Cigna Healthcare Advantage 3-Tier Prescription Drug List

Coverage as of January 1, 2026

For the State of California

View your drug list online: **Cigna.com/druglist**
24/7 Customer Service: **800.Cigna24 (800.244.6224)**
View your coverage info online: myCigna® App or **myCigna.com®**

Last updated: 12/01/2025. This drug list is subject to change and all prior versions are no longer in effect.

cigna healthcare

View your drug list online, 24/7

This document was last updated on 12/01/2025.* Go online to see the most up-to-date information about the medications your plan covers.

- **Cigna.com/druglist.** Choose **Advantage 3 Tier** from the dropdown list. Then type in your medication name or view the full list.
- **myCigna App[1] or myCigna.com.** Log into your account and use the Price a Medication tool to see how your medication is covered.

Questions?

- **By phone:** Call the toll-free number on your Cigna Healthcare® ID card. We're here 24/7/365.
- **myCigna.com:** Click to Chat - Monday-Friday, 9:00 am-8:00 pm EST.

Information about this drug list

Frequently asked questions (FAQs)

Here are answers to questions you may have about your drug list and prescription medication coverage.

Q. How often is the drug list updated? How do I know if my medication coverage changed?
A. We review and update the drug list on a regular basis to make sure you have coverage for low-cost, safe and effective medications. We make changes for many reasons; for example, when a new medication comes out or is no longer available, or when a medication's price changes. These changes may include:

- **Moving a medication to a lower cost tier.** This can happen at any time during the year.
- **Moving a brand medication to a higher cost tier when a generic comes out.** This can happen at any time during the year.
- **Moving a medication to a higher cost tier and/or no longer covering a medication.** This typically happens twice a year on January I and July I.
- **Adding extra coverage rules (requirements) to a medication.** This typically happens twice a year on January I and July I.

When we make a change that affects your medication (for example, it'll cost more, won't be covered, and/or has an extra coverage requirement), we let you know before it happens. This way, you have time to talk with your doctor about your options. Only you and your doctor can decide what's best for your treatment.

Q. Why doesn't my plan cover certain medications?
A. To help lower your overall health care costs, your plan doesn't cover certain high-cost brand-name medications that have lower-cost alternatives that can treat the same condition. If your medication isn't covered and your doctor feels a different medication isn't right for you, your doctor's office can ask us to cover it through our review process.

There are also some medications and products that your plan won't cover for any reason because they're a "plan (or benefit) exclusion." This means the medication or product isn't on your drug list, and there's no option to ask us to cover it through our review process.

For example, your plan doesn't cover (or "excludes"):

- Prescription medications that treat allergies (ex. Allegra, Clarinex, Xyzal and generics) and heartburn/stomach acid conditions (ex. Nexium, Prilosec OTC and generics).
- Medications that treat lifestyle conditions, such as infertility, erectile dysfunction and smoking cessation.[2]
- Medications that the U.S. Food and Drug Administration (FDA) hasn't approved.

Q. How do you decide which medications to cover?
A. The Cigna Healthcare Prescription Drug List is developed with the help of the Cigna Healthcare Pharmacy and Therapeutics (P&T) Committee, which is a group of practicing doctors and pharmacists, most of whom work outside of Cigna Healthcare. The group meets regularly to review medical evidence and information provided by federal agencies, drug manufacturers, medical professional associations, national organizations and peer-reviewed journals about the safety and effectiveness of medications that are newly approved by the FDA and medications already on the market.

The Cigna Healthcare Health Plan Commercial Value Assessment Committee (HVAC) then looks at the results of the P&T Committee's clinical review, as well as the medication's overall value and other factors before adding it to, or removing it from, the drug list.

Information about this drug list

Frequently asked questions (FAQs)

Q. Why do certain medications need approval before my plan will cover them?
A. The review process helps make sure you're getting coverage for the right medication, at the right cost, in the right amount and for the right situation.

Q. How do I know if a medication needs approval?
A. Check your drug list or log in to the myCigna App or **myCigna.com** and use the Price a Medication tool. If the medication has:

- **PA** (Prior Authorization) or **ST** (Step Therapy) next to it, it needs approval before your plan will cover it.
- **QL** (Quantity Limit) next to it, you may need approval depending on how much you're filling at one time.
- **AGE** (Age Requirement) next to it, you may need approval depending on your age.

Q. What types of medications typically need approval?
A. Medications that:

- May not be safe when you take them with other medications.
- Have lower-cost alternatives that work just as well at treating the same condition.
- Should only be used for certain health conditions.
- Are often used in the wrong way or are abused (taken more often than you should).

Q. What types of medications typically have quantity limits?
A. Medications that are often:

- Taken in a greater amount or used for a longer time than they should be.
- Used in the wrong way or are abused (taken more often than you should).

Q. What medications are part of Step Therapy?
A. They're typically high-cost medications that treat conditions such as:

- ADD/ADHD
- Allergies
- Bladder problems
- Breathing problems
- Depression
- High blood pressure
- High cholesterol
- Osteoporosis
- Pain
- Skin conditions
- Sleep disorders

Q. Why does my medication have an age requirement?
A. Not all medications are right for all ages. Some medications work best for people of a certain age or within a certain age range. As you get older, body changes can decrease the body's ability to break down or get rid of certain medications. This means that the medication may stay in your body longer. So, an older adult may need a lower dose of the medication or a different medication that's safer.

Q. How do I get approval (prior authorization) for my medication?
A. Ask your doctor's office to contact us to start the coverage review process. They know how the review process works and will take care of everything for you. In case the office asks, they can download a request form from our provider portal at **cignaforhcp.com**.

We'll review the information your doctor sends us to make sure you meet the medication's coverage rules (requirements). We'll send you and your doctor a letter with our decision (approved/not approved) and next steps. It can take up to five (5) business days to hear from us. You can always check with your doctor's office to find out if we've made a decision. Or, you can log in to the myCigna App or **myCigna.com** to see where your medication is in the review process or to read about the decision we made.

Many times, we don't get all of the information we need from the doctor's office to approve coverage. If we don't approve your medication, your doctor can send us more information to review, using the same process as before. We're happy to review the request again. Depending on what your doctor sends this time, we may be able to approve coverage. Or you and your doctor can appeal the decision by sending us a request, in writing, that explains why we should cover the medication.

- **For non-urgent requests**, we'll let you and your doctor know within 72 hours of the decision. If approved, coverage will be provided until the prescription runs out (including refills).
- **For urgent requests based on exigent circumstances**, we'll let you and your doctor know within 24 hours of the decision. If approved, coverage will be provided for the duration of the exigency. If we don't respond to a completed prior authorization exception request within 72 hours of receiving a non-urgent request and 24 hours of receiving a request based on exigent circumstances, the request will be considered approved and your plan can't deny coverage of the medication. Also, if you've already received approval for your plan to cover your medication, we can't limit or exclude coverage for that medication if your doctor continues to prescribe it to treat your condition (as long as the medication is appropriately prescribed and is safe and effective in treating your condition).

Q. My plan doesn't cover my medication. I need to take it because it's medically necessary for my treatment. How do I get approval (prior authorization) for my medication?
A. If your doctor feels that your medication is necessary for your treatment and an alternative isn't right for you, your doctor can ask us to consider approving coverage of your medication. Ask your doctor's office to contact us to start the coverage review process. They know how the review process works and will take care of everything for you. In case the office asks, they can download a request form from our provider portal at **cignaforhcp.com**.

We'll review the information your doctor sends us to make sure you meet the medication's coverage rules (requirements). We'll send you and your doctor a letter with our decision (approved/not approved) and next steps. It can take up to five (5) business days to hear from us. You can always check with your doctor's office to find out if we've made a decision. Or, you can log in to the myCigna App or **myCigna.com** to see where your medication is in the review process or to read about the decision we made.

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- **For non-urgent requests**, we'll let you and your doctor know within 72 hours of the decision. If approved, coverage will be provided until the prescription runs out (including refills).
- **For urgent requests based on exigent circumstances**, we'll let you and your doctor know within 24 hours of the decision. If approved, coverage will be provided for the duration of the exigency. **It's important to know that when medications are approved, it's typically for one year of coverage.** If your medication is approved for less time, it's because there's a clinical reason based on our coverage rules (requirements) for the medication and/or the reviewing doctor.

Q. My medication is part of the Step Therapy program. I don't want to try an alternative. How do I get approval (prior authorization) for my medication?
A. If you and your doctor feel an alternative medication won't work for you, your doctor can ask us to consider approving coverage of your current medication. Ask your doctor's office to contact us

to start the coverage review process. They know how the review process works and will take care of everything for you. In case the office asks, they can download a request form from our provider portal at **cignaforhcp.com**.

We'll review the information your doctor sends us to make sure you meet the medication's coverage rules (requirements). We'll send you and your doctor a letter with our decision (approved/not approved) and next steps. It can take up to five (5) business days to hear from us. You can always check with your doctor's office to find out if we've made a decision. Or, you can log in to the myCigna App or **myCigna.com** to see where your medication is in the review process or to read about the decision we made.

Many times, we don't get all of the information we need from the doctor's office to approve coverage. If we don't approve your medication, your doctor can send us more information to review, using the same process as before. We're happy to review the request again. Depending on what your doctor sends this time, we may be able to approve coverage. Or you and your doctor can appeal the decision by sending us a request, in writing, that explains why we should cover the medication.

- **For non-urgent requests**, we'll let you and your doctor know within 72 hours of the decision. If approved, coverage will be provided until the prescription runs out (including refills).
- **For urgent requests based on exigent circumstances**, we'll let you and your doctor know within 24 hours of the decision. If approved, coverage will be provided for the duration of the exigency. If we don't respond to a completed prior authorization exception request within 72 hours of receiving a non-urgent request and 24 hours of receiving a request based on exigent circumstances, the request will be considered approved and your plan can't deny coverage of the medication.

Your Step Therapy rights under California State law:

1. A carrier may impose prior authorization requirements on prescription drug benefits.
2. When there is more than one drug that is appropriate for the treatment of a medical condition, a carrier may require step therapy.
    a. In circumstances where an insured is changing policies, the new policy shall not require a repeat of step therapy when that insured is already being treated for a medical condition by a prescription drug provided that the drug is appropriately prescribed and is considered safe and effective. A new policy can impose a prior authorization requirement for the continued coverage of a prescription drug prescribed pursuant to step therapy imposed by the former policy. A new policy must also allow a prescribing provider to prescribe another drug covered by the new policy that is medically appropriate for the insured.
3. A carrier shall provide coverage for the medically necessary dosage and quantity of the drug prescribed for the treatment of a medical condition consistent with professionally recognized standards of practice.

Q. What happens if I try to fill a prescription that needs approval but I don't get approval ahead of time?

A. When your pharmacist tries to fill your prescription, they'll see that the medication needs our approval before it can be covered. Because you didn't get approval ahead of time, your plan won't cover its cost. If that happens, ask your doctor to contact us to start the coverage review process.

You can still fill it (without using your plan/insurance), but you'll pay its full price at the pharmacy counter. And, if you do this, your costs can't be applied to your annual deductible or out-of-pocket maximum.

Information about this drug list

Frequently asked questions (FAQs) *(cont.)*

Q. What happens if I try to fill a prescription that has a quantity limit?
A. Your pharmacist will only fill the amount your plan covers. If you want to fill more than what's allowed, your doctor's office can ask us to cover it through our review process.

Q. Are all of the medications on this drug list approved by the FDA?
A. Yes.

Q. Does my plan cover medications that the FDA recently approved?
A. We review all recently approved medications and products to see if they should be covered, and if so, at what cost-share (tier). These include, but are not limited to, medications, medical supplies and/or devices covered under standard pharmacy benefits. It can take up to six months from the date the FDA approved them for us to make a decision.

If your doctor wants you to use a recently approved medication, your doctor's office can ask us to cover it through our review process.

Q. What are preventive medications?
A. Preventive medications can help keep you from getting certain long-term health conditions such as asthma, depression, diabetes, heart attack, high blood pressure, high cholesterol, osteoporosis (a disease that causes bones to become weak), prenatal nutrient deficiency (when a pregnant person doesn't get enough of the nutrients they need) and stroke. They improve your changes of staying well and living longer.

Q. Which medications are covered under the health care reform law?
A. The Patient Protection and Affordable Care Act (PPACA), also known as health care reform, helps make health care and preventive care more affordable. PPACA requires health plans to cover the full cost of certain preventive medications and over-the-counter (OTC) products. This means you don't have to pay anything – not even a copay, coinsurance or deductible for these products.

To see a list of $0 medications, go to **Cigna.com/PDL** and click on the dropdown next to "Drug Lists for Employer Plans." Under the Preventive Drug Lists section, click on the link for the PPACA No Cost-Share Preventive Drug List.

Q. I see several medications on this drug list that can be used to treat my condition. Will my doctor write me a prescription for all of them?
A. No. Just because a medication is listed on your plan's drug list doesn't mean your doctor will write you a prescription for it. Your doctor will work with you to find the medication he or she feels is best for your specific treatment.

Q. How can I find out how much I'll pay for a specific medication?
A. When you and your doctor are thinking about the right medication for your treatment, knowing how much it costs, what lower-cost options are available, and which pharmacies have the best prices can help you avoid surprises. Log in to the myCigna App or **myCigna.com** and use the Price a Medication tool to see how much your medication costs before you get to the pharmacy counter – or even before you leave your doctor's office.[3]

Q. What's a cost-share?
A. It's the amount you pay out of your own pocket for a covered prescription and/or an eligible health care or related service. For some plans, the cost-share is a copay; for other plans, it's a coinsurance.

Q. How can I save money on my prescription medications?
A. You should think about using a medication that's covered on a lower tier, such as a generic or preferred brand medication, or by filling a 90-day supply (if your plan allows). Ask your doctor if one of these options may work for you.

Information about this drug list

Frequently asked questions (FAQs) *(cont.)*

Q. What's a generic medication?
A. A generic is the same as its brand-name version. It has the same active ingredient, strength and dosage form, treats the same condition(s), and works in the same way – and typically costs less.[4] Generics are typically sold under their chemical or scientific name, instead of the brand name.

Q. Do generics work the same as brand-name medications?
A. Yes. A generic medication works in the same way and provides the same clinical benefit as the brand-name medication.[4]

Q. What are the differences between generic and brand-name medications?
A. The generic and brand-name medication may[4]:

- Look different. For example, generics may have a different shape, size or color than their brand-name versions.
- Have a different flavor and/or different preservatives, come in different packaging and/or with different labeling and may expire at different times.

It's important to know that these differences don't affect how the generic works.

Q. What is a "biosimilar" medication?
A. A biosimilar is "highly similar" to its original biologic medication, which is also known as a reference product, that the FDA has already approved. Even though biosimilars aren't identical to the original medication, they're used to treat the same conditions, and provide the same clinical outcomes and treatment benefits. There are no clinical differences in how safe they are to use and how well they work. They also typically cost less.[5]

Q. How do I know which pharmacies are in my plan's network?
A. There are thousands of retail pharmacies in your plan's network. They include local pharmacies, grocery stores, retail chains and wholesale warehouse stores – all places where you may already shop. And some stores are open 24-hours. To find an in-network pharmacy near you, log in to the myCigna App or **myCigna.com**. Then click on the Prescriptions tab and choose "Find a Pharmacy" from the dropdown list.

Q. My pharmacy isn't in my plan's network. Can I continue to fill my prescriptions there?
A. To get the most from your plan coverage, you should use an in-network pharmacy. If your plan offers out-of-network coverage, you'll pay your out-of-network cost-share to fill a prescription there.

Q. Do I have to use home delivery to fill my prescription?
A. It depends on your plan. Some plans require you to fill maintenance medications through Express Scripts® Pharmacy and/or specialty medications through Accredo® Specialty Pharmacy for them to be covered.[6] Log in to the myCigna App or **myCigna.com**, or check your plan materials, to find out what your plan requires.

Q. Can I fill my prescriptions by mail?
A. Yes, as long as your plan offers home delivery.[6]

Fill maintenance medications through Express Scripts Pharmacy

Express Scripts Pharmacy is a convenient option when you're taking a medication on a regular basis to treat an ongoing health condition. It's simple and safe, and saves you trips to the pharmacy. To learn more, go to **Cigna.com/homedelivery**.

- Easily order, manage, track and pay for your medications on your phone or online.
- Get standard shipping at no extra cost.[7]
- Fill up to a 90-day supply at one time.
- Talk with a pharmacist, 24/7.
- Sign up for automatic refills or refill reminders so you don't miss a dose.[8]
- Use a payment plan (if you need it).

Here are two easy ways to get started:

1. **Online.** Log in to the myCigna App or **myCigna.com** and click on the Prescriptions tab. Choose My Medications from the dropdown list. Then click the button next to your medication name to move your prescription(s) from your retail pharmacy to home delivery. Or,
2. **By phone.**
   - Call your doctor's office. Ask them to send a 90-day prescription (with refills) to Express Scripts home delivery. Or,
   - Call Express Scripts Pharmacy at **800.835.3784**. They'll contact your doctor's office to get your prescription. Have your ID card, doctor's contact information and medication name(s) ready when you call.

Fill specialty medications through Accredo Specialty Pharmacy

If you're using a specialty medication, Accredo's team can help you manage your rare and/or complex medical condition. They'll also fill and ship your specialty medication to you, so you don't have to stand in line at the pharmacy. To learn more, go to **Cigna.com/specialty**.

- Talk with specially-trained pharmacists and nurses, 24/7.
- Get fast shipping at no extra cost.[7]
- Sign up for refills and reminders. Some refills can be done by text.[9]
- Get help paying for your medication (if you need it).
- Manage and track your medications online.

To get started, call **877.826.7657**, Monday–Friday, 7:00 am–10:00 pm CST and Saturdays, 7:00 am–4:00 pm CST.

Q. I take a specialty medication to treat my multiple sclerosis. My plan requires me to fill my medication through Accredo. How do I get started?
A. Some plans allow one or more fills at a retail pharmacy before switching to Accredo. Check your plan materials to find out if your plan allows retail fills.

To get started using Accredo, call **877.826.7657**, Monday–Friday, 7:00 am–10:00 pm CST and Saturdays, 7:00 am–4:00 pm CST. Be sure to call them about two weeks before your next refill so they have time to get a new prescription from your doctor's office.

Q. I take a specialty medication that can only be filled at certain pharmacies in the United States. How do I fill my prescription?
A. Talk with your doctor. He or she should be able to tell you which in-network pharmacies can fill your prescription. Once you find a pharmacy, ask your doctor to send them your prescription.

You may also be able to use Accredo to fill your prescription; they have access to most specialty medications.[6] Call Accredo at **877.826.7657**, Monday–Friday, 7:00 am–10:00 pm CST or Saturdays, 7:00 am–4:00 pm CST, for more information.

Q. How do I fill my prescription?
A. First, you'll need to get a prescription from your doctor. Then, your doctor can either:

1. **Send it electronically** to the in-network retail pharmacy of your choice, Express Scripts home delivery or Accredo. Or
2. **Give you a paper prescription.** You can bring it to the in-network retail pharmacy of your choice or mail it to Express Scripts Pharmacy or Accredo.

Q. How can I get help with my specialty medication?
A. Managing a rare and/or complex medical condition isn't easy. Accredo's team of specialty-trained pharmacists and nurses can help. They'll also fill and ship your specialty medication to you, so you don't have to stand in line at the pharmacy.

Go to **Cigna.com/specialty** to learn more about Accredo or call **877.826.7657**, Monday–Friday, 7:00 am–10:00 pm CST or Saturdays, 7:00 am–4:00 pm CST.

Information about this drug list

Frequently asked questions (FAQs) *(cont.)*

Q. Where can I find more information about my pharmacy benefits?
A. Use the online tools and resources on the myCigna App or **myCigna.com**. You can find out how much your medication costs (and what lower-cost options may be available), see which medications your plan covers, find an in-network pharmacy, ask a pharmacist a question, see your pharmacy claims and coverage details, and more. You can also manage your home delivery orders.

Q. How can I find out my cost-share for each tier of the drug list?
A. We put covered medications into tiers (or cost-share levels). Typically, the higher the tier, the higher the price you'll pay for the medication. Here are three places you can go to find out how much you'll pay for your medication based on the tier it's listed in, including the maximum cost-share amount allowed:

1. **Check your Cigna Healthcare ID card.** It lists your cost-share for Tier 1, Tier 2 and Tier 3 medications.
2. **Log in to the myCigna App or myCigna.com to view your pharmacy coverage information.** You can also use the Price a Medication tool to find out how much your medication may cost you at the different pharmacies in your plan's network.
3. **Check your Summary of Benefits** coverage document.

Q. What's the difference between medications covered under the pharmacy benefit and medical benefit?
A. Some medications are covered under the pharmacy benefit, some are covered under the medical benefit and others are covered under both benefits. Log in to the myCigna App or **myCigna.com**, or check your plan materials, to learn more about how your plan covers your medication.

- Medications that you fill at the pharmacy and take yourself are typically covered under the pharmacy benefit.
- Medications that are injected or infused and are given to you at a doctor's office, hospital, an infusion center or at home are typically covered under the medical benefit.

Why this matters: Which benefit the medication's covered under may affect how much it costs, if it needs approval from Cigna Healthcare before your plan will cover it and/or if you have to fill it through a certain pharmacy to be covered. Check your medical summary of benefits coverage to learn more about how your plan covers your medication.

Q. I take an oral cancer medication. How much will it cost me to fill?
A. On January 1, 2015, California passed a bill limiting the cost-share for oral chemotherapy medications. This means that if you have both your medical and pharmacy benefits through Cigna Healthcare, here's how certain oral cancer medications are covered:

- **For copay plans:** These medications will be covered at 100%, or no cost-share ($0) to you.
- **For high deductible health plans (HDHPs) that include a Health Savings Account (HSA) or qualified HDHPs:** You'll pay your plan deductible first. After that, these medications will be covered at 100%, or no cost-share ($0) to you. This is because of a federal HSA requirement.
- **For plans with a combined deductible [including Health Reimbursements Accounts (HRAs) with a combined deductible]:** You'll pay your plan deductible first. After that, these medications will be covered at 100%, or no cost-share ($0) to you.
- **For plans with a split deductible [including Health Reimbursements Accounts (HRAs) with a split deductible]:** These medications will be covered at 100%, or no cost-share ($0) to you.

Information about this drug list

Frequently asked questions (FAQs) *(cont.)*

Q. How are medications, devices and FDA-approved diabetic, contraceptive and federally-mandated products covered under the pharmacy benefit?
A. Here is how these products are covered under the pharmacy benefit:

- **Preventive care medications and products covered under the Patient Protection and Affordable Care Act (PPACA), also known as "health care reform:"**
  - **Contraceptives:** Covered at 100%, or no cost-share ($0) to you. Certain prescription contraceptives are available at their applicable cost-share.
  - **Tobacco cessation products:** Up to two (2) 90-day courses of treatment per plan year are covered at 100%, or no cost-share ($0) to you. Certain prescription tobacco cessation products are available at their applicable cost-share.
  - **Certain vitamins:** Covered at 100%, or no cost-share ($0) to you. All other prescription vitamins are available at their applicable cost-share and deductible (if applicable).
- **Certain over-the-counter (OTC) products:** If you have a prescription from your doctor, these are covered at 100%, or no cost-share ($0) to you. All other OTC products are excluded from coverage.
- **Oral fertility medications:** Covered at their applicable tier cost-share. For some plans, injectable fertility medications are covered under the medical benefit.
- **Generic preventive care medications:** Covered at 100%, or no cost-share ($0) to you before you meet your deductible. You'll pay your deductible and applicable cost-share to fill a preferred brand and/or non-preferred brand preventive care medication.
- **Diabetic supplies:** Covered at their applicable cost-share.
- **Growth Hormones:** Need approval from Cigna Healthcare before your plan will cover them (prior authorization). If approved, you'll pay your applicable tier cost-share to fill the medication.
- **Vaccines:** Vaccines are now covered under the pharmacy benefit. Not all plans cover vaccines in the same way. Log in to the myCigna App or **myCigna.com**, or check your plan materials, to find out how your specific plan covers them.
- **Compounded medications:** If the medication is more than $200, you'll need approval from Cigna Healthcare before your plan will cover them (prior authorization). If approved, you'll pay your applicable tier cost-share to fill the medication.

Words you may need to know

- **Brand name drug:** A drug that is marketed under a proprietary, trademark-protected name. A brand name drug is listed in this formulary in all CAPITAL letters.
- **Coinsurance:** A percentage of the cost of a covered health care benefit that you pay after you have paid the deductible, if a deductible applies to the health care benefit.
- **Copayment:** A fixed dollar amount that you pay for a covered health care benefit after you have paid the deductible, if a deductible applies to the health care benefit.
- **Deductible:** The amount you pay for covered health care benefits that are subject to the deductible before your health insurer begins to pay. If your health insurance policy has a deductible, it may have either one deductible or separate deductibles for medical benefits and prescription drug benefits. After you pay your deductible, you usually pay only a copayment or coinsurance for covered health care benefits. Your insurance company pays the rest.

Information about this drug list

Words you may need to know *(cont.)*

- **Drug tier:** A group of prescription drugs that correspond to a specified cost sharing tier in your health insurance policy. The drug tier in which a prescription drug is placed determines your portion of the cost for the drug.
- **Exception request:** A request for coverage of a non-formulary drug. If you, your designee, or your prescribing health care provider submits a request for coverage of a non-formulary drug, your insurer must cover the non-formulary drug when it is medically necessary for you to take the drug.
- **Exigent circumstances:** When you are suffering from a medical condition that may seriously jeopardize your life, health, or ability to regain maximum function, or when you are undergoing a current course of treatment using a non-formulary drug.
- **Formulary or prescription drug list:** The list of drugs that is covered by your health insurance policy under the prescription drug benefit of the policy.
- **Generic drug:** A drug that is the same as its brand name drug equivalent in dosage, strength, effect, how it is taken, quality, safety, and intended use. A generic drug is listed in this formulary in italicized lowercase letters.
- **Medically Necessary:** Health care benefits needed to diagnose, treat, or prevent a medical condition or its symptoms and that meet accepted standards of medicine. Health insurance usually does not cover health care benefits that are not medically necessary.
- **Non-formulary drug:** A prescription drug that is not listed on this formulary.
- **Out-of-pocket costs:** Your expenses for health care benefits that aren't reimbursed by your health insurance. Out-of-pocket costs include deductibles, copayments, and coinsurance for covered health care benefits, plus all costs for health care benefits that are not covered.
- **Prescribing provider:** A health care provider who can write a prescription for a drug to diagnose, treat, or prevent a medical condition.
- **Prescription:** An oral, written, or electronic order from a prescribing provider authorizing a prescription drug to be provided to a specific individual.
- **Prescription drug:** A drug that by law requires a prescription.
- **Prior Authorization:** A decision by your health insurer that a health care benefit is medically necessary for you. If a prescription drug is subject to prior authorization in this formulary, your prescribing provider must request approval from your health insurer to cover the drug before you fill your prescription. Your health insurer must grant a prior authorization request when it is medically necessary for you to take the drug.
- **Step Therapy:** A specific sequence in which prescription drugs for a particular medical condition must be tried. If a drug is subject to step therapy in this formulary, you may have to try one or more other drugs before your health insurance policy will cover that drug for your medical condition. If your prescribing provider submits a request for an exception to the step therapy requirement, your health insurer must grant the request when it is medically necessary for you to take the drug.
- **Quantity Limits:** For some medications, your plan will only cover up to a certain amount over a certain length of time. For example, 30mg per day for 30 days. Quantity limits help to make sure you're receiving coverage for the right medication, in the right amount, and for the right situation. Your plan will only cover a larger amount if your doctor requests and receives approval from Cigna Healthcare.
- **Age Requirements:** For certain medications, you must be within a specific age range for your plan to cover them. This is because some medications aren't considered clinically appropriate for individuals who aren't within that age range.

Information about this drug list

About this drug list

This is a list of the most commonly prescribed medications covered on the Cigna Healthcare Advantage 3-Tier Prescription Drug List as of January 1, 2026. **The drug list is updated often**; so, not all of the medications your plan covers may be listed here. Also, your plan may not cover all of these medications. Log in to the myCigna App or **myCigna.com** to see which medications your plan covers.

Important: Your plan doesn't cover prescription medications that treat allergies (ex. Allegra®, Clarinex®, Xyzal® and generics) and heartburn/stomach acid conditions (ex. Nexium®, Prilosec OTC® and generics). Instead, you can buy them as over-the-counter (OTC) products at your local pharmacy or retail store without a prescription.

How to read this drug list

Medications are listed alphabetically by their generic and brand names within their therapeutic category and class.* You can also find your medication using the index at the end of this drug list.

- The generic version of a brand-name medication is listed in parentheses and all *lowercase italicized* letters next to the brand-name medication.
- If a generic equivalent for a brand-name medication is both available and covered, the generic will be listed separately from the brand-name medication in all *lowercase italicized* letters.
- If a generic equivalent for a brand-name medication isn't available on the market or isn't covered, the medication won't be listed separately by its generic version.
- If a generic medication is marketed under a proprietary, trademark-protected brand name, the brand-name medication will be listed after the generic version in parentheses and regular typeface with the first letter of each word capitalized. For example: *quinapril hcl* (Accupril).

Tiers

We put covered medications into tiers (or cost-share levels). Typically, the higher the tier, the higher the price you'll pay for the medication.

Tier 1	**Generics. These medications are covered at your plan's lowest cost-share.** Generics work in the same way and provide the same clinical benefits as their brand-name versions – and typically cost much less.[4]	**$**
Tier 2	**Preferred Brands.** These medications typically have one or more lower-cost generic that treats the same condition.	**$$**
Tier 3	**Non-Preferred Brands. These medications are covered at your plan's highest cost-share.** Non-preferred brands typically have a generic and/or preferred brand alternative(s) that treats the same condition.	**$$$**

* Medications are listed in the therapeutic category and class provided by First Databank.

Information about this drug list

How to read this drug list *(cont.)*

Letters (acronyms) in the Notes column
In this drug list, some medications have **letters (acronyms)** next to them in the Notes column. Here's what they mean.

PA	**Prior Authorization*** – This medication needs approval from Cigna Healthcare before your plan will cover it. Your doctor's office will have to send us information to review to make sure you meet the medication's coverage rules (requirements).
QL	**Quantity Limit*** – Your plan will only cover so much of this medication at one time. If your doctor wants you to fill more than what's allowed, your doctor's office can ask us to cover more.
ST	**Step Therapy*** – This is a high-cost medication that has a lower-cost alternative(s) that treats the same condition. Your plan won't cover this medication until you try at least one preferred medication first (typically a generic or preferred brand) and can show that it didn't work for you. If your doctor feels a preferred medication isn't right for you, your doctor's office can ask us to cover the higher-cost medication.
AGE	**Age Requirement*** – Your plan will only cover this medication if you're a certain age or within a certain age range. If you're not within the allowed age range and your doctor wants you to use the medication, your doctor's office can ask us to cover it.
SP	This is a **specialty medication**, which is used to treat a rare and/or complex medical condition. Some plans have extra coverage rules (requirements) for specialty medications. For example, some may only cover up to a 30-day supply and/or require you to fill it at a preferred specialty pharmacy to be covered.
HD	**Home Delivery Medications** – Some plans only cover certain maintenance medications if they're filled through home delivery with Express Scripts Pharmacy. Depending on your plan, you may be able to get coverage for one, two or three fills at an in-network retail pharmacy before you have to switch to home delivery.
PPACA	Health care reform under the **Patient Protection and Affordable Care Act (PPACA)** requires plans to cover the full cost of this preventive medication or product. This means you don't have to pay anything – not even a copay, coinsurance or deductible.
CSL	**Oral Cancer Medications Subject to Cost-Share Limits** – State law in California limits the cost-share (or amount you pay out-of-pocket) for certain oral chemotherapy medications.

* **Not all plans have extra coverage rules (requirements) on medications.** Log in to the myCigna App or myCigna.com, or check your plan materials, to see if yours does.

Information about this drug list

How to read this drug list *(cont.)*

Use the table below to understand how medications are covered on the Cigna Healthcare Advantage 3-Tier Prescription Drug List.*

ANALGESICS (Pain Relief and Inflammatory Disease)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANALGESIC, NON-SALICYLATE AND BARBITURATE COMBINAT		
butalbital/acetaminophen	T1	
ANALGESIC, SALICYLATE, BARBITURATE, XANTHINE COMB.		
butalb-aspirin-caffe 50-325-40	T1	QL (6 tabs/day)
butalbital-asa-caffeine cap (Fiorinal)	T1	QL (6 caps/day)
FIORINAL (*butalbital-aspirin-caffeine*)	T3	QL (6 caps/day)
ANALGESIC, NON-SALICYLATE, BARBITURATE, XANTHINE COMB.		
butalb/acetaminophen/caffeine	T3	
butalb/acetaminophen/caffeine (Esgic)	T3	QL (6 caps/day)
butalb-acetamin-caff 50-300-40 (Fioricet)	T1	QL (6 caps/day)
butalb-acetamin-caff 50-325-40 (Esgic)	T1	QL (6 tabs/day)
ESGIC 50-325-40 MG TABLET (*butalbital-acetaminophen-caffe*)	T3	QL (6 tabs/day)
ESGIC CAPSULE (*zebutal*)	T3	QL (6 caps/day)
FIORICET (*phrenilin forte*)	T1	QL (6 caps/day)
ANALGESIC/ANTIPYRETICS, SALICYLATES		
choline salicyl/mag salicylate	T1	HD
diflunisal	T1	HD
ANTI-MIGRAINE PREPARATIONS		
AIMOVIG AUTOINJECTOR	T2	PA
AJOVY AUTOINJECTOR	T2	PA
AJOVY SYRINGE	T2	PA
almotriptan malate	T1	QL (12 tabs/30 days)
CAFERGOT (*ergotamine-caffeine*)	T3	QL (40 tabs/28 days)
dihydroergotamine 1 mg/ml amp	T1	QL (10 amps/30 days)
eletriptan hydrobromide	T1	QL (6 tabs/30 days)
EMGALITY PEN	T2	PA
EMGALITY SYRINGE	T2	PA
ergotamine tartrate/caffeine	T1	
ergotamine tartrate/caffeine (Cafergot)	T1	QL (40 tabs/28 days)

Therapeutic drug category and class describes the condition the medication is used to treat.

Coverage requirements and limits lets you know if your plan has extra requirements before it will cover the medication.

Drug tier gives you an idea of how much you may pay for a medication.

Prescription drug name is the name of the medication.

Medications are listed in **alphabetical order (A-Z)** within each column.

Brand name medications are in all **CAPITAL** letters.

Generic medications are in **lowercase italics**.

* This table is just an example. It may not show how these medications are currently covered on this drug list.

Information about this drug list

How to find your medication

First, look for the therapeutic category/class your medication is in using the alphabetical list below. Then, go to that page to see the covered medications available to treat the condition.

Information about this drug list

How to find your medication *(cont.)*

Information about this drug list

How to find your medication *(cont.)*

List of Prescription Medications

ANALGESICS (Pain Relief and Inflammatory Disease)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANALGESIC, NON-SALICYLATE AND BARBITURATE COMBINAT		
butalbital/acetaminophen	T1	
butalbital-acetaminophn 50-325	T1	
ANALGESIC, SALICYLATE, BARBITURATE, XANTHINE COMB.		
butalbital-aspirin-caffeine cp	T1	QL(6 CAPS/DAY)
butalbital-aspirin-caffeine tb	T1	QL(6 TABS/DAY)
ANALGESIC, NON-SALICYLATE, BARBITURATE, XANTHINE COMB.		
butalb/acetaminophen/caffeine (Esgic)	T3	QL(6 CAPS/DAY)
butalb-acetamin-caff 50-300-40 (Fioricet)	T1	QL(6 CAPS/DAY)
butalb-acetamin-caff 50-325-40	T1	QL(6 TABS/DAY)
butalb-acetamin-caff 50-325-40 (Esgic)	T1	QL(6 CAPS/DAY)
ANALGESIC/ANTIPYRETICS, SALICYLATES		
diflunisal	T1	HD
ANALGESIC/ANTIPYRETICS, NON-SALICYLATES		
acetaminophen 1,000mg/100ml vl	T1	
acetaminophen 1000mg/100ml bag	T1	
ACETAMINOPHEN 1000MG/100ML BAG	T3	
acetaminophen 500 mg/50 ml bag	T1	
ACETAMINOPHEN 500 MG/50 ML BAG	T3	
acetaminophen 650 mg/65 ml bag	T1	
ANALGESICS, NEURONAL-TYPE CALCIUM CHANNEL BLOCKERS		
PRIALT	T3	SP
ANALGESICS, NON-OPIOID		
clonidine 1,000 mcg/10 ml vial (Duraclon)	T1	
clonidine 5,000 mcg/10 ml vial	T1	
DURACLON *(clonidine hcl/pf)*	T3	
ANTI-MIGRAINE PREPARATIONS		
AIMOVIG AUTOINJECTOR	T2	PA
AJOVY AUTOINJECTOR	T2	PA
AJOVY AUTOINJECTOR (3 PACK)	T2	PA
AJOVY SYRINGE	T2	PA
almotriptan malate	T1	QL(12 TABS/30 DAYS)
dihydroergotamine 1 mg/ml amp	T1	QL
eletriptan hydrobromide (Relpax)	T1	QL(6 TABS/30 DAYS)
EMGALITY PEN	T2	PA
EMGALITY SYRINGE	T2	PA

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANALGESICS (Pain Relief and Inflammatory Disease) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-MIGRAINE PREPARATIONS *(cont.)*		
ergotamine tartrate/caffeine	T1	QL(40 TABS/28 DAYS)
frovatriptan succinate (Frova)	T1	QL(18 TABS/30 DAYS)
naratriptan hcl	T1	QL(9 TABS/30 DAYS)
NURTEC ODT	T2	PA QL(16 TABS/30 DAYS)
QULIPTA	T2	PA QL(1 TAB/DAY)
rizatriptan benzoate	T1	QL(12 TABS/30 DAYS)
rizatriptan benzoate (Maxalt Mlt)	T1	QL(12 TABS/30 DAYS)
rizatriptan benzoate (Maxalt)	T1	QL(12 TABS/30 DAYS)
sumatriptan	T1	QL(12 UNITS/30 DAYS)
sumatriptan 4 mg/0.5 ml inject (Imitrex)	T1	QL(4 MLS/30 DAYS)
sumatriptan 6 mg/0.5 ml vial	T1	QL(5 MLS/30 DAYS)
sumatriptan 6 mg/0.5ml autoinj (Imitrex)	T1	QL(4 MLS/30 DAYS)
sumatriptan succ 100 mg tablet (Imitrex)	T1	QL(9 TABS/30 DAYS)
sumatriptan succ 25 mg tablet (Imitrex)	T1	QL(9 TABS/30 DAYS)
sumatriptan succ 50 mg tablet (Imitrex)	T1	QL(9 TABS/30 DAYS)
sumatriptan succ/naproxen sod (Treximet)	T1	QL(18 TABS/30 DAYS)
UBRELVY	T2	PA QL(0.67 TABS/DAY)
VYEPTI	T3	PA SP
ZAVZPRET	T2	PA QL(6 UNITS/30 DAYS)
zolmitriptan	T1	QL(6 TABS/30 DAYS)
zolmitriptan 2.5 mg tablet (Zomig)	T1	QL(6 TABS/30 DAYS)
zolmitriptan 5 mg tablet (Zomig)	T1	QL(6 TABS/30 DAYS)
NSAIDS, CYCLOOXYGENASE INHIBITOR-TYPE ANALGESICS		
diclofenac pot 50 mg tablet	T1	HD
diclofenac potassium	T1	HD
ketorolac 10 mg tablet	T1	QL(20 TABS/30 DAYS)
ketorolac 15 mg/ml syringe	T1	QL(8 MLS/DAY)
ketorolac 15 mg/ml vial	T1	QL(8 MLS/DAY)
ketorolac 30 mg/ml syringe	T1	QL(4 MLS/DAY)
ketorolac 30 mg/ml vial	T1	QL(4 MLS/DAY)

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List of Prescription Medications

ANALGESICS (Pain Relief and Inflammatory Disease) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
NSAIDS, CYCLOOXYGENASE INHIBITOR-TYPE ANALGESICS *(cont.)*		
ketorolac 300 mg/10 ml vial	T1	
ketorolac 60 mg/2 ml syringe	T1	QL(4 MLS/DAY)
ketorolac 60 mg/2 ml vial	T1	QL(4 MLS/DAY)
OPIOID ANALGESIC AND NON-SALICYLATE ANALGESICS		
acetamin-codein 300-30 mg/12.5	T1	
acetaminop-codeine 120-12 mg/5	T1	
acetaminophen-cod #2 tablet	T1	PA
acetaminophen-cod #3 tablet	T1	PA
acetaminophen-cod #4 tablet	T1	PA
hydrocodone/acetaminophen	T1	PA
hydrocodone/acetaminophen (Lortab)	T1	PA
HYDROCODONE-ACETAMINOPHEN	T1	PA
LORTAB *(hydrocodone/acetaminophen)*	T1	PA
NALOCET	T1	PA
oxycodone hcl/acetaminophen	T1	PA
oxycodone hcl/acetaminophen (Percocet)	T1	PA
PRIMLEV	T1	PA
prolate 10-300 mg tablet	T1	PA
prolate 5-300 mg tablet	T1	PA
prolate 7.5-300 mg tablet	T1	PA
tramadol hcl/acetaminophen	T1	
OPIOID ANALGESIC AND NSAID COMBINATION		
hydrocodone/ibuprofen	T1	PA
ALFENTANIL HCL *(alfentanil hcl)*	T3	PA
fentanyl 1,000 mcg/20 ml vial	T1	
fentanyl 100 mcg/2 ml ampul	T1	
fentanyl 100 mcg/2 ml syringe	T1	
fentanyl 100 mcg/2 ml vial	T1	
fentanyl 2,500 mcg/50 ml bag	T1	
fentanyl 2,500 mcg/50 ml vial	T1	
FENTANYL 25 MCG/0.5 ML SYRINGE	T3	
fentanyl 250 mcg/5 ml ampul	T1	
FENTANYL 250 MCG/5 ML SYRINGE	T1	
fentanyl 250 mcg/5 ml vial	T1	

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List of Prescription Medications

ANALGESICS (Pain Relief and Inflammatory Disease) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
OPIOID ANALGESIC, ANESTHETIC ADJUNCT AGENTS		
fentanyl 5,000 mcg/100 ml bag	T1	
fentanyl 50 mcg/ml syringe	T1	
remifentanil hcl (Ultiva)	T1	PA
sufentanil citrate	T1	PA
fentanyl 50 mcg/ml vial	T1	
fentanyl 500 mcg/10 ml vial	T1	
fentanyl citrate/pf	T1	
remifentanil hcl (Ultiva)	T1	PA
sufentanil citrate	T1	PA
ULTIVA (*remifentanil hcl*)	T3	PA
OPIOID ANALGESIC AND NON-SALICYLATE XANTHINE COMB		
acetaminophen/caff/dihydrocod	T1	PA
TREZIX	T3	PA
OPIOID ANALGESICS		
ACTIQ (*fentanyl citrate*)	T3	PA
BELBUCA	T2	QL(2 FILMS/DAY)
buprenorphine (Butrans)	T1	QL(4 PATCHES/28 DAYS)
buprenorphine hcl	T1	
butorphanol 1 mg/ml vial	T1	
butorphanol 10 mg/ml spray	T1	PA QL(6 BOTTLES/30 DAYS)
butorphanol 2 mg/ml vial	T1	
butorphanol 4 mg/2 ml vial	T1	
BUTRANS (*buprenorphine*)	T3	QL(4 PATCHES/28 DAYS)
codeine sulfate	T1	PA
DEMEROL	T3	PA
DILAUDID 0.2 MG/ML SYRINGE	T3	PA
DILAUDID 0.5 MG/0.5 ML SYRINGE	T3	PA
DILAUDID 1 MG/ML SYRINGE	T3	PA
DILAUDID 2 MG/ML SYRINGE	T3	PA
DILAUDID 4 MG/ML SYRINGE	T3	

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List of Prescription Medications

ANALGESICS (Pain Relief and Inflammatory Disease) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
OPIOID ANALGESICS *(cont.)*		
fentanyl	T1	PA
fentanyl 1 mg/100 ml-0.9% nacl	T1	
FENTANYL 1 MG/100 ML-0.9% NACL	T1	
FENTANYL 1,000 MCG/100 ML-NS	T3	
FENTANYL 1,000MCG/100-0.9%NACL	T1	
fentanyl 1,000mcg/50-0.9% nacl	*T1*	
fentanyl 1,250mcg/250-0.9%nacl	*T1*	
fentanyl 10 mcg/ml-0.9% nacl	*T1*	
fentanyl 100 mcg/2 ml carpujct	*T1*	
FENTANYL 100 MCG/2 ML CARPUJCT	T1	
fentanyl 100 mcg/2 ml syringe	T1	
fentanyl 2 mcg-bup 0.0625%-ns	T1	
FENTANYL 2 MCG-BUP 0.0625%-NS	T1	
FENTANYL 2 MCG-BUPIV 0.1%-NS	T1	
fentanyl 2 mcg-bupiv 0.125%-ns	T1	
FENTANYL 2 MCG-BUPIV 0.125%-NS	T1	
FENTANYL 2 MCG-BUPIV 0.125%-NS	T3	
FENTANYL 2 MCG-BUPIVAC 0.1%-NS	T1	
fentanyl 2,000mcg/100-0.9%nacl	T1	
FENTANYL 2,500 MCG/50 ML SYRNG	T1	
fentanyl 2,500 mcg/50 ml-ns	T1	
FENTANYL 2,500MCG/250-0.9%NACL	T1	
FENTANYL 2,750 MCG/55 ML SYRNG	T1	
fentanyl 2.5mg/250ml-0.9% nacl	T1	
FENTANYL 2.5MG/250ML-0.9% NACL	T1	
FENTANYL 250 MCG/5 ML SYRINGE	T1	
FENTANYL 4 MCG-BUPIV 0.125%-NS	T1	
fentanyl 5,000mcg/250-0.9%nacl	T1	
FENTANYL 500 MCG/50ML-0.9%NACL	T1	
FENTANYL 550 MCG/55ML-0.9%NACL	T1	
FENTANYL CIT 400 MCG BUCCAL TB	T1	PA

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List of Prescription Medications

ANALGESICS (Pain Relief and Inflammatory Disease) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
OPIOID ANALGESICS *(cont.)*		
FENTANYL CIT 600 MCG BUCCAL TB	T1	PA
FENTANYL CIT 800 MCG BUCCAL TB	T1	PA
fentanyl cit otfc 1,600 mcg (Actiq)	T1	PA
fentanyl citrate otfc 200 mcg	T1	PA
fentanyl citrate otfc 400 mcg	T1	PA
fentanyl citrate otfc 800 mcg	T1	PA
fentanyl/ropivacaine/ns/pf	T1	
FENTANYL-ROPIVACAINE-0.9% NACL	T1	
hydrocodone bitartrate	T1	PA
hydrocodone bitartrate (Hysingla Er)	T1	PA
hydromorphone 0.2 mg/ml syring	T1	PA
HYDROMORPHONE 0.25 MG/0.5 ML	T3	PA
HYDROMORPHONE 0.5 MG/0.5 ML	T3	PA
hydromorphone 0.5 mg/0.5ml syr	T1	PA
hydromorphone 1 mg/ml carpujct	T1	PA
hydromorphone 1 mg/ml solution (Dilaudid)	T1	PA
hydromorphone 1 mg/ml syringe	T1	PA
HYDROMORPHONE 1 MG/ML VIAL	T3	PA
HYDROMORPHONE 1 MG/ML-NS SYRNG (*hydromorphone hcl/0.9% nacl/pf*)	T3	PA
hydromorphone 10 mg/50 ml-ns	T1	PA
HYDROMORPHONE 10 MG/50 ML-NS	T3	PA
HYDROMORPHONE 10 MG/50 ML-NS *(hydromorphone hcl/0.9% nacl/pf)*	T3	PA
hydromorphone 10 mg/50 ml-ns (Hydromorphone Hcl-0.9% Nacl)	T1	PA
hydromorphone 10 mg/ml ampule	T1	PA
hydromorphone 10 mg/ml vial	T1	PA
hydromorphone 15 mg/30 ml-ns	T1	
hydromorphone 2 mg tablet (Dilaudid)	T1	PA
hydromorphone 2 mg/ml carpujct	T1	PA
hydromorphone 2 mg/ml syringe	T1	PA
hydromorphone 2 mg/ml vial	T1	PA
HYDROMORPHONE 2 MG/ML-NS SYRNG	T3	PA
HYDROMORPHONE 20 MG/100 ML-NS	T3	PA
HYDROMORPHONE 25 MG/50 ML-NS	T3	PA
hydromorphone 3 mg suppos	T1	PA
HYDROMORPHONE 30 MG/30 ML-NS	T3	

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List of Prescription Medications

ANALGESICS (Pain Relief and Inflammatory Disease) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
OPIOID ANALGESICS *(cont.)*		
hydromorphone 4 mg tablet (Dilaudid)	T1	PA
hydromorphone 4 mg/ml carpujct	T1	PA
HYDROMORPHONE 4 MG/ML VIAL	T3	PA
hydromorphone 40 mg/20 ml vial	T1	PA
hydromorphone 5 mg/5 ml soln (Dilaudid)	T1	PA
hydromorphone 50 mg/5 ml amp	T1	PA
hydromorphone 50 mg/5 ml vial	T1	PA
HYDROMORPHONE 50 MG/50 ML-NS	T3	PA
hydromorphone 500 mg/50 ml vl	T1	PA
HYDROMORPHONE 55 MG/55 ML-NS	T3	PA
HYDROMORPHONE 6 MG/30 ML-NS *(hydromorphone hcl/0.9% nacl/pf)*	T3	PA
hydromorphone 8 mg tablet (Dilaudid)	T1	PA
hydromorphone hcl	T1	PA
hydromorphone hcl 1 mg/ml amp	T1	PA
HYDROMORPHONE HCL-WATER	T3	PA
HYSINGLA ER (*hydrocodone bitartrate*)	T2	PA
INFUMORPH	T3	PA
LAZANDA	T3	PA
meperidine hcl	T1	PA
meperidine hcl/pf	T1	PA
methadone hcl	T1	PA
METHADONE HCL-0.9% NACL	T3	
MITIGO	T3	PA
MITIGO *(morphine sulfate/pf)*	T3	PA
MORPHINE 1 MG/2 ML SYRINGE	T3	PA
MORPHINE 1 MG/ML-0.9% NACL SYR (*morphine sulfate/0.9% nacl/pf*)	T3	PA
MORPHINE 10 MG/0.7 ML AUTO-INJ	T3	PA
morphine 10 mg/10 ml vial	T1	PA
morphine 10 mg/ml carpuject	T1	PA
MORPHINE 10 MG/ML SYRINGE	T3	PA
morphine 100mg/100ml-0.9% nacl	T1	PA
MORPHINE 100MG/100ML-0.9% NACL	T3	PA
MORPHINE 100MG/100ML-0.9% NACL *(morphine sulfate/0.9% nacl/pf)*	T3	
morphine 2 mg/2 ml-0.9% nacl	T1	PA

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List of Prescription Medications

ANALGESICS (Pain Relief and Inflammatory Disease) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
OPIOID ANALGESICS *(cont.)*		
MORPHINE 2 MG/2 ML-0.9% NACL *(morphine sulfate/0.9% nacl/pf)*	T3	PA
morphine 2 mg/2 ml-nacl syring	T1	PA
morphine 2 mg/ml carpuject	T1	PA
morphine 2 mg/ml syringe	T1	PA
MORPHINE 2 MG/ML SYRINGE	T3	PA
MORPHINE 2 MG/ML-0.9% NACL SYR *(morphine sulfate/0.9% nacl/pf)*	T3	PA
morphine 30 mg/30 ml pca vial	T1	PA
morphine 30 mg/30 ml-0.9% nacl	T1	PA
morphine 30 mg/30 ml-nacl syrg	T1	PA
morphine 4 mg/ml carpuject	T1	PA
morphine 4 mg/ml syringe	T1	PA
MORPHINE 4 MG/ML-0.9% NACL SYR *(morphine sulfate/0.9% nacl/pf)*	T3	PA
morphine 5 mg/10 ml vial	T1	PA
morphine 5 mg/5 ml-0.9% nacl	T1	PA
morphine 50 mg/50 ml-0.9% nacl	T1	PA
MORPHINE 50 MG/50 ML-0.9% NACL	T3	PA
MORPHINE 50 MG/50 ML-0.9% NACL *(morphine sulfate/0.9% nacl/pf)*	T3	
morphine 50 mg/50 ml-nacl syrg	T1	
MORPHINE 500MG/100ML-0.9% NACL	T3	PA
MORPHINE 55 MG/55 ML-0.9% NACL	T3	PA
morphine sulf 1,000 mg/20 ml	T1	PA
morphine sulf 10 mg suppos	T1	PA
morphine sulf 10 mg/5 ml cup	T1	PA
morphine sulf 10 mg/5 ml soln	T1	PA
morphine sulf 100 mg/5 ml conc	T1	PA
morphine sulf 2,500 mg/50 ml	T1	PA
morphine sulf 20 mg suppos	T1	PA
morphine sulf 20 mg/5 ml soln	T1	PA
morphine sulf 30 mg suppos	T1	PA
morphine sulf 5 mg suppos	T1	PA
morphine sulfate	T1	PA
morphine sulfate (Ms Contin)	T1	PA
morphine sulfate 10 mg/ml vial	T1	PA

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
OPIOID ANALGESICS *(cont.)*		
MORPHINE SULFATE 10 MG/ML VIAL (*morphine sulfate*)	T3	PA
MORPHINE SULFATE 2 MG/ML VIAL	T3	PA
morphine sulfate 4 mg/ml vial	T1	PA
MORPHINE SULFATE 4 MG/ML VIAL	T3	PA
MORPHINE SULFATE 5 MG/ML VIAL (*morphine sulfate*)	T3	PA
morphine sulfate 50 mg/ml vial	T1	PA
MORPHINE SULFATE 8 MG/ML VIAL	T3	PA
morphine sulfate ir 15 mg tab	T1	PA
morphine sulfate ir 30 mg tab	T1	PA
morphine sulfate/pf	T3	PA
MS CONTIN (*morphine sulfate*)	T3	PA
nalbuphine hcl	T1	
NUCYNTA	T3	PA
NUCYNTA ER	T3	PA
OLINVYK	T3	PA
opium/belladonna alkaloids	T1	PA
OXAYDO	T3	PA
oxycodone hcl (ir) 10 mg tab	T1	PA
oxycodone hcl (ir) 15 mg tab (Roxicodone)	T1	PA
oxycodone hcl (ir) 20 mg tab	T1	PA
oxycodone hcl (ir) 30 mg tab (Roxicodone)	T1	PA
oxycodone hcl (ir) 5 mg cap	T1	PA
oxycodone hcl (ir) 5 mg tablet (Roxicodone)	T1	PA
oxycodone hcl 100 mg/5 ml conc	T1	PA
oxycodone hcl 5 mg/5 ml cup	T1	PA
oxycodone hcl 5 mg/5 ml soln	T1	PA
OXYCODONE HCL ER	T1	PA
oxymorphone hcl	T1	PA
pentazocine hcl/naloxone hcl	T1	PA
ROXYBOND	T3	PA
tramadol er 100 mg tablet	T1	QL(1 TAB/DAY)
tramadol er 200 mg tablet	T1	QL(1 TAB/DAY)
tramadol er 300 mg tablet	T1	QL(1 TAB/DAY)
tramadol hcl 100 mg tablet	T1	QL(4 TABS/DAY)
tramadol hcl 50 mg tablet	T1	QL(8 TABS/DAY)

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ANALGESICS (Pain Relief and Inflammatory Disease) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
OPIOID ANALGESICS *(cont.)*		
TRAMADOL HCL 75 MG TABLET	T3	QL(5 TABS/DAY)
TRAMADOL HCL ER 100 MG CAPSULE	T1	QL(1 CAP/DAY)
tramadol hcl er 100 mg tablet	T1	QL(1 TAB/DAY)
TRAMADOL HCL ER 200 MG CAPSULE	T1	QL(1 CAP/DAY)
tramadol hcl er 200 mg tablet	T1	QL(1 TAB/DAY)
TRAMADOL HCL ER 300 MG CAPSULE	T1	QL(1 CAP/DAY)
tramadol hcl er 300 mg tablet	T1	QL(1 TAB/DAY)
XTAMPZA ER	T2	PA
OPIOID, SALICYLATE. ANALGESIC, BARBITUATE, XANTHINE		
codeine/butalbital/asa/caffein	T1	PA
OPIOID, NON-SALICYL. ANALGESIC, BARBITUATE, XANTHINE		
butalbit/acetamin/caff/codeine	T1	PA
butalbit/acetamin/caff/codeine (Fioricet With Codeine)	T1	PA
SKELETAL MUSCLE RELAXANT, SALICYLAT, OPIOID ANALGESC		
carisoprodol/aspirin/codeine	T1	PA
ANALGESICS (Urinary Tract Conditions)		
URINARY TRACT ANALGESIC AGENTS		
ELMIRON	T3	
RIMSO-50	T3	
ANESTHETICS (Miscellaneous)		
GENERAL ANESTHETICS, INHALANT		
desflurane	T1	
isoflurane	T1	
isoflurane	T3	
sevoflurane (Ultane)	T1	
SUPRANE	T3	
ULTANE (*sevoflurane*)	T3	
GENERAL ANESTHETICS, INJECTABLE		
AMIDATE (*etomidate*)	T3	
BREVITAL SODIUM	T3	
DIPRIVAN (*propofol*)	T3	
etomidate (Amidate)	T1	
KETALAR	T3	
KETALAR (*ketamine hcl*)	T3	
ketamine hcl	T1	

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ANESTHETICS (Miscellaneous) *(cont.)*		
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GENERAL ANESTHETICS, INJECTABLE-BENZODIAZEPINE TYPE		
KETAMINE HCL	T1	
ketamine hcl (Ketalar)	T1	
ketamine hcl in 0.9 % nacl	T1	
KETAMINE HCL-0.9% NACL	T1	
methohexital sodium	T1	
METHOHEXITAL-STERILE WATER	T1	
propofol (Diprivan)	T1	
midazolam hcl	T1	
midazolam hcl/pf	T1	
MIDAZOLAM HCL-0.9% NACL	T1	
MIDAZOLAM HCL-D5W	T1	
MIDAZOLAM-0.9% NACL	T1	
ANESTHETICS (Pain Relief and Inflammatory Disease)		
LOCAL ANESTHETICS		
ARTICADENT DENTAL	T3	
BUFFERED LIDOCAINE	T3	
BUFFERED LIDOCAINE (*lidocaine with 8.4% sod bicarb*)	T3	
bupivacaine hcl (Marcaine)	T1	
bupivacaine hcl (Sensorcaine)	T1	
bupivacaine hcl in dextrose/pf	T1	
bupivacaine hcl/epinephrine (Marcaine-Epinephrine)	T1	
bupivacaine hcl/epinephrine/pf (Marcaine-Epinephrine)	T1	
bupivacaine hcl/epinephrine/pf (Sensorcaine-Mpf Epinephrine)	T1	
bupivacaine hcl/pf	T1	
bupivacaine hcl/pf (Marcaine)	T1	
bupivacaine hcl/pf (*Sensorcaine-Mpf*)	T1	
bupivacaine hcl/pf (Sensorcaine-Mpf)	T3	
BUPIVACAINE HCL-0.9% NACL	T1	
chloroprocaine hcl/pf (Nesacaine-Mpf)	T1	
CITANEST FORTE DENTAL	T3	
CITANEST PLAIN DENTAL	T3	
EXPAREL	T3	
lidocaine hcl	T1	

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
LOCAL ANESTHETICS *(cont.)*		
LIDOCAINE HCL	T1	
lidocaine hcl (Xylocaine)	T1	
lidocaine hcl/epinephrine (Xylocaine With Epinephrine)	T1	
lidocaine hcl/epinephrine bit	T1	
lidocaine hcl/epinephrine bit	T3	
lidocaine hcl/epinephrine/pf	T1	
lidocaine hcl/epinephrine/pf (Xylocaine With Epinephrine)	T1	
lidocaine hcl/epinephrine/pf (Xylocaine-Mpf With Epinephrine)	T1	
lidocaine hcl/pf	T1	
lidocaine hcl/pf (Xylocaine-Mpf)	T1	
lidocaine in nacl,iso-osmot/pf	T1	
MARCAINE *(bupivacaine hcl)*	T3	
MARCAINE *(bupivacaine hcl/pf)*	T3	
MARCAINE SPINAL	T3	
MARCAINE-EPINEPHRINE	T3	
MARCAINE-EPINEPHRINE *(bupivacaine hcl/epinephrine)*	T3	
MARCAINE-EPINEPHRINE *(bupivacaine hcl/epinephrine/pf)*	T3	
mepivacaine hcl	T1	
mepivacaine hcl/pf	T1	
NAROPIN	T3	
NESACAINE	T3	
NESACAINE-MPF *(chloroprocaine hcl/pf)*	T3	
ORABLOC	T3	
POLOCAINE	T1	
POSIMIR	T3	
ropivacaine 0.2% 20 mg/10 ml	T1	
ropivacaine 0.2% 200 mg/100 ml	T1	
ropivacaine 0.2% 40 mg/20 ml	T1	
ropivacaine 0.2% 400 mg/200 ml	T1	
ropivacaine 0.5% 100 mg/20 ml	T1	
ROPIVACAINE 0.5% 1000 MG/200ML	T3	
ropivacaine 0.5% 150 mg/30 ml	T1	
ropivacaine 0.5% 500 mg/100 ml	T1	
ROPIVACAINE 0.5% 500 MG/100 ML	T3	
ropivacaine 0.75% 150 mg/20 ml	T1	

