



Cigna Healthcare Advantage 4-Tier Prescription Drug List

Coverage as of January 1, 2026

For the State of California

Exclusive Provider Organization (EPO), LocalPlus (LocalPlus IN/LocalPlus), Open Access Plus (OAPIN/OAP), Preferred Provider Organization (PPO), SureFit

View your drug list online: Cigna.com/PDL

24/7 Customer Service: **800.Cigna24 (800.244.6224)**

View your coverage info online: myCigna® App or myCigna.com®

Last updated: 01/01/2026. This drug list is subject to change and all prior versions are no longer in effect.



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View your drug list online, 24/7

This document was last updated on 01/01/2026.*

- You can use the Price a Medication tool on the myCigna App¹ or **myCigna.com** to see the most up-to-date list of the medications your plan covers.
- You can also see a pdf of this document on **Cigna.com/PDL**. Click on the dropdown next to "Drug Lists for Employer Plans." Scroll down to the section for California Employer Drug Lists; then click on **California Advantage 4 Tier (all specialty medications covered on tier 4) (CDI) [PDF]**.

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.

* Drug list created: originally created 01/01/2004

Last updated: 01/01/2026, for changes starting 01/01/2026

Next planned update: 04/01/2026, for changes starting 07/01/2026

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 1 and July 1.
- **Adding extra coverage rules (requirements) to a medication.** This typically happens twice a year on January 1 and July 1.

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) (cont.)

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.

Information about this drug list

Frequently asked questions (FAQs) (cont.)

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.

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. **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

Information about this drug list

Frequently asked questions (FAQs) (cont.)

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 chances 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 may⁴:

- 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).

Information about this drug list

Frequently asked questions (FAQs) (cont.)

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, Tier 3 and Tier 4 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 4-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. ³	\$
Tier 2	Preferred Brands. These medications typically have one or more lower-cost generic that treats the same condition.	\$\$
Tier 3	Non-Preferred Brands. Non-preferred brands typically have a generic and/or preferred brand alternative(s) that treats the same condition.	\$\$\$
Tier 4	Specialty. These medications are covered at your plan's highest cost-share. This tier includes both injectable and oral (those you take by mouth) specialty medications.	\$\$\$\$

* 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 4-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		
<i>butalbital/acetaminophen</i>	T1	
ANALGESIC, SALICYLATE, BARBITURATE, XANTHINE COMB.		
<i>butalb-aspirin-caffe 50-325-40</i>	T1	QL (6 tabs/day)
<i>butalbital-asa-caffeine cap</i> (Fiorinal)	T1	QL (6 caps/day)
FIORINAL (<i>butalbital-aspirin-caffeine</i>)	T3	QL (6 caps/day)
ANALGESIC, NON-SALICYLATE, BARBITURATE, XANTHINE COMB.		
<i>butalb/acetaminophen/caffeine</i>	T3	
<i>butalb/acetaminophen/caffeine</i> (Esgic)	T3	QL (6 caps/day)
<i>butalb-acetamin-caff 50-300-40</i> (Fioricet)	T1	QL (6 caps/day)
<i>butalb-acetamin-caff 50-325-40</i> (Esgic)	T1	QL (6 tabs/day)
ESGIC 50-325-40 MG TABLET (<i>butalbital-acetaminophen-caffe</i>)	T3	QL (6 tabs/day)
ESGIC CAPSULE (<i>zebutal</i>)	T3	QL (6 caps/day)
FIORICET (<i>phrenilin forte</i>)	T1	QL (6 caps/day)
ANALGESIC/ANTIPYRETICS, SALICYLATES		
<i>choline salicyl/mag salicylate</i>	T1	HD
<i>diflunisal</i>	T1	HD
ANTI-MIGRAINE PREPARATIONS		
AIMOVIG AUTOINJECTOR	T2	PA
AJOVY AUTOINJECTOR	T2	PA
AJOVY SYRINGE	T2	PA
<i>almotriptan malate</i>	T1	QL (12 tabs/30 days)
CAFERGOT (<i>ergotamine-caffeine</i>)	T3	QL (40 tabs/28 days)
<i>dihydroergotamine 1 mg/ml amp</i>	T1	QL (10 amps/30 days)
<i>eletriptan hydrobromide</i>	T1	QL (6 tabs/30 days)
EMGALITY PEN	T2	PA
EMGALITY SYRINGE	T2	PA
<i>ergotamine tartrate/caffeine</i>	T1	
<i>ergotamine tartrate/caffeine</i> (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.

Condition	Page	Condition	Page
Analgesics (Pain Relief and Inflammatory Disease)	19-28	ANTIINFECTIVES/MISCELLANEOUS (Miscellaneous)	62
Analgesics (Urinary Tract Conditions)	28	Anti-Inflammatory Tumor Necrosis Factor Inhibiting Agents (Pain Relief and Inflammatory Disease)	62, 63
Anesthetics (Miscellaneous)	28, 29	Anti-Neoplastics (Cancer)	63-80
Anesthetics (Pain Relief and Inflammatory Disease)	29-31	Anti-Neoplastics (Skin Conditions)	80
Anesthetics (Urinary Tract Conditions)	32	ANTIPARASITICS (Eye Conditions)	80
Anti-Allergy (Allergy and Nasal Sprays)	32	Anti-Parasitics (Infections)	80, 81
ANTIALLERGY (Skin Conditions)	32	Anti-Parkinson's Drugs (Parkinson's Disease)	81, 82
Anti-Arthritics (Pain Relief and Inflammatory Disease)	32-36	Anti-Platelet Drugs (Blood Thinners/Anti-Clotting)	82, 83
Anti-Asthmatics (Asthma/COPD/Respiratory)	36-38	Antivirals (Aids/Hiv)	83-86
Antibiotics (Ear Medications)	38, 39	Antivirals (Eye Conditions)	86
Antibiotics (Eye Conditions)	39	Antivirals (Infections)	86-88
Antibiotics (Infections)	40-49	Antivirals (Skin Conditions)	88
Antibiotics (Miscellaneous)	49	Autonomic Drugs (Allergy/Nasal Sprays)	88
Antibiotics (Skin Conditions)	49, 50	Autonomic Drugs (Alzheimer's Disease)	88, 89
Anti-Coagulants (Blood Thinners/Anti-Clotting)	50-52	Autonomic Drugs (Attention Deficit Hyperactivity Disorder)	89
Antidotes (Gastrointestinal/Heartburn)	53	Autonomic Drugs (Blood Pressure/Heart Medications)	89, 90
Antidotes (Substance Abuse)	53	Autonomic Drugs (Miscellaneous)	90, 91
Anti-Fungals (Eye Conditions)	53	Autonomic Drugs (Urinary Tract Conditions)	91
Anti-Fungals (Feminine Products)	53	Biologicals (Allergy/Nasal Sprays)	91
Anti-Fungals (Infections)	53-55	Biologicals (Blood Pressure/Heart Medications)	91
Anti-Fungals (Skin Conditions)	55	Biologicals (Miscellaneous)	91, 92
Antihistamine and Decongestant Combination (Allergy/Nasal Sprays)	55, 56	Biologicals (Vaccines)	92-96
Antihistamines (Allergy/Nasal Sprays)	56	Biologicals (Allergy/Nasal Sprays)	87
Antihistamines (Eye Conditions)	56	Biologicals (Blood Pressure/Heart Medications)	87
Anti-Hyperglycemics (Diabetes)	56-60	Biologicals (Miscellaneous)	87, 88
ANTIINFECTIVES (Infections)	61	Biologicals (Vaccines)	88-90

Information about this drug list

How to find your medication (cont.)

Condition	Page	Condition	Page
Blood (Blood Modifiers/Bleeding Disorders)	96-98	Elect/Caloric/H2O (Miscellaneous)	138-140
Blood (Blood Thinners/Anti-Clotting)	98, 99	Elect/Caloric/H2O (Nutritional/Dietary)	140-146
Cardiac Drugs (Blood Pressure/Heart Medications)	99-103	Elect/Caloric/H2O (Urinary Tract Conditions)	146, 147
CARDIOVASCULAR (Allergy/Nasal Sprays)	103,104	Gastrointestinal (Cholesterol Medications)	147
Cardiovascular (Asthma/COPD/Respiratory)	104, 105	Gastrointestinal (Gastrointestinal/Heartburn)	147-154
Cardiovascular (Blood Pressure/Heart Medications)	105-110	Gastrointestinal (Pain Relief and Inflammatory Disease)	154
Cardiovascular (Cholesterol Medications)	111-113	Gastrointestinal (Skin Conditions)	155
Cardiovascular (Miscellaneous)	113	Hormones (Gastrointestinal/Heartburn)	155
CNS Drugs (Alzheimer's Disease)	113, 114	Hormones (Hormonal Agents)	155-161
CNS Drugs (Miscellaneous)	114, 115	Hormones (Infertility)	161, 162
CNS DRUGS (Multiple Sclerosis)	115, 116	Hormones (Miscellaneous)	162
CNS Drugs (Pain Relief and Inflammatory Disease)	116	Hormones (Osteoporosis Products)	162
CNS Drugs (Seizure Disorders)	117-121	Immunosuppressants (Miscellaneous)	162
CNS Drugs (Sleep Disorders/Sedatives)	121	Immunosuppressants (Pain Relief and Inflammatory Disease)	162-164
Colony Stimulating Factors (Blood Modifiers/Bleeding Disorders)	121, 122	Immunosuppressants (Skin Conditions)	164
COLONY STIMULATING FACTORS (Blood Pressure/Heart Medications)	122	Immunosuppressants (Transplant Medications)	164, 165
Colony Stimulating Factors (Cancer)	122	Miscellaneous Medical Supplies, Devices, Non-Drug (Diabetes)	165-184
Contraceptives (Contraception Products)	123, 124	Miscellaneous Medical Supplies, Devices, Non-Drug (Diagnostic Test Devices, Supplies, and Services Miscellaneous)	184-190
Cough/Cold Preparations (Allergy/Nasal Sprays)	124	Muscle Relaxants (Pain Relief and Inflammatory Disease)	190, 191
Cough/Cold Preparations (Cough/Cold Medications)	124, 125	Prenatal Vitamins (Nutritional/Dietary)	191-193
Diagnostic (Diabetes)	125	Psychotherapeutic Drugs (Anxiety/Depression/Bipolar Disorder)	193-198
Diagnostic (Miscellaneous)	125-131	Psychotherapeutic Drugs (Attention Deficit Hyperactivity Disorder)	198-200
Diuretics (Diuretics)	131, 132	Psychotherapeutic Drugs (Schizophrenia/Anti-Psychotics)	200-203
EENT Preps (Allergy/Nasal Sprays)	133	Psychotherapeutic Drugs (Sleep Disorders/Sedatives)	203
EENT Preps (Ear Medications)	133	Sedative/Hypnotics (Sleep Disorders/Sedatives)	203, 204
EENT Preps (Eye Conditions)	133-137	Skin Preps (Miscellaneous)	204, 205
Elect/Caloric/H2O (Cholesterol Medications)	137		
Elect/Caloric/H2O (Dental Products)	137, 138		
Elect/Caloric/H2O (Diabetes)	138		

Information about this drug list

How to find your medication (cont.)

Condition	Page	Condition	Page
Skin Preps (Skin Conditions)	206-213	Unclassified Drug Products (Multiple Sclerosis)	224
SMOKING DETERRENTS (Smoking Cessation)	213	Unclassified Drug Products (Nutritional/Dietary)	224
Thyroid Prep (Hormonal Agents)	213, 214	Unclassified Drug Products (Osteoporosis Products)	225, 226
Unclassified Drug Products (Aids/Hiv)	214	Unclassified Drug Products (Pain Relief and Inflammatory Disease)	226
Unclassified Drug Products (Asthma/COPD/Respiratory)	214, 215	Unclassified Drug Products (Skin Conditions)	226
Unclassified Drug Products (Blood Modifiers/Bleeding Disorders)	216	Unclassified Drug Products (Substance Abuse)	227
Unclassified Drug Products (Cancer)	216, 217	Unclassified Drug Products (Transplant Medications)	227
Unclassified Drug Products (Dental Products)	217	Unclassified Drug Products (Urinary Tract Conditions)	227, 228
UNCLASSIFIED DRUG PRODUCTS (Diabetes)	217	Unclassified Drug Products (Weight Management)	228
UNCLASSIFIED DRUG PRODUCTS (Erectile Dysfunction)	217, 218	Vitamins (Nutritional/Dietary)	228-231
Unclassified Drug Products (Eye Conditions)	218	Vitamins (Vitamins)	232
Unclassified Drug Products (Gastrointestinal/Heartburn)	218		
UNCLASSIFIED DRUG PRODUCTS (Hormonal Agents)	218, 219		
Unclassified Drug Products (Miscellaneous)	219-224		

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		
<i>butalbital/acetaminophen</i>	T1	
<i>butalbital-acetaminophen 50-325</i>	T1	
ANALGESIC, SALICYLATE, BARBITURATE, XANTHINE COMB.		
<i>butalbital-aspirin-caffeine cp</i>	T1	QL(6 CAPS/DAY)
<i>butalbital-aspirin-caffeine tb</i>	T1	QL(6 TABS/DAY)
ANALGESIC, NON-SALICYLATE, BARBITURATE, XANTHINE COMB.		
<i>butalb/acetaminophen/caffeine (Esgic)</i>	T3	QL(6 CAPS/DAY)
<i>butalb-acetamin-caff 50-300-40 (Fioricet)</i>	T1	QL(6 CAPS/DAY)
<i>butalb-acetamin-caff 50-325-40</i>	T1	QL(6 TABS/DAY)
<i>butalb-acetamin-caff 50-325-40 (Esgic)</i>	T1	QL(6 CAPS/DAY)
ANALGESIC/ANTIPYRETICS, SALICYLATES		
<i>diflunisal</i>	T1	HD
ANALGESIC/ANTIPYRETICS, NON-SALICYLATES		
<i>acetaminophen 1,000mg/100ml vial</i>	T1	
<i>acetaminophen 1000mg/100ml bag</i>	T1	
ACETAMINOPHEN 1000MG/100ML BAG	T3	
<i>acetaminophen 500 mg/50 ml bag</i>	T1	
ACETAMINOPHEN 500 MG/50 ML BAG	T3	
<i>acetaminophen 650 mg/65 ml bag</i>	T1	
ANALGESICS, NEURONAL-TYPE CALCIUM CHANNEL BLOCKERS		
PRIALT	T4	SP
ANALGESICS, NON-OPIOID		
<i>clonidine 1,000 mcg/10 ml vial (Duraclon)</i>	T1	
<i>clonidine 5,000 mcg/10 ml vial</i>	T1	
DURACLON (<i>clonidine hcl/pf</i>)	T3	
ANTI-MIGRAINE PREPARATIONS		
AIMOVIG AUTOINJECTOR	T2	PA
AJOVY AUTOINJECTOR	T2	PA
AJOVY AUTOINJECTOR (3 PACK)	T2	PA
AJOVY SYRINGE	T2	PA
<i>almotriptan malate</i>	T1	QL(12 TABS/30 DAYS)
<i>dihydroergotamine 1 mg/ml amp</i>	T1	QL
<i>eletriptan hydrobromide (Relpax)</i>	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

T4 – Specialty Medications
 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.)		
<i>ergotamine tartrate/caffeine</i>	T1	QL(40 TABS/28 DAYS)
<i>frovatriptan succinate (Frova)</i>	T1	QL(18 TABS/30 DAYS)
<i>naratriptan hcl</i>	T1	QL(9 TABS/30 DAYS)
NURTEC ODT	T2	PA QL(16 TABS/30 DAYS)
QULIPTA	T2	PA QL(1 TAB/DAY)
<i>rizatriptan benzoate</i>	T1	QL(12 TABS/30 DAYS)
<i>rizatriptan benzoate (Maxalt Mlt)</i>	T1	QL(12 TABS/30 DAYS)
<i>rizatriptan benzoate (Maxalt)</i>	T1	QL(12 TABS/30 DAYS)
<i>sumatriptan</i>	T1	QL(12 UNITS/30 DAYS)
<i>sumatriptan 4 mg/0.5 ml inject (Imitrex)</i>	T1	QL(4 MLS/30 DAYS)
<i>sumatriptan 6 mg/0.5 ml vial</i>	T1	QL(5 MLS/30 DAYS)
<i>sumatriptan 6 mg/0.5ml autoinj (Imitrex)</i>	T1	QL(4 MLS/30 DAYS)
<i>sumatriptan succ 100 mg tablet (Imitrex)</i>	T1	QL(9 TABS/30 DAYS)
<i>sumatriptan succ 25 mg tablet (Imitrex)</i>	T1	QL(9 TABS/30 DAYS)
<i>sumatriptan succ 50 mg tablet (Imitrex)</i>	T1	QL(9 TABS/30 DAYS)
<i>sumatriptan succ/naproxen sod (Treximet)</i>	T1	QL(18 TABS/30 DAYS)
UBRELVY	T2	PA QL(0.67 TABS/DAY)
VYEPTI	T4	PA SP
ZAVZPRET	T2	PA QL(6 UNITS/30 DAYS)
<i>zolmitriptan</i>	T1	QL(6 TABS/30 DAYS)
<i>zolmitriptan 2.5 mg tablet (Zomig)</i>	T1	QL(6 TABS/30 DAYS)
<i>zolmitriptan 5 mg tablet (Zomig)</i>	T1	QL(6 TABS/30 DAYS)
NSAIDS, CYCLOOXYGENASE INHIBITOR-TYPE ANALGESICS		
<i>diclofenac pot 50 mg tablet</i>	T1	HD
<i>diclofenac potassium</i>	T1	HD
<i>ketorolac 10 mg tablet</i>	T1	QL(20 TABS/30 DAYS)
<i>ketorolac 15 mg/ml syringe</i>	T1	QL(8 MLS/DAY)
<i>ketorolac 15 mg/ml vial</i>	T1	QL(8 MLS/DAY)
<i>ketorolac 30 mg/ml syringe</i>	T1	QL(4 MLS/DAY)
<i>ketorolac 30 mg/ml vial</i>	T1	QL(4 MLS/DAY)

T1 – Typically Generics
 T2 – Typically Preferred Brands
 T3 – Typically Non-Preferred Brands

T4 – Specialty Medications
 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
NSAIDS, CYCLOOXYGENASE INHIBITOR-TYPE ANALGESICS (cont.)		
<i>ketorolac 300 mg/10 ml vial</i>	T1	
<i>ketorolac 60 mg/2 ml syringe</i>	T1	QL(4 MLS/DAY)
<i>ketorolac 60 mg/2 ml vial</i>	T1	QL(4 MLS/DAY)
OPIOID ANALGESIC AND NON-SALICYLATE ANALGESICS		
<i>acetamin-codein 300-30 mg/12.5</i>	T1	
<i>acetaminop-codeine 120-12 mg/5</i>	T1	
<i>acetaminophen-cod #2 tablet</i>	T1	PA
<i>acetaminophen-cod #3 tablet</i>	T1	PA
<i>acetaminophen-cod #4 tablet</i>	T1	PA
<i>hydrocodone/acetaminophen</i>	T1	PA
<i>hydrocodone/acetaminophen (Lortab)</i>	T1	PA
HYDROCODONE-ACETAMINOPHEN	T1	PA
LORTAB (<i>hydrocodone/acetaminophen</i>)	T1	PA
NALOCET	T1	PA
<i>oxycodone hcl/acetaminophen</i>	T1	PA
<i>oxycodone hcl/acetaminophen (Percocet)</i>	T1	PA
PRIMLEV	T1	PA
<i>prolate 10-300 mg tablet</i>	T1	PA
<i>prolate 5-300 mg tablet</i>	T1	PA
<i>prolate 7.5-300 mg tablet</i>	T1	PA
<i>tramadol hcl/acetaminophen</i>	T1	
OPIOID ANALGESIC AND NSAID COMBINATION		
<i>hydrocodone/ibuprofen</i>	T1	PA
ALFENTANIL HCL (<i>alfentanil hcl</i>)	T3	PA
<i>fentanyl 1,000 mcg/20 ml vial</i>	T1	
<i>fentanyl 100 mcg/2 ml ampul</i>	T1	
<i>fentanyl 100 mcg/2 ml syringe</i>	T1	
<i>fentanyl 100 mcg/2 ml vial</i>	T1	
<i>fentanyl 2,500 mcg/50 ml bag</i>	T1	
<i>fentanyl 2,500 mcg/50 ml vial</i>	T1	
FENTANYL 25 MCG/0.5 ML SYRINGE	T3	
<i>fentanyl 250 mcg/5 ml ampul</i>	T1	
FENTANYL 250 MCG/5 ML SYRINGE	T1	
<i>fentanyl 250 mcg/5 ml vial</i>	T1	

T1 – Typically Generics
 T2 – Typically Preferred Brands
 T3 – Typically Non-Preferred Brands

T4 – Specialty Medications
 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
OPIOID ANALGESIC, ANESTHETIC ADJUNCT AGENTS		
<i>fentanyl 5,000 mcg/100 ml bag</i>	T1	
<i>fentanyl 50 mcg/ml syringe</i>	T1	
<i>remifentanyl hcl (Ultiva)</i>	T1	PA
<i>sufentanyl citrate</i>	T1	PA
<i>fentanyl 50 mcg/ml vial</i>	T1	
<i>fentanyl 500 mcg/10 ml vial</i>	T1	
<i>fentanyl citrate/pf</i>	T1	
<i>remifentanyl hcl (Ultiva)</i>	T1	PA
<i>sufentanyl citrate</i>	T1	PA
ULTIVA (<i>remifentanyl hcl</i>)	T3	PA
OPIOID ANALGESIC AND NON-SALICYLATE XANTHINE COMB		
<i>acetaminophen/caff/dihydrocod</i>	T1	PA
TREZIX	T3	PA
OPIOID ANALGESICS		
ACTIQ (<i>fentanyl citrate</i>)	T3	PA
BELBUCA	T2	QL(2 FILMS/DAY)
<i>buprenorphine (Butrans)</i>	T1	QL(4 PATCHES/28 DAYS)
<i>buprenorphine hcl</i>	T1	
<i>butorphanol 1 mg/ml vial</i>	T1	
<i>butorphanol 10 mg/ml spray</i>	T1	PA QL(6 BOTTLES/30 DAYS)
<i>butorphanol 2 mg/ml vial</i>	T1	
<i>butorphanol 4 mg/2 ml vial</i>	T1	
BUTRANS (<i>buprenorphine</i>)	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	

T1 – Typically Generics
 T2 – Typically Preferred Brands
 T3 – Typically Non-Preferred Brands

T4 – Specialty Medications
 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
OPIOID ANALGESICS (cont.)		
<i>fentanyl</i>	T1	PA
<i>fentanyl 1 mg/100 ml-0.9% nacl</i>	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	
<i>fentanyl 1,000mcg/50-0.9% nacl</i>	T1	
<i>fentanyl 1,250mcg/250-0.9%nacl</i>	T1	
<i>fentanyl 10 mcg/ml-0.9% nacl</i>	T1	
<i>fentanyl 100 mcg/2 ml carpuct</i>	T1	
FENTANYL 100 MCG/2 ML CARPUJCT	T1	
<i>fentanyl 100 mcg/2 ml syringe</i>	T1	
<i>fentanyl 2 mcg-bup 0.0625%-ns</i>	T1	
FENTANYL 2 MCG-BUP 0.0625%-NS	T1	
FENTANYL 2 MCG-BUPIV 0.1%-NS	T1	
<i>fentanyl 2 mcg-bupiv 0.125%-ns</i>	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	
<i>fentanyl 2,000mcg/100-0.9%nacl</i>	T1	
FENTANYL 2,500 MCG/50 ML SYRNG	T1	
<i>fentanyl 2,500 mcg/50 ml-ns</i>	T1	
FENTANYL 2,500MCG/250-0.9%NACL	T1	
FENTANYL 2,750 MCG/55 ML SYRNG	T1	
<i>fentanyl 2.5mg/250ml-0.9% nacl</i>	T1	
FENTANYL 2.5MG/250ML-0.9% NACL	T1	
FENTANYL 250 MCG/5 ML SYRINGE	T1	
FENTANYL 4 MCG-BUPIV 0.125%-NS	T1	
<i>fentanyl 5,000mcg/250-0.9%nacl</i>	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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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
OPIOID ANALGESICS (cont.)		
FENTANYL CIT 600 MCG BUCCAL TB	T1	PA
FENTANYL CIT 800 MCG BUCCAL TB	T1	PA
<i>fentanyl cit otc 1,600 mcg (Actiq)</i>	T1	PA
<i>fentanyl citrate otc 200 mcg</i>	T1	PA
<i>fentanyl citrate otc 400 mcg</i>	T1	PA
<i>fentanyl citrate otc 800 mcg</i>	T1	PA
<i>fentanyl/ropivacaine/ns/pf</i>	T1	
FENTANYL-ROPIVACAINE-0.9% NACL	T1	
<i>hydrocodone bitartrate</i>	T1	PA
<i>hydrocodone bitartrate (Hysingla Er)</i>	T1	PA
<i>hydromorphone 0.2 mg/ml syring</i>	T1	PA
HYDROMORPHONE 0.25 MG/0.5 ML	T3	PA
HYDROMORPHONE 0.5 MG/0.5 ML	T3	PA
<i>hydromorphone 0.5 mg/0.5ml syr</i>	T1	PA
<i>hydromorphone 1 mg/ml carpuct</i>	T1	PA
<i>hydromorphone 1 mg/ml solution (Dilaudid)</i>	T1	PA
<i>hydromorphone 1 mg/ml syringe</i>	T1	PA
HYDROMORPHONE 1 MG/ML VIAL	T3	PA
HYDROMORPHONE 1 MG/ML-NS SYRNG (<i>hydromorphone hcl/0.9% nacl/pf</i>)	T3	PA
<i>hydromorphone 10 mg/50 ml-ns</i>	T1	PA
HYDROMORPHONE 10 MG/50 ML-NS	T3	PA
HYDROMORPHONE 10 MG/50 ML-NS (<i>hydromorphone hcl/0.9% nacl/pf</i>)	T3	PA
<i>hydromorphone 10 mg/50 ml-ns (Hydromorphone Hcl-0.9% Nacl)</i>	T1	PA
<i>hydromorphone 10 mg/ml ampule</i>	T1	PA
<i>hydromorphone 10 mg/ml vial</i>	T1	PA
<i>hydromorphone 15 mg/30 ml-ns</i>	T1	
<i>hydromorphone 2 mg tablet (Dilaudid)</i>	T1	PA
<i>hydromorphone 2 mg/ml carpuct</i>	T1	PA
<i>hydromorphone 2 mg/ml syringe</i>	T1	PA
<i>hydromorphone 2 mg/ml vial</i>	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
<i>hydromorphone 3 mg suppos</i>	T1	PA
HYDROMORPHONE 30 MG/30 ML-NS	T3	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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

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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 (<i>morphine sulfate/0.9% nacl/pf</i>)	T3	PA
<i>morphine 2 mg/2 ml-nacl syring</i>	T1	PA
<i>morphine 2 mg/ml carpuject</i>	T1	PA
<i>morphine 2 mg/ml syringe</i>	T1	PA
MORPHINE 2 MG/ML SYRINGE	T3	PA
MORPHINE 2 MG/ML-0.9% NACL SYR (<i>morphine sulfate/0.9% nacl/pf</i>)	T3	PA
<i>morphine 30 mg/30 ml pca vial</i>	T1	PA
<i>morphine 30 mg/30 ml-0.9% nacl</i>	T1	PA
<i>morphine 30 mg/30 ml-nacl syrg</i>	T1	PA
<i>morphine 4 mg/ml carpuject</i>	T1	PA
<i>morphine 4 mg/ml syringe</i>	T1	PA
MORPHINE 4 MG/ML-0.9% NACL SYR (<i>morphine sulfate/0.9% nacl/pf</i>)	T3	PA
<i>morphine 5 mg/10 ml vial</i>	T1	PA
<i>morphine 5 mg/5 ml-0.9% nacl</i>	T1	PA
<i>morphine 50 mg/50 ml-0.9% nacl</i>	T1	PA
MORPHINE 50 MG/50 ML-0.9% NACL	T3	PA
MORPHINE 50 MG/50 ML-0.9% NACL (<i>morphine sulfate/0.9% nacl/pf</i>)	T3	
<i>morphine 50 mg/50 ml-nacl syrg</i>	T1	
MORPHINE 500MG/100ML-0.9% NACL	T3	PA
MORPHINE 55 MG/55 ML-0.9% NACL	T3	PA
<i>morphine sulf 1,000 mg/20 ml</i>	T1	PA
<i>morphine sulf 10 mg suppos</i>	T1	PA
<i>morphine sulf 10 mg/5 ml cup</i>	T1	PA
<i>morphine sulf 10 mg/5 ml soln</i>	T1	PA
<i>morphine sulf 100 mg/5 ml conc</i>	T1	PA
<i>morphine sulf 2,500 mg/50 ml</i>	T1	PA
<i>morphine sulf 20 mg suppos</i>	T1	PA
<i>morphine sulf 20 mg/5 ml soln</i>	T1	PA
<i>morphine sulf 30 mg suppos</i>	T1	PA
<i>morphine sulf 5 mg suppos</i>	T1	PA
<i>morphine sulfate</i>	T1	PA
<i>morphine sulfate (Ms Contin)</i>	T1	PA
<i>morphine sulfate 10 mg/ml vial</i>	T1	PA

T1 – Typically Generics
 T2 – Typically Preferred Brands
 T3 – Typically Non-Preferred Brands

T4 – Specialty Medications
 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
OPIOID ANALGESICS (cont.)		
MORPHINE SULFATE 10 MG/ML VIAL (<i>morphine sulfate</i>)	T3	PA
MORPHINE SULFATE 2 MG/ML VIAL	T3	PA
<i>morphine sulfate 4 mg/ml vial</i>	T1	PA
MORPHINE SULFATE 4 MG/ML VIAL	T3	PA
MORPHINE SULFATE 5 MG/ML VIAL (<i>morphine sulfate</i>)	T3	PA
<i>morphine sulfate 50 mg/ml vial</i>	T1	PA
MORPHINE SULFATE 8 MG/ML VIAL	T3	PA
<i>morphine sulfate ir 15 mg tab</i>	T1	PA
<i>morphine sulfate ir 30 mg tab</i>	T1	PA
<i>morphine sulfate/pf</i>	T3	PA
MS CONTIN (<i>morphine sulfate</i>)	T3	PA
<i>nalbuphine hcl</i>	T1	
NUCYNTA	T3	PA
NUCYNTA ER	T3	PA
OLINVYK	T3	PA
<i>opium/belladonna alkaloids</i>	T1	PA
OXAYDO	T3	PA
<i>oxycodone hcl (ir) 10 mg tab</i>	T1	PA
<i>oxycodone hcl (ir) 15 mg tab</i> (Roxicodone)	T1	PA
<i>oxycodone hcl (ir) 20 mg tab</i>	T1	PA
<i>oxycodone hcl (ir) 30 mg tab</i> (Roxicodone)	T1	PA
<i>oxycodone hcl (ir) 5 mg cap</i>	T1	PA
<i>oxycodone hcl (ir) 5 mg tablet</i> (Roxicodone)	T1	PA
<i>oxycodone hcl 100 mg/5 ml conc</i>	T1	PA
<i>oxycodone hcl 5 mg/5 ml cup</i>	T1	PA
<i>oxycodone hcl 5 mg/5 ml soln</i>	T1	PA
OXYCODONE HCL ER	T1	PA
<i>oxymorphone hcl</i>	T1	PA
<i>pentazocine hcl/naloxone hcl</i>	T1	PA
ROXYBOND	T3	PA
<i>tramadol er 100 mg tablet</i>	T1	QL(1 TAB/DAY)
<i>tramadol er 200 mg tablet</i>	T1	QL(1 TAB/DAY)
<i>tramadol er 300 mg tablet</i>	T1	QL(1 TAB/DAY)
<i>tramadol hcl 100 mg tablet</i>	T1	QL(4 TABS/DAY)
<i>tramadol hcl 50 mg tablet</i>	T1	QL(8 TABS/DAY)

T1 – Typically Generics
 T2 – Typically Preferred Brands
 T3 – Typically Non-Preferred Brands

T4 – Specialty Medications
 PA – Prior Authorization
 QL – Quantity Limit

ST – Step Therapy
 AGE – Age Requirement
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HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
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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.)		
TRAMADOL HCL 75 MG TABLET	T3	QL(5 TABS/DAY)
TRAMADOL HCL ER 100 MG CAPSULE	T1	QL(1 CAP/DAY)
<i>tramadol hcl er 100 mg tablet</i>	T1	QL(1 TAB/DAY)
TRAMADOL HCL ER 200 MG CAPSULE	T1	QL(1 CAP/DAY)
<i>tramadol hcl er 200 mg tablet</i>	T1	QL(1 TAB/DAY)
TRAMADOL HCL ER 300 MG CAPSULE	T1	QL(1 CAP/DAY)
<i>tramadol hcl er 300 mg tablet</i>	T1	QL(1 TAB/DAY)
XTAMPZA ER	T2	PA
OPIOID, SALICYLATE, ANALGESIC, BARBITUATE, XANTHINE		
<i>codeine/butalbital/asa/caffeine</i>	T1	PA
OPIOID, NON-SALICYL. ANALGESIC, BARBITUATE, XANTHINE		
<i>butalbit/acetamin/caff/codeine</i>	T1	PA
<i>butalbit/acetamin/caff/codeine (Fioricet With Codeine)</i>	T1	PA
SKELETAL MUSCLE RELAXANT, SALICYLATE, OPIOID ANALGESIC		
<i>carisoprodol/aspirin/codeine</i>	T1	PA
ANALGESICS (Urinary Tract Conditions)		
URINARY TRACT ANALGESIC AGENTS		
ELMIRON	T3	
RIMSO-50	T3	
ANESTHETICS (Miscellaneous)		
GENERAL ANESTHETICS, INHALANT		
<i>desflurane</i>	T1	
<i>isoflurane</i>	T1	
<i>isoflurane</i>	T3	
<i>sevoflurane (Ultane)</i>	T1	
SUPRANE	T3	
ULTANE (<i>sevoflurane</i>)	T3	
GENERAL ANESTHETICS, INJECTABLE		
AMIDATE (<i>etomidate</i>)	T3	
BREVITAL SODIUM	T3	
DIPRIVAN (<i>propofol</i>)	T3	
<i>etomidate (Amidate)</i>	T1	
KETALAR	T3	
KETALAR (<i>ketamine hcl</i>)	T3	
<i>ketamine hcl</i>	T1	

T1 – Typically Generics
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List of Prescription Medications

ANESTHETICS (Miscellaneous) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GENERAL ANESTHETICS, INJECTABLE-BENZODIAZEPINE TYPE		
KETAMINE HCL	T1	
<i>ketamine hcl</i> (Ketalar)	T1	
<i>ketamine hcl in 0.9% nacl</i>	T1	
KETAMINE HCL-0.9% NACL	T1	
<i>methohexital sodium</i>	T1	
METHOHEXITAL-STERILE WATER	T1	
<i>propofol</i> (Diprivan)	T1	
<i>midazolam hcl</i>	T1	
<i>midazolam hcl/pf</i>	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 (<i>lidocaine with 8.4% sod bicarb</i>)	T3	
<i>bupivacaine hcl</i> (Marcaine)	T1	
<i>bupivacaine hcl</i> (Sensorcaine)	T1	
<i>bupivacaine hcl in dextrose/pf</i>	T1	
<i>bupivacaine hcl/epinephrine</i> (Marcaine-Epinephrine)	T1	
<i>bupivacaine hcl/epinephrine/pf</i> (Marcaine-Epinephrine)	T1	
<i>bupivacaine hcl/epinephrine/pf</i> (Sensorcaine-Mpf Epinephrine)	T1	
<i>bupivacaine hcl/pf</i>	T1	
<i>bupivacaine hcl/pf</i> (Marcaine)	T1	
<i>bupivacaine hcl/pf</i> (Sensorcaine-Mpf)	T1	
<i>bupivacaine hcl/pf</i> (Sensorcaine-Mpf)	T3	
BUPIVACAINE HCL-0.9% NACL	T1	
<i>chloroprocaine hcl/pf</i> (Nesacaine-Mpf)	T1	
CITANEST FORTE DENTAL	T3	
CITANEST PLAIN DENTAL	T3	
EXPAREL	T3	
<i>lidocaine hcl</i>	T1	

T1 – Typically Generics
 T2 – Typically Preferred Brands
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List of Prescription Medications

ANESTHETICS (Pain Relief and Inflammatory Disease) (cont.)

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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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

ANESTHETICS (Pain Relief and Inflammatory Disease) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LOCAL ANESTHETICS (cont.)		
<i>ropivacaine 1% 100 mg/10 ml v1</i>	T1	
<i>ropivacaine 1% 200 mg/20 ml v1</i>	T1	
<i>ropivacaine hcl 0.5% syringe</i>	T1	
ROPIVACAINE HCL 0.5% SYRINGE	T1	
ROPIVACAINE HCL-0.9% NAACL	T1	
ROPIVACAINE HCL-NAACL	T1	
SENSORCAINE 0.25% VIAL (bupivacaine hcl)	T3	
<i>sensorcaine 0.5% vial (Marcaine)</i>	T1	
SENSORCAINE WITH DEXTROSE	T1	
SENSORCAINE-MPF 0.25% VIAL (<i>bupivacaine hcl/pf</i>)	T3	
<i>sensorcaine-mpf 0.5% vial (Marcaine)</i>	T1	
SENSORCAINE-MPF 0.75% VIAL (<i>bupivacaine hcl/pf</i>)	T3	
SENSORCAINE-MPF EPINEPHRINE	T3	
SENSORCAINE-MPF EPINEPHRINE (<i>bupivacaine hcl/epinephrine/pf</i>)	T3	
<i>tetracaine hcl/pf</i>	T1	
XYLOCAINE (<i>lidocaine hcl</i>)	T3	
XYLOCAINE WITH EPINEPHRINE (<i>lidocaine hcl/epinephrine</i>)	T3	
XYLOCAINE WITH EPINEPHRINE (<i>lidocaine hcl/epinephrine/pf</i>)	T3	
XYLOCAINE-MPF	T3	
XYLOCAINE-MPF (<i>lidocaine hcl/pf</i>)	T3	
XYLOCAINE-MPF WITH EPINEPHRINE	T3	
XYLOCAINE-MPF WITH EPINEPHRINE (<i>lidocaine hcl/epinephrine/pf</i>)	T3	
ZINGO	T3	
ZYNRELEF	T3	
L.E.T. (LIDO-EPINEPH-TETRA)	T3	
<i>lidocaine 5% ointment</i>	T1	QL(145 GMS/30 DAYS)
<i>lidocaine 5% patch (Lidocan li)</i>	T1	
<i>lidocaine 5% patch (Lidoderm)</i>	T1	
<i>lidocaine hcl</i>	T1	
<i>lidocaine/prilocaine</i>	T1	
ZTLIDO	T2	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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

ANESTHETICS (Urinary Tract Conditions)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
URINARY TRACT ANESTHETIC/ANALGESIC AGNT (AZO-DYE)		
<i>phenazopyridine hcl</i> (Pyridium)	T1	
ANTI-ALLERGY (Allergy/Nasal Sprays)		
MAST CELL STABILIZERS		
<i>cromolyn 100 mg/5 ml oral conc</i> (Gastrocrom)	T1	
ANTIALLERGY (Skin Conditions)		
ANTIPRURITICS, SYSTEMIC		
KORSUVA	T4	PA SP
ANTI-ARTHRITICS (Pain Relief and Inflammatory Disease)		
ANALGESIC/ANTIPYRETICS, SALICYLATES		
DISALCID (<i>salsalate</i>)	T3	HD
<i>salsalate</i> (Disalcid)	T1	HD
ANTI-ARTHRITIC AND CHELATING AGENTS		
DEPEN (<i>penicillamine</i>)	T4	PA QL(6 TABS/DAY) SP
<i>penicillamine 250 mg capsule</i> (Cuprimine)	T4	PA QL(6 CAPS/DAY) SP
<i>penicillamine 250 mg tablet</i> (Depen)	T4	PA QL(6 TABS/DAY) SP
ANTI-ARTHRITIC, FOLATE ANTAGONIST AGENTS		
OTREXUP	T2	PA
ANTI-INFLAMMATORY, PYRIMIDINE SYNTHESIS INHIBITOR		
<i>leflunomide</i> (Arava)	T1	HD
ANTI-INFLAMMATORY, PHOSPHODIESTERASE-4(PDE4) INHIB.		
OTEZLA 10-20 MG STARTER 28 DAY	T4	PA QL(55 TABS/365 DAYS) SP HD
OTEZLA 10-20-30MG START 28 DAY	T4	PA QL(55 TABS/365 DAYS) SP HD
OTEZLA 20 MG TABLET	T4	PA QL(2 TABS/DAY) SP HD
OTEZLA 30 MG TABLET	T4	PA QL(2 TABS/DAY) SP HD
OTEZLA XR 75 MG TABLET	T4	PA QL(1 TAB/DAY) SP HD
OTEZLA XR INITIATION PK 28 DAY	T4	PA QL(41 TABS/365 DAYS) SP HD
ANTI-INFLAMMATORY/ANTIARTHRITICS AGENTS, MISC.		
DUROLANE	T4	PA SP HD
EUFLEXXA	T4	PA SP HD
GEL-ONE	T4	PA SP HD
GELSYN-3	T4	PA SP HD
GENVISC 850	T4	PA SP

T1 – Typically Generics
 T2 – Typically Preferred Brands
 T3 – Typically Non-Preferred Brands

T4 – Specialty Medications
 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

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	T4	PA SP HD
HYMOVIS	T4	PA SP HD
HYMOVIS ONE	T4	PA SP HD
MONOVISC	T4	PA SP HD
ORTHOVISC	T4	PA SP HD
SUPARTZ FX	T4	PA SP HD
SYNOJOYNT	T4	PA SP
SYNVISC	T4	PA SP HD
SYNVISC-ONE	T4	PA SP HD
TRILURON	T4	PA SP HD
TRIVISC	T4	PA SP
VISCO-3	T4	PA SP HD
ANTI-INFLAMMATORY, SEL.COSTIM.MOD., T-CELL INHIBITOR		
ORENCIA 125 MG/ML SYRINGE	T4	PA QL(4 SYR/AUTO-INJ/28 DAYS) SP HD
ORENCIA 250 MG VIAL	T4	PA SP HD
ORENCIA 50 MG/0.4 ML SYRINGE	T4	PA QL(4 SYR/AUTO-INJ/28 DAYS) SP HD
ORENCIA 87.5 MG/0.7 ML SYRINGE	T4	PA QL(4 SYR/AUTO-INJ/28 DAYS) SP HD
ORENCIA CLICKJECT	T4	PA QL(4 SYR/AUTO-INJ/28 DAYS) SP HD
COLCHICINE		
<i>colchicine 0.6 mg capsule (Mitigare)</i>	T1	HD
<i>colchicine 0.6 mg tablet (Colcrys)</i>	T1	HD
MITIGARE (colchicine)	T2	
HYPERURICEMIA TX - URATE-OXIDASE ENZYME-TYPE		
ELITEK	T4	SP
KRYSTEXXA	T4	PA SP
HYPERURICEMIA TX - XANTHINE OXIDASE INHIBITORS		
<i>allopurinol 100 mg tablet (Zyloprim)</i>	T1	HD
<i>allopurinol 300 mg tablet</i>	T1	HD
<i>allopurinol sodium</i>	T1	
allopurinol sodium	T3	
<i>febuxostat 40 mg tablet (Uloric)</i>	T1	QL(1 TAB/DAY) HD
<i>febuxostat 80 mg tablet (Uloric)</i>	T1	HD
JANUS KINASE (JAK) INHIBITORS		
OLUMIANT	T4	PA QL(30 TABS/30 DAYS) SP HD
RINVOQ	T4	PA QL(1 TAB/DAY) SP HD

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands

T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit

ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication

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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
JANUS KINASE (JAK) INHIBITORS (cont.)		
RINVOQ LQ	T4	PA QL(12 MLS/DAY) SP HD
XELJANZ 1 MG/ML SOLUTION	T4	PA QL(480 MLS/30 DAYS) SP HD
XELJANZ 10 MG TABLET	T4	PA QL(2 TABS/DAY) SP HD
XELJANZ 5 MG TABLET	T4	PA QL(2 TABS/DAY) SP HD
XELJANZ XR	T4	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

T1 – Typically Generics
 T2 – Typically Preferred Brands
 T3 – Typically Non-Preferred Brands

T4 – Specialty Medications
 PA – Prior Authorization
 QL – Quantity Limit

ST – Step Therapy
 AGE – Age Requirement
 SP – Specialty Medication

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

T1 – Typically Generics
 T2 – Typically Preferred Brands
 T3 – Typically Non-Preferred Brands

T4 – Specialty Medications
 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

ANTI-ARTHRITICS (Pain Relief and Inflammatory Disease) (cont.)

