0.6, 0.8mg	120 tablets
*AcipHex [™] ^{PA} 20 mg	60 tablets
*AcipHex [™] Sprinkle ^{PA} 5, 10mg	60 capsules
*Actiq [®] ^{PA} 200, 400, 600, 800, 1200, 1600 mcg	120 lozenges
Actonel [®] ^(ST) 150 mg	1 tablet
Actonel [®] ^(ST) 35 mg	4 tablets
Actonel [®] ^(ST) 5, 30 mg	30 tablets
ACTOplus Met [®] ^(ST)	60 tablets
ACTOplus Met [®] XR ^(ST) 15mg/1000mg	60 tablets
ACTOplus Met [®] XR ^(ST) 30mg/1000mg	30 tablets
Actos [™] 15 mg	45 tablets
Actos [™] 30 mg, 45 mg	30 tablets
*Acular [®]	10 mL
*Acular LS [®]	5 mL
Acular PF [®]	12 vials
Adderall [®] XR 20, 30 mg	60 capsules
Adderall [®] XR 5, 10, 15, 25 mg	30 capsules
Advair [®] Diskus ^(ST) 100-50, 250-50, 500-50 mcg/act	1 package (package size 28, 60)
Advair [®] HFA ^(ST) 45/21, 115/21, 230/21 mcg/act	2 inhalers
Advicor [®] ^(ST) 1000/20, 750/20, 500/20 mg/mg	60 tablets
*Aerobid [®] /Aerobid-M [®]	3 inhalers

*Non-covered medication—quantity limits apply to members with approved formulary exceptions

**New to market medication—non covered while under review. Quantity limits apply to members with approved formulary exceptions

(ST) = Step therapy required

(PA) = Prior authorization required

(SP) = Specialty pharmacy program

(SPO) = Specialty pharmacy only. Benefits are not available for this medication when administered in an outpatient setting, such as a doctor's office or hospital, unless the medication is obtained from a specialty pharmacy



MASSACHUSETTS

Blue Cross Blue Shield of Massachusetts is an Independent
Licensee of the Blue Cross and Blue Shield Association

Policy 727 Quality Care Dosing (QCD) Guidelines

Drug Product	Maximum Quantity Per RX
alendronate 35, 70 mg	4 tablets
alendronate 5, 10, 40 mg	30 tablets
alendronate solution 70 mg	3 bottles/300 ml
*Alora [®]	8 patches
*Alrex [™]	20 mL
*Alsuma [™] 0.6mg/0.5ml Auto-Injector	2 Auto-Injectors
Altoprev [®] (ST) 20,40, 60mg	30 tablets
Alupent [®] 0.65 mg/act	3 inhalers
*Alvesco [®] 80, 160 mcg	2 inhalers
*Ambien [™] CR (ST) 6.25, 12.5 mg	14 tablets
*Ambien [™] (ST) 5, 10 mg	14 tablets
Amerge [™] 1, 2.5 mg	9 tablets
Amitiza [®] 8 mg	60 capsules
Amitiza [®] 24 mg	60 capsules
amlodipine 10 mg	30 tablets
amlodipine 2.5, 5 mg	45 tablets
amlodipine-atorvastatin (all strengths)	30 tablets
Ampyra [®] PA (SP) 10 mg	60 tablets
*Anzemet [®] 50, 100 mg	1 tablet
*Aplenzin [™] ER (ST) 174, 348, 522 mg	30 tablets
*Aranesp [®] (PA) (SPO)	4 vials or syringes

*Non-covered medication—quantity limits apply to members with approved formulary exceptions

**New to market medication—non covered while under review. Quantity limits apply to members with approved formulary exceptions

(ST) = Step therapy required

(PA) = Prior authorization required

(SP) = Specialty pharmacy program

(SPO) = Specialty pharmacy only. Benefits are not available for this medication when administered in an outpatient setting, such as a doctor's office or hospital, unless the medication is obtained from a specialty pharmacy



MASSACHUSETTS

Blue Cross Blue Shield of Massachusetts is an Independent
Licensee of the Blue Cross and Blue Shield Association

Policy 727 Quality Care Dosing (QCD) Guidelines

Drug Product	Maximum Quantity Per RX
Arava [®] 10, 20 mg	30 tablets
*Arcapta Neohaler [™] 75mcg	1 package (30 capsules)
*Arixtra [®] (all strengths)	30 syringes
*Asmanex Twisthaler [®] 110, 220 mcg/act	2 inhalers
Astelin [®] nasal spray	2 bottles
*Astepro [™] 0.15% nasal spray	2 bottles
*Atelvia DR [™] (ST) 35mg	4 tablets
Atrovent [®] 0.03% nasal spray	2 bottles
Atrovent [®] 0.06% nasal spray	1 bottle
Atrovent [®] HFA inhaler	2 inhalers
*Auvi-Q [™]	2 units/injectors
Avandamet [™] (ST) (all strengths)	60 tablets
Avandia [®] (ST) 2, 4 mg	60 tablets
Avandia [®] (ST) 8 mg	30 tablets
*Avinza [®] 30, 45, 60, 75, 90, 120 mg	60 capsules
Avonex [®] (SPO)	4 vials or syringes
*Axert [®] 6.25, 12.5 mg	12 tablets
Azelsatine nasal spray	2 bottles
*Azmecort [®]	2 inhalers
*Beconase AQ [®]	2 inhalers
Belviq [®] (PA)	60 tablets