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
LOCAL ANESTHETICS *(cont.)*		
ropivacaine 1% 100 mg/10 ml vl	T1	
ropivacaine 1% 200 mg/20 ml vl	T1	
ropivacaine hcl 0.5% syringe	T1	
ROPIVACAINE HCL 0.5% SYRINGE	T1	
ROPIVACAINE HCL-0.9% NACL	T1	
ROPIVACAINE HCL-NACL	T1	
SENSORCAINE 0.25% VIAL (bupivacaine hcl)	T3	
sensorcaine 0.5% vial (Marcaine)	T1	
SENSORCAINE WITH DEXTROSE	T1	
SENSORCAINE-MPF 0.25% VIAL *(bupivacaine hcl/pf)*	T3	
*sensorcaine-mpf 0.5% vial (*Marcaine*)*	T1	
SENSORCAINE-MPF 0.75% VIAL *(bupivacaine hcl/pf)*	T3	
SENSORCAINE-MPF EPINEPHRINE	T3	
SENSORCAINE-MPF EPINEPHRINE (*bupivacaine hcl/epinephrine/pf*)	T3	
tetracaine hcl/pf	T1	
XYLOCAINE (*lidocaine hcl*)	T3	
XYLOCAINE WITH EPINEPHRINE (*lidocaine hcl/epinephrine*)	T3	
XYLOCAINE WITH EPINEPHRINE *(lidocaine hcl/epinephrine/pf)*	T3	
XYLOCAINE-MPF	T3	
XYLOCAINE-MPF *(lidocaine hcl/pf)*	T3	
XYLOCAINE-MPF WITH EPINEPHRINE	T3	
XYLOCAINE-MPF WITH EPINEPHRINE (*lidocaine hcl/epinephrine/pf*)	T3	
ZINGO	T3	
ZYNRELEF	T3	
L.E.T. (LIDO-EPINEPH-TETRA)	T3	
lidocaine 5% ointment	T1	QL(145 GMS/30 DAYS)
*lidocaine 5% patch (*Lidocan li*)*	T1	
lidocaine 5% patch (Lidoderm)	T1	
lidocaine hcl	T1	
lidocaine/prilocaine	T1	
ZTLIDO	T2	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANESTHETICS (Urinary Tract Conditions)		
URINARY TRACT ANESTHETIC/ANALGESIC AGNT (AZO-DYE)		
phenazopyridine hcl (Pyridium)	T1	
ANTI-ALLERGY (Allergy/Nasal Sprays)		
MAST CELL STABILIZERS		
cromolyn 100 mg/5 ml oral conc (Gastrocrom)	T1	
ANTIALLERGY (Skin Conditions)		
ANTIPRURITICS, SYSTEMIC		
KORSUVA	T3	PA SP
ANTI-ARTHRITICS (Pain Relief and Inflammatory Disease)		
ANALGESIC/ANTIPYRETICS, SALICYLATES		
DISALCID (*salsalate*)	T3	HD
salsalate (Disalcid)	T1	HD
ANTI-ARTHRITIC AND CHELATING AGENTS		
DEPEN (*penicillamine*)	T3	PA QL(6 TABS/DAY) SP
penicillamine 250 mg capsule (Cuprimine)	T1	PA QL(6 CAPS/DAY) SP
penicillamine 250 mg tablet (Depen)	T1	PA QL(6 TABS/DAY) SP
ANTI-ARTHRITIC, FOLATE ANTAGONIST AGENTS		
OTREXUP	T2	PA
ANTI-INFLAMMATORY, PYRIMIDINE SYNTHESIS INHIBITOR		
leflunomide (Arava)	T1	HD
ANTI-INFLAMMATORY, PHOSPHODIESTERASE-4(PDE4) INHIB.		
OTEZLA 10-20 MG STARTER 28 DAY	T2	PA QL(55 TABS/365 DAYS) SP HD
OTEZLA 10-20-30MG START 28 DAY	T2	PA QL(55 TABS/365 DAYS) SP HD
OTEZLA 20 MG TABLET	T2	PA QL(2 TABS/DAY) SP HD
OTEZLA 30 MG TABLET	T2	PA QL(2 TABS/DAY) SP HD
OTEZLA XR 75 MG TABLET	T2	PA QL(1 TAB/DAY) SP HD
OTEZLA XR INITIATION PK 28 DAY	T2	PA QL(41 TABS/365 DAYS) SP HD
ANTI-INFLAMMATORY/ANTIARTHRITICS AGENTS, MISC.		
DUROLANE	T2	PA SP HD
EUFLEXXA	T2	PA SP HD
GEL-ONE	T3	PA SP HD
GELSYN-3	T2	PA SP HD
GENVISC 850	T3	PA SP

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ANTI-ARTHRITICS (Pain Relief and Inflammatory Disease) *(con't.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-INFLAMMATORY/ANTIARTHRITICS AGENTS, MISC. *(con't.)*		
HYALGAN	T3	PA SP HD
HYMOVIS	T3	PA SP HD
HYMOVIS ONE	T3	PA SP HD
MONOVISC	T3	PA SP HD
ORTHOVISC	T3	PA SP HD
SUPARTZ FX	T3	PA SP HD
SYNOJOYNT	T3	PA SP
SYNVISC	T3	PA SP HD
SYNVISC-ONE	T3	PA SP HD
TRILURON	T3	PA SP HD
TRIVISC	T3	PA SP
VISCO-3	T3	PA SP HD
ANTI-INFLAMMATORY, SEL.COSTIM.MOD., T-CELL INHIBITOR		
ORENCIA 125 MG/ML SYRINGE	T3	PA QL(4 SYR/AUTO-INJ/28 DAYS) SP HD
ORENCIA 250 MG VIAL	T3	PA SP HD
ORENCIA 50 MG/0.4 ML SYRINGE	T3	PA QL(4 SYR/AUTO-INJ/28 DAYS) SP HD
ORENCIA 87.5 MG/0.7 ML SYRINGE	T3	PA QL(4 SYR/AUTO-INJ/28 DAYS) SP HD
ORENCIA CLICKJECT	T3	PA QL(4 SYR/AUTO-INJ/28 DAYS) SP HD
COLCHICINE		
colchicine 0.6 mg capsule (Mitigare)	T1	HD
colchicine 0.6 mg tablet (Colcrys)	T1	HD
MITIGARE (colchicine)	T2	
HYPERURICEMIA TX - URATE-OXIDASE ENZYME-TYPE		
ELITEK	T2	SP
KRYSTEXXA	T3	PA SP
HYPERURICEMIA TX - XANTHINE OXIDASE INHIBITORS		
allopurinol 100 mg tablet (Zyloprim)	T1	HD
allopurinol 300 mg tablet	T1	HD
allopurinol sodium	T1	
allopurinol sodium	T3	
febuxostat 40 mg tablet (Uloric)	T1	QL(1 TAB/DAY) HD
febuxostat 80 mg tablet (Uloric)	T1	HD
JANUS KINASE (JAK) INHIBITORS		
OLUMIANT	T3	PA QL(30 TABS/30 DAYS) SP HD
RINVOQ	T2	PA QL(1 TAB/DAY) SP HD

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ANTI-ARTHRITICS (Pain Relief and Inflammatory Disease) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
JANUS KINASE (JAK) INHIBITORS *(cont.)*		
RINVOQ LQ	T2	PA QL(12 MLS/DAY) SP HD
XELJANZ 1 MG/ML SOLUTION	T2	PA QL(480 MLS/30 DAYS) SP HD
XELJANZ 10 MG TABLET	T2	PA QL(2 TABS/DAY) SP HD
XELJANZ 5 MG TABLET	T2	PA QL(2 TABS/DAY) SP HD
XELJANZ XR	T2	PA QL(1 TAB/DAY) SP HD
NSAID ANALGESIC AND NON-SALICYLATE ANALGESIC COMB		
COMBOGESIC IV	T3	
NSAIDS (COX NON-SPEC.INHIB) AND PROSTAGLANDIN ANALOG		
ARTHROTEC 50 (*diclofenac sodium/misoprostol*)	T3	ST HD
ARTHROTEC 75 (*diclofenac sodium/misoprostol*)	T3	ST HD
diclofenac sodium/misoprostol (Arthrotec 50)	T1	HD
diclofenac sodium/misoprostol (Arthrotec 75)	T1	HD
NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE ANALGESICS		
ANAPROX DS (*naproxen sodium*)	T3	ST HD
CALDOLOR	T3	
DAYPRO (*oxaprozin*)	T3	ST HD
diclofenac sod dr 25 mg tab	T1	HD
diclofenac sod dr 50 mg tab	T1	HD
diclofenac sod dr 75 mg tab	T1	HD
diclofenac sod ec 25 mg tab	T1	HD
diclofenac sod ec 50 mg tab	T1	HD
diclofenac sod ec 75 mg tab	T1	HD
diclofenac sodium	T1	HD
EC-NAPROSYN (*naproxen*)	T3	ST HD
etodolac	T1	HD
etodolac (Lodine)	T1	HD
FELDENE (piroxicam)	T3	ST HD
fenoprofen 600 mg tablet (Nalfon)	T1	HD
flurbiprofen	T1	HD
ibuprofen	T1	HD
indomethacin	T1	HD
indomethacin 25 mg capsule	T1	HD
indomethacin 25 mg/5 ml susp (Indocin)	T1	HD

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE ANALGESICS *(cont.)*		
indomethacin 25 mg/5 ml susp (Indocin)	T1	HD
indomethacin 50 mg capsule	T1	HD
indomethacin 50 mg suppository (Indocin)	T1	HD
ketoprofen 50 mg capsule	T1	HD
ketoprofen 75 mg capsule	T1	HD
ketoprofen er 200 mg capsule	T1	HD
LODINE (*etodolac*)	T3	ST HD
meclofenamate sodium	T1	HD
meloxicam 15 mg tablet	T1	HD
meloxicam 7.5 mg tablet	T1	HD
nabumetone (Relafen)	T1	HD
NALFON 600 MG TABLET *(fenoprofen calcium)*	T3	ST HD
NAPROSYN 500 MG TABLET *(naproxen)*	T3	ST HD
naproxen (Ec-Naprosyn)	T1	HD
naproxen 250 mg tablet	T1	HD
naproxen 375 mg tablet	T1	HD
naproxen 500 mg kit (Naprosyn)	T1	HD
naproxen 500 mg tablet (Naprosyn)	T1	HD
naproxen dr 375 mg tablet (Ec-Naprosyn)	T1	HD
naproxen dr 500 mg tablet (Ec-Naprosyn)	T1	HD
naproxen sodium	T1	HD
naproxen sodium (Anaprox Ds)	T1	HD
oxaprozin 600 mg caplet (Daypro)	T1	HD
oxaprozin 600 mg tablet (Daypro)	T1	HD
piroxicam	T1	HD
piroxicam (Feldene)	T1	HD
sulindac	T1	HD
tolmetin sodium	T1	HD
tolmetin sodium (Tolectin 600)	T1	HD
NSAIDS, CYCLOOXYGENASE-2(COX-2) SELECTIVE INHIBITOR		
celecoxib 100 mg capsule (Celebrex)	T1	QL(2 CAPS/DAY) HD
celecoxib 200 mg capsule (Celebrex)	T1	QL(2 CAPS/DAY) HD
celecoxib 400 mg capsule (Celebrex)	T1	QL(1 CAP/DAY) HD
celecoxib 50 mg capsule (Celebrex)	T1	QL(2 CAPS/DAY) HD

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List of Prescription Medications

ANTI-ARTHRITICS (Pain Relief and Inflammatory Disease) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
URICOSURIC AGENTS		
probenecid	T1	HD
probenecid/colchicine	T1	HD
ANTIASTHMATICS (Asthma/COPD/Respiratory)		
5-LIPOXYGENASE INHIBITORS		
zileuton	T1	HD
ANTICHOLINERGICS, ORALLY INHALED LONG ACTING		
INCRUSE ELLIPTA	T2	HD
SPIRIVA RESPIMAT	T2	QL(1 INHALER/30 DAYS) HD
tiotropium 18 mcg cap-inhaler (Spiriva Handihaler)	T1	HD
tiotropium 18 mcg cap-inhaler (Spiriva Handihaler)	T1	QL(1 INHALER/30 DAYS) HD
ANTICHOLINERGICS, ORALLY INHALED SHORT ACTING		
ATROVENT HFA	T2	HD
ipratropium bromide	T1	HD
BETA-ADRENERGIC AGENTS		
albuterol 2 mg/5 ml syrup cup	T1	HD
albuterol 8 mg/20 ml syrup cup	T1	HD
albuterol sulf 2 mg/5 ml syrup	T1	HD
albuterol sulfate 2 mg tab	T1	HD
albuterol sulfate 4 mg tab	T1	HD
albuterol sulfate er 4 mg tab	T1	HD
albuterol sulfate er 8 mg tab	T1	HD
terbutaline sulfate	T1	HD
BETA-ADRENERGIC AGENTS, INHALED, SHORT ACTING		
albuterol 100 mg/20 ml soln	T1	
albuterol 15 mg/3 ml solution	T1	
albuterol 2.5 mg/0.5 ml sol	T1	
albuterol 25 mg/5 ml solution	T1	
albuterol 5 mg/ml solution	T1	
albuterol 75 mg/15 ml soln	T1	
albuterol hfa 90 mcg inhaler	T1	QL(1 INHALER/30 DAYS)
albuterol sul 0.63 mg/3 ml sol	T1	
albuterol sul 1.25 mg/3 ml sol	T1	
albuterol sul 2.5 mg/3 ml soln	T1	
levalbuterol hcl (Xopenex Concentrate)	T1	
levalbuterol hcl (Xopenex)	T1	

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List of Prescription Medications

ANTIASTHMATICS (Asthma/COPD/Respiratory) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
BETA-ADRENERGIC AGENTS, INHALED, SHORT ACTING *(cont.)*		
XOPENEX *(levalbuterol hcl)*	T3	
XOPENEX CONCENTRATE (*levalbuterol hcl*)	T3	
BETA-ADRENERGIC AGENTS, INHALED, ULTRA-LONG ACTING		
STRIVERDI RESPIMAT	T2	QL(1 INHALER/30 DAYS) HD
BETA-ADRENERGIC AGENTS, ORALLY INHALED,LONG ACTING		
arformoterol tartrate (Brovana)	T1	QL(4 MLS/DAY) HD
formoterol fumarate (Perforomist)	T1	QL(240 MLS/30 DAYS) HD
BETA-ADRENERGIC AND ANTICHOLINERGIC COMBO, INHALED		
ANORO ELLIPTA 62.5-25 MCG INH	T2	QL(1 INHALER/30 DAYS) HD
COMBIVENT RESPIMAT	T2	QL(2 INHALERS/30 DAYS)
ipratropium/albuterol sulfate	T1	HD
STIOLTO RESPIMAT	T2	QL(1 INHALER/30 DAYS) HD
BETA-ADRENERGIC AND GLUCOCORTICOID COMBO, INHALED		
AIRSUPRA	T2	QL(2 GMS/28 DAYS) HD
budesonide/formoterol fumarate (Symbicort)	T1	QL(1 INHALER/30 DAYS) HD
DULERA 100 MCG-5 MCG INHALER	T2	QL(1 INHALER/30 DAYS) HD
DULERA 200 MCG-5 MCG INHALER	T2	QL(1 INHALER/30 DAYS) HD
DULERA 50 MCG-5 MCG INHALER	T2	QL(1 INHALER/30 DAYS) HD
fluticasone propion/salmeterol (Advair Diskus)	T1	QL(1 INHALER/30 DAYS)
fluticasone-salmeterol 100-50 (Advair Diskus)	T1	QL(1 INHALER/30 DAYS) HD
fluticasone-salmeterol 250-50 (Advair Diskus)	T1	QL(1 INHALER/30 DAYS) HD
fluticasone-salmeterol 500-50 (Advair Diskus)	T1	QL(1 INHALER/30 DAYS) HD
GLUCOCORTICOIDS, ORALLY INHALED		
ALVESCO	T2	HD
ASMANEX HFA	T2	QL(1 INHALER/30 DAYS) HD
ASMANEX TWISTHALER 110 MCG #30	T2	QL(1 INHALER/30 DAYS) HD
ASMANEX TWISTHALER 220 MCG #14	T2	HD
ASMANEX TWISTHALER 220 MCG #30	T2	QL(1 INHALER/30 DAYS) HD
ASMANEX TWISTHALER 220 MCG #60	T2	QL(1 INHALER/30 DAYS) HD
ASMANEX TWISTHALR 220 MCG #120	T2	QL(1 INHALER/30 DAYS) HD
budesonide 0.25 mg/2 ml susp (Pulmicort)	T1	QL(4 MLS/DAY) HD

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List of Prescription Medications

ANTIASTHMATICS (Asthma/COPD/Respiratory) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
GLUCOCORTICOIDS, ORALLY INHALED *(cont.).*		
budesonide 0.5 mg/2 ml susp (Pulmicort)	T1	QL(4 MLS/DAY) HD
budesonide 1 mg/2 ml inh susp (Pulmicort)	T1	QL(2 MLS/DAY) HD
QVAR REDIHALER	T2	
INTERLEUKIN-5 (IL-5) ANTAGONISTS, MAB		
NUCALA	T2	PA SP HD
INTERLEUKIN-5 (IL-5) RECEPTOR ALPHA ANTAGONIST, MAB		
FASENRA	T2	PA SP HD
FASENRA PEN	T2	PA SP HD
LEUKOTRIENE RECEPTOR ANTAGONISTS		
ACCOLATE (zafirlukast)	T3	HD
montelukast sodium	T1	HD
montelukast sodium (Singulair)	T1	HD
zafirlukast (Accolate)	T1	HD
MAST CELL STABILIZERS, ORALLY INHALED		
cromolyn 20 mg/2 ml neb soln	T1	QL (480ml/30 days) HD
MONOCLONAL ANTIBODIES TO IMMUNOGLOBULIN E (IGE)		
XOLAIR	T2	PA SP HD
MUCOLYTICS		
acetylcysteine	T1	
PHOSPHODIESTERASE-4 (PDE4) INHIBITORS		
roflumilast 250 mcg tablet (Daliresp)	T3	QL (28 tabs/180 days) HD
roflumilast 500 mcg tablet (Daliresp)	T3	QL (2 tabs/day) HD
XANTHINES		
aminophylline	T1	
THEO-24	T3	HD
theophylline anhydrous	T1	HD
theophylline in dextrose 5 %	T1	
ANTIBIOTICS (Ear Medications)		
EAR PREPARATIONS, ANTIBIOTICS		
ciprofloxacin hcl	T1	
CORTISPORIN-TC	T3	
neomycin/polymyxin b/hydrocort	T1	
ofloxacin	T1	

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List of Prescription Medications

ANTIBIOTICS (Ear Medications) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
OTIC PREPARATIONS, ANTI-INFLAMMATORY-ANTIBIOTICS		
ciprofloxacin hcl/dexameth	T1	
ciprofloxacin/hydrocortisone	T1	
OTOVEL	T3	
ANTIBIOTICS (Eye Conditions)		
EYE ANTIBIOTIC AND GLUCOCORTICOID COMBINATIONS		
neomycin/bacit/p-myx/hydrocort	T1	
neomycin/polymyxin b/dexametha (Maxitrol)	T1	
neomycin/polymyxin b/hydrocort	T1	
TOBRADEX	T3	
TOBRADEX ST	T2	
tobramycin/dexamethasone	T1	
ZYLET	T3	
EYE SULFONAMIDES		
sulfacetamide sodium	T1	
sulfacetamide/prednisolone sp	T1	
OPHTHALMIC ANTIBIOTICS		
AZASITE	T2	
bacitracin	T1	
bacitracin/polymyxin b sulfate	T1	
BESIVANCE	T2	
ciprofloxacin hcl	T1	
erythromycin base	T1	
gatifloxacin	T1	
gentamicin sulfate	T1	
levofloxacin	T1	
moxifloxacin hcl	T1	
moxifloxacin hcl (Vigamox)	T1	
MOXIFLOXACIN HCL-BSS	T1	
MOXIFLOXACIN HCL-NACL	T1	
neomycin/bacitracin/polymyxinb	T1	
neomycin/polymyxn b/gramicidin	T1	
ofloxacin (Ocuflox)	T1	
polymyxin b sulf/trimethoprim	T1	
tobramycin 0.3% eye drop	T1	

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ANTIBIOTICS (Infections)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ABSORBABLE SULFONAMIDE ANTIBACTERIAL AGENTS		
BACTRIM (*sulfamethoxazole-trimethoprim*)	T3	
BACTRIM DS (*sulfamethoxazole-trimethoprim*)	T3	
sulfadiazine	T1	
sulfamethoxazole/trimethoprim	T1	
sulfamethoxazole/trimethoprim	T3	
sulfamethoxazole/trimethoprim (Bactrim Ds)	T1	
sulfamethoxazole/trimethoprim (Bactrim)	T1	
AMINOGLYCOSIDE ANTIBIOTICS		
amikacin sulfate	T1	
ARIKAYCE	T3	PA SP
gentamicin in nacl, iso-osm	T1	
gentamicin sulfate	T1	
GENTAMICIN SULFATE	T1	
GENTAMICIN SULFATE IN NS	T1	
gentamicin sulfate/pf	T1	
KITABIS PAK	T3	PA QL(10 MLS/DAY) SP HD
neomycin sulfate	T1	
STREPTOMYCIN SULFATE	T1	
TOBI PODHALER	T2	PA QL(8 CAPS/DAY) SP HD
tobramycin 300 mg/4 ml ampule (Bethkis)	T1	PA QL(8 MLS/DAY) SP HD
tobramycin 300 mg/5 ml ampule (Tobi)	T1	PA QL(10 MLS/DAY) SP HD
TOBRAMYCIN PAK 300 MG/5 ML	T3	PA QL(10 MLS/DAY) SP HD
tobramycin sulfate	T1	
tobramycin/sodium chloride	T1	
ZEMDRI	T3	
ANAEROBIC ANTIPROTOZOAL-ANTIBACTERIAL AGENTS		
FLAGYL (*metronidazole*)	T3	
LIKMEZ	T3	PA
metronidazole 250 mg tablet	T1	
metronidazole 375 mg capsule (Flagyl)	T1	
metronidazole 500 mg tablet	T1	
metronidazole 500 mg/100 ml	T1	
metronidazole/sodium chloride	T3	
ANTIBIOTIC, ANTIBACTERIAL, MISC.		
fosfomycin tromethamine	T1	

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List of Prescription Medications

ANTIBIOTICS (Infections) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIBIOTIC, ANTIBACTERIAL, MISC *(cont.)*.		
methenamine hippurate	T1	
methenamine mandelate	T1	
PRIMSOL	T3	
trimethoprim	T1	
ANTIBIOTICS, MISCELLANEOUS, OTHER		
bacitracin	T1	
ANTILEPROTICS		
dapsone 100 mg tablet	T1	
dapsone 25 mg tablet	T1	
THALOMID	T2	PA SP HD
ANTI-MYCOBACTERIUM AGENTS		
ethambutol hcl	T1	HD
isoniazid	T1	HD
ANTI-MYCOBACTERIUM AGENTS		
PASER	T3	HD
pyrazinamide	T1	HD
rifabutin (Mycobutin)	T1	HD
ANTITUBERCULAR ANTIBIOTICS		
cycloserine	T1	
PRETOMANID	T3	PA QL(1 TAB/DAY)
PRIFTIN	T3	
RIFADIN (*rifampin*)	T3	
RIFAMATE	T3	
rifampin	T1	
rifampin (Rifadin)	T1	
RIFATER	T3	
SIRTURO	T3	SP
BETALACTAMS		
AZACTAM (*aztreonam*)	T3	
aztreonam (Azactam)	T1	
CAYSTON	T3	PA QL(3 MLS/DAY) SP HD
XACDURO	T3	

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List of Prescription Medications

ANTIBIOTICS (Infections) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTITUBERCULAR ANTIBIOTICS *(cont.)*		
ertapenem sodium	T1	
imipenem/cilastatin sodium	T1	
imipenem/cilastatin sodium (Primaxin)	T1	
meropenem 2 gram vial	T1	
meropenem iv 1 gm vial	T1	
meropenem iv 500 mg vial	T1	
MEROPENEM-0.9% NACL	T1	
PRIMAXIN (*imipenem/cilastatin sodium*)	T3	
RECARBRIO	T3	
VABOMERE	T3	
CEPHALOSPORIN ANTIBIOTICS - IST GENERATION		
cefadroxil	T1	
cefazolin 1 g/50 ml-dextrose	T1	
cefazolin 1 gm add-van vial	T1	
cefazolin 1 gm vial	T1	
cefazolin 10 gm vial	T1	
CEFAZOLIN 2 G/100 ML-DEXTROSE	T1	
cefazolin 2 g/50 ml-dextrose	T1	
CEFAZOLIN 2 GM VIAL	T3	
cefazolin 20 gm bulk vial	T1	
CEFAZOLIN 3 G/150 ML-DEXTROSE	T3	
CEFAZOLIN 3 G/50 ML-DEXTROSE	T3	
cefazolin 3 gm vial	T1	
CEFAZOLIN 3 GM VIAL	T3	
cefazolin 500 mg vial	T1	
cefazolin sod 100 gm bulk bag	T1	
cefazolin sod 300 gm bulk bag	T1	
CEFAZOLIN SODIUM-0.9% NACL	T1	
CEFAZOLIN SODIUM-STERILE WATER	T1	
cephalexin	T1	

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List of Prescription Medications

ANTIBIOTICS (Infections) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
CEPHALOSPORIN ANTIBIOTICS - 2ND GENERATION		
cefaclor	T1	
CEFOTAN	T3	
cefotetan disodium	T1	
cefoxitin sodium	T1	
cefoxitin sodium/dextrose,iso	T1	
cefprozil	T1	
cefuroxime axetil	T1	
cefuroxime sodium	T1	
CEPHALOSPORIN ANTIBIOTICS - 3RD GENERATION		
AVYCAZ	T3	
cefdinir	T1	
cefixime	T1	
cefotaxime sodium	T1	
cefpodoxime proxetil	T1	
ceftazidime	T1	
CEFTAZIDIME	T1	
CEFTRIAXONE	T1	
ceftriaxone in is-osm dextrose	T1	
ceftriaxone sodium	T1	
CEPHALOSPORIN ANTIBIOTICS - 4TH GENERATION		
cefepime hcl	T1	
CEFEPIME HCL	T1	
cefepime in iso-osm dextrose	T1	
CEFEPIME-DEXTROSE	T1	
CEPHALOSPORINS - 5TH GENERATION		
TEFLARO	T3	
ZERBAXA	T3	
FETROJA	T3	
CHLORAMPHENICOL ANTIBIOTICS AND DERIVATIVES		
chloramphenicol sod succinate	T1	
GLYCYLCYCLINES		
tigecycline (Tygacil)	T1	
TYGACIL (*tigecycline*)	T3	
LINCOSAMIDE ANTIBIOTICS		
CLEOCIN HCL (clindamycin hcl)	T3	

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List of Prescription Medications

ANTIBIOTICS (Infections) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
LINCOSAMIDE ANTIBIOTICS		
CLEOCIN PEDIATRIC (*clindamycin palmitate hcl*)	T3	
CLEOCIN PHOSPHATE (*clindamycin phosphate*)	T3	
clindamycin 300 mg/50 ml-d5w	T1	
CLINDAMYCIN 300 MG/50 ML-D5W	T3	
clindamycin 600 mg/50 ml-d5w	T1	
CLINDAMYCIN 600 MG/50 ML-D5W	T3	
clindamycin 900 mg/50 ml-d5w	T1	
CLINDAMYCIN 900 MG/50 ML-D5W	T3	
clindamycin hcl (Cleocin Hcl)	T1	
clindamycin palmitate hcl (Cleocin Pediatric)	T1	
clindamycin phosphate (Cleocin Phosphate)	T1	
CLINDAMYCIN-0.9% NACL	T1	
LINCOCIN	T3	
lincomycin hcl	T1	
LIPOGLYCOPEPTIDE ANTIBIOTICS		
dalbavancin hcl	T1	
DALVANCE	T3	
KIMYRSA	T3	
ORBACTIV	T3	
VIBATIV	T3	
MACROLIDE ANTIBIOTICS		
azithromycin	T1	
azithromycin (Zithromax Tri-Pak)	T1	
azithromycin (Zithromax)	T1	
clarithromycin	T1	
DIFICID 200 MG TABLET *(fidaxomicin)*	T3	QL(28 TABS/28 DAYS)
DIFICID 40 MG/ML SUSPENSION	T3	QL(5 MLS/DAY)
ERYPED 200 *(erythromycin ethylsuccinate)*	T3	
ERY-TAB *(erythromycin base)*	T3	
ERYTHROCIN LACTOBIONATE	T3	
ERYTHROCIN LACTOBIONATE *(erythromycin lactobionate)*	T3	
erythromycin base	T1	
erythromycin base	T3	
erythromycin base (Ery-Tab)	T1	

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ANTIBIOTICS (Infections) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
MACROLIDE ANTIBIOTICS		
erythromycin ethylsuccinate	T1	
erythromycin ethylsuccinate	T3	
erythromycin ethylsuccinate (E.E.S. 200)	T1	
*erythromycin ethylsuccinate (*Eryped 200*)*	T1	
*erythromycin ethylsuccinate (*Eryped 400*)*	T1	
*erythromycin lactobionate (*Erythrocin Lactobionate*)*	T1	
erythromycin stearate	T1	
*fidaxomicin (*Dificid*)*	T1	QL(28 TABS/28 DAYS)
ZITHROMAX *(azithromycin)*	T3	
ZITHROMAX TRI-PAK *(azithromycin)*	T3	
NITROFURAN DERIVATIVES ANTIBACTERIAL AGENTS		
FURADANTIN (*nitrofurantoin*)	T3	
MACROBID (*nitrofurantoin monohyd/m-cryst*)	T3	
nitrofurantoin 25 mg/5 ml susp (Furadantin)	T1	
nitrofurantoin mcr 100 mg cap	T1	
nitrofurantoin mcr 25 mg cap	T1	
nitrofurantoin mcr 50 mg cap	T1	
nitrofurantoin monohyd/m-cryst (Macrobid)	T1	
OXAZOLIDINONE ANTIBIOTICS		
*linezolid (*Zyvox*)*	T1	PA
linezolid 600mg/300ml-0.9%nacl	T1	
LINEZOLID 600MG/300ML-0.9%NACL	T3	
linezolid in dextrose 5% (Zyvox)	T1	
SIVEXTRO 200 MG TABLET	T3	PA
SIVEXTRO 200 MG VIAL	T3	
ZYVOX 100 MG/5 ML SUSPENSION (*linezolid*)	T3	PA
ZYVOX 200 MG/100 ML-D5W	T3	
ZYVOX 600 MG TABLET (*linezolid*)	T3	PA
ZYVOX 600 MG/300 ML-D5W (*linezolid in dextrose 5%*)	T3	
PENICILLIN ANTIBIOTICS		
amoxicillin	T1	
amoxicillin/potassium clav	T1	
amoxicillin/potassium clav (Augmentin Es-600)	T1	
amoxicillin/potassium clav (Augmentin Xr)	T1	
amoxicillin/potassium clav (Augmentin)	T1	

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ANTIBIOTICS (Infections) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
PENICILLIN ANTIBIOTICS *(cont.)*		
ampicillin sod/sulbactam sod	T1	
ampicillin sod/sulbactam sod (Unasyn)	T1	
ampicillin sodium	T1	
ampicillin trihydrate	T1	
BICILLIN C-R	T3	
BICILLIN L-A	T3	
dicloxacillin sodium	T1	
EXTENCILLINE	T3	
LENTOCILIN S	T3	
MOXATAG	T3	
nafcillin in dextrose,iso-osm	T1	
nafcillin sodium	T1	
oxacillin in dextrose(iso-osm)	T1	
oxacillin sodium	T1	
penicillin g potassium	T1	
penicillin g sodium	T1	
PENICILLIN GK-ISO-OSM DEXTROSE	T1	
penicillin v potassium	T1	
PIPERACILLIN-TAZO 3.375 G DPLX	T3	
PIPERACILLIN-TAZO 4.5 G DUPLEX	T3	
piperacil-tazo 2.25 gm add vl	T1	
piperacil-tazo 3.375 gm add vl	T1	
piperacil-tazo 4.5 gm add vial	T1	
piperacil-tazobact 13.5 gm vl	T1	
PIPERACIL-TAZOBACT 13.5 GM VL	T1	
piperacil-tazobact 2.25 gm vl	T1	
piperacil-tazobact 3.375 gm vl	T1	
piperacil-tazobact 4.5 gm vial	T1	
piperacil-tazobact 40.5 gram	T1	
UNASYN (*ampicillin sod/sulbactam sod*)	T3	
ZOSYN	T3	
PLEUROMUTILIN DERIVATIVES		
XENLETA 150 MG/15 ML VIAL	T3	
XENLETA 600 MG TABLET	T3	PA QL (10 tabs/30 days)

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ANTIBIOTICS (Infections) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
POLYMYXIN ANTIBIOTICS AND DERIVATIVES		
colistin (colistimethate na) (Coly-mycin M Parenteral)	T1	
COLY-MYCIN M PARENTERAL (colistimethate)	T3	
polymyxin b sulfate	T1	
QUINOLONE ANTIBIOTICS		
AVELOX IV (*moxifloxacin-sod.chloride(iso)*)	T3	
BAXDELA 300 MG VIAL	T3	
BAXDELA 450 MG TABLET	T3	PA
CIPRO (*ciprofloxacin hcl*)	T3	
CIPRO (*ciprofloxacin*)	T3	
ciprofloxacin (Cipro)	T1	
ciprofloxacin hcl	T1	
ciprofloxacin hcl (Cipro)	T1	
ciprofloxacin in 5 % dextrose	T1	
FACTIVE	T3	
levofloxacin	T1	
levofloxacin in dextrose 5 %	T1	
MOXIFLOXACIN	T1	
moxifloxacin hcl	T1	
moxifloxacin-sod.chloride(iso) (Avelox Iv)	T1	
ofloxacin	T1	
RIFAMYCINS AND RELATED DERIVATIVE ANTIBIOTICS		
AEMCOLO	T3	QL(12 TABS/30 DAYS)
XIFAXAN 200 MG TABLET	T2	QL(9 TABS/30 DAYS)
XIFAXAN 550 MG TABLET	T2	QL(42 TABS/30 DAYS)
STREPTOGRAMIN ANTIBIOTICS		
SYNERCID	T3	
TETRACYCLINE ANTIBIOTICS		
coremino er 135 mg tablet	T1	
coremino er 45 mg tablet	T1	QL(1 TAB/DAY)
coremino er 90 mg tablet	T1	
demeclocycline hcl	T1	
doxycycline 50 mg tablet (Targadox)	T1	
doxycycline hyclate	T1	
doxycycline hyclate 100 mg cap	T1	
doxycycline hyclate 100 mg tab (Lymepak)	T1	

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List of Prescription Medications

ANTIBIOTICS (Infections) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
TETRACYCLINE ANTIBIOTICS		
doxycycline hyclate 100 mg vl	T1	
doxycycline hyclate 150 mg tab (Acticlate)	T1	
doxycycline hyclate 50 mg cap	T1	
doxycycline hyclate 75 mg tab (Acticlate)	T1	
doxycycline monohydrate	T1	
MINOCIN	T3	
minocycline er 105 mg tablet	T1	
*minocycline er 115 mg tablet (*Solodyn*)*	T1	
minocycline er 135 mg tablet	T1	
minocycline er 45 mg tablet	T1	QL(1 TAB/DAY)
minocycline er 55 mg tablet	T1	
minocycline er 65 mg tablet	T1	
minocycline er 80 mg tablet	T1	
minocycline er 90 mg tablet	T1	
minocycline hcl	T1	
TETRACYCLINE ANTIBIOTICS *(cont.)*		
NUZYRA 100 MG VIAL	T3	SP
NUZYRA 150 MG TABLET	T3	PA QL(30 TABS/28 DAYS) SP
tetracycline 250 mg capsule	T1	
tetracycline 500 mg capsule	T1	
XERAVA	T3	
VAGINAL ANTIBIOTICS		
clindamycin phosphate (Cleocin)	T1	
metronidazole	T1	
metronidazole vaginal 0.75% gl	T1	
VANCOMYCIN ANTIBIOTICS AND DERIVATIVES		
TYZAVAN	T3	
VANCOMYCIN	T1	
vancomycin 1 gm add-van vial	T1	
vancomycin 1 gm vial	T1	
VANCOMYCIN 1 GRAM/200 ML BAG	T3	
VANCOMYCIN 1.25 GM/250 ML BAG	T3	
VANCOMYCIN 1.25 GRAM/250ML-D5W	T1	
VANCOMYCIN 1.25 GRAM/250ML-D5W	T3	
VANCOMYCIN 1.5 GRAM/250 ML-D5W	T1	

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ANTIBIOTICS (Infections) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
VANCOMYCIN ANTIBIOTICS AND DERIVATIVES *(cont.)*		
VANCOMYCIN 1.5 GRAM/300 ML BAG	T3	
VANCOMYCIN 1.5 GRAM/300 ML-D5W	T3	
VANCOMYCIN 1.75 GM/350 ML BAG	T3	
VANCOMYCIN 2 GRAM/400 ML BAG	T3	
vancomycin 25 mg/ml oral soln	T1	
vancomycin 250 mg/5ml oral sol (Firvanq)	T1	
vancomycin 50 mg/ml oral soln (Firvanq)	T1	
vancomycin 500 mg add-van vial	T1	
vancomycin 500 mg vial	T1	
VANCOMYCIN 500 MG/100 ML BAG	T3	
VANCOMYCIN 750 MG ADD-VAN VIAL	T1	
VANCOMYCIN 750 MG/150 ML BAG	T3	
vancomycin hcl 1.25 gram vial	T1	
vancomycin hcl 1.5 gram vial	T1	
VANCOMYCIN HCL 1.75 GRAM VIAL	T3	
vancomycin hcl 10 gm vial	T1	
vancomycin hcl 125 mg capsule (Vancocin Hcl)	T1	
VANCOMYCIN HCL 1G/200 ML BAG	T1	
VANCOMYCIN HCL 2 GRAM VIAL	T3	
vancomycin hcl 250 mg capsule (Vancocin Hcl)	T1	
vancomycin hcl 5 gm vial	T1	
vancomycin hcl 750 mg vial	T1	
VANCOMYCIN HCL-0.9% NACL	T1	
VANCOMYCIN-D5W 500 MG/100 ML	T1	
ANTIBIOTICS (Miscellaneous)		
CYCLIC LIPOPEPTIDES		
daptomycin	T1	
DAPTOMYCIN	T1	
DAPTOMYCIN-0.9% NACL	T3	
ANTIBIOTICS (Skin Conditions)		
TOPICAL ANTIBIOTIC AND ANTI-INFLAMMATORY STEROID		
NEO-SYNALAR	T3	

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ANTIBIOTICS (Skin Conditions)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
TOPICAL ANTIBIOTICS		
BENZAMYCIN (*erythromycin-benzoyl peroxide*)	T3	
CENTANY	T3	
CENTANY AT	T3	
CLEOCIN T (*clindamycin phosphate*)	T3	
clindamycin phosphate	T1	
clindamycin phosphate (Cleocin T)	T1	
clindamycin phosphate (Clindagel)	T1	
clindamycin phosphate (Evoclin)	T1	
erythromycin base in ethanol	T1	
erythromycin/benzoyl peroxide (Benzamycin)	T1	
EVOCLIN (*clindamycin phosphate*)	T3	
gentamicin sulfate	T1	
mupirocin 2% ointment	T1	
XEPI	T3	
TOPICAL SULFONAMIDES		
mafenide acetate	T1	
PLEXION	T3	
SILVADENE (*silver sulfadiazine*)	T3	
silver sulfadiazine (Silvadene)	T1	
sulfacetamide sodium/sulfur	T1	
SULFAMYLON	T3	
ANTICOAGULANTS (Blood Thinners/Anti-Clotting)		
ANTICOAGULANTS, COUMARIN TYPE		
warfarin sodium	T1	HD
CITRATES AS ANTICOAGULANTS		
ACD SOLUTION A	T3	
ACD-A	T3	
ANTICOAG SODIUM CITRATE 4% SOL	T3	
CITRATE PHOSPHATE DEXTROSE	T1	
TRICITRASOL	T3	
DIRECT FACTOR XA INHIBITORS		
ELIQUIS	T2	PA
ELIQUIS SPRINKLE	T2	PA QL (1 TAB/DAY)

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List of Prescription Medications

ANTICOAGULANTS (Blood Thinners/Anti-Clotting) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DIRECT FACTOR XA INHIBITORS		
rivaroxaban (Xarelto)	T1	
XARELTO	T2	
XARELTO (*rivaroxaban*)	T2	
HEPARIN AND RELATED PREPARATIONS		
ARIXTRA 10 MG/0.8 ML SYRINGE (*fondaparinux sodium*)	T3	QL(0.8 ML/DAY) SP
ARIXTRA 2.5 MG/0.5 ML SYRINGE *(fondaparinux sodium)*	T3	QL(0.5 ML/DAY) SP
ARIXTRA *5 MG/0.4 ML SYRINGE (fondaparinux sodium)*	T3	QL(0.4 ML/DAY) SP
ARIXTRA *7.5 MG/0.6 ML SYRINGE (fondaparinux sodium)*	T3	QL(0.6 ML/DAY) SP
enoxaparin 100 mg/ml syringe (Lovenox)	T1	QL(2 SYRINGES/DAY) SP
enoxaparin 120 mg/0.8 ml syr (Lovenox)	T1	QL(2 SYRINGES/DAY) SP
enoxaparin 40 mg/0.4 ml syr (Lovenox)	T1	QL (2 SYRINGES/DAY) SP
enoxaparin 150 mg/ml syringe (Lovenox)	T1	QL(2 SYRINGES/DAY) SP
enoxaparin 30 mg/0.3 ml syr (Lovenox)	T1	QL(2 SYRINGES/DAY) SP
enoxaparin 300 mg/3 ml vial (Lovenox)	T1	QL(1 VIAL/DAY) SP
enoxaparin 40 mg/0.4 ml syr (Lovenox)	T1	QL(2 SYRINGES/DAY) SP
enoxaparin 60 mg/0.6 ml syr (Lovenox)	T1	QL(2 SYRINGES/DAY) SP
enoxaparin 80 mg/0.8 ml syr (Lovenox)	T1	QL(2 SYRINGES/DAY) SP
fondaparinux 10 mg/0.8 ml syr (Arixtra)	T1	QL(0.8 ML/DAY) SP
fondaparinux 2.5 mg/0.5 ml syr (Arixtra)	T1	QL(0.5 ML/DAY) SP
fondaparinux 5 mg/0.4 ml syr (Arixtra)	T1	QL(0.4 ML/DAY) SP
fondaparinux 7.5 mg/0.6 ml syr (Arixtra)	T1	QL(0.6 ML/DAY) SP
FRAGMIN 10,000 UNIT/4 ML VIAL	T3	QL(1 VIAL/DAY) SP
FRAGMIN 10,000 UNIT/ML SYRINGE	T3	QL(2 SYRINGES/DAY) SP
FRAGMIN 12,500 UNIT/0.5 ML SYR	T3	QL(2 SYRINGES/DAY) SP
FRAGMIN 15,000 UNIT/0.6 ML SYR	T3	QL(2 SYRINGES/DAY) SP
FRAGMIN 18,000 UNIT/0.72 ML	T3	QL(2 SYRINGES/DAY) SP
FRAGMIN 2,500 UNIT/0.2 ML SYR	T3	QL(2 SYRINGES/DAY) SP
FRAGMIN 5,000 UNIT/0.2 ML SYR	T3	QL(2 SYRINGES/DAY) SP
FRAGMIN 7,500 UNIT/0.3 ML SYR	T3	QL(2 SYRINGES/DAY) SP
FRAGMIN 95,000 UNIT/3.8 ML VL	T3	QL(1 VIAL/DAY) SP
heparin 1,000 unit/500 ml-ns	T1	
heparin 10,000 unit/10 ml vial	T1	
HEPARIN 2,000 UNIT/1,000 ML-NS (*heparin sodium,porcine/ns/pf*)	T3	
heparin 2,000 unit/1,000 ml-ns (Heparin Sodium-0.9% Nacl)	T1	
heparin 2,000 unit/2 ml vial	T1	

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ANTICOAGULANTS (Blood Thinners/Anti-Clotting) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
HEPARIN AND RELATED PREPARATIONS		
HEPARIN 30,000 UNIT/1,000-NS	T1	
heparin 30,000 unit/30 ml vial	T1	
heparin 40,000 unit/4 ml vial	T1	
HEPARIN 5,000 UNIT/1,000 ML-NS	T1	
HEPARIN 5,000 UNIT/500 ML-NS	T1	
heparin 5,000 unit/ml carpujct	T1	
heparin 50,000 unit/10 ml vial	T1	
heparin 50,000 unit/5 ml vial	T1	
heparin sod 1,000 unit/ml vial	T1	
heparin sod 10,000 unit/ml vl	T1	
heparin sod 20,000 unit/ml vl	T1	
heparin sod 5,000 unit/0.5 ml	T1	
HEPARIN SOD 5,000 UNIT/0.5 ML	T1	
HEPARIN SOD 5,000 UNIT/0.5 ML	T3	
heparin sod 5,000 unit/ml syrg	T1	
HEPARIN SOD 5,000 UNIT/ML SYRG	T3	
heparin sod 5,000 unit/ml vial	T1	
heparin sod,porcine/0.9 % nacl	T1	
heparin sod,pork in 0.45% nacl	T1	
heparin sodium,porcine	T1	
heparin sodium,porcine/d5w	T1	
heparin sodium,porcine/pf	T1	
HEPARIN SODIUM-0.45% NACL	T1	
THROMBIN INHIBITORS, SELECTIVE, DIRECT, REVERSIBLE		
ARGATROBAN	T3	SP
argatroban in 0.9 % sod chlor	T1	SP HD
dabigatran etexilate mesylate (Pradaxa)	T1	HD
THROMBIN INHIBITORS, SEL, DIRECT, REVERS-HIRUDIN TYPE		
ANGIOMAX	T3	
BIVALIRUDIN 250 MG ADD-VANT VL	T1	
*bivalirudin 250 mg vial (*Angiomax*)*	T1	
BIVALIRUDIN RTU 250 MG/50 ML	T3	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIDOTES (Gastrointestinal/Heartburn)		
MU-OPIOID RECEPTOR ANTAGONISTS, PERIPHERALLY-ACTING		
MOVANTIK	T2	PA
RELISTOR 12 MG/0.6 ML SYRINGE	T3	PA
RELISTOR 12 MG/0.6 ML VIAL	T3	PA
RELISTOR 8 MG/0.4 ML SYRINGE	T3	PA
SYMPROIC	T2	PA
ANTIDOTES (Substance Abuse)		
OPIOID ANTAGONISTS		
KLOXXADO	T2	QL(2 UNITS/30 DAYS)
NALMEFENE HCL	T3	QL(4 MLS/30 DAYS)
naloxone 0.4 mg/ml carpuject	T1	
naloxone 0.4 mg/ml syringe	T1	
naloxone 0.4 mg/ml vial	T1	
naloxone 2 mg/2 ml syringe	T1	
naloxone 4 mg/10 ml vial	T1	
naloxone hcl 4 mg nasal spray (Narcan)	T1	QL(2 UNITS/30 DAYS)
naltrexone hcl	T1	QL(180 TABS/30 DAYS)
NARCAN (*naloxone hcl*)	T2	QL(2 UNITS/30 DAYS)
OPVEE	T3	QL(2 UNITS/30 DAYS)
REXTOVY	T2	QL(2 UNITS/30 DAYS)
ZIMHI	T3	QL(2 SYRINGES/30 DAYS)
ANTIFUNGALS (Eye Conditions)		
OPHTHALMIC ANTIFUNGAL AGENTS		
NATACYN	T3	
ANTIFUNGALS (Feminine Products)		
VAGINAL ANTIFUNGALS		
GYNAZOLE 1	T1	
miconazole nitrate	T1	
terconazole	T1	
ANTIFUNGALS (Infections)		
ANTIFUNGAL AGENTS		
ANCOBON (flucytosine)	T3	
clotrimazole	T1	

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List of Prescription Medications

ANTIFUNGALS (Infections)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIFUNGAL AGENTS		
CRESEMBA 186 MG CAPSULE	T3	PA
CRESEMBA 372 MG VIAL	T3	
CRESEMBA 74.5 MG CAPSULE	T3	PA
fluconazole	T1	
fluconazole (Diflucan)	T1	
fluconazole in nacl,iso-osm	T1	
flucytosine (Ancobon)	T1	
itraconazole	T1	
itraconazole (Sporanox)	T1	
ketoconazole	T1	
NOXAFIL 300 MG POWDERMIX SUSP	T3	
NOXAFIL 300 MG/16.7 ML VIAL (*posaconazole*)	T3	
ORAVIG	T3	
posaconazole	T1	
posaconazole (Noxafil)	T1	
terbinafine hcl	T1	
VFEND *(voriconazole)*	T3	PA
VFEND IV *(voriconazole)*	T3	
VIVJOA	T3	PA SP
voriconazole 200 mg tablet (Vfend)	T1	PA
voriconazole 200 mg vial (Vfend Iv)	T1	
voriconazole 40 mg/ml susp (Vfend)	T1	PA
voriconazole 50 mg tablet (Vfend)	T1	PA
voriconazole/hpbcd	T1	
ABELCET	T3	
AMBISOME (amphotericin b liposome)	T3	
amphotericin b	T1	
amphotericin b liposome (Ambisome)	T1	
CANCIDAS *(caspofungin acetate)*	T3	
caspofungin acetate	T1	
caspofungin acetate (Cancidas)	T1	
ERAXIS	T3	
griseofulvin ultra 125 mg tab	T1	

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ANTIFUNGALS (Infections) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIFUNGAL ANTIBIOTICS		
griseofulvin ultra 165 mg tab	T1	QL(4 TABS/DAY)
griseofulvin ultra 250 mg tab	T1	
griseofulvin, microsize	T1	
micafungin sodium (Mycamine)	T1	
MICAFUNGIN-0.9% NACL	T3	
MYCAMINE *(micafungin sodium)*	T3	
nystatin	T1	
REZZAYO	T3	PA
ANTIFUNGALS (Skin Conditions)		
TOPICAL ANTIFUNGAL/ANTI-INFLAMMATORY, STEROID AGENT		
clotrimazole/betamethasone dip	T1	
TOPICAL ANTIFUNGAILS		
ciclodan 0.77% cream (Loprox)	T1	
CICLODAN 0.77% CREAM KIT	T3	
CICLODAN 8% KIT	T3	
ciclodan 8% solution	T1	
ciclopirox	T1	
ciclopirox olamine (Loprox)	T1	
ciclopirox/urea/camph/men/euc	T1	
econazole nitrate 1% cream	T1	
ECOZA	T3	
EXODERM	T1	QL(4 TABS/DAY)
ketoconazole	T1	
ketoconazole (Extina)	T1	
LOPROX 0.77% TOPICAL SUSP (*ciclopirox olamine*)	T3	
LULICONAZOLE	T1	
naftifine hcl	T1	
naftifine hcl (Naftin)	T1	
NAFTIN (*naftifine hcl*)	T3	PA
nystatin	T1	
nystatin/triamcinolone acet	T1	
ANTIHISTAMINE AND DECONGESTANT COMBINATION (Allergy/Nasal Sprays)		
1ST GEN ANTIHISTAMINE AND DECONGESTANT COMBINATION		
phenylephrine hcl/prometh hcl	T1	

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List of Prescription Medications

ANTIHISTAMINE AND DECONGESTANT COMBINATION (Allergy/Nasal Sprays)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
2ND GEN ANTIHISTAMINE AND DECONGESTANT COMBINATION		
CLARINEX-D 12 HOUR	T3	
ANTIHISTAMINES (Allergy/Nasal Sprays)		
ANTIHISTAMINES - 1ST GENERATION		
carbinoxamine 4 mg/5 ml liquid	T1	
carbinoxamine maleate	T1	
carbinoxamine maleate 4 mg tab	T1	
clemastine fum 2.68 mg tablet	T1	
clemastine fumarate	T1	
cyproheptadine hcl	T1	
diphenhydramine hcl	T1	
hydroxyzine hcl	T1	
hydroxyzine pamoate	T1	
hydroxyzine pamoate (Vistaril)	T1	
PHENERGAN *(promethazine hcl)*	T3	
promethazine hcl	T1	
promethazine hcl (Phenergan)	T1	
VISTARIL (*hydroxyzine pamoate*)	T3	
ANTIHISTAMINES - 2ND GENERATION		
cetirizine hcl	T1	HD
desloratadine 2.5 mg odt	T1	QL(1 TAB/DAY) HD
desloratadine 5 mg odt	T1	HD
desloratadine 5 mg tablet	T1	HD
levocetirizine dihydrochloride	T1	HD
QUZYTTIR	T3	
ANTIHISTAMINES (Eye Conditions)		
azelastine hcl 0.05% drops	T1	
bepotastine besilate	T1	
epinastine hcl	T1	
olopatadine hcl 0.1% eye drops	T1	
olopatadine hcl 0.2% eye drop	T1	
ANTIHYPERGLYCEMICS (Diabetes)		
ANTIHYPERGLY, INCRETIN MIMETIC (GLP-1 RECEP.AGONIST)		
BYDUREON BCISE	T2	PA QL(4 MLS/28 DAYS)

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ANTIHYPERGLYCEMICS (Diabetes) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIHYPERGLY, INCRETIN MIMETIC (GLP-1 RECEP.AGONIST) *(cont.)*		
exenatide	T1	PA QL(3 MLS/30 DAYS)
liraglutide (Victoza 2-Pak)	T1	PA QL(3 PENS/30 DAYS)
liraglutide (Victoza 3-Pak)	T1	PA QL(3 PENS/30 DAYS)
OZEMPIC	T2	PA QL(3 MLS/28 DAYS)
RYBELSUS	T2	PA QL(1 TAB/DAY)
TRULICITY	T2	PA QL(2 MLS/28 DAYS)
ANTIHYPERGLY, INSULIN, LONG ACT-GLP-1 RECEPT.AGONIST		
SOLIQUA 100-33	T2	
ANTIHYPERGLYCEMIC - DOPAMINE RECEPTOR AGONISTS		
CYCLOSET	T3	HD
ANTIHYPERGLYCEMIC - INCRETIN MIMETICS COMBINATION		
MOUNJARO 10 MG/0.5 ML PEN	T2	PA QL(2 MLS/30 DAYS)
MOUNJARO 12.5 MG/0.5 ML PEN	T2	PA QL(2 MLS/30 DAYS)
MOUNJARO 15 MG/0.5 ML PEN	T2	PA QL(2 MLS/30 DAYS)
MOUNJARO 2.5 MG/0.5 ML PEN	T2	PA QL(2 MLS/365 DAYS)
MOUNJARO 5 MG/0.5 ML PEN	T2	PA QL(2 MLS/30 DAYS)
MOUNJARO 7.5 MG/0.5 ML PEN	T2	PA QL(2 MLS/30 DAYS)
ANTIHYPERGLYCEMIC, ALPHA-GLUCOSIDASE INHIBITORS		
acarbose (Precose)	T1	HD
miglitol	T1	HD
PRECOSE *(acarbose)*	T3	HD
ANTIHYPERGLYCEMIC, AMYLIN ANALOG-TYPE		
SYMLINPEN 60	T2	
SYMLINPEN 120	T2	HD
metformin hcl	T1	HD
metformin hcl 1,000 mg tablet	T1	HD
metformin hcl 500 mg tablet	T1	HD
metformin hcl 500 mg/5 ml cup (Riomet)	T1	HD
metformin hcl 500 mg/5 ml soln (Riomet)	T1	HD
metformin hcl 750 mg tablet	T1	HD
metformin hcl 850 mg tablet	T1	HD
RIOMET *(metformin hcl)*	T3	HD
ANTIHYPERGLYCEMIC, DPP-4 INHIBITORS		
JANUVIA	T2	QL (1 TAB/DAY) ST HD

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List of Prescription Medications

ANTIHYPERGLYCEMICS (Diabetes) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIHYPERGLYCEMIC, DPP-4 INHIBITORS *(cont.)*		
saxagliptin hcl (Onglyza)	T1	QL(1 TAB/DAY) HD
ANTIHYPERGLYCEMIC, INSULIN-RELEASE STIMULANT TYPE		
glimepiride 1 mg tablet	T1	HD
glimepiride 2 mg tablet	T1	HD
GLIMEPIRIDE 3 MG TABLET	T3	HD
glimepiride 4 mg tablet	T1	HD
glipizide (Glucotrol XL)	T1	HD
glipizide 10 mg tablet	T1	HD
GLIPIZIDE 2.5 MG TABLET	T3	HD
glipizide 5 mg tablet	T1	HD
GLUCOTROL XL (glipizide)	T3	HD
glyburide	T1	HD
glyburide,micronized	T1	HD
glyburide,micronized (Glynase)	T1	HD
GLYNASE (*glyburide,micronized*)	T3	HD
nateglinide	T1	HD
repaglinide	T1	HD
ANTIHYPERGLYCEMIC, SGLT-2 AND DPP-4 INHIBITOR COMB		
GLYXAMBI	T2	QL (1 TAB/DAY) ST HD
ANTIHYPERGLYCEMIC, THIAZOLIDINEDIONE AND BIGUANIDE		
ACTOPLUS MET (*pioglitazone-metformin*)	T3	HD
pioglitazone hcl/metformin hcl	T1	HD
pioglitazone hcl/metformin hcl (Actoplus Met)	T1	HD
ANTIHYPERGLYCEMIC, THIAZOLIDINEDIONE-SULFONYLUREA		
DUETACT (*pioglitazone-glimepiride*)	T3	HD
pioglitazone hcl/glimepiride (Duetact)	T1	HD
ANTIHYPERGLYCEMIC, DPP-4 INHIBITOR-BIGUANIDE COMBS.		
JANUMET	T2	QL (2 TABS/DAY) ST HD
JANUMET	T2	ST QL(2 TABS/DAY) HD
JANUMET XR 100-1,000 MG TABLET	T2	ST QL(1 TAB/DAY) HD
JANUMET XR 50-1,000 MG TABLET	T2	ST QL(2 TABS/DAY) HD
JANUMET XR 50-500 MG TABLET	T2	ST QL(1 TAB/DAY) HD
linagliptin/metformin hcl	T1	QL(2 TABS/DAY) HD

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ANTIHYPERGLYCEMICS (Diabetes) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIHYPERGLYCEMIC, DPP-4 INHIBITOR-BIGUANIDE COMBS. *(cont.)*		
saxagliptin-metformin er 5-500 (Kombiglyze Xr)	T1	QL(1 TAB/DAY) HD
saxagliptin-metformn er 5-1000 (Kombiglyze Xr)	T1	QL(1 TAB/DAY) HD
saxagliptn-metform er 2.5-1000 (Kombiglyze Xr)	T1	QL(2 TABS/DAY) HD
ANTIHYPERGLYCEMIC, INSULIN-RELEASE STIM.-BIGUANIDE		
glipizide/metformin hcl	T1	HD
glyburide/metformin hcl	T1	HD
ANTIHYPERGLYCEMIC, THIAZOLIDINEDIONE (PPARG AGONIST)		
pioglitazone hcl (Actos)	T1	HD
ANTIHYPERGLYCEMIC-SGLT2 INHIBITOR-BIGUANIDE COMBS.		
SYNJARDY	T2	ST QL(2 TABS/DAY) HD
SYNJARDY XR 10-1,000 MG TABLET	T2	ST QL(2 TABS/DAY) HD
SYNJARDY XR 12.5-1,000 MG TAB	T2	ST QL(2 TABS/DAY) HD
SYNJARDY XR 25-1,000 MG TABLET	T2	ST QL(1 TAB/DAY) HD
SYNJARDY XR 5-1,000 MG TABLET	T2	ST QL(2 TABS/DAY) HD
XIGDUO XR 10 MG-1,000 MG TAB	T2	ST QL(1 TAB/DAY) HD
XIGDUO XR 10 MG-500 MG TABLET	T2	ST QL(1 TAB/DAY) HD
XIGDUO XR 2.5 MG-1,000 MG TAB	T2	ST QL(2 TABS/DAY) HD
XIGDUO XR 5 MG-1,000 MG TABLET	T2	ST QL(2 TABS/DAY) HD
XIGDUO XR 5 MG-500 MG TABLET	T2	ST QL(1 TAB/DAY) HD
ANTIHYPERGLYCEMIC-SOD/GLUC COTRANSPORT2(SGLT2) INH		
FARXIGA	T2	ST QL(1 TAB/DAY)
JARDIANCE	T2	ST QL(1 TAB/DAY) HD
ANTIHYPERGLY-SGLT-2 INHIB, DPP-4 INHIB, BIGUANIDE CB		
TRIJARDY XR 10-5-1,000 MG TAB	T2	ST QL(1 TAB/DAY) HD
TRIJARDY XR 12.5-2.5-1,000 MG	T2	ST QL(2 TABS/DAY) HD
TRIJARDY XR 25-5-1,000 MG TAB	T2	ST QL(1 TAB/DAY) HD
TRIJARDY XR 5-2.5-1,000 MG TAB	T2	ST QL(2 TABS/DAY) HD
INSULINS		
BASAGLAR KWIKPEN U-100	T2	QL(1.5 MLS/DAY) HD
BASAGLAR TEMPO PEN U-100	T2	QL(1.5 MLS/DAY) HD
HUMALOG	T2	QL(1.5 MLS/DAY) HD
HUMALOG JUNIOR KWIKPEN	T2	QL(1.5 MLS/DAY) HD
HUMALOG KWIKPEN U-100	T2	QL(1.5 MLS/DAY) HD
HUMALOG KWIKPEN U-200	T2	QL(1 ML/DAY) HD
HUMALOG MIX 50-50 KWIKPEN	T2	QL(2 MLS/DAY) HD

