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

Coverage as of January 1, 2026

For the State of California
Exclusive Provider Organization (EPO), LocalPlus (LocalPlus IN/LocalPlus), Open Access Plus (OAPIN/OAP), Preferred Provider Organization (PPO), SureFit

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

Last updated: 08/01/2025. This drug list is subject to change and all prior versions are no longer in effect.

View your drug list online, 24/7

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

- You can use the Price a Medication tool on the myCigna App[1] or **myCigna.com** to see the most up-to-date list of the medications your plan covers.
- You can also see a pdf of this document on **Cigna.com/PDL.** Click on the dropdown next to "Drug Lists for Employer Plans." Scroll down to the section for California Employer Drug Lists; then click on **California Legacy (Standard) 4 Tier (all specialty medications covered on tier 4) (CDI) [PDF]**.

Questions?

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

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

Last updated: 12/01/2025, for changes starting 01/01/2026

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

Information about this drug list

Frequently asked questions (FAQs)

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

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

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

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

Q. Why doesn't my plan cover certain medications?
A. There are some medications and products that your plan won't cover for any reason because they're a "plan (or benefit) exclusion." This means the medication or product isn't on your drug list, and there's no option to ask us to cover it through our review process. For example, your plan doesn't cover (or "excludes") medications that the U.S. Food and Drug Administration (FDA) hasn't approved.

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

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

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

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

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

Information about this drug list

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

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

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

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

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

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

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

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

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

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

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

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

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

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:

I. 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 changes of staying well and living longer.

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

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

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

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

- 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.

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

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

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

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

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

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

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

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

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

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

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

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

1. **Check your Cigna Healthcare ID card.** It lists your cost-share for Tier 1, Tier 2, Tier 3 and Tier 4 medications.
2. **Log in to the myCigna App or myCigna.com to view your pharmacy coverage information.** You can also use the Price a Medication tool to find out how much your medication may cost you at the different pharmacies in your plan's network.
3. **Check your Summary of Benefits** coverage document.

Information about this drug list

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

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

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

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

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

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

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

- **Preventive care medications and products covered under the Patient Protection and Affordable Care Act (PPACA), also known as "health care reform:"**
  - **Contraceptives:** Covered at 100%, or no cost-share ($0) to you. Certain prescription contraceptives are available at their applicable cost-share.
  - **Tobacco cessation products:** Up to two (2) 90-day courses of treatment per plan year are covered at 100%, or no cost-share ($0) to you. Certain prescription tobacco cessation products are available at their applicable cost-share.
  - **Certain vitamins:** Covered at 100%, or no cost-share ($0) to you. All other prescription vitamins are available at their applicable cost-share and deductible (if applicable).
- **Certain over-the-counter (OTC) products:** If you have a prescription from your doctor, these are covered at 100%, or no cost-share ($0) to you. All other OTC products are excluded from coverage.
- **Oral fertility medications:** Covered at their applicable tier cost-share. For some plans, injectable fertility medications are covered under the medical benefit.

Information about this drug list

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

- **Generic preventive care medications:** Covered at 100%, or no cost-share ($0) to you before you meet your deductible. You'll pay your deductible and applicable cost-share to fill a preferred brand and/or non-preferred brand preventive care medication.
- **Diabetic supplies:** Covered at their applicable cost-share.
- **Growth Hormones:** Need approval from Cigna Healthcare before your plan will cover them (prior authorization). If approved, you'll pay your applicable tier cost-share to fill the medication.
- **Vaccines:** Vaccines are now covered under the pharmacy benefit. Not all plans cover vaccines in the same way. Log in to the myCigna App or **myCigna.com**, or check your plan materials, to find out how your specific plan covers them.
- **Compounded medications:** If the medication is more than $200, you'll need approval from Cigna Healthcare before your plan will cover them (prior authorization). If approved, you'll pay your applicable tier cost-share to fill the medication.

Words you may need to know

- **Brand name drug:** A drug that is marketed under a proprietary, trademark-protected name. A brand name drug is listed in this formulary in all CAPITAL letters.
- **Coinsurance:** A percentage of the cost of a covered health care benefit that you pay after you have paid the deductible, if a deductible applies to the health care benefit.
- **Copayment:** A fixed dollar amount that you pay for a covered health care benefit after you have paid the deductible, if a deductible applies to the health care benefit.
- **Deductible:** The amount you pay for covered health care benefits that are subject to the deductible before your health insurer begins to pay. If your health insurance policy has a deductible, it may have either one deductible or separate deductibles for medical benefits and prescription drug benefits. After you pay your deductible, you usually pay only a copayment or coinsurance for covered health care benefits. Your insurance company pays the rest.
- **Drug tier:** A group of prescription drugs that correspond to a specified cost sharing tier in your health insurance policy. The drug tier in which a prescription drug is placed determines your portion of the cost for the drug.
- **Exception request:** A request for coverage of a non-formulary drug. If you, your designee, or your prescribing health care provider submits a request for coverage of a non-formulary drug, your insurer must cover the non-formulary drug when it is medically necessary for you to take the drug.
- **Exigent circumstances:** When you are suffering from a medical condition that may seriously jeopardize your life, health, or ability to regain maximum function, or when you are undergoing a current course of treatment using a non-formulary drug.
- **Formulary or prescription drug list:** The list of drugs that is covered by your health insurance policy under the prescription drug benefit of the policy.
- **Generic drug:** A drug that is the same as its brand name drug equivalent in dosage, strength, effect, how it is taken, quality, safety, and intended use. A generic drug is listed in this formulary in italicized lowercase letters.
- **Medically Necessary:** Health care benefits needed to diagnose, treat, or prevent a medical condition or its symptoms and that meet accepted standards of medicine. Health insurance usually does not cover health care benefits that are not medically necessary.

Information about this drug list

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

- **Non-formulary drug:** A prescription drug that is not listed on this formulary.
- **Out-of-pocket costs:** Your expenses for health care benefits that aren't reimbursed by your health insurance. Out-of-pocket costs include deductibles, copayments, and coinsurance for covered health care benefits, plus all costs for health care benefits that are not covered.
- **Prescribing provider:** A health care provider who can write a prescription for a drug to diagnose, treat, or prevent a medical condition.
- **Prescription:** An oral, written, or electronic order from a prescribing provider authorizing a prescription drug to be provided to a specific individual.
- **Prescription drug:** A drug that by law requires a prescription.
- **Prior Authorization:** A decision by your health insurer that a health care benefit is medically necessary for you. If a prescription drug is subject to prior authorization in this formulary, your prescribing provider must request approval from your health insurer to cover the drug before you fill your prescription. Your health insurer must grant a prior authorization request when it is medically necessary for you to take the drug.
- **Step Therapy:** A specific sequence in which prescription drugs for a particular medical condition must be tried. If a drug is subject to step therapy in this formulary, you may have to try one or more other drugs before your health insurance policy will cover that drug for your medical condition. If your prescribing provider submits a request for an exception to the step therapy requirement, your health insurer must grant the request when it is medically necessary for you to take the drug.
- **Quantity Limits:** For some medications, your plan will only cover up to a certain amount over a certain length of time. For example, 30mg per day for 30 days. Quantity limits help to make sure you're receiving coverage for the right medication, in the right amount, and for the right situation. Your plan will only cover a larger amount if your doctor requests and receives approval from Cigna Healthcare.
- **Age Requirements:** For certain medications, you must be within a specific age range for your plan to cover them. This is because some medications aren't considered clinically appropriate for individuals who aren't within that age range.

Information about this drug list

About this drug list

This is a list of the most commonly prescribed medications covered on the Cigna Healthcare Legacy (Standard) 4-Tier Prescription Drug List as of January 1, 2026. **The drug list is updated often**; so, not all of the medications your plan covers may be listed here. Also, your plan may not cover all of these medications. Log in to the myCigna App or **myCigna.com** to see which medications your plan covers.

How to read this drug list

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

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

Tiers

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

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

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

Information about this drug list

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

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

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

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

Information about this drug list

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

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

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

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

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

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

Prescription drug name is the name of the medication.

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

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

Generic medications are in **lowercase italics**.

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

Information about this drug list

How to find your medication

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

Information about this drug list

How to find your medication *(cont.)*

Information about this drug list

How to find your medication *(cont.)*

List of Prescription Medications

ANALGESICS (Pain Relief and Inflammatory Disease)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANALGESIC, NON-SALICYLATE AND BARBITURATE COMBINAT		
BUPAP *(butalbital/acetaminophen)*	T3	PA
butalbital/acetaminophen	T1	
butalbital-acetaminophn 25-325	T1	PA
butalbital-acetaminophn 50-300	T1	
butalbital-acetaminophn 50-300 (Bupap)	T1	PA
butalbital-acetaminophn 50-325	T1	
ANALGESIC, SALICYLATE, BARBITURATE, XANTHINE COMB.		
butalbital-aspirin-caffeine cp	T1	QL(6 CAPS/DAY)
butalbital-aspirin-caffeine tb	T1	QL(6 TABS/DAY)
ANALGESIC, NON-SALICYLATE, BARBITURATE, XANTHINE COMB.		
butal-ace-caf 50-325-40mg/15ml	T1	PA QL(90 MLS/DAY)
butalb/acetaminophen/caffeine (Esgic)	T3	QL(6 CAPS/DAY)
butalb-acetamin-caff 50-300-40 (Fioricet)	T1	QL(6 CAPS/DAY)
butalb-acetamin-caff 50-325-40	T1	QL(6 TABS/DAY)
butalb-acetamin-caff 50-325-40 (Esgic)	T1	QL(6 CAPS/DAY)
ESGIC (*butalb/acetaminophen/caffeine*)	T3	PA QL(6 CAPS/DAY)
FIORICET (*butalb/acetaminophen/caffeine*)	T3	PA QL(6 CAPS/DAY)
ANALGESIC/ANTIPYRETICS, SALICYLATES		
diflunisal	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 (*diclofenac potassium*)	T3	PA
diclofenac pot 50 mg powdr pkt (Cambia)	T1	PA
dihydroergotamine 1 mg/ml amp	T1	QL
dihydroergotamine 4 mg/ml spry (Migranal)	T1	PA QL(8 MLS/30 DAYS)
eletriptan hydrobromide (Relpax)	T1	QL(6 TABS/30 DAYS)
ELYXYB	T3	PA QL(43.2 MLS/30 DAYS)

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
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PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANALGESICS (Pain Relief and Inflammatory Disease) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-MIGRAINE PREPARATIONS *(cont.)*		
EMGALITY PEN	T2	PA
EMGALITY SYRINGE	T2	PA
ERGOMAR	T3	PA
ergotamine tartrate/caffeine	T1	QL(40 TABS/28 DAYS)
FROVA *(frovatriptan succinate)*	T3	PA QL(18 TABS/30 DAYS)
IMITREX 100 MG TABLET (*sumatriptan succinate*)	T3	PA QL(9 TABS/30 DAYS)
IMITREX 25 MG TABLET (*sumatriptan succinate*)	T3	PA QL(9 TABS/30 DAYS)
IMITREX 4 MG/0.5 ML CARTRIDGES (*sumatriptan succinate*)	T3	PA QL(4 MLS/30 DAYS)
IMITREX 4 MG/0.5 ML PEN INJECT (*sumatriptan succinate*)	T3	PA QL(4 MLS/30 DAYS)
IMITREX 50 MG TABLET (*sumatriptan succinate*)	T3	PA QL(9 TABS/30 DAYS)
IMITREX 6 MG/0.5 ML CARTRIDGES (*sumatriptan succinate*)	T3	PA QL(4 MLS/30 DAYS)
IMITREX 6 MG/0.5 ML PEN INJECT (*sumatriptan succinate*)	T3	PA QL(4 MLS/30 DAYS)
MAXALT (*rizatriptan benzoate*)	T3	PA QL(12 TABS/30 DAYS)
MAXALT MLT (*rizatriptan benzoate*)	T3	PA QL(12 TABS/30 DAYS)
MIGRANAL (*dihydroergotamine mesylate*)	T3	PA QL(8 MLS/30 DAYS)
naratriptan hcl	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 *(eletriptan hydrobromide)*	T3	PA QL(6 TABS/30 DAYS)
REYVOW	T3	PA QL(8 TABS/30 DAYS)
rizatriptan benzoate	T1	QL(12 TABS/30 DAYS)
rizatriptan benzoate (Maxalt Mlt)	T1	QL(12 TABS/30 DAYS)
rizatriptan benzoate(Maxalt)	T1	QL(12 TABS/30 DAYS)
sumatriptan	T1	QL(12 UNITS/30 DAYS)
*sumatriptan 4 mg/0.5 ml inject (*Imitrex*)*	T1	QL(4 MLS/30 DAYS)
sumatriptan 6 mg/0.5 ml vial	T1	QL(5 MLS/30 DAYS)
*sumatriptan 6 mg/0.5ml autoinj (*Imitrex*)*	T1	QL(4 MLS/30 DAYS)
*sumatriptan succ 100 mg tablet (*Imitrex*)*	T1	QL(9 TABS/30 DAYS)
*sumatriptan succ 25 mg tablet (*Imitrex*)*	T1	QL(9 TABS/30 DAYS)
*sumatriptan succ 50 mg tablet (*Imitrex*)*	T1	QL(9 TABS/30 DAYS)
*sumatriptan succ/naproxen sod (*Treximet*)*	T1	QL(18 TABS/30 DAYS)
SYMBRAVO	T3	PA QL(9 TABS/28 DAYS)

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PPACA – No Cost-Share Preventive Medication
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List of Prescription Medications

ANALGESICS (Pain Relief and Inflammatory Disease) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-MIGRAINE PREPARATIONS *(cont.)*		
TOSYMRA	T3	PA QL(12 UNITS/30 DAYS)
TREXIMET (*sumatriptan succ/naproxen sod*)	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)
zolmitriptan	T1	QL(6 TABS/30 DAYS)
zolmitriptan 2.5 mg tablet (Zomig)	T1	QL(6 TABS/30 DAYS)
ZOLMITRIPTAN 2.5MG NASAL SPRAY	T3	PA QL(12 UNITS/30 DAYS)
zolmitriptan 5 mg nasal spray (Zomig)	T1	PA QL(12 UNITS/30 DAYS)
zolmitriptan 5 mg tablet (Zomig)	T1	QL(6 TABS/30 DAYS)
ZOMIG 2.5 MG NASAL SPRAY	T3	PA QL(12 UNITS/30 DAYS)
ZOMIG 2.5 MG TABLET (*zolmitriptan*)	T3	PA QL(6 TABS/30 DAYS)
ZOMIG 5 MG NASAL SPRAY (*zolmitriptan*)	T3	PA QL(12 UNITS/30 DAYS)
ZOMIG 5 MG TABLET (*zolmitriptan*)	T3	PA QL(6 TABS/30 DAYS)
NASAL NSAIDS, COX NON-SELECTIVE,SYSTEMIC ANALGESIC		
SPRIX	T3	PA QL(5 UNITS/30 DAYS)
NSAIDS, CYCLOOXYGENASE INHIBITOR-TYPE ANALGESICS		
diclofenac pot 25 mg tablet	T1	PA HD
diclofenac pot 50 mg tablet	T1	HD
diclofenac potassium	T1	PA HD
diclofenac potassium 25 mg cap (Zipsor)	T1	PA HD
ketorolac 10 mg tablet	T1	QL(20 TABS/30 DAYS)
ketorolac 15 mg/ml syringe	T1	QL(8 MLS/DAY)
ketorolac 15 mg/ml vial	T1	QL(8 MLS/DAY)
ketorolac 30 mg/ml syringe	T1	QL(4 MLS/DAY)
ketorolac 30 mg/ml vial	T1	QL(4 MLS/DAY)
ketorolac 300 mg/10 ml vial	T1	
ketorolac 60 mg/2 ml syringe	T1	QL(4 MLS/DAY)
ketorolac 60 mg/2 ml vial	T1	QL(4 MLS/DAY)
mefenamic acid	T1	PA HD
ZIPSOR (*diclofenac potassium*)	T3	PA HD

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PPACA – No Cost-Share Preventive Medication
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List of Prescription Medications

ANALGESICS (Pain Relief and Inflammatory Disease) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
OPIOID ANALGESIC AND NON-SALICYLATE ANALGESICS		
acetamin-codein 300-30 mg/12.5	T1	
acetaminop-codeine 120-12 mg/5	T1	
acetaminophen-cod #2 tablet	T1	PA
acetaminophen-cod #3 tablet	T1	PA
acetaminophen-cod #4 tablet	T1	PA
hydrocodone/acetaminophen	T1	PA
hydrocodone/acetaminophen (Lortab)	T1	PA
HYDROCODONE-ACETAMINOPHEN	T1	PA
LORTAB (*hydrocodone/acetaminophen*)	T1	PA
NALOCET	T1	PA
oxycodone hcl/acetaminophen	T1	PA
oxycodone hcl/acetaminophen (Percocet)	T1	PA
PERCOCET (*oxycodone hcl/acetaminophen*)	T3	PA
PRIMLEV	T1	PA
PROLATE 10 MG-300 MG/5 ML SOLN	T3	PA
prolate 10-300 mg tablet	T1	PA
prolate 5-300 mg tablet	T1	PA
prolate 7.5-300 mg tablet	T1	PA
tramadol hcl/acetaminophen	T1	
OPIOID ANALGESIC AND NSAID COMBINATION		
hydrocodone/ibuprofen	T1	PA
OPIOID ANALGESIC AND NON-SALICYLATE XANTHINE COMB		
acetaminophen/caff/dihydrocod	T1	PA
TREZIX	T3	PA
OPIOID ANALGESICS		
ACTIQ (*fentanyl citrate*)	T3	PA
BELBUCA	T2	QL(2 FILMS/DAY)
buprenorphine (Butrans)	T1	QL(4 PATCHES/28 DAYS)
butorphanol tartrate	T1	PA QL(6 BOTTLES/30 DAYS)
BUTRANS (buprenorphine)	T3	QL(4 PATCHES/28 DAYS)
codeine sulfate	T1	PA
CONZIP	T3	PA QL(1 CAP/DAY)
DILAUDID (*hydromorphone hcl*)	T3	PA
fentanyl	T1	PA

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List of Prescription Medications

ANALGESICS (Pain Relief and Inflammatory Disease) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
OPIOID ANALGESICS *(cont.)*		
fentanyl citrate	T1	PA
FENTANYL CITRATE	T1	PA
fentanyl citrate (Actiq)	T1	PA
FENTORA	T3	PA
hydrocodone bitartrate	T1	PA
hydrocodone bitartrate (Hysingla Er)	T1	PA
hydromorphone hcl	T1	PA
hydromorphone hcl (Dilaudid)	T1	PA
HYSINGLA ER (*hydrocodone bitartrate*)	T2	PA
LAZANDA	T3	PA
levorphanol tartrate	T1	PA
meperidine hcl	T1	PA
methadone hcl	T1	PA
morphine sulfate	T1	PA
morphine sulfate (Ms Contin)	T1	PA
MS CONTIN (*morphine sulfate*)	T3	PA
NUCYNTA	T2	PA
NUCYNTA ER	T3	PA
opium/belladonna alkaloids	T1	PA
OXAYDO	T3	PA
oxycodone hcl	T1	PA
oxycodone hcl (ir) 10 mg tab	T1	PA
oxycodone hcl (ir) 15 mg tab (Roxicodone)	T1	PA
oxycodone hcl (ir) 20 mg tab	T1	PA
oxycodone hcl (ir) 30 mg tab (Roxicodone)	T1	PA
oxycodone hcl (ir) 5 mg cap	T1	PA
oxycodone hcl (ir) 5 mg tablet (Roxicodone)	T1	PA
OXYCODONE HCL 10 MG TABLET	T3	PA
oxycodone hcl 100 mg/5 ml conc	T1	PA
OXYCODONE HCL 15 MG TABLET	T3	PA
OXYCODONE HCL 30 MG TABLET	T3	PA
OXYCODONE HCL 5 MG TABLET	T3	PA
oxycodone hcl 5 mg/5 ml cup	T1	PA
oxycodone hcl 5 mg/5 ml soln	T1	PA

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List of Prescription Medications

ANALGESICS (Pain Relief and Inflammatory Disease) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
OPIOID ANALGESICS *(cont.)*		
OXYCODONE HCL ER	T1	PA
OXYCONTIN	T3	PA
oxymorphone hcl	T1	PA
pentazocine hcl/naloxone hcl	T1	PA
ROXICODONE (*oxycodone hcl*)	T3	PA
ROXYBOND	T3	PA
tramadol er 100 mg tablet	T1	QL(1 TAB/DAY)
tramadol er 200 mg tablet	T1	QL(1 TAB/DAY)
tramadol er 300 mg tablet	T1	QL(1 TAB/DAY)
tramadol hcl 100 mg tablet	T1	QL(4 TABS/DAY)
TRAMADOL HCL 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)
tramadol hcl 50 mg tablet	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)
tramadol hcl er 100 mg tablet	T1	QL(1 TAB/DAY)
TRAMADOL HCL ER 200 MG CAPSULE	T1	QL(1 CAP/DAY)
tramadol hcl er 200 mg tablet	T1	QL(1 TAB/DAY)
TRAMADOL HCL ER 300 MG CAPSULE	T1	QL(1 CAP/DAY)
tramadol hcl er 300 mg tablet	T1	QL(1 TAB/DAY)
XTAMPZA ER	T2	PA
OPIOID AND SALICYLATE ANALGESICS, BARBIT, XANTHINE		
codeine/butalbital/asa/caffein	T1	PA
OPIOID, NON-SALICYL. ANALGESIC, BARBITUATE, XANTHINE		
butalbit/acetamin/caff/codeine	T1	PA
butalbit/acetamin/caff/codeine (Fioricet With Codeine)	T1	PA
FIORICET WITH CODEINE (*butalb-acetaminoph-caff-codein*)	T3	PA
SKELETAL MUSCLE RELAXANT, SALICYLAT, OPIOID ANALGESC		
carisoprodol/aspirin/codeine	T1	PA
ANALGESICS (Urinary Tract Conditions)		
URINARY TRACT ANALGESIC AGENTS		
ELMIRON	T2	
RIMSO-50	T2	

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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 Ii)	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	
PYRIDIUM (*phenazopyridine hcl*)	T3	PA
ANTI-ALLERGY (Allergy/Nasal Sprays)		
MAST CELL STABILIZERS		
cromolyn 100 mg/5 ml oral conc (Gastrocrom)	T1	
GASTROCROM (*cromolyn sodium*)	T3	PA
ANTI-ARTHRITICS (Pain Relief and Inflammatory Disease)		
ANALGESIC/ANTIPYRETICS, SALICYLATES		
DISALCID (*salsalate*)	T3	HD
salsalate (Disalcid)	T1	HD

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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 (*penicillamine*)	T4	PA QL(6 CAPS/DAY) SP
DEPEN (*penicillamine*)	T4	PA QL(6 TABS/DAY) SP
penicillamine 250 mg capsule (Cuprimine)	T4	PA QL(6 CAPS/DAY) SP
penicillamine 250 mg tablet (Depen)	T4	PA QL(6 TABS/DAY) SP
ANTI-ARTHRITIC, FOLATE ANTAGONIST AGENTS		
OTREXUP	T2	PA
RASUVO	T3	PA
ANTI-INFLAM. INTERLEUKIN-I RECEPTOR ANTAGONIST		
KINERET	T4	PA QL(28 UNITS/28 DAYS) SP
ANTI-INFLAMMATORY, PYRIMIDINE SYNTHESIS INHIBITOR		
ARAVA (*leflunomide*)	T3	PA HD
leflunomide (Arava)	T1	HD
ANTI-INFLAMMATORY, PHOSPHODIESTERASE-4(PDE4) INHIB.		
OTEZLA 10-20 MG STARTER 28 DAY	T4	PA QL(55 TABS/365 DAYS) SP HD
OTEZLA 10-20-30MG START 28 DAY	T4	PA QL(55 TABS/365 DAYS) SP HD
OTEZLA 20 MG TABLET	T4	PA QL(2 TABS/DAY) SP HD
OTEZLA 30 MG TABLET	T4	PA QL(2 TABS/DAY) SP HD
OTEZLA XR 75 MG TABLET	T4	PA QL(1 TAB/DAY) SP HD
OTEZLA XR INITIATION PK 28 DAY	T4	PA QL(41 TABS/365 DAYS) SP HD
ANTI-INFLAMMATORY, SEL.COSTIM.MOD., T-CELL INHIBITOR		
ORENCIA	T4	PA QL(4 SYR/AUTO-INJ/28 DAYS) SP HD
ORENCIA CLICKJECT	T4	PA QL(4 SYR/AUTO-INJ/28 DAYS) SP HD
COLCHICINE		
colchicine 0.6 mg capsule (Mitigare)	T1	
colchicine 0.6 mg tablet (Colcrys)	T1	HD
COLCRYS (*colchicine*)	T3	PA HD
GLOPERBA	T3	PA QL(10 MLS/DAY) HD
MITIGARE (*colchicine*)	T2	
GOLD SALTS		
RIDAURA	T3	PA
HYPERURICEMIA TX - XANTHINE OXIDASE INHIBITORS		
allopurinol 100 mg tablet (Zyloprim)	T1	HD
allopurinol 200 mg tablet	T1	PA HD
allopurinol 300 mg tablet	T1	HD
febuxostat 40 mg tablet (Uloric)	T1	QL(1 TAB/DAY) HD

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
HYPERURICEMIA TX - XANTHINE OXIDASE INHIBITORS *(cont.)*		
febuxostat 80 mg tablet (Uloric)	T1	HD
ULORIC 40 MG TABLET (*febuxostat*)	T3	PA QL(1 TAB/DAY) HD
ULORIC 80 MG TABLET (*febuxostat*)	T3	PA HD
ZYLOPRIM (*allopurinol*)	T3	HD
JANUS KINASE (JAK) INHIBITORS		
OLUMIANT	T4	PA QL(30 TABS/30 DAYS) SP HD
RINVOQ	T4	PA QL(1 TAB/DAY) SP HD
RINVOQ LQ	T4	PA QL(12 MLS/DAY) SP HD
XELJANZ 1 MG/ML SOLUTION	T4	PA QL(480 MLS/30 DAYS) SP HD
XELJANZ 10 MG TABLET	T4	PA QL(2 TABS/DAY) SP HD
XELJANZ 5 MG TABLET	T4	PA QL(2 TABS/DAY) SP HD
XELJANZ XR	T4	PA QL(1 TAB/DAY) SP HD
NSAID ANALGESIC AND NON-SALICYLATE ANALGESIC COMB		
COMBOGESIC	T3	PA
NSAIDS (COX NON-SPEC.INHIB) AND PROSTAGLANDIN ANALOG		
ARTHROTEC 50 (*diclofenac sodium-misoprostol*)	T3	ST HD
ARTHROTEC 75 (*diclofenac sodium-misoprostol*)	T3	ST HD
diclofenac sodium-misoprostol (Arthrotec 50)	T1	HD
diclofenac sodium-misoprostol (Arthrotec 75)	T1	HD
NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE ANALGESICS		
ANAPROX DS (*naproxen sodium ds*)	T3	ST HD
COXANTO	T3	PA HD
DAYPRO (*oxaprozin*)	T3	ST HD
DICLOFENAC	T3	PA HD
diclofenac sod dr 25 mg tab	T1	HD
diclofenac sod dr 50 mg tab	T1	HD
diclofenac sod dr 75 mg tab	T1	HD
diclofenac sod ec 25 mg tab	T1	HD
diclofenac sod ec 50 mg tab	T1	HD
diclofenac sod ec 75 mg tab	T1	HD
diclofenac sodium	T1	HD
EC-NAPROSYN (*naproxen*)	T3	ST HD
etodolac	T1	HD
etodolac (Lodine)	T1	HD

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE ANALGESICS *(cont.)*		
FELDENE (*piroxicam*)	T3	ST HD
FENOPROFEN 200 MG CAPSULE	T1	PA HD
fenoprofen 400 mg capsule (Nalfon)	T1	PA HD
fenoprofen 600 mg tablet (Nalfon)	T1	HD
FENOPRON	T3	PA HD
FENORTHO	T1	PA HD
flurbiprofen	T1	HD
ibuprofen	T1	HD
INDOCIN (indomethacin)	T3	PA HD
indomethacin	T1	HD
INDOMETHACIN 20 MG CAPSULE	T3	PA HD
indomethacin 25 mg capsule	T1	HD
indomethacin 25 mg/5 ml susp (Indocin)	T1	HD
indomethacin 50 mg capsule	T1	HD
indomethacin 50 mg suppository (Indocin)	T1	HD
ketoprofen 25 mg capsule	T1	PA HD
ketoprofen 50 mg capsule	T1	HD
ketoprofen 75 mg capsule	T1	HD
ketoprofen er 200 mg capsule	T1	HD
LODINE (*etodolac*)	T3	ST HD
meclofenamate sodium	T1	HD
meloxicam (Mobic)	T1	HD
meloxicam 10 mg capsule (Vivlodex)	T1	PA HD
meloxicam 15 mg tablet	T1	HD
meloxicam 5 mg capsule (Vivlodex)	T1	PA QL(1 CAP/DAY) HD
meloxicam 7.5 mg tablet	T1	HD
MELOXICAM 7.5 MG/5 ML SUSP	T3	PA HD
nabumetone (Relafen)	T1	HD
NALFON 400 MG CAPSULE (*fenoprofen calcium*)	T3	PA HD
NALFON 600 MG TABLET (*profeno*)	T3	ST HD
NAPRELAN (*naproxen sodium*)	T3	PA HD
NAPROSYN 125 MG/5 ML SUSPEN (*naproxen*)	T3	PA HD
NAPROSYN 500 MG TABLET (*naproxen*)	T3	ST HD
naproxen (Ec-naprosyn)	T1	HD

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NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE ANALGESICS *(cont.)*		
*naproxen 125 mg/5 ml suspen (*Naprosyn*)*	T1	PA HD
naproxen 250 mg tablet	T1	HD
naproxen 375 mg tablet	T1	HD
*naproxen 500 mg kit (*Naprosyn*)*	T1	HD
*naproxen 500 mg tablet (*Naprosyn*)*	T1	HD
*naproxen dr 375 mg tablet (*Ec-Naprosyn*)*	T1	HD
*naproxen dr 500 mg tablet (*Ec-Naprosyn*)*	T1	HD
naproxen sodium	T1	HD
*naproxen sodium (*Anaprox Ds*)*	T1	HD
*naproxen sodium (*Naprelan*)*	T1	PA HD
OXAPROZIN 300 MG CAPSULE	T3	PA HD
*oxaprozin 600 mg tablet (*Daypro*)*	T1	HD
piroxicam	T1	HD
piroxicam (Feldene)	T1	HD
RELAFEN (*nabumetone*)	T3	PA HD
RELAFEN DS	T3	PA HD
sulindac	T1	HD
TIVORBEX	T3	PA HD
TOLECTIN 600 *(tolmetin sodium)*	T3	PA HD
tolmetin sodium	T1	HD
tolmetin sodium (Tolectin 600)	T1	HD
VIVLODEX 10 MG CAPSULE (*meloxicam, submicronized*)	T3	PA HD
VIVLODEX 5 MG CAPSULE (*meloxicam, submicronized*)	T3	PA QL(1 CAP/DAY) HD
ZORVOLEX	T3	PA HD
NSAIDS, CYCLOOXYGENASE-2(COX-2) SELECTIVE INHIBITOR		
CELEBREX 100 MG CAPSULE (*celecoxib*)	T3	PA QL(2 CAPS/DAY)
CELEBREX 200 MG CAPSULE (*celecoxib*)	T3	PA QL(2 CAPS/DAY)
CELEBREX 400 MG CAPSULE (*celecoxib*)	T3	PA QL(1 CAP/DAY)
CELEBREX 50 MG CAPSULE (*celecoxib*)	T3	PA QL(2 CAPS/DAY)
celecoxib 100 mg capsule (Celebrex)	T1	QL(2 CAPS/DAY) HD
celecoxib 200 mg capsule (Celebrex)	T1	QL(2 CAPS/DAY) HD
celecoxib 400 mg capsule (Celebrex)	T1	QL(1 CAP/DAY) HD
celecoxib 50 mg capsule (Celebrex)	T1	QL(2 CAPS/DAY) HD

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
URICOSURIC AGENTS		
probenecid	T1	HD
probenecid/colchicine	T1	HD
ANTI-ASTHMATICS (Asthma/COPD/Respiratory)		
5-LIPOXYGENASE INHIBITORS		
zileuton	T1	HD
ZYFLO	T3	PA HD
ANTICHOLINERGICS, ORALLY INHALED LONG ACTING		
INCRUSE ELLIPTA	T2	HD
SPIRIVA HANDIHALER 18 MCG CAP (*tiotropium bromide*)	T3	PA QL(1 INHALER/30 DAYS) HD
SPIRIVA RESPIMAT	T2	QL(1 INHALER/30 DAYS) HD
tiotropium 18 mcg cap-inhaler (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
ipratropium bromide	T1	HD
BETA-ADRENERGIC AGENTS		
albuterol sulf 2 mg/5 ml syrup	T1	HD
albuterol 8 mg/20 ml syrup cup	T1	HD
albuterol sulf 2 mg/5 ml syrup	T1	HD
albuterol sulfate 2 mg tab	T1	HD
albuterol sulfate 4 mg tab	T1	HD
albuterol sulfate er 4 mg tab	T1	HD
albuterol sulfate er 8 mg tab	T1	HD
terbutaline sulfate	T1	HD
BETA-ADRENERGIC AGENTS, INHALED, SHORT ACTING		
albuterol 100 mg/20 ml soln	T1	
albuterol 15 mg/3 ml solution	T1	
albuterol 75 mg/15 ml soln	T1	
albuterol 2.5 mg/0.5 ml sol	T1	

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ANTI-ASTHMATICS (Asthma/COPD/Respiratory) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
BETA-ADRENERGIC AGENTS, INHALED, SHORT ACTING *(cont.)*		
albuterol 25 mg/5 ml solution	T1	
albuterol 5 mg/ml solution	T1	
albuterol sul 0.63 mg/3 ml sol	T1	
albuterol sul 1.25 mg/3 ml sol	T1	
albuterol sul 2.5 mg/3 ml soln	T1	
albuterol hfa 90 mcg inhaler	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 (*levalbuterol hcl*)	T3	
XOPENEX CONCENTRATE (*levalbuterol concentrate*)	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		
arformoterol tartrate (Brovana)	T1	QL(4 MLS/DAY) HD
BROVANA *(arformoterol tartrate)*	T3	PA QL(4 MLS/DAY) HD
BETA-ADRENERGIC AGENTS, ORALLY INHALED, LONG ACTING		
formoterol fumarate (Perforomist)	T1	QL(240 MLS/30 DAYS) HD
PERFOROMIST (*formoterol fumarate*)	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
ipratropium/albuterol sulfate	T1	HD
STIOLTO RESPIMAT INHAL SPRAY	T2	QL(1 INHALER/30 DAYS) HD
UMECLIDINIUM-VILANTEROL	T3	PA QL(1 INHALER/30 DAYS) HD

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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 (*fluticasone propion/salmeterol*)	T3	ST QL(1 INHALER/30 DAYS) HD
ADVAIR 250-50 DISKUS (*fluticasone propion/salmeterol*)	T3	ST QL(1 INHALER/30 DAYS) HD
ADVAIR 500-50 DISKUS (*fluticasone propion/salmeterol*)	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 INHALR	T2	QL(1 INHALER/30 DAYS) HD
BREO ELLIPTA 200-25 MCG INHALR	T2	QL(1 INHALER/30 DAYS) HD
BREO ELLIPTA 50-25 MCG INHALER	T2	QL(1 INHALER/30 DAYS) HD
budesonide/formoterol fumarate (Symbicort)	T1	QL(1 INHALER/30 DAYS) HD
DULERA 100 MCG-5 MCG INHALER	T2	QL(1 INHALER/30 DAYS) HD
DULERA 200 MCG-5 MCG INHALER	T2	QL(1 INHALER/30 DAYS) HD
DULERA 50 MCG-5 MCG INHALER	T2	QL(1 INHALER/30 DAYS) HD
fluticasone propion/salmeterol (Advair Diskus)	T1	QL(1 INHALER/30 DAYS)
fluticasone-salmeterol 100-50 (Advair Diskus)	T1	QL(1 INHALER/30 DAYS) HD
FLUTICASONE-SALMETEROL 113-14	T3	PA QL(1 INHALER/30 DAYS) HD
FLUTICASONE-SALMETEROL 232-14	T3	PA QL(1 INHALER/30 DAYS) HD
fluticasone-salmeterol 250-50 (Advair Diskus)	T1	QL(1 INHALER/30 DAYS) HD
fluticasone-salmeterol 500-50 (Advair Diskus)	T1	QL(1 INHALER/30 DAYS) HD
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

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
BETA-ADRENERGIC AGENTS AND GLUCOCORTICOID COMBO, INHALED *(cont.)*		
SYMBICORT 160-4.5 MCG INHALER (*budesonide/formoterol fumarate*)	T3	ST QL(1 INHALER/30 DAYS) HD
SYMBICORT 80-4.5 MCG INHALER (*budesonide/formoterol fumarate*)	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)
GLUCOCORTICOIDS, 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
*budesonide 0.25 mg/2 ml susp (*Pulmicort*)*	T1	QL(4 MLS/DAY) HD
*budesonide 0.5 mg/2 ml susp (*Pulmicort*)*	T1	QL(4 MLS/DAY) HD
*budesonide 1 mg/2 ml inh susp (*Pulmicort*)*	T1	QL(2 MLS/DAY) HD
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 (*budesonide*)	T3	PA QL(4 MLS/DAY) HD
PULMICORT 0.5 MG/2 ML RESPULE (*budesonide*)	T3	PA QL(4 MLS/DAY) HD
PULMICORT 1 MG/2 ML RESPULE (*budesonide*)	T3	PA QL(2 MLS/DAY) HD