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

T1 – Typically Generics
 T2 – Typically Preferred Brands
 T3 – Typically Non-Preferred Brands

T4 – Specialty Medications
 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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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 (<i>levalbuterol hcl</i>)	T3	
XOPENEX CONCENTRATE (<i>levalbuterol hcl</i>)	T3	
BETA-ADRENERGIC AGENTS, INHALED, ULTRA-LONG ACTING		
STRIVERDI RESPIMAT	T2	QL(1 INHALER/30 DAYS) HD
BETA-ADRENERGIC AGENTS, ORALLY INHALED, LONG ACTING		
<i>arformoterol tartrate</i> (Brovana)	T1	QL(4 MLS/DAY) HD
<i>formoterol fumarate</i> (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)
<i>ipratropium/albuterol sulfate</i>	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
<i>budesonide/formoterol fumarate</i> (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
<i>fluticasone propion/salmeterol</i> (Advair Diskus)	T1	QL(1 INHALER/30 DAYS)
<i>fluticasone-salmeterol 100-50</i> (Advair Diskus)	T1	QL(1 INHALER/30 DAYS) HD
<i>fluticasone-salmeterol 250-50</i> (Advair Diskus)	T1	QL(1 INHALER/30 DAYS) HD
<i>fluticasone-salmeterol 500-50</i> (Advair Diskus)	T1	QL(1 INHALER/30 DAYS) HD
GLUCOCORTICOID, 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
<i>budesonide 0.25 mg/2 ml susp</i> (Pulmicort)	T1	QL(4 MLS/DAY) HD

T1 – Typically Generics
 T2 – Typically Preferred Brands
 T3 – Typically Non-Preferred Brands

T4 – Specialty Medications
 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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List of Prescription Medications

ANTIASTHMATICS (Asthma/COPD/Respiratory) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GLUCOCORTICOIDS, ORALLY INHALED (cont.)		
<i>budesonide 0.5 mg/2 ml susp</i> (Pulmicort)	T1	QL (4 MLS/DAY) HD
<i>budesonide 1 mg/2 ml inh susp</i> (Pulmicort)	T1	QL (2 MLS/DAY) HD
QVAR REDHALER	T2	
INTERLEUKIN-5 (IL-5) ANTAGONISTS, MAB		
NUCALA	T4	PA SP HD
INTERLEUKIN-5 (IL-5) RECEPTOR ALPHA ANTAGONIST, MAB		
FASENRA	T4	PA SP HD
FASENRA PEN	T4	PA SP HD
LEUKOTRIENE RECEPTOR ANTAGONISTS		
ACCOLATE (zafirlukast)	T3	HD
<i>montelukast sodium</i>	T1	HD
montelukast sodium (Singulair)	T1	HD
<i>zafirlukast (Accolate)</i>	T1	HD
MAST CELL STABILIZERS, ORALLY INHALED		
<i>cromolyn 20 mg/2 ml neb soln</i>	T1	QL (480ml/30 days) HD
MONOCLONAL ANTIBODIES TO IMMUNOGLOBULIN E (IGE)		
XOLAIR	T4	PA SP HD
MUCOLYTICS		
<i>acetylcysteine</i>	T1	
PHOSPHODIESTERASE-4 (PDE4) INHIBITORS		
<i>roflumilast 250 mcg tablet</i> (Daliresp)	T3	QL (28 tabs/180 days) HD
<i>roflumilast 500 mcg tablet</i> (Daliresp)	T3	QL (2 tabs/day) HD
XANTHINES		
<i>aminophylline</i>	T1	
THEO-24	T3	HD
<i>theophylline anhydrous</i>	T1	HD
<i>theophylline in dextrose 5 %</i>	T1	
ANTIBIOTICS (Ear Medications)		
EAR PREPARATIONS, ANTIBIOTICS		
<i>ciprofloxacin hcl</i>	T1	
CORTISPORIN-TC	T3	
<i>neomycin/polymyxin b/hydrocort</i>	T1	
<i>ofloxacin</i>	T1	

T1 – Typically Generics
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T4 – Specialty Medications
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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		
<i>ciprofloxacin hcl/dexameth</i>	T1	
<i>ciprofloxacin/hydrocortisone</i>	T1	
OTOVEL	T3	
ANTIBIOTICS (Eye Conditions)		
EYE ANTIBIOTIC AND GLUCOCORTICOID COMBINATIONS		
<i>neomycin/bacit/p-myx/hydrocort</i>	T1	
<i>neomycin/polymyxin b/dexametha</i> (Maxitrol)	T1	
<i>neomycin/polymyxin b/hydrocort</i>	T1	
TOBRADEX	T3	
TOBRADEX ST	T2	
<i>tobramycin/dexamethasone</i>	T1	
ZYLET	T3	
EYE SULFONAMIDES		
<i>sulfacetamide sodium</i>	T1	
<i>sulfacetamide/prednisolone sp</i>	T1	
OPHTHALMIC ANTIBIOTICS		
AZASITE	T2	
<i>bacitracin</i>	T1	
<i>bacitracin/polymyxin b sulfate</i>	T1	
BESIVANCE	T2	
<i>ciprofloxacin hcl</i>	T1	
<i>erythromycin base</i>	T1	
<i>gatifloxacin</i>	T1	
<i>gentamicin sulfate</i>	T1	
<i>levofloxacin</i>	T1	
<i>moxifloxacin hcl</i>	T1	
<i>moxifloxacin hcl</i> (Vigamox)	T1	
MOXIFLOXACIN HCL-BSS	T1	
MOXIFLOXACIN HCL-NACL	T1	
<i>neomycin/bacitracin/polymyxinb</i>	T1	
<i>neomycin/polymyxn b/gramicidin</i>	T1	
<i>ofloxacin</i> (Ocuflox)	T1	
<i>polymyxin b sulf/trimethoprim</i>	T1	
<i>tobramycin 0.3% eye drop</i>	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

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AGE – Age Requirement

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List of Prescription Medications

ANTIBIOTICS (Infections)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ABSORBABLE SULFONAMIDE ANTIBACTERIAL AGENTS		
BACTRIM (<i>sulfamethoxazole-trimethoprim</i>)	T3	
BACTRIM DS (<i>sulfamethoxazole-trimethoprim</i>)	T3	
<i>sulfadiazine</i>	T1	
<i>sulfamethoxazole/trimethoprim</i>	T1	
<i>sulfamethoxazole/trimethoprim</i>	T3	
<i>sulfamethoxazole/trimethoprim</i> (Bactrim Ds)	T1	
<i>sulfamethoxazole/trimethoprim</i> (Bactrim)	T1	
AMINOGLYCOSIDE ANTIBIOTICS		
<i>amikacin sulfate</i>	T1	
ARIKAYCE	T4	PA SP
<i>gentamicin in nacl, iso-osm</i>	T1	
<i>gentamicin sulfate</i>	T1	
GENTAMICIN SULFATE	T1	
GENTAMICIN SULFATE IN NS	T1	
<i>gentamicin sulfate/pf</i>	T1	
KITABIS PAK	T4	PA QL(10 MLS/DAY) SP HD
<i>neomycin sulfate</i>	T1	
STREPTOMYCIN SULFATE	T1	
TOBI PODHALER	T4	PA QL(8 CAPS/DAY) SP HD
<i>tobramycin 300 mg/4 ml ampule</i> (Bethkis)	T4	PA QL(8 MLS/DAY) SP HD
<i>tobramycin 300 mg/5 ml ampule</i> (Tobi)	T4	PA QL(10 MLS/DAY) SP HD
TOBRAMYCIN PAK 300 MG/5 ML	T4	PA QL(10 MLS/DAY) SP HD
<i>tobramycin sulfate</i>	T1	
<i>tobramycin/sodium chloride</i>	T1	
ZEMDRI	T3	
ANAEROBIC ANTIPROTOZOAL-ANTIBACTERIAL AGENTS		
FLAGYL (<i>metronidazole</i>)	T3	
LIKMEZ	T3	PA
<i>metronidazole 250 mg tablet</i>	T1	
<i>metronidazole 375 mg capsule</i> (Flagyl)	T1	
<i>metronidazole 500 mg tablet</i>	T1	
<i>metronidazole 500 mg/100 ml</i>	T1	
<i>metronidazole/sodium chloride</i>	T3	
ANTIBIOTIC, ANTIBACTERIAL, MISC.		
<i>fosfomicin tromethamine</i>	T1	

T1 – Typically Generics
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List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIBIOTIC, ANTIBACTERIAL, MISC (cont.)		
<i>methenamine hippurate</i>	T1	
<i>methenamine mandelate</i>	T1	
PRIMSOL	T3	
<i>trimethoprim</i>	T1	
ANTIBIOTICS, MISCELLANEOUS, OTHER		
<i>bacitracin</i>	T1	
ANTILEPTOTICS		
<i>dapsone 100 mg tablet</i>	T1	
<i>dapsone 25 mg tablet</i>	T1	
THALOMID	T4	PA SP HD
ANTI-MYCOBACTERIUM AGENTS		
<i>ethambutol hcl</i>	T1	HD
<i>isoniazid</i>	T1	HD
ANTI-MYCOBACTERIUM AGENTS		
PASER	T3	HD
<i>pyrazinamide</i>	T1	HD
<i>rifabutin (Mycobutin)</i>	T1	HD
ANTITUBERCULAR ANTIBIOTICS		
<i>cycloserine</i>	T1	
PRETOMANID	T3	PA QL(1 TAB/DAY)
PRIFTIN	T3	
RIFADIN (<i>rifampin</i>)	T3	
RIFAMATE	T3	
<i>rifampin</i>	T1	
<i>rifampin (Rifadin)</i>	T1	
RIFATER	T3	
SIRTURO	T3	SP
BETALACTAMS		
AZACTAM (<i>aztreonam</i>)	T3	
<i>aztreonam (Azactam)</i>	T1	
CAYSTON	T4	PA QL(3 MLS/DAY) SP HD
XACDURO	T3	

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ANTIBIOTICS (Infections) (cont.)

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

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ANTIBIOTICS (Infections) (cont.)

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

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ANTIBIOTICS (Infections) (cont.)

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

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List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)

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

T1 – Typically Generics
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List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PENICILLIN ANTIBIOTICS (cont.)		
<i>ampicillin sod/sulbactam sod</i>	T1	
<i>ampicillin sod/sulbactam sod (Unasyn)</i>	T1	
<i>ampicillin sodium</i>	T1	
<i>ampicillin trihydrate</i>	T1	
BICILLIN C-R	T3	
BICILLIN L-A	T3	
<i>dicloxacillin sodium</i>	T1	
EXTENCILLINE	T3	
LENTOCILIN S	T3	
MOXATAG	T3	
<i>naftillin in dextrose,iso-osm</i>	T1	
<i>naftillin sodium</i>	T1	
<i>oxacillin in dextrose(iso-osm)</i>	T1	
<i>oxacillin sodium</i>	T1	
<i>penicillin g potassium</i>	T1	
<i>penicillin g sodium</i>	T1	
PENICILLIN GK-ISO-OSM DEXTROSE	T1	
<i>penicillin v potassium</i>	T1	
PIPERACILLIN-TAZO 3.375 G DPLX	T3	
PIPERACILLIN-TAZO 4.5 G DUPLEX	T3	
<i>piperacil-tazo 2.25 gm add vl</i>	T1	
<i>piperacil-tazo 3.375 gm add vl</i>	T1	
<i>piperacil-tazo 4.5 gm add vial</i>	T1	
<i>piperacil-tazobact 13.5 gm vl</i>	T1	
PIPERACIL-TAZOBACT 13.5 GM VL	T1	
<i>piperacil-tazobact 2.25 gm vl</i>	T1	
<i>piperacil-tazobact 3.375 gm vl</i>	T1	
<i>piperacil-tazobact 4.5 gm vial</i>	T1	
<i>piperacil-tazobact 40.5 gram</i>	T1	
UNASYN (<i>ampicillin sod/sulbactam sod</i>)	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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List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
POLYMYXIN ANTIBIOTICS AND DERIVATIVES		
<i>colistin (colistimethate na)</i> (Coly-mycin M Parenteral)	T1	
COLY-MYCIN M PARENTERAL (colistimethate)	T3	
<i>polymyxin b sulfate</i>	T1	
QUINOLONE ANTIBIOTICS		
AVELOX IV (<i>moxifloxacin-sod.chloride(iso)</i>)	T3	
BAXDELA 300 MG VIAL	T3	
BAXDELA 450 MG TABLET	T3	PA
CIPRO (<i>ciprofloxacin hcl</i>)	T3	
CIPRO (<i>ciprofloxacin</i>)	T3	
<i>ciprofloxacin</i> (Cipro)	T1	
<i>ciprofloxacin hcl</i>	T1	
<i>ciprofloxacin hcl</i> (Cipro)	T1	
<i>ciprofloxacin in 5 % dextrose</i>	T1	
FACTIVE	T3	
<i>levofloxacin</i>	T1	
<i>levofloxacin in dextrose 5 %</i>	T1	
MOXIFLOXACIN	T1	
<i>moxifloxacin hcl</i>	T1	
<i>moxifloxacin-sod.chloride(iso)</i> (Avelox Iv)	T1	
<i>ofloxacin</i>	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		
<i>coremino er 135 mg tablet</i>	T1	
<i>coremino er 45 mg tablet</i>	T1	QL(1 TAB/DAY)
<i>coremino er 90 mg tablet</i>	T1	
<i>demeclocycline hcl</i>	T1	
<i>doxycycline 50 mg tablet</i> (Targadox)	T1	
<i>doxycycline hyclate</i>	T1	
<i>doxycycline hyclate 100 mg cap</i>	T1	
<i>doxycycline hyclate 100 mg tab</i> (Lymepak)	T1	

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ANTIBIOTICS (Infections) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TETRACYCLINE ANTIBIOTICS		
<i>doxycycline hyclate 100 mg vial</i>	T1	
<i>doxycycline hyclate 150 mg tab (Acticlate)</i>	T1	
<i>doxycycline hyclate 50 mg cap</i>	T1	
<i>doxycycline hyclate 75 mg tab (Acticlate)</i>	T1	
doxycycline monohydrate	T1	
MINOCIN	T3	
<i>minocycline er 105 mg tablet</i>	T1	
<i>minocycline er 115 mg tablet (Solodyn)</i>	T1	
<i>minocycline er 135 mg tablet</i>	T1	
<i>minocycline er 45 mg tablet</i>	T1	QL(1 TAB/DAY)
<i>minocycline er 55 mg tablet</i>	T1	
<i>minocycline er 65 mg tablet</i>	T1	
<i>minocycline er 80 mg tablet</i>	T1	
<i>minocycline er 90 mg tablet</i>	T1	
<i>minocycline hcl</i>	T1	
TETRACYCLINE ANTIBIOTICS (cont.)		
NUZYRA 100 MG VIAL	T4	SP
NUZYRA 150 MG TABLET	T4	PA QL(30 TABS/28 DAYS) SP
<i>tetracycline 250 mg capsule</i>	T1	
<i>tetracycline 500 mg capsule</i>	T1	
XERAVA	T3	
VAGINAL ANTIBIOTICS		
<i>clindamycin phosphate (Cleocin)</i>	T1	
<i>metronidazole</i>	T1	
<i>metronidazole vaginal 0.75% gel</i>	T1	
VANCOMYCIN ANTIBIOTICS AND DERIVATIVES		
TYZAVAN	T3	
VANCOMYCIN	T1	
<i>vancomycin 1 gm add-van vial</i>	T1	
<i>vancomycin 1 gm vial</i>	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	
<i>vancomycin 25 mg/ml oral soln</i>	T1	
<i>vancomycin 250 mg/5ml oral sol (Firvanq)</i>	T1	
<i>vancomycin 50 mg/ml oral soln (Firvanq)</i>	T1	
<i>vancomycin 500 mg add-van vial</i>	T1	
<i>vancomycin 500 mg vial</i>	T1	
VANCOMYCIN 500 MG/100 ML BAG	T3	
VANCOMYCIN 750 MG ADD-VAN VIAL	T1	
VANCOMYCIN 750 MG/150 ML BAG	T3	
<i>vancomycin hcl 1.25 gram vial</i>	T1	
<i>vancomycin hcl 1.5 gram vial</i>	T1	
VANCOMYCIN HCL 1.75 GRAM VIAL	T3	
<i>vancomycin hcl 10 gm vial</i>	T1	
<i>vancomycin hcl 125 mg capsule (Vancocin Hcl)</i>	T1	
VANCOMYCIN HCL 1G/200 ML BAG	T1	
VANCOMYCIN HCL 2 GRAM VIAL	T3	
<i>vancomycin hcl 250 mg capsule (Vancocin Hcl)</i>	T1	
<i>vancomycin hcl 5 gm vial</i>	T1	
<i>vancomycin hcl 750 mg vial</i>	T1	
VANCOMYCIN HCL-0.9% NAACL	T1	
VANCOMYCIN-D5W 500 MG/100 ML	T1	
ANTIBIOTICS (Miscellaneous)		
CYCLIC LIPOPEPTIDES		
<i>daptomycin</i>	T1	
DAPTOMYCIN	T1	
DAPTOMYCIN-0.9% NAACL	T3	
ANTIBIOTICS (Skin Conditions)		
TOPICAL ANTIBIOTIC AND ANTI-INFLAMMATORY STEROID		
NEO-SYNALAR	T3	

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 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIBIOTICS (Skin Conditions)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL ANTIBIOTICS		
BENZAMYCIN (<i>erythromycin-benzoyl peroxide</i>)	T3	
CENTANY	T3	
CENTANY AT	T3	
CLEOCIN T (<i>clindamycin phosphate</i>)	T3	
<i>clindamycin phosphate</i>	T1	
<i>clindamycin phosphate</i> (Cleocin T)	T1	
<i>clindamycin phosphate</i> (Clindagel)	T1	
<i>clindamycin phosphate</i> (Evoclin)	T1	
<i>erythromycin base in ethanol</i>	T1	
<i>erythromycin/benzoyl peroxide</i> (Benzamycin)	T1	
EVOCLIN (<i>clindamycin phosphate</i>)	T3	
<i>gentamicin sulfate</i>	T1	
<i>mupirocin 2% ointment</i>	T1	
XEPI	T3	
TOPICAL SULFONAMIDES		
<i>mafenide acetate</i>	T1	
PLEXION	T3	
SILVADENE (<i>silver sulfadiazine</i>)	T3	
<i>silver sulfadiazine</i> (Silvadene)	T1	
<i>sulfacetamide sodium/sulfur</i>	T1	
SULFAMYLON	T3	
ANTICOAGULANTS (Blood Thinners/Anti-Clotting)		
ANTICOAGULANTS, COUMARIN TYPE		
<i>warfarin sodium</i>	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)

T1 – Typically Generics
 T2 – Typically Preferred Brands
 T3 – Typically Non-Preferred Brands

T4 – Specialty Medications
 PA – Prior Authorization
 QL – Quantity Limit

ST – Step Therapy
 AGE – Age Requirement
 SP – Specialty Medication

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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		
<i>rivaroxaban</i> (Xarelto)	T1	
XARELTO	T2	
XARELTO (<i>rivaroxaban</i>)	T2	
HEPARIN AND RELATED PREPARATIONS		
ARIXTRA 10 MG/0.8 ML SYRINGE (<i>fondaparinux sodium</i>)	T4	QL(0.8 ML/DAY) SP
ARIXTRA 2.5 MG/0.5 ML SYRINGE (<i>fondaparinux sodium</i>)	T4	QL(0.5 ML/DAY) SP
ARIXTRA 5 MG/0.4 ML SYRINGE (<i>fondaparinux sodium</i>)	T4	QL(0.4 ML/DAY) SP
ARIXTRA 7.5 MG/0.6 ML SYRINGE (<i>fondaparinux sodium</i>)	T4	QL(0.6 ML/DAY) SP
<i>enoxaparin</i> 100 mg/ml syringe (Lovenox)	T4	QL(2 SYRINGES/DAY) SP
<i>enoxaparin</i> 120 mg/0.8 ml syr (Lovenox)	T4	QL(2 SYRINGES/DAY) SP
<i>enoxaparin</i> 40 mg/0.4 ml syr (Lovenox)	T4	QL (2 SYRINGES/DAY) SP
<i>enoxaparin</i> 150 mg/ml syringe (Lovenox)	T4	QL(2 SYRINGES/DAY) SP
<i>enoxaparin</i> 30 mg/0.3 ml syr (Lovenox)	T4	QL(2 SYRINGES/DAY) SP
<i>enoxaparin</i> 300 mg/3 ml vial (Lovenox)	T4	QL(1 VIAL/DAY) SP
<i>enoxaparin</i> 40 mg/0.4 ml syr (Lovenox)	T4	QL(2 SYRINGES/DAY) SP
<i>enoxaparin</i> 60 mg/0.6 ml syr (Lovenox)	T4	QL(2 SYRINGES/DAY) SP
<i>enoxaparin</i> 80 mg/0.8 ml syr (Lovenox)	T4	QL(2 SYRINGES/DAY) SP
<i>fondaparinux</i> 10 mg/0.8 ml syr (Arixtra)	T4	QL(0.8 ML/DAY) SP
<i>fondaparinux</i> 2.5 mg/0.5 ml syr (Arixtra)	T4	QL(0.5 ML/DAY) SP
<i>fondaparinux</i> 5 mg/0.4 ml syr (Arixtra)	T4	QL(0.4 ML/DAY) SP
<i>fondaparinux</i> 7.5 mg/0.6 ml syr (Arixtra)	T4	QL(0.6 ML/DAY) SP
FRAGMIN 10,000 UNIT/4 ML VIAL	T4	QL(1 VIAL/DAY) SP
FRAGMIN 10,000 UNIT/ML SYRINGE	T4	QL(2 SYRINGES/DAY) SP
FRAGMIN 12,500 UNIT/0.5 ML SYR	T4	QL(2 SYRINGES/DAY) SP
FRAGMIN 15,000 UNIT/0.6 ML SYR	T4	QL(2 SYRINGES/DAY) SP
FRAGMIN 18,000 UNIT/0.72 ML	T4	QL(2 SYRINGES/DAY) SP
FRAGMIN 2,500 UNIT/0.2 ML SYR	T4	QL(2 SYRINGES/DAY) SP
FRAGMIN 5,000 UNIT/0.2 ML SYR	T4	QL(2 SYRINGES/DAY) SP
FRAGMIN 7,500 UNIT/0.3 ML SYR	T4	QL(2 SYRINGES/DAY) SP
FRAGMIN 95,000 UNIT/3.8 ML VL	T4	QL(1 VIAL/DAY) SP
<i>heparin</i> 1,000 unit/500 ml-ns	T1	
<i>heparin</i> 10,000 unit/10 ml vial	T1	
HEPARIN 2,000 UNIT/1,000 ML-NS (<i>heparin sodium,porcine/ns/pf</i>)	T3	
<i>heparin</i> 2,000 unit/1,000 ml-ns (Heparin Sodium-0.9% Nacl)	T1	
<i>heparin</i> 2,000 unit/2 ml vial	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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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List of Prescription Medications

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	
<i>heparin 30,000 unit/30 ml vial</i>	T1	
<i>heparin 40,000 unit/4 ml vial</i>	T1	
HEPARIN 5,000 UNIT/1,000 ML-NS	T1	
HEPARIN 5,000 UNIT/500 ML-NS	T1	
<i>heparin 5,000 unit/ml carpuct</i>	T1	
<i>heparin 50,000 unit/10 ml vial</i>	T1	
<i>heparin 50,000 unit/5 ml vial</i>	T1	
<i>heparin sod 1,000 unit/ml vial</i>	T1	
<i>heparin sod 10,000 unit/ml vl</i>	T1	
<i>heparin sod 20,000 unit/ml vl</i>	T1	
<i>heparin sod 5,000 unit/0.5 ml</i>	T1	
HEPARIN SOD 5,000 UNIT/0.5 ML	T1	
HEPARIN SOD 5,000 UNIT/0.5 ML	T3	
<i>heparin sod 5,000 unit/ml syrg</i>	T1	
HEPARIN SOD 5,000 UNIT/ML SYRG	T3	
<i>heparin sod 5,000 unit/ml vial</i>	T1	
<i>heparin sod,porcine/0.9 % nacl</i>	T1	
<i>heparin sod,pork in 0.45% nacl</i>	T1	
<i>heparin sodium,porcine</i>	T1	
<i>heparin sodium,porcine/d5w</i>	T1	
<i>heparin sodium,porcine/pf</i>	T1	
HEPARIN SODIUM-0.45% NACL	T1	
THROMBIN INHIBITORS, SELECTIVE, DIRECT, REVERSIBLE		
ARGATROBAN	T4	SP
argatroban in 0.9 % sod chlor	T4	SP HD
dabigatran etexilate mesylate (Pradaxa)	T1	HD
THROMBIN INHIBITORS, SEL, DIRECT, REVERS-HIRUDIN TYPE		
ANGIOMAX	T3	
BIVALIRUDIN 250 MG ADD-VANT VL	T1	
<i>bivalirudin 250 mg vial (Angiomax)</i>	T1	
BIVALIRUDIN RTU 250 MG/50 ML	T3	

T1 – Typically Generics
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List of Prescription Medications

ANTIDOTES (Gastrointestinal/Heartburn)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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)
<i>naloxone 0.4 mg/ml carpject</i>	T1	
<i>naloxone 0.4 mg/ml syringe</i>	T1	
<i>naloxone 0.4 mg/ml vial</i>	T1	
<i>naloxone 2 mg/2 ml syringe</i>	T1	
<i>naloxone 4 mg/10 ml vial</i>	T1	
naloxone hcl 4 mg nasal spray (Narcan)	T1	QL(2 UNITS/30 DAYS)
<i>naltrexone hcl</i>	T1	QL(180 TABS/30 DAYS)
NARCAN (<i>naloxone hcl</i>)	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	
<i>miconazole nitrate</i>	T1	
<i>terconazole</i>	T1	
ANTIFUNGALS (Infections)		
ANTIFUNGAL AGENTS		
ANCOBON (flucytosine)	T3	
<i>clotrimazole</i>	T1	

T1 – Typically Generics
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 T3 – Typically Non-Preferred Brands

T4 – Specialty Medications
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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
<i>fluconazole</i>	T1	
<i>fluconazole (Diflucan)</i>	T1	
<i>fluconazole in nacl,iso-osm</i>	T1	
<i>flucytosine (Ancobon)</i>	T1	
<i>itraconazole</i>	T1	
<i>itraconazole (Sporanox)</i>	T1	
<i>ketoconazole</i>	T1	
NOXAFIL 300 MG POWDERMIX SUSP	T3	
NOXAFIL 300 MG/16.7 ML VIAL (<i>posaconazole</i>)	T3	
ORAVIG	T3	
<i>posaconazole</i>	T1	
<i>posaconazole (Noxafil)</i>	T1	
<i>terbinafine hcl</i>	T1	
VFEND (<i>voriconazole</i>)	T3	PA
VFEND IV (<i>voriconazole</i>)	T3	
VIVJOA	T4	PA SP
<i>voriconazole 200 mg tablet (Vfend)</i>	T1	PA
<i>voriconazole 200 mg vial (Vfend Iv)</i>	T1	
<i>voriconazole 40 mg/ml susp (Vfend)</i>	T1	PA
<i>voriconazole 50 mg tablet (Vfend)</i>	T1	PA
<i>voriconazole/hpbccl</i>	T1	
ABELCET	T3	
AMBISOME (amphotericin b liposome)	T3	
<i>amphotericin b</i>	T1	
<i>amphotericin b liposome (Ambisome)</i>	T1	
CANCIDAS (<i>caspofungin acetate</i>)	T3	
<i>caspofungin acetate</i>	T1	
<i>caspofungin acetate (Cancidas)</i>	T1	
ERAXIS	T3	
<i>griseofulvin ultra 125 mg tab</i>	T1	

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List of Prescription Medications

ANTIFUNGALS (Infections) (cont.)

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

T1 – Typically Generics
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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
QUZYTIR	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-I RECEPTORAGONIST)		
BYDUREON BCISE	T2	PA QL(4 MLS/28 DAYS)

T1 – Typically Generics
 T2 – Typically Preferred Brands
 T3 – Typically Non-Preferred Brands

T4 – Specialty Medications
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List of Prescription Medications

ANTIHYPERTENSIVES (Diabetes) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIHYPERTENSIVE, INCRETIN MIMETIC (GLP-1 RECEPTOR AGONIST) (cont.)		
<i>exenatide</i>	T1	PA QL (3 MLS/30 DAYS)
<i>liraglutide</i> (Victoza 2-Pak)	T1	PA QL (3 PENS/30 DAYS)
<i>liraglutide</i> (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)
ANTIHYPERTENSIVE, INSULIN, LONG ACT-GLP-1 RECEPTOR AGONIST		
SOLIQUA 100-33	T2	
ANTIHYPERTENSIVE - DOPAMINE RECEPTOR AGONISTS		
CYCLOSET	T3	HD
ANTIHYPERTENSIVE - 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)
ANTIHYPERTENSIVE, ALPHA-GLUCOSIDASE INHIBITORS		
<i>acarbose</i> (Precose)	T1	HD
<i>miglitol</i>	T1	HD
PRECOSE (<i>acarbose</i>)	T3	HD
ANTIHYPERTENSIVE, AMYLIN ANALOG-TYPE		
SYMLINPEN 60	T2	
SYMLINPEN 120	T2	HD
<i>metformin hcl</i>	T1	HD
<i>metformin hcl 1,000 mg tablet</i>	T1	HD
<i>metformin hcl 500 mg tablet</i>	T1	HD
<i>metformin hcl 500 mg/5 ml cup</i> (Riomet)	T1	HD
<i>metformin hcl 500 mg/5 ml soln</i> (Riomet)	T1	HD
<i>metformin hcl 750 mg tablet</i>	T1	HD
<i>metformin hcl 850 mg tablet</i>	T1	HD
RIOMET (<i>metformin hcl</i>)	T3	HD
ANTIHYPERTENSIVE, DPP-4 INHIBITORS		
JANUVIA	T2	QL (1 TAB/DAY) ST HD

T1 – Typically Generics
 T2 – Typically Preferred Brands
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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.)		
<i>saxagliptin hcl</i> (Onglyza)	T1	QL(1 TAB/DAY) HD
ANTIHYPERGLYCEMIC, INSULIN-RELEASE STIMULANT TYPE		
<i>glimepiride 1 mg tablet</i>	T1	HD
<i>glimepiride 2 mg tablet</i>	T1	HD
GLIMEPIRIDE 3 MG TABLET	T3	HD
<i>glimepiride 4 mg tablet</i>	T1	HD
<i>glipizide</i> (Glucotrol XL)	T1	HD
<i>glipizide 10 mg tablet</i>	T1	HD
GLIPIZIDE 2.5 MG TABLET	T3	HD
<i>glipizide 5 mg tablet</i>	T1	HD
GLUCOTROL XL (<i>glipizide</i>)	T3	HD
<i>glyburide</i>	T1	HD
<i>glyburide,micronized</i>	T1	HD
<i>glyburide,micronized</i> (Glynase)	T1	HD
GLYNASE (<i>glyburide,micronized</i>)	T3	HD
<i>nateglinide</i>	T1	HD
<i>repaglinide</i>	T1	HD
ANTIHYPERGLYCEMIC, SGLT-2 AND DPP-4 INHIBITOR COMB		
GLYXAMBI	T2	QL (1 TAB/DAY) ST HD
ANTIHYPERGLYCEMIC, THIAZOLIDINEDIONE AND BIGUANIDE		
ACTOPLUS MET (<i>pioglitazone-metformin</i>)	T3	HD
<i>pioglitazone hcl/metformin hcl</i>	T1	HD
<i>pioglitazone hcl/metformin hcl</i> (Actoplus Met)	T1	HD
ANTIHYPERGLYCEMIC, THIAZOLIDINEDIONE-SULFONYLUREA		
DUETACT (<i>pioglitazone-glimepiride</i>)	T3	HD
<i>pioglitazone hcl/glimepiride</i> (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
<i>linagliptin/metformin hcl</i>	T1	QL(2 TABS/DAY) HD

T1 – Typically Generics
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List of Prescription Medications

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-metformin er 5-1000 (Kombiglyze Xr)	T1	QL(1 TAB/DAY) HD
saxagliptin-metformin 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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List of Prescription Medications

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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List of Prescription Medications

ANTIINFECTIVES/MISCELLANEOUS (Infections)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
2ND GEN. ANAEROBIC ANTIPROTOZOAL-ANTIBACTERIAL		
<i>tinidazole</i>	T1	
ANTHELMINTICS		
<i>albendazole</i>	T1	
BILTRICIDE (<i>praziquantel</i>)	T3	
EMVERM	T1	
<i>ivermectin 3 mg tablet</i> (Stromectol)	T1	PA
<i>ivermectin 6 mg tablet</i>	T1	PA
<i>praziquantel</i> (Biltricide)	T1	
STROMEKTOL (<i>ivermectin</i>)	T3	PA
ANTIMALARIAL DRUGS		
ARTESUNATE	T3	
<i>atovaquone/proguanil hcl</i> (Malarone)	T1	
<i>chloroquine phosphate</i>	T1	
COARTEM	T3	PA QL (24 TABS/30 DAYS)
<i>hydroxychloroquine sulfate</i>	T1	
<i>hydroxychloroquine sulfate</i> (Plaquenil)	T1	
KRINTAFEL	T3	PA QL (2 TABS/30 DAYS)
MALARONE (<i>atovaquone/proguanil hcl</i>)	T3	PA
<i>mefloquine hcl</i>	T1	
PRIMAQUINE (<i>primaquine phosphate</i>)	T1	
<i>primaquine phosphate</i> (Primaquine)	T1	
<i>pyrimethamine 25 mg tablet</i> (Daraprim)	T1	PA
<i>pyrimethamine 25 mg tablet</i> (Daraprim)	T4	PA SP
<i>quinine sulfate</i>	T1	
ANTIPROTOZOAL DRUGS, MISCELLANEOUS		
<i>atovaquone</i> (Meproon)	T1	
BENZNIDAZOLE	T3	
IMPAVIDO	T3	PA
LAMPIT	T3	
NEBUPENT (<i>pentamidine isethionate</i>)	T3	
PENTAM 300 (<i>pentamidine isethionate</i>)	T3	
<i>pentamidine isethionate</i> (Nebupent)	T1	
<i>pentamidine isethionate</i> (Pentam 300)	T1	

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List of Prescription Medications

ANTIINFECTIVES/MISCELLANEOUS (Miscellaneous)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIBACTERIAL AGENTS, MISCELLANEOUS		
<i>glycine urologic solution</i>	T1	
<i>glycine urologic solution</i>	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-ADB(M) 10 MG SYRG	T4	PA QL (2 PENS/SYRINGES/28 DAYS) SP HD
ADALIMUMAB-ADB(M) 20 MG SYRG	T4	PA QL (2 PENS/SYRINGES/28 DAYS) SP HD
ADALIMUMAB-ADB(M) 40 MG SYRG	T4	PA QL (4 SRNGE KITS/28 DAYS) SP HD
ADALIMUMAB-ADB(M) PEN	T4	PA QL (4 KITS/28 DAYS) SP HD
ADALIMUMAB-RYVK(CF)	T4	PA QL (4 SRNGE KITS/28 DAYS) SP HD
ADALIMUMAB-RYVK(CF) AUTOINJECT	T4	PA QL SP HD
AVSOLA	T4	PA SP HD
CIMZIA (2 PACK)	T4	PA QL (1 KIT/28 DAYS) SP HD
CIMZIA 200 MG/ML SYRINGE KIT	T4	PA QL (2 PENS/SYRINGES/28 DAYS) SP
CIMZIA 2X200 MG/ML(X3)START KT	T4	PA QL (1 STARTER KIT/365 DAYS) SP HD
CYLTEZO(CF) 10 MG/0.2 ML SYRNG	T4	PA QL (2 PENS/SYRINGES/28 DAYS) SP HD
CYLTEZO(CF) 20 MG/0.4 ML SYRNG	T4	PA QL (2 PENS/SYRINGES/28 DAYS) SP HD
CYLTEZO(CF) 40 MG/0.4 ML SYRNG	T4	PA QL (4 SRNGE KITS/28 DAYS) SP HD
CYLTEZO(CF) 40 MG/0.8 ML SYRNG	T4	PA QL (4 SRNGE KITS/28 DAYS) SP HD
CYLTEZO(CF) PEN	T4	PA QL (4 KITS/28 DAYS) SP HD
CYLTEZO(CF) PEN CROHN'S-UC-HS	T4	PA QL (1 STARTER KIT/365 DAYS) SP HD
CYLTEZO(CF) PEN PSORIASIS-UV	T4	PA QL (1 STARTER KIT/365 DAYS) SP HD
ENBREL 25 MG/0.5 ML SYRINGE	T4	PA QL (8 MLS/28 DAYS) SP HD
ENBREL 25 MG/0.5 ML VIAL	T4	PA QL (8 MLS/28 DAYS) SP HD
ENBREL 50 MG/ML SYRINGE	T4	PA QL (4 MLS/28 DAYS) SP HD
ENBREL MINI	T4	PA QL (4 MLS/28 DAYS) SP HD
ENBREL SURECLICK	T4	PA QL (4 MLS/28 DAYS) SP HD
HUMIRA	T4	PA QL (4 SRNGE KITS/28 DAYS) SP HD
HUMIRA PEN	T4	PA QL (4 KITS/28 DAYS) SP HD

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List of Prescription Medications

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	T4	PA QL(2 PENS/SYRINGES/28 DAYS) SP HD
HUMIRA(CF) 20 MG/0.2 ML SYRING	T4	PA QL(2 PENS/SYRINGES/28 DAYS) SP HD
HUMIRA(CF) 40 MG/0.4 ML SYRING	T4	PA QL(4 SRNGE KITS/28 DAYS) SP HD
HUMIRA(CF) PEN 40 MG/0.4 ML	T4	PA QL(4 KITS/28 DAYS) SP HD
HUMIRA(CF) PEN 80 MG/0.8 ML	T4	PA QL(2 PENS/28 DAYS) SP HD
HUMIRA(CF) PEN CROHN'S-UC-HS	T4	PA QL(1 STARTER KIT/365 DAYS) SP HD
HUMIRA(CF) PEN PSOR-UV-ADOL HS	T4	PA QL(1 STARTER KIT/365 DAYS) SP HD
INFLECTRA	T4	PA SP HD
RENFLEXIS	T4	PA SP HD
SIMLANDI(CF) 20 MG/0.2 ML SYRG	T4	PA QL(2 PENS/SYRINGES/28 DAYS) SP HD
SIMLANDI(CF) 40 MG/0.4 ML SYRG	T4	PA QL(4 SRNGE KITS/28 DAYS) SP HD
SIMLANDI(CF) 80 MG/0.8 ML SYRG	T4	PA QL(2 PENS/SYRINGES/28 DAYS) SP HD
SIMLANDI(CF) AI 40 MG/0.4 ML	T4	PA QL SP HD
SIMLANDI(CF) AI 80 MG/0.8 ML	T4	PA QL(2 AUTO-INJS/28 DAYS) SP HD
SIMPONI 100 MG/ML PEN INJECTOR	T4	PA QL(1 PEN/28 DAYS) SP HD
SIMPONI 100 MG/ML SYRINGE	T4	PA QL(1 SYRINGE/28 DAYS) SP HD
SIMPONI ARIA	T4	PA SP HD

ANTINEOPLASTICS (Cancer)

ANP - SELECTIVE RETINOID X RECEPTOR AGONISTS (RXR)

<i>bexarotene 75 mg capsule (Targetin)</i>	T4	PA SP HD
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ANTIBIOTIC ANTINEOPLASTICS

ADRIAMYCIN (<i>doxorubicin hcl</i>)	T4	PA SP
<i>bleomycin sulfate</i>	T4	PA SP
<i>dactinomycin</i>	T4	PA SP
<i>daunorubicin hcl</i>	T4	PA SP
DOXIL (<i>doxorubicin hcl peg-liposomal</i>)	T4	PA SP
<i>doxorubicin hcl</i>	T4	PA SP
<i>doxorubicin hcl (Adriamycin)</i>	T4	PA SP
<i>doxorubicin hcl peg-liposomal (Doxil)</i>	T4	PA SP
ELLENC	T4	PA SP
ELLENC (<i>epirubicin hcl</i>)	T4	PA SP
<i>epirubicin 200 mg/100 ml vial (Ellence)</i>	T4	PA SP
<i>epirubicin hcl 200 mg vial</i>	T4	SP

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List of Prescription Medications

ANTINEOPLASTICS (Cancer) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIBIOTIC ANTINEOPLASTICS		
IDAMYCIN PFS (<i>idarubicin hcl</i>)	T4	PA SP
<i>idarubicin hcl (Idamycin Pfs)</i>	T4	PA SP
<i>epirubicin hcl 200 mg vial</i>	T4	SP
IDAMYCIN PFS (<i>idarubicin hcl</i>)	T4	PA SP
<i>idarubicin hcl (Idamycin Pfs)</i>	T4	PA SP
<i>mitomycin (Mutamycin)</i>	T4	PA SP
<i>mitomycin</i>	T4	PA SP
<i>valrubicin (Valstar)</i>	T4	SP
VALSTAR (<i>valrubicin</i>)	T4	SP
ZANOSAR	T4	PA SP
ZUSDURI	T4	PA SP
ANTI-CD20 (B LYMPHOCYTE) MONOCLONAL ANTIBODY		
GAZYVA	T4	PA SP
RIABNI	T4	PA SP
RITUXAN	T4	PA SP
RITUXAN HYCELA	T4	PA SP
RUXIENCE	T4	PA SP
TRUXIMA	T4	PA SP
ANTINEOPLAST HUM VEGF INHIBITOR RECOMB MC ANTIBODY		
ALYMSYS	T4	PA SP
AVASTIN	T4	PA SP
JOBEVNE	T4	PA SP
MVASI	T4	PA SP
VEGZELMA	T4	PA SP
ZIRABEV	T4	PA SP
ANTINEOPLAST, HISTONE DEACETYLASE (HDAC) INHIBITORS		
BELEODAQ	T4	PA SP

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List of Prescription Medications