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ANTIHYPERGLYCEMICS (Diabetes) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
INSULINS *(cont.)*		
HUMALOG MIX 75-25	T2	QL(2 MLS/DAY) HD
HUMALOG MIX 75-25 KWIKPEN	T2	QL(2 MLS/DAY) HD
HUMALOG TEMPO PEN U-100	T2	QL(1.5 MLS/DAY) HD
HUMULIN 70/30 KWIKPEN	T2	QL(2 MLS/DAY) HD
HUMULIN 70-30	T2	QL(2 MLS/DAY) HD
HUMULIN N	T2	QL(1.5 MLS/DAY) HD
HUMULIN N KWIKPEN	T2	QL(1.5 MLS/DAY) HD
HUMULIN R	T2	QL(1.5 MLS/DAY) HD
HUMULIN R U-500	T2	QL(1 ML/DAY) HD
HUMULIN R U-500 KWIKPEN	T2	QL(1 ML/DAY) HD
INSULIN LISPRO	T2	QL(1.5 MLS/DAY) HD
INSULIN LISPRO JUNIOR KWIKPEN	T2	QL(1.5 MLS/DAY) HD
INSULIN LISPRO KWIKPEN U-100	T2	QL(1.5 MLS/DAY) HD
INSULIN LISPRO PROTAMINE MIX	T2	QL(2 MLS/DAY) HD
LYUMJEV	T2	QL(1.5 MLS/DAY) HD
LYUMJEV KWIKPEN U-100	T2	QL(1.5 MLS/DAY) HD
LYUMJEV KWIKPEN U-200	T2	QL(1 ML/DAY) HD
LYUMJEV TEMPO PEN U-100	T2	QL(1.5 MLS/DAY) HD
REZVOGLAR KWIKPEN	T2	QL(1.5 MLS/DAY) HD
TRESIBA	T2	QL(1.5 MLS/DAY) HD
TRESIBA FLEXTOUCH U-100	T2	QL(1.5 MLS/DAY) HD
TRESIBA FLEXTOUCH U-200	T2	QL(0.9 MLS/DAY) HD
ANTIINFECTIVES (Infections)		
PENICILLIN ANTIBIOTICS		
amoxicillin	T1	
2ND GEN. ANAEROBIC ANTIPROTOZOAL-ANTIBACTERIAL		
tinidazole	T1	
ANTIINFECTIVES/MISCELLANEOUS (Feminine Products)		
VAGINAL ANTISEPTICS		
acetic acid/oxyquinoline (Relagard)	T1	
RELAGARD (*acetic acid/oxyquinoline*)	T3	
TRIMO-SAN	T3	

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ANTIINFECTIVES/MISCELLANEOUS (Infections)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
2ND GEN. ANAEROBIC ANTIPROTOZOAL-ANTIBACTERIAL		
tinidazole	T1	
ANTHELMINTICS		
albendazole	T1	
BILTRICIDE (*praziquantel*)	T3	
EMVERM	T1	
ivermectin 3 mg tablet (Stromectol)	T1	PA
ivermectin 6 mg tablet	T1	PA
praziquantel (Biltricide)	T1	
STROMECTOL (*ivermectin*)	T3	PA
ANTIMALARIAL DRUGS		
ARTESUNATE	T3	
atovaquone/proguanil hcl (Malarone)	T1	
chloroquine phosphate	T1	
COARTEM	T3	PA QL(24 TABS/30 DAYS)
hydroxychloroquine sulfate	T1	
hydroxychloroquine sulfate (Plaquenil)	T1	
KRINTAFEL	T3	PA QL(2 TABS/30 DAYS)
MALARONE (*atovaquone/proguanil hcl*)	T3	PA
mefloquine hcl	T1	
PRIMAQUINE (primaquine phosphate)	T1	
primaquine phosphate (Primaquine)	T1	
pyrimethamine 25 mg tablet (Daraprim)	T1	PA
pyrimethamine 25 mg tablet (Daraprim)	T1	PA SP
quinine sulfate	T1	
ANTIPROTOZOAL DRUGS, MISCELLANEOUS		
atovaquone (Mepron)	T1	
BENZNIDAZOLE	T3	
IMPAVIDO	T3	PA
LAMPIT	T3	
NEBUPENT (*pentamidine isethionate*)	T3	
PENTAM 300 (*pentamidine isethionate*)	T3	
pentamidine isethionate (Nebupent)	T1	
pentamidine isethionate (Pentam 300)	T1	

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ANTIINFECTIVES/MISCELLANEOUS (Miscellaneous)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIBACTERIAL AGENTS, MISCELLANEOUS		
glycine urologic solution	T1	
glycine urologic solution	T3	
ANTISEPTICS,GENERAL		
ALCOHOL SWABSTICK	T3	
ISOPROPYL ALCOHOL	T3	
MEDI-FIRST ISOPROPYL ALCOHOL	T3	
ANTIINFLAM.TUMOR NECROSIS FACTOR INHIBITING AGENTS (Pain Relief And Inflammatory Disease)		
ANTI-INFLAMMATORY TUMOR NECROSIS FACTOR INHIBITOR		
ADALIMUMAB-ADBM(CF) 10 MG SYRG	T2	PA QL(2 PENS/SYRINGES/28 DAYS) SP HD
ADALIMUMAB-ADBM(CF) 20 MG SYRG	T2	PA QL(2 PENS/SYRINGES/28 DAYS) SP HD
ADALIMUMAB-ADBM(CF) 40 MG SYRG	T2	PA QL(4 SRNGE KITS/28 DAYS) SP HD
ADALIMUMAB-ADBM(CF) PEN	T2	PA QL(4 KITS/28 DAYS) SP HD
ADALIMUMAB-RYVK(CF)	T2	PA QL(4 SRNGE KITS/28 DAYS) SP HD
ADALIMUMAB-RYVK(CF) AUTOINJECT	T2	PA QL SP HD
AVSOLA	T2	PA SP HD
CIMZIA (2 PACK)	T2	PA QL(1 KIT/28 DAYS) SP HD
CIMZIA 200 MG/ML SYRINGE KIT	T2	PA QL(2 PENS/SYRINGES/28 DAYS) SP
CIMZIA 2X200 MG/ML(X3)START KT	T2	PA QL(1 STARTER KIT/365 DAYS) SP HD
CYLTEZO(CF) 10 MG/0.2 ML SYRNG	T2	PA QL(2 PENS/SYRINGES/28 DAYS) SP HD
CYLTEZO(CF) 20 MG/0.4 ML SYRNG	T2	PA QL(2 PENS/SYRINGES/28 DAYS) SP HD
CYLTEZO(CF) 40 MG/0.4 ML SYRNG	T2	PA QL(4 SRNGE KITS/28 DAYS) SP HD
CYLTEZO(CF) 40 MG/0.8 ML SYRNG	T2	PA QL(4 SRNGE KITS/28 DAYS) SP HD
CYLTEZO(CF) PEN	T2	PA QL(4 KITS/28 DAYS) SP HD
CYLTEZO(CF) PEN CROHN'S-UC-HS	T2	PA QL(1 STARTER KIT/365 DAYS) SP HD
CYLTEZO(CF) PEN PSORIASIS-UV	T2	PA QL(1 STARTER KIT/365 DAYS) SP HD
ENBREL 25 MG/0.5 ML SYRINGE	T2	PA QL(8 MLS/28 DAYS) SP HD
ENBREL 25 MG/0.5 ML VIAL	T2	PA QL(8 MLS/28 DAYS) SP HD
ENBREL 50 MG/ML SYRINGE	T2	PA QL(4 MLS/28 DAYS) SP HD
ENBREL MINI	T2	PA QL(4 MLS/28 DAYS) SP HD
ENBREL SURECLICK	T2	PA QL(4 MLS/28 DAYS) SP HD
HUMIRA	T2	PA QL(4 SRNGE KITS/28 DAYS) SP HD
HUMIRA PEN	T2	PA QL(4 KITS/28 DAYS) SP HD

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ANTIINFLAM.TUMOR NECROSIS FACTOR INHIBITING AGENTS (Pain Relief And Inflammatory Disease) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-INFLAMMATORY TUMOR NECROSIS FACTOR INHIBITOR *(cont.)*		
HUMIRA(CF) 10 MG/0.1 ML SYRING	T2	PA QL(2 PENS/SYRINGES/28 DAYS) SP HD
HUMIRA(CF) 20 MG/0.2 ML SYRING	T2	PA QL(2 PENS/SYRINGES/28 DAYS) SP HD
HUMIRA(CF) 40 MG/0.4 ML SYRING	T2	PA QL(4 SRNGE KITS/28 DAYS) SP HD
HUMIRA(CF) PEN 40 MG/0.4 ML	T2	PA QL(4 KITS/28 DAYS) SP HD
HUMIRA(CF) PEN 80 MG/0.8 ML	T2	PA QL(2 PENS/28 DAYS) SP HD
HUMIRA(CF) PEN CROHN'S-UC-HS	T2	PA QL(1 STARTER KIT/365 DAYS) SP HD
HUMIRA(CF) PEN PSOR-UV-ADOL HS	T2	PA QL(1 STARTER KIT/365 DAYS) SP HD
INFLECTRA	T2	PA SP HD
RENFLEXIS	T3	PA SP HD
SIMLANDI(CF) 20 MG/0.2 ML SYRG	T2	PA QL(2 PENS/SYRINGES/28 DAYS) SP HD
SIMLANDI(CF) 40 MG/0.4 ML SYRG	T2	PA QL(4 SRNGE KITS/28 DAYS) SP HD
SIMLANDI(CF) 80 MG/0.8 ML SYRG	T2	PA QL(2 PENS/SYRINGES/28 DAYS) SP HD
SIMLANDI(CF) AI 40 MG/0.4 ML	T2	PA QL SP HD
SIMLANDI(CF) AI 80 MG/0.8 ML	T2	PA QL(2 AUTO-INJS/28 DAYS) SP HD
SIMPONI 100 MG/ML PEN INJECTOR	T2	PA QL(1 PEN/28 DAYS) SP HD
SIMPONI 100 MG/ML SYRINGE	T2	PA QL(1 SYRINGE/28 DAYS) SP HD
SIMPONI ARIA	T2	PA SP HD
ANTINEOPLASTICS (Cancer)		
ANP - SELECTIVE RETINOID X RECEPTOR AGONISTS (RXR)		
bexarotene 75 mg capsule (Targretin)	T1	PA SP HD
ANTIBIOTIC ANTINEOPLASTICS		
ADRIAMYCIN *(doxorubicin hcl)*	T3	PA SP
bleomycin sulfate	T1	PA SP
dactinomycin	T1	PA SP
daunorubicin hcl	T1	PA SP
DOXIL *(doxorubicin hcl peg-liposomal)*	T3	PA SP
doxorubicin hcl	T1	PA SP
doxorubicin hcl (Adriamycin)	T1	PA SP
doxorubicin hcl peg-liposomal (Doxil)	T1	PA SP
ELLENCE	T3	PA SP
ELLENCE *(epirubicin hcl)*	T3	PA SP
epirubicin 200 mg/100 ml vial (Ellence)	T1	PA SP
epirubicin hcl 200 mg vial	T1	SP

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ANTINEOPLASTICS (Cancer) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIBIOTIC ANTINEOPLASTICS		
IDAMYCIN PFS *(idarubicin hcl)*	T3	PA SP
idarubicin hcl (Idamycin Pfs)	T1	PA SP
epirubicin hcl 200 mg vial	T1	SP
IDAMYCIN PFS (*idarubicin hcl*)	T3	PA SP
idarubicin hcl (Idamycin Pfs)	T1	PA SP
mitomycin (Mutamycin)	T1	PA SP
mitomycin	T1	PA SP
valrubicin (Valstar)	T1	SP
VALSTAR (*valrubicin*)	T2	SP
ZANOSAR	T2	PA SP
ZUSDURI	T3	PA SP
ANTI-CD20 (B LYMPHOCYTE) MONOCLONAL ANTIBODY		
GAZYVA	T3	PA SP
RIABNI	T2	PA SP
RITUXAN	T2	PA SP
RITUXAN HYCELA	T2	PA SP
RUXIENCE	T2	PA SP
TRUXIMA	T2	PA SP
ANTINEOPLAST HUM VEGF INHIBITOR RECOMB MC ANTIBODY		
ALYMSYS	T3	PA SP
AVASTIN	T2	PA SP
JOBEVNE	T3	PA SP
MVASI	T2	PA SP
VEGZELMA	T3	PA SP
ZIRABEV	T2	PA SP
ANTINEOPLAST, HISTONE DEACETYLASE (HDAC) INHIBITORS		
BELEODAQ	T3	PA SP

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ANTINEOPLASTICS (Cancer) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTINEOPLAST, HISTONE DEACETYLASE (HDAC) INHIBITORS *(cont.)*		
ISTODAX	T3	PA SP
romidepsin 10 mg kit	T1	PA SP
romidepsin 10 mg vial	T1	PA SP
ROMIDEPSIN 27.5 MG/5.5 ML VIAL	T3	PA SP
ZOLINZA	T2	PA QL(4 CAPS/DAY) SP HD CSL
ANTINEOPLASTIC - ALKYLATING AGENTS		
ALKERAN 2 MG TABLET (*melphalan*)	T3	SP CSL
ALKERAN 50 MG VIAL (*melphalan hcl*)	T3	PA SP
BELRAPZO	T3	PA SP HD
*bendamustine 100 mg vial (*Treanda*)*	T1	PA SP
BENDAMUSTINE 100 MG/4 ML VIAL	T1	PA SP HD
bendamustine 25 mg vial (Treanda)	T1	PA SP
BENDEKA	T3	PA SP HD
BICNU *(carmustine)*	T2	SP
*busulfan (*Busulfex*)*	T1	SP
BUSULFEX (*busulfan*)	T2	SP
carboplatin	T1	PA SP
*carmustine 100 mg vial (*Bicnu*)*	T1	SP
CARMUSTINE 300 MG VIAL	T3	SP
CARMUSTINE 50 MG VIAL	T3	SP
cisplatin 100 mg/100 ml vial	T1	PA SP
cisplatin 200 mg/200 ml vial	T1	PA SP
CISPLATIN 50 MG VIAL	T3	PA SP
cisplatin 50 mg/50 ml vial	T1	PA SP
cyclophosphamide 1 gm vial	T1	SP
CYCLOPHOSPHAMIDE 1 GM/10 ML VL	T3	SP
CYCLOPHOSPHAMIDE 1 GM/5 ML VL	T3	SP
cyclophosphamide 2 gm vial	T1	SP
CYCLOPHOSPHAMIDE 2 GM/10 ML VL	T3	SP
CYCLOPHOSPHAMIDE 2 GM/20 ML VL	T3	SP
cyclophosphamide 25 mg capsule	T1	SP HD CSL
cyclophosphamide 50 mg capsule	T1	SP HD CSL
cyclophosphamide 500 mg vial	T1	SP
CYCLOPHOSPHAMIDE 500 MG/2.5 ML	T3	SP
CYCLOPHOSPHAMIDE 500 MG/5ML VL	T3	SP

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ANTINEOPLASTICS (Cancer) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTINEOPLASTIC - ALKYLATING AGENTS *(cont.)*		
EVOMELA	T3	PA SP
FRINDOVYX	T3	PA SP
GLEOSTINE	T2	CSL
GLIADEL	T3	SP CSL
HYDREA (*hydroxyurea*)	T3	CSL
hydroxyurea (Hydrea)	T1	CSL
IFEX (ifosfamide)	T3	PA SP
ifosfamide	T1	PA SP
ifosfamide (Ifex)	T1	PA SP
KYXATA	T3	PA SP
LEUKERAN	T2	CSL
lomustine	T1	CSL
melphalan hcl (Alkeran)	T1	PA SP
MYLERAN	T2	CSL
oxaliplatin	T1	PA SP
TEMODAR	T3	PA SP
temozolomide	T1	PA SP HD CSL
TEPADINA	T3	PA SP
TEPADINA (thiotepa)	T3	PA SP
thiotepa	T1	PA SP
thiotepa (Tepadina)	T1	PA SP
TREANDA (*bendamustine hcl*)	T3	PA SP
VIVIMUSTA	T3	PA SP
YONDELIS	T3	PA SP
ZEPZELCA	T3	PA SP
ANTINEOPLASTIC - ANTIANDROGENIC AGENTS		
abiraterone acetate (Zytiga)	T1	PA CSL
abiraterone acetate 250 mg tab (Zytiga)	T1	PA SP HD CSL
abiraterone acetate 500 mg tab (Zytiga)	T1	PA SP HD CSL
bicalutamide (Casodex)	T1	CSL
CASODEX *(bicalutamide)*	T3	CSL
ERLEADA	T2	PA SP HD CSL
EULEXIN (flutamide)	T3	CSL
flutamide (Eulexin)	T1	CSL

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ANTINEOPLASTICS (Cancer) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTINEOPLASTIC - ANTIANDROGENIC AGENTS		
nilutamide (Nilandron)	T1	QL(4 TABS/DAY) CSL
NUBEQA	T2	PA SP HD CSL
XTANDI	T2	PA SP HD CSL
ANTINEOPLASTIC - ANTIBIOTIC AND ANTIMETABOLITE		
VYXEOS	T3	PA SP
ANTINEOPLASTIC - ANTI-CD38 MONOCLONAL ANTIBODY		
DARZALEX	T3	PA SP HD
DARZALEX FASPRO	T3	PA SP
SARCLISA	T3	PA SP
ANTINEOPLASTIC - ANTIMETABOLITES		
ALIMTA (*pemetrexed disodium*)	T3	PA SP
ARRANON (*nelarabine*)	T2	PA SP
AVGEMSI	T3	PA SP
AXTLE	T3	PA
azacitidine (Vidaza)	T1	PA SP
capecitabine 150 mg tablet (Xeloda)	T1	PA SP HD CSL
capecitabine 500 mg tablet (Xeloda)	T1	PA SP HD CSL
cladribine 10 mg/10 ml vial	T1	PA SP
clofarabine	T1	PA SP
cytarabine	T1	PA SP
cytarabine/pf	T1	PA SP
DACOGEN *(decitabine)*	T3	PA SP
decitabine (Dacogen)	T1	PA SP
floxuridine	T1	PA SP
fludarabine phosphate	T1	PA SP
fluorouracil	T1	PA SP
fluorouracil 1 gram/20 ml vial	T1	PA SP
fluorouracil 2.5 gram/50 ml vl	T1	PA SP
fluorouracil 5 gram/100 ml vl	T1	PA SP
fluorouracil 500 mg/10 ml vial	T1	PA SP
FOLOTYN 20 MG/ML VIAL	T2	PA SP
FOLOTYN 40 MG/2 ML VIAL	T3	PA SP
gemcitabine 1 gram/26.3 ml vl	T1	PA SP

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List of Prescription Medications

ANTINEOPLASTICS (Cancer) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTINEOPLASTIC - ANTIMETABOLITES *(cont.)*		
gemcitabine 2 gram/52.6 ml vl	T1	PA SP
gemcitabine 200 mg/5.26 ml vl	T1	PA SP
gemcitabine hcl 1 gram vial	T1	PA SP
GEMCITABINE HCL 1 GRAM/10 ML	T3	PA SP
GEMCITABINE HCL 1.5 GRAM/15 ML	T3	PA SP
gemcitabine hcl 2 gram vial	T1	PA SP
GEMCITABINE HCL 2 GRAM/20 ML	T3	PA SP
gemcitabine hcl 200 mg vial	T1	PA SP
GEMCITABINE HCL 200 MG/2 ML VL	T3	PA SP
INFUGEM	T3	PA SP HD
INLEXZO	T3	PA SP
INQOVI	T3	PA SP HD CSL
JYLAMVO	T3	CSL
LONSURF	T3	PA SP HD CSL
mercaptopurine 20 mg/ml suspen (Purixan)	T1	SP CSL
mercaptopurine 50 mg tablet	T1	CSL
methotrexate 1 gm vial	T1	
methotrexate 2.5 mg tablet	T1	CSL
methotrexate 250 mg/10 ml vial	T1	
methotrexate 50 mg/2 ml vial	T1	
methotrexate sodium/pf	T1	
nelarabine (Arranon)	T1	PA SP
NIPENT	T3	PA SP
ONUREG	T3	PA QL(14 TABS/28 DAYS) SP CSL
PEMETREXED	T3	PA
pemetrexed disodium 1 gm vial	T1	PA SP
PEMETREXED DISODIUM 1 GM/40 ML	T3	PA
pemetrexed disodium 100 mg vl (Alimta)	T1	PA SP
PEMETREXED DISODIUM 100 MG/4ML	T3	PA
pemetrexed disodium 500 mg vl (Alimta)	T1	PA SP
PEMETREXED DISODIUM 500MG/20ML	T3	PA
pemetrexed disodium 750 mg vl	T1	PA SP
PEMETREXED DISODIUM 750 MG VL	T3	PA SP
PEMFEXY	T3	PA
PEMRYDI RTU	T3	PA

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ANTINEOPLASTICS (Cancer) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTINEOPLASTIC - ANTIMETABOLITES *(cont.)*		
PRALATREXATE	T3	PA SP
PURIXAN (*mercaptopurine*)	T3	SP CSL
TABLOID	T3	CSL
TREXALL	T2	CSL
VIDAZA (*azacitidine*)	T3	PA SP
XATMEP	T3	CSL
XELODA (*capecitabine*)	T3	PA SP HD CSL
ANTINEOPLASTIC - ANTI-SLAMF7 MONOCLONAL ANTIBODY		
EMPLICITI	T3	PA SP HD
ANTINEOPLASTIC - AROMATASE INHIBITORS		
anastrozole (Arimidex)	T1	HD PPACA CSL
ARIMIDEX (*anastrozole*)	T3	HD CSL
AROMASIN (*exemestane*)	T3	HD CSL
exemestane (Aromasin)	T1	HD PPACA CSL
letrozole (Femara)	T1	HD CSL
ANTINEOPLASTIC - BRAF KINASE INHIBITORS		
OJEMDA 100 MG TAB (400MG DOSE)	T3	PA QL(1 PACKET/28 Days) SP CSL
OJEMDA 100 MG TAB (500MG DOSE)	T3	PA QL(1 PACKET/28 Days) SP CSL
OJEMDA 100 MG TAB (600MG DOSE)	T3	PA QL(1 PACKET/28 Days) SP CSL
OJEMDA 25 MG/ML ORAL SUSP	T3	PA QL(8 BOTTLES/28 DAYS) SP CSL
TAFINLAR 10 MG TABLET FOR SUSP	T2	PA QL(30 TABS/DAY) SP HD CSL
TAFINLAR 50 MG CAPSULE	T2	PA QL(4 CAPS/DAY) SP HD CSL
TAFINLAR 75 MG CAPSULE	T2	PA QL(4 CAPS/DAY) SP HD CSL
ZELBORAF	T2	PA SP HD CSL
ANTINEOPLASTIC - CD19 (B LYMPHOCYTE) MC ANTIBODY		
MONJUVI	T3	PA SP
ANTINEOPLASTIC - EGFR AND MET RECEPTOR INHIB, MAB		
RYBREVANT	T3	PA SP
ANTINEOPLASTIC - EPOTHILONES AND ANALOGS		
IXEMPRA	T2	PA SP
ANTINEOPLASTIC - HEDGEHOG PATHWAY INHIBITOR		
DAURISMO	T3	PA SP HD CSL
ERIVEDGE	T2	PA SP HD CSL
ODOMZO	T2	PA SP HD CSL

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ANTINEOPLASTICS (Cancer) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTINEOPLASTIC - IMMUNOTHERAPY, VIRUS-BASED AGENTS		
IMLYGIC	T3	PA SP
ANTINEOPLASTIC - JANUS KINASE (JAK) INHIBITORS		
JAKAFI	T3	PA SP HD
ANTINEOPLASTIC - KRAS PROTEIN INHIBITOR		
LUMAKRAS 120 MG TABLET	T3	PA QL(8 TABS/DAY) SP HD CSL
LUMAKRAS 240 MG TABLET	T3	PA QL(4 TABS/DAY) SP HD CSL
LUMAKRAS 320 MG TABLET	T3	PA QL(3 TABS/DAY) SP HD CSL
ANTINEOPLASTIC - MEK KINASE INHIBITORS		
COTELLIC	T2	PA SP HD CSL
GOMEKLI	T3	PA SP CSL
KOSELUGO 10 MG CAPSULE	T3	PA QL(10 CAPS/DAY) SP CSL
KOSELUGO 25 MG CAPSULE	T3	PA QL(4 CAPS/DAY) SP CSL
KOSELUGO 5 MG SPRINKLE CAPSULE	T3	PA QL(20 CAPS/DAY) SP CSL
KOSELUGO 7.5 MG SPRINKLE CAP	T3	PA QL(12 CAPS/DAY) SP CSL
MEKINIST 0.05 MG/ML SOLUTION	T2	PA QL(40 MLS/DAY) SP HD CSL
MEKINIST 0.5 MG TABLET	T2	PA QL(3 TABS/DAY) SP HD CSL
MEKINIST 2 MG TABLET	T2	PA QL(1 TAB/DAY) SP HD CSL
ANTINEOPLASTIC - MICROTUBULE INHIBITORS		
eribulin mesylate (Halaven)	T1	PA SP
HALAVEN (eribulin mesylate)	T3	PA SP
ANTINEOPLASTIC - MTOR KINASE INHIBITORS		
everolimus (Afinitor)	T1	PA QL(1 TAB/DAY) SP CSL
everolimus 10 mg tablet (Afinitor)	T1	PA QL(1 TAB/DAY) SP HD CSL
everolimus 2 mg tab for susp (Afinitor Disperz)	T1	PA QL(1 TAB/DAY) SP CSL
everolimus 2.5 mg tablet (Afinitor)	T1	PA QL(1 TAB/DAY) SP HD CSL
everolimus 3 mg tab for susp (Afinitor Disperz)	T1	PA QL(1 TAB/DAY) SP CSL
everolimus 5 mg tab for susp (Afinitor Disperz)	T1	PA QL(1 TAB/DAY) SP CSL
everolimus 5 mg tablet (Afinitor)	T1	PA QL(1 TAB/DAY) SP HD CSL
everolimus 7.5 mg tablet (Afinitor)	T1	PA QL(1 TAB/DAY) SP HD CSL
FYARRO	T3	PA SP
temsirolimus (Torisel)	T1	PA SP
TORISEL *(temsirolimus)*	T2	PA SP

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ANTINEOPLASTIC - PROTEIN METHYLTRANSFERASE INHIBIT		
TAZVERIK	T3	PA SP
ANTINEOPLASTIC - TOPOISOMERASE I INHIBITORS		
CAMPTOSAR	T3	PA SP
CAMPTOSAR (*irinotecan hcl*)	T3	PA SP
HYCAMTIN	T3	PA SP HD CSL
irinotecan hcl	T1	PA SP
irinotecan hcl (Camptosar)	T1	PA SP
ONIVYDE	T3	PA SP
topotecan hcl	T1	PA SP HD
ANTINEOPLASTIC - VEGF-A, B AND PLGF INHIBITORS		
ZALTRAP	T3	PA SP
ANTINEOPLASTIC - VEGFR ANTAGONIST		
CYRAMZA	T3	PA SP
ANTINEOPLASTIC - VINCA ALKALOIDS		
vinblastine sulfate	T1	PA SP
vincristine sulfate	T1	PA SP
vinorelbine tartrate (Navelbine)	T1	PA SP
ANTINEOPLASTIC- CD22 ANTIBODY-CYTOTOXIC ANTIBIOTIC		
BESPONSA	T3	PA SP
ANTINEOPLASTIC- CD33 ANTIBODY-CYTOTOXIC ANTIBIOTIC		
MYLOTARG	T3	PA SP
ANTINEOPLASTIC COMB - KINASE AND AROMATASE INHIBIT		
KISQALI FEMARA CO-PACK	T2	PA QL(1 TAB/28 DAYS) SP CSL
ANTINEOPLASTIC EGF RECEPTOR BLOCKER MCLON ANTIBODY		
ERBITUX	T2	PA SP
HERCEPTIN	T3	PA SP
HERCEPTIN HYLECTA	T3	PA SP
HERCESSI	T3	PA SP
HERZUMA	T3	PA SP
KANJINTI	T2	PA SP
OGIVRI	T2	PA SP
ONTRUZANT	T3	PA SP
PERJETA	T3	PA SP
PHESGO	T3	PA SP HD

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTINEOPLASTIC EGF RECEPTOR BLOCKER MCLON ANTIBODY *(con't.)*		
PORTRAZZA	T3	PA SP
TRAZIMERA	T2	PA SP
VECTIBIX	T2	PA SP
ANTINEOPLASTIC IMMUNOMODULATOR AGENTS		
lenalidomide	T1	PA QL(1 CAP/DAY) SP HD CSL
POMALYST	T2	PA QL(21 CAPS/28 DAYS) SP HD CSL
REVLIMID	T2	PA QL(1 CAP/DAY) SP HD CSL
ANTINEOPLASTIC LHRH (GNRH) AGONIST, PITUITARY SUPPR.		
CAMCEVI	T3	PA SP
ELIGARD	T3	SP HD
leuprolide acetate	T1	PA SP HD
LEUPROLIDE DEPOT	T3	PA SP
LUTRATE DEPOT	T3	PA SP
TRELSTAR	T3	SP HD
ZOLADEX	T2	PA SP HD
ANTINEOPLASTIC LHRH(GNRH) ANTAGONIST,PITUIT.SUPPRS		
FIRMAGON	T2	PA SP HD
ORGOVYX	T3	PA SP CSL
ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS		
ALECENSA	T2	PA QL(8 CAPS/DAY) SP HD CSL
ALIQOPA	T3	PA SP
ALUNBRIG 180 MG TABLET	T2	PA QL(1 TAB/DAY) SP CSL
ALUNBRIG 30 MG TABLET	T2	PA QL(2 TABS/DAY) SP CSL
ALUNBRIG 90 MG TABLET	T2	PA QL(1 TAB/DAY) SP CSL
ALUNBRIG 90 MG-180 MG TAB PACK	T2	PA QL(1 TAB/DAY) SP CSL
AYVAKIT	T3	PA QL(1 TAB/DAY) SP CSL
BALVERSA	T3	PA SP CSL
BORTEZOMIB 1 MG VIAL	T3	PA SP
BORTEZOMIB 2.5 MG VIAL	T3	PA SP
bortezomib 3.5 mg vial (Velcade)	T1	PA SP
BORTEZOMIB 3.5 MG/1.4 ML VIAL	T3	PA SP
BOSULIF 100 MG CAPSULE	T3	PA QL(3 CAPS/DAY) SP HD CSL
BOSULIF 100 MG TABLET	T3	PA QL(3 TABS/DAY) SP HD CSL
BOSULIF 400 MG TABLET	T3	PA QL(1 TAB/DAY) SP HD CSL
BOSULIF 50 MG CAPSULE	T3	PA QL(3 CAPS/DAY) SP HD CSL

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS		
BOSULIF 500 MG TABLET	T3	PA QL(1 TAB/DAY) SP HD CSL
BRUKINSA 160 MG TABLET	T2	PA QL(2 TABS/DAY) SP CSL
BRUKINSA 80 MG CAPSULE	T2	PA QL(4 CAPS/DAY) SP CSL
CABOMETYX	T2	PA SP HD CSL
CALQUENCE	T2	PA SP CSL
CAPRELSA 100 MG TABLET	T3	PA QL(2 TABS/DAY) SP CSL
CAPRELSA 300 MG TABLET	T3	PA QL(1 TAB/DAY) SP CSL
COMETRIQ 100 MG DAILY-DOSE PK	T3	PA QL(56 CAPS/28 DAYS) SP HD CSL
COMETRIQ 140 MG DAILY-DOSE PK	T3	PA QL(112 CAPS/28 DAYS) SP HD CSL
COMETRIQ 60 MG DAILY-DOSE PACK	T3	PA QL(84 CAPS/28 DAYS) SP HD CSL
COPIKTRA	T3	PA SP CSL
DANZITEN	T2	PA SP CSL
dasatinib 100 mg tablet (Sprycel)	T1	QL(1 TAB/DAY) SP HD CSL
dasatinib 140 mg tablet (Sprycel)	T1	QL(1 TAB/DAY) SP HD CSL
dasatinib 20 mg tablet (Sprycel)	T1	QL(3 TABS/DAY) SP HD CSL
dasatinib 50 mg tablet (Sprycel)	T1	QL(1 TAB/DAY) SP HD CSL
dasatinib 70 mg tablet (Sprycel)	T1	QL(2 TABS/DAY) SP HD CSL
dasatinib 80 mg tablet (Sprycel)	T1	QL(1 TAB/DAY) SP HD CSL
ENSACOVE 100 MG CAPSULE	T2	PA QL(2 CAPS/DAY) SP CSL
ENSACOVE 25 MG CAPSULE	T2	PA QL(9 CAPS/DAY) SP CSL
erlotinib hcl	T1	PA SP HD CSL
FOTIVDA	T3	PA QL(21 CAPS/28 DAYS) SP CSL
FRUZAQLA 1 MG CAPSULE	T2	PA QL(84 CAPS/28 DAYS) SP CSL
FRUZAQLA 5 MG CAPSULE	T2	PA QL(21 CAPS/28 DAYS) SP CSL
GAVRETO	T3	PA QL(4 CAPS/DAY) SP CSL
gefitinib (Iressa)	T1	PA SP HD CSL
GILOTRIF	T3	PA SP HD CSL
IBRANCE 100 MG CAPSULE	T3	PA QL(21 CAPS/28 DAYS) SP HD CSL

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS *(cont.)*		
IBRANCE 100 MG TABLET	T3	PA QL(21 TABS/28 DAYS) SP HD CSL
IBRANCE 125 MG CAPSULE	T3	PA QL(21 CAPS/28 DAYS) SP HD CSL
IBRANCE 125 MG TABLET	T3	PA QL(21 TABS/28 DAYS) SP HD CSL
IBRANCE 75 MG CAPSULE	T3	PA QL(21 CAPS/28 DAYS) SP HD CSL
IBRANCE 75 MG TABLET	T3	PA QL(21 TABS/28 DAYS) SP HD CSL
IBTROZI	T3	PA SP CSL
imatinib mesylate 100 mg tab (Gleevec)	T1	QL(6 TABS/DAY) SP HD CSL
imatinib mesylate 400 mg tab (Gleevec)	T1	QL(2 TABS/DAY) SP HD CSL
IMBRUVICA 140 MG CAPSULE	T2	PA QL(4 CAPS/DAY) SP CSL
IMBRUVICA 140 MG TABLET	T2	PA QL(1 TAB/DAY) SP CSL
IMBRUVICA 280 MG TABLET	T2	PA QL(1 TAB/DAY) SP CSL
IMBRUVICA 420 MG TABLET	T2	PA QL(1 TAB/DAY) SP CSL
IMBRUVICA 70 MG CAPSULE	T2	PA QL(1 CAP/DAY) SP CSL
IMBRUVICA 70 MG/ML SUSPENSION	T2	PA QL(8 MLS/DAY) SP CSL
IMKELDI	T2	PA SP CSL
INLYTA	T3	PA SP HD CSL
INREBIC	T3	PA SP HD CSL
IRESSA (*gefitinib*)	T3	PA SP HD CSL
ITOVEBI	T3	PA SP HD CSL
IWILFIN	T3	PA QL(8 TABS/DAY) SP CSL
JAYPIRCA 100 MG TABLET	T3	PA QL(2 TABS/DAY) SP CSL
JAYPIRCA 50 MG TABLET	T3	PA QL(1 TAB/DAY) SP CSL
KISQALI 200 MG DAILY DOSE	T2	PA QL(21 TABS/28 DAYS) SP HD CSL
KISQALI 400 MG DAILY DOSE	T2	PA QL(42 TABS/28 DAYS) SP HD CSL
KISQALI 600 MG DAILY DOSE	T2	PA QL(63 TABS/28 DAYS) SP HD CSL
KYPROLIS	T3	PA SP HD
lapatinib ditosylate (Tykerb)	T1	PA QL(6 TABS/DAY) SP HD CSL
LAZCLUZE	T3	PA SP CSL
LENVIMA	T2	PA SP HD CSL
LORBRENA 100 MG TABLET	T3	PA QL(1 TAB/DAY) SP HD CSL
LORBRENA 25 MG TABLET	T3	PA QL(3 TABS/DAY) SP HD CSL

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS *(cont.)*		
LYNPARZA	T2	PA QL(4 TABS/DAY) SP HD CSL
LYTGOBI 12 MG DOSE (3X 4MG TB)	T3	PA QL(3 TABS/DAY) SP CSL
LYTGOBI 16 MG DOSE (4X 4MG TB)	T3	PA QL(4 TABS/DAY) SP CSL
LYTGOBI 20 MG DOSE (5X 4MG TB)	T3	PA QL(5 TABS/DAY) SP CSL
NERLYNX	T3	PA SP HD CSL
nilotinib hcl (Tasigna)	T1	PA QL(4 CAPS/DAY) SP HD CSL
NINLARO	T3	PA QL(3 CAPS/28 DAYS) SP HD CSL
OGSIVEO 100 MG TABLET	T3	PA QL(2 TABS/DAY) SP CSL
OGSIVEO 150 MG TABLET	T3	PA QL(2 TABS/DAY) SP CSL
OGSIVEO 50 MG TABLET	T3	PA QL(6 TABS/DAY) SP CSL
OJJAARA	T3	PA QL(1 TAB/DAY) SP CSL
pazopanib hcl 200 mg tablet (Votrient)	T1	PA QL(4 TABS/DAY) SP CSL
PEMAZYRE	T3	PA QL(14 TABS/21 DAYS) SP CSL
PIQRAY	T2	PA SP CSL
QINLOCK	T3	PA QL(3 TABS/DAY) SP CSL
RETEVMO 120 MG TABLET	T3	PA QL(2 TABS/DAY) SP HD CSL
RETEVMO 160 MG TABLET	T3	PA QL(2 TABS/DAY) SP HD CSL
RETEVMO 40 MG CAPSULE	T3	PA QL(6 CAPS/DAY) SP HD CSL
RETEVMO 40 MG TABLET	T3	PA QL(3 TABS/DAY) SP HD CSL
RETEVMO 80 MG CAPSULE	T3	PA QL(4 CAPS/DAY) SP HD CSL
RETEVMO 80 MG TABLET	T3	PA QL(2 TABS/DAY) SP HD CSL
REVUFORJ 110 MG TABLET	T3	PA QL(4 TABS/DAY) SP CSL
REVUFORJ 160 MG TABLET	T3	PA QL(2 TABS/DAY) SP CSL
REVUFORJ 25 MG TABLET	T3	PA QL(8 TABS/DAY) SP CSL
ROMVIMZA	T3	PA QL(8 CAPS/28 DAYS) SP CSL
ROZLYTREK	T3	PA SP HD CSL
RUBRACA	T2	PA QL(4 TABS/DAY) SP CSL
RYDAPT	T3	PA SP HD CSL
SCEMBLIX 100 MG TABLET	T2	PA SP CSL
SCEMBLIX 20 MG TABLET	T2	PA QL(2 TABS/DAY) SP CSL
SCEMBLIX 40 MG TABLET	T2	PA SP CSL
sorafenib tosylate (Nexavar)	T1	PA QL(4 TABS/DAY) SP HD CSL
STIVARGA	T2	PA QL(84 TABS/28 DAYS) SP HD CSL
sunitinib malate (Sutent)	T1	PA QL(1 CAP/DAY) SP HD CSL

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS *(cont.)*		
TABRECTA	T3	PA QL(4 TABS/DAY) SP HD CSL
TAGRISSO	T3	PA SP HD CSL
TALZENNA 0.1 MG CAPSULE	T3	PA QL(1 CAP/DAY) SP CSL
TALZENNA 0.1 MG SOFTGEL	T3	PA QL(1 CAP/DAY) SP CSL
TALZENNA 0.25 MG CAPSULE	T3	PA QL(1 CAP/DAY) SP CSL
TALZENNA 0.25 MG SOFTGEL	T3	PA QL(1 CAP/DAY) SP CSL
TALZENNA 0.35 MG SOFTGEL	T3	PA QL(1 CAP/DAY) SP CSL
TALZENNA 0.5 MG CAPSULE	T3	PA SP CSL
TALZENNA 0.5 MG SOFTGEL	T3	PA SP CSL
TALZENNA 0.75 MG SOFTGEL	T3	PA SP CSL
TALZENNA 1 MG CAPSULE	T3	PA QL(1 CAP/DAY) SP CSL
TALZENNA 1 MG SOFTGEL	T3	PA QL(1 CAP/DAY) SP CSL
TEPMETKO	T3	PA QL(2 TABS/DAY) SP CSL
TRUQAP	T2	PA QL(64 TABS/28 DAYS) SP CSL
TUKYSA	T3	PA SP CSL
TURALIO	T3	PA QL(4 CAPS/DAY) SP CSL
VANFLYTA	T3	PA QL(2 TABS/DAY) SP CSL
VERZENIO	T2	PA QL(2 TABS/DAY) SP HD CSL
VITRAKVI	T3	PA SP HD CSL
VIZIMPRO	T3	PA SP HD CSL
VONJO	T3	PA QL(4 CAPS/DAY) SP CSL
XALKORI 150 MG PELLET	T3	PA QL(6 PELLETS/DAY) SP HD CSL
XALKORI 20 MG PELLET	T3	PA QL(4 PELLETS/DAY) SP HD CSL
XALKORI 200 MG CAPSULE	T3	PA QL(4 CAPS/DAY) SP HD CSL
XALKORI 250 MG CAPSULE	T3	PA QL(4 CAPS/DAY) SP HD CSL
XALKORI 50 MG PELLET	T3	PA QL(4 PELLETS/DAY) SP HD CSL
XOSPATA	T3	PA SP CSL
ZEJULA	T2	PA QL(1 TAB/DAY) SP CSL
ZYDELIG	T3	PA QL(2 TABS/DAY) SP HD CSL
ANTINEOPLASTIC, ANTI-PROGRAMMED DEATH-I (PD-I) MAB		
JEMPERLI	T3	PA SP
KEYTRUDA	T3	PA SP
KEYTRUDA QLEX	T3	PA SP
LIBTAYO	T3	PA SP
LOQTORZI	T3	PA SP

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List of Prescription Medications

ANTINEOPLASTICS (Cancer) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS *(cont.)*		
OPDIVO	T3	PA SP HD
TEVIMBRA	T3	PA SP
ZYNYZ	T3	PA SP
ANTINEOPLASTIC-B CELL LYMPHOMA-2 (BCL-2) INHIBITORS		
VENCLEXTA	T3	PA SP
VENCLEXTA STARTING PACK	T3	PA SP
ANTINEOPLASTIC-ENZYME INHIB, ANTIANDROGEN COMB.		
AKEEGA	T3	PA QL(2 TABS/DAY) SP CSL
ANTINEOPLASTIC-HYPOXIA INDUCIBLE FACTOR (HIF) INH		
WELIREG	T3	PA QL(3 TABS/DAY) SP CSL
ANTINEOPLASTIC-IMMUNOTHERAPY CHECKPOINT INHIB COMB		
OPDUALAG	T3	PA SP HD
ANTINEOPLASTIC-INTERLEUKIN-6 (IL-6) INHIB, ANTIBODY		
SYLVANT	T3	PA SP
ANTINEOPLASTIC-ISOCITRATE DEHYDROGENASE INHIBITORS		
IDHIFA	T3	PA SP HD CSL
REZLIDHIA	T3	PA QL(2 CAPS/DAY) SP CSL
TIBSOVO	T3	PA SP CSL
VORANIGO	T3	PA SP CSL
ANTINEOPLASTIC-ISOCITRATE DEHYDROGENASE INHIBITORS		
ADCETRIS	T3	PA SP
BIZENGRI	T3	PA SP
BLENREP	T3	PA SP
BLINCYTO	T3	PA SP
COLUMVI	T3	PA SP HD
DATROWAY	T3	PA SP
ELAHERE	T3	PA SP
ELREXFIO	T3	PA SP
EMRELIS	T3	PA SP
ENHERTU	T3	PA SP HD
EPKINLY	T3	PA SP
IMDELLTRA	T3	PA SP
KADCYLA	T3	PA SP
LUNSUMIO	T3	PA SP
LYNOZYFIC	T3	PA SP

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ANTINEOPLASTICS (Cancer) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTINEOPLASTIC-ISOCITRATE DEHYDROGENASE INHIBITORS *(cont.)*		
PADCEV	T3	PA SP
POLIVY	T3	PA SP HD
POTELIGEO	T3	PA SP
TALVEY	T3	PA SP
TECVAYLI	T3	PA SP
TIVDAK	T3	PA SP HD
TRODELVY	T3	PA SP
UNITUXIN	T3	PA SP
VYLOY	T3	PA SP
ZEVALIN	T2	PA SP
ZYNLONTA	T3	PA SP
ANTINEOPLASTICS, MISCELLANEOUS		
ABRAXANE (*paclitaxel protein-bound*)	T2	PA SP
arsenic trioxide	T1	PA SP
arsenic trioxide (Trisenox)	T1	PA SP
ASPARLAS	T3	SP
BCG (TICE STRAIN)	T3	SP
BEIZRAY-ALBUMIN	T3	PA
dacarbazine	T1	PA SP
DOCEFREZ	T3	PA SP
docetaxel 160 mg/16 ml vial	T1	PA SP
docetaxel 160 mg/8 ml vial	T1	PA SP HD
docetaxel 20 mg/2 ml vial	T1	PA SP
docetaxel 20 mg/ml vial	T1	PA SP
docetaxel 80 mg/4 ml vial	T1	PA SP
docetaxel 80 mg/8 ml vial	T1	PA SP
ERWINASE	T3	PA SP
ETOPOPHOS	T2	PA SP
etoposide	T1	PA SP
etoposide 1,000 mg/50 ml vial	T1	PA SP
etoposide 100 mg/5 ml vial	T1	PA SP
etoposide 50 mg capsule	T1	SP HD CSL

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ANTINEOPLASTICS (Cancer) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTINEOPLASTICS, MISCELLANEOUS *(cont.)*		
etoposide 500 mg/25 ml vial	T1	PA SP
JEVTANA	T3	PA SP HD
LYSODREN	T2	CSL
MATULANE	T2	SP CSL
mitoxantrone hcl	T1	PA SP
ONCASPAR	T2	PA SP
paclitaxel	T1	PA SP
paclitaxel protein-bound (Abraxane)	T1	PA SP
RYLAZE	T3	PA SP
tretinoin 10 mg capsule	T1	PA CSL
TRISENOX (*arsenic trioxide*)	T2	PA SP
ANTINEOPLASTIC-SELECT INHIB OF NUCLEAR EXP (SINE)		
XPOVIO	T3	PA SP
ANTI-PROGRAMMED CELL DEATH-LIGAND I (PD-LI) MAB		
BAVENCIO	T3	PA SP
IMFINZI	T3	PA SP
TECENTRIQ	T3	PA SP HD
TECENTRIQ HYBREZA	T3	PA SP HD
UNLOXCYT	T3	PA SP
CYTOTOXIC T-LYMPHOCYTE ANTIGEN (CTLA-4) RMC ANTIBODY		
IMJUDO	T3	PA SP HD
YERVOY	T3	PA SP HD
IMMUNOMODULATORS		
ACTIMMUNE	T2	PA SP HD
ALFERON N	T2	PA SP HD
PROLEUKIN	T2	PA SP
PHOTOACTIVATED, ANTINEOPLASTIC AGENTS (SYSTEMIC)		
PHOTOFRIN	T2	SP
UVADEX	T2	
RADIOACTIVE THERAPEUTIC AGENTS		
AZEDRA DOSIMETRIC	T3	PA SP
AZEDRA THERAPEUTIC	T3	PA SP
SELECTIVE ESTROGEN RECEPTOR MODULATORS (SERMS)		
FARESTON (*toremifene citrate*)	T3	QL(2 TABS/DAY) HD CSL
FASLODEX (*fulvestrant*)	T2	PA SP HD

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ANTINEOPLASTICS (Cancer) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
SELECTIVE ESTROGEN RECEPTOR MODULATORS (SERMS)		
fulvestrant (Faslodex)	T1	PA SP HD
ORSERDU 345 MG TABLET	T3	PA QL(1 TAB/DAY) SP CSL
ORSERDU 86 MG TABLET	T3	PA QL(3 TABS/DAY) SP CSL
SOLTAMOX	T2	HD CSL
tamoxifen citrate	T1	HD PPACA CSL
toremifene citrate (Fareston)	T1	QL(2 TABS/DAY) HD CSL
STEROID ANTINEOPLASTICS		
megestrol 20 mg tablet	T1	CSL
megestrol 40 mg tablet	T1	CSL
ANTINEOPLASTICS (Skin Conditions)		
PHOTOACT, TOPICAL ANTINEOPLAST, PREMALIGNANT LESIONS		
LEVULAN	T3	SP
TOPICAL ANTINEOPLASTIC PREMALIGNANT LESION AGENTS		
bexarotene 1% gel (Targretin)	T1	SP HD
EFUDEX (*fluorouracil*)	T3	
FLUOROPLEX	T2	
FLUOROURACIL 0.5% CREAM	T1	
fluorouracil 2% topical soln	T1	
fluorouracil 5% cream (Efudex)	T1	
fluorouracil 5% topical soln	T1	
PANRETIN	T3	SP HD
VALCHLOR	T3	SP HD
ANTIPARASITICS (Eye Conditions)		
OPHTHALMIC (EYE) ANTIPARASITICS		
XDEMVY	T2	PA QL(10 MLS/56 DAYS) SP
ANTIPARASITICS (Infections)		
ANTIPARASITICS		
ALINIA 100 MG/5 ML SUSPENSION	T3	
nitazoxanide (Alinia)	T1	
TOPICAL ANTIPARASITICS		
crotamiton	T1	
ELIMITE (permethrin)	T3	
EURAX	T3	
lindane	T1	

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ANTIPARASITICS (Infections) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
TOPICAL ANTIPARASITICS		
malathion (Ovide)	T1	
OVIDE *(malathion)*	T3	
permethrin (Elimite)	T1	
spinosad (Natroba)	T1	
ULESFIA	T3	
ANTIPARASITICS (Skin Conditions)		
TOPICAL ANTIPARASITICS		
lindane	T1	
malathion (Ovide)	T1	
OVIDE (malathion)	T3	
ANTIPARKINSON DRUGS (Parkinson's Disease)		
ANTIPARKINSONISM DRUGS, ANTICHOLINERGIC		
benztropine mesylate	T1	HD
trihexyphenidyl hcl	T1	HD
ANTIPARKINSONISM DRUGS, OTHER		
amantadine hcl	T1	HD
APOKYN	T3	PA SP HD
apomorphine hcl	T1	PA SP
bromocriptine mesylate	T1	HD
carbidopa/levodopa	T1	HD
carbidopa/levodopa (Sinemet)	T1	HD
carbidopa/levodopa/entacapone	T1	HD
carbidopa/levodopa/entacapone (Stalevo 100)	T1	HD
carbidopa/levodopa/entacapone (Stalevo 75)	T1	HD
carbidopa-levo er 25-100 tab	T1	HD
carbidopa-levo er 50-200 tab	T1	HD
CREXONT	T3	ST HD
DUOPA	T3	SP HD
entacapone	T1	HD
INBRIJA	T3	PA SP HD
NEUPRO	T3	HD
NOURIANZ	T3	PA QL(1 TAB/DAY) SP HD

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List of Prescription Medications

ANTIPARKINSON DRUGS (Parkinson's Disease) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIPARKINSONISM DRUGS, OTHER *(cont.)*		
pramipexole di-hcl	T1	HD
pramipexole er 0.375 mg tablet	T1	QL(1 TAB/DAY) HD
pramipexole er 0.75 mg tablet	T1	HD
pramipexole er 1.5 mg tablet	T1	QL(1 TAB/DAY) HD
pramipexole er 2.25 mg tablet	T1	QL(1 TAB/DAY) HD
pramipexole er 3 mg tablet	T1	HD
pramipexole er 3.75 mg tablet	T1	HD
pramipexole er 4.5 mg tablet	T1	HD
rasagiline mesylate 0.5 mg tab (Azilect)	T1	QL(1 TAB/DAY) HD
rasagiline mesylate 1 mg tab (Azilect)	T1	HD
ropinirole hcl	T1	HD
RYTARY	T3	ST HD
selegiline hcl	T1	HD
SINEMET *(carbidopa/levodopa)*	T3	HD
STALEVO 100 (carbidopa/levodopa/entacapone)	T3	HD
STALEVO 75 *(carbidopa/levodopa/entacapone)*	T3	HD
TASMAR (*tolcapone*)	T3	HD
tolcapone (Tasmar)	T1	HD
XADAGO	T3	ST HD
DECARBOXYLASE INHIBITORS		
carbidopa (Lodosyn)	T1	
ANTIPLATELET DRUGS (Blood Thinners/Anti-Clotting)		
PLATELET AGGREGATION INHIBITORS		
AGGRASTAT	T3	
aspirin/dipyridamole	T1	HD
ASPIRIN-OMEPRAZOLE DR 81-40 MG	T3	HD
cilostazol	T1	HD
clopidogrel bisulfate	T1	HD
clopidogrel bisulfate (Plavix)	T1	HD
dipyridamole 25 mg tablet	T1	HD
dipyridamole 50 mg tablet	T1	HD
dipyridamole 75 mg tablet	T1	HD

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List of Prescription Medications

ANTIPLATELET DRUGS (Blood Thinners/Anti-Clotting) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
PLATELET AGGREGATION INHIBITORS *(cont.)*		
eptifibatide	T1	
EPTIFIBATIDE	T1	
prasugrel hcl (Effient)	T1	HD
ticagrelor (Brilinta)	T1	HD
tirofiban-0.9% sodium chloride	T1	
ZONTIVITY	T3	HD
PLATELET REDUCING AGENTS		
AGRYLIN (*anagrelide hcl*)	T3	
anagrelide hcl	T1	
anagrelide hcl (Agrylin)	T1	
ANTIVIRALS (AIDS/HIV)		
ANTIRETROVIRAL - ANTI-CD4 DOMAIN 2 MONOCLONAL AB		
TROGARZO	T3	PA SP
ANTIRETROVIRAL - CAPSID INHIBITORS		
SUNLENCA 300 MG TABLET	T3	PA QL(5 TABS/180 DAYS) SP
SUNLENCA 4- 300 MG TABLET	T3	PA QL(5 TABS/180 DAYS) SP
SUNLENCA 463.5 MG/1.5 ML VIAL	T3	PA SP
SUNLENCA 5- 300 MG TABLET	T3	PA QL(5 TABS/180 DAYS) SP
ANTIRETROVIRAL-INTEGRASE INHIBITOR AND NNRTI COMB.		
CABENUVA	T3	PA SP
JULUCA	T2	QL(1 TAB/DAY) SP
ANTIRETROVIRAL-INTEGRASE INHIBITOR AND NRTI COMB.		
DOVATO	T2	QL(1 TAB/DAY) SP
ANTIRETROVIRAL-NRTIS AND INTEGRASE INHIBITORS COMB		
TRIUMEQ	T2	QL(1 TAB/DAY) SP
TRIUMEQ PD	T2	QL(6 TABS/DAY) SP
ANTIRETROVIRAL-NUCLEOSIDE, NUCLEOTIDE, PROTEASE INH.		
SYMTUZA	T2	SP
ANTIVIRALS, HIV-SPEC, NON-PEPTIDIC PROTEASE INHIB		
APTIVUS	T2	PA SP
darunavir (Prezista)	T1	SP
PREZCOBIX	T3	PA SP
PREZISTA 100 MG/ML SUSPENSION	T2	SP
PREZISTA 150 MG TABLET	T2	SP
PREZISTA 75 MG TABLET	T2	SP

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ANTIVIRALS (AIDS/HIV) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIVIRALS, HIV-SPEC, NUCLEOSIDE-NUCLEOTIDE ANALOG		
CIMDUO	T3	PA SP
DESCOVY 120-15 MG TABLET	T2	SP
DESCOVY 200-25 MG TABLET	T2	SP PPACA
*emtricitabine-tenofv 100-150mg (*Truvada*)*	T1	SP
*emtricitabine-tenofv 133-200mg (*Truvada*)*	T1	SP
*emtricitabine-tenofv 167-250mg (*Truvada*)*	T1	SP
*emtricitabine-tenofv 200-300mg (*Truvada*)*	T1	SP PPACA
ANTIVIRALS, HIV-SPEC., NUCLEOSIDE ANALOG, RTI COMB		
*abacavir sulfate/lamivudine (*Epzicom*)*	T1	PA SP
*lamivudine/zidovudine (*Combivir*)*	T1	SP
ANTIVIRALS, HIV-SPECIFIC, CCR5 CO-RECEPTOR ANTAG.		
*maraviroc (*Selzentry*)*	T1	PA SP
SELZENTRY 20 MG/ML ORAL SOLN	T2	PA SP
ANTIVIRALS, HIV-SPECIFIC, CD4 ATTACHMENT INHIBITOR		
RUKOBIA	T3	PA QL(2 TABS/DAY) SP
ANTIVIRALS, HIV-SPECIFIC, FUSION INHIBITORS		
FUZEON	T2	PA SP
ANTIVIRALS, HIV-SPECIFIC, NON-NUCLEOSIDE, RTI		
EDURANT	T3	PA SP
EDURANT PED	T3	PA SP
efavirenz	T1	PA SP
etravirine (Intelence)	T1	SP
INTELENCE 25 MG TABLET	T3	PA SP
nevirapine	T1	PA SP
PIFELTRO	T3	PA SP
ANTIVIRALS, HIV-SPECIFIC, NUCLEOSIDE ANALOG, RTI		
abacavir sulfate	T1	PA SP
*abacavir sulfate (*Ziagen*)*	T1	PA SP
emtricitabine (Emtriva)	T1	SP
EMTRIVA 10 MG/ML SOLUTION	T2	PA SP
*lamivudine 10 mg/ml oral soln (*Epivir*)*	T1	SP
*lamivudine 150 mg tablet (*Epivir*)*	T1	SP
lamivudine 300 mg tablet (Epivir)	T1	PA SP
*lamivudine 300 mg/30ml sol cup (*Epivir*)*	T1	SP

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ANTIVIRALS (AIDS/HIV) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIVIRALS, HIV-SPECIFIC, NUCLEOSIDE ANALOG, RTI *(cont.)*		
RETROVIR 200 MG/20 ML VIAL	T3	PA SP
zidovudine	T1	SP
zidovudine (Retrovir)	T1	SP
tenofovir disoproxil fumarate (Viread)	T1	PA SP
VIREAD 150 MG TABLET	T2	PA SP
VIREAD 200 MG TABLET	T2	PA SP
VIREAD 250 MG TABLET	T2	PA SP
VIREAD POWDER	T2	PA SP
ANTIVIRALS, HIV-SPECIFIC, PROTEASE INHIBITOR COMB		
lopinavir/ritonavir	T1	SP
lopinavir/ritonavir (Kaletra)	T1	SP
ANTIVIRALS, HIV-SPECIFIC, PROTEASE INHIBITORS		
atazanavir sulfate	T1	PA SP
atazanavir sulfate (Reyataz)	T1	PA SP
EVOTAZ	T3	PA SP
fosamprenavir calcium	T1	PA SP
NORVIR 100 MG POWDER PACKET	T2	SP
REYATAZ 50 MG POWDER PACKET	T2	PA SP
ritonavir (Norvir)	T1	SP
ANTIVIRALS, HIV-I INTEGRASE STRAND TRANSFER INHIBTR		
APRETUDE	T2	SP PPACA
ISENTRESS	T2	SP
ISENTRESS HD	T2	PA SP
TIVICAY	T2	SP
TIVICAY PD	T2	SP
ARTV NUCLEOSIDE, NUCLEOTIDE, NON-NUCLEOSIDE RTI COMB		
DELSTRIGO	T3	PA QL(1 TAB/DAY) SP
efavirenz/emtricit/tenofovr df	T1	QL(1 TAB/DAY) SP
efavirenz/lamivu/tenofov disop (Symfi Lo)	T1	QL(1 TAB/DAY) SP
efavirenz/lamivu/tenofov disop (Symfi)	T1	QL(1 TAB/DAY) SP
emtricita/rilpivirine/tenof df (Complera)	T1	QL(1 TAB/DAY) SP
ODEFSEY	T3	PA QL(1 TAB/DAY) SP
ARV-NUCLEOSIDE, NUCLEOTIDE RTI, INTEGRASE INHIBITORS		
BIKTARVY	T2	QL(1 TAB/DAY) SP
GENVOYA	T2	QL(1 TAB/DAY) SP

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ARV-NUCLEOSIDE, NUCLEOTIDE RTI, INTEGRASE INHIBITORS		
STRIBILD	T3	PA QL(1 TAB/DAY) SP
ANTIVIRALS (Eye Conditions)		
EYE ANTIVIRALS		
trifluridine	T1	
ZIRGAN	T3	
ANTIVIRALS (Infections)		
ANTIVIRAL - MAIN PROTEASE (MPRO) INHIBITOR		
PAXLOVID	T2	QL(1 TAB/120 DAYS)
ANTIVIRAL - RNA POLYMERASE INHIBITOR		
LAGEVRIO (EUA)	T2	QL(1 PACK/120 DAYS)
ANTIVIRAL MONOCLONAL ANTIBODIES		
BEYFORTUS	T3	PPACA
ENFLONSIA	T3	PPACA
EVUSHELD (EUA)	T3	
SYNAGIS	T3	PA SP HD
ANTIVIRALS, GENERAL		
acyclovir 200 mg capsule	T1	
acyclovir 200 mg/5 ml susp	T1	
acyclovir 200 mg/5 ml susp cup	T1	
acyclovir 400 mg tablet	T1	
acyclovir 800 mg tablet	T1	
acyclovir 800 mg/20ml susp cup	T1	
acyclovir sodium	T1	
cidofovir	T1	SP
famciclovir	T1	
FLUMADINE (*rimantadine hcl*)	T3	
foscarnet sodium (Foscavir)	T1	
FOSCAVIR *(foscarnet sodium)*	T3	
GANCICLOVIR	T3	SP
ganciclovir sodium	T1	SP
LIVTENCITY	T3	PA QL(4 TABS/DAY) SP
oseltamivir 6 mg/ml suspension (Tamiflu)	T1	QL(180 MLS/30 DAYS)
oseltamivir phos 30 mg capsule (Tamiflu)	T1	QL(20 CAPS/30 DAYS)
oseltamivir phos 45 mg capsule (Tamiflu)	T1	QL(10 CAPS/30 DAYS)

