



Cigna Healthcare Legacy (Performance) 3-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: 08/01/2025. This drug list is subject to change and all prior versions are no longer in effect.



What's Inside?	Page
Information about this drug list	3
· Frequently asked questions (FAQs)	3
· Words you may need to know	10
· About this drug list	12
· How to read this drug list	12
· How to find your medication	15
List of prescription medications	18
Exclusions and limitations for coverage	291
Index of medications	292

View your drug list online, 24/7

This document was last updated on 12/01/2025.*

- 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 Legacy (Performance) 3 Tier (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: 12/01/2025, 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. There are 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") 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.

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.

Information about this drug list

Frequently asked questions (FAQs) (cont.)

Q. What types of medications typically need approval?

A. Medications that:

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

Q. What types of medications typically have quantity limits?

A. Medications that are often:

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

Q. What medications are part of Step Therapy?

A. They're typically high-cost medications that treat conditions such as:

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

Q. Why does my medication have an age requirement?

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

Q. How do I get approval (prior authorization) for my medication?

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

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

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

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

Information about this drug list

Frequently asked questions (FAQs) (cont.)

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 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

Information about this drug list

Frequently asked questions (FAQs) (cont.)

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.

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.

Information about this drug list

Frequently asked questions (FAQs) (cont.)

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.²

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.

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.³ 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.³

Q. What are the differences between generic and brand-name medications?

A. The generic and brand-name medication may³:

- 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.

Information about this drug list

Frequently asked questions (FAQs) (cont.)

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.⁴

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.⁵ 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.⁵

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.⁶
- 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.⁷
- Use a payment plan (if you need it).

Here are two easy ways to get started:

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

Fill specialty medications through Accredo Specialty Pharmacy

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

- Talk with specially-trained pharmacists and nurses, 24/7.

Information about this drug list

Frequently asked questions (FAQs) (cont.)

- Get fast shipping at no extra cost.⁶
- Sign up for refills and reminders. Some refills can be done by text.⁸
- 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.⁵ 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.

Q. Where can I find more information about my pharmacy benefits?

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

Q. How can I find out my cost-share for each tier of the drug list?

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

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

Information about this drug list

Frequently asked questions (FAQs) (cont.)

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](https://www.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.

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.

Information about this drug list

Frequently asked questions (FAQs) (cont.)

- **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.
- **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.

Information about this drug list

Words you may need to know (cont.)

- **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 Legacy (Performance) 3-Tier Prescription Drug List as of January 1, 2026. **The drug list is updated often**; so, not all of the medications your plan covers may be listed here. Also, your plan may not cover all of these medications. Log in to the myCigna App or **myCigna.com** to see which medications your plan covers.

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. These medications are covered at your plan's highest cost-share. Non-preferred brands typically have a generic and/or preferred brand alternative(s) that treats the same condition.	\$\$\$

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

Information about this drug list

How to read this drug list (cont.)

Letters (acronyms) in the Notes column

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

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

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

Information about this drug list

How to read this drug list (cont.)

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

ANALGESICS (Pain Relief and Inflammatory Disease)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANALGESIC, NON-SALICYLATE AND BARBITURATE COMBINAT		
<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)	19-30	Anti-Infectives (Infections)	70
Analgesics (Urinary Tract Conditions)	30	Anti-Infectives/Miscellaneous (Feminine Products)	70
Anesthetics (Miscellaneous)	30, 31	Anti-Infectives/Miscellaneous (Infections)	70, 71
Anesthetics (Pain Relief and Inflammatory Disease)	31-33	Anti-Infectives/Miscellaneous (Miscellaneous)	72
Anesthetics (Urinary Tract Conditions)	33	Anti-Inflammatory Tumor Necrosis Factor Inhibiting Agents (Pain Relief and Inflammatory Disease)	72-75
Anti-Allergy (Allergy and Nasal Sprays)	33	Anti-Neoplastics (Cancer)	75-93
Anti-Arthritics (Pain Relief and Inflammatory Disease)	33-38	Anti-Neoplastics (Skin Conditions)	93
Anti-Asthmatics (Asthma/COPD/Respiratory)	38-42	ANTIPARASITICS (Eye Conditions)	93
Antibiotics (Ear Medications)	42	Anti-Parasitics (Infections)	93
Antibiotics (Eye Conditions)	43, 44	ANTIPARASITICS (Skin Conditions)	94
Antibiotics (Infections)	44-55	Anti-Parkinson's Drugs (Parkinson's Disease)	94-96
Antibiotics (Miscellaneous)	55	Anti-Platelet Drugs (Blood Thinners/Anti-Clotting)	96
Antibiotics (Skin Conditions)	55, 56	Antivirals (Aids/Hiv)	96-100
Anti-Coagulants (Blood Thinners/Anti-Clotting)	56-59	Antivirals (Eye Conditions)	100
Antidotes (Gastrointestinal/Heartburn)	59	Antivirals (Infections)	100-102
Antidotes (Substance Abuse)	59	Antivirals (Skin Conditions)	102, 103
Anti-Fungals (Eye Conditions)	59	Autonomic Drugs (Allergy/Nasal Sprays)	103
Anti-Fungals (Feminine Products)	60	Autonomic Drugs (Alzheimer's Disease)	103, 104
Anti-Fungals (Infections)	60, 61	Autonomic Drugs (Attention Deficit Hyperactivity Disorder)	104, 105
Anti-Fungals (Skin Conditions)	61, 62	Autonomic Drugs (Blood Pressure/Heart Medications)	105
Antihistamine and Decongestant Combination (Allergy/Nasal Sprays)	62	Autonomic Drugs (Miscellaneous)	106, 107
Antihistamines (Allergy/Nasal Sprays)	62, 63	Autonomic Drugs (Urinary Tract Conditions)	107
Antihistamines (Eye Conditions)	63	Biologicals (Allergy/Nasal Sprays)	107
Anti-Hyperglycemics (Diabetes)	64-70		
Anti-Infectives (Feminine Products)	70		
Anti-Infectives (Feminine Products)	63		

Information about this drug list

How to find your medication (cont.)

Condition	Page	Condition	Page
Biologicals (Blood Pressure/ Heart Medications)	107	Elect/Caloric/H2O (Urinary Tract Conditions)	176, 177
Biologicals (Vaccines)	94-96	Elect/Caloric/H2O (Dental Products)	167, 168
Blood (Blood Modifiers/Bleeding Disorders)	96-98	Elect/Caloric/H2O (Diabetes)	168
Biologicals (Miscellaneous)	94	Elect/Caloric/H2O (Miscellaneous)	168-170
Biologicals (Vaccines)	108-111	Elect/Caloric/H2O (Nutritional/Dietary)	170-176
Blood (Blood Modifiers/Bleeding Disorders)	112-114	Gastrointestinal (Cholesterol Medications)	177
Cardiac Drugs (Blood Pressure/Heart Medications)	115-119	Gastrointestinal (Gastrointestinal/ Heartburn)	177-188
Cardiovascular (Allergy/Nasal Sprays)	120	Gastrointestinal (Pain Relief and Inflammatory Disease)	188
Cardiovascular (Asthma/COPD/Respiratory)	120-122	Hormones (Hormonal Agents)	188-197
Cardiovascular (Blood Pressure/ Heart Medications)	122-129	Hormones (Infertility)	197
Cardiovascular (Cholesterol Medications)	129-133	Hormones (Miscellaneous)	197
Cardiovascular (Miscellaneous)	133	Hormones (Osteoporosis Products)	198
CNS Drugs (Alzheimer's Disease)	133, 134	Immunosuppressants (Miscellaneous)	198
CNS Drugs (Miscellaneous)	134, 135	Immunosuppressants (Pain Relief and Inflammatory Disease)	198-200
CNS Drugs (Multiple Sclerosis)	135, 136	IMMUNOSUPPRESSANTS (Skin Conditions)	200
CNS Drugs (Pain Relief and Inflammatory Disease)	137	Immunosuppressants (Transplant Medications)	200-202
CNS Drugs (Seizure Disorders)	137-143	Miscellaneous Medical Supplies, Devices, Non-Drug (Diabetes)	202-230
CNS DRUGS (Sleep Disorders/Sedatives)	143	Miscellaneous Medical Supplies, Devices, Non-Drug (Miscellaneous)	230-235
Colony Stimulating Factors (Blood Modifiers/Bleeding Disorders)	143, 144	Muscle Relaxants (Pain Relief and Inflammatory Disease)	236, 237
Colony Stimulating Factors (Cancer)	144, 145	Prenatal Vitamins (Nutritional/Dietary)	237-240
Contraceptives (Contraception Products)	145-147	Psychotherapeutic Drugs (Anxiety/ Depression/Bipolar Disorder)	240-246
Cough/Cold Preparations (Allergy/Nasal Sprays)	147, 148	Psychotherapeutic Drugs (Attention Deficit Hyperactivity Disorder)	247-250
Diagnostic (Diabetes)	148-153	Psychotherapeutic Drugs (Schizophrenia/ Anti-Psychotics)	250-255
Diagnostic (Miscellaneous)	153-158	PSYCHOTHERAPEUTIC DRUGS (Seizure Disorders)	255
Diuretics (Diuretics)	158-160	Psychotherapeutic Drugs (Sleep Disorders/Sedatives)	255
EENT Preps (Allergy/Nasal Sprays)	160, 161	Sedative/Hypnotics (Sleep Disorders/ Sedatives)	255-257
EENT Preps (Ear Medications)	161	Unclassified Drug Products (Asthma/COPD/ Respiratory)	271, 272
EENT Preps (Eye Conditions)	161, 166		
Elect/Caloric/H2O (Cholesterol Medications)	167		

Information about this drug list

How to find your medication (cont.)

Condition	Page	Condition	Page
Skin Preps (Miscellaneous)	257, 258	Unclassified Drug Products (Eye Conditions)	275
Skin Preps (Pain Relief and Inflammatory Disease)	258, 259	Unclassified Drug Products (Gastrointestinal/Heartburn)	275
Skin Preps (Skin Conditions)	259- 268	Unclassified Drug Products (Hormonal Agents)	275, 276
Smoking Deterrents (Smoking Cessation)	268	Unclassified Drug Products (Miscellaneous)	276-282
Thyroid Prep (Hormonal Agents)	269-271	Unclassified Drug Products (Multiple Sclerosis)	282
Unclassified Drug Products (Blood Modifiers/Bleeding Disorders)	272	Unclassified Drug Products (Osteoporosis Products)	283, 284
Unclassified Drug Products (Blood Pressure/Heart Medications)	272, 273	Unclassified Drug Products (Pain Relief and Inflammatory Disease)	284
Unclassified Drug Products (Cancer)	273, 274	Unclassified Drug Products (Seizure Disorders)	284
Unclassified Drug Products (Dental Products)	274	Unclassified Drug Products (Skin Conditions)	284, 285
Unclassified Drug Products (Diabetes)	274	Unclassified Drug Products (Substance Abuse)	285
Unclassified Drug Products (Erectile Dysfunction)	274, 275	Unclassified Drug Products (Transplant Medications)	285
Unclassified Drug Products (Nutritional/Dietary)	282	Unclassified Drug Products (Urinary Tract Conditions)	285-287
		Unclassified Drug Products (Weight Management)	287
		Vitamins (Nutritional/Dietary)	287-290
		Vitamins (Vitamins)	290

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		
BUPAP (butalbital/acetaminophen)	T3	PA
<i>butalbital/acetaminophen</i>	T1	
<i>butalbital-acetaminophen 25-325</i>	T1	PA
<i>butalbital-acetaminophen 50-300</i>	T1	
<i>butalbital-acetaminophen 50-300 (Bupap)</i>	T1	PA
<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>butal-ace-caf 50-325-40mg/15ml</i>	T1	PA QL(90 MLS/DAY)
<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 (Esgic)</i>	T1	QL(6 CAPS/DAY)
<i>ESGIC (butalb/acetaminophen/caffeine)</i>	T3	PA QL(6 CAPS/DAY)
<i>FIORICET (butalb/acetaminophen/caffeine)</i>	T3	PA QL(6 CAPS/DAY)
ANALGESIC/ANTIPYRETICS, SALICYLATES		
<i>acetaminophen 1,000mg/100ml</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	T3	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 (clonidine hcl/pf)	T3	
JOURNAVX	T3	QL(30 TABS/90 DAYS)
ANTI-MIGRAINE PREPARATIONS		
ACETAMINOPHEN 1000MG/100ML BAG	T3	
<i>acetaminophen 1,000mg/100ml vl (Ofirmev)</i>	T1	
OFIRMEV (<i>acetaminophen</i>)	T3	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANALGESICS (Pain Relief And Inflammatory Disease) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIMIGRAINE PREPARATIONS (cont.)		
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)
CAMBIA (<i>diclofenac potassium</i>)	T3	PA
<i>diclofenac pot 50 mg powdr pkt</i> (Cambia)	T1	PA
<i>dihydroergotamine 1 mg/ml amp</i>	T1	QL
<i>dihydroergotamine 4 mg/ml spry</i> (Migranal)	T1	PA QL(8 MLS/30 DAYS)
<i>eletriptan hydrobromide</i> (Relpax)	T1	QL(6 TABS/30 DAYS)
ELYXYB	T3	PA QL(43.2 MLS/30 DAYS)
EMGALITY PEN	T2	PA
EMGALITY SYRINGE	T2	PA
ERGOMAR	T3	PA
<i>ergotamine tartrate/caffeine</i>	T1	QL(40 TABS/28 DAYS)
FROVA (<i>frovatriptan succinate</i>)	T3	PA QL(18 TABS/30 DAYS)
<i>frovatriptan succinate</i> (Frova)	T1	QL(18 TABS/30 DAYS)
IMITREX 100 MG TABLET (<i>sumatriptan succinate</i>)	T3	PA QL(9 TABS/30 DAYS)
IMITREX 25 MG TABLET (<i>sumatriptan succinate</i>)	T3	PA QL(9 TABS/30 DAYS)
IMITREX 4 MG/0.5 ML CARTRIDGES (<i>sumatriptan succinate</i>)	T3	PA QL(4 MLS/30 DAYS)
IMITREX 4 MG/0.5 ML PEN INJECT (<i>sumatriptan succinate</i>)	T3	PA QL(4 MLS/30 DAYS)
IMITREX 50 MG TABLET (<i>sumatriptan succinate</i>)	T3	PA QL(9 TABS/30 DAYS)
IMITREX 6 MG/0.5 ML CARTRIDGES (<i>sumatriptan succinate</i>)	T3	PA QL(4 MLS/30 DAYS)
IMITREX 6 MG/0.5 ML PEN INJECT (<i>sumatriptan succinate</i>)	T3	PA QL(4 MLS/30 DAYS)
MAXALT (<i>rizatriptan benzoate</i>)	T3	PA QL(12 TABS/30 DAYS)
MAXALT MLT (<i>rizatriptan benzoate</i>)	T3	PA QL(12 TABS/30 DAYS)
MIGRANAL (<i>dihydroergotamine mesylate</i>)	T3	PA QL(8 MLS/30 DAYS)
<i>naratriptan hcl</i>	T1	QL(9 TABS/30 DAYS)
NURTEC ODT	T2	PA QL(16 TABS/30 DAYS)
ONZETRA XSAIL	T3	PA QL(16 INHALERS/30 DAYS)
QULIPTA	T2	PA QL(1 TAB/DAY)
RELPAK (<i>eletriptan hydrobromide</i>)	T3	PA QL(6 TABS/30 DAYS)
REYVOW	T3	PA QL(8 TABS/30 DAYS)

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANALGESICS (Pain Relief And Inflammatory Disease) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-MIGRAINE PREPARATIONS		
<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)
SYMBRAVO	T3	PA QL(9 TABS/28 DAYS)
TOSYMRA	T3	PA QL(12 UNITS/30 DAYS)
TREXIMET (<i>sumatriptan succ/naproxen sod</i>)	T3	PA QL(18 TABS/30 DAYS)
TRUDHESA	T3	PA QL(8 MLS/30 DAYS)
UBRELVY	T2	PA QL(0.67 TABS/DAY)
VYEPTI	T3	PA SP
ZAVZPRET	T2	PA QL(6 UNITS/30 DAYS)
ZEMBRACE SYMTOUCH	T3	PA QL(8 MLS/30 DAYS)
<i>zolmitriptan 2.5 mg tablet (Zomig)</i>	T1	QL(6 TABS/30 DAYS)
ZOLMITRIPTAN 2.5MG NASAL SPRAY	T3	PA QL(12 UNITS/30 DAYS)
<i>zolmitriptan 5 mg nasal spray (Zomig)</i>	T1	PA QL(12 UNITS/30 DAYS)
<i>zolmitriptan 5 mg tablet (Zomig)</i>	T1	QL(6 TABS/30 DAYS)
ZOMIG 2.5 MG NASAL SPRAY	T3	PA QL(12 UNITS/30 DAYS)
ZOMIG 2.5 MG TABLET (zolmitriptan)	T3	PA QL(6 TABS/30 DAYS)
ZOMIG 5 MG NASAL SPRAY (zolmitriptan)	T3	PA QL(12 UNITS/30 DAYS)
ZOMIG 5 MG TABLET (zolmitriptan)	T3	PA QL(6 TABS/30 DAYS)

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANALGESICS (Pain Relief And Inflammatory Disease) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NASAL NSAIDS, COX NON-SELECTIVE, SYSTEMIC ANALGESIC		
SPRIX	T3	PA QL(5 UNITS/30 DAYS)
NSAIDS, CYCLOOXYGENASE INHIBITOR-TYPE ANALGESICS		
<i>diclofenac pot 25 mg tablet</i>	T1	PA HD
<i>diclofenac pot 50 mg tablet</i>	T1	HD
<i>diclofenac potassium 25 mg cap (Zipsor)</i>	T1	PA HD
<i>ketorolac 10 mg tablet</i>	T1	QL(20 TABS/30 DAYS)
<i>ketorolac 15 mg/ml</i>	T1	QL(8 MLS/DAY)
<i>ketorolac 30 mg/ml</i>	T1	QL(4 MLS/DAY)
<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)
<i>mefenamic acid</i>	T1	PA HD
ZIPSOR (<i>diclofenac potassium</i>)	T3	PA HD
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 (hydrocodone/acetaminophen)	T1	PA
NALOCET	T1	PA
<i>oxycodone hcl/acetaminophen (Percocet)</i>	T1	PA
PERCOCET (oxycodone hcl/acetaminophen)	T3	PA
PRIMLEV	T1	PA
PROLATE 10 MG-300 MG/5 ML SOLN	T3	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	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANALGESICS (Pain Relief And Inflammatory Disease) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPIOID ANALGESIC AND NSAID COMBINATION		
<i>hydrocodone/ibuprofen</i>	T1	PA
OPIOID ANALGESIC, ANESTHETIC ADJUNCT AGENTS		
ALFENTANIL HCL (<i>alfentanil hcl</i>)	T3	PA
<i>fentanyl 1,000 mcg/20 ml vial</i>	T1	
<i>fentanyl 100 mcg/2 ml</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	
<i>fentanyl 5,000 mcg/100 ml bag</i>	T1	
<i>fentanyl 50 mcg/ml syringe</i>	T1	
<i>fentanyl 50 mcg/ml vial</i>	T1	
<i>fentanyl 500 mcg/10 ml vial</i>	T1	
<i>fentanyl citrate/pf</i>	T1	
<i>remifentanil hcl (Ultiva)</i>	T1	PA
<i>sufentanil citrate</i>	T1	PA
ULTIVA (remifentanil hcl)	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	

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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.)		
BUTRANS (<i>buprenorphine</i>)	T3	QL(4 PATCHES/28 DAYS)
<i>codeine sulfate</i>	T1	PA
CONZIP	T3	PA QL(1 CAP/DAY)
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 TABLET (<i>hydromorphone</i>)	T3	PA
DILAUDID 2 MG/ML SYRINGE	T3	PA
DILAUDID 4 MG TABLET (<i>hydromorphone</i>)	T3	PA
DILAUDID 4 MG/ML SYRINGE	T3	PA
DILAUDID 5 MG/5 ML ORAL LIQUID (<i>hydromorphone hcl</i>)	T3	PA
DILAUDID 8 MG TABLET (<i>hydromorphone hcl</i>)	T3	PA
<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 carpujct</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	

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T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANALGESICS (Pain Relief And Inflammatory Disease) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPIOID ANALGESICS (cont.)		
FENTANYL 2,750 MCG/55 ML SYR	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
FENTANYL CIT 600 MCG BUCCAL TB	T1	PA
FENTANYL CIT 800 MCG BUCCAL TB	T1	PA
<i>fentanyl cit otfc 1,600 mcg (Actiq)</i>	T1	PA
<i>fentanyl citrate otfc 200 mcg</i>	T1	PA
<i>fentanyl citrate otfc 400 mcg</i>	T1	PA
<i>fentanyl citrate otfc 800 mcg</i>	T1	PA
<i>fentanyl/ropivacaine/ns/pf</i>	T1	
FENTANYL-ROPIVACAINE-0.9% NACL	T1	
<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 carpujct</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

T1 – Typically Generics

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QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

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 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 carpujct</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	
<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>levorphanol tartrate</i>	T1	PA
<i>meperidine hcl</i>	T1	PA
<i>meperidine hcl/pf</i>	T1	PA
<i>methadone hcl</i>	T1	PA
METHADONE HCL-0.9% NAACL	T3	

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T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANALGESICS (Pain Relief And Inflammatory Disease) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPIOID ANALGESICS (cont.)		
MITIGO (morphine sulfate/pf)	T3	PA
MORPHINE 1 MG/2 ML SYRINGE	T3	PA
MORPHINE 1 MG/ML-0.9% NACL SYR (morphine sulfate/0.9% nacl/pf)	T3	PA
MORPHINE 10 MG/0.7 ML AUTO-INJ	T3	PA
<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
<i>morphine 2 mg/2 ml-0.9% nacl</i>	T1	PA
MORPHINE 2 MG/2 ML-0.9% NACL (morphine sulfate/0.9% nacl/pf)	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 (morphine sulfate/0.9% nacl/pf)	T3	PA
<i>morphine 30 mg/30 ml pca vial</i>	T1	PA
<i>morphine 30 mg/30 ml-0.9% nacl</i>	T1	
<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 (morphine sulfate/0.9% nacl/pf)	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
<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

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T3 – Typically Non-Preferred Brands

ST – Step Therapy

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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.)		
<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 (Ms Contin)</i>	T1	PA
<i>morphine sulfate 10 mg/ml vial</i>	T1	PA
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 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	T2	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 (Roxicodone)</i>	T1	PA
<i>oxycodone hcl (ir) 20 mg tab</i>	T1	PA

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List of Prescription Medications

ANALGESICS (Pain Relief And Inflammatory Disease) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPIOID ANALGESICS (cont.)		
<i>oxycodone hcl (ir) 30 mg tab (Roxicodone)</i>	T1	PA
<i>oxycodone hcl (ir) 5 mg cap</i>	T1	PA
<i>oxycodone hcl (ir) 5 mg tablet (Roxicodone)</i>	T1	PA
OXYCODONE HCL 10 MG TABLET	T3	PA
<i>oxycodone hcl 100 mg/5 ml conc</i>	T1	PA
OXYCODONE HCL 15 MG TABLET	T3	PA
OXYCODONE HCL 30 MG TABLET	T3	PA
OXYCODONE HCL 5 MG TABLET	T3	PA
<i>oxycodone hcl 5 mg/5 ml</i>	T1	PA
OXYCODONE HCL ER	T1	PA
OXYCONTIN	T3	PA
<i>oxymorphone hcl</i>	T1	PA
<i>pentazocine hcl/naloxone hcl</i>	T1	PA
ROXICODONE (<i>oxycodone hcl</i>)	T3	PA
ROXYBOND	T3	PA
SUBSYS	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)
TRAMADOL HCL 25 MG TABLET	T3	PA QL(4 TABS/DAY)
TRAMADOL HCL 25 MG/5 ML CUP	T3	PA QL(80 MLS/DAY)
TRAMADOL HCL 5 MG/ML SOLUTION	T3	PA QL(80 MLS/DAY)
<i>tramadol hcl 50 mg tablet</i>	T1	QL(8 TABS/DAY)
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

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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 AND SALICYLATE ANALGESICS, BARBIT, XANTHINE		
<i>codeine/butalbital/asa/caffeine</i>	T1	PA
OPIOID, NON-SALICYL. ANALGESIC, BARBITUATE, XANTHINE		
<i>butalbital/acetamin/caff/codeine</i>	T1	PA
<i>butalbital/acetamin/caff/codeine</i> (Fioricet With Codeine)	T1	PA
FIORICET WITH CODEINE (<i>butalbital/acetamin/caff/codeine</i>)	T3	PA
SKELETAL MUSCLE RELAXANT, SALICYLATE, OPIOID ANALGESIC		
<i>carisoprodol/aspirin/codeine</i>	T1	PA
ANALGESICS (Urinary Tract Conditions)		
URINARY TRACT ANALGESIC AGENTS		
ELMIRON	T2	
RIMSO-50	T2	
ANESTHETICS (Miscellaneous)		
GENERAL ANESTHETICS, INHALANT		
desflurane	T1	
<i>isoflurane</i>	T1	
<i>isoflurane</i>	T3	
sevoflurane (Ultane)	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</i> (Amidate)	T1	
KETALAR (<i>ketamine hcl</i>)	T3	
<i>ketamine hcl</i>	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	

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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		
<i>midazolam hcl</i>	T1	
<i>midazolam hcl/pf</i>	T1	
MIDAZOLAM HCL-0.8% NACL	T3	
MIDAZOLAM HCL-0.9% NACL	T1	
MIDAZOLAM-0.9% NACL	T1	
<i>midazolam hcl/hcl pf</i>	T1	
ANESTHETICS (Pain Relief And Inflammatory Disease)		
LOCAL ANESTHETICS		
ARTICADENT DENTAL	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> (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	
<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	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LOCAL ANESTHETICS (cont.)		
<i>lidocaine hcl/epinephrine/pf (Xylocaine With Epinephrine)</i>	T1	
<i>lidocaine hcl/epinephrine/pf (Xylocaine-Mpf With Epinephrine)</i>	T1	
<i>lidocaine hcl/pf</i>	T1	
<i>lidocaine hcl/pf (Xylocaine-Mpf)</i>	T1	
<i>lidocaine in nacl,iso-osmot/pf</i>	T1	
MARCAINE (<i>bupivacaine hcl/pf</i>)	T3	
MARCAINE-EPINEPHRINE (<i>bupivacaine hcl/epinephrine/pf</i>)	T3	
<i>mepivacaine hcl/pf</i>	T1	
NAROPIN	T3	
NESACAINE-MPF (<i>chloroprocaine hcl/pf</i>)	T3	
ORABLOC	T3	
POLOCAINE	T1	
POSIMIR	T3	
ROPIVACAINE HCL-NACL	T1	
SENSORCAINE 0.25% VIAL (<i>bupivacaine hcl</i>)	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 (<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/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	

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL LOCAL ANESTHETICS		
L.E.T. (LIDO-EPINEPH-TETRA)	T3	
<i>lidocaine</i> (Lidocan li)	T1	PA
<i>lidocaine</i> (Lidoderm)	T1	PA
<i>lidocaine 5% ointment</i>	T1	QL(145 GMS/30 DAYS)
<i>lidocaine 5% patch</i> (Lidocan li) (Lidoderm)	T1	
<i>lidocaine hcl</i>	T1	
<i>lidocaine/prilocaine</i>	T1	
LIDOCAN II (lidocaine)	T3	PA
LIDODERM (lidocaine)	T3	PA
SYNERA	T3	PA
ZTLIDO	T2	
ANESTHETICS (Urinary Tract Conditions)		
URINARY TRACT ANESTHETIC/ANALGESIC AGNT (AZO-DYE)		
<i>phenazopyridine hcl</i> (Pyridium)	T1	
PYRIDIUM (<i>phenazopyridine hcl</i>)	T3	PA
ANTI-ALLERGY (Allergy/Nasal Sprays)		
MAST CELL STABILIZERS		
<i>cromolyn 100 mg/5 ml oral conc</i> (Gastrocrom)	T1	
GASTROCROM (<i>cromolyn sodium</i>)	T3	PA
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		
CUPRIMINE (<i>penicillamine</i>)	T3	PA QL(6 CAPS/DAY) SP
DEPEN (<i>penicillamine</i>)	T3	PA QL(6 TABS/DAY) SP
<i>penicillamine 250 mg capsule</i> (Cuprimine)	T1	PA QL(6 CAPS/DAY) SP
<i>penicillamine 250 mg tablet</i> (Depen)	T1	PA QL(6 TABS/DAY) SP
ANTI-ARTHRITIC, FOLATE ANTAGONIST AGENTS		
OTREXUP	T2	PA
RASUVO	T3	PA
ANTI-INFLAM. INTERLEUKIN-I RECEPTOR ANTAGONIST		
KINERET	T3	PA QL(28 UNITS/28 DAYS) SP

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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
ANTI-INFLAMMATORY, PYRIMIDINE SYNTHESIS INHIBITOR		
ARAVA (<i>leflunomide</i>)	T3	HD
<i>leflunomide</i> (Arava)	T1	HD
ANTI-INFLAMMATORY, PHOSPHODIESTERASE-4(PDE4) INHIB.		
OTEZLA 10-20 MG STARTER 28 DAY	T2	PA QL(55 TABS/365 DAYS) SP HD
OTEZLA 10-20-30MG START 28 DAY	T2	PA QL(55 TABS/365 DAYS) SP HD
OTEZLA 20 MG TABLET	T2	PA QL(2 TABS/DAY) SP HD
OTEZLA 30 MG TABLET	T2	PA QL(2 TABS/DAY) SP HD
OTEZLA XR 75 MG TABLET	T2	PA QL(1 TAB/DAY) SP HD
OTEZLA XR INITIATION PK 28 DAY	T2	PA QL(41 TABS/365 DAYS) SP HD
ANTI-INFLAMMATORY/ANTIARTHRITICS AGENTS, MISC.		
DUROLANE	T2	PA SP HD
EUFLEXXA	T2	PA SP HD
GEL-ONE	T3	PA SP HD
GELSYN-3	T2	PA SP HD
GENVISC 850	T3	PA SP
HYALGAN	T3	PA SP HD
HYMOVIS	T3	PA SP HD
HYMOVIS ONE	T3	PA SP HD
MONOVISC	T3	PA SP HD
ORTHOVISC	T3	PA SP HD
SUPARTZ FX	T3	PA SP HD
SYNOJOYNT	T3	PA SP
SYNVISC	T3	PA SP HD
SYNVISC-ONE	T3	PA SP HD
TRILURON	T3	PA SP HD
TRIVISC	T3	PA SP
VISCO-3	T3	PA SP HD
ANTI-INFLAMMATORY, SEL.COSTIM.MOD., T-CELL INHIBITOR		
ORENCIA 125 MG/ML SYRINGE	T3	PA QL(4 SYR/AUTO-INJ/28 DAYS) SP HD
ORENCIA 250 MG VIAL	T3	PA SP HD
ORENCIA 50 MG/0.4 ML SYRINGE	T3	PA QL(4 SYR/AUTO-INJ/28 DAYS) SP HD
ORENCIA 87.5 MG/0.7 ML SYRINGE	T3	PA QL(4 SYR/AUTO-INJ/28 DAYS) SP HD
ORENCIA CLICKJECT	T3	PA QL(4 SYR/AUTO-INJ/28 DAYS) SP HD

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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
COLCHICINE		
<i>colchicine 0.6 mg capsule (Mitigare)</i>	T1	
<i>colchicine 0.6 mg tablet (Colcrys)</i>	T1	HD
COLCRYS (colchicine)	T3	PA HD
GLOPERBA	T3	PA QL(10 MLS/DAY) HD
MITIGARE (colchicine)	T2	
GOLD SALTS		
RIDAURA	T2	
HYPERURICEMIA TX - URATE-OXIDASE ENZYME-TYPE		
ELITEK	T2	SP
KRYSTEXXA	T3	PA SP
HYPERURICEMIA TX - XANTHINE OXIDASE INHIBITORS		
<i>allopurinol 100 mg tablet (Zyloprim)</i>	T1	HD
<i>allopurinol 200 mg tablet</i>	T1	PA HD
<i>allopurinol 300 mg tablet</i>	T1	HD
<i>allopurinol sodium</i>	T1	
<i>allopurinol sodium</i>	T3	
<i>febuxostat 40 mg tablet (Uloric)</i>	T1	QL(1 TAB/DAY) HD
<i>febuxostat 80 mg tablet (Uloric)</i>	T1	HD
ULORIC 40 MG TABLET (<i>febuxostat</i>)	T3	PA QL(1 TAB/DAY) HD
ULORIC 80 MG TABLET (<i>febuxostat</i>)	T3	PA HD
ZYLOPRIM (<i>allopurinol</i>)	T3	PA HD
JANUS KINASE (JAK) INHIBITORS		
OLUMIANT	T3	PA QL(30 TABS/30 DAYS) SP HD
RINVOQ	T2	PA QL(1 TAB/DAY) SP HD
RINVOQ LQ	T2	PA QL(12 MLS/DAY) SP HD
XELJANZ 1 MG/ML SOLUTION	T2	PA QL(480 MLS/30 DAYS) SP HD
XELJANZ 10 MG TABLET	T2	PA QL(2 TABS/DAY) SP HD
XELJANZ 5 MG TABLET	T2	PA QL(2 TABS/DAY) SP HD
XELJANZ XR	T2	PA QL(1 TAB/DAY) SP HD
NSAID ANALGESIC AND NON-SALICYLATE ANALGESIC COMB		
COMBOGESIC	T3	PA
COMBOGESIC IV	T3	
NSAIDS (COX NON-SPEC.INHIB) AND PROSTAGLANDIN ANALOG		
ARTHROTEC 50 (<i>diclofenac sodium/misoprostol</i>)	T3	ST HD
ARTHROTEC 75 (<i>diclofenac sodium/misoprostol</i>)	T3	ST HD

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NSAIDS (COX NON-SPEC.INHIB) AND PROSTAGLANDIN ANALOG (cont.)		
<i>diclofenac sodium/misoprostol</i> (Arthrotec 50)	T1	HD
<i>diclofenac sodium/misoprostol</i> (Arthrotec 75)	T1	HD
NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE ANALGESICS		
ANAPROX DS (naproxen sodium)	T3	ST HD
CALDOLOR	T3	
COXANTO	T3	PA HD
DAYPRO (<i>oxaprozin</i>)	T3	ST HD
DICLOFENAC	T3	PA HD
<i>diclofenac sod dr 25 mg tab</i>	T1	HD
<i>diclofenac sod dr 50 mg tab</i>	T1	HD
<i>diclofenac sod dr 75 mg tab</i>	T1	HD
<i>diclofenac sod ec 25 mg tab</i>	T1	HD
<i>diclofenac sod ec 50 mg tab</i>	T1	HD
<i>diclofenac sod ec 75 mg tab</i>	T1	HD
diclofenac sodium	T1	HD
EC-NAPROSYN (<i>naproxen</i>)	T3	ST HD
<i>etodolac</i> (Lodine)	T1	HD
FELDENE (<i>piroxicam</i>)	T3	ST HD
FENOPROFEN 200 MG CAPSULE	T1	PA HD
<i>fenoprofen 400 mg capsule</i> (Nalfon)	T1	PA HD
<i>fenoprofen 600 mg tablet</i> (Nalfon)	T1	HD
FENOPRON	T3	PA HD
FENORTHO	T1	PA HD
<i>flurbiprofen</i>	T1	HD
<i>ibuprofen</i>	T1	HD
INDOCIN (<i>indomethacin</i>)	T3	PA HD
indomethacin	T1	HD
INDOMETHACIN 20 MG CAPSULE	T3	PA HD
<i>indomethacin 25 mg capsule</i>	T1	HD
<i>indomethacin 25 mg/5 ml susp</i> (Indocin)	T1	HD
<i>indomethacin 50 mg capsule</i>	T1	HD
<i>indomethacin 50 mg suppository</i> (Indocin)	T1	HD
<i>ketoprofen 25 mg capsule</i>	T1	PA HD
<i>ketoprofen 50 mg capsule</i>	T1	HD
<i>ketoprofen 75 mg capsule</i>	T1	HD

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T3 – Typically Non-Preferred Brands

ST – Step Therapy

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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>ketoprofen er 200 mg capsule</i>	T1	HD
LODINE (<i>etodolac</i>)	T3	ST HD
<i>meclofenamate sodium</i>	T1	HD
<i>meloxicam 10 mg capsule (Vivlodex)</i>	T1	PA HD
<i>meloxicam 15 mg tablet</i>	T1	HD
<i>meloxicam 5 mg capsule (Vivlodex)</i>	T1	PA QL(1 CAP/DAY) HD
<i>meloxicam 7.5 mg tablet</i>	T1	HD
MELOXICAM 7.5 MG/5 ML SUSP	T3	PA HD
nabumetone (Relafen)	T1	HD
NALFON 400 MG CAPSULE (<i>fenoprofen calcium</i>)	T3	PA HD
NALFON 600 MG TABLET (<i>fenoprofen calcium</i>)	T3	ST HD
NAPRELAN (<i>naproxen sodium</i>)	T3	PA HD
NAPROSYN 125 MG/5 ML SUSPEN (<i>naproxen</i>)	T3	PA HD
NAPROSYN 500 MG TABLET (<i>naproxen</i>)	T3	ST HD
<i>naproxen (Ec-Naprosyn)</i>	T1	HD
<i>naproxen 125 mg/5 ml suspen (Naprosyn)</i>	T1	PA 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 (Anaprox Ds)</i>	T1	HD
<i>naproxen sodium (Naprelan)</i>	T1	PA HD
OXAPROZIN 300 MG CAPSULE	T3	PA HD
<i>oxaprozin 600 mg</i>	T1	HD
<i>piroxicam (Feldene)</i>	T1	HD
RELAFEN (nabumetone)	T3	PA HD
RELAFEN DS	T3	PA HD
<i>sulindac</i>	T1	HD
TIVORBEX	T3	PA HD
TOLECTIN 600 (<i>tolmetin sodium</i>)	T3	PA HD
<i>tolmetin sodium</i>	T1	HD
<i>tolmetin sodium (Tolectin 600)</i>	T1	HD

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ST – Step Therapy

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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.)		
VIVLODEX 10 MG CAPSULE (<i>meloxicam, submicronized</i>)	T3	PA HD
VIVLODEX 5 MG CAPSULE (<i>meloxicam, submicronized</i>)	T3	PA QL(1 CAP/DAY) HD
ZORVOLEX	T3	PA HD
NSAIDS, CYCLOOXYGENASE-2(COX-2) SELECTIVE INHIBITOR		
CELEBREX 100 MG CAPSULE (<i>celecoxib</i>)	T3	PA QL(2 CAPS/DAY)
CELEBREX 200 MG CAPSULE (<i>celecoxib</i>)	T3	PA QL(2 CAPS/DAY)
CELEBREX 400 MG CAPSULE (<i>celecoxib</i>)	T3	PA QL(1 CAP/DAY)
CELEBREX 50 MG CAPSULE (<i>celecoxib</i>)	T3	PA QL(2 CAPS/DAY)
<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
URICOSURIC AGENTS		
<i>probenecid</i>	T1	HD
<i>probenecid/colchicine</i>	T1	HD
ANTI-ASTHMATICS (Asthma/COPD/Respiratory)		
5-LIPOXYGENASE INHIBITORS		
<i>zileuton</i>	T1	HD
ZYFLO	T3	PA HD
ANTICHOLINERGICS, ORALLY INHALED LONG ACTING		
INCRUSE ELLIPTA	T2	HD
SPIRIVA HANDIHALER 18 MCG CAP (<i>tiotropium bromide</i>)	T3	PA QL(1 INHALER/30 DAYS) HD
SPIRIVA HANDIHALER 18 MCG CAP (<i>tiotropium bromide</i>)	T3	PA QL(1 INHALER/90 DAYS) HD
SPIRIVA RESPIMAT	T2	QL(1 INHALER/30 DAYS) HD
<i>tiotropium 18 mcg cap-inhaler (Spiriva Handihaler)</i>	T1	QL(1 INHALER/30 DAYS) HD
TUDORZA PRESSAIR 400 MCG INHAL	T3	ST QL(1 INHALER/30 DAYS) HD
YUPELRI	T3	PA HD
ANTICHOLINERGICS, ORALLY INHALED SHORT ACTING		
ATROVENT HFA	T2	QL(2 INHALERS/30 DAYS) HD
<i>ipratropium bromide</i>	T1	HD
BETA-ADRENERGIC AGENTS		
<i>albuterol 2 mg/5 ml syrup cup</i>	T1	HD

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List of Prescription Medications

ANTI-ASTHMATICS (Asthma/COPD/Respiratory) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BETA-ADRENERGIC AGENTS (con't.)		
<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)
ALBUTEROL HFA 90 MCG INHALER	T3	PA 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 (Xopenex Concentrate)</i>	T1	
<i>levalbuterol hcl (Xopenex)</i>	T1	
LEVALBUTEROL TARTRATE HFA	T3	PA QL(15 GMS/30 DAYS)
PROAIR	T3	PA QL(2 INHALERS/30 DAYS)
VENTOLIN HFA	T3	PA QL(1 INHALER/30 DAYS)
XOPENEX (levalbuterol hcl)	T3	
XOPENEX CONCENTRATE (levalbuterol hcl)	T3	
XOPENEX HFA	T3	PA QL(15 GMS/30 DAYS)
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 (Brovana)</i>	T1	QL(4 MLS/DAY) HD
BROVANA (<i>arformoterol tartrate</i>)	T3	PA QL(4 MLS/DAY) HD
<i>formoterol fumarate (Perforomist)</i>	T1	QL(240 MLS/30 DAYS) HD
PERFOROMIST (<i>formoterol fumarate</i>)	T3	PA QL(240 MLS/30 DAYS) HD

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List of Prescription Medications

ANTI-ASTHMATICS (Asthma/COPD/Respiratory) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BETA-ADRENERGIC AGENTS, ORALLY INHALED, LONG ACTING (cont.)		
SEREVENT DISKUS	T3	ST QL(1 BLISTER/30 DAYS) HD
BETA-ADRENERGIC AND ANTICHOLINERGIC COMBO, INHALED		
ANORO ELLIPTA 62.5-25 MCG INH	T2	HD
ANORO ELLIPTA 62.5-25 MCG INH	T2	QL(1 INHALER/30 DAYS) HD
BEVESPI AEROSPHERE	T3	PA QL(1 INHALER/30 DAYS) HD
COMBIVENT RESPIMAT	T2	QL(2 INHALERS/30 DAYS)
DUAKLIR PRESSAIR	T3	PA QL(1 INHALER/30 DAYS) HD
<i>ipratropium/albuterol sulfate</i>	T1	HD
STIOLTO RESPIMAT	T2	QL(1 INHALER/30 DAYS) HD
UMECLIDINIUM-VILANTEROL	T3	PA QL(1 INHALER/30 DAYS) HD
BETA-ADRENERGIC AGENTS AND GLUCOCORTICOID COMBO, INHALED		
ADVAIR 100-50 DISKUS (<i>fluticasone propion/salmeterol</i>)	T3	ST QL(1 INHALER/30 DAYS) HD
ADVAIR 250-50 DISKUS (<i>fluticasone propion/salmeterol</i>)	T3	ST QL(1 INHALER/30 DAYS) HD
ADVAIR 500-50 DISKUS (<i>fluticasone propion/salmeterol</i>)	T3	ST QL(1 INHALER/30 DAYS) HD
ADVAIR HFA 115-21 MCG INHALER	T2	QL(1 INHALER/30 DAYS) HD
ADVAIR HFA 230-21 MCG INHALER	T2	QL(1 INHALER/30 DAYS) HD
ADVAIR HFA 45-21 MCG INHALER	T2	QL(1 INHALER/30 DAYS) HD
AIRDUO RESPICLICK	T3	ST QL(1 INHALER/30 DAYS) HD
AIRSUPRA	T2	QL(2 GMS/28 DAYS) HD
BREO ELLIPTA 100-25 MCG INHALER	T2	QL(1 INHALER/30 DAYS) HD
BREO ELLIPTA 200-25 MCG INHALER	T2	QL(1 INHALER/30 DAYS) HD
BREO ELLIPTA 50-25 MCG INHALER	T2	QL(1 INHALER/30 DAYS) HD
<i>budesonide/formoterol fumarate (Symbicort)</i>	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 (Advair Diskus)</i>	T1	QL(1 INHALER/30 DAYS)
<i>fluticasone-salmeterol 100-50 (Advair Diskus)</i>	T1	QL(1 INHALER/30 DAYS) HD
FLUTICASONE-SALMETEROL 113-14	T3	PA QL(1 INHALER/30 DAYS) HD
FLUTICASONE-SALMETEROL 232-14	T3	PA QL(1 INHALER/30 DAYS) HD
<i>fluticasone-salmeterol 250-50 (Advair Diskus)</i>	T1	QL(1 INHALER/30 DAYS) HD
<i>fluticasone-salmeterol 500-50 (Advair Diskus)</i>	T1	QL(1 INHALER/30 DAYS) HD
FLUTICASONE-SALMETEROL 55-14	T3	PA QL(1 INHALER/30 DAYS) HD
FLUTICASONE-SALMETEROL HFA	T3	PA QL(1 INHALER/30 DAYS) HD
FLUTICASONE-VILANTEROL	T3	PA QL(1 INHALER/30 DAYS) HD

T1 – Typically Generics

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AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTI-ASTHMATICS (Asthma/COPD/Respiratory) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BETA-ADRENERGIC AGENTS AND GLUCOCORTICOID COMBO, INHALED (cont.)		
SYMBICORT 160-4.5 MCG INHALER (<i>budesonide/formoterol fumarate</i>)	T3	ST QL(1 INHALER/30 DAYS) HD
SYMBICORT 80-4.5 MCG INHALER (<i>budesonide/formoterol fumarate</i>)	T3	ST QL(1 INHALER/30 DAYS) HD
BETA-ADRENERGIC-ANTICHOLINERGIC-GLUCOCORT, INHALED		
BREZTRI AEROSPHERE INHALER	T2	QL(1 INHALER/30 DAYS)
TRELEGY ELLIPTA 100-62.5-25	T2	QL(1 BLISTER/30 DAYS)
TRELEGY ELLIPTA 200-62.5-25	T2	QL(1 BLISTER/30 DAYS)
GLUCOCORTICIDS, ORALLY INHALED		
ALVESCO	T2	HD
ARMONAIR DIGIHALER	T3	ST HD
ARNUITY ELLIPTA	T3	ST
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 (Pulmicort)</i>	T1	QL(4 MLS/DAY) HD
<i>budesonide 0.5 mg/2 ml susp (Pulmicort)</i>	T1	QL(4 MLS/DAY) HD
<i>budesonide 1 mg/2 ml inh susp (Pulmicort)</i>	T1	QL(2 MLS/DAY) HD
FLUTICASONE FUROATE	T3	ST HD
FLUTICASONE PROP 100MCG DISKUS	T3	PA QL(1 INHALER/30 DAYS) HD
FLUTICASONE PROP 250 MCG DISK	T3	PA QL(4 INHALERS/30 DAYS) HD
FLUTICASONE PROP 50 MCG DISKUS	T3	PA QL(1 INHALER/30 DAYS) HD
FLUTICASONE PROP HFA 110 MCG	T3	PA QL(1 INHALER/30 DAYS) HD
FLUTICASONE PROP HFA 220 MCG	T3	PA QL(2 INHALERS/30 DAYS) HD
FLUTICASONE PROP HFA 44 MCG	T3	PA QL(1 INHALER/30 DAYS) HD
PULMICORT 0.25 MG/2 ML RESPUL (<i>budesonide</i>)	T3	PA QL(4 MLS/DAY) HD
PULMICORT 0.5 MG/2 ML RESPULE (<i>budesonide</i>)	T3	PA QL(4 MLS/DAY) HD
PULMICORT 1 MG/2 ML RESPULE (<i>budesonide</i>)	T3	PA QL(2 MLS/DAY) HD
PULMICORT FLEXHALER	T3	PA HD
QVAR REDIHALER	T2	
INTERLEUKIN-5(IL-5) RECEPTOR ALPHA ANTAGONIST, MAB		
CINQAIR	T3	PA SP
NUCALA	T2	PA SP HD

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List of Prescription Medications

ANTI-ASTHMATICS (Asthma/COPD/Respiratory) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LEUKOTRIENE RECEPTOR ANTAGONISTS		
ACCOLATE (<i>zafirlukast</i>)	T3	HD
<i>montelukast sodium</i> (Singular)	T1	HD
SINGULAIR (<i>montelukast sodium</i>)	T3	PA
<i>zafirlukast</i> (Accolate)	T1	HD
MAST CELL STABILIZERS, ORALLY INHALED		
<i>cromolyn 20 mg/2 ml neb soln</i>	T1	QL(480 MLS/30 DAYS) HD
MONOCLONAL ANTIBODIES TO IMMUNOGLOBULIN E (IGE)		
XOLAIR	T2	PA SP HD
MUCOLYTICS		
<i>acetylcysteine</i>	T1	
PHOSPHODIESTERASE (PDE) INHIBITORS		
DALIRESP 250 MCG TABLET (<i>roflumilast</i>)	T3	PA QL(28 TABS/180 DAYS) HD
DALIRESP 500 MCG TABLET (<i>roflumilast</i>)	T3	PA QL(2 TABS/DAY) HD
OHTUVAYRE	T3	PA QL(60 MLS/30 DAYS) SP
<i>roflumilast 250 mcg tablet (Daliresp)</i>	T1	QL(28 TABS/180 DAYS) HD
<i>roflumilast 500 mcg tablet (Daliresp)</i>	T1	QL(2 TABS/DAY) HD
XANTHINES		
<i>aminophylline</i>	T1	
ELIXOPHYLLIN	T3	PA HD
THEO-24	T2	HD
<i>theophylline anhydrous</i>	T1	HD
ANTIBIOTICS (Ear Medications)		
EAR PREPARATIONS,ANTIBIOTICS		
CETRAXAL	T3	PA
<i>ciprofloxacin hcl</i>	T1	
CORTISPORIN-TC	T3	
<i>neomycin/polymyxin b/hydrocort</i>	T1	
<i>ofloxacin</i>	T1	
OTIC PREPARATIONS, ANTI-INFLAMMATORY-ANTIBIOTICS		
CIPRO HC	T3	PA
<i>ciprofloxacin hcl/dexameth</i>	T1	
CIPROFLOXACIN HCL-FLUOCINOLONE	T3	PA
<i>ciprofloxacin/hydrocortisone</i>	T1	PA
OTOVEL	T3	

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List of Prescription Medications

ANTIBIOTICS (Eye Medications)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EYE ANTIBIOTIC AND GLUCOCORTICOID COMBINATIONS		
MAXITROL (<i>neomycin/polymyxin b/dexametha</i>)	T3	PA
<i>neomycin/bacit/p-myx/hydrocort</i>	T1	
EYE ANTIBIOTIC AND GLUCOCORTICOID COMBINATIONS		
<i>neomycin/polymyxin b/dexametha</i> (Maxitrol)	T1	
<i>neomycin/polymyxin b/hydrocort</i>	T1	
TOBRADEX	T2	
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	
CILOXAN	T3	PA
<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	
OCUFLOX (<i>ofloxacin</i>)	T3	PA
<i>ofloxacin</i> (Ocuflox)	T1	
<i>polymyxin b sulf/trimethoprim</i>	T1	
<i>tobramycin 0.3% eye drop</i>	T1	
TOBEX	T3	PA

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List of Prescription Medications

ANTIBIOTICS (Eye Medications) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPHTHALMIC ANTIBIOTICS (cont.)		
VIGAMOX (moxifloxacin hcl)	T3	PA
ANTIBIOTICS (Infections)		
2ND GEN. ANAEROBIC ANTIPROTOZOAL-ANTIBACTERIAL		
SOLOSEC	T2	
ABSORBABLE SULFONAMIDE ANTIBACTERIAL AGENTS		
BACTRIM (sulfamethoxazole/trimethoprim)	T3	
BACTRIM DS (sulfamethoxazole/trimethoprim)	T3	
sulfadiazine	T1	
sulfamethoxazole/trimethoprim	T1	
sulfamethoxazole/trimethoprim	T3	
sulfamethoxazole/trimethoprim (Bactrim Ds)	T1	
sulfamethoxazole/trimethoprim (Bactrim)	T1	
AMINOGLYCOSIDE ANTIBIOTICS		
amikacin sulfate	T1	
ARIKAYCE	T3	PA SP
BETHKIS (tobramycin)	T3	PA QL(8 MLS/DAY) SP HD
gentamicin in nacl, iso-osm	T1	
gentamicin sulfate	T1	
GENTAMICIN SULFATE	T1	
GENTAMICIN SULFATE IN NS	T1	
gentamicin sulfate/pf	T1	
KITABIS PAK	T3	PA QL(10 MLS/DAY) SP HD
neomycin sulfate	T1	
STREPTOMYCIN SULFATE	T1	
TOBI (tobramycin in 0.225% sod chlor)	T3	PA QL(10 MLS/DAY) SP HD
TOBI PODHALER	T2	PA QL(8 CAPS/DAY) SP HD
tobramycin 300 mg/4 ml ampule (Bethkis)	T1	PA QL(8 MLS/DAY) SP HD
TOBRAMYCIN PAK 300 MG/5 ML	T3	PA QL (10ml/day) SP HD

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List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AMINOGLYCOSIDE ANTIBIOTICS (cont.)		
<i>tobramycin 300 mg/5 ml ampule (Tobi)</i>	T1	PA QL(10 MLS/DAY) SP HD
TOBRAMYCIN PAK 300 MG/5 ML	T3	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
METRONIDAZOLE 125 MG TABLET	T3	PA
<i>metronidazole 250 mg tablet</i>	T1	
<i>metronidazole 375 mg capsule (Flagyl)</i>	T1	
<i>metronidazole 500 mg tablet</i>	T1	
<i>metronidazole 500 mg/100 ml</i>	T1	
<i>metronidazole/sodium chloride</i>	T3	
<i>metronidazole/sodium chloride</i>	T1	
ANTIBIOTIC, ANTIBACTERIAL, MISC.		
<i>fosfomicin tromethamine</i>	T1	
<i>methenamine hippurate</i>	T1	
<i>methenamine mandelate</i>	T1	
PRIMSOL	T3	
<i>trimethoprim</i>	T1	
ANTIBIOTICS, MISCELLANEOUS, OTHER		
<i>bacitracin</i>	T1	
ANTILEPROTICS		
<i>dapsone 100 mg tablet</i>	T1	
<i>dapsone 25 mg tablet</i>	T1	
THALOMID	T3	PA SP HD
ANTI-MYCOBACTERIUM AGENTS		
<i>ethambutol hcl</i>	T1	HD
<i>isoniazid</i>	T1	HD
MYCOBUTIN (<i>rifabutin</i>)	T3	PA HD
PASER	T2	HD

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List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-MYCOBACTERIUM AGENTS (cont.)		
pyrazinamide	T1	HD
rifabutin (Mycobutin)	T1	HD
ANTI-TUBERCULAR ANTIBIOTICS		
cycloserine	T1	
PRETOMANID	T3	PA QL(1 TAB/DAY)
PRIFTIN	T3	
RIFADIN (rifampin)	T3	
rifampin (Rifadin)	T1	
SIRTURO	T3	SP
BETALACTAMS		
AZACTAM (aztreonam)	T3	
aztreonam (Azactam)	T1	
CAYSTON	T3	PA QL(3 MLS/DAY) SP HD
XACDURO	T3	
CARBAPENEM/PENEM ANTIBIOTICS		
ertapenem sodium	T1	
imipenem/cilastatin sodium	T1	
imipenem/cilastatin sodium (Primaxin)	T1	
meropenem 2 gram vial	T1	
MEROPENEM 2 GRAM VIAL	T3	PA
meropenem iv 1 gm vial	T1	
meropenem iv 500 mg vial	T1	
MEROPENEM-0.9% NACL	T1	
PRIMAXIN (imipenem/cilastatin sodium)	T3	
RECARBRIO	T3	
VABOMERE	T3	
CEPHALOSPORIN ANTIBIOTICS - 1ST GENERATION		
cefadroxil	T1	
cefazolin 1 g/50 ml-dextrose	T1	
cefazolin 1 gm add-van vial	T1	
cefazolin 1 gm vial	T1	
cefazolin 10 gm vial	T1	
CEFAZOLIN 2 G/100 ML-DEXTROSE	T1	
cefazolin 2 g/50 ml-dextrose	T1	
CEFAZOLIN 2 GM VIAL	T3	

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List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CEPHALOSPORIN ANTIBIOTICS - 1ST GENERATION (cont.)		
<i>cefazolin 20 gm bulk vial</i>	T1	
CEFAZOLIN 3 G/150 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	
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>cefpodoxime proxetil</i>	T1	
<i>ceftazidime</i>	T1	
CEFTAZIDIME	T1	
CEFTRIAXONE	T1	
<i>ceftriaxone in is-osm dextrose</i>	T1	
<i>ceftriaxone sodium</i>	T1	

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List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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	
CEPHALOSPORIN ANTIBIOTICS - SIDEROPHORE		
FETROJA	T3	
CHLORAMPHENICOL ANTIBIOTICS AND DERIVATIVES		
<i>chloramphenicol sod succinate</i>	T1	
GLYCYLCYCLINES		
<i>tigecycline (Tygacil)</i>	T1	
TYGACIL (tigecycline)	T3	
LINCOSAMIDE ANTIBIOTICS		
CLEOCIN HCL 150 MG CAPSULE (<i>clindamycin hcl</i>)	T3	
CLEOCIN HCL 300 MG CAPSULE (<i>clindamycin hcl</i>)	T3	
CLEOCIN HCL 75 MG CAPSULE (<i>clindamycin hcl</i>)	T2	
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% NAACL	T1	
LINCOCIN	T3	
<i>lincomycin hcl</i>	T1	
LIPOGLYCOPEPTIDE ANTIBIOTICS		
<i>dalbavancin hcl</i>	T1	
DALVANCE	T3	

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List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LIPOGLYCOPEPTIDE ANTIBIOTICS (cont.)		
KIMYRSA	T3	
ORBACTIV	T3	
VIBATIV	T3	
MACROLIDE ANTIBIOTICS		
<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)
E.E.S. 200 (<i>erythromycin ethylsuccinate</i>)	T3	PA
ERYPED 200 (<i>erythromycin ethylsuccinate</i>)	T3	
ERYPED 400 (<i>erythromycin ethylsuccinate</i>)	T3	PA
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	PA
<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 (nitrofurantoin)	T3	
MACROBID (nitrofurantoin monohyd/m-cryst)	T3	
<i>nitrofurantoin 25 mg/5 ml susp</i> (Furadantin)	T1	
NITROFURANTOIN 50 MG/5 ML SUSP	T3	PA
<i>nitrofurantoin mcr 100 mg cap</i>	T1	
<i>nitrofurantoin mcr 25 mg cap</i>	T1	

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List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NITROFURAN DERIVATIVES ANTIBACTERIAL AGENTS (con't)		
<i>nitrofurantoin mcr 50 mg cap</i>	T1	
<i>nitrofurantoin monohyd/m-cryst (Macrobid)</i>	T1	
OXAZOLIDINONE ANTIBIOTICS		
<i>linezolid (Zyvox)</i>	T1	PA
<i>linezolid 600mg/300ml-0.9%nacl</i>	T1	
LINEZOLID 600MG/300ML-0.9%NACL	T3	
<i>linezolid in dextrose 5% (Zyvox)</i>	T1	
SIVEXTRO 200 MG TABLET	T3	PA
SIVEXTRO 200 MG VIAL	T3	
ZYVOX 100 MG/5 ML SUSPENSION (linezolid)	T3	PA
ZYVOX 200 MG/100 ML-D5W	T3	
ZYVOX 600 MG TABLET (linezolid)	T3	PA
ZYVOX 600 MG/300 ML-D5W (linezolid in dextrose 5%)	T3	
PENICILLIN ANTIBIOTICS		
<i>amoxicillin</i>	T1	
<i>amoxicillin/potassium clav</i>	T1	
<i>ampicillin sod/sulbactam sod (Unasyn)</i>	T1	
<i>ampicillin sodium</i>	T1	
ampicillin trihydrate	T1	
AUGMENTIN (amoxicillin/potassium clav)	T3	PA
AUGMENTIN ES-600 (amoxicillin/potassium clav)	T3	PA
AUGMENTIN XR (amoxicillin/potassium clav)	T3	PA
BICILLIN C-R	T3	
BICILLIN L-A	T3	
<i>dicloxacillin sodium</i>	T1	
EXTENCILLINE	T3	
LENTOCILIN S	T3	
MOXATAG	T3	
<i>nafcillin in dextrose,iso-osm</i>	T1	
<i>nafcillin 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	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PENICILLIN ANTIBIOTICS (con't)		
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 (ampicillin sod/sulbactam sod)	T3	
ZOSYN	T3	
PLEUROMUTILIN DERIVATIVES		
XENLETA 150 MG/15 ML VIAL	T3	
XENLETA 600 MG TABLET	T3	PA QL (10 TABS/30 DAYS)
POLYMYXIN ANTIBIOTICS AND DERIVATIVES		
<i>colistin (colistimethate na)</i> (Coly-mycin M Parenteral)	T1	
COLY-MYCIN M PARENTERAL (<i>colistimethate</i>)	T3	
<i>polymyxin b sulfate</i>	T1	
QUINOLONE ANTIBIOTICS		
AVELOX IV (moxifloxacin-sod.chloride(iso))	T2	
BAXDELA 300 MG VIAL	T3	
BAXDELA 450 MG TABLET	T3	
CIPRO 10% SUSPENSION (ciprofloxacin)	T2	PA
CIPRO 250 MG TABLET (ciprofloxacin hcl)	T3	
CIPRO 5% SUSPENSION (ciprofloxacin)	T2	
CIPRO 500 MG TABLET (ciprofloxacin hcl)	T3	
<i>ciprofloxacin (Cipro)</i>	T1	
<i>ciprofloxacin hcl</i>	T1	
<i>ciprofloxacin hcl (Cipro)</i>	T1	
<i>ciprofloxacin in 5 % dextrose</i>	T1	

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List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
QUINOLONE ANTIBIOTICS		
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		
ACTICLATE (doxycycline hyclate)	T3	ST
<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	
DORYX (doxycycline hyclate)	T3	PA
DORYX MPC	T3	PA
<i>doxycycline 50 mg tablet</i> (Targadox)	T1	
<i>doxycycline hyc dr 100 mg tab</i>	T1	PA
<i>doxycycline hyc dr 150 mg tab</i>	T1	PA
<i>doxycycline hyc dr 200 mg tab</i> (Doryx)	T1	PA
<i>doxycycline hyc dr 50 mg tab</i>	T1	PA
<i>doxycycline hyc dr 75 mg tab</i>	T1	PA
DOXYCYCLINE HYC DR 80 MG TAB	T3	PA
<i>doxycycline hyclate 100 mg cap</i>	T1	
<i>doxycycline hyclate 100 mg tab</i> (Lymepak)	T1	
<i>doxycycline hyclate 100 mg vl</i>	T1	
<i>doxycycline hyclate 150 mg tab</i> (Acticlate)	T1	

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List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TETRACYCLINE ANTIBIOTICS (con't.)		
<i>doxycycline hyclate 50 mg cap</i>	T1	
<i>doxycycline hyclate 75 mg tab (Acticlate)</i>	T1	
<i>doxycycline monohydrate (Oracea)</i>	T1	PA
EMROSI	T3	PA
LYMEPAK (<i>doxycycline hyclate</i>)	T3	PA
MINOCIN	T3	
MINOCYCLINE ER	T3	ST
<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	
MINOLIRA ER	T3	ST
NUZYRA 100 MG VIAL	T3	SP
NUZYRA 150 MG TABLET	T3	PA QL(30 TABS/28 DAYS) SP
ORACEA (<i>doxycycline monohydrate</i>)	T3	PA
SEYSARA	T3	PA
SOLODYN (<i>minocycline hcl</i>)	T3	PA
TARGADOX (<i>doxycycline hyclate</i>)	T3	PA
<i>tetracycline 250 mg capsule</i>	T1	
<i>tetracycline 250 mg tablet</i>	T1	PA
<i>tetracycline 500 mg capsule</i>	T1	
<i>tetracycline 500 mg tablet</i>	T1	PA
XERAVA	T3	
XIMINO	T3	ST
VAGINAL ANTIBIOTICS		
CLEOCIN (<i>clindamycin phosphate</i>)	T3	PA
<i>clindamycin phosphate (Cleocin)</i>	T1	
CLINDESSE	T3	
<i>metronidazole</i>	T1	

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List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TETRACYCLINE ANTIBIOTICS (con't.)		
<i>metronidazole vaginal 0.75% gl</i>	T1	
NUVESSA	T3	PA
XACIATO	T3	PA
FIRVANQ (<i>vancomycin hcl</i>)	T3	PA
TYZAVAN	T3	
VANCOGIN HCL (<i>vancomycin hcl</i>)	T3	PA
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	
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	
VANCOMYCIN 25 MG/ML ORAL SOLN	T3	PA
<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	

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List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VANCOMYCIN ANTIBIOTICS AND DERIVATIVES		
<i>vancomycin hcl 250 mg capsule</i> (Vancocin Hcl)	T1	
<i>vancomycin hcl 5 gm vial</i>	T1	
<i>vancomycin hcl 750 mg vial</i>	T1	
VANCOMYCIN HCL-0.9% NACL	T1	
VANCOMYCIN-D5W 500 MG/100 ML	T1	
ANTIBIOTICS (Miscellaneous)		
CYCLIC LIPOPEPTIDES		
DAPTOMYCIN	T1	
DAPTOMYCIN-0.9% NACL	T3	
ANTIBIOTICS (Skin Conditions)		
TOPICAL ANTIBIOTIC AND ANTI-INFLAMMATORY STEROID		
NEO-SYNALAR	T3	
TOPICAL ANTIBIOTICS		
AMZEEQ	T3	PA
BENZAMYCIN (<i>erythromycin/benzoyl peroxide</i>)	T3	
CENTANY	T3	
CENTANY AT	T3	
CLEOCIN T (<i>clindamycin phosphate</i>)	T3	
CLINDAGEL (<i>clindamycin phosphate</i>)	T3	PA
<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% cream</i>	T1	PA
<i>mupirocin calcium</i>	T1	
XEPI	T3	
ZILXI	T3	PA
TOPICAL SULFONAMIDES		
AVAR-E	T3	PA

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List of Prescription Medications

ANTIBIOTICS (Skin Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL SULFONAMIDES (cont.)		
AVAR-E GREEN	T3	PA
<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	
ANTI-COAGULANTS (Blood Thinners/Anti-Clotting)		
ANTI-COAGULANTS, COUMARIN TYPE		
<i>warfarin sodium</i>	T1	HD
CITRATES AS ANTI-COAGULANTS		
ACD SOLUTION A	T3	
ACD-A	T3	
ANTICOAGULANT SODIUM CITRATE	T3	
CITRATE PHOSPHATE DEXTROSE	T1	
SODIUM CITRATE	T1	
TRICITRASOL	T3	
DIRECT FACTOR XA INHIBITORS		
ELIQUIS	T2	
ELIQUIS SPRINKLE	T2	
<i>rivaroxaban</i> (Xarelto)	T1	
SAVAYSA 15 MG TABLET	T3	PA QL(1 TAB/DAY)
SAVAYSA 30 MG TABLET	T3	PA QL(1 TAB/DAY)
SAVAYSA 60 MG TABLET	T3	PA
XARELTO	T2	
XARELTO (<i>rivaroxaban</i>)	T2	
HEPARIN AND RELATED PREPARATIONS		
ARIXTRA 10 MG/0.8 ML SYRINGE (<i>fondaparinux sodium</i>)	T3	QL(0.8 ML/DAY) SP
ARIXTRA 2.5 MG/0.5 ML SYRINGE (<i>fondaparinux sodium</i>)	T3	QL(0.5 ML/DAY) SP
ARIXTRA 5 MG/0.4 ML SYRINGE (<i>fondaparinux sodium</i>)	T3	QL(0.4 ML/DAY) SP
ARIXTRA 7.5 MG/0.6 ML SYRINGE (<i>fondaparinux sodium</i>)	T3	QL(0.6 ML/DAY) SP

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List of Prescription Medications

ANTI-COAGULANTS (Blood Thinners/Anti-Clotting) (cont.)