ANTINEOPLASTICS (Cancer) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTINEOPLAST, HISTONE DEACETYLASE (HDAC) INHIBITORS (cont.)		
ISTODAX	T4	PA SP
<i>romidepsin 10 mg kit</i>	T4	PA SP
<i>romidepsin 10 mg vial</i>	T4	PA SP
ROMIDEPSIN 27.5 MG/5.5 ML VIAL	T4	PA SP
ZOLINZA	T4	PA QL (4 CAPS/DAY) SP HD CSL
ANTINEOPLASTIC - ALKYLATING AGENTS		
ALKERAN 2 MG TABLET (<i>melphalan</i>)	T4	SP CSL
ALKERAN 50 MG VIAL (<i>melphalan hcl</i>)	T4	PA SP
BELRAPZO	T4	PA SP HD
<i>bendamustine 100 mg vial (Treanda)</i>	T4	PA SP
BENDAMUSTINE 100 MG/4 ML VIAL	T4	PA SP HD
<i>bendamustine 25 mg vial (Treanda)</i>	T4	PA SP
BENDEKA	T4	PA SP HD
BICNU (<i>carmustine</i>)	T4	SP
<i>busulfan (Busulfex)</i>	T4	SP
BUSULFEX (<i>busulfan</i>)	T4	SP
<i>carboplatin</i>	T4	PA SP
<i>carmustine 100 mg vial (Bicnu)</i>	T4	SP
CARMUSTINE 300 MG VIAL	T4	SP
CARMUSTINE 50 MG VIAL	T4	SP
<i>cisplatin 100 mg/100 ml vial</i>	T4	PA SP
<i>cisplatin 200 mg/200 ml vial</i>	T4	PA SP
CISPLATIN 50 MG VIAL	T4	PA SP
<i>cisplatin 50 mg/50 ml vial</i>	T4	PA SP
<i>cyclophosphamide 1 gm vial</i>	T4	SP
CYCLOPHOSPHAMIDE 1 GM/10 ML VL	T4	SP
CYCLOPHOSPHAMIDE 1 GM/5 ML VL	T4	SP
<i>cyclophosphamide 2 gm vial</i>	T4	SP
CYCLOPHOSPHAMIDE 2 GM/10 ML VL	T4	SP
CYCLOPHOSPHAMIDE 2 GM/20 ML VL	T4	SP
<i>cyclophosphamide 25 mg capsule</i>	T4	SP HD CSL
<i>cyclophosphamide 50 mg capsule</i>	T4	SP HD CSL
<i>cyclophosphamide 500 mg vial</i>	T4	SP
CYCLOPHOSPHAMIDE 500 MG/2.5 ML	T4	SP
CYCLOPHOSPHAMIDE 500 MG/5ML VL	T4	SP

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List of Prescription Medications

ANTINEOPLASTICS (Cancer) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTINEOPLASTIC - ALKYLATING AGENTS (cont.)		
EVOMELA	T4	PA SP
FRINDOVYX	T4	PA SP
GLEOSTINE	T2	CSL
GLIADEL	T4	SP CSL
HYDREA (<i>hydroxyurea</i>)	T3	CSL
<i>hydroxyurea</i> (Hydrea)	T1	CSL
IFEX (<i>ifosfamide</i>)	T4	PA SP
<i>ifosfamide</i>	T4	PA SP
<i>ifosfamide</i> (Ifex)	T4	PA SP
KYXATA	T4	PA SP
LEUKERAN	T2	CSL
<i>lomustine</i>	T1	CSL
<i>melphalan hcl</i> (Alkeran)	T4	PA SP
MYLERAN	T2	CSL
<i>oxaliplatin</i>	T4	PA SP
TEMODAR	T4	PA SP
<i>temozolomide</i>	T4	PA SP HD CSL
TEPADINA	T4	PA SP
TEPADINA (<i>thiotepa</i>)	T4	PA SP
<i>thiotepa</i>	T4	PA SP
<i>thiotepa</i> (Tepadina)	T4	PA SP
TREANDA (<i>bendamustine hcl</i>)	T4	PA SP
VIVIMUSTA	T4	PA SP
YONDELIS	T4	PA SP
ZEPZELCA	T4	PA SP
ANTINEOPLASTIC - ANTIANDROGENIC AGENTS		
<i>abiraterone acetate</i> (Zytiga)	T1	PA CSL
<i>abiraterone acetate 250 mg tab</i> (Zytiga)	T4	PA SP HD CSL
<i>abiraterone acetate 500 mg tab</i> (Zytiga)	T4	PA SP HD CSL
<i>bicalutamide</i> (Casodex)	T1	CSL
CASODEX (<i>bicalutamide</i>)	T3	CSL
ERLEADA	T4	PA SP HD CSL
EULEXIN (<i>flutamide</i>)	T3	CSL
<i>flutamide</i> (Eulexin)	T1	CSL

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List of Prescription Medications

ANTINEOPLASTICS (Cancer) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTINEOPLASTIC - ANTIANDROGENIC AGENTS		
<i>nilutamide</i> (Nilandron)	T1	QL (4 TABS/DAY) CSL
NUBEQA	T4	PA SP HD CSL
XTANDI	T4	PA SP HD CSL
ANTINEOPLASTIC - ANTIBIOTIC AND ANTIMETABOLITE		
VYXEOS	T4	PA SP
ANTINEOPLASTIC - ANTI-CD38 MONOCLONAL ANTIBODY		
DARZALEX	T4	PA SP HD
DARZALEX FASPRO	T4	PA SP
SARCLISA	T4	PA SP
ANTINEOPLASTIC - ANTIMETABOLITES		
<i>ALIMTA</i> (<i>pemetrexed disodium</i>)	T4	PA SP
<i>ARRANON</i> (<i>nelarabine</i>)	T4	PA SP
AVGEMSI	T4	PA SP
AXTLE	T3	PA
<i>azacitidine</i> (Vidaza)	T4	PA SP
<i>capecitabine 150 mg tablet</i> (Xeloda)	T4	PA SP HD CSL
<i>capecitabine 500 mg tablet</i> (Xeloda)	T4	PA SP HD CSL
<i>cladribine 10 mg/10 ml vial</i>	T4	PA SP
<i>clofarabine</i>	T4	PA SP
<i>cytarabine</i>	T4	PA SP
<i>cytarabine/pf</i>	T4	PA SP
DACOGEN (<i>decitabine</i>)	T4	PA SP
<i>decitabine</i> (Dacogen)	T4	PA SP
<i>floxuridine</i>	T4	PA SP
<i>fludarabine phosphate</i>	T4	PA SP
<i>fluorouracil</i>	T4	PA SP
<i>fluorouracil 1 gram/20 ml vial</i>	T4	PA SP
<i>fluorouracil 2.5 gram/50 ml vial</i>	T4	PA SP
<i>fluorouracil 5 gram/100 ml vial</i>	T4	PA SP
<i>fluorouracil 500 mg/10 ml vial</i>	T4	PA SP
FOLOTYN 20 MG/ML VIAL	T4	PA SP
FOLOTYN 40 MG/2 ML VIAL	T4	PA SP
<i>gemcitabine 1 gram/26.3 ml vial</i>	T4	PA SP

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ANTINEOPLASTICS (Cancer) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTINEOPLASTIC - ANTIMETABOLITES (cont.)		
<i>gemcitabine 2 gram/52.6 ml vial</i>	T4	PA SP
<i>gemcitabine 200 mg/5.26 ml vial</i>	T4	PA SP
<i>gemcitabine hcl 1 gram vial</i>	T4	PA SP
GEMCITABINE HCL 1 GRAM/10 ML	T4	PA SP
GEMCITABINE HCL 1.5 GRAM/15 ML	T4	PA SP
<i>gemcitabine hcl 2 gram vial</i>	T4	PA SP
GEMCITABINE HCL 2 GRAM/20 ML	T4	PA SP
<i>gemcitabine hcl 200 mg vial</i>	T4	PA SP
GEMCITABINE HCL 200 MG/2 ML VL	T4	PA SP
INFUGEM	T4	PA SP HD
INLEXZO	T4	PA SP
INQOVI	T4	PA SP HD CSL
JYLAMVO	T3	CSL
LONSURF	T4	PA SP HD CSL
<i>mercaptopurine 20 mg/ml suspen (Purixan)</i>	T4	SP CSL
<i>mercaptopurine 50 mg tablet</i>	T1	CSL
<i>methotrexate 1 gm vial</i>	T1	
<i>methotrexate 2.5 mg tablet</i>	T1	CSL
<i>methotrexate 250 mg/10 ml vial</i>	T1	
<i>methotrexate 50 mg/2 ml vial</i>	T1	
<i>methotrexate sodium/pf</i>	T1	
<i>nelarabine (Arranon)</i>	T4	PA SP
NIPENT	T4	PA SP
ONUREG	T4	PA QL (14 TABS/28 DAYS) SP CSL
PEMETREXED	T3	PA
<i>pemetrexed disodium 1 gm vial</i>	T4	PA SP
PEMETREXED DISODIUM 1 GM/40 ML	T3	PA
<i>pemetrexed disodium 100 mg vial (Alimta)</i>	T4	PA SP
PEMETREXED DISODIUM 100 MG/4ML	T3	PA
<i>pemetrexed disodium 500 mg vial (Alimta)</i>	T4	PA SP
PEMETREXED DISODIUM 500MG/20ML	T3	PA
<i>pemetrexed disodium 750 mg vial</i>	T4	PA SP
PEMETREXED DISODIUM 750 MG VL	T4	PA SP
PEMFEXY	T3	PA
PEMRYDI RTU	T3	PA

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List of Prescription Medications

ANTINEOPLASTICS (Cancer) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTINEOPLASTIC - ANTIMETABOLITES (cont.)		
PRALATREXATE	T4	PA SP
PURIXAN (<i>mercaptopurine</i>)	T4	SP CSL
TABLOID	T3	CSL
TREXALL	T2	CSL
VIDAZA (<i>azacitidine</i>)	T4	PA SP
XATMEP	T3	CSL
XELODA (<i>capecitabine</i>)	T4	PA SP HD CSL
ANTINEOPLASTIC - ANTI-SLAMF7 MONOCLONAL ANTIBODY		
EMPLICITI	T4	PA SP HD
ANTINEOPLASTIC - AROMATASE INHIBITORS		
anastrozole (<i>Arimidex</i>)	T1	HD PPACA CSL
ARIMIDEX (<i>anastrozole</i>)	T3	HD CSL
AROMASIN (<i>exemestane</i>)	T3	HD CSL
<i>exemestane</i> (Aromasin)	T1	HD PPACA CSL
<i>letrozole</i> (Femara)	T1	HD CSL
ANTINEOPLASTIC - BRAF KINASE INHIBITORS		
OJEMDA 100 MG TAB (400MG DOSE)	T4	PA QL(1 PACKET/28 Days) SP CSL
OJEMDA 100 MG TAB (500MG DOSE)	T4	PA QL(1 PACKET/28 Days) SP CSL
OJEMDA 100 MG TAB (600MG DOSE)	T4	PA QL(1 PACKET/28 Days) SP CSL
OJEMDA 25 MG/ML ORAL SUSP	T4	PA QL(8 BOTTLES/28 DAYS) SP CSL
TAFINLAR 10 MG TABLET FOR SUSP	T4	PA QL(30 TABS/DAY) SP HD CSL
TAFINLAR 50 MG CAPSULE	T4	PA QL(4 CAPS/DAY) SP HD CSL
TAFINLAR 75 MG CAPSULE	T4	PA QL(4 CAPS/DAY) SP HD CSL
ZELBORAF	T4	PA SP HD CSL
ANTINEOPLASTIC - CD19 (B LYMPHOCYTE) MC ANTIBODY		
MONJUVI	T4	PA SP
ANTINEOPLASTIC - EGFR AND MET RECEPTOR INHIB, MAB		
RYBREVA	T4	PA SP
ANTINEOPLASTIC - EPOTHILONES AND ANALOGS		
IXEMPRA	T4	PA SP
ANTINEOPLASTIC - HEDGEHOG PATHWAY INHIBITOR		
DAURISMO	T4	PA SP HD CSL
ERIVEDGE	T4	PA SP HD CSL
ODOMZO	T4	PA SP HD CSL

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List of Prescription Medications

ANTINEOPLASTICS (Cancer) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTINEOPLASTIC - IMMUNOTHERAPY, VIRUS-BASED AGENTS		
IMLYGIC	T4	PA SP
ANTINEOPLASTIC - JANUS KINASE (JAK) INHIBITORS		
JAKAFI	T4	PA SP HD
ANTINEOPLASTIC - KRAS PROTEIN INHIBITOR		
LUMAKRAS 120 MG TABLET	T4	PA QL(8 TABS/DAY) SP HD CSL
LUMAKRAS 240 MG TABLET	T4	PA QL(4 TABS/DAY) SP HD CSL
LUMAKRAS 320 MG TABLET	T4	PA QL(3 TABS/DAY) SP HD CSL
ANTINEOPLASTIC - MEK KINASE INHIBITORS		
COTELLIC	T4	PA SP HD CSL
GOMEKLI	T4	PA SP CSL
KOSELUGO 10 MG CAPSULE	T4	PA QL(10 CAPS/DAY) SP CSL
KOSELUGO 25 MG CAPSULE	T4	PA QL(4 CAPS/DAY) SP CSL
KOSELUGO 5 MG SPRINKLE CAPSULE	T4	PA QL(20 CAPS/DAY) SP CSL
KOSELUGO 7.5 MG SPRINKLE CAP	T4	PA QL(12 CAPS/DAY) SP CSL
MEKINIST 0.05 MG/ML SOLUTION	T4	PA QL(40 MLS/DAY) SP HD CSL
MEKINIST 0.5 MG TABLET	T4	PA QL(3 TABS/DAY) SP HD CSL
MEKINIST 2 MG TABLET	T4	PA QL(1 TAB/DAY) SP HD CSL
ANTINEOPLASTIC - MICROTUBULE INHIBITORS		
<i>eribulin mesylate</i> (Halaven)	T4	PA SP
HALAVEN (<i>eribulin mesylate</i>)	T4	PA SP
ANTINEOPLASTIC - MTOR KINASE INHIBITORS		
<i>everolimus</i> (Afinitor)	T4	PA QL(1 TAB/DAY) SP CSL
<i>everolimus 10 mg tablet</i> (Afinitor)	T4	PA QL(1 TAB/DAY) SP HD CSL
<i>everolimus 2 mg tab for susp</i> (Afinitor Disperz)	T4	PA QL(1 TAB/DAY) SP CSL
<i>everolimus 2.5 mg tablet</i> (Afinitor)	T4	PA QL(1 TAB/DAY) SP HD CSL
<i>everolimus 3 mg tab for susp</i> (Afinitor Disperz)	T4	PA QL(1 TAB/DAY) SP CSL
<i>everolimus 5 mg tab for susp</i> (Afinitor Disperz)	T4	PA QL(1 TAB/DAY) SP CSL
<i>everolimus 5 mg tablet</i> (Afinitor)	T4	PA QL(1 TAB/DAY) SP HD CSL
<i>everolimus 7.5 mg tablet</i> (Afinitor)	T4	PA QL(1 TAB/DAY) SP HD CSL
FYARRO	T4	PA SP
<i>temsirolimus</i> (Torisel)	T4	PA SP
TORISEL (<i>temsirolimus</i>)	T4	PA SP

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ANTINEOPLASTICS (Cancer) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTINEOPLASTIC - PROTEIN METHYLTRANSFERASE INHIBIT		
TAZVERIK	T4	PA SP
ANTINEOPLASTIC - TOPOISOMERASE I INHIBITORS		
CAMPTOSAR	T4	PA SP
CAMPTOSAR (<i>irinotecan hcl</i>)	T4	PA SP
HYCANTIN	T4	PA SP HD CSL
<i>irinotecan hcl</i>	T4	PA SP
<i>irinotecan hcl</i> (Camptosar)	T4	PA SP
ONIVYDE	T4	PA SP
<i>topotecan hcl</i>	T4	PA SP HD
ANTINEOPLASTIC - VEGF-A, B AND PLGF INHIBITORS		
ZALTRAP	T4	PA SP
ANTINEOPLASTIC - VEGFR ANTAGONIST		
CYRAMZA	T4	PA SP
ANTINEOPLASTIC - VINCA ALKALOIDS		
<i>vinblastine sulfate</i>	T4	PA SP
<i>vincristine sulfate</i>	T4	PA SP
<i>vinorelbine tartrate</i> (Navelbine)	T4	PA SP
ANTINEOPLASTIC- CD22 ANTIBODY-CYTOTOXIC ANTIBIOTIC		
BESPOLSA	T4	PA SP
ANTINEOPLASTIC- CD33 ANTIBODY-CYTOTOXIC ANTIBIOTIC		
MYLOTARG	T4	PA SP
ANTINEOPLASTIC COMB - KINASE AND AROMATASE INHIBIT		
KISQALI FEMARA CO-PACK	T4	PA QL(1 TAB/28 DAYS) SP CSL
ANTINEOPLASTIC EGF RECEPTOR BLOCKER MCLON ANTIBODY		
ERBITUX	T4	PA SP
HERCEPTIN	T4	PA SP
HERCEPTIN HYLECTA	T4	PA SP
HERCESSI	T4	PA SP
HERZUMA	T4	PA SP
KANJINTI	T4	PA SP
OGIVRI	T4	PA SP
ONTRUZANT	T4	PA SP
PERJETA	T4	PA SP
PHESGO	T4	PA SP HD

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ANTINEOPLASTIC EGF RECEPTOR BLOCKER MCLON ANTIBODY (con't.)		
PORTRAZZA	T4	PA SP
TRAZIMERA	T4	PA SP
VECTIBIX	T4	PA SP
ANTINEOPLASTIC IMMUNOMODULATOR AGENTS		
<i>lenalidomide</i>	T4	PA QL(1 CAP/DAY) SP HD CSL
POMALYST	T4	PA QL(21 CAPS/28 DAYS) SP HD CSL
REVLIMID	T4	PA QL(1 CAP/DAY) SP HD CSL
ANTINEOPLASTIC LHRH (GNRH) AGONIST, PITUITARY SUPPR.		
CAMCEVI	T4	PA SP
ELIGARD	T4	SP HD
<i>leuprolide acetate</i>	T4	PA SP HD
LEUPROLIDE DEPOT	T4	PA SP
LUTRATE DEPOT	T4	PA SP
TRELSTAR	T4	SP HD
ZOLADEX	T4	PA SP HD
ANTINEOPLASTIC LHRH(GNRH) ANTAGONIST,PITUIT.SUPPRS		
FIRMAGON	T4	PA SP HD
ORGOVYX	T4	PA SP CSL
ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS		
ALECENSA	T4	PA QL(8 CAPS/DAY) SP HD CSL
ALIQOPA	T4	PA SP
ALUNBRIG 180 MG TABLET	T4	PA QL(1 TAB/DAY) SP CSL
ALUNBRIG 30 MG TABLET	T4	PA QL(2 TABS/DAY) SP CSL
ALUNBRIG 90 MG TABLET	T4	PA QL(1 TAB/DAY) SP CSL
ALUNBRIG 90 MG-180 MG TAB PACK	T4	PA QL(1 TAB/DAY) SP CSL
AYVAKIT	T4	PA QL(1 TAB/DAY) SP CSL
BALVERSA	T4	PA SP CSL
BORTEZOMIB 1 MG VIAL	T4	PA SP
BORTEZOMIB 2.5 MG VIAL	T4	PA SP
<i>bortezomib 3.5 mg vial (Velcade)</i>	T4	PA SP
BORTEZOMIB 3.5 MG/1.4 ML VIAL	T4	PA SP
BOSULIF 100 MG CAPSULE	T4	PA QL(3 CAPS/DAY) SP HD CSL
BOSULIF 100 MG TABLET	T4	PA QL(3 TABS/DAY) SP HD CSL
BOSULIF 400 MG TABLET	T4	PA QL(1 TAB/DAY) SP HD CSL
BOSULIF 50 MG CAPSULE	T4	PA QL(3 CAPS/DAY) SP HD CSL

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ANTINEOPLASTICS (Cancer) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS		
BOSULIF 500 MG TABLET	T4	PA QL(1 TAB/DAY) SP HD CSL
BRUKINSA 160 MG TABLET	T4	PA QL(2 TABS/DAY) SP CSL
BRUKINSA 80 MG CAPSULE	T4	PA QL(4 CAPS/DAY) SP CSL
CABOMETYX	T4	PA SP HD CSL
CALQUENCE	T4	PA SP CSL
CAPRELSA 100 MG TABLET	T4	PA QL(2 TABS/DAY) SP CSL
CAPRELSA 300 MG TABLET	T4	PA QL(1 TAB/DAY) SP CSL
COMETRIQ 100 MG DAILY-DOSE PK	T4	PA QL(56 CAPS/28 DAYS) SP HD CSL
COMETRIQ 140 MG DAILY-DOSE PK	T4	PA QL(112 CAPS/28 DAYS) SP HD CSL
COMETRIQ 60 MG DAILY-DOSE PACK	T4	PA QL(84 CAPS/28 DAYS) SP HD CSL
COPIKTRA	T4	PA SP CSL
DANZITEN	T4	PA SP CSL
<i>dasatinib 100 mg tablet (Sprycel)</i>	T4	QL(1 TAB/DAY) SP HD CSL
<i>dasatinib 140 mg tablet (Sprycel)</i>	T4	QL(1 TAB/DAY) SP HD CSL
<i>dasatinib 20 mg tablet (Sprycel)</i>	T4	QL(3 TABS/DAY) SP HD CSL
<i>dasatinib 50 mg tablet (Sprycel)</i>	T4	QL(1 TAB/DAY) SP HD CSL
<i>dasatinib 70 mg tablet (Sprycel)</i>	T4	QL(2 TABS/DAY) SP HD CSL
<i>dasatinib 80 mg tablet (Sprycel)</i>	T4	QL(1 TAB/DAY) SP HD CSL
ENSACOVE 100 MG CAPSULE	T4	PA QL(2 CAPS/DAY) SP CSL
ENSACOVE 25 MG CAPSULE	T4	PA QL(9 CAPS/DAY) SP CSL
<i>erlotinib hcl</i>	T4	PA SP HD CSL
FOTIVDA	T4	PA QL(21 CAPS/28 DAYS) SP CSL
FRUZAQLA 1 MG CAPSULE	T4	PA QL(84 CAPS/28 DAYS) SP CSL
FRUZAQLA 5 MG CAPSULE	T4	PA QL(21 CAPS/28 DAYS) SP CSL
GAVRETO	T4	PA QL(4 CAPS/DAY) SP CSL
<i>gefitinib (Iressa)</i>	T4	PA SP HD CSL
GILOTRIF	T4	PA SP HD CSL
IBRANCE 100 MG CAPSULE	T4	PA QL(21 CAPS/28 DAYS) SP HD CSL

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ANTINEOPLASTICS (Cancer) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS (cont.)		
IBRANCE 100 MG TABLET	T4	PA QL(21 TABS/28 DAYS) SP HD CSL
IBRANCE 125 MG CAPSULE	T4	PA QL(21 CAPS/28 DAYS) SP HD CSL
IBRANCE 125 MG TABLET	T4	PA QL(21 TABS/28 DAYS) SP HD CSL
IBRANCE 75 MG CAPSULE	T4	PA QL(21 CAPS/28 DAYS) SP HD CSL
IBRANCE 75 MG TABLET	T4	PA QL(21 TABS/28 DAYS) SP HD CSL
IBTROZI	T4	PA SP CSL
<i>imatinib mesylate 100 mg tab (Gleevec)</i>	T4	QL(6 TABS/DAY) SP HD CSL
<i>imatinib mesylate 400 mg tab (Gleevec)</i>	T4	QL(2 TABS/DAY) SP HD CSL
IMBRUVICA 140 MG CAPSULE	T4	PA QL(4 CAPS/DAY) SP CSL
IMBRUVICA 140 MG TABLET	T4	PA QL(1 TAB/DAY) SP CSL
IMBRUVICA 280 MG TABLET	T4	PA QL(1 TAB/DAY) SP CSL
IMBRUVICA 420 MG TABLET	T4	PA QL(1 TAB/DAY) SP CSL
IMBRUVICA 70 MG CAPSULE	T4	PA QL(1 CAP/DAY) SP CSL
IMBRUVICA 70 MG/ML SUSPENSION	T4	PA QL(8 MLS/DAY) SP CSL
IMKELDI	T4	PA SP CSL
INLYTA	T4	PA SP HD CSL
INREBIC	T4	PA SP HD CSL
IRESSA (<i>gefitinib</i>)	T4	PA SP HD CSL
ITOVEBI	T4	PA SP HD CSL
IWILFIN	T4	PA QL(8 TABS/DAY) SP CSL
JAYPIRCA 100 MG TABLET	T4	PA QL(2 TABS/DAY) SP CSL
JAYPIRCA 50 MG TABLET	T4	PA QL(1 TAB/DAY) SP CSL
KISQALI 200 MG DAILY DOSE	T4	PA QL(21 TABS/28 DAYS) SP HD CSL
KISQALI 400 MG DAILY DOSE	T4	PA QL(42 TABS/28 DAYS) SP HD CSL
KISQALI 600 MG DAILY DOSE	T4	PA QL(63 TABS/28 DAYS) SP HD CSL
KYPROLIS	T4	PA SP HD
<i>lapatinib ditosylate (Tykerb)</i>	T4	PA QL(6 TABS/DAY) SP HD CSL
LAZCLUZE	T4	PA SP CSL
LENVIMA	T4	PA SP HD CSL
LORBRENA 100 MG TABLET	T4	PA QL(1 TAB/DAY) SP HD CSL
LORBRENA 25 MG TABLET	T4	PA QL(3 TABS/DAY) SP HD CSL

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ANTINEOPLASTICS (Cancer) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS (cont.)		
LYNPARZA	T4	PA QL(4 TABS/DAY) SP HD CSL
LYTGOBI 12 MG DOSE (3X 4MG TB)	T4	PA QL(3 TABS/DAY) SP CSL
LYTGOBI 16 MG DOSE (4X 4MG TB)	T4	PA QL(4 TABS/DAY) SP CSL
LYTGOBI 20 MG DOSE (5X 4MG TB)	T4	PA QL(5 TABS/DAY) SP CSL
NERLYNX	T4	PA SP HD CSL
<i>nilotinib hcl (Tasigna)</i>	T4	PA QL(4 CAPS/DAY) SP HD CSL
NINLARO	T4	PA QL(3 CAPS/28 DAYS) SP HD CSL
OGSIVEO 100 MG TABLET	T4	PA QL(2 TABS/DAY) SP CSL
OGSIVEO 150 MG TABLET	T4	PA QL(2 TABS/DAY) SP CSL
OGSIVEO 50 MG TABLET	T4	PA QL(6 TABS/DAY) SP CSL
OJJAARA	T4	PA QL(1 TAB/DAY) SP CSL
<i>pazopanib hcl 200 mg tablet (Votrient)</i>	T4	PA QL(4 TABS/DAY) SP CSL
PEMAZYRE	T4	PA QL(14 TABS/21 DAYS) SP CSL
PIQRAY	T4	PA SP CSL
QINLOCK	T4	PA QL(3 TABS/DAY) SP CSL
RETEVMO 120 MG TABLET	T4	PA QL(2 TABS/DAY) SP HD CSL
RETEVMO 160 MG TABLET	T4	PA QL(2 TABS/DAY) SP HD CSL
RETEVMO 40 MG CAPSULE	T4	PA QL(6 CAPS/DAY) SP HD CSL
RETEVMO 40 MG TABLET	T4	PA QL(3 TABS/DAY) SP HD CSL
RETEVMO 80 MG CAPSULE	T4	PA QL(4 CAPS/DAY) SP HD CSL
RETEVMO 80 MG TABLET	T4	PA QL(2 TABS/DAY) SP HD CSL
REVUFORJ 110 MG TABLET	T4	PA QL(4 TABS/DAY) SP CSL
REVUFORJ 160 MG TABLET	T4	PA QL(2 TABS/DAY) SP CSL
REVUFORJ 25 MG TABLET	T4	PA QL(8 TABS/DAY) SP CSL
ROMVIMZA	T4	PA QL(8 CAPS/28 DAYS) SP CSL
ROZLYTREK	T4	PA SP HD CSL
RUBRACA	T4	PA QL(4 TABS/DAY) SP CSL
RYDAPT	T4	PA SP HD CSL
SCEMBLIX 100 MG TABLET	T4	PA SP CSL
SCEMBLIX 20 MG TABLET	T4	PA QL(2 TABS/DAY) SP CSL
SCEMBLIX 40 MG TABLET	T4	PA SP CSL
<i>sorafenib tosylate (Nexavar)</i>	T4	PA QL(4 TABS/DAY) SP HD CSL
STIVARGA	T4	PA QL(84 TABS/28 DAYS) SP HD CSL
<i>sunitinib malate (Sutent)</i>	T4	PA QL(1 CAP/DAY) SP HD CSL

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ANTINEOPLASTICS (Cancer) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS (cont.)		
TABRECTA	T4	PA QL(4 TABS/DAY) SP HD CSL
TAGRISSO	T4	PA SP HD CSL
TALZENNA 0.1 MG CAPSULE	T4	PA QL(1 CAP/DAY) SP CSL
TALZENNA 0.1 MG SOFTGEL	T4	PA QL(1 CAP/DAY) SP CSL
TALZENNA 0.25 MG CAPSULE	T4	PA QL(1 CAP/DAY) SP CSL
TALZENNA 0.25 MG SOFTGEL	T4	PA QL(1 CAP/DAY) SP CSL
TALZENNA 0.35 MG SOFTGEL	T4	PA QL(1 CAP/DAY) SP CSL
TALZENNA 0.5 MG CAPSULE	T4	PA SP CSL
TALZENNA 0.5 MG SOFTGEL	T4	PA SP CSL
TALZENNA 0.75 MG SOFTGEL	T4	PA SP CSL
TALZENNA 1 MG CAPSULE	T4	PA QL(1 CAP/DAY) SP CSL
TALZENNA 1 MG SOFTGEL	T4	PA QL(1 CAP/DAY) SP CSL
TEPMETKO	T4	PA QL(2 TABS/DAY) SP CSL
TRUQAP	T4	PA QL(64 TABS/28 DAYS) SP CSL
TUKYSA	T4	PA SP CSL
TURALIO	T4	PA QL(4 CAPS/DAY) SP CSL
VANFLYTA	T4	PA QL(2 TABS/DAY) SP CSL
VERZENIO	T4	PA QL(2 TABS/DAY) SP HD CSL
VITRAKVI	T4	PA SP HD CSL
VIZIMPRO	T4	PA SP HD CSL
VONJO	T4	PA QL(4 CAPS/DAY) SP CSL
XALKORI 150 MG PELLETT	T4	PA QL(6 PELLETS/DAY) SP HD CSL
XALKORI 20 MG PELLETT	T4	PA QL(4 PELLETS/DAY) SP HD CSL
XALKORI 200 MG CAPSULE	T4	PA QL(4 CAPS/DAY) SP HD CSL
XALKORI 250 MG CAPSULE	T4	PA QL(4 CAPS/DAY) SP HD CSL
XALKORI 50 MG PELLETT	T4	PA QL(4 PELLETS/DAY) SP HD CSL
XOSPATA	T4	PA SP CSL
ZEJULA	T4	PA QL(1 TAB/DAY) SP CSL
ZYDELIG	T4	PA QL(2 TABS/DAY) SP HD CSL
ANTINEOPLASTIC, ANTI-PROGRAMMED DEATH-1 (PD-1) MAB		
JEMPERLI	T4	PA SP
KEYTRUDA	T4	PA SP
KEYTRUDA QLEX	T4	PA SP
LIBTAYO	T4	PA SP
LOQTORZI	T4	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	T4	PA SP HD
TEVIMBRA	T4	PA SP
ZYNYZ	T4	PA SP
ANTINEOPLASTIC-B CELL LYMPHOMA-2 (BCL-2) INHIBITORS		
VENCLEXTA	T4	PA SP
VENCLEXTA STARTING PACK	T4	PA SP
ANTINEOPLASTIC-ENZYME INHIB, ANTIANDROGEN COMB.		
AKEEGA	T4	PA QL(2 TABS/DAY) SP CSL
ANTINEOPLASTIC-HYPOXIA INDUCIBLE FACTOR (HIF) INH		
WELIREG	T4	PA QL(3 TABS/DAY) SP CSL
ANTINEOPLASTIC-IMMUNOTHERAPY CHECKPOINT INHIB COMB		
OPDUALAG	T4	PA SP HD
ANTINEOPLASTIC-INTERLEUKIN-6 (IL-6) INHIB, ANTIBODY		
SYLVANT	T4	PA SP
ANTINEOPLASTIC-ISOCITRATE DEHYDROGENASE INHIBITORS		
IDHIFA	T4	PA SP HD CSL
REZLIDHIA	T4	PA QL(2 CAPS/DAY) SP CSL
TIBSOVO	T4	PA SP CSL
VORANIGO	T4	PA SP CSL
ANTINEOPLASTIC-ISOCITRATE DEHYDROGENASE INHIBITORS		
ADCETRIS	T4	PA SP
BIZENGRI	T4	PA SP
BLENREP	T4	PA SP
BLINCYTO	T4	PA SP
COLUMVI	T4	PA SP HD
DATROWAY	T4	PA SP
ELAHERE	T4	PA SP
ELREXFIO	T4	PA SP
EMRELIS	T4	PA SP
ENHERTU	T4	PA SP HD
EPKINLY	T4	PA SP
IMDELLTRA	T4	PA SP
KADCYLA	T4	PA SP
LUNSUMIO	T4	PA SP
LYNOZYFIC	T4	PA SP

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List of Prescription Medications

ANTINEOPLASTICS (Cancer) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTINEOPLASTIC-ISOCITRATE DEHYDROGENASE INHIBITORS (cont.)		
PADCEV	T4	PA SP
POLIVY	T4	PA SP HD
POTELIGEO	T4	PA SP
TALVEY	T4	PA SP
TECVAYLI	T4	PA SP
TIVDAK	T4	PA SP HD
TRODELVY	T4	PA SP
UNITUXIN	T4	PA SP
VYLOY	T4	PA SP
ZEVALIN	T4	PA SP
ZYNLONTA	T4	PA SP
ANTINEOPLASTICS, MISCELLANEOUS		
ABRAXANE (<i>paclitaxel protein-bound</i>)	T4	PA SP
<i>arsenic trioxide</i>	T4	PA SP
<i>arsenic trioxide (Trisenox)</i>	T4	PA SP
ASPARLAS	T4	SP
BCG (TICE STRAIN)	T4	SP
BEIZRAY-ALBUMIN	T4	PA
<i>dacarbazine</i>	T4	PA SP
DOCEFREZ	T4	PA SP
<i>docetaxel 160 mg/16 ml vial</i>	T4	PA SP
<i>docetaxel 160 mg/8 ml vial</i>	T4	PA SP HD
<i>docetaxel 20 mg/2 ml vial</i>	T4	PA SP
<i>docetaxel 20 mg/ml vial</i>	T4	PA SP
<i>docetaxel 80 mg/4 ml vial</i>	T4	PA SP
<i>docetaxel 80 mg/8 ml vial</i>	T4	PA SP
ERWINASE	T4	PA SP
ETOPOPHOS	T4	PA SP
<i>etoposide</i>	T4	PA SP
<i>etoposide 1,000 mg/50 ml vial</i>	T4	PA SP
<i>etoposide 100 mg/5 ml vial</i>	T4	PA SP
<i>etoposide 50 mg capsule</i>	T4	SP HD CSL

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ANTINEOPLASTICS (Cancer) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTINEOPLASTICS, MISCELLANEOUS (cont.)		
<i>etoposide 500 mg/25 ml vial</i>	T4	PA SP
JEVTANA	T4	PA SP HD
LYSODREN	T2	CSL
MATULANE	T4	SP CSL
<i>mitoxantrone hcl</i>	T4	PA SP
ONCASPAR	T4	PA SP
<i>paclitaxel</i>	T4	PA SP
<i>paclitaxel protein-bound (Abraxane)</i>	T4	PA SP
RYLAZE	T4	PA SP
<i>tretinoin 10 mg capsule</i>	T1	PA CSL
TRISENOX (<i>arsenic trioxide</i>)	T4	PA SP
ANTINEOPLASTIC-SELECT INHIB OF NUCLEAR EXP (SINE)		
XPOVIO	T4	PA SP
ANTI-PROGRAMMED CELL DEATH-LIGAND 1 (PD-L1) MAB		
BAVENCIO	T4	PA SP
IMFINZI	T4	PA SP
TECENTRIQ	T4	PA SP HD
TECENTRIQ HYBREZA	T4	PA SP HD
UNLOXCYT	T4	PA SP
CYTOTOXIC T-LYMPHOCYTE ANTIGEN (CTLA-4) RMC ANTIBODY		
IMJUDO	T4	PA SP HD
YERVOY	T4	PA SP HD
IMMUNOMODULATORS		
ACTIMMUNE	T4	PA SP HD
ALFERON N	T4	PA SP HD
PROLEUKIN	T4	PA SP
PHOTOACTIVATED, ANTINEOPLASTIC AGENTS (SYSTEMIC)		
PHOTOFRIN	T4	SP
UVADEX	T2	
RADIOACTIVE THERAPEUTIC AGENTS		
AZEDRA DOSIMETRIC	T4	PA SP
AZEDRA THERAPEUTIC	T4	PA SP
SELECTIVE ESTROGEN RECEPTOR MODULATORS (SERMS)		
FARESTON (<i>toremifene citrate</i>)	T3	QL(2 TABS/DAY) HD CSL
FASLODEX (<i>fulvestrant</i>)	T4	PA SP HD

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ANTINEOPLASTICS (Cancer) (cont.)		
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SELECTIVE ESTROGEN RECEPTOR MODULATORS (SERMS)		
<i>fulvestrant</i> (Faslodex)	T4	PA SP HD
ORSERDU 345 MG TABLET	T4	PA QL(1 TAB/DAY) SP CSL
ORSERDU 86 MG TABLET	T4	PA QL(3 TABS/DAY) SP CSL
SOLTAMOX	T2	HD CSL
<i>tamoxifen citrate</i>	T1	HD PPACA CSL
<i>toremifene citrate</i> (Fareston)	T1	QL(2 TABS/DAY) HD CSL
STEROID ANTINEOPLASTICS		
<i>megestrol 20 mg tablet</i>	T1	CSL
<i>megestrol 40 mg tablet</i>	T1	CSL
ANTINEOPLASTICS (Skin Conditions)		
PHOTOACT, TOPICAL ANTINEOPLAST, PREMALIGNANT LESIONS		
LEVULAN	T4	SP
TOPICAL ANTINEOPLASTIC PREMALIGNANT LESION AGENTS		
<i>bexarotene 1% gel</i> (Targretin)	T4	SP HD
EFUDEX (<i>fluorouracil</i>)	T3	
FLUOROPLEX	T2	
FLUOROURACIL 0.5% CREAM	T1	
<i>fluorouracil 2% topical soln</i>	T1	
<i>fluorouracil 5% cream</i> (Efudex)	T1	
<i>fluorouracil 5% topical soln</i>	T1	
PANRETIN	T4	SP HD
VALCHLOR	T4	SP HD
ANTIPARASITICS (Eye Conditions)		
OPHTHALMIC (EYE) ANTIPARASITICS		
XDEMZY	T4	PA QL(10 MLS/56 DAYS) SP
ANTIPARASITICS (Infections)		
ANTIPARASITICS		
ALINIA 100 MG/5 ML SUSPENSION	T3	
<i>nitazoxanide</i> (Alinia)	T1	
TOPICAL ANTIPARASITICS		
<i>crotamiton</i>	T1	
ELIMITE (permethrin)	T3	
EURAX	T3	
<i>lindane</i>	T1	

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List of Prescription Medications

ANTIPARASITICS (Infections) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL ANTIPARASITICS		
<i>malathion</i> (Ovide)	T1	
OVIDE (<i>malathion</i>)	T3	
<i>permethrin</i> (Elimite)	T1	
<i>spinosad</i> (Natroba)	T1	
ULESFIA	T3	

ANTIPARASITICS (Skin Conditions)

TOPICAL ANTIPARASITICS		
<i>lindane</i>	T1	
<i>malathion</i> (Ovide)	T1	
OVIDE (<i>malathion</i>)	T3	

ANTIPARKINSON DRUGS (Parkinson's Disease)

ANTIPARKINSONISM DRUGS, ANTICHOLINERGIC		
<i>benztropine mesylate</i>	T1	HD
<i>trihexyphenidyl hcl</i>	T1	HD
ANTIPARKINSONISM DRUGS, OTHER		
<i>amantadine hcl</i>	T1	HD
APOKYN	T4	PA SP HD
<i>apomorphine hcl</i>	T4	PA SP
<i>bromocriptine mesylate</i>	T1	HD
<i>carbidopa/levodopa</i>	T1	HD
<i>carbidopa/levodopa</i> (Sinemet)	T1	HD
<i>carbidopa/levodopa/entacapone</i>	T1	HD
<i>carbidopa/levodopa/entacapone</i> (Stalevo 100)	T1	HD
<i>carbidopa/levodopa/entacapone</i> (Stalevo 75)	T1	HD
<i>carbidopa-levo er 25-100 tab</i>	T1	HD
<i>carbidopa-levo er 50-200 tab</i>	T1	HD
CREXONT	T3	ST HD
DUOPA	T4	SP HD
<i>entacapone</i>	T1	HD
INBRIJA	T4	PA SP HD
NEUPRO	T3	HD
NOURIANZ	T4	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.)		
<i>pramipexole di-hcl</i>	T1	HD
<i>pramipexole er 0.375 mg tablet</i>	T1	QL(1 TAB/DAY) HD
<i>pramipexole er 0.75 mg tablet</i>	T1	HD
<i>pramipexole er 1.5 mg tablet</i>	T1	QL(1 TAB/DAY) HD
<i>pramipexole er 2.25 mg tablet</i>	T1	QL(1 TAB/DAY) HD
<i>pramipexole er 3 mg tablet</i>	T1	HD
<i>pramipexole er 3.75 mg tablet</i>	T1	HD
<i>pramipexole er 4.5 mg tablet</i>	T1	HD
<i>rasagiline mesylate 0.5 mg tab (Azilect)</i>	T1	QL(1 TAB/DAY) HD
<i>rasagiline mesylate 1 mg tab (Azilect)</i>	T1	HD
<i>ropinirole hcl</i>	T1	HD
RYTARY	T3	ST HD
<i>selegiline hcl</i>	T1	HD
SINEMET (<i>carbidopa/levodopa</i>)	T3	HD
STALEVO 100 (<i>carbidopa/levodopa/entacapone</i>)	T3	HD
STALEVO 75 (<i>carbidopa/levodopa/entacapone</i>)	T3	HD
TASMAR (<i>tolcapone</i>)	T3	HD
<i>tolcapone (Tasmar)</i>	T1	HD
XADAGO	T3	ST HD
DECARBOXYLASE INHIBITORS		
<i>carbidopa (Lodosyn)</i>	T1	
ANTIPLATELET DRUGS (Blood Thinners/Anti-Clotting)		
PLATELET AGGREGATION INHIBITORS		
AGGRASTAT	T3	
<i>aspirin/dipyridamole</i>	T1	HD
ASPIRIN-OMEPRAZOLE DR 81-40 MG	T3	HD
<i>cilostazol</i>	T1	HD
<i>clopidogrel bisulfate</i>	T1	HD
<i>clopidogrel bisulfate (Plavix)</i>	T1	HD
<i>dipyridamole 25 mg tablet</i>	T1	HD
<i>dipyridamole 50 mg tablet</i>	T1	HD
<i>dipyridamole 75 mg tablet</i>	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.)		
<i>eptifibatide</i>	T1	
EPTIFIBATIDE	T1	
<i>prasugrel hcl</i> (Effient)	T1	HD
<i>ticagrelor</i> (Brilinta)	T1	HD
<i>tirofiban-0.9% sodium chloride</i>	T1	
ZONTIVITY	T3	HD
PLATELET REDUCING AGENTS		
<i>AGRYLIN (anagrelide hcl)</i>	T3	
<i>anagrelide hcl</i>	T1	
<i>anagrelide hcl</i> (Agrylin)	T1	
ANTIVIRALS (AIDS/HIV)		
ANTIRETROVIRAL - ANTI-CD4 DOMAIN 2 MONOCLONAL AB		
TROGARZO	T4	PA SP
ANTIRETROVIRAL - CAPSID INHIBITORS		
SUNLENCA 300 MG TABLET	T4	PA QL(5 TABS/180 DAYS) SP
SUNLENCA 4- 300 MG TABLET	T4	PA QL(5 TABS/180 DAYS) SP
SUNLENCA 463.5 MG/1.5 ML VIAL	T4	PA SP
SUNLENCA 5- 300 MG TABLET	T4	PA QL(5 TABS/180 DAYS) SP
ANTIRETROVIRAL-INTEGRASE INHIBITOR AND NNRTI COMB.		
CABENUVA	T4	PA SP
JULUCA	T4	QL(1 TAB/DAY) SP
ANTIRETROVIRAL-INTEGRASE INHIBITOR AND NRTI COMB.		
DOVATO	T4	QL(1 TAB/DAY) SP
ANTIRETROVIRAL-NRTIS AND INTEGRASE INHIBITORS COMB		
TRIUMEQ	T4	QL(1 TAB/DAY) SP
TRIUMEQ PD	T4	QL(6 TABS/DAY) SP
ANTIRETROVIRAL-NUCLEOSIDE, NUCLEOTIDE, PROTEASE INH.		
SYM TUZA	T4	SP
ANTIVIRALS, HIV-SPEC, NON-PEPTIDIC PROTEASE INHIB		
APTIVUS	T4	PA SP
<i>darunavir</i> (Prezista)	T4	SP
PREZCOBIX	T4	PA SP
PREZISTA 100 MG/ML SUSPENSION	T4	SP
PREZISTA 150 MG TABLET	T4	SP
PREZISTA 75 MG TABLET	T4	SP