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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	T4	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
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List of Prescription Medications

ANTIBIOTICS (Ear Medications) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
OTIC PREPARATIONS, ANTI-INFLAMMATORY-ANTIBIOTICS		
CIPRO HC	T3	PA
ciprofloxacin hcl/dexameth	T1	
CIPROFLOXACIN HCL-FLUOCINOLONE	T3	PA
ciprofloxacin/hydrocortisone	T1	PA
OTOVEL	T3	
ANTIBIOTICS (Eye Conditions)		
EYE ANTIBIOTIC AND GLUCOCORTICOID COMBINATIONS		
MAXITROL (*neomycin-polymyxin-dexameth*)	T3	PA
neomycin/bacit/p-myx/hydrocort	T1	
neomycin/polymyxin b/dexametha (Maxitrol)	T1	
neomycin/polymyxin b/hydrocort	T1	
TOBRADEX	T2	
TOBRADEX ST	T2	
tobramycin/dexamethasone	T1	
ZYLET	T3	
EYE SULFONAMIDES		
sulfacetamide sodium	T1	
sulfacetamide/prednisolone sp	T1	
OPHTHALMIC ANTIBIOTICS		
AZASITE	T2	
bacitracin	T1	
bacitracin/polymyxin b sulfate	T1	
BESIVANCE	T2	
CILOXAN	T3	PA
ciprofloxacin hcl	T1	
erythromycin base	T1	
gatifloxacin	T1	
gentamicin sulfate	T1	
levofloxacin	T1	
moxifloxacin hcl (Vigamox)	T1	
neomycin sulf/bacitracin/poly	T1	
neomycin/polymyxn b/gramicidin	T1	
OCUFLOX (*ofloxacin*)	T3	PA

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List of Prescription Medications

ANTIBIOTICS (Eye Conditions) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
OPHTHALMIC ANTIBIOTICS *(cont.)*		
ofloxacin (Ocuflox)	T1	
polymyxin b sulf/trimethoprim	T1	
tobramycin 0.3% eye drop	T1	
TOBREX	T3	PA
VIGAMOX (*moxifloxacin hcl*)	T3	PA
ANTIBIOTICS (Infections)		
2ND GEN. ANAEROBIC ANTIPROTOZOAL-ANTIBACTERIAL		
SOLOSEC	T2	
ABSORBABLE SULFONAMIDE ANTIBACTERIAL AGENTS		
BACTRIM (*sulfamethoxazole-trimethoprim*)	T3	
BACTRIM DS (*sulfamethoxazole-trimethoprim*)	T3	
sulfadiazine	T1	
sulfamethoxazole/trimethoprim	T3	
sulfamethoxazole/trimethoprim (Bactrim Ds)	T1	
sulfamethoxazole/trimethoprim (Bactrim)	T1	
AMINOGLYCOSIDE ANTIBIOTICS		
ARIKAYCE	T4	PA SP
BETHKIS (*tobramycin*)	T4	PA QL(8 MLS/DAY) SP HD
gentamicin sulfate	T1	
gentamicin sulfate/pf	T1	
KITABIS PAK	T4	PA QL(10 MLS/DAY) SP HD
neomycin sulfate	T1	
TOBI (*tobramycin in 0.225% sod chlor*)	T4	PA QL(10 MLS/DAY) SP HD
TOBI PODHALER	T4	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)	T4	PA QL(8 MLS/DAY) SP HD
tobramycin 300 mg/5 ml ampule (Tobi)	T4	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	T4	PA QL(10 MLS/DAY) SP HD

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ANTIBIOTICS (Infections) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANAEROBIC ANTIPROTOZOAL-ANTIBACTERIAL AGENTS		
FLAGYL (*metronidazole*)	T3	
LIKMEZ	T3	PA
METRONIDAZOLE 125 MG TABLET	T3	PA
metronidazole 250 mg tablet	T1	
*metronidazole 375 mg capsule (*Flagyl*)*	T1	
metronidazole 500 mg tablet	T1	
ANTIBIOTIC, ANTIBACTERIAL, MISC.		
fosfomycin tromethamine	T1	
methenamine hippurate	T1	
methenamine mandelate	T1	
PRIMSOL	T2	
trimethoprim	T1	
ANTILEPROTICS		
dapsone 100 mg tablet	T1	
dapsone 25 mg tablet	T1	
THALOMID	T4	PA SP HD
ANTI-MYCOBACTERIUM AGENTS		
ethambutol hcl	T1	HD
isoniazid	T1	HD
MYCOBUTIN (*rifabutin*)	T3	PA HD
PASER	T2	HD
pyrazinamide	T1	HD
rifabutin (Mycobutin)	T1	HD
ANTI-TUBERCULAR ANTIBIOTICS		
cycloserine	T1	
PRETOMANID	T3	PA QL(1 TAB/DAY)
PRIFTIN	T3	
rifampin	T1	
SIRTURO	T3	SP
BETALACTAMS		
CAYSTON	T4	PA QL(3 MLS/DAY) SP HD
CEPHALOSPORIN ANTIBIOTICS - IST GENERATION		
cefadroxil	T1	
cephalexin	T1	

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ANTIBIOTICS (Infections) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
CEPHALOSPORIN ANTIBIOTICS - 2ND GENERATION		
cefaclor	T1	
cefprozil	T1	
cefuroxime axetil	T1	
CEPHALOSPORIN ANTIBIOTICS - 3RD GENERATION		
cefdinir	T1	
cefixime	T1	
cefpodoxime proxetil	T1	
ceftriaxone sodium	T1	
LINCOSAMIDE ANTIBIOTICS		
CLEOCIN HCL 150 MG CAPSULE (*clindamycin hcl*)	T3	
CLEOCIN HCL 300 MG CAPSULE (*clindamycin hcl*)	T3	
CLEOCIN HCL 75 MG CAPSULE (*clindamycin hcl*)	T2	
CLEOCIN PEDIATRIC (*clindamycin palmitate hcl*)	T3	
clindamycin hcl (Cleocin Hcl)	T1	
clindamycin palmitate hcl (Cleocin Pediatric)	T1	
MACROLIDE ANTIBIOTICS		
azithromycin	T1	
*azithromycin (*Zithromax Tri-Pak*)*	T1	
*azithromycin (*Zithromax*)*	T1	
clarithromycin	T1	
DIFICID 200 MG TABLET (fidaxomicin)	T3	QL(28 TABS/28 DAYS)
DIFICID 40 MG/ML SUSPENSION	T3	QL(5 MLS/DAY)
E.E.S. 200 (*erythromycin ethylsuccinate*)	T3	PA
ERYPED 200 (*erythromycin ethylsuccinate*)	T3	
ERYPED 400 (*erythromycin ethylsuccinate*)	T3	PA
ery-tab dr 250 mg tablet	T3	
ery-tab dr 333 mg tablet	T2	
ERY-TAB DR 500 MG TABLET (*erythromycin base*)	T3	
erythromycin base	T1	
erythromycin base (Ery-tab)	T1	
erythromycin ethylsuccinate	T1	
erythromycin ethylsuccinate	T2	
erythromycin ethylsuccinate (E.E.S. 200)	T1	
erythromycin ethylsuccinate (Eryped 200)	T1	

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ANTIBIOTICS (Infections) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
MACROLIDE ANTIBIOTICS *(cont.)*		
erythromycin ethylsuccinate (Eryped 400)	T1	
erythromycin stearate	T1	
fidaxomicin (Dificid)	T1	QL(28 TABS/28 DAYS)
ZITHROMAX (azithromycin)	T3	
ZITHROMAX TRI-PAK (*azithromycin*)	T3	
NITROFURAN DERIVATIVES ANTIBACTERIAL AGENTS		
FURADANTIN (*nitrofurantoin*)	T3	
MACROBID (*nitrofurantoin mono-macro*)	T3	
nitrofurantoin 25 mg/5 ml susp (Furadantin)	T1	
NITROFURANTOIN 50 MG/5 ML SUSP	T3	PA
nitrofurantoin mcr 100 mg cap	T1	
nitrofurantoin mcr 25 mg cap	T1	
nitrofurantoin mcr 50 mg cap	T1	
nitrofurantoin monohyd/m-cryst (Macrobid)	T1	
OXAZOLIDINONE ANTIBIOTICS		
linezolid (Zyvox)	T1	PA
SIVEXTRO	T3	PA
ZYVOX (*linezolid*)	T3	PA
PENICILLIN ANTIBIOTICS		
amoxicillin	T1	
amoxicillin/potassium clav	T1	
amoxicillin/potassium clav (Augmentin Es-600)	T1	
amoxicillin/potassium clav (Augmentin Xr)	T1	
amoxicillin/potassium clav (Augmentin)	T1	
ampicillin trihydrate	T1	
AUGMENTIN 125-31.25 MG/5 ML	T2	PA
AUGMENTIN 250-62.5 MG/5 ML (*amoxicillin-clavulanate potass*)	T3	PA
AUGMENTIN ES-600 (*amoxicillin/potassium clav*)	T3	PA
AUGMENTIN XR (*amoxicillin-clavulanate pot er*)	T3	PA
dicloxacillin sodium	T1	
MOXATAG	T3	
penicillin v potassium	T1	

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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 (*ciprofloxacin*)	T2	
CIPRO 250 MG TABLET (*ciprofloxacin hcl*)	T3	
CIPRO 5% SUSPENSION (*ciprofloxacin*)	T2	
CIPRO 500 MG TABLET (*ciprofloxacin hcl*)	T3	
ciprofloxacin (Cipro)	T1	
ciprofloxacin hcl	T1	
ciprofloxacin hcl (Cipro)	T1	
FACTIVE	T3	
levofloxacin	T1	
moxifloxacin hcl (Avelox)	T1	
ofloxacin	T1	
RIFAMYCINS AND RELATED DERIVATIVE ANTIBIOTICS		
AEMCOLO	T3	QL(12 TABS/30 DAYS)
XIFAXAN 200 MG TABLET	T2	QL(9 TABS/30 DAYS)
XIFAXAN 550 MG TABLET	T2	QL(42 TABS/30 DAYS)
TETRACYCLINE ANTIBIOTICS		
ACTICLATE (*doxycycline hyclate*)	T3	ST
coremino er 135 mg tablet	T1	
coremino er 45 mg tablet	T1	QL(1 TAB/DAY)
coremino er 90 mg tablet	T1	
demeclocycline hcl	T1	
DORYX	T3	PA
DORYX (*doxycycline hyclate*)	T3	PA
DORYX MPC	T3	PA
doxycycline 50 mg tablet (Targadox)	T1	
doxycycline hyc dr 100 mg tab	T1	PA
doxycycline hyc dr 150 mg tab	T1	PA
doxycycline hyc dr 200 mg tab (Doryx)	T1	PA
doxycycline hyc dr 50 mg tab	T1	PA
doxycycline hyc dr 75 mg tab	T1	PA

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ANTIBIOTICS (Infections) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
TETRACYCLINE ANTIBIOTICS *(cont.)*		
DOXYCYCLINE HYC DR 80 MG TAB	T3	PA
doxycycline hyclate 100 mg cap (	T1	
doxycycline hyclate 100 mg tab (Lymepak)	T1	
doxycycline hyclate 150 mg tab (Acticlate)	T1	
doxycycline hyclate 50 mg cap	T1	
doxycycline hyclate 75 mg tab (Acticlate)	T1	
doxycycline monohydrate (Oracea)	T1	
doxycycline monohydrate	T1	
EMROSI	T3	PA
MINOCIN (*minocycline hcl*)	T3	PA
MINOCYCLINE ER	T3	ST
minocycline er 105 mg tablet	T1	
minocycline er 115 mg tablet (Solodyn)	T1	
minocycline er 135 mg tablet	T1	
minocycline er 45 mg tablet	T1	QL(1 TAB/DAY)
minocycline er 55 mg tablet	T1	
minocycline er 65 mg tablet	T1	
minocycline er 80 mg tablet	T1	
minocycline er 90 mg tablet	T1	
minocycline hcl	T1	
MINOLIRA ER	T3	ST
NUZYRA	T4	PA QL(30 TABS/28 DAYS) SP
ORACEA (*doxycycline monohydrate*)	T3	PA
SEYSARA	T3	PA
SOLODYN (*minocycline hcl er*)	T3	PA
TARGADOX (*doxycycline hyclate*)	T3	PA
tetracycline 250 mg capsule, 500 mg capsule	T1	
tetracycline 250 mg tablet, 500 mg tablet	T1	PA
XIMINO	T3	ST
VAGINAL ANTIBIOTICS		
CLEOCIN	T3	PA
CLEOCIN (*clindamycin phosphate*)	T3	PA
clindamycin phosphate (Cleocin)	T1	
CLINDESSE	T3	

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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
VANCOCIN HCL (*vancomycin hcl*)	T3	PA
vancomycin 25 mg/ml oral soln	T1	
VANCOMYCIN 25 MG/ML ORAL SOLN	T3	PA
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	

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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
mafenide acetate	T1	
PLEXION	T3	
SILVADENE (*silver sulfadiazine*)	T3	
silver sulfadiazine (Silvadene)	T1	
sulfacetamide sodium/sulfur	T1	
SULFAMYLON	T2	
ANTI-COAGULANTS (Blood Thinners/Anti-Clotting)		
ANTI-COAGULANTS, COUMARIN TYPE		
warfarin sodium	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	
rivaroxaban (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 (*rivaroxaban*)	T2	
HEPARIN AND RELATED PREPARATIONS		
ARIXTRA 10 MG/0.8 ML SYRINGE (*fondaparinux sodium*)	T4	QL(0.8 ML/DAY) SP
ARIXTRA 2.5 MG/0.5 ML SYRINGE (*fondaparinux sodium*)	T4	QL(0.5 ML/DAY) SP
ARIXTRA 5 MG/0.4 ML SYRINGE (*fondaparinux sodium*)	T4	QL(0.4 ML/DAY) SP

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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 (*fondaparinux sodium*)	T4	QL(0.6 ML/DAY) SP
enoxaparin 100 mg/ml syringe (Lovenox)	T4	QL(2 SYRINGES/DAY) SP
enoxaparin 120 mg/0.8 ml syr (Lovenox)	T4	QL(2 SYRINGES/DAY) SP
enoxaparin 150 mg/ml syringe (Lovenox)	T4	QL(2 SYRINGES/DAY) SP
enoxaparin 30 mg/0.3 ml syr (Lovenox)	T4	QL(2 SYRINGES/DAY) SP
enoxaparin 300 mg/3 ml vial (Lovenox)	T4	QL(1 VIAL/DAY) SP
enoxaparin 40 mg/0.4 ml syr (Lovenox)	T4	QL(2 SYRINGES/DAY) SP
enoxaparin 60 mg/0.6 ml syr (Lovenox)	T4	QL(2 SYRINGES/DAY) SP
enoxaparin 80 mg/0.8 ml syr (Lovenox)	T4	QL(2 SYRINGES/DAY) SP
*fondaparinux 10 mg/0.8 ml syr (*Arixtra*)*	T4	QL(0.8 ML/DAY) SP
*fondaparinux 2.5 mg/0.5 ml syr (*Arixtra*)*	T4	QL(0.5 ML/DAY) SP
*fondaparinux 5 mg/0.4 ml syr (*Arixtra*)*	T4	QL(0.4 ML/DAY) SP
*fondaparinux 7.5 mg/0.6 ml syr (*Arixtra*)*	T4	QL(0.6 ML/DAY) SP
FRAGMIN 10,000 UNIT/4 ML VIAL	T4	QL(1 VIAL/DAY) SP
FRAGMIN 10,000 UNIT/ML SYRINGE	T4	QL(2 SYRINGES/DAY) SP
FRAGMIN 12,500 UNIT/0.5 ML SYR	T4	QL(2 SYRINGES/DAY) SP
FRAGMIN 15,000 UNIT/0.6 ML SYR	T4	QL(2 SYRINGES/DAY) SP
FRAGMIN 18,000 UNIT/0.72 ML	T4	QL(2 SYRINGES/DAY) SP
FRAGMIN 2,500 UNIT/0.2 ML SYR	T4	QL(2 SYRINGES/DAY) SP
FRAGMIN 5,000 UNIT/0.2 ML SYR	T4	QL(2 SYRINGES/DAY) SP
FRAGMIN 7,500 UNIT/0.3 ML SYR	T4	QL(2 SYRINGES/DAY) SP
FRAGMIN 95,000 UNIT/3.8 ML VL	T4	QL(1 VIAL/DAY) SP
heparin 10,000 unit/10 ml vial	T1	
heparin 2,000 unit/2 ml vial	T1	
heparin 30,000 unit/30 ml vial	T1	
heparin 40,000 unit/4 ml vial	T1	
heparin 5,000 unit/ml carpujct	T1	
heparin 50,000 unit/10 ml vial	T1	
heparin 50,000 unit/5 ml vial	T1	
heparin sod 1,000 unit/ml vial	T1	
heparin sod 10,000 unit/ml vl	T1	
heparin sod 20,000 unit/ml vl	T1	
heparin sod 5,000 unit/0.5 ml	T1	
HEPARIN SOD 5,000 UNIT/0.5 ML	T1	

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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	
heparin sod 5,000 unit/ml syrg	T3	
heparin sod 5,000 unit/ml vial	T1	
LOVENOX 100 MG/ML SYRINGE (*enoxaparin sodium*)	T4	PA QL(2 SYRINGES/DAY) SP
LOVENOX 120 MG/0.8 ML SYRINGE (*enoxaparin sodium*)	T4	PA QL(2 SYRINGES/DAY) SP
LOVENOX 150 MG/ML SYRINGE (*enoxaparin sodium*)	T4	PA QL(2 SYRINGES/DAY) SP
LOVENOX 30 MG/0.3 ML SYRINGE (*enoxaparin sodium*)	T4	PA QL(2 SYRINGES/DAY) SP
LOVENOX 300 MG/3 ML VIAL (*enoxaparin sodium*)	T4	PA QL(1 VIAL/DAY) SP
LOVENOX 40 MG/0.4 ML SYRINGE (*enoxaparin sodium*)	T4	PA QL(2 SYRINGES/DAY) SP
LOVENOX 60 MG/0.6 ML SYRINGE (*enoxaparin sodium*)	T4	PA QL(2 SYRINGES/DAY) SP
LOVENOX 80 MG/0.8 ML SYRINGE (*enoxaparin sodium*)	T4	PA QL(2 SYRINGES/DAY) SP
THROMBIN INHIBITORS, SELECTIVE, DIRECT, REVERSIBLE		
dabigatran etexilate mesylate (Pradaxa)	T1	HD
PRADAXA 110 MG CAPSULE (*dabigatran etexilate mesylate*)	T3	PA HD
PRADAXA 110 MG PELLET PACK	T4	PA QL(2 PACKS/DAY) SP
PRADAXA 150 MG CAPSULE (*dabigatran etexilate mesylate*)	T3	PA HD
PRADAXA 150 MG PELLET PACK	T4	PA QL(2 PACKS/DAY) SP
PRADAXA 20 MG PELLET PACK	T4	PA QL(2 PACKS/DAY) SP
PRADAXA 30 MG PELLET PACK	T4	PA QL(4 PACKS/DAY) SP
PRADAXA 40 MG PELLET PACK	T4	PA QL(4 PACKS/DAY) SP
PRADAXA 50 MG PELLET PACK	T4	PA QL(4 PACKS/DAY) SP
PRADAXA 75 MG CAPSULE (*dabigatran etexilate mesylate*)	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)
naloxone 0.4 mg/ml carpuject	T1	
naloxone 0.4 mg/ml vial	T1	

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List of Prescription Medications

ANTIDOTES (Substance Abuse) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
OPIOID ANTAGONISTS *(cont.)*		
naloxone 0.4 mg/ml vial	T1	
naloxone 2 mg/2 ml syringe	T1	
naloxone 4 mg/10 ml vial	T1	
naloxone hcl 4 mg nasal spray (Narcan)	T1	QL(2 UNITS/30 DAYS)
naltrexone hcl	T1	QL(180 TABS/30 DAYS)
NARCAN (*naloxone hcl*)	T2	QL(2 UNITS/30 DAYS)
OPVEE	T3	QL(2 UNITS/30 DAYS)
REXTOVY	T2	QL(2 UNITS/30 DAYS)
ZIMHI	T3	QL(2 SYRINGES/30 DAYS)
ANTI-FUNGALS (Eye Conditions)		
OPHTHALMIC ANTI-FUNGAL AGENTS		
NATACYN	T2	
ANTI-FUNGALS (Feminine Products)		
VAGINAL ANTI-FUNGALS		
GYNAZOLE 1	T1	
miconazole nitrate	T1	
terconazole	T1	
ANTI-FUNGALS (Infections)		
ANTI-FUNGAL AGENTS		
ANCOBON (*flucytosine*)	T3	
clotrimazole	T1	
CRESEMBA	T3	PA
DIFLUCAN (*fluconazole*)	T3	PA
fluconazole	T1	
fluconazole (Diflucan)	T1	
flucytosine (Ancobon)	T1	
itraconazole	T1	
itraconazole (Sporanox)	T1	
ketoconazole	T1	
NOXAFIL 40 MG/ML SUSPENSION	T3	
NOXAFIL DR 100 MG TABLET (*posaconazole*)	T3	PA
ORAVIG	T3	
posaconazole	T1	

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ANTI-FUNGALS (Infections) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-FUNGAL AGENTS *(cont.)*		
posaconazole (Noxafil)	T1	
SPORANOX (*itraconazole*)	T3	PA
terbinafine hcl	T1	
TOLSURA	T3	
VFEND (*voriconazole*)	T3	PA
VIVJOA	T4	PA SP
voriconazole (Vfend)	T1	PA
ANTI-FUNGAL ANTIBIOTICS		
BREXAFEMME	T3	PA
FULVICIN P-G	T3	PA QL(4 TABS/DAY)
griseofulvin ultra 125 mg tab	T1	
griseofulvin ultra 165 mg tab	T1	QL(4 TABS/DAY)
griseofulvin ultra 250 mg tab	T1	
griseofulvin, microsize	T1	
nystatin	T1	
ANTI-FUNGALS (Skin Conditions)		
TOPICAL ANTI-FUNGAL/ANTI-INFLAMMATORY, STEROID AGENT		
clotrimazole/betamethasone dip	T1	
TOPICAL ANTI-FUNGALS		
ciclodan 0.77% cream (Loprox)	T1	
CICLODAN 0.77% CREAM KIT	T3	
CICLODAN 8% KIT	T3	
ciclodan 8% solution	T1	
ciclopirox	T1	
ciclopirox olamine (Loprox)	T1	
ciclopirox/urea/camph/men/euc	T1	
econazole nitrate 1% cream	T1	
ECOZA	T3	
ERTACZO	T3	PA
EXELDERM	T3	PA
EXODERM	T1	
EXTINA (*ketoconazole*)	T3	PA
JUBLIA	T3	PA

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ANTI-FUNGALS (Skin Conditions) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
TOPICAL ANTI-FUNGALS *(cont.)*		
ketoconazole	T1	
ketoconazole (Extina)	T1	
LOPROX 0.77% CREAM (*ciclopirox*)	T3	PA
LOPROX 0.77% SUSPENSION KIT	T3	
LOPROX 0.77% TOPICAL SUSP (*ciclopirox olamine*)	T3	
LULICONAZOLE	T1	
LUZU	T3	PA
MICONAZOLE-ZINC OXIDE-PETROLTM	T1	PA
naftifine hcl	T1	
naftifine hcl (Naftin)	T1	
NAFTIN (*naftifine hcl*)	T2	
nystatin	T1	
nystatin/triamcinolone acet	T1	
oxiconazole nitrate	T1	PA
OXISTAT	T2	PA
SULCONAZOLE NITRATE	T3	PA
tavaborole	T1	PA
VUSION	T3	PA
XOLEGEL	T3	PA
ANTIHISTAMINE AND DECONGESTANT COMBINATION (Allergy/Nasal Sprays)		
1ST GEN ANTIHISTAMINE AND DECONGESTANT COMBINATION		
phenylephrine hcl/prometh hcl	T1	
2ND GEN ANTIHISTAMINE AND DECONGESTANT COMBINATION		
CLARINEX-D 12 HOUR	T3	
ANTIHISTAMINES (Allergy/Nasal Sprays)		
ANTIHISTAMINES - 1ST GENERATION		
carbinoxamine 4 mg/5 ml liquid	T1	
carbinoxamine maleate	T1	
carbinoxamine maleate 4 mg tab	T1	
carbinoxamine maleate 6 mg tab	T1	PA
CARBINOXAMINE MALEATE ER	T3	PA
clemastine 0.5 mg/5 ml syrup	T1	PA
clemastine fum 2.68 mg tablet	T1	

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List of Prescription Medications

ANTIHISTAMINES (Allergy/Nasal Sprays) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIHISTAMINES - 1ST GENERATION *(cont.)*		
clemastine fumarate	T1	
cyproheptadine hcl	T1	
dexchlorpheniramine maleate (Ryclora)	T1	PA
hydroxyzine hcl	T1	
hydroxyzine pamoate	T1	
hydroxyzine pamoate (Vistaril)	T1	
KARBINAL ER	T3	PA
promethazine hcl	T1	
RYCLORA (*dexchlorpheniramine maleate*)	T3	PA
RYVENT	T3	PA
VISTARIL (*hydroxyzine pamoate*)	T3	
ANTIHISTAMINES - 2ND GENERATION		
cetirizine hcl	T1	HD
CLARINEX (*desloratadine*)	T3	PA HD
DESLORATADINE 0.5 MG/ML SOLN	T3	HD
desloratadine 2.5 mg odt	T1	QL(1 TAB/DAY) HD
desloratadine 5 mg odt	T1	HD
desloratadine 5 mg tablet (Clarinex)	T1	HD
levocetirizine dihydrochloride	T1	HD
ANTIHISTAMINES (Eye Conditions)		
EYE ANTIHISTAMINES		
azelastine hcl 0.05% drops	T1	
bepotastine besilate (Bepreve)	T1	
BEPREVE (*bepotastine besilate*)	T3	PA
epinastine hcl	T1	
olopatadine hcl 0.1% eye drops	T1	
olopatadine hcl 0.2% eye drop	T1	
ZERVIATE	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

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ANTI-HYPERGLYCEMICS (Diabetes) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIHYPERGLY, INCRETIN MIMETIC (GLP-1 RECEP.AGONIST)		
BYDUREON	T2	PA QL(4 MLS/28 DAYS)
BYETTA	T3	PA QL(3 MLS/30 DAYS)
exenatide	T1	PA QL(3 MLS/30 DAYS)
liraglutide 2-pak 18 mg/3 ml (Victoza 2-Pak)	T1	PA QL(3 PENS/30 DAYS)
liraglutide 2-pak 18 mg/3 ml (Victoza 3-Pak)	T1	PA QL(3 PENS/30 DAYS)
liraglutide 3-pak 18 mg/3 ml (Victoza 2-Pak)	T1	PA QL(3 PENS/30 DAYS)
liraglutide 3-pak 18 mg/3 ml (Victoza 3-Pak)	T1	PA QL(3 PENS/30 DAYS)
OZEMPIC	T2	PA QL(3 MLS/28 DAYS)
RYBELSUS	T2	PA QL(1 TAB/DAY)
TRULICITY	T2	PA QL(2 MLS/28 DAYS)
VICTOZA 2-PAK (liraglutide)	T3	PA QL(3 PENS/30 DAYS)
VICTOZA 3-PAK (liraglutide)	T3	PA QL(3 PENS/30 DAYS)
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		
acarbose (Precose)	T1	HD
miglitol	T1	HD
PRECOSE (*acarbose*)	T3	HD
ANTI-HYPERGLYCEMIC, AMYLIN ANALOG-TYPE		
SYMLINPEN 120	T2	HD
SYMLINPEN 60	T2	
ANTI-HYPERGLYCEMIC, BIGUANIDE TYPE		
GLUMETZA (*metformin hcl*)	T3	PA
metformin hcl	T1	HD
metformin hcl	T1	PA HD
metformin hcl (Glumetza)	T1	PA HD

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ANTI-HYPERGLYCEMICS (Diabetes) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-HYPERGLYCEMIC, BIGUANIDE TYPE *(cont.)*		
metformin hcl 1,000 mg tablet	T1	HD
metformin hcl 500 mg tablet	T1	HD
metformin hcl 500 mg/5 ml cup (Riomet)	T1	HD
metformin hcl 500 mg/5 ml soln (Riomet)	T1	HD
METFORMIN HCL 625 MG TABLET	T3	PA HD
metformin hcl 750 mg tablet	T1	HD
METFORMIN HCL 750 MG TABLET	T3	PA HD
metformin hcl 850 mg tablet	T1	HD
RIOMET (*metformin hcl*)	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 (saxagliptin hcl)	T3	PA QL(1 TAB/DAY) HD
saxagliptin hcl (Onglyza)	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		
glimepiride 1 mg tablet	T1	HD
glimepiride 2 mg tablet	T1	HD
GLIMEPIRIDE 3 MG TABLET	T3	HD
glimepiride 4 mg tablet	T1	HD
glipizide (Glucotrol XI)	T1	HD
glipizide 10 mg tablet	T1	HD
GLIPIZIDE 2.5 MG TABLET	T3	HD
glipizide 5 mg tablet	T1	HD
GLUCOTROL XL (*glipizide*)	T3	HD
glyburide	T1	HD
glyburide,micronized	T1	HD
glyburide, micronized (Glynase)	T1	HD
GLYNASE (*glyburide micronized*)	T3	HD
nateglinide	T1	HD
repaglinide	T1	HD

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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 (*pioglitazone-metformin*)	T3	HD
pioglitazone hcl/metformin hcl	T1	HD
pioglitazone hcl/metformin hcl (Actoplus Met)	T1	HD
ANTI-HYPERGLYCEMIC, THIAZOLIDINEDIONE-SULFONYLUREA		
DUETACT (*pioglitazone hcl/glimepiride*)	T3	HD
pioglitazone hcl/glimepiride (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 (*saxagliptin hcl/metformin hcl*)	T3	PA QL(2 TABS/DAY) HD
KOMBIGLYZE XR 5-1,000 MG TAB (*saxagliptin hcl/metformin hcl*)	T3	PA QL(1 TAB/DAY) HD
KOMBIGLYZE XR 5-500 MG TABLET (*saxagliptin hcl/metformin hcl*)	T3	PA QL(1 TAB/DAY) HD
linagliptin/metformin hcl	T1	QL(2 TABS/DAY) HD
*saxagliptin-metformin er 5-500 (*Kombiglyze Xr*)*	T1	QL(1 TAB/DAY) HD
*saxagliptin-metformn er 5-1000 (*Kombiglyze Xr*)*	T1	QL(1 TAB/DAY) HD
*saxagliptn-metform er 2.5-1000 (*Kombiglyze Xr*)*	T1	QL(2 TABS/DAY) HD
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

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ANTI-HYPERGLYCEMIC, INSULIN-RELEASE STIM.-BIGUANIDE		
glipizide/metformin hcl	T1	HD
glyburide/metformin hcl	T1	HD
ANTI-HYPERGLYCEMIC, THIAZOLIDINEDIONE (PPARG AGONIST)		
ACTOS (*pioglitazone hcl*)	T3	PA HD
pioglitazone hcl (Actos)	T1	HD
ANTI-HYPERGLYCEMIC-GLUCOCORTICOID RECEPTOR BLOCKER		
KORLYM (*mifepristone*)	T4	PA SP
mifepristone 300 mg tablet (Korlym)	T4	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

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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

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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
MERILOG	T3	PA QL(1.5 MLS/DAY) HD
MERILOG 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

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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		
acetic acid/oxyquinoline (Relagard)	T1	
RELAGARD (*acetic acid/oxyquinoline*)	T3	
TRIMO-SAN	T3	
ANTI-INFECTIVES/MISCELLANEOUS (Infections)		
2ND GEN. ANAEROBIC ANTI-PROTOZOAL-ANTIBACTERIAL		
tinidazole	T1	
AMEBICIDES		
HUMATIN	T3	PA
ANTHELMINTICS		
albendazole	T1	
BILTRICIDE (*praziquantel*)	T3	
EMVERM	T1	
ivermectin 3 mg tablet (Stromectol)	T1	PA
ivermectin 6 mg tablet	T1	PA
praziquantel (Biltricide)	T1	
STROMECTOL (*ivermectin*)	T3	PA

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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*)	T4	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)	T4	PA SP
quinine sulfate	T1	
SOVUNA	T3	PA
ANTI-PROTOZOAL DRUGS, MISCELLANEOUS		
atovaquone (Mepron)	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	

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

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

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-INFLAMMATORY TUMOR NECROSIS FACTOR INHIBITOR *(cont.)*		
HYRIMOZ(CF) 40 MG/0.4 ML SYRNG	T4	PA QL(4 SYRINGES/28 DAYS) SP HD
HYRIMOZ(CF) PEDI CROHN 80 MG	T4	PA QL(3 SYRINGES/365 DAYS) SP HD
HYRIMOZ(CF) PEDI CROHN 80-40MG	T4	PA QL(1 SYRINGE/365 DAYS) SP HD
HYRIMOZ(CF) PEN 40 MG/0.4 ML	T4	PA QL(4 PENS/28 DAYS) SP HD
HYRIMOZ(CF) PEN 80 MG/0.8 ML	T4	PA QL(2 PENS/28 DAYS) SP HD
HYRIMOZ(CF) PEN CROHN-UC START	T4	PA QL(3 PENS/365 DAYS) SP HD
HYRIMOZ(CF) PEN PSORIASIS	T4	PA QL(1 PEN/365 DAYS) SP HD
IDACIO(CF) PEN CROHN'S-UC(6PK)	T4	PA QL(1 STARTER KIT/365 DAYS) SP HD
IDACIO(CF) PEN PSORIASIS (4PK)	T4	PA QL(2 KITS/365 DAYS) SP HD
INFLECTRA	T4	PA SP HD
INFLIXIMAB	T4	PA SP HD
REMICADE	T4	PA SP HD
SIMLANDI(CF) 20 MG/0.2 ML SYRG	T4	PA QL(2 PENS/SYRINGES/28 DAYS) SP HD
SIMLANDI(CF) 40 MG/0.4 ML SYRG	T4	PA QL(4 SRNGE KITS/28 DAYS) SP HD
SIMLANDI(CF) 80 MG/0.8 ML SYRG	T4	PA QL(2 PENS/SYRINGES/28 DAYS) SP HD
SIMLANDI(CF) AI 40 MG/0.4 ML	T4	PA QL SP HD
SIMLANDI(CF) AI 80 MG/0.8 ML	T4	PA QL(2 AUTO-INJS/28 DAYS) SP HD
SIMPONI 100 MG/ML PEN INJECTOR	T4	PA QL(1 PEN/28 DAYS) SP HD
SIMPONI 100 MG/ML SYRINGE	T4	PA QL(1 SYRINGE/28 DAYS) SP HD
SIMPONI 50 MG/0.5 ML PEN INJEC	T4	PA QL(1 PEN/28 DAYS) SP HD
SIMPONI 50 MG/0.5 ML SYRINGE	T4	PA QL(1 SYRINGE/28 DAYS) SP HD
SIMPONI ARIA	T4	PA SP HD
YUFLYMA(CF) 20 MG/0.2 ML SYRNG	T4	PA QL(2 PENS/SYRINGES/28 DAYS) SP
YUFLYMA(CF) 40 MG/0.4 ML SYRNG	T4	PA QL(4 SRNGE KITS/28 DAYS) SP
YUFLYMA(CF) 40MG/0.4ML AUTOINJ	T4	PA QL SP
YUFLYMA(CF) 80MG/0.8ML AUTOINJ	T4	PA QL(2 AUTO-INJS/28 DAYS) SP
YUFLYMA(CF) AI CROHN'S-UC-HS	T4	PA QL(3 PENS/365 DAYS) SP
YUSIMRY(CF) PEN	T4	PA QL(4 PENS/28 DAYS) SP
ANTI-NEOPLASTICS (Cancer)		
ANP - SELECTIVE RETINOID X RECEPTOR AGONISTS (RXR)		
bexarotene 75 mg capsule (Targretin)	T4	PA SP HD CSL
TARGRETIN 75 MG CAPSULE (*bexarotene*)	T4	PA SP HD CSL
ANTI-NEOPLAST, HISTONE DEACETYLASE (HDAC) INHIBITORS		
ZOLINZA	T4	PA SP HD