*Non-covered medication—quantity limits apply to members with approved formulary exceptions

**New to market medication—non covered while under review. Quantity limits apply to members with approved formulary exceptions

(ST) = Step therapy required

(PA) = Prior authorization required

(SP) = Specialty pharmacy program

(SPO) = Specialty pharmacy only. Benefits are not available for this medication when administered in an outpatient setting, such as a doctor's office or hospital, unless the medication is obtained from a specialty pharmacy



MASSACHUSETTS

Blue Cross Blue Shield of Massachusetts is an Independent
Licensee of the Blue Cross and Blue Shield Association

Policy 727 Quality Care Dosing (QCD) Guidelines

Drug Product	Maximum Quantity Per RX
Betaseron [®] (SP)	15 vials
*Binosto [™] (ST) 70mg	4 tablets
*Boniva [®] (ST) 150 mg	1 tablet
*Boniva [®] (ST) 2.5 mg	30 tablets
**Brintellix [®] (ST) 5, 10, 20 mg	30 tablets
**Brisdelle 7.5mg	30 tablets
Budeprion [™] SR 100, 150, 200 mg	60 tablets
Budeprion [™] XL 150, 300 mg	30 tablets
budesonide ampules	70 ampules
Budesonide nasal spray 5ml	5 bottles
Budesonide nasal spray 9ml	3 bottles
Bunavail [®] (PA) 2.1mg/0.3mg, 4.2mg/0.7mg, 6.3mg/1mg SL Film	30 films
buprenorphine-naloxone SL [®] (PA) 2mg/0.5mg, 8mg/2mg	30 tablets
bupropion SR 100, 150, 200 mg	60 tablets
bupropion XL 150, 300 mg	30 tablets
butorphanol nasal spray	2 bottles
*Butrans [™] 5, 10, 15, 20 mcg/hr	4 patches
cabergoline	8 tablets
*Caduet [®] (ST) (all strengths)	30 tablets
*Cardura 1 mg	30 tablets
*Cardura [®] 2, 4, 8 mg	60 tablets

*Non-covered medication—quantity limits apply to members with approved formulary exceptions

**New to market medication—non covered while under review. Quantity limits apply to members with approved formulary exceptions

(ST) = Step therapy required

(PA) = Prior authorization required

(SP) = Specialty pharmacy program

(SPO) = Specialty pharmacy only. Benefits are not available for this medication when administered in an outpatient setting, such as a doctor's office or hospital, unless the medication is obtained from a specialty pharmacy



MASSACHUSETTS

Blue Cross Blue Shield of Massachusetts is an Independent
Licensee of the Blue Cross and Blue Shield Association

Policy 727 Quality Care Dosing (QCD) Guidelines

Drug Product	Maximum Quantity Per RX
*Cardura [®] XL 4, 8 mg	30 tablets
Catapres [®] TTS	4 patches
Celebrex [™] (ST) 50, 100, 200, 400 mg	60 capsules
*Celexa [®] (ST) 10, 20, 40 mg	45 tablets
*Cesamet [™] 1 mg	30 capsules
Ciclodin [™] Solution/kit	1 bottle/kit
ciclopirox nail lacquer	1 bottle/kit
citalopram 10, 20, 40 mg	45 tablets
Climara [™]	4 patches
Climara PRO [™]	4 patches
clonidine patch	4 patches
*CNL 8 [®] nail kit	1 kit
Combivent [®] 21/120 mcg/act	2 inhalers
Combivent [®] Respimat	2 inhalers
Concerta [®] 18, 27, 54 mg	30 tablets
Concerta [®] 36 mg	60 tablets
Copaxone [®] (SPO)	1 box
Crestor [®] (ST) 5, 10, 20, 40 mg 30 tablets	30 tablets
Crolom [®] ophthalmic	20 mL
cromolyn sodium ophthalmic	20 mL
Cymbalta [®] (ST) 20mg, 60mg	60 capsules

*Non-covered medication—quantity limits apply to members with approved formulary exceptions

**New to market medication—non covered while under review. Quantity limits apply to members with approved formulary exceptions

(ST) = Step therapy required

(PA) = Prior authorization required

(SP) = Specialty pharmacy program

(SPO) = Specialty pharmacy only. Benefits are not available for this medication when administered in an outpatient setting, such as a doctor's office or hospital, unless the medication is obtained from a specialty pharmacy



MASSACHUSETTS

Blue Cross Blue Shield of Massachusetts is an Independent
Licensee of the Blue Cross and Blue Shield Association

