



Cigna Healthcare Legacy (Standard) 3-Tier Prescription Drug List

Coverage as of January 1, 2026

For the State of California

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

View your drug list online: **Cigna.com/druglist**

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

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

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 This drug list is subject to change and all prior versions are no longer in effect.



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	13
• How to read this drug list	13
• How to find your medication	16
List of prescription medications	19
Exclusions and limitations for coverage	237
Index of medications	238

View your drug list online, 24/7

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

- **Cigna.com/druglist.** Choose **Legacy 3 Tier** from the dropdown list. Then type in your medication name or view the full list.
- **myCigna App¹ or myCigna.com.** Log into your account and use the Price a Medication tool to see how your medication is covered.

Questions?

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

* 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 | • High cholesterol |
| • Allergies | • Osteoporosis |
| • Bladder problems | • Pain |
| • Breathing problems | • Skin conditions |
| • Depression | • Sleep disorders |
| • High blood pressure | |

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](https://mycigna.com) to see where your medication is in the review process or to read about the decision we made.

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

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

Information about this drug list

Frequently asked questions (FAQs) (cont.)

hours of receiving a request based on exigent circumstances, the request will be considered approved and your plan can't deny coverage of the medication. Also, if you've already received approval for your plan to cover your medication, we can't limit or exclude coverage for that medication if your doctor continues to prescribe it to treat your condition (as long as the medication is appropriately prescribed and is safe and effective in treating your condition).

Q. My plan doesn't cover my medication. I need to take it because it's medically necessary for my treatment. How do I get approval (prior authorization) for my medication?

A. If your doctor feels that your medication is necessary for your treatment and an alternative isn't right for you, your doctor can ask us to consider approving coverage of your medication. Ask your doctor's office to contact us to start the coverage review process. They know how the review process works and will take care of everything for you. In case the office asks, they can download a request form from our provider portal at **cignaforhcp.com**.

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

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

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

Q. My medication is part of the Step Therapy program. I don't want to try an alternative. How do I get approval (prior authorization) for my medication?

A. If you and your doctor feel an alternative medication won't work for you, your doctor can ask us to consider approving coverage of your current medication. Ask your doctor's office to contact us to start the coverage review process. They know how the review process works and will take care of everything for you. In case the office asks, they can download a request form from our provider portal at **cignaforhcp.com**.

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

Many times, we don't get all of the information we need from the doctor's office to approve coverage. If we don't approve your medication, your doctor can send us more information to review, using the same process as before. We're happy to review the request

Information about this drug list

Frequently asked questions (FAQs) (cont.)

again. Depending on what your doctor sends this time, we may be able to approve coverage. Or you and your doctor can appeal the decision by sending us a request, in writing, that explains why we should cover the medication.

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

Your Step Therapy rights under California State law:

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

3. A carrier shall provide coverage for the medically necessary dosage and quantity of the drug prescribed for the treatment of a medical condition consistent with professionally recognized standards of practice.

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

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

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

Q. What happens if I try to fill a prescription that has a quantity limit?

A. Your pharmacist will only fill the amount your plan covers. If you want to fill more than what's allowed, your doctor's office can ask us to cover it through our review process.

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

A. Yes.

Q. Does my plan cover medications that the FDA recently approved?

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

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

Information about this drug list

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

Q. What are preventive medications?

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

Q. Which medications are covered under the health care reform law?

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

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

Q. I see several medications on this drug list that can be used to treat my condition. Will my doctor write me a prescription for all of them?

A. No. Just because a medication is listed on your plan's drug list doesn't mean your doctor will write you a prescription for it. Your doctor will work with you to find the medication he or she feels is best for your specific treatment.

Q. How can I find out how much I'll pay for a specific medication?

A. When you and your doctor are thinking about the right medication for your treatment, knowing how much it costs, what lower-cost options are available, and which pharmacies have the best prices can help you avoid surprises. Log in to the myCigna App or **myCigna.com** and use the Price a Medication tool to

see how much your medication costs before you get to the pharmacy counter – or even before you leave your doctor's office.²

Q. What's a cost-share?

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

Q. How can I save money on my prescription medications?

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

Q. What's a generic medication?

A. A generic is the same as its brand-name version. It has the same active ingredient, strength and dosage form, treats the same condition(s), and works in the same way – and typically costs less.³ Generics are typically sold under their chemical or scientific name, instead of the brand name.

Q. Do generics work the same as brand-name medications?

A. Yes. A generic medication works in the same way and provides the same clinical benefit as the brand-name medication.³

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

A. The generic and brand-name medication may³:

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

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

Information about this drug list

Frequently asked questions (FAQs) (cont.)

Q. What is a "biosimilar" medication?

A. A biosimilar is "highly similar" to its original biologic medication, which is also known as a reference product, that the FDA has already approved. Even though biosimilars aren't identical to the original medication, they're used to treat the same conditions, and provide the same clinical outcomes and treatment benefits. There are no clinical differences in how safe they are to use and how well they work. They also typically cost less.⁴

Q. How do I know which pharmacies are in my plan's network?

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

Q. My pharmacy isn't in my plan's network. Can I continue to fill my prescriptions there?

A. To get the most from your plan coverage, you should use an in-network pharmacy. If your plan offers out-of-network coverage, you'll pay your out-of-network cost-share to fill a prescription there.

Q. Do I have to use home delivery to fill my prescription?

A. It depends on your plan. Some plans require you to fill maintenance medications through Express Scripts[®] Pharmacy and/or specialty medications through Accredo[®] Specialty Pharmacy for them to be covered.⁵ Log in to the myCigna App or **myCigna.com**, or check your plan materials, to find out what your plan requires.

Q. Can I fill my prescriptions by mail?

A. Yes, as long as your plan offers home delivery.⁵

Fill maintenance medications through Express Scripts Pharmacy

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

- Easily order, manage, track and pay for your medications on your phone or online.
- Get standard shipping at no extra cost.⁶
- Fill up to a 90-day supply at one time.
- Talk with a pharmacist, 24/7.
- Sign up for automatic refills or refill reminders so you don't miss a dose.⁷
- Use a payment plan (if you need it).

Here are two easy ways to get started:

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

Fill specialty medications through Accredo Specialty Pharmacy

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

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

Information about this drug list

Frequently asked questions (FAQs) (cont.)

- Get fast shipping at no extra cost.⁶
- Sign up for refills and reminders. Some refills can be done by text.⁸
- Get help paying for your medication (if you need it).
- Manage and track your medications online.

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

Q. I take a specialty medication to treat my multiple sclerosis. My plan requires me to fill my medication through Accredo. How do I get started?

A. Some plans allow one or more fills at a retail pharmacy before switching to Accredo. Check your plan materials to find out if your plan allows retail fills.

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

Q. I take a specialty medication that can only be filled at certain pharmacies in the United States. How do I fill my prescription?

A. Talk with your doctor. He or she should be able to tell you which in-network pharmacies can fill your prescription. Once you find a pharmacy, ask your doctor to send them your prescription.

You may also be able to use Accredo to fill your prescription; they have access to most specialty medications.⁵ Call Accredo at **877.826.7657**, Monday–Friday, 7:00 am–10:00 pm CST or Saturdays, 7:00 am–4:00 pm CST, for more information.

Q. How do I fill my prescription?

A. First, you'll need to get a prescription from your doctor. Then, your doctor can either:

1. **Send it electronically** to the in-network retail pharmacy of your choice, Express Scripts home delivery or Accredo. Or

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

Q. How can I get help with my specialty medication?

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

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

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

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

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

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

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

Information about this drug list

Frequently asked questions (FAQs) (cont.)

Q. What's the difference between medications covered under the pharmacy benefit and medical benefit?

A. Some medications are covered under the pharmacy benefit, some are covered under the medical benefit and others are covered under both benefits. Log in to the myCigna App or **myCigna.com**, 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 (Standard) 3-Tier Prescription Drug List as of January 1, 2026. **The drug list is updated often;** so, not all of the medications your plan covers may be listed here. Also, your plan may not cover all of these medications. Log in to the myCigna App or **myCigna.com** to see which medications your plan covers.

How to read this drug list

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

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

Tiers

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

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

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

Information about this drug list

How to read this drug list (cont.)

Letters (acronyms) in the Notes column

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

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

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

Information about this drug list

How to read this drug list (cont.)

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

ANALGESICS (Pain Relief and Inflammatory Disease)			Therapeutic drug category and class describes the condition the medication is used to treat.
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits	Coverage requirements and limits lets you know if your plan has extra requirements before it will cover the medication.
ANALGESIC, NON-SALICYLATE AND BARBITURATE COMBINAT			
<i>butorbital/acetaminophen</i>	T1		
ANALGESIC, SALICYLATE, BARBITURATE, XANTHINE COMB.			
<i>butorbital-aspirin-caffe 50-325-40</i>	T1	QL (6 tabs/day)	
<i>butorbital-asa-cafeine cap</i> (Fiorinal)	T1	QL (6 caps/day)	
FIORINAL (<i>butorbital-aspirin-cafeine</i>)	T3	QL (6 caps/day)	
ANALGESIC, NON-SALICYLATE, BARBITURATE, XANTHINE COMB.			
<i>butorbital/acetaminophen/cafeine</i>	T3		
<i>butorbital/acetaminophen/cafeine</i> (Esgic)	T3	QL (6 caps/day)	
<i>butorbital-acetamin-caff 50-300-40</i> (Fioricet)	T1	QL (6 caps/day)	
<i>butorbital-acetamin-caff 50-325-40</i> (Esgic)	T1	QL (6 tabs/day)	
ESGIC 50-325-40 MG TABLET (<i>butorbital-acetaminophen-caffe</i>)	T3	QL (6 tabs/day)	
ESGIC CAPSULE (<i>zebutorbital</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-cafeine</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/cafeine</i>	T1		
<i>ergotamine tartrate/cafeine</i> (Cafergot)	T1	QL (40 tabs/28 days)	

*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)	19-24	Anti-Obesity Drugs (Weight Management)	71
Analgesics (Urinary Tract Conditions)	24	Anti-Parasitics (Eye Conditions)	71
Anesthetics (Miscellaneous)	25	Anti-Parasitics (Infections)	72
Anesthetics (Pain Relief and Inflammatory Disease)	25	Anti-Parasitics (Skin Conditions)	72
Anesthetics (Urinary Tract Conditions)	25	Anti-Parkinson's Drugs (Parkinson's Disease)	72-74
Anti-Allergy (Allergy and Nasal Sprays)	25	Anti-Platelet Drugs (Blood Thinners/Anti-Clotting)	74
Anti-Arthritics (Pain Relief and Inflammatory Disease)	25-30	Antivirals (Aids/Hiv)	74-78
Anti-Asthmatics (Asthma/COPD/Respiratory)	30-34	Antivirals (Eye Conditions)	78
Antibiotics (Ear Medications)	34, 35	Antivirals (Infections)	78-80
Antibiotics (Eye Conditions)	35, 36	Antivirals (Skin Conditions)	80
Antibiotics (Infections)	36-42	Autonomic Drugs (Allergy/Nasal Sprays)	80, 81
Antibiotics (Skin Conditions)	42, 43	Autonomic Drugs (Alzheimer's Disease)	81
Anti-Coagulants (Blood Thinners/Anti-Clotting)	43-45	Autonomic Drugs (Attention Deficit Hyperactivity Disorder)	81, 82
Antidotes (Gastrointestinal/Heartburn)	45	Autonomic Drugs (Blood Pressure/Heart Medications)	82, 83
Antidotes (Substance Abuse)	45, 46	Autonomic Drugs (Urinary Tract Conditions)	83
Anti-Fungals (Eye Conditions)	46	Biologicals (Allergy/Nasal Sprays)	83
Anti-Fungals (Feminine Products)	46	Biologicals (Blood Pressure/Heart Medications)	83
Anti-Fungals (Infections)	46, 47	Biologicals (Miscellaneous)	83
Anti-Fungals (Skin Conditions)	47, 48	Biologicals (Vaccines)	83-87
Antihistamine and Decongestant Combination (Allergy/Nasal Sprays)	48	Blood (Blood Modifiers/Bleeding Disorders)	87-89
Anti-histamines (Allergy/Nasal Sprays)	48, 49	Blood (Blood Thinners/Anti-Clotting)	89
Antihistamines (Eye Conditions)	49	Cardiac Drugs (Blood Pressure/Heart Medications)	90-93
Anti-Hyperglycemics (Diabetes)	49-56	Cardiovascular (Asthma/COPD/Respiratory)	93, 94
Anti-Infectives/Miscellaneous (Feminine Products)	56	Cardiovascular (Blood Pressure/Heart Medications)	94-101
Anti-Infectives/Miscellaneous (Infections)	56, 57	Cardiovascular (Cholesterol Medications)	101-105
Anti-Inflammatory Tumor Necrosis Factor Inhibiting Agents (Pain Relief and Inflammatory Disease)	58-60	CARDIOVASCULAR (Miscellaneous)	105
Anti-Neoplastics (Cancer)	60-70	CNS Drugs (Alzheimer's Disease)	105
Anti-Neoplastics (Skin Conditions)	70	CNS Drugs (Miscellaneous)	105, 106

Information about this drug list

How to find your medication (cont.)

Condition	Page	Condition	Page
CNS Drugs (Multiple Sclerosis)	106, 107	Immunosuppressants (Pain Relief and Inflammatory Disease)	154, 155
CNS Drugs (Pain Relief and Inflammatory Disease)	107, 108	Immunosuppressants (Skin Conditions)	156
CNS Drugs (Seizure Disorders)	108-113	Immunosuppressants (Transplant Medications)	156, 157
CNS Drugs (Sleep Disorders/Sedatives)	114	Miscellaneous Medical Supplies, Devices, Non-Drug (Diabetes)	157-180
Colony Stimulating Factors (Blood Modifiers/Bleeding Disorders)	114, 115	Miscellaneous Medical Supplies, Devices, Non-Drug (Miscellaneous)	180, 188
Colony Stimulating Factors (Cancer)	115	Muscle Relaxants (Pain Relief and Inflammatory Disease)	188-189
Contraceptives (Contraception Products)	115-117	Prenatal Vitamins (Nutritional/Dietary)	189-192
Cough/Cold Preparations (Allergy/Nasal Sprays)	117	Psychotherapeutic Drugs (Anxiety/Depression/Bipolar Disorder)	193-199
Cough/Cold Preparations (Cough/Cold Medications)	117, 118	Psychotherapeutic Drugs (Attention Deficit Hyperactivity Disorder)	199-202
Diagnostic (Diabetes)	118-123	Psychotherapeutic Drugs (Schizophrenia/Anti-Psychotics)	202-206
Diagnostic (Miscellaneous)	123, 124	Psychotherapeutic Drugs (Seizure Disorders)	206
Diuretics (Diuretics)	125-127	Psychotherapeutic Drugs (Sleep Disorders/Sedatives)	206
EENT Preps (Allergy/Nasal Sprays)	127	Sedative/Hypnotics (Sleep Disorders/Sedatives)	206, 207
EENT Preps (Ear Medications)	128	Skin Preps (Miscellaneous)	207, 208
EENT Preps (Eye Conditions)	128-132	Skin Preps (Pain Relief and Inflammatory Disease)	208, 209
Elect/Caloric/H2O (Cholesterol Medications)	132	Skin Preps (Skin Conditions)	209-219
Elect/Caloric/H2O (Dental Products)	132, 133	Smoking Deterrents (Smoking Cessation)	219
Elect/Caloric/H2O (Diabetes)	133	Thyroid Prep (Hormonal Agents)	219, 221
Elect/Caloric/H2O (Miscellaneous)	134	Unclassified Drug Products (Aids/Hiv)	221
Elect/Caloric/H2O (Nutritional/Dietary)	134-137	Unclassified Drug Products (Asthma/COPD/Respiratory)	221, 222
Elect/Caloric/H2O (Urinary Tract Conditions)	137	Unclassified Drug Products (Blood Modifiers/Bleeding Disorders)	222
Gastrointestinal (Cholesterol Medications)	137	Unclassified Drug Products (Blood Pressure/Heart Medications)	222, 223
Gastrointestinal (Gastrointestinal/Heartburn)	137-146		
Gastrointestinal (Pain Relief and Inflammatory Disease)	146		
HEMATOPOIETIC GROWTH FACTORS (Miscellaneous)	146		
Hormones (Gastrointestinal/Heartburn)	146, 147		
Hormones (Hormonal Agents)	147-153		
Hormones (Infertility)	154		
Hormones (Miscellaneous)	154		
Hormones (Osteoporosis Products)	154		

Information about this drug list

How to find your medication (cont.)

Condition	Page	Condition	Page
Unclassified Drug Products (Cancer)	223	Unclassified Drug Products (Pain Relief and Inflammatory Disease)	230
Unclassified Drug Products (Dental Products)	223	Unclassified Drug Products (Seizure Disorders)	230
Unclassified Drug Products (Diabetes)	223	Unclassified Drug Products (Skin Conditions)	230, 231
Unclassified Drug Products (Erectile Dysfunction)	223, 224	Unclassified Drug Products (Substance Abuse)	231
Unclassified Drug Products (Eye Conditions)	224	Unclassified Drug Products (Transplant Medications)	231
Unclassified Drug Products (Gastrointestinal/Heartburn)	224	Unclassified Drug Products (Urinary Tract Conditions)	231-233
Unclassified Drug Products (Hormonal Agents)	224	Unclassified Drug Products (Weight Management)	233
Unclassified Drug Products (Miscellaneous)	225-229	Vitamins (Nutritional/Dietary)	233, 236
Unclassified Drug Products (Nutritional/Dietary)	229		
Unclassified Drug Products (Osteoporosis Products)	229, 230		

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 (<i>butalbital/acetaminophen</i>)	T3	PA
<i>butalbital/acetaminophen</i>	T1	
<i>butalbital-acetaminophen 25-325</i>	T1	PA
<i>butalbital-acetaminophen 50-300</i>	T1	
<i>butalbital-acetaminophen 50-300 (Bupap)</i>	T1	PA
<i>butalbital-acetaminophen 50-325</i>	T1	
ANALGESIC, SALICYLATE, BARBITURATE, XANTHINE COMB.		
<i>butalbital-aspirin-caffeine cp</i>	T1	QL(6 CAPS/DAY)
<i>butalbital-aspirin-caffeine tb</i>	T1	QL(6 TABS/DAY)
ANALGESIC, NON-SALICYLATE, BARBITURATE, XANTHINE COMB.		
<i>butal-ace-caf 50-325-40mg/15ml</i>	T1	PA QL(90 MLS/DAY)
<i>butalb/acetaminophen/caffeine (Esgic)</i>	T3	QL(6 CAPS/DAY)
<i>butalb-acetamin-caff 50-300-40 (Fioricet)</i>	T1	QL(6 CAPS/DAY)
<i>butalb-acetamin-caff 50-325-40</i>	T1	QL(6 TABS/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>diflunisal</i>	T1	HD
DOLOBID	T3	PA
ANALGESICS, NON-OPIOID		
JOURNAVX	T3	QL(30 TABS/90 DAYS)
ANTI-MIGRAINE PREPARATIONS		
AIMOVIG AUTOINJECTOR	T2	PA
AJOVY AUTOINJECTOR	T2	PA
AJOVY AUTOINJECTOR (3 PACK)	T2	PA
AJOVY SYRINGE	T2	PA
almotriptan malate	T1	QL(12 TABS/30 DAYS)
CAMBIA (<i>diclofenac potassium</i>)	T3	PA
<i>diclofenac pot 50 mg powdr pkt (Cambia)</i>	T1	PA
<i>dihydroergotamine 1 mg/ml amp</i>	T1	QL
<i>dihydroergotamine 4 mg/ml spry (Migranal)</i>	T1	PA QL(8 MLS/30 DAYS)
<i>eletriptan hydrobromide (Relpax)</i>	T1	QL(6 TABS/30 DAYS)
ELYXYB	T3	PA QL(43.2 MLS/30 DAYS)

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-MIGRAINE PREPARATIONS (cont.)		
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)
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)
<i>rizatriptan benzoate</i>	T1	QL(12 TABS/30 DAYS)
<i>rizatriptan benzoate (Maxalt Mlt)</i>	T1	QL(12 TABS/30 DAYS)
<i>rizatriptan benzoate(Maxalt)</i>	T1	QL(12 TABS/30 DAYS)
<i>sumatriptan</i>	T1	QL(12 UNITS/30 DAYS)
<i>sumatriptan 4 mg/0.5 ml inject (Imitrex)</i>	T1	QL(4 MLS/30 DAYS)
<i>sumatriptan 6 mg/0.5 ml vial</i>	T1	QL(5 MLS/30 DAYS)
<i>sumatriptan 6 mg/0.5ml autoinj (Imitrex)</i>	T1	QL(4 MLS/30 DAYS)
<i>sumatriptan succ 100 mg tablet (Imitrex)</i>	T1	QL(9 TABS/30 DAYS)
<i>sumatriptan succ 25 mg tablet (Imitrex)</i>	T1	QL(9 TABS/30 DAYS)
<i>sumatriptan succ 50 mg tablet (Imitrex)</i>	T1	QL(9 TABS/30 DAYS)
<i>sumatriptan succ/naproxen sod (Treximet)</i>	T1	QL(18 TABS/30 DAYS)
SYMBRAVO	T3	PA QL(9 TABS/28 DAYS)

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-MIGRAINE PREPARATIONS (cont.)		
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)
ZAVZPRET	T2	PA QL (6 UNITS/30 DAYS)
ZEMBRACE SYMTOUCH	T3	PA QL (8 MLS/30 DAYS)
<i>zolmitriptan</i>	T1	QL (6 TABS/30 DAYS)
<i>zolmitriptan 2.5 mg tablet (Zomig)</i>	T1	QL (6 TABS/30 DAYS)
ZOLMITRIPTAN 2.5MG NASAL SPRAY	T3	PA QL (12 UNITS/30 DAYS)
<i>zolmitriptan 5 mg nasal spray (Zomig)</i>	T1	PA QL (12 UNITS/30 DAYS)
<i>zolmitriptan 5 mg tablet (Zomig)</i>	T1	QL (6 TABS/30 DAYS)
ZOMIG 2.5 MG NASAL SPRAY	T3	PA QL (12 UNITS/30 DAYS)
ZOMIG 2.5 MG TABLET (<i>zolmitriptan</i>)	T3	PA QL (6 TABS/30 DAYS)
ZOMIG 5 MG NASAL SPRAY (<i>zolmitriptan</i>)	T3	PA QL (12 UNITS/30 DAYS)
ZOMIG 5 MG TABLET (<i>zolmitriptan</i>)	T3	PA QL (6 TABS/30 DAYS)
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</i>	T1	PA 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 syringe</i>	T1	QL (8 MLS/DAY)
<i>ketorolac 15 mg/ml vial</i>	T1	QL (8 MLS/DAY)
<i>ketorolac 30 mg/ml syringe</i>	T1	QL (4 MLS/DAY)
<i>ketorolac 30 mg/ml vial</i>	T1	QL (4 MLS/DAY)
<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

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPIOID ANALGESIC AND NON-SALICYLATE ANALGESICS		
<i>acetamin-codein 300-30 mg/12.5</i>	T1	
<i>acetaminop-codeine 120-12 mg/5</i>	T1	
<i>acetaminophen-cod #2 tablet</i>	T1	PA
<i>acetaminophen-cod #3 tablet</i>	T1	PA
<i>acetaminophen-cod #4 tablet</i>	T1	PA
<i>hydrocodone/acetaminophen</i>	T1	PA
<i>hydrocodone/acetaminophen (Lortab)</i>	T1	PA
HYDROCODONE-ACETAMINOPHEN	T1	PA
LORTAB (<i>hydrocodone/acetaminophen</i>)	T1	PA
NALOCET	T1	PA
<i>oxycodone hcl/acetaminophen</i>	T1	PA
<i>oxycodone hcl/acetaminophen (Percocet)</i>	T1	PA
PERCOCET (<i>oxycodone hcl/acetaminophen</i>)	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	
OPIOID ANALGESIC AND NSAID COMBINATION		
<i>hydrocodone/ibuprofen</i>	T1	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>butorphanol tartrate</i>	T1	PA QL(6 BOTTLES/30 DAYS)
BUTRANS (<i>buprenorphine</i>)	T3	QL(4 PATCHES/28 DAYS)
<i>codeine sulfate</i>	T1	PA
CONZIP	T3	PA QL(1 CAP/DAY)
DILAUDID (<i>hydromorphone hcl</i>)	T3	PA
<i>fentanyl</i>	T1	PA

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPIOID ANALGESICS (cont.)		
<i>fentanyl citrate</i>	T1	PA
FENTANYL CITRATE	T1	PA
<i>fentanyl citrate (Actiq)</i>	T1	PA
FENTORA	T3	PA
<i>hydrocodone bitartrate</i>	T1	PA
<i>hydrocodone bitartrate (Hysingla Er)</i>	T1	PA
<i>hydromorphone hcl</i>	T1	PA
<i>hydromorphone hcl (Dilaudid)</i>	T1	PA
HYSINGLA ER (<i>hydrocodone bitartrate</i>)	T2	PA
LAZANDA	T3	PA
<i>levorphanol tartrate</i>	T1	PA
<i>meperidine hcl</i>	T1	PA
<i>methadone hcl</i>	T1	PA
<i>morphine sulfate</i>	T1	PA
<i>morphine sulfate (Ms Contin)</i>	T1	PA
MS CONTIN (<i>morphine sulfate</i>)	T3	PA
NUCYNTA	T2	PA
NUCYNTA ER	T3	PA
<i>opium/belladonna alkaloids</i>	T1	PA
OXAYDO	T3	PA
<i>oxycodone hcl</i>	T1	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
<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 cup</i>	T1	PA
<i>oxycodone hcl 5 mg/5 ml soln</i>	T1	PA

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

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

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANESTHETICS (Miscellaneous)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GENERAL ANESTHETICS, INHALANT		
desflurane	T1	
isoflurane	T1	
isoflurane	T3	
sevoflurane (Ultane)	T1	
SUPRANE	T3	
ULTANE (sevoflurane)	T3	
ANESTHETICS (Pain Relief and Inflammatory Disease)		
LOCAL ANESTHETICS		
lidocaine hcl	T1	
TOPICAL LOCAL ANESTHETICS		
lidocaine (Lidocan li)	T1	PA
lidocaine (Lidoderm)	T1	PA
lidocaine 5% ointment	T1	QL(145 GMS/30 DAYS)
lidocaine 5% patch (Lidocan II)	T1	
lidocaine 5% patch (Lidoderm)	T1	
lidocaine hcl	T1	
lidocaine/prilocaine	T1	
LIDOCAN II (lidocaine)	T3	PA
LIDODERM (lidocaine)	T3	PA
SYNERA	T3	PA
ZTLIDO	T2	
ANESTHETICS (Urinary Tract Conditions)		
URINARY TRACT ANESTHETIC/ANALGESIC AGNT (AZO-DYE)		
phenazopyridine hcl (Pyridium)	T1	PA
PYRIDIUM (phenazopyridine hcl)	T3	
ANTI-ALLERGY (Allergy/Nasal Sprays)		
MAST CELL STABILIZERS		
cromolyn 100 mg/5 ml oral conc (Gastrocrom)	T1	PA
GASTROCROM (cromolyn sodium)	T3	
ANTI-ARTHRITICS (Pain Relief and Inflammatory Disease)		
ANALGESIC/ANTIPYRETICS, SALICYLATES		
DISALCID (salsalate)	T3	HD
salsalate (Disalcid)	T1	HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-ARTHRITIC AND CHELATING AGENTS		
CUPRIMINE (<i>penicillamine</i>)	T3	PA QL(6 CAPS/DAY) SP
DEPEN (<i>penicillamine</i>)	T3	PA QL(6 TABS/DAY) SP
<i>penicillamine 250 mg capsule</i> (Cuprimine)	T1	PA QL(6 CAPS/DAY) SP
<i>penicillamine 250 mg tablet</i> (Depen)	T1	PA QL(6 TABS/DAY) SP
ANTI-ARTHRITIC, FOLATE ANTAGONIST AGENTS		
OTREXUP	T2	PA
RASUVO	T3	PA
ANTI-INFLAM. INTERLEUKIN-I RECEPTOR ANTAGONIST		
KINERET	T3	PA QL(28 UNITS/28 DAYS) SP
ANTI-INFLAMMATORY, PYRIMIDINE SYNTHESIS INHIBITOR		
ARAVA (<i>leflunomide</i>)	T3	PA HD
<i>leflunomide</i> (Arava)	T1	HD
ANTI-INFLAMMATORY, PHOSPHODIESTERASE-4(PDE4) INHIB.		
OTEZLA 10-20 MG STARTER 28 DAY	T2	PA QL(55 TABS/365 DAYS) SP HD
OTEZLA 10-20-30MG START 28 DAY	T2	PA QL(55 TABS/365 DAYS) SP HD
OTEZLA 20 MG TABLET	T2	PA QL(2 TABS/DAY) SP HD
OTEZLA 30 MG TABLET	T2	PA QL(2 TABS/DAY) SP HD
OTEZLA XR 75 MG TABLET	T2	PA QL(1 TAB/DAY) SP HD
OTEZLA XR INITIATION PK 28 DAY	T2	PA QL(41 TABS/365 DAYS) SP HD
ANTI-INFLAMMATORY, SEL.COSTIM.MOD., T-CELL INHIBITOR		
ORENCIA	T3	PA QL(4 SYR/AUTO-INJ/28 DAYS) SP HD
ORENCIA CLICKJECT	T3	PA QL(4 SYR/AUTO-INJ/28 DAYS) SP HD
COLCHICINE		
<i>colchicine 0.6 mg capsule</i> (Mitigare)	T1	
<i>colchicine 0.6 mg tablet</i> (Colcrys)	T1	HD
COLCRYS (<i>colchicine</i>)	T3	PA HD
GLOPERBA	T3	PA QL(10 MLS/DAY) HD
MITIGARE (<i>colchicine</i>)	T2	
GOLD SALTS		
RIDAURA	T3	PA
HYPERURICEMIA TX - XANTHINE OXIDASE INHIBITORS		
<i>allopurinol 100 mg tablet</i> (Zyloprim)	T1	HD
<i>allopurinol 200 mg tablet</i>	T1	PA HD
<i>allopurinol 300 mg tablet</i>	T1	HD
<i>febuxostat 40 mg tablet</i> (Uloric)	T1	QL(1 TAB/DAY) HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HYPERURICEMIA TX - XANTHINE OXIDASE INHIBITORS (cont.)		
<i>febuxostat 80 mg tablet</i> (Uloric)	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	HD
JANUS KINASE (JAK) INHIBITORS		
OLUMIANT	T3	PA QL(30 TABS/30 DAYS) SP HD
RINVOQ	T2	PA QL(1 TAB/DAY) SP HD
RINVOQ LQ	T2	PA QL(12 MLS/DAY) SP HD
XELJANZ 1 MG/ML SOLUTION	T2	PA QL(480 MLS/30 DAYS) SP HD
XELJANZ 10 MG TABLET	T2	PA QL(2 TABS/DAY) SP HD
XELJANZ 5 MG TABLET	T2	PA QL(2 TABS/DAY) SP HD
XELJANZ XR	T2	PA QL(1 TAB/DAY) SP HD
NSAID ANALGESIC AND NON-SALICYLATE ANALGESIC COMB		
COMBOGESIC	T3	PA
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
<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 (<i>naproxen sodium ds</i>)	T3	ST HD
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
<i>diclofenac sodium</i>	T1	HD
EC-NAPROSYN (<i>naproxen</i>)	T3	ST HD
<i>etodolac</i>	T1	HD
<i>etodolac</i> (Lodine)	T1	HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE ANALGESICS (cont.)		
FELDENE (<i>piroxicam</i>)	T3	ST HD
FENOPROFEN 200 MG CAPSULE	T1	PA HD
<i>fenoprofen 400 mg capsule (Nalfon)</i>	T1	PA HD
<i>fenoprofen 600 mg tablet (Nalfon)</i>	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
<i>indomethacin</i>	T1	HD
INDOMETHACIN 20 MG CAPSULE	T3	PA HD
<i>indomethacin 25 mg capsule</i>	T1	HD
<i>indomethacin 25 mg/5 ml susp (Indocin)</i>	T1	HD
<i>indomethacin 50 mg capsule</i>	T1	HD
<i>indomethacin 50 mg suppository (Indocin)</i>	T1	HD
<i>ketoprofen 25 mg capsule</i>	T1	PA HD
<i>ketoprofen 50 mg capsule</i>	T1	HD
<i>ketoprofen 75 mg capsule</i>	T1	HD
<i>ketoprofen er 200 mg capsule</i>	T1	HD
LODINE (<i>etodolac</i>)	T3	ST HD
<i>meclofenamate sodium</i>	T1	HD
<i>meloxicam (Mobic)</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
<i>nabumetone (Relafen)</i>	T1	HD
NALFON 400 MG CAPSULE (<i>fenoprofen calcium</i>)	T3	PA HD
NALFON 600 MG TABLET (<i>profeno</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

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE ANALGESICS (cont.)		
<i>naproxen 125 mg/5 ml suspen</i> (Naprosyn)	T1	PA HD
<i>naproxen 250 mg tablet</i>	T1	HD
<i>naproxen 375 mg tablet</i>	T1	HD
<i>naproxen 500 mg kit</i> (Naprosyn)	T1	HD
<i>naproxen 500 mg tablet</i> (Naprosyn)	T1	HD
<i>naproxen dr 375 mg tablet</i> (Ec-Naprosyn)	T1	HD
<i>naproxen dr 500 mg tablet</i> (Ec-Naprosyn)	T1	HD
<i>naproxen sodium</i>	T1	HD
<i>naproxen sodium</i> (Anaprox Ds)	T1	HD
<i>naproxen sodium</i> (Naprelan)	T1	PA HD
OXAPROZIN 300 MG CAPSULE	T3	PA HD
<i>oxaprozin 600 mg tablet</i> (Daypro)	T1	HD
<i>piroxicam</i>	T1	HD
<i>piroxicam</i> (Feldene)	T1	HD
RELAFEN (<i>nabumetone</i>)	T3	PA HD
RELAFEN DS	T3	PA HD
<i>sulindac</i>	T1	HD
TIVORBEX	T3	PA HD
TOLECTIN 600 (<i>tolmetin sodium</i>)	T3	PA HD
<i>tolmetin sodium</i>	T1	HD
<i>tolmetin sodium</i> (Tolectin 600)	T1	HD
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</i> (Celebrex)	T1	QL(2 CAPS/DAY) HD
<i>celecoxib 200 mg capsule</i> (Celebrex)	T1	QL(2 CAPS/DAY) HD
<i>celecoxib 400 mg capsule</i> (Celebrex)	T1	QL(1 CAP/DAY) HD
<i>celecoxib 50 mg capsule</i> (Celebrex)	T1	QL(2 CAPS/DAY) HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
URICOSURIC AGENTS		
<i>probenecid</i>	T1	HD
<i>probenecid/colchicine</i>	T1	HD
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 RESPIMAT	T2	QL(1 INHALER/30 DAYS) HD
<i>tiotropium 18 mcg cap-inhaler</i> (Spiriva Handihaler)	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 sulf 2 mg/5 ml syrup</i>	T1	HD
<i>albuterol 8 mg/20 ml syrup cup</i>	T1	HD
<i>albuterol sulf 2 mg/5 ml syrup</i>	T1	HD
<i>albuterol sulfate 2 mg tab</i>	T1	HD
<i>albuterol sulfate 4 mg tab</i>	T1	HD
<i>albuterol sulfate er 4 mg tab</i>	T1	HD
<i>albuterol sulfate er 8 mg tab</i>	T1	HD
<i>terbutaline sulfate</i>	T1	HD
BETA-ADRENERGIC AGENTS, INHALED, SHORT ACTING		
<i>albuterol 100 mg/20 ml soln</i>	T1	
<i>albuterol 15 mg/3 ml solution</i>	T1	
<i>albuterol 75 mg/15 ml soln</i>	T1	
<i>albuterol 2.5 mg/0.5 ml sol</i>	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BETA-ADRENERGIC AGENTS, INHALED, SHORT ACTING (cont.)		
<i>albuterol 25 mg/5 ml solution</i>	T1	
<i>albuterol 5 mg/ml solution</i>	T1	
<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>albuterol hfa 90 mcg inhaler</i>	T1	QL(1 INHALER/30 DAYS)
ALBUTEROL HFA 90 MCG INHALER	T3	PA QL(1 INHALER/30 DAYS)
LEVALBUTEROL TARTRATE HFA	T3	PA QL(15 GMS/30 DAYS)
PROAIR DIGIHALER	T3	PA QL(2 INHALERS/30 DAYS)
PROAIR RESPICLICK	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 concentrate</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
BETA-ADRENERGIC AGENTS, ORALLY INHALED, LONG ACTING		
<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
SEREVENT DISKUS	T3	ST QL(1 BLISTER/30 DAYS) HD
BETA-ADRENERGIC AND ANTICHOLINERGIC COMBO, INHALED		
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 INHAL SPRAY	T2	QL(1 INHALER/30 DAYS) HD
UMECLIDINIUM-VILANTEROL	T3	PA QL(1 INHALER/30 DAYS) HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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 DIGIHALER	T3	ST QL(1 INHALER/30 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</i> (Symbicort)	T1	QL(1 INHALER/30 DAYS) HD
DULERA 100 MCG-5 MCG INHALER	T2	QL(1 INHALER/30 DAYS) HD
DULERA 200 MCG-5 MCG INHALER	T2	QL(1 INHALER/30 DAYS) HD
DULERA 50 MCG-5 MCG INHALER	T2	QL(1 INHALER/30 DAYS) HD
<i>fluticasone propion/salmeterol</i> (Advair Diskus)	T1	QL(1 INHALER/30 DAYS)
<i>fluticasone-salmeterol 100-50</i> (Advair Diskus)	T1	QL(1 INHALER/30 DAYS) HD
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</i> (Advair Diskus)	T1	QL(1 INHALER/30 DAYS) HD
<i>fluticasone-salmeterol 500-50</i> (Advair Diskus)	T1	QL(1 INHALER/30 DAYS) HD
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

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTI-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

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GLUCOCORTICOIDS, ORALLY INHALED (cont.)		
PULMICORT FLEXHALER	T3	PA HD
QVAR REDIHALER	T2	
INTERLEUKIN-5 (IL-5) ANTAGONISTS, MAB		
NUCALA	T2	PA SP HD
INTERLEUKIN-5(IL-5) RECEPTOR ALPHA ANTAGONIST, MAB		
FASENRA PEN	T2	PA SP HD
LEUKOTRIENE RECEPTOR ANTAGONISTS		
ACCOLATE (zafirlukast)	T3	HD
montelukast sodium	T1	HD
montelukast sodium (Singulair)	T1	HD
SINGULAIR (montelukast sodium)	T3	PA
zafirlukast (Accolate)	T1	HD
MAST CELL STABILIZERS, ORALLY INHALED		
cromolyn 20 mg/2 ml neb soln	T1	QL(480 MLS/30 DAYS) HD
MONOCLONAL ANTIBODIES TO IMMUNOGLOBULIN E (IGE)		
XOLAIR	T2	PA SP HD
MUCOLYTICS		
acetylcysteine	T1	
PHOSPHODIESTERASE-4 (PDE4) INHIBITORS		
DALIRESP 250 MCG TABLET	T3	PA QL(28 TABS/180 DAYS) HD
DALIRESP 500 MCG TABLET	T3	PA QL(2 TABS/DAY) HD
OHTUVAYRE	T3	PA QL(60 MLS/30 DAYS) SP
roflumilast 250 mcg tablet (Daliresp)	T1	QL(28 TABS/180 DAYS) HD
roflumilast 500 mcg tablet (Daliresp)	T1	QL(2 TABS/DAY) HD
XANTHINES		
ELIXOPHYLLIN	T3	PA HD
THEO-24	T2	HD
theophylline anhydrous	T1	HD

ANTIBIOTICS (Ear Medications)

EAR PREPARATIONS, ANTIBIOTICS		
CETRAXAL	T3	PA
ciprofloxacin hcl	T1	
CORTISPORIN-TC	T3	
neomycin/polymyxin b/hydrocort	T1	
ofloxacin	T1	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTIBIOTICS (Ear Medications) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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	

ANTIBIOTICS (Eye Conditions)

EYE ANTIBIOTIC AND GLUCOCORTICOID COMBINATIONS		
MAXITROL (<i>neomycin-polymyxin-dexameth</i>)	T3	PA
<i>neomycin/bacit/p-myx/hydrocort</i>	T1	
<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	PA
<i>bacitracin</i>	T1	
<i>bacitracin/polymyxin b sulfate</i>	T1	
BESIVANCE	T2	
CILOXAN	T3	
<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> (Vigamox)	T1	
<i>neomycin sulf/bacitracin/poly</i>	T1	
<i>neomycin/polymyxn b/gramicidin</i>	T1	
OCUFLOX (<i>ofloxacin</i>)	T3	PA

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTIBIOTICS (Eye Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPHTHALMIC ANTIBIOTICS (cont.)		
<i>ofloxacin</i> (Ocuflox)	T1	PA
<i>polymyxin b sulf/trimethoprim</i>	T1	
<i>tobramycin 0.3% eye drop</i>	T1	
TOBREX	T3	
VIGAMOX (<i>moxifloxacin hcl</i>)	T3	

ANTIBIOTICS (Infections)

2ND GEN. ANAEROBIC ANTIPROTOZOAL-ANTIBACTERIAL		
SOLOSEC	T2	
ABSORBABLE SULFONAMIDE ANTIBACTERIAL AGENTS		
BACTRIM (sulfamethoxazole-trimethoprim)	T3	
BACTRIM DS (sulfamethoxazole-trimethoprim)	T3	
sulfadiazine	T1	
sulfamethoxazole/trimethoprim	T3	
sulfamethoxazole/trimethoprim (Bactrim Ds)	T1	
sulfamethoxazole/trimethoprim (Bactrim)	T1	
AMINOGLYCOSIDE ANTIBIOTICS		
ARIKAYCE	T3	PA SP
BETHKIS (tobramycin)	T3	PA QL(8 MLS/DAY) SP HD
gentamicin sulfate	T1	
gentamicin sulfate/pf	T1	
KITABIS PAK	T3	PA QL(10 MLS/DAY) SP HD
neomycin sulfate	T1	
TOBI (tobramycin in 0.225% sod chlor)	T3	PA QL(10 MLS/DAY) SP HD
TOBI PODHALER	T2	PA QL(8 CAPS/DAY) SP HD
tobramycin 1, 200 mg/30 ml vial	T1	
tobramycin 1.2 gm vial	T1	PA
tobramycin 1.2 gram/30 ml vial	T1	
tobramycin 20 mg/2 ml vial	T1	
tobramycin 300 mg/4 ml ampule (Bethkis)	T1	PA QL(8 MLS/DAY) SP HD
tobramycin 300 mg/5 ml ampule (Tobi)	T1	PA QL(10 MLS/DAY) SP HD
tobramycin 40 mg/ml vial	T1	
tobramycin 80 mg/2 ml vial	T1	
TOBRAMYCIN PAK 300 MG/5 ML	T3	PA QL(10 MLS/DAY) SP HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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	
ANTIBIOTIC, ANTIBACTERIAL, MISC.		
<i>fosfomycin tromethamine</i>	T1	
<i>methenamine hippurate</i>	T1	
<i>methenamine mandelate</i>	T1	
PRIMSOL	T2	
<i>trimethoprim</i>	T1	
ANTILEPROTICS		
<i>dapsone 100 mg tablet</i>	T1	
<i>dapsone 25 mg tablet</i>	T1	
THALOMID	T2	PA SP HD
ANTI-MYCOBACTERIUM AGENTS		
<i>ethambutol hcl</i>	T1	HD
<i>isoniazid</i>	T1	HD
MYCIBUTIN (<i>rifabutin</i>)	T3	PA HD
PASER	T2	HD
<i>pyrazinamide</i>	T1	HD
<i>rifabutin (Mycobutin)</i>	T1	HD
ANTI-TUBERCULAR ANTIBIOTICS		
<i>cycloserine</i>	T1	
PRETOMANID	T3	PA QL(1 TAB/DAY)
PRIFTIN	T3	
<i>rifampin</i>	T1	
SIRTURO	T3	SP
BETALACTAMS		
CAYSTON	T3	PA QL(3 MLS/DAY) SP HD
CEPHALOSPORIN ANTIBIOTICS - 1ST GENERATION		
<i>cefadroxil</i>	T1	
<i>cephalexin</i>	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CEPHALOSPORIN ANTIBIOTICS - 2ND GENERATION		
<i>cefaclor</i>	T1	
<i>cefprozil</i>	T1	
<i>cefuroxime axetil</i>	T1	
CEPHALOSPORIN ANTIBIOTICS - 3RD GENERATION		
<i>cefdinir</i>	T1	
<i>cefixime</i>	T1	
<i>cefprozime proxetil</i>	T1	
<i>ceftriaxone sodium</i>	T1	
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	
<i>clindamycin hcl</i> (Cleocin Hcl)	T1	
<i>clindamycin palmitate hcl</i> (Cleocin Pediatric)	T1	
MACROLIDE ANTIBIOTICS		
<i>azithromycin</i>	T1	
<i>azithromycin</i> (Zithromax Tri-Pak)	T1	
<i>azithromycin</i> (Zithromax)	T1	
<i>clarithromycin</i>	T1	
DIFICID 200 MG TABLET (fidaxomicin)	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
<i>ery-tab dr 250 mg tablet</i>	T3	
<i>ery-tab dr 333 mg tablet</i>	T2	
ERY-TAB DR 500 MG TABLET (<i>erythromycin base</i>)	T3	
<i>erythromycin base</i>	T1	
<i>erythromycin base</i> (Ery-tab)	T1	
<i>erythromycin ethylsuccinate</i>	T1	
<i>erythromycin ethylsuccinate</i>	T2	
<i>erythromycin ethylsuccinate</i> (E.E.S. 200)	T1	
<i>erythromycin ethylsuccinate</i> (Eryped 200)	T1	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MACROLIDE ANTIBIOTICS (cont.)		
<i>erythromycin ethylsuccinate</i> (Eryped 400)	T1	
<i>erythromycin stearate</i>	T1	
<i>fidaxomicin</i> (Difcid)	T1	QL(28 TABS/28 DAYS)
ZITHROMAX (azithromycin)	T3	
ZITHROMAX TRI-PAK (<i>azithromycin</i>)	T3	
NITROFURAN DERIVATIVES ANTIBACTERIAL AGENTS		
FURADANTIN (<i>nitrofurantoin</i>)	T3	
MACROBID (<i>nitrofurantoin mono-macro</i>)	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	
<i>nitrofurantoin mcr 50 mg cap</i>	T1	
<i>nitrofurantoin monohyd/m-cryst</i> (Macrobid)	T1	
OXAZOLIDINONE ANTIBIOTICS		
<i>linezolid</i> (Zyvox)	T1	PA
SIVEXTRO	T3	PA
ZYVOX (<i>linezolid</i>)	T3	PA
PENICILLIN ANTIBIOTICS		
<i>amoxicillin</i>	T1	
<i>amoxicillin/potassium clav</i>	T1	
<i>amoxicillin/potassium clav</i> (Augmentin Es-600)	T1	
<i>amoxicillin/potassium clav</i> (Augmentin Xr)	T1	
<i>amoxicillin/potassium clav</i> (Augmentin)	T1	
<i>ampicillin trihydrate</i>	T1	
AUGMENTIN 125-31.25 MG/5 ML	T2	PA
AUGMENTIN 250-62.5 MG/5 ML (<i>amoxicillin-clavulanate potass</i>)	T3	PA
AUGMENTIN ES-600 (<i>amoxicillin/potassium clav</i>)	T3	PA
AUGMENTIN XR (<i>amoxicillin-clavulanate pot er</i>)	T3	PA
<i>dicloxacillin sodium</i>	T1	
MOXATAG	T3	
<i>penicillin v potassium</i>	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PLEUROMUTILIN DERIVATIVES		
XENLETA	T3	PA QL (10 TABS/30 DAYS)
QUINOLONE ANTIBIOTICS		
BAXDELA	T3	PA
CIPRO 10% SUSPENSION (<i>ciprofloxacin</i>)	T2	
CIPRO 250 MG TABLET (<i>ciprofloxacin hcl</i>)	T3	
CIPRO 5% SUSPENSION (<i>ciprofloxacin</i>)	T2	
CIPRO 500 MG TABLET (<i>ciprofloxacin hcl</i>)	T3	
<i>ciprofloxacin</i> (Cipro)	T1	
<i>ciprofloxacin hcl</i>	T1	
<i>ciprofloxacin hcl</i> (Cipro)	T1	
FACTIVE	T3	
<i>levofloxacin</i>	T1	
<i>moxifloxacin hcl</i> (Avelox)	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)
TETRACYCLINE ANTIBIOTICS		
ACTICLATE (<i>doxycycline hyclate</i>)	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	T3	PA
DORYX (<i>doxycycline hyclate</i>)	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

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TETRACYCLINE ANTIBIOTICS (cont.)		
DOXYCYCLINE HCl DR 80 MG TAB	T3	PA
<i>doxycycline hyclate 100 mg cap (</i>	T1	
<i>doxycycline hyclate 100 mg tab (Lymepak)</i>	T1	
<i>doxycycline hyclate 150 mg tab (Acticlate)</i>	T1	
<i>doxycycline hyclate 50 mg cap</i>	T1	
<i>doxycycline hyclate 75 mg tab (Acticlate)</i>	T1	
<i>doxycycline monohydrate (Oracea)</i>	T1	
<i>doxycycline monohydrate</i>	T1	
EMROSI	T3	PA
MINOCIN (<i>minocycline hcl</i>)	T3	PA
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	T3	PA QL(30 TABS/28 DAYS) SP
ORACEA (<i>doxycycline monohydrate</i>)	T3	PA
SEYSARA	T3	PA
SOLODYN (<i>minocycline hcl er</i>)	T3	PA
TARGADOX (<i>doxycycline hyclate</i>)	T3	PA
<i>tetracycline 250 mg capsule, 500 mg capsule</i>	T1	
<i>tetracycline 250 mg tablet, 500 mg tablet</i>	T1	PA
XIMINO	T3	ST
VAGINAL ANTIBIOTICS		
CLEOCIN	T3	PA
CLEOCIN (<i>clindamycin phosphate</i>)	T3	PA
<i>clindamycin phosphate (Cleocin)</i>	T1	
CLINDESSE	T3	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VAGINAL ANTIBIOTICS (cont.)		
metronidazole	T1	
metronidazole vaginal 0.75% gl	T1	
NUVESSA	T3	PA
XACIATO	T3	PA
VANCOMYCIN ANTIBIOTICS AND DERIVATIVES		
FIRVANQ	T3	PA
FIRVANQ (vancomycin hcl)	T3	PA
VANOCIN HCL (vancomycin hcl)	T3	PA
vancomycin 25 mg/ml oral soln	T1	PA
VANCOMYCIN 25 MG/ML ORAL SOLN	T3	
vancomycin 250 mg/5ml oral sol (Firvanq)	T1	
vancomycin 50 mg/ml oral soln (Firvanq)	T1	
vancomycin hcl 125 mg capsule (Vancocin Hcl)	T1	
vancomycin hcl 250 mg capsule (Vancocin Hcl)	T1	

ANTIBIOTICS (Skin Conditions)

TOPICAL ANTIBIOTIC AND ANTI-INFLAMMATORY STEROID		
NEO-SYNALAR	T3	
TOPICAL ANTIBIOTICS		
AMZEEQ	T3	PA
BENZAMYCIN (erythromycin-benzoyl peroxide)	T3	
CENTANY	T3	
CENTANY AT	T3	
CLEOCIN T (clindamycin phosphate)	T3	
CLINDAGEL (clindamycin phosphate)	T3	PA
clindamycin phosphate	T1	
clindamycin phosphate (Cleocin T)	T1	
clindamycin phosphate (Clindagel)	T1	
clindamycin phosphate (Evoclin)	T1	
erythromycin base in ethanol	T1	
erythromycin/benzoyl peroxide (Benzamycin)	T1	
EVOCLIN (clindamycin phosphate)	T3	
gentamicin sulfate	T1	
mupirocin 2% cream	T1	PA
mupirocin 2% ointment	T1	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTIBIOTICS (Skin Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL ANTIBIOTICS (cont.)		
XEPI	T3	
ZILXI	T3	PA
TOPICAL SULFONAMIDES		
AVAR-E	T3	PA
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	T2	

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	
ANTICOAG SODIUM CITRATE 4% SOL	T3	
CITRATE PHOSPHATE DEXTROSE	T1	
SODIUM CITRATE	T1	
DIRECT FACTOR XA INHIBITORS		
ELIQUIS	T2	
ELIQUIS SPRINKLE	T2	
<i>rivaroxaban</i> (Xarelto)	T1	
SAVAYSA 15 MG TABLET	T3	PA QL(1 TAB/DAY)
SAVAYSA 30 MG TABLET	T3	PA QL(1 TAB/DAY)
SAVAYSA 60 MG TABLET	T3	PA
XARELTO	T2	
XARELTO (<i>rivaroxaban</i>)	T2	
HEPARIN AND RELATED PREPARATIONS		
ARIXTRA 10 MG/0.8 ML SYRINGE (<i>fondaparinux sodium</i>)	T3	QL(0.8 ML/DAY) SP
ARIXTRA 2.5 MG/0.5 ML SYRINGE (<i>fondaparinux sodium</i>)	T3	QL(0.5 ML/DAY) SP
ARIXTRA 5 MG/0.4 ML SYRINGE (<i>fondaparinux sodium</i>)	T3	QL(0.4 ML/DAY) SP

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HEPARIN AND RELATED PREPARATIONS (cont.)		
ARIXTRA 7.5 MG/0.6 ML SYRINGE (<i>fondaparinux sodium</i>)	T3	QL(0.6 ML/DAY) SP
<i>enoxaparin 100 mg/ml syringe</i> (Lovenox)	T1	QL(2 SYRINGES/DAY) SP
<i>enoxaparin 120 mg/0.8 ml syr</i> (Lovenox)	T1	QL(2 SYRINGES/DAY) SP
<i>enoxaparin 150 mg/ml syringe</i> (Lovenox)	T1	QL(2 SYRINGES/DAY) SP
<i>enoxaparin 30 mg/0.3 ml syr</i> (Lovenox)	T1	QL(2 SYRINGES/DAY) SP
<i>enoxaparin 300 mg/3 ml vial</i> (Lovenox)	T1	QL(1 VIAL/DAY) SP
<i>enoxaparin 40 mg/0.4 ml syr</i> (Lovenox)	T1	QL(2 SYRINGES/DAY) SP
<i>enoxaparin 60 mg/0.6 ml syr</i> (Lovenox)	T1	QL(2 SYRINGES/DAY) SP
<i>enoxaparin 80 mg/0.8 ml syr</i> (Lovenox)	T1	QL(2 SYRINGES/DAY) SP
<i>fondaparinux 10 mg/0.8 ml syr</i> (Arixtra)	T1	QL(0.8 ML/DAY) SP
<i>fondaparinux 2.5 mg/0.5 ml syr</i> (Arixtra)	T1	QL(0.5 ML/DAY) SP
<i>fondaparinux 5 mg/0.4 ml syr</i> (Arixtra)	T1	QL(0.4 ML/DAY) SP
<i>fondaparinux 7.5 mg/0.6 ml syr</i> (Arixtra)	T1	QL(0.6 ML/DAY) SP
FRAGMIN 10,000 UNIT/4 ML VIAL	T2	QL(1 VIAL/DAY) SP
FRAGMIN 10,000 UNIT/ML SYRINGE	T2	QL(2 SYRINGES/DAY) SP
FRAGMIN 12,500 UNIT/0.5 ML SYR	T2	QL(2 SYRINGES/DAY) SP
FRAGMIN 15,000 UNIT/0.6 ML SYR	T2	QL(2 SYRINGES/DAY) SP
FRAGMIN 18,000 UNIT/0.72 ML	T2	QL(2 SYRINGES/DAY) SP
FRAGMIN 2,500 UNIT/0.2 ML SYR	T2	QL(2 SYRINGES/DAY) SP
FRAGMIN 5,000 UNIT/0.2 ML SYR	T2	QL(2 SYRINGES/DAY) SP
FRAGMIN 7,500 UNIT/0.3 ML SYR	T2	QL(2 SYRINGES/DAY) SP
FRAGMIN 95,000 UNIT/3.8 ML VL	T2	QL(1 VIAL/DAY) SP
<i>heparin 10,000 unit/10 ml vial</i>	T1	
<i>heparin 2,000 unit/2 ml vial</i>	T1	
<i>heparin 30,000 unit/30 ml vial</i>	T1	
<i>heparin 40,000 unit/4 ml vial</i>	T1	
<i>heparin 5,000 unit/ml carpuct</i>	T1	
<i>heparin 50,000 unit/10 ml vial</i>	T1	
<i>heparin 50,000 unit/5 ml vial</i>	T1	
<i>heparin sod 1,000 unit/ml vial</i>	T1	
<i>heparin sod 10,000 unit/ml vl</i>	T1	
<i>heparin sod 20,000 unit/ml vl</i>	T1	
<i>heparin sod 5,000 unit/0.5 ml</i>	T1	
HEPARIN SOD 5,000 UNIT/0.5 ML	T1	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HEPARIN AND RELATED PREPARATIONS (cont.)		
HEPARIN SOD 5,000 UNIT/0.5 ML	T3	
HEPARIN SOD 5,000 UNIT/ML SYRG	T3	
<i>heparin sod 5,000 unit/ml syrg</i>	T3	
<i>heparin sod 5,000 unit/ml vial</i>	T1	
LOVENOX 100 MG/ML SYRINGE (<i>enoxaparin sodium</i>)	T3	PA QL(2 SYRINGES/DAY) SP
LOVENOX 120 MG/0.8 ML SYRINGE (<i>enoxaparin sodium</i>)	T3	PA QL(2 SYRINGES/DAY) SP
LOVENOX 150 MG/ML SYRINGE (<i>enoxaparin sodium</i>)	T3	PA QL(2 SYRINGES/DAY) SP
LOVENOX 30 MG/0.3 ML SYRINGE (<i>enoxaparin sodium</i>)	T3	PA QL(2 SYRINGES/DAY) SP
LOVENOX 300 MG/3 ML VIAL (<i>enoxaparin sodium</i>)	T3	PA QL(1 VIAL/DAY) SP
LOVENOX 40 MG/0.4 ML SYRINGE (<i>enoxaparin sodium</i>)	T3	PA QL(2 SYRINGES/DAY) SP
LOVENOX 60 MG/0.6 ML SYRINGE (<i>enoxaparin sodium</i>)	T3	PA QL(2 SYRINGES/DAY) SP
LOVENOX 80 MG/0.8 ML SYRINGE (<i>enoxaparin sodium</i>)	T3	PA QL(2 SYRINGES/DAY) SP
THROMBIN INHIBITORS, SELECTIVE, DIRECT, REVERSIBLE		
<i>dabigatran etexilate mesylate</i> (Pradaxa)	T1	HD
PRADAXA 110 MG CAPSULE (<i>dabigatran etexilate mesylate</i>)	T3	PA HD
PRADAXA 110 MG PELLET PACK	T3	PA QL(2 PACKS/DAY) SP
PRADAXA 150 MG CAPSULE (<i>dabigatran etexilate mesylate</i>)	T3	PA HD
PRADAXA 150 MG PELLET PACK	T3	PA QL(2 PACKS/DAY) SP
PRADAXA 20 MG PELLET PACK	T3	PA QL(2 PACKS/DAY) SP
PRADAXA 30 MG PELLET PACK	T3	PA QL(4 PACKS/DAY) SP
PRADAXA 40 MG PELLET PACK	T3	PA QL(4 PACKS/DAY) SP
PRADAXA 50 MG PELLET PACK	T3	PA QL(4 PACKS/DAY) SP
PRADAXA 75 MG CAPSULE (<i>dabigatran etexilate mesylate</i>)	T3	PA HD
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)
<i>naloxone 0.4 mg/ml carpject</i>	T1	
<i>naloxone 0.4 mg/ml vial</i>	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIDOTES (Substance Abuse) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPIOID ANTAGONISTS (cont.)		
<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 (<i>naloxone hcl</i>)	T2	QL(2 UNITS/30 DAYS)
OPVEE	T3	QL(2 UNITS/30 DAYS)
REXTOVY	T2	QL(2 UNITS/30 DAYS)
ZIMHI	T3	QL(2 SYRINGES/30 DAYS)

ANTI-FUNGALS (Eye Conditions)

OPHTHALMIC ANTI-FUNGAL AGENTS

NATACYN	T2	
---------	----	--

ANTI-FUNGALS (Feminine Products)

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	T3	PA
DIFLUCAN (<i>fluconazole</i>)	T3	PA
<i>fluconazole</i>	T1	
<i>fluconazole</i> (Diflucan)	T1	
<i>flucytosine</i> (Ancobon)	T1	
<i>itraconazole</i>	T1	
<i>itraconazole</i> (Sporanox)	T1	
<i>ketoconazole</i>	T1	
NOXAFIL 40 MG/ML SUSPENSION	T3	
NOXAFIL DR 100 MG TABLET (<i>posaconazole</i>)	T3	PA
ORAVIG	T3	
<i>posaconazole</i>	T1	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTI-FUNGALS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-FUNGAL AGENTS (cont.)		
<i>posaconazole</i> (Noxafil)	T1	
SPORANOX (<i>itraconazole</i>)	T3	PA
<i>terbinafine hcl</i>	T1	
TOLSURA	T3	
VFEND (<i>voriconazole</i>)	T3	PA
VIVJOA	T3	PA SP
<i>voriconazole</i> (Vfend)	T1	PA
ANTI-FUNGAL ANTIBIOTICS		
BREXAFEMME	T3	PA
FULVICIN P-G	T3	PA QL(4 TABS/DAY)
<i>griseofulvin ultra 125 mg tab</i>	T1	
<i>griseofulvin ultra 165 mg tab</i>	T1	QL(4 TABS/DAY)
<i>griseofulvin ultra 250 mg tab</i>	T1	
<i>griseofulvin, microsize</i>	T1	
<i>nystatin</i>	T1	
ANTI-FUNGALS (Skin Conditions)		
TOPICAL ANTI-FUNGAL/ANTI-INFLAMMATORY, STEROID AGENT		
<i>clotrimazole/betamethasone dip</i>	T1	
TOPICAL ANTI-FUNGALS		
<i>ciclodan 0.77% cream</i> (Loprox)	T1	
CICLODAN 0.77% CREAM KIT	T3	
CICLODAN 8% KIT	T3	
<i>ciclodan 8% solution</i>	T1	
<i>ciclopirox</i>	T1	
<i>ciclopirox olamine</i> (Loprox)	T1	
<i>ciclopirox/urea/camph/men/euc</i>	T1	
<i>econazole nitrate 1% cream</i>	T1	
ECOZA	T3	
ERTACZO	T3	PA
EXELDERM	T3	PA
EXODERM	T1	
EXTINA (<i>ketoconazole</i>)	T3	PA
JUBLIA	T3	PA

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTI-FUNGALS (Skin Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL ANTI-FUNGALS (cont.)		
<i>ketoconazole</i>	T1	
<i>ketoconazole</i> (Extina)	T1	
LOPROX 0.77% CREAM (<i>ciclopirox</i>)	T3	PA
LOPROX 0.77% SUSPENSION KIT	T3	
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>	T1	
<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>tavaborole</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</i>	T1	
<i>carbinoxamine maleate 4 mg tab</i>	T1	
<i>carbinoxamine maleate 6 mg tab</i>	T1	PA
CARBINOXAMINE MALEATE ER	T3	PA
<i>clemastine 0.5 mg/5 ml syrup</i>	T1	PA
<i>clemastine fum 2.68 mg tablet</i>	T1	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTIHISTAMINES (Allergy/Nasal Sprays) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIHISTAMINES - 1ST GENERATION (cont.)		
<i>clemastine fumarate</i>	T1	
<i>cyproheptadine hcl</i>	T1	
<i>dexchlorpheniramine maleate</i> (Ryclora)	T1	PA
<i>hydroxyzine hcl</i>	T1	
<i>hydroxyzine pamoate</i>	T1	
<i>hydroxyzine pamoate</i> (Vistaril)	T1	
KARBINAL ER	T3	PA
<i>promethazine hcl</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
DESLOTATADINE 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</i> (Clarinx)	T1	HD
<i>levocetirizine dihydrochloride</i>	T1	HD
ANTIHISTAMINES (Eye Conditions)		
EYE ANTIHISTAMINES		
<i>azelastine hcl 0.05% drops</i>	T1	
<i>bepotastine besilate</i> (Bepreve)	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
ANTI-HYPERGLYCEMICS (Diabetes)		
ANTIHYPERGLY, DPP-4 ENZYME INHIB.-THIAZOLIDINEDIONE		
ALOGLIPTIN-PIOGLITAZONE	T3	PA QL(1 TAB/DAY) HD
OSENI	T3	PA QL(1 TAB/DAY) HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTI-HYPERGLYCEMICS (Diabetes) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIHYPERGLY, INCRETIN MIMETIC (GLP-1 RECEPT.AGONIST)		
BYDUREON	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 2-pak 18 mg/3 ml (Victoza 2-Pak)</i>	T1	PA QL(3 PENS/30 DAYS)
<i>liraglutide 2-pak 18 mg/3 ml (Victoza 3-Pak)</i>	T1	PA QL(3 PENS/30 DAYS)
<i>liraglutide 3-pak 18 mg/3 ml (Victoza 2-Pak)</i>	T1	PA QL(3 PENS/30 DAYS)
<i>liraglutide 3-pak 18 mg/3 ml (Victoza 3-Pak)</i>	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)
ANTI-HYPERGLY, INSULIN, LONG ACT-GLP-1 RECEPT.AGONIST		
SOLIQUA 100-33	T2	
XULTOPHY 100-3.6	T3	PA
ANTIHYPERGLYCEMIC - INCRETIN MIMETICS COMBINATION		
MOUNJARO 10 MG/0.5 ML PEN	T2	PA QL(2 MLS/30 DAYS)
MOUNJARO 12.5 MG/0.5 ML PEN	T2	PA QL(2 MLS/30 DAYS)
MOUNJARO 15 MG/0.5 ML PEN	T2	PA QL(2 MLS/30 DAYS)
MOUNJARO 2.5 MG/0.5 ML PEN	T2	PA QL(2 MLS/365 DAYS)
MOUNJARO 5 MG/0.5 ML PEN	T2	PA QL(2 MLS/30 DAYS)
MOUNJARO 7.5 MG/0.5 ML PEN	T2	PA QL(2 MLS/30 DAYS)
ANTI-HYPERGLYCEMIC, ALPHA-GLUCOSIDASE INHIBITORS		
<i>acarbose (Precose)</i>	T1	HD
<i>miglitol</i>	T1	HD
PRECOSE (<i>acarbose</i>)	T3	HD
ANTI-HYPERGLYCEMIC, AMYLIN ANALOG-TYPE		
SYMLINPEN 120	T2	HD
SYMLINPEN 60	T2	
ANTI-HYPERGLYCEMIC, BIGUANIDE TYPE		
GLUMETZA (<i>metformin hcl</i>)	T3	PA
<i>metformin hcl</i>	T1	HD
<i>metformin hcl</i>	T1	PA HD
<i>metformin hcl (Glumetza)</i>	T1	PA HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTI-HYPERGLYCEMICS (Diabetes) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-HYPERGLYCEMIC, BIGUANIDE TYPE (cont.)		
<i>metformin hcl 1,000 mg tablet</i>	T1	HD
<i>metformin hcl 500 mg tablet</i>	T1	HD
<i>metformin hcl 500 mg/5 ml cup (Riomet)</i>	T1	HD
<i>metformin hcl 500 mg/5 ml soln (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
ANTI-HYPERGLYCEMIC, 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
ANTI-HYPERGLYCEMIC, 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 XL)</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
<i>glyburide</i>	T1	HD
<i>glyburide, micronized</i>	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

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTI-HYPERGLYCEMICS (Diabetes) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-HYPERGLYCEMIC, 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
ANTI-HYPERGLYCEMIC, THIAZOLIDINEDIONE AND BIGUANIDE		
ACTOPLUS MET (<i>pioglitazone-metformin</i>)	T3	HD
<i>pioglitazone hcl/metformin hcl</i>	T1	HD
<i>pioglitazone hcl/metformin hcl</i> (Actoplus Met)	T1	HD
ANTI-HYPERGLYCEMIC, THIAZOLIDINEDIONE-SULFONYLUREA		
DUETACT (<i>pioglitazone hcl/glimepiride</i>)	T3	HD
<i>pioglitazone hcl/glimepiride</i> (Duetact)	T1	HD
ANTI-HYPERGLYCEMIC, DPP-4 INHIBITOR-BIGUANIDE COMBS.		
ALOGLIPTIN-METFORMIN	T3	PA QL (2 tabs/day) HD
JANUMET	T2	QL (2 tabs/day) ST HD
JANUMET XR 100-1,000 MG TABLET	T2	QL (1 tab/day) ST HD
JANUMET XR 50-1,000 MG TABLET	T2	QL (2 tabs/day) ST HD
JANUMET XR 50-500 MG TABLET	T2	QL (1 tab/day) ST HD
JENTADUETO	T3	PA QL (4 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 (<i>saxagliptin hcl/metformin hcl</i>)	T3	PA QL (2 TABS/DAY) HD
KOMBIGLYZE XR 5-1,000 MG TAB (<i>saxagliptin hcl/metformin hcl</i>)	T3	PA QL (1 TAB/DAY) HD
KOMBIGLYZE XR 5-500 MG TABLET (<i>saxagliptin hcl/metformin hcl</i>)	T3	PA QL (1 TAB/DAY) HD
<i>linagliptin/metformin hcl</i>	T1	QL (2 TABS/DAY) HD
<i>saxagliptin-metformin er 5-500</i> (Kombiglyze Xr)	T1	QL (1 TAB/DAY) HD
<i>saxagliptin-metformin er 5-1000</i> (Kombiglyze Xr)	T1	QL (1 TAB/DAY) HD
<i>saxagliptin-metformin er 2.5-1000</i> (Kombiglyze Xr)	T1	QL (2 TABS/DAY) HD
SITAGLIPTIN-METFORMIN	T3	PA QL (2 TABS/DAY) HD
SITAGLIPTIN-METFO ER 50-500, 100-1,000	T3	PA QL (1 TAB/DAY) HD
SITAGLIPTIN-METFOR ER 50-1,000	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

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTI-HYPERGLYCEMICS (Diabetes) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-HYPERGLYCEMIC, INSULIN-RELEASE STIM.-BIGUANIDE		
<i>glipizide/metformin hcl</i>	T1	HD
<i>glyburide/metformin hcl</i>	T1	HD
ANTI-HYPERGLYCEMIC, THIAZOLIDINEDIONE (PPARG AGONIST)		
ACTOS (<i>pioglitazone hcl</i>)	T3	PA HD
<i>pioglitazone hcl</i> (Actos)	T1	HD
ANTI-HYPERGLYCEMIC-GLUCOCORTICOID RECEPTOR BLOCKER		
KORLYM (<i>mifepristone</i>)	T3	PA SP
<i>mifepristone 300 mg tablet</i> (Korlym)	T1	PA SP
ANTI-HYPERGLYCEMIC-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	T2	ST QL(2 TABS/DAY) HD
SYNJARDY XR 10-1,000 MG TABLET	T2	ST QL(2 TABS/DAY) HD
SYNJARDY XR 12.5-1,000 MG TAB	T2	ST QL(2 TABS/DAY) HD
SYNJARDY XR 25-1,000 MG TABLET	T2	ST QL(1 TAB/DAY) HD
SYNJARDY XR 5-1,000 MG TABLET	T2	ST QL(2 TABS/DAY) HD
XIGDUO XR 10 MG-1,000 MG TAB	T2	ST QL(1 TAB/DAY) HD
XIGDUO XR 10 MG-500 MG TABLET	T2	ST QL(1 TAB/DAY) HD
XIGDUO XR 2.5 MG-1,000 MG TAB	T2	ST QL(2 TABS/DAY) HD
XIGDUO XR 5 MG-1,000 MG TABLET	T2	ST QL(2 TABS/DAY) HD
XIGDUO XR 5 MG-500 MG TABLET	T2	ST QL(1 TAB/DAY) HD
ANTIHYPERGLY-SGLT-2 INHIB, DPP-4 INHIB, BIGUANIDE CB		
BRENZAVVY	T3	PA QL(1 TAB/DAY) HD
DAPAGLIFLOZIN	T3	PA QL(1 TAB/DAY) HD
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

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTI-HYPERGLYCEMICS (Diabetes) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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
FIASP FLEXTOUCH	T3	PA QL(1.5 MLS/DAY) HD
FIASP PENFILL	T3	PA QL(1.5 MLS/DAY) HD
HUMALOG	T2	QL(1.5 MLS/DAY) HD
HUMALOG JUNIOR KWIKPEN	T2	QL(1.5 MLS/DAY) HD
HUMALOG KWIKPEN U-100	T2	QL(1.5 MLS/DAY) HD
HUMALOG KWIKPEN U-200	T2	QL(1 ML/DAY) HD
HUMALOG MIX 50-50 KWIKPEN	T2	QL(2 MLS/DAY) HD
HUMALOG MIX 75-25	T2	QL(2 MLS/DAY) HD
HUMALOG MIX 75-25 KWIKPEN	T2	QL(2 MLS/DAY) HD
HUMALOG TEMPO PEN U-100	T2	QL(1.5 MLS/DAY) HD
HUMULIN 70/30 KWIKPEN	T2	QL(2 MLS/DAY) HD
HUMULIN 70-30	T2	QL(2 MLS/DAY) HD
HUMULIN N	T2	QL(1.5 MLS/DAY) HD
HUMULIN N KWIKPEN	T2	QL(1.5 MLS/DAY) HD
HUMULIN R	T2	QL(1.5 MLS/DAY) HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTI-HYPERGLYCEMICS (Diabetes) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
INSULINS (cont.)		
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 FLEXTOUCH	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
MERIOLOG	T3	PA QL(1.5 MLS/DAY) HD
MERIOLOG SOLOSTAR	T3	PA QL(1.5 MLS/DAY) HD
NOVOLOG MIX 70-30	T2	QL(2 MLS/DAY) HD
NOVOLOG MIX 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

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTI-HYPERGLYCEMICS (Diabetes) (cont.)