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ANTI-NEOPLASTICS (Cancer) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTINEOPLASTIC - ALKYLATING AGENTS		
ALKERAN (*melphalan*)	T4	SP CSL
cyclophosphamide 25 mg capsule	T4	SP HD CSL
cyclophosphamide 50 mg capsule	T4	SP HD CSL
CYCLOPHOSPHAMIDE 50 MG TABLET	T4	PA SP HD CSL
GLEOSTINE	T2	CSL
HYDREA (*hydroxyurea*)	T3	CSL
hydroxyurea (Hydrea)	T1	CSL
LEUKERAN	T2	CSL
lomustine	T1	CSL
MYLERAN	T2	CSL
temozolomide	T4	PA SP HD CSL
ANTI-NEOPLASTIC - ANTI-ANDROGENIC AGENTS		
abiraterone acetate (Zytiga)	T1	PA CSL
abiraterone acetate 250 mg tab (Zytiga)	T4	PA SP HD CSL
abiraterone acetate 500 mg tab (Zytiga)	T4	PA SP HD CSL
bicalutamide (Casodex)	T1	CSL
CASODEX (*bicalutamide*)	T3	CSL
EULEXIN (*flutamide*)	T3	CSL
flutamide (Eulexin)	T1	CSL
NILANDRON (*nilutamide*)	T3	PA QL(4 TABS/DAY) CSL
nilutamide (Nilandron)	T1	QL(4 TABS/DAY) CSL
NUBEQA	T4	PA SP HD CSL
XTANDI	T4	PA SP HD CSL
YONSA	T4	PA SP HD CSL
ZYTIGA (*abiraterone acetate*)	T4	PA SP HD CSL
ANTI-NEOPLASTIC - ANTI-METABOLITES		
capecitabine 150 mg tablet (Xeloda)	T4	PA SP HD CSL
capecitabine 500 mg tablet (Xeloda)	T4	PA SP HD CSL
INQOVI	T4	PA SP HD CSL
JYLAMVO	T3	CSL
LONSURF	T4	PA SP HD CSL

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ANTI-NEOPLASTICS (Cancer) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-NEOPLASTIC - ANTI-METABOLITES *(cont.)*		
mercaptopurine 20 mg/ml suspen (Purixan)	T4	SP CSL
mercaptopurine 50 mg tablet	T1	CSL
methotrexate 2.5 mg tablet	T1	CSL
methotrexate 250 mg/10 ml vial	T1	
methotrexate 50 mg/2 ml vial	T1	
methotrexate sodium/pf	T1	
ONUREG	T4	PA QL(14 TABS/28 DAYS) SP CSL
PURIXAN (*mercaptopurine*)	T4	SP CSL
TABLOID	T3	CSL
TREXALL	T2	CSL
XATMEP	T3	CSL
XELODA (*capecitabine*)	T4	PA SP HD CSL
ANTI-NEOPLASTIC - AROMATASE INHIBITORS		
anastrozole (Arimidex)	T1	HD PPACA CSL
ARIMIDEX (*anastrozole*)	T3	HD CSL
AROMASIN (*exemestane*)	T3	HD CSL
exemestane (Aromasin)	T1	HD PPACA CSL
FEMARA (*letrozole*)	T3	PA HD CSL
letrozole (Femara)	T1	HD CSL
ANTI-NEOPLASTIC - BRAF KINASE INHIBITORS		
BRAFTOVI	T4	PA SP HD CSL
OJEMDA 100 MG TAB (400MG DOSE)	T4	PA QL(1 PACKET/28 Days) SP CSL
OJEMDA 100 MG TAB (500MG DOSE)	T4	PA QL(1 PACKET/28 Days) SP CSL
OJEMDA 100 MG TAB (600MG DOSE)	T4	PA QL(1 PACKET/28 Days) SP CSL
OJEMDA 25 MG/ML ORAL SUSP	T4	PA QL(8 BOTTLES/28 DAYS) SP CSL
TAFINLAR 10 MG TABLET FOR SUSP	T4	PA QL(30 TABS/DAY) SP HD CSL
TAFINLAR 50 MG CAPSULE	T4	PA QL(4 CAPS/DAY) SP HD CSL
TAFINLAR 75 MG CAPSULE	T4	PA QL(4 CAPS/DAY) SP HD CSL
ZELBORAF	T4	PA SP HD CSL
ANTINEOPLASTIC - EGFR AND MET RECEPTOR INHIB, MAB		
RYBREVANT	T4	PA SP
ANTI-NEOPLASTIC - HEDGEHOG PATHWAY INHIBITOR		
DAURISMO	T4	PA SP HD CSL
ERIVEDGE	T4	PA SP HD CSL
ODOMZO	T4	PA SP HD CSL

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List of Prescription Medications

ANTI-NEOPLASTICS (Cancer) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-NEOPLASTIC - JANUS KINASE (JAK) INHIBITORS		
JAKAFI	T4	PA QL(2 TABS/DAY) SP HD CSL
ANTI-NEOPLASTIC - KRAS PROTEIN INHIBITOR		
KRAZATI	T4	PA QL(6 TABS/DAY) SP CSL
LUMAKRAS 120 MG TABLET	T4	PA QL(8 TABS/DAY) SP HD CSL
LUMAKRAS 240 MG TABLET	T4	PA QL(4 TABS/DAY) SP HD CSL
LUMAKRAS 320 MG TABLET	T4	PA QL(3 TABS/DAY) SP HD CSL
ANTI-NEOPLASTIC - MEKI AND MEK2 KINASE INHIBITORS		
COTELLIC	T4	PA SP HD CSL
GOMEKLI	T4	PA SP CSL
KOSELUGO 10 MG CAPSULE	T4	PA QL(10 CAPS/DAY) SP CSL
KOSELUGO 25 MG CAPSULE	T4	PA QL(4 CAPS/DAY) SP CSL
KOSELUGO 5 MG SPRINKLE CAPSULE	T4	PA QL(20 CAPS/DAY) SP CSL
KOSELUGO 7.5 MG SPRINKLE CAP	T4	PA QL(12 CAPS/DAY) SP CSL
MEKINIST 0.05 MG/ML SOLUTION	T4	PA QL(40 MLS/DAY) SP HD CSL
MEKINIST 0.5 MG TABLET	T4	PA QL(3 TABS/DAY) SP HD CSL
MEKINIST 2 MG TABLET	T4	PA QL(1 TAB/DAY) SP HD CSL
MEKTOVI	T4	PA QL(6 TABS/DAY) SP HD CSL
ANTI-NEOPLASTIC - MTOR KINASE INHIBITORS		
AFINITOR (*everolimus*)	T4	PA SP HD
AFINITOR DISPERZ (*everolimus*)	T4	PA QL(1 TAB/DAY) SP CSL
everolimus (Afinitor)	T4	PA QL(1 tab/day) SP HD CSL
everolimus 10 mg tablet (Afinitor)	T4	PA QL(1 TAB/DAY) SP HD CSL
everolimus 2 mg tab for susp (Afinitor Disperz)	T4	PA QL(1 TAB/DAY) SP CSL
everolimus 2.5 mg tablet (Afinitor)	T4	PA QL(1 TAB/DAY) SP HD CSL
everolimus 3 mg tab for susp (Afinitor Disperz)	T4	PA QL(1 TAB/DAY) SP CSL
everolimus 5 mg tab for susp (Afinitor Disperz)	T4	PA QL(1 TAB/DAY) SP CSL
everolimus 5 mg tablet (Afinitor)	T4	PA QL(1 TAB/DAY) SP HD CSL
everolimus 7.5 mg tablet (Afinitor)	T4	PA QL(1 TAB/DAY) SP HD CSL
FYARRO	T4	PA SP
ANTI-NEOPLASTIC - PROTEIN METHYLTRANSFERASE INHIBIT		
TAZVERIK	T4	PA SP CSL
ANTINEOPLASTIC - SYSTEMIC ENZYME INHIBITORS COMBS		
AVMAPKI-FAKZYNJA	T4	PA SP CSL

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List of Prescription Medications

ANTI-NEOPLASTICS (Cancer) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-NEOPLASTIC - TOPOISOMERASE I INHIBITORS		
HYCAMTIN	T4	PA SP HD CSL
ANTI-NEOPLASTIC COMB - KINASE AND AROMATASE INHIBIT		
KISQALI FEMARA CO-PACK	T4	PA QL(1 TAB/28 DAYS) SP CSL
ANTI-NEOPLASTIC EGF RECEPTOR BLOCKER MCLON ANTIBODY		
PHESGO	T4	PA SP HD
ANTI-NEOPLASTIC IMMUNOMODULATOR AGENTS		
lenalidomide	T4	PA QL(1 CAP/DAY) SP HD CSL
POMALYST	T4	PA QL(21 CAPS/28 DAYS) SP HD CSL
REVLIMID	T4	PA QL(1 CAP/DAY) SP HD CSL
ANTI-NEOPLASTIC LHRH (GNRH) AGONIST, PITUITARY SUPPR.		
leuprolide acetate	T4	PA SP HD
LEUPROLIDE DEPOT	T4	PA SP
LUPRON DEPOT 22.5 MG 3MO KIT	T4	PA SP HD
LUPRON DEPOT 45 MG 6MO KIT	T4	PA SP HD
LUPRON DEPOT 7.5 MG KIT	T4	PA SP HD
LUPRON DEPOT-4 MONTH KIT	T4	PA SP HD
LUPRON DEPOT	T4	PA SP
ZOLADEX	T4	PA SP HD
ANTI-NEOPLASTIC LHRH (GNRH) ANTAGONIST, PITUIT.SUPPRS		
FIRMAGON	T4	PA SP HD
ORGOVYX	T4	PA SP CSL
ANTI-NEOPLASTIC SYSTEMIC ENZYME INHIBITORS		
ALECENSA	T4	PA QL(8 CAPS/DAY) SP HD CSL
ALUNBRIG 180 MG TABLET	T4	PA QL(1 TAB/DAY) SP CSL
ALUNBRIG 30 MG TABLET	T4	PA QL(2 TABS/DAY) SP CSL
ALUNBRIG 90 MG TABLET	T4	PA QL(1 TAB/DAY) SP CSL
ALUNBRIG 90 MG-180 MG TAB PACK	T4	PA QL(1 TAB/DAY) SP CSL
AUGTYRO 160 MG CAPSULE	T4	PA QL(2 CAPS/DAY) SP CSL
AUGTYRO 40 MG CAPSULE	T4	PA QL(8 CAPS/DAY) SP CSL
AYVAKIT	T4	PA QL(1 TAB/DAY) SP CSL
BALVERSA	T4	PA SP CSL
BOSULIF 100 MG CAPSULE	T4	PA QL(3 CAPS/DAY) SP HD CSL
BOSULIF 100 MG TABLET	T4	PA QL(3 TABS/DAY) SP HD CSL

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ANTI-NEOPLASTICS (Cancer) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-NEOPLASTIC SYSTEMIC ENZYME INHIBITORS		
BOSULIF 400 MG TABLET	T4	PA QL(1 TAB/DAY) SP HD CSL
BOSULIF 50 MG CAPSULE	T4	PA QL(3 CAPS/DAY) SP HD CSL
BOSULIF 500 MG TABLET	T4	PA QL(1 TAB/DAY) SP HD CSL
BRUKINSA 160 MG TABLET	T4	PA QL(2 TABS/DAY) SP CSL
BRUKINSA 80 MG CAPSULE	T4	PA QL(4 CAPS/DAY) SP CSL
CABOMETYX	T4	PA SP HD CSL
CALQUENCE	T4	PA SP CSL
CAPRELSA 100 MG TABLET	T4	PA QL(2 TABS/DAY) SP CSL
CAPRELSA 300 MG TABLET	T4	PA QL(1 TAB/DAY) SP CSL
COMETRIQ 100 MG DAILY-DOSE PK	T4	PA QL(56 CAPS/28 DAYS) SP HD CSL
COMETRIQ 140 MG DAILY-DOSE PK	T4	PA QL(112 CAPS/28 DAYS) SP HD CSL
COMETRIQ 60 MG DAILY-DOSE PACK	T4	PA QL(84 CAPS/28 DAYS) SP HD CSL
COPIKTRA	T4	PA SP CSL
DANZITEN	T4	PA SP CSL
dasatinib 100 mg tablet (Sprycel)	T4	QL(1 TAB/DAY) SP CSL
dasatinib 100 mg tablet (Sprycel)	T4	QL(1 TAB/DAY) SP HD CSL
dasatinib 140 mg tablet (Sprycel)	T4	QL(1 TAB/DAY) SP CSL
dasatinib 140 mg tablet (Sprycel)	T4	QL(1 TAB/DAY) SP HD CSL
dasatinib 20 mg tablet (Sprycel)	T4	QL(3 TABS/DAY) SP CSL
dasatinib 20 mg tablet (Sprycel)	T4	QL(3 TABS/DAY) SP HD CSL
dasatinib 50 mg tablet (Sprycel)	T4	QL(1 TAB/DAY) SP CSL
dasatinib 50 mg tablet (Sprycel)	T4	QL(1 TAB/DAY) SP HD CSL
dasatinib 70 mg tablet (Sprycel)	T4	QL(2 TABS/DAY) SP CSL
dasatinib 70 mg tablet (Sprycel)	T4	QL(2 TABS/DAY) SP HD CSL
dasatinib 80 mg tablet (Sprycel)	T4	QL(1 TAB/DAY) SP CSL
dasatinib 80 mg tablet (Sprycel)	T4	QL(1 TAB/DAY) SP HD CSL
ENSACOVE 25 MG CAPSULE	T4	PA QL(9 CAPS/DAY) SP CSL
ENSACOVE 100 MG CAPSULE	T4	PA QL(2 CAPS/DAY) SP CSL
erlotinib hcl	T4	PA SP HD CSL
FOTIVDA	T4	PA QL(21 CAPS/28 DAYS) SP CSL
FRUZAQLA 1 MG CAPSULE	T4	PA QL(84 CAPS/28 DAYS) SP CSL
FRUZAQLA 5 MG CAPSULE	T4	PA QL(21 CAPS/28 DAYS) SP CSL
GAVRETO	T4	PA QL(4 CAPS/DAY) SP CSL
gefitinib (*Iressa*)	T4	PA SP HD CSL

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

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ANTI-NEOPLASTICS (Cancer) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-NEOPLASTIC SYSTEMIC ENZYME INHIBITORS *(cont.)*		
LYNPARZA	T4	PA QL(4 TABS/DAY) SP HD CSL
LYTGOBI 12 MG DOSE (3X 4MG TB)	T4	PA QL(3 TABS/DAY) SP CSL
LYTGOBI 16 MG DOSE (4X 4MG TB)	T4	PA QL(4 TABS/DAY) SP CSL
LYTGOBI 20 MG DOSE (5X 4MG TB)	T4	PA QL(5 TABS/DAY) SP CSL
NERLYNX	T4	PA SP HD CSL
NEXAVAR (*sorafenib tosylate*)	T4	PA QL(4 TABS/DAY) SP HD CSL
*nilotinib hcl (*Tasigna*)*	T4	PA SP CSL
NILOTINIB D-TARTRATE	T4	PA QL(4 CAPS/DAY) SP HD CSL
NINLARO	T4	PA QL(3 CAPS/28 DAYS) SP HD CSL
OGSIVEO 100 MG TABLET	T4	PA QL(2 TABS/DAY) SP CSL
OGSIVEO 150 MG TABLET	T4	PA QL(2 TABS/DAY) SP CSL
OGSIVEO 50 MG TABLET	T4	PA QL(6 TABS/DAY) SP CSL
OJJAARA	T4	PA QL(1 TAB/DAY) SP CSL
pazopanib 200 mg tablet (Votrient)	T4	PA QL(4 TABS/DAY) SP CSL
PEMAZYRE	T4	PA QL(14 TABS/21 DAYS) SP CSL
PIQRAY	T4	PA SP CSL
QINLOCK	T4	PA QL(3 TABS/DAY) SP CSL
RETEVMO 120 MG TABLET	T4	PA QL(2 TABS/DAY) SP HD CSL
RETEVMO 160 MG TABLET	T4	PA QL(2 TABS/DAY) SP HD CSL
RETEVMO 40 MG CAPSULE	T4	PA QL(6 CAPS/DAY) SP HD CSL
RETEVMO 40 MG TABLET	T4	PA QL(3 TABS/DAY) SP HD CSL
RETEVMO 80 MG CAPSULE	T4	PA QL(4 CAPS/DAY) SP HD CSL
RETEVMO 80 MG TABLET	T4	PA QL(2 TABS/DAY) SP HD CSL
REVUFORJ 25 MG TABLET	T4	PA QL(8 TABS/DAY) SP CSL
REVUFORJ 110 MG TABLET	T4	PA QL(4 TABS/DAY) SP CSL
REVUFORJ 160 MG TABLET	T4	PA QL(2 TABS/DAY) SP CSL
ROMVIMZA	T4	PA QL(8 CAPS/28 DAYS) SP CSL
ROZLYTREK	T4	PA SP HD CSL
RUBRACA	T4	PA QL(4 TABS/DAY) SP CSL
RYDAPT	T4	PA SP HD CSL
SCEMBLIX 100 MG TABLET	T4	PA SP CSL
SCEMBLIX 20 MG TABLET	T4	PA QL(2 TABS/DAY) SP CSL
SCEMBLIX 40 MG TABLET	T4	PA SP CSL
sorafenib tosylate (Nexavar)	T4	PA QL(4 TABS/DAY) SP HD CSL
SPRYCEL 100 MG TABLET (*dasatinib*)	T4	PA QL(1 TAB/DAY) SP HD CSL

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ANTI-NEOPLASTICS (Cancer) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-NEOPLASTIC SYSTEMIC ENZYME INHIBITORS *(cont.)*		
SPRYCEL 140 MG TABLET (*dasatinib*)	T4	PA QL(1 TAB/DAY) SP HD CSL
SPRYCEL 20 MG TABLET (*dasatinib*)	T4	PA QL(3 TABS/DAY) SP HD CSL
SPRYCEL 50 MG TABLET (*dasatinib*)	T4	PA QL(1 TAB/DAY) SP HD CSL
SPRYCEL 70 MG TABLET (*dasatinib*)	T4	PA QL(2 TABS/DAY) SP HD CSL
SPRYCEL 80 MG TABLET (*dasatinib*)	T4	PA QL(1 TAB/DAY) SP HD CSL
STIVARGA	T4	PA QL(84 TABS/28 DAYS) SP HD CSL
sunitinib malate (Sutent)	T4	PA QL(1 CAP/DAY) SP HD CSL
SUTENT (*sunitinib malate*)	T4	PA QL(1 CAP/DAY) SP HD CSL
TABRECTA	T4	PA QL(4 TABS/DAY) SP HD CSL
TAGRISSO	T4	PA SP HD CSL
TALZENNA 0.1 MG CAPSULE	T4	PA QL(1 CAP/DAY) SP CSL
TALZENNA 0.1 MG SOFTGEL	T4	PA QL(1 CAP/DAY) SP CSL
TALZENNA 0.25 MG CAPSULE	T4	PA QL(1 CAP/DAY) SP CSL
TALZENNA 0.25 MG SOFTGEL	T4	PA QL(1 CAP/DAY) SP CSL
TALZENNA 0.35 MG SOFTGEL	T4	PA QL(1 CAP/DAY) SP CSL
TALZENNA 0.5 MG CAPSULE	T4	PA SP CSL
TALZENNA 0.5 MG SOFTGEL	T4	PA SP CSL
TALZENNA 0.75 MG SOFTGEL	T4	PA SP CSL
TALZENNA 1 MG CAPSULE	T4	PA QL(1 CAP/DAY) SP CSL
TALZENNA 1 MG SOFTGEL	T4	PA QL(1 CAP/DAY) SP CSL
TASIGNA (*nilotinib hcl*)	T4	PA QL(4 CAPS/DAY) SP HD CSL
TEPMETKO	T4	PA QL(2 TABS/DAY) SP CSL
TRUQAP	T4	PA QL(64 TABS/28 DAYS) SP CSL
TUKYSA	T4	PA SP CSL
TURALIO	T4	PA QL(4 CAPS/DAY) SP CSL
TYKERB (*lapatinib ditosylate*)	T4	PA QL(6 TABS/DAY) SP HD CSL
UKONIQ	T4	PA QL (4 tabs/day) SP
VANFLYTA	T4	PA QL(2 TABS/DAY) SP CSL
VERZENIO	T4	PA QL(2 TABS/DAY) SP HD CSL
VITRAKVI	T4	PA SP HD CSL
VIZIMPRO	T4	PA SP HD CSL
VONJO	T4	PA QL(4 CAPS/DAY) SP CSL
VOTRIENT *(pazopanib hcl)*	T4	PA QL(4 TABS/DAY) SP HD CSL
XALKORI 150 MG PELLET	T4	PA QL(6 PELLETS/DAY) SP HD CSL

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ANTI-NEOPLASTICS (Cancer) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-NEOPLASTIC SYSTEMIC ENZYME INHIBITORS *(cont.)*		
XALKORI 20 MG PELLET	T4	PA QL(4 PELLETS/DAY) SP HD CSL
XALKORI 200 MG CAPSULE	T4	PA QL(4 CAPS/DAY) SP HD CSL
XALKORI 250 MG CAPSULE	T4	PA QL(4 CAPS/DAY) SP HD CSL
XALKORI 50 MG PELLET	T4	PA QL(4 PELLETS/DAY) SP HD CSL
XOSPATA	T4	PA SP CSL
ZEJULA	T4	PA QL(1 TAB/DAY) SP CSL
ZYDELIG	T4	PA QL(2 TABS/DAY) SP HD CSL
ZYKADIA	T4	PA QL(3 TABS/DAY) SP HD CSL
ANTI-NEOPLASTIC, ANTI-PROGRAMMED DEATH-I (PD-I) MAB		
LIBTAYO	T4	PA SP
OPDIVO	T4	PA SP HD
ANTI-NEOPLASTIC-B CELL LYMPHOMA-2(BCL-2) INHIBITORS		
VENCLEXTA	T4	PA SP CSL
VENCLEXTA STARTING PACK	T4	PA SP CSL
ANTINEOPLASTIC-ENZYME INHIB, ANTIANDROGEN COMB.		
AKEEGA	T4	PA QL(2 TABS/DAY) SP CSL
ANTINEOPLASTIC-HYPOXIA INDUCIBLE FACTOR (HIF) INH		
WELIREG	T4	PA QL(3 TABS/DAY) SP CSL
ANTINEOPLASTIC-IMMUNOTHERAPY CHECKPOINT INHIB COMB		
OPDUALAG	T4	PA SP HD
ANTI-NEOPLASTIC-ISOCITRATE DEHYDROGENASE INHIBITORS		
IDHIFA	T4	PA SP HD CSL
REZLIDHIA	T4	PA QL(2 CAPS/DAY) SP CSL
TIBSOVO	T4	PA SP CSL
VORANIGO	T4	PA SP CSL
ANTI-NEOPLASTICS ANTIBODY/ANTIBODY-DRUG COMPLEXES		
ENHERTU	T4	PA SP HD
TIVDAK	T4	PA SP HD
VYLOY	T4	PA SP
ANTI-NEOPLASTICS, MISCELLANEOUS		
etoposide	T4	SP HD CSL
LYSODREN	T2	CSL
MATULANE	T4	SP CSL
tretinoin 10 mg capsule	T1	PA CSL

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ANTI-NEOPLASTICS (Cancer) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-NEOPLASTIC-SELECT INHIB OF NUCLEAR EXP (SINE)		
XPOVIO	T4	PA SP CSL
CYTOTOXIC T-LYMPHOCYTE ANTIGEN (CTLA-4) RMC ANTIBODY		
YERVOY	T4	PA SP HD
IMMUNOMODULATORS		
ACTIMMUNE	T4	PA SP HD
BESREMI	T4	PA QL(2 SYRINGES/28 DAYS) SP
SELECTIVE ESTROGEN RECEPTOR MODULATORS (SERMS)		
FARESTON (*toremifene citrate*)	T3	QL(2 TABS/DAY) HD CSL
ORSERDU 345 MG TABLET	T4	PA QL(1 TAB/DAY) SP CSL
ORSERDU 86 MG TABLET	T4	PA QL(3 TABS/DAY) SP CSL
SOLTAMOX	T3	HD CSL
tamoxifen citrate	T1	HD PPACA CSL
toremifene citrate (Fareston)	T1	QL(2 TABS/DAY) HD CSL
STEROID ANTI-NEOPLASTICS		
megestrol 20 mg tablet	T1	CSL
megestrol 40 mg tablet	T1	CSL
ANTI-NEOPLASTICS (Skin Conditions)		
PHOTOACT, TOPICAL ANTI-NEOPLAST, PREMALIGNANT LESIONS		
LEVULAN	T4	SP
TOPICAL ANTI-NEOPLASTIC PREMALIGNANT LESION AGENTS		
bexarotene 1% gel (Targretin)	T4	SP HD
CARAC	T3	PA
diclofenac sodium 3% gel	T1	PA
EFUDEX (*fluorouracil*)	T3	
FLUOROPLEX	T2	
fluorouracil	T1	
FLUOROURACIL	T1	
fluorouracil (Efudex)	T1	
KLISYRI	T3	PA QL(5 PACKS/30 DAYS)
PANRETIN	T4	SP HD
TARGRETIN 1% GEL (*bexarotene*)	T4	PA SP HD
VALCHLOR	T4	SP HD

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ANTI-OBESITY DRUGS (Weight Management)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-OBESITY - ANOREXIC AGENTS		
benzphetamine hcl	T1	
diethylpropion hcl	T1	
LOMAIRA	T3	PA
phendimetrazine tartrate	T1	
phentermine 15 mg capsule	T1	
phentermine 30 mg capsule	T1	
phentermine 37.5 mg capsule	T1	
phentermine 37.5 mg tablet	T1	
phentermine 8 mg tablet	T1	PA
phentermine/topiramate (Qsymia)	T1	
QSYMIA (*phentermine/topiramate*)	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	T4	PA QL(9 MLS/30 DAYS) SP
ANTI-OBESITY GLUCAGON-LIKE PEPTIDE-1 RECEP AGONIST		
liraglutide 18 mg/3 ml pen (Saxenda)	T1	PA
liraglutide 5-pak 18 mg/3 ml (Saxenda)	T1	PA
SAXENDA	T3	PA
WEGOVY	T2	PA QL(4 PENS/28 DAYS)
ANTI-OBESITY - OPIOID ANTAG-NOREPI, DOPAMINE RU INHIB		
CONTRAVE	T3	PA
FAT ABSORPTION DECREASING AGENTS		
ORLISTAT	T3	PA
XENICAL	T3	PA
ANTIPARASITICS (Eye Conditions)		
OPHTHALMIC (EYE) ANTIPARASITICS		
XDEMVY	T4	PA QL(10 MLS/56 DAYS) SP

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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 *(nitazoxanide)*	T3	PA
nitazoxanide (Alinia)	T1	
TOPICAL ANTI-PARASITICS		
crotamiton (Eurax)	T1	
ELIMITE (*permethrin*)	T3	
EURAX 10% CREAM	T2	
EURAX 10% LOTION	T3	
lindane	T1	
*malathion (*Ovide*)*	T1	
NATROBA (*spinosad*)	T3	PA
OVIDE (*malathion*)	T3	
permethrin (Elimite)	T1	
spinosad (Natroba)	T1	
ULESFIA	T3	
ANTIPARASITICS (Skin Conditions)		
TOPICAL ANTIPARASITICS		
lindane	T1	
*malathion (*Ovide*)*	T1	
OVIDE *(malathion)*	T3	
ANTI-PARKINSON DRUGS (Parkinson's Disease)		
ANTI-PARKINSONISM DRUGS, ANTI-CHOLINERGIC		
benztropine mesylate	T1	HD
trihexyphenidyl hcl	T1	HD
ANTI-PARKINSONISM DRUGS, OTHER		
amantadine hcl	T1	HD
APOKYN	T4	PA SP HD
apomorphine hcl	T4	PA SP
AZILECT 0.5 MG TABLET (*rasagiline mesylate*)	T3	PA QL(1 TAB/DAY) HD
AZILECT 1 MG TABLET (*rasagiline mesylate*)	T3	PA HD
bromocriptine mesylate	T1	HD
carbidopa/levodopa (Sinemet)	T1	HD
carbidopa/levodopa/entacapone	T1	HD
carbidopa/levodopa/entacapone (Stalevo 75)	T1	HD

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ANTI-PARKINSON DRUGS (Parkinson's Disease) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-PARKINSONISM DRUGS, OTHER *(cont.)*		
carbidopa/levodopa/entacapone (Stalevo 100)	T1	HD
carbidopa-levo er 25-100 tab	T1	HD
carbidopa-levo er 50-200 tab	T1	HD
CREXONT	T3	ST HD
DHIVY	T3	PA HD
DUOPA	T3	SP HD
entacapone	T1	HD
GOCOVRI	T3	
INBRIJA	T3	PA SP HD
NEUPRO	T3	HD
NOURIANZ	T4	PA QL(1 TAB/DAY) SP HD
ONAPGO	T4	PA QL(20 MLS/DAY) SP
ONGENTYS	T3	PA QL(1 CAP/DAY) HD
pramipexole di-hcl	T1	HD
pramipexole er 0.375 mg tablet	T1	QL(1 TAB/DAY) HD
pramipexole er 0.75 mg tablet	T1	HD
pramipexole er 1.5 mg tablet	T1	QL(1 TAB/DAY) HD
pramipexole er 2.25 mg tablet	T1	QL(1 TAB/DAY) HD
pramipexole er 3 mg tablet	T1	HD
pramipexole er 3.75 mg tablet	T1	HD
pramipexole er 4.5 mg tablet	T1	HD
rasagiline mesylate 0.5 mg tab (Azilect)	T1	QL(1 TAB/DAY) HD
rasagiline mesylate 1 mg tab (Azilect)	T1	HD
ropinirole hcl	T1	HD
RYTARY	T3	ST HD
selegiline hcl	T1	HD
SINEMET (*carbidopa-levodopa*)	T3	HD
STALEVO 100 (*carbidopa-levodopa-entacapone*)	T3	HD
STALEVO 75 (*carbidopa-levodopa-entacapone*)	T3	HD
TASMAR (*tolcapone*)	T3	HD
tolcapone (Tasmar)	T1	HD
XADAGO	T3	ST HD
VYALEV	T4	PA SP HD
ZELAPAR	T3	PA HD

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ANTI-PARKINSON DRUGS (Parkinson's Disease) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DECARBOXYLASE INHIBITORS		
carbidopa (Lodosyn)	T1	
LODOSYN (*carbidopa*)	T3	PA
ANTI-PLATELET DRUGS (Blood Thinners/Anti-Clotting)		
PLATELET AGGREGATION INHIBITORS		
aspirin/dipyridamole	T1	HD
ASPIRIN-OMEPRAZOLE	T3	PA HD
BRILINTA (*ticagrelor*)	T3	PA HD
cilostazol	T1	HD
clopidogrel bisulfate	T1	HD
clopidogrel bisulfate (Plavix)	T1	HD
dipyridamole	T1	HD
EFFIENT (*prasugrel hcl*)	T3	PA HD
PLAVIX (*clopidogrel*)	T3	PA HD
prasugrel hcl (Effient)	T1	HD
ticagrelor (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 (*anagrelide hcl*)	T3	
anagrelide hcl	T1	
anagrelide hcl (Agrylin)	T1	
ANTIVIRALS (AIDS/HIV)		
ANTI-RETROVIRAL - CAPSID INHIBITORS		
SUNLENCA 300 MG TABLET	T4	PA QL(5 TABS/180 DAYS) SP
SUNLENCA 4- 300 MG TABLET	T4	PA QL(5 TABS/180 DAYS) SP
SUNLENCA 463.5 MG/1.5 ML VIAL	T4	PA SP
SUNLENCA 5- 300 MG TABLET	T4	PA QL(5 TABS/180 DAYS) SP
ANTIRETROVIRAL - CAPSID INHIBITORS (PREP)		
YEZTUGO 463.5 MG/1.5 ML VIAL	T4	SP PPACA

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

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

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ANTIVIRALS (AIDS/HIV) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIVIRALS, HIV-SPECIFIC, NUCLEOSIDE ANALOG, RTI *(cont.)*		
tenofovir disoproxil fumarate (Viread)	T4	PA SP
VIREAD 150 MG TABLET	T4	PA SP
VIREAD 200 MG TABLET	T4	PA SP
VIREAD 250 MG TABLET	T4	PA SP
VIREAD 300 MG TABLET (*tenofovir disoproxil fumarate*)	T4	PA SP
VIREAD POWDER	T4	PA SP
ANTIVIRALS - HIV-SPECIFIC, PROTEASE INHIBITOR COMB		
KALETRA	T4	PA SP
KALETRA (*lopinavir/ritonavir*)	T4	PA SP
lopinavir/ritonavir	T4	SP
lopinavir/ritonavir (Kaletra)	T4	SP
ANTIVIRALS - HIV-SPECIFIC, PROTEASE INHIBITORS		
atazanavir sulfate	T4	PA SP
atazanavir sulfate (Reyataz)	T4	PA SP
EVOTAZ	T4	PA SP
fosamprenavir calcium	T4	PA SP
NORVIR 100 MG POWDER PACKET	T4	SP
NORVIR 100 MG TABLET (*ritonavir*)	T4	PA SP
REYATAZ 200 MG CAPSULE (*atazanavir sulfate*)	T4	PA SP
REYATAZ 300 MG CAPSULE (*atazanavir sulfate*)	T4	PA SP
REYATAZ 50 MG POWDER PACKET	T4	PA SP
ritonavir (Norvir)	T4	SP
VIRACEPT	T4	PA SP
ANTIVIRALS - HIV-I INTEGRASE STRAND TRANSFER INHIBTR		
APRETUDE	T4	SP PPACA
ISENTRESS	T4	SP
ISENTRESS HD	T4	PA SP
TIVICAY	T4	SP
TIVICAY PD	T4	SP
ARTV NUCLEOSIDE, NUCLEOTIDE, NON-NUCLEOSIDE RTI COMB		
COMPLERA *(emtricita/rilpivirine/tenof df)*	T4	PA QL(1 TAB/DAY) SP
DELSTRIGO	T4	PA QL(1 TAB/DAY) SP
efavirenz/emtricit/tenofovr df	T4	QL(1 TAB/DAY) SP
efavirenz/emtricit/tenofovr df (Complera)	T4	QL(1 TAB/DAY) SP

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ANTIVIRALS (AIDS/HIV) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ARTV NUCLEOSIDE, NUCLEOTIDE, NON-NUCLEOSIDE RTI COMB *(cont.)*		
efavirenz/lamivu/tenofov disop (Symfi Lo)	T4	QL(1 TAB/DAY) SP
efavirenz/lamivu/tenofov disop (Symfi)	T4	QL(1 TAB/DAY) SP
ODEFSEY	T4	PA QL(1 TAB/DAY) SP
SYMFI (*efavirenz-lamivu-tenofov disop*)	T4	PA QL(1 TAB/DAY) SP
SYMFI LO (*efavirenz-lamivu-tenofov disop*)	T4	PA QL(1 TAB/DAY) SP
ARV-NUCLEOSIDE, NUCLEOTIDE RTI, INTEGRASE INHIBITORS		
BIKTARVY	T4	QL(1 TAB/DAY) SP
GENVOYA	T4	QL(1 TAB/DAY) SP
STRIBILD	T4	PA QL(1 TAB/DAY) SP
ANTIVIRALS (Eye Conditions)		
EYE ANTIVIRALS		
trifluridine	T1	
ZIRGAN	T3	
ANTIVIRALS (Infections)		
ANTIVIRAL - MAIN PROTEASE (MPRO) INHIBITOR		
PAXLOVID	T2	QL(1 TAB/120 DAYS)
ANTIVIRAL - RNA POLYMERASE INHIBITOR		
LAGEVRIO (EUA)	T2	QL(1 PACK/120 DAYS)
ANTIVIRAL MONOCLONAL ANTIBODIES		
BEYFORTUS	T3	PPACA
ANTIVIRALS, GENERAL		
acyclovir 200 mg capsule	T1	
acyclovir 200 mg/5 ml susp	T1	
acyclovir 200 mg/5 ml susp cup	T1	
acyclovir 400 mg tablet	T1	
acyclovir 800 mg tablet	T1	
acyclovir 800 mg/20ml susp cup	T1	
famciclovir	T1	
FLUMADINE (*rimantadine hcl*)	T3	
LIVTENCITY	T4	PA QL(4 TABS/DAY) SP
oseltamivir 6 mg/ml suspension (Tamiflu)	T1	QL(180 MLS/30 DAYS)
oseltamivir phos 30 mg capsule (Tamiflu)	T1	QL(20 CAPS/30 DAYS)
oseltamivir phos 45 mg capsule (Tamiflu)	T1	QL(10 CAPS/30 DAYS)