Policy 727 Quality Care Dosing (QCD) Guidelines

Drug Product	Maximum Quantity Per RX
Cymbalta [®] (ST) 30mg	30 capsules
*desvenlafaxine ER (ST) 50 mg, 100 mg	30 tablets
*Dexilant [™] (PA) 30, 60 mg	60 capsules
dexmethylphenidate 30mg	60 capsules
dexmethylphenidate 15, 40mg	30 capsules
dextroamphetamine/amphetamine ER 5, 10, 15, 25 mg	30 capsules
dextroamphetamine/amphetamine ER 20, 30 mg	60 capsules
Diflucan [®] 150 mg	5 tablets
dihydroergotamine nasal spray 4 mg/ml	4 ampuls/sprays
doxazosin 1 mg	30 tablets
doxazosin 2, 4, 8 mg	60 tablets
Dulera [®] (ST) 100mcg/5mcg, 200mcg/5mcg	2 inhalers
duloxetine 20mg, 60mg	60 capsules
duloxetine 30mg	30 capsules
*Duragesic [®] (PA) 12, 25, 50, 75, 100 mcg/hr	15 patches
*Dymista [™] 137mcg/50mcg	2 bottles
*Edluar [™] (ST) 5, 10 mg	14 tablets
*Effexor [®] XR (ST) 150 mg	60 capsules
*Effexor [®] XR (ST) 37.5 mg, 75 mg	30 capsules
*Embeda [®] 20/0.8, 30/1.2, 50/2, 60/2.4, 80/3.2, 100/4 mg	90 capsules
Emend [®] 40, 125 mg	1 capsule

*Non-covered medication—quantity limits apply to members with approved formulary exceptions

**New to market medication—non covered while under review. Quantity limits apply to members with approved formulary exceptions

(ST) = Step therapy required

(PA) = Prior authorization required

(SP) = Specialty pharmacy program

(SPO) = Specialty pharmacy only. Benefits are not available for this medication when administered in an outpatient setting, such as a doctor's office or hospital, unless the medication is obtained from a specialty pharmacy



MASSACHUSETTS

Blue Cross Blue Shield of Massachusetts is an Independent
Licensee of the Blue Cross and Blue Shield Association

Policy 727 Quality Care Dosing (QCD) Guidelines

Drug Product	Maximum Quantity Per RX
Emend [®] 80 mg	2 capsules
Emend [®] tri-fold pack	1 pack
Enbrel [®] (PA) (SP) 25 mg kit	16 vials
Enbrel [®] (PA) (SPO) 50 mg syringe	7.84 mL (8 syringes)
enoxaparin (all strengths)	60 ampuls or syringes
epinephrine injection	2 units/injectors
Epi-Pen [®] Auto-Injector	2 units/injectors
Epogen [®] (PA) (SPO) 2,000, 3,000, 4,000, 10,000, 40,000 units/mL	12 mL
Epogen [®] (PA) (SPO) 20,000 units/mL	6 mL
escitalopram 5, 10, 20mg	45 tablets
*esomeprazole strontium [®] (PA) 24.65 mg, 49.3 mg	60 capsules
Estraderm patch	8 patches
estradiol patch	4 patches
*Estrasorb [®] box (56 pouches)	1 box (56 pouches)
*EstroGel [®] tube/pump	1 tube/pump
Eszopiclone Tablets	14 tablets
*Evamist [™] bottle	2 bottles
Evzio [™] Injector	2 units/injectors (1 box)
*Exalgo [™] ER 8, 12, 16 mg	60 tablets
*Extavia [®] (SPO) 0.3mg kit	1 kit
Famciclovir 125, 500 mg	21 tablets

*Non-covered medication—quantity limits apply to members with approved formulary exceptions

**New to market medication—non covered while under review. Quantity limits apply to members with approved formulary exceptions

(ST) = Step therapy required

(PA) = Prior authorization required

(SP) = Specialty pharmacy program

(SPO) = Specialty pharmacy only. Benefits are not available for this medication when administered in an outpatient setting, such as a doctor's office or hospital, unless the medication is obtained from a specialty pharmacy



MASSACHUSETTS

Blue Cross Blue Shield of Massachusetts is an Independent
Licensee of the Blue Cross and Blue Shield Association

Policy 727 Quality Care Dosing (QCD) Guidelines

Drug Product	Maximum Quantity Per RX
Famciclovir 250 mg	60 tablets
*Famvir [®] 125, 500 mg	21 tablets
*Famvir [®] 250 mg	60 tablets
fentanyl oral/mucosal (PA) 200,400,600,800,1200,1600 mcg	120 lozenges
fentanyl patch ^(PA) 12, 25, 50, 75, 100 mcg/hr	15 patches
*Fentora [®] ^(PA) 100, 200, 300, 400, 600, 800 mcg	120 tablets
*Flonase [®] 50 mcg/act	2 bottles
Flovent [®] Diskus 50, 100, 250 mcg	2 inhalers
Flovent [®] HFA 110, 220, 44 mcg 13gm	2 inhalers
Flovent [®] HFA 110, 220, 44 mcg 7.9gm	2 inhalers
fluconazole 150 mg	5 tablets
flunisolide 0.025% sol	2 bottles
fluoxetine 10, 20 mg	90 capsules/tablets
fluoxetine 40 mg	60 capsules
fluoxetine DR ^(ST)	4 capsules
fluticasone 50 mcg/act	2 bottles
fluvastatin 20mg	30 capsules
fluvastatin 40mg	60 capsules
fluvoxamine 100 mg	90 tablets
fluvoxamine 25 mg	45 tablets
fluvoxamine 50 mg	60 tablets

*Non-covered medication—quantity limits apply to members with approved formulary exceptions

**New to market medication—non covered while under review. Quantity limits apply to members with approved formulary exceptions

(ST) = Step therapy required

(PA) = Prior authorization required

(SP) = Specialty pharmacy program

(SPO) = Specialty pharmacy only. Benefits are not available for this medication when administered in an outpatient setting, such as a doctor's office or hospital, unless the medication is obtained from a specialty pharmacy