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

ANTI-INFECTIVES/MISCELLANEOUS (Feminine Products)

VAGINAL ANTISEPTICS		
<i>acetic acid/oxyquinoline</i> (Relagard)	T1	
RELAGARD (<i>acetic acid/oxyquinoline</i>)	T3	
TRIMO-SAN	T3	

ANTI-INFECTIVES/MISCELLANEOUS (Infections)

2ND GEN. ANAEROBIC ANTI-PROTOZOAL-ANTIBACTERIAL		
<i>tinidazole</i>	T1	
AMEBICIDES		
HUMATIN	T3	PA
ANTHELMINTICS		
<i>albendazole</i>	T1	
BILTRICIDE (<i>praziquantel</i>)	T3	
EMVERM	T1	
<i>ivermectin 3 mg tablet</i> (Stromectol)	T1	PA
<i>ivermectin 6 mg tablet</i>	T1	PA
<i>praziquantel</i> (Biltricide)	T1	
STROMECTOL (<i>ivermectin</i>)	T3	PA

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTI-INFECTIVES/MISCELLANEOUS (Infections) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-MALARIAL DRUGS		
ARAKODA	T3	PA
atovaquone/proguanil hcl (Malarone)	T1	
chloroquine phosphate	T1	
COARTEM	T3	PA QL(24 TABS/30 DAYS)
DARAPRIM (pyrimethamine)	T3	PA SP
hydroxychloroquine sulfate	T1	
hydroxychloroquine sulfate (Plaquenil)	T1	
KRINTAFEL	T3	PA QL(2 TABS/30 DAYS)
MALARONE (atovaquone-proguanil hcl)	T3	PA
mefloquine hcl	T1	
PLAQUENIL (hydroxychloroquine sulfate)	T3	PA
PRIMAQUINE (primaquine phosphate)	T1	
primaquine phosphate (Primaquine)	T1	
pyrimethamine 25 mg tablet (Daraprim)	T1	PA SP
quinine sulfate	T1	
SOVUNA	T3	PA
ANTI-PROTOZOAL DRUGS, MISCELLANEOUS		
atovaquone (Meproon)	T1	
BENZNIDAZOLE	T3	
IMPAVIDO	T3	PA
LAMPIT	T3	
MEPRON (atovaquone)	T3	PA
NEBUPENT (pentamidine isethionate)	T3	
pentamidine isethionate (Nebupent)	T1	
glycine urologic solution	T1	
glycine urologic solution	T3	
ANTISEPTICS, GENERAL		
ALCOHOL SWABSTICK	T3	
CVS ISOPROPYL ALCOHOL 91% SPRY	T1	
GS ISOPROPYL ALCOHOL 70% SPRAY	T1	
ISOPROPYL ALCOHOL 70% SPRAY	T1	
MEDI-FIRST ISOPROPYL ALCOHOL	T3	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTI-INFLAM.TUMOR NECROSIS FACTOR INHIBITING AGENTS (Pain Relief And Inflammatory Disease)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-INFLAMMATORY TUMOR NECROSIS FACTOR INHIBITOR		
ABRILADA(CF) 20 MG/0.4 ML SYRN	T3	PA QL(2 PENS/SYRINGES/28 DAYS) SP
ABRILADA(CF) 40 MG/0.8 ML SYRN	T3	PA QL(4 SRNGE KITS/28 DAYS) SP
ABRILADA(CF) PEN	T3	PA QL(4 KITS/28 DAYS) SP
ABRILADA(CF) PEN (2 PACK)	T3	PA QL(4 KITS/28 DAYS) SP
ADALIMUMAB-AACF(CF) (2 PK)	T3	PA QL(4 SRNGE KITS/28 DAYS) SP HD
ADALIMUMAB-AACF(CF) PEN (2 PK)	T3	PA QL(4 KITS/28 DAYS) SP HD
ADALIMUMAB-AACF(CF) PEN CROHNS	T3	PA QL(1 STARTER KIT/365 DAYS) SP HD
ADALIMUMAB-AACF(CF) PEN PS-UV	T3	PA QL(2 KITS/365 DAYS) SP HD
ADALIMUMAB-AATY(CF) 20MG/0.2ML	T3	PA QL(2 PENS/SYRINGES/28 DAYS) SP
ADALIMUMAB-AATY(CF) 40MG/0.4ML	T3	PA QL(4 SRNGE KITS/28 DAYS) SP
ADALIMUMAB-AATY(CF) 80MG/0.8ML	T3	PA QL(2 AUTO-INJS/28 DAYS) SP
ADALIMUMAB-AATY(CF) AI CROHNS	T3	PA QL(3 PENS/365 DAYS) SP
ADALIMUMAB-ADAZ(CF) 10MG/0.1ML	T3	PA QL(2 SYRINGES/28 DAYS) SP
ADALIMUMAB-ADAZ(CF) 20MG/0.2ML	T3	PA QL(2 SYRINGES/28 DAYS) SP
ADALIMUMAB-ADAZ(CF) 40 MG SYRG	T3	PA QL(4 SYRINGES/28 DAYS) SP
ADALIMUMAB-ADAZ(CF) PEN 40 MG	T3	PA QL(4 PENS/28 DAYS) SP
ADALIMUMAB-ADAZ(CF) PEN 80 MG	T3	PA QL(2 PENS/28 DAYS) SP
ADALIMUMAB-ADB(M) 10 MG SYRG	T2	PA QL(2 PENS/SYRINGES/28 DAYS) SP HD
ADALIMUMAB-ADB(M) 20 MG SYRG	T2	PA QL(2 PENS/SYRINGES/28 DAYS) SP HD
ADALIMUMAB-ADB(M) 40 MG SYRG	T2	PA QL(4 SRNGE KITS/28 DAYS) SP HD
ADALIMUMAB-ADB(M) (CF) PEN	T2	PA QL(4 KITS/28 DAYS) SP HD
ADALIMUMAB-ADB(M) (CF) PEN	T2	PA QL(4 KITS/28 DAYS) SP HD
ADALIMUMAB-FKJP(CF) 20 MG SYRG	T3	PA QL(2 PENS/SYRINGES/28 DAYS) SP
ADALIMUMAB-FKJP(CF) 40 MG SYRG	T3	PA QL(4 SRNGE KITS/28 DAYS) SP
ADALIMUMAB-FKJP(CF) PEN	T3	PA QL(4 KITS/28 DAYS) SP
ADALIMUMAB-RYVK(CF)	T2	PA QL(4 SRNGE KITS/28 DAYS) SP HD
ADALIMUMAB-RYVK(CF) AUTOINJECT	T2	PA QL SP HD
AMJEVITA(CF) 10MG/0.2ML SYRING	T3	PA QL(2 SYRINGES/28 DAYS) SP HD
AMJEVITA(CF) 20MG/0.2ML SYRING	T3	PA QL(2 SYRINGES/28 DAYS) SP HD
AMJEVITA(CF) 40MG/0.4ML AUTOIN	T3	PA QL(4 AUTO-INJS/28 DAYS) SP HD
AMJEVITA(CF) 40MG/0.4ML SYRING	T3	PA QL(4 SYRINGES/28 DAYS) SP HD
AMJEVITA(CF) 40MG/0.8ML AUTOIN	T3	PA QL(4 AUTO-INJS/28 DAYS) SP HD
AMJEVITA(CF) 40MG/0.8ML SYRING	T3	PA QL(4 SYRINGES/28 DAYS) SP HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTI-INFLAM.TUMOR NECROSIS FACTOR INHIBITING AGENTS (Pain Relief And Inflammatory Disease) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-INFLAMMATORY TUMOR NECROSIS FACTOR INHIBITOR (cont.)		
AMJEVITA(CF) 80MG/0.8ML AUTOIN	T3	PA QL(2 AUTO-INJS/28 DAYS) SP HD
AVSOLA	T2	PA SP HD
CIMZIA (2 PACK)	T2	PA QL(1 KIT/28 DAYS) SP HD
CIMZIA 200 MG/ML SYRINGE KIT	T2	PA QL(2 PENS/SYRINGES/28 DAYS) SP
CIMZIA 2X200 MG/ML(X3)START KT	T2	PA QL(1 STARTER KIT/365 DAYS) SP HD
CYLTEZO(CF) 10 MG/0.2 ML SYRNG	T2	PA QL(2 PENS/SYRINGES/28 DAYS) SP HD
CYLTEZO(CF) 20 MG/0.4 ML SYRNG	T2	PA QL(2 PENS/SYRINGES/28 DAYS) SP HD
CYLTEZO(CF) 40 MG/0.4 ML SYRNG	T2	PA QL(4 SRNGE KITS/28 DAYS) SP HD
CYLTEZO(CF) 40 MG/0.8 ML SYRNG	T2	PA QL(4 SRNGE KITS/28 DAYS) SP HD
CYLTEZO(CF) PEN	T2	PA QL(4 KITS/28 DAYS) SP HD
CYLTEZO(CF) PEN CROHN'S-UC-HS	T2	PA QL(1 STARTER KIT/365 DAYS) SP HD
CYLTEZO(CF) PEN PSORIASIS-UV	T2	PA QL(1 STARTER KIT/365 DAYS) SP HD
ENBREL 25 MG/0.5 ML SYRINGE	T2	PA QL(8 MLS/28 DAYS) SP HD
ENBREL 25 MG/0.5 ML VIAL	T2	PA QL(8 MLS/28 DAYS) SP HD
ENBREL 50 MG/ML SYRINGE	T2	PA QL(4 MLS/28 DAYS) SP HD
ENBREL MINI	T2	PA QL(4 MLS/28 DAYS) SP HD
ENBREL SURECLICK	T2	PA QL(4 MLS/28 DAYS) SP HD
HADLIMA	T3	PA QL(4 SYRINGES/28 DAYS) SP HD
HADLIMA PUSHTOUCH	T3	PA QL(4 AUTO-INJS/28 DAYS) SP HD
HULIO(CF)	T3	PA QL(4 SYRINGES/28 DAYS) SP HD
HADLIMA(CF) PUSHTOUCH	T3	PA QL(4 AUTO-INJS/28 DAYS) SP HD
HULIO(CF) 20 MG/0.4 ML SYRINGE	T3	PA QL(2 PENS/SYRINGES/28 DAYS) SP
HULIO(CF) 40 MG/0.8 ML SYRINGE	T3	PA QL(4 SRNGE KITS/28 DAYS) SP
HULIO(CF) PEN	T3	PA QL(4 KITS/28 DAYS) SP
HUMIRA	T2	PA QL(4 SRNGE KITS/28 DAYS) SP HD
HUMIRA PEN	T2	PA QL(4 KITS/28 DAYS) SP HD
HUMIRA(CF) 10 MG/0.1 ML SYRING	T2	PA QL(2 PENS/SYRINGES/28 DAYS) SP HD
HUMIRA(CF) 20 MG/0.2 ML SYRING	T2	PA QL(2 PENS/SYRINGES/28 DAYS) SP HD
HUMIRA(CF) 40 MG/0.4 ML SYRING	T2	PA QL(4 SRNGE KITS/28 DAYS) SP HD
HUMIRA(CF) PEN 40 MG/0.4 ML	T2	PA QL(4 KITS/28 DAYS) SP HD
HUMIRA(CF) PEN 80 MG/0.8 ML	T2	PA QL(2 PENS/28 DAYS) SP HD
HUMIRA(CF) PEN CROHN'S-UC-HS	T2	PA QL(1 STARTER KIT/365 DAYS) SP HD
HYRIMOZ(CF) 10 MG/0.1 ML SYRNG	T3	PA QL(2 SYRINGES/28 DAYS) SP HD
HYRIMOZ(CF) 20 MG/0.2 ML SYRNG	T3	PA QL(2 SYRINGES/28 DAYS) SP HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTI-INFLAM.TUMOR NECROSIS FACTOR INHIBITING AGENTS (Pain Relief And Inflammatory Disease) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-INFLAMMATORY TUMOR NECROSIS FACTOR INHIBITOR (cont.)		
HYRIMOZ(CF) 40 MG/0.4 ML SYRNG	T3	PA QL(4 SYRINGES/28 DAYS) SP HD
HYRIMOZ(CF) PEDI CROHN 80 MG	T3	PA QL(3 SYRINGES/365 DAYS) SP HD
HYRIMOZ(CF) PEDI CROHN 80-40MG	T3	PA QL(1 SYRINGE/365 DAYS) SP HD
HYRIMOZ(CF) PEN 40 MG/0.4 ML	T3	PA QL(4 PENS/28 DAYS) SP HD
HYRIMOZ(CF) PEN 80 MG/0.8 ML	T3	PA QL(2 PENS/28 DAYS) SP HD
HYRIMOZ(CF) PEN CROHN-UC START	T3	PA QL(3 PENS/365 DAYS) SP HD
HYRIMOZ(CF) PEN PSORIASIS	T3	PA QL(1 PEN/365 DAYS) SP HD
IDACIO(CF) PEN CROHN'S-UC(6PK)	T3	PA QL(1 STARTER KIT/365 DAYS) SP HD
IDACIO(CF) PEN PSORIASIS (4PK)	T3	PA QL(2 KITS/365 DAYS) SP HD
INFLECTRA	T2	PA SP HD
INFLIXIMAB	T3	PA SP HD
REMICADE	T3	PA SP HD
SIMLANDI(CF) 20 MG/0.2 ML SYRG	T2	PA QL(2 PENS/SYRINGES/28 DAYS) SP HD
SIMLANDI(CF) 40 MG/0.4 ML SYRG	T2	PA QL(4 SRNGE KITS/28 DAYS) SP HD
SIMLANDI(CF) 80 MG/0.8 ML SYRG	T2	PA QL(2 PENS/SYRINGES/28 DAYS) SP HD
SIMLANDI(CF) AI 40 MG/0.4 ML	T2	PA QL SP HD
SIMLANDI(CF) AI 80 MG/0.8 ML	T2	PA QL(2 AUTO-INJS/28 DAYS) SP HD
SIMPONI 100 MG/ML PEN INJECTOR	T2	PA QL(1 PEN/28 DAYS) SP HD
SIMPONI 100 MG/ML SYRINGE	T2	PA QL(1 SYRINGE/28 DAYS) SP HD
SIMPONI 50 MG/0.5 ML PEN INJEC	T3	PA QL(1 PEN/28 DAYS) SP HD
SIMPONI 50 MG/0.5 ML SYRINGE	T3	PA QL(1 SYRINGE/28 DAYS) SP HD
SIMPONI ARIA	T2	PA SP HD
YUFLYMA(CF) 20 MG/0.2 ML SYRNG	T3	PA QL(2 PENS/SYRINGES/28 DAYS) SP
YUFLYMA(CF) 40 MG/0.4 ML SYRNG	T3	PA QL(4 SRNGE KITS/28 DAYS) SP
YUFLYMA(CF) 40MG/0.4ML AUTOINJ	T3	PA QL SP
YUFLYMA(CF) 80MG/0.8ML AUTOINJ	T3	PA QL(2 AUTO-INJS/28 DAYS) SP
YUFLYMA(CF) AI CROHN'S-UC-HS	T3	PA QL(3 PENS/365 DAYS) SP
YUSIMRY(CF) PEN	T3	PA QL(4 PENS/28 DAYS) SP
ANTI-NEOPLASTICS (Cancer)		
ANP - SELECTIVE RETINOID X RECEPTOR AGONISTS (RXR)		
bexarotene 75 mg capsule (Targretin)	T1	PA SP HD CSL
TARGRETIN 75 MG CAPSULE (bexarotene)	T3	PA SP HD CSL
ANTI-NEOPLAST, HISTONE DEACETYLASE (HDAC) INHIBITORS		
ZOLINZA	T2	PA SP HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTI-NEOPLASTICS (Cancer) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTINEOPLASTIC - ALKYLATING AGENTS		
ALKERAN (<i>melphalan</i>)	T3	SP CSL
<i>cyclophosphamide 25 mg capsule</i>	T1	SP HD CSL
<i>cyclophosphamide 50 mg capsule</i>	T1	SP HD CSL
CYCLOPHOSPHAMIDE 50 MG TABLET	T3	PA SP HD CSL
GLEOSTINE	T2	CSL
HYDREA (<i>hydroxyurea</i>)	T3	CSL
<i>hydroxyurea</i> (Hydrea)	T1	CSL
LEUKERAN	T2	CSL
<i>lomustine</i>	T1	CSL
MYLERAN	T2	CSL
<i>temozolomide</i>	T1	PA SP HD CSL
ANTI-NEOPLASTIC - ANTI-ANDROGENIC AGENTS		
<i>abiraterone acetate</i> (Zytiga)	T1	PA CSL
<i>abiraterone acetate 250 mg tab</i> (Zytiga)	T1	PA HD CSL
<i>abiraterone acetate 250 mg tab</i> (Zytiga)	T1	PA SP HD CSL
<i>abiraterone acetate 500 mg tab</i> (Zytiga)	T1	PA SP HD CSL
<i>bicalutamide</i> (Casodex)	T1	CSL
CASODEX (<i>bicalutamide</i>)	T3	CSL
EULEXIN (<i>flutamide</i>)	T3	CSL
<i>flutamide</i> (Eulexin)	T1	CSL
NILANDRON (<i>nilutamide</i>)	T3	PA QL(4 TABS/DAY) CSL
<i>nilutamide</i> (Nilandron)	T1	QL(4 TABS/DAY) CSL
NUBEQA	T2	PA SP HD CSL
XTANDI	T2	PA SP HD CSL
YONSA	T3	PA SP HD CSL
ZYTIGA (<i>abiraterone acetate</i>)	T3	PA SP HD CSL
ANTI-NEOPLASTIC - ANTI-METABOLITES		
<i>capecitabine 150 mg tablet</i> (Xeloda)	T1	PA HD CSL
<i>capecitabine 150 mg tablet</i> (Xeloda)	T1	PA SP HD CSL
<i>capecitabine 500 mg tablet</i> (Xeloda)	T1	PA HD CSL
<i>capecitabine 500 mg tablet</i> (Xeloda)	T1	PA SP HD CSL
INQOVI	T3	PA SP HD CSL
JYLAMVO	T3	CSL
LONSURF	T3	PA SP HD CSL

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTI-NEOPLASTICS (Cancer) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-NEOPLASTIC - ANTI-METABOLITES (cont.)		
<i>mercaptopurine 20 mg/ml suspen (Purixan)</i>	T1	SP CSL
<i>mercaptopurine 50 mg tablet</i>	T1	CSL
<i>methotrexate 2.5 mg tablet</i>	T1	CSL
<i>methotrexate 250 mg/10 ml vial</i>	T1	
<i>methotrexate 50 mg/2 ml vial</i>	T1	
<i>methotrexate sodium/pf</i>	T1	
ONUREG	T3	PA QL (14 TABS/28 DAYS) SP CSL
PURIXAN (<i>mercaptopurine</i>)	T3	SP CSL
TABLOID	T3	CSL
TREXALL	T2	CSL
XATMEP	T3	CSL
XELODA (<i>capecitabine</i>)	T3	PA SP HD CSL
ANTI-NEOPLASTIC - 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
ANTI-NEOPLASTIC - BRAF KINASE INHIBITORS		
BRAFTOVI	T3	PA SP HD CSL
OJEMDA 100 MG TAB (400MG DOSE)	T3	PA QL (1 PACKET/28 Days) SP CSL
OJEMDA 100 MG TAB (500MG DOSE)	T3	PA QL (1 PACKET/28 Days) SP CSL
OJEMDA 100 MG TAB (600MG DOSE)	T3	PA QL (1 PACKET/28 Days) SP CSL
OJEMDA 25 MG/ML ORAL SUSP	T3	PA QL (8 BOTTLES/28 DAYS) SP CSL
TAFINLAR 10 MG TABLET FOR SUSP	T2	PA QL (30 TABS/DAY) SP HD CSL
TAFINLAR 50 MG CAPSULE	T2	PA QL (4 CAPS/DAY) SP HD CSL
TAFINLAR 75 MG CAPSULE	T2	PA QL (4 CAPS/DAY) SP HD CSL
ZELBORAF	T2	PA SP HD CSL
ANTINEOPLASTIC - EGFR AND MET RECEPTOR INHIB, MAB		
RYBRENT	T3	PA SP
ANTI-NEOPLASTIC - HEDGEHOG PATHWAY INHIBITOR		
DAURISMO	T3	PA SP HD CSL
ERIVEDGE	T2	PA SP HD CSL
ODOMZO	T2	PA SP HD CSL

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTI-NEOPLASTICS (Cancer) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-NEOPLASTIC - JANUS KINASE (JAK) INHIBITORS		
JAKAFI	T3	PA QL(2 TABS/DAY) SP HD CSL
ANTI-NEOPLASTIC - KRAS PROTEIN INHIBITOR		
KRAZATI	T3	PA QL(6 TABS/DAY) SP CSL
LUMAKRAS 120 MG TABLET	T3	PA QL(8 TABS/DAY) SP HD CSL
LUMAKRAS 240 MG TABLET	T3	PA QL(4 TABS/DAY) SP HD CSL
LUMAKRAS 320 MG TABLET	T3	PA QL(3 TABS/DAY) SP HD CSL
ANTI-NEOPLASTIC - MEKI AND MEK2 KINASE INHIBITORS		
COTELLIC	T2	PA SP HD CSL
GOMEKLI	T3	PA SP CSL
KOSELUGO 10 MG CAPSULE	T3	PA QL(10 CAPS/DAY) SP CSL
KOSELUGO 25 MG CAPSULE	T3	PA QL(4 CAPS/DAY) SP CSL
KOSELUGO 5 MG SPRINKLE CAPSULE	T3	PA QL(20 CAPS/DAY) SP CSL
KOSELUGO 7.5 MG SPRINKLE CAP	T3	PA QL(12 CAPS/DAY) SP CSL
MEKINIST 0.05 MG/ML SOLUTION	T2	PA QL(40 MLS/DAY) SP HD CSL
MEKINIST 0.5 MG TABLET	T2	PA QL(3 TABS/DAY) SP HD CSL
MEKINIST 2 MG TABLET	T2	PA QL(1 TAB/DAY) SP HD CSL
MEKTOVI	T3	PA QL(6 TABS/DAY) SP HD CSL
ANTI-NEOPLASTIC - MTOR KINASE INHIBITORS		
AFINITOR (<i>everolimus</i>)	T3	PA SP HD
AFINITOR DISPERZ (<i>everolimus</i>)	T3	PA QL(1 TAB/DAY) SP CSL
<i>everolimus</i> (Afinitor)	T1	PA QL(1 tab/day) SP HD CSL
<i>everolimus 10 mg tablet</i> (Afinitor)	T1	PA QL(1 TAB/DAY) SP HD CSL
<i>everolimus 2 mg tab for susp</i> (Afinitor Disperz)	T1	PA QL(1 TAB/DAY) SP CSL
<i>everolimus 2.5 mg tablet</i> (Afinitor)	T1	PA QL(1 TAB/DAY) SP HD CSL
<i>everolimus 3 mg tab for susp</i> (Afinitor Disperz)	T1	PA QL(1 TAB/DAY) SP CSL
<i>everolimus 5 mg tab for susp</i> (Afinitor Disperz)	T1	PA QL(1 TAB/DAY) SP CSL
<i>everolimus 5 mg tablet</i> (Afinitor)	T1	PA QL(1 TAB/DAY) SP HD CSL
<i>everolimus 7.5 mg tablet</i> (Afinitor)	T1	PA QL(1 TAB/DAY) SP HD CSL
FYARRO	T3	PA SP
ANTI-NEOPLASTIC - PROTEIN METHYLTRANSFERASE INHIBIT		
TAZVERIK	T3	PA SP CSL
ANTINEOPLASTIC - SYSTEMIC ENZYME INHIBITORS COMBS		
AVMAPKI-FAKZYNJA	T3	PA SP CSL

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTI-NEOPLASTICS (Cancer) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-NEOPLASTIC - TOPOISOMERASE I INHIBITORS		
HYCAMTIN	T3	PA SP HD CSL
ANTI-NEOPLASTIC COMB - KINASE AND AROMATASE INHIBIT		
KISQALI FEMARA CO-PACK	T2	PA QL(1 TAB/28 DAYS) SP CSL
ANTI-NEOPLASTIC EGF RECEPTOR BLOCKER MCLON ANTIBODY		
PHESGO	T3	PA SP HD
ANTI-NEOPLASTIC IMMUNOMODULATOR AGENTS		
lenalidomide	T1	PA QL(1 CAP/DAY) SP HD CSL
POMALYST	T2	PA QL(21 CAPS/28 DAYS) SP HD CSL
REVLIMID	T2	PA QL(1 CAP/DAY) SP HD CSL
ANTI-NEOPLASTIC LHRH (GNRH) AGONIST, PITUITARY SUPPR.		
<i>leuprolide acetate</i>	T1	PA SP HD
LEUPROLIDE DEPOT	T3	PA SP
LUPRON DEPOT 22.5 MG 3MO KIT	T3	PA SP HD
LUPRON DEPOT 45 MG 6MO KIT	T3	PA SP HD
LUPRON DEPOT 7.5 MG KIT	T3	PA SP HD
LUPRON DEPOT-4 MONTH KIT	T3	PA SP HD
LUPRON DEPOT	T3	PA SP
ZOLADEX	T2	PA SP HD
ANTI-NEOPLASTIC LHRH (GNRH) ANTAGONIST, PITUIT.SUPPRS		
FIRMAGON	T3	PA SP HD
ORGOVYX	T3	PA SP CSL
ANTI-NEOPLASTIC SYSTEMIC ENZYME INHIBITORS		
ALECENSA	T2	PA QL(8 CAPS/DAY) SP HD CSL
ALUNBRIG 180 MG TABLET	T2	PA QL(1 TAB/DAY) SP CSL
ALUNBRIG 30 MG TABLET	T2	PA QL(2 TABS/DAY) SP CSL
ALUNBRIG 90 MG TABLET	T2	PA QL(1 TAB/DAY) SP CSL
ALUNBRIG 90 MG-180 MG TAB PACK	T2	PA QL(1 TAB/DAY) SP CSL
AUGTYRO 160 MG CAPSULE	T3	PA QL(2 CAPS/DAY) SP CSL
AUGTYRO 40 MG CAPSULE	T3	PA QL(8 CAPS/DAY) SP CSL
AYVAKIT	T3	PA QL(1 TAB/DAY) SP CSL
BALVERSA	T3	PA SP CSL
BOSULIF 100 MG CAPSULE	T3	PA QL(3 CAPS/DAY) SP HD CSL
BOSULIF 100 MG TABLET	T3	PA QL(3 TABS/DAY) SP HD CSL

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTI-NEOPLASTICS (Cancer) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-NEOPLASTIC SYSTEMIC ENZYME INHIBITORS		
BOSULIF 400 MG TABLET	T3	PA QL(1 TAB/DAY) SP HD CSL
BOSULIF 50 MG CAPSULE	T3	PA QL(3 CAPS/DAY) SP HD CSL
BOSULIF 500 MG TABLET	T3	PA QL(1 TAB/DAY) SP HD CSL
BRUKINSA 160 MG TABLET	T2	PA QL(2 TABS/DAY) SP CSL
BRUKINSA 80 MG CAPSULE	T2	PA QL(4 CAPS/DAY) SP CSL
CABOMETYX	T2	PA SP HD CSL
CALQUENCE	T2	PA SP CSL
CAPRELSA 100 MG TABLET	T3	PA QL(2 TABS/DAY) SP CSL
CAPRELSA 300 MG TABLET	T3	PA QL(1 TAB/DAY) SP CSL
COMETRIQ 100 MG DAILY-DOSE PK	T3	PA QL(56 CAPS/28 DAYS) SP HD CSL
COMETRIQ 140 MG DAILY-DOSE PK	T3	PA QL(112 CAPS/28 DAYS) SP HD CSL
COMETRIQ 60 MG DAILY-DOSE PACK	T3	PA QL(84 CAPS/28 DAYS) SP HD CSL
COPIKTRA	T3	PA SP CSL
DANZITEN	T2	PA SP CSL
<i>dasatinib 100 mg tablet (Sprycel)</i>	T1	QL(1 TAB/DAY) SP CSL
<i>dasatinib 100 mg tablet (Sprycel)</i>	T1	QL(1 TAB/DAY) SP HD CSL
<i>dasatinib 140 mg tablet (Sprycel)</i>	T1	QL(1 TAB/DAY) SP CSL
<i>dasatinib 140 mg tablet (Sprycel)</i>	T1	QL(1 TAB/DAY) SP HD CSL
<i>dasatinib 20 mg tablet (Sprycel)</i>	T1	QL(3 TABS/DAY) SP CSL
<i>dasatinib 20 mg tablet (Sprycel)</i>	T1	QL(3 TABS/DAY) SP HD CSL
<i>dasatinib 50 mg tablet (Sprycel)</i>	T1	QL(1 TAB/DAY) SP CSL
<i>dasatinib 50 mg tablet (Sprycel)</i>	T1	QL(1 TAB/DAY) SP HD CSL
<i>dasatinib 70 mg tablet (Sprycel)</i>	T1	QL(2 TABS/DAY) SP CSL
<i>dasatinib 70 mg tablet (Sprycel)</i>	T1	QL(2 TABS/DAY) SP HD CSL
<i>dasatinib 80 mg tablet (Sprycel)</i>	T1	QL(1 TAB/DAY) SP CSL
<i>dasatinib 80 mg tablet (Sprycel)</i>	T1	QL(1 TAB/DAY) SP HD CSL
ENSACOVE 25 MG CAPSULE	T2	PA QL(9 CAPS/DAY) SP CSL
ENSACOVE 100 MG CAPSULE	T2	PA QL(2 CAPS/DAY) SP CSL
<i>erlotinib hcl</i>	T1	PA SP HD CSL
FOTIVDA	T3	PA QL(21 CAPS/28 DAYS) SP CSL
FRUZAQLA 1 MG CAPSULE	T2	PA QL(84 CAPS/28 DAYS) SP CSL
FRUZAQLA 5 MG CAPSULE	T2	PA QL(21 CAPS/28 DAYS) SP CSL
GAVRETO	T3	PA QL(4 CAPS/DAY) SP CSL
gefitinib (<i>Iressa</i>)	T1	PA SP HD CSL

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTI-NEOPLASTICS (Cancer) (cont.)

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

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTI-NEOPLASTICS (Cancer) (cont.)

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

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTI-NEOPLASTICS (Cancer) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-NEOPLASTIC SYSTEMIC ENZYME INHIBITORS (cont.)		
SPRYCEL 140 MG TABLET (<i>dasatinib</i>)	T3	PA QL(1 TAB/DAY) SP HD CSL
SPRYCEL 20 MG TABLET (<i>dasatinib</i>)	T3	PA QL(3 TABS/DAY) SP HD CSL
SPRYCEL 50 MG TABLET (<i>dasatinib</i>)	T3	PA QL(1 TAB/DAY) SP HD CSL
SPRYCEL 70 MG TABLET (<i>dasatinib</i>)	T3	PA QL(2 TABS/DAY) SP HD CSL
SPRYCEL 80 MG TABLET (<i>dasatinib</i>)	T3	PA QL(1 TAB/DAY) SP HD CSL
STIVARGA	T2	PA QL(84 TABS/28 DAYS) SP HD CSL
<i>sunitinib malate</i> (Sutent)	T1	PA QL(1 CAP/DAY) SP HD CSL
SUTENT (<i>sunitinib malate</i>)	T3	PA QL(1 CAP/DAY) SP HD CSL
TABRECTA	T3	PA QL(4 TABS/DAY) SP HD CSL
TAGRISSO	T3	PA SP HD CSL
TALZENNA 0.1 MG CAPSULE	T3	PA QL(1 CAP/DAY) SP CSL
TALZENNA 0.1 MG SOFTGEL	T3	PA QL(1 CAP/DAY) SP CSL
TALZENNA 0.25 MG CAPSULE	T3	PA QL(1 CAP/DAY) SP CSL
TALZENNA 0.25 MG SOFTGEL	T3	PA QL(1 CAP/DAY) SP CSL
TALZENNA 0.35 MG SOFTGEL	T3	PA QL(1 CAP/DAY) SP CSL
TALZENNA 0.5 MG CAPSULE	T3	PA SP CSL
TALZENNA 0.5 MG SOFTGEL	T3	PA SP CSL
TALZENNA 0.75 MG SOFTGEL	T3	PA SP CSL
TALZENNA 1 MG CAPSULE	T3	PA QL(1 CAP/DAY) SP CSL
TALZENNA 1 MG SOFTGEL	T3	PA QL(1 CAP/DAY) SP CSL
TASIGNA (<i>nilotinib hcl</i>)	T3	PA QL(4 CAPS/DAY) SP HD CSL
TEPMETKO	T3	PA QL(2 TABS/DAY) SP CSL
TRUQAP	T2	PA QL(64 TABS/28 DAYS) SP CSL
TUKYSA	T3	PA SP CSL
TURALIO	T3	PA QL(4 CAPS/DAY) SP CSL
TYKERB (<i>lapatinib ditosylate</i>)	T3	PA QL(6 TABS/DAY) SP HD CSL
UKONIQ	T3	PA QL (4 tabs/day) SP
VANFLYTA	T3	PA QL(2 TABS/DAY) SP CSL
VERZENIO	T2	PA QL(2 TABS/DAY) SP HD CSL
VITRAKVI	T3	PA SP HD CSL
VIZIMPRO	T3	PA SP HD CSL
VONJO	T3	PA QL(4 CAPS/DAY) SP CSL
VOTRIENT (<i>pazopanib hcl</i>)	T3	PA QL(4 TABS/DAY) SP HD CSL
XALKORI 150 MG PELLET	T3	PA QL(6 PELLETS/DAY) SP HD CSL

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTI-NEOPLASTICS (Cancer) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-NEOPLASTIC SYSTEMIC ENZYME INHIBITORS (cont.)		
XALKORI 20 MG PELLET	T3	PA QL(4 PELLETS/DAY) SP HD CSL
XALKORI 200 MG CAPSULE	T3	PA QL(4 CAPS/DAY) SP HD CSL
XALKORI 250 MG CAPSULE	T3	PA QL(4 CAPS/DAY) SP HD CSL
XALKORI 50 MG PELLET	T3	PA QL(4 PELLETS/DAY) SP HD CSL
XOSPATA	T3	PA SP CSL
ZEJULA	T2	PA QL(1 TAB/DAY) SP CSL
ZYDELIG	T3	PA QL(2 TABS/DAY) SP HD CSL
ZYKADIA	T3	PA QL(3 TABS/DAY) SP HD CSL
ANTI-NEOPLASTIC, ANTI-PROGRAMMED DEATH-1 (PD-1) MAB		
LIBTAYO	T2	PA SP
OPDIVO	T3	PA SP HD
ANTI-NEOPLASTIC-B CELL LYMPHOMA-2(BCL-2) INHIBITORS		
VENCLEXTA	T2	PA SP CSL
VENCLEXTA STARTING PACK	T2	PA SP CSL
ANTINEOPLASTIC-ENZYME INHIB, ANTIANDROGEN COMB.		
AKEEGA	T3	PA QL(2 TABS/DAY) SP CSL
ANTINEOPLASTIC-HYPOXIA INDUCIBLE FACTOR (HIF) INH		
WELIREG	T3	PA QL(3 TABS/DAY) SP CSL
ANTINEOPLASTIC-IMMUNOTHERAPY CHECKPOINT INHIB COMB		
OPDUALAG	T3	PA SP HD
ANTI-NEOPLASTIC-ISOCITRATE DEHYDROGENASE INHIBITORS		
IDHIFA	T3	PA SP HD CSL
REZLIDHIA	T3	PA QL(2 CAPS/DAY) SP CSL
TIBSOVO	T3	PA SP CSL
VORANIGO	T3	PA SP CSL
ANTI-NEOPLASTICS ANTIBODY/ANTIBODY-DRUG COMPLEXES		
ENHERTU	T3	PA SP HD
TIVDAK	T3	PA SP HD
VYLOY	T3	PA SP
ANTI-NEOPLASTICS, MISCELLANEOUS		
<i>etoposide</i>	T1	SP HD CSL
LYSODREN	T2	CSL
MATULANE	T2	SP CSL
<i>tretinoin 10 mg capsule</i>	T1	PA CSL

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTI-NEOPLASTICS (Cancer) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-NEOPLASTIC-SELECT INHIB OF NUCLEAR EXP (SINE)		
XPOVIO	T3	PA SP CSL
CYTOTOXIC T-LYMPHOCYTE ANTIGEN (CTLA-4) RMC ANTIBODY		
YERVOY	T3	PA SP HD
IMMUNOMODULATORS		
ACTIMMUNE	T2	PA SP HD
BESREMI	T3	PA QL(2 SYRINGES/28 DAYS) SP
SELECTIVE ESTROGEN RECEPTOR MODULATORS (SERMS)		
FARESTON (<i>toremifene citrate</i>)	T3	QL(2 TABS/DAY) HD CSL
ORSERDU 345 MG TABLET	T3	PA QL(1 TAB/DAY) SP CSL
ORSERDU 86 MG TABLET	T3	PA QL(3 TABS/DAY) SP CSL
SOLTAMOX	T3	HD CSL
<i>tamoxifen citrate</i>	T1	HD PPACA CSL
<i>toremifene citrate</i> (Fareston)	T1	QL(2 TABS/DAY) HD CSL
STEROID ANTI-NEOPLASTICS		
<i>megestrol 20 mg tablet</i>	T1	CSL
<i>megestrol 40 mg tablet</i>	T1	CSL
ANTI-NEOPLASTICS (Skin Conditions)		
PHOTOACT, TOPICAL ANTI-NEOPLAST, PREMALIGNANT LESIONS		
LEVULAN	T3	SP
TOPICAL ANTI-NEOPLASTIC PREMALIGNANT LESION AGENTS		
<i>bexarotene 1% gel</i> (Targretin)	T1	SP HD
CARAC	T3	PA
<i>diclofenac sodium 3% gel</i>	T1	PA
EFUDEX (<i>fluorouracil</i>)	T3	
FLUOROPLEX	T2	
<i>fluorouracil</i>	T1	
FLUOROURACIL	T1	
<i>fluorouracil</i> (Efudex)	T1	
KLISYRI	T3	PA QL(5 PACKS/30 DAYS)
PANRETIN	T3	SP HD
TARGRETIN 1% GEL (<i>bexarotene</i>)	T3	PA SP HD
VALCHLOR	T3	SP HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTI-OBESITY DRUGS (Weight Management)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-OBESITY - ANOREXIC AGENTS		
<i>benzphetamine hcl</i>	T1	
<i>diethylpropion hcl</i>	T1	
LOMAIRA	T3	PA
<i>phendimetrazine tartrate</i>	T1	
<i>phentermine 15 mg capsule</i>	T1	
<i>phentermine 30 mg capsule</i>	T1	
<i>phentermine 37.5 mg capsule</i>	T1	
<i>phentermine 37.5 mg tablet</i>	T1	
<i>phentermine 8 mg tablet</i>	T1	PA
<i>phentermine/topiramate (Qsymia)</i>	T1	
QSYMIA (<i>phentermine/topiramate</i>)	T3	PA
ANTI-OBESITY - INCRETIN MIMETICS COMBINATION		
ZEPBOUND 2.5 MG/0.5 ML PEN	T2	PA QL(2 MLS/365 DAYS)
ZEPBOUND 10 MG/0.5 ML PEN	T2	PA QL(2 MLS/30 DAYS)
ZEPBOUND 7.5 MG/0.5 ML PEN	T3	PA QL(9 MLS/30 DAYS) SP
ZEPBOUND 10 MG/0.5 ML PEN	T2	PA QL(2 MLS/30 DAYS)
ZEPBOUND 12.5 MG/0.5 ML PEN	T2	PA QL(2 MLS/30 DAYS)
ZEPBOUND 15 MG/0.5 ML PEN	T2	PA QL(2 MLS/30 DAYS)
ANTI-OBESITY - MELANOCORTIN 4 RECEPTOR AGONISTS		
IMCIVREE	T3	PA QL(9 MLS/30 DAYS) SP
ANTI-OBESITY GLUCAGON-LIKE PEPTIDE-1 RECEPTOR AGONIST		
<i>liraglutide 18 mg/3 ml pen (Saxenda)</i>	T1	PA
<i>liraglutide 5-pak 18 mg/3 ml (Saxenda)</i>	T1	PA
SAXENDA	T3	PA
WEGOVY	T2	PA QL(4 PENS/28 DAYS)
ANTI-OBESITY - OPIOID ANTAG-NOREPI, DOPAMINE RECEPTOR INHIB		
CONTRAVE	T3	PA
FAT ABSORPTION DECREASING AGENTS		
ORLISTAT	T3	PA
XENICAL	T3	PA
ANTIPARASITICS (Eye Conditions)		
OPHTHALMIC (EYE) ANTIPARASITICS		
XDEMVY	T2	PA QL(10 MLS/56 DAYS) SP

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTI-PARASITICS (Infections)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-PARASITICS		
ALINIA 100 MG/5 ML SUSPENSION	T3	
ALINIA 500 MG TABLET (<i>nitazoxanide</i>)	T3	PA
<i>nitazoxanide</i> (Alinia)	T1	
TOPICAL ANTI-PARASITICS		
<i>crotamiton</i> (Eurax)	T1	
ELIMITE (<i>permethrin</i>)	T3	
EURAX 10% CREAM	T2	
EURAX 10% LOTION	T3	
<i>lindane</i>	T1	
<i>malathion</i> (Ovide)	T1	
NATROBA (<i>spinosad</i>)	T3	PA
OVIDE (<i>malathion</i>)	T3	
<i>permethrin</i> (Elimite)	T1	
<i>spinosad</i> (Natroba)	T1	
ULESFIA	T3	
ANTIPARASITICS (Skin Conditions)		
TOPICAL ANTIPARASITICS		
<i>lindane</i>	T1	
<i>malathion</i> (Ovide)	T1	
OVIDE (<i>malathion</i>)	T3	
ANTI-PARKINSON DRUGS (Parkinson's Disease)		
ANTI-PARKINSONISM DRUGS, ANTI-CHOLINERGIC		
<i>benztropine mesylate</i>	T1	HD
<i>trihexyphenidyl hcl</i>	T1	HD
ANTI-PARKINSONISM DRUGS, OTHER		
<i>amantadine hcl</i>	T1	HD
APOKYN	T3	PA SP HD
<i>apomorphine hcl</i>	T1	PA SP
AZILECT 0.5 MG TABLET (<i>rasagiline mesylate</i>)	T3	PA QL(1 TAB/DAY) HD
AZILECT 1 MG TABLET (<i>rasagiline mesylate</i>)	T3	PA HD
<i>bromocriptine mesylate</i>	T1	HD
<i>carbidopa/levodopa</i> (Sinemet)	T1	HD
<i>carbidopa/levodopa/entacapone</i>	T1	HD
<i>carbidopa/levodopa/entacapone</i> (Stalevo 75)	T1	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-PARKINSONISM DRUGS, OTHER (cont.)		
<i>carbidopa/levodopa/entacapone</i> (Stalevo 100)	T1	HD
<i>carbidopa-levo er 25-100 tab</i>	T1	HD
<i>carbidopa-levo er 50-200 tab</i>	T1	HD
CREXONT	T3	ST HD
DHIVY	T3	PA HD
DUOPA	T3	SP HD
<i>entacapone</i>	T1	HD
GOCOVRI	T3	
INBRIJA	T3	PA SP HD
NEUPRO	T3	HD
NOURIANZ	T3	PA QL(1 TAB/DAY) SP HD
ONAPGO	T3	PA QL(20 MLS/DAY) SP
ONGENTYS	T3	PA QL(1 CAP/DAY) HD
<i>pramipexole di-hcl</i>	T1	HD
<i>pramipexole er 0.375 mg tablet</i>	T1	QL(1 TAB/DAY) HD
<i>pramipexole er 0.75 mg tablet</i>	T1	HD
<i>pramipexole er 1.5 mg tablet</i>	T1	QL(1 TAB/DAY) HD
<i>pramipexole er 2.25 mg tablet</i>	T1	QL(1 TAB/DAY) HD
<i>pramipexole er 3 mg tablet</i>	T1	HD
<i>pramipexole er 3.75 mg tablet</i>	T1	HD
<i>pramipexole er 4.5 mg tablet</i>	T1	HD
<i>rasagiline mesylate 0.5 mg tab</i> (Azilect)	T1	QL(1 TAB/DAY) HD
<i>rasagiline mesylate 1 mg tab</i> (Azilect)	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</i> (Tasmar)	T1	HD
XADAGO	T3	ST HD
VYALEV	T3	PA SP HD
ZELAPAR	T3	PA HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
------------------------	-----------	----------------------------------

DECARBOXYLASE INHIBITORS

<i>carbidopa</i> (Lodosyn)	T1	
LODOSYN (<i>carbidopa</i>)	T3	PA

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

PLATELET AGGREGATION INHIBITORS

<i>aspirin/dipyridamole</i>	T1	HD
ASPIRIN-OMEPRazole	T3	PA HD
BRILINTA (<i>ticagrelor</i>)	T3	PA HD
<i>cilostazol</i>	T1	HD
<i>clopidogrel bisulfate</i>	T1	HD
<i>clopidogrel bisulfate</i> (Plavix)	T1	HD
<i>dipyridamole</i>	T1	HD
EFFIENT (<i>prasugrel hcl</i>)	T3	PA HD
PLAVIX (<i>clopidogrel</i>)	T3	PA HD
<i>prasugrel hcl</i> (Effient)	T1	HD
<i>ticagrelor</i> (Brilinta)	T1	HD
YOSPRALA DR 325-40 MG TABLET	T3	PA
YOSPRALA DR 81-40 MG TABLET	T3	PA HD
ZONTIVITY	T3	HD

PLATELET REDUCING AGENTS

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

ANTIVIRALS (AIDS/HIV)

ANTI-RETROVIRAL - CAPSID INHIBITORS

SUNLENCA 300 MG TABLET	T3	PA QL(5 TABS/180 DAYS) SP
SUNLENCA 4- 300 MG TABLET	T3	PA QL(5 TABS/180 DAYS) SP
SUNLENCA 463.5 MG/1.5 ML VIAL	T3	PA SP
SUNLENCA 5- 300 MG TABLET	T3	PA QL(5 TABS/180 DAYS) SP

ANTIRETROVIRAL - CAPSID INHIBITORS (PREP)

YEZTUGO 463.5 MG/1.5 ML VIAL	T2	SP PPACA
------------------------------	----	----------

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTIVIRALS (AIDS/HIV) (cont.)

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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTIVIRALS (AIDS/HIV) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ARTV NUCLEOSIDE, NUCLEOTIDE, NON-NUCLEOSIDE RTI COMB (cont.)		
<i>efavirenz/lamivu/tenofovir disop (Symfi Lo)</i>	T1	QL(1 TAB/DAY) SP
<i>efavirenz/lamivu/tenofovir disop (Symfi)</i>	T1	QL(1 TAB/DAY) SP
ODEFSEY	T3	PA QL(1 TAB/DAY) SP
SYMFI (<i>efavirenz-lamivu-tenofovir disop</i>)	T3	PA QL(1 TAB/DAY) SP
SYMFI LO (<i>efavirenz-lamivu-tenofovir disop</i>)	T3	PA QL(1 TAB/DAY) SP
ARV-NUCLEOSIDE, NUCLEOTIDE RTI, INTEGRASE INHIBITORS		
BIKTARVY	T2	QL(1 TAB/DAY) SP
GENVOYA	T2	QL(1 TAB/DAY) SP
STRIBILD	T3	PA QL(1 TAB/DAY) SP
ANTIVIRALS (Eye Conditions)		
EYE ANTIVIRALS		
<i>trifluridine</i>	T1	
ZIRGAN	T3	
ANTIVIRALS (Infections)		
ANTIVIRAL - MAIN PROTEASE (MPRO) INHIBITOR		
PAXLOVID	T2	QL(1 TAB/120 DAYS)
ANTIVIRAL - RNA POLYMERASE INHIBITOR		
LAGEVRIO (EUA)	T2	QL(1 PACK/120 DAYS)
ANTIVIRAL MONOCLONAL ANTIBODIES		
BEYFORTUS	T3	PPACA
ANTIVIRALS, GENERAL		
<i>acyclovir 200 mg capsule</i>	T1	
<i>acyclovir 200 mg/5 ml susp</i>	T1	
<i>acyclovir 200 mg/5 ml susp cup</i>	T1	
<i>acyclovir 400 mg tablet</i>	T1	
<i>acyclovir 800 mg tablet</i>	T1	
<i>acyclovir 800 mg/20ml susp cup</i>	T1	
<i>famciclovir</i>	T1	
FLUMADINE (<i>rimantadine hcl</i>)	T3	
LIVTENCITY	T3	PA QL(4 TABS/DAY) SP
<i>oseltamivir 6 mg/ml suspension (Tamiflu)</i>	T1	QL(180 MLS/30 DAYS)
<i>oseltamivir phos 30 mg capsule (Tamiflu)</i>	T1	QL(20 CAPS/30 DAYS)
<i>oseltamivir phos 45 mg capsule (Tamiflu)</i>	T1	QL(10 CAPS/30 DAYS)

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTIVIRALS (Infections) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIVIRALS, GENERAL (cont.)		
<i>oseltamivir phos 75 mg capsule</i> (Tamiflu)	T1	QL(10 CAPS/30 DAYS)
PREVMIS 20 MG PELLET PACKET	T3	SP
PREVMIS 120 MG PELLET PACKET	T3	SP
PREVMIS 240 MG TABLET	T3	SP HD
PREVMIS 480 MG TABLET	T3	SP HD
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 (<i>oseltamivir phosphate</i>)	T3	QL(20 CAPS/30 DAYS)
TAMIFLU 45 MG CAPSULE (<i>oseltamivir phosphate</i>)	T3	QL(10 CAPS/30 DAYS)
TAMIFLU 6 MG/ML SUSPENSION (<i>oseltamivir phosphate</i>)	T3	QL(180 MLS/30 DAYS)
TAMIFLU 75 MG CAPSULE (<i>oseltamivir phosphate</i>)	T3	QL(10 CAPS/30 DAYS)
TEMBEXA	T3	
<i>valacyclovir hcl</i> (Valtrex)	T1	
VALCYTE (<i>valganciclovir hcl</i>)	T3	PA
<i>valganciclovir hcl</i> (Valcyte)	T1	
VALTREX (<i>valacyclovir hcl</i>)	T3	
XOFLUZA	T3	QL(2 TABS/30 DAYS)
HEP C - NS5A, NS3/4A, NUCLEOTIDE NS5B INHIB COMBO		
VOSEVI	T2	PA QL(1 TAB/DAY) SP HD
HEP C VIRUS, NUCLEOTIDE ANALOG NS5B POLYMERASE INH		
SOVALDI 200 MG TABLET	T3	PA QL(1 TAB/DAY) SP HD
SOVALDI 400 MG TABLET	T3	PA QL(1 TAB/DAY) SP HD
SOVALDI 150 MG, 200 MG PELLET PACKET	T3	PA QL(1 PACK/DAY) SP HD
HEP C VIRUS-NS5B POLYMERASE AND NS5A INHIB. COMBO.		
EPCLUSA 150-37.5 MG PELLET PKT	T2	PA QL(1 PACK/DAY) SP HD
EPCLUSA 200 MG-50 MG TABLET	T2	PA QL(1 TAB/DAY) SP HD
EPCLUSA 200 MG-50 MG TABLET	T2	PA QL(1 PACK/DAY) SP HD
EPCLUSA 400 MG-100 MG TABLET	T2	PA QL(1 TAB/DAY) SP HD
HARVONI 33.75-150 MG PELLET PK	T2	PA QL(1 PACK/DAY) SP HD
HARVONI 45-200 MG PELLET PACKET	T2	PA QL(1 PACK/DAY) SP HD
HARVONI 45-200 MG TABLET	T2	PA QL(1 TAB/DAY) SP HD
HARVONI 90-400 MG TABLET	T2	PA QL(1 TAB/DAY) SP HD
LEDIPASVIR-SOFOSBUVIR	T3	PA QL(1 TAB/DAY) SP HD
SOFOSBUVIR-VELPATASVIR	T3	PA QL(1 TAB/DAY) SP HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTIVIRALS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HEPATITIS B TREATMENT AGENTS		
<i>adefovir dipivoxil</i>	T1	SP HD
BARACLUDE 0.05 MG/ML SOLUTION	T2	SP HD
BARACLUDE 0.5 MG TABLET (<i>entecavir</i>)	T3	PA QL(1 TAB/DAY) SP HD
BARACLUDE 1 MG TABLET (<i>entecavir</i>)	T3	PA SP HD
<i>entecavir 0.5 mg tablet</i> (Baraclude)	T1	QL(1 TAB/DAY) SP HD
<i>entecavir 1 mg tablet</i> (Baraclude)	T1	SP HD
<i>lamivudine</i>	T1	SP
VELMIDY	T2	SP HD
HEPATITIS C TREATMENT AGENTS		
PEGASYS	T2	PA SP HD
<i>ribavirin</i>	T1	SP HD
HEPATITIS C VIRUS- NS5A AND NS3/4A INHIBITOR COMB		
MAVYRET 100-40 MG TABLET	T3	PA QL(3 TABS/DAY) SP HD
MAVYRET 50-20 MG PELLETT PACKET	T3	PA QL(5 PACKS/DAY) SP HD
ZEPATIER	T2	PA QL(1 TAB/DAY) SP HD
ANTIVIRALS (Skin Conditions)		
TOPICAL ANTIVIRAL AND ANTI-INFLAMMATORY STEROID		
XERESE	T3	PA QL (5gm/30 days)
TOPICAL ANTIVIRALS		
<i>acyclovir 5% cream</i> (Zovirax)	T1	PA QL(5 GMS/30 DAYS)
<i>acyclovir 5% ointment</i> (Zovirax)	T1	PA QL(15 GMS/30 DAYS)
DENAVIR (<i>penciclovir</i>)	T3	QL(5 GMS/30 DAYS)
<i>penciclovir</i> (Denavir)	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 GENITAL WART-HPV TREATMENT AGENTS		
VEREGEN	T3	PA
AUTONOMIC DRUGS (Allergy/Nasal Sprays)		
ANAPHYLAXIS THERAPY AGENTS		
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</i> (Epipen Jr 2-Pak)	T1	QL(4 UNITS/30 DAYS)
<i>epinephrine 0.15 mg auto-inject</i> (Epipen Jr)	T1	QL(4 UNITS/30 DAYS)

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

AUTONOMIC DRUGS (Allergy/Nasal Sprays) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANAPHYLAXIS THERAPY AGENTS (cont.)		
EPINEPHRINE 0.3 MG AUTO-INJECT	T3	PA QL(4 UNITS/30 DAYS)
<i>epinephrine 0.3 mg auto-inject</i> (Epipen 2-Pak)	T1	QL(4 UNITS/30 DAYS)
<i>epinephrine 0.3 mg auto-inject</i> (Epipen)	T1	QL(4 UNITS/30 DAYS)
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
<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	HD
<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> (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-amphet er</i>)	T3	PA ST QL(1 CAP/DAY)
ADZENYS XR-ODT	T3	PA QL(1 TAB/DAY)

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ADRENERGICS, AROMATIC, NON-CATECHOLAMINE (cont.)		
<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
<i>dextroamphetamine sulfate</i>	T3	PA ST
<i>dextroamphetamine sulfate</i> (Zenzedi)	T1	PA
<i>dextroamphetamine/amphetamine</i> (Adderall Xr)	T1	PA QL(1 CAP/DAY)
<i>dextroamphetamine/amphetamine</i> (Adderall)	T1	PA
<i>dextroamphetamine/amphetamine</i> (Mydayis)	T1	PA QL(1 CAP/DAY)
DYANAVAL XR 10 MG TABLET	T3	PA QL(1 TAB/DAY)
DYANAVAL XR 15 MG TABLET	T3	PA QL(1 TAB/DAY)
DYANAVAL XR 2.5 MG/ML SUSP	T3	PA QL(8 MLS/DAY)
DYANAVAL XR 20 MG TABLET	T3	PA QL(1 TAB/DAY)
DYANAVAL XR 5 MG TABLET	T3	PA QL(1 TAB/DAY)
EVEKEO (<i>amphetamine sulfate</i>)	T3	PA
EVEKEO ODT	T3	PA
<i>methamphetamine hcl</i> (Desoxyn)	T1	PA
MYDAYIS (<i>dextroamphetamine/amphetamine</i>)	T3	PA QL(1 CAP/DAY)
XELSTRYM	T3	PA QL(1 PATCH/DAY)
ZENZEDI	T3	PA ST
ZENZEDI (<i>dextroamphetamine sulfate</i>)	T3	PA ST
AUTONOMIC DRUGS (Blood Pressure/Heart Medications)		
ADRENERGIC VASOPRESSOR AGENTS		
<i>droxidopa 100 mg capsule</i> (Northera)	T1	SP HD
<i>droxidopa 200 mg capsule</i> (Northera)	T1	SP HD
<i>droxidopa 300 mg capsule</i> (Northera)	T1	SP HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ADRENERGIC VASOPRESSOR AGENTS (cont.)		
<i>midodrine hcl</i>	T1	
NORTHERA (<i>droxidopa</i>)	T3	PA SP HD
ALPHA-ADRENERGIC BLOCKING AGENTS		
DIBENZYLINE (<i>phenoxybenzamine hcl</i>)	T3	HD
<i>phenoxybenzamine hcl</i> (Dibenzylamine)	T1	HD

AUTONOMIC DRUGS (Urinary Tract Conditions)

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

BIOLOGICALS (Allergy/Nasal Sprays)

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

BIOLOGICALS (Blood Pressure/Heart Medications)

PLASMA KALLIKREIN INHIBITORS		
TAKHZYRO	T3	PA SP HD

BIOLOGICALS (Miscellaneous)

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

BIOLOGICALS (Vaccines)

COVID-19 VACCINES		
COMIRNATY	T2	PPACA
COMIRNATY 2023-2024	T2	PPACA
COMIRNATY 2024-2025	T2	PPACA
COMIRNATY 2025-2026 (12Y UP)	T2	PPACA

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

BIOLOGICALS (Vaccines) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
COVID-19 VACCINES (cont.)		
COMIRNATY 2025-2026(5-11Y)	T2	PPACA
JANSSEN COVID-19 VACCINE (EUA)	T2	PPACA
MNEXSPIKE 2025-2026 (12Y UP)	T2	PPACA
MODERNA COVID (12Y UP)VAC(EUA)	T2	PPACA
MODERNA COVID 23-24(6M-11Y)EUA	T2	PPACA
MODERNA COVID 24-25(6M-11Y)EUA	T2	PPACA
MODERNA COVID BIVAL(6MO UP)EUA	T2	PPACA
MODERNA COVID BIVAL(6MO-5Y)EUA	T2	PPACA
MODERNA COVID(6M-5Y) VACC(EUA)	T2	PPACA
MODERNA COVID-19 BOOSTER (EUA)	T2	PPACA
NOVAVAX COVID 2023-2024 (EUA)	T2	PPACA
NOVAVAX COVID 2024-2025 (EUA)	T2	PPACA
NOVAVAX COVID-19 VACC,ADJ(EUA)	T2	PPACA
NUVAXOVID 2025-2026	T2	PPACA
PFIZER COVID (12Y UP) VAC(EUA)	T2	PPACA
PFIZER COVID (5-11Y) VAC (EUA)	T2	PPACA
PFIZER COVID (6M-4Y) VACC(EUA)	T2	PPACA
PFIZER COVID 2023-24(5-11Y)EUA	T2	PPACA
PFIZER COVID 2023-24(6M-4Y)EUA	T2	PPACA
PFIZER COVID 2024-25(5-11Y)EUA	T2	PPACA
PFIZER COVID 2024-25(6M-4Y)EUA	T2	PPACA
PFIZER COVID BIVAL (12Y UP)EUA	T2	PPACA
PFIZER COVID BIVAL (5-11YR)EUA	T2	PPACA
PFIZER COVID BIVAL (6MO-4Y)EUA	T2	PPACA
PFIZER COVID-19 VACCINE (EUA)	T2	PPACA
SPIKEVAX 2023-2024	T2	PPACA
SPIKEVAX 2024-2025	T2	PPACA
SPIKEVAX 2025-2026 (12Y UP)	T2	PPACA
SPIKEVAX 2025-2026 (6M-11Y)	T2	PPACA
SPIKEVAX COVID (18Y UP) VACC	T2	PPACA
ENTERIC VIRUS VACCINES		
IPOLE	T2	PPACA
ROTARIX	T3	PPACA
ROTATEQ	T3	PPACA

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

BIOLOGICALS (Vaccines) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GRAM NEGATIVE COCCI VACCINES		
BEXSERO	T2	PPACA
MENACTRA	T2	
MENQUADFI	T2	PPACA
MENVEO A-C-Y-W-135-DIP	T2	PPACA
PENBRAYA	T2	PPACA
PENMENVY MEN A-B-C-W-Y	T2	PPACA
TRUMENBA	T2	PPACA
GRAM POSITIVE COCCI VACCINES		
CAPVAXIVE	T2	PPACA
PNEUMOVAX 23	T2	PPACA
PREVNAR 13	T2	
PREVNAR 20	T2	PPACA
VAXNEUVANCE	T2	PPACA
INFLUENZA VIRUS VACCINES		
AFLURIA 2025-2026	T2	
AFLURIA 2025-2026 (3YR UP)	T2	PPACA
AFLURIA QUAD 2022-2023	T2	PPACA
AFLURIA QUAD 2022-23 (3YR UP)	T2	PPACA
AFLURIA QUAD 2023-2024	T2	PPACA
AFLURIA QUAD 2023-24 (3YR UP)	T2	PPACA
AFLURIA TRIV 2024-25 (3YR UP)	T2	PPACA
AFLURIA TRIVALENT 2024-25	T2	PPACA
FLUAD 2025-2026	T2	PPACA
FLUAD QUAD 2022-2023	T2	PPACA
FLUAD QUAD 2023-2024	T2	PPACA
FLUAD TRIVALENT 2024-2025	T2	PPACA
FLUARIX 2025-2026	T2	PPACA
FLUARIX QUAD 2022-2023	T2	PPACA
FLUARIX QUAD 2023-2024	T2	PPACA
FLUARIX TRIVALENT 2024-2025	T2	PPACA
FLUBLOK 2025-2026	T2	PPACA
FLUBLOK QUAD 2022-2023	T2	PPACA
FLUBLOK QUAD 2023-2024	T2	PPACA
FLUBLOK TRIVALENT 2024-2025	T2	PPACA

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

BIOLOGICALS (Vaccines) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
INFLUENZA VIRUS VACCINES (cont.)		
FLUCELVAX 2025-2026 SYRINGE	T2	PPACA
FLUCELVAX 2025-2026 VIAL	T2	
FLUCELVAX QUAD 2022-2023	T2	PPACA
FLUCELVAX QUAD 2023-2024	T2	PPACA
FLUCELVAX TRIVALENT 2024-2025	T2	PPACA
FLULAVAL 2025-2026	T2	PPACA
FLULAVAL QUAD 2022-2023	T2	PPACA
FLULAVAL QUAD 2023-2024	T2	PPACA
FLULAVAL TRIVALENT 2024-2025	T2	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	T2	PPACA
FLUZONE 2025-2026 VIAL	T2	
FLUZONE HIGH-DOSE 2025-2026	T2	PPACA
FLUZONE HIGH-DOSE QUAD 2022-23	T2	PPACA
FLUZONE HIGH-DOSE QUAD 2023-24	T2	PPACA
FLUZONE HIGH-DOSE TRIV 2024-25	T2	PPACA
FLUZONE QUAD 2022-2023	T2	PPACA
FLUZONE QUAD 2023-2024	T2	PPACA
FLUZONE TRIVALENT 2024-2025	T2	PPACA
NEUROTOXIC VIRUS VACCINES		
DENGVAXIA	T2	PPACA
TOXIN-PRODUCING BACILLI VACCINES/TOXOIDS		
BCG VACCINE (TICE STRAIN)	T2	SP
VACCINE/TOXOID PREPARATIONS, COMBINATIONS		
ACTHIB	T2	PPACA
ADACEL TDAP	T2	PPACA
BOOSTRIX TDAP	T2	PPACA
DAPTACEL DTAP	T2	PPACA
DIPHTHERIA-TETANUS TOXOIDS-PED	T2	
HIBERIX	T2	PPACA

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

BIOLOGICALS (Vaccines) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VACCINE/TOXOID PREPARATIONS, COMBINATIONS (cont.)		
INFANRIX DTAP	T2	PPACA
KINRIX	T2	PPACA
M-M-R II VACCINE	T2	PPACA
PEDVAXHIB	T2	PPACA
PENTACEL	T2	PPACA
PENTACEL ACTHIB COMPONENT	T2	PPACA
PRIORIX	T2	PPACA
PROQUAD	T2	PPACA
QUADRACEL DTAP-IPV	T2	PPACA
TDVAX	T2	PPACA
TENIVAC	T2	PPACA
VAXELIS	T2	PPACA
VIRAL/TUMORIGENIC VACCINES		
ABRYVO	T3	PPACA
ACAM2000 (NATIONAL STOCKPILE)	T3	
AREXVY	T3	PPACA
ENGRIX-B ADULT	T2	PPACA
ENGRIX-B PEDIATRIC-ADOLESCENT	T2	PPACA
ERVEBO (NATIONAL STOCKPILE)	T3	
GARDASIL 9	T2	PPACA
HEPLISAV-B	T2	PPACA
JYNNEOS (NATIONAL STOCKPILE)	T3	
JYNNEOS	T3	PPACA
MRESVIA	T3	PPACA
PEDIARIX	T2	PPACA
PREHEVBRIO	T2	PPACA
RECOMBIVAX HB	T2	PPACA
SHINGRIX	T2	QL(2 KITS/720 DAYS) PPACA
TWINRIX	T2	PPACA
VARIVAX VACCINE	T2	PPACA
BLOOD (Blood Modifiers/Bleeding Disorders)		
AGENTS TO TX THROMBOTIC THROMBOCYTOPENIC PURPURA		
CABLIVI	T3	PA SP

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-FIBRINOLYTIC AGENTS		
AMICAR (<i>aminocaproic acid</i>)	T3	SP HD
<i>aminocaproic acid</i> (Amicar)	T1	SP HD
<i>tranexamic acid</i>	T1	SP
ANTI-HEMOPHILIC FACTORS		
ALTUVIIIQ	T3	PA SP HD
ADYNOVATE	T2	PA SP HD
AFSTYLA	T2	PA SP HD
ALPHANATE	T3	PA SP HD
ALTUVIIIQ	T2	PA SP HD
ELOCTATE	T2	PA SP HD
ESPEROCT	T2	PA SP HD
HEMOFIL M	T3	PA SP HD
HUMATE-P	T3	PA SP HD
JIVI	T2	PA SP HD
KOATE	T3	PA SP HD
KOGENATE FS	T2	PA SP HD
KOVALTRY	T2	PA SP HD
NOVOEIGHT	T2	PA SP HD
NUWIQ	T3	PA SP HD
RECOMBINATE	T3	PA SP HD
WILATE	T3	PA SP HD
XYNTHA	T3	PA SP HD
XYNTHA SOLOFUSE	T3	PA SP HD
COMPLEMENT (C3) INHIBITORS		
EMPAVELI	T2	PA SP
FABHALTA	T2	PA QL(2 CAPS/DAY) SP
TAVNEOS	T3	PA QL(6 CAPS/DAY) SP
VOYDEYA	T2	PA QL(1 PACKET/28 Days) SP
HEMOPHILIA TREATMENT AGENTS, NON-FACTOR REPLACEMENT		
ALHEMO PEN	T2	PA SP
HEMLIBRA	T2	PA SP HD
HYMPAVZI PEN	T2	PA SP
QFITLIA	T3	PA SP
QFITLIA PEN	T3	PA SP

