



Cigna Healthcare Legacy (Performance) 4-Tier Prescription Drug List

Coverage as of January 1, 2026

For the State of California

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

View your drug list online: Cigna.com/PDL

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

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

Last updated: 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 This drug list is subject to change and all prior versions are no longer in effect.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	11
· 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) 4 Tier (all specialty medications covered on tier 4) (CDI) [PDF]**.

Questions?

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

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

Last updated: 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, Tier 3 and Tier 4 medications.
2. **Log in to the myCigna App or myCigna.com to view your pharmacy coverage information.** You can also use the Price a Medication tool to find out how much your medication may cost you at the different pharmacies in your plan's network.
3. **Check your Summary of Benefits** coverage document.

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

How to read this drug list

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

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

Tiers

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

Tier 1	Generics. These medications are covered at your plan's lowest cost-share. Generics work in the same way and provide the same clinical benefits as their brand-name versions – and typically cost much less. ³	\$
Tier 2	Preferred Brands. These medications typically have one or more lower-cost generic that treats the same condition.	\$\$
Tier 3	Non-Preferred Brands. Non-preferred brands typically have a generic and/or preferred brand alternative(s) that treats the same condition.	\$\$\$
Tier 4	Specialty. These medications are covered at your plan's highest cost-share. This tier includes both injectable and oral (those you take by mouth) specialty medications.	\$\$\$\$

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

Information about this drug list

How to read this drug list (cont.)

Letters (acronyms) in the Notes column

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

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

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

Information about this drug list

How to read this drug list (cont.)

Use the table below to understand how medications are covered on the Cigna Healthcare Legacy (Performance) 4-Tier Prescription Drug List.*

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

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

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

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

Prescription drug name is the name of the medication.

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

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

Generic medications are in **lowercase italics**.

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

Information about this drug list

How to find your medication

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

Condition	Page	Condition	Page
Analgesics (Pain Relief and Inflammatory Disease)	19-30	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		

Information about this drug list

How to find your medication (cont.)

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

Information about this drug list

How to find your medication (cont.)

Condition	Page	Condition	Page
Prenatal Vitamins (Nutritional/Dietary)	237-240	Unclassified Drug Products (Diabetes)	274
Psychotherapeutic Drugs (Anxiety/Depression/Bipolar Disorder)	240-246	Unclassified Drug Products (Erectile Dysfunction)	274, 275
Psychotherapeutic Drugs (Attention Deficit Hyperactivity Disorder)	247-250	Unclassified Drug Products (Eye Conditions)	275
Psychotherapeutic Drugs (Schizophrenia/Anti-Psychotics)	250-255	Unclassified Drug Products (Gastrointestinal/Heartburn)	275
PSYCHOTHERAPEUTIC DRUGS (Seizure Disorders)	255	Unclassified Drug Products (Hormonal Agents)	275, 276
Psychotherapeutic Drugs (Sleep Disorders/Sedatives)	255	Unclassified Drug Products (Miscellaneous)	276-282
Sedative/Hypnotics (Sleep Disorders/Sedatives)	255-257	Unclassified Drug Products (Multiple Sclerosis)	282
Skin Preps (Miscellaneous)	257, 258	Unclassified Drug Products (Nutritional/Dietary)	282
Skin Preps (Pain Relief and Inflammatory Disease)	258, 259	Unclassified Drug Products (Seizure Disorders)	229
Skin Preps (Skin Conditions)	259-268	Unclassified Drug Products (Osteoporosis Products)	283, 284
Smoking Deterrents (Smoking Cessation)	268	Unclassified Drug Products (Pain Relief and Inflammatory Disease)	284
Thyroid Prep (Hormonal Agents)	269-271	Unclassified Drug Products (Seizure Disorders)	284
Unclassified Drug Products (Asthma/COPD/Respiratory)	271, 272	Unclassified Drug Products (Skin Conditions)	284, 285
Unclassified Drug Products (Blood Modifiers/Bleeding Disorders)	272	Unclassified Drug Products (Substance Abuse)	285
Unclassified Drug Products (Blood Pressure/Heart Medications)	272, 273	Unclassified Drug Products (Transplant Medications)	285
Unclassified Drug Products (Cancer)	273, 274	Unclassified Drug Products (Urinary Tract Conditions)	285-287
Unclassified Drug Products (Dental Products)	274	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-acetaminophn 25-325</i>	T1	PA
<i>butalbital-acetaminophn 50-300</i>	T1	
<i>butalbital-acetaminophn 50-300 (Bupap)</i>	T1	PA
<i>butalbital-acetaminophn 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)
ESGIC (<i>butalb/acetaminophen/caffeine</i>)	T3	PA QL(6 CAPS/DAY)
FIORICET (<i>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	T4	SP
ANALGESICS, NON-OPIOID		
<i>clonidine 1,000 mcg/10 ml vial (Duraclon)</i>	T1	
<i>clonidine 5,000 mcg/10 ml vial</i>	T1	
DURACLON (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
 T2 – Typically Preferred Brands
 T3 – Typically Non-Preferred Brands

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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)
RELPAX (<i>eletriptan hydrobromide</i>)	T3	PA QL(6 TABS/30 DAYS)
REYVOW	T3	PA QL(8 TABS/30 DAYS)

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-MIGRAINE PREPARATIONS		
<i>rizatriptan benzoate</i> (Maxalt Mlt)	T1	QL(12 TABS/30 DAYS)
<i>rizatriptan benzoate</i> (Maxalt)	T1	QL(12 TABS/30 DAYS)
<i>sumatriptan</i>	T1	QL(12 UNITS/30 DAYS)
<i>sumatriptan 4 mg/0.5 ml inject</i> (Imitrex)	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</i> (Imitrex)	T1	QL(4 MLS/30 DAYS)
<i>sumatriptan succ 100 mg tablet</i> (Imitrex)	T1	QL(9 TABS/30 DAYS)
<i>sumatriptan succ 25 mg tablet</i> (Imitrex)	T1	QL(9 TABS/30 DAYS)
<i>sumatriptan succ 50 mg tablet</i> (Imitrex)	T1	QL(9 TABS/30 DAYS)
<i>sumatriptan succ/naproxen sod</i> (Treximet)	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</i> (Zomig)	T1	QL(6 TABS/30 DAYS)
ZOLMITRIPTAN 2.5MG NASAL SPRAY	T3	PA QL(12 UNITS/30 DAYS)
<i>zolmitriptan 5 mg nasal spray</i> (Zomig)	T1	PA QL(12 UNITS/30 DAYS)
<i>zolmitriptan 5 mg tablet</i> (Zomig)	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
 T2 – Typically Preferred Brands
 T3 – Typically Non-Preferred Brands

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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
 T2 – Typically Preferred Brands
 T3 – Typically Non-Preferred Brands

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPIOID ANALGESIC 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	

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

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

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPIOID ANALGESICS (cont.)		
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	
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 carpuct</i>	T1	
FENTANYL 100 MCG/2 ML CARPUJCT	T1	
<i>fentanyl 100 mcg/2 ml syringe</i>	T1	
<i>fentanyl 2 mcg-bup 0.0625%-ns</i>	T1	
FENTANYL 2 MCG-BUP 0.0625%-NS	T1	
FENTANYL 2 MCG-BUPIV 0.1%-NS	T1	
<i>fentanyl 2 mcg-bupiv 0.125%-ns</i>	T1	
FENTANYL 2 MCG-BUPIV 0.125%-NS	T1	
FENTANYL 2 MCG-BUPIV 0.125%-NS	T3	
FENTANYL 2 MCG-BUPIVAC 0.1%-NS	T1	
<i>fentanyl 2,000mcg/100-0.9%nacl</i>	T1	
FENTANYL 2,500 MCG/50 ML SYRNG	T1	
<i>fentanyl 2,500 mcg/50 ml-ns</i>	T1	
FENTANYL 2,500MCG/250-0.9%NACL	T1	

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPIOID ANALGESICS (cont.)		
FENTANYL 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 carpuct</i>	T1	PA
<i>hydromorphone 1 mg/ml solution (Dilaudid)</i>	T1	PA
<i>hydromorphone 1 mg/ml syringe</i>	T1	PA
HYDROMORPHONE 1 MG/ML VIAL	T3	PA
HYDROMORPHONE 1 MG/ML-NS SYRNG (<i>hydromorphone hcl/0.9% nacl/pf</i>)	T3	PA
<i>hydromorphone 10 mg/50 ml-ns</i>	T1	PA
HYDROMORPHONE 10 MG/50 ML-NS	T3	PA
HYDROMORPHONE 10 MG/50 ML-NS (<i>hydromorphone hcl/0.9% nacl/pf</i>)	T3	PA
<i>hydromorphone 10 mg/50 ml-ns (Hydromorphone Hcl-0.9% Nacl)</i>	T1	PA
<i>hydromorphone 10 mg/ml ampule</i>	T1	PA

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPIOID ANALGESICS (cont.)		
<i>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	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPIOID ANALGESICS (cont.)		
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

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPIOID ANALGESICS (cont.)		
<i>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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPIOID ANALGESICS (cont.)		
<i>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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPIOID 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	

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

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

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANESTHETICS (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% NAACL	T3	
MIDAZOLAM HCL-0.9% NAACL	T1	
MIDAZOLAM-0.9% NAACL	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% NAACL	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
 T2 – Typically Preferred Brands
 T3 – Typically Non-Preferred Brands

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LOCAL ANESTHETICS (cont.)		
<i>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	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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 (<i>lidocaine</i>)	T3	PA
LIDODERM (<i>lidocaine</i>)	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>)	T4	PA QL(6 CAPS/DAY) SP
DEPEN (<i>penicillamine</i>)	T4	PA QL(6 TABS/DAY) SP
<i>penicillamine 250 mg capsule</i> (Cuprimine)	T4	PA QL(6 CAPS/DAY) SP
<i>penicillamine 250 mg tablet</i> (Depen)	T4	PA QL(6 TABS/DAY) SP
ANTI-ARTHRITIC, FOLATE ANTAGONIST AGENTS		
OTREXUP	T2	PA
RASUVO	T3	PA
ANTI-INFLAM. INTERLEUKIN-1 RECEPTOR ANTAGONIST		
KINERET	T3	PA QL(28 UNITS/28 DAYS) SP

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

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

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTI-ARTHRITICS (Pain Relief and Inflammatory Disease) (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	T4	PA QL(55 TABS/365 DAYS) SP HD
OTEZLA 10-20-30MG START 28 DAY	T4	PA QL(55 TABS/365 DAYS) SP HD
OTEZLA 20 MG TABLET	T4	PA QL(2 TABS/DAY) SP HD
OTEZLA 30 MG TABLET	T4	PA QL(2 TABS/DAY) SP HD
OTEZLA XR 75 MG TABLET	T4	PA QL(1 TAB/DAY) SP HD
OTEZLA XR INITIATION PK 28 DAY	T4	PA QL(41 TABS/365 DAYS) SP HD
ANTI-INFLAMMATORY/ANTIARTHRITICS AGENTS, MISC.		
DUROLANE	T4	PA SP HD
EUFLEXXA	T4	PA SP HD
GEL-ONE	T4	PA SP HD
GELSYN-3	T4	PA SP HD
GENVISC 850	T4	PA SP
HYALGAN	T4	PA SP HD
HYMOVIS	T4	PA SP HD
HYMOVIS ONE	T4	PA SP HD
MONOVISC	T4	PA SP HD
ORTHOVISC	T4	PA SP HD
SUPARTZ FX	T4	PA SP HD
SYNOJOYNT	T4	PA SP
SYNVISC	T4	PA SP HD
SYNVISC-ONE	T4	PA SP HD
TRILURON	T4	PA SP HD
TRIVISC	T4	PA SP
VISCO-3	T4	PA SP HD
ANTI-INFLAMMATORY, SEL.COSTIM.MOD., T-CELL INHIBITOR		
ORENCIA 125 MG/ML SYRINGE	T4	PA QL(4 SYR/AUTO-INJ/28 DAYS) SP HD
ORENCIA 250 MG VIAL	T4	PA SP HD
ORENCIA 50 MG/0.4 ML SYRINGE	T4	PA QL(4 SYR/AUTO-INJ/28 DAYS) SP HD
ORENCIA 87.5 MG/0.7 ML SYRINGE	T4	PA QL(4 SYR/AUTO-INJ/28 DAYS) SP HD
ORENCIA CLICKJECT	T4	PA QL(4 SYR/AUTO-INJ/28 DAYS) SP HD

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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	T4	PA QL(30 TABS/30 DAYS) SP HD
RINVOQ	T4	PA QL(1 TAB/DAY) SP HD
RINVOQ LQ	T4	PA QL(12 MLS/DAY) SP HD
XELJANZ 1 MG/ML SOLUTION	T4	PA QL(480 MLS/30 DAYS) SP HD
XELJANZ 10 MG TABLET	T4	PA QL(2 TABS/DAY) SP HD
XELJANZ 5 MG TABLET	T4	PA QL(2 TABS/DAY) SP HD
XELJANZ XR	T4	PA QL(1 TAB/DAY) SP HD
NSAID ANALGESIC AND NON-SALICYLATE ANALGESIC COMB		
COMBOGESIC	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

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

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

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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 (tolmetin sodium)	T3	PA HD
<i>tolmetin sodium</i>	T1	HD
<i>tolmetin sodium (Tolectin 600)</i>	T1	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTI-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 (<i>levalbuterol hcl</i>)	T3	
XOPENEX CONCENTRATE (<i>levalbuterol hcl</i>)	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

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTI-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
 T2 – Typically Preferred Brands
 T3 – Typically Non-Preferred Brands

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTI-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	T4	PA SP
NUCALA	T4	PA SP HD

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

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

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTI-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> (Singulair)	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	T4	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	T4	PA QL(60 MLS/30 DAYS) SP
<i>roflumilast 250 mcg tablet</i> (Daliresp)	T1	QL(28 TABS/180 DAYS) HD
<i>roflumilast 500 mcg tablet</i> (Daliresp)	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	

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

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

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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	
TOBREX	T3	PA

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIBIOTICS (Eye Medications) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPHTHALMIC ANTIBIOTICS (cont.)		
VIGAMOX (<i>moxifloxacin hcl</i>)	T3	PA
ANTIBIOTICS (Infections)		
2ND GEN. ANAEROBIC ANTIPROTOZOAL-ANTIBACTERIAL		
SOLOSEC	T2	
ABSORBABLE SULFONAMIDE ANTIBACTERIAL AGENTS		
BACTRIM (<i>sulfamethoxazole/trimethoprim</i>)	T3	
BACTRIM DS (<i>sulfamethoxazole/trimethoprim</i>)	T3	
<i>sulfadiazine</i>	T1	
<i>sulfamethoxazole/trimethoprim</i>	T1	
<i>sulfamethoxazole/trimethoprim</i>	T3	
<i>sulfamethoxazole/trimethoprim</i> (Bactrim Ds)	T1	
<i>sulfamethoxazole/trimethoprim</i> (Bactrim)	T1	
AMINOGLYCOSIDE ANTIBIOTICS		
<i>amikacin sulfate</i>	T1	
ARIKAYCE	T4	PA SP
BETHKIS (<i>tobramycin</i>)	T4	PA QL(8 MLS/DAY) SP HD
<i>gentamicin in nacl, iso-osm</i>	T1	
<i>gentamicin sulfate</i>	T1	
GENTAMICIN SULFATE	T1	
GENTAMICIN SULFATE IN NS	T1	
<i>gentamicin sulfate/pf</i>	T1	
KITABIS PAK	T4	PA QL(10 MLS/DAY) SP HD
<i>neomycin sulfate</i>	T1	
STREPTOMYCIN SULFATE	T1	
TOBI (<i>tobramycin in 0.225% sod chlor</i>)	T4	PA QL(10 MLS/DAY) SP HD
TOBI PODHALER	T4	PA QL(8 CAPS/DAY) SP HD
<i>tobramycin 300 mg/4 ml ampule</i> (Bethkis)	T4	PA QL(8 MLS/DAY) SP HD
TOBRAMYCIN PAK 300 MG/5 ML	T4	PA QL (10ml/day) SP HD

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

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

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

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

ANTIBIOTICS (Infections) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AMINOGLYCOSIDE ANTIBIOTICS (cont.)		
<i>tobramycin 300 mg/5 ml ampule (Tobi)</i>	T4	PA QL(10 MLS/DAY) SP HD
TOBRAMYCIN PAK 300 MG/5 ML	T4	PA QL(10 MLS/DAY) SP HD
<i>tobramycin sulfate</i>	T1	
<i>tobramycin/sodium chloride</i>	T1	
ZEMDRI	T3	
ANAEROBIC ANTIPROTOZOAL-ANTIBACTERIAL AGENTS		
FLAGYL (<i>metronidazole</i>)	T3	
LIKMEZ	T3	PA
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	T4	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

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

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

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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	T4	SP
BETALACTAMS		
AZACTAM (aztreonam)	T3	
aztreonam (Azactam)	T1	
CAYSTON	T4	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	

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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	

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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% NACL	T1	
LINCOCIN	T3	
<i>lincomycin hcl</i>	T1	
LIPOGLYCOPEPTIDE ANTIBIOTICS		
<i>dalbavancin hcl</i>	T1	
DALVANCE	T3	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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	

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NITROFURAN DERIVATIVES ANTIBACTERIAL AGENTS (cont')		
<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
 T2 – Typically Preferred Brands
 T3 – Typically Non-Preferred Brands

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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 sulfat</i> e	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	

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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	

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

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

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TETRACYCLINE ANTIBIOTICS (cont.)		
<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	T4	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	

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

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

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TETRACYCLINE ANTIBIOTICS (cont.)		
<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	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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>)	T4	QL(0.8 ML/DAY) SP
ARIXTRA 2.5 MG/0.5 ML SYRINGE (<i>fondaparinux sodium</i>)	T4	QL(0.5 ML/DAY) SP
ARIXTRA 5 MG/0.4 ML SYRINGE (<i>fondaparinux sodium</i>)	T4	QL(0.4 ML/DAY) SP
ARIXTRA 7.5 MG/0.6 ML SYRINGE (<i>fondaparinux sodium</i>)	T4	QL(0.6 ML/DAY) SP

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

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

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTI-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>	T4	QL(2 SYRINGES/DAY) SP
<i>enoxaparin 120 mg/0.8 ml syr (Lovenox)</i>	T4	QL(2 SYRINGES/DAY) SP
<i>enoxaparin 150 mg/ml syringe (Lovenox)</i>	T4	QL(2 SYRINGES/DAY) SP
<i>enoxaparin 30 mg/0.3 ml syr (Lovenox)</i>	T4	QL(2 SYRINGES/DAY) SP
<i>enoxaparin 300 mg/3 ml vial (Lovenox)</i>	T4	QL(1 VIAL/DAY) SP
<i>enoxaparin 40 mg/0.4 ml syr (Lovenox)</i>	T4	QL(2 SYRINGES/DAY) SP
<i>enoxaparin 60 mg/0.6 ml syr (Lovenox)</i>	T4	QL(2 SYRINGES/DAY) SP
<i>enoxaparin 80 mg/0.8 ml syr (Lovenox)</i>	T4	QL(2 SYRINGES/DAY) SP
<i>fondaparinux 10 mg/0.8 ml syr (Arixtra)</i>	T4	QL(0.8 ML/DAY) SP
<i>fondaparinux 2.5 mg/0.5 ml syr (Arixtra)</i>	T4	QL(0.5 ML/DAY) SP
<i>fondaparinux 5 mg/0.4 ml syr (Arixtra)</i>	T4	QL(0.4 ML/DAY) SP
<i>fondaparinux 7.5 mg/0.6 ml syr (Arixtra)</i>	T4	QL(0.6 ML/DAY) SP
FRAGMIN 10,000 UNIT/4 ML VIAL	T4	QL(1 VIAL/DAY) SP
FRAGMIN 10,000 UNIT/ML SYRINGE	T4	QL(2 SYRINGES/DAY) SP
FRAGMIN 12,500 UNIT/0.5 ML SYR	T4	QL(2 SYRINGES/DAY) SP
FRAGMIN 15,000 UNIT/0.6 ML SYR	T4	QL(2 SYRINGES/DAY) SP
FRAGMIN 18,000 UNIT/0.72 ML	T4	QL(2 SYRINGES/DAY) SP
FRAGMIN 2,500 UNIT/0.2 ML SYR	T4	QL(2 SYRINGES/DAY) SP
FRAGMIN 5,000 UNIT/0.2 ML SYR	T4	QL(2 SYRINGES/DAY) SP
FRAGMIN 7,500 UNIT/0.3 ML SYR	T4	QL(2 SYRINGES/DAY) SP
FRAGMIN 95,000 UNIT/3.8 ML VL	T4	QL(1 VIAL/DAY) SP
<i>heparin 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	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTI-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 vial</i>	T1	
<i>heparin sod 20,000 unit/ml vial</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>)	T4	PA QL(2 SYRINGES/DAY) SP
LOVENOX 120 MG/0.8 ML SYRINGE (<i>enoxaparin sodium</i>)	T4	PA QL(2 SYRINGES/DAY) SP
LOVENOX 150 MG/ML SYRINGE (<i>enoxaparin sodium</i>)	T4	PA QL(2 SYRINGES/DAY) SP
LOVENOX 30 MG/0.3 ML SYRINGE (<i>enoxaparin sodium</i>)	T4	PA QL(2 SYRINGES/DAY) SP
LOVENOX 300 MG/3 ML VIAL (<i>enoxaparin sodium</i>)	T4	PA QL(1 VIAL/DAY) SP
LOVENOX 40 MG/0.4 ML SYRINGE (<i>enoxaparin sodium</i>)	T4	PA QL(2 SYRINGES/DAY) SP
LOVENOX 60 MG/0.6 ML SYRINGE (<i>enoxaparin sodium</i>)	T4	PA QL(2 SYRINGES/DAY) SP
LOVENOX 80 MG/0.8 ML SYRINGE (<i>enoxaparin sodium</i>)	T4	PA QL(2 SYRINGES/DAY) SP
THROMBIN INHIBITORS, SELECTIVE, DIRECT, REVERSIBLE		
ARGATROBAN	T4	SP
<i>argatroban in 0.9 % sod chlor</i>	T4	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	T4	PA QL(2 PACKS/DAY) SP
PRADAXA 150 MG CAPSULE (<i>dabigatran etexilate mesylate</i>)	T3	PA HD
PRADAXA 150 MG PELLETT PACK	T4	PA QL(2 PACKS/DAY) SP
PRADAXA 20 MG PELLETT PACK	T4	PA QL(2 PACKS/DAY) SP

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTI-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	T4	PA QL(4 PACKS/DAY) SP
PRADAXA 40 MG PELLETT PACK	T4	PA QL(4 PACKS/DAY) SP
PRADAXA 50 MG PELLETT PACK	T4	PA QL(4 PACKS/DAY) SP
PRADAXA 75 MG CAPSULE (dabigatran etexilate mesylate)	T4	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
 T2 – Typically Preferred Brands
 T3 – Typically Non-Preferred Brands

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTI-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	T4	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	

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTI-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	

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTI-FUNGALS (Skin Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL ANTI-FUNGALS (con't.)		
EXTINA (<i>ketoconazole</i>)	T3	PA
JUBLIA	T3	PA
<i>ketoconazole</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	
--------------------------------------	----	--

2ND GEN ANTIHISTAMINE AND DECONGESTANT COMBINATION

CLARINEX-D 12 HOUR	T3	
--------------------	----	--

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

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIHISTAMINES (Allergy/Nasal Sprays)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIHISTAMINES - 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	
RYCLORA (<i>dexchlorpheniramine maleate</i>)	T3	PA
RYVENT	T3	PA
VISTARIL (<i>hydroxyzine pamoate</i>)	T3	
ANTIHISTAMINES - 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	
ANTIHISTAMINES (Eye Conditions)		
EYE ANTIHISTAMINES		
<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	
ZERVATE	T3	PA

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTI-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

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTI-HYPERGLYCEMICS (Diabetes) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIHYPERTHYCEMIC, 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
ANTIHYPERTHYCEMIC, 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
ANTIHYPERTHYCEMIC, THIAZOLIDINEDIONE-SULFONYLUREA		
DUETACT (pioglitazone hcl/glimepiride)	T3	HD
<i>pioglitazone hcl/glimepiride (Duetact)</i>	T1	HD
ANTIHYPERTHYCEMIC,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

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTI-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(PARG AGONIST)		
ACTOS (pioglitazone hcl)	T3	PA HD
<i>pioglitazone hcl (Actos)</i>	T1	HD
ANTIHYPERGLYCEMIC-GLUCOCORTICOID RECEPTOR BLOCKER		
KORLYM (mifepristone)	T4	PA SP
<i>mifepristone 300 mg tablet (Korlym)</i>	T4	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

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

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

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTI-HYPERGLYCEMICS (Diabetes) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIHYPERGLYCEMIC-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
ANTIHYPERGLY-SGLT-2 INHIB,DPP-4 INHIB,BIGUANIDE CB		
TRIJARDY XR 10-5-1,000 MG TAB	T2	ST QL(1 TAB/DAY) HD
TRIJARDY XR 12.5-2.5-1,000 MG	T2	ST QL(2 TABS/DAY) HD
TRIJARDY XR 25-5-1,000 MG TAB	T2	ST QL(1 TAB/DAY) HD
TRIJARDY XR 5-2.5-1,000 MG TAB	T2	ST QL(2 TABS/DAY) HD
INSULINS		
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
 T2 – Typically Preferred Brands
 T3 – Typically Non-Preferred Brands

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTI-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

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTI-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	
--------------------	----	--

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

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

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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		
atovaquone (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	

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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	T4	PA QL(2 PENS/SYRINGES/28 DAYS) SP
ABRILADA(CF) 40 MG/0.8 ML SYRN	T4	PA QL(4 SRNGE KITS/28 DAYS) SP
ABRILADA(CF) PEN	T4	PA QL(4 KITS/28 DAYS) SP
ADALIMUMAB-AACF(CF) (2 PK)	T4	PA QL(4 SRNGE KITS/28 DAYS) SP HD
ADALIMUMAB-AACF(CF) PEN (2 PK)	T4	PA QL(4 KITS/28 DAYS) SP HD
ADALIMUMAB-AACF(CF) PEN CROHNS	T4	PA QL(1 STARTER KIT/365 DAYS) SP HD
ADALIMUMAB-AACF(CF) PEN PS-UV	T4	PA QL(2 KITS/365 DAYS) SP HD
ADALIMUMAB-AATY(CF) 20MG/0.2ML	T4	PA QL(2 PENS/SYRINGES/28 DAYS) SP
ADALIMUMAB-AATY(CF) 40MG/0.4ML	T4	PA QL(4 SRNGE KITS/28 DAYS) SP
ADALIMUMAB-AATY(CF) 80MG/0.8ML	T4	PA QL(2 AUTO-INJS/28 DAYS) SP
ADALIMUMAB-AATY(CF) AI CROHNS	T4	PA QL(3 PENS/365 DAYS) SP
ADALIMUMAB-ADAZ(CF) 10MG/0.1ML	T4	PA QL(2 SYRINGES/28 DAYS) SP
ADALIMUMAB-ADAZ(CF) 20MG/0.2ML	T4	PA QL(2 SYRINGES/28 DAYS) SP
ADALIMUMAB-ADAZ(CF) 40 MG SYRG	T4	PA QL(4 SYRINGES/28 DAYS) SP
ADALIMUMAB-ADAZ(CF) PEN 40 MG	T4	PA QL(4 PENS/28 DAYS) SP
ADALIMUMAB-ADAZ(CF) PEN 80 MG	T4	PA QL(2 PENS/28 DAYS) SP
ADALIMUMAB-ADB(M)CF) 10 MG SYRG	T4	PA QL(2 PENS/SYRINGES/28 DAYS) SP HD
ADALIMUMAB-ADB(M)CF) 20 MG SYRG	T4	PA QL(2 PENS/SYRINGES/28 DAYS) SP HD
ADALIMUMAB-ADB(M)CF) 40 MG SYRG	T4	PA QL(4 SRNGE KITS/28 DAYS) SP HD
ADALIMUMAB-ADB(M)CF) PEN	T4	PA QL(4 KITS/28 DAYS) SP HD
ADALIMUMAB-FKJP(CF) 20 MG SYRG	T4	PA QL(2 PENS/SYRINGES/28 DAYS) SP
ADALIMUMAB-FKJP(CF) 40 MG SYRG	T4	PA QL(4 SRNGE KITS/28 DAYS) SP
ADALIMUMAB-FKJP(CF) PEN	T4	PA QL(4 KITS/28 DAYS) SP
ADALIMUMAB-RYVK(CF)	T4	PA QL(4 SRNGE KITS/28 DAYS) SP HD

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

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

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

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

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	T4	PA QL SP HD
AMJEVITA(CF) 10MG/0.2ML SYRING	T4	PA QL(2 SYRINGES/28 DAYS) SP HD
AMJEVITA(CF) 20MG/0.2ML SYRING	T4	PA QL(2 SYRINGES/28 DAYS) SP HD
AMJEVITA(CF) 40MG/0.4ML AUTOIN	T4	PA QL(4 AUTO-INJS/28 DAYS) SP HD
AMJEVITA(CF) 40MG/0.4ML SYRING	T4	PA QL(4 SYRINGES/28 DAYS) SP HD
AMJEVITA(CF) 80MG/0.8ML AUTOIN	T4	PA QL(2 AUTO-INJS/28 DAYS) SP HD
AVSOLA	T4	PA SP HD
CIMZIA (2 PACK)	T4	PA QL(1 KIT/28 DAYS) SP HD
CIMZIA 200 MG/ML SYRINGE KIT	T4	PA QL(2 PENS/SYRINGES/28 DAYS) SP
CIMZIA 2X200 MG/ML(X3)START KT	T4	PA QL(1 STARTER KIT/365 DAYS) SP HD
CYLTEZO(CF) 10 MG/0.2 ML SYRNG	T4	PA QL(2 PENS/SYRINGES/28 DAYS) SP HD
CYLTEZO(CF) 20 MG/0.4 ML SYRNG	T4	PA QL(2 PENS/SYRINGES/28 DAYS) SP HD
CYLTEZO(CF) 40 MG/0.4 ML SYRNG	T4	PA QL(4 SRNGE KITS/28 DAYS) SP HD
CYLTEZO(CF) 40 MG/0.8 ML SYRNG	T4	PA QL(4 SRNGE KITS/28 DAYS) SP HD
CYLTEZO(CF) PEN	T4	PA QL(4 KITS/28 DAYS) SP HD
CYLTEZO(CF) PEN CROHN'S-UC-HS	T4	PA QL(1 STARTER KIT/365 DAYS) SP HD
ENBREL 25 MG/0.5 ML	T4	PA QL(8 MLS/28 DAYS) SP HD
ENBREL 50 MG/ML SYRINGE	T4	PA QL(4 MLS/28 DAYS) SP HD
ENBREL MINI	T4	PA QL(4 MLS/28 DAYS) SP HD
ENBREL SURECLICK	T4	PA QL(4 MLS/28 DAYS) SP HD
HADLIMA	T4	PA QL(4 SYRINGES/28 DAYS) SP HD
HADLIMA PUSHTOUCH	T4	PA QL(4 AUTO-INJS/28 DAYS) SP HD
HADLIMA(CF)	T4	PA QL(4 SYRINGES/28 DAYS) SP HD
HADLIMA(CF) PUSHTOUCH	T4	PA QL(4 AUTO-INJS/28 DAYS) SP HD
HULIO(CF) 20 MG/0.4 ML SYRINGE	T4	PA QL(2 PENS/SYRINGES/28 DAYS) SP
HULIO(CF) 40 MG/0.8 ML SYRINGE	T4	PA QL(4 SRNGE KITS/28 DAYS) SP
HULIO(CF) PEN	T4	PA QL(4 KITS/28 DAYS) SP
HUMIRA	T4	PA QL(4 SRNGE KITS/28 DAYS) SP HD
HUMIRA PEN	T4	PA QL(4 KITS/28 DAYS) SP HD
HUMIRA(CF) 10 MG/0.1 ML SYRING	T4	PA QL(2 PENS/SYRINGES/28 DAYS) SP HD

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

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

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

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

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	T4	PA QL(2 PENS/SYRINGES/28 DAYS) SP HD
HUMIRA(CF) 40 MG/0.4 ML SYRING	T4	PA QL(4 SRNGE KITS/28 DAYS) SP HD
HUMIRA(CF) PEN 40 MG/0.4 ML	T4	PA QL(4 KITS/28 DAYS) SP HD
HUMIRA(CF) PEN 80 MG/0.8 ML	T4	PA QL(2 PENS/28 DAYS) SP HD
HUMIRA(CF) PEN CROHN'S-UC-HS	T4	PA QL(1 STARTER KIT/365 DAYS) SP HD
HUMIRA(CF) PEN PSOR-UV-ADOL HS	T4	PA QL(1 STARTER KIT/365 DAYS) SP HD
HYRIMOZ(CF) 10 MG/0.1 ML SYRNG	T4	PA QL(2 SYRINGES/28 DAYS) SP HD
HYRIMOZ(CF) 20 MG/0.2 ML SYRNG	T4	PA QL(2 SYRINGES/28 DAYS) SP HD
HYRIMOZ(CF) 40 MG/0.4 ML SYRNG	T4	PA QL(4 SYRINGES/28 DAYS) SP HD
HYRIMOZ(CF) PEDI CROHN 80 MG	T4	PA QL(3 SYRINGES/365 DAYS) SP HD
HYRIMOZ(CF) PEDI CROHN 80-40MG	T4	PA QL(1 SYRINGE/365 DAYS) SP HD
HYRIMOZ(CF) PEN 40 MG/0.4 ML	T4	PA QL(4 PENS/28 DAYS) SP HD
HYRIMOZ(CF) PEN 80 MG/0.8 ML	T4	PA QL(2 PENS/28 DAYS) SP HD
HYRIMOZ(CF) PEN CROHN-UC START	T4	PA QL(3 PENS/365 DAYS) SP HD
HYRIMOZ(CF) PEN PSORIASIS	T4	PA QL(1 PEN/365 DAYS) SP HD
IDACIO(CF) PEN CROHN'S-UC(6PK)	T4	PA QL(1 STARTER KIT/365 DAYS) SP HD
IDACIO(CF) PEN PSORIASIS (4PK)	T4	PA QL(2 KITS/365 DAYS) SP HD
INFLECTRA	T4	PA SP HD
INFLIXIMAB	T4	PA SP HD
REMICADE	T4	PA SP HD
RENFLEXIS	T4	PA SP HD
SIMLANDI(CF) 20 MG/0.2 ML SYRG	T4	PA QL(2 PENS/SYRINGES/28 DAYS) SP HD
SIMLANDI(CF) 40 MG/0.4 ML SYRG	T4	PA QL(4 SRNGE KITS/28 DAYS) SP HD
SIMLANDI(CF) 80 MG/0.8 ML SYRG	T4	PA QL(2 PENS/SYRINGES/28 DAYS) SP HD
SIMPONI 100 MG/ML PEN INJECTOR	T4	PA QL(1 PEN/28 DAYS) SP HD
SIMPONI 100 MG/ML SYRINGE	T4	PA QL(1 SYRINGE/28 DAYS) SP HD
SIMPONI 50 MG/0.5 ML PEN INJEC	T4	PA QL(1 PEN/28 DAYS) SP HD
SIMPONI 50 MG/0.5 ML SYRINGE	T4	PA QL(1 SYRINGE/28 DAYS) SP HD
SIMPONI ARIA	T4	PA SP HD
YUFLYMA(CF) 20 MG/0.2 ML SYRNG	T4	PA QL(2 PENS/SYRINGES/28 DAYS) SP
YUFLYMA(CF) 40 MG/0.4 ML SYRNG	T4	PA QL(4 SRNGE KITS/28 DAYS) SP
YUFLYMA(CF) 40MG/0.4ML AUTOINJ	T4	PA QL SP