MASSACHUSETTS

Blue Cross Blue Shield of Massachusetts is an Independent
Licensee of the Blue Cross and Blue Shield Association

Policy 727 Quality Care Dosing (QCD) Guidelines

Drug Product	Maximum Quantity Per RX
fluvoxamine CR 100mg	30 tablets
fluvoxamine CR 150mg	60 tablets
*Focalin [®] XR 5, 10, 15 mg	30 capsules
*Focalin [®] XR 20,30,40 mg	60 capsules
fondaparinux (all strengths)	30 syringes
Foradil [®] 12 mcg/cap	1 package (pkg. sizes 12 & 60)
*Forfivo [™] 450mg	30 tablets
Forteo [®] (PA) (SPO) 600 mcg/2.4 mL	2.4 mL (1 pen device)
*Fosamax [®] (ST) 35, 70 mg	4 tablets
*Fosamax [®] (ST) 5, 10, 40 mg	30 tablets
Fosamax [®] oral solution	4 bottles
Fosamax [®] Plus D (ST)	4 tablets
*Fragmin [®] 10,000 units/ml multi-dose vial	38 mL (4 vials)
*Fragmin [®] 10,000 units/mL syringe	30 mL (30 syringes)
*Fragmin [®] 12,500 units/0.5 mL syringe	15 mL (30 syringes)
*Fragmin [®] 15,000 units/0.6 mL syringe	18 mL (30 syringes)
*Fragmin [®] 18,000 units/0.72 mL syringe	21.6 mL (30 syringes)
*Fragmin [®] 2,500, 5,000 units/0.2 mL syringe	6 mL (30 syringes)
*Fragmin [®] 25,000 units/mL multi-dose vial	15.2 mL (4 vials)
*Fragmin [®] 7,500 units/0.3 mL syringe	9 mL (30 syringes)
*Frova [™] 2.5 mg	9 tablets

*Non-covered medication—quantity limits apply to members with approved formulary exceptions

**New to market medication—non covered while under review. Quantity limits apply to members with approved formulary exceptions

(ST) = Step therapy required

(PA) = Prior authorization required

(SP) = Specialty pharmacy program

(SPO) = Specialty pharmacy only. Benefits are not available for this medication when administered in an outpatient setting, such as a doctor's office or hospital, unless the medication is obtained from a specialty pharmacy



MASSACHUSETTS

Blue Cross Blue Shield of Massachusetts is an Independent
Licensee of the Blue Cross and Blue Shield Association

Policy 727 Quality Care Dosing (QCD) Guidelines

Drug Product	Maximum Quantity Per RX
Fulyzaq ^{®(PA)} 125mg	60 tablets
Gilenya ^{™(SP)} 0.5 mg	28 capsules
Glucose testing strips (all brands)	300 strips
Granisetron 1mg	4 tablets
Granisol [™] oral solution	1 bottle
Granix	30 prefilled syringes
Grastek ^{®(PA)} SL tablets	30 tablets
Hetlioz ^{™(PA)} 20mg	30 tablets
Humira ^{®(PA)(SP)} 40 mg/0.8 mL	4 pens or syringes
Humira [®] Crohn's starter pack ^{(PA)(SPO)}	6 (1 pack)
Hydromorphone ER ^(PA) 8, 12, 16, 32mg tabs	60 tablets
*Hytrin [®] 1, 5 mg	30 capsules
*Hytrin [®] 2, 10 mg	60 capsules
ibandronate 150mg	1 tablet
Imitrex [®] 25, 50, 100 mg	9 tablets
Imitrex [®] 5 mg, 20 mg nasal spray	6 nasal spray devices
Imitrex [®] Syringe (injection)	1 kit (2 syringes)
Infergen ^{®(PA)(SPO)} 9, 15 mcg	12 vials or syringes
Insulin vials (all formulary brands and non-formulary brands*)	4 vials (40 mls)
Insulin cartridges (all formulary brands and non-formulary brands*)	15 cartridges (45mls)
*Intermezzo ^{®(ST)} 1.75, 3.75 mg	14 tablets

*Non-covered medication—quantity limits apply to members with approved formulary exceptions

**New to market medication—non covered while under review. Quantity limits apply to members with approved formulary exceptions

(ST) = Step therapy required

(PA) = Prior authorization required

(SP) = Specialty pharmacy program

(SPO) = Specialty pharmacy only. Benefits are not available for this medication when administered in an outpatient setting, such as a doctor's office or hospital, unless the medication is obtained from a specialty pharmacy



MASSACHUSETTS

Blue Cross Blue Shield of Massachusetts is an Independent
Licensee of the Blue Cross and Blue Shield Association

Policy 727 Quality Care Dosing (QCD) Guidelines

Drug Product	Maximum Quantity Per RX
ipratropium 0.03% nasal spray	2 bottles
ipratropium 0.06% nasal spray	1 bottle
itraconazole 100 mg	30 capsules
*Kadian [®] (PA) 10, 20, 30, 50, 60, 80, 100, 200 mg	90 capsules
ketorolac ophthalmic 0.4%	5 mL
ketorolac ophthalmic 0.5%	10 mL
*Khedezla [®] 50 mg, 100 mg	30 tablets
*Kytril [™]	4 tablets
*Kytril [™] oral solution 30 mL	1 bottle
*Lamisil [®] 250 mg	30 tablets
*Lamisil [®] granules 125 mg	2 packs
*Lamisil [®] granules 187.5 mg	1 pack
lansoprazole (PA) 30 mg	60 capsules
*Lazanda [®] (PA) 0.1, 0.4 mg	23 units
leflunomide 10, 20 mg	30 tablets
*Lescol [®] (ST) 20 mg	30 capsules
*Lescol [®] (ST) 40 mg	60 capsules
*Lescol [®] XL (ST) 80 mg	30 tablets
Lexapro [™] (ST) 5, 10, 20 mg	45 tablets
lidocaine patch 5%	90 patches
Lidoderm [®] 5%	90 patches