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

BLOOD (Blood Modifiers/Bleeding Disorders) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SICKLE CELL ANEMIA AGENTS		
PYRUKYND 20 MG TABLET	T3	PA QL(2 TABS/DAY) SP
PYRUKYND 20-5 MG TAPER PACK	T3	PA QL(2 PACKS/270 DAYS) SP
PYRUKYND 5 MG TABLET	T3	PA QL(2 TABS/DAY) SP
PYRUKYND 5 MG TAPER PACK	T3	PA QL(2 PACKS/270 DAYS) SP
PYRUKYND 50 MG TABLET	T3	PA QL(2 TABS/DAY) SP
PYRUKYND 50-20 MG TAPER PACK	T3	PA QL(2 PACKS/270 DAYS) SP
SICKLE CELL ANEMIA AGENTS		
DROXIA	T2	
OXBRYTA 300 MG TABLET	T3	PA QL(3 TABS/DAY) SP
OXBRYTA 300 MG TABLET FOR SUSP	T3	PA QL(5 TABS/DAY) SP
OXBRYTA 500 MG TABLET	T3	PA QL(3 TABS/DAY) SP
SIKLOS	T3	PA
XROMI	T3	PA
TOPICAL HEMOSTATICS		
ASTRINGYN	T3	
AVITENE	T3	
ENDO-AVITENE	T3	
EVICEL	T3	
<i>gelatin sponge, absorb/porcine</i> (Gelfoam)	T1	
GELFOAM	T3	
GELFOAM (<i>gelatin sponge,absorb/porcine</i>)	T3	
GELFOAM COMPRESSED	T3	
MONSEL's	T3	
RECOTHROM	T3	
SURGICEL	T3	
SURGIFOAM	T1	
SYRINGE AVITENE	T3	
THROMBI-GEL (<i>thrombin/cal/cmc/gel/dress,hem</i>)	T3	
THROMBIN-JMI	T3	
THROMBI-PAD	T3	
ULTRAFOAM	T3	
BLOOD (Blood Thinners/Anti-Clotting)		
HEMORRHEOLOGIC AGENTS		
<i>pentoxifylline</i>	T1	HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

CARDIAC DRUGS (Blood Pressure/Heart Medications)		
ANTI-ANGINAL, ANTI-ISCHEMIC AGENTS, NON-HEMODYNAMIC		
RANEXA (<i>ranolazine</i>)	T3	PA QL(4 TABS/DAY) HD
<i>ranolazine</i>	T1	QL(4 TABS/DAY) HD
<i>ranolazine</i> (Ranexa)	T1	QL (4 tabs/day) HD
ANTI-ARRHYTHMICS		
<i>amiodarone hcl</i>	T1	HD
<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>mexiletine hcl</i>	T1	HD
MULTAQ	T2	HD
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>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
TIKOSYN 500 MCG CAPSULE (<i>dofetilide</i>)	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 er</i>)	T3	HD
CARDIZEM (<i>diltiazem hcl</i>)	T3	PA HD
CARDIZEM CD (<i>diltiazem 24hr er (cd)</i>)	T3	PA HD
CARDIZEM LA 120 MG TABLET	T3	PA QL(1 TAB/DAY) HD
CARDIZEM LA 180 MG TABLET (<i>matzim la</i>)	T3	PA HD
CARDIZEM LA 240 MG TABLET (<i>matzim la</i>)	T3	PA HD
CARDIZEM LA 300 MG TABLET (<i>matzim la</i>)	T3	PA HD
CARDIZEM LA 360 MG TABLET (<i>matzim la</i>)	T3	PA HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

CARDIAC DRUGS (Blood Pressure/Heart Medications) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CALCIUM CHANNEL BLOCKING AGENTS (con't.)		
CARDIZEM LA 420 MG TABLET (<i>matzim la</i>)	T3	PA HD
CONJUPRI	T3	PA HD
<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 hcl</i>	T1	HD
<i>diltiazem hcl</i> (Cardizem Cd)	T1	HD
<i>diltiazem hcl</i> (Cardizem La)	T1	HD
<i>diltiazem hcl</i> (Cardizem)	T1	HD
<i>diltiazem hcl</i> (Tiazac)	T1	HD
<i>felodipine</i>	T1	HD
<i>isradipine</i>	T1	
KATERZIA	T3	PA QL(10 MLS/DAY) HD
LEVAMLODIPINE MALEATE	T3	PA HD
<i>nicardipine hcl</i>	T1	HD
<i>nifedipine</i>	T1	HD
<i>nifedipine</i> (Adalat Cc)	T1	HD
<i>nifedipine</i> (Procardia XI)	T1	HD
<i>nimodipine</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</i> (Sular)	T1	HD
<i>nisoldipine er 20 mg tablet</i>	T1	QL(1 TAB/DAY) HD
<i>nisoldipine er 25.5 mg tablet</i>	T1	HD
<i>nisoldipine er 30 mg tablet</i>	T1	HD
<i>nisoldipine er 34 mg tablet</i> (Sular)	T1	HD
<i>nisoldipine er 40 mg tablet</i>	T1	HD
<i>nisoldipine er 8.5 mg tablet</i> (Sular)	T1	HD
NORLIQVA	T2	PA QL(10 MLS/DAY) HD
NORVASC (<i>amlodipine besylate</i>)	T3	PA

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

CARDIAC DRUGS (Blood Pressure/Heart Medications) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CALCIUM CHANNEL BLOCKING AGENTS (con't.)		
NYMALIZE	T3	
PROCARDIA XL (<i>nifedipine</i>)	T3	PA HD
SULAR (<i>nisoldipine</i>)	T3	HD
TIAZAC (<i>diltiazem hcl</i>)	T3	HD
verapamil hcl	T1	HD
verapamil hcl (Calan Sr)	T1	HD
verapamil hcl (Verelan Pm)	T1	HD
verapamil hcl (Verelan)	T1	HD
VERELAN (<i>verapamil hcl</i>)	T3	HD
VERELAN PM (<i>verapamil hcl</i>)	T3	HD
CARDIAC MYOSIN INHIBITOR		
CAMZYOS	T3	PA QL(1 CAP/DAY) SP HD
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 125 mcg tablet (Lanoxin)	T1	HD
digoxin 250 mcg tablet (Lanoxin)	T1	HD
digoxin 62.5 mcg tablet (Lanoxin)	T1	PA HD
LANOXIN (<i>digoxin</i>)	T3	PA HD
HEART RATE REDUCING, SA SELECTIVE I(F) CURRENT INH.		
CORLANOR 5 MG TABLET (<i>ivabradine hcl</i>)	T3	PA HD
CORLANOR 5 MG/5 ML ORAL SOLN	T2	PA SP HD
CORLANOR 7.5 MG TABLET (<i>ivabradine hcl</i>)	T3	PA HD
ivabradine hcl (Corlanor)	T1	PA HD
SOLUBLE GUANYLATE CYCLASE (SGC) STIMULATOR		
VERQUVO	T2	PA QL(1 TAB/DAY)
VASODILATORS, CORONARY		
GONITRO	T3	HD
ISORDIL (<i>isosorbide dinitrate</i>)	T3	PA HD
ISORDIL TITRADOSE (<i>isosorbide dinitrate</i>)	T3	PA HD
isosorbide dinitrate 10 mg tab	T1	HD
isosorbide dinitrate 20 mg tab	T1	HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

CARDIAC DRUGS (Blood Pressure/Heart Medications) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VASODILATORS, CORONARY (con't.)		
<i>isosorbide dinitrate 30 mg tab</i>	T1	HD
<i>isosorbide dinitrate 40 mg tab (Isordil)</i>	T1	PA HD
<i>isosorbide dinitrate 5 mg tab (Isordil Titrados)</i>	T1	HD
<i>isosorbide mononitrate</i>	T1	HD
MINITRAN	T1	HD
NITRO-DUR 0.1 MG/HR PATCH	T3	HD
NITRO-DUR 0.2 MG/HR PATCH	T3	HD
NITRO-DUR 0.3 MG/HR PATCH	T2	HD
NITRO-DUR 0.4 MG/HR PATCH	T3	HD
NITRO-DUR 0.6 MG/HR PATCH	T3	HD
NITRO-DUR 0.8 MG/HR PATCH	T2	HD
<i>nitroglycerin</i>	T1	HD
<i>nitroglycerin 0.3 mg tablet sl (Nitrostat)</i>	T1	HD
<i>nitroglycerin 0.4 mg tablet sl (Nitrostat)</i>	T1	HD
<i>nitroglycerin 0.6 mg tablet sl (Nitrostat)</i>	T1	HD
<i>nitroglycerin 400 mcg spray (Nitrolingual)</i>	T1	HD
NITROLINGUAL (<i>nitroglycerin</i>)	T3	HD
NITROMIST (<i>nitroglycerin</i>)	T3	HD
NITROSTAT (<i>nitroglycerin</i>)	T3	HD
CARDIOVASCULAR (Asthma/COPD/Respiratory)		
PULM ANTI-HTN,SOLUBLE GUANYLATE CYCLASE STIMULATOR		
ADEMPAS	T2	PA SP HD
PULM.ANTI-HTN,SEL.C-GMP PHOSPHODIESTERASE T5 INHIB		
ADCIRCA (<i>tadalafil</i>)	T3	PA SP HD
REVATIO (<i>sildenafil citrate</i>)	T3	PA SP HD
<i>sildenafil 10 mg/ml oral susp (Revatio)</i>	T1	PA SP HD
<i>sildenafil 20 mg tablet (Revatio)</i>	T1	PA SP HD
<i>tadalafil (Adcirca)</i>	T1	PA SP HD
<i>tadalafil 20 mg tablet (Adcirca)</i>	T1	PA SP HD
TADLIQ	T3	PA SP HD
PULMONARY ANTI-HTN, ENDOTHELIN RECEPTOR ANTAGONIST		
<i>ambrisentan (Letairis)</i>	T1	PA SP HD
<i>bosentan (Tracleer)</i>	T1	PA SP HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

CARDIOVASCULAR (Asthma/COPD/Respiratory) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PULMONARY ANTI-HTN, ENDOTHELIN RECEPTOR ANTAGONIST (con't.)		
LETAIRIS (<i>ambrisentan</i>)	T3	PA SP HD
OPSUMIT	T2	PA SP HD
TRACLEER 125 MG TABLET (<i>bosentan</i>)	T3	PA SP HD
TRACLEER 32 MG TABLET FOR SUSP	T2	PA SP HD
TRACLEER 62.5 MG TABLET (<i>bosentan</i>)	T3	PA SP HD
PULMONARY ANTIHYPER AGENT, ACTRIIA-FC		
WINREVAIR	T3	PA SP HD
WINREVAIR (2 PACK)	T3	PA SP HD
PULMONARY ANTIHYPERTENSIVES, PROSTACYCLIN-TYPE		
ORENITRAM ER	T3	PA SP HD
ORENITRAM MONTH 1 TITRATION KT	T3	PA QL(168 TABS/180 DAYS) SP HD
ORENITRAM MONTH 2 TITRATION KT	T3	PA QL(336 TABS/180 DAYS) SP HD
ORENITRAM MONTH 3 TITRATION KT	T3	PA QL(252 TABS/180 DAYS) SP HD
TYVASO	T3	PA SP HD
TYVASO DPI	T2	PA SP HD
TYVASO INSTITUTIONAL START KIT	T3	PA SP HD
TYVASO REFILL KIT	T3	PA SP HD
TYVASO STARTER KIT	T3	PA SP HD
UPTRAVI	T2	PA SP HD
VENTAVIS	T2	PA SP HD
PULMONARY HTN-ENDOTHELIN RECEPT ANTG-CGMP PDE5 INH		
OPSYNVI	T2	PA QL(1 TAB/DAY) SP HD

CARDIOVASCULAR (Blood Pressure/Heart Medications)

ACE INHIBITOR-CALCIUM CHANNEL BLOCKER COMBINATION		
<i>amlodipine besylate/benazepril</i>	T1	HD
<i>amlodipine besylate/benazepril</i> (Lotrel)	T1	HD
LOTREL (<i>amlodipine besylate-benazepril</i>)	T3	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

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ACE INHIBITOR-THIAZIDE OR THIAZIDE-LIKE DIURETIC		
ACCURETIC (quinapril-hydrochlorothiazide)	T3	ST HD
benazepril/hydrochlorothiazide	T1	HD
benazepril/hydrochlorothiazide (Lotensin Hct)	T1	HD
captopril-hctz 25-15 mg tablet	T1	QL(3 TABS/DAY) HD
captopril-hctz 25-25 mg tablet	T1	QL(2 TABS/DAY) HD
captopril-hctz 50-15 mg tablet	T1	QL(3 TABS/DAY) HD
captopril-hctz 50-25 mg tablet	T1	QL(2 TABS/DAY) HD
enalapril/hydrochlorothiazide	T1	HD
enalapril/hydrochlorothiazide (Vaseretic)	T1	HD
fosinopril/hydrochlorothiazide	T1	HD
lisinopril/hydrochlorothiazide (Zestoretic)	T1	HD
LOTENSIN HCT (benazepril-hydrochlorothiazide)	T3	ST HD
quinapril/hydrochlorothiazide (Accuretic)	T1	HD
VASERETIC (enalapril-hydrochlorothiazide)	T3	ST HD
ZESTORETIC (lisinopril-hydrochlorothiazide)	T3	ST HD
ALPHA/BETA-ADRENERGIC BLOCKING AGENTS		
carvedilol (Coreg)	T1	HD
carvedilol er 10 mg capsule (Coreg Cr)	T1	QL(1 CAP/DAY) HD
carvedilol er 20 mg capsule (Coreg Cr)	T1	QL(1 CAP/DAY) HD
carvedilol er 40 mg capsule (Coreg Cr)	T1	QL(1 CAP/DAY) HD
carvedilol er 80 mg capsule (Coreg Cr)	T1	HD
COREG (carvedilol)	T3	PA HD
COREG CR 10 MG CAPSULE (carvedilol phosphate)	T3	PA QL(1 CAP/DAY) HD
COREG CR 20 MG CAPSULE (carvedilol phosphate)	T3	PA QL(1 CAP/DAY) HD
COREG CR 40 MG CAPSULE (carvedilol phosphate)	T3	PA QL(1 CAP/DAY) HD
COREG CR 80 MG CAPSULE (carvedilol phosphate)	T3	PA HD
labetalol hcl 100 mg tablet	T1	HD
labetalol hcl 200 mg tablet	T1	HD
labetalol hcl 300 mg tablet	T1	HD
LABETALOL HCL 400 MG TABLET	T3	HD
ALPHA-ADRENERGIC BLOCKING AGENTS		
CARDURA (doxazosin mesylate)	T3	HD
CARDURA XL	T3	HD
doxazosin mesylate (Cardura)	T1	HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ALPHA-ADRENERGIC BLOCKING AGENTS (con't.)		
MINIPRESS (<i>prazosin hcl</i>)	T3	HD
<i>prazosin hcl</i>	T1	HD
<i>prazosin hcl</i> (Minipress)	T1	HD
<i>terazosin hcl</i>	T1	HD
TEZRULY	T3	PA HD
ANGIOTEN.RECEPTR ANTAG-CALCIUM CHANL BLKR-THIAZIDE		
<i>amlodipine/valsartan/hcthiazid</i> (Exforge Hct)	T1	HD
EXFORGE HCT (<i>amlodipine/valsartan/hcthiazid</i>)	T3	PA HD
<i>olmesartan/amlodipin/hcthiazid</i> (Tribenzor)	T1	HD
TRIBENZOR (<i>olmesartan-amlodipine-hctz</i>)	T3	PA 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</i> (Entresto)	T1	QL(2 TABS/DAY) HD
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

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANGIOTENSIN RECEPTOR ANTAG.-THIAZIDE DIURETIC COMB (con't.)		
<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-olmesartan</i>)	T3	PA HD
AZOR 10-40 MG TABLET (<i>amlodipine-olmesartan</i>)	T3	PA HD
AZOR 5-20 MG TABLET (<i>amlodipine-olmesartan</i>)	T3	PA QL(1 TAB/DAY) HD
AZOR 5-40 MG TABLET (<i>amlodipine-olmesartan</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
<i>telmisartan-amlodipine 80-5 mg</i>	T1	HD
ANTI-HYPERTENSIVES, ACE INHIBITORS		
ACCUPRIL (<i>quinapril hcl</i>)	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
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

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-HYPERTENSIVES, ACE INHIBITORS (cont.)		
ramipril (Altace)	T1	HD
trandolapril	T1	HD
VASOTEC (enalapril maleate)	T3	PA HD
ZESTRIL (lisinopril)	T3	PA HD
ANTIHYPERSENSITIVES, ANGIOTENSIN RECEPTOR ANTAGONIST		
ARBLI	T3	PA HD
ATACAND (candesartan cilexetil)	T3	PA HD
AVAPRO (irbesartan)	T3	PA HD
BENICAR 5 MG TABLET (olmesartan medoxomil)	T3	PA HD
BENICAR 20 MG TABLET (olmesartan medoxomil)	T3	PA QL(1 TAB/DAY) HD
BENICAR 40 MG TABLET (olmesartan medoxomil)	T3	PA HD
candesartan cilexetil (Atacand)	T1	HD
COZAAR (losartan potassium)	T3	PA HD
DIOVAN (valsartan)	T3	PA HD
EDARBI 40 MG TABLET	T3	PA QL(1 TAB/DAY) HD
EDARBI 80 MG TABLET	T3	PA HD
eprosartan mesylate	T1	HD
irbesartan	T1	HD
irbesartan (Avapro)	T1	HD
losartan potassium (Cozaar)	T1	HD
MICARDIS 40 MG TABLET (telmisartan)	T3	PA QL(1 TAB/DAY) HD
MICARDIS 80 MG TABLET (telmisartan)	T3	PA HD
olmesartan medoxomil 20 mg tab (Benicar)	T1	QL(1 TAB/DAY) HD
olmesartan medoxomil 40 mg tab (Benicar)	T1	HD
olmesartan medoxomil 5 mg tab (Benicar)	T1	HD
telmisartan 20 mg tablet (Micardis)	T1	QL(1 TAB/DAY) HD
telmisartan 40 mg tablet (Micardis)	T1	QL(1 TAB/DAY) HD
telmisartan 80 mg tablet (Micardis)	T1	HD
valsartan 160 mg tablet (Diovan)	T1	HD
valsartan 20 mg/5 ml solution	T1	HD
VALSARTAN 20 MG/5 ML SOLUTION	T3	ST HD
valsartan 320 mg tablet (Diovan)	T1	HD
valsartan 40 mg tablet (Diovan)	T1	HD
valsartan 80 mg tablet (Diovan)	T1	HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-HYPERTENSIVES, GANGLIONIC BLOCKERS		
VECAMEYL	T1	
ANTI-HYPERTENSIVES, MISCELLANEOUS		
DEMSEY (metyrosine)	T3	PA HD
metyrosine (Demser)	T1	PA HD
ANTI-HYPERTENSIVES, SYMPATHOLYTIC		
CATAPRES-TTS 1 (clonidine)	T3	PA HD
CATAPRES-TTS 2 (clonidine)	T3	PA HD
CATAPRES-TTS 3 (clonidine)	T3	PA HD
clonidine (Catapres-tts 1)	T1	HD
clonidine (Catapres-tts 2)	T1	HD
clonidine (Catapres-tts 3)	T1	HD
clonidine hcl	T1	HD
CLONIDINE HCL ER 0.17 MG TAB	T3	PA QL(2 TABS/DAY) HD
guanfacine hcl	T1	HD
methylodopa	T1	HD
methylodopa/hydrochlorothiazide	T1	HD
NEXICLON XR	T3	PA QL(2 TABS/DAY) HD
ANTI-HYPERTENSIVES, VASODILATORS		
hydralazine hcl	T1	HD
minoxidil	T1	HD
BETA-ADRENERGIC BLOCKING AGENTS		
acebutolol hcl	T1	HD
atenolol (Tenormin)	T1	HD
BETAPACE (sotalol af)	T3	PA HD
BETAPACE AF (sotalol af)	T3	PA HD
betaxolol hcl	T1	HD
bisoprolol fumarate 10 mg tab	T1	HD
BISOPROLOL FUMARATE 2.5 MG TAB	T3	PA QL(1 TAB/DAY) HD
bisoprolol fumarate 5 mg tab	T1	HD
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

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BETA-ADRENERGIC BLOCKING AGENTS (cont.)		
HEMANGEOL	T3	PA
INDERAL LA (<i>propranolol hcl er</i>)	T3	PA HD
INDERAL XL	T3	PA HD
INNOPRAN XL	T3	PA HD
KAPSPARGO SPRINKLE	T3	PA HD
LOPRESSOR	T3	PA HD
LOPRESSOR (<i>metoprolol tartrate</i>)	T3	PA HD
<i>metoprolol succinate</i> (Toprol XL)	T1	HD
<i>metoprolol tartrate</i>	T1	HD
<i>metoprolol tartrate</i> (Lopressor)	T1	HD
<i>nadolol</i>	T1	HD
<i>nebivolol 10 mg tablet</i> (Bystolic)	T1	QL (1 TAB/DAY) HD
<i>nebivolol 2.5 mg tablet</i> (Bystolic)	T1	QL (1 TAB/DAY) HD
<i>nebivolol 20 mg tablet</i> (Bystolic)	T1	HD
<i>nebivolol 5 mg tablet</i> (Bystolic)	T1	QL (1 TAB/DAY) HD
<i>pindolol</i>	T1	HD
<i>propranolol hcl</i>	T1	HD
<i>propranolol hcl</i> (Inderal La)	T1	HD
<i>sotalol hcl</i> (Betapace Af)	T1	HD
<i>sotalol hcl</i> (Betapace)	T1	HD
SOTYLIZE	T3	HD
TENORMIN (<i>atenolol</i>)	T3	PA HD
<i>timolol maleate</i>	T1	HD
TOPROL XL (<i>metoprolol succinate</i>)	T3	PA HD
BETA-BLOCKERS AND THIAZIDE, THIAZIDE-LIKE DIURETICS		
<i>atenolol/chlorthalidone</i> (Tenoretic 100)	T1	HD
<i>atenolol/chlorthalidone</i> (Tenoretic 50)	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

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ENDOTHELIN RECEPTOR ANTAGONISTS		
TRYVIO	T3	PA SP
RENIN INHIBITOR, DIRECT		
<i>aliskiren 150 mg tablet</i> (Tekturna)	T1	QL(1 TAB/DAY) HD
<i>aliskiren 300 mg tablet</i> (Tekturna)	T1	HD
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
RENIN INHIBITOR, DIRECT AND THIAZIDE DIURETIC COMB		
TEKTURNA HCT	T2	HD
VASODILATORS, COMBINATION		
BIDIL (<i>isosorbide dinit/hydralazine</i>)	T3	PA QL(6 TABS/DAY) HD
<i>isosorbide dinit/hydralazine</i> (Bidil)	T1	QL(6 TABS/DAY) HD
VASODILATORS, PERIPHERAL		
<i>ergoloid mesylates</i>	T1	
<i>isoxsuprine hcl</i>	T1	
CARDIOVASCULAR (Cholesterol Medications)		
ANTI-HYPERLIP.HMG COA REDUCT INHIB-CHOLEST.AB.INHIB		
<i>ezetimibe/atorvastatin calcium</i>	T1	PA HD
<i>ezetimibe/simvastatin</i> (Vytorin)	T1	HD
ROSUVASTATIN-EZETIMIBE	T3	PA HD
ROSZET	T3	PA HD
VYTORIN (<i>ezetimibe-simvastatin</i>)	T3	PA HD
ANTI-HYPERLIPID- HMG-COA RI-CALCIUM CHANNEL BLOCKER		
<i>amlodipine-atorvast 10-10 mg</i> (Caduet)	T1	HD
<i>amlodipine-atorvast 10-20 mg</i> (Caduet)	T1	HD
<i>amlodipine-atorvast 10-40 mg</i> (Caduet)	T1	HD
<i>amlodipine-atorvast 10-80 mg</i> (Caduet)	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</i> (Caduet)	T1	HD
<i>amlodipine-atorvast 5-20 mg</i> (Caduet)	T1	QL(1 TAB/DAY) HD
<i>amlodipine-atorvast 5-40 mg</i> (Caduet)	T1	QL(1 TAB/DAY) HD
<i>amlodipine-atorvast 5-80 mg</i> (Caduet)	T1	HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

CARDIOVASCULAR (Cholesterol Medications) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-HYPERLIPID- HMG-COA RI-CALCIUM CHANNEL BLOCKER (con't.)		
CADUET 10 MG-10 MG TABLET (<i>amlodipine-atorvastatin</i>)	T3	HD
CADUET 10 MG-20 MG TABLET (<i>amlodipine-atorvastatin</i>)	T3	HD
CADUET 10 MG-40 MG TABLET (<i>amlodipine-atorvastatin</i>)	T3	HD
CADUET 10 MG-80 MG TABLET (<i>amlodipine-atorvastatin</i>)	T3	HD
CADUET 5 MG-10 MG TABLET (<i>amlodipine-atorvastatin</i>)	T3	HD
CADUET 5 MG-20 MG TABLET (<i>amlodipine-atorvastatin</i>)	T3	QL(1 TAB/DAY) HD
CADUET 5 MG-40 MG TABLET (<i>amlodipine-atorvastatin</i>)	T3	QL(1 TAB/DAY) HD
CADUET 5 MG-80 MG TABLET (<i>amlodipine-atorvastatin</i>)	T3	HD
ANTI-HYPERLIPIDEMIC - APOLIPOPROTEIN INHIBITOR		
TRYNGOLZA	T3	PA QL(1 AUTO-INJ/28 DAYS) SP
ANTI-HYPERLIPIDEMIC - ATP CITRATE LYASE INHIBITOR		
NEXLETOL	T2	PA QL(1 TAB/DAY)
ANTI-HYPERLIPIDEMIC - MTP INHIBITOR		
JUXTAPID 5 MG CAPSULE	T3	PA QL(1 CAP/DAY) SP HD
JUXTAPID 10 MG CAPSULE	T3	PA QL(1 CAP/DAY) SP HD
JUXTAPID 20 MG CAPSULE	T3	PA QL(2 CAPS/DAY) SP HD
JUXTAPID 30 MG CAPSULE	T3	PA QL(2 CAPS/DAY) SP HD
ANTI-HYPERLIPIDEMIC - PCSK9 INHIBITORS		
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

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

CARDIOVASCULAR (Cholesterol Medications) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-HYPERLIPIDEMIC-HMGCOA REDUCTASE INHIB (Statins) (cont.)		
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
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 er</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>pravastatin sodium</i>	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	T3	PA HD
ZYPITAMAG	T3	ST HD
BILE SALT SEQUESTRANTS		
<i>cholestyramine</i>	T1	HD
<i>cholestyramine</i> (Questran Light)	T1	HD
<i>cholestyramine (with sugar)</i> (Questran)	T1	HD
<i>cholestyramine/aspartame</i>	T1	HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

CARDIOVASCULAR (Cholesterol Medications) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BILE SALT SEQUESTRANTS (cont.)		
<i>colesevelam hcl</i> (Welchol)	T1	HD
COLESTID	T3	HD
COLESTID (<i>colestipol hcl</i>)	T3	HD
<i>colestipol hcl</i>	T1	HD
<i>colestipol hcl</i> (Colestid)	T1	HD
QUESTRAN (<i>cholestyramine</i>)	T3	HD
QUESTRAN LIGHT (<i>cholestyramine</i>)	T3	HD
WELCHOL (<i>colesevelam hcl</i>)	T3	PA HD
LIPOTROPICS		
<i>ezetimibe</i> (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
<i>fenofibric acid</i> (Fibricor)	T1	HD
FENOGLIDE (<i>fenofibrate</i>)	T3	PA HD
FIBRICOR (<i>fenofibric acid</i>)	T3	ST HD
<i>gemfibrozil</i> (Lopid)	T1	HD
LIPOFEN	T3	ST HD
LOPID (<i>gemfibrozil</i>)	T3	HD
<i>niacin</i>	T1	HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

CARDIOVASCULAR (Cholesterol Medications) (cont.)

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

CARDIOVASCULAR (MISCELLANEOUS)

ENDOTHELIN-ANGIOTENSIN RECEPTOR ANTAGONIST

FILSPARI	T2	PA QL(1 TAB/DAY) SP
----------	----	---------------------

CNS DRUGS (Alzheimer's Disease)

ALZHEIMER'S THERAPY, NMDA RECEPTOR ANTAGONISTS

<i>memantine hcl</i> (Namenda)	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> (Namenda Xr)	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 er</i>)	T3	PA QL(1 CAP/DAY) HD
NAMENDA XR 28 MG CAPSULE (<i>memantine hcl er</i>)	T3	PA HD
NAMENDA XR 7 MG CAPSULE (<i>memantine hcl er</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
NAMZARIC 21 MG-10 MG CAPSULE (<i>memantine hcl/donepezil hcl</i>)	T3	PA QL(2 CAPS/DAY) HD
NAMZARIC 28 MG-10 MG CAPSULE (<i>memantine hcl/donepezil hcl</i>)	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

LEQEMBI IQLIK 360 MG/1.8 ML	T3	PA SP
-----------------------------	----	-------

CNS DRUGS (Miscellaneous)

AMYOTROPHIC LATERAL SCLEROSIS AGENTS

RADICAVA ORS 105 MG/5 ML SUSP	T3	PA QL(50 MLS/30 DAYS) SP HD
RADICAVA ORS STARTER KIT SUSP	T3	PA QL(70 MLS/365 DAYS) SP HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

CNS DRUGS (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AMYOTROPHIC LATERAL SCLEROSIS AGENTS (cont.)		
RILUTEK (<i>riluzole</i>)	T3	PA SP HD
<i>riluzole</i> (Rilutek)	T1	SP HD
TEGLUTIK	T3	PA SP
TIGLUTIK	T3	PA SP
DRUGS TO TREAT MOVEMENT DISORDERS		
AUSTEDO	T3	PA SP HD
AUSTEDO XR 6 MG TABLET	T3	PA QL(3 TABS/DAY) SP HD
AUSTEDO XR 12 MG TABLET	T3	PA QL(1 TAB/DAY) SP HD
AUSTEDO XR 18 MG TABLET	T3	PA QL(1 TAB/DAY) SP HD
AUSTEDO XR 24 MG TABLET	T3	PA QL(2 TABS/DAY) SP HD
AUSTEDO XR 30 MG TABLET	T3	PA QL(1 TAB/DAY) SP HD
AUSTEDO XR 36 MG TABLET	T3	PA QL(1 TAB/DAY) SP HD
AUSTEDO XR 42 MG TABLET	T3	PA QL(1 TAB/DAY) SP HD
AUSTEDO XR 48 MG TABLET	T3	PA QL(1 TAB/DAY) SP HD
AUSTEDO XR TITRATION KIT(WK1-4)	T3	PA QL(1 KIT/180 DAYS) SP HD
HORIZANT	T3	PA
INGREZZA	T3	PA QL(1 CAP/DAY) SP
INGREZZA INITIATION PK (TARDIV)	T3	PA QL(28 CAPS/365 DAYS) SP
INGREZZA SPRINKLE	T3	PA QL(1 CAP/DAY) SP
<i>tetrabenazine</i> (Xenazine)	T1	PA SP HD
XENAZINE (<i>tetrabenazine</i>)	T3	PA SP HD
GLYPROMATE (GPE) ANALOGS		
DAYBUE	T3	PA QL(120 MLS/DAY) SP
PSEUDOBULBAR AFFECT (PBA) AGENTS, NMDA ANTAGONISTS		
NUDEXTA	T3	QL(4 CAPS/DAY)
XANTHINES		
<i>caffeine citrate</i>	T1	HD
CNS DRUGS (Multiple Sclerosis)		
AGENTS TO TREAT MULTIPLE SCLEROSIS		
AUBAGIO (<i>teriflunomide</i>)	T3	PA SP HD
AVONEX (4 PACK)	T2	PA SP HD
AVONEX PEN (4 PACK)	T2	PA SP HD
BAFIERTAM	T2	PA SP HD
BETASERON	T2	PA SP HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CNS DRUGS (Multiple Sclerosis) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AGENTS TO TREAT MULTIPLE SCLEROSIS (cont.)		
<i>cladribine</i>	T1	PA SP HD
COPAXONE (<i>glatiramer acetate</i>)	T3	PA SP HD
<i>dimethyl fumarate 30d start pk</i> (Tecfidera)	T1	SP HD
<i>dimethyl fumarate dr 120 mg cp</i> (Tecfidera)	T1	HD
<i>dimethyl fumarate dr 120 mg cp</i> (Tecfidera)	T1	SP HD
<i>dimethyl fumarate dr 240 mg cp</i> (Tecfidera)	T1	HD
<i>dimethyl fumarate dr 240 mg cp</i> (Tecfidera)	T1	SP HD
<i>fingolimod hcl</i> (Gilenya)	T1	SP HD
GILENYA 0.25 MG CAPSULE	T3	PA QL(1 CAP/DAY) SP
GILENYA 0.5 MG CAPSULE (<i>fingolimod hcl</i>)	T3	PA SP HD
<i>glatiramer acetate</i> (Copaxone)	T1	SP HD
KESIMPTA PEN	T2	PA SP HD
MAVENCLAD	T3	PA SP HD
MAYZENT	T2	PA SP HD
PLEGRIDY	T2	PA SP HD
PLEGRIDY PEN	T2	PA SP HD
PONVORY	T3	PA SP HD
REBIF	T2	PA SP HD
REBIF REBIDOSE	T2	PA SP HD
TASCENSO ODT	T3	PA QL(1 TAB/DAY) SP HD
TECFIDERA (<i>dimethyl fumarate</i>)	T3	PA SP HD
<i>teriflunomide</i> (Aubagio)	T1	SP HD
VUMERITY	T2	PA SP HD
AGTS TX NEUROMUSC TRANSMISSION DIS, POT-CHAN BLKR		
AMPYRA (<i>dalfampridine</i>)	T3	PA SP HD
<i>dalfampridine er 10 mg tablet</i> (Ampyra)	T1	PA HD
<i>dalfampridine er 10 mg tablet</i> (Ampyra)	T1	PA SP HD
FIRDAPSE	T3	PA QL(8 TABS/DAY) SP
SPHINGOSINE I-PHOSPHATE (SIP) RECEPTOR MODULATOR		
ZEPOSIA	T2	PA SP HD
CNS DRUGS (Pain Relief And Inflammatory Disease)		
CALCITONIN GENE-RELATED PEPTIDE (CGRP) INHIBITORS		
EMGALITY SYRINGE	T2	PA

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

CNS DRUGS (Pain Relief And Inflammatory Disease) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
POSTHERPETIC NEURALGIA AGENTS		
<i>gabapentin</i> (Gralise)	T1	
GRALISE ER 300 MG TABLET (<i>gabapentin</i>)	T3	
GRALISE ER 450 MG TABLET (<i>gabapentin</i>)	T3	PA
GRALISE ER 600 MG TABLET (<i>gabapentin</i>)	T3	
GRALISE ER 750 MG TABLET (<i>gabapentin</i>)	T3	PA
GRALISE ER 900 MG TABLET (<i>gabapentin</i>)	T3	PA
SPHINGOSINE 1-PHOSPHATE (SIP) RECEPTOR MODULATOR		
VELSIPITY	T2	PA QL(30 TABS/30 DAYS) SP HD
ZEPOSIA	T2	PA SP HD
CNS DRUGS (Seizure Disorders)		
ANTI-CONVULSANT - BENZODIAZEPINE TYPE		
<i>clobazam</i> (Onfi)	T1	HD
<i>clonazepam</i>	T1	HD
<i>clonazepam</i> (Klonopin)	T1	HD
DIASTAT (<i>diazepam</i>)	T3	PA HD
<i>diazepam</i> 10 mg rectal gel syst	T1	HD
<i>diazepam</i> 10mg rectal gel (2pk)	T1	HD
<i>diazepam</i> 2.5 mg rectal gel sys (Diastat)	T1	HD
<i>diazepam</i> 20 mg rectal gel syst	T1	HD
<i>diazepam</i> 20mg rectal gel (2pk)	T1	HD
KLONOPIN (<i>clonazepam</i>)	T3	PA HD
LIBERVANT	T3	PA QL(10 FILMS/30 DAYS) HD
NAYZILAM	T2	PA QL(10 UNITS/30 DAYS) HD
ONFI (<i>clobazam</i>)	T3	PA HD
SYMPAZAN	T3	PA HD
VALTOCO	T2	PA QL(10 BLISTER PACKS/30 DAYS) HD
ANTI-CONVULSANT - CANNABINOID TYPE		
EPIDIOLEX	T3	PA SP HD
ANTI-CONVULSANTS		
APTIOM 200 MG TABLET (<i>eslicarbazepine acetate</i>)	T3	PA QL(1 TAB/DAY) HD
APTIOM 400 MG TABLET (<i>eslicarbazepine acetate</i>)	T3	PA QL(1 TAB/DAY) HD
APTIOM 600 MG TABLET (<i>eslicarbazepine acetate</i>)	T3	PA HD
APTIOM 800 MG TABLET (<i>eslicarbazepine acetate</i>)	T3	PA HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

CNS DRUGS (Seizure Disorders) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-CONVULSANTS (cont.)		
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	T3	PA HD
<i>carbamazepine</i> (Carbatrol)	T1	HD
<i>carbamazepine</i> (Tegretol Xr)	T1	HD
<i>carbamazepine</i> (Tegretol)	T1	HD
<i>carbamazepine</i> 100 mg tab chew	T1	HD
<i>carbamazepine</i> 100 mg/5 ml cup	T1	HD
<i>carbamazepine</i> 100 mg/5 ml susp (Tegretol)	T1	HD
CARBAMAZEPINE 200 MG TAB CHEW	T3	HD
<i>carbamazepine</i> 200 mg tablet (Tegretol)	T1	HD
<i>carbamazepine</i> 200 mg/10 ml cup	T1	HD
CARBATROL (<i>carbamazepine</i>)	T3	PA HD
CELONTIN (<i>methsuximide</i>)	T3	HD
DEPAKOTE (<i>divalproex sodium</i>)	T3	PA HD
DEPAKOTE ER (<i>divalproex sodium er</i>)	T3	PA HD
DEPAKOTE SPRINKLE (<i>divalproex sodium</i>)	T3	PA HD
DIACOMIT	T3	PA SP HD
DILANTIN 100 MG CAPSULE (<i>phenytoin sodium extended</i>)	T3	PA HD
DILANTIN 30 MG CAPSULE	T2	PA HD
DILANTIN 50 MG INFATAB (<i>phenytoin</i>)	T3	PA HD
DILANTIN-125 (<i>phenytoin</i>)	T3	PA HD
<i>divalproex sodium</i> (Depakote Er)	T1	HD
<i>divalproex sodium</i> (Depakote Sprinkle)	T1	HD
<i>divalproex sodium</i> (Depakote)	T1	HD
ELEPSIA XR	T3	PA HD
EPRONTIA (<i>topiramate</i>)	T3	PA HD
<i>eslicarbazepine</i> 200 mg, 400 mg tablet	T1	PA QL (1 TAB/DAY) HD
<i>eslicarbazepine</i> 600 mg, 800 mg tablet	T1	PA HD
<i>ethosuximide</i> (Zarontin)	T1	HD
<i>felbamate</i> (Felbatol)	T1	HD
FELBATOL (<i>felbamate</i>)	T3	PA HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CNS DRUGS (Seizure Disorders) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-CONVULSANTS (cont.)		
FINTEPLA	T3	PA SP HD
FYCOMPA 0.5 MG/ML ORAL SUSP	T3	PA HD
FYCOMPA 2 MG TABLET (<i>perampanel</i>)	T3	PA HD
FYCOMPA 4 MG TABLET (<i>perampanel</i>)	T3	PA QL(1 TAB/DAY) HD
FYCOMPA 6 MG TABLET (<i>perampanel</i>)	T3	PA QL(1 TAB/DAY) HD
FYCOMPA 8 MG TABLET (<i>perampanel</i>)	T3	PA HD
FYCOMPA 10 MG TABLET (<i>perampanel</i>)	T3	PA HD
FYCOMPA 12 MG TABLET (<i>perampanel</i>)	T3	PA HD
<i>gabapentin</i>	T1	HD
<i>gabapentin</i> (Neurontin)	T1	HD
GABARONE	T3	PA HD
KEPPRA (<i>levetiracetam</i>)	T3	PA HD
KEPPRA XR (<i>levetiracetam</i>)	T3	PA HD
<i>lacosamide</i> (Vimpat)	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
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

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

CNS DRUGS (Seizure Disorders) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-CONVULSANTS (cont.)		
<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 750 mg tablet</i> (Keppra)	T1	HD
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
NEURONTIN (<i>gabapentin</i>)	T3	PA HD
<i>oxcarbazepine</i> (Oxtellar Xr)	T1	PA HD
<i>oxcarbazepine</i> (Trileptal)	T1	HD
OXTELLAR XR (<i>oxcarbazepine</i>)	T3	PA HD
<i>perampanel 10 mg tablet</i> (Fycompa)	T1	PA HD
<i>perampanel 12 mg tablet</i> (Fycompa)	T1	PA HD
<i>perampanel 2 mg tablet</i> (Fycompa)	T1	PA HD
<i>perampanel 4 mg tablet</i> (Fycompa)	T1	PA QL(1 TAB/DAY) HD
<i>perampanel 6 mg tablet</i> (Fycompa)	T1	PA QL(1 TAB/DAY) HD
<i>perampanel 8 mg tablet</i> (Fycompa)	T1	PA HD
PHENYTEK (<i>phenytoin sodium extended</i>)	T3	PA HD
<i>phenytoin</i>	T1	HD
<i>phenytoin</i> (Dilantin)	T1	HD
<i>phenytoin</i> (Dilantin-125)	T1	HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

CNS DRUGS (Seizure Disorders) (cont.)

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

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

CNS DRUGS (Seizure Disorders) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-CONVULSANTS (cont.)		
<i>topiramate er 100 mg capsule</i> (Trokendi Xr)	T1	QL(1 CAP/DAY) HD
<i>topiramate er 200 mg capsule</i> (Trokendi Xr)	T1	HD
<i>topiramate er 25 mg capsule</i> (Trokendi Xr)	T1	QL(1 CAP/DAY) HD
<i>topiramate er 50 mg capsule</i> (Trokendi Xr)	T1	HD
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</i> (Sabril)	T1	SP HD
<i>vigadrone 500 mg powder packet</i> (Sabril)	T1	SP HD
<i>vigadrone 500 mg tablet</i> (Sabril)	T1	PA SP HD
VIGAFYDE	T3	PA SP
VIMPAT 10 MG/ML SOLUTION (<i>lacosamide</i>)	T2	HD
VIMPAT 100 MG TABLET (<i>lacosamide</i>)	T3	PA HD
VIMPAT 150 MG TABLET (<i>lacosamide</i>)	T3	PA HD
VIMPAT 200 MG TABLET (<i>lacosamide</i>)	T3	PA 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>	T1	HD
<i>zonisamide</i> (Zonegran)	T1	HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

CNS DRUGS (Sleep Disorders/Sedatives)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NARCOLEPSY TX-H3-RECEPT.ANTAGONIST/INVERSE AGONIST		
WAKIX	T3	PA QL(2 TABS/DAY) SP HD
COLONY STIMULATING FACTORS (Blood Modifiers/Bleeding Disorders)		
ERYTHROPOIESIS-STIMULATING AGENTS		
ARANESP	T2	PA SP
EPOGEN	T2	PA SP
MIRCERA	T3	PA SP
PROCRT	T2	PA SP
RETACRIT	T2	PA SP
LEUKOCYTE (WBC) STIMULANTS		
FULPHILA	T3	PA SP
FYLNETRA	T3	PA SP
GRANIX	T3	PA SP
LEUKINE	T2	SP
NEULASTA	T2	PA SP
NEULASTA ONPRO	T2	PA SP HD
NEUPOGEN	T3	PA SP
NIVESTYM	T2	SP HD
NYPOZI	T3	PA SP
NYVEPRIA	T2	PA SP
STIMUFEND	T3	PA SP
UDENYCA	T2	PA SP
UDENYCA AUTOINJECTOR	T2	PA SP
UDENYCA ONBODY	T2	PA SP
ZARXIO	T2	SP HD
ZIEXTENZO	T3	PA SP
THROMBOPOIETIN RECEPTOR AGONISTS		
ALVAIZ 18 MG, 54 MG TABLET	T3	PA QL(1 TAB/DAY) SP
ALVAIZ 36 MG, 54 MG TABLET	T3	PA QL(2 TABS/DAY) SP
DOPTELET	T2	PA SP HD
DOPTELET SPRINKLE	T2	PA SP HD
<i>eltrombopag olamine</i> (Promacta)	T1	PA SP HD
MULPLETA	T3	PA SP HD
PROMACTA (<i>eltrombopag olamine</i>)	T3	PA SP HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

COLONY STIMULATING FACTORS (Blood Pressure/Heart Medications)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LEUKOCYTE (WBC) STIMULANTS		
RELEUKO	T3	PA SP
ROLVEDON	T2	PA SP
COLONY STIMULATING FACTORS (Cancer)		
CXCR4 CHEMOKINE RECEPTOR ANTAGONIST		
XOLREMDI	T3	PA QL(4 CAPS/DAY) SP CSL
CONTRACEPTIVES (Contraception Products)		
CONTRACEPTIVES, INTRAVAGINAL, SYSTEMIC		
ANNOVERA	T3	PPACA
etonogestrel/ethinyl estradiol (Nuvaring)	T1	PPACA
NUVARING (etonogestrel-ethinyl estradiol)	T3	PPACA
CONTRACEPTIVES, IMPLANTABLE		
NEXPLANON	T2	SP PPACA
CONTRACEPTIVES, INJECTABLE		
DEPO-PROVERA (medroxyprogesterone acetate)	T3	PPACA
DEPO-SUBQ PROVERA 104	T3	PPACA
medroxyprogesterone 150 mg/ml (Depo-provera)	T1	PPACA
CONTRACEPTIVES, INTRAVAGINAL		
PHEXX	T3	PA PPACA
PHEXXI	T3	PA PPACA
CONTRACEPTIVES, ORAL		
AVERI	T3	PA HD PPACA
BALCOLTRA (levonorgest/eth.estradiol/iron)	T3	HD PPACA
BEYAZ (rajani)	T3	HD PPACA
desog-e.estradiol/e.estradiol	T1	HD PPACA
desog-e.estradiol/e.estradiol	T1	PPACA
desogestrel-ethinyl estradiol	T1	HD PPACA
drospir/eth estra/levomefol ca (Beyaz)	T1	HD PPACA
drospir/eth estra/levomefol ca (Safyral)	T1	HD PPACA
ELLA	T3	HD PPACA
ESTROSTEP FE (tri-legest fe)	T1	HD PPACA
ethinyl estradiol/drospirenone (Yasmin 28)	T1	PPACA
ethinyl estradiol/drospirenone (Yasmin 28)	T1	HD PPACA
ethinyl estradiol/drospirenone (Yaz)	T1	HD PPACA

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

CONTRACEPTIVES (Contraception Products) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CONTRACEPTIVES, ORAL (cont.)		
<i>ethynodiol d-ethinyl estradiol</i>	T3	PA HD PPACA
FEMLYV	T3	PA HD PPACA
<i>levonorgest/eth.estradiol/iron</i> (Balcoltra)	T1	HD PPACA
<i>levonorgestrel/ethin.estradiol</i>	T1	HD PPACA
<i>I-norgest/e.estradiol-e.estrad</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</i> (Loestrin)	T1	HD PPACA
<i>norethindrone</i>	T1	HD PPACA
<i>norethindrone ac-eth estradiol</i> (Loestrin)	T1	HD PPACA
<i>norethindrone-e.estradiol-iron</i>	T1	HD PPACA
<i>norethindrone-e.estradiol-iron</i> (Loestrin Fe)	T1	HD PPACA
<i>norethindrone-e.estradiol-iron</i> (Taytulla)	T1	HD PPACA
<i>norethindrone-ethin. estradiol</i>	T1	HD PPACA
<i>norethin-ee 1.5-0.03 mg (21) tb</i> (Loestrin)	T1	HD PPACA
<i>norgestimate-ethinyl estradiol</i>	T1	HD PPACA
<i>norgestrel-ethinyl estradiol</i>	T1	HD PPACA
SAFYRAL (<i>drospir/eth estro/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
TWIRLA	T3	HD PPACA

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CONTRACEPTIVES (Contraception Products) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIAPHRAGMS/CERVICAL CAP		
CAYA CONTOURED	T2	PPACA
FEMCAP	T2	PPACA
WIDE SEAL DIAPHRAGM	T3	PPACA
INTRA-UTERINE DEVICES (IUDS)		
KYLEENA	T3	SP PPACA
LILETTA	T3	SP PPACA
MIRENA	T3	SP PPACA
MIUDELLA	T3	SP PPACA
PARAGARD T 380-A	T3	SP PPACA
PARAGARD T 380A (SINGLE HAND)	T3	SP PPACA
SKYLA	T3	SP PPACA
COUGH/COLD PREPARATIONS (Allergy/Nasal Sprays)		
1ST GEN ANTIHIST-DECONGEST-ANTICHOLINERGIC COMB		
RESPA A.R. (pseudoephed/chlor-mal/bell alk)	T3	
COUGH/COLD PREPARATIONS (Cough/Cold Medications)		
ANTI-TUSSIVES, NON-OPIOID		
benzonatate 100 mg capsule	T1	
benzonatate 150 mg capsule	T1	PA
benzonatate 200 mg capsule	T1	
NON-OPIOID ANTITUS-1ST GEN.ANTIHISTAMINE-DECONGEST		
BROMFED DM (brompheniramine-pseudoephed-dm)	T3	PA
brompheniramine/pseudoephed/dm (Bromfed Dm)	T1	
NON-OPIOID ANTITUSSIVE-1ST GEN ANTIHISTAMINE COMB.		
promethazine/dextromethorphan	T1	
OPIOID ANTITUSSIV-1ST GEN. ANTIHISTAMINE-DECONGEST		
CAPCOF	T3	
HISTEX-AC	T3	
MAXI-TUSS CD	T3	
POLY-TUSSIN AC	T3	
promethazine/phenyleph/codeine	T1	PA QL (480 MLS/30 DAYS)
OPIOID ANTI-TUSSIVE-1ST GENERATION ANTIHISTAMINE		
hydrocodone/chlorphen p-stirex	T1	PA
promethazine-codeine solution	T1	PA QL (480 MLS/30 DAYS)

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

COUGH/COLD PREPARATIONS (Cough/Cold Medications) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPIOID ANTI-TUSSIVE-1ST GENERATION ANTIHISTAMINE (cont.)		
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 (480ml/22 days)
<i>hydrocodone-homatropine 5-1.5</i>	T1	PA QL (180 tabs/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 (480ml/30 days)
OPIOID ANTITUSSIVE-DECONGESTANT-EXPECTORANT COMB		
CODITUSSIN DAC	T3	
OPIOID ANTI-TUSSIVE-EXPECTORANT COMBINATION		
<i>codeine phosphate/guaifenesin</i>	T1	
CODITUSSIN AC	T1	
GUAIFENESIN-CODEINE	T1	
MAR-COF CG	T3	
NINJACOF-XG	T1	
OBREDON	T3	PA QL (960 MLS/30 DAYS)

DIAGNOSTIC (Diabetes)

BLOOD SUGAR DIAGNOSTICS		
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	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

DIAGNOSTIC (Diabetes) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BLOOD SUGAR DIAGNOSTICS (cont.)		
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	
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	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

DIAGNOSTIC (Diabetes) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BLOOD SUGAR DIAGNOSTICS (cont.)		
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	
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 STRIPS	T3	
FORA V12	T3	
FORA V20	T3	
FORA V30A	T3	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

DIAGNOSTIC (Diabetes) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BLOOD SUGAR DIAGNOSTICS (cont.)		
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	
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	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

DIAGNOSTIC (Diabetes) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BLOOD SUGAR DIAGNOSTICS (cont.)		
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	
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	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

DIAGNOSTIC (Diabetes) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BLOOD SUGAR DIAGNOSTICS (cont.)		
RIGHTEST GT333 TEST STRIP	T3	
SMART SENSE TEST STRIPS	T3	
SMARTTEST 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	
UNISTRIPI	T3	
VIVAGUARD INO TEST STRIP	T3	
URINE GLUCOSE TEST AIDS		
DIASTIX REAGENT	T1	
DIAGNOSTIC (Miscellaneous)		
BLOOD TESTING PREPARATIONS		
FORA GTCL KETONE TEST STRIP	T1	
FORA TN'G ADV VOICE KETO STRIP	T1	
GOJJI BLOOD KETONE TEST STRIP	T1	
NOVAMAX PLUS	T1	
PRECISION XTR B-KETONE STRIP	T1	
DIAGNOSTIC PREPARATIONS, MISCELLANEOUS		
ADVANCED DNA MEDICATED COLLECT	T3	
ARIDOL	T3	
<i>lidocaine hcl/glycerin</i>	T1	
PROVOCHOLINE	T3	
TC99M SULFUR COLLOID PREP	T1	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

DIAGNOSTIC (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EYE DIAGNOSTIC AGENTS		
<i>fluorescein sodium</i>	T1	
<i>ful-glo 1 mg ophth strip</i>	T1	
FUL-GLO EYE STRIPS	T3	
<i>lissamine green</i>	T1	
GASTROINTESTINAL RADIOPAQUE DIAGNOSTICS		
<i>diatrizoate meglumine, sodium</i> (Gastrografin)	T1	
ENTEROVU	T3	
E-Z DISK	T3	
E-Z-HD	T3	
E-Z-PAQUE	T3	
E-Z-PASTE	T3	
GASTROGRAFIN (<i>diatrizoate meglumine, sodium</i>)	T3	
GASTROMARK	T3	
LIQUID E-Z PAQUE	T3	
LIQUID POLIBAR PLUS	T3	
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	
METABOLIC FUNCTION DIAGNOSTICS		
METOPIRONE	T2	
RADIOPHARMACEUTICALS ELEMENTS		
INDICLOR	T3	
URINARY TRACT RADIOPAQUE DIAGNOSTICS		
CYSTO-CONRAY II	T3	
CYSTOGRAFIN	T3	
CYSTOGRAFIN-DILUTE	T3	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

DIURETICS (Diuretics)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
URINE ACETONE TEST AIDS		
KETONE CARE TEST STRIP	T1	
KETONE TEST STRIP	T1	
KETOSTIX REAGENT	T1	
TRUEPLUS KETONE TEST STRIP	T1	
CHEK-STIX	T1	
CHEMSTRIP	T1	
CHEMSTRIP 10 WITH SG	T1	
CHEMSTRIP 2 GP	T1	
CHEMSTRIP 50B	T1	
CHEMSTRIP 7	T1	
CHEMSTRIP 9	T1	
COMBISTIX REAGENT	T1	
HEMA-COMBISTIX	T1	
KETO-DIASTIX REAGENT	T1	
LABSTIX REAGENT	T1	
MULTISTIX	T1	
MULTISTIX 10 SG	T1	
MULTISTIX 5	T1	
MULTISTIX 7	T1	
MULTISTIX 8 SG	T1	
MULTISTIX 9	T1	
MULTISTIX 9 SG	T1	
URISTIX 4	T1	
URISTIX REAGENT	T1	
ARGININE VASOPRESSIN (AVP) RECEPTOR ANTAGONISTS		
SAMSCA (<i>tolvaptan</i>)	T3	PA SP
<i>tolvaptan 15 mg tablet (Samsca)</i>	T1	SP
<i>tolvaptan 30 mg tablet (Samsca)</i>	T1	SP
CARBONIC ANHYDRASE INHIBITORS		
<i>acetazolamide</i>	T1	HD
<i>methazolamide</i>	T1	HD
LOOP DIURETICS		
<i>bumetanide</i>	T1	HD
EDECIN (<i>ethacrynic acid</i>)	T3	PA

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

DIURETICS (Diuretics) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LOOP DIURETICS (cont.)		
<i>ethacrynic acid</i> (Edecrin)	T1	PA
FUROSCIX	T3	PA QL(2 KITS/30 DAYS) SP
<i>furosemide</i>	T1	HD
<i>furosemide</i> (Lasix)	T1	HD
LASIX (<i>furosemide</i>)	T3	PA HD
LASIX ONYU 80 MG/2.67 ML KIT	T3	PA QL(2 KITS/30 DAYS)
SOAANZ	T3	PA HD
<i>toremide</i>	T1	HD
POLYCYSTIC KIDNEY DISEASE AGENT, AVP RECEPTOR ANTAG		
JYNARQUE (<i>tolvaptan</i>)	T3	SP
<i>tolvaptan 15 mg tablet</i> (Jynarque)	T1	SP
<i>tolvaptan 15 mg-15 mg tablet</i> (Jynarque)	T1	PA SP
<i>tolvaptan 30 mg tablet</i> (Jynarque)	T1	SP
<i>tolvaptan 30 mg-15 mg tablet</i> (Jynarque)	T1	PA SP
<i>tolvaptan 45 mg-15 mg tablet</i> (Jynarque)	T1	PA SP
<i>tolvaptan 60 mg-30 mg tablet</i> (Jynarque)	T1	PA SP
<i>tolvaptan 90 mg-30 mg tablet</i> (Jynarque)	T1	PA SP
POTASSIUM SPARING DIURETICS		
ALDACTONE (<i>spironolactone</i>)	T3	PA HD
<i>amiloride hcl</i>	T1	HD
CAROSPIR (<i>spironolactone</i>)	T2	PA
DYRENIUM (<i>triamterene</i>)	T3	PA HD
<i>eplerenone</i> (Inspra)	T1	HD
INSPIRA (<i>eplerenone</i>)	T3	PA HD
KERENDIA	T2	PA QL(1 TAB/DAY)
<i>spironolactone 100 mg tablet</i> (Aldactone)	T1	HD
<i>spironolactone 25 mg tablet</i> (Aldactone)	T1	HD
<i>spironolactone 25 mg/5 ml susp</i> (Carospir)	T1	
<i>spironolactone 50 mg tablet</i> (Aldactone)	T1	HD
<i>triamterene</i> (Dyrenium)	T1	HD
POTASSIUM SPARING DIURETICS IN COMBINATION		
<i>amiloride/hydrochlorothiazide</i>	T1	HD
<i>spironolact/hydrochlorothiazid</i>	T1	HD
<i>triamterene/hydrochlorothiazid</i>	T1	HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

DIURETICS (Diuretics) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
THIAZIDE AND RELATED DIURETICS		
<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
THALITONE	T3	PA HD
EENT PREPS (Allergy/Nasal Sprays)		
NASAL ANTIHISTAMINE		
<i>azelastine 0.1% (137 mcg) spray</i>	T1	HD
<i>olopatadine 665 mcg nasal spray</i> (Patanase)	T1	HD
PATANASE (<i>olopatadine hcl</i>)	T3	HD
NASAL ANTIHISTAMINE AND ANTI-INFLAM. STEROID COMB.		
<i>azelastine/fluticasone</i> (Dymista)	T1	HD
DYMISTA (<i>azelastine-fluticasone</i>)	T3	ST HD
RYALTRIS	T3	PA QL(1 GM/30 DAYS) HD
NASAL ANTI-INFLAMMATORY STEROIDS		
<i>flunisolide</i>	T1	HD
<i>fluticasone prop 50 mcg spray</i>	T1	HD
<i>mometasone furoate 50 mcg spray</i>	T1	QL(68 GMS/30 DAYS) HD
OMNARIS	T3	ST HD
QNASL	T3	ST
QNASL CHILDREN	T3	
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	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

EENT PREPS (Ear Medications)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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	T2	QL(4 BOTTLES/30 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	T3	PA
ALREX (<i>loteprednol etabonate</i>)	T3	PA
<i>bromfenac sodium</i>	T1	
<i>bromfenac sodium</i> (Bromsite)	T1	
<i>bromfenac sodium</i> (Prolensa)	T1	
BROMSITE (<i>bromfenac sodium</i>)	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 (<i>difluprednate</i>)	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	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

EENT PREPS (Eye Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EYE ANTI-INFLAMMATORY AGENTS (con't.)		
INVELTYS	T3	ST
<i>ketorolac 0.4% ophth solution (Acular Ls)</i>	T1	
<i>ketorolac 0.5% ophth solution (Acular)</i>	T1	
LOTEMAX 0.5% EYE DROPS (<i>loteprednol etabonate</i>)	T3	PA
LOTEMAX 0.5% EYE OINTMENT	T3	ST
LOTEMAX 0.5% OPHTHALMIC GEL (<i>loteprednol etabonate</i>)	T3	PA
LOTEMAX SM	T3	ST
<i>loteprednol etabonate (Alrex)</i>	T1	
<i>loteprednol etabonate (Lotemax)</i>	T1	
MAXIDEX	T3	PA
NEVANAC	T3	PA
PRED FORTE (<i>prednisolone acetate</i>)	T3	PA
PRED MILD	T3	PA
<i>prednisolone acetate (Pred Forte)</i>	T1	
<i>prednisolone sodium phosphate</i>	T1	
PROLENSA (<i>bromfenac sodium</i>)	T3	
EYE LOCAL ANESTHETICS		
AKTEN	T3	
ALCAINE (<i>proparacaine hcl</i>)	T3	
ALTAFLUOR BENOX (<i>benoxinate hcl/fluorescein sod</i>)	T3	
FLUORESCEIN-BENOXINATE	T3	
<i>proparacaine hcl (Alcaine)</i>	T1	
<i>proparacaine/fluorescein sod</i>	T1	
<i>tetracaine hcl</i>	T1	
TETRACAINE HCL	T1	
EYE MAST CELL STABILIZERS		
ALOCRIAL	T3	PA
<i>cromolyn 4% eye drops</i>	T1	
EYE PREPARATIONS, MISCELLANEOUS (OTC)		
GELFILM	T3	
EYE VASOCONSTRICTORS		
<i>phenylephrine hcl</i>	T1	
UPNEEQ	T3	PA

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

EENT PREPS (Eye Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MIOTICS AND OTHER INTRAOCULAR PRESSURE REDUCERS		
ALPHAGAN P (<i>brimonidine tartrate</i>)	T3	PA HD
<i>apraclonidine hcl</i>	T1	HD
AZOPT (<i>brinzolamide</i>)	T3	PA HD
<i>betaxolol hcl</i>	T1	HD
BETIMOL	T3	PA HD
BETIMOL (<i>timolol</i>)	T3	PA HD
BETOPTIC S	T2	HD
<i>bimatoprost</i>	T1	QL(10 MLS/30 DAYS) HD
<i>brimonidine tartrate</i>	T1	HD
<i>brimonidine tartrate</i> (Alphagan P)	T1	HD
<i>brimonidine tartrate/timolol</i> (Combigan)	T1	HD
<i>brinzolamide</i> (Azopt)	T1	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</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
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
PHOSPHOLINE IODIDE	T2	SP HD
<i>pilocarpine 1% eye drops</i>	T1	HD
<i>pilocarpine 2% eye drops</i>	T1	HD
<i>pilocarpine 4% eye drops</i>	T1	HD
<i>pilocarpine hcl 1.25% eye drop</i> (Vuity)	T1	PA HD
QLOSI	T3	PA
RHOPRESSA	T3	
ROCKLATAN	T3	
SIMBRINZA	T2	HD
<i>tafluprost/pf</i> (Zioptan)	T1	QL(60 DROPPERS/30 DAYS) HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

EENT PREPS (Eye Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MIOTICS AND OTHER INTRAOCULAR PRESSURE REDUCERS (con't.)		
<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
<i>timolol maleate/pf</i> (Timoptic Ocudose)	T1	HD
TIMOPTIC (<i>timolol maleate</i>)	T3	PA HD
TIMOPTIC OCUDOSE	T3	PA HD
TIMOPTIC OCUDOSE (<i>timolol maleate/pf</i>)	T3	PA HD
TIMOPTIC-XE (<i>timolol maleate</i>)	T3	PA HD
TRAVATAN Z (<i>travoprost</i>)	T3	PA HD
<i>travoprost</i> (Travatan Z)	T1	HD
VIZZ	T3	PA HD
VUITY (<i>pilocarpine hcl</i>)	T3	PA HD
VYZULTA	T3	PA
XALATAN (<i>latanoprost</i>)	T3	PA HD
ZIOPATAN (<i>tafluprost/pf</i>)	T3	PA QL(60 DROPPERS/30 DAYS) HD
MYDRIATICS		
<i>atropine 1% eye drop</i>	T1	HD
<i>atropine 1% eye drops</i>	T1	HD
ATROPINE 1% EYE DROPS	T3	PA HD
<i>atropine 1% eye ointment</i>	T1	HD
CYCLOGYL 0.5% EYE DROPS	T2	HD
CYCLOGYL 1% EYE DROPS	T3	HD
CYCLOGYL 1% EYE DROPS (<i>cyclopentolate hcl</i>)	T3	HD
CYCLOGYL 2% EYE DROPS (<i>cyclopentolate hcl</i>)	T3	HD
CYCLOMYDRIL	T2	HD
<i>cyclopentolate hcl</i>	T1	HD
<i>cyclopentolate hcl</i> (Cyclogyl)	T1	HD
<i>homatropine hbr</i>	T1	HD
MYDRIACYL (<i>tropicamide</i>)	T3	HD
PAREMYD	T3	HD
<i>tropicamide</i>	T1	HD
<i>tropicamide</i> (Mydracyl)	T1	HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

EENT PREPS (Eye Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPHTHALMIC ANTI-FIBROTIC AGENTS		
MITOSOL	T3	
OPHTHALMIC ANTI-INFLAMMATORY IMMUNOMODULATOR-TYPE		
CEQUA	T2	
cyclosporine 0.05% eye emuls (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 CYSTINE DEPLETING AGENTS		
CYSTADROPS	T3	PA QL(20 MLS/28 DAYS) SP
CYSTARAN 0.44% EYE DROPS	T3	PA QL(120 MLS/28 DAYS) SP
OPHTHALMIC HUMAN NERVE GROWTH FACTOR (HNGF)		
OXERVATE	T3	PA SP HD
OPHTHALMIC TRPM8 AGONISTS		
TRYPTYR	T3	
ELECT/CALORIC/H2O (Cholesterol Medications)		
ORAL LIPID SUPPLEMENTS		
DOJOLVI	T3	PA SP HD
ELECT/CALORIC/H2O (Dental Products)		
FLUORIDE PREPARATIONS		
CLINPRO 5000	T3	
FLORIVA 0.25 MG/ML DROPS	T3	PPACA
fluoride (sodium)	T1	
fluoride (sodium) (Prevident 5000 Plus)	T1	
fluoride (sodium) (Prevident)	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))	T2	
PREVIDENT 1.1% GEL (sodium fluoride)	T3	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ELECT/CALORIC/H2O (Dental Products) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FLUORIDE PREPARATIONS (con't.)		
PREVIDENT 5000 BOOSTER PLUS	T3	
PREVIDENT 5000 DRY MOUTH	T3	
PREVIDENT 5000 ENAMEL PROTECT	T3	
PREVIDENT 5000 ORTHO DEFENSE	T3	
PREVIDENT 5000 PLUS (fluoride (sodium))	T3	PA
PREVIDENT 5000 SENSITIVE	T3	
PREVIDENT DENTAL RINSE (fluoride (sodium))	T2	
PREVIDENT KIDS	T3	
sodium fluoride/potassium nit (Prevident 5000 Sensitive)	T1	
sodium fluoride 1.1% gel (Prevident)	T1	
sodium fluoride 5000 ppm paste	T1	
sodium fluoride/potassium nit	T1	
PEDIATRIC VITAMIN PREPARATIONS		
fluoride (sodium)	T1	PPACA
sodium fluoride 0.25 (0.55) mg	T1	PPACA
sodium fluoride 0.5 mg(1.1 mg)	T1	PPACA
sodium fluoride 0.5 mg/ml drop	T1	PPACA
sodium fluoride 1 mg (2.2 mg)	T1	PPACA
ELECT/CALORIC/H2O (Diabetes)		
AGENTS TO TREAT HYPOGLYCEMIA (HYPERGLYCEMICS)		
BAQSIMI	T2	QL(2 UNITS/30 DAYS)
diazoxide (Proglycem)	T1	
glucagon 1 mg emergency kit	T1	QL(2 VIALS/30 DAYS)
GLUCAGON 1 MG EMERGENCY KIT	T3	QL(2 KITS/30 DAYS)
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)

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ELECT/CALORIC/H2O (Miscellaneous)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NUCLEIC ACID/NUCLEOTIDE SUPPLEMENTS		
XURIDEN	T3	PA SP
ELECT/CALORIC/H2O (Nutritional/Dietary)		
CALCIUM REPLACEMENT		
<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	T3	PA
FOSRENOL (<i>lanthanum carbonate</i>)	T3	PA
<i>lanthanum carbonate</i> (Fosrenol)	T1	
LOKELMA	T2	
MAGNEBIND 400	T3	
REVELA (<i>sevelamer carbonate</i>)	T3	PA
<i>sevelamer carbonate</i> (Renvela)	T1	
<i>sevelamer hcl</i>	T1	
<i>sodium polystyrene sulfon/sorb</i>	T1	
<i>sodium polystyrene sulfonate</i>	T1	
<i>sps 15 gm/60 ml suspension</i>	T1	
<i>sps 30 gm/120 ml enema susp</i>	T3	
VELPHORO	T2	
VELTASSA	T2	
XPHOZAH	T3	PA SP
FLUORIDE PREPARATIONS		
CLINPRO 5000	T3	
<i>fluoride (sodium)</i>	T1	
<i>fluoride (sodium)</i> (Prevident 5000 Plus)	T1	
<i>fluoride (sodium)</i> (Prevident)	T1	
FLUORIDEX	T1	
FLUORIMAX 5000	T3	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FLUORIDE PREPARATIONS (con't.)		
JUST RIGHT 5000	T3	
PREVIDENT 0.2% RINSE (fluoride (sodium))	T2	
PREVIDENT 1.1% GEL (fluoride (sodium))	T3	
PREVIDENT 5000 BOOSTER PLUS	T3	
PREVIDENT 5000 DRY MOUTH	T3	
PREVIDENT 5000 ORTHO DEFENSE	T3	
PREVIDENT 5000 PLUS (fluoride (sodium))	T3	PA
PREVIDENT DENTAL RINSE (fluoride (sodium))	T2	
PREVIDENT KIDS	T3	
sodium fluoride 0.2% rinse (Prevident)	T1	
sodium fluoride 1.1% cream (Prevident 5000 Plus)	T1	
sodium fluoride 1.1% gel (Prevident)	T1	
sodium fluoride 5000 ppm paste	T1	
IODINE CONTAINING AGENTS		
potassium iodide	T1	
potassium iodide/iodine	T1	
SSKI	T1	
IRON REPLACEMENT		
ACCRUFER	T3	
ACTIVE FE	T3	
CITRANATAL BLOOM	T3	
CORVITE 150	T3	
CORVITE FE	T3	
FERIVA 21-7	T3	
FERRALET 90	T3	
ferrous fum/vit c/b12-if/folic	T1	
ferrous fumarate/folic acid (Hemocyte-F)	T1	
FUSION PLUS	T3	
HEMATRON-AF	T3	
HEMAX	T3	
HEMOCYTE PLUS (mv-mins no.73/iron fum/folic)	T3	
HEMOCYTE-F (ferrous fumarate/folic acid)	T3	
INTEGRA F (iron fum,ps/folic acid/vitc/b3)	T3	
INTEGRA PLUS (iron fum,ps/folic/bcomp,c no.9)	T3	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
IRON REPLACEMENT (cont.)		
<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/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	
NEONATAL FE	T3	
NUFERA	T3	
PROFERRIN-FORTE	T3	
VITAFOL	T2	
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
POTASSIUM REPLACEMENT		
EFFER-K 10 MEQ TABLET EFF	T3	
EFFER-K 20 MEQ TABLET EFF	T3	
<i>effer-k 25 meq tablet eff</i>	T1	
POKONZA 10 MEQ PACKET	T3	PA
POKONZA 15 MEQ PACKET	T3	
<i>potassium bicarbonate/cit ac</i>	T1	
<i>potassium chloride</i>	T1	
<i>potassium chloride</i>	T2	
<i>potassium cl 10% (20 meq/15ml)</i>	T1	
<i>potassium cl 20 meq packet</i>	T1	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
POTASSIUM REPLACEMENT (con't.)		
<i>potassium cl 20% (40 meq/15ml)</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% (20 meq/15ml) cup</i>	T1	
<i>potassium cl 10% (40 meq/30ml) cup</i>	T1	
<i>potassium cl 20% (40 meq/15ml) cup</i>	T1	
PROTEIN REPLACEMENT		
AQNEURSA	T3	PA SP