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

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List of Prescription Medications

ANTI-COAGULANTS (Blood Thinners/Anti-Clotting) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HEPARIN AND RELATED PREPARATIONS (cont.)		
<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	
LOVENOX 100 MG/ML SYRINGE (<i>enoxaparin sodium</i>)	T3	PA QL(2 SYRINGES/DAY) SP
LOVENOX 120 MG/0.8 ML SYRINGE (<i>enoxaparin sodium</i>)	T3	PA QL(2 SYRINGES/DAY) SP
LOVENOX 150 MG/ML SYRINGE (<i>enoxaparin sodium</i>)	T3	PA QL(2 SYRINGES/DAY) SP
LOVENOX 30 MG/0.3 ML SYRINGE (<i>enoxaparin sodium</i>)	T3	PA QL(2 SYRINGES/DAY) SP
LOVENOX 300 MG/3 ML VIAL (<i>enoxaparin sodium</i>)	T3	PA QL(1 VIAL/DAY) SP
LOVENOX 40 MG/0.4 ML SYRINGE (<i>enoxaparin sodium</i>)	T3	PA QL(2 SYRINGES/DAY) SP
LOVENOX 60 MG/0.6 ML SYRINGE (<i>enoxaparin sodium</i>)	T3	PA QL(2 SYRINGES/DAY) SP
LOVENOX 80 MG/0.8 ML SYRINGE (<i>enoxaparin sodium</i>)	T3	PA QL(2 SYRINGES/DAY) SP
THROMBIN INHIBITORS, SELECTIVE, DIRECT, REVERSIBLE		
ARGATROBAN	T3	SP
<i>argatroban in 0.9 % sod chlor</i>	T1	SP HD
<i>dabigatran etexilate mesylate (Pradaxa)</i>	T1	HD
PRADAXA 110 MG CAPSULE (<i>dabigatran etexilate mesylate</i>)	T3	PA HD
PRADAXA 110 MG PELLETT PACK	T3	PA QL(2 PACKS/DAY) SP
PRADAXA 150 MG CAPSULE (<i>dabigatran etexilate mesylate</i>)	T3	PA HD
PRADAXA 150 MG PELLETT PACK	T3	PA QL(2 PACKS/DAY) SP
PRADAXA 20 MG PELLETT PACK	T3	PA QL(2 PACKS/DAY) SP

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List of Prescription Medications

ANTI-COAGULANTS (Blood Thinners/Anti-Clotting) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
THROMBIN INHIBITORS, SELECTIVE, DIRECT, REVERSIBLE (cont.)		
PRADAXA 30 MG PELLETT PACK	T3	PA QL(4 PACKS/DAY) SP
PRADAXA 40 MG PELLETT PACK	T3	PA QL(4 PACKS/DAY) SP
PRADAXA 50 MG PELLETT PACK	T3	PA QL(4 PACKS/DAY) SP
PRADAXA 75 MG CAPSULE (dabigatran etexilate mesylate)	T3	PA HD
THROMBIN INHIBITORS, SEL, DIRECT, REVERS-HIRUDIN TYPE		
ANGIOMAX (<i>bivalirudin</i>)	T3	
<i>bivalirudin 250 mg vial (Angiomax)</i>	T1	
BIVALIRUDIN RTU 250 MG/50 ML	T3	

ANTIDOTES (Gastrointestinal/Heartburn)

MU-OPIOID RECEPTOR ANTAGONISTS, PERIPHERALLY-ACTING		
MOVANTIK	T2	PA
RELISTOR	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	
<i>naloxone hcl 4 mg nasal spray (Narcan)</i>	T1	QL(2 UNITS/30 DAYS)
<i>naltrexone hcl</i>	T1	QL(180 TABS/30 DAYS)
NARCAN (naloxone hcl)	T2	QL(2 UNITS/30 DAYS)
OPVEE	T3	QL(2 UNITS/30 DAYS)
REXTOVY	T2	QL(2 UNITS/30 DAYS)
ZIMHI	T3	QL(2 SYRINGES/30 DAYS)

ANTI-FUNGALS (Eye Conditions)

OPHTHALMIC ANTI-FUNGAL AGENTS		
NATACYN	T2	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTI-FUNGALS (Feminine Products)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VAGINAL ANTI-FUNGALS		
GYNAZOLE 1	T1	
<i>miconazole nitrate</i>	T1	
<i>terconazole</i>	T1	
ANTI-FUNGALS (Infections)		
ANTI-FUNGAL AGENTS		
ANCOBON (<i>flucytosine</i>)	T3	
<i>clotrimazole</i>	T1	
CRESEMBA 186 MG CAPSULE	T3	PA
CRESEMBA 372 MG VIAL	T3	
CRESEMBA 74.5 MG CAPSULE	T3	PA
DIFLUCAN (<i>fluconazole</i>)	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	
NOXAFIL 40 MG/ML SUSPENSION (<i>posaconazole</i>)	T3	PA
ORAVIG	T3	
<i>posaconazole</i>	T1	
<i>posaconazole (Noxafil)</i>	T1	
SPORANOX (<i>itraconazole</i>)	T3	PA
<i>terbinafine hcl</i>	T1	
TOLSURA	T3	
VFEND (<i>voriconazole</i>)	T3	PA
VIVJOA	T3	PA SP
<i>voriconazole 200 mg tablet (Vfend)</i>	T1	PA
<i>voriconazole 200 mg vial (Vfend lv)</i>	T1	
<i>voriconazole 40 mg/ml susp (Vfend)</i>	T1	PA
<i>voriconazole 50 mg tablet (Vfend)</i>	T1	PA
<i>voriconazole/hpbc</i>	T1	

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List of Prescription Medications

ANTI-FUNGALS (Infections) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-FUNGAL ANTIBIOTICS		
ABELCET	T3	
AMBISOME (amphotericin b liposome)	T3	
amphotericin b liposome (Ambisome)	T1	
BREXAFEMME	T3	PA
CANCIDAS (caspofungin acetate)	T3	
caspofungin acetate (Cancidas)	T1	
ERAXIS	T3	
FULVICIN P-G	T3	PA QL(4 TABS/DAY)
griseofulvin ultra 125 mg tab	T1	
griseofulvin ultra 165 mg tab	T1	QL(4 TABS/DAY)
griseofulvin ultra 250 mg tab	T1	
griseofulvin, microsize	T1	
micafungin sodium (Mycamine)	T1	
MICAFUNGIN-0.9% NACL	T3	
MYCAMINE (micafungin sodium)	T3	
nystatin	T1	
REZZAYO	T3	PA
ANTI-FUNGALS (Skin Conditions)		
TOPICAL ANTI-FUNGAL/ANTI-INFLAMMATORY, STEROID AGENT		
clotrimazole/betamethasone dip	T1	
TOPICAL ANTI-FUNGALS		
ciclodan 0.77% cream (Loprox)	T1	
CICLODAN 0.77% CREAM KIT	T3	
CICLODAN 8% KIT	T3	
ciclodan 8% solution	T1	
ciclopirox olamine (Loprox)	T1	
ciclopirox/urea/camph/men/euc	T1	
econazole nitrate 1% cream	T1	
ECOZA	T3	
ERTACZO	T3	PA
EXELDERM	T3	PA
EXODERM	T1	

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List of Prescription Medications

ANTI-FUNGALS (Skin Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL ANTI-FUNGALS (con't.)		
EXTINA (<i>ketconazole</i>)	T3	PA
JUBLIA	T3	PA
<i>ketconazole</i> (Extina)	T1	
LOPROX 0.77% CREAM (<i>ciclopirox olamine</i>)	T3	PA
LOPROX 0.77% TOPICAL SUSP (<i>ciclopirox olamine</i>)	T3	
LULICONAZOLE	T1	
LUZU	T3	PA
MICONAZOLE-ZINC OXIDE-PETROLTM	T1	PA
<i>naftifine hcl</i> (Naftin)	T1	
NAFTIN (<i>naftifine hcl</i>)	T2	
<i>nystatin</i>	T1	
<i>nystatin/triamcinolone acet</i>	T1	
<i>oxiconazole nitrate</i>	T1	PA
OXISTAT	T2	PA
SULCONAZOLE NITRATE	T3	PA
<i>tavorole</i>	T1	PA
VUSION	T3	PA
XOLEGEL	T3	PA

ANTIHISTAMINE AND DECONGESTANT COMBINATION (Allergy/Nasal Sprays)

1ST GEN ANTIHISTAMINE AND DECONGESTANT COMBINATION

<i>phenylephrine hcl/prometh hcl</i>	T1	
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2ND GEN ANTIHISTAMINE AND DECONGESTANT COMBINATION

CLARINEX-D 12 HOUR	T3	
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ANTIHISTAMINES (Allergy/Nasal Sprays)

ANTIHISTAMINES - 1ST GENERATION

<i>carbinoxamine 4 mg/5 ml liquid</i>	T1	
<i>carbinoxamine maleate 4 mg tab</i>	T1	
<i>carbinoxamine maleate 6 mg tab</i>	T1	PA
CARBINOXAMINE MALEATE ER	T3	PA

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List of Prescription Medications

ANTI-HISTAMINES (Allergy/Nasal Sprays)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-HISTAMINES - 1ST GENERATION		
<i>clemastine 0.5 mg/5 ml syrup</i>	T1	PA
<i>clemastine fum 2.68 mg tablet</i>	T1	
<i>clemastine fumarate</i>	T1	
<i>cyproheptadine hcl</i>	T1	
<i>dexchlorpheniramine maleate (Ryclora)</i>	T1	PA
<i>diphenhydramine hcl</i>	T1	
<i>hydroxyzine hcl</i>	T1	
<i>hydroxyzine pamoate</i>	T1	
<i>hydroxyzine pamoate (Vistaril)</i>	T1	
KARBINAL ER	T3	PA
PHENERGAN (<i>promethazine</i>)	T3	
<i>promethazine hcl (Phenergan)</i>	T1	
RYCLOLA (<i>dexchlorpheniramine maleate</i>)	T3	PA
RYVENT	T3	PA
VISTARIL (<i>hydroxyzine pamoate</i>)	T3	
ANTI-HISTAMINES - 2ND GENERATION		
<i>cetirizine hcl</i>	T1	HD
CLARINEX (<i>desloratadine</i>)	T3	PA HD
DES LorATADINE 0.5 MG/ML SOLN	T3	HD
<i>desloratadine 2.5 mg odt</i>	T1	QL(1 TAB/DAY) HD
<i>desloratadine 5 mg odt</i>	T1	HD
<i>desloratadine 5 mg tablet (Clarinet)</i>	T1	HD
<i>levocetirizine dihydrochloride</i>	T1	HD
QUZYTIR	T3	
ANTI-HISTAMINES (Eye Conditions)		
EYE ANTI-HISTAMINES		
<i>azelastine hcl 0.05% drops</i>	T1	
<i>bepotastine besilate (Bepreve)</i>	T1	
BEPREVE (<i>bepotastine besilate</i>)	T3	PA
<i>epinastine hcl</i>	T1	
<i>olopatadine hcl 0.1% eye drops</i>	T1	
<i>olopatadine hcl 0.2% eye drop</i>	T1	
ZERVIAE	T3	PA

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List of Prescription Medications

ANTI-HYPERGLYCEMICS (Diabetes)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIHYPENGLY, DPP-4 ENZYME INHIB.-THIAZOLIDINEDIONE		
ALOGLIPTIN-PIOGLITAZONE	T3	PA QL(1 TAB/DAY) HD
OSENI	T3	PA QL(1 TAB/DAY) HD
ANTIHYPENGLY, INCRETIN MIMETIC (GLP-I RECEPT.AGONIST)		
BYDUREON BCISE	T2	PA QL(4 MLS/28 DAYS)
BYETTA	T3	PA QL(3 MLS/30 DAYS)
<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)
VICTOZA 2-PAK (liraglutide)	T3	PA QL(3 PENS/30 DAYS)
VICTOZA 3-PAK (liraglutide)	T3	PA QL(3 PENS/30 DAYS)
ANTIHYPENGLY,INSULIN,LONG ACT-GLP-I RECEPT.AGONIST		
SOLIQUA 100-33	T2	
XULTOPHY 100-3.6	T3	PA
ANTIHYPENGLYCEMIC - DOPAMINE RECEPTOR AGONISTS		
CYCLOSET	T3	HD
ANTIHYPENGLYCEMIC - 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)
ANTIHYPENGLYCEMIC, ALPHA-GLUCOSIDASE INHIBITORS		
<i>acarbose</i> (Precose)	T1	HD
<i>miglitol</i>	T1	HD
PRECOSE (acarbose)	T3	HD
ANTIHYPENGLYCEMIC, AMYLIN ANALOG-TYPE		
SYMLINPEN 120	T2	HD
SYMLINPEN 60	T2	
ANTIHYPENGLYCEMIC, BIGUANIDE TYPE		
GLUMETZA (<i>metformin hcl</i>)	T3	PA
<i>metformin hcl</i>	T1	HD

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List of Prescription Medications

ANTI-HYPERGLYCEMICS (Diabetes) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIHYPERGLYCEMIC, BIGUANIDE TYPE (cont.)		
<i>metformin hcl (Glumetza)</i>	T1	PA HD
<i>metformin hcl 1,000 mg tablet</i>	T1	HD
<i>metformin hcl 500 mg/5 ml (Riomet)</i>	T1	HD
METFORMIN HCL 625 MG TABLET	T3	PA HD
<i>metformin hcl 750 mg tablet</i>	T1	HD
METFORMIN HCL 750 MG TABLET	T3	PA HD
<i>metformin hcl 850 mg tablet</i>	T1	HD
RIOMET (<i>metformin hcl</i>)	T3	HD
ANTIHYPERGLYCEMIC, DPP-4 INHIBITORS		
ALOGLIPTIN	T3	PA QL(1 TAB/DAY) HD
JANUVIA	T2	ST QL(1 TAB/DAY) HD
NESINA	T3	PA QL(1 TAB/DAY) HD
ONGLYZA (<i>saxagliptin hcl</i>)	T3	PA QL(1 TAB/DAY) HD
<i>saxagliptin hcl (Onglyza)</i>	T1	QL(1 TAB/DAY) HD
SITAGLIPTIN	T3	PA QL(1 TAB/DAY) HD
TRADJENTA	T3	PA QL(1 TAB/DAY) HD
ZITUVIO	T3	PA 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 (Glucotrol XI)</i>	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
glyburide	T1	HD
<i>glyburide,micronized (Glynase)</i>	T1	HD
GLYNASE (<i>glyburide,micronized</i>)	T3	HD
<i>nateglinide</i>	T1	HD
<i>repaglinide</i>	T1	HD

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List of Prescription Medications

ANTI-HYPERGLYCEMICS (Diabetes) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIHYPERGLYCEMIC, SGLT-2 AND DPP-4 INHIBITOR COMB		
GLYXAMBI	T2	ST QL(1 TAB/DAY) HD
QTERN	T3	ST QL(1 TAB/DAY) HD
STEGLUJAN	T3	ST QL(1 TAB/DAY) HD
ANTIHYPERGLYCEMIC, THIAZOLIDINEDIONE AND BIGUANIDE		
ACTOPLUS MET (pioglitazone hcl/metformin hcl)	T3	HD
<i>pioglitazone hcl/metformin hcl</i>	T1	HD
<i>pioglitazone hcl/metformin hcl (Actoplus Met)</i>	T1	HD
ANTIHYPERGLYCEMIC, THIAZOLIDINEDIONE-SULFONYLUREA		
DUETACT (pioglitazone hcl/glimepiride)	T3	HD
<i>pioglitazone hcl/glimepiride (Duetact)</i>	T1	HD
ANTIHYPERGLYCEMIC, DPP-4 INHIBITOR-BIGUANIDE COMBS.		
ALOGLIPTIN-METFORMIN	T3	PA QL(2 TABS/DAY) 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
JENTADUETO	T3	PA QL(2 TABS/DAY) HD
JENTADUETO XR 2.5 MG-1,000 MG	T3	PA QL(2 TABS/DAY) HD
JENTADUETO XR 5 MG-1,000 MG TB	T3	PA QL(1 TAB/DAY) HD
KAZANO	T3	PA QL(2 TABS/DAY) HD
KOMBIGLYZE XR 2.5-1,000 MG TAB (saxagliptin hcl/metformin hcl)	T3	PA QL(2 TABS/DAY) HD
KOMBIGLYZE XR 5-1,000 MG TAB (saxagliptin hcl/metformin hcl)	T3	PA QL(1 TAB/DAY) HD
KOMBIGLYZE XR 5-500 MG TABLET (saxagliptin hcl/metformin hcl)	T3	PA QL(1 TAB/DAY) HD
<i>linagliptin/metformin hcl</i>	T1	QL(2 TABS/DAY) HD
<i>saxagliptin-metformin er 5-500 (Kombiglyze Xr)</i>	T1	QL(1 TAB/DAY) HD
<i>saxagliptin-metformin er 5-1000 (Kombiglyze Xr)</i>	T1	QL(1 TAB/DAY) HD
<i>saxagliptin-metformin er 2.5-1000 (Kombiglyze Xr)</i>	T1	QL(2 TABS/DAY) HD
SITAGLIPTIN-METFO ER 100-1,000	T3	PA QL(1 TAB/DAY) HD

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List of Prescription Medications

ANTI-HYPERGLYCEMICS (Diabetes) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIHYPERGLYCEMIC,DPP-4 INHIBITOR-BIGUANIDE COMBS.		
SITAGLIPTIN-METFOR ER 50-1,000	T3	PA QL(2 TABS/DAY) HD
SITAGLIPTIN-METFORM ER 50-500	T3	PA QL(1 TAB/DAY) HD
SITAGLIPTIN-METFORMIN	T3	PA QL(2 TABS/DAY) HD
ZITUVIMET	T3	PA QL(2 TABS/DAY) HD
ZITUVIMET XR 100-1,000 MG TAB	T3	PA QL(1 TAB/DAY) HD
ZITUVIMET XR 50-1000 MG TABLET	T3	PA QL(2 TABS/DAY) HD
ZITUVIMET XR 50-500 MG TABLET	T3	PA QL(1 TAB/DAY) HD
ANTIHYPERGLYCEMIC,INSULIN-RELEASE STIM.-BIGUANIDE		
<i>glipizide/metformin hcl</i>	T1	HD
<i>glyburide/metformin hcl</i>	T1	HD
ANTIHYPERGLYCEMIC,THIAZOLIDINEDIONE(PPARG AGONIST)		
ACTOS (pioglitazone hcl)	T3	PA HD
<i>pioglitazone hcl (Actos)</i>	T1	HD
ANTIHYPERGLYCEMIC-GLUCOCORTICOID RECEPTOR BLOCKER		
KORLYM (mifepristone)	T3	PA SP
<i>mifepristone 300 mg tablet (Korlym)</i>	T1	PA SP
ANTIHYPERGLYCEMIC-SGLT2 INHIBITOR-BIGUANIDE COMBS.		
DAPAGLIFLOZIN-METFO ER 10-1000	T3	PA QL(1 TAB/DAY) HD
DAPAGLIFLOZIN-METFOR ER 5-1000	T3	PA QL(2 TABS/DAY) HD
INVOKAMET	T3	PA QL(2 TABS/DAY) HD
INVOKAMET XR	T3	PA QL(2 TABS/DAY) HD
SEGLUROMET	T3	PA 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-SGLT2 INHIBITOR-BIGUANIDE COMBS.		
BRENZAVVY	T3	PA QL(1 TAB/DAY) HD
DAPAGLIFLOZIN	T3	PA QL(1 TAB/DAY) HD

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List of Prescription Medications

ANTI-HYPERGLYCEMICS (Diabetes) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIHYPERTHYCEMIC-SGLT2 INHIBITOR-BIGUANIDE COMBS. (cont.)		
FARXIGA	T2	ST QL(1 TAB/DAY)
INVOKANA	T3	PA QL(1 TAB/DAY) HD
JARDIANCE	T2	ST QL(1 TAB/DAY) HD
STEGLATRO	T3	PA QL(1 TAB/DAY) HD
ANTIHYPERTHYCEMIC-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		
ADMELOG	T3	PA QL(1.5 MLS/DAY) HD
ADMELOG SOLOSTAR	T3	PA QL(1.5 MLS/DAY) HD
AFREZZA 12 UNIT CARTRIDGE	T3	PA QL(12 CRTGS/DAY) HD
AFREZZA 4 UNIT CARTRIDGE	T3	PA QL(36 CRTGS/DAY) HD
AFREZZA 4 UNIT/8 UNIT/12 UNIT	T3	PA QL(6 CRTGS/DAY) HD
AFREZZA 8 UNIT CARTRIDGE	T3	PA QL(18 CRTGS/DAY) HD
AFREZZA 90-4 UNIT / 90-8 UNIT	T3	PA QL(12 CRTGS/DAY) HD
AFREZZA 90-8 UNIT / 90-12 UNIT	T3	PA QL(6 CRTGS/DAY) HD
APIDRA	T3	PA QL(1.5 MLS/DAY) HD
APIDRA SOLOSTAR	T3	PA QL(1.5 MLS/DAY) HD
BASAGLAR KWIKPEN U-100	T2	QL(1.5 MLS/DAY) HD
BASAGLAR TEMPO PEN U-100	T2	QL(1.5 MLS/DAY) HD
FIASP	T3	PA QL(1.5 MLS/DAY) HD
HUMALOG	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
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

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTI-HYPERGLYCEMICS (Diabetes) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
INSULINS (cont.)		
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 ASPART	T3	PA QL(1.5 MLS/DAY) HD
INSULIN ASPART FLEXPEN	T3	PA QL(1.5 MLS/DAY) HD
INSULIN ASPART PENFILL	T3	PA QL(1.5 MLS/DAY) HD
INSULIN ASPART PROT MIX 70-30	T3	PA QL(2 MLS/DAY) HD
INSULIN DEGLUDEC	T3	PA QL(1.5 MLS/DAY) HD
INSULIN DEGLUDEC PEN (U-100)	T3	PA QL(1.5 MLS/DAY) HD
INSULIN DEGLUDEC PEN (U-200)	T3	PA QL(0.9 MLS/DAY) HD
INSULIN GLARGINE	T3	PA QL(1.5 MLS/DAY) HD
INSULIN GLARGINE MAX SOLOSTAR	T3	PA QL(0.6 MLS/DAY) HD
INSULIN GLARGINE SOLOSTAR U100	T3	PA QL(1.5 MLS/DAY) HD
INSULIN GLARGINE SOLOSTAR U300	T3	PA QL(0.6 MLS/DAY) HD
INSULIN GLARGINE-YFGN	T3	PA QL(1.5 MLS/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
KIRSTY	T3	PA QL(1.5 MLS/DAY) HD
KIRSTY PEN	T3	PA QL(1.5 MLS/DAY) HD
LANTUS	T3	PA QL(1.5 MLS/DAY) HD
LANTUS SOLOSTAR	T3	PA QL(1.5 MLS/DAY) HD
LEVEMIR	T3	PA QL(1.5 MLS/DAY) HD
LEVEMIR FLEXPEN	T3	PA QL(1.5 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
MERILOG	T3	PA QL(1.5 MLS/DAY) HD
MERILOG SOLOSTAR	T3	PA QL(1.5 MLS/DAY) HD

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QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTI-HYPERGLYCEMICS (Diabetes) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
INSULINS (cont.)		
NOVOLIN 70-30	T2	QL(2 MLS/DAY) HD
NOVOLIN 70-30 FLEXPEN	T2	QL(2 MLS/DAY) HD
NOVOLIN N	T2	QL(1.5 MLS/DAY) HD
NOVOLIN N FLEXPEN	T2	QL(1.5 MLS/DAY) HD
NOVOLIN R	T2	QL(1.5 MLS/DAY) HD
NOVOLIN R FLEXPEN	T2	QL(1.5 MLS/DAY) HD
NOVOLOG	T3	PA QL(1.5 MLS/DAY) HD
NOVOLOG FLEXPEN	T3	PA QL(1.5 MLS/DAY) HD
NOVOLOG MIX 70-30	T3	PA QL(2 MLS/DAY) HD
NOVOLOG MIX 70-30 FLEXPEN	T3	PA QL(2 MLS/DAY) HD
NOVOLOG PENFILL	T3	PA QL(1.5 MLS/DAY) HD
REZVOGLAR KWIKPEN	T2	QL(1.5 MLS/DAY) HD
SEMGLEE (YFGN)	T3	PA QL(1.5 MLS/DAY) HD
SEMGLEE (YFGN) PEN	T3	PA QL(1.5 MLS/DAY) HD
TOUJEO MAX SOLOSTAR	T3	PA QL(0.6 MLS/DAY) HD
TOUJEO SOLOSTAR	T3	PA QL(0.6 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		
<i>ampicillin sodium</i>	T1	
ANTIINFECTIVES/MISCELLANEOUS (Feminine Products)		
VAGINAL ANTISEPTICS		
<i>acetic acid/oxyquinoline</i> (Relagard)	T1	
RELAGARD (acetic acid/oxyquinoline)	T3	
TRIMO-SAN	T3	
ANTIINFECTIVES/MISCELLANEOUS (Infections)		
AMEBICIDES		
HUMATIN	T3	PA
ANTHELMINTICS		
<i>albendazole</i>	T1	

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List of Prescription Medications

ANTIINFECTIVES/MISCELLANEOUS (Infections) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTHELMINTICS (cont.)		
BILTRICIDE (praziquantel)	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 (ivermectin)	T3	PA
ANTIMALARIAL DRUGS		
ARAKODA	T3	PA
ARTESUNATE	T3	
<i>atovaquone/proguanil hcl</i> (Malarone)	T1	
<i>chloroquine phosphate</i>	T1	
COARTEM	T3	PA QL(24 TABS/30 DAYS)
DARAPRIM (<i>pyrimethamine</i>)	T3	PA SP
<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	
PLAQUENIL (<i>hydroxychloroquine sulfate</i>)	T3	PA
PRIMAQUINE (<i>primaquine phosphate</i>)	T1	
<i>primaquine phosphate</i> (Primaquine)	T1	
<i>pyrimethamine 25 mg tablet</i> (Daraprim)	T1	PA SP
<i>quinine sulfate</i>	T1	
SOVUNA	T3	PA
ANTIPROTOZOAL DRUGS,MISCELLANEOUS		
<i>atovaquone</i> (MeproN)	T1	
BENZNIDAZOLE	T3	
IMPAVIDO	T3	PA
LAMPIT	T3	
MEPRON (<i>atovaquone</i>)	T3	PA
NEBUPENT (<i>pentamidine isethionate</i>)	T3	
PENTAM 300 (<i>pentamidine isethionate</i>)	T3	
<i>pentamidine isethionate</i> (Nebupent) (Pentam 300)	T1	

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List of Prescription Medications

ANTIINFECTIVES/MISCELLANEOUS (Miscellaneous) (cont.)

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		
ABRILADA(CF) 20 MG/0.4 ML SYRN	T3	PA QL(2 PENS/SYRINGES/28 DAYS) SP
ABRILADA(CF) 40 MG/0.8 ML SYRN	T3	PA QL(4 SRNGE KITS/28 DAYS) SP
ABRILADA(CF) PEN	T3	PA QL(4 KITS/28 DAYS) SP
ADALIMUMAB-AACF(CF) (2 PK)	T3	PA QL(4 SRNGE KITS/28 DAYS) SP HD
ADALIMUMAB-AACF(CF) PEN (2 PK)	T3	PA QL(4 KITS/28 DAYS) SP HD
ADALIMUMAB-AACF(CF) PEN CROHNS	T3	PA QL(1 STARTER KIT/365 DAYS) SP HD
ADALIMUMAB-AACF(CF) PEN PS-UV	T3	PA QL(2 KITS/365 DAYS) SP HD
ADALIMUMAB-AATY(CF) 20MG/0.2ML	T3	PA QL(2 PENS/SYRINGES/28 DAYS) SP
ADALIMUMAB-AATY(CF) 40MG/0.4ML	T3	PA QL(4 SRNGE KITS/28 DAYS) SP
ADALIMUMAB-AATY(CF) 80MG/0.8ML	T3	PA QL(2 AUTO-INJS/28 DAYS) SP
ADALIMUMAB-AATY(CF) AI CROHNS	T3	PA QL(3 PENS/365 DAYS) SP
ADALIMUMAB-ADAZ(CF) 10MG/0.1ML	T3	PA QL(2 SYRINGES/28 DAYS) SP
ADALIMUMAB-ADAZ(CF) 20MG/0.2ML	T3	PA QL(2 SYRINGES/28 DAYS) SP
ADALIMUMAB-ADAZ(CF) 40 MG SYRG	T3	PA QL(4 SYRINGES/28 DAYS) SP
ADALIMUMAB-ADAZ(CF) PEN 40 MG	T3	PA QL(4 PENS/28 DAYS) SP
ADALIMUMAB-ADAZ(CF) PEN 80 MG	T3	PA QL(2 PENS/28 DAYS) SP
ADALIMUMAB-ADB(M) 10 MG SYRG	T2	PA QL(2 PENS/SYRINGES/28 DAYS) SP HD
ADALIMUMAB-ADB(M) 20 MG SYRG	T2	PA QL(2 PENS/SYRINGES/28 DAYS) SP HD
ADALIMUMAB-ADB(M) 40 MG SYRG	T2	PA QL(4 SRNGE KITS/28 DAYS) SP HD
ADALIMUMAB-ADB(M) PEN	T2	PA QL(4 KITS/28 DAYS) SP HD
ADALIMUMAB-FKJP(CF) 20 MG SYRG	T3	PA QL(2 PENS/SYRINGES/28 DAYS) SP
ADALIMUMAB-FKJP(CF) 40 MG SYRG	T3	PA QL(4 SRNGE KITS/28 DAYS) SP
ADALIMUMAB-FKJP(CF) PEN	T3	PA QL(4 KITS/28 DAYS) SP
ADALIMUMAB-RYVK(CF)	T2	PA QL(4 SRNGE KITS/28 DAYS) SP HD

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List of Prescription Medications

ANTIINFLAM.TUMOR NECROSIS FACTOR INHIBITING AGENTS (Pain Relief And Inflammatory Disease) (con't)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-INFLAMMATORY TUMOR NECROSIS FACTOR INHIBITOR (con't.)		
ADALIMUMAB-RYVK(CF) AUTOINJECT	T2	PA QL SP HD
AMJEVITA(CF) 10MG/0.2ML SYRING	T3	PA QL(2 SYRINGES/28 DAYS) SP HD
AMJEVITA(CF) 20MG/0.2ML SYRING	T3	PA QL(2 SYRINGES/28 DAYS) SP HD
AMJEVITA(CF) 40MG/0.4ML AUTOIN	T3	PA QL(4 AUTO-INJS/28 DAYS) SP HD
AMJEVITA(CF) 40MG/0.4ML SYRING	T3	PA QL(4 SYRINGES/28 DAYS) SP HD
AMJEVITA(CF) 80MG/0.8ML AUTOIN	T3	PA QL(2 AUTO-INJS/28 DAYS) SP HD
AVSOLA	T2	PA SP HD
CIMZIA (2 PACK)	T2	PA QL(1 KIT/28 DAYS) SP HD
CIMZIA 200 MG/ML SYRINGE KIT	T2	PA QL(2 PENS/SYRINGES/28 DAYS) SP
CIMZIA 2X200 MG/ML(X3)START KT	T2	PA QL(1 STARTER KIT/365 DAYS) SP HD
CYLTEZO(CF) 10 MG/0.2 ML SYRNG	T2	PA QL(2 PENS/SYRINGES/28 DAYS) SP HD
CYLTEZO(CF) 20 MG/0.4 ML SYRNG	T2	PA QL(2 PENS/SYRINGES/28 DAYS) SP HD
CYLTEZO(CF) 40 MG/0.4 ML SYRNG	T2	PA QL(4 SRNGE KITS/28 DAYS) SP HD
CYLTEZO(CF) 40 MG/0.8 ML SYRNG	T2	PA QL(4 SRNGE KITS/28 DAYS) SP HD
CYLTEZO(CF) PEN	T2	PA QL(4 KITS/28 DAYS) SP HD
CYLTEZO(CF) PEN CROHN'S-UC-HS	T2	PA QL(1 STARTER KIT/365 DAYS) SP HD
ENBREL 25 MG/0.5 ML	T2	PA QL(8 MLS/28 DAYS) SP HD
ENBREL 50 MG/ML SYRINGE	T2	PA QL(4 MLS/28 DAYS) SP HD
ENBREL MINI	T2	PA QL(4 MLS/28 DAYS) SP HD
ENBREL SURECLICK	T2	PA QL(4 MLS/28 DAYS) SP HD
HADLIMA	T3	PA QL(4 SYRINGES/28 DAYS) SP HD
HADLIMA PUSHTOUCH	T3	PA QL(4 AUTO-INJS/28 DAYS) SP HD
HADLIMA(CF)	T3	PA QL(4 SYRINGES/28 DAYS) SP HD
HADLIMA(CF) PUSHTOUCH	T3	PA QL(4 AUTO-INJS/28 DAYS) SP HD
HULIO(CF) 20 MG/0.4 ML SYRINGE	T3	PA QL(2 PENS/SYRINGES/28 DAYS) SP
HULIO(CF) 40 MG/0.8 ML SYRINGE	T3	PA QL(4 SRNGE KITS/28 DAYS) SP
HULIO(CF) PEN	T3	PA QL(4 KITS/28 DAYS) SP
HUMIRA	T2	PA QL(4 SRNGE KITS/28 DAYS) SP HD
HUMIRA PEN	T2	PA QL(4 KITS/28 DAYS) SP HD
HUMIRA(CF) 10 MG/0.1 ML SYRING	T2	PA QL(2 PENS/SYRINGES/28 DAYS) SP HD

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List of Prescription Medications

ANTIINFLAM.TUMOR NECROSIS FACTOR INHIBITING AGENTS (Pain Relief And Inflammatory Disease) (con't)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-INFLAMMATORY TUMOR NECROSIS FACTOR INHIBITOR (con't.)		
HUMIRA(CF) 20 MG/0.2 ML SYRING	T2	PA QL(2 PENS/SYRINGES/28 DAYS) SP HD
HUMIRA(CF) 40 MG/0.4 ML SYRING	T2	PA QL(4 SRNGE KITS/28 DAYS) SP HD
HUMIRA(CF) PEN 40 MG/0.4 ML	T2	PA QL(4 KITS/28 DAYS) SP HD
HUMIRA(CF) PEN 80 MG/0.8 ML	T2	PA QL(2 PENS/28 DAYS) SP HD
HUMIRA(CF) PEN CROHN'S-UC-HS	T2	PA QL(1 STARTER KIT/365 DAYS) SP HD
HUMIRA(CF) PEN PSOR-UV-ADOL HS	T2	PA QL(1 STARTER KIT/365 DAYS) SP HD
HYRIMOZ(CF) 10 MG/0.1 ML SYRNG	T3	PA QL(2 SYRINGES/28 DAYS) SP HD
HYRIMOZ(CF) 20 MG/0.2 ML SYRNG	T3	PA QL(2 SYRINGES/28 DAYS) SP HD
HYRIMOZ(CF) 40 MG/0.4 ML SYRNG	T3	PA QL(4 SYRINGES/28 DAYS) SP HD
HYRIMOZ(CF) PEDI CROHN 80 MG	T3	PA QL(3 SYRINGES/365 DAYS) SP HD
HYRIMOZ(CF) PEDI CROHN 80-40MG	T3	PA QL(1 SYRINGE/365 DAYS) SP HD
HYRIMOZ(CF) PEN 40 MG/0.4 ML	T3	PA QL(4 PENS/28 DAYS) SP HD
HYRIMOZ(CF) PEN 80 MG/0.8 ML	T3	PA QL(2 PENS/28 DAYS) SP HD
HYRIMOZ(CF) PEN CROHN-UC START	T3	PA QL(3 PENS/365 DAYS) SP HD
HYRIMOZ(CF) PEN PSORIASIS	T3	PA QL(1 PEN/365 DAYS) SP HD
IDACIO(CF) PEN CROHN'S-UC(6PK)	T3	PA QL(1 STARTER KIT/365 DAYS) SP HD
IDACIO(CF) PEN PSORIASIS (4PK)	T3	PA QL(2 KITS/365 DAYS) SP HD
INFLECTRA	T2	PA SP HD
INFLIXIMAB	T3	PA SP HD
REMICADE	T3	PA SP HD
RENFLEXIS	T3	PA SP HD
SIMLANDI(CF) 20 MG/0.2 ML SYRG	T2	PA QL(2 PENS/SYRINGES/28 DAYS) SP HD
SIMLANDI(CF) 40 MG/0.4 ML SYRG	T2	PA QL(4 SRNGE KITS/28 DAYS) SP HD
SIMLANDI(CF) 80 MG/0.8 ML SYRG	T2	PA QL(2 PENS/SYRINGES/28 DAYS) SP HD
SIMPONI 100 MG/ML PEN INJECTOR	T2	PA QL(1 PEN/28 DAYS) SP HD
SIMPONI 100 MG/ML SYRINGE	T2	PA QL(1 SYRINGE/28 DAYS) SP HD
SIMPONI 50 MG/0.5 ML PEN INJEC	T3	PA QL(1 PEN/28 DAYS) SP HD
SIMPONI 50 MG/0.5 ML SYRINGE	T3	PA QL(1 SYRINGE/28 DAYS) SP HD
SIMPONI ARIA	T2	PA SP HD
YUFLYMA(CF) 20 MG/0.2 ML SYRNG	T3	PA QL(2 PENS/SYRINGES/28 DAYS) SP
YUFLYMA(CF) 40 MG/0.4 ML SYRNG	T3	PA QL(4 SRNGE KITS/28 DAYS) SP
YUFLYMA(CF) 40MG/0.4ML AUTOINJ	T3	PA QL SP

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List of Prescription Medications

ANTIINFLAM.TUMOR NECROSIS FACTOR INHIBITING AGENTS (Pain Relief And Inflammatory Disease) (con't)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-INFLAMMATORY TUMOR NECROSIS FACTOR INHIBITOR (con't.)		
YUFLYMA(CF) 80MG/0.8ML AUTOINJ	T3	PA QL(2 AUTO-INJS/28 DAYS) SP
YUFLYMA(CF) AI CROHN'S-UC-HS	T3	PA QL(3 PENS/365 DAYS) SP
YUSIMRY(CF) PEN	T3	PA QL(4 PENS/28 DAYS) SP
ANTINEOPLASTICS (Cancer)		
ANP - SELECTIVE RETINOID X RECEPTOR AGONISTS (RXR)		
<i>bexarotene 75 mg capsule (Targretin)</i>	T1	PA SP HD CSL
TARGRETIN 75 MG CAPSULE (bexarotene)	T3	PA SP HD CSL
ANTIBIOTIC ANTINEOPLASTICS		
ADRIAMYCIN (<i>doxorubicin hcl</i>)	T3	PA SP
<i>bleomycin sulfate</i>	T1	PA SP
<i>dactinomycin</i>	T1	PA SP
<i>daunorubicin hcl</i>	T1	PA SP
DOXIL (<i>doxorubicin hcl peg-liposomal</i>)	T3	PA SP
<i>doxorubicin hcl (Adriamycin)</i>	T1	PA SP
<i>doxorubicin hcl peg-liposomal (Doxil)</i>	T1	PA SP
ELLENCÉ (<i>epirubicin hcl</i>)	T2	PA SP
<i>epirubicin 200 mg/100 ml vial (Ellence)</i>	T1	PA SP
<i>epirubicin hcl 200 mg vial</i>	T1	SP
IDAMYCIN PFS (<i>idarubicin hcl</i>)	T3	PA SP
<i>idarubicin hcl (Idamycin Pfs)</i>	T1	PA SP
<i>mitomycin</i>	T1	PA SP
<i>valrubicin (Valstar)</i>	T1	SP
VALSTAR (<i>valrubicin</i>)	T2	SP
ZANOSAR	T2	PA SP
ZUSDURI	T3	PA SP
ANTI-CD20 (B LYMPHOCYTE) MONOCLONAL ANTIBODY		
GAZYVA	T3	PA SP
RIABNI	T2	PA SP
RITUXAN	T2	PA SP
RITUXAN HYCELA	T2	PA SP
RUXIENCE	T2	PA SP
TRUXIMA	T2	PA SP

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List of Prescription Medications

ANTINEOPLASTICS (Cancer) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTINEOPLAST HUM VEGF INHIBITOR RECOMB MC ANTIBODY		
ALYMSYS	T3	PA SP
AVASTIN	T2	PA SP
JOBEVNE	T3	PA SP
MVASI	T2	PA SP
VEGZELMA	T3	PA SP
ZIRABEV	T2	PA SP
ANTINEOPLAST,HISTONE DEACETYLASE (HDAC) INHIBITORS		
BELEODAQ	T3	PA SP
ISTODAX	T3	PA SP
<i>romidepsin 10 mg kit</i>	T1	PA SP
<i>romidepsin 10 mg vial</i>	T1	PA SP
ROMIDEPSIN 27.5 MG/5.5 ML VIAL	T3	PA SP
ZOLINZA	T2	PA QL(4 CAPS/DAY) SP HD CSL
ANTINEOPLASTIC - ALKYLATING AGENTS		
ALKERAN 2 MG TABLET (<i>melfalan</i>)	T3	SP CSL
ALKERAN 50 MG VIAL (<i>melfalan</i>)	T3	PA SP
BELRAPZO	T3	PA SP HD
<i>bendamustine 100 mg vial (Treanda)</i>	T1	PA SP
BENDAMUSTINE 100 MG/4 ML VIAL	T1	PA SP HD
<i>bendamustine 25 mg vial (Treanda)</i>	T1	PA SP
BENDEKA	T3	PA SP HD
BICNU (<i>carmustine</i>)	T2	SP
<i>busulfan (Busulfex)</i>	T1	SP
BUSULFEX (<i>busulfan</i>)	T2	SP
<i>carboplatin</i>	T1	PA SP
<i>carmustine 100 mg vial (Bicnu)</i>	T1	SP
CARMUSTINE 300 MG VIAL	T3	SP
CARMUSTINE 50 MG VIAL	T3	SP
<i>cisplatin 100 mg/100 ml vial</i>	T1	PA SP
<i>cisplatin 200 mg/200 ml vial</i>	T1	PA SP
CISPLATIN 50 MG VIAL	T3	PA SP
<i>cisplatin 50 mg/50 ml vial</i>	T1	PA SP
<i>cyclophosphamide 1 gm vial</i>	T1	SP
CYCLOPHOSPHAMIDE 1 GM/10 ML VL	T3	SP
CYCLOPHOSPHAMIDE 1 GM/2 ML VL	T3	PA SP

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTINEOPLASTICS (Cancer) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTINEOPLASTIC - ALKYLATING AGENTS		
CYCLOPHOSPHAMIDE 1 GM/5 ML VL	T3	SP
<i>cyclophosphamide 2 gm vial</i>	T1	SP
CYCLOPHOSPHAMIDE 2 GM/10 ML VL	T3	SP
CYCLOPHOSPHAMIDE 2 GM/20 ML VL	T3	SP
CYCLOPHOSPHAMIDE 2 GM/4 ML VL	T3	PA SP
<i>cyclophosphamide 25 mg capsule</i>	T1	SP HD CSL
<i>cyclophosphamide 50 mg capsule</i>	T1	SP HD CSL
CYCLOPHOSPHAMIDE 50 MG TABLET	T3	PA SP HD CSL
<i>cyclophosphamide 500 mg vial</i>	T1	SP
CYCLOPHOSPHAMIDE 500 MG/2.5 ML	T3	SP
CYCLOPHOSPHAMIDE 500 MG/ML VL	T3	PA SP
EVOMELA	T3	PA SP
FRINDOVYX	T3	PA SP
GLEOSTINE	T2	CSL
GLIADEL	T3	SP CSL
HYDREA (<i>hydroxyurea</i>)	T3	CSL
<i>hydroxyurea</i> (Hydrea)	T1	CSL
IFEX (<i>ifosfamide</i>)	T2	PA SP
<i>ifosfamide</i>	T1	PA SP
<i>ifosfamide</i> (Ifex)	T1	PA SP
IVRA	T3	PA SP
KYXATA	T3	PA SP
LEUKERAN	T2	CSL
<i>lomustine</i>	T1	CSL
<i>melphalan hcl</i> (Alkeran)	T1	PA SP
MYLERAN	T2	CSL
<i>oxaliplatin</i>	T1	PA SP
TEMODAR	T3	PA SP
<i>temozolomide</i>	T1	PA SP HD CSL
TEPADINA (<i>thiotepa</i>)	T3	PA SP
TEPYLUTE	T3	PA SP
<i>thiotepa</i> (Tepadina)	T1	PA SP

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List of Prescription Medications

ANTINEOPLASTICS (Cancer) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTINEOPLASTIC - ALKYLATING AGENTS		
TREANDA (<i>bendamustine hcl</i>)	T3	PA SP
VIVIMUSTA	T3	PA SP
YONDELIS	T3	PA SP
ZEPZELCA	T3	PA SP
ANTINEOPLASTIC - ANTIANDROGENIC AGENTS		
<i>abiraterone acetate</i> (Zytiga)	T1	PA CSL
<i>abiraterone acetate 250 mg tab</i> (Zytiga)	T1	PA SP HD CSL
<i>abiraterone acetate 500 mg tab</i> (Zytiga)	T1	PA SP HD CSL
<i>bicalutamide</i> (Casodex)	T1	CSL
CASODEX (<i>bicalutamide</i>)	T3	CSL
ERLEADA	T2	PA SP HD CSL
EULEXIN (<i>flutamide</i>)	T3	CSL
<i>flutamide</i> (Eulexin)	T1	CSL
NILANDRON (<i>nilutamide</i>)	T3	PA QL(4 TABS/DAY) CSL
<i>nilutamide</i> (Nilandron)	T1	QL(4 TABS/DAY) CSL
NUBEQA	T2	PA SP HD CSL
XTANDI	T2	PA SP HD CSL
YONSA	T3	PA SP HD CSL
ZYTIGA (<i>abiraterone acetate</i>)	T3	PA SP HD CSL
ANTINEOPLASTIC - ANTIBIOTIC AND ANTIMETABOLITE		
VYXEOS	T3	PA SP
ANTINEOPLASTIC - ANTI-CD38 MONOCLONAL ANTIBODY		
DARZALEX	T3	PA SP HD
DARZALEX FASPRO	T3	PA SP
SARCLISA	T3	PA SP
ANTINEOPLASTIC - ANTIMETABOLITES		
ALIMTA (<i>pemetrexed disodium</i>)	T3	PA SP
ARRANON (<i>nelarabine</i>)	T2	PA SP
AVGEMSI	T3	PA SP
AXTLE	T3	PA
<i>azacitidine</i> (Vidaza)	T1	PA SP
<i>capecitabine 150 mg tablet</i> (Xeloda)	T1	PA HD CSL
<i>capecitabine 150 mg tablet</i> (Xeloda)	T1	PA SP HD CSL
<i>capecitabine 500 mg tablet</i> (Xeloda)	T1	PA HD CSL

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List of Prescription Medications

ANTINEOPLASTICS (Cancer) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTINEOPLASTIC - ANTIMETABOLITES		
<i>capecitabine 500 mg tablet (Xeloda)</i>	T1	PA SP HD CSL
<i>cladribine 10 mg/10 ml vial</i>	T1	PA SP
<i>clofarabine</i>	T1	PA SP
<i>cytarabine</i>	T1	PA SP
<i>cytarabine/pf</i>	T1	PA SP
DACOGEN (<i>decitabine</i>)	T3	PA SP
<i>decitabine (Dacogen)</i>	T1	PA SP
<i>floxuridine</i>	T1	PA SP
<i>fludarabine phosphate</i>	T1	PA SP
<i>fluorouracil</i>	T1	PA SP
<i>fluorouracil 1 gram/20 ml vial</i>	T1	PA SP
<i>fluorouracil 2.5 gram/50 ml vl</i>	T1	PA SP
<i>fluorouracil 5 gram/100 ml vl</i>	T1	PA SP
<i>fluorouracil 500 mg/10 ml vial</i>	T1	PA SP
FOLOTYN 20 MG/ML VIAL	T2	PA SP
FOLOTYN 40 MG/2 ML VIAL	T3	PA SP
<i>gemcitabine 1 gram/26.3 ml vl</i>	T1	PA SP
<i>gemcitabine 2 gram/52.6 ml vl</i>	T1	PA SP
<i>gemcitabine 200 mg/5.26 ml vl</i>	T1	PA SP
<i>gemcitabine hcl 1 gram vial</i>	T1	PA SP
GEMCITABINE HCL 1 GRAM/10 ML	T3	PA SP
GEMCITABINE HCL 1.5 GRAM/15 ML	T3	PA SP
<i>gemcitabine hcl 2 gram vial</i>	T1	PA SP
GEMCITABINE HCL 2 GRAM/20 ML	T3	PA SP
<i>gemcitabine hcl 200 mg vial</i>	T1	PA SP
GEMCITABINE HCL 200 MG/2 ML VL	T3	PA SP
INFUGEM	T3	PA SP HD
INLEXZO	T3	PA SP
INQOVI	T3	PA SP HD CSL
JYLAMVO	T3	CSL
LONSURF	T3	PA SP HD CSL
<i>mercaptopurine 20 mg/ml suspen (Purixan)</i>	T1	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

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List of Prescription Medications

ANTINEOPLASTICS (Cancer) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTINEOPLASTIC - ANTIMETABOLITES		
<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>	T1	PA SP
NIPENT	T3	PA SP
ONUREG	T3	PA QL(14 TABS/28 DAYS) SP CSL
PEMETREXED	T3	PA
<i>pemetrexed disodium 1 gm vial</i>	T1	PA SP
PEMETREXED DISODIUM 1 GM/40 ML	T3	PA
<i>pemetrexed disodium 100 mg vl (Alimta)</i>	T1	PA SP
PEMETREXED DISODIUM 100 MG/4ML	T3	PA
<i>pemetrexed disodium 500 mg vl (Alimta)</i>	T1	PA SP
PEMETREXED DISODIUM 500MG/20ML	T3	PA
<i>pemetrexed disodium 750 mg vl</i>	T1	PA SP
PEMETREXED DISODIUM 750 MG VL	T3	PA SP
PEMFEXY	T3	PA
PEMRYDI RTU	T3	PA
PRALATREXATE	T3	PA SP
PURIXAN (<i>mercaptopurine</i>)	T3	SP CSL
TABLOID	T3	CSL
TREXALL	T2	CSL
VIDAZA (<i>azacitidine</i>)	T3	PA SP
XATMEP	T3	CSL
XELODA (<i>capecitabine</i>)	T3	PA SP HD CSL
ANTINEOPLASTIC - ANTI-SLAMF7 MONOCLONAL ANTIBODY		
EMPLICITI	T3	PA SP HD
ANTINEOPLASTIC - AROMATASE INHIBITORS		
<i>anastrozole (Arimidex)</i>	T1	HD PPACA CSL
ARIMIDEX (<i>anastrozole</i>)	T3	HD CSL
AROMASIN (<i>exemestane</i>)	T3	HD CSL
<i>exemestane (Aromasin)</i>	T1	HD PPACA CSL
FEMARA (<i>letrozole</i>)	T3	PA HD CSL
<i>letrozole (Femara)</i>	T1	HD CSL

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List of Prescription Medications

ANTINEOPLASTICS (Cancer) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTINEOPLASTIC - BRAF KINASE INHIBITORS		
BRAFTOVI	T3	PA SP HD CSL
OJEMDA 100 MG TAB (400MG DOSE)	T3	PA QL(1 PACKET/28 Days) SP CSL
OJEMDA 100 MG TAB (500MG DOSE)	T3	PA QL(1 PACKET/28 Days) SP CSL
OJEMDA 100 MG TAB (600MG DOSE)	T3	PA QL(1 PACKET/28 Days) SP CSL
OJEMDA 25 MG/ML ORAL SUSP	T3	PA QL(8 BOTTLES/28 DAYS) SP CSL
TAFINLAR 10 MG TABLET FOR SUSP	T2	PA QL(30 TABS/DAY) SP HD CSL
TAFINLAR 50 MG CAPSULE	T2	PA QL(4 CAPS/DAY) SP HD CSL
TAFINLAR 75 MG CAPSULE	T2	PA QL(4 CAPS/DAY) SP HD CSL
ZELBORAF	T2	PA SP HD CSL
ANTINEOPLASTIC - CD19 (B LYMPHOCYTE) MC ANTIBODY		
MONJUVI	T3	PA SP
ANTINEOPLASTIC - EGFR AND MET RECEPTOR INHIB, MAB		
RYBREVANT	T3	PA SP
ANTINEOPLASTIC - EPOTHILONES AND ANALOGS		
IXEMPRA		
ANTINEOPLASTIC - HEDGEHOG PATHWAY INHIBITOR		
DAURISMO	T3	PA SP HD CSL
ERIVEDGE	T2	PA SP HD CSL
ODOMZO	T2	PA SP HD CSL
ANTINEOPLASTIC - IMMUNOTHERAPY, T-CELL ENGAGER		
KIMMTRAK	T3	PA SP
ANTINEOPLASTIC - IMMUNOTHERAPY, VIRUS-BASED AGENTS		
IMLYGIC	T3	PA SP
ANTINEOPLASTIC - JANUS KINASE (JAK) INHIBITORS		
JAKAFI	T3	PA QL(2 TABS/DAY) SP HD CSL
ANTINEOPLASTIC - KRAS PROTEIN INHIBITOR		
KRAZATI	T3	PA QL(6 TABS/DAY) SP CSL
LUMAKRAS 120 MG TABLET	T3	PA QL(8 TABS/DAY) SP HD CSL
LUMAKRAS 240 MG TABLET	T3	PA QL(4 TABS/DAY) SP HD CSL
LUMAKRAS 320 MG TABLET	T3	PA QL(3 TABS/DAY) SP HD CSL
ANTINEOPLASTIC - MEK KINASE INHIBITORS		
COTELLIC	T2	PA SP HD CSL
GOMEKLI	T3	PA SP CSL
KOSELUGO 10 MG CAPSULE	T3	PA QL(10 CAPS/DAY) SP CSL
KOSELUGO 25 MG CAPSULE	T3	PA QL(4 CAPS/DAY) SP CSL
KOSELUGO 5 MG SPRINKLE CAPSULE	T3	PA QL(20 CAPS/DAY) SP CSL

T1 – Typically Generics

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SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTINEOPLASTICS (Cancer) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTINEOPLASTIC - MEK KINASE INHIBITORS (con't.)		
KOSELUGO 7.5 MG SPRINKLE CAP	T3	PA QL(12 CAPS/DAY) SP CSL
MEKINIST 0.05 MG/ML SOLUTION	T2	PA QL(40 MLS/DAY) SP HD CSL
MEKINIST 0.5 MG TABLET	T2	PA QL(3 TABS/DAY) SP HD CSL
MEKINIST 2 MG TABLET	T2	PA QL(1 TAB/DAY) SP HD CSL
MEKTOVI	T3	PA QL(6 TABS/DAY) SP HD CSL
ANTINEOPLASTIC - MICROTUBULE INHIBITORS		
<i>eribulin mesylate</i> (Halaven)	T1	PA SP
HALAVEN (<i>eribulin mesylate</i>)	T3	PA SP
ANTINEOPLASTIC - MTOR KINASE INHIBITORS		
AFINITOR (<i>everolimus</i>)	T3	PA QL(1 TAB/DAY) SP HD CSL
AFINITOR DISPERZ (<i>everolimus</i>)	T3	PA QL(1 TAB/DAY) SP CSL
<i>everolimus</i> (Afinitor)	T1	PA QL(1 TAB/DAY) SP CSL
<i>everolimus 10 mg tablet</i> (Afinitor)	T1	PA QL(1 TAB/DAY) SP HD CSL
<i>everolimus 2 mg tab for susp</i> (Afinitor Disperz)	T1	PA QL(1 TAB/DAY) SP CSL
<i>everolimus 2.5 mg tablet</i> (Afinitor)	T1	PA QL(1 TAB/DAY) SP HD CSL
<i>everolimus 3 mg tab for susp</i> (Afinitor Disperz)	T1	PA QL(1 TAB/DAY) SP CSL
<i>everolimus 5 mg tab for susp</i> (Afinitor Disperz)	T1	PA QL(1 TAB/DAY) SP CSL
<i>everolimus 5 mg tablet</i> (Afinitor)	T1	PA QL(1 TAB/DAY) SP HD CSL
<i>everolimus 7.5 mg tablet</i> (Afinitor)	T1	PA QL(1 TAB/DAY) SP HD CSL
FYARRO	T3	PA SP
ANTINEOPLASTIC - MTOR KINASE INHIBITORS		
<i>temsirolimus</i> (Torisel)	T1	PA SP
TORISEL (<i>temsirolimus</i>)	T2	PA SP
ANTINEOPLASTIC - PROTEIN METHYLTRANSFERASE INHIBIT		
TAZVERIK	T3	PA SP CSL
ANTINEOPLASTIC - SYSTEMIC ENZYME INHIBITORS COMBS		
AVMAPKI-FAKZYNJA	T3	PA SP CSL
ANTINEOPLASTIC - TOPOISOMERASE I INHIBITORS		
CAMPTOSAR 100 MG/5 ML VIAL (<i>irinotecan hcl</i>)	T2	PA SP
CAMPTOSAR 300 MG/15 ML VIAL	T3	PA SP
CAMPTOSAR 40 MG/2 ML VIAL (<i>irinotecan hcl</i>)	T2	PA SP
HYCAMTIN	T3	PA SP HD CSL
<i>irinotecan hcl</i> (Camptosar)	T1	PA SP
ONIVYDE	T3	PA SP
<i>topotecan hcl</i>	T1	PA SP HD

T1 – Typically Generics

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T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTINEOPLASTICS (Cancer) (con't.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTINEOPLASTIC - VEGF-A,B AND PLGF INHIBITORS		
ZALTRAP	T3	PA SP
ANTINEOPLASTIC - VEGFR ANTAGONIST		
CYRAMZA	T3	PA SP
ANTINEOPLASTIC - VINCA ALKALOIDS		
<i>vinblastine sulfate</i>	T1	PA SP
<i>vincristine sulfate</i>	T1	PA SP
<i>vinorelbine tartrate</i>	T1	PA SP
ANTINEOPLASTIC- CD22 ANTIBODY-CYTOTOXIC ANTIBIOTIC		
BESPOLSA	T3	PA SP
ANTINEOPLASTIC- CD33 ANTIBODY-CYTOTOXIC ANTIBIOTIC		
MYLOTARG	T3	PA SP
ANTINEOPLASTIC COMB - KINASE AND AROMATASE INHIBIT		
KISQALI FEMARA CO-PACK	T2	PA QL(1 TAB/28 DAYS) SP CSL
ANTINEOPLASTIC EGF RECEPTOR BLOCKER MCLON ANTIBODY		
ERBITUX	T2	PA SP
HERCEPTIN	T3	PA SP
HERCEPTIN HYLECTA	T3	PA SP
HERCESSI	T3	PA SP
HERZUMA	T3	PA SP
KANJINTI	T2	PA SP
ANTINEOPLASTIC EGF RECEPTOR BLOCKER MCLON ANTIBODY		
OGIVRI	T2	PA SP
ONTRUZANT	T3	PA SP
PERJETA	T3	PA SP
PHESGO	T3	PA SP HD
PORTRAZZA	T3	PA SP
TRAZIMERA	T2	PA SP
VECTIBIX	T2	PA SP
ANTINEOPLASTIC IMMUNOMODULATOR AGENTS		
<i>lenalidomide</i>	T1	PA QL(1 CAP/DAY) SP HD CSL
POMALYST	T2	PA QL(21 CAPS/28 DAYS) SP HD CSL

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

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

ANTINEOPLASTICS (Cancer) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTINEOPLASTIC IMMUNOMODULATOR AGENTS (cont.)		
REVLIMID	T2	PA QL(1 CAP/DAY) SP HD CSL
ANTINEOPLASTIC LHRH(GNRH) AGONIST,PITUITARY SUPPR.		
CAMCEVI	T3	PA SP
ELIGARD	T3	SP HD
<i>leuprolide acetate</i>	T1	PA SP HD
LEUPROLIDE DEPOT	T3	PA SP
LUPRON DEPOT 22.5 MG 3MO KIT	T3	PA SP HD
LUPRON DEPOT 45 MG 6MO KIT	T3	PA SP HD
LUPRON DEPOT 7.5 MG KIT	T3	PA SP HD
LUPRON DEPOT-4 MONTH KIT	T3	PA SP HD
LUTRATE DEPOT	T3	PA SP
TRELSTAR	T3	SP HD
VABRINTY	T3	PA SP
ZOLADEX	T2	PA SP HD
ANTINEOPLASTIC LHRH(GNRH) ANTAGONIST,PITUIT.SUPPRS		
FIRMAGON	T2	PA SP HD
ORGOVYX	T3	PA SP CSL
ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS		
ALECENSA	T2	PA QL(8 CAPS/DAY) SP HD CSL
ALIQOPA	T3	PA SP
ALUNBRIG 180 MG TABLET	T2	PA QL(1 TAB/DAY) SP CSL
ALUNBRIG 30 MG TABLET	T2	PA QL(2 TABS/DAY) SP CSL
ALUNBRIG 90 MG TABLET	T2	PA QL(1 TAB/DAY) SP CSL
ALUNBRIG 90 MG-180 MG TAB PACK	T2	PA QL(1 TAB/DAY) SP CSL
AUGTYRO 160 MG CAPSULE	T3	PA QL(2 CAPS/DAY) SP CSL
AUGTYRO 40 MG CAPSULE	T3	PA QL(8 CAPS/DAY) SP CSL
AYVAKIT	T3	PA QL(1 TAB/DAY) SP CSL
BALVERSA	T3	PA SP CSL
BORTEZOMIB 1 MG VIAL	T3	PA SP
BORTEZOMIB 2.5 MG VIAL	T3	PA SP
bortezomib 3.5 mg vial (Velcade)	T1	PA SP
BORTEZOMIB 3.5 MG/1.4 ML VIAL	T3	PA SP
BORUZU	T3	PA SP
BOSULIF 100 MG CAPSULE	T3	PA QL(3 CAPS/DAY) SP HD CSL

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T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTINEOPLASTICS (Cancer) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS (con't.)		
BOSULIF 100 MG TABLET	T3	PA QL(3 TABS/DAY) SP HD CSL
BOSULIF 400 MG TABLET	T3	PA QL(1 TAB/DAY) SP HD CSL
BOSULIF 50 MG CAPSULE	T3	PA QL(3 CAPS/DAY) SP HD CSL
BOSULIF 500 MG TABLET	T3	PA QL(1 TAB/DAY) SP HD CSL
BRUKINSA 160 MG TABLET	T2	PA QL(2 TABS/DAY) SP CSL
BRUKINSA 80 MG CAPSULE	T2	PA QL(4 CAPS/DAY) SP CSL
CABOMETYX	T2	PA SP HD CSL
CALQUENCE	T2	PA SP CSL
CAPRELSA 100 MG TABLET	T3	PA QL(2 TABS/DAY) SP CSL
CAPRELSA 300 MG TABLET	T3	PA QL(1 TAB/DAY) SP CSL
COMETRIQ 100 MG DAILY-DOSE PK	T3	PA QL(56 CAPS/28 DAYS) SP HD CSL
COMETRIQ 140 MG DAILY-DOSE PK	T3	PA QL(112 CAPS/28 DAYS) SP HD CSL
COMETRIQ 60 MG DAILY-DOSE PACK	T3	PA QL(84 CAPS/28 DAYS) SP HD CSL
COPIKTRA	T3	PA SP CSL
DANZITEN	T2	PA SP CSL
<i>dasatinib 100 mg tablet (Sprycel)</i>	T1	QL(1 TAB/DAY) SP CSL
<i>dasatinib 100 mg tablet (Sprycel)</i>	T1	QL(1 TAB/DAY) SP HD CSL
<i>dasatinib 140 mg tablet (Sprycel)</i>	T1	QL(1 TAB/DAY) SP CSL
<i>dasatinib 140 mg tablet (Sprycel)</i>	T1	QL(1 TAB/DAY) SP HD CSL
<i>dasatinib 20 mg tablet (Sprycel)</i>	T1	QL(3 TABS/DAY) SP CSL
<i>dasatinib 20 mg tablet (Sprycel)</i>	T1	QL(3 TABS/DAY) SP HD CSL
<i>dasatinib 50 mg tablet (Sprycel)</i>	T1	QL(1 TAB/DAY) SP CSL
<i>dasatinib 50 mg tablet (Sprycel)</i>	T1	QL(1 TAB/DAY) SP HD CSL
<i>dasatinib 70 mg tablet (Sprycel)</i>	T1	QL(2 TABS/DAY) SP CSL
<i>dasatinib 70 mg tablet (Sprycel)</i>	T1	QL(2 TABS/DAY) SP HD CSL
<i>dasatinib 80 mg tablet (Sprycel)</i>	T1	QL(1 TAB/DAY) SP CSL
<i>dasatinib 80 mg tablet (Sprycel)</i>	T1	QL(1 TAB/DAY) SP HD CSL
ENSACOVE 100 MG CAPSULE	T2	PA QL(2 CAPS/DAY) SP CSL

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T2 – Typically Preferred Brands

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CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTINEOPLASTICS (Cancer) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS (con't.)		
ENSACOVE 25 MG CAPSULE	T2	PA QL(9 CAPS/DAY) SP CSL
<i>erlotinib hcl</i>	T1	PA SP HD CSL
FOTIVDA	T3	PA QL(21 CAPS/28 DAYS) SP CSL
FRUZAQLA 1 MG CAPSULE	T2	PA QL(84 CAPS/28 DAYS) SP CSL
FRUZAQLA 5 MG CAPSULE	T2	PA QL(21 CAPS/28 DAYS) SP CSL
GAVRETO	T3	PA QL(4 CAPS/DAY) SP CSL
<i>gefitinib (Iressa)</i>	T1	PA SP HD CSL
GILOTRIF	T3	PA SP HD CSL
GLEEVEC 100 MG TABLET (imatinib mesylate)	T3	PA QL(6 TABS/DAY) SP HD CSL
GLEEVEC 400 MG TABLET (imatinib mesylate)	T3	PA QL(2 TABS/DAY) SP HD CSL
IBRANCE 100 MG CAPSULE	T3	PA QL(21 CAPS/28 DAYS) SP HD CSL
IBRANCE 100 MG TABLET	T3	PA QL(21 TABS/28 DAYS) SP HD CSL
IBRANCE 125 MG CAPSULE	T3	PA QL(21 CAPS/28 DAYS) SP HD CSL
IBRANCE 125 MG TABLET	T3	PA QL(21 TABS/28 DAYS) SP HD CSL
IBRANCE 75 MG CAPSULE	T3	PA QL(21 CAPS/28 DAYS) SP HD CSL
IBRANCE 75 MG TABLET	T3	PA QL(21 TABS/28 DAYS) SP HD CSL
IBTROZI	T3	PA SP CSL
ICLUSIG	T3	PA QL(1 TAB/DAY) SP CSL
<i>imatinib mesylate 100 mg tab (Gleevec)</i>	T1	QL(6 TABS/DAY) SP HD CSL
<i>imatinib mesylate 400 mg tab (Gleevec)</i>	T1	QL(2 TABS/DAY) SP HD CSL
IMBRUVICA 140 MG CAPSULE	T2	PA QL(4 CAPS/DAY) SP CSL
IMBRUVICA 140 MG TABLET	T2	PA QL(1 TAB/DAY) SP CSL
IMBRUVICA 280 MG TABLET	T2	PA QL(1 TAB/DAY) SP CSL
IMBRUVICA 420 MG TABLET	T2	PA QL(1 TAB/DAY) SP CSL
IMBRUVICA 70 MG CAPSULE	T2	PA QL(1 CAP/DAY) SP CSL
IMBRUVICA 70 MG/ML SUSPENSION	T2	PA QL(8 MLS/DAY) SP CSL
IMKELDI	T2	PA SP CSL
INLYTA	T3	PA SP HD CSL
INREBIC	T3	PA SP HD CSL
IRESSA (<i>gefitinib</i>)	T3	PA SP HD CSL
ITOVEBI	T3	PA SP HD CSL
IWILFIN	T3	PA QL(8 TABS/DAY) SP CSL

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTINEOPLASTICS (Cancer) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS (con't.)		
JAYPIRCA 100 MG TABLET	T3	PA QL(2 TABS/DAY) SP CSL
JAYPIRCA 50 MG TABLET	T3	PA QL(1 TAB/DAY) SP CSL
KISQALI 200 MG DAILY DOSE	T2	PA QL(21 TABS/28 DAYS) SP HD CSL
KISQALI 400 MG DAILY DOSE	T2	PA QL(42 TABS/28 DAYS) SP HD CSL
KISQALI 600 MG DAILY DOSE	T2	PA QL(63 TABS/28 DAYS) SP HD CSL
KYPROLIS	T3	PA SP HD
<i>lapatinib ditosylate (Tykerb)</i>	T1	PA QL(6 TABS/DAY) SP HD CSL
LAZCLUZE	T3	PA SP CSL
LENVIMA	T2	PA SP HD CSL
LORBRENA 100 MG TABLET	T3	PA QL(1 TAB/DAY) SP HD CSL
LORBRENA 25 MG TABLET	T3	PA QL(3 TABS/DAY) SP HD CSL
LYNPARZA	T2	PA QL(4 TABS/DAY) SP HD CSL
LYTGOBI 12 MG DOSE (3X 4MG TB)	T3	PA QL(3 TABS/DAY) SP CSL
LYTGOBI 16 MG DOSE (4X 4MG TB)	T3	PA QL(4 TABS/DAY) SP CSL
LYTGOBI 20 MG DOSE (5X 4MG TB)	T3	PA QL(5 TABS/DAY) SP CSL
NERLYNX	T3	PA SP HD CSL
NEXAVAR (<i>sorafenib tosylate</i>)	T3	PA QL(4 TABS/DAY) SP HD CSL
NILOTINIB D-TARTRATE	T3	PA SP CSL
<i>nilotinib hcl (Tasigna)</i>	T1	PA QL(4 CAPS/DAY) SP HD CSL
NINLARO	T3	PA QL(3 CAPS/28 DAYS) SP HD CSL
OGSIVEO 100 MG TABLET	T3	PA QL(2 TABS/DAY) SP CSL
OGSIVEO 150 MG TABLET	T3	PA QL(2 TABS/DAY) SP CSL
OGSIVEO 50 MG TABLET	T3	PA QL(6 TABS/DAY) SP CSL
OJJAARA	T3	PA QL(1 TAB/DAY) SP CSL
<i>pazopanib hcl 200 mg tablet (Votrient)</i>	T1	PA QL(4 TABS/DAY) SP CSL
PEMAZYRE	T3	PA QL(14 TABS/21 DAYS) SP CSL
PIQRAY	T2	PA SP CSL
QINLOCK	T3	PA QL(3 TABS/DAY) SP CSL
RETEVMO 120 MG TABLET	T3	PA QL(2 TABS/DAY) SP HD CSL
RETEVMO 160 MG TABLET	T3	PA QL(2 TABS/DAY) SP HD CSL
RETEVMO 40 MG CAPSULE	T3	PA QL(6 CAPS/DAY) SP HD CSL
RETEVMO 40 MG TABLET	T3	PA QL(3 TABS/DAY) SP HD CSL
RETEVMO 80 MG CAPSULE	T3	PA QL(4 CAPS/DAY) SP HD CSL
RETEVMO 80 MG TABLET	T3	PA QL(2 TABS/DAY) SP HD CSL
REVUFORJ 110 MG TABLET	T3	PA QL(4 TABS/DAY) SP CSL

T1 – Typically Generics

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SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTINEOPLASTICS (Cancer) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS (con't.)		
REVUFORJ 160 MG TABLET	T3	PA QL(2 TABS/DAY) SP CSL
REVUFORJ 25 MG TABLET	T3	PA QL(8 TABS/DAY) SP CSL
ROMVIMZA	T3	PA QL(8 CAPS/28 DAYS) SP CSL
ROZLYTREK	T3	PA SP HD CSL
RUBRACA	T2	PA QL(4 TABS/DAY) SP CSL
RYDAPT	T3	PA SP HD CSL
RYTELO	T3	PA SP
SCEMBLIX 100 MG TABLET	T2	PA SP CSL
SCEMBLIX 20 MG TABLET	T2	PA QL(2 TABS/DAY) SP CSL
SCEMBLIX 40 MG TABLET	T2	PA SP CSL
<i>sorafenib tosylate</i> (Nexavar)	T1	PA QL(4 TABS/DAY) SP HD CSL
SPRYCEL 100 MG TABLET (dasatinib)	T3	PA QL(1 TAB/DAY) SP HD CSL
SPRYCEL 140 MG TABLET (dasatinib)	T3	PA QL(1 TAB/DAY) SP HD CSL
SPRYCEL 20 MG TABLET (dasatinib)	T3	PA QL(3 TABS/DAY) SP HD CSL
SPRYCEL 50 MG TABLET (dasatinib)	T3	PA QL(1 TAB/DAY) SP HD CSL
SPRYCEL 70 MG TABLET (dasatinib)	T3	PA QL(2 TABS/DAY) SP HD CSL
SPRYCEL 80 MG TABLET (dasatinib)	T3	PA QL(1 TAB/DAY) SP HD CSL
STIVARGA	T2	PA QL(84 TABS/28 DAYS) SP HD CSL
<i>sunitinib malate</i> (Sutent)	T1	PA QL(1 CAP/DAY) SP HD CSL
SUTENT (sunitinib malate)	T3	PA QL(1 CAP/DAY) SP HD CSL
TABRECTA	T3	PA QL(4 TABS/DAY) SP HD CSL
TAGRISSO	T3	PA SP HD CSL
TALZENNA 0.1 MG CAPSULE	T3	PA QL(1 CAP/DAY) SP CSL
TALZENNA 0.1 MG SOFTGEL	T3	PA QL(1 CAP/DAY) SP CSL
TALZENNA 0.25 MG CAPSULE	T3	PA QL(1 CAP/DAY) SP CSL
TALZENNA 0.25 MG SOFTGEL	T3	PA QL(1 CAP/DAY) SP CSL
TALZENNA 0.35 MG SOFTGEL	T3	PA QL(1 CAP/DAY) SP CSL
TALZENNA 0.5 MG CAPSULE	T3	PA SP CSL
TALZENNA 0.5 MG SOFTGEL	T3	PA SP CSL
TALZENNA 0.75 MG SOFTGEL	T3	PA SP CSL
TALZENNA 1 MG CAPSULE	T3	PA QL(1 CAP/DAY) SP CSL
TALZENNA 1 MG SOFTGEL	T3	PA QL(1 CAP/DAY) SP CSL
TASIGNA (nilotinib hcl)	T3	PA QL(4 CAPS/DAY) SP HD CSL
TEPMETKO	T3	PA QL(2 TABS/DAY) SP CSL
TRUQAP	T2	PA QL(64 TABS/28 DAYS) SP CSL

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T3 – Typically Non-Preferred Brands

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HD – May require home delivery pharmacy

List of Prescription Medications

ANTINEOPLASTICS (Cancer) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS (con't.)		
TUKYSA	T3	PA SP CSL
TURALIO	T3	PA QL(4 CAPS/DAY) SP CSL
TYKERB (<i>lapatinib ditosylate</i>)	T3	PA QL(6 TABS/DAY) SP HD CSL
VANFLYTA	T3	PA QL(2 TABS/DAY) SP CSL
VELCADE (<i>bortezomib</i>)	T3	PA SP
VERZENIO	T2	PA QL(2 TABS/DAY) SP HD CSL
VITRAKVI	T3	PA SP HD CSL
VIZIMPRO	T3	PA SP HD CSL
VONJO	T3	PA QL(4 CAPS/DAY) SP CSL
VOTRIENT (<i>pazopanib hcl</i>)	T3	PA QL(4 TABS/DAY) SP HD CSL
XALKORI 150 MG PELLETT	T3	PA QL(6 PELLETS/DAY) SP HD CSL
XALKORI 20 MG PELLETT	T3	PA QL(4 PELLETS/DAY) SP HD CSL
XALKORI 200 MG CAPSULE	T3	PA QL(4 CAPS/DAY) SP HD CSL
XALKORI 250 MG CAPSULE	T3	PA QL(4 CAPS/DAY) SP HD CSL
XALKORI 50 MG PELLETT	T3	PA QL(4 PELLETS/DAY) SP HD CSL
XOSPATA	T3	PA SP CSL
ZEJULA	T2	PA QL(1 TAB/DAY) SP CSL
ZYDELIG	T3	PA QL(2 TABS/DAY) SP HD CSL
ZYKADIA	T3	PA QL(3 TABS/DAY) SP HD CSL
ANTINEOPLASTIC, ANTI-PROGRAMMED DEATH-1 (PD-1) MAB		
JEMPERLI	T3	PA SP
KEYTRUDA	T3	PA SP
KEYTRUDA QLEX	T3	PA SP
LIBTAYO	T3	PA SP
LOQTORZI	T3	PA SP
OPDIVO	T3	PA SP HD
OPDIVO QVANTIG	T3	PA SP
TEVIMBRA	T3	PA SP
ZYNYZ	T3	PA SP
ANTINEOPLASTIC-B CELL LYMPHOMA-2(BCL-2) INHIBITORS		
VENCLEXTA	T2	PA SP CSL
VENCLEXTA STARTING PACK	T2	PA SP CSL
ANTINEOPLASTIC-ENZYME INHIB, ANTIANDROGEN COMB.		
AKEEGA	T3	PA QL(2 TABS/DAY) SP CSL

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HD – May require home delivery pharmacy

List of Prescription Medications

ANTI-NEOPLASTICS (Cancer) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTINEOPLASTIC-HYPOXIA INDUCIBLE FACTOR (HIF) INH		
WELIREG	T3	PA QL(3 TABS/DAY) SP CSL
ANTINEOPLASTIC-IMMUNOTHERAPY CHECKPOINT INHIB COMB		
OPDUALAG	T3	PA SP HD
ANTINEOPLASTIC-INTERLEUKIN-6(IL-6)INHIB,ANTIBODY		
SYLVANT	T3	PA SP
ANTINEOPLASTIC-ISOCITRATE DEHYDROGENASE INHIBITORS		
IDHIFA	T3	PA SP HD CSL
REZLIDHIA	T3	PA QL(2 CAPS/DAY) SP CSL
TIBSOVO	T3	PA SP CSL
VORANIGO	T3	PA SP CSL
ANTINEOPLASTICS ANTIBODY/ANTIBODY-DRUG COMPLEXES		
ADCETRIS	T3	PA SP
BIZENGRI	T3	PA SP
BLENREP	T3	PA SP
BLINCYTO	T3	PA SP
COLUMVI	T3	PA SP HD
DATROWAY	T3	PA SP
ELAHERE	T3	PA SP
ELREXFIO	T3	PA SP
EMRELIS	T3	PA SP
ENHERTU	T3	PA SP HD
EPKINLY	T3	PA SP
IMDELLTRA	T3	PA SP
KADCYLA	T3	PA SP
LUNSUMIO	T3	PA SP
LYNOZYFIC	T3	PA SP
PADCEV	T3	PA SP
POLIVY	T3	PA SP HD
POTELIGEO	T3	PA SP
TALVEY	T3	PA SP
TECVAYLI	T3	PA SP

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List of Prescription Medications

ANTI-NEOPLASTICS (Cancer) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTINEOPLASTICS ANTIBODY/ANTIBODY-DRUG COMPLEXES (con't.)		
TIVDAK	T3	PA SP HD
TRODELVY	T3	PA SP
UNITUXIN	T3	PA SP
VYLOY	T3	PA SP
ZEVALIN	T2	PA SP
ZIIHERA	T3	PA SP
ZYNLONTA	T3	PA SP
ANTINEOPLASTICS, MISCELLANEOUS		
ABRAXANE (paclitaxel protein-bound)	T2	PA SP
arsenic trioxide	T1	PA SP
arsenic trioxide (Trisenox)	T1	PA SP
ASPARLAS	T3	SP
BCG (TICE STRAIN)	T3	SP
BEIZRAY-ALBUMIN	T3	PA
dacarbazine	T1	PA SP
DOCEFREZ	T3	PA SP
docetaxel 160 mg/16 ml vial	T1	PA SP
docetaxel 160 mg/8 ml vial	T1	PA SP HD
docetaxel 20 mg/2 ml vial	T1	PA SP
docetaxel 20 mg/ml vial	T1	PA SP
docetaxel 80 mg/4 ml vial	T1	PA SP
docetaxel 80 mg/8 ml vial	T1	PA SP
DOCIVYX	T3	PA SP
ERWINASE	T3	PA SP
ETOPOPHOS	T2	PA SP
etoposide	T1	PA SP
etoposide 1,000 mg/50 ml vial	T1	PA SP
etoposide 100 mg/5 ml vial	T1	PA SP
etoposide 50 mg capsule	T1	SP HD CSL
etoposide 500 mg/25 ml vial	T1	PA SP
JEVTANA	T3	PA SP HD
LYSODREN	T2	CSL
MATULANE	T2	SP CSL
mitoxantrone hcl	T1	PA SP

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List of Prescription Medications

ANTI-NEOPLASTICS (Cancer) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTINEOPLASTICS, MISCELLANEOUS (con't.)		
ONCASPAR	T2	PA SP
<i>paclitaxel</i>	T1	PA SP
<i>paclitaxel protein-bound (Abraxane)</i>	T1	PA SP
RYLAZE	T3	PA SP
<i>tretinoin 10 mg capsule</i>	T1	PA CSL
TRISENOX (<i>arsenic trioxide</i>)	T2	PA SP
ANTINEOPLASTIC-SELECT INHIB OF NUCLEAR EXP (SINE)		
XPOVIO	T3	PA SP CSL
ANTI-PROGRAMMED CELL DEATH-LIGAND 1 (PD-L1) MAB		
BAVENCIO	T3	PA SP
IMFINZI	T3	PA SP
TECENTRIQ	T3	PA SP HD
TECENTRIQ HYBREZA	T3	PA SP HD
UNLOXCYT	T3	PA SP
CYTOTOXIC T-LYMPHOCYTE ANTIGEN(CTLA-4)RMC ANTIBODY		
IMJUDO	T3	PA SP HD
YERVOY	T3	PA SP HD
IMMUNOMODULATORS		
ACTIMMUNE	T2	PA SP HD
ALFERON N	T2	PA SP HD
BESREMI	T3	PA QL(2 SYRINGES/28 DAYS) SP
PROLEUKIN	T2	PA SP
PHOTOACTIVATED, ANTINEOPLASTIC AGENTS (SYSTEMIC)		
PHOTOFRIN	T2	SP
UVADEX	T2	
RADIOACTIVE THERAPEUTIC AGENTS		
AZEDRA DOSIMETRIC	T3	PA SP
AZEDRA THERAPEUTIC	T3	PA SP
SELECTIVE ESTROGEN RECEPTOR MODULATORS (SERMS)		
FARESTON (<i>toremifene citrate</i>)	T3	QL(2 TABS/DAY) HD CSL
FASLODEX (<i>fulvestrant</i>)	T2	PA SP HD
<i>fulvestrant (Faslodex)</i>	T1	PA SP HD
ORSERDU 345 MG TABLET	T3	PA QL(1 TAB/DAY) SP CSL
ORSERDU 86 MG TABLET	T3	PA QL(3 TABS/DAY) SP CSL

T1 – Typically Generics

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List of Prescription Medications

ANTI-NEOPLASTICS (Cancer) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SELECTIVE ESTROGEN RECEPTOR MODULATORS (SERMS)		
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
ANTI-NEOPLASTIC - BRAF KINASE INHIBITORS		
ANTINEOPLASTICS (Skin Conditions)		
PHOTOACT, TOPICAL ANTINEOPLAST, PREMALIGNANT LESIONS		
LEVULAN	T3	SP
TOPICAL ANTINEOPLASTIC PREMALIGNANT LESION AGENTS		
<i>bexarotene 1% gel</i> (Targretin)	T1	SP HD
CARAC	T3	PA
<i>diclofenac sodium 3% gel</i>	T1	PA
EFUDEX (fluorouracil)	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	
KLISYRI	T3	PA QL(5 PACKS/30 DAYS)
PANRETIN	T3	SP HD
TARGRETIN 1% GEL (bexarotene)	T3	PA SP HD
VALCHLOR	T3	SP HD
ANTIPARASITICS (Eye Conditions)		
OPHTHALMIC (EYE) ANTIPARASITICS		
XDEMVY	T2	PA QL(10 MLS/56 DAYS) SP
ANTIPARASITICS (Infections)		
ANTIPARASITICS		
ALINIA 100 MG/5 ML SUSPENSION	T3	
ALINIA 500 MG TABLET (nitazoxanide)	T3	PA
<i>nitazoxanide</i> (Alinia)	T1	