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ANTIVIRALS (Infections) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIVIRALS, GENERAL *(cont.)*		
oseltamivir phos 75 mg capsule (Tamiflu)	T1	QL(10 CAPS/30 DAYS)
PREVYMIS 120 MG PELLET PACKET	T3	SP
PREVYMIS 20 MG PELLET PACKET	T3	SP
PREVYMIS 240 MG TABLET	T3	SP HD
PREVYMIS 240 MG/12 ML VIAL	T3	SP
PREVYMIS 480 MG TABLET	T3	SP HD
PREVYMIS 480 MG/24 ML VIAL	T3	SP
RAPIVAB	T3	
RELENZA	T3	QL(20 BLISTERS/30 DAYS)
rimantadine hcl (Flumadine)	T1	
TAMIFLU 30 MG CAPSULE *(oseltamivir phosphate)*	T3	QL(20 CAPS/30 DAYS)
TAMIFLU 45 MG CAPSULE (*oseltamivir phosphate*)	T3	QL(10 CAPS/30 DAYS)
TAMIFLU 6 MG/ML SUSPENSION (*oseltamivir phosphate*)	T3	QL(180 MLS/30 DAYS)
TAMIFLU 75 MG CAPSULE (*oseltamivir phosphate*)	T3	QL(10 CAPS/30 DAYS)
TEMBEXA	T3	
valacyclovir hcl (Valtrex)	T1	
valganciclovir hcl (Valcyte)	T1	
VALTREX (*valacyclovir hcl*)	T3	
XOFLUZA	T3	QL(2 TABS/30 DAYS)
HEP C - NS5A, NS3/4A, NUCLEOTIDE NS5B INHIB COMBO		
VOSEVI	T2	PA SP HD
HEP C VIRUS-NS5B POLYMERASE AND NS5A INHIB. COMBO.		
EPCLUSA 150-37.5 MG PELLET PKT	T2	PA QL(1 PACK/DAY) SP HD
EPCLUSA 200 MG-50 MG TABLET	T2	PA QL(1 TAB/DAY) SP HD
EPCLUSA 200-50 MG PELLET PACK	T2	PA QL(1 PACK/DAY) SP HD
EPCLUSA 400 MG-100 MG TABLET	T2	PA QL(1 TAB/DAY) SP HD
HARVONI 33.75-150 MG PELLET PK	T2	PA QL(1 PACK/DAY) SP HD
HARVONI 45-200 MG PELLET PACKT	T2	PA QL(1 PACK/DAY) SP HD
HARVONI 45-200 MG TABLET	T2	PA QL(1 TAB/DAY) SP HD
HARVONI 90-400 MG TABLET	T2	PA QL(1 TAB/DAY) SP HD
HEPATITIS B TREATMENT AGENTS		
adefovir dipivoxil	T1	SP HD
BARACLUDE 0.05 MG/ML SOLUTION	T2	SP HD
*entecavir 0.5 mg tablet (*Baraclude*)*	T1	QL(1 TAB/DAY) SP HD
*entecavir 1 mg tablet (*Baraclude*)*	T1	SP HD

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List of Prescription Medications

ANTIVIRALS (Infections) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
HEPATITIS B TREATMENT AGENTS		
lamivudine	T1	SP
VEMLIDY	T2	SP HD
PEGASYS	T2	PA SP HD
ribavirin	T1	SP HD
HEPATITIS C VIRUS- NS5A AND NS3/4A INHIBITOR COMB		
ZEPATIER	T2	PA QL(1 TAB/DAY) SP HD
ANTIVIRALS (Skin Conditions)		
TOPICAL ANTIVIRALS		
penciclovir (Denavir)	T1	QL(5 GMS/30 DAYS)
AUTONOMIC DRUGS (Allergy/Nasal Sprays)		
ANAPHYLAXIS THERAPY AGENTS		
ADYPHREN	T1	
ADYPHREN AMP	T1	
*epinephrine 0.15 mg auto-injct (*Epipen Jr 2-Pak*)*	T1	QL(4 UNITS/30 DAYS)
*epinephrine 0.15 mg auto-injct (*Epipen Jr*)*	T1	QL(4 UNITS/30 DAYS)
*epinephrine 0.3 mg auto-inject (*Epipen 2-Pak*)*	T1	QL(4 UNITS/30 DAYS)
*epinephrine 0.3 mg auto-inject (*Epipen*)*	T1	QL(4 UNITS/30 DAYS)
EPINEPHRINE PROFESSIONAL EMS	T3	
EPINEPHRINE PROFESSIONAL KIT	T3	
EPINEPHRINESNAP-EMS	T3	
EPINEPHRINESNAP-V	T3	
AUTONOMIC DRUGS (Alzheimer's Disease)		
CHOLINESTERASE INHIBITORS		
ADLARITY	T2	PA QL(4 PATCHES/28 DAYS) HD
BLOXIVERZ (*neostigmine methylsulfate*)	T3	
donepezil hcl	T1	HD
donepezil hcl (Aricept)	T1	HD
EXELON (rivastigmine)	T3	HD
galantamine er 16 mg capsule	T1	HD
galantamine er 24 mg capsule	T1	HD
galantamine er 8 mg capsule	T1	QL(1 CAP/DAY) HD
galantamine hbr	T1	HD
neostigmine methylsulfate	T1	

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AUTONOMIC DRUGS (Alzheimer's Disease) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
CHOLINESTERASE INHIBITORS *(cont.)*		
NEOSTIGMINE METHYLSULFATE	T1	
neostigmine methylsulfate (Bloxiverz)	T1	
physostigmine salicylate	T1	
pyridostigmine 60 mg/5 ml cup (Mestinon)	T1	HD
pyridostigmine 60 mg/5 ml soln (Mestinon)	T1	HD
pyridostigmine br 60 mg tablet (Mestinon)	T1	HD
pyridostigmine bromide	T3	
pyridostigmine bromide (Mestinon)	T1	HD
rivastigmine (Exelon)	T1	HD
rivastigmine tartrate	T1	HD
AUTONOMIC DRUGS (Attention Deficit Hyperactivity Disorder)[10]		
ADRENERGICS, AROMATIC, NON-CATECHOLAMINE		
amphetamine sulfate (Evekeo)	T1	PA
dextroamphetamine er 10 mg cap (Dexedrine)	T1	PA QL(1 CAP/DAY)
dextroamphetamine er 15 mg cap (Dexedrine)	T1	PA QL(3 CAPS/DAY)
dextroamphetamine er 5 mg cap	T1	PA QL(1 CAP/DAY)
dextroamphetamine sulfate	T1	PA
dextroamphetamine sulfate	T3	PA ST
dextroamphetamine sulfate (Zenzedi)	T1	PA
dextroamphetamine/amphetamine (Adderall Xr)	T1	PA QL(1 CAP/DAY)
dextroamphetamine/amphetamine (Adderall)	T1	PA
dextroamphetamine/amphetamine (Mydayis)	T1	PA QL(1 CAP/DAY)
methamphetamine hcl (Desoxyn)	T1	PA
XELSTRYM	T3	PA QL(1 PATCH/DAY)
ZENZEDI (dextroamphetamine sulfate)	T3	PA ST
AUTONOMIC DRUGS (Blood Pressure/Heart Medications)		
ADRENERGIC VASOPRESSOR AGENTS		
droxidopa 100 mg capsule (Northera)	T1	SP HD
droxidopa 200 mg capsule (Northera)	T1	SP HD
droxidopa 300 mg capsule (Northera)	T1	SP HD
midodrine hcl	T1	

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AUTONOMIC DRUGS (Blood Pressure/Heart Medications)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ALPHA-ADRENERGIC BLOCKING AGENTS		
DIBENZYLINE (phenoxybenzamine hcl)	T3	HD
phenoxybenzamine hcl (Dibenzyline)	T1	HD
phentolamine mesylate	T1	HD
AUTONOMIC DRUGS (Miscellaneous)		
ADRENERGIC AGENTS, CATECHOLAMINES		
dopamine hcl	T1	
dopamine hcl in dextrose 5 %	T1	
epinephrine	T3	
epinephrine 1 mg/10 ml abbojct	T1	
epinephrine 1 mg/10 ml luerjet	T1	
EPINEPHRINE 1 MG/ML AMPUL	T1	
epinephrine 1 mg/ml vial	T1	
epinephrine 10 mg/10 ml vial	T1	
epinephrine 30 mg/30 ml vial	T1	
epinephrine hcl in 0.9 % nacl	T1	
epinephrine hcl in dextrose 5%	T1	
isoproterenol hcl	T1	
LEVOPHED *(norepinephrine bitartrate)*	T3	
norepineph 16 mg/250-0.9% nacl	T1	
NOREPINEPH 32 MG/250-0.9% NACL	T3	
norepinephr 4 mg/250-0.9% nacl	T1	
NOREPINEPHR 8 MG/500-0.9% NACL *(norepinephrine bit/0.9 % nacl)*	T1	
norepinephrine bitartrate	T1	
norepinephrine bitartrate (Levophed)	T1	
norepinephrine bitartrate/d5w	T1	
NOREPINEPHRINE BITARTRATE-D5W	T1	
NEUROMUSCULAR BLOCKING AGENTS		
atracurium besylate	T1	
BOTOX 100 UNIT VIAL	T3	PA SP
BOTOX 200 UNIT VIAL	T3	PA SP HD
*cisatracurium besylate (*Nimbex*)*	T1	
DAXXIFY	T3	PA SP
DYSPORT	T3	PA SP HD
MYOBLOC	T3	PA SP HD
NIMBEX (cisatracurium besylate)	T3	

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AUTONOMIC DRUGS (Miscellaneous) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
NEUROMUSCULAR BLOCKING AGENTS *(cont.)*		
pancuronium bromide	T1	
QUELICIN *(succinylcholine chloride)*	T3	
rocuronium bromide	T1	
succinylcholine chloride	T1	
SUCCINYLCHOLINE CHLORIDE	T1	
succinylcholine chloride (Quelicin)	T1	
*succinylcholine chloride (*Quelicin*)*	T3	
SUCCINYLCHOLINE CHLORIDE-NACL	T1	
succinylcholine/sod cl,iso/pf	T1	
vecuronium bromide	T1	
VECURONIUM BROMIDE-WATER	T1	
XEOMIN	T3	PA SP HD
AUTONOMIC DRUGS (Urinary Tract Conditions)		
PARASYMPATHETIC AGENTS		
bethanechol chloride	T1	HD
cevimeline hcl (Evoxac)	T1	HD
*pilocarpine hcl 5 mg tablet (*Salagen*)*	T1	HD
*pilocarpine hcl 7.5 mg tablet (*Salagen*)*	T1	HD
SALAGEN (pilocarpine hcl)	T3	HD
BIOLOGICALS (Allergy/Nasal Sprays)		
ALLERGENIC EXTRACTS, THERAPEUTIC		
GRASTEK	T3	PA QL(1 TAB/DAY)
ODACTRA	T3	PA QL(1 TAB/DAY)
ORALAIR	T3	PA QL(1 TAB/DAY)
RAGWITEK	T3	PA QL(1 TAB/DAY)
BIOLOGICALS (Blood Pressure/Heart Medications)		
PLASMA KALLIKREIN INHIBITORS		
TAKHZYRO	T3	PA SP HD
BIOLOGICALS (Miscellaneous)		
ANTISERA		
HYPERRHO	T3	SP

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BIOLOGICALS (Miscellaneous) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTISERA *(cont.)*		
MICRHOGAM ULTRA-FILTERED PLUS	T3	SP
RHOGAM ULTRA-FILTERED PLUS	T3	SP
RHOPHYLAC	T3	SP
WINRHO SDF	T3	SP HD
PKU TREATMENT AGENTS - PHENYLALANINE AMMONIA LYASE		
PALYNZIQ	T3	PA SP HD
BIOLOGICALS (Vaccines)		
COVID-19 VACCINES		
COMIRNATY	T3	PPACA
COMIRNATY 2023-2024	T3	PPACA
COMIRNATY 2024-2025	T3	PPACA
COMIRNATY 2025-2026 (12Y UP)	T3	PPACA
COMIRNATY 2025-2026(5-11Y)	T3	PPACA
JANSSEN COVID-19 VACCINE (EUA)	T3	PPACA
MNEXSPIKE 2025-2026 (12Y UP)	T3	PPACA
MODERNA COVID (12Y UP)VAC(EUA)	T3	PPACA
MODERNA COVID 23-24(6M-11Y)EUA	T3	PPACA
MODERNA COVID 24-25(6M-11Y)EUA	T3	PPACA
MODERNA COVID BIVAL(6MO UP)EUA	T3	PPACA
MODERNA COVID BIVAL(6MO-5Y)EUA	T3	PPACA
MODERNA COVID(6M-5Y) VACC(EUA)	T3	PPACA
MODERNA COVID-19 BOOSTER (EUA)	T3	PPACA
NOVAVAX COVID 2023-2024 (EUA)	T3	PPACA
NOVAVAX COVID 2024-2025 (EUA)	T3	PPACA
NOVAVAX COVID-19 VACC,ADJ(EUA)	T3	PPACA
NUVAXOVID 2025-2026	T3	PPACA
PFIZER COVID (12Y UP) VAC(EUA)	T3	PPACA
PFIZER COVID (5-11Y) VAC (EUA)	T3	PPACA
PFIZER COVID (6M-4Y) VACC(EUA)	T3	PPACA
PFIZER COVID 2023-24(5-11Y)EUA	T3	PPACA
PFIZER COVID 2023-24(6M-4Y)EUA	T3	PPACA
PFIZER COVID 2024-25(5-11Y)EUA	T3	PPACA
PFIZER COVID 2024-25(6M-4Y)EUA	T3	PPACA
PFIZER COVID BIVAL (12Y UP)EUA	T3	PPACA

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BIOLOGICALS (Vaccines)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
COVID-19 VACCINES		
PFIZER COVID BIVAL (5-11YR)EUA	T3	PPACA
PFIZER COVID BIVAL (6MO-4Y)EUA	T3	PPACA
PFIZER COVID-19 VACCINE (EUA)	T3	PPACA
SPIKEVAX 2023-2024	T3	PPACA
SPIKEVAX 2024-2025	T3	PPACA
SPIKEVAX 2025-2026 (12Y UP)	T3	PPACA
SPIKEVAX 2025-2026 (6M-11Y)	T3	PPACA
SPIKEVAX COVID (18Y UP) VACC	T3	PPACA
ENTERIC VIRUS VACCINES		
IPOL	T3	PPACA
ROTARIX	T3	PPACA
ROTATEQ	T3	PPACA
GRAM NEGATIVE COCCI VACCINES		
BEXSERO	T3	PPACA
MENACTRA	T3	
MENQUADFI	T3	PPACA
MENVEO A-C-Y-W-135-DIP	T3	PPACA
PENBRAYA	T3	PPACA
PENMENVY MEN A-B-C-W-Y	T3	PPACA
TRUMENBA	T3	PPACA
GRAM POSITIVE COCCI VACCINES		
CAPVAXIVE	T3	PPACA
PNEUMOVAX 23	T3	PPACA
PREVNAR 13	T3	
PREVNAR 20	T3	PPACA
VAXNEUVANCE	T3	PPACA
INFLUENZA VIRUS VACCINES		
AFLURIA 2025-2026	T3	
AFLURIA 2025-2026 (3YR UP)	T3	PPACA
AFLURIA QUAD 2022-2023	T3	PPACA
AFLURIA QUAD 2022-23 (3YR UP)	T3	PPACA
AFLURIA QUAD 2023-2024	T3	PPACA
AFLURIA QUAD 2023-24 (3YR UP)	T3	PPACA
AFLURIA TRIV 2024-25 (3YR UP)	T3	PPACA
AFLURIA TRIVALENT 2024-25	T3	PPACA

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BIOLOGICALS (Vaccines) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
INFLUENZA VIRUS VACCINES *(cont.)*		
FLUAD 2025-2026	T3	PPACA
FLUAD QUAD 2022-2023	T3	PPACA
FLUAD QUAD 2023-2024	T3	PPACA
FLUAD TRIVALENT 2024-2025	T3	PPACA
FLUARIX 2025-2026	T3	PPACA
FLUARIX QUAD 2022-2023	T3	PPACA
FLUARIX QUAD 2023-2024	T3	PPACA
FLUARIX TRIVALENT 2024-2025	T3	PPACA
FLUBLOK 2025-2026	T3	PPACA
FLUBLOK QUAD 2022-2023	T3	PPACA
FLUBLOK QUAD 2023-2024	T3	PPACA
FLUBLOK TRIVALENT 2024-2025	T3	PPACA
FLUCELVAX 2025-2026 SYRINGE	T3	PPACA
FLUCELVAX 2025-2026 VIAL	T3	
FLUCELVAX QUAD 2022-2023	T3	PPACA
FLUCELVAX QUAD 2023-2024	T3	PPACA
FLUCELVAX TRIVALENT 2024-2025	T3	PPACA
FLULAVAL 2025-2026	T3	PPACA
FLULAVAL QUAD 2022-2023	T3	PPACA
FLULAVAL QUAD 2023-2024	T3	PPACA
FLULAVAL TRIVALENT 2024-2025	T3	PPACA
FLUMIST 2025-2026	T3	PPACA
FLUMIST HOME 2025-2026	T3	PPACA
FLUMIST QUAD 2022-2023	T3	PPACA
FLUMIST QUAD 2023-2024	T3	PPACA
FLUMIST TRIVALENT 2024-2025	T3	PPACA
FLUZONE 2025-2026 SYRINGE	T3	PPACA
FLUZONE 2025-2026 VIAL	T3	
FLUZONE HIGH-DOSE 2025-2026	T3	PPACA
FLUZONE HIGH-DOSE QUAD 2022-23	T3	PPACA
FLUZONE HIGH-DOSE QUAD 2023-24	T3	PPACA
FLUZONE HIGH-DOSE TRIV 2024-25	T3	PPACA

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BIOLOGICALS (Vaccines) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
INFLUENZA VIRUS VACCINES *(cont.)*		
FLUZONE QUAD 2022-2023	T3	PPACA
FLUZONE QUAD 2023-2024	T3	PPACA
FLUZONE TRIVALENT 2024-2025	T3	PPACA
NEUROTOXIC VIRUS VACCINES		
DENGVAXIA	T3	PPACA
TOXIN-PRODUCING BACILLI VACCINES/TOXOIDS		
BCG VACCINE (TICE STRAIN)	T3	SP
VACCINE/TOXOID PREPARATIONS, COMBINATIONS		
ACTHIB	T3	PPACA
ADACEL TDAP	T3	PPACA
BOOSTRIX TDAP	T3	PPACA
DAPTACEL DTAP	T3	PPACA
DIPHTHERIA-TETANUS TOXOIDS-PED	T3	
HIBERIX	T3	PPACA
INFANRIX DTAP	T3	PPACA
KINRIX	T3	PPACA
M-M-R II VACCINE	T3	PPACA
PEDVAXHIB	T3	PPACA
PENTACEL	T3	PPACA
PENTACEL ACTHIB COMPONENT	T3	PPACA
PRIORIX	T3	PPACA
PROQUAD	T3	PPACA
QUADRACEL DTAP-IPV	T3	PPACA
TDVAX	T3	PPACA
TENIVAC	T3	PPACA
VAXELIS	T3	PPACA
VIRAL/TUMORIGENIC VACCINES		
ABRYSVO	T3	PPACA
ACAM2000 (NATIONAL STOCKPILE)	T3	
AREXVY	T3	PPACA
ENGERIX-B ADULT	T3	PPACA
ENGERIX-B PEDIATRIC-ADOLESCENT	T3	PPACA

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BIOLOGICALS (Vaccines) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
VACCINE/TOXOID PREPARATIONS, COMBINATIONS *(cont.)*		
ERVEBO (NATIONAL STOCKPILE)	T3	
GARDASIL 9	T3	PPACA
HEPLISAV-B	T3	PPACA
JYNNEOS	T3	
JYNNEOS (NATIONAL STOCKPILE)	T3	
MRESVIA	T3	PPACA
PEDIARIX	T3	PPACA
PREHEVBRIO	T3	PPACA
RECOMBIVAX HB	T3	PPACA
SHINGRIX	T3	QL(2 KITS/720 DAYS) PPACA
TWINRIX	T3	PPACA
VARIVAX VACCINE	T3	PPACA
BLOOD (Blood Modifiers/Bleeding Disorders)		
AGENTS TO TX THROMBOTIC THROMBOCYTOPENIC PURPURA		
ADZYNMA	T3	PA SP
CABLIVI	T3	PA SP
ANTIFIBRINOLYTIC AGENTS		
AMICAR (*aminocaproic acid*)	T3	SP HD
aminocaproic acid	T1	SP HD
aminocaproic acid (Amicar)	T1	SP HD
CYKLOKAPRON (tranexamic acid)	T3	SP
FIBRYGA	T3	PA SP
RIASTAP	T3	PA SP
tranexamic acid	T1	SP
tranexamic acid (Cyklokapron)	T1	SP
tranexamic acid in nacl,iso-os	T1	SP
ANTIHEMOPHILIC FACTORS		
ADVATE	T3	PA SP HD
ADYNOVATE	T2	PA SP HD
AFSTYLA	T2	PA SP HD
ALPHANATE	T3	PA SP HD
ALTUVIIIO	T2	PA SP HD
ELOCTATE	T2	PA SP HD
ESPEROCT	T2	PA SP HD

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BLOOD (Blood Modifiers/Bleeding Disorders) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIHEMOPHILIC FACTORS		
HEMOFIL M	T3	PA SP HD
HUMATE-P	T3	PA SP HD
JIVI	T2	PA SP HD
KOATE	T3	PA SP HD
KOGENATE FS	T2	PA SP HD
KOVALTRY	T2	PA SP HD
NOVOEIGHT	T2	PA SP HD
NUWIQ	T3	PA SP HD
RECOMBINATE	T3	PA SP HD
WILATE	T3	PA SP HD
XYNTHA	T3	PA SP HD
XYNTHA SOLOFUSE	T3	PA SP HD
BLOOD FACTORS, MISCELLANEOUS		
VONVENDI	T3	SP HD
COAGULANTS		
protamine sulfate	T1	
COMPLEMENT (C3) INHIBITORS		
BKEMV	T3	PA SP
EMPAVELI	T2	PA SP
ENJAYMO	T3	PA SP
EPYSQLI	T3	PA SP
FABHALTA	T2	PA QL(2 CAPS/DAY) SP
SOLIRIS	T2	PA SP
TAVNEOS	T3	PA QL(6 CAPS/DAY) SP
ULTOMIRIS	T3	PA SP HD
VOYDEYA	T2	PA QL(1 PACKET/28 Days) SP
FACTOR IX COMPLEX (PCC) PREPARATIONS		
KCENTRA	T3	SP
FACTOR X PREPARATIONS		
COAGADEX	T3	PA SP
HEMOPHILIA TREATMENT AGENTS, NON-FACTOR REPLACEMENT		
ALHEMO PEN	T2	PA SP
HEMLIBRA	T2	PA SP HD
HYMPAVZI PEN	T2	PA SP
PROTEIN C PREPARATIONS		
CEPROTIN	T3	PA SP

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
PYRUVATE KINASE ACTIVATORS		
PYRUKYND 20 MG TABLET	T3	PA QL(2 TABS/DAY) SP
PYRUKYND 20-5 MG TAPER PACK	T3	PA QL(2 PACKS/270 DAYS) SP
PYRUKYND 5 MG TABLET	T3	PA QL(2 TABS/DAY) SP
PYRUKYND 5 MG TAPER PACK	T3	PA QL(2 PACKS/270 DAYS) SP
PYRUKYND 50 MG TABLET	T3	PA QL(2 TABS/DAY) SP
PYRUKYND 50-20 MG TAPER PACK	T3	PA QL(2 PACKS/270 DAYS) SP
SICKLE CELL ANEMIA AGENTS		
ADAKVEO	T3	PA SP
DROXIA	T2	
SIKLOS	T3	PA
TOPICAL HEMOSTATICS		
ASTRINGYN	T3	
AVITENE	T3	
ENDO-AVITENE	T3	
EVICEL	T3	
gelatin sponge,absorb/porcine (Gelfoam)	T1	
GELFOAM	T3	
GELFOAM (*gelatin sponge,absorb/porcine*)	T3	
GELFOAM COMPRESSED	T3	
MONSEL'S	T3	
RECOTHROM	T3	
SURGICEL	T3	
SURGIFOAM	T1	
SYRINGE AVITENE	T3	
THROMBI-GEL (*thrombin/cal/cmc/gel/dress,hem*)	T3	
THROMBIN-JMI	T3	
THROMBI-PAD	T3	
ULTRAFOAM	T3	
BLOOD (Blood Thinners/Anti-Clotting)		
ANTICOAGULANT REVERSAL AGENT FOR FACTOR XA INHIB.		
ANDEXXA	T3	SP
ANTICOAGULANT REVERSAL AGENT, DIRECT THROMBIN INHIB		
PRAXBIND	T3	SP
HEMORRHEOLOGIC AGENTS		
pentoxifylline	T1	HD

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List of Prescription Medications

BLOOD (Blood Thinners/Anti-Clotting)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
THROMBOLYTIC - NUCLEOTIDE TYPE		
DEFITELIO	T3	PA SP
THROMBOLYTIC ENZYMES		
ACTIVASE	T3	
CATHFLO ACTIVASE	T3	
RETAVASE	T3	
TNKASE	T3	
CARDIAC DRUGS (Blood Pressure/Heart Medications)		
ANTIANGINAL, ANTI-ISCHEMIC AGENTS, NON-HEMODYNAMIC		
ranolazine	T1	QL(4 TABS/DAY) HD
ranolazine (Ranexa)	T1	QL(4 TABS/DAY) HD
ANTIARRHYTHMICS		
adenosine	T1	
amiodarone 150 mg/3 ml syringe	T1	
amiodarone 150 mg/3 ml vial	T1	
amiodarone 450 mg/9 ml vial	T1	
amiodarone 900 mg/18 ml vial	T1	
amiodarone hcl 100 mg tablet	T1	HD
amiodarone hcl 200 mg tablet	T1	HD
amiodarone hcl 400 mg tablet	T1	HD
CORVERT *(ibutilide fumarate)*	T3	PA
*disopyramide phosphate (*Norpace*)*	T1	HD
*dofetilide 125 mcg capsule (*Tikosyn*)*	T1	QL(8 CAPS/DAY) HD
*dofetilide 250 mcg capsule (*Tikosyn*)*	T1	QL(4 CAPS/DAY) HD
*dofetilide 500 mcg capsule (*Tikosyn*)*	T1	QL(2 CAPS/DAY) HD
flecainide acetate	T1	HD
ibutilide fumarate (Corvert)	T1	
lidocaine hcl/dextrose 5 %/pf	T1	
lidocaine hcl/pf	T1	
mexiletine hcl	T1	HD
NORPACE CR	T3	HD
CORVERT *(ibutilide fumarate)*	T3	PA
disopyramide phosphate (Norpace)	T1	HD
dofetilide 125 mcg capsule (Tikosyn)	T1	QL(8 CAPS/DAY) HD
dofetilide 250 mcg capsule (Tikosyn)	T1	QL(4 CAPS/DAY) HD

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List of Prescription Medications

CARDIAC DRUGS (Blood Pressure/Heart Medications) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIARRHYTHMICS *(cont.)*		
dofetilide 500 mcg capsule (Tikosyn)	T1	QL(2 CAPS/DAY) HD
flecainide acetate	T1	HD
ibutilide fumarate (Corvert)	T1	
lidocaine hcl/dextrose 5 %/pf	T1	
lidocaine hcl/pf	T1	
mexiletine hcl	T1	HD
PROCAINAMIDE HCL	T1	HD
propafenone hcl	T1	HD
quinidine gluconate	T1	HD
quinidine sulfate	T1	HD
CALCIUM CHANNEL BLOCKING AGENTS		
amlodipine besylate (Norvasc)	T1	HD
CALAN SR *(verapamil hcl)*	T3	HD
CARDENE I.V.	T3	
CARDENE I.V. (*nicardipine hcl*)	T3	
CLEVIPREX	T3	
diltiazem 100 mg add-van vial	T1	
diltiazem 120 mg tablet (Cardizem)	T1	HD
diltiazem 125 mg/25 ml vial	T1	
diltiazem 24h er(la) 120 mg tb (Cardizem La)	T1	QL(1 TAB/DAY) HD
diltiazem 24h er(la) 180 mg tb (Cardizem La)	T1	HD
diltiazem 24h er(la) 240 mg tb (Cardizem La	T1	HD
diltiazem 24h er(la) 300 mg tb (Cardizem La)	T1	HD
diltiazem 24h er(la) 360 mg tb (Cardizem La)	T1	HD
diltiazem 24h er(la) 420 mg tb (Cardizem La)	T1	HD
diltiazem 25 mg/5 ml vial	T1	
diltiazem 30 mg tablet (Cardizem)	T1	HD
diltiazem 50 mg/10 ml vial	T1	
diltiazem 60 mg tablet (Cardizem)	T1	HD
diltiazem 90 mg tablet	T1	HD
diltiazem hcl	T1	HD
diltiazem hcl (Cardizem Cd)	T1	HD

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CARDIAC DRUGS (Blood Pressure/Heart Medications) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
CALCIUM CHANNEL BLOCKING AGENTS *(cont.)*		
diltiazem hcl (Cardizem La)	T1	HD
diltiazem hcl (Tiazac)	T1	HD
DILTIAZEM HCL-0.7% NACL	T3	
DILTIAZEM HCL-0.9% NACL	T1	
DILTIAZEM HCL-NACL	T3	
felodipine	T1	HD
isradipine	T1	
nicardipin 20mg/200ml-0.9%nacl	T1	
NICARDIPIN 20MG/200ML-0.9%NACL	T3	
nicardipin 40mg/200ml-0.9%nacl	T1	
NICARDIPIN 40MG/200ML-0.9%NACL	T3	
NICARDIPINE 1 MG/10 ML-NS SYRG	T1	
nicardipine 20 mg capsule	T1	HD
nicardipine 25 mg/10 ml ampule (Cardene I.V.)	T1	
nicardipine 25 mg/10 ml vial	T1	
nicardipine 30 mg capsule	T1	HD
nicardipine in nacl, iso-osm	T1	
nifedipine	T1	HD
nifedipine (Procardia XL)	T1	HD
nimodipine 30 mg capsule	T1	HD
nimodipine 60 mg/20 ml soln	T1	
nisoldipine er 17 mg tablet (Sular)	T1	HD
nisoldipine er 20 mg tablet	T1	QL(1 TAB/DAY) HD
nisoldipine er 25.5 mg tablet	T1	HD
nisoldipine er 30 mg tablet	T1	HD
nisoldipine er 34 mg tablet (Sular)	T1	HD
nisoldipine er 40 mg tablet	T1	HD
nisoldipine er 8.5 mg tablet (Sular)	T1	HD
NORLIQVA	T2	PA QL(10 MLS/DAY) HD
NYMALIZE	T3	
SULAR (*nisoldipine*)	T3	HD
TIAZAC (*diltiazem hcl*)	T3	HD
verapamil hcl	T1	HD
verapamil hcl (Calan Sr)	T1	HD
verapamil hcl (Verelan Pm)	T1	HD

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
CALCIUM CHANNEL BLOCKING AGENTS *(cont.)*		
verapamil hcl (Verelan)	T1	HD
VERELAN *(verapamil hcl)*	T3	HD
VERELAN PM (*verapamil hcl*)	T3	HD
CARDIOPLEGIC SOLUTIONS		
CARDIOPLEGIA DEL NIDO FORMULA	T3	
CARDIOPLEGIA HIGH POTASSIUM	T3	
CARDIOPLEGIA IND 8:1 NON-ENRCH	T3	
CARDIOPLEGIA INDUCTION 4:1	T3	
CARDIOPLEGIA INDUCTION 8:1	T3	
CARDIOPLEGIA MAINTENANCE 4:1	T3	
CARDIOPLEGIA MAINTENANCE 8:1	T3	
CARDIOPLEGIA REPERFUSATE 4:1	T3	
cardioplegic solution no.1 (Plegisol)	T1	
PLEGISOL	T3	
CARDIAC MYOSIN INHIBITOR		
CAMZYOS	T3	PA QL(1 CAP/DAY) SP HD
CARDIOPLEGIC SOLUTIONS		
CARDIOPLEGIA DEL NIDO FORMULA	T3	
CARDIOPLEGIA HIGH POTASSIUM	T3	
CARDIOPLEGIA IND 8:1 NON-ENRCH	T3	
CARDIOPLEGIA INDUCTION 4:1	T3	
CARDIOPLEGIA INDUCTION 8:1	T3	
CARDIOPLEGIA MAINTENANCE 4:1	T3	
CARDIOPLEGIA MAINTENANCE 8:1	T3	
CARDIOPLEGIA REPERFUSATE 4:1	T3	
cardioplegic solution no.1	T1	
PLEGISOL	T3	
DIGITALIS GLYCOSIDES		
digoxin (Lanoxin)	T1	HD
digoxin 0.05 mg/ml solution	T1	HD
digoxin 0.125 mg tablet (Lanoxin)	T1	HD
digoxin 0.25 mg tablet (Lanoxin)	T1	HD
digoxin 0.25 mg/ml syringe	T1	HD
digoxin 125 mcg tablet (Lanoxin)	T1	HD
digoxin 250 mcg tablet (Lanoxin)	T1	HD

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CARDIAC DRUGS (Blood Pressure/Heart Medications) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DIGITALIS GLYCOSIDES *(cont.)*		
digoxin 500 mcg/2 ml ampule (Lanoxin)	T1	HD
LANOXIN 500 MCG/2 ML AMPULE *(digoxin)*	T3	HD
LANOXIN 500 MCG/2 ML VIAL	T3	HD
LANOXIN PEDIATRIC	T3	HD
HEART RATE REDUCING, SA SELECTIVE I (F) CURRENT INH.		
CORLANOR 5 MG/5 ML ORAL SOLN	T2	PA SP HD
ivabradine hcl (Corlanor)	T1	PA HD
INOTROPIC DRUGS		
dobutamine hcl	T1	
dobutamine hcl in dextrose 5 %	T1	
milrinone lactate	T1	
milrinone lactate/d5w	T1	
SOLUBLE GUANYLATE CYCLASE (SGC) STIMULATOR		
VERQUVO	T2	PA QL(1 tab/day)
VASODILATORS, CORONARY		
isosorbide dinitrate 10 mg tab	T1	HD
isosorbide dinitrate 20 mg tab	T1	HD
isosorbide dinitrate 30 mg tab	T1	HD
isosorbide dinitrate 5 mg tab (Isordil Titradose)	T1	HD
isosorbide mononitrate	T1	HD
NITRO-DUR	T3	HD
nitroglycerin	T1	HD
nitroglycerin 0.3 mg tablet sl (Nitrostat)	T1	HD
nitroglycerin 0.4 mg tablet sl (Nitrostat)	T1	HD
nitroglycerin 0.6 mg tablet sl (Nitrostat)	T1	HD
nitroglycerin 400 mcg spray (Nitrolingual)	T1	HD
nitroglycerin 50 mg/10 ml vial	T1	
nitroglycerin in 5 % dextrose	T1	HD
NITROLINGUAL (*nitroglycerin*)	T3	HD
NITROMIST (*nitroglycerin*)	T3	HD
NITROSTAT (*nitroglycerin*)	T3	HD
CARDIOVASCULAR (Allergy/Nasal Sprays)		
SYMPATHOMIMETIC AGENTS		
AKOVAZ	T3	
BIORPHEN	T3	

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CARDIOVASCULAR (Allergy/Nasal Sprays) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
SYMPATHOMIMETIC AGENTS *(con't.)*		
ephedrine sulfate	T1	
EPHEDRINE SULFATE	T1	
ephedrine sulfate/0.9% nacl/pf	T1	
EPHEDRINE SULFATE-0.9% NACL	T1	
EPHEDRINE SULFATE-NACL	T1	
IMMPHENTIV	T3	
phenylephrine hcl	T1	
phenylephrine hcl (Vazculep)	T1	
phenylephrine hcl in 0.9% nacl	T1	
PHENYLEPHRINE HCL-0.9% NACL	T1	
VAZCULEP (*phenylephrine hcl*)	T3	
CARDIOVASCULAR (Asthma/COPD/Respiratory)		
PULM ANTI-HTN, SOLUBLE GUANYLATE CYCLASE STIMULATOR		
ADEMPAS	T2	PA SP HD
PULM.ANTI-HTN, SEL.C-GMP PHOSPHODIESTERASE T5 INHIB		
REVATIO 10 MG/12.5 ML VIAL	T3	PA SP HD
sildenafil 10 mg/12.5 ml vial	T1	PA SP HD
sildenafil 10 mg/ml oral susp (Revatio)	T1	PA SP HD
sildenafil 20 mg tablet (Revatio)	T1	PA SP HD
tadalafil (Adcirca)	T1	PA SP HD
tadalafil 20 mg tablet (Adcirca)	T1	PA SP HD
PULMONARY ANTI-HTN, ENDOTHELIN RECEPTOR ANTAGONIST		
ambrisentan (Letairis)	T1	PA SP HD
bosentan (Tracleer)	T1	PA SP HD
OPSUMIT	T2	PA SP HD
TRACLEER 125 MG TABLET (*bosentan*)	T3	PA SP HD
TRACLEER 32 MG TABLET FOR SUSP (*bosentan*)	T2	PA SP HD
TRACLEER 62.5 MG TABLET (*bosentan*)	T3	PA SP HD
PULMONARY ANTIHYPER AGENT, ACTRIIA-FC		
WINREVAIR	T3	PA SP HD
WINREVAIR (2 PACK)	T3	PA SP HD
PULMONARY ANTIHYPERTENSIVES, PROSTACYCLIN-TYPE		
epoprostenol sodium	T1	PA SP HD
epoprostenol sodium 0.5 mg vl	T1	PA SP

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List of Prescription Medications

CARDIOVASCULAR (Asthma/COPD/Respiratory) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
PULMONARY ANTIHYPERTENSIVES, PROSTACYCLIN-TYPE *(cont.)*		
epoprostenol sodium 0.5 mg vl	T1	PA SP HD
epoprostenol sodium 1.5 mg vl	T1	PA SP HD
FLOLAN	T3	PA SP
ORENITRAM ER	T3	PA SP HD
ORENITRAM MONTH 1 TITRATION KT	T3	PA QL(168 TABS/180 DAYS) SP HD
TYVASO DPI	T2	PA SP HD
TYVASO INSTITUTIONAL START KIT	T3	PA SP HD
TYVASO REFILL KIT	T3	PA SP HD
TYVASO STARTER KIT	T3	PA SP HD
UPTRAVI 1,000 MCG TABLET	T2	PA SP HD
UPTRAVI 1,200 MCG TABLET	T2	PA SP HD
UPTRAVI 1,400 MCG TABLET	T2	PA SP HD
UPTRAVI 1,600 MCG TABLET	T2	PA SP HD
UPTRAVI 1,800 MCG VIAL	T3	PA SP
UPTRAVI 200 MCG TABLET	T2	PA SP HD
UPTRAVI 200-800 TITRATION PACK	T2	PA SP HD
UPTRAVI 400 MCG TABLET	T2	PA SP HD
UPTRAVI 600 MCG TABLET	T2	PA SP HD
UPTRAVI 800 MCG TABLET	T2	PA SP HD
YUTREPIA	T2	PA SP HD
PULMONARY HTN-ENDOTHELIN RECEPT ANTG-CGMP PDE5 INH		
OPSYNVI	T2	PA QL(1 TAB/DAY) SP HD
CARDIOVASCULAR (Blood Pressure/Heart Medications)		
ACE INHIBITOR-CALCIUM CHANNEL BLOCKER COMBINATION		
amlodipine besylate/benazepril	T1	HD
amlodipine besylate/benazepril (Lotrel)	T1	HD

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CARDIOVASCULAR (Blood Pressure/Heart Medications)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ACE INHIBITOR-CALCIUM CHANNEL BLOCKER COMBINATION		
PRESTALIA 14 MG-10 MG TABLET	T3	HD
PRESTALIA 3.5 MG-2.5 MG TABLET	T3	QL(1 TAB/DAY) HD
PRESTALIA 7 MG-5 MG TABLET	T3	QL(1 TAB/DAY) HD
trandolapril/verapamil hcl	T1	HD
ACE INHIBITOR-THIAZIDE OR THIAZIDE-LIKE DIURETIC		
benazepril/hydrochlorothiazide	T1	HD
benazepril/hydrochlorothiazide (Lotensin Hct)	T1	HD
captopril-hctz 25-15 mg tablet	T1	QL(3 TABS/DAY) HD
captopril-hctz 25-25 mg tablet	T1	QL(2 TABS/DAY) HD
captopril-hctz 50-15 mg tablet	T1	QL(3 TABS/DAY) HD
captopril-hctz 50-25 mg tablet	T1	QL(2 TABS/DAY) HD
enalapril/hydrochlorothiazide	T1	HD
enalapril/hydrochlorothiazide (Vaseretic)	T1	HD
fosinopril/hydrochlorothiazide	T1	HD
lisinopril/hydrochlorothiazide (Zestoretic)	T1	HD
quinapril/hydrochlorothiazide (Accuretic)	T1	HD
ALPHA/BETA-ADRENERGIC BLOCKING AGENTS		
carvedilol (Coreg)	T1	HD
carvedilol er 10 mg capsule (Coreg Cr)	T1	QL(1 CAP/DAY) HD
carvedilol er 20 mg capsule (Coreg Cr)	T1	QL(1 CAP/DAY) HD
carvedilol er 40 mg capsule (Coreg Cr)	T1	QL(1 CAP/DAY) HD
carvedilol er 80 mg capsule (Coreg Cr)	T1	HD
LABETALOL HCL 10 MG/2 ML SYRNG	T3	
labetalol hcl 100 mg tablet	T1	HD
labetalol hcl 100 mg/20 ml vl	T1	
labetalol hcl 20 mg/4 ml crpjt	T1	QL(1 CAP/DAY) HD
labetalol hcl 20 mg/4 ml syrng	T1	QL(1 CAP/DAY) HD
labetalol hcl 20 mg/4 ml vial	T1	QL(1 CAP/DAY) HD
labetalol hcl 200 mg tablet	T1	HD
labetalol hcl 200 mg/40 ml vl	T1	
labetalol hcl 300 mg tablet	T1	HD
LABETALOL HCL 400 MG TABLET	T3	HD
LABETALOL HCL-DEXTROSE	T3	
LABETALOL HCL-NACL	T3	

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CARDIOVASCULAR (Blood Pressure/Heart Medications) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ALPHA-ADRENERGIC BLOCKING AGENTS		
CARDURA XL	T3	HD
doxazosin mesylate (Cardura)	T1	HD
MINIPRESS *(prazosin hcl)*	T3	HD
prazosin hcl	T1	HD
prazosin hcl (Minipress)	T1	HD
terazosin hcl	T1	HD
ANGIOTEN.RECEPTR ANTAG-CALCIUM CHANL BLKR-THIAZIDE		
amlodipine/valsartan/hcthiazid	T1	HD
olmesartan/amlodipin/hcthiazid	T1	HD
ANGIOTENSIN RECEPT-NEPRILYSIN INHIBITOR COMB (ARNI)		
ENTRESTO SPRINKLE	T3	QL(2 TABS/DAY)
sacubitril/valsartan (Entresto)	T1	QL(2 TABS/DAY) HD
ANGIOTENSIN RECEPTOR ANTAG.-THIAZIDE DIURETIC COMB		
candesartan/hydrochlorothiazid (Atacand Hct)	T1	HD
irbesartan/hydrochlorothiazide (Avalide)	T1	HD
losartan/hydrochlorothiazide (Hyzaar)	T1	HD
olmesartan-hctz 20-12.5 mg tab (Benicar Hct)	T1	QL(1 TAB/DAY) HD
olmesartan-hctz 40-12.5 mg tab (Benicar Hct)	T1	HD
olmesartan-hctz 40-25 mg tab (Benicar Hct)	T1	HD
telmisartan-hctz 40-12.5 mg tb (Micardis Hct)	T1	QL(1 TAB/DAY) HD
telmisartan-hctz 80-12.5 mg tb (Micardis Hct)	T1	HD
telmisartan-hctz 80-25 mg tab (Micardis Hct)	T1	HD
valsartan/hydrochlorothiazide (Diovan Hct)	T1	HD
ANGIOTENSIN RECEPTOR BLOCKR-CALCIUM CHANNEL BLOCKR		
amlodipine besylate/valsartan	T1	HD
amlodipine-olmesartan 10-20 mg	T1	HD
amlodipine-olmesartan 10-40 mg	T1	HD
amlodipine-olmesartan 5-20 mg	T1	QL (1 TAB/DAY) HD
amlodipine-olmesartan 5-40 mg (Azor)	T1	HD
telmisartan-amlodipine 40-10	T1	HD
telmisartan-amlodipine 40-5 mg	T1	QL(1 TAB/DAY) HD
telmisartan-amlodipine 80-10	T1	HD
telmisartan-amlodipine 80-5 mg	T1	HD
ANTIHYPERTENSIVES, ACE INHIBITORS		
benazepril hcl	T1	HD
benazepril hcl (Lotensin)	T1	HD

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIHYPERTENSIVES, ACE INHIBITORS *(cont.)*		
captopril	T1	HD
enalapril maleate (Epaned)	T1	HD
enalapril maleate (Vasotec)	T1	HD
enalaprilat dihydrate	T1	
fosinopril sodium	T1	HD
lisinopril (Zestril)	T1	HD
moexipril hcl	T1	HD
perindopril erbumine	T1	HD
quinapril hcl (Accupril)	T1	HD
ramipril	T1	HD
ramipril (Altace)	T1	HD
trandolapril	T1	HD
ANTIHYPERTENSIVES, ANGIOTENSIN RECEPTOR ANTAGONIST		
candesartan cilexetil (Atacand)	T1	HD
eprosartan mesylate	T1	HD
irbesartan	T1	HD
irbesartan (Avapro)	T1	HD
losartan potassium (Cozaar)	T1	HD
olmesartan medoxomil 20 mg tab (Benicar)	T1	QL(1 TAB/DAY) HD
olmesartan medoxomil 40 mg tab (Benicar)	T1	HD
olmesartan medoxomil 5 mg tab (Benicar)	T1	HD
telmisartan 20 mg tablet	T1	QL(1 TAB/DAY) HD
telmisartan 40 mg tablet (Micardis)	T1	QL(1 TAB/DAY) HD
telmisartan 80 mg tablet (Micardis)	T1	HD
valsartan 160 mg tablet (Diovan)	T1	HD
valsartan 20 mg/5 ml solution	T1	HD
valsartan 320 mg tablet (Diovan)	T1	HD
valsartan 40 mg tablet (Diovan)	T1	HD
valsartan 80 mg tablet (Diovan)	T1	HD
ANTIHYPERTENSIVES, GANGLIONIC BLOCKERS		
VECAMYL	T1	
ANTIHYPERTENSIVES, MISCELLANEOUS		
metyrosine (Demser)	T1	PA HD
nitroprusside sodium	T1	

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List of Prescription Medications

CARDIOVASCULAR (Blood Pressure/Heart Medications) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIHYPERTENSIVES, SYMPATHOLYTIC		
clonidine (Catapres-Tts 1)	T1	HD
clonidine (Catapres-Tts 2)	T1	HD
clonidine (Catapres-Tts 3)	T1	HD
clonidine hcl 0.1 mg tablet	T1	HD
clonidine hcl 0.2 mg tablet	T1	HD
clonidine hcl 0.3 mg tablet	T1	HD
guanfacine hcl	T1	HD
methyldopa	T1	HD
methyldopa/hydrochlorothiazide	T1	HD
methyldopate hcl	T1	
ANTIHYPERTENSIVES, VASODILATORS		
hydralazine hcl	T1	HD
minoxidil	T1	HD
BETA-ADRENERGIC BLOCKING AGENTS		
acebutolol hcl	T1	HD
atenolol (Tenormin)	T1	HD
betaxolol hcl	T1	HD
bisoprolol fumarate 10 mg tab	T1	HD
bisoprolol fumarate 5 mg tab	T1	HD
BREVIBLOC	T3	
esmolol hcl	T1	
ESMOLOL HCL-WATER	T1	
esmolol in sodium chloride,iso	T1	
metoprolol succinate (Toprol XL)	T1	HD
metoprolol tartrate	T1	HD
metoprolol tartrate (Lopressor)	T1	HD
nadolol	T1	HD
nebivolol 10 mg tablet (Bystolic)	T1	QL(1 TAB/DAY) HD
nebivolol 2.5 mg tablet (Bystolic)	T1	QL(1 TAB/DAY) HD
nebivolol 20 mg tablet (Bystolic)	T1	HD
nebivolol 5 mg tablet (Bystolic)	T1	QL(1 TAB/DAY) HD
pindolol	T1	HD
propranolol hcl	T1	HD
propranolol hcl (Inderal La)	T1	HD

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CARDIOVASCULAR (Blood Pressure/Heart Medications) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
BETA-ADRENERGIC BLOCKING AGENTS *(cont.)*		
SOTALOL HCL	T1	
sotalol hcl (Betapace Af)	T1	HD
sotalol hcl (Betapace)	T1	HD
SOTYLIZE	T3	HD
timolol maleate	T1	HD
BETA-BLOCKERS AND THIAZIDE, THIAZIDE-LIKE DIURETICS		
atenolol/chlorthalidone (Tenoretic 100)		
atenolol/chlorthalidone (Tenoretic 50)		
bisoprolol/hydrochlorothiazide		
metoprolol/hydrochlorothiazide		
propranolol/hydrochlorothiazid	T1	HD
MUSCARINIC RECEPTOR ANTAGONISTS (ANTICHOLINERGIC)		
ATROPEN	T3	
PATENT DUCTUS ARTERIOSUS TREAT. AGENTS, NSAID-TYPE		
ibuprofen lysine/pf (Neoprofen)	T1	
indomethacin 1 mg vial	T1	
NEOPROFEN (*ibuprofen lysine/pf*)	T3	
RENIN INHIBITOR, DIRECT		
aliskiren 150 mg tablet (Tekturna)	T1	QL(1 TAB/DAY) HD
aliskiren 300 mg tablet (Tekturna)	T1	HD
VASODILATORS, COMBINATION		
isosorbide dinit/hydralazine (Bidil)	T1	QL(6 TABS/DAY) HD
VASODILATORS, MISCELLANEOUS		
alprostadil	T1	
PROSTIN VR PEDIATRIC	T3	
PARATHYROID HORMONES		
YORVIPATH	T3	
VASODILATORS, PERIPHERAL		
ergoloid mesylates	T1	
isoxsuprine hcl	T1	
papaverine hcl	T1	

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List of Prescription Medications

CARDIOVASCULAR (Cholesterol Medications)		
ANTIHYPERLIP.HMG COA REDUCT INHIB-CHOLEST.AB.INHIB		
ezetimibe/simvastatin (Vytorin)	T1	HD
ANTIHYPERLIPID- HMG-COA RI-CALCIUM CHANNEL BLOCKER		
amlodipine-atorvast 10-10 mg (Caduet)	T1	HD
amlodipine-atorvast 10-20 mg (Caduet)	T1	HD
amlodipine-atorvast 10-40 mg (Caduet)	T1	HD
amlodipine-atorvast 10-80 mg (Caduet)	T1	HD
amlodipine-atorvast 2.5-10 mg	T1	HD
amlodipine-atorvast 2.5-20 mg	T1	QL(1 TAB/DAY) HD
amlodipine-atorvast 2.5-40 mg	T1	QL(1 TAB/DAY) HD
amlodipine-atorvast 5-10 mg (Caduet)	T1	HD
amlodipine-atorvast 5-20 mg (Caduet)	T1	QL(1 TAB/DAY) HD
amlodipine-atorvast 5-40 mg (Caduet)	T1	QL(1 TAB/DAY) HD
*amlodipine-atorvast 5-80 mg (*Caduet*)*	T1	HD
CADUET 10 MG-10 MG TABLET *(amlodipine/atorvastatin)*	T3	HD
CADUET 10 MG-20 MG TABLET *(amlodipine/atorvastatin)*	T3	HD
CADUET 10 MG-40 MG TABLET *(amlodipine/atorvastatin)*	T3	HD
CADUET 10 MG-80 MG TABLET *(amlodipine/atorvastatin)*	T3	HD
CADUET 5 MG-10 MG TABLET *(amlodipine/atorvastatin)*	T3	HD
CADUET 5 MG-20 MG TABLET *(amlodipine/atorvastatin)*	T3	QL(1 TAB/DAY) HD
CADUET 5 MG-40 MG TABLET *(amlodipine/atorvastatin)*	T3	QL(1 TAB/DAY) HD
CADUET 5 MG-80 MG TABLET *(amlodipine/atorvastatin)*	T3	HD
ANTIHYPERLIPIDEMIC - ANGIOPOIETIN-LIKE 3 INHIBITOR		
EVKEEZA	T3	PA SP
ANTIHYPERLIPIDEMIC - APOLIPOPROTEIN INHIBITOR		
TRYNGOLZA	T3	PA QL(1 AUTO-INJ/28 DAYS) SP
ANTIHYPERLIPIDEMIC - PCSK9 INHIBITORS		
LEQVIO	T3	PA SP
REPATHA PUSHTRONEX	T2	
REPATHA SURECLICK	T2	
REPATHA SYRINGE	T2	
ANTIHYPERLIPIDEMIC-HMGCOA REDUCTASE INHIB (STATINS)		
*atorvastatin 10 mg tablet (*Lipitor*)*	T1	HD PPACA
*atorvastatin 20 mg tablet (*Lipitor*)*	T1	HD PPACA
*atorvastatin 40 mg tablet (*Lipitor*)*	T1	HD
*atorvastatin 80 mg tablet (*Lipitor*)*	T1	HD
fluvastatin sodium	T1	HD PPACA

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CARDIOVASCULAR (Cholesterol Medications) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIHYPERLIPIDEMIC-HMGCOA REDUCTASE INHIB (STATINS) *(cont.)*		
fluvastatin sodium (Lescol XL)	T1	HD PPACA
lovastatin 10 mg tablet	T1	HD
lovastatin 20 mg tablet	T1	HD PPACA
lovastatin 40 mg tablet	T1	HD PPACA
pitavastatin 1 mg tablet (Livalo)	T1	QL(1 TAB/DAY) HD PPACA
pitavastatin 2 mg tablet (Livalo)	T1	QL(1 TAB/DAY) HD PPACA
pitavastatin 4 mg tablet (Livalo)	T1	HD PPACA
pravastatin sodium	T1	HD PPACA
rosuvastatin calcium 10 mg tab (Crestor)	T1	QL(1 TAB/DAY) HD PPACA
rosuvastatin calcium 20 mg tab (Crestor)	T1	QL(1 TAB/DAY) HD
rosuvastatin calcium 40 mg tab (Crestor)	T1	HD
rosuvastatin calcium 5 mg tab (Crestor)	T1	QL(1 TAB/DAY) HD PPACA
simvastatin 10 mg tablet (Zocor)	T1	HD PPACA
simvastatin 20 mg tablet (Zocor)	T1	HD PPACA
simvastatin 40 mg tablet (Zocor)	T1	HD PPACA
simvastatin 5 mg tablet	T1	HD
simvastatin 80 mg tablet	T1	QL(1 TAB/DAY) HD
BILE SALT SEQUESTRANTS		
cholestyramine	T1	HD
cholestyramine (Questran Light)	T1	HD
cholestyramine (with sugar) (Questran)	T1	HD
cholestyramine/aspartame	T1	HD
colesevelam hcl (Welchol)	T1	HD
COLESTID	T3	HD
COLESTID *(colestipol hcl)*	T3	HD
colestipol hcl	T1	HD
colestipol hcl (Colestid)	T1	HD
QUESTRAN *(cholestyramine (with sugar))*	T3	HD
QUESTRAN LIGHT (cholestyramine)	T3	HD
LIPOTROPICS		
ezetimibe (Zetia)	T1	HD
fenofibrate 120 mg tablet (Fenoglide)	T1	HD
fenofibrate 130 mg capsule	T1	HD
fenofibrate 134 mg capsule	T1	HD
fenofibrate 145 mg tablet (Tricor)	T1	HD

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CARDIOVASCULAR (Cholesterol Medications) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
LIPOTROPICS *(cont.)*		
FENOFIBRATE 150 MG CAPSULE	T1	HD
fenofibrate 160 mg tablet	T1	HD
fenofibrate 200 mg capsule	T1	HD
fenofibrate 40 mg tablet (Fenoglide)	T1	HD
fenofibrate 43 mg capsule	T1	HD
fenofibrate 48 mg tablet (Tricor)	T1	HD
FENOFIBRATE 50 MG CAPSULE	T1	HD
fenofibrate 54 mg tablet	T1	HD
fenofibrate 67 mg capsule	T1	HD
fenofibric acid	T1	HD
fenofibric acid (choline)	T1	HD
fenofibric acid (Fibricor)	T1	HD
FIBRICOR (fenofibric acid)	T3	ST HD
gemfibrozil (Lopid)	T1	HD
LIPOFEN	T3	ST HD
LOPID (*gemfibrozil*)	T3	HD
niacin	T1	HD
CARDIOVASCULAR (Miscellaneous)		
ENDOTHELIN-ANGIOTENSIN RECEPTOR ANTAGONIST		
FILSPARI	T2	PA QL(1 TAB/DAY) SP
VENOSCLEROSING AGENTS		
ASCLERA	T3	PA SP
ETHAMOLIN	T3	
sodium tetradecyl sulfate (Sotradecol)	T1	
SOTRADECOL	T3	
SOTRADECOL (*sodium tetradecyl sulfate*)	T3	
CNS DRUGS (Alzheimer's Disease)		
ALZHEIMER'S THERAPY, NMDA RECEPTOR ANTAGONISTS		
memantine hcl	T1	HD
MEMANTINE HCL	T1	HD
memantine hcl er 14 mg capsule (Namenda Xr)	T1	QL(1 CAP/DAY) HD
memantine hcl er 21 mg capsule	T1	HD
memantine hcl er 28 mg capsule (Namenda Xr)	T1	HD
memantine hcl er 7 mg capsule (Namenda Xr)	T1	QL(1 CAP/DAY) HD

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CNS DRUGS (Alzheimer's Disease) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ALZHEIMER'S THERAPY, NMDA RECEPTOR ANTAGONISTS *(cont.)*		
NAMENDA	T3	HD
NAMENDA XR TITRATION PACK	T3	QL(112 CAPS/365 DAYS) HD
ALZHEIMER'S THX,NMDA RECEPTOR ANTAG-CHOLINES INHIB		
memantine hcl/donepezil hcl (Namzaric)	T1	QL(2 CAPS/DAY) HD
AMYLOID DIRECTED MONOCLONAL ANTIBODY		
ADUHELM	T3	PA SP
CNS DRUGS (Miscellaneous)		
ALCOHOL, SYSTEMIC USE		
ALCOHOL, DEHYDRATED	T1	
ethyl alcohol	T1	
AMYOTROPHIC LATERAL SCLEROSIS AGENTS		
edaravone 30 mg/100 ml bag	T1	PA SP
EDARAVONE 30 MG/100 ML VIAL	T3	PA SP
edaravone 60 mg/100 ml bag	T1	PA SP
EDARAVONE 60 MG/100 ML VIAL	T3	PA SP
RADICAVA	T3	PA SP
RADICAVA ORS 105 MG/5 ML SUSP	T3	PA QL(50 MLS/30 DAYS) SP HD
RADICAVA ORS STARTER KIT SUSP	T3	PA QL(70 MLS/365 DAYS) SP HD
riluzole (Rilutek)	T1	SP HD
TEGLUTIK	T3	PA SP
TIGLUTIK	T3	PA SP
CENTRAL NERVOUS SYSTEM STIMULANTS		
DOPRAM	T3	
DRUGS TO TREAT MOVEMENT DISORDERS		
AUSTEDO	T3	PA SP HD
AUSTEDO XR 12 MG TABLET	T3	PA QL(1 TAB/DAY) SP HD
AUSTEDO XR 18 MG TABLET	T3	PA QL(1 TAB/DAY) SP HD
AUSTEDO XR 24 MG TABLET	T3	PA QL(2 TABS/DAY) SP HD
AUSTEDO XR 30 MG TABLET	T3	PA QL(1 TAB/DAY) SP HD
AUSTEDO XR 36 MG TABLET	T3	PA QL(1 TAB/DAY) SP HD
AUSTEDO XR 42 MG TABLET	T3	PA QL(1 TAB/DAY) SP HD
AUSTEDO XR 48 MG TABLET	T3	PA QL(1 TAB/DAY) SP HD
AUSTEDO XR 6 MG TABLET	T3	PA QL(3 TABS/DAY) SP HD
AUSTEDO XR TITRATION KT(WK1-4)	T3	PA QL(1 KIT/180 DAYS) SP HD
INGREZZA	T3	PA QL(1 CAP/DAY) SP

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List of Prescription Medications