*Non-covered medication—quantity limits apply to members with approved formulary exceptions

**New to market medication—non covered while under review. Quantity limits apply to members with approved formulary exceptions

(ST) = Step therapy required

(PA) = Prior authorization required

(SP) = Specialty pharmacy program

(SPO) = Specialty pharmacy only. Benefits are not available for this medication when administered in an outpatient setting, such as a doctor's office or hospital, unless the medication is obtained from a specialty pharmacy



MASSACHUSETTS

Blue Cross Blue Shield of Massachusetts is an Independent
Licensee of the Blue Cross and Blue Shield Association

Policy 727 Quality Care Dosing (QCD) Guidelines

Drug Product	Maximum Quantity Per RX
*Lipitor [®] (ST) 10, 20, 40, 80 mg	30 tablets
*Liptruzet [®] (ST) 10/10, 10/20, 10/40, 10/80mg	30 tablets
*Livalo [®] (ST) 1, 2, 4 mg	30 tablets
Lotronex [®] 0.5, 1 mg	60 tablets
lovastatin 10 mg	30 tablets
lovastatin 20, 40 mg	60 tablets
*Lovenox [®] (all strengths)	60 ampuls or syringes
Lunesta [®] (ST) 1, 2, 3 mg	14 tablets
*Luvox [®] CR (ST) 100 mg	30 tablets
*Luvox [®] CR (ST) 150 mg	60 tablets
*Lysteda [™]	30 tablets
*Maxair [®] Autohaler 200 mcg/act	2 inhalers
*Maxalt [®] 5, 10 mg	18 tablets
*Maxalt-MLT [®] 5, 10 mg	18 tablets
Meloxicam 7.5, 15 mg	30 tablets
*Menostar [®]	4 patches
Metadate [®] CD 10, 20, 30 mg	30 capsules
Metadate [®] CD 40, 50, 60 mg	60 capsules
methylphenidate CD 10, 20, 30 mg	30 capsules
methylphenidate CD 40, 50, 60 mg	60 capsules
methylphenidate ER 18, 27, 54 mg	30 tablets

*Non-covered medication—quantity limits apply to members with approved formulary exceptions

**New to market medication—non covered while under review. Quantity limits apply to members with approved formulary exceptions

(ST) = Step therapy required

(PA) = Prior authorization required

(SP) = Specialty pharmacy program

(SPO) = Specialty pharmacy only. Benefits are not available for this medication when administered in an outpatient setting, such as a doctor's office or hospital, unless the medication is obtained from a specialty pharmacy



MASSACHUSETTS

Blue Cross Blue Shield of Massachusetts is an Independent
Licensee of the Blue Cross and Blue Shield Association

Policy 727 Quality Care Dosing (QCD) Guidelines

Drug Product	Maximum Quantity Per RX
methamphetamine ER 36mg	60 tablets
*Mevacor [®] (ST) 10 mg	30 tablets
*Mevacor [®] (ST) 20, 40 mg	60 tablets
Migranal [®] 4 mg/mL	4 ampuls/sprays
Minivelle [™]	8 patches
mirtazapine 15 mg	45 tablets
mirtazapine 7.5, 30, 45 mg	30 tablets
mirtazapine rapid dissolve 15, 30, 45 mg	30 tablets
*Mobic [®] 7.5, 15 mg	30 tablets
morphine sulfate ER (PA) 15, 30, 60, 100, 200 mg	120 tablets
Moxeza [®] 0.50%	1 package (3mL)
MS Contin [®] (PA) 15, 30, 60, 100, 200 mg	120 tablets
naratriptan 1, 2.5 mg	9 tablets
*Nasacort AQ [®] 55 mcg/act	2 bottles
*Nasonex [®] (ST) 50 mcg/act	2 bottles
NebuPent [™] 300 mg sol	1 container
Neulasta [®] (SP) 1.2 mL	2 syringes
Neupogen [®] (SP)	30 vials or syringes
*Nexium [™] (PA) 10, 20, 40 mg	60 capsules/packets
*Norvasc [®] 10 mg	30 tablets
*Norvasc [®] 2.5, 5 mg	45 tablets

*Non-covered medication—quantity limits apply to members with approved formulary exceptions

**New to market medication—non covered while under review. Quantity limits apply to members with approved formulary exceptions

(ST) = Step therapy required

(PA) = Prior authorization required

(SP) = Specialty pharmacy program

(SPO) = Specialty pharmacy only. Benefits are not available for this medication when administered in an outpatient setting, such as a doctor's office or hospital, unless the medication is obtained from a specialty pharmacy



MASSACHUSETTS

Blue Cross Blue Shield of Massachusetts is an Independent
Licensee of the Blue Cross and Blue Shield Association