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List of Prescription Medications

ANTIVIRALS (AIDS/HIV) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIVIRALS, HIV-SPEC, NUCLEOSIDE-NUCLEOTIDE ANALOG		
CIMDUO	T4	PA SP
DESCOVY 120-15 MG TABLET	T4	SP
DESCOVY 200-25 MG TABLET	T4	SP PPACA
<i>emtricitabine-tenofv 100-150mg (Truvada)</i>	T4	SP
<i>emtricitabine-tenofv 133-200mg (Truvada)</i>	T4	SP
<i>emtricitabine-tenofv 167-250mg (Truvada)</i>	T4	SP
<i>emtricitabine-tenofv 200-300mg (Truvada)</i>	T4	SP PPACA
ANTIVIRALS, HIV-SPEC., NUCLEOSIDE ANALOG, RTI COMB		
<i>abacavir sulfate/lamivudine (Epzicom)</i>	T4	PA SP
<i>lamivudine/zidovudine (Combivir)</i>	T4	SP
ANTIVIRALS, HIV-SPECIFIC, CCR5 CO-RECEPTOR ANTAG.		
<i>maraviroc (Selzentry)</i>	T4	PA SP
SELZENTRY 20 MG/ML ORAL SOLN	T4	PA SP
ANTIVIRALS, HIV-SPECIFIC, CD4 ATTACHMENT INHIBITOR		
RUKOBIA	T4	PA QL (2 TABS/DAY) SP
ANTIVIRALS, HIV-SPECIFIC, FUSION INHIBITORS		
FUZEON	T4	PA SP
ANTIVIRALS, HIV-SPECIFIC, NON-NUCLEOSIDE, RTI		
EDURANT	T4	PA SP
EDURANT PED	T4	PA SP
<i>efavirenz</i>	T4	PA SP
<i>etravirine (Intelece)</i>	T4	SP
INTELENCE 25 MG TABLET	T4	PA SP
<i>nevirapine</i>	T4	PA SP
PIFELTRO	T4	PA SP
ANTIVIRALS, HIV-SPECIFIC, NUCLEOSIDE ANALOG, RTI		
<i>abacavir sulfate</i>	T4	PA SP
<i>abacavir sulfate (Ziagen)</i>	T4	PA SP
<i>emtricitabine (Emtriva)</i>	T4	SP
EMTRIVA 10 MG/ML SOLUTION	T4	PA SP
<i>lamivudine 10 mg/ml oral soln (Epivir)</i>	T4	SP
<i>lamivudine 150 mg tablet (Epivir)</i>	T4	SP
<i>lamivudine 300 mg tablet (Epivir)</i>	T4	PA SP
<i>lamivudine 300 mg/30ml sol cup (Epivir)</i>	T4	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	T4	PA SP
<i>zidovudine</i>	T4	SP
<i>zidovudine (Retrovir)</i>	T4	SP
<i>tenofovir disoproxil fumarate (Viread)</i>	T4	PA SP
VIREAD 150 MG TABLET	T4	PA SP
VIREAD 200 MG TABLET	T4	PA SP
VIREAD 250 MG TABLET	T4	PA SP
VIREAD POWDER	T4	PA SP
ANTIVIRALS, HIV-SPECIFIC, PROTEASE INHIBITOR COMB		
<i>lopinavir/ritonavir</i>	T4	SP
<i>lopinavir/ritonavir (Kaletra)</i>	T4	SP
ANTIVIRALS, HIV-SPECIFIC, PROTEASE INHIBITORS		
<i>atazanavir sulfate</i>	T4	PA SP
<i>atazanavir sulfate (Reyataz)</i>	T4	PA SP
EVOTAZ	T4	PA SP
<i>fosamprenavir calcium</i>	T4	PA SP
NORVIR 100 MG POWDER PACKET	T4	SP
REYATAZ 50 MG POWDER PACKET	T4	PA SP
<i>ritonavir (Norvir)</i>	T4	SP
ANTIVIRALS, HIV-I INTEGRASE STRAND TRANSFER INHIBTR		
APRETUDE	T4	SP PPACA
ISENTRESS	T4	SP
ISENTRESS HD	T4	PA SP
TIVICAY	T4	SP
TIVICAY PD	T4	SP
ARTV NUCLEOSIDE, NUCLEOTIDE, NON-NUCLEOSIDE RTI COMB		
DELSTRIGO	T4	PA QL(1 TAB/DAY) SP
<i>efavirenz/emtricit/tenofovr df</i>	T4	QL(1 TAB/DAY) SP
<i>efavirenz/lamivu/tenofov disop (Symfi Lo)</i>	T4	QL(1 TAB/DAY) SP
<i>efavirenz/lamivu/tenofov disop (Symfi)</i>	T4	QL(1 TAB/DAY) SP
<i>emtricit/rilpivirine/tenof df (Complera)</i>	T4	QL(1 TAB/DAY) SP
ODEFSEY	T4	PA QL(1 TAB/DAY) SP
ARV-NUCLEOSIDE, NUCLEOTIDE RTI, INTEGRASE INHIBITORS		
BIKTARVY	T4	QL(1 TAB/DAY) SP
GENVOYA	T4	QL(1 TAB/DAY) SP

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ANTIVIRALS (AIDS/HIV) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ARV-NUCLEOSIDE, NUCLEOTIDE RTI, INTEGRASE INHIBITORS		
STRIBILD	T4	PA QL(1 TAB/DAY) SP
ANTIVIRALS (Eye Conditions)		
EYE ANTIVIRALS		
<i>trifluridine</i>	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	T4	PA SP HD
ANTIVIRALS, GENERAL		
<i>acyclovir 200 mg capsule</i>	T1	
<i>acyclovir 200 mg/5 ml susp</i>	T1	
<i>acyclovir 200 mg/5 ml susp cup</i>	T1	
<i>acyclovir 400 mg tablet</i>	T1	
<i>acyclovir 800 mg tablet</i>	T1	
<i>acyclovir 800 mg/20ml susp cup</i>	T1	
<i>acyclovir sodium</i>	T1	
<i>cidofovir</i>	T4	SP
<i>famciclovir</i>	T1	
FLUMADINE (<i>rimantadine hcl</i>)	T3	
<i>foscarnet sodium (Foscavir)</i>	T1	
FOSCAVIR (<i>foscarnet sodium</i>)	T3	
GANCICLOVIR	T4	SP
<i>ganciclovir sodium</i>	T4	SP
LIVTENCITY	T4	PA QL(4 TABS/DAY) SP
<i>oseltamivir 6 mg/ml suspension (Tamiflu)</i>	T1	QL(180 MLS/30 DAYS)
<i>oseltamivir phos 30 mg capsule (Tamiflu)</i>	T1	QL(20 CAPS/30 DAYS)
<i>oseltamivir phos 45 mg capsule (Tamiflu)</i>	T1	QL(10 CAPS/30 DAYS)

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List of Prescription Medications

ANTIVIRALS (Infections) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIVIRALS, GENERAL (cont.)		
<i>oseltamivir phos 75 mg capsule (Tamiflu)</i>	T1	QL(10 CAPS/30 DAYS)
PREVMIS 120 MG PELLETT PACKET	T4	SP
PREVMIS 20 MG PELLETT PACKET	T4	SP
PREVMIS 240 MG TABLET	T4	SP HD
PREVMIS 240 MG/12 ML VIAL	T4	SP
PREVMIS 480 MG TABLET	T4	SP HD
PREVMIS 480 MG/24 ML VIAL	T4	SP
RAPIVAB	T3	
RELENZA	T3	QL(20 BLISTERS/30 DAYS)
<i>rimantadine hcl (Flumadine)</i>	T1	
TAMIFLU 30 MG CAPSULE (<i>oseltamivir phosphate</i>)	T3	QL(20 CAPS/30 DAYS)
TAMIFLU 45 MG CAPSULE (<i>oseltamivir phosphate</i>)	T3	QL(10 CAPS/30 DAYS)
TAMIFLU 6 MG/ML SUSPENSION (<i>oseltamivir phosphate</i>)	T3	QL(180 MLS/30 DAYS)
TAMIFLU 75 MG CAPSULE (<i>oseltamivir phosphate</i>)	T3	QL(10 CAPS/30 DAYS)
TEMBEXA	T3	
<i>valacyclovir hcl (Valtrex)</i>	T1	
<i>valganciclovir hcl (Valcyte)</i>	T1	
VALTrex (<i>valacyclovir hcl</i>)	T3	
XOFLUZA	T3	QL(2 TABS/30 DAYS)
HEP C - NS5A, NS3/4A, NUCLEOTIDE NS5B INHIB COMBO		
VOSEVI	T4	PA SP HD
HEP C VIRUS-NS5B POLYMERASE AND NS5A INHIB. COMBO.		
EPCLUSA 150-37.5 MG PELLETT PKT	T4	PA QL(1 PACK/DAY) SP HD
EPCLUSA 200 MG-50 MG TABLET	T4	PA QL(1 TAB/DAY) SP HD
EPCLUSA 200-50 MG PELLETT PACK	T4	PA QL(1 PACK/DAY) SP HD
EPCLUSA 400 MG-100 MG TABLET	T4	PA QL(1 TAB/DAY) SP HD
HARVONI 33.75-150 MG PELLETT PK	T4	PA QL(1 PACK/DAY) SP HD
HARVONI 45-200 MG PELLETT PACKT	T4	PA QL(1 PACK/DAY) SP HD
HARVONI 45-200 MG TABLET	T4	PA QL(1 TAB/DAY) SP HD
HARVONI 90-400 MG TABLET	T4	PA QL(1 TAB/DAY) SP HD
HEPATITIS B TREATMENT AGENTS		
<i>adefovir dipivoxil</i>	T4	SP HD
BARACLUDGE 0.05 MG/ML SOLUTION	T4	SP HD
<i>entecavir 0.5 mg tablet (Baraclude)</i>	T4	QL(1 TAB/DAY) SP HD
<i>entecavir 1 mg tablet (Baraclude)</i>	T4	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	T4	SP
VELMIDY	T4	SP HD
PEGASYS	T4	PA SP HD
<i>ribavirin</i>	T4	SP HD
HEPATITIS C VIRUS- NS5A AND NS3/4A INHIBITOR COMB		
ZEPATIER	T4	PA QL(1 TAB/DAY) SP HD

ANTIVIRALS (Skin Conditions)

TOPICAL ANTIVIRALS		
<i>peniclovir</i> (Denavir)	T1	QL(5 GMS/30 DAYS)

AUTONOMIC DRUGS (Allergy/Nasal Sprays)

ANAPHYLAXIS THERAPY AGENTS		
ADYPHREN	T1	
ADYPHREN AMP	T1	
<i>epinephrine 0.15 mg auto-inject</i> (Epipen Jr 2-Pak)	T1	QL(4 UNITS/30 DAYS)
<i>epinephrine 0.15 mg auto-inject</i> (Epipen Jr)	T1	QL(4 UNITS/30 DAYS)
<i>epinephrine 0.3 mg auto-inject</i> (Epipen 2-Pak)	T1	QL(4 UNITS/30 DAYS)
<i>epinephrine 0.3 mg auto-inject</i> (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 (<i>neostigmine methylsulfate</i>)	T3	
<i>donepezil hcl</i>	T1	HD
<i>donepezil hcl</i> (Aricept)	T1	HD
EXELON (rivastigmine)	T3	HD
<i>galantamine er 16 mg capsule</i>	T1	HD
<i>galantamine er 24 mg capsule</i>	T1	HD
<i>galantamine er 8 mg capsule</i>	T1	QL(1 CAP/DAY) HD
<i>galantamine hbr</i>	T1	HD
<i>neostigmine methylsulfate</i>	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	
<i>neostigmine methylsulfate</i> (Bloxivert)	T1	
<i>physostigmine salicylate</i>	T1	
<i>pyridostigmine 60 mg/5 ml cup</i> (Mestinon)	T1	HD
<i>pyridostigmine 60 mg/5 ml soln</i> (Mestinon)	T1	HD
<i>pyridostigmine br 60 mg tablet</i> (Mestinon)	T1	HD
<i>pyridostigmine bromide</i>	T3	
<i>pyridostigmine bromide</i> (Mestinon)	T1	HD
<i>rivastigmine</i> (Exelon)	T1	HD
<i>rivastigmine tartrate</i>	T1	HD

AUTONOMIC DRUGS (Attention Deficit Hyperactivity Disorder)¹⁰

ADRENERGICS, AROMATIC, NON-CATECHOLAMINE		
<i>amphetamine sulfate</i> (Evekeo)	T1	PA
<i>dextroamphetamine er 10 mg cap</i> (Dexedrine)	T1	PA QL(1 CAP/DAY)
<i>dextroamphetamine er 15 mg cap</i> (Dexedrine)	T1	PA QL(3 CAPS/DAY)
<i>dextroamphetamine er 5 mg cap</i>	T1	PA QL(1 CAP/DAY)
<i>dextroamphetamine sulfate</i>	T1	PA
<i>dextroamphetamine sulfate</i>	T3	PA ST
<i>dextroamphetamine sulfate</i> (Zenedi)	T1	PA
<i>dextroamphetamine/amphetamine</i> (Adderall Xr)	T1	PA QL(1 CAP/DAY)
<i>dextroamphetamine/amphetamine</i> (Adderall)	T1	PA
<i>dextroamphetamine/amphetamine</i> (Mydayis)	T1	PA QL(1 CAP/DAY)
<i>methamphetamine hcl</i> (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		
<i>droxidopa 100 mg capsule</i> (Northera)	T4	SP HD
<i>droxidopa 200 mg capsule</i> (Northera)	T4	SP HD
<i>droxidopa 300 mg capsule</i> (Northera)	T4	SP HD
<i>midodrine hcl</i>	T1	

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List of Prescription Medications

AUTONOMIC DRUGS (Blood Pressure/Heart Medications)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ALPHA-ADRENERGIC BLOCKING AGENTS		
DIBENZYLINE (phenoxybenzamine hcl)	T3	HD
<i>phenoxybenzamine hcl (Dibenzyline)</i>	T1	HD
<i>phentolamine mesylate</i>	T1	HD
AUTONOMIC DRUGS (Miscellaneous)		
ADRENERGIC AGENTS, CATECHOLAMINES		
<i>dopamine hcl</i>	T1	
<i>dopamine hcl in dextrose 5 %</i>	T1	
<i>epinephrine</i>	T3	
<i>epinephrine 1 mg/10 ml abbojct</i>	T1	
<i>epinephrine 1 mg/10 ml luerjet</i>	T1	
EPINEPHRINE 1 MG/ML AMPUL	T1	
<i>epinephrine 1 mg/ml vial</i>	T1	
<i>epinephrine 10 mg/10 ml vial</i>	T1	
<i>epinephrine 30 mg/30 ml vial</i>	T1	
<i>epinephrine hcl in 0.9 % nacl</i>	T1	
<i>epinephrine hcl in dextrose 5%</i>	T1	
<i>isoproterenol hcl</i>	T1	
LEVOPHED (<i>norepinephrine bitartrate</i>)	T3	
<i>norepineph 16 mg/250-0.9% nacl</i>	T1	
NOREPINEPH 32 MG/250-0.9% NACL	T3	
<i>norepinephr 4 mg/250-0.9% nacl</i>	T1	
NOREPINEPHR 8 MG/500-0.9% NACL (<i>norepinephrine bit/0.9 % nacl</i>)	T1	
<i>norepinephrine bitartrate</i>	T1	
<i>norepinephrine bitartrate (Levophed)</i>	T1	
<i>norepinephrine bitartrate/d5w</i>	T1	
NOREPINEPHRINE BITARTRATE-D5W	T1	
NEUROMUSCULAR BLOCKING AGENTS		
<i>atracurium besylate</i>	T1	
BOTOX 100 UNIT VIAL	T4	PA SP
BOTOX 200 UNIT VIAL	T4	PA SP HD
<i>cisatracurium besylate (Nimbex)</i>	T1	
DAXXIFY	T4	PA SP
DYSPORT	T4	PA SP HD
MYOBLOC	T4	PA SP HD
NIMBEX (<i>cisatracurium besylate</i>)	T3	

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AUTONOMIC DRUGS (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NEUROMUSCULAR BLOCKING AGENTS (cont.)		
<i>pancuronium bromide</i>	T1	
QUELICIN (<i>succinylcholine chloride</i>)	T3	
<i>rocuronium bromide</i>	T1	
<i>succinylcholine chloride</i>	T1	
SUCCINYLCOLINE CHLORIDE	T1	
<i>succinylcholine chloride</i> (Quelicin)	T1	
<i>succinylcholine chloride</i> (Quelicin)	T3	
SUCCINYLCOLINE CHLORIDE-NACL	T1	
<i>succinylcholine/sod cl,iso/pf</i>	T1	
<i>vecuronium bromide</i>	T1	
VECURONIUM BROMIDE-WATER	T1	
XEOMIN	T4	PA SP HD
AUTONOMIC DRUGS (Urinary Tract Conditions)		
PARASYMPATHETIC AGENTS		
<i>bethanechol chloride</i>	T1	HD
<i>cevimeline hcl</i> (Evoxac)	T1	HD
<i>pilocarpine hcl 5 mg tablet</i> (Salagen)	T1	HD
<i>pilocarpine hcl 7.5 mg tablet</i> (Salagen)	T1	HD
SALAGEN (<i>pilocarpine hcl</i>)	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	T4	PA SP HD
BIOLOGICALS (Miscellaneous)		
ANTISERA		
HYPERRHO	T4	SP

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BIOLOGICALS (Miscellaneous) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTISERA (cont.)		
MICRHOGAM ULTRA-FILTERED PLUS	T4	SP
RHOGAM ULTRA-FILTERED PLUS	T4	SP
RHOPHYLAC	T4	SP
WINRHO SDF	T4	SP HD
PKU TREATMENT AGENTS - PHENYLALANINE AMMONIA LYASE		
PALYNZIQ	T4	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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List of Prescription Medications

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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List of Prescription Medications

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)	T4	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		
ABRYVO	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	T4	PA SP
CABLIVI	T4	PA SP
ANTIFIBRINOLYTIC AGENTS		
AMICAR (<i>aminocaproic acid</i>)	T4	SP HD
<i>aminocaproic acid</i>	T4	SP HD
<i>aminocaproic acid (Amicar)</i>	T4	SP HD
CYKLOKAPRON (<i>tranexamic acid</i>)	T4	SP
FIBRYGA	T4	PA SP
RIASTAP	T4	PA SP
<i>tranexamic acid</i>	T4	SP
<i>tranexamic acid (Cyklokapron)</i>	T4	SP
<i>tranexamic acid in nacl,iso-os</i>	T4	SP
ANTIHEMOPHILIC FACTORS		
ADVATE	T4	PA SP HD
ADYNOVATE	T4	PA SP HD
AFSTYLA	T4	PA SP HD
ALPHANATE	T4	PA SP HD
ALTUVIIIO	T4	PA SP HD
ELOCTATE	T4	PA SP HD
ESPEROCT	T4	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	T4	PA SP HD
HUMATE-P	T4	PA SP HD
JIVI	T4	PA SP HD
KOATE	T4	PA SP HD
KOGENATE FS	T4	PA SP HD
KOVALTRY	T4	PA SP HD
NOVOEIGHT	T4	PA SP HD
NUWIQ	T4	PA SP HD
RECOMBINATE	T4	PA SP HD
WILATE	T4	PA SP HD
XYNTHA	T4	PA SP HD
XYNTHA SOLOFUSE	T4	PA SP HD
BLOOD FACTORS, MISCELLANEOUS		
VONVENDI	T4	SP HD
COAGULANTS		
<i>protamine sulfate</i>	T1	
COMPLEMENT (C3) INHIBITORS		
BKEMV	T4	PA SP
EMPAVELI	T4	PA SP
ENJAYMO	T4	PA SP
EPYSQLI	T4	PA SP
FABHALTA	T4	PA QL (2 CAPS/DAY) SP
SOLIRIS	T4	PA SP
TAVNEOS	T4	PA QL (6 CAPS/DAY) SP
ULTOMIRIS	T4	PA SP HD
VOYDEYA	T4	PA QL (1 PACKET/28 Days) SP
FACTOR IX COMPLEX (PCC) PREPARATIONS		
KCENTRA	T4	SP
FACTOR X PREPARATIONS		
COAGADEX	T4	PA SP
HEMOPHILIA TREATMENT AGENTS, NON-FACTOR REPLACEMENT		
ALHEMO PEN	T4	PA SP
HEMLIBRA	T4	PA SP HD
HYMPAVZI PEN	T4	PA SP
PROTEIN C PREPARATIONS		
CEPROTIN	T4	PA SP

T1 – Typically Generics
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List of Prescription Medications

BLOOD (Blood Modifiers/Bleeding Disorders) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PYRUVATE KINASE ACTIVATORS		
PYRUKYND 20 MG TABLET	T4	PA QL(2 TABS/DAY) SP
PYRUKYND 20-5 MG TAPER PACK	T4	PA QL(2 PACKS/270 DAYS) SP
PYRUKYND 5 MG TABLET	T4	PA QL(2 TABS/DAY) SP
PYRUKYND 5 MG TAPER PACK	T4	PA QL(2 PACKS/270 DAYS) SP
PYRUKYND 50 MG TABLET	T4	PA QL(2 TABS/DAY) SP
PYRUKYND 50-20 MG TAPER PACK	T4	PA QL(2 PACKS/270 DAYS) SP
SICKLE CELL ANEMIA AGENTS		
ADAKVEO	T4	PA SP
DROXIA	T2	
SIKLOS	T3	PA
TOPICAL HEMOSTATICS		
ASTRINGYN	T3	
AVITENE	T3	
ENDO-AVITENE	T3	
EVICEL	T3	
<i>gelatin sponge,absorb/porcine (Gelfoam)</i>	T1	
GELFOAM	T3	
GELFOAM (<i>gelatin sponge,absorb/porcine</i>)	T3	
GELFOAM COMPRESSED	T3	
MONSEL'S	T3	
RECOTHROM	T3	
SURGICEL	T3	
SURGIFOAM	T1	
SYRINGE AVITENE	T3	
THROMBI-GEL (<i>thrombin/cal/cmc/gel/dress,hem</i>)	T3	
THROMBIN-JMI	T3	
THROMBI-PAD	T3	
ULTRAFOAM	T3	

BLOOD (Blood Thinners/Anti-Clotting)

ANTICOAGULANT REVERSAL AGENT FOR FACTOR XA INHIB.		
ANDEXXA	T4	SP
ANTICOAGULANT REVERSAL AGENT, DIRECT THROMBIN INHIB		
PRAXBIND	T4	SP
HEMORRHEOLOGIC AGENTS		
<i>pentoxifylline</i>	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	T4	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		
<i>ranolazine</i>	T1	QL(4 TABS/DAY) HD
<i>ranolazine (Ranexa)</i>	T1	QL(4 TABS/DAY) HD
ANTIARRHYTHMICS		
<i>adenosine</i>	T1	
<i>amiodarone 150 mg/3 ml syringe</i>	T1	
<i>amiodarone 150 mg/3 ml vial</i>	T1	
<i>amiodarone 450 mg/9 ml vial</i>	T1	
<i>amiodarone 900 mg/18 ml vial</i>	T1	
<i>amiodarone hcl 100 mg tablet</i>	T1	HD
<i>amiodarone hcl 200 mg tablet</i>	T1	HD
<i>amiodarone hcl 400 mg tablet</i>	T1	HD
<i>CORVERT (ibutilide fumarate)</i>	T3	PA
<i>disopyramide phosphate (Norpace)</i>	T1	HD
<i>dofetilide 125 mcg capsule (Tikosyn)</i>	T1	QL(8 CAPS/DAY) HD
<i>dofetilide 250 mcg capsule (Tikosyn)</i>	T1	QL(4 CAPS/DAY) HD
<i>dofetilide 500 mcg capsule (Tikosyn)</i>	T1	QL(2 CAPS/DAY) HD
<i>flecainide acetate</i>	T1	HD
<i>ibutilide fumarate (Corvert)</i>	T1	
<i>lidocaine hcl/dextrose 5 %/pf</i>	T1	
<i>lidocaine hcl/pf</i>	T1	
<i>mexiletine hcl</i>	T1	HD
<i>NORPACE CR</i>	T3	HD
<i>CORVERT (ibutilide fumarate)</i>	T3	PA
<i>disopyramide phosphate (Norpace)</i>	T1	HD
<i>dofetilide 125 mcg capsule (Tikosyn)</i>	T1	QL(8 CAPS/DAY) HD
<i>dofetilide 250 mcg capsule (Tikosyn)</i>	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.)		
<i>dofetilide 500 mcg capsule (Tikosyn)</i>	T1	QL(2 CAPS/DAY) HD
<i>flecainide acetate</i>	T1	HD
<i>ibutilide fumarate (Corvert)</i>	T1	
<i>lidocaine hcl/dextrose 5 %/pf</i>	T1	
<i>lidocaine hcl/pf</i>	T1	
<i>mexiletine hcl</i>	T1	HD
PROCAINAMIDE HCL	T1	HD
<i>propafenone hcl</i>	T1	HD
<i>quinidine gluconate</i>	T1	HD
<i>quinidine sulfate</i>	T1	HD
CALCIUM CHANNEL BLOCKING AGENTS		
<i>amlodipine besylate (Norvasc)</i>	T1	HD
CALAN SR (<i>verapamil hcl</i>)	T3	HD
CARDENE I.V.	T3	
CARDENE I.V. (<i>nicardipine hcl</i>)	T3	
CLEVIPREX	T3	
<i>diltiazem 100 mg add-van vial</i>	T1	
<i>diltiazem 120 mg tablet (Cardizem)</i>	T1	HD
<i>diltiazem 125 mg/25 ml vial</i>	T1	
<i>diltiazem 24h er(la) 120 mg tb (Cardizem La)</i>	T1	QL(1 TAB/DAY) HD
<i>diltiazem 24h er(la) 180 mg tb (Cardizem La)</i>	T1	HD
<i>diltiazem 24h er(la) 240 mg tb (Cardizem La)</i>	T1	HD
<i>diltiazem 24h er(la) 300 mg tb (Cardizem La)</i>	T1	HD
<i>diltiazem 24h er(la) 360 mg tb (Cardizem La)</i>	T1	HD
<i>diltiazem 24h er(la) 420 mg tb (Cardizem La)</i>	T1	HD
<i>diltiazem 25 mg/5 ml vial</i>	T1	
<i>diltiazem 30 mg tablet (Cardizem)</i>	T1	HD
<i>diltiazem 50 mg/10 ml vial</i>	T1	
<i>diltiazem 60 mg tablet (Cardizem)</i>	T1	HD
<i>diltiazem 90 mg tablet</i>	T1	HD
<i>diltiazem hcl</i>	T1	HD
<i>diltiazem hcl (Cardizem Cd)</i>	T1	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
CALCIUM CHANNEL BLOCKING AGENTS (cont.)		
<i>diltiazem hcl</i> (Cardizem La)	T1	HD
<i>diltiazem hcl</i> (Tiazac)	T1	HD
DILTIAZEM HCL-0.7% NACL	T3	
DILTIAZEM HCL-0.9% NACL	T1	
DILTIAZEM HCL-NACL	T3	
<i>felodipine</i>	T1	HD
<i>isradipine</i>	T1	
<i>nicardipin 20mg/200ml-0.9%nacl</i>	T1	
NICARDIPIN 20MG/200ML-0.9%NACL	T3	
<i>nicardipin 40mg/200ml-0.9%nacl</i>	T1	
NICARDIPIN 40MG/200ML-0.9%NACL	T3	
NICARDIPINE 1 MG/10 ML-NS SYRG	T1	
<i>nicardipine 20 mg capsule</i>	T1	HD
<i>nicardipine 25 mg/10 ml ampule</i> (Cardene I.V.)	T1	
<i>nicardipine 25 mg/10 ml vial</i>	T1	
<i>nicardipine 30 mg capsule</i>	T1	HD
<i>nicardipine in nacl, iso-osm</i>	T1	
<i>nifedipine</i>	T1	HD
<i>nifedipine</i> (Procardia XL)	T1	HD
<i>nimodipine 30 mg capsule</i>	T1	HD
<i>nimodipine 60 mg/20 ml soln</i>	T1	
<i>nisoldipine er 17 mg tablet</i> (Sular)	T1	HD
<i>nisoldipine er 20 mg tablet</i>	T1	QL(1 TAB/DAY) HD
<i>nisoldipine er 25.5 mg tablet</i>	T1	HD
<i>nisoldipine er 30 mg tablet</i>	T1	HD
<i>nisoldipine er 34 mg tablet</i> (Sular)	T1	HD
<i>nisoldipine er 40 mg tablet</i>	T1	HD
<i>nisoldipine er 8.5 mg tablet</i> (Sular)	T1	HD
NORLIQVA	T2	PA QL(10 MLS/DAY) HD
NYMALIZE	T3	
SULAR (<i>nisoldipine</i>)	T3	HD
TIAZAC (<i>diltiazem hcl</i>)	T3	HD
<i>verapamil hcl</i>	T1	HD
<i>verapamil hcl</i> (Calan Sr)	T1	HD
<i>verapamil hcl</i> (Verelan Pm)	T1	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
CALCIUM CHANNEL BLOCKING AGENTS (cont.)		
<i>verapamil hcl</i> (Verelan)	T1	HD
VERELAN (<i>verapamil hcl</i>)	T3	HD
VERELAN PM (<i>verapamil hcl</i>)	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	
<i>cardioplegic solution no. 1</i> (Plegisol)	T1	
PLEGISOL	T3	
CARDIAC MYOSIN INHIBITOR		
CAMZYOS	T4	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	
<i>cardioplegic solution no. 1</i>	T1	
PLEGISOL	T3	
DIGITALIS GLYCOSIDES		
<i>digoxin</i> (Lanoxin)	T1	HD
<i>digoxin 0.05 mg/ml solution</i>	T1	HD
<i>digoxin 0.125 mg tablet</i> (Lanoxin)	T1	HD
<i>digoxin 0.25 mg tablet</i> (Lanoxin)	T1	HD
<i>digoxin 0.25 mg/ml syringe</i>	T1	HD
<i>digoxin 125 mcg tablet</i> (Lanoxin)	T1	HD
<i>digoxin 250 mcg tablet</i> (Lanoxin)	T1	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
DIGITALIS GLYCOSIDES (cont.)		
<i>digoxin 500 mcg/2 ml ampule (Lanoxin)</i>	T1	HD
LANOXIN 500 MCG/2 ML AMPULE (<i>digoxin</i>)	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	T4	PA SP HD
<i>ivabradine hcl (Corlanor)</i>	T1	PA HD
INOTROPIC DRUGS		
<i>dobutamine hcl</i>	T1	
<i>dobutamine hcl in dextrose 5 %</i>	T1	
<i>milrinone lactate</i>	T1	
<i>milrinone lactate/d5w</i>	T1	
SOLUBLE GUANYLATE CYCLASE (SGC) STIMULATOR		
VERQUVO	T2	PA QL(1 tab/day)
VASODILATORS, CORONARY		
<i>isosorbide dinitrate 10 mg tab</i>	T1	HD
<i>isosorbide dinitrate 20 mg tab</i>	T1	HD
<i>isosorbide dinitrate 30 mg tab</i>	T1	HD
<i>isosorbide dinitrate 5 mg tab (Isordil Titradose)</i>	T1	HD
<i>isosorbide mononitrate</i>	T1	HD
NITRO-DUR	T3	HD
<i>nitroglycerin</i>	T1	HD
<i>nitroglycerin 0.3 mg tablet sl (Nitrostat)</i>	T1	HD
<i>nitroglycerin 0.4 mg tablet sl (Nitrostat)</i>	T1	HD
<i>nitroglycerin 0.6 mg tablet sl (Nitrostat)</i>	T1	HD
nitroglycerin 400 mcg spray (Nitrolingual)	T1	HD
nitroglycerin 50 mg/10 ml vial	T1	
nitroglycerin in 5 % dextrose	T1	HD
NITROLINGUAL (<i>nitroglycerin</i>)	T3	HD
NITROMIST (<i>nitroglycerin</i>)	T3	HD
NITROSTAT (<i>nitroglycerin</i>)	T3	HD
CARDIOVASCULAR (Allergy/Nasal Sprays)		
SYMPATHOMIMETIC AGENTS		
AKOVAZ	T3	
BIORPHEN	T3	

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List of Prescription Medications

CARDIOVASCULAR (Allergy/Nasal Sprays) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SYMPATHOMIMETIC AGENTS (con't.)		
<i>ephedrine sulfate</i>	T1	
EPHEDRINE SULFATE	T1	
<i>ephedrine sulfate/0.9% nacl/pf</i>	T1	
EPHEDRINE SULFATE-0.9% NACL	T1	
EPHEDRINE SULFATE-NACL	T1	
IMMPHENTIV	T3	
<i>phenylephrine hcl</i>	T1	
<i>phenylephrine hcl (Vazculep)</i>	T1	
<i>phenylephrine hcl in 0.9% nacl</i>	T1	
PHENYLEPHRINE HCL-0.9% NACL	T1	
VAZCULEP (<i>phenylephrine hcl</i>)	T3	
CARDIOVASCULAR (Asthma/COPD/Respiratory)		
PULM ANTI-HTN, SOLUBLE GUANYLATE CYCLASE STIMULATOR		
ADEMPAS	T4	PA SP HD
PULM.ANTI-HTN, SEL.C-GMP PHOSPHODIESTERASE T5 INHIB		
REVATIO 10 MG/12.5 ML VIAL	T4	PA SP HD
<i>sildenafil 10 mg/12.5 ml vial</i>	T4	PA SP HD
<i>sildenafil 10 mg/ml oral susp (Revatio)</i>	T4	PA SP HD
sildenafil 20 mg tablet (Revatio)	T4	PA SP HD
<i>tadalafil (Adcirca)</i>	T4	PA SP HD
<i>tadalafil 20 mg tablet (Adcirca)</i>	T4	PA SP HD
PULMONARY ANTI-HTN, ENDOTHELIN RECEPTOR ANTAGONIST		
<i>ambrisentan (Letairis)</i>	T4	PA SP HD
<i>bosentan (Tracleer)</i>	T4	PA SP HD
OPSUMIT	T4	PA SP HD
TRACLEER 125 MG TABLET (<i>bosentan</i>)	T4	PA SP HD
TRACLEER 32 MG TABLET FOR SUSP (<i>bosentan</i>)	T4	PA SP HD
TRACLEER 62.5 MG TABLET (<i>bosentan</i>)	T4	PA SP HD
PULMONARY ANTIHYPER AGENT, ACTRIIA-FC		
WINREVAIR	T4	PA SP HD
WINREVAIR (2 PACK)	T4	PA SP HD
PULMONARY ANTIHYPERTENSIVES, PROSTACYCLIN-TYPE		
<i>epoprostenol sodium</i>	T4	PA SP HD
<i>epoprostenol sodium 0.5 mg vl</i>	T4	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.)		
<i>epoprostenol sodium 0.5 mg vI</i>	T4	PA SP HD
<i>epoprostenol sodium 1.5 mg vI</i>	T4	PA SP HD
FLOLAN	T4	PA SP
ORENITRAM ER	T4	PA SP HD
ORENITRAM MONTH 1 TITRATION KIT	T4	PA QL(168 TABS/180 DAYS) SP HD
TYVASO DPI	T4	PA SP HD
TYVASO INSTITUTIONAL START KIT	T4	PA SP HD
TYVASO REFILL KIT	T4	PA SP HD
TYVASO STARTER KIT	T4	PA SP HD
UPTRAVI 1,000 MCG TABLET	T4	PA SP HD
UPTRAVI 1,200 MCG TABLET	T4	PA SP HD
UPTRAVI 1,400 MCG TABLET	T4	PA SP HD
UPTRAVI 1,600 MCG TABLET	T4	PA SP HD
UPTRAVI 1,800 MCG VIAL	T4	PA SP
UPTRAVI 200 MCG TABLET	T4	PA SP HD
UPTRAVI 200-800 TITRATION PACK	T4	PA SP HD
UPTRAVI 400 MCG TABLET	T4	PA SP HD
UPTRAVI 600 MCG TABLET	T4	PA SP HD
UPTRAVI 800 MCG TABLET	T4	PA SP HD
YUTREPIA	T4	PA SP HD
PULMONARY HTN-ENDOTHELIN RECEPT ANTG-CGMP PDE5 INH		
OPSYNVI	T4	PA QL(1 TAB/DAY) SP HD
CARDIOVASCULAR (Blood Pressure/Heart Medications)		
ACE INHIBITOR-CALCIUM CHANNEL BLOCKER COMBINATION		
<i>amlodipine besylate/benazepril</i>	T1	HD
amlodipine besylate/benazepril (Lotrel)	T1	HD

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List of Prescription Medications

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
<i>trandolapril/verapamil hcl</i>	T1	HD
ACE INHIBITOR-THIAZIDE OR THIAZIDE-LIKE DIURETIC		
<i>benazepril/hydrochlorothiazide</i>	T1	HD
<i>benazepril/hydrochlorothiazide (Lotensin Hct)</i>	T1	HD
<i>captopril-hctz 25-15 mg tablet</i>	T1	QL(3 TABS/DAY) HD
<i>captopril-hctz 25-25 mg tablet</i>	T1	QL(2 TABS/DAY) HD
<i>captopril-hctz 50-15 mg tablet</i>	T1	QL(3 TABS/DAY) HD
<i>captopril-hctz 50-25 mg tablet</i>	T1	QL(2 TABS/DAY) HD
<i>enalapril/hydrochlorothiazide</i>	T1	HD
<i>enalapril/hydrochlorothiazide (Vaseretic)</i>	T1	HD
<i>fosinopril/hydrochlorothiazide</i>	T1	HD
<i>lisinopril/hydrochlorothiazide (Zestoretic)</i>	T1	HD
<i>quinapril/hydrochlorothiazide (Accuretic)</i>	T1	HD
ALPHA/BETA-ADRENERGIC BLOCKING AGENTS		
<i>carvedilol (Coreg)</i>	T1	HD
<i>carvedilol er 10 mg capsule (Coreg Cr)</i>	T1	QL(1 CAP/DAY) HD
<i>carvedilol er 20 mg capsule (Coreg Cr)</i>	T1	QL(1 CAP/DAY) HD
<i>carvedilol er 40 mg capsule (Coreg Cr)</i>	T1	QL(1 CAP/DAY) HD
<i>carvedilol er 80 mg capsule (Coreg Cr)</i>	T1	HD
LABETALOL HCL 10 MG/2 ML SYRNG	T3	
<i>labetalol hcl 100 mg tablet</i>	T1	HD
<i>labetalol hcl 100 mg/20 ml vl</i>	T1	
<i>labetalol hcl 20 mg/4 ml crpjt</i>	T1	QL(1 CAP/DAY) HD
<i>labetalol hcl 20 mg/4 ml syrng</i>	T1	QL(1 CAP/DAY) HD
<i>labetalol hcl 20 mg/4 ml vial</i>	T1	QL(1 CAP/DAY) HD
<i>labetalol hcl 200 mg tablet</i>	T1	HD
<i>labetalol hcl 200 mg/40 ml vl</i>	T1	
<i>labetalol hcl 300 mg tablet</i>	T1	HD
LABETALOL HCL 400 MG TABLET	T3	HD
LABETALOL HCL-DEXTROSE	T3	
LABETALOL HCL-NACL	T3	

T1 – Typically Generics
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T4 – Specialty Medications
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ST – Step Therapy
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List of Prescription Medications

CARDIOVASCULAR (Blood Pressure/Heart Medications) (cont.)

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

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List of Prescription Medications

CARDIOVASCULAR (Blood Pressure/Heart Medications) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIHYPERTENSIVES, ACE INHIBITORS (cont.)		
<i>captopril</i>	T1	HD
<i>enalapril maleate</i> (Epaned)	T1	HD
<i>enalapril maleate</i> (Vasotec)	T1	HD
<i>enalaprilat dihydrate</i>	T1	
<i>fosinopril sodium</i>	T1	HD
<i>lisinopril</i> (Zestril)	T1	HD
<i>moexipril hcl</i>	T1	HD
<i>perindopril erbumine</i>	T1	HD
<i>quinapril hcl</i> (Accupril)	T1	HD
<i>ramipril</i>	T1	HD
<i>ramipril</i> (Altace)	T1	HD
<i>trandolapril</i>	T1	HD
ANTIHYPERTENSIVES, ANGIOTENSIN RECEPTOR ANTAGONIST		
<i>candesartan cilexetil</i> (Atacand)	T1	HD
<i>eprosartan mesylate</i>	T1	HD
<i>irbesartan</i>	T1	HD
<i>irbesartan</i> (Avapro)	T1	HD
<i>losartan potassium</i> (Cozaar)	T1	HD
<i>olmesartan medoxomil 20 mg tab</i> (Benicar)	T1	QL(1 TAB/DAY) HD
<i>olmesartan medoxomil 40 mg tab</i> (Benicar)	T1	HD
<i>olmesartan medoxomil 5 mg tab</i> (Benicar)	T1	HD
<i>telmisartan 20 mg tablet</i>	T1	QL(1 TAB/DAY) HD
<i>telmisartan 40 mg tablet</i> (Micardis)	T1	QL(1 TAB/DAY) HD
<i>telmisartan 80 mg tablet</i> (Micardis)	T1	HD
<i>valsartan 160 mg tablet</i> (Diovan)	T1	HD
<i>valsartan 20 mg/5 ml solution</i>	T1	HD
<i>valsartan 320 mg tablet</i> (Diovan)	T1	HD
<i>valsartan 40 mg tablet</i> (Diovan)	T1	HD
<i>valsartan 80 mg tablet</i> (Diovan)	T1	HD
ANTIHYPERTENSIVES, GANGLIONIC BLOCKERS		
VECAMYL	T1	
ANTIHYPERTENSIVES, MISCELLANEOUS		
<i>metyrosine</i> (Demser)	T1	PA HD
<i>nitroprusside sodium</i>	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		
<i>clonidine</i> (Catapres-Tts 1)	T1	HD
<i>clonidine</i> (Catapres-Tts 2)	T1	HD
<i>clonidine</i> (Catapres-Tts 3)	T1	HD
<i>clonidine hcl 0.1 mg tablet</i>	T1	HD
<i>clonidine hcl 0.2 mg tablet</i>	T1	HD
<i>clonidine hcl 0.3 mg tablet</i>	T1	HD
<i>guanfacine hcl</i>	T1	HD
<i>methyldopa</i>	T1	HD
<i>methyldopa/hydrochlorothiazide</i>	T1	HD
<i>methyldopate hcl</i>	T1	
ANTIHYPERTENSIVES, VASODILATORS		
<i>hydralazine hcl</i>	T1	HD
<i>minoxidil</i>	T1	HD
BETA-ADRENERGIC BLOCKING AGENTS		
<i>acebutolol hcl</i>	T1	HD
<i>atenolol</i> (Tenormin)	T1	HD
<i>betaxolol hcl</i>	T1	HD
<i>bisoprolol fumarate 10 mg tab</i>	T1	HD
<i>bisoprolol fumarate 5 mg tab</i>	T1	HD
BREVIBLOC	T3	
<i>esmolol hcl</i>	T1	
ESMOLOL HCL-WATER	T1	
<i>esmolol in sodium chloride, iso</i>	T1	
<i>metoprolol succinate</i> (Toprol XL)	T1	HD
<i>metoprolol tartrate</i>	T1	HD
<i>metoprolol tartrate</i> (Lopressor)	T1	HD
<i>nadolol</i>	T1	HD
<i>nebivolol 10 mg tablet</i> (Bystolic)	T1	QL(1 TAB/DAY) HD
<i>nebivolol 2.5 mg tablet</i> (Bystolic)	T1	QL(1 TAB/DAY) HD
<i>nebivolol 20 mg tablet</i> (Bystolic)	T1	HD
<i>nebivolol 5 mg tablet</i> (Bystolic)	T1	QL(1 TAB/DAY) HD
<i>pindolol</i>	T1	HD
<i>propranolol hcl</i>	T1	HD
<i>propranolol hcl</i> (Inderal La)	T1	HD

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List of Prescription Medications

CARDIOVASCULAR (Blood Pressure/Heart Medications) (cont.)