CNS DRUGS (Miscellaneous) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DRUGS TO TREAT MOVEMENT DISORDERS *(cont.) (cont.)*		
INGREZZA INITIATION PK(TARDIV)	T3	PA QL(28 CAPS/365 DAYS) SP
INGREZZA SPRINKLE	T3	PA QL(1 CAP/DAY) SP
tetrabenazine (Xenazine)	T1	PA SP HD
PSEUDOBULBAR AFFECT (PBA) AGENTS, NMDA ANTAGONISTS		
NUEDEXTA	T3	QL (4 caps/day)
XANTHINES		
CAFCIT (*caffeine citrate*)	T3	HD
CAFFEINE AND SODIUM BENZOATE	T1	HD
caffeine citrate	T1	HD
caffeine citrate (Cafcit)	T1	HD
caffeine/sodium benzoate	T1	HD
CNS DRUGS (Multiple Sclerosis)		
AGENTS TO TREAT MULTIPLE SCLEROSIS		
AVONEX (4 PACK)	T2	PA SP HD
AVONEX PEN (4 PACK)	T2	PA SP HD
BAFIERTAM	T2	PA SP HD
BETASERON	T2	PA SP HD
BRIUMVI	T3	PA SP
cladribine 10 mg x 10 tab pk	T1	PA SP HD
cladribine 10 mg x 4 tablet pk	T1	PA SP HD
cladribine 10 mg x 5 tablet pk	T1	PA SP HD
cladribine 10 mg x 6 tablet pk	T1	PA SP HD
cladribine 10 mg x 7 tablet pk	T1	PA SP HD
cladribine 10 mg x 8 tablet pk	T1	PA SP HD
cladribine 10 mg x 9 tablet pk	T1	PA SP HD
dimethyl fumarate 30d start pk (Tecfidera)	T1	SP HD
dimethyl fumarate dr 120 mg cp (Tecfidera)	T1	HD
dimethyl fumarate dr 120 mg cp (Tecfidera)	T1	SP HD
dimethyl fumarate dr 240 mg cp (Tecfidera)	T1	HD
DIMETHYL FUMARATE DR 240 MG CP (TECFIDERA)	T1	SP HD
fingolimod hcl (Gilenya)	T1	SP HD
glatiramer acetate (Copaxone)	T1	SP HD
KESIMPTA PEN	T2	PA SP HD
LEMTRADA	T3	PA SP HD

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CNS DRUGS (Multiple Sclerosis)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
AGENTS TO TREAT MULTIPLE SCLEROSIS		
MAVENCLAD	T3	PA SP HD
MAYZENT	T2	PA SP HD
OCREVUS	T2	PA SP HD
OCREVUS ZUNOVO	T2	PA SP
PLEGRIDY	T2	PA SP HD
PLEGRIDY PEN	T2	PA SP HD
REBIF	T2	PA SP HD
REBIF REBIDOSE	T2	PA SP HD
teriflunomide (Aubagio)	T1	SP HD
VUMERITY	T2	PA SP HD
AGTS TX NEUROMUSC TRANSMISSION DIS, POT-CHAN BLKR		
KESIMPTA PEN	T2	PA SP HD
LEMTRADA	T3	PA SP HD
MAVENCLAD	T3	PA SP HD
dalfampridine er 10 mg tablet (Ampyra)	T1	PA SP HD
FIRDAPSE	T3	PA QL(8 TABS/DAY) SP
SPHINGOSINE 1-PHOSPHATE (SIP) RECEPTOR MODULATOR		
ZEPOSIA	T2	PA SP HD
CNS DRUGS (Pain Relief And Inflammatory Disease)		
CALCITONIN GENE-RELATED PEPTIDE (CGRP) INHIBITORS		
EMGALITY SYRINGE	T2	PA
POSTHERPETIC NEURALGIA AGENTS		
gabapentin (Gralise)	T1	
GRALISE ER 300 MG TABLET *(gabapentin)*	T3	
GRALISE ER 600 MG TABLET *(gabapentin)*	T3	HD
SPHINGOSINE 1-PHOSPHATE (SIP) RECEPTOR MODULATOR		
VELSIPITY	T2	PA QL(30 TABS/30 DAYS) SP HD
ZEPOSIA	T2	PA SP HD

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List of Prescription Medications

CNS DRUGS (Seizure Disorders)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTICONVULSANT - BENZODIAZEPINE TYPE		
clobazam (Onfi)	T1	HD
clonazepam	T1	HD
clonazepam (Klonopin)	T1	HD
DIASTAT (*diazepam*)	T3	PA HD
diazepam 10 mg rectal gel syrg	T1	HD
diazepam 10mg rectal gel (2pk)	T1	HD
diazepam 2.5mg rectal gel(2pk) (Diastat)	T1	HD
diazepam 20 mg rectal gel syrg	T1	HD
diazepam 20mg rectal gel (2pk)	T1	HD
KLONOPIN (*clonazepam*)	T3	PA HD
NAYZILAM	T2	PA QL(10 UNITS/30 DAYS) HD
VALTOCO	T2	PA QL(10 BLISTER PACKS/30 DAYS) HD
ANTICONVULSANT - CANNABINOID TYPE		
EPIDIOLEX	T3	PA SP HD
ANTICONVULSANTS		
BRIVIACT 10 MG TABLET	T3	PA HD
BRIVIACT 10 MG/ML ORAL SOLN	T3	PA HD
BRIVIACT 100 MG TABLET	T3	PA HD
BRIVIACT 25 MG TABLET	T3	PA HD
BRIVIACT 50 MG TABLET	T3	PA HD
BRIVIACT 50 MG/5 ML VIAL	T3	HD
BRIVIACT 75 MG TABLET	T3	PA HD
carbamazepine (Carbatrol)	T1	HD
carbamazepine (Tegretol Xr)	T1	HD
carbamazepine (Tegretol)	T1	HD
carbamazepine 100 mg tab chew	T1	HD
carbamazepine 100 mg/5 ml cup	T1	HD
carbamazepine 100 mg/5 ml susp (Tegretol)	T1	HD
CARBAMAZEPINE 200 MG TAB CHEW	T3	HD
carbamazepine 200 mg tablet (Tegretol)	T1	HD
carbamazepine 200 mg/10 ml cup	T1	HD

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CNS DRUGS (Seizure Disorders) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTICONVULSANTS *(cont.)*		
CARBATROL (*carbamazepine*)	T3	PA HD
CELONTIN (*methsuximide*)	T3	HD
CEREBYX (*fosphenytoin sodium*)	T3	
DIACOMIT	T3	PA SP HD
DILANTIN 100 MG CAPSULE *(phenytoin sodium extended)*	T3	PA HD
DILANTIN 30 MG CAPSULE	T2	PA HD
DILANTIN 50 MG INFATAB *(phenytoin)*	T3	PA HD
DILANTIN-125 *(phenytoin)*	T3	PA HD
divalproex sodium (Depakote Er)	T1	HD
divalproex sodium (Depakote Sprinkle)	T1	HD
divalproex sodium (Depakote)	T1	HD
eslicarbazepine 200 mg tablet (Aptiom)	T1	PA QL(1 TAB/DAY) HD
eslicarbazepine 400 mg tablet (Aptiom)	T1	PA QL(1 TAB/DAY) HD
eslicarbazepine 600 mg tablet (Aptiom)	T1	PA HD
eslicarbazepine 800 mg tablet (Aptiom)	T1	PA HD
ethosuximide (Zarontin)	T1	HD
felbamate (Felbatol)	T1	HD
FINTEPLA	T3	PA SP HD
fosphenytoin sodium (Cerebyx)	T1	
FYCOMPA 0.5 MG/ML ORAL SUSP	T2	PA HD
gabapentin	T1	HD
gabapentin (Neurontin)	T1	HD
KEPPRA 500 MG/5 ML VIAL (levetiracetam)	T3	
lacosamide (Vimpat)	T1	HD
lamotrigine (Lamictal (Blue))	T1	HD
lamotrigine (Lamictal (Green))	T1	HD
lamotrigine (Lamictal (Orange))	T1	HD
lamotrigine (Lamictal Odt (Blue))	T1	HD
lamotrigine (Lamictal Odt (Green))	T1	HD
lamotrigine (Lamictal Odt (Orange))	T1	HD
lamotrigine (Lamictal Odt)	T1	HD
lamotrigine (Lamictal Xr)	T1	HD
lamotrigine (Lamictal)	T1	HD
levetiracetam (Keppra Xr)	T1	HD

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CNS DRUGS (Seizure Disorders) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTICONVULSANTS *(cont.)*		
levetiracetam (Keppra)	T1	HD
levetiracetam 1,000 mg tablet (Keppra)	T1	HD
levetiracetam 1,000mg/10ml cup (Keppra)	T1	HD
levetiracetam 100 mg/ml soln (Keppra)	T1	HD
LEVETIRACETAM 250 MG TAB SUSP	T3	PA HD
levetiracetam 250 mg tablet (Keppra)	T1	HD
levetiracetam 500 mg tablet (Keppra)	T1	HD
levetiracetam 500 mg/5 ml cup	T1	HD
levetiracetam 500 mg/5 ml soln	T1	HD
levetiracetam 500 mg/5 ml vial (Keppra)	T1	
levetiracetam 750 mg tablet (Keppra)	T1	HD
levetiracetam-nacl 1,000mg/100	T1	
levetiracetam-nacl 1,500mg/100	T1	
LEVETIRACETAM-NACL 250 MG/50ML	T3	
levetiracetam-nacl 500 mg/100	T1	
LYRICA 20 MG/ML ORAL SOLUTION (*pregabalin*)	T3	PA HD
methsuximide (Celontin)	T1	HD
NEURONTIN 400 MG CAPSULE *(gabapentin)*	T3	HD
NEURONTIN 600 MG TABLET *(gabapentin)*	T3	HD
NEURONTIN 800 MG TABLET (*gabapentin*)	T3	HD
oxcarbazepine (Oxtellar Xr)	T1	PA HD
oxcarbazepine (Trileptal)	T1	HD
OXTELLAR XR (oxcarbazepine)	T3	PA HD
perampanel 10 mg tablet (Fycompa)	T1	PA HD
perampanel 12 mg tablet (Fycompa)	T1	PA HD
perampanel 2 mg tablet (Fycompa)	T1	PA HD
perampanel 4 mg tablet (Fycompa)	T1	PA QL(1 TAB/DAY) HD
perampanel 6 mg tablet (Fycompa)	T1	PA QL(1 TAB/DAY) HD
perampanel 8 mg tablet (Fycompa)	T1	PA HD
PHENYTEK (*phenytoin sodium extended*)	T3	PA HD

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List of Prescription Medications

CNS DRUGS (Seizure Disorders) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTICONVULSANTS *(cont.)*		
phenytoin	T1	HD
phenytoin (Dilantin)	T1	HD
phenytoin (Dilantin-125)	T1	HD
phenytoin sodium	T1	HD
phenytoin sodium extended (Dilantin)	T1	HD
phenytoin sodium extended (Phenytek)	T1	HD
pregabalin (Lyrica)	T1	HD
primidone 250 mg tablet (Mysoline)	T1	HD
primidone 50 mg tablet (Mysoline)	T1	HD
rufinamide 200 mg tablet (Banzel)	T1	PA QL(16 TABS/DAY) HD
rufinamide 40 mg/ml suspension (Banzel)	T1	PA QL(80 MLS/DAY) HD
rufinamide 400 mg tablet (Banzel)	T1	PA QL(8 TABS/DAY) HD
SPRITAM	T3	PA HD
subvenite 100 mg tablet (Lamictal)	T1	HD
subvenite 150 mg tablet (Lamictal)	T1	HD
subvenite 200 mg tablet (Lamictal)	T1	HD
subvenite 25 mg tablet (Lamictal)	T1	HD
TEGRETOL (*carbamazepine*)	T3	PA HD
TEGRETOL XR (*carbamazepine*)	T3	PA HD
tiagabine hcl 12 mg tablet	T1	QL(8 TABS/DAY) HD
tiagabine hcl 16 mg tablet	T1	QL(6 TABS/DAY) HD
tiagabine hcl 2 mg tablet	T1	HD
tiagabine hcl 4 mg tablet	T1	HD
topiramate (Qudexy Xr)	T1	HD
*topiramate 100 mg tablet (*Topamax*)*	T1	HD
*topiramate 15 mg sprinkle cap (*Topamax*)*	T1	HD
*topiramate 200 mg tablet (*Topamax*)*	T1	HD
*topiramate 25 mg sprinkle cap (*Topamax*)*	T1	HD
*topiramate 25 mg tablet (*Topamax*)*	T1	HD
*topiramate 25 mg/ml solution (*Eprontia*)*	T1	HD
topiramate 50 mg sprinkle cap	T1	HD
topiramate 50 mg tablet (Topamax)	T1	HD
topiramate er 100 mg capsule (Trokendi Xr)	T1	QL(1 CAP/DAY) HD
topiramate er 200 mg capsule (Trokendi Xr)	T1	HD

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CNS DRUGS (Seizure Disorders) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTICONVULSANTS *(cont.)*		
topiramate er 25 mg capsule (Trokendi Xr)	T1	QL(1 CAP/DAY) HD
topiramate er 50 mg capsule (Trokendi Xr)	T1	HD
TROKENDI XR 100 MG CAPSULE (*topiramate*)	T3	QL(1 CAP/DAY) HD
TROKENDI XR 200 MG CAPSULE (*topiramate*)	T3	HD
TROKENDI XR 25 MG CAPSULE (*topiramate*)	T3	QL(1 CAP/DAY) HD
TROKENDI XR 50 MG CAPSULE (*topiramate*)	T3	HD
valproic acid	T1	HD
valproic acid (as sodium salt)	T1	HD
vigabatrin (Sabril)	T1	SP HD
vigadrone 500 mg powder packet (Sabril)	T1	SP HD
VIMPAT 10 MG/ML SOLUTION (*lacosamide*)	T2	HD
VIMPAT 200 MG/20 ML VIAL (*lacosamide*)	T3	HD
XCOPRI 100 MG TABLET	T3	PA QL(1 TABLET/DAY) HD
XCOPRI 12.5-25 MG TITRATION PK	T3	PA QL(28 TABS/28 DAYS) HD
XCOPRI 150 MG TABLET	T3	PA QL(1 TABLET/DAY) HD
XCOPRI 150-200 MG TITRATION PK	T3	PA QL(28 TABS/28 DAYS) HD
XCOPRI 200 MG TABLET	T3	PA QL(2 TABS/DAY) HD
XCOPRI 25 MG TABLET	T3	PA QL(1 TABLET/DAY) HD
XCOPRI 250 MG DAILY DOSE PACK	T3	PA QL(56 TABS/28 DAYS) HD
XCOPRI 350 MG DAILY DOSE PACK	T3	PA QL(56 TABS/28 DAYS) HD
XCOPRI 50 MG TABLET	T3	PA QL(1 TABLET/DAY) HD
XCOPRI 50-100 MG TITRATION PAK	T3	PA QL(28 TABS/28 DAYS) HD
ZARONTIN (ethosuximide)	T3	PA HD
zonisamide	T1	HD
zonisamide (Zonegran)	T1	HD
CNS DRUGS (Sleep Disorders/Sedatives)		
NARCOLEPSY TX-H3-RECEPT.ANTAGONIST/INVERSE AGONIST		
WAKIX	T3	PA QL (2 tabs/day) SP HD
COLONY STIMULATING FACTORS (Blood Modifiers/Bleeding Disorders)		
ERYTHROPOIESIS-STIMULATING AGENTS		
ARANESP	T2	PA SP
EPOGEN	T2	PA SP
MIRCERA	T3	PA SP
PROCRIT	T2	PA SP
RETACRIT	T2	PA SP

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COLONY STIMULATING FACTORS (Blood Modifiers/Bleeding Disorders)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
LEUKOCYTE (WBC) STIMULANTS		
FULPHILA	T3	PA SP
FYLNETRA	T3	PA SP
GRANIX	T3	PA SP
LEUKINE	T2	SP
NEULASTA	T2	PA SP
NEULASTA ONPRO	T2	PA SP HD
NEUPOGEN	T3	PA SP
NIVESTYM	T2	SP HD
NYPOZI	T3	PA SP
NYVEPRIA	T2	PA SP
STIMUFEND	T3	PA SP
UDENYCA	T2	PA SP
UDENYCA AUTOINJECTOR	T2	PA SP
UDENYCA ONBODY	T2	PA SP
ZARXIO	T2	SP HD
ZIEXTENZO	T3	PA SP
THROMBOPOIETIN RECEPTOR AGONISTS		
DOPTELET	T2	PA SP HD
DOPTELET SPRINKLE	T2	PA SP HD
eltrombopag olamine (Promacta)	T1	PA SP HD
MULPLETA	T3	PA SP HD
NPLATE	T3	PA SP
COLONY STIMULATING FACTORS (Blood Pressure/Heart Medications)		
LEUKOCYTE (WBC) STIMULANTS		
RELEUKO	T3	PA SP
ROLVEDON	T2	PA SP
COLONY STIMULATING FACTORS (Cancer)		
CXCR4 CHEMOKINE RECEPTOR ANTAGONIST		
RELEUKO	T3	PA SP
ROLVEDON	T2	PA SP
XOLREMDI	T3	PA QL(4 caps/day) SP CSL

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CONTRACEPTIVES (Contraception Products)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
CONTRACEPTIVES, INTRAVAGINAL, SYSTEMIC		
etonogestrel/ethinyl estradiol (Nuvaring)	T1	PPACA
CONTRACEPTIVES, IMPLANTABLE		
NEXPLANON	T3	SP PPACA
CONTRACEPTIVES, INJECTABLE		
DEPO-PROVERA (*medroxyprogesterone acetate*)	T3	PPACA
DEPO-SUBQ PROVERA 104	T3	PPACA
medroxyprogesterone 150 mg/ml (Depo-Provera)	T1	PPACA
CONTRACEPTIVES, ORAL		
desog-e.estradiol/e.estradiol	T1	HD PPACA
desogestrel-ethinyl estradiol	T1	HD PPACA
drospir/eth estra/levomefol ca (Beyaz)	T1	HD PPACA
drospir/eth estra/levomefol ca (Safyral)	T1	HD PPACA
ELLA	T3	HD PPACA
ethinyl estradiol/drospirenone (Yasmin 28)	T1	HD PPACA
ethinyl estradiol/drospirenone (Yaz)	T1	HD PPACA
ethynodiol d-ethinyl estradiol	T1	HD PPACA
levonorgest/eth.estradiol/iron (Balcoltra)	T1	HD PPACA
levonorgestrel/ethin.estradiol	T1	HD PPACA
l-norgest/e.estradiol-e.estrad	T1	HD PPACA
noreth-ethinyl estradiol/iron	T1	HD PPACA
noreth-ethinyl estradiol/iron	T3	HD PPACA
CONTRACEPTIVES, ORAL *(cont.)*		
norethind-eth estrad 1-0.02 mg (Loestrin)	T1	HD PPACA
norethindrone	T1	HD PPACA
norethindrone ac/eth estradiol (Loestrin)	T1	HD PPACA
norethindrone-e.estradiol-iron	T1	HD PPACA
norethindrone-e.estradiol-iron (Loestrin Fe)	T1	HD PPACA
norethindrone-e.estradiol-iron (Taytulla)	T1	HD PPACA
norethindrone-ethin. estradiol	T1	HD PPACA
norethin-ee 1.5-0.03 mg(21) tb (Loestrin)	T1	HD PPACA
norgestimate-ethinyl estradiol	T1	HD PPACA
norgestrel-ethinyl estradiol	T1	HD PPACA

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CONTRACEPTIVES (Contraception Products)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
CONTRACEPTIVES, TRANSDERMAL		
norelgestromin/ethin.estradiol	T1	HD PPACA
DIAPHRAGMS/CERVICAL CAP		
CAYA CONTOURED	T2	PPACA
FEMCAP	T2	PPACA
WIDE SEAL DIAPHRAGM	T3	PPACA
INTRA-UTERINE DEVICES (IUDS)		
KYLEENA	T3	SP PPACA
LILETTA	T3	SP PPACA
MIRENA	T3	SP PPACA
MIUDELLA	T3	SP PPACA
PARAGARD T 380-A	T3	SP PPACA
PARAGARD T 380A (SINGLE HAND)	T3	SP PPACA
SKYLA	T3	SP PPACA
COUGH/COLD PREPARATIONS (Allergy/Nasal Sprays)		
IST GEN ANTIHIST-DECONGEST-ANTICHOLINERGIC COMB		
RESPA A.R.	T3	
COUGH/COLD PREPARATIONS (Cough/Cold Medications)		
ANTITUSSIVES, NON-OPIOID		
benzonatate 100 mg capsule	T1	
benzonatate 200 mg capsule	T1	
NON-OPIOID ANTITUS-IST GEN.ANTIHISTAMINE-DECONGEST		
brompheniramine/pseudoephed/dm (Bromfed Dm)	T1	
NON-OPIOID ANTITUSSIVE-IST GEN ANTIHISTAMINE COMB.		
promethazine/dextromethorphan	T1	
OPIOID ANTITUSSIVE-IST GENERATION ANTIHISTAMINE		
hydrocodone/chlorphen p-stirex	T1	PA
promethazine hcl/codeine	T1	PA QL(480 MLS/30 DAYS)
TUXARIN ER	T3	PA QL(2 TABS/DAY)
TUZISTRA XR	T3	PA QL(960 MLS/30 DAYS)
OPIOID ANTITUSSIVE-ANTICHOLINERGIC COMBINATIONS		
HYCODAN 5 MG-1.5 MG TABLET (*hydrocodone bit/homatrop me-br*)	T3	PA QL(180 TABS/30 DAYS)
HYCODAN 5 MG-1.5 MG/5 ML CUP	T3	PA QL(480 MLS/30 DAYS)
HYCODAN 5 MG-1.5 MG/5 ML SOLN *(hydrocodone bit/homatrop me-br)*	T3	PA QL(480 MLS/30 DAYS)

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List of Prescription Medications

COUGH/COLD PREPARATIONS (Cough/Cold Medications)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
OPIOID ANTITUSSIVE-ANTICHOLINERGIC COMBINATIONS *(cont.)*		
hydrocodone bit/homatrop me-br (Hycodan)	T1	PA QL(480 MLS/30 DAYS)
hydrocodone-homatrop 5 ml cup	T1	PA QL(480 MLS/30 DAYS)
hydrocodone-homatropine 5-1.5 (Hycodan)	T1	PA QL(180 TABS/30 DAYS)
hydrocodone-homatropine soln (Hycodan)	T1	PA QL(480 MLS/30 DAYS)
OPIOID ANTITUSSIVE-DECONGESTANT-EXPECTORANT COMB		
CODITUSSIN DAC	T3	
OPIOID ANTITUSSIVE-EXPECTORANT COMBINATION		
codeine phosphate/guaifenesin	T1	
CODITUSSIN AC	T1	
GUAIFENESIN-CODEINE	T1	
MAR-COF CG	T3	
NINJACOF-XG	T1	
OBREDON	T3	PA QL(960 MLS/30 DAYS)
DIAGNOSTIC (Diabetes)		
BLOOD SUGAR DIAGNOSTICS		
FREESTYLE INSULINX	T2	
FREESTYLE INSULINX TEST STRIPS	T2	
FREESTYLE LITE TEST STRIP	T2	
FREESTYLE PRECISION NEO	T2	
FREESTYLE TEST STRIPS	T2	
PRECISION XTRA TEST STRIPS	T2	
RELION TRUE METRIX TEST STRIP	T2	
TRUE METRIX GLUCOSE TEST STRIP	T2	
URINE GLUCOSE TEST AIDS		
DIASTIX REAGENT	T3	
DIAGNOSTIC (Miscellaneous)		
ADRENAL RADIOACTIVE DIAGNOSTICS		
ADREVIEW	T3	
BILIARY DIAGNOSTICS		
CHOLETEC	T3	
TC99M MEBROFENIN PREP	T1	
BILIARY DIAGNOSTICS, RADIOPAQUE		
indocyanine green (Spy-Mis)	T1	

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DIAGNOSTIC (Miscellaneous) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
BILIARY DIAGNOSTICS, RADIOPAQUE *(cont.)*		
SINOGRAFIN	T3	
SPY-MIS (*indocyanine green*)	T3	
BLOOD TESTING PREPARATIONS		
FORA GTEL KETONE TEST STRIP	T3	
FORA TN'G ADV VOICE KETO STRIP	T3	
GOJJI BLOOD KETONE TEST STRIP	T3	
NOVAMAX PLUS	T3	
PRECISION XTR B-KETONE STRIP	T3	
CARDIOVASCULAR DIAGNOSTICS - RADIOACTIVE		
adenosine	T1	
DEFINITY	T3	
DEFINITY RT	T3	
dipyridamole 50 mg/10 ml vial	T1	
LEXISCAN	T3	
OPTISON	T3	
regadenoson 0.4 mg/5 ml syring	T1	
REGADENOSON 0.4 MG/5 ML VIAL	T3	
CARDIOVASCULAR DIAGNOSTICS, NON-RADIOPAQUE AGENTS		
adenosine	T1	
DEFINITY	T1	
DEFINITY RT	T3	
dipyridamole 50 mg/10 ml vial	T1	
LEXISCAN	T3	
OPTISON	T3	
regadenoson 0.4 mg/5 ml syring	T1	
REGADENOSON 0.4 MG/5 ML VIAL		
CARDIOVASCULAR DIAGNOSTICS-RADIOPAQUE		
iodixanol	T1	
iopamidol	T1	
ISOVUE-200	T3	
ISOVUE-250	T3	
ISOVUE-300	T3	
ISOVUE-370	T3	

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DIAGNOSTIC (Miscellaneous) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
CARDIOVASCULAR DIAGNOSTICS-RADIOPAQUE *(cont.)*		
ISOVUE-370 (iopamidol)	T3	
ISOVUE-M 200	T3	
ISOVUE-M 300	T3	
OMNIPAQUE	T3	
OPTIRAY 240	T3	
OPTIRAY 300	T3	
OPTIRAY 320	T3	
OPTIRAY 350	T3	
ULTRAVIST	T3	
VISIPAQUE	T3	
CEREBRAL SPINAL RADIOACTIVE DIAGNOSTICS		
INDIUM IN-111 DTPA	T3	
DOTAREM	T3	
gadoterate meglumine	T1	
gadoteridol	T1	
MAGNEVIST	T3	
MULTIHANCE	T3	
MULTIHANCE MULTIPACK	T3	
OMNISCAN	T3	
PROHANCE	T3	
PROHANCE MULTIPACK	T3	
DIAGNOSTIC PREPARATIONS, MISCELLANEOUS		
ADVANCED DNA MEDICATED COLLECT	T3	
ARIDOL	T3	
DMSA	T3	
DRAXIMAGE DTPA	T3	
ELUCIREM	T3	
GADAVIST	T3	
gadobutrol	T1	
GLUCAGON HCL	T1	
GOZELLIX	T3	
ILLUCCIX	T3	
isosulfan blue	T1	
lidocaine hcl/glycerin	T1	
LIPIODOL	T3	

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DIAGNOSTIC PREPARATIONS, MISCELLANEOUS *(cont.)*		
LOCAMETZ	T3	
LUMASON	T3	
LYMPHAZURIN	T3	
NETSPOT	T3	
PROVOCHOLINE	T3	
TC 99M SULFUR COLLOID PREP	T1	
TC99M MEDRONATE PREP	T1	
VUEWAY	T3	
DIAGNOSTIC RADIOPHARM - AMYLOID/TAU IMAGING		
AMYVID	T3	
VIZAMYL	T3	PA
DIAGNOSTIC RADIOPHARM - DOPAMINE TRANSPORTER (DAT)		
DATSCAN	T3	
EYE DIAGNOSTIC AGENTS		
AK-FLUOR	T3	
AK-FLUOR (fluorescein sodium)	T3	
fluorescein sodium	T1	
fluorescein sodium (Ak-Fluor)	T1	
fluorescein sodium (Ak-Fluor)	T3	
ful-glo 1 mg opth strip	T1	
FUL-GLO EYE STRIPS	T3	
lissamine green	T1	
FLUORESCENCE CYSTOSCOPY/OPTICAL IMAGING AGENTS		
CYSVIEW	T3	
GASTROINTESTINAL RADIOPAQUE DIAGNOSTICS		
diatrizoate meglumine, sodium (Gastrografin)	T1	
ENTERO VU	T3	
E-Z DISK	T3	
E-Z-HD	T3	
E-Z-PAQUE	T3	
E-Z-PASTE	T3	
GASTROGRAFIN (*diatrizoate meglumine, sodium*)	T3	
GASTROMARK	T3	
LIQUID E-Z PAQUE	T3	
LIQUID POLIBAR PLUS	T3	

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
GASTROINTESTINAL RADIOPAQUE DIAGNOSTICS *(cont.)*		
NEULUMEX	T3	
POLIBAR ACB	T3	
READI-CAT 2	T3	
SITZMARKS	T3	
TAGITOL V	T3	
VANILLA SILQ	T3	
VARIBAR HONEY	T3	
VARIBAR NECTAR	T3	
VARIBAR PUDDING	T3	
VARIBAR THIN HONEY	T3	
VARIBAR THIN LIQUID	T3	
HEPATIC DIAGNOSTICS		
EOVIST	T3	
HISTAMINE PREPARATIONS		
HISTATROL INTRADERMAL	T3	
HISTATROL PERCUTANEOUS	T3	
METABOLIC FUNCTION DIAGNOSTICS		
CHIRHOSTIM	T3	
METOPIRONE	T3	
R-GENE 10	T3	
NEOPLASM MONOCLONAL DIAGNOSTIC AGENTS		
PROSTASCINT	T3	
RADIOACTIVE DIAGNOSTICS, GENERAL		
indium-111 chlor/pentetreotide	T1	
OCTREOSCAN	T3	
RADIOACTIVE DIAGONISTICS - PROSTATIC IMAGING AGENT		
AXUMIN	T3	
RADIOACTIVE DX RADIOLABEL OF AUTOLOGOUS LEUKOCYTES		
INDIUM IN-111 OXYQUINOLINE	T1	
RADIOACTIVE DX RADIOLABEL OF SYNTHETIC AMINO ACIDS		
AXUMIN	T3	
RADIOACTIVE DX RADIOLABEL OF AUTOLOGOUS LEUKOCYTES		
INDIUM IN-111 OXYQUINOLINE	T1	
RADIOACTIVE METABOLIC FUNCTION DIAGNOSTICS		
FLUDEOXYGLUCOSE F-18	T3	

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DIAGNOSTIC (Miscellaneous) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
RADIOPHARMACEUTICALS ELEMENTS		
GALLIUM GA-68 DOTATOC	T3	
INDICLOR	T3	
TECHNELITE TC-99M GENERATOR	T3	
RENAL FUNCTION DIAGNOSTICS AGENTS		
BLUDIGO	T3	
URINARY TRACT RADIOPAQUE DIAGNOSTICS		
CONRAY	T3	
CONRAY-30	T3	
CONRAY-43	T3	
CYSTO-CONRAY II	T3	
CYSTOGRAFIN	T3	
CYSTOGRAFIN-DILUTE	T3	
diatrizoate meglumine, sodium	T3	
URINE ACETONE TEST AIDS		
KETONE CARE TEST STRIP	T3	
KETONE TEST STRIP	T3	
KETOSTIX REAGENT	T3	
TRUEPLUS KETONE TEST STRIP	T3	
CHEK-STIX	T3	
CHEMSTRIP	T3	
CHEMSTRIP 10 WITH SG	T3	
CHEMSTRIP 2 GP	T3	
CHEMSTRIP 50B	T3	
CHEMSTRIP 7	T3	
CHEMSTRIP 9	T3	
COMBISTIX REAGENT	T3	
HEMA-COMBISTIX	T3	
KETO-DIASTIX REAGENT	T3	
LABSTIX REAGENT	T3	
MULTISTIX	T3	
MULTISTIX 10 SG	T3	
MULTISTIX 5	T3	
MULTISTIX 7	T3	

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List of Prescription Medications

DIAGNOSTIC (Miscellaneous) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
URINE ACETONE TEST AIDS		
MULTISTIX 8 SG	T3	
MULTISTIX 9	T3	
MULTISTIX 9 SG	T3	
URISTIX 4	T3	
URISTIX REAGENT	T3	
DIURETICS (Diuretics)		
ARGININE VASOPRESSIN (AVP) RECEPTOR ANTAGONISTS		
tolvaptan 15 mg tablet (Samsca)	T1	SP
tolvaptan 30 mg tablet (Samsca)	T1	SP
VAPRISOL-5% DEXTROSE	T3	
CARBONIC ANHYDRASE INHIBITORS		
acetazolamide	T1	HD
acetazolamide sodium	T1	
methazolamide	T1	HD
LOOP DIURETICS		
bumetanide	T1	HD
ethacrynate sodium (Sodium Edecrin)	T1	
furosemide 1,000 mg/100 ml vl	T1	
furosemide 10 mg/ml solution	T1	HD
furosemide 100 mg/10 ml vial	T1	
furosemide 20 mg tablet (Lasix)	T1	HD
furosemide 20 mg/2 ml vial	T1	
furosemide 40 mg tablet (Lasix)	T1	HD
furosemide 40 mg/4 ml syringe	T1	
furosemide 40 mg/4 ml vial	T1	
furosemide 40 mg/5 ml soln	T1	HD
furosemide 500 mg/50 ml vial	T1	
furosemide 80 mg tablet (Lasix)	T1	HD
FUROSEMIDE-0.9% NACL *(furosemide in 0.9 % nacl)*	T3	
SODIUM EDECRIN *(ethacrynate sodium)*	T3	
torsemide	T1	HD

T1 – Typically Generics
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List of Prescription Medications

DIURETICS (Diuretics) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
OSMOTIC DIURETICS		
mannitol	T1	
mannitol	T3	
mannitol (Osmitrol)	T1	
OSMITROL (*mannitol*)	T3	
tolvaptan 15 mg tablet (Jynarque)	T1	SP
tolvaptan 15 mg-15 mg tablet (Jynarque)	T1	PA SP
tolvaptan 30 mg tablet (Jynarque)	T1	SP
tolvaptan 30 mg-15 mg tablet (Jynarque)	T1	PA SP
tolvaptan 45 mg-15 mg tablet (Jynarque)	T1	PA SP
tolvaptan 60 mg-30 mg tablet (Jynarque)	T1	PA SP
tolvaptan 90 mg-30 mg tablet (Jynarque)	T1	PA SP
POTASSIUM SPARING DIURETICS		
amiloride hcl	T1	HD
CAROSPIR (*spironolactone*)	T2	PA
eplerenone (Inspra)	T1	HD
KERENDIA	T2	PA QL(1 TAB/DAY)
spironolactone 100 mg tablet (Aldactone)	T1	HD
spironolactone 25 mg tablet (Aldactone)	T1	HD
spironolactone 25 mg/5 ml susp (Carospir)	T1	
spironolactone 50 mg tablet (Aldactone)	T1	HD
triamterene (Dyrenium)	T1	HD
POTASSIUM SPARING DIURETICS IN COMBINATION		
amiloride/hydrochlorothiazide	T1	HD
spironolact/hydrochlorothiazid	T1	HD
triamterene/hydrochlorothiazid	T1	HD
THIAZIDE AND RELATED DIURETICS		
chlorothiazide sodium (Sodium Diuril)	T1	
chlorthalidone	T1	HD
DIURIL	T3	HD
hydrochlorothiazide	T1	HD
indapamide	T1	HD
metolazone	T1	HD
SODIUM DIURIL (*chlorothiazide sodium*)	T3	

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List of Prescription Medications

EENT PREPS (Allergy/Nasal Sprays)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
NASAL ANTIHISTAMINE		
azelastine 0.1% (137 mcg) spry	T1	HD
olopatadine 665 mcg nasal spry (Patanase)	T1	HD
PATANASE *(olopatadine hcl)*	T3	HD
NASAL ANTIHISTAMINE AND ANTI-INFLAM. STEROID COMB.		
azelastine/fluticasone	T1	HD
NASAL ANTI-INFLAMMATORY STEROIDS		
flunisolide	T1	HD
fluticasone prop 50 mcg spray	T1	HD
mometasone furoate 50 mcg spry	T1	QL(68 GMS/30 DAYS) HD
NOSE PREPARATIONS, MISCELLANEOUS (RX)		
ipratropium bromide	T1	HD
NOSE PREPARATIONS, VASOCONSTRICTORS (RX)		
ADRENALIN CHLORIDE	T3	
epinephrine hcl (Adrenalin Chloride)	T1	
EENT PREPS (Ear Medications)		
EAR PREPARATIONS ANTI-INFLAMMATORY		
DERMOTIC (*fluocinolone acetonide oil*)	T3	
fluocinolone acetonide oil (Dermotic)	T1	
EAR PREPARATIONS, MISC. ANTI-INFECTIVES		
acetic acid	T1	
hydrocortisone/acetic acid	T1	
EENT PREPS (Eye Conditions)		
ARTIFICIAL TEARS		
LACRISERT	T3	
MIEBO	T2	QL(4 BOTTLES/30 DAYS)
EYE ANTI-INFECTIVES (RX ONLY)		
BETADINE	T3	
EYE ANTI-INFLAMMATORY AGENTS		
bromfenac sodium	T1	
bromfenac sodium (Bromsite)	T1	
bromfenac sodium (Prolensa)	T1	
dexamethasone sodium phosphate	T1	
diclofenac 0.1% eye drops	T1	

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List of Prescription Medications

EENT PREPS (Eye Conditions) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
EYE ANTI-INFLAMMATORY AGENTS *(con't.)*		
difluprednate (Durezol)	T1	
EYSUVIS	T2	QL(8.3 ML/14 DAYS)
fluorometholone (Fml)	T1	
flurbiprofen sodium	T1	
ILEVRO	T3	
ILUVIEN	T3	SP
ketorolac 0.4% ophth solution (Acular Ls)	T1	
ketorolac 0.5% ophth solution (Acular)	T1	
loteprednol etabonate (Alrex)	T1	
loteprednol etabonate (Lotemax)	T1	
OZURDEX	T3	SP
prednisolone acetate (Pred Forte)	T1	
prednisolone sodium phosphate	T1	
PROLENSA *(bromfenac sodium)*	T3	
TRIESENCE	T3	
XIPERE	T3	PA SP HD
EYE IRRIGATIONS		
balanced salt irrig soln no.2	T3	
BSS PLUS	T3	
EYE LOCAL ANESTHETICS		
AKTEN	T3	
ALCAINE (*proparacaine hcl*)	T3	
ALTAFLUOR BENOX (*benoxinate hcl/fluorescein sod*)	T3	
FLUORESCEIN-BENOXINATE	T3	
proparacaine hcl (Alcaine)	T1	
proparacaine/fluorescein sod	T1	
tetracaine hcl	T1	
TETRACAINE HCL	T1	
EYE MAST CELL STABILIZERS		
cromolyn 4% eye drops	T1	
EYE MYDRIATIC AND NSAID COMBINATIONS		
OMIDRIA	T3	
EYE PREPARATIONS, MISCELLANEOUS (OTC)		
GELFILM	T3	

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List of Prescription Medications

EENT PREPS (Eye Conditions) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
EYE VASOCONSTRICTORS		
phenylephrine hcl	T1	
MIOTICS AND OTHER INTRAOCULAR PRESSURE REDUCERS		
apraclonidine hcl	T1	HD
betaxolol hcl	T1	HD
BETOPTIC S	T2	HD
bimatoprost	T1	QL(10 MLS/30 DAYS) HD
brimonidine tartrate	T1	HD
brimonidine tartrate (Alphagan P)	T1	HD
brimonidine tartrate/timolol (Combigan)	T1	HD
brinzolamide (Azopt)	T1	HD
carbachol	T3	HD
carteolol hcl	T1	HD
dorzolamide hcl	T1	HD
dorzolamide hcl/timolol maleat (Cosopt)	T1	HD
dorzolamide/timolol/pf (Cosopt Pf)	T1	HD
DURYSTA	T3	PA SP HD
latanoprost (Xalatan)	T1	HD
levobunolol hcl	T1	HD
MIOCHOL-E	T3	HD
PHOSPHOLINE IODIDE	T3	SP HD
pilocarpine 1% eye drops	T1	HD
pilocarpine 2% eye drops	T1	HD
pilocarpine 4% eye drops	T1	HD
RHOPRESSA	T3	
ROCKLATAN	T3	
SIMBRINZA	T2	HD
tafluprost/pf (Zioptan)	T1	QL(60 DROPPERS/30 DAYS) HD
timolol (Betimol)	T1	HD
timolol maleate (Istalol)	T1	HD
timolol maleate (Timoptic)	T1	HD
timolol maleate (Timoptic-Xe)	T1	HD
timolol maleate/pf	T1	HD
timolol maleate/pf (Timoptic Ocudose)	T1	HD
travoprost (Travatan Z)	T1	HD

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List of Prescription Medications

EENT PREPS (Eye Conditions) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
MYDRIATICS		
atropine 1% eye drop	T1	HD
atropine 1% eye drops	T1	HD
atropine 1% eye ointment	T1	HD
CYCLOGYL	T3	HD
CYCLOGYL (*cyclopentolate hcl*)	T3	HD
CYCLOMYDRIL	T3	HD
cyclopentolate hcl	T1	HD
cyclopentolate hcl (Cyclogyl)	T1	HD
homatropine hbr	T1	HD
MYDRIACYL *(tropicamide)*	T3	HD
PAREMYD	T3	HD
tropicamide	T1	HD
tropicamide (Mydriacyl)	T1	HD
OPHTH VASC. ENDOTHELIAL GROWTH FACTOR ANTAGONISTS		
EYLEA	T3	PA SP
EYLEA HD	T3	PA SP
PAVBLU	T3	PA SP
OPHTH. VEGF-A RECEPTOR ANTAG. RCMB MC ANTIBODY		
BEOVU	T3	PA SP
BYOOVIZ	T3	PA SP
CIMERLI	T3	PA SP
LUCENTIS	T3	PA SP
OPHTHALMIC ANTIFIBROTIC AGENTS		
MITOSOL	T3	
OPHTHALMIC ANTI-INFLAMMATORY IMMUNOMODULATOR-TYPE		
CEQUA	T2	
cyclosporine 0.05% eye emuls (Restasis)	T1	HD
RESTASIS (*cyclosporine*)	T2	HD
XIIDRA	T2	HD
OPHTHALMIC COMPLEMENT INHIBITORS		
IZERVAY	T3	PA SP
SYFOVRE	T3	PA SP HD

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List of Prescription Medications

EENT PREPS (Eye Conditions) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
OPHTHALMIC CYSTINE DEPLETING AGENTS		
CYSTADROPS	T3	PA QL(20 MLS/28 DAYS) SP
CYSTARAN	T3	PA QL(120 MLS/28 DAYS) SP
OPHTHALMIC HUMAN NERVE GROWTH FACTOR (HNGF)		
OXERVATE	T3	PA SP HD
OPHTHALMIC PREPARATIONS, MISCELLANEOUS		
AMVISC	T3	SP
AMVISC PLUS	T3	SP
DISCOVISC	T3	
DUOVISC	T3	
HEALON GV PRO	T3	
hyaluronate sodium	T1	SP
PROVISC	T3	SP
VISCOAT	T3	
OPHTHALMIC SURGICAL AIDS		
CELLUGEL	T3	
hypromellose	T1	
MEMBRANEBLUE	T3	
VISIONBLUE	T3	
OPHTHALMIC TRPM8 AGONISTS		
TRYPTYR	T3	
OPHTHALMIC VEGF-A AND ANG-2 INHIB, BISPECIFIC AB		
VABYSMO	T3	
ELECT/CALORIC/H2O (Cholesterol Medications)		
ORAL LIPID SUPPLEMENTS		
DOJOLVI	T3	PA SP HD
ELECT/CALORIC/H2O (Dental Products)		
FLUORIDE PREPARATIONS		
CLINPRO 5000	T3	
FLORIVA	T3	PPACA
fluoride (sodium)	T1	
fluoride (sodium) (Prevident 5000 Plus)	T1	
fluoride (sodium) (Prevident)	T1	
FLUORIDEX	T1	
FLUORIDEX SENSITIVITY RELIEF	T3	
FLUORIMAX 5000	T3	

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List of Prescription Medications

ELECT/CALORIC/H2O (Dental Products) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
FLUORIDE PREPARATIONS *(cont.)*		
FLUORIMAX 5000 SENSITIVE	T3	
FRAICHE 5000 PREVI	T3	
JUST RIGHT 5000	T3	
PREVIDENT	T3	
PREVIDENT (*fluoride (sodium)*)	T3	
PREVIDENT 5000 DRY MOUTH	T3	
PREVIDENT 5000 ENAMEL PROTECT	T3	
PREVIDENT 5000 ORTHO DEFENSE	T3	
PREVIDENT 5000 SENSITIVE	T3	
PREVIDENT KIDS	T3	
sodium fluoride 0.2% rinse (Prevident)	T1	
sodium fluoride 1.1% cream (Prevident 5000 Plus)	T1	
sodium fluoride 1.1% gel (Prevident)	T1	
sodium fluoride 5000 ppm paste	T1	
sodium fluoride/potassium nit	T1	
fluoride (sodium)	T1	PPACA
sodium fluoride 0.25 (0.55) mg	T1	PPACA
sodium fluoride 0.5 mg(1.1 mg)	T1	PPACA
sodium fluoride 0.5 mg/ml drop	T1	PPACA
sodium fluoride 1 mg (2.2 mg)	T1	PPACA
ELECT/CALORIC/H2O (Diabetes)		
AGENTS TO TREAT HYPOGLYCEMIA (HYPERGLYCEMICS)		
BAQSIMI	T2	QL(2 UNITS/30 DAYS)
diazoxide (Proglycem)	T1	
glucagon 1 mg emergency kit	T1	QL(2 VIALS/30 DAYS)
GLUCAGON 1 MG EMERGENCY KIT	T3	QL(2 KITS/30 DAYS)
ZEGALOGUE AUTOINJECTOR	T2	QL(1.2 ML/30 DAYS)
ZEGALOGUE SYRINGE	T2	QL(1.2 ML/30 DAYS)
ELECT/CALORIC/H2O (Miscellaneous)		
BICARBONATE PRODUCING/CONTAINING AGENTS		
sodium acetate	T1	
sodium bicarbonate	T1	
sodium bicarbonate in d5w	T1	

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List of Prescription Medications

ELECT/CALORIC/H2O (Miscellaneous)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DRUGS USED TO TREAT ACIDOSIS		
THAM	T3	
tromethamine	T1	
IV SOLUTIONS: DEXTROSE AND LACTATED RINGERS		
dextrose 5%-lactated ringers	T1	
IV SOLUTIONS: DEXTROSE-SALINE		
dextrose 10 % and 0.2 % nacl	T1	
dextrose 10 % and 0.45 % nacl	T1	
dextrose 2.5 % and 0.45 % nacl	T1	
dextrose 5 % and 0.3 % nacl	T1	
dextrose 5 % and 0.9 % nacl	T1	
IV SOLUTIONS: DEXTROSE-SALINE *(cont.)*		
dextrose 5 %-0.2 % sod chlorid	T1	
dextrose 5 %-0.45 % sod chlord	T1	
IV SOLUTIONS: DEXTROSE-WATER		
dextrose 10%-water iv solution	T1	
dextrose 20%-water iv soln	T1	
dextrose 25%-water syringe	T1	
DEXTROSE 30%-WATER IV SOLN	T3	
DEXTROSE 40%-WATER IV SOLN	T3	
dextrose 5%-water 100 ml	T1	
dextrose 5%-water 100 ml (Glucose In Water)	T1	
dextrose 5%-water 50 ml (Glucose In Water)	T1	
dextrose 5%-water iv soln	T1	
dextrose 5%-water iv soln (Glucose In Water)	T1	
dextrose 50%-water abboject	T1	
DEXTROSE 50%-WATER IV SOLN	T3	
dextrose 50%-water syringe	T1	
dextrose 50%-water vial	T1	
dextrose 70%-water 3,000 ml	T1	
dextrose 70%-water iv soln	T1	
GLUCOSE IN WATER *(dextrose 5 % in water)*	T1	
NUCLEIC ACID/NUCLEOTIDE SUPPLEMENTS		
XURIDEN	T3	PA SP

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List of Prescription Medications

ELECT/CALORIC/H2O (Miscellaneous)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
PARENTERAL AMINO ACID SOLUTIONS AND COMBINATIONS		
AMINOSYN	T3	
AMINOSYN II	T3	
AMINOSYN II WITH ELECTROLYTES	T3	
AMINOSYN M	T3	
AMINOSYN WITH ELECTROLYTES	T3	
AMINOSYN-PF	T3	
AMINOSYN-RF	T3	
CLINIMIX	T3	
CLINIMIX E	T3	
CLINISOL	T3	
KABIVEN	T3	
parenteral amino acid 10% no.6	T3	
parenteral amino acid 10% no.7	T3	
PERIKABIVEN	T3	
PLENAMINE	T3	
PROSOL	T3	
TROPHAMINE	T3	
ELECT/CALORIC/H2O (Nutritional/Dietary)		
CALCIUM REPLACEMENT		
calcium chloride	T1	
CALCIUM GLU 1,000MG/100ML-NACL	T3	
calcium glu 2,000mg/100ml-nacl	T1	
CALCIUM GLU 2,000MG/100ML-NACL	T3	
calcium gluc 1,000mg/50ml-nacl	T1	
CALCIUM GLUC 1,000MG/50ML-NACL	T1	
calcium gluconate	T1	
calcium gluconate in 0.9% nacl	T1	
calcium/mag/d3/b12/fa/b6/boron	T1	
CARBOHYDRATES		
ENFAMIL	T3	
GLUTOL	T3	
ELECTROLYTE DEPLETERS		
AURYXIA	T3	QL(12 TABS/DAY)

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ELECT/CALORIC/H2O (Nutritional/Dietary)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ELECTROLYTE DEPLETERS *(cont.)*		
calcium acetate	T1	
lanthanum carbonate (Fosrenol)	T1	
LOKELMA	T2	
MAGNEBIND 400	T3	
sevelamer carbonate (Renvela)	T1	
sevelamer hcl	T1	
sodium polystyrene sulfon/sorb	T1	
sodium polystyrene sulfonate	T1	
sps 15 gm/60 ml suspension	T1	
sps 30 gm/120 ml enema susp	T3	
VELPHORO	T2	
VELTASSA	T2	
ELECTROLYTE MAINTENANCE		
electrolyte-148 solution	T1	QL (12 tabs/day)
electrolyte-48 solution/d5w	T1	
electrolyte-a solution	T1	
IONOSOL B WITH DEXTROSE 5%	T3	
IONOSOL MB-DEXTROSE 5%	T3	
ISOLYTE P WITH DEXTROSE	T3	
ISOLYTE S	T3	
NORMOSOL-M AND DEXTROSE	T3	
NORMOSOL-R	T3	
NORMOSOL-R AND DEXTROSE	T3	
NORMOSOL-R PH 7.4	T3	
PLASMA-LYTE A PH 7.4	T3	
ringer's solution	T1	
ringer's solution,lactated	T1	
TPN ELECTROLYTES (*sodium/pot/mag/calc/chlor/acet*)	T3	
TPN ELECTROLYTES II	T3	
FLUORIDE PREPARATIONS		
CLINPRO 5000	T3	
fluoride (sodium)	T1	
fluoride (sodium) (Prevident 5000 Plus)	T1	
fluoride (sodium) (Prevident)	T1	
FLUORIDEX	T1	

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List of Prescription Medications

ELECT/CALORIC/H2O (Nutritional/Dietary) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
FLUORIDE PREPARATIONS		
FLUORIMAX 5000	T3	
JUST RIGHT 5000	T3	
PREVIDENT	T3	
PREVIDENT (*fluoride (sodium)*)	T3	
PREVIDENT 5000 DRY MOUTH	T3	
PREVIDENT 5000 ORTHO DEFENSE	T3	
PREVIDENT KIDS	T3	
sodium fluoride 0.2% rinse (Prevident)	T1	
sodium fluoride 1.1% cream (Prevident 5000 Plus)	T1	
sodium fluoride 1.1% gel (Prevident)	T1	
sodium fluoride 5000 ppm paste	T1	
IODINE CONTAINING AGENTS		
IODOPEN	T3	
potassium iodide	T1	
potassium iodide/iodine		
SSKI	T1	
IRON REPLACEMENT		
ACCRUFER	T3	
ACTIVE FE	T3	
CITRANATAL BLOOM	T3	
CORVITE 150	T3	
CORVITE FE	T3	
FERAHEME (*ferumoxytol*)	T3	PA
FERIVA 21-7	T3	
FERRALET 90	T3	
FERRLECIT (*sodium ferric gluconat/sucrose*)	T3	
ferrous fum/vit c/b12-if/folic	T1	
ferrous fumarate/folic acid (Hemocyte-F)	T1	
ferumoxytol (Feraheme)	T1	PA
FUSION PLUS	T3	
HEMATRON-AF	T3	
HEMAX	T3	
HEMOCYTE PLUS (*mv-mins no.73/iron fum/folic*)	T3	
HEMOCYTE-F (*ferrous fumarate/folic acid*)	T3	

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ELECT/CALORIC/H2O (Nutritional/Dietary) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
IRON REPLACEMENT*(cont.)*		
INFED	T3	
INJECTAFER	T3	PA
INTEGRA F (*iron fum,ps/folic acid/vitc/b3*)	T3	
INTEGRA PLUS (*iron fum,ps/folic/bcomp,c no.9*)	T3	
iron aspgly,ps/c/b12/fa/ca/suc	T1	
iron aspgly/c/b12/fa/ca-th/suc	T1	
iron bg,ps/vitc/b12/fa/calcium	T1	
iron fum,ag/c/b12/folic/ca/suc	T1	
iron fum,ps/folic acid/vitc/b3 (Integra F)	T1	
iron fum,ps/folic/bcomp,c no.9 (Integra Plus)	T1	
iron fumarate/vit c/vit b12/fa	T1	
iron ps complex/b12/folic acid	T1	
iron sucrose complex	T1	
iron/c/folic acd/mv cmb11/calc	T1	
iron/folic ac/vit bcomp,c/min	T1	
iron/folic acid/b12/c/docusate	T1	
iron/folic acid/c/b6/b12/zinc	T1	
IROSPAN	T3	
MONOFERRIC	T3	PA
NEONATAL FE	T3	
NUFERA	T3	
PROFERRIN-FORTE	T3	
sodium ferric gluconat/sucrose (Ferrlecit)	T1	
TRIFERIC	T3	PA
VENOFER	T3	
VITAFOL	T3	
MAGNESIUM SALTS REPLACEMENT		
magnesium chloride	T1	
magnesium sulfate	T1	
magnesium sulfate in water	T1	
MAGNESIUM SULFATE-D5W	T1	
MINERAL REPLACEMENT, MISCELLANEOUS		
ADDAMEL N	T3	
chromic chloride	T1	

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List of Prescription Medications

ELECT/CALORIC/H2O (Nutritional/Dietary) *(cont.)*

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MINERAL REPLACEMENT, MISCELLANEOUS *(cont.)*		
cupric chloride	T1	
manganese chloride	T1	
MULTRYS	T3	
PEDITRACE	T3	
SELENIOUS ACID 12 MCG/2 ML VL	T3	
selenious acid 400 mcg/10 ml	T1	
SELENIOUS ACID 600 MCG/10 ML	T1	
TRALEMENT	T3	
PEDIATRIC VITAMIN PREPARATIONS		
fluoride (sodium)	T1	PPACA
sodium fluoride 0.25 (0.55) mg	T1	PPACA
sodium fluoride 0.5 mg(1.1 mg)	T1	PPACA
sodium fluoride 0.5 mg/ml drop	T1	PPACA
sodium fluoride 1 mg (2.2 mg)	T1	PPACA
PHOSPHATE REPLACEMENT		
GLYCOPHOS	T3	
potassium phos,m-basic-d-basic	T1	
POTASSIUM PHOSPHATE-0.9% NACL	T3	
POTASSIUM PHOSPHATES	T3	
sod phosphate,monobasic-dibas	T1	
POTASSIUM REPLACEMENT		
EFFER-K 10 MEQ TABLET EFF	T3	
EFFER-K 20 MEQ TABLET EFF	T3	
effer-k 25 meq tablet eff	T1	
potassium acetate	T1	
potassium bicarbonate/cit ac	T1	
potassium chloride	T1	
potassium chloride	T3	
potassium chloride in 0.9%nacl	T1	
potassium chloride in d5w	T1	
potassium chloride in lr-d5	T1	
potassium chloride in water	T1	
potassium chloride/d5-0.2%nacl	T1	
potassium chloride/d5-0.3%nacl	T1	
potassium chloride/d5-0.45nacl	T1	
potassium chloride/d5-0.9%nacl	T1	

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
POTASSIUM REPLACEMENT *(cont.)*		
potassium chloride-0.45% nacl	T1	
potassium cl 10 meq/100 ml sol	T1	
potassium cl 10 meq/5 ml conc	T1	
potassium cl 10 meq/50 ml sol	T1	
potassium cl 10% (20 meq/15ml)	T1	
POTASSIUM CL 2 MEQ/ML CONC *(potassium chloride)*	T3	
potassium cl 20 meq packet	T1	
potassium cl 20 meq/10 ml conc	T1	
potassium cl 20 meq/100 ml sol	T1	
potassium cl 20 meq/50 ml sol	T1	
potassium cl 20% (40 meq/15ml)	T1	
potassium cl 30 meq/100 ml sol	T1	
potassium cl 40 meq/100 ml sol	T1	
potassium cl 40 meq/20 ml conc	T1	
potassium cl 60 meq/30 ml conc	T1	
potassium cl er 10 meq capsule	T1	
potassium cl er 10 meq tablet	T1	
potassium cl er 15 meq tablet	T1	
POTASSIUM CL ER 15 MEQ TABLET	T3	
potassium cl er 20 meq tablet	T1	
potassium cl er 8 meq capsule	T1	
potassium cl er 8 meq tablet	T1	
potassium cl10%(20meq/15ml)cup	T1	
potassium cl10%(40meq/30ml)cup	T1	
potassium cl20%(40meq/15ml)cup	T1	
POTASSIUM CL-LIDOCAINE-NS *(potassium cl/lido/0.9 % nacl)*	T3	
PROTEIN REPLACEMENT		
AQNEURSA	T3	PA SP
SODIUM/SALINE PREPARATIONS		
0.9 % sodium chloride	T1	
KENDALL 0.9% NACL WITH CAP	T1	
saline 0.45% soln-excel con	T1	
saline 0.9% flush 10 ml syr	T1	
saline 0.9% flush 5 ml syr	T1	
sodium chloride 0.45% soln	T1	

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SODIUM/SALINE PREPARATIONS		
sodium chloride 0.9 % (flush)	T1	
sodium chloride 0.9% (pwr inj)	T1	
sodium chloride 0.9% 1,000 ml	T1	
sodium chloride 0.9% 10 ml syr	T1	
sodium chloride 0.9% 100 ml	T1	
sodium chloride 0.9% 250 ml	T1	
sodium chloride 0.9% 50 ml	T1	
sodium chloride 0.9% 500 ml	T1	
sodium chloride 0.9% sol-excel	T1	
sodium chloride 0.9% soln	T1	
sodium chloride 0.9% solution	T1	
sodium chloride 0.9% syringe	T1	
sodium chloride 0.9% vial	T1	
sodium chloride 0.9% zr syr	T1	
sodium chloride 100 meq/40 ml	T1	
sodium chloride 120 meq/30 ml	T1	
sodium chloride 3% iv soln	T1	
sodium chloride 4 meq/ml vl	T1	
sodium chloride 400 meq/100 ml	T1	
sodium chloride 5% iv soln	T1	
sodium chloride 50 meq/20 ml	T1	
sodium chloride 800 meq/200 ml	T1	
SWABFLUSH	T3	
ZINC REPLACEMENT		
zinc chloride	T1	
zinc sulfate	T1	
ELECT/CALORIC/H2O (Urinary Tract Conditions)		
DIALYSIS SOLUTIONS		
DELFLEX WITH 1.5% DEXTROSE	T3	
DELFLEX WITH 2.5% DEXTROSE	T3	
DIANEAL PD-2 W-1.5% DEXTROSE	T3	
DIANEAL PD-2 W-2.5% DEXTROSE	T2	
DIANEAL PD-2 W-4.25% DEXTROSE	T3	
DIANEAL WITH 1.5% DEXTROSE	T3	
DIANEAL WITH 2.5% DEXTROSE	T3	

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ELECT/CALORIC/H2O (Urinary Tract Conditions)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DIALYSIS SOLUTIONS		
DIANEAL WITH 4.25% DEXTROSE	T3	
EXTRANEAL ICODEXTRIN DIALYSIS	T3	
perit. dialysis no.6-dex 1.5 %	T3	
periton.dialysis 7-dextr 2.5 %	T3	
periton.dialysis 8-dext 4.25 %	T3	
PHOXILLUM	T3	
PRISMASOL	T3	
URINARY PH MODIFIERS		
citric acid/sodium citrate	T1	HD
K-PHOS NO.2	T3	HD
K-PHOS ORIGINAL	T3	HD
ORACIT	T3	HD
potassium citrate	T1	HD
potassium citrate (Urocit-K)	T1	HD
potassium citrate/citric acid	T1	HD
RENACIDIN	T3	HD
sod/pot/k cit/sod cit/cit acid	T1	HD
UROCIT-K (potassium citrate)	T3	HD
UROQID-ACID NO.2	T3	HD
GASTROINTESTINAL (Cholesterol Medications)		
LIPOTROPICS		
icosapent ethyl (Vascepa)	T1	HD
omega-3 acid ethyl esters (Lovaza)	T1	HD
VASCEPA *(icosapent ethyl)*	T2	HD
GASTROINTESTINAL (Gastrointestinal/Heartburn)		
AMMONIA INHIBITORS		
AMMONUL (*sodium benzoate/sod phenylacet*)	T3	
glycerol phenylbutyrate	T1	HD
lactulose	T1	
lactulose	T1	HD
lactulose 10 gm/15 ml solution	T1	PA SP HD
LITHOSTAT	T3	PA QL(8 Bottles/30 Days) SP HD
OLPRUVA	T3	
PHEBURANE	T2	SP HD