Policy 727 Quality Care Dosing (QCD) Guidelines

Drug Product	Maximum Quantity Per RX
olanzepine/fluoxetine 6/25, 6/50, 12/25, 12/50 mg/mg	30 capsules
omeprazole ^(PA) 10, 20, 40 mg	60 capsules
*omeprazole/sodium bicarbonate ^(PA)	60 capsules
*Omnaris™ 50 mcg	2 bottles
Omontys® ^(PA) ^(SP) 10mg/mL	1 vial
Omontys® ^(PA) ^(SP) 20mg/2mL	2 vials
ondansetron 24 mg	1 tablet
ondansetron 4 mg/5 mL solution	150 mL
ondansetron/ODT 4, 8 mg	24 tablets/orally disintegrating tablets
*Onmel™	30 tablets
*Onsolis™ ^(PA) ^(SP) 200, 400, 600, 800, 1200 mcg	120 film strips
*Opana® ER ^(PA) 5, 7.5, 10, 15, 20, 30, 40 mg	90 tablets
Oralair® ^(PA) SL Tablets	30 tablets
*Oramorph® SR ^(PA) 15, 30, 60, 100 mg	120 tablets
Otezla® ^(PA) 10, 20, 30 mg	60 tablets
oxycodone ER ^(PA) 10, 20, 40 mg	90 tablets
oxycodone ER ^(PA) 80mg	120 tablets
OxyContin® ^(PA) 10, 15, 20, 30, 40 mg	90 tablets
OxyContin® ^(PA) 60, 80 mg	120 tablets
oxymorphone ER ^(PA) 5, 7.5, 10, 15, 20, 30, 40 mg	90 tablets
pantoprazole ^(PA) 20, 40 mg	60 tablets/packets

*Non-covered medication—quantity limits apply to members with approved formulary exceptions

**New to market medication—non covered while under review. Quantity limits apply to members with approved formulary exceptions

(ST) = Step therapy required

(PA) = Prior authorization required

(SP) = Specialty pharmacy program

(SPO) = Specialty pharmacy only. Benefits are not available for this medication when administered in an outpatient setting, such as a doctor's office or hospital, unless the medication is obtained from a specialty pharmacy



MASSACHUSETTS

Blue Cross Blue Shield of Massachusetts is an Independent
Licensee of the Blue Cross and Blue Shield Association

Policy 727 Quality Care Dosing (QCD) Guidelines

Drug Product	Maximum Quantity Per RX
paroxetine 10, 40 mg	45 tablets
paroxetine 20, 30 mg	60 tablets
paroxetine CR 12.5 mg	30 tablets
paroxetine CR 25, 37.5 mg	60 tablets
*Patanase [®] 0.6%	2 bottles
*Paxil [™] ^(ST) 10, 40 mg	45 tablets
*Paxil [™] ^(ST) 20, 30 mg	60 tablets
*Paxil [™] CR ^(ST) 12.5 mg	30 tablets
*Paxil [™] CR ^(ST) 25, 37.5 mg	60 tablets
Pediaprox-4 [™] 8%	1 kit
Pegasys [®] ^(SPO)	4 vials or 1 package
PEG-Intron [®] ^(SPO)	4 syringes or pens
*Penlac [™]	1 bottle
*Pexeva [®] ^(ST) 10, 40 mg	45 tablets
*Pexeva [®] ^(ST) 20, 30 mg	60 tablets
Pioglitazone ^(ST) 15mg	45 tablets
Pioglitazone ^(ST) 30, 45mg	30 tablets
pioglitazone-metformin ^(ST)	60 tablets
*Pravachol [®] ^(ST) 10, 20, 40, 80 mg	30 tablets
pravastatin 10, 20, 40, 80 mg	30 tablets
*Prevacid [®] ^(PA) 30 mg	60 capsules/solutabs

*Non-covered medication—quantity limits apply to members with approved formulary exceptions

**New to market medication—non covered while under review. Quantity limits apply to members with approved formulary exceptions

(ST) = Step therapy required

(PA) = Prior authorization required

(SP) = Specialty pharmacy program

(SPO) = Specialty pharmacy only. Benefits are not available for this medication when administered in an outpatient setting, such as a doctor's office or hospital, unless the medication is obtained from a specialty pharmacy



MASSACHUSETTS

Blue Cross Blue Shield of Massachusetts is an Independent
Licensee of the Blue Cross and Blue Shield Association

Policy 727 Quality Care Dosing (QCD) Guidelines

Drug Product	Maximum Quantity Per RX
*Prevacid [®] oral suspension (PA) 25, 30 mg	60 packets
*Prevpac [®] patient pack	1 package (pkg. size 14)
*Prilosec [™] (PA) 10, 20, 25, 40 mg	30 capsules/suspension packs
*Pristiq [™] (ST) 50, 100 mg	30 tablets
ProAir [™] HFA 90 mcg/act	3 inhalers
Procrit [®] (PA) (SPO) 2,000, 3,000, 4,000, 10,000, 20,000, 40,000 units/mL	12 mL
Procrit [®] (PA) (SPO) 20,000 units/mL	6 mL
*Protonix [®] (PA) 20, 40 mg	60 tablets/packets
*Proventil [®] HFA 108 mcg/act	3 inhalers
*Prozac [®] (ST) 10 mg capsule	30 capsules
*Prozac [®] (ST) 10 mg tablet	45 tablets
*Prozac [®] (ST) 20 mg	30 capsules
*Prozac [®] (ST) 40 mg	60 capsules
*Prozac [®] Weekly (ST) 90 mg	4 capsules
Pulmicort [®] Flexhaler [™]	2 inhalers
Pulmicort [®] Respules [™] 0.25, 0.5, 1 mg/2mL	70 ampuls
*QNASL [™] 80mcg	1 box
Quaaliquin [™]	42 capsules
quinine sulfate 324mg	42 capsules
Qutenza [®] (SP) 8%	4 patches