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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	T4	PA QL(2 AUTO-INJS/28 DAYS) SP
YUFLYMA(CF) AI CROHN'S-UC-HS	T4	PA QL(3 PENS/365 DAYS) SP
YUSIMRY(CF) PEN	T4	PA QL(4 PENS/28 DAYS) SP
ANTINEOPLASTICS (Cancer)		
ANP - SELECTIVE RETINOID X RECEPTOR AGONISTS (RXR)		
<i>bexarotene 75 mg capsule (Targretin)</i>	T4	PA SP HD CSL
TARGRETIN 75 MG CAPSULE (bexarotene)	T4	PA SP HD CSL
ANTIBIOTIC ANTINEOPLASTICS		
ADRIAMYCIN (<i>doxorubicin hcl</i>)	T4	PA SP
<i>bleomycin sulfate</i>	T4	PA SP
<i>dactinomycin</i>	T4	PA SP
<i>daunorubicin hcl</i>	T4	PA SP
DOXIL (<i>doxorubicin hcl peg-liposomal</i>)	T4	PA SP
<i>doxorubicin hcl (Adriamycin)</i>	T4	PA SP
<i>doxorubicin hcl peg-liposomal (Doxil)</i>	T4	PA SP
ELLENCÉ (<i>epirubicin hcl</i>)	T4	PA SP
<i>epirubicin 200 mg/100 ml vial (Ellence)</i>	T4	PA SP
<i>epirubicin hcl 200 mg vial</i>	T4	SP
IDAMYCIN PFS (<i>idarubicin hcl</i>)	T4	PA SP
<i>idarubicin hcl (Idamycin Pfs)</i>	T4	PA SP
<i>mitomycin</i>	T4	PA SP
<i>valrubicin (Valstar)</i>	T4	SP
VALSTAR (<i>valrubicin</i>)	T4	SP
ZANOSAR	T4	PA SP
ZUSDURI	T4	PA SP
ANTI-CD20 (B LYMPHOCYTE) MONOCLONAL ANTIBODY		
GAZYVA	T4	PA SP
RIABNI	T4	PA SP
RITUXAN	T4	PA SP
RITUXAN HYCELA	T4	PA SP
RUXIENCE	T4	PA SP
TRUXIMA	T4	PA SP

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTINEOPLASTICS (Cancer) (con't)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTINEOPLAST HUM VEGF INHIBITOR RECOMB MC ANTIBODY		
ALYMSYS	T4	PA SP
AVASTIN	T4	PA SP
JOBEVNE	T4	PA SP
MVASI	T4	PA SP
VEGZELMA	T4	PA SP
ZIRABEV	T4	PA SP
ANTINEOPLAST,HISTONE DEACETYLASE (HDAC) INHIBITORS		
BELEODAQ	T4	PA SP
ISTODAX	T4	PA SP
<i>romidepsin 10 mg kit</i>	T4	PA SP
<i>romidepsin 10 mg vial</i>	T4	PA SP
ROMIDEPSIN 27.5 MG/5.5 ML VIAL	T4	PA SP
ZOLINZA	T4	PA QL(4 CAPS/DAY) SP HD CSL
ANTINEOPLASTIC - ALKYLATING AGENTS		
ALKERAN 2 MG TABLET (<i>melfalan</i>)	T4	SP CSL
ALKERAN 50 MG VIAL (<i>melfalan</i>)	T4	PA SP
BELRAPZO	T4	PA SP HD
<i>bendamustine 100 mg vial (Treanda)</i>	T4	PA SP
BENDAMUSTINE 100 MG/4 ML VIAL	T4	PA SP HD
<i>bendamustine 25 mg vial (Treanda)</i>	T4	PA SP
BENDEKA	T4	PA SP HD
BICNU (<i>carmustine</i>)	T4	SP
<i>busulfan (Busulfex)</i>	T4	SP
BUSULFEX (<i>busulfan</i>)	T4	SP
<i>carboplatin</i>	T4	PA SP
<i>carmustine 100 mg vial (Bicnu)</i>	T4	SP
CARMUSTINE 300 MG VIAL	T4	SP
CARMUSTINE 50 MG VIAL	T4	SP
<i>cisplatin 100 mg/100 ml vial</i>	T4	PA SP
<i>cisplatin 200 mg/200 ml vial</i>	T4	PA SP
CISPLATIN 50 MG VIAL	T4	PA SP
<i>cisplatin 50 mg/50 ml vial</i>	T4	PA SP
<i>cyclophosphamide 1 gm vial</i>	T4	SP
CYCLOPHOSPHAMIDE 1 GM/10 ML VL	T4	SP
CYCLOPHOSPHAMIDE 1 GM/2 ML VL	T4	PA SP

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTINEOPLASTICS (Cancer) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTINEOPLASTIC - ALKYLATING AGENTS		
CYCLOPHOSPHAMIDE 1 GM/5 ML VL	T4	SP
<i>cyclophosphamide 2 gm vial</i>	T4	SP
CYCLOPHOSPHAMIDE 2 GM/10 ML VL	T4	SP
CYCLOPHOSPHAMIDE 2 GM/20 ML VL	T4	SP
CYCLOPHOSPHAMIDE 2 GM/4 ML VL	T4	PA SP
<i>cyclophosphamide 25 mg capsule</i>	T4	SP HD CSL
<i>cyclophosphamide 50 mg capsule</i>	T4	SP HD CSL
CYCLOPHOSPHAMIDE 50 MG TABLET	T4	PA SP HD CSL
<i>cyclophosphamide 500 mg vial</i>	T4	SP
CYCLOPHOSPHAMIDE 500 MG/2.5 ML	T4	SP
CYCLOPHOSPHAMIDE 500 MG/ML VL	T4	PA SP
EVOMELA	T4	PA SP
FRINDOVYX	T4	PA SP
GLEOSTINE	T4	CSL
GLIADEL	T4	SP CSL
HYDREA (<i>hydroxyurea</i>)	T4	CSL
<i>hydroxyurea (Hydrea)</i>	T4	CSL
IFEX (<i>ifosfamide</i>)	T4	PA SP
<i>ifosfamide</i>	T4	PA SP
<i>ifosfamide (Ifex)</i>	T4	PA SP
IVRA	T4	PA SP
KYXATA	T4	PA SP
LEUKERAN	T4	CSL
<i>lomustine</i>	T4	CSL
<i>melphalan hcl (Alkeran)</i>	T4	PA SP
MYLERAN	T4	CSL
<i>oxaliplatin</i>	T4	PA SP
TEMODAR	T4	PA SP
<i>temozolomide</i>	T4	PA SP HD CSL
TEPADINA (<i>thiotepa</i>)	T4	PA SP
TEPYLUTE	T4	PA SP
<i>thiotepa (Tepadina)</i>	T4	PA SP

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTINEOPLASTICS (Cancer) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTINEOPLASTIC - ALKYLATING AGENTS		
TREANDA (<i>bendamustine hcl</i>)	T4	PA SP
VIVIMUSTA	T4	PA SP
YONDELIS	T4	PA SP
ZEPZELCA	T4	PA SP
ANTINEOPLASTIC - ANTIANDROGENIC AGENTS		
<i>abiraterone acetate</i> (Zytiga)	T1	PA CSL
<i>abiraterone acetate 250 mg tab</i> (Zytiga)	T4	PA SP HD CSL
<i>abiraterone acetate 500 mg tab</i> (Zytiga)	T4	PA SP HD CSL
<i>bicalutamide</i> (Casodex)	T1	CSL
CASODEX (<i>bicalutamide</i>)	T3	CSL
ERLEADA	T4	PA SP HD CSL
EULEXIN (<i>flutamide</i>)	T3	CSL
<i>flutamide</i> (Eulexin)	T1	CSL
NILANDRON (<i>nilutamide</i>)	T3	PA QL(4 TABS/DAY) CSL
<i>nilutamide</i> (Nilandron)	T1	QL(4 TABS/DAY) CSL
NUBEQA	T4	PA SP HD CSL
XTANDI	T4	PA SP HD CSL
YONSA	T4	PA SP HD CSL
ZYTIGA (<i>abiraterone acetate</i>)	T4	PA SP HD CSL
ANTINEOPLASTIC - ANTIBIOTIC AND ANTIMETABOLITE		
VYXEOS	T4	PA SP
ANTINEOPLASTIC - ANTI-CD38 MONOCLONAL ANTIBODY		
DARZALEX	T4	PA SP HD
DARZALEX FASPRO	T4	PA SP
SARCLISA	T4	PA SP
ANTINEOPLASTIC - ANTIMETABOLITES		
ALIMTA (<i>pemetrexed disodium</i>)	T4	PA SP
ARRANON (<i>nelarabine</i>)	T4	PA SP
AVGEMSI	T4	PA SP
AXTLE	T3	PA
<i>azacitidine</i> (Vidaza)	T4	PA SP
<i>capecitabine 150 mg tablet</i> (Xeloda)	T1	PA HD CSL
<i>capecitabine 150 mg tablet</i> (Xeloda)	T4	PA SP HD CSL
<i>capecitabine 500 mg tablet</i> (Xeloda)	T1	PA HD CSL

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTINEOPLASTICS (Cancer) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTINEOPLASTIC - ANTIMETABOLITES		
<i>capecitabine 500 mg tablet (Xeloda)</i>	T4	PA SP HD CSL
<i>cladribine 10 mg/10 ml vial</i>	T4	PA SP
<i>clofarabine</i>	T4	PA SP
<i>cytarabine</i>	T4	PA SP
<i>cytarabine/pf</i>	T4	PA SP
DACOGEN (<i>decitabine</i>)	T4	PA SP
<i>decitabine (Dacogen)</i>	T4	PA SP
<i>floxuridine</i>	T4	PA SP
<i>fludarabine phosphate</i>	T4	PA SP
<i>fluorouracil</i>	T4	PA SP
<i>fluorouracil 1 gram/20 ml vial</i>	T4	PA SP
<i>fluorouracil 2.5 gram/50 ml vl</i>	T4	PA SP
<i>fluorouracil 5 gram/100 ml vl</i>	T4	PA SP
<i>fluorouracil 500 mg/10 ml vial</i>	T4	PA SP
FOLOTYN 20 MG/ML VIAL	T4	PA SP
FOLOTYN 40 MG/2 ML VIAL	T4	PA SP
<i>gemcitabine 1 gram/26.3 ml vl</i>	T4	PA SP
<i>gemcitabine 2 gram/52.6 ml vl</i>	T4	PA SP
<i>gemcitabine 200 mg/5.26 ml vl</i>	T4	PA SP
<i>gemcitabine hcl 1 gram vial</i>	T4	PA SP
GEMCITABINE HCL 1 GRAM/10 ML	T4	PA SP
GEMCITABINE HCL 1.5 GRAM/15 ML	T4	PA SP
<i>gemcitabine hcl 2 gram vial</i>	T4	PA SP
GEMCITABINE HCL 2 GRAM/20 ML	T4	PA SP
<i>gemcitabine hcl 200 mg vial</i>	T4	PA SP
GEMCITABINE HCL 200 MG/2 ML VL	T4	PA SP
INFUGEM	T4	PA SP HD
INLEXZO	T4	PA SP
INQOVI	T4	PA SP HD CSL
JYLAMVO	T3	CSL
LONSURF	T4	PA SP HD CSL
<i>mercaptopurine 20 mg/ml suspen (Purixan)</i>	T4	SP CSL
<i>mercaptopurine 50 mg tablet</i>	T1	CSL
<i>methotrexate 1 gm vial</i>	T1	
<i>methotrexate 2.5 mg tablet</i>	T1	CSL

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTINEOPLASTICS (Cancer) (con't.)

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>	T4	PA SP
NIPENT	T4	PA SP
ONUREG	T4	PA QL(14 TABS/28 DAYS) SP CSL
PEMETREXED	T3	PA
<i>pemetrexed disodium 1 gm vial</i>	T4	PA SP
PEMETREXED DISODIUM 1 GM/40 ML	T3	PA
<i>pemetrexed disodium 100 mg vl (Alimta)</i>	T4	PA SP
PEMETREXED DISODIUM 100 MG/4ML	T3	PA
<i>pemetrexed disodium 500 mg vl (Alimta)</i>	T4	PA SP
PEMETREXED DISODIUM 500MG/20ML	T3	PA
<i>pemetrexed disodium 750 mg vl</i>	T4	PA SP
PEMETREXED DISODIUM 750 MG VL	T4	PA SP
PEMFEXY	T3	PA
PEMRYDI RTU	T3	PA
PRALATREXATE	T4	PA SP
PURIXAN (<i>mercaptopurine</i>)	T4	SP CSL
TABLOID	T3	CSL
TREXALL	T2	CSL
VIDAZA (<i>azacitidine</i>)	T4	PA SP
XATMEP	T3	CSL
XELODA (<i>capecitabine</i>)	T4	PA SP HD CSL
ANTINEOPLASTIC - ANTI-SLAMF7 MONOCLONAL ANTIBODY		
EMPLICITI	T4	PA SP HD
ANTINEOPLASTIC - AROMATASE INHIBITORS		
<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

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTINEOPLASTICS (Cancer) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTINEOPLASTIC - BRAF KINASE INHIBITORS		
BRAFTOVI	T4	PA SP HD CSL
OJEMDA 100 MG TAB (400MG DOSE)	T4	PA QL(1 PACKET/28 Days) SP CSL
OJEMDA 100 MG TAB (500MG DOSE)	T4	PA QL(1 PACKET/28 Days) SP CSL
OJEMDA 100 MG TAB (600MG DOSE)	T4	PA QL(1 PACKET/28 Days) SP CSL
OJEMDA 25 MG/ML ORAL SUSP	T4	PA QL(8 BOTTLES/28 DAYS) SP CSL
TAFINLAR 10 MG TABLET FOR SUSP	T4	PA QL(30 TABS/DAY) SP HD CSL
TAFINLAR 50 MG CAPSULE	T4	PA QL(4 CAPS/DAY) SP HD CSL
TAFINLAR 75 MG CAPSULE	T4	PA QL(4 CAPS/DAY) SP HD CSL
ZELBORAF	T4	PA SP HD CSL
ANTINEOPLASTIC - CD19 (B LYMPHOCYTE) MC ANTIBODY		
MONJUVI	T4	PA SP
ANTINEOPLASTIC - EGFR AND MET RECEPTOR INHIB, MAB		
RYBREVANT	T4	PA SP
ANTINEOPLASTIC - EPOCHILONES AND ANALOGS		
IXEMPRA		
ANTINEOPLASTIC - HEDGEHOG PATHWAY INHIBITOR		
DAURISMO	T4	PA SP HD CSL
ERIVEDGE	T4	PA SP HD CSL
ODOMZO	T4	PA SP HD CSL
ANTINEOPLASTIC - IMMUNOTHERAPY, T-CELL ENGAGER		
KIMMTRAK	T4	PA SP
ANTINEOPLASTIC - IMMUNOTHERAPY, VIRUS-BASED AGENTS		
IMLYGIC	T4	PA SP
ANTINEOPLASTIC - JANUS KINASE (JAK) INHIBITORS		
JAKAFI	T4	PA QL(2 TABS/DAY) SP HD CSL
ANTINEOPLASTIC - KRAS PROTEIN INHIBITOR		
KRAZATI	T4	PA QL(6 TABS/DAY) SP CSL
LUMAKRAS 120 MG TABLET	T4	PA QL(8 TABS/DAY) SP HD CSL
LUMAKRAS 240 MG TABLET	T4	PA QL(4 TABS/DAY) SP HD CSL
LUMAKRAS 320 MG TABLET	T4	PA QL(3 TABS/DAY) SP HD CSL
ANTINEOPLASTIC - MEK KINASE INHIBITORS		
COTELLIC	T4	PA SP HD CSL
GOMEKLI	T4	PA SP CSL
KOSELUGO 10 MG CAPSULE	T4	PA QL(10 CAPS/DAY) SP CSL
KOSELUGO 25 MG CAPSULE	T4	PA QL(4 CAPS/DAY) SP CSL
KOSELUGO 5 MG SPRINKLE CAPSULE	T4	PA QL(20 CAPS/DAY) SP CSL

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

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

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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	T4	PA QL(12 CAPS/DAY) SP CSL
MEKINIST 0.05 MG/ML SOLUTION	T4	PA QL(40 MLS/DAY) SP HD CSL
MEKINIST 0.5 MG TABLET	T4	PA QL(3 TABS/DAY) SP HD CSL
MEKINIST 2 MG TABLET	T4	PA QL(1 TAB/DAY) SP HD CSL
MEKTOVI	T4	PA QL(6 TABS/DAY) SP HD CSL
ANTINEOPLASTIC - MICROTUBULE INHIBITORS		
<i>eribulin mesylate</i> (Halaven)	T4	PA SP
HALAVEN (<i>eribulin mesylate</i>)	T4	PA SP
ANTINEOPLASTIC - MTOR KINASE INHIBITORS		
AFINITOR (<i>everolimus</i>)	T4	PA QL(1 TAB/DAY) SP HD CSL
AFINITOR DISPERZ (<i>everolimus</i>)	T4	PA QL(1 TAB/DAY) SP CSL
<i>everolimus</i> (Afinitor)	T4	PA QL(1 TAB/DAY) SP CSL
<i>everolimus 10 mg tablet</i> (Afinitor)	T4	PA QL(1 TAB/DAY) SP HD CSL
<i>everolimus 2 mg tab for susp</i> (Afinitor Disperz)	T4	PA QL(1 TAB/DAY) SP CSL
<i>everolimus 2.5 mg tablet</i> (Afinitor)	T4	PA QL(1 TAB/DAY) SP HD CSL
<i>everolimus 3 mg tab for susp</i> (Afinitor Disperz)	T4	PA QL(1 TAB/DAY) SP CSL
<i>everolimus 5 mg tab for susp</i> (Afinitor Disperz)	T4	PA QL(1 TAB/DAY) SP CSL
<i>everolimus 5 mg tablet</i> (Afinitor)	T4	PA QL(1 TAB/DAY) SP HD CSL
<i>everolimus 7.5 mg tablet</i> (Afinitor)	T4	PA QL(1 TAB/DAY) SP HD CSL
FYARRO	T4	PA SP
ANTINEOPLASTIC - MTOR KINASE INHIBITORS		
<i>temsirolimus</i> (Torisel)	T4	PA SP
TORISEL (<i>temsirolimus</i>)	T4	PA SP
ANTINEOPLASTIC - PROTEIN METHYLTRANSFERASE INHIBIT		
TAZVERIK	T4	PA SP CSL
ANTINEOPLASTIC - SYSTEMIC ENZYME INHIBITORS COMBS		
AVMAPKI-FAKZYNJA	T4	PA SP CSL
ANTINEOPLASTIC - TOPOISOMERASE I INHIBITORS		
CAMPTOSAR 100 MG/5 ML VIAL (<i>irinotecan hcl</i>)	T4	PA SP
CAMPTOSAR 300 MG/15 ML VIAL	T4	PA SP
CAMPTOSAR 40 MG/2 ML VIAL (<i>irinotecan hcl</i>)	T4	PA SP
HYCANTIN	T4	PA SP HD CSL
<i>irinotecan hcl</i> (Camptosar)	T4	PA SP
ONIVYDE	T4	PA SP
<i>topotecan hcl</i>	T4	PA SP HD

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

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

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

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) (con't.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTINEOPLASTIC - VEGF-A,B AND PLGF INHIBITORS		
ZALTRAP	T4	PA SP
ANTINEOPLASTIC - VEGFR ANTAGONIST		
CYRAMZA	T4	PA SP
ANTINEOPLASTIC - VINCA ALKALOIDS		
<i>vinblastine sulfate</i>	T4	PA SP
<i>vincristine sulfate</i>	T4	PA SP
<i>vinorelbine tartrate</i>	T4	PA SP
ANTINEOPLASTIC- CD22 ANTIBODY-CYTOTOXIC ANTIBIOTIC		
BESPONSA	T4	PA SP
ANTINEOPLASTIC- CD33 ANTIBODY-CYTOTOXIC ANTIBIOTIC		
MYLOTARG	T4	PA SP
ANTINEOPLASTIC COMB - KINASE AND AROMATASE INHIBIT		
KISQALI FEMARA CO-PACK	T4	PA QL(1 TAB/28 DAYS) SP CSL
ANTINEOPLASTIC EGF RECEPTOR BLOCKER MCLON ANTIBODY		
ERBITUX	T4	PA SP
HERCEPTIN	T4	PA SP
HERCEPTIN HYLECTA	T4	PA SP
HERCESSI	T4	PA SP
HERZUMA	T4	PA SP
KANJINTI	T4	PA SP
ANTINEOPLASTIC EGF RECEPTOR BLOCKER MCLON ANTIBODY		
OGIVRI	T4	PA SP
ONTRUZANT	T4	PA SP
PERJETA	T4	PA SP
PHESGO	T4	PA SP HD
PORTRAZZA	T4	PA SP
TRAZIMERA	T4	PA SP
VECTIBIX	T4	PA SP
ANTINEOPLASTIC IMMUNOMODULATOR AGENTS		
<i>lenalidomide</i>	T4	PA QL(1 CAP/DAY) SP HD CSL
POMALYST	T4	PA QL(21 CAPS/28 DAYS) SP HD CSL

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTINEOPLASTICS (Cancer) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTINEOPLASTIC IMMUNOMODULATOR AGENTS (con't.)		
REVLIMID	T4	PA QL(1 CAP/DAY) SP HD CSL
ANTINEOPLASTIC LHRH(GNRH) AGONIST,PITUITARY SUPPR.		
CAMCEVI	T4	PA SP
ELIGARD	T4	SP HD
<i>leuprolide acetate</i>	T4	PA SP HD
LEUPROLIDE DEPOT	T4	PA SP
LUPRON DEPOT 22.5 MG 3MO KIT	T4	PA SP HD
LUPRON DEPOT 45 MG 6MO KIT	T4	PA SP HD
LUPRON DEPOT 7.5 MG KIT	T4	PA SP HD
LUPRON DEPOT-4 MONTH KIT	T4	PA SP HD
LUTRATE DEPOT	T4	PA SP
TRELSTAR	T4	SP HD
VABRINTY	T4	PA SP
ZOLADEX	T4	PA SP HD
ANTINEOPLASTIC LHRH(GNRH) ANTAGONIST,PITUIT.SUPPRS		
FIRMAGON	T4	PA SP HD
ORGOVYX	T4	PA SP CSL
ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS		
ALECENSA	T4	PA QL(8 CAPS/DAY) SP HD CSL
ALIQOPA	T4	PA SP
ALUNBRIG 180 MG TABLET	T4	PA QL(1 TAB/DAY) SP CSL
ALUNBRIG 30 MG TABLET	T4	PA QL(2 TABS/DAY) SP CSL
ALUNBRIG 90 MG TABLET	T4	PA QL(1 TAB/DAY) SP CSL
ALUNBRIG 90 MG-180 MG TAB PACK	T4	PA QL(1 TAB/DAY) SP CSL
AUGTYRO 160 MG CAPSULE	T4	PA QL(2 CAPS/DAY) SP CSL
AUGTYRO 40 MG CAPSULE	T4	PA QL(8 CAPS/DAY) SP CSL
AYVAKIT	T4	PA QL(1 TAB/DAY) SP CSL
BALVERSA	T4	PA SP CSL
BORTEZOMIB 1 MG VIAL	T4	PA SP
BORTEZOMIB 2.5 MG VIAL	T4	PA SP
bortezomib 3.5 mg vial (Velcade)	T4	PA SP
BORTEZOMIB 3.5 MG/1.4 ML VIAL	T4	PA SP
BORUZU	T4	PA SP
BOSULIF 100 MG CAPSULE	T4	PA QL(3 CAPS/DAY) SP HD CSL

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTINEOPLASTICS (Cancer) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS (con't.)		
BOSULIF 100 MG TABLET	T4	PA QL(3 TABS/DAY) SP HD CSL
BOSULIF 400 MG TABLET	T4	PA QL(1 TAB/DAY) SP HD CSL
BOSULIF 50 MG CAPSULE	T4	PA QL(3 CAPS/DAY) SP HD CSL
BOSULIF 500 MG TABLET	T4	PA QL(1 TAB/DAY) SP HD CSL
BRUKINSA 160 MG TABLET	T4	PA QL(2 TABS/DAY) SP CSL
BRUKINSA 80 MG CAPSULE	T4	PA QL(4 CAPS/DAY) SP CSL
CABOMETYX	T4	PA SP HD CSL
CALQUENCE	T4	PA SP CSL
CAPRELSA 100 MG TABLET	T4	PA QL(2 TABS/DAY) SP CSL
CAPRELSA 300 MG TABLET	T4	PA QL(1 TAB/DAY) SP CSL
COMETRIQ 100 MG DAILY-DOSE PK	T4	PA QL(56 CAPS/28 DAYS) SP HD CSL
COMETRIQ 140 MG DAILY-DOSE PK	T4	PA QL(112 CAPS/28 DAYS) SP HD CSL
COMETRIQ 60 MG DAILY-DOSE PACK	T4	PA QL(84 CAPS/28 DAYS) SP HD CSL
COPIKTRA	T4	PA SP CSL
DANZITEN	T4	PA SP CSL
<i>dasatinib 100 mg tablet (Sprycel)</i>	T4	QL(1 TAB/DAY) SP CSL
<i>dasatinib 100 mg tablet (Sprycel)</i>	T4	QL(1 TAB/DAY) SP HD CSL
<i>dasatinib 140 mg tablet (Sprycel)</i>	T4	QL(1 TAB/DAY) SP CSL
<i>dasatinib 140 mg tablet (Sprycel)</i>	T4	QL(1 TAB/DAY) SP HD CSL
<i>dasatinib 20 mg tablet (Sprycel)</i>	T4	QL(3 TABS/DAY) SP CSL
<i>dasatinib 20 mg tablet (Sprycel)</i>	T4	QL(3 TABS/DAY) SP HD CSL
<i>dasatinib 50 mg tablet (Sprycel)</i>	T4	QL(1 TAB/DAY) SP CSL
<i>dasatinib 50 mg tablet (Sprycel)</i>	T4	QL(1 TAB/DAY) SP HD CSL
<i>dasatinib 70 mg tablet (Sprycel)</i>	T4	QL(2 TABS/DAY) SP CSL
<i>dasatinib 70 mg tablet (Sprycel)</i>	T4	QL(2 TABS/DAY) SP HD CSL
<i>dasatinib 80 mg tablet (Sprycel)</i>	T4	QL(1 TAB/DAY) SP CSL
<i>dasatinib 80 mg tablet (Sprycel)</i>	T4	QL(1 TAB/DAY) SP HD CSL
ENSACOVE 100 MG CAPSULE	T4	PA QL(2 CAPS/DAY) SP CSL

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTINEOPLASTICS (Cancer) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS (con't.)		
ENSACOVE 25 MG CAPSULE	T4	PA QL(9 CAPS/DAY) SP CSL
<i>erlotinib hcl</i>	T4	PA SP HD CSL
FOTIVDA	T4	PA QL(21 CAPS/28 DAYS) SP CSL
FRUZAQLA 1 MG CAPSULE	T4	PA QL(84 CAPS/28 DAYS) SP CSL
FRUZAQLA 5 MG CAPSULE	T4	PA QL(21 CAPS/28 DAYS) SP CSL
GAVRETO	T4	PA QL(4 CAPS/DAY) SP CSL
<i>gefitinib (Iressa)</i>	T4	PA SP HD CSL
GILOTRIF	T4	PA SP HD CSL
GLEEVEC 100 MG TABLET (imatinib mesylate)	T4	PA QL(6 TABS/DAY) SP HD CSL
GLEEVEC 400 MG TABLET (imatinib mesylate)	T4	PA QL(2 TABS/DAY) SP HD CSL
IBRANCE 100 MG CAPSULE	T4	PA QL(21 CAPS/28 DAYS) SP HD CSL
IBRANCE 100 MG TABLET	T4	PA QL(21 TABS/28 DAYS) SP HD CSL
IBRANCE 125 MG CAPSULE	T4	PA QL(21 CAPS/28 DAYS) SP HD CSL
IBRANCE 125 MG TABLET	T4	PA QL(21 TABS/28 DAYS) SP HD CSL
IBRANCE 75 MG CAPSULE	T4	PA QL(21 CAPS/28 DAYS) SP HD CSL
IBRANCE 75 MG TABLET	T4	PA QL(21 TABS/28 DAYS) SP HD CSL
IBTROZI	T4	PA SP CSL
ICLUSIG	T4	PA QL(1 TAB/DAY) SP CSL
<i>imatinib mesylate 100 mg tab (Gleevec)</i>	T4	QL(6 TABS/DAY) SP HD CSL
<i>imatinib mesylate 400 mg tab (Gleevec)</i>	T4	QL(2 TABS/DAY) SP HD CSL
IMBRUVICA 140 MG CAPSULE	T4	PA QL(4 CAPS/DAY) SP CSL
IMBRUVICA 140 MG TABLET	T4	PA QL(1 TAB/DAY) SP CSL
IMBRUVICA 280 MG TABLET	T4	PA QL(1 TAB/DAY) SP CSL
IMBRUVICA 420 MG TABLET	T4	PA QL(1 TAB/DAY) SP CSL
IMBRUVICA 70 MG CAPSULE	T4	PA QL(1 CAP/DAY) SP CSL
IMBRUVICA 70 MG/ML SUSPENSION	T4	PA QL(8 MLS/DAY) SP CSL
IMKELDI	T4	PA SP CSL
INLYTA	T4	PA SP HD CSL
INREBIC	T4	PA SP HD CSL
IRESSA (<i>gefitinib</i>)	T4	PA SP HD CSL
ITOVEBI	T4	PA SP HD CSL
IWILFIN	T4	PA QL(8 TABS/DAY) SP CSL

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTINEOPLASTICS (Cancer) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS (con't.)		
JAYPIRCA 100 MG TABLET	T4	PA QL(2 TABS/DAY) SP CSL
JAYPIRCA 50 MG TABLET	T4	PA QL(1 TAB/DAY) SP CSL
KISQALI 200 MG DAILY DOSE	T4	PA QL(21 TABS/28 DAYS) SP HD CSL
KISQALI 400 MG DAILY DOSE	T4	PA QL(42 TABS/28 DAYS) SP HD CSL
KISQALI 600 MG DAILY DOSE	T4	PA QL(63 TABS/28 DAYS) SP HD CSL
KYPROLIS	T4	PA SP HD
<i>lapatinib ditosylate</i> (Tykerb)	T4	PA QL(6 TABS/DAY) SP HD CSL
LAZCLUZE	T4	PA SP CSL
LENVIMA	T4	PA SP HD CSL
LORBRENA 100 MG TABLET	T4	PA QL(1 TAB/DAY) SP HD CSL
LORBRENA 25 MG TABLET	T4	PA QL(3 TABS/DAY) SP HD CSL
LYNPARZA	T4	PA QL(4 TABS/DAY) SP HD CSL
LYTGOBI 12 MG DOSE (3X 4MG TB)	T4	PA QL(3 TABS/DAY) SP CSL
LYTGOBI 16 MG DOSE (4X 4MG TB)	T4	PA QL(4 TABS/DAY) SP CSL
LYTGOBI 20 MG DOSE (5X 4MG TB)	T4	PA QL(5 TABS/DAY) SP CSL
NERLYNX	T4	PA SP HD CSL
NEXAVAR (<i>sorafenib tosylate</i>)	T4	PA QL(4 TABS/DAY) SP HD CSL
NILOTINIB D-TARTRATE	T4	PA SP CSL
<i>nilotinib hcl</i> (Tasigna)	T4	PA QL(4 CAPS/DAY) SP HD CSL
NINLARO	T4	PA QL(3 CAPS/28 DAYS) SP HD CSL
OGSIVEO 100 MG TABLET	T4	PA QL(2 TABS/DAY) SP CSL
OGSIVEO 150 MG TABLET	T4	PA QL(2 TABS/DAY) SP CSL
OGSIVEO 50 MG TABLET	T4	PA QL(6 TABS/DAY) SP CSL
OJJAARA	T4	PA QL(1 TAB/DAY) SP CSL
<i>pazopanib hcl 200 mg tablet</i> (Votrient)	T4	PA QL(4 TABS/DAY) SP CSL
PEMAZYRE	T4	PA QL(14 TABS/21 DAYS) SP CSL
PIQRAY	T4	PA SP CSL
QINLOCK	T4	PA QL(3 TABS/DAY) SP CSL
RETEVMO 120 MG TABLET	T4	PA QL(2 TABS/DAY) SP HD CSL
RETEVMO 160 MG TABLET	T4	PA QL(2 TABS/DAY) SP HD CSL
RETEVMO 40 MG CAPSULE	T4	PA QL(6 CAPS/DAY) SP HD CSL
RETEVMO 40 MG TABLET	T4	PA QL(3 TABS/DAY) SP HD CSL
RETEVMO 80 MG CAPSULE	T4	PA QL(4 CAPS/DAY) SP HD CSL
RETEVMO 80 MG TABLET	T4	PA QL(2 TABS/DAY) SP HD CSL
REVUFORJ 110 MG TABLET	T4	PA QL(4 TABS/DAY) SP CSL