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ANTIVIRALS (Infections) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIVIRALS, GENERAL *(cont.)*		
oseltamivir phos 75 mg capsule (Tamiflu)	T1	QL(10 CAPS/30 DAYS)
PREVYMIS 20 MG PELLET PACKET	T4	SP
PREVYMIS 120 MG PELLET PACKET	T4	SP
PREVYMIS 240 MG TABLET	T4	SP HD
PREVYMIS 480 MG TABLET	T4	SP HD
RELENZA	T3	QL(20 BLISTERS/30 DAYS)
rimantadine hcl (Flumadine)	T1	
SITAVIG	T3	PA QL(2 TABS/30 DAYS)
TAMIFLU 30 MG CAPSULE (*oseltamivir phosphate*)	T3	QL(20 CAPS/30 DAYS)
TAMIFLU 45 MG CAPSULE (*oseltamivir phosphate*)	T3	QL(10 CAPS/30 DAYS)
TAMIFLU 6 MG/ML SUSPENSION (*oseltamivir phosphate*)	T3	QL(180 MLS/30 DAYS)
TAMIFLU 75 MG CAPSULE (*oseltamivir phosphate*)	T3	QL(10 CAPS/30 DAYS)
TEMBEXA	T3	
valacyclovir hcl (Valtrex)	T1	
VALCYTE (*valganciclovir hcl*)	T3	PA
valganciclovir hcl (Valcyte)	T1	
VALTREX (*valacyclovir hcl*)	T3	
XOFLUZA	T3	QL(2 TABS/30 DAYS)
HEP C - NS5A, NS3/4A, NUCLEOTIDE NS5B INHIB COMBO		
VOSEVI	T4	PA QL(1 TAB/DAY) SP HD
HEP C VIRUS, NUCLEOTIDE ANALOG NS5B POLYMERASE INH		
SOVALDI 200 MG TABLET	T4	PA QL(1 TAB/DAY) SP HD
SOVALDI 400 MG TABLET	T4	PA QL(1 TAB/DAY) SP HD
SOVALDI 150 MG, 200 MG PELLET PACKET	T4	PA QL(1 PACK/DAY) SP HD
HEP C VIRUS-NS5B POLYMERASE AND NS5A INHIB. COMBO.		
EPCLUSA 150-37.5 MG PELLET PKT	T4	PA QL(1 PACK/DAY) SP HD
EPCLUSA 200 MG-50 MG TABLET	T4	PA QL(1 TAB/DAY) SP HD
EPCLUSA 200 MG-50 MG TABLET	T4	PA QL(1 PACK/DAY) SP HD
EPCLUSA 400 MG-100 MG TABLET	T4	PA QL(1 TAB/DAY) SP HD
HARVONI 33.75-150 MG PELLET PK	T4	PA QL(1 PACK/DAY) SP HD
HARVONI 45-200 MG PELLET PACKT	T4	PA QL(1 PACK/DAY) SP HD
HARVONI 45-200 MG TABLET	T4	PA QL(1 TAB/DAY) SP HD
HARVONI 90-400 MG TABLET	T4	PA QL(1 TAB/DAY) SP HD
LEDIPASVIR-SOFOSBUVIR	T4	PA QL(1 TAB/DAY) SP HD
SOFOSBUVIR-VELPATASVIR	T4	PA QL(1 TAB/DAY) SP HD

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ANTIVIRALS (Infections) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
HEPATITIS B TREATMENT AGENTS		
adefovir dipivoxil	T4	SP HD
BARACLUDE 0.05 MG/ML SOLUTION	T4	SP HD
BARACLUDE 0.5 MG TABLET (*entecavir*)	T4	PA QL(1 TAB/DAY) SP HD
BARACLUDE 1 MG TABLET (*entecavir*)	T4	PA SP HD
entecavir 0.5 mg tablet (Baraclude)	T4	QL(1 TAB/DAY) SP HD
entecavir 1 mg tablet (Baraclude)	T4	SP HD
lamivudine	T4	SP
VEMLIDY	T4	SP HD
HEPATITIS C TREATMENT AGENTS		
PEGASYS	T4	PA SP HD
ribavirin	T4	SP HD
HEPATITIS C VIRUS- NS5A AND NS3/4A INHIBITOR COMB		
MAVYRET 100-40 MG TABLET	T4	PA QL(3 TABS/DAY) SP HD
MAVYRET 50-20 MG PELLET PACKET	T4	PA QL(5 PACKS/DAY) SP HD
ZEPATIER	T4	PA QL(1 TAB/DAY) SP HD
ANTIVIRALS (Skin Conditions)		
TOPICAL ANTIVIRAL AND ANTI-INFLAMMATORY STEROID		
XERESE	T3	PA QL (5gm/30 days)
TOPICAL ANTIVIRALS		
acyclovir 5% cream (Zovirax)	T1	PA QL(5 GMS/30 DAYS)
acyclovir 5% ointment (Zovirax)	T1	PA QL(15 GMS/30 DAYS)
DENAVIR (*penciclovir*)	T3	QL(5 GMS/30 DAYS)
penciclovir (Denavir)	T1	QL(5 GMS/30 DAYS)
ZOVIRAX 5% CREAM (*acyclovir*)	T3	PA QL(5 GMS/30 DAYS)
ZOVIRAX 5% OINTMENT (*acyclovir*)	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-INJCT	T3	PA QL(4 UNITS/30 DAYS)
epinephrine 0.15 mg auto-injct (Epipen Jr 2-Pak)	T1	QL(4 UNITS/30 DAYS)
epinephrine 0.15 mg auto-injct (Epipen Jr)	T1	QL(4 UNITS/30 DAYS)

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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)
epinephrine 0.3 mg auto-inject (Epipen 2-Pak)	T1	QL(4 UNITS/30 DAYS)
epinephrine 0.3 mg auto-inject (Epipen)	T1	QL(4 UNITS/30 DAYS)
EPIPEN (*epinephrine*)	T3	PA QL(4 UNITS/30 DAYS)
EPIPEN 2-PAK (*epinephrine*)	T3	PA QL(4 UNITS/30 DAYS)
EPIPEN JR (*epinephrine*)	T3	PA QL(4 UNITS/30 DAYS)
EPIPEN JR 2-PAK (*epinephrine*)	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 (*donepezil hcl*)	T3	PA HD
donepezil hcl	T1	HD
donepezil hcl (Aricept)	T1	HD
EXELON (*rivastigmine*)	T3	HD
galantamine er 16 mg capsule	T1	HD
galantamine er 24 mg capsule	T1	HD
galantamine er 8 mg capsule	T1	QL(1 CAP/DAY) HD
galantamine hbr	T1	HD
MESTINON (*pyridostigmine bromide*)	T3	HD
pyridostigmine 60 mg/5 ml cup (Mestinon)	T1	HD
pyridostigmine 60 mg/5 ml soln (Mestinon)	T1	HD
PYRIDOSTIGMINE BR 30 MG TABLET	T3	PA QL(20 TABS/DAY) HD
pyridostigmine br 60 mg tablet (Mestinon)	T1	HD
pyridostigmine bromide (Mestinon)	T1	HD
rivastigmine (Exelon)	T1	HD
rivastigmine tartrate	T1	HD
ZUNVEYL	T3	PA QL(2 TABS/DAY) HD
AUTONOMIC DRUGS (Attention Deficit Hyperactivity Disorder)[9]		
ADRENERGICS, AROMATIC, NON-CATECHOLAMINE		
ADDERALL (*dextroamphetamine-amphetamine*)	T3	PA
ADDERALL XR (*dextroamphetamine-amphet er*)	T3	PA ST QL(1 CAP/DAY)
ADZENYS XR-ODT	T3	PA QL(1 TAB/DAY)

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AUTONOMIC DRUGS (Attention Deficit Hyperactivity Disorder)[9] *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ADRENERGICS, AROMATIC, NON-CATECHOLAMINE *(cont.)*		
amphetamine sulfate (Evekeo)	T1	PA
DESOXYN (*methamphetamine hcl*)	T3	PA
DEXEDRINE SPANSULE 10 MG (*dextroamphetamine sulfate*)	T3	PA QL(1 CAP/DAY)
DEXEDRINE SPANSULE 15 MG CAP (*dextroamphetamine sulfate*)	T3	PA QL(3 CAPS/DAY)
dextroamphetamine er 10 mg cap (Dexedrine)	T1	PA QL(1 CAP/DAY)
dextroamphetamine er 15 mg cap (Dexedrine)	T1	PA QL(3 CAPS/DAY)
dextroamphetamine er 5 mg cap	T1	PA QL(1 CAP/DAY)
dextroamphetamine sulfate	T1	PA
dextroamphetamine sulfate	T3	PA ST
dextroamphetamine sulfate (Zenzedi)	T1	PA
dextroamphetamine/amphetamine (Adderall Xr)	T1	PA QL(1 CAP/DAY)
dextroamphetamine/amphetamine (Adderall)	T1	PA
dextroamphetamine/amphetamine (Mydayis)	T1	PA QL(1 CAP/DAY)
DYANAVEL XR 10 MG TABLET	T3	PA QL(1 TAB/DAY)
DYANAVEL XR 15 MG TABLET	T3	PA QL(1 TAB/DAY)
DYANAVEL XR 2.5 MG/ML SUSP	T3	PA QL(8 MLS/DAY)
DYANAVEL XR 20 MG TABLET	T3	PA QL(1 TAB/DAY)
DYANAVEL XR 5 MG TABLET	T3	PA QL(1 TAB/DAY)
EVEKEO (*amphetamine sulfate*)	T3	PA
EVEKEO ODT	T3	PA
methamphetamine hcl (Desoxyn)	T1	PA
MYDAYIS *(dextroamphetamine/amphetamine)*	T3	PA QL(1 CAP/DAY)
XELSTRYM	T3	PA QL(1 PATCH/DAY)
ZENZEDI	T3	PA ST
ZENZEDI (*dextroamphetamine sulfate*)	T3	PA ST
AUTONOMIC DRUGS (Blood Pressure/Heart Medications)		
ADRENERGIC VASOPRESSOR AGENTS		
droxidopa 100 mg capsule (Northera)	T4	SP HD
droxidopa 200 mg capsule (Northera)	T4	SP HD
droxidopa 300 mg capsule (Northera)	T4	SP HD

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AUTONOMIC DRUGS (Blood Pressure/Heart Medications) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ADRENERGIC VASOPRESSOR AGENTS *(cont.)*		
midodrine hcl	T1	
NORTHERA (*droxidopa*)	T4	PA SP HD
ALPHA-ADRENERGIC BLOCKING AGENTS		
DIBENZYLINE (*phenoxybenzamine hcl*)	T3	HD
phenoxybenzamine hcl (Dibenzyline)	T1	HD
AUTONOMIC DRUGS (Urinary Tract Conditions)		
PARASYMPATHETIC AGENTS		
bethanechol chloride	T1	HD
cevimeline hcl (Evoxac)	T1	HD
EVOXAC (*cevimeline hcl*)	T3	PA HD
pilocarpine hcl 5 mg tablet (Salagen)	T1	HD
pilocarpine hcl 7.5 mg tablet (Salagen)	T1	HD
SALAGEN (*pilocarpine hcl*)	T3	HD
BIOLOGICALS (Allergy/Nasal Sprays)		
ALLERGENIC EXTRACTS, THERAPEUTIC		
GRASTEK	T3	PA QL(1 TAB/DAY)
ODACTRA	T3	PA QL(1 TAB/DAY)
ORALAIR	T3	PA QL(1 TAB/DAY)
PALFORZIA	T4	PA SP
RAGWITEK	T3	PA QL(1 TAB/DAY)
BIOLOGICALS (Blood Pressure/Heart Medications)		
PLASMA KALLIKREIN INHIBITORS		
TAKHZYRO	T4	PA SP HD
BIOLOGICALS (Miscellaneous)		
PKU TREATMENT AGENTS - PHENYLALANINE AMMONIA LYASE		
PALYNZIQ	T4	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

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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		
IPOL	T2	PPACA
ROTARIX	T3	PPACA
ROTATEQ	T3	PPACA

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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

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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)	T4	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

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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		
ABRYSVO	T3	PPACA
ACAM2000 (NATIONAL STOCKPILE)	T3	
AREXVY	T3	PPACA
ENGERIX-B ADULT	T2	PPACA
ENGERIX-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	T4	PA SP

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BLOOD (Blood Modifiers/Bleeding Disorders) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-FIBRINOLYTIC AGENTS		
AMICAR (*aminocaproic acid*)	T4	SP HD
aminocaproic acid (Amicar)	T4	SP HD
tranexamic acid	T4	SP
ANTI-HEMOPHILIC FACTORS		
ALTUVIIIO	T4	PA SP HD
ADYNOVATE	T4	PA SP HD
AFSTYLA	T4	PA SP HD
ALPHANATE	T4	PA SP HD
ALTUVIIIO	T4	PA SP HD
ELOCTATE	T4	PA SP HD
ESPEROCT	T4	PA SP HD
HEMOFIL M	T4	PA SP HD
HUMATE-P	T4	PA SP HD
JIVI	T4	PA SP HD
KOATE	T4	PA SP HD
KOGENATE FS	T4	PA SP HD
KOVALTRY	T4	PA SP HD
NOVOEIGHT	T4	PA SP HD
NUWIQ	T4	PA SP HD
RECOMBINATE	T4	PA SP HD
WILATE	T4	PA SP HD
XYNTHA	T4	PA SP HD
XYNTHA SOLOFUSE	T4	PA SP HD
COMPLEMENT (C3) INHIBITORS		
EMPAVELI	T4	PA SP
FABHALTA	T4	PA QL(2 CAPS/DAY) SP
TAVNEOS	T4	PA QL(6 CAPS/DAY) SP
VOYDEYA	T4	PA QL(1 PACKET/28 Days) SP
HEMOPHILIA TREATMENT AGENTS, NON-FACTOR REPLACEMENT		
ALHEMO PEN	T4	PA SP
HEMLIBRA	T4	PA SP HD
HYMPAVZI PEN	T4	PA SP
QFITLIA	T4	PA SP
QFITLIA PEN	T4	PA SP

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BLOOD (Blood Modifiers/Bleeding Disorders) *(con't.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
SICKLE CELL ANEMIA AGENTS		
PYRUKYND 20 MG TABLET	T4	PA QL(2 TABS/DAY) SP
PYRUKYND 20-5 MG TAPER PACK	T4	PA QL(2 PACKS/270 DAYS) SP
PYRUKYND 5 MG TABLET	T4	PA QL(2 TABS/DAY) SP
PYRUKYND 5 MG TAPER PACK	T4	PA QL(2 PACKS/270 DAYS) SP
PYRUKYND 50 MG TABLET	T4	PA QL(2 TABS/DAY) SP
PYRUKYND 50-20 MG TAPER PACK	T4	PA QL(2 PACKS/270 DAYS) SP
SICKLE CELL ANEMIA AGENTS		
DROXIA	T2	
OXBRYTA 300 MG TABLET	T4	PA QL(3 TABS/DAY) SP
OXBRYTA 300 MG TABLET FOR SUSP	T4	PA QL(5 TABS/DAY) SP
OXBRYTA 500 MG TABLET	T4	PA QL(3 TABS/DAY) SP
SIKLOS	T3	PA
XROMI	T3	PA
TOPICAL HEMOSTATICS		
ASTRINGYN	T3	
AVITENE	T3	
ENDO-AVITENE	T3	
EVICEL	T3	
gelatin sponge, absorb/porcine (Gelfoam)	T1	
GELFOAM	T3	
GELFOAM (*gelatin sponge,absorb/porcine*)	T3	
GELFOAM COMPRESSED	T3	
MONSEL's	T3	
RECOTHROM	T3	
SURGICEL	T3	
SURGIFOAM	T1	
SYRINGE AVITENE	T3	
THROMBI-GEL (*thrombin/cal/cmc/gel/dress,hem*)	T3	
THROMBIN-JMI	T3	
THROMBI-PAD	T3	
ULTRAFOAM	T3	
BLOOD (Blood Thinners/Anti-Clotting)		
HEMORRHEOLOGIC AGENTS		
pentoxifylline	T1	HD

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CARDIAC DRUGS (Blood Pressure/Heart Medications)		
ANTI-ANGINAL, ANTI-ISCHEMIC AGENTS, NON-HEMODYNAMIC		
RANEXA (*ranolazine*)	T3	PA QL(4 TABS/DAY) HD
ranolazine	T1	QL(4 TABS/DAY) HD
ranolazine (Ranexa)	T1	QL (4 tabs/day) HD
ANTI-ARRHYTHMICS		
amiodarone hcl	T1	HD
disopyramide phosphate (Norpace)	T1	HD
dofetilide 125 mcg capsule (Tikosyn)	T1	QL(8 CAPS/DAY) HD
dofetilide 250 mcg capsule (Tikosyn)	T1	QL(4 CAPS/DAY) HD
dofetilide 500 mcg capsule (Tikosyn)	T1	QL(2 CAPS/DAY) HD
flecainide acetate	T1	HD
mexiletine hcl	T1	HD
MULTAQ	T2	HD
NORPACE (*disopyramide phosphate*)	T3	PA HD
NORPACE CR	T3	HD
pacerone 100 mg tablet	T3	PA HD
pacerone 200 mg tablet	T1	HD
pacerone 400 mg tablet	T3	PA HD
propafenone hcl	T1	HD
quinidine gluconate	T1	HD
quinidine sulfate	T1	HD
TIKOSYN 125 MCG CAPSULE (*dofetilide*)	T3	PA QL(8 CAPS/DAY) HD
TIKOSYN 250 MCG CAPSULE (*dofetilide*)	T3	PA QL(4 CAPS/DAY) HD
TIKOSYN 500 MCG CAPSULE (*dofetilide*)	T3	PA QL(2 CAPS/DAY) HD
CALCIUM CHANNEL BLOCKER AND NSAID, COX-2 INHIBITOR		
CONSENSI	T3	PA QL(1 TAB/DAY)
CALCIUM CHANNEL BLOCKING AGENTS		
amlodipine besylate (Norvasc)	T1	HD
CALAN SR (*verapamil er*)	T3	HD
CARDIZEM (*diltiazem hcl*)	T3	PA HD
CARDIZEM CD (*diltiazem 24hr er (cd)*)	T3	PA HD
CARDIZEM LA 120 MG TABLET	T3	PA QL(1 TAB/DAY) HD
CARDIZEM LA 180 MG TABLET (*matzim la*)	T3	PA HD
CARDIZEM LA 240 MG TABLET (*matzim la*)	T3	PA HD
CARDIZEM LA 300 MG TABLET (*matzim la*)	T3	PA HD
CARDIZEM LA 360 MG TABLET (*matzim la*)	T3	PA HD

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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 (*matzim la*)	T3	PA HD
CONJUPRI	T3	PA HD
diltiazem 24h er(la) 120 mg tb (Cardizem La)	T1	QL(1 TAB/DAY) HD
diltiazem 24h er(la) 180 mg tb (Cardizem La)	T1	HD
diltiazem 24h er(la) 240 mg tb (Cardizem La)	T1	HD
diltiazem 24h er(la) 300 mg tb (Cardizem La)	T1	HD
diltiazem 24h er(la) 360 mg tb (Cardizem La)	T1	HD
diltiazem 24h er(la) 420 mg tb (Cardizem La)	T1	HD
diltiazem hcl	T1	HD
diltiazem hcl (Cardizem Cd)	T1	HD
diltiazem hcl (Cardizem La)	T1	HD
diltiazem hcl (Cardizem)	T1	HD
diltiazem hcl (Tiazac)	T1	HD
felodipine	T1	HD
isradipine	T1	
KATERZIA	T3	PA QL(10 MLS/DAY) HD
LEVAMLODIPINE MALEATE	T3	PA HD
nicardipine hcl	T1	HD
nifedipine	T1	HD
nifedipine (Adalat Cc)	T1	HD
nifedipine (Procardia XI)	T1	HD
nimodipine	T1	HD
nimodipine 30 mg capsule	T1	HD
nimodipine 60 mg/20 ml soln	T1	
nisoldipine er 17 mg tablet (Sular)	T1	HD
nisoldipine er 20 mg tablet	T1	QL(1 TAB/DAY) HD
nisoldipine er 25.5 mg tablet	T1	HD
nisoldipine er 30 mg tablet	T1	HD
nisoldipine er 34 mg tablet (Sular)	T1	HD
nisoldipine er 40 mg tablet	T1	HD
nisoldipine er 8.5 mg tablet (Sular)	T1	HD
NORLIQVA	T2	PA QL(10 MLS/DAY) HD
NORVASC (*amlodipine besylate*)	T3	PA

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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 (*nifedipine*)	T3	PA HD
SULAR (*nisoldipine*)	T3	HD
TIAZAC (*diltiazem hcl*)	T3	HD
verapamil hcl	T1	HD
verapamil hcl (Calan Sr)	T1	HD
verapamil hcl (Verelan Pm)	T1	HD
verapamil hcl (Verelan)	T1	HD
VERELAN (*verapamil hcl*)	T3	HD
VERELAN PM (*verapamil hcl*)	T3	HD
CARDIAC MYOSIN INHIBITOR		
CAMZYOS	T4	PA QL(1 CAP/DAY) SP HD
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 (*digoxin*)	T3	PA HD
HEART RATE REDUCING, SA SELECTIVE I(F) CURRENT INH.		
CORLANOR 5 MG TABLET (*ivabradine hcl*)	T3	PA HD
CORLANOR 5 MG/5 ML ORAL SOLN	T4	PA SP HD
CORLANOR 7.5 MG TABLET (*ivabradine hcl*)	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 (*isosorbide dinitrate*)	T3	PA HD
ISORDIL TITRADOSE (*isosorbide dinitrate*)	T3	PA HD
isosorbide dinitrate 10 mg tab	T1	HD
isosorbide dinitrate 20 mg tab	T1	HD

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CARDIAC DRUGS (Blood Pressure/Heart Medications) *(con't.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
VASODILATORS, CORONARY *(con't.)*		
isosorbide dinitrate 30 mg tab	T1	HD
isosorbide dinitrate 40 mg tab (Isordil)	T1	PA HD
isosorbide dinitrate 5 mg tab (Isordil Titradose)	T1	HD
isosorbide mononitrate	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
nitroglycerin	T1	HD
nitroglycerin 0.3 mg tablet sl (Nitrostat)	T1	HD
nitroglycerin 0.4 mg tablet sl (Nitrostat)	T1	HD
nitroglycerin 0.6 mg tablet sl (Nitrostat)	T1	HD
nitroglycerin 400 mcg spray (Nitrolingual)	T1	HD
NITROLINGUAL (*nitroglycerin*)	T3	HD
NITROMIST (*nitroglycerin*)	T3	HD
NITROSTAT (*nitroglycerin*)	T3	HD
CARDIOVASCULAR (Asthma/COPD/Respiratory)		
PULM ANTI-HTN,SOLUBLE GUANYLATE CYCLASE STIMULATOR		
ADEMPAS	T4	PA SP HD
PULM.ANTI-HTN,SEL.C-GMP PHOSPHODIESTERASE T5 INHIB		
ADCIRCA (*tadalafil*)	T4	PA SP HD
REVATIO (*sildenafil citrate*)	T4	PA SP HD
sildenafil 10 mg/ml oral susp (Revatio)	T4	PA SP HD
sildenafil 20 mg tablet (Revatio)	T4	PA SP HD
tadalafil (Adcirca)	T4	PA SP HD
tadalafil 20 mg tablet (Adcirca)	T4	PA SP HD
TADLIQ	T4	PA SP HD
PULMONARY ANTI-HTN, ENDOTHELIN RECEPTOR ANTAGONIST		
ambrisentan (Letairis)	T4	PA SP HD
bosentan (Tracleer)	T4	PA SP HD

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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 (*ambrisentan*)	T4	PA SP HD
OPSUMIT	T4	PA SP HD
TRACLEER 125 MG TABLET (*bosentan*)	T4	PA SP HD
TRACLEER 32 MG TABLET FOR SUSP	T4	PA SP HD
TRACLEER 62.5 MG TABLET (*bosentan*)	T4	PA SP HD
PULMONARY ANTIHYPER AGENT, ACTRIIA-FC		
WINREVAIR	T4	PA SP HD
WINREVAIR (2 PACK)	T4	PA SP HD
PULMONARY ANTIHYPERTENSIVES, PROSTACYCLIN-TYPE		
ORENITRAM ER	T4	PA SP HD
ORENITRAM MONTH 1 TITRATION KT	T4	PA QL(168 TABS/180 DAYS) SP HD
ORENITRAM MONTH 2 TITRATION KT	T4	PA QL(336 TABS/180 DAYS) SP HD
ORENITRAM MONTH 3 TITRATION KT	T4	PA QL(252 TABS/180 DAYS) SP HD
TYVASO	T4	PA SP HD
TYVASO DPI	T4	PA SP HD
TYVASO INSTITUTIONAL START KIT	T4	PA SP HD
TYVASO REFILL KIT	T4	PA SP HD
TYVASO STARTER KIT	T4	PA SP HD
UPTRAVI	T4	PA SP HD
VENTAVIS	T4	PA SP HD
PULMONARY HTN-ENDOTHELIN RECEPT ANTG-CGMP PDE5 INH		
OPSYNVI	T4	PA QL(1 TAB/DAY) SP HD
CARDIOVASCULAR (Blood Pressure/Heart Medications)		
ACE INHIBITOR-CALCIUM CHANNEL BLOCKER COMBINATION		
amlodipine besylate/benazepril	T1	HD
amlodipine besylate/benazepril (Lotrel)	T1	HD
LOTREL (*amlodipine besylate-benazepril*)	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
trandolapril/verapamil hcl	T1	HD

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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

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ALPHA-ADRENERGIC BLOCKING AGENTS *(con't.)*		
MINIPRESS (*prazosin hcl*)	T3	HD
prazosin hcl	T1	HD
prazosin hcl (Minipress)	T1	HD
terazosin hcl	T1	HD
TEZRULY	T3	PA HD
ANGIOTEN.RECEPTR ANTAG-CALCIUM CHANL BLKR-THIAZIDE		
amlodipine/valsartan/hcthiazid (Exforge Hct)	T1	HD
EXFORGE HCT (*amlodipine/valsartan/hcthiazid*)	T3	PA HD
olmesartan/amlodipin/hcthiazid (Tribenzor)	T1	HD
TRIBENZOR (*olmesartan-amlodipine-hctz*)	T3	PA HD
ANGIOTENSIN RECEPT-NEPRILYSIN INHIBITOR COMB (ARNI)		
ENTRESTO (*sacubitril/valsartan*)	T3	PA QL(2 TABS/DAY)
ENTRESTO SPRINKLE	T2	HD
sacubitril/valsartan (Entresto)	T1	QL(2 TABS/DAY) HD
ANGIOTENSIN RECEPTOR ANTAG.-THIAZIDE DIURETIC COMB		
ATACAND HCT (*candesartan-hydrochlorothiazid*)	T3	PA HD
AVALIDE (*irbesartan-hydrochlorothiazide*)	T3	PA HD
BENICAR HCT 20-12.5 MG TABLET (*olmesartan-hydrochlorothiazide*)	T3	PA QL(1 TAB/DAY) HD
BENICAR HCT 40-12.5 MG TABLET (*olmesartan-hydrochlorothiazide*)	T3	PA HD
BENICAR HCT 40-25 MG TABLET (*olmesartan-hydrochlorothiazide*)	T3	PA HD
candesartan/hydrochlorothiazid (Atacand Hct)	T1	HD
DIOVAN HCT (*valsartan-hydrochlorothiazide*)	T3	PA HD
EDARBYCLOR	T3	PA HD
HYZAAR (*losartan-hydrochlorothiazide*)	T3	PA HD
irbesartan/hydrochlorothiazide (Avalide)	T1	HD
losartan/hydrochlorothiazide (Hyzaar)	T1	HD
MICARDIS HCT 40-12.5 MG TABLET (*telmisartan-hydrochlorothiazid*)	T3	ST QL(1 TAB/DAY) HD
MICARDIS HCT 80-12.5 MG TABLET (*telmisartan-hydrochlorothiazid*)	T3	ST HD
MICARDIS HCT 80-25 MG TABLET (*telmisartan-hydrochlorothiazid*)	T3	ST HD
olmesartan-hctz 20-12.5 mg tab (Benicar Hct)	T1	QL(1 TAB/DAY) HD
olmesartan-hctz 40-12.5 mg tab (Benicar Hct)	T1	HD
olmesartan-hctz 40-25 mg tab (Benicar Hct)	T1	HD
telmisartan-hctz 40-12.5 mg tb (Micardis Hct)	T1	QL(1 TAB/DAY) HD
telmisartan-hctz 80-12.5 mg tb (Micardis Hct)	T1	HD

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List of Prescription Medications

CARDIOVASCULAR (Blood Pressure/Heart Medications) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANGIOTENSIN RECEPTOR ANTAG.-THIAZIDE DIURETIC COMB *(con't.)*		
telmisartan-hctz 80-25 mg tab (Micardis Hct)	T1	HD
valsartan/hydrochlorothiazide (Diovan Hct)	T1	HD
ANGIOTENSIN RECEPTOR BLOCKR-CALCIUM CHANNEL BLOCKR		
amlodipine besylate/valsartan (Exforge)	T1	HD
amlodipine-olmesartan 10-20 mg (Azor)	T1	HD
amlodipine-olmesartan 10-40 mg (Azor)	T1	HD
amlodipine-olmesartan 5-20 mg (Azor)	T1	QL(1 TAB/DAY) HD
amlodipine-olmesartan 5-40 mg (Azor)	T1	HD
AZOR 10-20 MG TABLET (*amlodipine-olmesartan*)	T3	PA HD
AZOR 10-40 MG TABLET (*amlodipine-olmesartan*)	T3	PA HD
AZOR 5-20 MG TABLET (*amlodipine-olmesartan*)	T3	PA QL(1 TAB/DAY) HD
AZOR 5-40 MG TABLET (*amlodipine-olmesartan*)	T3	PA HD
EXFORGE (*amlodipine besylate/valsartan*)	T3	PA HD
telmisartan-amlodipine 40-10	T1	HD
telmisartan-amlodipine 40-5 mg	T1	QL(1 TAB/DAY) HD
telmisartan-amlodipine 80-10	T1	HD
telmisartan-amlodipine 80-5 mg	T1	HD
ANTI-HYPERTENSIVES, ACE INHIBITORS		
ACCUPRIL (*quinapril hcl*)	T3	ST HD
ALTACE (*ramipril*)	T3	PA HD
benazepril hcl	T1	HD
benazepril hcl (Lotensin)	T1	HD
captopril	T1	HD
enalapril maleate (Epaned)	T1	HD
enalapril maleate (Vasotec)	T1	HD
EPANED (*enalapril maleate*)	T3	PA HD
fosinopril sodium	T1	HD
lisinopril (Zestril)	T1	HD
LOTENSIN (*benazepril hcl*)	T3	ST HD
moexipril hcl	T1	HD
perindopril erbumine	T1	HD
QBRELIS	T3	PA HD
quinapril hcl (Accupril)	T1	HD
ramipril	T1	HD

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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
ANTIHYPERTENSIVES, 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

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-HYPERTENSIVES, GANGLIONIC BLOCKERS		
VECAMYL	T1	
ANTI-HYPERTENSIVES, MISCELLANEOUS		
DEMSER (*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
methyldopa	T1	HD
methyldopa/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

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

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ENDOTHELIN RECEPTOR ANTAGONISTS		
TRYVIO	T4	PA SP
RENIN INHIBITOR, DIRECT		
aliskiren 150 mg tablet (Tekturna)	T1	QL(1 TAB/DAY) HD
aliskiren 300 mg tablet (Tekturna)	T1	HD
TEKTURNA 150 MG TABLET (*aliskiren hemifumarate*)	T3	PA QL(1 TAB/DAY) HD
TEKTURNA 300 MG TABLET (*aliskiren hemifumarate*)	T3	PA HD
RENIN INHIBITOR, DIRECT AND THIAZIDE DIURETIC COMB		
TEKTURNA HCT	T2	HD
VASODILATORS, COMBINATION		
BIDIL (*isosorbide dinit/hydralazine*)	T3	PA QL(6 TABS/DAY) HD
isosorbide dinit/hydralazine (Bidil)	T1	QL(6 TABS/DAY) HD
VASODILATORS, PERIPHERAL		
ergoloid mesylates	T1	
isoxsuprine hcl	T1	
CARDIOVASCULAR (Cholesterol Medications)		
ANTI-HYPERLIP.HMG COA REDUCT INHIB-CHOLEST.AB.INHIB		
ezetimibe/atorvastatin calcium	T1	PA HD
ezetimibe/simvastatin (Vytorin)	T1	HD
ROSUVASTATIN-EZETIMIBE	T3	PA HD
ROSZET	T3	PA HD
VYTORIN (*ezetimibe-simvastatin*)	T3	PA HD
ANTI-HYPERLIPID- HMG-COA RI-CALCIUM CHANNEL BLOCKER		
amlodipine-atorvast 10-10 mg (Caduet)	T1	HD
amlodipine-atorvast 10-20 mg (Caduet)	T1	HD
amlodipine-atorvast 10-40 mg (Caduet)	T1	HD
amlodipine-atorvast 10-80 mg (Caduet)	T1	HD
amlodipine-atorvast 2.5-10 mg	T1	HD
amlodipine-atorvast 2.5-20 mg	T1	QL(1 TAB/DAY) HD
amlodipine-atorvast 2.5-40 mg	T1	QL(1 TAB/DAY) HD
amlodipine-atorvast 5-10 mg (Caduet)	T1	HD
amlodipine-atorvast 5-20 mg (Caduet)	T1	QL(1 TAB/DAY) HD
amlodipine-atorvast 5-40 mg (Caduet)	T1	QL(1 TAB/DAY) HD
amlodipine-atorvast 5-80 mg (Caduet)	T1	HD

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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 (*amlodipine-atorvastatin*)	T3	HD
CADUET 10 MG-20 MG TABLET (*amlodipine-atorvastatin*)	T3	HD
CADUET 10 MG-40 MG TABLET (*amlodipine-atorvastatin*)	T3	HD
CADUET 10 MG-80 MG TABLET (*amlodipine-atorvastatin*)	T3	HD
CADUET 5 MG-10 MG TABLET (*amlodipine-atorvastatin*)	T3	HD
CADUET 5 MG-20 MG TABLET (*amlodipine-atorvastatin*)	T3	QL(1 TAB/DAY) HD
CADUET 5 MG-40 MG TABLET (*amlodipine-atorvastatin*)	T3	QL(1 TAB/DAY) HD
CADUET 5 MG-80 MG TABLET (*amlodipine-atorvastatin*)	T3	HD
ANTI-HYPERLIPIDEMIC - APOLIPOPROTEIN INHIBITOR		
TRYNGOLZA	T4	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	T4	PA QL(1 CAP/DAY) SP HD
JUXTAPID 10 MG CAPSULE	T4	PA QL(1 CAP/DAY) SP HD
JUXTAPID 20 MG CAPSULE	T4	PA QL(2 CAPS/DAY) SP HD
JUXTAPID 30 MG CAPSULE	T4	PA QL(2 CAPS/DAY) SP HD
ANTI-HYPERLIPIDEMIC - PCSK9 INHIBITORS		
PRALUENT PEN	T3	PA
REPATHA PUSHTRONEX	T2	
REPATHA SURECLICK	T2	
REPATHA SYRINGE	T2	
ANTI-HYPERLIPIDEMIC-ACLY AND CHOLES 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
atorvastatin 10 mg tablet (Lipitor)	T1	HD PPACA
atorvastatin 20 mg tablet (Lipitor)	T1	HD PPACA
atorvastatin 40 mg tablet (Lipitor)	T1	HD
atorvastatin 80 mg tablet (Lipitor)	T1	HD
CRESTOR 10 MG TABLET (*rosuvastatin calcium*)	T3	PA QL(1 TAB/DAY) HD

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

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CARDIOVASCULAR (Cholesterol Medications) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
BILE SALT SEQUESTRANTS *(cont.)*		
colesevelam hcl (Welchol)	T1	HD
COLESTID	T3	HD
COLESTID (*colestipol hcl*)	T3	HD
colestipol hcl	T1	HD
colestipol hcl (Colestid)	T1	HD
QUESTRAN (*cholestyramine*)	T3	HD
QUESTRAN LIGHT (*cholestyramine*)	T3	HD
WELCHOL (*colesevelam hcl*)	T3	PA HD
LIPOTROPICS		
ezetimibe (Zetia)	T1	HD
fenofibrate 120 mg tablet (Fenoglide)	T1	HD
fenofibrate 130 mg capsule	T1	HD
fenofibrate 134 mg capsule	T1	HD
fenofibrate 145 mg tablet (Tricor)	T1	HD
FENOFIBRATE 150 MG CAPSULE	T1	HD
fenofibrate 160 mg tablet	T1	HD
fenofibrate 200 mg capsule	T1	HD
FENOFIBRATE 30 MG CAPSULE	T3	PA HD
fenofibrate 40 mg tablet (Fenoglide)	T1	HD
fenofibrate 43 mg capsule	T1	HD
fenofibrate 48 mg tablet (Tricor)	T1	HD
FENOFIBRATE 50 MG CAPSULE	T1	HD
fenofibrate 54 mg tablet	T1	HD
fenofibrate 67 mg capsule	T1	HD
FENOFIBRATE 90 MG CAPSULE	T3	PA HD
fenofibric acid	T1	HD
fenofibric acid (choline)	T1	HD
fenofibric acid (Fibricor)	T1	HD
FENOGLIDE (*fenofibrate*)	T3	PA HD
FIBRICOR (*fenofibric acid*)	T3	ST HD
gemfibrozil (Lopid)	T1	HD
LIPOFEN	T3	ST HD
LOPID (*gemfibrozil*)	T3	HD
niacin	T1	HD