Elect/Caloric/H2O (Urinary Tract Conditions)

DIALYSIS SOLUTIONS		
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
UROCIT-K (<i>potassium citrate er</i>)	T3	HD
UROQID-ACID NO.2	T2	HD

GASTROINTESTINAL (Cholesterol Medications)

LIPOTROPICS		
<i>icosapent ethyl (Vascepa)</i>	T1	HD
LOVAZA (<i>omega-3 acid ethyl esters</i>)	T3	PA HD
<i>omega-3 acid ethyl esters (Lovaza)</i>	T1	HD
VASCEPA (<i>icosapent ethyl</i>)	T2	PA HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn)		
AMMONIA INHIBITORS		
BUPHENYL (<i>sodium phenylbutyrate</i>)	T3	PA SP HD
<i>glycerol phenylbutyrate</i>	T1	SP HD
<i>lactulose</i>	T1	
<i>lactulose</i>	T1	HD
<i>lactulose 10 gm/15 ml solution</i>	T1	
LITHOSTAT	T2	HD
OLPRUVA	T3	PA SP HD
PHEBURANE	T2	PA QL (8 BOTTLES/30 DAYS) SP HD
RAVICTI	T3	PA SP HD
<i>sodium phenylbutyrate (Buphenyl)</i>	T1	SP HD
ANTI-CHOLINERGICS, QUATERNARY AMMONIUM		
<i>chlordiazepoxide/clidinium br (Librax)</i>	T1	
CUVPOSA (<i>glycopyrrolate</i>)	T3	
DARTISLA	T3	PA
GLYCATÉ	T3	
<i>glycopyrrolate 1 mg tablet (Robinul)</i>	T1	
<i>glycopyrrolate 1 mg/5 ml soln (Cuvposa)</i>	T1	
<i>glycopyrrolate 1.5 mg tablet</i>	T1	PA
<i>glycopyrrolate 2 mg tablet (Robinul Forte)</i>	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	
DICYCLOMINE 40 MG TABLET	T3	PA
ANTI-DIARRHEAL - G.I. CHLORIDE CHANNEL INHIBITORS		
MYTESI	T3	SP
ANTI-DIARRHEAL - TRYPTOPHAN HYDROXYLASE INHIBITOR		
XERMELO	T3	PA SP
ANTI-DIARRHEAL MICROORGANISMS AGENTS		
RESTORA RX	T3	PA SP

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-DIARRHEALS		
<i>diphenoxylate hcl/atropine</i>	T1	
<i>diphenoxylate hcl/atropine</i> (Lomotil)	T1	
LOMOTIL (<i>diphenoxylate-atropine</i>)	T3	PA
<i>loperamide hcl</i>	T1	
MOTOFEN	T3	
<i>opium tincture</i>	T1	PA
ANTI-EMETIC, CANNABINOID-TYPE		
<i>dronabinol</i> (Marinol)	T1	
MARINOL (<i>dronabinol</i>)	T3	PA
SYNDROS	T3	PA
ANTI-EMETIC/ANTI-VERTIGO AGENTS		
AKYNZEO	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</i> (Emend)	T1	QL(12 CAPS/28 DAYS)
<i>aprepitant 40 mg capsule</i>	T1	QL(1 CAP/28 DAYS)
<i>aprepitant 80 mg capsule</i> (Emend)	T1	QL(8 CAPS/28 DAYS)
BONJESTA	T3	
COMPAZINE (<i>prochlorperazine maleate</i>)	T3	
COMPAZINE (<i>prochlorperazine</i>)	T3	
DICLEGIS (<i>doxylamine succinate/vit b6</i>)	T3	PA QL(4 TABS/DAY)
<i>doxylamine succinate/vit b6</i> (Diclegis)	T1	QL(4 tabs/day)
EMEND 125 MG POWDER PACKET	T3	PA QL(12 PACKS/28 DAYS)
EMEND 150 MG VIAL (<i>fosaprepitant dimeglumine</i>)	T3	
EMEND 80 MG CAPSULE (<i>aprepitant</i>)	T3	PA QL(8 CAPS/28 DAYS)
EMEND TRIPACK (<i>aprepitant</i>)	T3	PA QL(12 CAPS/28 DAYS)
<i>fosaprepitant dimeglumine</i> (Emend)	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	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-EMETIC/ANTI-VERTIGO AGENTS (cont.)		
<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>prochlorperazine (Compazine)</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	
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
<i>misoprostol (Cytotec)</i>	T1	HD
<i>sucralfate</i>	T1	HD
<i>sucralfate (Carafate)</i>	T1	HD
ANTI-ULCER-H.PYLORI AGENTS		
<i>bismuth/metronid/tetracycline (Pylera)</i>	T1	
<i>lansoprazole/amoxicilin/clarith</i>	T1	
OMECLAMOX-PAK	T3	PA
PYLERA (<i>bismuth/metronid/tetracycline</i>)	T3	PA
TALICIA	T3	PA
VOQUEZNA TRIPLE PAK	T3	PA
VOQUEZNA DUAL PAK	T3	PA
BELLADONNA ALKALOIDS		
DONNATAL	T3	PA HD
DONNATAL (<i>phenobarb/hyoscy/atropine/scop</i>)	T3	PA 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-sl)</i>	T1	HD
<i>hyoscyamine sulfate (Nulev)</i>	T1	HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BELLADONNA ALKALOIDS (cont.)		
<i>hyoscyamine sulfate</i> (Nulev)	T3	HD
LEVBIID (<i>hyoscyamine sulfate</i>)	T3	PA HD
LEVSIN (<i>hyoscyamine sulfate</i>)	T3	HD
LEVSIN-SL (<i>hyoscyamine sulfate</i>)	T3	PA HD
<i>methscopolamine bromide</i>	T1	HD
NULEV (<i>hyoscyamine sulfate</i>)	T3	HD
<i>phenobarb/hyoscy/atropine/scop</i>	T1	HD
<i>phenobarb/hyoscy/atropine/scop</i> (Donnatal)	T1	HD
<i>phenobarb/hyoscy/atropine/scop</i> (Phenobarbital-belladonna)	T1	HD
PHENOBARBITAL-BELLADONNA (<i>phenobarb/hyoscy/atropine/scop</i>)	T3	HD
SYMAX DUOTAB	T2	HD
BILE SALTS		
CHENODAL	T3	PA SP HD
CHOLBAM	T3	PA SP HD
CTEXLI	T3	PA SP
RELTONE	T3	PA HD
URSO FORTE (<i>ursodiol</i>)	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</i> (Urso Forte)	T1	HD
CHRONIC INFLAM. COLON DX, 5-A-SALICYLAT, RECTAL TX		
CANASA (<i>mesalamine</i>)	T3	PA
<i>mesalamine 1,000 mg supp</i> (Canasa)	T1	
<i>mesalamine 4 gm/60 ml enema</i> (Sfrowasa)	T1	
<i>mesalamine 4 gm/60 ml kit</i> (Rowasa)	T1	
ROWASA (<i>mesalamine</i>)	T3	PA
SFROWASA (<i>mesalamine</i>)	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

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DRUG TX-CHRONIC INFLAM. COLON DX, 5-AMINOSALICYLAT (cont.)		
<i>balsalazide disodium</i> (Colazal)	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</i> (Apriso)	T1	HD
<i>mesalamine</i> (Pentasa)	T1	HD
<i>mesalamine</i> 800 mg dr tablet (Asacol Hd)	T1	HD
<i>mesalamine</i> dr 1.2 gm tablet (Lialda)	T1	HD
PENTASA 250 MG CAPSULE	T3	ST HD
PENTASA 500 MG CAPSULE (<i>mesalamine</i>)	T3	HD
<i>sulfasalazine</i> (Azulfidine)	T1	HD
FARNESOID X RECEPTOR (FXR) AGONIST, BILE AC ANALOG		
OCALIVA	T3	PA SP HD
FECAL MICROBIOTA TRANSPLANTATION (FMT)		
VOWST	T3	PA QL (12 CAPS/56 DAYS) SP
GASTRIC ENZYMES		
SUCRAID	T3	PA SP
HISTAMINE H2-RECEPTOR INHIBITORS		
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</i> (Analpram Hc)	T1	
PROCORT	T3	
PROCTOFOAM-HC	T2	
HISTAMINE H2-RECEPTOR INHIBITORS		
<i>cimetidine hcl</i>	T1	HD
<i>famotidine</i>	T1	HD
<i>famotidine</i> (Pepcid)	T1	HD
<i>nizatidine</i>	T1	HD
PEPCID (<i>famotidine</i>)	T1	PA HD
IBS AGENTS, MIXED OPIOID RECEPTOR AGONISTS/ANTAGONISTS		
VIBERZI	T2	HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
IBS AGENTS, SODIUM-HYDROGEN EXCHANGER 3(NHE3) INHIB		
IBSRELA	T3	PA QL (2 TABS/DAY)
IBS-C/CIC AGENTS, GUANYLATE CYCLASE-C AGONIST		
LINZESS	T2	
TRULANCE	T2	
ILEAL BILE ACID TRANSPORTER (IBAT) INHIBITOR		
BYLVAY	T3	PA SP HD
LIVMARLI	T3	PA SP
INTEGRIN RECEPTOR ANTAGONIST, MONOCLONAL ANTIBODY		
ENTYVIO	T2	PA SP HD
INTESTINAL MOTILITY STIMULANTS		
GIMOTI	T3	PA SP
metoclopramide hcl	T1	
metoclopramide hcl (Reglan)	T1	
MOTEGRITY	T3	PA
prucalopride succinate (Motegrity)	T1	
REGLAN (metoclopramide hcl)	T3	
IRRITABLE BOWEL SYND. AGENT, 5-HT4 PARTIAL AGONIST		
ZELNORM	T3	PA
IRRITABLE BOWEL SYNDROME AGENTS, 5-HT3 ANTAGONIST		
alosetron hcl (Lotronex)	T1	SP HD
LOTROXEX (alosetron hcl)	T3	PA SP HD
LAXATIVES AND CATHARTICS		
AMITIZA (lubiprostone)	T3	PA
bisac/nac/nahco3/kcl/peg 3350	T1	PPACA
CLENPIQ	T3	PA PPACA
GOLYTELY (peg-3350 and electrolytes)	T3	PA PPACA
KRISTALOSE	T3	PA
lactulose	T1	
lactulose 10 gm packet	T1	PA
lactulose 10 gm/15 ml soln cup	T1	
lactulose 10 gm/15 ml solution	T1	
lactulose 20 gm packet	T1	
lactulose 20 gm/30 ml soln cup	T1	
lactulose 20 gm/30 ml solution	T1	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LAXATIVES AND CATHARTICS (cont.)		
<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 (<i>sodium, potassium,mag sulfates</i>)	T3	PA PPACA
SUTAB	T3	PA PPACA
LOCAL ANORECTAL NITRATE PREPARATIONS		
<i>nitroglycerin 0.4% ointment</i> (Rectiv)	T1	
RECTIV (<i>nitroglycerin</i>)	T3	
PANCREATIC ENZYMES		
CREON	T3	PA HD
PANCREAZE	T2	HD
PERTZYE	T3	PA HD
VIOKACE	T3	HD
ZENPEP	T2	HD
POTASSIUM-COMPETITIVE ACID BLOCKERS (PCABS)		
VOQUEENZA	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	T3	PA QL (2 CAPS/DAY)
DEXILANT DR 60 MG CAPSULE	T3	PA QL (1 CAP/DAY)
<i>dexlansoprazole dr 30 mg cap</i>	T1	QL (2 CAPS/DAY)
<i>dexlansoprazole dr 60 mg cap</i> (Dexilant)	T1	QL (1 CAP/DAY)
<i>esomeprazole dr 10 mg packet</i> (Nexium)	T1	QL (4 PACKS/DAY) HD
<i>esomeprazole dr 2.5 mg packet</i> (Nexium)	T1	QL (16 PACKS/DAY) HD
<i>esomeprazole dr 20 mg packet</i> (Nexium)	T1	QL (2 PACKS/DAY) HD
<i>esomeprazole dr 40 mg packet</i> (Nexium)	T1	QL (1 PACK/DAY) HD
<i>esomeprazole dr 5 mg packet</i> (Nexium)	T1	QL (8 PACKS/DAY) HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PROTON-PUMP INHIBITORS (cont.)		
<i>esomeprazole mag dr 20 mg cap</i> (Nexium)	T1	QL(2 CAPS/DAY) HD
<i>esomeprazole mag dr 40 mg cap</i> (Nexium)	T1	QL(1 CAP/DAY) HD
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 capsule</i> (Prevacid)	T1	QL(2 TABS/DAY) HD
<i>lansoprazole dr 30 mg capsule</i> (Prevacid)	T1	QL(1 CAP/DAY) HD
<i>lansoprazole odt 30 mg tablet</i> (Prevacid)	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	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
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	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</i> (Zegerid)	T1	PA QL(2 CAPS/DAY) HD
<i>omeprazole-bicarb 20-1, 680 pkt</i> (Zegerid)	T1	PA QL(2 PACKS/DAY) HD
<i>omeprazole-bicarb 40-1, 100 cap</i> (Zegerid)	T1	PA QL(1 CAP/DAY) HD
<i>omeprazole-bicarb 40-1, 680 pkt</i> (Zegerid)	T1	PA QL(1 PACK/DAY) HD
<i>pantoprazole 40 mg suspension</i> (Protonix)	T1	QL(1 PACK/DAY) HD
<i>pantoprazole sod dr 20 mg tab</i> (Protonix)	T1	QL(2 TABS/DAY) HD
<i>pantoprazole sod dr 40 mg tab</i> (Protonix)	T1	QL(1 TAB/DAY) HD
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)

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PROTON-PUMP INHIBITORS (cont.)		
RABEPRAZOLE DR 10 MG SPRNKL CP	T3	QL(2 CAPS/DAY) HD
<i>rabeprazole sod dr 20 mg tab</i> (Aciphex)	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
RECTAL PREPARATIONS		
ANUSOL-HC (<i>hydrocortisone acetate</i>)	T3	PA
<i>hydrocortisone acetate</i>	T1	
<i>hydrocortisone acetate</i> (Anusol-hc)	T1	
SBS - GLUCAGON-LIKE PEPTIDE-2 (GLP-2) ANALOGS		
GATTEX	T3	PA SP HD
GASTROINTESTINAL (Pain Relief And Inflammatory Disease)		
HEMORRHOID PREP, ANTI-INFLAM STEROID-LOCAL ANESTHET		
ANA-LEX	T1	
ANALPRAM HC 1% CREAM	T3	
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/lidocaine/aloe</i>	T1	
<i>hydrocortisone/pramoxine</i>	T1	
<i>hydrocortisone/pramoxine</i> (Analpram Hc)	T1	
<i>lidocaine/hydrocortisone ac</i>	T1	
LIDOCAINE-HYDROCORTISONE	T1	
PROCORT	T3	
PROCTOFOAM-HC	T2	
HEMATOPOIETIC GROWTH FACTORS (Miscellaneous)		
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)
HORMONES (Gastrointestinal/Heartburn)		
RECTAL/LOWER BOWEL PREP., GLUCOCORT. (NON-HEMORR)		
<i>budesonide 2 mg rectal foam</i> (Uceris)	T1	QL(2 KITS/180 DAYS)
CORTENEMA (<i>hydrocortisone</i>)	T3	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

HORMONES (Gastrointestinal/Heartburn) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
RECTAL/LOWER BOWEL PREP., GLUCOCORT. (NON-HEMORR)		
CORTIFOAM	T3	PA
<i>hydrocortisone</i> (Cortenema)	T1	
UCERIS 2 MG RECTAL FOAM (<i>budesonide</i>)	T3	PA QL(2 KITS/180 DAYS)
HORMONES (Hormonal Agents)		
ADRENAL STEROID INHIBITORS		
ISTURISA 1 MG TABLET	T3	PA QL(8 TABS/DAY) SP
ISTURISA 5 MG TABLET	T3	PA QL(2 TABS/DAY) SP
RECORLEV	T3	PA QL(8 TABS/DAY) SP
ADRENOCORTICOTROPHIC HORMONES		
ACTHAR SELFJECT	T3	PA SP HD
CORTROPHIN	T3	PA SP HD
ANDROGEN/ESTROGEN PREPS FOR FEMALE SEXUAL DYSFUNC		
INTRAROSA	T3	QL(30 INSERTS/30 DAYS)
ANDROGENIC AGENTS		
ANDROGEL 1% (25 MG/2.5 G) PKT (<i>testosterone</i>)	T3	PA QL(150 GMS/30 DAYS)
ANDROGEL 1% (50 MG/5 G) PKT (<i>testosterone</i>)	T3	PA QL(300 GMS/30 DAYS)
ANDROGEL 1.62% GEL PUMP (<i>testosterone</i>)	T3	PA QL(150 GMS/30 DAYS)
DEPO-TESTOSTERONE	T3	
DEPO-TESTOSTERONE (<i>testosterone cypionate</i>)	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 (<i>testosterone</i>)	T3	PA QL(10 GMS/DAY)
<i>testosterone 1% (25mg/2.5g) pk</i> (Androgel)	T1	PA QL(150 GMS/30 DAYS)
<i>testosterone 1% (50 mg/5 g) pk</i> (Vogelxo)	T1	PA QL(300 GMS/30 DAYS)
<i>testosterone 1.62% (2.5 g) pkt</i> (Androgel)	T1	PA QL(150 GMS/30 DAYS)

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

HORMONES (Hormonal Agents) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANDROGENIC AGENTS (cont.)		
testosterone 1.62% gel pump (Androgel)	T1	PA QL(150 GMS/30 DAYS)
testosterone 1.62% (1.25 g) pkt (Androgel)	T1	PA QL(75 GMS/30 DAYS)
testosterone 10 mg gel pump	T1	PA QL(120 GMS/30 DAYS)
testosterone 12.5 mg/1.25 gram	T1	PA QL(150 GMS/30 DAYS)
testosterone 30 mg/1.5 ml pump	T1	PA QL(180 MLS/30 DAYS)
testosterone 50 mg/5 gram gel (Testim)	T1	PA QL(10 GMS/DAY)
testosterone 50 mg/5 gram gel (Vogelxo)	T1	PA QL(10 GMS/DAY)
TESTOSTERONE 50 MG/5 GRAM PKT	T1	PA QL(300 GMS/30 DAYS)
testosterone cypionate	T1	
testosterone cypionate (Depo-Testosterone)	T1	
testosterone enanthate	T1	
TLANDO	T3	PA QL(4 CAPS/DAY)
UNDECATREX	T3	PA QL(4 CAPS/DAY)
VOGELXO 12.5 MG/1.25 GRAM PUMP	T3	PA QL(150 GMS/30 DAYS)
VOGELXO 50 MG/5 GRAM GEL (testosterone)	T3	PA QL(10 GMS/DAY)
VOGELXO 50 MG/5 GRAM GEL PACKET	T3	PA QL(300 GMS/30 DAYS)
XYOSTED	T3	PA QL(2 ML/28 DAYS)
ANTI-DIURETIC AND VASOPRESSOR HORMONES		
DDAVP 0.1 MG TABLET (desmopressin acetate)	T3	PA HD
DDAVP 0.2 MG TABLET (desmopressin acetate)	T3	PA HD
DDAVP 4 MCG/ML AMPUL (desmopressin acetate)	T3	PA SP
DDAVP 40 MCG/10 ML VIAL (desmopressin acetate)	T3	PA SP
desmopressin 0.01% solution	T1	HD
desmopressin 10 mcg/0.1 ml spr	T1	HD
desmopressin 40 mcg/10 ml vial (Ddavp)	T1	SP
desmopressin ac 4 mcg/ml ampul (Ddavp)	T1	SP
desmopressin ac 4 mcg/ml vial (Ddavp)	T1	SP
desmopressin acetate 0.1 mg tb (Ddavp)	T1	HD
desmopressin acetate 0.2 mg tb (Ddavp)	T1	HD
NOCTIVA	T3	PA
ESTROGEN AND PROGESTIN COMBINATIONS		
BIJUVA	T3	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

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		
ESTRATEST H.S. (<i>estrogen, ester/me-testosterone</i>)	T3	PA HD
<i>estrogen, ester/me-testosterone</i>	T1	HD
<i>estrogen, ester/me-testosterone</i> (Estratest H.S.)	T1	HD
ESTROGENIC AGENTS		
ACTIVELLA (<i>estradiol/norethindrone acet</i>)	T3	PA HD
CLIMARA (<i>estradiol</i>)	T3	PA HD
CLIMARA PRO	T3	PA HD
COMBIPATCH	T2	
DELESTROGEN (<i>estradiol valerate</i>)	T3	PA HD
DEPO-ESTRADIOL	T3	HD
DIVIGEL (<i>estradiol</i>)	T3	PA HD
ELESTRIN	T3	PA HD
ESTRACE (<i>estradiol</i>)	T1	HD
<i>estradiol</i> (Climara)	T1	QL (16 PATCHES/28 DAYS) HD
<i>estradiol</i> (Minivelle)	T1	QL (16 PATCHES/28 DAYS) HD
<i>estradiol</i> (Vivelle-dot)	T1	QL (16 patches/28 days) HD
<i>estradiol 0.06% 1.25g gel pump</i> (Estrogel)	T1	HD
<i>estradiol 0.1% (0.25mg) gel pk</i> (Divigel)	T1	HD
<i>estradiol 0.1% (0.5mg) gel pkt</i> (Divigel)	T1	HD
<i>estradiol 0.1% (0.75mg) gel pk</i> (Divigel)	T1	HD
<i>estradiol 0.1% (1 mg) gel pkt</i> (Divigel)	T1	HD
<i>estradiol 0.1% (1.25mg) gel pk</i> (Divigel)	T1	HD
<i>estradiol 0.5 mg tablet</i>	T1	HD
<i>estradiol 1 mg tablet</i>	T1	HD
<i>estradiol 2 mg tablet</i>	T1	HD
<i>estradiol valerate</i> (Delestrogen)	T1	HD
<i>estradiol/norethindrone acet</i>	T1	HD
<i>estradiol/norethindrone acet</i> (Activella)	T1	HD
ESTROGEL (<i>estradiol</i>)	T3	PA HD
<i>estrogens, conjugated</i> (Premarin)	T1	HD
EVAMIST	T3	HD
MENEST	T3	HD
MENOSTAR	T3	QL (8 PATCHES/28 DAYS) HD
MINIVELLE (<i>Iyllana</i>)	T3	PA QL (16 PATCHES/28 DAYS) HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

HORMONES (Hormonal Agents) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ESTROGENIC AGENTS (cont.)		
<i>norethind-eth estrad 0.5-2.5 (Femhrt)</i>	T1	HD
<i>norethindrone ac/eth estradiol</i>	T1	HD
<i>norethin-eth estrad 1 mg-5 mcg</i>	T1	HD
PREMARIN (<i>estrogens, conjugated</i>)	T2	HD
PREMPHASE	T2	HD
PREMPRO	T2	HD
VIVELLE-DOT (<i>estradiol</i>)	T3	PA QL (16 PATCHES/28 DAYS) HD
ESTROGEN-PROGESTIN WITH ANTI-MINERALOCORTICOID COMB		
ANGELIQ	T3	HD
ESTROGEN-SELECTIVE ESTROGEN RECEPTOR MOD (SERM) COMB		
DUAVEE	T2	
GLUCOCORTICOIDS		
AGAMREE	T3	PA QL (10 MLS/DAY) SP
ALKINDI SPRINKLE	T3	PA SP
<i>budesonide</i>	T1	
<i>budesonide (Uceris)</i>	T1	PA QL (1 TAB/DAY)
CORTEF (<i>hydrocortisone</i>)	T3	PA
<i>cortisone acetate</i>	T1	
<i>deflazacort (Emflaza)</i>	T1	PA SP
<i>deflazacort (Emflaza)</i>	T1	PA SP HD
<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	
<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	
EMFLAZA (<i>deflazacort</i>)	T3	PA SP HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

HORMONES (Hormonal Agents) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GLUCOCORTICOIDS (cont.)		
EOHILIA	T3	PA QL(1800 MLS/180 DAYS)
HEMADY	T3	
<i>hydrocortisone</i> (Cortef)	T1	
KHINDIVI	T3	PA SP
MEDROL 16 MG TABLET (<i>methylprednisolone</i>)	T3	
MEDROL 2 MG TABLET	T2	
MEDROL 4 MG DOSEPAK (<i>methylprednisolone</i>)	T3	
MEDROL 4 MG TABLET (<i>methylprednisolone</i>)	T3	
MEDROL 8 MG TABLET (<i>methylprednisolone</i>)	T3	
<i>methylprednisolone</i>	T1	
<i>methylprednisolone</i> (Medrol)	T1	
ORAPRED ODT (<i>prednisolone sodium phos odt</i>)	T3	
<i>prednisolone</i>	T1	
<i>prednisolone sodium phosphate</i>	T1	
<i>prednisolone sodium phosphate</i> (Orapred Odt)	T1	
<i>prednisone</i>	T1	
TAPERDEX	T1	PA
TARPEYO	T3	PA QL(4 CAPS/DAY) SP
UCERIS 9 MG ER TABLET (<i>budesonide</i>)	T3	PA QL(1 TAB/DAY)
ZCORT	T3	PA
GROWTH HORMONE RELEASING HORMONE (GHRH) AND ANALOGS		
EGRIFTA SV	T3	PA SP HD
EGRIFTA WR	T3	PA SP HD
GROWTH HORMONES		
GENOTROPIN	T2	PA SP HD
HUMATROPE	T3	PA SP HD
NGENLA	T2	PA SP
NORDITROPIN FLEXPPO	T3	PA SP HD
NUTROPIN AQ NUSPIN	T3	PA SP HD
OMNITROPE	T2	PA SP HD
SEROSTIM	T2	PA SP HD
SKYTROFA	T2	PA SP HD
SOGROYA	T3	PA SP
ZOMACTON	T3	PA SP HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

HORMONES (Hormonal Agents) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
INSULIN-LIKE GROWTH FACTOR-I (IGF-I) HORMONES		
INCRELEX	T2	PA SP
LHRH (GNRH) AGONIST ANALOG PITUITARY SUPPRESSANTS		
LUPRON DEPOT 11.25 MG 3MO KIT	T2	PA SP HD
LUPRON DEPOT 3.75 MG KIT	T2	PA SP HD
SYNAREL	T3	PA SP HD
LHRH (GNRH) ANTAGONIST, ESTROGEN AND PROGESTIN COMB		
MYFEMBREE	T2	PA QL(1 TAB/DAY)
ORIAHNN	T2	PA QL(2 CAPS/DAY)
LHRH (GNRH) ANTAGONIST, PITUITARY SUPPRESSANT AGENTS		
<i>cetorelix acetate</i> (Cetrotide)	T1	PA SP
CETROTIDE (<i>cetorelix acetate</i>)	T2	PA SP
<i>ganirelix acet 250 mcg/0.5 ml</i> (Ganirelix Acetate)	T1	PA SP
GANIRELIX ACET 250 MCG/0.5 ML (<i>ganirelix acetate</i>)	T2	PA SP
<i>ganirelix acetate</i> (Ganirelix Acetate)	T1	PA SP
ORILISSA 150 MG TABLET	T2	PA QL(1 TAB/DAY)
ORILISSA 200 MG TABLET	T2	PA QL(2 TABS/DAY)
LHRH (GNRH) AGNST PIT.SUP-CENTRAL PRECOCIOUS PUBERTY		
FENSOLVI	T2	PA SP
LUPRON DEPOT-PED	T3	PA SP HD
MINERALOCORTICIDS		
<i>fludrocortisone acetate</i>	T1	HD
OXYTOCICS		
CERVIDIL	T3	
<i>methylergonovine maleate</i>	T1	
PREPIDIL	T3	
PARATHYROID HORMONES		
YORVIPATH	T3	PA SP
PITUITARY SUPPRESSIVE AGENTS		
<i>cabergoline</i>	T1	QL(16 TABS/28 DAYS) HD
CRENESSITY 25 MG CAPSULE	T3	PA QL(4 CAPS/DAY) SP
CRENESSITY 50 MG CAPSULE	T3	PA QL(2 CAPS/DAY) SP
CRENESSITY 100 MG CAPSULE	T3	PA QL(2 CAPS/DAY) SP
CRENESSITY 50 MG/ML SOLUTION	T3	PA QL(8 MLS/DAY) SP
<i>danazol</i>	T1	HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

HORMONES (Hormonal Agents) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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
PROMETRIUM (progesterone, micronized)	T3	PA HD
PROVERA (medroxyprogesterone acetate)	T3	PA HD
SOMATOSTATIC AGENTS		
lanreotide 120 mg/0.5 ml syrng	T1	PA SP HD
LANREOTIDE 120 MG/0.5 ML SYRNG	T3	PA SP HD
MYCAPSSA	T3	PA QL(4 CAPS/DAY) SP
octreotide acetate	T1	PA SP HD
octreotide acetate (Sandostatin)	T1	PA SP HD
octreotide acetate,mi-spheres (Sandostatin Lar Depot)	T1	PA SP
SANDOSTATIN (octreotide acetate)	T3	PA SP HD
SANDOSTATIN LAR DEPOT (octreotide acetate,mi-spheres)	T3	PA SP
SIGNIFOR	T3	PA SP
SIGNIFOR LAR	T3	PA SP
SOMATULINE DEPOT	T2	PA SP HD
VAGINAL ESTROGEN 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 PACK	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)
estradiol 0.01% cream (Estrace)	T1	HD
estradiol 10 mcg vaginal insrt (Vagifem)	T1	QL(36 TABS/28 DAYS) HD
ESTRING	T3	PA QL(2 RINGS/90 DAYS) HD
FEMRING	T3	PA HD
PREMARIN	T2	HD
VAGIFEM (estradiol)	T3	PA QL(36 TABS/28 DAYS) HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

HORMONES (Infertility)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FERTILITY STIMULATING PREPARATIONS, NON-FSH		
<i>clomiphene citrate</i>	T1	
FOLLICLE-STIMULATING AND LUTEINIZING HORMONES		
MENOPUR	T2	PA SP
FOLLICLE-STIMULATING HORMONE (FSH)		
FOLLISTIM AQ	T3	PA SP
GONAL-F	T2	PA SP
GONAL-F RFF REDI-JECT	T2	PA SP
HUMAN CHORIONIC GONADOTROPIN (HCG)		
CHORIONIC GONADOTROPIN	T3	PA SP
NOVAREL	T2	PA SP
OVIDREL	T2	PA SP
PREGNYL	T2	PA SP
PREGNANCY FACILITATING/MAINTAINING AGENT, HORMONAL		
CRINONE 8% GEL	T3	PA
ENDOMETRIN (<i>progesterone, micronized</i>)	T2	
<i>progesterone 100 mg vag insert</i> (Endometrin)	T1	
HORMONES (Miscellaneous)		
LEPTIN HORMONE ANALOGS		
MYALEPT	T3	PA SP HD
HORMONES (Osteoporosis Products)		
BONE FORMATION STIMULATING AGTS - PTH REL PEPTIDES		
TYMLOS	T3	PA QL(1 PEN/30 DAYS) SP HD
BONE RESORPTION INHIBITORS		
<i>calcitonin, salmon, synthetic</i>	T1	HD
<i>calcitonin, salmon, synthetic</i> (Miacalcin)	T1	HD
MIACALCIN (<i>calcitonin, salmon, synthetic</i>)	T3	HD
IMMUNOSUPPRESSANTS (Pain Relief And Inflammatory Disease)		
HUMAN INTERLEUKIN 12/23 (IL-12/13) INHIBITORS, MAB		
IMULDOSA	T3	PA QL(1 SYRINGE/84 DAYS) SP
OTULFI	T3	PA QL(1 SYRINGE/84 DAYS) SP
PYZCHIVA	T3	PA QL(1 SYRINGE/84 DAYS) SP
SELARSDI	T2	PA QL(1 SYRINGE/84 DAYS) SP
STELARA	T2	PA QL(1 SYRINGE/84 DAYS) SP HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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 (con't)		
STEQEYMA	T3	PA QL(1 SYRINGE/84 DAYS) SP
USTEKINUMAB	T3	PA QL(1 SYRINGE/84 DAYS) SP HD
USTEKINUMAB-AEKN 45 MG SYRINGE	T3	PA QL(1 SYRINGE/84 DAYS) SP
USTEKINUMAB-AEKN 90 MG/ML SYR	T3	PA QL(1 SYRINGE/84 DAYS) SP
USTEKINUMAB-TTWE	T2	PA QL(1 SYRINGE/84 DAYS) SP HD
YESINTEK	T2	PA QL(1 SYRINGE/84 DAYS) SP
IL-23 RECEPTOR ANTAGONIST, MONOCLONAL ANTIBODY		
OMVOH 100 MG/ML PEN	T2	PA QL(2 PENS/28 DAYS) SP HD
OMVOH 100 MG/ML SYRINGE	T2	PA QL(2 SYRINGES/28 DAYS) SP HD
OMVOH 200 MG DOSE - 2 PENS	T2	PA QL(2 PENS/28 DAYS) SP HD
OMVOH 200 MG DOSE - 2 SYRINGES	T2	PA QL(2 SYRINGES/28 DAYS) SP HD
OMVOH 200 MG/2 ML PEN	T2	PA QL SP HD
OMVOH 200 MG/2 ML SYRINGE	T2	PA QL SP HD
OMVOH 300 MG DOSE - 2 PENS	T2	PA QL(3 MLS/28 DAYS) SP HD
OMVOH 300 MG DOSE - 2 SYRINGES	T2	PA QL(3 MLS/28 DAYS) SP HD
SKYRIZI ON-BODY	T2	PA QL(1 CARTRIDGE/56 DAYS) SP HD
TREMFYA	T2	PA QL(1 SYRINGE/56 DAYS) SP HD
TREMFYA 100 MG/ML PEN	T2	PA QL(1 ML/56 DAYS) SP HD
TREMFYA 200 MG/2 ML PEN	T2	PA QL(2 SYRINGE/28 DAYS) SP HD
TREMFYA ONE-PRESS	T2	PA QL(1 AUTO-INJ/56 DAYS) SP HD
TREMFYA PEN INDUCTION (2 PEN)	T2	PA QL(12 MLS/365 DAYS) SP HD
INTERLEUKIN-4(IL-4) RECEPTOR ALPHA ANTAGONIST, MAB		
DUPIXENT PEN	T2	PA SP HD
DUPIXENT SYRINGE	T2	PA SP HD
INTERLEUKIN-6 (IL-6) RECEPTOR INHIBITORS		
ACTEMRA	T2	PA QL(3.6 ML/28 DAYS) SP HD
ACTEMRA ACTPEN	T2	PA QL(3.6 ML/28 DAYS) SP HD
ENSPRYNG	T3	PA SP HD
KEVZARA	T3	PA QL(2 PENS/SYRINGES/28 DAYS) SP HD
TYENNE	T2	PA QL(3.6 ML/28 DAYS) SP
TYENNE AUTOINJECTOR	T2	PA QL(3.6 ML/28 DAYS) SP
INTERLEUKIN-3I(IL-3I)RECEPTOR ALPHA ANTAGONIST,MAB		
NEMLUVIO	T2	PA SP HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

IMMUNOSUPPRESSANTS (Skin Conditions)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL IMMUNOSUPPRESSIVE AGENTS		
ELIDEL (<i>pimecrolimus</i>)	T3	PA
HYFTOR	T3	PA SP
<i>pimecrolimus</i> (Elidel)	T1	
<i>tacrolimus</i> 0.03% ointment	T1	
<i>tacrolimus</i> 0.1% ointment	T1	

IMMUNOSUPPRESSANTS (Transplant Medications)

IMMUNOSUPPRESSIVES		
ASTAGRAF XL	T3	SP HD
AZASAN (<i>azathioprine</i>)	T3	PA SP HD
<i>azathioprine</i> 100 mg tablet (Azasan)	T1	PA SP HD
<i>azathioprine</i> 50 mg tablet (Imuran)	T1	SP HD
<i>azathioprine</i> 75 mg tablet (Azasan)	T1	PA SP HD
CELLCEPT (<i>mycophenolate mofetil</i>)	T3	PA SP HD
<i>cyclosporine</i> 100 mg capsule (Sandimmune)	T1	SP HD
<i>cyclosporine</i> 25 mg capsule (Sandimmune)	T1	SP HD
<i>cyclosporine</i> , modified	T1	SP HD
<i>cyclosporine</i> , modified (Neoral)	T1	SP HD
ENVARUS XR	T3	SP HD
<i>everolimus</i> 0.25 mg tablet (Zortress)	T1	SP HD
<i>everolimus</i> 0.5 mg tablet (Zortress)	T1	SP HD
<i>everolimus</i> 0.75 mg tablet (Zortress)	T1	SP HD
<i>everolimus</i> 1 mg tablet (Zortress)	T1	SP HD
IMURAN (<i>azathioprine</i>)	T3	PA SP HD
LUPKYNIS	T3	PA QL(6 CAPS/DAY) SP
<i>mycophenolate mofetil</i> (Cellcept)	T1	SP HD
<i>mycophenolate sodium</i> (Myfortic)	T1	SP HD
MYFORTIC (<i>mycophenolate sodium</i>)	T3	PA SP HD
MYHIBBIN	T3	PA SP
NEORAL (<i>cyclosporine</i> , modified)	T3	PA SP HD
PROGRAF 0.2 MG GRANULE PACKET	T3	SP HD
PROGRAF 0.5 MG CAPSULE (<i>tacrolimus</i>)	T3	PA SP HD
PROGRAF 1 MG CAPSULE (<i>tacrolimus</i>)	T3	PA SP HD
PROGRAF 1 MG GRANULE PACKET	T3	SP HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

IMMUNOSUPPRESSANTS (Transplant Medications) (cont.)

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

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

DIABETIC SUPPLIES		
ACCU-CHEK	T1	
ACCU-CHEK FASTCLIX LANCING DEV	T1	
ACCU-CHEK GUIDE CONTROL SOLN	T1	
ACCU-CHEK SMARTVIEW CONTRL SOL	T1	
ACCU-CHEK SOFTCLIX	T1	
ACCUTREND GLUCOSE CONTROL	T1	PA QL (1 syringe/365 days)
ADJUSTABLE LANCING DEVICE	T1	PA QL (3/30 days)
ADVANCED LANCING DEVICE	T1	PA QL (1 syringe/67 days)
ADVOCATE CONTROL SOLUTION	T1	PA QL(1 UNIT/365 DAYS)
ADVOCATE LANCING DEVICE	T1	PA QL(3 sensors/30 days)
ADVOCATE RAPID-SAFE LANCING DV	T1	
ADVOCATE REDI-CODE+ CTRL SOLN	T1	
AGAMATRIX CONTROL	T1	
AGAMATRIX CONTROL SOLUTION	T1	PA QL(2 units/28 days)
ALKALINE BATTERIES	T1	PA QL (1 reader/day)
ALTERNATE SITE LANCING DEVICE	T1	PA QL(2 sensors/21 days)
AQUA LANCE LANCING DEVICE	T1	PA QL(2 units/28 days)
ASSURE 4 CONTROL SOLUTION	T1	PA QL(1 unit/720 days)
ASSURE CONTROL SOLUTION	T1	PA QL(1 unit/720 days)
ASSURE DOSE	T1	PA QL(1 unit/720 days)

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIABETIC SUPPLIES (cont.)		
ASSURE PRISM	T1	
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	
BLOOD GLUCOSE CONTROL	T1	
BLOOD-GLUCOSE CONTROL	T1	
BREEZE 2	T1	
CAREONE	T1	
CARESENS	T1	
CARESENS S CONTROL SOLUTION	T1	
CARETOUCH CONTROL SOLUTION	T1	
CARETOUCH LANCING DEVICE	T1	
CEQUR SIMPLICITY	T2	
CEQUR SIMPLICITY INSERTER	T2	
CHEMSTRIP BG DIARY	T1	
CHOSEN LANCING DEVICE	T1	
CLEVER CHOICE CONTROL SOLUTION	T1	
CONTOUR	T1	
CONTOUR NEXT CONTROL SOLUTION	T1	
CONTROL SOLUTION	T1	
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	
DROPLET GENTEEL LANCING DEVICE	T1	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIABETIC SUPPLIES (cont.)		
DROPLET LANCING DEVICE	T1	
EASY MINI EJECT LANCING DEVICE	T1	
EASY PLUS II CONTROL SOLN HIGH	T1	
EASY PLUS II CONTROL SOLN LOW	T1	
EASY STEP CONTROL SOLUTION	T1	
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 CONTROL SOLUTION	T1	
EASY TOUCH LANCING DEVICE	T1	
EASY TRAK CONTROL SOLN HIGH	T1	
EASY TRAK CONTROL SOLN LOW	T1	
EASY TRAK II CONTROL SOLUTION	T1	
EASYGLUCO PLUS CONTROL NORMAL	T1	
EASYMAX 15 LEVEL 2 SOLUTION	T1	
EASYMAX NORMAL CONTROL SOLN	T1	
ELEMENT COMPACT CONTROL SOLN	T1	
ELEMENT CONTROL SOLUTION	T1	
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 TALK CONTROL SOLUTION	T1	
ENLITE SERTER	T1	
EVENCARE G2 CONTROL SOLUTION	T1	
EVENCARE G3 CONTROL SOLUTION	T1	
EVOLUTION CONTROL SOLUTION	T1	
FONDCIRCLE CONTROL SOLUTION	T1	
FONDCIRCLE LANCING DEVICE	T1	
FORA 6 CONNECT MULTIFUNCTN MTR	T3	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIABETIC SUPPLIES (cont.)		
FORA CONTROL SOLUTION	T1	
FORA GTEL MULTIFUNCTN MONITOR	T1	
FORA KETONE CONTROL SOLUTION	T3	
FORA LANCING DEVICE	T1	
FORA TN'G ADVANCE PRO MONITOR	T3	
FORA TN'GO ADV MOBILE MULT MTR	T3	
FORA TN'GO ADVANCE MULTIFN MTR	T3	
FORACARE GDH	T1	
FORTISCARE	T1	
FREESTYLE CONTROL SOLUTION	T1	
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)
GE100 CONTROL SOLUTION NORMAL	T1	
GENTEEL VACUUM LANCING DEVICE	T1	
GLUCOCARD 01 CONTROL	T1	
GLUCOCARD EXPRESSION CNTRL SLN	T1	
GLUCOCARD SHINE CONTROL SOLN	T1	
GLUCOCOM AUTOLINK	T1	
GLUCOCOM CONTROL SOLUTION	T1	
GLUCOSE CONTROL	T1	
GLUCOSE CONTROL SOLUTION	T1	
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	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIABETIC SUPPLIES (cont.)		
GUARDIAN TRANSMITTER TAPE	T1	
HEALTHPRO GLUCOSE CONTROL SOLN	T1	
HEALTHY ACCENTS AUTOLET	T1	
HYPOLANCE	T1	
IHEALTH CONTROL SOLN LEVEL 2	T1	
INCONTROL LANCING DEVICE	T1	
INFINITY CONTROL SOLUTION	T1	
INFINITY VOICE CONTROL SOLN	T1	
INPEN (FOR HUMALOG)	T1	
INPEN (FOR NOVOLOG OR FIASP)	T1	
INSUL-CAP	T1	
INSUL-EZE	T1	
LANCING DEVICE	T1	
LANCING SYSTEM	T1	
LANZO	T1	
LITE TOUCH LANCING PEN	T1	
MEDISENSE	T1	
MEDISENSE GLUCOSE KETONE	T1	
MEDISENSE GLUCOSE KETONE CONTR	T1	
MEDTRONIC REMOTE CONTROL	T1	
MICRODOT HIGH-LOW CONTROL SOL	T1	
MICRODOT NORMAL CONTROL SOLUT	T1	
MICROLET 2	T1	
MICROLET NEXT LANCING DEVICE	T1	
MINI LANCING DEVICE	T1	
MINIMED QUICK-SERTER	T1	
MULTI-LANCET	T1	
MYGLUCOHEALTH CONTROL SOLUTION	T1	
NOVA MAX PLUS GLUC-KETON METER	T1	
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)

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIABETIC SUPPLIES (cont.)		
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 LANCING DEVICE	T1	
ON CALL PLUS CONTROL	T1	
ON CALL PLUS LANCING DEVICE	T1	
ON CALL VIVID CONTROL	T1	
ONETOUCH DELICA PLUS LANC DEV	T1	
ONETOUCH ULTRA CONTROL SOLN	T1	
ONETOUCH VERIO HIGH CNTRL SOLN	T1	
ONETOUCH VERIO MID CNTRL SOLN	T1	
OPTUMRX GLUCOSE CONTROL SOLN	T1	
OVAL TAPE	T1	
PIP GLUCOSE CONTROL SOLUTION	T1	
PRECISION XTRA KETONE-GLUCOSE	T3	
PRODIGY CONTROL SOLUTION	T1	
PRODIGY LANCING DEVICE	T1	
REFUAH PLUS GLUCOSE CONTROL	T1	
RELIAMED MINI LANCING DEVICE	T1	
RIGHTEST CONTROL SOLUTION	T1	
RIGHTEST GD500	T1	
SAFE-CLIP	T1	
SIL-SERTER	T1	
SIMPLERA SENSOR	T3	PA
SIMPLERA SYNC SENSOR	T3	PA
SMARTDIABETES VANTAGE	T1	
SMARTEST	T1	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIABETIC SUPPLIES (cont.)		
SOLUS V2 CONTROL SOLUTION	T1	
SOLUS V2 LANCING DEVICE	T1	
SURE COMFORT LANCING PEN	T1	
SUREFLEX	T1	
SURE-PEN	T1	
SURE-TEST EASYPLUS MINI SOLN	T1	
TELCARE CONTROL SOLUTION	T1	
TRUE METRIX	T1	
TRUECONTROL	T1	
TRUEDRAW	T1	
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	
ULTRATRAK CONTROL SOL NORMAL	T1	
ULTRATRAK CONTROL SOLUTION	T1	
ULTRATRAK ULTIMATE CNTRL SOLN	T1	
UNISTIK 2	T1	
UNISTRIP	T1	
V-GO 20	T2	
V-GO 30	T2	
V-GO 40	T2	
VIVAGUARD INO CONTROL SOLUTION	T1	
VIVAGUARD LANCING DEVICE	T1	
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

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT,MISC (GROUP I) (cont.)		
ADVOCATE LANCET	T1	
ADVOCATE LANCETS	T1	
ADVOCATE SAFETY LANCET	T1	
AGAMATRIX ULTRA-THIN LANCET	T1	
ALTERNATE SITE LANCETS	T1	
ASSURE HAEMOLANCE PLUS	T1	
ASSURE LANCE	T1	
ASSURE LANCE PLUS	T1	
BD MICROTAINER LANCETS	T1	
BLOOD LANCETS	T1	
BULLSEYE MINI SAFETY LANCETS	T1	
BUTTERFLY TOUCH LANCET	T1	
CAREONE	T1	
CARESENS LANCET	T1	
CARETOUCH SAFETY LANCETS	T1	
CARETOUCH TWIST LANCET	T1	
CHOSEN LANCET	T1	
CHOSEN SAFETY LANCET	T1	
CLEVER CHEK LANCETS	T1	
COAGUCHEK	T1	
COLOR LANCETS	T1	
COMFORT EZ	T1	
COMFORT LANCETS	T1	
COMFORT TOUCH PLUS SAFETY LANC	T1	
COMFORT TOUCH ULT THIN LANCET	T1	
DROPLET LANCETS	T1	
DROPSAFE ACTI-LANCE	T1	
EASY COMFORT LANCETS	T1	
EASY TOUCH PULL-TOP 26G LANCET	T1	
EASY TOUCH PULL-TOP 28G LANCET	T1	
EASY TOUCH PULL-TOP 30G LANCET	T1	
EASY TOUCH PULL-TOP 32G LANCET	T1	
EASY TOUCH SAFETY 21G LANCETS	T1	
EASY TOUCH SAFETY 23G LANCETS	T1	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT,MISC (GROUP I) (cont.)		
EASY TOUCH SAFETY 26G LANCETS	T1	
EASY TOUCH SAFETY 28G LANCETS	T1	
EASY TOUCH SAFETY 30G LANCETS	T1	
EASY TOUCH SAFETY 32G LANCETS	T1	
EASY TOUCH TWIST 26G LANCETS	T1	
EASY TOUCH TWIST 28G LANCETS	T1	
EASY TOUCH TWIST 30G LANCETS	T1	
EASY TOUCH TWIST 32G LANCETS	T1	
EASY TOUCH TWIST 33G LANCETS	T1	
EASY TWIST & CAP LANCETS	T1	
EMBRACE 30G LANCETS	T1	
EMBRACE SAFETY LANCET	T1	
EZ SMART LANCETS	T1	
EZ-LETS	T1	
FIFTY50 SAFETY SEAL LANCETS	T1	
FINGERSTIX	T1	
FONDCIRCLE LANCET	T1	
FORA LANCETS	T1	
FORACARE LANCETS	T1	
FREESTYLE LANCETS	T1	
FREESTYLE UNISTIK 2	T1	
GLUCOCOM	T1	
GLUCOCOM LANCETS	T1	
GOJJI LANCETS	T1	
HEALTHY ACCENTS UNILET LANCET	T1	
INCONTROL SUPER THIN LANCETS	T1	
INCONTROL ULTRA THIN LANCETS	T1	
INJECT EASE LANCETS	T1	
INVACARE LANCETS	T1	
lancets	T1	
LANCETS	T1	
LITE TOUCH 28G LANCETS	T1	
LITE TOUCH 30G LANCETS	T1	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT,MISC (GROUP I) (cont.)		
LITE TOUCH 33G LANCETS	T1	
MEDISENSE THIN LANCETS	T1	
MEDLANCE PLUS	T1	
MICRO THIN LANCET	T1	
MICRO THIN LANCETS	T1	
MICROLET	T1	
MOBILE LANCETS	T1	
MONOLET LANCETS	T1	
MONOLET THIN LANCETS	T1	
MYGLUCOHEALTH LANCETS	T1	
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	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT,MISC (GROUP I) (cont.)		
RELIAMED SAFETY SEAL LANCETS	T1	
RIGHTEST GL300 LANCETS	T1	
SAFETY LANCETS	T1	
SAFETY SEAL LANCETS	T1	
SAFETY-LET	T1	
SINGLE-LET	T1	
SMART SENSE	T1	
SMART SENSE LANCETS	T1	
SMARTTEST LANCET	T1	
SOLUS V2	T1	
SOLUS V2 LANCETS	T1	
STERILANCE TL	T1	
STERILE LANCETS	T1	
SUPER THIN LANCETS	T1	
SURE COMFORT LANCETS	T1	
SURE-LANCE	T1	
SURE-TOUCH	T1	
TECHLITE LANCETS	T1	
TELCARE ULTRA THIN 30G LANCETS	T1	
THIN LANCETS	T1	
TOPCARE UNIVERSAL1 LANCET	T1	
TOPCARE UNIVERSAL1 THIN LANCET	T1	
TRUE COMFORT LANCET	T1	
TRUE COMFORT SAFETY LANCET	T1	
TRUEPLUS LANCET	T1	
TRUEPLUS LANCETS	T1	
TWIST LANCETS	T1	
TWIST TOP LANCET	T1	
ULTILET BASIC	T1	
ULTILET CLASSIC	T1	
ULTILET LANCETS	T1	
ULTILET SAFETY	T1	
ULTRA THIN LANCET	T1	
ULTRA THIN LANCETS	T1	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT,MISC (GROUP I) (cont.)		
ULTRA THIN PLUS LANCETS	T1	
ULTRA-CARE LANCETS	T1	
ULTRALANCE	T1	
ULTRA-THIN II 28G LANCETS	T1	
ULTRA-THIN II 30G LANCETS	T1	
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	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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
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

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NEEDLES/NEEDLELESS DEVICES (cont.)		
EXEL HUBER NEEDLE	T1	
EXEL HYPODERMIC NEEDLE	T1	
EXEL MTI DRAWING NEEDLE	T1	
FILTER ASPIRATOR NEEDLE	T1	
FILTER NEEDLE	T1	
FLOW-EZE	T1	
HEALTHWISE PEN NEEDLE	T1	PA
HEALTHY ACCENTS UNIFINE PENTIP	T1	PA
INCONTROL PEN NEEDLE	T1	
INSULIN PEN NEEDLE	T1	PA
INSUPEN PEN NEEDLE	T1	PA
INTEGRA NEEDLE	T1	PA
INTEGRA PRECISIONGLIDE NEEDLE	T1	
LIFESHIELD BLUNT CANNULA	T1	
LITE TOUCH 31GX1/4" PEN NEEDLE	T1	
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	T1	PA
MONOJECT FILTER NEEDLE	T1	
NANO 2ND GEN PEN NEEDLE	T1	
NANO PEN NEEDLE	T1	
NEEDLE	T1	
NEEDLES	T1	
<i>needles,safety huber,disposabl</i>	T1	
NOKOR ADMIX NEEDLE	T1	
NOKOR NEEDLE	T1	
NOVOFINE 32	T1	PA
NOVOFINE AUTOCOVER	T1	PA
NOVOFINE PLUS	T1	PA
PEN NEEDLE	T1	PA

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NEEDLES/NEEDLELESS DEVICES (cont.)		
PEN NEEDLES	T1	PA
PENTIPS PEN NEEDLE	T1	PA
PERFECT POINT SAFETY NEEDLE	T1	
PHASEAL PROTECTOR	T1	
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

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NEEDLES/NEEDLELESS DEVICES (cont.)		
TRUEPLUS PEN NEEDLE	T1	PA
ULTICARE PEN NEEDLE	T1	PA
ULTICARE SAFETY PEN NEEDLE	T1	PA
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 NDL 29GX1/2"	T1	PA
ULTRA-THIN II PEN NDL 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
VERIFINE PLUS PEN NEEDLE-SHARP	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

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SYRINGES AND ACCESSORIES (cont.)		
BD INS SYR 0.3 ML 8MMX31G(1/2)	T1	
BD INS SYR UF 0.3ML 12.7MMX30G	T1	
BD INS SYR UF 0.5ML 12.7MMX30G	T1	
BD INS SYRN UF 1 ML 12.7MMX30G	T1	
BD INS SYRN UF 1 ML 30G 12.7MM	T1	
BD INS SYRNG 0.3 ML 29GX12.7MM	T1	
BD INS SYRNG 0.5 ML 29GX12.7MM	T1	
BD INS SYRNG UF 0.3 ML 8MMX31G	T1	
BD INS SYRNG UF 0.5 ML 8MMX31G	T1	
BD INSULIN SYR 0.5 ML 28GX1/2"	T1	
BD INSULIN SYR 1 ML 27GX12.7MM	T1	
BD INSULIN SYR 1 ML 27GX5/8"	T1	
BD INSULIN SYR 1 ML 28GX1/2"	T1	
BD INSULIN SYR 1 ML 29GX12.7MM	T1	
BD INSULIN SYR UF 1 ML 8MMX31G	T1	
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

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SYRINGES AND ACCESSORIES (cont.)		
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
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

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SYRINGES AND ACCESSORIES (cont.)		
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
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	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

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SYRINGES AND ACCESSORIES (cont.)		
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
INSULIN SYRINGE 1 ML 30G 1/2"	T1	PA
INSULIN SYRINGE 1 ML 30G 5/16"	T1	PA
INSULIN SYRINGE 1 ML 30GX1/2"	T1	PA
INSULIN SYRINGE 1 ML 30GX5/16"	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

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SYRINGES AND ACCESSORIES (cont.)		
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
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	T1	
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	T1	
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

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SYRINGES AND ACCESSORIES (cont.)		
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
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 INSULIN SYRINGE	T1	
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

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SYRINGES AND ACCESSORIES (cont.)		
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
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
<i>syringe and needle,insulin,1ml</i>	T1	PA
<i>syringe-needle,insulin,0.5 ml</i>	T1	PA
<i>syring-needl,disp,insul,0.3 ml</i>	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

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SYRINGES AND ACCESSORIES (cont.)		
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
ULTIGUARD SAFE0.5ML 30G 12.7MM	T1	PA
ULTIGUARD SAFEPAK 1ML 31G 8MM	T3	PA
ULTIGUARD SAFEPAK 0.3ML 31G 8MM	T3	PA
ULTIGUARD SAFEPAK 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	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) (cont.)		
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 LANCET	T1	
ADVOCATE LANCETS	T1	
ADVOCATE SAFETY LANCET	T1	
AGAMATRIX ULTRA-THIN LANCET	T1	
ALTERNATE SITE LANCETS	T1	
ASSURE HAEMOLANCE PLUS	T1	
ASSURE LANCE	T1	
ASSURE LANCE PLUS	T1	
BD MICROTAINER LANCETS	T1	
BLOOD LANCETS	T1	
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	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) (cont.)		
DROPLET LANCETS	T1	
DROPSAFE ACTI-LANCE	T1	
EASY COMFORT LANCETS	T1	
EASY TOUCH PULL-TOP 26G LANCET	T1	
EASY TOUCH PULL-TOP 28G LANCET	T1	
EASY TOUCH PULL-TOP 30G LANCET	T1	
EASY TOUCH PULL-TOP 32G LANCET	T1	
EASY TOUCH SAFETY 21G LANCETS	T1	
EASY TOUCH SAFETY 23G LANCETS	T1	
EASY TOUCH SAFETY 26G LANCETS	T1	
EASY TOUCH SAFETY 28G LANCETS	T1	
EASY TOUCH SAFETY 30G LANCETS	T1	
EASY TOUCH SAFETY 32G LANCETS	T1	
EASY TOUCH TWIST 26G LANCETS	T1	
EASY TOUCH TWIST 28G LANCETS	T1	
EASY TOUCH TWIST 30G LANCETS	T1	
EASY TOUCH TWIST 32G LANCETS	T1	
EASY TOUCH TWIST 33G LANCETS	T1	
EASY TWIST & CAP LANCETS	T1	
EMBRACE 30G LANCETS	T1	
EMBRACE SAFETY LANCET	T1	
EZ SMART LANCETS	T1	
EZ-LETS	T1	
FIFTY50 SAFETY SEAL LANCETS	T1	
FINGERSTIX	T1	
FONDCIRCLE LANCET	T1	
FORA LANCETS	T1	
FORA V10-V12-D10-D20 STRP-LNCT	T1	
FORACARE LANCETS	T1	
FREESTYLE LANCETS	T1	
FREESTYLE UNISTIK 2	T1	
GLUCOCOM	T1	
GLUCOCOM LANCETS	T1	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) (cont.)		
GOJJI LANCET-GLUCOSE TEST STRP	T1	
GOJJI LANCETS	T1	
HEALTHY ACCENTS UNILET LANCET	T1	
INCONTROL SUPER THIN LANCETS	T1	
INCONTROL ULTRA THIN LANCETS	T1	
INJECT EASE LANCETS	T1	
INVACARE LANCETS	T1	
<i>lancets</i>	T1	
LANCETS	T1	
LITE TOUCH 28G LANCETS	T1	
LITE TOUCH 30G LANCETS	T1	
LITE TOUCH 33G LANCETS	T1	
MEDISENSE THIN LANCETS	T1	
MEDLANCE PLUS	T1	
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	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) (cont.)		
PERFECT POINT SAFETY LANCETS	T1	
PIP LANCET	T1	
POGO AUTOMATIC TEST CARTRIDGE	T1	
PRESSURE ACTIVATED LANCETS	T1	
PRO COMFORT LANCET	T1	
PRO COMFORT LANCETS	T1	
PRO COMFORT SAFETY LANCET	T1	
PRODIGY LANCETS	T1	
PRODIGY TWIST TOP LANCET	T1	
PURE COMFORT LANCETS	T1	
PURE COMFORT SAFETY LANCETS	T1	
PUSH BUTTON SAFETY LANCETS	T1	
READYLANCE SAFETY LANCETS	T1	
RELIAMED	T1	
RELIAMED SAFETY SEAL LANCETS	T1	
RIGHTEST GL300 LANCETS	T1	
SAFETY LANCETS	T1	
SAFETY SEAL LANCETS	T1	
SAFETY-LET	T1	
SINGLE-LET	T1	
SMART SENSE	T1	
SMART SENSE LANCETS	T1	
SMARTTEST LANCET	T1	
SOLUS V2	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	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) (cont.)		
THIN LANCETS	T1	
TOPCARE UNIVERSAL1 LANCET	T1	
TOPCARE UNIVERSAL1 THIN LANCET	T1	
TRUE COMFORT LANCET	T1	
TRUE COMFORT SAFETY LANCET	T1	
TRUEPLUS LANCET	T1	
TRUEPLUS LANCETS	T1	
TWIST LANCETS	T1	
TWIST TOP LANCET	T1	
ULTILET BASIC	T1	
ULTILET CLASSIC	T1	
ULTILET LANCETS	T1	
ULTILET SAFETY	T1	
ULTRA THIN LANCET	T1	
ULTRA THIN LANCETS	T1	
ULTRA THIN PLUS LANCETS	T1	
ULTRA-CARE LANCETS	T1	
ULTRALANCE	T1	
ULTRA-THIN II 28G LANCETS	T1	
ULTRA-THIN II 30G LANCETS	T1	
ULTRATIC 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	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) (cont.)		
UNISTIK 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	T1	
ALCOH-WIPE	T1	
LASIX ONYU REUSABLE UNIT	T3	PA QL(1 UNIT/365 DAYS)
RESPIRATORY AIDS, DEVICES, EQUIPMENT		
ACE AEROSOL CLOUD ENHANCER	T2	QL(1 SPACER/365 DAYS)
AEROCHAMBER MECHANICAL VENT	T2	QL(1 SPACER/365 DAYS)
AEROCHAMBER MINI	T2	QL(1 SPACER/365 DAYS)
AEROCHAMBER MV	T2	QL(1 SPACER/365 DAYS)
AEROCHAMBER PLUS FLOW-VU	T2	QL(1 SPACER/365 DAYS)
AEROCHAMBER Z-STAT PLUS	T2	QL(1 SPACER/365 DAYS)
AEROCHAMBER2GO	T2	QL(1 SPACER/365 DAYS)
AEROTRACH PLUS	T2	QL(1 SPACER/365 DAYS)
AEROVENT PLUS	T2	QL(1 SPACER/365 DAYS)
BREATHERITE	T2	QL(1 SPACER/365 DAYS)
BREATHERITE SPACER-ADULT MASK	T2	QL(1 SPACER/365 DAYS)
BREATHERITE SPACER-INFANT MASK	T2	QL(1 SPACER/365 DAYS)
BREATHERITE SPACER-LG CHLD MSK	T2	QL(1 SPACER/365 DAYS)
BREATHERITE SPACER-NEONATE MSK	T2	QL(1 SPACER/365 DAYS)

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
RESPIRATORY AIDS, DEVICES, EQUIPMENT (cont.)		
BREATHERITE SPACER-SM CHLD MSK	T2	QL(1 SPACER/365 DAYS)
BREATHRITE	T2	QL(1 SPACER/365 DAYS)
CLEVER CHOICE HOLDING CHAMBER	T2	QL(1 SPACER/365 DAYS)
COMFORTSEAL	T2	QL(1 UNIT/365 DAYS)
COMPACT SPACE CHAMBER	T2	QL(1 SPACER/365 DAYS)
EASIVENT HOLDING CHAMBER	T2	QL(1 SPACER/365 DAYS)
EASIVENT MASK-LARGE	T2	QL(1 UNIT/365 DAYS)
EASIVENT MASK-MEDIUM	T2	QL(1 UNIT/365 DAYS)
EASIVENT MASK-SMALL	T2	QL(1 UNIT/365 DAYS)
FLEXICHAMBER	T2	QL(1 SPACER/365 DAYS)
FLEXICHAMBER MASK	T2	QL(1 UNIT/365 DAYS)
LITEAIRE	T2	QL(1 SPACER/365 DAYS)
LITETOUCH	T2	QL(1 UNIT/365 DAYS)
MICROCHAMBER	T2	QL(1 SPACER/365 DAYS)
MICROSPACER	T2	QL(1 SPACER/365 DAYS)
MOUTHPIECE	T2	
ONE WAY MOUTHPIECE	T2	
OPTICHAMBER	T2	QL(1 UNIT/365 DAYS)
OPTICHAMBER DIAMOND	T2	QL(1 SPACER/365 DAYS)
PANDA MASK	T2	
PEDIATRIC MASK	T2	
PEDIATRIC PANDA MASK	T2	
POCKET CHAMBER	T2	QL(1 SPACER/365 DAYS)
PRIMEAIRE	T2	QL(1 SPACER/365 DAYS)
PRO COMFORT SPACER-ADULT MASK	T3	QL(1 SPACER/365 DAYS)
PRO COMFORT SPACER-CHILD MASK	T3	QL(1 SPACER/365 DAYS)
PRO COMFORT SPACER-INFANT MASK	T3	
PROCARE SPACER WITH ADULT MASK	T2	QL(1 SPACER/365 DAYS)
PROCARE SPACER WITH CHILD MASK	T2	QL(1 SPACER/365 DAYS)
PROCHAMBER	T2	QL(1 SPACER/365 DAYS)
PURE COMFORT SPACER WITH MASK	T2	QL(1 SPACER/365 DAYS)
RITEFLO	T2	QL(1 SPACER/365 DAYS)
SIDESTREAM PEDIATRIC	T2	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
RESPIRATORY AIDS, DEVICES, EQUIPMENT (cont.)		
SILICONE MASK-INFANT	T2	QL(1 UNIT/365 DAYS)
SILICONE MASK-PEDIATRIC	T2	
SPACE CHAMBER	T2	QL(1 SPACER/365 DAYS)
SPACE CHAMBER-LARGE MASK	T2	QL(1 SPACER/365 DAYS)
SPACE CHAMBER-MEDIUM MASK	T2	QL(1 SPACER/365 DAYS)
SPACE CHAMBER-SMALL MASK	T2	QL(1 SPACER/365 DAYS)
VORTEX ADULT MASK	T3	
VORTEX HOLDING CHAMBER	T2	QL(1 SPACER/365 DAYS)
VORTEX VHC FROG MASK	T2	QL(1 SPACER/365 DAYS)
VORTEX VHC LADYBUG MASK	T2	QL(1 SPACER/365 DAYS)
VORTEX VHC PEDIATRIC MASK	T2	QL(1 SPACER/365 DAYS)
MUSCLE RELAXANTS (Pain Relief And Inflammatory Disease)		
SKELETAL MUSCLE RELAXANTS		
AMRIX ER 15 MG CAPSULE (cyclobenzaprine hcl)	T3	PA QL(1 CAP/DAY)
AMRIX ER 30 MG CAPSULE (cyclobenzaprine hcl)	T3	PA QL(1 CAP/DAY)
baclofen 5 mg, 10mg, 20mg tablet	T3	PA
baclofen 5 mg/5 ml solution	T1	HD
baclofen 10 mg/5 ml solution	T1	HD
baclofen 25 mg/5 ml suspension (Fleqsuvy)	T1	PA HD
carisoprodol (Soma)	T1	HD
carisoprodol/aspirin	T1	PA HD
chlorzoxazone 250 mg tablet	T1	HD
chlorzoxazone 375 mg tablet (Lorzone)	T1	HD
chlorzoxazone 500 mg tablet	T1	
chlorzoxazone 750 mg tablet (Lorzone)	T1	
cyclobenzaprine er 15 mg cap (Amrix)	T1	PA
cyclobenzaprine er 30 mg cap (Amrix)	T1	PA
cyclobenzaprine hcl	T1	
cyclobenzaprine hcl (Fexmid)	T1	PA
DANTRIUM (dantrolene sodium)	T1	PA QL(1 CAP/DAY)
dantrolene sodium	T1	PA
dantrolene sodium (Dantrium)	T1	
FEXMID (cyclobenzaprine hcl)	T1	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

MUSCLE RELAXANTS (Pain Relief And Inflammatory Disease) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SKELETAL MUSCLE RELAXANTS (cont.)		
FLEQSUVY (<i>baclofen</i>)	T3	PA HD
LORZONE (<i>chlorzoxazone</i>)	T3	PA
LYVISPAH	T3	PA
<i>metaxalone 400 mg tablet</i>	T1	
METAXALONE 640 MG TABLET	T3	PA
<i>metaxalone 800 mg tablet</i>	T1	
<i>methocarbamol</i>	T1	
<i>methocarbamol 1,000 mg tablet</i>	T1	
METHOCARBAMOL 1,000 MG TABLET	T3	PA
<i>methocarbamol 500 mg tablet</i>	T1	
<i>methocarbamol 750 mg tablet</i>	T1	
NORGESIC (<i>orphenadrine/aspirin/caffeine</i>)	T3	PA
NORGESIC FORTE (<i>orphenadrine/aspirin/caffeine</i>)	T3	PA
<i>orphenadrine citrate</i>	T1	
<i>orphenadrine/aspirin/caffeine (Norgesic Forte)</i>	T1	PA
<i>orphenadrine/aspirin/caffeine (Norgesic)</i>	T1	PA
OZOBAX	T3	PA HD
OZOBAX DS	T3	PA HD
SOMA (<i>carisoprodol</i>)	T3	PA
SOMA (<i>vanadom</i>)	T1	PA
<i>tizanidine hcl 2 mg capsule (Zanaflex)</i>	T1	
<i>tizanidine hcl 2 mg tablet</i>	T1	PA
<i>tizanidine hcl 4 mg capsule (Zanaflex)</i>	T1	
<i>tizanidine hcl 4 mg tablet (Zanaflex)</i>	T1	PA
<i>tizanidine hcl 6 mg capsule (Zanaflex)</i>	T3	
ZANAFLEX	T3	
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	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