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

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

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTINEOPLASTICS (Cancer) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS (con't.)		
REVUFORJ 160 MG TABLET	T4	PA QL(2 TABS/DAY) SP CSL
REVUFORJ 25 MG TABLET	T4	PA QL(8 TABS/DAY) SP CSL
ROMVIMZA	T4	PA QL(8 CAPS/28 DAYS) SP CSL
ROZLYTREK	T4	PA SP HD CSL
RUBRACA	T4	PA QL(4 TABS/DAY) SP CSL
RYDAPT	T4	PA SP HD CSL
RYTELO	T4	PA SP
SCEMBLIX 100 MG TABLET	T4	PA SP CSL
SCEMBLIX 20 MG TABLET	T4	PA QL(2 TABS/DAY) SP CSL
SCEMBLIX 40 MG TABLET	T4	PA SP CSL
<i>sorafenib tosylate (Nexavar)</i>	T4	PA QL(4 TABS/DAY) SP HD CSL
SPRYCEL 100 MG TABLET (dasatinib)	T4	PA QL(1 TAB/DAY) SP HD CSL
SPRYCEL 140 MG TABLET (dasatinib)	T4	PA QL(1 TAB/DAY) SP HD CSL
SPRYCEL 20 MG TABLET (dasatinib)	T4	PA QL(3 TABS/DAY) SP HD CSL
SPRYCEL 50 MG TABLET (dasatinib)	T4	PA QL(1 TAB/DAY) SP HD CSL
SPRYCEL 70 MG TABLET (dasatinib)	T4	PA QL(2 TABS/DAY) SP HD CSL
SPRYCEL 80 MG TABLET (dasatinib)	T4	PA QL(1 TAB/DAY) SP HD CSL
STIVARGA	T4	PA QL(84 TABS/28 DAYS) SP HD CSL
<i>sunitinib malate (Sutent)</i>	T4	PA QL(1 CAP/DAY) SP HD CSL
SUTENT (sunitinib malate)	T4	PA QL(1 CAP/DAY) SP HD CSL
TABRECTA	T4	PA QL(4 TABS/DAY) SP HD CSL
TAGRISSO	T4	PA SP HD CSL
TALZENNA 0.1 MG CAPSULE	T4	PA QL(1 CAP/DAY) SP CSL
TALZENNA 0.1 MG SOFTGEL	T4	PA QL(1 CAP/DAY) SP CSL
TALZENNA 0.25 MG CAPSULE	T4	PA QL(1 CAP/DAY) SP CSL
TALZENNA 0.25 MG SOFTGEL	T4	PA QL(1 CAP/DAY) SP CSL
TALZENNA 0.35 MG SOFTGEL	T4	PA QL(1 CAP/DAY) SP CSL
TALZENNA 0.5 MG CAPSULE	T4	PA SP CSL
TALZENNA 0.5 MG SOFTGEL	T4	PA SP CSL
TALZENNA 0.75 MG SOFTGEL	T4	PA SP CSL
TALZENNA 1 MG CAPSULE	T4	PA QL(1 CAP/DAY) SP CSL
TALZENNA 1 MG SOFTGEL	T4	PA QL(1 CAP/DAY) SP CSL
TASIGNA (nilotinib hcl)	T4	PA QL(4 CAPS/DAY) SP HD CSL
TEPMETKO	T4	PA QL(2 TABS/DAY) SP CSL
TRUQAP	T4	PA QL(64 TABS/28 DAYS) SP CSL

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTINEOPLASTICS (Cancer) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS (con't.)		
TUKYSA	T4	PA SP CSL
TURALIO	T4	PA QL(4 CAPS/DAY) SP CSL
TYKERB (<i>lapatinib ditosylate</i>)	T4	PA QL(6 TABS/DAY) SP HD CSL
VANFLYTA	T4	PA QL(2 TABS/DAY) SP CSL
VELCADE (<i>bortezomib</i>)	T4	PA SP
VERZENIO	T4	PA QL(2 TABS/DAY) SP HD CSL
VITRAKVI	T4	PA SP HD CSL
VIZIMPRO	T4	PA SP HD CSL
VONJO	T4	PA QL(4 CAPS/DAY) SP CSL
VOTRIENT (<i>pazopanib hcl</i>)	T4	PA QL(4 TABS/DAY) SP HD CSL
XALKORI 150 MG PELLETT	T4	PA QL(6 PELLETS/DAY) SP HD CSL
XALKORI 20 MG PELLETT	T4	PA QL(4 PELLETS/DAY) SP HD CSL
XALKORI 200 MG CAPSULE	T4	PA QL(4 CAPS/DAY) SP HD CSL
XALKORI 250 MG CAPSULE	T4	PA QL(4 CAPS/DAY) SP HD CSL
XALKORI 50 MG PELLETT	T4	PA QL(4 PELLETS/DAY) SP HD CSL
XOSPATA	T4	PA SP CSL
ZEJULA	T4	PA QL(1 TAB/DAY) SP CSL
ZYDELIG	T4	PA QL(2 TABS/DAY) SP HD CSL
ZYKADIA	T4	PA QL(3 TABS/DAY) SP HD CSL
ANTINEOPLASTIC, ANTI-PROGRAMMED DEATH-I (PD-I) MAB		
JEMPERLI	T4	PA SP
KEYTRUDA	T4	PA SP
KEYTRUDA QLEX	T4	PA SP
LIBTAYO	T4	PA SP
LOQTORZI	T4	PA SP
OPDIVO	T4	PA SP HD
OPDIVO QVANTIG	T4	PA SP
TEVIMBRA	T4	PA SP
ZYNYZ	T4	PA SP
ANTINEOPLASTIC-B CELL LYMPHOMA-2(BCL-2) INHIBITORS		
VENCLEXTA	T4	PA SP CSL
VENCLEXTA STARTING PACK	T4	PA SP CSL
ANTINEOPLASTIC-ENZYME INHIB, ANTIANDROGEN COMB.		
AKEEGA	T4	PA QL(2 TABS/DAY) SP CSL

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

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

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTI-NEOPLASTICS (Cancer) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTINEOPLASTIC-HYPOXIA INDUCIBLE FACTOR (HIF) INH		
WELIREG	T4	PA QL(3 TABS/DAY) SP CSL
ANTINEOPLASTIC-IMMUNOTHERAPY CHECKPOINT INHIB COMB		
OPDUALAG	T4	PA SP HD
ANTINEOPLASTIC-INTERLEUKIN-6(IL-6)INHIB,ANTIBODY		
SYLVANT	T4	PA SP
ANTINEOPLASTIC-ISOCITRATE DEHYDROGENASE INHIBITORS		
IDHIFA	T4	PA SP HD CSL
REZLIDHIA	T4	PA QL(2 CAPS/DAY) SP CSL
TIBSOVO	T4	PA SP CSL
VORANIGO	T4	PA SP CSL
ANTINEOPLASTICS ANTIBODY/ANTIBODY-DRUG COMPLEXES		
ADCETRIS	T4	PA SP
BIZENGRI	T4	PA SP
BLENREP	T4	PA SP
BLINCYTO	T4	PA SP
COLUMVI	T4	PA SP HD
DATROWAY	T4	PA SP
ELAHERE	T4	PA SP
ELREXFIO	T4	PA SP
EMRELIS	T4	PA SP
ENHERTU	T4	PA SP HD
EPKINLY	T4	PA SP
IMDELLTRA	T4	PA SP
KADCYLA	T4	PA SP
LUNSUMIO	T4	PA SP
LYNOZYFIC	T4	PA SP
PADCEV	T4	PA SP
POLIVY	T4	PA SP HD
POTELIGEO	T4	PA SP
TALVEY	T4	PA SP
TECVAYLI	T4	PA SP

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

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

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTI-NEOPLASTICS (Cancer) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTINEOPLASTICS ANTIBODY/ANTIBODY-DRUG COMPLEXES (con't.)		
TIVDAK	T4	PA SP HD
TRODELVY	T4	PA SP
UNITUXIN	T4	PA SP
VYLOY	T4	PA SP
ZEVALIN	T4	PA SP
ZIIHERA	T4	PA SP
ZYNLONTA	T4	PA SP
ANTINEOPLASTICS, MISCELLANEOUS		
ABRAXANE (<i>paclitaxel protein-bound</i>)	T4	PA SP
<i>arsenic trioxide</i>	T4	PA SP
<i>arsenic trioxide (Trisenox)</i>	T4	PA SP
ASPARLAS	T4	SP
BCG (TICE STRAIN)	T4	SP
BEIZRAY-ALBUMIN	T4	PA
<i>dacarbazine</i>	T4	PA SP
DOCEFREZ	T4	PA SP
<i>docetaxel 160 mg/16 ml vial</i>	T4	PA SP
<i>docetaxel 160 mg/8 ml vial</i>	T4	PA SP HD
<i>docetaxel 20 mg/2 ml vial</i>	T4	PA SP
<i>docetaxel 20 mg/ml vial</i>	T4	PA SP
<i>docetaxel 80 mg/4 ml vial</i>	T4	PA SP
<i>docetaxel 80 mg/8 ml vial</i>	T4	PA SP
DOCIVYX	T4	PA SP
ERWINASE	T4	PA SP
ETOPHOS	T4	PA SP
<i>etoposide</i>	T4	PA SP
<i>etoposide 1,000 mg/50 ml vial</i>	T4	PA SP
<i>etoposide 100 mg/5 ml vial</i>	T4	PA SP
<i>etoposide 50 mg capsule</i>	T4	SP HD CSL
<i>etoposide 500 mg/25 ml vial</i>	T4	PA SP
JEVTANA	T4	PA SP HD
LYSODREN	T4	CSL
MATULANE	T4	SP CSL
<i>mitoxantrone hcl</i>	T4	PA SP

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

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

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTI-NEOPLASTICS (Cancer) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTINEOPLASTICS, MISCELLANEOUS (con't.)		
ONCASPAR	T4	PA SP
<i>paclitaxel</i>	T4	PA SP
<i>paclitaxel protein-bound (Abraxane)</i>	T4	PA SP
RYLAZE	T4	PA SP
<i>tretinoin 10 mg capsule</i>	T4	PA CSL
TRISENOX (<i>arsenic trioxide</i>)	T4	PA SP
ANTINEOPLASTIC-SELECT INHIB OF NUCLEAR EXP (SINE)		
XPOVIO	T4	PA SP CSL
ANTI-PROGRAMMED CELL DEATH-LIGAND 1 (PD-L1) MAB		
BAVENCIO	T4	PA SP
IMFINZI	T4	PA SP
TECENTRIQ	T4	PA SP HD
TECENTRIQ HYBREZA	T4	PA SP HD
UNLOXCYT	T4	PA SP
CYTOTOXIC T-LYMPHOCYTE ANTIGEN(CTLA-4)RMC ANTIBODY		
IMJUDO	T4	PA SP HD
YERVOY	T4	PA SP HD
IMMUNOMODULATORS		
ACTIMMUNE	T4	PA SP HD
ALFERON N	T4	PA SP HD
BESREMI	T4	PA QL(2 SYRINGES/28 DAYS) SP
PROLEUKIN	T4	PA SP
PHOTOACTIVATED, ANTINEOPLASTIC AGENTS (SYSTEMIC)		
PHOTOFRIN	T4	SP
UVADEX	T2	
RADIOACTIVE THERAPEUTIC AGENTS		
AZEDRA DOSIMETRIC	T4	PA SP
AZEDRA THERAPEUTIC	T4	PA SP
SELECTIVE ESTROGEN RECEPTOR MODULATORS (SERMS)		
FARESTON (<i>toremifene citrate</i>)	T3	QL(2 TABS/DAY) HD CSL
FASLODEX (<i>fulvestrant</i>)	T4	PA SP HD
<i>fulvestrant (Faslodex)</i>	T4	PA SP HD
ORSERDU 345 MG TABLET	T4	PA QL(1 TAB/DAY) SP CSL
ORSERDU 86 MG TABLET	T4	PA QL(3 TABS/DAY) SP CSL

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

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

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTI-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	T4	SP
TOPICAL ANTINEOPLASTIC PREMALIGNANT LESION AGENTS		
<i>bexarotene 1% gel</i> (Targretin)	T4	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	T4	SP HD
TARGRETIN 1% GEL (bexarotene)	T4	PA SP HD
VALCHLOR	T4	SP HD
ANTIPARASITICS (Eye Conditions)		
OPHTHALMIC (EYE) ANTIPARASITICS		
XDEMVY	T4	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
 T2 – Typically Preferred Brands
 T3 – Typically Non-Preferred Brands

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIPARASITICS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL ANTIPARASITICS		
crotamiton	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>)	T4	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	T4	PA SP HD
<i>apomorphine hcl</i>	T4	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

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-PARKINSONISM DRUGS, OTHER (cont.)		
<i>carbidopa-levo er 25-100 tab</i>	T1	HD
<i>carbidopa-levo 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	T4	PA QL(1 TAB/DAY) SP HD
ONAPGO	T4	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	T4	PA SP HD
XADAGO	T3	ST HD
ZELAPAR	T3	PA HD

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTI-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	T4	PA SP
ANTI-RETROVIRAL - CAPSID INHIBITORS		
SUNLENCA 300 MG TABLET	T4	PA QL(5 TABS/180 DAYS) SP

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIVIRALS (AIDS/HIV) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-RETROVIRAL - CAPSID INHIBITORS (cont.)		
SUNLENCA 4- 300 MG TABLET	T4	PA QL(5 TABS/180 DAYS) SP
SUNLENCA 463.5 MG/1.5 ML VIAL	T4	PA SP
SUNLENCA 5- 300 MG TABLET	T4	PA QL(5 TABS/180 DAYS) SP
ANTI-RETROVIRAL - INTEGRASE INHIBITOR AND NNRTI COMB.		
CABENUVA	T4	PA SP
JULUCA	T4	SP
ANTI-RETROVIRAL - INTEGRASE INHIBITOR AND NRTI COMB.		
DOVATO	T4	SP
ANTI-RETROVIRAL - NRTIS AND INTEGRASE INHIBITORS COMB		
TRIUMEQ	T4	QL(1 TAB/DAY) SP
TRIUMEQ PD	T4	QL(6 TABS/DAY) SP
ANTI-RETROVIRAL - NUCLEOSIDE, NUCLEOTIDE, PROTEASE INH.		
SYM TUZA	T4	QL(1 TAB/DAY) SP
ANTIVIRALS - HIV-SPEC, NON-PEPTIDIC PROTEASE INHIB		
APTIVUS	T4	PA SP
<i>darunavir</i> (Prezista)	T4	SP
PREZCOBIX	T4	PA SP
PREZISTA 100 MG/ML SUSPENSION	T4	SP
PREZISTA 150 MG TABLET	T4	SP
PREZISTA 600 MG TABLET (<i>darunavir</i>)	T4	PA SP
PREZISTA 75 MG TABLET	T4	SP
PREZISTA 800 MG TABLET (<i>darunavir</i>)	T4	PA SP
ANTIVIRALS - HIV-SPEC, NUCLEOSIDE-NUCLEOTIDE ANALOG		
CIMDUO	T4	PA SP
DESCOVY 120-15 MG TABLET	T4	SP
DESCOVY 200-25 MG TABLET	T4	SP PPACA
<i>emtricitabine-tenofv 100-150mg</i> (Truvada)	T4	SP
<i>emtricitabine-tenofv 133-200mg</i> (Truvada)	T4	SP
<i>emtricitabine-tenofv 167-250mg</i> (Truvada)	T4	SP
<i>emtricitabine-tenofv 200-300mg</i> (Truvada)	T4	SP PPACA
TRUVADA (<i>emtricitabine/tenofovir</i> (<i>tdf</i>))	T4	PA SP
ANTIVIRALS - HIV-SPEC, NUCLEOSIDE ANALOG, RTI COMB		
<i>abacavir sulfate/lamivudine</i> (Epzicom)	T4	PA SP
COMBIVIR (<i>lamivudine/zidovudine</i>)	T4	PA SP
EPZICOM (<i>abacavir sulfate/lamivudine</i>)	T4	PA SP
<i>lamivudine/zidovudine</i> (Combivir)	T4	SP

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIVIRALS (AIDS/HIV) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIVIRALS - HIV-SPECIFIC, CCR5 CO-RECEPTOR ANTAG.		
<i>maraviroc</i> (Selzentry)	T4	PA SP
SELZENTRY 150 MG TABLET (maraviroc)	T4	PA SP
SELZENTRY 20 MG/ML ORAL SOLN	T4	PA SP
SELZENTRY 300 MG TABLET (maraviroc)	T4	PA SP
ANTIVIRALS - HIV-SPECIFIC, CD4 ATTACHMENT INHIBITOR		
RUKOBIA	T4	PA QL(2 TABS/DAY) SP
ANTIVIRALS - HIV-SPECIFIC, FUSION INHIBITORS		
FUZEON	T4	PA SP
ANTIVIRALS - HIV-SPECIFIC, NON-NUCLEOSIDE, RTI		
EDURANT	T4	PA SP
EDURANT PED	T4	PA SP
ANTIVIRALS - HIV-SPECIFIC, NON-NUCLEOSIDE, RTI (cont.)		
<i>efavirenz</i>	T4	PA SP
<i>etravirine</i> (Intence)	T4	SP
INTELENCE (etravirine)	T4	PA SP
<i>nevirapine</i>	T4	PA SP
PIFELTRO	T4	PA SP
ANTIVIRALS - HIV-SPECIFIC, NUCLEOSIDE ANALOG, RTI		
<i>abacavir sulfate</i>	T4	PA SP
<i>abacavir sulfate</i> (Ziagen)	T4	PA SP
<i>didanosine</i>	T4	PA SP
<i>emtricitabine</i> (Emtriva)	T4	SP
EMTRIVA 10 MG/ML SOLUTION	T4	PA SP
EMTRIVA 200 MG CAPSULE (emtricitabine)	T4	PA SP
EPIVIR (lamivudine)	T4	PA SP
<i>lamivudine 10 mg/ml oral soln</i> (Epivir)	T4	SP
<i>lamivudine 150 mg tablet</i> (Epivir)	T4	SP
<i>lamivudine 300 mg tablet</i> (Epivir)	T4	PA SP
<i>lamivudine 300 mg/30ml sol cup</i> (Epivir)	T4	SP
RETROVIR (<i>zidovudine</i>)	T4	PA SP
<i>stavudine</i>	T4	PA SP
ZIAGEN (<i>abacavir sulfate</i>)	T4	PA SP
<i>zidovudine</i>	T4	SP

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIVIRALS (AIDS/HIV) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIVIRALS - HIV-SPECIFIC, NUCLEOSIDE ANALOG, RTI		
<i>zidovudine</i> (Retrovir)	T4	SP
<i>tenofovir disoproxil fumarate</i> (Viread)	T4	PA SP
VIREAD 150 MG TABLET	T4	PA SP
VIREAD 200 MG TABLET	T4	PA SP
VIREAD 250 MG TABLET	T4	PA SP
VIREAD 300 MG TABLET (tenofovir disoproxil fumarate)	T4	PA SP
VIREAD POWDER	T4	PA SP
ANTIVIRALS, HIV-SPECIFIC, PROTEASE INHIBITOR COMB		
KALETRA (lopinavir/ritonavir)	T4	PA SP
<i>lopinavir/ritonavir</i> (Kaletra)	T4	SP
<i>atazanavir sulfate</i>	T4	PA SP
<i>atazanavir sulfate</i> (Reyataz)	T4	PA SP
EVOTAZ	T4	PA SP
<i>fosamprenavir calcium</i>	T4	PA SP
NORVIR 100 MG POWDER PACKET	T4	SP
NORVIR 100 MG TABLET (<i>ritonavir</i>)	T4	PA SP
REYATAZ 200 MG CAPSULE (<i>atazanavir sulfate</i>)	T4	PA SP
REYATAZ 300 MG CAPSULE (<i>atazanavir sulfate</i>)	T4	PA SP
REYATAZ 50 MG POWDER PACKET	T4	PA SP
<i>ritonavir</i> (Norvir)	T4	SP
VIRACEPT	T4	PA SP
ANTIVIRALS - HIV-1 INTEGRASE STRAND TRANSFER INHIBTR		
APRETUDE	T4	SP PPACA
ISENTRESS	T4	SP
ISENTRESS HD	T4	PA SP
TIVICAY	T4	SP
TIVICAY PD	T4	SP
ARTV NUCLEOSIDE, NUCLEOTIDE, NON-NUCLEOSIDE RTI COMB		
COMPLERA (<i>emtricitabine/rilpivirine/tenofovir disoproxil fumarate</i>)	T4	PA QL(1 TAB/DAY) SP
DELSTRIGO	T4	PA QL(1 TAB/DAY) SP
<i>efavirenz/emtricitabine/tenofovir disoproxil fumarate</i>	T4	QL(1 TAB/DAY) SP
<i>efavirenz/lamivudine/tenofovir disoproxil fumarate</i> (Symfi Lo)	T4	QL(1 TAB/DAY) SP

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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>	T4	QL(1 TAB/DAY) SP
<i>emtricitra/rilpivirine/tenof df (Complera)</i>	T4	QL(1 TAB/DAY) SP
ODEFSEY	T4	PA QL(1 TAB/DAY) SP
SYMFI (<i>efavirenz/lamivu/tenofov disop</i>)	T4	PA QL(1 TAB/DAY) SP
SYMFI LO (<i>efavirenz/lamivu/tenofov disop</i>)	T4	PA QL(1 TAB/DAY) SP
ARV-NUCLEOSIDE, NUCLEOTIDE RTI, INTEGRASE INHIBITORS		
BIKTARVY	T4	QL(1 TAB/DAY) SP
GENVOYA	T4	QL(1 TAB/DAY) SP
STRIBILD	T4	PA QL(1 TAB/DAY) SP

ANTIVIRALS (Eye Conditions)

EYE ANTIVIRALS

<i>trifluridine</i>	T1	
ZIRGAN	T3	

ANTIVIRALS (Infections)

ANTIVIRAL - MAIN PROTEASE (MPRO) INHIBITOR

PAXLOVID	T2	QL(1 TAB/120 DAYS)
----------	----	--------------------

ANTIVIRAL - RNA POLYMERASE INHIBITOR

SYNAGIS	T4	PA SP HD
---------	----	----------

ANTIVIRAL MONOCLONAL ANTIBODIES

BEYFORTUS	T3	PPACA
ENFLONIA	T3	PPACA
EVUSHELD (EUA)	T3	
SYNAGIS	T4	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>	T4	SP
<i>famciclovir</i>	T1	
FLUMADINE (<i>rimantadine hcl</i>)	T3	

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

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

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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	T4	SP
<i>ganciclovir sodium</i>	T4	SP
LIVTENCITY	T4	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	T4	SP
PREVMIS 20 MG PELLETT PACKET	T4	SP
PREVMIS 240 MG TABLET	T4	SP HD
PREVMIS 240 MG/12 ML VIAL	T4	SP
PREVMIS 480 MG TABLET	T4	SP HD
PREVMIS 480 MG/24 ML VIAL	T4	SP
RAPIVAB	T3	
RELENZA	T3	QL(20 BLISTERS/30 DAYS)
<i>rimantadine hcl</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	T4	PA QL(1 TAB/DAY) SP HD
HEP C VIRUS, NUCLEOTIDE ANALOG NS5B POLYMERASE INH		
SOVALDI 150 MG PELLETT PACKET	T4	PA QL(1 PACK/DAY) SP HD

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

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

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

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

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	T4	PA QL(1 PACK/DAY) SP HD
SOVALDI 200 MG TABLET	T4	PA QL(1 TAB/DAY) SP HD
SOVALDI 400 MG TABLET	T4	PA QL(1 TAB/DAY) SP HD
HEP C VIRUS-NS5B POLYMERASE AND NS5A INHIB. COMBO.		
EPCLUSA 150-37.5 MG PELLETT PKT	T4	PA QL(1 PACK/DAY) SP HD
EPCLUSA 200 MG-50 MG TABLET	T4	PA QL(1 TAB/DAY) SP HD
EPCLUSA 200-50 MG PELLETT PACK	T4	PA QL(1 PACK/DAY) SP HD
EPCLUSA 400 MG-100 MG TABLET	T4	PA QL(1 TAB/DAY) SP HD
HARVONI 33.75-150 MG PELLETT PK	T4	PA QL(1 PACK/DAY) SP HD
HARVONI 45-200 MG PELLETT PACKT	T4	PA QL(1 PACK/DAY) SP HD
HARVONI 45-200 MG TABLET	T4	PA QL(1 TAB/DAY) SP HD
HARVONI 90-400 MG TABLET	T4	PA QL(1 TAB/DAY) SP HD
LEDIPASVIR-SOFOSBUVIR	T4	PA QL(1 TAB/DAY) SP HD
SOFOSBUVIR-VELPATASVIR	T4	PA QL(1 TAB/DAY) SP HD
HEPATITIS B TREATMENT AGENTS		
<i>adefovir dipivoxil</i>	T4	SP HD
BARACLUDE 0.05 MG/ML SOLUTION	T4	SP HD
BARACLUDE 0.5 MG TABLET (<i>entecavir</i>)	T4	PA QL(1 TAB/DAY) SP HD
BARACLUDE 1 MG TABLET (<i>entecavir</i>)	T4	PA SP HD
<i>entecavir 0.5 mg tablet</i> (Baraclude)	T4	QL(1 TAB/DAY) SP HD
<i>entecavir 1 mg tablet</i> (Baraclude)	T4	SP HD
<i>lamivudine</i>	T4	SP
VEMLIDY	T4	SP HD
HEPATITIS C TREATMENT AGENTS		
PEGASYS	T4	PA SP HD
<i>ribavirin</i>	T4	SP HD
HEPATITIS C VIRUS- NS5A AND NS3/4A INHIBITOR COMB		
MAVYRET 100-40 MG TABLET	T4	PA QL(3 TABS/DAY) SP HD
MAVYRET 50-20 MG PELLETT PACKET	T4	PA QL(5 PACKS/DAY) SP HD
ZEPATIER	T4	PA QL(1 TAB/DAY) SP HD
ANTIVIRALS (Skin Conditions)		
TOPICAL ANTIVIRAL AND ANTI-INFLAMMATORY STEROID		
XERESE	T3	PA QL(5 GMS/30 DAYS)

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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	

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

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

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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>	T4	SP HD
<i>droxidopa 200 mg capsule (Northera)</i>	T1	HD
<i>droxidopa 200 mg capsule (Northera)</i>	T4	SP HD
<i>droxidopa 300 mg capsule (Northera)</i>	T1	HD
<i>droxidopa 300 mg capsule (Northera)</i>	T4	SP HD
<i>midodrine hcl</i>	T1	
NORTHERA (<i>droxidopa</i>)	T4	PA SP HD
ALPHA-ADRENERGIC BLOCKING AGENTS		
DIBENZYLIN (<i>phenoxybenzamine hcl</i>)	T3	HD
<i>phenoxybenzamine hcl (Dibenzylin)</i>	T1	HD
<i>phentolamine mesylate</i>	T1	HD

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

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>	T4	PA SP
<i>BOTOX 200 UNIT VIAL</i>	T4	PA SP HD
<i>cisatracurium besylate (Nimbex)</i>	T1	
<i>DAXXIFY</i>	T4	PA SP
<i>DYSPORT</i>	T4	PA SP HD
<i>MYOBLOC</i>	T4	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	

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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	T4	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	T4	PA SP
RAGWITEK	T3	PA QL(1 TAB/DAY)

BIOLOGICALS (Blood Pressure/Heart Medications)

PLASMA KALLIKREIN INHIBITORS		
TAKHZYRO	T4	PA SP HD

BIOLOGICALS (Miscellaneous)

ANTISERA		
HYPERRHO	T4	SP
RHOGAM ULTRA-FILTERED PLUS	T4	SP
RHOPHYLAC	T4	SP
WINRHO SDF	T4	SP HD

PKU TREATMENT AGENTS - PHENYLALANINE AMMONIA LYASE		
PALYNZIQ	T4	PA SP HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

BIOLOGICALS (Vaccines) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ENTERIC VIRUS VACCINES		
IPOLE	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

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

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

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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)	T4	SP
VACCINE/TOXOID PREPARATIONS, COMBINATIONS		
ACTHIB	T3	PPACA
ADACEL TDAP	T3	PPACA
BOOSTRIX TDAP	T3	PPACA
DAPTACEL DTAP	T3	PPACA

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

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

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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		
ABRYSV0	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
PREHEVBRI0	T3	PPACA
RECOMBIVAX HB	T3	PPACA
SHINGRIX	T3	QL(2 KITS/720 DAYS) PPACA
TWINRIX	T3	PPACA
VARIVAX VACCINE	T3	PPACA

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

BLOOD (Blood Modifiers/Bleeding Disorders)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AGENTS TO TX THROMBOTIC THROMBOCYTOPENIC PURPURA		
ADZYNMA	T4	PA SP
CABLIVI	T4	PA SP
ANTI-FIBRINOLYTIC AGENTS		
AMICAR (aminocaproic acid)	T4	SP HD
<i>aminocaproic acid</i>	T4	SP HD
<i>aminocaproic acid (Amicar)</i>	T4	SP HD
CYKLOKAPRON (tranexamic acid)	T4	SP
FIBRYGA	T4	PA SP
RIASTAP	T4	PA SP
<i>tranexamic acid</i>	T4	SP
<i>tranexamic acid (Cyklokapron)</i>	T4	SP
<i>tranexamic acid in nacl,iso-os</i>	T4	SP
ANTI-HEMOPHILIC FACTORS		
ADVATE	T4	PA SP HD
ADYNOVATE	T4	PA SP HD
AFSTYLA	T4	PA SP HD
ALPHANATE	T4	PA SP HD
ALTUVIIIQ	T4	PA SP HD
ELOCTATE	T4	PA SP HD
ESPEROCT	T4	PA SP HD
HEMOFIL M	T4	PA SP HD
HUMATE-P	T4	PA SP HD
JIVI	T4	PA SP HD
KOATE	T4	PA SP HD
KOGENATE FS	T4	PA SP HD
KOVALTRY	T4	PA SP HD
NOVOEIGHT	T4	PA SP HD
NUWIQ	T4	PA SP HD
RECOMBINATE	T4	PA SP HD
WILATE	T4	PA SP HD
XYNTHA	T4	PA SP HD
XYNTHA SOLOFUSE	T4	PA SP HD
BLOOD FACTORS,MISCELLANEOUS		
VONVENDI	T4	SP HD

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
COAGULANTS		
<i>protamine sulfate</i>	T1	
COMPLEMENT INHIBITORS		
BKEMV	T4	PA SP
EMPAVELI	T4	PA SP
ENJAYMO	T4	PA SP
EPYSQLI	T4	PA SP
FABHALTA	T4	PA QL(2 CAPS/DAY) SP
PIASKY	T4	PA SP
SOLIRIS	T4	PA SP
TAVNEOS	T4	PA QL(6 CAPS/DAY) SP
ULTOMIRIS	T4	PA SP HD
VOYDEYA	T4	PA QL(1 PACKET/28 Days) SP
FACTOR IX COMPLEX (PCC) PREPARATIONS		
KCENTRA	T4	SP
FACTOR X PREPARATIONS		
COAGADEX	T4	PA SP
FACTOR XIII PREPARATIONS		
CORIFACT	T4	PA SP
TRETTEN	T4	PA SP
HEMOPHILIA TREATMENT AGENTS, NON-FACTOR REPLACEMENT		
ALHEMO PEN	T4	PA SP
HEMLIBRA	T4	PA SP HD
HYMPAVZI PEN	T4	PA SP
QFITLIA	T4	PA SP
QFITLIA PEN	T4	PA SP
PROTEIN C PREPARATIONS		
CEPROTIN	T4	PA SP
SICKLE CELL ANEMIA AGENTS		
ADAKVEO	T4	PA SP
DROXIA	T2	
OXBRYTA 300 MG TABLET	T4	PA QL(3 TABS/DAY) SP
OXBRYTA 300 MG TABLET FOR SUSP	T4	PA QL(5 TABS/DAY) SP
OXBRYTA 500 MG TABLET	T4	PA QL(3 TABS/DAY) SP
SIKLOS	T3	PA
XROMI	T3	PA

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

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

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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	T4	SP
ANTICOAGULANT REVERSAL AGENT, DIRECT THROMBIN INHIB		
PRAXBIND	T4	SP
HEMORRHOLOGIC AGENTS		
<i>pentoxifylline</i>	T1	HD
THROMBOLYTIC - NUCLEOTIDE TYPE		
DEFITELIO	T4	PA SP
THROMBOLYTIC ENZYMES		
ACTIVASE	T3	
CATHFLO ACTIVASE	T3	
RETAVASE	T3	
TNKASE	T3	

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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 (<i>disopyramide phosphate</i>)	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
 T2 – Typically Preferred Brands
 T3 – Typically Non-Preferred Brands

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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	T4	PA QL(1 CAP/DAY) SP HD
CARDIOPLEGIC SOLUTIONS		
CARDIOPLEGIA DEL NIDO FORMULA	T3	
CARDIOPLEGIA HIGH POTASSIUM	T3	
CARDIOPLEGIA IND 8:1 NON-ENRCH	T3	
CARDIOPLEGIA INDUCTION 4:1	T3	
CARDIOPLEGIA INDUCTION 8:1	T3	
CARDIOPLEGIA MAINTENANCE 4:1	T3	
CARDIOPLEGIA MAINTENANCE 8:1	T3	
CARDIOPLEGIA REPERFUSATE 4:1	T3	
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

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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	T4	PA SP HD
CORLANOR 7.5 MG TABLET (<i>ivabradine hcl</i>)	T3	PA HD
<i>ivabradine hcl</i> (<i>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</i> (<i>Isordil</i>)	T1	PA HD
<i>isosorbide dinitrate 5 mg tab</i> (<i>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</i> (<i>Nitrostat</i>)	T1	HD
<i>nitroglycerin 0.4 mg tablet sl</i> (<i>Nitrostat</i>)	T1	HD
<i>nitroglycerin 0.6 mg tablet sl</i> (<i>Nitrostat</i>)	T1	HD
<i>nitroglycerin 400 mcg spray</i> (<i>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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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	T4	PA SP HD
PULM.ANTI-HTN, SEL.C-GMP PHOSPHODIESTERASE T5 INHIB		
ADCIRCA (tadalafil)	T4	PA SP HD
REVATIO (sildenafil citrate)	T4	PA SP HD
<i>sildenafil 10 mg/12.5 ml vial</i>	T4	PA SP HD
<i>sildenafil 10 mg/ml oral susp (Revatio)</i>	T4	PA SP HD
<i>sildenafil 20 mg tablet (Revatio)</i>	T4	PA SP HD
<i>tadalafil (Adcirca)</i>	T4	PA SP HD
<i>tadalafil 20 mg tablet (Adcirca)</i>	T4	PA SP HD
TADLIQ	T4	PA SP HD
PULMONARY ANTI-HTN, ENDOTHELIN RECEPTOR ANTAGONIST		
<i>ambrisentan (Letairis)</i>	T4	PA SP HD
<i>bosentan (Tracleer)</i>	T4	PA SP HD
LETAIRIS (<i>ambrisentan</i>)	T4	PA SP HD
OPSUMIT	T4	PA SP HD
TRACLEER 125 MG TABLET (<i>bosentan</i>)	T4	PA SP HD
TRACLEER 32 MG TABLET FOR SUSP (<i>bosentan</i>)	T4	PA SP HD