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

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List of Prescription Medications

CARDIOVASCULAR (Cholesterol Medications)		
ANTIHYPERLIPIDEMIC - HMG COA REDUCT INHIB-CHOLEST.AB.INHIB		
<i>ezetimibe/simvastatin (Vytorin)</i>	T1	HD
ANTIHYPERLIPID- HMG-COA RI-CALCIUM CHANNEL BLOCKER		
<i>amlodipine-atorvast 10-10 mg (Caduet)</i>	T1	HD
<i>amlodipine-atorvast 10-20 mg (Caduet)</i>	T1	HD
<i>amlodipine-atorvast 10-40 mg (Caduet)</i>	T1	HD
<i>amlodipine-atorvast 10-80 mg (Caduet)</i>	T1	HD
<i>amlodipine-atorvast 2.5-10 mg</i>	T1	HD
<i>amlodipine-atorvast 2.5-20 mg</i>	T1	QL(1 TAB/DAY) HD
<i>amlodipine-atorvast 2.5-40 mg</i>	T1	QL(1 TAB/DAY) HD
<i>amlodipine-atorvast 5-10 mg (Caduet)</i>	T1	HD
<i>amlodipine-atorvast 5-20 mg (Caduet)</i>	T1	QL(1 TAB/DAY) HD
<i>amlodipine-atorvast 5-40 mg (Caduet)</i>	T1	QL(1 TAB/DAY) HD
<i>amlodipine-atorvast 5-80 mg (Caduet)</i>	T1	HD
CADUET 10 MG-10 MG TABLET (<i>amlodipine/atorvastatin</i>)	T3	HD
CADUET 10 MG-20 MG TABLET (<i>amlodipine/atorvastatin</i>)	T3	HD
CADUET 10 MG-40 MG TABLET (<i>amlodipine/atorvastatin</i>)	T3	HD
CADUET 10 MG-80 MG TABLET (<i>amlodipine/atorvastatin</i>)	T3	HD
CADUET 5 MG-10 MG TABLET (<i>amlodipine/atorvastatin</i>)	T3	HD
CADUET 5 MG-20 MG TABLET (<i>amlodipine/atorvastatin</i>)	T3	QL(1 TAB/DAY) HD
CADUET 5 MG-40 MG TABLET (<i>amlodipine/atorvastatin</i>)	T3	QL(1 TAB/DAY) HD
CADUET 5 MG-80 MG TABLET (<i>amlodipine/atorvastatin</i>)	T3	HD
ANTIHYPERLIPIDEMIC - ANGIOPOIETIN-LIKE 3 INHIBITOR		
EVKEEZA	T4	PA SP
ANTIHYPERLIPIDEMIC - APOLIPOPROTEIN INHIBITOR		
TRYNGOLZA	T4	PA QL(1 AUTO-INJ/28 DAYS) SP
ANTIHYPERLIPIDEMIC - PCSK9 INHIBITORS		
LEQVIO	T4	PA SP
REPATHA PUSHTRONEX	T2	
REPATHA SURECLICK	T2	
REPATHA SYRINGE	T2	
ANTIHYPERLIPIDEMIC-HMGCOA REDUCTASE INHIB (STATINS)		
<i>atorvastatin 10 mg tablet (Lipitor)</i>	T1	HD PPACA
<i>atorvastatin 20 mg tablet (Lipitor)</i>	T1	HD PPACA
<i>atorvastatin 40 mg tablet (Lipitor)</i>	T1	HD
<i>atorvastatin 80 mg tablet (Lipitor)</i>	T1	HD
<i>fluvastatin sodium</i>	T1	HD PPACA

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List of Prescription Medications

CARDIOVASCULAR (Cholesterol Medications) (cont.)

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

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List of Prescription Medications

CARDIOVASCULAR (Cholesterol Medications) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LIPOTROPICS (cont.)		
FENOFIBRATE 150 MG CAPSULE	T1	HD
<i>fenofibrate 160 mg tablet</i>	T1	HD
<i>fenofibrate 200 mg capsule</i>	T1	HD
<i>fenofibrate 40 mg tablet (Fenoglide)</i>	T1	HD
<i>fenofibrate 43 mg capsule</i>	T1	HD
<i>fenofibrate 48 mg tablet (Tricor)</i>	T1	HD
FENOFIBRATE 50 MG CAPSULE	T1	HD
<i>fenofibrate 54 mg tablet</i>	T1	HD
<i>fenofibrate 67 mg capsule</i>	T1	HD
<i>fenofibric acid</i>	T1	HD
<i>fenofibric acid (choline)</i>	T1	HD
<i>fenofibric acid (Fibricor)</i>	T1	HD
FIBRICOR (fenofibric acid)	T3	ST HD
<i>gemfibrozil (Lopid)</i>	T1	HD
LIPOFEN	T3	ST HD
LOPID (<i>gemfibrozil</i>)	T3	HD
<i>niacin</i>	T1	HD

CARDIOVASCULAR (Miscellaneous)

ENDOTHELIN-ANGIOTENSIN RECEPTOR ANTAGONIST		
FILSPARI	T4	PA QL(1 TAB/DAY) SP
VENOSCLEROSING AGENTS		
ASCLERA	T4	PA SP
ETHAMOLIN	T3	
<i>sodium tetradecyl sulfate (Sotradecol)</i>	T1	
SOTRADECOL	T3	
<i>SOTRADECOL (sodium tetradecyl sulfate)</i>	T3	

CNS DRUGS (Alzheimer's Disease)

ALZHEIMER'S THERAPY, NMDA RECEPTOR ANTAGONISTS		
<i>memantine hcl</i>	T1	HD
MEMANTINE HCL	T1	HD
<i>memantine hcl er 14 mg capsule (Namenda Xr)</i>	T1	QL(1 CAP/DAY) HD
<i>memantine hcl er 21 mg capsule</i>	T1	HD
<i>memantine hcl er 28 mg capsule (Namenda Xr)</i>	T1	HD
<i>memantine hcl er 7 mg capsule (Namenda Xr)</i>	T1	QL(1 CAP/DAY) HD

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List of Prescription Medications

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		
<i>memantine hcl/donepezil hcl</i> (Namzaric)	T1	QL(2 CAPS/DAY) HD
AMYLOID DIRECTED MONOCLONAL ANTIBODY		
ADUHELM	T4	PA SP
CNS DRUGS (Miscellaneous)		
ALCOHOL, SYSTEMIC USE		
ALCOHOL, DEHYDRATED	T1	
<i>ethyl alcohol</i>	T1	
AMYOTROPHIC LATERAL SCLEROSIS AGENTS		
<i>edaravone 30 mg/100 ml bag</i>	T4	PA SP
EDARAVONE 30 MG/100 ML VIAL	T4	PA SP
<i>edaravone 60 mg/100 ml bag</i>	T4	PA SP
EDARAVONE 60 MG/100 ML VIAL	T4	PA SP
RADICAVA	T4	PA SP
RADICAVA ORS 105 MG/5 ML SUSP	T4	PA QL(50 MLS/30 DAYS) SP HD
RADICAVA ORS STARTER KIT SUSP	T4	PA QL(70 MLS/365 DAYS) SP HD
<i>riluzole</i> (Rilutek)	T4	SP HD
TEGLUTIK	T4	PA SP
TIGLUTIK	T4	PA SP
CENTRAL NERVOUS SYSTEM STIMULANTS		
DOPRAM	T3	
DRUGS TO TREAT MOVEMENT DISORDERS		
AUSTEDO	T4	PA SP HD
AUSTEDO XR 12 MG TABLET	T4	PA QL(1 TAB/DAY) SP HD
AUSTEDO XR 18 MG TABLET	T4	PA QL(1 TAB/DAY) SP HD
AUSTEDO XR 24 MG TABLET	T4	PA QL(2 TABS/DAY) SP HD
AUSTEDO XR 30 MG TABLET	T4	PA QL(1 TAB/DAY) SP HD
AUSTEDO XR 36 MG TABLET	T4	PA QL(1 TAB/DAY) SP HD
AUSTEDO XR 42 MG TABLET	T4	PA QL(1 TAB/DAY) SP HD
AUSTEDO XR 48 MG TABLET	T4	PA QL(1 TAB/DAY) SP HD
AUSTEDO XR 6 MG TABLET	T4	PA QL(3 TABS/DAY) SP HD
AUSTEDO XR TITRATION KT(WK1-4)	T4	PA QL(1 KIT/180 DAYS) SP HD
INGREZZA	T4	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)	T4	PA QL(28 CAPS/365 DAYS) SP
INGREZZA SPRINKLE	T4	PA QL(1 CAP/DAY) SP
<i>tetrabenazine (Xenazine)</i>	T4	PA SP HD
PSEUDOBULBAR AFFECT (PBA) AGENTS, NMDA ANTAGONISTS		
NUEDEXTA	T3	QL (4 caps/day)
XANTHINES		
CAFCIT (<i>caffeine citrate</i>)	T3	HD
CAFFEINE AND SODIUM BENZOATE	T1	HD
<i>caffeine citrate</i>	T1	HD
<i>caffeine citrate (Cafcit)</i>	T1	HD
<i>caffeine/sodium benzoate</i>	T1	HD
CNS DRUGS (Multiple Sclerosis)		
AGENTS TO TREAT MULTIPLE SCLEROSIS		
AVONEX (4 PACK)	T4	PA SP HD
AVONEX PEN (4 PACK)	T4	PA SP HD
BAFIERTAM	T4	PA SP HD
BETASERON	T4	PA SP HD
BRIUMVI	T4	PA SP
<i>cladribine 10 mg x 10 tab pk</i>	T4	PA SP HD
<i>cladribine 10 mg x 4 tablet pk</i>	T4	PA SP HD
<i>cladribine 10 mg x 5 tablet pk</i>	T4	PA SP HD
<i>cladribine 10 mg x 6 tablet pk</i>	T4	PA SP HD
<i>cladribine 10 mg x 7 tablet pk</i>	T4	PA SP HD
<i>cladribine 10 mg x 8 tablet pk</i>	T4	PA SP HD
<i>cladribine 10 mg x 9 tablet pk</i>	T4	PA SP HD
<i>dimethyl fumarate 30d start pk (Tecfidera)</i>	T4	SP HD
<i>dimethyl fumarate dr 120 mg cp (Tecfidera)</i>	T1	HD
<i>dimethyl fumarate dr 120 mg cp (Tecfidera)</i>	T4	SP HD
<i>dimethyl fumarate dr 240 mg cp (Tecfidera)</i>	T1	HD
DIMETHYL FUMARATE DR 240 MG CP (TECFIDERA)	T4	SP HD
fingolimod hcl (Gilenya)	T4	SP HD
glatiramer acetate (Copaxone)	T4	SP HD
KESIMPTA PEN	T4	PA SP HD
LEMTRADA	T4	PA SP HD

T1 – Typically Generics
 T2 – Typically Preferred Brands
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T4 – Specialty Medications
 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

CNS DRUGS (Multiple Sclerosis)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AGENTS TO TREAT MULTIPLE SCLEROSIS		
MAVENCLAD	T4	PA SP HD
MAYZENT	T4	PA SP HD
OCREVUS	T4	PA SP HD
OCREVUS ZUNOVO	T4	PA SP
PLEGRIDY	T4	PA SP HD
PLEGRIDY PEN	T4	PA SP HD
REBIF	T4	PA SP HD
REBIF REBIDOSE	T4	PA SP HD
<i>teriflunomide (Aubagio)</i>	T4	SP HD
VUMERITY	T4	PA SP HD
AGTS TX NEUROMUSC TRANSMISSION DIS, POT-CHAN BLKR		
KESIMPTA PEN	T4	PA SP HD
LEMRADA	T4	PA SP HD
MAVENCLAD	T4	PA SP HD
<i>dalfampridine er 10 mg tablet (Ampyra)</i>	T4	PA SP HD
FIRDAPSE	T4	PA QL (8 TABS/DAY) SP
SPHINGOSINE I-PHOSPHATE (SIP) RECEPTOR MODULATOR		
ZEPOSIA	T4	PA SP HD
CNS DRUGS (Pain Relief And Inflammatory Disease)		
CALCITONIN GENE-RELATED PEPTIDE (CGRP) INHIBITORS		
EMGALITY SYRINGE	T2	PA
POSTHERPETIC NEURALGIA AGENTS		
<i>gabapentin (Gralise)</i>	T1	
GRALISE ER 300 MG TABLET (<i>gabapentin</i>)	T3	
GRALISE ER 600 MG TABLET (<i>gabapentin</i>)	T3	HD
SPHINGOSINE I-PHOSPHATE (SIP) RECEPTOR MODULATOR		
VELSIPITY	T4	PA QL (30 TABS/30 DAYS) SP HD
ZEPOSIA	T4	PA SP HD

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AGE – Age Requirement
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List of Prescription Medications

CNS DRUGS (Seizure Disorders)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTICONVULSANT - BENZODIAZEPINE TYPE		
<i>clobazam</i> (Onfi)	T1	HD
<i>clonazepam</i>	T1	HD
clonazepam (Klonopin)	T1	HD
DIASTAT (<i>diazepam</i>)	T3	PA HD
<i>diazepam 10 mg rectal gel syrg</i>	T1	HD
<i>diazepam 10mg rectal gel (2pk)</i>	T1	HD
<i>diazepam 2.5mg rectal gel(2pk)</i> (Diastat)	T1	HD
<i>diazepam 20 mg rectal gel syrg</i>	T1	HD
<i>diazepam 20mg rectal gel (2pk)</i>	T1	HD
KLONOPIN (<i>clonazepam</i>)	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	T4	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
<i>carbamazepine</i> (Carbatrol)	T1	HD
<i>carbamazepine</i> (Tegretol Xr)	T1	HD
<i>carbamazepine</i> (Tegretol)	T1	HD
<i>carbamazepine 100 mg tab chew</i>	T1	HD
<i>carbamazepine 100 mg/5 ml cup</i>	T1	HD
<i>carbamazepine 100 mg/5 ml susp</i> (Tegretol)	T1	HD
CARBAMAZEPINE 200 MG TAB CHEW	T3	HD
<i>carbamazepine 200 mg tablet</i> (Tegretol)	T1	HD
<i>carbamazepine 200 mg/10 ml cup</i>	T1	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.)		
CARBATROL (<i>carbamazepine</i>)	T3	PA HD
CELONTIN (<i>methsuximide</i>)	T3	HD
CEREBYX (<i>fosphenytoin sodium</i>)	T3	
DIACOMIT	T4	PA SP HD
DILANTIN 100 MG CAPSULE (<i>phenytoin sodium extended</i>)	T3	PA HD
DILANTIN 30 MG CAPSULE	T2	PA HD
DILANTIN 50 MG INFATAB (<i>phenytoin</i>)	T3	PA HD
DILANTIN-125 (<i>phenytoin</i>)	T3	PA HD
<i>divalproex sodium</i> (Depakote Er)	T1	HD
<i>divalproex sodium</i> (Depakote Sprinkle)	T1	HD
<i>divalproex sodium</i> (Depakote)	T1	HD
<i>eslicarbazepine 200 mg tablet</i> (Aptiom)	T1	PA QL(1 TAB/DAY) HD
<i>eslicarbazepine 400 mg tablet</i> (Aptiom)	T1	PA QL(1 TAB/DAY) HD
<i>eslicarbazepine 600 mg tablet</i> (Aptiom)	T1	PA HD
<i>eslicarbazepine 800 mg tablet</i> (Aptiom)	T1	PA HD
<i>ethosuximide</i> (Zarontin)	T1	HD
<i>felbamate</i> (Felbatol)	T1	HD
FINTEPLA	T4	PA SP HD
<i>fosphenytoin sodium</i> (Cerebyx)	T1	
FYCOMPA 0.5 MG/ML ORAL SUSP	T2	PA HD
<i>gabapentin</i>	T1	HD
<i>gabapentin</i> (Neurontin)	T1	HD
KEPPRA 500 MG/5 ML VIAL (<i>levetiracetam</i>)	T3	
<i>lacosamide</i> (Vimpat)	T1	HD
<i>lamotrigine</i> (Lamictal (Blue))	T1	HD
<i>lamotrigine</i> (Lamictal (Green))	T1	HD
<i>lamotrigine</i> (Lamictal (Orange))	T1	HD
<i>lamotrigine</i> (Lamictal Odt (Blue))	T1	HD
<i>lamotrigine</i> (Lamictal Odt (Green))	T1	HD
<i>lamotrigine</i> (Lamictal Odt (Orange))	T1	HD
<i>lamotrigine</i> (Lamictal Odt)	T1	HD
<i>lamotrigine</i> (Lamictal Xr)	T1	HD
<i>lamotrigine</i> (Lamictal)	T1	HD
<i>levetiracetam</i> (Keppra Xr)	T1	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.)		
<i>levetiracetam</i> (Keppra)	T1	HD
<i>levetiracetam 1,000 mg tablet</i> (Keppra)	T1	HD
<i>levetiracetam 1,000mg/10ml cup</i> (Keppra)	T1	HD
<i>levetiracetam 100 mg/ml soln</i> (Keppra)	T1	HD
LEVETIRACETAM 250 MG TAB SUSP	T3	PA HD
<i>levetiracetam 250 mg tablet</i> (Keppra)	T1	HD
<i>levetiracetam 500 mg tablet</i> (Keppra)	T1	HD
<i>levetiracetam 500 mg/5 ml cup</i>	T1	HD
<i>levetiracetam 500 mg/5 ml soln</i>	T1	HD
<i>levetiracetam 500 mg/5 ml vial</i> (Keppra)	T1	
<i>levetiracetam 750 mg tablet</i> (Keppra)	T1	HD
<i>levetiracetam-nacl 1,000mg/100</i>	T1	
<i>levetiracetam-nacl 1,500mg/100</i>	T1	
LEVETIRACETAM-NACL 250 MG/50ML	T3	
<i>levetiracetam-nacl 500 mg/100</i>	T1	
LYRICA 20 MG/ML ORAL SOLUTION (<i>pregabalin</i>)	T3	PA HD
<i>methsuximide</i> (Celontin)	T1	HD
NEURONTIN 400 MG CAPSULE (<i>gabapentin</i>)	T3	HD
NEURONTIN 600 MG TABLET (<i>gabapentin</i>)	T3	HD
NEURONTIN 800 MG TABLET (<i>gabapentin</i>)	T3	HD
<i>oxcarbazepine</i> (Oxtellar Xr)	T1	PA HD
<i>oxcarbazepine</i> (Trileptal)	T1	HD
OXTELLAR XR (<i>oxcarbazepine</i>)	T3	PA HD
<i>perampanel 10 mg tablet</i> (Fycompa)	T1	PA HD
<i>perampanel 12 mg tablet</i> (Fycompa)	T1	PA HD
<i>perampanel 2 mg tablet</i> (Fycompa)	T1	PA HD
<i>perampanel 4 mg tablet</i> (Fycompa)	T1	PA QL(1 TAB/DAY) HD
<i>perampanel 6 mg tablet</i> (Fycompa)	T1	PA QL(1 TAB/DAY) HD
<i>perampanel 8 mg tablet</i> (Fycompa)	T1	PA HD
PHENYTEK (<i>phenytoin sodium extended</i>)	T3	PA HD

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T4 – Specialty Medications

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List of Prescription Medications

CNS DRUGS (Seizure Disorders) (cont.)

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

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T4 – Specialty Medications
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List of Prescription Medications

CNS DRUGS (Seizure Disorders) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTICONVULSANTS (cont.)		
<i>topiramate er 25 mg capsule</i> (Trokendi Xr)	T1	QL(1 CAP/DAY) HD
<i>topiramate er 50 mg capsule</i> (Trokendi Xr)	T1	HD
TROKENDI XR 100 MG CAPSULE (<i>topiramate</i>)	T3	QL(1 CAP/DAY) HD
TROKENDI XR 200 MG CAPSULE (<i>topiramate</i>)	T3	HD
TROKENDI XR 25 MG CAPSULE (<i>topiramate</i>)	T3	QL(1 CAP/DAY) HD
TROKENDI XR 50 MG CAPSULE (<i>topiramate</i>)	T3	HD
<i>valproic acid</i>	T1	HD
<i>valproic acid (as sodium salt)</i>	T1	HD
<i>vigabatrin</i> (Sabril)	T4	SP HD
<i>vigadrone 500 mg powder packet</i> (Sabril)	T4	SP HD
VIMPAT 10 MG/ML SOLUTION (<i>lacosamide</i>)	T2	HD
VIMPAT 200 MG/20 ML VIAL (<i>lacosamide</i>)	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 (<i>ethosuximide</i>)	T3	PA HD
<i>zonisamide</i>	T1	HD
<i>zonisamide</i> (Zonegran)	T1	HD

CNS DRUGS (Sleep Disorders/Sedatives)

NARCOLEPSY TX-H3-RECEPT.ANTAGONIST/INVERSE AGONIST

WAKIX	T4	PA QL (2 tabs/day) SP HD
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COLONY STIMULATING FACTORS (Blood Modifiers/Bleeding Disorders)

ERYTHROPOIESIS-STIMULATING AGENTS

ARANESP	T4	PA SP
EPOGEN	T4	PA SP
MIRCERA	T4	PA SP
PROCRIT	T4	PA SP
RETACRIT	T4	PA SP

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List of Prescription Medications

COLONY STIMULATING FACTORS (Blood Modifiers/Bleeding Disorders)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LEUKOCYTE (WBC) STIMULANTS		
FULPHILA	T4	PA SP
FYLNETRA	T4	PA SP
GRANIX	T4	PA SP
LEUKINE	T4	SP
NEULASTA	T4	PA SP
NEULASTA ONPRO	T4	PA SP HD
NEUPOGEN	T4	PA SP
NIVESTYM	T4	SP HD
NYPOZI	T4	PA SP
NYVEPRIA	T4	PA SP
STIMUFEND	T4	PA SP
UDENYCA	T4	PA SP
UDENYCA AUTOINJECTOR	T4	PA SP
UDENYCA ONBODY	T4	PA SP
ZARXIO	T4	SP HD
ZIEXTENZO	T4	PA SP
THROMBOPOIETIN RECEPTOR AGONISTS		
DOPTELET	T4	PA SP HD
DOPTELET SPRINKLE	T4	PA SP HD
<i>eltrombopag olamine (Promacta)</i>	T4	PA SP HD
MULPLETA	T4	PA SP HD
NPLATE	T4	PA SP
COLONY STIMULATING FACTORS (Blood Pressure/Heart Medications)		
LEUKOCYTE (WBC) STIMULANTS		
RELEUKO	T4	PA SP
ROLVEDON	T4	PA SP
COLONY STIMULATING FACTORS (Cancer)		
CXCR4 CHEMOKINE RECEPTOR ANTAGONIST		
RELEUKO	T4	PA SP
ROLVEDON	T4	PA SP
XOLREMDI	T4	PA QL (4 caps/day) SP CSL

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List of Prescription Medications

CONTRACEPTIVES (Contraception Products)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CONTRACEPTIVES, INTRAVAGINAL, SYSTEMIC		
<i>etonogestrel/ethinyl estradiol</i> (Nuvaring)	T1	PPACA
CONTRACEPTIVES, IMPLANTABLE		
NEXPLANON	T4	SP PPACA
CONTRACEPTIVES, INJECTABLE		
DEPO-PROVERA (<i>medroxyprogesterone acetate</i>)	T3	PPACA
DEPO-SUBQ PROVERA 104	T3	PPACA
<i>medroxyprogesterone 150 mg/ml</i> (Depo-Provera)	T1	PPACA
CONTRACEPTIVES, ORAL		
<i>desog-e.estradiol/e.estradiol</i>	T1	HD PPACA
<i>desogestrel-ethinyl estradiol</i>	T1	HD PPACA
<i>drospir/eth estra/levomefol ca</i> (Beyaz)	T1	HD PPACA
<i>drospir/eth estra/levomefol ca</i> (Safyral)	T1	HD PPACA
ELLA	T3	HD PPACA
<i>ethinyl estradiol/drospirenone</i> (Yasmin 28)	T1	HD PPACA
<i>ethinyl estradiol/drospirenone</i> (Yaz)	T1	HD PPACA
<i>ethynodiol d-ethinyl estradiol</i>	T1	HD PPACA
<i>levonorgest/eth.estradiol/iron</i> (Balcoltra)	T1	HD PPACA
<i>levonorgestrel/ethin.estradiol</i>	T1	HD PPACA
<i>l-norgest/e.estradiol-e.estrad</i>	T1	HD PPACA
<i>noreth-ethinyl estradiol/iron</i>	T1	HD PPACA
<i>noreth-ethinyl estradiol/iron</i>	T3	HD PPACA
CONTRACEPTIVES, ORAL (cont.)		
<i>norethind-eth estrad 1-0.02 mg</i> (Loestrin)	T1	HD PPACA
<i>norethindrone</i>	T1	HD PPACA
<i>norethindrone ac/eth estradiol</i> (Loestrin)	T1	HD PPACA
<i>norethindrone-e.estradiol-iron</i>	T1	HD PPACA
<i>norethindrone-e.estradiol-iron</i> (Loestrin Fe)	T1	HD PPACA
<i>norethindrone-e.estradiol-iron</i> (Taytulla)	T1	HD PPACA
<i>norethindrone-ethin. estradiol</i>	T1	HD PPACA
<i>norethin-ee 1.5-0.03 mg(21) tb</i> (Loestrin)	T1	HD PPACA
<i>norgestimate-ethinyl estradiol</i>	T1	HD PPACA
<i>norgestrel-ethinyl estradiol</i>	T1	HD PPACA

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List of Prescription Medications

CONTRACEPTIVES (Contraception Products)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CONTRACEPTIVES, TRANSDERMAL		
<i>norelgestromin/ethin.estradiol</i>	T1	HD PPACA
DIAPHRAGMS/CERVICAL CAP		
CAYA CONTOURED	T2	PPACA
FEMCAP	T2	PPACA
WIDE SEAL DIAPHRAGM	T3	PPACA
INTRA-UTERINE DEVICES (IUDS)		
KYLEENA	T4	SP PPACA
LILETTA	T4	SP PPACA
MIRENA	T4	SP PPACA
MIUDELLA	T4	SP PPACA
PARAGARD T 380-A	T4	SP PPACA
PARAGARD T 380A (SINGLE HAND)	T4	SP PPACA
SKYLA	T4	SP PPACA
COUGH/COLD PREPARATIONS (Allergy/Nasal Sprays)		
1ST GEN ANTIHIST-DECONGEST-ANTICHOLINERGIC COMB		
RESPA A.R.	T3	
COUGH/COLD PREPARATIONS (Cough/Cold Medications)		
ANTITUSSIVES, NON-OPIOID		
<i>benzonatate 100 mg capsule</i>	T1	
<i>benzonatate 200 mg capsule</i>	T1	
NON-OPIOID ANTITUS-1ST GEN.ANTIHISTAMINE-DECONGEST		
<i>brompheniramine/pseudoephed/dm (Bromfed Dm)</i>	T1	
NON-OPIOID ANTITUSSIVE-1ST GEN ANTIHISTAMINE COMB.		
<i>promethazine/dextromethorphan</i>	T1	
OPIOID ANTITUSSIVE-1ST GENERATION ANTIHISTAMINE		
<i>hydrocodone/chlorphen p-stirex</i>	T1	PA
<i>promethazine hcl/codeine</i>	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 (<i>hydrocodone bit/homatrop me-br</i>)	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 (<i>hydrocodone bit/homatrop me-br</i>)	T3	PA QL(480 MLS/30 DAYS)

T1 – Typically Generics
 T2 – Typically Preferred Brands
 T3 – Typically Non-Preferred Brands

T4 – Specialty Medications
 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

COUGH/COLD PREPARATIONS (Cough/Cold Medications)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPIOID ANTITUSSIVE-ANTICHOLINERGIC COMBINATIONS (cont.)		
<i>hydrocodone bit/homatrop me-br</i> (Hycodan)	T1	PA QL(480 MLS/30 DAYS)
<i>hydrocodone-homatrop 5 ml cup</i>	T1	PA QL(480 MLS/30 DAYS)
<i>hydrocodone-homatropine 5-1.5</i> (Hycodan)	T1	PA QL(180 TABS/30 DAYS)
<i>hydrocodone-homatropine soln</i> (Hycodan)	T1	PA QL(480 MLS/30 DAYS)
OPIOID ANTITUSSIVE-DECONGESTANT-EXPECTORANT COMB		
CODITUSSIN DAC	T3	
OPIOID ANTITUSSIVE-EXPECTORANT COMBINATION		
<i>codeine phosphate/guaifenesin</i>	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		
<i>indocyanine green</i> (Spy-Mis)	T1	

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List of Prescription Medications

DIAGNOSTIC (Miscellaneous) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BILIARY DIAGNOSTICS, RADIOPAQUE (cont.)		
SINOGRAFIN	T3	
SPY-MIS (<i>indocyanine green</i>)	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		
<i>adenosine</i>	T1	
DEFINITY	T3	
DEFINITY RT	T3	
<i>dipyridamole 50 mg/10 ml vial</i>	T1	
LEXISCAN	T3	
OPTISON	T3	
<i>regadenoson 0.4 mg/5 ml syring</i>	T1	
REGADENOSON 0.4 MG/5 ML VIAL	T3	
CARDIOVASCULAR DIAGNOSTICS, NON-RADIOPAQUE AGENTS		
<i>adenosine</i>	T1	
DEFINITY	T1	
DEFINITY RT	T3	
<i>dipyridamole 50 mg/10 ml vial</i>	T1	
LEXISCAN	T3	
OPTISON	T3	
<i>regadenoson 0.4 mg/5 ml syring</i>	T1	
REGADENOSON 0.4 MG/5 ML VIAL		
CARDIOVASCULAR DIAGNOSTICS-RADIOPAQUE		
<i>iodixanol</i>	T1	
<i>iopamidol</i>	T1	
ISOVUE-200	T3	
ISOVUE-250	T3	
ISOVUE-300	T3	
ISOVUE-370	T3	

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List of Prescription Medications

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	
<i>gadoterate meglumine</i>	T1	
<i>gadoteridol</i>	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	
<i>gadobutrol</i>	T1	
<i>GLUCAGON HCL</i>	T1	
<i>GOZELLIX</i>	T3	
ILLUCCIX	T3	
<i>isosulfan blue</i>	T1	
<i>lidocaine hcl/glycerin</i>	T1	
LIPIODOL	T3	

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List of Prescription Medications

DIAGNOSTIC (Miscellaneous) (cont.)

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	
<i>fluorescein sodium</i>	T1	
<i>fluorescein sodium (Ak-Fluor)</i>	T1	
<i>fluorescein sodium (Ak-Fluor)</i>	T3	
<i>ful-glo 1 mg ophth strip</i>	T1	
FUL-GLO EYE STRIPS	T3	
<i>lissamine green</i>	T1	
FLUORESCENCE CYSTOSCOPY/OPTICAL IMAGING AGENTS		
CYSVIEW	T3	
GASTROINTESTINAL RADIOPAQUE DIAGNOSTICS		
<i>diatrizoate meglumine, sodium (Gastrografin)</i>	T1	
ENTEROVU	T3	
E-Z DISK	T3	
E-Z-HD	T3	
E-Z-PAQUE	T3	
E-Z-PASTE	T3	
GASTROGRAFIN (<i>diatrizoate meglumine, sodium</i>)	T3	
GASTROMARK	T3	
LIQUID E-Z PAQUE	T3	
LIQUID POLIBAR PLUS	T3	

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List of Prescription Medications

DIAGNOSTIC (Miscellaneous) (cont.)

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		
PROTASCINT	T3	
RADIOACTIVE DIAGNOSTICS, GENERAL		
<i>indium-111 chlor/pentetreotide</i>	T1	
OCTREOSCAN	T3	
RADIOACTIVE DIAGNOSTICS - 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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List of Prescription Medications

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	
<i>diatrizoate meglumine, sodium</i>	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		
<i>tolvaptan 15 mg tablet (Samsca)</i>	T4	SP
<i>tolvaptan 30 mg tablet (Samsca)</i>	T4	SP
VAPRISOL-5% DEXTROSE	T3	
CARBONIC ANHYDRASE INHIBITORS		
<i>acetazolamide</i>	T1	HD
<i>acetazolamide sodium</i>	T1	
<i>methazolamide</i>	T1	HD
LOOP DIURETICS		
<i>bumetanide</i>	T1	HD
<i>ethacrynate sodium (Sodium Edecrin)</i>	T1	
<i>furosemide 1,000 mg/100 ml vial</i>	T1	
<i>furosemide 10 mg/ml solution</i>	T1	HD
<i>furosemide 100 mg/10 ml vial</i>	T1	
<i>furosemide 20 mg tablet (Lasix)</i>	T1	HD
<i>furosemide 20 mg/2 ml vial</i>	T1	
<i>furosemide 40 mg tablet (Lasix)</i>	T1	HD
<i>furosemide 40 mg/4 ml syringe</i>	T1	
<i>furosemide 40 mg/4 ml vial</i>	T1	
<i>furosemide 40 mg/5 ml soln</i>	T1	HD
<i>furosemide 500 mg/50 ml vial</i>	T1	
<i>furosemide 80 mg tablet (Lasix)</i>	T1	HD
FUROSEMIDE-0.9% NACL (<i>furosemide in 0.9 % nacl</i>)	T3	
SODIUM EDECRIN (<i>ethacrynate sodium</i>)	T3	
<i>torseamide</i>	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		
<i>mannitol</i>	T1	
<i>mannitol</i>	T3	
<i>mannitol</i> (Osmitrol)	T1	
OSMITROL (<i>mannitol</i>)	T3	
<i>tolvaptan 15 mg tablet</i> (Jynarque)	T4	SP
<i>tolvaptan 15 mg-15 mg tablet</i> (Jynarque)	T4	PA SP
<i>tolvaptan 30 mg tablet</i> (Jynarque)	T4	SP
<i>tolvaptan 30 mg-15 mg tablet</i> (Jynarque)	T4	PA SP
<i>tolvaptan 45 mg-15 mg tablet</i> (Jynarque)	T4	PA SP
<i>tolvaptan 60 mg-30 mg tablet</i> (Jynarque)	T4	PA SP
<i>tolvaptan 90 mg-30 mg tablet</i> (Jynarque)	T4	PA SP
POTASSIUM SPARING DIURETICS		
<i>amiloride hcl</i>	T1	HD
CAROSPIR (<i>spironolactone</i>)	T2	PA
<i>eplerenone</i> (Inspra)	T1	HD
KERENDIA	T2	PA QL(1 TAB/DAY)
<i>spironolactone 100 mg tablet</i> (Aldactone)	T1	HD
<i>spironolactone 25 mg tablet</i> (Aldactone)	T1	HD
<i>spironolactone 25 mg/5 ml susp</i> (Carospir)	T1	
<i>spironolactone 50 mg tablet</i> (Aldactone)	T1	HD
<i>triamterene</i> (Dyrenium)	T1	HD
POTASSIUM SPARING DIURETICS IN COMBINATION		
<i>amiloride/hydrochlorothiazide</i>	T1	HD
<i>spironolact/hydrochlorothiazid</i>	T1	HD
<i>triamterene/hydrochlorothiazid</i>	T1	HD
THIAZIDE AND RELATED DIURETICS		
<i>chlorothiazide sodium</i> (Sodium Diuril)	T1	
<i>chlorthalidone</i>	T1	HD
DIURIL	T3	HD
<i>hydrochlorothiazide</i>	T1	HD
<i>indapamide</i>	T1	HD
<i>metolazone</i>	T1	HD
SODIUM DIURIL (<i>chlorothiazide sodium</i>)	T3	

T1 – Typically Generics

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T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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List of Prescription Medications

EENT PREPS (Allergy/Nasal Sprays)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NASAL ANTIHISTAMINE		
<i>azelastine 0.1% (137 mcg) spray</i>	T1	HD
<i>olopatadine 665 mcg nasal spray (Patanase)</i>	T1	HD
PATANASE (<i>olopatadine hcl</i>)	T3	HD
NASAL ANTIHISTAMINE AND ANTI-INFLAM. STEROID COMB.		
<i>azelastine/fluticasone</i>	T1	HD
NASAL ANTI-INFLAMMATORY STEROIDS		
<i>flunisolide</i>	T1	HD
<i>fluticasone prop 50 mcg spray</i>	T1	HD
<i>mometasone furoate 50 mcg spray</i>	T1	QL(68 GMS/30 DAYS) HD
NOSE PREPARATIONS, MISCELLANEOUS (RX)		
<i>ipratropium bromide</i>	T1	HD
NOSE PREPARATIONS, VASOCONSTRICTORS (RX)		
ADRENALIN CHLORIDE	T3	
<i>epinephrine hcl (Adrenalin Chloride)</i>	T1	
EENT PREPS (Ear Medications)		
EAR PREPARATIONS ANTI-INFLAMMATORY		
DERMOTIC (<i>fluocinolone acetonide oil</i>)	T3	
<i>fluocinolone acetonide oil (Dermotic)</i>	T1	
EAR PREPARATIONS, MISC. ANTI-INFECTIVES		
<i>acetic acid</i>	T1	
<i>hydrocortisone/acetic acid</i>	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		
<i>bromfenac sodium</i>	T1	
<i>bromfenac sodium (Bromsite)</i>	T1	
<i>bromfenac sodium (Prolensa)</i>	T1	
<i>dexamethasone sodium phosphate</i>	T1	
<i>diclofenac 0.1% eye drops</i>	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 (cont.)		
<i>difluprednate (Durezol)</i>	T1	
EYSUVIS	T2	QL(8.3 ML/14 DAYS)
<i>fluorometholone (Fml)</i>	T1	
<i>flurbiprofen sodium</i>	T1	
ILEVRO	T3	
ILLUVIEN	T4	SP
<i>ketorolac 0.4% ophth solution (Acular Ls)</i>	T1	
<i>ketorolac 0.5% ophth solution (Acular)</i>	T1	
<i>loteprednol etabonate (Alrex)</i>	T1	
<i>loteprednol etabonate (Lotemax)</i>	T1	
OZURDEX	T4	SP
<i>prednisolone acetate (Pred Forte)</i>	T1	
<i>prednisolone sodium phosphate</i>	T1	
PROLENSA (<i>bromfenac sodium</i>)	T3	
TRIESENCE	T3	
XIPERE	T4	PA SP HD
EYE IRRIGATIONS		
<i>balanced salt irrig soln no.2</i>	T3	
BSS PLUS	T3	
EYE LOCAL ANESTHETICS		
AKTEN	T3	
ALCAINE (<i>proparacaine hcl</i>)	T3	
ALTAFLUOR BENOX (<i>benoxinate hcl/fluorescein sod</i>)	T3	
FLUORESCEIN-BENOXINATE	T3	
<i>proparacaine hcl (Alcaine)</i>	T1	
<i>proparacaine/fluorescein sod</i>	T1	
<i>tetracaine hcl</i>	T1	
TETRACAINE HCL	T1	
EYE MAST CELL STABILIZERS		
<i>cromolyn 4% eye drops</i>	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		
<i>phenylephrine hcl</i>	T1	
MOTICS AND OTHER INTRAOCULAR PRESSURE REDUCERS		
<i>apraclonidine hcl</i>	T1	HD
<i>betaxolol hcl</i>	T1	HD
BETOPTIC S	T2	HD
<i>bimatoprost</i>	T1	QL(10 MLS/30 DAYS) HD
<i>brimonidine tartrate</i>	T1	HD
<i>brimonidine tartrate (Alphagan P)</i>	T1	HD
<i>brimonidine tartrate/timolol (Combigan)</i>	T1	HD
<i>brinzolamide (Azopt)</i>	T1	HD
<i>carbachol</i>	T3	HD
<i>carteolol hcl</i>	T1	HD
<i>dorzolamide hcl</i>	T1	HD
<i>dorzolamide hcl/timolol maleat (Cosopt)</i>	T1	HD
<i>dorzolamide/timolol/pf (Cosopt Pf)</i>	T1	HD
DURYSTA	T4	PA SP HD
<i>latanoprost (Xalatan)</i>	T1	HD
<i>levobunolol hcl</i>	T1	HD
MIOCHOL-E	T3	HD
PHOSPHOLINE IODIDE	T4	SP HD
<i>pilocarpine 1% eye drops</i>	T1	HD
<i>pilocarpine 2% eye drops</i>	T1	HD
<i>pilocarpine 4% eye drops</i>	T1	HD
RHOPRESSA	T3	
ROCKLATAN	T3	
SIMBRINZA	T2	HD
<i>tafluprost/pf (Zioptan)</i>	T1	QL(60 DROPPERS/30 DAYS) HD
<i>timolol (Betimol)</i>	T1	HD
<i>timolol maleate (Istalol)</i>	T1	HD
<i>timolol maleate (Timoptic)</i>	T1	HD
<i>timolol maleate (Timoptic-Xe)</i>	T1	HD
<i>timolol maleate/pf</i>	T1	HD
<i>timolol maleate/pf (Timoptic Ocudose)</i>	T1	HD
<i>travoprost (Travatan Z)</i>	T1	HD

T1 – Typically Generics
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T4 – Specialty Medications
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ST – Step Therapy
 AGE – Age Requirement
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List of Prescription Medications

EENT PREPS (Eye Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MYDRIATICS		
<i>atropine 1% eye drop</i>	T1	HD
<i>atropine 1% eye drops</i>	T1	HD
<i>atropine 1% eye ointment</i>	T1	HD
CYCLOGYL	T3	HD
CYCLOGYL (<i>cyclopentolate hcl</i>)	T3	HD
CYCLOMYDRIL	T3	HD
<i>cyclopentolate hcl</i>	T1	HD
<i>cyclopentolate hcl (Cyclogyl)</i>	T1	HD
<i>homatropine hbr</i>	T1	HD
MYDRIACYL (<i>tropicamide</i>)	T3	HD
PAREMYD	T3	HD
<i>tropicamide</i>	T1	HD
<i>tropicamide (Mydriacyl)</i>	T1	HD
OPHTH VASC. ENDOTHELIAL GROWTH FACTOR ANTAGONISTS		
EYLEA	T4	PA SP
EYLEA HD	T4	PA SP
PAVBLU	T4	PA SP
OPHTH. VEGF-A RECEPTOR ANTAG. RCMB MC ANTIBODY		
BEOVU	T4	PA SP
BYOOVIZ	T4	PA SP
CIMERLI	T4	PA SP
LUCENTIS	T4	PA SP
OPHTHALMIC ANTIFIBROTIC AGENTS		
MITOSOL	T3	
OPHTHALMIC ANTI-INFLAMMATORY IMMUNOMODULATOR-TYPE		
CEQUA	T2	
<i>cyclosporine 0.05% eye emuls (Restasis)</i>	T1	HD
RESTASIS (<i>cyclosporine</i>)	T2	HD
XIIDRA	T2	HD
OPHTHALMIC COMPLEMENT INHIBITORS		
IZERVAY	T4	PA SP
SYFOVRE	T4	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	T4	PA QL(20 MLS/28 DAYS) SP
CYSTARAN	T4	PA QL(120 MLS/28 DAYS) SP
OPHTHALMIC HUMAN NERVE GROWTH FACTOR (HNGF)		
OXERVATE	T4	PA SP HD
OPHTHALMIC PREPARATIONS, MISCELLANEOUS		
AMVISC	T4	SP
AMVISC PLUS	T4	SP
DISCOVISC	T3	
DUOVISC	T3	
HEALON GV PRO	T3	
<i>hyaluronate sodium</i>	T4	SP
PROVISC	T4	SP
VISCOAT	T3	
OPHTHALMIC SURGICAL AIDS		
CELLUGEL	T3	
<i>hypromellose</i>	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	T4	PA SP HD
ELECT/CALORIC/H2O (Dental Products)		
FLUORIDE PREPARATIONS		
CLINPRO 5000	T3	
FLORIVA	T3	PPACA
<i>fluoride (sodium)</i>	T1	
<i>fluoride (sodium) (Prevident 5000 Plus)</i>	T1	
<i>fluoride (sodium) (Prevident)</i>	T1	
FLUORIDEX	T1	
FLUORIDEX SENSITIVITY RELIEF	T3	
FLUORIMAX 5000	T3	