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CARDIOVASCULAR (Cholesterol Medications) *(cont.)*		
LIPOTROPICS *(cont.)*		
niacin	T1	PA HD
NIACOR	T3	PA HD
TRICOR (*fenofibrate nanocrystallized*)	T3	ST HD
ZETIA (*ezetimibe*)	T3	PA HD
CARDIOVASCULAR (MISCELLANEOUS)		
ENDOTHELIN-ANGIOTENSIN RECEPTOR ANTAGONIST		
FILSPARI	T4	PA QL(1 TAB/DAY) SP
CNS DRUGS (Alzheimer's Disease)		
ALZHEIMER'S THERAPY, NMDA RECEPTOR ANTAGONISTS		
memantine hcl (Namenda)	T1	HD
MEMANTINE HCL	T1	HD
memantine hcl er 14 mg capsule (Namenda Xr)	T1	QL(1 CAP/DAY) HD
memantine hcl er 21 mg capsule (Namenda Xr)	T1	HD
memantine hcl er 28 mg capsule (Namenda Xr)	T1	HD
memantine hcl er 7 mg capsule (Namenda Xr)	T1	QL(1 CAP/DAY) HD
NAMENDA	T2	HD
NAMENDA XR 14 MG CAPSULE (*memantine hcl er*)	T3	PA QL(1 CAP/DAY) HD
NAMENDA XR 28 MG CAPSULE (*memantine hcl er*)	T3	PA HD
NAMENDA XR 7 MG CAPSULE (*memantine hcl er*)	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		
memantine hcl/donepezil hcl (Namzaric)	T1	QL(2 CAPS/DAY) HD
NAMZARIC 14 MG-10 MG CAPSULE (*memantine hcl/donepezil hcl*)	T3	PA QL(2 CAPS/DAY) HD
NAMZARIC 21 MG-10 MG CAPSULE (*memantine hcl/donepezil hcl*)	T3	PA QL(2 CAPS/DAY) HD
NAMZARIC 28 MG-10 MG CAPSULE (*memantine hcl/donepezil hcl*)	T3	PA QL(2 CAPS/DAY) HD
NAMZARIC 7 MG-10 MG CAPSULE	T3	PA QL(2 CAPS/DAY) HD
NAMZARIC TITRATION PACK	T3	PA QL(112 CAPS/365 DAYS) HD
AMYLOID DIRECTED MONOCLONAL ANTIBODY		
LEQEMBI IQLIK 360 MG/1.8 ML	T4	PA SP
CNS DRUGS (Miscellaneous)		
AMYOTROPHIC LATERAL SCLEROSIS AGENTS		
RADICAVA ORS 105 MG/5 ML SUSP	T4	PA QL(50 MLS/30 DAYS) SP HD
RADICAVA ORS STARTER KIT SUSP	T4	PA QL(70 MLS/365 DAYS) SP HD

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List of Prescription Medications

CNS DRUGS (Miscellaneous) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
AMYOTROPHIC LATERAL SCLEROSIS AGENTS *(cont.)*		
RILUTEK (*riluzole*)	T4	PA SP HD
riluzole (Rilutek)	T4	SP HD
TEGLUTIK	T4	PA SP
TIGLUTIK	T4	PA SP
DRUGS TO TREAT MOVEMENT DISORDERS		
AUSTEDO	T4	PA SP HD
AUSTEDO XR 6 MG TABLET	T4	PA QL(3 TABS/DAY) SP HD
AUSTEDO XR 12 MG TABLET	T4	PA QL(1 TAB/DAY) SP HD
AUSTEDO XR 18 MG TABLET	T4	PA QL(1 TAB/DAY) SP HD
AUSTEDO XR 24 MG TABLET	T4	PA QL(2 TABS/DAY) SP HD
AUSTEDO XR 30 MG TABLET	T4	PA QL(1 TAB/DAY) SP HD
AUSTEDO XR 36 MG TABLET	T4	PA QL(1 TAB/DAY) SP HD
AUSTEDO XR 42 MG TABLET	T4	PA QL(1 TAB/DAY) SP HD
AUSTEDO XR 48 MG TABLET	T4	PA QL(1 TAB/DAY) SP HD
AUSTEDO XR TITRATION KT(WK1-4)	T4	PA QL(1 KIT/180 DAYS) SP HD
HORIZANT	T3	PA
INGREZZA	T4	PA QL(1 CAP/DAY) SP
INGREZZA INITIATION PK (TARDIV)	T4	PA QL(28 CAPS/365 DAYS) SP
INGREZZA SPRINKLE	T4	PA QL(1 CAP/DAY) SP
tetrabenazine (Xenazine)	T4	PA SP HD
XENAZINE (*tetrabenazine*)	T4	PA SP HD
GLYPROMATE (GPE) ANALOGS		
DAYBUE	T4	PA QL(120 MLS/DAY) SP
PSEUDOBULBAR AFFECT (PBA) AGENTS, NMDA ANTAGONISTS		
NUEDEXTA	T3	QL(4 CAPS/DAY)
XANTHINES		
caffeine citrate	T1	HD
CNS DRUGS (Multiple Sclerosis)		
AGENTS TO TREAT MULTIPLE SCLEROSIS		
AUBAGIO (*teriflunomide*)	T4	PA SP HD
AVONEX (4 PACK)	T4	PA SP HD
AVONEX PEN (4 PACK)	T4	PA SP HD
BAFIERTAM	T4	PA SP HD
BETASERON	T4	PA SP HD

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List of Prescription Medications

CNS DRUGS (Multiple Sclerosis) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
AGENTS TO TREAT MULTIPLE SCLEROSIS *(cont.)*		
cladribine	T4	PA SP HD
COPAXONE (*glatiramer acetate*)	T4	PA SP HD
dimethyl fumarate 30d start pk (Tecfidera)	T4	SP HD
dimethyl fumarate dr 120 mg cp (Tecfidera)	T4	SP HD
dimethyl fumarate dr 240 mg cp (Tecfidera)	T4	SP HD
fingolimod hcl (Gilenya)	T4	SP HD
GILENYA 0.25 MG CAPSULE	T4	PA QL(1 CAP/DAY) SP
GILENYA 0.5 MG CAPSULE (*fingolimod hcl*)	T4	PA SP HD
glatiramer acetate (Copaxone)	T4	SP HD
KESIMPTA PEN	T4	PA SP HD
MAVENCLAD	T4	PA SP HD
MAYZENT	T4	PA SP HD
PLEGRIDY	T4	PA SP HD
PLEGRIDY PEN	T4	PA SP HD
PONVORY	T4	PA SP HD
REBIF	T4	PA SP HD
REBIF REBIDOSE	T4	PA SP HD
TASCENSO ODT	T4	PA QL(1 TAB/DAY) SP HD
TECFIDERA (*dimethyl fumarate*)	T4	PA SP HD
teriflunomide (Aubagio)	T4	SP HD
VUMERITY	T4	PA SP HD
AGTS TX NEUROMUSC TRANSMISSION DIS, POT-CHAN BLKR		
AMPYRA (*dalfampridine*)	T4	PA SP HD
dalfampridine er 10 mg tablet (Ampyra)	T4	PA HD
dalfampridine er 10 mg tablet (Ampyra)	T4	PA SP HD
FIRDAPSE	T4	PA QL(8 TABS/DAY) SP
SPHINGOSINE 1-PHOSPHATE (SIP) RECEPTOR MODULATOR		
ZEPOSIA	T4	PA SP HD
CNS DRUGS (Pain Relief And Inflammatory Disease)		
CALCITONIN GENE-RELATED PEPTIDE (CGRP) INHIBITORS		
EMGALITY SYRINGE	T2	PA

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CNS DRUGS (Pain Relief And Inflammatory Disease) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
POSTHERPETIC NEURALGIA AGENTS		
gabapentin (Gralise)	T1	
GRALISE ER 300 MG TABLET (*gabapentin*)	T3	
GRALISE ER 450 MG TABLET (*gabapentin*)	T3	PA
GRALISE ER 600 MG TABLET (*gabapentin*)	T3	
GRALISE ER 750 MG TABLET (*gabapentin*)	T3	PA
GRALISE ER 900 MG TABLET (*gabapentin*)	T3	PA
SPHINGOSINE I-PHOSPHATE (SIP) RECEPTOR MODULATOR		
VELSIPITY	T4	PA QL(30 TABS/30 DAYS) SP HD
ZEPOSIA	T4	PA SP HD
CNS DRUGS (Seizure Disorders)		
ANTI-CONVULSANT - BENZODIAZEPINE TYPE		
clobazam (Onfi)	T1	HD
clonazepam	T1	HD
clonazepam (Klonopin)	T1	HD
DIASTAT (*diazepam*)	T3	PA HD
diazepam 10 mg rectal gel syst	T1	HD
diazepam 10mg rectal gel (2pk)	T1	HD
diazepam 2.5 mg rectal gel sys (Diastat)	T1	HD
diazepam 20 mg rectal gel syst	T1	HD
diazepam 20mg rectal gel (2pk)	T1	HD
KLONOPIN (*clonazepam*)	T3	PA HD
LIBERVANT	T3	PA QL(10 FILMS/30 DAYS) HD
NAYZILAM	T2	PA QL(10 UNITS/30 DAYS) HD
ONFI (*clobazam*)	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 (*eslicarbazepine acetate*)	T3	PA QL(1 TAB/DAY) HD
APTIOM 400 MG TABLET (*eslicarbazepine acetate*)	T3	PA QL(1 TAB/DAY) HD
APTIOM 600 MG TABLET (*eslicarbazepine acetate*)	T3	PA HD
APTIOM 800 MG TABLET (*eslicarbazepine acetate*)	T3	PA HD

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CNS DRUGS (Seizure Disorders) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-CONVULSANTS *(cont.)*		
BANZEL 200 MG TABLET (*rufinamide*)	T3	PA QL(16 TABS/DAY) HD
BANZEL 40 MG/ML SUSPENSION (*rufinamide*)	T3	PA QL(80 MLS/DAY) HD
BANZEL 400 MG TABLET (*rufinamide*)	T3	PA QL(8 TABS/DAY) HD
BRIVIACT	T3	PA HD
carbamazepine (Carbatrol)	T1	HD
carbamazepine (Tegretol Xr)	T1	HD
carbamazepine (Tegretol)	T1	HD
carbamazepine 100 mg tab chew	T1	HD
carbamazepine 100 mg/5 ml cup	T1	HD
carbamazepine 100 mg/5 ml susp (Tegretol)	T1	HD
CARBAMAZEPINE 200 MG TAB CHEW	T3	HD
carbamazepine 200 mg tablet (Tegretol)	T1	HD
carbamazepine 200 mg/10 ml cup	T1	HD
CARBATROL (*carbamazepine*)	T3	PA HD
CELONTIN (*methsuximide*)	T3	HD
DEPAKOTE (*divalproex sodium*)	T3	PA HD
DEPAKOTE ER (*divalproex sodium er*)	T3	PA HD
DEPAKOTE SPRINKLE (*divalproex sodium*)	T3	PA HD
DIACOMIT	T3	PA SP HD
DILANTIN 100 MG CAPSULE (*phenytoin sodium extended*)	T3	PA HD
DILANTIN 30 MG CAPSULE	T2	PA HD
DILANTIN 50 MG INFATAB (*phenytoin*)	T3	PA HD
DILANTIN-125 (*phenytoin*)	T3	PA HD
divalproex sodium (Depakote Er)	T1	HD
divalproex sodium (Depakote Sprinkle)	T1	HD
divalproex sodium (Depakote)	T1	HD
ELEPSIA XR	T3	PA HD
EPRONTIA (*topiramate*)	T3	PA HD
eslicarbazepine 200 mg, 400 mg tablet	T1	PA QL(1 TAB/DAY) HD
eslicarbazepine 600 mg, 800 mg tablet	T1	PA HD
ethosuximide (Zarontin)	T1	HD
felbamate (Felbatol)	T1	HD
FELBATOL (*felbamate*)	T3	PA HD

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CNS DRUGS (Seizure Disorders) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-CONVULSANTS *(cont.)*		
FINTEPLA	T4	PA SP HD
FYCOMPA 0.5 MG/ML ORAL SUSP	T3	PA HD
FYCOMPA 2 MG TABLET (*perampanel*)	T3	PA HD
FYCOMPA 4 MG TABLET (*perampanel*)	T3	PA QL(1 TAB/DAY) HD
FYCOMPA 6 MG TABLET (*perampanel*)	T3	PA QL(1 TAB/DAY) HD
FYCOMPA 8 MG TABLET (*perampanel*)	T3	PA HD
FYCOMPA 10 MG TABLET (*perampanel*)	T3	PA HD
FYCOMPA 12 MG TABLET (*perampanel*)	T3	PA HD
gabapentin	T1	HD
gabapentin (Neurontin)	T1	HD
GABARONE	T3	PA HD
KEPPRA (*levetiracetam*)	T3	PA HD
KEPPRA XR (levetiracetam)	T3	PA HD
lacosamide (Vimpat)	T1	HD
LAMICTAL (BLUE) (*lamotrigine*)	T3	PA HD
LAMICTAL (GREEN) (*lamotrigine*)	T3	PA HD
LAMICTAL (*lamotrigine*)	T3	PA HD
LAMICTAL (ORANGE) (*lamotrigine*)	T3	PA HD
LAMICTAL ODT (BLUE) (*lamotrigine*)	T3	PA HD
LAMICTAL ODT (GREEN) (*lamotrigine*)	T3	PA HD
LAMICTAL ODT (*lamotrigine*)	T3	PA HD
LAMICTAL ODT (ORANGE) (*lamotrigine*)	T3	PA HD
LAMICTAL XR (BLUE)	T3	PA HD
LAMICTAL XR (GREEN)	T3	PA HD
LAMICTAL XR (*lamotrigine*)	T3	PA HD
LAMICTAL XR (ORANGE)	T3	PA HD
lamotrigine (Lamictal (blue))	T1	HD
lamotrigine (Lamictal (green))	T1	HD
lamotrigine (Lamictal (orange))	T1	HD
lamotrigine (Lamictal Odt (blue))	T1	HD
lamotrigine (Lamictal Odt (green))	T1	HD
lamotrigine (Lamictal Odt (orange))	T1	HD
lamotrigine (Lamictal Odt)	T1	HD
lamotrigine (Lamictal Xr)	T1	HD

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List of Prescription Medications

CNS DRUGS (Seizure Disorders) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-CONVULSANTS *(cont.)*		
lamotrigine (Lamictal)	T1	HD
levetiracetam (Keppra Xr)	T1	HD
levetiracetam (Keppra)	T1	HD
levetiracetam 1,000 mg tablet (Keppra)	T1	HD
levetiracetam 1,000mg/10ml cup (Keppra)	T1	HD
*levetiracetam 100 mg/ml soln (*Keppra*)*	T1	HD
LEVETIRACETAM 250 MG TAB SUSP	T3	PA HD
*levetiracetam 250 mg tablet (*Keppra*)*	T1	HD
*levetiracetam 500 mg tablet (*Keppra*)*	T1	HD
levetiracetam 500 mg/5 ml cup	T1	HD
levetiracetam 500 mg/5 ml soln	T1	HD
*levetiracetam 750 mg tablet (*Keppra*)*	T1	HD
LYRICA (*pregabalin*)	T3	PA HD
methsuximide (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 (*primidone*)	T3	PA HD
NEURONTIN *(gabapentin)*	T3	PA HD
*oxcarbazepine (*Oxtellar Xr*)*	T1	PA HD
oxcarbazepine (Trileptal)	T1	HD
OXTELLAR XR (*oxcarbazepine*)	T3	PA HD
perampanel 10 mg tablet (Fycompa)	T1	PA HD
*perampanel 12 mg tablet (*Fycompa*)*	T1	PA HD
*perampanel 2 mg tablet (*Fycompa*)*	T1	PA HD
*perampanel 4 mg tablet (*Fycompa*)*	T1	PA QL(1 TAB/DAY) HD
*perampanel 6 mg tablet (*Fycompa*)*	T1	PA QL(1 TAB/DAY) HD
*perampanel 8 mg tablet (*Fycompa*)*	T1	PA HD
PHENYTEK *(phenytoin sodium extended)*	T3	PA HD
phenytoin	T1	HD
*phenytoin (*Dilantin*)*	T1	HD
*phenytoin (*Dilantin-125*)*	T1	HD

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

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CNS DRUGS (Seizure Disorders) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-CONVULSANTS *(cont.)*		
topiramate er 100 mg capsule (Trokendi Xr)	T1	QL(1 CAP/DAY) HD
topiramate er 200 mg capsule (Trokendi Xr)	T1	HD
topiramate er 25 mg capsule (Trokendi Xr)	T1	QL(1 CAP/DAY) HD
topiramate er 50 mg capsule (Trokendi Xr)	T1	HD
TRILEPTAL (*oxcarbazepine*)	T3	PA HD
TROKENDI XR 100 MG CAPSULE (*topiramate*)	T3	QL(1 CAP/DAY) HD
TROKENDI XR 200 MG CAPSULE (*topiramate*)	T3	HD
TROKENDI XR 25 MG CAPSULE (*topiramate*)	T3	QL(1 CAP/DAY) HD
TROKENDI XR 50 MG CAPSULE (*topiramate*)	T3	HD
valproic acid	T1	HD
valproic acid (as sodium salt)	T1	HD
vigabatrin (Sabril)	T4	SP HD
vigadrone 500 mg powder packet (Sabril)	T4	SP HD
vigadrone 500 mg tablet (Sabril)	T4	PA SP HD
VIGAFYDE	T4	PA SP
VIMPAT 10 MG/ML SOLUTION (*lacosamide*)	T2	HD
VIMPAT 100 MG TABLET (*lacosamide*)	T3	PA HD
VIMPAT 150 MG TABLET (*lacosamide*)	T3	PA HD
VIMPAT 200 MG TABLET (*lacosamide*)	T3	PA HD
VIMPAT 50 MG TABLET (*lacosamide*)	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 (*ethosuximide*)	T3	PA HD
ZONEGRAN (*zonisamide*)	T3	PA HD
ZONISADE	T3	PA QL(6 MLS/30 DAYS) HD
zonisamide	T1	HD
zonisamide (Zonegran)	T1	HD

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CNS DRUGS (Sleep Disorders/Sedatives)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
NARCOLEPSY TX-H3-RECEPT.ANTAGONIST/INVERSE AGONIST		
WAKIX	T4	PA QL(2 TABS/DAY) SP HD
COLONY STIMULATING FACTORS (Blood Modifiers/Bleeding Disorders)		
ERYTHROPOIESIS-STIMULATING AGENTS		
ARANESP	T4	PA SP
EPOGEN	T4	PA SP
MIRCERA	T4	PA SP
PROCRIT	T4	PA SP
RETACRIT	T4	PA SP
LEUKOCYTE (WBC) STIMULANTS		
FULPHILA	T4	PA SP
FYLNETRA	T4	PA SP
GRANIX	T4	PA SP
LEUKINE	T4	SP
NEULASTA	T4	PA SP
NEULASTA ONPRO	T4	PA SP HD
NEUPOGEN	T4	PA SP
NIVESTYM	T4	SP HD
NYPOZI	T4	PA SP
NYVEPRIA	T4	PA SP
STIMUFEND	T4	PA SP
UDENYCA	T4	PA SP
UDENYCA AUTOINJECTOR	T4	PA SP
UDENYCA ONBODY	T4	PA SP
ZARXIO	T4	SP HD
ZIEXTENZO	T4	PA SP
THROMBOPOIETIN RECEPTOR AGONISTS		
ALVAIZ 18 MG, 54 MG TABLET	T4	PA QL(1 TAB/DAY) SP
ALVAIZ 36 MG, 54 MG TABLET	T4	PA QL(2 TABS/DAY) SP
DOPTELET	T4	PA SP HD
DOPTELET SPRINKLE	T4	PA SP HD
eltrombopag olamine (Promacta)	T4	PA SP HD
MULPLETA	T4	PA SP HD
PROMACTA (*eltrombopag olamine*)	T4	PA SP HD

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COLONY STIMULATING FACTORS (Blood Pressure/Heart Medications)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
LEUKOCYTE (WBC) STIMULANTS		
RELEUKO	T4	PA SP
ROLVEDON	T4	PA SP
COLONY STIMULATING FACTORS (Cancer)		
CXCR4 CHEMOKINE RECEPTOR ANTAGONIST		
XOLREMDI	T4	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	T4	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

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CONTRACEPTIVES (Contraception Products) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
CONTRACEPTIVES, ORAL *(cont.)*		
ethynodiol d-ethinyl estradiol	T3	PA HD PPACA
FEMLYV	T3	PA HD PPACA
levonorgest/eth.estradiol/iron (Balcoltra)	T1	HD PPACA
levonorgestrel/ethin.estradiol	T1	HD PPACA
l-norgest/e.estradiol-e.estrad	T1	HD PPACA
LO LOESTRIN FE	T3	PA
LOESTRIN (*norethindrone ac/eth estradiol*)	T3	HD PPACA
LOESTRIN FE (*norethindrone-e.estradiol-iron*)	T3	HD PPACA
NATAZIA	T3	HD PPACA
NEXTSTELLIS	T3	HD PPACA
noreth-ethinyl estradiol/iron	T1	HD PPACA
noreth-ethinyl estradiol/iron	T3	HD PPACA
norethind-eth estrad 1-0.02 mg (Loestrin)	T1	HD PPACA
norethindrone	T1	HD PPACA
norethindrone ac-eth estradiol (Loestrin)	T1	HD PPACA
norethindrone-e.estradiol-iron	T1	HD PPACA
norethindrone-e.estradiol-iron (Loestrin Fe)	T1	HD PPACA
norethindrone-e.estradiol-iron (Taytulla)	T1	HD PPACA
norethindrone-ethin. estradiol	T1	HD PPACA
norethin-ee 1.5-0.03 mg (21) tb (Loestrin)	T1	HD PPACA
norgestimate-ethinyl estradiol	T1	HD PPACA
norgestrel-ethinyl estradiol	T1	HD PPACA
SAFYRAL (*drospir/eth estra/levomefol ca*)	T3	HD PPACA
SLYND	T3	HD PPACA
TAYTULLA (*norethindrone-e.estradiol-iron*)	T3	HD PPACA
TYBLUME	T3	HD PPACA
YASMIN 28 (ethinyl estradiol/drospirenone)	T3	HD PPACA
YAZ (ethinyl estradiol/drospirenone)	T3	HD PPACA
CONTRACEPTIVES,TRANSDERMAL		
norelgestromin/ethin.estradiol	T1	HD PPACA
TWIRLA	T3	HD PPACA

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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	T4	SP PPACA
LILETTA	T4	SP PPACA
MIRENA	T4	SP PPACA
MIUDELLA	T4	SP PPACA
PARAGARD T 380-A	T4	SP PPACA
PARAGARD T 380A (SINGLE HAND)	T4	SP PPACA
SKYLA	T4	SP PPACA
COUGH/COLD PREPARATIONS (Allergy/Nasal Sprays)		
1ST GEN ANTIHIST-DECONGEST-ANTICHOLINERGIC COMB		
RESPA A.R. (*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)

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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 (*hydrocodone bit/homatrop me-br*)	T3	PA QL(180 TABS/30 DAYS)
HYCODAN 5 MG-1.5 MG/5 ML CUP	T3	PA QL(480 MLS/30 DAYS)
HYCODAN 5 MG-1.5 MG/5 ML SOLN (*hydrocodone bit/homatrop me-br*)	T3	PA QL(480 MLS/30 DAYS)
hydrocodone bit/homatrop me-br (Hycodan)	T1	PA QL (480ml/22 days)
hydrocodone-homatropine 5-1.5	T1	PA QL (180 tabs/30 days)
hydrocodone-homatropine 5-1.5 (Hycodan)	T1	PA QL(180 TABS/30 DAYS)
hydrocodone-homatropine soln (Hycodan)	T1	PA QL (480ml/30 days)
OPIOID ANTITUSSIVE-DECONGESTANT-EXPECTORANT COMB		
CODITUSSIN DAC	T3	
OPIOID ANTI-TUSSIVE-EXPECTORANT COMBINATION		
codeine phosphate/guaifenesin	T1	
CODITUSSIN AC	T1	
GUAIFENESIN-CODEINE	T1	
MAR-COF CG	T3	
NINJACOF-XG	T1	
OBREDON	T3	PA QL(960 MLS/30 DAYS)
DIAGNOSTIC (Diabetes)		
BLOOD SUGAR DIAGNOSTICS		
ACCU-CHEK AVIVA PLUS	T2	
ACCU-CHEK GUIDE TEST STRIP	T2	
ACCU-CHEK SMARTVIEW TEST STRIP	T2	
ACCUTREND GLUCOSE TEST STRIP	T2	
ADVANCED GLUCOSE TEST STRIP	T3	
ADVANCED GLUCOSE TEST STRIPS	T3	
ADVOCATE REDI-CODE	T3	
ADVOCATE REDI-CODE+	T3	
ADVOCATE TEST STRIP	T3	
AGAMATRIX AMP	T3	
AGAMATRIX JAZZ TEST STRIP	T3	
AGAMATRIX PRESTO	T3	

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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	

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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	

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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	

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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	

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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	
SMARTEST TEST	T3	
SOLUS V2 TEST STRIPS	T3	
SURE-TEST EASYPLUS MINI STRIP	T3	
TELCARE TEST STRIPS	T3	
TEST N'GO	T3	
TEST STRIPS	T3	
TRUE METRIX GLUCOSE TEST STRIP	T2	
TRUE METRIX GLUCOSE TEST STRIP	T3	
TRUETEST TEST STRIPS	T3	
TRUETRACK TEST STRIP	T3	
ULTIMA	T3	
ULTRATRAK TEST STRIP	T3	
ULTRATRAK ULTIMATE TEST STRIPS	T3	
UNISTRIP1	T3	
VIVAGUARD INO TEST STRIP	T3	
URINE GLUCOSE TEST AIDS		
DIASTIX REAGENT	T1	
DIAGNOSTIC (Miscellaneous)		
BLOOD TESTING PREPARATIONS		
FORA GTEL 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	
lidocaine hcl/glycerin	T1	
PROVOCHOLINE	T3	
TC99M SULFUR COLLOID PREP	T1	

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List of Prescription Medications

DIAGNOSTIC (Miscellaneous) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
EYE DIAGNOSTIC AGENTS		
fluorescein sodium	T1	
ful-glo 1 mg opth strip	T1	
FUL-GLO EYE STRIPS	T3	
lissamine green	T1	
GASTROINTESTINAL RADIOPAQUE DIAGNOSTICS		
diatrizoate meglumine, sodium (Gastrografin)	T1	
ENTERO VU	T3	
E-Z DISK	T3	
E-Z-HD	T3	
E-Z-PAQUE	T3	
E-Z-PASTE	T3	
GASTROGRAFIN (*diatrizoate meglumine, sodium*)	T3	
GASTROMARK	T3	
LIQUID E-Z PAQUE	T3	
LIQUID POLIBAR PLUS	T3	
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	

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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 (*tolvaptan*)	T4	PA SP
tolvaptan 15 mg tablet (Samsca)	T4	SP
tolvaptan 30 mg tablet (Samsca)	T4	SP
CARBONIC ANHYDRASE INHIBITORS		
acetazolamide	T1	HD
methazolamide	T1	HD
LOOP DIURETICS		
bumetanide	T1	HD
EDECRIN (*ethacrynic acid*)	T3	PA

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DIURETICS (Diuretics) *(cont.)*		
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LOOP DIURETICS *(cont.)*		
ethacrynic acid (Edecrin)	T1	PA
FUROSCIX	T4	PA QL(2 KITS/30 DAYS) SP
furosemide	T1	HD
furosemide (Lasix)	T1	HD
LASIX (*furosemide*)	T3	PA HD
LASIX ONYU 80 MG/2.67 ML KIT	T3	PA QL(2 KITS/30 DAYS)
SOAANZ	T3	PA HD
torsemide	T1	HD
POLYCYSTIC KIDNEY DISEASE AGENT, AVP RECEP. ANTAG		
JYNARQUE *(tolvaptan)*	T4	SP
tolvaptan 15 mg tablet (Jynarque)	T4	SP
tolvaptan 15 mg-15 mg tablet (Jynarque)	T4	PA SP
tolvaptan 30 mg tablet (Jynarque)	T4	SP
tolvaptan 30 mg-15 mg tablet (Jynarque)	T4	PA SP
tolvaptan 45 mg-15 mg tablet (Jynarque)	T4	PA SP
tolvaptan 60 mg-30 mg tablet (Jynarque)	T4	PA SP
tolvaptan 90 mg-30 mg tablet (Jynarque)	T4	PA SP
POTASSIUM SPARING DIURETICS		
ALDACTONE (*spironolactone*)	T3	PA HD
amiloride hcl	T1	HD
CAROSPIR (*spironolactone*)	T2	PA
DYRENIUM (*triamterene*)	T3	PA HD
eplerenone (Inspra)	T1	HD
INSPRA *(eplerenone)*	T3	PA HD
KERENDIA	T2	PA QL(1 TAB/DAY)
spironolactone 100 mg tablet (Aldactone)	T1	HD
spironolactone 25 mg tablet (Aldactone)	T1	HD
spironolactone 25 mg/5 ml susp (Carospir)	T1	
spironolactone 50 mg tablet (Aldactone)	T1	HD
triamterene (Dyrenium)	T1	HD
POTASSIUM SPARING DIURETICS IN COMBINATION		
amiloride/hydrochlorothiazide	T1	HD
spironolact/hydrochlorothiazid	T1	HD
triamterene/hydrochlorothiazid	T1	HD

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List of Prescription Medications

DIURETICS (Diuretics) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
THIAZIDE AND RELATED DIURETICS		
chlorthalidone	T1	HD
DIURIL	T2	HD
HEMICLOR	T3	PA QL(1 TAB/DAY) HD
hydrochlorothiazide	T1	HD
indapamide	T1	HD
INZIRQO	T3	PA HD
metolazone	T1	HD
THALITONE	T3	PA HD
EENT PREPS (Allergy/Nasal Sprays)		
NASAL ANTIHISTAMINE		
azelastine 0.1% (137 mcg) spry	T1	HD
olopatadine 665 mcg nasal spry (Patanase)	T1	HD
PATANASE (*olopatadine hcl*)	T3	HD
NASAL ANTIHISTAMINE AND ANTI-INFLAM. STEROID COMB.		
azelastine/fluticasone (Dymista)	T1	HD
DYMISTA (*azelastine-fluticasone*)	T3	ST HD
RYALTRIS	T3	PA QL(1 GM/30 DAYS) HD
NASAL ANTI-INFLAMMATORY STEROIDS		
flunisolide	T1	HD
fluticasone prop 50 mcg spray	T1	HD
mometasone furoate 50 mcg spry	T1	QL(68 GMS/30 DAYS) HD
OMNARIS	T3	ST HD
QNASL	T3	ST
QNASL CHILDREN	T3	
XHANCE	T3	ST HD
ZETONNA	T3	ST HD
NOSE PREPARATIONS, MISCELLANEOUS (RX)		
ipratropium bromide	T1	HD
NOSE PREPARATIONS, VASOCONSTRICTORS (RX)		
ADRENALIN CHLORIDE	T3	
epinephrine hcl	T1	

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List of Prescription Medications

EENT PREPS (Ear Medications)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
EAR PREPARATIONS ANTI-INFLAMMATORY		
DERMOTIC (*fluocinolone acetonide oil*)	T3	
fluocinolone acetonide oil (Dermotic)	T1	
EAR PREPARATIONS, MISC. ANTI-INFECTIVES		
acetic acid	T1	
hydrocortisone/acetic acid	T1	
EENT PREPS (Eye Conditions)		
ARTIFICIAL TEARS		
LACRISERT	T3	
MIEBO	T2	QL(4 BOTTLES/30 DAYS)
EYE ANTI-INFECTIVES (RX ONLY)		
BETADINE	T2	
EYE ANTI-INFLAMMATORY AGENTS		
ACULAR (*ketorolac tromethamine*)	T3	PA
ACULAR LS (*ketorolac tromethamine*)	T3	PA
ACUVAIL	T3	PA
ALREX	T3	PA
ALREX (*loteprednol etabonate*)	T3	PA
bromfenac sodium	T1	
bromfenac sodium (Bromsite)	T1	
bromfenac sodium (Prolensa)	T1	
BROMSITE (*bromfenac sodium*)	T3	PA
CLOBETASOL 0.05% EYE DROP	T3	PA
dexamethasone sodium phosphate	T1	
diclofenac 0.1% eye drops	T1	
difluprednate (Durezol)	T1	
DUREZOL (*difluprednate*)	T3	PA
EYSUVIS	T2	QL(8.3 ML/14 DAYS)
FLAREX	T3	PA
fluorometholone (Fml)	T1	
flurbiprofen sodium	T1	
FML (*fluorometholone*)	T3	PA
FML FORTE	T3	PA
ILEVRO	T3	

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List of Prescription Medications

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

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List of Prescription Medications

EENT PREPS (Eye Conditions) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
MIOTICS AND OTHER INTRAOCULAR PRESSURE REDUCERS		
ALPHAGAN P (*brimonidine tartrate*)	T3	PA HD
apraclonidine hcl	T1	HD
AZOPT (*brinzolamide*)	T3	PA HD
betaxolol hcl	T1	HD
BETIMOL	T3	PA HD
BETIMOL (*timolol*)	T3	PA HD
BETOPTIC S	T2	HD
bimatoprost	T1	QL(10 MLS/30 DAYS) HD
brimonidine tartrate	T1	HD
brimonidine tartrate (Alphagan P)	T1	HD
*brimonidine tartrate/timolol (*Combigan*)*	T1	HD
brinzolamide (Azopt)	T1	HD
carteolol hcl	T1	HD
COMBIGAN (*brimonidine tartrate/timolol*)	T3	PA HD
COSOPT (*dorzolamide hcl/timolol maleat*)	T3	PA HD
COSOPT PF (*dorzolamide-timolol*)	T3	PA HD
dorzolamide hcl	T1	HD
dorzolamide hcl/timolol maleat (Cosopt)	T1	HD
dorzolamide/timolol/pf (Cosopt Pf)	T1	HD
IOPIDINE	T3	PA HD
ISTALOL (*timolol maleate*)	T3	PA HD
IYUZEH	T3	PA QL(30 VIALS/30 DAYS) HD
latanoprost (Xalatan)	T1	HD
levobunolol hcl	T1	HD
LUMIGAN	T3	PA HD
PHOSPHOLINE IODIDE	T2	SP HD
pilocarpine 1% eye drops	T1	HD
pilocarpine 2% eye drops	T1	HD
pilocarpine 4% eye drops	T1	HD
pilocarpine hcl 1.25% eye drop (Vuity)	T1	PA HD
QLOSI	T3	PA
RHOPRESSA	T3	
ROCKLATAN	T3	
SIMBRINZA	T2	HD
tafluprost/pf (Zioptan)	T1	QL(60 DROPPERS/30 DAYS) HD

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List of Prescription Medications

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

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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	T4	PA QL(20 MLS/28 DAYS) SP
CYSTARAN 0.44% EYE DROPS	T4	PA QL(120 MLS/28 DAYS) SP
OPHTHALMIC HUMAN NERVE GROWTH FACTOR (HNGF)		
OXERVATE	T4	PA SP HD
OPHTHALMIC TRPM8 AGONISTS		
TRYPTYR	T3	
ELECT/CALORIC/H2O (Cholesterol Medications)		
ORAL LIPID SUPPLEMENTS		
DOJOLVI	T4	PA SP HD
ELECT/CALORIC/H2O (Dental Products)		
FLUORIDE PREPARATIONS		
CLINPRO 5000	T3	
FLORIVA 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	

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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 HYPOPEN 1-PACK	T2	QL(2 SYR/AUTO-INJ/30 DAYS)
GVOKE HYPOPEN 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)

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List of Prescription Medications

ELECT/CALORIC/H2O (Miscellaneous)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
NUCLEIC ACID/NUCLEOTIDE SUPPLEMENTS		
XURIDEN	T4	PA SP
ELECT/CALORIC/H2O (Nutritional/Dietary)		
CALCIUM REPLACEMENT		
calcium/mag/d3/b12/fa/b6/boron	T1	
CARBOHYDRATES		
ENFAMIL	T3	
GLUTOL	T3	
ELECTROLYTE DEPLETERS		
AURYXIA	T3	QL(12 TABS/DAY)
calcium acetate	T1	
FERRIC CITRATE	T3	PA QL(12 TABS/DAY)
FOSRENOL	T3	PA
FOSRENOL (*lanthanum carbonate*)	T3	PA
lanthanum carbonate (Fosrenol)	T1	
LOKELMA	T2	
MAGNEBIND 400	T3	
RENVELA (*sevelamer carbonate*)	T3	PA
sevelamer carbonate (Renvela)	T1	
sevelamer hcl	T1	
sodium polystyrene sulfon/sorb	T1	
sodium polystyrene sulfonate	T1	
sps 15 gm/60 ml suspension	T1	
sps 30 gm/120 ml enema susp	T3	
VELPHORO	T2	
VELTASSA	T2	
XPHOZAH	T4	PA SP
FLUORIDE PREPARATIONS		
CLINPRO 5000	T3	
fluoride (sodium)	T1	
fluoride (sodium) (Prevident 5000 Plus)	T1	
fluoride (sodium) (Prevident)	T1	
FLUORIDEX	T1	
FLUORIMAX 5000	T3	

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List of Prescription Medications

ELECT/CALORIC/H2O (Nutritional/Dietary) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
FLUORIDE PREPARATIONS *(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	