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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)	T4	PA SP HD
PULMONARY ANTIHYPER AGENT, ACTRIIA-FC		
WINREVAIR	T4	PA SP HD
WINREVAIR (2 PACK)	T4	PA SP HD
PULMONARY ANTIHYPERTENSIVES, PROSTACYCLIN-TYPE		
<i>epoprostenol sodium</i>	T4	PA SP HD
<i>epoprostenol sodium 0.5 mg vI</i>	T4	PA SP
<i>epoprostenol sodium 0.5 mg vI</i>	T4	PA SP HD
<i>epoprostenol sodium 1.5 mg vI</i>	T4	PA SP
<i>epoprostenol sodium 1.5 mg vI</i>	T4	PA SP HD
FLOLAN	T4	PA SP
ORENITRAM ER	T4	PA SP HD
ORENITRAM MONTH 1 TITRATION KT	T4	PA QL(168 TABS/180 DAYS) SP HD
ORENITRAM MONTH 2 TITRATION KT	T4	PA QL(336 TABS/180 DAYS) SP HD
ORENITRAM MONTH 3 TITRATION KT	T4	PA QL(252 TABS/180 DAYS) SP HD
REMODULIN (<i>treprostinil sodium</i>)	T4	PA SP HD
<i>treprostinil sodium (Remodulin)</i>	T4	PA SP HD
TYVASO	T4	PA SP HD
TYVASO DPI	T4	PA SP HD
TYVASO INSTITUTIONAL START KIT	T4	PA SP HD
TYVASO REFILL KIT	T4	PA SP HD
TYVASO STARTER KIT	T4	PA SP HD
UPTRAVI 1,000 MCG TABLET	T4	PA SP HD
UPTRAVI 1,200 MCG TABLET	T4	PA SP HD
UPTRAVI 1,400 MCG TABLET	T4	PA SP HD
UPTRAVI 1,600 MCG TABLET	T4	PA SP HD
UPTRAVI 1,800 MCG VIAL	T4	PA SP
UPTRAVI 200 MCG TABLET	T4	PA SP HD
UPTRAVI 200-800 TITRATION PACK	T4	PA SP HD
UPTRAVI 400 MCG TABLET	T4	PA SP HD
UPTRAVI 600 MCG TABLET	T4	PA SP HD
UPTRAVI 800 MCG TABLET	T4	PA SP HD
YUTREPIA	T4	PA SP HD

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PULMONARY HTN-ENDOTHELIN RECEPT ANTG-CGMP PDE5 INH		
OPSYNVI	T4	PA QL(1 tab/day) SP HD

CARDIOVASCULAR (Blood Pressure/Heart Medications)

ACE INHIBITOR-CALCIUM CHANNEL BLOCKER COMBINATION		
<i>amlodipine besylate/benazepril</i>	T1	HD
<i>amlodipine besylate/benazepril (Lotrel)</i>	T1	HD
LOTREL (amlodipine besylate/benazepril)	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 (quinapril/hydrochlorothiazide)	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 (benazepril/hydrochlorothiazide)	T3	ST HD
<i>quinapril/hydrochlorothiazide (Accuretic)</i>	T1	HD
VASERETIC (enalapril/hydrochlorothiazide)	T3	ST HD
ZESTORETIC (lisinopril/hydrochlorothiazide)	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

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

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

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

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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	T4	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

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
RENIN INHIBITOR, DIRECT AND THIAZIDE DIURETIC COMB		
TEKURNA 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 (ezetimibe/simvastatin)	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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CARDIOVASCULAR (Cholesterol Medications) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIHYPERLIPIDEMIC - ANGIOPOIETIN-LIKE 3 INHIBITOR		
EVKEEZA	T4	PA SP
ANTIHYPERLIPIDEMIC - APOLIPOPROTEIN INHIBITOR		
TRYNGOLZA	T4	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	T4	PA QL(1 CAP/DAY) SP HD
JUXTAPID 20 MG CAPSULE	T4	PA QL(2 CAPS/DAY) SP HD
JUXTAPID 30 MG CAPSULE	T4	PA QL(2 CAPS/DAY) SP HD
JUXTAPID 5 MG CAPSULE	T4	PA QL(1 CAP/DAY) SP HD
ANTI-HYPERLIPIDEMIC - PCSK9 INHIBITORS		
LEQVIO	T4	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

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

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

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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	T4	PA QL(1 tab/day) SP HD
CARDIOVASCULAR (Miscellaneous)		
VENOSCLEROSING AGENTS		
ASCLERA	T4	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
 T2 – Typically Preferred Brands
 T3 – Typically Non-Preferred Brands

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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	T4	PA SP
KISUNLA	T4	PA SP
LEQEMBI	T4	PA SP
LEQEMBI IQLIK	T4	PA SP
CNS DRUGS (Miscellaneous)		
ALCOHOL, SYSTEMIC USE		
ALCOHOL, DEHYDRATED	T1	
<i>ethyl alcohol</i>	T1	
AMYOTROPHIC LATERAL SCLEROSIS AGENTS		
<i>edaravone 30 mg/100 ml bag</i>	T4	PA SP
EDARAVONE 30 MG/100 ML VIAL	T4	PA SP
<i>edaravone 60 mg/100 ml bag</i>	T4	PA SP
EDARAVONE 60 MG/100 ML VIAL	T4	PA SP
RADICAVA	T4	PA SP
RADICAVA ORS 105 MG/5 ML SUSP	T4	PA QL(50 MLS/30 DAYS) SP HD
RADICAVA ORS STARTER KIT SUSP	T4	PA QL(70 MLS/365 DAYS) SP HD
RILUTEK (riluzole)	T4	PA SP HD
<i>riluzole (Rilutek)</i>	T4	SP HD
TEGLUTIK	T4	PA SP
TIGLUTIK	T4	PA SP
CENTRAL NERVOUS SYSTEM STIMULANTS		
DOPRAM	T3	
DRUGS TO TREAT MOVEMENT DISORDERS		
AUSTEDO	T4	PA SP HD
AUSTEDO XR 12 MG TABLET	T4	PA QL(1 TAB/DAY) SP HD
AUSTEDO XR 18 MG TABLET	T4	PA QL(1 TAB/DAY) SP HD
AUSTEDO XR 24 MG TABLET	T4	PA QL(2 TABS/DAY) SP HD
AUSTEDO XR 30 MG TABLET	T4	PA QL(1 TAB/DAY) SP HD

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CNS DRUGS (Miscellaneous) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DRUGS TO TREAT MOVEMENT DISORDERS		
AUSTEDO XR 36 MG TABLET	T4	PA QL(1 TAB/DAY) SP HD
AUSTEDO XR 42 MG TABLET	T4	PA QL(1 TAB/DAY) SP HD
AUSTEDO XR 48 MG TABLET	T4	PA QL(1 TAB/DAY) SP HD
AUSTEDO XR 6 MG TABLET	T4	PA QL(3 TABS/DAY) SP HD
AUSTEDO XR TITRATION KIT(WK1-4)	T4	PA QL(1 KIT/180 DAYS) SP HD
HORIZANT	T3	PA
INGREZZA	T4	PA QL(1 CAP/DAY) SP
INGREZZA INITIATION PK(TARDIV)	T4	PA QL(28 CAPS/365 DAYS) SP
INGREZZA SPRINKLE	T4	PA QL(1 CAP/DAY) SP
tetrabenazine (Xenazine)	T4	PA SP HD
XENAZINE (tetrabenazine)	T4	PA SP HD
GLYPROMATE (GPE) ANALOGS		
DAYBUE	T4	PA QL(120 MLS/DAY) SP
PSEUDOBULBAR AFFECT (PBA) AGENTS, NMDA ANTAGONISTS		
NUJEXTA	T3	QL(4 CAPS/DAY)
XANTHINES		
CAF CIT (<i>caffeine citrate</i>)	T3	HD
CAFFEINE AND SODIUM BENZOATE	T1	HD
<i>caffeine citrate</i>	T1	HD
<i>caffeine citrate (Cafcit)</i>	T1	HD
<i>caffeine/sodium benzoate</i>	T1	HD
CNS DRUGS (Multiple Sclerosis)		
AGENTS TO TREAT MULTIPLE SCLEROSIS		
AUBAGIO (<i>teriflunomide</i>)	T4	PA SP HD
AVONEX (4 PACK)	T4	PA SP HD
AVONEX PEN (4 PACK)	T4	PA SP HD
BAFIERTAM	T4	PA SP HD
BETASERON	T4	PA SP HD
BRIUMVI	T4	PA SP
<i>cladribine 10 mg x 10 tab pk</i>	T4	PA SP HD
<i>cladribine 10 mg x 4 tablet pk</i>	T4	PA SP HD
<i>cladribine 10 mg x 5 tablet pk</i>	T4	PA SP HD
<i>cladribine 10 mg x 6 tablet pk</i>	T4	PA SP HD
<i>cladribine 10 mg x 7 tablet pk</i>	T4	PA SP HD
<i>cladribine 10 mg x 8 tablet pk</i>	T4	PA SP HD

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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>	T4	PA SP HD
COPAXONE (<i>glatiramer acetate</i>)	T4	PA SP HD
<i>dimethyl fumarate 30d start pk</i> (Tecfidera)	T4	SP HD
<i>dimethyl fumarate dr 120 mg cp</i> (Tecfidera)	T1	HD
<i>dimethyl fumarate dr 120 mg cp</i> (Tecfidera)	T4	SP HD
<i>dimethyl fumarate dr 240 mg cp</i> (Tecfidera)	T1	HD
<i>dimethyl fumarate dr 240 mg cp</i> (Tecfidera)	T4	SP HD
<i>fingolimod hcl</i> (Gilenya)	T4	SP HD
GILENYA 0.25 MG CAPSULE	T4	PA QL(1 CAP/DAY) SP
GILENYA 0.5 MG CAPSULE (<i>fingolimod hcl</i>)	T4	PA SP HD
<i>glatiramer acetate</i> (Copaxone)	T4	SP HD
TASCENSO ODT	T3	PA QL(1 tab/day) SP HD
KESIMPTA PEN	T4	PA SP HD
LEMTRADA	T4	PA SP HD
MAVENCLAD	T4	PA SP HD
MAYZENT	T4	PA SP HD
OCREVUS	T4	PA SP HD
OCREVUS ZUNOVO	T4	PA SP
PLEGRIDY	T4	PA SP HD
PONVORY	T4	PA SP HD
REBIF	T4	PA SP HD
REBIF REBIDOSE	T4	PA SP HD
TASCENSO ODT	T4	PA QL(1 TAB/DAY) SP HD
TECFIDERA (<i>dimethyl fumarate</i>)	T4	PA SP HD
<i>teriflunomide</i> (Aubagio)	T4	SP HD
VUMERITY	T4	PA SP HD
AGTS TX NEUROMUSC TRANSMISSION DIS, POT-CHAN BLKR		
AMPYRA (<i>dalfampridine</i>)	T4	PA SP HD
<i>dalfampridine er 10 mg tablet</i> (Ampyra)	T4	PA SP HD
FIRDAPSE	T4	PA QL(8 TABS/DAY) SP

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

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

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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 1-PHOSPHATE (SIP) RECEPTOR MODULATOR		
VELSIPITY	T4	PA QL(30 TABS/30 DAYS) SP HD
ZEPOSIA	T4	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> (Diatat)	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	T4	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

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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	T4	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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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	T4	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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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 1,000 mg tablet</i> (Keppra)	T1	HD
<i>levetiracetam 1,000mg/10ml cup</i> (Keppra)	T1	HD
<i>levetiracetam 100 mg/ml soln</i> (Keppra)	T1	HD
LEVETIRACETAM 250 MG TAB SUSP	T3	PA HD
<i>levetiracetam 250 mg tablet</i> (Keppra)	T1	HD
<i>levetiracetam 500 mg tablet</i> (Keppra)	T1	HD
<i>levetiracetam 500 mg/5 ml cup</i>	T1	HD
<i>levetiracetam 500 mg/5 ml soln</i>	T1	HD
<i>levetiracetam 500 mg/5 ml vial</i> (Keppra)	T1	
<i>levetiracetam 750 mg tablet</i> (Keppra)	T1	HD
<i>levetiracetam-nacl 1,000mg/100</i>	T1	
<i>levetiracetam-nacl 1,500mg/100</i>	T1	
<i>primidone 50 mg tablet</i> (Mysoline)	T1	HD
LEVETIRACETAM-NAACL 250 MG/50ML	T3	
<i>levetiracetam-nacl 500 mg/100</i>	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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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>)	T4	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

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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>	T4	SP HD
<i>vigadrone 500 mg powder packet (Sabril)</i>	T4	SP HD
<i>vigadrone 500 mg tablet (Sabril)</i>	T4	PA SP HD
VIGAFYDE	T4	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
 T2 – Typically Preferred Brands
 T3 – Typically Non-Preferred Brands

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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	T4	PA QL(2 TABS/DAY) SP HD
COLONY STIMULATING FACTORS (Blood Modifiers/Bleeding Disorders)		
ERYTHROPOIESIS-STIMULATING AGENTS		
ARANESP	T4	PA SP
EPOGEN	T4	PA SP
MIRCERA	T4	PA SP
PROCRIT	T4	PA SP
RETACRIT	T4	PA SP
LEUKOCYTE (WBC) STIMULANTS		
FULPHILA	T4	PA SP
FYLNETRA	T4	PA SP
GRANIX	T4	PA SP

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LEUKOCYTE (WBC) STIMULANTS (cont.)		
LEUKINE	T4	SP
NEULASTA	T4	PA SP
NEULASTA ONPRO	T4	PA SP HD
NEUPOGEN	T4	PA SP
NIVESTYM	T4	SP HD
NYPOZI	T4	PA SP
NYVEPRIA	T4	PA SP
RYZNEUTA	T4	PA SP
STIMUFEND	T4	PA SP
UDENYCA	T4	PA SP
UDENYCA AUTOINJECTOR	T4	PA SP
UDENYCA ONBODY	T4	PA SP
ZARXIO	T4	SP HD
ZIEXTENZO	T4	PA SP
THROMBOPOIETIN RECEPTOR AGONISTS		
ALVAIZ 18 MG TABLET	T4	PA QL(1 TAB/DAY) SP
ALVAIZ 36 MG TABLET	T4	PA QL(2 TABS/DAY) SP
ALVAIZ 54 MG TABLET	T4	PA QL(2 TABS/DAY) SP
ALVAIZ 9 MG TABLET	T4	PA QL(1 TAB/DAY) SP
DOPTELET	T4	PA SP HD
DOPTELET SPRINKLE	T4	PA SP HD
<i>eltrombopag olamine (Promacta)</i>	T4	PA SP HD
MULPLETA	T4	PA SP HD
NPLATE	T4	PA SP
PROMACTA (<i>eltrombopag olamine</i>)	T4	PA SP HD
COLONY STIMULATING FACTORS (Blood Pressure/Heart Medications)		
LEUKOCYTE (WBC) STIMULANTS		
RELEUKO	T4	PA SP
ROLVEDON	T4	PA SP
COLONY STIMULATING FACTORS (Cancer)		
CXCR4 CHEMOKINE RECEPTOR ANTAGONIST		
APHEXDA	T4	PA SP

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

COLONY STIMULATING FACTORS (Cancer) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CXCR4 CHEMOKINE RECEPTOR ANTAGONIST		
MOZOBIL (<i>plerixafor</i>)	T4	PA SP
<i>plerixafor</i> (Mozobil)	T4	PA SP
XOLREMDI	T4	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	T4	SP PPACA
CONTRACEPTIVES, INJECTABLE		
DEPO-PROVERA (<i>medroxyprogesterone acetate</i>)	T3	PPACA
DEPO-SUBQ PROVERA 104	T3	PPACA
<i>medroxyprogesterone 150 mg/ml</i> (Depo-Provera)	T1	PPACA
CONTRACEPTIVES, 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

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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	T4	SP PPACA
LILETTA	T4	SP PPACA
MIRENA	T4	SP PPACA
MIUDELLA	T4	SP PPACA

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

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

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CONTRACEPTIVES (Contraception Products) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
INTRA-UTERINE DEVICES (IUDS) (cont.)		
PARAGARD T 380-A	T4	SP PPACA
PARAGARD T 380A (SINGLE HAND)	T4	SP PPACA
SKYLA	T4	SP PPACA
COUGH/COLD PREPARATIONS (Allergy/Nasal Sprays)		
1ST GEN ANTIHIST-DECONGEST-ANTICHOLINERGIC COMB		
RESPA A.R. (<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)

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

COUGH/COLD PREPARATIONS (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	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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	

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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	

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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	

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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	

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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	

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

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

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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	

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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	T4	SP
KETOSTIX REAGENT	T4	SP
TRUEPLUS KETONE TEST STRIP	T4	SP
URINE MULTIPLE TEST AIDS		
CHEK-STIX	T4	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	

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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>)	T4	PA SP
<i>tolvaptan 15 mg tablet (Samsca)</i>	T4	SP
<i>tolvaptan 30 mg tablet (Samsca)</i>	T4	SP
VAPRISOL-5% DEXTROSE	T3	
CARBONIC ANHYDRASE INHIBITORS		
<i>acetazolamide</i>	T1	HD
<i>acetazolamide sodium</i>	T1	
<i>methazolamide</i>	T1	HD
LOOP DIURETICS		
<i>bumetanide</i>	T1	HD
EDECIN (<i>ethacrynic acid</i>)	T3	PA
<i>ethacrynate sodium (Sodium Edecrin)</i>	T1	
<i>ethacrynic acid (Edecrin)</i>	T1	PA
FUROSCIX	T4	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	

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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)	T4	PA SP
<i>tolvaptan 15 mg tablet (Jynarque)</i>	T4	SP
<i>tolvaptan 15 mg-15 mg tablet (Jynarque)</i>	T4	PA SP
<i>tolvaptan 30 mg tablet (Jynarque)</i>	T4	SP
<i>tolvaptan 30 mg-15 mg tablet (Jynarque)</i>	T4	PA SP
<i>tolvaptan 45 mg-15 mg tablet (Jynarque)</i>	T4	PA SP
<i>tolvaptan 60 mg-30 mg tablet (Jynarque)</i>	T4	PA SP
<i>tolvaptan 90 mg-30 mg tablet (Jynarque)</i>	T4	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

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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 (olopatadine hcl)	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)

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

EENT PREPS (Allergy/Nasal Sprays) (con't.)

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 spry</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</i> (Dermotic)	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	

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

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

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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	T4	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> (Alrex)	T1	
<i>loteprednol etabonate</i> (Lotemax)	T1	
MAXIDEX	T3	PA
NEVANAC	T3	PA
OZURDEX	T4	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	

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

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

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

EENT PREPS (Eye Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EYE ANTI-INFLAMMATORY AGENTS (cont.)		
XIPERE	T4	PA SP HD
EYE IRRIGATIONS		
<i>balanced salt irrig soln no.2</i>	T3	
BSS PLUS	T3	
EYE LOCAL ANESTHETICS		
AKTEN	T3	
ALCAINE (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

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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	T4	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	T4	SP HD
<i>pilocarpine 1% eye drops</i>	T1	HD
<i>pilocarpine 2% eye drops</i>	T1	HD
<i>pilocarpine 4% eye drops</i>	T1	HD
<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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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
ZIOPTAN (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 (Cyclogyl)</i>	T1	HD
<i>homatropine hbr</i>	T1	HD
MYDRIACYL (<i>tropicamide</i>)	T3	HD
PAREMYD	T3	HD
<i>tropicamide</i>	T1	HD
<i>tropicamide (Mydriacyl)</i>	T1	HD
OPHTH VASC. ENDOTHELIAL GROWTH FACTOR ANTAGONISTS		
BEOVU	T4	PA SP
BYOOVIZ	T4	PA SP
CIMERLI	T4	PA SP
LUCENTIS	T4	PA SP
SUSVIMO	T4	PA SP

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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	T4	PA SP
SYFOVRE	T4	PA SP HD
OPHTHALMIC CYSTINE DEPLETING AGENTS		
CYSTADROPS	T4	PA QL(20 MLS/28 DAYS) SP
CYSTARAN	T4	PA QL(120 MLS/28 DAYS) SP
OPHTHALMIC HUMAN NERVE GROWTH FACTOR (HNGF)		
OXERVATE	T4	PA SP HD
OPHTHALMIC PREPARATIONS, MISCELLANEOUS		
AMVISC	T4	SP
AMVISC PLUS	T4	SP
DISCOVISC	T3	
DUOVISC	T3	
HEALON GV PRO	T3	
<i>hyaluronate sodium</i>	T4	SP
PROVISC	T4	SP
VISCOAT	T3	
OPHTHALMIC SURGICAL AIDS		
CELLUGEL	T3	
<i>hypromellose</i>	T1	
MEMBRANEBLUE	T3	
VISIONBLUE	T3	
OPHTHALMIC TRPM8 AGONISTS		
TRYPTYR	T3	
OPHTHALMIC VEGF-A AND ANG-2 INHIB, BISPECIFIC AB		
VABYSMO	T4	PA SP

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ELECT/CALORIC/H2O (Cholesterol Medications)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ORAL LIPID SUPPLEMENTS		
DOJOLVI	T4	PA SP HD

ELECT/CALORIC/H2O (Dental Products)

FLUORIDE PREPARATIONS		
CLINPRO 5000	T3	
FLORIVA	T3	PPACA
<i>fluoride (sodium)</i>	T1	
<i>fluoride (sodium) (Prevident 5000 Plus)</i>	T1	
<i>fluoride (sodium) (Prevident)</i>	T1	
FLUORIDEX	T1	
FLUORIDEX SENSITIVITY RELIEF	T3	
FLUORIMAX 5000	T3	
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

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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	

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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	T4	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	

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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 (Fosrenol)</i>	T1	
LOKELMA	T2	
MAGNEBIND 400	T3	
REVELA (<i>sevelamer carbonate</i>)	T3	PA
<i>sevelamer carbonate (Renvela)</i>	T1	
<i>sevelamer hcl</i>	T1	
<i>sodium polystyrene sulfon/sorb</i>	T1	

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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	T4	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	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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	
PREVIDENT 5000 PLUS (<i>fluoride (sodium)</i>)	T3	PA
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	
ACTIVE FE	T3	
CITRANATAL BLOOM	T3	
CORVITE 150	T3	
CORVITE FE	T3	
FERAHEME (<i>ferumoxytol</i>)	T3	PA
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	PA
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	PA
INTEGRA F (<i>iron fum,ps/folic acid/vitc/b3</i>)	T3	
INTEGRA PLUS (<i>iron fum,ps/folic/bcomp,c no.9</i>)	T3	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

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

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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 cl 10%(20meq/15ml)cup</i>	T1	
<i>potassium cl 10%(40meq/30ml)cup</i>	T1	
<i>potassium cl 20%(40meq/15ml)cup</i>	T1	
POTASSIUM CL-LIDOCAINE-NS (<i>potassium cl/lido/0.9 % nacl</i>)	T3	
PROTEIN REPLACEMENT		
AQNEURSA	T4	PA SP
SODIUM/SALINE PREPARATIONS		
<i>0.9 % sodium chloride</i>	T1	
KENDALL 0.9% NACL WITH CAP	T1	
<i>saline 0.45% soln-excel con</i>	T1	
<i>saline 0.9% flush 10 ml syr</i>	T1	
<i>saline 0.9% flush 5 ml syr</i>	T1	
<i>sodium chloride 0.45% soln</i>	T1	
<i>sodium chloride 0.9 % (flush)</i>	T1	

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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)	T4	PA SP HD

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

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

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

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

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AMMONIA INHIBITORS (cont.)		
<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	T4	PA SP HD
PHEBURANE	T4	PA QL(8 Bottles/30 Days) SP HD
RAVICTI	T4	PA SP HD
<i>sodium benzoate/sod phenylacet (Ammonul)</i>	T1	
<i>sodium phenylbutyrate (Buphenyl)</i>	T4	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	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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	T4	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)

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

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

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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/amoxicilin/clarith</i>	T1	
<i>bismuth/metronid/tetracycline</i> (Pylera)	T1	
<i>lansoprazole/amoxicilin/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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BELLADONNA ALKALOIDS (con't.)		
<i>hyoscyamine sulf</i> 0.125 mg tab (Levsin)	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
LEVBIID (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	T4	PA SP HD
CHOLBAM	T4	PA SP HD
CTEXLI	T4	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	

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

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

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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	T4	PA SP HD
FECAL MICROBIOTA TRANSPLANTATION (FMT)		
VOWST	T4	PA QL(12 CAPS/56 DAYS) SP
GASTRIC ENZYMES		
SUCRAID	T4	PA SP
HEMORRHOID PREP,ANTI-INFLAM STEROID-LOCAL ANESTHET		
ANALPRAM HC 1% CREAM	T3	
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	

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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	T4	PA SP HD
LIVMARLI	T4	PA SP HD
INTESTINAL MOTILITY STIMULANTS		
GIMOTI	T4	PA SP
<i>metoclopramide hcl</i>	T1	
<i>metoclopramide hcl (Reglan)</i>	T1	
MOTEGRITY	T3	PA
REGLAN (<i>metoclopramide hcl</i>)	T3	
IRRITABLE BOWEL SYND. AGENT, 5-HT4 PARTIAL AGONIST		
ZELNORM	T3	PA

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

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

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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)	T4	SP HD
LOTRONEX (<i>alosetron hcl</i>)	T4	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

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

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

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

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

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 Iv)</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

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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	T4	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	T4	PA QL(8 TABS/DAY) SP
ISTURISA 5 MG TABLET	T4	PA QL(2 TABS/DAY) SP
RECORLEV	T4	PA QL(8 TABS/DAY) SP

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

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

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

HORMONES (Hormonal Agents) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ADRENOCORTICOTROPHIC HORMONES		
ACTHAR	T4	PA SP HD
ACTHAR SELFJECT	T4	PA SP HD
CORTROPHIN	T4	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)

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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)	T4	SP
desmopressin ac 4 mcg/ml ampul (Ddavp)	T4	SP
desmopressin ac 4 mcg/ml vial (Ddavp)	T4	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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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	T4	PA QL(10 MLS/DAY) SP
ALKINDI SPRINKLE	T4	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>	T4	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	

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

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

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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>)	T4	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	T4	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

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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 vl (Kenalog-40)</i>	T1	
<i>triamcinolone acet 400 mg/10ml (Kenalog-40)</i>	T1	
<i>triamcinolone acet 50mg/5ml vl</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	T4	PA SP HD
EGRIFTA SV	T4	PA SP HD
GROWTH HORMONES		
GENOTROPIN	T4	PA SP HD
HUMATROPE	T4	PA SP HD
NGENLA	T4	PA SP
NORDITROPIN FLEXPRO	T4	PA SP HD
NUTROPIN AQ NUSPIN	T4	PA SP HD
OMNITROPE	T4	PA SP HD
SEROSTIM	T4	PA SP HD
SKYTROFA	T4	PA SP HD
SOGROYA	T4	PA SP
ZOMACTON	T4	PA SP HD
INSULIN-LIKE GROWTH FACTOR-I (IGF-I) HORMONES		
INCRELEX	T4	PA SP HD
LHRH (GNRH) AGONIST ANALOG PITUITARY SUPPRESSANTS		
LUPRON DEPOT 11.25 MG 3MO KIT	T4	PA SP HD
LUPRON DEPOT 3.75 MG KIT	T4	PA SP HD
SYNAREL	T4	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>	T4	PA SP
CETROTIDE (<i>cetrotelix acetate</i>)	T4	PA SP

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

HORMONES (Hormonal Agents) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LHRH (GNRH) ANTAGONIST, PITUITARY SUPPRESSANT AGENTS (cont.)		
<i>ganirelix acet 250 mcg/0.5 ml</i> (Ganirelix Acetate)	T4	PA SP
GANIRELIX ACET 250 MCG/0.5 ML (ganirelix acetate)	T4	PA SP
<i>ganirelix acetate</i> (Ganirelix Acetate)	T4	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	T4	PA SP
LUPRON DEPOT-PED	T4	PA SP HD
SUPPRELIN LA	T4	PA SP HD
TRIPTODUR	T4	PA SP
MINERALOCORTICIDS		
<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	T4	PA SP
PITUITARY SUPPRESSIVE AGENTS		
<i>cabergoline</i>	T1	QL(16 TABS/28 DAYS) HD
CRENESSITY 100 MG CAPSULE	T4	PA QL(4 CAPS/DAY) SP
CRENESSITY 25 MG CAPSULE	T4	PA QL(2 CAPS/DAY) SP
CRENESSITY 50 MG CAPSULE	T4	PA QL(2 CAPS/DAY) SP
CRENESSITY 50 MG/ML SOLUTION	T4	PA QL(8 MLS/DAY) SP
<i>danazol</i>	T1	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

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	T4	SP HD
PROMETRIUM (progesterone, micronized)	T3	PA HD
PROVERA (medroxyprogesterone acetate)	T3	PA HD
RENIN-ANGIOTENSIN-ALDOSTERONE SYS. (RAAS) HORMONES		
GIAPREZA	T4	SP
SOMATOSTATIC AGENTS		
lanreotide 120 mg/0.5 ml syrng	T4	PA SP HD
LANREOTIDE 120 MG/0.5 ML SYRNG	T4	PA SP HD
MYCAPSSA	T4	PA QL(4 CAPS/DAY) SP
octreotide acetate	T4	PA SP HD
octreotide acetate (Sandostatin)	T4	PA SP HD
octreotide acetate,mi-spheres (Sandostatin Lar Depot)	T4	PA SP
SANDOSTATIN 0.05 MG/ML AMPUL (octreotide acetate)	T4	PA SP HD
SANDOSTATIN 0.1 MG/ML AMPUL (octreotide acetate)	T4	PA SP HD
SANDOSTATIN 0.5 MG/ML AMPUL (octreotide acetate)	T4	PA SP HD
SANDOSTATIN LAR DEPOT (octreotide acetate)	T4	PA SP
SIGNIFOR	T4	PA SP
SIGNIFOR LAR	T4	PA SP
SOMATULINE DEPOT	T4	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)

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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	T4	PA SP
FOLLICLE-STIMULATING HORMONE (FSH)		
FOLLISTIM AQ	T4	PA SP
GONAL-F	T4	PA SP
GONAL-F RFF REDI-JECT	T4	PA SP
HUMAN CHORIONIC GONADOTROPIN (HCG)		
CHORIONIC GONADOTROPIN	T4	PA SP
NOVAREL	T4	PA SP
OVIDREL	T4	PA SP
PREGNYL	T4	PA SP
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	T4	PA SP HD

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

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

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

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

HORMONES (Osteoporosis Products)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BONE FORMATION STIMULATING AGTS - PTH REL PEPTIDES		
TYMLOS	T4	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 (calcitonin,salmon,synthetic)	T3	HD
IMMUNOSUPPRESSANTS (Miscellaneous)		
IMMUNOSUPPRESSANT-INTERFERON GAMMA INHIBITOR, MAB		
GAMIFANT	T4	PA SP
SAPHNELO	T4	PA SP
IMMUNOSUPPRESSANTS (Pain Relief And Inflammatory Disease)		
ANTI-CD19 (B LYMPHOCYTE) MONOCLONAL ANTIBODY		
UPLIZNA	T4	PA SP
HUMAN INTERLEUKIN 12/23 (IL-12/13) INHIBITORS, MAB		
IMULDOSA 130 MG/26 ML VIAL	T4	PA SP
IMULDOSA 45 MG/0.5 ML SYRINGE	T4	PA QL(1 SYRINGE/84 DAYS) SP
IMULDOSA 90 MG/ML SYRINGE	T4	PA QL(1 SYRINGE/84 DAYS) SP
OTULFI 130 MG/26 ML VIAL	T4	PA SP
OTULFI 45 MG/0.5 ML	T4	PA QL(1 SYRINGE/84 DAYS) SP
OTULFI 90 MG/ML SYRINGE	T4	PA QL(1 SYRINGE/84 DAYS) SP
PYZCHIVA 130 MG/26 ML VIAL	T4	PA SP
PYZCHIVA 45 MG/0.5 ML	T4	PA QL(1 SYRINGE/84 DAYS) SP
PYZCHIVA 90 MG/ML SYRINGE	T4	PA QL(1 SYRINGE/84 DAYS) SP
SELARSDI 130 MG/26 ML VIAL	T4	PA SP
SELARSDI 45 MG/0.5 ML SYRINGE	T4	PA QL(1 SYRINGE/84 DAYS) SP
SELARSDI 45 MG/0.5 ML VIAL	T4	PA QL(1 SYRINGE/84 DAYS) SP
SELARSDI 90 MG/ML SYRINGE	T4	PA QL(1 SYRINGE/84 DAYS) SP
STARJEMZA 130 MG/26 ML VIAL	T4	PA SP
STELARA 130 MG/26 ML VIAL	T4	PA SP HD
STELARA 45 MG/0.5 ML SYRINGE	T4	PA QL(1 SYRINGE/84 DAYS) SP HD
STELARA 45 MG/0.5 ML VIAL	T4	PA QL(1 SYRINGE/84 DAYS) SP HD
STELARA 90 MG/ML SYRINGE	T4	PA QL(1 SYRINGE/84 DAYS) SP HD