T1 – Typically Generics

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CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTIPARASITICS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL ANTIPARASITICS		
<i>crotamiton</i>	T1	
ELIMITE (<i>permethrin</i>)	T3	
EURAX 10% CREAM	T2	
EURAX 10% LOTION	T3	
<i>lindane</i>	T1	
<i>malathion</i> (Ovide)	T1	
NATROBA (<i>spinosad</i>)	T3	PA
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	PA SP
ANTI-PARKINSON DRUGS (Parkinson's Disease)		
ANTIPARKINSONISM DRUGS,ANTICHOLINERGIC		
<i>benztropine mesylate</i>	T1	HD
<i>trihexyphenidyl hcl</i>	T1	HD
ANTI-PARKINSONISM DRUGS, OTHER		
<i>amantadine hcl</i>	T1	HD
APOKYN	T3	PA SP HD
<i>apomorphine hcl</i>	T1	PA SP
AZILECT 0.5 MG TABLET (<i>rasagiline mesylate</i>)	T3	PA QL(1 TAB/DAY) HD
AZILECT 1 MG TABLET (<i>rasagiline mesylate</i>)	T3	PA HD
<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

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ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTI-PARKINSON DRUGS (Parkinson's Disease) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-PARKINSONISM DRUGS, OTHER (cont.)		
<i>carbidopa-levodopa er 25-100 tab</i>	T1	HD
<i>carbidopa-levodopa er 50-200 tab</i>	T1	HD
CREXONT	T3	ST HD
DHIVY	T3	PA HD
DUOPA	T3	SP HD
<i>entacapone</i>	T1	HD
GOCOVRI	T3	
INBRIJA	T3	PA SP HD
NEUPRO	T3	HD
NOURIANZ	T3	PA QL(1 TAB/DAY) SP HD
ONAPGO	T3	PA QL(20 MLS/DAY) SP
ONGENTYS	T3	PA QL(1 CAP/DAY) HD
<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
VYALEV	T3	PA SP HD
XADAGO	T3	ST HD
ZELAPAR	T3	PA HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTI-PARKINSON DRUGS (Parkinson's Disease) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>carbidopa</i> (Lodosyn)	T1	
LODOSYN (<i>carbidopa</i>)	T3	PA

ANTI-PLATELET DRUGS (Blood Thinners/Anti-Clotting)

PLATELET AGGREGATION INHIBITORS		
AGGRASTAT	T3	
<i>aspirin/dipyridamole</i>	T1	HD
ASPIRIN-OMEPRAZOLE	T3	PA HD
BRILINTA (ticagrelor)	T3	PA 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
EFFIENT (prasugrel hcl)	T3	PA HD
<i>eptifibatide</i>	T1	
EPTIFIBATIDE	T1	
PLAVIX (clopidogrel bisulfate)	T3	PA HD
<i>prasugrel hcl (Effient)</i>	T1	HD
<i>ticagrelor (Brilinta)</i>	T1	HD
<i>tirofiban-0.9% sodium chloride</i>	T1	
YOSPRALA DR 325-40 MG TABLET	T3	PA
YOSPRALA DR 81-40 MG TABLET	T3	PA HD
ZONTIVITY	T3	HD

PLATELET REDUCING AGENTS		
AGRYLIN (anagrelide hcl)	T3	
<i>anagrelide hcl</i>	T1	
<i>anagrelide hcl (Agrylin)</i>	T1	

ANTIVIRALS (AIDS/HIV)

ANTIRETROVIRAL - ANTI-CD4 DOMAIN 2 MONOCLONAL AB		
TROGARZO	T3	PA SP
ANTI-RETROVIRAL - CAPSID INHIBITORS		
SUNLENCA 300 MG TABLET	T3	PA QL(5 TABS/180 DAYS) SP

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List of Prescription Medications

ANTIVIRALS (AIDS/HIV) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-RETROVIRAL - CAPSID INHIBITORS (cont.)		
SUNLENCA 4- 300 MG TABLET	T3	PA QL(5 TABS/180 DAYS) SP
SUNLENCA 463.5 MG/1.5 ML VIAL	T3	PA SP
SUNLENCA 5- 300 MG TABLET	T3	PA QL(5 TABS/180 DAYS) SP
ANTI-RETROVIRAL - INTEGRASE INHIBITOR AND NNRTI COMB.		
CABENUVA	T3	PA SP
JULUCA	T3	SP
ANTI-RETROVIRAL - INTEGRASE INHIBITOR AND NRTI COMB.		
DOVATO	T3	SP
ANTI-RETROVIRAL - NRTIS AND INTEGRASE INHIBITORS COMB		
TRIUMEQ	T2	QL(1 TAB/DAY) SP
TRIUMEQ PD	T2	QL(6 TABS/DAY) SP
ANTI-RETROVIRAL - NUCLEOSIDE, NUCLEOTIDE, PROTEASE INH.		
SYMITUZA	T2	QL(1 TAB/DAY) SP
ANTIVIRALS - HIV-SPEC, NON-PEPTIDIC PROTEASE INHIB		
APTIVUS	T2	PA SP
<i>darunavir</i> (Prezista)	T1	SP
PREZCOBIX	T3	PA SP
PREZISTA 100 MG/ML SUSPENSION	T2	SP
PREZISTA 150 MG TABLET	T2	SP
PREZISTA 600 MG TABLET (<i>darunavir</i>)	T3	PA SP
PREZISTA 75 MG TABLET	T2	SP
PREZISTA 800 MG TABLET (<i>darunavir</i>)	T3	PA SP
ANTIVIRALS - HIV-SPEC, NUCLEOSIDE-NUCLEOTIDE ANALOG		
CIMDUO	T3	PA SP
DESCOVY 120-15 MG TABLET	T2	SP
DESCOVY 200-25 MG TABLET	T2	SP PPACA
<i>emtricitabine-tenofv 100-150mg</i> (Truvada)	T1	SP
<i>emtricitabine-tenofv 133-200mg</i> (Truvada)	T1	SP
<i>emtricitabine-tenofv 167-250mg</i> (Truvada)	T1	SP
<i>emtricitabine-tenofv 200-300mg</i> (Truvada)	T1	SP PPACA
TRUVADA (<i>emtricitabine/tenofovir (tdf)</i>)	T3	PA SP
ANTIVIRALS - HIV-SPEC, NUCLEOSIDE ANALOG, RTI COMB		
<i>abacavir sulfate/lamivudine</i> (Epzicom)	T1	PA SP
COMBIVIR (<i>lamivudine/zidovudine</i>)	T3	PA SP
EPZICOM (<i>abacavir sulfate/lamivudine</i>)	T3	PA SP
<i>lamivudine/zidovudine</i> (Combivir)	T1	SP

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List of Prescription Medications

ANTIVIRALS (AIDS/HIV) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIVIRALS - HIV-SPECIFIC, CCR5 CO-RECEPTOR ANTAG.		
<i>maraviroc</i> (Selzentry)	T1	PA SP
SELZENTRY 150 MG TABLET (maraviroc)	T3	PA SP
SELZENTRY 20 MG/ML ORAL SOLN	T2	PA SP
SELZENTRY 300 MG TABLET (maraviroc)	T3	PA SP
ANTIVIRALS - HIV-SPECIFIC, CD4 ATTACHMENT INHIBITOR		
RUKOBIA	T3	PA QL(2 TABS/DAY) SP
ANTIVIRALS - HIV-SPECIFIC, FUSION INHIBITORS		
FUZEON	T3	PA SP
ANTIVIRALS - HIV-SPECIFIC, NON-NUCLEOSIDE, RTI		
EDURANT	T3	PA SP
EDURANT PED	T3	PA SP
ANTIVIRALS - HIV-SPECIFIC, NON-NUCLEOSIDE, RTI (cont.)		
<i>efavirenz</i>	T1	PA SP
<i>etravirine</i> (Intelence)	T1	SP
INTELENCE (etravirine)	T3	PA SP
<i>nevirapine</i>	T1	PA SP
PIFELTRO	T3	PA SP
ANTIVIRALS - HIV-SPECIFIC, NUCLEOSIDE ANALOG, RTI		
<i>abacavir sulfate</i>	T1	PA SP
<i>abacavir sulfate</i> (Ziagen)	T1	PA SP
<i>didanosine</i>	T1	PA SP
<i>emtricitabine</i> (Emtriva)	T1	SP
EMTRIVA 10 MG/ML SOLUTION	T2	PA SP
EMTRIVA 200 MG CAPSULE (emtricitabine)	T3	PA SP
EPIVIR (lamivudine)	T3	PA SP
<i>lamivudine 10 mg/ml oral soln</i> (EpiVir)	T1	SP
<i>lamivudine 150 mg tablet</i> (EpiVir)	T1	SP
<i>lamivudine 300 mg tablet</i> (EpiVir)	T1	PA SP
<i>lamivudine 300 mg/30ml sol cup</i> (EpiVir)	T1	SP
RETROVIR (<i>zidovudine</i>)	T3	PA SP
<i>stavudine</i>	T1	PA SP
ZIAGEN (<i>abacavir sulfate</i>)	T3	PA SP
<i>zidovudine</i>	T1	SP

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List of Prescription Medications

ANTIVIRALS (AIDS/HIV) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIVIRALS - HIV-SPECIFIC, NUCLEOSIDE ANALOG, RTI		
<i>zidovudine</i> (Retrovir)	T1	SP
<i>tenofovir disoproxil fumarate</i> (Viread)	T1	PA SP
VIREAD 150 MG TABLET	T2	PA SP
VIREAD 200 MG TABLET	T2	PA SP
VIREAD 250 MG TABLET	T2	PA SP
VIREAD 300 MG TABLET (tenofovir disoproxil fumarate)	T3	PA SP
VIREAD POWDER	T2	PA SP
ANTIVIRALS, HIV-SPECIFIC, PROTEASE INHIBITOR COMB		
KALETRA (lopinavir/ritonavir)	T3	PA SP
<i>lopinavir/ritonavir</i> (Kaletra)	T1	SP
<i>atazanavir sulfate</i>	T1	PA SP
<i>atazanavir sulfate</i> (Reyataz)	T1	PA SP
EVOTAZ	T3	PA SP
<i>fosamprenavir calcium</i>	T1	PA SP
NORVIR 100 MG POWDER PACKET	T2	SP
NORVIR 100 MG TABLET (<i>ritonavir</i>)	T3	PA SP
REYATAZ 200 MG CAPSULE (<i>atazanavir sulfate</i>)	T3	PA SP
REYATAZ 300 MG CAPSULE (<i>atazanavir sulfate</i>)	T3	PA SP
REYATAZ 50 MG POWDER PACKET	T2	PA SP
<i>ritonavir</i> (Norvir)	T1	SP
VIRACEPT	T2	PA SP
ANTIVIRALS - HIV-I INTEGRASE STRAND TRANSFER INHIBTR		
APRETUDE	T2	SP PPACA
ISENTRESS	T2	SP
ISENTRESS HD	T2	PA SP
TIVICAY	T2	SP
TIVICAY PD	T2	SP
ARTV NUCLEOSIDE, NUCLEOTIDE, NON-NUCLEOSIDE RTI COMB		
COMPLERA (<i>emtricitabine/rilpivirine/tenofovir DF</i>)	T3	PA QL(1 TAB/DAY) SP
DELSTRIGO	T3	PA QL(1 TAB/DAY) SP
<i>efavirenz/emtricitabine/tenofovir DF</i>	T1	QL(1 TAB/DAY) SP
<i>efavirenz/lamivudine/tenofovir DF</i> (Symfi Lo)	T1	QL(1 TAB/DAY) SP

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List of Prescription Medications

ANTIVIRALS (AIDS/HIV) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ARTV NUCLEOSIDE, NUCLEOTIDE, NON-NUCLEOSIDE RTI COMB (cont.)		
<i>efavirenz/lamivu/tenofov disop (Symfi)</i>	T1	QL(1 TAB/DAY) SP
<i>emtricitra/rilpivirine/tenof df (Complera)</i>	T1	QL(1 TAB/DAY) SP
ODEFSEY	T3	PA QL(1 TAB/DAY) SP
SYMFI (<i>efavirenz/lamivu/tenofov disop</i>)	T3	PA QL(1 TAB/DAY) SP
SYMFI LO (<i>efavirenz/lamivu/tenofov disop</i>)	T3	PA QL(1 TAB/DAY) SP
ARV-NUCLEOSIDE, NUCLEOTIDE RTI, INTEGRASE INHIBITORS		
BIKTARVY	T2	QL(1 TAB/DAY) SP
GENVOYA	T2	QL(1 TAB/DAY) SP
STRIBILD	T3	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		
SYNAGIS	T3	PA SP HD
ANTIVIRAL MONOCLONAL ANTIBODIES		
BEYFORTUS	T3	PPACA
ENFLONIA	T3	PPACA
EVUSHELD (EUA)	T3	
SYNAGIS	T3	PA SP HD
<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>	T1	SP
<i>famciclovir</i>	T1	
FLUMADINE (rimantadine hcl)	T3	

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List of Prescription Medications

ANTIVIRALS (Infections) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIVIRALS, GENERAL (cont.)		
<i>foscarnet sodium</i> (Foscavir)	T1	
FOSCAVIR (<i>foscarnet sodium</i>)	T3	
GANCICLOVIR	T3	SP
<i>ganciclovir sodium</i>	T1	SP
LIVTENCITY	T3	PA QL(4 TABS/DAY) SP
<i>oseltamivir 6 mg/ml suspension</i> (Tamiflu)	T1	QL(180 MLS/30 DAYS)
<i>oseltamivir phos 30 mg capsule</i> (Tamiflu)	T1	QL(20 CAPS/30 DAYS)
<i>oseltamivir phos 45 mg capsule</i> (Tamiflu)	T1	QL(10 CAPS/30 DAYS)
<i>oseltamivir phos 75 mg capsule</i> (Tamiflu)	T1	QL(10 CAPS/30 DAYS)
PREVMIS 120 MG PELLETT PACKET	T3	SP
PREVMIS 20 MG PELLETT PACKET	T3	SP
PREVMIS 240 MG TABLET	T3	SP HD
PREVMIS 240 MG/12 ML VIAL	T3	SP
PREVMIS 480 MG TABLET	T3	SP HD
PREVMIS 480 MG/24 ML VIAL	T3	SP
RAPIVAB	T3	
RELENZA	T3	QL(20 BLISTERS/30 DAYS)
<i>rimantadine hcl</i> (Flumadine)	T1	
SITAVIG	T3	PA QL(2 TABS/30 DAYS)
TAMIFLU 30 MG CAPSULE (oseltamivir phosphate)	T3	QL(20 CAPS/30 DAYS)
TAMIFLU 45 MG CAPSULE (oseltamivir phosphate)	T3	QL(10 CAPS/30 DAYS)
TAMIFLU 6 MG/ML SUSPENSION (oseltamivir phosphate)	T3	QL(180 MLS/30 DAYS)
TAMIFLU 75 MG CAPSULE (oseltamivir phosphate)	T3	QL(10 CAPS/30 DAYS)
TEMBEXA	T3	
<i>valacyclovir hcl</i> (Valtrex)	T1	
VALCYTE (valganciclovir hcl)	T3	PA
<i>valganciclovir hcl</i> (Valcyte)	T1	
VALTREX (valacyclovir hcl)	T3	
XOFLUZA	T3	QL(2 TABS/30 DAYS)
HEP C - NS5A, NS3/4A, NON-NUCLEO.NS5B INHIB COMB.		
VOSEVI	T2	PA QL(1 TAB/DAY) SP HD
HEP C VIRUS, NUCLEOTIDE ANALOG NS5B POLYMERASE INH		
SOVALDI 150 MG PELLETT PACKET	T3	PA QL(1 PACK/DAY) SP HD

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List of Prescription Medications

ANTIVIRALS (Infections) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HEP C VIRUS, NUCLEOTIDE ANALOG NS5B POLYMERASE INH (cont.)		
SOVALDI 200 MG PELLETT PACKET	T3	PA QL(1 PACK/DAY) SP HD
SOVALDI 200 MG TABLET	T3	PA QL(1 TAB/DAY) SP HD
SOVALDI 400 MG TABLET	T3	PA QL(1 TAB/DAY) SP HD
HEP C VIRUS-NS5B POLYMERASE AND NS5A INHIB. COMBO.		
EPCLUSA 150-37.5 MG PELLETT PKT	T2	PA QL(1 PACK/DAY) SP HD
EPCLUSA 200 MG-50 MG TABLET	T2	PA QL(1 TAB/DAY) SP HD
EPCLUSA 200-50 MG PELLETT PACK	T2	PA QL(1 PACK/DAY) SP HD
EPCLUSA 400 MG-100 MG TABLET	T2	PA QL(1 TAB/DAY) SP HD
HARVONI 33.75-150 MG PELLETT PK	T2	PA QL(1 PACK/DAY) SP HD
HARVONI 45-200 MG PELLETT PACKT	T2	PA QL(1 PACK/DAY) SP HD
HARVONI 45-200 MG TABLET	T2	PA QL(1 TAB/DAY) SP HD
HARVONI 90-400 MG TABLET	T2	PA QL(1 TAB/DAY) SP HD
LEDIPASVIR-SOFOSBUVIR	T3	PA QL(1 TAB/DAY) SP HD
SOFOSBUVIR-VELPATASVIR	T3	PA QL(1 TAB/DAY) SP HD
HEPATITIS B TREATMENT AGENTS		
<i>adefovir dipivoxil</i>	T1	SP HD
BARACLUDE 0.05 MG/ML SOLUTION	T2	SP HD
BARACLUDE 0.5 MG TABLET (<i>entecavir</i>)	T3	PA QL(1 TAB/DAY) SP HD
BARACLUDE 1 MG TABLET (<i>entecavir</i>)	T3	PA SP HD
<i>entecavir 0.5 mg tablet</i> (Baraclude)	T1	QL(1 TAB/DAY) SP HD
<i>entecavir 1 mg tablet</i> (Baraclude)	T1	SP HD
<i>lamivudine</i>	T1	SP
VEMLIDY	T2	SP HD
HEPATITIS C TREATMENT AGENTS		
PEGASYS	T2	PA SP HD
<i>ribavirin</i>	T1	SP HD
HEPATITIS C VIRUS- NS5A AND NS3/4A INHIBITOR COMB		
MAVYRET 100-40 MG TABLET	T3	PA QL(3 TABS/DAY) SP HD
MAVYRET 50-20 MG PELLETT PACKET	T3	PA QL(5 PACKS/DAY) SP HD
ZEPATIER	T2	PA QL(1 TAB/DAY) SP HD
ANTIVIRALS (Skin Conditions)		
TOPICAL ANTIVIRAL AND ANTI-INFLAMMATORY STEROID		
XERESE	T3	PA QL(5 GMS/30 DAYS)

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ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTIVIRALS (Skin Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL ANTIVIRALS		
<i>acyclovir 5% cream (Zovirax)</i>	T1	PA QL(5 GMS/30 DAYS)
<i>acyclovir 5% ointment (Zovirax)</i>	T1	PA QL(15 GMS/30 DAYS)
DENAVIR (<i>penciclovir</i>)	T3	QL(5 GMS/30 DAYS)
<i>penciclovir (Denavir)</i>	T1	QL(5 GMS/30 DAYS)
ZOVIRAX 5% CREAM (<i>acyclovir</i>)	T3	PA QL(5 GMS/30 DAYS)
ZOVIRAX 5% OINTMENT (<i>acyclovir</i>)	T3	PA QL(15 GMS/30 DAYS)
TOPICAL ANTIVIRALS		
VEREGEN	T3	PA

AUTONOMIC DRUGS (Allergy/Nasal Sprays)

ANAPHYLAXIS THERAPY AGENTS		
ADYPHREN	T1	
ADYPHREN AMP	T1	
AUVI-Q	T3	PA QL(4 UNITS/30 DAYS)
EPINEPHRINE 0.15 MG AUTO-INJECT	T3	PA QL(4 UNITS/30 DAYS)
<i>epinephrine 0.15 mg auto-inject (Epipen Jr)</i>	T1	QL(4 UNITS/30 DAYS)
EPINEPHRINE 0.3 MG AUTO-INJECT	T3	PA QL(4 UNITS/30 DAYS)
<i>epinephrine 0.3 mg auto-inject (Epipen)</i>	T1	QL(4 UNITS/30 DAYS)
EPINEPHRINE PROFESSIONAL EMS	T3	
EPINEPHRINE PROFESSIONAL KIT	T3	
EPINEPHRINESNAP-EMS	T3	
EPINEPHRINESNAP-V	T3	
EPIPEN (<i>epinephrine</i>)	T3	PA QL(4 UNITS/30 DAYS)
EPIPEN 2-PAK (<i>epinephrine</i>)	T3	PA QL(4 UNITS/30 DAYS)
EPIPEN JR (<i>epinephrine</i>)	T3	PA QL(4 UNITS/30 DAYS)
EPIPEN JR 2-PAK (<i>epinephrine</i>)	T3	PA QL(4 UNITS/30 DAYS)
NEFFY	T2	QL(4 UNITS/30 DAYS)

AUTONOMIC DRUGS (Alzheimer's Disease)

CHOLINESTERASE INHIBITORS		
ADLARITY	T2	PA QL(4 PATCHES/28 DAYS) HD
ARICEPT (<i>donepezil hcl</i>)	T3	PA HD
BLOXIVERZ (<i>neostigmine methylsulfate</i>)	T3	

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List of Prescription Medications

AUTONOMIC DRUGS (Alzheimer's Disease) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CHOLINESTERASE INHIBITORS (cont.)		
<i>donepezil hcl</i>	T1	HD
<i>donepezil hcl</i> (Aricept)	T1	HD
EXELON (<i>rivastigmine</i>)	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
MESTINON (<i>pyridostigmine bromide</i>)	T3	PA HD
<i>neostigmine methylsulfate</i>	T1	
NEOSTIGMINE METHYLSULFATE	T1	
<i>neostigmine methylsulfate</i> (Bloxiverz)	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
PYRIDOSTIGMINE BR 30 MG TABLET	T3	PA QL(20 TABS/DAY) 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
ZUNVEYL	T3	PA QL(2 TABS/DAY) HD

AUTONOMIC DRUGS (Attention Deficit Hyperactivity Disorder)⁹

ADRENERGICS, AROMATIC, NON-CATECHOLAMINE

ADDERALL (<i>dextroamphetamine/amphetamine</i>)	T3	PA
ADDERALL XR (<i>dextroamphetamine/amphetamine</i>)	T3	PA ST QL(1 CAP/DAY)
ADZENYS XR-ODT	T3	PA QL(1 TAB/DAY)
<i>amphetamine sulfate</i> (Evekeo)	T1	PA
DESOXYN (<i>methamphetamine hcl</i>)	T3	PA
DEXEDRINE SPANSULE 10 MG (<i>dextroamphetamine sulfate</i>)	T3	PA QL(1 CAP/DAY)
DEXEDRINE SPANSULE 15 MG CAP (<i>dextroamphetamine sulfate</i>)	T3	PA QL(3 CAPS/DAY)
<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

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

AUTONOMIC DRUGS (Attention Deficit Hyperactivity Disorder)⁹ (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ADRENERGICS, AROMATIC, NON-CATECHOLAMINE (cont.)		
<i>dextroamphetamine sulfate</i>	T3	PA ST
<i>dextroamphetamine sulfate (Zenzedi)</i>	T1	PA
<i>dextroamphetamine/amphetamine (Adderall Xr)</i>	T1	PA QL(1 CAP/DAY)
<i>dextroamphetamine/amphetamine (Adderall)</i>	T1	PA
<i>dextroamphetamine/amphetamine (Mydayis)</i>	T1	PA QL(1 CAP/DAY)
DYANAVEL XR 10 MG TABLET	T3	PA QL(1 TAB/DAY)
DYANAVEL XR 15 MG TABLET	T3	PA QL(1 TAB/DAY)
<i>dextroamphetamine/amphetamine (Adderall Xr)</i>	T1	PA QL(1 cap/day)
<i>dextroamphetamine/amphetamine (Mydayis)</i>	T1	PA QL(1 cap/day)
DYANAVEL XR 2.5 MG/ML SUSP	T3	PA QL(8 MLS/DAY)
DYANAVEL XR 20 MG TABLET	T3	PA QL(1 TAB/DAY)
DYANAVEL XR 5 MG TABLET	T3	PA QL(1 TAB/DAY)
EVEKEO (<i>amphetamine sulfate</i>)	T3	PA
EVEKEO ODT	T3	PA
<i>methamphetamine hcl (Desoxyn)</i>	T1	PA
MYDAYIS (<i>dextroamphetamine/amphetamine</i>)	T3	PA QL(1 CAP/DAY)
XELSTRYM	T3	PA QL(1 PATCH/DAY)
ZENZEDI (<i>dextroamphetamine sulfate</i>)	T3	PA ST

AUTONOMIC DRUGS (Blood Pressure/Heart Medications)

ADRENERGIC VASOPRESSOR AGENTS		
<i>droxidopa 100 mg capsule (Northera)</i>	T1	HD
<i>droxidopa 100 mg capsule (Northera)</i>	T1	SP HD
<i>droxidopa 200 mg capsule (Northera)</i>	T1	HD
<i>droxidopa 200 mg capsule (Northera)</i>	T1	SP HD
<i>droxidopa 300 mg capsule (Northera)</i>	T1	HD
<i>droxidopa 300 mg capsule (Northera)</i>	T1	SP HD
<i>midodrine hcl</i>	T1	
NORTHERA (<i>droxidopa</i>)	T3	PA SP HD
ALPHA-ADRENERGIC BLOCKING AGENTS		
DIBENZYLINE (<i>phenoxybenzamine hcl</i>)	T3	HD
<i>phenoxybenzamine hcl (Dibenzylina)</i>	T1	HD
<i>phentolamine mesylate</i>	T1	HD

T1 – Typically Generics

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T2 – Typically Preferred Brands

QL – Quantity Limit

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CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

AUTONOMIC DRUGS (Miscellaneous)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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	
<i>EPINEPHRINE 1 MG/ML AMPUL</i>	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	
<i>LEVOPHED (norepinephrine bitartrate)</i>	T3	
<i>norepineph 16 mg/250-0.9% nacl</i>	T1	
<i>NOREPINEPH 32 MG/250-0.9% NACL</i>	T3	
<i>norepinephr 4 mg/250-0.9% nacl</i>	T1	
<i>NOREPINEPHR 8 MG/500-0.9% NACL (norepinephrine bit/0.9 % nacl)</i>	T1	
<i>norepinephrine bitartrate</i>	T1	
<i>norepinephrine bitartrate (Levophed)</i>	T1	
<i>norepinephrine bitartrate/d5w</i>	T1	
<i>NOREPINEPHRINE BITARTRATE-D5W</i>	T1	
NEUROMUSCULAR BLOCKING AGENTS		
<i>atracurium besylate</i>	T1	
<i>BOTOX 100 UNIT VIAL</i>	T3	PA SP
<i>BOTOX 200 UNIT VIAL</i>	T3	PA SP HD
<i>cisatracurium besylate (Nimbex)</i>	T1	
<i>DAXXIFY</i>	T3	PA SP
<i>DYSPORT</i>	T3	PA SP HD
<i>MYOBLOC</i>	T3	PA SP HD
<i>NIMBEX (cisatracurium besylate)</i>	T3	
<i>pancuronium bromide</i>	T1	
<i>QUELICIN (succinylcholine chloride)</i>	T3	
<i>rocuronium bromide</i>	T1	
<i>succinylcholine chloride</i>	T1	

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ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

AUTONOMIC DRUGS (Miscellaneous) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ADRENERGIC AGENTS, CATECHOLAMINES (cont.)		
SUCCINYLCOLINE CHLORIDE	T1	
<i>succinylcholine chloride (Quelicin)</i>	T1	
<i>succinylcholine chloride (Quelicin)</i>	T3	
SUCCINYLCOLINE CHLORIDE-NACL	T1	
<i>succinylcholine/sod cl,iso/pf</i>	T1	
<i>vecuronium bromide</i>	T1	
VECURONIUM BROMIDE-WATER	T1	
XEOMIN	T3	PA SP HD

AUTONOMIC DRUGS (Urinary Tract Conditions)

PARASYMPATHETIC AGENTS		
<i>bethanechol chloride</i>	T1	HD
<i>cevimeline hcl (Evoxac)</i>	T1	HD
EVOXAC (cevimeline hcl)	T3	PA HD
<i>pilocarpine hcl 5 mg tablet (Salagen)</i>	T1	HD
<i>pilocarpine hcl 7.5 mg tablet (Salagen)</i>	T1	HD
SALAGEN (pilocarpine hcl)	T3	HD

BIOLOGICALS (Allergy/Nasal Sprays)

ALLERGENIC EXTRACTS, THERAPEUTIC		
GRASTEK	T3	PA QL(1 TAB/DAY)
ODACTRA	T3	PA QL(1 TAB/DAY)
ORALAIR	T3	PA QL(1 TAB/DAY)
PALFORZIA	T3	PA SP
RAGWITEK	T3	PA QL(1 TAB/DAY)

BIOLOGICALS (Blood Pressure/Heart Medications)

PLASMA KALLIKREIN INHIBITORS		
TAKHZYRO	T3	PA SP HD

BIOLOGICALS (Miscellaneous)

ANTISERA		
HYPERRHO	T3	SP
RHOGAM ULTRA-FILTERED PLUS	T3	SP
RHOPHYLAC	T3	SP
WINRHO SDF	T3	SP HD

PKU TREATMENT AGENTS - PHENYLALANINE AMMONIA LYASE		
PALYNZIQ	T3	PA SP HD

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List of Prescription Medications

BIOLOGICALS (Vaccines)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
COVID-19 VACCINES		
COMIRNATY	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 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 2024-25(5-11Y)EUA	T3	PPACA
PFIZER COVID 2024-25(6M-4Y)EUA	T3	PPACA
PFIZER COVID BIVAL (12Y UP)EUA	T3	PPACA
PFIZER COVID BIVAL (5-11YR)EUA	T3	PPACA
PFIZER COVID BIVAL (6MO-4Y)EUA	T3	PPACA
PFIZER COVID-19 VACCINE (EUA)	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

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List of Prescription Medications

BIOLOGICALS (Vaccines) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ENTERIC VIRUS VACCINES		
IPOD	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	PPACA
PREVNAR 20	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
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

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CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

BIOLOGICALS (Vaccines) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
INFLUENZA VIRUS VACCINES (cont.)		
FLUBLOK QUAD 2022-2023	T3	PPACA
FLUBLOK TRIVALENT 2024-2025	T3	PPACA
FLUCELVAX 2025-2026 SYRINGE	T3	PPACA
FLUCELVAX 2025-2026 VIAL	T3	
FLUCELVAX QUAD 2023-2024	T3	PPACA
FLUCELVAX TRIVALENT 2024-2025	T3	PPACA
FLULAVAL 2025-2026	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
FLUZONE QUAD 2022-2023	T3	PPACA
FLUZONE QUAD 2023-2024	T3	PPACA
FLUZONE TRIVALENT 2024-2025	T3	PPACA
TOXIN-PRODUCING BACILLI VACCINES/TOXOIDS		
BCG VACCINE (TICE STRAIN)	T3	SP
VACCINE/TOXOID PREPARATIONS, COMBINATIONS		
ACTHIB	T3	PPACA
ADACEL TDAP	T3	PPACA
BOOSTRIX TDAP	T3	PPACA
DAPTACEL DTAP	T3	PPACA

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

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CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

BIOLOGICALS (Vaccines) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VACCINE/TOXOID PREPARATIONS, COMBINATIONS (con't)		
DIPHtheria-TETANUS TOXOIDS-PED	T3	
HIBERIX	T3	PPACA
INFANRIX DTAP	T3	PPACA
KINRIX	T3	PPACA
M-M-R II VACCINE	T3	PPACA
PEDVAXHIB	T3	PPACA
PENTACEL	T3	PPACA
PENTACEL ACTHIB COMPONENT	T3	PPACA
PRIORIX	T3	PPACA
PROQUAD	T3	PPACA
QUADRACEL DTAP-IPV	T3	PPACA
TDVAX	T3	PPACA
TENIVAC	T3	PPACA
VAXELIS	T3	PPACA
VIRAL/TUMORIGENIC VACCINES		
ABRYSVO	T3	PPACA
ACAM2000 (NATIONAL STOCKPILE)	T3	
AREXVY	T3	PPACA
ENGERIX-B ADULT	T3	PPACA
ENGERIX-B PEDIATRIC-ADOLESCENT	T3	PPACA
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

T1 – Typically Generics

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T2 – Typically Preferred Brands

QL – Quantity Limit

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CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

BLOOD (Blood Modifiers/Bleeding Disorders)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AGENTS TO TX THROMBOTIC THROMBOCYTOPENIC PURPURA		
ADZYNMA	T3	PA SP
CABLIVI	T3	PA SP
ANTI-FIBRINOLYTIC AGENTS		
AMICAR (aminocaproic acid)	T3	SP HD
<i>aminocaproic acid</i>	T1	SP HD
<i>aminocaproic acid (Amicar)</i>	T1	SP HD
CYKLOKAPRON (tranexamic acid)	T3	SP
FIBRYGA	T3	PA SP
RIASTAP	T3	PA SP
<i>tranexamic acid</i>	T1	SP
<i>tranexamic acid (Cyklokapron)</i>	T1	SP
<i>tranexamic acid in nacl,iso-os</i>	T1	SP
ANTI-HEMOPHILIC FACTORS		
ADVATE	T3	PA SP HD
ADYNOVATE	T2	PA SP HD
AFSTYLA	T2	PA SP HD
ALPHANATE	T3	PA SP HD
ALTUVIIIO	T2	PA SP HD
ELOCTATE	T2	PA SP HD
ESPEROCT	T2	PA SP HD
HEMOFIL M	T3	PA SP HD
HUMATE-P	T3	PA SP HD
JIVI	T2	PA SP HD
KOATE	T3	PA SP HD
KOGENATE FS	T2	PA SP HD
KOVALTRY	T2	PA SP HD
NOVOEIGHT	T2	PA SP HD
NUWIQ	T3	PA SP HD
RECOMBINATE	T3	PA SP HD
WILATE	T3	PA SP HD
XYNTHA	T3	PA SP HD
XYNTHA SOLOFUSE	T3	PA SP HD
BLOOD FACTORS,MISCELLANEOUS		
VONVENDI	T3	SP HD

T1 – Typically Generics

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AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
COAGULANTS		
<i>protamine sulfate</i>	T1	
COMPLEMENT INHIBITORS		
BKEMV	T3	PA SP
EMPAVELI	T2	PA SP
ENJAYMO	T3	PA SP
EPYSQLI	T3	PA SP
FABHALTA	T2	PA QL(2 CAPS/DAY) SP
PIASKY	T3	PA SP
SOLIRIS	T2	PA SP
TAVNEOS	T3	PA QL(6 CAPS/DAY) SP
ULTOMIRIS	T3	PA SP HD
VOYDEYA	T2	PA QL(1 PACKET/28 Days) SP
FACTOR IX COMPLEX (PCC) PREPARATIONS		
KCENTRA	T3	SP
FACTOR X PREPARATIONS		
COAGADEX	T3	PA SP
FACTOR XIII PREPARATIONS		
CORIFACT	T3	PA SP
TRETEN	T3	PA SP
HEMOPHILIA TREATMENT AGENTS, NON-FACTOR REPLACEMENT		
ALHEMO PEN	T2	PA SP
HEMLIBRA	T2	PA SP HD
HYMPAVZI PEN	T2	PA SP
QFITLIA	T3	PA SP
QFITLIA PEN	T3	PA SP
PROTEIN C PREPARATIONS		
CEPROTIN	T3	PA SP
SICKLE CELL ANEMIA AGENTS		
ADAKVEO	T3	PA SP
DROXIA	T2	
OXBRYTA 300 MG TABLET	T3	PA QL(3 TABS/DAY) SP
OXBRYTA 300 MG TABLET FOR SUSP	T3	PA QL(5 TABS/DAY) SP
OXBRYTA 500 MG TABLET	T3	PA QL(3 TABS/DAY) SP
SIKLOS	T3	PA
XROMI	T3	PA

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL HEMOSTATICS		
ASTRINGYN	T3	
AVITENE	T3	
ENDO-AVITENE	T3	
EVICEL	T3	
<i>gelatin sponge,absorb/porcine (Gelfoam)</i>	T1	
GELFOAM	T3	
GELFOAM (gelatin sponge,absorb/porcine)	T3	
GELFOAM COMPRESSED	T3	
MONSEL'S	T3	
RECOTHROM	T3	
SURGICEL	T3	
SURGIFOAM	T1	
SYRINGE AVITENE	T3	
THROMBI-GEL (<i>thrombin/cal/cmc/gel/dress,hem</i>)	T3	
THROMBIN-JMI	T3	
THROMBI-PAD	T3	
ULTRAFOAM	T3	
ANTICOAGULANT REVERSAL AGENT FOR FACTOR XA INHIB.		
ANDEXXA	T3	SP
ANTICOAGULANT REVERSAL AGENT, DIRECT THROMBIN INHIB		
PRAXBIND	T3	SP
HEMORRHOLOGIC AGENTS		
<i>pentoxifylline</i>	T1	HD
THROMBOLYTIC - NUCLEOTIDE TYPE		
DEFITELIO	T3	PA SP
THROMBOLYTIC ENZYMES		
ACTIVASE	T3	
CATHFLO ACTIVASE	T3	
RETAVASE	T3	
TNKASE	T3	

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List of Prescription Medications

CARDIAC DRUGS (Blood Pressure/Heart Medications)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-ANGINAL, ANTI-ISCHEMIC AGENTS, NON-HEMODYNAMIC		
RANEXA (<i>ranolazine er</i>)	T3	PA QL (4 tabs/day) HD
<i>ranolazine</i> (Ranexa)	T1	QL (4 tabs/day) HD
ANTI-ARRHYTHMICS		
<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
CORVERT (<i>ibutilide fumarate</i>)	T3	PA
<i>disopyramide phosphate</i> (Norpace)	T1	HD
<i>dofetilide 125 mcg capsule</i> (Tikosyn)	T1	QL(8 CAPS/DAY) HD
<i>dofetilide 250 mcg capsule</i> (Tikosyn)	T1	QL(4 CAPS/DAY) HD
<i>dofetilide 500 mcg capsule</i> (Tikosyn)	T1	QL(2 CAPS/DAY) HD
<i>flecainide acetate</i>	T1	HD
<i>ibutilide fumarate</i> (Corvert)	T1	
<i>lidocaine hcl/dextrose 5 %/pf</i>	T1	
<i>lidocaine hcl/pf</i>	T1	
<i>mexiletine hcl</i>	T1	HD
MULTAQ	T2	HD
NEXTERONE	T3	
NORPACE (disopyramide phosphate)	T3	PA HD
NORPACE CR	T3	HD
<i>pacerone 100 mg tablet</i>	T3	PA HD
<i>pacerone 200 mg tablet</i>	T1	HD
<i>pacerone 400 mg tablet</i>	T3	PA HD
<i>procainamide 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
TIKOSYN 125 MCG CAPSULE (<i>dofetilide</i>)	T3	PA QL(8 CAPS/DAY) HD
TIKOSYN 250 MCG CAPSULE (<i>dofetilide</i>)	T3	PA QL(4 CAPS/DAY) HD

T1 – Typically Generics

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T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

CARDIAC DRUGS (Blood Pressure/Heart Medications) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-ARRHYTHMICS (cont.)		
TIKOSYN 500 MCG CAPSULE (dofetilide)	T3	PA QL(2 CAPS/DAY) HD
CALCIUM CHANNEL BLOCKER AND NSAID, COX-2 INHIBITOR		
CONSENSI	T3	PA QL(1 TAB/DAY)
CALCIUM CHANNEL BLOCKING AGENTS		
<i>amlodipine besylate</i> (Norvasc)	T1	HD
CALAN SR (<i>verapamil hcl</i>)	T3	HD
CARDENE I.V.	T3	
CARDENE I.V. (nicardipine hcl)	T3	
CARDIZEM (diltiazem hcl)	T3	PA HD
CARDIZEM CD (diltiazem hcl)	T3	PA HD
CARDIZEM LA 120 MG TABLET (<i>diltiazem hcl</i>)	T3	PA QL(1 TAB/DAY) HD
CARDIZEM LA 180 MG TABLET (<i>diltiazem hcl</i>)	T3	PA HD
CARDIZEM LA 240 MG TABLET (<i>diltiazem hcl</i>)	T3	PA HD
CARDIZEM LA 300 MG TABLET (<i>diltiazem hcl</i>)	T3	PA HD
CARDIZEM LA 360 MG TABLET (<i>diltiazem hcl</i>)	T3	PA HD
CARDIZEM LA 420 MG TABLET (<i>diltiazem hcl</i>)	T3	PA HD
CLEVIPREX	T3	
CONJUPRI	T3	PA HD
<i>diltiazem 100 mg add-van vial</i>	T1	
<i>diltiazem 120 mg tablet</i> (Cardizem)	T1	HD
<i>diltiazem 125 mg/25 ml vial</i>	T1	
<i>diltiazem 24h er(la) 120 mg tb</i> (Cardizem La)	T1	QL(1 TAB/DAY) HD
<i>diltiazem 24h er(la) 180 mg tb</i> (Cardizem La)	T1	HD
<i>diltiazem 24h er(la) 240 mg tb</i> (Cardizem La)	T1	HD
<i>diltiazem 24h er(la) 300 mg tb</i> (Cardizem La)	T1	HD
<i>diltiazem 24h er(la) 360 mg tb</i> (Cardizem La)	T1	HD
<i>diltiazem 24h er(la) 420 mg tb</i> (Cardizem La)	T1	HD
<i>diltiazem 25 mg/5 ml vial</i>	T1	
<i>diltiazem 30 mg tablet</i> (Cardizem)	T1	HD
<i>diltiazem 50 mg/10 ml vial</i>	T1	
<i>diltiazem 60 mg tablet</i> (Cardizem)	T1	HD
<i>diltiazem 90 mg tablet</i>	T1	HD
<i>diltiazem hcl</i>	T1	HD
<i>diltiazem hcl</i> (Cardizem Cd)	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.)		
diltiazem hcl (Cardizem La)	T1	HD
diltiazem hcl (Tiazac)	T1	HD
DILTIAZEM HCL-0.7% NACL	T3	
DILTIAZEM HCL-0.9% NACL	T1	
DILTIAZEM HCL-NACL	T3	
<i>felodipine</i>	T1	HD
<i>isradipine</i>	T1	
KATERZIA	T3	PA QL(10 MLS/DAY) HD
LEVAMLODIPINE MALEATE	T3	PA HD
<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 (Cardene I.V.)</i>	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 (Procardia XI)</i>	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 (Sular)</i>	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 (Sular)</i>	T1	HD
<i>nisoldipine er 40 mg tablet</i>	T1	HD
<i>nisoldipine er 8.5 mg tablet (Sular)</i>	T1	HD
NORLIQVA	T2	PA QL(10 MLS/DAY) HD
NORVASC (amlodipine besylate)	T3	PA
NYMALIZE	T3	
PROCARDIA XL (nifedipine)	T3	PA HD
SULAR (nisoldipine)	T3	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.)		
TIAZAC (diltiazem hcl)	T3	HD
verapamil hcl (Calan Sr)	T1	HD
verapamil hcl (Verelan Pm)	T1	HD
verapamil hcl (Verelan)	T1	HD
VERELAN (verapamil hcl)	T3	HD
VERELAN PM (verapamil hcl)	T3	HD
CARDIAC MYOSIN INHIBITOR		
CAMZYOS	T3	PA QL(1 CAP/DAY) SP HD
CARDIOPLEGIC SOLUTIONS		
CARDIOPLEGIA DEL NIDO FORMULA	T3	
CARDIOPLEGIA HIGH POTASSIUM	T3	
CARDIOPLEGIA IND 8:1 NON-ENRCH	T3	
CARDIOPLEGIA INDUCTION 4:1	T3	
CARDIOPLEGIA INDUCTION 8:1	T3	
CARDIOPLEGIA MAINTENANCE 4:1	T3	
CARDIOPLEGIA MAINTENANCE 8:1	T3	
CARDIOPLEGIA REPERFUSATE 4:1	T3	
cardioplegic solution no.1	T1	
PLEGISOL	T3	
DIGITALIS GLYCOSIDES		
digoxin (Lanoxin)	T1	HD
digoxin 0.05 mg/ml solution	T1	HD
digoxin 0.125 mg tablet (Lanoxin)	T1	HD
digoxin 0.25 mg tablet (Lanoxin)	T1	HD
digoxin 0.25 mg/ml syringe	T1	HD
digoxin 125 mcg tablet (Lanoxin)	T1	HD
digoxin 250 mcg tablet (Lanoxin)	T1	HD
digoxin 500 mcg/2 ml ampule (Lanoxin)	T1	HD
digoxin 62.5 mcg tablet (Lanoxin)	T1	PA HD
LANOXIN 125 MCG TABLET (digoxin)	T3	PA HD
LANOXIN 250 MCG TABLET (digoxin)	T3	PA HD
LANOXIN 500 MCG/2 ML AMPULE (digoxin)	T3	HD
LANOXIN 500 MCG/2 ML VIAL	T3	HD
LANOXIN 62.5 MCG TABLET (digoxin)	T3	PA HD
LANOXIN PEDIATRIC	T3	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
HEART RATE REDUCING, SA SELECTIVE I(F) CURRENT INH.		
CORLANOR 5 MG TABLET (<i>ivabradine hcl</i>)	T3	PA HD
CORLANOR 5 MG/5 ML ORAL SOLN	T2	PA SP HD
CORLANOR 7.5 MG TABLET (<i>ivabradine hcl</i>)	T3	PA 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	
VASODILATORS, CORONARY		
GONITRO	T3	HD
ISORDIL (isosorbide dinitrate)	T3	PA HD
ISORDIL TITRADOSE (isosorbide dinitrate)	T3	PA HD
<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 40 mg tab (Isordil)</i>	T1	PA HD
<i>isosorbide dinitrate 5 mg tab (Isordil Titradose)</i>	T1	HD
<i>isosorbide mononitrate</i>	T1	HD
NITRO-DUR 0.1 MG/HR PATCH	T3	HD
NITRO-DUR 0.2 MG/HR PATCH	T3	HD
NITRO-DUR 0.3 MG/HR PATCH	T2	HD
NITRO-DUR 0.4 MG/HR PATCH	T3	HD
NITRO-DUR 0.6 MG/HR PATCH	T3	HD
NITRO-DUR 0.8 MG/HR PATCH	T2	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
<i>nitroglycerin 400 mcg spray (Nitrolingual)</i>	T1	HD
<i>nitroglycerin 50 mg/10 ml vial</i>	T1	
<i>nitroglycerin in 5 % dextrose</i>	T1	
NITROLINGUAL (<i>nitroglycerin</i>)	T3	HD
NITROMIST (<i>nitroglycerin</i>)	T3	HD
NITROSTAT (<i>nitroglycerin</i>)	T3	HD

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List of Prescription Medications

CARDIOVASCULAR (Allergy/Nasal Sprays)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SYMPATHOMIMETIC AGENTS		
AKOVAZ	T3	
BIORPHEN	T3	
<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 (phenylephrine hcl)	T3	
CARDIOVASCULAR (Asthma/COPD/Respiratory)		
PULM ANTI-HTN, SOLUBLE GUANYLATE CYCLASE STIMULATOR		
ADEMPAS	T3	PA SP HD
PULM.ANTI-HTN, SEL.C-GMP PHOSPHODIESTERASE T5 INHIB		
ADCIRCA (tadalafil)	T3	PA SP HD
REVATIO (sildenafil citrate)	T3	PA SP HD
<i>sildenafil 10 mg/12.5 ml vial</i>	T1	PA SP HD
<i>sildenafil 10 mg/ml oral susp (Revatio)</i>	T1	PA SP HD
<i>sildenafil 20 mg tablet (Revatio)</i>	T1	PA SP HD
<i>tadalafil (Adcirca)</i>	T1	PA SP HD
<i>tadalafil 20 mg tablet (Adcirca)</i>	T1	PA SP HD
TADLIQ	T3	PA SP HD
PULMONARY ANTI-HTN, ENDOTHELIN RECEPTOR ANTAGONIST		
<i>ambrisentan (Letairis)</i>	T1	PA SP HD
<i>bosentan (Tracleer)</i>	T1	PA SP HD
LETAIRIS (<i>ambrisentan</i>)	T3	PA SP HD
OPSUMIT	T2	PA SP HD
TRACLEER 125 MG TABLET (bosentan)	T3	PA SP HD
TRACLEER 32 MG TABLET FOR SUSP (bosentan)	T2	PA SP HD

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List of Prescription Medications

CARDIOVASCULAR (Asthma/COPD/Respiratory) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PULMONARY ANTI-HTN, ENDOTHELIN RECEPTOR ANTAGONIST (cont.)		
TRACLEER 62.5 MG TABLET (bosentan)	T3	PA SP HD
PULMONARY ANTIHYPER AGENT, ACTRIIA-FC		
WINREVAIR	T3	PA SP HD
WINREVAIR (2 PACK)	T3	PA SP HD
PULMONARY ANTIHYPERTENSIVES, PROSTACYCLIN-TYPE		
<i>epoprostenol sodium</i>	T1	PA SP HD
<i>epoprostenol sodium 0.5 mg v1</i>	T1	PA SP
<i>epoprostenol sodium 0.5 mg v1</i>	T1	PA SP HD
<i>epoprostenol sodium 1.5 mg v1</i>	T1	PA SP
<i>epoprostenol sodium 1.5 mg v1</i>	T1	PA SP HD
FLOLAN	T3	PA SP
ORENITRAM ER	T3	PA SP HD
ORENITRAM MONTH 1 TITRATION KT	T3	PA QL(168 TABS/180 DAYS) SP HD
ORENITRAM MONTH 2 TITRATION KT	T3	PA QL(336 TABS/180 DAYS) SP HD
ORENITRAM MONTH 3 TITRATION KT	T3	PA QL(252 TABS/180 DAYS) SP HD
REMODULIN (<i>treprostinil sodium</i>)	T3	PA SP HD
<i>treprostinil sodium (Remodulin)</i>	T1	PA SP HD
TYVASO	T3	PA SP HD
TYVASO DPI	T2	PA SP HD
TYVASO INSTITUTIONAL START KIT	T3	PA SP HD
TYVASO REFILL KIT	T3	PA SP HD
TYVASO STARTER KIT	T3	PA SP HD
UPTRAVI 1,000 MCG TABLET	T2	PA SP HD
UPTRAVI 1,200 MCG TABLET	T2	PA SP HD
UPTRAVI 1,400 MCG TABLET	T2	PA SP HD
UPTRAVI 1,600 MCG TABLET	T2	PA SP HD
UPTRAVI 1,800 MCG VIAL	T3	PA SP
UPTRAVI 200 MCG TABLET	T2	PA SP HD
UPTRAVI 200-800 TITRATION PACK	T2	PA SP HD
UPTRAVI 400 MCG TABLET	T2	PA SP HD
UPTRAVI 600 MCG TABLET	T2	PA SP HD
UPTRAVI 800 MCG TABLET	T2	PA SP HD
YUTREPIA	T2	PA SP HD

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List of Prescription Medications

CARDIOVASCULAR (Asthma/COPD/Respiratory) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PULMONARY HTN-ENDOTHELIN RECEPT ANTG-CGMP PDE5 INH		
OPSYNVI	T2	PA QL(1 tab/day) SP HD

CARDIOVASCULAR (Blood Pressure/Heart Medications)

ACE INHIBITOR-CALCIUM CHANNEL BLOCKER COMBINATION		
<i>amlodipine besylate/benazepril</i>	T1	HD
<i>amlodipine besylate/benazepril (Lotrel)</i>	T1	HD
LOTREL (<i>amlodipine besylate/benazepril</i>)	T3	PA HD
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		
ACCURETIC (<i>quinapril/hydrochlorothiazide</i>)	T3	ST HD
<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
LOTENSIN HCT (<i>benazepril/hydrochlorothiazide</i>)	T3	ST HD
<i>quinapril/hydrochlorothiazide (Accuretic)</i>	T1	HD
VASERETIC (<i>enalapril/hydrochlorothiazide</i>)	T3	ST HD
ZESTORETIC (<i>lisinopril/hydrochlorothiazide</i>)	T3	ST 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
COREG (<i>carvedilol</i>)	T3	PA HD
COREG CR 10 MG CAPSULE (<i>carvedilol phosphate</i>)	T3	PA QL(1 CAP/DAY) HD

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ACE INHIBITOR-THIAZIDE OR THIAZIDE-LIKE DIURETIC (cont.)		
COREG CR 20 MG CAPSULE (<i>carvedilol phosphate</i>)	T3	PA QL(1 CAP/DAY) HD
COREG CR 40 MG CAPSULE (<i>carvedilol phosphate</i>)	T3	PA QL(1 CAP/DAY) HD
COREG CR 80 MG CAPSULE (<i>carvedilol phosphate</i>)	T3	PA HD
LABELALOL 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	
<i>labetalol hcl 20 mg/4 ml syrng</i>	T1	
<i>labetalol hcl 20 mg/4 ml vial</i>	T1	
<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
LABELALOL HCL 400 MG TABLET	T3	HD
LABELALOL HCL-DEXTROSE	T3	
LABELALOL HCL-NACL	T3	
ALPHA-ADRENERGIC BLOCKING AGENTS		
CARDURA (<i>doxazosin mesylate</i>)	T3	PA HD
CARDURA XL	T3	HD
<i>doxazosin mesylate (Cardura)</i>	T1	HD
MINIPRESS (<i>prazosin hcl</i>)	T3	HD
<i>prazosin hcl (Minipress)</i>	T1	HD
<i>terazosin hcl</i>	T1	HD
TEZRULY	T3	PA HD
ANGIOTEN.RECEPTR ANTAG-CALCIUM CHANL BLKR-THIAZIDE		
<i>amlodipine/valsartan/hcthiazid (Exforge Hct)</i>	T1	HD
EXFORGE HCT (<i>amlodipine-valsartan-hctz</i>)	T3	PA HD
<i>olmesartan/amlodipin/hcthiazid (Tribenzor)</i>	T1	HD
TRIBENZOR (<i>olmesartan-amlodipine-hctz</i>)	T3	HD
ANGIOTENSIN RECEPT-NEPRILYSIN INHIBITOR COMB (ARNI)		
ENTRESTO (<i>sacubitril/valsartan</i>)	T3	PA QL(2 TABS/DAY)
ENTRESTO SPRINKLE	T2	HD
<i>sacubitril/valsartan (Entresto)</i>	T1	QL(2 TABS/DAY) HD

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANGIOTENSIN RECEPTOR ANTAG.-THIAZIDE DIURETIC COMB		
ATACAND HCT (<i>candesartan/hydrochlorothiazid</i>)	T3	PA HD
AVALIDE (<i>irbesartan/hydrochlorothiazide</i>)	T3	PA HD
BENICAR HCT 20-12.5 MG TABLET (<i>olmesartan/hydrochlorothiazide</i>)	T3	PA QL(1 TAB/DAY) HD
BENICAR HCT 40-12.5 MG TABLET (<i>olmesartan/hydrochlorothiazide</i>)	T3	PA HD
BENICAR HCT 40-25 MG TABLET (<i>olmesartan/hydrochlorothiazide</i>)	T3	PA HD
<i>candesartan/hydrochlorothiazid</i> (Atacand Hct)	T1	HD
DIOVAN HCT (<i>valsartan/hydrochlorothiazide</i>)	T3	PA HD
EDARBYCLOR	T3	PA HD
HYZAAR (<i>losartan/hydrochlorothiazide</i>)	T3	PA HD
<i>irbesartan/hydrochlorothiazide</i> (Avalide)	T1	HD
<i>losartan/hydrochlorothiazide</i> (Hyzaar)	T1	HD
MICARDIS HCT 40-12.5 MG TABLET (<i>telmisartan/hydrochlorothiazid</i>)	T3	ST QL(1 TAB/DAY) HD
MICARDIS HCT 80-12.5 MG TABLET (<i>telmisartan/hydrochlorothiazid</i>)	T3	ST HD
MICARDIS HCT 80-25 MG TABLET (<i>telmisartan/hydrochlorothiazid</i>)	T3	ST 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> (Exforge)	T1	HD
<i>amlodipine-olmesartan 10-20 mg</i> (Azor)	T1	HD
<i>amlodipine-olmesartan 10-40 mg</i> (Azor)	T1	HD
<i>amlodipine-olmesartan 5-20 mg</i> (Azor)	T1	QL(1 TAB/DAY) HD
<i>amlodipine-olmesartan 5-40 mg</i> (Azor)	T1	HD
AZOR 10-20 MG TABLET (<i>amlodipine bes/olmesartan med</i>)	T3	PA HD
AZOR 10-40 MG TABLET (<i>amlodipine bes/olmesartan med</i>)	T3	PA HD
AZOR 5-20 MG TABLET (<i>amlodipine bes/olmesartan med</i>)	T3	PA QL(1 TAB/DAY) HD
AZOR 5-40 MG TABLET (<i>amlodipine bes/olmesartan med</i>)	T3	PA HD
EXFORGE (<i>amlodipine besylate/valsartan</i>)	T3	PA 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

T1 – Typically Generics

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AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANGIOTENSIN RECEPTOR BLOCKR-CALCIUM CHANNEL BLOCKR (cont.)		
<i>telmisartan-amlodipine 80-5 mg</i>	T1	HD
ANTI-HYPERTENSIVES, ACE INHIBITORS		
ACCUPRIL (quinapril hcl)	T3	ST HD
ALTACE (<i>ramipril</i>)	T3	PA HD
<i>benazepril hcl</i>	T1	HD
<i>benazepril hcl</i> (Lotensin)	T1	HD
<i>captopril</i>	T1	HD
<i>enalapril maleate</i> (Epaned)	T1	HD
<i>enalapril maleate</i> (Vasotec)	T1	HD
<i>enalaprilat dihydrate</i>	T1	
EPANED (<i>enalapril maleate</i>)	T3	PA HD
<i>fosinopril sodium</i>	T1	HD
<i>lisinopril</i> (Zestril)	T1	HD
LOTENSIN (<i>benazepril hcl</i>)	T3	ST HD
<i>moexipril hcl</i>	T1	HD
<i>perindopril erbumine</i>	T1	HD
QBRELIS	T3	PA HD
<i>quinapril hcl</i> (Accupril)	T1	HD
<i>ramipril</i>	T1	HD
<i>ramipril</i> (Altace)	T1	HD
<i>trandolapril</i>	T1	HD
VASOTEC (<i>enalapril maleate</i>)	T3	PA HD
ZESTRIL (<i>lisinopril</i>)	T3	PA HD
ANTI-HYPERTENSIVES, ANGIOTENSIN RECEPTOR ANTAGONIST		
ARBLI	T3	PA HD
ATACAND (<i>candesartan cilexetil</i>)	T3	PA HD
AVAPRO (<i>irbesartan</i>)	T3	PA HD
BENICAR 20 MG TABLET (<i>olmesartan medoxomil</i>)	T3	PA QL(1 TAB/DAY) HD
BENICAR 40 MG TABLET (<i>olmesartan medoxomil</i>)	T3	PA HD
BENICAR 5 MG TABLET (<i>olmesartan medoxomil</i>)	T3	PA HD
<i>candesartan cilexetil</i> (Atacand)	T1	HD
COZAAR (<i>losartan potassium</i>)	T3	PA HD
DIOVAN (<i>valsartan</i>)	T3	PA HD
EDARBI 40 MG TABLET	T3	PA QL(1 TAB/DAY) HD
EDARBI 80 MG TABLET	T3	PA HD

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-HYPERTENSIVES, ANGIOTENSIN RECEPTOR ANTAGONIST (cont.)		
<i>eprosartan mesylate</i>	T1	HD
<i>irbesartan</i>	T1	HD
<i>irbesartan (Avapro)</i>	T1	HD
<i>losartan potassium (Cozaar)</i>	T1	HD
MICARDIS 40 MG TABLET (<i>telmisartan</i>)	T3	PA QL(1 TAB/DAY) HD
MICARDIS 80 MG TABLET (<i>telmisartan</i>)	T3	PA HD
<i>olmesartan medoxomil 20 mg tab (Benicar)</i>	T1	QL(1 TAB/DAY) HD
<i>olmesartan medoxomil 40 mg tab (Benicar)</i>	T1	HD
<i>olmesartan medoxomil 5 mg tab (Benicar)</i>	T1	HD
<i>telmisartan 20 mg tablet</i>	T1	QL(1 TAB/DAY) HD
<i>telmisartan 40 mg tablet (Micardis)</i>	T1	QL(1 TAB/DAY) HD
<i>telmisartan 80 mg tablet (Micardis)</i>	T1	HD
<i>valsartan 160 mg tablet (Diovan)</i>	T1	HD
<i>valsartan 20 mg/5 ml solution</i>	T1	HD
VALSARTAN 20 MG/5 ML SOLUTION	T3	ST HD
<i>valsartan 320 mg tablet (Diovan)</i>	T1	HD
<i>valsartan 40 mg tablet (Diovan)</i>	T1	HD
<i>valsartan 80 mg tablet (Diovan)</i>	T1	HD
ANTIHYPERTENSIVES, GANGLIONIC BLOCKERS		
VECAMYL	T1	
ANTI-HYPERTENSIVES, MISCELLANEOUS		
DEMSEER (<i>metyrosine</i>)	T3	PA HD
<i>metyrosine (Demser)</i>	T1	PA HD
<i>nitroprusside sodium (Nitropress)</i>	T1	
ANTI-HYPERTENSIVES, SYMPATHOLYTIC		
CATAPRES-TTS 1 (<i>clonidine</i>)	T3	PA HD
CATAPRES-TTS 2 (<i>clonidine</i>)	T3	PA HD
CATAPRES-TTS 3 (<i>clonidine</i>)	T3	PA HD
<i>clonidine (Catapres-Tts 1)</i>	T1	HD
<i>clonidine (Catapres-Tts 2)</i>	T1	HD
<i>clonidine (Catapres-Tts 3)</i>	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
CLONIDINE HCL ER 0.17 MG TAB	T3	PA QL(2 TABS/DAY) HD

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-HYPERTENSIVES, SYMPATHOLYTIC (cont.)		
<i>guanfacine hcl</i>	T1	HD
<i>methyldopa</i>	T1	HD
<i>methyldopa/hydrochlorothiazide</i>	T1	HD
<i>methyldopate hcl</i>	T1	
NEXICLON XR	T3	PA QL(2 TABS/DAY) HD
ANTI-HYPERTENSIVES, VASODILATORS		
<i>hydralazine hcl</i>	T1	HD
<i>minoxidil</i>	T1	HD
BETA-ADRENERGIC BLOCKING AGENTS		
<i>acebutolol hcl</i>	T1	HD
<i>atenolol (Tenormin)</i>	T1	HD
BETAPACE (sotalol hcl)	T3	PA HD
BETAPACE AF (sotalol hcl)	T3	PA HD
<i>betaxolol hcl</i>	T1	HD
<i>bisoprolol fumarate 10 mg tab</i>	T1	HD
BISOPROLOL FUMARATE 2.5 MG TAB	T3	PA QL(1 TAB/DAY) HD
<i>bisoprolol fumarate 5 mg tab</i>	T1	HD
BREVIBLOC	T3	
BYSTOLIC 10 MG TABLET (nebivolol hcl)	T3	PA QL(1 TAB/DAY) HD
BYSTOLIC 2.5 MG TABLET (nebivolol hcl)	T3	PA QL(1 TAB/DAY) HD
BYSTOLIC 20 MG TABLET (nebivolol hcl)	T3	PA HD
BYSTOLIC 5 MG TABLET (nebivolol hcl)	T3	PA QL(1 TAB/DAY) HD
<i>esmolol hcl</i>	T1	
ESMOLOL HCL-WATER	T1	
<i>esmolol in sodium chloride,iso</i>	T1	
HEMANGEOL	T3	PA
INDERAL LA (propranolol hcl)	T3	PA HD
INDERAL XL	T3	PA HD
INNOPRAN XL	T3	PA HD
KAPSPARGO SPRINKLE	T3	PA HD
LOPRESSOR (metoprolol tartrate)	T3	PA HD
<i>metoprolol succinate (Toprol XL)</i>	T1	HD
<i>metoprolol tartrate</i>	T1	HD
<i>metoprolol tartrate (Lopressor)</i>	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.)		
<i>nadolol</i>	T1	HD
<i>nebivolol 10 mg tablet (Bystolic)</i>	T1	QL(1 TAB/DAY) HD
<i>nebivolol 2.5 mg tablet (Bystolic)</i>	T1	QL(1 TAB/DAY) HD
<i>nebivolol 20 mg tablet (Bystolic)</i>	T1	HD
<i>nebivolol 5 mg tablet (Bystolic)</i>	T1	QL(1 TAB/DAY) HD
<i>pindolol</i>	T1	HD
<i>propranolol hcl</i>	T1	HD
<i>propranolol hcl (Inderal La)</i>	T1	HD
SOTALOL HCL	T1	HD
SOTYLIZE	T3	HD
TENORMIN (atenolol)	T3	PA HD
<i>timolol maleate</i>	T1	HD
TOPROL XL (metoprolol succinate)	T3	PA HD
BETA-BLOCKERS AND THIAZIDE, THIAZIDE-LIKE DIURETICS		
<i>atenolol/chlorthalidone (Tenoretic 100)</i>	T1	HD
<i>atenolol/chlorthalidone (Tenoretic 50)</i>	T1	HD
<i>bisoprolol/hydrochlorothiazide</i>	T1	HD
<i>metoprolol/hydrochlorothiazide</i>	T1	HD
<i>propranolol/hydrochlorothiazid</i>	T1	HD
TENORETIC 100 (<i>atenolol/chlorthalidone</i>)	T3	PA HD
TENORETIC 50 (<i>atenolol/chlorthalidone</i>)	T3	PA HD
ENDOTHELIN RECEPTOR ANTAGONISTS		
TRYVIO	T3	PA SP
MUSCARINIC RECEPTOR ANTAGONISTS (ANTICHOLINERGIC)		
ATROPEN	T3	
PATENT DUCTUS ARTERIOSUS TREAT. AGENTS, NSAID-TYPE		
<i>ibuprofen lysine/pf (Neoprofen)</i>	T1	
<i>indomethacin 1 mg vial</i>	T1	
NEOPROFEN (<i>ibuprofen lysine/pf</i>)	T3	
RENIN INHIBITOR, DIRECT		
<i>aliskiren 150 mg tablet (Tekturna)</i>	T1	QL(1 TAB/DAY) HD
<i>aliskiren 300 mg tablet (Tekturna)</i>	T1	HD
TEKTURNA 150 MG TABLET (<i>aliskiren hemifumarate</i>)	T3	PA QL(1 TAB/DAY) HD
TEKTURNA 300 MG TABLET (<i>aliskiren hemifumarate</i>)	T3	PA HD

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
RENIN INHIBITOR, DIRECT AND THIAZIDE DIURETIC COMB		
TEKTURNA HCT	T2	HD
VASODILATORS, COMBINATION		
BIDIL (<i>isosorbide dinit/hydralazine</i>)	T3	PA QL (6 TABS/DAY) HD
<i>isosorbide dinit/hydralazine (Bidil)</i>	T1	QL (6 TABS/DAY) HD
VASODILATORS, PERIPHERAL		
<i>ergoloid mesylates</i>	T1	
<i>isoxsuprine hcl</i>	T1	
<i>papaverine hcl</i>	T1	

CARDIOVASCULAR (Cholesterol Medications)

ANTI-HYPERLIP.HMG COA REDUCT INHIB-CHOLEST.AB.INHIB		
<i>ezetimibe/atorvastatin calcium</i>	T1	PA HD
EZETIMIBE/SIMVASTATIN (VYTORIN)	T1	HD
ROSUVASTATIN-EZETIMIBE	T3	PA HD
ROSZET	T3	PA HD
VYTORIN (<i>ezetimibe/simvastatin</i>)	T3	PA HD
ANTI-HYPERLIPID- 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
<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 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

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List of Prescription Medications

CARDIOVASCULAR (Cholesterol Medications) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIHYPERLIPIDEMIC - ANGIOPOIETIN-LIKE 3 INHIBITOR		
EVKEEZA	T3	PA SP
ANTIHYPERLIPIDEMIC - APOLIPOPROTEIN INHIBITOR		
TRYNGOLZA	T3	PA QL(1 AUTO-INJ/28 DAYS) SP
ANTIHYPERLIPIDEMIC - ATP CITRATE LYASE INHIBITOR		
NEXLETOL	T2	PA QL(1 TAB/DAY)
ANTI-HYPERLIPIDEMIC - MTP INHIBITOR		
JUXTAPID 10 MG CAPSULE	T3	PA QL(1 CAP/DAY) SP HD
JUXTAPID 20 MG CAPSULE	T3	PA QL(2 CAPS/DAY) SP HD
JUXTAPID 30 MG CAPSULE	T3	PA QL(2 CAPS/DAY) SP HD
JUXTAPID 5 MG CAPSULE	T3	PA QL(1 CAP/DAY) SP HD
ANTI-HYPERLIPIDEMIC - PCSK9 INHIBITORS		
LEQVIO	T3	PA SP
PRALUENT PEN	T3	PA
REPATHA PUSHTRONEX	T2	
REPATHA SURECLICK	T2	
REPATHA SYRINGE	T2	
ANTI-HYPERLIPIDEMIC-ACLY AND CHOLEST ABSORP INHIB		
NEXLIZET	T2	PA QL(1 TAB/DAY)
ANTI-HYPERLIPIDEMIC-HMGCOA REDUCTASE INHIB (Statins)		
ALTOPREV 20 MG TABLET	T3	ST QL(1 TAB/DAY) HD
ALTOPREV 40 MG TABLET	T3	ST HD
ALTOPREV 60 MG TABLET	T3	ST HD
ATORVALIQ	T3	ST HD
<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
CRESTOR 10 MG TABLET (<i>rosuvastatin calcium</i>)	T3	PA QL(1 TAB/DAY) HD
CRESTOR 20 MG TABLET (<i>rosuvastatin calcium</i>)	T3	PA QL(1 TAB/DAY) HD
CRESTOR 40 MG TABLET (<i>rosuvastatin calcium</i>)	T3	PA HD

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List of Prescription Medications

CARDIOVASCULAR (Cholesterol Medications) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-HYPERLIPIDEMIC-HMGCOA REDUCTASE INHIB (Statins) (cont.)		
CRESTOR 5 MG TABLET (<i>rosuvastatin calcium</i>)	T3	PA QL(1 TAB/DAY) HD
FLOLIPID	T3	ST HD
<i>fluvastatin sodium</i>	T1	HD PPACA
<i>fluvastatin sodium</i> (Lescol XL)	T1	HD PPACA
LESCOL XL (<i>fluvastatin sodium</i>)	T3	PA HD
LIPITOR (<i>atorvastatin calcium</i>)	T3	PA HD
LIVALO 1 MG TABLET (<i>pitavastatin calcium</i>)	T3	PA QL(1 TAB/DAY) HD
LIVALO 2 MG TABLET (<i>pitavastatin calcium</i>)	T3	PA QL(1 TAB/DAY) HD
LIVALO 4 MG TABLET (<i>pitavastatin calcium</i>)	T3	PA HD
<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</i> (Livalo)	T1	QL(1 TAB/DAY) HD PPACA
<i>pitavastatin 2 mg tablet</i> (Livalo)	T1	QL(1 TAB/DAY) HD PPACA
<i>pitavastatin 4 mg tablet</i> (Livalo)	T1	HD PPACA
<i>rosuvastatin calcium 10 mg tab</i> (Crestor)	T1	QL(1 TAB/DAY) HD PPACA
<i>rosuvastatin calcium 20 mg tab</i> (Crestor)	T1	QL(1 TAB/DAY) HD
<i>rosuvastatin calcium 40 mg tab</i> (Crestor)	T1	HD
<i>rosuvastatin calcium 5 mg tab</i> (Crestor)	T1	QL(1 TAB/DAY) HD PPACA
<i>simvastatin 10 mg tablet</i> (Zocor)	T1	HD PPACA
<i>simvastatin 20 mg tablet</i> (Zocor)	T1	HD PPACA
<i>simvastatin 40 mg tablet</i> (Zocor)	T1	HD PPACA
<i>simvastatin 5 mg tablet</i>	T1	HD
<i>simvastatin 80 mg tablet</i>	T1	QL(1 TAB/DAY) HD
ZOCOR (<i>simvastatin</i>)	T3	PA HD
ZYPITAMAG	T3	ST HD
BILE SALT SEQUESTRANTS		
<i>cholestyramine (with sugar)</i> (Questran)	T1	HD
<i>cholestyramine/aspartame</i>	T1	HD
<i>cholestyramine/aspartame</i> (Questran Light)	T1	HD
<i>colesevelam hcl</i> (Welchol)	T1	HD

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List of Prescription Medications

CARDIOVASCULAR (Cholesterol Medications) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BILE SALT SEQUESTRANTS (con't.)		
<i>cholestyramine</i>	T1	HD
<i>cholestyramine</i> (Questran Light)	T1	HD
<i>cholestyramine</i> (with sugar) (Questran)	T1	HD
<i>cholestyramine/aspartame</i>	T1	HD
<i>colesevelam hcl</i> (Welchol)	T1	HD
COLESTID (colestipol hcl)	T3	HD
<i>colestipol hcl</i> (Colestid)	T1	HD
QUESTRAN (<i>cholestyramine</i>)	T3	HD
QUESTRAN LIGHT (<i>prevalite</i>)	T3	HD
WELCHOL (<i>colesevelam hcl</i>)	T3	PA HD
LIPOTROPICS		
ezetimibe (Zetia)	T1	HD
<i>fenofibrate 120 mg tablet</i> (Fenoglide)	T1	HD
<i>fenofibrate 130 mg capsule</i>	T1	HD
<i>fenofibrate 134 mg capsule</i>	T1	HD
<i>fenofibrate 145 mg tablet</i> (Tricor)	T1	HD
FENOFIBRATE 150 MG CAPSULE	T1	HD
<i>fenofibrate 160 mg tablet</i>	T1	HD
<i>fenofibrate 200 mg capsule</i>	T1	HD
FENOFIBRATE 30 MG CAPSULE	T3	PA HD
<i>fenofibrate 40 mg tablet</i> (Fenoglide)	T1	HD
<i>fenofibrate 43 mg capsule</i>	T1	HD
<i>fenofibrate 48 mg tablet</i> (Tricor)	T1	HD
FENOFIBRATE 50 MG CAPSULE	T1	HD
<i>fenofibrate 54 mg tablet</i>	T1	HD
<i>fenofibrate 67 mg capsule</i>	T1	HD
FENOFIBRATE 90 MG CAPSULE	T3	PA HD
<i>fenofibric acid</i>	T1	HD
<i>fenofibric acid (choline)</i>	T1	HD
fenofibric acid (Fibricor)	T1	HD
FENOGLIDE (<i>fenofibrate</i>)	T3	PA HD
FIBRICOR (<i>fenofibric acid</i>)	T3	ST HD

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List of Prescription Medications

CARDIOVASCULAR (Cholesterol Medications) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LIPOTROPICS (con't.)		
<i>gemfibrozil</i> (Lopid)	T1	HD
LIPOFEN	T3	ST HD
LOPID (<i>gemfibrozil</i>)	T3	HD
<i>niacin</i>	T1	PA HD
NIACOR	T3	PA HD
TRICOR (<i>fenofibrate nanocrystallized</i>)	T3	ST HD
ZETIA (<i>ezetimibe</i>)	T3	PA HD
ENDOTHELIN-ANGIOTENSIN RECEPTOR ANTAGONIST		
FILSPARI	T2	PA QL(1 tab/day) SP HD
CARDIOVASCULAR (Miscellaneous)		
VENOSCLEROSING AGENTS		
ASCLERA	T3	PA SP
ETHAMOLIN	T3	
<i>sodium tetradecyl sulfate</i> (Sotradecol)	T3	
SOTRADECOL (sodium tetradecyl sulfate)	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</i> (Namenda Xr)	T1	QL(1 CAP/DAY) HD
<i>memantine hcl er 21 mg capsule</i>	T1	HD
<i>memantine hcl er 28 mg capsule</i> (Namenda Xr)	T1	HD
<i>memantine hcl er 7 mg capsule</i> (Namenda Xr)	T1	QL(1 CAP/DAY) HD
NAMENDA	T2	HD
NAMENDA XR 14 MG CAPSULE (<i>memantine hcl</i>)	T3	PA QL(1 CAP/DAY) HD
NAMENDA XR 28 MG CAPSULE (<i>memantine hcl</i>)	T3	PA HD
NAMENDA XR 7 MG CAPSULE (<i>memantine hcl</i>)	T3	PA QL(1 CAP/DAY) 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
NAMZARIC 14 MG-10 MG CAPSULE (<i>memantine hcl/donepezil hcl</i>)	T3	PA QL(2 CAPS/DAY) HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