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GASTROINTESTINAL (Gastrointestinal/Heartburn) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
AMMONIA INHIBITORS *(cont.)*		
sodium benzoate/sod phenylacet (Ammonul)	T1	
sodium phenylbutyrate (Buphenyl)	T1	
ANTICHOLINERGICS, QUATERNARY AMMONIUM		
*chlordiazepoxide/clidinium br (*Librax*)*	T1	
CUVPOSA (glycopyrrolate)	T3	
GLYCATE	T3	
glycopyrrolate 0.2 mg/ml vial	T1	
glycopyrrolate 0.4 mg/2 ml vl	T1	
GLYCOPYRROLATE 0.6 MG/3 ML SYR	T1	
glycopyrrolate 1 mg tablet (Robinul)	T1	
*glycopyrrolate 1 mg/5 ml soln (*Cuvposa*)*	T1	
glycopyrrolate 1 mg/5 ml syrng	T1	
GLYCOPYRROLATE 1 MG/5 ML SYRNG	T1	
glycopyrrolate 1 mg/5 ml vial	T1	
glycopyrrolate 2 mg tablet (Robinul Forte)	T1	
glycopyrrolate 4 mg/20 ml vial	T1	
GLYCOPYRROLATE-WATER	T1	
ANTICHOLINERGICS/ANTISPASMODICS		
dicyclomine 10 mg capsule	T1	
dicyclomine 10 mg/5 ml soln	T1	
dicyclomine 20 mg tablet	T1	
dicyclomine 20 mg/2 ml ampul	T1	
dicyclomine 20 mg/2 ml vial	T1	
DICYCLOMINE 40 MG TABLET	T3	
ANTIDIARRHEAL - G.I. CHLORIDE CHANNEL INHIBITORS		
MYTESI	T3	
ANTIDIARRHEAL - TRYPTOPHAN HYDROXYLASE INHIBITOR		
XERMELO	T3	PA SP
ANTIDIARRHEALS		
diphenoxylate hcl/atropine	T1	
*diphenoxylate hcl/atropine (*Lomotil*)*	T1	
loperamide hcl	T1	
MOTOFEN	T3	
opium tincture	T1	PA
ANTIEMETIC, CANNABINOID-TYPE		
*dronabinol (*Marinol*)*	T1	

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GASTROINTESTINAL (Gastrointestinal/Heartburn) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIEMETIC/ANTIVERTIGO AGENTS		
AKYNZEO 235-0.25 MG VIAL	T3	
AKYNZEO 235-0.25 MG/20 ML VIAL	T3	
AKYNZEO 300-0.5 MG CAPSULE	T3	PA QL(4 CAPS/28 DAYS)
aprepitant 125 mg capsule	T1	QL(4 CAPS/28 DAYS)
aprepitant 125-80-80 mg pack (Emend)	T1	QL(12 CAPS/28 DAYS)
aprepitant 40 mg capsule	T1	QL(1 CAP/28 DAYS)
*aprepitant 80 mg capsule (*Emend*)*	T1	QL(8 CAPS/28 DAYS)
BARHEMSYS	T3	
BONJESTA	T3	
CINVANTI	T3	
COMPAZINE (*prochlorperazine maleate)*	T3	
COMPAZINE (*prochlorperazine*)	T3	
dimenhydrinate	T1	
doxylamine succinate/vit b6 (Diclegis)	T1	QL(4 TABS/DAY)
EMEND 125 MG POWDER PACKET	T3	PA QL(12 PACKS/28 DAYS)
EMEND 150 MG VIAL *(fosaprepitant dimeglumine)*	T3	
FOCINVEZ	T3	
fosaprepitant dimeglumine (Emend)	T1	
granisetron hcl	T1	
granisetron hcl/pf	T1	
ondansetron hcl	T1	
ondansetron hcl/pf	T1	
ondansetron odt 4 mg tablet	T1	
ondansetron odt 8 mg tablet	T1	
palonosetron 0.25 mg/5 ml vial (Posfrea)	T1	
palonosetron hcl 0.25 mg/5 ml	T1	PA
POSFREA *(palonosetron hcl)*	T3	
*prochlorperazine (*Compazine*)*	T1	
prochlorperazine edisylate	T1	
*prochlorperazine maleate (*Compazine*)*	T1	
promethazine hcl	T1	
SANCUSO	T3	PA QL(4 PATCHES/30 DAYS)
*scopolamine (*Transderm-Scop*)*	T1	
SUSTOL	T3	
TIGAN	T3	

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIEMETIC/ANTIVERTIGO AGENTS		
TRANSDERM-SCOP *(scopolamine)*	T3	
trimethobenzamide hcl	T1	
VARUBI	T3	PA QL(4 TABS/28 DAYS)
ANTI-ULCER PREPARATIONS		
CYTOTEC (misoprostol)	T3	HD
misoprostol (Cytotec)	T1	HD
sucralfate	T1	HD
sucralfate (Carafate)	T1	HD
ANTI-ULCER-H.PYLORI AGENTS		
bismuth/metronid/tetracycline (Pylera)	T1	
lansoprazole/amoxiciln/clarith	T1	
BELLADONNA ALKALOIDS		
atropine 0.25 mg/5 ml syringe	T1	
atropine 0.4 mg/ml vial	T1	
ATROPINE 0.4 MG/ML VIAL	T3	
atropine 0.5 mg/5 ml abboject	T1	
atropine 0.5 mg/5 ml syringe	T1	
atropine 0.8 mg/2 ml syringe	T1	
atropine 1 mg/10 ml abboject	T1	
atropine 1 mg/10 ml syringe	T1	
ATROPINE 1 MG/2.5 ML SYRINGE	T1	
ATROPINE 1 MG/2.5 ML SYRINGE	T3	
atropine 1 mg/ml vial	T1	
ATROPINE 1 MG/ML VIAL	T3	
atropine 8 mg/20 ml vial	T1	
hyoscyamine 0.125 mg odt (Nulev)	T1	HD
hyoscyamine 0.125 mg tab sl (Levsin-SL)	T1	HD
hyoscyamine 0.125 mg/5 ml elix	T1	HD
hyoscyamine 0.125 mg/ml drop	T1	HD
hyoscyamine sulf 0.125 mg tab (Levsin)	T1	HD
hyoscyamine sulfate	T1	HD
hyoscyamine sulfate (Levbid)	T1	HD

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GASTROINTESTINAL (Gastrointestinal/Heartburn) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
BELLADONNA ALKALOIDS *(cont.)*		
hyoscyamine sulfate (Levsin)	T1	HD
hyoscyamine sulfate (Levsin-SL)	T1	HD
hyoscyamine sulfate (Nulev)	T1	HD
hyoscyamine sulfate (Nulev)	T3	HD
HYOSCYAMINE SULFATE 0.5 MG/ML	T3	HD
LEVSIN (*hyoscyamine sulfate*)	T3	HD
methscopolamine bromide	T1	HD
NULEV (*hyoscyamine sulfate*)	T3	HD
phenobarb/hyoscy/atropine/scop	T1	HD
phenobarb/hyoscy/atropine/scop (Donnatal)	T1	HD
phenobarb/hyoscy/atropine/scop (Phenobarbital-Belladonna)	T1	HD
PHENOBARBITAL-BELLADONNA (*phenobarb/hyoscy/atropine/scop*)	T3	HD
SYMAX DUOTAB	T3	HD
BILE SALTS		
CHENODAL	T3	PA SP HD
CHOLBAM	T3	PA SP HD
CTEXLI	T3	PA SP
URSO FORTE (*ursodiol*)	T3	HD
ursodiol 250 mg tablet	T1	HD
ursodiol 300 mg capsule	T1	HD
ursodiol 500 mg tablet (Urso Forte)	T1	HD
CHOLERETICS		
KINEVAC	T3	
CHRONIC INFLAM. COLON DX, 5-A-SALICYLAT, RECTAL TX		
mesalamine 1,000 mg supp (Canasa)	T1	
mesalamine 4 gm/60 ml enema (Sfrowasa)	T1	
mesalamine 4 gm/60 ml kit (Rowasa)	T1	
SFROWASA (*mesalamine*)	T3	
APRISO (*mesalamine*)	T3	HD
balsalazide disodium (Colazal)	T1	HD
mesalamine	T1	HD
mesalamine (Apriso)	T1	HD
mesalamine (Pentasa)	T1	HD

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DRUG TX-CHRONIC INFLAM. COLON DX, 5-AMINOSALICYLAT		
mesalamine 800 mg dr tablet (Asacol Hd)	T1	HD
mesalamine dr 1.2 gm tablet (Lialda)	T1	HD
PENTASA 500 MG CAPSULE *(mesalamine)*	T3	HD
sulfasalazine (Azulfidine)	T1	HD
FARNESOID X RECEPTOR (FXR) AGONIST, BILE AC ANALOG		
OCALIVA	T3	PA SP HD
FECAL MICROBIOTA TRANSPLANTATION (FMT)		
VOWST	T3	PA QL(12 CAPS/56 DAYS) SP
GASTRIC ENZYMES		
SUCRAID	T3	PA SP
HEMORRHOID PREP,ANTI-INFLAM STEROID-LOCAL ANESTHET		
ANALPRAM HC 1% CREAM	T3	
hydrocortisone/pramoxine	T1	
hydrocortisone/pramoxine (Analpram Hc)	T1	
PROCORT	T3	
PROCTOFOAM-HC	T3	
HISTAMINE H2-RECEPTOR INHIBITORS		
cimetidine hcl	T1	HD
famotidine	T1	HD
IBS AGENTS, MIXED OPIOID RECEP AGONISTS/ANTAGONISTS		
VIBERZI	T2	HD
IBS-C/CIC AGENTS, GUANYLATE CYCLASE-C AGONIST		
LINZESS	T2	
TRULANCE	T2	
INTEGRIN RECEPTOR ANTAGONIST, MONOCLONAL ANTIBODY		
ENTYVIO	T2	PA SP HD
INTESTINAL MOTILITY STIMULANTS		
metoclopramide hcl	T1	
metoclopramide hcl (Reglan)	T1	
prucalopride succinate (Motegrity)	T1	
REGLAN (metoclopramide hcl)	T3	
IRRITABLE BOWEL SYNDROME AGENTS, 5-HT3 ANTAGONIST		
alosetron hcl	T1	SP HD
IV FAT EMULSIONS		
CLINOLIPID	T3	
fat emulsions (Nutrilipid)	T3	

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
IV FAT EMULSIONS *(cont.)*		
INTRALIPID	T3	
NUTRILIPID (*fat emulsions*)	T3	
OMEGAVEN	T3	
SMOFLIPID	T3	
LAXATIVES AND CATHARTICS		
bisac/nacl/nahco3/kcl/peg 3350	T1	PPACA
lactulose	T1	
lactulose 10 gm/15 ml soln cup	T1	
lactulose 10 gm/15 ml solution	T1	
lactulose 20 gm packet	T1	
lactulose 20 gm/30 ml soln cup	T1	
lactulose 20 gm/30 ml solution	T1	
lubiprostone (Amitiza)	T1	
peg3350/sod sul/nacl/kcl/asb/c (Moviprep)	T1	PPACA
peg3350/sod sulf,bicarb,cl/kcl	T1	PPACA
peg3350/sod sulf,bicarb,cl/kcl (Golytely)	T1	PPACA
sodium chloride/nahco3/kcl/peg	T1	PPACA
sodium, potassium,mag sulfates (Suprep)	T1	PPACA
LOCAL ANORECTAL NITRATE PREPARATIONS		
nitroglycerin 0.4% ointment (Rectiv)	T1	
RECTIV (*nitroglycerin*)	T3	
PANCREATIC ENZYMES		
PANCREAZE	T2	HD
VIOKACE	T3	HD
ZENPEP	T2	HD
POTASSIUM-COMPETITIVE ACID BLOCKERS (PCABS)		
VOQUEZNA	T3	PA QL(1 tab/day)
PROTON-PUMP INHIBITORS		
dexlansoprazole dr 30 mg cap	T1	QL(2 CAPS/DAY)
dexlansoprazole dr 60 mg cap	T1	QL(1 CAP/DAY)
esomeprazole dr 10 mg packet (Nexium)	T1	QL(4 PACKS/DAY) HD
esomeprazole dr 2.5 mg packet (Nexium)	T1	QL(16 PACKS/DAY) HD
esomeprazole dr 20 mg packet (Nexium)	T1	QL(2 PACKS/DAY) HD

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
PROTON-PUMP INHIBITORS *(cont.)*		
esomeprazole dr 40 mg packet (Nexium)	T1	QL(1 PACK/DAY) HD
esomeprazole dr 5 mg packet (Nexium)	T1	QL(8 PACKS/DAY) HD
esomeprazole mag dr 20 mg cap	T1	QL(2 CAPS/DAY) HD
esomeprazole mag dr 40 mg cap	T1	QL(1 CAP/DAY) HD
esomeprazole sodium	T1	
lansoprazole dr 15 mg capsule	T1	QL(2 CAPS/DAY) HD
lansoprazole dr 15 mg odt (Prevacid)	T1	QL(2 TABS/DAY) HD
lansoprazole dr 30 mg capsule	T1	QL(1 CAP/DAY) HD
lansoprazole dr 30 mg odt (Prevacid)	T1	QL(1 TAB/DAY) HD
omeprazole dr 10 mg capsule	T1	QL(4 CAPS/DAY) HD
omeprazole dr 20 mg capsule	T1	QL(2 CAPS/DAY) HD
omeprazole dr 40 mg capsule	T1	QL(1 CAP/DAY) HD
omeprazole-bicarb 20-1,100 cap	T1	PA QL(2 CAPS/DAY) HD
omeprazole-bicarb 20-1,680 pkt	T1	PA QL(2 PACKS/DAY) HD
omeprazole-bicarb 40-1,100 cap	T1	PA QL(1 CAP/DAY) HD
omeprazole-bicarb 40-1,680 pkt	T1	PA QL(1 PACK/DAY) HD
pantoprazole dr 40 mg susp pkt	T1	QL(1 PACK/DAY) HD
pantoprazole sod dr 20 mg tab	T1	QL(2 TABS/DAY) HD
pantoprazole sod dr 40 mg tab	T1	QL(1 TAB/DAY) HD
pantoprazole sodium 40 mg vial	T1	
rabeprazole sodium	T1	QL(1 TAB/DAY) HD
SBS - GLUCAGON-LIKE PEPTIDE-2 (GLP-2) ANALOGS		
GATTEX	T3	PA SP HD
GASTROINTESTINAL (Pain Relief And Inflammatory Disease)		
HEMORRHOID PREP, ANTI-INFLAM STEROID-LOCAL ANESTHET		
ANA-LEX	T1	
ANALPRAM HC 1% CREAM	T3	
hydrocortisone/lidocaine/aloe	T1	
hydrocortisone/pramoxine	T1	
hydrocortisone/pramoxine (Analpram Hc)	T1	
lidocaine/hydrocortisone ac	T1	
LIDOCAINE-HYDROCORTISONE	T1	
PROCORT	T3	
PROCTOFOAM-HC	T3	

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List of Prescription Medications

GASTROINTESTINAL (Skin Conditions)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
KERATINOCYTE GROWTH FACTOR (KGF)		
KEPIVANCE	T3	SP
HORMONES (Gastrointestinal/Heartburn)		
RECTAL/LOWER BOWEL PREP., GLUCOCORT. (NON-HEMORR)		
budesonide 2 mg rectal foam (Uceris)	T1	QL(2 KITS/180 DAYS)
CORTENEMA (*hydrocortisone*)	T3	
hydrocortisone (Cortenema)	T1	
HORMONES (Hormonal Agents)		
ADRENOCORTICOTROPHIC HORMONES		
ACTHAR	T3	PA SP HD
CORTROPHIN GEL 400 UNIT/5 ML	T3	PA SP HD
CORTROPHIN GEL 80 UNIT/ML VIAL	T3	PA SP HD
cosyntropin (Cortrosyn)	T1	
ANDROGEN/ESTROGEN PREPS FOR FEMALE SEXUAL DYSFUNC		
INTRAROSA	T3	
ANDROGENIC AGENTS		
AVEED	T3	PA SP
DEPO-TESTOSTERONE	T3	
DEPO-TESTOSTERONE (*testosterone cypionate*)	T3	
METHITEST	T1	
methyltestosterone	T1	
oxandrolone	T1	PA
TESTOPEL	T3	PA
testosterone 1% (25mg/2.5g) pk (Androgel)	T1	PA QL(150 GMS/30 DAYS)
testosterone 1% (50 mg/5 g) pk (Androgel)	T1	PA QL(300 GMS/30 DAYS)
testosterone 1.62% (2.5 g) pkt	T1	PA QL(150 GMS/30 DAYS)
testosterone 1.62% gel pump (Androgel)	T1	PA QL(150 GMS/30 DAYS)
testosterone 1.62%(1.25 g) pkt	T1	PA QL(75 GMS/30 DAYS)
testosterone 10 mg gel pump	T1	PA QL(120 GMS/30 DAYS)
testosterone 12.5 mg/1.25 gram	T1	PA QL(150 GMS/30 DAYS)
testosterone 30 mg/1.5 ml pump	T1	PA QL(180 MLS/30 DAYS)
testosterone 50 mg/5 gram gel (Testim)	T1	PA QL(10 GMS/DAY)
testosterone 50 mg/5 gram gel (Vogelxo)	T1	PA QL(10 GMS/DAY)
TESTOSTERONE 50 MG/5 GRAM PKT	T1	PA QL(300 GMS/30 DAYS)

List of Prescription Medications

HORMONES (Hormonal Agents) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANDROGENIC AGENTS *(cont.)*		
testosterone cypionate	T1	PA QL (120 gm/30 days)
testosterone cypionate (Depo-Testosterone)	T1	PA QL (150gm/30 days)
testosterone enanthate	T1	PA QL (150gm/30 days)
ANTIDIURETIC AND VASOPRESSOR HORMONES		
desmopressin 0.01% solution	T1	HD
desmopressin 0.01% spray	T1	HD
desmopressin 10 mcg/0.1 ml spr	T1	HD
desmopressin 40 mcg/10 ml vial	T1	SP
desmopressin ac 4 mcg/ml ampul	T1	SP
desmopressin ac 4 mcg/ml vial	T1	SP
desmopressin acetate 0.1 mg tb (Ddavp)	T1	
desmopressin acetate 0.2 mg tb (Ddavp)	T1	
NOCTIVA	T3	PA
STIMATE	T3	SP
vasopressin	T1	
VASOPRESSIN-D5W	T1	
VASOSTRICT	T3	
ESTROGEN AND PROGESTIN COMBINATIONS		
BIJUVA	T3	
ESTROGEN/ANDROGEN COMBINATIONS		
estrogen,ester/me-testosterone	T1	HD
estrogen,ester/me-testosterone (Estratest H.S.)	T1	HD
ESTROGENIC AGENTS		
COMBIPATCH	T2	
DEPO-ESTRADIOL	T3	HD
estradiol (Climara)	T1	HD
estradiol (Minivelle)	T1	QL(16 PATCHES/28 DAYS) HD
estradiol (Vivelle-Dot)	T1	QL(16 PATCHES/28 DAYS) HD
estradiol 0.06% 1.25g gel pump (Estrogel)	T1	HD
estradiol 0.1% (0.25mg) gel pk (Divigel)	T1	HD
estradiol 0.1% (0.5mg) gel pkt (Divigel)	T1	HD
estradiol 0.1% (0.75mg) gel pk (Divigel)	T1	HD
estradiol 0.1% (1 mg) gel pkt (Divigel)	T1	HD
estradiol 0.1% (1.25mg) gel pk (Divigel)	T1	HD
estradiol 0.5 mg tablet	T1	HD

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HORMONES (Hormonal Agents) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ESTROGENIC AGENTS *(cont.)*		
estradiol 1 mg tablet	T1	HD
estradiol 2 mg tablet	T1	HD
estradiol valerate (Delestrogen)	T1	HD
estradiol/norethindrone acet	T1	HD
estradiol/norethindrone acet (Activella)	T1	HD
estrogens, conjugated (Premarin)	T1	HD
EVAMIST	T3	HD
MENEST	T3	HD
MENOSTAR	T3	QL(8 PATCHES/28 DAYS) HD
norethind-eth estrad 0.5-2.5	T1	HD
norethindrone ac/eth estradiol	T1	HD
norethin-eth estrad 1 mg-5 mcg	T1	HD
PREMARIN	T2	HD
PREMARIN *(estrogens, conjugated)*	T2	HD
PREMPHASE	T2	HD
PREMPRO	T2	HD
ESTROGEN-PROGESTIN WITH ANTIMINERALOCORTICOID COMB		
ANGELIQ	T3	HD
ESTROGEN-SELECTIVE ESTROGEN RECEPTOR MOD (SERM) COMB		
DUAVEE	T2	
GLUCOCORTICOIDS		
BETA 1	T3	
betamethasone acetate,sod phos (Celestone)	T1	
BSP 0820	T3	
budesonide	T1	
budesonide (Uceris)	T1	PA QL(1 TAB/DAY)
CELESTONE (*betamethasone acetate,sod phos*)	T3	
cortisone acetate	T1	
deflazacort (Emflaza)	T1	PA SP HD
DEPO-MEDROL	T3	
dexamethasone	T1	

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HORMONES (Hormonal Agents) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
GLUCOCORTICOIDS *(cont.)*		
dexamethasone 0.5 mg tablet	T1	
dexamethasone 0.5 mg/5 ml elx	T1	
dexamethasone 0.5 mg/5 ml liq	T1	
dexamethasone 0.75 mg tablet	T1	
dexamethasone 1 mg tablet	T1	
dexamethasone 1.5 mg tablet	T1	
dexamethasone 2 mg tablet	T1	
dexamethasone 4 mg tablet	T1	
dexamethasone 6 mg tablet	T1	
dexamethasone sodium phosp/pf	T1	
dexamethasone sodium phosphate	T1	
*hydrocortisone (*Cortef*)*	T1	
hydrocortisone sod succinate	T1	
KENALOG-10	T3	
KENALOG-40 (*triamcinolone acetonide*)	T3	
KENALOG-80	T3	
MEDROL	T3	
MEDROL (*methylprednisolone*)	T3	
MEDROLOAN II SUIK	T3	
methylprednisolone	T1	
*methylprednisolone (*Medrol*)*	T1	
methylprednisolone acetate	T1	
methylprednisolone sod succ	T1	
*methylprednisolone sod succ (*Solu-Medrol*)*	T1	
MILLIPRED 10 MG/5 ML SOLUTION (*prednisolone sodium phosphate*)	T3	
ORAPRED ODT *(prednisolone sodium phosphate)*	T3	
prednisolone	*T1*	
prednisolone sodium phosphate	*T1*	
*prednisolone sodium phosphate (*Orapred Odt*)*	*T1*	
prednisone	*T1*	
PRO-C-DURE 5	T3	
PRO-C-DURE 6	T3	
SOLU-CORTEF	T3	
SOLU-MEDROL	T3	
SOLU-MEDROL (*methylprednisolone sod succ*)	T3	

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
GLUCOCORTICOIDS *(cont.)*		
triamcinolone acet 200 mg/5 ml (Kenalog-40)	T1	
triamcinolone acet 40 mg/ml vl (Kenalog-40)	T1	
triamcinolone acet 400 mg/10ml (Kenalog-40)	T1	
triamcinolone acet 50mg/5ml vl	T1	
UCERIS 9 MG ER TABLET (*budesonide*)	T3	PA QL(1 TAB/DAY)
ZILRETTA	T3	PA
GROWTH HORMONE RELEASING HORMONE (GHRH) AND ANALOGS		
EGRIFTA	T3	PA SP HD
EGRIFTA SV	T3	PA SP HD
GROWTH HORMONES		
GENOTROPIN	T2	PA SP HD
OMNITROPE	T2	PA SP HD
SEROSTIM	T2	PA SP HD
SKYTROFA	T2	PA SP HD
LHRH (GNRH) AGONIST ANALOG PITUITARY SUPPRESSANTS		
LUPRON DEPOT 11.25 MG 3MO KIT	T2	PA SP HD
LUPRON DEPOT 3.75 MG KIT	T2	PA SP HD
LHRH (GNRH) ANTAGONIST, ESTROGEN AND PROGESTIN COMB		
MYFEMBREE	T2	PA QL(1 TAB/DAY)
ORIAHNN	T2	PA QL(2 CAPS/DAY)
LHRH (GNRH) ANTAGONIST, PITUITARY SUPPRESSANT AGENTS		
CETROTIDE	T3	PA SP
CETROTIDE *(cetrorelix acetate)*	T2	PA SP
ganirelix acet 250 mcg/0.5 ml (Ganirelix Acetate)	T1	PA SP
GANIRELIX ACET 250 MCG/0.5 ML (*ganirelix acetate*)	T3	PA SP
ganirelix acetate (Ganirelix Acetate)	T1	PA SP
ORILISSA 150 MG TABLET	T2	PA QL(1 TAB/DAY)
ORILISSA 200 MG TABLET	T2	PA QL(2 TABS/DAY)
LHRH (GNRH) AGNST PIT.SUP-CENTRAL PRECOCIOUS PUBERTY		
FENSOLVI	T2	PA SP
TRIPTODUR	T2	PA SP
MINERALOCORTICOIDS		
fludrocortisone acetate	T1	HD

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HORMONES (Hormonal Agents) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
LHRH (GNRH) ANTAGONIST, PITUITARY SUPPRESSANT AGENTS *(cont.)*		
carboprost 250 mcg/ml ampul (Hemabate)	T1	
CARBOPROST 250 MCG/ML SYRINGE	T3	
carboprost 250 mcg/ml vial	T1	
CARBOPROST 250 MCG/ML VIAL	T1	
CERVIDIL	T3	
HEMABATE (*carboprost tromethamine*)	T3	
methylergonovine maleate	T1	
METHYLERGONOVINE MALEATE	T1	
oxytocin (Pitocin)	T1	
OXYTOCIN-LACTATED RINGERS	T1	
PITOCIN (oxytocin)	T3	
PREPIDIL	T3	
PARATHYROID HORMONES		
YORVIPATH	T3	PA SP
PITUITARY SUPPRESSIVE AGENTS		
cabergoline	T1	QL(16 TABS/28 DAYS) HD
CRENESSITY 100 MG CAPSULE	T3	PA QL(4 CAPS/DAY) SP
CRENESSITY 25 MG CAPSULE	T3	PA QL(2 CAPS/DAY) SP
CRENESSITY 50 MG CAPSULE	T3	PA QL(2 CAPS/DAY) SP
CRENESSITY 50 MG/ML SOLUTION	T3	PA QL(8 MLS/DAY) SP
danazol	T1	HD
PROGESTATIONAL AGENTS		
CRINONE 4% GEL	T3	PA HD
medroxyprogesterone 10 mg tab (Provera)	T1	HD
medroxyprogesterone 2.5 mg tab (Provera)	T1	HD
medroxyprogesterone 5 mg tab (Provera)	T1	HD
norethindrone acetate	T1	HD
progesterone 100 mg capsule (Prometrium)	T1	HD
progesterone 200 mg capsule (Prometrium)	T1	HD
progesterone 500 mg/10 ml vial	T1	SP HD
RENIN-ANGIOTENSIN-ALDOSTERONE SYS. (RAAS) HORMONES		
GIAPREZA	T3	SP

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List of Prescription Medications

HORMONES (Hormonal Agents) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
SOMATOSTATIC AGENTS		
lanreotide 120 mg/0.5 ml syrng	T1	PA SP HD
LANREOTIDE 120 MG/0.5 ML SYRNG	T3	PA SP HD
octreotide acetate	T1	PA SP HD
octreotide acetate (Sandostatin)	T1	PA SP HD
octreotide acetate,mi-spheres (Sandostatin Lar Depot)	T1	PA SP
SANDOSTATIN 0.05 MG/ML AMPUL (*octreotide acetate*)	T2	PA SP HD
SANDOSTATIN 0.1 MG/ML AMPUL (*octreotide acetate*)	T3	PA SP HD
SANDOSTATIN 0.5 MG/ML AMPUL (*octreotide acetate*)	T3	PA SP HD
SANDOSTATIN LAR DEPOT (*octreotide acetate,mi-spheres*)	T3	PA SP
SIGNIFOR	T3	PA SP
SIGNIFOR LAR	T3	PA SP
SOMATULINE DEPOT	T2	PA SP HD
VAGINAL ESTROGEN PREPARATIONS		
estradiol (Vagifem)	T1	QL(36 TABS/28 DAYS)
estradiol 0.01% cream (Estrace)	T1	HD
estradiol 10 mcg vaginal insrt (Vagifem)	T1	QL(36 TABS/28 DAYS) HD
PREMARIN	T2	HD
HORMONES (Infertility)		
FERTILITY STIMULATING PREPARATIONS, NON-FSH		
clomiphene citrate	T1	
FOLLICLE-STIMULATING AND LUTEINIZING HORMONES		
MENOPUR	T3	PA SP
FOLLICLE-STIMULATING HORMONE (FSH)		
FOLLISTIM AQ	T3	PA SP
GONAL-F	T2	PA SP
GONAL-F RFF REDI-JECT	T2	PA SP
HUMAN CHORIONIC GONADOTROPIN (HCG)		
CHORIONIC GONADOTROPIN	T3	PA SP
NOVAREL	T2	PA SP
OVIDREL	T2	PA SP
PREGNYL	T2	PA SP
PREGNANCY FACILITATING/MAINTAINING AGENT, HORMONAL		
CRINONE 8% GEL	T2	PA

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HORMONES (Infertility)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
PREGNANCY FACILITATING/MAINTAINING AGENT, HORMONAL		
ENDOMETRIN (*progesterone, micronized*)	T2	
progesterone 100 mg vag insert (Endometrin)	T1	
PREGNANCY MAINTAINING AGENT, HORMONAL		
hydroxyprogesterone caproat/pf	T1	PA
hydroxyprogesterone caproate	T1	PA
MAKENA	T3	PA
HORMONES (Miscellaneous)		
LEPTIN HORMONE ANALOGS		
MYALEPT	T3	PA SP HD
HORMONES (Osteoporosis Products)		
BONE RESORPTION INHIBITORS		
calcitonin,salmon,synthetic	T1	HD
calcitonin,salmon,synthetic (Miacalcin)	T1	HD
MIACALCIN (*calcitonin,salmon,synthetic*)	T3	HD
IMMUNOSUPPRESSANTS (Miscellaneous)		
IMMUNOSUPPRESSANT-INTERFERON GAMMA INHIBITOR, MAB		
GAMIFANT	T3	PA SP
SAPHNELO	T3	PA SP
IMMUNOSUPPRESSANTS (Pain Relief And Inflammatory Disease)		
ANTI-CD19 (B LYMPHOCYTE) MONOCLONAL ANTIBODY		
UPLIZNA	T3	PA SP HD
HUMAN INTERLEUKIN 12/23 (IL-12/13) INHIBITORS, MAB		
SELARSDI 130 MG/26 ML VIAL	T2	PA SP
SELARSDI 45 MG/0.5 ML SYRINGE	T2	PA QL(1 SYRINGE/84 DAYS) SP
SELARSDI 45 MG/0.5 ML VIAL	T2	PA QL(1 SYRINGE/84 DAYS) SP
SELARSDI 90 MG/ML SYRINGE	T2	PA QL(1 SYRINGE/84 DAYS) SP
STARJEMZA 130 MG/26 ML VIAL	T3	PA SP
STELARA 45 MG/0.5 ML SYRINGE	T2	PA QL(1 SYRINGE/84 DAYS) SP HD
STELARA 45 MG/0.5 ML VIAL	T2	PA QL(1 SYRINGE/84 DAYS) SP HD
STELARA 90 MG/ML SYRINGE	T2	PA QL(1 SYRINGE/84 DAYS) SP HD
USTEKINUMAB-TTWE 130MG/26ML VL	T2	PA SP HD
USTEKINUMAB-TTWE 45 MG SYRINGE	T2	PA QL(1 SYRINGE/84 DAYS) SP HD
USTEKINUMAB-TTWE 90 MG/ML SYR	T2	PA QL(1 SYRINGE/84 DAYS) SP HD

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List of Prescription Medications

IMMUNOSUPPRESSANTS (Pain Relief And Inflammatory Disease)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
HUMAN INTERLEUKIN 12/23 (IL-12/13) INHIBITORS, MAB		
YESINTEK 130 MG/26 ML VIAL	T2	PA SP
YESINTEK 45 MG/0.5 ML SYRINGE	T2	PA QL(1 SYRINGE/84 DAYS) SP
YESINTEK 45 MG/0.5 ML VIAL	T2	PA QL(1 SYRINGE/84 DAYS) SP
YESINTEK 90 MG/ML SYRINGE	T2	PA QL(1 SYRINGE/84 DAYS) SP
IL-23 RECEPTOR ANTAGONIST, MONOCLONAL ANTIBODY		
OMVOH 100 MG/ML PEN	T2	PA QL(2 PENS/28 DAYS) SP HD
OMVOH 100 MG/ML SYRINGE	T2	PA QL(2 SYRINGES/28 DAYS) SP HD
OMVOH 200 MG DOSE - 2 PENS	T2	PA QL(2 PENS/28 DAYS) SP HD
OMVOH 200 MG DOSE - 2 SYRINGES	T2	PA QL(2 SYRINGES/28 DAYS) SP HD
OMVOH 200 MG/2 ML PEN	T2	PA QL SP HD
OMVOH 200 MG/2 ML SYRINGE	T2	PA QL SP HD
OMVOH 300 MG DOSE - 2 PENS	T2	PA QL(3 MLS/28 DAYS) SP HD
OMVOH 300 MG DOSE - 2 SYRINGES	T2	PA QL(3 MLS/28 DAYS) SP HD
OMVOH 300 MG/15 ML VIAL	T2	PA SP HD
SKYRIZI 600 MG/10 ML VIAL	T2	PA SP HD
SKYRIZI ON-BODY	T2	PA QL(1 CARTRIDGE/56 DAYS) SP HD
TREMFYA 100 MG/ML PEN	T2	PA QL(1 ML/56 DAYS) SP HD
TREMFYA 100 MG/ML SYRINGE	T2	PA QL(1 SYRINGE/56 DAYS) SP HD
TREMFYA 200 MG/2 ML PEN	T2	PA QL(2 SYRINGE/28 DAYS) SP HD
TREMFYA 200 MG/2 ML SYRINGE	T2	PA QL(1 SYRINGE/56 DAYS) SP HD
TREMFYA 200 MG/20 ML VIAL	T2	PA SP HD
TREMFYA ONE-PRESS	T2	PA QL(1 AUTO-INJ/56 DAYS) SP HD
TREMFYA PEN INDUCTION (2 PEN)	T2	PA QL(12 MLS/365 DAYS) SP HD
INTERLEUKIN-4 (IL-4) RECEPTOR ALPHA ANTAGONIST, MAB		
DUPIXENT PEN	T2	PA SP HD
DUPIXENT SYRINGE	T2	PA SP HD
INTERLEUKIN-6 (IL-6) RECEPTOR INHIBITORS		
ACTEMRA 162 MG/0.9 ML SYRINGE	T2	PA QL(3.6 ML/28 DAYS) SP HD
ACTEMRA 200 MG/10 ML VIAL	T2	PA SP HD
ACTEMRA 400 MG/20 ML VIAL	T2	PA SP HD
ACTEMRA 80 MG/4 ML VIAL	T2	PA SP HD
ACTEMRA ACTPEN	T2	PA QL(3.6 ML/28 DAYS) SP HD
AVTOZMA	T3	PA SP
ENSPRYNG	T3	PA SP HD

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IMMUNOSUPPRESSANTS (Pain Relief And Inflammatory Disease)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
INTERLEUKIN-6 (IL-6) RECEPTOR INHIBITORS		
KEVZARA	T3	PA QL(2 PENS/SYRINGES/28 DAYS) SP HD
TYENNE 162 MG/0.9 ML SYRINGE	T2	PA QL(3.6 ML/28 DAYS) SP
TYENNE 200 MG/10 ML VIAL	T2	PA SP
TYENNE 400 MG/20 ML VIAL	T2	PA SP
TYENNE 80 MG/4 ML VIAL	T2	PA SP
TYENNE AUTOINJECTOR	T2	PA QL(3.6 ML/28 DAYS) SP
INTERLEUKIN-31(IL-31)RECEPTOR ALPHA ANTAGONIST,MAB		
NEMLUVIO	T2	PA SP HD
IMMUNOSUPPRESSANTS (Skin Conditions)		
TOPICAL IMMUNOSUPPRESSIVE AGENTS		
HYFTOR	T3	PA SP
pimecrolimus (Elidel)	T1	
tacrolimus 0.03% ointment	T1	
tacrolimus 0.1% ointment	T1	
IMMUNOSUPPRESSANTS (Transplant Medications)		
IMMUNOSUPP - MONOCLONAL AB INHIBITING T LYMPH FXN		
NIKTIMVO	T3	PA SP
SIMULECT	T2	SP
IMMUNOSUPPRESSIVES		
ASTAGRAF XL	T3	SP HD
azathioprine 50 mg tablet (Imuran)	T1	SP HD
azathioprine sodium	T1	
CELLCEPT 500 MG VIAL *(mycophenolate mofetil hcl)*	T2	SP
cyclosporine 100 mg capsule (Sandimmune)	T1	SP HD
cyclosporine 25 mg capsule (Sandimmune)	T1	SP HD
cyclosporine 250 mg/5 ml ampul (Sandimmune)	T1	SP
cyclosporine, modified	T1	SP HD
cyclosporine, modified (Neoral)	T1	SP HD
ENVARSUS *XR*	T3	SP HD
everolimus 0.25 mg tablet (Zortress)	T1	SP HD
everolimus 0.5 mg tablet (Zortress)	T1	SP HD

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List of Prescription Medications

IMMUNOSUPPRESSANTS (Transplant Medications) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
IMMUNOSUPPRESSIVES *(cont.)*		
everolimus 0.75 mg tablet (Zortress)	T1	SP HD
everolimus 1 mg tablet (Zortress)	T1	SP HD
LUPKYNIS	T3	PA QL(6 CAPS/DAY) SP
mycophenolate 200 mg/ml susp (Cellcept)	T1	SP HD
mycophenolate 250 mg capsule (Cellcept)	T1	SP HD
mycophenolate 500 mg tablet (Cellcept)	T1	SP HD
mycophenolate 500 mg vial (Cellcept)	T1	SP
mycophenolate sodium (Myfortic)	T1	SP HD
NULOJIX	T3	PA SP
PROGRAF 0.2 MG GRANULE PACKET	T3	SP HD
PROGRAF 1 MG GRANULE PACKET	T3	SP HD
PROGRAF 5 MG/ML AMPULE	T2	SP
SANDIMMUNE 100 MG/ML SOLN	T3	SP HD
sirolimus	T1	SP HD
sirolimus (Rapamune)	T1	SP HD
tacrolimus 0.5 mg capsule (ir) (Prograf)	T1	SP HD
tacrolimus 1 mg capsule (ir) (Prograf)	T1	SP HD
tacrolimus 5 mg capsule (ir) (Prograf)	T1	SP HD
TACROLIMUS 5 MG/ML VIAL	T3	SP
ZORTRESS *(everolimus)*	T3	SP HD
MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes)		
DIABETIC SUPPLIES		
2TEK CONTROL SOLUTION	T1	
2TEK GLUCOSE-WRIST MONITOR KIT	T3	
ACCU-CHEK	T1	
ACCU-CHEK FASTCLIX LANCING DEV	T1	
ACCU-CHEK GUIDE CONTROL SOLN	T1	
ACCU-CHEK GUIDE ME GLUCOSE MTR	T3	
ACCU-CHEK GUIDE MONITOR SYSTEM	T3	
ACCU-CHEK SMARTVIEW CONTRL SOL	T1	
ACCU-CHEK SOFTCLIX	T1	
ACCUTREND GLUCOSE CONTROL	T1	
ADJUSTABLE LANCING DEVICE	T1	
ADVANCED ALL-IN-ONE METER	T3	
ADVANCED BLOOD GLUCOSE METER	T3	

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MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DIABETIC SUPPLIES *(cont.)*		
ADVANCED GLUCOSE METER	T3	
ADVANCED LANCING DEVICE	T1	
ADVOCATE BLOOD GLUCOSE MONITOR	T3	
ADVOCATE CONTROL SOLUTION	T1	
ADVOCATE DUO	T3	
ADVOCATE LANCING DEVICE	T1	
ADVOCATE RAPID-SAFE LANCING DV	T1	
ADVOCATE REDI-CODE DUO	T3	
ADVOCATE REDI-CODE GLU METER	T3	
ADVOCATE REDI-CODE GLU MONITOR	T3	
ADVOCATE REDI-CODE PLUS	T3	
ADVOCATE REDI-CODE+ CTRL SOLN	T1	
AGAMATRIX AMP GLUC MONITOR SYS	T3	
AGAMATRIX CONTROL	T1	
AGAMATRIX CONTROL SOLUTION	T1	
AGAMATRIX JAZZ WIRELESS 2	T3	
AGAMATRIX PRESTO SYSTEM KIT	T3	
ALKALINE BATTERIES	T1	
ALTERNATE SITE LANCING DEVICE	T1	
AQUA LANCE LANCING DEVICE	T1	
ASSURE 4 CONTROL SOLUTION	T1	
ASSURE CONTROL SOLUTION	T1	
ASSURE DOSE	T1	PA QL(1 UNIT/365 DAYS)
ASSURE PLATINUM GLUCOSE METER	T3	PA QL(3 SENSORS/30 DAYS)
ASSURE PRISM	T1	
ASSURE PRISM MULTI METER	T3	
ASSURE TITANIUM GLUCOSE SYSTEM	T3	
AT HOME A1C	T1	
AUTOJECT 2	T1	PA QL (1 SYRINGE/365 DAYS)
AUTO-LANCET MINI	T1	PA QL (3/30 DAYS)
AUTOLET IMPRESSION	T1	PA QL (1 SYRINGE/67 DAYS)
AUTOLET LANCING DEVICE	T1	
AUTOLET LITE	T1	
AUTOLET PLUS	T1	

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DIABETIC SUPPLIES *(cont.)*		
AUTOPEN	T1	
BIOTEL CARE BGM-4	T3	
BLOOD GLUCOSE CONTROL	T1	
BLOOD GLUCOSE METER	T3	
BLOOD GLUCOSE MONITORING	T3	
BLOOD-GLUCOSE CONTROL	T1	
BLOOD-GLUCOSE METER	T3	
BLULINK DIABETIC TEST BUNDLE	T3	
BLULINK GLUCOSE MONITOR SYSTEM	T3	
BREEZE 2	T1	
CAREONE	T1	
CARESENS	T1	
CARESENS N BLOOD GLUCOSE SYST	T3	
CARESENS N FELIZ BT GLUCOS MTR	T3	
CARESENS N FELIZ GLUCOSE METER	T3	
CARESENS N VOICE	T3	
CARESENS S CONTROL SOLUTION	T1	
CARESENS S FIT BT GLUCOSE MTR	T3	
CARESENS S FIT GLUCOSE METER	T3	
CARETOUCH CONTROL SOLUTION	T1	
CARETOUCH GLUCOSE MONITORING	T3	
CARETOUCH LANCING DEVICE	T1	
CEQUR SIMPLICITY	T2	
CEQUR SIMPLICITY INSERTER	T2	
CHEMSTRIP BG DIARY	T1	
CHOSEN LANCING DEVICE	T1	
CLEVER CHEK BLOOD GLUCOSE SYST	T3	PA QL(2 UNITS/30 DAYS)
CLEVER CHOICE	T3	PA QL (1 READER/DAY)
CLEVER CHOICE BLOOD GLUC SYS	T3	PA QL (2 SENSORS/21 DAYS)
CLEVER CHOICE CONTROL SOLUTION	T1	PA QL(1 UNIT/720 DAYS)
CLEVER CHOICE HD GLUCOSE SYST	T3	PA QL(2 UNITS/28 DAYS)
CLEVER CHOICE MICRO	T3	PA QL (1 READER/DAY)
CLEVER CHOICE PRO GLUCOSE MTR	T3	PA QL (3/30 DAYS)

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DIABETIC SUPPLIES *(cont.)*		
CLEVER CHOICE TALK GLUCOSE SYS	T3	PA QL (1 READER/DAY)
CONTOUR METER	T3	PA QL (2/28 DAYS)
CONTOUR NEXT	T3	
CONTOUR NEXT CONTROL SOLUTION	T1	
CONTOUR NEXT EZ	T3	
CONTOUR NEXT GEN	T3	
CONTOUR NEXT GLUCOSE METER	T3	
CONTOUR NEXT LINK	T3	
CONTOUR NEXT LINK 2.4	T3	
CONTOUR NEXT ONE	T3	
CONTOUR PLUS BLUE	T3	
CONTOUR SOLUTION	T1	
CONTROL SOLUTION	T1	
COOL BLOOD GLUCOSE	T3	
COOL BLOOD GLUCOSE METER	T3	
COOL CONTROL SOLUTION	T1	
DEXCOM G6 RECEIVER	T2	PA QL(1 UNIT/365 DAYS)
DEXCOM G6 SENSOR	T2	PA QL(3 SENSORS/30 DAYS)
DEXCOM G6 TRANSMITTER	T2	PA QL(1 UNIT/90 DAYS)
DEXCOM G7 15 DAY SENSOR	T2	PA QL(3 SENSORS/30 DAYS)
DEXCOM G7 RECEIVER	T2	PA QL(1 UNIT/365 DAYS)
DEXCOM G7 SENSOR	T2	PA QL(3 SENSORS/30 DAYS)
DIATRUE	T1	
DIATRUE PLUS BLOOD GLUCOSE SYS	T3	
DROPLET GENTEEL LANCING DEVICE	T1	
DROPLET LANCING DEVICE	T1	
EASY MINI EJECT LANCING DEVICE	T1	
EASY PLUS II BLOOD GLUCOSE SYS	T3	
EASY PLUS II CONTROL SOLN HIGH	T1	
EASY PLUS II CONTROL SOLN LOW	T1	
EASY STEP BLOOD GLUCOSE METER	T3	
EASY STEP CONTROL SOLUTION	T1	
EASY TALK BLOOD GLUCOSE METER	T3	

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DIABETIC SUPPLIES *(cont.)*		
EASY TALK CONTROL SOLN LOW	T1	
EASY TALK HIGH CONTROL SOLN	T1	
EASY TALK PLUS II HIGH CONTROL	T1	
EASY TALK PLUS II LOW CTRL SLN	T1	
EASY TOUCH BLULINK CTRL SOLN	T1	
EASY TOUCH BLULINK GLUC SYST	T3	
EASY TOUCH CONTROL SOLUTION	T1	
EASY TOUCH GLUCOSE MONITOR	T3	
EASY TOUCH LANCING DEVICE	T1	
EASY TRAK BLOOD GLUCOSE METER	T3	QL (1 KIT/365 DAYS)
EASY TRAK CONTROL SOLN HIGH	T1	QL (30 PODS/30 DAYs)
EASY TRAK CONTROL SOLN LOW	T1	QL (1 KIT/365 DAYS)
EASY TRAK II	T3	QL (30 PODS/30 DAYS)
EASY TRAK II CONTROL SOLUTION	T1	QL
EASYGLUCO	T3	QL
EASYGLUCO METER STARTER KIT	T3	QL (6 BOXES/30 DAYS)
EASYGLUCO PLUS CONTROL NORMAL	T1	
EASYMAX 15 LEVEL 2 SOLUTION	T1	
EASYMAX NG	T3	
EASYMAX NORMAL CONTROL SOLN	T1	
EASYMAX T1	T3	
EASYMAX V SPEAKING	T3	
EASY-TOUCH	T3	
ELEMENT COMPACT CONTROL SOLN	T1	
ELEMENT COMPACT GLUCOSE METER	T3	
ELEMENT COMPACT V	T3	
ELEMENT CONTROL SOLUTION	T1	
ELEMENT PLUS	T3	
EMBRACE BLOOD GLUCOSE SYSTEM	T3	
EMBRACE EVO BLOOD GLUCOSE KIT	T3	
EMBRACE EVO BLOOD GLUCOSE MTR	T3	
EMBRACE EVO LEVEL 1 CTRL SOLN	T1	
EMBRACE GLUC CONTROL SOLN HIGH	T1	
EMBRACE GLUCOSE CONTROL SOLN	T1	

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DIABETIC SUPPLIES *(cont.)*		
EMBRACE LANCING DEVICE	T1	
EMBRACE PRO	T1	
EMBRACE PRO BLOOD GLUCOSE MTR	T3	
EMBRACE TALK	T3	
EMBRACE TALK CONTROL SOLUTION	T1	
EMBRACE WAVE PLUS GLUCOSE MTR	T3	
ENLITE SERTER	T1	
EVENCARE G2 BLOOD GLUCOSE SYS	T3	
EVENCARE G2 CONTROL SOLUTION	T1	
EVENCARE G3 BLOOD GLUCOSE SYS	T3	
EVENCARE G3 CONTROL SOLUTION	T1	
EVENCARE MINI MONITOR SYSTEM	T3	
EVOLUTION BLOOD GLUCOSE METER	T3	
EVOLUTION CONTROL SOLUTION	T1	
EZ SMART PLUS SYSTEM KIT	T3	
EZ SMART SYSTEM KIT	T3	
FONDCIRCLE CONTROL SOLUTION	T1	
FONDCIRCLE LANCING DEVICE	T1	
FORA 6 CONNECT MULTIFUNCTN MTR	T3	
FORA CONTROL SOLUTION	T1	
FORA D10	T3	
FORA D15 GLUCOSE-BP MONITOR	T3	
FORA D20 BLOOD GLUCOSE SYSTEM	T3	
FORA D40D GLUCOSE-BP MONITOR	T3	
FORA D40G GLUCOSE-BP MONITOR	T3	
FORA G20 BLOOD GLUCOSE SYSTEM	T3	
FORA G30A	T3	
FORA GD50	T3	
FORA GTEL MULTIFUNCTN MONITOR	T3	
FORA KETONE CONTROL SOLUTION	T3	
FORA LANCING DEVICE	T1	
FORA PREMIUM V10	T3	
FORA TEST N'GO VOICE	T3	REFILL KIT: 30 UNITS/30 DAYS

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DIABETIC SUPPLIES *(cont.)*		
FORA TN'G ADVANCE PRO MONITOR	T3	STARTER KIT: 1 KIT/365 DAYS; REFILL KIT: 30 UNITS/30 DAYS
FORA TN'G VOICE	T3	
FORA TN'GO ADV MOBILE MULT MTR	T3	
FORA TN'GO ADVANCE MULTIFN MTR	T3	
FORA V10 BLOOD GLUCOSE SYSTEM	T3	
FORA V12 BLOOD GLUCOSE SYSTEM	T3	
FORA V20 BLOOD GLUCOSE SYSTEM	T3	
FORA V30A BLOOD GLUCOSE SYSTEM	T3	
FORACARE GD20 GLUCOSE SYSTEM	T3	
FORACARE GD40A	T3	
FORACARE GD40B	T3	
FORACARE GDH	T1	
FORTISCARE	T1	
FORTISCARE T1 BLOOD GLUC SYS	T3	
FREESTYLE CONTROL SOLUTION	T1	
FREESTYLE FLASH SYSTEM	T3	
FREESTYLE FREEDOM	T3	
FREESTYLE FREEDOM LITE	T2	
FREESTYLE INSULINX	T2	
FREESTYLE LIBRE 14 DAY READER	T2	PA QL(1 UNIT/720 DAYS)
FREESTYLE LIBRE 14 DAY SENSOR	T2	PA QL(2 SENSORS/28 DAYS)
FREESTYLE LIBRE 2 PLUS SENSOR	T2	PA QL(2 UNITS/30 DAYS)
FREESTYLE LIBRE 2 READER	T2	PA QL(1 UNIT/720 DAYS)
FREESTYLE LIBRE 2 SENSOR	T2	PA QL(2 SENSORS/28 DAYS)
FREESTYLE LIBRE 3 PLUS SENSOR	T2	PA QL(2 UNITS/28 DAYS)
FREESTYLE LIBRE 3 READER	T2	PA QL(1 UNIT/720 DAYS)
FREESTYLE LIBRE 3 SENSOR	T2	PA QL(2 UNITS/28 DAYS)
FREESTYLE LITE METER	T2	
FREESTYLE PRECISION NEO METER	T2	
FREESTYLE SIDEKICK II	T3	
FREESTYLE SYSTEM	T3	
GE100 BLOOD GLUCOSE SYSTEM	T3	
GE100 CONTROL SOLUTION NORMAL	T1	

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DIABETIC SUPPLIES *(cont.)*		
GE333 BLOOD GLUCOSE SYSTEM	T3	
GENTEEL VACUUM LANCING DEVICE	T1	
GLUCO NAVII GLUCOSE MONITOR KT	T3	
GLUCOCARD 01	T3	
GLUCOCARD 01 CONTROL	T1	
GLUCOCARD EXPRESSION CNTRL SLN	T1	
GLUCOCARD EXPRESSION METER	T3	
GLUCOCARD EXPRESSION METER KIT	T3	
GLUCOCARD SHINE CONNEX METER	T3	
GLUCOCARD SHINE CONTROL SOLN	T1	
GLUCOCARD SHINE EXPRESS METER	T3	
GLUCOCARD SHINE METER	T3	
GLUCOCARD SHINE METER KIT	T3	
GLUCOCARD SHINE XL	T3	
GLUCOCARD VITAL METER KIT	T3	
GLUCOCOM AUTOLINK	T1	
GLUCOCOM BLOOD GLUCOSE	T3	
GLUCOCOM CONTROL SOLUTION	T1	
GLUCOSE CONTROL	T1	
GLUCOSE CONTROL SOLUTION	T1	
GNP TRUE METRIX AIR GLUC METER	T3	
GOJJI GLUCOSE CONTROL SOLUTION	T1	
GOJJI KETONE CONTROL SOLUTION	T3	
GOJJI LANCING DEVICE	T1	
GOJJI MULTI-FUNCTIONAL METER	T3	
GUARDIAN RT CHARGER	T1	
GUARDIAN TEST PLUG	T1	
GUARDIAN TRANSMITTER TAPE	T1	
HEALTHPRO GLUCOSE CONTROL SOLN	T1	
HEALTHPRO GLUCOSE MONITOR	T3	
HEALTHY ACCENTS AUTOLET	T1	
HUMANA TRUE METRIX AIR METER	T3	
HYPOLANCE	T1	

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DIABETIC SUPPLIES *(cont.)*		
IGLUCOSE BLOOD GLUCOSE MONITOR	T3	
IHEALTH CONTROL SOLN LEVEL 2	T1	
IHEALTH GLUCO PLUS METER	T3	
INCONTROL LANCING DEVICE	T1	
INFINITY	T3	
INFINITY CONTROL SOLUTION	T1	
INFINITY VOICE CONTROL SOLN	T1	
INFINITY VOICE GLUCOSE MONITOR	T3	
INPEN (FOR HUMALOG)	T1	
INPEN (FOR NOVOLOG OR FIASP)	T1	
INSUL-CAP	T1	
INSUL-EZE	T1	
LANCING DEVICE	T1	
LANCING SYSTEM	T1	
LANZO	T1	
LITE TOUCH LANCING PEN	T1	
MEDISENSE	T1	
MEDISENSE GLUCOSE KETONE	T1	
MEDISENSE GLUCOSE KETONE CONTR	T1	
MEDTRONIC REMOTE CONTROL	T1	
MICRODOT BLOOD GLUCOSE SYSTEM	T3	
MICRODOT HIGH-LOW CONTROL SOL	T1	
MICRODOT NORMAL CONTROL SOLUT	T1	
MICROLET 2	T1	
MICROLET NEXT LANCING DEVICE	T1	
MINI LANCING DEVICE	T1	
MINIMED QUICK-SERTER	T1	
MULTI-LANCET	T1	
MYGLUCOHEALTH CONTROL SOLUTION	T1	
MYGLUCOHEALTH MONITORING KIT	T3	
NEWTEK	T3	
NOVA MAX PLUS GLUC-KETON METER	T3	
NOVAMAX PLUS GLU-KET	T1	
NOVOPEN ECHO	T1	

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DIABETIC SUPPLIES *(cont.)*		
OMNIPOD 5 (G6/LIBRE 2 PLUS)	T2	QL(30 CRTGS/30 DAYS)
OMNIPOD 5 DEXG7G6 INTRO(GEN 5)	T2	QL(1 UNIT/365 DAYS)
OMNIPOD 5 DEXG7G6 PODS (GEN 5)	T2	QL(30 CRTGS/30 DAYS)
OMNIPOD 5 G6-G7 INTRO KT(GEN5)	T2	QL(1 UNIT/365 DAYS)
OMNIPOD 5 G6-G7 PODS (GEN 5)	T2	QL(30 CRTGS/30 DAYS)
OMNIPOD 5 INTRO(G6/LIBRE2PLUS)	T2	QL(1 UNIT/365 DAYS)
OMNIPOD CLASSIC PDM KIT(GEN 3)	T2	QL(1 UNIT/365 DAYS)
OMNIPOD CLASSIC PODS (GEN 3)	T2	QL(30 CRTGS/30 DAYS)
OMNIPOD DASH INTRO KIT (GEN 4)	T2	QL(1 UNIT/365 DAYS)
OMNIPOD DASH PODS (GEN 4)	T2	QL(30 CRTGS/30 DAYS)
OMNIPOD GO PODS	T2	QL(30 CRTGS/30 DAYS)
ON CALL EXPRESS CONTROL SOLN	T1	
ON CALL EXPRESS METER	T3	
ON CALL LANCING DEVICE	T1	
ON CALL PLUS CONTROL	T1	
ON CALL PLUS LANCING DEVICE	T1	
ON CALL PLUS METER	T3	
ON CALL VIVID CONTROL	T1	
ON CALL VIVID METER	T3	
ON CALL VIVID PAL	T3	
ONETOUCH DELICA PLUS LANC DEV	T1	
ONETOUCH ULTRA CONTROL SOLN	T1	
ONETOUCH ULTRA2	T3	
ONETOUCH VERIO FLEX METER	T3	
ONETOUCH VERIO HIGH CNTRL SOLN	T1	
ONETOUCH VERIO MID CNTRL SOLN	T1	
ONETOUCH VERIO REFLECT METER	T3	
OPTUMRX BLOOD GLUCOSE METER	T3	
OPTUMRX BLOOD GLUCOSE SYSTEM	T3	
OPTUMRX GLUCOSE CONTROL SOLN	T1	
OVAL TAPE	T1	
PHARMACIST CHOICE GLUCOSE SYS	T3	
PHARMACIST CHOICE MINI GLU SYS	T3	
PIP BLOOD GLUCOSE MONITOR	T3	
PIP GLUCOSE CONTROL SOLUTION	T1	

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DIABETIC SUPPLIES *(cont.)*		
POGO AUTOMATIC BLOOD GLUC SYS	T3	
PRECISION XTRA KETONE-GLUCOSE	T3	
PRECISION XTRA MONITOR	T2	
PRECISION XTRA MONITOR NFRS	T2	
PREMIER BLU	T3	
PREMIER CLASSIC GLUCOSE METER	T3	
PREMIER COMPACT GLUCOSE METER	T3	
PREMIER VOICE	T3	
PREMIUM BLOOD GLUCOSE	T3	
PREMIUM V10 BLOOD GLUCOSE MTR	T3	
PRESTO PRO	T3	
PRO VOICE V8 GLUCOSE MONITOR	T3	
PRO VOICE V9 GLUCOSE MONITOR	T3	
PRODIGY	T3	
PRODIGY AUTOCODE	T3	
PRODIGY CONTROL SOLUTION	T1	
PRODIGY LANCING DEVICE	T1	
PRODIGY POCKET	T3	
PRODIGY VOICE	T3	
QUINTET AC BLOOD GLUCOSE METER	T3	
QUINTET BLOOD GLUCOSE SYSTEM	T3	
REFUAH PLUS GLUCOSE CONTROL	T1	
REFUAH PLUS MONITORING SYSTEM	T3	
RELIAMED MINI LANCING DEVICE	T1	
RELION ALL-IN-ONE	T3	
RELION CONFIRM	T3	
RELION MICRO	T3	
RELION PRIME	T3	
RELION TRUE METRIX AIR GLU MTR	T2	
RELION ULTIMA GLUCOSE METER	T3	
REVEAL BLOOD GLUCOSE METER	T3	
RIGHTEST CONTROL SOLUTION	T1	
RIGHTEST GD500	T1	
RIGHTEST GM100 SYSTEM	T3	
RIGHTEST GM300 SYSTEM	T3	

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MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) *(cont.)*

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIABETIC SUPPLIES *(cont.)*		
RIGHTEST GM550 SYSTEM	T3	
RIGHTEST GT333 GLUCOSE METER	T3	
SAFE-CLIP	T1	
SIL-SERTER	T1	
SMART SENSE MONITORING SYSTEM	T3	
SMARTDIABETES VANTAGE	T1	
SMARTEST	T1	
SMARTEST EJECT	T3	
SMARTEST PERSONA	T3	
SMARTEST PRONTO	T3	
SMARTEST PROTEGE	T3	
SOLUS V2 AUDIBLE METER	T3	
SOLUS V2 AUDIBLE METER SYS KIT	T3	
SOLUS V2 CONTROL SOLUTION	T1	
SOLUS V2 LANCING DEVICE	T1	
SURE COMFORT LANCING PEN	T1	
SUREFLEX	T1	
SURE-PEN	T1	
SURE-TEST EASYPLUS MINI METER	T3	
SURE-TEST EASYPLUS MINI SOLN	T1	
TELCARE BGM	T3	
TELCARE BLOOD GLUCOSE MONITOR	T3	
TELCARE CONTROL SOLUTION	T1	
TEST N'GO BLOOD GLUCOSE SYSTEM	T3	
TRUE METRIX	T1	
TRUE METRIX AIR GLUCOSE METER	T2	
TRUE METRIX BLOOD GLUCOSE MTR	T2	
TRUE METRIX BLOOD GLUCOSE MTR	T3	
TRUE METRIX GO	T2	
TRUECONTROL	T1	
TRUEDRAW	T1	
TRUERESULT BLOOD GLUCOSE SYSTM	T3	
TRUETRACK BLOOD GLUCOSE SYSTEM	T3	
TRUETRACK SMART SYSTEM	T3	
TWIIST REFILL KT(CSST-NDL-SYR)	T2	QL(30 KITS/30 DAYS)