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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	T4	PA SP
STEQEYMA 45 MG/0.5 ML SYRINGE	T4	PA QL(1 SYRINGE/84 DAYS) SP
STEQEYMA 90 MG/ML SYRINGE	T4	PA QL(1 SYRINGE/84 DAYS) SP
USTEKINUMAB 130 MG/26 ML VIAL	T4	PA SP HD
USTEKINUMAB 45 MG/0.5 ML VIAL	T4	PA QL(1 SYRINGE/84 DAYS) SP HD
USTEKINUMAB 45MG/0.5ML SYRINGE	T4	PA QL(1 SYRINGE/84 DAYS) SP HD
USTEKINUMAB 90 MG/ML SYRINGE	T4	PA QL(1 SYRINGE/84 DAYS) SP HD
USTEKINUMAB-AEKN 45 MG SYRINGE	T4	PA QL(1 SYRINGE/84 DAYS) SP
USTEKINUMAB-AEKN 90 MG/ML SYR	T4	PA QL(1 SYRINGE/84 DAYS) SP
USTEKINUMAB-TTWE 130MG/26ML VL	T4	PA SP HD
USTEKINUMAB-TTWE 45 MG SYRINGE	T4	PA QL(1 SYRINGE/84 DAYS) SP HD
USTEKINUMAB-TTWE 90 MG/ML SYR	T4	PA QL(1 SYRINGE/84 DAYS) SP HD
YESINTEK 130 MG/26 ML VIAL	T4	PA SP
YESINTEK 45 MG/0.5 ML SYRINGE	T4	PA QL(1 SYRINGE/84 DAYS) SP
YESINTEK 45 MG/0.5 ML VIAL	T4	PA QL(1 SYRINGE/84 DAYS) SP
YESINTEK 90 MG/ML SYRINGE	T4	PA QL(1 SYRINGE/84 DAYS) SP
IL-23 RECEPTOR ANTAGONIST, MONOCLONAL ANTIBODY		
OMVOH 100 MG/ML PEN	T4	PA QL(2 PENS/28 DAYS) SP HD
OMVOH 100 MG/ML SYRINGE	T4	PA QL(2 SYRINGES/28 DAYS) SP HD
OMVOH 200 MG DOSE - 2 PENS	T4	PA QL(2 PENS/28 DAYS) SP HD
OMVOH 200 MG DOSE - 2 SYRINGES	T4	PA QL(2 SYRINGES/28 DAYS) SP HD
OMVOH 200 MG/2 ML PEN	T4	PA QL SP HD
OMVOH 200 MG/2 ML SYRINGE	T4	PA QL SP HD
OMVOH 300 MG DOSE - 2 PENS	T4	PA QL(3 MLS/28 DAYS) SP HD
OMVOH 300 MG DOSE - 2 SYRINGES	T4	PA QL(3 MLS/28 DAYS) SP HD
OMVOH 300 MG/15 ML VIAL	T4	PA SP HD
SKYRIZI 600 MG/10 ML VIAL	T4	PA SP HD
SKYRIZI ON-BODY	T4	PA QL(1 CARTRIDGE/56 DAYS) SP HD
TREMFYA 100 MG/ML PEN	T4	PA QL(1 ML/56 DAYS) SP HD
TREMFYA 100 MG/ML SYRINGE	T4	PA QL(1 SYRINGE/56 DAYS) SP HD
TREMFYA 200 MG/2 ML PEN	T4	PA QL(2 SYRINGE/28 DAYS) SP HD
TREMFYA 200 MG/2 ML SYRINGE	T4	PA QL(1 SYRINGE/56 DAYS) SP HD
TREMFYA 200 MG/20 ML VIAL	T4	PA SP HD
TREMFYA ONE-PRESS	T4	PA QL(1 AUTO-INJ/56 DAYS) SP HD

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

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

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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)	T4	PA QL(12 MLS/365 DAYS) SP HD
INTERLEUKIN-4(IL-4) RECEPTOR ALPHA ANTAGONIST, MAB		
DUPIXENT PEN	T4	PA SP HD
DUPIXENT SYRINGE	T4	PA SP HD
INTERLEUKIN-6 (IL-6) RECEPTOR INHIBITORS		
ACTEMRA 162 MG/0.9 ML SYRINGE	T4	PA QL(3.6 ML/28 DAYS) SP HD
ACTEMRA 200 MG/10 ML VIAL	T4	PA SP HD
ACTEMRA 400 MG/20 ML VIAL	T4	PA SP HD
ACTEMRA 80 MG/4 ML VIAL	T4	PA SP HD
ACTEMRA ACTPEN	T4	PA QL(3.6 ML/28 DAYS) SP HD
AVTOZMA	T4	PA SP
ENSPRYNG	T4	PA SP HD
KEVZARA	T4	PA QL(2 PENS/SYRINGES/28 DAYS) SP HD
TOFIDENCE	T4	PA SP
TYENNE 162 MG/0.9 ML SYRINGE	T4	PA QL(3.6 ML/28 DAYS) SP
TYENNE 200 MG/10 ML VIAL	T4	PA SP
TYENNE 400 MG/20 ML VIAL	T4	PA SP
TYENNE 80 MG/4 ML VIAL	T4	PA SP
TYENNE AUTOINJECTOR	T4	PA QL(3.6 ML/28 DAYS) SP
IMMUNOSUPPRESSANTS (SKIN CONDITIONS)		
INTERLEUKIN-3I(IL-3I)RECEPTOR ALPHA ANTAGONIST,MAB		
NEMLUVIO	T4	PA SP HD
TOPICAL IMMUNOSUPPRESSIVE AGENTS		
ELIDEL (<i>pimecrolimus</i>)	T3	PA
HYFTOR	T4	PA SP
<i>pimecrolimus</i> (Elidel)	T1	
<i>tacrolimus 0.03% ointment</i>	T1	
<i>tacrolimus 0.1% ointment</i>	T1	
IMMUNOSUPPRESSANTS (Transplant Medications)		
IMMUNOSUPPRESSANT - MONOCLONAL ANTIBODY		
NIKTIMVO	T4	PA SP
SIMULECT	T4	SP

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

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

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

IMMUNOSUPPRESSANTS (Transplant Medications) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
IMMUNOSUPPRESSIVES		
ASTAGRAF XL	T4	SP HD
AZASAN (azathioprine)	T4	PA SP HD
<i>azathioprine 100 mg tablet (Azasan)</i>	T4	PA SP HD
<i>azathioprine 50 mg tablet (Imuran)</i>	T4	SP HD
<i>azathioprine 75 mg tablet (Azasan)</i>	T4	PA SP HD
<i>azathioprine sodium</i>	T1	
CELLCEPT 200 MG/ML ORAL SUSP (<i>mycophenolate mofetil</i>)	T4	PA SP HD
CELLCEPT 250 MG CAPSULE (<i>mycophenolate mofetil</i>)	T4	PA SP HD
CELLCEPT 500 MG TABLET (<i>mycophenolate mofetil</i>)	T4	PA SP HD
CELLCEPT 500 MG VIAL (<i>mycophenolate mofetil hcl</i>)	T4	SP
<i>cyclosporine 100 mg capsule (Sandimmune)</i>	T4	SP HD
<i>cyclosporine 25 mg capsule (Sandimmune)</i>	T4	SP HD
<i>cyclosporine 250 mg/5 ml ampul (Sandimmune)</i>	T4	SP
<i>cyclosporine, modified</i>	T4	SP HD
<i>cyclosporine, modified (Neoral)</i>	T4	SP HD
ENVARUSUS XR	T4	SP HD
<i>everolimus 0.25 mg tablet (Zortress)</i>	T4	SP HD
<i>everolimus 0.5 mg tablet (Zortress)</i>	T4	SP HD
<i>everolimus 0.75 mg tablet (Zortress)</i>	T4	SP HD
<i>everolimus 1 mg tablet (Zortress)</i>	T4	SP HD
IMURAN (<i>azathioprine</i>)	T4	PA SP HD
LUPKYNIS	T4	PA QL(6 CAPS/DAY) SP
<i>mycophenolate 200 mg/ml susp (Cellcept)</i>	T4	SP HD
<i>mycophenolate 250 mg capsule (Cellcept)</i>	T4	SP HD
<i>mycophenolate 500 mg tablet (Cellcept)</i>	T4	SP HD
<i>mycophenolate 500 mg vial (Cellcept)</i>	T4	SP
<i>mycophenolate sodium (Cellcept)</i>	T4	SP HD
MYFORTIC (<i>mycophenolate sodium</i>)	T4	PA SP HD
MYHIBBIN	T4	PA SP
NEORAL (<i>cyclosporine, modified</i>)	T4	PA SP HD
NULOJIX	T4	PA SP
PROGRAF 0.2 MG GRANULE PACKET	T4	SP HD
PROGRAF 0.5 MG CAPSULE (<i>tacrolimus</i>)	T4	PA SP HD
PROGRAF 1 MG CAPSULE (<i>tacrolimus</i>)	T4	PA SP HD

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

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

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

IMMUNOSUPPRESSANTS (Transplant Medications) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
IMMUNOSUPPRESSIVES (cont.)		
PROGRAF 1 MG GRANULE PACKET	T4	SP HD
PROGRAF 5 MG CAPSULE (<i>tacrolimus</i>)	T4	PA SP HD
PROGRAF 5 MG/ML AMPULE	T4	SP
RAPAMUNE (<i>sirolimus</i>)	T4	PA SP HD
SANDIMMUNE 100 MG CAPSULE (<i>cyclosporine</i>)	T4	PA SP HD
SANDIMMUNE 100 MG/ML SOLN	T4	SP HD
SANDIMMUNE 25 MG CAPSULE (<i>cyclosporine</i>)	T4	PA SP HD
SANDIMMUNE 50 MG/ML AMPUL (<i>cyclosporine</i>)	T4	PA SP
<i>sirolimus</i>	T4	SP HD
<i>sirolimus</i> (Rapamune)	T4	SP HD
<i>tacrolimus</i> 0.5 mg capsule (<i>ir</i>) (Prograf)	T4	SP HD
<i>tacrolimus</i> 1 mg capsule (<i>ir</i>) (Prograf)	T4	SP HD
<i>tacrolimus</i> 5 mg capsule (<i>ir</i>) (Prograf)	T4	SP HD
TACROLIMUS 5 MG/ML VIAL	T4	SP
ZORTRESS (<i>everolimus</i>)	T4	SP HD

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

DIABETIC SUPPLIES (cont.)		
2TEK CONTROL SOLUTION	T1	
2TEK GLUCOSE-WRIST MONITOR KIT	T3	
ACCU-CHEK	T1	
ACCU-CHEK FASTCLIX LANCING DEV	T1	
ACCU-CHEK GUIDE CONTROL SOLN	T1	
ACCU-CHEK GUIDE ME GLUCOSE MTR	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

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

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

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

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

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

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

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	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

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	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

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	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

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

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

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

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 ULTTHIN 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

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (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 UNIVERSAL 1 LANCET	T1	
TOPCARE UNIVERSAL 1 THIN LANCET	T1	
TRUE COMFORT LANCET	T1	
TRUE COMFORT SAFETY LANCET	T1	
TRUEPLUS LANCET	T1	
TRUEPLUS LANCETS	T1	
TWIST LANCETS	T1	
TWIST TOP LANCET	T1	
ULTILET BASIC	T1	
ULTILET CLASSIC	T1	
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	

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

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

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

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

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

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

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

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

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (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 SYRING 0.5 ML 27G 1/2"	T1	PA
INSULIN SYRING 0.5 ML 27G 13MM	T1	PA
INSULIN SYRING 0.5 ML 28G 1/2"	T1	PA
INSULIN SYRING 0.5 ML 29G 1/2"	T1	PA
INSULIN SYRING 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

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (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
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands

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

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

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

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

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Miscellaneous) (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	
SOLUSV2 28G LANCETS	T1	
SOLUSV2 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	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MUSCLE RELAXANTS (Pain Relief And Inflammatory Disease)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SKELLETAL 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

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SKELETAL 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	

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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>pnv 19/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	

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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 Redicew 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>prenata,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	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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	

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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	T4	PA SP
ANTIDEPRESSANT - POSTPARTUM DEPRESSION (PPD)		
ZURZUVAE 20 MG CAPSULE	T4	PA QL(28 CAPS/270 DAYS) SP HD
ZURZUVAE 25 MG CAPSULE	T4	PA QL(28 CAPS/270 DAYS) SP HD
ZURZUVAE 30 MG CAPSULE	T4	PA QL(14 CAPS/270 DAYS) SP HD
BIPOLAR DISORDER DRUGS		
EQUETRO	T3	HD
<i>lithium carbonate</i>	T1	HD
<i>lithium carbonate (Lithobid)</i>	T1	HD
<i>lithium citrate</i>	T1	HD
LITHOBID (lithium carbonate)	T3	PA HD

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

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

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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>phenelzine 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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

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

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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</i> (Aptensio Xr)	T1	PA QL(1 CAP/DAY)
<i>methylphenidate er 18 mg tab</i> (Concerta) (Relexxii)	T1	PA QL(1 TAB/DAY)
<i>methylphenidate er 20 mg cap</i> (Aptensio Xr)	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</i> (Concerta)	T1	PA QL(1 TAB/DAY)
<i>methylphenidate er 27 mg tab</i> (Relexxii)	T1	PA QL(1 TAB/DAY)
<i>methylphenidate er 30 mg cap</i> (Aptensio Xr)	T1	PA QL(1 CAP/DAY)
<i>methylphenidate er 36 mg tab</i> (Concerta) (Relexxii)	T1	PA QL(2 TABS/DAY)
<i>methylphenidate er 40 mg cap</i> (Aptensio Xr)	T1	PA QL(1 CAP/DAY)
METHYLPHENIDATE ER 45 MG TAB	T3	PA QL(1 TAB/DAY)
<i>methylphenidate er 50 mg cap</i> (Aptensio Xr)	T1	PA QL(1 CAP/DAY)
<i>methylphenidate er 54 mg tab</i> (Concerta)	T1	PA QL(1 TAB/DAY)
<i>methylphenidate er 54 mg tab</i> (Relexxii)	T1	PA QL(1 TAB/DAY)
<i>methylphenidate er 60 mg cap</i> (Aptensio Xr)	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</i> (Ritalin La)	T1	PA QL(1 CAP/DAY)
<i>methylphenidate er(la) 20mg cp</i> (Ritalin La)	T1	PA QL(1 CAP/DAY)
<i>methylphenidate er(la) 30mg cp</i> (Ritalin La)	T1	PA QL(2 CAPS/DAY)
<i>methylphenidate er(la) 40mg cp</i> (Ritalin La)	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</i> (Metadate Cd)	T1	PA QL(1 CAP/DAY)
<i>methylphenidate hcl</i> (Methylin)	T1	PA
<i>methylphenidate hcl</i> (Ritalin)	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

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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.)		
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
 T2 – Typically Preferred Brands
 T3 – Typically Non-Preferred Brands

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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.)		
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

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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 Xt)	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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics)⁹ (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIPSYCHOTICS, ATYP, D2 PARTIAL AGONIST/5HT MIXED (cont.)		
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
 T2 – Typically Preferred Brands
 T3 – Typically Non-Preferred Brands

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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	T4	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)

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

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

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-NARCOLEPSY, ANTI-CATAPLEXY, SEDATIVE-TYPE AGENT		
LUMRYZ	T4	PA QL(1 PACK/DAY) SP HD
LUMRYZ STARTER PACK	T3	PA QL SP HD
SODIUM OXYBATE	T4	PA QL(18 MLS/DAY) SP HD
XYREM	T4	PA QL(18 MLS/DAY) SP HD
XYWAV	T4	PA QL(18 MLS/DAY) SP HD
BARBITURATES		
AMYTAL SODIUM	T3	
NEMBUTAL SODIUM (pentobarbital sodium)	T3	PA
<i>pentobarbital sodium (Nembutal Sodium)</i>	T1	PA
<i>phenobarbital</i>	T1	
HYPNOTICS, MELATONIN MT1/MT2 RECEPTOR AGONISTS		
HETLIOZ (tasimelteon)	T4	PA SP HD
HETLIOZ LQ	T4	PA SP HD
<i>ramelteon (Rozerem)</i>	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 (Ativan)</i>	T1	
QUAZEPAM	T1	
RESTORIL (<i>temazepam</i>)	T3	PA
<i>temazepam (Restoril)</i>	T1	
<i>triazolam (Halcion)</i>	T1	
SEDATIVE-HYPNOTICS, NON-BARBITURATE		
AMBIEN (<i>zolpidem tartrate</i>)	T3	PA
AMBIEN CR 12.5 MG TABLET (<i>zolpidem tartrate</i>)	T3	PA

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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</i> (Silenor)	T1	QL(1 TAB/DAY)
<i>doxepin hcl 6 mg tablet</i> (Silenor)	T1	
EDLUAR 10 MG SL TABLET	T3	PA
EDLUAR 5 MG SL TABLET	T3	PA QL(1 TAB/DAY)
<i>eszopiclone</i> (Lunesta)	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</i> (Ambien Cr)	T1	
<i>zolpidem tart er 6.25 mg tab</i> (Ambien Cr)	T1	QL(1 TAB/DAY)
<i>zolpidem tartrate 10 mg tablet</i> (Ambien)	T1	
<i>zolpidem tartrate 5 mg tablet</i> (Ambien)	T1	
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	

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

SKIN PREPS (Miscellaneous) (con't.)

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	T4	PA QL(2 MLS/28 DAYS) SP HD
COSENTYX	T3	PA SP

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

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

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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)	T4	PA QL(2 MLS/28 DAYS) SP HD
COSENTYX 150 MG/ML SYRINGE	T4	PA QL(1 ML/28 DAYS) SP HD
COSENTYX 75 MG/0.5 ML SYRINGE	T4	PA QL(0.5 MLS/28 DAYS) SP HD
COSENTYX SENSOREADY (2 PENS)	T4	PA QL(2 MLS/28 DAYS) SP HD
COSENTYX SENSOREADY PEN	T4	PA QL(1 ML/28 DAYS) SP HD
COSENTYX UNOREADY PEN	T4	PA QL(2 MLS/28 DAYS) SP HD
ILUMYA	T4	PA QL(1 UNIT/84 DAYS) SP HD
<i>methoxsalen</i>	T1	
SILIQ	T4	PA QL(3 MLS/28 DAYS) SP HD
SKYRIZI 150 MG/ML SYRINGE	T4	PA QL(150 MG/84 DAYS) SP HD
SKYRIZI PEN	T4	PA QL(150 MG/84 DAYS) SP HD
SOTYKTU	T4	PA QL(1 TAB/DAY) SP HD
SPEVIGO 150 MG/ML SYRINGE	T4	PA QL(2 MLS/28 DAYS) SP HD
SPEVIGO 300 MG/2 ML SYRINGE	T4	PA QL(2 MLS/28 DAYS) SP HD
SPEVIGO 450 MG/7.5 ML VIAL	T4	PA SP HD
TALTZ AUTOINJECTOR	T4	PA QL(1 AUTO-INJECTOR/28 DAYS) SP HD
TALTZ AUTOINJECTOR (2 PACK)	T4	PA QL(1 AUTO-INJECTOR/28 DAYS) SP HD
TALTZ AUTOINJECTOR (3 PACK)	T4	PA QL(1 AUTO-INJECTOR/28 DAYS) SP HD
TALTZ SYRINGE	T4	PA QL(1 SYRINGE/28 DAYS) SP HD
TOPICAL ANTI-INFLAMMATORY, NSAIDS		
<i>diclofenac 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	

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

SKIN PREPS (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	
CABTREO	T3	PA
<i>clindamyc-bnz 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-bnz 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	

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

SKIN PREPS (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	

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

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

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

SKIN PREPS (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	

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

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

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

SKIN PREPS (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	

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

SKIN PREPS (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	

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

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

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

SKIN PREPS (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

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

SKIN PREPS (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 butyr 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

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

SKIN PREPS (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	

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

SKIN PREPS (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

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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	T4	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

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
THYROID HORMONES (con't.)		
<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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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	T4	SP
UNCLASSIFIED DRUG PRODUCTS (Asthma/COPD/Respiratory)		
CYSTIC FIBROSIS - INHALED OSMOTIC AGENTS		
BRONCHITOL	T4	PA SP HD
CYSTIC FIBROSIS-CFTR POTENTIATOR-CORRECTOR COMBIN.		
ALYFTREK 10-50-125 MG TABLET	T4	PA QL(2 TABS/DAY) SP HD
ALYFTREK 4-20-50 MG TABLET	T4	PA QL(3 TABS/DAY) SP HD
ORKAMBI 100 MG-125 MG TABLET	T4	PA QL(4 TABS/DAY) SP HD
ORKAMBI 100-125 MG GRANULE PKT	T4	PA QL(2 PACKS/DAY) SP HD
ORKAMBI 150-188 MG GRANULE PKT	T4	PA QL(2 PACKS/DAY) SP HD
ORKAMBI 200 MG-125 MG TABLET	T4	PA QL(4 TABS/DAY) SP HD
ORKAMBI 75-94 MG GRANULE PKT	T4	PA QL(2 PACKS/DAY) SP HD
SYMDEKO	T4	PA QL(2 TABS/DAY) SP HD
TRIKAFTA 100-50-75 MG/150 MG	T4	PA QL(3 TABS/DAY) SP HD
TRIKAFTA 100-50-75 MG/75MG PKT	T4	PA QL(2 UNITS/DAY) SP HD
TRIKAFTA 50-25-37.5 MG/75 MG	T4	PA QL(3 TABS/DAY) SP HD
TRIKAFTA 80-40-60MG/59.5MG PKT	T4	PA QL(2 UNITS/DAY) SP HD
CYSTIC FIB-TRANSMEMB CONDUCT.REG.(CFTR) POTENTIATOR		
KALYDECO 13.4 MG GRANULES PKT	T4	PA QL(2 PACKS/DAY) SP HD
KALYDECO 150 MG TABLET	T4	PA QL(2 TABS/DAY) SP HD
KALYDECO 25 MG GRANULES PACKET	T4	PA QL(2 PACKS/DAY) SP HD
KALYDECO 5.8 MG GRANULES PKT	T4	PA QL(2 PACKS/DAY) SP HD
KALYDECO 50 MG GRANULES PACKET	T4	PA QL(2 PACKS/DAY) SP HD
KALYDECO 75 MG GRANULES PACKET	T4	PA QL(2 PACKS/DAY) SP HD

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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	T4	PA SP HD
PULMONARY FIBROSIS - SYSTEMIC ENZYME INHIBITORS		
OFEV	T4	PA SP HD
SYSTEMIC ENZYME INHIBITORS		
ARALAST NP	T4	PA SP
GLASSIA	T4	PA SP
JOENJA	T4	PA QL(2 TABS/DAY) SP
PROLASTIN C	T4	PA SP HD
VIJOICE 125 MG TABLET	T4	PA QL(1 TAB/DAY) SP
VIJOICE 250 MG DAILY DOSE PACK	T4	PA QL(2 TABS/DAY) SP
VIJOICE 50 MG GRANULE PACKET	T4	PA QL(1 TAB/DAY) SP
VIJOICE 50 MG TABLET	T4	PA QL(1 TAB/DAY) SP
ZEMAIRA 1,000 MG VIAL	T4	PA SP
ZEMAIRA 4,000 MG VIAL	T4	PA SP HD
ZEMAIRA 5,000 MG VIAL	T4	PA SP HD
ZOKINVY	T4	PA QL(4 CAPS/DAY) SP
THYMIC STROMAL LYMPHOPOIETIN (TSLP) INHIBITORS		
TEZSPIRE 210 MG/1.91 ML PEN	T4	PA QL(1 PEN/28 DAYS) SP HD
TEZSPIRE 210 MG/1.91 ML SYRING	T4	PA SP HD

UNCLASSIFIED DRUG PRODUCTS (Blood Modifiers/Bleeding Disorders)

ANTI-INFLAMMATORY - ANTIMITOTICS		
LODOCO	T3	PA
ANTI-PORPHYRIA FACTORS		
PANHEMATIN	T4	SP
ERYTHROID MATURATION AGENTS		
REBLOZYL	T4	PA SP

UNCLASSIFIED DRUG PRODUCTS (Blood Pressure/Heart Medications)

SPLEEN TYROSINE KINASE INHIBITORS		
TAVALISSE	T4	PA SP

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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>)	T4	PA SP
<i>icatibant acetate</i> (Firazyr)	T4	PA SP HD
PLASMA KALLIKREIN INHIBITORS		
KALBITOR	T4	PA SP HD
ORLADEYO	T4	PA QL (1 caps/day) SP

UNCLASSIFIED DRUG PRODUCTS (Cancer)

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

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Cancer) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
RADIOACTIVE THERAPEUTIC AGENTS		
LUTATHERA	T4	PA SP
<i>strontium-89 chloride</i>	T1	PA
XOFIGO	T3	PA
UNCLASSIFIED DRUG PRODUCTS (Dental Products)		
DENTAL AIDS AND PREPARATIONS		
<i>chlorhexidine gluconate (Peridex)</i>	T1	
PERIDEX (<i>chlorhexidine gluconate</i>)	T3	
<i>triamcinolone 0.1% paste</i>	T1	
<i>triamcinolone acetonide</i>	T1	
PERIODONTAL COLLAGENASE INHIBITORS		
<i>doxycycline hyclate 20 mg tab</i>	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	T4	PA SP
DRUGS TO TREAT ERECTILE DYSFUNCTION (ED)		
<i>avanafil (Stendra)</i>	T1	QL(8 TABS/30 DAYS)
CAVERJECT	T3	QL(6 INJECTIONS/30 DAYS)
CIALIS 10 MG TABLET (<i>tadalafil</i>)	T3	ST QL(8 TABS/30 DAYS)
CIALIS 20 MG TABLET (<i>tadalafil</i>)	T3	ST QL(8 TABS/30 DAYS)
CIALIS 5 MG TABLET (<i>tadalafil</i>)	T3	ST QL(1 TAB/DAY)
EDEX	T3	QL(6 INJECTIONS/30 DAYS)
MUSE	T2	QL(6 SUPPS/30 DAYS)
<i>sildenafil 100 mg tablet (Viagra)</i>	T1	QL(8 TABS/30 DAYS) HD
<i>sildenafil 25 mg tablet (Viagra)</i>	T1	QL(8 TABS/30 DAYS) HD
<i>sildenafil 50 mg tablet (Viagra)</i>	T1	QL(8 TABS/30 DAYS) HD
STENDRA (<i>avanafil</i>)	T3	ST QL(8 TABS/30 DAYS)
<i>tadalafil 10 mg tablet (Cialis)</i>	T1	QL(8 TABS/30 DAYS) HD
<i>tadalafil 2.5 mg tablet</i>	T1	QL(1 TAB/DAY) HD
<i>tadalafil 20 mg tablet (Cialis)</i>	T1	QL(8 TABS/30 DAYS) HD

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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>varденаfil hcl</i>	T1	QL(8 TABS/30 DAYS)
VIAGRA (<i>sildenafil citrate</i>)	T3	ST QL(8 TABS/30 DAYS)

UNCLASSIFIED DRUG PRODUCTS (Eye Conditions)

INSULIN-LIKE GROWTH FACTOR RECEPTOR (IGF-R) INHIB		
TEPEZZA	T4	PA SP HD
NICOTINIC RECEPT.PARTIAL AGONIST, ALPHA4BETA2 SPEC		
TYRVAYA	T2	QL(8.4 MLS/30 DAYS)
OCULAR PHOTOACTIVATED VESSEL-OCCLUDING AGENTS		
VISUDYNE	T4	SP

UNCLASSIFIED DRUG PRODUCTS (Gastrointestinal/Heartburn)

ORAL MUCOSITIS/STOMATITIS AGENTS		
GELCLAIR	T3	
ORAMAGICRX	T3	
PPAR AGONIST		
IQIRVO	T4	PA SP HD
LIVDELZI	T4	PA SP
SALIVA STIMULANT AGENTS		
NUMOISYN	T2	
THYROID HORMONE RECEPTOR (THR) AGONIST		
REZDIFFRA	T4	PA QL(1 TAB/DAY) SP HD

UNCLASSIFIED DRUG PRODUCTS (Hormonal Agents)

GROWTH HORMONE RECEPTOR ANTAGONISTS		
SOMAVERT	T4	PA SP HD
HYPERPARATHYROID TX AGENTS - VITAMIN D ANALOG-TYPE		
<i>doxercalciferol</i>	T1	
<i>doxercalciferol (Hectorol)</i>	T1	
HECTOROL (<i>doxercalciferol</i>)	T3	
<i>paricalcitol 1 mcg capsule (Zemlar)</i>	T4	SP HD

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

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

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

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

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	T4	SP
<i>paricalcitol 2 mcg capsule (Zemplar)</i>	T4	SP HD
PARICALCITOL 2 MCG/ML VIAL	T4	SP
<i>paricalcitol 2 mcg/ml vial (Zemplar)</i>	T4	SP
<i>paricalcitol 4 mcg capsule</i>	T4	SP HD
PARICALCITOL 5 MCG/ML VIAL	T4	SP
<i>paricalcitol 5 mcg/ml vial (Zemplar)</i>	T4	SP
RAYALDEE	T3	
ZEMPLAR 1 MCG CAPSULE (<i>paricalcitol</i>)	T4	SP HD
ZEMPLAR 10 MCG/2 ML VIAL (<i>paricalcitol</i>)	T4	SP
ZEMPLAR 2 MCG CAPSULE (<i>paricalcitol</i>)	T4	SP HD
ZEMPLAR 2 MCG/ML VIAL (<i>paricalcitol</i>)	T4	SP
ZEMPLAR 5 MCG/ML VIAL (<i>paricalcitol</i>)	T4	SP
MENOPAUSAL SYMPT SUPP-SEL ESTROGEN RECEPT MODULATOR		
OSPHENA	T3	QL(30 TABS/30 DAYS) HD
UNCLASSIFIED DRUG PRODUCTS (Miscellaneous)		
ABORTIFACIENT-PROGESTERONE RECEPTOR ANTAGONISTS		
MIFEPREX	T3	
<i>mifepristone (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>	T4	PA SP HD
KEVEYIS (<i>dichlorphenamide</i>)	T4	PA SP
AMMONIA INHIBITORS		
CARBAGLU (<i>carglumic acid</i>)	T4	SP HD
<i>carglumic acid (Carbaglu)</i>	T4	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

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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	T4	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>)	T4	PA SP HD
<i>pirfenidone 267 mg capsule</i>	T4	PA SP HD
<i>pirfenidone 267 mg tablet</i> (Esbriet)	T4	PA SP HD
PIRFENIDONE 534 MG TABLET	T4	PA SP HD
<i>pirfenidone 801 mg tablet</i> (Esbriet)	T4	PA SP HD
BENZODIAZEPINE ANTAGONISTS		
<i>flumazenil</i>	T1	
CI ESTERASE INHIBITORS		
BERINERT	T4	PA SP HD
CINRYZE	T4	PA SP HD
HAEGARDA	T4	PA SP HD
RUCONEST	T4	PA SP HD
CALCIMIMETIC, PARATHYROID CALCIUM ENHANCER		
<i>cinacalcet hcl</i> (Sensipar)	T4	SP
PARSABIV	T4	PA SP
SENSIPAR (<i>cinacalcet hcl</i>)	T4	PA SP
CATHETER LOCK SOLUTIONS		
DEFENCATH	T3	
CHOLINESTERASE REACTIVAT.-MUSCARINIC ANTG.ANTIDOTE		
DUODOTE	T3	
CHOLINESTERASE REACTIVATING, ORGANOPHOS. ANTIDOTES		
PRALIDOXIME CHLORIDE	T1	
PROTOPAM CHLORIDE	T3	

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
COMPLEMENT INHIBITORS		
VEOPOZ	T4	SP
ZILBRYSQ	T4	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	T4	PA SP HD
GENERAL INHALATION AGENTS		
HYPER-SAL	T3	
<i>nebusal 3% vial</i>	T1	
NEBUSAL 6% VIAL	T3	
<i>sodium chloride 0.9% inhal vl</i>	T1	
<i>sodium chloride 10% vial</i>	T1	
<i>sodium chloride 3% vial</i>	T1	
<i>sodium chloride 7% vial</i>	T1	
<i>sodium chloride for inhalation</i>	T1	
GENETIC D/O TX - SMN PROTEIN DEFICIENCY TREATMENT		
EVRYSDI	T4	PA SP HD
SPINRAZA	T4	PA SP HD
GENETIC D/O TX-EXON SKIPPING ANTISENSE OLIGONUCLEO		
AMONDYS-45	T4	PA SP
EXONDYS-51	T4	PA SP
VILTEPSO	T4	PA SP
VYONDYS-53	T4	PA SP
GENETIC DISORDER THERAPY - HDAC INHIBITOR		
DUVYZAT	T4	PA SP
GLUCOSYLCERAMIDE SYNTHASE (GCS) INHIBITOR		
CERDELGA	T4	PA SP HD
<i>miglustat (Zavesca)</i>	T4	PA SP HD
OPFOLDA	T4	PA QL(8 CAPS/30 DAYS) SP HD

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

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

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GLUCOSYLCERAMIDE SYNTHASE (GCS) INHIBITOR (cont.)		
ZAVESCA (<i>miglustat</i>)	T4	PA SP HD
HEAT SHOCK PROTEIN (HSP) MODULATING AGENTS		
MIPLYFFA	T4	PA SP
HYDROXYPHENYL-PYRUVATE DIOXYGENASE(HPPD) INHIBITOR		
<i>nitisinone</i> (Orfadin)	T4	PA SP HD
NITYR	T4	PA SP
ORFADIN (<i>nitisinone</i>)	T4	PA SP
HYPOACTIVE SEXUAL DESIRE DISORDER (HSDD) TX AGENTS		
ADDYI	T3	QL(1 TAB/DAY)
VYLEESI	T4	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)		
RYONCIL	T4	PA SP
METABOLIC DISEASE ENZYME REPLACE, HYPOPHOSPHATASIA		
STRENSIQ	T4	PA SP
METABOLIC DISEASE ENZYME REPLACEMENT, ASMD		
STRENSIQ	T4	PA SP
METABOLIC DISEASE ENZYME REPLACEMENT, BATTEN DISEA		
BRINEURA	T4	PA SP
METABOLIC DISEASE ENZYME REPLACEMENT, FABRY'S DX		
ELFABRIO	T4	PA SP
FABRAZYME	T4	PA SP HD
METABOLIC DISEASE ENZYME REPLACEMENT, GAUCHER'S DX		
CEREZYME	T4	PA SP HD
ELELYSO	T4	PA SP
VPRIV	T4	PA SP HD
METABOLIC DISEASE ENZYME REPLACEMENT, MOCD		
NULIBRY	T4	PA SP