CNS DRUGS (Alzheimer's Disease)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ALZHEIMER'S THX, NMDA RECEPTOR ANTAG-CHOLINES INHIB		
NAMZARIC 21 MG-10 MG CAPSULE (memantine hcl/donepezil hcl)	T3	PA QL(2 CAPS/DAY) HD
NAMZARIC 28 MG-10 MG CAPSULE (memantine hcl/donepezil hcl)	T3	PA QL(2 CAPS/DAY) HD
NAMZARIC 7 MG-10 MG CAPSULE	T3	PA QL(2 CAPS/DAY) HD
NAMZARIC TITRATION PACK	T3	PA QL(112 CAPS/365 DAYS) HD
AMYLOID DIRECTED MONOCLONAL ANTIBODY		
ADUHELM	T3	PA SP
KISUNLA	T3	PA SP
LEQEMBI	T3	PA SP
LEQEMBI IQLIK	T3	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>	T1	PA SP
EDARAVONE 30 MG/100 ML VIAL	T3	PA SP
<i>edaravone 60 mg/100 ml bag</i>	T1	PA SP
EDARAVONE 60 MG/100 ML VIAL	T3	PA SP
RADICAVA	T3	PA SP
RADICAVA ORS 105 MG/5 ML SUSP	T3	PA QL(50 MLS/30 DAYS) SP HD
RADICAVA ORS STARTER KIT SUSP	T3	PA QL(70 MLS/365 DAYS) SP HD
RILUTEK (riluzole)	T3	PA SP HD
<i>riluzole (Rilutek)</i>	T1	SP HD
TEGLUTIK	T3	PA SP
TIGLUTIK	T3	PA SP
CENTRAL NERVOUS SYSTEM STIMULANTS		
DOPRAM	T3	
DRUGS TO TREAT MOVEMENT DISORDERS		
AUSTEDO	T3	PA SP HD
AUSTEDO XR 12 MG TABLET	T3	PA QL(1 TAB/DAY) SP HD
AUSTEDO XR 18 MG TABLET	T3	PA QL(1 TAB/DAY) SP HD
AUSTEDO XR 24 MG TABLET	T3	PA QL(2 TABS/DAY) SP HD
AUSTEDO XR 30 MG TABLET	T3	PA QL(1 TAB/DAY) SP HD

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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		
AUSTEDO XR 36 MG TABLET	T3	PA QL(1 TAB/DAY) SP HD
AUSTEDO XR 42 MG TABLET	T3	PA QL(1 TAB/DAY) SP HD
AUSTEDO XR 48 MG TABLET	T3	PA QL(1 TAB/DAY) SP HD
AUSTEDO XR 6 MG TABLET	T3	PA QL(3 TABS/DAY) SP HD
AUSTEDO XR TITRATION KIT(WK1-4)	T3	PA QL(1 KIT/180 DAYS) SP HD
HORIZANT	T3	PA
INGREZZA	T3	PA QL(1 CAP/DAY) SP
INGREZZA INITIATION PK(TARDIV)	T3	PA QL(28 CAPS/365 DAYS) SP
INGREZZA SPRINKLE	T3	PA QL(1 CAP/DAY) SP
<i>tetrabenazine</i> (Xenazine)	T1	PA SP HD
XENAZINE (tetrabenazine)	T3	PA SP HD
GLYPROMATE (GPE) ANALOGS		
DAYBUE	T3	PA QL(120 MLS/DAY) SP
PSEUDOBLBAR AFFECT (PBA) AGENTS, NMDA ANTAGONISTS		
NUJEXTA	T3	QL(4 CAPS/DAY)
XANTHINES		
CAFICIT (<i>caffeine citrate</i>)	T3	HD
CAFFEINE AND SODIUM BENZOATE	T1	HD
<i>caffeine citrate</i>	T1	HD
<i>caffeine citrate</i> (Cafcit)	T1	HD
<i>caffeine/sodium benzoate</i>	T1	HD
CNS DRUGS (Multiple Sclerosis)		
AGENTS TO TREAT MULTIPLE SCLEROSIS		
AUBAGIO (<i>teriflunomide</i>)	T3	PA SP HD
AVONEX (4 PACK)	T2	PA SP HD
AVONEX PEN (4 PACK)	T2	PA SP HD
BAFIERTAM	T2	PA SP HD
BETASERON	T2	PA SP HD
BRIUMVI	T3	PA SP
<i>cladribine 10 mg x 10 tab pk</i>	T1	PA SP HD
<i>cladribine 10 mg x 4 tablet pk</i>	T1	PA SP HD
<i>cladribine 10 mg x 5 tablet pk</i>	T1	PA SP HD
<i>cladribine 10 mg x 6 tablet pk</i>	T1	PA SP HD
<i>cladribine 10 mg x 7 tablet pk</i>	T1	PA SP HD
<i>cladribine 10 mg x 8 tablet pk</i>	T1	PA SP HD

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List of Prescription Medications

CNS DRUGS (Multiple Sclerosis) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AGENTS TO TREAT MULTIPLE SCLEROSIS (cont.)		
<i>cladribine 10 mg x 9 tablet pk</i>	T1	PA SP HD
COPAXONE (<i>glatiramer acetate</i>)	T3	PA SP HD
<i>dimethyl fumarate 30d start pk</i> (Tecfidera)	T1	SP HD
<i>dimethyl fumarate dr 120 mg cp</i> (Tecfidera)	T1	HD
<i>dimethyl fumarate dr 120 mg cp</i> (Tecfidera)	T1	SP HD
<i>dimethyl fumarate dr 240 mg cp</i> (Tecfidera)	T1	HD
<i>dimethyl fumarate dr 240 mg cp</i> (Tecfidera)	T1	SP HD
<i>fingolimod hcl</i> (Gilenya)	T1	SP HD
GILENYA 0.25 MG CAPSULE	T3	PA QL(1 CAP/DAY) SP
GILENYA 0.5 MG CAPSULE (<i>fingolimod hcl</i>)	T3	PA SP HD
<i>glatiramer acetate</i> (Copaxone)	T1	SP HD
TASCENSO ODT	T3	PA QL(1 tab/day) SP HD
KESIMPTA PEN	T2	PA SP HD
LEMTRADA	T3	PA SP HD
MAVENCLAD	T3	PA SP HD
MAYZENT	T2	PA SP HD
OCREVUS	T2	PA SP HD
OCREVUS ZUNOVO	T2	PA SP
PLEGRIDY	T2	PA SP HD
PONVORY	T3	PA SP HD
REBIF	T2	PA SP HD
REBIF REBIDOSE	T2	PA SP HD
TASCENSO ODT	T3	PA QL(1 TAB/DAY) SP HD
TECFIDERA (<i>dimethyl fumarate</i>)	T3	PA SP HD
<i>teriflunomide</i> (Aubagio)	T1	SP HD
VUMERITY	T2	PA SP HD
AGTS TX NEUROMUSC TRANSMISSION DIS, POT-CHAN BLKR		
AMPYRA (<i>dalfampridine</i>)	T3	PA SP HD
<i>dalfampridine er 10 mg tablet</i> (Ampyra)	T1	PA SP HD
FIRDAPSE	T3	PA QL(8 TABS/DAY) SP

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List of Prescription Medications

CNS DRUGS (Pain Relief And Inflammatory Disease)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
POSTHERPETIC NEURALGIA AGENTS		
GRALISE (<i>gabapentin</i>)	T3	PA
SPHINGOSINE I-PHOSPHATE (SIP) RECEPTOR MODULATOR		
VELSIPITY	T2	PA QL(30 TABS/30 DAYS) SP HD
ZEPOSIA	T2	PA SP HD

CNS DRUGS (Seizure Disorders)

ANTI-CONVULSANT - BENZODIAZEPINE TYPE		
<i>clobazam</i> (Onfi)	T1	HD
<i>clonazepam</i>	T1	HD
<i>clonazepam</i> (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
LIBERVANT	T3	PA QL(10 FILMS/30 DAYS) HD
NAYZILAM	T2	PA QL(10 UNITS/30 DAYS) HD
ONFI (<i>clobazam</i>)	T3	PA HD
SYMPAZAN	T3	PA HD
VALTOCO	T2	PA QL(10 BLISTER PACKS/30 DAYS) HD
ANTI-CONVULSANT - CANNABINOID TYPE		
EPIDIOLEX	T3	PA SP HD
ANTI-CONVULSANTS		
APTIOM 200 MG TABLET (<i>eslicarbazepine acetate</i>)	T3	PA QL(1 TAB/DAY) HD
APTIOM 400 MG TABLET (<i>eslicarbazepine acetate</i>)	T3	PA QL(1 TAB/DAY) HD
APTIOM 600 MG TABLET (<i>eslicarbazepine acetate</i>)	T3	PA HD
APTIOM 800 MG TABLET (<i>eslicarbazepine acetate</i>)	T3	PA HD
BANZEL 200 MG TABLET (<i>rufinamide</i>)	T3	PA QL(16 TABS/DAY) HD
BANZEL 40 MG/ML SUSPENSION (<i>rufinamide</i>)	T3	PA QL(80 MLS/DAY) HD
BANZEL 400 MG TABLET (<i>rufinamide</i>)	T3	PA QL(8 TABS/DAY) HD
BRIVIACT 10 MG TABLET	T3	PA HD

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List of Prescription Medications

CNS DRUGS (Seizure Disorders) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-CONVULSANTS (cont.)		
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 (Carbatrol)</i>	T1	HD
<i>carbamazepine (Tegretol Xr)</i>	T1	HD
<i>carbamazepine (Tegretol)</i>	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 (Tegretol)</i>	T1	HD
CARBAMAZEPINE 200 MG TAB CHEW	T3	HD
<i>carbamazepine 200 mg tablet (Tegretol)</i>	T1	HD
<i>carbamazepine 200 mg/10 ml cup</i>	T1	HD
CARBATROL (<i>carbamazepine</i>)	T3	PA HD
CELONTIN (<i>methsuximide</i>)	T3	HD
CEREBYX (<i>fosphenytoin sodium</i>)	T3	
DEPAKOTE (<i>divalproex sodium</i>)	T3	PA HD
DEPAKOTE ER (<i>divalproex sodium</i>)	T3	PA HD
DEPAKOTE SPRINKLE (<i>divalproex sodium</i>)	T3	PA HD
DIACOMIT	T3	PA SP HD
DILANTIN	T3	PA HD
DILANTIN (<i>phenytoin sodium extended</i>)	T3	PA HD
DILANTIN (<i>phenytoin</i>)	T3	PA HD
DILANTIN-125 (<i>phenytoin</i>)	T3	PA HD
<i>divalproex sodium (Depakote Er)</i>	T1	HD
<i>divalproex sodium (Depakote Sprinkle)</i>	T1	HD
<i>divalproex sodium (Depakote)</i>	T1	HD
ELEPSIA XR	T3	PA HD
EPRONTIA (<i>topiramate</i>)	T3	PA HD
<i>eslicarbazepine 200 mg tablet (Aptiom)</i>	T1	PA QL(1 TAB/DAY) HD
<i>eslicarbazepine 400 mg tablet (Aptiom)</i>	T1	PA QL(1 TAB/DAY) HD

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List of Prescription Medications

CNS DRUGS (Seizure Disorders) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-CONVULSANTS (cont.)		
<i>eslicarbazepine 600 mg tablet (Aptiom)</i>	T1	PA HD
<i>eslicarbazepine 800 mg tablet (Aptiom)</i>	T1	PA HD
ethosuximide (Zarontin)	T1	HD
felbamate (Felbatol)	T1	HD
FELBATOL (felbamate)	T3	PA HD
FINTEPLA	T3	PA SP HD
<i>fosphenytoin sodium (Cerebyx)</i>	T1	
FYCOMPA 0.5 MG/ML ORAL SUSP	T2	PA HD
FYCOMPA 10 MG TABLET (perampanel)	T3	PA HD
FYCOMPA 12 MG TABLET (perampanel)	T3	PA HD
FYCOMPA 2 MG TABLET (perampanel)	T3	PA HD
FYCOMPA 4 MG TABLET (perampanel)	T3	PA QL(1 TAB/DAY) HD
FYCOMPA 6 MG TABLET (perampanel)	T3	PA QL(1 TAB/DAY) HD
FYCOMPA 8 MG TABLET (perampanel)	T3	PA HD
<i>gabapentin</i>	T1	HD
<i>gabapentin (Neurontin)</i>	T1	HD
GABARONE	T3	PA HD
KEPPRA 1,000 MG TABLET (<i>levetiracetam</i>)	T3	PA HD
KEPPRA 100 MG/ML ORAL SOLN (<i>levetiracetam</i>)	T3	PA HD
KEPPRA 250 MG TABLET (<i>levetiracetam</i>)	T3	PA HD
KEPPRA 500 MG TABLET (<i>levetiracetam</i>)	T3	PA HD
KEPPRA 500 MG/5 ML VIAL (<i>levetiracetam</i>)	T3	
KEPPRA 750 MG TABLET (<i>levetiracetam</i>)	T3	PA HD
KEPPRA XR (<i>levetiracetam</i>)	T3	PA HD
<i>lacosamide (Vimpat)</i>	T1	HD
LAMICTAL (BLUE) (<i>lamotrigine</i>)	T3	PA HD
LAMICTAL (GREEN) (<i>lamotrigine</i>)	T3	PA HD
LAMICTAL (<i>lamotrigine</i>)	T3	PA HD
LAMICTAL (ORANGE) (<i>lamotrigine</i>)	T3	PA HD
LAMICTAL ODT (BLUE) (<i>lamotrigine</i>)	T3	PA HD
LAMICTAL ODT (GREEN) (<i>lamotrigine</i>)	T3	PA HD
LAMICTAL ODT (<i>lamotrigine</i>)	T3	PA HD
LAMICTAL ODT (ORANGE) (<i>lamotrigine</i>)	T3	PA HD
LAMICTAL XR (BLUE)	T3	PA HD
LAMICTAL XR (GREEN)	T3	PA HD

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T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

CNS DRUGS (Seizure Disorders) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-CONVULSANTS (cont.)		
LAMICTAL XR (<i>lamotrigine</i>)	T3	PA HD
LAMICTAL XR (ORANGE)	T3	PA 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
<i>levetiracetam</i> (Keppra)	T1	HD
<i>levetiracetam</i> 1,000 mg tablet (Keppra)	T1	HD
<i>levetiracetam</i> 1,000mg/10ml cup (Keppra)	T1	HD
<i>levetiracetam</i> 100 mg/ml soln (Keppra)	T1	HD
LEVETIRACETAM 250 MG TAB SUSP	T3	PA HD
<i>levetiracetam</i> 250 mg tablet (Keppra)	T1	HD
<i>levetiracetam</i> 500 mg tablet (Keppra)	T1	HD
<i>levetiracetam</i> 500 mg/5 ml cup	T1	HD
<i>levetiracetam</i> 500 mg/5 ml soln	T1	HD
<i>levetiracetam</i> 500 mg/5 ml vial (Keppra)	T1	
<i>levetiracetam</i> 750 mg tablet (Keppra)	T1	HD
<i>levetiracetam-nacl</i> 1,000mg/100	T1	
<i>levetiracetam-nacl</i> 1,500mg/100	T1	
<i>primidone</i> 50 mg tablet (Mysoline)	T1	HD
LEVETIRACETAM-NAACL 250 MG/50ML	T3	
<i>levetiracetam-nacl</i> 500 mg/100	T1	
LYRICA (<i>pregabalin</i>)	T3	PA HD
<i>methsuximide</i> (Celontin)	T1	HD
MOTPOLY XR 100 MG CAPSULE	T3	PA QL(1 CAP/DAY) HD
MOTPOLY XR 150 MG CAPSULE	T3	PA QL(2 CAPS/DAY) HD
MOTPOLY XR 200 MG CAPSULE	T3	PA QL(2 CAPS/DAY) HD
MYSOLINE (<i>primidone</i>)	T3	PA HD

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List of Prescription Medications

CNS DRUGS (Seizure Disorders) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-CONVULSANTS (cont.)		
NEURONTIN (<i>gabapentin</i>)	T3	PA HD
<i>oxcarbazepine (Oxtellar Xr)</i>	T1	PA HD
<i>oxcarbazepine (Trileptal)</i>	T1	HD
OXTELLAR XR (<i>oxcarbazepine</i>)	T3	PA HD
<i>perampanel 10 mg tablet (Fycompa)</i>	T1	PA HD
<i>perampanel 12 mg tablet (Fycompa)</i>	T1	PA HD
<i>perampanel 2 mg tablet (Fycompa)</i>	T1	PA HD
<i>perampanel 4 mg tablet (Fycompa)</i>	T1	PA QL(1 TAB/DAY) HD
<i>perampanel 6 mg tablet (Fycompa)</i>	T1	PA QL(1 TAB/DAY) HD
<i>perampanel 8 mg tablet (Fycompa)</i>	T1	PA HD
PHENYTEK (<i>phenytoin sodium extended</i>)	T3	PA HD
<i>phenytoin</i>	T1	HD
<i>phenytoin (Dilantin)</i>	T1	HD
<i>phenytoin (Dilantin-125)</i>	T1	HD
<i>phenytoin sodium</i>	T1	HD
<i>phenytoin sodium extended (Dilantin)</i>	T1	HD
<i>phenytoin sodium extended (Phenytek)</i>	T1	HD
<i>pregabalin (Lyrica)</i>	T1	HD
PRIMIDONE 125 MG TABLET	T3	PA HD
<i>primidone 250 mg tablet (Mysoline)</i>	T1	HD
<i>primidone 50 mg tablet (Mysoline)</i>	T1	HD
QUDEXY XR (<i>topiramate</i>)	T3	PA HD
<i>rufinamide 200 mg tablet (Banzel)</i>	T1	PA QL(16 TABS/DAY) HD
<i>rufinamide 40 mg/ml suspension (Banzel)</i>	T1	PA QL(80 MLS/DAY) HD
<i>rufinamide 400 mg tablet (Banzel)</i>	T1	PA QL(8 TABS/DAY) HD
VIMPAT 200 MG/20 ML VIAL	T3	HD
SABRIL (<i>vigabatrin</i>)	T3	PA SP HD
SPRITAM	T3	PA HD
<i>subvenite 100 mg tablet (Lamictal)</i>	T1	HD
<i>subvenite 150 mg tablet (Lamictal)</i>	T1	HD
<i>subvenite 200 mg tablet (Lamictal)</i>	T1	HD
<i>subvenite 25 mg tablet (Lamictal)</i>	T1	HD
TEGRETOL (<i>carbamazepine</i>)	T3	PA HD

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List of Prescription Medications

CNS DRUGS (Seizure Disorders) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-CONVULSANTS (cont.)		
TEGRETOL XR (carbamazepine)	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
TOPAMAX (<i>topiramate</i>)	T3	PA HD
<i>topiramate (Qudexy Xr)</i>	T1	HD
<i>topiramate 100 mg tablet (Topamax)</i>	T1	HD
<i>topiramate 15 mg sprinkle cap (Topamax)</i>	T1	HD
<i>topiramate 200 mg tablet (Topamax)</i>	T1	HD
<i>topiramate 25 mg sprinkle cap (Topamax)</i>	T1	HD
<i>topiramate 25 mg tablet (Topamax)</i>	T1	HD
<i>topiramate 25 mg/ml solution (Eprontia)</i>	T1	HD
<i>topiramate 50 mg sprinkle cap</i>	T1	HD
TOPIRAMATE 50 MG SPRINKLE CAP	T3	PA HD
<i>topiramate 50 mg tablet (Topamax)</i>	T1	HD
<i>topiramate er 100 mg capsule (Trokendi Xr)</i>	T1	QL(1 CAP/DAY) HD
<i>topiramate er 200 mg capsule (Trokendi Xr)</i>	T1	HD
<i>topiramate er 25 mg capsule (Trokendi Xr)</i>	T1	QL(1 CAP/DAY) HD
<i>topiramate er 50 mg capsule (Trokendi Xr)</i>	T1	HD
TRILEPTAL (<i>oxcarbazepine</i>)	T3	PA 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 (Sabril)</i>	T1	SP HD
<i>vigadrone 500 mg powder packet (Sabril)</i>	T1	SP HD
<i>vigadrone 500 mg tablet (Sabril)</i>	T1	PA SP HD
VIGAFYDE	T3	PA SP
VIMPAT 10 MG/ML SOLUTION (<i>lacosamide</i>)	T2	HD
VIMPAT 100 MG TABLET (<i>lacosamide</i>)	T3	PA HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

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List of Prescription Medications

CNS DRUGS (Seizure Disorders) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-CONVULSANTS (cont.)		
VIMPAT 150 MG TABLET (<i>lacosamide</i>)	T3	PA HD
VIMPAT 200 MG TABLET (<i>lacosamide</i>)	T3	PA HD
VIMPAT 200 MG/20 ML VIAL (<i>lacosamide</i>)	T3	HD
VIMPAT 50 MG TABLET (<i>lacosamide</i>)	T3	PA 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
ZONEGRAN (<i>zonisamide</i>)	T3	PA HD
ZONISADE	T3	PA QL(6 MLS/30 DAYS) HD
<i>zonisamide</i> (Zonegran)	T1	HD

CNS DRUGS (SLEEP DISORDERS/SEDATIVES)

NARCOLEPSY TX-H3-RECEPT.ANTAGONIST/INVERSE AGONIST

WAKIX	T3	PA QL(2 TABS/DAY) SP HD
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COLONY STIMULATING FACTORS (Blood Modifiers/Bleeding Disorders)

ERYTHROPOIESIS-STIMULATING AGENTS

ARANESP	T2	PA SP
EPOGEN	T2	PA SP
MIRCERA	T3	PA SP
PROCRIT	T2	PA SP
RETACRIT	T2	PA SP

LEUKOCYTE (WBC) STIMULANTS

FULPHILA	T3	PA SP
FYLNETRA	T3	PA SP
GRANIX	T3	PA SP

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List of Prescription Medications

COLONY STIMULATING FACTORS (Blood Modifiers/Bleeding Disorders) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LEUKOCYTE (WBC) STIMULANTS (cont.)		
LEUKINE	T2	SP
NEULASTA	T2	PA SP
NEULASTA ONPRO	T2	PA SP HD
NEUPOGEN	T3	PA SP
NIVESTYM	T2	SP HD
NYPOZI	T3	PA SP
NYVEPRIA	T2	PA SP
RYZNEUTA	T3	PA SP
STIMUFEND	T3	PA SP
UDENYCA	T2	PA SP
UDENYCA AUTOINJECTOR	T2	PA SP
UDENYCA ONBODY	T2	PA SP
ZARXIO	T2	SP HD
ZIEXTENZO	T3	PA SP
THROMBOPOIETIN RECEPTOR AGONISTS		
ALVAIZ 18 MG TABLET	T3	PA QL(1 TAB/DAY) SP
ALVAIZ 36 MG TABLET	T3	PA QL(2 TABS/DAY) SP
ALVAIZ 54 MG TABLET	T3	PA QL(2 TABS/DAY) SP
ALVAIZ 9 MG TABLET	T3	PA QL(1 TAB/DAY) SP
DOPTELET	T2	PA SP HD
DOPTELET SPRINKLE	T2	PA SP HD
<i>eltrombopag olamine (Promacta)</i>	T1	PA SP HD
MULPLETA	T3	PA SP HD
NPLATE	T3	PA SP
PROMACTA (<i>eltrombopag olamine</i>)	T3	PA SP HD
COLONY STIMULATING FACTORS (Blood Pressure/Heart Medications)		
LEUKOCYTE (WBC) STIMULANTS		
RELEUKO	T3	PA SP
ROLVEDON	T2	PA SP
COLONY STIMULATING FACTORS (Cancer)		
CXCR4 CHEMOKINE RECEPTOR ANTAGONIST		
APHEXDA	T3	PA SP

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List of Prescription Medications

COLONY STIMULATING FACTORS (Cancer) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CXCR4 CHEMOKINE RECEPTOR ANTAGONIST		
MOZOBIL (<i>plerixafor</i>)	T3	PA SP
<i>plerixafor</i> (Mozobil)	T1	PA SP
XOLREMDI	T3	PA QL(4 CAPS/DAY) SP CSL
CONTRACEPTIVES (Contraception Products)		
CONTRACEPTIVES, INTRAVAGINAL, SYSTEMIC		
ANNOVERA	T3	PPACA
<i>etonogestrel/ethinyl estradiol</i> (Nuvaring)	T1	PPACA
NUVARING (<i>etonogestrel/ethinyl estradiol</i>)	T3	PPACA
CONTRACEPTIVES, IMPLANTABLE		
NEXPLANON	T3	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, INTRAVAGINAL		
PHEXX	T3	PA PPACA
PHEXXI	T3	PA PPACA
CONTRACEPTIVES, ORAL		
AVERI	T3	PA HD PPACA
BALCOLTRA (<i>levonorgest/eth.estradiol/iron</i>)	T3	HD PPACA
BEYAZ (<i>drospir/eth estra/levomefol ca</i>)	T3	HD PPACA
<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
FEMLYV	T3	PA HD PPACA
<i>levonorgest/eth.estradiol/iron</i> (Balcoltra)	T1	HD PPACA

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List of Prescription Medications

CONTRACEPTIVES (Contraception Products) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CONTRACEPTIVES, ORAL (cont.)		
<i>levonorgestrel/ethin.estradiol</i>	T1	HD PPACA
<i>l-norgest/e.estradiol-e.estradiol</i>	T1	HD PPACA
LO LOESTRIN FE	T3	PA
LOESTRIN (<i>norethindrone ac/eth estradiol</i>)	T3	HD PPACA
LOESTRIN FE (<i>norethindrone-e.estradiol-iron</i>)	T3	HD PPACA
NATAZIA	T3	HD PPACA
NEXTSTELLIS	T3	HD PPACA
<i>noreth-ethinyl estradiol/iron</i>	T1	HD PPACA
<i>noreth-ethinyl estradiol/iron</i>	T3	HD PPACA
<i>norethind-eth estrad 1-0.02 mg (Loestrin)</i>	T1	HD PPACA
NORETHINDRONE	T1	HD PPACA
<i>norethindrone ac/eth estradiol (Loestrin)</i>	T1	HD PPACA
<i>norethindrone-e.estradiol-iron</i>	T1	HD PPACA
<i>norethindrone-e.estradiol-iron (Loestrin Fe)</i>	T1	HD PPACA
<i>norethindrone-e.estradiol-iron (Taytulla)</i>	T1	HD PPACA
<i>norethindrone-ethin. estradiol</i>	T1	HD PPACA
<i>norethin-ee 1.5-0.03 mg(21) tb (Loestrin)</i>	T1	HD PPACA
<i>norgestimate-ethinyl estradiol</i>	T1	HD PPACA
<i>norgestrel-ethinyl estradiol</i>	T1	HD PPACA
SAFYRAL (<i>drospir/eth estra/levomefol ca</i>)	T3	HD PPACA
SLYND	T3	HD PPACA
TAYTULLA (<i>norethindrone-e.estradiol-iron</i>)	T3	HD PPACA
TYBLUME	T3	HD PPACA
YASMIN 28 (<i>ethinyl estradiol/drospirenone</i>)	T3	HD PPACA
YAZ (<i>ethinyl estradiol/drospirenone</i>)	T3	HD PPACA
CONTRACEPTIVES, TRANSDERMAL		
<i>norelgestromin/ethin.estradiol</i>	T1	HD PPACA
<i>norelgestromin/ethin.estradiol</i>	T1	PPACA
TWIRLA	T3	HD PPACA
INTRA-UTERINE DEVICES (IUDS)		
KYLEENA	T3	SP PPACA
LILETTA	T3	SP PPACA
MIRENA	T3	SP PPACA
MIUDELLA	T3	SP PPACA

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List of Prescription Medications

CONTRACEPTIVES (Contraception Products) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
INTRA-UTERINE DEVICES (IUDS) (cont.)		
PARAGARD T 380-A	T3	SP PPACA
PARAGARD T 380A (SINGLE HAND)	T3	SP PPACA
SKYLA	T3	SP PPACA
COUGH/COLD PREPARATIONS (Allergy/Nasal Sprays)		
1ST GEN ANTIHIST-DECONGEST-ANTICHOLINERGIC COMB		
RESPA A.R. (<i>pseudoephed/chlor-mal/bell alk</i>)	T3	
ANTI-TUSSIVES, NON-OPIOID		
<i>benzonatate 100 mg capsule</i>	T1	
<i>benzonatate 150 mg capsule</i>	T1	PA
<i>benzonatate 200 mg capsule</i>	T1	
NON-OPIOID ANTI-TUS-1ST GEN.ANTIHISTAMINE-DECONGEST		
BROMFED DM (<i>brompheniramine-pseudoephed-dm</i>)	T3	PA
<i>brompheniramine/pseudoephed/dm</i> (Bromfed Dm)	T1	
NON-OPIOID ANTI-TUSSIVE-1ST GEN ANTIHISTAMINE COMB.		
<i>promethazine/dextromethorphan</i>	T1	
OPIOID ANTI-TUSSIV-1ST GEN. ANTIHISTAMINE-DECONGEST		
CAPCOF	T3	
HISTEX-AC	T3	
MAXI-TUSS CD	T3	
POLY-TUSSIN AC	T3	
<i>promethazine/phenyleph/codeine</i>	T1	PA QL(480 MLS/30 DAYS)
OPIOID ANTI-TUSSIVE-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 ANTI-TUSSIVE-ANTI-CHOLINERGIC 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)
<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)

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List of Prescription Medications

COUGH/COLD PREPARATIONS (Allergy/Nasal Sprays) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPIOID ANTI-TUSSIVE-DECONGESTANT-EXPECTORANT COMB		
CODITUSSIN DAC	T3	
OPIOID ANTI-TUSSIVE-EXPECTORANT COMBINATION		
codeine phosphate/guaifenesin	T1	
CODITUSSIN AC	T1	
GUAIFENESIN-CODEINE	T1	
MAR-COF CG	T3	
NINJACOF-XG	T1	
OBREDON	T3	PA QL(960 MLS/30 DAYS)
DIAGNOSTIC (Diabetes)		
BLOOD SUGAR DIAGNOSTICS		
ACCU-CHEK AVIVA PLUS	T2	
ACCU-CHEK GUIDE TEST STRIP	T2	
ACCU-CHEK SMARTVIEW TEST STRIP	T2	
ACCUTREND GLUCOSE TEST STRIP	T2	
ADVANCED GLUCOSE TEST STRIP	T3	
ADVANCED GLUCOSE TEST STRIPS	T3	
ADVOCATE REDI-CODE	T3	
ADVOCATE REDI-CODE+	T3	
ADVOCATE TEST STRIP	T3	
AGAMATRIX AMP	T3	
AGAMATRIX JAZZ TEST STRIP	T3	
AGAMATRIX PRESTO	T3	
ASSURE 4 TEST STRIPS	T3	
ASSURE PLATINUM	T3	
ASSURE PLATINUM TEST STRIP	T3	
ASSURE PRISM MULTI	T3	
ASSURE TITANIUM TEST STRIP	T3	
BLOOD GLUCOSE TEST STRIP	T3	
BLULINK GLUCOSE TEST STRIP	T3	
CARESENS N	T3	
CARESENS S TEST STRIP	T3	
CARETOUCH TEST STRIP	T3	
CLEVER CHOICE MICRO TEST STRIP	T3	

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List of Prescription Medications

DIAGNOSTIC (Diabetes)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BLOOD SUGAR DIAGNOSTICS		
CLEVER CHOICE PRO	T3	
CLEVER CHOICE TALK	T3	
CLEVER CHOICE TEST STRIPS	T3	
CLEVER CHOICE VOICE+ TST STRIP	T3	
CONTOUR NEXT TEST STRIP	T3	
CONTOUR PLUS TEST STRIP	T3	
CONTOUR TEST STRIP	T3	
COOL GLUCOSE TEST STRIP	T3	
CVS TRUE METRIX GLUC TEST STRP	T3	
DIATRUE PLUS	T3	
EASY PLUS II TEST STRIP	T3	
EASY STEP	T3	
EASY TALK GLUCOSE TEST STRIP	T3	
EASY TALK PLUS II TEST STRIP	T3	
EASY TOUCH BLULINK TEST STRIP	T3	
EASY TOUCH TEST STRIP	T3	
EASY TRAK GLUCOSE TEST STRIP	T3	
EASY TRAK II TEST STRIP	T3	
EASYGLUCO PLUS	T3	
EASYGLUCO TEST STRIPS	T3	
EASYMAX 15 GLUCOSE TEST STRIP	T3	
EASYMAX GLUCOSE TEST STRIPS	T3	
ELEMENT COMPACT	T3	
ELEMENT TEST STRIPS	T3	
EMBRACE EVO TEST STRIPS	T3	
EMBRACE GLUCOSE TEST STRIPS	T3	
EMBRACE PRO TEST STRIP	T3	
EMBRACE TALK TEST STRIP	T3	
EMBRACE TEST STRIPS	T3	
EMBRACE WAVE GLUCOSE TEST STRP	T3	
EVENCARE G2 TEST STRIP	T3	
EVENCARE G3 TEST STRIP	T3	
EVENCARE MINI GLUCOSE TEST STR	T3	
EVENCARE PROVIEW TEST STRIP	T3	

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List of Prescription Medications

DIAGNOSTIC (Diabetes)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BLOOD SUGAR DIAGNOSTICS		
EVOLUTION TEST STRIPS	T3	
EZ SMART	T3	
EZ SMART PLUS	T3	
FIFTY50 TEST STRIP	T3	
FORA 6 CONNECT GLUCOSE STRIP	T3	
FORA 6CONN-GTEL-TN'G ADV STRIP	T3	
FORA D15G	T3	
FORA D20	T3	
FORA D40-G31 TEST STRIPS	T3	
FORA G20	T3	
FORA G30-PREMIUM V10 TEST STRP	T3	
FORA GD50 TEST STRIPS	T3	
FORA GTEL GLUCOSE TEST STRIP	T3	
FORA TEST STRIP	T3	
FORA TN'G ADVAN PRO TEST STRIP	T3	
FORA TN'G VOICE TEST STRIPS	T3	
FORA V10	T3	
FORA V10-V12-D10-D20	T3	
FORA V12	T3	
FORA V20	T3	
FORA V30A	T3	
FORACARE GD20	T3	
FORACARE GD40	T3	
FORTISCARE G1 TEST STRIP	T3	
FORTISCARE GLUCOSE TEST STRIPS	T3	
FREESTYLE INSULINX	T2	
FREESTYLE INSULINX TEST STRIPS	T2	
FREESTYLE LITE TEST STRIP	T2	
FREESTYLE PRECISION NEO	T2	
FREESTYLE TEST STRIPS	T2	
GE100 BLOOD GLUCOSE TEST STRIP	T3	
GE333 BLOOD GLUCOSE TEST STRIP	T3	
GENSTRIP	T3	
GLUCO NAVII	T3	
GLUCOCARD 01 SENSOR PLUS	T3	

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List of Prescription Medications

DIAGNOSTIC (Diabetes)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BLOOD SUGAR DIAGNOSTICS		
GLUCOCARD EXPRESSION TEST STRP	T3	
GLUCOCARD SHINE TEST STRIPS	T3	
GLUCOCARD VITAL	T3	
GLUCOCARD VITAL SENSOR	T3	
GLUCOCOM GLUCOSE	T3	
GLUCOSE TEST STRIP	T3	
GNP TRUE METRIX TEST STRIP	T3	
GOJJI BLOOD GLUCOSE TEST STRIP	T3	
HARMONY GLUCOSE TEST STRIP	T3	
HEALTHPRO GLUCOSE TEST STRIPS	T3	
HUMANA TRUE METRIX TEST STRIP	T3	
IGLUCOSE TEST STRIP	T3	
IHEALTH GLUCOSE TEST STRIP	T3	
INFINITY TEST STRIPS	T3	
INFINITY VOICE TEST STRIP	T3	
MICRO	T3	
MICRODOT TEST STRIPS	T3	
MICRODOT XTRA	T3	
MYGLUCOHEALTH	T3	
NEUTEK 2TEK TEST STRIPS	T3	
NOVA MAX GLUCOSE TEST STRIPS	T3	
ON CALL EXPRESS TEST STRIP	T3	
ON CALL PLUS TEST STRIP	T3	
ON CALL VIVID TEST STRIP	T3	
ONETOUCH ULTRA TEST STRIP	T3	PA
ONETOUCH VERIO TEST STRIP	T3	PA
OPTIUM	T3	
OPTIUM EZ	T3	
OPTUMRX TEST STRIP	T3	
PHARMACIST CHOICE	T3	
PIP BLOOD GLUCOSE TEST STRIP	T3	
PLATINUM TEST STRIP	T3	
PRECISION PCX	T3	
PRECISION PCX PLUS	T3	

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List of Prescription Medications

DIAGNOSTIC (Diabetes)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BLOOD SUGAR DIAGNOSTICS		
PRECISION POINT OF CARE	T3	
PRECISION Q-I-D	T3	
PRECISION XTRA TEST STRIPS	T2	
PREMIER TEST STRIP	T3	
PREMIUM BLOOD GLUCOSE TEST	T3	
PREMIUM V10	T3	
PRO VOICE V8-V9 TEST STRIP	T3	
PRODIGY NO CODING	T3	
QUINTET	T3	
QUINTET AC	T3	
REFUAH PLUS	T3	
RELION CONFIRM-MICRO	T3	
RELION PRIME TEST STRIPS	T3	
RELION TRUE METRIX TEST STRIP	T2	
REVEAL TEST STRIP	T3	
RIGHTEST GS100 TEST STRIP	T3	
RIGHTEST GS300 TEST STRIP	T3	
RIGHTEST GS550 TEST STRIP	T3	
RIGHTEST GT333 TEST STRIP	T3	
SMART SENSE TEST STRIPS	T3	
SMARTEST TEST	T3	
SOLUS V2 TEST STRIPS	T3	
SURE-TEST EASYPLUS MINI STRIP	T3	
TELCARE TEST STRIPS	T3	
TEST N'GO	T3	
TEST STRIPS	T3	
TRUE METRIX GLUCOSE TEST STRIP	T2	
TRUE METRIX GLUCOSE TEST STRIP	T3	
TRUETEST TEST STRIPS	T3	
TRUETRACK TEST STRIP	T3	
ULTIMA	T3	
ULTRATRAK TEST STRIP	T3	
ULTRATRAK ULTIMATE TEST STRIPS	T3	
UNISTRIP1	T3	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

DIAGNOSTIC (Diabetes)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BLOOD SUGAR DIAGNOSTICS		
VIVAGUARD INO TEST STRIP	T3	
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 (Spy-Mis)</i>	T1	
SINOGRAFIN	T3	
SPY-MIS (indocyanine green)	T3	
BLOOD TESTING PREPARATIONS		
FORA GTEL KETONE TEST STRIP	T3	
FORA TN'G ADV VOICE KETO STRIP	T3	
GOJJI BLOOD KETONE TEST STRIP	T3	
NOVAMAX PLUS	T3	
PRECISION XTR B-KETONE STRIP	T3	
CARDIOVASCULAR DIAGNOSTICS - RADIOACTIVE		
AMMONIA N-13	T3	
MYOVIEW	T3	
TC99M PYROPHOSPHATE PREP	T1	
TC99M SESTAMIBI PREP	T1	
THALLOUS CHLORIDE TL-201	T1	
CARDIOVASCULAR DIAGNOSTICS, NON-RADIOPAQUE AGENTS		
<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	

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List of Prescription Medications

DIAGNOSTIC (Miscellaneous) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CARDIOVASCULAR DIAGNOSTICS-RADIOPAQUE		
<i>iodixanol</i>	T1	
<i>iopamidol</i>	T1	
ISOVUE-200	T3	
ISOVUE-250	T3	
ISOVUE-300	T3	
ISOVUE-370	T3	
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	

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List of Prescription Medications

DIAGNOSTIC (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIAGNOSTIC PREPARATIONS, MISCELLANEOUS		
gadobutrol	T1	
GLUCAGON HCL	T1	
GOZELLIX	T3	
ILLUCCIX	T3	
<i>isosulfan blue</i>	T1	
<i>lidocaine hcl/glycerin</i>	T1	
LIPIODOL	T3	
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 oph 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	

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List of Prescription Medications

DIAGNOSTIC (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GASTROINTESTINAL RADIOPAQUE DIAGNOSTICS (cont.)		
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	
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	
RADIOACTIVE DIAGNOSTICS, GENERAL		
<i>indium-111 chlor/pentetreotide</i>	T1	
OCTREOSCAN	T3	
RADIOACTIVE DIAGONISTICS - PROSTATIC IMAGING AGENT		
AXUMIN	T3	
RADIOACTIVE DX RADIOLABEL OF AUTOLOGOUS LEUKOCYTES		
INDIUM IN-111 OXYQUINOLINE	T1	

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List of Prescription Medications

DIAGNOSTIC (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
RADIOACTIVE METABOLIC FUNCTION DIAGNOSTICS		
FLUDEOXYGLUCOSE F-18	T3	
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 <i>diatrizoate meglumine, sodium</i>	T3	
URINE ACETONE TEST AIDS		
KETONE CARE TEST STRIP	T3	PA QL SP
KETONE TEST STRIP	T3	SP
KETOSTIX REAGENT	T3	SP
TRUEPLUS KETONE TEST STRIP	T3	SP
URINE MULTIPLE TEST AIDS		
CHEK-STIX	T3	SP
CHEMSTRIP	T2	
CHEMSTRIP 10 WITH SG	T2	
CHEMSTRIP 2 GP	T2	
CHEMSTRIP 50B	T2	
CHEMSTRIP 7	T2	
CHEMSTRIP 9	T2	
COMBISTIX REAGENT	T3	
HEMA-COMBISTIX	T3	
KETO-DIASTIX REAGENT	T3	
LABSTIX REAGENT	T3	
MULTISTIX	T3	
MULTISTIX 10 SG	T3	
MULTISTIX 5	T3	

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List of Prescription Medications

DIAGNOSTIC (Miscellaneous) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
URINE MULTIPLE TEST AIDS (cont.)		
MULTISTIX 7	T3	
MULTISTIX 8 SG	T3	
MULTISTIX 9	T3	
MULTISTIX 9 SG	T3	
URISTIX 4	T3	
URISTIX REAGENT	T3	

DIURETICS (Diuretics)

ARGININE VASOPRESSIN (AVP) RECEPTOR ANTAGONISTS		
SAMSCA (<i>tolvaptan</i>)	T3	PA SP
<i>tolvaptan 15 mg tablet (Samsca)</i>	T1	SP
<i>tolvaptan 30 mg tablet (Samsca)</i>	T1	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
EDECRIN (<i>ethacrynic acid</i>)	T3	PA
<i>ethacrynate sodium (Sodium Edecrin)</i>	T1	
<i>ethacrynic acid (Edecrin)</i>	T1	PA
FUROSCIX	T3	PA QL(2 KITS/30 DAYS) SP
<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	

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List of Prescription Medications

DIURETICS (Diuretics) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LOOP DIURETICS (cont.)		
<i>furosemide 80 mg tablet (Lasix)</i>	T1	HD
FUROSEMIDE-0.9% NAACL (<i>furosemide in 0.9 % nacl</i>)	T3	
LASIX (<i>furosemide</i>)	T3	PA HD
LASIX ONYU	T3	PA QL(2 KITS/30 DAYS)
SOAANZ	T3	PA HD
SODIUM EDECRIN (ethacrynate sodium)	T3	
<i>toremide</i>	T1	HD
OSMOTIC DIURETICS		
<i>mannitol</i>	T1	
<i>mannitol (Osmitrol)</i>	T1	
OSMITROL 10% (50 GM/500 ML) (<i>mannitol</i>)	T3	
<i>osmitrol 20% (100 gm/500 ml)</i>	T2	
<i>osmitrol 20% (50 gm/250 ml)</i>	T2	
POLYCYSTIC KIDNEY DISEASE AGENT, AVP RECEPT. ANTAG		
JYNARQUE (tolvaptan)	T3	PA SP
<i>tolvaptan 15 mg tablet (Jynarque)</i>	T1	SP
<i>tolvaptan 15 mg-15 mg tablet (Jynarque)</i>	T1	PA SP
<i>tolvaptan 30 mg tablet (Jynarque)</i>	T1	SP
<i>tolvaptan 30 mg-15 mg tablet (Jynarque)</i>	T1	PA SP
<i>tolvaptan 45 mg-15 mg tablet (Jynarque)</i>	T1	PA SP
<i>tolvaptan 60 mg-30 mg tablet (Jynarque)</i>	T1	PA SP
<i>tolvaptan 90 mg-30 mg tablet (Jynarque)</i>	T1	PA SP
POTASSIUM SPARING DIURETICS		
ALDACTONE (<i>spironolactone</i>)	T3	PA HD
<i>amiloride hcl</i>	T1	HD
CAROSPIR (<i>spironolactone</i>)	T2	PA
DYRENIUM (<i>triamterene</i>)	T3	PA HD
<i>eplerenone (Inspra)</i>	T1	HD
INSPRA (<i>eplerenone</i>)	T3	PA HD

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List of Prescription Medications

DIURETICS (Diuretics) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
POTASSIUM SPARING DIURETICS (cont.)		
KERENDIA	T2	PA QL(1 TAB/DAY)
<i>spironolactone 100 mg tablet (Aldactone)</i>	T1	HD
<i>spironolactone 25 mg tablet (Aldactone)</i>	T1	HD
<i>spironolactone 25 mg/5 ml susp (Carospir)</i>	T1	
<i>spironolactone 50 mg tablet (Aldactone)</i>	T1	HD
<i>triamterene (Dyrenium)</i>	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 (Sodium Diuril)</i>	T1	
<i>chlorthalidone</i>	T1	HD
DIURIL	T2	HD
HEMICLOR	T3	PA QL(1 TAB/DAY) HD
<i>hydrochlorothiazide</i>	T1	HD
<i>indapamide</i>	T1	HD
INZIRQO	T3	PA HD
<i>metolazone</i>	T1	HD
SODIUM DIURIL (<i>chlorothiazide sodium</i>)	T2	
THALITONE	T3	PA HD
<i>indapamide</i>	T1	HD
INZIRQO	T3	PA HD
<i>metolazone</i>	T1	HD
SODIUM DIURIL (<i>chlorothiazide sodium</i>)	T2	
THALITONE	T3	PA HD

EENT PREPS (Allergy/Nasal Sprays)

NASAL ANTIHISTAMINE		
<i>azelastine 0.1% (137 mcg) spry</i>	T1	HD
<i>olopatadine 665 mcg nasal spry (Patanase)</i>	T1	HD
PATANASE (<i>olopatadine hcl</i>)	T3	HD
NASAL ANTIHISTAMINE AND ANTI-INFLAM. STEROID COMB.		
<i>azelastine/fluticasone (Dymista)</i>	T1	HD
DYMISTA (<i>azelastine-fluticasone</i>)	T3	ST HD
RYALTRIS	T3	PA QL (1 gm/30 days)

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List of Prescription Medications

EENT PREPS (Allergy/Nasal Sprays) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NASAL ANTI-INFLAMMATORY STEROIDS		
<i>flunisolide</i>	T1	HD
<i>fluticasone prop 50 mcg spray</i>	T1	HD
NASAL ANTI-INFLAMMATORY STEROIDS (cont.)		
<i>mometasone furoate 50 mcg spray</i>	T1	QL(68 GMS/30 DAYS) HD
OMNARIS	T3	ST HD
QNASL	T3	ST
QNASL CHILDREN	T3	
SINUVA	T3	PA SP
XHANCE	T3	ST HD
ZETONNA	T3	ST HD
NOSE PREPARATIONS, MISCELLANEOUS (RX)		
<i>ipratropium bromide</i>	T1	HD
NOSE PREPARATIONS, VASOCONSTRICTORS (RX)		
ADRENALIN CHLORIDE	T3	
<i>epinephrine hcl</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	T3	PA QL(4 BOTTLES/22 DAYS)
EYE ANTI-INFECTIVES (RX ONLY)		
BETADINE	T2	
EYE ANTI-INFLAMMATORY AGENTS		
ACULAR (<i>ketorolac tromethamine</i>)	T3	PA
ACULAR LS (<i>ketorolac tromethamine</i>)	T3	PA
ACUVAIL	T3	PA
ALREX (<i>loteprednol etabonate</i>)	T3	PA
<i>bromfenac sodium</i>	T1	
<i>bromfenac sodium (Bromsite)</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>bromfenac sodium</i> (Prolensa)	T1	
BROMSITE (bromfenac sodium)	T3	PA
CLOBETASOL 0.05% EYE DROP	T3	PA
<i>dexamethasone sodium phosphate</i>	T1	
<i>diclofenac 0.1% eye drops</i>	T1	
<i>difluprednate</i> (Durezol)	T1	
DUREZOL (difluprednate)	T3	PA
EYSUVIS	T2	QL(8.3 ML/14 DAYS)
FLAREX	T3	PA
<i>fluorometholone</i> (Fml)	T1	
<i>flurbiprofen sodium</i>	T1	
FML (<i>fluorometholone</i>)	T3	PA
FML FORTE	T3	PA
ILEVRO	T3	
ILLUVIEN	T3	SP
INVELTYS	T3	ST
<i>ketorolac 0.4% ophth solution</i> (Acular Ls)	T1	
<i>ketorolac 0.5% ophth solution</i> (Acular)	T1	
LOTEMAX 0.5% EYE DROPS (loteprednol etabonate)	T3	PA
LOTEMAX 0.5% EYE OINTMENT	T3	ST
LOTEMAX 0.5% OPHTHALMIC GEL (loteprednol etabonate)	T3	PA
LOTEMAX SM	T3	ST
<i>loteprednol etabonate</i> (Airex)	T1	
<i>loteprednol etabonate</i> (Lotemax)	T1	
MAXIDEX	T3	PA
NEVANAC	T3	PA
OZURDEX	T3	SP
PRED FORTE (prednisolone acetate)	T3	PA
PRED MILD	T3	PA
<i>prednisolone acetate</i> (Pred Forte)	T1	
<i>prednisolone sodium phosphate</i>	T1	
PROLENSA (<i>bromfenac sodium</i>)	T3	
TRIESENCE	T3	

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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.)		
XIPERE	T3	PA SP HD
EYE IRRIGATIONS		
<i>balanced salt irrig soln no.2</i>	T3	
BSS PLUS	T3	
EYE LOCAL ANESTHETICS		
AKTEN	T3	
ALCAINE (proparacaine hcl)	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	
TETRACAINE HCL	T1	
EYE MAST CELL STABILIZERS		
ALOCRIAL	T3	PA
<i>cromolyn 4% eye drops</i>	T1	
EYE MYDRIATIC AND NSAID COMBINATIONS		
OMIDRIA	T3	
EYE PREPARATIONS, MISCELLANEOUS (OTC)		
GELFILM	T3	
EYE VASOCONSTRICTORS		
<i>phenylephrine hcl</i>	T1	
UPNEEQ	T3	PA
MIOTICS AND OTHER INTRAOCULAR PRESSURE REDUCERS		
ALPHAGAN P (<i>brimonidine tartrate</i>)	T3	PA HD
<i>apraclonidine hcl</i>	T1	HD
AZOPT (brinzolamide)	T3	PA HD
<i>betaxolol hcl</i>	T1	HD
BETIMOL	T3	PA HD
BETIMOL (timolol)	T3	PA HD
BETOPTIC S	T2	HD
<i>bimatoprost</i>	T1	QL(10 MLS/30 DAYS) HD

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List of Prescription Medications

EENT PREPS (Eye Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MIOTICS AND OTHER INTRAOCULAR PRESSURE REDUCERS (cont.)		
<i>brimonidine tartrate</i> (Alphagan P)	T1	HD
<i>brimonidine tartrate/timolol</i> (Combigan)	T1	HD
<i>brinzolamide</i> (Azopt)	T1	HD
<i>carbachol</i>	T3	HD
<i>carteolol hcl</i>	T1	HD
COMBIGAN (<i>brimonidine tartrate/timolol</i>)	T3	PA HD
COSOPT (<i>dorzolamide hcl/timolol maleat</i>)	T3	PA HD
COSOPT PF (<i>dorzolamide/timolol/pf</i>)	T3	PA HD
<i>dorzolamide hcl</i>	T1	HD
<i>dorzolamide hcl/timolol maleat</i> (Cosopt)	T1	HD
<i>dorzolamide/timolol/pf</i> (Cosopt Pf)	T1	HD
DURYSTA	T3	PA SP HD
IOPIDINE	T3	PA HD
ISTALOL (<i>timolol maleate</i>)	T3	PA HD
IYUZEH	T3	PA QL(30 VIALS/30 DAYS) HD
<i>latanoprost</i> (Xalatan)	T1	HD
<i>levobunolol hcl</i>	T1	HD
LUMIGAN	T3	PA HD
MIOCHOL-E	T3	HD
PHOSPHOLINE IODIDE	T2	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
<i>pilocarpine hcl 1.25% eye drop</i> (Vuity)	T1	PA HD
QLOSI	T3	PA
RHOPRESSA	T3	
ROCKLATAN	T3	
SIMBRINZA	T2	HD
<i>tafluprost/pf</i> (Zioptan)	T1	QL(60 DROPPERS/30 DAYS) HD
<i>timolol</i> (Betimol)	T1	HD
<i>timolol maleate</i> (Istalol)	T1	HD
<i>timolol maleate</i> (Timoptic)	T1	HD
<i>timolol maleate</i> (Timoptic-Xe)	T1	HD
<i>timolol maleate/pf</i>	T1	HD

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CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

EENT PREPS (Eye Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MIOTICS AND OTHER INTRAOCULAR PRESSURE REDUCERS (cont.)		
timolol maleate/pf (Timoptic Ocudose)	T1	HD
TIMOPTIC (timolol maleate)	T3	PA HD
TIMOPTIC OCUDOSE (timolol maleate/pf)	T3	PA HD
TIMOPTIC-XE (<i>timolol maleate</i>)	T3	PA HD
TRAVATAN Z (travoprost)	T3	PA HD
<i>travoprost</i> (Travatan Z)	T1	HD
VIZZ	T3	PA HD
VUITY (pilocarpine hcl)	T3	PA HD
VYZULTA	T3	PA
XALATAN (latanoprost)	T3	PA HD
ZIOPATAN (tafluprost/pf)	T3	PA QL(60 DROPPERS/30 DAYS) HD
MYDRIATICS		
<i>atropine 1% eye drop</i>	T1	HD
<i>atropine 1% eye drops</i>	T1	HD
ATROPINE 1% EYE DROPS	T3	PA HD
<i>atropine 1% eye ointment</i>	T1	HD
CYCLOGYL 0.5% EYE DROPS	T2	HD
CYCLOGYL 1% EYE DROPS	T3	HD
CYCLOGYL 1% EYE DROPS (<i>cyclopentolate hcl</i>)	T3	HD
CYCLOGYL 2% EYE DROPS (<i>cyclopentolate hcl</i>)	T3	HD
CYCLOMYDRIL	T2	HD
<i>cyclopentolate hcl</i> (Cyclogyl)	T1	HD
<i>homatropine hbr</i>	T1	HD
MYDRIACYL (<i>tropicamide</i>)	T3	HD
PAREMYD	T3	HD
<i>tropicamide</i>	T1	HD
<i>tropicamide</i> (Mydriacyl)	T1	HD
OPHTH VASC. ENDOTHELIAL GROWTH FACTOR ANTAGONISTS		
BEOVU	T3	PA SP
BYOOVIZ	T3	PA SP
CIMERLI	T3	PA SP
LUCENTIS	T3	PA SP
SUSVIMO	T3	PA SP

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List of Prescription Medications

EENT PREPS (Eye Conditions) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPHTHALMIC ANTI-FIBROTIC AGENTS		
MITOSOL	T3	
OPHTHALMIC ANTI-INFLAMMATORY IMMUNOMODULATOR-TYPE		
CEQUA	T2	
<i>cyclosporine 0.05% eye emuls</i> (Restasis)	T1	HD
RESTASIS (cyclosporine)	T2	HD
RESTASIS MULTIDOSE	T3	PA HD
VERKAZIA	T3	PA QL(1 BOX/30 DAYS) HD
VEVYE	T3	PA HD
XIIDRA	T2	HD
OPHTHALMIC COMPLEMENT INHIBITORS		
IZERVAY	T3	PA SP
SYFOVRE	T3	PA SP HD
OPHTHALMIC CYSTINE DEPLETING AGENTS		
CYSTADROPS	T3	PA QL(20 MLS/28 DAYS) SP
CYSTARAN	T3	PA QL(120 MLS/28 DAYS) SP
OPHTHALMIC HUMAN NERVE GROWTH FACTOR (HNGF)		
OXERVATE	T3	PA SP HD
OPHTHALMIC PREPARATIONS, MISCELLANEOUS		
AMVISC	T3	SP
AMVISC PLUS	T3	SP
DISCOVISC	T3	
DUOVISC	T3	
HEALON GV PRO	T3	
<i>hyaluronate sodium</i>	T1	SP
PROVISC	T3	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	PA SP

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List of Prescription Medications

ELECT/CALORIC/H2O (Cholesterol Medications)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ORAL LIPID SUPPLEMENTS		
DOJOLVI	T3	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	
FLUORIMAX 5000 SENSITIVE	T3	
FRAICHE 5000 PREVI	T3	
JUST RIGHT 5000	T3	
PREVIDENT 0.2% RINSE (fluoride (sodium))	T3	
PREVIDENT 1.1% GEL (fluoride (sodium))	T3	
PREVIDENT 5000 BOOSTER PLUS	T2	
PREVIDENT 5000 DRY MOUTH	T2	
PREVIDENT 5000 ENAMEL PROTECT	T2	
PREVIDENT 5000 ORTHO DEFENSE	T2	
PREVIDENT 5000 PLUS (fluoride (sodium))	T3	PA
PREVIDENT 5000 SENSITIVE	T2	
<i>PREVIDENT DENTAL RINSE (fluoride (sodium))</i>	T3	
PREVIDENT KIDS	T2	
<i>sodium fluoride 0.2% rinse (Prevident)</i>	T1	
<i>sodium fluoride 1.1% cream (Prevident 5000 Plus)</i>	T1	
<i>sodium fluoride 1.1% gel (Prevident)</i>	T1	
<i>sodium fluoride 5000 ppm paste</i>	T1	
<i>sodium fluoride/potassium nit</i>	T1	
PEDIATRIC VITAMIN PREPARATIONS		
<i>fluoride (sodium)</i>	T1	PPACA
<i>sodium fluoride 0.25 (0.55) mg</i>	T1	PPACA

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List of Prescription Medications

ELECT/CALORIC/H2O (Dental Products) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PEDIATRIC VITAMIN PREPARATIONS (con't.)		
<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
ELECT/CALORIC/H2O (Diabetes)		
AGENTS TO TREAT HYPOGLYCEMIA (HYPERGLYCEMICS)		
BAQSIMI	T2	QL(2 UNITS/30 DAYS)
<i>diazoxide (Proglycem)</i>	T1	
<i>glucagon 1 mg emergency kit</i>	T1	QL(2 VIALS/30 DAYS)
GLUCAGON 1 MG EMERGENCY KIT	T3	QL(2 KITS/30 DAYS)
GVOKE	T2	QL(2 VIALS/30 DAYS)
GVOKE HYOPEN 1-PACK	T2	QL(2 SYR/AUTO-INJ/30 DAYS)
GVOKE HYOPEN 2-PACK	T2	QL(2 SYR/AUTO-INJ/30 DAYS)
GVOKE PFS 1-PACK SYRINGE	T2	QL(2 SYR/AUTO-INJ/30 DAYS)
GVOKE PFS 2-PACK SYRINGE	T2	QL(2 SYR/AUTO-INJ/30 DAYS)
PROGLYCEM (diazoxide)	T3	PA
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		
<i>sodium acetate</i>	T1	
<i>sodium bicarbonate</i>	T1	
<i>sodium bicarbonate in d5w</i>	T1	
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	

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List of Prescription Medications

ELECT/CALORIC/H2O (Miscellaneous) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
IV SOLUTIONS: DEXTROSE-SALINE (con't.)		
<i>dextrose 5 %-0.2 % sod chlorid</i>	T1	
<i>dextrose 5 %-0.45 % sod chlrd</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 (dextrose 5 % in water)	T1	
NUCLEIC ACID/NUCLEOTIDE SUPPLEMENTS		
XURIDEN	T3	PA SP
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	

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List of Prescription Medications

ELECT/CALORIC/H2O (Miscellaneous) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PARENTERAL AMINO ACID SOLUTIONS AND COMBINATIONS (con't.)		
<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)
<i>calcium acetate</i>	T1	
FERRIC CITRATE	T3	PA QL(12 TABS/DAY)
FOSRENOL (<i>lanthanum carbonate</i>)	T3	PA
<i>lanthanum carbonate</i> (Fosrenol)	T1	
LOKELMA	T2	
MAGNEBIND 400	T3	
REVELA (<i>sevelamer carbonate</i>)	T3	PA
<i>sevelamer carbonate</i> (Renvela)	T1	
<i>sevelamer hcl</i>	T1	
<i>sodium polystyrene sulfon/sorb</i>	T1	

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List of Prescription Medications

ELECT/CALORIC/H2O (Nutritional/Dietary) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ELECTROLYTE DEPLETERS (con't.)		
<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	
XPHOZAH	T3	PA SP
ELECTROLYTE MAINTENANCE		
<i>electrolyte-148 solution</i>	T1	
<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 (sodium/pot/mag/calc/chlor/acet)	T3	
TPN ELECTROLYTES II	T3	
FLUORIDE PREPARATIONS		
CLINPRO 5000	T3	
<i>fluoride (sodium)</i>	T1	
<i>fluoride (sodium) (Prevident 5000 Plus)</i>	T1	
<i>fluoride (sodium) (Prevident)</i>	T1	
FLUORIDEX	T1	
FLUORIMAX 5000	T3	
JUST RIGHT 5000	T3	
PREVIDENT 0.2% RINSE (<i>fluoride (sodium)</i>)	T3	
PREVIDENT 1.1% GEL (<i>fluoride (sodium)</i>)	T3	
PREVIDENT 5000 BOOSTER PLUS	T2	
PREVIDENT 5000 DRY MOUTH	T2	

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List of Prescription Medications

ELECT/CALORIC/H2O (Nutritional/Dietary) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ELECTROLYTE DEPLETERS (con't.)		
PREVIDENT 5000 ORTHO DEFENSE	T2	PA
PREVIDENT 5000 PLUS (<i>fluoride (sodium)</i>)	T3	
PREVIDENT DENTAL RINSE (<i>fluoride (sodium)</i>)	T3	
PREVIDENT KIDS	T2	
<i>sodium fluoride 0.2% rinse (Prevident)</i>	T1	
<i>sodium fluoride 1.1% cream (Prevident 5000 Plus)</i>	T1	
<i>sodium fluoride 1.1% gel (Prevident)</i>	T1	
<i>sodium fluoride 5000 ppm paste</i>	T1	
IODINE CONTAINING AGENTS		
IODOPEN	T3	
<i>potassium iodide</i>	T1	
<i>potassium iodide/iodine</i>	T1	
SSKI	T3	
IRON REPLACEMENT		
ACCRUFER	T3	PA
ACTIVE FE	T3	
CITRANATAL BLOOM	T3	
CORVITE 150	T3	
CORVITE FE	T3	
FERAHEME (<i>ferumoxytol</i>)	T3	
FERIVA 21-7	T3	
FERRALET 90	T3	
FERRLECIT (<i>sodium ferric gluconat/sucrose</i>)	T3	
<i>ferrous fum/vit c/b12-if/folic</i>	T1	
<i>ferrous fumarate/folic acid (Hemocyte-F)</i>	T1	
<i>ferumoxytol (Feraheme)</i>	T1	
FUSION PLUS	T3	
HEMATRON-AF	T3	
HEMAX	T3	
HEMOCYTE PLUS (<i>mv-mins no.73/iron fum/folic</i>)	T3	
HEMOCYTE-F (<i>ferrous fumarate/folic acid</i>)	T3	
INFED	T3	
INJECTAFER	T3	
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	

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List of Prescription Medications

ELECT/CALORIC/H2O (Nutritional/Dietary) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
IRON REPLACEMENT (con't.)		
<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	
<i>cupric chloride</i>	T1	
<i>manganese chloride</i>	T1	
MULTRY5	T3	
PEDITRACE	T3	
SELENIOS ACID 12 MCG/2 ML VL	T3	

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List of Prescription Medications

ELECT/CALORIC/H2O (Nutritional/Dietary) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MINERAL REPLACEMENT, MISCELLANEOUS (con't.)		
<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% NACL	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	
POKONZA 10 MEQ PACKET	T3	PA
POKONZA 15 MEQ PACKET	T3	
<i>potassium acetate</i>	T1	
<i>potassium bicarbonate/cit ac</i>	T1	
<i>potassium chloride</i>	T1	
<i>potassium chloride</i>	T2	
<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	
<i>potassium chloride-0.45% nacl</i>	T1	
<i>potassium cl 10 meq/100 ml sol</i>	T1	

T1 – Typically Generics

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T2 – Typically Preferred Brands

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SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ELECT/CALORIC/H2O (Nutritional/Dietary) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
POTASSIUM REPLACEMENT (con't.)		
<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	T3	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	
<i>sodium chloride 0.9 % (flush)</i>	T1	

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ELECT/CALORIC/H2O (Nutritional/Dietary) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SODIUM/SALINE PREPARATIONS (con't.)		
<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	

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List of Prescription Medications

ELECT/CALORIC/H2O (Urinary Tract Conditions) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIALYSIS SOLUTIONS		
DIANEAL WITH 1.5% DEXTROSE	T3	
DIANEAL WITH 2.5% DEXTROSE	T3	
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	T2	HD
K-PHOS ORIGINAL	T2	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
UROCID-K (potassium citrate)	T3	HD
UROQID-ACID NO.2	T2	HD
GASTROINTESTINAL (Cholesterol Medications)		
LIPOTROPICS		
<i>icosapent ethyl (Vascepa)</i>	T1	HD
LOVAZA (omega-3 acid ethyl esters)	T3	PA HD
<i>omega-3 acid ethyl esters (Lovaza)</i>	T1	HD
VASCEPA (icosapent ethyl)	T2	PA HD
GASTROINTESTINAL (Gastrointestinal/Heartburn)		
AMMONIA INHIBITORS		
AMMONUL (sodium benzoate/sod phenylacet)	T3	
BUPHENYL (sodium phenylbutyrate)	T3	PA SP HD

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List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AMMONIA INHIBITORS (con't.)		
<i>glycerol phenylbutyrate</i>	T1	SP HD
<i>lactulose</i>	T1	HD
<i>lactulose 10 gm/15 ml solution</i>	T1	
LITHOSTAT	T2	HD
OLPRUVA	T3	PA SP HD
PHEBURANE	T2	PA QL(8 Bottles/30 Days) SP HD
RAVICTI	T3	PA SP HD
<i>sodium benzoate/sod phenylacet (Ammonul)</i>	T1	
<i>sodium phenylbutyrate (Buphenyl)</i>	T1	SP HD
ANTI-CHOLINERGICS, QUATERNARY AMMONIUM		
<i>chlordiazepoxide/clidinium br (Librax)</i>	T1	
CUVPOSA (<i>glycopyrrolate</i>)	T3	
DARTISLA	T3	PA
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 (Robinul)</i>	T1	
<i>glycopyrrolate 1 mg/5 ml soln (Cuvposa)</i>	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 1.5 mg tablet</i>	T1	PA
<i>glycopyrrolate 2 mg tablet (Robinul Forte)</i>	T1	
<i>glycopyrrolate 4 mg/20 ml vial</i>	T1	
GLYCOPYRROLATE-WATER	T1	
LIBRAX (<i>chlordiazepoxide/clidinium br</i>)	T3	PA
ROBINUL (<i>glycopyrrolate</i>)	T3	PA
ROBINUL FORTE (<i>glycopyrrolate</i>)	T3	PA
ANTI-CHOLINERGICS/ANTI-SPASMODICS		
<i>dicyclomine 10 mg capsule</i>	T1	
<i>dicyclomine 10 mg/5 ml soln</i>	T1	
<i>dicyclomine 20 mg tablet</i>	T1	

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GASTROINTESTINAL (Gastrointestinal/Heartburn) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-CHOLINERGICS/ANTI-SPASMODICS (con't.)		
<i>dicyclomine 20 mg/2 ml ampul</i>	T1	
<i>dicyclomine 20 mg/2 ml vial</i>	T1	
DICYCLOMINE 40 MG TABLET	T3	PA
ANTI-DIARRHEAL - G.I. CHLORIDE CHANNEL INHIBITORS		
MYTESI	T3	
ANTI-DIARRHEAL - TRYPTOPHAN HYDROXYLASE INHIBITOR		
XERMELO	T3	PA SP
ANTI-DIARRHEALS		
<i>diphenoxylate hcl/atropine</i>	T1	
<i>diphenoxylate hcl/atropine (Lomotil)</i>	T1	
LOMOTIL (<i>diphenoxylate hcl/atropine</i>)	T3	PA
<i>loperamide hcl</i>	T1	
MOTOFEN	T3	
<i>opium tincture</i>	T1	PA
ANTI-EMETIC, CANNABINOID-TYPE		
<i>dronabinol (Marinol)</i>	T1	
MARINOL (<i>dronabinol</i>)	T3	PA
SYNDROS	T3	PA
ANTI-EMETIC/ANTI-VERTIGO 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)
ANTIVERT	T3	PA
ANZEMET	T3	PA
<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</i>)	T3	
DICLEGIS (<i>doxylamine succinate/vit b6</i>)	T3	PA QL(4 TABS/DAY)

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List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-EMETIC/ANTI-VERTIGO AGENTS (con't.)		
<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 (fosaprepitant dimeglumine)	T3	
EMEND 80 MG CAPSULE (aprepitant)	T3	PA QL(8 CAPS/28 DAYS)
EMEND TRIPACK (aprepitant)	T3	PA QL(12 CAPS/28 DAYS)
FOCINVEZ	T3	
<i>fosaprepitant dimeglumine (Emend)</i>	T1	
<i>granisetron hcl</i>	T1	
<i>granisetron hcl/pf</i>	T1	
<i>meclizine 50 mg tablet</i>	T1	PA
MECLIZINE 50 MG TABLET	T3	PA
<i>ondansetron hcl</i>	T1	
<i>ondansetron hcl/pf</i>	T1	
ONDANSETRON ODT 16 MG TABLET	T3	PA
<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	
<i>palonosetron hcl 0.25 mg/5 ml</i>	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	
TRANSDERM-SCOP (<i>scopolamine</i>)	T3	
<i>trimethobenzamide hcl</i>	T1	
VARUBI	T3	PA QL(4 TABS/28 DAYS)
ANTI-ULCER PREPARATIONS		
CARAFATE (<i>sucralfate</i>)	T3	PA HD
CYTOTEC (<i>misoprostol</i>)	T3	HD

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List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-ULCER PREPARATIONS (con't.)		
<i>misoprostol</i> (Cytotec)	T1	HD
<i>sucralfate</i> (Carafate)	T1	HD
ANTI-ULCER-H.PYLORI AGENTS		
<i>bismuth/metronid/tetracycline</i> (Pylera)	T1	
HELIDAC	T3	PA
<i>lansoprazole/amoxiciln/clarith</i>	T1	
<i>bismuth/metronid/tetracycline</i> (Pylera)	T1	
<i>lansoprazole/amoxiciln/clarith</i>	T1	
OMECLAMOX-PAK	T3	PA
PYLERA (bismuth/metronid/tetracycline)	T3	PA
TALICIA	T3	PA
VOQUEZNA DUAL PAK	T3	PA
VOQUEZNA TRIPLE PAK	T3	PA
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	
DONNATAL	T3	PA HD
DONNATAL (<i>phenobarb/hyoscy/atropine/scop</i>)	T3	PA HD
<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

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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 sulf</i> 0.125 mg tab (<i>Levsin</i>)	T1	HD
<i>hyoscyamine sulfate</i>	T1	HD
<i>hyoscyamine sulfate (Levbid)</i>	T1	HD
<i>hyoscyamine sulfate (Levsin)</i>	T1	HD
<i>hyoscyamine sulfate (Levsin-SI)</i>	T1	HD
<i>hyoscyamine sulfate (Nulev)</i>	T1	HD
HYOSCYAMINE SULFATE 0.5 MG/ML	T3	HD
LEVVID (hyoscyamine sulfate)	T3	PA HD
LEVSIN (hyoscyamine sulfate)	T3	HD
LEVSIN-SL (hyoscyamine sulfate)	T3	PA HD
<i>methscopolamine bromide</i>	T1	HD
NULEV (hyoscyamine sulfate)	T3	HD
<i>phenobarb/hyoscy/atropine/scop</i>	T1	HD
<i>phenobarb/hyoscy/atropine/scop (Donnatal)</i>	T1	HD
<i>phenobarb/hyoscy/atropine/scop (Phenobarbital-Belladonna)</i>	T1	HD
PHENOBARBITAL-BELLADONNA (<i>phenobarb/hyoscy/atropine/scop</i>)	T3	HD
SYMAX DUOTAB	T2	HD
BILE SALTS		
CHENODAL	T3	PA SP HD
CHOLBAM	T3	PA SP HD
CTEXLI	T3	PA SP
RELTONE	T3	PA HD
URSO FORTE (ursodiol)	T3	HD
<i>ursodiol 200 mg capsule</i>	T1	PA HD
<i>ursodiol 250 mg tablet</i>	T1	HD
<i>ursodiol 300 mg capsule</i>	T1	HD
<i>ursodiol 400 mg capsule</i>	T1	PA HD
<i>ursodiol 500 mg tablet (Urso Forte)</i>	T1	HD
CHOLERETICS		
KINEVAC	T3	
CHRONIC INFLAM. COLON DX, 5-A-SALICYLAT, RECTAL TX		
CANASA (<i>mesalamine</i>)	T3	PA
<i>mesalamine 1,000 mg supp (Canasa)</i>	T1	
<i>mesalamine 4 gm/60 ml enema (Sfrowasa)</i>	T1	

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GASTROINTESTINAL (Gastrointestinal/Heartburn) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CHRONIC INFLAM. COLON DX, 5-A-SALICYLAT, RECTAL TX (con't.)		
<i>mesalamine 4 gm/60 ml kit (Rowasa)</i>	T1	
ROWASA (mesalamine w/cleansing wipes)	T3	PA
SFROWASA (mesalamine)	T3	
DRUG TX-CHRONIC INFLAM. COLON DX, 5-AMINOSALICYLAT		
APRISO (<i>mesalamine</i>)	T3	HD
ASACOL HD (<i>mesalamine</i>)	T3	ST HD
AZULFIDINE (<i>sulfasalazine</i>)	T3	PA HD
<i>balsalazide disodium (Colazal)</i>	T1	HD
COLAZAL (<i>balsalazide disodium</i>)	T3	ST HD
DIPENTUM	T3	ST HD
LIALDA (<i>mesalamine</i>)	T3	ST
<i>mesalamine</i>	T1	HD
<i>mesalamine (Apriso)</i>	T1	HD
<i>mesalamine (Pentasa)</i>	T1	HD
<i>mesalamine 800 mg dr tablet (Asacol Hd)</i>	T1	HD
<i>mesalamine dr 1.2 gm tablet (Lialda)</i>	T1	HD
PENTASA 250 MG CAPSULE	T3	ST 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	T3	PA SP HD
FECAL MICROBIOTA TRANSPLANTATION (FMT)		
VOWST	T3	PA QL(12 CAPS/56 DAYS) SP
GASTRIC ENZYMES		
SUCRAID	T3	PA SP
HEMORRHOID PREP,ANTI-INFLAM STEROID-LOCAL ANESTHET		
ANALPRAM HC 1% CREAM	T3	
ANALPRAM HC 2.5%-1% CREAM (<i>hydrocortisone/pramoxine</i>)	T3	PA
ANALPRAM HC 2.5%-1% CRM SINGLE (<i>hydrocortisone/pramoxine</i>)	T3	PA
<i>hydrocortisone/pramoxine</i>	T1	
<i>hydrocortisone/pramoxine (Analpram Hc)</i>	T1	
PROCORT	T3	
PROCTOFOAM-HC	T2	