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
IRON REPLACEMENT *(con't.)*		
iron aspgly,ps/c/b12/fa/ca/suc	T1	
iron aspgly/c/b12/fa/ca-th/suc	T1	
iron bg,ps/vitc/b12/fa/calcium	T1	
iron fum,ag/c/b12/folic/ca/suc	T1	
iron fum,ps/folic acid/vitc/b3 (Integra F)	T1	
iron fum,ps/folic/bcomp,c no.9 (Integra Plus)	T1	
iron fumarate/vit c/vit b12/fa	T1	
iron ps complex/b12/folic acid	T1	
iron/c/folic acd/mv cmb11/calc	T1	
iron/folic ac/vit bcomp,c/min	T1	
iron/folic acid/b12/c/docusate	T1	
iron/folic acid/c/b6/b12/zinc	T1	
IROSPAN	T3	
NEONATAL FE	T3	
NUFERA	T3	
PROFERRIN-FORTE	T3	
VITAFOL	T2	
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
POTASSIUM REPLACEMENT		
EFFER-K 10 MEQ TABLET EFF	T3	
EFFER-K 20 MEQ TABLET EFF	T3	
effer-k 25 meq tablet eff	T1	
POKONZA 10 MEQ PACKET	T3	PA
POKONZA 15 MEQ PACKET	T3	
potassium bicarbonate/cit ac	T1	
potassium chloride	T1	
potassium chloride	T2	
potassium cl 10% (20 meq/15ml)	T1	
potassium cl 20 meq packet	T1	

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
POTASSIUM REPLACEMENT *(con't.)*		
potassium cl 20% (40 meq/15ml)	T1	
potassium cl er 10 meq capsule	T1	
potassium cl er 10 meq tablet	T1	
potassium cl er 15 meq tablet	T1	
POTASSIUM CL ER 15 MEQ TABLET	T3	
potassium cl er 20 meq tablet	T1	
potassium cl er 8 meq capsule	T1	
potassium cl er 8 meq tablet	T1	
potassium cl10%(20meq/15ml)cup	T1	
potassium cl10%(40meq/30ml)cup	T1	
potassium cl20%(40meq/15ml)cup	T1	
PROTEIN REPLACEMENT		
AQNEURSA	T4	PA SP
Elect/Caloric/H2O (Urinary Tract Conditions)		
DIALYSIS SOLUTIONS		
PRISMASOL	T3	
URINARY PH MODIFIERS		
citric acid/sodium citrate	T1	HD
K-PHOS NO.2	T2	HD
K-PHOS ORIGINAL	T2	HD
ORACIT	T3	HD
potassium citrate	T1	HD
potassium citrate (Urocit-k)	T1	HD
potassium citrate/citric acid	T1	HD
RENACIDIN	T3	HD
sod/pot/k cit/sod cit/cit acid	T1	HD
UROCIT-K (*potassium citrate er*)	T3	HD
UROQID-ACID NO.2	T2	HD
GASTROINTESTINAL (Cholesterol Medications)		
LIPOTROPICS		
icosapent ethyl (Vascepa)	T1	HD
LOVAZA (*omega-3 acid ethyl esters*)	T3	PA HD
omega-3 acid ethyl esters (Lovaza)	T1	HD
VASCEPA (*icosapent ethyl*)	T2	PA HD

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GASTROINTESTINAL (Gastrointestinal/Heartburn)		
AMMONIA INHIBITORS		
BUPHENYL (*sodium phenylbutyrate*)	T4	PA SP HD
glycerol phenylbutyrate	T4	SP HD
lactulose	T1	
lactulose	T1	HD
lactulose 10 gm/15 ml solution	T1	
LITHOSTAT	T2	HD
OLPRUVA	T4	PA SP HD
PHEBURANE	T4	PA QL(8 BOTTLES/30 DAYS) SP HD
RAVICTI	T4	PA SP HD
sodium phenylbutyrate (Buphenyl)	T4	SP HD
ANTI-CHOLINERGICS, QUATERNARY AMMONIUM		
chlordiazepoxide/clidinium br (Librax)	T1	
CUVPOSA (*glycopyrrolate*)	T3	
DARTISLA	T3	PA
GLYCATE	T3	
*glycopyrrolate 1 mg tablet (*Robinul*)*	T1	
*glycopyrrolate 1 mg/5 ml soln (*Cuvposa*)*	T1	
glycopyrrolate 1.5 mg tablet	T1	PA
*glycopyrrolate 2 mg tablet (*Robinul Forte*)*	T1	
LIBRAX (*chlordiazepoxide/clidinium br*)	T3	PA
ROBINUL (*glycopyrrolate*)	T3	PA
ROBINUL FORTE (*glycopyrrolate*)	T3	PA
ANTI-CHOLINERGICS/ANTI-SPASMODICS		
dicyclomine 10 mg capsule	T1	
dicyclomine 10 mg/5 ml soln	T1	
dicyclomine 20 mg tablet	T1	
DICYCLOMINE 40 MG TABLET	T3	PA
ANTI-DIARRHEAL - G.I. CHLORIDE CHANNEL INHIBITORS		
MYTESI	T4	SP
ANTI-DIARRHEAL - TRYPTOPHAN HYDROXYLASE INHIBITOR		
XERMELO	T4	PA SP
ANTI-DIARRHEAL MICROORGANISMS AGENTS		
RESTORA RX	T4	PA SP

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List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-DIARRHEALS		
diphenoxylate hcl/atropine	T1	
diphenoxylate hcl/atropine (Lomotil)	T1	
LOMOTIL (*diphenoxylate-atropine*)	T3	PA
loperamide hcl	T1	
MOTOFEN	T3	
opium tincture	T1	PA
ANTI-EMETIC, CANNABINOID-TYPE		
dronabinol (Marinol)	T1	
MARINOL (*dronabinol*)	T3	PA
SYNDROS	T3	PA
ANTI-EMETIC/ANTI-VERTIGO AGENTS		
AKYNZEO	T3	PA QL(4 CAPS/28 DAYS)
ANTIVERT	T3	PA
ANZEMET	T3	PA
aprepitant 125 mg capsule	T1	QL(4 CAPS/28 DAYS)
aprepitant 125-80-80 mg pack (Emend)	T1	QL(12 CAPS/28 DAYS)
aprepitant 40 mg capsule	T1	QL(1 CAP/28 DAYS)
aprepitant 80 mg capsule (Emend)	T1	QL(8 CAPS/28 DAYS)
BONJESTA	T3	
COMPAZINE (*prochlorperazine maleate*)	T3	
COMPAZINE (*prochlorperazine*)	T3	
DICLEGIS (*doxylamine succinate/vit b6*)	T3	PA QL(4 TABS/DAY)
doxylamine succinate/vit b6 (Diclegis)	T1	QL(4 tabs/day)
EMEND 125 MG POWDER PACKET	T3	PA QL(12 PACKS/28 DAYS)
EMEND 150 MG VIAL (*fosaprepitant dimeglumine*)	T3	
EMEND 80 MG CAPSULE (*aprepitant*)	T3	PA QL(8 CAPS/28 DAYS)
EMEND TRIPACK (*aprepitant*)	T3	PA QL(12 CAPS/28 DAYS)
fosaprepitant dimeglumine (Emend)	T1	
granisetron hcl	T1	
granisetron hcl/pf	T1	
meclizine 50 mg tablet	T1	PA
MECLIZINE 50 MG TABLET	T3	PA
ondansetron hcl	T1	

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GASTROINTESTINAL (Gastrointestinal/Heartburn) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-EMETIC/ANTI-VERTIGO AGENTS *(cont.)*		
ondansetron hcl/pf	T1	
ONDANSETRON ODT 16 MG TABLET	T3	PA
ondansetron odt 4 mg tablet	T1	
ondansetron odt 8 mg tablet	T1	
prochlorperazine (Compazine)	T1	
prochlorperazine maleate (Compazine)	T1	
promethazine hcl	T1	
SANCUSO	T3	PA QL(4 PATCHES/30 DAYS)
scopolamine (Transderm-scop)	T1	
TRANSDERM-SCOP (*scopolamine*)	T3	
trimethobenzamide hcl	T1	
VARUBI	T3	PA QL(4 TABS/28 DAYS)
ANTI-ULCER PREPARATIONS		
CARAFATE (*sucralfate*)	T3	PA HD
CYTOTEC (*misoprostol*)	T3	HD
misoprostol (Cytotec)	T1	HD
sucralfate	T1	HD
sucralfate (Carafate)	T1	HD
ANTI-ULCER-H.PYLORI AGENTS		
bismuth/metronid/tetracycline (Pylera)	T1	
lansoprazole/amoxiciln/clarith	T1	
OMECLAMOX-PAK	T3	PA
PYLERA (*bismuth/metronid/tetracycline*)	T3	PA
TALICIA	T3	PA
VOQUEZNA TRIPLE PAK	T3	PA
VOQUEZNA DUAL PAK	T3	PA
BELLADONNA ALKALOIDS		
DONNATAL	T3	PA HD
DONNATAL (*phenobarb/hyoscy/atropine/scop*)	T3	PA HD
hyoscyamine sulfate	T1	HD
hyoscyamine sulfate (Levbid)	T1	HD
hyoscyamine sulfate (Levsin)	T1	HD
hyoscyamine sulfate (Levsin-sl)	T1	HD
hyoscyamine sulfate (Nulev)	T1	HD

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GASTROINTESTINAL (Gastrointestinal/Heartburn) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
BELLADONNA ALKALOIDS *(cont.)*		
hyoscyamine sulfate (Nulev)	T3	HD
LEVBID (*hyoscyamine sulfate*)	T3	PA HD
LEVSIN (*hyoscyamine sulfate*)	T3	HD
LEVSIN-SL (*hyoscyamine sulfate*)	T3	PA HD
methscopolamine bromide	T1	HD
NULEV (*hyoscyamine sulfate*)	T3	HD
phenobarb/hyoscy/atropine/scop	T1	HD
phenobarb/hyoscy/atropine/scop (Donnatal)	T1	HD
phenobarb/hyoscy/atropine/scop (Phenobarbital-belladonna)	T1	HD
PHENOBARBITAL-BELLADONNA (*phenobarb/hyoscy/atropine/scop*)	T3	HD
SYMAX DUOTAB	T2	HD
BILE SALTS		
CHENODAL	T4	PA SP HD
CHOLBAM	T4	PA SP HD
CTEXLI	T4	PA SP
RELTONE	T3	PA HD
URSO FORTE (*ursodiol*)	T3	HD
ursodiol 200 mg capsule	T1	PA HD
ursodiol 250 mg tablet	T1	HD
ursodiol 300 mg capsule	T1	HD
ursodiol 400 mg capsule	T1	PA HD
ursodiol 500 mg tablet (Urso Forte)	T1	HD
CHRONIC INFLAM. COLON DX, 5-A-SALICYLAT, RECTAL TX		
CANASA (*mesalamine*)	T3	PA
mesalamine 1,000 mg supp (Canasa)	T1	
mesalamine 4 gm/60 ml enema (Sfrowasa)	T1	
mesalamine 4 gm/60 ml kit (Rowasa)	T1	
ROWASA (*mesalamine*)	T3	PA
SFROWASA (*mesalamine*)	T3	
DRUG TX-CHRONIC INFLAM. COLON DX, 5-AMINOSALICYLAT		
APRISO (*mesalamine*)	T3	HD
ASACOL HD (*mesalamine*)	T3	ST HD
AZULFIDINE (*sulfasalazine*)	T3	PA HD

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GASTROINTESTINAL (Gastrointestinal/Heartburn) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DRUG TX-CHRONIC INFLAM. COLON DX, 5-AMINOSALICYLAT *(cont.)*		
balsalazide disodium (Colazal)	T1	HD
COLAZAL (*balsalazide disodium*)	T3	ST HD
DIPENTUM	T3	ST HD
LIALDA (*mesalamine*)	T3	ST
mesalamine	T1	HD
mesalamine (Apriso)	T1	HD
mesalamine (Pentasa)	T1	HD
mesalamine 800 mg dr tablet (Asacol Hd)	T1	HD
mesalamine dr 1.2 gm tablet (Lialda)	T1	HD
PENTASA 250 MG CAPSULE	T3	ST HD
PENTASA 500 MG CAPSULE (*mesalamine*)	T3	HD
sulfasalazine (Azulfidine)	T1	HD
FARNESOID X RECEPTOR (FXR) AGONIST, BILE AC ANALOG		
OCALIVA	T4	PA SP HD
FECAL MICROBIOTA TRANSPLANTATION (FMT)		
VOWST	T4	PA QL(12 CAPS/56 DAYS) SP
GASTRIC ENZYMES		
SUCRAID	T4	PA SP
HISTAMINE H2-RECEPTOR INHIBITORS		
ANALPRAM HC 1% CREAM	T3	
ANALPRAM HC 2.5%-1% CREAM (*hydrocortisone/pramoxine*)	T3	PA
ANALPRAM HC 2.5%-1% CRM SINGLE (*hydrocortisone/pramoxine*)	T3	PA
hydrocortisone/pramoxine	T1	
hydrocortisone/pramoxine (Analpram Hc)	T1	
PROCORT	T3	
PROCTOFOAM-HC	T2	
HISTAMINE H2-RECEPTOR INHIBITORS		
cimetidine hcl	T1	HD
famotidine	T1	HD
famotidine (Pepcid)	T1	HD
nizatidine	T1	HD
PEPCID (*famotidine*)	T1	PA HD
IBS AGENTS, MIXED OPIOID RECEP AGONISTS/ANTAGONISTS		
VIBERZI	T2	HD

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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	T4	PA SP HD
LIVMARLI	T4	PA SP
INTEGRIN RECEPTOR ANTAGONIST, MONOCLONAL ANTIBODY		
ENTYVIO	T4	PA SP HD
INTESTINAL MOTILITY STIMULANTS		
GIMOTI	T4	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)	T4	SP HD
LOTRONEX (*alosetron hcl*)	T4	PA SP HD
LAXATIVES AND CATHARTICS		
AMITIZA *(lubiprostone)*	T3	PA
bisac/nacl/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	

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
LAXATIVES AND CATHARTICS *(cont.)*		
lubiprostone (Amitiza)	T1	
MOVIPREP (*peg3350-sod sul-nacl-kcl-asb-c*)	T3	PA PPACA
OSMOPREP	T3	PA PPACA
peg3350/sod sul/nacl/kcl/asb/c (Moviprep)	T1	PPACA
peg3350/sod sulf,bicarb,cl/kcl	T1	PPACA
peg3350/sod sulf, bicarb, cl/kcl (Golytely)	T1	PPACA
PLENVU	T3	PA PPACA
sodium chloride/nahco3/kcl/peg	T1	PPACA
*sodium, potassium,mag sulfates (*Suprep*)*	T1	PPACA
SUFLAVE	T3	PA PPACA
SUPREP (sodium, potassium,mag sulfates)	T3	PA PPACA
SUTAB	T3	PA PPACA
LOCAL ANORECTAL NITRATE PREPARATIONS		
nitroglycerin 0.4% ointment (Rectiv)	T1	
RECTIV (*nitroglycerin*)	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)		
VOQUENZA	T3	PA QL(1 TAB/DAY)
PROTON-PUMP INHIBITORS		
ACIPHEX (*rabeprazole sodium*)	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)
dexlansoprazole dr 30 mg cap	T1	QL(2 CAPS/DAY)
dexlansoprazole dr 60 mg cap (Dexilant)	T1	QL(1 CAP/DAY)
esomeprazole dr 10 mg packet (Nexium)	T1	QL(4 PACKS/DAY) HD
esomeprazole dr 2.5 mg packet (Nexium)	T1	QL(16 PACKS/DAY) HD
esomeprazole dr 20 mg packet (Nexium)	T1	QL(2 PACKS/DAY) HD
esomeprazole dr 40 mg packet (Nexium)	T1	QL(1 PACK/DAY) HD
esomeprazole dr 5 mg packet (Nexium)	T1	QL(8 PACKS/DAY) HD

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GASTROINTESTINAL (Gastrointestinal/Heartburn) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
PROTON-PUMP INHIBITORS *(cont.)*		
esomeprazole mag dr 20 mg cap (Nexium)	T1	QL(2 CAPS/DAY) HD
esomeprazole mag dr 40 mg cap (Nexium)	T1	QL(1 CAP/DAY) HD
ESOMEPRAZOLE STRONTIUM	T3	QL(1 CAP/DAY) HD
KONVOMEP	T3	PA QL(20 MLS/DAY) HD
lansoprazole dr 15 mg capsule	T1	QL(2 CAPS/DAY) HD
lansoprazole dr 15 mg capsule (Prevacid)	T1	QL(2 TABS/DAY) HD
lansoprazole dr 30 mg capsule (Prevacid)	T1	QL(1 CAP/DAY) HD
lansoprazole odt 30 mg tablet (Prevacid)	T1	QL(1 TAB/DAY) HD
NEXIUM DR 10 MG PACKET (*esomeprazole magnesium*)	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 (*esomeprazole magnesium*)	T3	PA QL(2 CAPS/DAY) HD
NEXIUM DR 20 MG PACKET (*esomeprazole magnesium*)	T3	PA QL(2 PACKS/DAY) HD
NEXIUM DR 40 MG CAPSULE (*esomeprazole magnesium*)	T3	PA QL(1 CAP/DAY) HD
NEXIUM DR 40 MG PACKET (*esomeprazole magnesium*)	T3	PA QL(1 PACK/DAY) HD
NEXIUM DR 5 MG PACKET	T3	PA QL(8 PACKS/DAY) HD
omeprazole dr 10 mg capsule	T1	QL(4 CAPS/DAY) HD
omeprazole dr 20 mg capsule	T1	QL(2 CAPS/DAY) HD
omeprazole dr 40 mg capsule	T1	QL(1 CAP/DAY) HD
omeprazole-bicarb 20-1, 100 cap (Zegerid)	T1	PA QL(2 CAPS/DAY) HD
omeprazole-bicarb 20-1, 680 pkt (Zegerid)	T1	PA QL(2 PACKS/DAY) HD
omeprazole-bicarb 40-1, 100 cap (Zegerid)	T1	PA QL(1 CAP/DAY) HD
omeprazole-bicarb 40-1, 680 pkt (Zegerid)	T1	PA QL(1 PACK/DAY) HD
pantoprazole 40 mg suspension (Protonix)	T1	QL(1 PACK/DAY) HD
pantoprazole sod dr 20 mg tab (Protonix)	T1	QL(2 TABS/DAY) HD
pantoprazole sod dr 40 mg tab (Protonix)	T1	QL(1 TAB/DAY) HD
PREVACID DR 15 MG SOLUTAB (*lansoprazole*)	T3	PA QL(2 TABS/DAY)
PREVACID DR 30 MG CAPSULE (*lansoprazole*)	T3	PA QL(1 CAP/DAY)
PREVACID DR 30 MG SOLUTAB (*lansoprazole*)	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 (*pantoprazole sodium*)	T3	PA QL(1 PACK/DAY)
PROTONIX DR 20 MG TABLET (*pantoprazole sodium*)	T3	PA QL(2 TABS/DAY)
PROTONIX DR 40 MG TABLET (*pantoprazole sodium*)	T3	PA QL(1 TAB/DAY)

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PROTON-PUMP INHIBITORS *(cont.)*		
RABEPRAZOLE DR 10 MG SPRNKL CP	T3	QL(2 CAPS/DAY) HD
rabeprazole sod dr 20 mg tab (Aciphex)	T1	QL(1 TAB/DAY) HD
ZEGERID 20 MG CAPSULE (*omeprazole-sodium bicarbonate*)	T3	PA QL(2 CAPS/DAY) HD
ZEGERID 20 MG PACKET (*omeprazole-sodium bicarbonate*)	T3	PA QL(2 PACKS/DAY) HD
ZEGERID 40 MG CAPSULE (*omeprazole-sodium bicarbonate*)	T3	PA QL(1 CAP/DAY) HD
ZEGERID 40 MG PACKET (*omeprazole-sodium bicarbonate*)	T3	PA QL(1 PACK/DAY) HD
RECTAL PREPARATIONS		
ANUSOL-HC (*hydrocortisone acetate*)	T3	PA
hydrocortisone acetate	T1	
hydrocortisone acetate (Anusol-hc)	T1	
SBS - GLUCAGON-LIKE PEPTIDE-2 (GLP-2) ANALOGS		
GATTEX	T4	PA SP HD
GASTROINTESTINAL (Pain Relief And Inflammatory Disease)		
HEMORRHOID PREP, ANTI-INFLAM STEROID-LOCAL ANESTHET		
ANA-LEX	T1	
ANALPRAM HC 1% CREAM	T3	
ANALPRAM HC 2.5%-1% CREAM (*hydrocortisone/pramoxine*)	T3	PA
ANALPRAM HC 2.5%-1% CRM SINGLE (*hydrocortisone/pramoxine*)	T3	PA
hydrocortisone/lidocaine/aloe	T1	
hydrocortisone/pramoxine	T1	
hydrocortisone/pramoxine (Analpram Hc)	T1	
lidocaine/hydrocortisone ac	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)		
budesonide 2 mg rectal foam (Uceris)	T1	QL(2 KITS/180 DAYS)
CORTENEMA (*hydrocortisone*)	T3	

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RECTAL/LOWER BOWEL PREP., GLUCOCORT. (NON-HEMORR)		
CORTIFOAM	T3	PA
hydrocortisone (Cortenema)	T1	
UCERIS 2 MG RECTAL FOAM (*budesonide*)	T3	PA QL(2 KITS/180 DAYS)
HORMONES (Hormonal Agents)		
ADRENAL STEROID INHIBITORS		
ISTURISA 1 MG TABLET	T4	PA QL(8 TABS/DAY) SP
ISTURISA 5 MG TABLET	T4	PA QL(2 TABS/DAY) SP
RECORLEV	T4	PA QL(8 TABS/DAY) SP
ADRENOCORTICOTROPHIC HORMONES		
ACTHAR SELFJECT	T4	PA SP HD
CORTROPHIN	T4	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 (*testosterone*)	T3	PA QL(150 GMS/30 DAYS)
ANDROGEL 1% (50 MG/5 G) PKT (*testosterone*)	T3	PA QL(300 GMS/30 DAYS)
ANDROGEL 1.62% GEL PUMP (*testosterone*)	T3	PA QL(150 GMS/30 DAYS)
DEPO-TESTOSTERONE	T3	
DEPO-TESTOSTERONE (*testosterone cypionate*)	T3	
JATENZO 158 MG CAPSULE	T3	PA QL(4 CAPS/DAY)
JATENZO 198 MG CAPSULE	T3	PA QL(4 CAPS/DAY)
JATENZO 237 MG CAPSULE	T3	PA QL(2 CAPS/DAY)
KYZATREX 100 MG CAPSULE	T3	PA QL(2 CAPS/DAY)
KYZATREX 150 MG CAPSULE	T3	PA QL(4 CAPS/DAY)
KYZATREX 200 MG CAPSULE	T3	PA QL(4 CAPS/DAY)
METHITEST	T1	
methyltestosterone	T1	
NATESTO	T3	PA QL(3 UNITS/30 DAYS)
oxandrolone	T1	PA
TESTIM (*testosterone*)	T3	PA QL(10 GMS/DAY)
testosterone 1% (25mg/2.5g) pk (Androgel)	T1	PA QL(150 GMS/30 DAYS)
testosterone 1% (50 mg/5 g) pk (Vogelxo)	T1	PA QL(300 GMS/30 DAYS)
testosterone 1.62% (2.5 g) pkt (Androgel)	T1	PA QL(150 GMS/30 DAYS)

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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 PACKT	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*)	T4	PA SP
DDAVP 40 MCG/10 ML VIAL (*desmopressin acetate*)	T4	PA SP
desmopressin 0.01% solution	T1	HD
desmopressin 10 mcg/0.1 ml spr	T1	HD
*desmopressin 40 mcg/10 ml vial (*Ddavp*)*	T4	SP
*desmopressin ac 4 mcg/ml ampul (*Ddavp*)*	T4	SP
*desmopressin ac 4 mcg/ml vial (*Ddavp*)*	T4	SP
*desmopressin acetate 0.1 mg tb (*Ddavp*)*	T1	HD
*desmopressin acetate 0.2 mg tb (*Ddavp*)*	T1	HD
NOCTIVA	T3	PA
ESTROGEN AND PROGESTIN COMBINATIONS		
BIJUVA	T3	

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

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ESTROGENIC AGENTS *(cont.)*		
norethind-eth estrad 0.5-2.5 (Femhrt)	T1	HD
norethindrone ac/eth estradiol	T1	HD
norethin-eth estrad 1 mg-5 mcg	T1	HD
PREMARIN (*estrogens, conjugated*)	T2	HD
PREMPHASE	T2	HD
PREMPRO	T2	HD
VIVELLE-DOT (*estradiol*)	T3	PA QL(16 PATCHES/28 DAYS) HD
ESTROGEN-PROGESTIN WITH ANTI-MINERALOCORTICOID COMB		
ANGELIQ	T3	HD
ESTROGEN-SELECTIVE ESTROGEN RECEPTOR MOD (SERM) COMB		
DUAVEE	T2	
GLUCOCORTICOIDS		
AGAMREE	T4	PA QL(10 MLS/DAY) SP
ALKINDI SPRINKLE	T4	PA SP
budesonide	T1	
budesonide (Uceris)	T1	PA QL(1 TAB/DAY)
CORTEF (*hydrocortisone*)	T3	PA
cortisone acetate	T1	
deflazacort (Emflaza)	T4	PA SP
deflazacort (Emflaza)	T4	PA SP HD
dexamethasone	T1	
dexamethasone 0.5 mg tablet	T1	
dexamethasone 0.5 mg/5 ml elx	T1	
dexamethasone 0.5 mg/5 ml liq	T1	
dexamethasone 0.75 mg tablet	T1	
dexamethasone 1 mg tablet	T1	
dexamethasone 1.5 mg tablet	T1	
dexamethasone 10 day 1.5 mg tb	T1	PA
dexamethasone 13 day 1.5 mg tb	T1	PA
dexamethasone 2 mg tablet	T1	
dexamethasone 4 mg tablet	T1	
dexamethasone 6 day 1.5 mg tab	T1	PA
dexamethasone 6 mg tablet	T1	
EMFLAZA (*deflazacort*)	T4	PA SP HD

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GLUCOCORTICOIDS *(cont.)*		
EOHILIA	T3	PA QL(1800 MLS/180 DAYS)
HEMADY	T3	
hydrocortisone (Cortef)	T1	
KHINDIVI	T4	PA SP
MEDROL 16 MG TABLET (*methylprednisolone*)	T3	
MEDROL 2 MG TABLET	T2	
MEDROL 4 MG DOSEPAK (*methylprednisolone*)	T3	
MEDROL 4 MG TABLET (*methylprednisolone*)	T3	
MEDROL 8 MG TABLET (*methylprednisolone*)	T3	
methylprednisolone	T1	
methylprednisolone (Medrol)	T1	
ORAPRED ODT (*prednisolone sodium phos odt*)	T3	
prednisolone	T1	
prednisolone sodium phosphate	T1	
prednisolone sodium phosphate (Orapred Odt)	T1	
prednisone	T1	
TAPERDEX	T1	PA
TARPEYO	T4	PA QL(4 CAPS/DAY) SP
UCERIS 9 MG ER TABLET (*budesonide*)	T3	PA QL(1 TAB/DAY)
ZCORT	T3	PA
GROWTH HORMONE RELEASING HORMONE (GHRH) AND ANALOGS		
EGRIFTA SV	T4	PA SP HD
EGRIFTA WR	T4	PA SP HD
GROWTH HORMONES		
GENOTROPIN	T4	PA SP HD
HUMATROPE	T4	PA SP HD
NGENLA	T4	PA SP
NORDITROPIN FLEXPRO	T4	PA SP HD
NUTROPIN AQ NUSPIN	T4	PA SP HD
OMNITROPE	T4	PA SP HD
SEROSTIM	T4	PA SP HD
SKYTROFA	T4	PA SP HD
SOGROYA	T4	PA SP
ZOMACTON	T4	PA SP HD

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
INSULIN-LIKE GROWTH FACTOR-I (IGF-I) HORMONES		
INCRELEX	T4	PA SP
LHRH (GNRH) AGONIST ANALOG PITUITARY SUPPRESSANTS		
LUPRON DEPOT 11.25 MG 3MO KIT	T4	PA SP HD
LUPRON DEPOT 3.75 MG KIT	T4	PA SP HD
SYNAREL	T4	PA SP HD
LHRH (GNRH) ANTAGONIST, ESTROGEN AND PROGESTIN COMB		
MYFEMBREE	T2	PA QL(1 TAB/DAY)
ORIAHNN	T2	PA QL(2 CAPS/DAY)
LHRH (GNRH) ANTAGONIST, PITUITARY SUPPRESSANT AGENTS		
cetrorelix acetate (Cetrotide)	T4	PA SP
CETROTIDE (*cetrorelix acetate*)	T4	PA SP
ganirelix acet 250 mcg/0.5 ml (Ganirelix Acetate)	T4	PA SP
GANIRELIX ACET 250 MCG/0.5 ML (*ganirelix acetate*)	T4	PA SP
ganirelix acetate (Ganirelix Acetate)	T4	PA SP
ORILISSA 150 MG TABLET	T2	PA QL(1 TAB/DAY)
ORILISSA 200 MG TABLET	T2	PA QL(2 TABS/DAY)
LHRH (GNRH) AGNST PIT.SUP-CENTRAL PRECOCIOUS PUBERTY		
FENSOLVI	T4	PA SP
LUPRON DEPOT-PED	T4	PA SP HD
MINERALOCORTICOIDS		
fludrocortisone acetate	T1	HD
OXYTOCICS		
CERVIDIL	T3	
methylergonovine maleate	T1	
PREPIDIL	T3	
PARATHYROID HORMONES		
YORVIPATH	T4	PA SP
PITUITARY SUPPRESSIVE AGENTS		
cabergoline	T1	QL(16 TABS/28 DAYS) HD
CRENESSITY 25 MG CAPSULE	T4	PA QL(4 CAPS/DAY) SP
CRENESSITY 50 MG CAPSULE	T4	PA QL(2 CAPS/DAY) SP
CRENESSITY 100 MG CAPSULE	T4	PA QL(2 CAPS/DAY) SP
CRENESSITY 50 MG/ML SOLUTION	T4	PA QL(8 MLS/DAY) SP
danazol	T1	HD

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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	T4	PA SP HD
LANREOTIDE 120 MG/0.5 ML SYRNG	T4	PA SP HD
MYCAPSSA	T4	PA QL(4 CAPS/DAY) SP
octreotide acetate	T4	PA SP HD
octreotide acetate (Sandostatin)	T4	PA SP HD
octreotide acetate,mi-spheres (Sandostatin Lar Depot)	T4	PA SP
SANDOSTATIN (*octreotide acetate*)	T4	PA SP HD
SANDOSTATIN LAR DEPOT (*octreotide acetate,mi-spheres*)	T4	PA SP
SIGNIFOR	T4	PA SP
SIGNIFOR LAR	T4	PA SP
SOMATULINE DEPOT	T4	PA SP HD
VAGINAL ESTROGEN FOR SEXUAL DYSFUNCTION		
IMVEXXY 10 MCG MAINTENANCE PAK	T3	PA QL(16 INSERTS/28 DAYS) HD
IMVEXXY 10 MCG STARTER PACK	T3	PA QL(36 INSERTS/28 DAYS) HD
IMVEXXY 4 MCG MAINTENANCE 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

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List of Prescription Medications

HORMONES (Infertility)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
FERTILITY STIMULATING PREPARATIONS, NON-FSH		
clomiphene citrate	T1	
FOLLICLE-STIMULATING AND LUTEINIZING HORMONES		
MENOPUR	T4	PA SP
FOLLICLE-STIMULATING HORMONE (FSH)		
FOLLISTIM AQ	T4	PA SP
GONAL-F	T4	PA SP
GONAL-F RFF REDI-JECT	T4	PA SP
HUMAN CHORIONIC GONADOTROPIN (HCG)		
CHORIONIC GONADOTROPIN	T4	PA SP
NOVAREL	T4	PA SP
OVIDREL	T4	PA SP
PREGNYL	T4	PA SP
PREGNANCY FACILITATING/MAINTAINING AGENT, HORMONAL		
CRINONE 8% GEL	T3	PA
ENDOMETRIN (*progesterone, micronized*)	T2	
progesterone 100 mg vag insert (Endometrin)	T1	
HORMONES (Miscellaneous)		
LEPTIN HORMONE ANALOGS		
MYALEPT	T4	PA SP HD
HORMONES (Osteoporosis Products)		
BONE FORMATION STIMULATING AGTS - PTH REL PEPTIDES		
TYMLOS	T4	PA QL(1 PEN/30 DAYS) SP HD
BONE RESORPTION INHIBITORS		
calcitonin, salmon, synthetic	T1	HD
calcitonin,salmon,synthetic (Miacalcin)	T1	HD
MIACALCIN (*calcitonin,salmon,synthetic*)	T3	HD
IMMUNOSUPPRESSANTS (Pain Relief And Inflammatory Disease)		
HUMAN INTERLEUKIN 12/23 (IL-12/13) INHIBITORS, MAB		
IMULDOSA	T4	PA QL(1 SYRINGE/84 DAYS) SP
OTULFI	T4	PA QL(1 SYRINGE/84 DAYS) SP
PYZCHIVA	T4	PA QL(1 SYRINGE/84 DAYS) SP
SELARSDI	T4	PA QL(1 SYRINGE/84 DAYS) SP
STELARA	T4	PA QL(1 SYRINGE/84 DAYS) SP HD

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List of Prescription Medications

IMMUNOSUPPRESSANTS (Pain Relief And Inflammatory Disease) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
HUMAN INTERLEUKIN 12/23 (IL-12/13) INHIBITORS, MAB *(con't)*		
STEQEYMA	T4	PA QL(1 SYRINGE/84 DAYS) SP
USTEKINUMAB	T4	PA QL(1 SYRINGE/84 DAYS) SP HD
USTEKINUMAB-AEKN 45 MG SYRINGE	T4	PA QL(1 SYRINGE/84 DAYS) SP
USTEKINUMAB-AEKN 90 MG/ML SYR	T4	PA QL(1 SYRINGE/84 DAYS) SP
USTEKINUMAB-TTWE	T4	PA QL(1 SYRINGE/84 DAYS) SP HD
YESINTEK	T4	PA QL(1 SYRINGE/84 DAYS) SP
IL-23 RECEPTOR ANTAGONIST, MONOCLONAL ANTIBODY		
OMVOH 100 MG/ML PEN	T4	PA QL(2 PENS/28 DAYS) SP HD
OMVOH 100 MG/ML SYRINGE	T4	PA QL(2 SYRINGES/28 DAYS) SP HD
OMVOH 200 MG DOSE - 2 PENS	T4	PA QL(2 PENS/28 DAYS) SP HD
OMVOH 200 MG DOSE - 2 SYRINGES	T4	PA QL(2 SYRINGES/28 DAYS) SP HD
OMVOH 200 MG/2 ML PEN	T4	PA QL SP HD
OMVOH 200 MG/2 ML SYRINGE	T4	PA QL SP HD
OMVOH 300 MG DOSE - 2 PENS	T4	PA QL(3 MLS/28 DAYS) SP HD
OMVOH 300 MG DOSE - 2 SYRINGES	T4	PA QL(3 MLS/28 DAYS) SP HD
SKYRIZI ON-BODY	T4	PA QL(1 CARTRIDGE/56 DAYS) SP HD
TREMFYA	T4	PA QL(1 SYRINGE/56 DAYS) SP HD
TREMFYA 100 MG/ML PEN	T4	PA QL(1 ML/56 DAYS) SP HD
TREMFYA 200 MG/2 ML PEN	T4	PA QL(2 SYRINGE/28 DAYS) SP HD
TREMFYA ONE-PRESS	T4	PA QL(1 AUTO-INJ/56 DAYS) SP HD
TREMFYA PEN INDUCTION (2 PEN)	T4	PA QL(12 MLS/365 DAYS) SP HD
INTERLEUKIN-4(IL-4) RECEPTOR ALPHA ANTAGONIST, MAB		
DUPIXENT PEN	T4	PA SP HD
DUPIXENT SYRINGE	T4	PA SP HD
INTERLEUKIN-6 (IL-6) RECEPTOR INHIBITORS		
ACTEMRA	T4	PA QL(3.6 ML/28 DAYS) SP HD
ACTEMRA ACTPEN	T4	PA QL(3.6 ML/28 DAYS) SP HD
ENSPRYNG	T4	PA SP HD
KEVZARA	T4	PA QL(2 PENS/SYRINGES/28 DAYS) SP HD
TYENNE	T4	PA QL(3.6 ML/28 DAYS) SP
TYENNE AUTOINJECTOR	T4	PA QL(3.6 ML/28 DAYS) SP
INTERLEUKIN-31(IL-31)RECEPTOR ALPHA ANTAGONIST,MAB		
NEMLUVIO	T4	PA SP HD

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List of Prescription Medications