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
METABOLIC DISEASE ENZYME REPLACEMENT, POMPE DISEASE		
LUMIZYME	T4	PA SP
NEXVIAZYME	T4	PA SP HD
POMBILITI	T4	PA SP HD
METABOLIC DX ENZYME REPLACE, MUCOPOLYSACCHARIDOSIS		
ALDURAZYME	T4	PA SP HD
ELAPRASE	T4	PA SP
MEPSEVII	T4	PA SP
NAGLAZYME	T4	PA SP
VIMIZIM	T4	PA SP
METABOLIC DX ENZYME REPLACEMENT,ALPHA-MANNO SIDOSIS		
LAMZEDE	T4	PA SP
METABOLIC DX ENZYME REPLACEMENT, LYSO.ACID LIP.DEF.		
KANUMA	T4	PA SP
METABOLIC DX ENZYME REPLACEMENT, SEV.COMB.IMMUNE DEF.		
REVCIVI	T4	PA SP
METALLIC POISON, AGENTS TO TREAT		
BAL IN OIL	T3	PA
CHEMET	T3	
CUVRIOR	T4	PA SP
<i>deferasirox (Exjade)</i>	T4	SP HD
<i>deferasirox (Jadenu Sprinkle)</i>	T4	SP HD
<i>deferasirox (Jadenu)</i>	T4	SP HD
<i>deferiprone (Ferriprox (3 Times A Day))</i>	T4	PA SP HD
<i>deferiprone (Ferriprox)</i>	T4	PA SP
<i>deferoxamine mesylate</i>	T1	
<i>deferoxamine mesylate (Desferal Mesylate)</i>	T1	
DESFERAL MESYLATE (<i>deferoxamine mesylate</i>)	T3	
EXJADE (<i>deferasirox</i>)	T4	PA SP HD
FERRIPROX	T4	PA SP
FERRIPROX (<i>deferiprone</i>)	T4	PA SP
GALZIN	T4	SP
JADENU (<i>deferasirox</i>)	T4	PA SP HD
JADENU SPRINKLE (<i>deferasirox</i>)	T4	PA SP HD
NITHIODOLE	T3	

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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 (<i>trientine hcl</i>)	T4	PA SP HD
<i>trientine hcl 250 mg capsule</i> (Syprine)	T4	PA SP HD
TRIENTINE HCL 500 MG CAPSULE	T4	PA SP HD
NATRIURETIC PEPTIDES		
VOXZOGO	T4	PA SP HD
NEONATAL FC RECEPTOR (FCRN) INHIBITORS		
IMAAVY	T4	PA SP HD
RYSTIGGO	T4	PA SP
VYVGART	T4	PA SP HD
VYVGART HYTRULO	T4	PA SP HD
NUCLEAR FACTOR ERYTHROID 2-REL. FACTOR 2 ACTIVATOR		
SKYCLARYS	T4	PA QL(3 caps/day) SP
OINTMENT/CREAM BASES		
RADIAGEL	T3	
OXALOSIS AGENT - OXALATE INHIBITOR, SIRNA BASED		
OXLUMO	T4	PA SP
RIVFLOZA 128 MG/0.8 ML SYRINGE	T4	PA QL(1 SYRINGE/30 DAYS) SP
RIVFLOZA 160 MG/ML SYRINGE	T4	PA QL(1 SYRINGE/30 DAYS) SP
RIVFLOZA 80 MG/0.5 ML VIAL	T3	PA SP
PHARMACOLOGICAL CHAPERONE-ALPHA-GALACTOSID.A STABZ		
GALAFOLD	T4	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)	T4	PA SP HD
<i>javygtor 500 mg powder packet</i> (Kuvan)	T4	PA SP
KUVAN (<i>sapropterin dihydrochloride</i>)	T4	PA SP HD
<i>sapropterin dihydrochloride</i> (Kuvan)	T4	PA SP HD
PROTEIN STABILIZERS		
ATTRUBY	T4	PA QL(4 TABS/DAY) SP
VYNDAMAX	T4	PA QL(1 CAP/DAY) SP HD
VYNDAQEL	T4	PA QL(4 CAPS/DAY) SP

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

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

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
RETINOIC ACID RECEPTOR (RAR) AGONISTS		
SOHONOS	T4	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	T4	SP HD
TREATMENT OF HYPERPHAGIA IN PRADER-WILLI SYNDROME		
VYKAT XR	T4	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	T4	PA SP
TYSABRI	T4	PA SP HD
UNCLASSIFIED DRUG PRODUCTS (Nutritional/Dietary)		
METABOLIC DEFICIENCY AGENTS		
<i>betaine (Cystadane)</i>	T4	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>)	T4	SP

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

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

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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	T4	PA QL(0.08 MLS/DAY) SP
EVENITY (2 SYRINGES)	T4	PA QL(0.08 MLS/DAY) SP
BONE FORMATION STIM. AGENTS - PARATHYROID HORMONE		
BONSITY (<i>teriparatide</i>)	T4	PA QL(0.09 MLS/DAY) SP
FORTEO (<i>teriparatide</i>)	T4	PA QL(0.09 MLS/DAY) SP HD
<i>teriparatide</i> (Bonsity)	T4	PA QL(0.09 MLS/DAY) SP HD
<i>teriparatide</i> (Forteo)	T4	PA QL(0.09 MLS/DAY) SP HD
BONE RESORPTION INHIBITOR AND VITAMIN D COMBS.		
FOSAMAX PLUS D	T3	ST HD
BONE RESORPTION INHIBITORS		
ACTONEL (<i>risedronate sodium</i>)	T3	PA HD
<i>alendronate sodium</i>	T1	HD
<i>alendronate sodium</i> (Fosamax)	T1	HD
ADELVIA (<i>risedronate sodium</i>)	T3	ST HD
BILDYOS	T4	PA SP
BILPREVDA	T4	PA SP
BINOSTO	T3	ST HD
BOMYNTRA	T4	PA SP
CONEXXENCE	T4	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>	T4	SP HD
<i>ibandronate 3 mg/3 ml vial</i>	T4	SP HD
<i>ibandronate sodium 150 mg tab</i>	T1	HD
JUBBONTI	T4	PA SP
OSENVELT	T4	PA SP
<i>pamidronate disodium</i>	T1	SP HD
PROLIA	T4	PA SP
<i>raloxifene hcl</i> (Evista)	T1	HD PPACA
RECLAST (<i>zoledronic acid/mannitol-water</i>)	T4	SP HD
<i>risedronate sodium</i>	T1	HD

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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	T4	PA SP
WYOST	T4	PA SP
XGEVA	T4	PA SP
<i>zoledronic acid 4 mg vial</i>	T4	SP HD
ZOLEDRONIC ACID 4 MG/100 ML	T4	SP HD
<i>zoledronic acid 4 mg/5 ml vial</i>	T4	SP HD
<i>zoledronic acid 5 mg/100 ml (Reclast)</i>	T4	SP HD

UNCLASSIFIED DRUG PRODUCTS (Pain Relief And Inflammatory Disease)

ANTI-INFLAM. INTERLEUKIN-I RECEPTOR ANTAGONIST		
ARCALYST	T4	PA SP HD
ANTI-INFLAMMATORY, INTERLEUKIN-I BETA BLOCKERS		
ILARIS	T4	PA SP HD
FIBROMYALGIA AGENTS, SEROTONIN-NOREPINEPH RU INHIB		
SAVELLA	T2	HD
IMMUNOMODULATOR, B-LYMPHOCYTE STIM (BLYS)-SPEC INHIB		
BENLYSTA 120 MG VIAL	T4	PA SP
BENLYSTA 200 MG/ML AUTOINJECT	T4	PA SP HD
BENLYSTA 200 MG/ML SYRINGE	T4	PA SP HD
BENLYSTA 400 MG VIAL	T4	PA SP
JOINT CONTRACTURE THERAPY, COLLAGENASE ENZYME		
XIAFLEX	T4	PA SP

UNCLASSIFIED DRUG PRODUCTS (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	T4	PA SP HD
EBGLYSS PEN	T4	PA SP
EBGLYSS SYRINGE	T4	PA SP
JANUS KINASE (JAK) INHIBITORS		
LEQSELVI	T4	PA QL(2 TABS/DAY) SP HD
LITFULO	T4	PA QL(1 CAP/DAY) SP HD

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

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

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

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

UNCLASSIFIED DRUG PRODUCTS (Skin Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
WOUND HEALING AGENTS, LOCAL		
<i>balsam peru/castor oil</i>	T1	
FILSUEZ	T4	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	T4	SP HD
<i>buprenorphine hcl</i>	T1	
<i>buprenorphine hcl/naloxone hcl (Suboxone)</i>	T1	
SUBLOCADE	T4	SP
SUBOXONE (buprenorphine hcl/naloxone hcl)	T3	
ZUBSOLV	T2	

UNCLASSIFIED DRUG PRODUCTS (Transplant Medications)

RHO KINASE INHIBITOR		
REZUROCK	T4	PA SP HD

UNCLASSIFIED DRUG PRODUCTS (Urinary Tract Conditions)

BENIGN PROSTATIC HYPERTROPHY/MICTURITION AGENTS		
<i>alfuzosin hcl (Uroxatral)</i>	T1	HD
AVODART (dutasteride)	T3	PA HD
<i>dutasteride (Avodart)</i>	T1	HD
<i>finasteride (Proscar)</i>	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 (Rapaflo)</i>	T1	QL(1 CAP/DAY) HD
<i>silodosin 8 mg capsule (Rapaflo)</i>	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 (Jalyn)</i>	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
 T2 – Typically Preferred Brands
 T3 – Typically Non-Preferred Brands

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CYSTINE-DEPLETING AGENTS, NEPHROPATHIC CYSTINOSIS		
CYSTAGON	T4	SP
PROCYSBI	T4	PA SP HD
ENDOTHELIN RECEPTOR ANTAGONISTS		
VANRAFIA	T4	PA QL(1 TAB/DAY) SP
KIDNEY STONE AGENTS		
THIOLA (tiopronin)	T4	PA SP
THIOLA EC (tiopronin)	T4	PA SP
<i>tiopronin (Thiola Ec)</i>	T4	SP
<i>tiopronin 100 mg tablet (Thiola)</i>	T4	SP
<i>tiopronin dr 100 mg tablet (Thiola Ec)</i>	T4	SP
<i>tiopronin dr 100 mg tablet (Thiola Ec)</i>	T4	SP HD
<i>tiopronin dr 300 mg tablet (Thiola Ec)</i>	T4	SP
<i>tiopronin dr 300 mg tablet (Thiola Ec)</i>	T4	SP HD
OVERACTIVE BLADDER AGENTS, BETA-3 ADRENERGIC RECEPTOR ANTAGONISTS		
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 ANTAGONISTS		
<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
 T2 – Typically Preferred Brands
 T3 – Typically Non-Preferred Brands

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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>trospium chloride</i>	T1	HD

UNCLASSIFIED DRUG PRODUCTS (Weight Management)

APPETITE STIM. FOR ANOREXIA, CACHEXIA, WASTING SYND.		
<i>megestrol 400 mg/10 ml cup</i>	T1	
<i>megestrol 625 mg/5 ml susp</i>	T1	
<i>megestrol acet 40 mg/ml susp</i>	T1	
<i>megestrol acet 400 mg/10 ml</i>	T1	

VITAMINS (Nutritional/Dietary)

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	
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	

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

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
2-IN-1	213, 230
2TEK	151, 202

A

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

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

Index of Medications

AKLIEF	263	ALYMSYS	76
AKOVAZ	120	amantadine.....	94
AKTEN	163	AMBIEN	256, 257
AKYNZEO.....	179	AMBISOME.....	61
ALA-SCALP	264	ambrisentan.....	120
albuterol.....	38, 39, 40	amcinonide.....	264
ALBUTEROL	39	AMICAR	112
ALCAINE	163	AMIDATE	30
alclometasone	264	amikacin.....	44
ALCOH	235	amiloride.....	159, 160
alcohol.....	134, 257, 261, 282	aminocaproic	112
ALCOHOL	72, 134, 257, 258, 261, 262, 282	aminophylline.....	42
ALDACTONE.....	159	AMINOSYN	169
ALDURAZYME.....	280	amiodarone.....	115
ALECENSA	84	AMITIZA	185
alendronate.....	283	amitriptyline	246
ALFENTANIL	23, 293	amitriptyline/chlordiazepoxide.....	246
ALFERON	92	AMJEVITA.....	73
alfuzosin	285	amlodipine.....	116, 117, 122, 123, 124, 125, 129
ALHEMO.....	113	AMMONIA	153
ALIMTA.....	78	AMMONUL.....	177
ALINIA	93	AMONDYS	278
ALIQOPA.....	84	amoxapine	246
aliskiren.....	128	amoxicillin.....	50
ALKALINE.....	203	AMPHADASE	268
ALKERAN.....	76	amphetamine.....	104, 105
ALKINDI.....	192	amphotericin.....	61
allopurinol.....	35	ampicillin	50, 51, 70
almotriptan.....	20	AMPYRA.....	136
almotriptan malate.....	15	AMRIX	236
ALOCRIIL.....	163	AMVISC	166
ALOGLIPTIN.....	64, 65, 66	AMYTAL	256
alosetron	185	AMYVID.....	155
ALPHAGAN.....	163	AMZEEQ	55
ALPHANATE.....	112	ANAFRANIL.....	246
alprazolam	240, 241	anagrelide	96
ALREX.....	161	ANA-LEX	188
ALTABAX.....	264	ANALPRAM.....	183, 188, 267
ALTACE.....	125	ANAPROX.....	36
ALTAFLUOR.....	163	anastrozole.....	80
ALTERNATE	203, 214, 230	ANCOBON.....	60
ALTOPREV.....	130	ANDEXXA	114
ALTRENO.....	268	ANDROGEL	189
ALTRIXA.....	240	ANGELIQ.....	192
ALTUVIIIO	112	ANGIOMAX.....	59
ALUNBRIG.....	84	ANIMI	287
ALVAIZ	144	ANNOVERA.....	145
ALVESCO.....	41	ANORO	40
ALYFTREK	271	anthralin.....	260

Index of Medications

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

Index of Medications

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

Index of Medications

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

Index of Medications

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

Index of Medications

CEQUA	166	CIPROFLOXACIN.....	42
CEQUR	204	cisatracurium	106
CERDELGA	278	cisplatin.....	76
CEREBYX.....	138	CISPLATIN.....	76
CEREZYME.....	279	citalopram.....	242, 243
CERVIDIL.....	195	CITALOPRAM.....	243
cetirizine.....	63	CITANEST.....	31
CETRAXAL.....	42	CITRANATAL.....	172, 237, 240, 290
cetrotorelix.....	194	CITRATE.....	56, 130, 170
cevimeline.....	107	citric.....	177
CHANTIX.....	269	cladribine.....	79, 135, 136
CHEK.....	148, 157, 202, 204, 213, 214, 230, 231	CLARINEX.....	62, 63
CHEMET.....	280	CLARINEX-D.....	62
CHEMSTRIP.....	157, 204	clarithromycin.....	49
CHENODAL.....	182	clemastine.....	63
CHIRHOSTIM.....	156	CLENPIQ.....	185
chloramphenicol.....	48	CLEOCIN.....	48, 53, 55
chlordiazepoxide.....	178, 240, 246	CLEVER.....	148, 149, 204, 214, 231
chlorhexidine.....	274	CLEVIPREX.....	116
chloroprocaine.....	31, 32	CLICKFINE.....	219, 221
chloroquine.....	71	CLIMARA.....	191
chlorothiazide.....	160	CLINDAGEL.....	55
chlorpromazine.....	255	clindamyc.....	260
chlorthalidone.....	128, 160	clindamycin.....	48, 53, 55, 260
chlorzoxazone.....	236	CLINDAMYCIN.....	48
CHOLBAM.....	182	CLINDESSE.....	53
cholestyramine.....	131, 132	CLINIMIX.....	169
CHOLETEC.....	153	CLINISOL.....	169
choline salicyl/mag salicylate.....	15	CLINOLIPID.....	185
CHORIONIC.....	197	CLINPRO.....	167, 171
CHOSEN.....	204, 214, 231	clobazam.....	137
chromic.....	173	clobetasol.....	264, 266
CIALIS.....	274	CLOBETASOL.....	162, 264
ciclodan.....	61	CLOBEX.....	264
CICLODAN.....	61	clodan.....	265
ciclopirox.....	61, 62	CLODAN.....	265
cidofovir.....	100	CLODERM.....	265
cilostazol.....	96	clofarabine.....	79
CILOXAN.....	43	clomiphene citrate.....	197
CIMDUO.....	97	clomipramine.....	246
CIMERLI.....	165	clonazepam.....	137
cimetidine.....	184	clonidine.....	19, 126, 247
CIMZIA.....	73	CLONIDINE.....	126
cinacalcet.....	277	clopidogrel.....	96
CINQAIR.....	41	clorazepate.....	240
CINRYZE.....	277	clotrimazole.....	60, 61
CINVANTI.....	179	clozapine.....	250
CIPRO.....	42, 51	CLOZARIL.....	250
ciprofloxacin.....	42, 43, 51	COAGADEX.....	113

Index of Medications

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

Index of Medications

CYSTOGRAFIN.....	157	DEMEROL	24
CYSVIEW	155	DEMSEK.....	126
cytarabine	79	DENAVIR.....	103
CYTOMEL.....	269	DEPAKOTE.....	138
CYTOTEC	180	DEPEN.....	33, 300
D		DEPO.....	145, 189, 191, 192
dabigatran.....	58, 59	DERMA	265
dacarbazine.....	91	DERMACINRX	237
DACOGEN	79	DERMOTIC	161
dactinomycin	75	DESCOVY	97
dalbavancin.....	48	DESFERAL.....	280
dalfampridine	136	desflurane	30
DALIRESP	42	desipramine	246
DALVANCE.....	48	desloratadine	63
danazol.....	195	DESLORATADINE.....	63
DANTRIUM	236	desmopressin.....	190
dantrolene.....	236	desog.....	145
DANZITEN.....	85	desogestrel.....	145
DAPAGLIFLOZIN	67	desonide.....	265, 267
dapsone.....	45, 260	desoximetasone.....	265, 266
DAPSONE.....	260	DESOXYN.....	104
DAPTACEL.....	110	desvenlafaxine	245
DAPTOMYCIN	55	DESVENLAFAXINE	244
DARAPRIM	71	DETROL.....	286
darifenacin	286	dexamethasone	43, 162, 192, 193
DARTISLA	178	dexchlorpheniramine	63
darunavir.....	97	DEXCOM	205
DARZALEX.....	78	DEXEDRINE.....	104
dasatinib	85, 88	DEXILANT.....	186
DATROWAY	90	dexlansoprazole	186
DATSCAN	155	dexmedetomidine	257
daunorubicin.....	75	dexmethylphenidate	248
DAURISMO	81	dexrazoxane hcl	273
DAXXIFY	106	dextroamphetamine.....	104, 105
DAYBUE.....	135	dextrose.....	31, 46, 47, 48, 50, 51, 52, 106, 115, 119, 168, 169
DAYTRANA	248	DEXTROSE	32, 46, 47, 48, 51, 56, 123, 158, 168, 169, 171, 176, 177
DAYVIGO	257	DHIVY	95
DDAVP	190	DIACOMIT.....	138
decitabine	79	DIALYVITE.....	288, 289
DEFENCATH	277	DIANEAL.....	176, 177
deferasirox.....	280	DIASTAT	137
deferiprone.....	280	DIASTIX	153, 157
deferoxamine.....	280	diatrizoate	155, 156, 157
DEFINITY	153	DIATRUE	149, 205
DEFITELIO.....	114	diazepam	137, 241
deflazacort	192, 193	diazoxide.....	168
DELESTROGEN.....	191	DIBENZYLINE.....	105
DELSTRIGO	99	dichlorphenamide	276
demeclocycline.....	52	DICLEGIS.....	179

Index of Medications

diclofenac.....	20, 22, 35, 36, 93, 162, 259	DOPTLET.....	144
DICLOFENAC.....	36, 259	DORAL.....	256
dicloxacillin.....	50	DORYX.....	52
dicyclomine.....	178, 179	dorzolamide.....	164
DICYCLOMINE.....	179	DOTAREM.....	154
didanosine.....	98	DOVATO.....	97
DIFFERIN.....	268	doxazosin.....	123
DIFICID.....	49	doxepin.....	246, 257, 260
diflorasone.....	265	doxercalciferol.....	275
DIFLUCAN.....	60	DOXIL.....	75
diflunisal.....	15	doxorubicin.....	75
difluprednate.....	162	doxycycline.....	52, 53, 274
DIGIFAB.....	277	DOXYCYCLINE.....	52
digoxin.....	118	doxylamine.....	179, 180
dihydroergotamine.....	15, 20	DRAXIMAGE.....	154
DILANTIN.....	138	DRIZALMA.....	245
DILAUDID.....	24	dronabinol.....	179
diltiazem.....	116, 117, 118	droperidol.....	255
DILTIAZEM.....	117	DROPLET.....	205, 214, 219, 223, 231
diluent.....	278	DROPSAFE.....	214, 219, 221, 223, 231, 258, 261
DILUENT.....	278	drospir.....	145, 146
dimenhydrinate.....	180	DROXIA.....	113
dimethyl.....	136, 278	droxidopa.....	105
DIOVAN.....	124, 125	DRYSOL.....	260
DIPENTUM.....	183	DUAKLIR.....	40
diphenhydramine.....	63	DUAVEE.....	192
diphenoxylate.....	179	DUET.....	237, 240
DIPHThERIA.....	111	DUETACT (pioglitazone hcl/glimepiride).....	66
DIPRIVAN.....	30	DULERA.....	40
DIPROLENE.....	265	duloxetine.....	244, 245
dipyridamole.....	96, 153	DUOBRII.....	261
DISALCID.....	33	DUODOTE.....	277
DISCOVISC.....	166	DUOPA.....	95
disopyramide.....	115	DUOVISC.....	166
disulfiram.....	277	DUPIXENT.....	200
DIURIL.....	160	DURACLON.....	19
divalproex.....	138	DUREZOL.....	162
DIVIGEL.....	191	DUROLANE.....	34
DMSA.....	154	DURYSTA.....	164
dobutamine.....	119	dutasteride.....	285
DOCEFREZ.....	91	DUVYZAT.....	278
docetaxel.....	91	DYANAVEL.....	105
DOCIVYX.....	91	DYMISTA.....	160
dofetilide.....	115, 116	DYRENIUM.....	159
DOJOLVI.....	167	DYSPORT.....	106
donepezil.....	103, 104, 133, 134	E	
DONNATAL.....	181	EASY.....	149, 205, 206, 214, 215, 219, 223, 224, 231, 232, 258, 261
dopamine.....	106	EASYGLUCO.....	149, 206
DOPRAM.....	134	EASYMAX.....	149, 206

Index of Medications

ECLIPSE.....	219, 224	EMPAVELI	113
EC-NAPROSYN	36	EMPLICITI	80
econazole	61	EMRELIS	90
ECOZA.....	61	EMROSI.....	53
edaravone	134	EMSAM	242
EDARAVONE	134	emtricitata	99, 100
EDARBI	125	emtricitabine.....	97, 98
EDARBYCLOR	124	EMTRIVA.....	98
EDECIN	158, 159	EMVERM	71
EDETATE.....	279	enalapril	122, 125
EDEX.....	274	enalaprilat.....	125
EDLUAR	257	ENBRACE	288
EDURANT	98	ENBREL.....	73
E.E.S.....	49	ENDO	114
efavirenz.....	98, 99, 100	ENDO-AVITENE.....	114
effier	174	ENDOMETRIN	197
EFFER.....	174	ENFAMIL.....	170
EFFEXOR	245	ENFLONIA	100
EFFIENT	96	ENGERIX	111
EFUDEX.....	93	ENHERTU	90
EGRIFTA	194	ENJAYMO	113
ELAHERE.....	90	ENLITE	206
ELAPRASE	280	ENLYTE.....	287
electrolyte	171	enoxaparin	57, 58
ELELYSO.....	279	ENSACOVE.....	85, 86
ELEMENT	149, 206	ENSPRYNG.....	200
ELEPSIA	138	ENSTILAR.....	268
ELESTRIN	191	entacapone	94, 95
eletriptan.....	20	ENTADFI.....	285
eletriptan hydrobromide	15	entecavir.....	102
ELIDEL	200	ENTERO.....	155
ELIGARD	84	ENTRESTO.....	123
ELIMITE	94	ENVARBUS.....	201
ELIQUIS.....	56	EOHILIA	193
ELITEK.....	35	EOVIST	156
ELIXOPHYLLIN.....	42	EPANED	125
ELLA	145	EPCLUSA.....	102
ELLENC	75	ephedrine.....	120
ELLIOTTS.....	278	EPHEDRINE	120
ELMIRON	30	EPIDIOLEX	137
ELOCTATE.....	112	EPIDUO	260
ELREXFIO	90	EPIFOAM	267
eltrombopag	144	epinastine	63
ELUCIREM.....	154	epinephrine.....	31, 32, 103, 106, 161
ELYXYB	20	EPINEPHRINE.....	32, 103, 106
EMBRACE	149, 206, 215, 219, 232	EPINEPHRINESNAP.....	103
EMBRIVA	240	EPIPEN	103
EMEND	180	epirubicin	75
EMGALITY	15, 20	EPIVIR.....	98

Index of Medications

EPKINLY	90	ethacrynate	158, 159
eplerenone	159	ethacrynic	158
EPOGEN	143	ethambutol	45
epoprostenol	121, 278	ETHAMOLIN	133
EPRONTIA	138	ethinyl	145, 146
eprosartan	126	ethosuximide	139, 143
eptifibatide	96	ethyl	134, 177
EPTIFIBATIDE	96	ETHYOL	273
EPYSQLI	113	etodolac	36, 37
EPZICOM	97	etomidate	30
EQL	224	etonogestrel	145
EQUETRO	241	ETOPOPHOS	91
ERAXIS	61	etoposide	91
ERBITUX	83	etravirine	98
ergoloid	129	EUCRISA	263
ERGOMAR	20	EUFLEXXA	34
ergotamine	20	EULEXIN	78
ergotamine tartrate/caffeine	15	EURAX	94
eribulin mesylate	82	EVAMIST	191
ERIVEDGE	81	EVEKEO	105
ERLEADA	78	EVENCARE	149, 206, 207
ERMEZA	269	EVENTY	283
ERTACZO	61	everolimus	82, 201, 202
ertapenem	46	EVICEL	114
ERVEBO	111	EVISTA	283
ERWINASE	91	EVKEEZA	130
ERYPED	49	Evoclin	55
ERY-TAB	49	EVOCLIN	55
ERYTHROCIN	49	EVOLUTION	150, 207
erythromycin	43, 49, 55	EVOMELA	77
ERZOFRI	251	EVOTAZ	99
ESBRIET	277	EVOXAC	107
escitalopram	243	EVRYSDI	278
ESGIC	15, 19	EVUSHELD	100
eslicarbazepine	137, 138, 139	EXEL	219, 224
esmolol	127	EXELDERM	61
ESMOLOL	127	EXELON	104
esomeprazole	186, 187	exemestane	80
ESOMEPRAZOLE	186	exenatide	64
ESPEROCT	112	EXFORGE	123, 124
estazolam	256	EXJADE	280
ESTRACE	196	EXODERM	61
estradiol	145, 146, 191, 192, 196, 197	EXONDYS	278
ESTRATEST	190	EXPAREL	31
ESTRING	197	EXTENCILLINE	50
ESTROGEL	191	EXTINA	62
estrogen	190, 191	EXTRANEAL	177
estrogens	191, 192	EYSUVIS	162
eszopiclone	257	E-Z	156

Index of Medications

EZ.....	150, 151, 204, 207, 214, 215, 219, 223, 231, 232	FILSPARI.....	133
ezetimibe.....	129, 132, 133	FILSUEZ.....	285
F		FILTER.....	219, 220
FABHALTA.....	113	FINACEA.....	263
FABIOR.....	263	finasteride.....	285
FACTIVE.....	52	FINGERSTIX.....	215, 232
famciclovir.....	100	fingolimod.....	136
famotidine.....	184	FINTEPLA.....	139
FAMOTIDINE.....	184	FIORICET.....	15, 19, 30
FANAPT.....	251	FIORINAL.....	15
FARESTON.....	92	FIRAZYR.....	273
FARXIGA.....	68	FIRMAGON.....	84
FASLODEX.....	92	FIRVANQ.....	54
fat emulsions.....	185	FLAGYL.....	45
febuxostat.....	35	FLAREX.....	162
felbamate.....	139	flecainide.....	115
FELBATOL.....	139	FLECTOR.....	259
FELDENE.....	36	FLEQSUVY.....	236
felodipine.....	117	FLOLAN.....	121, 278
FEMARA.....	80, 83	FLOLIPID.....	131
FEMLYV.....	145	FLORIVA.....	167, 288
FEMRING.....	197	FLOW.....	220
fenofibrate.....	132, 133	floxuridine.....	79
FENOFIBRATE.....	132	FLUAD.....	109
fenofibric.....	132	FLUARIX.....	109
FENOGLIDE.....	132	FLUBLOK.....	109, 110
fenoprofen.....	36, 37	FLUCELVAX.....	110
FENOPROFEN.....	36	fluconazole.....	60
FENOPRON.....	36	flucytosine.....	60
FENORTHO.....	36	fludarabine.....	79
FENSOLVI.....	195	FLUDEOXYGLUCOSE.....	157
fentanyl.....	23, 24, 25	fludrocortisone.....	195
FENTANYL.....	23, 24, 25	FLULAVAL.....	110
FERAHEME.....	172	FLUMADINE.....	100
FERIVA.....	172	flumazenil.....	277
FERRALET.....	172	FLUMIST.....	110
FERRIC.....	170	flunisolide.....	161
FERRIPROX.....	280	fluocinolone.....	161, 265, 266
FERRLECIT.....	172	fluocinonide.....	265, 267
ferrous.....	172	fluorescein.....	155, 163
ferumoxytol.....	172	FLUORESC EIN.....	163
FETROJA.....	48	fluoride.....	167, 168, 171, 172, 174, 288, 289
FETZIMA.....	245	FLUORIDEX.....	167, 171
FEXMID.....	236	FLUORIMAX.....	167, 171
FIASP.....	68, 209	fluorometholone.....	162
FIBRICOR.....	132	FLUOROPLEX.....	93
FIBRYGA.....	112	fluorouracil.....	79, 93
fidaxomicin.....	49	FLUOROURACIL.....	93
FIFTY50.....	150, 215, 224, 232	fluoxetine.....	243, 244, 255

Index of Medications

fluphenazine	255	FUROSCIX	158
flurazepam	256	furosemide	158, 159
flurbiprofen	36, 162	FUROSEMIDE	159
flutamide	78	FUSION	98, 172
fluticasone	40, 160, 161, 265	FUZEON	98
FLUTICASONE	40, 41	FYARRO	82
fluticasone propion/salmeterol	40	FYCOMPA	139
fluvastatin	131	FYLNETRA	143
fluvoxamine	243	G	
FLUZONE	110	gabapentin	137, 139, 141
FML	162	GABARONE	139
FOCALIN	248	GABLOFEN	236
FOCINVEZ	180	GADAVIST	154
FOLATEXCEL	240	gadobutrol	155
folic	172, 173, 238, 239, 287, 288, 289	gadoterate	154
FOLLISTIM	197	gadoteridol	154
FOLOTYN	79	GALAFOLD	281
fomepizole	277	galantamine	104
fondaparinux	56, 57	GALLIUM	157
FONDCIRCLE	207, 215, 232	GALZIN	280
FORA	150, 153, 207, 215, 232	GAMIFANT	198
FORACARE	150, 207, 208, 215, 232	ganciclovir	101
FORFIVO	242	GANCICLOVIR	101
formoterol	39, 40, 41	ganirelix	195
FORTAVIT	288	GANIRELIX	195
FORTEO	283	GARDASIL	111
FORTISCARE	150, 208	GASTROCROM	33
FOSAMAX	283	GASTROGRAFIN	156
fosamprenavir	99	GASTROMARK	156
fosaprepitant	180	gatifloxacin	43
foscarnet	101	GATTEX	188
FOSCAVIR	101	GAVRETO	86
fosfomycin	45	GAZYVA	75
fosinopril	122, 125	GE100	150, 208
fosphenytoin	138, 139	GE333	150, 208
FOSRENOL	170	gefitinib	86
FOTIVDA	86	gelatin sponge	114
FRAGMIN	57	GELCLAIR	275
FRAICHE	167	GELFILM	163
FREESTYLE	150, 208, 215, 224, 232	GELFOAM	114
FRINDOVYX	77	GEL-ONE	34
FROVA	20	GELSYN	34
frovatriptan	20	gemcitabine	79
FRUZAQLA	86	GEMCITABINE	79
FUL-GLO	155	gemfibrozil	133
FULPHILA	143	GEMTESA	286
fulvestrant	92	GENOTROPIN	194
FULVICIN	61	GENSTRIP	150
FURADANTIN	49	gentamicin	43, 44, 55

Index of Medications

GENTAMICIN.....	44	griseofulvin	61
GENVISC.....	34	GUAIACOL	262
GENVOYA.....	100	GUAIFENESIN	148
Geodon.....	253	guanfacine	127, 247
GEODON	251	GUARDIAN.....	209
GIAPREZA.....	196	GVOKE	168
GILENYA	136	GYNAZOLE.....	60
GILOTRIF	86	H	
GIMOTI.....	184	HADLIMA	73
GIVLAARI.....	278	HAEGARDA.....	277
GLASSIA	272	HALAVEN.....	82
glatiramer acetate.....	136	halcinonide	265
GLEEVEC.....	86	HALCION.....	256
GLEOSTINE	77	halobetasol	265
GLIADEL	77	HALOG.....	265
glimepiride.....	65, 66	haloperidol.....	255
GLIMEPIRIDE	65	HARMONY.....	151, 237
glipizide.....	65, 67	HARVONI	102
GLIPIZIDE.....	65	HEALON.....	166
GLOPERBA	35	HEALTHPRO.....	151, 209
glucagon	168	HEALTHWISE.....	220, 224
GLUCAGON	155, 168, 188	HEALTHY	209, 215, 220, 232
GLUCO	150, 208, 209	HECTOROL.....	275
GLUCOCARD.....	150, 151, 208, 209	HELIDAC	181
GLUCOCOM.....	151, 209, 215, 232	HEMA	157
GLUCOTROL.....	65	HEMABATE.....	195
GLUMETZA	64	HEMADY.....	193
GLUTOL.....	170	HEMANGEOL.....	127
glyburide.....	65, 67	HEMATRON.....	172
GLYCATE.....	178	HEMAX	172
glycerol.....	178	HEMICLOR.....	160
glycine.....	72	HEMLIBRA.....	113
GLYCOPHOS.....	174	HEMOCYTE.....	172
glycopyrrolate.....	178	HEMOFIL	112
GLYCOPYRROLATE	178	heparin.....	57, 58
GLYNASE.....	65	HEPARIN	56, 57, 58
GLYXAMBI	66	HEPLISAV.....	111
GNP	151, 209, 224	HERCEPTIN	83
GOCOVRI.....	95	HERCESSI.....	83
GOJJI.....	151, 153, 209, 215, 232	HERZUMA.....	83
GOLYTELY	185	HETLIOZ.....	256
GOMEKLI	81	HIBERIX	111
GONAL-F	197	HISTATROL.....	156
GONITRO	119	HISTEX.....	147
GOZELLIX.....	155	homatropine	147, 165
GRALISE.....	137	HORIZANT	135
granisetron.....	180	HULIO	73
GRANIX.....	143	HUMALOG	68, 209
GRASTEK	107	HUMANA.....	151, 209