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GASTROINTESTINAL (Gastrointestinal/Heartburn) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HISTAMINE H2-RECEPTOR INHIBITORS		
<i>cimetidine</i>	T1	HD
<i>cimetidine hcl</i>	T1	HD
<i>famotidine 20 mg piggyback</i>	T1	
<i>famotidine 20 mg tablet (Pepcid)</i>	T1	HD
<i>famotidine 20 mg/2 ml vial</i>	T1	
FAMOTIDINE 20 MG/5 ML VIAL	T3	
<i>famotidine 200 mg/20 ml vial</i>	T1	
FAMOTIDINE 200 MG/50 ML VIAL	T3	
<i>famotidine 40 mg tablet (Pepcid)</i>	T1	HD
FAMOTIDINE 40 MG/10 ML VIAL	T3	
<i>famotidine 40 mg/4 ml vial</i>	T1	
<i>famotidine 40 mg/5 ml susp</i>	T1	HD
<i>famotidine 500 mg/50 ml vial</i>	T1	
nizatidine	T1	HD
PEPCID (famotidine)	T3	PA HD
IBS AGENTS, MIXED OPIOID RECEPTOR AGONISTS/ANTAGONISTS		
VIBERZI	T2	HD
IBS AGENTS, SODIUM-HYDROGEN EXCHANGER 3 (NHE3) INHIBITORS		
IBSRELA	T3	PA QL(2 TABS/DAY)
IBS-C/CIC AGENTS, GUANYLATE CYCLASE-C AGONIST		
LINZESS	T2	
TRULANCE	T2	
ILEAL BILE ACID TRANSPORTER (IBAT) INHIBITOR		
BYLVAY	T3	PA SP HD
LIVMARLI	T3	PA SP HD
INTESTINAL MOTILITY STIMULANTS		
GIMOTI	T3	PA SP
<i>metoclopramide hcl</i>	T1	
<i>metoclopramide hcl (Reglan)</i>	T1	
MOTEGRITY	T3	PA
REGLAN (<i>metoclopramide hcl</i>)	T3	
IRRITABLE BOWEL SYNDROME AGENT, 5-HT4 PARTIAL AGONIST		
ZELNORM	T3	PA

T1 – Typically Generics

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AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (con't)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
IRRITABLE BOWEL SYNDROME AGENTS, 5-HT3 ANTAGONIST		
<i>alosetron hcl</i> (Lotronex)	T3	SP HD
LOTROXEX (<i>alosetron hcl</i>)	T3	PA SP HD
IV FAT EMULSIONS		
CLINOLIPID	T3	
<i>fat emulsions</i> (Nutrilipid)	T3	
INTRALIPID	T3	
NUTRILIPID (fat emulsions)	T3	
OMEGAVEN	T3	
SMOFLIPID	T3	
LAXATIVES AND CATHARTICS		
AMITIZA (lubiprostone)	T3	PA
<i>bisac/nacl/nahco3/kcl/peg 3350</i>	T1	PPACA
CLENPIQ	T3	PA PPACA
GOLYTELY (peg3350/sod sulf,bicarb,cl/kcl)	T3	PA PPACA
KRISTALOSE	T3	PA
<i>lactulose</i>	T1	
<i>lactulose 10 gm packet</i>	T1	PA
<i>lactulose 10 gm/15 ml soln cup</i>	T1	
<i>lactulose 10 gm/15 ml solution</i>	T1	
<i>lactulose 20 gm packet</i>	T1	
<i>lactulose 20 gm/30 ml soln cup</i>	T1	
<i>lactulose 20 gm/30 ml solution</i>	T1	
<i>lubiprostone</i> (Amitiza)	T1	
MOVIPREP (<i>peg3350/sod sul/nacl/kcl/asb/c</i>)	T3	PA PPACA
OSMOPREP	T3	PA PPACA
<i>peg3350/sod sul/nacl/kcl/asb/c</i> (Moviprep)	T1	PPACA
<i>peg3350/sod sulf,bicarb,cl/kcl</i>	T1	PPACA
<i>peg3350/sod sulf,bicarb,cl/kcl</i> (Golytely)	T1	PPACA
PLENVU	T3	PA PPACA
<i>sodium chloride/nahco3/kcl/peg</i>	T1	PPACA
<i>sodium, potassium, mag sulfates</i> (Suprep)	T1	PPACA
SUFLAVE	T3	PA PPACA
SUPREP (sodium, potassium, mag sulfates)	T3	PA PPACA
SUTAB	T3	PA PPACA

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List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LOCAL ANORECTAL NITRATE PREPARATIONS		
<i>nitroglycerin 0.4% ointment (Rectiv)</i>	T1	
RECTIV (<i>nitroglycerin</i>)	T3	
PANCREATIC ENZYMES		
CREON	T3	PA HD
PANCREAZE	T2	HD
PERTZYE	T3	PA HD
VIOKACE	T3	HD
ZENPEP	T3	HD
POTASSIUM-COMPETITIVE ACID BLOCKERS (PCABS)		
VOQUEZNA	T3	PA QL(1 tab/day)
PROTON-PUMP INHIBITORS		
ACIPHEX (<i>rabeprazole sodium</i>)	T3	PA QL(1 TAB/DAY)
DEXILANT DR 30 MG CAPSULE (<i>dexlansoprazole</i>)	T3	PA QL(2 CAPS/DAY)
DEXILANT DR 60 MG CAPSULE (<i>dexlansoprazole</i>)	T3	PA QL(1 CAP/DAY)
<i>dexlansoprazole dr 30 mg cap (Dexilant)</i>	T1	QL(2 CAPS/DAY)
<i>dexlansoprazole dr 60 mg cap (Dexilant)</i>	T1	QL(1 CAP/DAY)
<i>esomeprazole dr 10 mg packet (Nexium)</i>	T1	QL(4 PACKS/DAY) HD
<i>esomeprazole dr 2.5 mg packet (Nexium)</i>	T1	QL(16 PACKS/DAY) HD
<i>esomeprazole dr 20 mg packet (Nexium)</i>	T1	QL(2 PACKS/DAY) HD
<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 (Nexium)</i>	T1	QL(2 CAPS/DAY) HD
<i>esomeprazole mag dr 40 mg cap (Nexium)</i>	T1	QL(1 CAP/DAY) HD
<i>esomeprazole sodium</i>	T1	
ESOMEPRAZOLE STRONTIUM	T3	QL(1 CAP/DAY) HD
KONVOMEF	T3	PA QL(20 MLS/DAY) HD
<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 (Prevacid)</i>	T1	QL(1 CAP/DAY) HD
<i>lansoprazole dr 30 mg odt (Prevacid)</i>	T1	QL(1 TAB/DAY) HD
NEXIUM DR 10 MG PACKET (<i>esomeprazole magnesium</i>)	T3	PA QL(4 PACKS/DAY) HD
NEXIUM DR 2.5 MG PACKET (<i>esomeprazole magnesium</i>)	T3	PA QL(16 PACKS/DAY) HD
NEXIUM DR 20 MG CAPSULE (<i>esomeprazole magnesium</i>)	T3	PA QL(2 CAPS/DAY) HD
NEXIUM DR 20 MG PACKET (<i>esomeprazole magnesium</i>)	T3	PA 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.)		
NEXIUM DR 40 MG CAPSULE (<i>esomeprazole magnesium</i>)	T3	PA QL(1 CAP/DAY) HD
NEXIUM DR 40 MG PACKET (<i>esomeprazole magnesium</i>)	T3	PA QL(1 PACK/DAY) HD
NEXIUM DR 5 MG PACKET (<i>esomeprazole magnesium</i>)	T3	PA QL(8 PACKS/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 (Zegerid)</i>	T1	PA QL(2 CAPS/DAY) HD
<i>omeprazole-bicarb 20-1,680 pkt (Zegerid)</i>	T1	PA QL(2 PACKS/DAY) HD
<i>omeprazole-bicarb 40-1,100 cap (Zegerid)</i>	T1	PA QL(1 CAP/DAY) HD
<i>omeprazole-bicarb 40-1,680 pkt (Zegerid)</i>	T1	PA QL(1 PACK/DAY) HD
<i>pantoprazole dr 40 mg susp pkt (Protonix)</i>	T1	QL(1 PACK/DAY) HD
PANTOPRAZOLE SOD 40 MG/50ML-NS	T3	
PANTOPRAZOLE SOD 40MG/100ML-NS	T3	HD
PANTOPRAZOLE SOD 80MG/100ML-NS	T3	HD
<i>pantoprazole sod dr 20 mg tab (Protonix)</i>	T1	QL(2 TABS/DAY) HD
<i>pantoprazole sod dr 40 mg tab (Protonix)</i>	T1	QL(1 TAB/DAY) HD
<i>pantoprazole sodium 40 mg vial (Protonix lv)</i>	T1	
PREVACID DR 15 MG SOLUTAB (<i>lansoprazole</i>)	T3	PA QL(2 TABS/DAY)
PREVACID DR 30 MG CAPSULE (<i>lansoprazole</i>)	T3	PA QL(1 CAP/DAY)
PREVACID DR 30 MG SOLUTAB (<i>lansoprazole</i>)	T3	PA QL(1 TAB/DAY)
PRILOSEC DR 10 MG SUSPENSION	T3	QL(4 PACKS/DAY) HD
PRILOSEC DR 2.5 MG SUSPENSION	T3	QL(16 PACKS/DAY) HD
PROTONIX 40 MG SUSPENSION (<i>pantoprazole sodium</i>)	T3	PA QL(1 PACK/DAY)
PROTONIX DR 20 MG TABLET (<i>pantoprazole sodium</i>)	T3	PA QL(2 TABS/DAY)
PROTONIX DR 40 MG TABLET (<i>pantoprazole sodium</i>)	T3	PA QL(1 TAB/DAY)
PROTONIX IV (<i>pantoprazole sodium</i>)	T3	
RABEPRAZOLE DR 10 MG SPRNKL CP	T3	QL(2 CAPS/DAY) HD
<i>rabeprazole sod dr 20 mg tab (Aciphex)</i>	T1	QL(1 TAB/DAY) HD
ZEGERID 20 MG CAPSULE (<i>omeprazole/sodium bicarbonate</i>)	T3	PA QL(2 CAPS/DAY) HD
ZEGERID 20 MG PACKET (<i>omeprazole/sodium bicarbonate</i>)	T3	PA QL(2 PACKS/DAY) HD
ZEGERID 40 MG CAPSULE (<i>omeprazole/sodium bicarbonate</i>)	T3	PA QL(1 CAP/DAY) HD
ZEGERID 40 MG PACKET (<i>omeprazole/sodium bicarbonate</i>)	T3	PA QL(1 PACK/DAY) HD

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List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
RECTAL PREPARATIONS		
ANUSOL-HC (<i>hydrocortisone acetate</i>)	T3	PA
<i>hydrocortisone acetate</i>	T1	
<i>hydrocortisone acetate (Anusol-Hc)</i>	T1	
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	
ANALPRAM HC 2.5%-1% CREAM (<i>hydrocortisone/pramoxine</i>)	T3	PA
<i>ANALPRAM HC 2.5%-1% CRM SINGLE (hydrocortisone/pramoxine)</i>	T3	PA
<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	T2	

KERATINOCYTE GROWTH FACTOR (KGF)		
KEPIVANCE	T3	SP

HYPOXIA INDUCIBLE FACTOR PROLYL HYDROXYLASE INH.		
VAFSEO 150 MG TABLET	T3	PA QL(1 TAB/DAY)
VAFSEO 300 MG TABLET	T3	PA QL(2 TABS/DAY)

RECTAL/LOWER BOWEL PREP., GLUCOCORT. (NON-HEMORR)		
<i>budesonide 2 mg rectal foam</i>	T1	QL(2 KITS/180 DAYS)
CORTENEMA (<i>hydrocortisone</i>)	T3	
CORTIFOAM	T3	PA
<i>hydrocortisone (Cortenema)</i>	T1	
UCERIS 2 MG RECTAL FOAM (<i>budesonide</i>)	T3	PA QL(2 KITS/180 DAYS)

HORMONES (Hormonal Agents)

ADRENAL STEROID INHIBITORS		
ISTURISA 1 MG TABLET	T3	PA QL(8 TABS/DAY) SP
ISTURISA 5 MG TABLET	T3	PA QL(2 TABS/DAY) SP
RECORLEV	T3	PA QL(8 TABS/DAY) SP

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List of Prescription Medications

HORMONES (Hormonal Agents) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ADRENOCORTICOTROPHIC HORMONES		
ACTHAR	T3	PA SP HD
ACTHAR SELFJECT	T3	PA SP HD
CORTROPHIN	T3	PA SP HD
CORTROSYN (<i>cosyntropin</i>)	T3	
<i>cosyntropin</i> (Cortrosyn)	T1	
ANDROGEN/ESTROGEN PREPS FOR FEMALE SEXUAL DYSFUNC		
INTRAROSA	T3	
ANDROGENIC AGENTS		
ANDROGEL 1% (25 MG/2.5 G) PKT (testosterone)	T3	PA QL(150 GMS/30 DAYS)
ANDROGEL 1% (50 MG/5 G) PKT (testosterone)	T3	PA QL(300 GMS/30 DAYS)
ANDROGEL 1.62% GEL PUMP (testosterone)	T3	PA QL(150 GMS/30 DAYS)
AVEED	T3	PA SP
AZMIRO	T3	PA
DEPO-TESTOSTERONE	T3	
DEPO-TESTOSTERONE (testosterone cypionate)	T3	
JATENZO 158 MG CAPSULE	T3	PA QL(4 CAPS/DAY)
JATENZO 198 MG CAPSULE	T3	PA QL(4 CAPS/DAY)
JATENZO 237 MG CAPSULE	T3	PA QL(2 CAPS/DAY)
KYZATREX 100 MG CAPSULE	T3	PA QL(2 CAPS/DAY)
KYZATREX 150 MG CAPSULE	T3	PA QL(4 CAPS/DAY)
KYZATREX 200 MG CAPSULE	T3	PA QL(4 CAPS/DAY)
METHITEST	T1	
<i>methyltestosterone</i>	T1	
NATESTO	T3	PA QL(3 UNITS/30 DAYS)
<i>oxandrolone</i>	T1	PA
TESTIM (testosterone)	T3	PA QL(10 GMS/DAY)
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)

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T3 – Typically Non-Preferred Brands

ST – Step Therapy

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List of Prescription Medications

HORMONES (Hormonal Agents) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANDROGENIC AGENTS (cont.)		
testosterone 12.5 mg/1.25 gram	T1	PA QL(150 GMS/30 DAYS)
testosterone 30 mg/1.5 ml pump	T1	PA QL(180 MLS/30 DAYS)
testosterone 50 mg/5 gram gel (Testim)	T1	PA QL(10 GMS/DAY)
testosterone 50 mg/5 gram gel (Vogelxo)	T1	PA QL(10 GMS/DAY)
TESTOSTERONE 50 MG/5 GRAM PKT	T1	PA QL(300 GMS/30 DAYS)
testosterone cypionate	T1	
testosterone cypionate (Depo-Testosterone)	T1	
testosterone enanthate	T1	
TLANDO	T3	PA QL(4 CAPS/DAY)
UNDECATREX	T3	PA QL(4 CAPS/DAY)
VOGELXO 12.5 MG/1.25 GRAM PUMP	T3	PA QL(150 GMS/30 DAYS)
VOGELXO 50 MG/5 GRAM GEL (testosterone)	T3	PA QL(10 GMS/DAY)
VOGELXO 50 MG/5 GRAM GEL PACKET	T3	PA QL(300 GMS/30 DAYS)
XYOSTED	T3	PA QL(2 ML/28 DAYS)
ANTI-DIURETIC AND VASOPRESSOR HORMONES		
DDAVP 0.1 MG TABLET (desmopressin acetate)	T3	PA HD
DDAVP 0.2 MG TABLET (desmopressin acetate)	T3	PA HD
DDAVP 4 MCG/ML AMPUL (desmopressin acetate)	T3	PA SP
DDAVP 40 MCG/10 ML VIAL (desmopressin acetate)	T3	PA SP
desmopressin 0.01% solution	T1	HD
desmopressin 10 mcg/0.1 ml spr	T1	HD
desmopressin 40 mcg/10 ml vial (Ddavp)	T1	SP
desmopressin ac 4 mcg/ml ampul (Ddavp)	T1	SP
desmopressin ac 4 mcg/ml vial (Ddavp)	T1	SP
desmopressin acetate 0.1 mg tb (Ddavp)	T1	HD
desmopressin acetate 0.2 mg tb (Ddavp)	T1	HD
NOCTIVA	T3	PA
vasopressin 20 unit/ml vial	T1	
VASOPRESSIN 20 UNIT/ML VIAL	T3	
vasopressin 200 unit/10 ml vl	T1	
VASOSTRICT	T3	
ESTROGEN AND PROGESTIN COMBINATIONS		
BIJUVA	T3	
ESTROGEN/ANDROGEN COMBINATIONS		
ESTRATEST H.S. (estrogen,ester/me-testosterone)	T3	PA HD

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List of Prescription Medications

HORMONES (Hormonal Agents) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ESTROGEN/ANDROGEN COMBINATIONS (cont.)		
<i>estrogen, ester/me-testosterone</i>	T1	HD
<i>estrogen, ester/me-testosterone (Estratest H.S.)</i>	T1	HD
ESTROGENIC AGENTS		
ACTIVELLA (estradiol/norethindrone acet)	T3	PA HD
CLIMARA (estradiol)	T3	PA HD
CLIMARA PRO	T3	PA HD
COMBIPATCH	T2	
DELESTROGEN (estradiol valerate)	T3	PA HD
DEPO-ESTRADIOL	T3	HD
DIVIGEL (estradiol)	T3	PA HD
ELESTRIN	T3	PA HD
estradiol (Climara)	T1	HD
estradiol (Minivelle)	T1	QL(16 PATCHES/28 DAYS) HD
estradiol (Vivelle-Dot)	T1	QL(16 PATCHES/28 DAYS) HD
<i>estradiol 0.06% 1.25g gel pump (Estrogel)</i>	T1	HD
<i>estradiol 0.1% (0.25mg) gel pk (Divigel)</i>	T1	HD
<i>estradiol 0.1% (0.5mg) gel pkt (Divigel)</i>	T1	HD
<i>estradiol 0.1% (0.75mg) gel pk (Divigel)</i>	T1	HD
<i>estradiol 0.1% (1 mg) gel pkt (Divigel)</i>	T1	HD
<i>estradiol 0.1% (1.25mg) gel pk (Divigel)</i>	T1	HD
<i>estradiol 0.5 mg tablet</i>	T1	HD
<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
ESTROGEL (<i>estradiol</i>)	T3	PA HD
<i>estrogens, conjugated (Premarin)</i>	T1	HD
EVAMIST	T3	HD
MENEST	T3	HD
MENOSTAR	T3	QL(8 PATCHES/28 DAYS) HD
MINIVELLE (<i>estradiol</i>)	T3	PA QL(16 PATCHES/28 DAYS) HD
<i>norethind-eth estrad 0.5-2.5</i>	T1	HD
<i>norethindrone ac/eth estradiol</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>norethin-eth estrad 1 mg-5 mcg</i>	T1	HD
PREMARIN	T2	HD
PREMARIN (estrogens, conjugated)	T2	HD
PREMPHASE	T2	HD
PREMPRO	T2	HD
VIVELLE-DOT (<i>estradiol</i>)	T3	PA QL(16 PATCHES/28 DAYS) HD
ESTROGEN-PROGESTIN WITH ANTI-MINERALOCORTICOID COMB		
ANGELIQ	T3	HD
ESTROGEN-SELECTIVE ESTROGEN RECEPTOR MOD (SERM) COMB		
DUAVEE	T2	
GLUCOCORTICOIDS		
AGAMREE	T3	PA QL(10 MLS/DAY) SP
ALKINDI SPRINKLE	T3	PA SP
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 (betamethasone acetate,sod phos)	T2	
CORTEF (hydrocortisone)	T3	PA
<i>cortisone acetate</i>	T1	
<i>deflazacort (Emflaza)</i>	T1	PA SP HD
DEPO-MEDROL	T3	
<i>dexamethasone</i>	T1	
<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 10 day 1.5 mg tb</i>	T1	PA
<i>dexamethasone 13 day 1.5 mg tb</i>	T1	PA
<i>dexamethasone 2 mg tablet</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 4 mg tablet</i>	T1	
<i>dexamethasone 6 day 1.5 mg tab</i>	T1	PA
<i>dexamethasone 6 mg tablet</i>	T1	
<i>dexamethasone sodium phosp/pf</i>	T1	
<i>dexamethasone sodium phosphate</i>	T1	
EMFLAZA (<i>deflazacort</i>)	T3	PA SP HD
EOHILIA	T3	PA QL(1800 MLS/180 DAYS)
HEMADY	T3	
<i>hydrocortisone (Cortef)</i>	T1	
<i>hydrocortisone sod succinate</i>	T1	
KENALOG-10	T3	
KENALOG-40 (<i>triamcinolone acetonide</i>)	T3	
KENALOG-80	T3	
KHINDIVI	T3	PA SP
MEDROL 16 MG TABLET (<i>methylprednisolone</i>)	T3	
MEDROL 2 MG TABLET	T2	
MEDROL 4 MG DOSEPAK (<i>methylprednisolone</i>)	T3	
MEDROL 4 MG TABLET (<i>methylprednisolone</i>)	T3	
MEDROL 8 MG TABLET (<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	
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	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

HORMONES (Hormonal Agents) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GLUCOCORTICOIDS (cont.)		
TAPERDEX	T1	PA
TARPEYO	T3	PA QL(4 CAPS/DAY) SP
<i>triamcinolone acet 200 mg/5 ml (Kenalog-40)</i>	T1	
<i>triamcinolone acet 40 mg/ml v1 (Kenalog-40)</i>	T1	
<i>triamcinolone acet 400 mg/10ml (Kenalog-40)</i>	T1	
<i>triamcinolone acet 50mg/5ml v1</i>	T1	
UCERIS 9 MG ER TABLET (<i>budesonide</i>)	T3	PA QL(1 TAB/DAY)
ZCORT	T3	PA
ZILRETTA	T3	PA
GROWTH HORMONE RELEASING HORMONE (GHRH) AND ANALOGS		
EGRIFTA	T3	PA SP HD
EGRIFTA SV	T3	PA SP HD
GROWTH HORMONES		
GENOTROPIN	T2	PA SP HD
HUMATROPE	T3	PA SP HD
NGENLA	T2	PA SP
NORDITROPIN FLEXPRO	T3	PA SP HD
NUTROPIN AQ NUSPIN	T3	PA SP HD
OMNITROPE	T2	PA SP HD
SEROSTIM	T2	PA SP HD
SKYTROFA	T2	PA SP HD
SOGROYA	T3	PA SP
ZOMACTON	T3	PA SP HD
INSULIN-LIKE GROWTH FACTOR-I (IGF-I) HORMONES		
INCRELEX	T3	PA SP HD
LHRH (GNRH) AGONIST ANALOG PITUITARY SUPPRESSANTS		
LUPRON DEPOT 11.25 MG 3MO KIT	T2	PA SP HD
LUPRON DEPOT 3.75 MG KIT	T2	PA SP HD
SYNAREL	T3	PA SP HD
LHRH (GNRH) ANTAGONIST, ESTROGEN AND PROGESTIN COMB		
MYFEMBREE	T2	PA QL (24 MONTH THERAPY)
ORIAHNN	T2	PA QL (2 CAPS/DAY)
LHRH (GNRH) ANTAGONIST, PITUITARY SUPPRESSANT AGENTS		
<i>cetrotelix acetate (Cetrotide)</i>	T1	PA SP
CETROTIDE (<i>cetrotelix acetate</i>)	T2	PA SP

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List of Prescription Medications

HORMONES (Hormonal Agents) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LHRH (GNRH) ANTAGONIST, PITUITARY SUPPRESSANT AGENTS (con't.)		
<i>ganirelix acet 250 mcg/0.5 ml</i> (Ganirelix Acetate)	T1	PA SP
GANIRELIX ACET 250 MCG/0.5 ML (ganirelix acetate)	T2	PA SP
<i>ganirelix acetate</i> (Ganirelix Acetate)	T1	PA SP
ORLISSA 150 MG TABLET	T2	PA QL(1 TAB/DAY)
ORLISSA 200 MG TABLET	T2	PA QL(2 TABS/DAY)
LHRH (GNRH) AGNST PIT.SUP-CENTRAL PRECOCIOUS PUBERTY		
FENSOLVI	T3	PA SP
LUPRON DEPOT-PED	T3	PA SP HD
SUPPRELIN LA	T3	PA SP HD
TRIPTODUR	T3	PA SP
MINERALOCORTICOIDS		
<i>fludrocortisone acetate</i>	T1	HD
OXYTOCICS		
<i>carboprost 250 mcg/ml ampul</i> (Hemabate)	T1	
CARBOPROST 250 MCG/ML SYRINGE	T3	
<i>carboprost 250 mcg/ml vial</i>	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 (oxytocin)	T3	
PREPIDIL	T3	
PARATHYROID HORMONES		
YORVIPATH	T3	PA SP
PITUITARY SUPPRESSIVE AGENTS		
<i>cabergoline</i>	T1	QL(16 TABS/28 DAYS) HD
CRENESSITY 100 MG CAPSULE	T3	PA QL(4 CAPS/DAY) SP
CRENESSITY 25 MG CAPSULE	T3	PA QL(2 CAPS/DAY) SP
CRENESSITY 50 MG CAPSULE	T3	PA QL(2 CAPS/DAY) SP
CRENESSITY 50 MG/ML SOLUTION	T3	PA QL(8 MLS/DAY) SP
<i>danazol</i>	T1	HD

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List of Prescription Medications

HORMONES (Hormonal Agents) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PROGESTATIONAL AGENTS		
CRINONE 4% GEL	T3	PA HD
medroxyprogesterone 10 mg tab (Provera)	T1	HD
medroxyprogesterone 2.5 mg tab (Provera)	T1	HD
medroxyprogesterone 5 mg tab (Provera)	T1	HD
norethindrone acetate	T1	HD
progesterone 100 mg capsule (Prometrium)	T1	HD
progesterone 200 mg capsule (Prometrium)	T1	HD
progesterone 500 mg/10 ml vial	T1	SP HD
PROMETRIUM (progesterone, micronized)	T3	PA HD
PROVERA (medroxyprogesterone acetate)	T3	PA HD
RENIN-ANGIOTENSIN-ALDOSTERONE SYS. (RAAS) HORMONES		
GIAPREZA	T3	SP
SOMATOSTATIC AGENTS		
lanreotide 120 mg/0.5 ml syrng	T1	PA SP HD
LANREOTIDE 120 MG/0.5 ML SYRNG	T3	PA SP HD
MYCAPSSA	T3	PA QL(4 CAPS/DAY) SP
octreotide acetate	T1	PA SP HD
octreotide acetate (Sandostatin)	T1	PA SP HD
octreotide acetate,mi-spheres (Sandostatin Lar Depot)	T1	PA SP
SANDOSTATIN 0.05 MG/ML AMPUL (octreotide acetate)	T2	PA SP HD
SANDOSTATIN 0.1 MG/ML AMPUL (octreotide acetate)	T3	PA SP HD
SANDOSTATIN 0.5 MG/ML AMPUL (octreotide acetate)	T3	PA SP HD
SANDOSTATIN LAR DEPOT (octreotide acetate)	T3	PA SP
SIGNIFOR	T3	PA SP
SIGNIFOR LAR	T3	PA SP
SOMATULINE DEPOT	T2	PA SP HD
VAGINAL ESTROGEN FOR SEXUAL DYSFUNCTION		
IMVEXXY 10 MCG MAINTENANCE PAK	T3	PA QL(16 INSERTS/28 DAYS) HD
IMVEXXY 10 MCG STARTER PACK	T3	PA QL(36 INSERTS/28 DAYS) HD
IMVEXXY 4 MCG MAINTENANCE PAK	T3	PA QL(16 INSERTS/28 DAYS) HD
IMVEXXY 4 MCG STARTER PACK	T3	PA QL(36 INSERTS/28 DAYS) HD
VAGINAL ESTROGEN PREPARATIONS		
ESTRACE (estradiol)	T3	PA HD
estradiol (Vagifem)	T1	QL(36 TABS/28 DAYS)

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List of Prescription Medications

HORMONES (Hormonal Agents) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VAGINAL ESTROGEN PREPARATIONS (cont.)		
<i>estradiol 0.01% cream (Estrace)</i>	T1	HD
<i>estradiol 10 mcg vaginal insrt (Vagifem)</i>	T1	QL(36 TABS/28 DAYS) HD
ESTRING	T3	PA QL(2 RINGS/90 DAYS) HD
FEMRING	T3	PA HD
PREMARIN	T2	HD
VAGIFEM (<i>estradiol</i>)	T3	PA QL(36 TABS/28 DAYS) HD
HORMONES (Infertility)		
FERTILITY STIMULATING PREPARATIONS, NON-FSH		
<i>clomiphene citrate</i>	T1	
FOLLICLE-STIMULATING AND LUTEINIZING HORMONES		
MENOPUR	T3	PA SP
FOLLICLE-STIMULATING HORMONE (FSH)		
FOLLISTIM AQ	T3	PA SP
GONAL-F	T3	PA SP
GONAL-F RFF REDI-JECT	T3	PA SP
HUMAN CHORIONIC GONADOTROPIN (HCG)		
CHORIONIC GONADOTROPIN	T3	PA SP
NOVAREL	T2	PA SP
OVIDREL	T2	PA SP
PREGNYL	T2	PA SP
FACILITATING/MAINTAINING AGENT, HORMONAL		
CRINONE 8% GEL	T2	
ENDOMETRIN (<i>progesterone, micronized</i>)	T2	
<i>progesterone 100 mg vag insert (Endometrin)</i>	T1	
PREGNANCY FACILITATING/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	T3	PA SP HD

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List of Prescription Medications

HORMONES (Osteoporosis Products)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BONE FORMATION STIMULATING AGTS - PTH REL PEPTIDES		
TYMLOS	T3	PA QL(1 PEN/30 DAYS) SP HD
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	T3	PA SP
SAPHNELO	T3	PA SP
IMMUNOSUPPRESSANTS (Pain Relief And Inflammatory Disease)		
ANTI-CD19 (B LYMPHOCYTE) MONOCLONAL ANTIBODY		
UPLIZNA	T3	PA SP
HUMAN INTERLEUKIN 12/23 (IL-12/13) INHIBITORS, MAB		
IMULDOSA 130 MG/26 ML VIAL	T3	PA SP
IMULDOSA 45 MG/0.5 ML SYRINGE	T3	PA QL(1 SYRINGE/84 DAYS) SP
IMULDOSA 90 MG/ML SYRINGE	T3	PA QL(1 SYRINGE/84 DAYS) SP
OTULFI 130 MG/26 ML VIAL	T3	PA SP
OTULFI 45 MG/0.5 ML	T3	PA QL(1 SYRINGE/84 DAYS) SP
OTULFI 90 MG/ML SYRINGE	T3	PA QL(1 SYRINGE/84 DAYS) SP
PYZCHIVA 130 MG/26 ML VIAL	T3	PA SP
PYZCHIVA 45 MG/0.5 ML	T3	PA QL(1 SYRINGE/84 DAYS) SP
PYZCHIVA 90 MG/ML SYRINGE	T3	PA QL(1 SYRINGE/84 DAYS) SP
SELARSDI 130 MG/26 ML VIAL	T2	PA SP
SELARSDI 45 MG/0.5 ML SYRINGE	T2	PA QL(1 SYRINGE/84 DAYS) SP
SELARSDI 45 MG/0.5 ML VIAL	T2	PA QL(1 SYRINGE/84 DAYS) SP
SELARSDI 90 MG/ML SYRINGE	T2	PA QL(1 SYRINGE/84 DAYS) SP
STARJEMZA 130 MG/26 ML VIAL	T3	PA SP
STELARA 130 MG/26 ML VIAL	T3	PA SP HD
STELARA 45 MG/0.5 ML SYRINGE	T2	PA QL(1 SYRINGE/84 DAYS) SP HD
STELARA 45 MG/0.5 ML VIAL	T2	PA QL(1 SYRINGE/84 DAYS) SP HD
STELARA 90 MG/ML SYRINGE	T2	PA QL(1 SYRINGE/84 DAYS) SP HD

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T2 – Typically Preferred Brands

QL – Quantity Limit

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CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

IMMUNOSUPPRESSANTS (Pain Relief And Inflammatory Disease) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HUMAN INTERLEUKIN 12/23 (IL-12/13) INHIBITORS, MAB		
STEQEYMA 130 MG/26 ML VIAL	T3	PA SP
STEQEYMA 45 MG/0.5 ML SYRINGE	T3	PA QL(1 SYRINGE/84 DAYS) SP
STEQEYMA 90 MG/ML SYRINGE	T3	PA QL(1 SYRINGE/84 DAYS) SP
USTEKINUMAB 130 MG/26 ML VIAL	T3	PA SP HD
USTEKINUMAB 45 MG/0.5 ML VIAL	T3	PA QL(1 SYRINGE/84 DAYS) SP HD
USTEKINUMAB 45MG/0.5ML SYRINGE	T3	PA QL(1 SYRINGE/84 DAYS) SP HD
USTEKINUMAB 90 MG/ML SYRINGE	T3	PA QL(1 SYRINGE/84 DAYS) SP HD
USTEKINUMAB-AEKN 45 MG SYRINGE	T3	PA QL(1 SYRINGE/84 DAYS) SP
USTEKINUMAB-AEKN 90 MG/ML SYR	T3	PA QL(1 SYRINGE/84 DAYS) SP
USTEKINUMAB-TTWE 130MG/26ML VL	T2	PA SP HD
USTEKINUMAB-TTWE 45 MG SYRINGE	T2	PA QL(1 SYRINGE/84 DAYS) SP HD
USTEKINUMAB-TTWE 90 MG/ML SYR	T2	PA QL(1 SYRINGE/84 DAYS) SP HD
YESINTEK 130 MG/26 ML VIAL	T2	PA SP
YESINTEK 45 MG/0.5 ML SYRINGE	T2	PA QL(1 SYRINGE/84 DAYS) SP
YESINTEK 45 MG/0.5 ML VIAL	T2	PA QL(1 SYRINGE/84 DAYS) SP
YESINTEK 90 MG/ML SYRINGE	T2	PA QL(1 SYRINGE/84 DAYS) SP
IL-23 RECEPTOR ANTAGONIST, MONOCLONAL ANTIBODY		
OMVOH 100 MG/ML PEN	T2	PA QL(2 PENS/28 DAYS) SP HD
OMVOH 100 MG/ML SYRINGE	T2	PA QL(2 SYRINGES/28 DAYS) SP HD
OMVOH 200 MG DOSE - 2 PENS	T2	PA QL(2 PENS/28 DAYS) SP HD
OMVOH 200 MG DOSE - 2 SYRINGES	T2	PA QL(2 SYRINGES/28 DAYS) SP HD
OMVOH 200 MG/2 ML PEN	T2	PA QL SP HD
OMVOH 200 MG/2 ML SYRINGE	T2	PA QL SP HD
OMVOH 300 MG DOSE - 2 PENS	T2	PA QL(3 MLS/28 DAYS) SP HD
OMVOH 300 MG DOSE - 2 SYRINGES	T2	PA QL(3 MLS/28 DAYS) SP HD
OMVOH 300 MG/15 ML VIAL	T2	PA SP HD
SKYRIZI 600 MG/10 ML VIAL	T2	PA SP HD
SKYRIZI ON-BODY	T2	PA QL(1 CARTRIDGE/56 DAYS) SP HD
TREMFYA 100 MG/ML PEN	T2	PA QL(1 ML/56 DAYS) SP HD
TREMFYA 100 MG/ML SYRINGE	T2	PA QL(1 SYRINGE/56 DAYS) SP HD
TREMFYA 200 MG/2 ML PEN	T2	PA QL(2 SYRINGE/28 DAYS) SP HD
TREMFYA 200 MG/2 ML SYRINGE	T2	PA QL(1 SYRINGE/56 DAYS) SP HD
TREMFYA 200 MG/20 ML VIAL	T2	PA SP HD
TREMFYA ONE-PRESS	T2	PA QL(1 AUTO-INJ/56 DAYS) SP HD

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List of Prescription Medications

IMMUNOSUPPRESSANTS (Pain Relief And Inflammatory Disease) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
IL-23 RECEPTOR ANTAGONIST, MONOCLONAL ANTIBODY (cont.)		
TREMFYA PEN INDUCTION (2 PEN)	T2	PA QL(12 MLS/365 DAYS) SP HD
INTERLEUKIN-4(IL-4) RECEPTOR ALPHA ANTAGONIST, MAB		
DUPIXENT PEN	T3	PA SP HD
DUPIXENT SYRINGE	T3	PA SP HD
INTERLEUKIN-6 (IL-6) RECEPTOR INHIBITORS		
ACTEMRA 162 MG/0.9 ML SYRINGE	T2	PA QL(3.6 ML/28 DAYS) SP HD
ACTEMRA 200 MG/10 ML VIAL	T2	PA SP HD
ACTEMRA 400 MG/20 ML VIAL	T2	PA SP HD
ACTEMRA 80 MG/4 ML VIAL	T2	PA SP HD
ACTEMRA ACTPEN	T2	PA QL(3.6 ML/28 DAYS) SP HD
AVTOZMA	T3	PA SP
ENSPRYNG	T3	PA SP HD
KEVZARA	T3	PA QL(2 PENS/SYRINGES/28 DAYS) SP HD
TOFIDENCE	T3	PA SP
TYENNE 162 MG/0.9 ML SYRINGE	T2	PA QL(3.6 ML/28 DAYS) SP
TYENNE 200 MG/10 ML VIAL	T2	PA SP
TYENNE 400 MG/20 ML VIAL	T2	PA SP
TYENNE 80 MG/4 ML VIAL	T2	PA SP
TYENNE AUTOINJECTOR	T2	PA QL(3.6 ML/28 DAYS) SP
IMMUNOSUPPRESSANTS (SKIN CONDITIONS)		
INTERLEUKIN-3I(IL-3I)RECEPTOR ALPHA ANTAGONIST,MAB		
NEMLUVIO	T2	PA SP HD
TOPICAL IMMUNOSUPPRESSIVE AGENTS		
ELIDEL (pimecrolimus)	T3	PA
HYFTOR	T3	PA SP
<i>pimecrolimus (Elidel)</i>	T1	
<i>tacrolimus 0.03% ointment</i>	T1	
<i>tacrolimus 0.1% ointment</i>	T1	
IMMUNOSUPPRESSANTS (Transplant Medications)		
IMMUNOSUPPRESSANT - MONOCLONAL ANTIBODY		
NIKTIMVO	T3	PA SP
SIMULECT	T2	SP

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List of Prescription Medications

IMMUNOSUPPRESSANTS (Transplant Medications) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
IMMUNOSUPPRESSIVES		
ASTAGRAF XL	T3	SP HD
AZASAN (azathioprine)	T3	PA SP HD
azathioprine 100 mg tablet (Azasan)	T1	PA SP HD
azathioprine 50 mg tablet (Imuran)	T1	SP HD
azathioprine 75 mg tablet (Azasan)	T1	PA SP HD
azathioprine sodium	T1	
CELLCEPT 200 MG/ML ORAL SUSP (<i>mycophenolate mofetil</i>)	T3	PA SP HD
CELLCEPT 250 MG CAPSULE (<i>mycophenolate mofetil</i>)	T3	PA SP HD
CELLCEPT 500 MG TABLET (<i>mycophenolate mofetil</i>)	T3	PA SP HD
CELLCEPT 500 MG VIAL (<i>mycophenolate mofetil hcl</i>)	T2	SP
cyclosporine 100 mg capsule (Sandimmune)	T1	SP HD
cyclosporine 25 mg capsule (Sandimmune)	T1	SP HD
cyclosporine 250 mg/5 ml ampul (Sandimmune)	T1	SP
cyclosporine, modified	T1	SP HD
cyclosporine, modified (Neoral)	T1	SP HD
ENVARUSUS XR	T3	SP HD
everolimus 0.25 mg tablet (Zortress)	T1	SP HD
everolimus 0.5 mg tablet (Zortress)	T1	SP HD
everolimus 0.75 mg tablet (Zortress)	T1	SP HD
everolimus 1 mg tablet (Zortress)	T1	SP HD
IMURAN (azathioprine)	T3	PA SP HD
LUPKYNIS	T3	PA QL(6 CAPS/DAY) SP
mycophenolate 200 mg/ml susp (Cellcept)	T1	SP HD
mycophenolate 250 mg capsule (Cellcept)	T1	SP HD
mycophenolate 500 mg tablet (Cellcept)	T1	SP HD
mycophenolate 500 mg vial (Cellcept)	T1	SP
mycophenolate sodium (Cellcept)	T1	SP HD
MYFORTIC (<i>mycophenolate sodium</i>)	T3	PA SP HD
MYHIBBIN	T3	PA SP
NEORAL (<i>cyclosporine, modified</i>)	T3	PA SP HD
NULOJIX	T3	PA SP
PROGRAF 0.2 MG GRANULE PACKET	T3	SP HD
PROGRAF 0.5 MG CAPSULE (tacrolimus)	T3	PA SP HD
PROGRAF 1 MG CAPSULE (tacrolimus)	T3	PA SP HD

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List of Prescription Medications

IMMUNOSUPPRESSANTS (Transplant Medications) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
IMMUNOSUPPRESSIVES (cont.)		
PROGRAF 1 MG GRANULE PACKET	T3	SP HD
PROGRAF 5 MG CAPSULE (<i>tacrolimus</i>)	T3	PA SP HD
PROGRAF 5 MG/ML AMPULE	T2	SP
RAPAMUNE (<i>sirolimus</i>)	T3	PA SP HD
SANDIMMUNE 100 MG CAPSULE (<i>cyclosporine</i>)	T3	PA SP HD
SANDIMMUNE 100 MG/ML SOLN	T2	SP HD
SANDIMMUNE 25 MG CAPSULE (<i>cyclosporine</i>)	T3	PA SP HD
SANDIMMUNE 50 MG/ML AMPUL (<i>cyclosporine</i>)	T3	PA SP
<i>sirolimus</i>	T1	SP HD
<i>sirolimus</i> (Rapamune)	T1	SP HD
<i>tacrolimus</i> 0.5 mg capsule (ir) (Prograf)	T1	SP HD
<i>tacrolimus</i> 1 mg capsule (ir) (Prograf)	T1	SP HD
<i>tacrolimus</i> 5 mg capsule (ir) (Prograf)	T1	SP HD
TACROLIMUS 5 MG/ML VIAL	T3	SP
ZORTRESS (<i>everolimus</i>)	T3	SP HD

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

DIABETIC SUPPLIES (cont.)		
ZTEK CONTROL SOLUTION	T1	
ZTEK 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	T2	
ACCU-CHEK GUIDE MONITOR SYSTEM	T2	
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	
ADVANCED GLUCOSE METER	T3	
ADVANCED LANCING DEVICE	T1	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIABETIC SUPPLIES (cont.)		
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	T3	
ADVOCATE REDI-CODE DUO	T3	
ADVOCATE REDI-CODE PLUS	T3	
ADVOCATE REDI-CODE+ CTRL SOLN	T1	
AGAMATRIX AMP	T3	
AGAMATRIX CONTROL	T1	
AGAMATRIX CONTROL SOLUTION	T1	
AGAMATRIX JAZZ WIRELESS 2	T3	
AGAMATRIX PRESTO	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	
ASSURE PLATINUM	T3	
ASSURE PRISM	T1	
ASSURE PRISM MULTI	T3	
ASSURE TITANIUM GLUCOSE SYSTEM	T3	
AT HOME A1C	T1	
AUTOJECT 2	T1	
AUTO-LANCET MINI	T1	
AUTOLET IMPRESSION	T1	
AUTOLET LANCING DEVICE	T1	
AUTOLET LITE	T1	
AUTOLET PLUS	T1	
AUTOPEN	T1	
BIOTEL CARE BGM-4	T3	
BLOOD GLUCOSE CONTROL	T1	
BLOOD GLUCOSE METER	T3	

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List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIABETIC SUPPLIES (cont.)		
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	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	
CLEVER CHOICE	T3	
CLEVER CHOICE BLOOD GLUC SYST	T3	
CLEVER CHOICE CONTROL SOLUTION	T1	
CLEVER CHOICE HD GLUCOSE SYST	T3	
CLEVER CHOICE MICRO	T3	
CLEVER CHOICE PRO	T3	
CLEVER CHOICE TALK	T3	
CONTOUR METER	T3	
CONTOUR NEXT	T3	
CONTOUR NEXT CONTROL SOLUTION	T1	
CONTOUR NEXT EZ	T3	
CONTOUR NEXT GEN	T3	

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIABETIC SUPPLIES (cont.)		
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	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	T3	
EASY STEP CONTROL SOLUTION	T1	
EASY TALK BLOOD GLUCOSE METER	T3	
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	

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIABETIC SUPPLIES (cont.)		
EASY TRAK BLOOD GLUCOSE METER	T3	
EASY TRAK CONTROL SOLN HIGH	T1	
EASY TRAK CONTROL SOLN LOW	T1	
EASY TRAK II	T3	
EASY TRAK II CONTROL SOLUTION	T1	
EASYGLUCO	T3	
EASYGLUCO METER STARTER KIT	T3	
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	T3	
ELEMENT COMPACT CONTROL SOLN	T1	
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	
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	

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List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIABETIC SUPPLIES (cont.)		
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	T3	
EZ SMART PLUS	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	T3	
FORA D40D GLUCOSE-BP MONITOR	T3	
FORA D40G GLUCOSE-BP MONITOR	T3	
FORA G20	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	
FORA TN'G ADVANCE PRO MONITOR	T3	
FORA TN'G VOICE	T3	
FORA TN'GO ADV MOBILE MULT MTR	T3	
FORA TN'GO ADVANCE MULTIFN MTR	T3	
FORA V10	T3	
FORA V12	T3	
FORA V20	T3	
FORA V30A	T3	
FORACARE GD20	T3	
FORACARE GD40A	T3	
FORACARE GD40B	T3	

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MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIABETIC SUPPLIES (cont.)		
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	
GE333 BLOOD GLUCOSE SYSTEM	T3	
GENTEEL VACUUM LANCING DEVICE	T1	
GLUCO NAVII	T3	
GLUCOCARD 01	T3	
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	

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List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIABETIC SUPPLIES (cont.)		
GLUCOCARD SHINE XL	T3	
GLUCOCARD VITAL	T3	
GLUCOCOM AUTOLINK	T1	
GLUCOCOM BLOOD GLUCOSE	T3	
GLUCOCOM CONTROL SOLUTION	T1	
GLUCOSE CONTROL	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	
IGLUCOSE BLOOD GLUCOSE MONITOR	T3	
IHEALTH CONTROL SOLN LEVEL 2	T1	
IHEALTH GLUCO PLUS METER	T3	
INCONTROL LANCING DEVICE	T1	
INFINITY	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	
MEDTRONIC REMOTE CONTROL	T1	

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIABETIC SUPPLIES (cont.)		
MICRODOT BLOOD GLUCOSE SYSTEM	T3	
MICRODOT HIGH-LOW CONTROL SOL	T1	
MICRODOT NORMAL CONTROL SOLUT	T1	
MICROLET 2	T1	
MINI LANCING DEVICE	T1	
MINIMED QUICK-SERTER	T1	
MULTI-LANCET	T1	
MYGLUCOHEALTH	T3	
MYGLUCOHEALTH CONTROL SOLUTION	T1	
NEWTEK	T3	
NOVA MAX PLUS GLUC-KETON METER	T3	
NOVAMAX PLUS GLU-KET	T1	
NOVOPEN ECHO	T1	
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	

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIABETIC SUPPLIES (cont.)		
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	T3	
PIP BLOOD GLUCOSE MONITOR	T3	
PIP GLUCOSE CONTROL SOLUTION	T1	
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	T3	
PRESTO PRO	T3	
PRO VOICE V8 GLUCOSE MONITOR	T3	
PRO VOICE V9 GLUCOSE MONITOR	T3	
PRODIGY	T3	
QUINTET	T3	
QUINTET AC	T3	
REFUAH PLUS	T3	
REFUAH PLUS GLUCOSE CONTROL	T1	
RELIAMED MINI LANCING DEVICE	T1	
RELION ALL-IN-ONE	T3	
RELION CONFIRM	T3	

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MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIABETIC SUPPLIES (cont.)		
RELION MICRO	T3	
RELION PRIME	T3	
RELION TRUE METRIX AIR GLU MTR	T2	
REVEAL BLOOD GLUCOSE METER	T3	
RIGHTEST CONTROL SOLUTION	T1	
RIGHTEST GD500	T1	
RIGHTEST GM100 SYSTEM	T3	
RIGHTEST GM300 SYSTEM	T3	
RIGHTEST GM550 SYSTEM	T3	
RIGHTEST GT333 GLUCOSE METER	T3	
SAFE-CLIP	T1	
SIL-SERTER	T1	
SIMPLERA SENSOR	T3	PA
SIMPLERA SYNC SENSOR	T3	PA
SMART SENSE MONITORING SYSTEM	T3	
SMARTDIABETES VANTAGE	T1	
SMARTTEST	T1	
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	T3	
TRUE METRIX	T1	
TRUE METRIX GO	T2	
TRUECONTROL	T1	
TRUEDRAW	T1	

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MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIABETIC SUPPLIES (cont.)		
TRUERESULT BLOOD GLUCOSE SYSTM	T3	
TRUETRACK BLOOD GLUCOSE SYSTEM	T3	
TRUETRACK SMART SYSTEM	T3	
TWIIST REFILL KT(CSST-NDL-SYR)	T2	QL(30 KITS/30 DAYS)
TWIIST RFL(INFUS-CSST-NDL-SYR)	T2	QL(30 KITS/30 DAYS)
TWIIST STARTER KIT	T2	QL(1 KIT/365 DAYS)
ULTI-LANCE	T1	
ULTIMA	T3	
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	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT,MISC (GROUP I) (con't.)		
ADVOCATE LANCETS	T1	
ADVOCATE SAFETY LANCET	T1	
AGAMATRIX ULTRA-THIN LANCET	T1	
ALTERNATE SITE LANCETS	T1	
ASSURE HAEMOLANCE PLUS	T1	
ASSURE	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	
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	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT,MISC (GROUP I) (con't.)		
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	
FORACARE LANCETS	T1	
FREESTYLE LANCETS	T1	
FREESTYLE UNISTIK 2	T1	
GLUCOCOM	T1	
GLUCOCOM LANCETS	T1	
GOJJI LANCETS	T1	
HEALTHY ACCENTS UNILET LANCET	T1	
INCONTROL SUPER THIN LANCETS	T1	
INCONTROL ULTRA THIN LANCETS	T1	
INJECT EASE LANCETS	T1	
INVACARE LANCETS	T1	
lancets	T1	
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	

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List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT,MISC (GROUP I) (con't.)		
MICROLET	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	
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	

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List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT,MISC (GROUP I) (con't.)		
SINGLE-LET	T1	
SMART SENSE	T1	
SMART SENSE LANCETS	T1	
SMARTTEST 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 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	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT,MISC (GROUP I) (con't.)		
ULTRALC LANCETS	T1	
UNILET COMFORTOUCH	T1	
UNILET EXCELITE	T1	
UNILET EXCELITE II	T1	
UNILET GP LANCET	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	
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		
1ST TIER UNIFINE PENTIPS	T1	PA
1ST TIER UNIFINE PENTIPS PLUS	T1	PA
ADVOCATE PEN NEEDLE	T1	PA
ADVOCATE PEN NEEDLES	T1	PA

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List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NEEDLES/NEEDLELESS DEVICES (con't.)		
AQINJECT PEN NEEDLE	T1	PA
ASSURE ID DUO PRO SFTY PEN NDL	T1	PA
ASSURE ID PEN NEEDLE	T1	PA
ASSURE ID PRO PEN NEEDLE	T1	PA
AUTOSHIELD DUO PEN NEEDLE	T1	
BLUNT NEEDLE	T1	
CAREFINE PEN NEEDLE	T1	PA
CAREPOINT PRECISION NEEDLE	T1	
CARETOUCH HYPODERMIC NEEDLE	T1	
CARETOUCH PEN NEEDLE	T1	PA
CLICKFINE	T1	PA
COMFORT EZ PEN NEEDLE	T1	PA
COMFORT EZ PRO SAFETY PEN NDL	T1	PA
COMFORT TOUCH PEN NEEDLE	T1	PA
DROPLET MICRON PEN NEEDLE	T1	PA
DROPLET PEN NEEDLE	T1	PA
DROPSAFE PEN NEEDLE	T1	PA
DROPSAFE SICURA SAFETY NEEDLE	T1	
EASY COMFORT PEN NEEDLE	T1	PA
EASY COMFORT PEN NEEDLES	T1	PA
EASY COMFORT SAFETY PEN NEEDLE	T1	PA
EASY GLIDE PEN NEEDLE	T1	PA
EASY TOUCH FLIPLock NEEDLE	T1	
EASY TOUCH FLIPLock NEEDLES	T1	
EASY TOUCH HYPODERMIC NEEDLE	T1	
EASY TOUCH PEN NEEDLE	T1	PA
EASY TOUCH SAFETY PEN NEEDLE	T1	PA
EASYPPOINT NEEDLE	T1	
ECLIPSE NEEDLE	T1	
EMBRACE PEN NEEDLE	T1	PA
EXEL HUBER NEEDLE	T1	
EXEL HYPODERMIC NEEDLE	T1	
EXEL MTI DRAWING NEEDLE	T2	
FILTER ASPIRATOR NEEDLE	T1	
FILTER NEEDLE	T1	

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List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NEEDLES/NEEDLELESS DEVICES (con't.)		
FLOW-EZE	T1	
HEALTHWISE PEN NEEDLE	T1	PA
HEALTHY ACCENTS UNIFINE PENTIP	T1	PA
HYPODERMIC NEEDLE	T1	
INCONTROL PEN NEEDLE	T1	PA
INSULIN PEN NEEDLE	T1	PA
INSUPEN PEN NEEDLE	T1	PA
INTEGRA NEEDLE	T1	
INTEGRA PRECISIONGLIDE NEEDLE	T1	
LIFESHIELD BLUNT CANNULA	T1	
LITE TOUCH 31GX1/4" PEN NEEDLE	T1	PA
LITE TOUCH PEN NEEDLE 29G	T1	PA
LITE TOUCH PEN NEEDLE 31G	T1	PA
MAXICOMFORT II PEN NEEDLE	T1	PA
MAXICOMFORT SAFETY PEN NEEDLE	T1	PA
MINI PEN NEEDLE	T1	PA
MINI ULTRA-THIN II	T1	PA
MONOJECT BLOOD COLLECTION	T2	
MONOJECT FILTER NEEDLE	T1	
NANO 2ND GEN PEN NEEDLE	T1	
NANO PEN NEEDLE	T1	
NEEDLES	T1	
NOKOR ADMIX NEEDLE	T1	
NOKOR NEEDLE	T1	
NOVOFINE 32	T1	PA
NOVOFINE AUTOCOVER	T1	PA
NOVOFINE PLUS	T1	PA
PEN NEEDLE	T1	PA
PEN NEEDLES	T1	PA
PENTIPS PEN NEEDLE	T1	PA
PERFECT POINT SAFETY NEEDLE	T1	
PHASEAL PROTECTOR	T2	

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MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NEEDLES/NEEDLELESS DEVICES (con't.)		
PIP PEN NEEDLE	T1	PA
POLY HUB NEEDLE	T1	
PRECISIONGLIDE	T1	
PRECISIONGLIDE NEEDLE	T1	
PREVENT DROPSAFE PEN NEEDLE	T1	PA
PRO COMFORT PEN NEEDLE	T1	PA
PURE COMFORT PEN NEEDLE	T1	PA
PURE COMFORT SAFETY PEN NEEDLE	T1	PA
RAYA SURE PEN NEEDLE	T1	PA
REGULAR BEVEL NEEDLES	T1	
SAFETY PEN NEEDLE	T1	PA
SAFETYGLIDE NEEDLE	T1	
SECURESAFE PEN NEEDLE	T1	PA
SHORT BEVEL NEEDLES	T1	
SIMPLI PEN NEEDLE	T1	PA
SKY SAFETY PEN NEEDLE	T1	PA
SPECIALTY USE NEEDLES	T1	
SURE COMFORT	T1	PA
SURE COMFORT PEN NEEDLE	T1	PA
SURE COMFORT SAFETY PEN NEEDLE	T1	PA
SURE-FINE PEN NEEDLES	T1	PA
TECHLITE PEN NEEDLE	T1	PA
TECHLITE PLUS PEN NEEDLE	T1	PA
TERUMO SURGUARD2	T1	
THIN WALL NEEDLES	T1	
TOPCARE CLICKFINE	T1	PA
TRANSFER NEEDLE	T1	
TRUE COMFORT PEN NEEDLE	T1	PA
TRUE COMFORT PRO PEN NEEDLE	T1	PA
TRUE COMFORT SAFETY PEN NEEDLE	T1	PA
TRUEPLUS PEN NEEDLE	T1	PA
ULTICARE PEN NEEDLE	T1	PA
ULTICARE SAFETY PEN NEEDLE	T1	PA

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List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NEEDLES/NEEDLELESS DEVICES (con't.)		
ULTIGUARD SAFEPACK-PEN NEEDLE	T1	PA
ULTILET PEN NEEDLE	T1	PA
ULTRA FLO PEN NEEDLE	T1	PA
ULTRA THIN	T1	PA
ULTRACARE PEN NEEDLE	T1	PA
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	
ULTRA-THIN II PEN ND1 29GX1/2"	T1	PA
ULTRA-THIN II PEN ND1 31GX5/16	T1	PA
UNIFINE PEN NEEDLE	T1	PA
UNIFINE PENTIPS	T1	PA
UNIFINE PENTIPS MAXFLOW	T1	PA
UNIFINE PENTIPS PLUS	T1	PA
UNIFINE PENTIPS PLUS MAXFLOW	T1	PA
UNIFINE PROTECT	T1	PA
UNIFINE SAFECONTROL PEN NEEDLE	T1	PA
UNIFINE ULTRA PEN NEEDLE	T1	PA
VERIFINE PEN NEEDLE	T1	PA
VERIFINE PLUS PEN NEEDLE	T1	PA
YALE NEEDLES	T1	
SYRINGES AND ACCESSORIES		
ADVOCATE SYRINGES	T1	PA
AQ INSULIN SYR 0.5 ML 30G 8MM	T1	PA
AQ INSULIN SYR 1 ML 31G 8MM	T1	PA
AQ INSULIN SYRIN 1 ML 29G 12MM	T1	PA
ASSURE ID INSULIN SAFETY	T1	PA
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	

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MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SYRINGES AND ACCESSORIES (con't.)		
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	
BROOKS INSULIN 0.3ML SYRN	T1	PA
CA INS SYR 0.3 ML 30GX5/16"	T1	PA
CA INS SYR 0.3 ML 31GX5/16"	T1	PA
CA INS SYR 0.5 ML 30GX5/16"	T1	PA
CA INS SYR 0.5 ML 31GX5/16"	T1	PA
CA INSULIN SYR 0.3 ML 29GX1/2"	T1	PA
CA INSULIN SYR 0.5 ML 29GX1/2"	T1	PA
CA INSULIN SYR 1 ML 29GX1/2"	T1	PA
CA INSULIN SYR 1 ML 30GX5/16"	T1	PA
CA INSULIN SYR 1 ML 31GX5/16"	T1	PA
CAREONE SYR 0.3 ML 30GX1/2"	T1	PA
CAREONE SYR 0.5 ML 30GX1/2"	T1	PA
CAREONE SYR 1 ML 30GX1/2"	T1	PA
CARETOUCH INSULIN SYRINGE	T1	PA
COMFORT EZ INSULIN SYRINGE	T1	PA
DROPLET INSULIN SYRINGE	T1	PA
DROPSAFE INSULIN SYRINGE	T1	PA
EASY COMFORT INSULIN SYRINGE	T1	PA
EASY GLIDE INSULIN SYRINGE	T1	PA
EASY TOUCH FLIPLOCK INSULIN	T1	PA
EASY TOUCH INSULIN SAFETY	T1	PA
EASY TOUCH INSULIN SYR 0.3 ML	T1	PA
EASY TOUCH INSULIN SYR 0.5 ML	T1	PA

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MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SYRINGES AND ACCESSORIES (con't.)		
EASY TOUCH INSULIN SYR 1 ML	T1	PA
EASY TOUCH INSULIN SYRINGE	T1	PA
EASY TOUCH LUER LOCK INSULIN	T1	PA
EASY TOUCH SHEATHLOCK INSULIN	T1	PA
EASY TOUCH UNI-SLIP	T1	PA
EASY-TOUCH INSULIN SYRINGE	T1	PA
ECLIPSE SYRINGE	T1	
EQL INS SYR 1 ML 29GX1/2"	T1	PA
EQL INSUL SYR 0.3 ML 31GX5/16"	T1	PA
EQL INSUL SYR 0.5 ML 31GX5/16"	T1	PA
EQL INSULIN 0.3 ML SYRINGE	T1	PA
EQL INSULIN 0.5 ML SYRINGE	T1	PA
EQL INSULIN 1 ML SYRINGE	T1	PA
EQL INSULIN SYR 1 ML 31GX5/16"	T1	PA
EXEL INS SYR U100 1 ML 28GX1/2	T1	PA
EXEL U100 0.3 ML 29GX1/2"	T1	PA
EXEL U100 0.3 ML 30GX5/16"	T1	PA
EXEL U100 0.5 ML 28GX1/2"	T1	PA
EXEL U100 0.5 ML 29GX1/2"	T1	PA
EXEL U100 0.5 ML 30GX5/16"	T1	PA
EXEL U100 1 ML 30GX5/16"	T1	PA
EXEL U100 INS SYR 1 ML 29GX1/2	T1	PA
FIFTY50 INS 0.3 ML 31GX5/16"	T1	PA
FIFTY50 INS 0.5 ML 31GX5/16"	T1	PA
FIFTY50 INS SYR 1 ML 31GX5/16"	T1	PA
FREESTYLE PRECISION	T1	PA
GNP INS SYR 0.3 ML 29GX1/2"	T1	PA
GNP INS SYRINGE 1 ML 28G 1/2"	T1	PA
GNP INSUL SYR 0.3 ML 31GX5/16"	T1	PA
GNP INSUL SYR 0.5 ML 31GX5/16"	T1	PA
GNP INSULIN SYR 1 ML 31GX5/16"	T1	PA
HEALTHWISE INSULIN SYRINGE	T1	PA
INSULIN 1 ML SYRINGE	T1	PA
INSULIN 1/2 ML SYRINGE	T1	PA

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MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SYRINGES AND ACCESSORIES (con't.)		
INSULIN 3/10 ML SYRINGE	T1	PA
INSULIN SYR 0.3 ML 30GX5/16"	T1	PA
INSULIN SYR 0.3ML 31GX1/4(1/2)	T1	PA
INSULIN SYR 0.5 ML 28G 12.7MM	T1	
INSULIN SYRIN 0.3 ML 29GX1/2"	T1	PA
INSULIN SYRIN 0.3 ML 30GX1/2"	T1	PA
INSULIN SYRIN 0.3 ML 30GX5/16"	T1	PA
INSULIN SYRIN 0.3 ML 31GX5/16"	T1	PA
INSULIN SYRIN 0.5 ML 28G 1/2"	T1	PA
INSULIN SYRIN 0.5 ML 28GX1/2"	T1	PA
INSULIN SYRIN 0.5 ML 29GX1/2"	T1	PA
INSULIN SYRIN 0.5 ML 30G 1/2"	T1	PA
INSULIN SYRIN 0.5 ML 30G 5/16"	T1	PA
INSULIN SYRIN 0.5 ML 30GX1/2"	T1	PA
INSULIN SYRIN 0.5 ML 30GX5/16"	T1	PA
INSULIN SYRIN 0.5 ML 31G 5/16"	T1	PA
INSULIN SYRIN 0.5 ML 31GX5/16"	T1	PA
INSULIN SYRIN 1 ML 29GX1/2"	T1	PA
INSULIN SYRINGE 0.5 ML 27G 1/2"	T1	PA
INSULIN SYRINGE 0.5 ML 27G 13MM	T1	PA
INSULIN SYRINGE 0.5 ML 28G 1/2"	T1	PA
INSULIN SYRINGE 0.5 ML 29G 1/2"	T1	PA
INSULIN SYRINGE 0.5 ML 29GX1/2"	T1	PA
INSULIN SYRINGE 0.3 ML 31GX1/4	T1	PA
INSULIN SYRINGE 0.5 ML 31GX1/4	T1	PA
INSULIN SYRINGE 1 ML	T1	PA
INSULIN SYRINGE 1 ML 27G 1/2"	T1	PA
INSULIN SYRINGE 1 ML 27G 13MM	T1	PA
INSULIN SYRINGE 1 ML 27G 16MM	T1	
INSULIN SYRINGE 1 ML 27GX1/2"	T1	PA
INSULIN SYRINGE 1 ML 28G 1/2"	T1	PA
INSULIN SYRINGE 1 ML 28G 13MM	T1	PA
INSULIN SYRINGE 1 ML 28GX1/2"	T1	PA
INSULIN SYRINGE 1 ML 29G 1/2"	T1	PA
INSULIN SYRINGE 1 ML 29GX1/2"	T1	PA

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SYRINGES AND ACCESSORIES (con't.)		
INSULIN SYRINGE 1 ML 30G 1/2"	T1	PA
INSULIN SYRINGE 1 ML 30G 5/16"	T1	PA
INSULIN SYRINGE 1 ML 31G 5/16"	T1	PA
INSULIN SYRINGE 1 ML 31GX1/4"	T1	PA
INSULIN SYRINGE 1 ML 31GX5/16"	T1	PA
INSULIN SYRINGE 1ML 28G 12.7MM	T1	
INSULIN SYRINGE U-500	T1	
KINRAY INS SYR 1 ML 31GX5/16"	T1	PA
KINRAY SYRING 0.3 ML 31GX5/16"	T1	PA
KINRAY SYRING 0.5 ML 31GX5/16"	T1	PA
KMART VALU PLUS SYR 1/2 ML	T1	PA
KRO INS SYR 0.3 ML 29GX1/2"	T1	PA
KRO INS SYRIN 0.5 ML 31GX5/16"	T1	PA
KRO INSULIN SYR 1 ML 30GX5/16"	T1	PA
KROGER INS SYR 0.3 ML 30GX5/16	T1	PA
KROGER INS SYR 0.5 ML 29GX1/2"	T1	PA
KROGER INS SYR 1 ML 29GX1/2"	T1	PA
KROGER INS SYR 1 ML 31GX5/16"	T1	PA
KROGER SYR 0.5 ML 30GX5/16"	T1	PA
KROGER SYRING 0.3 ML 31GX5/16"	T1	PA
LEADER INS SYR 0.3 ML 29GX1/2"	T1	PA
LEADER INS SYR 0.5 ML 28GX1/2"	T1	PA
LEADER INS SYR 0.5 ML 29GX1/2"	T1	PA
LEADER INS SYR 0.5 ML 30GX1/2"	T1	PA
LEADER INS SYR 1 ML 28GX1/2"	T1	PA
LEADER INS SYR 1 ML 29GX1/2"	T1	PA
LEADER INS SYR 1 ML 30GX5/16"	T1	PA
LEADER INS SYR 1 ML 31GX5/16"	T1	PA
LEADER INSULIN SYRINGE 0.3 ML	T1	PA
LEADER SYRING 0.3 ML 31GX5/16"	T1	PA
LEADER SYRING 0.5 ML 31GX5/16"	T1	PA
LITE TOUCH INSULIN 0.5 ML SYR	T1	PA
LITE TOUCH INSULIN 1 ML SYR	T1	PA

T1 – Typically Generics

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PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SYRINGES AND ACCESSORIES (con't.)		
LITE TOUCH INSULIN SYR 0.3 ML	T1	PA
LITE TOUCH INSULIN SYR 0.5 ML	T1	PA
LITE TOUCH INSULIN SYR 1 ML	T1	PA
LITETOUCH INSULIN SYRINGE	T1	PA
MAGELLAN INSULIN SAFETY SYRNG	T1	PA
MAGELLAN INSULIN SYRINGE	T1	PA
MAXI-COMFORT	T1	PA
MAXICOMFORT INSULIN SYRINGE	T1	PA
MINIMED RESERVOIR 1.8 ML	T1	
MINIMED RESERVOIR 3 ML	T3	
MONOJECT	T1	PA
MONOJECT INSULIN SAFETY SYRNG	T1	PA
MONOJECT INSULIN SYRINGE	T1	PA
MS INS SYR 0.5 ML 29GX1/2"	T1	PA
MS INS SYR 1 ML 29GX1/2"	T1	PA
MS INS SYRINGE 1 ML 30GX1/2"	T1	PA
MS INSUL SYR 0.3 ML 31GX5/16"	T1	PA
MS INSUL SYR 0.5 ML 30GX1/2"	T1	PA
MS INSUL SYR 0.5 ML 31GX5/16"	T1	PA
MS INSULIN SYR 0.3 ML 29GX1/2"	T1	PA
MS INSULIN SYR 1 ML 31GX5/16"	T1	PA
MS INSULIN SYRINGE 0.3 ML	T1	PA
PARADIGM RESERVOIR 1.8 ML	T1	
PARADIGM RESERVOIR 3 ML	T3	
PREF PLUS INS 0.3 ML 29GX1/2"	T1	PA
PREF PLUS SYR 0.5 ML 30GX5/16"	T1	PA
PREF PLUS SYRING 1 ML 29GX1/2"	T1	PA
PREFERRED PLUS 0.3 ML 30GX5/16	T1	PA
PREFERRED PLUS 0.5 ML 29GX1/2"	T1	PA
PREFERRED PLUS SYRINGE 0.5 ML	T1	PA
PREFERRED PLUS SYRINGE 1 ML	T1	PA
PREFPLS INS SYR 1 ML 30GX5/16"	T1	PA
PRO COMFORT INSULIN SYRINGE	T1	PA

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ST – Step Therapy

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List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SYRINGES AND ACCESSORIES (con't.)		
PRODIGY INSULIN SYRINGE	T1	PA
PUB INS SYRIN 0.3 ML 30GX1/2"	T1	PA
PUB INS SYRINGE 1 ML 30GX1/2"	T1	PA
PUB INSUL SYR 0.3 ML 31GX5/16"	T1	PA
PUB INSUL SYR 0.5 ML 30GX1/2"	T1	PA
PUB INSUL SYR 0.5 ML 31GX5/16"	T1	PA
PUB INSULIN SYR 1 ML 31GX5/16"	T1	PA
RA INS SYR 0.5 ML 29GX1/2"	T1	PA
RA INS SYR 0.5 ML 30GX5/16"	T1	PA
RA INS SYR 1 ML 29GX1/2"	T1	PA
RA INS SYRINGE 1 ML 30GX5/16"	T1	PA
RELION INS SYR 0.3 ML 29GX1/2"	T1	PA
RELION INS SYR 0.3 ML 31GX6MM	T1	PA
RELION INS SYR 0.5 ML 29GX1/2"	T1	PA
RELION INS SYR 0.5 ML 31GX6MM	T1	PA
RELION INS SYR 1 ML 29GX1/2"	T1	PA
RELION INS SYR 1 ML 31GX15/64"	T1	PA
RELION INS SYR 1 ML 31GX5/16"	T1	PA
RELION INSULIN SYR 0.5 ML	T1	PA
RELION SYRING 0.3 ML 31GX5/16"	T1	PA
RELION SYRING 0.5 ML 31GX5/16"	T1	PA
SAFESNAP INSULIN SYRINGE	T1	PA
SAFETYGLIDE SYRINGE	T1	
SECURESAFE INSULIN SYRINGE	T1	PA
SM INS SYR 0.5 ML 29GX1/2"	T1	PA
SM INS SYR 0.5 ML 30GX5/16"	T1	PA
SM INS SYR 1 ML 29GX1/2"	T1	PA
SM INS SYRING 0.3 ML 30GX5/16"	T1	PA
SM INS SYRINGE 1 ML 28GX1/2"	T1	PA
SM INS SYRINGE 1 ML 30GX5/16"	T1	PA
SM INSUL SYR 0.3 ML 31GX5/16"	T1	PA
SM INSUL SYR 0.5 ML 31GX5/16"	T1	PA
SM INSULIN SYR 0.3 ML 29GX1/2"	T1	PA
SM INSULIN SYR 0.5 ML 28GX1/2"	T1	PA
SM INSULIN SYR 1 ML 31GX5/16"	T1	PA

T1 – Typically Generics

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CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SYRINGES AND ACCESSORIES (con't.)		
SURE COMFORT	T1	PA
SURE COMFORT INSULIN SYRINGE	T1	PA
SURE-JECT INS 0.3 ML 31GX5/16"	T1	PA
SURE-JECT INS 0.5 ML 31GX5/16"	T1	PA
SURE-JECT INSULIN SYRINGE	T1	PA
syringe and needle,insulin,1ml	T1	PA
syringe-needle,insulin,0.5 ml	T1	PA
syring-needl,disp,insul,0.3 ml	T1	PA
TECHLITE INSULIN SYRINGE	T1	PA
TERUMO INS SYR 0.3 ML 29GX1/2"	T1	PA
TERUMO INSULIN SYRINGE	T1	PA
THINPRO INSULIN SYRINGE	T1	PA
TOPCARE ULTRA COMFORT	T1	PA
TRUE COMFORT INSULIN SYRINGE	T1	PA
TRUE COMFORT PRO INS SYRINGE	T1	PA
TRUE COMFORT SAFE INSULIN SYRG	T1	PA
TRUEPLUS INSULIN SYRINGE	T1	PA
ULTICARE INS SYR 1 ML 31GX5/16"	T1	PA
ULTICARE	T1	PA
ULTICARE INS SAFETY 1ML 29X1/2	T1	PA
ULTICARE INS SYR 1 ML 28GX1/2"	T1	PA
ULTICARE INS SYR 1 ML 29GX1/2"	T1	PA
ULTICARE INSULIN SYRINGE	T1	PA
ULTICARE SAFETY 0.5 ML 29GX1/2	T1	PA
ULTICARE SYR 0.3 ML 30GX5/16"	T1	PA
ULTICARE SYR 0.3 ML 31GX5/16"	T1	PA
ULTICARE SYR 0.5 ML 29GX1/2"	T1	PA
ULTICARE SYR 0.5 ML 30GX5/16"	T1	PA
ULTICARE SYR 0.5 ML 31GX5/16"	T1	PA
ULTICARE SYR 1 ML 30GX5/16"	T1	PA
ULTICARE SYRIN 0.3 ML 29GX1/2"	T1	PA
ULTICARE SYRIN 0.5 ML 28GX1/2"	T1	PA
ULTIGUARD SAFE 1ML 30G 12.7MM	T3	PA
ULTIGUARD SAFE0.3ML 30G 12.7MM	T3	PA

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List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SYRINGES AND ACCESSORIES (con't.)		
ULTIGUARD SAFE0.5ML 30G 12.7MM	T1	PA
ULTIGUARD SAFEPACK 1ML 31G 8MM	T3	PA
ULTIGUARD SAFEPK 0.3ML 31G 8MM	T3	PA
ULTIGUARD SAFEPK 0.5ML 31G 8MM	T1	PA
ULTILET INSULIN SYRINGE	T1	PA
ULTRA COMFORT	T1	PA
ULTRA FLO INSULIN SYRINGE	T1	PA
ULTRACARE INSULIN SYRINGE	T1	PA
ULTRA-FINE INSULIN SYRINGE	T1	
ULTRA-THIN II 1 ML 31GX5/16"	T1	PA
ULTRA-THIN II INS 0.3 ML 30G	T1	PA
ULTRA-THIN II INS 0.3 ML 31G	T1	PA
ULTRA-THIN II INS 0.5 ML 29G	T1	PA
ULTRA-THIN II INS 0.5 ML 30G	T1	PA
ULTRA-THIN II INS 0.5 ML 31G	T1	PA
ULTRA-THIN II INS SYR 1 ML 29G	T1	PA
ULTRA-THIN II INS SYR 1 ML 30G	T1	PA
VANISHPOINT	T1	PA
VANISHPOINT INSULIN SYRINGE	T1	PA
VEO INSULIN SYRINGE	T1	
VERIFINE INSULIN SYRINGE	T1	PA