IMMUNOSUPPRESSANTS (Skin Conditions)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
TOPICAL IMMUNOSUPPRESSIVE AGENTS		
ELIDEL (*pimecrolimus*)	T3	PA
HYFTOR	T4	PA SP
pimecrolimus (Elidel)	T1	
tacrolimus 0.03% ointment	T1	
tacrolimus 0.1% ointment	T1	
IMMUNOSUPPRESSANTS (Transplant Medications)		
IMMUNOSUPPRESSIVES		
ASTAGRAF XL	T4	SP HD
AZASAN (*azathioprine*)	T4	PA SP HD
azathioprine 100 mg tablet (Azasan)	T4	PA SP HD
azathioprine 50 mg tablet (Imuran)	T4	SP HD
azathioprine 75 mg tablet (Azasan)	T4	PA SP HD
CELLCEPT (*mycophenolate mofetil*)	T4	PA SP HD
cyclosporine 100 mg capsule (Sandimmune)	T4	SP HD
cyclosporine 25 mg capsule (Sandimmune)	T4	SP HD
cyclosporine, modified	T4	SP HD
cyclosporine, modified (Neoral)	T4	SP HD
ENVARSUS XR	T4	SP HD
everolimus 0.25 mg tablet (Zortress)	T4	SP HD
everolimus 0.5 mg tablet (Zortress)	T4	SP HD
everolimus 0.75 mg tablet (Zortress)	T4	SP HD
everolimus 1 mg tablet (Zortress)	T4	SP HD
IMURAN (*azathioprine*)	T4	PA SP HD
LUPKYNIS	T4	PA QL(6 CAPS/DAY) SP
mycophenolate mofetil (Cellcept)	T4	SP HD
mycophenolate sodium (Myfortic)	T4	SP HD
MYFORTIC (*mycophenolate sodium*)	T4	PA SP HD
MYHIBBIN	T4	PA SP
NEORAL (*cyclosporine, modified*)	T4	PA SP HD
PROGRAF 0.2 MG GRANULE PACKET	T4	SP HD
PROGRAF 0.5 MG CAPSULE (*tacrolimus*)	T4	PA SP HD
PROGRAF 1 MG CAPSULE (*tacrolimus*)	T4	PA SP HD
PROGRAF 1 MG GRANULE PACKET	T4	SP HD

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List of Prescription Medications

IMMUNOSUPPRESSANTS (Transplant Medications) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
IMMUNOSUPPRESSIVES *(cont.)*		
PROGRAF 5 MG CAPSULE (*tacrolimus*)	T4	PA SP HD
RAPAMUNE (*sirolimus*)	T4	PA SP HD
SANDIMMUNE 100 MG CAPSULE (*cyclosporine*)	T4	PA SP HD
SANDIMMUNE 100 MG/ML SOLN	T4	SP HD
SANDIMMUNE 25 MG CAPSULE (*cyclosporine*)	T4	PA SP HD
sirolimus	T4	SP HD
sirolimus (Rapamune)	T4	SP HD
tacrolimus 0.5 mg capsule (ir) (Prograf)	T4	SP HD
tacrolimus 1 mg capsule (ir) (Prograf)	T4	SP HD
tacrolimus 5 mg capsule (ir) (Prograf)	T4	SP HD
ZORTRESS (*everolimus*)	T4	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)

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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	

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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	

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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	

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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)

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List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DIABETIC SUPPLIES *(cont.)*		
OMNIPOD 5 G6-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	

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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
T2 – Typically Preferred Brands
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List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
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	

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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	

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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	

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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	
SMARTEST 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 UNIVERSAL 1 LANCET	T1	
TOPCARE UNIVERSAL 1 THIN LANCET	T1	
TRUE COMFORT LANCET	T1	
TRUE COMFORT SAFETY LANCET	T1	
TRUEPLUS LANCET	T1	
TRUEPLUS LANCETS	T1	
TWIST LANCETS	T1	
TWIST TOP LANCET	T1	
ULTILET BASIC	T1	
ULTILET CLASSIC	T1	
ULTILET LANCETS	T1	
ULTILET SAFETY	T1	
ULTRA THIN LANCET	T1	
ULTRA THIN LANCETS	T1	

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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	
ULTRATLC 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	

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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
EASYPOINT NEEDLE	T1	
ECLIPSE NEEDLE	T1	
EMBRACE PEN NEEDLE	T1	PA

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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	
needles,safety huber,disposabl	T1	
NOKOR ADMIX NEEDLE	T1	
NOKOR NEEDLE	T1	
NOVOFINE 32	T1	PA
NOVOFINE AUTOCOVER	T1	PA
NOVOFINE PLUS	T1	PA
PEN NEEDLE	T1	PA

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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

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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

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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

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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

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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

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List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
SYRINGES AND ACCESSORIES *(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

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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

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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

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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
syringe and needle,insulin,1ml	T1	PA
syringe-needle,insulin,0.5 ml	T1	PA
syring-needl,disp,insul,0.3 ml	T1	PA
TECHLITE INSULIN SYRINGE	T1	PA
TERUMO INS SYR 0.3 ML 29GX1/2"	T1	PA
TERUMO INSULIN SYRINGE	T1	PA
THINPRO INSULIN SYRINGE	T1	PA
TOPCARE ULTRA COMFORT	T1	PA
TRUE COMFORT INSULIN SYRINGE	T1	PA
TRUE COMFORT PRO INS SYRINGE	T1	PA
TRUE COMFORT SAFE INSULIN SYRG	T1	PA
TRUEPLUS INSULIN SYRINGE	T1	PA
ULTCARE 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

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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 SAFEPACK 1ML 31G 8MM	T3	PA
ULTIGUARD SAFEPK 0.3ML 31G 8MM	T3	PA
ULTIGUARD SAFEPK 0.5ML 31G 8MM	T1	PA
ULTILET INSULIN SYRINGE	T1	PA
ULTRA COMFORT	T1	PA
ULTRA FLO INSULIN SYRINGE	T1	PA
ULTRACARE INSULIN SYRINGE	T1	PA
ULTRA-FINE INSULIN SYRINGE	T1	
ULTRA-THIN II 1 ML 31GX5/16"	T1	PA
ULTRA-THIN II INS 0.3 ML 30G	T1	PA
ULTRA-THIN II INS 0.3 ML 31G	T1	PA
ULTRA-THIN II INS 0.5 ML 29G	T1	PA
ULTRA-THIN II INS 0.5 ML 30G	T1	PA
ULTRA-THIN II INS 0.5 ML 31G	T1	PA
ULTRA-THIN II INS SYR 1 ML 29G	T1	PA
ULTRA-THIN II INS SYR 1 ML 30G	T1	PA
VANISHPOINT	T1	PA
VANISHPOINT INSULIN SYRINGE	T1	PA
VEO INSULIN SYRINGE	T1	
VERIFINE INSULIN SYRINGE	T1	PA
MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Miscellaneous)		
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I)		
1ST TIER UNILET COMFORTOUCH	T1	
2-IN-1 LANCET DEVICE	T1	

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MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Miscellaneous) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) *(cont.)*		
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	

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MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Miscellaneous) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) *(cont.)*		
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	

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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	
lancets	T1	
LANCETS	T1	
LITE TOUCH 28G LANCETS	T1	
LITE TOUCH 30G LANCETS	T1	
LITE TOUCH 33G LANCETS	T1	
MEDISENSE THIN LANCETS	T1	
MEDLANCE PLUS	T1	
MEDLANCE PLUS SPECIAL BLADE	T1	
MICRO THIN LANCET	T1	
MICRO THIN LANCETS	T1	
MICROLET	T1	
MICROTAINER LANCETS	T1	
MOBILE LANCETS	T1	
MONOLET LANCETS	T1	
MONOLET THIN LANCETS	T1	
MYGLUCOHEALTH LANCETS	T1	
NOVA SAFETY LANCETS	T1	
NOVA SUREFLEX	T1	
ON CALL LANCET	T1	
ON CALL PLUS LANCET	T1	
ONETOUCH DELICA PLUS LANCET	T1	
ONETOUCH DELICA SAFETY LANCET	T1	
ONETOUCH LANCETS	T1	
ONETOUCH SURESOFT	T1	
ONETOUCH ULTRASOFT 2 LANCET	T1	
ON-THE-GO	T1	

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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	
SMARTEST 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	

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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	
ULTRATLC 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	

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MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Miscellaneous) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) *(cont.)*		
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)

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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	

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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	

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
SKELETAL MUSCLE RELAXANTS *(cont.)*		
FLEQSUVY (*baclofen*)	T3	PA HD
LORZONE (*chlorzoxazone*)	T3	PA
LYVISPAH	T3	PA
metaxalone 400 mg tablet	T1	
METAXALONE 640 MG TABLET	T3	PA
metaxalone 800 mg tablet	T1	
methocarbamol	T1	
methocarbamol 1,000 mg tablet	T1	
METHOCARBAMOL 1,000 MG TABLET	T3	PA
methocarbamol 500 mg tablet	T1	
methocarbamol 750 mg tablet	T1	
NORGESIC (*orphenadrine/aspirin/caffeine*)	T3	PA
NORGESIC FORTE (*orphenadrine/aspirin/caffeine*)	T3	PA
orphenadrine citrate	T1	
orphenadrine/aspirin/caffeine (Norgesic Forte)	T1	PA
*orphenadrine/aspirin/caffeine (*Norgesic*)*	T1	PA
OZOBAX	T3	PA HD
OZOBAX DS	T3	PA HD
SOMA (*carisoprodol*)	T3	PA
SOMA (*vanadom*)	T1	PA
*tizanidine hcl 2 mg capsule (*Zanaflex*)*	T1	
tizanidine hcl 2 mg tablet	T1	PA
*tizanidine hcl 4 mg capsule (*Zanaflex*)*	T1	
*tizanidine hcl 4 mg tablet (*Zanaflex*)*	T1	PA
*tizanidine hcl 6 mg capsule (*Zanaflex*)*	T3	
ZANAFLEX	T3	
ZANAFLEX (*tizanidine hcl*)	T3	
PRE-NATAL VITAMINS (Nutritional/Dietary)		
PRENATAL VITAMIN PREPARATIONS		
BAL-CARE DHA ESSENTIAL	T2	
CITRANATAL 90 DHA	T2	
CITRANATAL ASSURE	T2	
CITRANATAL DHA	T2	

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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	
mynatal capsule	T2	
mynatal ultracaplet	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	
pnv 11/iron fum/folic acid/om3	T1	
pnv 119/iron fum/folic acid	T1	
pnv 66/iron/folic/docusate/dha	T1	
pnv 69/iron/folic/docusate/dha	T1	
pnv 80/iron fum/folic/dss/dha	T1	
pnv no.118/iron fumarate/fa	T1	
pnv no.154/iron fum/folic acid	T1	
pnv no.52/iron/fa/omega-3/dha	T1	
pnv,calcium 72/iron,carb/folic	T1	
pnv,calcium 72/iron/folic acid	T1	

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PRE-NATAL VITAMINS (Nutritional/Dietary) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
PRENATAL VITAMIN PREPARATIONS *(cont.)*		
pnv19/iron bg,s.p/folic ac/om3	T1	
pnv81/iron ps,edta/folic/omeg3	T1	
PREGEN DHA	T3	PA
PRENATA	T2	
prenatal 105/iron/folic ac/dha	T1	
prenatal 12/iron/folic/dss/om3	T1	
PRENATAL 19	T1	
prenatal 53/iron/folic ac/omg3	T1	
prenatal 54/iron/folic ac/omg3	T1	
prenatal 71/iron/folic ac/dha	T1	
prenatal 93/iron/folate 9/dha	T1	
*prenatal no.42/folic acid (*Vitamedmd Redichew Rx*)*	T2	
PRENATAL PLUS VITAMIN-MINERAL	T2	
PRENATAL PLUS-DHA	T1	
prenatal vit 27,calc/iron/fa	T1	
prenatal vit 55/iron/folic/om3	T1	
prenatal vit,cal 73/iron/folic	T2	
prenatal vit,cal 76/iron/folic	T3	
prenatal vit,cal 78/iron/folic	T3	
prenatal vit/iron fum/folic ac	T1	
prenatal vits 86/iron/folic ac	T1	
prenatal,calc 40/iron/folate 1	T1	
PRENATE ENHANCE	T2	
PRENATE RESTORE	T2	
PRIMACARE	T2	
PROVIDA OB	T2	
SELECT-OB	T2	
SELECT-OB (*prenatal vit 128/iron/folic ac*)	T2	
SELECT-OB + DHA	T2	
THRIVITE RX	T1	
TRICARE	T2	
TRISTART DHA	T2	
VITAFOL FE PLUS	T3	

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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

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PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)[9]		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ALPHA-2 RECEPTOR ANTAGONIST ANTI-DEPRESSANTS		
mirtazapine	T1	HD
mirtazapine (Remeron)	T1	HD
REMERON (*mirtazapine*)	T3	PA HD
ANTI-ANXIETY - BENZODIAZEPINES		
alprazolam	T1	
alprazolam (Xanax Xr)	T1	
alprazolam (Xanax)	T1	
ATIVAN (*lorazepam*)	T3	PA
chlordiazepoxide hcl	T1	
clorazepate dipotassium	T1	
diazepam 10 mg tablet (Valium)	T1	
diazepam 2 mg tablet (Valium)	T1	
diazepam 25 mg/5 ml oral conc	T1	
diazepam 5 mg tablet (Valium)	T1	
diazepam 5 mg/5 ml oral cup	T1	
diazepam 5 mg/5 ml solution	T1	
diazepam 5 mg/ml oral conc	T1	
lorazepam	T1	
lorazepam (Ativan)	T1	
LOREEV XR	T3	PA QL(1 CAP/DAY)
oxazepam	T1	
VALIUM (*diazepam*)	T3	PA
XANAX (*alprazolam*)	T3	PA
XANAX XR (*alprazolam xr*)	T3	PA
ANTI-ANXIETY DRUGS		
BUCAPSOL	T3	PA
buspirone hcl	T1	HD
meprobamate	T1	
ANTIDEPRESSANT - NMDA RECEPTOR ANTAGONIST		
SPRAVATO	T4	PA SP
ANTIDEPRESSANT- POST PARTUM DEPPRESSION (PPD)		
ZURZUVAE 20 MG CAPSULE	T4	PA QL(28 CAPS/270 DAYS) SP HD
ZURZUVAE 25 MG CAPSULE	T4	PA QL(28 CAPS/270 DAYS) SP HD
ZURZUVAE 30 MG CAPSULE	T4	PA QL(14 CAPS/270 DAYS) SP HD

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
BIPOLAR DISORDER DRUGS		
EQUETRO	T3	HD
lithium carbonate	T1	HD
lithium carbonate (Lithobid)	T1	HD
lithium citrate	T1	HD
LITHOBID (*lithium carbonate er*)	T3	PA HD
MAOIS -NON-SELECTIVE, IRREVERSIBLE ANTI-DEPRESSANTS		
MARPLAN	T3	QL(12 TABS/DAY)
NARDIL (*phenelzine sulfate*)	T3	PA
PARNATE (*tranylcypromine sulfate*)	T3	PA
phenelzine sulfate (Nardil)	T1	
tranylcypromine sulfate (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
bupropion hcl 100 mg tablet	T1	QL(4 TABS/DAY) HD
bupropion hcl 75 mg tablet	T1	QL(6 TABS/DAY) HD
bupropion hcl sr 100 mg tablet (Wellbutrin Sr)	T1	QL(4 TABS/DAY) HD
bupropion hcl sr 150 mg tablet (Wellbutrin Sr)	T1	QL(2 TABS/DAY) HD
bupropion hcl sr 200 mg tablet (Wellbutrin Sr)	T1	QL(2 TABS/DAY) HD
bupropion hcl xl 150 mg tablet (Wellbutrin XI)	T1	QL(3 TABS/DAY) HD
bupropion hcl xl 300 mg tablet (Wellbutrin XI)	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 (*bupropion hcl sr*)	T3	PA QL(4 TABS/DAY)
WELLBUTRIN SR 150 MG TABLET (*bupropion hcl sr*)	T3	PA QL(2 TABS/DAY)
WELLBUTRIN SR 200 MG TABLET (*bupropion hcl sr*)	T3	PA QL(2 TABS/DAY)

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
NOREPINEPHRINE AND DOPAMINE REUPTAKE INHIB (NDRIs) *(cont.)*		
WELLBUTRIN XL 150 MG TABLET (*bupropion xl*)	T3	PA QL(3 TABS/DAY)
WELLBUTRIN XL 300 MG TABLET (*bupropion xl*)	T3	PA QL(1 TAB/DAY)
SELECTIVE SEROTONIN 5-HT2A INVERSE AGONISTS (SSIAs)		
NUPLAZID	T4	PA SP HD
SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIs)		
CELEXA 10 MG TABLET (*citalopram hbr*)	T3	PA QL(6 TABS/DAY) HD
CELEXA 20 MG TABLET (*citalopram hbr*)	T3	PA QL(3 TABS/DAY) HD
CELEXA 40 MG TABLET (*citalopram hbr*)	T3	PA QL(1 TAB/DAY) HD
citalopram hbr 10 mg tablet (Celexa)	T1	QL(6 TABS/DAY) HD
citalopram hbr 10 mg/5 ml soln	T1	QL(30 MLS/DAY) HD
citalopram hbr 20 mg tablet (Celexa)	T1	QL(3 TABS/DAY) HD
citalopram hbr 20 mg/10 ml sol	T1	QL(30 MLS/DAY) HD
CITALOPRAM HBR 30 MG CAPSULE	T3	PA QL(1 CAP/DAY) HD
citalopram hbr 40 mg tablet (Celexa)	T1	QL(1 TAB/DAY) HD
escitalopram 10 mg tablet (Lexapro)	T1	QL(2 TABS/DAY) HD
escitalopram 10 mg/10 ml cup	T1	QL(20 MLS/DAY) HD
escitalopram 20 mg tablet (Lexapro)	T1	QL(1 TAB/DAY) HD
escitalopram 5 mg tablet (Lexapro)	T1	QL(4 TABS/DAY) HD
escitalopram oxalate 5 mg/5 ml	T1	QL(20 MLS/DAY) HD
fluoxetine 20 mg/5 ml soln cup	T1	QL(20 MLS/DAY) HD
fluoxetine 20 mg/5 ml solution	T1	QL(20 MLS/DAY) HD
fluoxetine hcl	T1	QL (4 caps/28 days) HD
fluoxetine hcl 10 mg capsule (Prozac)	T1	QL(8 CAPS/DAY) HD
fluoxetine hcl 10 mg tablet	T1	HD
fluoxetine hcl 20 mg capsule (Prozac)	T1	QL(4 CAPS/DAY) HD
fluoxetine hcl 20 mg tablet	T1	HD
fluoxetine hcl 40 mg capsule (Prozac)	T1	QL(2 CAPS/DAY) HD
fluoxetine hcl 60 mg tablet	T1	QL(1 TAB/DAY) HD
fluvoxamine er 100 mg capsule	T1	QL(3 CAPS/DAY) HD
fluvoxamine er 150 mg capsule	T1	QL(2 CAPS/DAY) HD

T1 – Typically Generics
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List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)[9] *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIs) *(cont.)*		
fluvoxamine maleate 100 mg tab	T1	QL(3 TABS/DAY) HD
fluvoxamine maleate 25 mg tab	T1	QL(12 TABS/DAY) HD
fluvoxamine maleate 50 mg tab	T1	QL(6 TABS/DAY) HD
LEXAPRO 10 MG TABLET (*escitalopram oxalate*)	T3	PA QL(2 TABS/DAY)
LEXAPRO 20 MG TABLET (*escitalopram oxalate*)	T3	PA QL(1 TAB/DAY)
LEXAPRO 5 MG TABLET (*escitalopram oxalate*)	T3	PA QL(4 TABS/DAY)
paroxetine cr 12.5 mg tablet (Paxil Cr)	T1	QL(1 TAB/DAY) HD
paroxetine cr 25 mg tablet (Paxil Cr)	T1	QL(3 TABS/DAY) HD
paroxetine cr 37.5 mg tablet (Paxil Cr)	T1	QL(2 TABS/DAY) HD
paroxetine er 12.5 mg tablet (Paxil Cr)	T1	QL(1 TAB/DAY) HD
paroxetine er 25 mg tablet (Paxil Cr)	T1	QL(3 TABS/DAY) HD
paroxetine er 37.5 mg tablet (Paxil Cr)	T1	QL(2 TABS/DAY) HD
paroxetine hcl 10 mg tablet (Paxil)	T1	QL(6 TABS/DAY) HD
paroxetine hcl 10 mg/5 ml susp	T1	QL(30 MLS/DAY) HD
paroxetine hcl 20 mg tablet (Paxil)	T1	QL(3 TABS/DAY) HD
paroxetine hcl 30 mg tablet (Paxil)	T1	QL(2 TABS/DAY) HD
paroxetine hcl 40 mg tablet (Paxil)	T1	QL(1 TAB/DAY) HD
PAXIL 10 MG TABLET (*paroxetine hcl*)	T3	PA QL(6 TABS/DAY) HD
PAXIL 20 MG TABLET (*paroxetine hcl*)	T3	PA QL(3 TABS/DAY) HD
PAXIL 30 MG TABLET (*paroxetine hcl*)	T3	PA QL(2 TABS/DAY) HD
PAXIL 40 MG TABLET (*paroxetine hcl*)	T3	PA QL(1 TAB/DAY) HD
PAXIL CR 12.5 MG TABLET (*paroxetine er*)	T3	PA QL(1 TAB/DAY) HD
PAXIL CR 25 MG TABLET (*paroxetine er*)	T3	PA QL(3 TABS/DAY) HD
PAXIL CR 37.5 MG TABLET (*paroxetine er*)	T3	PA QL(2 TABS/DAY) HD
PROZAC 10 MG PULVULE (*fluoxetine hcl*)	T3	PA QL(8 CAPS/DAY)
PROZAC 20 MG PULVULE (*fluoxetine hcl*)	T3	PA QL(4 CAPS/DAY)
PROZAC 40 MG PULVULE (*fluoxetine hcl*)	T3	PA QL(2 CAPS/DAY)
sertraline 150 mg capsule	T1	QL(1 CAP/DAY) HD
sertraline 20 mg/ml oral conc (Zoloft)	T1	QL(10 MLS/DAY) HD
sertraline 200 mg capsule	T1	QL(1 CAP/DAY) HD
sertraline hcl 100 mg tablet (Zoloft)	T1	QL(2 TABS/DAY) HD
sertraline hcl 25 mg tablet (Zoloft)	T1	QL(8 TABS/DAY) HD
sertraline hcl 50 mg tablet (Zoloft)	T1	QL(4 TABS/DAY) HD

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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 (*sertraline hcl*)	T3	PA QL(2 TABS/DAY)
ZOLOFT 20 MG/ML ORAL CONC (*sertraline hcl*)	T3	PA QL(10 MLS/DAY)
ZOLOFT 25 MG TABLET (*sertraline hcl*)	T3	PA QL(8 TABS/DAY)
ZOLOFT 50 MG TABLET (*sertraline hcl*)	T3	PA QL(4 TABS/DAY)
SEROTONIN-2 ANTAGONIST/REUPTAKE INHIBITORS (SARIs)		
nefazodone hcl	T1	HD
RALDESY	T3	PA HD
trazodone hcl	T1	HD
SEROTONIN-NOREPINEPHRINE REUPTAKE-INHIB (SNRIs)		
CYMBALTA 20 MG CAPSULE (*duloxetine hcl*)	T3	PA QL(6 CAPS/DAY) HD
CYMBALTA 30 MG CAPSULE (*duloxetine hcl*)	T3	PA QL(4 CAPS/DAY) HD
CYMBALTA 60 MG CAPSULE (*duloxetine hcl*)	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
desvenlafaxine succnt er 100mg (Pristiq)	T1	QL(4 TABS/DAY) HD
desvenlafaxine succnt er 25 mg (Pristiq)	T1	QL(16 TABS/DAY) HD
desvenlafaxine succnt er 50 mg (Pristiq)	T1	QL(1 TAB/DAY) HD
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
duloxetine hcl dr 20 mg cap (Cymbalta)	T1	QL(6 CAPS/DAY) HD
duloxetine hcl dr 30 mg cap (Cymbalta)	T1	QL(4 CAPS/DAY) HD
duloxetine hcl dr 40 mg cap	T1	QL(3 CAPS/DAY) HD
duloxetine hcl dr 60 mg cap (Cymbalta)	T1	QL(2 CAPS/DAY) HD
EFFEXOR XR 150 MG CAPSULE (*venlafaxine hcl er*)	T3	PA QL(2 CAPS/DAY)
EFFEXOR XR 37.5 MG CAPSULE (*venlafaxine hcl er*)	T3	PA QL(8 CAPS/DAY)
EFFEXOR XR 75 MG CAPSULE (*venlafaxine hcl er*)	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)

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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 (*desvenlafaxine succinate er*)	T3	PA QL(4 TABS/DAY) HD
PRISTIQ ER 25 MG TABLET (*desvenlafaxine succinate er*)	T3	PA QL(16 TABS/DAY) HD
PRISTIQ ER 50 MG TABLET (*desvenlafaxine succinate er*)	T3	PA QL(1 TAB/DAY) HD
VENLAFAXINE BESYLATE ER	T3	PA QL(2 TABS/DAY) HD
venlafaxine hcl 100 mg tablet	T1	QL(3 TABS/DAY) HD
venlafaxine hcl 25 mg tablet	T1	QL(15 TABS/DAY) HD
venlafaxine hcl 37.5 mg tablet	T1	QL(10 TABS/DAY) HD
venlafaxine hcl 50 mg tablet	T1	QL(7 TABS/DAY) HD
venlafaxine hcl 75 mg tablet	T1	QL(5 TABS/DAY) HD
venlafaxine hcl er 150 mg cap (Effexor Xr)	T1	QL(2 CAPS/DAY) HD
venlafaxine hcl er 150 mg tab	T1	QL(2 TABS/DAY) HD
venlafaxine hcl er 225 mg tab	T1	QL(1 TAB/DAY) HD
venlafaxine hcl er 37.5 mg cap (Effexor Xr)	T1	QL(8 CAPS/DAY) HD
venlafaxine hcl er 37.5 mg tab	T1	QL(8 TABS/DAY) HD
venlafaxine hcl er 75 mg cap (Effexor Xr)	T1	QL(4 CAPS/DAY) HD
venlafaxine hcl er 75 mg tab	T1	QL(4 TABS/DAY) HD
SSRI AND 5HTIA PARTIAL AGONIST 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
vilazodone hcl 10 mg tablet (Viibryd)	T1	QL(1 TAB/DAY) HD
vilazodone hcl 20 mg tablet (Viibryd)	T1	QL(1 TAB/DAY) HD
vilazodone hcl 40 mg tablet (Viibryd)	T1	HD
SSRI, SEROTONIN RECEPTOR MODULATOR 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		
amitriptyline/chlordiazepoxide	T1	HD
TRICYCLIC ANTI-DEPRESSANT-PHENOTHIAZINE COMBINATNS		
perphenazine/amitriptyline hcl	T1	HD
TRICYCLIC ANTI-DEPRESSANTS, REL.NON-SEL.REUPT-INHIB		
amitriptyline hcl	T1	HD
amoxapine	T1	HD

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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)

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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 (*lisdexamfetamine dimesylate*)	T3	PA QL(1 CAP/DAY)
VYVANSE 10 MG CHEWABLE TABLET (*lisdexamfetamine dimesylate*)	T3	PA QL(1 TAB/DAY)
VYVANSE 20 MG CAPSULE (*lisdexamfetamine dimesylate*)	T3	PA QL(1 CAP/DAY)
VYVANSE 20 MG CHEWABLE TABLET (*lisdexamfetamine dimesylate*)	T3	PA QL(1 TAB/DAY)
VYVANSE 30 MG CAPSULE (*lisdexamfetamine dimesylate*)	T3	PA QL(1 CAP/DAY)
VYVANSE 30 MG CHEWABLE TABLET (*lisdexamfetamine dimesylate*)	T3	PA QL(1 TAB/DAY)
VYVANSE 40 MG CAPSULE (*lisdexamfetamine dimesylate*)	T3	PA QL(1 CAP/DAY)
VYVANSE 40 MG CHEWABLE TABLET (*lisdexamfetamine dimesylate*)	T3	PA QL(1 TAB/DAY)
VYVANSE 50 MG CAPSULE (*lisdexamfetamine dimesylate*)	T3	PA QL(1 CAP/DAY)
VYVANSE 50 MG CHEWABLE TABLET (*lisdexamfetamine dimesylate*)	T3	PA QL(1 TAB/DAY)
VYVANSE 60 MG CAPSULE (*lisdexamfetamine dimesylate*)	T3	PA QL(1 CAP/DAY)
VYVANSE 60 MG CHEWABLE TABLET (*lisdexamfetamine dimesylate*)	T3	PA QL(1 TAB/DAY)
VYVANSE 70 MG CAPSULE (*lisdexamfetamine dimesylate*)	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 (*guanfacine hcl er*)	T3	PA HD
KAPVAY (*clonidine hcl er*)	T3	PA
ONYDA XR	T3	PA
TX FOR ATTENTION DEFICIT-HYPERACT (ADHD)/NARCOLEPSY		
APTENSIO XR (*methylphenidate hcl*)	T3	PA ST QL(1 CAP/DAY)
AZSTARYS	T3	PA ST QL(1 CAP/DAY)
CONCERTA ER 18 MG TABLET (*methylphenidate hcl*)	T3	PA ST QL(1 TAB/DAY)
CONCERTA ER 27 MG TABLET (*methylphenidate hcl*)	T3	PA ST QL(1 TAB/DAY)
CONCERTA ER 36 MG TABLET (*methylphenidate hcl*)	T3	PA ST QL(2 TABS/DAY)
CONCERTA ER 54 MG TABLET (*methylphenidate hcl*)	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 (*methylphenidate*)	T3	PA QL(1 PATCH/DAY)
*dexmethylphenidate hcl (*Focalin Xr*)*	T1	PA QL(1 CAP/DAY)
*dexmethylphenidate hcl (*Focalin*)*	T1	PA
FOCALIN *(dexmethylphenidate hcl)*	T3	PA ST

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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 *(dexmethylphenidate hcl)*	T3	PA ST QL(1 CAP/DAY)
JORNAY PM	T3	PA ST QL(1 CAP/DAY)
METADATE CD *(methylphenidate hcl)*	T3	PA QL(1 CAP/DAY)
METHYLIN *(methylphenidate hcl)*	T3	PA
methylphenidate (Daytrana)	T1	PA QL(1 PATCH/DAY)
methylphenidate er 10 mg cap (Aptensio Xr)	T1	PA QL(1 CAP/DAY)
methylphenidate er 10 mg tab	T1	PA QL(2 TABS/DAY)
methylphenidate er 15 mg cap (Aptensio Xr)	T1	PA QL(1 CAP/DAY)
methylphenidate er 18 mg tab (Concerta)	T1	PA QL(1 TAB/DAY)
methylphenidate er 18 mg tab (Relexxii)	T1	PA QL(1 TAB/DAY)
methylphenidate er 20 mg cap (Aptensio Xr)	T1	PA QL(1 CAP/DAY)
methylphenidate er 20 mg tab	T1	PA QL(3 TABS/DAY)
methylphenidate er 27 mg tab (Concerta)	T1	PA QL(1 TAB/DAY)
methylphenidate er 27 mg tab (Relexxii)	T1	PA QL(1 TAB/DAY)
methylphenidate er 30 mg cap (Aptensio Xr)	T1	PA QL(1 CAP/DAY)
methylphenidate er 36 mg tab (Concerta)	T1	PA QL(2 TABS/DAY)
methylphenidate er 36 mg tab (Relexxii)	T1	PA QL(2 TABS/DAY)
methylphenidate er 40 mg cap (Aptensio Xr)	T1	PA QL(1 CAP/DAY)
METHYLPHENIDATE ER 45 MG TAB	T3	PA QL(1 TAB/DAY)
methylphenidate er 50 mg cap (Aptensio Xr)	T1	PA QL(1 CAP/DAY)
methylphenidate er 54 mg tab (Concerta)	T1	PA QL(1 TAB/DAY)
methylphenidate er 54 mg tab (Relexxii)	T1	PA QL(1 TAB/DAY)
methylphenidate er 60 mg cap (Aptensio Xr)	T1	PA QL(1 CAP/DAY)
METHYLPHENIDATE ER 63 MG TAB	T3	PA QL(1 TAB/DAY)
methylphenidate er 72 mg tab	T1	PA QL(1 TAB/DAY)
methylphenidate er(la) 10mg cp (Ritalin La)	T1	PA QL(1 CAP/DAY)
methylphenidate er(la) 20mg cp (Ritalin La)	T1	PA QL(1 CAP/DAY)
methylphenidate er(la) 30mg cp (Ritalin La)	T1	PA QL(2 CAPS/DAY)
methylphenidate er(la) 40mg cp (Ritalin La)	T1	PA QL(1 CAP/DAY)
methylphenidate er(la) 60mg cp	T1	PA QL(1 CAP/DAY)
methylphenidate hcl	T1	PA
methylphenidate hcl (Metadate Cd)	T1	PA QL(1 CAP/DAY)
methylphenidate hcl (Methylin)	T1	PA

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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.)*		
methylphenidate hcl (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 (*methylphenidate hcl*)	T3	PA QL(1 TAB/DAY)
RELEXXII ER 27 MG TABLET (*methylphenidate hcl*)	T3	PA QL(1 TAB/DAY)
RELEXXII ER 36 MG TABLET (*methylphenidate hcl*)	T3	PA QL(2 TABS/DAY)
RELEXXII ER 45 MG TABLET	T3	PA QL(1 TAB/DAY)
RELEXXII ER 54 MG TABLET (*methylphenidate hcl*)	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 (*methylphenidate hcl*)	T3	PA ST
RITALIN LA 10 MG CAPSULE (*methylphenidate hcl*)	T3	PA ST QL(1 CAP/DAY)
RITALIN LA 20 MG CAPSULE (*methylphenidate hcl*)	T3	PA ST QL(1 CAP/DAY)
RITALIN LA 30 MG CAPSULE (*methylphenidate hcl*)	T3	PA ST QL(2 CAPS/DAY)
RITALIN LA 40 MG CAPSULE (*methylphenidate hcl*)	T3	PA ST QL(1 CAP/DAY)
TX FOR ATTENTION DEFICIT-HYPERACT.(ADHD), NRI-TYPE		
atomoxetine hcl 10, 18, 25, 60, 80, 100 mg capsule (Strattera)	T1	HD
atomoxetine hcl 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 (*atomoxetine hcl*)	T3	PA HD
STRATTERA 100 MG CAPSULE (*atomoxetine hcl*)	T3	PA HD
STRATTERA 18 MG CAPSULE (*atomoxetine hcl*)	T3	PA HD
STRATTERA 25 MG CAPSULE (*atomoxetine hcl*)	T3	PA HD
STRATTERA 40 MG CAPSULE (*atomoxetine hcl*)	T3	PA QL(1 CAP/DAY) HD
STRATTERA 60 MG CAPSULE (*atomoxetine hcl*)	T3	PA HD
STRATTERA 80 MG CAPSULE (*atomoxetine hcl*)	T3	PA HD
PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics)[9]		
ANTI-PSYCH, DOPAMINE ANTAG., DIPHENYLBUTYLPIPERIDINES		
pimozide	T1	

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PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics)[9] *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-PSYCHOTIC,ATYPICAL,DOPAMINE,SEROTONIN ANTAGNST		
asenapine maleate (Saphris)	T1	
CAPLYTA	T3	ST QL(1 CAP/DAY)
clozapine	T1	
clozapine (Clozaril)	T1	
CLOZARIL (*clozapine*)	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 (*ziprasidone hcl*)	T3	PA
INVEGA ER 3 MG TABLET (*paliperidone er*)	T3	PA QL(1 TAB/DAY)
INVEGA ER 6 MG TABLET (*paliperidone er*)	T3	PA
INVEGA ER 9 MG TABLET (*paliperidone er*)	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
lurasidone hcl 120 mg tablet (Latuda)	T1	
lurasidone hcl 20 mg tablet (Latuda)	T1	
lurasidone hcl 40 mg tablet (Latuda)	T1	QL(1 TAB/DAY)
lurasidone hcl 60 mg tablet (Latuda)	T1	QL(1 TAB/DAY)
lurasidone hcl 80 mg tablet (Latuda)	T1	
LYBALVI	T3	ST QL(1 TAB/DAY)
olanzapine	T1	

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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 ANTAGNST *(cont.)*		
olanzapine (Zyprexa Zydis)	T1	
olanzapine (Zyprexa)	T1	
paliperidone er 1.5 mg tablet	T1	
paliperidone er 3 mg tablet (Invega)	T1	QL(1 TAB/DAY)
paliperidone er 6 mg tablet (Invega)	T1	
paliperidone er 9 mg tablet (Invega)	T1	
QUETIAPINE 150 MG TABLET	T3	PA
quetiapine fumarate (Seroquel Xr)	T1	
quetiapine fumarate 100 mg tab (Seroquel)	T1	
quetiapine fumarate 200 mg tab (Seroquel)	T1	
quetiapine fumarate 25 mg tab (Seroquel)	T1	
quetiapine fumarate 300 mg tab (Seroquel)	T1	
quetiapine fumarate 400 mg tab (Seroquel)	T1	
quetiapine fumarate 50 mg tab (Seroquel)	T1	
RISPERDAL (*risperidone*)	T3	PA
risperidone	T1	
risperidone (Risperdal)	T1	
SAPHRIS (*asenapine maleate*)	T3	ST
SECUADO	T3	ST
SEROQUEL (*quetiapine fumarate*)	T3	ST
SEROQUEL XR (*quetiapine fumarate er*)	T3	ST
VERSACLOZ	T3	PA
ziprasidone hcl (Geodon)	T1	
ZYPREXA (*olanzapine*)	T3	PA
ZYPREXA ZYDIS (*olanzapine odt*)	T3	PA
ANTI-PSYCHOTIC-ATYPICAL, D3/D2 PARTIAL AG-5HT MIXED		
VRAYLAR 1.5 MG CAPSULE	T3	ST QL(1 CAP/DAY)
VRAYLAR 3 MG CAPSULE	T3	ST QL(1 CAP/DAY)
VRAYLAR 4.5 MG CAPSULE	T3	ST
VRAYLAR 6 MG CAPSULE	T3	ST
ANTIPSYCHOTICS, ATYP, D2 PARTIAL AGONIST/5HT MIXED		
ABILIFY 10 MG TABLET (*aripiprazole*)	T3	ST
ABILIFY 15 MG TABLET (*aripiprazole*)	T3	ST