Index of Medications

HUMATE	112	IDACIO	74
HUMATIN	70	IDAMYCIN	75
HUMATROPE	194	idarubicin	75
HUMIRA	73, 74	IDHIFA	90
HUMULIN	68, 69	IFEX	77
HYALGAN	34	ifosfamide	77
hyaluronate	166	IGLUCOSE	151, 209
HYCAMTIN	82	IHEALTH	151, 209
HYCODAN	147	ILARIS	284
hydralazine	127	ILEVRO	162
HYDREA	77	ILLUCCIX	155
hydrochlorothiazide	122, 124, 127, 128, 160	ILUMYA	259
hydrocodone	22, 23, 25, 26, 147	ILUVIEN	162
HYDROCODONE	22	IMAAVY	281
hydrocodone/ibuprofen	23	imatinib	86
hydrocort	42, 43, 265	IMBRUVICA	86
hydrocortisone	42, 161, 183, 188, 192, 193, 264, 265, 266, 267	IMDELLTRA	90
hydrocortisone/acetic acid	161	IMFINZI	92
hydrogen peroxide	258	imipenem	46
hydromorphone	24, 25, 26	imipramine	246
HYDROMORPHONE	25, 26	IMITREX	20
hydroxychloroquine	71	IMJUDO	92
hydroxyprogesterone	197	IMKELDI	86
hydroxyurea	77	IMLYGIC	81
hydroxyzine	63	IMMPHENTIV	120
HYFTOR	200	IMPAVIDO	71
HYLENEX	282	IMPEKLO	266
HYMOVIS	34	IMPOYZ	266
HYMPAVZI	113	IMULDOSA	198
hyoscyamine	181, 182	IMURAN	201
HYOSCYAMINE	182	IMVEXXY	196
HYPER	278	INBRIJA	95
HYPERRHO	107	INCONTROL	209, 215, 220, 232, 258, 261
HYPODERMIC	219, 220	INCRELEX	194
HYPOLANCE	209	INCRUSE	38
hypromellose	166	indapamide	160
HYRIMOZ	74	INDERAL	127
HYSINGLA	26	INDICLOR	157
HYZAAR	124	indium	156
I		INDIUM	154, 156
ibandronate	283	INDOCIN	36
IBRANCE	86	indocyanine	153
IBSRELA	184	indomethacin	36, 128
IBTROZI	86	INDOMETHACIN	36
ibuprofen	23, 36, 128	INFANRIX	111
ibutilide	115	INFASURF	272
icatibant	273	INFED	172
ICLUSIG	86	INFINITY	151, 209
icosapent	177	INFLECTRA	74

Index of Medications

INFLIXIMAB.....	74	isoniazid.....	45
INFUGEM.....	79	ISOPROPRANOL.....	282
INFUMORPH.....	26	isopropyl.....	282
INFUVITE.....	288	ISOPROPYL.....	72, 282
INGREZZA.....	135	isoproterenol.....	106
INJECT.....	20, 103, 215, 232	ISORDIL.....	119
INJECTAFER.....	172	isosorbide.....	119, 129
INLEXZO.....	79	isosulfan.....	155
INLYTA.....	86	isotretinoin.....	259
INNOPRAN.....	127	ISOVUE.....	154
INPEFA.....	274	isoxsuprine.....	129
INPEN.....	209	isradipine.....	117
INQOVI.....	79	ISTALOL.....	164
INREBIC.....	86	ISTODAX.....	76
INSPRA.....	159	ISTURISA.....	188
INSTACLEAN.....	282	ITOVEBI.....	86
INSUL.....	209, 224, 227, 228	itraconazole.....	60
INSULIN.....	64, 65, 67, 69, 194, 220, 222, 223, 224, 225, 226, 227, 228, 229, 230, 275	ivabradine.....	119
INSUPEN.....	220	ivermectin.....	71, 263
INTEGRA.....	172, 220	IVRA.....	77
INTELENCE.....	98	IWILFIN.....	86
INTRALIPID.....	185	IXEMPRA.....	81
INTRAROSA.....	189	IYUZEH.....	164
INTUNIV.....	247	IZERVAY.....	166
INVACARE.....	215, 232	J	
INVEGA.....	251	JADENU.....	280
INVELTYS.....	162	JAKAFI.....	81
INVOKAMET.....	67	JALYN.....	285
INVOKANA.....	68	JANSSEN.....	108
INZIRQO.....	160	JANUMET.....	66
iodine.....	172, 267	JANUVIA.....	65
iodixanol.....	154	JARDIANCE.....	68
IODOFLEX.....	267	JATENZO.....	189
IODOPEN.....	172	javygtor.....	281
IODOSORB.....	267	JAYPIRCA.....	87
IONOSOL.....	171	JEMPERLI.....	89
iopamidol.....	154	JENTADUETO.....	66
IOPIDINE.....	164	JEVTANA.....	91
IPOL.....	109	JIVI.....	112
ipratropium.....	38, 40, 161	JOBEVNE.....	76
IQIRVO.....	275	JOENJA.....	272
irbesartan.....	124, 125, 126	JORNAY.....	248
IRESSA.....	86	JOURNAVX.....	19
irinotecan.....	82	JUBBONTI.....	283
iron.....	145, 146, 172, 173, 238, 239, 287, 288	JUBLIA.....	62
IROSPAN.....	173	JULUCA.....	97
ISENTRESS.....	99	JUST.....	167, 171
isoflurane.....	30	JUST RIGHT.....	167
ISOLYTE.....	171		

Index of Medications

JUXTAPID.....	130	KLISYRI.....	93
JYLAMVO.....	79	KLONOPIN.....	137
JYNARQUE.....	159	KLOXXADO.....	59
JYNNEOS.....	111	KMART.....	226
K		KOATE.....	112
KABIVEN.....	169	KOGENATE.....	112
KADCYLA.....	90	KOMBIGLYZE.....	66
KALBITOR.....	273	KONVOMEK.....	186
KALETRA.....	99	KORLYM.....	67
KALYDECO.....	271	KOSELUGO.....	81, 82
KANJINTI.....	83	KOSHER.....	237
KANUMA.....	280	KOVALTRY.....	112
KAPSPARGO.....	127	K-PHOS.....	177
KAPVAY.....	247	KRAZATI.....	81
KARBINAL.....	63	KRINTAFEL.....	71
KATERZIA.....	117	KRISTALOSE.....	185
KAZANO.....	66	KRO.....	226
KCENTRA.....	113	KROGER.....	226
KENALOG.....	193, 266	KRYSTEXXA.....	35
KENDALL.....	175	KUVAN.....	281
KEPIVANCE.....	188	KYLEENA.....	146
KEPPRA.....	139	KYPROLIS.....	87
KERENDIA.....	160	KYXATA.....	77
KESIMPTA.....	136	KYZATREX.....	189
KETALAR.....	30	L	
ketamine.....	30	labetalol.....	123
KETAMINE HCL-0.9% NACL.....	30	LABELALOL.....	123
KETO.....	153, 157	LABSTIX.....	157
ketoconazole.....	60, 62	lacosamide.....	139, 142, 143
KETONE.....	153, 157, 207, 209, 211	LACRISERT.....	161
ketoprofen.....	36, 37	lactulose.....	178, 185
ketorolac.....	22, 161, 162	LAMICTAL.....	139, 140
KETOSTIX.....	157	lamivudine.....	97, 98, 102
KEVEYIS.....	276	lamotrigine.....	139, 140
KEVZARA.....	200	LAMPIT.....	71
KEYTRUDA.....	89	LAMZEDE.....	280
KHAPZORY.....	273	lancets.....	215
KHINDIVI.....	193	LANCING.....	202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213
KIMMTRAK.....	81	LANOXIN.....	118
KIMYRSA.....	49	lanreotide.....	196
KINERET.....	33, 309	LANREOTIDE.....	196
KINEVAC.....	182	lansoprazole.....	181, 186, 187
KINRAY.....	226	lansoprazole/amoxicilin/clarith.....	181
KINRIX.....	111	lanthanum.....	170
KIRSTY.....	69	LANTUS.....	69
KISQALI.....	83, 87	LANZO.....	209
KISUNLA.....	134	lapatinib.....	87, 89
KITABIS.....	44	LASIX.....	159
KLARON.....	260	latanoprost.....	164, 165

Index of Medications

LATUDA	251, 252	LIDOCAINE	31, 175, 188
LAZANDA	26	LIDOCAN	33
LAZCLUZE	87	LIDODERM	33
LEADER	226	LIFESHIELD	220
LEDIPASVIR	102	LIKMEZ	45
leflunomide	34	LILETTA	146
LEMTRADA	136	linagliptin	66
lenalidomide	83	LINCOCIN	48
LENTOCILIN	50	lincomycin	48
LENVIMA	87	lindane	94
LEQEMBI	134	linezolid	50
LEQVIO	130	LINEZOLID	50
LESCOL	131	LINZESS	184
L.E.T.	33, 310	LIORESAL	236
LETAIRIS	120	liothyronine	269, 270, 271
letrozole	80	LIPIODOL	155
leucovorin	273	LIPITOR	131
LEUKERAN	77	LIPOFEN	133
LEUKINE	144	LIQUID	24, 156
leuprolide	84	liraglutide	64
LEUPROLIDE	84	lisdexamphetamine	247
levabuterol	39	lisinopril	122, 125
LEVALBUTEROL	39	lissamine green	155
LEVAMLODIPINE	117	LITE	150, 203, 208, 209, 215, 220, 226, 227, 232
LEVBID	182	LITETOUCH	227
LEVEMIR	69	lithium	241
levetiracetam	139, 140	LITHOBID	241
LEVETIRACETAM	140	LITHOSTAT	178
levobunolol	164	LIVALO	131
levocarnitine	282, 283	LIVDELZI	275
levocetirizine	63	Livmarli	184
levofloxacin	43, 52	LIVTENCITY	101
levoleucovorin	273	LOCAMETZ	155
levonorgest	145	LOCOID	266
levonorgestrel	146	LODINE	37
LEVOPHED	106	LODOCO	272
levorphanol	26	LODOSYN	96
levothyroxine	269, 270, 271	LOESTRIN	146
LEVOTHYROXINE	269, 270	lofexidine	285
LEVSIN	182	LOKELMA	170
LEVULAN	93	LO LOESTRIN	146
LEXAPRO	243	LOMOTIL	179
LEXISCAN	153	lomustine	77
LIALDA	183	LONSURF	79
LIBERVANT	137	loperamide	179
LIBRAX	178	LOPID	133
LIBTAYO	89	lopinavir	99
LICART	259	LOPRESSOR	127
lidocaine	31, 32, 33, 115, 155, 188, 267	LOPROX	62

Index of Medications

LOQTORZI.....	89	MAGNESIUM.....	173
lorazepam.....	240, 241, 256	MAGNEVIST.....	154
LORBRENA.....	87	MAKENA.....	197
LOREEV.....	241	MALARONE.....	71
LORTAB.....	22	malathion.....	94
LORZONE.....	236	manganese.....	173
losartan.....	124, 125, 126	mannitol.....	159, 283
LOTEMAX.....	162	MAR.....	148
LOTENSIN.....	122, 125	maraviroc.....	98
loteprednol.....	161, 162	MARCAINE.....	32
LOTREL.....	122	MARINOL.....	179
LOTRONEX.....	185	MARNATAL.....	237
lovastatin.....	131	MATERNACEL.....	240
LOVAZA.....	177	MATERVIA.....	240
LOVENOX.....	58	MATULANE.....	91
loxapine.....	254	MAVENCLAD.....	136
lubiprostone.....	185	MAVYRET.....	102
LUCEMYRA.....	285	MAXALT.....	20
LUCENTIS.....	165	MAXI.....	147, 227
LULICONAZOLE.....	62	MAXICOMFORT.....	220, 227
LUMAKRAS.....	81	MAXIDEX.....	162
LUMASON.....	155	MAXITROL.....	43
LUMIGAN.....	164	MAXI-TUSS CD.....	147
LUMIZYME.....	280	MAYZENT.....	136
LUMRYZ.....	256	meclizine.....	180
LUNESTA.....	257	MECLIZINE.....	180
LUNSUMIO.....	90	meclofenamate.....	37
LUPKYNIS.....	201	MEDI-FIRST.....	72
LUPRON.....	84, 194, 195	MEDIHONEY.....	264
lurasidone.....	251, 252	MEDISENSE.....	209, 215, 232
LUTATHERA.....	274	MEDLANCE.....	215, 232, 233
LUTRATE.....	84	MEDROL.....	192, 193
LUZU.....	62	MEDROLOAN.....	193
LYBALVI.....	252	medroxyprogesterone.....	145, 196
LYMEPAK.....	53	MEDTRONIC.....	209
LYMPHAZURIN.....	155	mefenamic.....	22
LYNOZYFIC.....	90	mefloquine.....	71
LYNPARZA.....	87	megestrol.....	93, 287
LYRICA.....	140, 284	MEKINIST.....	82
LYSODREN.....	91	MEKTOVI.....	82
LYTGObI.....	87	meloxicam.....	37, 38
LYUMJEV.....	69	MELOXICAM.....	37
LYVISPAH.....	236	melphalan.....	76, 77
M		memantine.....	133, 134
MACROBID.....	49	MEMBRANEBLUE.....	166
mafenide.....	56	MENACTRA.....	109
MAGELLAN.....	227	MENEST.....	191
MAGNEBIND.....	170	MENOPUR.....	197
magnesium.....	173, 186, 187	MENOSTAR.....	191

Index of Medications

MENQUADFI.....	109	metolazone.....	160
MENVEO.....	109	METOPIRONE.....	156
meperidine.....	26	metoprolol.....	127, 128
MEPHYTON.....	290	METROCREAM.....	263
mepivacaine.....	32	METROGEL.....	263
meprobamate.....	241	metronidazole.....	45, 53, 54, 263
MEPRON.....	71	METRONIDAZOLE.....	45
MEPSEVII.....	280	metronidazole/sodium chloride.....	45
mercaptopurine.....	79, 80	metryrosine.....	126
MERILOG.....	69	mexiletine.....	115
meropenem.....	46	MIACALCIN.....	198
MEROPENEM.....	46	micafungin.....	61
mesalamine.....	182, 183	MICAFUNGIN-0.9% NACL.....	61
MESNEX.....	273	MICARDIS.....	124, 126
MESTINON.....	104	miconazole.....	60
METADATE.....	248	MICONAZOLE.....	62
metaxalone.....	236, 237	MICORT.....	266
METAXALONE.....	236	MICRO.....	148, 151, 152, 204, 212, 215, 222, 233, 268
metformin.....	64, 65, 66, 67	MICRODOT.....	151, 210
METFORMIN.....	65, 66, 67	MICROLET.....	210, 216, 233
methadone.....	26	MICROTAINER.....	214, 231, 233
METHADONE.....	26	midazolam.....	31
methamphetamine.....	104, 105	MIDAZOLAM.....	31
METHAVER.....	289	midodrine.....	105
methazolamide.....	158	MIEBO.....	161
methenamine.....	45	MIFEPREX.....	276
methimazole.....	269	mifepristone.....	67, 276
METHITEST.....	189	miglitol.....	64
methocarbamol.....	237	miglustat.....	278, 279
METHOCARBAMOL.....	237	MIGRANAL.....	20
methohexital.....	30	milrinone.....	119
METHOHEXITAL.....	30	MINI.....	73, 149, 152, 203, 205, 207, 210, 211, 212, 214, 218, 220, 222, 231, 235, 240
methotrexate.....	79, 80	MINIMED.....	210, 227
methoxsalen.....	259	MINIPRESS.....	123
methscopolamine.....	182	MINIVELLE.....	191
methsuximide.....	138, 140	MINOCIN.....	53
methyl.....	262	minocycline.....	53
methyldopa.....	127	MINOCYCLINE.....	53
methyl dopate.....	127	MINOLIRA.....	53
methylene.....	276	minoxidil.....	127
METHYLENE.....	276	MIOCHOL.....	164
methylergonovine.....	195	MIPLYFFA.....	279
METHYLERGONOVINE.....	195	mirabegron.....	286
METHYLIN.....	248	MIRCERA.....	143
methylphenidate.....	247, 248, 249, 250	MIRENA.....	146
METHYLPHENIDATE.....	249	mirtazapine.....	240
methylprednisolone.....	193	misoprostol.....	35, 36, 180, 181
methyltestosterone.....	189	MITIGARE.....	35
metoclopramide.....	184	MITIGO.....	27

Index of Medications

mitomycin.....	75	MYCAMINE.....	61
MITOSOL.....	166	MYCAPSSA.....	196
mitoxantrone.....	91	MYCOBUTIN.....	45
MIUDELLA.....	146	mycophenolate.....	201
M-M-R.....	111	MYDAYIS.....	105
MNEXSPIKE.....	108	MYDRIACYL.....	165
MOBILE.....	207, 216, 233	Myfembree.....	194
modafinil.....	255	MYFORTIC.....	201
MODERNA.....	108	MYGLUCOHEALTH.....	151, 210, 216, 233
moexipril.....	125	MYHIBBIN.....	201
molindone.....	255	MYLERAN.....	77
mometasone.....	161, 266	MYLOTARG.....	83
MONJUVI.....	81	mynatal.....	238
MONOFERRIC.....	173	MYOBLOC.....	106
MONOJECT.....	220, 227	MYVIEW.....	153
MONOLET.....	216, 233	MYRBETRIQ.....	286
MONOVISC.....	34	MYSOLINE.....	140
MONSEL'S.....	114	MYTESI.....	179
montelukast.....	42	N	
morphine.....	27, 28	nabumetone.....	37
MORPHINE.....	27, 28	nadolol.....	128
MOTEGRITY.....	184	nafcillin.....	50
MOTOFEN.....	179	naftifine.....	62
MOTPOLY.....	140	NAFTIN.....	62
MOUNJARO.....	64	NAGLAZYME.....	280
MOVANTIK.....	59	nalbuphine.....	28
MOVIPREP.....	185	NALFON.....	37
MOXATAG.....	50	NALMEFENE.....	59
moxifloxacin.....	43, 44, 51, 52	NALOCET.....	22
MOXIFLOXACIN.....	43, 52	naloxone.....	29, 59, 285
Mozobil.....	145	naltrexone.....	59
MOZOBIL.....	145	NAMENDA.....	133
MRESVIA.....	111	NAMZARIC.....	133, 134
MS.....	28, 227	NANO.....	220, 222, 239
MS CONTIN.....	28	NAPRELAN.....	37
MULPLETA.....	144	NAPROSYN.....	36, 37
MULTAQ.....	115	naproxen.....	21, 36, 37
MULTI.....	148, 203, 209, 210	naratriptan.....	20
MULTIHANCE.....	154	NARCAN.....	59
MULTISTIX.....	157, 158	NAROPIN.....	32
multivit.....	288, 289	NATACHEW.....	238
MULTRY'S.....	173	NATACYN.....	59
mupirocin.....	55	NATAL.....	237, 238, 239, 240
MURI-LUBE.....	282	NATAZIA.....	146
MUSE.....	274	nateglinide.....	65
mv.....	172, 173, 288	NATESTO.....	189
MVASI.....	76	NATROBA.....	94
mvn.....	287, 288	NAYZILAM.....	137
MYALEPT.....	197	neбиволol.....	127, 128

Index of Medications

NEBUPENT.....	71	NICARDIPINE.....	117
nebusal.....	278	NICOTROL.....	269
NEBUSAL.....	278	nifedipine.....	117
NEEDLES.....	218, 219, 220, 221, 222	NIKTIMVO.....	200
NEEVODHA.....	288	NILANDRON.....	78
nefazodone.....	244	nilotinib.....	87, 88
NEFFY.....	103	NILOTINIB.....	87
nelarabine.....	78, 80	nilutamide.....	78
NEMBUTAL.....	256	NIMBEX.....	106
NEMLUVIO.....	200	nimodipine.....	117
NEOMATERNA.....	240	NINJACOF.....	148
neomycin.....	42, 43, 44, 258	NINLARO.....	87
NEONATAL.....	173, 238, 281	NIPENT.....	80
NEOPROFEN.....	128	nisoldipine.....	117
NEORAL.....	201	nitazoxanide.....	93
neostigmine.....	103, 104	NITHIODOTE.....	280
NEOSTIGMINE.....	104	nitisonone.....	279
NEO-SYNALAR.....	55	NITRO.....	119
NEPHRON.....	289	nitrofurantoin.....	49, 50
NERLYNX.....	87	NITROFURANTOIN.....	49
NESACAINE.....	32	nitroglycerin.....	119, 186
NESINA.....	65	NITROLINGUAL.....	119
NESTABS.....	238, 288	NITROMIST.....	119
NETSPOT.....	155	nitroprusside.....	126
neuac.....	260	NITROSTAT.....	119
NEUAC.....	260	NITYR.....	279
NEULASTA.....	144	NIVA.....	288, 289
NEULUMEX.....	156	NIVESTYM.....	144
NEUPOGEN.....	144	nizatidine.....	184
NEUPRO.....	95	NOCTIVA.....	190
NEURONTIN.....	141	NOKOR.....	220
NEUTEK.....	151	NORDITROPIN.....	194
NEVANAC.....	162	norelgestromin.....	146
nevirapine.....	98	norepineph.....	106
NEXAVAR.....	87	NOREPINEPH.....	106, 284
NEXICLON.....	127	norepinephr.....	106
NEXIUM.....	186, 187	NOREPINEPHR.....	106
NEXLETOL.....	130	norepinephrine.....	106
NEXLIZET.....	130	NOREPINEPHRINE.....	106, 242, 244, 245
NEXPLANON.....	145	noreth.....	146
NEXTERONE.....	115	norethin.....	146, 192
NEXTSTELLIS.....	146	norethind.....	146, 191
NEXVIAZYME.....	280	norethindrone.....	146, 191, 196
NGENLA.....	194	NORGESIC.....	237
niacin.....	133	norgestimate.....	146
NIACOR.....	133	norgestrel.....	146
nicardipin.....	117	NORITATE.....	263
NICARDIPIN.....	117	NORLIQVA.....	117
nicardipine.....	116, 117	NORMOSOL.....	171

Index of Medications

NORPACE	115	octreotide.....	196
Northera.....	105	OCUFLOX	43
NORTHERA	105	ODACTRA.....	107
nortriptyline.....	246	ODEFSEY.....	100
NORVASC.....	117	ODOMZO	81
NORVIR.....	99	OFEV.....	272
NOURIANZ.....	95	OFIRMEV	19
NOVA.....	151, 210, 216, 233	ofloxacin.....	42, 43, 52
NOVAMAX	153, 210	OGIVRI.....	83
NOVAREL	197	OGSIVEO.....	87
NOVAVAX.....	108	OHTUVAYRE.....	42
NOVOEIGHT.....	112	OJEMDA.....	81
NOVOFINE	220	OJJAARA	87
NOVOLIN	70	olanzapine	252, 253, 255
NOVOLOG	70, 209	OLINVYK.....	28
NOVOPEN	210	olmesartan.....	123, 124, 125, 126
NOXFIL	60	olmesartan/amlodipin/hcthiazid	123
NPLATE.....	144	olopatadine.....	63, 160
NUBEQA	78	OLPRUVA.....	178
NUCALA.....	41	OLUMIANT.....	35
NUCORT.....	266	OLUX.....	266
NUCYNTA	28	om-3.....	288
NUDEXTA.....	135	OMECLAMOX	181
NULEV	182	omega.....	177, 238
NULIBRY	279	OMEGAVEN	185
NULOJIX.....	201	omeprazole.....	187
NUMOISYN.....	275	OMIDRIA.....	163
NUPLAZID.....	242	OMNARIS	161
NURTEC	20	OMNIPAQUE.....	154
NUTRILIPID.....	185	OMNIPOD.....	210
NUTROPIN	194	OMNISCAN.....	154
NUVARING.....	145	OMNITROPE.....	194
NUVAXOVID.....	108	OMVOH	199
NUVESSA.....	54	ONAPGO.....	95
NUVIGIL.....	255	ON CALL	151, 210, 216, 233
NUWIQ	112	ONCASPAR.....	92
NUZYRA	53	ondansetron.....	180
NYMALIZE.....	117	ONDANSETRON.....	180
NYPOZI.....	144	ONETOUCH	151, 210, 211, 216, 233
nystatin	61, 62	ONEXTON.....	260
NYVEPRIA.....	144	ONFI.....	137
O		ONGENTYS	95
OB.....	238, 239, 240, 287, 288	ONGLYZA	65
OBREDON	148	ONIVYDE	82
OBSTETRIX.....	238	ON-THE-GO.....	216, 233
OBTREX.....	238	ONTRUZANT.....	83
OICALIVA.....	183	ONUREG	80
OCREVUS.....	136	ONZETRA	20
OCTREOSCAN	156	OPDIVO.....	89

Index of Medications

OPDUALAG.....	90	oxaprozin.....	36, 37
OPFOLDA.....	278	OXAPROZIN.....	37
OPIPZA.....	254	OXAYDO.....	28
opium.....	28, 179	oxazepam.....	241
OPSUMIT.....	120	OXBRYTA.....	113
OPSYNVI.....	122	oxcarbazepine.....	141, 142
OPTIRAY.....	154	OXERVATE.....	166
OPTISON.....	153	oxiconazole.....	62
OPTIUM.....	151	OXISTAT.....	62
OPTUMRX.....	151, 211	OXLUMO.....	281
OPVEE.....	59	OXTELLAR.....	141
OPZELURA.....	267	oxybutynin.....	287
ORABLOC.....	32	OXYBUTYNIN.....	287
ORACEA.....	53	oxycodone.....	22, 28, 29
ORACIT.....	177	OXYCODONE.....	29
ORALAIR.....	107	OXYCONTIN.....	29
ORAMAGICRX.....	275	oxymorphone.....	29
ORAPRED.....	193	OXYTOCIN.....	195
ORAVIG.....	60	OXYTROL.....	287
ORBACTIV.....	49	OZEMPIC.....	64
ORENCIA.....	34	OZOBAX.....	237
ORENITRAM.....	121	OZURDEX.....	162
Orfadin.....	279	P	
ORFADIN.....	279	pacerone.....	115
ORGOVYX.....	84	paclitaxel.....	91, 92
ORIAHNN.....	194	PADCEV.....	90
ORLISSA.....	195	PALFORZIA.....	107
ORKAMBI.....	271	paliperidone.....	251, 252
ORLADEYO.....	273	palonosetron.....	180
orphenadrine.....	237	PALYNZIQ.....	107
ORSERDU.....	92	PAMELOR.....	246
ORTHOVISC.....	34	pamidronate.....	283
oseltamivir.....	101	PANCREAZE.....	186
OSENI.....	64	pancuronium.....	106
OSENVELT.....	283	PANDEL.....	266
osmitrol.....	159	PANHEMATIN.....	272
OSMITROL.....	159	PANRETIN.....	93
OSMOPREP.....	185	pantoprazole.....	187
OSPHENA.....	276	PANTOPRAZOLE.....	187
OTEZLA.....	34	papaverine.....	129
OTOVEL.....	42	PARADIGM.....	227
OTREXUP.....	33, 316	PARAGARD.....	147
OTULFI.....	198	PAREMYD.....	165
OVACE.....	261	parenteral.....	170
OVAL.....	211	paricalcitol.....	275, 276
OVIDE.....	94	PARICALCITOL.....	276
oxacillin.....	50	PARNATE.....	242
oxaliplatin.....	77	paroxetine.....	243, 244, 279
oxandrolone.....	189	PARSABIV.....	277

Index of Medications

PASER	45	PFIZER	108
PATANASE.....	160	PH 12.....	278
PAXIL	244	PHARMABASE.....	263
PAXLOVID	100	PHARMACIST.....	151, 211
pazopanib	87, 89	PHASEAL	220
ped	288	PHEBURANE.....	178
pedi	288, 289	phenazopyridine	33
PEDIARIX	111	phenelzine	242
PEDITRACE	173	PHENERGAN.....	63
PEDMARK.....	273	phenobarb	181, 182
PEDVAXHIB.....	111	phenobarbital	256
peg3350.....	185	PHENOBARBITAL.....	182
PEGASYS	102	phenoxybenzamine	105
PEMAZYRE	87	phentolamine	105
pemetrexed.....	78, 80	phenylephrine.....	62, 120, 163
PEMETREXED	80	PHENYLEPHRINE.....	120
PEMFEXY.....	80	phenylephrine hcl/prometh hcl	62
PEMRYDI	80	PHENYTEK.....	141
PENBRAYA	109	phenytoin.....	138, 141
penciclovir.....	103	PHESGO	83
penicillamine	33, 317	PHEXX.....	145
penicillin.....	50, 51	PHEXXI.....	145
PENICILLIN	50, 51, 70	PHOSPHOLINE.....	164
PENMENVY	109	PHOTOFRIN.....	92
PENTACEL	111	PHOXILLUM.....	177
PENTAM	71	PHYSIOLYTE.....	258
pentamidine	71	PHYSIOSOL.....	258
PENTASA	183	physostigmine	104
pentazocine.....	29	phytonadione.....	290
PENTETATE	281	PHYTONADIONE	290
PENTIPS.....	218, 220, 222	PIASKY.....	113
pentobarbital	256	PIFELTRO.....	98
pentoxifylline	114	pilocarpine	107, 164, 165
PEPCID.....	184	pimecrolimus	200
perampanel.....	139, 141	pimozide	250
PERCOCET.....	22	pindolol.....	128
PERFECT	216, 220, 233	pioglitazone	66, 67
PERFOROMIST.....	39	PIP	151, 211, 216, 221, 233
PERIDEX.....	274	piperacil.....	51
PERIKABIVEN.....	170	PIPERACIL.....	51
perindopril	125	PIPERACILLIN	51
perit	177	PIQRAY	87
periton.....	177	pirfenidone	277
PERJETA.....	83	PIRFENIDONE	277
permethrin	94	piroxicam.....	36, 37
perphenazine.....	246, 255	pitavastatin	131
perphenazine/amitriptyline hcl	246	PITOCIN.....	195
PERSERIS	252	PLAQUENIL.....	71
PERTZYE	186	PLASMA	107, 171, 273

Index of Medications

PLATINUM.....	148, 151, 203	prednisolone.....	43, 162, 193
PLAVIX.....	96	prednisone.....	193
PLEGISOL.....	118	PREF.....	227
PLEGRIDY.....	136	PREFERRED.....	227
PLENAMINE.....	170	PREFPLS.....	227
PLENVU.....	185	pregabalin.....	140, 141, 284
plerixafor.....	145	PREGEN.....	238
PLEXION.....	56	PREGENNA.....	240
PNEUMOVAX.....	109	PREHEVBRIO.....	111
prn.....	238	PREMARIN.....	192, 197
PNV.....	240	PREMIER.....	152, 211, 238
prn19.....	238	PREMIUM.....	150, 152, 207, 211
prn81.....	238	PREMPHASE.....	192
podofilox.....	262, 263	PREMPRO.....	192
POGO.....	211, 233	PRENATA.....	238
POKONZA.....	174	prenatal.....	238, 239
POLIBAR.....	156	PRENATAL.....	237, 238, 239, 240
POLIVY.....	90	PRENATE.....	239, 240, 288
POLOCAINE.....	32	PREPIDIL.....	195
POLY.....	147, 221, 289, 290	PRESSURE.....	163, 164, 165, 216, 233
polyethylene.....	282	PRESTALIA.....	122
polymyxin.....	42, 43, 51	PRESTO.....	148, 203, 211, 213
POLY-TUSSIN AC.....	147	PRETOMANID.....	46
POMALYST.....	83	PREVACID.....	187
POMBILITI.....	280	PREVENT.....	221
PONVORY.....	136	PREVIDENT.....	167, 171, 172
PORTRAZZA.....	83	PREVNAR.....	109
posaconazole.....	60	PREVYMIS.....	101
POSFREA.....	180	PREZCOBIX.....	97
POSIMIR.....	32	PREZISTA.....	97
potassium.....	20, 22, 50, 51, 125, 126, 167, 172, 174, 175, 177, 185, 267	PRIALT.....	19
POTASSIUM.....	118, 159, 160, 174, 175, 176, 186	PRIFTIN.....	46
POTELIGEO.....	90	PRILOSEC.....	187
PRADAXA.....	58, 59	PRIMACARE.....	239
PRALATREXATE.....	80	primaquine.....	71
PRALIDOXIME.....	277	PRIMAQUINE.....	71
PRALUENT.....	130	PRIMAXIN.....	46
pramipexole.....	95	primidone.....	140, 141
PRAMOSONE.....	267	PRIMIDONE.....	141
prasugrel.....	96	PRIMLEV.....	22
PRAXBIND.....	114	PRIMSOL.....	45
prazosin.....	123	PRIORIX.....	111
PRECEDEX.....	257	PRISMASOL.....	177
PRECISION.....	150, 151, 152, 153, 208, 211, 219, 224	PRISTIQ.....	245
PRECISIONGLIDE.....	220, 221	PRO149, 150, 152, 166, 191, 193, 204, 206, 207, 211, 213, 216, 218, 219, 221, 227, 229, 230, 233, 235, 258, 261, 262	
PRECOSE.....	64	PROAIR.....	39
PRED.....	162	probenecid.....	38
PRED FORTE.....	162	procainamide.....	115
prednicarbate.....	266		