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	
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	

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List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Miscellaneous) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT,MISC (GROUP I) (con't.)		
ASSURE HAEMOLANCE PLUS	T1	
ASSURE LANCE	T1	
ASSURE LANCE PLUS	T1	
BD MICROTAINER LANCETS	T1	
BLOOD LANCETS	T1	
BLULINK BG SYSTEM REFILL	T3	
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	

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List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Miscellaneous) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT,MISC (GROUP I) (con't.)		
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	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	
INVACARE LANCETS	T1	
LITE TOUCH 28G LANCETS	T1	
LITE TOUCH 30G LANCETS	T1	
LITE TOUCH 33G LANCETS	T1	
MEDISENSE THIN LANCETS	T1	
MEDLANCE PLUS	T1	

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List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Miscellaneous) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT,MISC (GROUP I) (con't.)		
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	
PURE COMFORT LANCETS	T1	
PURE COMFORT SAFETY LANCETS	T1	
PUSH BUTTON SAFETY LANCETS	T1	

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List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Miscellaneous) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT,MISC (GROUP I) (con't.)		
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	
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	

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T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Miscellaneous) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT,MISC (GROUP I) (con't.)		
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 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	
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	

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List of Prescription Medications

MUSCLE RELAXANTS (Pain Relief And Inflammatory Disease)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SKELTAL MUSCLE RELAXANTS (con't.)		
AMRIX ER 15 MG CAPSULE (<i>cyclobenzaprine hcl</i>)	T3	PA QL(1 CAP/DAY)
AMRIX ER 30 MG CAPSULE (<i>cyclobenzaprine hcl</i>)	T3	PA
<i>baclofen 0.05 mg/ml syringe</i> (Gablofen)	T1	
<i>baclofen 10 mg tablet</i>	T1	HD
<i>baclofen 10 mg/20 ml vial</i> (Gablofen)	T1	
<i>baclofen 10 mg/5 ml solution</i>	T1	HD
<i>baclofen 15 mg tablet</i>	T1	PA HD
<i>baclofen 20 mg tablet</i>	T1	HD
<i>baclofen 20,000 mcg/20 ml vial</i> (Gablofen)	T1	
<i>baclofen 25 mg/5 ml suspension</i> (Fleqsuvy)	T1	PA HD
BACLOFEN 40 MG/20 ML REFL KIT	T3	
<i>baclofen 40 mg/20 ml vial</i> (Gablofen)	T1	
<i>baclofen 40,000 mcg/20 ml vial</i> (Gablofen)	T1	
<i>baclofen 5 mg tablet</i>	T1	HD
<i>baclofen 5 mg/5 ml solution</i>	T1	HD
<i>carisoprodol</i> (Soma)	T1	
<i>carisoprodol/aspirin</i>	T1	
<i>chlorzoxazone 250 mg tablet</i>	T1	PA
<i>chlorzoxazone 375 mg tablet</i> (Lorzone)	T1	PA
<i>chlorzoxazone 500 mg tablet</i>	T1	
<i>chlorzoxazone 750 mg tablet</i> (Lorzone)	T1	PA
<i>cyclobenzaprine er 15 mg cap</i> (Amrix)	T1	PA QL(1 CAP/DAY)
<i>cyclobenzaprine er 30 mg cap</i> (Amrix)	T1	PA
<i>cyclobenzaprine hcl</i>	T1	
DANTRIUM (<i>dantrolene sodium</i>)	T3	
<i>dantrolene sodium</i> (Dantrium)	T1	
FEXMID (<i>cyclobenzaprine hcl</i>)	T3	
FLEQSUVY (<i>baclofen</i>)	T3	PA HD
GABLOFEN (<i>baclofen</i>)	T3	
LIORESAL INTRATHECAL	T3	
LORZONE (<i>chlorzoxazone</i>)	T3	PA
LYVISPAH	T3	PA
<i>metaxalone 400 mg tablet</i>	T1	
METAXALONE 640 MG TABLET	T3	PA

T1 – Typically Generics

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AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

MUSCLE RELAXANTS (Pain Relief And Inflammatory Disease) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SKELLETAL MUSCLE RELAXANTS (con't.)		
<i>metaxalone 800 mg tablet</i>	T1	
METHOCARBAMOL 1,000 MG TABLET	T3	PA
<i>methocarbamol 1,000 mg/10 ml (Robaxin)</i>	T1	
<i>methocarbamol 500 mg tablet</i>	T1	
<i>methocarbamol 750 mg tablet</i>	T1	
NORGESIC (orphenadrine/aspirin/caffeine)	T3	PA
NORGESIC FORTE (orphenadrine/aspirin/caffeine)	T3	PA
<i>orphenadrine citrate</i>	T1	
<i>orphenadrine/aspirin/caffeine (Norgesic Forte)</i>	T1	PA
OZOBAX	T3	PA HD
OZOBAX DS	T3	PA HD
ROBAXIN (<i>methocarbamol</i>)	T3	
RYANODEX	T3	
SOMA (<i>carisoprodol</i>)	T3	PA
<i>tizanidine hcl 2 mg capsule (Zanaflex)</i>	T1	PA
<i>tizanidine hcl 2 mg tablet</i>	T1	
<i>tizanidine hcl 4 mg capsule (Zanaflex)</i>	T1	PA
<i>tizanidine hcl 4 mg tablet (Zanaflex)</i>	T1	
<i>tizanidine hcl 6 mg capsule (Zanaflex)</i>	T1	PA
ZANAFLEX (<i>tizanidine hcl</i>)	T3	

PRE-NATAL VITAMINS (Nutritional/Dietary)

PRENATAL VITAMIN PREPARATIONS		
BAL-CARE DHA ESSENTIAL	T2	
CITRANATAL 90 DHA	T2	
CITRANATAL ASSURE	T2	
CITRANATAL DHA	T2	
CITRANATAL HARMONY	T2	
CITRANATAL RX	T2	
DERMACINRX PRENATRIX	T3	PA
DERMACINRX PRENATRYL	T3	PA
DERMACINRX PRETRATE	T3	PA
DUET DHA BALANCED	T2	
KOSHER PRENATAL PLUS IRON	T2	
MARNATAL-F	T2	

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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		
<i>mynatal capsule</i>	T3	
<i>mynatal ultracaplet</i>	T1	
NATACHEW	T2	
NEONATAL COMPLETE	T3	
NEONATAL PLUS	T3	
NEONATAL-DHA	T3	
NESTABS	T2	
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	T2	
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	
PREGEN DHA	T3	PA
PRENATA	T2	
<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	

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List of Prescription Medications

PRE-NATAL VITAMINS (Nutritional/Dietary) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PRENATAL VITAMIN PREPARATIONS		
<i>prenatal 71/iron/folic ac/dha</i>	T1	
<i>prenatal 93/iron/folate 9/dha</i>	T1	
<i>prenatal no.42/folic acid</i> (Vitamedmd Redichew Rx)	T2	
PRENATAL PLUS VITAMIN-MINERAL	T2	
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	T2	
PRENATE RESTORE	T2	
PRIMACARE	T2	
PROVIDA OB	T2	
SELECT-OB	T2	
SELECT-OB (prenatal vit 128/iron/folic ac)	T2	
SELECT-OB + DHA	T2	
THRIVITE RX	T1	
TRICARE	T2	
TRISTART DHA	T2	
VITAFOL FE PLUS	T3	
VITAFOL NANO	T2	
VITAFOL ULTRA	T2	
VITAFOL-OB	T1	
VITAFOL-OB+DHA	T2	
VITAFOL-ONE	T2	
VITAMEDMD ONE RX	T2	
VITAMEDMD REDICHEW RX (prenatal no.42/folic acid)	T2	
VITAPEARL	T3	
VITATRUE	T3	

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List of Prescription Medications

PRE-NATAL VITAMINS (Nutritional/Dietary) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PRENATAL VITAMINS WITH LOW OR NO IRON		
ALTRIXA OB	T3	PA
AZESCO	T3	PA
CITRANATAL B-CALM	T2	
DUET DHA 400	T2	
EMBRIVA	T3	PA
FOLATEXCEL	T3	PA
MATERNACEL	T3	PA
MATERVIA	T3	PA
NATAL PNV	T3	PA
NEOMATERNA	T3	PA
PNV TABS 20-1	T3	PA
PREGENNA	T3	PA
PRENATE DHA	T2	
PRENATE ELITE	T2	
PRENATE MINI	T2	
PRENATE PIXIE	T2	
PRENATE STAR	T3	
R-NATAL OB	T1	
TRINAZ	T3	PA
VITAFOL GUMMIES	T2	
VITALARA	T3	PA
ZALVIT	T3	PA
ZIPHEX	T3	PA

PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)⁹

ALPHA-2 RECEPTOR ANTAGONIST ANTI-DEPRESSANTS		
<i>mirtazapine</i>	T1	HD
REMERON (mirtazapine)	T3	PA HD
ANTI-ANXIETY - BENZODIAZEPINES		
<i>alprazolam (Xanax Xr)</i>	T1	
<i>alprazolam (Xanax)</i>	T1	
ATIVAN (<i>lorazepam</i>)	T3	PA
<i>chlordiazepoxide hcl</i>	T1	
<i>clorazepate dipotassium</i>	T1	

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List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)⁹ (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-ANXIETY - BENZODIAZEPINES (cont.)		
<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 (Ativan)</i>	T1	
LOREEV XR	T3	PA QL(1 CAP/DAY)
<i>oxazepam</i>	T1	
VALIUM (<i>diazepam</i>)	T3	PA
XANAX (<i>alprazolam</i>)	T3	PA
XANAX XR (<i>alprazolam</i>)	T3	PA
ANTI-ANXIETY DRUGS		
BUCAPSOL	T3	PA
<i>bupirone hcl</i>	T1	HD
<i>meprobamate</i>	T1	
ANTIDEPRESSANT - NMDA RECEPTOR ANTAGONIST		
SPRAVATO	T3	PA SP
ANTIDEPRESSANT - POSTPARTUM DEPRESSION (PPD)		
ZURZUVAE 20 MG CAPSULE	T3	PA QL(28 CAPS/270 DAYS) SP HD
ZURZUVAE 25 MG CAPSULE	T3	PA QL(28 CAPS/270 DAYS) SP HD
ZURZUVAE 30 MG CAPSULE	T3	PA QL(14 CAPS/270 DAYS) SP HD
BIPOLAR DISORDER DRUGS		
EQUETRO	T3	HD
<i>lithium carbonate</i>	T1	HD
<i>lithium carbonate (Lithobid)</i>	T1	HD
<i>lithium citrate</i>	T1	HD
LITHOBID (lithium carbonate)	T3	PA HD

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List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)⁹ (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BIPOLAR DISORDER DRUGS (con't.)		
PARNATE (<i>tranylcypromine sulfate</i>)	T3	PA
<i>phenezine sulfate</i> (Nardil)	T1	
<i>tranylcypromine sulfate</i> (Parnate)	T1	
MONOAMINE OXIDASE (MAO) INHIBITOR ANTI-DEPRESSANTS		
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)
NDMA RECEPTOR ANTAGONIST AND NDRI COMB		
AUVELITY	T2	ST QL(2 TABS/DAY)
NOREPINEPHRINE AND DOPAMINE REUPTAKE INHIB (NDRIs)		
APLENZIN ER 174 MG TABLET	T3	PA QL(3 TABS/DAY) HD
APLENZIN ER 348 MG TABLET	T3	PA QL(1 TAB/DAY) HD
APLENZIN ER 522 MG TABLET	T3	PA QL(1 TAB/DAY) HD
<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</i> (Wellbutrin Sr)	T1	QL(4 TABS/DAY) HD
<i>bupropion hcl sr 150 mg tablet</i> (Wellbutrin Sr)	T1	QL(2 TABS/DAY) HD
<i>bupropion hcl sr 200 mg tablet</i> (Wellbutrin Sr)	T1	QL(2 TABS/DAY) HD
<i>bupropion hcl xl 150 mg tablet</i> (Wellbutrin XL)	T1	QL(3 TABS/DAY) HD
<i>bupropion hcl xl 300 mg tablet</i> (Wellbutrin XL)	T1	QL(1 TAB/DAY) HD
BUPROPION HCL XL 450 MG TABLET	T3	PA QL(1 TAB/DAY) HD
FORFIVO XL	T3	PA QL(1 TAB/DAY) HD
WELLBUTRIN SR 100 MG TABLET (<i>bupropion hcl</i>)	T3	PA QL(4 TABS/DAY)
WELLBUTRIN SR 150 MG TABLET (<i>bupropion hcl</i>)	T3	PA QL(2 TABS/DAY)
WELLBUTRIN SR 200 MG TABLET (<i>bupropion hcl</i>)	T3	PA QL(2 TABS/DAY)
WELLBUTRIN XL 150 MG TABLET (<i>bupropion hcl</i>)	T3	PA QL(3 TABS/DAY)
WELLBUTRIN XL 300 MG TABLET (<i>bupropion hcl</i>)	T3	PA QL(1 TAB/DAY)
SELECTIVE SEROTONIN 5-HT_{2A} INVERSE AGONISTS (SSiAs)		
NUPLAZID	T3	PA SP HD
SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIs)		
CELEXA 10 MG TABLET (<i>citalopram hydrobromide</i>)	T3	PA QL(6 TABS/DAY) HD
CELEXA 20 MG TABLET (<i>citalopram hydrobromide</i>)	T3	PA QL(3 TABS/DAY) HD
CELEXA 40 MG TABLET (<i>citalopram hydrobromide</i>)	T3	PA QL(1 TAB/DAY) HD
<i>citalopram hbr 10 mg tablet</i> (Celexa)	T1	QL(6 TABS/DAY) HD

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List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)⁹ (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIs) (con't.)		
<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
CITALOPRAM HBR 30 MG CAPSULE	T3	PA QL(1 CAP/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 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
<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
LEXAPRO 10 MG TABLET (<i>escitalopram oxalate</i>)	T3	PA QL(2 TABS/DAY)
LEXAPRO 20 MG TABLET (<i>escitalopram oxalate</i>)	T3	PA QL(1 TAB/DAY)
LEXAPRO 5 MG TABLET (<i>escitalopram oxalate</i>)	T3	PA QL(4 TABS/DAY)
<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

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List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)⁹ (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIs) (con't.)		
<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
PAXIL 10 MG TABLET (<i>paroxetine hcl</i>)	T3	PA QL(6 TABS/DAY) HD
PAXIL 20 MG TABLET (<i>paroxetine hcl</i>)	T3	PA QL(3 TABS/DAY) HD
PAXIL 30 MG TABLET (<i>paroxetine hcl</i>)	T3	PA QL(2 TABS/DAY) HD
PAXIL 40 MG TABLET (<i>paroxetine hcl</i>)	T3	PA QL(1 TAB/DAY) HD
PAXIL CR 12.5 MG TABLET (<i>paroxetine hcl</i>)	T3	PA QL(1 TAB/DAY) HD
PAXIL CR 25 MG TABLET (<i>paroxetine hcl</i>)	T3	PA QL(3 TABS/DAY) HD
PAXIL CR 37.5 MG TABLET (<i>paroxetine hcl</i>)	T3	PA QL(2 TABS/DAY) HD
PROZAC 10 MG PULVULE (<i>fluoxetine hcl</i>)	T3	PA QL(8 CAPS/DAY)
PROZAC 20 MG PULVULE (<i>fluoxetine hcl</i>)	T3	PA QL(4 CAPS/DAY)
PROZAC 40 MG PULVULE (<i>fluoxetine hcl</i>)	T3	PA QL(2 CAPS/DAY)
<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
ZOLOFT 100 MG TABLET (<i>sertraline hcl</i>)	T3	PA QL(2 TABS/DAY)
ZOLOFT 20 MG/ML ORAL CONC (<i>sertraline hcl</i>)	T3	PA QL(10 MLS/DAY)
ZOLOFT 25 MG TABLET (<i>sertraline hcl</i>)	T3	PA QL(8 TABS/DAY)
ZOLOFT 50 MG TABLET (<i>sertraline hcl</i>)	T3	PA QL(4 TABS/DAY)
SEROTONIN-2 ANTAGONIST/REUPTAKE INHIBITORS (SARIs)		
<i>nefazodone hcl</i>	T1	HD
RALDESY	T3	PA HD
<i>trazodone hcl</i>	T1	HD
SEROTONIN-NOREPINEPHRINE REUPTAKE-INHIB (SNRIs)		
CYMBALTA 20 MG CAPSULE (<i>duloxetine hcl</i>)	T3	PA QL(6 CAPS/DAY) HD
CYMBALTA 30 MG CAPSULE (<i>duloxetine hcl</i>)	T3	PA QL(4 CAPS/DAY) HD
CYMBALTA 60 MG CAPSULE (<i>duloxetine hcl</i>)	T3	PA QL(2 CAPS/DAY) HD
DESVENLAFAXINE ER 100 MG TAB	T3	PA QL(4 TABS/DAY) HD
DESVENLAFAXINE ER 50 MG TAB	T3	PA QL(8 TABS/DAY) HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)⁹ (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SEROTONIN-NOREPINEPHRINE REUPTAKE-INHIB (SNRIs) (con't.)		
<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
DRIZALMA SPRINKLE DR 20 MG CAP	T3	ST QL(1 CAP/DAY) HD
DRIZALMA SPRINKLE DR 30 MG CAP	T3	ST QL(1 CAP/DAY) HD
DRIZALMA SPRINKLE DR 40 MG CAP	T3	ST QL(1 CAP/DAY) HD
DRIZALMA SPRINKLE DR 60 MG CAP	T3	ST QL(2 CAPS/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
<i>duloxetine hcl dr 60 mg cap (Cymbalta)</i>	T1	QL(2 CAPS/DAY) HD
EFFEXOR XR 150 MG CAPSULE (<i>venlafaxine hcl</i>)	T3	PA QL(2 CAPS/DAY)
EFFEXOR XR 37.5 MG CAPSULE (<i>venlafaxine hcl</i>)	T3	PA QL(8 CAPS/DAY)
EFFEXOR XR 75 MG CAPSULE (<i>venlafaxine hcl</i>)	T3	PA QL(4 CAPS/DAY)
FETZIMA 20-40 MG TITRATION PAK	T3	PA QL(28 CAPS/180 DAYS)
FETZIMA ER 120 MG CAPSULE	T3	PA QL(1 CAP/DAY)
FETZIMA ER 20 MG CAPSULE	T3	PA QL(6 CAPS/DAY)
FETZIMA ER 40 MG CAPSULE	T3	PA QL(3 CAPS/DAY)
FETZIMA ER 80 MG CAPSULE	T3	PA QL(1 CAP/DAY)
PRISTIQ ER 100 MG TABLET (<i>desvenlafaxine succinate</i>)	T3	PA QL(4 TABS/DAY) HD
PRISTIQ ER 25 MG TABLET (<i>desvenlafaxine succinate</i>)	T3	PA QL(16 TABS/DAY) HD
PRISTIQ ER 50 MG TABLET (<i>desvenlafaxine succinate</i>)	T3	PA QL(1 TAB/DAY) HD
VENLAFAXINE BESYLATE ER	T3	PA QL(2 TABS/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

T1 – Typically Generics

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PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)⁹ (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SSRI AND 5HT1A PARTIAL AGONIST ANTI-DEPRESSANTS		
VIIBRYD 10 MG TABLET (<i>vilazodone hcl</i>)	T3	PA QL(1 TAB/DAY) HD
VIIBRYD 20 MG TABLET (<i>vilazodone hcl</i>)	T3	PA QL(1 TAB/DAY) HD
VIIBRYD 40 MG TABLET (<i>vilazodone hcl</i>)	T3	PA HD
<i>vilazodone hcl 10 mg tablet</i> (Viibryd)	T1	QL(1 TAB/DAY) HD
<i>vilazodone hcl 20 mg tablet</i> (Viibryd)	T1	QL(1 TAB/DAY) HD
<i>vilazodone hcl 40 mg tablet</i> (Viibryd)	T1	HD
SSRI, SEROTONIN RECEPTOR MODULATOR ANTI-DEPRESSANTS		
TRINTELLIX 10 MG TABLET	T2	QL(1 TAB/DAY)
TRINTELLIX 20 MG TABLET	T2	
TRINTELLIX 5 MG TABLET	T2	QL(1 TAB/DAY)
TRICYCLIC ANTI-DEPRESSANT-BENZODIAZEPINE COMBINATNS		
<i>amitriptyline/chlordiazepoxide</i>	T1	HD
TRICYCLIC ANTI-DEPRESSANT-PHENOTHIAZINE COMBINATNS		
<i>perphenazine/amitriptyline hcl</i>	T1	HD
TRICYCLIC ANTI-DEPRESSANTS, REL.NON-SEL.REUPT-INHIB		
<i>amitriptyline hcl</i>	T1	HD
<i>amoxapine</i>	T1	HD
ANAFRANIL (<i>clomipramine hcl</i>)	T3	PA HD
<i>clomipramine hcl</i> (Anafranil)	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
TRICYCLIC ANTI-DEPRESSANTS, REL.NON-SEL.REUPT-INHIB		
<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</i> (Pamelor)	T1	HD
PAMELOR (<i>nortriptyline hcl</i>)	T3	PA HD
<i>protriptyline hcl</i>	T1	HD
<i>trimipramine maleate</i>	T1	HD

T1 – Typically Generics

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T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Attention Deficit Hyperactivity Disorder)⁹

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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)
VYVANSE 10 MG CAPSULE (lisdexamfetamine dimesylate)	T3	PA QL(1 CAP/DAY)
VYVANSE 10 MG CHEWABLE TABLET (lisdexamfetamine dimesylate)	T3	PA QL(1 TAB/DAY)
VYVANSE 20 MG CAPSULE (lisdexamfetamine dimesylate)	T3	PA QL(1 CAP/DAY)
VYVANSE 20 MG CHEWABLE TABLET (lisdexamfetamine dimesylate)	T3	PA QL(1 TAB/DAY)
VYVANSE 30 MG CAPSULE (lisdexamfetamine dimesylate)	T3	PA QL(1 CAP/DAY)
VYVANSE 30 MG CHEWABLE TABLET (lisdexamfetamine dimesylate)	T3	PA QL(1 TAB/DAY)
VYVANSE 40 MG CAPSULE (lisdexamfetamine dimesylate)	T3	PA QL(1 CAP/DAY)
VYVANSE 40 MG CHEWABLE TABLET (<i>lisdexamfetamine dimesylate</i>)	T3	PA QL(1 TAB/DAY)
VYVANSE 50 MG CAPSULE (<i>lisdexamfetamine dimesylate</i>)	T3	PA QL(1 CAP/DAY)
VYVANSE 50 MG CHEWABLE TABLET (<i>lisdexamfetamine dimesylate</i>)	T3	PA QL(1 TAB/DAY)
VYVANSE 60 MG CAPSULE (<i>lisdexamfetamine dimesylate</i>)	T3	PA QL(1 CAP/DAY)
VYVANSE 60 MG CHEWABLE TABLET (<i>lisdexamfetamine dimesylate</i>)	T3	PA QL(1 TAB/DAY)
VYVANSE 70 MG CAPSULE (<i>lisdexamfetamine dimesylate</i>)	T3	PA QL(1 CAP/DAY)
TX FOR ADHD - SELECTIVE ALPHA-2 RECEPTOR AGONIST		
<i>clonidine hcl (Kapvay)</i>	T1	
<i>guanfacine hcl (Intuniv)</i>	T1	HD
INTUNIV (<i>guanfacine hcl er</i>)	T3	PA HD
KAPVAY (<i>clonidine hcl er</i>)	T3	PA
TX FOR ATTENTION DEFICIT-HYPERACT (ADHD)/NARCOLEPSY		
ADHANSIA XR	T3	PA QL (1 cap/day) ST
APTENSIO XR (<i>methylphenidate er</i>)	T3	PA QL (1 cap/day) ST

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T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Attention Deficit Hyperactivity Disorder)⁹ (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TX FOR ATTENTION DEFICIT-HYPERACT (ADHD)/NARCOLEPSY (con't.)		
CONCERTA ER 27 MG TABLET (<i>methylphenidate hcl</i>)	T3	PA ST QL(1 TAB/DAY)
CONCERTA ER 36 MG TABLET (<i>methylphenidate hcl</i>)	T3	PA ST QL(2 TABS/DAY)
CONCERTA ER 54 MG TABLET (<i>methylphenidate hcl</i>)	T3	PA ST QL(1 TAB/DAY)
COTEMPLA XR-ODT 17.3 MG TABLET	T3	PA QL(1 TAB/DAY)
COTEMPLA XR-ODT 25.9 MG TABLET	T3	PA QL(2 TABS/DAY)
COTEMPLA XR-ODT 8.6 MG TABLET	T3	PA QL(1 TAB/DAY)
DAYTRANA (<i>methylphenidate</i>)	T3	PA QL(1 PATCH/DAY)
<i>dexmethylphenidate hcl</i> (Focalin Xr)	T1	PA QL(1 CAP/DAY)
<i>dexmethylphenidate hcl</i> (Focalin)	T1	PA
FOCALIN (<i>dexmethylphenidate hcl</i>)	T3	PA ST
FOCALIN XR (<i>dexmethylphenidate hcl</i>)	T3	PA ST QL(1 CAP/DAY)
JORNAY PM	T3	PA ST QL(1 CAP/DAY)
METADATE CD (<i>methylphenidate hcl</i>)	T3	PA QL(1 CAP/DAY)
METHYLIN (<i>methylphenidate hcl</i>)	T3	PA
<i>methylphenidate</i> (Daytrana)	T1	PA QL(1 PATCH/DAY)
<i>methylphenidate er 10 mg cap</i> (Aptensio Xr)	T1	PA QL(1 CAP/DAY)
<i>methylphenidate er 10 mg tab</i>	T1	PA QL(2 TABS/DAY)
CONCERTA ER 27 MG TABLET (<i>methylphenidate hcl</i>)	T3	PA ST QL(1 TAB/DAY)
CONCERTA ER 36 MG TABLET (<i>methylphenidate hcl</i>)	T3	PA ST QL(2 TABS/DAY)
CONCERTA ER 54 MG TABLET (<i>methylphenidate hcl</i>)	T3	PA ST QL(1 TAB/DAY)
COTEMPLA XR-ODT 17.3 MG TABLET	T3	PA QL(1 TAB/DAY)
COTEMPLA XR-ODT 25.9 MG TABLET	T3	PA QL(2 TABS/DAY)
COTEMPLA XR-ODT 8.6 MG TABLET	T3	PA QL(1 TAB/DAY)
DAYTRANA (<i>methylphenidate</i>)	T3	PA QL(1 PATCH/DAY)
<i>dexmethylphenidate hcl</i> (Focalin Xr)	T1	PA QL(1 CAP/DAY)
<i>dexmethylphenidate hcl</i> (Focalin)	T1	PA
FOCALIN (<i>dexmethylphenidate hcl</i>)	T3	PA ST
FOCALIN XR (<i>dexmethylphenidate hcl</i>)	T3	PA ST QL(1 CAP/DAY)
JORNAY PM	T3	PA ST QL(1 CAP/DAY)
METADATE CD (<i>methylphenidate hcl</i>)	T3	PA QL(1 CAP/DAY)
METHYLIN (<i>methylphenidate hcl</i>)	T3	PA
<i>methylphenidate</i> (Daytrana)	T1	PA QL(1 PATCH/DAY)
<i>methylphenidate er 10 mg cap</i> (Aptensio Xr)	T1	PA QL(1 CAP/DAY)
<i>methylphenidate er 10 mg tab</i>	T1	PA QL(2 TABS/DAY)

T1 – Typically Generics

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T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Attention Deficit Hyperactivity Disorder)⁹ (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TX FOR ATTENTION DEFICIT-HYPERACT (ADHD)/NARCOLEPSY (cont.)		
<i>methylphenidate er 15 mg cap (Aptensio Xr)</i>	T1	PA QL(1 CAP/DAY)
<i>methylphenidate er 18 mg tab (Concerta) (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) (Relexxii)</i>	T1	PA QL(2 TABS/DAY)
<i>methylphenidate er 40 mg cap (Aptensio Xr)</i>	T1	PA QL(1 CAP/DAY)
METHYLPHENIDATE ER 45 MG TAB	T3	PA QL(1 TAB/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)
METHYLPHENIDATE ER 63 MG TAB	T3	PA QL(1 TAB/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
QUILLICHEW ER 20 MG CHEW TAB	T3	PA QL(1 TAB/DAY)
QUILLICHEW ER 30 MG CHEW TAB	T3	PA QL(2 TABS/DAY)
QUILLICHEW ER 40 MG CHEW TAB	T3	PA QL(1 TAB/DAY)
QUILLIVANT XR	T3	PA QL(12 MLS/DAY)
RELEXXII ER 18 MG TABLET (<i>methylphenidate hcl</i>)	T3	PA QL(1 TAB/DAY)
RELEXXII ER 27 MG TABLET (<i>methylphenidate hcl</i>)	T3	PA QL(1 TAB/DAY)
RELEXXII ER 36 MG TABLET (<i>methylphenidate hcl</i>)	T3	PA QL(2 TABS/DAY)
RELEXXII ER 45 MG TABLET	T3	PA QL(1 TAB/DAY)
RELEXXII ER 54 MG TABLET (<i>methylphenidate hcl</i>)	T3	PA QL(1 TAB/DAY)

T1 – Typically Generics

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T2 – Typically Preferred Brands

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SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Attention Deficit Hyperactivity Disorder)⁹ (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TX FOR ATTENTION DEFICIT-HYPERACT (ADHD)/NARCOLEPSY (cont.)		
RELEXXII ER 63 MG TABLET	T3	PA QL(1 TAB/DAY)
RELEXXII ER 72 MG TABLET	T3	PA QL(1 TAB/DAY)
RITALIN (methylphenidate hcl)	T3	PA ST
RITALIN LA 10 MG CAPSULE (methylphenidate hcl)	T3	PA ST QL(1 CAP/DAY)
RITALIN LA 20 MG CAPSULE (methylphenidate hcl)	T3	PA ST QL(1 CAP/DAY)
RITALIN LA 30 MG CAPSULE (methylphenidate hcl)	T3	PA ST QL(2 CAPS/DAY)
RITALIN LA 40 MG CAPSULE (methylphenidate hcl)	T3	PA ST QL(1 CAP/DAY)
TX FOR ATTENTION DEFICIT-HYPERACT.(ADHD), NRI-TYPE		
atomoxetine hcl 10 mg capsule (Strattera)	T1	HD
atomoxetine hcl 100 mg capsule (Strattera)	T1	HD
atomoxetine hcl 18 mg capsule (Strattera)	T1	HD
atomoxetine hcl 25 mg capsule (Strattera)	T1	HD
atomoxetine hcl 40 mg capsule (Strattera)	T1	QL(1 CAP/DAY) HD
atomoxetine hcl 60 mg capsule (Strattera)	T1	HD
atomoxetine hcl 80 mg capsule (Strattera)	T1	HD
QELBREE ER 100 MG CAPSULE	T3	PA QL(1 CAP/DAY)
QELBREE ER 150 MG CAPSULE	T3	PA QL(2 CAPS/DAY)
QELBREE ER 200 MG CAPSULE	T3	PA QL(3 CAPS/DAY)
STRATTERA 10 MG CAPSULE (atomoxetine hcl)	T3	PA HD
STRATTERA 100 MG CAPSULE (atomoxetine hcl)	T3	PA HD
STRATTERA 18 MG CAPSULE (atomoxetine hcl)	T3	PA HD
STRATTERA 25 MG CAPSULE (atomoxetine hcl)	T3	PA HD
STRATTERA 40 MG CAPSULE (atomoxetine hcl)	T3	PA QL(1 CAP/DAY) HD
STRATTERA 60 MG CAPSULE (atomoxetine hcl)	T3	PA HD
STRATTERA 80 MG CAPSULE (atomoxetine hcl)	T3	PA HD
PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics)⁹		
ANTI-PSYCH, DOPAMINE ANTAG., DIPHENYLBUTYLPIPERIDINES		
pimozide	T1	
ANTI-PSYCHOTIC, ATYPICAL, DOPAMINE, SEROTONIN ANTAGNIST		
asenapine maleate (Saphris)	T1	
CAPLYTA	T3	ST QL(1 CAP/DAY)
clozapine (Clozaril)	T1	
CLOZARIL (clozapine)	T3	PA

T1 – Typically Generics

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T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics)⁹ (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-PSYCHOTIC, ATYPICAL, DOPAMINE, SEROTONIN ANTAGONIST (con't.)		
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)
FANAPT 1 MG TABLET	T3	PA QL(4 TABS/DAY)
FANAPT 10 MG TABLET	T3	PA QL(4 TABS/DAY)
FANAPT 12 MG TABLET	T3	PA
FANAPT 2 MG TABLET	T3	PA QL(4 TABS/DAY)
FANAPT 4 MG TABLET	T3	PA QL(4 TABS/DAY)
FANAPT 6 MG TABLET	T3	PA QL(4 TABS/DAY)
FANAPT 8 MG TABLET	T3	PA QL(4 TABS/DAY)
FANAPT TITRATION PACK A	T3	PA QL(32 TABS/365 DAYS)
FANAPT TITRATION PACK B	T3	PA QL(48 TABS/365 DAYS)
FANAPT TITRATION PACK C	T3	PA QL(32 TABS/365 DAYS)
GEODON 20 MG CAPSULE (<i>ziprasidone hcl</i>)	T3	PA
GEODON 20 MG/ML VIAL (<i>ziprasidone mesylate</i>)	T3	
GEODON 40 MG CAPSULE (<i>ziprasidone hcl</i>)	T3	PA
GEODON 60 MG CAPSULE (<i>ziprasidone hcl</i>)	T3	PA
GEODON 80 MG CAPSULE (<i>ziprasidone hcl</i>)	T3	PA
INVEGA ER 3 MG TABLET (<i>paliperidone</i>)	T3	PA QL(1 TAB/DAY)
INVEGA ER 6 MG TABLET (<i>paliperidone</i>)	T3	PA
INVEGA ER 9 MG TABLET (<i>paliperidone</i>)	T3	PA
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)
LATUDA 120 MG TABLET (<i>lurasidone hcl</i>)	T3	PA
LATUDA 20 MG TABLET (<i>lurasidone hcl</i>)	T3	PA
LATUDA 40 MG TABLET (<i>lurasidone hcl</i>)	T3	PA QL(1 TAB/DAY)

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics)⁹ (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-PSYCHOTIC, ATYPICAL, DOPAMINE, SEROTONIN ANTAGNIST (con't.)		
LATUDA 60 MG TABLET (<i>lurasidone hcl</i>)	T3	PA QL(1 TAB/DAY)
LATUDA 80 MG TABLET (<i>lurasidone hcl</i>)	T3	PA
<i>lurasidone hcl 120 mg tablet</i> (Latuda)	T1	
<i>lurasidone hcl 20 mg tablet</i> (Latuda)	T1	
<i>lurasidone hcl 40 mg tablet</i> (Latuda)	T1	QL(1 TAB/DAY)
<i>lurasidone hcl 60 mg tablet</i> (Latuda)	T1	QL(1 TAB/DAY)
<i>lurasidone hcl 80 mg tablet</i> (Latuda)	T1	
LYBALVI	T3	ST QL(1 TAB/DAY)
<i>olanzapine</i>	T1	
<i>olanzapine</i> (Zyprexa Zydis)	T1	
<i>olanzapine</i> (Zyprexa)	T1	
<i>paliperidone er 1.5 mg tablet</i>	T1	
<i>paliperidone er 3 mg tablet</i> (Invega)	T1	QL(1 TAB/DAY)
<i>paliperidone er 6 mg tablet</i> (Invega)	T1	
<i>paliperidone er 9 mg tablet</i> (Invega)	T1	
PERSERIS	T3	QL(1 UNIT/28 DAYS)
<i>risperidone microspheres</i>	T1	QL
QUETIAPINE 150 MG TABLET	T3	PA
<i>quetiapine fumarate</i> (Seroquel Xr)	T1	
<i>quetiapine fumarate 100 mg tab</i> (Seroquel)	T1	
<i>quetiapine fumarate 200 mg tab</i> (Seroquel)	T1	
<i>quetiapine fumarate 25 mg tab</i> (Seroquel)	T1	
<i>quetiapine fumarate 300 mg tab</i> (Seroquel)	T1	
<i>quetiapine fumarate 400 mg tab</i> (Seroquel)	T1	
<i>quetiapine fumarate 50 mg tab</i> (Seroquel)	T1	
RISPERDAL (<i>risperidone</i>)	T3	PA
RISPERDAL CONSTA (<i>risperidone microspheres</i>)	T3	PA QL(4 VIALS/28 DAYS)
<i>risperidone</i>	T1	
<i>risperidone</i> (Risperdal)	T1	
<i>risperidone microspheres</i> (Risperdal Consta)	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

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T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics)⁹ (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-PSYCHOTIC, ATYPICAL, DOPAMINE, SEROTONIN ANTAGONIST (con't.)		
SEROQUEL XR (quetiapine fumarate)	T3	ST
UZEDY ER 100 MG/0.28 ML SYRING	T3	QL(1 UNIT/30 DAYS)
UZEDY ER 125 MG/0.35 ML SYRING	T3	QL(1 UNIT/30 DAYS)
UZEDY ER 150 MG/0.42 ML SYRING	T3	QL(1 UNIT/45 DAYS)
UZEDY ER 200 MG/0.56 ML SYRING	T3	QL(1 UNIT/45 DAYS)
UZEDY ER 250 MG/0.7 ML SYRINGE	T3	QL(1 UNIT/45 DAYS)
UZEDY ER 50 MG/0.14 ML SYRINGE	T3	QL(1 UNIT/30 DAYS)
UZEDY ER 75 MG/0.21 ML SYRINGE	T3	QL(1 UNIT/30 DAYS)
VERSACLOZ	T3	PA
<i>ziprasidone mesylate</i> (Geodon)	T1	
ZYPREXA 10 MG TABLET (olanzapine)	T3	PA
ZYPREXA 10 MG VIAL (olanzapine)	T3	
ZYPREXA 15 MG TABLET (olanzapine)	T3	PA
ZYPREXA 2.5 MG TABLET (olanzapine)	T3	PA
ZYPREXA 20 MG TABLET (olanzapine)	T3	PA
ZYPREXA 5 MG TABLET (olanzapine)	T3	PA
ZYPREXA 7.5 MG TABLET (olanzapine)	T3	PA
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)
ZYPREXA ZYDIS (olanzapine)	T3	PA
ANTI-PSYCHOTIC-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 10 MG TABLET (aripiprazole)	T3	ST
ABILIFY 15 MG TABLET (aripiprazole)	T3	ST
ABILIFY 2 MG TABLET (aripiprazole)	T3	ST
ABILIFY 20 MG TABLET (aripiprazole)	T3	ST

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SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics)⁹ (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIPSYCHOTICS, ATYP, D2 PARTIAL AGONIST/5HT MIXED (con't.)		
ABILIFY 30 MG TABLET (aripiprazole)	T3	ST
ABILIFY 5 MG TABLET (aripiprazole)	T3	ST QL(1 TAB/DAY)
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	
ABILIFY MYCITE	T3	PA
<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	
OPIPZA 10 MG FILM	T3	PA QL(3 FILMS/DAY)
OPIPZA 2 MG FILM	T3	PA QL(1 FILM/DAY)
OPIPZA 5 MG FILM	T3	PA QL(3 FILMS/DAY)
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
ANTI-PSYCHOTICS, DOPAMINE AND SEROTONIN ANTAGONISTS		
<i>loxapine succinate</i>	T1	
ANTIPSYCHOTICS, MUSCARINIC AGONIST/ANTAGONIST COMB		
COBENFY	T3	PA QL(2 CAPS/DAY)
COBENFY STARTER PACK	T3	PA QL(56 CAPS/180 DAYS)

T1 – Typically Generics

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T2 – Typically Preferred Brands

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SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics)⁹ (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-PSYCHOTICS, DOPAMINE ANTAGONISTS, THIOXANTHENES		
<i>thiothixene</i>	T1	
ANTIPSYCHOTICS, DOPAMINE ANTAGONISTS, BUTYROPHENONES		
<i>droperidol</i>	T1	
<i>haloperidol</i>	T1	
<i>haloperidol decanoate</i>	T1	
<i>haloperidol lactate</i>	T1	
ANTI-PSYCHOTICS, DOPAMINE ANTAGONIST, DIHYDROINDOLONES		
<i>molindone hcl</i>	T1	
ANTI-PSYCHOTICS, 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	
ANTIPSYCHOTICS, ATYP, D2 PARTIAL AGONIST/5HT MIXED		
<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-ANTI-PSYCH, ATYPICAL, DOPAMINE, SEROTONIN ANTAG		
<i>olanzapine/fluoxetine hcl</i>	T1	
<i>olanzapine/fluoxetine hcl</i>	T1	

PSYCHOTHERAPEUTIC DRUGS (Seizure Disorders)

NEUROACTIVE STEROID GABA-A RECEPTOR MODULATOR		
ZTALMY	T3	PA QL(36 MLS/DAY) SP

PSYCHOTHERAPEUTIC DRUGS (Sleep Disorders/Sedatives)

NARCOLEPSY AND SLEEP DISORDER THERAPY AGENTS		
<i>armodafinil</i> (Nuvigil)	T1	PA
<i>modafinil</i> (Provigil)	T1	PA
NUVIGIL (<i>armodafinil</i>)	T3	PA
PROVIGIL (<i>modafinil</i>)	T3	PA
SUNOSI	T2	PA QL (1 tab/day)

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List of Prescription Medications

SEDATIVE/HYPNOTICS (Sleep Disorders/Sedatives) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-NARCOLEPSY, ANTI-CATAPLEXY, SEDATIVE-TYPE AGENT		
LUMRYZ	T3	PA QL(1 PACK/DAY) SP HD
LUMRYZ STARTER PACK	T3	PA QL SP HD
SODIUM OXYBATE	T3	PA QL(18 MLS/DAY) SP HD
XYREM	T3	PA QL(18 MLS/DAY) SP HD
XYWAV	T3	PA QL(18 MLS/DAY) SP HD
BARBITURATES		
AMYTAL SODIUM	T3	
NEMBUTAL SODIUM (<i>pentobarbital sodium</i>)	T3	PA
<i>pentobarbital sodium</i> (Nembutal Sodium)	T1	PA
<i>phenobarbital</i>	T1	
HYPNOTICS, MELATONIN MT1/MT2 RECEPTOR AGONISTS		
HETLIOZ (<i>tasimelteon</i>)	T3	PA SP HD
HETLIOZ LQ	T3	PA SP HD
<i>ramelteon</i> (Rozerem)	T1	QL(1 TAB/DAY)
ROZEREM (<i>ramelteon</i>)	T3	PA QL(1 TAB/DAY)
<i>tasimelteon</i>	T1	PA SP
SEDATIVE-HYPNOTICS - BENZODIAZEPINES		
ATIVAN (<i>lorazepam</i>)	T3	PA
DORAL	T3	
<i>estazolam</i>	T1	
<i>flurazepam hcl</i>	T1	
HALCION (<i>triazolam</i>)	T3	
<i>lorazepam</i> (Ativan)	T1	
QUAZEPAM	T1	
RESTORIL (<i>temazepam</i>)	T3	PA
<i>temazepam</i> (Restoril)	T1	
<i>triazolam</i> (Halcion)	T1	
SEDATIVE-HYPNOTICS, NON-BARBITURATE		
AMBIEN (<i>zolpidem tartrate</i>)	T3	PA
AMBIEN CR 12.5 MG TABLET (<i>zolpidem tartrate</i>)	T3	PA

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T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

SEDATIVE/HYPNOTICS (Sleep Disorders/Sedatives) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SEDATIVE-HYPNOTICS, NON-BARBITURATE (con't.)		
AMBIEN CR 6.25 MG TABLET (<i>zolpidem tartrate</i>)	T3	PA QL(1 TAB/DAY)
BELSOMRA	T3	PA
DAYVIGO	T2	ST QL(1 TAB/DAY)
<i>dexmedetomidine hcl</i>	T1	
<i>dexmedetomidine in 0.9 % nacl</i>	T1	
<i>doxepin hcl 3 mg tablet (Silenor)</i>	T1	QL(1 TAB/DAY)
<i>doxepin hcl 6 mg tablet (Silenor)</i>	T1	
EDLUAR 10 MG SL TABLET	T3	PA
EDLUAR 5 MG SL TABLET	T3	PA QL(1 TAB/DAY)
<i>eszopiclone (Lunesta)</i>	T1	
LUNESTA (<i>eszopiclone</i>)	T3	PA
PRECEDEX (<i>dexmedetomidine in 0.9 % nacl</i>)	T3	
QUVIVIQ	T3	PA QL(1 TAB/DAY)
SILENOR 3 MG TABLET (<i>doxepin hcl</i>)	T3	PA QL(1 TAB/DAY)
SILENOR 6 MG TABLET (<i>doxepin hcl</i>)	T3	PA
<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 (Ambien Cr)</i>	T1	
<i>zolpidem tart er 6.25 mg tab (Ambien Cr)</i>	T1	QL(1 TAB/DAY)
<i>zolpidem tartrate 10 mg tablet (Ambien)</i>	T1	
<i>zolpidem tartrate 5 mg tablet (Ambien)</i>	T1	
ZOLPIDEM TARTRATE 7.5 MG CAP	T3	PA
ZOLPIMIST	T3	PA

SKIN PREPS (Miscellaneous)

ANTISEPTICS,GENERAL		
<i>alcohol antiseptic pads</i>	T1	
ALCOHOL PREP PADS	T1	
ALCOHOL SWAB	T1	
ALCOHOL SWABS	T1	
ALCOHOL WIPES	T1	
CARETOUCH ALCOHOL PREP PAD	T1	
CURITY ALCOHOL PREPS	T1	

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List of Prescription Medications

SKIN PREPS (Miscellaneous) (cont.)			
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits	
ANTISEPTICS, GENERAL			
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		
sodium chloride 0.9% irrig.	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		
SKIN PREPS (Pain Relief And Inflammatory Disease)			
ANTI-PSORIATIC AGENTS, SYSTEMIC			
<i>acitretin</i>	T1		
BIMZELX	T3	PA QL(2 MLS/28 DAYS) SP HD	
COSENTYX	T3	PA SP	

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List of Prescription Medications

SKIN PREPS (Pain Relief And Inflammatory Disease) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-PSORIATIC AGENTS, SYSTEMIC (con't.)		
COSENTYX (2 SYRINGES)	T3	PA QL(2 MLS/28 DAYS) SP HD
COSENTYX 150 MG/ML SYRINGE	T3	PA QL(1 ML/28 DAYS) SP HD
COSENTYX 75 MG/0.5 ML SYRINGE	T3	PA QL(0.5 MLS/28 DAYS) SP HD
COSENTYX SENSOREADY (2 PENS)	T3	PA QL(2 MLS/28 DAYS) SP HD
COSENTYX SENSOREADY PEN	T3	PA QL(1 ML/28 DAYS) SP HD
COSENTYX UNOREADY PEN	T3	PA QL(2 MLS/28 DAYS) SP HD
ILUMYA	T3	PA QL(1 UNIT/84 DAYS) SP HD
<i>methoxsalen</i>	T1	
SILIQ	T3	PA QL(3 MLS/28 DAYS) SP HD
SKYRIZI 150 MG/ML SYRINGE	T2	PA QL(150 MG/84 DAYS) SP HD
SKYRIZI PEN	T2	PA QL(150 MG/84 DAYS) SP HD
SOTYKTU	T2	PA QL(1 TAB/DAY) SP HD
SPEVIGO 150 MG/ML SYRINGE	T3	PA QL(2 MLS/28 DAYS) SP HD
SPEVIGO 300 MG/2 ML SYRINGE	T3	PA QL(2 MLS/28 DAYS) SP HD
SPEVIGO 450 MG/7.5 ML VIAL	T3	PA SP HD
TALTZ AUTOINJECTOR	T2	PA QL(1 AUTO-INJECTOR/28 DAYS) SP HD
TALTZ AUTOINJECTOR (2 PACK)	T2	PA QL(1 AUTO-INJECTOR/28 DAYS) SP HD
TALTZ AUTOINJECTOR (3 PACK)	T2	PA QL(1 AUTO-INJECTOR/28 DAYS) SP HD
TALTZ SYRINGE	T2	PA QL(1 SYRINGE/28 DAYS) SP HD
TOPICAL ANTI-INFLAMMATORY, NSAIDS		
<i>diclofenac 1.5% topical soln</i>	T1	PA HD
<i>diclofenac 2% solution pump</i>	T1	PA HD
DICLOFENAC EPOLAMINE	T3	PA QL(2 PATCHES/DAY) HD
<i>diclofenac sodium 1% gel</i>	T1	QL(1000 GMS/30 DAYS) HD
FLECTOR	T2	PA QL(2 PATCHES/DAY) HD
LICART	T2	PA QL(1 PATCH/DAY) HD
SKIN PREPS (Skin Conditions)		
ACNE AGENTS, SYSTEMIC		
ABSORICA (isotretinoin)	T3	
ABSORICA LD	T3	ST
<i>isotretinoin (Absorica)</i>	T1	

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List of Prescription Medications

SKIN PREPS (Skin Conditions) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ACNE AGENTS, TOPICAL		
ACANYA (clindamycin phos/benzoyl perox)	T3	
ACZONE (<i>dapsone</i>)	T3	
<i>adapalene/benzoyl peroxide</i>	T1	
<i>adapalene/benzoyl peroxide (Epiduo Forte)</i>	T1	
AZELEX	T2	
CABTREGO	T3	PA
<i>clindamycin-benzoyl perox 1.2-3.75% (Onexton)</i>	T1	PA
<i>clindamycin phos/benzoyl perox</i>	T1	
<i>clindamycin phos/benzoyl perox (Acanya)</i>	T1	
<i>clindamycin/tretinoin (Veltin)</i>	T1	
<i>clindamycin/tretinoin (Ziana)</i>	T1	
<i>clindamycin-benzoyl perox 1-5%</i>	T1	
<i>clindamycin-benzoyl perox 1-5% pmp</i>	T1	
dapsone 5% gel (Aczone)	T1	
DAPSONE 7.5% GEL	T3	PA
<i>dapsone 7.5% gel pump (Aczone)</i>	T1	
EPIDUO FORTE (<i>adapalene/benzoyl peroxide</i>)	T3	PA
KLARON (sulfacetamide sodium)	T3	
NEUAC 1.2-5% KIT	T3	
<i>neuac gel</i>	T1	
ONEXTON (<i>clindamycin phos/benzoyl perox</i>)	T3	
<i>sulfacetamide sodium (Klaron)</i>	T1	
TWYNEO	T3	
VELTIN (clindamycin/tretinoin)	T3	PA
ZIANA (clindamycin/tretinoin)	T3	PA
ANTI-PERSPIRANTS		
DRYSOL	T3	
ANTI-PRURITICS, TOPICAL		
<i>doxepin 5% cream (Zonalon)</i>	T1	PA QL(90 GMS/30 DAYS)
<i>doxepin (Zonalon)</i>	T3	PA QL(90 GMS/30 DAYS)
ZONALON (doxepin hcl)	T3	PA QL(90 GMS/30 DAYS)
ANTI-PSORIATICS AGENTS		
<i>anthralin</i>	T1	
<i>calcipotriene 0.005% cream</i>	T1	

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T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

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T3 – Typically Non-Preferred Brands

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List of Prescription Medications

SKIN PREPS (Skin Conditions) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-PSORIATICS AGENTS		
CALCIPOTRIENE 0.005% FOAM	T3	PA
<i>calcipotriene 0.005% ointment</i>	T1	
<i>calcipotriene 0.005% solution</i>	T1	
<i>calcitriol 3 mcg/g ointment (Vectical)</i>	T1	QL(800 GMS/30 DAYS)
DUOBRII	T3	
SORILUX	T3	PA
<i>tazarotene 0.05% cream (Tazorac)</i>	T1	
<i>tazarotene 0.05% gel (Tazorac)</i>	T1	
<i>tazarotene 0.1% cream (Tazorac)</i>	T1	
<i>tazarotene 0.1% gel (Tazorac)</i>	T1	
TAZORAC 0.05% CREAM (<i>tazarotene</i>)	T2	
TAZORAC 0.05% GEL (<i>tazarotene</i>)	T2	
TAZORAC 0.1% CREAM (<i>tazarotene</i>)	T3	
TAZORAC 0.1% GEL (<i>tazarotene</i>)	T2	
VECTICAL (<i>calcitriol</i>)	T3	QL(800 GMS/30 DAYS)
VTAMA	T3	PA QL(60 GMS/30 DAYS)
ZORYVE 0.3% CREAM	T3	PA QL(1 GM/30 DAYS)
ANTI-SEBORRHEIC AGENTS		
OVACE PLUS	T3	
<i>selenium sulfide</i>	T1	
<i>sulfacetamide sodium</i>	T1	
ANTISEPTICS, GENERAL		
<i>alcohol antiseptic pads</i>	T1	
ALCOHOL PREP PADS	T1	
ALCOHOL SWABS	T1	
ALCOHOL WIPES	T1	
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	

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List of Prescription Medications

SKIN PREPS (Skin Conditions) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTISEPTICS, GENERAL (con't.)		
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	
emollient combination no.44	T1	
XCLAIR	T3	
IMMUNOMODULATORS		
imiquimod 3.75% cream (Zyclara)	T1	
<i>imiquimod 3.75% cream pump (Zyclara)</i>	T1	
imiquimod 5% cream packet	T3	
ZYCLARA 2.5% CREAM PUMP	T1	
ZYCLARA 3.75% CREAM (imiquimod)	T3	PA QL (4 BOTS/30 DAYS)
ZYCLARA 3.75% CREAM PUMP (imiquimod)	T3	PA QL (112 PACKS/30 DAYS)
ZYCLARA 3.75% CREAM PUMP	T3	PA
IRRITANTS/COUNTER-IRRITANTS		
<i>methyl salicylate</i>	T1	
JANUS KINASE (JAK) INHIBITORS		
<i>CIBINQO</i>	T2	PA QL(30 TABS/30 DAYS) SP
KERATOLYTICS		
benzepro 6% foaming cloths	T1	
BENZEPRO 7% CREAMY WASH (benzoyl peroxide microspheres)	T3	
benzoyl peroxide	T1	
<i>benzoyl peroxide (Pacnex)</i>	T1	
CONDYLOX (podofilox)	T3	PA
ENZOCLEAR	T3	
<i>INOVA</i>	T3	
PACNEX (benzoyl peroxide)	T3	
podofilox	T1	

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List of Prescription Medications

SKIN PREPS (Skin Conditions) (con't.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
KERATOLYTICS (con't.)		
<i>podofilox</i> (Condylox)	T1	
PR BENZOYL PEROXIDE (<i>benzoyl peroxide microspheres</i>)	T3	
<i>silver nitrate</i>	T1	
PROTECTIVES		
BIONECT	T3	
PHARMABASE BARRIER (<i>zinc oxide</i>)	T3	
<i>zinc oxide</i>	T1	
ROSACEA AGENTS, TOPICAL		
<i>azelaic acid</i> (Finacea)	T1	
FINACEA (azelaic acid)	T3	PA
<i>ivermectin 1% cream</i> (Soolantra)	T1	
METROCREAM (<i>metronidazole</i>)	T3	PA
METROGEL (<i>metronidazole</i>)	T3	PA
<i>metronidazole</i>	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% gl</i>	T1	
<i>metronidazole topical 1% gel</i> (Metrogel)	T1	
NORITATE	T3	PA
SOOLANTRA (<i>ivermectin</i>)	T3	
TISSUE/WOUND ADHESIVES		
ARTISS	T3	
TISSEEL VHSD	T3	
TOP. ANTI-INFLAM., PHOSPHODIESTERASE-4 (PDE4) INHIB		
EUCRISA	T2	ST
ZORYVE 0.15% CREAM	T2	ST QL(60 GMS/30 DAYS)
ZORYVE 0.3% FOAM	T3	PA QL(1 GM/30 DAYS)
TOPICAL ACNE AGENT,RETINOIC ACID RECEPTOR AGONIST		
AKLIEF	T3	
ARAZLO	T2	
FABIOR	T3	
TAZAROTENE 0.1% FOAM	T3	

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List of Prescription Medications

SKIN PREPS (Skin Conditions) (con't.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL AGENTS, MISCELLANEOUS		
MEDIHONEY	T3	
<i>trichloroacetic acid</i>	T3	
TRICHLOROACETIC ACID (trichloroacetic acid)	T3	
TOPICAL ANTIANDROGENIC AGENTS		
WINLEVI	T3	PA
TOPICAL ANTIBIOTIC PLEUROMUTILIN DERIVATIVES		
ALTABAX	T3	
TOPICAL ANTICHOLINERGIC HYPERHIDROSIS TX AGENTS		
QBREXZA	T3	
SOFDRA	T3	PA
TOPICAL ANTI-INFLAMMATORY STEROIDAL		
ALA-SCALP (hydrocortisone)	T3	ST
<i>alclometasone dipropionate</i>	T1	
<i>amcinonide 0.1% cream</i>	T1	
<i>amcinonide 0.1% ointment</i>	T1	PA
ANUSOL-HC (hydrocortisone)	T3	PA
AQUA GLYCOLIC HC	T3	
<i>betamethasone dipropionate</i>	T1	
<i>betamethasone valerate</i>	T1	
<i>betamethasone/propylene glyc (Diprolene)</i>	T1	
BRYHALI	T3	ST
CAPEX SHAMPOO	T3	ST
CLOBETASOL 0.025% CREAM	T3	PA
<i>clobetasol 0.05% cream</i>	T1	
<i>clobetasol 0.05% gel</i>	T1	
<i>clobetasol 0.05% ointment (Temovate)</i>	T1	
<i>clobetasol 0.05% shampoo (Clobex)</i>	T1	
<i>clobetasol 0.05% solution</i>	T1	
<i>clobetasol 0.05% topical lotn</i>	T1	
<i>clobetasol prop 0.05% foam (Olux)</i>	T1	
<i>clobetasol prop 0.05% spray (Clobex)</i>	T1	
<i>clobetasol propionate/emoll</i>	T1	
CLOBEX (<i>clobetasol propionate</i>)	T3	PA
clocortolone pivalate (Cloderm)	T1	

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List of Prescription Medications

SKIN PREPS (Skin Conditions) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL ANTI-INFLAMMATORY STEROIDAL (con't.)		
CLODAN 0.05% KIT	T3	ST
<i>clodan 0.05% shampoo (Clobex)</i>	T1	
CLODERM (<i>clocortolone pivalate</i>)	T3	ST
CORDRAN (<i>flurandrenolide</i>)	T3	PA
DERMA-SMOOTHIE-FS (<i>fluocinolone acetonide</i>)	T3	ST
<i>desonide</i>	T1	
<i>desonide (Tridesilon)</i>	T1	
<i>desoximetasone (Topicort)</i>	T1	
<i>diflorasone diacet/emollient</i>	T1	PA
<i>diflorasone diacetate</i>	T1	PA
DIPROLENE (<i>betamethasone/propylene glyc</i>)	T3	ST
<i>fluocinolone acetonide</i>	T1	
<i>fluocinolone acetonide (Derma-Smoothe-Fs)</i>	T1	
<i>fluocinolone acetonide (Synalar)</i>	T1	
<i>fluocinolone/shower cap (Derma-Smoothe-Fs)</i>	T1	
<i>fluocinonide (Vanos)</i>	T1	
<i>fluocinonide/emollient base</i>	T1	
<i>flurandrenolide (Cordran)</i>	T1	PA
<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% cream (Halog)</i>	T1	PA
<i>halcinonide 0.1% solution</i>	T1	
<i>halobetasol propionate</i>	T1	
HALOG 0.1% CREAM (<i>halcinonide</i>)	T3	PA
HALOG 0.1% OINTMENT	T3	PA
HALOG 0.1% SOLUTION	T3	ST
<i>hydrocort buty 0.1% lipo cream (Locoid Lipocream)</i>	T1	PA
<i>hydrocortisone</i>	T1	PA

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SKIN PREPS (Skin Conditions) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL ANTI-INFLAMMATORY STEROIDAL (con't.)		
<i>hydrocortisone (Ala-Scalp)</i>	T1	
<i>hydrocortisone (Anusol-Hc)</i>	T1	
<i>hydrocortisone acetate</i>	T1	
<i>hydrocortisone buty 0.1% cream</i>	T1	
<i>hydrocortisone butyr 0.1% lotn</i>	T1	PA
<i>hydrocortisone butyr 0.1% oint</i>	T1	
<i>hydrocortisone butyr 0.1% soln</i>	T1	
<i>hydrocortisone valerate</i>	T1	
IMPEKLO	T3	PA
IMPOYZ	T3	PA
KENALOG (<i>triamcinolone acetonide</i>)	T3	PA
LOCOID LIPOCREAM (<i>hydrocortisone butyrate/emoll</i>)	T3	PA
MICORT-HC	T3	PA
<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
OLUX (<i>clobetasol propionate</i>)	T3	PA
PANDEL	T3	PA
<i>prednicarbate</i>	T1	
SCALACORT DK	T3	ST
SERNIVO	T3	PA
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	
SERNIVO	T3	PA
SYNALAR (<i>fluocinolone acetonide</i>)	T3	ST

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List of Prescription Medications

SKIN PREPS (Skin Conditions) (con't.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL ANTI-INFLAMMATORY STEROIDAL (con't.)		
<i>triamcinolone 0.05% ointment</i>	T1	PA
<i>triamcinolone 0.1% cream</i>	T1	
<i>triamcinolone 0.1% lotion</i>	T1	
<i>triamcinolone 0.1% ointment</i>	T1	
<i>triamcinolone 0.147 mg/g spray (Kenalog)</i>	T1	PA
<i>triamcinolone 0.5% cream</i>	T1	
<i>triamcinolone 0.5% ointment</i>	T1	
<i>triamcinolone acetonide</i>	T1	PA
TRIDESILON (<i>desonide</i>)	T3	PA
ULTRAVATE	T3	PA
VANOS (<i>fluocinonide</i>)	T3	PA
VERDESO	T3	PA
TOPICAL ANTI-INFLAMMATORY STEROID-LOCAL ANESTHETIC		
ANALPRAM HC 2.5%-1% LOTION	T3	PA
EPIFOAM	T3	
<i>hydrocortisone/pramoxine</i>	T1	
<i>lidocaine/hydrocortisone ac</i>	T1	
PRAMOSONE 1% LOTION	T2	
PRAMOSONE 1%-1% CREAM	T2	
PRAMOSONE 1%-1% OINTMENT	T2	
PRAMOSONE 2.5%-1% CREAM	T3	
PRAMOSONE 2.5%-1% LOTION	T3	
PRAMOSONE 2.5%-1% OINTMENT	T2	
TOPICAL JANUS KINASE (JAK) INHIBITORS		
OPZELURA	T3	PA
TOPICAL NITRIC OXIDE RELEASING AGENTS		
ZELSUVMI 10.3% GEL	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	

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List of Prescription Medications

SKIN PREPS (Skin Conditions) (con't.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL VIT D ANALOG/ANTI-INFLAMMATORY STEROID		
<i>calcipotriene/betamethasone (Taclonex)</i>	T1	
ENSTILAR	T3	PA
TACLONEX (<i>calcipotriene/betamethasone</i>)	T3	PA
WYNZORA	T3	PA
TOPICAL/MUCOUS MEMBR./SUBCUT. ENZYMES		
AMPHADASE	T3	
SANTYL	T2	QL(60 GMS/30 DAYS)
VITRASE	T3	
VITAMIN A DERIVATIVES		
<i>adapalene (Differin)</i>	T1	PA
ALTRENO	T3	PA
ATRALIN (<i>tretinoin</i>)	T3	PA
DIFFERIN	T3	PA
RETIN-A 0.01% GEL (<i>tretinoin</i>)	T3	
RETIN-A 0.025% CREAM (<i>tretinoin</i>)	T3	PA
RETIN-A 0.025% GEL (<i>tretinoin</i>)	T3	
RETIN-A 0.05% CREAM (<i>tretinoin</i>)	T3	PA
RETIN-A 0.1% CREAM (<i>tretinoin</i>)	T3	PA
RETIN-A MICRO (<i>tretinoin microspheres</i>)	T3	PA
RETIN-A MICRO PUMP	T3	PA
RETIN-A MICRO PUMP (<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
<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

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List of Prescription Medications

SMOKING DETERRENTS (Smoking Cessation) ⁸		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SMOKING DETERRENT AGENTS (GANGLIONIC STIM, OTHERS)		
NICOTROL	T2	PPACA
NICOTROL NS	T2	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)		
ANTI-THYROID PREPARATIONS		
<i>methimazole</i>	T1	HD
<i>propylthiouracil</i>	T1	HD
THYROID FUNCTION DIAGNOSTIC AGENTS		
THYROGEN	T3	SP
THYROID HORMONES		
<i>adthyza 120 mg tablet</i>	T1	HD
ADTHYZA 130 MG TABLET	T3	PA HD
<i>adthyza 15 mg tablet</i>	T1	HD
ADTHYZA 16.25 MG TABLET	T3	PA HD
<i>adthyza 30 mg tablet</i>	T1	HD
ADTHYZA 32.5 MG TABLET	T3	PA HD
<i>adthyza 60 mg tablet</i>	T1	HD
ADTHYZA 65 MG TABLET	T3	PA HD
<i>adthyza 90 mg tablet</i>	T1	HD
ADTHYZA 97.5 MG TABLET	T3	PA HD
ARMOUR THYROID	T3	PA HD
CYTOMEL (<i>liothyronine sodium</i>)	T3	HD
ERMEZA	T3	PA HD
LEVOTHYROXINE 100 MCG CAPSULE	T3	HD
<i>levothyroxine 100 mcg tablet (Synthroid)</i>	T1	HD

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List of Prescription Medications

THYROID PREPS (Hormonal Agents) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
THYROID HORMONES (cont.)		
<i>levothyroxine 100 mcg vial</i>	T1	HD
LEVOTHYROXINE 100 MCG/5 ML VL	T1	HD
LEVOTHYROXINE 100 MCG/ML VIAL	T3	HD
LEVOTHYROXINE 112 MCG CAPSULE	T3	HD
<i>levothyroxine 112 mcg tablet (Synthroid)</i>	T1	HD
LEVOTHYROXINE 125 MCG CAPSULE	T3	HD
<i>levothyroxine 125 mcg tablet (Synthroid)</i>	T1	HD
LEVOTHYROXINE 13 MCG CAPSULE	T3	HD
LEVOTHYROXINE 137 MCG CAPSULE	T3	HD
<i>levothyroxine 137 mcg tablet (Synthroid)</i>	T1	HD
LEVOTHYROXINE 150 MCG CAPSULE	T3	HD
<i>levothyroxine 150 mcg tablet (Synthroid)</i>	T1	HD
LEVOTHYROXINE 175 MCG CAPSULE	T3	HD
<i>levothyroxine 175 mcg tablet (Synthroid)</i>	T1	HD
LEVOTHYROXINE 200 MCG CAPSULE	T3	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
LEVOTHYROXINE 25 MCG CAPSULE	T3	HD
<i>levothyroxine 25 mcg tablet (Synthroid)</i>	T1	HD
<i>levothyroxine 300 mcg tablet (Synthroid)</i>	T1	HD
LEVOTHYROXINE 50 MCG CAPSULE	T3	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
LEVOTHYROXINE 75 MCG CAPSULE	T3	HD
<i>levothyroxine 75 mcg tablet (Synthroid)</i>	T1	HD
LEVOTHYROXINE 88 MCG CAPSULE	T3	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

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List of Prescription Medications

THYROID PREPS (Hormonal Agents) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
THYROID HORMONES (con't.)		
liothyronine sod 50 mcg tab (Cytomel)	T1	HD
liothyronine sodium (Cytomel)	T1	HD
SYNTHROID (levothyroxine sodium)	T3	PA HD
THYQUIDITY	T3	PA HD
thyroid,pork	T1	HD
TIROSINT	T3	HD
TIROSINT-SOL	T3	HD
TRIOSTAT (liothyronine sodium)	T3	
CYTOCHROME P450 INHIBITORS		
TYBOST	T3	SP
UNCLASSIFIED DRUG PRODUCTS (Asthma/COPD/Respiratory)		
CYSTIC FIBROSIS - INHALED OSMOTIC AGENTS		
BRONCHITOL	T3	PA SP HD
CYSTIC FIBROSIS-CFTR POTENTIATOR-CORRECTOR COMBIN.		
ALYFTREK 10-50-125 MG TABLET	T3	PA QL(2 TABS/DAY) SP HD
ALYFTREK 4-20-50 MG TABLET	T3	PA QL(3 TABS/DAY) SP HD
ORKAMBI 100 MG-125 MG TABLET	T3	PA QL(4 TABS/DAY) SP HD
ORKAMBI 100-125 MG GRANULE PKT	T3	PA QL(2 PACKS/DAY) SP HD
ORKAMBI 150-188 MG GRANULE PKT	T3	PA QL(2 PACKS/DAY) SP HD
ORKAMBI 200 MG-125 MG TABLET	T3	PA QL(4 TABS/DAY) SP HD
ORKAMBI 75-94 MG GRANULE PKT	T3	PA QL(2 PACKS/DAY) SP HD
SYMDEKO	T3	PA QL(2 TABS/DAY) SP HD
TRIKAFTA 100-50-75 MG/150 MG	T3	PA QL(3 TABS/DAY) SP HD
TRIKAFTA 100-50-75 MG/75MG PKT	T3	PA QL(2 UNITS/DAY) SP HD
TRIKAFTA 50-25-37.5 MG/75 MG	T3	PA QL(3 TABS/DAY) SP HD
TRIKAFTA 80-40-60MG/59.5MG PKT	T3	PA QL(2 UNITS/DAY) SP HD
CYSTIC FIB-TRANSMEMB CONDUCT.REG.(CFTR) POTENTIATOR		
KALYDECO 13.4 MG GRANULES PKT	T3	PA QL(2 PACKS/DAY) SP HD
KALYDECO 150 MG TABLET	T3	PA QL(2 TABS/DAY) SP HD
KALYDECO 25 MG GRANULES PACKET	T3	PA QL(2 PACKS/DAY) SP HD
KALYDECO 5.8 MG GRANULES PKT	T3	PA QL(2 PACKS/DAY) SP HD
KALYDECO 50 MG GRANULES PACKET	T3	PA QL(2 PACKS/DAY) SP HD
KALYDECO 75 MG GRANULES PACKET	T3	PA QL(2 PACKS/DAY) SP HD

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T2 – Typically Preferred Brands

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List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Asthma/COPD/Respiratory) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LUNG SURFACTANTS		
CUROSURF	T3	
INFASURF	T3	
SURVANTA	T3	
MUCOLYTICS		
PULMOZYME	T3	PA SP HD
PULMONARY FIBROSIS - SYSTEMIC ENZYME INHIBITORS		
OFEV	T3	PA SP HD
SYSTEMIC ENZYME INHIBITORS		
ARALAST NP	T3	PA SP
GLASSIA	T3	PA SP
JOENJA	T3	PA QL(2 TABS/DAY) SP
PROLASTIN C	T3	PA SP HD
VIJOICE 125 MG TABLET	T3	PA QL(1 TAB/DAY) SP
VIJOICE 250 MG DAILY DOSE PACK	T3	PA QL(2 TABS/DAY) SP
VIJOICE 50 MG GRANULE PACKET	T3	PA QL(1 TAB/DAY) SP
VIJOICE 50 MG TABLET	T3	PA QL(1 TAB/DAY) SP
ZEMAIRA 1,000 MG VIAL	T3	PA SP
ZEMAIRA 4,000 MG VIAL	T3	PA SP HD
ZEMAIRA 5,000 MG VIAL	T3	PA SP HD
ZOKINIVY	T3	PA QL(4 CAPS/DAY) SP
THYMIC STROMAL LYMPHOPOIETIN (TSLP) INHIBITORS		
TEZSPIRE 210 MG/1.91 ML PEN	T2	PA QL(1 PEN/28 DAYS) SP HD
TEZSPIRE 210 MG/1.91 ML SYRING	T2	PA SP HD

UNCLASSIFIED DRUG PRODUCTS (Blood Modifiers/Bleeding Disorders)

ANTI-INFLAMMATORY - ANTIMITOTICS		
LODOCO	T3	PA
ANTI-PORPHYRIA FACTORS		
PANHEMATIN	T3	SP
ERYTHROID MATURATION AGENTS		
REBLOZYL	T3	PA SP

UNCLASSIFIED DRUG PRODUCTS (Blood Pressure/Heart Medications)

SPLEEN TYROSINE KINASE INHIBITORS		
TAVALISSE	T2	PA SP

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List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Blood Pressure/Heart Medications)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BRADYKININ B2 RECEPTOR ANTAGONISTS		
FIRAZYR (<i>icatibant acetate</i>)	T3	PA SP
<i>icatibant acetate</i> (Firazyr)	T3	PA SP HD
PLASMA KALLIKREIN INHIBITORS		
KALBITOR	T3	PA SP HD
ORLADEYO	T3	PA QL (1 caps/day) SP

UNCLASSIFIED DRUG PRODUCTS (Cancer)

CHEMOTHERAPY RESCUE/ANTIDOTE AGENTS		
<i>dexrazoxane hcl</i>	T1	SP
ETHYOL (<i>amifostine crystalline</i>)	T3	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</i> (Mesnex)	T1	SP
<i>mesna 400 mg tablet</i> (Mesnex)	T1	SP CSL
MESNEX 1 GRAM/10 ML VIAL (<i>mesna</i>)	T3	SP
MESNEX 400 MG TABLET (<i>mesna</i>)	T3	SP CSL
PEDMARK	T3	PA
VISTOGARD	T3	SP CSL
VORAXAZE	T3	PA SP
INTRAPLEURAL SCLEROSING AGENTS, ANTINEOPLAST. ADJ.		
SCLEROSOL	T3	
STERILE TALC	T1	
STERITALC	T3	

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List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Cancer) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
RADIOACTIVE THERAPEUTIC AGENTS		
LUTATHERA	T3	PA SP
strontium-89 chloride	T1	PA
XOFIGO	T3	PA

UNCLASSIFIED DRUG PRODUCTS (Dental Products)

DENTAL AIDS AND PREPARATIONS		
chlorhexidine gluconate (Peridex)	T1	
PERIDEX (chlorhexidine gluconate)	T3	
triamcinolone 0.1% paste	T1	
triamcinolone acetonide	T1	
PERIODONTAL COLLAGENASE INHIBITORS		
doxycycline hyclate 20 mg tab	T1	

UNCLASSIFIED DRUG PRODUCTS (Diabetes)

ANTIHYPERGLYCEMIC-SOD/GLUC COTRANSPORT2(SGLT2) INH		
INPEFA	T3	PA QL(1 TAB/DAY) HD

UNCLASSIFIED DRUG PRODUCTS (Erectile Dysfunction)

DISEASE MODIFYING AGENTS FOR TYPE I DIABETES		
TZIELD	T3	PA SP
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)
MUSE	T2	QL(6 SUPPS/30 DAYS)
sildenafil 100 mg tablet (Viagra)	T1	QL(8 TABS/30 DAYS) HD
sildenafil 25 mg tablet (Viagra)	T1	QL(8 TABS/30 DAYS) HD
sildenafil 50 mg tablet (Viagra)	T1	QL(8 TABS/30 DAYS) HD
STENDRA (avanafil)	T3	ST QL(8 TABS/30 DAYS)
tadalafil 10 mg tablet (Cialis)	T1	QL(8 TABS/30 DAYS) HD
tadalafil 2.5 mg tablet	T1	QL(1 TAB/DAY) HD
tadalafil 20 mg tablet (Cialis)	T1	QL(8 TABS/30 DAYS) HD

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List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Erectile Dysfunction) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DRUGS TO TREAT ERECTILE DYSFUNCTION (ED) (cont.)		
<i>tadalafil 5 mg tablet (Cialis)</i>	T1	QL(1 TAB/DAY) HD
<i>vardenafil hcl</i>	T1	QL(8 TABS/30 DAYS)
<i>VIAGRA (sildenafil citrate)</i>	T3	ST QL(8 TABS/30 DAYS)

UNCLASSIFIED DRUG PRODUCTS (Eye Conditions)

INSULIN-LIKE GROWTH FACTOR RECEPTOR (IGF-R) INHIB		
TEPEZZA	T3	PA SP HD
NICOTINIC RECEPT.PARTIAL AGONIST, ALPHA4BETA2 SPEC		
TYRVAYA	T2	QL(8.4 MLS/30 DAYS)
OCULAR PHOTOACTIVATED VESSEL-OCCLUDING AGENTS		
VISUDYNE	T3	SP