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MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DIABETIC SUPPLIES *(cont.)*		
TWIIST RFL(INFUS-CSST-NDL-SYR)	T2	QL(30 KITS/30 DAYS)
TWIIST STARTER KIT	T2	QL(1 KIT/365 DAYS)
ULTI-LANCE	T1	
ULTRATRAK BLOOD GLUCOSE METER	T3	
ULTRATRAK CONTROL SOL NORMAL	T1	
ULTRATRAK CONTROL SOLUTION	T1	
ULTRATRAK PRO	T3	
ULTRATRAK ULTIMATE CNTRL SOLN	T1	
ULTRATRAK ULTIMATE GLUCOSE MTR	T3	
UNISTIK 2	T1	
UNISTRIP	T1	
V-GO 20	T2	
V-GO 30	T2	
V-GO 40	T2	
VIVAGUARD INO CONTROL SOLUTION	T1	
VIVAGUARD INO GLUCOSE METER	T3	
VIVAGUARD INO SMART GLUC METER	T3	
VIVAGUARD LANCING DEVICE	T1	
WAVESENSE AMP	T3	
WAVESENSE PRESTO	T3	
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I)		
1ST TIER UNILET COMFORTOUCH	T1	
2-IN-1 LANCET DEVICE	T1	
ACCU-CHEK FASTCLIX LANCET DRUM	T1	
ACCU-CHEK SAFE-T-PRO	T1	
ACCU-CHEK SAFE-T-PRO PLUS	T1	
ACCU-CHEK SOFTCLIX	T1	
ACTI-LANCE	T1	
ADVANCED TRAVEL LANCETS	T1	
ADVOCATE LANCETS	T1	
ADVOCATE SAFETY LANCET	T1	
AGAMATRIX ULTRA-THIN LANCET	T1	
ALTERNATE SITE LANCETS	T1	
ASSURE HAEMOLANCE PLUS	T1	
ASSURE LANCE	T1	
ASSURE LANCE PLUS	T1	

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DIABETIC SUPPLIES *(cont.)*		
BD MICROTAINER LANCETS	T1	
BLOOD LANCETS	T1	
BULLSEYE MINI SAFETY LANCETS	T1	
BUTTERFLY TOUCH LANCET	T1	
CAREONE	T1	
CARESENS LANCET	T1	
CARETOUCH SAFETY LANCETS	T1	
CARETOUCH TWIST LANCET	T1	
CHOSEN LANCET	T1	
CHOSEN SAFETY LANCET	T1	
CLEVER CHEK LANCETS	T1	
COAGUCHEK	T1	
COLOR LANCETS	T1	
COMFORT EZ	T1	
COMFORT LANCETS	T1	
COMFORT TOUCH PLUS SAFETY LANC	T1	
COMFORT TOUCH ULT THIN LANCET	T1	
DROPLET LANCETS	T1	
DROPSAFE ACTI-LANCE	T1	
EASY COMFORT LANCETS	T1	
EASY TOUCH PULL-TOP 26G LANCET	T1	
EASY TOUCH PULL-TOP 28G LANCET	T1	
EASY TOUCH PULL-TOP 30G LANCET	T1	
EASY TOUCH PULL-TOP 32G LANCET	T1	
EASY TOUCH SAFETY 21G LANCETS	T1	
EASY TOUCH SAFETY 23G LANCETS	T1	
EASY TOUCH SAFETY 26G LANCETS	T1	
EASY TOUCH SAFETY 28G LANCETS	T1	
EASY TOUCH SAFETY 30G LANCETS	T1	
EASY TOUCH SAFETY 32G LANCETS	T1	
EASY TOUCH TWIST 26G LANCETS	T1	
EASY TOUCH TWIST 28G LANCETS	T1	
EASY TOUCH TWIST 30G LANCETS	T1	
EASY TOUCH TWIST 32G LANCETS	T1	
EASY TOUCH TWIST 33G LANCETS	T1	

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DIABETIC SUPPLIES *(cont.)*		
EASY TWIST & CAP LANCETS	T1	
EMBRACE 30G LANCETS	T1	
EMBRACE SAFETY LANCET	T1	
EZ SMART LANCETS	T1	
EZ-LETS	T1	
FIFTY50 SAFETY SEAL LANCETS	T1	
FINGERSTIX	T1	
FONDCIRCLE LANCET	T1	
FORA LANCETS	T1	
FORACARE LANCETS	T1	
FREESTYLE LANCETS	T1	
FREESTYLE UNISTIK 2	T1	
GLUCOCOM	T1	
GLUCOCOM LANCETS	T1	
GOJJI LANCETS	T1	
HEALTHY ACCENTS UNILET LANCET	T1	
INCONTROL SUPER THIN LANCETS	T1	
INCONTROL ULTRA THIN LANCETS	T1	
INJECT EASE LANCETS	T1	
INVACARE LANCETS	T1	
lancets	T1	
LANCETS	T1	
LITE TOUCH 28G LANCETS	T1	
LITE TOUCH 30G LANCETS	T1	
LITE TOUCH 33G LANCETS	T1	
MEDISENSE THIN LANCETS	T1	
MEDLANCE PLUS	T1	
MICRO THIN LANCET	T1	
MICRO THIN LANCETS	T1	
MICROLET	T1	
MOBILE LANCETS	T1	
MONOLET LANCETS	T1	
MONOLET THIN LANCETS	T1	
MYGLUCOHEALTH LANCETS	T1	

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DIABETIC SUPPLIES *(cont.)*		
NOVA SAFETY LANCETS	T1	
NOVA SUREFLEX	T1	
ON CALL LANCET	T1	
ON CALL PLUS LANCET	T1	
ONETOUCH DELICA PLUS LANCET	T1	
ONETOUCH DELICA SAFETY LANCET	T1	
ONETOUCH LANCETS	T1	
ONETOUCH SURESOFT	T1	
ONETOUCH ULTRASOFT 2 LANCET	T1	
ON-THE-GO	T1	
PERFECT POINT SAFETY LANCETS	T1	
PIP LANCET	T1	
PRESSURE ACTIVATED LANCETS	T1	
PRO COMFORT LANCET	T1	
PRO COMFORT LANCETS	T1	
PRO COMFORT SAFETY LANCET	T1	
PRODIGY LANCETS	T1	
PRODIGY TWIST TOP LANCET	T1	
PURE COMFORT LANCETS	T1	
PURE COMFORT SAFETY LANCETS	T1	
PUSH BUTTON SAFETY LANCETS	T1	
READYLANCE SAFETY LANCETS	T1	
RELIAMED	T1	
RELIAMED SAFETY SEAL LANCETS	T1	
RIGHTEST GL300 LANCETS	T1	
SAFETY LANCETS	T1	
SAFETY SEAL LANCETS	T1	
SAFETY-LET	T1	
SINGLE-LET	T1	
SMART SENSE	T1	
SMART SENSE LANCETS	T1	
SMARTEST LANCET	T1	
SOLUS V2 28G LANCETS	T1	
SOLUS V2 LANCETS	T1	

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DIABETIC SUPPLIES *(cont.)*		
STERILANCE TL	T1	
STERILE LANCETS	T1	
SUPER THIN LANCETS	T1	
SURE COMFORT LANCETS	T1	
SURE-LANCE	T1	
SURE-TOUCH	T1	
TECHLITE LANCETS	T1	
TELCARE ULTRA THIN 30G LANCETS	T1	
THIN LANCETS	T1	
TOPCARE UNIVERSAL1 LANCET	T1	
TOPCARE UNIVERSAL1 THIN LANCET	T1	
TRUE COMFORT LANCET	T1	
TRUE COMFORT SAFETY LANCET	T1	
TRUEPLUS LANCET	T1	
TRUEPLUS LANCETS	T1	
TWIST LANCETS	T1	
TWIST TOP LANCET	T1	
ULTILET BASIC	T1	
ULTILET CLASSIC	T1	
ULTILET LANCETS	T1	
ULTILET SAFETY	T1	
ULTRA THIN LANCET	T1	
ULTRA THIN LANCETS	T1	
ULTRA THIN PLUS LANCETS	T1	
ULTRA-CARE LANCETS	T1	
ULTRALANCE	T1	
ULTRA-THIN II 28G LANCETS	T1	
ULTRA-THIN II 30G LANCETS	T1	
ULTRATLC LANCETS	T1	
UNILET COMFORTOUCH	T1	
UNILET EXCELITE	T1	
UNILET EXCELITE II	T1	
UNILET GP LANCET	T1	
UNILET LANCET	T1	
UNILET LANCETS	T1	

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DIABETIC SUPPLIES *(cont.)*		
UNISTIK 2 COMFORT	T1	
UNISTIK 2 EXTRA	T1	
UNISTIK 2 NORMAL	T1	
UNISTIK 3	T1	
UNISTIK 3 COMFORT	T1	
UNISTIK 3 DUAL	T1	
UNISTIK 3 EXTRA	T1	
UNISTIK 3 NORMAL	T1	
UNISTIK COMFORT	T1	
UNISTIK CZT	T1	
UNISTIK EXTRA	T1	
UNISTIK NORMAL	T1	
UNISTIK PRO	T1	
UNISTIK SAFETY	T1	
UNISTIK TOUCH	T1	
UNIVERSAL 1	T1	
VERIFINE SAFETY LANCET MINI	T1	
VERIFINE UNIVERSAL LANCET	T1	
VIVAGUARD LANCET	T1	
VIVAGUARD SAFETY LANCET	T1	
NEEDLES/NEEDLELESS DEVICES		
AUTOSHIELD DUO PEN NEEDLE	T1	
BLUNT NEEDLE	T1	
CAREPOINT PRECISION NEEDLE	T1	
CARETOUCH HYPODERMIC NEEDLE	T1	
DROPSAFE SICURA SAFETY NEEDLE	T1	
EASY TOUCH FLIPLOCK NEEDLE	T1	
EASY TOUCH FLIPLOCK NEEDLES	T1	
EASY TOUCH HYPODERMIC NEEDLE	T1	
EASYPOINT NEEDLE	T1	
ECLIPSE NEEDLE	T1	
EXEL HUBER NEEDLE	T1	
EXEL HYPODERMIC NEEDLE	T1	
EXEL MTI DRAWING NEEDLE	T2	
FILTER ASPIRATOR NEEDLE	T1	

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
NEEDLES/NEEDLELESS DEVICES *(cont.)*		
FILTER NEEDLE	T1	
FLOW-EZE	T1	
HYPODERMIC NEEDLE	T1	
INTEGRA NEEDLE	T1	
INTEGRA PRECISIONGLIDE NEEDLE	T1	
LIFESHIELD BLUNT CANNULA	T1	
MONOJECT BLOOD COLLECTION	T2	
MONOJECT FILTER NEEDLE	T1	
NANO 2ND GEN PEN NEEDLE	T1	
NANO PEN NEEDLE	T1	
NEEDLE	T1	
NEEDLES	T1	
needles,safety huber,disposabl	T1	
NOKOR ADMIX NEEDLE	T1	
NOKOR NEEDLE	T1	
PERFECT POINT SAFETY NEEDLE	T1	
PHASEAL PROTECTOR	T2	
POLY HUB NEEDLE	T1	
PRECISIONGLIDE	T1	
PRECISIONGLIDE NEEDLE	T1	
REGULAR BEVEL NEEDLES	T1	
SAFETYGLIDE NEEDLE	T1	
SHORT BEVEL NEEDLES	T1	
SPECIALTY USE NEEDLES	T1	
TERUMO SURGUARD2	T1	
TERUMO SURGUARD2	T1	
THIN WALL NEEDLES	T1	
TRANSFER NEEDLE	T1	
ULTRA-FINE MICRO PEN NEEDLE	T1	
ULTRA-FINE MINI PEN NEEDLE	T1	
ULTRA-FINE NANO PEN NEEDLE	T1	
ULTRA-FINE ORIGINAL PEN NEEDLE	T1	
ULTRA-FINE PEN NEEDLE	T1	
ULTRA-FINE SHORT PEN NEEDLE	T1	
YALE NEEDLES	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SYRINGES AND ACCESSORIES		
BD INS SYR 0.3 ML 8MMX31G(1/2)	T1	
BD INS SYR UF 0.3ML 12.7MMX30G	T1	
BD INS SYR UF 0.5ML 12.7MMX30G	T1	
BD INS SYRN UF 1 ML 12.7MMX30G	T1	
BD INS SYRN UF 1 ML 30G 12.7MM	T1	
BD INS SYRNG 0.3 ML 29GX12.7MM	T1	
BD INS SYRNG 0.5 ML 29GX12.7MM	T1	
BD INS SYRNG UF 0.3 ML 8MMX31G	T1	
BD INS SYRNG UF 0.5 ML 8MMX31G	T1	
BD INSULIN SYR 0.5 ML 28GX1/2"	T1	
BD INSULIN SYR 1 ML 27GX12.7MM	T1	
BD INSULIN SYR 1 ML 27GX5/8"	T1	
BD INSULIN SYR 1 ML 28GX1/2"	T1	
BD INSULIN SYR 1 ML 29GX12.7MM	T1	
BD INSULIN SYR UF 1 ML 8MMX31G	T1	
ECLIPSE SYRINGE	T1	
INSULIN SYR 0.5 ML 28G 12.7MM	T1	
INSULIN SYRINGE 1 ML 27G 16MM	T1	
INSULIN SYRINGE 1ML 28G 12.7MM	T1	
INSULIN SYRINGE U-500	T1	
MINIMED RESERVOIR 1.8 ML	T1	
MINIMED RESERVOIR 3 ML	T3	
PARADIGM RESERVOIR 1.8 ML	T1	
PARADIGM RESERVOIR 3 ML	T3	
SAFETYGLIDE INSULIN SYRINGE	T1	
SAFETYGLIDE SYRINGE	T1	
ULTRA-FINE INSULIN SYRINGE	T1	
VEO INSULIN SYRINGE	T1	

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Miscellaneous)

DURABLE MEDICAL EQUIPMENT,MISC (GROUP I)		
1ST TIER UNILET COMFORTOUCH	T1	
2-IN-1 LANCET DEVICE	T1	
ACCU-CHEK FASTCLIX LANCET DRUM	T1	
ACCU-CHEK SAFE-T-PRO	T1	
ACCU-CHEK SAFE-T-PRO PLUS	T1	

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MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Miscellaneous)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DURABLE MEDICAL EQUIPMENT,MISC (GROUP I)		
ACCU-CHEK SOFTCLIX	T1	
ACTI-LANCE	T1	
ADVANCED TRAVEL LANCETS	T1	
ADVOCATE LANCET	T1	
ADVOCATE LANCETS	T1	
ADVOCATE SAFETY LANCET	T1	
AGAMATRIX ULTRA-THIN LANCET	T1	
ALTERNATE SITE LANCETS	T1	
ASSURE HAEMOLANCE PLUS	T1	
ASSURE LANCE	T1	
ASSURE LANCE PLUS	T1	
BD MICROTAINER LANCETS	T1	
BLOOD LANCETS	T1	
BULLSEYE MINI SAFETY LANCETS	T1	
BUTTERFLY TOUCH LANCET	T1	
CAREONE	T1	
CARESENS LANCET	T1	
CARETOUCH SAFETY LANCETS	T1	
CARETOUCH TWIST LANCET	T1	
CHOSEN LANCET	T1	
CHOSEN SAFETY LANCET	T1	
CLEVER CHEK LANCETS	T1	
COAGUCHEK	T1	
COLOR LANCETS	T1	
COMFORT EZ	T1	
COMFORT LANCETS	T1	
COMFORT TOUCH PLUS SAFETY LANC	T1	
COMFORT TOUCH ULT THIN LANCET	T1	
DROPLET LANCETS	T1	
DROPSAFE ACTI-LANCE	T1	
EASY COMFORT LANCETS	T1	
EASY TOUCH PULL-TOP 26G LANCET	T1	
EASY TOUCH PULL-TOP 28G LANCET	T1	
EASY TOUCH PULL-TOP 30G LANCET	T1	

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MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Miscellaneous) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DURABLE MEDICAL EQUIPMENT,MISC (GROUP I) *(cont.)*		
EASY TOUCH PULL-TOP 32G LANCET	T1	
EASY TOUCH SAFETY 21G LANCETS	T1	
EASY TOUCH SAFETY 23G LANCETS	T1	
EASY TOUCH SAFETY 26G LANCETS	T1	
EASY TOUCH SAFETY 28G LANCETS	T1	
EASY TOUCH SAFETY 30G LANCETS	T1	
EASY TOUCH SAFETY 32G LANCETS	T1	
EASY TOUCH TWIST 26G LANCETS	T1	
EASY TOUCH TWIST 28G LANCETS	T1	
EASY TOUCH TWIST 30G LANCETS	T1	
EASY TOUCH TWIST 32G LANCETS	T1	
EASY TOUCH TWIST 33G LANCETS	T1	
EASY TWIST & CAP LANCETS	T1	
EMBRACE 30G LANCETS	T1	
EMBRACE SAFETY LANCET	T1	
EZ SMART LANCETS	T1	
EZ-LETS	T1	
FIFTY50 SAFETY SEAL LANCETS	T1	
FINGERSTIX	T1	
FONDCIRCLE LANCET	T1	
FORA LANCETS	T1	
FORA V10-V12-D10-D20 STRP-LNCT	T3	
FORACARE LANCETS	T1	
FREESTYLE LANCETS	T1	
FREESTYLE UNISTIK 2	T1	
GLUCOCOM	T1	
GLUCOCOM LANCETS	T1	
GOJJI LANCET-GLUCOSE TEST STRP	T3	
GOJJI LANCETS	T1	
HEALTHY ACCENTS UNILET LANCET	T1	
INCONTROL SUPER THIN LANCETS	T1	
INCONTROL ULTRA THIN LANCETS	T1	
INJECT EASE LANCETS	T1	

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List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Miscellaneous) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DURABLE MEDICAL EQUIPMENT,MISC (GROUP I) *(cont.)*		
INVACARE LANCETS	T1	
lancets	T1	
LANCETS	T1	
LITE TOUCH 28G LANCETS	T1	
LITE TOUCH 30G LANCETS	T1	
LITE TOUCH 33G LANCETS	T1	
MEDISENSE THIN LANCETS	T1	
MEDLANCE PLUS	T1	
MEDLANCE PLUS SPECIAL BLADE	T1	
MICRO THIN LANCET	T1	
MICRO THIN LANCETS	T1	
MICROLET	T1	
MICROTAINER LANCETS	T1	
MOBILE LANCETS	T1	
MONOLET LANCETS	T1	
MONOLET THIN LANCETS	T1	
MYGLUCOHEALTH LANCETS	T1	
NOVA SAFETY LANCETS	T1	
NOVA SUREFLEX	T1	
ON CALL LANCET	T1	
ON CALL PLUS LANCET	T1	
ONETOUCH DELICA PLUS LANCET	T1	
ONETOUCH DELICA SAFETY LANCET	T1	
ONETOUCH LANCETS	T1	
ONETOUCH SURESOFT	T1	
ONETOUCH ULTRASOFT 2 LANCET	T1	
ON-THE-GO	T1	
PERFECT POINT SAFETY LANCETS	T1	
PIP LANCET	T1	
POGO AUTOMATIC TEST CARTRIDGE	T3	
PRESSURE ACTIVATED LANCETS	T1	
PRO COMFORT LANCET	T1	
PRO COMFORT LANCETS	T1	
PRO COMFORT SAFETY LANCET	T1	
PRODIGY LANCETS	T1	
PRODIGY TWIST TOP LANCET	T1	

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Miscellaneous) *(cont.)*

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT,MISC (GROUP I) *(cont.)*		
PURE COMFORT LANCETS	T1	
PURE COMFORT SAFETY LANCETS	T1	
PUSH BUTTON SAFETY LANCETS	T1	
READYLANCE SAFETY LANCETS	T1	
RELIAMED	T1	
RELIAMED SAFETY SEAL LANCETS	T1	
RIGHTEST GL300 LANCETS	T1	
SAFETY LANCETS	T1	
SAFETY SEAL LANCETS	T1	
SAFETY-LET	T1	
SINGLE-LET	T1	
SMART SENSE	T1	
SMART SENSE LANCETS	T1	
SMARTEST LANCET	T1	
SOLUS V2 28G LANCETS	T1	
SOLUS V2 LANCETS	T1	
STERILANCE TL	T1	
STERILE LANCETS	T1	
SUPER THIN LANCETS	T1	
SURE COMFORT LANCETS	T1	
SURE-LANCE	T1	
SURE-TOUCH	T1	
TECHLITE LANCETS	T1	
TELCARE ULTRA THIN 30G LANCETS	T1	
THIN LANCETS	T1	
TOPCARE UNIVERSAL 1 LANCET	T1	
TOPCARE UNIVERSAL 1 THIN LANCET	T1	
TRUE COMFORT LANCET	T1	
TRUE COMFORT SAFETY LANCET	T1	
TRUEPLUS LANCET	T1	
TRUEPLUS LANCETS	T1	
TWIST LANCETS	T1	
TWIST TOP LANCET	T1	
ULTILET BASIC	T1	
ULTILET CLASSIC	T1	

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DURABLE MEDICAL EQUIPMENT,MISC (GROUP I) *(cont.)*		
ULTILET LANCETS	T1	
ULTILET SAFETY	T1	
ULTRA THIN LANCET	T1	
ULTRA THIN LANCETS	T1	
ULTRA THIN PLUS LANCETS	T1	
ULTRA-CARE LANCETS	T1	
ULTRALANCE	T1	
ULTRA-THIN II 28G LANCETS	T1	
ULTRA-THIN II 30G LANCETS	T1	
ULTRATLC LANCETS	T1	
UNILET COMFORTOUCH	T1	
UNILET EXCELITE	T1	
UNILET EXCELITE II	T1	
UNILET GP LANCET	T1	
TRUE COMFORT LANCET / SAFETY LANCET	T1	
TRUEPLUS LANCETS	T1	
TWIST LANCETS / TOP LANCET	T1	
ULTILET	T1	
ULTRA THIN	T1	
ULTRA-CARE LANCETS	T1	
ULTRALANCE	T1	
UNILET LANCET	T1	
UNILET LANCETS	T1	
UNISTIK 2 COMFORT	T1	
UNISTIK 2 EXTRA	T1	
UNISTIK 2 NORMAL	T1	
UNISTIK 3	T1	
UNISTIK 3 COMFORT	T1	
UNISTIK 3 DUAL	T1	
UNISTIK 3 EXTRA	T1	
UNISTIK 3 NORMAL	T1	
UNISTIK COMFORT	T1	
UNISTIK CZT	T1	
UNISTIK EXTRA	T1	
UNISTIK NORMAL	T1	

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DURABLE MEDICAL EQUIPMENT,MISC (GROUP I) *(cont.)*		
UNISTIK PRO	T1	
UNISTIK SAFETY	T1	
UNISTIK TOUCH	T1	
UNIVERSAL 1	T1	
VERIFINE SAFETY LANCET MINI	T1	
VERIFINE UNIVERSAL LANCET	T1	
VIVAGUARD LANCET	T1	
VIVAGUARD SAFETY LANCET	T1	
MEDICAL SUPPLIES,MISCELLANEOUS		
ALCOH-GLOVE	T3	
ALCOH-WIPE	T3	
MUSCLE RELAXANTS (Pain Relief And Inflammatory Disease)		
SKELETAL MUSCLE RELAXANTS		
baclofen 0.05 mg/ml syringe (Gablofen)	T1	
baclofen 10 mg tablet	T1	HD
baclofen 10 mg/20 ml vial (Gablofen)	T1	
baclofen 10 mg/5 ml solution	T1	HD
baclofen 20 mg tablet	T1	HD
baclofen 20,000 mcg/20 ml vial (Gablofen)	T1	
BACLOFEN 40 MG/20 ML REFLL KIT	T3	
baclofen 40 mg/20 ml vial (Gablofen)	T1	
baclofen 40,000 mcg/20 ml vial (Gablofen)	T1	
baclofen 5 mg tablet	T1	HD
baclofen 5 mg/5 ml solution	T1	HD
carisoprodol (Soma)	T1	
carisoprodol/aspirin	T1	
chlorzoxazone 500 mg tablet	T1	
cyclobenzaprine hcl	T1	
cyclobenzaprine hcl (Fexmid)	T1	
DANTRIUM	T3	
DANTRIUM *(dantrolene sodium)*	T3	
dantrolene sodium	T1	
dantrolene sodium (Dantrium)	T1	
FEXMID (*cyclobenzaprine hcl*)	T3	

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List of Prescription Medications

MUSCLE RELAXANTS (Pain Relief And Inflammatory Disease) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
SKELETAL MUSCLE RELAXANTS *(cont.)*		
GABLOFEN	T3	
GABLOFEN *(baclofen)*	T3	
LIORESAL INTRATHECAL	T3	
metaxalone 400 mg tablet	T1	
metaxalone 800 mg tablet	T1	HD
methocarbamol	T1	
methocarbamol 1,000 mg tablet	T1	
methocarbamol 1,000 mg/10 ml (Robaxin)	T1	
methocarbamol 500 mg tablet	T1	
methocarbamol 750 mg tablet	T1	
orphenadrine citrate	T1	
ROBAXIN *(methocarbamol)*	T3	
RYANODEX	T3	
tizanidine hcl 2 mg tablet	T1	
tizanidine hcl 4 mg tablet (Zanaflex)	T1	
ZANAFLEX	T3	
ZANAFLEX (*tizanidine hcl*)	T3	
PRE-NATAL VITAMINS (Nutritional/Dietary)		
PRENATAL VITAMIN PREPARATIONS		
BAL-CARE DHA ESSENTIAL	T3	
CITRANATAL 90 DHA	T3	
CITRANATAL ASSURE	T3	
CITRANATAL DHA	T3	
CITRANATAL HARMONY	T3	
CITRANATAL RX	T3	
DERMACINRX PRETRATE	T3	
DUET DHA BALANCED	T3	
KOSHER PRENATAL PLUS IRON	T3	
MARNATAL-F	T3	
mynatal capsule	T3	
mynatal ultracaplet	T1	
NATACHEW	T3	
NEONATAL COMPLETE	T3	
NEONATAL PLUS	T3	

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PRE-NATAL VITAMINS (Nutritional/Dietary)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
PRENATAL VITAMIN PREPARATIONS		
NEONATAL-DHA	T3	
NESTABS	T2	
prenatal vits15/iron/folic/dss	T1	
VITAFOL FE+	T3	
NESTABS ABC	T2	
NESTABS DHA	T2	
OB COMPLETE ONE	T2	
OB COMPLETE PETITE	T2	
OB COMPLETE PREMIER	T2	
OB COMPLETE WITH DHA	T2	
OBSTETRIX EC	T3	
OBTREX DHA	T3	
pnv 11/iron fum/folic acid/om3	T1	
pnv 119/iron fum/folic acid	T1	
pnv 66/iron/folic/docusate/dha	T1	
pnv 69/iron/folic/docusate/dha	T1	
pnv 80/iron fum/folic/dss/dha	T1	
pnv no.118/iron fumarate/fa	T1	
pnv no.154/iron fum/folic acid	T1	
pnv no.52/iron/fa/omega-3/dha	T1	
pnv,calcium 72/iron,carb/folic	T1	
pnv,calcium 72/iron/folic acid	T1	
pnv19/iron bg,s.p/folic ac/om3	T1	
pnv81/iron ps,edta/folic/omeg3	T1	
PRENATA	T3	
prenatal 105/iron/folic ac/dha	T1	
prenatal 12/iron/folic/dss/om3	T1	
PRENATAL *19*	T1	
prenatal 53/iron/folic ac/omg3	T1	
prenatal 54/iron/folic ac/omg3	T1	
prenatal 71/iron/folic ac/dha	T1	
prenatal 93/iron/folate 9/dha	T1	
*prenatal no.42/folic acid (*Vitamedmd Redichew Rx*)*	T3	
PRENATAL PLUS VITAMIN-MINERAL	T2	

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
PRENATAL VITAMIN PREPARATIONS		
PRENATAL PLUS-DHA	T1	
prenatal vit 27,calc/iron/fa	T1	
prenatal vit 55/iron/folic/om3	T1	
prenatal vit,cal 73/iron/folic	T3	
prenatal vit,cal 76/iron/folic	T3	
prenatal vit,cal 78/iron/folic	T3	
prenatal vit/iron fum/folic ac	T1	
prenatal vits 86/iron/folic ac	T1	
prenatal,calc 40/iron/folate 1	T1	
PRENATE ENHANCE	T3	
PRENATE RESTORE	T3	
PRIMACARE	T3	
PROVIDA OB	T3	
SELECT-OB (*prenatal vit 128/iron/folic ac*)	T3	
SELECT-OB + DHA	T2	
THRIVITE RX	T1	
TRICARE	T3	
TRISTART DHA	T3	
VITAFOL FE PLUS	T3	
VITAFOL NANO	T3	
VITAFOL ULTRA	T3	
VITAFOL-OB	T1	
VITAFOL-OB+DHA	T3	
VITAFOL-ONE	T3	
VITAMEDMD ONE RX	T3	
VITAMEDMD REDICHEW RX (*prenatal no.42/folic acid*)	T3	
VITAPEARL	T3	
VITATRUE	T3	
PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)[10]		
ALPHA-2 RECEPTOR ANTAGONIST ANTIDEPRESSANTS		
mirtazapine	T1	HD
mirtazapine (Remeron)	T1	HD
ANTI-ANXIETY - BENZODIAZEPINES		
alprazolam	T1	
alprazolam (Xanax Xr)	T1	

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PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)[10] *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-ANXIETY - BENZODIAZEPINES *(cont.)*		
*alprazolam (*Xanax*)*	T1	
chlordiazepoxide hcl	T1	
clorazepate dipotassium	T1	
*diazepam 10 mg tablet (*Valium*)*	T1	
diazepam 10 mg/2 ml carpuject	T1	
diazepam 10 mg/2 ml syringe	T1	
*diazepam 2 mg tablet (*Valium*)*	T1	
diazepam 25 mg/5 ml oral conc	T1	
*diazepam 5 mg tablet (*Valium*)*	T1	
diazepam 5 mg/5 ml oral cup	T1	
diazepam 5 mg/5 ml solution	T1	
diazepam 5 mg/ml oral conc	T1	
diazepam 50 mg/10 ml vial	T1	
lorazepam	T1	
lorazepam (Ativan)	T1	
oxazepam	T1	
ANTI-ANXIETY DRUGS		
buspirone hcl	T1	HD
meprobamate	T1	
ANTIDEPRESSANT - POSTPARTUM DEPRESSION (PPD)		
ZURZUVAE 20 MG CAPSULE	T3	PA QL(28 CAPS/270 DAYS) SP HD
ZURZUVAE 25 MG CAPSULE	T3	PA QL(28 CAPS/270 DAYS) SP HD
ZURZUVAE 30 MG CAPSULE	T3	PA QL(14 CAPS/270 DAYS) SP HD
BIPOLAR DISORDER DRUGS		
EQUETRO	T3	HD
lithium carbonate	T1	HD
*lithium carbonate (*Lithobid*)*	T1	HD
lithium citrate	T1	HD
MAOIS -NON-SELECTIVE, IRREVERSIBLE ANTIDEPRESSANTS		
MARPLAN	T3	QL(12 TABS/DAY)

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PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)[10] *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
MAOIS -NON-SELECTIVE, IRREVERSIBLE ANTIDEPRESSANTS *(con't.)*		
phenelzine sulfate (Nardil)	T1	
tranylcypromine sulfate (Parnate)	T1	
MONOAMINE OXIDASE (MAO) INHIBITOR ANTIDEPRESSANTS		
EMSAM 12 MG/24 HOURS PATCH	T3	QL(1 PATCH/DAY)
EMSAM 6 MG/24 HOURS PATCH	T3	QL(2 PATCHES/DAY)
EMSAM 9 MG/24 HOURS PATCH	T3	QL(1 PATCH/DAY)
NOREPINEPHRINE AND DOPAMINE REUPTAKE INHIB (NDRIS)		
bupropion hcl 100 mg tablet	T1	QL(4 TABS/DAY) HD
bupropion hcl 75 mg tablet	T1	QL(6 TABS/DAY) HD
bupropion hcl sr 100 mg tablet (Wellbutrin Sr)	T1	QL(4 TABS/DAY) HD
bupropion hcl sr 150 mg tablet (Wellbutrin Sr)	T1	QL(2 TABS/DAY) HD
bupropion hcl sr 200 mg tablet (Wellbutrin Sr)	T1	QL(2 TABS/DAY) HD
bupropion hcl xl 150 mg tablet (Wellbutrin Xl)	T1	QL(3 TABS/DAY) HD
bupropion hcl xl 300 mg tablet (Wellbutrin Xl)	T1	QL(1 TAB/DAY) HD
SELECTIVE SEROTONIN 5-HT2A INVERSE AGONISTS (SSIA)		
NUPLAZID	T3	PA SP HD
SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS)		
citalopram hbr 10 mg tablet (Celexa)	T1	QL(6 TABS/DAY) HD
citalopram hbr 10 mg/5 ml soln	T1	QL(30 MLS/DAY) HD
citalopram hbr 20 mg tablet (Celexa)	T1	QL(3 TABS/DAY) HD
citalopram hbr 20 mg/10 ml cup	T1	QL(30 MLS/DAY) HD
citalopram hbr 40 mg tablet (Celexa)	T1	QL(1 TAB/DAY) HD
escitalopram 10 mg tablet (Lexapro)	T1	QL(2 TABS/DAY) HD
escitalopram 10 mg/10 ml cup	T1	QL(20 MLS/DAY) HD
escitalopram 20 mg tablet (Lexapro)	T1	QL(1 TAB/DAY) HD
escitalopram 5 mg tablet (Lexapro)	T1	QL(4 TABS/DAY) HD
escitalopram oxalate 5 mg/5 ml	T1	QL(20 MLS/DAY) HD
fluoxetine 20 mg/5 ml soln cup	T1	QL(20 MLS/DAY) HD
fluoxetine 20 mg/5 ml solution	T1	QL(20 MLS/DAY) HD
fluoxetine hcl	T1	QL(4 CAPS/28 DAYS) HD
fluoxetine hcl 10 mg capsule (Prozac)	T1	QL(8 CAPS/DAY) HD
fluoxetine hcl 10 mg tablet	T1	HD
fluoxetine hcl 20 mg capsule (Prozac)	T1	QL(4 CAPS/DAY) HD
fluoxetine hcl 20 mg tablet	T1	HD

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS) *(cont.)*		
fluoxetine hcl 40 mg capsule (Prozac)	T1	QL(2 CAPS/DAY) HD
fluoxetine hcl 60 mg tablet	T1	QL(1 TAB/DAY) HD
fluvoxamine er 100 mg capsule	T1	QL(3 CAPS/DAY) HD
fluvoxamine er 150 mg capsule	T1	QL(2 CAPS/DAY) HD
fluvoxamine maleate 100 mg tab	T1	QL(3 TABS/DAY) HD
fluvoxamine maleate 25 mg tab	T1	QL(12 TABS/DAY) HD
fluvoxamine maleate 50 mg tab	T1	QL(6 TABS/DAY) HD
paroxetine cr 12.5 mg tablet (Paxil Cr)	T1	QL(1 TAB/DAY) HD
paroxetine cr 25 mg tablet (Paxil Cr)	T1	QL(3 TABS/DAY) HD
paroxetine cr 37.5 mg tablet (Paxil Cr)	T1	QL(2 TABS/DAY) HD
paroxetine er 12.5 mg tablet (Paxil Cr)	T1	QL(1 TAB/DAY) HD
paroxetine er 25 mg tablet (Paxil Cr)	T1	QL(3 TABS/DAY) HD
paroxetine er 37.5 mg tablet (Paxil Cr)	T1	QL(2 TABS/DAY) HD
paroxetine hcl 10 mg tablet (Paxil)	T1	QL(6 TABS/DAY) HD
paroxetine hcl 10 mg/5 ml susp	T1	QL(30 MLS/DAY) HD
paroxetine hcl 20 mg tablet (Paxil)	T1	QL(3 TABS/DAY) HD
paroxetine hcl 30 mg tablet (Paxil)	T1	QL(2 TABS/DAY) HD
paroxetine hcl 40 mg tablet (Paxil)	T1	QL(1 TAB/DAY) HD
sertraline 150 mg capsule	T1	QL(1 CAP/DAY) HD
sertraline 20 mg/ml oral conc (Zoloft)	T1	QL(10 MLS/DAY) HD
sertraline 200 mg capsule	T1	QL(1 CAP/DAY) HD
sertraline hcl 100 mg tablet (Zoloft)	T1	QL(2 TABS/DAY) HD
sertraline hcl 25 mg tablet (Zoloft)	T1	QL(8 TABS/DAY) HD
sertraline hcl 50 mg tablet (Zoloft)	T1	QL(4 TABS/DAY) HD
SEROTONIN-2 ANTAGONIST/REUPTAKE INHIBITORS (SARIS)		
nefazodone hcl	T1	HD
trazodone hcl	T1	HD
SEROTONIN-NOREPINEPHRINE REUPTAKE-INHIB (SNRIS)		
desvenlafaxine succnt er 100mg (Pristiq)	T1	QL(4 TABS/DAY) HD
desvenlafaxine succnt er 25 mg (Pristiq)	T1	QL(16 TABS/DAY) HD
desvenlafaxine succnt er 50 mg (Pristiq)	T1	QL(1 TAB/DAY) HD
duloxetine hcl dr 20 mg cap (Cymbalta)	T1	QL(6 CAPS/DAY) HD
duloxetine hcl dr 30 mg cap (Cymbalta)	T1	QL(4 CAPS/DAY) HD
duloxetine hcl dr 40 mg cap	T1	QL(3 CAPS/DAY) HD

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PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)[10] *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
SEROTONIN-NOREPINEPHRINE REUPTAKE-INHIB (SNRIS) *(cont.)*		
*duloxetine hcl dr 60 mg cap (*Cymbalta*)*	T1	QL(2 CAPS/DAY) HD
venlafaxine hcl 100 mg tablet	T1	QL(3 TABS/DAY) HD
venlafaxine hcl 25 mg tablet	T1	QL(15 TABS/DAY) HD
venlafaxine hcl 37.5 mg tablet	T1	QL(10 TABS/DAY) HD
venlafaxine hcl 50 mg tablet	T1	QL(7 TABS/DAY) HD
venlafaxine hcl 75 mg tablet	T1	QL(5 TABS/DAY) HD
*venlafaxine hcl er 150 mg cap (*Effexor Xr*)*	T1	QL(2 CAPS/DAY) HD
venlafaxine hcl er 150 mg tab	T1	QL(2 TABS/DAY) HD
venlafaxine hcl er 225 mg tab	T1	QL(1 TAB/DAY) HD
venlafaxine hcl er 37.5 mg cap (Effexor Xr*)*	T1	QL(8 CAPS/DAY) HD
venlafaxine hcl er 37.5 mg tab	T1	QL(8 TABS/DAY) HD
*venlafaxine hcl er 75 mg cap (*Effexor Xr*)*	T1	QL(4 CAPS/DAY) HD
venlafaxine hcl er 75 mg tab	T1	QL(4 TABS/DAY) HD
SSRI AND 5HTIA PARTIAL AGONIST ANTIDEPRESSANTS		
vilazodone hcl 10 mg tablet (Viibryd)	T1	QL(1 TAB/DAY) HD
*vilazodone hcl 20 mg tablet (*Viibryd*)*	T1	QL(1 TAB/DAY) HD
*vilazodone hcl 40 mg tablet (*Viibryd*)*	T1	HD
SSRI, SEROTONIN RECEPTOR MODULATOR ANTIDEPRESSANTS		
TRINTELLIX 10 MG TABLET	T2	QL(1 TAB/DAY)
TRINTELLIX 20 MG TABLET	T2	
TRINTELLIX 5 MG TABLET	T2	QL(1 TAB/DAY)
TRICYCLIC ANTIDEPRESSANT-BENZODIAZEPINE COMBINATNS		
amitriptyline/chlordiazepoxide	T1	HD
TRICYCLIC ANTIDEPRESSANT-PHENOTHIAZINE COMBINATNS		
perphenazine/amitriptyline hcl	T1	HD
TRICYCLIC ANTIDEPRESSANTS, REL.NON-SEL.REUPT-INHIB		
amitriptyline hcl	T1	HD
amoxapine	T1	HD
clomipramine hcl (Anafranil)	T1	HD
desipramine hcl	T1	HD
doxepin 10 mg capsule	T1	HD
doxepin 10 mg/ml oral conc	T1	HD
doxepin 100 mg capsule	T1	HD
doxepin 150 mg capsule	T1	HD

T1 – Typically Generics
T2 – Typically Preferred Brands
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AGE – Age Requirement
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HD – May require home delivery pharmacy

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CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)[10] *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
TRICYCLIC ANTIDEPRESSANTS, REL.NON-SEL.REUPT-INHIB *(cont.)*		
doxepin 25 mg capsule	T1	HD
doxepin 50 mg capsule	T1	HD
doxepin 75 mg capsule	T1	HD
imipramine hcl	T1	HD
imipramine pamoate	T1	HD
nortriptyline hcl	T1	HD
nortriptyline hcl (Pamelor)	T1	HD
protriptyline hcl	T1	HD
trimipramine maleate	T1	HD
PSYCHOTHERAPEUTIC DRUGS (Attention Deficit Hyperactivity Disorder)[9]		
ADRENERGICS, AROMATIC, NON-CATECHOLAMINE		
*lisdexamfetamine 10 mg capsule (*Vyvanse*)*	T1	PA QL(1 CAP/DAY)
*lisdexamfetamine 10 mg tb chew (*Vyvanse*)*	T1	PA QL(1 TAB/DAY)
*lisdexamfetamine 20 mg capsule (*Vyvanse*)*	T1	PA QL(1 CAP/DAY)
*lisdexamfetamine 20 mg tb chew (*Vyvanse*)*	T1	PA QL(1 TAB/DAY)
*lisdexamfetamine 30 mg capsule (*Vyvanse*)*	T1	PA QL(1 CAP/DAY)
*lisdexamfetamine 30 mg tb chew (*Vyvanse*)*	T1	PA QL(1 TAB/DAY)
*lisdexamfetamine 40 mg capsule (*Vyvanse*)*	T1	PA QL(1 CAP/DAY)
*lisdexamfetamine 40 mg tb chew (*Vyvanse*)*	T1	PA QL(1 TAB/DAY)
*lisdexamfetamine 50 mg capsule (*Vyvanse*)*	T1	PA QL(1 CAP/DAY)
*lisdexamfetamine 50 mg tb chew (*Vyvanse*)*	T1	PA QL(1 TAB/DAY)
*lisdexamfetamine 60 mg capsule (*Vyvanse*)*	T1	PA QL(1 CAP/DAY)
*lisdexamfetamine 60 mg tb chew (*Vyvanse*)*	T1	PA QL(1 TAB/DAY)
*lisdexamfetamine 70 mg capsule (*Vyvanse*)*	T1	PA QL(1 CAP/DAY)
TX FOR ADHD - SELECTIVE ALPHA-2 RECEPTOR AGONIST		
*clonidine hcl er 0.1 mg tablet (*Kapvay*)*	T1	
*guanfacine hcl (*Intuniv*)*	T1	HD
TX FOR ATTENTION DEFICIT-HYPERACT (ADHD) /NARCOLEPSY		
DAYTRANA (methylphenidate)	T3	PA QL(1 PATCH/DAY)
dexmethylphenidate hcl (Focalin Xr)	T1	PA QL(1 CAP/DAY)
dexmethylphenidate hcl (Focalin)	T1	PA
FOCALIN (*dexmethylphenidate hcl*)	T3	PA ST
METHYLIN *(methylphenidate hcl)*	T3	PA
*methylphenidate (*Daytrana*)*	T1	PA QL(1 PATCH/DAY)
*methylphenidate er 10 mg cap (*Aptensio Xr*)*	T1	PA QL(1 CAP/DAY)
methylphenidate er 10 mg tab	T1	PA QL(2 TABS/DAY)
*methylphenidate er 15 mg cap (*Aptensio Xr*)*	T1	PA QL(1 CAP/DAY)

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Attention Deficit Hyperactivity Disorder)[10] *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
TX FOR ATTENTION DEFICIT-HYPERACT (ADHD) /NARCOLEPSY *(cont.)*		
methylphenidate er 18 mg tab (Concerta)	T1	PA QL(1 TAB/DAY)
methylphenidate er 18 mg tab (Relexxii)	T1	PA QL(1 TAB/DAY)
methylphenidate er 20 mg cap (Aptensio Xr)	T1	PA QL(1 CAP/DAY)
methylphenidate er 20 mg tab	T1	PA QL(3 TABS/DAY)
methylphenidate er 27 mg tab (Concerta)	T1	PA QL(1 TAB/DAY)
methylphenidate er 27 mg tab (Relexxii)	T1	PA QL(1 TAB/DAY)
methylphenidate er 30 mg cap (Aptensio Xr)	T1	PA QL(1 CAP/DAY)
methylphenidate er 36 mg tab (Concerta)	T1	PA QL(2 TABS/DAY)
methylphenidate er 36 mg tab (Relexxii)	T1	PA QL(2 TABS/DAY)
methylphenidate er 40 mg cap (Aptensio Xr)	T1	PA QL(1 CAP/DAY)
methylphenidate er 50 mg cap (Aptensio Xr)	T1	PA QL(1 CAP/DAY)
methylphenidate er 54 mg tab (Concerta)	T1	PA QL(1 TAB/DAY)
methylphenidate er 54 mg tab (Relexxii)	T1	PA QL(1 TAB/DAY)
methylphenidate er 60 mg cap (Aptensio Xr)	T1	PA QL(1 CAP/DAY)
methylphenidate er 72 mg tab	T1	PA QL(1 TAB/DAY)
methylphenidate er(la) 10mg cp (Ritalin La)	T1	PA QL(1 CAP/DAY)
methylphenidate er(la) 20mg cp (Ritalin La)	T1	PA QL(1 CAP/DAY)
methylphenidate er(la) 30mg cp (Ritalin La)	T1	PA QL(2 CAPS/DAY)
methylphenidate er(la) 40mg cp (Ritalin La)	T1	PA QL(1 CAP/DAY)
methylphenidate er(la) 60mg cp	T1	PA QL(1 CAP/DAY)
methylphenidate hcl	T1	PA
methylphenidate hcl (Metadate Cd)	T1	PA QL(1 CAP/DAY)
methylphenidate hcl (Methylin)	T1	PA
methylphenidate hcl (Ritalin)	T1	PA
QUILLIVANT XR	T3	PA QL(12 MLS/DAY)
RITALIN *(methylphenidate hcl)*	T3	PA ST
TX FOR ATTENTION DEFICIT-HYPERACT. (ADHD) , NRI-TYPE		
atomoxetine hcl 10 mg capsule (Strattera)	T1	HD
atomoxetine hcl 100 mg capsule (Strattera)	T1	HD
atomoxetine hcl 18 mg capsule (Strattera)	T1	HD
atomoxetine hcl 25 mg capsule (Strattera)	T1	HD
atomoxetine hcl 40 mg capsule (Strattera)	T1	QL(1 CAP/DAY) HD

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List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Attention Deficit Hyperactivity Disorder)[10] *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
TX FOR ATTENTION DEFICIT-HYPERACT. (ADHD) , NRI-TYPE *(cont.)*		
atomoxetine hcl 60 mg capsule (Strattera)	T1	HD
atomoxetine hcl 80 mg capsule (Strattera)	T1	HD
PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics)[10]		
ANTIPSYCH, DOPAMINE ANTAG., DIPHENYLBUTYLPIPERIDINES		
pimozide	T1	
ANTIPSYCHOTIC, ATYPICAL, DOPAMINE, SEROTONIN ANTAGNST		
asenapine maleate (Saphris)	T1	
CAPLYTA	T3	ST QL(1 CAP/DAY)
clozapine	T1	
clozapine (Clozaril)	T1	
ERZOFRI 117 MG/0.75 ML SYRINGE	T2	QL(2 SYRINGES/28 DAYS)
ERZOFRI 156 MG/ML SYRINGE	T2	QL(1 SYRINGES/28 DAYS)
ERZOFRI 234 MG/1.5 ML SYRINGE	T2	QL(1 SYRINGES/28 DAYS)
ERZOFRI 351 MG/2.25 ML SYRINGE	T2	QL(1 SYRINGE/180 DAYS)
ERZOFRI 39 MG/0.25 ML SYRINGE	T2	QL(2 SYRINGES/28 DAYS)
ERZOFRI 78 MG/0.5 ML SYRINGE	T2	QL(2 SYRINGES/28 DAYS)
GEODON 20 MG/ML VIAL (*ziprasidone mesylate*)	T3	
INVEGA HAFYERA	T2	QL(1 SYRINGE/180 DAYS)
INVEGA SUSTENNA 117 MG/0.75 ML	T2	QL(2 SYRINGES/28 DAYS)
INVEGA SUSTENNA 156 MG/ML SYRG	T2	QL(1 SYRINGES/28 DAYS)
INVEGA SUSTENNA 234 MG/1.5 ML	T2	QL(1 SYRINGES/28 DAYS)
INVEGA SUSTENNA 39 MG/0.25 ML	T2	QL(2 SYRINGES/28 DAYS)
INVEGA SUSTENNA 78 MG/0.5 ML	T2	QL(2 SYRINGES/28 DAYS)
INVEGA TRINZA	T2	QL(2 SYRINGES/90 DAYS)
lurasidone hcl 120 mg tablet (Latuda)	T1	
lurasidone hcl 20 mg tablet (Latuda)	T1	
lurasidone hcl 40 mg tablet (Latuda)	T1	QL(1 TAB/DAY)
lurasidone hcl 60 mg tablet (Latuda)	T1	QL(1 TAB/DAY)
lurasidone hcl 80 mg tablet (Latuda)	T1	
olanzapine	T1	
olanzapine (Zyprexa Zydis)	T1	
olanzapine (Zyprexa)	T1	

T3 – Typically Non-Preferred Brands ST – Step Therapy HD – May require home delivery pharmacy

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics)[10] *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIPSYCHOTIC, ATYPICAL, DOPAMINE, SEROTONIN ANTAGNST *(cont.)*		
paliperidone er 1.5 mg tablet	T1	
paliperidone er 3 mg tablet (Invega)	T1	QL(1 TAB/DAY)
paliperidone er 6 mg tablet (Invega)	T1	
paliperidone er 9 mg tablet (Invega)	T1	
PERSERIS	T3	QL(1 UNIT/28 DAYS)
quetiapine fumarate (Seroquel Xr)	T1	
quetiapine fumarate 100 mg tab (Seroquel)	T1	
quetiapine fumarate 200 mg tab (Seroquel)	T1	
quetiapine fumarate 25 mg tab (Seroquel)	T1	
quetiapine fumarate 300 mg tab (Seroquel)	T1	
quetiapine fumarate 400 mg tab (Seroquel)	T1	
quetiapine fumarate 50 mg tab (Seroquel)	T1	
risperidone	T1	
risperidone (Risperdal)	T1	
risperidone microspheres (Risperdal Consta)	T1	QL(4 VIALS/28 DAYS)
RYKINDO	T3	QL(4 VIALS/28 DAYS)
SAPHRIS (*asenapine maleate*)	T3	ST
SECUADO	T3	ST
SEROQUEL (*quetiapine fumarate*)	T3	ST
UZEDY ER 100 MG/0.28 ML SYRING	T3	QL(1 UNIT/30 DAYS)
UZEDY ER 125 MG/0.35 ML SYRING	T3	QL(1 UNIT/30 DAYS)
UZEDY ER 150 MG/0.42 ML SYRING	T3	QL(1 UNIT/45 DAYS)
UZEDY ER 200 MG/0.56 ML SYRING	T3	QL(1 UNIT/45 DAYS)
UZEDY ER 250 MG/0.7 ML SYRINGE	T3	QL(1 UNIT/45 DAYS)
UZEDY ER 50 MG/0.14 ML SYRINGE	T3	QL(1 UNIT/30 DAYS)
UZEDY ER 75 MG/0.21 ML SYRINGE	T3	QL(1 UNIT/30 DAYS)
ziprasidone hcl (Geodon)	T1	
ziprasidone mesylate (Geodon)	T1	
ZYPREXA 10 MG VIAL (*olanzapine*)	T3	
ZYPREXA RELPREVV 210 MG VIAL	T3	QL(4 VIALS/28 DAYS)
ZYPREXA RELPREVV 210 MG VL KIT	T3	QL(4 VIALS/28 DAYS)
ZYPREXA RELPREVV 300 MG VIAL	T3	QL(4 VIALS/28 DAYS)
ZYPREXA RELPREVV 300 MG VL KIT	T3	QL(4 VIALS/28 DAYS)
ZYPREXA RELPREVV 405 MG VIAL	T3	QL(2 VIALS/28 DAYS)
ZYPREXA RELPREVV 405 MG VL KIT	T3	QL(2 VIALS/28 DAYS)

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List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics)[10] *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIPSYCHOTIC-ATYPICAL, D3/D2 PARTIAL AG-5HT MIXED		
VRAYLAR 1.5 MG CAPSULE	T3	ST QL(1 CAP/DAY)
VRAYLAR 3 MG CAPSULE	T3	ST QL(1 CAP/DAY)
VRAYLAR 4.5 MG CAPSULE	T3	ST
VRAYLAR 6 MG CAPSULE	T3	ST
ANTIPSYCHOTICS, ATYP, D2 PARTIAL AGONIST/5HT MIXED		
ABILIFY ASIMTUFII	T2	QL(1 UNIT/60 DAYS)
ABILIFY MAINTENA ER 300 MG SYR	T2	QL(2 VIALS/SYRINGES/30 DAYS)
ABILIFY MAINTENA ER 300 MG VL	T2	QL(2 VIALS/SYRINGES/30 DAYS)
ABILIFY MAINTENA ER 400 MG SYR	T2	QL(2 VIALS/SYRINGES/30 DAYS)
ABILIFY MAINTENA ER 400 MG VL	T2	
aripiprazole	T1	
aripiprazole 1 mg/ml solution	T1	
aripiprazole 10 mg tablet (Abilify)	T1	
aripiprazole 15 mg tablet (Abilify)	T1	
aripiprazole 2 mg tablet (Abilify)	T1	
aripiprazole 20 mg tablet (Abilify)	T1	
aripiprazole 30 mg tablet (Abilify)	T1	
aripiprazole 5 mg tablet (Abilify)	T1	QL(1 TAB/DAY)
ARISTADA ER 1064 MG/3.9 ML SYR	T2	
ARISTADA ER 441 MG/1.6 ML SYRN	T2	QL(2 UNITS/30 DAYS)
ARISTADA ER 662 MG/2.4 ML SYRN	T2	QL(2 UNITS/30 DAYS)
ARISTADA ER 882 MG/3.2 ML SYRN	T2	QL(2 UNITS/30 DAYS)
ARISTADA INITIO	T2	
REXULTI 0.25 MG TABLET	T2	ST QL(1 TAB/DAY)
REXULTI 0.5 MG TABLET	T2	ST QL(1 TAB/DAY)
REXULTI 1 MG TABLET	T2	ST QL(1 TAB/DAY)
REXULTI 2 MG TABLET	T2	ST QL(1 TAB/DAY)
REXULTI 3 MG TABLET	T2	ST
REXULTI 4 MG TABLET	T2	ST
ANTIPSYCHOTICS, DOPAMINE AND SEROTONIN ANTAGONISTS		
loxapine succinate	T1	
ANTIPSYCHOTICS,DOPAMINE ANTAGONISTS, THIOXANTHENES		
thiothixene	T1	
ANTIPSYCHOTICS, DOPAMINE ANTAGONISTS, BUTYROPHENONES		
droperidol	T1	
HALDOL (*haloperidol lactate*)	T3	

T3 – Typically Non-Preferred Brands ST – Step Therapy HD – May require home delivery pharmacy

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics)[10] *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIPSYCHOTICS, DOPAMINE ANTAGONISTS, BUTYROPHENONES *(cont.)*		
haloperidol decanoate	T3	
haloperidol lactate	T3	
ANTIPSYCHOTICS, DOPAMINE ANTAGONST, DIHYDROINDOLONES		
molindone hcl	T1	
ANTIPSYCHOTICS, PHENOTHIAZINES		
chlorpromazine hcl	T1	
fluphenazine decanoate	T1	
fluphenazine hcl	T1	
perphenazine	T1	
thioridazine hcl	T1	
trifluoperazine hcl	T1	
SSRI-ANTIPSYCH, ATYPICAL, DOPAMINE, SEROTONIN ANTAG		
olanzapine/fluoxetine hcl	T1	
PSYCHOTHERAPEUTIC DRUGS (Sleep Disorders/Sedatives)		
NARCOLEPSY AND SLEEP DISORDER THERAPY AGENTS		
armodafinil	T1	PA
modafinil (Provigil)	T1	PA
SUNOSI	T2	PA QL (1 tab/day)
SEDATIVE/HYPNOTICS (Sleep Disorders/Sedatives)		
ANTI-NARCOLEPSY, ANTI-CATAPLEXY, SEDATIVE-TYPE AGENT		
LUMRYZ	T3	PA QL(1 PACK/DAY) SP HD
LUMRYZ STARTER PACK	T3	PA QL SP HD
SODIUM OXYBATE 0.5 G/ML SOLN	T3	PA QL(18 MLS/DAY) SP HD
XYWAV	T3	PA QL(18 MLS/DAY) SP HD
BARBITURATES		
AMYTAL SODIUM	T3	
NEMBUTAL SODIUM (pentobarbital sodium)	T3	PA
pentobarbital sodium (Nembutal Sodium)	T1	PA
BARBITURATES *(cont.)*		
phenobarbital	T1	
phenobarbital sodium	T1	
HYPNOTICS, MELATONIN MT1/MT2 RECEPTOR AGONISTS		
HETLIOZ LQ	T3	PA SP HD
ramelteon (Rozerem)	T1	QL(1 TAB/DAY)
tasimelteon (Hetlioz)	T1	PA SP

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List of Prescription Medications

SEDATIVE/HYPNOTICS (Sleep Disorders/Sedatives) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
SEDATIVE-HYPNOTICS - BENZODIAZEPINES		
DORAL	T3	
estazolam	T1	
flurazepam hcl	T1	
HALCION (*triazolam*)	T3	
lorazepam	T1	
lorazepam (Ativan)	T1	
QUAZEPAM	T1	
temazepam (Restoril)	T1	
triazolam	T1	
triazolam (Halcion)	T1	
SEDATIVE-HYPNOTICS, NON-BARBITURATE		
DAYVIGO	T2	ST QL(1 TAB/DAY)
dexmedetomidine hcl	T1	
DEXMEDETOMIDINE HCL	T1	
dexmedetomidine in 0.9 % nacl	T1	
doxepin hcl 3 mg tablet (Silenor)	T1	QL(1 TAB/DAY)
doxepin hcl 6 mg tablet (Silenor)	T1	
eszopiclone (Lunesta)	T1	
PRECEDEX	T3	
PRECEDEX *(dexmedetomidine in 0.9 % nacl)*	T3	
zaleplon	T1	
zolpidem tart 1.75 mg tab sl	T1	
zolpidem tart 3.5 mg tablet sl	T1	
zolpidem tart er 12.5 mg tab (Ambien Cr)	T1	
zolpidem tart er 6.25 mg tab (Ambien Cr)	T1	QL(1 TAB/DAY)
zolpidem tartrate 10 mg tablet (Ambien)	T1	
zolpidem tartrate 5 mg tablet (Ambien)	T1	
SKIN PREPS (Miscellaneous)		
ANTISEPTICS,GENERAL		
alcohol antiseptic pads	T1	
ALCOHOL PREP PADS	T1	
ALCOHOL SWAB	T1	
ALCOHOL SWABS	T1	
ALCOHOL WIPES	T1	
CARETOUCH ALCOHOL PREP PAD	T1	

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List of Prescription Medications

SKIN PREPS (Miscellaneous)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTISEPTICS,GENERAL		
CURITY ALCOHOL PREPS	T1	
DROPSAFE PREP PADS	T1	
EASY COMFORT ALCOHOL PAD	T1	
EASY TOUCH ALCOHOL PREP PADS	T1	
INCONTROL ALCOHOL PADS	T1	
PRO COMFORT ALCOHOL PADS	T1	
PURE COMFORT ALCOHOL PAD	T1	
SINGLE USE SWAB	T1	
SURE COMFORT ALCOHOL	T1	
SURE-PREP ALCOHOL PREP PADS	T1	
TRUE COMFORT ALCOHOL PADS	T1	
TRUE COMFORT PRO ALCOHOL PADS	T1	
ULTILET ALCOHOL SWAB	T1	
WEBCOL	T1	
IRRIGANTS		
acetic acid	T1	
neomycin sulf/polymyxin b sulf	T1	
PHYSIOLYTE *(physiological irrig soln no.1)*	T3	
PHYSIOSOL *(physiological irrig soln no.1)*	T3	
ringer's solution	T1	
ringer's solution,lactated	T1	
sod,pot chlor/mag/sod,pot phos	T3	
sodium chloride 0.9% irrig	T1	
sodium chloride 0.9% irrig.	T1	
SODIUM CHLORIDE 0.9% IRRIG.	T3	
sodium chloride 0.9% prcss sol	T1	
sodium chloride irrig solution	T1	
SORBITOL	T1	
SORBITOL-MANNITOL	T1	
water for irrigation,sterile	T1	
OXIDIZING AGENTS		
hydrogen peroxide	T1	

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List of Prescription Medications