*Non-covered medication—quantity limits apply to members with approved formulary exceptions

**New to market medication—non covered while under review. Quantity limits apply to members with approved formulary exceptions

(ST) = Step therapy required

(PA) = Prior authorization required

(SP) = Specialty pharmacy program

(SPO) = Specialty pharmacy only. Benefits are not available for this medication when administered in an outpatient setting, such as a doctor's office or hospital, unless the medication is obtained from a specialty pharmacy



MASSACHUSETTS

Blue Cross Blue Shield of Massachusetts is an Independent
Licensee of the Blue Cross and Blue Shield Association

Policy 727 Quality Care Dosing (QCD) Guidelines

Drug Product	Maximum Quantity Per RX
QVAR™ 40 mcg/act	2 inhalers
QVAR™ 80 mcg/act	1 inhaler
rabeprazole 20mg	60 tablets
Ragwitek™ ^(PA) SL Tablets	30 tablets
Rapiflux® 20mg	90 tablets
Rebif® ^(SPO)	15 syringes/auto-injectors
*Relpax® 20, 40 mg	12 tablets
*Remeron® 15 mg	45 tablets
*Remeron® 7.5, 30, 45 mg	30 tablets
*Remeron® Soltab	30 tablets
Restasis® 0.05% ^(PA)	2 packages (64 units)
*Rhinocort® Aqua 32 mcg/act 5mL	5 bottles
*Rhinocort® Aqua 32 mcg/act 9mL	3 bottles
*Ritalin® LA 10, 20 mg	30 capsules
*Ritalin® LA 30, 40 mg	60 capsules
rizatriptan 5 mg, 10 mg	18 tablets
rizatriptan ODT 5 mg, 10 mg	18 tablets
Rozerem™ ^(ST) 8 mg	14 tablets
*Sancuso® 3.1mg/24hr	1 patch
*Sarafem® ^(ST) 10, 20 mg	30 capsules
Selfemra® 10, 20 mg	30 tablets

*Non-covered medication—quantity limits apply to members with approved formulary exceptions

**New to market medication—non covered while under review. Quantity limits apply to members with approved formulary exceptions

(ST) = Step therapy required

(PA) = Prior authorization required

(SP) = Specialty pharmacy program

(SPO) = Specialty pharmacy only. Benefits are not available for this medication when administered in an outpatient setting, such as a doctor's office or hospital, unless the medication is obtained from a specialty pharmacy



MASSACHUSETTS

Blue Cross Blue Shield of Massachusetts is an Independent
Licensee of the Blue Cross and Blue Shield Association

Policy 727 Quality Care Dosing (QCD) Guidelines

Drug Product	Maximum Quantity Per RX
Serevent [®] Diskus 50 mcg/dose	1 inhaler
sertraline 100 mg	60 tablets
sertraline 25, 50 mg	45 tablets
*Silenor [®] (ST) 3, 6 mg	14 tablets
*Simcor [®] (ST) 500 mg/20 mg	30 tablets
*Simcor [®] (ST) 750/20, 1000/20 mg/mg	60 tablets
Simponi [™] (PA) (SP) 50, 100 mg	1 syringe/autoinjector
simvastatin 5, 10, 20 40 80 mg 30 tablets	30 tablets
Sonata [®] (ST) 5, 10 mg	14 capsules
Spiriva [®] HandiHaler (Pack of 30)	60 capsules
Spiriva [®] HandiHaler (Pack of 6)	36 capsules
*Sporanox [®] 100 mg	30 capsules
Strattera [™] (PA) 40, 60 mg	60 tablets
Strattera [™] (PA) 10, 18, 25, 80, 100 mg	30 tablets
Suboxone [®] (PA) 4mg/1mg, 12mg/3mg	30 film strips
Suboxone [®] (PA) 8mg/1mg	60 film strips
Suboxone [®] (PA) 2mg/0.5mg	90 film strips
*Subsys [™] (PA)	3 kits
sumatriptan 25, 50, 100 mg	9 tablets
sumatriptan 5mg, 20 mg nasal spray	6 nasal spray devices
sumatriptan syringe (injection)	1 kit (2 syringes)

*Non-covered medication—quantity limits apply to members with approved formulary exceptions

**New to market medication—non covered while under review. Quantity limits apply to members with approved formulary exceptions

(ST) = Step therapy required

(PA) = Prior authorization required

(SP) = Specialty pharmacy program

(SPO) = Specialty pharmacy only. Benefits are not available for this medication when administered in an outpatient setting, such as a doctor's office or hospital, unless the medication is obtained from a specialty pharmacy



MASSACHUSETTS

Blue Cross Blue Shield of Massachusetts is an Independent
Licensee of the Blue Cross and Blue Shield Association