PRE-NATAL VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PRENATAL VITAMIN PREPARATIONS (cont.)		
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	
<i>mynatal capsule</i>	T2	
<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	T2	
<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	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

PRE-NATAL VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PRENATAL VITAMIN PREPARATIONS (cont.)		
<i>pnv19/iron bg,s.p/folic ac/om3</i>	T1	PA
<i>pnv81/iron ps,edta/folic/omeg3</i>	T1	
PREGEN DHA	T3	
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	
<i>prenatal 71/iron/folic ac/dha</i>	T1	
<i>prenatal 93/iron/folate 9/dha</i>	T1	
<i>prenatal no.42/folic acid (Vitamedmd Redichew Rx)</i>	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>	T2	
<i>prenatal vit,cal 76/iron/folic</i>	T3	
<i>prenatal vit,cal 78/iron/folic</i>	T3	
<i>prenatal vit/iron fum/folic ac</i>	T1	
<i>prenatal vits 86/iron/folic ac</i>	T1	
<i>prenatal,calc 40/iron/folate 1</i>	T1	
PRENATE ENHANCE	T2	
PRENATE RESTORE	T2	
PRIMACARE	T2	
PROVIDA OB	T2	
SELECT-OB	T2	
SELECT-OB (<i>prenatal vit 128/iron/folic ac</i>)	T2	
SELECT-OB + DHA	T2	
THRIVITE RX	T1	
TRICARE	T2	
TRISTART DHA	T2	
VITAFOL FE PLUS	T3	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

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 (cont.)			
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		
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	T2		
R-NATAL OB	T1		
TRINAZ	T3	PA	
VITAFOL GUMMIES	T2		
VITALARA	T3	PA	
ZALVIT	T3	PA	
ZIPHEX	T3	PA	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)⁹

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ALPHA-2 RECEPTOR ANTAGONIST ANTI-DEPRESSANTS		
<i>mirtazapine</i>	T1	HD
<i>mirtazapine</i> (Remeron)	T1	HD
REMERON (<i>mirtazapine</i>)	T3	PA HD
ANTI-ANXIETY - BENZODIAZEPINES		
<i>alprazolam</i>	T1	
<i>alprazolam</i> (Xanax Xr)	T1	
<i>alprazolam</i> (Xanax)	T1	
ATIVAN (<i>lorazepam</i>)	T3	PA
<i>chlordiazepoxide hcl</i>	T1	
<i>clorazepate dipotassium</i>	T1	
<i>diazepam 10 mg tablet</i> (Valium)	T1	
<i>diazepam 2 mg tablet</i> (Valium)	T1	
<i>diazepam 25 mg/5 ml oral conc</i>	T1	
<i>diazepam 5 mg tablet</i> (Valium)	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>lorazepam</i>	T1	
<i>lorazepam</i> (Ativan)	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 xr</i>)	T3	PA
ANTI-ANXIETY DRUGS		
BUCAPSOL	T3	PA
<i>buspirone hcl</i>	T1	HD
<i>meprobamate</i>	T1	
ANTIDEPRESSANT - NMDA RECEPTOR ANTAGONIST		
SPRAVATO	T3	PA SP
ANTIDEPRESSANT- POST PARTUM DEPRESSION (PPD)		
ZURZUVAE 20 MG CAPSULE	T3	PA QL(28 CAPS/270 DAYS) SP HD
ZURZUVAE 25 MG CAPSULE	T3	PA QL(28 CAPS/270 DAYS) SP HD
ZURZUVAE 30 MG CAPSULE	T3	PA QL(14 CAPS/270 DAYS) SP HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder) ⁹ (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BIPOLAR DISORDER DRUGS		
EQUETRO	T3	HD
<i>lithium carbonate</i>	T1	HD
<i>lithium carbonate</i> (Lithobid)	T1	HD
<i>lithium citrate</i>	T1	HD
LITHOBID (<i>lithium carbonate er</i>)	T3	PA HD
MAOIS -NON-SELECTIVE, IRREVERSIBLE ANTI-DEPRESSANTS		
MARPLAN	T3	QL(12 TABS/DAY)
NARDIL (<i>phenelzine sulfate</i>)	T3	PA
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 sr</i>)	T3	PA QL(4 TABS/DAY)
WELLBUTRIN SR 150 MG TABLET (<i>bupropion hcl sr</i>)	T3	PA QL(2 TABS/DAY)
WELLBUTRIN SR 200 MG TABLET (<i>bupropion hcl sr</i>)	T3	PA QL(2 TABS/DAY)

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder) ⁹ (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NOREPINEPHRINE AND DOPAMINE REUPTAKE INHIB (NDRIs) (cont.)		
WELLBUTRIN XL 150 MG TABLET (<i>bupropion xl</i>)	T3	PA QL(3 TABS/DAY)
WELLBUTRIN XL 300 MG TABLET (<i>bupropion xl</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 hbr</i>)	T3	PA QL(6 TABS/DAY) HD
CELEXA 20 MG TABLET (<i>citalopram hbr</i>)	T3	PA QL(3 TABS/DAY) HD
CELEXA 40 MG TABLET (<i>citalopram hbr</i>)	T3	PA QL(1 TAB/DAY) HD
<i>citalopram hbr 10 mg tablet</i> (Celexa)	T1	QL(6 TABS/DAY) HD
<i>citalopram hbr 10 mg/5 ml soln</i>	T1	QL(30 MLS/DAY) HD
<i>citalopram hbr 20 mg tablet</i> (Celexa)	T1	QL(3 TABS/DAY) HD
<i>citalopram hbr 20 mg/10 ml sol</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</i> (Celexa)	T1	QL(1 TAB/DAY) HD
<i>escitalopram 10 mg tablet</i> (Lexapro)	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</i> (Lexapro)	T1	QL(1 TAB/DAY) HD
<i>escitalopram 5 mg tablet</i> (Lexapro)	T1	QL(4 TABS/DAY) HD
<i>escitalopram oxalate 5 mg/5 ml</i>	T1	QL(20 MLS/DAY) HD
<i>fluoxetine 20 mg/5 ml soln cup</i>	T1	QL(20 MLS/DAY) HD
<i>fluoxetine 20 mg/5 ml solution</i>	T1	QL(20 MLS/DAY) HD
<i>fluoxetine hcl</i>	T1	QL (4 caps/28 days) HD
<i>fluoxetine hcl 10 mg capsule</i> (Prozac)	T1	QL(8 CAPS/DAY) HD
<i>fluoxetine hcl 10 mg tablet</i>	T1	HD
<i>fluoxetine hcl 20 mg capsule</i> (Prozac)	T1	QL(4 CAPS/DAY) HD
<i>fluoxetine hcl 20 mg tablet</i>	T1	HD
<i>fluoxetine hcl 40 mg capsule</i> (Prozac)	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

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIs) (cont.)		
<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
<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 er</i>)	T3	PA QL(1 TAB/DAY) HD
PAXIL CR 25 MG TABLET (<i>paroxetine er</i>)	T3	PA QL(3 TABS/DAY) HD
PAXIL CR 37.5 MG TABLET (<i>paroxetine er</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

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIs) (cont.)		
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
<i>desvenlafaxine succnt er 100mg</i> (Pristiq)	T1	QL(4 TABS/DAY) HD
<i>desvenlafaxine succnt er 25 mg</i> (Pristiq)	T1	QL(16 TABS/DAY) HD
<i>desvenlafaxine succnt er 50 mg</i> (Pristiq)	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</i> (Cymbalta)	T1	QL(6 CAPS/DAY) HD
<i>duloxetine hcl dr 30 mg cap</i> (Cymbalta)	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</i> (Cymbalta)	T1	QL(2 CAPS/DAY) HD
EFFEXOR XR 150 MG CAPSULE (<i>venlafaxine hcl er</i>)	T3	PA QL(2 CAPS/DAY)
EFFEXOR XR 37.5 MG CAPSULE (<i>venlafaxine hcl er</i>)	T3	PA QL(8 CAPS/DAY)
EFFEXOR XR 75 MG CAPSULE (<i>venlafaxine hcl er</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)

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SEROTONIN-NOREPINEPHRINE REUPTAKE-INHIB (SNRIs) (cont.)		
PRISTIQ ER 100 MG TABLET (<i>desvenlafaxine succinate er</i>)	T3	PA QL(4 TABS/DAY) HD
PRISTIQ ER 25 MG TABLET (<i>desvenlafaxine succinate er</i>)	T3	PA QL(16 TABS/DAY) HD
PRISTIQ ER 50 MG TABLET (<i>desvenlafaxine succinate er</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
SSRI AND 5HT1A PARTIAL AGONIST ANTI-DEPRESSANTS		
VIIBRYD 10 MG TABLET	T3	PA QL(1 TAB/DAY) HD
VIIBRYD 20 MG TABLET	T3	PA QL(1 TAB/DAY) HD
VIIBRYD 40 MG TABLET	T3	PA HD
<i>vilazodone hcl 10 mg tablet (Viibryd)</i>	T1	QL(1 TAB/DAY) HD
<i>vilazodone hcl 20 mg tablet (Viibryd)</i>	T1	QL(1 TAB/DAY) HD
<i>vilazodone hcl 40 mg tablet (Viibryd)</i>	T1	HD
SSRI, SEROTONIN RECEPTOR MODULATOR 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

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TRICYCLIC ANTI-DEPRESSANTS, REL.NON-SEL.REUPT-INHIB (cont.)		
ANAFRANIL (clomipramine hcl)	T3	PA HD
clomipramine hcl (Anafranil)	T1	HD
desipramine hcl	T1	HD
doxepin 10 mg capsule	T1	HD
doxepin 10 mg/ml oral conc	T1	HD
doxepin 100 mg capsule	T1	HD
doxepin 150 mg capsule	T1	HD
doxepin 25 mg capsule	T1	HD
doxepin 50 mg capsule	T1	HD
doxepin 75 mg capsule	T1	HD
imipramine pamoate	T1	HD
imipramine hcl	T1	HD
maprotiline hcl	T1	HD
nortriptyline hcl	T1	HD
nortriptyline hcl (Pamelor)	T1	HD
PAMELOR (nortriptyline hcl)	T3	PA HD
protriptyline hcl	T1	HD
trimipramine maleate	T1	HD

PSYCHOTHERAPEUTIC DRUGS (Attention Deficit Hyperactivity Disorder)⁹

ADRENERGICS, AROMATIC, NON-CATECHOLAMINE		
lisdexamfetamine 10 mg capsule (Vyvanse)	T1	PA QL(1 CAP/DAY)
lisdexamfetamine 10 mg tb chew (Vyvanse)	T1	PA QL(1 TAB/DAY)
lisdexamfetamine 20 mg capsule (Vyvanse)	T1	PA QL(1 CAP/DAY)
lisdexamfetamine 20 mg tb chew (Vyvanse)	T1	PA QL(1 TAB/DAY)
lisdexamfetamine 30 mg capsule (Vyvanse)	T1	PA QL(1 CAP/DAY)
lisdexamfetamine 30 mg tb chew (Vyvanse)	T1	PA QL(1 TAB/DAY)
lisdexamfetamine 40 mg capsule (Vyvanse)	T1	PA QL(1 CAP/DAY)
lisdexamfetamine 40 mg tb chew (Vyvanse)	T1	PA QL(1 TAB/DAY)
lisdexamfetamine 50 mg capsule (Vyvanse)	T1	PA QL(1 CAP/DAY)
lisdexamfetamine 50 mg tb chew (Vyvanse)	T1	PA QL(1 TAB/DAY)
lisdexamfetamine 60 mg capsule (Vyvanse)	T1	PA QL(1 CAP/DAY)
lisdexamfetamine 60 mg tb chew (Vyvanse)	T1	PA QL(1 TAB/DAY)
lisdexamfetamine 70 mg capsule (Vyvanse)	T1	PA QL(1 CAP/DAY)

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ADRENERGICS, AROMATIC, NON-CATECHOLAMINE (cont.)		
VYVANSE 10 MG CAPSULE (<i>lisdexamfetamine dimesylate</i>)	T3	PA QL(1 CAP/DAY)
VYVANSE 10 MG CHEWABLE TABLET (<i>lisdexamfetamine dimesylate</i>)	T3	PA QL(1 TAB/DAY)
VYVANSE 20 MG CAPSULE (<i>lisdexamfetamine dimesylate</i>)	T3	PA QL(1 CAP/DAY)
VYVANSE 20 MG CHEWABLE TABLET (<i>lisdexamfetamine dimesylate</i>)	T3	PA QL(1 TAB/DAY)
VYVANSE 30 MG CAPSULE (<i>lisdexamfetamine dimesylate</i>)	T3	PA QL(1 CAP/DAY)
VYVANSE 30 MG CHEWABLE TABLET (<i>lisdexamfetamine dimesylate</i>)	T3	PA QL(1 TAB/DAY)
VYVANSE 40 MG CAPSULE (<i>lisdexamfetamine dimesylate</i>)	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		
clonidine hcl er 0.1 mg tablet (Kapvay)	T1	
guanfacine hcl (Intuniv)	T1	HD
INTUNIV (<i>guanfacine hcl er</i>)	T3	PA HD
KAPVAY (<i>clonidine hcl er</i>)	T3	PA
ONYDA XR	T3	PA
TX FOR ATTENTION DEFICIT-HYPERACT (ADHD)/NARCOLEPSY		
APTENSIO XR (<i>methylphenidate hcl</i>)	T3	PA ST QL(1 CAP/DAY)
AZSTARYS	T3	PA ST QL(1 CAP/DAY)
CONCERTA ER 18 MG TABLET (<i>methylphenidate hcl</i>)	T3	PA ST QL(1 TAB/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)
dexmethylphenidate hcl (Focalin Xr)	T1	PA QL(1 CAP/DAY)
dexmethylphenidate hcl (Focalin)	T1	PA
FOCALIN (<i>dexmethylphenidate hcl</i>)	T3	PA ST

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TX FOR ATTENTION DEFICIT-HYPERACT (ADHD)/NARCOLEPSY (cont.)		
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)
<i>methylphenidate er 15 mg cap</i> (Aptensio Xr)	T1	PA QL (1 CAP/DAY)
<i>methylphenidate er 18 mg tab</i> (Concerta)	T1	PA QL (1 TAB/DAY)
<i>methylphenidate er 18 mg tab</i> (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)	T1	PA QL (2 TABS/DAY)
<i>methylphenidate er 36 mg tab</i> (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

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (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 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)
RELEXXII ER 63 MG TABLET	T3	PA QL(1 TAB/DAY)
RELEXXII ER 72 MG TABLET	T3	PA QL(1 TAB/DAY)
RITALIN (<i>methylphenidate hcl</i>)	T3	PA ST
RITALIN LA 10 MG CAPSULE (<i>methylphenidate hcl</i>)	T3	PA ST QL(1 CAP/DAY)
RITALIN LA 20 MG CAPSULE (<i>methylphenidate hcl</i>)	T3	PA ST QL(1 CAP/DAY)
RITALIN LA 30 MG CAPSULE (<i>methylphenidate hcl</i>)	T3	PA ST QL(2 CAPS/DAY)
RITALIN LA 40 MG CAPSULE (<i>methylphenidate hcl</i>)	T3	PA ST QL(1 CAP/DAY)
TX FOR ATTENTION DEFICIT-HYPERACT.(ADHD), NRI-TYPE		
<i>atomoxetine hcl</i> 10, 18, 25, 60, 80, 100 mg capsule (Strattera)	T1	HD
<i>atomoxetine hcl</i> 40 mg capsule (Strattera)	T1	QL (1 cap/day) 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 (<i>atomoxetine hcl</i>)	T3	PA HD
STRATTERA 100 MG CAPSULE (<i>atomoxetine hcl</i>)	T3	PA HD
STRATTERA 18 MG CAPSULE (<i>atomoxetine hcl</i>)	T3	PA HD
STRATTERA 25 MG CAPSULE (<i>atomoxetine hcl</i>)	T3	PA HD
STRATTERA 40 MG CAPSULE (<i>atomoxetine hcl</i>)	T3	PA QL(1 CAP/DAY) HD
STRATTERA 60 MG CAPSULE (<i>atomoxetine hcl</i>)	T3	PA HD
STRATTERA 80 MG CAPSULE (<i>atomoxetine hcl</i>)	T3	PA HD
PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics)⁹		
ANTI-PSYCH, DOPAMINE ANTAG., DIPHENYLBUTYLPIPERIDINES		
<i>pimozide</i>	T1	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics)⁹ (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-PSYCHOTIC, ATYPICAL, DOPAMINE, SEROTONIN ANTAGONIST		
<i>asenapine maleate</i> (Saphris)	T1	
CAPLYTA	T3	ST QL (1 CAP/DAY)
<i>clozapine</i>	T1	
<i>clozapine</i> (Clozaril)	T1	
CLOZARIL (<i>clozapine</i>)	T3	PA
ERZOFRI	T3	PA QL (4 TABS/DAY)
FANAPT 1 MG TABLET	T3	PA QL (4 TABS/DAY)
FANAPT 10 MG TABLET	T3	PA
FANAPT 12 MG TABLET	T3	PA QL (4 TABS/DAY)
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) ST
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 (<i>ziprasidone hcl</i>)	T3	PA
INVEGA ER 3 MG TABLET (<i>paliperidone er</i>)	T3	PA QL (1 TAB/DAY)
INVEGA ER 6 MG TABLET (<i>paliperidone er</i>)	T3	PA
INVEGA ER 9 MG TABLET (<i>paliperidone er</i>)	T3	PA
LATUDA 120 MG TABLET	T3	PA
LATUDA 20 MG TABLET	T3	PA
LATUDA 40 MG TABLET	T3	PA QL (1 TAB/DAY)
LATUDA 60 MG TABLET	T3	PA QL (1 TAB/DAY)
LATUDA 80 MG TABLET	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	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics)⁹ (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-PSYCHOTIC, ATYPICAL, DOPAMINE, SEROTONIN ANTAGNIST (cont.)		
<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	
QUETIAPINE 150 MG TABLET	T3	PA
<i>quetiapine fumarate</i> (Seroquel Xr)	T1	
<i>quetiapine fumarate 100 mg tab</i> (Seroquel)	T1	
<i>quetiapine fumarate 200 mg tab</i> (Seroquel)	T1	
<i>quetiapine fumarate 25 mg tab</i> (Seroquel)	T1	
<i>quetiapine fumarate 300 mg tab</i> (Seroquel)	T1	
<i>quetiapine fumarate 400 mg tab</i> (Seroquel)	T1	
<i>quetiapine fumarate 50 mg tab</i> (Seroquel)	T1	
RISPERDAL (<i>risperidone</i>)	T3	PA
<i>risperidone</i>	T1	
<i>risperidone</i> (Risperdal)	T1	
SAPHRIS (<i>asenapine maleate</i>)	T3	ST
SECUADO	T3	ST
SEROQUEL (<i>quetiapine fumarate</i>)	T3	ST
SEROQUEL XR (<i>quetiapine fumarate er</i>)	T3	ST
VERSACLOZ	T3	PA
<i>ziprasidone hcl</i> (Geodon)	T1	
ZYPREXA (<i>olanzapine</i>)	T3	PA
ZYPREXA ZYDIS (<i>olanzapine odt</i>)	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 (<i>aripiprazole</i>)	T3	ST
ABILIFY 15 MG TABLET (<i>aripiprazole</i>)	T3	ST

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics)⁹ (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIPSYCHOTICS, ATYP, D2 PARTIAL AGONIST/5HT MIXED (cont.)		
ABILIFY 2 MG TABLET (<i>aripiprazole</i>)	T3	ST
ABILIFY 20 MG TABLET (<i>aripiprazole</i>)	T3	ST
ABILIFY 30 MG TABLET (<i>aripiprazole</i>)	T3	ST
ABILIFY 5 MG TABLET (<i>aripiprazole</i>)	T3	ST QL(1 TAB/DAY)
ABILIFY MYCITE	T3	PA
<i>aripiprazole</i>	T1	
<i>aripiprazole 1 mg/ml solution</i>	T1	
<i>aripiprazole 10 mg tablet (Abilify)</i>	T1	
<i>aripiprazole 15 mg tablet (Abilify)</i>	T1	
<i>aripiprazole 2 mg tablet (Abilify)</i>	T1	
<i>aripiprazole 20 mg tablet (Abilify)</i>	T1	
<i>aripiprazole 30 mg tablet (Abilify)</i>	T1	
<i>aripiprazole 5 mg tablet (Abilify)</i>	T1	QL(1 TAB/DAY)
OPIPZA 2 MG FILM	T3	PA QL(1 FILM/DAY)
OPIPZA 5 MG FILM	T3	PA QL(3 FILMS/DAY)
OPIPZA 10 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)
ANTI-PSYCHOTICS, DOPAMINE ANTAGONISTS, THIOXANTHENES		
<i>thiothixene</i>	T1	
ANTI-PSYCHOTICS, DOPAMINE ANTAGONISTS, BUTYROPHENONES		
<i>haloperidol</i>	T1	
<i>haloperidol lactate</i>	T1	
ANTI-PSYCHOTICS, DOPAMINE ANTAGONST, DIHYDROINDOLONES		
<i>molindone hcl</i>	T1	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics) ⁹ (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-PSYCHOTICS, PHENOTHIAZINES		
<i>chlorpromazine hcl</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	
PSYCHOTHERAPEUTIC DRUGS (Seizure Disorders)		
NEUROACTIVE STEROID GABA-A RECEPTOR MODULATOR		
ZTALMY	T3	PA QL(36 MLS/DAY) SP
PSYCHOTHERAPEUTIC DRUGS (Sleep Disorders/Sedatives)		
NARCOLEPSY AND SLEEP DISORDER THERAPY AGENTS		
<i>armodafinil</i> (Nuvigil)	T1	PA
<i>modafinil</i> (Provigil)	T1	PA
NUVIGIL (<i>armodafinil</i>)	T3	PA
PROVIGIL (<i>modafinil</i>)	T3	PA
SUNOSI	T2	PA QL(1 TAB/DAY)
SEDATIVE/HYPNOTICS (Sleep Disorders/Sedatives)		
ANTI-NARCOLEPSY,ANTI-CATAPLEXY,SEDATIVE-TYPE AGENT		
LUMRYZ	T3	PA QL(1 PACK/DAY) SP HD
LUMRYZ STARTER PACK	T3	PA QL SP HD
SODIUM OXYBATE	T3	PA QL(18 MLS/DAY) SP HD
XYREM	T3	PA QL(18 MLS/DAY) SP HD
XYWAV	T3	PA QL(18 MLS/DAY) SP HD
BARBITURATES		
<i>phenobarbital</i>	T1	
HYPNOTICS, MELATONIN MT1/MT2 RECEPTOR AGONISTS		
HETLIOZ (<i>tasimelteon</i>)	T3	PA SP HD
HETLIOZ LQ	T3	PA SP HD
<i>ramelteon</i> (Rozerem)	T1	QL(1 TAB/DAY)
ROZEREM (<i>ramelteon</i>)	T3	PA QL(1 TAB/DAY)
<i>tasimelteon</i> (Hetlioz)	T1	PA SP

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

SEDATIVE/HYPNOTICS (Sleep Disorders/Sedatives) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SEDATIVE-HYPNOTICS, NON-BARBITURATE		
DORAL	T3	
<i>estazolam</i>	T1	
<i>flurazepam hcl</i>	T1	
HALCION (<i>triazolam</i>)	T3	
<i>midazolam hcl</i>	T1	
QUAZEPAM	T1	
RESTORIL (<i>temazepam</i>)	T3	PA
<i>temazepam</i> (Restoril)	T1	
<i>triazolam</i>	T1	
<i>triazolam</i> (Halcion)	T1	
SEDATIVE-HYPNOTICS, NON-BARBITURATE		
AMBIEN (<i>zolpidem tartrate</i>)	T3	PA
AMBIEN CR 12.5 MG TABLET (<i>zolpidem tartrate</i>)	T3	PA
AMBIEN CR 6.25 MG TABLET (<i>zolpidem tartrate er</i>)	T3	PA QL(1 TAB/DAY)
BELSOMRA	T3	PA
DAYVIGO	T2	ST QL(1 TAB/DAY)
<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
QUVIVQ	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

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

SKIN PREPS (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
IRRIGANTS (cont.)		
SORBITOL	T1	
SORBITOL-MANNITOL	T1	
water for irrigation, sterile	T1	
OXIDIZING AGENTS		
hydrogen peroxide	T1	
SKIN PREPS (Pain Relief And Inflammatory Disease)		
ANTI-PSORIATIC AGENTS, SYSTEMIC		
acitretin	T1	
BIMZELX	T3	PA QL(2 MLS/28 DAYS) SP HD
BIMZELX AUTOINJECTOR	T3	PA QL(2 MLS/28 DAYS) SP HD
COSENTYX (2 SYRINGES)	T3	PA QL(2 MLS/28 DAYS) SP HD
COSENTYX 150 MG/ML SYRINGE	T3	PA QL(1 ML/28 DAYS) SP HD
COSENTYX 75 MG/0.5 ML SYRINGE	T3	PA QL(0.5 MLS/28 DAYS) SP HD
COSENTYX SENSOREADY (2 PENS)	T3	PA QL(2 MLS/28 DAYS) SP HD
COSENTYX SENSOREADY PEN	T3	PA QL(1 ML/28 DAYS) SP HD
COSENTYX UNOREADY PEN	T3	PA QL(2 MLS/28 DAYS) SP HD
ILUMYA	T3	PA QL(1 UNIT/84 DAYS) SP HD
methoxsalen (Oxsoralen-ultra)	T1	
SILIQ	T3	PA QL(3 MLS/28 DAYS) SP HD
SKYRIZI	T2	PA QL(150 MG/84 DAYS) SP HD
SKYRIZI PEN	T2	PA QL(150 MG/84 DAYS) SP HD
SOTYKTU	T2	PA QL(1 TAB/DAY) SP HD
SPEVIGO	T3	PA QL(2 MLS/28 DAYS) SP HD
TALTZ AUTOINJECTOR	T2	PA QL(1 AUTO-INJECTOR/28 DAYS) SP HD
TALTZ AUTOINJECTOR (2 PACK)	T2	PA QL(1 AUTO-INJECTOR/28 DAYS) SP HD
TALTZ AUTOINJECTOR (3 PACK)	T2	PA QL(1 AUTO-INJECTOR/28 DAYS) SP HD
TALTZ SYRINGE	T2	PA QL(1 SYRINGE/28 DAYS) SP HD
TOPICAL ANTI-INFLAMMATORY, NSAIDS		
diclofenac 1.5% topical soln	T1	PA HD
diclofenac 2% solution pump	T1	PA HD
DICLOFENAC EPOLAMINE	T3	PA QL(2 PATCHES/DAY) HD
diclofenac sodium 1% gel	T1	QL(1000 GMS/30 DAYS) HD
FLECTOR	T2	PA QL(2 PATCHES/DAY) HD
LICART	T2	PA QL(1 PATCH/DAY) HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

SKIN PREPS (Skin Conditions)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ACNE AGENTS, SYSTEMIC		
ABSORICA (<i>isotretinoin</i>)	T3	
ABSORICA LD	T3	ST
<i>isotretinoin</i> (Absorica)	T1	
ACNE AGENTS, TOPICAL		
ACANYA (<i>clindamycin phos-benzoyl perox</i>)	T3	
ACZONE (<i>dapsone</i>)	T3	
<i>adapalene/benzoyl peroxide</i>	T1	
<i>adapalene/benzoyl peroxide</i> (Epiduo Forte)	T1	
AZELEX	T2	
CABTREO	T3	PA
<i>clindamycin-bnz perox 1.2-3.75%</i> (Onexton)	T1	PA
<i>clindamycin phos/benzoyl perox</i>	T1	
<i>clindamycin phos/benzoyl perox</i> (Acanya)	T1	
<i>clindamycin/tretinoin</i> (Veltrin)	T1	
<i>clindamycin/tretinoin</i> (Ziana)	T1	
<i>clindamycin-benzoyl perox 1-5%</i>	T1	
<i>clindamycin-bnz perox 1-5% pmp</i>	T1	
ACNE AGENTS, TOPICAL		
<i>dapsone 5% gel</i> (Aczone)	T1	
DAPSONE 7.5% GEL PUMP	T3	PA
<i>dapsone 7.5% gel pump</i> (Aczone)	T1	
EPIDUO FORTE	T3	PA
EPIDUO FORTE (<i>adapalene/benzoyl peroxide</i>)	T3	PA
KLARON (<i>sulfacetamide sodium</i>)	T3	
NEUAC 1.2-5% KIT	T3	
<i>neuac gel</i>	T1	
ONEXTON (<i>clindamycin phos/benzoyl perox</i>)	T3	
<i>sulfacetamide sodium</i> (Klaron)	T1	
TWYNEO	T3	
VELTRIN	T3	PA
ZIANA (<i>clindamycin phos-tretinoin</i>)	T3	PA
ANTI-PERSPIRANTS		
DRYSOL	T2	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-PRURITICS, TOPICAL		
<i>doxepin 5% cream</i> (Zonalon)	T1	PA QL(90 GMS/30 DAYS)
<i>doxepin hcl</i> (Zonalon)	T3	PA QL(90 GMS/30 DAYS)
ZONALON	T3	PA QL(90 GMS/30 DAYS)
ZONALON (<i>prudoxin</i>)	T3	PA QL(90 GMS/30 DAYS)
ANTI-PSORIATICS AGENTS		
<i>anthralin</i>	T1	
<i>calcipotriene 0.005% cream</i>	T1	
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</i> (Vectical)	T1	QL(800 GMS/30 DAYS)
DUOBRII	T3	
SORILUX	T3	PA
<i>tazarotene 0.05% cream</i> (Tazorac)	T1	
<i>tazarotene 0.05% gel</i> (Tazorac)	T1	
<i>tazarotene 0.1% cream</i> (Tazorac)	T1	
<i>tazarotene 0.1% gel</i> (Tazorac)	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% FOAM	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 SWAB	T1	
ALCOHOL SWABS	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTISEPTICS,GENERAL (cont.)		
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	
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	T1	
EMOLLIENTS		
XCLAIR	T3	
IMMUNOMODULATORS		
imiquimod 3.75% cream (Zyclara)	T1	PA QL(112 PACKS/30 DAYS)
imiquimod 3.75% cream pump (Zyclara)	T1	PA
imiquimod 5% cream packet (Aldara)	T1	
ZYCLARA 2.5% CREAM PUMP	T3	PA QL(30 GMS/30 DAYS)
ZYCLARA 3.75% CREAM (imiquimod)	T3	PA QL(112 PACKS/30 DAYS)
ZYCLARA 3.75% CREAM PUMP (imiquimod)	T3	PA
IRRITANTS/COUNTER-IRRITANTS		
methyl salicylate	T1	
JANUS KINASE (JAK) INHIBITORS		
CIBINQO	T2	PA QL(30 TABS/30 DAYS) SP

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
KERATOLYTICS		
<i>benzepro 6% foaming cloths</i>	T1	
BENZEPRO 7% CREAMY WASH (<i>benzoyl peroxide microspheres</i>)	T3	
<i>benzoyl peroxide</i>	T1	
<i>benzoyl peroxide</i> (Pacnex)	T1	
CONDYLOX (<i>podofilox</i>)	T3	PA
ENZOCLEAR	T3	
INOVA	T3	
PACNEX (<i>benzoyl peroxide</i>)	T3	
<i>podofilox</i>	T1	
<i>podofilox</i> (Condylox)	T1	
PR BENZOYL PEROXIDE (<i>benzoyl peroxide microspheres</i>)	T3	
<i>silver nitrate</i>	T1	
PROTECTIVES		
PHARMABASE BARRIER (<i>zinc oxide</i>)	T3	
<i>zinc oxide</i>	T1	
ZINC OXIDE	T1	
ROSACEA AGENTS, TOPICAL		
<i>azelaic acid</i> (Finacea)	T1	
FINACEA	T3	PA
FINACEA (<i>azelaic acid</i>)	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</i> (Metrocream)	T1	
<i>metronidazole 0.75% cream</i> (Metrocream)	T1	
<i>metronidazole 0.75% lotion</i>	T1	
<i>metronidazole top 1% gel pump</i>	T1	
<i>metronidazole topical 0.75% gl</i>	T1	
<i>metronidazole topical 1% gel</i> (Metrogel)	T1	
NORITATE	T3	PA
SOOLANTRA (<i>ivermectin</i>)	T3	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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	
TOPICAL AGENTS, MISCELLANEOUS		
MEDIHONEY	T3	
<i>trichloroacetic acid</i>	T3	
TRICHLOROACETIC ACID	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 (<i>scalacort</i>)	T3	ST
<i>alclometasone dipropionate</i>	T1	
<i>amcinonide 0.1% cream</i>	T1	
<i>amcinonide 0.1% ointment</i>	T1	PA
ANUSOL-HC 2.5% CREAM (<i>proctozone-hc</i>)	T3	PA
AQUA GLYCOLIC HC	T3	
<i>betamethasone dipropionate</i>	T1	
<i>betamethasone valerate</i>	T1	
<i>betamethasone/propylene glyc</i>	T1	
<i>betamethasone/propylene glyc</i> (Diprolene)	T1	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL ANTI-INFLAMMATORY STEROIDAL (cont.)		
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
<i>clocortolone pivalate (Cloderm)</i>	T1	
CLODAN 0.05% KIT	T3	ST
<i>clodan 0.05% shampoo (Clobex)</i>	T1	
CLODERM	T3	ST
CLODERM (<i>clocortolone pivalate</i>)	T3	ST
CORDRAN	T3	PA
CORDRAN (<i>flurandrenolide</i>)	T3	PA
DERMA-SMOOTHIE-FS (<i>fluocinolone acetonide</i>)	T3	ST
DERMA-SMOOTHIE-FS (<i>fluocinolone/shower cap</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</i>	T1	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL ANTI-INFLAMMATORY STEROIDAL (cont.)		
<i>fluocinonide</i> (Vanos)	T1	
<i>fluocinonide/emollient base</i>	T1	
<i>flurandrenolide</i> (Cordran)	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</i> (Halog)	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</i> (Locoid Lipocream)	T1	PA
<i>hydrocortisone</i>	T1	
<i>hydrocortisone</i> (Ala-Scalp)	T1	
<i>hydrocortisone</i> (Anusol-Hc)	T1	
<i>hydrocortisone acetate</i>	T1	
<i>hydrocortisone buty 0.1% cream</i>	T1	
<i>hydrocortisone butyr 0.1% 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

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL ANTI-INFLAMMATORY STEROIDAL (cont.)		
PANDEL	T3	PA
<i>prednicarbate</i>	T1	
SCALACORT DK	T3	ST
SERNIVO	T3	PA
SYNALAR	T3	ST
SYNALAR (<i>fluocinolone acetonide</i>)	T3	ST
SYNALARTS	T3	ST
TEMOVATE (<i>clobetasol propionate</i>)	T3	ST
TEXACORT	T3	ST
TOPICORT (<i>desoximetasone</i>)	T3	ST
<i>triamcinolone 0.025% cream</i>	T1	
<i>triamcinolone 0.025% lotion</i>	T1	
<i>triamcinolone 0.025% oint</i>	T1	
<i>triamcinolone 0.05% 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 acetoneide</i>	T1	
<i>triamcinolone acetoneide</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	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL ANTI-INFLAMMATORY STEROID-LOCAL ANESTHETIC (cont.)		
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	T3	PA
TOPICAL PREPARATIONS, ANTIBACTERIALS		
<i>iodine/potassium iodide</i>	T1	
<i>iodine/sodium iodide</i>	T1	
IODOFLEX	T3	
IODOSORB	T3	
<i>silver nitrate</i>	T1	
TOPICAL VIT D ANALOG/ANTI-INFLAMMATORY STEROID		
<i>calcipotriene/betamethasone (Taclonex)</i>	T1	
ENSTILAR	T3	PA
TACLONEX (<i>calcipotriene/betamethasone</i>)	T3	PA
WYNZORA	T3	PA
TOPICAL/MUCOUS MEMBR./SUBCUT. ENZYMES		
SANTYL	T2	QL(60 GMS/30 DAYS)
VITAMIN A DERIVATIVES		
<i>adapalene (Differin)</i>	T1	PA
ADAPALENE	T1	PA
<i>adapalene (Plixda)</i>	T1	PA
ALTRENO	T3	PA
ATRALIN (<i>tretinoin</i>)	T3	PA
DIFFERIN	T3	PA
DIFFERIN (<i>adapalene</i>)	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	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN A DERIVATIVES (cont.)		
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 microsphere</i>)	T3	PA
RETIN-A MICRO PUMP	T3	PA
RETIN-A MICRO PUMP (<i>tretinoin microsphere</i>)	T3	PA
<i>tretinoin 0.01% gel</i> (Retin-a)	T1	
<i>tretinoin 0.025% cream</i> (Retin-a)	T1	PA
<i>tretinoin 0.025% gel</i> (Retin-a)	T1	
<i>tretinoin 0.05% cream</i> (Retin-a)	T1	PA
<i>tretinoin 0.05% gel</i> (Atralin)	T1	PA
<i>tretinoin 0.1% cream</i> (Retin-a)	T1	PA
<i>tretinoin microspheres</i> (Retin-a Micro Pump)	T1	PA
<i>tretinoin microspheres</i> (Retin-a Micro)	T1	PA
SMOKING DETERRENTS (Smoking Cessation)⁸		
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> (Tapazole)	T1	HD
<i>propylthiouracil</i>	T1	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

THYROID PREPS (Hormonal Agents) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
THYROID HORMONES		
<i>adthyza 120 mg tablet</i>	T1	PA HD
ADTHYZA 130 MG TABLET	T3	PA HD
<i>adthyza 15 mg tablet</i>	T1	PA HD
ADTHYZA 16.25 MG TABLET	T3	PA HD
<i>adthyza 30 mg tablet</i>	T1	PA HD
ADTHYZA 32.5 MG TABLET	T3	PA HD
<i>adthyza 60 mg tablet</i>	T1	PA 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	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
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
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

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

THYROID PREPS (Hormonal Agents) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
THYROID HORMONES (cont.)		
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 sodium (Cytomel)</i>	T1	HD
SYNTHROID (<i>levothyroxine sodium</i>)	T3	PA HD
THYQUIDITY	T3	PA HD
<i>thyroid, pork</i>	T1	HD
TIROSINT	T3	HD
TIROSINT-SOL	T3	HD

UNCLASSIFIED DRUG PRODUCTS (AIDS/HIV)

CYTOCHROME P450 INHIBITORS		
TYBOST	T3	SP

UNCLASSIFIED DRUG PRODUCTS (Asthma/COPD/Respiratory)

CYSTIC FIBROSIS - INHALED OSMOTIC AGENTS		
BRONCHITOL	T3	PA SP HD
CYSTIC FIBROSIS-CFTR POTENTIATOR-CORRECTOR COMBIN.		
ALYFTREK 10-50-125 MG TABLET	T3	PA QL(2 TABS/DAY) SP HD
ALYFTREK 4-20-50 MG TABLET	T3	PA QL(3 TABS/DAY) SP HD
ORKAMBI 100 MG-125 MG TABLET	T3	PA QL(4 TABS/DAY) SP HD
ORKAMBI 100-125 MG GRANULE PKT	T3	PA QL(2 PACKS/DAY) SP HD
ORKAMBI 150-188 MG GRANULE PKT	T3	PA QL(2 PACKS/DAY) SP HD
ORKAMBI 200 MG-125 MG TABLET	T3	PA QL(4 TABS/DAY) SP HD
ORKAMBI 75-94 MG GRANULE PKT	T3	PA QL(2 PACKS/DAY) SP HD
SYMDEKO	T3	PA QL(2 TABS/DAY) SP HD
TRIKAFTA 100-50-75 MG/150 MG	T3	PA QL(3 TABS/DAY) SP HD
TRIKAFTA 100-50-75 MG/75MG PKT	T3	PA QL(2 UNITS/DAY) SP HD
TRIKAFTA 50-25-37.5 MG/75 MG	T3	PA QL(3 TABS/DAY) SP HD
TRIKAFTA 80-40-60MG/59.5MG PKT	T3	PA QL(2 UNITS/DAY) SP HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Asthma/COPD/Respiratory) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CYSTIC FIB-TRANSMEMB CONDUCT.REG.(CFTR) POTENTIATOR		
KALYDECO 13.4 MG GRANULES PKT	T3	PA QL(2 PACKS/DAY) SP HD
KALYDECO 5.8 MG TABLET	T3	PA QL(2 PACKS/DAY) SP HD
KALYDECO 150 MG TABLET	T3	PA QL(2 TABS/DAY) SP HD
KALYDECO 25 MG GRANULES PACKET	T3	PA QL(2 PACKS/DAY) SP HD
KALYDECO 50 MG GRANULES PACKET	T3	PA QL(2 PACKS/DAY) SP HD
KALYDECO 75 MG GRANULES PACKET	T3	PA QL(2 PACKS/DAY) SP HD
LUNG SURFACTANTS		
CUROSURF	T3	
INFASURF	T3	
SURVANTA	T3	
MUCOLYTICS		
PULMOZYME	T2	PA SP HD
PULMONARY FIBROSIS - SYSTEMIC ENZYME INHIBITORS		
OFEV	T2	PA SP HD
SYSTEMIC ENZYME INHIBITORS		
JOENJA	T3	PA QL(2 TABS/DAY) SP
VIJOICE 125 MG TABLET	T3	PA QL(1 TAB/DAY) SP
VIJOICE 250 MG DAILY DOSE PACK	T3	PA QL(2 TABS/DAY) SP
VIJOICE 50 MG GRANULE PACKET	T3	PA QL(1 TAB/DAY) SP
VIJOICE 50 MG TABLET	T3	PA QL(1 TAB/DAY) SP
ZOKINVY	T3	PA QL(4 CAPS/DAY) SP
THYMIC STROMAL LYMPHOPOIETIN (TSLP) INHIBITORS		
TEZSPIRE 210 MG/1.91 ML PEN	T2	PA QL(1 PEN/28 DAYS) SP HD
TEZSPIRE 210 MG/1.91 ML SYRING	T2	PA SP HD
UNCLASSIFIED DRUG PRODUCTS (Blood Modifiers/Bleeding Disorders)		
SPLEEN TYROSINE KINASE INHIBITORS		
TAVALISSE	T2	PA SP
UNCLASSIFIED DRUG PRODUCTS (Blood Pressure/Heart Medications)		
ANTI-INFLAMMATORY-ANTIMITOTICS		
LODOCO	T3	PA
BRADYKININ B2 RECEPTOR ANTAGONISTS		
FIRAZYR (<i>icatibant acetate</i>)	T3	PA SP
<i>icatibant acetate</i> (Firazyr)	T1	PA SP HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Blood Pressure/Heart Medications) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PLASMA KALLIKREIN INHIBITORS		
KALBITOR	T3	PA SP HD
ORLADEYO	T3	PA QL(1 CAP/DAY) SP
UNCLASSIFIED DRUG PRODUCTS (Cancer)		
CHEMOTHERAPY RESCUE/ANTIDOTE AGENTS		
<i>leucovorin calcium</i>	T1	CSL
<i>mesna</i> (Mesnex)	T1	SP CSL
MESNEX (<i>mesna</i>)	T3	SP CSL
VISTOGARD	T3	SP CSL
UNCLASSIFIED DRUG PRODUCTS (Dental Products)		
DENTAL AIDS AND PREPARATIONS		
<i>chlorhexidine gluconate</i> (Peridex)	T1	
PERIDEX (<i>periogard</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)		
DRUGS TO TREAT ERECTILE DYSFUNCTION (ED)		
<i>avanafil</i> (Stendra)	T1	QL(8 TABS/30 DAYS)
CAVERJECT	T3	PA 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	PA QL(6 INJECTIONS/30 DAYS)
IFE-BIMIX 30/1	T2	
MUSE	T2	PA QL(6 SUPPS/30 DAYS)
<i>sildenafil 100 mg, 50 mg, 20 mg tablet</i> (Viagra)	T1	QL(8 TABS/30 DAYS) HD
STENDRA (<i>avanafil</i>)	T3	ST QL(8 TABS/30 DAYS)
<i>tadalafil 2.5 mg tablet</i>	T1	QL(1 TAB/DAY) HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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</i> (Cialis)	T1	QL(1 TAB/DAY) HD
<i>tadalafil 10 mg tablet</i> (Cialis)	T1	QL(8 TABS/30 DAYS) HD
<i>tadalafil 20 mg tablet</i> (Cialis)	T1	QL(8 TABS/30 DAYS) HD
<i>varafenafil 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)

NICOTINIC RECEPT.PARTIAL AGONIST, ALPHA4BETA2 SPEC		
TYRVAYA	T2	QL(8.4 MLS/30 DAYS)

UNCLASSIFIED DRUG PRODUCTS (Gastrointestinal/Heartburn)

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

UNCLASSIFIED DRUG PRODUCTS (Hormonal Agents)

GROWTH HORMONE RECEPTOR ANTAGONISTS		
SOMAVERT	T2	PA SP HD
HYPERPARATHYROID TX AGENTS - VITAMIN D ANALOG-TYPE		
<i>doxercalciferol</i>	T1	
<i>paricalcitol</i>	T1	SP HD
<i>paricalcitol</i> (Zemlar)	T1	SP HD
RAYALDEE	T3	
ZEMPLAR (<i>paricalcitol</i>)	T3	SP HD
MENOPAUSAL SYMPT SUPP-SEL ESTROGEN RECEPT MODULATOR		
OSPHENA	T3	QL(30 TABS/30 DAYS) HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Miscellaneous)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ABORTIFACIENT-PROGESTERONE RECEPTOR ANTAGONISTS		
MIFEPREX	T3	
mifepristone 200 mg tablet	T1	
AGENTS TO TX PERIODIC PARALYSIS - CARBON ANHYD INH		
dichlorphenamide (Keveyis)	T1	PA SP HD
KEVEYIS (dichlorphenamide)	T3	PA SP
AMMONIA INHIBITORS		
CARBAGLU (carglumic acid)	T3	SP HD
carglumic acid (Carbaglu)	T1	SP HD
AMYLOIDOSIS AGENTS-TRANSTHYRETIN (TTR) SUPPRESSION		
WAINUA	T3	PA QL(1 AUTO-INJ/28 DAYS) SP
ANTI-ALCOHOLIC PREPARATIONS		
acamprosate calcium	T1	
disulfiram	T1	
ANTI-FIBROTIC THERAPY - PYRIDONE ANALOGS		
ESBRIET	T3	PA SP HD
pirfenidone 267 mg capsule	T1	PA SP HD
pirfenidone 267 mg tablet (Esbriet)	T1	PA SP HD
PIRFENIDONE 534 MG TABLET	T3	PA SP HD
pirfenidone 801 mg tablet (Esbriet)	T1	PA SP HD
CI ESTERASE INHIBITORS		
BERINERT	T3	PA SP HD
CINRYZE	T3	PA SP HD
HAEGARDA	T3	PA SP HD
RUCONEST	T3	PA SP HD
CALCIMIMETIC,PARATHYROID CALCIUM ENHANCER		
cinacalcet hcl (Sensipar)	T1	SP
SENSIPAR (cinacalcet hcl)	T3	PA SP
COMPLEMENT INHIBITORS		
ZILBRYSQ	T3	PA QL(1 SYRINGE/DAY) SP
CRYOPRESERVATIVE AGENTS		
dimethyl sulfoxide	T1	
FACTOR XII INHIBITORS		
ANDEMBRY AUTOINJECTOR	T3	PA SP

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GENERAL INHALATION AGENTS		
HYPER-SAL	T3	
nebusal 3% vial	T1	
NEBUSAL 6% VIAL	T3	
sodium chloride 0.9% inhal vl	T1	
sodium chloride 10% vial	T1	
sodium chloride 3% vial	T1	
sodium chloride 7% vial	T1	
sodium chloride for inhalation	T1	
GENETIC D/O TX - SMN PROTEIN DEFICIENCY TREATMENT		
EVRYSDI	T3	PA SP HD
GENETIC DISORDER THERAPY - HDAC INHIBITOR		
DUVYZAT	T3	PA SP
GLUCOSYLCERAMIDE SYNTHASE (GCS) INHIBITOR		
CERDELGA	T2	PA SP HD
miglustat (Zavesca)	T1	PA SP HD
OPFOLDA	T3	PA QL(8 CAPS/30 DAYS) SP HD
ZAVESCA (miglustat)	T3	PA SP HD
HEAT SHOCK PROTEIN (HSP) MODULATING AGENTS		
MIPLYFFA	T3	PA SP
HYDROXYPHENYL-PYRUVATE DIOXYGENASE(HPPD) INHIBITOR		
nitisinone (Orfadin)	T1	PA SP HD
NITYR	T2	PA SP
ORFADIN	T3	PA SP
ORFADIN (nitisinone)	T3	PA SP
HYPOACTIVE SEXUAL DESIRE DISORDER (HSDD) TX AGENTS		
ADDYI	T3	PA QL(1 TAB/DAY)
VYLEESI	T3	PA QL(8 AUTO-INJS/30 DAYS) SP
MENOPAUSAL SYMPTOMS SUPPRESSANT - SSRI's		
paroxetine mesylate	T1	QL(1 cap/day) HD
MENOPAUSAL SYMPTOMS SUPPRESSANT-NK RECEPTOR ANTAG		
VEOZAH	T3	QL(1 TAB/DAY)
METABOLIC DISEASE ENZYME REPLACE, HYPOPHOSPHATASIA		
STRENSIQ	T2	PA SP

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
METABOLIC DISEASE ENZYME REPLACEMENT, MOCD		
NULIBRY	T3	PA SP
METALLIC POISON, AGENTS TO TREAT		
CHEMET	T3	
CUVRIOR	T3	PA SP
<i>deferasirox</i> (Exjade)	T1	SP HD
<i>deferasirox</i> (Jadenu Sprinkle)	T1	SP HD
<i>deferasirox</i> (Jadenu)	T1	SP HD
<i>deferiprone</i> (Ferriprox (3 Times A Day))	T1	PA SP HD
<i>deferiprone</i> (Ferriprox)	T1	PA SP
EXJADE (<i>deferasirox</i>)	T3	PA SP HD
FERRIPROX	T3	PA SP
FERRIPROX (2 TIMES A DAY)	T3	PA SP
FERRIPROX (3 TIMES A DAY) (<i>deferiprone</i>)	T3	PA SP
FERRIPROX (<i>deferiprone</i>)	T3	PA SP
GALZIN	T3	SP
JADENU (<i>deferasirox</i>)	T3	PA SP HD
JADENU SPRINKLE (<i>deferasirox</i>)	T3	PA SP HD
RADIOGARDASE	T3	
SYPRINE (<i>trientine hcl</i>)	T3	PA SP HD
<i>trientine hcl</i> 250 mg capsule (Syprine)	T1	PA SP HD
TRIENTINE HCL 500 MG CAPSULE	T3	PA SP HD
NATRIURETIC PEPTIDES		
VOXZOGO	T3	PA SP HD
NEONATAL FC RECEPTOR (FCRN) INHIBITORS		
VYVGART HYTRULO	T3	PA SP HD
NUCLEAR FACTOR ERYTHROID 2-REL. FACTOR 2 ACTIVATOR		
SKYCLARYS	T3	PA QL(3 CAPS/DAY) SP
OINTMENT/CREAM BASES		
RADIAGEL	T1	
OXALOSIS AGENT - OXALATE INHIBITOR, SIRNA BASED		
RIVFLOZA 128 MG/0.8 ML SYRINGE	T3	PA QL(1 SYRINGE/30 DAYS) SP
RIVFLOZA 160 MG/ML SYRINGE	T3	PA QL(1 SYRINGE/30 DAYS) SP
RIVFLOZA 80 MG/0.5 ML VIAL	T3	PA SP

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PHARMACOLOGICAL CHAPERONE-ALPHA-GALACTOSID.A STABZ		
GALAFOLD	T3	PA SP HD
PKU TX AGENT-COFACTOR OF PHENYLALANINE HYDROXYLASE		
<i>javygtor 100 mg powder packet</i> (Kuvan)	T1	PA SP
<i>javygtor 100 mg tablet</i> (Kuvan)	T1	PA SP HD
<i>javygtor 500 mg powder packet</i> (Kuvan)	T1	PA SP
KUVAN (<i>sapropterin dihydrochloride</i>)	T3	PA SP HD
<i>sapropterin dihydrochloride</i> (Kuvan)	T1	PA SP HD
PROTEIN STABILIZERS		
ATTRUBY	T3	PA QL(4 TABS/DAY) SP
VYNDAMAX	T3	PA QL(1 CAP/DAY) SP HD
VYNDAQEL	T3	PA QL(4 CAPS/DAY) SP
RETINOIC ACID RECEPTOR (RAR) AGONISTS		
SOHONOS	T3	PA SP
SOLVENTS		
<i>cvs isopropyl alcohol 91%</i>	T1	
CVS ISOPROPYL ALCOHOL 91%	T1	
<i>cvs isopropyl rub alcohol 70%</i>	T1	
CVS ISOPROPYL RUB ALCOHOL 70%	T3	
<i>eqi isopropyl alcohol 91%</i>	T1	
<i>eqi isopropyl rub alcohol 70%</i>	T1	
FT ISOPROPYL ALCOHOL 91%	T1	
FT ISOPROPYL RUB ALCOHOL 70%	T3	
GNP ISOPROPYL ALCOHOL 70%	T3	
GNP ISOPROPYL ALCOHOL 91%	T1	
<i>gnp isopropyl alcohol 99%</i>	T1	
GS ISOPROPYL ALCOHOL 70%	T3	
GS ISOPROPYL ALCOHOL 91%	T1	
<i>hm isopropyl alcohol 70%</i>	T1	
<i>hm isopropyl alcohol 91%</i>	T1	
INSTACLEAN	T1	
ISOPROPANOL	T1	
<i>isopropyl 70% alcohol</i>	T1	
<i>isopropyl alcohol</i>	T1	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SOLVENTS (cont.)		
isopropyl alcohol 70%	T1	
ISOPROPYL ALCOHOL 70%	T3	
isopropyl alcohol 91%	T1	
isopropyl alcohol 99%	T1	
isopropyl rubbing alcohol 70%	T1	
ISOPROPYL RUBBING ALCOHOL 70%	T3	
ISOPROPYL RUBBING ALCOHOL 91%	T1	
kro isopropyl alcohol 91%	T1	
MURI-LUBE MINERAL OIL	T1	
polyethylene glycol	T1	
ra isopropyl alcohol 70%	T1	
ra isopropyl alcohol 91%	T1	
sm isopropyl alcohol 70%	T1	
swan isopropyl alcohol 70%	T1	
THYMIC STROMAL LYMPHOPOIETIN (TSLP) INHIBITORS		
VYKAT XR	T3	PA SP
UNCLASSIFIED DRUG PRODUCTS (Nutritional/Dietary)		
METABOLIC DEFICIENCY AGENTS		
betaine (Cystadane)	T1	SP
CARNITOR (levocarnitine (with sugar))	T3	PA
CARNITOR (levocarnitine)	T3	PA
CARNITOR SF (levocarnitine)	T3	PA
CULTURELLE IBS COMPLETE SUPPRT	T3	
CYSTADANE (betaine)	T3	SP
levocarnitine (Carnitor Sf)	T1	
levocarnitine (Carnitor)	T1	
levocarnitine (with sugar) (Carnitor)	T1	
UNCLASSIFIED DRUG PRODUCTS (Osteoporosis Products)		
BONE FORMATION STIM. AGENTS - PARATHYROID HORMONE		
BONIVA (ibandronate sodium)	T3	PA QL(0.09 MLS/DAY) SP
FORTEO (teriparatide)	T3	PA QL(0.09 MLS/DAY) SP HD
teriparatide (Bonsity)	T1	PA QL(0.09 MLS/DAY) SP HD
teriparatide (Forteo)	T1	PA QL(0.09 MLS/DAY) SP HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Osteoporosis Products) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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
ATELVIA (<i>risedronate sodium dr</i>)	T3	ST HD
BINOSTO	T3	ST HD
EVISTA (<i>raloxifene hcl</i>)	T3	PA HD
FOSAMAX (<i>alendronate sodium</i>)	T3	ST HD
<i>ibandronate sodium</i>	T1	HD
<i>raloxifene hcl</i> (Evista)	T1	HD PPACA
<i>risedronate sodium</i>	T1	HD
<i>risedronate sodium</i> (Actonel)	T1	HD
<i>risedronate sodium</i> (Atelvia)	T1	HD

UNCLASSIFIED DRUG PRODUCTS (Pain Relief And Inflammatory Disease)

ANTI-INFLAM. INTERLEUKIN-I RECEPTOR ANTAGONIST		
ARCALYST	T3	PA SP HD
ANTI-INFLAMMATORY, INTERLEUKIN-I BETA BLOCKERS		
ILARIS	T3	PA SP HD
FIBROMYALGIA AGENTS, SEROTONIN-NOREPINEPH RU INHIB		
SAVELLA	T2	
IMMUNOMODULATOR, B-LYMPHOCYTE STIM (BLYS)-SPEC INHIB		
BENLYSTA	T3	PA SP HD

UNCLASSIFIED DRUG PRODUCTS (Seizure Disorders)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NEUROPATHIC AGENTS		
LYRICA CR (<i>pregabalin</i>)	T3	HD
<i>pregabalin</i> (Lyrica Cr)	T1	HD

UNCLASSIFIED DRUG PRODUCTS (Skin Conditions)

INTERLEUKIN-I3 (IL-I3) INHIBITORS,MAB		
ADBRY	T2	PA SP HD
ADBRY AUTOINJECTOR	T2	PA SP HD
EBGLYSS PEN	T2	PA SP
EBGLYSS SYRINGE	T2	PA SP

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Skin Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
JANUS KINASE (JAK) INHIBITORS		
LEQSELVI	T3	PA QL(2 TABS/DAY) SP HD
LITFULO	T3	PA QL(1 CAP/DAY) SP HD
WOUND HEALING AGENTS, LOCAL		
FILSUVEZ	T3	PA SP

UNCLASSIFIED DRUG PRODUCTS (Substance Abuse)

OPIOID WITHDRAWAL THER, ALPHA-2 ADRENERGIC AGONIST		
<i>lofexidine hcl</i> (Lucemyra)	T1	QL(192 TABS/30 DAYS)
LUCEMYRA (<i>lofexidine hcl</i>)	T2	QL(192 TABS/30 DAYS)
OPIOID WITHDRAWAL THERAPY AGENTS, OPIOID-TYPE		
<i>buprenorphine hcl</i>	T1	
<i>buprenorphine hcl/naloxone hcl</i>	T1	
<i>buprenorphine hcl/naloxone hcl</i> (Suboxone)	T1	
SUBOXONE (<i>buprenorphine-naloxone</i>)	T3	
ZUBSOLV	T2	

UNCLASSIFIED DRUG PRODUCTS (Transplant Medications)

RHO KINASE INHIBITOR		
REZUROCK	T3	PA SP

UNCLASSIFIED DRUG PRODUCTS (Urinary Tract Conditions)

BENIGN PROSTATIC HYPERTROPHY/MICTURITION AGENTS		
<i>alfuzosin hcl</i> (Uroxatral)	T1	HD
AVODART (<i>dutasteride</i>)	T3	PA HD
<i>dutasteride</i> (Avodart)	T1	HD
<i>finasteride</i> (Proscar)	T1	HD
PROSCAR (<i>finasteride</i>)	T3	PA HD
RAPAFLO 4 MG CAPSULE (<i>silodosin</i>)	T3	PA QL(1 CAP/DAY) HD
RAPAFLO 8 MG CAPSULE (<i>silodosin</i>)	T3	PA HD
<i>silodosin 4 mg capsule</i> (Rapaflo)	T1	QL(1 CAP/DAY) HD
<i>silodosin 8 mg capsule</i> (Rapaflo)	T1	HD
<i>tamsulosin hcl</i>	T1	HD
UROXATRAL (<i>alfuzosin hcl er</i>)	T3	PA HD
BPH 5-ALPHA-REDUCTASE INHIB-ALPHA1-ADRENOCEP ANTAG		
<i>dutasteride/tamsulosin hcl</i> (Jalyn)	T1	HD
JALYN (<i>dutasteride/tamsulosin hcl</i>)	T3	PA HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BPH AGENT-5-ALPHA-REDUCTASE INH AND PDE5 INH COMB		
ENTADFI	T3	PA QL(1 CAP/DAY)
CYSTINE-DEPLETING AGENTS, NEPHROPATHIC CYSTINOSIS		
CYSTAGON	T2	SP
PROCYSBI	T3	PA SP HD
ENDOTHELIN RECEPTOR ANTAGONISTS		
VANRAFIA	T2	PA QL(1 TAB/DAY) SP
KIDNEY STONE AGENTS		
THIOLA (<i>tiopronin</i>)	T3	PA SP
THIOLA EC (<i>tiopronin</i>)	T3	PA SP
<i>tiopronin</i> (Thiola Ec)	T1	SP
<i>tiopronin 100 mg tablet</i> (Thiola)	T1	SP
<i>tiopronin dr 100 mg tablet</i> (Thiola Ec)	T1	SP HD
<i>tiopronin dr 300 mg tablet</i> (Thiola Ec)	T1	SP HD
OVERACTIVE BLADDER AGENTS, BETA-3 ADRENERGIC RECEPTOR		
GEMTESA	T3	ST QL(1 TAB/DAY) HD
<i>mirabegron er 25 mg tablet</i> (Myrbetriq)	T1	QL(1 TAB/DAY) HD
<i>mirabegron er 50 mg tablet</i> (Myrbetriq)	T1	HD
MYRBETRIQ ER 25 MG TABLET (<i>mirabegron</i>)	T3	ST QL(1 TAB/DAY) HD
MYRBETRIQ ER 50 MG TABLET (<i>mirabegron</i>)	T3	ST HD
MYRBETRIQ ER 8 MG/ML SUSP	T3	ST HD
URINARY TRACT ANTI-SPASMODIC, M(3) SELECTIVE ANTAGONIST		
<i>darifenacin er 15 mg tablet</i>	T1	HD
<i>darifenacin er 7.5 mg tablet</i> (Enablex)	T1	QL(1 TAB/DAY) HD
<i>solifenacin 10 mg tablet</i> (Vesicare)	T1	HD
<i>solifenacin 5 mg tablet</i> (Vesicare)	T1	QL(1 TAB/DAY) HD
VESICARE 10 MG TABLET (<i>solifenacin succinate</i>)	T3	ST HD
VESICARE 5 MG TABLET (<i>solifenacin succinate</i>)	T3	ST QL(1 TAB/DAY) HD
VESICARE LS	T3	ST HD
URINARY TRACT ANTI-SPASMODIC/ANTI-INCONTINENCE AGENT		
DETROL (<i>tolterodine tartrate</i>)	T3	ST HD
DETROL LA 2 MG CAPSULE (<i>tolterodine tartrate er</i>)	T3	ST QL(1 CAP/DAY) HD
DETROL LA 4 MG CAPSULE (<i>tolterodine tartrate er</i>)	T3	ST HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
URINARY TRACT ANTI-SPASMODIC/ANTI-INCONTINENCE AGENT (cont.)		
<i>fesoterodine er 4 mg tablet (Toviaz)</i>	T1	QL(1 TAB/DAY) HD
<i>fesoterodine er 8 mg tablet (Toviaz)</i>	T1	HD
<i>flavoxate hcl</i>	T1	HD
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)

ANTIOXIDANT MULTIVITAMIN COMBINATIONS		
MACUVEX	T2	
MACUZIN	T2	
FOLIC ACID PREPARATIONS		
ENLYTE	T2	
<i>folic acid</i>	T1	
<i>folic acid/b6/ca phos/ginger</i>	T1	
GERIATRIC VITAMIN PREPARATIONS		
REQ49+	T2	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MULTIVITAMIN PREPARATIONS		
ANIMI-3	T2	
BACMIN	T2	
CONCEPT DHA (<i>mvn-min75/iron/iron ps/om3/dha</i>)	T3	
CONCEPT OB (<i>mvn-min 74/iron fum/iron/fa</i>)	T2	
CORVITE	T2	
DIALYVITE 800 WITH IRON	T2	
ENBRACE HR	T2	
<i>folic/mvi ther-min/lycop/lut</i>	T1	
FORTAVIT	T2	
<i>multivit 47/iron/folate 1/dha</i>	T1	
<i>multivit no.18/iron no.1/folic</i> (Tandem Plus)	T1	
<i>multivit no.51/iron/folic acid</i>	T1	
<i>multivit-min69/iron/folic acid</i>	T1	
<i>multivit-mins no.7/folic acid</i>	T1	
<i>mv-mins 71/iron/folic no.1/dha</i>	T1	
<i>mvn no.53/iron/folic/dss/dha</i>	T1	
<i>mvn-min 74/iron fum/iron/fa</i> (Concept Ob)	T1	
<i>mvn-min75/iron/iron ps/om3/dha</i> (Concept Dha)	T1	
NEEVODHA	T2	
NESTABS ONE	T2	
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>)	T2	
STROVITE ONE	T2	
TANDEM PLUS (<i>multivit no.18/iron no.1/folic</i>)	T3	
UDAMIN SP	T2	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PEDIATRIC VITAMIN PREPARATIONS		
FLORIVA 0.25 MG CHEW TABLET	T2	PPACA
FLORIVA 0.5 MG CHEWABLE TABLET	T2	PPACA
FLORIVA 1 MG CHEWABLE TABLET	T2	PPACA
<i>ped mvit a,c,d3 no.21/fluoride</i>	T1	PPACA
<i>pedi multivit no.12 w-fluoride</i>	T2	PPACA
POLY-VI-FLOR	T2	PPACA
QUFLORA FE	T2	
QUFLORA PED 0.25 MG CHEW TAB	T2	
QUFLORA PED 0.25 MG/ML DROP	T2	PPACA
QUFLORA PED 0.5 MG CHEW TAB	T2	
QUFLORA PED 0.5 MG/ML DROP	T2	PPACA
QUFLORA PED 1 MG CHEW TAB	T2	PPACA
TRI-VI-FLOR	T2	PPACA
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	T2	HD
DIALYVITE 5000	T2	HD
DIALYVITE SUPREME D	T2	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	T2	HD
NEPHRON FA	T3	HD
NIVA-FOL (<i>cyanocobalamin/folic ac/vit b6</i>)	T1	HD
VITAL-D RX	T2	HD
VITA-RESPA	T2	HD
VITAMIN B12 PREPARATIONS		
<i>cyanocobalamin (vitamin b-12)</i>	T1	
<i>cyanocobalamin (vitamin b-12) (Nascobal)</i>	T1	
NASCOBAL (<i>cyanocobalamin (vitamin b-12)</i>)	T3	PA

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN D PREPARATIONS		
<i>calcitriol 0.25 mcg capsule</i>	T1	
<i>calcitriol 0.5 mcg capsule</i>	T1	
<i>calcitriol 1 mcg/ml solution</i>	T1	
<i>ergocalciferol (vitamin d2)</i>	T1	HD
VITAMIN K PREPARATIONS		
MEPHYTON (<i>phytonadione</i>)	T3	
<i>phytonadione (vit k1)</i> (Mephyton)	T1	
MULTIVITAMIN PREPARATIONS		
CITRANATAL MEDLEY	T3	
PEDIATRIC VITAMIN PREPARATIONS		
POLY-VI-FLOR	T2	PPACA
POLY-VI-FLOR WITH IRON	T2	PPACA

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

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,¹¹ 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

1ST TIER UNIFINE	169
1ST TIER UNILET	163
1ST TIER UNILET COMFORTOUCH	180
2-IN-1 LANCET DEVICE.....	163, 180

A

abacavir	75, 76
abacavir sulfate	76
abacavir sulfate/lamivudine	75
ABILIFY	204, 205
abiraterone	61
abiraterone acetate 250 mg tab (Zytiga)	61
abiraterone acetate 500 mg tab (Zytiga)	61
ABRILADA(CF) 20 MG/0.4 ML SYRN	58
ABRILADA(CF) 40 MG/0.8 ML SYRN	58
ABRILADA(CF) PEN	58
ABRILADA(CF) PEN (2 PACK)	58
ABRYSVO	87
ABSORICA	210
ACAM2000 (NATIONAL STOCKPILE)	87
acamprosate	225
ACANYA	210
acarbose	50
ACCOLATE	34
ACCRUFER	135
ACCU-CHEK	157, 163
ACCU-CHEK AVIVA PLUS	118
ACCU-CHEK FASTCLIX LANCET DRUM	181
ACCU-CHEK FASTCLIX LANCING DEV	157
ACCU-CHEK GUIDE CONTROL SOLN	157
ACCU-CHEK GUIDE TEST STRIP	118
ACCU-CHEK SAFE-T-PRO	181
ACCU-CHEK SAFE-T-PRO PLUS	181
ACCU-CHEK SMARTVIEW CONTRL SOL	157
ACCU-CHEK SMARTVIEW TEST STRIP	118
ACCU-CHEK SOFTCLIX	157, 181
ACCUPRIL	97
ACCURETIC	95
ACCU-TREND GLUCOSE CONTROL	157
ACCU-TREND GLUCOSE TEST STRIP	118
ACD	43
ACE AEROSOL CLOUD ENHANCER	186
acebutolol	99
acetamin-codein 300-30 mg/12.5	22
acetaminop-codeine 120-12 mg/5	22
acetaminophen/caff/dihydrocod	22
acetaminophen-cod	22
acetazolamide	125
acetic acid	56, 128, 208

acetylcysteine	34
ACIPHEX	144
acitretin	209
ACTEMRA	155
ACTHAR	147
ACTHIB	86
ACTICLATE	40
ACTI-LANCE	163, 181
ACTIMMUNE	70
ACTIQ	22
ACTIVE FE	135
ACTIVEVILLA (estradiol/norethindrone acet)	149
ACTONEL	230
ACTOPLUS	52
ACTOS	53
ACULAR	128
ACUVAIL	128
acyclovir	78, 80
acyclovir 200 mg/5 ml susp	78
acyclovir 200 mg/5 ml susp cup	78
ACZONE (dapsone)	210
ADACEL	86
ADALIMUMAB-AACF(CF) (2 PK)	58
ADALIMUMAB-AACF(CF) PEN (2 PK)	58
ADALIMUMAB-AACF(CF) PEN CROHNS	58
ADALIMUMAB-AACF(CF) PEN PS-UV	58
ADALIMUMAB-AATY(CF) 20MG/0.2ML	58
ADALIMUMAB-AATY(CF) 40MG/0.4ML	58
ADALIMUMAB-AATY(CF) 80MG/0.8ML	58
ADALIMUMAB-AATY(CF) AI CROHNS	58
ADALIMUMAB-ADAZ(CF) 10MG/0.1ML	58
ADALIMUMAB-ADAZ(CF) 20MG/0.2ML	58
ADALIMUMAB-ADAZ(CF) 40 MG SYRG	58
ADALIMUMAB-ADAZ(CF) PEN 40 MG	58
ADALIMUMAB-ADAZ(CF) PEN 80 MG	58
ADALIMUMAB-ADB(M)CF 10 MG SYRG	58
ADALIMUMAB-ADB(M)CF 20 MG SYRG	58
ADALIMUMAB-ADB(M)CF 40 MG SYRG	58
ADALIMUMAB-ADB(M)CF PEN	58
ADALIMUMAB-ADB(M)CF PEN	58
ADALIMUMAB-FKJP(CF) 20 MG SYRG	58
ADALIMUMAB-FKJP(CF) 40 MG SYRG	58
ADALIMUMAB-FKJP(CF) PEN	58
ADALIMUMAB-RYVK(CF)	58
ADALIMUMAB-RYVK(CF) AUTOINJECT	58
adapalene	210, 218
ADAPALENE	218
adapalene/benzoyl peroxide (Epiduo Forte)	210
ADBRY	230