UNCLASSIFIED DRUG PRODUCTS (Gastrointestinal/Heartburn)

ORAL MUCOSITIS/STOMATITIS AGENTS		
GELCLAIR	T3	
ORAMAGICRX	T3	
PPAR AGONIST		
IQIRVO	T2	PA SP HD
LIVDELZI	T3	PA SP
SALIVA STIMULANT AGENTS		
NUMOISYN	T2	
THYROID HORMONE RECEPTOR (THR) AGONIST		
REZDIFFRA	T3	PA QL(1 TAB/DAY) SP HD

UNCLASSIFIED DRUG PRODUCTS (Hormonal Agents)

GROWTH HORMONE RECEPTOR ANTAGONISTS		
SOMAVERT	T3	PA SP HD
HYPERPARATHYROID TX AGENTS - VITAMIN D ANALOG-TYPE		
<i>doxercalciferol</i>	T1	
<i>doxercalciferol (Hectorol)</i>	T1	
HECTOROL (<i>doxercalciferol</i>)	T3	
<i>paricalcitol 1 mcg capsule (Zemplar)</i>	T1	SP HD

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List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Hormonal Agents) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HYPERPARATHYROID TX AGENTS - VITAMIN D ANALOG-TYPE (cont.)		
PARICALCITOL 10 MCG/2 ML VIAL	T3	SP
<i>paricalcitol 2 mcg capsule (Zemplar)</i>	T1	SP HD
PARICALCITOL 2 MCG/ML VIAL	T3	SP
<i>paricalcitol 2 mcg/ml vial (Zemplar)</i>	T1	SP
<i>paricalcitol 4 mcg capsule</i>	T1	SP HD
PARICALCITOL 5 MCG/ML VIAL	T3	SP
<i>paricalcitol 5 mcg/ml vial (Zemplar)</i>	T1	SP
RAYALDEE	T3	
ZEMPLAR 1 MCG CAPSULE (<i>paricalcitol</i>)	T3	SP HD
ZEMPLAR 10 MCG/2 ML VIAL (<i>paricalcitol</i>)	T2	SP
ZEMPLAR 2 MCG CAPSULE (<i>paricalcitol</i>)	T3	SP HD
ZEMPLAR 2 MCG/ML VIAL (<i>paricalcitol</i>)	T2	SP
ZEMPLAR 5 MCG/ML VIAL (<i>paricalcitol</i>)	T2	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 (Mifeprex)</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</i>	T1	
PROVAYBLUE	T3	
AGENTS TO TX PERIODIC PARALYSIS - CARBON ANHYD INH		
<i>dichlorphenamide (Keveyis)</i>	T1	PA SP HD
KEVEYIS (<i>dichlorphenamide</i>)	T3	PA SP
AMMONIA INHIBITORS		
CARBAGLU (<i>carglumic acid</i>)	T3	SP HD
<i>carglumic acid (Carbaglu)</i>	T1	SP HD
AMYLOIDOSIS AGENTS-TRANSTHYRETIN (TTR) SUPPRESSION		
AMVUTTRA	T4	PA SP
ONPATTRO	T4	PA SP
WAINUA	T4	PA QL(1 AUTO-INJ/28 DAYS) SP

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List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-ALCOHOLIC PREPARATIONS		
<i>acamprosate calcium</i>	T1	
<i>disulfiram</i>	T1	
VIVITROL	T2	SP HD
ANTIDOTES, MISCELLANEOUS		
ACETADOTE (<i>acetylcysteine</i>)	T3	
<i>acetylcysteine</i> (Acetadote)	T1	
CYANOKIT	T3	
DIGIFAB	T3	
<i>fomepizole</i>	T1	
SODIUM NITRITE	T1	
ANTI-FIBROTIC THERAPY - PYRIDONE ANALOGS		
ESBRIET (<i>pirfenidone</i>)	T3	PA SP HD
<i>pirfenidone 267 mg capsule</i>	T1	PA SP HD
<i>pirfenidone 267 mg tablet</i> (Esbriet)	T1	PA SP HD
PIRFENIDONE 534 MG TABLET	T3	PA SP HD
<i>pirfenidone 801 mg tablet</i> (Esbriet)	T1	PA SP HD
BENZODIAZEPINE ANTAGONISTS		
<i>flumazenil</i>	T1	
CI ESTERASE INHIBITORS		
BERINERT	T3	PA SP HD
CINRYZE	T3	PA SP HD
HAEGARDA	T3	PA SP HD
RUCONEST	T3	PA SP HD
CALCIMIMETIC, PARATHYROID CALCIUM ENHANCER		
<i>cinacalcet hcl</i> (Sensipar)	T1	SP
PARSABIV	T3	PA SP
SENSIPAR (<i>cinacalcet hcl</i>)	T3	PA SP
CATHETER LOCK SOLUTIONS		
DEFENCATH	T3	
CHOLINESTERASE REACTIVAT.-MUSCARINIC ANTG.ANTIDOTE		
DUODOTE	T3	
CHOLINESTERASE REACTIVATING, ORGANOPHOS. ANTIDOTES		
PRALIDOXIME CHLORIDE	T1	
PROTOPAM CHLORIDE	T3	

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List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
COMPLEMENT INHIBITORS		
VEOPOZ	T3	SP
ZILBRYSQ	T3	PA QL(1 SYRINGE/DAY) 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	
DRUGS TO TREAT ACUTE HEPATIC PORPHYRIA (AHP)		
GIVLAARI	T3	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	T3	PA SP HD
SPINRAZA	T3	PA SP HD
GENETIC D/O TX-EXON SKIPPING ANTISENSE OLIGONUCLEO		
AMONDYS-45	T3	PA SP
EXONDYS-51	T3	PA SP
VILTEPSO	T3	PA SP
VYONDYS-53	T3	PA SP
GENETIC DISORDER THERAPY - HDAC INHIBITOR		
DUVYZAT	T3	PA SP
GLUCOSYLCERAMIDE SYNTHASE (GCS) INHIBITOR		
CERDELGA	T2	PA SP HD
<i>miglustat (Zavesca)</i>	T1	PA SP HD
OPFOLDA	T3	PA QL(8 CAPS/30 DAYS) SP HD

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UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GLUCOSYLCERAMIDE SYNTHASE (GCS) INHIBITOR (cont.)		
ZAVESCA (<i>miglustat</i>)	T3	PA SP HD
HEAT SHOCK PROTEIN (HSP) MODULATING AGENTS		
MIPLYFFA	T3	PA SP
HYDROXYPHENYL-PYRUVATE DIOXYGENASE(HPPD) INHIBITOR		
<i>nitisinone</i> (Orfadin)	T1	PA SP HD
NITYR	T2	PA SP
ORFADIN (<i>nitisinone</i>)	T3	PA SP
HYPOACTIVE SEXUAL DESIRE DISORDER (HSDD) TX AGENTS		
ADDYI	T3	QL(1 TAB/DAY)
VYLEESI	T3	PA QL(8 AUTO-INJS/30 DAYS) 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
MENOPAUSAL SYMPTOMS SUPPRESSANT-NK RECEPTOR ANTAG		
VEOZAH	T3	QL(1 TAB/DAY)
MESENCHYMAL STROMAL CELL (MSC)		
RYNCIL	T3	PA SP
METABOLIC DISEASE ENZYME REPLACE, HYPOPHOSPHATASIA		
STRENSIQ	T3	PA SP
METABOLIC DISEASE ENZYME REPLACEMENT, ASMD		
STRENSIQ	T3	PA SP
METABOLIC DISEASE ENZYME REPLACEMENT, BATTEN DISEA		
BRINEURA	T3	PA SP
METABOLIC DISEASE ENZYME REPLACEMENT, FABRY'S DX		
ELFABRIO	T3	PA SP
FABRAZYME	T3	PA SP HD
METABOLIC DISEASE ENZYME REPLACEMENT, GAUCHER'S DX		
CEREZYME	T3	PA SP HD
ELELYSO	T3	PA SP
VPRIV	T3	PA SP HD
METABOLIC DISEASE ENZYME REPLACEMENT, MOCD		
NULIBRY	T3	PA SP

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UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
METABOLIC DISEASE ENZYME REPLACEMENT, POMPE DISEASE		
LUMIZYME	T3	PA SP
NEXVIAZYME	T3	PA SP HD
POMBILITI	T3	PA SP HD
METABOLIC DX ENZYME REPLACE, MUCOPOLYSACCHARIDOSIS		
ALDURAZYME	T3	PA SP HD
ELAPRASE	T2	PA SP
MEPSEVII	T3	PA SP
NAGLAZYME	T3	PA SP
VIMIZIM	T3	PA SP
METABOLIC DX ENZYME REPLACEMENT,ALPHA-MANNO SIDOSIS		
LAMZEDE	T3	PA SP
METABOLIC DX ENZYME REPLACEMENT, LYSO.ACID LIP.DEF.		
KANUMA	T3	PA SP
METABOLIC DX ENZYME REPLACEMENT, SEV.COMB.IMMUNE DEF.		
REVCIVI	T3	PA SP
METALLIC POISON, AGENTS TO TREAT		
BAL IN OIL	T3	PA
CHEMET	T3	
CUVRIOR	T3	PA SP
<i>deferasirox (Exjade)</i>	T1	SP HD
<i>deferasirox (Jadenu Sprinkle)</i>	T1	SP HD
<i>deferasirox (Jadenu)</i>	T1	SP HD
<i>deferiprone (Ferriprox (3 Times A Day))</i>	T1	PA SP HD
<i>deferiprone (Ferriprox)</i>	T1	PA SP
<i>deferoxamine mesylate</i>	T1	
<i>deferoxamine mesylate (Desferal Mesylate)</i>	T1	
DESFERAL MESYLATE (deferoxamine mesylate)	T3	
EXJADE (deferasirox)	T3	PA SP HD
FERRIPROX	T3	PA SP
FERRIPROX (deferiprone)	T3	PA SP
GALZIN	T3	SP
JADENU (deferasirox)	T3	PA SP HD
JADENU SPRINKLE (deferasirox)	T3	PA SP HD
NITHIODOLE	T3	

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UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
METALLIC POISON, AGENTS TO TREAT (cont.)		
PENTETATE CALCIUM TRISODIUM	T1	
PENTETATE ZINC TRISODIUM	T1	
RADIOGARDASE	T3	
<i>sodium thiosulf</i> (poison treat)	T1	
SYPRINE (trientine hcl)	T3	PA SP HD
<i>trientine hcl 250 mg capsule</i> (Syprine)	T1	PA SP HD
TRIENTINE HCL 500 MG CAPSULE	T3	PA SP HD
NATRIURETIC PEPTIDES		
VOXZOGO	T3	PA SP HD
NEONATAL FC RECEPTOR (FCRN) INHIBITORS		
IMAAVY	T3	PA SP HD
RYSTIGGO	T3	PA SP
VYVGART	T3	PA SP HD
VYVGART HYTRULO	T3	PA SP HD
NUCLEAR FACTOR ERYTHROID 2-REL. FACTOR 2 ACTIVATOR		
SKYCLARYS	T3	PA QL(3 caps/day) SP
OINTMENT/CREAM BASES		
RADIAGEL	T3	
OXALOSIS AGENT - OXALATE INHIBITOR, SIRNA BASED		
OXLUMO	T3	PA SP
RIVFLOZA 128 MG/0.8 ML SYRINGE	T3	PA QL(1 SYRINGE/30 DAYS) SP
RIVFLOZA 160 MG/ML SYRINGE	T3	PA QL(1 SYRINGE/30 DAYS) SP
RIVFLOZA 80 MG/0.5 ML VIAL	T3	PA SP
PHARMACOLOGICAL CHAPERONE-ALPHA-GALACTOSID.A STABZ		
GALAFOLD	T3	PA SP HD
PKU TX AGENT-COFACTOR OF PHENYLALANINE HYDROXYLASE		
<i>javygtor 100 mg powder packet</i> (Kuvan)	T1	
<i>javygtor 100 mg tablet</i> (Kuvan)	T1	PA SP HD
<i>javygtor 500 mg powder packet</i> (Kuvan)	T1	PA SP
KUVAN (<i>sapropterin dihydrochloride</i>)	T3	PA SP HD
<i>sapropterin dihydrochloride</i> (Kuvan)	T1	PA SP HD
PROTEIN STABILIZERS		
ATTRUBY	T3	PA QL(4 TABS/DAY) SP
VYNDAMAX	T3	PA QL(1 CAP/DAY) SP HD
VYNDAQEL	T3	PA QL(4 CAPS/DAY) SP

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
RETINOIC ACID RECEPTOR (RAR) AGONISTS		
SOHONOS	T3	PA SP
SODIUM/SALINE PREPARATIONS		
<i>bacteriostatic saline vial</i>	T1	
SOLVENTS		
INSTACLEAN	T3	
ISOPROPANOL	T3	
<i>isopropyl alcohol</i>	T3	
ISOPROPYL ALCOHOL	T3	
ISOPROPYL RUBBING ALCOHOL	T3	
MURI-LUBE MINERAL OIL	T3	
<i>polyethylene glycol</i>	T1	
TOPICAL/MUCOUS MEMBR./SUBCUT. ENZYMES		
HYLENEX	T3	SP HD
TREATMENT OF HYPERPHAGIA IN PRADER-WILLI SYNDROME		
VYKAT XR	T3	PA SP
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 (Multiple Sclerosis)		
LEUKOCYTE ADHESION INHIB, ALPHA4-MEDIAT IGG4K MC AB		
TYRUKO	T3	PA SP
TYSABRI	T3	PA SP HD
UNCLASSIFIED DRUG PRODUCTS (Nutritional/Dietary)		
METABOLIC DEFICIENCY AGENTS		
<i>betaine (Cystadane)</i>	T1	SP
CARNITOR (<i>levocarnitine (with sugar)</i>)	T3	PA
CARNITOR (<i>levocarnitine</i>)	T3	PA
CARNITOR SF (<i>levocarnitine</i>)	T3	PA
CULTURELLE IBS COMPLETE SUPPRT	T3	
CYSTADANE (<i>betaine</i>)	T3	SP

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List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Osteoporosis Products)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
METABOLIC DEFICIENCY AGENTS (con't.)		
<i>levocarnitine</i> (Carnitor Sf)	T1	
<i>levocarnitine</i> (Carnitor)	T1	
<i>levocarnitine (with sugar)</i> (Carnitor)	T1	
BONE FORMATION AGENTS - SCLEROSTIN INHIBITOR, MONO		
EVENITY	T3	PA QL(0.08 MLS/DAY) SP
EVENITY (2 SYRINGES)	T3	PA QL(0.08 MLS/DAY) SP
BONE FORMATION STIM. AGENTS - PARATHYROID HORMONE		
BONSITY (<i>teriparatide</i>)	T3	PA QL(0.09 MLS/DAY) SP
FORTEO (<i>teriparatide</i>)	T3	PA QL(0.09 MLS/DAY) SP HD
<i>teriparatide</i> (Bonsity)	T1	PA QL(0.09 MLS/DAY) SP HD
<i>teriparatide</i> (Forteo)	T1	PA QL(0.09 MLS/DAY) SP HD
BONE RESORPTION INHIBITOR AND VITAMIN D COMBS.		
FOSAMAX PLUS D	T3	ST HD
BONE RESORPTION INHIBITORS		
ACTONEL (<i>risedronate sodium</i>)	T3	PA HD
<i>alendronate sodium</i>	T1	HD
<i>alendronate sodium</i> (Fosamax)	T1	HD
AELVIA (<i>risedronate sodium</i>)	T3	ST HD
BILDYOS	T3	PA SP
BILPREVDA	T3	PA SP
BINOSTO	T3	ST HD
BOMYNTRA	T3	PA SP
CONEXENCE	T3	PA SP
EVISTA (<i>raloxifene hcl</i>)	T3	PA HD
FOSAMAX (<i>alendronate sodium</i>)	T3	ST HD
<i>ibandronate 3 mg/3 ml syringe</i>	T1	SP HD
<i>ibandronate 3 mg/3 ml vial</i>	T1	SP HD
<i>ibandronate sodium 150 mg tab</i>	T1	HD
JUBBONTI	T2	PA SP
OSEVELT	T3	PA SP
<i>pamidronate disodium</i>	T1	SP HD
PROLIA	T3	PA SP
<i>raloxifene hcl</i> (Evista)	T1	HD PPACA
RECLAST (<i>zoledronic acid/mannitol-water</i>)	T3	SP HD
<i>risedronate sodium</i>	T1	HD

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List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Osteoporosis Products) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BONE RESORPTION INHIBITORS (con't.)		
<i>risedronate sodium (Actonel) (Atelvia)</i>	T1	HD
STOBOCLO	T3	PA SP
WYOST	T2	PA SP
XGEVA	T3	PA SP
<i>zoledronic acid 4 mg vial</i>	T1	SP HD
ZOLEDRONIC ACID 4 MG/100 ML	T3	SP HD
<i>zoledronic acid 4 mg/5 ml vial</i>	T1	SP HD
<i>zoledronic acid 5 mg/100 ml (Reclast)</i>	T1	SP HD

UNCLASSIFIED DRUG PRODUCTS (Pain Relief And Inflammatory Disease)

ANTI-INFLAM. INTERLEUKIN-I RECEPTOR ANTAGONIST		
ARCALYST	T3	PA SP HD
ANTI-INFLAMMATORY, INTERLEUKIN-I BETA BLOCKERS		
ILARIS	T3	PA SP HD
FIBROMYALGIA AGENTS, SEROTONIN-NOREPINEPH RU INHIB		
SAVELLA	T2	HD
IMMUNOMODULATOR, B-LYMPHOCYTE STIM (BLYS)-SPEC INHIB		
BENLYSTA 120 MG VIAL	T3	PA SP
BENLYSTA 200 MG/ML AUTOINJECT	T3	PA SP HD
BENLYSTA 200 MG/ML SYRINGE	T3	PA SP HD
BENLYSTA 400 MG VIAL	T3	PA SP
JOINT CONTRACTURE THERAPY, COLLAGENASE ENZYME		
XIAFLEX	T3	PA SP

UNCLASSIFIED DRUG PRODUCTS (Seizure Disorders)

NEUROPATHIC AGENTS		
LYRICA CR (pregabalin)	T3	HD
pregabalin (Lyrica Cr)	T1	HD

UNCLASSIFIED DRUG PRODUCTS (Skin Conditions)

INTERLEUKIN-I3 (IL-I3) INHIBITORS, MAB		
ADBRY	T2	PA SP HD
EBGLYSS PEN	T2	PA SP
EBGLYSS SYRINGE	T2	PA SP
JANUS KINASE (JAK) INHIBITORS		
LEQSELVI	T3	PA QL(2 TABS/DAY) SP HD
LITFULO	T3	PA QL(1 CAP/DAY) SP HD

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List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Skin Conditions) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
WOUND HEALING AGENTS, LOCAL		
<i>balsam peru/castor oil</i>	T1	
FILSUEVZ	T3	PA SP
VENELEX	T3	

UNCLASSIFIED DRUG PRODUCTS (Substance Abuse)

OPIOID WITHDRAWAL THER, ALPHA-2 ADRENERGIC AGONIST		
<i>lofexidine hcl</i>	T1	QL(192 tabs/30 days)
LUCEMYRA	T2	QL (168 tabs/14 days)

OPIOID WITHDRAWAL THERAPY AGENTS, OPIOID-TYPE		
BRIXADI	T3	SP HD
<i>buprenorphine hcl</i>	T1	
<i>buprenorphine hcl/naloxone hcl</i> (Suboxone)	T1	
SUBLOCADE	T3	SP
SUBOXONE (buprenorphine hcl/naloxone hcl)	T3	
ZUBSOLV	T2	

UNCLASSIFIED DRUG PRODUCTS (Transplant Medications)

RHO KINASE INHIBITOR		
REZUROCK	T3	PA SP HD

UNCLASSIFIED DRUG PRODUCTS (Urinary Tract Conditions)

BENIGN PROSTATIC HYPERTROPHY/MICTURITION AGENTS		
<i>alfuzosin hcl</i> (Uroxatral)	T1	HD
AVODART (dutasteride)	T3	PA HD
<i>dutasteride</i> (Avodart)	T1	HD
<i>finasteride</i> (Proscar)	T1	HD
PROSCAR (finasteride)	T3	PA HD
RAPAFLO 4 MG CAPSULE (silodosin)	T3	PA QL(1 CAP/DAY) HD
RAPAFLO 8 MG CAPSULE (silodosin)	T3	PA 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
UROXATRAL (<i>alfuzosin hcl</i>)	T3	PA HD

BPH 5-ALPHA-REDUCTASE INHIB-ALPHA1-ADRENOCEP ANTAG		
<i>dutasteride/tamsulosin hcl</i> (Jalyn)	T1	HD
JALYN (dutasteride/tamsulosin hcl)	T3	PA HD

BPH AGENT-5-ALPHA-REDUCTASE INH AND PDE5 INH COMB		
ENTADFI	T3	PA QL(1 cap/day)

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

List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Urinary Tract Conditions) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CYSTINE-DEPLETING AGENTS, NEPHROPATHIC CYSTINOSIS		
CYSTAGON	T2	SP
PROCYSBI	T3	PA SP HD
ENDOTHELIN RECEPTOR ANTAGONISTS		
VANRAFIA	T2	PA QL(1 TAB/DAY) SP
KIDNEY STONE AGENTS		
THIOLA (tiopronin)	T3	PA SP
THIOLA EC (tiopronin)	T3	PA SP
<i>tiopronin (Thiola Ec)</i>	T1	SP
<i>tiopronin 100 mg tablet (Thiola)</i>	T1	SP
<i>tiopronin dr 100 mg tablet (Thiola Ec)</i>	T1	SP
<i>tiopronin dr 100 mg tablet (Thiola Ec)</i>	T1	SP HD
<i>tiopronin dr 300 mg tablet (Thiola Ec)</i>	T1	SP
<i>tiopronin dr 300 mg tablet (Thiola Ec)</i>	T1	SP HD
OVERACTIVE BLADDER AGENTS, BETA-3 ADRENERGIC RECEPTOR		
GEMTESA	T3	ST QL(1 TAB/DAY) HD
<i>mirabegron er 25 mg tablet (Myrbetriq)</i>	T1	QL(1 TAB/DAY) HD
<i>mirabegron er 50 mg tablet (Myrbetriq)</i>	T1	HD
MYRBETRIQ ER 25 MG TABLET (<i>mirabegron</i>)	T3	ST QL(1 TAB/DAY) HD
MYRBETRIQ ER 50 MG TABLET (<i>mirabegron</i>)	T3	ST HD
MYRBETRIQ ER 8 MG/ML SUSP	T3	ST HD
URINARY TRACT ANTI-SPASMODIC, M(3) SELECTIVE ANTAGONIST		
<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
VESICARE 10 MG TABLET (solifenacin succinate)	T3	ST HD
VESICARE 5 MG TABLET (solifenacin succinate)	T3	ST QL(1 TAB/DAY) HD
VESICARE LS	T3	ST HD
URINARY TRACT ANTI-SPASMODIC/ANTI-INCONTINENCE AGENT		
DETROL (tolterodine tartrate)	T3	ST HD
DETROL LA 2 MG CAPSULE (tolterodine tartrate)	T3	ST QL(1 CAP/DAY) HD
DETROL LA 4 MG CAPSULE (tolterodine tartrate)	T3	ST HD
fesoterodine er 4 mg tablet (Toviaz)	T1	QL(1 TAB/DAY) HD
<i>fesoterodine er 8 mg tablet (Toviaz)</i>	T1	HD
flavoxate hcl	T1	HD

T1 – Typically Generics

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T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Urinary Tract Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
URINARY TRACT ANTI-SPASMODIC/ANTI-INCONTINENCE AGENT (cont.)		
OXYBUTYNIN 2.5 MG TABLET	T3	PA 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
OXYTROL	T3	ST 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
TOVIAZ ER 4 MG TABLET (<i>fesoterodine fumarate</i>)	T3	PA QL(1 TAB/DAY) HD
TOVIAZ ER 8 MG TABLET (<i>fesoterodine fumarate</i>)	T3	PA HD
<i>tropium 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)

FOLIC ACID PREPARATIONS

<i>megestrol 400 mg/10 ml cup</i>	T1	
<i>megestrol 625 mg/5 ml susp</i>	T1	

FOLIC ACID PREPARATIONS

ENLYTE	T3	
<i>folic acid</i>	T1	
<i>folic acid/b6/ca phos/ginger</i>	T1	

GERIATRIC VITAMIN PREPARATIONS

REQ49+	T3	
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MULTIVITAMIN PREPARATIONS

ANIMI-3	T2	
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	

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List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MULTIVITAMIN PREPARATIONS (cont.)		
CORVITE	T3	
DIALYVITE 800 WITH IRON	T3	
ENBRACE HR	T2	
<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 (Tandem Plus)</i>	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 (Concept Ob)</i>	T1	
<i>mvn-min75/iron/iron ps/om3/dha (Concept Dha)</i>	T1	
NEEVODHA	T2	
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	T2	
PRENATE CHEWABLE	T2	
PRENATE ESSENTIAL	T2	
PROTECT IRON	T2	
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	
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

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List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PEDIATRIC VITAMIN PREPARATIONS		
<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	T2	PPACA
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
<i>folic acid/vit bcomp,c/cu/zinc</i>	T1	HD
METHAVER	T3	HD
NEPHRON FA	T3	HD
NIVA-FOL (<i>cyanocobalamin/folic ac/vit b6</i>)	T1	HD
VITAL-D RX	T3	HD
<i>vitamins b1,b2,b3,b5,and b6</i>	T1	HD
VITA-RESPA	T3	HD

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List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN B1 PREPARATIONS (cont.)		
<i>thiamine hcl</i>	T1	
VITAMIN B6 PREPARATIONS		
pyridoxine hcl (vitamin b6)	T1	
VITAMIN B12 PREPARATIONS		
cyanocobalamin (vitamin b-12)	T1	
<i>cyanocobalamin (vitamin b-12) (Nascobal)</i>	T1	
<i>hydroxocobalamin</i>	T1	
NASCOBAL (cyanocobalamin (vitamin b-12))	T3	PA
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	
VITAMINS (Vitamins)		
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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T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

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:¹⁰

- 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,¹¹ sexual dysfunction, cosmetic purposes, weight loss, smoking cessation,¹² or athletic enhancement.
 - Prescription vitamins (other than prenatal vitamins) or dietary supplements unless state or federal law requires coverage of such products.
 - Immunization agents, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions and medications used for travel prophylaxis.
 - Replacement of prescription medications and related supplies due to loss or theft.
 - Medications which are to be taken by or administered to a covered person while they are a patient in a licensed hospital, skilled nursing facility, rest home or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceuticals.
 - Prescriptions more than one year from the date of issue.
 - Coverage for prescription medication products for the amount dispensed (days' supply) which is more than the applicable supply limit, or is less than any applicable supply minimum set forth in The Schedule, or which is more than the quantity limit(s) or dosage limit(s) set by the P&T Committee.
 - More than one prescription order or refill for a given prescription supply period for the same prescription medication product prescribed by one or more doctors and dispensed by one or more pharmacies.
 - Prescription medication products dispensed outside the jurisdiction of the United States, except as required for emergency or urgent care treatment.
- In addition to the plan's standard pharmacy exclusions, certain new FDA-approved medication products (including, but not limited to, medications, medical supplies or devices that are covered under standard pharmacy benefit plans) may not be covered for the first six months of market availability unless approved by Cigna Healthcare as medically necessary.

Index of Medications

Symbols

0.9 %.....	175
1ST.....	46, 47, 62, 63, 147, 213, 218, 230, 292
2-IN-1	213, 230, 292
2TEK	151, 202, 292

A

abacavir.....	97, 98, 292
ABELCET	61, 292
ABILIFY	253, 254, 292
abiraterone.....	78, 292
ABRAXANE.....	91, 292
ABRILADA.....	72, 292
ABRYSCO.....	111
ABSORICA.....	259, 292
ACAM2000.....	111
acamprosate.....	277, 292
ACANYA.....	260, 292
acarbose.....	64, 292
ACCOLATE.....	42, 292
ACCRUFER	172
ACCU.....	148, 202, 213, 230, 292
ACCUPRIL	125, 292
ACCURETIC	122, 292
ACCU TREND.....	148, 202, 292
ACD.....	56, 292
acebutolol	127, 292
ACETADOTE	277, 292
acetamin	15, 19, 22, 30, 292, 297
acetaminop.....	22, 292, 308
acetaminophen.....	15, 19, 22, 23, 292, 297, 307, 308, 316, 325
ACETAMINOPHEN.....	19, 292, 295, 307
acetaminophen 1000mg/100ml v1	19
acetazolamide.....	158, 292
acetic.....	70, 161, 258, 292, 307
acetylcysteine	42, 277, 292
ACIPHEX	186, 292
acitretin.....	258, 292
ACTEMRA	200, 292
ACTHAR.....	189, 292
ACTHIB	110, 111, 292
ACTI	213, 214, 230, 231
ACTICLATE.....	52, 292
ACTIMMUNE	92, 292
ACTIQ.....	23, 292
ACTIVASE.....	114
ACTIVE.....	172
ACTIVELLA.....	191, 292
ACTONEL.....	283, 292
ACTOPLUS.....	66, 292

ACTOS.....	67, 292
ACULAR.....	161, 292
ACUVAIL	161, 292
acyclovir.....	100, 103, 292
ACZONE	260, 292
ADACEL	110, 292
ADAKVEO	113, 292
ADALIMUMAB.....	72, 73, 292
adapalene.....	260, 268, 292
ADCETRIS	90, 292
ADCIRCA.....	120, 292
ADDAMEL.....	173, 292
ADDERALL.....	104, 292
ADDYI.....	279, 292
ADEMPAS	120
adenosine.....	115, 153, 292
ADHANSIA.....	247
ADJUSTABLE.....	202, 292
ADLARITY	103
ADMELOG.....	68, 292
ADRENALIN	161, 292
ADREVIEW	153, 292
ADRIAMYCIN.....	75, 292
adthyza.....	269
ADTHYZA.....	269, 292
ADUHELM	134, 292
ADVAIR	40, 292
ADVANCED	148, 154, 202, 213, 230, 292
ADVATE.....	112
ADVOCATE.....	148, 203, 214, 218, 222, 230, 292
ADYNOVATE.....	112
ADYPHREN	103, 292
ADZENYS.....	104, 292
ADZYNMA.....	112
AEMCOLO	52
AFINITOR	82, 292
AFLURIA	109
AFREZZA.....	68, 292
AFSTYLA.....	112
AGAMATRIX.....	148, 203, 214, 230, 292
AGAMREE	192, 292
AGGRASTAT	96
AGRYLIN.....	96, 293
AIMOVIG.....	15, 20
AIRDUO	40, 293
AIRSUPRA.....	40, 293
AJOVY.....	15, 20, 293
AKEEGA.....	89, 293
AK-FLUOR.....	155, 293

Index of Medications

AKLIEF	263, 293	amantadine.....	94, 293
AKOVAZ	120, 293	AMBIEN	256, 257, 293
AKTEN	163	AMBISOME.....	61, 293
AKYNZEO.....	179, 293	ambrisentan.....	120, 293
ALA-SCALP	264, 293	amcinonide.....	264, 293
albuterol.....	38, 39, 40, 293, 308	AMICAR.....	112, 293
ALBUTEROL.....	39, 293	AMIDATE	30, 293
ALCAINE	163, 293	amikacin.....	44, 293
alclometasone	264, 293	amiloride.....	159, 160, 293
ALCOH	235	aminocaproic	112, 293
alcohol.....	134, 257, 261, 282	aminophylline.....	42, 293
ALCOHOL.....	72, 134, 257, 258, 261, 262, 282, 293	AMINOSYN.....	169, 293
ALDACTONE.....	159, 293	amiodarone.....	115, 293
ALDURAZYME.....	280, 293	AMITIZA	185, 293
ALECENSA	84, 293	amitriptyline	246, 293, 317
alendronate.....	283, 293	amitriptyline/chlordiazepoxide.....	246
ALFERON	92, 293	AMJEVITA.....	73, 293
alfuzosin	285, 293	amlodipine.....	116, 117, 122, 123, 124, 125, 129, 293, 324
ALHEMO.....	113, 293	AMMONIA.....	153
ALIMTA.....	78, 293	AMMONUL.....	177, 293
ALINIA	93, 293	AMONDYS	278, 293
ALIQOPA.....	84, 293	amoxapine	246
aliskiren.....	128, 293	amoxicillin.....	50, 293
ALKALINE.....	203, 293	AMPHADASE.....	268
ALKERAN.....	76, 293	amphetamine.....	104, 105, 293
ALKINDI.....	192, 293	amphotericin.....	61, 293
allopurinol.....	35, 293	ampicillin	50, 51, 70, 293
almotriptan.....	15, 20, 293	AMPYRA	136, 293
almotriptan malate.....	15	AMRIX	236, 293
ALOCRIAL.....	163, 293	AMVISC.....	166, 294
ALOGLIPTIN.....	64, 65, 66, 293	AMYTAL	256, 294
alosectron	185	AMYVID.....	155
ALPHAGAN.....	163, 293	AMZEEQ	55, 294
ALPHANATE.....	112	ANAFRANIL.....	246, 294
alprazolam	240, 241, 293	anagrelide	96, 294
ALREX.....	161, 293	ANA-LEX	188, 294
ALTABAX.....	264	ANALPRAM.....	183, 188, 267, 294
ALTACE.....	125	ANAPROX.....	36, 294
ALTAFLUOR.....	163, 293	anastrozole.....	80, 294
ALTERNATE.....	203, 214, 230, 293	ANCOBON.....	60
ALTOPREV.....	130, 293	ANDEXXA	114
ALTRENO.....	268, 293	ANDROGEL.....	189, 294
ALTRIXA.....	240	ANGELIQ.....	192
ALTUVIIIO	112, 293	ANGIOMAX.....	59, 294
ALUNBRIG.....	84, 293	ANIMI	287
ALVAIZ	144, 293	ANNOVERA.....	145, 294
ALVESCO.....	41	ANORO	40, 294
ALYFTREK	271, 293	anthralin.....	260, 294
ALYMSYS.....	76	ANTICOAGULANT.....	56, 114

Index of Medications

ANTIVERT	179	ASACOL	183, 294
ANUSOL	188, 264, 294	ASCLERA	133, 294
ANZEMET	179, 294	ASCOR	290
APHEXDA	144, 294	ascorbic	290
APIDRA	68, 294	asenapine.....	250
APLENZIN	242, 294	ASMANEX.....	41
APO	269	ASPARLAS	91, 294
APOKYN	94, 294	ASPIRIN	96, 294
apomorphine	94	aspirin/dipyridamole.....	96
apraclonidine	163, 294	ASSURE	148, 203, 214, 219, 222, 231, 237, 294
aprepitant.....	179, 180, 294	ASTAGRAF	201, 294
APRETUDE.....	99	ASTRINGYN	114, 294
APRISO	183, 294	ATACAND.....	124, 125, 294
APTENSIO	247	atazanavir.....	99, 294
APTIOM	137, 294	ATELVIA	283, 294
APTIVUS	97, 294	atenolol	127, 128, 294
AQ.....	194, 197, 222	AT HOME	203, 294
AQNEURSA	175	ATIVAN	240, 256, 294
AQUASOL	289	atomoxetine.....	250, 294
ARAKODA	71, 294	ATORVALIQ	130
ARALAST	272, 294	atorvastatin.....	129, 130, 131, 294
ARANESP	143, 294	atovaquone	71, 294
ARAVA	34	atracurium.....	106, 294
ARAZLO	263, 294	ATRALIN	268, 294
ARBLI.....	125	ATROPEN	128
ARCALYST.....	284	atropine.....	165, 179, 181, 182, 294, 317
AREXVY	111	ATROPINE	165, 181, 294
arformoterol.....	39, 294	ATROVENT	38, 295
argatroban.....	58	ATTRUBY	281, 295
ARGATROBAN.....	58, 294	AUBAGIO	135
ARICEPT	103, 294	AUGMENTIN.....	50, 295
ARIDOL	154, 294	AUGTYRO	84, 295
ARIKAYCE.....	44, 294	AURYXIA	170, 295
ARIMIDEX.....	80, 294	AUSTEDO.....	134, 135, 295
aripiprazole	253, 254, 294	AUTOJECT	203, 295
ARISTADA	254, 294	AUTO-LANCET.....	203, 295
ARIXTRA	56, 294	AUTOLET.....	203, 209, 295
armodafinil	255	AUTOPEN	203
ARMONAIR.....	41	AUTOSHIELD.....	219, 295
ARMOUR	269, 294	AUVELITY	242
ARNUITY.....	41	AUVI	103, 295
AROMASIN	80, 294	AVALIDE.....	124, 295
ARRANON.....	78, 294	avanafil.....	274
arsenic	91, 92, 294	AVAPRO	125
ARTESUNATE	71	AVAR.....	55, 56, 295
ARTHROTEC	35, 294	AVASTIN	76, 295
ARTICADENT.....	31, 294	AVEED.....	189, 295
ARTISS	263	AVELOX.....	51, 295
		AVERI.....	145

Index of Medications

AVGEMSI	78	BAXDELA	51, 295
AVITENE	114, 295, 303, 323	BCG	91, 110, 295
AVMAPKI	82, 295	b complex	289
AVODART	285, 295	BD	214, 222, 223, 231, 295
AVONEX	135, 295	BEIZRAY	91
AVSOLA	73, 295	BELBUCA	23, 295
AVTOZMA	200	BELEODAQ	76, 295
AVYCAZ	47, 295	BELRAPZO	76, 295
AXTLE	78	BELSOMRA	257, 295
AXUMIN	156, 295	benazepril	122, 125, 295
AYVAKIT	84, 295	bendamustine	76, 78, 295
azacitidine	78, 80, 295	BENDAMUSTINE	76, 295
AZACTAM	46, 295	BENDEKA	76, 295
AZASAN	201, 295	BENICAR	124, 125, 295
AZASITE	43	BENZAMYCIN	55, 295
azathioprine	201, 295	BENZNIDAZOLE	71, 295
AZEDRA	92, 295	benzonatate	147, 295
azelaic	263, 295	BENZOYL	263, 318
azelastine	63, 160, 295	benztropine	94, 295
AZELEX	260, 295	BEOVU	165, 295
AZESCO	240	bepotastine	63
AZILECT	94, 295	BEPREVE	63, 296
azithromycin	49, 295	BERINERT	277, 296
AZMIRO	189	BESIVANCE	43, 296
AZOPT	163, 295	BESPONSA	83, 296
AZOR	124, 295	BESREMI	92, 296
aztreonam	46, 295	BETA	38, 39, 40, 41, 122, 127, 128, 192, 284, 286, 296
AZULFIDINE	183, 295	BETADINE	161
B		betaine	282
bacitracin	43, 45, 295, 314	betamethasone	61, 192, 264, 265, 268, 296
baclofen	236, 295	BETAPACE	127, 296
BACLOFEN	236, 295	BETASERON	135, 296
BACMIN	287	betaxolol	127, 163, 296
bacteriostatic	282, 295	bethanechol	107, 296
BACTRIM	44, 295	BETHKIS	44, 296
BAFIERTAM	135, 295	BETIMOL	163, 296
balanced salt irrig soln no.2	163	BETOPTIC	163, 296
BAL-CARE	237	BEVESPI	40, 296
BALCOLTRA	145, 295	bexarotene	75, 93, 296
BAL IN OIL	280, 295	BEXSERO	109, 296
balsalazide	183, 295	BEYAZ	145, 296
balsam	285, 295	BEYFORTUS	100
BALVERSA	84, 295	bicalutamide	78, 296
BANZEL	137, 295	BICILLIN	50, 296
BAQSIMI	168, 295	BICNU	76, 296
BARACLUDE	102, 295	BIDIL	129, 296
BARHEMSYS	179, 295	BIJUVA	190
BASAGLAR	68, 295	BIKTARVY	100
BAVENCIO	92, 295	BILDYOS	283

Index of Medications

BILPREVDA	283	BROMSITE	162, 296
BILTRICIDE	71, 296	BRONCHITOL	271, 296
bimatoprost.....	163, 296	BROOKS.....	223
BIMZELX	258, 296	BROVANA	39, 296
BINOSTO	283, 296	BRUKINSA	85, 296
BIONECT	263, 296	BRYHALI	264, 296
BIORPHEN.....	120, 296	BSP	192, 296
BIOTEL	203	BSS	163
bisac	185, 296	BUCAPSOL.....	241
bismuth.....	181	budesonide	40, 41, 188, 192, 194, 296
bisoprolol	127, 128, 296	BUFFERED.....	31, 296
bivalirudin	59, 296	BULLSEYE.....	214, 231, 296
BIVALIRUDIN	59, 296	bumetanide	158, 296
BIZENGRI	90	BUPAP	19, 296
BKEMV.....	113, 296	BUPHENYL	177, 296
BLENREP	90, 296	bupivacaine.....	31, 32, 296
bleomycin	75, 296	BUPIVACAINE	31, 296
BLINCYTO	90, 296	buprenorphine.....	23, 24, 285, 296
BLOXIVERZ.....	103, 296	bupropion	242, 269, 296
BLUDIGO.....	157	BUPROPION.....	242, 296
BLULINK.....	148, 149, 204, 205, 231, 296	buspirone	241, 296
BLUNT.....	219, 220, 296	busulfan	76, 297
BOMYNTRA.....	283	BUSULFEX	76, 297
BONJESTA.....	179, 296	butal	19
BONSITY	283	butalb.....	15, 19, 297
BOOSTRIX.....	110, 296	butalb-acetamin-caff 50-300-40.....	15
bortezomib	84, 89	butalb-acetamin-caff 50-325-40.....	15
BORTEZOMIB.....	84, 296	butalb/acetaminophen/caffeine.....	15
bosentan	120, 121, 296	butalb-aspirin-caffe 50-325-40.....	15
BOSULIF.....	84, 85, 296	butalbit.....	30, 297
BOTOX.....	106, 296	butalbital.....	15, 19, 297, 299
BRAFTOVI	81, 296	butalbital/acetaminophen	15
BREEZE	204, 296	butalbital-asa-caffeine cap (Fiorinal)	15
BRENZAVVY.....	67, 296	butorphanol	23, 297
BREO.....	40, 296	BUTRANS.....	24, 297
BREVIBLOC	127, 296	BUTTERFLY	214, 231, 297
BREVITAL.....	30, 296	BYDUREON	64, 297
BREXAFEMME.....	61, 296	BYETTA	64, 297
BREZTRI	41, 296	BYLVAY	184
BRILINTA.....	96, 296	BYOOVIZ	165
brimonidine	163, 164, 296	BYSTOLIC	127, 297
BRINEURA	279	C	
brinzolamide.....	163, 164, 296	CA	1, 223, 331
BRIUMVI	135, 296	CABENUVA	97
BRIVIACT	137, 138, 296	cabergoline	195, 297
BROMFED.....	147	CABLIVI.....	112
bromfenac.....	161, 162, 296	CABOMETYX	85, 297
bromocriptine.....	94, 296	CABTREG	260, 297
brompheniramine/pseudoephed/dm	147	CADUET	129, 297

Index of Medications

CAFCIT	135	CAREONE	204, 214, 223, 231, 297
CAFERGOT	15	CAREPOINT	219
caffeine.....	15, 19, 20, 135, 297, 303	CARESENS	148, 204, 214, 231, 297
CAFFEINE.....	135, 297	CARETOUCH	148, 204, 214, 219, 223, 231, 257, 261, 297
caffeine citrate	135	carglumic	276, 297
CALAN	116, 297	carisoprodol	30, 236, 237, 297
calcipotriene	260, 261, 268, 297	carmustine	76, 297
CALCIPOTRIENE	261	CARMUSTINE	76
calcitonin.....	198, 297	CARNITOR.....	282, 297
calcitonin,salmon,synthetic.....	198	CAROSPIR.....	159, 297
calcitriol.....	261, 290, 297	carteolol	164, 297
calcium.....	37, 55, 99, 129, 130, 131, 170, 173, 238, 273, 277, 297, 304	carvedilol.....	122, 123, 297
CALCIUM	19, 116, 117, 118, 122, 123, 124, 125, 129, 170, 277, 279, 281, 297	CASODEX.....	78, 297
CALDOLOR.....	36, 297	caspofungin	61, 297
CALQUENCE.....	85, 297	CATAPRES.....	126, 297
CAMBIA.....	20, 297	CATHFLO ACTIVASE	114
CAMCEVI.....	84	CAVERJECT	274, 297
CAMPTOSAR.....	82, 297	CAYSTON	46, 297
CAMZYOS.....	118, 297	cefaclor.....	47, 297
CANASA	182, 297	cefadroxil.....	46, 297
CANCIDAS.....	61, 297	cefazolin	46, 47, 297
candesartan	124, 125, 297	CEFAZOLIN.....	46, 47, 297
CAPCOF	147	cefdinir	47, 297
capecitabine.....	78, 79, 80, 297	cefepime	48, 298
CAPEX.....	264, 297	CEFEPIME	48, 298
CAPLYTA	250, 297	cefixime.....	47, 298
CAPRELSA	85, 297	CEFOTAN.....	47, 298
captopril	122, 125, 297	cefotaxime	47, 298
CAPVAXIVE.....	109	cefotetan	47, 298
CARAC	93, 297	cefoxitin.....	47, 298
CARAFATE.....	180, 297	cefpodoxime	47, 298
carbachol.....	164, 297	cefprozil.....	47, 298
CARBAGLU.....	276, 297	ceftazidime	47, 298
carbamazepine	138, 141, 142, 297	CEFTAZIDIME.....	47
CARBAMAZEPINE.....	138	ceftriaxone	47, 298
CARBATROL.....	138, 297	CEFTRIAXONE.....	47, 298
carbidopa	94, 95, 96, 297	cefuroxime	47, 298
carbinoxamine	62, 297	CELEBREX.....	38, 298
CARBINOXAMINE.....	62	celecoxib	38, 298
carboplatin	76, 297	CELESTONE.....	192, 298
carboprost	195	CELEXA.....	242, 298
CARBOPROST	195, 297	CELLCEPT	201, 298
CARDENE.....	116, 297	CELLUGEL.....	166, 298
CARDIOPLEGIA.....	118, 297	CELONTIN	138, 298
cardioplegic.....	118, 297	CENTANY	55, 298
CARDIZEM.....	116, 297	cephalexin.....	47, 298
CARDURA	123, 297	CEPROTIN	113
CAREFINE.....	219, 297	CEQUA	166, 298

Index of Medications

CEQR	204, 298	cisatracurium	106, 298
CERDELGA	278, 298	cisplatin	76, 298
CEREBYX	138, 298	CISPLATIN	76
CEREZYME	279	citalopram	242, 243, 298
CERVIDIL	195, 298	CITALOPRAM	243
cetirizine	63, 298	CITANEST	31, 298
CETRAXAL	42	CITRANATAL	172, 237, 240, 290, 298
cetrotrelax	194	CITRATE	56, 130, 170, 298, 322
cevimeline	107, 298	citric	177
CHANTIX	269, 298	cladribine	79, 135, 136, 298
CHEK	148, 157, 202, 204, 213, 214, 230, 231, 292	CLARINEX	62, 63, 298
CHEMET	280, 298	CLARINEX-D	62
CHEMSTRIP	157, 204	clarithromycin	49, 298
CHENODAL	182, 298	clemastine	63, 298
CHIRHOSTIM	156, 298	CLENPIQ	185, 298
chloramphenicol	48, 298	CLEOCIN	48, 53, 55, 298
chlordiazepoxide	178, 240, 246, 293, 298	CLEVER	148, 149, 204, 214, 231, 298
chlorhexidine	274, 298	CLEVIPREX	116, 298
chloroprocaine	31, 32, 298	CLICKFINE	219, 221, 298
chloroquine	71, 298	CLIMARA	191, 298
chlorothiazide	160, 298	CLINDAGEL	55, 299
chlorpromazine	255, 298	clindamyc	260, 299
chlorthalidone	128, 160, 298	clindamycin	48, 53, 55, 260, 299
chlorzoxazone	236, 298	CLINDAMYCIN	48, 299
CHOLBAM	182, 298	CLINDESSE	53, 299
cholestyramine	131, 132, 298	CLINIMIX	169, 299
CHOLETEC	153, 298	CLINISOL	169, 299
choline salicyl/mag salicylate	15	CLINOLIPID	185, 299
CHORIONIC	197, 298	CLINPRO	167, 171, 299
CHOSEN	204, 214, 231, 298	clobazam	137, 299
chromic	173, 298	clobetasol	264, 266, 299
CIALIS	274, 298	CLOBETASOL	162, 264
ciclodan	61, 298	CLOBEX	264, 299
CICLODAN	61, 298	clodan	265, 299
ciclopirox	61, 62, 298	CLODAN	265, 299
cidofovir	100, 298	CLODERM	265, 299
cilostazol	96, 298	clofarabine	79, 299
CILOXAN	43, 298	clomiphene citrate	197
CIMDUO	97, 298	clomipramine	246, 299
CIMERLI	165	clonazepam	137, 299
cimetidine	184, 298	clonidine	19, 126, 247, 299
CIMZIA	73, 298	CLONIDINE	126
cinacalcet	277, 298	clopidogrel	96, 299
CINQAIR	41	clorazepate	240, 299
CINRYZE	277, 298	clotrimazole	60, 61, 299
CINVANTI	179, 298	clozapine	250, 299
CIPRO	42, 51, 298	CLOZARIL	250, 299
ciprofloxacin	42, 43, 51, 298	COAGADEX	113
CIPROFLOXACIN	42, 298	COAGUCHEK	214, 231, 299

Index of Medications

COARTEM	71, 299	CORTROSYN.....	189, 299
COBENFY	254, 299	CORVERT.....	115, 299
codeine.....	22, 24, 30, 147, 148, 292, 297, 299	CORVITE.....	172, 288
CODITUSSIN.....	148	COSENTYX.....	258, 259, 299
COLAZAL	183, 299	COSOPT	164, 299
colchicine.....	35, 38, 299, 318	cosyntropin	189, 299
COLCRYS	35, 299	COTELLIC	81, 299
colesevelam.....	131, 132, 299	COTEMPLA	248, 299
COLESTID.....	132, 299	COXANTO.....	36, 299
colestipol.....	132, 299	COZAAR.....	125, 299
colistin.....	51	CRENESSITY.....	195, 299
COLOR.....	214, 231, 299	CREON	186
COLUMVI	90	CRESEMBA	60, 299
COLY-MYCIN M PARENTERAL	51	CRESTOR.....	130, 131, 299
COMBIGAN	164, 299	CREXONT	95
COMBIPATCH	191, 299	CRINONE.....	196, 197, 299
COMBISTIX	157	cromolyn.....	33, 42, 163, 300
COMBIVENT.....	40, 299	crotamiton.....	94, 300
COMBIVIR.....	97, 299	CTEXLI	182, 300
COMBOGESIC.....	35, 299	CULTURELLE.....	282
COMETRIQ.....	85, 299	cupric.....	173, 300
COMFORT ...212, 214, 216, 217, 218, 219, 221, 223, 227, 229, 230, 231, 233, 234, 235, 258, 261, 262, 299, 302, 323, 326		CURITY	257, 261
COMIRNATY.....	108	CUROSURF.....	272
COMPAZINE.....	179, 299	CUVPOSA	178, 300
COMPLERA	99, 299	CUVRIOR.....	280, 300
CONCEPT	287	CVS	149
CONCERTA	248, 299	cyanocobalamin	289, 290, 300
CONEXXENCE.....	283, 299	CYANOKIT	277, 300
CONJUPRI	116, 299	cyclobenzaprine.....	236, 300
CONRAY	157, 299, 300	CYCLOGYL.....	165, 300
CONSENSI.....	116, 299	CYCLOMYDRIL.....	165, 300
CONTOUR.....	149, 204, 205, 299	cyclopentolate.....	165, 300
CONZIP	24	cyclophosphamide	76, 77, 300
COOL.....	149, 205, 299	CYCLOPHOSPHAMIDE	76, 77, 300
COPAXONE.....	136, 299	cycloserine	46
COPIKTRA	85, 299	CYCLOSET	64, 300
CORDRAN	265, 299	cyclosporine.....	166, 201, 202, 300
COREG.....	122, 123, 299	CYKLOKAPRON.....	112, 300
coremino.....	52, 299	CYLTEZO	73, 300
CORIFACT	113	CYMBALTA.....	244, 300
CORLANOR	119, 299	cyproheptadine.....	63, 300
CORTEF	192, 193, 299, 322	CYRAMZA.....	83
CORTENEMA.....	188, 299	CYSTADROPS.....	166
CORTIFOAM.....	188, 299	CYSTAGON.....	286, 300
cortisone.....	192, 299	CYSTARAN.....	166
CORTISPORIN.....	42, 299	CYSTO.....	157, 300
CORTROPHIN	189	CYSTOGRAFIN.....	157, 300
		CYSVIEW	155

Index of Medications

cytarabine.....	79, 300	DEMSEK.....	126
CYTOMEL.....	269, 300	DENAVIR.....	103
CYTOTEC.....	180, 300	DEPAKOTE.....	138, 300
D		DEPO.....	145, 189, 191, 192, 300
dabigatran.....	58, 59, 300	DERMA.....	265, 300
dacarbazine.....	91, 300	DERMACINRX.....	237
DACOGEN.....	79, 300	DERMOTIC.....	161
dactinomycin.....	75, 300	DESCOVY.....	97, 300
dalbavancin.....	48	DESFERAL.....	280, 301
dalfampridine.....	136, 300	desflurane.....	30, 301
DALIRESP.....	42, 300	desipramine.....	246, 301
DALVANCE.....	48, 300	desloratadine.....	63, 301
danazol.....	195, 300	DESLOTATADINE.....	63
DANTRIUM.....	236, 300	desmopressin.....	190, 301
dantrolene.....	236, 300	desog.....	145, 301
DANZITEN.....	85	desogestrel.....	145, 301
DAPAGLIFLOZIN.....	67, 300	desonide.....	265, 267, 301
dapsone.....	45, 260, 300	desoximetasone.....	265, 266, 301
DAPSONE.....	260, 300	DESOPYN.....	104, 301
DAPTACEL.....	110, 300	desvenlafaxine.....	245, 301
daptomycin.....	300	DESVENLAFAXINE.....	244, 301
DAPTOMYCIN.....	55, 300	DETROL.....	286, 301
DARAPRIM.....	71, 300	dexamethasone.....	43, 162, 192, 193, 301, 325
darifenacin.....	286, 300	dexchlorpheniramine.....	63, 301
DARTISLA.....	178, 300	DEXCOM.....	205, 301
darunavir.....	97, 300	DEXEDRINE.....	104, 301
DARZALEX.....	78, 300	DEXILANT.....	186, 301
dasatinib.....	85, 88, 300	dexlansoprazole.....	186, 301
DATROWAY.....	90	dexmedetomidine.....	257, 301
DATSCAN.....	155	dexamethylphenidate.....	248, 301
daunorubicin.....	75, 300	dextrazoxane hcl.....	273
DAURISMO.....	81, 300	dextroamphetamine.....	104, 105, 301
DAXXIFY.....	106, 300	dextrose.....	31, 46, 47, 48, 50, 51, 52, 106, 115, 119, 168, 169
DAYBUE.....	135	DEXTROSE.....	32, 46, 47, 48, 51, 56, 123, 158, 168, 169, 171, 176, 177, 298
DAYTRANA.....	248, 300	DHIVY.....	95
DAYVIGO.....	257, 300	DIACOMIT.....	138, 301
DDAVP.....	190, 300	DIALYVITE.....	288, 289
decitabine.....	79, 300	DIANEAL.....	176, 177, 301
DEFENCATH.....	277	DIASTAT.....	137, 301
deferasirox.....	280, 300	DIASTIX.....	153, 157
deferiprone.....	280, 300	diatrizoate.....	155, 156, 157, 301
deferoxamine.....	280, 300	DIATRUE.....	149, 205, 301
DEFINITY.....	153, 300	diazepam.....	137, 241, 301
DEFITELIO.....	114	diazoxide.....	168, 301
deflazacort.....	192, 193, 300	DIBENZYLIN.....	105
DELESTROGEN.....	191, 300	dichlorphenamide.....	276, 301
DELSTRIGO.....	99, 300	DICLEGIS.....	179, 301
demeclocycline.....	52, 300	diclofenac.....	20, 22, 35, 36, 93, 162, 259, 301
DEMEROL.....	24	DICLOFENAC.....	36, 259, 301

Index of Medications

dicloxacillin	50, 301	DORYX	52, 301
dicyclomine.....	178, 179, 301	dorzolamide.....	164, 302
DICYCLOMINE.....	179	DOTAREM	154, 302
didanosine	98, 301	DOVATO	97
DIFFERIN	268, 301	doxazosin	123, 302
DIFICID	49, 301	doxepin	246, 257, 260, 302
diflorasone	265, 301	doxercalciferol.....	275, 302
DIFLUCAN	60, 301	DOXIL.....	75, 302
diflunisal	15	doxorubicin	75, 302
difluprednate	162	doxycycline	52, 53, 274, 302
DIGIFAB	277, 301	DOXYCYCLINE.....	52, 302
digoxin	118, 301	doxylamine	179, 180, 302
dihydroergotamine.....	15, 20, 301	DRAXIMAGE.....	154, 302
DILANTIN.....	138, 301	DRIZALMA.....	245, 302
DILAUDID	24, 301	dronabinol.....	179
diltiazem	116, 117, 118, 301	droperidol.....	255, 302
DILTIAZEM.....	117, 301	DROPLET.....	205, 214, 219, 223, 231, 302
diluent.....	278, 301	DROPSAFE.....	214, 219, 221, 223, 231, 258, 261, 302
DILUENT	278, 301, 317	drospir	145, 146, 302
dimenhydrinate	180, 301	DROXIA.....	113, 302
dimethyl.....	136, 278, 301	droxidopa.....	105, 302
DIOVAN.....	124, 125, 301	DRYSOL	260
DIPENTUM.....	183, 301	DUAKLIR.....	40
diphenhydramine	63, 301	DUAVEE.....	192
diphenoxylate.....	179	DUET.....	237, 240
DIPHThERIA	111, 301	DUETACT (pioglitazone hcl/glimepiride).....	66
DIPRIVAN.....	30, 301	DULERA	40, 302
DIPROLENE.....	265, 301	duloxetine	244, 245, 302
dipyridamole.....	96, 153, 294, 301	DUOBRII.....	261, 302
DISALCID	33	DUODOTE	277
DISCOVISC	166, 301	DUOPA	95, 302
disopyramide	115, 301	DUOVISC.....	166, 302
disulfiram.....	277, 301	DUPIXENT.....	200
DIURIL.....	160, 301, 322	DURACLON	19, 302
divalproex.....	138, 301	DUREZOL	162, 302
DIVIGEL.....	191, 301	DUROLANE.....	34, 302
DMSA	154, 301	DURYSTA	164, 302
dobutamine	119, 301	dutasteride.....	285, 302
DOCEFREZ.....	91, 301	DUVYZAT	278
docetaxel.....	91, 301	DYANA VEL	105, 302
DOCIVYX.....	91, 301	DYMISTA.....	160
dofetilide	115, 116, 301	DYRENIUM	159, 302
DOJOLVI.....	167, 301	DYSPORT	106, 302
donepezil	103, 104, 133, 134, 301	E	
DONNATAL	181, 301	EASY.....	149, 205, 206, 214, 215, 219, 223, 224, 231, 232, 258, 261, 302
dopamine.....	106, 301	EASYGLUCO.....	149, 206, 302
DOPRAM	134, 301	EASYMAX.....	149, 206, 302
DOPTELET.....	144, 301	ECLIPSE.....	219, 224, 302
DORAL	256, 301	EC-NAPROSYN.....	36, 302

Index of Medications

econazole	61, 302	EMRELIS	90
ECOZA	61, 302	EMROSI	53, 303
edaravone	134, 302	EMSAM	242
EDARAVONE	134	emtricitata	99, 100, 303
EDARBI	125, 302	emtricitabine	97, 98, 303
EDARBYCLOR	124, 302	EMTRIVA	98, 303
EDECIN	158, 159, 302, 322	EMVERM	71, 303
EDETATE	279	enalapril	122, 125, 303
EDEX	274, 302	enalaprilat	125, 303
EDLUAR	257, 302	ENBRACE	288
EDURANT	98, 302	ENBREL	73, 303
E.E.S.	49, 302	ENDO	114, 303
efavirenz	98, 99, 100, 302	ENDO-AVITENE	114, 303
effe	174, 302	ENDOMETRIN	197, 303
EFFER	174, 302	ENFAMIL	170
EFFEXOR	245, 302	ENFLONIA	100
EFFIENT	96, 302	ENGERIX	111, 303
EFUDEX	93, 302	ENHERTU	90, 303
EGRIFTA	194	ENJAYMO	113
ELAHERE	90	ENLITE	206, 303
ELAPRASE	280, 302	ENLYTE	287
electrolyte	171, 302	enoxaparin	57, 58, 303
ELELYSO	279	ENSACOVE	85, 86, 303
ELEMENT	149, 206, 302	ENSPRYNG	200, 303
ELEPSIA	138, 302	ENSTILAR	268, 303
ELESTRIN	191, 302	entacapone	94, 95, 303
eletriptan	15, 20, 302	ENTADFI	285, 303
eletriptan hydrobromide	15	entecavir	102, 303
ELIDEL	200, 302	ENTERO	155, 303
ELIGARD	84, 302	ENTRESTO	123, 303
ELIMITE	94, 302	ENVARUSUS	201, 303
ELIQUIS	56, 302	EOHILIA	193
ELITEK	35	EOVIST	156
ELIXOPHYLLIN	42	EPANED	125, 303
ELLA	145, 302	EPCLUSA	102, 303
ELLECE	75, 302	ephedrine	120, 303
ELLIOTTS	278, 302	EPHEDRINE	120, 303
ELMIRON	30, 302	EPIDIOLEX	137
ELOCTATE	112	EPIDUO	260
ELREXFIO	90	EPIFOAM	267, 303
eltrombopag	144	epinastine	63, 303
ELUCIREM	154	epinephrine	31, 32, 103, 106, 161, 303
ELYXYB	20, 302	EPINEPHRINE	32, 103, 106, 303
EMBRACE	149, 206, 215, 219, 232, 303	EPINEPHRINESNAP	103, 303
EMBRIVA	240	EPIPEN	103, 303
EMEND	180, 303	epirubicin	75, 303
EMGALITY	15, 20, 303	EPIVIR	98, 303
EMPAVELI	113	EPKINLY	90
EMPLICITI	80, 303	eplerenone	159, 303

Index of Medications

EPOGEN.....	143, 303	ethambutol.....	45, 304
epoprostenol.....	121, 278, 303	ETHAMOLIN.....	133, 304
EPRONTIA.....	138, 303	ethinyl.....	145, 146, 301, 304, 315
eprosartan.....	126, 303	ethosuximide.....	139, 143, 304
eptifibatide.....	96, 303	ethyl.....	134, 177, 315
EPTIFIBATIDE.....	96, 303	ETHYOL.....	273, 304
EPYSQLI.....	113, 303	etodolac.....	36, 37, 304
EPZICOM.....	97, 303	etomidate.....	30, 304
EQL.....	224	etonogestrel.....	145, 304
EQUETRO.....	241, 303	ETOPOPHOS.....	91, 304
ERAXIS.....	61, 303	etoposide.....	91, 304
ERBITUX.....	83, 303	etravirine.....	98
ergoloid.....	129	EUCRISA.....	263, 304
ERGOMAR.....	20, 303	EUFLEXXA.....	34, 304
ergotamine.....	15, 20, 303	EULEXIN.....	78
ergotamine tartrate/caffeine.....	15	EURAX.....	94, 304
eribulin mesylate.....	82	EVAMIST.....	191, 304
ERIVEDGE.....	81, 303	EVEKEO.....	105, 304
ERLEADA.....	78	EVENCARE.....	149, 206, 207, 304
ERMEZA.....	269, 303	EVENITY.....	283, 304
ERTACZO.....	61, 303	everolimus.....	82, 201, 202, 304
ertapenem.....	46, 303	EVICEL.....	114, 304
ERVEBO.....	111, 303	EVISTA.....	283, 304
ERWINASE.....	91	EVKEEZA.....	130
ERYPED.....	49, 303	EVOCLIN.....	55, 304
ERY-TAB.....	49, 303	EVOLUTION.....	150, 207, 304
ERYTHROCIN.....	49, 303	EVOMELA.....	77, 304
erythromycin.....	43, 49, 55, 303	EVOTAZ.....	99, 304
ERZOFRI.....	251	EVOXAC.....	107, 304
ESBRIET.....	277	EVRYSDI.....	278, 304
escitalopram.....	243, 303	EVUSHELD.....	100
ESGIC.....	15, 19, 303	EXEL.....	219, 224, 304
eslicarbazepine.....	137, 138, 139	EXELDERM.....	61, 304
esmolol.....	127, 303	EXELON.....	104, 304
ESMOLOL.....	127, 303	exemestane.....	80, 304
esomeprazole.....	186, 187, 303	exenatide.....	64
ESOMEPRAZOLE.....	186, 303	EXFORGE.....	123, 124, 304
ESPEROCT.....	112	EXJADE.....	280, 304
estazolam.....	256, 303	EXODERM.....	61, 304
ESTRACE.....	196, 303	EXONDYS.....	278, 304
estradiol.....	145, 146, 191, 192, 196, 197, 301, 303, 304, 310, 311, 314, 315	EXPAREL.....	31, 304
ESTRATEST.....	190, 303	EXTENCILLINE.....	50, 304
ESTRING.....	197, 303	EXTINA.....	62, 304
ESTROGEL.....	191	EXTRANEAL.....	177, 304
estrogen.....	190, 191, 303	EYSUVIS.....	162, 304
estrogens.....	191, 192	E-Z.....	156, 304, 310
eszopiclone.....	257, 303	EZ.....	150, 151, 204, 207, 214, 215, 219, 223, 231, 232, 304, 317
ethacrynate.....	158, 159, 303	ezetimibe.....	129, 132, 133, 304
ethacrynic.....	158, 303		

F

Index of Medications

FABHALTA.....	113, 304	FINACEA.....	263, 305
FABIOR.....	263, 304	finasteride.....	285, 305
FACTIVE.....	52	FINGERSTIX.....	215, 232, 305
famciclovir.....	100, 304	fingolimod.....	136
famotidine.....	184, 304	FINTEPLA.....	139, 305
FAMOTIDINE.....	184, 304	FIORICET.....	15, 19, 30, 305
FANAPT.....	251, 304	FIORINAL.....	15
FARESTON.....	92, 304	FIRAZYR.....	273
FARXIGA.....	68, 304	FIRMAGON.....	84, 305
FASLODEX.....	92, 304	FIRVANQ.....	54, 305
fat emulsions.....	185, 304	FLAGYL.....	45, 305
febuxostat.....	35, 304	FLAREX.....	162, 305
felbamate.....	139, 304	flecainide.....	115, 305
FELBATOL.....	139, 304	FLECTOR.....	259, 305
FELDENE.....	36, 304	FLEQSUVY.....	236, 305
felodipine.....	117, 304	FLOLAN.....	121, 278, 305, 317
FEMARA.....	80, 83, 304, 309	FLOLIPID.....	131, 305
FEMLYV.....	145	FLORIVA.....	167, 288
FEMRING.....	197, 304	FLOW.....	220, 305
fenofibrate.....	132, 133, 304	floxuridine.....	79, 305
FENOFIBRATE.....	132, 304	FLUAD.....	109
fenofibric.....	132, 304	FLUARIX.....	109
FENOGLIDE.....	132, 304	FLUBLOK.....	109, 110
fenoprofen.....	36, 37, 304	FLUCELVAX.....	110
FENOPROFEN.....	36, 304	fluconazole.....	60, 305
FENOPRON.....	36	flucytosine.....	60, 305
FENORTHO.....	36	fludarabine.....	79, 305
FENSOLVI.....	195	FLUDEOXYGLUCOSE.....	157, 305
fentanyl.....	23, 24, 25, 304	fludrocortisone.....	195
FENTANYL.....	23, 24, 25, 304	FLULAVAL.....	110
FERAHEME.....	172	FLUMADINE.....	100, 305
FERIVA.....	172	flumazenil.....	277
FERRALET.....	172	FLUMIST.....	110
FERRIC.....	170	flunisolide.....	161, 305
FERRIPROX.....	280, 304	fluocinolone.....	161, 265, 266, 305
FERRLECIT.....	172	fluocinonide.....	265, 267, 305
ferrous.....	172	fluorescein.....	155, 163, 295, 305, 319
ferumoxytol.....	172	FLUORESC EIN.....	163
FETROJA.....	48, 304	fluoride.....	167, 168, 171, 172, 174, 288, 289, 305, 322
FETZIMA.....	245, 304	FLUORIDEX.....	167, 171, 305
FEXMID.....	236, 304	FLUORIMAX.....	167, 171
FIASP.....	68, 209, 304	fluorometholone.....	162, 305
FIBRICOR.....	132, 304	FLUOROPLEX.....	93, 305
FIBRYGA.....	112, 304	fluorouracil.....	79, 93, 305
fidaxomicin.....	49	FLUOROURACIL.....	93, 305
FIFTY50.....	150, 215, 224, 232, 304	fluoxetine.....	243, 244, 255, 305
FILSPARI.....	133	fluphenazine.....	255, 305
FILSUVEZ.....	285, 304	flurazepam.....	256
FILTER.....	219, 220, 304	flurbiprofen.....	36, 162, 305

Index of Medications

flutamide.....	78, 305	FUSION.....	98, 172
fluticasone.....	40, 160, 161, 265, 305	FUZEON.....	98
FLUTICASONE.....	40, 41, 305	FYARRO.....	82
fluticasone propion/salmeterol.....	40, 305	FYCOMPA.....	139, 305
fluvastatin.....	131, 305	FYLNETRA.....	143
fluvoxamine.....	243, 305	G	
FLUZONE.....	110	gabapentin.....	137, 139, 141, 306
FML.....	162, 305	GABARONE.....	139, 306
FOCALIN.....	248, 305	GABLOFEN.....	236, 306
FOCINVEZ.....	180, 305	GADAVIST.....	154, 306
FOLATEXCEL.....	240	gadobutrol.....	155
folic.....	172, 173, 238, 239, 287, 288, 289, 305, 313, 318	gadoterate.....	154, 306
FOLLISTIM.....	197	gadoteridol.....	154
FOLOTYN.....	79, 305	GALAFOLD.....	281
fomepizole.....	277, 305	galantamine.....	104, 306
fondaparinux.....	56, 57, 305	GALLIUM.....	157
FONDIRCLE.....	207, 215, 232	GALZIN.....	280, 306
FORA.....	150, 153, 207, 215, 232, 305	GAMIFANT.....	198, 306
FORACARE.....	150, 207, 208, 215, 232, 305	ganciclovir.....	101, 306
FORFIVO.....	242, 305	GANCICLOVIR.....	101, 306
formoterol.....	39, 40, 41	ganirelix.....	195, 306
FORTAVIT.....	288	GANIRELIX.....	195, 306
FORTEO.....	283, 305	GARDASIL.....	111, 306
FORTISCARE.....	150, 208, 305	GASTROCROM.....	33, 306
FOSAMAX.....	283, 305	GASTROGRAFIN.....	156, 306
fosamprenavir.....	99, 305	GASTROMARK.....	156, 306
fosaprepitant.....	180, 305	gatifloxacin.....	43, 306
foscarnet.....	101, 305	GATTEX.....	188
FOSCAVIR.....	101, 305	GAVRETO.....	86, 306
fosfomycin.....	45, 305	GAZYVA.....	75, 306
fosinopril.....	122, 125, 305	GE100.....	150, 208, 306
fosphenytoin.....	138, 139, 305	GE333.....	150, 208, 306
FOSRENOL.....	170, 305	gefitinib.....	86
FOTIVDA.....	86	gelatin sponge.....	114, 306
FRAGMIN.....	57, 305	GELCLAIR.....	275
FRAICHE.....	167, 305	GELFILM.....	163
FREESTYLE.....	150, 208, 215, 224, 232, 305	GELFOAM.....	114, 306
FRINDOVYX.....	77	GEL-ONE.....	34, 306
FROVA.....	20	GELSYN.....	34
frovatriptan.....	20, 305	gemcitabine.....	79, 306
FRUZAQLA.....	86, 305	GEMCITABINE.....	79
FUL-GLO.....	155, 305	gemfibrozil.....	133, 306
FULPHILA.....	143, 305	GEMTESA.....	286, 306
fulvestrant.....	92, 305	GENOTROPIN.....	194, 306
FULVICIN.....	61, 305	GENSTRIP.....	150
FURADANTIN.....	49, 305	gentamicin.....	43, 44, 55, 306
FUROSCIX.....	158, 305	GENTAMICIN.....	44, 306
furosemide.....	158, 159, 305	GENVISC.....	34, 306
FUROSEMIDE.....	159, 305	GENVOYA.....	100

Index of Medications

Geodon.....	253	guanfacine	127, 247, 306
GEODON	251, 306	GUARDIAN.....	209, 306
GIAPREZA.....	196	GVOKE	168, 306
GILENYA	136	GYNAZOLE.....	60
GILOTRIF	86, 306	H	
GIMOTI.....	184	HADLIMA	73, 306
GIVLAARI.....	278	HAEGARDA.....	277, 306
GLASSIA	272, 306	HALAVEN.....	82, 306
glatiramer acetate.....	136, 306	halcinonide	265, 307
GLEEVEC	86, 306	HALCION.....	256, 307
GLEOSTINE	77, 306	halobetasol	265, 307
GLIADEL	77, 306	HALOG.....	265, 307
glimepiride.....	65, 66, 306, 318	haloperidol.....	255, 307
GLIMEPIRIDE	65, 306	HARMONY.....	151, 237
glipizide.....	65, 67, 306	HARVONI	102, 307
GLIPIZIDE.....	65	HEALON.....	166, 307
GLOPERBA	35, 306	HEALTHPRO.....	151, 209
glucagon	168, 306	HEALTHWISE.....	220, 224, 307
GLUCAGON	155, 168, 188, 306	HEALTHY	209, 215, 220, 232, 307
GLUCO	150, 208, 209	HECTOROL.....	275, 307
GLUCOCARD.....	150, 151, 208, 209, 306	HELIDAC	181
GLUCOCOM.....	151, 209, 215, 232, 306	HEMA	157
GLUCOTROL.....	65, 306	HEMABATE	195, 307
GLUMETZA	64	HEMADY.....	193, 307
GLUTOL.....	170	HEMANGEOL.....	127, 307
glyburide.....	65, 67, 306	HEMATRON.....	172
GLYATE.....	178, 306	HEMAX	172
glycerol.....	178	HEMICLOR	160, 307
glycine.....	72, 306	HEMLIBRA.....	113, 307
GLYCOPHOS.....	174, 306	HEMOCYTE.....	172, 307
glycopyrrolate	178, 306	HEMOFIL	112
GLYCOPYRRROLATE.....	178, 306	heparin.....	57, 58, 307
GLYNASE.....	65, 306	HEPARIN	56, 57, 58, 307
GLYXAMBI	66, 306	HEPLISAV.....	111, 307
GNP	151, 209, 224	HERCEPTIN	83, 307
GOCOVRI.....	95, 306	HERCESSI.....	83
GOJJI.....	151, 153, 209, 215, 232, 306	HERZUMA.....	83, 307
GOLYTELY	185, 306	HETLIOZ.....	256, 307
GOMEKLI	81, 306	HIBERIX	111, 307
GONAL-F	197	HISTATROL.....	156
GONITRO	119, 306	HISTEX.....	147
GOZELLIX.....	155	homatropine	147, 165, 307
GRALISE.....	137	HORIZANT	135, 307
granisetron.....	180, 306	HULIO.....	73, 307
GRANIX.....	143, 306	HUMALOG	68, 209, 307
GRASTEK	107, 306	HUMANA.....	151, 209
griseofulvin	61, 306	HUMATE	112
GUAIACOL	262	HUMATIN.....	70
GUAIFENESIN	148, 307	HUMATROPE	194, 307