Policy 727 Quality Care Dosing (QCD) Guidelines

Drug Product	Maximum Quantity Per RX
*Sumavel Dosepro [®] 6mg/0.5 mL	3 systems
Symbicort [®] Inhaler (ST)	2 inhalers
Symbyax [™] (ST) 6/25, 6/50, 12/25, 12/50 mg/mg	30 capsules
terazosin 1, 5 mg	30 tablets/capsules
terazosin 2, 10 mg	60 tablets/capsules
terbinafine 250 mg	30 tablets
*Terbinex [™]	1 kit
tranexamic acid	30 tablets
*Treximet [™] 85 mg/500mg	9 tablets
triamcinolone nasal spray	2 bottles
Tudorza [™] Pressair [™]	2 inhalers
valacyclovir 500mg, 1gm	30 tablets
Valtrex [®] 500mg, 1gm	30 tablets
venlafaxine ER capsules 150 mg	60 capsules
venlafaxine ER capsules 37.5, 75 mg	30 capsules
venlafaxine ER tablets (ST) 37.5, 75, 225 mg	30 capsules
venlafaxine ER tablets (ST) 150 mg	60 capsules
*Ventolin [®] HFA 90 mcg/act	3 inhalers
*Veramyst [™]	2 bottles
Vigamox [™] 0.05%	1 bottle (3 mL)
*Viibryd [®] (ST) 10, 20, 40mg	30 tablets

*Non-covered medication—quantity limits apply to members with approved formulary exceptions

**New to market medication—non covered while under review. Quantity limits apply to members with approved formulary exceptions

(ST) = Step therapy required

(PA) = Prior authorization required

(SP) = Specialty pharmacy program

(SPO) = Specialty pharmacy only. Benefits are not available for this medication when administered in an outpatient setting, such as a doctor's office or hospital, unless the medication is obtained from a specialty pharmacy



MASSACHUSETTS

Blue Cross Blue Shield of Massachusetts is an Independent
Licensee of the Blue Cross and Blue Shield Association

Policy 727 Quality Care Dosing (QCD) Guidelines

Drug Product	Maximum Quantity Per RX
Vivelle [®]	8 patches
Vivelle [®] -Dot	8 patches
Vivitrol ^(SPO)	1 vial
*Vytarin [™] (ST) 10/10, 10/20, 10/40, 10/80 mg/mg	30 tablets
*Vyvanase [™] 30, 50, 70 mg	30 capsules
*Wellbutrin [®] SR (ST) 100, 150, 200 mg	60 tablets
*Wellbutrin [®] XL (ST) 150, 300 mg	30 tablets
Xartemis [™] XR (PA) Tablets	60 tablets
*Xopenex [®] HFA Inhaler	3 inhalers
zaleplon 5, 10 mg	14 capsules
*Zegerid [®] (PA)	30 capsules/packets
Zetia [™] (ST) 10 mg	30 tablets
*Zetonna [®] 0.037mcg/act	2 bottles
*Zocor [®] (ST) 5, 10, 20, 40, 80 mg	30 tablets
*Zofran [®] 24 mg	1 tablet
*Zofran [®] ODT 4, 8 mg	24 tablets/orally disintegrating tablets
Zofran [®] solution 4 mg/5 mL	150 mL
*Zohydro [™] ER (PA) Capsules	60 capsules
zolmitriptan 2.5 mg	12 tablets
zolmitriptan 5 mg	9 tablets
zolmitriptan ODT 2.5 mg	12 tablets

*Non-covered medication—quantity limits apply to members with approved formulary exceptions

**New to market medication—non covered while under review. Quantity limits apply to members with approved formulary exceptions

(ST) = Step therapy required

(PA) = Prior authorization required

(SP) = Specialty pharmacy program

(SPO) = Specialty pharmacy only. Benefits are not available for this medication when administered in an outpatient setting, such as a doctor's office or hospital, unless the medication is obtained from a specialty pharmacy



MASSACHUSETTS

Blue Cross Blue Shield of Massachusetts is an Independent
Licensee of the Blue Cross and Blue Shield Association

Policy 727 Quality Care Dosing (QCD) Guidelines

Drug Product	Maximum Quantity Per RX
zolmitriptan ODT 5 mg	9 tablets
Zoloft™ (ST) 100 mg	60 tablets
Zoloft™ (ST) 25, 50 mg	45 tablets
zolpidem 5, 10 mg	14 tablets
zolpidem CR 6.25, 12.5 mg	14 tablets
*Zolpimist® (ST)	7.7 mL (1 package)
*Zomig® nasal spray 5 mg	6 nasal spray devices
*Zomig® / ZMT™ 2.5 mg	12 tablets
*Zomig® / ZMT™ 5 mg	9 tablets
Zubsolv® 1.4mg/0.36mg	90 tablets
Zubsolv® 5.7mg/1.4mg	60 tablets
*Zuplenz® 4, 8mg	24 film strips
Zymar™ 0.3%	1 bottle (3 mL)
*Zymaxid® 0.5%	2.5 mL (1 bottle)

Click link to access [Pharmacy Medical Policy 621](#)

*Non-covered medication—quantity limits apply to members with approved formulary exceptions

**New to market medication—non covered while under review. Quantity limits apply to members with approved formulary exceptions

(ST) = Step therapy required

(PA) = Prior authorization required

(SP) = Specialty pharmacy program

(SPO) = Specialty pharmacy only. Benefits are not available for this medication when administered in an outpatient setting, such as a doctor's office or hospital, unless the medication is obtained from a specialty pharmacy