Index of Medications

ADCIRCA (tadalafil)	93	AFLURIA QUAD 2023-2024	85
ADDERALL	81	AFLURIA TRIV 2024-25 (3YR UP)	85
ADDYI	226	AFLURIA TRIVALENT 2024-25	85
adefovir	80	AFREZZA	54
ADEMPAS	93	AFSTYLA	88
ADJUSTABLE LANCING DEVICE	157	AGAMATRIX AMP	118
ADLARITY	81	AGAMATRIX CONTROL	157
ADMELOG	54	AGAMATRIX CONTROL SOLUTION	157
ADRENALIN	127	AGAMATRIX JAZZ TEST STRIP	118
adthyza	220	AGAMATRIX PRESTO	118
ADTHYZA	220	AGAMATRIX ULTRA-THIN LANCET	164, 181
adthyza 90 mg tablet	220	AGAMREE	150
ADVAIR 100-50 DISKUS (fluticasone propion/salmeterol)	32	AGRYLIN	74
ADVAIR 250-50 DISKUS (fluticasone propion/salmeterol)	32	AIMOVIG	15, 19
ADVAIR 500-50 DISKUS (fluticasone propion/salmeterol)	32	AIRDUO DIGIHALER	32
ADVAIR HFA 45-21 MCG INHALER	32	AJOVY	15, 19
ADVAIR HFA 115-21 MCG INHALER	32	AJOVY AUTOINJECTOR (3 PACK)	19
ADVAIR HFA 230-21 MCG INHALER	32	AKLIEF	214
ADVANCED	123, 163	AKTEN	129
ADVANCED DNA MEDICATED COLLECT	123	AKYNZEO	139
ADVANCED GLUCOSE TEST STRIP	118	ALA-SCALP	214
ADVANCED GLUCOSE TEST STRIPS	118	albendazole	56
ADVANCED LANCING DEVICE	157	albuterol	30, 31
ADVANCED TRAVEL LANCETS	181	albuterol 25 mg/5 ml solution	31
ADVOCATE	164, 169	albuterol hfa 90 mcg inhaler	31
ADVOCATE CONTROL SOLUTION	157	ALBUTEROL HFA 90 MCG INHALER	31
ADVOCATE LANCET	181	ALCAINE	129
ADVOCATE LANCETS	181	alclometasone	214
ADVOCATE LANCING DEVICE	157	ALCOH-GLOVE	186
ADVOCATE RAPID-SAFE LANCING DV	157	ALCOHOL	57
ADVOCATE REDI-CODE	118	alcohol antiseptic pads	208, 211
ADVOCATE REDI-CODE+	118	ALCOHOL PREP PADS	208, 211
ADVOCATE REDI-CODE+ CTRL SOLN	157	ALCOHOL SWAB	208, 211
ADVOCATE SAFETY LANCET	164, 181	ALCOHOL SWABS	208, 211
ADVOCATE SYRINGES	172	ALCOHOL WIPES	208, 212
ADVOCATE TEST STRIP	118	ALCOH-WIPE	186
ADYNOVATE	88	ALDACTONE	126
ADZENYS	81	ALECENSA	64
AEMCOLO	40	alendronate	230
AEROCHAMBER	186	alfuzosin	231
AEROTRACH	186	ALHEMO	88
AEROVENT	186	ALINIA	72
AFINITOR	63	aliskiren	101
AFINITOR DISPERZ (everolimus)	63	ALKALINE BATTERIES	157
AFLURIA 2025-2026	85	ALKERAN	61
AFLURIA 2025-2026 (3YR UP)	85	ALKINDI	150
AFLURIA QUAD 2022-23 (3YR UP)	85	allopurinol	27
AFLURIA QUAD 2022-2023	85	allopurinol 100 mg tablet (Zyloprim)	26
AFLURIA QUAD 2023-24 (3YR UP)	85	allopurinol 200 mg tablet	26

Index of Medications

allopurinol 300 mg tablet	26	amoxapine	198
almotriptan malate.....	15, 19	amoxicillin.....	39
ALOCRIIL.....	129	amoxicillin/potassium clav (Augmentin Es-600).....	39
ALOGLIPTIN.....	49, 51, 52	amphetamine.....	81, 82
ALOGLIPTIN-PIOGLITAZONE.....	49	ampicillin.....	39
alosetron.....	143	AMPYRA (dalfampridine).....	107
ALPHAGAN.....	130	AMRIX ER 15 MG CAPSULE (cyclobenzaprine hcl).....	188
ALPHANATE.....	88	AMRIX ER 30 MG CAPSULE (cyclobenzaprine hcl).....	188
alprazolam.....	193	AMZEEQ.....	42
ALREX.....	128	ANA.....	146
ALTABAX.....	214	ANAFRANIL.....	199
ALTACE.....	97	anagrelide.....	74
ALTAFLUOR BENOX (benoxinate hcl/fluorescein sod).....	129	ANALPRAM HC 1% CREAM.....	142, 146
ALTERNATE SITE LANCETS.....	164, 181	ANALPRAM HC 2.5%-1% CREAM (hydrocortisone/pramoxine).....	142, 146
ALTERNATE SITE LANCING DEVICE.....	157	ANALPRAM HC 2.5%-1% CRM SINGLE (hydrocortisone/pramoxine).....	142, 146
ALTOPREV.....	102	ANALPRAM HC 2.5%-1% LOTION.....	217
ALTRENO.....	218	ANAPROX DS.....	27
ALTRIXA OB.....	192	anastrozole.....	62
ALTUVIIIIO.....	88	ANCOBON.....	46
ALUNBRIG 30 MG TABLET.....	64	ANDEMBRY AUTOINJECTOR.....	225
ALUNBRIG 90 MG-180 MG TAB PACK.....	64	ANDROGEL.....	147
ALUNBRIG 90 MG TABLET.....	64	ANGELIQ.....	150
ALUNBRIG 180 MG TABLET.....	64	ANIMI-3.....	234
ALVAIZ.....	114	ANNOVERA.....	115
ALVESCO.....	33	ANORO ELLIPTA 62.5-25 MCG INH.....	31
ALYFTREK.....	221	anthralin.....	211
amantadine.....	72	ANTICOAG.....	43
AMBIEN.....	207	ANTIVERT.....	139
AMBIEN CR 12.5 MG TABLET (zolpidem tartrate).....	207	ANUSOL.....	214
AMBIEN (zolpidem tartrate).....	207	ANUSOL-HC (hydrocortisone acetate).....	146
ambrisentan.....	93, 94	ANZEMET.....	139
amcinonide 0.1% cream.....	214	APIDRA.....	54
amcinonide 0.1% ointment.....	214	APLENZIN.....	194
AMICAR.....	88	APOKYN.....	72
amiloride.....	126	apomorphine hcl.....	72
aminocaproic.....	88	APO-VARENICLINE 0.5 MG TABLET.....	219
aminocaproic acid (Amicar).....	88	APO-VARENICLINE 1 MG TABLET.....	219
amiodarone.....	90	apraclonidine hcl.....	130
AMITIZA.....	143	aprepitant.....	139
amitriptyline.....	198	APRETUDE.....	77
AMJEVITA(CF) 10MG/0.2ML SYRING.....	58	APRISO (mesalamine).....	141
AMJEVITA(CF) 20MG/0.2ML SYRING.....	58	APTENSIO XR (methylphenidate hcl).....	200
AMJEVITA(CF) 40MG/0.4ML AUTOIN.....	58	APTiom 200 MG TABLET (eslicarbazepine acetate).....	108
AMJEVITA(CF) 40MG/0.4ML SYRING.....	58	APTiom 400 MG TABLET (eslicarbazepine acetate).....	108
AMJEVITA(CF) 40MG/0.8ML AUTOIN.....	58	APTiom 600 MG TABLET (eslicarbazepine acetate).....	108
AMJEVITA(CF) 40MG/0.8ML SYRING.....	58	APTiom 800 MG TABLET (eslicarbazepine acetate).....	108
AMJEVITA(CF) 80MG/0.8ML AUTOIN.....	59	APTIVUS.....	75
amlodipine.....	90, 91, 94, 96, 97, 101, 102	AQINJECT.....	169
		AQ INSULIN SYR 0.5 ML 30G 8MM.....	172

Index of Medications

AQ INSULIN SYR 1 ML 31G 8MM	172	ASSURE PLATINUM TEST STRIP	119
AQ INSULIN SYRIN 1 ML 29G 12MM.....	172	ASSURE PRISM.....	158
AQNEURSA	137	ASSURE PRISM MULTI.....	119
AQUA.....	214	ASSURE TITANIUM TEST STRIP	119
AQUA LANCE LANCING DEVICE	157	ASTAGRAF	156
ARAKODA	57	ASTRINGYN	89
ARANESP	114	ATACAND.....	96, 98
ARAVA	26	atazanavir.....	77
ARAZLO	214	atazanavir sulfate.....	77
ARBLI.....	98	ATELVIA	230
ARCALYST.....	230	atenolol	99, 100
AREXVY	87	AT HOME A1C.....	158
arformoterol tartrate.....	31	ATIVAN	193
ARICEPT.....	81	atomoxetine.....	202
ARIDOL.....	123	ATORVALIQ	102
ARIKAYCE.....	36	atorvastatin.....	102, 103
ARIMIDEX.....	62	atovaquone.....	57
aripiprazole	204, 205	atovaquone/proguanil.....	57
ARIXTRA 2.5 MG/0.5 ML SYRINGE (fondaparinux sodium).....	43	ATRALIN	218
ARIXTRA 5 MG/0.4 ML SYRINGE (fondaparinux sodium).....	43	atropine.....	131, 139, 141
ARIXTRA 7.5 MG/0.6 ML SYRINGE (fondaparinux sodium).....	44	atropine 1% eye drop	131
ARIXTRA 10 MG/0.8 ML SYRINGE (fondaparinux sodium).....	43	ATROPINE 1% EYE DROPS	131
armodafinil	206	atropine 1% eye ointment	131
ARMONAIR DIGIHALER.....	33	ATROVENT HFA.....	30
ARMOUR	220	ATTRUBY	228
ARNUITY ELLIPTA.....	33	AUBAGIO	106
AROMASIN	62	AUGMENTIN.....	39
ARTHROTEC.....	27	AUGMENTIN ES-600 (amoxicillin/potassium clav)	39
ARTISS	214	AUGTYRO 40 MG CAPSULE	64
ASACOL	141	AUGTYRO 160 MG CAPSULE	64
asenapine.....	203, 204	AURYXIA.....	134
ASMANEX HFA	33	AUSTEDO.....	106
ASMANEX TWISTHALER 110 MCG #30.....	33	AUSTEDO XR 30 MG TABLET	106
ASMANEX TWISTHALER 220 MCG #14.....	33	AUSTEDO XR 36 MG TABLET	106
ASMANEX TWISTHALER 220 MCG #30.....	33	AUSTEDO XR 42 MG TABLET	106
ASMANEX TWISTHALER 220 MCG #60.....	33	AUTOJECT 2	158
ASMANEX TWISTHALR 220 MCG #120.....	33	AUTO-LANCET MINI	158
aspirin/dipyridamole.....	74	AUTOLET IMPRESSION	158
ASPIRIN-OMEPRAZOLE.....	74	AUTOLET LANCING DEVICE.....	158
ASSURE	164, 169	AUTOLET LITE.....	158
ASSURE 4 CONTROL SOLUTION	157	AUTOLET PLUS	158
ASSURE 4 TEST STRIPS.....	119	AUTOPEN.....	158
ASSURE CONTROL SOLUTION	157	AUTOSHIELD DUO PEN NEEDLE	169
ASSURE DOSE.....	157	AUVELITY	194
ASSURE HAEMOLANCE PLUS	181	AUVI-Q.....	80
ASSURE ID INSULIN SAFETY	172	AVALIDE.....	96
ASSURE LANCE.....	181	avanafil.....	223
ASSURE LANCE PLUS	181	AVAPRO	98
ASSURE PLATINUM	119	AVAR.....	43

Index of Medications

AVAR-E GREEN	43	BAXDELA	40
AVERI	115	BCG VACCINE	86
AVITENE	89	b complex 11/folic/c/biot/zinc	235
AVMAPKI-FAKZYNJA	63	b comp no3/folic/c/biotin/zinc	235
AVODART	231	BD	164
AVONEX (4 PACK)	106	BD INS SYR 0.3 ML 8MMX31G(1/2)	173
AVONEX PEN (4 PACK)	106	BD INS SYRNG 0.3 ML 29GX12.7MM	173
AVSOLA	59	BD INS SYRNG 0.5 ML 29GX12.7MM	173
AYVAKIT	64	BD INS SYRNG UF 0.3 ML 8MMX31G	173
AZASAN (azathioprine)	156	BD INS SYRNG UF 0.5 ML 8MMX31G	173
AZASITE	35	BD INS SYRN UF 1 ML 12.7MMX30G	173
azathioprine	156	BD INS SYRN UF 1 ML 30G 12.7MM	173
azathioprine 50 mg tablet (Imuran)	156	BD INS SYR UF 0.3ML 12.7MMX30G	173
azathioprine 75 mg tablet (Azasan)	156	BD INS SYR UF 0.5ML 12.7MMX30G	173
azathioprine 100 mg tablet (Azasan)	156	BD INSULIN SYR 0.5 ML 28GX1/2"	173
azelaic	213	BD INSULIN SYR 1 ML 27GX5/8"	173
azelastine	49, 127	BD INSULIN SYR 1 ML 27GX12.7MM	173
AZELEX	210	BD INSULIN SYR 1 ML 28GX1/2"	173
AZESCO	192	BD INSULIN SYR 1 ML 29GX12.7MM	173
AZILECT	72	BD INSULIN SYR UF 1 ML 8MMX31G	173
azithromycin	38, 39	BD MICROTAINER LANCETS	181
azithromycin (Zithromax)	38	BELBUCA	22
azithromycin (Zithromax Tri-Pak)	38	BELSOMRA	207
AZOPT	130	benazepril	94, 95, 97
AZOR	97	benazepril/hydrochlorothiazide	95
AZSTARYS	200	BENICAR	96, 98
AZULFIDINE	141	BENLYSTA	230
B		BENZAMYCIN	42
bacitracin	35	benzebro 6% foaming cloths	213
bacitracin/polymyxin b sulfate	35	BENZEPRO 7% CREAMY WASH (benzoyl peroxide microspheres)	213
baclofen	188, 189	BENZNIDAZOLE	57
baclofen 5 mg/5 ml solution	188	benzonatate	117
baclofen 10 mg/5 ml solution	188	benzonatate 100 mg capsule	117
BACMIN	234	benzoyl	42, 210, 213
BACTRIM	36	benzoyl peroxide	213
BACTRIM DS	36	benzphetamine	71
BACTRIM (sulfamethoxazole-trimethoprim)	36	benztropine	72
BAFIERTAM	106	bepotastine besilate (Bepreve)	49
BAL-CARE DHA ESSENTIAL	189	BEPREVE (bepotastine besilate)	49
BALCOLTRA	115	BERINERT	225
balsalazide	142	BESIVANCE	35
BALVERSA	64	BESREMI	70
BANZEL	109	BETADINE	128
BANZEL 200 MG TABLET (rufinamide)	109	betaine	229
BANZEL 400 MG TABLET (rufinamide)	109	betamethasone	47, 214, 218
BAQSIMI	133	betamethasone/propylene glyc	214
BARACLUDE	80	betamethasone valerate	214
BASAGLAR	54	BETAPACE	99
BASAGLAR TEMPO PEN U-100	54	BETASERON	106

Index of Medications

betaxolol	99, 130	BREEZE 2	158
bethanechol	83	BRENZAVVY.....	53
BETHKIS.....	36	BREO ELLIPTA 50-25 MCG INHALER.....	32
BETIMOL.....	130	BREO ELLIPTA 100-25 MCG INHALR	32
BETIMOL (timolol).....	130	BREO ELLIPTA 200-25 MCG INHALR	32
BETOPTIC.....	130	BREXAFEMME.....	47
BEVESPI AEROSPHERE	31	BREZTRI AEROSPHERE INHALER.....	33
bexarotene	60	BRILINTA (ticagrelor)	74
bexarotene 1% gel (Targretin)	70	brimonidine	130
bexarotene 75 mg capsule (Targretin)	60	brimonidine tartrate/timolol (Combigan)	130
BEXSERO.....	85	brinzolamide	130
BEYAZ	115	BRIVIACT	109
BEYFORTUS.....	78	BROMFED.....	117
bicalutamide	61	bromfenac.....	128
bicalutamide (Casodex)	61	bromfenac sodium (Prolensa).....	128
BIDIL (isosorbide dinit/hydralazine)	101	bromocriptine mesylate	72
BIJUVA	148	brompheniramine.....	117
BIKTARVY	78	BROMSITE	128
BILTRICIDE	56	BRONCHITOL	221
bimatoprost.....	130	BROOKS INSULIN 0.3ML SYRN	173
BIMZELX.....	209	BROVANA	31
BIMZELX AUTOINJECTOR	209	BRUKINSA 80 MG CAPSULE.....	65
BINOSTO	230	BRUKINSA 160 MG TABLET.....	65
bisac/nacl/naHco3/kcl/peg.....	143	BRYHALI	215
bismuth/metronid/tetracycline (Pylera)	140	BUCAPSOL.....	193
BISOPROLOL	99	budesonide.....	32, 150
bisoprolol fumarate 5 mg tab.....	99	budesonide 0.5 mg/2 ml susp (Pulmicort)	33
bisoprolol fumarate 10 mg tab	99	budesonide 0.25 mg/2 ml susp (Pulmicort)	33
bisoprolol/hydrochlorothiazide.....	100	budesonide 1 mg/2 ml inh susp (Pulmicort)	33
BLOOD GLUCOSE CONTROL.....	158	budesonide 2 mg rectal foam (Uceris)	146
BLOOD-GLUCOSE CONTROL.....	158	BULLSEYE.....	164
BLOOD GLUCOSE TEST STRIP	119	BULLSEYE MINI SAFETY LANCETS.....	181
BLOOD LANCETS.....	164, 181	bumetanide	125
BLULINK BG SYSTEM REFILL	181	BUPAP (butalbital/acetaminophen)	19
BLULINK GLUCOSE TEST STRIP	119	BUPHENYL (sodium phenylbutyrate)	138
BLUNT NEEDLE	169	buprenorphine	22, 231
BONIVA.....	229	buprenorphine hcl/naloxone hcl.....	231
BONJESTA.....	139	bupropion	194, 195, 219
BOOSTRIX.....	86	BUPROPION.....	194
bosentan	93, 94	bupropion hcl sr 150 mg tablet.....	219
BOSULIF 50 MG CAPSULE.....	65	buspirone	193
BOSULIF 100 MG CAPSULE.....	64	butal-ace-caf 50-325-40mg/15ml	19
BOSULIF 100 MG TABLET.....	64	butalb-acetamin-caff 50-300-40.....	15, 19
BOSULIF 400 MG TABLET	65	butalb-acetamin-caff 50-325-40.....	15, 19
BOSULIF 500 MG TABLET	65	butalb-acetamin-caff 50-325-40 (Esgic).....	19
BRAFTOVI	62	butalb/acetaminophen/caffeine.....	15
BREATHERITE.....	186, 187	butalb/acetaminophen/caffeine (Esgic).....	19
BREATHRITE.....	187	butalb-aspirin-caffe 50-325-40	15
		butalbit/acetamin/caff/codeine	24

Index of Medications

butalbital/acetaminophen	15, 19	CANASA	141
butalbital-acetaminophn 25-325.....	19	candesartan	96, 98
butalbital-acetaminophn 50-300.....	19	CAPCOF	117
butalbital-acetaminophn 50-300 (Bupap)	19	capecitabine.....	62
butalbital-acetaminophn 50-325.....	19	capecitabine 150 mg tablet (Xeloda)	61
butalbital-asa-caffeine cap (Fiorinal)	15	capecitabine 500 mg tablet (Xeloda)	61
butalbital-aspirin-caffeine cp	19	CAPEX.....	215
butalbital-aspirin-caffeine tb.....	19	CAPLYTA	203
butorphanol tartrate.....	22	CAPRELSA 100 MG TABLET.....	65
BUTRANS.....	22	CAPRELSA 300 MG TABLET.....	65
BUTTERFLY	164	captopril	95, 97
BUTTERFLY TOUCH LANCET	181	captopril-hctz	95
BYDUREON.....	50	CAPVAXIVE.....	85
BYETTA.....	50	CARAC	70
BYLVAY	143	CARAFATE.....	140
BYSTOLIC 2.5 MG TABLET (nebivolol hcl).....	99	CARBAGLU.....	225
BYSTOLIC 5 MG TABLET (nebivolol hcl).....	99	carbamazepine	109
BYSTOLIC 10 MG TABLET (nebivolol hcl).....	99	CARBAMAZEPINE.....	109
BYSTOLIC 20 MG TABLET (nebivolol hcl).....	99	carbamazepine 100 mg/5 ml cup.....	109
C		carbamazepine 100 mg/5 ml susp (Tegretol)	109
CABENUVA	75	carbamazepine 100 mg tab chew	109
cabergoline	152	carbamazepine 200 mg/10 ml cup	109
CABLIVI.....	87	carbamazepine 200 mg tablet (Tegretol)	109
CABOMETYX	65	CARBATROL (carbamazepine)	109
CABTREO	210	carbidopa	72, 73, 74
CADUET	102	carbidopa/levodopa	72
CAFERGOT	15	carbidopa/levodopa/entacapone	72
caffeine.....	106, 189	carbidopa/levodopa/entacapone (Stalevo 100)	73
CA INS SYR 0.3 ML 30GX5/16"	173	carbidopa-levo er 25-100 tab.....	73
CA INS SYR 0.3 ML 31GX5/16"	173	carbidopa-levo er 50-200 tab.....	73
CA INS SYR 0.5 ML 30GX5/16"	173	carbinoxamine	48
CA INS SYR 0.5 ML 31GX5/16"	173	carbinoxamine maleate.....	48
CA INSULIN SYR 0.3 ML 29GX1/2"	173	carbinoxamine maleate 6 mg tab.....	48
CA INSULIN SYR 0.5 ML 29GX1/2"	173	CARBINOXAMINE MALEATE ER.....	48
CA INSULIN SYR 1 ML 29GX1/2"	173	CARDIZEM	90, 91
CA INSULIN SYR 1 ML 30GX5/16"	173	CARDURA	95
CA INSULIN SYR 1 ML 31GX5/16"	173	CAREFINE.....	169
CALAN	90	CAREONE.....	158, 164, 181
calcipotriene	211, 218	CAREONE SYR 0.3 ML 30GX1/2"	173
CALCIPOTRIENE	211	CAREONE SYR 0.5 ML 30GX1/2"	173
calcipotriene 0.005% cream	211	CAREONE SYR 1 ML 30GX1/2"	173
calcitonin.....	154	CAREPOINT.....	169
calcitonin,salmon,synthetic (Miacalcin)	154	CARESENS	158, 164
calcitriol.....	211, 236	CARESENS LANCET.....	181
calcium.....	102, 103, 134, 223, 225	CARESENS N.....	119
calcium/mag/d3/b12/fa/b6/boron.....	134	CARESENS S CONTROL SOLUTION	158
CALQUENCE.....	65	CARESENS S TEST STRIP	119
CAMBIA (diclofenac potassium)	19	CARETOUCH	169
CAMZYOS	92	CARETOUCH ALCOHOL PREP PAD	208, 212

Index of Medications

CARETOUCH CONTROL SOLUTION	158	CHEMET	227
CARETOUCH HYPODERMIC NEEDLE	169	CHEMSTRIP	125
CARETOUCH INSULIN SYRINGE	173	CHEMSTRIP 2 GP	125
CARETOUCH LANCING DEVICE	158	CHEMSTRIP 7	125
CARETOUCH SAFETY LANCETS	164, 181	CHEMSTRIP 9	125
CARETOUCH TEST STRIP	119	CHEMSTRIP 10 WITH SG	125
CARETOUCH TWIST LANCET	164, 181	CHEMSTRIP 50B	125
carglumic	225	CHEMSTRIP BG DIARY	158
carisoprodol	24, 188, 189	CHENODAL	141
carisoprodol/aspirin	24	chlordiazepoxide	138, 193, 198
carisoprodol/aspirin/codeine	24	chlordiazepoxide/clidinium	138
CARNITOR (levocarnitine)	229	chlorhexidine	223
CARNITOR (levocarnitine (with sugar))	229	chloroquine phosphate	57
CARNITOR SF (levocarnitine)	229	chlorpromazine	206
CAROSPIR	126	chlorthalidone	100, 127
carteolol	130	chlorzoxazone	189
carvedilol	95	chlorzoxazone 250 mg tablet	188
CASODEX	61	chlorzoxazone 375 mg tablet (Lorzone)	188
CATAPRES	99	chlorzoxazone 500 mg tablet	188
CAVERJECT	223	chlorzoxazone 750 mg tablet (Lorzone)	188
CAYA	117	CHOLBAM	141
CAYSTON	37	cholestyramine	103, 104
cefaclor	38	cholestyramine/aspartame	103
cefadroxil	37	cholestyramine (with sugar) (Questran)	103
cefdinir	38	choline salicyl/mag salicylate	15
cefixime	38	CHORIONIC GONADOTROPIN	154
cefpodoxime	38	CHOSEN LANCET	164, 181
cefprozil	38	CHOSEN LANCING DEVICE	158
ceftriaxone	38	CHOSEN SAFETY LANCET	164, 181
cefuroxime	38	CIALIS	223
CELEBREX	29	CIALIS 10 MG TABLET (tadalafil)	223
celecoxib	29	CIBINQO	212
CELEXA	195	ciclodan	47
CELLCEPT	156	CICLODAN	47
CELONTIN (methsuximide)	109	ciclopirox	47, 48
CENTANY	42	ciclopirox/urea/camph/men/euc	47
cephalexin	37	cilostazol	74
CEQUA	132	CILOXAN	35
CEQR SIMPLICITY	158	CIMDUO	75
CEQR SIMPLICITY INSERTER	158	imetidine	142
CERDELGA	226	CIMZIA (2 PACK)	59
CERVIDIL	152	CIMZIA 2X200 MG/ML(X3)START KT	59
cetirizine	49	CIMZIA 200 MG/ML SYRINGE KIT	59
CETRAXAL	34	cinacalcet hcl (Sensipar)	225
cetorelix acetate (Cetrotide)	152	CINRYZE	225
CETROTIDE (cetorelix acetate)	152	CIPRO	40
cevimeline	83	ciprofloxacin	34, 40
CHANTIX	219	ciprofloxacin hcl	34, 35, 40
CHEK-STIX	125	ciprofloxacin hcl/dexameth	35

Index of Medications

CIPROFLOXACIN HCL-FLUOCINOLONE	35	CLINPRO	132
ciprofloxacin/hydrocortisone.....	35	CLINPRO 5000.....	134
CIPRO HC	35	clobazam.....	108
citalopram.....	195	clobetasol.....	215
CITALOPRAM HBR 30 MG CAPSULE	195	CLOBETASOL.....	215
CITRANATAL 90 DHA.....	189	clobetasol 0.05% cream.....	215
CITRANATAL ASSURE.....	189	CLOBETASOL 0.05% EYE DROP	128
CITRANATAL B-CALM	192	clobetasol 0.05% gel.....	215
CITRANATAL BLOOM.....	135	clobetasol 0.05% ointment (Temovate).....	215
CITRANATAL DHA.....	189	clobetasol 0.05% shampoo (Clobex).....	215
CITRANATAL HARMONY	190	clobetasol 0.05% solution.....	215
CITRANATAL MEDLEY	236	clobetasol 0.05% topical lotn	215
CITRANATAL RX.....	190	clobetasol prop 0.05% foam (Olux).....	215
CITRATE	43	clobetasol prop 0.05% spray (Clobex).....	215
CITRATE PHOSPHATE DEXTROSE	43	clobetasol propionate/emoll.....	215
citric acid/sodium citrate.....	137	CLOBEX.....	215
cladribine.....	107	clocortolone pivalate (Cloderm).....	215
CLARINEX.....	48, 49	CLODAN 0.05% KIT	215
clarithromycin.....	38	clodan 0.05% shampoo (Clobex)	215
clemastine.....	49	CLODERM	215
clemastine 0.5 mg/5 ml syrup.....	48	CLODERM (clocortolone pivalate)	215
clemastine fum 2.68 mg tablet.....	48	clomiphene.....	154
CLENPIQ	143	clomipramine.....	199
CLEOCIN	38, 41, 42	clonazepam.....	108
CLEOCIN PEDIATRIC (clindamycin palmitate hcl)	38	clonidine	99, 200
CLEVER.....	187	clonidine hcl.....	99
CLEVER CHEK LANCETS.....	164, 181	clonidine hcl er 0.1 mg tablet (Kapvay).....	200
CLEVER CHOICE CONTROL SOLUTION.....	158	CLONIDINE HCL ER 0.17 MG TAB	99
CLEVER CHOICE MICRO TEST STRIP	119	clopidogrel	74
CLEVER CHOICE PRO	119	clorazepate.....	193
CLEVER CHOICE TALK.....	119	clotrimazole	46, 47
CLEVER CHOICE TEST STRIPS	119	clozapine.....	203
CLEVER CHOICE VOICE+ TST STRIP	119	CLOZARIL.....	203
CLICKFINE.....	169	COAGUCHEK.....	164, 181
CLIMARA	149	COARTEM	57
CLIMARA (estradiol).....	149	COBENFY	205
CLINDAGEL (clindamycin phosphate)	42	COBENFY STARTER PACK.....	205
clindamycin-bnz perox 1.2-3.75% (Onexton)	210	codeine.....	117
clindamycin.....	38, 41, 42, 210	codeine/butalbital/asa/cafein	24
clindamycin-benzoyl perox 1-5%	210	codeine phosphate/guaifenesin.....	118
clindamycin-bnz perox 1-5% pmp.....	210	codeine sulfate.....	22
clindamycin phos/benzoyl perox	210	CODITUSSIN AC	118
clindamycin phos/benzoyl perox (Acanya).....	210	CODITUSSIN DAC.....	118
clindamycin phosphate (Clindagel)	42	COLAZAL	142
clindamycin/tretinoin (Veltin).....	210	colchicine	26, 30
clindamycin/tretinoin (Ziana)	210	COLCRYL.....	26
CLINDESSE.....	41	colesevelam	104

Index of Medications

COLESTID.....	104	COPIKTRA.....	65
COLESTID (colestipol hcl).....	104	CORDRAN.....	215
colestipol.....	104	CORDRAN (flurandrenolide).....	215
colestipol hcl.....	104	COREG.....	95
COLOR LANCETS.....	164, 181	COREG CR 10 MG CAPSULE (carvedilol phosphate).....	95
COMBIGAN (brimonidine tartrate/timolol).....	130	COREG CR 20 MG CAPSULE (carvedilol phosphate).....	95
COMBIPATCH.....	149	COREG CR 40 MG CAPSULE (carvedilol phosphate).....	95
COMBISTIX REAGENT.....	125	COREG CR 80 MG CAPSULE (carvedilol phosphate).....	95
COMBIVENT RESPIMAT.....	31	coremino.....	40
COMBIVIR.....	75	CORLANOR 5 MG/5 ML ORAL SOLN.....	92
COMBOGESIC.....	27	CORLANOR 5 MG TABLET (ivabradine hcl).....	92
COMETRIQ 60 MG DAILY-DOSE PACK.....	65	CORLANOR 7.5 MG TABLET (ivabradine hcl).....	92
COMETRIQ 100 MG DAILY-DOSE PK.....	65	CORTEF.....	150
COMETRIQ 140 MG DAILY-DOSE PK.....	65	CORTENEMA.....	146
COMFORT.....	169, 171	CORTIFOAM.....	147
COMFORT EZ.....	164, 181	cortisone.....	150
COMFORT EZ INSULIN SYRINGE.....	173	CORTISPORIN-TC.....	34
COMFORT LANCETS.....	164, 181	CORTROPHIN.....	147
COMFORTSEAL.....	187	CORVITE.....	234
COMFORT TOUCH PLUS SAFETY LANC.....	164, 181	CORVITE 150.....	135
COMFORT TOUCH ULT THIN LANCET.....	164, 181	CORVITE FE.....	135
COMIRNATY.....	83	COSENTYX.....	209
COMIRNATY 2023-2024.....	83	COSENTYX 75 MG/0.5 ML SYRINGE.....	209
COMIRNATY 2024-2025.....	83	COSENTYX 150 MG/ML SYRINGE.....	209
COMIRNATY 2025-2026(5-11Y).....	84	COSENTYX SENSOREADY (2 PENS).....	209
COMIRNATY 2025-2026 (12Y UP).....	83	COSENTYX SENSOREADY PEN.....	209
COMPACT.....	187	COSENTYX UNOREADY PEN.....	209
COMPAZINE.....	139	COSOPT.....	130
COMPLERA.....	77	COSOPT (dorzolamide hcl/timolol maleat).....	130
CONCEPT DHA (mvn-min75/iron/iron ps/om3/dha).....	234	COTELLIC.....	63
CONCEPT OB (mvn-min 74/iron fum/iron/fa).....	234	COTEMPLA.....	200
CONCERTA ER 18 MG TABLET (methylphenidate hcl).....	200	COTEMPLA XR-ODT 8.6 MG TABLET.....	200
CONCERTA ER 27 MG TABLET (methylphenidate hcl).....	200	COTEMPLA XR-ODT 17.3 MG TABLET.....	200
CONCERTA ER 36 MG TABLET (methylphenidate hcl).....	200	COXANTO.....	27
CONCERTA ER 54 MG TABLET (methylphenidate hcl).....	200	COZAAR.....	98
CONDYLOX.....	213	CRENESSITY.....	152
CONJUPRI.....	91	CRENESSITY 25 MG CAPSULE.....	152
CONSENSI.....	90	CREON.....	144
CONTOUR.....	158	CRESEMBA.....	46
CONTOUR NEXT CONTROL SOLUTION.....	158	CRESTOR.....	102, 103
CONTOUR NEXT TEST STRIP.....	119	CREXONT.....	73
CONTOUR PLUS TEST STRIP.....	119	CRINONE.....	153, 154
CONTOUR TEST STRIP.....	119	cromolyn.....	25, 34, 129
CONTRACE.....	71	crotamiton.....	72
CONTROL SOLUTION.....	158	CTEXLI.....	141
CONZIP.....	22	CULTURELLE IBS COMPLETE SUPPRT.....	229
COOL CONTROL SOLUTION.....	158	CUPRIMINE (penicillamine).....	26
COOL GLUCOSE TEST STRIP.....	119	CURITY ALCOHOL PREPS.....	208, 212
COPAXONE (glatiramer acetate).....	107	CUROSURF.....	222

Index of Medications

CUVPOSA (glycopyrrolate)	138	DAPAGLIFLOZIN	53
CUVRIOR	227	dapsone	210
cvs isopropyl alcohol 91%	228	DAPSONE	210
CVS ISOPROPYL ALCOHOL 91%	228	dapsone 25 mg tablet	37
CVS ISOPROPYL ALCOHOL 91% SPRY	57	dapsone 100 mg tablet	37
cvs isopropyl rub alcohol 70%	228	DAPTACEL	86
CVS ISOPROPYL RUB ALCOHOL 70%	228	DARAPRIM	57
CVS TRUE METRIX GLUC TEST STRP	119	darifenacin	232
cyanocobalamin	235	DARTISLA	138
cyanocobalamin/folic ac/vit b6	235	darunavir (Prezista)	75
cyanocobalamin/folic ac/vit b6 (Niva-Fol)	235	dasatinib 20 mg tablet (Sprycel)	65
cyanocobalamin (vitamin b-12) (Nascobal)	235	dasatinib 50 mg tablet (Sprycel)	65
cyclobenzaprine	188, 189	dasatinib 70 mg tablet (Sprycel)	65
CYCLOGYL	131	dasatinib 80 mg tablet (Sprycel)	65
CYCLOGYL 0.5% EYE DROPS	131	dasatinib 100 mg tablet (Sprycel)	65
CYCLOMYDRIL	131	dasatinib 140 mg tablet (Sprycel)	65
cyclopentolate	131	DAURISMO	62
cyclophosphamide	61	DAYBUE	106
CYCLOPHOSPHAMIDE	61	DAYPRO	27
cycloserine	37	DAYTRANA (methylphenidate)	200
cyclosporine	156, 157	DAYVIGO	207
cyclosporine 0.05% eye emuls (Restasis)	132	DDAVP	148
cyclosporine 25 mg capsule (Sandimmune)	156	DDAVP 4 MCG/ML AMPUL (desmopressin acetate)	148
cyclosporine 100 mg capsule (Sandimmune)	156	DDAVP 40 MCG/10 ML VIAL (desmopressin acetate)	148
CYLTEZO(CF) 10 MG/0.2 ML SYRNG	59	deferasirox	227
CYLTEZO(CF) 20 MG/0.4 ML SYRNG	59	deferiprone	227
CYLTEZO(CF) 40 MG/0.4 ML SYRNG	59	deferiprone (Ferriprox (3 Times A Day))	227
CYLTEZO(CF) 40 MG/0.8 ML SYRNG	59	deflazacort	150
CYLTEZO(CF) PEN	59	DELESTROGEN	149
CYLTEZO(CF) PEN CROHN'S-UC-HS	59	DELSTRIGO	77
CYLTEZO(CF) PEN PSORIASIS-UV	59	demeclocycline	40
CYMBALTA	197	DEMSEER	99
cyproheptadine	49	DENAVIR (penciclovir)	80
CYSTADANE (betaine)	229	DENGAXIA	86
CYSTADROPS	132	DEPAKOTE	109
CYSTAGON	232	DEPEN	26
CYSTARAN 0.44% EYE DROPS	132	DEPO-ESTRADIOL	149
CYSTO-CONRAY	124	DEPO-PROVERA (medroxyprogesterone acetate)	115
CYSTOGRAFIN	124	DEPO-SUBQ	115
CYTOMEL	220	DEPO-TESTOSTERONE	147
CYTOTEC	140	DERMACINRX PRENATRIX	190
D		DERMACINRX PRENATRYL	190
dabigatran	45	DERMACINRX PRETRATE	190
dalfampridine er 10 mg tablet (Ampyra)	107	DERMA-SMOOTH-ES (fluocinolone acetonide)	215
DALIRESP	34	DERMA-SMOOTH-ES (fluocinolone/shower cap)	215
danazol	152	DERMOTIC	128
DANTRIUM	188	DESCOVY 120-15 MG TABLET	75
dantrolene	188	DESCOVY 200-25 MG TABLET	75
DANZITEN	65	desflurane	25

Index of Medications

desipramine	199	DIATRUE PLUS	119
desloratadine	49	diazepam	108, 193
desmopressin	148	diazepam 2 mg tablet (Valium)	193
desmopressin 40 mcg/10 ml vial (Ddvp)	148	diazepam 5 mg/5 ml oral cup	193
desmopressin ac 4 mcg/ml ampul (Ddvp)	148	diazepam 5 mg/5 ml solution	193
desmopressin ac 4 mcg/ml vial (Ddvp)	148	diazepam 5 mg/ml oral conc	193
desog-e.estradiol/e.estradiol	115	diazepam 5 mg tablet (Valium)	193
desogestrel-ethinyl	115	diazepam 10mg rectal gel (2pk)	108
desonide	215	diazepam 10 mg tablet (Valium)	193
desonide (Tridesilon)	215	diazepam 20mg rectal gel (2pk)	108
desoximetasone (Topicort)	215	diazepam 25 mg/5 ml oral conc	193
DESOXYN (methamphetamine hcl)	82	diazoxide	133
desvenlafaxine	197, 198	DIBENZYLINE	83
DESVENLAFAXINE	197	dichlorphenamide (Keveyis)	225
DETROL	232	DICLEGIS (doxylamine succinate/vit b6)	139
dexamethasone	35, 128, 150	diclofenac	70, 128, 209
dexamethasone 6 day 1.5 mg tab	150	DICLOFENAC	27, 209
dexchlorpheniramine	49	diclofenac 2% solution pump	209
DEXCOM G6 RECEIVER	158	diclofenac pot 25 mg tablet	21
DEXCOM G6 SENSOR	158	diclofenac pot 50 mg powdr pkt (Cambia)	19
DEXCOM G6 TRANSMITTER	158	diclofenac pot 50 mg tablet	21
DEXCOM G7 15 DAY SENSOR	158	diclofenac potassium	21
DEXCOM G7 RECEIVER	158	diclofenac potassium 25 mg cap (Zipsor)	21
DEXCOM G7 SENSOR	158	diclofenac sod dr	27
DEXEDRINE SPANSULE 10 MG (dextroamphetamine sulfate)	82	diclofenac sod ec	27
DEXEDRINE SPANSULE 15 MG CAP (dextroamphetamine sulfate)	82	diclofenac sodium	27
DEXILANT	144	diclofenac sodium 1% gel	209
dexlansoprazole	144	diclofenac sodium/misoprostol	27
dexmethylphenidate	200	dicloxacillin	39
dexmethylphenidate hcl (Focalin Xr)	200	dicyclomine 10 mg/5 ml soln	138
dextroamphetamine	81	dicyclomine 10 mg capsule	138
dextroamphetamine/amphetamine (Adderall)	82	dicyclomine 20 mg tablet	138
dextroamphetamine/amphetamine (Adderall Xr)	82	DICYCLOMINE 40 MG TABLET	138
dextroamphetamine/amphetamine (Mydayis)	82	didanosine	76
dextroamphetamine er 5 mg cap	82	diethylpropion	71
dextroamphetamine er 10 mg cap (Dexedrine)	82	DIFFERIN	218
dextroamphetamine er 15 mg cap (Dexedrine)	82	DIFICID	38
dextroamphetamine sulfate	82	DIFICID 200 MG TABLET (fidaxomicin)	38
dextroamphetamine sulfate (Zenzedi)	82	diflorasone diacetate	215
DHIVY	73	diflorasone diacet/emollient	215
DIACOMIT	109	DIFLUCAN	46
DIALYVITE 800 WITH IRON	234	diflunisal	15, 19
DIALYVITE 3000	235	difluprednate (Durezol)	128
DIALYVITE 5000	235	digoxin	92
DIALYVITE SUPREME D	235	digoxin 0.05 mg/ml solution	92
DIASTAT	108	digoxin 0.25 mg tablet (Lanoxin)	92
DIASTIX REAGENT	123	digoxin 0.125 mg tablet (Lanoxin)	92
diatrizoate meglumine, sodium (Gastrografin)	124	digoxin 62.5 mcg tablet (Lanoxin)	92
DIATRUE	158	digoxin 125 mcg tablet (Lanoxin)	92

Index of Medications

digoxin 250 mcg tablet (Lanoxin).....	92	doxycycline hyclate 100 mg tab (Lymepak).....	41
dihydroergotamine.....	15	doxycycline monohydrate.....	41
dihydroergotamine 1 mg/ml amp.....	19	doxylamine.....	139
dihydroergotamine 4 mg/ml spray (Migranal).....	19	DRIZALMA.....	197
DILANTIN.....	109	dronabinol.....	139
DILAUDID (hydromorphone hcl).....	22	DROPLET.....	169
diltiazem.....	90, 91	DROPLET GENTEEL LANCING DEVICE.....	158
diltiazem 24h er(la) 120 mg tb (Cardizem La).....	91	DROPLET INSULIN SYRINGE.....	173
diltiazem 24h er(la) 180 mg tb (Cardizem La).....	91	DROPLET LANCETS.....	164, 182
diltiazem 24h er(la) 240 mg tb (Cardizem La).....	91	DROPLET LANCING DEVICE.....	159
diltiazem 24h er(la) 300 mg tb (Cardizem La).....	91	DROPSAFE.....	169, 171
diltiazem 24h er(la) 360 mg tb (Cardizem La).....	91	DROPSAFE ACTI-LANCE.....	164, 182
diltiazem 24h er(la) 420 mg tb (Cardizem La).....	91	DROPSAFE INSULIN SYRINGE.....	173
dimethyl.....	107, 225	DROPSAFE PREP PADS.....	208, 212
dimethyl fumarate 30d start pk (Tecfidera).....	107	drospir/eth estra/levomefol.....	115
dimethyl fumarate dr 120 mg cp (Tecfidera).....	107	DROXIA.....	89
dimethyl fumarate dr 240 mg cp (Tecfidera).....	107	droxidopa.....	83
DIOVAN.....	96, 98	droxidopa 100 mg capsule (Northera).....	82
DIPENTUM.....	142	droxidopa 200 mg capsule (Northera).....	82
diphenoxylate.....	139	droxidopa 300 mg capsule (Northera).....	82
DIPHThERIA.....	86	DRYSOL.....	210
DIPROLENE (betamethasone/propylene glyc).....	215	DUAKLIR PRESSAIR.....	31
dipyridamole.....	74	DUAVEE.....	150
DISALCID.....	25	DUETACT (pioglitazone hcl/glimepiride).....	52
disopyramide.....	90	DUET DHA 400.....	192
disulfiram.....	225	DUET DHA BALANCED.....	190
DIURIL.....	127	DULERA 50 MCG-5 MCG INHALER.....	32
divalproex.....	109	DULERA 100 MCG-5 MCG INHALER.....	32
DIVIGEL (estradiol).....	149	DULERA 200 MCG-5 MCG INHALER.....	32
dofetilide.....	90	duloxetine.....	197
DOJOLVI.....	132	DUOBRII.....	211
DOLOBID.....	19	DUOPA.....	73
donepezil.....	81	DUPIXENT.....	155
DONNATAL.....	140	DUREZOL (difluprednate).....	128
DONNATAL (phenobarb/hyoscy/atropine/scop).....	140	dutasteride.....	231
DOPTELET.....	114	dutasteride/tamsulosin hcl (Jalyn).....	231
DOPTELET SPRINKLE.....	114	DUVYZAT.....	226
DORAL.....	207	DYANAVAL XR 2.5 MG/ML SUSP.....	82
DORYX.....	40	DYANAVAL XR 5 MG TABLET.....	82
dorzolamide.....	130	DYANAVAL XR 10 MG TABLET.....	82
dorzolamide hcl.....	130	DYANAVAL XR 15 MG TABLET.....	82
DOVATO.....	75	DYANAVAL XR 20 MG TABLET.....	82
doxazosin.....	95	DYMISTA.....	127
doxepin.....	199, 207, 211	DYRENIUM.....	126
doxercalciferol.....	224	E	
doxycycline.....	40, 41, 223	EASIVENT HOLDING CHAMBER.....	187
DOXYCYCLINE.....	41	EASIVENT MASK-LARGE.....	187
		EASIVENT MASK-MEDIUM.....	187

Index of Medications

EASIVENT MASK-SMALL	187	EASY TOUCH SAFETY 28G LANCETS	165, 182
EASY	169	EASY TOUCH SAFETY 30G LANCETS	165, 182
EASY COMFORT ALCOHOL PAD	208, 212	EASY TOUCH SAFETY 32G LANCETS	165, 182
EASY COMFORT INSULIN SYRINGE	173	EASY TOUCH SHEATHLOCK INSULIN	174
EASY COMFORT LANCETS	164, 182	EASY TOUCH TEST STRIP	119
EASY GLIDE INSULIN SYRINGE	173	EASY TOUCH TWIST 26G LANCETS	165, 182
EASYGLUCO PLUS	119	EASY TOUCH TWIST 28G LANCETS	165, 182
EASYGLUCO PLUS CONTROL NORMAL	159	EASY TOUCH TWIST 30G LANCETS	165, 182
EASYGLUCO TEST STRIPS	119	EASY TOUCH TWIST 32G LANCETS	165, 182
EASYMAX 15 GLUCOSE TEST STRIP	119	EASY TOUCH TWIST 33G LANCETS	165, 182
EASYMAX 15 LEVEL 2 SOLUTION	159	EASY TOUCH UNI-SLIP	174
EASYMAX GLUCOSE TEST STRIPS	119	EASY TRAK CONTROL SOLN HIGH	159
EASYMAX NORMAL CONTROL SOLN	159	EASY TRAK CONTROL SOLN LOW	159
EASY MINI EJECT LANCING DEVICE	159	EASY TRAK GLUCOSE TEST STRIP	119
EASY PLUS II CONTROL SOLN HIGH	159	EASY TRAK II CONTROL SOLUTION	159
EASY PLUS II CONTROL SOLN LOW	159	EASY TRAK II TEST STRIP	119
EASY PLUS II TEST STRIP	119	EASY TWIST & CAP LANCETS	165, 182
EASYPOINT NEEDLE	169	EBGLYSS	230
EASY STEP	119	ECLIPSE NEEDLE	169
EASY STEP CONTROL SOLUTION	159	ECLIPSE SYRINGE	174
EASY TALK CONTROL SOLN LOW	159	EC-NAPROSYN	27
EASY TALK GLUCOSE TEST STRIP	119	econazole nitrate 1% cream	47
EASY TALK HIGH CONTROL SOLN	159	ECOZA	47
EASY TALK PLUS II HIGH CONTROL	159	EDARBI	98
EASY TALK PLUS II LOW CTRL SLN	159	EDARBYCLOR	96
EASY TALK PLUS II TEST STRIP	119	EDECIN	125
EASY TOUCH ALCOHOL PREP PADS	208, 212	EDEX	223
EASY TOUCH BLULINK CTRL SOLN	159	EDLUAR	207
EASY TOUCH BLULINK TEST STRIP	119	EDURANT	76
EASY TOUCH CONTROL SOLUTION	159	EDURANT PED	76
EASY TOUCH FLIPLOCK INSULIN	174	E.E.S.	38
EASY TOUCH FLIPLOCK NEEDLE	169	efavirenz	76, 77, 78
EASY TOUCH FLIPLOCK NEEDLES	169	efavirenz/emtricit/tenofovr df	77
EASY TOUCH HYPODERMIC NEEDLE	169	effe-k	136
EASY TOUCH INSULIN SAFETY	174	EFFER-K	136
EASY TOUCH INSULIN SYR 0.3 ML	174	EFFEXOR	197
EASY TOUCH INSULIN SYR 0.5 ML	174	EFFIENT	74
EASY TOUCH INSULIN SYR 1 ML	174	EFUDEX	70
EASY TOUCH INSULIN SYRINGE	174	EGRIFTA	151
EASY-TOUCH INSULIN SYRINGE	174	EGRIFTA WR	151
EASY TOUCH LANCING DEVICE	159	ELEMENT COMPACT	120
EASY TOUCH LUER LOCK INSULIN	174	ELEMENT COMPACT CONTROL SOLN	159
EASY TOUCH PULL-TOP 26G LANCET	164, 182	ELEMENT CONTROL SOLUTION	159
EASY TOUCH PULL-TOP 28G LANCET	164, 182	ELEMENT TEST STRIPS	120
EASY TOUCH PULL-TOP 30G LANCET	164, 182	ELEPSIA	109
EASY TOUCH PULL-TOP 32G LANCET	164, 182	ELESTRIN	149
EASY TOUCH SAFETY 21G LANCETS	164, 182	eletriptan hydrobromide	15
EASY TOUCH SAFETY 23G LANCETS	164, 182	eletriptan hydrobromide (Relpax)	19
EASY TOUCH SAFETY 26G LANCETS	165, 182	ELIDEL	156

Index of Medications

ELIMITE	72	ENLITE SERTER	159
ELIQUIS.....	43	ENLYTE.....	233
ELIQUIS SPRINKLE.....	43	enoxaparin	44, 45
ELIXOPHYLLIN.....	34	ENSACOVE.....	65
ELLA	115	ENSPRYNG.....	155
ELMIRON	24	ENSTILAR.....	218
ELOCTATE.....	88	entacapone	72, 73
eltrombopag olamine (Promacta)	114	ENTADFI.....	232
ELYXYB.....	19	entecavir.....	80
EMBRACE 30G LANCETS.....	165, 182	ENTERO.....	124
EMBRACE EVO LEVEL 1 CTRL SOLN.....	159	ENTRESTO (sacubitril/valsartan)	96
EMBRACE EVO TEST STRIPS.....	120	ENTRESTO SPRINKLE.....	96
EMBRACE GLUC CONTROL SOLN HIGH.....	159	ENTYVIO.....	143
EMBRACE GLUCOSE CONTROL SOLN.....	159	ENVARBUS.....	156
EMBRACE GLUCOSE TEST STRIPS.....	120	ENZOCLEAR.....	213
EMBRACE LANCING DEVICE.....	159	EOHILIA	151
EMBRACE PEN NEEDLE.....	169	EPANED (enalapril maleate)	97
EMBRACE PRO.....	159	EPCLUSA.....	79
EMBRACE PRO TEST STRIP	120	EPCLUSA 150-37.5 MG PELLET PKT	79
EMBRACE SAFETY LANCET	165, 182	EPCLUSA 200 MG-50 MG TABLET	79
EMBRACE TALK CONTROL SOLUTION.....	159	EPIDIOLEX	108
EMBRACE TALK TEST STRIP	120	EPIDUO.....	210
EMBRACE TEST STRIPS.....	120	EPIDUO FORTE (adapalene/benzoyl peroxide)	210
EMBRACE WAVE GLUCOSE TEST STRP	120	EPIFOAM	217
EMBRIVA	192	epinastine	49
EMEND	139	epinephrine.....	81
EMFLAZA (deflazacort)	150	EPINEPHRINE 0.3 MG AUTO-INJECT	81
EMGALITY	15, 20, 107	epinephrine 0.3 mg auto-inject (Epipen).....	81
Empaveli	88	EPINEPHRINE 0.15 MG AUTO-INJECT	80
EMROSI.....	41	epinephrine 0.15 mg auto-inject (Epipen Jr).....	80
EMSAM	194	epinephrine 0.15 mg auto-inject (Epipen Jr 2-Pak)	80
emtricitabine.....	75, 76	epinephrine hcl	127
emtricitabine-tenofv	75	EPIPEN.....	81
EMTRIVA.....	76	EPIVIR.....	76
EMVERM	56	eplerenone (Inspra)	126
enalapril	95, 97, 98	EPOGEN	114
enalapril/hydrochlorothiazide.....	95	EPRONTIA (topiramate)	109
enalapril maleate (Epaned).....	97	eprosartan.....	98
ENBRACE HR.....	234	EPZICOM (abacavir sulfate/lamivudine)	75
ENBREL 25 MG/0.5 ML SYRINGE.....	59	EQL INS SYR 1 ML 29GX1/2"	174
ENBREL 25 MG/0.5 ML VIAL.....	59	EQL INSULIN 0.3 ML SYRINGE	174
ENBREL 50 MG/ML SYRINGE.....	59	EQL INSULIN 0.5 ML SYRINGE	174
ENBREL MINI	59	EQL INSULIN 1 ML SYRINGE	174
ENBREL SURECLICK	59	EQL INSULIN SYR 1 ML 31GX5/16"	174
ENDO-AVITENE.....	89	EQL INSUL SYR 0.3 ML 31GX5/16"	174
ENDOMETRIN (progesterone, micronized).....	154	EQL INSUL SYR 0.5 ML 31GX5/16"	174
ENFAMIL.....	134	eqi isopropyl alcohol 91%.....	228
ENGERIX-B	87	eqi isopropyl rub alcohol 70%	228
ENHERTU	69	EQUETRO	194

Index of Medications

ergocalciferol (vitamin d2)	236	ethinyl estradiol	115, 116
ergoloid	101	ethosuximide (Zarontin).....	109
ERGOMAR.....	20	ethynodiol	116
ergotamine tartrate/cafeine.....	15, 20	etodolac	27, 28
ERIVEDGE	62	etonogestrel/ethinyl estradiol.....	115
erlotinib hcl.....	65	etoposide	69
ERMEZA.....	220	etravirine (Intelence)	76
ERTACZO	47	EUCRISA	214
ERVEBO	87	EULEXIN (flutamide).....	61
ERYPED	38	EURAX	72
ery-tab	38	EVAMIST.....	149
ERY-TAB DR 500 MG TABLET (erythromycin base)	38	EVEKEO.....	82
erythromycin.....	35, 38, 39, 42	EVENCARE G2 CONTROL SOLUTION	159
erythromycin ethylsuccinate	38	EVENCARE G2 TEST STRIP	120
erythromycin ethylsuccinate (E.E.S. 200)	38	EVENCARE G3 CONTROL SOLUTION	159
ERZOFRI	203	EVENCARE G3 TEST STRIP	120
ESBRIET	225	EVENCARE MINI GLUCOSE TEST STR.....	120
escitalopram	195, 196	EVENCARE PROVIEW TEST STRIP	120
escitalopram 10 mg/10 ml cup.....	195	everolimus.....	63, 157
ESGIC	15	everolimus 0.5 mg tablet (Zortress).....	156
ESGIC (butalb/acetaminophen/cafeine)	19	everolimus 0.25 mg tablet (Zortress)	156
eslicarbazepine	109	everolimus 0.75 mg tablet (Zortress)	156
esomeprazole.....	144, 145	everolimus 1 mg tablet (Zortress).....	156
ESOMEPRAZOLE.....	145	everolimus 2.5 mg tablet (Afinitor)	63
esomeprazole dr 5 mg packet (Nexium)	144	everolimus 2 mg tab for susp (Afinitor Disperz).....	63
ESPEROCT.....	88	everolimus 3 mg tab for susp (Afinitor Disperz).....	63
estazolam.....	207	everolimus 5 mg tab for susp (Afinitor Disperz).....	63
ESTRACE.....	149, 153	everolimus 5 mg tablet (Afinitor)	63
estradiol	115, 116, 149, 150, 153	everolimus 7.5 mg tablet (Afinitor)	63
estradiol 0.1% (0.5mg) gel pkt (Divigel)	149	everolimus 10 mg tablet (Afinitor)	63
estradiol 0.1% (0.25mg) gel pk (Divigel).....	149	EVICEL	89
estradiol 0.1% (0.75mg) gel pk (Divigel).....	149	EVISTA (raloxifene hcl)	230
estradiol 0.1% (1.25mg) gel pk (Divigel).....	149	EVOCLIN	42
estradiol 0.1% (1 mg) gel pkt (Divigel).....	149	EVOLUTION CONTROL SOLUTION	159
estradiol 0.5 mg tablet.....	149	EVOLUTION TEST STRIPS	120
estradiol 1 mg tablet	149	EVOTAZ.....	77
estradiol 2 mg tablet	149	EVOXAC	83
estradiol (Minivelle)	149	EVRYSDI	226
estradiol/norethindrone acet	149	EXELDERM.....	47
ESTRATEST H.S. (estrogen,ester/me-testosterone)	149	EXEL HUBER NEEDLE.....	170
ESTRING.....	153	EXEL HYPODERMIC NEEDLE.....	170
ESTROGEL.....	149	EXEL INS SYR U100 1 ML 28GX1/2.....	174
estrogen	149	EXEL MTI DRAWING NEEDLE	170
estrogen,ester/me-testosterone	149	EXELON.....	81
estrogens, conjugated (Premarin).....	149	EXEL U100 0.3 ML 29GX1/2"	174
ESTROSTEP	115	EXEL U100 0.3 ML 30GX5/16"	174
eszopiclone	207	EXEL U100 0.5 ML 28GX1/2"	174
ethacrynic	125, 126	EXEL U100 0.5 ML 29GX1/2"	174
ethambutol.....	37	EXEL U100 0.5 ML 30GX5/16"	174

Index of Medications

EXEL U100 1 ML 30GX5/16"	174	FENORTHO	28
EXEL U100 INS SYR 1 ML 29GX1/2	174	FENSOLVI	152
exemestane	62	fentanyl	22, 23
exenatide	50	fentanyl citrate	23
EXFORGE (amlodipine besylate/valsartan)	97	FENTANYL CITRATE	23
EXFORGE HCT (amlodipine/valsartan/hcthiazid)	96	FENTORA	23
EXJADE	227	FERIVA 21-7	135
EXODERM	47	FERRALET 90	135
EXTINA	47	FERRIC	134
EYSUVIS	128	FERRIPROX	227
E-Z	124	FERRIPROX (3 TIMES A DAY) (deferiprone)	227
ezetimibe	101, 104, 105	FERRIPROX (deferiprone)	227
EZ-LETS	165, 182	ferrous fumarate/folic acid (Hemocyte-F)	135
EZ SMART	120	ferrous fum/vit c/b12-if/folic	135
EZ SMART LANCETS	165, 182	fesoterodine er 4 mg tablet (Toviaz)	233
EZ SMART PLUS	120	fesoterodine er 8 mg tablet (Toviaz)	233
F		FETZIMA	197
FABHALTA	88	FEXMID	188
FABIOR	214	FIASP	54
FACTIVE	40	FIBRICOR	104
famciclovir	78	fidaxomicin (Difcid)	39
famotidine	142	FIFTY50 INS 0.3 ML 31GX5/16"	174
FANAPT	203	FIFTY50 INS 0.5 ML 31GX5/16"	174
FANAPT TITRATION PACK A	203	FIFTY50 INS SYR 1 ML 31GX5/16"	174
FANAPT TITRATION PACK B	203	FIFTY50 SAFETY SEAL LANCETS	165, 182
FANAPT TITRATION PACK C	203	FIFTY50 TEST STRIP	120
FARESTON	70	FILSPARI	105
FARXIGA	53	FILSUEZ	231
febuxostat	26, 27	FILTER ASPIRATOR NEEDLE	170
felbamate	109	FILTER NEEDLE	170
FELBATOL	109	FINACEA	213
FELDENE	28	finasteride	231
felodipine	91	FINGERSTIX	165, 182
FEMARA	62, 64	ingolimod hcl (Gilenya)	107
FEMCAP	117	FINTEPLA	110
FEMLYV	116	FIORICET	15, 24
FEMRING	153	FIORICET (butalb/acetaminophen/caffeine)	19
fenofibrate	104	FIORINAL	15
FENOFIBRATE	104	FIRAZYR (icatibant acetate)	222
FENOFIBRATE 30 MG CAPSULE	104	FIRDAPSE	107
FENOFIBRATE 90 MG CAPSULE	104	FIRMAGON	64
fenofibric	104	FIRVANQ	42
fenofibric acid (choline)	104	FIRVANQ (vancomycin hcl)	42
fenofibric acid (Fibricor)	104	FLAGYL	37
FENOGLIDE	104	FLAREX	128
FENOPROFEN 200 MG CAPSULE	28	flavoxate hcl	233
fenopropfen 400 mg capsule (Nalfon)	28	flecainide	90
fenopropfen 600 mg tablet (Nalfon)	28	FLECTOR	209
FENOPRON	28	FLEQSUVY	189

Index of Medications

FLEXICHAMBER.....	187	fluoride (sodium).....	132, 133, 134, 136
FLOLIPID	103	fluoride (sodium) (Prevident)	134
FLORIVA 0.5 MG CHEWABLE TABLET	235	fluoride (sodium) (Prevident 5000 Plus)	134
FLORIVA 0.25 MG CHEW TABLET	235	FLUORIDEX	132, 134
FLORIVA 0.25 MG/ML DROPS.....	132	FLUORIMAX 5000	132, 134
FLORIVA 1 MG CHEWABLE TABLET	235	FLUORIMAX 5000 SENSITIVE	132
FLOW-EZE.....	170	fluorometholone.....	128
FLUAD 2025-2026	85	FLUOROPLEX	70
FLUAD QUAD 2022-2023	85	fluorouracil	70
FLUAD QUAD 2023-2024	85	FLUOROURACIL	70
FLUAD TRIVALENT 2024-2025.....	85	fluoxetine	195, 196, 206
FLUARIX 2025-2026.....	85	fluoxetine 20 mg/5 ml soln cup.....	195
FLUARIX QUAD 2022-2023	85	fluoxetine 20 mg/5 ml solution	195
FLUARIX QUAD 2023-2024	85	fluoxetine hcl 10 mg tablet.....	195
FLUARIX TRIVALENT 2024-2025.....	85	fluphenazine	206
FLUBLOK 2025-2026	85	flurandrenolide (Cordran)	216
FLUBLOK QUAD 2022-2023.....	85	flurazepam hcl	207
FLUBLOK QUAD 2023-2024.....	85	flurbiprofen	28, 128
FLUBLOK TRIVALENT 2024-2025	85	flutamide (Eulexin)	61
FLUCELVAX 2025-2026 SYRINGE	86	fluticasone.....	32, 127
FLUCELVAX 2025-2026 VIAL	86	FLUTICASONE.....	33
FLUCELVAX QUAD 2022-2023	86	fluticasone prop 0.05% cream	216
FLUCELVAX QUAD 2023-2024.....	86	fluticasone prop 0.05% lotion.....	216
FLUCELVAX TRIVALENT 2024-2025	86	fluticasone prop 0.005% oint.....	216
fluconazole.....	46	FLUTICASONE PROP 50 MCG DISKUS	33
flucytosine.....	46	FLUTICASONE PROP 100MCG DISKUS	33
fludrocortisone.....	152	FLUTICASONE PROP 250 MCG DISK.....	33
FLULAVAL 2025-2026.....	86	FLUTICASONE PROP HFA 44 MCG.....	33
FLULAVAL QUAD 2022-2023	86	FLUTICASONE PROP HFA 110 MCG.....	33
FLULAVAL QUAD 2023-2024.....	86	FLUTICASONE PROP HFA 220 MCG.....	33
FLULAVAL TRIVALENT 2024-2025	86	fluticasone propionate.....	216
FLUMADINE.....	78	fluticasone propion/salmeterol	32
FLUMIST 2025-2026.....	86	FLUTICASONE-SALMETEROL 55-14.....	32
FLUMIST HOME 2025-2026	86	fluticasone-salmeterol 100-50 (Advair Diskus).....	32
FLUMIST QUAD 2022-2023.....	86	FLUTICASONE-SALMETEROL 113-14.....	32
FLUMIST QUAD 2023-2024.....	86	FLUTICASONE-SALMETEROL 232-14.....	32
FLUMIST TRIVALENT 2024-2025	86	fluticasone-salmeterol 250-50 (Advair Diskus).....	32
flunisolide	127	fluticasone-salmeterol 500-50 (Advair Diskus).....	32
fluocinolone	128	FLUTICASONE-SALMETEROL HFA	32
fluocinolone acetonide	215	FLUTICASONE-VILANTEROL.....	32
fluocinolone acetonide (Derma-Smoothe-Fs)	215	fluvastatin	103
fluocinolone acetonide (Synalar)	215	fluvoxamine	195, 196
fluocinolone/shower cap (Derma-Smoothe-Fs)	215	FLUZONE 2025-2026 SYRINGE.....	86
fluocinonide	215	FLUZONE 2025-2026 VIAL.....	86
fluocinonide/emollient base	216	FLUZONE HIGH-DOSE 2025-2026.....	86
fluocinonide (Vanos)	216	FLUZONE HIGH-DOSE QUAD 2022-23.....	86
fluorescein.....	124, 129	FLUZONE HIGH-DOSE QUAD 2023-24.....	86
FLUORESCIN-BENOXINATE.....	129	FLUZONE HIGH-DOSE TRIV 2024-25	86
fluoride.....	132, 133		

Index of Medications

FLUZONE QUAD 2022-2023	86	FORA V10-V12-D10-D20 STRP-LNCT	182
FLUZONE QUAD 2023-2024	86	FORA V12	120
FLUZONE TRIVALENT 2024-2025	86	FORA V20	120
FML	128	FORA V30A	120
FOCALIN (dexmethylphenidate hcl)	200	FORFIVO	194
FOCALIN XR (dexmethylphenidate hcl)	201	formoterol fumarate (Perforomist)	31
FOLATEXCEL	192	FORTAVIT	234
folic	233	FORTEO (teriparatide)	229
folic acid/b6/ca phos/ginger	233	FORTISCARE	160
folic acid/vit bcomp,c/cu/zinc	235	FORTISCARE G1 TEST STRIP	121
folic acid/vit b complex and c	235	FORTISCARE GLUCOSE TEST STRIPS	121
folic/mvi ther-min/lycop/lut	234	FOSAMAX	230
FOLLISTIM	154	FOSAMAX (alendronate sodium)	230
fondaparinux 2.5 mg/0.5 ml syr (Arixtra)	44	fosamprenavir calcium	77
fondaparinux 5 mg/0.4 ml syr (Arixtra)	44	fosaprepitant	139
fondaparinux 7.5 mg/0.6 ml syr (Arixtra)	44	fosfomycin	37
fondaparinux 10 mg/0.8 ml syr (Arixtra)	44	fosinopril	95, 97
FONDCIRCLE CONTROL SOLUTION	159	fosinopril/hydrochlorothiazide	95
FONDCIRCLE LANCET	165, 182	FOSRENOL	134
FONDCIRCLE LANCING DEVICE	159	FOSRENOL (lanthanum carbonate)	134
FORA 6 CONNECT GLUCOSE STRIP	120	Fotivda	65
FORA 6 CONNECT MULTIFUNCTN MTR	159	FRAGMIN 2,500 UNIT/0.2 ML SYR	44
FORA 6CONN-GTEL-TN'G ADV STRIP	120	FRAGMIN 5,000 UNIT/0.2 ML SYR	44
FORACARE GD20	121	FRAGMIN 7,500 UNIT/0.3 ML SYR	44
FORACARE GD40	121	FRAGMIN 10,000 UNIT/4 ML VIAL	44
FORACARE GDH	160	FRAGMIN 10,000 UNIT/ML SYRINGE	44
FORACARE LANCETS	165, 182	FRAGMIN 12,500 UNIT/0.5 ML SYR	44
FORA CONTROL SOLUTION	160	FRAGMIN 15,000 UNIT/0.6 ML SYR	44
FORA D15G	120	FRAGMIN 18,000 UNIT/0.72 ML	44
FORA D20	120	FRAGMIN 95,000 UNIT/3.8 ML VL	44
FORA D40-G31 TEST STRIPS	120	FRAICHE 5000 PREVI	132
FORA G20	120	FREESTYLE CONTROL SOLUTION	160
FORA G30-PREMIUM V10 TEST STRP	120	FREESTYLE INSULINX	121
FORA GD50 TEST STRIPS	120	FREESTYLE INSULINX TEST STRIPS	121
FORA GTEL GLUCOSE TEST STRIP	120	FREESTYLE LANCETS	165, 182
FORA GTEL KETONE TEST STRIP	123	FREESTYLE LIBRE 2 PLUS SENSOR	160
FORA GTEL MULTIFUNCTN MONITOR	160	FREESTYLE LIBRE 2 READER	160
FORA KETONE CONTROL SOLUTION	160	FREESTYLE LIBRE 2 SENSOR	160
FORA LANCETS	165, 182	FREESTYLE LIBRE 3 PLUS SENSOR	160
FORA LANCING DEVICE	160	FREESTYLE LIBRE 3 READER	160
FORA TEST STRIP	120	FREESTYLE LIBRE 3 SENSOR	160
FORA TN'G ADVANCE PRO MONITOR	160	FREESTYLE LIBRE 14 DAY READER	160
FORA TN'G ADVAN PRO TEST STRIP	120	FREESTYLE LIBRE 14 DAY SENSOR	160
FORA TN'G ADV VOICE KETO STRIP	123	FREESTYLE LITE TEST STRIP	121
FORA TN'GO ADVANCE MULTIFN MTR	160	FREESTYLE PRECISION	174
FORA TN'GO ADV MOBILE MULT MTR	160	FREESTYLE PRECISION NEO	121
FORA TN'G VOICE TEST STRIPS	120	FREESTYLE TEST STRIPS	121
FORA V10	120	FREESTYLE UNISTIK 2	165, 182
FORA V10-V12-D10-D20 STRIPS	120	FROVA (frovatriptan succinate)	20