T1 – Typically Generics
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T3 – Typically Non-Preferred Brands

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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 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	

T1 – Typically Generics
 T2 – Typically Preferred Brands
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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	
<i>tromethamine</i>	T1	
IV SOLUTIONS: DEXTROSE AND LACTATED RINGERS		
<i>dextrose 5%-lactated ringers</i>	T1	
IV SOLUTIONS: DEXTROSE-SALINE		
<i>dextrose 10 % and 0.2 % nacl</i>	T1	
<i>dextrose 10 % and 0.45 % nacl</i>	T1	
<i>dextrose 2.5 % and 0.45 % nacl</i>	T1	
<i>dextrose 5 % and 0.3 % nacl</i>	T1	
<i>dextrose 5 % and 0.9 % nacl</i>	T1	
IV SOLUTIONS: DEXTROSE-SALINE (cont.)		
<i>dextrose 5 %-0.2 % sod chlorid</i>	T1	
<i>dextrose 5 %-0.45 % sod chlord</i>	T1	
IV SOLUTIONS: DEXTROSE-WATER		
<i>dextrose 10%-water iv solution</i>	T1	
<i>dextrose 20%-water iv soln</i>	T1	
<i>dextrose 25%-water syringe</i>	T1	
DEXTROSE 30%-WATER IV SOLN	T3	
DEXTROSE 40%-WATER IV SOLN	T3	
<i>dextrose 5%-water 100 ml</i>	T1	
<i>dextrose 5%-water 100 ml (Glucose In Water)</i>	T1	
<i>dextrose 5%-water 50 ml (Glucose In Water)</i>	T1	
<i>dextrose 5%-water iv soln</i>	T1	
<i>dextrose 5%-water iv soln (Glucose In Water)</i>	T1	
<i>dextrose 50%-water abboject</i>	T1	
DEXTROSE 50%-WATER IV SOLN	T3	
<i>dextrose 50%-water syringe</i>	T1	
<i>dextrose 50%-water vial</i>	T1	
<i>dextrose 70%-water 3,000 ml</i>	T1	
<i>dextrose 70%-water iv soln</i>	T1	
GLUCOSE IN WATER (<i>dextrose 5 % in water</i>)	T1	
NUCLEIC ACID/NUCLEOTIDE SUPPLEMENTS		
XURIDEN	T4	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	
<i>parenteral amino acid 10% no.6</i>	T3	
<i>parenteral amino acid 10% no.7</i>	T3	
PERIKABIVEN	T3	
PLENAMINE	T3	
PROSOL	T3	
TROPHAMINE	T3	
ELECT/CALORIC/H2O (Nutritional/Dietary)		
CALCIUM REPLACEMENT		
<i>calcium chloride</i>	T1	
CALCIUM GLU 1,000MG/100ML-NACL	T3	
<i>calcium glu 2,000mg/100ml-nacl</i>	T1	
CALCIUM GLU 2,000MG/100ML-NACL	T3	
<i>calcium gluc 1,000mg/50ml-nacl</i>	T1	
CALCIUM GLUC 1,000MG/50ML-NACL	T1	
<i>calcium gluconate</i>	T1	
<i>calcium gluconate in 0.9% nacl</i>	T1	
<i>calcium/mag/d3/b12/fa/b6/boron</i>	T1	
CARBOHYDRATES		
ENFAMIL	T3	
GLUTOL	T3	
ELECTROLYTE DEPLETERS		
AURYXIA	T3	QL(12 TABS/DAY)

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List of Prescription Medications

ELECT/CALORIC/H2O (Nutritional/Dietary)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ELECTROLYTE DEPLETERS (cont.)		
<i>calcium acetate</i>	T1	
<i>lanthanum carbonate</i> (Fosrenol)	T1	
LOKELMA	T2	
MAGNEBIND 400	T3	
<i>sevelamer carbonate</i> (Renvela)	T1	
<i>sevelamer hcl</i>	T1	
<i>sodium polystyrene sulfon/sorb</i>	T1	
<i>sodium polystyrene sulfonate</i>	T1	
<i>sps 15 gm/60 ml suspension</i>	T1	
<i>sps 30 gm/120 ml enema susp</i>	T3	
VELPHORO	T2	
VELTASSA	T2	
ELECTROLYTE MAINTENANCE		
<i>electrolyte-148 solution</i>	T1	QL (12 tabs/day)
<i>electrolyte-48 solution/d5w</i>	T1	
<i>electrolyte-a solution</i>	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	
<i>ringer's solution</i>	T1	
<i>ringer's solution,lactated</i>	T1	
TPN ELECTROLYTES (<i>sodium/pot/mag/calc/chlor/acet</i>)	T3	
TPN ELECTROLYTES II	T3	
FLUORIDE PREPARATIONS		
CLINPRO 5000	T3	
<i>fluoride (sodium)</i>	T1	
<i>fluoride (sodium)</i> (Prevident 5000 Plus)	T1	
<i>fluoride (sodium)</i> (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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List of Prescription Medications

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 (<i>iron fum,ps/folic acid/vitc/b3</i>)	T3	
INTEGRA PLUS (<i>iron fum,ps/folic/bcomp,c no.9</i>)	T3	
<i>iron aspgly,ps/c/b12/fa/ca/suc</i>	T1	
<i>iron aspgly/c/b12/fa/ca-th/suc</i>	T1	
<i>iron bg,ps/vitc/b12/fa/calcium</i>	T1	
<i>iron fum,ag/c/b12/folic/ca/suc</i>	T1	
<i>iron fum,ps/folic acid/vitc/b3</i> (Integra F)	T1	
<i>iron fum,ps/folic/bcomp,c no.9</i> (Integra Plus)	T1	
<i>iron fumarate/vit c/vit b12/fa</i>	T1	
<i>iron ps complex/b12/folic acid</i>	T1	
<i>iron sucrose complex</i>	T1	
<i>iron/c/folic acd/mv cmb11/calc</i>	T1	
<i>iron/folic ac/vit bcomp,c/min</i>	T1	
<i>iron/folic acid/b12/c/docusate</i>	T1	
<i>iron/folic acid/c/b6/b12/zinc</i>	T1	
IROSPAN	T3	
MONOFERRIC	T3	PA
NEONATAL FE	T3	
NUFERA	T3	
PROFERRIN-FORTE	T3	
<i>sodium ferric gluconat/sucrose</i> (Ferrlecit)	T1	
TRIFERIC	T3	PA
VENOFER	T3	
VITAFOL	T3	
MAGNESIUM SALTS REPLACEMENT		
<i>magnesium chloride</i>	T1	
<i>magnesium sulfate</i>	T1	
<i>magnesium sulfate in water</i>	T1	
MAGNESIUM SULFATE-D5W	T1	
MINERAL REPLACEMENT, MISCELLANEOUS		
ADDAMEL N	T3	
<i>chromic chloride</i>	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.)		
<i>cupric chloride</i>	T1	
<i>manganese chloride</i>	T1	
MULTRY5	T3	
PEDITRACE	T3	
SELENIOS ACID 12 MCG/2 ML VL	T3	
<i>selenious acid 400 mcg/10 ml</i>	T1	
SELENIOS ACID 600 MCG/10 ML	T1	
TRALEMENT	T3	
PEDIATRIC VITAMIN PREPARATIONS		
<i>fluoride (sodium)</i>	T1	PPACA
<i>sodium fluoride 0.25 (0.55) mg</i>	T1	PPACA
<i>sodium fluoride 0.5 mg(1.1 mg)</i>	T1	PPACA
<i>sodium fluoride 0.5 mg/ml drop</i>	T1	PPACA
<i>sodium fluoride 1 mg (2.2 mg)</i>	T1	PPACA
PHOSPHATE REPLACEMENT		
GLYCOPHOS	T3	
<i>potassium phos,m-basic-d-basic</i>	T1	
POTASSIUM PHOSPHATE-0.9% NAACL	T3	
POTASSIUM PHOSPHATES	T3	
<i>sod phosphate,monobasic-dibas</i>	T1	
POTASSIUM REPLACEMENT		
EFFER-K 10 MEQ TABLET EFF	T3	
EFFER-K 20 MEQ TABLET EFF	T3	
<i>effe-r-k 25 meq tablet eff</i>	T1	
<i>potassium acetate</i>	T1	
<i>potassium bicarbonate/cit ac</i>	T1	
<i>potassium chloride</i>	T1	
<i>potassium chloride</i>	T3	
<i>potassium chloride in 0.9%nacl</i>	T1	
<i>potassium chloride in d5w</i>	T1	
<i>potassium chloride in lr-d5</i>	T1	
<i>potassium chloride in water</i>	T1	
<i>potassium chloride/d5-0.2%nacl</i>	T1	
<i>potassium chloride/d5-0.3%nacl</i>	T1	
<i>potassium chloride/d5-0.45nacl</i>	T1	
<i>potassium chloride/d5-0.9%nacl</i>	T1	

T1 – Typically Generics
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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
POTASSIUM REPLACEMENT (cont.)		
<i>potassium chloride-0.45% nacl</i>	T1	
<i>potassium cl 10 meq/100 ml sol</i>	T1	
<i>potassium cl 10 meq/5 ml conc</i>	T1	
<i>potassium cl 10 meq/50 ml sol</i>	T1	
<i>potassium cl 10% (20 meq/15ml)</i>	T1	
POTASSIUM CL 2 MEQ/ML CONC (<i>potassium chloride</i>)	T3	
<i>potassium cl 20 meq packet</i>	T1	
<i>potassium cl 20 meq/10 ml conc</i>	T1	
<i>potassium cl 20 meq/100 ml sol</i>	T1	
<i>potassium cl 20 meq/50 ml sol</i>	T1	
<i>potassium cl 20% (40 meq/15ml)</i>	T1	
<i>potassium cl 30 meq/100 ml sol</i>	T1	
<i>potassium cl 40 meq/100 ml sol</i>	T1	
<i>potassium cl 40 meq/20 ml conc</i>	T1	
<i>potassium cl 60 meq/30 ml conc</i>	T1	
<i>potassium cl er 10 meq capsule</i>	T1	
<i>potassium cl er 10 meq tablet</i>	T1	
<i>potassium cl er 15 meq tablet</i>	T1	
POTASSIUM CL ER 15 MEQ TABLET	T3	
<i>potassium cl er 20 meq tablet</i>	T1	
<i>potassium cl er 8 meq capsule</i>	T1	
<i>potassium cl er 8 meq tablet</i>	T1	
<i>potassium cl10%(20meq/15ml)cup</i>	T1	
<i>potassium cl10%(40meq/30ml)cup</i>	T1	
<i>potassium cl20%(40meq/15ml)cup</i>	T1	
POTASSIUM CL-LIDOCAINE-NS (<i>potassium cl/lido/0.9 % nacl</i>)	T3	
PROTEIN REPLACEMENT		
AQNEURSA	T4	PA SP
SODIUM/SALINE PREPARATIONS		
<i>0.9 % sodium chloride</i>	T1	
KENDALL 0.9% NACL WITH CAP	T1	
<i>saline 0.45% soln-excel con</i>	T1	
<i>saline 0.9% flush 10 ml syr</i>	T1	
<i>saline 0.9% flush 5 ml syr</i>	T1	
<i>sodium chloride 0.45% soln</i>	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SODIUM/SALINE PREPARATIONS		
<i>sodium chloride 0.9% (flush)</i>	T1	
<i>sodium chloride 0.9% (pwr inj)</i>	T1	
<i>sodium chloride 0.9% 1,000 ml</i>	T1	
<i>sodium chloride 0.9% 10 ml syr</i>	T1	
<i>sodium chloride 0.9% 100 ml</i>	T1	
<i>sodium chloride 0.9% 250 ml</i>	T1	
<i>sodium chloride 0.9% 50 ml</i>	T1	
<i>sodium chloride 0.9% 500 ml</i>	T1	
<i>sodium chloride 0.9% sol-excel</i>	T1	
<i>sodium chloride 0.9% soln</i>	T1	
<i>sodium chloride 0.9% solution</i>	T1	
<i>sodium chloride 0.9% syringe</i>	T1	
<i>sodium chloride 0.9% vial</i>	T1	
<i>sodium chloride 0.9% zr syr</i>	T1	
<i>sodium chloride 100 meq/40 ml</i>	T1	
<i>sodium chloride 120 meq/30 ml</i>	T1	
<i>sodium chloride 3% iv soln</i>	T1	
<i>sodium chloride 4 meq/ml vl</i>	T1	
<i>sodium chloride 400 meq/100 ml</i>	T1	
<i>sodium chloride 5% iv soln</i>	T1	
<i>sodium chloride 50 meq/20 ml</i>	T1	
<i>sodium chloride 800 meq/200 ml</i>	T1	
SWABFLUSH	T3	
ZINC REPLACEMENT		
<i>zinc chloride</i>	T1	
<i>zinc sulfate</i>	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	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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

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List of Prescription Medications

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	
<i>perit. dialysis no.6-dex 1.5 %</i>	T3	
<i>periton.dialysis 7-dextr 2.5 %</i>	T3	
<i>periton.dialysis 8-dext 4.25 %</i>	T3	
PHOXILLUM	T3	
PRISMASOL	T3	
URINARY PH MODIFIERS		
<i>citric acid/sodium citrate</i>	T1	HD
K-PHOS NO.2	T3	HD
K-PHOS ORIGINAL	T3	HD
ORACIT	T3	HD
<i>potassium citrate</i>	T1	HD
<i>potassium citrate (Urocit-K)</i>	T1	HD
<i>potassium citrate/citric acid</i>	T1	HD
RENACIDIN	T3	HD
<i>sod/pot/k cit/sod cit/cit acid</i>	T1	HD
UROCIT-K (potassium citrate)	T3	HD
UROQID-ACID NO.2	T3	HD
GASTROINTESTINAL (Cholesterol Medications)		
LIPOTROPICS		
<i>icosapent ethyl (Vascepa)</i>	T1	HD
<i>omega-3 acid ethyl esters (Lovaza)</i>	T1	HD
VASCEPA (<i>icosapent ethyl</i>)	T2	HD
GASTROINTESTINAL (Gastrointestinal/Heartburn)		
AMMONIA INHIBITORS		
AMMONUL (<i>sodium benzoate/sod phenylacet</i>)	T3	
<i>glycerol phenylbutyrate</i>	T1	HD
<i>lactulose</i>	T1	
<i>lactulose</i>	T1	HD
<i>lactulose 10 gm/15 ml solution</i>	T4	PA SP HD
LITHOSTAT	T4	PA QL(8 Bottles/30 Days) SP HD
OLPRUVA	T3	
PHEBURANE	T4	SP HD

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List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AMMONIA INHIBITORS (cont.)		
<i>sodium benzoate/sod phenylacet</i> (Ammonul)	T1	
<i>sodium phenylbutyrate</i> (Buphenyl)	T1	
ANTICHOLINERGICS, QUATERNARY AMMONIUM		
<i>chlordiazepoxide/clidinium br</i> (Librax)	T1	
CUVPOSA (glycopyrrolate)	T3	
GLYCATE	T3	
<i>glycopyrrolate 0.2 mg/ml vial</i>	T1	
<i>glycopyrrolate 0.4 mg/2 ml vl</i>	T1	
GLYCOPYRROLATE 0.6 MG/3 ML SYR	T1	
<i>glycopyrrolate 1 mg tablet</i> (Robinul)	T1	
<i>glycopyrrolate 1 mg/5 ml soln</i> (Cuvposa)	T1	
<i>glycopyrrolate 1 mg/5 ml syrng</i>	T1	
GLYCOPYRROLATE 1 MG/5 ML SYRNG	T1	
<i>glycopyrrolate 1 mg/5 ml vial</i>	T1	
<i>glycopyrrolate 2 mg tablet</i> (Robinul Forte)	T1	
<i>glycopyrrolate 4 mg/20 ml vial</i>	T1	
GLYCOPYRROLATE-WATER	T1	
ANTICHOLINERGICS/ANTISPASMODICS		
<i>dicyclomine 10 mg capsule</i>	T1	
<i>dicyclomine 10 mg/5 ml soln</i>	T1	
<i>dicyclomine 20 mg tablet</i>	T1	
<i>dicyclomine 20 mg/2 ml ampul</i>	T1	
<i>dicyclomine 20 mg/2 ml vial</i>	T1	
DICYCLOMINE 40 MG TABLET	T3	
ANTIDIARRHEAL - G.I. CHLORIDE CHANNEL INHIBITORS		
MYTESI	T3	
ANTIDIARRHEAL - TRYPTOPHAN HYDROXYLASE INHIBITOR		
XERMELO	T4	PA SP
ANTIDIARRHEALS		
<i>diphenoxylate hcl/atropine</i>	T1	
<i>diphenoxylate hcl/atropine</i> (Lomotil)	T1	
<i>loperamide hcl</i>	T1	
MOTOFEN	T3	
<i>opium tincture</i>	T1	PA
ANTIEMETIC, CANNABINOID-TYPE		
<i>dronabinol</i> (Marinol)	T1	

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List of Prescription Medications

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)
<i>aprepitant 125 mg capsule</i>	T1	QL(4 CAPS/28 DAYS)
<i>aprepitant 125-80-80 mg pack (Emend)</i>	T1	QL(12 CAPS/28 DAYS)
<i>aprepitant 40 mg capsule</i>	T1	QL(1 CAP/28 DAYS)
<i>aprepitant 80 mg capsule (Emend)</i>	T1	QL(8 CAPS/28 DAYS)
BARHEMSYS	T3	
BONJESTA	T3	
CINVANTI	T3	
COMPAZINE (<i>prochlorperazine maleate</i>)	T3	
COMPAZINE (<i>prochlorperazine</i>)	T3	
<i>dimenhydrinate</i>	T1	
<i>doxylamine succinate/vit b6 (Diclegis)</i>	T1	QL(4 TABS/DAY)
EMEND 125 MG POWDER PACKET	T3	PA QL(12 PACKS/28 DAYS)
EMEND 150 MG VIAL (<i>fosaprepitant dimeglumine</i>)	T3	
FOCINVEZ	T3	
<i>fosaprepitant dimeglumine (Emend)</i>	T1	
<i>granisetron hcl</i>	T1	
<i>granisetron hcl/pf</i>	T1	
<i>ondansetron hcl</i>	T1	
<i>ondansetron hcl/pf</i>	T1	
<i>ondansetron odt 4 mg tablet</i>	T1	
<i>ondansetron odt 8 mg tablet</i>	T1	
<i>palonosetron 0.25 mg/5 ml vial (Posfrea)</i>	T1	
palonosetron hcl 0.25 mg/5 ml	T1	PA
POSFREA (<i>palonosetron hcl</i>)	T3	
<i>prochlorperazine (Compazine)</i>	T1	
<i>prochlorperazine edisylate</i>	T1	
<i>prochlorperazine maleate (Compazine)</i>	T1	
<i>promethazine hcl</i>	T1	
SANCUSO	T3	PA QL(4 PATCHES/30 DAYS)
<i>scopolamine (Transderm-Scop)</i>	T1	
SUSTOL	T3	
TIGAN	T3	

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List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)

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

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List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BELLADONNA ALKALOIDS (cont.)		
<i>hyoscyamine sulfate</i> (Levsin)	T1	HD
<i>hyoscyamine sulfate</i> (Levsin-SI)	T1	HD
<i>hyoscyamine sulfate</i> (Nulev)	T1	HD
<i>hyoscyamine sulfate</i> (Nulev)	T3	HD
HYOSCYAMINE SULFATE 0.5 MG/ML	T3	HD
LEVSIN (<i>hyoscyamine sulfate</i>)	T3	HD
<i>methscopolamine bromide</i>	T1	HD
NULEV (<i>hyoscyamine sulfate</i>)	T3	HD
phenobarb/hyoscy/atropine/scop	T1	HD
<i>phenobarb/hyoscy/atropine/scop</i> (Donnatal)	T1	HD
<i>phenobarb/hyoscy/atropine/scop</i> (Phenobarbital-Belladonna)	T1	HD
PHENOBARBITAL-BELLADONNA (<i>phenobarb/hyoscy/atropine/scop</i>)	T3	HD
SYMAX DUOTAB	T3	HD
BILE SALTS		
CHENODAL	T4	PA SP HD
CHOLBAM	T4	PA SP HD
CTEXLI	T4	PA SP
URSO FORTE (<i>ursodiol</i>)	T3	HD
<i>ursodiol 250 mg tablet</i>	T1	HD
<i>ursodiol 300 mg capsule</i>	T1	HD
<i>ursodiol 500 mg tablet</i> (Urso Forte)	T1	HD
CHOLERETICS		
KINEVAC	T3	
CHRONIC INFLAM. COLON DX, 5-A-SALICYLAT, RECTAL TX		
<i>mesalamine 1,000 mg supp</i> (Canasa)	T1	
<i>mesalamine 4 gm/60 ml enema</i> (Sfrowasa)	T1	
<i>mesalamine 4 gm/60 ml kit</i> (Rowasa)	T1	
SFROWASA (<i>mesalamine</i>)	T3	
APRISO (<i>mesalamine</i>)	T3	HD
<i>balsalazide disodium</i> (Colazal)	T1	HD
<i>mesalamine</i>	T1	HD
<i>mesalamine</i> (Apriso)	T1	HD
<i>mesalamine</i> (Pentasa)	T1	HD

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List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DRUG TX-CHRONIC INFLAM. COLON DX, 5-AMINOSALICYLAT		
<i>mesalamine 800 mg dr tablet (Asacol Hd)</i>	T1	HD
<i>mesalamine dr 1.2 gm tablet (Lialda)</i>	T1	HD
PENTASA 500 MG CAPSULE (<i>mesalamine</i>)	T3	HD
<i>sulfasalazine (Azulfidine)</i>	T1	HD
FARNESOID X RECEPTOR (FXR) AGONIST, BILE AC ANALOG		
OCALIVA	T4	PA SP HD
FECAL MICROBIOTA TRANSPLANTATION (FMT)		
VOWST	T4	PA QL(12 CAPS/56 DAYS) SP
GASTRIC ENZYMES		
SUCRAID	T4	PA SP
HEMORRHOID PREP,ANTI-INFLAM STEROID-LOCAL ANESTHET		
ANALPRAM HC 1% CREAM	T3	
<i>hydrocortisone/pramoxine</i>	T1	
<i>hydrocortisone/pramoxine (Analpram Hc)</i>	T1	
PROCORT	T3	
PROCTOFOAM-HC	T3	
HISTAMINE H2-RECEPTOR INHIBITORS		
<i>cimetidine hcl</i>	T1	HD
<i>famotidine</i>	T1	HD
IBS AGENTS, MIXED OPIOID RECEPTOR AGONISTS/ANTAGONISTS		
VIBERZI	T2	HD
IBS-C/CIC AGENTS, GUANYLATE CYCLASE-C AGONIST		
LINZESS	T2	
TRULANCE	T2	
INTEGRIN RECEPTOR ANTAGONIST, MONOCLONAL ANTIBODY		
ENTYVIO	T4	PA SP HD
INTESTINAL MOTILITY STIMULANTS		
<i>metoclopramide hcl</i>	T1	
<i>metoclopramide hcl (Reglan)</i>	T1	
<i>prucalopride succinate (Motegrity)</i>	T1	
REGLAN (metoclopramide hcl)	T3	
IRRITABLE BOWEL SYNDROME AGENTS, 5-HT3 ANTAGONIST		
<i>alosetron hcl</i>	T4	SP HD
IV FAT EMULSIONS		
CLINOLIPID	T3	
<i>fat emulsions (Nutralipid)</i>	T3	

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List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)

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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List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PROTON-PUMP INHIBITORS (cont.)		
<i>esomeprazole dr 40 mg packet (Nexium)</i>	T1	QL(1 PACK/DAY) HD
<i>esomeprazole dr 5 mg packet (Nexium)</i>	T1	QL(8 PACKS/DAY) HD
<i>esomeprazole mag dr 20 mg cap</i>	T1	QL(2 CAPS/DAY) HD
<i>esomeprazole mag dr 40 mg cap</i>	T1	QL(1 CAP/DAY) HD
<i>esomeprazole sodium</i>	T1	
<i>lansoprazole dr 15 mg capsule</i>	T1	QL(2 CAPS/DAY) HD
<i>lansoprazole dr 15 mg odt (Prevacid)</i>	T1	QL(2 TABS/DAY) HD
<i>lansoprazole dr 30 mg capsule</i>	T1	QL(1 CAP/DAY) HD
<i>lansoprazole dr 30 mg odt (Prevacid)</i>	T1	QL(1 TAB/DAY) HD
<i>omeprazole dr 10 mg capsule</i>	T1	QL(4 CAPS/DAY) HD
<i>omeprazole dr 20 mg capsule</i>	T1	QL(2 CAPS/DAY) HD
<i>omeprazole dr 40 mg capsule</i>	T1	QL(1 CAP/DAY) HD
<i>omeprazole-bicarb 20-1,100 cap</i>	T1	PA QL(2 CAPS/DAY) HD
<i>omeprazole-bicarb 20-1,680 pkt</i>	T1	PA QL(2 PACKS/DAY) HD
<i>omeprazole-bicarb 40-1,100 cap</i>	T1	PA QL(1 CAP/DAY) HD
<i>omeprazole-bicarb 40-1,680 pkt</i>	T1	PA QL(1 PACK/DAY) HD
<i>pantoprazole dr 40 mg susp pkt</i>	T1	QL(1 PACK/DAY) HD
<i>pantoprazole sod dr 20 mg tab</i>	T1	QL(2 TABS/DAY) HD
<i>pantoprazole sod dr 40 mg tab</i>	T1	QL(1 TAB/DAY) HD
<i>pantoprazole sodium 40 mg vial</i>	T1	
<i>rabeprazole sodium</i>	T1	QL(1 TAB/DAY) HD
SBS - GLUCAGON-LIKE PEPTIDE-2 (GLP-2) ANALOGS		
GATTEX	T4	PA SP HD
GASTROINTESTINAL (Pain Relief And Inflammatory Disease)		
HEMORRHOID PREP, ANTI-INFLAM STEROID-LOCAL ANESTHET		
ANA-LEX	T1	
ANALPRAM HC 1% CREAM	T3	
<i>hydrocortisone/lidocaine/aloe</i>	T1	
<i>hydrocortisone/pramoxine</i>	T1	
<i>hydrocortisone/pramoxine (Analpram Hc)</i>	T1	
<i>lidocaine/hydrocortisone ac</i>	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	T4	SP
HORMONES (Gastrointestinal/Heartburn)		
RECTAL/LOWER BOWEL PREP., GLUCOCORT. (NON-HEMORR)		
<i>budesonide 2 mg rectal foam (Uceris)</i>	T1	QL(2 KITS/180 DAYS)
CORTENEMA (<i>hydrocortisone</i>)	T3	
<i>hydrocortisone (Cortenema)</i>	T1	
HORMONES (Hormonal Agents)		
ADRENOCORTICOTROPHIC HORMONES		
ACTHAR	T4	PA SP HD
CORTROPHIN GEL 400 UNIT/5 ML	T4	PA SP HD
CORTROPHIN GEL 80 UNIT/ML VIAL	T4	PA SP HD
<i>cosyntropin (Cortrosyn)</i>	T1	
ANDROGEN/ESTROGEN PREPS FOR FEMALE SEXUAL DYSFUNC		
INTRAROSA	T3	
ANDROGENIC AGENTS		
AVEED	T4	PA SP
DEPO-TESTOSTERONE	T3	
DEPO-TESTOSTERONE (<i>testosterone cypionate</i>)	T3	
METHITEST	T1	
<i>methyltestosterone</i>	T1	
<i>oxandrolone</i>	T1	PA
TESTOPEL	T3	PA
<i>testosterone 1% (25mg/2.5g) pk (AndroGel)</i>	T1	PA QL(150 GMS/30 DAYS)
<i>testosterone 1% (50 mg/5 g) pk (AndroGel)</i>	T1	PA QL(300 GMS/30 DAYS)
<i>testosterone 1.62% (2.5 g) pkt</i>	T1	PA QL(150 GMS/30 DAYS)
<i>testosterone 1.62% gel pump (AndroGel)</i>	T1	PA QL(150 GMS/30 DAYS)
<i>testosterone 1.62%(1.25 g) pkt</i>	T1	PA QL(75 GMS/30 DAYS)
<i>testosterone 10 mg gel pump</i>	T1	PA QL(120 GMS/30 DAYS)
<i>testosterone 12.5 mg/1.25 gram</i>	T1	PA QL(150 GMS/30 DAYS)
<i>testosterone 30 mg/1.5 ml pump</i>	T1	PA QL(180 MLS/30 DAYS)
<i>testosterone 50 mg/5 gram gel (Testim)</i>	T1	PA QL(10 GMS/DAY)
<i>testosterone 50 mg/5 gram gel (Vogelxo)</i>	T1	PA QL(10 GMS/DAY)
TESTOSTERONE 50 MG/5 GRAM PKT	T1	PA QL(300 GMS/30 DAYS)

T1 – Typically Generics

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T4 – Specialty Medications

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AGE – Age Requirement

SP – Specialty Medication

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List of Prescription Medications

HORMONES (Hormonal Agents) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANDROGENIC AGENTS (cont.)		
<i>testosterone cypionate</i>	T1	PA QL (120 gm/30 days)
<i>testosterone cypionate</i> (Depo-Testosterone)	T1	PA QL (150gm/30 days)
<i>testosterone enanthate</i>	T1	PA QL (150gm/30 days)
ANTIDIURETIC AND VASOPRESSOR HORMONES		
<i>desmopressin 0.01% solution</i>	T1	HD
<i>desmopressin 0.01% spray</i>	T1	HD
<i>desmopressin 10 mcg/0.1 ml spr</i>	T1	HD
<i>desmopressin 40 mcg/10 ml vial</i>	T4	SP
<i>desmopressin ac 4 mcg/ml ampul</i>	T4	SP
<i>desmopressin ac 4 mcg/ml vial</i>	T4	SP
<i>desmopressin acetate 0.1 mg tb</i> (Ddvp)	T1	
<i>desmopressin acetate 0.2 mg tb</i> (Ddvp)	T1	
NOCTIVA	T3	PA
STIMATE	T4	SP
<i>vasopressin</i>	T1	
VASOPRESSIN-D5W	T1	
VASOSTRICT	T3	
ESTROGEN AND PROGESTIN COMBINATIONS		
BIJUVA	T3	
ESTROGEN/ANDROGEN COMBINATIONS		
<i>estrogen, ester/me-testosterone</i>	T1	HD
<i>estrogen, ester/me-testosterone</i> (Estratest H.S.)	T1	HD
ESTROGENIC AGENTS		
COMBIPATCH	T2	
DEPO-ESTRADIOL	T3	HD
<i>estradiol</i> (Climara)	T1	HD
<i>estradiol</i> (Minivelle)	T1	QL(16 PATCHES/28 DAYS) HD
<i>estradiol</i> (Vivelle-Dot)	T1	QL(16 PATCHES/28 DAYS) HD
<i>estradiol 0.06% 1.25g gel pump</i> (Estrogel)	T1	HD
<i>estradiol 0.1% (0.25mg) gel pk</i> (Divigel)	T1	HD
<i>estradiol 0.1% (0.5mg) gel pkt</i> (Divigel)	T1	HD
<i>estradiol 0.1% (0.75mg) gel pk</i> (Divigel)	T1	HD
<i>estradiol 0.1% (1 mg) gel pkt</i> (Divigel)	T1	HD
<i>estradiol 0.1% (1.25mg) gel pk</i> (Divigel)	T1	HD
<i>estradiol 0.5 mg tablet</i>	T1	HD

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List of Prescription Medications

HORMONES (Hormonal Agents) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ESTROGENIC AGENTS (cont.)		
<i>estradiol 1 mg tablet</i>	T1	HD
<i>estradiol 2 mg tablet</i>	T1	HD
<i>estradiol valerate (Delestrogen)</i>	T1	HD
<i>estradiol/norethindrone acet</i>	T1	HD
<i>estradiol/norethindrone acet (Activella)</i>	T1	HD
<i>estrogens, conjugated (Premarin)</i>	T1	HD
EVAMIST	T3	HD
MENEST	T3	HD
MENOSTAR	T3	QL(8 PATCHES/28 DAYS) HD
<i>norethind-eth estrad 0.5-2.5</i>	T1	HD
<i>norethindrone ac/eth estradiol</i>	T1	HD
<i>norethin-eth estrad 1 mg-5 mcg</i>	T1	HD
PREMARIN	T2	HD
PREMARIN (<i>estrogens, conjugated</i>)	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	
<i>betamethasone acetate,sod phos (Celestone)</i>	T1	
BSP 0820	T3	
<i>budesonide</i>	T1	
<i>budesonide (Uceris)</i>	T1	PA QL(1 TAB/DAY)
CELESTONE (<i>betamethasone acetate,sod phos</i>)	T3	
<i>cortisone acetate</i>	T1	
<i>deflazacort (Emflaza)</i>	T4	PA SP HD
DEPO-MEDROL	T3	
<i>dexamethasone</i>	T1	

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List of Prescription Medications

HORMONES (Hormonal Agents) (cont.)

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

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List of Prescription Medications

HORMONES (Hormonal Agents) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GLUCOCORTICOIDS (cont.)		
<i>triamcinolone acet 200 mg/5 ml</i> (Kenalog-40)	T1	
<i>triamcinolone acet 40 mg/ml vl</i> (Kenalog-40)	T1	
<i>triamcinolone acet 400 mg/10ml</i> (Kenalog-40)	T1	
<i>triamcinolone acet 50mg/5ml vl</i>	T1	
UCERIS 9 MG ER TABLET (<i>budesonide</i>)	T3	PA QL(1 TAB/DAY)
ZILRETTA	T3	PA
GROWTH HORMONE RELEASING HORMONE (GHRH) AND ANALOGS		
EGRIFTA	T4	PA SP HD
EGRIFTA SV	T4	PA SP HD
GROWTH HORMONES		
GENOTROPIN	T4	PA SP HD
OMNITROPE	T4	PA SP HD
SEROSTIM	T4	PA SP HD
SKYTROFA	T4	PA SP HD
LHRH (GNRH) AGONIST ANALOG PITUITARY SUPPRESSANTS		
LUPRON DEPOT 11.25 MG 3MO KIT	T4	PA SP HD
LUPRON DEPOT 3.75 MG KIT	T4	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	T4	PA SP
CETROTIDE (<i>cetrotorelix acetate</i>)	T4	PA SP
<i>ganirelix acet 250 mcg/0.5 ml</i> (Ganirelix Acetate)	T4	PA SP
GANIRELIX ACET 250 MCG/0.5 ML (<i>ganirelix acetate</i>)	T4	PA SP
<i>ganirelix acetate</i> (Ganirelix Acetate)	T4	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	T4	PA SP
TRIPTODUR	T4	PA SP
MINERALOCORTICOIDS		
<i>fludrocortisone acetate</i>	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 (<i>carboprost tromethamine</i>)	T3	
<i>methylergonovine maleate</i>	T1	
METHYLERGONOVINE MALEATE	T1	
<i>oxytocin</i> (Pitocin)	T1	
OXYTOCIN-LACTATED RINGERS	T1	
PITOCIN (<i>oxytocin</i>)	T3	
PREPIDIL	T3	
PARATHYROID HORMONES		
YORVIPATH	T4	PA SP
PITUITARY SUPPRESSIVE AGENTS		
<i>cabergoline</i>	T1	QL(16 TABS/28 DAYS) HD
CRENESSITY 100 MG CAPSULE	T4	PA QL(4 CAPS/DAY) SP
CRENESSITY 25 MG CAPSULE	T4	PA QL(2 CAPS/DAY) SP
CRENESSITY 50 MG CAPSULE	T4	PA QL(2 CAPS/DAY) SP
CRENESSITY 50 MG/ML SOLUTION	T4	PA QL(8 MLS/DAY) SP
danazol	T1	HD
PROGESTATIONAL AGENTS		
CRINONE 4% GEL	T3	PA HD
<i>medroxyprogesterone 10 mg tab</i> (Provera)	T1	HD
<i>medroxyprogesterone 2.5 mg tab</i> (Provera)	T1	HD
<i>medroxyprogesterone 5 mg tab</i> (Provera)	T1	HD
<i>norethindrone acetate</i>	T1	HD
<i>progesterone 100 mg capsule</i> (Prometrium)	T1	HD
<i>progesterone 200 mg capsule</i> (Prometrium)	T1	HD
<i>progesterone 500 mg/10 ml vial</i>	T4	SP HD
RENIN-ANGIOTENSIN-ALDOSTERONE SYS. (RAAS) HORMONES		
GIAPREZA	T4	SP

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List of Prescription Medications

HORMONES (Hormonal Agents) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SOMATOSTATIC AGENTS		
<i>lanreotide 120 mg/0.5 ml syrng</i>	T4	PA SP HD
LANREOTIDE 120 MG/0.5 ML SYRNG	T4	PA SP HD
<i>octreotide acetate</i>	T4	PA SP HD
<i>octreotide acetate (Sandostatin)</i>	T4	PA SP HD
<i>octreotide acetate,mi-spheres (Sandostatin Lar Depot)</i>	T4	PA SP
SANDOSTATIN 0.05 MG/ML AMPUL (<i>octreotide acetate</i>)	T4	PA SP HD
SANDOSTATIN 0.1 MG/ML AMPUL (<i>octreotide acetate</i>)	T4	PA SP HD
SANDOSTATIN 0.5 MG/ML AMPUL (<i>octreotide acetate</i>)	T4	PA SP HD
SANDOSTATIN LAR DEPOT (<i>octreotide acetate,mi-spheres</i>)	T4	PA SP
SIGNIFOR	T4	PA SP
SIGNIFOR LAR	T4	PA SP
SOMATULINE DEPOT	T4	PA SP HD
VAGINAL ESTROGEN PREPARATIONS		
<i>estradiol (Vagifem)</i>	T1	QL(36 TABS/28 DAYS)
<i>estradiol 0.01% cream (Estrace)</i>	T1	HD
<i>estradiol 10 mcg vaginal insrt (Vagifem)</i>	T1	QL(36 TABS/28 DAYS) HD
PREMARIN	T2	HD
HORMONES (Infertility)		
FERTILITY STIMULATING PREPARATIONS, NON-FSH		
<i>clomiphene citrate</i>	T1	
FOLLICLE-STIMULATING AND LUTEINIZING HORMONES		
MENOPUR	T4	PA SP
FOLLICLE-STIMULATING HORMONE (FSH)		
FOLLISTIM AQ	T4	PA SP
GONAL-F	T4	PA SP
GONAL-F RFF REDI-JECT	T4	PA SP
HUMAN CHORIONIC GONADOTROPIN (HCG)		
CHORIONIC GONADOTROPIN	T4	PA SP
NOVAREL	T4	PA SP
OVIDREL	T4	PA SP
PREGNYL	T4	PA SP
PREGNANCY FACILITATING/MAINTAINING AGENT, HORMONAL		
CRINONE 8% GEL	T2	PA

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List of Prescription Medications

HORMONES (Infertility)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PREGNANCY FACILITATING/MAINTAINING AGENT, HORMONAL		
ENDOMETRIN (<i>progesterone, micronized</i>)	T2	
<i>progesterone 100 mg vag insert</i> (Endometrin)	T1	
PREGNANCY MAINTAINING AGENT, HORMONAL		
<i>hydroxyprogesterone caproat/pf</i>	T1	PA
<i>hydroxyprogesterone caproate</i>	T1	PA
MAKENA	T3	PA
HORMONES (Miscellaneous)		
LEPTIN HORMONE ANALOGS		
MYALEPT	T4	PA SP HD
HORMONES (Osteoporosis Products)		
BONE RESORPTION INHIBITORS		
<i>calcitonin, salmon, synthetic</i>	T1	HD
<i>calcitonin, salmon, synthetic</i> (Miacalcin)	T1	HD
MIACALCIN (<i>calcitonin, salmon, synthetic</i>)	T3	HD
IMMUNOSUPPRESSANTS (Miscellaneous)		
IMMUNOSUPPRESSANT-INTERFERON GAMMA INHIBITOR, MAB		
GAMIFANT	T4	PA SP
SAPHNELO	T4	PA SP
IMMUNOSUPPRESSANTS (Pain Relief And Inflammatory Disease)		
ANTI-CD19 (B LYMPHOCYTE) MONOCLONAL ANTIBODY		
UPLIZNA	T4	PA SP HD
HUMAN INTERLEUKIN 12/23 (IL-12/13) INHIBITORS, MAB		
SELARSDI 130 MG/26 ML VIAL	T4	PA SP
SELARSDI 45 MG/0.5 ML SYRINGE	T4	PA QL(1 SYRINGE/84 DAYS) SP
SELARSDI 45 MG/0.5 ML VIAL	T4	PA QL(1 SYRINGE/84 DAYS) SP
SELARSDI 90 MG/ML SYRINGE	T4	PA QL(1 SYRINGE/84 DAYS) SP
STARJEMZA 130 MG/26 ML VIAL	T4	PA SP
STELARA 45 MG/0.5 ML SYRINGE	T4	PA QL(1 SYRINGE/84 DAYS) SP HD
STELARA 45 MG/0.5 ML VIAL	T4	PA QL(1 SYRINGE/84 DAYS) SP HD
STELARA 90 MG/ML SYRINGE	T4	PA QL(1 SYRINGE/84 DAYS) SP HD
USTEKINUMAB-TTWE 130MG/26ML VL	T4	PA SP HD
USTEKINUMAB-TTWE 45 MG SYRINGE	T4	PA QL(1 SYRINGE/84 DAYS) SP HD
USTEKINUMAB-TTWE 90 MG/ML SYR	T4	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	T4	PA SP
YESINTEK 45 MG/0.5 ML SYRINGE	T4	PA QL(1 SYRINGE/84 DAYS) SP
YESINTEK 45 MG/0.5 ML VIAL	T4	PA QL(1 SYRINGE/84 DAYS) SP
YESINTEK 90 MG/ML SYRINGE	T4	PA QL(1 SYRINGE/84 DAYS) SP
IL-23 RECEPTOR ANTAGONIST, MONOCLONAL ANTIBODY		
OMVOH 100 MG/ML PEN	T4	PA QL(2 PENS/28 DAYS) SP HD
OMVOH 100 MG/ML SYRINGE	T4	PA QL(2 SYRINGES/28 DAYS) SP HD
OMVOH 200 MG DOSE - 2 PENS	T4	PA QL(2 PENS/28 DAYS) SP HD
OMVOH 200 MG DOSE - 2 SYRINGES	T4	PA QL(2 SYRINGES/28 DAYS) SP HD
OMVOH 200 MG/2 ML PEN	T4	PA QL SP HD
OMVOH 200 MG/2 ML SYRINGE	T4	PA QL SP HD
OMVOH 300 MG DOSE - 2 PENS	T4	PA QL(3 MLS/28 DAYS) SP HD
OMVOH 300 MG DOSE - 2 SYRINGES	T4	PA QL(3 MLS/28 DAYS) SP HD
OMVOH 300 MG/15 ML VIAL	T4	PA SP HD
SKYRIZI 600 MG/10 ML VIAL	T4	PA SP HD
SKYRIZI ON-BODY	T4	PA QL(1 CARTRIDGE/56 DAYS) SP HD
TREMFYA 100 MG/ML PEN	T4	PA QL(1 ML/56 DAYS) SP HD
TREMFYA 100 MG/ML SYRINGE	T4	PA QL(1 SYRINGE/56 DAYS) SP HD
TREMFYA 200 MG/2 ML PEN	T4	PA QL(2 SYRINGE/28 DAYS) SP HD
TREMFYA 200 MG/2 ML SYRINGE	T4	PA QL(1 SYRINGE/56 DAYS) SP HD
TREMFYA 200 MG/20 ML VIAL	T4	PA SP HD
TREMFYA ONE-PRESS	T4	PA QL(1 AUTO-INJ/56 DAYS) SP HD
TREMFYA PEN INDUCTION (2 PEN)	T4	PA QL(12 MLS/365 DAYS) SP HD
INTERLEUKIN-4 (IL-4) RECEPTOR ALPHA ANTAGONIST, MAB		
DUPIXENT PEN	T4	PA SP HD
DUPIXENT SYRINGE	T4	PA SP HD
INTERLEUKIN-6 (IL-6) RECEPTOR INHIBITORS		
ACTEMRA 162 MG/0.9 ML SYRINGE	T4	PA QL(3.6 ML/28 DAYS) SP HD
ACTEMRA 200 MG/10 ML VIAL	T4	PA SP HD
ACTEMRA 400 MG/20 ML VIAL	T4	PA SP HD
ACTEMRA 80 MG/4 ML VIAL	T4	PA SP HD
ACTEMRA ACTPEN	T4	PA QL(3.6 ML/28 DAYS) SP HD
AVTOZMA	T4	PA SP
ENSPRYNG	T4	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	T4	PA QL (2 PENS/SYRINGES/28 DAYS) SP HD
TYENNE 162 MG/0.9 ML SYRINGE	T4	PA QL (3.6 ML/28 DAYS) SP
TYENNE 200 MG/10 ML VIAL	T4	PA SP
TYENNE 400 MG/20 ML VIAL	T4	PA SP
TYENNE 80 MG/4 ML VIAL	T4	PA SP
TYENNE AUTOINJECTOR	T4	PA QL (3.6 ML/28 DAYS) SP
INTERLEUKIN-3 (IL-3) RECEPTOR ALPHA ANTAGONIST, MAB		
NEMLUVIO	T4	PA SP HD