Index of Medications

HUMIRA	73, 74, 307	IDHIFA	90, 307
HUMULIN	68, 69, 307	IFEX	77, 307
HYALGAN	34, 307	ifosfamide	77, 308
hyaluronate	166	IGLUCOSE	151, 209
HYCAMTIN	82, 307	IHEALTH	151, 209
HYCODAN	147, 307	ILARIS	284
hydralazine	127	ILEVRO	162, 308
HYDREA	77, 307	ILLUCCIX	155
hydrochlorothiazide	122, 124, 127, 128, 160, 295, 303, 305, 307, 308, 310, 311, 319, 327	ILUMYA	259, 308
hydrocodone	22, 23, 25, 26, 147, 307	ILUVIEN	162, 308
HYDROCODONE	22, 307	IMAAVY	281
hydrocodone/ibuprofen	23	imatinib	86, 308
hydrocort	42, 43, 265, 307, 314	IMBRUVICA	86, 308
hydrocortisone	42, 161, 183, 188, 192, 193, 264, 265, 266, 267, 307	IMDELLTRA	90, 308
hydrocortisone/acetic acid	161	IMFINZI	92, 308
hydrogen peroxide	258	imipenem	46, 308
hydromorphone	24, 25, 26, 307	imipramine	246, 308
HYDROMORPHONE	25, 26, 307	IMITREX	20, 308
hydroxychloroquine	71, 307	IMJUDO	92, 308
hydroxyprogesterone	197, 307	IMKELDI	86, 308
hydroxyurea	77, 307	IMLYGIC	81
hydroxyzine	63, 307	IMMPHENTIV	120
HYFTOR	200, 307	IMPAVIDO	71, 308
HYLENEX	282	IMPEKLO	266, 308
HYMOVIS	34, 307	IMPOYZ	266, 308
HYMPAVZI	113, 307	IMULDOSA	198, 308
hyoscyamine	181, 182, 307	IMURAN	201, 308
HYOSCYAMINE	182, 307	IMVEXXY	196
HYPER	278, 307	INBRIJA	95, 308
HYPERRHO	107, 307	INCONTROL	209, 215, 220, 232, 258, 261, 308
HYPODERMIC	219, 220, 307	INCRELEX	194
HYPOLANCE	209	INCRUSE	38, 308
hypromellose	166, 307	indapamide	160, 308
HYRIMOZ	74, 307	INDERAL	127, 308
HYSINGLA	26, 307	INDICLOR	157, 308
HYZAAR	124, 307	indium	156
I		INDIUM	154, 156, 308
ibandronate	283, 307	INDOCIN	36, 308
IBRANCE	86, 307	indocyanine	153, 308
IBSRELA	184	indomethacin	36, 128, 308
IBTROZI	86, 307	INDOMETHACIN	36
ibuprofen	23, 36, 128, 307	INFANRIX	111, 308
ibutilide	115, 307	INFASURF	272
icatibant	273	INFED	172
ICLUSIG	86, 307	INFINITY	151, 209
icosapent	177, 307	INFLECTRA	74, 308
IDACIO	74, 307	INFLIXIMAB	74
IDAMYCIN	75, 307	INFUGEM	79, 308
idarubicin	75, 307	INFUMORPH	26

Index of Medications

INFUVITE	288, 308	ISOPROPYL	72, 282
INGREZZA	135, 308	isoproterenol	106, 308
INJECT	20, 103, 215, 232, 308	ISORDIL	119, 308
INJECTAFER	172	isosorbide	119, 129, 308
INLEXZO	79	isosulfan	155, 308
INLYTA	86, 308	isotretinoin	259, 308
INNOPRAN	127, 308	ISOVUE	154, 308
INPEFA	274	isoxsuprine	129
INPEN	209, 308	isradipine	117, 309
INQOVI	79, 308	ISTALOL	164, 309
INREBIC	86, 308	ISTODAX	76, 309
INSPRA	159, 308	ISTURISA	188, 309
INSTACLEAN	282	ITOVEBI	86, 309
INSUL	209, 224, 227, 228	itraconazole	60, 309
INSULIN	64, 65, 67, 69, 194, 220, 222, 223, 224, 225, 226, 227, 228, 229, 230, 275, 308	ivabradine	119, 309
INSUPEN	220, 308	ivermectin	71, 263, 309
INTEGRA	172, 220, 308	IVRA	77
INTELENCE	98, 308	IWILFIN	86, 309
INTRALIPID	185, 308	IXEMPRA	81, 309
INTRAROSA	189	IYUZEH	164, 309
INTUNIV	247	IZERVAY	166
INVACARE	215, 232, 308	J	
INVEGA	251, 308	JADENU	280, 309
INVELTYS	162, 308	JAKAFI	81, 309
INVOKAMET	67, 308	JALYN	285, 309
INVOKANA	68, 308	JANSSEN	108, 309
INZIRQO	160, 308	JANUMET	66, 309
iodine	172, 267, 308	JANUVIA	65, 309
iodixanol	154	JARDIANCE	68, 309
IODOFLEX	267, 308	JATENZO	189, 309
IODOPEN	172, 308	javygtor	281, 309
IODOSORB	267, 308	JAYPIRCA	87
IONOSOL	171, 308	JEMPERLI	89
iopamidol	154	JENTADUETO	66, 309
IOPIDINE	164, 308	JEVTANA	91, 309
IPOL	109, 308	JIVI	112
ipratropium	38, 40, 161, 308	JOBEVNE	76
IQIRVO	275	JOENJA	272, 309
irbesartan	124, 125, 126, 308	JORNAY	248, 309
IRESSA	86, 308	JOURNAVX	19, 309
irinotecan	82, 308	JUBBONTI	283, 309
iron	145, 146, 172, 173, 238, 239, 287, 288, 313, 318	JUBLIA	62, 309
IROSPAN	173	JULUCA	97
ISENTRESS	99	JUST	167, 171
isoflurane	30, 308	JUST RIGHT	167
ISOLYTE	171, 308	JUXTAPID	130, 309
isoniazid	45, 308	JYLAMVO	79
ISOPROPANOL	282	JYNARQUE	159, 309
isopropyl	282, 308		

Index of Medications

JYNNEOS	111, 309	KOATE	112
K		KOGENATE	112
KABIVEN	169, 309	KOMBIGLYZE	66, 309
KADCYLA	90, 309	KONVOMEPE	186, 309
KALBITOR	273	KORLYM	67, 309
KALETRA	99, 309	KOSELUGO	81, 82, 309
KALYDECO	271, 309	KOSHER	237
KANJINTI	83, 309	KOVALTRY	112
KANUMA	280	K-PHOS	177, 309
KAPSPARGO	127, 309	KRAZATI	81, 309
KAPVAY	247	KRINTAFEL	71, 309
KARBINAL	63, 309	KRISTALOSE	185, 309
KATERZIA	117, 309	KRO	226
KAZANO	66, 309	KROGER	226
KCENTRA	113, 309	KRYSTEXXA	35, 309
KENALOG	193, 266, 309	KUVAN	281, 310
KENDALL	175, 309	KYLEENA	146, 310
KEPIVANCE	188	KYPROLIS	87, 310
KEPPRA	139, 309	KYXATA	77
KERENDIA	160, 309	KYZATREX	189, 310
KESIMPTA	136, 309	L	
KETALAR	30, 309	labetalol	123, 310
ketamine	30, 309	LABELALOL	123, 310
KETAMINE HCL-0.9% NACL	30	LABSTIX	157
KETO	153, 157	lacosamide	139, 142, 143
ketoconazole	60, 62, 309	LACRISERT	161
KETONE	153, 157, 207, 209, 211	lactulose	178, 185, 310
ketoprofen	36, 37, 309	LAMICTAL	139, 140, 310
ketorolac	22, 161, 162, 309	lamivudine	97, 98, 102, 292, 310
KETOSTIX	157	lamotrigine	139, 140, 310
KEVEYIS	276, 309	LAMPIT	71, 310
KEVZARA	200, 309	LAMZEDE	280
KEYTRUDA	89, 309	lancets	215, 310
KHAPZORY	273, 309	LANCING	202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213
KHINDIVI	193, 309	LANOXIN	118, 310
KIMMTRAK	81	lanreotide	196
KIMYRSA	49	LANREOTIDE	196, 310
KINEVAC	182	lansoprazole	181, 186, 187, 310
KINRAY	226	lansoprazole/amoxicilin/clarith	181
KINRIX	111, 309	lanthanum	170, 310
KIRSTY	69, 309	LANTUS	69, 310
KISQALI	83, 87, 309	LANZO	209
KISUNLA	134, 309	lapatinib	87, 89, 310
KITABIS	44, 309	LASIX	159, 310
KLARON	260, 309	latanoprost	164, 165, 310
KLISYRI	93, 309	LATUDA	251, 252, 310
KLONOPIN	137, 309	LAZANDA	26, 310
KLOXXADO	59	LAZCLUZE	87
KMART	226	LEADER	226

Index of Medications

LEDIPASVIR.....	102, 310	LILETTA.....	146, 310
leflunomide.....	34	linagliptin.....	66
LEMTRADA.....	136, 310	LINCOCIN.....	48, 310
lenalidomide.....	83, 310	lincomycin.....	48, 310
LENTOCILIN.....	50, 310	lindane.....	94
LENVIMA.....	87, 310	linezolid.....	50, 310
LEQEMBI.....	134, 310	LINEZOLID.....	50
LEQVIO.....	130	LINZESS.....	184
LESCOL.....	131, 310	LIORESAL.....	236, 310
LETAIRIS.....	120, 310	liothyronine.....	269, 270, 271, 310
letrozole.....	80, 310	LIPIODOL.....	155, 310
leucovorin.....	273, 310	LIPITOR.....	131, 310
LEUKERAN.....	77, 310	LIPOFEN.....	133, 310
LEUKINE.....	144, 310	LIQUID.....	24, 156, 310
leuprolide.....	84, 310	liraglutide.....	64
LEUPROLIDE.....	84, 310	lisdexamfetamine.....	247, 310
levabuterol.....	39, 310	lisinopril.....	122, 125, 310
LEVALBUTEROL.....	39	lissamine green.....	155
LEVAMLODIPINE.....	117	LITE.....	150, 203, 208, 209, 215, 220, 226, 227, 232, 310
LEVBID.....	182, 310	LITETOUCH.....	227, 310
LEVEMIR.....	69, 310	lithium.....	241, 311
levetiracetam.....	139, 140, 310	LITHOBID.....	241, 311
LEVETIRACETAM.....	140	LITHOSTAT.....	178, 311
levobunolol.....	164, 310	LIVALO.....	131, 311
levocarnitine.....	282, 283, 310	LIVDELZI.....	275
levocetirizine.....	63	Livmarli.....	184
levofloxacin.....	43, 52, 310	LIVTENCITY.....	101, 311
levoleucovorin.....	273, 310	LOCAMETZ.....	155
levonorgest.....	145, 310	LOCOID.....	266, 311
levonorgestrel.....	146, 310	LODINE.....	37, 311
LEVOPHED.....	106, 310	LODOCO.....	272
levorphanol.....	26	LODOSYN.....	96
levothyroxine.....	269, 270, 271, 310	LOESTRIN.....	146, 311
LEVOTHYROXINE.....	269, 270	lofedidine.....	285
LEVSIN.....	182, 310	LOKELMA.....	170, 311
LEVULAN.....	93, 310	LO LOESTRIN.....	146, 311
LEXAPRO.....	243, 310	LOMOTIL.....	179, 311
LEXISCAN.....	153, 310	lomustine.....	77
LIALDA.....	183, 310	LONSURF.....	79, 311
LIBERVANT.....	137, 310	loperamide.....	179, 311
LIBRAX.....	178, 310	LOPID.....	133, 311
LIBTAYO.....	89, 310	lopinavir.....	99, 311
LICART.....	259, 310	LOPRESSOR.....	127, 311
lidocaine.....	31, 32, 33, 115, 155, 188, 267, 310	LOPROX.....	62, 311
LIDOCAINE.....	31, 175, 188, 296, 310	LOQTORZI.....	89, 311
LIDOCAN.....	33, 310	lorazepam.....	240, 241, 256, 311
LIDODERM.....	33	LORBRENA.....	87, 311
LIFESHIELD.....	220, 310	LOREEV.....	241, 311
LIKMEZ.....	45, 310	LORTAB.....	22, 311

Index of Medications

LORZONE	236, 311	manganese	173, 311
losartan	124, 125, 126, 311	mannitol.....	159, 283, 311, 329
LOTEMAX.....	162, 311	MAR.....	148
LOTENSIN.....	122, 125, 311	maraviroc	98
loteprednol.....	161, 162, 311	MARCAINE	32, 311
LOTREL.....	122	MARINOL.....	179
LOTRONEX	185	MARNATAL	237
lovastatin.....	131, 311	MATERNACEL	240
LOVAZA.....	177, 311	MATERVIA	240
LOVENOX	58, 311	MATULANE.....	91, 311
loxapine.....	254	MAVENCLAD	136, 311
lubiprostone.....	185, 311	MAVYRET	102
LUCEMYRA	285	MAXALT.....	20, 311
LUCENTIS.....	165, 311	MAXI.....	147, 227
LULICONAZOLE.....	62, 311	MAXICOMFORT	220, 227, 311
LUMAKRAS.....	81	MAXIDEX.....	162, 311
LUMASON.....	155, 311	MAXITROL	43
LUMIGAN.....	164, 311	MAXI-TUSS CD	147
LUMIZYME.....	280, 311	MAYZENT	136, 311
LUMRYZ.....	256, 311	meclizine.....	180
LUNESTA.....	257, 311	MECLIZINE.....	180
LUNSUMIO	90, 311	meclofenamate.....	37, 312
LUPKYNIS	201, 311	MEDI-FIRST.....	72
LUPRON.....	84, 194, 195, 311	MEDIHONEY.....	264, 312
lurasidone	251, 252, 311	MEDISENSE	209, 215, 232, 312
LUTATHERA.....	274, 311	MEDLANCE.....	215, 232, 233, 312
LUTRATE	84	MEDROL	192, 193, 300, 312, 322
LUZU.....	62, 311	MEDROLOAN	193, 312
LYBALVI	252	medroxyprogesterone	145, 196, 312
LYMEPAK	53	MEDTRONIC.....	209
LYMPHAZURIN	155, 311	mefenamic.....	22, 312
LYNOZYFIC.....	90	mefloquine.....	71, 312
LYNPARZA	87, 311	megestrol.....	93, 287, 312
LYRICA	140, 284, 311	MEKINIST.....	82, 312
LYSODREN	91, 311	MEKTOVI.....	82, 312
LYTGOBI	87, 311	meloxicam	37, 38, 312
LYUMJEV	69, 311	MELOXICAM.....	37
LYVISPAH.....	236, 311	melphalan.....	76, 77, 312
M		memantine	133, 134, 312
MACROBID	49, 311	MEMBRANEBLUE	166, 312
mafenide.....	56, 311	MENACTRA.....	109, 312
MAGELLAN.....	227, 311	MENEST.....	191, 312
MAGNEBIND.....	170	MENOPUR.....	197
magnesium.....	173, 186, 187, 311	MENOSTAR.....	191, 312
MAGNESIUM	173, 311	MENQUADFI.....	109, 312
MAGNEVIST.....	154, 311	MENVEO.....	109, 312
MAKENA.....	197, 311	meperidine.....	26, 312
MALARONE	71, 311	MEPHYTON	290, 312
malathion.....	94, 311	mepivacaine.....	32, 312

Index of Medications

meprobamate	241, 312	metronidazole.....	45, 53, 54, 263, 312
MEPRON.....	71, 312	METRONIDAZOLE	45
MEPSEVII.....	280, 312	metronidazole/sodium chloride.....	45
mercaptapurine	79, 80, 312	metyrosine	126
MERIOLOG.....	69, 312	mexiletine	115, 312
meropenem	46, 312	MIACALCIN.....	198, 312
MEROPENEM.....	46, 312	micafungin.....	61, 312
mesalamine	182, 183, 312	MICAFUNGIN-0.9% NACL	61
MESNEX.....	273, 312	MICARDIS.....	124, 126, 312
MESTINON.....	104, 312	miconazole.....	60
METADATE.....	248, 312	MICONAZOLE	62, 312
metaxalone.....	236, 237, 312	MICORT.....	266
METAXALONE.....	236	MICRO	148, 151, 152, 204, 212, 215, 222, 233, 268, 312
metformin.....	64, 65, 66, 67, 312, 318	MICRODOT.....	151, 210, 312
METFORMIN.....	65, 66, 67, 312	MICROLET.....	210, 216, 233, 312
methadone	26, 312	MICROTAINER.....	214, 231, 233, 312
METHADONE.....	26	midazolam	31, 312
methamphetamine	104, 105, 312	MIDAZOLAM	31
METHAVER	289	midodrine	105, 312
methazolamide.....	158, 312	MIEBO.....	161
methenamine	45, 312	MIFEPREX.....	276
methimazole.....	269, 312	mifepristone.....	67, 276, 312
METHITEST	189, 312	miglitol.....	64, 312
methocarbamol	237, 312	miglustat.....	278, 279, 312
METHOCARBAMOL.....	237	MIGRANAL	20, 312
methohexital.....	30	milrinone.....	119, 312
METHOHEXITAL.....	30, 312	MINI73, 149, 152, 203, 205, 207, 210, 211, 212, 214, 218, 220, 222, 231, 235, 240, 302, 313	
methotrexate	79, 80, 312	MINIMED.....	210, 227, 313
methoxsalen	259, 312	MINIPRESS	123, 313
methscopolamine.....	182, 312	MINIVELLE.....	191, 313
methsuximide.....	138, 140	MINOCIN	53, 313
methyl.....	262	minocycline.....	53, 313
methyl dopa.....	127, 312	MINOCYCLINE	53, 313
methyl dopate	127, 312	MINOLIRA.....	53, 313
methylene.....	276, 312	minoxidil	127
METHYLENE.....	276	MIOCHOL.....	164, 313
methylergonovine	195, 312	MIPLYFFA.....	279
METHYLERGONOVINE.....	195	mirabegron	286, 313
METHYLIN	248, 312	MIRCERA	143, 313
methylphenidate	247, 248, 249, 250, 312	MIRENA	146, 313
METHYLPHENIDATE	249, 312	mirtazapine.....	240, 313
methylprednisolone	193, 312	misoprostol	35, 36, 180, 181, 301, 313
methyltestosterone.....	189, 312	MITIGARE.....	35, 313
metoclopramide	184	MITIGO	27, 313
metolazone	160, 312	mitomycin.....	75, 313
METOPIRONE.....	156, 312	MITOSOL.....	166
metoprolol	127, 128, 312	mitoxantrone	91, 313
METROCREAM.....	263, 312	MIUDELLA.....	146
METROGEL	263, 312	M-M-R.....	111, 313

Index of Medications

MNEXSPIKE	108	MYDRIACYL.....	165, 313
MOBILE.....	207, 216, 233, 313	Myfembree.....	194
modafinil.....	255	MYFORTIC	201, 313
MODERNA.....	108, 313	MYGLUCOHEALTH	151, 210, 216, 233, 313
moexipril.....	125, 313	MYHIBBIN	201, 313
molindone.....	255	MYLERAN.....	77, 313
mometasone.....	161, 266, 313	MYLOTARG	83, 313
MONJUVI.....	81, 313	mynatal.....	238
MONOFERRIC	173	MYOBLOC	106, 313
MONOJECT	220, 227, 313	MYOVIEW.....	153
MONOLET.....	216, 233, 313	MYRBETRIQ.....	286, 313
MONOVISC	34, 313	MYSOLINE.....	140, 313
MONSEL'S.....	114, 313	MYTESI.....	179
montelukast.....	42, 313	N	
morphine	27, 28, 313	nabumetone	37, 313
MORPHINE	27, 28	nadolol.....	128, 313
MOTEGRITY.....	184	nafcillin.....	50, 313
MOTOFEN	179, 313	naftifine.....	62, 313
MOTPOLY.....	140, 313	NAFTIN.....	62, 313
MOUNJARO.....	64	NAGLAZYME	280, 313
MOVANTIK.....	59	nalbuphine.....	28
MOVIPREP.....	185, 313	NALFON.....	37, 314
MOXATAG.....	50, 313	NALMEFENE.....	59
moxifloxacin.....	43, 44, 51, 52, 313	NALOCET	22, 314
MOXIFLOXACIN	43, 52, 313	naloxone.....	29, 59, 285, 314, 317
Mozobil	145	naltrexone.....	59, 314
MOZOBIL	145, 313	NAMENDA.....	133, 314
MRESVIA	111	NAMZARIC	133, 134, 314
MS.....	28, 227, 313	NANO	220, 222, 239, 314
MS CONTIN.....	28, 313	NAPRELAN	37
MULPLETA.....	144, 313	NAPROSYN.....	36, 37, 302, 314
MULTAQ.....	115, 313	naproxen	21, 36, 37, 314
MULTI.....	148, 203, 209, 210	naratriptan	20, 314
MULTIHANCE.....	154, 313	NARCAN	59, 314
MULTISTIX.....	157, 158	NAROPIN	32, 314
multivit.....	288, 289, 313	NATACHEW.....	238
MULTRYS.....	173	NATACYN.....	59
mupirocin.....	55, 313	NATAL.....	237, 238, 239, 240
MURI-LUBE	282, 313	NATAZIA	146, 314
MUSE.....	274, 313	nateglinide.....	65, 314
mv.....	172, 173, 288, 313	NATESTO.....	189, 314
MVASI.....	76	NATROBA.....	94, 314
mvn.....	287, 288, 313	NAYZILAM.....	137, 314
MYALEPT	197	neбиволol	127, 128
MYCAMINE.....	61, 313	NEBUPENT.....	71, 314
MYCAPSSA.....	196, 313	nebusal.....	278, 314
MYCOBUTIN	45	NEBUSAL.....	278, 314
mycophenolate.....	201, 313	NEEDLES.....	218, 219, 220, 221, 222, 314
MYDAYIS	105, 313	NEEVODHA.....	288

Index of Medications

nefazodone	244	nilotinib	87, 88
NEFFY	103	NILOTINIB	87
nelarabine	78, 80	nilutamide	78, 314
NEMBUTAL	256, 314	NIMBEX	106, 314
NEMLUVIO	200	nimodipine	117, 314
NEOMATERNA	240	NINJACOF	148
neomycin	42, 43, 44, 258, 314	NINLARO	87, 314
NEONATAL	173, 238, 281	NIPENT	80, 314
NEOPROFEN	128, 314	nisoldipine	117, 314
NEORAL	201, 314	nitazoxanide	93, 314
neostigmine	103, 104, 314	NITHIODOTE	280, 314
NEOSTIGMINE	104, 314	nitisinone	279, 314
NEO-SYNALAR	55	NITRO	119, 314
NEPHRON	289	nitrofurantoin	49, 50, 314
NERLYNX	87, 314	NITROFURANTOIN	49
NESACAINE	32, 314	nitroglycerin	119, 186, 314
NESINA	65, 314	NITROLINGUAL	119, 314
NESTABS	238, 288	NITROMIST	119, 314
NETSPOT	155, 314	nitroprusside	126
neuac	260, 314	NITROSTAT	119, 314
NEUAC	260, 314	NITYR	279, 314
NEULASTA	144, 314	NIVA	288, 289
NEULUMEX	156, 314	NIVESTYM	144, 314
NEUPOGEN	144, 314	nizatidine	184, 314
NEUPRO	95, 314	NOCTIVA	190, 314
NEURONTIN	141, 314	NOKOR	220, 314
NEUTEK	151	NORDITROPIN	194, 314
NEVANAC	162, 314	norelgestromin	146, 314
nevirapine	98, 314	norepineph	106
NEXAVAR	87, 314	NOREPINEPH	106, 284
NEXICLON	127	norepinephr	106
NEXIUM	186, 187, 314	NOREPINEPHR	106
NEXLETOL	130, 314	norepinephrine	106, 315
NEXLIZET	130, 314	NOREPINEPHRINE	106, 242, 244, 245, 315
NEXPLANON	145	noreth	146, 315
NEXTERONE	115, 314	norethin	146, 192, 315
NEXTSTELLIS	146	norethind	146, 191, 315
NEXVIAZYME	280	norethindrone	146, 191, 196, 315
NGENLA	194, 314	NORGESIC	237, 315
niacin	133, 314	norgestimate	146, 315
NIACOR	133, 314	norgestrel	146, 315
nicardipin	117	NORITATE	263, 315
NICARDIPIN	117, 314	NORLIQVA	117, 315
nicardipine	116, 117, 314	NORMOSOL	171, 315
NICARDIPINE	117, 314	NORPACE	115, 315
NICOTROL	269, 314	Nothera	105
nifedipine	117, 314	NORTHERA	105, 315
NIKTIMVO	200	nortriptyline	246, 315
NILANDRON	78, 314	NORVASC	117, 315

Index of Medications

NORVIR.....	99, 315	OFEV.....	272
NOURIANZ.....	95, 315	OFIRMEV.....	19
NOVA.....	151, 210, 216, 233, 315	ofloxacin.....	42, 43, 52, 315
NOVAMAX.....	153, 210	OGIVRI.....	83, 315
NOVAREL.....	197, 315	OGSIVEO.....	87, 315
NOVAVAX.....	108, 315	OHTUVAYRE.....	42
NOVOEIGHT.....	112	OJEMDA.....	81, 315
NOVOFINE.....	220, 315	OJJAARA.....	87, 315
NOVOLIN.....	70	olanzapine.....	252, 253, 255, 315
NOVOLOG.....	70, 209, 315	OLINVYK.....	28
NOVOPEN.....	210, 315	olmesartan.....	123, 124, 125, 126, 315
NOXAFIL.....	60, 315	olmesartan/amlodipin/hcthiazyd.....	123
NPLATE.....	144, 315	olopatadine.....	63, 160, 315
NUBEQA.....	78, 315	OLPRUVA.....	178
NUCALA.....	41, 315	OLUMIANT.....	35, 315
NUCORT.....	266, 315	OLUX.....	266, 315
NUCYNTA.....	28, 315	om-3.....	288
NUEDEXTA.....	135	OMECLAMOX.....	181, 315
NULEV.....	182, 315	omega.....	177, 238, 315
NULIBRY.....	279	OMEGAVEN.....	185, 315
NULOJIX.....	201, 315	omeprazole.....	187, 315
NUMOISYN.....	275	OMIDRIA.....	163
NUPLAZID.....	242	OMNARIS.....	161, 315
NURTEC.....	20, 315	OMNIPAQUE.....	154, 315
NUTRILIPID.....	185, 315	OMNIPOD.....	210, 315
NUTROPIN.....	194, 315	OMNISCAN.....	154, 315
NUVARING.....	145, 315	OMNITROPE.....	194, 315
NUVAXOVID.....	108	OMVOH.....	199, 315
NUVESSA.....	54, 315	ONAPGO.....	95, 315
NUVIGIL.....	255	ON CALL.....	151, 210, 216, 233, 315
NUWIQ.....	112	ONCASPAR.....	92, 315
NUZYRA.....	53, 315	ondansetron.....	180, 315
NYMALIZE.....	117, 315	ONDANSETRON.....	180, 315
NYPOZI.....	144, 315	ONETOUCH.....	151, 210, 211, 216, 233, 315
nystatin.....	61, 62, 315	ONEXTON.....	260, 316
NYVEPRIA.....	144, 315	ONFI.....	137, 316
O		ONGENTYS.....	95, 316
OB.....	238, 239, 240, 287, 288	ONGLYZA.....	65, 316
OBREDON.....	148, 315	ONIVYDE.....	82, 316
OBSTETRIX.....	238, 315	ON-THE-GO.....	216, 233, 316
OBTREX.....	238, 315	ONTRUZANT.....	83, 316
OCALIVA.....	183	ONUREG.....	80, 316
OCREVUS.....	136, 315	ONZETRA.....	20, 316
OCTREOSCAN.....	156, 315	OPDIVO.....	89, 316
octreotide.....	196, 315	OPDUALAG.....	90
OCUFLOX.....	43, 315	OPFOLDA.....	278
ODACTRA.....	107, 315	OPIPZA.....	254, 316
ODEFSEY.....	100, 315	opium.....	28, 179, 316
ODOMZO.....	81, 315	OPSUMIT.....	120, 316

Index of Medications

OPSYNVI.....	122
OPTIRAY.....	154, 316
OPTISON.....	153, 316
OPTIUM.....	151
OPTUMRX.....	151, 211, 316
OPVEE.....	59, 316
OPZELURA.....	267
ORABLOC.....	32, 316
ORACEA.....	53, 316
ORACIT.....	177, 316
ORALAIR.....	107, 316
ORAMAGICRX.....	275, 316
ORAPRED.....	193, 316
ORAVIG.....	60
ORBACTIV.....	49, 316
ORENCIA.....	34, 316
ORENITRAM.....	121, 316
Orfadin.....	279
ORFADIN.....	279, 316
ORGOVYX.....	84, 316
ORIAHNN.....	194
ORLISSA.....	195, 316
ORKAMBI.....	271, 316
ORLADEYO.....	273
orphenadrine.....	237, 316
ORSERDU.....	92
ORTHOVISC.....	34, 316
oseltamivir.....	101, 316
OSENI.....	64, 316
OSENVELT.....	283, 316
osmitrol.....	159, 316
OSMITROL.....	159, 316
OSMOPREP.....	185, 316
OSPHENA.....	276
OTEZLA.....	34, 316
OTOVEL.....	42, 316
OTULFI.....	198, 316
OVACE.....	261, 316
OVAL.....	211, 316
OVIDE.....	94, 316
oxacillin.....	50, 316
oxaliplatin.....	77, 316
oxandrolone.....	189, 316
oxaprozin.....	36, 37, 316
OXAPROZIN.....	37, 316
OXAYDO.....	28, 316
oxazepam.....	241, 316
OXBRYTA.....	113, 316
oxcarbazepine.....	141, 142, 316
OXERVATE.....	166
oxiconazole.....	62, 316
OXISTAT.....	62, 316
OXLUMO.....	281
OXTELLAR.....	141, 316
oxybutynin.....	287, 316
OXYBUTYNIN.....	287
oxycodone.....	22, 28, 29, 307, 316
OXYCODONE.....	29, 316
OXYCONTIN.....	29
oxymorphone.....	29
OXYTOCIN.....	195, 316
OXYTROL.....	287, 316
OZEMPIC.....	64, 316
OZOBAX.....	237, 316
OZURDEX.....	162, 316
P	
pacerone.....	115, 316
paclitaxel.....	91, 92, 316
PADCEV.....	90, 316
PALFORZIA.....	107, 316
paliperidone.....	251, 252, 316
palonosetron.....	180, 316
PALYNZIQ.....	107, 316
PAMELOR.....	246, 316
pamidronate.....	283, 316
PANCREAZE.....	186
pancuronium.....	106, 316
PANDEL.....	266, 316
PANHEMATIN.....	272
PANRETIN.....	93
pantoprazole.....	187, 317
PANTOPRAZOLE.....	187, 317
papaverine.....	129
PARADIGM.....	227, 317
PARAGARD.....	147, 317
PAREMYD.....	165, 317
parenteral.....	170, 317
paricalcitol.....	275, 276, 317
PARICALCITOL.....	276, 317
PARNATE.....	242, 317
paroxetine.....	243, 244, 279, 317
PARSABIV.....	277, 317
PASER.....	45, 317
PATANASE.....	160, 317
PAXIL.....	244, 317
PAXLOVID.....	100
pazopanib.....	87, 89, 317
ped.....	288

Index of Medications

pedi	288, 289	phenelzine	242, 317
PEDIARIX	111, 317	PHENERGAN	63, 317
PEDITRACE	173, 317	phenobarb	181, 182, 317
PEDMARK	273	phenobarbital	256, 317
PEDVAXHIB	111, 317	PHENOBARBITAL	182, 317
peg3350	185, 317	phenoxybenzamine	105
PEGASYS	102	phentolamine	105
PEMAZYRE	87, 317	phenylephrine	62, 120, 163, 317
pemetrexed	78, 80	PHENYLEPHRINE	120, 317
PEMETREXED	80	phenylephrine hcl/prometh hcl	62
PEMFEXY	80	PHENYTEK	141, 317
PEMRYDI	80, 317	phenytoin	138, 141, 317
PENBRAYA	109, 317	PHESGO	83, 317
penciclovir	103	PHEXX	145
penicillin	50, 51, 317	PHEXXI	145, 317
PENICILLIN	50, 51, 70, 317	PHOSPHOLINE	164, 317
PENMENVY	109	PHOTOFRIN	92, 317
PENTACEL	111, 317	PHOXILLUM	177, 317
PENTAM	71, 317	PHYSIOLYTE	258, 317
pentamidine	71, 317	PHYSIOSOL	258, 317
PENTASA	183	physostigmine	104
pentazocine	29, 317	phytonadione	290, 317
PENTETATE	281, 317	PHYTONADIONE	290, 317
PENTIPS	218, 220, 222	PIASKY	113, 317
pentobarbital	256, 317	PIFELTRO	98, 317
pentoxifylline	114	pilocarpine	107, 164, 165, 317
PEPCID	184, 317	pimecrolimus	200, 317
perampanel	139, 141	pimozide	250
PERCOCET	22, 317	pindolol	128, 317
PERFECT	216, 220, 233	pioglitazone	66, 67, 317, 318
PERFOROMIST	39	PIP	151, 211, 216, 221, 233, 318
PERIDEX	274, 317	piperacil	51
PERIKABIVEN	170, 317	PIPERACIL	51
perindopril	125, 317	PIPERACILLIN	51, 318
perit	177, 317	PIQRAY	87, 318
periton	177, 317	pirfenidone	277, 318
PERJETA	83, 317	PIRFENIDONE	277
permethrin	94, 317	piroxicam	36, 37, 318
perphenazine	246, 255, 317	pitavastatin	131, 318
perphenazine/amitriptyline hcl	246	PITOCIN	195, 318
PERSERIS	252, 317	PLAQUENIL	71, 318
PERTZYE	186	PLASMA	107, 171, 273, 318
PFIZER	108, 317	PLATINUM	148, 151, 203
PH 12	278, 317	PLAVIX	96, 318
PHARMABASE	263, 317	PLEGISOL	118, 318
PHARMACIST	151, 211	PLEGRIDY	136, 318
PHASEAL	220	PLENAMINE	170, 318
PHEBURANE	178, 317	PLENVU	185, 318
phenazopyridine	33, 317	plerixafor	145

Index of Medications

PLEXION	56	PREGEN	238
PNEUMOVAX	109	PREGENNA	240
pnv	238, 318	PREHEVBRIO.....	111
PNV	240	PREMARIN.....	192, 197, 318
pnv19	238	PREMIER.....	152, 211, 238
pnv81	238	PREMIUM.....	150, 152, 207, 211
podofilox	262, 263, 318	PREMPHASE.....	192, 318
POGO.....	211, 233	PREMPRO	192, 318
POKONZA	174, 318	PRENATA.....	238
POLIBAR.....	156, 310, 318	prenatal.....	7, 238, 239, 291, 318
POLIVY	90, 318	PRENATAL.....	237, 238, 239, 240, 318
POLOCAINE.....	32, 318	PRENATE.....	239, 240, 288
POLY	147, 221, 289, 290, 318	PREPIDIL.....	195, 318
polyethylene	282	PRESSURE.....	163, 164, 165, 216, 233, 318
polymyxin	42, 43, 51, 295, 314, 318	PRESTALIA.....	122, 318
POLY-TUSSIN AC.....	147	PRESTO	148, 203, 211, 213
POMALYST.....	83, 318	PRETOMANID	46, 318
POMBILITI.....	280, 318	PREVACID	187, 318
PONVORY	136	PREVENT	221, 318
PORTRAZZA.....	83, 318	PREVIDENT.....	167, 171, 172, 318
posaconazole	60, 318	PREVNAR.....	109
POSFREA	180, 318	PREVYMIS	101, 318
POSIMIR	32	PREZCOBIX.....	97, 318
potassium ...20, 22, 50, 51, 125, 126, 167, 172, 174, 175, 177, 185, 267, 293, 301, 308, 318, 322		PREZISTA	97, 318
POTASSIUM	118, 159, 160, 174, 175, 176, 186, 318	PRIALT	19, 318
POTELIGEO.....	90, 318	PRIFTIN	46, 318
PRADAXA	58, 59, 318	PRILOSEC	187, 318
PRALATREXATE	80	PRIMACARE.....	239
PRALIDOXIME	277	primaquine	71
PRALUENT	130, 318	PRIMAQUINE.....	71
pramipexole	95, 318	PRIMAXIN.....	46, 318
PRAMOSONE.....	267, 318	primidone	140, 141, 318
prasugrel	96, 318	PRIMIDONE	141
PRAXBIND	114	PRIMLEV.....	22, 318
prazosin.....	123, 318	PRIMSOL	45, 318
PRECEDEX.....	257, 318	PRIORIX	111
PRECISION	150, 151, 152, 153, 208, 211, 219, 224, 318	PRISMASOL.....	177, 318
PRECISIONGLIDE	220, 221, 318	PRISTIQ.....	245, 318
PRECOSE	64, 318	PRO149, 150, 152, 166, 191, 193, 204, 206, 207, 211, 213, 216, 218, 219, 221, 227, 229, 230, 233, 235, 258, 261, 262, 318, 319	
PRED.....	162, 318	PROAIR	39
PRED FORTE.....	162, 318	probenecid.....	38, 318
prednicarbate	266, 318	procainamide	115, 318
prednisolone	43, 162, 193, 318	PROCAINAMIDE	115
prednisone	193, 318	PROCARDIA	117, 319
PREF	227	prochlorperazine.....	179, 180, 319
PREFERRED.....	227	PROCORT	183, 188, 319
PREFPLS	227	PROCRT.....	143, 319
pregabalin.....	140, 141, 284, 318	PROCTOFOAM	183, 188, 319

Index of Medications

PROCYSBI.....	286, 319	QBRELIS.....	125, 319
PRODIGY.....	152, 211, 216, 228, 233, 319	QBREXZA.....	264
progesterone.....	196, 197, 319	QELBREE.....	250, 319
PROGLYCEM.....	168, 319	QFITLIA.....	113, 319
PROGRAF.....	201, 202, 319	QINLOCK.....	87, 319
PROHANCE.....	154, 319	QLOSI.....	164, 319
PROLASTIN.....	272, 319	QNASL.....	161, 319
prolate.....	22	QTERN.....	66, 319
PROLATE.....	22	QUADRACEL.....	111, 319
PROLENSA.....	162, 319	QUAZEPAM.....	256, 319
PROLEUKIN.....	92, 319	QUDEXY.....	141, 319
PROLIA.....	283, 319	QUELICIN.....	106, 319
PROMACTA.....	144, 319	QUESTRAN.....	132
promethazine.....	63, 147, 180, 319	quetiapine.....	252, 253, 319
PROMETRIUM.....	196, 319	QUETIAPINE.....	252
propafenone.....	115, 319	QUFLORA.....	289
proparacaine.....	163, 319	QUILLICHEW.....	249, 319
propofol.....	30	QUILLIVANT.....	249, 319
propranolol.....	127, 128, 319	quinapril.....	13, 122, 125, 319
propylthiouracil.....	269, 319	quinidine.....	115, 319
PROQUAD.....	111, 319	quinine.....	71, 319
PROSCAR.....	285, 319	QUINTET.....	152, 211
PROSOL.....	170, 319	QULIPTA.....	20, 319
protamine.....	113, 319	QUVIVIQ.....	257, 319
PROTECT.....	167, 222, 288	QUZYTIR.....	63
PROTONIX.....	187, 319	QVAR.....	41, 319
PROTOPAM.....	277	R	
protriptyline.....	246, 319	RA.....	228
PROVAYBLUE.....	276, 319	rabeprazole.....	186, 187, 319
PROVERA.....	145, 196, 300, 319	RABEPRAZOLE.....	187, 319
PROVIDA.....	239	RADIAGEL.....	281
PROVIGIL.....	255	RADICAVA.....	134, 319, 320
PROVISC.....	166, 319	RADIOGARDASE.....	281, 320
PROVOCHOLINE.....	155, 319	RAGWITEK.....	107, 320
PROZAC.....	244, 319	RALDESY.....	244
PUB.....	228	raloxifene.....	283, 320
PULMICORT.....	41, 319	ramelteon.....	256, 320
PULMOZYME.....	272	ramipril.....	125, 320
PURE.....	216, 221, 233, 258, 261, 319	RANEXA.....	115
PURIXAN.....	80, 319	ranolazine.....	115
PUSH.....	216, 233, 319	RAPAFLO.....	285, 320
PYLERA.....	181	RAPAMUNE.....	202, 320
pyrazinamide.....	46, 319	RAPIVAB.....	101, 320
PYRIDIUM.....	33, 319	rasagiline.....	94, 95, 320
pyridostigmine.....	104, 319	RAVICTI.....	178, 320
PYRIDOSTIGMINE.....	104, 319	RAYA.....	221, 320
pyrimethamine.....	71, 319	RAYALDEE.....	276, 320
PYZCHIVA.....	198, 319	READI.....	156, 320
Q		READYLANCE.....	216, 234, 320

Index of Medications

REBIF.....	136, 320	REYATAZ.....	99, 320
REBLOZYL.....	272	REYVOW.....	20, 320
RECARBRIO.....	46, 320	REZDIFFRA.....	275, 320
RECLAST.....	283, 320	REZLIDHIA.....	90, 320
RECOMBINATE.....	112	REZUROCK.....	285, 320
RECOMBIVAX.....	111, 320	REZVOGLAR.....	70, 320
RECORLEV.....	188, 320	REZZAYO.....	61
RECOTHROM.....	114, 320	R-GENE.....	156, 320
RECTIV.....	186	RHOGAM.....	107, 320
REFUAH.....	152, 211, 320	RHOPHYLAC.....	107, 320
regadenoson.....	153	RHOPRESSA.....	164, 320
REGADENOSON.....	153	RIABNI.....	75
REGLAN.....	184	RIASTAP.....	112, 320
REGULAR.....	221, 320	ribavirin.....	102, 320
RELAFEN.....	37	RIDAURA.....	35
RELAGARD.....	70, 320	rifabutin.....	45, 46, 320
RELENZA.....	101, 320	RIFADIN.....	46, 320
RELEUKO.....	144	rifampin.....	46, 320
RELEXII.....	249, 250, 320	RIGHTEST.....	152, 212, 216, 234, 320
RELIAMED.....	211, 216, 234, 320	RILUTEK.....	134, 320
RELION.....	152, 211, 212, 228	rimantadine.....	100, 101, 320
RELISTOR.....	59	RIMSO.....	30, 320
RELPAK.....	20, 320	ringer's.....	171, 258, 320
RELTONE.....	182, 320	RINVOQ.....	35, 320
REMERON.....	240, 320	RIOMET.....	65, 320
REMICADE.....	74, 320	risedronate.....	283, 284, 321
remifentanyl.....	23, 320	RISPERDAL.....	252, 321
REMODULIN.....	121, 278, 320	risperidone.....	252, 321
RENACIDIN.....	177, 320	RITALIN.....	250, 321
RENFLEXIS.....	74, 320	ritonavir.....	99, 311, 321
RENVELA.....	170, 320	RITUXAN.....	75, 321
repaglinide.....	65, 320	rivastigmine.....	104, 321
REPATHA.....	130, 320	RIVFLOZA.....	281, 321
REQ49.....	287	rizatriptan.....	20, 21, 321
RESPA.....	147, 289, 320	R-NATAL.....	240
RESTASIS.....	166, 320	ROBAXIN.....	237, 321
RESTORIL.....	256, 320	ROBINUL.....	178, 321
RETACRIT.....	143, 320	ROCKLATAN.....	164, 321
RETAVASE.....	114	rocuronium.....	106, 321
RETEVMO.....	87, 320	roflumilast.....	42, 321
RETIN.....	268, 320	ROLVEDON.....	144, 321
RETROVIR.....	98, 320	romidepsin.....	76
REVATIO.....	120, 320	ROMIDEPSIN.....	76, 321
REVCovi.....	280	ROMVIMZA.....	88, 321
REVEAL.....	152, 212	ropinirole.....	95, 321
REVLIMID.....	84, 320	ROPIVACAINE.....	32
REVUFORJ.....	87, 88, 320	rosuvastatin.....	130, 131, 321
REXTOVY.....	59, 320	ROSUVASTATIN.....	129
REXULTI.....	254, 320	ROSZET.....	129

Index of Medications

ROTARIX.....	109, 321	SCALACORT.....	266, 321
ROTATEQ.....	109, 321	SCEMBLIX.....	88, 321
ROWASA.....	183, 321	SCLEROSOL.....	273
ROXICODONE.....	29, 321	scopolamine.....	180, 321
ROXYBOND.....	29, 321	SECUADO.....	252, 321
ROZEREM.....	256	SECURESAFE.....	221, 228, 321
ROZLYTREK.....	88, 321	SEGLUROMET.....	67, 321
RUBRACA.....	88, 321	SELARSDI.....	198, 321
RUCONEST.....	277, 321	SELECT.....	92, 239
rufinamide.....	137, 141, 321	selegiline.....	95, 321
RUKOBIA.....	98	selenious.....	174
RUXIENCE.....	75, 321	SELENIOS.....	173, 174, 321
RYALTRIS.....	160	selenium.....	261, 321
RYANODEX.....	237, 321	SELZENTRY.....	98, 321
RYBELSUS.....	64, 321	SEMGLEE.....	70, 321
RYBREVANT.....	81	SENSIPAR.....	277, 321
RYCLORA.....	63, 321	sensorcaine.....	32, 321
RYDAPT.....	88, 321	SENSORCAINE.....	32, 321
RYKINDO.....	252	SEREVENT.....	40, 321
RYLAZE.....	92	SERNIVO.....	266, 321
RYONCIL.....	279	SEROQUEL.....	252, 253, 321
RYSTIGGO.....	281	SEROSTIM.....	194, 321
RYTARY.....	95, 321	sertraline.....	244, 322
RYTELO.....	88, 321	sevelamer.....	170, 322
RYVENT.....	63, 321	sevoflurane.....	30, 322
RYZNEUTA.....	144, 321	SEYSARA.....	53, 322
S		SFROWASA.....	183, 322
SABRIL.....	141, 321	SHINGRIX.....	111, 322
sacubitril.....	123, 321	SHORT.....	38, 39, 221, 222, 322
SAFE.....	203, 212, 213, 229, 230, 321	SIGNIFOR.....	196, 322
SAFESNAP.....	228	SIL.....	212, 322
SAFETYGLIDE.....	221, 228	sildenafil.....	120, 274, 275, 322
SAFYRAL.....	146, 321	SILENOR.....	257, 322
SALAGEN.....	107, 321	silodosin.....	285, 322
saline.....	175	SILVADENE.....	56, 322
salsalate.....	33	silver.....	56, 263, 267, 322
SAMSCA.....	158, 321	SIMBRINZA.....	164, 322
SANCUSO.....	180, 321	SIMLANDI.....	74, 322
SANDIMMUNE.....	202, 321	SIMPLERA.....	212
SANDOSTATIN.....	196, 321	SIMPLI.....	221
SANTYL.....	268	SIMPONI.....	74, 322
SAPHNELO.....	198	SIMULECT.....	200, 322
SAPHRIS.....	252, 321	simvastatin.....	129, 131, 304, 322
sapropterin.....	281, 321	SINEMET.....	95, 322
SARCLISA.....	78, 321	SINGLE.....	147, 183, 188, 217, 234, 258, 262, 322
SAVAYSA.....	56, 321	SINGULAIR.....	42, 322
SAVELLA.....	284	SINOGRAFIN.....	153, 322
saxagliptin.....	65, 66	SINUVA.....	161, 322
saxagliptn.....	66	sirolimus.....	202, 322

Index of Medications

SIRTURO	46, 322	SOVUNA	71
SITAGLIPTIN	65, 66, 67, 322	SPECIALTY	221, 322
SITAVIG	101, 322	SPEVIGO	259, 322
SITZMARKS	156, 322	SPIKEVAX	108, 322
SIVEXTRO	50, 322	spinosad	94, 322
SKY	221	SPINRAZA	278, 322
SKYCLARYS	281	SPIRIVA	38, 322
SKYLA	147, 322	spironolactone	159, 160, 322
SKYRIZI	199, 259, 322	SPORANOX	60, 322
SKYTROFA	194, 322	SPRAVATO	241
SLYND	146, 322	SPRITAM	141, 322
SM	162, 228	SPRYCEL	88, 322
SMART	150, 152, 207, 212, 213, 215, 217, 232, 234, 304, 322	sps	171, 322
SMARTDIABETES	212, 322	SPY-MIS	153
SMARTEST	152, 212, 217, 234, 322	SSKI	172, 322
SMOFLIPID	185, 322	STALEVO	95, 323
SOAAANZ	159	STARJEMZA	198
SODIUM	30, 47, 56, 58, 135, 159, 160, 175, 176, 184, 256, 258, 277, 282, 296, 297, 322	stavudine	98, 323
sodium chloride	45, 96, 127, 175, 176, 292, 312, 322	STEGLATRO	68, 323
SODIUM DIURIL	160	STELARA	198, 323
sodium fluoride	167	STENDRA	274, 323
sodium tetradecyl sulfate	133, 322	STEQEYMA	199, 323
sod phosphate	174, 322	STERILANCE	217, 234, 323
sod,pot chlor/mag/sod,pot phos	258	STERILE	30, 47, 217, 234, 273, 312, 323
sod/pot/k cit/sod cit/cit acid	177	STERITALC	273
SOFOSBUVIR	102, 310, 322	STIMUFEND	144, 323
SOGROYA	194	STIOLTO	40, 323
SOHONOS	282	STIVARGA	88, 323
solifenacin	286, 322	STOBOCLO	284, 323
SOLIQUA	64, 322	STRATTERA	250, 323
SOLIRIS	113, 322	STRENSIQ	279
SOLODYN	53, 322	STREPTOMYCIN	44, 323
SOLOSEC	44, 322	STRIBILD	100
SOLTAMOX	93, 322	STRIVERDI	39, 323
SOLU	193, 322	STROMEKTOL	71
SOLUS	152, 212, 217, 234, 322	strontium	274, 323
SOLUVITA	289	STROVITE	288
SOMA	237, 322	SUBLOCADE	285, 323
SOMATULINE	196, 322	SUBOXONE	285, 323
SOMAVERT	275	SUBSYS	29, 323
SOOLANTRA	263, 322	subvenite	141
sorafenib	87, 88	succinylcholine	106, 107, 323
SORBITOL	258, 322	SUCCINYLCHOLINE	107, 323
SORILUX	261, 322	SUCRAID	183
SOTALOL	128, 322	sucrafate	180, 181, 323
SOTRADECOL	133, 322	sufentanil	23, 323
SOTYKTU	259	SUFLAVE	185, 323
SOTYLIZE	128, 322	SULAR	117, 323
SOVALDI	101, 102, 322	SULCONAZOLE	62, 323

Index of Medications

sulfacetamide	43, 56, 260, 261, 323	TABLOID	80, 323
sulfadiazine	44, 322, 323	TABRECTA	88, 323
sulfamethoxazole	44, 323	TACLONEX	268, 323
SULFAMYLON	56, 323	tacrolimus	200, 201, 202, 323
sulfasalazine	183	TACROLIMUS	202
sulindac	37, 323	tadalafil	120, 274, 275, 323
sumatriptan	20, 21, 323	tadalafil 5 mg tablet	275
sunitinib	88	TADLIQ	120, 324
SUNLENCA	96, 97, 323	TAFINLAR	81, 324
SUNOSI	255	tafluprost	164, 165
SUPARTZ	34, 323	TAGITOL	156, 324
SUPER	215, 217, 232, 234, 323	TAGRISSO	88, 324
SUPPRELIN	195	TAKHZYRO	107
SUPRANE	30, 323	TALICIA	181, 324
SUPREP	185, 323	TALTZ	259, 324
SURE	152, 212, 217, 221, 229, 234, 258, 262, 323	TALVEY	90
SUREFLEX	212, 216, 233, 323	TALZENNA	88, 324
SURE-TEST	152, 212, 323	TAMIFLU	101, 324
SURGICEL	114	tamoxifen	93, 324
SURVANTA	272	tamsulosin	285, 302, 324
SUSTOL	180, 323	TANDEM	288
SUSVIMO	165	TAPERDEX	194, 324
SUTAB	185, 323	TARGADOX	53, 324
SUTENT	88, 323	TARGRETIN	75, 93, 324
SWABFLUSH	176, 323	TARPEYO	194, 324
SYFOVRE	166, 323	TASCENSO	136
SYLVANT	90, 323	TASIGNA	88, 324
SYMAX	182	tasimelteon	256
SYMBICORT	41, 323	TASMAR	95, 324
SYMBRAVO	21, 323	tavaborole	62, 324
SYMDEKO	271, 323	TAVALISSE	272
SYMFI	100, 323	TAVNEOS	113, 324
SYMLINPEN	64, 323	TAYTULLA	146, 324
SYMPAZAN	137, 323	tazarotene	261, 324
SYMPROIC	59	TAZAROTENE	263, 324
SYM TUZA	97, 323	TAZORAC	261, 324
SYNAGIS	100, 323	TAZVERIK	82, 324
SYNALAR	55, 266, 314, 323	TC 99M	155
SYNAREL	194, 323	TC99M	153, 155, 324
SYNDROS	179	TDVAX	111, 324
SYNERCID	52	TECENTRIQ	92, 324
SYNJARDY	67, 323	TECHLITE	217, 221, 229, 234, 324
SYNOJOYNT	34, 323	TECHNELITE	157, 324
SYNTHROID	271, 323	TECVAYLI	90
SYNVISC	34, 323	TEFLARO	48
SYPRINE	281, 323	TEGLUTIK	134
syring	25, 27, 153, 229	TEGRETOL	141, 142, 324
SYRINGE	15, 20, 23, 24, 25, 27, 34, 56, 57, 58, 73, 74, 110, 114, 200, 308, 323	TEKTURNA	128, 129, 324
		TELCARE	152, 212, 217, 234, 324

T

Index of Medications

telmisartan.....	124, 125, 126, 324	THRIVITE.....	239
temazepam.....	256, 324	THROMBI.....	114, 324
TEMBEXA.....	101	THROMBIN.....	58, 59, 114, 324
TEMODAR.....	77	THYQUIDITY.....	271, 324
TEMOVATE.....	266, 324	THYROGEN.....	269
temozolomide.....	77, 324	thyroid.....	271, 324
temsirolimus.....	82, 324	tiagabine.....	142, 325
TENIVAC.....	111, 324	TIAZAC.....	118, 325
tenofovir.....	97, 99, 324	TIBSOVO.....	90, 325
TENORETIC.....	128, 324	ticagrelor.....	96
TENORMIN.....	128, 324	TIGAN.....	180, 325
TEPADINA.....	77, 324	TIGLUTIK.....	134, 325
TEPEZZA.....	275	TIKOSYN.....	115, 116, 325
TEPMETKO.....	88, 324	timolol.....	128, 163, 164, 165, 325
TEPYLUTE.....	77	TIMOPTIC.....	165, 325
terazosin.....	123, 324	tiopronin.....	286, 325
terbinafine.....	60, 324	tiotropium.....	38
terbutaline.....	39	tirofiban.....	96, 325
terconazole.....	60	TIROSINT.....	271, 325
teriflunomide.....	135, 136, 324	TISSEEL.....	263
teriparatide.....	283, 324	TIVDAK.....	91
TERUMO.....	221, 229, 324	TIVICAY.....	99
TEST.....	148, 149, 150, 151, 152, 153, 157, 158, 204, 207, 209, 212, 232, 233, 296, 323	TIVORBEX.....	37
TESTIM.....	189, 324	tizanidine.....	237, 325
TESTOPEL.....	189, 324	TLANDO.....	190, 325
testosterone.....	189, 190, 191, 303, 324	TNKASE.....	114
TESTOSTERONE.....	189, 190, 300, 324	TOBI.....	44, 325
tetrabenazine.....	135, 324	TOBRADEX.....	43, 325
tetracaine.....	32, 324	tobramycin.....	43, 44, 45, 325
TETRACAINE.....	163	TOBRAMYCIN.....	44, 45, 325
tetracycline.....	53, 181, 324	TOBREX.....	43, 325
TEVIMBRA.....	89, 324	TOFIDENCE.....	200, 325
TEXACORT.....	266, 324	tolcapone.....	95, 325
TEZRULY.....	123, 324	TOLECTIN.....	37, 325
TEZSPIRE.....	272	tolmetin.....	37, 325
THALITONE.....	160, 324	TOLSURA.....	60, 325
THALLOUS.....	153	tolterodine.....	286, 287, 325
THALOMID.....	45	tolvaptan.....	158, 159, 325
THAM.....	168, 324	TOPAMAX.....	142, 325
THEO.....	42, 324	TOPCARE.....	217, 221, 229, 234, 325
theophylline.....	42, 324	TOPICORT.....	266, 325
thiamine.....	290	topiramate.....	138, 141, 142, 325
THIN.....	156, 214, 215, 216, 217, 220, 221, 222, 230, 231, 232, 233, 234, 235, 324, 326	TOPIRAMATE.....	142, 325
THINPRO.....	229, 324	topotecan.....	82, 325
THIOLA.....	286	TOPROL.....	128, 325
thioridazine.....	255, 324	toremifene.....	92, 93, 325
thiotepa.....	77, 324	TORISEL.....	82, 325
thiothixene.....	255	toremide.....	159, 325
		TOSYMRA.....	21, 325

Index of Medications

TOUJEO.....	70, 325	trimethoprim.....	43, 44, 45, 323, 326
TOVIAZ.....	287, 325	trimipramine.....	246
TPN.....	171, 325	TRIMO.....	70, 326
TRACLEER.....	120, 121, 325	TRINAZ.....	240
TRADJENTA.....	65, 325	TRINTELLIX.....	246
TRALEMENT.....	174	TRIOSTAT.....	271, 326
tramadol.....	22, 29, 325	TRIPTODUR.....	195
TRAMADOL.....	29, 325	TRISENOX.....	92, 326
trandolapril.....	122, 125, 325	TRISTART.....	239
tranexamic.....	112, 325	TRIUMEQ.....	97, 326
TRANSDERM.....	180, 325	TRI-VI.....	289
TRANSFER.....	99, 221, 325	TRIVISC.....	34, 326
tranylcypromine.....	242, 325	TRODELVY.....	91, 326
TRAVATAN.....	165, 325	TROGARZO.....	96
travoprost.....	165, 325	TROKENDI.....	142, 326
TRAZIMERA.....	83, 325	tromethamine.....	45, 161, 168, 195, 305
trazodone.....	244	TROPHAMINE.....	170, 326
TREANDA.....	78, 325	tropicamide.....	165, 326
TRELEGY.....	41, 325	trospium.....	287, 326
TRELSTAR.....	84, 325	TRUDHESA.....	21, 326
TREMFYA.....	199, 200, 325	TRUE.....	149, 151, 152, 209, 212, 217, 221, 229, 234, 258, 262, 326
treprostinil.....	121, 278, 325	TRUECONTROL.....	212, 326
TRESIBA.....	70, 325	TRUEDRAW.....	212, 326
tretinoin.....	92, 260, 268, 325	TRUEPLUS.....	157, 217, 221, 229, 234, 326
TRETTEN.....	113	TRUERESULT.....	213
TREXALL.....	80, 325	TRUETEST.....	152
TREXIMET.....	21, 325	TRUETRACK.....	152, 213
TREZIX.....	23	TRULANCE.....	184
triamcinolone.....	62, 193, 194, 266, 267, 274, 325	TRULICITY.....	64, 326
triamterene.....	159, 160, 325	TRUMENBA.....	109, 326
triazolam.....	256	TRUQAP.....	88
TRIBENZOR.....	123	TRUVADA.....	97, 326
TRICARE.....	239	TRYNGOLZA.....	130
trichloroacetic.....	264, 325	TRYPTYR.....	166
TRICITRASOL.....	56, 325	TRYVIO.....	128
TRICOR.....	133, 325	TUDORZA.....	38
TRIDESILON.....	267, 325	TUKYSA.....	89, 326
trientine.....	281, 325	TURALIO.....	89, 326
TRIENTINE.....	281	TUXARIN.....	147, 326
TRIESENCE.....	162, 325	TUZISTRA.....	147, 326
TRIFERIC.....	173	TWIIST.....	213
trifluoperazine.....	255, 325	TWINRIX.....	111, 326
trifluridine.....	100, 326	TWIRLA.....	146, 326
trihexyphenidyl.....	94, 326	TWIST.....	214, 215, 216, 217, 231, 232, 233, 234, 326
TRIJARDY.....	68, 326	TWYNEO.....	260
TRIKAFTA.....	271, 326	TYBLUME.....	146, 326
TRILEPTAL.....	142, 326	TYBOST.....	271
TRILURON.....	34, 326	TYENNE.....	200, 326
trimethobenzamide.....	180, 326	TYKERB.....	89, 326

Index of Medications

TYMLOS.....	198	URSO.....	182, 327
TYRUKO.....	282	ursodiol.....	182, 327
TYRVAYA.....	275, 326	USTEKINUMAB.....	199, 327
TYSABRI.....	282, 326	UVADEX.....	92, 327
TYVASO.....	121, 326	UZEDY.....	253
TYZAVAN.....	54	V	
TZIELD.....	274	VABOMERE.....	46, 327
U		VABRINTY.....	84
UBRELVY.....	21, 326	VABYSMO.....	166
UCERIS.....	188, 194, 326	VAFSEO.....	188
UDAMIN.....	288	VAGIFEM.....	197, 327
UDENYCA.....	144, 326	valacyclovir.....	101, 327
ULESFIA.....	94, 326	VALCHLOR.....	93, 327
ULORIC.....	35, 326	VALCYTE.....	101, 327
ULTANE.....	30, 326	valganciclovir.....	101, 327
ULTCARE.....	229	VALIUM.....	241, 327
ULTI.....	213, 326	valproic.....	142, 327
ULTICARE.....	221, 229, 326	valrubicin.....	75, 327
ULTIGUARD.....	222, 229, 230, 326	valsartan.....	123, 124, 125, 126, 327
ULTILET.....	217, 222, 230, 234, 258, 262, 326	VALSARTAN.....	126, 327
ULTIMA.....	152, 213	valsartan/hydrochlorothiazide.....	124
ULTIVA.....	23, 326	VALSTAR.....	75, 327
ULTOMIRIS.....	113, 326	VALTOCO.....	137, 327
ULTRA.....	39, 107, 151, 211, 214, 215, 217, 220, 222, 229, 230, 232, 234, 235, 239, 316, 326	VALTRESX.....	101, 327
ULTRACARE.....	222, 230, 326	VANOCOCIN.....	54, 327
ULTRAFOAM.....	114, 326	vancomycin.....	54, 55, 327
ULTRALANCE.....	217, 235, 326	VANCOMYCIN.....	54, 55, 327
ULTRATLC.....	218, 235, 326	VANFLYTA.....	89, 327
ULTRATRAK.....	152, 213, 326	VANILLA.....	156
ULTRAVATE.....	267, 326	VANISHPOINT.....	230, 327
ULTRAVIST.....	154, 326	VANOS.....	267, 327
UMECLIDINIUM.....	40, 326	VANRAFIA.....	286, 327
UNASYN.....	51, 326	VAPRISOL.....	158, 327
UNDECATREX.....	190, 326	ildenafil.....	275
UNIFINE.....	218, 220, 222, 326	varenicline.....	269, 327
UNILET.....	213, 215, 218, 230, 232, 235, 326	VARIBAR.....	156, 327
UNISTIK.....	213, 215, 218, 232, 235, 326	VARIVAX.....	111, 327
UNISTRIP.....	213, 326	VARUBI.....	180, 327
UNISTRIP1.....	152	VASCEPA.....	177, 327
UNITUXIN.....	91, 326	VASERETIC.....	122, 327
UNIVERSAL.....	218, 235, 326	vasopressin.....	190, 327
UNLOXCYT.....	92	VASOPRESSIN.....	158, 190, 327
UPLIZNA.....	198	vasopressin 200 unit/10 ml vial.....	190
UPNEEQ.....	163	VASOSTRICT.....	190, 327
UPTRAVI.....	121, 326	VASOTEC.....	125, 327
URISTIX.....	158	VAXELIS.....	111, 327
UROCIT.....	177, 327	VAZCULEP.....	120, 327
UROQID.....	177, 327	VECAMEYL.....	126
UROXATRAL.....	285, 327	VECTIBIX.....	83, 327

Index of Medications

VECTICAL.....	261, 327	VIRACEPT	99, 327
vecuronium.....	107	VIREAD.....	99, 327
VECURONIUM.....	107	VISCO.....	34, 328
VEGZELMA.....	76, 327	VISCOAT.....	166
VELCADE.....	89, 327	VISIONBLUE.....	166, 328
VELPHORO.....	171, 327	VISIPAQUE.....	154, 328
VELSIPITY.....	137, 327	VISTARIL.....	63, 328
VELTASSA.....	171, 327	VISTOGARD.....	273, 328
VELTIN.....	260, 327	VISUDYNE.....	275
VEMLIDY.....	102, 327	VITA.....	289
VENCLEXTA.....	89, 327	VITAFOL.....	173, 239, 240, 328
VENELEX.....	285, 327	VITALARA.....	240
venlafaxine.....	245, 327	VITALIPID.....	289, 328
VENLAFAXINE.....	245	VITAMEDMD.....	239
VENOFER.....	173	vitamins.....	10, 289, 291, 328
VENTOLIN.....	39	VITAPEARL.....	239
VEO.....	230	VITATRUE.....	239
VEOPOZ.....	278, 327	VITLIPID.....	289, 290, 328
VEOZAH.....	279, 327	VITRAKVI.....	89, 328
verapamil.....	116, 118, 122, 325, 327	VITRASE.....	268
VERDESO.....	267, 327	VIVAGUARD.....	153, 213, 218, 235, 328
VEREGEN.....	103, 327	VIVELLE.....	192, 328
VERELAN.....	118, 327	VIVIMUSTA.....	78
VERIFINE.....	218, 222, 230, 235, 327	VIVITROL.....	277, 328
VERKAZIA.....	166, 327	VIVJOA.....	60, 328
VERSACLOZ.....	253, 327	VIVLODEX.....	38
VERZENIO.....	89, 327	VIZAMYL.....	155
VESICARE.....	286, 327	VIZIMPRO.....	89, 328
VEVYE.....	166, 327	VIZZ.....	165
VFEND.....	60, 327	VOGELXO.....	190, 328
V-GO.....	213, 327	VONJO.....	89
VIAGRA.....	275, 327	VONVENDI.....	112
VIBATIV.....	49, 327	VOQUEZNA.....	181, 186, 328
VIBERZI.....	184	VORANIGO.....	90
VICTOZA.....	64, 327	VORAXAZE.....	273, 328
VIDAZA.....	80, 327	voriconazole.....	60, 328
vigadrone.....	142	VOSEVI.....	101
VIGAFYDE.....	142	VOTRIENT.....	89, 328
VIGAMOX.....	44, 327	VOWST.....	183
VIIBRYD.....	246, 327	VOXZOGO.....	281
VIJOICE.....	272, 327	VOYDEYA.....	113, 328
vilazodone.....	246	VPRIV.....	279
VILTEPSO.....	278, 327	VRAYLAR.....	253
VIMIZIM.....	280, 327	VTAMA.....	261
VIMPAT.....	141, 142, 143, 327	VUEWAY.....	155
vinblastine.....	83, 327	VUITY.....	165, 328
vincristine.....	83, 327	VUMERITY.....	136, 328
vinorelbine.....	83, 327	VUSION.....	62, 328
VIOKACE.....	186	VYALEV.....	95, 328

Index of Medications

VYEPTI.....	21, 328	XIAFLEX.....	284
VYKAT.....	282	XIFAXAN.....	52
VYLEESI.....	279, 328	XIGDUO.....	67, 328
VYLOY.....	91, 328	XIIDRA.....	166, 328
VYNDAMAX.....	281, 328	XIMINO.....	53, 328
VYNDAQEL.....	281, 328	XIPERE.....	163
VYONDYS.....	278, 328	XOFIGO.....	274, 328
VYTORIN.....	129, 328	XOFLUZA.....	101, 328
VYVANSE.....	247, 328	XOLAIR.....	42, 328
VYVGART.....	281	XOLEGEL.....	62, 328
VYXEOS.....	78, 328	XOLREMDI.....	145, 328
VYZULTA.....	165, 328	XOPENEX.....	39, 328
W		XOSPATA.....	89, 328
WAKIX.....	143	XPHOZAH.....	171, 328
warfarin.....	56	XPOVIO.....	92, 328
water.....	169, 173, 174, 258, 282, 283, 328, 329	XROMI.....	113
WAVESENSE.....	213, 328	XTANDI.....	78, 329
WELCHOL.....	132	XULTOPHY.....	64, 329
WELIREG.....	90	XURIDEN.....	169
WELLBUTRIN.....	242, 328	XYLOCAINE.....	32, 329
WILATE.....	112	XYNTHA.....	112
WINLEVI.....	264	XYOSTED.....	190, 329
WINREVAIR.....	121, 328	XYREM.....	256, 329
WINRHO.....	107, 328	XYWAV.....	256, 329
WYNZORA.....	268	Y	
WYOST.....	284, 328	YASMIN.....	146, 329
X		YAZ.....	146, 329
XACDURO.....	46	YERVOY.....	92, 329
XACIATO.....	54, 328	YESINTEK.....	199, 329
XADAGO.....	95, 328	YONDELIS.....	78, 329
XALATAN.....	165, 328	YONSA.....	78, 329
XALKORI.....	89, 328	YORVIPATH.....	195
XANAX.....	241, 328	YOSPRALA.....	96, 329
XARELTO.....	56, 328	YUFLYMA.....	74, 75, 329
XATMEP.....	80, 328	YUPELRI.....	38
XCOPRI.....	143, 328	YUTREPIA.....	121, 329
XDEMYVY.....	93, 328	Z	
XELJANZ.....	35, 328	zafirlukast.....	42, 329
XELODA.....	80, 328	zaleplon.....	257, 329
XELSTRYM.....	105, 328	ZALTRAP.....	83, 329
XENAZINE.....	135, 328	ZALVIT.....	240
XENLETA.....	51	ZANAFLEX.....	237, 329
XEOMIN.....	107	ZANOSAR.....	75, 329
XEPI.....	55	ZARONTIN.....	143, 329
XERAVA.....	53, 328	ZARXIO.....	144, 329
XERESE.....	102	ZAVESCA.....	279, 329
XERMELO.....	179	ZAVZPRET.....	21
XGEVA.....	284, 328	ZCORT.....	194, 329
XHANCE.....	161, 328	ZEGALOGUE.....	168

Index of Medications

ZEGERID.....	187, 329	ZOLOFT.....	244, 329
ZEJULA.....	89, 329	zolpidem.....	256, 257, 329
ZELAPAR.....	95, 329	ZOLPIDEM.....	257
ZELBORAF.....	81, 329	ZOLPIMIST.....	257, 329
ZELNORM.....	184, 329	ZOMACTON.....	194
ZELSUVMI.....	267	ZOMIG.....	21
ZEMAIRA.....	272, 329	ZONALON.....	260, 329
ZEMBRACE.....	21, 329	ZONEGRAN.....	143, 330
ZEMDRI.....	45, 329	ZONISADE.....	143, 330
ZEMPLAR.....	276, 329	zonisamide.....	143, 330
ZENPEP.....	186	ZONTIVITY.....	96, 330
ZEPATIER.....	102	ZORTRESS.....	202, 330
ZEPOSIA.....	137, 329	ZORVOLEX.....	38
ZEPZELCA.....	78, 329	ZORYVE.....	261, 263, 330
ZERBAXA.....	48	ZOSYN.....	51
ZERVIAE.....	63, 329	ZOVIRAX.....	103, 330
ZESTORETIC.....	122, 329	ZTALMY.....	255
ZESTRIL.....	125, 329	ZUBSOLV.....	285, 330
ZETIA.....	133, 329	ZUNVEYL.....	104, 330
ZETONNA.....	161, 329	ZURZUVAE.....	241
ZEVALIN.....	91, 329	ZUSDURI.....	75
ZIAGEN.....	98, 329	ZYCLARA.....	262
ZIANA.....	260, 329	ZYDELIG.....	89, 330
zidovudine.....	97, 98, 99, 292, 310, 329	ZYFLO.....	38
ZIEXTENZO.....	144, 329	ZYKADIA.....	89, 330
ZIIHERA.....	91, 329	ZYLET.....	43, 330
ZILBRYSQ.....	278, 329	ZYLOPRIM.....	35, 330
zileuton.....	38, 329	ZYNLONTA.....	91
ZILRETTA.....	194, 329	ZYNRELEF.....	32
ZILXI.....	55	ZYNYZ.....	89, 330
ZIMHI.....	59, 329	ZYPITAMAG.....	131, 330
zinc.....	173, 176, 263, 289, 329	ZYPREXA.....	253, 330
ZINGO.....	32, 329	ZYTIGA.....	78, 330
ZIOPTAN.....	165, 329	ZYVOX.....	50, 330
ZIPHEX.....	240		
ziprasidone.....	251, 253, 329		
ZIPSOR.....	22, 329		
ZIRABEV.....	76, 329		
ZIRGAN.....	100, 329		
ZITHROMAX.....	49, 329		
ZITUVIMET.....	67		
ZITUVIO.....	65, 329		
ZOCOR.....	131, 329		
ZOKINVY.....	272, 329		
ZOLADEX.....	84, 329		
zoledronic.....	283, 284, 329		
ZOLEDRONIC.....	284		
ZOLINZA.....	76, 329		
zolmitriptan.....	21, 329		

Index of Medications

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Russian – ВНИМАНИЕ: Если вы говорите на русском, доступны бесплатные услуги языковой помощи. Также бесплатно предоставляются соответствующие вспомогательные средства и услуги для предоставления информации в доступных форматах. Позвоните по телефону 1-800-244-6224 (TTY: Наберите 711) или обратитесь к вашему провайдеру.

Arabic – تنبيه: إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر أيضًا مساعدات قابلة للوصول إليها، وذلك مجانًا. اتصل بالرقم 1-800-244-6224 (TTY: اطلب 711) أو تحدث إلى مقدم الخدمة الخاص بك.

French Creole – ATANSYON: Si ou pale Kreyòl Ayisyen, sèvis asistans lang gratis yo disponib pou ou. Ekipman ak sèvis adisyonèl ki apwopriye pou bay enfòmasyon nan fòm ki aksesib yo disponib tou gratis. Rele 1-800-244-6224 (TTY: Rele 711) oswa pale ak founisè ou a.

French – ATTENTION : Si vous parlez français, des services d'assistance linguistique gratuits sont disponibles pour vous. Des aides et des services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-800-244-6224 (TTY : composez le 711) ou parlez à votre fournisseur.

Portuguese – ATENÇÃO: Se você fala português, serviços gratuitos de assistência linguística estão disponíveis para você. Auxílios e serviços apropriados para fornecer informações em formatos acessíveis também estão disponíveis gratuitamente. Ligue para 1-800-244-6224 (TTY: disque 711) ou fale com seu prestador de serviços.

Polish – UWAGA: Jeśli mówisz po polsku, dostępne są bezpłatne usługi pomocy językowej. Odpowiednie pomoce i usługi wspierające w celu dostarczenia informacji w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 1-800-244-6224 (TTY: wybierz 711) lub skontaktuj się ze swoim dostawcą usług.

Japanese – 注意: 日本語を話す場合は、無料の言語支援サービスが利用できます。アクセス可能な形式で情報を提供するための適切な補助機器やサービスも無料で利用できます。1-800-244-6224 (TTY: 711 にダイヤル) に電話するか、提供者に話してください。

Italian – ATTENZIONE: Se parli italiano, sono disponibili per te servizi gratuiti di assistenza linguistica. Sono disponibili gratuitamente anche ausili e servizi appropriati per fornire informazioni in formati accessibili. Chiama il numero 1-800-244-6224 (TTY: componi il 711) o parla con il tuo fornitore.

German – Achtung: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistentendienste zur Verfügung. Geeignete Hilfsmittel und Dienste, um Informationen in barrierefreien Formaten bereitzustellen, sind ebenfalls kostenlos verfügbar. Rufen Sie 1-800-244-6224 an (TTY: Wählen Sie 711) oder sprechen Sie mit Ihrem Anbieter.

Persian (Farsi) – همچنین، وسایل و خدمات کمکی مناسب برای در دسترس است. خدمات رایگان کمک زبان برای شما صحبت می‌کنند، توجه: اگر به فارسی تماس بگیرید یا با (شماره 711 را بگیرید: TTY) ارائه اطلاعات در قالبهای قابل دسترس به صورت رایگان در دسترس هستند. با شماره 1-800-244-6224 ارائه‌دهنده خود صحبت کنید