Index of Medications

FRUZAQLA.....	65	gemfibrozil.....	104
FT ISOPROPYL ALCOHOL 91%.....	228	GEMTESA.....	232
FT ISOPROPYL RUB ALCOHOL 70%.....	228	GENOTROPIN.....	151
ful-glo.....	124	GENSTRIP.....	121
FUL-GLO.....	124	gentamicin.....	36, 42
FULPHILA.....	114	gentamicin sulfate.....	35
FULVICIN P-G.....	47	GENTEEL VACUUM LANCING DEVICE.....	160
FURADANTIN.....	39	GENVOYA.....	78
FUROSCIX.....	126	GEODON.....	203
furosemide.....	126	GILENYA 0.5 MG CAPSULE (fingolimod hcl).....	107
FUSION PLUS.....	135	GILENYA 0.25 MG CAPSULE.....	107
FUZEON.....	76	GILOTRIF.....	66
FYARRO.....	63	GIMOTI.....	143
FYCOMPA.....	110	glatiramer.....	107
FYCOMPA 2 MG TABLET (perampanel).....	110	GLEEVEC 100 MG TABLET (imatinib mesylate).....	66
FYCOMPA 4 MG TABLET (perampanel).....	110	GLEEVEC 400 MG TABLET (imatinib mesylate).....	66
FYCOMPA 6 MG TABLET (perampanel).....	110	GLEOSTINE.....	61
FYCOMPA 8 MG TABLET (perampanel).....	110	glimepiride.....	52
FYCOMPA 10 MG TABLET (perampanel).....	110	GLIMEPIRIDE.....	51
FYCOMPA 12 MG TABLET (perampanel).....	110	glimepiride 1 mg tablet.....	51
FYLNETRA.....	114	glimepiride 2 mg tablet.....	51
G		glimepiride 4 mg tablet.....	51
gabapentin.....	108, 110	glipizide.....	51, 53
GABARONE.....	110	GLIPIZIDE 2.5 MG TABLET.....	51
GALAFOLD.....	228	glipizide 5 mg tablet.....	51
galantamine.....	81	glipizide 10 mg tablet.....	51
galantamine er 8 mg capsule.....	81	GLOPERBA.....	26
galantamine er 16 mg capsule.....	81	glucagon 1 mg emergency kit.....	133
galantamine er 24 mg capsule.....	81	GLUCAGON 1 MG EMERGENCY KIT.....	133
GALZIN.....	227	GLUCOCARD 01 CONTROL.....	160
ganirelix.....	152	GLUCOCARD 01 SENSOR PLUS.....	121
GANIRELIX.....	152	GLUCOCARD EXPRESSION CNTRL SLN.....	160
ganirelix acetate (Ganirelix Acetate).....	152	GLUCOCARD EXPRESSION TEST STRP.....	121
GARDASIL 9.....	87	GLUCOCARD SHINE CONTROL SOLN.....	160
GASTROCROM.....	25	GLUCOCARD SHINE TEST STRIPS.....	121
GASTROGRAFIN (diatrizoate meglumine, sodium).....	124	GLUCOCARD VITAL.....	121
GASTROMARK.....	124	GLUCOCARD VITAL SENSOR.....	121
gatifloxacin.....	35	GLUCOCOM.....	165, 182
GATTEX.....	146	GLUCOCOM AUTOLINK.....	160
GAVRETO.....	65	GLUCOCOM CONTROL SOLUTION.....	160
GE100 BLOOD GLUCOSE TEST STRIP.....	121	GLUCOCOM GLUCOSE.....	121
GE100 CONTROL SOLUTION NORMAL.....	160	GLUCOCOM LANCETS.....	165, 182
GE333 BLOOD GLUCOSE TEST STRIP.....	121	GLUCO NAVII.....	121
gefitinib (Iressa).....	65	GLUCOSE CONTROL.....	160
gelatin.....	89	GLUCOSE CONTROL SOLUTION.....	160
GELCLAIR.....	224	GLUCOSE TEST STRIP.....	121
GELFILM.....	129	GLUCOTROL XL (glipizide).....	51
GELFOAM.....	89	GLUMETZA (metformin hcl).....	50
GELFOAM (gelatin sponge,absorb/porcine).....	89	GLUTOL.....	134

Index of Medications

glyburide.....	51, 53	GS ISOPROPYL ALCOHOL 91%	228
glyburide,micronized.....	51	GUAIACOL	212
GLYCAT.....	138	GUAIFENESIN-CODEINE	118
glycerol phenylbutyrate.....	138	guanfacine	99, 200
glycine urologic.....	57	GUARDIAN RT CHARGER.....	160
glycine urologic solution	57	GUARDIAN TEST PLUG	160
glycopyrrolate	138	GUARDIAN TRANSMITTER TAPE	161
glycopyrrolate 1.5 mg tablet.....	138	GVOKE	133
glycopyrrolate 1 mg/5 ml soln (Cuvposa)	138	GYNAZOLE.....	46
glycopyrrolate 1 mg tablet (Robinul).....	138	H	
glycopyrrolate 2 mg tablet (Robinul Forte)	138	HADLIMA	59
GLYNASE.....	51	HADLIMA(CF) PUSH TOUCH.....	59
GLYXAMBI	52	HADLIMA PUSH TOUCH.....	59
GNP INS SYR 0.3 ML 29GX1/2"	174	HAEGARDA.....	225
GNP INS SYRINGE 1 ML 28G 1/2"	174	halcinonide 0.1% cream (Halog).....	216
GNP INSULIN SYR 1 ML 31GX5/16"	175	halcinonide 0.1% solution	216
GNP INSUL SYR 0.3 ML 31GX5/16"	174	HALCION (triazolam)	207
GNP INSUL SYR 0.5 ML 31GX5/16"	175	halobetasol propionate.....	216
GNP ISOPROPYL ALCOHOL 70%.....	228	HALOG 0.1% CREAM (halcinonide)	216
GNP ISOPROPYL ALCOHOL 91%.....	228	HALOG 0.1% OINTMENT	216
gnp isopropyl alcohol 99%	228	HALOG 0.1% SOLUTION.....	216
GNP TRUE METRIX TEST STRIP	121	haloperidol.....	205
GOCOVRI.....	73	HARMONY GLUCOSE TEST STRIP	121
GOJJI BLOOD GLUCOSE TEST STRIP	121	HARVONI	79
GOJJI BLOOD KETONE TEST STRIP	123	HEALTHPRO GLUCOSE CONTROL SOLN.....	161
GOJJI GLUCOSE CONTROL SOLUTION.....	160	HEALTHPRO GLUCOSE TEST STRIPS	121
GOJJI KETONE CONTROL SOLUTION	160	HEALTHWISE	170
GOJJI LANCET-GLUCOSE TEST STRP	183	HEALTHWISE INSULIN SYRINGE	175
GOJJI LANCETS	165, 183	HEALTHY	170
GOJJI LANCING DEVICE	160	HEALTHY ACCENTS AUTOLET	161
GOJJI MULTI-FUNCTIONAL METER.....	160	HEALTHY ACCENTS UNILET LANCET	165, 183
GOLYTELY	143	HEMA-COMBISTIX	125
GOMEKLI	63	HEMADY.....	151
GONAL.....	154	HEMANGEOL.....	100
GONITRO	92	HEMATRON-AF.....	135
GRALISE ER 300 MG TABLET (gabapentin)	108	HEMAX	135
GRALISE ER 450 MG TABLET (gabapentin)	108	HEMICLOR	127
GRALISE ER 600 MG TABLET (gabapentin)	108	HEMLIBRA.....	88
GRALISE ER 750 MG TABLET (gabapentin)	108	HEMOCYTE-F (ferrous fumarate/folic acid)	135
GRALISE ER 900 MG TABLET (gabapentin)	108	HEMOCYTE PLUS (mv-mins no.73/iron fum/folic)	135
granisetron.....	139	HEMOFIL M.....	88
GRANIX.....	114	heparin.....	44, 45
GRASTEK	83	HEPARIN	44
griseofulvin	47	heparin 2,000 unit/2 ml vial	44
griseofulvin ultra 125 mg tab.....	47	heparin 5,000 unit/ml carpuct.....	44
griseofulvin ultra 165 mg tab.....	47	HEPARIN SOD 5,000 UNIT/0.5 ML.....	45
griseofulvin ultra 250 mg tab.....	47	HEPARIN SOD 5,000 UNIT/ML SYRG	45
GS ISOPROPYL ALCOHOL 70%	228	HEPLISAV-B.....	87
GS ISOPROPYL ALCOHOL 70% SPRAY.....	57	HETLIOZ LQ.....	206

Index of Medications

HETLIOZ (tasimelteon)	206	hydrocortisone acetate	216
HIBERIX	86	hydrocortisone (Ala-Scalp)	216
HISTEX-AC	117	hydrocortisone (Anusol-Hc)	216
hm isopropyl alcohol 70%	228	hydrocortisone buty 0.1% cream	216
hm isopropyl alcohol 91%	228	hydrocortisone butyr 0.1% lotn	216
homatropine	118, 131	hydrocortisone butyr 0.1% oint	216
HORIZANT	106	hydrocortisone butyr 0.1% soln	216
HULIO	59	hydrocortisone/pramoxine	142, 146, 217
HULIO(CF) 20 MG/0.4 ML SYRINGE	59	hydrocortisone/pramoxine (Analpram Hc)	142
HULIO(CF) 40 MG/0.8 ML SYRINGE	59	hydrocortisone valerate	216
HULIO(CF) PEN	59	hydrogen peroxide	209
HUMALOG	54	hydromorphone hcl	23
HUMALOG TEMPO PEN U-100	54	hydroxychloroquine	57
HUMANA TRUE METRIX TEST STRIP	121	hydroxychloroquine sulfate	57
HUMATE-P	88	hydroxyurea	61
HUMATIN	56	hydroxyzine	49
HUMATROPE	151	HYFTOR	156
HUMIRA	59	HYMPAVZI	88
HUMIRA(CF) 10 MG/0.1 ML SYRING	59	hyoscyamine	140, 141
HUMIRA(CF) 20 MG/0.2 ML SYRING	59	HYPER	226
HUMIRA(CF) 40 MG/0.4 ML SYRING	59	HYPOLANCE	161
HUMIRA(CF) PEN 40 MG/0.4 ML	59	HYRIMOZ(CF) 10 MG/0.1 ML SYRNG	59
HUMIRA(CF) PEN 80 MG/0.8 ML	59	HYRIMOZ(CF) 20 MG/0.2 ML SYRNG	59
HUMIRA(CF) PEN CROHN'S-UC-HS	59	HYRIMOZ(CF) 40 MG/0.4 ML SYRNG	60
HUMIRA PEN	59	HYRIMOZ(CF) PEDI CROHN 80-40MG	60
HUMULIN	55	HYRIMOZ(CF) PEDI CROHN 80 MG	60
HUMULIN 70-30	54	HYRIMOZ(CF) PEN 40 MG/0.4 ML	60
HUMULIN 70/30 KWIKPEN	54	HYRIMOZ(CF) PEN 80 MG/0.8 ML	60
HUMULIN N	54	HYRIMOZ(CF) PEN CROHN-UC START	60
HUMULIN N KWIKPEN	54	HYRIMOZ(CF) PEN PSORIASIS	60
HUMULIN R	54	HYSINGLA ER (hydrocodone bitartrate)	23
HYCAMTIN	64	HYZAAR	96
HYCODAN 5 MG-1.5 MG/5 ML CUP	118	I	
HYCODAN 5 MG-1.5 MG/5 ML SOLN (hydrocodone bit/homatrop me-br)	118	ibandronate	229
HYCODAN 5 MG-1.5 MG TABLET (hydrocodone bit/homatrop me-br)	118	ibandronate sodium	230
hydralazine	99	IBRANCE 75 MG CAPSULE	66
HYDREA	61	IBRANCE 75 MG TABLET	66
hydrochlorothiazide	95, 96, 97, 99, 100, 126, 127	IBRANCE 100 MG CAPSULE	66
hydrocodone	117, 118	IBRANCE 100 MG TABLET	66
hydrocodone/acetaminophen	22	IBRANCE 125 MG CAPSULE	66
HYDROCODONE-ACETAMINOPHEN	22	IBRANCE 125 MG TABLET	66
hydrocodone/acetaminophen (Lortab)	22	IBSRELA	143
hydrocodone bitartrate	23	IBTROZI	66
hydrocodone-homatropine 5-1.5 (Hycodan)	118	ibuprofen	22, 28
hydrocodone/ibuprofen	22	icatibant	222
hydrocort buty 0.1% lipo cream (Locoid Lipocream)	216	icatibant acetate (Firazyr)	222
hydrocortisone	128, 146, 147, 150, 151, 216, 217	ICLUSIG	66
		icosapent	137

Index of Medications

IDACIO(CF) PEN CROHN'S-UC(6PK)	60	INDOCIN (indomethacin).....	28
IDACIO(CF) PEN PSORIASIS (4PK)	60	indomethacin.....	28
IDHIFA	69	INDOMETHACIN 20 MG CAPSULE	28
IFE-BIMIX	223	indomethacin 25 mg/5 ml susp (Indocin)	28
IGLUCOSE TEST STRIP	121	indomethacin 25 mg capsule.....	28
IHEALTH CONTROL SOLN LEVEL 2	161	indomethacin 50 mg capsule.....	28
IHEALTH GLUCOSE TEST STRIP	121	indomethacin 50 mg suppository (Indocin).....	28
ILARIS	230	INFANRIX	87
ILEVRO.....	128	INFASURF	222
ILUMYA.....	209	INFINITY CONTROL SOLUTION	161
imatinib mesylate 100 mg tab (Gleevec)	66	INFINITY TEST STRIPS.....	121
imatinib mesylate 400 mg tab (Gleevec)	66	INFINITY VOICE CONTROL SOLN.....	161
IMBRUVICA 70 MG CAPSULE	66	INFINITY VOICE TEST STRIP	121
IMBRUVICA 70 MG/ML SUSPENSION	66	INFLECTRA	60
IMBRUVICA 140 MG CAPSULE	66	INFLIXIMAB.....	60
IMBRUVICA 140 MG TABLET	66	INGREZZA.....	106
IMBRUVICA 280 MG TABLET	66	INGREZZA SPRINKLE	106
IMBRUVICA 420 MG TABLET	66	INJECT EASE LANCETS.....	165, 183
IMCIVREE.....	71	INLYTA	66
imipramine	199	INNOPRAN.....	100
imipramine hcl.....	199	INOVA	213
imiquimod	212	INPEFA	223
imiquimod 3.75% cream pump (Zyclara)	212	INPEN (FOR HUMALOG).....	161
IMITREX 4 MG/0.5 ML CARTRIDGES (sumatriptan succinate)	20	INPEN (FOR NOVOLOG OR FIASP)	161
IMITREX 4 MG/0.5 ML PEN INJECT (sumatriptan succinate)	20	INQOVI.....	61
IMITREX 6 MG/0.5 ML CARTRIDGES (sumatriptan succinate)	20	INREBIC.....	66
IMITREX 6 MG/0.5 ML PEN INJECT (sumatriptan succinate)	20	INSPRA (eplerenone).....	126
IMITREX 25 MG TABLET (sumatriptan succinate)	20	INSTACLEAN	228
IMITREX 50 MG TABLET (sumatriptan succinate)	20	INSUL-CAP	161
IMITREX 100 MG TABLET (sumatriptan succinate)	20	INSUL-EZE	161
IMKELDI.....	66	INSULIN	50, 51, 53, 55, 152, 170
IMPAVIDO	57	INSULIN 1/2 ML SYRINGE.....	175
IMPEKLO.....	216	INSULIN 1 ML SYRINGE.....	175
IMPOYZ	216	INSULIN 3/10 ML SYRINGE.....	175
IMULDOSA	154	INSULIN ASPART PROT MIX 70-30.....	55
IMURAN	156	INSULIN DEGLUDEC.....	55
IMVEXXY	153	INSULIN DEGLUDEC PEN (U-100).....	55
INBRIJA.....	73	INSULIN DEGLUDEC PEN (U-200).....	55
INCONTROL	170	INSULIN GLARGINE	55
INCONTROL ALCOHOL PADS	208, 212	INSULIN GLARGINE SOLOSTAR U100.....	55
INCONTROL LANCING DEVICE.....	161	INSULIN GLARGINE SOLOSTAR U300.....	55
INCONTROL SUPER THIN LANCETS	165, 183	INSULIN GLARGINE-YFGN.....	55
INCONTROL ULTRA THIN LANCETS.....	165, 183	INSULIN SYR 0.3 ML 30GX5/16".....	175
INCRELEX.....	152	INSULIN SYR 0.3ML 31GX1/4(1/2).....	175
INCRUSE ELLIPTA	30	INSULIN SYR 0.5 ML 28G 12.7MM.....	175
indapamide.....	127	INSULIN SYRIN 0.3 ML 29GX1/2"	175
INDERAL	100	INSULIN SYRIN 0.3 ML 30GX1/2"	175
INDICLOR	124	INSULIN SYRIN 0.3 ML 30GX5/16"	175
		INSULIN SYRIN 0.3 ML 31GX5/16"	175

Index of Medications

INSULIN SYRIN 0.5 ML 28G 1/2"	175	INVOKAMET	53
INSULIN SYRIN 0.5 ML 28GX1/2"	175	INVOKANA	53
INSULIN SYRIN 0.5 ML 29GX1/2"	175	INZIRQO	127
INSULIN SYRIN 0.5 ML 30G 1/2"	175	iodine	135, 218
INSULIN SYRIN 0.5 ML 30G 5/16"	175	IODOFLEX	218
INSULIN SYRIN 0.5 ML 30GX1/2"	175	IODOSORB	218
INSULIN SYRIN 0.5 ML 30GX5/16"	175	IOPIDINE	130
INSULIN SYRIN 0.5 ML 31G 5/16"	175	IPOLE	84
INSULIN SYRIN 0.5 ML 31GX5/16"	175	ipratropium	127
INSULIN SYRIN 1 ML 29GX1/2"	175	ipratropium/albuterol sulfate	31
INSULIN SYRINGE 0.5 ML 27G 1/2"	175	ipratropium bromide	30
INSULIN SYRINGE 0.5 ML 27G 13MM	175	IQIRVO	224
INSULIN SYRINGE 0.5 ML 28G 1/2"	175	irbesartan	96, 98
INSULIN SYRINGE 0.5 ML 29G 1/2"	175	irbesartan/hydrochlorothiazide	96
INSULIN SYRINGE 0.5 ML 29GX1/2"	175	IRESSA (gefitinib)	66
INSULIN SYRINGE 0.3 ML	175	iron aspgly/c/b12/fa/ca-th/suc	136
INSULIN SYRINGE 0.3 ML 31GX1/4	175	iron aspgly,ps/c/b12/fa/ca/suc	136
INSULIN SYRINGE 0.5 ML 31GX1/4	175	iron bg,ps/vitc/b12/fa/calcium	136
INSULIN SYRINGE 1 ML	175	iron/c/folic acid/mv cmb11/calc	136
INSULIN SYRINGE 1 ML 27G 1/2"	175	iron/folic acid/b12/c/docusate	136
INSULIN SYRINGE 1 ML 27G 13MM	175	iron/folic acid/c/b6/b12/zinc	136
INSULIN SYRINGE 1 ML 27G 16MM	176	iron/folic ac/vit bcomp,c/min	136
INSULIN SYRINGE 1 ML 27GX1/2"	176	iron fum,ag/c/b12/folic/ca/suc	136
INSULIN SYRINGE 1 ML 28G 1/2"	176	iron fumarate/vit c/vit b12/fa	136
INSULIN SYRINGE 1ML 28G 12.7MM	176	iron fum,ps/folic acid/vitc/b3 (Integra F)	136
INSULIN SYRINGE 1 ML 28G 13MM	176	iron fum,ps/folic/bcomp,c no.9 (Integra Plus)	136
INSULIN SYRINGE 1 ML 28GX1/2"	176	iron ps complex/b12/folic acid	136
INSULIN SYRINGE 1 ML 29G 1/2"	176	IROSPAN	136
INSULIN SYRINGE 1 ML 29GX1/2"	176	ISENTRESS	77
INSULIN SYRINGE 1 ML 30G 1/2"	176	isoflurane	25
INSULIN SYRINGE 1 ML 30G 5/16"	176	isoniazid	37
INSULIN SYRINGE 1 ML 30GX1/2"	176	ISOPROPANOL	228
INSULIN SYRINGE 1 ML 30GX5/16"	176	isopropyl 70% alcohol	228
INSULIN SYRINGE 1 ML 31G 5/16"	176	isopropyl alcohol	228
INSULIN SYRINGE 1 ML 31GX1/4"	176	isopropyl alcohol 70%	229
INSULIN SYRINGE 1 ML 31GX5/16"	176	ISOPROPYL ALCOHOL 70%	229
INSULIN SYRINGE U-500	176	ISOPROPYL ALCOHOL 70% SPRAY	57
INSUPEN	170	isopropyl alcohol 91%	229
INTEGRA F (iron fum,ps/folic acid/vitc/b3)	135	isopropyl alcohol 99%	229
INTEGRA NEEDLE	170	isopropyl rubbing alcohol 70%	229
INTEGRA PLUS (iron fum,ps/folic/bcomp,c no.9)	135	ISOPROPYL RUBBING ALCOHOL 70%	229
INTEGRA PRECISIONGLIDE NEEDLE	170	ISOPROPYL RUBBING ALCOHOL 91%	229
INTELENCE	76	ISORDIL	92
INTELENCE (etravirine)	76	isosorbide	92, 93
INTRAROSA	147	isosorbide dinit/hydralazine (Bidil)	101
INTUNIV	200	isotretinoin	210
INVACARE LANCETS	165, 183	isoxsuprine	101
INVEGA	203	isradipine	91
INVELTYS	129	ISTALOL	130

Index of Medications

ISTURISA 1 MG TABLET	147	KAPVAY	200
ISTURISA 5 MG TABLET	147	KARBINAL.....	49
ITOVEBI	66	KATERZIA.....	91
itraconazole.....	46, 47	KAZANO	52
ivabradine	92	KENALOG (triamcinolone acetonide)	216
ivermectin	56	KEPPRA	110
ivermectin 1% cream (Soolantra).....	213	KEPPRA XR (levetiracetam).....	110
ivermectin 3 mg tablet (Stromectol)	56	KERENDIA.....	126
ivermectin 6 mg tablet.....	56	KESIMPTA.....	107
IWILFIN.....	66	ketoconazole	46, 48
IYUZEH	130	KETO-DIASTIX REAGENT	125
J		KETONE CARE TEST STRIP	125
JADENU	227	KETONE TEST STRIP	125
JAKAFI	63	ketoprofen 25 mg capsule.....	28
JALYN (dutasteride/tamsulosin hcl)	231	ketoprofen 50 mg capsule.....	28
JANSSEN COVID-19 VACCINE (EUA)	84	ketoprofen 75 mg capsule.....	28
JANUMET	52	ketoprofen er 200 mg capsule.....	28
JANUVIA.....	51	ketorolac.....	21, 128, 129
JARDIANCE.....	53	KETOSTIX REAGENT	125
JATENZO	147	KEVEYIS (dichlorphenamide).....	225
javygtor 100 mg powder packet (Kuvan)	228	KEVZARA.....	155
javygtor 100 mg tablet (Kuvan).....	228	KHINDIVI	151
javygtor 500 mg powder packet (Kuvan)	228	KINERET.....	26
JAYPIRCA 50 MG TABLET	66	KINRAY INS SYR 1 ML 31GX5/16"	176
JAYPIRCA 100 MG TABLET	66	KINRAY SYRING 0.3 ML 31GX5/16"	176
JENTADUETO	52	KINRAY SYRING 0.5 ML 31GX5/16"	176
JIVI.....	88	KINRIX	87
JOENJA	222	KIRSTY	55
JORNAY PM.....	201	KIRSTY PEN	55
JOURNAVX.....	19	KISQALI.....	64, 66
JUBLIA	47	KITABIS.....	36
JULUCA.....	75	KLARON.....	210
JUST RIGHT 5000	132, 135	KLISYRI.....	70
JUXTAPID 5 MG CAPSULE.....	102	KLONOPIN.....	108
JUXTAPID 10 MG CAPSULE.....	102	Kloxxado.....	45
JUXTAPID 20 MG CAPSULE.....	102	KMART VALU PLUS SYR 1/2 ML.....	176
JUXTAPID 30 MG CAPSULE.....	102	KOATE	88
JYLAMVO	61	KOGENATE FS	88
JYNARQUE.....	126	KOMBIGLYZE XR 2.5-1,000 MG TAB (saxagliptin hcl/metformin hcl)	52
JYNNEOS	87	KOMBIGLYZE XR 5-1,000 MG TAB (saxagliptin hcl/metformin hcl)	52
JYNNEOS (NATIONAL STOCKPILE)	87	KOMBIGLYZE XR 5-500 MG TABLET (saxagliptin hcl/metformin hcl)	52
K		KONVOMEF	145
KALBITOR	223	KORLYM (mifepristone)	53
KALETRA	77	KOSELUGO.....	63
KALETRA (lopinavir/ritonavir).....	77	KOSELUGO 5 MG SPRINKLE CAPSULE	63
KALYDECO	222	KOSELUGO 7.5 MG SPRINKLE CAP.....	63
KALYDECO 13.4 MG GRANULES PKT	222	KOSHER PRENATAL PLUS IRON	190
KAPSPARGO	100	KOVALTRY.....	88

Index of Medications

K-PHOS.....	137	lamivudine/zidovudine	75
KRAZATI.....	63	lamotrigine	110, 111
KRINTAFEL.....	57	LAMPIT.....	57
KRISTALOSE.....	143	lancets	165, 183
KROGER INS SYR 0.3 ML 30GX5/16.....	176	LANCETS.....	163, 164, 165, 183
KROGER INS SYR 0.5 ML 29GX1/2".....	176	LANCING DEVICE.....	161
KROGER INS SYR 1 ML 29GX1/2".....	176	LANCING SYSTEM.....	161
KROGER INS SYR 1 ML 31GX5/16".....	176	LANOXIN	92
KROGER SYR 0.5 ML 30GX5/16".....	176	lanreotide 120 mg/0.5 ml syrng.....	153
KROGER SYRING 0.3 ML 31GX5/16".....	176	LANREOTIDE 120 MG/0.5 ML SYRNG	153
KRO INS SYR 0.3 ML 29GX1/2".....	176	lansoprazole.....	140, 145
KRO INS SYRIN 0.5 ML 31GX5/16".....	176	lansoprazole dr 15 mg capsule	145
KRO INSULIN SYR 1 ML 30GX5/16".....	176	lanthanum	134
kro isopropyl alcohol 91%.....	229	LANTUS.....	55
KUVAN.....	228	LANZO	161
KYLEENA	117	lapatinib.....	66
KYZATREX 100 MG CAPSULE.....	147	LASIX.....	126
KYZATREX 150 MG CAPSULE.....	147	LASIX ONYU 80 MG/2.67 ML KIT	126
KYZATREX 200 MG CAPSULE.....	147	LASIX ONYU REUSABLE UNIT	186
L			
labetalol hcl 100 mg tablet.....	95	latanoprost.....	130, 131
labetalol hcl 200 mg tablet.....	95	LATUDA	203
labetalol hcl 300 mg tablet.....	95	LAZANDA	23
LABETALOL HCL 400 MG TABLET.....	95	LAZCLUZE.....	66
LABSTIX REAGENT.....	125	LEADER INS SYR 0.3 ML 29GX1/2".....	176
lacosamide (Vimpat).....	110	LEADER INS SYR 0.5 ML 28GX1/2".....	176
LACRISERT.....	128	LEADER INS SYR 0.5 ML 29GX1/2".....	176
lactulose.....	138, 143	LEADER INS SYR 0.5 ML 30GX1/2".....	176
lactulose 10 gm/15 ml soln cup.....	143	LEADER INS SYR 1 ML 28GX1/2".....	177
lactulose 10 gm/15 ml solution.....	143	LEADER INS SYR 1 ML 29GX1/2".....	177
lactulose 10 gm packet	143	LEADER INS SYR 1 ML 30GX5/16".....	177
lactulose 20 gm/30 ml soln cup.....	143	LEADER INS SYR 1 ML 31GX5/16".....	177
lactulose 20 gm/30 ml solution.....	143	LEADER INSULIN SYRINGE 0.3 ML.....	177
LAGEVRIO (EUA)	78	LEADER SYRING 0.3 ML 31GX5/16".....	177
LAMICTAL.....	110	LEADER SYRING 0.5 ML 31GX5/16".....	177
LAMICTAL (BLUE) (lamotrigine)	110	LEDIPASVIR.....	79
LAMICTAL (GREEN) (lamotrigine).....	110	leflunomide.....	26
LAMICTAL ODT (BLUE) (lamotrigine).....	110	lenalidomide.....	64
LAMICTAL ODT (GREEN) (lamotrigine)	110	LENVIMA	66
LAMICTAL ODT (lamotrigine).....	110	LEQEMBI.....	105
LAMICTAL ODT (ORANGE) (lamotrigine).....	110	LEQSELVI	231
LAMICTAL (ORANGE) (lamotrigine).....	110	LESCOL	103
LAMICTAL XR (BLUE)	110	LETAIRIS	94
LAMICTAL XR (GREEN).....	110	letrozole.....	62
LAMICTAL XR (lamotrigine)	110	leucovorin	223
LAMICTAL XR (ORANGE).....	110	LEUKERAN.....	61
lamivudine	75, 76, 80	LEUKINE.....	114
lamivudine 300 mg/30ml sol cup (Epivir)	76	leuprolide.....	64
		LEUPROLIDE.....	64

Index of Medications

levabuterol hcl	31	LEXAPRO	196
LEVALBUTEROL TARTRATE HFA.....	31	LIALDA.....	142
LEVAMLODIPINE MALEATE	91	LIBERVANT	108
LEVBID (hyoscyamine sulfate)	141	LIBRAX (chlordiazepoxide/clidinium br).....	138
LEVEMIR.....	55	LIBTAYO	69
levetiracetam	110, 111	LICART	209
levetiracetam 1,000mg/10ml cup (Keppra).....	111	lidocaine.....	25, 146, 217
levetiracetam 1,000 mg tablet (Keppra)	111	LIDOCAINE.....	146
levetiracetam 100 mg/ml soln (Keppra)	111	lidocaine 5% ointment.....	25
levetiracetam 250 mg tablet (Keppra).....	111	lidocaine hcl	25
LEVETIRACETAM 250 MG TAB SUSP	111	lidocaine hcl/glycerin	123
levetiracetam 500 mg/5 ml cup	111	lidocaine (Lidocan li)	25
levetiracetam 500 mg/5 ml soln.....	111	lidocaine (Lidoderm)	25
levetiracetam 500 mg tablet (Keppra).....	111	LIDOCAN.....	25
levetiracetam 750 mg tablet (Keppra).....	111	LIDODERM.....	25
levobunolol	130	LIFESHIELD BLUNT CANNULA.....	170
levocarnitine	229	LIKMEZ	37
levocetirizine dihydrochloride	49	LILETTA.....	117
levofloxacin	35, 40	linagliptin/metformin hcl.....	52
levonorgest/eth.estradiol/iron	116	lindane	72
levonorgestrel/ethin.estradiol	116	linezolid.....	39
levorphanol tartrate.....	23	LINZESS	143
LEVOTHYROXINE 13 MCG CAPSULE	220	liothyronine.....	220
LEVOTHYROXINE 25 MCG CAPSULE	220	liothyronine sodium (Cytomel)	221
levothyroxine 25 mcg tablet (Synthroid).....	220	LIPITOR	103
LEVOTHYROXINE 50 MCG CAPSULE	220	LIPOFEN.....	104
levothyroxine 50 mcg tablet (Synthroid).....	220	LIQUID	124
LEVOTHYROXINE 75 MCG CAPSULE	221	liraglutide 2-pak 18 mg/3 ml (Victoza 2-Pak)	50
levothyroxine 75 mcg tablet (Synthroid).....	221	liraglutide 2-pak 18 mg/3 ml (Victoza 3-Pak)	50
LEVOTHYROXINE 88 MCG CAPSULE	221	liraglutide 3-pak 18 mg/3 ml (Victoza 2-Pak)	50
levothyroxine 88 mcg tablet (Synthroid).....	221	liraglutide 3-pak 18 mg/3 ml (Victoza 3-Pak)	50
LEVOTHYROXINE 100 MCG CAPSULE	220	liraglutide 5-pak 18 mg/3 ml (Saxenda).....	71
levothyroxine 100 mcg tablet (Synthroid).....	220	liraglutide 18 mg/3 ml pen (Saxenda).....	71
LEVOTHYROXINE 112 MCG CAPSULE	220	lisdexamphetamine 10 mg capsule (Vyvanse)	199
levothyroxine 112 mcg tablet (Synthroid).....	220	lisdexamphetamine 10 mg tb chew (Vyvanse).....	199
LEVOTHYROXINE 125 MCG CAPSULE	220	lisdexamphetamine 20 mg capsule (Vyvanse)	199
levothyroxine 125 mcg tablet (Synthroid).....	220	lisdexamphetamine 20 mg tb chew (Vyvanse).....	199
LEVOTHYROXINE 137 MCG CAPSULE	220	lisdexamphetamine 30 mg capsule (Vyvanse)	199
levothyroxine 137 mcg tablet (Synthroid).....	220	lisdexamphetamine 30 mg tb chew (Vyvanse).....	199
LEVOTHYROXINE 150 MCG CAPSULE	220	lisdexamphetamine 40 mg capsule (Vyvanse)	199
levothyroxine 150 mcg tablet (Synthroid).....	220	lisdexamphetamine 40 mg tb chew (Vyvanse).....	199
LEVOTHYROXINE 175 MCG CAPSULE	220	lisdexamphetamine 50 mg capsule (Vyvanse)	199
levothyroxine 175 mcg tablet (Synthroid).....	220	lisdexamphetamine 50 mg tb chew (Vyvanse).....	199
LEVOTHYROXINE 200 MCG CAPSULE	220	lisdexamphetamine 60 mg capsule (Vyvanse)	199
levothyroxine 200 mcg tablet (Synthroid).....	220	lisdexamphetamine 60 mg tb chew (Vyvanse).....	199
levothyroxine 300 mcg tablet (Synthroid).....	220	lisdexamphetamine 70 mg capsule (Vyvanse)	199
levothyroxine sodium (Synthroid).....	221	lisinopril	95, 97, 98
LEVSIN (hyoscyamine sulfate)	141	lisinopril/hydrochlorothiazide	95
LEVSIN-SL (hyoscyamine sulfate).....	141	lissamine	124
LEVULAN.....	70		

Index of Medications

LITEAIRE	187	LORTAB (hydrocodone/acetaminophen)	22
LITE TOUCH	170	LORZONE	189
LITETOUCH	187	losartan	96, 98
LITE TOUCH 28G LANCETS	165, 183	losartan/hydrochlorothiazide	96
LITE TOUCH 30G LANCETS	165, 183	LOTEMAX 0.5% EYE DROPS (loteprednol etabonate)	129
LITE TOUCH 33G LANCETS	166, 183	LOTEMAX 0.5% EYE OINTMENT	129
LITE TOUCH INSULIN 0.5 ML SYR	177	LOTEMAX 0.5% OPHTHALMIC GEL (loteprednol etabonate)	129
LITE TOUCH INSULIN 1 ML SYR	177	LOTEMAX SM	129
LITE TOUCH INSULIN SYR 0.3 ML	177	LOTENSIN	95, 97
LITE TOUCH INSULIN SYR 0.5 ML	177	loteprednol etabonate (Alrex)	129
LITE TOUCH INSULIN SYR 1 ML	177	loteprednol etabonate (Lotemax)	129
LITETOUCH INSULIN SYRINGE	177	LOTREL	94
LITE TOUCH LANCING PEN	161	LOTRONEX	143
LITE TOUCH PEN NEEDLE 29G	170	lovastatin	103
LITE TOUCH PEN NEEDLE 31G	170	LOVAZA (omega-3 acid ethyl esters)	137
LITFULO	231	LOVENOX	45
lithium	194	loxapine	205
LITHOBID	194	lubiprostone	144
LITHOSTAT	138	LUCEMYRA	231
LIVALO	103	LULICONAZOLE	48
LIVDELZI	224	LUMAKRAS 120 MG TABLET	63
Livmarli	143	LUMAKRAS 240 MG TABLET	63
LIVTENCITY	78	LUMAKRAS 320 MG TABLET	63
l-norgest/e.estradiol-e.estrad	116	LUMIGAN	130
LOCOID LIPOCREAM (hydrocortisone butyrate/emoll)	216	LUMRYZ	206
LODINE	28	LUMRYZ STARTER PACK	206
LODOCO	222	LUNESTA	207
LODOSYN	74	LUPKYNIS	156
LOESTRIN	116	LUPRON	64, 152
LOESTRIN FE (norethindrone-e.estradiol-iron)	116	LUPRON DEPOT 3.75 MG KIT	152
LOESTRIN (norethindrone ac/eth estradiol)	116	LUPRON DEPOT-4 MONTH KIT	64
lofexidine	231	LUPRON DEPOT 7.5 MG KIT	64
LOKELMA	134	LUPRON DEPOT 11.25 MG 3MO KIT	152
LO LOESTRIN FE	116	LUPRON DEPOT 22.5 MG 3MO KIT	64
LOMAIRA	71	LUPRON DEPOT 45 MG 6MO KIT	64
LOMOTIL	139	lurasidone hcl 20 mg tablet (Latuda)	203
lomustine	61	lurasidone hcl 40 mg tablet (Latuda)	203
LONSURF	61	lurasidone hcl 60 mg tablet (Latuda)	203
loperamide	139	lurasidone hcl 80 mg tablet (Latuda)	203
LOPID	104	lurasidone hcl 120 mg tablet (Latuda)	203
lopinavir/ritonavir	77	LUZU	48
lopinavir/ritonavir (Kaletra)	77	LYBALVI	203
LOPRESSOR	100	LYNPARZA	67
LOPROX	48	LYRICA CR (pregabalin)	230
LOPROX 0.77% TOPICAL SUSP (ciclopirox olamine)	48	LYRICA (pregabalin)	111
lorazepam	193	LYSODREN	69
LORBRENA 25 MG TABLET	66	LYTGOBI 12 MG DOSE (3X 4MG TB)	67
LORBRENA 100 MG TABLET	66	LYTGOBI 16 MG DOSE (4X 4MG TB)	67
LOREEV	193	LYTGOBI 20 MG DOSE (5X 4MG TB)	67

Index of Medications

LYUMJEV	55	medroxyprogesterone 10 mg tab (Provera)	153
LYUMJEV TEMPO PEN U-100.....	55	MEDTRONIC REMOTE CONTROL.....	161
LYVISPAH.....	189	mefenamic acid	21
M		mefloquine.....	57
MACROBID	39	megestrol 20 mg tablet.....	70
MACUVEX.....	233	megestrol 40 mg tablet.....	70
MACUZIN.....	233	megestrol 400 mg/10 ml cup.....	233
mafenide.....	43	megestrol 625 mg/5 ml susp.....	233
MAGELLAN INSULIN SAFETY SYRNG	177	megestrol acet 40 mg/ml susp	233
MAGELLAN INSULIN SYRINGE.....	177	megestrol acet 400 mg/10 ml	233
MAGNEBIND 400.....	134	MEKINIST.....	63
MALARONE	57	MEKTOVI.....	63
malathion (Ovide)	72	meloxicam	28
maprotiline	199	meloxicam 5 mg capsule (Vivlodex).....	28
maraviroc (Selzentry)	76	MELOXICAM 7.5 MG/5 ML SUSP.....	28
MAR-COF CG	118	meloxicam 7.5 mg tablet.....	28
MARINOL.....	139	meloxicam 10 mg capsule (Vivlodex).....	28
MARNATAL-F.....	190	meloxicam 15 mg tablet	28
MARPLAN.....	194	melphalan.....	61
MATERNACEL	192	memantine	105
MATERVIA	192	MEMANTINE HCL.....	105
MATULANE.....	69	memantine hcl/donepezil hcl (Namzaric).....	105
MAVENCLAD	107	MENACTRA.....	85
MAVYRET 50-20 MG PELLETT PACKET	80	MENEST	149
MAVYRET 100-40 MG TABLET.....	80	MENOPUR.....	154
MAXALT MLT (rizatriptan benzoate)	20	MENOSTAR.....	149
MAXALT (rizatriptan benzoate)	20	MENQUADFI.....	85
MAXI-COMFORT.....	177	MENVEO.....	85
MAXICOMFORT	170	meperidine hcl.....	23
MAXICOMFORT INSULIN SYRINGE.....	177	MEPHYTON	236
MAXIDEX.....	129	meprobamate	193
MAXITROL	35	MEPRON.....	57
MAXI-TUSS CD	117	mercaptopurine	62
MAYZENT	107	MERIOLOG.....	55
meclizine.....	139	MERIOLOG SOLOSTAR.....	55
MECLIZINE.....	139	mesalamine	141, 142
meclofenamate sodium.....	28	mesalamine (Pentasa).....	142
MEDI-FIRST ISOPROPYL ALCOHOL	57	mesna.....	223
MEDIHONEY	214	MESNEX (mesna).....	223
MEDISENSE	161	MESTINON.....	81
MEDISENSE GLUCOSE KETONE.....	161	METADATE CD (methylphenidate hcl)	201
MEDISENSE GLUCOSE KETONE CONTR.....	161	metaxalone 400 mg tablet.....	189
MEDISENSE THIN LANCETS.....	166, 183	METAXALONE 640 MG TABLET	189
MEDLANCE PLUS.....	166, 183	metaxalone 800 mg tablet.....	189
MEDLANCE PLUS SPECIAL BLADE	183	metformin.....	50, 51, 52, 53
MEDROL	151	METFORMIN.....	52
medroxyprogesterone	115, 153	metformin hcl	50
medroxyprogesterone 2.5 mg tab (Provera)	153	metformin hcl 1,000 mg tablet.....	51
medroxyprogesterone 5 mg tab (Provera).....	153	metformin hcl 500 mg/5 ml cup (Riomet)	51

Index of Medications

metformin hcl 500 mg/5 ml soln (Riomet).....	51	methylphenidate er 72 mg tab	201
metformin hcl 500 mg tablet.....	51	methylphenidate er(la) 10mg cp (Ritalin La).....	201
METFORMIN HCL 625 MG TABLET.....	51	methylphenidate er(la) 20mg cp (Ritalin La).....	201
metformin hcl 750 mg tablet.....	51	methylphenidate er(la) 30mg cp (Ritalin La).....	201
METFORMIN HCL 750 MG TABLET.....	51	methylphenidate er(la) 40mg cp (Ritalin La).....	201
metformin hcl 850 mg tablet.....	51	methylphenidate er(la) 60mg cp.....	201
methadone hcl.....	23	methylphenidate hcl	201
methamphetamine	82	methylphenidate hcl (Metadate Cd).....	201
METHAVER	235	methylphenidate hcl (Methylin).....	201
methazolamide.....	125	methylphenidate hcl (Ritalin)	202
methenamine	37	methylprednisolone	151
methimazole.....	219	methyl salicylate.....	212
METHITEST	147	methyltestosterone.....	147
methocarbamol.....	189	metoclopramide	143
methocarbamol 1,000 mg tablet.....	189	metolazone	127
METHOCARBAMOL 1,000 MG TABLET	189	METOPIRON.....	124
methocarbamol 500 mg tablet.....	189	metoprolol	100
methocarbamol 750 mg tablet.....	189	METROCREAM (metronidazole)	213
methotrexate	62	METROGEL	213
methotrexate 2.5 mg tablet	62	metronidazole.....	37, 42, 213
methotrexate 50 mg/2 ml vial.....	62	METRONIDAZOLE	37
methotrexate 250 mg/10 ml vial.....	62	metronidazole 0.75% cream (Metrocream).....	213
methoxsalen	209	metronidazole 0.75% lotion	213
methscopolamine.....	141	metronidazole 250 mg tablet	37
methsuximide (Celontin).....	111	metronidazole 375 mg capsule (Flagyl)	37
methyl dopa.....	99	metronidazole 500 mg tablet	37
methylergonovine	152	metronidazole top 1% gel pump.....	213
METHYLIN (methylphenidate hcl)	201	metronidazole topical 0.75% gl.....	213
methylphenidate (Daytrana).....	201	metronidazole topical 1% gel (Metrogel)	213
methylphenidate er 10 mg cap (Aptensio Xr)	201	metronidazole vaginal 0.75% gl.....	42
methylphenidate er 10 mg tab	201	metyrosine	99
methylphenidate er 15 mg cap (Aptensio Xr)	201	mexiletine	90
methylphenidate er 18 mg tab (Concerta).....	201	MIACALCIN (calcitonin,salmon,synthetic)	154
methylphenidate er 18 mg tab (Relexxii).....	201	MICARDIS.....	96, 98
methylphenidate er 20 mg cap (Aptensio Xr)	201	miconazole.....	46
methylphenidate er 20 mg tab	201	MICONAZOLE-ZINC OXIDE-PETROLTM	48
methylphenidate er 27 mg tab (Concerta).....	201	MICORT-HC.....	216
methylphenidate er 27 mg tab (Relexxii).....	201	MICRO	121
methylphenidate er 30 mg cap (Aptensio Xr)	201	MICROCHAMBER.....	187
methylphenidate er 36 mg tab (Concerta).....	201	MICRODOT HIGH-LOW CONTROL SOL	161
methylphenidate er 36 mg tab (Relexxii).....	201	MICRODOT NORMAL CONTROL SOLUT	161
methylphenidate er 40 mg cap (Aptensio Xr)	201	MICRODOT TEST STRIPS	121
METHYLPHENIDATE ER 45 MG TAB	201	MICRODOT XTRA.....	121
methylphenidate er 50 mg cap (Aptensio Xr)	201	MICROLET.....	166, 183
methylphenidate er 54 mg tab (Concerta).....	201	MICROLET 2.....	161
methylphenidate er 54 mg tab (Relexxii).....	201	MICROLET NEXT LANCING DEVICE	161
methylphenidate er 60 mg cap (Aptensio Xr)	201	MICROSPACER.....	187
METHYLPHENIDATE ER 63 MG TAB	201	MICROTAINER LANCETS	183

Index of Medications

MICRO THIN LANCET.....	166, 183	moexipril.....	97
MICRO THIN LANCETS.....	166, 183	molindone.....	205
midazolam hcl.....	207	mometasone furoate 0.1% cream.....	216
midodrine.....	83	mometasone furoate 0.1% oint.....	216
MIEBO.....	128	mometasone furoate 0.1% soln.....	216
MIFEPREX.....	225	mometasone furoate 50 mcg spry.....	127
mifepristone.....	53	MONOJECT.....	177
mifepristone 200 mg tablet.....	225	MONOJECT BLOOD COLLECTION.....	170
miglitol.....	50	MONOJECT FILTER NEEDLE.....	170
miglustat.....	226	MONOJECT INSULIN SAFETY SYRNG.....	177
miglustat (Zavesca).....	226	MONOJECT INSULIN SYRINGE.....	177
MIGRANAL (dihydroergotamine mesylate).....	20	MONOLET LANCETS.....	166, 183
MINI.....	164, 170, 186	MONOLET THIN LANCETS.....	166, 183
MINI LANCING DEVICE.....	161	MONSEL's.....	89
MINIMED QUICK-SERTER.....	161	montelukast sodium.....	34
MINIMED RESERVOIR.....	177	morphine sulfate.....	23
MINIPRESS.....	96	MOTEGRITY.....	143
MINITRAN.....	93	MOTOFEN.....	139
MINIVELLE.....	149	MOTPOLY XR 100 MG CAPSULE.....	111
MINOCIN.....	41	MOTPOLY XR 150 MG CAPSULE.....	111
minocycline.....	41	MOTPOLY XR 200 MG CAPSULE.....	111
MINOCYCLINE.....	41	MOUNJARO 2.5 MG/0.5 ML PEN.....	50
minocycline er 65 mg tablet.....	41	MOUNJARO 5 MG/0.5 ML PEN.....	50
minocycline er 80 mg tablet.....	41	MOUNJARO 7.5 MG/0.5 ML PEN.....	50
minocycline er 105 mg tablet.....	41	MOUNJARO 10 MG/0.5 ML PEN.....	50
minocycline hcl.....	41	MOUNJARO 12.5 MG/0.5 ML PEN.....	50
MINOLIRA.....	41	MOUNJARO 15 MG/0.5 ML PEN.....	50
minoxidil.....	99	MOUTHPIECE.....	187
MIPLYFFA.....	226	MOVANTIK.....	45
mirabegron.....	232	MOVIPREP.....	144
MIRCERA.....	114	MOXATAG.....	39
MIRENA.....	117	moxifloxacin.....	40
mirtazapine.....	193	moxifloxacin hcl.....	35
misoprostol.....	27, 140	MRESVIA.....	87
MITIGARE.....	26	MS CONTIN (morphine sulfate).....	23
MITOSOL.....	132	MS INS SYR 0.5 ML 29GX1/2".....	177
MIUDELLA.....	117	MS INS SYR 1 ML 29GX1/2".....	177
M-M-R II.....	87	MS INS SYRINGE 1 ML 30GX1/2".....	177
MNEXSPIKE 2025-2026 (12Y UP).....	84	MS INSULIN SYR 0.3 ML 29GX1/2".....	177
MOBILE LANCETS.....	166, 183	MS INSULIN SYR 1 ML 31GX5/16".....	177
modafinil.....	206	MS INSULIN SYRINGE 0.3 ML.....	177
MODERNA COVID(6M-5Y) VACC(EUA).....	84	MS INSUL SYR 0.3 ML 31GX5/16".....	177
MODERNA COVID (12Y UP)VAC(EUA).....	84	MS INSUL SYR 0.5 ML 30GX1/2".....	177
MODERNA COVID-19 BOOSTER (EUA).....	84	MS INSUL SYR 0.5 ML 31GX5/16".....	177
MODERNA COVID 23-24(6M-11Y)EUA.....	84	MULPLETA.....	114
MODERNA COVID 24-25(6M-11Y)EUA.....	84	MULTAQ.....	90
MODERNA COVID BIVAL(6MO-5Y)EUA.....	84	MULTI-LANCET.....	161
MODERNA COVID BIVAL(6MO UP)EUA.....	84	MULTISTIX.....	125

Index of Medications

MULTISTIX 5	125	naloxone hcl 4 mg nasal spray (Narcan)	46
MULTISTIX 7	125	naltrexone	46
MULTISTIX 8 SG	125	NAMENDA	105
MULTISTIX 9	125	NAMENDA XR TITRATION PACK	105
MULTISTIX 9 SG	125	NAMZARIC 7 MG-10 MG CAPSULE	105
MULTISTIX 10 SG	125	NAMZARIC 14 MG-10 MG CAPSULE (memantine hcl/donepezil hcl)	105
multivit 47/iron/folate 1/dha	234	NAMZARIC 21 MG-10 MG CAPSULE (memantine hcl/donepezil hcl)	105
multivit-min69/iron/folic acid	234	NAMZARIC 28 MG-10 MG CAPSULE (memantine hcl/donepezil hcl)	105
multivit-mins no.7/folic acid	234	NAMZARIC TITRATION PACK	105
multivit no.18/iron no.1/folic (Tandem Plus)	234	NANO 2ND GEN PEN NEEDLE	170
multivit no.51/iron/folic acid	234	NANO PEN NEEDLE	170
mupirocin 2% cream	42	NAPRELAN (naproxen sodium)	28
mupirocin 2% ointment	42	NAPROSYN	27
MURI-LUBE MINERAL OIL	229	NAPROSYN 125 MG/5 ML SUSPEN (naproxen)	28
MUSE	223	NAPROSYN 500 MG TABLET (naproxen)	28
mv-mins 71/iron/folic no.1/dha	234	naproxen	27, 28
mvn-min 74/iron fum/iron/fa (Concept Ob)	234	naproxen 125 mg/5 ml suspen (Naprosyn)	29
mvn-min75/iron/iron ps/om3/dha (Concept Dha)	234	naproxen 250 mg tablet	29
mvn no.53/iron/folic/dss/dha	234	naproxen 375 mg tablet	29
MYALEPT	154	naproxen 500 mg kit (Naprosyn)	29
MYCAPSSA	153	naproxen 500 mg tablet (Naprosyn)	29
MYCOBUTIN	37	naproxen dr 375 mg tablet (Ec-Naprosyn)	29
mycophenolate	156	naproxen dr 500 mg tablet (Ec-Naprosyn)	29
MYDAYIS	82	naproxen sodium	29
MYDRIACYL	131	naproxen sodium (Anaprox Ds)	29
Myfembree	152	naproxen sodium (Naprelan)	29
MYFORTIC (mycophenolate sodium)	156	naratriptan hcl	20
MYGLUCOHEALTH	121	NARCAN (naloxone hcl)	46
MYGLUCOHEALTH CONTROL SOLUTION	161	NARDIL	194
MYGLUCOHEALTH LANCETS	166, 183	NASCOBAL (cyanocobalamin (vitamin b-12))	235
MYHIBBIN	156	NATACHEW	190
MYLERAN	61	NATACYN	46
mynatal capsule	190	NATAL PNV	192
mynatal ultracaplet	190	NATAZIA	116
MYRBETRIQ	232	nateglinide	51
MYRBETRIQ ER 8 MG/ML SUSP	232	NATESTO	147
MYSOLINE (primidone)	111	NATROBA	72
MYTESI	138	NAYZILAM	108
N		nebivolol 2.5 mg tablet (Bystolic)	100
nabumetone (Relafen)	28	nebivolol 5 mg tablet (Bystolic)	100
nadolol	100	nebivolol 10 mg tablet (Bystolic)	100
naftifine	48	nebivolol 20 mg tablet (Bystolic)	100
NAFTIN	48	NEBUPENT	57
NALFON	28	nebusal	226
NALFON 400 MG CAPSULE (fenoprofen calcium)	28	NEBUSAL	226
NALOCET	22	NEEDLE	170
naloxone	24, 45, 46, 231	NEEDLES	170
naloxone 0.4 mg/ml vial	46	needles,safety huber,disposabl	170

Index of Medications

NEEVODHA	234	NILOTINIB D-TARTRATE	67
nefazodone	197	nilotinib hcl (Tasigna).....	67
NEFFY	81	nilutamide.....	61
NEMLUVIO.....	155	nimodipine.....	91
NEOMATERNA	192	nimodipine 30 mg capsule.....	91
neomycin	35, 36, 208	nimodipine 60 mg/20 ml soln.....	91
neomycin/bacit/p-myx/hydrocort.....	35	NINJACOF-XG	118
neomycin/polymyxin b/dexametha	35	NINLARO	67
neomycin/polymyxin b/hydrocort.....	34, 35	nisoldipine	91, 92
neomycin/polymyxn b/gramicidin.....	35	nitazoxanide.....	72
neomycin sulf/bacitracin/poly	35	nitisinone (Orfadin)	226
NEONATAL COMPLETE	190	NITRO-DUR.....	93
NEONATAL-DHA	190	nitrofurantoin.....	39
NEONATAL FE	136	NITROFURANTOIN 50 MG/5 ML SUSP.....	39
NEONATAL PLUS.....	190	nitroglycerin	93
NEORAL (cyclosporine, modified).....	156	nitroglycerin 0.3 mg tablet sl (Nitrostat)	93
NEO-SYNALAR.....	42	nitroglycerin 0.4 mg tablet sl (Nitrostat)	93
NEPHRON FA	235	nitroglycerin 0.4% ointment (Rectiv).....	144
NERLYNX	67	nitroglycerin 0.6 mg tablet sl (Nitrostat)	93
NESINA	51	NITROLINGUAL.....	93
NESTABS.....	190	NITROMIST.....	93
NESTABS ABC.....	190	NITROSTAT.....	93
NESTABS DHA	190	NITYR.....	226
NESTABS ONE.....	234	NIVA-FOL (cyanocobalamin/folic ac/vit b6).....	235
neuac.....	210	NIVA-PLUS (multivit-min 60/iron fum/folic)	234
NEUAC	210	NIVESTYM	114
NEULASTA	114	nizatidine	142
NEULUMEX.....	124	NOCTIVA.....	148
NEUPOGEN.....	114	NOKOR ADMIX NEEDLE.....	170
NEUPRO.....	73	NOKOR NEEDLE	170
NEURONTIN (gabapentin)	111	NORDITROPIN.....	151
NEUTEK 2TEK TEST STRIPS.....	122	norelgestromin/ethin.estradiol	116
NEVANAC	129	noreth.....	116
nevirapine	76	norethind	116, 150
NEXAVAR (sorafenib tosylate)	67	norethindrone	116, 149, 150, 153
NEXICLON XR.....	99	norethindrone-e.estradiol-iron.....	116
NEXIUM.....	145	norethin-ee.....	116
NEXLETOL.....	102	norethin-eth estrad	150
NEXLIZET	102	NORGESIC FORTE (orphenadrine/aspirin/cafeine)	189
NEXPLANON.....	115	NORGESIC (orphenadrine/aspirin/cafeine)	189
Nextstellis.....	116	norgestimate.....	116
NGENLA.....	151	norgestrel	116
niacin.....	104, 105	NORITATE.....	213
NIACOR.....	105	NORLIQVA.....	91
nicardipine	91	NORPACE	90
NICOTROL	219	NORTHERA	83
nifedipine.....	91	nortriptyline.....	199
NILANDRON	61	NORVASC.....	91

Index of Medications

NORVIR.....	77
NOURIANZ.....	73
NOVA MAX GLUCOSE TEST STRIPS.....	122
NOVAMAX PLUS.....	123
NOVA MAX PLUS GLUC-KETON METER.....	161
NOVAMAX PLUS GLU-KET.....	161
NOVAREL.....	154
NOVA SAFETY LANCETS.....	166, 183
NOVA SUREFLEX.....	166, 183
NOVAVAX COVID-19 VACC,ADJ(EUA).....	84
NOVAVAX COVID 2023-2024 (EUA).....	84
NOVAVAX COVID 2024-2025 (EUA).....	84
NOVOEIGHT.....	88
NOVOFINE.....	170
NOVOLIN N.....	55
NOVOLIN N FLEXPEN.....	55
NOVOLIN R.....	56
NOVOLIN R FLEXPEN.....	56
NOVOLOG.....	55, 56
NOVOLOG FLEXPEN.....	56
NOVOLOG MIX 70-30.....	56
NOVOLOG MIX 70-30 FLEXPEN.....	56
NOVOLOG PENFILL.....	56
NOVOPEN ECHO.....	161
NOXAFIL.....	46
NUBEQA.....	61
NUCALA.....	34
NUCORT.....	216
NUCYNTA.....	23
NUCYNTA ER.....	23
NUDEXTA.....	106
NUFERA.....	136
NULEV (hyoscyamine sulfate).....	141
NULIBRY.....	227
NUMOISYN.....	224
NUPLAZID.....	195
NURTEC ODT.....	20
NUTROPIN.....	151
NUVARING.....	115
NUVAXOVID 2025-2026.....	84
NUVESSA.....	42
NUVIGIL.....	206
NUWIQ.....	88
NUZYRA.....	41
NYMALIZE.....	92
NYPOZI.....	114
nystatin.....	47, 48
NYVEPRIA.....	114

O

OB COMPLETE.....	234
OB COMPLETE ONE.....	190
OB COMPLETE PETITE.....	190
OB COMPLETE PREMIER.....	190
OB COMPLETE WITH DHA.....	190
OBREDON.....	118
OBSTETRIX EC.....	190
OBTREX DHA.....	190
OCALIVA.....	142
octreotide.....	153
octreotide acetate,mi-spheres (Sandostatin Lar Depot).....	153
OCUFLOX.....	35
ODACTRA.....	83
ODEFSEY.....	78
ODOMZO.....	62
OFEV.....	222
ofloxacin.....	34, 35, 36, 40
OGSIVEO 50 MG TABLET.....	67
OGSIVEO 100 MG TABLET.....	67
OGSIVEO 150 MG TABLET.....	67
OHTUVAYRE.....	34
OJEMDA 25 MG/ML ORAL SUSP.....	62
OJEMDA 100 MG TAB (400MG DOSE).....	62
OJEMDA 100 MG TAB (500MG DOSE).....	62
OJEMDA 100 MG TAB (600MG DOSE).....	62
OJJAARA.....	67
olanzapine.....	203, 204, 206
olmesartan.....	96, 97, 98
olmesartan/amlodipin/hcthiazid.....	96
olmesartan-hctz.....	96
olopatadine.....	127
olopatadine hcl 0.1% eye drops.....	49
olopatadine hcl 0.2% eye drop.....	49
OLPRUVA.....	138
OLUMIANT.....	27
OLUX (clobetasol propionate).....	216
om-3/dha/epa/b12/fa/b6/phytost.....	234
OMECLAMOX.....	140
omega-3.....	137
omeprazole.....	145, 146
OMNARIS.....	127
OMNIPOD 5 DEXG7G6 INTRO(GEN 5).....	161
OMNIPOD 5 DEXG7G6 PODS (GEN 5).....	161
OMNIPOD 5 G6-G7 INTRO KT(GEN5).....	162
OMNIPOD 5 G6-G7 PODS (GEN 5).....	162
OMNIPOD 5 (G6/LIBRE 2 PLUS).....	161
OMNIPOD 5 INTRO(G6/LIBRE2PLUS).....	162

Index of Medications

OMNIPOD CLASSIC PDM KIT (GEN 3)	162	OPDIVO	69
OMNIPOD CLASSIC PODS (GEN 3)	162	OPDUALAG	69
OMNIPOD DASH INTRO KIT (GEN 4)	162	OPFOLDA	226
OMNIPOD DASH PODS (GEN 4)	162	OPIZA	205
OMNIPOD GO PODS	162	opium	23, 139
OMNITROPE	151	opium/belladonna alkaloids	23
OMVOH	155	OPSUMIT	94
OMVOH 200 MG/2 ML PEN	155	OPSYNVI	94
OMVOH 200 MG/2 ML SYRINGE	155	OPTICHAMBER	187
OMVOH 200 MG DOSE - 2 PENS	155	OPTIUM	122
OMVOH 200 MG DOSE - 2 SYRINGES	155	OPTIUM EZ	122
OMVOH 300 MG DOSE - 2 PENS	155	OPTUMRX GLUCOSE CONTROL SOLN	162
OMVOH 300 MG DOSE - 2 SYRINGES	155	OPTUMRX TEST STRIP	122
ONAPGO	73	OPVEE	46
ON CALL EXPRESS CONTROL SOLN	162	OPZELURA	218
ON CALL EXPRESS TEST STRIP	122	ORACEA (doxycycline monohydrate)	41
ON CALL LANCET	166, 183	ORACIT	137
ON CALL LANCING DEVICE	162	ORALAIR	83
ON CALL PLUS CONTROL	162	ORAMAGICRX	224
ON CALL PLUS LANCET	166, 183	ORAPRED	151
ON CALL PLUS LANCING DEVICE	162	ORAVIG	46
ON CALL PLUS TEST STRIP	122	ORENCIA	26
ON CALL VIVID CONTROL	162	ORENITRAM	94
ON CALL VIVID TEST STRIP	122	ORENITRAM MONTH 1 TITRATION KT	94
ondansetron	139, 140	ORENITRAM MONTH 2 TITRATION KT	94
ONDANSETRON	140	ORENITRAM MONTH 3 TITRATION KT	94
ondansetron odt 4 mg tablet	140	ORFADIN	226
ondansetron odt 8 mg tablet	140	ORFADIN (nitisinone)	226
ONETOUCH DELICA PLUS LANC DEV	162	ORGOVYX	64
ONETOUCH DELICA PLUS LANCET	166, 183	ORIAHNN	152
ONETOUCH DELICA SAFETY LANCET	166, 183	ORILISSA	152
ONETOUCH LANCETS	166, 183	ORKAMBI	221
ONETOUCH SURESOFT	166, 183	ORKAMBI 75-94 MG GRANULE PKT	221
ONETOUCH ULTRA CONTROL SOLN	162	ORLADEYO	223
ONETOUCH ULTRASOFT 2 LANCET	166, 183	ORLISTAT	71
ONETOUCH ULTRA TEST STRIP	122	orphenadrine	189
ONETOUCH VERIO HIGH CNTRL SOLN	162	orphenadrine/aspirin/caffeine (Norgesic)	189
ONETOUCH VERIO MID CNTRL SOLN	162	ORSERDU 86 MG TABLET	70
ONETOUCH VERIO TEST STRIP	122	ORSERDU 345 MG TABLET	70
ONE WAY MOUTHPIECE	187	ORTHO	133
ONEXTON	210	oseltamivir	78, 79
ONFI	108	OSENI	49
ONGENTYS	73	OSMOPREP	144
ONGLYZA (saxagliptin hcl)	51	OSPHENA	224
ON-THE-GO	166, 183	OTEZLA 10-20-30MG START 28 DAY	26
ONUREG	62	OTEZLA 10-20 MG STARTER 28 DAY	26
ONYDA XR	200	OTEZLA 20 MG TABLET	26
ONZETRA XSAIL	20	OTEZLA 30 MG TABLET	26

Index of Medications

OTEZLA XR 75 MG TABLET	26	OXYCONTIN	24
OTEZLA XR INITIATION PK 28 DAY	26	oxymorphone hcl	24
OTOVEL	35	OXYTROL	233
OTREXUP	26	OZEMPIC	50
OTULFI	154	OZOBAX	189
OVACE	211	P	
OVAL TAPE	162	pacerone	90
OVIDE (malathion)	72	PACNEX	213
OVIDREL	154	PALFORZIA	83
oxandrolone	147	paliperidone	203, 204
oxaprozin	27	PALYNZIQ	83
OXAPROZIN	29	PAMELOR	199
oxaprozin 600 mg caplet (Daypro)	29	PANCREAZE	144
oxaprozin 600 mg tablet (Daypro)	29	PANDA MASK	187
OXAYDO	23	PANDEL	217
oxazepam	193	PANRETIN	70
OXBRYTA 300 MG TABLET	89	pantoprazole	145
OXBRYTA 300 MG TABLET FOR SUSP	89	PARADIGM	177
OXBRYTA 500 MG TABLET	89	PARAGARD	117
oxcarbazepine (Oxtellar Xr)	111	PARAGARD T 380A (SINGLE HAND)	117
oxcarbazepine (Trileptal)	111	PAREMYD	131
OXERVATE	132	paricalcitol	224
oxiconazole nitrate	48	PARNATE	194
OXISTAT	48	paroxetine	196, 226
OXTELLAR XR (oxcarbazepine)	111	paroxetine hcl 10 mg/5 ml susp	196
oxybutynin	233	PASER	37
OXYBUTYNIN 2.5 MG TABLET	233	PATANASE (olopatadine hcl)	127
oxybutynin 5 mg/5 ml soln cup	233	PAXIL	196
oxybutynin 5 mg/5 ml solution	233	PAXLOVID	78
oxybutynin 5 mg/5 ml syrup	233	pazopanib hcl	67
oxybutynin 5 mg tablet	233	PEDIARIX	87
oxycodone	23	PEDIATRIC MASK	187
oxycodone hcl	22, 23	PEDIATRIC PANDA MASK	187
oxycodone hcl 5 mg/5 ml cup	23	pedi multivit no.12 w-fluoride	235
oxycodone hcl 5 mg/5 ml soln	23	ped mvit a,c,d3 no.21/fluoride	235
OXYCODONE HCL 5 MG TABLET	23	PEDVAXHIB	87
OXYCODONE HCL 10 MG TABLET	23	peg3350	144
OXYCODONE HCL 15 MG TABLET	23	peg3350/sod sulf,bicarb,cl/kcl	144
OXYCODONE HCL 30 MG TABLET	23	PEGASYS	80
oxycodone hcl 100 mg/5 ml conc	23	PEMAZYRE	67
oxycodone hcl/acetaminophen	22	PEN	20, 34, 71, 102, 107, 155, 169, 170, 171
OXYCODONE HCL ER	24	PENBRAYA	85
oxycodone hcl (ir) 5 mg cap	23	penciclovir (Denavir)	80
oxycodone hcl (ir) 5 mg tablet (Roxicodone)	23	penicillamine	26
oxycodone hcl (ir) 10 mg tab	23	penicillamine 250 mg capsule (Cuprimine)	26
oxycodone hcl (ir) 15 mg tab (Roxicodone)	23	penicillamine 250 mg tablet (Depen)	26
oxycodone hcl (ir) 20 mg tab	23	penicillin v potassium	39
oxycodone hcl (ir) 30 mg tab (Roxicodone)	23	PENMENVY MEN A-B-C-W-Y	85