Index of Medications

PROCAINAMIDE.....	115	PYRIDIDIUM.....	33
PROCARDIA.....	117	pyridostigmine.....	104
prochlorperazine.....	179, 180	PYRIDOSTIGMINE.....	104
PROCORT.....	183, 188	pyrimethamine.....	71
PROCRIT.....	143	PYZCHIVA.....	198
PROCTOFOAM.....	183, 188	Q	
PROCYSBI.....	286	QBRELIS.....	125
PRODIGY.....	152, 211, 216, 228, 233	QBREXZA.....	264
progesterone.....	196, 197	QELBREE.....	250
PROGLYCEM.....	168	QFITLIA.....	113
PROGRAF.....	201, 202	QINLOCK.....	87
PROHANCE.....	154	QLOSI.....	164
PROLASTIN.....	272	QNASL.....	161
prolate.....	22	QTERN.....	66
PROLATE.....	22	QUADRACEL.....	111
PROLENSA.....	162	QUAZEPAM.....	256
PROLEUKIN.....	92	QUDEXY.....	141
PROLIA.....	283	QUELICIN.....	106
PROMACTA.....	144	QUESTRAN.....	132
promethazine.....	63, 147, 180	quetiapine.....	252, 253
PROMETRIUM.....	196	QUETIAPINE.....	252
propafenone.....	115	QUFLORA.....	289
proparacaine.....	163	QUILLICHEW.....	249
propofol.....	30	QUILLIVANT.....	249
propranolol.....	127, 128	quinapril.....	122, 125
propylthiouracil.....	269	quinidine.....	115
PROQUAD.....	111	quinine.....	71
PROSCAR.....	285	QUINTET.....	152, 211
PROSOL.....	170	QULIPTA.....	20
protamine.....	113	QUVIVIQ.....	257
PROTECT.....	167, 222, 288	QUZYTIR.....	63
PROTONIX.....	187	QVAR.....	41
PROTOPAM.....	277	R	
protriptyline.....	246	RA.....	228
PROVAYBLUE.....	276	rabeprazole.....	186, 187
PROVERA.....	145, 196	RABEPRAZOLE.....	187
PROVIDA.....	239	RADIAGEL.....	281
PROVIGIL.....	255	RADICAVA.....	134
PROVISC.....	166	RADIOGARDASE.....	281
PROVOCHOLINE.....	155	RAGWITEK.....	107
PROZAC.....	244	RALDESY.....	244
PUB.....	228	raloxifene.....	283
PULMICORT.....	41	ramelteon.....	256
PULMOZYME.....	272	ramipril.....	125
PURE.....	216, 221, 233, 258, 261	RANEXA.....	115
PURIXAN.....	80	ranolazine.....	115
PUSH.....	216, 233	RAPAFLO.....	285
PYLERA.....	181	RAPAMUNE.....	202
pyrazinamide.....	46	RAPIVAB.....	101

Index of Medications

rasagiline.....	94, 95	REVATIO.....	120
RASUVO.....	33, 320	REVCovi.....	280
RAVICTI.....	178	REVEAL.....	152, 212
RAYA.....	221	REVLIMID.....	84
RAYALDEE.....	276	REVUFORJ.....	87, 88
READI.....	156	REXTOVY.....	59
READYLANCÉ.....	216, 234	REXULTI.....	254
REBIF.....	136	REYATAZ.....	99
REBLOZYL.....	272	REYVOW.....	20
RECARBRIO.....	46	REZDIFFRA.....	275
RECLAST.....	283	REZLIDHIA.....	90
RECOMBINATE.....	112	REZUROCK.....	285
RECOMBIVAX.....	111	REZVOGLAR.....	70
RECORLEV.....	188	REZZAYO.....	61
RECOTHROM.....	114	R-GENE.....	156
RECTIV.....	186	RHOGAM.....	107
REFUAH.....	152, 211	RHOPHYLAC.....	107
regadenoson.....	153	RHOPRESSA.....	164
REGADENOSON.....	153	RIABNI.....	75
REGLAN.....	184	RIASTAP.....	112
REGULAR.....	221	ribavirin.....	102
RELAFEN.....	37	RIDAURA.....	35
RELAGARD.....	70	rifabutin.....	45, 46
RELENZA.....	101	RIFADIN.....	46
RELEUKO.....	144	rifampin.....	46
RELEXII.....	249, 250	RIGHTEST.....	152, 212, 216, 234
RELIAMED.....	211, 216, 234	RILUTEK.....	134
RELION.....	152, 211, 212, 228	riluzole.....	134
RELISTOR.....	59	rimantadine.....	100, 101
RELPAK.....	20	RIMSO.....	30
RELSTONE.....	182	ringer's.....	171, 258
REMERON.....	240	RINVOQ.....	35
REMICADE.....	74	RIOMET.....	65
remifentanyl.....	23	risedronate.....	283, 284
REMODULIN.....	121, 278	RISPERDAL.....	252
RENACIDIN.....	177	risperidone.....	252
RENFLEXIS.....	74	RITALIN.....	250
REVELA.....	170	ritonavir.....	99
repaglinide.....	65	RITUXAN.....	75
REPATHA.....	130	rivastigmine.....	104
REQ49.....	287	RIVFLOZA.....	281
RESPA.....	147, 289	rizatriptan.....	20, 21
RESTASIS.....	166	R-NATAL.....	240
RESTORIL.....	256	ROBAXIN.....	237
RETACRIT.....	143	ROBINUL.....	178
RETAVASE.....	114	ROCKLATAN.....	164
RETEVMO.....	87	rocuronium.....	106
RETIN.....	268	roflumilast.....	42
RETROVIR.....	98	ROLVEDON.....	144

Index of Medications

romidepsin.....	76	SAPHNELO.....	198
ROMIDEPSIN.....	76	SAPHRIS.....	252
ROMVIMZA.....	88	sapropterin.....	281
ropinirole.....	95	SARCLISA.....	78
ROPIVACAINE.....	32	SAVAYSA.....	56
rosuvastatin.....	130, 131	SAVELLA.....	284
ROSUVASTATIN.....	129	saxagliptin.....	65, 66
ROSZET.....	129	saxagliptn.....	66
ROTARIX.....	109	SCALACORT.....	266
ROTATEQ.....	109	SCSEMBLIX.....	88
ROWASA.....	183	SCLEROSOL.....	273
ROXICODONE.....	29	scopolamine.....	180
ROXYBOND.....	29	SECUADO.....	252
ROZEREM.....	256	SECURESAFE.....	221, 228
ROZLYTREK.....	88	SEGLUROMET.....	67
RUBRACA.....	88	SELARSDI.....	198
RUCONEST.....	277	SELECT.....	92, 239
rufinamide.....	137, 141	selegiline.....	95
RUKOBIA.....	98	selenious.....	174
RUXIENCE.....	75	SELENIUS.....	173, 174
RYALTRIS.....	160	selenium.....	261
RYANODEX.....	237	SELZENTRY.....	98
RYBELSUS.....	64	SEMGLEE.....	70
RYBREVANT.....	81	SENSIPAR.....	277
RYCLORA.....	63	sensorcaine.....	32
RYDAPT.....	88	SENSORCAINE.....	32
RYKINDO.....	252	SEREVENT.....	40
RYLAZE.....	92	SERNIVO.....	266
RYONCIL.....	279	SEROQUEL.....	252, 253
RYSTIGGO.....	281	SEROSTIM.....	194
RYTARY.....	95	sertraline.....	244
RYTELO.....	88	sevelamer.....	170
RYVENT.....	63	sevoflurane.....	30
RYZNEUTA.....	144	SEYSARA.....	53
S		SFROWASA.....	183
SABRIL.....	141	SHINGRIX.....	111
sacubitril.....	123	SHORT.....	38, 39, 221, 222
SAFE.....	203, 212, 213, 229, 230	SIGNIFOR.....	196
SAFESNAP.....	228	SIL.....	212
SAFETYGLIDE.....	221, 228	sildenafil.....	120, 274, 275
SAFYRAL.....	146	SILENOR.....	257
SALAGEN.....	107	silodosin.....	285
saline.....	175	SILVADENE.....	56
salsalate.....	33	silver.....	56, 263, 267
SAMSCA.....	158	SIMBRINZA.....	164
SANCUSO.....	180	SIMLANDI.....	74
SANDIMMUNE.....	202	SIMPLERA.....	212
SANDOSTATIN.....	196	SIMPLI.....	221
SANTYL.....	268	SIMPONI.....	74

Index of Medications

SIMULECT.....	200	sorafenib	87, 88
simvastatin.....	129, 131	SORBITOL.....	258
SINEMET.....	95	SORILUX	261
SINGLE.....	147, 183, 188, 217, 234, 258, 262	SOTALOL	128
SINGULAIR.....	42	SOTRADECOL.....	133
SINOGRAFIN.....	153	SOTYKTU	259
SINUVA.....	161	SOTYLIZE	128
sirolimus.....	202	SOVALDI	101, 102
SIRTURO	46	SOVUNA	71
SITAGLIPTIN.....	65, 66, 67	SPECIALTY	221
SITAVIG.....	101	SPEVIGO	259
SITZMARKS	156	SPIKEVAX.....	108
SIVEXTRO	50	spinosad.....	94
SKY	221	SPINRAZA.....	278
SKYCLARYS.....	281	SPIRIVA.....	38
SKYLA.....	147	spironolactone.....	159, 160
SKYRIZI.....	199, 259	SPORANOX.....	60
SKYTROFA	194	SPRAVATO.....	241
SLYND	146	SPRITAM.....	141
SM.....	162, 228	SPRYCEL	88
SMART.....	150, 152, 207, 212, 213, 215, 217, 232, 234	sps.....	171
SMARTDIABETES.....	212	SPY-MIS	153
SMARTEST.....	152, 212, 217, 234	SSKI	172
SMOFLIPID	185	STALEVO.....	95
SOAAANZ.....	159	STARJEMZA.....	198
SODIUM.....	30, 47, 56, 58, 135, 159, 160, 175, 176, 184, 256, 258, 277, 282	stavudine.....	98
sodium chloride.....	45, 96, 127, 175, 176	STEGLATRO.....	68
SODIUM DIURIL.....	160	STELARA.....	198
sodium fluoride.....	167	STENDRA	274
sodium tetradecyl sulfate.....	133	STEQEYMA	199
sod phosphate	174	STERILANCE.....	217, 234
sod,pot chlor/mag/sod,pot phos.....	258	STERILE.....	30, 47, 217, 234, 273
sod/pot/k cit/sod cit/cit acid.....	177	STERITALC.....	273
SOFOSBUVIR	102	STIMUFEND.....	144
SOGROYA.....	194	STIOLTO	40
SOHONOS.....	282	STIVARGA.....	88
solifenacin.....	286	STOBOCLO	284
SOLIQUA.....	64	STRATTERA.....	250
SOLIRIS.....	113	STRENSIQ	279
SOLODYN.....	53	STREPTOMYCIN	44
SOLOSEC.....	44	STRIBILD.....	100
SOLTAMOX.....	93	STRIVERDI.....	39
SOLU.....	193	STROMECTOL	71
SOLUS.....	152, 212, 217, 234	strontium	274
SOLUVITA	289	STROVITE.....	288
SOMA	237	SUBLOCADE.....	285
SOMATULINE.....	196	SUBOXONE	285
SOMAVERT	275	SUBSYS.....	29
SOOLANTRA.....	263	subvenite.....	141

Index of Medications

succinylcholine	106, 107	SYNERCID	52
SUCCINYLSCHOLINE.....	107	SYNJARDY	67
SUCRAID	183	SYNOJOYNT.....	34
sucralfate.....	180, 181	SYNTHROID	271
sufentanil	23	SYNVISC.....	34
SUFLAVE.....	185	SYPRINE	281
SULAR	117	syring.....	25, 27, 153, 229
SULCONAZOLE.....	62	T	
sulfacetamide	43, 56, 260, 261	TABLOID.....	80
sulfadiazine.....	44	TABRECTA.....	88
sulfamethoxazole.....	44	TACLONEX.....	268
SULFAMYLON.....	56	tacrolimus	200, 201, 202
sulfasalazine.....	183	TACROLIMUS.....	202
sulindac.....	37	tadalafil	120, 274, 275
sumatriptan	20, 21	tadalafil 5 mg tablet.....	275
sunitinib	88	TADLIQ.....	120
SUNLENCA	96, 97	TAFINLAR	81
SUNOSI.....	255	tafluprost.....	164, 165
SUPARTZ.....	34	TAGITOL	156
SUPER.....	215, 217, 232, 234	TAGRISSO	88
SUPPRELIN	195	TAKHZYRO.....	107
SUPRANE.....	30	TALICIA	181
SUPREP	185	TALTZ.....	259
SURE.....	152, 212, 217, 221, 229, 234, 258, 262	TALVEY	90
SUREFLEX.....	212, 216, 233	TALZENNA.....	88
SURE-TEST.....	152, 212	TAMIFLU	101
SURGICEL	114	tamoxifen	93
SURVANTA.....	272	tamsulosin	285
SUSTOL	180	TANDEM	288
SUSVIMO.....	165	TAPERDEX.....	194
SUTAB.....	185	TARGADOX.....	53
SUTENT.....	88	TARGRETIN	75, 93
SWABFLUSH.....	176	TARPEYO.....	194
SYFOVRE.....	166	TASCENSO	136
SYLVANT	90	TASIGNA	88
SYMAX	182	tasimelteon.....	256
SYMBICORT	41	TASMAR	95
SYMBRAVO.....	21	tavaborole	62
SYMDEKO.....	271	TAVALISSE	272
SYMFI	100	TAVNEOS	113
SYMLINPEN.....	64	TAYTULLA	146
SYMPAZAN.....	137	tazarotene	261
SYMPROIC.....	59	TAZAROTENE	263
SYMTUZA	97	TAZORAC	261
SYNAGIS.....	100	TAZVERIK.....	82
SYNALAR.....	55, 266	TC 99M	155
SYNAREL	194	TC99M.....	153, 155
SYNDROS.....	179	TDVAX.....	111
SYNERA	33, 323	TECENTRIQ	92

Index of Medications

TECHLITE	217, 221, 229, 234	theophylline.....	42
TECHNELITE.....	157	thiamine.....	290
TECVAYLI.....	90	THIN.....	156, 214, 215, 216, 217, 220, 221, 222, 230, 231, 232, 233, 234, 235
TEFLARO.....	48	THINPRO.....	229
TEGLUTIK.....	134	THIOLA.....	286
TEGRETOL.....	141, 142	thioridazine.....	255
TEKTURNA.....	128, 129	thiotepa.....	77
TELCARE.....	152, 212, 217, 234	thiothixene.....	255
telmisartan.....	124, 125, 126	THRIVITE.....	239
temazepam.....	256	THROMBI.....	114
TEMBEXA.....	101	THROMBIN.....	58, 59, 114
TEMODAR.....	77	THYQUIDITY.....	271
TEMOVATE.....	266	THYROGEN.....	269
temozolomide.....	77	thyroid.....	271
temsirolimus.....	82	tiagabine.....	142
TENIVAC.....	111	TIAZAC.....	118
tenofovir.....	97, 99	TIBSOVO.....	90
TENORETIC.....	128	ticagrelor.....	96
TENORMIN.....	128	TIGAN.....	180
TEPADINA.....	77	TIGLUTIK.....	134
TEPEZZA.....	275	TIKOSYN.....	115, 116
TEPMETKO.....	88	timolol.....	128, 163, 164, 165
TEPYLUTE.....	77	TIMOPTIC.....	165
terazosin.....	123	tiopronin.....	286
terbinafine.....	60	tiotropium.....	38
terbutaline.....	39	tirofiban.....	96
terconazole.....	60	TIROSINT.....	271
teriflunomide.....	135, 136	TISSEEL.....	263
teriparatide.....	283	TIVDAK.....	91
TERUMO.....	221, 229	TIVICAY.....	99
TEST.....	148, 149, 150, 151, 152, 153, 157, 158, 204, 207, 209, 212, 232, 233	TIVORBEX.....	37
TESTIM.....	189	tizanidine.....	237
TESTOPEL.....	189	TLANDO.....	190
testosterone.....	189, 190, 191	TNKASE.....	114
TESTOSTERONE.....	189, 190	TOBI.....	44
tetrabenazine.....	135	TOBRADEX.....	43
tetracaine.....	32	tobramycin.....	43, 44, 45
TETRACAINE.....	163	TOBRAMYCIN.....	44, 45
tetracycline.....	53, 181	TOBRESX.....	43
TEVIMBRA.....	89	TOFIDENCE.....	200
TEXACORT.....	266	tolcapone.....	95
TEZRULY.....	123	TOLECTIN.....	37
TEZSPIRE.....	272	tolmetin.....	37
THALITONE.....	160	TOLSURA.....	60
THALLOUS.....	153	tolterodine.....	286, 287
THALOMID.....	45	tolvaptan.....	158, 159
THAM.....	168	TOPAMAX.....	142
THEO.....	42	TOPCARE.....	217, 221, 229, 234
		TOPICORT.....	266

Index of Medications

topiramate	138, 141, 142	trifluoperazine.....	255
TOPIRAMATE	142	trifluridine	100
topotecan.....	82	trihexyphenidyl.....	94
TOPROL.....	128	TRIJARDY.....	68
toremifene.....	92, 93	TRIKAFTA.....	271
TORISEL	82	TRILEPTAL	142
torseamide.....	159	TRILURON.....	34
TOSYMRA.....	21	trimethobenzamide.....	180
TOUJEO.....	70	trimethoprim	43, 44, 45
TOVIAZ.....	287	trimipramine.....	246
TPN.....	171	TRIMO.....	70
TRACLEER.....	120, 121	TRINAZ	240
TRADJENTA	65	TRINTELLIX.....	246
TRALEMENT	174	TRIOSTAT	271
tramadol	22, 29	TRIPTODUR.....	195
TRAMADOL	29	TRISENOX	92
trandolapril.....	122, 125	TRISTART	239
tranexamic	112	TRIUMEQ.....	97
TRANSDERM	180	TRI-VI	289
TRANSFER	99, 221	TRIVISC.....	34
tranlycypromine	242	TRODELVY	91
TRAVATAN.....	165	TROGARZO	96
travoprost.....	165	TROKENDI.....	142
TRAZIMERA.....	83	tromethamine.....	45, 161, 168, 195
trazodone.....	244	TROPHAMINE.....	170
TREANDA.....	78	tropicamide.....	165
TRELEGY	41	tropium.....	287
TRELSTAR.....	84	TRUDHESA.....	21
TREMFYA.....	199, 200	TRUE.....	149, 151, 152, 209, 212, 217, 221, 229, 234, 258, 262
treprostinil.....	121, 278	TRUECONTROL	212
TRESIBA.....	70	TRUEDRAW	212
tretinoin.....	92, 260, 268	TRUEPLUS.....	157, 217, 221, 229, 234
TRETTEN	113	TRUERESULT	213
TREXALL.....	80	TRUETEST.....	152
TREXIMET.....	21	TRUETRACK.....	152, 213
TREZIX	23	TRULANCE.....	184
triamcinolone.....	62, 193, 194, 266, 267, 274	TRULICITY.....	64
triamterene	159, 160	TRUMENBA	109
triazolam.....	256	TRUQAP	88
TRIBENZOR	123	TRUVADA.....	97
TRICARE.....	239	TRYNGOLZA	130
trichloroacetic	264	TRYPTYR.....	166
TRICITRASOL	56	TRYVIO	128
TRICOR.....	133	TUDORZA	38
TRIDESILON	267	TUKYSA	89
trientine.....	281	TURALIO	89
TRIENTINE.....	281	TUXARIN.....	147
TRIESENCE.....	162	TUZISTRA	147
TRIFERIC	173	TWIIST.....	213

Index of Medications

TWINRIX.....	111	UNLOXCYT.....	92
TWIRLA.....	146	UPLIZNA.....	198
TWIST.....	214, 215, 216, 217, 231, 232, 233, 234	UPNEEQ.....	163
TWYNEO.....	260	UPTRAVI.....	121
TYBLUME.....	146	URISTIX.....	158
TYBOST.....	271	UROCIT.....	177
TYENNE.....	200	UROQID.....	177
TYKERB.....	89	UROXATRAL.....	285
TYMLOS.....	198	URSO.....	182
TYRUKO.....	282	ursodiol.....	182
TYRVAYA.....	275	USTEKINUMAB.....	199
TYSABRI.....	282	UVADEX.....	92
TYVASO.....	121	UZEDY.....	253
TYZAVAN.....	54	V	
TZIELD.....	274	VABOMERE.....	46
U		VABRINTY.....	84
UBRELVY.....	21	VABYSMO.....	166
UCERIS.....	188, 194	VAFSEO.....	188
UDAMIN.....	288	VAGIFEM.....	197
UDENYCA.....	144	valacyclovir.....	101
ULESFIA.....	94	VALCHLOR.....	93
ULORIC.....	35	VALCYTE.....	101
ULTANE.....	30	valganciclovir.....	101
ULTCARE.....	229	VALIUM.....	241
ULTI.....	213	valproic.....	142
ULTICARE.....	221, 229	valrubicin.....	75
ULTIGUARD.....	222, 229, 230	valsartan.....	123, 124, 125, 126
ULTILET.....	217, 222, 230, 234, 258, 262	VALSARTAN.....	126
ULTIMA.....	152, 213	valsartan/hydrochlorothiazide.....	124
ULTIVA.....	23	VALSTAR.....	75
ULTOMIRIS.....	113	VALTOCO.....	137
ULTRA.....	39, 107, 151, 211, 214, 215, 217, 220, 222, 229, 230, 232, 234, 235, 239	VALTRES.....	101
ULTRACARE.....	222, 230	VANOCOCIN.....	54
ULTRAFOAM.....	114	vancomycin.....	54, 55
ULTRALANCE.....	217, 235	VANCOMYCIN.....	54, 55
ULTRATLC.....	218, 235	VANFLYTA.....	89
ULTRATRAK.....	152, 213	VANILLA.....	156
ULTRAVATE.....	267	VANISHPOINT.....	230
ULTRAVIST.....	154	VANOS.....	267
UMECLIDINIUM.....	40	VANRAFIA.....	286
UNASYN.....	51	VAPRISOL.....	158
UNDECATREX.....	190	vardenafil hcl.....	275
UNIFINE.....	218, 220, 222	varenicline.....	269
UNILET.....	213, 215, 218, 230, 232, 235	VARIBAR.....	156
UNISTIK.....	213, 215, 218, 232, 235	VARIVAX.....	111
UNISTRIP.....	213	VARUBI.....	180
UNISTRIP1.....	152	VASCEPA.....	177
UNITUXIN.....	91	VASERETIC.....	122
UNIVERSAL.....	218, 235	vasopressin.....	190

Index of Medications

VASOPRESSIN.....	158, 190	vilazodone.....	246
vasopressin 200 unit/10 ml.....	190	VILTEPSO.....	278
VASOSTRICT.....	190	VIMIZIM.....	280
VASOTEC.....	125	VIMPAT.....	141, 142, 143
VAXELIS.....	111	vinblastine.....	83
VAZCULEP.....	120	vincristine.....	83
VECAMYL.....	126	vinorelbine.....	83
VECTIBIX.....	83	VIOKACE.....	186
VECTICAL.....	261	VIRACEPT.....	99
vecuronium.....	107	VIREAD.....	99
VECURONIUM.....	107	VISCO.....	34
VEGZELMA.....	76	VISCOAT.....	166
VELCADE.....	89	VISIONBLUE.....	166
VELPHORO.....	171	VISIPAQUE.....	154
VELSIPITY.....	137	VISTARIL.....	63
VELTASSA.....	171	VISTOGARD.....	273
VELTIN.....	260	VISUDYNE.....	275
VEMLIDY.....	102	VITA.....	289
VENCLEXTA.....	89	VITAFOL.....	173, 239, 240
VENELEX.....	285	VITALARA.....	240
venlafaxine.....	245	VITALIPID.....	289
VENLAFAXINE.....	245	VITAMEDMD.....	239
VENOFER.....	173	vitamins.....	289
VENTOLIN.....	39	VITAPEARL.....	239
VEO.....	230	VITATRUE.....	239
VEOPOZ.....	278	VITLIPID.....	289, 290
VEOZAH.....	279	VITRAKVI.....	89
verapamil.....	116, 118, 122	VITRASE.....	268
VERDESO.....	267	VIVAGUARD.....	153, 213, 218, 235
VEREGEN.....	103	VIVELLE.....	192
VERELAN.....	118	VIVIMUSTA.....	78
VERIFINE.....	218, 222, 230, 235	VIVITROL.....	277
VERKAZIA.....	166	VIVJOA.....	60
VERSACLOZ.....	253	VIVLODEX.....	38
VERZENIO.....	89	VIZAMYL.....	155
VESICARE.....	286	VIZIMPRO.....	89
VEVYE.....	166	VIZZ.....	165
VFEND.....	60	VOGELXO.....	190
V-GO.....	213	VONJO.....	89
VIAGRA.....	275	VONVENDI.....	112
VIBATIV.....	49	VOQUEZNA.....	181, 186
VIBERZI.....	184	VORANIGO.....	90
VICTOZA.....	64	VORAXAZE.....	273
VIDAZA.....	80	voriconazole.....	60
vigadrone.....	142	VOSEVI.....	101
VIGAFYDE.....	142	VOTRIENT.....	89
VIGAMOX.....	44	VOWST.....	183
VIBRYD.....	246	VOXZOGO.....	281
VIJOICE.....	272	VOYDEYA.....	113

Index of Medications

VPRIV.....	279	XENLETA.....	51
VRAYLAR.....	253	XEOMIN.....	107
VTAMA.....	261	XEPI.....	55
VUEWAY.....	155	XERAVA.....	53
VUITY.....	165	XERESE.....	102
VUMERITY.....	136	XERMELO.....	179
VUSION.....	62	XGEVA.....	284
VYALEV.....	95	XHANCE.....	161
VYEPTI.....	21	XIAFLEX.....	284
VYKAT.....	282	XIFAXAN.....	52
VYLEESI.....	279	XIGDUO.....	67
VYLOY.....	91	XIIDRA.....	166
VYNDAMAX.....	281	XIMINO.....	53
VYNDAQEL.....	281	XIPERE.....	163
VYONDYS.....	278	XOFIGO.....	274
VYTORIN.....	129	XOFLUZA.....	101
VYVANSE.....	247	XOLAIR.....	42
VYVGART.....	281	XOLEGEL.....	62
VYXEOS.....	78	XOLREMDI.....	145
VYZULTA.....	165	XOPENEX.....	39
W		XOSPATA.....	89
WAKIX.....	143	XPHOZAH.....	171
warfarin.....	56	XPOVIO.....	92
water.....	169, 173, 174, 258, 282, 283	XROMI.....	113
WAVESENSE.....	213	XTANDI.....	78
WELCHOL.....	132	XULTOPHY.....	64
WELIREG.....	90	XURIDEN.....	169
WELLBUTRIN.....	242	XYLOCAINE.....	32
WILATE.....	112	XYNTHA.....	112
WINLEVI.....	264	XYOSTED.....	190
WINREVAIR.....	121	XYREM.....	256
WINRHO.....	107	XYWAV.....	256
WYNZORA.....	268	Y	
WYOST.....	284	YASMIN.....	146
X		YAZ.....	146
XACDURO.....	46	YERVOY.....	92
XACIATO.....	54	YESINTEK.....	199
XADAGO.....	95	YONDELIS.....	78
XALATAN.....	165	YONSA.....	78
XALKORI.....	89	YORVIPATH.....	195
XANAX.....	241	YOSPRALA.....	96
XARELTO.....	56	YUFLYMA.....	74, 75
XATMEP.....	80	YUPELRI.....	38
XCOPRI.....	143	YUTREPIA.....	121
XDEMVI.....	93	Z	
XELJANZ.....	35	zafirlukast.....	42
XELODA.....	80	zaleplon.....	257
XELSTRYM.....	105	ZALTRAP.....	83
XENAZINE.....	135	ZALVIT.....	240

Index of Medications

ZANAFLEX.....	237	ZITUVIO.....	65
ZANOSAR.....	75	ZOCOR.....	131
ZARONTIN.....	143	ZOKINVY.....	272
ZARXIO.....	144	ZOLADEX.....	84
ZAVESCA.....	279	zoledronic.....	283, 284
ZAVZPRET.....	21	ZOLEDRONIC.....	284
ZCORT.....	194	ZOLINZA.....	76
ZEGALOGUE.....	168	zolmitriptan.....	21
ZEGERID.....	187	ZOLOFT.....	244
ZEJULA.....	89	zolpidem.....	256, 257
ZELAPAR.....	95	ZOLPIDEM.....	257
ZELBORAF.....	81	ZOLPIMIST.....	257
ZELNORM.....	184	ZOMACTON.....	194
ZELSUVMI.....	267	ZOMIG.....	21
ZEMAIRA.....	272	ZONALON.....	260
ZEMBRACE.....	21	ZONEGRAN.....	143
ZEMDRI.....	45	ZONISADE.....	143
ZEMPLAR.....	276	zonisamide.....	143
ZENPEP.....	186	ZONTIVITY.....	96
ZEPATIER.....	102	ZORTRESS.....	202
ZEPOSIA.....	137	ZORVOLEX.....	38
ZEPZELCA.....	78	ZORYVE.....	261, 263
ZERBAXA.....	48	ZOSYN.....	51
ZERVIAE.....	63	ZOVIRAX.....	103
ZESTORETIC.....	122	ZTALMY.....	255
ZESTRIL.....	125	ZTLIDO.....	33, 329
ZETIA.....	133	ZUBSOLV.....	285
ZETONNA.....	161	ZUNVEYL.....	104
ZEVALIN.....	91	ZURZUVAE.....	241
ZIAGEN.....	98	ZUSDURI.....	75
ZIANA.....	260	ZYCLARA.....	262
zidovudine.....	97, 98, 99	ZYDELIG.....	89
ZIEXTENZO.....	144	ZYFLO.....	38
ZIIHERA.....	91	ZYKADIA.....	89
ZILBRYSQ.....	278	ZYLET.....	43
zileuton.....	38	ZYLOPRIM.....	35
ZILRETTA.....	194	ZYNLONTA.....	91
ZILXI.....	55	ZYNRELEF.....	32
ZIMHI.....	59	ZYNYZ.....	89
zinc.....	173, 176, 263, 289	ZYPITAMAG.....	131
ZINGO.....	32	ZYPREXA.....	253
ZIOPTAN.....	165	ZYTIGA.....	78
ZIPHEX.....	240	ZYVOX.....	50
ziprasidone.....	251, 253		
ZIPSOR.....	22		
ZIRABEV.....	76		
ZIRGAN.....	100		
ZITHROMAX.....	49		
ZITUVIMET.....	67		

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

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



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

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

Cigna Healthcare products and services are provided exclusively by or through operating subsidiaries of The Cigna Group.

Discrimination is against the law

Cigna Healthcare® complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, ancestry, religion, marital status, gender, sexual orientation, gender identity or sexual stereotypes.

Cigna Healthcare does not exclude people or treat them less favorably differently because of race, color, national origin, age, disability, sex, ancestry, religion, marital status, gender, sexual orientation, gender identity or sexual stereotypes.

Cigna Healthcare:

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

If you need reasonable modifications, appropriate auxiliary aids and services or language assistance services, contact the Civil Rights Coordinator.

If you believe that Cigna Healthcare has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, ancestry, religion, marital status, gender, sexual orientation, gender identity or sexual stereotypes, you can file a grievance with the Civil Rights Coordinator

P.O. Box 188016, Chattanooga, TN 37422,
877.822.6561 (TTY: Dial 711)

ACAGrievance@CignaHealthcare.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

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

Complaint forms are available at <https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html>



Cigna Healthcare products and services are provided exclusively by or through operating subsidiaries of The Cigna Group, including Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company, Evernorth Behavioral Health, Inc., Evernorth Care Solutions, Inc. and HMO or service company subsidiaries of Cigna Health Corporation, including Cigna HealthCare of Arizona, Inc. Cigna HealthCare of California, Inc. Cigna HealthCare of Colorado, Inc. Cigna HealthCare of Connecticut, Inc. Cigna HealthCare of Florida, Inc. Cigna HealthCare of Georgia, Inc. Cigna HealthCare of Illinois, Inc., Cigna HealthCare of Indiana, Inc., Cigna HealthCare of St. Louis, Inc., Cigna HealthCare of North Carolina, Inc., Cigna HealthCare of New Jersey, Inc., Cigna HealthCare of South Carolina, Inc., Cigna HealthCare of Tennessee, Inc., and Cigna HealthCare of Texas, Inc. ATTENTION: If you speak languages other than English, language assistance service, free of charge are available to you. For current Cigna Healthcare customers, call the number on the back of your ID card. Otherwise, call 1.800.244.6224 (TTY: Dial 711). ATENCIÓN: Si usted habla un idioma que no sea inglés, tiene a su disposición servicios gratuitos de asistencia lingüística. Si es un cliente actual de Cigna

Proficiency of Language Assistance Services

English – ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-800-244-6224 (TTY: Dial 711) or speak to your provider.

Spanish – ATENCIÓN: Si habla español, los servicios de asistencia lingüística gratuitos están disponibles para usted. También están disponibles de forma gratuita ayudas y servicios auxiliares adecuados para proporcionar información en formatos accesibles. Llame al 1-800-244-6224 (TTY: Marque 711) o hable con su proveedor.

Chinese – 注意: 如果您讲中文, 我们提供免费的语言援助服务。适当的辅助设备和服务也可以免费提供, 以提供无障碍格式的信息。请拨打 1-800-244-6224 (TTY: 拨打 711) 或与您的服务提供者联系。

Vietnamese – XIN LƯU Ý: Nếu bạn nói tiếng Việt, dịch vụ hỗ trợ ngôn ngữ miễn phí có sẵn cho bạn. Các thiết bị và dịch vụ hỗ trợ phù hợp để cung cấp thông tin ở định dạng có thể tiếp cận cũng có sẵn miễn phí. Gọi số 1-800-244-6224 (TTY: Gọi 711) hoặc nói chuyện với nhà cung cấp của bạn.

Korean – 주의: 한국어를 사용하시는 경우, 무료 언어 지원 서비스가 제공됩니다. 접근 가능한 형식으로 정보를 제공하기 위한 적절한 보조 기기 및 서비스도 무료로 제공됩니다. 1-800-244-6224 (TTY: 711 로 전화) 로 전화하시거나 제공자에게 문의하십시오.

Tagalog – PAUNAWA: Kung ikaw ay nagsasalita ng Tagalog, ang mga libreng serbisyo ng tulong sa wika ay magagamit para sa iyo. Ang mga angkop na pantulong na kagamitan at serbisyo upang magbigay ng impormasyon sa mga naa-access na format ay magagamit din ng libre. Tumawag sa 1-800-244-6224 (TTY: Tumawag sa 711) o makipag-usap sa iyong tagapagbigay.

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: 711 اطلب) 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: comporre 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 می‌کنید، 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