IMMUNOSUPPRESSANTS (Skin Conditions)

TOPICAL IMMUNOSUPPRESSIVE AGENTS		
HYFTOR	T4	PA SP
<i>pimecrolimus (Elidel)</i>	T1	
<i>tacrolimus 0.03% ointment</i>	T1	
<i>tacrolimus 0.1% ointment</i>	T1	

IMMUNOSUPPRESSANTS (Transplant Medications)

IMMUNOSUPP - MONOCLONAL AB INHIBITING T LYMPH FXN		
NIKTIMVO	T4	PA SP
SIMULECT	T4	SP
IMMUNOSUPPRESSIVES		
ASTAGRAF XL	T4	SP HD
<i>azathioprine 50 mg tablet (Imuran)</i>	T4	SP HD
<i>azathioprine sodium</i>	T1	
CELLCEPT 500 MG VIAL (<i>mycophenolate mofetil hcl</i>)	T4	SP
<i>cyclosporine 100 mg capsule (Sandimmune)</i>	T4	SP HD
<i>cyclosporine 25 mg capsule (Sandimmune)</i>	T4	SP HD
<i>cyclosporine 250 mg/5 ml ampul (Sandimmune)</i>	T4	SP
<i>cyclosporine, modified</i>	T4	SP HD
<i>cyclosporine, modified (Neoral)</i>	T4	SP HD
ENVARUSUS XR	T4	SP HD
<i>everolimus 0.25 mg tablet (Zortress)</i>	T4	SP HD
<i>everolimus 0.5 mg tablet (Zortress)</i>	T4	SP HD

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 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

IMMUNOSUPPRESSANTS (Transplant Medications) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
IMMUNOSUPPRESSIVES (cont.)		
<i>everolimus 0.75 mg tablet (Zortress)</i>	T4	SP HD
<i>everolimus 1 mg tablet (Zortress)</i>	T4	SP HD
LUPKYNIS	T4	PA QL(6 CAPS/DAY) SP
<i>mycophenolate 200 mg/ml susp (Cellcept)</i>	T4	SP HD
<i>mycophenolate 250 mg capsule (Cellcept)</i>	T4	SP HD
<i>mycophenolate 500 mg tablet (Cellcept)</i>	T4	SP HD
<i>mycophenolate 500 mg vial (Cellcept)</i>	T4	SP
<i>mycophenolate sodium (Myfortic)</i>	T4	SP HD
NULOJIX	T4	PA SP
PROGRAF 0.2 MG GRANULE PACKET	T4	SP HD
PROGRAF 1 MG GRANULE PACKET	T4	SP HD
PROGRAF 5 MG/ML AMPULE	T4	SP
SANDIMMUNE 100 MG/ML SOLN	T4	SP HD
<i>sirolimus</i>	T4	SP HD
<i>sirolimus (Rapamune)</i>	T4	SP HD
<i>tacrolimus 0.5 mg capsule (ir) (Prograf)</i>	T4	SP HD
<i>tacrolimus 1 mg capsule (ir) (Prograf)</i>	T4	SP HD
<i>tacrolimus 5 mg capsule (ir) (Prograf)</i>	T4	SP HD
TACROLIMUS 5 MG/ML VIAL	T4	SP
ZORTRESS (<i>everolimus</i>)	T4	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	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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

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	

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands

T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit

ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication

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List of Prescription Medications

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

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	
CEQR SIMPLICITY	T2	
CEQR 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 SYST	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)

T1 – Typically Generics

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T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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List of Prescription Medications

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

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	

T1 – Typically Generics

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T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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List of Prescription Medications

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

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	

T1 – Typically Generics

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List of Prescription Medications

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

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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

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ST – Step Therapy

AGE – Age Requirement

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List of Prescription Medications

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

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	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

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List of Prescription Medications

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

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	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIABETIC SUPPLIES (cont.)		
IGLUPOSE 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	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

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List of Prescription Medications

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

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	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

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List of Prescription Medications

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

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	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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

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 SYSTEM	T3	
TRUETRACK BLOOD GLUCOSE SYSTEM	T3	
TRUETRACK SMART SYSTEM	T3	
TWIIIST REFILL KT(CSST-NDL-SYR)	T2	QL(30 KITS/30 DAYS)

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands

T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit

ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication

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List of Prescription Medications

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	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

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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	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

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List of Prescription Medications

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

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	
<i>lancets</i>	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	

T1 – Typically Generics
 T2 – Typically Preferred Brands
 T3 – Typically Non-Preferred Brands

T4 – Specialty Medications
 PA – Prior Authorization
 QL – Quantity Limit

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List of Prescription Medications

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

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	
SMARTTEST LANCET	T1	
SOLUS V2 28G LANCETS	T1	
SOLUS V2 LANCETS	T1	

T1 – Typically Generics
 T2 – Typically Preferred Brands
 T3 – Typically Non-Preferred Brands

T4 – Specialty Medications
 PA – Prior Authorization
 QL – Quantity Limit

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List of Prescription Medications

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

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	

T1 – Typically Generics
 T2 – Typically Preferred Brands
 T3 – Typically Non-Preferred Brands

T4 – Specialty Medications
 PA – Prior Authorization
 QL – Quantity Limit

ST – Step Therapy
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List of Prescription Medications

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

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	
EASYPPOINT NEEDLE	T1	
ECLIPSE NEEDLE	T1	
EXEL HUBER NEEDLE	T1	
EXEL HYPODERMIC NEEDLE	T1	
EXEL MTI DRAWING NEEDLE	T2	
FILTER ASPIRATOR NEEDLE	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

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List of Prescription Medications

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

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	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

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List of Prescription Medications

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

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	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

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List of Prescription Medications

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	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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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.)		
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	

T1 – Typically Generics

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T3 – Typically Non-Preferred Brands

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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.)		
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	

I1 – Typically Generics

I4 – Specialty Medications

S1 – Step Therapy

HU – may require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

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	

T1 – Typically Generics
 T2 – Typically Preferred Brands
 T3 – Typically Non-Preferred Brands

T4 – Specialty Medications
 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

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

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	

T1 – Typically Generics
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 T3 – Typically Non-Preferred Brands

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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.)		
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		
<i>baclofen 0.05 mg/ml syringe (Gablofen)</i>	T1	
<i>baclofen 10 mg tablet</i>	T1	HD
<i>baclofen 10 mg/20 ml vial (Gablofen)</i>	T1	
<i>baclofen 10 mg/5 ml solution</i>	T1	HD
<i>baclofen 20 mg tablet</i>	T1	HD
<i>baclofen 20,000 mcg/20 ml vial (Gablofen)</i>	T1	
BACLOFEN 40 MG/20 ML REFL KIT	T3	
<i>baclofen 40 mg/20 ml vial (Gablofen)</i>	T1	
<i>baclofen 40,000 mcg/20 ml vial (Gablofen)</i>	T1	
<i>baclofen 5 mg tablet</i>	T1	HD
<i>baclofen 5 mg/5 ml solution</i>	T1	HD
<i>carisoprodol (Soma)</i>	T1	
<i>carisoprodol/aspirin</i>	T1	
<i>chlorzoxazone 500 mg tablet</i>	T1	
<i>cyclobenzaprine hcl</i>	T1	
<i>cyclobenzaprine hcl (Fexmid)</i>	T1	
DANTRIUM	T3	
<i>DANTRIUM (dantrolene sodium)</i>	T3	
<i>dantrolene sodium</i>	T1	
<i>dantrolene sodium (Dantrium)</i>	T1	
FEXMID (<i>cyclobenzaprine hcl</i>)	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 (<i>baclofen</i>)	T3	
LIORESAL INTRATHECAL	T3	
<i>metaxalone 400 mg tablet</i>	T1	
<i>metaxalone 800 mg tablet</i>	T1	HD
<i>methocarbamol</i>	T1	
<i>methocarbamol 1,000 mg tablet</i>	T1	
<i>methocarbamol 1,000 mg/10 ml (Robaxin)</i>	T1	
<i>methocarbamol 500 mg tablet</i>	T1	
<i>methocarbamol 750 mg tablet</i>	T1	
<i>orphenadrine citrate</i>	T1	
ROBAXIN (<i>methocarbamol</i>)	T3	
RYANODEX	T3	
<i>tizanidine hcl 2 mg tablet</i>	T1	
<i>tizanidine hcl 4 mg tablet (Zanaflex)</i>	T1	
ZANAFLEX	T3	
ZANAFLEX (<i>tizanidine hcl</i>)	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	
<i>mynatal capsule</i>	T3	
<i>mynatal ultracaplet</i>	T1	
NATACHEW	T3	
NEONATAL COMPLETE	T3	
NEONATAL PLUS	T3	

T1 – Typically Generics
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 T3 – Typically Non-Preferred Brands

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List of Prescription Medications

PRE-NATAL VITAMINS (Nutritional/Dietary)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PRENATAL VITAMIN PREPARATIONS		
NEONATAL-DHA	T3	
NESTABS	T2	
<i>prenatal vits 15/iron/folic/dss</i>	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	
<i>pnv 11/iron fum/folic acid/om3</i>	T1	
<i>pnv 119/iron fum/folic acid</i>	T1	
<i>pnv 66/iron/folic/docusate/dha</i>	T1	
<i>pnv 69/iron/folic/docusate/dha</i>	T1	
<i>pnv 80/iron fum/folic/dss/dha</i>	T1	
<i>pnv no. 118/iron fumarate/fa</i>	T1	
<i>pnv no. 154/iron fum/folic acid</i>	T1	
<i>pnv no. 52/iron/fa/omega-3/dha</i>	T1	
<i>pnv,calcium 72/iron,carb/folic</i>	T1	
<i>pnv,calcium 72/iron/folic acid</i>	T1	
<i>pnv19/iron bg,s.p/folic ac/om3</i>	T1	
<i>pnv81/iron ps,edta/folic/omeg3</i>	T1	
PRENATA	T3	
<i>prenatal 105/iron/folic ac/dha</i>	T1	
<i>prenatal 12/iron/folic/dss/om3</i>	T1	
PRENATAL 19	T1	
<i>prenatal 53/iron/folic ac/omg3</i>	T1	
<i>prenatal 54/iron/folic ac/omg3</i>	T1	
<i>prenatal 71/iron/folic ac/dha</i>	T1	
<i>prenatal 93/iron/folate 9/dha</i>	T1	
<i>prenatal no.42/folic acid (Vitamedmd Redichew Rx)</i>	T3	
PRENATAL PLUS VITAMIN-MINERAL	T2	

T1 – Typically Generics
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List of Prescription Medications

PRE-NATAL VITAMINS (Nutritional/Dietary)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PRENATAL VITAMIN PREPARATIONS		
PRENATAL PLUS-DHA	T1	
<i>prenatal vit 27,calc/iron/fa</i>	T1	
<i>prenatal vit 55/iron/folic/om3</i>	T1	
<i>prenatal vit,cal 73/iron/folic</i>	T3	
<i>prenatal vit,cal 76/iron/folic</i>	T3	
<i>prenatal vit,cal 78/iron/folic</i>	T3	
<i>prenatal vit/iron fum/folic ac</i>	T1	
<i>prenatal vits 86/iron/folic ac</i>	T1	
<i>prenatal,calc 40/iron/folate 1</i>	T1	
PRENATE ENHANCE	T3	
PRENATE RESTORE	T3	
PRIMACARE	T3	
PROVIDA OB	T3	
SELECT-OB (<i>prenatal vit 128/iron/folic ac</i>)	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 (<i>prenatal no.42/folic acid</i>)	T3	
VITAPEARL	T3	
VITATRUE	T3	

PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)¹⁰

ALPHA-2 RECEPTOR ANTAGONIST ANTIDEPRESSANTS		
<i>mirtazapine</i>	T1	HD
<i>mirtazapine (Remeron)</i>	T1	HD
ANTI-ANXIETY - BENZODIAZEPINES		
<i>alprazolam</i>	T1	
<i>alprazolam (Xanax Xr)</i>	T1	

T1 – Typically Generics
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 T3 – Typically Non-Preferred Brands
 T4 – Specialty Medications
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List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)¹⁰ (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-ANXIETY - BENZODIAZEPINES (cont.)		
<i>alprazolam (Xanax)</i>	T1	
<i>chlordiazepoxide hcl</i>	T1	
<i>clorazepate dipotassium</i>	T1	
<i>diazepam 10 mg tablet (Valium)</i>	T1	
<i>diazepam 10 mg/2 ml carpject</i>	T1	
<i>diazepam 10 mg/2 ml syringe</i>	T1	
<i>diazepam 2 mg tablet (Valium)</i>	T1	
<i>diazepam 25 mg/5 ml oral conc</i>	T1	
<i>diazepam 5 mg tablet (Valium)</i>	T1	
<i>diazepam 5 mg/5 ml oral cup</i>	T1	
<i>diazepam 5 mg/5 ml solution</i>	T1	
<i>diazepam 5 mg/ml oral conc</i>	T1	
<i>diazepam 50 mg/10 ml vial</i>	T1	
<i>lorazepam</i>	T1	
<i>lorazepam (Ativan)</i>	T1	
<i>oxazepam</i>	T1	
ANTI-ANXIETY DRUGS		
<i>bupirone hcl</i>	T1	HD
<i>meprobamate</i>	T1	
ANTIDEPRESSANT - POSTPARTUM DEPRESSION (PPD)		
ZURZUVAE 20 MG CAPSULE	T4	PA QL(28 CAPS/270 DAYS) SP HD
ZURZUVAE 25 MG CAPSULE	T4	PA QL(28 CAPS/270 DAYS) SP HD
ZURZUVAE 30 MG CAPSULE	T4	PA QL(14 CAPS/270 DAYS) SP HD
BIPOLAR DISORDER DRUGS		
EQUETRO	T3	HD
<i>lithium carbonate</i>	T1	HD
<i>lithium carbonate (Lithobid)</i>	T1	HD
<i>lithium citrate</i>	T1	HD
MAOIS -NON-SELECTIVE, IRREVERSIBLE ANTIDEPRESSANTS		
MARPLAN	T3	QL(12 TABS/DAY)

T1 – Typically Generics
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List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)¹⁰ (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MAOIS -NON-SELECTIVE, IRREVERSIBLE ANTIDEPRESSANTS (con't.)		
<i>phenelzine sulfate (Nardil)</i>	T1	
<i>tranylcypromine sulfate (Parnate)</i>	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)		
<i>bupropion hcl 100 mg tablet</i>	T1	QL(4 TABS/DAY) HD
<i>bupropion hcl 75 mg tablet</i>	T1	QL(6 TABS/DAY) HD
<i>bupropion hcl sr 100 mg tablet (Wellbutrin Sr)</i>	T1	QL(4 TABS/DAY) HD
<i>bupropion hcl sr 150 mg tablet (Wellbutrin Sr)</i>	T1	QL(2 TABS/DAY) HD
<i>bupropion hcl sr 200 mg tablet (Wellbutrin Sr)</i>	T1	QL(2 TABS/DAY) HD
<i>bupropion hcl xl 150 mg tablet (Wellbutrin XL)</i>	T1	QL(3 TABS/DAY) HD
<i>bupropion hcl xl 300 mg tablet (Wellbutrin XL)</i>	T1	QL(1 TAB/DAY) HD
SELECTIVE SEROTONIN 5-HT_{2A} INVERSE AGONISTS (SSIA)		
NUPLAZID	T4	PA SP HD
SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS)		
<i>citalopram hbr 10 mg tablet (Celexa)</i>	T1	QL(6 TABS/DAY) HD
<i>citalopram hbr 10 mg/5 ml soln</i>	T1	QL(30 MLS/DAY) HD
<i>citalopram hbr 20 mg tablet (Celexa)</i>	T1	QL(3 TABS/DAY) HD
<i>citalopram hbr 20 mg/10 ml cup</i>	T1	QL(30 MLS/DAY) HD
<i>citalopram hbr 40 mg tablet (Celexa)</i>	T1	QL(1 TAB/DAY) HD
<i>escitalopram 10 mg tablet (Lexapro)</i>	T1	QL(2 TABS/DAY) HD
<i>escitalopram 10 mg/10 ml cup</i>	T1	QL(20 MLS/DAY) HD
<i>escitalopram 20 mg tablet (Lexapro)</i>	T1	QL(1 TAB/DAY) HD
<i>escitalopram 5 mg tablet (Lexapro)</i>	T1	QL(4 TABS/DAY) HD
<i>escitalopram oxalate 5 mg/5 ml</i>	T1	QL(20 MLS/DAY) HD
<i>fluoxetine 20 mg/5 ml soln cup</i>	T1	QL(20 MLS/DAY) HD
<i>fluoxetine 20 mg/5 ml solution</i>	T1	QL(20 MLS/DAY) HD
<i>fluoxetine hcl</i>	T1	QL(4 CAPS/28 DAYS) HD
<i>fluoxetine hcl 10 mg capsule (Prozac)</i>	T1	QL(8 CAPS/DAY) HD
<i>fluoxetine hcl 10 mg tablet</i>	T1	HD
<i>fluoxetine hcl 20 mg capsule (Prozac)</i>	T1	QL(4 CAPS/DAY) HD
<i>fluoxetine hcl 20 mg tablet</i>	T1	HD

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List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)¹⁰ (cont.)

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

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 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

PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)¹⁰ (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SEROTONIN-NOREPINEPHRINE REUPTAKE-INHIB (SNRIS) (cont.)		
<i>duloxetine hcl dr 60 mg cap (Cymbalta)</i>	T1	QL(2 CAPS/DAY) HD
<i>venlafaxine hcl 100 mg tablet</i>	T1	QL(3 TABS/DAY) HD
<i>venlafaxine hcl 25 mg tablet</i>	T1	QL(15 TABS/DAY) HD
<i>venlafaxine hcl 37.5 mg tablet</i>	T1	QL(10 TABS/DAY) HD
<i>venlafaxine hcl 50 mg tablet</i>	T1	QL(7 TABS/DAY) HD
<i>venlafaxine hcl 75 mg tablet</i>	T1	QL(5 TABS/DAY) HD
<i>venlafaxine hcl er 150 mg cap (Effexor Xr)</i>	T1	QL(2 CAPS/DAY) HD
<i>venlafaxine hcl er 150 mg tab</i>	T1	QL(2 TABS/DAY) HD
<i>venlafaxine hcl er 225 mg tab</i>	T1	QL(1 TAB/DAY) HD
<i>venlafaxine hcl er 37.5 mg cap (Effexor Xr)</i>	T1	QL(8 CAPS/DAY) HD
<i>venlafaxine hcl er 37.5 mg tab</i>	T1	QL(8 TABS/DAY) HD
<i>venlafaxine hcl er 75 mg cap (Effexor Xr)</i>	T1	QL(4 CAPS/DAY) HD
<i>venlafaxine hcl er 75 mg tab</i>	T1	QL(4 TABS/DAY) HD
SSRI AND 5HT1A PARTIAL AGONIST ANTIDEPRESSANTS		
<i>vilazodone hcl 10 mg tablet (Viibryd)</i>	T1	QL(1 TAB/DAY) HD
<i>vilazodone hcl 20 mg tablet (Viibryd)</i>	T1	QL(1 TAB/DAY) HD
<i>vilazodone hcl 40 mg tablet (Viibryd)</i>	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		
<i>amitriptyline/chlordiazepoxide</i>	T1	HD
TRICYCLIC ANTIDEPRESSANT-PHENOTHIAZINE COMBINATNS		
<i>perphenazine/amitriptyline hcl</i>	T1	HD
TRICYCLIC ANTIDEPRESSANTS, REL.NON-SEL.REUPT-INHIB		
<i>amitriptyline hcl</i>	T1	HD
<i>amoxapine</i>	T1	HD
<i>clomipramine hcl (Anafranil)</i>	T1	HD
<i>desipramine hcl</i>	T1	HD
<i>doxepin 10 mg capsule</i>	T1	HD
<i>doxepin 10 mg/ml oral conc</i>	T1	HD
<i>doxepin 100 mg capsule</i>	T1	HD
<i>doxepin 150 mg capsule</i>	T1	HD

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands

T4 – Specialty Medications
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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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.)		
<i>doxepin 25 mg capsule</i>	T1	HD
<i>doxepin 50 mg capsule</i>	T1	HD
<i>doxepin 75 mg capsule</i>	T1	HD
<i>imipramine hcl</i>	T1	HD
<i>imipramine pamoate</i>	T1	HD
<i>nortriptyline hcl</i>	T1	HD
<i>nortriptyline hcl (Pamelor)</i>	T1	HD
<i>protriptyline hcl</i>	T1	HD
<i>trimipramine maleate</i>	T1	HD

PSYCHOTHERAPEUTIC DRUGS (Attention Deficit Hyperactivity Disorder)⁹

ADRENERGICS, AROMATIC, NON-CATECHOLAMINE		
<i>lisdexamfetamine 10 mg capsule (Vyvanse)</i>	T1	PA QL(1 CAP/DAY)
<i>lisdexamfetamine 10 mg tb chew (Vyvanse)</i>	T1	PA QL(1 TAB/DAY)
<i>lisdexamfetamine 20 mg capsule (Vyvanse)</i>	T1	PA QL(1 CAP/DAY)
<i>lisdexamfetamine 20 mg tb chew (Vyvanse)</i>	T1	PA QL(1 TAB/DAY)
<i>lisdexamfetamine 30 mg capsule (Vyvanse)</i>	T1	PA QL(1 CAP/DAY)
<i>lisdexamfetamine 30 mg tb chew (Vyvanse)</i>	T1	PA QL(1 TAB/DAY)
<i>lisdexamfetamine 40 mg capsule (Vyvanse)</i>	T1	PA QL(1 CAP/DAY)
<i>lisdexamfetamine 40 mg tb chew (Vyvanse)</i>	T1	PA QL(1 TAB/DAY)
<i>lisdexamfetamine 50 mg capsule (Vyvanse)</i>	T1	PA QL(1 CAP/DAY)
<i>lisdexamfetamine 50 mg tb chew (Vyvanse)</i>	T1	PA QL(1 TAB/DAY)
<i>lisdexamfetamine 60 mg capsule (Vyvanse)</i>	T1	PA QL(1 CAP/DAY)
<i>lisdexamfetamine 60 mg tb chew (Vyvanse)</i>	T1	PA QL(1 TAB/DAY)
<i>lisdexamfetamine 70 mg capsule (Vyvanse)</i>	T1	PA QL(1 CAP/DAY)
TX FOR ADHD - SELECTIVE ALPHA-2 RECEPTOR AGONIST		
<i>clonidine hcl er 0.1 mg tablet (Kapvay)</i>	T1	
<i>guanfacine hcl (Intuniv)</i>	T1	HD
TX FOR ATTENTION DEFICIT-HYPERACT (ADHD) /NARCOLEPSY		
DAYTRANA (methylphenidate)	T3	PA QL(1 PATCH/DAY)
<i>dexmethylphenidate hcl (Focalin Xr)</i>	T1	PA QL(1 CAP/DAY)
<i>dexmethylphenidate hcl (Focalin)</i>	T1	PA
FOCALIN (<i>dexmethylphenidate hcl</i>)	T3	PA ST
METHYLIN (<i>methylphenidate hcl</i>)	T3	PA
<i>methylphenidate (Daytrana)</i>	T1	PA QL(1 PATCH/DAY)
<i>methylphenidate er 10 mg, 15 mg cap (Aptensio Xr)</i>	T1	PA QL(1 CAP/DAY)
<i>methylphenidate er 10 mg tab</i>	T1	PA QL(2 TABS/DAY)

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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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) /NARCOLEPSY (cont.)		
<i>methylphenidate er 18 mg tab (Concerta)</i>	T1	PA QL(1 TAB/DAY)
<i>methylphenidate er 18 mg tab (Relexxii)</i>	T1	PA QL(1 TAB/DAY)
<i>methylphenidate er 20 mg cap (Aptensio Xr)</i>	T1	PA QL(1 CAP/DAY)
<i>methylphenidate er 20 mg tab</i>	T1	PA QL(3 TABS/DAY)
<i>methylphenidate er 27 mg tab (Concerta)</i>	T1	PA QL(1 TAB/DAY)
<i>methylphenidate er 27 mg tab (Relexxii)</i>	T1	PA QL(1 TAB/DAY)
<i>methylphenidate er 30 mg cap (Aptensio Xr)</i>	T1	PA QL(1 CAP/DAY)
<i>methylphenidate er 36 mg tab (Concerta)</i>	T1	PA QL(2 TABS/DAY)
<i>methylphenidate er 36 mg tab (Relexxii)</i>	T1	PA QL(2 TABS/DAY)
<i>methylphenidate er 40 mg cap (Aptensio Xr)</i>	T1	PA QL(1 CAP/DAY)
<i>methylphenidate er 50 mg cap (Aptensio Xr)</i>	T1	PA QL(1 CAP/DAY)
<i>methylphenidate er 54 mg tab (Concerta)</i>	T1	PA QL(1 TAB/DAY)
<i>methylphenidate er 54 mg tab (Relexxii)</i>	T1	PA QL(1 TAB/DAY)
<i>methylphenidate er 60 mg cap (Aptensio Xr)</i>	T1	PA QL(1 CAP/DAY)
<i>methylphenidate er 72 mg tab</i>	T1	PA QL(1 TAB/DAY)
<i>methylphenidate er(la) 10mg cp (Ritalin La)</i>	T1	PA QL(1 CAP/DAY)
<i>methylphenidate er(la) 20mg cp (Ritalin La)</i>	T1	PA QL(1 CAP/DAY)
<i>methylphenidate er(la) 30mg cp (Ritalin La)</i>	T1	PA QL(2 CAPS/DAY)
<i>methylphenidate er(la) 40mg cp (Ritalin La)</i>	T1	PA QL(1 CAP/DAY)
<i>methylphenidate er(la) 60mg cp</i>	T1	PA QL(1 CAP/DAY)
<i>methylphenidate hcl</i>	T1	PA
<i>methylphenidate hcl (Metadate Cd)</i>	T1	PA QL(1 CAP/DAY)
<i>methylphenidate hcl (Methylin)</i>	T1	PA
<i>methylphenidate hcl (Ritalin)</i>	T1	PA
QUILLIVANT XR	T3	PA QL(12 MLS/DAY)
RITALIN (<i>methylphenidate hcl</i>)	T3	PA ST
TX FOR ATTENTION DEFICIT-HYPERACT. (ADHD) , NRI-TYPE		
<i>atomoxetine hcl 10 mg capsule (Strattera)</i>	T1	HD
<i>atomoxetine hcl 100 mg capsule (Strattera)</i>	T1	HD
<i>atomoxetine hcl 18 mg capsule (Strattera)</i>	T1	HD
<i>atomoxetine hcl 25 mg capsule (Strattera)</i>	T1	HD
<i>atomoxetine hcl 40 mg capsule (Strattera)</i>	T1	QL(1 CAP/DAY) HD

T1 – Typically Generics
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T4 – Specialty Medications
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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.)		
<i>atomoxetine hcl 60 mg capsule (Strattera)</i>	T1	HD
<i>atomoxetine hcl 80 mg capsule (Strattera)</i>	T1	HD

PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics)¹⁰

ANTIPSYCH, DOPAMINE ANTAG., DIPHENYLBUTYLPIPERIDINES		
<i>pimozide</i>	T1	
ANTIPSYCHOTIC, ATYPICAL, DOPAMINE, SEROTONIN ANTAGNST		
<i>asenapine maleate (Saphris)</i>	T1	
CAPLYTA	T3	ST QL(1 CAP/DAY)
<i>clozapine</i>	T1	
<i>clozapine (Clozaril)</i>	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 (<i>ziprasidone mesylate</i>)	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)
<i>lurasidone hcl 120 mg tablet (Latuda)</i>	T1	
<i>lurasidone hcl 20 mg tablet (Latuda)</i>	T1	
<i>lurasidone hcl 40 mg tablet (Latuda)</i>	T1	QL(1 TAB/DAY)
<i>lurasidone hcl 60 mg tablet (Latuda)</i>	T1	QL(1 TAB/DAY)
<i>lurasidone hcl 80 mg tablet (Latuda)</i>	T1	
<i>olanzapine</i>	T1	
<i>olanzapine (Zyprexa Zydis)</i>	T1	
<i>olanzapine (Zyprexa)</i>	T1	

T1 – Typically Generics
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T4 – Specialty Medications
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List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics)⁹⁰ (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIPSYCHOTIC, ATYPICAL, DOPAMINE, SEROTONIN ANTAGNIST (cont.)		
<i>paliperidone er 1.5 mg tablet</i>	T1	
<i>paliperidone er 3 mg tablet (Invega)</i>	T1	QL(1 TAB/DAY)
<i>paliperidone er 6 mg tablet (Invega)</i>	T1	
<i>paliperidone er 9 mg tablet (Invega)</i>	T1	
PERSERIS	T3	QL(1 UNIT/28 DAYS)
<i>quetiapine fumarate (Seroquel Xr)</i>	T1	
<i>quetiapine fumarate 100 mg tab (Seroquel)</i>	T1	
<i>quetiapine fumarate 200 mg tab (Seroquel)</i>	T1	
<i>quetiapine fumarate 25 mg tab (Seroquel)</i>	T1	
<i>quetiapine fumarate 300 mg tab (Seroquel)</i>	T1	
<i>quetiapine fumarate 400 mg tab (Seroquel)</i>	T1	
<i>quetiapine fumarate 50 mg tab (Seroquel)</i>	T1	
<i>risperidone</i>	T1	
<i>risperidone (Risperdal)</i>	T1	
<i>risperidone microspheres (Risperdal Consta)</i>	T1	QL(4 VIALS/28 DAYS)
RYKINDO	T3	QL(4 VIALS/28 DAYS)
SAPHRIS (<i>asenapine maleate</i>)	T3	ST
SECUADO	T3	ST
SEROQUEL (<i>quetiapine fumarate</i>)	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)
<i>ziprasidone hcl (Geodon)</i>	T1	
<i>ziprasidone mesylate (Geodon)</i>	T1	
ZYPREXA 10 MG VIAL (<i>olanzapine</i>)	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)

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics)^o (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 ASIMTUFI	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	
<i>aripiprazole</i>	T1	
<i>aripiprazole 1 mg/ml solution</i>	T1	
<i>aripiprazole 10 mg tablet (Abilify)</i>	T1	
<i>aripiprazole 15 mg tablet (Abilify)</i>	T1	
<i>aripiprazole 2 mg tablet (Abilify)</i>	T1	
<i>aripiprazole 20 mg tablet (Abilify)</i>	T1	
<i>aripiprazole 30 mg tablet (Abilify)</i>	T1	
<i>aripiprazole 5 mg tablet (Abilify)</i>	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		
<i>loxapine succinate</i>	T1	
ANTIPSYCHOTICS, DOPAMINE ANTAGONISTS, THIOXANTHENES		
<i>thiothixene</i>	T1	
ANTIPSYCHOTICS, DOPAMINE ANTAGONISTS, BUTYROPHENONES		
<i>droperidol</i>	T1	
HALDOL (<i>haloperidol lactate</i>)	T3	

T1 – Typically Generics

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T4 – Specialty Medications

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AGE – Age Requirement

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List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics)⁹⁰ (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIPSYCHOTICS, DOPAMINE ANTAGONISTS, BUTYROPHENONES (cont.)		
<i>haloperidol decanoate</i>	T3	
<i>haloperidol lactate</i>	T3	
ANTIPSYCHOTICS, DOPAMINE ANTAGONST, DIHYDROINDOLONES		
<i>molindone hcl</i>	T1	
ANTIPSYCHOTICS, PHENOTHIAZINES		
<i>chlorpromazine hcl</i>	T1	
<i>fluphenazine decanoate</i>	T1	
<i>fluphenazine hcl</i>	T1	
<i>perphenazine</i>	T1	
<i>thioridazine hcl</i>	T1	
<i>trifluoperazine hcl</i>	T1	
SSRI-ANTIPSYCH, ATYPICAL, DOPAMINE, SEROTONIN ANTAG		
<i>olanzapine/fluoxetine hcl</i>	T1	

PSYCHOTHERAPEUTIC DRUGS (Sleep Disorders/Sedatives)

NARCOLEPSY AND SLEEP DISORDER THERAPY AGENTS		
<i>armodafinil</i>	T1	PA
<i>modafinil (Provigil)</i>	T1	PA
SUNOSI	T2	PA QL (1 tab/day)

SEDATIVE/HYPNOTICS (Sleep Disorders/Sedatives)

ANTI-NARCOLEPSY, ANTI-CATAPLEXY, SEDATIVE-TYPE AGENT		
LUMRYZ	T4	PA QL(1 PACK/DAY) SP HD
LUMRYZ STARTER PACK	T4	PA QL SP HD
SODIUM OXYBATE 0.5 G/ML SOLN	T4	PA QL(18 MLS/DAY) SP HD
XYWAV	T4	PA QL(18 MLS/DAY) SP HD
BARBITURATES		
AMYTAL SODIUM	T3	
NEMBUTAL SODIUM (pentobarbital sodium)	T3	PA
<i>pentobarbital sodium (Nembutal Sodium)</i>	T1	PA
BARBITURATES (cont.)		
<i>phenobarbital</i>	T1	
<i>phenobarbital sodium</i>	T1	
HYPNOTICS, MELATONIN MT1/MT2 RECEPTOR AGONISTS		
HETLIOZ LQ	T4	PA SP HD
<i>ramelteon (Rozerem)</i>	T1	QL(1 TAB/DAY)
<i>tasimelteon (Hetlioz)</i>	T4	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	
<i>estazolam</i>	T1	
<i>flurazepam hcl</i>	T1	
HALCION (<i>triazolam</i>)	T3	
<i>lorazepam</i>	T1	
<i>lorazepam</i> (Ativan)	T1	
QUAZEPAM	T1	
<i>temazepam</i> (Restoril)	T1	
<i>triazolam</i>	T1	
<i>triazolam</i> (Halcion)	T1	
SEDATIVE-HYPNOTICS, NON-BARBITURATE		
DAYVIGO	T2	ST QL(1 TAB/DAY)
<i>dexmedetomidine hcl</i>	T1	
DEXMEDETOMIDINE HCL	T1	
<i>dexmedetomidine in 0.9 % nacl</i>	T1	
<i>doxepin hcl 3 mg tablet</i> (Silenor)	T1	QL(1 TAB/DAY)
<i>doxepin hcl 6 mg tablet</i> (Silenor)	T1	
<i>eszopiclone</i> (Lunesta)	T1	
PRECEDEX	T3	
PRECEDEX (<i>dexmedetomidine in 0.9 % nacl</i>)	T3	
<i>zaleplon</i>	T1	
<i>zolpidem tart 1.75 mg tab sl</i>	T1	
<i>zolpidem tart 3.5 mg tablet sl</i>	T1	
<i>zolpidem tart er 12.5 mg tab</i> (Ambien Cr)	T1	
<i>zolpidem tart er 6.25 mg tab</i> (Ambien Cr)	T1	QL(1 TAB/DAY)
<i>zolpidem tartrate 10 mg tablet</i> (Ambien)	T1	
<i>zolpidem tartrate 5 mg tablet</i> (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	

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands

T4 – Specialty Medications
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

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		
<i>acetic acid</i>	T1	
<i>neomycin sulf/polymyxin b sulf</i>	T1	
PHYSIOLYTE (<i>physiological irrig soln no.1</i>)	T3	
PHYSIOSOL (<i>physiological irrig soln no.1</i>)	T3	
<i>ringer's solution</i>	T1	
<i>ringer's solution, lactated</i>	T1	
<i>sod, pot chlor/mag/sod, pot phos</i>	T3	
<i>sodium chloride 0.9% irrig</i>	T1	
<i>sodium chloride 0.9% irrig.</i>	T1	
SODIUM CHLORIDE 0.9% IRRIG.	T3	
<i>sodium chloride 0.9% prcss sol</i>	T1	
<i>sodium chloride irrig solution</i>	T1	
SORBITOL	T1	
SORBITOL-MANNITOL	T1	
<i>water for irrigation, sterile</i>	T1	
OXIDIZING AGENTS		
<i>hydrogen peroxide</i>	T1	

T1 – Typically Generics
 T2 – Typically Preferred Brands
 T3 – Typically Non-Preferred Brands

T4 – Specialty Medications
 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

SKIN PREPS (Pain Relief And Inflammatory Disease)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIPSORIATIC AGENTS, SYSTEMIC		
<i>acitretin</i>	T1	
BIMZELX	T4	PA QL (2 MLS/28 DAYS) SP HD
BIMZELX AUTOINJECTOR	T4	PA QL (2 MLS/28 DAYS) SP HD
COSENTYX	T4	PA SP
COSENTYX (2 SYRINGES)	T4	PA QL (2 MLS/28 DAYS) SP HD
COSENTYX 150 MG/ML SYRINGE	T4	PA QL (1 ML/28 DAYS) SP HD
COSENTYX 75 MG/0.5 ML SYRINGE	T4	PA QL (0.5 MLS/28 DAYS) SP HD
COSENTYX SENSOREADY (2 PENS)	T4	PA QL (2 MLS/28 DAYS) SP HD
COSENTYX SENSOREADY PEN	T4	PA QL (1 ML/28 DAYS) SP HD
COSENTYX UNOREADY PEN	T4	PA QL (2 MLS/28 DAYS) SP HD
ILUMYA	T4	PA QL (1 UNIT/84 DAYS) SP HD
<i>methoxsalen</i>	T1	
SILIQ	T4	PA QL (3 MLS/28 DAYS) SP HD
SKYRIZI 150 MG/ML SYRINGE	T4	PA QL (150 MG/84 DAYS) SP HD
SKYRIZI PEN	T4	PA QL (150 MG/84 DAYS) SP HD
SOTYKTU	T4	PA QL (1 TAB/DAY) SP HD
SPEVIGO 150 MG/ML SYRINGE	T4	PA QL (2 MLS/28 DAYS) SP HD
SPEVIGO 300 MG/2 ML SYRINGE	T4	PA QL (2 MLS/28 DAYS) SP HD
SPEVIGO 450 MG/7.5 ML VIAL	T4	PA SP HD
TALTZ AUTOINJECTOR	T4	PA QL (1 AUTO-INJECTOR/28 DAYS) SP HD
TALTZ AUTOINJECTOR (2 PACK)	T4	PA QL (1 AUTO-INJECTOR/28 DAYS) SP HD
TALTZ AUTOINJECTOR (3 PACK)	T4	PA QL (1 AUTO-INJECTOR/28 DAYS) SP HD
TALTZ SYRINGE	T4	PA QL (1 SYRINGE/28 DAYS) SP HD
TOPICAL ANTI-INFLAMMATORY, NSAIDS		
<i>diclofenac sodium 1% gel</i>	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 (<i>dapsone</i>)	T3	
<i>adapalene/benzoyl peroxide</i>	T1	
<i>adapalene/benzoyl peroxide</i> (Epiduo Forte)	T1	
<i>clindamycin phos/benzoyl perox</i>	T1	
<i>clindamycin phos/benzoyl perox</i> (Acanya)	T1	
<i>clindamycin/tretinoin</i> (Veltin)	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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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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	

T1 – Typically Generics
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 T3 – Typically Non-Preferred Brands

T4 – Specialty Medications
 PA – Prior Authorization
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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		
<i>ammonium lactate</i>	T1	
ATOPICLAIR	T3	
BIAFINE (<i>sonafine</i>)	T3	
IMMUNOMODULATORS		
<i>imiquimod</i>	T1	
IRRITANTS/COUNTER-IRRITANTS		
<i>methyl salicylate</i>	T1	
JANUS KINASE (JAK) INHIBITORS		
CIBINQO	T4	PA QL(30 TABS/30 DAYS) SP
KERATOLYTICS		
benzebro 6% foaming cloths	T1	
BENZEPRO 7% CREAMY WASH (<i>benzoyl peroxide microspheres</i>)	T3	
<i>benzoyl peroxide</i>	T1	
<i>benzoyl peroxide (Pacnex)</i>	T1	
ENZOCLEAR	T3	
INOVA	T3	

T1 – Typically Generics
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List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
KERATOLYTICS (cont.)		
PACNEX (<i>benzoyl peroxide</i>)	T3	
<i>podofilox</i>	T1	
<i>podofilox</i> (Condylox)	T1	
PR BENZOYL PEROXIDE (<i>benzoyl peroxide microspheres</i>)	T3	
silver nitrate	T1	
PROTECTIVES		
BIONECT	T3	
PHARMABASE BARRIER (<i>zinc oxide</i>)	T3	
<i>zinc oxide</i>	T1	
ZINC OXIDE	T1	
ROSACEA AGENTS, TOPICAL		
<i>azelaic acid</i> (Finacea)	T1	
<i>ivermectin 1% cream</i> (Soolantra)	T1	
<i>metronidazole</i>	T1	
<i>metronidazole</i> (Metrocream)	T1	
<i>metronidazole 0.75% cream</i> (Metrocream)	T1	
<i>metronidazole 0.75% lotion</i>	T1	
<i>metronidazole top 1% gel pump</i>	T1	
<i>metronidazole topical 0.75% gel</i>		
<i>metronidazole topical 1% gel</i> (Metrogel)		
SOOLANTRA (<i>ivermectin</i>)	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	
<i>trichloroacetic acid</i>	T4	PA SP
TRICHLOROACETIC ACID	T3	
TRICHLOROACETIC ACID (<i>trichloroacetic acid</i>)	T3	
TOPICAL ANTIBIOTIC PLEUROMUTILIN DERIVATIVES		
ALTABAX	T3	

T1 – Typically Generics
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T4 – Specialty Medications
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List of Prescription Medications

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-SMOOTHIE-FS (fluocinolone acetonide)	T3	ST
DERMA-SMOOTHIE-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-Smoother-Fs)	T1	

T1 – Typically Generics
 T2 – Typically Preferred Brands
 T3 – Typically Non-Preferred Brands

T4 – Specialty Medications
 PA – Prior Authorization
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ST – Step Therapy
 AGE – Age Requirement
 SP – Specialty Medication

HD – May require home delivery pharmacy
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List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)

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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

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CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)

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

T1 – Typically Generics
 T2 – Typically Preferred Brands
 T3 – Typically Non-Preferred Brands

T4 – Specialty Medications
 PA – Prior Authorization
 QL – Quantity Limit

ST – Step Therapy
 AGE – Age Requirement
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List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN A DERIVATIVES		
<i>tretinoin 0.05% gel (Atralin)</i>	T1	PA
<i>tretinoin 0.1% cream (Retin-A)</i>	T1	PA
<i>tretinoin microspheres (Retin-A Micro Pump)</i>	T1	PA
<i>tretinoin microspheres (Retin-A Micro)</i>	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
<i>varenicline 0.5 mg tablet</i>	T1	PPACA
<i>varenicline 1 mg cont month bx</i>	T1	PPACA
<i>varenicline 1 mg tablet</i>	T1	PPACA
<i>varenicline starting month box</i>	T1	PPACA
SMOKING DETERRENTS, OTHER		
<i>bupropion hcl sr 150 mg tablet</i>	T1	PPACA
THYROID PREPS (Hormonal Agents)		
ANTITHYROID PREPARATIONS		
<i>methimazole</i>	T1	HD
<i>propylthiouracil</i>	T1	HD
THYROID FUNCTION DIAGNOSTIC AGENTS		
THYROGEN	T4	SP
THYROID HORMONES		
<i>adthyza 120 mg tablet</i>	T1	HD
<i>adthyza 15 mg tablet</i>	T1	HD
<i>adthyza 30 mg tablet</i>	T1	HD
<i>adthyza 60 mg tablet</i>	T1	HD
<i>adthyza 90 mg tablet</i>	T1	HD
CYTOMEL (<i>liothyronine sodium</i>)	T3	HD
<i>levothyroxine 100 mcg tablet (Synthroid)</i>	T1	HD
<i>levothyroxine 100 mcg vial</i>	T1	HD

T1 – Typically Generics
 T2 – Typically Preferred Brands
 T3 – Typically Non-Preferred Brands

T4 – Specialty Medications
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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
<i>levothyroxine 112 mcg tablet (Synthroid)</i>	T1	HD
<i>levothyroxine 125 mcg tablet (Synthroid)</i>	T1	HD
<i>levothyroxine 137 mcg tablet (Synthroid)</i>	T1	HD
<i>levothyroxine 150 mcg tablet (Synthroid)</i>	T1	HD
<i>levothyroxine 175 mcg tablet (Synthroid)</i>	T1	HD
<i>levothyroxine 200 mcg tablet (Synthroid)</i>	T1	HD
<i>levothyroxine 200 mcg vial</i>	T1	HD
LEVOTHYROXINE 200 MCG/5 ML VL	T1	HD
<i>levothyroxine 25 mcg tablet (Synthroid)</i>	T1	HD
<i>levothyroxine 300 mcg tablet (Synthroid)</i>	T1	HD
<i>levothyroxine 50 mcg tablet (Synthroid)</i>	T1	HD
<i>levothyroxine 500 mcg vial</i>	T1	HD
LEVOTHYROXINE 500 MCG/5 ML VL	T1	HD
<i>levothyroxine 75 mcg tablet (Synthroid)</i>	T1	HD
<i>levothyroxine 88 mcg tablet (Synthroid)</i>	T1	HD
<i>levothyroxine sodium (Synthroid)</i>	T1	HD
<i>levothyroxine sodium (Synthroid)</i>	T3	HD
<i>liothyronine sod 10 mcg/ml vl (Triostat)</i>	T1	
<i>liothyronine sod 25 mcg tab (Cytomel)</i>	T1	HD
<i>liothyronine sod 5 mcg tab (Cytomel)</i>	T1	HD
<i>liothyronine sod 50 mcg tab (Cytomel)</i>	T1	HD
<i>liothyronine sodium (Cytomel)</i>	T1	HD
<i>thyroid,pork</i>	T1	HD
TRIOSTAT (liothyronine sodium)	T3	

UNCLASSIFIED DRUG PRODUCTS (AIDS/HIV)

CYTOCHROME P450 INHIBITORS

TYBOST	T4	SP
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UNCLASSIFIED DRUG PRODUCTS (Asthma/COPD/Respiratory)

CYSTIC FIBROSIS-CFTR POTENTIATOR-CORRECTOR COMBIN.