Index of Medications

PENTACEL.....	87	phentermine 8 mg tablet.....	71
PENTACEL ACTHIB COMPONENT.....	87	phentermine 15 mg capsule.....	71
pentamidine.....	57	phentermine 30 mg capsule.....	71
PENTASA 250 MG CAPSULE.....	142	phentermine 37.5 mg capsule.....	71
PENTASA 500 MG CAPSULE (mesalamine).....	142	phentermine 37.5 mg tablet.....	71
pentazocine hcl/naloxone hcl.....	24	phentermine/topiramate (Qsymia).....	71
PENTIPS.....	169	phenylephrine.....	48, 129
PENTIPS PEN NEEDLE.....	171	PHENYTEK (phenytoin sodium extended).....	111
pentoxifylline.....	89	phenytoin.....	109, 111
PEPCID.....	142	phenytoin (Dilantin).....	111
perampanel 2 mg tablet (Fycompa).....	111	phenytoin (Dilantin-125).....	111
perampanel 4 mg tablet (Fycompa).....	111	phenytoin sodium extended (Dilantin).....	112
perampanel 6 mg tablet (Fycompa).....	111	phenytoin sodium extended (Phenytek).....	112
perampanel 8 mg tablet (Fycompa).....	111	PHESGO.....	64
perampanel 10 mg tablet (Fycompa).....	111	PHEXX.....	115
perampanel 12 mg tablet (Fycompa).....	111	PHEXXI.....	115
PERCOCET (oxycodone hcl/acetaminophen).....	22	PHOSPHOLINE.....	130
PERFECT POINT SAFETY LANCETS.....	166, 184	PHYSIOLYTE (physiological irrig soln no.1).....	208
PERFECT POINT SAFETY NEEDLE.....	171	PHYSIOSOL (physiological irrig soln no.1).....	208
PERFOROMIST (formoterol fumarate).....	31	phytonadione.....	236
PERIDEX.....	223	PIFELTRO.....	76
perindopril.....	97	pilocarpine.....	83
permethrin.....	72	pilocarpine 1% eye drops.....	130
perphenazine.....	198, 206	pilocarpine 2% eye drops.....	130
PERTZYE.....	144	pilocarpine 4% eye drops.....	130
PFIZER COVID (5-11Y) VAC (EUA).....	84	pilocarpine hcl 1.25% eye drop (Vuity).....	130
PFIZER COVID (6M-4Y) VACC(EUA).....	84	pilocarpine hcl 5 mg tablet (Salagen).....	83
PFIZER COVID (12Y UP) VAC(EUA).....	84	pilocarpine hcl 7.5 mg tablet (Salagen).....	83
PFIZER COVID-19 VACCINE (EUA).....	84	pimecrolimus.....	156
PFIZER COVID 2023-24(5-11Y)EUA.....	84	pimozide.....	202
PFIZER COVID 2023-24(6M-4Y)EUA.....	84	pindolol.....	100
PFIZER COVID 2024-25(5-11Y)EUA.....	84	pioglitazone.....	52, 53
PFIZER COVID 2024-25(6M-4Y)EUA.....	84	pioglitazone hcl/metformin hcl.....	52
PFIZER COVID BIVAL (5-11YR)EUA.....	84	pioglitazone hcl/metformin hcl (Actoplus Met).....	52
PFIZER COVID BIVAL (6MO-4Y)EUA.....	84	PIP.....	171
PFIZER COVID BIVAL (12Y UP)EUA.....	84	PIP BLOOD GLUCOSE TEST STRIP.....	122
PHARMABASE BARRIER (zinc oxide).....	213	PIP GLUCOSE CONTROL SOLUTION.....	162
PHARMACIST CHOICE.....	122	PIP LANCET.....	166, 184
PHASEAL PROTECTOR.....	171	PIQRAY.....	67
PHEBURANE.....	138	pirfenidone.....	225
phenazopyridine hcl.....	25	pirfenidone 267 mg tablet (Esbriet).....	225
phendimetrazine.....	71	PIRFENIDONE 534 MG TABLET.....	225
phenelzine.....	194	pirfenidone 801 mg tablet (Esbriet).....	225
phenobarb.....	141	piroxicam.....	28, 29
phenobarb/hyoscy/atropine/scop.....	141	pitavastatin.....	103
phenobarbital.....	206	PLAQUENIL.....	57
PHENOBARBITAL-BELLADONNA (phenobarb/hyoscy/atropine/scop).....	141	PLATINUM TEST STRIP.....	122
phenoxybenzamine.....	83	PLAVIX.....	74

Index of Medications

PLEGRIDY	107	potassium cl er 20 meq tablet.....	137
PLENVU	144	potassium iodide	135
PLEXION	43	potassium iodide/iodine	135
PNEUMOVAX	85	PRADAXA 20 MG PELLET PACK	45
pnv 11/iron fum/folic acid/om3	190	PRADAXA 30 MG PELLET PACK	45
pnv19/iron bg,s.p/folic ac/om3	191	PRADAXA 40 MG PELLET PACK	45
pnv 66/iron/folic/docusate/dha	190	PRADAXA 50 MG PELLET PACK	45
pnv 69/iron/folic/docusate/dha	190	PRADAXA 75 MG CAPSULE (dabigatran etexilate mesylate)	45
pnv 80/iron fum/folic/dss/dha	190	PRADAXA 110 MG CAPSULE (dabigatran etexilate mesylate)	45
pnv81/iron ps,edta/folic/omeg3	191	PRADAXA 110 MG PELLET PACK	45
pnv 119/iron fum/folic acid	190	PRADAXA 150 MG CAPSULE (dabigatran etexilate mesylate)	45
pnv,calcium 72/iron,carb/folic	190	PRADAXA 150 MG PELLET PACK	45
pnv,calcium 72/iron/folic acid	190	PRALUENT	102
pnv no.52/iron/fa/omega-3/dha	190	pramipexole	73
pnv no.118/iron fumarate/fa	190	PRAMOSONE.....	217, 218
pnv no.154/iron fum/folic acid	190	PRAMOSONE 1%-1% CREAM.....	217
PNV TABS 20-1	192	prasugrel	74
POCKET.....	187	pravastatin	103
podofilox	213	praziquantel	56
podofilox (Condylox)	213	prazosin.....	96
POGO AUTOMATIC TEST CARTRIDGE.....	184	prazosin hcl	96
POKONZA 10 MEQ PACKET	136	PR BENZOYL PEROXIDE (benzoyl peroxide microspheres).....	213
POKONZA 15 MEQ PACKET	136	PRECISION	169
POLIBAR	124	PRECISIONGLIDE	171
polyethylene glycol.....	229	PRECISION PCX.....	122
POLY HUB NEEDLE.....	171	PRECISION PCX PLUS	122
polymyxin	34, 35, 36, 208	PRECISION POINT OF CARE	122
POLY-TUSSIN AC.....	117	PRECISION Q-I-D	122
POLY-VI-FLOR.....	235, 236	PRECISION XTRA KETONE-GLUCOSE.....	162
POLY-VI-FLOR WITH IRON.....	236	PRECISION XTRA TEST STRIPS.....	122
POMALYST.....	64	PRECISION XTR B-KETONE STRIP	123
Ponvory	107	PRECOSE.....	50
posaconazole	46, 47	PRED	129
potassium	21, 39, 98, 133, 135, 136, 137, 218	prednicarbate.....	217
POTASSIUM.....	126, 136, 137, 144	prednisolone.....	35, 129, 151
potassium bicarbonate	136	prednisone	151
potassium citrate	137	PREFERRED PLUS 0.3 ML 30GX5/16	178
potassium cl 10% (20 meq/15ml)	136	PREFERRED PLUS 0.5 ML 29GX1/2"	178
potassium cl 10%(20meq/15ml)cup.....	137	PREFERRED PLUS SYRINGE 0.5 ML	178
potassium cl 10%(40meq/30ml)cup.....	137	PREFERRED PLUS SYRINGE 1 ML	178
potassium cl 20% (40 meq/15ml)	137	PREFPLS INS SYR 1 ML 30GX5/16".....	178
potassium cl 20%(40meq/15ml)cup.....	137	PREF PLUS INS 0.3 ML 29GX1/2"	177
potassium cl 20 meq packet.....	136	PREF PLUS SYR 0.5 ML 30GX5/16"	177
potassium cl er 8 meq capsule.....	137	PREF PLUS SYRING 1 ML 29GX1/2"	177
potassium cl er 8 meq tablet.....	137	pregabalin (Lyrica).....	112
potassium cl er 10 meq capsule.....	137	pregabalin (Lyrica Cr)	230
potassium cl er 10 meq tablet.....	137	PREGEN DHA.....	191
potassium cl er 15 meq tablet.....	137	PREGENNA	192

Index of Medications

PREGNYL	154	PREVIDENT 0.2% RINSE (fluoride (sodium))	132, 135
PREHEVBRIO	87	PREVIDENT 1.1% GEL (fluoride (sodium))	135
PREMARIN	153	PREVIDENT 5000 BOOSTER PLUS	135
PREMARIN (estrogens, conjugated)	150	PREVIDENT 5000 DRY MOUTH	133, 135
PREMIER TEST STRIP	122	PREVIDENT 5000 ORTHO DEFENSE	135
PREMIUM BLOOD GLUCOSE TEST	122	PREVIDENT 5000 PLUS (fluoride (sodium))	133, 135
PREMIUM V10	122	PREVIDENT DENTAL RINSE (fluoride (sodium))	133, 135
PREMPHASE	150	PREVIDENT KIDS	135
PREMPRO	150	PREVNAR 13	85
PRENATA	191	PREVNAR 20	85
prenatal 12/iron/folic/dss/om3	191	PREVYMIS 20 MG PELLET PACKET	79
PRENATAL 19	191	PREVYMIS 120 MG PELLET PACKET	79
prenatal 53/iron/folic ac/omg3	191	PREVYMIS 240 MG TABLET	79
prenatal 54/iron/folic ac/omg3	191	PREVYMIS 480 MG TABLET	79
prenatal 71/iron/folic ac/dha	191	PREZCOBIX	75
prenatal 93/iron/folate 9/dha	191	PREZISTA	75
prenatal 105/iron/folic ac/dha	191	PRIFTIN	37
prenatal,calc 40/iron/folate 1	191	PRIOSEC	145
prenatal no.42/folic acid (Vitamedmd Redichew Rx)	191	PRIMACARE	191
PRENATAL PLUS-DHA	191	primaquine phosphate (Primaquine)	57
PRENATAL PLUS VITAMIN-MINERAL	191	PRIMAQUINE (primaquine phosphate)	57
prenatal vit 27,calc/iron/fa	191	PRIMEAIRE	187
prenatal vit 55/iron/folic/om3	191	primidone 50 mg tablet (Mysoline)	112
prenatal vit,cal 73/iron/folic	191	PRIMIDONE 125 MG TABLET	112
prenatal vit,cal 76/iron/folic	191	primidone 250 mg tablet (Mysoline)	112
prenatal vit,cal 78/iron/folic	191	PRIMLEV	22
prenatal vit/iron fum/folic ac	191	PRIMSOL	37
prenatal vits 86/iron/folic ac	191	PRIORIX	87
PRENATE AM	234	PRISMASOL	137
PRENATE CHEWABLE	234	PRISTIQ	198
PRENATE DHA	192	PROAIR DIGIHALER	31
PRENATE ELITE	192	PROAIR RESPICLICK	31
PRENATE ENHANCE	191	probenecid	30
PRENATE ESSENTIAL	234	probenecid/colchicine	30
PRENATE MINI	192	PROCARDIA XL (nifedipine)	92
PRENATE PIXIE	192	PROCARE SPACER WITH ADULT MASK	187
PRENATE RESTORE	191	PROCARE SPACER WITH CHILD MASK	187
PRENATE STAR	192	PROCHAMBER	187
PREPIDIL	152	prochlorperazine	139, 140
PRESSURE	130, 131	PRO COMFORT	171
PRESSURE ACTIVATED LANCETS	166, 184	PRO COMFORT ALCOHOL PADS	208, 212
PRESTALIA	94	PRO COMFORT INSULIN SYRINGE	178
PRETOMANID	37	PRO COMFORT LANCET	166, 184
PREVACID DR 15 MG SOLUTAB (lansoprazole)	145	PRO COMFORT LANCETS	166, 184
PREVACID DR 30 MG CAPSULE (lansoprazole)	145	PRO COMFORT SAFETY LANCET	166, 184
PREVACID DR 30 MG SOLUTAB (lansoprazole)	145	PRO COMFORT SPACER-ADULT MASK	187
PREVENT	171	PRO COMFORT SPACER-CHILD MASK	187
PREVIDENT	132, 133	PRO COMFORT SPACER-INFANT MASK	187

Index of Medications

PROCORT	142, 146	PUB INSULIN SYR 1 ML 31GX5/16"	178
PROCRIT	114	PUB INSUL SYR 0.3 ML 31GX5/16"	178
PROCTOFOAM	146	PUB INSUL SYR 0.5 ML 30GX1/2"	178
PROCTOFOAM-HC	142	PUB INSUL SYR 0.5 ML 31GX5/16"	178
PROCYSBI	232	PULMICORT 0.5 MG/2 ML RESPULE (budesonide)	33
PRODIGY CONTROL SOLUTION	162	PULMICORT 0.25 MG/2 ML RESPUL (budesonide)	33
PRODIGY INSULIN SYRINGE	178	PULMICORT 1 MG/2 ML RESPULE (budesonide)	33
PRODIGY LANCETS	166, 184	PULMICORT FLEXHALER	34
PRODIGY LANCING DEVICE	162	PULMOZYME	222
PRODIGY NO CODING	122	PURE COMFORT ALCOHOL PAD	208, 212
PRODIGY TWIST TOP LANCET	166, 184	PURE COMFORT LANCETS	166, 184
PROFERRIN-FORTE	136	PURE COMFORT PEN NEEDLE	171
progesterone 100 mg capsule (Prometrium)	153	PURE COMFORT SAFETY LANCETS	166, 184
progesterone 100 mg vag insert (Endometrin)	154	PURE COMFORT SAFETY PEN NEEDLE	171
progesterone 200 mg capsule (Prometrium)	153	PURE COMFORT SPACER WITH MASK	187
PROGLYCEM	133	PURIXAN (mercaptopurine)	62
PROGRAF 0.2 MG GRANULE PACKET	156	PUSH BUTTON SAFETY LANCETS	166, 184
PROGRAF 0.5 MG CAPSULE (tacrolimus)	156	PYLERA (bismuth/metronid/tetracycline)	140
PROGRAF 1 MG CAPSULE (tacrolimus)	156	pyrazinamide	37
PROGRAF 1 MG GRANULE PACKET	156	PYRIDIUM	25
PROGRAF 5 MG CAPSULE (tacrolimus)	157	pyridostigmine	81
prolate 5-300 mg tablet	22	PYRIDOSTIGMINE	81
prolate 7.5-300 mg tablet	22	pyridostigmine 60 mg/5 ml cup (Mestinon)	81
prolate 10-300 mg tablet	22	pyridostigmine 60 mg/5 ml soln (Mestinon)	81
PROLATE 10 MG-300 MG/5 ML SOLN	22	pyridostigmine br 60 mg tablet (Mestinon)	81
PROLENSA (bromfenac sodium)	129	pyrimethamine	57
PROMACTA (eltrombopag olamine)	114	PYRUKYND 5 MG TABLET	89
promethazine	49, 117, 140	PYRUKYND 5 MG TAPER PACK	89
PROMETRIUM (progesterone, micronized)	153	PYRUKYND 20-5 MG TAPER PACK	89
propafenone	90	PYRUKYND 20 MG TABLET	89
proparacaine	129	PYRUKYND 50-20 MG TAPER PACK	89
propranolol	100	PYRUKYND 50 MG TABLET	89
propylthiouracil	219	PYZCHIVA	154
PROQUAD	87	Q	
PROSCAR	231	QBRELIS	97
PROTECT IRON	234	QBREXZA	214
PROTONIX	145	QELBREE ER 100 MG CAPSULE	202
protriptyline	199	QELBREE ER 150 MG CAPSULE	202
PROVERA	115, 153	QELBREE ER 200 MG CAPSULE	202
PROVERA (medroxyprogesterone acetate)	153	QFITLIA	88
PROVIDA OB	191	QFITLIA PEN	88
PROVIGIL	206	QINLOCK	67
PROVOCHOLINE	123	QLOSI	130
PRO VOICE V8-V9 TEST STRIP	122	QNASL	127
PROZAC	196	QSYMIA (phentermine/topiramate)	71
prucalopride succinate (Motegrity)	143	QTERN	52
PUB INS SYRIN 0.3 ML 30GX1/2"	178	QUADRACEL	87
PUB INS SYRINGE 1 ML 30GX1/2"	178	QUAZEPAM	207

Index of Medications

QUDEXY XR (topiramate)	112	RANEXA (ranolazine).....	90
QUESTRAN	104	ranolazine	90
quetiapine	204	RAPAFLO.....	231
QUETIAPINE 150 MG TABLET	204	RAPAMUNE	157
quetiapine fumarate 25 mg tab (Seroquel).....	204	rasagiline.....	72, 73
quetiapine fumarate 50 mg tab (Seroquel).....	204	RASUVO.....	26
quetiapine fumarate 100 mg tab (Seroquel).....	204	RAVICTI.....	138
quetiapine fumarate 200 mg tab (Seroquel).....	204	RAYALDEE.....	224
quetiapine fumarate 300 mg tab (Seroquel).....	204	RAYA SURE PEN NEEDLE	171
quetiapine fumarate 400 mg tab (Seroquel).....	204	READI.....	124
QUFLORA FE	235	READYLANCE SAFETY LANCETS	166, 184
QUFLORA PED 0.5 MG CHEW TAB	235	REBIF	107
QUFLORA PED 0.5 MG/ML DROP	235	RECOMBINATE	88
QUFLORA PED 0.25 MG CHEW TAB	235	RECOMBIVAX.....	87
QUFLORA PED 0.25 MG/ML DROP	235	RECORLEV	147
QUFLORA PED 1 MG CHEW TAB	235	RECOTHROM.....	89
QUILLICHEW ER 20 MG CHEW TAB	202	RECTIV (nitroglycerin).....	144
QUILLICHEW ER 30 MG CHEW TAB	202	REFUAH PLUS	122
QUILLICHEW ER 40 MG CHEW TAB	202	REFUAH PLUS GLUCOSE CONTROL	162
QUILLIVANT XR	202	REGLAN	143
quinapril.....	95, 97	REGULAR BEVEL NEEDLES.....	171
quinapril/hydrochlorothiazide	95	RELAFEN DS	29
quinidine.....	90	RELAFEN (nabumetone).....	29
quinidine gluconate.....	90	RELAGARD (acetic acid/oxyquinoline).....	56
quinine sulfate	57	RELENZA.....	79
QUINTET	122	RELEUKO.....	115
QUINTET AC.....	122	RELEXII ER 18 MG TABLET (methylphenidate hcl).....	202
QULIPTA	20	RELEXII ER 27 MG TABLET (methylphenidate hcl).....	202
QUVIVQ	207	RELEXII ER 36 MG TABLET (methylphenidate hcl).....	202
QVAR REDHALER.....	34	RELEXII ER 45 MG TABLET	202
R		RELEXII ER 54 MG TABLET (methylphenidate hcl).....	202
rabeprazole	144, 146	RELEXII ER 63 MG TABLET	202
RABEPRAZOLE.....	146	RELEXII ER 72 MG TABLET	202
RADIAGEL.....	227	RELIAMED	166, 184
RADICAVA ORS 105 MG/5 ML SUSP.....	105	RELIAMED MINI LANCING DEVICE.....	162
RADICAVA ORS STARTER KIT SUSP	105	RELIAMED SAFETY SEAL LANCETS	167, 184
RADIOGARDASE	227	RELION CONFIRM-MICRO	122
RAGWITEK.....	83	RELION INS SYR 0.3 ML 29GX1/2"	178
RA INS SYR 0.5 ML 29GX1/2"	178	RELION INS SYR 0.3 ML 31GX6MM.....	178
RA INS SYR 0.5 ML 30GX5/16"	178	RELION INS SYR 0.5 ML 29GX1/2"	178
RA INS SYR 1 ML 29GX1/2"	178	RELION INS SYR 0.5 ML 31GX6MM.....	178
RA INS SYRINGE 1 ML 30GX5/16"	178	RELION INS SYR 1 ML 29GX1/2"	178
ra isopropyl alcohol 70%.....	229	RELION INS SYR 1 ML 31GX5/16"	178
ra isopropyl alcohol 91%.....	229	RELION INS SYR 1 ML 31GX15/64"	178
RALDESY	197	RELION INSULIN SYR 0.5 ML	178
raloxifene hcl (Evista)	230	RELION PRIME TEST STRIPS	122
ramelteon (Rozerem)	206	RELION SYRING 0.3 ML 31GX5/16"	178
ramipril.....	97, 98	RELION SYRING 0.5 ML 31GX5/16"	178

Index of Medications

RELION TRUE METRIX TEST STRIP	122	RIGHTEST GS550 TEST STRIP	122
RELISTOR	45	RIGHTEST GT333 TEST STRIP	123
RELPAK	20	RILUTEK	106
RELTONE	141	riluzole.....	106
REMERON.....	193	rimantadine	79
REMICADE	60	RIMSO-50.....	24
RENACIDIN	137	ringer's.....	208
RENVELA	134	RINVOQ.....	27
repaglinide	51	RIOMET.....	51
REPATHA.....	102	risedronate	230
REQ49+	233	risedronate sodium.....	230
RESPA A.R. (pseudoephed/chlor-mal/bell alk).....	117	risedronate sodium (Actonel).....	230
RESTASIS	132	risedronate sodium (Atelvia)	230
RESTASIS (cyclosporine).....	132	RISPERDAL	204
RESTORA RX	138	risperidone.....	204
RESTORIL (temazepam).....	207	RITALIN LA 10 MG CAPSULE (methylphenidate hcl).....	202
RETACRIT	114	RITALIN LA 20 MG CAPSULE (methylphenidate hcl).....	202
RETEVMO	67	RITALIN LA 30 MG CAPSULE (methylphenidate hcl).....	202
RETEVMO 40 MG TABLET.....	67	RITALIN LA 40 MG CAPSULE (methylphenidate hcl).....	202
RETEVMO 80 MG TABLET.....	67	RITALIN (methylphenidate hcl).....	202
RETEVMO 120 MG TABLET.....	67	RITEFLO.....	187
RETEVMO 160 MG TABLET.....	67	ritonavir.....	77
RETIN	218, 219	rivaroxaban (Xarelto)	43
RETROVIR	76	rivastigmine	81
REVATIO.....	93	RIVFLOZA 80 MG/0.5 ML VIAL	227
REVEAL TEST STRIP	122	RIVFLOZA 128 MG/0.8 ML SYRINGE	227
REVLIMID	64	RIVFLOZA 160 MG/ML SYRINGE	227
REVUFORJ	67	rizatriptan benzoate.....	20
REVUFORJ 25 MG TABLET.....	67	R-NATAL OB	192
REVUFORJ 110 MG TABLET.....	67	ROBINUL.....	138
REXTOVY	46	ROCKLATAN.....	130
REXULTI	205	roflumilast.....	34
REYATAZ	77	ROLVEDON.....	115
REYVOW.....	20	ROMVIMZA	67
REZDIFFRA.....	224	ropinirole.....	73
REZLIDHIA	69	rosuvastatin.....	102, 103
REZUROCK.....	231	ROSUVASTATIN-EZETIMIBE.....	101
REZVOGLAR KWIKPEN.....	56	Roszet.....	101
RHOPRESSA.....	130	ROTARIX.....	84
ribavirin	80	ROTATEQ.....	84
RIDAURA	26	ROWASA.....	141
rifabutin.....	37	ROXICODONE (oxycodone hcl)	24
rifampin.....	37	ROXYBOND.....	24
RIGHTEST CONTROL SOLUTION.....	162	ROZEREM (ramelteon).....	206
RIGHTEST GD500	162	ROZLYTREK.....	67
RIGHTEST GL300 LANCETS	167, 184	RUBRACA	67
RIGHTEST GS100 TEST STRIP	122	RUCONEST.....	225
RIGHTEST GS300 TEST STRIP	122	rufinamide	109

Index of Medications

rufinamide 40 mg/ml suspension (Banzel).....	112	SECURESAFE INSULIN SYRINGE.....	178
rufinamide 200 mg tablet (Banzel).....	112	SECURESAFE PEN NEEDLE.....	171
rufinamide 400 mg tablet (Banzel).....	112	SEGLUROMET.....	53
RUKOBIA.....	76	SELARSDI.....	154
RYALTRIS.....	127	SELECT-OB.....	191
RYBELSUS.....	50	SELECT-OB + DHA.....	191
RYBREVANT.....	62	SELECT-OB (prenatal vit 128/iron/folic ac).....	191
RYCLORA.....	49	selegiline.....	73
RYDAPT.....	67	selenium.....	211
RYTARY.....	73	SELZENTRY.....	76
RYVENT.....	49	SEMGLEE.....	56
S		SEMGLEE (YFGN) PEN.....	56
SABRIL (vigabatrin).....	112	SENSIPAR (cinacalcet hcl).....	225
sacubitril/valsartan (Entresto).....	96	SEREVENT DISKUS.....	31
SAFE-CLIP.....	162	SERNIVO.....	217
SAFESNAP INSULIN SYRINGE.....	178	SEROQUEL.....	204
SAFETY.....	164	SEROSTIM.....	151
SAFETYGLIDE INSULIN SYRINGE.....	178	sertraline.....	196, 197
SAFETYGLIDE NEEDLE.....	171	sertraline 150 mg capsule.....	196
SAFETYGLIDE SYRINGE.....	178	sertraline 200 mg capsule.....	196
SAFETY LANCETS.....	167, 184	sevelamer.....	134
SAFETY-LET.....	167, 184	sevoflurane.....	25
SAFETY PEN NEEDLE.....	171	SEYSARA.....	41
SAFETY SEAL LANCETS.....	167, 184	SFROWASA.....	141
SAFYRAL (drospir/eth estra/levomefol ca).....	116	SHINGRIX.....	87
SALAGEN.....	83	SHORT BEVEL NEEDLES.....	171
salsalate.....	25	SIDESTREAM PEDIATRIC.....	187
SAMSCA.....	125	SIGNIFOR.....	153
SANCUSO.....	140	SIGNIFOR LAR.....	153
SANDIMMUNE.....	157	SIKLOS.....	89
SANDOSTATIN.....	153	sildenafil.....	93, 223, 224
SANDOSTATIN LAR DEPOT (octreotide acetate,mi-spheres).....	153	SILENOR.....	207
SANTYL.....	218	SILICONE MASK-INFANT.....	188
SAPHRIS.....	204	SILICONE MASK-PEDIATRIC.....	188
sapropterin.....	228	SILIQ.....	209
SAVAYSA.....	43	silodosin.....	231
SAVELLA.....	230	SIL-SERTER.....	162
saxagliptin hcl (Onglyza).....	51	SILVADENE (silver sulfadiazine).....	43
saxagliptin-metformin er 5-500 (Kombiglyze Xr).....	52	silver.....	43, 218
saxagliptin-metformn er 5-1000 (Kombiglyze Xr).....	52	silver nitrate.....	213
saxagliptn-metform er 2.5-1000 (Kombiglyze Xr).....	52	SIMBRINZA.....	130
SAXENDA.....	71	SIMLANDI(CF) 20 MG/0.2 ML SYRG.....	60
SCALACORT DK.....	217	SIMLANDI(CF) 40 MG/0.4 ML SYRG.....	60
SCEMBLIX 20 MG TABLET.....	67	SIMLANDI(CF) 80 MG/0.8 ML SYRG.....	60
SCEMBLIX 40 MG TABLET.....	67	SIMLANDI(CF) AI 40 MG/0.4 ML.....	60
SCEMBLIX 100 MG TABLET.....	67	SIMLANDI(CF) AI 80 MG/0.8 ML.....	60
scopolamine.....	140	SIMPLERA SENSOR.....	162
SECUADO.....	204	SIMPLERA SYNC SENSOR.....	162

Index of Medications

SIMPLI PEN NEEDLE.....	171	sodium chloride 0.9% irrig.....	208
SIMPONI 50 MG/0.5 ML PEN INJEC.....	60	sodium chloride 0.9% irrig.....	208
SIMPONI 50 MG/0.5 ML SYRINGE.....	60	SODIUM CHLORIDE 0.9% IRRIG.....	208
SIMPONI 100 MG/ML PEN INJECTOR.....	60	sodium chloride 0.9% prcss sol.....	208
SIMPONI 100 MG/ML SYRINGE.....	60	sodium chloride 3% vial.....	226
SIMPONI ARIA.....	60	sodium chloride 7% vial.....	226
simvastatin.....	101, 103	sodium chloride 10% vial.....	226
SINEMET.....	73	sodium chloride for inhalation.....	226
SINGLE-LET.....	167, 184	sodium chloride irrig solution.....	208
SINGLE USE SWAB.....	208, 212	sodium chloride/nahco3/kcl/peg.....	144
SINGULAIR.....	34	SODIUM CITRATE.....	43
sirolimus.....	157	sodium fluoride.....	132, 133
SIRTURO.....	37	sodium fluoride 0.2% rinse (Prevident).....	135
SITAGLIPTIN.....	51, 52	sodium fluoride 0.5 mg (1.1 mg).....	133, 136
SITAGLIPTIN-METFO ER 50-500,100-1,000.....	52	sodium fluoride 0.5 mg/ml drop.....	133, 136
SITAGLIPTIN-METFOR ER 50-1,000.....	52	sodium fluoride 0.25 (0.55) mg.....	133, 136
SITAVIG.....	79	sodium fluoride 1.1% cream (Prevident 5000 Plus).....	135
SITZMARKS.....	124	sodium fluoride 1.1% gel (Prevident).....	133, 135
SIVEXTRO.....	39	sodium fluoride 1 mg (2.2 mg).....	133, 136
SKYCLARYS.....	227	sodium fluoride 5000 ppm paste.....	133, 135
SKYLA.....	117	sodium fluoride/potassium nit.....	133
SKYRIZI.....	209	SODIUM OXYBATE.....	206
SKYRIZI ON-BODY.....	155	sodium phenylbutyrate.....	138
SKYRIZI PEN.....	209	sodium polystyrene.....	134
SKY SAFETY PEN NEEDLE.....	171	sodium, potassium,mag sulfates (Suprep).....	144
SKYTROFA.....	151	sod, pot chlor/mag/sod, pot phos.....	208
SLYND.....	116	sod/pot/k cit/sod cit/cit acid.....	137
SMARTDIABETES VANTAGE.....	162	SOFDRA.....	214
SMARTEST.....	162	SOFOSBUVIR.....	79
SMARTEST LANCET.....	167, 184	SOGROYA.....	151
SMARTEST TEST.....	123	SOHONOS.....	228
SMART SENSE.....	167, 184	solifenacin.....	232
SMART SENSE LANCETS.....	167, 184	SOLQUA.....	50
SMART SENSE TEST STRIPS.....	123	SOLODYN.....	41
SM INS SYR 0.5 ML 29GX1/2".....	178	SOLOSEC.....	36
SM INS SYR 0.5 ML 30GX5/16".....	178	SOLTAMOX.....	70
SM INS SYR 1 ML 29GX1/2".....	179	SOLUS V2.....	167, 184
SM INS SYRING 0.3 ML 30GX5/16".....	179	SOLUS V2 CONTROL SOLUTION.....	163
SM INS SYRINGE 1 ML 28GX1/2".....	179	SOLUS V2 LANCETS.....	167, 184
SM INS SYRINGE 1 ML 30GX5/16".....	179	SOLUS V2 LANCING DEVICE.....	163
SM INSULIN SYR 0.3 ML 29GX1/2".....	179	SOLUS V2 TEST STRIPS.....	123
SM INSULIN SYR 0.5 ML 28GX1/2".....	179	SOMA.....	189
SM INSULIN SYR 1 ML 31GX5/16".....	179	SOMATULINE.....	153
SM INSUL SYR 0.3 ML 31GX5/16".....	179	SOMAVERT.....	224
SM INSUL SYR 0.5 ML 31GX5/16".....	179	SOOLANTRA (ivermectin).....	213
sm isopropyl alcohol 70%.....	229	sorafenib tosylate (Nexavar).....	67
SOAAZ.....	126	SORBITOL.....	209
sodium chloride 0.9% inhal vl.....	226	SORILUX.....	211

Index of Medications

sotalol.....	99, 100	STRATTERA 10 MG CAPSULE (atomoxetine hcl).....	202
SOTYKTU	209	STRENSIQ	226
SOTYLIZE	100	STRIBILD	78
SOVALDI	79	STRIVERDI.....	31
SOVUNA	57	STROMECTOL	56
SPACE CHAMBER.....	187, 188	STROVITE FORTE (multivit,iron,min 5/folic acid)	234
SPECIALTY USE NEEDLES	171	STROVITE ONE.....	234
SPEVIGO	209	SUBOXONE	231
SPIKEVAX 2023-2024.....	84	subvenite 25 mg tablet (Lamictal)	112
SPIKEVAX 2024-2025	84	subvenite 100 mg tablet (Lamictal)	112
SPIKEVAX 2025-2026 (6M-11Y)	84	subvenite 150 mg tablet (Lamictal)	112
SPIKEVAX 2025-2026 (12Y UP)	84	subvenite 200 mg tablet (Lamictal)	112
SPIKEVAX COVID (18Y UP) VACC	84	SUCRAID.....	142
spinosad.....	72	sucralfate.....	140
SPIRIVA HANDIHALER 18 MCG CAP (tiotropium bromide)	30	SUFLAVE.....	144
SPIRIVA RESPIMAT	30	SULAR	92
spironolact	126	SULCONAZOLE.....	48
spironolactone	126	sulfacetamide	35, 43, 210, 211
spironolactone 25 mg/5 ml susp (Carospir)	126	sulfacetamide/prednisolone sp.....	35
spironolactone 25 mg tablet (Aldactone).....	126	sulfadiazine.....	36, 43
spironolactone 50 mg tablet (Aldactone).....	126	sulfamethoxazole/trimethoprim.....	36
spironolactone 100 mg tablet (Aldactone)	126	sulfamethoxazole/trimethoprim (Bactrim)	36
SPORANOX.....	47	SULFAMYLON.....	43
SPRAVATO.....	193	sulfasalazine (Azulfidine)	142
SPRITAM.....	112	sulindac.....	29
SPRIX.....	21	sumatriptan	20
SPRYCEL 20 MG TABLET (dasatinib)	68	sumatriptan 4 mg/0.5 ml inject (Imitrex)	20
SPRYCEL 50 MG TABLET (dasatinib)	68	sumatriptan 6 mg/0.5ml autoinj (Imitrex)	20
SPRYCEL 70 MG TABLET (dasatinib)	68	sumatriptan 6 mg/0.5 ml vial	20
SPRYCEL 80 MG TABLET (dasatinib)	68	sumatriptan succ 25 mg tablet (Imitrex).....	20
SPRYCEL 100 MG TABLET (dasatinib)	67	sumatriptan succ 50 mg tablet (Imitrex).....	20
SPRYCEL 140 MG TABLET (dasatinib)	68	sumatriptan succ 100 mg tablet (Imitrex).....	20
sps	134	sumatriptan succ/naproxen sod (Treximet)	20
SSKI	135	sunitinib malate (Sutent)	68
STALEVO.....	73	SUNLENCA	74
stavudine.....	76	SUNOSI.....	206
STEGLATRO.....	53	SUPER THIN LANCETS	167, 184
STEGLUJAN.....	52	SUPRANE.....	25
STELARA.....	154	SUPREP (sodium, potassium,mag sulfates)	144
Stendra.....	223	SURE COMFORT	171, 179
STENDRA.....	223	SURE COMFORT ALCOHOL	208, 212
STEQEYMA	155	SURE COMFORT INSULIN SYRINGE.....	179
STERILANCE TL.....	167, 184	SURE COMFORT LANCETS	167, 184
STERILE LANCETS	167, 184	SURE COMFORT LANCING PEN	163
STIMUFEND.....	114	SURE COMFORT PEN NEEDLE.....	171
STIOLTO RESPIMAT	31	SURE COMFORT SAFETY PEN NEEDLE	171
STIVARGA.....	68	SURE-FINE PEN NEEDLES.....	171
STRATTERA.....	202	SUREFLEX.....	163

Index of Medications

SURE-JECT INS 0.3 ML 31GX5/16"	179	TAGITOL V	124
SURE-JECT INS 0.5 ML 31GX5/16"	179	TAGRISSO	68
SURE-JECT INSULIN SYRINGE	179	TAKHZYRO	83
SURE-LANCE	167, 184	TALICIA	140
SURE-PEN	163	TALTZ	209
SURE-PREP ALCOHOL PREP PADS	208, 212	TALZENNA 0.1 MG CAPSULE	68
SURE-TEST EASYPLUS MINI SOLN	163	TALZENNA 0.1 MG SOFTGEL	68
SURE-TEST EASYPLUS MINI STRIP	123	TALZENNA 0.5 MG CAPSULE	68
SURE-TOUCH	167, 184	TALZENNA 0.5 MG SOFTGEL	68
SURGICEL	89	TALZENNA 0.25 MG CAPSULE	68
SURGIFOAM	89	TALZENNA 0.25 MG SOFTGEL	68
SURVANTA	222	TALZENNA 0.35 MG SOFTGEL	68
SUTAB	144	TALZENNA 0.75 MG SOFTGEL	68
SUTENT (sunitinib malate)	68	TALZENNA 1 MG CAPSULE	68
swan isopropyl alcohol 70%	229	TALZENNA 1 MG SOFTGEL	68
SYMAX	141	TAMIFLU	79
SYMBICORT 80-4.5 MCG INHALER (budesonide/formoterol fumarate)	33	tamoxifen citrate	70
SYMBICORT 160-4.5 MCG INHALER (budesonide/formoterol fumarate)	33	tamsulosin hcl	231
SYMBRAVO	20	TANDEM PLUS (multivit no.18/iron no.1/folic)	234
SYMDEKO	221	TAPERDEX	151
SYMFI	78	TARGADOX (doxycycline hyclate)	41
SYMLINPEN	50	TARGRETIN	60
SYMPAZAN	108	TARGRETIN 1% GEL (bexarotene)	70
SYMPROIC	45	TARPEYO	151
SYMITUZA	75	TASCENSO ODT	107
SYNALAR	42, 217	TASIGNA (nilotinib hcl)	68
SYNALAR (fluocinolone acetonide)	217	tasimelteon (Hetlioz)	206
SYNALAR TS	217	TASMAR	73
SYNAREL	152	tavaborole	48
SYNDROS	139	TAVALISSE	222
SYNERA	25	TAVNEOS	88
SYNJARDY	53	TAYTULLA (norethindrone-e.estradiol-iron)	116
SYNTHROID (levothyroxine sodium)	221	tazarotene 0.1% cream (Tazorac)	211
SYPRINE	227	TAZAROTENE 0.1% FOAM	214
SYRINGE	45, 89, 102, 107, 133, 155, 209	tazarotene 0.1% gel (Tazorac)	211
syringe and needle,insulin,1ml	179	tazarotene 0.05% cream (Tazorac)	211
syringe-needle,insulin,0.5 ml	179	tazarotene 0.05% gel (Tazorac)	211
syring-needl,disp,insul,0.3 ml	179	TAZORAC 0.1% CREAM (tazarotene)	211
T		TAZORAC 0.1% GEL (tazarotene)	211
TABLOID	62	TAZORAC 0.05% CREAM (tazarotene)	211
TABRECTA	68	TAZORAC 0.05% GEL (tazarotene)	211
TACLONEX (calcipotriene/betamethasone)	218	TAZVERIK	63
tacrolimus	156, 157	TC99M	123
tadalafil	93, 223, 224	TDVAX	87
TADLIQ	93	TECFIDERA	107
TAFINLAR	62	TECHLITE INSULIN SYRINGE	179
TAFINLAR 50 MG CAPSULE	62	TECHLITE LANCETS	167, 184
TAFINLAR 75 MG CAPSULE	62	TECHLITE PEN NEEDLE	171
tafluprost/pf (Zioptan)	130	TECHLITE PLUS PEN NEEDLE	171

Index of Medications

TEGLUTIK.....	106	THALOMID.....	37
TEGRETOL (carbamazepine).....	112	THEO-24.....	34
TEGRETOL XR (carbamazepine).....	112	theophylline.....	34
TEKTRUNA.....	101	THIN.....	124
TELCARE CONTROL SOLUTION.....	163	THIN LANCETS.....	167, 185
TELCARE TEST STRIPS.....	123	THINPRO INSULIN SYRINGE.....	179
TELCARE ULTRA THIN 30G LANCETS.....	167, 184	THIN WALL NEEDLES.....	171
telmisartan.....	96, 97, 98	THIOLA EC (tiopronin).....	232
telmisartan-hctz.....	96, 97	THIOLA (tiopronin).....	232
temazepam (Restoril).....	207	thioridazine.....	206
TEMBEXA.....	79	thiothixene.....	205
TEMOVATE (clobetasol propionate).....	217	THRIVITE RX.....	191
temozolomide.....	61	THROMBI.....	89
TENIVAC.....	87	THROMBI-GEL (thrombin/cal/cmc/gel/dress,hem).....	89
tenofovir.....	77	THROMBIN.....	89
TENORETIC.....	100	THYQUIDITY.....	221
TENORMIN.....	100	thyroid.....	221
TEPMETKO.....	68	THYROID.....	220
terazosin.....	96	tiagabine hcl 2 mg tablet.....	112
terbinafine.....	47	tiagabine hcl 4 mg tablet.....	112
terbutaline.....	30	tiagabine hcl 12 mg tablet.....	112
terconazole.....	46	tiagabine hcl 16 mg tablet.....	112
teriflunomide.....	106, 107	TIAZAC (diltiazem hcl).....	92
teriparatide (Bonsity).....	229	TIBSOVO.....	69
teriparatide (Forteo).....	229	ticagrelor (Brilinta).....	74
TERUMO INS SYR 0.3 ML 29GX1/2".....	179	TIGLUTIK.....	106
TERUMO INSULIN SYRINGE.....	179	TIKOSYN.....	90
TERUMO SURGUARD2.....	171	timolol.....	100, 130, 131
TESTIM.....	147	timolol (Betimol).....	131
TEST N'GO.....	123	timolol maleate/pf.....	131
testosterone.....	147, 148, 149	TIMOPTIC.....	131
TESTOSTERONE.....	147, 148	TIMOPTIC OCUDOSE (timolol maleate/pf).....	131
testosterone 12.5 mg/1.25 gram.....	148	tinidazole.....	56
testosterone 50 mg/5 gram gel (Testim).....	148	tiopronin 100 mg tablet (Thiola).....	232
testosterone 50 mg/5 gram gel (Vogelxo).....	148	tiopronin dr 100 mg tablet (Thiola Ec).....	232
testosterone cypionate.....	148	tiopronin dr 300 mg tablet (Thiola Ec).....	232
testosterone cypionate (Depo-Testosterone).....	148	tiopronin (Thiola Ec).....	232
testosterone enanthate.....	148	tiotropium 18 mcg cap-inhaler (Spiriva Handihaler).....	30
TEST STRIPS.....	123	TIROSINT.....	221
tetrabenazine.....	106	TISSEEL.....	214
tetracaine.....	129	TIVDAK.....	69
TETRACAINE HCL.....	129	TIVICAY.....	77
tetracycline.....	41	TIVORBEX.....	29
TEXACORT.....	217	tizanidine.....	189
TEZRULY.....	96	tizanidine hcl 2 mg capsule (Zanaflex).....	189
TEZSPIRE 210 MG/1.91 ML PEN.....	222	tizanidine hcl 2 mg tablet.....	189
TEZSPIRE 210 MG/1.91 ML SYRING.....	222	tizanidine hcl 4 mg capsule (Zanaflex).....	189
THALITONE.....	127	tizanidine hcl 4 mg tablet (Zanaflex).....	189

Index of Medications

tizanidine hcl 6 mg capsule (Zanaflex)	189	TOUJEO	56
TLANDO	148	TOVIAZ ER 4 MG TABLET (fesoterodine fumarate)	233
TOBI	36	TOVIAZ ER 8 MG TABLET (fesoterodine fumarate)	233
TOBI (tobramycin in 0.225% sod chlor)	36	TRACLEER	94
TOBRADEX	35	TRADJENTA	51
tobramycin	35, 36	TRAMADOL	24
tobramycin/dexamethasone	35	tramadol er	24
TOBRAMYCIN PAK 300 MG/5 ML	36	tramadol hcl	24
TOBREX	36	TRAMADOL HCL	24
tolcapone	73	TRAMADOL HCL 5 MG/ML SOLUTION	24
TOLECTIN	29	TRAMADOL HCL 25 MG/5 ML CUP	24
tolmetin sodium	29	tramadol hcl 50 mg tablet	24
tolmetin sodium (Tolectin 600)	29	tramadol hcl 100 mg tablet	24
TOLSURA	47	tramadol hcl/acetaminophen	22
tolterodine	232, 233	trandolapril	94, 98
tolvaptan	125	tranexamic acid	88
tolvaptan 15 mg-15 mg tablet (Jynarque)	126	TRANSDERM	140
tolvaptan 15 mg tablet (Jynarque)	126	TRANSFER NEEDLE	171
tolvaptan 15 mg tablet (Samsca)	125	tranylcypromine	194
tolvaptan 30 mg-15 mg tablet (Jynarque)	126	TRAVATAN	131
tolvaptan 30 mg tablet (Jynarque)	126	travoprost	131
tolvaptan 45 mg-15 mg tablet (Jynarque)	126	trazodone	197
tolvaptan 60 mg-30 mg tablet (Jynarque)	126	TRELEGY ELLIPTA 100-62.5-25	33
tolvaptan 90 mg-30 mg tablet (Jynarque)	126	TRELEGY ELLIPTA 200-62.5-25	33
TOPAMAX (topiramate)	112	TREMFYA	155
TOPCARE CLICKFINE	171	TREMFYA 100 MG/ML PEN	155
TOPCARE ULTRA COMFORT	179	TREMFYA 200 MG/2 ML PEN	155
TOPCARE UNIVERSAL 1 LANCET	167, 185	TREMFYA ONE-PRESS	155
TOPCARE UNIVERSAL 1 THIN LANCET	167, 185	TREMFYA PEN INDUCTION (2 PEN)	155
TOPICORT (desoximetasone)	217	TRESIBA	56
topiramate 15 mg sprinkle cap (Topamax)	112	tretinoin	69, 210, 218, 219
topiramate 25 mg/ml solution (Eprontia)	112	TREXALL	62
topiramate 25 mg sprinkle cap (Topamax)	112	TREXIMET (sumatriptan succ/naproxen sod)	21
topiramate 25 mg tablet (Topamax)	112	TREZIX	22
topiramate 50 mg sprinkle cap	112	triamcinolone	223
TOPIRAMATE 50 MG SPRINKLE CAP	112	triamcinolone 0.1% cream	217
topiramate 50 mg tablet (Topamax)	112	triamcinolone 0.1% lotion	217
topiramate 100 mg tablet (Topamax)	112	triamcinolone 0.1% ointment	217
topiramate 200 mg tablet (Topamax)	112	triamcinolone 0.1% paste	223
topiramate er 25 mg capsule (Trokendi Xr)	113	triamcinolone 0.5% cream	217
topiramate er 50 mg capsule (Trokendi Xr)	113	triamcinolone 0.05% ointment	217
topiramate er 100 mg capsule (Trokendi Xr)	113	triamcinolone 0.025% cream	217
topiramate er 200 mg capsule (Trokendi Xr)	113	triamcinolone 0.025% lotion	217
topiramate (Qudexy Xr)	112	triamcinolone 0.025% oint	217
TOPROL	100	triamcinolone 0.147 mg/g spray (Kenalog)	217
toremifene	70	triamcinolone acetonide	217
torsemide	126	triamterene (Dyrenium)	126
TOSYMRA	21	triamterene/hydrochlorothiazid	126

Index of Medications

triazolam	207	TRUE COMFORT SAFE INSULIN SYRG	179
triazolam (Halcion)	207	TRUE COMFORT SAFETY LANCET	167, 185
TRIBENZOR	96	TRUE COMFORT SAFETY PEN NEEDLE	171
TRICARE	191	TRUECONTROL	163
trichloroacetic	214	TRUEDRAW	163
TRICHLOROACETIC	214	TRUE METRIX	163
TRICHLOROACETIC ACID (trichloroacetic acid)	214	TRUE METRIX GLUCOSE TEST STRIP	123
TRICOR (fenofibrate nanocrystallized)	105	TRUEPLUS INSULIN SYRINGE	179
TRIDESILON (desonide)	217	TRUEPLUS KETONE TEST STRIP	125
trientine	227	TRUEPLUS LANCET	167, 185
trientine hcl 250 mg capsule (Syprine)	227	TRUEPLUS LANCETS	167, 185
TRIENTINE HCL 500 MG CAPSULE	227	TRUEPLUS PEN NEEDLE	172
trifluoperazine	206	TRUETEST TEST STRIPS	123
trifluridine	78	TRUETRACK TEST STRIP	123
trihexyphenidyl	72	TRULANCE	143
TRIJARDY XR 5-2.5-1,000 MG TAB	54	TRULICITY	50
TRIJARDY XR 10-5-1,000 MG TAB	54	TRUMENBA	85
TRIJARDY XR 12.5-2.5-1,000 MG	54	TRUQAP	68
TRIJARDY XR 25-5-1,000 MG TAB	54	TRUVADA (emtricitabine/tenofovir (tdf))	75
TRIKAFTA 50-25-37.5 MG/75 MG	221	TRYNGOLZA	102
TRIKAFTA 80-40-60MG/59.5MG PKT	221	TRYPTYR	132
TRIKAFTA 100-50-75 MG/75MG PKT	221	TRYVIO	101
TRIKAFTA 100-50-75 MG/150 MG	221	TUDORZA PRESSAIR 400 MCG INHAL	30
TRILEPTAL (oxcarbazepine)	113	TUKYSA	68
trimethobenzamide	140	TURALIO	68
trimethoprim	36, 37	TUXARIN	118
trimipramine	199	TUZISTRA	118
TRIMO-SAN	56	TWIIST REFILL KT (CSST-NDL-SYR)	163
TRINAZ	192	TWIIST RFL (INFUS-CSST-NDL-SYR)	163
TRINTELLIX	198	TWIIST STARTER KIT	163
TRISTART DHA	191	TWINRIX	87
TRIUMEQ	75	TWIRLA	116
TRI-VI-FLOR	235	TWIST LANCETS	167, 185
TROKENDI XR 25 MG CAPSULE (topiramate)	113	TWIST TOP LANCET	167, 185
TROKENDI XR 50 MG CAPSULE (topiramate)	113	TWYNEO	210
TROKENDI XR 100 MG CAPSULE (topiramate)	113	TYBLUME	116
TROKENDI XR 200 MG CAPSULE (topiramate)	113	TYBOST	221
tropicamide	131	TYENNE	155
tropium	233	TYENNE AUTOINJECTOR	155
tropium chloride	233	TYKERB (lapatinib ditosylate)	68
TRUDHESA	21	TYMLOS	154
TRUE COMFORT ALCOHOL PADS	208, 212	TYRVAYA	224
TRUE COMFORT INSULIN SYRINGE	179	TYVASO	94
TRUE COMFORT LANCET	167, 185	TYVASO DPI	94
TRUE COMFORT PEN NEEDLE	171	TYVASO INSTITUTIONAL START KIT	94
TRUE COMFORT PRO ALCOHOL PADS	208, 212	TYVASO REFILL KIT	94
TRUE COMFORT PRO INS SYRINGE	179	TYVASO STARTER KIT	94
TRUE COMFORT PRO PEN NEEDLE	171		

Index of Medications

U

UBRELVY.....	21	ULTRACARE PEN NEEDLE.....	172
UCERIS 2 MG RECTAL FOAM (budesonide).....	147	ULTRA COMFORT.....	180
UCERIS 9 MG ER TABLET (budesonide).....	151	ULTRA-FINE INSULIN SYRINGE.....	180
UDAMIN SP.....	234	ULTRA-FINE MICRO PEN NEEDLE.....	172
UDENYCA.....	114	ULTRA-FINE MINI PEN NEEDLE.....	172
UDENYCA AUTOINJECTOR.....	114	ULTRA-FINE NANO PEN NEEDLE.....	172
UDENYCA ONBODY.....	114	ULTRA-FINE ORIGINAL PEN NEEDLE.....	172
UKONIQ.....	68	ULTRA-FINE PEN NEEDLE.....	172
ULESFIA.....	72	ULTRA-FINE SHORT PEN NEEDLE.....	172
ULORIC.....	27	ULTRA FLO INSULIN SYRINGE.....	180
ULTANE.....	25	ULTRA FLO PEN NEEDLE.....	172
ULTICARE INS SYR 1 ML 31GX5/16".....	179	ULTRAFOAM.....	89
ULTICARE.....	179	ULTRALANCE.....	168, 185
ULTICARE INS SAFETY 1ML 29X1/2.....	179	ULTRA THIN.....	172
ULTICARE INS SYR 1 ML 28GX1/2".....	179	ULTRA-THIN II 1 ML 31GX5/16".....	180
ULTICARE INS SYR 1 ML 29GX1/2".....	179	ULTRA-THIN II 28G LANCETS.....	168, 185
ULTICARE INSULIN SYRINGE.....	179	ULTRA-THIN II 30G LANCETS.....	168, 185
ULTICARE PEN NEEDLE.....	172	ULTRA-THIN II INS 0.3 ML 30G.....	180
ULTICARE SAFETY 0.5 ML 29GX1/2.....	179	ULTRA-THIN II INS 0.3 ML 31G.....	180
ULTICARE SAFETY PEN NEEDLE.....	172	ULTRA-THIN II INS 0.5 ML 29G.....	180
ULTICARE SYR 0.3 ML 30GX5/16".....	179	ULTRA-THIN II INS 0.5 ML 30G.....	180
ULTICARE SYR 0.3 ML 31GX5/16".....	180	ULTRA-THIN II INS 0.5 ML 31G.....	180
ULTICARE SYR 0.5 ML 29GX1/2".....	180	ULTRA-THIN II INS SYR 1 ML 29G.....	180
ULTICARE SYR 0.5 ML 30GX5/16".....	180	ULTRA-THIN II INS SYR 1 ML 30G.....	180
ULTICARE SYR 0.5 ML 31GX5/16".....	180	ULTRA-THIN II PEN NDL 29GX1/2".....	172
ULTICARE SYR 1 ML 30GX5/16".....	180	ULTRA-THIN II PEN NDL 31GX5/16.....	172
ULTICARE SYRIN 0.3 ML 29GX1/2".....	180	ULTRA THIN LANCET.....	167, 185
ULTICARE SYRIN 0.5 ML 28GX1/2".....	180	ULTRA THIN LANCETS.....	167, 185
ULTIGUARD SAFE0.3ML 30G 12.7MM.....	180	ULTRA THIN PLUS LANCETS.....	168, 185
ULTIGUARD SAFE0.5ML 30G 12.7MM.....	180	ULTRATLC LANCETS.....	168, 185
ULTIGUARD SAFE 1ML 30G 12.7MM.....	180	ULTRATRAK CONTROL SOL NORMAL.....	163
ULTIGUARD SAFEPAK 1ML 31G 8MM.....	180	ULTRATRAK CONTROL SOLUTION.....	163
ULTIGUARD SAFEPAK-PEN NEEDLE.....	172	ULTRATRAK TEST STRIP.....	123
ULTIGUARD SAFEPK 0.3ML 31G 8MM.....	180	ULTRATRAK ULTIMATE CNTRL SOLN.....	163
ULTIGUARD SAFEPK 0.5ML 31G 8MM.....	180	ULTRATRAK ULTIMATE TEST STRIPS.....	123
ULTI-LANCE.....	163	ULTRAVATE.....	217
ULTILET ALCOHOL SWAB.....	208, 212	UMECLIDINIUM.....	31
ULTILET BASIC.....	167, 185	UNDECATREX.....	148
ULTILET CLASSIC.....	167, 185	UNIFINE.....	169, 170
ULTILET INSULIN SYRINGE.....	180	UNIFINE PEN NEEDLE.....	172
ULTILET LANCETS.....	167, 185	UNIFINE PENTIPS.....	172
ULTILET PEN NEEDLE.....	172	UNIFINE PENTIPS MAXFLOW.....	172
ULTILET SAFETY.....	167, 185	UNIFINE PENTIPS PLUS.....	172
ULTIMA.....	123	UNIFINE PENTIPS PLUS MAXFLOW.....	172
ULTRA.....	31, 170	UNIFINE PROTECT.....	172
ULTRACARE INSULIN SYRINGE.....	180	UNIFINE SAFECONTROL PEN NEEDLE.....	172
ULTRA-CARE LANCETS.....	168, 185	UNIFINE ULTRA PEN NEEDLE.....	172
		UNILET.....	163

Index of Medications

UNILET COMFORTOUCH	168, 185	VALCYTE	79
UNILET EXCELITE	168, 185	valganciclovir	79
UNILET EXCELITE II	168, 185	VALIUM	193
UNILET GP LANCET	168, 185	valproic acid	113
UNILET LANCET	168, 185	valproic acid (as sodium salt)	113
UNILET LANCETS	168, 185	valsartan	96, 97, 98
UNISTIK 2	163	valsartan 20 mg/5 ml solution	98
UNISTIK 2 COMFORT	168, 185	VALSARTAN 20 MG/5 ML SOLUTION	98
UNISTIK 2 EXTRA	168, 185	valsartan 40 mg tablet (Diovan)	98
UNISTIK 2 NORMAL	168, 185	valsartan 80 mg tablet (Diovan)	98
UNISTIK 3	168, 185	valsartan 160 mg tablet (Diovan)	98
UNISTIK 3 COMFORT	168, 185	valsartan 320 mg tablet (Diovan)	98
UNISTIK 3 DUAL	168, 185	valsartan/hydrochlorothiazide	97
UNISTIK 3 EXTRA	168, 186	VALTOCO	108
UNISTIK 3 NORMAL	168, 186	VALTrex (valacyclovir hcl)	79
UNISTIK COMFORT	168, 186	VANCOCIN	42
UNISTIK CZT	168, 186	vancomycin	42
UNISTIK EXTRA	168, 186	vancomycin 25 mg/ml oral soln	42
UNISTIK NORMAL	168, 186	VANCOMYCIN 25 MG/ML ORAL SOLN	42
UNISTIK PRO	168, 186	vancomycin 50 mg/ml oral soln (Firvanq)	42
UNISTIK SAFETY	168, 186	vancomycin 250 mg/5ml oral sol (Firvanq)	42
UNISTIK TOUCH	168, 186	vancomycin hcl 125 mg capsule (Vancocin Hcl)	42
UNISTRIP	163	vancomycin hcl 250 mg capsule (Vancocin Hcl)	42
UNISTRIP1	123	VANFLYTA	68
UNIVERSAL 1	168, 186	VANILLA SILQ	124
UPNEEQ	129	VANISHPOINT	180
UPTRAVI	94	VANISHPOINT INSULIN SYRINGE	180
URISTIX 4	125	VANOS (fluocinonide)	217
URISTIX REAGENT	125	VANRAFIA	232
UROCIT	137	varденаfil hcl	224
UROQID	137	varenicline	219
UROXATRAL	231	varenicline 0.5 mg tablet	219
URSO	141	varenicline 1 mg tablet	219
ursodiol	141	varenicline starting month box	219
ursodiol 200 mg capsule	141	VARIBAR	124
ursodiol 250 mg tablet	141	VARIBAR THIN HONEY	124
ursodiol 300 mg capsule	141	VARIVAX	87
ursodiol 400 mg capsule	141	VARUBI	140
ursodiol 500 mg tablet (Urso Forte)	141	VASCEPA (icosapent ethyl)	137
USTEKINUMAB	155	VASERETIC	95
USTEKINUMAB-AEKN 45 MG SYRINGE	155	VASOTEC	98
USTEKINUMAB-AEKN 90 MG/ML SYR	155	VAXELIS	87
V		VAXNEUVANCE	85
VAFSEO 150 MG TABLET	146	VECAMEYL	99
VAFSEO 300 MG TABLET	146	VECTICAL	211
VAGIFEM (estradiol)	153	VELPHORO	134
valacyclovir	79	VELSIPITY	108
VALCHLOR	70	VELTASSA	134
		VELTIN	210

Index of Medications

VEMLIDY	80	VIMPAT 100 MG TABLET (lacosamide)	113
VENCLEXTA	69	VIMPAT 150 MG TABLET (lacosamide)	113
venlafaxine	197, 198	VIMPAT 200 MG TABLET (lacosamide)	113
VENLAFAXINE BESYLATE ER	198	VIOKACE	144
VENTAVIS	94	VIRACEPT	77
VENTOLIN HFA	31	VIREAD	77
VEO INSULIN SYRINGE	180	VISTARIL	49
VEOZAH	226	VISTOGARD	223
verapamil	90, 92, 94	VITAFOL	136
VERDESO	217	VITAFOL FE PLUS	191
VEREGEN	80	VITAFOL GUMMIES	192
VERELAN	92	VITAFOL NANO	192
VERELAN PM (verapamil hcl)	92	VITAFOL-OB	192
VERIFINE INSULIN SYRINGE	180	VITAFOL-OB+DHA	192
VERIFINE PEN NEEDLE	172	VITAFOL-ONE	192
VERIFINE PLUS PEN NEEDLE	172	VITAFOL ULTRA	192
VERIFINE PLUS PEN NEEDLE-SHARP	172	VITALARA	192
VERIFINE SAFETY LANCET MINI	168, 186	VITAL-D RX	235
VERIFINE UNIVERSAL LANCET	168, 186	VITAMEDMD ONE RX	192
VERKAZIA	132	VITAMEDMD REDICHEW RX (prenatal no.42/folic acid)	192
VERQUVO	92	VITAPEARL	192
VERSACLOZ	204	VITA-RESPA	235
VERZENIO	68	VITATRUE	192
VESICARE	232	VITRAKVI	68
VEVYE	132	VIVAGUARD INO CONTROL SOLUTION	163
VFEND	47	VIVAGUARD INO TEST STRIP	123
V-GO 20	163	VIVAGUARD LANCET	168, 186
V-GO 30	163	VIVAGUARD LANCING DEVICE	163
V-GO 40	163	VIVAGUARD SAFETY LANCET	168, 186
VIAGRA	224	VIVELLE-DOT (estradiol)	150
VIBERZI	142	VIVJOA	47
VICTOZA 2-PAK (liraglutide)	50	VIVLODEX 5 MG CAPSULE (meloxicam, submicronized)	29
VICTOZA 3-PAK (liraglutide)	50	VIVLODEX 10 MG CAPSULE (meloxicam, submicronized)	29
vigabatrin (Sabril)	113	VIZIMPRO	68
vigadrone 500 mg powder packet (Sabril)	113	VIZZ	131
vigadrone 500 mg tablet (Sabril)	113	VOGELXO	148
VIGAFYDE	113	VONJO	68
VIGAMOX (moxifloxacin hcl)	36	VOQUENZA	144
VIIBRYD	198	VOQUEZNA DUAL PAK	140
VIJOICE 50 MG GRANULE PACKET	222	VOQUEZNA TRIPLE PAK	140
VIJOICE 50 MG TABLET	222	VORANIGO	69
VIJOICE 125 MG TABLET	222	voriconazole	47
VIJOICE 250 MG DAILY DOSE PACK	222	VORTEX ADULT MASK	188
vilazodone hcl 10 mg tablet (Viibryd)	198	VORTEX HOLDING CHAMBER	188
vilazodone hcl 20 mg tablet (Viibryd)	198	VORTEX VHC FROG MASK	188
vilazodone hcl 40 mg tablet (Viibryd)	198	VORTEX VHC LADYBUG MASK	188
VIMPAT 10 MG/ML SOLUTION (lacosamide)	113	VORTEX VHC PEDIATRIC MASK	188
VIMPAT 50 MG TABLET (lacosamide)	113	VOSEVI	79

Index of Medications

VOTRIENT	68	XADAGO	73
VOWST	142	XALATAN	131
VOXZOGO	227	XALKORI	68, 69
VOYDEYA	88	XANAX	193
VRAYLAR	204	XARELTO	43
VTAMA	211	XARELTO (rivaroxaban)	43
VUITY (pilocarpine hcl)	131	XATMEP	62
VUMERITY	107	XCLAIR	212
VUSION	48	XCOPRI 12.5-25 MG TITRATION PK	113
VYALEV	73	XCOPRI 25 MG TABLET	113
VYKAT XR	229	XCOPRI 50-100 MG TITRATION PAK	113
VYLEESI	226	XCOPRI 50 MG TABLET	113
VYLOY	69	XCOPRI 100 MG TABLET	113
VYNDAMAX	228	XCOPRI 150-200 MG TITRATION PK	113
VYNDAQEL	228	XCOPRI 150 MG TABLET	113
VYTORIN	101	XCOPRI 200 MG TABLET	113
VYVANSE 10 MG CAPSULE (lisdexamfetamine dimesylate)	200	XCOPRI 250 MG DAILY DOSE PACK	113
VYVANSE 10 MG CHEWABLE TABLET (lisdexamfetamine dimesylate)	200	XCOPRI 350 MG DAILY DOSE PACK	113
VYVANSE 20 MG CAPSULE (lisdexamfetamine dimesylate)	200	XDEMVY	71
VYVANSE 20 MG CHEWABLE TABLET (lisdexamfetamine dimesylate)	200	XELJANZ	27
VYVANSE 30 MG CAPSULE (lisdexamfetamine dimesylate)	200	XELODA	62
VYVANSE 30 MG CHEWABLE TABLET (lisdexamfetamine dimesylate)	200	XELSTRYM	82
VYVANSE 40 MG CAPSULE (lisdexamfetamine dimesylate)	200	XENAZINE	106
VYVANSE 40 MG CHEWABLE TABLET (lisdexamfetamine dimesylate)	200	XENICAL	71
VYVANSE 50 MG CAPSULE (lisdexamfetamine dimesylate)	200	XENLETA	40
VYVANSE 50 MG CHEWABLE TABLET (lisdexamfetamine dimesylate)	200	XEPI	43
VYVANSE 60 MG CAPSULE (lisdexamfetamine dimesylate)	200	XERESE	80
VYVANSE 60 MG CHEWABLE TABLET (lisdexamfetamine dimesylate)	200	XERMELO	138
VYVANSE 70 MG CAPSULE (lisdexamfetamine dimesylate)	200	XHANCE	127
VYVGART	227	XIFAXAN	40
VYZULTA	131	XIGDUO	53
W		XIIDRA	132
WAINUA	225	XIMINO	41
WAKIX	114	XOFLUZA	79
warfarin	43	XOLAIR	34
water for irrigation	209	XOLEGEL	48
WEBCOL	208, 212	XOLREMDI	115
Wegovy	71	XOPENEX	31
WELCHOL	104	XOPENEX HFA	31
WELIREG	69	XOSPATA	69
WELLBUTRIN	194, 195	XPHOZAH	134
WIDE SEAL DIAPHRAGM	117	XPOVIO	70
WILATE	88	XROMI	89
WINLEVI	214	XTAMPZA ER	24
WINREVAIR	94	XTANDI	61
WINREVAIR (2 PACK)	94	XULTOPHY	50
WYNZORA	218	XURIDEN	134
X		XYNTHA	88
XACIATO	42	XYNTHA SOLOFUSE	88

Index of Medications

XYOSTED	148
XYREM	206
XYWAV	206

Y

YALE NEEDLES	172
YASMIN 28 (ethinyl estradiol/drospirenone)	116
YAZ (ethinyl estradiol/drospirenone)	116
YERVOY	70
YESINTEK	155
YEZTUGO 463.5 MG/1.5 ML VIAL	74
YONSA	61
YORVIPATH	152
YOSPRALA DR 81-40 MG TABLET	74
YOSPRALA DR 325-40 MG TABLET	74
YUFLYMA(CF) 20 MG/0.2 ML SYRNG	60
YUFLYMA(CF) 40MG/0.4ML AUTOINJ	60
YUFLYMA(CF) 40 MG/0.4 ML SYRNG	60
YUFLYMA(CF) 80MG/0.8ML AUTOINJ	60
YUFLYMA(CF) AI CROHN'S-UC-HS	60
YUPELRI	30
YUSIMRY(CF) PEN	60

Z

zafirlukast	34
zaleplon	207
ZALVIT	192
ZANAFLEX	189
ZANAFLEX (tizanidine hcl)	189
ZARONTIN (ethosuximide)	113
ZARXIO	114
ZAVESCA	226
ZAVZPRET	21
ZCORT	151
ZEGALOGUE AUTOINJECTOR	133
ZEGALOGUE SYRINGE	133
ZEGERID	146
ZEJULA	69
ZELAPAR	73
ZELBORAF	62
ZELNORM	143
ZELSUVMI	218
ZEMBRACE SYMTOUCH	21
ZEMPLAR	224
ZENPEP	144
ZENZEDI	82
ZENZEDI (dextroamphetamine sulfate)	82
ZEPATIER	80
ZEPBOUND	71
ZEPBOUND 2.5 MG/0.5 ML PEN	71

ZEPBOUND 10 MG/0.5 ML PEN	71
ZEPOSIA	107, 108
ZERVIAE	49
ZESTORETIC	95
ZESTRIL	98
ZETIA	105
ZETONNA	127
ZIAGEN (abacavir sulfate)	76
ZIANA	210
zidovudine	75, 76
ZIEXTENZO	114
ZILBRYSQ	225
zileuton	30
ZILXI	43
ZIMHI	46
zinc	213
ZINC OXIDE	213
ZIOPTAN (tafluprost/pf)	131
ZIPHEX	192
ziprasidone	203, 204
ZIPSOR (diclofenac potassium)	21
ZIRGAN	78
ZITHROMAX	39
ZITHROMAX (azithromycin)	39
ZITUVIMET	52
ZITUVIMET XR 50-500 MG TABLET	52
ZITUVIMET XR 50-1000 MG TABLET	52
ZITUVIMET XR 100-1,000 MG TAB	52
ZITUVIO	51
ZOCOR	103
ZOKINVY	222
ZOLADEX	64
ZOLINZA	60
zolmitriptan	21
ZOLMITRIPTAN 2.5MG NASAL SPRAY	21
zolmitriptan 2.5 mg tablet (Zomig)	21
zolmitriptan 5 mg nasal spray (Zomig)	21
zolmitriptan 5 mg tablet (Zomig)	21
ZOLOFT	197
zolpidem	207
zolpidem tart 1.75 mg tab sl	207
zolpidem tart 3.5 mg tablet sl	207
zolpidem tartrate 5 mg tablet (Ambien)	207
ZOLPIDEM TARTRATE 7.5 MG CAP	207
zolpidem tartrate 10 mg tablet (Ambien)	207
ZOLPIMIST	207
ZOMACTON	151
ZOMIG 2.5 MG NASAL SPRAY	21

Index of Medications

ZOMIG 2.5 MG TABLET (zolmitriptan).....	21
ZOMIG 5 MG NASAL SPRAY (zolmitriptan).....	21
ZOMIG 5 MG TABLET (zolmitriptan).....	21
ZONALON.....	211
ZONEGRAN (zonisamide)	113
ZONISADE.....	113
zonisamide.....	113
zonisamide (Zonegran)	113
ZONTIVITY	74
ZORTRESS.....	157
ZORVOLEX	29
ZORYVE	211
ZORYVE 0.3% FOAM.....	214
ZORYVE 0.15% CREAM	214
ZOVIRAX	80
ZTALMY	206
ZTLIDO.....	25
ZUBSOLV.....	231
ZUNVEYL.....	81
ZURZUVAE.....	193
ZYCLARA	212
ZYCLARA 3.75% CREAM PUMP (imiquimod)	212
ZYDELIG.....	69
ZYFLO	30
ZYKADIA.....	69
ZYLET.....	35
ZYLOPRIM	27
ZYPITAMAG.....	103
ZYPREXA	204
ZYTIGA	61
ZYVOX	39

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: اطلب 711) أو تحدث إلى مقدم الخدمة الخاص بك.

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

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

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

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

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

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

German – Achtung: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzen 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