SKIN PREPS (Pain Relief And Inflammatory Disease)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIPSORIATIC AGENTS, SYSTEMIC		
acitretin	T1	
BIMZELX	T3	PA QL(2 MLS/28 DAYS) SP HD
BIMZELX AUTOINJECTOR	T3	PA QL(2 MLS/28 DAYS) SP HD
COSENTYX	T3	PA SP
COSENTYX (2 SYRINGES)	T3	PA QL(2 MLS/28 DAYS) SP HD
COSENTYX 150 MG/ML SYRINGE	T3	PA QL(1 ML/28 DAYS) SP HD
COSENTYX 75 MG/0.5 ML SYRINGE	T3	PA QL(0.5 MLS/28 DAYS) SP HD
COSENTYX SENSOREADY (2 PENS)	T3	PA QL(2 MLS/28 DAYS) SP HD
COSENTYX SENSOREADY PEN	T3	PA QL(1 ML/28 DAYS) SP HD
COSENTYX UNOREADY PEN	T3	PA QL(2 MLS/28 DAYS) SP HD
ILUMYA	T3	PA QL(1 UNIT/84 DAYS) SP HD
methoxsalen	T1	
SILIQ	T3	PA QL(3 MLS/28 DAYS) SP HD
SKYRIZI 150 MG/ML SYRINGE	T2	PA QL(150 MG/84 DAYS) SP HD
SKYRIZI PEN	T2	PA QL(150 MG/84 DAYS) SP HD
SOTYKTU	T2	PA QL(1 TAB/DAY) SP HD
SPEVIGO 150 MG/ML SYRINGE	T3	PA QL(2 MLS/28 DAYS) SP HD
SPEVIGO 300 MG/2 ML SYRINGE	T3	PA QL(2 MLS/28 DAYS) SP HD
SPEVIGO 450 MG/7.5 ML VIAL	T3	PA SP HD
TALTZ AUTOINJECTOR	T2	PA QL(1 AUTO-INJECTOR/28 DAYS) SP HD
TALTZ AUTOINJECTOR (2 PACK)	T2	PA QL(1 AUTO-INJECTOR/28 DAYS) SP HD
TALTZ AUTOINJECTOR (3 PACK)	T2	PA QL(1 AUTO-INJECTOR/28 DAYS) SP HD
TALTZ SYRINGE	T2	PA QL(1 SYRINGE/28 DAYS) SP HD
TOPICAL ANTI-INFLAMMATORY, NSAIDS		
diclofenac sodium 1% gel	T1	QL (1000gm/30 days) HD
SKIN PREPS (Skin Conditions)		
ACNE AGENTS, SYSTEMIC		
ABSORICA (isotretinoin)	T3	
isotretinoin (Absorica)	T1	
ACNE AGENTS, TOPICAL		
ACZONE 7.5% GEL PUMP (*dapsone*)	T3	
adapalene/benzoyl peroxide	T1	
adapalene/benzoyl peroxide (Epiduo Forte)	T1	
clindamycin phos/benzoyl perox	T1	
clindamycin phos/benzoyl perox (Acanya)	T1	
clindamycin/tretinoin (Veltin)	T1	

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List of Prescription Medications

SKIN PREPS (Skin Conditions) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ACNE AGENTS, TOPICAL		
clindamycin/tretinoin (Ziana)	T1	
clindamycin-benzoyl perox 1-5%	T1	
clindamycin-bnz perox 1-5% pmp	T1	
dapsone 5% gel (Aczone)	T1	
dapsone 7.5% gel pump (Aczone)	T1	
KLARON *(sulfacetamide sodium)*	T3	
neuac gel	T1	
ONEXTON *(clindamycin phos/benzoyl perox)*	T3	
sulfacetamide sodium (Klaron)	T1	
TWYNEO	T3	
sulfacetamide sodium (Klaron)	T1	
ANTIPERSPIRANTS		
DRYSOL	T3	
ANTIPSORIATICS AGENTS		
anthralin	T1	
calcipotriene 0.005% cream	T1	
CALCIPOTRIENE 0.005% FOAM	T3	
calcipotriene 0.005% ointment	T1	
calcipotriene 0.005% solution	T1	
calcitriol 3 mcg/g ointment (Vectical)	T1	QL(800 GMS/30 DAYS)
tazarotene 0.05% cream (Tazorac)	T1	
tazarotene 0.05% gel (Tazorac)	T1	
tazarotene 0.1% cream (Tazorac)	T1	
tazarotene 0.1% gel (Tazorac)	T1	
TAZORAC *(tazarotene)*	T3	
ANTISEBORRHEIC AGENTS		
OVACE PLUS	T1	
selenium sulfide	T1	
sulfacetamide sodium	T1	
ANTISEPTICS,GENERAL		
alcohol antiseptic pads	T1	
ALCOHOL PREP PADS	T1	
ALCOHOL SWAB	T1	
ALCOHOL SWABS	T1	
ALCOHOL WIPES	T1	

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List of Prescription Medications

SKIN PREPS (Skin Conditions) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTISEPTICS,GENERAL		
CARETOUCH ALCOHOL PREP PAD	T1	
CURITY ALCOHOL PREPS	T1	
DROPSAFE PREP PADS	T1	
EASY COMFORT ALCOHOL PAD	T1	
EASY TOUCH ALCOHOL PREP PADS	T1	
INCONTROL ALCOHOL PADS	T1	
PRO COMFORT ALCOHOL PADS	T1	
PURE COMFORT ALCOHOL PAD	T1	
SINGLE USE SWAB	T1	
SURE COMFORT ALCOHOL	T1	
SURE-PREP ALCOHOL PREP PADS	T1	
TRUE COMFORT ALCOHOL PADS	T1	
TRUE COMFORT PRO ALCOHOL PADS	T1	
ULTILET ALCOHOL SWAB	T1	
WEBCOL	T1	
ANTISEPTICS, MISCELLANEOUS		
GUAIACOL	T3	
EMOLLIENTS		
ammonium lactate	T1	
ATOPICLAIR	T3	
BIAFINE (*sonafine*)	T3	
IMMUNOMODULATORS		
imiquimod	T1	
IRRITANTS/COUNTER-IRRITANTS		
methyl salicylate	T1	
JANUS KINASE (JAK) INHIBITORS		
CIBINQO	T2	PA QL(30 TABS/30 DAYS) SP
KERATOLYTICS		
benzepro 6% foaming cloths	T1	
BENZEPRO 7% CREAMY WASH (*benzoyl peroxide microspheres*)	T3	
benzoyl peroxide	T1	
benzoyl peroxide (Pacnex)	T1	
ENZOCLEAR	T3	
INOVA	T3	

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SKIN PREPS (Skin Conditions) *(cont.)*		
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KERATOLYTICS *(cont.)*		
PACNEX (*benzoyl peroxide*)	T3	
podofilox	T1	
podofilox (Condylox)	T1	
PR BENZOYL PEROXIDE (*benzoyl peroxide microspheres*)	T3	
silver nitrate	T1	
PROTECTIVES		
BIONECT	T3	
PHARMABASE BARRIER (*zinc oxide*)	T3	
zinc oxide	T1	
ZINC OXIDE	T1	
ROSACEA AGENTS, TOPICAL		
azelaic acid (Finacea)	T1	
ivermectin 1% cream (Soolantra)	T1	
metronidazole	T1	
metronidazole (Metrocream)	T1	
metronidazole 0.75% cream (Metrocream)	T1	
metronidazole 0.75% lotion	T1	
metronidazole top 1% gel pump	T1	
metronidazole topical 0.75% gl		
metronidazole topical 1% gel (Metrogel)		
SOOLANTRA (*ivermectin*)	T1	
TISSUE/WOUND ADHESIVES		
ARTISS	T3	
TISSEEL VHSD	T3	
TOP. ANTI-INFLAM., PHOSPHODIESTERASE-4 (PDE4) INHIB		
EUCRISA	T2	
ZORYVE 0.15% CREAM	T2	PA QL(60 gms/30 days)
TOPICAL AGENTS, MISCELLANEOUS		
MEDIHONEY	T3	
trichloroacetic acid	T3	PA SP
TRICHLOROACETIC ACID	T3	
TRICHLOROACETIC ACID (*trichloroacetic acid*)	T3	
TOPICAL ANTIBIOTIC PLEUROMUTILIN DERIVATIVES		
ALTABAX	T3	

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SKIN PREPS (Skin Conditions) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
TOPICAL ANTI-INFLAMMATORY STEROIDAL		
ALA-SCALP (*hydrocortisone*)	T3	ST
alclometasone dipropionate	T1	
amcinonide 0.1% cream	T1	
AQUA GLYCOLIC HC	T3	
betamethasone dipropionate	T1	
betamethasone valerate	T1	
betamethasone/propylene glyc	T1	
betamethasone/propylene glyc (Diprolene)	T1	
BRYHALI	T3	ST
CAPEX SHAMPOO	T3	ST
clobetasol 0.05% cream	T1	
clobetasol 0.05% gel	T1	
clobetasol 0.05% ointment (Temovate)	T1	
clobetasol 0.05% shampoo (Clobex)	T1	
clobetasol 0.05% solution	T1	
clobetasol 0.05% topical lotn	T1	
clobetasol prop 0.05% foam (Olux)	T1	
clobetasol prop 0.05% spray (Clobex)	T1	
clobetasol propionate/emoll	T1	
clocortolone pivalate (Cloderm)	T1	
CLODAN 0.05% KIT	T3	ST
clodan 0.05% shampoo (Clobex)	T1	
CLODERM	T3	ST
CLODERM (clocortolone pivalate)	T3	ST
DERMA-SMOOTHE-FS *(fluocinolone acetonide)*	T3	ST
DERMA-SMOOTHE-FS *(fluocinolone/shower cap)*	T3	ST
desonide	T1	
desonide (Tridesilon)	T1	
desoximetasone (Topicort)	T1	
DIPROLENE *(betamethasone/propylene glyc)*	T3	ST
fluocinolone acetonide	T1	
fluocinolone acetonide (Derma-Smoothe-Fs)	T1	

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
TOPICAL ANTI-INFLAMMATORY STEROIDAL *(cont.)*		
fluocinolone acetonide (Synalar)	T1	
fluocinolone/shower cap (Derma-Smoothe-Fs)	T1	
fluocinonide	T1	
fluocinonide (Vanos)	T1	
fluocinonide/emollient base	T1	
fluticasone prop 0.005% oint	T1	
fluticasone prop 0.05% cream	T1	
fluticasone prop 0.05% lotion	T1	
fluticasone propionate	T1	
halcinonide 0.1% solution	T1	
halobetasol propionate	T1	
hydrocortisone	T1	
hydrocortisone (Ala-Scalp)	T1	
hydrocortisone (Anusol-Hc)	T1	
hydrocortisone acetate	T1	
hydrocortisone buty 0.1% cream	T1	
hydrocortisone butyr 0.1% oint	T1	
hydrocortisone butyr 0.1% soln	T1	
hydrocortisone valerate	T1	
mometasone furoate 0.1% cream	T1	
mometasone furoate 0.1% oint	T1	
mometasone furoate 0.1% soln	T1	
NUCORT	T3	ST
prednicarbate	T1	
SCALACORT DK	T3	ST
SYNALAR	T3	ST
SYNALAR *(fluocinolone acetonide)*	T3	ST
SYNALAR TS	T3	ST
TEMOVATE *(clobetasol propionate)*	T3	ST
TEXACORT	T3	*ST*
TOPICORT *(desoximetasone)*	T3	*ST*
triamcinolone 0.025% cream	T1	
triamcinolone 0.025% lotion	T1	
triamcinolone 0.025% oint	T1	
triamcinolone 0.1% cream	T1	

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SKIN PREPS (Skin Conditions) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
TOPICAL ANTI-INFLAMMATORY STEROIDAL *(cont.)*		
triamcinolone 0.1% lotion	T1	
triamcinolone 0.1% ointment	T1	
triamcinolone 0.5% cream	T1	
triamcinolone 0.5% ointment	T1	
triamcinolone acetonide	T1	
TOPICAL ANTI-INFLAMMATORY STEROID-LOCAL ANESTHETIC		
EPIFOAM	T2	
hydrocortisone/pramoxine	T1	
lidocaine/hydrocortisone ac	T1	
PRAMOSONE	T3	
TOPICAL JANUS KINASE (JAK) INHIBITORS		
OPZELURA	T3	PA
TOPICAL PREPARATIONS, ANTIBACTERIALS		
iodine/potassium iodide	T1	
iodine/sodium iodide	T1	
IODOFLEX	T3	
IODOSORB	T3	
silver nitrate	T1	
TOPICAL VIT D ANALOG/ANTI-INFLAMMATORY STEROID		
calcipotriene/betamethasone (Taclonex)	T1	
TOPICAL/MUCOUS MEMBR./SUBCUT. ENZYMES		
AMPHADASE	T3	
SANTYL	T3	QL(60 GMS/30 DAYS)
VITRASE	T3	
VITAMIN A DERIVATIVES		
adapalene 0.1% cream (Differin)	T1	PA
ADAPALENE 0.1% LOTION	T1	PA
adapalene 0.1% solution	T1	PA
adapalene 0.3% gel	T1	PA
adapalene 0.3% gel pump (Differin)	T1	PA
RETIN-A MICRO PUMP 0.08% GEL *(tretinoin microspheres)*	T3	PA
tretinoin 0.01% gel (Retin-A)	T1	
tretinoin 0.025% cream (Retin-A)	T1	PA
tretinoin 0.025% gel (Retin-A)	T1	
tretinoin 0.05% cream (Retin-A)	T1	PA

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SKIN PREPS (Skin Conditions) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
VITAMIN A DERIVATIVES		
tretinoin 0.05% gel (Atralin)	T1	PA
tretinoin 0.1% cream (Retin-A)	T1	PA
tretinoin microspheres (Retin-A Micro Pump)	T1	PA
tretinoin microspheres (Retin-A Micro)	T1	PA
SMOKING DETERRENTS (Smoking Cessation)		
SMOKING DETERRENT AGENTS (GANGLIONIC STIM,OTHERS)		
NICOTROL	T3	PPACA
NICOTROL NS	T3	PPACA
SMOKING DETERRENT-NICOTINIC RECEPT.PARTIAL AGONIST		
APO-VARENICLINE 0.5 MG TABLET	T3	
APO-VARENICLINE 1 MG TABLET	T3	
CHANTIX	T3	PA
varenicline 0.5 mg tablet	T1	PPACA
varenicline 1 mg cont month bx	T1	PPACA
varenicline 1 mg tablet	T1	PPACA
varenicline starting month box	T1	PPACA
SMOKING DETERRENTS, OTHER		
bupropion hcl sr 150 mg tablet	T1	PPACA
THYROID PREPS (Hormonal Agents)		
ANTITHYROID PREPARATIONS		
methimazole	T1	HD
propylthiouracil	T1	HD
THYROID FUNCTION DIAGNOSTIC AGENTS		
THYROGEN	T3	SP
THYROID HORMONES		
adthyza 120 mg tablet	T1	HD
adthyza 15 mg tablet	T1	HD
adthyza 30 mg tablet	T1	HD
adthyza 60 mg tablet	T1	HD
adthyza 90 mg tablet	T1	HD
CYTOMEL *(liothyronine sodium)*	T3	HD
levothyroxine 100 mcg tablet (Synthroid)	T1	HD
levothyroxine 100 mcg vial	T1	HD

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List of Prescription Medications

THYROID PREPS (Hormonal Agents) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
THYROID HORMONES *(cont.)*		
LEVOTHYROXINE 100 MCG/5 ML VL	T1	HD
LEVOTHYROXINE 100 MCG/ML VIAL	T3	HD
levothyroxine 112 mcg tablet (Synthroid)	T1	HD
levothyroxine 125 mcg tablet (Synthroid)	T1	HD
levothyroxine 137 mcg tablet (Synthroid)	T1	HD
levothyroxine 150 mcg tablet (Synthroid)	T1	HD
levothyroxine 175 mcg tablet (Synthroid)	T1	HD
levothyroxine 200 mcg tablet (Synthroid)	T1	HD
levothyroxine 200 mcg vial	T1	HD
LEVOTHYROXINE 200 MCG/5 ML VL	T1	HD
levothyroxine 25 mcg tablet (Synthroid)	T1	HD
levothyroxine 300 mcg tablet (Synthroid)	T1	HD
levothyroxine 50 mcg tablet (Synthroid)	T1	HD
levothyroxine 500 mcg vial	T1	HD
LEVOTHYROXINE 500 MCG/5 ML VL	T1	HD
levothyroxine 75 mcg tablet (Synthroid)	T1	HD
levothyroxine 88 mcg tablet (Synthroid)	T1	HD
levothyroxine sodium (Synthroid)	T1	HD
levothyroxine sodium (Synthroid)	T3	HD
liothyronine sod 10 mcg/ml vl (Triostat)	T1	
liothyronine sod 25 mcg tab (Cytomel)	T1	HD
liothyronine sod 5 mcg tab (Cytomel)	T1	HD
liothyronine sod 50 mcg tab (Cytomel)	T1	HD
liothyronine sodium (Cytomel)	T1	HD
thyroid,pork	T1	HD
TRIOSTAT (liothyronine sodium)	T3	
UNCLASSIFIED DRUG PRODUCTS (AIDS/HIV)		
CYTOCHROME P450 INHIBITORS		
TYBOST	T3	SP
UNCLASSIFIED DRUG PRODUCTS (Asthma/COPD/Respiratory)		
CYSTIC FIBROSIS-CFTR POTENTIATOR-CORRECTOR COMBIN.		
ALYFTREK 10-50-125 MG TABLET	T3	PA QL(2 TABS/DAY) SP HD
ALYFTREK 4-20-50 MG TABLET	T3	PA QL(3 TABS/DAY) SP HD
ORKAMBI 100 MG-125 MG TABLET	T3	PA QL(4 TABS/DAY) SP HD

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UNCLASSIFIED DRUG PRODUCTS (Asthma/COPD/Respiratory) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
CYSTIC FIBROSIS-CFTR POTENTIATOR-CORRECTOR COMBIN. *(cont.)*		
ORKAMBI 100-125 MG GRANULE PKT	T3	PA QL(2 PACKS/DAY) SP HD
ORKAMBI 150-188 MG GRANULE PKT	T3	PA QL(2 PACKS/DAY) SP HD
ORKAMBI 200 MG-125 MG TABLET	T3	PA QL(4 TABS/DAY) SP HD
ORKAMBI 75-94 MG GRANULE PKT	T3	PA QL(2 PACKS/DAY) SP HD
SYMDEKO	T3	PA QL(2 TABS/DAY) SP HD
TRIKAFTA 100-50-75 MG/150 MG	T3	PA QL(3 TABS/DAY) SP HD
TRIKAFTA 100-50-75 MG/75MG PKT	T3	PA QL(2 UNITS/DAY) SP HD
TRIKAFTA 50-25-37.5 MG/75 MG	T3	PA QL(3 TABS/DAY) SP HD
TRIKAFTA 80-40-60MG/59.5MG PKT	T3	PA QL(2 UNITS/DAY) SP HD
CYSTIC FIB-TRANSMEMB CONDUCT.REG. (CFTR) POTENTIATOR		
KALYDECO 13.4 MG GRANULES PKT	T3	PA QL(2 PACKS/DAY) SP HD
KALYDECO 150 MG TABLET	T3	PA QL(2 TABS/DAY) SP HD
KALYDECO 25 MG GRANULES PACKET	T3	PA QL(2 PACKS/DAY) SP HD
KALYDECO 5.8 MG GRANULES PKT	T3	PA QL(2 PACKS/DAY) SP HD
KALYDECO 50 MG GRANULES PACKET	T3	PA QL(2 PACKS/DAY) SP HD
KALYDECO 75 MG GRANULES PACKET	T3	PA QL(2 PACKS/DAY) SP HD
LUNG SURFACTANTS		
CUROSURF	T3	
INFASURF	T3	
SURVANTA	T3	
MUCOLYTICS		
PULMOZYME	T3	PA SP HD
PULMONARY FIBROSIS - SYSTEMIC ENZYME INHIBITORS		
OFEV	T2	PA SP HD
SYSTEMIC ENZYME INHIBITORS		
GLASSIA	T3	PA SP
JOENJA	T3	PA QL(2 TABS/DAY) SP
PROLASTIN C	T3	PA SP HD
VIJOICE 125 MG TABLET	T3	PA QL(1 TAB/DAY) SP
VIJOICE 250 MG DAILY DOSE PACK	T3	PA QL(2 TABS/DAY) SP
VIJOICE 50 MG GRANULE PACKET	T3	PA QL(1 TAB/DAY) SP
VIJOICE 50 MG TABLET	T3	PA QL(1 TAB/DAY) SP
ZOKINVY	T3	PA QL(4 CAPS/DAY) SP
SYSTEMIC ENZYME INHIBITORS		
TEZSPIRE 210 MG/1.91 ML PEN	T2	PA QL(1 PEN/28 DAYS) SP HD
TEZSPIRE 210 MG/1.91 ML SYRING	T2	PA SP HD

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UNCLASSIFIED DRUG PRODUCTS (Blood Modifiers/Bleeding Disorders)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIPORPHYRIA FACTORS		
PANHEMATIN	T3	SP
ERYTHROID MATURATION AGENTS		
REBLOZYL	T3	PA SP
SPLEEN TYROSINE KINASE INHIBITORS		
TAVALISSE	T3	PA SP
BRADYKININ B2 RECEPTOR ANTAGONISTS		
icatibant acetate	T1	PA SP HD
PLASMA KALLIKREIN INHIBITORS		
KALBITOR	T3	PA SP HD
ORLADEYO	T3	PA QL (1 CAPS/DAY) SP
UNCLASSIFIED DRUG PRODUCTS (Cancer)		
CHEMOTHERAPY RESCUE/ANTIDOTE AGENTS		
dexrazoxane hcl	T1	SP
ETHYOL *(amifostine crystalline)*	T3	SP
KHAPZORY	T3	PA
leucovorin cal 100 mg/10 ml vl	T1	
leucovorin cal 500 mg/50 ml vl	T1	
leucovorin calcium 10 mg tab	T1	CSL
leucovorin calcium 100 mg vial	T1	
leucovorin calcium 15 mg tab	T1	CSL
leucovorin calcium 200 mg vial	T1	
leucovorin calcium 25 mg tab	T1	CSL
leucovorin calcium 350 mg vial	T1	
leucovorin calcium 5 mg tab	T1	CSL
leucovorin calcium 50 mg vial	T1	
leucovorin calcium 500 mg vial	T1	
levoleucovorin calcium	T1	PA
mesna 1 gram/10 ml vial (Mesnex)	T1	SP
mesna 400 mg tablet (Mesnex)	T1	SP CSL
MESNEX 1 GRAM/10 ML VIAL (mesna)	T3	SP
MESNEX 400 MG TABLET (mesna)	T3	SP CSL
PEDMARK	T3	PA
VISTOGARD	T3	SP CSL
VORAXAZE	T3	PA SP
INTRAPLEURAL SCLEROSING AGENTS, ANTINEOPLAST. ADJ.		
SCLEROSOL	T3	CSL

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UNCLASSIFIED DRUG PRODUCTS (Cancer) *(cont.)*		
INTRAPLEURAL SCLEROSING AGENTS, ANTINEOPLAST. ADJ. (con't.)		
STERILE TALC	T1	CSL
STERITALC	T3	CSL
RADIOACTIVE THERAPEUTIC AGENTS		
LUTATHERA	T3	PA SP
strontium-89 chloride	T1	PA
XOFIGO	T3	PA
UNCLASSIFIED DRUG PRODUCTS (Dental Products)		
DENTAL AIDS AND PREPARATIONS		
chlorhexidine gluconate (Peridex)	T1	
PERIDEX (*chlorhexidine gluconate*)	T3	
triamcinolone 0.1% paste	T1	
triamcinolone acetonide	T1	
PERIODONTAL COLLAGENASE INHIBITORS		
doxycycline hyclate 20 mg tab	T1	
UNCLASSIFIED DRUG PRODUCTS (Diabetes)		
DISEASE MODIFYING AGENTS FOR TYPE I DIABETES		
TZIELD	T3	PA SP
INSULIN-LIKE GROWTH FACTOR RECEPTOR (IGF-R) INHIB		
TEPEZZA	T3	PA SP HD
OCULAR PHOTOACTIVATED VESSEL-OCCLUDING AGENTS		
VISUDYNE	T3	SP
UNCLASSIFIED DRUG PRODUCTS (Erectile Dysfunction)		
DRUGS TO TREAT ERECTILE DYSFUNCTION (ED)		
avanafil (Stendra)	T1	QL(8 TABS/30 DAYS)
CAVERJECT	T3	QL(6 INJECTIONS/30 DAYS)
CIALIS 10 MG TABLET (*tadalafil*)	T3	ST QL(8 TABS/30 DAYS)
CIALIS 20 MG TABLET (*tadalafil*)	T3	ST QL(8 TABS/30 DAYS)
CIALIS 5 MG TABLET (*tadalafil*)	T3	ST QL(1 TAB/DAY)
EDEX	T3	QL(6 INJECTIONS/30 DAYS)
IFE-BIMIX 30/1	T3	
MUSE	T3	QL(6 SUPPS/30 DAYS)
sildenafil 100 mg tablet (Viagra)	T1	QL(8 TABS/30 DAYS) HD

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List of Prescription Medications

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
UNCLASSIFIED DRUG PRODUCTS (Erectile Dysfunction)		
DRUGS TO TREAT ERECTILE DYSFUNCTION (ED)		
sildenafil 25 mg tablet (Viagra)	T1	QL(8 TABS/30 DAYS) HD
sildenafil 50 mg tablet (Viagra)	T1	QL(8 TABS/30 DAYS) HD
STENDRA (avanafil)	T3	ST QL(8 TABS/30 DAYS)
tadalafil 10 mg tablet (Cialis)	T1	QL(8 TABS/30 DAYS) HD
tadalafil 2.5 mg tablet	T1	QL(1 TAB/DAY) HD
tadalafil 20 mg tablet (Cialis)	T1	QL(8 TABS/30 DAYS) HD
tadalafil 5 mg tablet (Cialis)	T1	QL(1 TAB/DAY) HD
vardenafil hcl	T1	QL(8 TABS/30 DAYS)
VIAGRA (*sildenafil citrate*)	T3	ST QL(8 TABS/30 DAYS)
UNCLASSIFIED DRUG PRODUCTS (Eye Conditions)		
INSULIN-LIKE GROWTH FACTOR RECEPTOR (IGF-R) INHIB		
TEPEZZA	T3	PA SP HD
NICOTINIC RECEPT.PARTIAL AGONIST, ALPHA4BETA2 SPEC		
TYRVAYA	T2	QL(8.4 MLS/30 DAYS)
OCULAR PHOTOACTIVATED VESSEL-OCCLUDING AGENTS		
VISUDYNE	T3	SP
UNCLASSIFIED DRUG PRODUCTS (Gastrointestinal/Heartburn)		
ORAL MUCOSITIS/STOMATITIS AGENTS		
GELCLAIR	T3	
ORAMAGICRX	T3	
PPAR AGONIST		
IQIRVO	T2	
SALIVA STIMULANT AGENTS		
NUMOISYN	T3	
THYROID HORMONE RECEPTOR (THR) AGONIST		
REZDIFFRA	T3	PA QL(1 TAB/DAY) SP HD
UNCLASSIFIED DRUG PRODUCTS (Hormonal Agents)		
GROWTH HORMONE RECEPTOR ANTAGONISTS		
SOMAVERT	T2	PA SP HD
HYPERPARATHYROID TX AGENTS - VITAMIN D ANALOG-TYPE		
doxercalciferol	T1	
doxercalciferol (Hectorol)	T1	
paricalcitol 1 mcg capsule (Zemplar)	T1	SP HD

T1 – Typically Generics
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T3 – Typically Non-Preferred Brands

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List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Hormonal Agents)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
HYPERPARATHYROID TX AGENTS - VITAMIN D ANALOG-TYPE *(con't.)*		
PARICALCITOL 10 MCG/2 ML VIAL	T3	SP
paricalcitol 10 mcg/2 ml vial (Zemplar)	T1	SP
paricalcitol 2 mcg capsule (Zemplar)	T1	SP HD
PARICALCITOL 2 MCG/ML VIAL	T3	SP
paricalcitol 2 mcg/ml vial (Zemplar)	T1	SP
paricalcitol 4 mcg capsule	T1	SP HD
PARICALCITOL 5 MCG/ML VIAL	T3	SP
paricalcitol 5 mcg/ml vial (Zemplar)	T1	SP
RAYALDEE	T3	
ZEMPLAR 1 MCG CAPSULE (*paricalcitol*)	T3	SP HD
ZEMPLAR 10 MCG/2 ML VIAL (*paricalcitol*)	T3	SP
ZEMPLAR 2 MCG CAPSULE (*paricalcitol*)	T3	SP HD
ZEMPLAR 2 MCG/ML VIAL (*paricalcitol*)	T3	SP
ZEMPLAR 5 MCG/ML VIAL (*paricalcitol*)	T3	SP
MENOPAUSAL SYMPT SUPP-SEL ESTROGEN RECEP MODULATOR		
OSPHENA	T3	QL(30 TABS/30 DAYS) HD
UNCLASSIFIED DRUG PRODUCTS (Miscellaneous)		
ABORTIFACIENT-PROGESTERONE RECEPTOR ANTAGONISTS		
MIFEPREX	T3	
mifepristone 200 mg tablet	T1	
ACID AND ALKALI POISON ANTIDOTES		
METHYLENE BLUE 1% (20 MG/2 ML)	T3	
methylene blue 1% vial	T1	
methylene blue 50 mg/10 ml amp	T1	
methylene blue 50 mg/10ml vial	T1	
PROVAYBLUE	T3	
AGENTS TO TX PERIODIC PARALYSIS - CARBON ANHYD INH		
dichlorphenamide (Keveyis)	T1	PA SP HD
AMMONIA INHIBITORS		
CARBAGLU (carglumic acid)	T3	SP HD
carglumic acid (Carbaglu)	T1	SP HD
AMYLOIDOSIS AGENTS-TRANSTHYRETIN (TTR) SUPPRESSION		
AMVUTTRA	T3	PA SP
ONPATTRO	T3	PA SP

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UNCLASSIFIED DRUG PRODUCTS (Miscellaneous)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-ALCOHOLIC PREPARATIONS		
acamprosate calcium	T1	
disulfiram	T1	
VIVITROL	T3	SP HD
ANTIDOTES, MISCELLANEOUS		
ACETADOTE (*acetylcysteine*)	T3	
acetylcysteine (Acetadote)	T1	
CYANOKIT	T3	
DIGIFAB	T3	
fomepizole	T1	
SODIUM NITRITE	T1	
ANTIFIBROTIC THERAPY - PYRIDONE ANALOGS		
pirfenidone 267 mg capsule	T1	PA SP HD
pirfenidone 267 mg tablet (Esbriet)	T1	PA SP HD
pirfenidone 801 mg tablet (Esbriet)	T1	PA SP HD
CI ESTERASE INHIBITORS		
BERINERT	T3	PA SP HD
CINRYZE	T3	PA SP HD
HAEGARDA	T3	PA SP HD
RUCONEST	T3	PA SP HD
CALCIMIMETIC,PARATHYROID CALCIUM ENHANCER		
cinacalcet hcl (Sensipar)	T1	SP
PARSABIV	T3	PA SP
CATHETER LOCK SOLUTIONS		
DEFENCATH	T3	
CHOLINESTERASE REACTIVAT.-MUSCARINIC ANTG.ANTIDOTE		
DUODOTE	T3	
COMPLEMENT INHIBITORS		
VEOPOZ	T3	SP
CRYOPRESERVATIVE AGENTS		
dimethyl sulfoxide	T3	
DILUENT SOLUTIONS		
diluent for epoprostenol(glyc)	T1	
DILUENT FOR REMODULIN	T3	
diluent for treprostinil (gly)	T1	
ELLIOTTS B	T3	
PH 12 DILUENT FOR FLOLAN	T3	

List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DRUGS TO TREAT ACUTE HEPATIC PORPHYRIA (AHP)		
GIVLAARI	T3	PA SP HD
GENERAL INHALATION AGENTS		
HYPER-SAL	T3	
nebusal 3% vial	T1	
NEBUSAL 6% VIAL	T3	
sodium chloride 0.9% inhal vl	T1	
sodium chloride 10% vial	T1	
sodium chloride 3% vial	T1	
sodium chloride 7% vial	T1	
sodium chloride for inhalation	T1	
GENETIC D/O TX - SMN PROTEIN DEFICIENCY TREATMENT		
EVRYSDI	T3	PA SP HD
SPINRAZA	T3	PA SP HD
GENETIC D/O TX-EXON SKIPPING ANTISENSE OLIGONUCLEO		
AMONDYS-45	T3	PA SP
EXONDYS-51	T3	PA SP
VILTEPSO	T3	PA SP
VYONDYS-53	T3	PA SP
GLUCOSYLCERAMIDE SYNTHASE (GCS) INHIBITOR		
CERDELGA	T2	PA SP HD
miglustat (Zavesca)	T1	PA SP HD
OPFOLDA	T3	PA QL(8 CAPS/30 DAYS) SP HD
HYDROXYPHENYL-PYRUVATE DIOXYGENASE(HPPD) INHIBITOR		
nitisinone (Orfadin)	T1	PA SP HD
NITYR	T2	PA SP
ORFADIN	T3	PA SP
ORFADIN (*nitisinone*)	T3	PA SP
LEAD POISONING, AGENTS TO TREAT (CHELATING-TYPE)		
CALCIUM DISODIUM VERSENATE	T1	PA
EDETATE CALCIUM DISODIUM	T3	PA
MENOPAUSAL SYMPTOMS SUPPRESSANT - SSRIS		
paroxetine mesylate	T1	QL(1 CAP/DAY) HD
MESENCHYMAL STROMAL CELL (MSC)		
RYONCIL	T3	PA SP
METABOLIC DISEASE ENZYME REPLACE, HYPOPHOSPHATASIA		
STRENSIQ	T2	PA SP

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List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
METABOLIC DISEASE ENZYME REPLACEMENT, ASMD		
XENPOZYME	T3	PA SP HD
METABOLIC DISEASE ENZYME REPLACEMENT, BATTEN DISEA		
BRINEURA	T3	PA SP
METABOLIC DISEASE ENZYME REPLACEMENT, FABRY'S DX		
ELFABRIO	T3	PA SP
FABRAZYME	T3	PA SP HD
METABOLIC DISEASE ENZYME REPLACEMENT, GAUCHER'S DX		
CEREZYME	T3	PA SP HD
ELELYSO	T3	PA SP
VPRIV	T3	PA SP HD
METABOLIC DISEASE ENZYME REPLACEMENT, MOCD		
NULIBRY	T3	PA SP
METABOLIC DISEASE ENZYME REPLACEMENT, POMPE DISEASE		
LUMIZYME	T3	PA SP
NEXVIAZYME	T3	PA SP HD
POMBILITI	T3	PA SP HD
METABOLIC DX ENZYME REPLACE, MUCOPOLYSACCHARIDOSIS		
ALDURAZYME	T3	PA SP HD
ELAPRASE	T2	PA SP
MEPSEVII	T3	PA SP
NAGLAZYME	T3	PA SP
VIMIZIM	T3	PA SP
METABOLIC DX ENZYME REPLACEMENT,ALPHA-MANNOSIDOSIS		
LAMZEDE	T3	PA SP
METABOLIC DX ENZYME REPLACEMENT, LYSO.ACID LIP.DEF.		
KANUMA	T3	PA SP
METABOLIC DX ENZYME REPLACEMT, SEV.COMB.IMMUNE DEF.		
REVCOVI	T3	PA SP
METALLIC POISON, AGENTS TO TREAT		
BAL IN OIL	T3	PA
CHEMET	T3	
deferasirox (Exjade)	T1	SP HD
deferasirox (Jadenu Sprinkle)	T1	SP HD
deferasirox (Jadenu)	T1	SP HD
deferiprone (Ferriprox (3 Times A Day))	T1	PA SP HD

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UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
METALLIC POISON, AGENTS TO TREAT *(cont.)*		
deferiprone (Ferriprox)	T1	PA SP
deferoxamine mesylate	T1	
deferoxamine mesylate (Desferal Mesylate)	T1	
DESFERAL MESYLATE (*deferoxamine mesylate*)	T3	
EXJADE (*deferasirox*)	T3	PA SP HD
FERRIPROX (2 TIMES A DAY)	T3	PA SP
FERRIPROX 100 MG/ML SOLUTION	T3	PA SP
GALZIN	T3	SP
NITHIODOTE	T3	
PENTETATE CALCIUM TRISODIUM	T1	
PENTETATE ZINC TRISODIUM	T1	
RADIOGARDASE	T3	
sodium thiosulf (poison treat)	T1	
trientine hcl 250 mg capsule (Syprine)	T1	PA SP HD
TRIENTINE HCL 500 MG CAPSULE	T3	PA SP HD
NATRIURETIC PEPTIDES		
VOXZOGO	T3	PA SP HD
NEONATAL FC RECEPTOR (FCRN) INHIBITORS		
IMAAVY	T3	PA SP HD
RYSTIGGO	T3	PA SP
VYVGART	T3	PA SP HD
VYVGART HYTRULO	T3	PA SP HD
OINTMENT/CREAM BASES		
RADIAGEL	T3	
PHARMACOLOGICAL CHAPERONE-ALPHA-GALACTOSID.A STABZ		
GALAFOLD	T3	PA SP HD
PKU TX AGENT-COFACTOR OF PHENYLALANINE HYDROXYLASE		
*javygtor 100 mg powder packet (*Kuvan*)*	T1	PA SP
*javygtor 100 mg tablet (*Kuvan*)*	T1	PA SP HD
*javygtor 500 mg powder packet (*Kuvan*)*	T1	PA SP
*sapropterin dihydrochloride (*Kuvan*)*	T1	PA SP
*sapropterin dihydrochloride (*Kuvan*)*	T1	PA SP HD
PROTEIN STABILIZERS		
ATTRUBY	T3	PA QL(4 TABS/DAY) SP
VYNDAMAX	T3	PA QL(1 CAP/DAY) SP HD

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UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
PROTEIN STABILIZERS *(cont.)*		
VYNDAQEL	T3	PA QL(4 CAPS/DAY) SP
RETINOIC ACID RECEPTOR (RAR) AGONISTS		
SOHONOS	T3	PA SP
SODIUM/SALINE PREPARATIONS		
bacteriostatic saline vial	T1	
SOLVENTS		
INSTACLEAN	T3	
ISOPROPANOL	T3	
isopropyl alcohol	T3	
ISOPROPYL ALCOHOL	T3	
ISOPROPYL RUBBING ALCOHOL	T3	
MURI-LUBE MINERAL OIL	T3	
polyethylene glycol	T1	
SUSPENDING AGENTS		
GELFILM	T3	
HYDROXYPROPYLCELLULOSE	T3	
HYPROMELLOSE	T3	
TOPICAL/MUCOUS MEMBR./SUBCUT. ENZYMES		
HYLENEX		
TREATMENT OF HYPERPHAGIA IN PRADER-WILLI SYNDROME		
water for inj.,bacteriostatic	T1	
water for injection,sterile	T1	
water/me-paraben/propylparaben	T1	
UNCLASSIFIED DRUG PRODUCTS (Multiple Sclerosis)		
LEUKOCYTE ADHESION INHIB, ALPHA4-MEDIAT IGG4K MC AB		
TYRUKO	T3	PA SP
TYSABRI	T3	PA SP HD
UNCLASSIFIED DRUG PRODUCTS (Nutritional/Dietary)		
METABOLIC DEFICIENCY AGENTS		
betaine (Cystadane)	T1	SP
CULTURELLE IBS COMPLETE SUPPRT	T3	
CYSTADANE *(betaine)*	T3	SP
levocarnitine (Carnitor Sf)	T1	
levocarnitine (Carnitor)	T1	
levocarnitine (with sugar) (Carnitor)	T1	

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UNCLASSIFIED DRUG PRODUCTS (Osteoporosis Products)		
BONE FORMATION AGENTS - SCLEROSTIN INHIBITOR, MONO		
EVENITY	T3	PA QL(0.08 MLS/DAY) SP
EVENITY (2 SYRINGES)	T3	PA QL(0.08 MLS/DAY) SP
BONE FORMATION STIM. AGENTS - PARATHYROID HORMONE		
teriparatide (Bonsity)	T1	PA QL(0.09 MLS/DAY) SP HD
teriparatide (Forteo)	T1	PA QL(0.09 MLS/DAY) SP HD
BONE RESORPTION INHIBITOR AND VITAMIN D COMBS.		
FOSAMAX PLUS D	T3	ST HD
BONE RESORPTION INHIBITORS		
alendronate sodium	T1	HD
*alendronate sodium (*Fosamax*)*	T1	HD
ATELVIA *(risedronate sodium)*	T3	ST HD
BILDYOS	T3	PA SP
BILPREVDA	T3	PA SP
BINOSTO	T3	ST HD
FOSAMAX (*alendronate sodium*)	T3	ST HD
ibandronate 3 mg/3 ml syringe	T1	SP HD
ibandronate 3 mg/3 ml vial	T1	SP HD
ibandronate sodium 150 mg tab	T1	HD
JUBBONTI	T2	PA SP
pamidronate disodium	T1	SP HD
PROLIA	T3	PA SP
raloxifene hcl (Evista)	T1	HD PPACA
RECLAST (*zoledronic acid/mannitol-water*)	T3	SP HD
risedronate sodium	T1	HD
risedronate sodium (Actonel)	T1	HD
risedronate sodium (Atelvia)	T1	HD
WYOST	T2	PA SP
XGEVA	T3	PA SP
zoledronic acid 4 mg vial	T1	SP HD
zoledronic acid 4 mg/100 ml	T1	SP HD
ZOLEDRONIC ACID 4 MG/100 ML	T3	SP HD
zoledronic acid 4 mg/5 ml vial	T1	SP HD
zoledronic acid 5 mg/100 ml	T1	SP HD
zoledronic acid 5 mg/100 ml (Reclast)	T1	SP HD

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UNCLASSIFIED DRUG PRODUCTS (Osteoporosis Products)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
THYMIC STROMAL LYMPHOPOIETIN (TSLP) INHIBITORS		
TEZSPIRE 210 MG/1.91 ML PEN	T2	PA QL(1 pen/28 days) SP HD
TEZSPIRE 210 MG/1.91 ML SYRING	T2	PA SP HD
TREATMENT OF HYPERPHAGIA IN PRADER-WILLI SYNDROME		
VYKAT XR	T3	PA SP
TOPICAL/MUCOUS MEMBR./SUBCUT. ENZYMES		
HYLENEX	T3	SP HD
WATER		
water for inj., bacteriostatic	T1	
water for injection, sterile	T1	
water/me-paraben/propylparaben	T1	
UNCLASSIFIED DRUG PRODUCTS (Pain Relief And Inflammatory Disease)		
ANTI-INFLAM. INTERLEUKIN-I RECEPTOR ANTAGONIST		
ARCALYST	T3	PA SP HD
ANTI-INFLAMMATORY, INTERLEUKIN-I BETA BLOCKERS		
ILARIS	T3	PA SP HD
FIBROMYALGIA AGENTS, SEROTONIN-NOREPINEPH RU INHIB		
SAVELLA	T3	
IMMUNOMODULATOR, B-LYMPHOCYTE STIM (BLYS) -SPEC INHIB		
BENLYSTA 120 MG VIAL	T3	PA SP
BENLYSTA 200 MG/ML AUTOINJECT	T3	PA SP HD
BENLYSTA 200 MG/ML SYRINGE	T3	PA SP HD
BENLYSTA 400 MG VIAL	T3	PA SP
JOINT CONTRACTURE THERAPY, COLLAGENASE ENZYME		
XIAFLEX	T3	PA SP
UNCLASSIFIED DRUG PRODUCTS (Skin Conditions)		
INTERLEUKIN-13 (IL-13) INHIBITORS, MAB		
ADBRY	T2	PA SP HD
ADBRY AUTOINJECTOR	T2	PA SP HD
EBGLYSS PEN	T2	PA SP
WOUND HEALING AGENTS, LOCAL		
balsam peru/castor oil	T1	
FILSUVEZ	T3	PA SP
VENELEX	T3	

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UNCLASSIFIED DRUG PRODUCTS (Substance Abuse)		
OPIOID WITHDRAWAL THER, ALPHA-2 ADRENERGIC AGONIST		
lofexidine hcl (Lucemyra)	T1	QL(192 TABS/30 DAYS)
LUCEMYRA (*lofexidine hcl*)	T2	QL(192 TABS/30 DAYS)
OPIOID WITHDRAWAL THERAPY AGENTS, OPIOID-TYPE		
BRIXADI	T3	SP HD
buprenorphine hcl	T1	
buprenorphine hcl/naloxone hcl	T1	
buprenorphine hcl/naloxone hcl (Suboxone)	T1	
SUBLOCADE	T3	SP
SUBOXONE (*buprenorphine hcl/naloxone hcl*)	T3	
ZUBSOLV	T2	
UNCLASSIFIED DRUG PRODUCTS (Transplant Medications)		
RHO KINASE INHIBITOR		
REZUROCK	T3	PA SP
UNCLASSIFIED DRUG PRODUCTS (Urinary Tract Conditions)		
BENIGN PROSTATIC HYPERTROPHY/MICTURITION AGENTS		
alfuzosin hcl (Uroxatral)	T1	HD
dutasteride (Avodart)	T1	HD
finasteride (Proscar)	T1	HD
silodosin 4 mg capsule (Rapaflo)	T1	QL(1 CAP/DAY) HD
silodosin 8 mg capsule (Rapaflo)	T1	HD
tamsulosin hcl	T1	HD
BPH 5-ALPHA-REDUCTASE INHIB-ALPHAI-ADRENOCEP ANTAG		
dutasteride/tamsulosin hcl (Jalyn)	T1	HD
CYSTINE-DEPLETING AGENTS, NEPHROPATHIC CYSTINOSIS		
CYSTAGON	T2	SP
ENDOTHELIN RECEPTOR ANTAGONISTS		
VANRAFIA	T2	PA QL(1 TAB/DAY) SP
KIDNEY STONE AGENTS		
tiopronin (Thiola Ec)	T1	SP
tiopronin 100 mg tablet (Thiola)	T1	SP
tiopronin dr 100 mg tablet (Thiola Ec)	T1	SP HD
tiopronin dr 300 mg tablet (Thiola Ec)	T1	SP HD

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UNCLASSIFIED DRUG PRODUCTS (Urinary Tract Conditions)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
OVERACTIVE BLADDER AGENTS, BETA-3 ADRENERGIC RECEP		
mirabegron er 25 mg tablet (Myrbetriq)	T1	QL(1 TAB/DAY) HD
mirabegron er 50 mg tablet (Myrbetriq)	T1	HD
URINARY TRACT ANTISPASMODIC, M (3) SELECTIVE ANTAG.		
darifenacin er 15 mg tablet	T1	HD
darifenacin er 7.5 mg tablet	T1	QL(1 TAB/DAY) HD
solifenacin 10 mg tablet (Vesicare)	T1	HD
solifenacin 5 mg tablet (Vesicare)	T1	QL(1 TAB/DAY) HD
URINARY TRACT ANTISPASMODIC/ANTIINCONTINENCE AGENT		
fesoterodine er 4 mg tablet (Toviaz)	T1	QL(1 TAB/DAY) HD
fesoterodine er 8 mg tablet (Toviaz)	T1	HD
flavoxate hcl	T1	HD
oxybutynin 5 mg tablet	T1	HD
oxybutynin 5 mg/5 ml soln cup	T1	HD
oxybutynin 5 mg/5 ml solution	T1	HD
oxybutynin 5 mg/5 ml syrup	T1	HD
oxybutynin chloride	T1	HD
tolterodine tart er 2 mg cap (Detrol La)	T1	QL(1 CAP/DAY) HD
tolterodine tart er 4 mg cap (Detrol La)	T1	HD
tolterodine tartrate (Detrol)	T1	HD
trospium chloride	T1	HD
UNCLASSIFIED DRUG PRODUCTS (Weight Management)		
APPETITE STIM. FOR ANOREXIA, CACHEXIA, WASTING SYND.		
megestrol 400 mg/10 ml cup	T1	
megestrol 625 mg/5 ml susp	T1	
megestrol acet 40 mg/ml susp	T1	
megestrol acet 400 mg/10 ml	T1	
VITAMINS (Nutritional/Dietary)		
ANTIOXIDANT MULTIVITAMIN COMBINATIONS		
MACUVEX	T3	
MACUZIN	T3	
FOLIC ACID PREPARATIONS		
ENLYTE	T3	
folic acid	T1	
folic acid/b6/ca phos/ginger	T1	

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CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
GERIATRIC VITAMIN PREPARATIONS		
REQ49+	T3	
MULTIVITAMIN PREPARATIONS		
ANIMI-3	T3	
BACMIN	T3	
CONCEPT DHA (*mvn-min75/iron/iron ps/om3/dha*)	T3	
CONCEPT OB (*mvn-min 74/iron fum/iron/fa*)	T3	
CORVITE	T3	
DIALYVITE 800 WITH IRON	T3	
ENBRACE HR	T3	
folic/mvi ther-min/lycop/lut	T1	
FORTAVIT	T3	
INFUVITE ADULT	T3	
multivit 47/iron/folate 1/dha	T1	
multivit no.18/iron no.1/folic (Tandem Plus)	T1	
multivit no.51/iron/folic acid	T1	
multivit-min69/iron/folic acid	T1	
multivit-mins no.7/folic acid	T1	
mv-mins 71/iron/folic no.1/dha	T1	
mvn no.53/iron/folic/dss/dha	T1	
mvn-min 74/iron fum/iron/fa (Concept Ob)	T1	
mvn-min75/iron/iron ps/om3/dha (Concept Dha)	T1	
NEEVODHA	T3	
NESTABS ONE	T3	
NIVA-PLUS (*multivit-min 60/iron fum/folic*)	T1	
OB COMPLETE	T3	
om-3/dha/epa/b12/fa/b6/phytost	T1	
PRENATE AM	T3	
PRENATE CHEWABLE	T3	
PRENATE ESSENTIAL	T3	
PROTECT IRON	T3	
STROVITE FORTE (*multivit,iron,min 5/folic acid*)	T3	
STROVITE ONE	T3	
TANDEM PLUS (*multivit no.18/iron no.1/folic*)	T3	
UDAMIN SP	T3	

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
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VITAMINS (Nutritional/Dietary)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
PEDIATRIC VITAMIN PREPARATIONS		
FLORIVA	T3	PPACA
FLORIVA PLUS	T3	
INFUVITE PEDIATRIC	T3	
ped mvit a,c,d3 no.21/fluoride	T1	PPACA
pedi multivit 45/fluoride/iron	T1	PPACA
pedi multivit no.12 w-fluoride	T3	PPACA
pedi multivit no.17 w-fluoride	T1	PPACA
pedi multivit no.2 w-fluoride	T1	PPACA
POLY-VI-FLOR	T3	PPACA
QUFLORA 0.125 MG GUMMIES	T3	
QUFLORA FE	T3	
QUFLORA PED 0.25 MG CHEW TAB	T3	
QUFLORA PED 0.25 MG/ML DROP	T3	PPACA
QUFLORA PED 0.5 MG CHEW TAB	T3	
QUFLORA PED 0.5 MG/ML DROP	T3	PPACA
QUFLORA PED 1 MG CHEW TAB	T3	PPACA
SOLUVITA MULTIVITAMIN FLUORIDE	T3	PPACA
SOLUVITA MULTIVITAMIN FLUORIDE (*pedi multivit no.82 w-fluoride*)	T3	PPACA
TRI-VI-FLOR	T3	PPACA
VITALIPID N INFANT	T3	
VITLIPID N INFANT	T3	
VITALIPID N INFANT	T3	
VITLIPID N INFANT	T3	
VITAMIN A PREPARATIONS		
AQUASOL A	T3	
VITAMIN B PREPARATIONS		
b comp no3/folic/c/biotin/zinc	T1	HD
b complex 11/folic/c/biot/zinc	T1	HD
cyanocobalamin/folic ac/vit b6	T1	HD
cyanocobalamin/folic ac/vit b6 (Niva-Fol)	T1	HD
DIALYVITE 3000	T3	HD
DIALYVITE 5000	T3	HD
DIALYVITE SUPREME D	T3	HD
folic acid/vit b complex and c	T1	HD
folic acid/vit b complex and c	T2	HD

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List of Prescription Medications

VITAMINS (Nutritional/Dietary)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
VITAMIN B PREPARATIONS *(con't.)*		
folic acid/vit bcomp,c/cu/zinc	T1	HD
METHAVER	T3	HD
NEPHRON FA	T3	HD
NIVA-FOL (cyanocobalamin/folic ac/vit b6)	T1	HD
VITAL-D RX	T3	HD
vitamins b1,b2,b3,b5,and b6	T1	HD
VITA-RESPA	T3	HD
VITAMIN BI PREPARATIONS		
thiamine hcl	T1	
VITAMIN BI2 PREPARATIONS		
cyanocobalamin (vitamin b-12)	T1	
cyanocobalamin (vitamin b-12) (Nascobal)	T1	
hydroxocobalamin	T1	
VITAMIN B6 PREPARATIONS		
pyridoxine hcl (vitamin b6)	T1	
VITAMIN C PREPARATIONS		
ASCOR	T3	
ascorbic acid	T1	
VITAMIN D PREPARATIONS		
calcitriol 0.25 mcg capsule	T1	
calcitriol 0.5 mcg capsule	T1	
calcitriol 1 mcg/ml ampul	T1	
calcitriol 1 mcg/ml solution	T1	
calcitriol 1 mcg/ml vial	T1	HD
ergocalciferol (vitamin d2)	T1	HD
VITAMIN K PREPARATIONS		
MEPHYTON (*phytonadione (vit k1)*)	T3	
phytonadione (vit k1)	T1	
phytonadione 1 mg/0.5 ml syr	T1	
PHYTONADIONE 1 MG/0.5 ML SYR	T1	
PHYTONADIONE 1 MG/0.5 ML VIAL	T3	
phytonadione 10 mg/ml ampul	T1	
phytonadione 10 mg/ml vial	T1	
phytonadione 5 mg tablet (Mephyton)	T1	

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List of Prescription Medications

VITAMINS (Vitamins)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
MULTIVITAMIN PREPARATIONS		
CITRANATAL MEDLEY	T3	
VITLIPID N ADULT	T3	
PEDIATRIC VITAMIN PREPARATIONS		
POLY-VI-FLOR	T3	PPACA
POLY-VI-FLOR WITH IRON	T3	PPACA

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Exclusions and limitations for coverage

Health benefit plans vary, but in general to be eligible for coverage a drug must be approved by the Food and Drug Administration (FDA), prescribed by a health care professional, purchased from a licensed pharmacy and be medically necessary. If your plan provides coverage for certain preventive prescription drugs with no cost-share, you may be required to use an in-network pharmacy to fill the prescription. If you use a pharmacy that does not participate in your plan's network, the prescription may not be covered. Certain drugs may require prior authorization, or be subject to step therapy, quantity limits or other utilization management requirements.

Plans generally do not provide coverage for the following under the pharmacy benefit, except as required by state or federal law, or by the terms of your specific plan:[11]

- Over-the-counter (OTC) medicines (those that do not require a prescription) except insulin unless state or federal law requires coverage of such medicines.
- Prescription medications or supplies for which there is a prescription or OTC therapeutic equivalent or therapeutic alternative.
- Doctor-administered injectable medications covered under the Plan's medical benefit, unless otherwise covered under the Plan's prescription drug list or approved by Cigna Healthcare.
- Implantable contraceptive devices covered under the Plan's medical benefit.
- Medications that are not medically necessary.
- Experimental or investigational medications, including U.S. Food and Drug Administration (FDA)-approved medications used for purposes other than those approved by the FDA unless the medication is recognized for the treatment of the particular indication.
- Medications that are not approved by the FDA.
- Prescription and non-prescription devices, supplies, and appliances other than those supplies specifically listed as covered.
- Medications used for fertility,[12] sexual dysfunction, cosmetic purposes, weight loss, smoking cessation,[12] or athletic enhancement.
- Prescription vitamins (other than prenatal vitamins) or dietary supplements unless state or federal law requires coverage of such products.
- Immunization agents, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions and medications used for travel prophylaxis.
- Replacement of prescription medications and related supplies due to loss or theft.
- Medications which are to be taken by or administered to a covered person while they are a patient in a licensed hospital, skilled nursing facility, rest home or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceuticals.
- Prescriptions more than one year from the date of issue.
- Coverage for prescription medication products for the amount dispensed (days' supply) which is more than the applicable supply limit, or is less than any applicable supply minimum set forth in The Schedule, or which is more than the quantity limit(s) or dosage limit(s) set by the P&T Committee.
- More than one prescription order or refill for a given prescription supply period for the same prescription medication product prescribed by one or more doctors and dispensed by one or more pharmacies.
- Prescription medication products dispensed outside the jurisdiction of the United States, except as required for emergency or urgent care treatment.

In addition to the plan's standard pharmacy exclusions, certain new FDA-approved medication products (including, but not limited to, medications, medical supplies or devices that are covered under standard pharmacy benefit plans) may not be covered for the first six months of market availability unless approved by Cigna Healthcare as medically necessary.

Index of Medications

Symbols

A

Index of Medications

Index of Medications

B

Index of Medications

C

Index of Medications

Index of Medications

Index of Medications

D

Index of Medications

Index of Medications

Index of Medications

F

Index of Medications

Index of Medications

G

H

Index of Medications

Index of Medications

J

K

Index of Medications

L

Index of Medications

M

Index of Medications

Index of Medications

N

Index of Medications

O

Index of Medications

P

Index of Medications

Index of Medications

Index of Medications

Index of Medications

S

Index of Medications

Index of Medications

T

Index of Medications

Index of Medications

Index of Medications

W

X

Index of Medications

Y

Z

Cigna Healthcare reserves the right to make changes to the drug list without notice. Your plan may cover additional medications; please refer to your enrollment materials for details. Cigna Healthcare does not take responsibility for any medication decisions made by the doctor or pharmacist. Cigna Healthcare may receive payments from manufacturers of certain preferred brand medications, and in limited instances, certain non-preferred brand medications, that may or may not be shared with your plan depending on its arrangement with Cigna Healthcare. Depending upon plan design, market conditions, the extent to which manufacturer payments are shared with your plan and other factors as of the date of service, the preferred brand medication may or may not represent the lowest-cost brand medication within its class for you and/or your plan.

Health benefit plans vary, but in general to be eligible for coverage a drug must be approved by the U.S. Food and Drug Administration (FDA), prescribed by a health care professional, purchased from a licensed pharmacy and medically necessary. If your plan provides coverage for certain prescription drugs with no cost-share, you may be required to use an in-network pharmacy to fill the prescription. If you use a pharmacy that does not participate in your plan's network, your prescription may not be covered, or reimbursement may be limited by your plan's copayment, coinsurance or deductible requirements. Certain features described in this document may not be applicable to your specific health plan, and plan features may vary by location and plan type. Refer to your plan documents for costs and complete details of your plan's prescription drug coverage.

1. App/online store terms and mobile phone carrier/data charges apply. Customers under age 13 (and/or their parent/guardian) will not be able to register at myCigna.com.
2. Smoking cessation medications are not usually covered under the plan, except as required by law or by the terms of your specific plan. Costs and complete details of the plan's prescription drug coverage, including a full list of exclusions and limitations, are set forth in the plan documents. If there are any differences between the information provided here and the plan documents, the information in the plan documents takes complete precedence.
3. Prices shown on myCigna are not guaranteed and coverage is subject to your plan terms and conditions. Visit myCigna for more information.
4. U.S. Food and Drug Administration (FDA) website, "Generic Drug Facts." Content current as of 11/01/21. fda.gov/drugs/generic-drugs/generic-drug-facts.
5. U.S. Food and Drug Administration (FDA) website, "Biosimilar Basics for Patients." Last updated 08/01/24. fda.gov/drugs/biosimilars/biosimilars-basics-patients.
6. **Not all plans offer Express Scripts Pharmacy and Accredo as covered pharmacy options.** Log in to the myCigna App or myCigna.com, or check your plan materials, to learn more about the pharmacies in your plan's network. Cigna Healthcare, Evernorth Health Services, Express Scripts and Accredo are all part of The Cigna Group. This means we have an ownership interest in Express Scripts Pharmacy's home delivery services and Accredo's specialty pharmacy services. However, you have the right to fill prescriptions at any pharmacy in your plan's network (as your plan allows).
7. Your plan pays the cost for standard shipping.
8. Express Scripts Pharmacy can automatically refill certain medications. Log in to the myCigna App or myCigna.com, or call 800.835.3784, to sign up. You can sign up to get emails and/or texts from Express Scripts Pharmacy. To get text messages, you'll have to sign up for the Express Scripts texting service. You can do this online or when you call 800.835.3784 to refill your prescription. Once you sign up, just reply to their welcome text to get started. Standard text messaging rates apply.
9. You can only refill certain specialty medications by text. To get text messages, you'll have to sign up for Accredo's texting service. You can do this when you call Accredo to refill your prescription. Once you sign up, just reply to their welcome text to get started. Standard text messaging rates apply.
10. **For insured plans that must follow Delaware's state insurance laws:** Brand-name antidepressants, smoking cessation, attention deficit hyperactivity disorder (ADHD) and anti-psychotic medications that don't have a generic equivalent available will be covered as Tier 2 (preferred brand). This is true even if the medication is listed as Tier 3 (non-preferred brand) on your plan's drug list. To find out how your specific plans covers these medications, log in to the myCigna App or myCigna.com, or call the number on your ID card.
11. Costs and complete details of the plan's prescription drug coverage are set forth in the plan documents. If there are any differences between the information provided here and the plan documents, the information in the plan documents takes complete precedence.
12. **For plans that must follow state insurance laws, such as Delaware:** Your plan may provide coverage for infertility medications and smoking cessation medications even if this drug list states that your plan may not cover them. To find out if your specific plan covers these medications, log in to the myCigna App or myCigna.com, or check your plan materials.

Para obtener ayuda en español llame al número en su tarjeta de Cigna Healthcare.

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Discrimination is against the law.

Medical coverage

Cigna Healthcare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Cigna Healthcare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Cigna Healthcare:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact customer service at the toll-free number shown on your ID card, and ask a Customer Service Associate for assistance.

If you believe that Cigna Healthcare has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by sending an email to **ACAGrievance@Cigna.com** or by writing to the following address:

Cigna Healthcare
Nondiscrimination Complaint Coordinator
P.O. Box 188016
Chattanooga, TN 37422

If you need assistance filing a written grievance, please call the number on the back of your ID card or send an email to **ACAGrievance@Cigna.com**. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
1.800.368.1019, 800.537.7697 (TDD)

Complaint forms are available at
http://www.hhs.gov/ocr/office/file/index.html

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U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
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