ALYFTREK 10-50-125 MG TABLET	T4	PA QL(2 TABS/DAY) SP HD
ALYFTREK 4-20-50 MG TABLET	T4	PA QL(3 TABS/DAY) SP HD
ORKAMBI 100 MG-125 MG TABLET	T4	PA QL(4 TABS/DAY) SP HD

T1 – Typically Generics
 T2 – Typically Preferred Brands
 T3 – Typically Non-Preferred Brands

T4 – Specialty Medications
 PA – Prior Authorization
 QL – Quantity Limit

ST – Step Therapy
 AGE – Age Requirement
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List of Prescription Medications

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	T4	PA QL(2 PACKS/DAY) SP HD
ORKAMBI 150-188 MG GRANULE PKT	T4	PA QL(2 PACKS/DAY) SP HD
ORKAMBI 200 MG-125 MG TABLET	T4	PA QL(4 TABS/DAY) SP HD
ORKAMBI 75-94 MG GRANULE PKT	T4	PA QL(2 PACKS/DAY) SP HD
SYMDEKO	T4	PA QL(2 TABS/DAY) SP HD
TRIKAFTA 100-50-75 MG/150 MG	T4	PA QL(3 TABS/DAY) SP HD
TRIKAFTA 100-50-75 MG/75MG PKT	T4	PA QL(2 UNITS/DAY) SP HD
TRIKAFTA 50-25-37.5 MG/75 MG	T4	PA QL(3 TABS/DAY) SP HD
TRIKAFTA 80-40-60MG/59.5MG PKT	T4	PA QL(2 UNITS/DAY) SP HD
CYSTIC FIB-TRANSMEMB CONDUCT.REG. (CFTR) POTENTIATOR		
KALYDECO 13.4 MG GRANULES PKT	T4	PA QL(2 PACKS/DAY) SP HD
KALYDECO 150 MG TABLET	T4	PA QL(2 TABS/DAY) SP HD
KALYDECO 25 MG GRANULES PACKET	T4	PA QL(2 PACKS/DAY) SP HD
KALYDECO 5.8 MG GRANULES PKT	T4	PA QL(2 PACKS/DAY) SP HD
KALYDECO 50 MG GRANULES PACKET	T4	PA QL(2 PACKS/DAY) SP HD
KALYDECO 75 MG GRANULES PACKET	T4	PA QL(2 PACKS/DAY) SP HD
LUNG SURFACTANTS		
CUROSURF	T3	
INFASURF	T3	
SURVANTA	T3	
MUCOLYTICS		
PULMOZYME	T4	PA SP HD
PULMONARY FIBROSIS - SYSTEMIC ENZYME INHIBITORS		
OFEV	T4	PA SP HD
SYSTEMIC ENZYME INHIBITORS		
GLASSIA	T4	PA SP
JOENJA	T4	PA QL(2 TABS/DAY) SP
PROLASTIN C	T4	PA SP HD
VIJOICE 125 MG TABLET	T4	PA QL(1 TAB/DAY) SP
VIJOICE 250 MG DAILY DOSE PACK	T4	PA QL(2 TABS/DAY) SP
VIJOICE 50 MG GRANULE PACKET	T4	PA QL(1 TAB/DAY) SP
VIJOICE 50 MG TABLET	T4	PA QL(1 TAB/DAY) SP
ZOKINVY	T4	PA QL(4 CAPS/DAY) SP
SYSTEMIC ENZYME INHIBITORS		
TEZSPIRE 210 MG/1.91 ML PEN	T4	PA QL(1 PEN/28 DAYS) SP HD
TEZSPIRE 210 MG/1.91 ML SYRING	T4	PA SP HD

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List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Blood Modifiers/Bleeding Disorders)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIPORPHYRIA FACTORS		
PANHEMATIN	T4	SP
ERYTHROID MATURATION AGENTS		
REBLOZYL	T4	PA SP
SPLEEN TYROSINE KINASE INHIBITORS		
TAVALISSE	T4	PA SP
BRADYKININ B2 RECEPTOR ANTAGONISTS		
<i>icatibant acetate</i>	T4	PA SP HD
PLASMA KALLIKREIN INHIBITORS		
KALBITOR	T4	PA SP HD
ORLADEYO	T4	PA QL (1 CAPS/DAY) SP

UNCLASSIFIED DRUG PRODUCTS (Cancer)

CHEMOTHERAPY RESCUE/ANTIDOTE AGENTS		
<i>dexrazoxane hcl</i>	T4	SP
ETHYOL (<i>amifostine crystalline</i>)	T4	SP
KHAPZORY	T3	PA
<i>leucovorin cal 100 mg/10 ml vl</i>	T1	
<i>leucovorin cal 500 mg/50 ml vl</i>	T1	
<i>leucovorin calcium 10 mg tab</i>	T1	CSL
<i>leucovorin calcium 100 mg vial</i>	T1	
<i>leucovorin calcium 15 mg tab</i>	T1	CSL
<i>leucovorin calcium 200 mg vial</i>	T1	
<i>leucovorin calcium 25 mg tab</i>	T1	CSL
<i>leucovorin calcium 350 mg vial</i>	T1	
<i>leucovorin calcium 5 mg tab</i>	T1	CSL
<i>leucovorin calcium 50 mg vial</i>	T1	
<i>leucovorin calcium 500 mg vial</i>	T1	
<i>levoleucovorin calcium</i>	T1	PA
<i>mesna 1 gram/10 ml vial (Mesnex)</i>	T4	SP
<i>mesna 400 mg tablet (Mesnex)</i>	T4	SP CSL
MESNEX 1 GRAM/10 ML VIAL (mesna)	T4	SP
MESNEX 400 MG TABLET (mesna)	T4	SP CSL
PEDMARK	T3	PA
VISTOGARD	T4	SP CSL
VORAXAZE	T4	PA SP
INTRAPLEURAL SCLEROSING AGENTS, ANTINEOPLAST. ADJ.		
SCLEROSOL	T3	CSL

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UNCLASSIFIED DRUG PRODUCTS (Cancer) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
INTRAPLEURAL SCLEROSING AGENTS, ANTINEOPLAST. ADJ. (con't.)		
STERILE TALC	T1	CSL
STERITALC	T3	CSL
RADIOACTIVE THERAPEUTIC AGENTS		
LUTATHERA	T4	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	T4	PA SP
INSULIN-LIKE GROWTH FACTOR RECEPTOR (IGF-R) INHIB		
TEPEZZA	T4	PA SP HD
OCULAR PHOTOACTIVATED VESSEL-OCCLUDING AGENTS		
VISUDYNE	T4	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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UNCLASSIFIED DRUG PRODUCTS (Erectile Dysfunction)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DRUGS TO TREAT ERECTILE DYSFUNCTION (ED)		
<i>sildenafil 25 mg tablet (Viagra)</i>	T1	QL(8 TABS/30 DAYS) HD
<i>sildenafil 50 mg tablet (Viagra)</i>	T1	QL(8 TABS/30 DAYS) HD
STENDRA (avanafil)	T3	ST QL(8 TABS/30 DAYS)
<i>tadalafil 10 mg tablet (Cialis)</i>	T1	QL(8 TABS/30 DAYS) HD
<i>tadalafil 2.5 mg tablet</i>	T1	QL(1 TAB/DAY) HD
<i>tadalafil 20 mg tablet (Cialis)</i>	T1	QL(8 TABS/30 DAYS) HD
<i>tadalafil 5 mg tablet (Cialis)</i>	T1	QL(1 TAB/DAY) HD
<i>vardeafil hcl</i>	T1	QL(8 TABS/30 DAYS)
VIAGRA (<i>sildenafil citrate</i>)	T3	ST QL(8 TABS/30 DAYS)
UNCLASSIFIED DRUG PRODUCTS (Eye Conditions)		
<i>INSULIN-LIKE GROWTH FACTOR RECEPTOR (IGF-R) INHIB</i>		
TEPEZZA	T4	PA SP HD
NICOTINIC RECEPT.PARTIAL AGONIST, ALPHA4BETA2 SPEC		
TYRVAYA	T2	QL(8.4 MLS/30 DAYS)
OCULAR PHOTOACTIVATED VESSEL-OCCLUDING AGENTS		
VISUDYNE	T4	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	T4	PA QL(1 TAB/DAY) SP HD
UNCLASSIFIED DRUG PRODUCTS (Hormonal Agents)		
GROWTH HORMONE RECEPTOR ANTAGONISTS		
SOMAVERT	T4	PA SP HD
HYPERPARATHYROID TX AGENTS - VITAMIN D ANALOG-TYPE		
<i>doxercalciferol</i>	T1	
<i>doxercalciferol (Hectorol)</i>	T1	
<i>paricalcitol 1 mcg capsule (Zemlar)</i>	T4	SP HD

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UNCLASSIFIED DRUG PRODUCTS (Hormonal Agents)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HYPERPARATHYROID TX AGENTS - VITAMIN D ANALOG-TYPE (cont.)		
PARICALCITOL 10 MCG/2 ML VIAL	T4	SP
<i>paricalcitol 10 mcg/2 ml vial (Zemplar)</i>	T4	SP
<i>paricalcitol 2 mcg capsule (Zemplar)</i>	T4	SP HD
PARICALCITOL 2 MCG/ML VIAL	T4	SP
<i>paricalcitol 2 mcg/ml vial (Zemplar)</i>	T4	SP
<i>paricalcitol 4 mcg capsule</i>	T4	SP HD
PARICALCITOL 5 MCG/ML VIAL	T4	SP
<i>paricalcitol 5 mcg/ml vial (Zemplar)</i>	T4	SP
RAYALDEE	T3	
ZEMPLAR 1 MCG CAPSULE (<i>paricalcitol</i>)	T4	SP HD
ZEMPLAR 10 MCG/2 ML VIAL (<i>paricalcitol</i>)	T4	SP
ZEMPLAR 2 MCG CAPSULE (<i>paricalcitol</i>)	T4	SP HD
ZEMPLAR 2 MCG/ML VIAL (<i>paricalcitol</i>)	T4	SP
ZEMPLAR 5 MCG/ML VIAL (<i>paricalcitol</i>)	T4	SP
MENOPAUSAL SYMPT SUPP-SEL ESTROGEN RECEPT MODULATOR		
OSPHENA	T3	QL(30 TABS/30 DAYS) HD
UNCLASSIFIED DRUG PRODUCTS (Miscellaneous)		
ABORTIFACIENT-PROGESTERONE RECEPTOR ANTAGONISTS		
MIFEPREX	T3	
<i>mifepristone 200 mg tablet</i>	T1	
ACID AND ALKALI POISON ANTIDOTES		
METHYLENE BLUE 1% (20 MG/2 ML)	T3	
<i>methylene blue 1% vial</i>	T1	
<i>methylene blue 50 mg/10 ml amp</i>	T1	
<i>methylene blue 50 mg/10ml vial</i>	T1	
PROVAYBLUE	T3	
AGENTS TO TX PERIODIC PARALYSIS - CARBON ANHYD INH		
<i>dichlorphenamide (Keveyis)</i>	T4	PA SP HD
AMMONIA INHIBITORS		
CARBAGLU (carglumic acid)	T4	SP HD
<i>carglumic acid (Carbaglu)</i>	T4	SP HD
AMYLOIDOSIS AGENTS-TRANSTHYRETIN (TTR) SUPPRESSION		
AMVUTTRA	T4	PA SP
ONPATTRO	T4	PA SP

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List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Miscellaneous)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-ALCOHOLIC PREPARATIONS		
<i>acamprosate calcium</i>	T1	
<i>disulfiram</i>	T1	
VIVITROL	T4	SP HD
ANTIDOTES, MISCELLANEOUS		
ACETADOTE (<i>acetylcysteine</i>)	T3	
<i>acetylcysteine (Acetadote)</i>	T1	
CYANOKIT	T3	
DIGIFAB	T3	
<i>fomepizole</i>	T1	
SODIUM NITRITE	T1	
ANTIFIBROTIC THERAPY - PYRIDONE ANALOGS		
<i>pirfenidone 267 mg capsule</i>	T4	PA SP HD
<i>pirfenidone 267 mg tablet (Esbriet)</i>	T4	PA SP HD
<i>pirfenidone 801 mg tablet (Esbriet)</i>	T4	PA SP HD
CI ESTERASE INHIBITORS		
BERINERT	T4	PA SP HD
CINRYZE	T4	PA SP HD
HAEGARDA	T4	PA SP HD
RUCONEST	T4	PA SP HD
CALCIMIMETIC, PARATHYROID CALCIUM ENHANCER		
<i>cinacalcet hcl (Sensipar)</i>	T4	SP
PARSABIV	T4	PA SP
CATHETER LOCK SOLUTIONS		
DEFENCATH	T3	
CHOLINESTERASE REACTIVAT.-MUSCARINIC ANTG.ANTIDOTE		
DUODOTE	T3	
COMPLEMENT INHIBITORS		
VEOPOZ	T4	SP
CRYOPRESERVATIVE AGENTS		
<i>dimethyl sulfoxide</i>	T3	
DILUENT SOLUTIONS		
<i>diluent for epoprostenol(glyc)</i>	T1	
DILUENT FOR REMODULIN	T3	
<i>diluent for treprostinil (gly)</i>	T1	
ELLIOTTS B	T3	
PH 12 DILUENT FOR FLOLAN	T3	

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UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DRUGS TO TREAT ACUTE HEPATIC PORPHYRIA (AHP)		
GIVLAARI	T4	PA SP HD
GENERAL INHALATION AGENTS		
HYPER-SAL	T3	
<i>nebusal 3% vial</i>	T1	
NEBUSAL 6% VIAL	T3	
<i>sodium chloride 0.9% inhal vl</i>	T1	
<i>sodium chloride 10% vial</i>	T1	
<i>sodium chloride 3% vial</i>	T1	
<i>sodium chloride 7% vial</i>	T1	
<i>sodium chloride for inhalation</i>	T1	
GENETIC D/O TX - SMN PROTEIN DEFICIENCY TREATMENT		
EVRYSDI	T4	PA SP HD
SPINRAZA	T4	PA SP HD
GENETIC D/O TX-EXON SKIPPING ANTISENSE OLIGONUCLEO		
AMONDYS-45	T4	PA SP
EXONDYS-51	T4	PA SP
VILTEPSO	T4	PA SP
VYONDYS-53	T4	PA SP
GLUCOSYLCERAMIDE SYNTHASE (GCS) INHIBITOR		
CERDELGA	T4	PA SP HD
<i>miglustat (Zavesca)</i>	T4	PA SP HD
OPFOLDA	T4	PA QL(8 CAPS/30 DAYS) SP HD
HYDROXYPHENYL-PYRUVATE DIOXYGENASE(HPPD) INHIBITOR		
<i>nitisinone (Orfadin)</i>	T4	PA SP HD
NITYR	T4	PA SP
ORFADIN	T4	PA SP
ORFADIN (<i>nitisinone</i>)	T4	PA SP
LEAD POISONING, AGENTS TO TREAT (CHELATING-TYPE)		
CALCIUM DISODIUM VERSENATE	T1	PA
EDETATE CALCIUM DISODIUM	T3	PA
MENOPAUSAL SYMPTOMS SUPPRESSANT - SSRIS		
<i>paroxetine mesylate</i>	T1	QL(1 CAP/DAY) HD
MESENCHYMAL STROMAL CELL (MSC)		
RYONCIL	T4	PA SP
METABOLIC DISEASE ENZYME REPLACE, HYPOPHOSPHATASIA		
STRENSIQ	T4	PA SP

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UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
METABOLIC DISEASE ENZYME REPLACEMENT, ASMD		
XENPOZYME	T4	PA SP HD
METABOLIC DISEASE ENZYME REPLACEMENT, BATTEN DISEA		
BRINEURA	T4	PA SP
METABOLIC DISEASE ENZYME REPLACEMENT, FABRY'S DX		
ELFABRIO	T4	PA SP
FABRAZYME	T4	PA SP HD
METABOLIC DISEASE ENZYME REPLACEMENT, GAUCHER'S DX		
CEREZYME	T4	PA SP HD
ELELYSO	T4	PA SP
VPRIV	T4	PA SP HD
METABOLIC DISEASE ENZYME REPLACEMENT, MOCD		
NULIBRY	T4	PA SP
METABOLIC DISEASE ENZYME REPLACEMENT, POMPE DISEASE		
LUMIZYME	T4	PA SP
NEXVIAZYME	T4	PA SP HD
POMBILITI	T4	PA SP HD
METABOLIC DX ENZYME REPLACE, MUCOPOLYSACCHARIDOSIS		
ALDURAZYME	T4	PA SP HD
ELAPRASE	T4	PA SP
MEPSEVII	T4	PA SP
NAGLAZYME	T4	PA SP
VIMIZIM	T4	PA SP
METABOLIC DX ENZYME REPLACEMENT, ALPHA-MANNOSIDOSIS		
LAMZEDE	T4	PA SP
METABOLIC DX ENZYME REPLACEMENT, LYSO.ACID LIP.DEF.		
KANUMA	T4	PA SP
METABOLIC DX ENZYME REPLACEMENT, SEV.COMB.IMMUNE DEF.		
REVCIVI	T4	PA SP
METALLIC POISON, AGENTS TO TREAT		
BAL IN OIL	T3	PA
CHEMET	T3	
<i>deferasirox (Exjade)</i>	T4	SP HD
<i>deferasirox (Jadenu Sprinkle)</i>	T4	SP HD
<i>deferasirox (Jadenu)</i>	T4	SP HD
<i>deferiprone (Ferriprox (3 Times A Day))</i>	T4	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.)		
<i>deferiprone (Ferriprox)</i>	T4	PA SP
<i>deferoxamine mesylate</i>	T1	
<i>deferoxamine mesylate (Desferal Mesylate)</i>	T1	
DESFERAL MESYLATE (<i>deferoxamine mesylate</i>)	T3	
EXJADE (<i>deferasirox</i>)	T4	PA SP HD
FERRIPROX (2 TIMES A DAY)	T4	PA SP
FERRIPROX 100 MG/ML SOLUTION	T4	PA SP
GALZIN	T4	SP
NITHIODOTE	T3	
PENTETATE CALCIUM TRISODIUM	T1	
PENTETATE ZINC TRISODIUM	T1	
RADIOGARDASE	T3	
<i>sodium thiosulf (poison treat)</i>	T1	
<i>trientine hcl 250 mg capsule (Syprine)</i>	T4	PA SP HD
TRIENTINE HCL 500 MG CAPSULE	T4	PA SP HD
NATRIURETIC PEPTIDES		
VOXZOGO	T4	PA SP HD
NEONATAL FC RECEPTOR (FCRN) INHIBITORS		
IMAAVY	T4	PA SP HD
RYSTIGGO	T4	PA SP
VYVGART	T4	PA SP HD
VYVGART HYTRULO	T4	PA SP HD
OINTMENT/CREAM BASES		
RADIAGEL	T3	
PHARMACOLOGICAL CHAPERONE-ALPHA-GALACTOSID.A STABZ		
GALAFOLD	T4	PA SP HD
PKU TX AGENT-COFACTOR OF PHENYLALANINE HYDROXYLASE		
<i>javygtor 100 mg powder packet (Kuvan)</i>	T4	PA SP
<i>javygtor 100 mg tablet (Kuvan)</i>	T4	PA SP HD
<i>javygtor 500 mg powder packet (Kuvan)</i>	T4	PA SP
<i>sapropterin dihydrochloride (Kuvan)</i>	T4	PA SP
<i>sapropterin dihydrochloride (Kuvan)</i>	T4	PA SP HD
PROTEIN STABILIZERS		
ATTRUBY	T4	PA QL (4 TABS/DAY) SP
VYNDAMAX	T4	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	T4	PA QL(4 CAPS/DAY) SP
RETINOIC ACID RECEPTOR (RAR) AGONISTS		
SOHONOS	T4	PA SP
SODIUM/SALINE PREPARATIONS		
<i>bacteriostatic saline vial</i>	T1	
SOLVENTS		
INSTACLEAN	T3	
ISOPROPANOL	T3	
isopropyl alcohol	T3	
ISOPROPYL ALCOHOL	T3	
ISOPROPYL RUBBING ALCOHOL	T3	
MURI-LUBE MINERAL OIL	T3	
<i>polyethylene glycol</i>	T1	
SUSPENDING AGENTS		
GELFILM	T3	
HYDROXYPROPYLCELLULOSE	T3	
HYPROMELLOSE	T3	
TOPICAL/MUCOUS MEMBR./SUBCUT. ENZYMES		
HYLENEX		
TREATMENT OF HYPERPHAGIA IN PRADER-WILLI SYNDROME		
<i>water for inj.,bacteriostatic</i>	T1	
<i>water for injection,sterile</i>	T1	
<i>water/me-paraben/propylparaben</i>	T1	
UNCLASSIFIED DRUG PRODUCTS (Multiple Sclerosis)		
LEUKOCYTE ADHESION INHIB, ALPHA4-MEDIAT IGG4K MC AB		
TYRUKO	T4	PA SP
TYSABRI	T4	PA SP HD
UNCLASSIFIED DRUG PRODUCTS (Nutritional/Dietary)		
METABOLIC DEFICIENCY AGENTS		
<i>betaine (Cystadane)</i>	T4	SP
CULTURELLE IBS COMPLETE SUPPRT	T3	
CYSTADANE (<i>betaine</i>)	T4	SP
<i>levocarnitine (Carnitor Sf)</i>	T1	
<i>levocarnitine (Carnitor)</i>	T1	
<i>levocarnitine (with sugar) (Carnitor)</i>	T1	

T1 – Typically Generics
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List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Osteoporosis Products)		
BONE FORMATION AGENTS - SCLEROSTIN INHIBITOR, MONO		
EVENITY	T4	PA QL(0.08 MLS/DAY) SP
EVENITY (2 SYRINGES)	T4	PA QL(0.08 MLS/DAY) SP
BONE FORMATION STIM. AGENTS - PARATHYROID HORMONE		
<i>teriparatide</i> (Bonsity)	T4	PA QL(0.09 MLS/DAY) SP HD
<i>teriparatide</i> (Forteo)	T4	PA QL(0.09 MLS/DAY) SP HD
BONE RESORPTION INHIBITOR AND VITAMIN D COMBS.		
FOSAMAX PLUS D	T3	ST HD
BONE RESORPTION INHIBITORS		
<i>alendronate sodium</i>	T1	HD
<i>alendronate sodium</i> (Fosamax)	T1	HD
ATELVIA (<i>risedronate sodium</i>)	T3	ST HD
BILDYOS	T4	PA SP
BILPREVDA	T4	PA SP
BINOSTO	T3	ST HD
FOSAMAX (<i>alendronate sodium</i>)	T3	ST HD
<i>ibandronate</i> 3 mg/3 ml syringe	T4	SP HD
<i>ibandronate</i> 3 mg/3 ml vial	T4	SP HD
<i>ibandronate sodium</i> 150 mg tab	T1	HD
JUBBONTI	T4	PA SP
<i>pamidronate disodium</i>	T4	SP HD
PROLIA	T4	PA SP
<i>raloxifene hcl</i> (Evista)	T1	HD PPACA
RECLAST (<i>zoledronic acid/mannitol-water</i>)	T4	SP HD
<i>risedronate sodium</i>	T1	HD
<i>risedronate sodium</i> (Actonel)	T1	HD
<i>risedronate sodium</i> (Atelvia)	T1	HD
WYOST	T4	PA SP
XGEVA	T4	PA SP
<i>zoledronic acid</i> 4 mg vial	T4	SP HD
<i>zoledronic acid</i> 4 mg/100 ml	T4	SP HD
ZOLEDRONIC ACID 4 MG/100 ML	T4	SP HD
<i>zoledronic acid</i> 4 mg/5 ml vial	T4	SP HD
<i>zoledronic acid</i> 5 mg/100 ml	T4	SP HD
<i>zoledronic acid</i> 5 mg/100 ml (Reclast)	T4	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	T4	PA QL(1 pen/28 days) SP HD
TEZSPIRE 210 MG/1.91 ML SYRING	T4	PA SP HD
TREATMENT OF HYPERPHAGIA IN PRADER-WILLI SYNDROME		
VYKAT XR	T4	PA SP
TOPICAL/MUCOUS MEMBR./SUBCUT. ENZYMES		
HYLENEX	T4	SP HD
WATER		
<i>water for inj., bacteriostatic</i>	T1	
<i>water for injection, sterile</i>	T1	
<i>water/me-paraben/propylparaben</i>	T1	
UNCLASSIFIED DRUG PRODUCTS (Pain Relief And Inflammatory Disease)		
ANTI-INFLAM. INTERLEUKIN-I RECEPTOR ANTAGONIST		
ARCALYST	T4	PA SP HD
ANTI-INFLAMMATORY, INTERLEUKIN-I BETA BLOCKERS		
ILARIS	T4	PA SP HD
FIBROMYALGIA AGENTS, SEROTONIN-NOREPINEPH RU INHIB		
SAVELLA	T3	
IMMUNOMODULATOR, B-LYMPHOCYTE STIM (BLYS) -SPEC INHIB		
BENLYSTA 120 MG VIAL	T4	PA SP
BENLYSTA 200 MG/ML AUTOINJECT	T4	PA SP HD
BENLYSTA 200 MG/ML SYRINGE	T4	PA SP HD
BENLYSTA 400 MG VIAL	T4	PA SP
JOINT CONTRACTURE THERAPY, COLLAGENASE ENZYME		
XIAFLEX	T4	PA SP
UNCLASSIFIED DRUG PRODUCTS (Skin Conditions)		
INTERLEUKIN-13 (IL-13) INHIBITORS, MAB		
ADBRY	T4	PA SP HD
ADBRY AUTOINJECTOR	T4	PA SP HD
EBGLYSS PEN	T4	PA SP
WOUND HEALING AGENTS, LOCAL		
<i>balsam peru/castor oil</i>	T1	
FILSUEVZ	T4	PA SP
VENELEX	T3	

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UNCLASSIFIED DRUG PRODUCTS (Substance Abuse)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPIOID WITHDRAWAL THER, ALPHA-2 ADRENERGIC AGONIST		
<i>lofexidine hcl</i> (Lucemyra)	T1	QL(192 TABS/30 DAYS)
LUCEMYRA (<i>lofexidine hcl</i>)	T2	QL(192 TABS/30 DAYS)
OPIOID WITHDRAWAL THERAPY AGENTS, OPIOID-TYPE		
BRIXADI	T4	SP HD
<i>buprenorphine hcl</i>	T1	
<i>buprenorphine hcl/naloxone hcl</i>	T1	
<i>buprenorphine hcl/naloxone hcl</i> (Suboxone)	T1	
SUBLOCADE	T4	SP
SUBOXONE (<i>buprenorphine hcl/naloxone hcl</i>)	T3	
ZUBSOLV	T2	
UNCLASSIFIED DRUG PRODUCTS (Transplant Medications)		
RHO KINASE INHIBITOR		
REZUROCK	T4	PA SP
UNCLASSIFIED DRUG PRODUCTS (Urinary Tract Conditions)		
BENIGN PROSTATIC HYPERTROPHY/MICTURITION AGENTS		
<i>alfuzosin hcl</i> (Uroxatral)	T1	HD
<i>dutasteride</i> (Avodart)	T1	HD
<i>finasteride</i> (Proscar)	T1	HD
<i>silodosin 4 mg capsule</i> (Rapaflo)	T1	QL(1 CAP/DAY) HD
<i>silodosin 8 mg capsule</i> (Rapaflo)	T1	HD
<i>tamsulosin hcl</i>	T1	HD
BPH 5-ALPHA-REDUCTASE INHIB-ALPHA1-ADRENOCEP ANTAG		
<i>dutasteride/tamsulosin hcl</i> (Jalyn)	T1	HD
CYSTINE-DEPLETING AGENTS, NEPHROPATHIC CYSTINOSIS		
CYSTAGON	T4	SP
ENDOTHELIN RECEPTOR ANTAGONISTS		
VANRAFIA	T4	PA QL(1 TAB/DAY) SP
KIDNEY STONE AGENTS		
<i>tiopronin</i> (Thiola Ec)	T4	SP
<i>tiopronin 100 mg tablet</i> (Thiola)	T4	SP
<i>tiopronin dr 100 mg tablet</i> (Thiola Ec)	T4	SP HD
<i>tiopronin dr 300 mg tablet</i> (Thiola Ec)	T4	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 RECEPTOR		
<i>mirabegron er 25 mg tablet (Myrbetriq)</i>	T1	QL(1 TAB/DAY) HD
<i>mirabegron er 50 mg tablet (Myrbetriq)</i>	T1	HD
URINARY TRACT ANTISPASMODIC, M (3) SELECTIVE ANTAG.		
<i>darifenacin er 15 mg tablet</i>	T1	HD
<i>darifenacin er 7.5 mg tablet</i>	T1	QL(1 TAB/DAY) HD
<i>solifenacin 10 mg tablet (Vesicare)</i>	T1	HD
<i>solifenacin 5 mg tablet (Vesicare)</i>	T1	QL(1 TAB/DAY) HD
URINARY TRACT ANTISPASMODIC/ANTIINCONTINENCE AGENT		
<i>fesoterodine er 4 mg tablet (Toviaz)</i>	T1	QL(1 TAB/DAY) HD
<i>fesoterodine er 8 mg tablet (Toviaz)</i>	T1	HD
<i>flavoxate hcl</i>	T1	HD
<i>oxybutynin 5 mg tablet</i>	T1	HD
<i>oxybutynin 5 mg/5 ml soln cup</i>	T1	HD
<i>oxybutynin 5 mg/5 ml solution</i>	T1	HD
<i>oxybutynin 5 mg/5 ml syrup</i>	T1	HD
<i>oxybutynin chloride</i>	T1	HD
<i>tolterodine tart er 2 mg cap (Detrol La)</i>	T1	QL(1 CAP/DAY) HD
<i>tolterodine tart er 4 mg cap (Detrol La)</i>	T1	HD
<i>tolterodine tartrate (Detrol)</i>	T1	HD
<i>trospium chloride</i>	T1	HD
UNCLASSIFIED DRUG PRODUCTS (Weight Management)		
APPETITE STIM. FOR ANOREXIA, CACHEXIA, WASTING SYND.		
<i>megestrol 400 mg/10 ml cup</i>	T1	
<i>megestrol 625 mg/5 ml susp</i>	T1	
<i>megestrol acet 40 mg/ml susp</i>	T1	
<i>megestrol acet 400 mg/10 ml</i>	T1	
VITAMINS (Nutritional/Dietary)		
ANTIOXIDANT MULTIVITAMIN COMBINATIONS		
MACUVEX	T3	
MACUZIN	T3	
FOLIC ACID PREPARATIONS		
ENLYTE	T3	
<i>folic acid</i>	T1	
<i>folic acid/b6/ca phos/ginger</i>	T1	

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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 (<i>mvn-min75/iron/iron ps/om3/dha</i>)	T3	
CONCEPT OB (<i>mvn-min 74/iron fum/iron/fa</i>)	T3	
CORVITE	T3	
DIALYVITE 800 WITH IRON	T3	
ENBRACE HR	T3	
<i>folic/mvi ther-min/lycop/lut</i>	T1	
FORTAVIT	T3	
INFUVITE ADULT	T3	
<i>multivit 47/iron/folate 1/dha</i>	T1	
<i>multivit no. 18/iron no. 1/folic</i> (Tandem Plus)	T1	
<i>multivit no.51/iron/folic acid</i>	T1	
<i>multivit-min69/iron/folic acid</i>	T1	
<i>multivit-mins no.7/folic acid</i>	T1	
<i>mv-mins 71/iron/folic no.1/dha</i>	T1	
<i>mvn no.53/iron/folic/dss/dha</i>	T1	
<i>mvn-min 74/iron fum/iron/fa</i> (Concept Ob)	T1	
<i>mvn-min75/iron/iron ps/om3/dha</i> (Concept Dha)	T1	
NEEVODHA	T3	
NESTABS ONE	T3	
NIVA-PLUS (<i>multivit-min 60/iron fum/folic</i>)	T1	
OB COMPLETE	T3	
<i>om-3/dha/epa/b12/fa/b6/phytost</i>	T1	
PRENATE AM	T3	
PRENATE CHEWABLE	T3	
PRENATE ESSENTIAL	T3	
PROTECT IRON	T3	
STROVITE FORTE (<i>multivit,iron,min 5/folic acid</i>)	T3	
STROVITE ONE	T3	
TANDEM PLUS (<i>multivit no. 18/iron no. 1/folic</i>)	T3	
UDAMIN SP	T3	

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List of Prescription Medications

VITAMINS (Nutritional/Dietary)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PEDIATRIC VITAMIN PREPARATIONS		
FLORIVA	T3	PPACA
FLORIVA PLUS	T3	
INFUVITE PEDIATRIC	T3	
<i>ped mvit a,c,d3 no.21/fluoride</i>	T1	PPACA
<i>pedi multivit 45/fluoride/iron</i>	T1	PPACA
<i>pedi multivit no.12 w-fluoride</i>	T3	PPACA
<i>pedi multivit no.17 w-fluoride</i>	T1	PPACA
<i>pedi multivit no.2 w-fluoride</i>	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 (<i>pedi multivit no.82 w-fluoride</i>)	T3	PPACA
TRI-VI-FLOR	T3	PPACA
VITALIPID N INFANT	T3	
VITLIPIID N INFANT	T3	
VITALIPID N INFANT	T3	
VITLIPIID N INFANT	T3	
VITAMIN A PREPARATIONS		
AQUASOL A	T3	
VITAMIN B PREPARATIONS		
<i>b comp no3/folic/c/biotin/zinc</i>	T1	HD
<i>b complex 11/folic/c/biot/zinc</i>	T1	HD
<i>cyanocobalamin/folic ac/vit b6</i>	T1	HD
<i>cyanocobalamin/folic ac/vit b6 (Niva-Fol)</i>	T1	HD
DIALYVITE 3000	T3	HD
DIALYVITE 5000	T3	HD
DIALYVITE SUPREME D	T3	HD
<i>folic acid/vit b complex and c</i>	T1	HD
<i>folic acid/vit b complex and c</i>	T2	HD

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VITAMINS (Nutritional/Dietary)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN B PREPARATIONS (con't.)		
<i>folic acid/vit bcomp,c/cu/zinc</i>	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 B1 PREPARATIONS		
<i>thiamine hcl</i>	T1	
VITAMIN B12 PREPARATIONS		
<i>cyanocobalamin (vitamin b-12)</i>	T1	
<i>cyanocobalamin (vitamin b-12) (Nascobal)</i>	T1	
<i>hydroxocobalamin</i>	T1	
VITAMIN B6 PREPARATIONS		
<i>pyridoxine hcl (vitamin b6)</i>	T1	
VITAMIN C PREPARATIONS		
ASCOR	T3	
<i>ascorbic acid</i>	T1	
VITAMIN D PREPARATIONS		
<i>calcitriol 0.25 mcg capsule</i>	T1	
<i>calcitriol 0.5 mcg capsule</i>	T1	
<i>calcitriol 1 mcg/ml ampul</i>	T1	
<i>calcitriol 1 mcg/ml solution</i>	T1	
<i>calcitriol 1 mcg/ml vial</i>	T1	HD
<i>ergocalciferol (vitamin d2)</i>	T1	HD
VITAMIN K PREPARATIONS		
MEPHYTON (<i>phytonadione (vit k1)</i>)	T3	
<i>phytonadione (vit k1)</i>	T1	
<i>phytonadione 1 mg/0.5 ml syr</i>	T1	
PHYTONADIONE 1 MG/0.5 ML SYR	T1	
PHYTONADIONE 1 MG/0.5 ML VIAL	T3	
<i>phytonadione 10 mg/ml ampul</i>	T1	
<i>phytonadione 10 mg/ml vial</i>	T1	
<i>phytonadione 5 mg tablet (Mephyton)</i>	T1	

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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.

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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](https://www.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](https://www.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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Proficiency of Language Assistance Services

English – ATTENTION: Language assistance services, free of charge, are available to you. For current Cigna customers, call the number on the back of your ID card. Otherwise, call 1.800.244.6224 (TTY: Dial 711).

Spanish – ATENCIÓN: Hay servicios de asistencia de idiomas, sin cargo, a su disposición. Si es un cliente actual de Cigna, llame al número que figura en el reverso de su tarjeta de identificación. Si no lo es, llame al 1.800.244.6224 (los usuarios de TTY deben llamar al 711).

Chinese – 注意：我們可為您免費提供語言協助服務。對於 Cigna 的現有客戶，請致電您的 ID 卡背面的號碼。其他客戶請致電 1.800.244.6224（聽障專線：請撥 711）。

Vietnamese – XIN LƯU Ý: Quý vị được cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Dành cho khách hàng hiện tại của Cigna, vui lòng gọi số ở mặt sau thẻ Hội viên. Các trường hợp khác xin gọi số 1.800.244.6224 (TTY: Quay số 711).

Korean – 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 현재 Cigna 가입자님들께서는 ID 카드 뒷면에 있는 전화번호로 연락해주시시오. 기타 다른 경우에는 1.800.244.6224 (TTY: 다이얼 711)번으로 전화해주시시오.

Tagalog – PAUNAWA: Makakakuha ka ng mga serbisyo sa tulong sa wika nang libre. Para sa mga kasalukuyang customer ng Cigna, tawagan ang numero sa likuran ng iyong ID card. O kaya, tumawag sa 1.800.244.6224 (TTY: I-dial ang 711).

Russian – ВНИМАНИЕ: вам могут предоставить бесплатные услуги перевода. Если вы уже участвуете в плане Cigna, позвоните по номеру, указанному на обратной стороне вашей идентификационной карточки участника плана. Если вы не являетесь участником одного из наших планов, позвоните по номеру 1.800.244.6224 (TTY: 711).

Arabic – برجاء الانتباه خدمات الترجمة المجانية متاحة لكم. لعملاء Cigna الحاليين برجاء الاتصال بالرقم المدون علي ظهر بطاقتكم الشخصية. او اتصل ب 1.800.244.6224 (TTY: اتصل ب 711).

French Creole – ATANSYON: Gen sèvis èd nan lang ki disponib gratis pou ou. Pou kliyan Cigna yo, rele nimewo ki dèyè kat ID ou. Sinon, rele nimewo 1.800.244.6224 (TTY: Rele 711).

French – ATTENTION: Des services d'aide linguistique vous sont proposés gratuitement. Si vous êtes un client actuel de Cigna, veuillez appeler le numéro indiqué au verso de votre carte d'identité. Sinon, veuillez appeler le numéro 1.800.244.6224 (ATS : composez le numéro 711).

Portuguese – ATENÇÃO: Tem ao seu dispor serviços de assistência linguística, totalmente gratuitos. Para clientes Cigna atuais, ligue para o número que se encontra no verso do seu cartão de identificação. Caso contrário, ligue para 1.800.244.6224 (Dispositivos TTY: marque 711).

Polish – UWAGA: w celu skorzystania z dostępnej, bezpłatnej pomocy językowej, obecni klienci firmy Cigna mogą dzwonić pod numer podany na odwrocie karty identyfikacyjnej. Wszystkie inne osoby prosimy o skorzystanie z numeru 1 800 244 6224 (TTY: wybierz 711).

Japanese – 注意事項: 日本語を話される場合、無料の言語支援サービスをご利用いただけます。現在のCignaのお客様は、IDカード裏面の電話番号まで、お電話にてご連絡ください。その他の方は、1.800.244.6224 (TTY: 711)まで、お電話にてご連絡ください。

Italian – ATTENZIONE: Sono disponibili servizi di assistenza linguistica gratuiti. Per i clienti Cigna attuali, chiamare il numero sul retro della tessera di identificazione. In caso contrario, chiamare il numero 1.800.244.6224 (utenti TTY: chiamare il numero 711).

German – ACHTUNG: Die Leistungen der Sprachunterstützung stehen Ihnen kostenlos zur Verfügung. Wenn Sie gegenwärtiger Cigna-Kunde sind, rufen Sie bitte die Nummer auf der Rückseite Ihrer Krankenversicherungskarte an. Andernfalls rufen Sie 1.800.244.6224 an (TTY: Wählen Sie 711).

Persian (Farsi) – توجه: خدمات کمک زبانی، به صورت رایگان به شما ارائه می‌شود. برای مشتریان فعلی Cigna، لطفاً با شماره‌ای که در پشت کارت شناسایی شماست تماس بگیرید. در غیر اینصورت با شماره 1.800.244.6224 (شماره تلفن ویژه ناشنویان: شماره 711 را شماره‌گیری کنید).