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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 (*aripiprazole*)	T3	ST
ABILIFY 20 MG TABLET (*aripiprazole*)	T3	ST
ABILIFY 30 MG TABLET (*aripiprazole*)	T3	ST
ABILIFY 5 MG TABLET (*aripiprazole*)	T3	ST QL(1 TAB/DAY)
ABILIFY MYCITE	T3	PA
aripiprazole	T1	
aripiprazole 1 mg/ml solution	T1	
aripiprazole 10 mg tablet (Abilify)	T1	
aripiprazole 15 mg tablet (Abilify)	T1	
aripiprazole 2 mg tablet (Abilify)	T1	
aripiprazole 20 mg tablet (Abilify)	T1	
aripiprazole 30 mg tablet (Abilify)	T1	
aripiprazole 5 mg tablet (Abilify)	T1	QL(1 TAB/DAY)
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		
loxapine succinate	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		
thiothixene	T1	
ANTI-PSYCHOTICS, DOPAMINE ANTAGONISTS, BUTYROPHENONES		
haloperidol	T1	
haloperidol lactate	T1	
ANTI-PSYCHOTICS, DOPAMINE ANTAGONST, DIHYDROINDOLONES		
molindone hcl	T1	

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-PSYCHOTICS, PHENOTHIAZINES		
chlorpromazine hcl	T1	
fluphenazine hcl	T1	
perphenazine	T1	
thioridazine hcl	T1	
trifluoperazine hcl	T1	
SSRI-ANTI-PSYCH, ATYPICAL, DOPAMINE, SEROTONIN ANTAG		
olanzapine/fluoxetine hcl	T1	
PSYCHOTHERAPEUTIC DRUGS (Seizure Disorders)		
NEUROACTIVE STEROID GABA-A RECEPTOR MODULATOR		
ZTALMY	T4	PA QL(36 MLS/DAY) SP
PSYCHOTHERAPEUTIC DRUGS (Sleep Disorders/Sedatives)		
NARCOLEPSY AND SLEEP DISORDER THERAPY AGENTS		
armodafinil (Nuvigil)	T1	PA
modafinil (Provigil)	T1	PA
NUVIGIL (*armodafinil*)	T3	PA
PROVIGIL (*modafinil*)	T3	PA
SUNOSI	T2	PA QL(1 TAB/DAY)
SEDATIVE/HYPNOTICS (Sleep Disorders/Sedatives)		
ANTI-NARCOLEPSY,ANTI-CATAPLEXY,SEDATIVE-TYPE AGENT		
LUMRYZ	T4	PA QL(1 PACK/DAY) SP HD
LUMRYZ STARTER PACK	T4	PA QL SP HD
SODIUM OXYBATE	T4	PA QL(18 MLS/DAY) SP HD
XYREM	T4	PA QL(18 MLS/DAY) SP HD
XYWAV	T4	PA QL(18 MLS/DAY) SP HD
BARBITURATES		
phenobarbital	T1	
HYPNOTICS, MELATONIN MT1/MT2 RECEPTOR AGONISTS		
HETLIOZ *(tasimelteon)*	T4	PA SP HD
HETLIOZ LQ	T4	PA SP HD
ramelteon (Rozerem)	T1	QL(1 TAB/DAY)
ROZEREM *(ramelteon)*	T3	PA QL(1 TAB/DAY)
tasimelteon (Hetlioz)	T4	PA SP

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SEDATIVE/HYPNOTICS (Sleep Disorders/Sedatives) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
SEDATIVE-HYPNOTICS, NON-BARBITURATE		
DORAL	T3	
estazolam	T1	
flurazepam hcl	T1	
HALCION (*triazolam*)	T3	
midazolam hcl	T1	
QUAZEPAM	T1	
RESTORIL (*temazepam*)	T3	PA
temazepam (Restoril)	T1	
triazolam	T1	
triazolam (Halcion)	T1	
SEDATIVE-HYPNOTICS, NON-BARBITURATE		
AMBIEN (*zolpidem tartrate*)	T3	PA
AMBIEN CR 12.5 MG TABLET (*zolpidem tartrate*)	T3	PA
AMBIEN CR 6.25 MG TABLET (*zolpidem tartrate er*)	T3	PA QL(1 TAB/DAY)
BELSOMRA	T3	PA
DAYVIGO	T2	ST QL(1 TAB/DAY)
doxepin hcl 3 mg tablet (Silenor)	T1	QL(1 TAB/DAY)
doxepin hcl 6 mg tablet (Silenor)	T1	
EDLUAR 10 MG SL TABLET	T3	PA
EDLUAR 5 MG SL TABLET	T3	PA QL(1 TAB/DAY)
eszopiclone (Lunesta)	T1	
LUNESTA (*eszopiclone*)	T3	PA
QUVIVQ	T3	PA QL(1 TAB/DAY)
SILENOR 3 MG TABLET (*doxepin hcl*)	T3	PA QL(1 TAB/DAY)
SILENOR 6 MG TABLET (*doxepin hcl*)	T3	PA
zaleplon	T1	
zolpidem tart 1.75 mg tab sl	T1	
zolpidem tart 3.5 mg tablet sl	T1	
zolpidem tart er 12.5 mg tab (Ambien Cr)	T1	
zolpidem tart er 6.25 mg tab (Ambien Cr)	T1	QL(1 TAB/DAY)
zolpidem tartrate 10 mg tablet (Ambien)	T1	
zolpidem tartrate 5 mg tablet (Ambien)	T1	
ZOLPIDEM TARTRATE 7.5 MG CAP	T3	PA
ZOLPIMIST	T3	PA

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List of Prescription Medications

SKIN PREPS (Miscellaneous)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTISEPTICS,GENERAL		
alcohol antiseptic pads	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		
acetic acid	T1	
neomycin sulf/polymyxin b sulf	T1	
PHYSIOLYTE (*physiological irrig soln no.1*)	T3	
PHYSIOSOL (*physiological irrig soln no.1*)	T3	
ringer's solution	T1	
ringer's solution, lactated	T1	
sod, pot chlor/mag/sod, pot phos	T3	
sodium chloride 0.9% irrig	T1	
sodium chloride 0.9% irrig.	T1	
SODIUM CHLORIDE 0.9% IRRIG.	T3	
sodium chloride 0.9% prcss sol	T1	
sodium chloride irrig solution	T1	

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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	T4	PA QL(2 MLS/28 DAYS) SP HD
BIMZELX AUTOINJECTOR	T4	PA QL(2 MLS/28 DAYS) SP HD
COSENTYX (2 SYRINGES)	T4	PA QL(2 MLS/28 DAYS) SP HD
COSENTYX 150 MG/ML SYRINGE	T4	PA QL(1 ML/28 DAYS) SP HD
COSENTYX 75 MG/0.5 ML SYRINGE	T4	PA QL(0.5 MLS/28 DAYS) SP HD
COSENTYX SENSOREADY (2 PENS)	T4	PA QL(2 MLS/28 DAYS) SP HD
COSENTYX SENSOREADY PEN	T4	PA QL(1 ML/28 DAYS) SP HD
COSENTYX UNOREADY PEN	T4	PA QL(2 MLS/28 DAYS) SP HD
ILUMYA	T4	PA QL(1 UNIT/84 DAYS) SP HD
methoxsalen (Oxsoralen-ultra)	T1	
SILIQ	T4	PA QL(3 MLS/28 DAYS) SP HD
SKYRIZI	T4	PA QL(150 MG/84 DAYS) SP HD
SKYRIZI PEN	T4	PA QL(150 MG/84 DAYS) SP HD
SOTYKTU	T4	PA QL(1 TAB/DAY) SP HD
SPEVIGO	T4	PA QL(2 MLS/28 DAYS) SP HD
TALTZ AUTOINJECTOR	T4	PA QL(1 AUTO-INJECTOR/28 DAYS) SP HD
TALTZ AUTOINJECTOR (2 PACK)	T4	PA QL(1 AUTO-INJECTOR/28 DAYS) SP HD
TALTZ AUTOINJECTOR (3 PACK)	T4	PA QL(1 AUTO-INJECTOR/28 DAYS) SP HD
TALTZ SYRINGE	T4	PA QL(1 SYRINGE/28 DAYS) SP HD
TOPICAL ANTI-INFLAMMATORY, NSAIDS		
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

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List of Prescription Medications

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

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SKIN PREPS (Skin Conditions) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-PRURITICS, TOPICAL		
doxepin 5% cream (Zonalon)	T1	PA QL(90 GMS/30 DAYS)
doxepin hcl (Zonalon)	T3	PA QL(90 GMS/30 DAYS)
ZONALON	T3	PA QL(90 GMS/30 DAYS)
ZONALON (*prudoxin*)	T3	PA QL(90 GMS/30 DAYS)
ANTI-PSORIATICS AGENTS		
anthralin	T1	
calcipotriene 0.005% cream	T1	
CALCIPOTRIENE 0.005% FOAM	T3	PA
calcipotriene 0.005% ointment	T1	
calcipotriene 0.005% solution	T1	
calcitriol 3 mcg/g ointment (Vectical)	T1	QL(800 GMS/30 DAYS)
DUOBRII	T3	
SORILUX	T3	PA
*tazarotene 0.05% cream (*Tazorac*)*	T1	
*tazarotene 0.05% gel (*Tazorac*)*	T1	
tazarotene 0.1% cream (Tazorac)	T1	
tazarotene 0.1% gel (Tazorac)	T1	
TAZORAC 0.05% CREAM (*tazarotene*)	T2	
TAZORAC 0.05% GEL (*tazarotene*)	T2	
TAZORAC 0.1% CREAM (*tazarotene*)	T3	
TAZORAC 0.1% GEL (*tazarotene*)	T2	
VECTICAL (*calcitriol*)	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	
selenium sulfide	T1	
sulfacetamide sodium	T1	
ANTISEPTICS,GENERAL		
alcohol antiseptic pads	T1	
ALCOHOL PREP PADS	T1	
ALCOHOL SWAB	T1	
ALCOHOL SWABS	T1	

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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	T4	PA QL(30 TABS/30 DAYS) SP

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

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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	
trichloroacetic acid	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 (*scalacort*)	T3	ST
alclometasone dipropionate	T1	
amcinonide 0.1% cream	T1	
amcinonide 0.1% ointment	T1	PA
ANUSOL-HC 2.5% CREAM (*proctozone-hc*)	T3	PA
AQUA GLYCOLIC HC	T3	
betamethasone dipropionate	T1	
betamethasone valerate	T1	
betamethasone/propylene glyc	T1	
betamethasone/propylene glyc (Diprolene)	T1	

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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
clobetasol 0.05% cream	T1	
clobetasol 0.05% gel	T1	
clobetasol 0.05% ointment (Temovate)	T1	
clobetasol 0.05% shampoo (Clobex)	T1	
clobetasol 0.05% solution	T1	
clobetasol 0.05% topical lotn	T1	
clobetasol prop 0.05% foam (Olux)	T1	
clobetasol prop 0.05% spray (Clobex)	T1	
clobetasol propionate/emoll	T1	
CLOBEX (*clobetasol propionate*)	T3	PA
clocortolone pivalate (Cloderm)	T1	
CLODAN 0.05% KIT	T3	ST
clodan 0.05% shampoo (Clobex)	T1	
CLODERM	T3	ST
CLODERM (*clocortolone pivalate*)	T3	ST
CORDRAN	T3	PA
CORDRAN (*flurandrenolide*)	T3	PA
DERMA-SMOOTHE-FS (*fluocinolone acetonide*)	T3	ST
DERMA-SMOOTHE-FS (*fluocinolone/shower cap*)	T3	ST
desonide	T1	
desonide (Tridesilon)	T1	
desoximetasone (Topicort)	T1	
diflorasone diacet/emollient	T1	PA
diflorasone diacetate	T1	PA
DIPROLENE *(betamethasone/propylene glyc)*	T3	ST
fluocinolone acetonide	T1	
fluocinolone acetonide (Derma-Smoothe-Fs)	T1	
fluocinolone acetonide (Synalar)	T1	
fluocinolone/shower cap (Derma-Smoothe-Fs)	T1	
fluocinonide	T1	

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TOPICAL ANTI-INFLAMMATORY STEROIDAL *(cont.)*		
fluocinonide (Vanos)	T1	
fluocinonide/emollient base	T1	
flurandrenolide (Cordran)	T1	PA
fluticasone prop 0.005% oint	T1	
fluticasone prop 0.05% cream	T1	
fluticasone prop 0.05% lotion	T1	
fluticasone propionate	T1	
halcinonide 0.1% cream (Halog)	T1	PA
halcinonide 0.1% solution	T1	
halobetasol propionate	T1	
HALOG 0.1% CREAM (*halcinonide*)	T3	PA
HALOG 0.1% OINTMENT	T3	PA
HALOG 0.1% SOLUTION	T3	ST
hydrocort buty 0.1% lipo cream (Locoid Lipocream)	T1	PA
hydrocortisone	T1	
hydrocortisone (Ala-Scalp)	T1	
hydrocortisone (Anusol-Hc)	T1	
hydrocortisone acetate	T1	
hydrocortisone buty 0.1% cream	T1	
hydrocortisone butyr 0.1% lotn	T1	PA
hydrocortisone butyr 0.1% oint	T1	
hydrocortisone butyr 0.1% soln	T1	
hydrocortisone valerate	T1	
IMPEKLO	T3	PA
IMPOYZ	T3	PA
KENALOG (*triamcinolone acetonide*)	T3	PA
LOCOID LIPOCREAM (*hydrocortisone butyrate/emoll*)	T3	PA
MICORT-HC	T3	PA
mometasone furoate 0.1% cream	T1	
mometasone furoate 0.1% oint	T1	
mometasone furoate 0.1% soln	T1	
NUCORT	T3	ST
OLUX (*clobetasol propionate*)	T3	PA

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
TOPICAL ANTI-INFLAMMATORY STEROIDAL *(cont.)*		
PANDEL	T3	PA
prednicarbate	T1	
SCALACORT DK	T3	ST
SERNIVO	T3	PA
SYNALAR	T3	ST
SYNALAR *(fluocinolone acetonide)*	T3	ST
SYNALAR TS	T3	ST
TEMOVATE (*clobetasol propionate*)	T3	ST
TEXACORT	T3	ST
TOPICORT (*desoximetasone*)	T3	ST
triamcinolone 0.025% cream	T1	
triamcinolone 0.025% lotion	T1	
triamcinolone 0.025% oint	T1	
triamcinolone 0.05% ointment	T1	PA
triamcinolone 0.1% cream	T1	
triamcinolone 0.1% lotion	T1	
triamcinolone 0.1% ointment	T1	
*triamcinolone 0.147 mg/g spray (*Kenalog*)*	T1	PA
triamcinolone 0.5% cream	T1	
triamcinolone 0.5% ointment	T1	
triamcinolone acetonide	T1	
triamcinolone acetonide	T1	PA
TRIDESILON (*desonide*)	T3	PA
ULTRAVATE	T3	PA
VANOS (*fluocinonide*)	T3	PA
VERDESO	T3	PA
TOPICAL ANTI-INFLAMMATORY STEROID-LOCAL ANESTHETIC		
ANALPRAM HC 2.5%-1% LOTION	T3	PA
EPIFOAM	T3	
hydrocortisone/pramoxine	T1	
lidocaine/hydrocortisone ac	T1	
PRAMOSONE 1% LOTION	T2	
PRAMOSONE 1%-1% CREAM	T2	

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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		
iodine/potassium iodide	T1	
iodine/sodium iodide	T1	
IODOFLEX	T3	
IODOSORB	T3	
silver nitrate	T1	
TOPICAL VIT D ANALOG/ANTI-INFLAMMATORY STEROID		
calcipotriene/betamethasone (Taclonex)	T1	
ENSTILAR	T3	PA
TACLONEX (*calcipotriene/betamethasone*)	T3	PA
WYNZORA	T3	PA
TOPICAL/MUCOUS MEMBR./SUBCUT. ENZYMES		
SANTYL	T2	QL(60 GMS/30 DAYS)
VITAMIN A DERIVATIVES		
adapalene (Differin)	T1	PA
ADAPALENE	T1	PA
adapalene (Plixda)	T1	PA
ALTRENO	T3	PA
ATRALIN (*tretinoin*)	T3	PA
DIFFERIN	T3	PA
DIFFERIN (*adapalene*)	T3	PA
RETIN-A 0.01% GEL (*tretinoin*)	T3	
RETIN-A 0.025% CREAM (*tretinoin*)	T3	PA
RETIN-A 0.025% GEL (*tretinoin*)	T3	

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SKIN PREPS (Skin Conditions) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
VITAMIN A DERIVATIVES *(cont.)*		
RETIN-A 0.05% CREAM (*tretinoin*)	T3	PA
RETIN-A 0.1% CREAM (*tretinoin*)	T3	PA
RETIN-A MICRO (*tretinoin microsphere*)	T3	PA
RETIN-A MICRO PUMP	T3	PA
RETIN-A MICRO PUMP (*tretinoin microsphere*)	T3	PA
tretinoin 0.01% gel (Retin-a)	T1	
tretinoin 0.025% cream (Retin-a)	T1	PA
tretinoin 0.025% gel (Retin-a)	T1	
tretinoin 0.05% cream (Retin-a)	T1	PA
tretinoin 0.05% gel (Atralin)	T1	PA
tretinoin 0.1% cream (Retin-a)	T1	PA
tretinoin microspheres (Retin-a Micro Pump)	T1	PA
tretinoin microspheres (Retin-a Micro)	T1	PA
SMOKING DETERRENTS (Smoking Cessation)[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
varenicline 0.5 mg tablet	T1	PPACA
varenicline 1 mg cont month bx	T1	PPACA
varenicline 1 mg tablet	T1	PPACA
varenicline starting month box	T1	PPACA
SMOKING DETERRENTS, OTHER		
bupropion hcl sr 150 mg tablet	T1	PPACA
THYROID PREPS (Hormonal Agents)		
ANTI-THYROID PREPARATIONS		
methimazole (Tapazole)	T1	HD
propylthiouracil	T1	HD

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THYROID PREPS (Hormonal Agents) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
THYROID HORMONES		
adthyza 120 mg tablet	T1	PA HD
ADTHYZA 130 MG TABLET	T3	PA HD
adthyza 15 mg tablet	T1	PA HD
ADTHYZA 16.25 MG TABLET	T3	PA HD
adthyza 30 mg tablet	T1	PA HD
ADTHYZA 32.5 MG TABLET	T3	PA HD
adthyza 60 mg tablet	T1	PA HD
ADTHYZA 65 MG TABLET	T3	PA HD
adthyza 90 mg tablet	T1	HD
ADTHYZA 97.5 MG TABLET	T3	PA HD
ARMOUR THYROID	T3	HD
CYTOMEL (*liothyronine sodium*)	T3	HD
ERMEZA	T3	PA HD
LEVOTHYROXINE 100 MCG CAPSULE	T3	HD
levothyroxine 100 mcg tablet (Synthroid)	T1	HD
LEVOTHYROXINE 112 MCG CAPSULE	T3	HD
levothyroxine 112 mcg tablet (Synthroid)	T1	HD
LEVOTHYROXINE 125 MCG CAPSULE	T3	HD
levothyroxine 125 mcg tablet (Synthroid)	T1	HD
LEVOTHYROXINE 13 MCG CAPSULE	T3	HD
LEVOTHYROXINE 137 MCG CAPSULE	T3	HD
levothyroxine 137 mcg tablet (Synthroid)	T1	HD
LEVOTHYROXINE 150 MCG CAPSULE	T3	HD
levothyroxine 150 mcg tablet (Synthroid)	T1	HD
LEVOTHYROXINE 175 MCG CAPSULE	T3	HD
levothyroxine 175 mcg tablet (Synthroid)	T1	HD
LEVOTHYROXINE 200 MCG CAPSULE	T3	HD
levothyroxine 200 mcg tablet (Synthroid)	T1	HD
LEVOTHYROXINE 25 MCG CAPSULE	T3	HD
levothyroxine 25 mcg tablet (Synthroid)	T1	HD
levothyroxine 300 mcg tablet (Synthroid)	T1	HD
LEVOTHYROXINE 50 MCG CAPSULE	T3	HD
levothyroxine 50 mcg tablet (Synthroid)	T1	HD

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THYROID PREPS (Hormonal Agents) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
THYROID HORMONES *(cont.)*		
LEVOTHYROXINE 75 MCG CAPSULE	T3	HD
levothyroxine 75 mcg tablet (Synthroid)	T1	HD
LEVOTHYROXINE 88 MCG CAPSULE	T3	HD
levothyroxine 88 mcg tablet (Synthroid)	T1	HD
levothyroxine sodium (Synthroid)	T1	HD
levothyroxine sodium (Synthroid)	T3	HD
liothyronine sodium (Cytomel)	T1	HD
SYNTHROID (*levothyroxine sodium*)	T3	PA HD
THYQUIDITY	T3	PA HD
thyroid, pork	T1	HD
TIROSINT	T3	HD
TIROSINT-SOL	T3	HD
UNCLASSIFIED DRUG PRODUCTS (AIDS/HIV)		
CYTOCHROME P450 INHIBITORS		
TYBOST	T3	SP
UNCLASSIFIED DRUG PRODUCTS (Asthma/COPD/Respiratory)		
CYSTIC FIBROSIS - INHALED OSMOTIC AGENTS		
BRONCHITOL	T4	PA SP HD
CYSTIC FIBROSIS-CFTR POTENTIATOR-CORRECTOR COMBIN.		
ALYFTREK 10-50-125 MG TABLET	T4	PA QL(2 TABS/DAY) SP HD
ALYFTREK 4-20-50 MG TABLET	T4	PA QL(3 TABS/DAY) SP HD
ORKAMBI 100 MG-125 MG TABLET	T4	PA QL(4 TABS/DAY) SP HD
ORKAMBI 100-125 MG GRANULE PKT	T4	PA QL(2 PACKS/DAY) SP HD
ORKAMBI 150-188 MG GRANULE PKT	T4	PA QL(2 PACKS/DAY) SP HD
ORKAMBI 200 MG-125 MG TABLET	T4	PA QL(4 TABS/DAY) SP HD
ORKAMBI 75-94 MG GRANULE PKT	T4	PA QL(2 PACKS/DAY) SP HD
SYMDEKO	T4	PA QL(2 TABS/DAY) SP HD
TRIKAFTA 100-50-75 MG/150 MG	T4	PA QL(3 TABS/DAY) SP HD
TRIKAFTA 100-50-75 MG/75MG PKT	T4	PA QL(2 UNITS/DAY) SP HD
TRIKAFTA 50-25-37.5 MG/75 MG	T4	PA QL(3 TABS/DAY) SP HD
TRIKAFTA 80-40-60MG/59.5MG PKT	T4	PA QL(2 UNITS/DAY) SP HD

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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	T4	PA QL(2 PACKS/DAY) SP HD
KALYDECO 5.8 MG TABLET	T4	PA QL(2 PACKS/DAY) SP HD
KALYDECO 150 MG TABLET	T4	PA QL(2 TABS/DAY) SP HD
KALYDECO 25 MG GRANULES PACKET	T4	PA QL(2 PACKS/DAY) SP HD
KALYDECO 50 MG GRANULES PACKET	T4	PA QL(2 PACKS/DAY) SP HD
KALYDECO 75 MG GRANULES PACKET	T4	PA QL(2 PACKS/DAY) SP HD
LUNG SURFACTANTS		
CUROSURF	T3	
INFASURF	T3	
SURVANTA	T3	
MUCOLYTICS		
PULMOZYME	T4	PA SP HD
PULMONARY FIBROSIS - SYSTEMIC ENZYME INHIBITORS		
OFEV	T4	PA SP HD
SYSTEMIC ENZYME INHIBITORS		
JOENJA	T4	PA QL(2 TABS/DAY) SP
VIJOICE 125 MG TABLET	T4	PA QL(1 TAB/DAY) SP
VIJOICE 250 MG DAILY DOSE PACK	T4	PA QL(2 TABS/DAY) SP
VIJOICE 50 MG GRANULE PACKET	T4	PA QL(1 TAB/DAY) SP
VIJOICE 50 MG TABLET	T4	PA QL(1 TAB/DAY) SP
ZOKINVY	T4	PA QL(4 CAPS/DAY) SP
THYMIC STROMAL LYMPHOPOIETIN (TSLP) INHIBITORS		
TEZSPIRE 210 MG/1.91 ML PEN	T4	PA QL(1 PEN/28 DAYS) SP HD
TEZSPIRE 210 MG/1.91 ML SYRING	T4	PA SP HD
UNCLASSIFIED DRUG PRODUCTS (Blood Modifiers/Bleeding Disorders)		
SPLEEN TYROSINE KINASE INHIBITORS		
TAVALISSE	T4	PA SP
UNCLASSIFIED DRUG PRODUCTS (Blood Pressure/Heart Medications)		
ANTI-INFLAMMATORY-ANTIMITOTICS		
LODOCO	T3	PA
BRADYKININ B2 RECEPTOR ANTAGONISTS		
FIRAZYR (*icatibant acetate*)	T4	PA SP
icatibant acetate (Firazyr)	T4	PA SP HD

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UNCLASSIFIED DRUG PRODUCTS (Blood Pressure/Heart Medications) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
PLASMA KALLIKREIN INHIBITORS		
KALBITOR	T4	PA SP HD
ORLADEYO	T4	PA QL(1 CAP/DAY) SP
UNCLASSIFIED DRUG PRODUCTS (Cancer)		
CHEMOTHERAPY RESCUE/ANTIDOTE AGENTS		
leucovorin calcium	T1	CSL
mesna (Mesnex)	T4	SP CSL
MESNEX (*mesna*)	T4	SP CSL
VISTOGARD	T4	SP CSL
UNCLASSIFIED DRUG PRODUCTS (Dental Products)		
DENTAL AIDS AND PREPARATIONS		
chlorhexidine gluconate (Peridex)	T1	
PERIDEX (*periogard*)	T3	
triamcinolone 0.1% paste	T1	
triamcinolone acetonide	T1	
PERIODONTAL COLLAGENASE INHIBITORS		
doxycycline hyclate 20 mg tab	T1	
UNCLASSIFIED DRUG PRODUCTS (Diabetes)		
ANTIHYPERGLYCEMIC-SOD/GLUC COTRANSPORT2(SGLT2) INH		
INPEFA	T3	PA QL(1 TAB/DAY) HD
UNCLASSIFIED DRUG PRODUCTS (Erectile Dysfunction)		
DRUGS TO TREAT ERECTILE DYSFUNCTION (ED)		
avanafil (Stendra)	T1	QL(8 TABS/30 DAYS)
CAVERJECT	T3	PA QL(6 INJECTIONS/30 DAYS)
CIALIS 10 MG TABLET (*tadalafil*)	T3	ST QL(8 TABS/30 DAYS)
CIALIS 20 MG TABLET (*tadalafil*)	T3	ST QL(8 TABS/30 DAYS)
CIALIS 5 MG TABLET (*tadalafil*)	T3	ST QL(1 TAB/DAY)
EDEX	T3	PA QL(6 INJECTIONS/30 DAYS)
IFE-BIMIX 30/1	T2	
MUSE	T2	PA QL(6 SUPPS/30 DAYS)
sildenafil 100 mg, 50 mg, 20 mg tablet (Viagra)	T1	QL(8 TABS/30 DAYS) HD
STENDRA *(avanafil)*	T3	ST QL(8 TABS/30 DAYS)
tadalafil 2.5 mg tablet	T1	QL(1 TAB/DAY) HD

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UNCLASSIFIED DRUG PRODUCTS (Erectile Dysfunction) *(cont.)*		
DRUGS TO TREAT ERECTILE DYSFUNCTION (ED) *(cont.)*		
tadalafil 5 mg tablet (Cialis)	T1	QL(1 TAB/DAY) HD
tadalafil 10 mg tablet (Cialis)	T1	QL(8 TABS/30 DAYS) HD
tadalafil 20 mg tablet (Cialis)	T1	QL(8 TABS/30 DAYS) HD
vardenafil hcl	T1	QL(8 TABS/30 DAYS)
VIAGRA (*sildenafil citrate*)	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	T4	PA SP HD
LIVDELZI	T4	PA SP
SALIVA STIMULANT AGENTS		
NUMOISYN	T3	
THYROID HORMONE RECEPTOR (THR) AGONIST		
REZDIFFRA	T4	PA QL(1 TAB/DAY) SP HD
UNCLASSIFIED DRUG PRODUCTS (Hormonal Agents)		
GROWTH HORMONE RECEPTOR ANTAGONISTS		
SOMAVERT	T4	PA SP HD
HYPERPARATHYROID TX AGENTS - VITAMIN D ANALOG-TYPE		
doxercalciferol	T1	
paricalcitol	T4	SP HD
paricalcitol (Zemplar)	T4	SP HD
RAYALDEE	T3	
ZEMPLAR (*paricalcitol*)	T4	SP HD
MENOPAUSAL SYMPT SUPP-SEL ESTROGEN RECEP MODULATOR		
OSPHENA	T3	QL(30 TABS/30 DAYS) HD

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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)	T4	PA SP HD
KEVEYIS (*dichlorphenamide*)	T4	PA SP
AMMONIA INHIBITORS		
CARBAGLU *(carglumic acid)*	T4	SP HD
carglumic acid (Carbaglu)	T4	SP HD
AMYLOIDOSIS AGENTS-TRANSTHYRETIN (TTR) SUPPRESSION		
WAINUA	T4	PA QL(1 AUTO-INJ/28 DAYS) SP
ANTI-ALCOHOLIC PREPARATIONS		
acamprosate calcium	T1	
disulfiram	T1	
ANTI-FIBROTIC THERAPY - PYRIDONE ANALOGS		
ESBRIET	T4	PA SP HD
pirfenidone 267 mg capsule	T4	PA SP HD
pirfenidone 267 mg tablet (Esbriet)	T4	PA SP HD
PIRFENIDONE 534 MG TABLET	T4	PA SP HD
pirfenidone 801 mg tablet (Esbriet)	T4	PA SP HD
CI ESTERASE INHIBITORS		
BERINERT	T4	PA SP HD
CINRYZE	T4	PA SP HD
HAEGARDA	T4	PA SP HD
RUCONEST	T4	PA SP HD
CALCIMIMETIC,PARATHYROID CALCIUM ENHANCER		
cinacalcet hcl (Sensipar)	T4	SP
SENSIPAR (*cinacalcet hcl*)	T4	PA SP
COMPLEMENT INHIBITORS		
ZILBRYSQ	T4	PA QL(1 SYRINGE/DAY) SP
CRYOPRESERVATIVE AGENTS		
dimethyl sulfoxide	T1	
FACTOR XII INHIBITORS		
ANDEMBRY AUTOINJECTOR	T4	PA SP

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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	T4	PA SP HD
GENETIC DISORDER THERAPY - HDAC INHIBITOR		
DUVYZAT	T4	PA SP
GLUCOSYLCERAMIDE SYNTHASE (GCS) INHIBITOR		
CERDELGA	T4	PA SP HD
miglustat (Zavesca)	T4	PA SP HD
OPFOLDA	T4	PA QL(8 CAPS/30 DAYS) SP HD
ZAVESCA (*miglustat*)	T4	PA SP HD
HEAT SHOCK PROTEIN (HSP) MODULATING AGENTS		
MIPLYFFA	T4	PA SP
HYDROXYPHENYL-PYRUVATE DIOXYGENASE(HPPD) INHIBITOR		
nitisinone (Orfadin)	T4	PA SP HD
NITYR	T4	PA SP
ORFADIN	T4	PA SP
ORFADIN (*nitisinone*)	T4	PA SP
HYPOACTIVE SEXUAL DESIRE DISORDER (HSDD) TX AGENTS		
ADDYI	T3	PA QL(1 TAB/DAY)
VYLEESI	T4	PA QL(8 AUTO-INJS/30 DAYS) SP
MENOPAUSAL SYMPTOMS SUPPRESSANT - SSRIs		
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	T4	PA SP

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
METABOLIC DISEASE ENZYME REPLACEMENT, MOCD		
NULIBRY	T4	PA SP
METALLIC POISON, AGENTS TO TREAT		
CHEMET	T3	
CUVRIOR	T4	PA SP
deferasirox (Exjade)	T4	SP HD
deferasirox (Jadenu Sprinkle)	T4	SP HD
deferasirox (Jadenu)	T4	SP HD
*deferiprone (*Ferriprox *(*3 Times A Day*))*	T4	PA SP HD
deferiprone (Ferriprox)	T4	PA SP
EXJADE (*deferasirox*)	T4	PA SP HD
FERRIPROX	T4	PA SP
FERRIPROX (2 TIMES A DAY)	T4	PA SP
FERRIPROX (3 TIMES A DAY) (*deferiprone*)	T4	PA SP
FERRIPROX (*deferiprone*)	T4	PA SP
GALZIN	T4	SP
JADENU (*deferasirox*)	T4	PA SP HD
JADENU SPRINKLE (*deferasirox*)	T4	PA SP HD
RADIOGARDASE	T3	
SYPRINE (*trientine hcl*)	T4	PA SP HD
*trientine hcl 250 mg capsule (*Syprine*)*	T4	PA SP HD
TRIENTINE HCL 500 MG CAPSULE	T4	PA SP HD
NATRIURETIC PEPTIDES		
VOXZOGO	T4	PA SP HD
NEONATAL FC RECEPTOR (FCRN) INHIBITORS		
VYVGART HYTRULO	T4	PA SP HD
NUCLEAR FACTOR ERYTHROID 2-REL. FACTOR 2 ACTIVATOR		
SKYCLARYS	T4	PA QL(3 CAPS/DAY) SP
OINTMENT/CREAM BASES		
RADIAGEL	T1	
OXALOSIS AGENT - OXALATE INHIBITOR, SIRNA BASED		
RIVFLOZA 128 MG/0.8 ML SYRINGE	T4	PA QL(1 SYRINGE/30 DAYS) SP
RIVFLOZA 160 MG/ML SYRINGE	T4	PA QL(1 SYRINGE/30 DAYS) SP
RIVFLOZA 80 MG/0.5 ML VIAL	T4	PA SP

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PHARMACOLOGICAL CHAPERONE-ALPHA-GALACTOSID.A STABZ		
GALAFOLD	T4	PA SP HD
PKU TX AGENT-COFACTOR OF PHENYLALANINE HYDROXYLASE		
*javygtor 100 mg powder packet (*Kuvan*)*	T4	PA SP
*javygtor 100 mg tablet (*Kuvan*)*	T4	PA SP HD
*javygtor 500 mg powder packet (*Kuvan*)*	T4	PA SP
KUVAN (*sapropterin dihydrochloride*)	T4	PA SP HD
sapropterin dihydrochloride (Kuvan)	T4	PA SP HD
PROTEIN STABILIZERS		
ATTRUBY	T4	PA QL(4 TABS/DAY) SP
VYNDAMAX	T4	PA QL(1 CAP/DAY) SP HD
VYNDAQEL	T4	PA QL(4 CAPS/DAY) SP
RETINOIC ACID RECEPTOR (RAR) AGONISTS		
SOHONOS	T4	PA SP
SOLVENTS		
cvs isopropyl alcohol 91%	T1	
CVS ISOPROPYL ALCOHOL 91%	T1	
cvs isopropyl rub alcohol 70%	T1	
CVS ISOPROPYL RUB ALCOHOL 70%	T3	
eql isopropyl alcohol 91%	T1	
eql isopropyl rub alcohol 70%	T1	
FT ISOPROPYL ALCOHOL 91%	T1	
FT ISOPROPYL RUB ALCOHOL 70%	T3	
GNP ISOPROPYL ALCOHOL 70%	T3	
GNP ISOPROPYL ALCOHOL 91%	T1	
gnp isopropyl alcohol 99%	T1	
GS ISOPROPYL ALCOHOL 70%	T3	
GS ISOPROPYL ALCOHOL 91%	T1	
hm isopropyl alcohol 70%	T1	
hm isopropyl alcohol 91%	T1	
INSTACLEAN	T1	
ISOPROPANOL	T1	
isopropyl 70% alcohol	T1	
isopropyl alcohol	T1	

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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	T4	PA SP
UNCLASSIFIED DRUG PRODUCTS (Nutritional/Dietary)		
METABOLIC DEFICIENCY AGENTS		
betaine (Cystadane)	T4	SP
CARNITOR (*levocarnitine (with sugar)*)	T3	PA
CARNITOR (*levocarnitine*)	T3	PA
CARNITOR SF (*levocarnitine*)	T3	PA
CULTURELLE IBS COMPLETE SUPPRT	T3	
CYSTADANE (betaine)	T4	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*)	T4	PA QL(0.09 MLS/DAY) SP
FORTEO (*teriparatide*)	T4	PA QL(0.09 MLS/DAY) SP HD
teriparatide (Bonsity)	T4	PA QL(0.09 MLS/DAY) SP HD
teriparatide (Forteo)	T4	PA QL(0.09 MLS/DAY) SP HD

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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 (*risedronate sodium*)	T3	PA HD
alendronate sodium	T1	HD
alendronate sodium (Fosamax)	T1	HD
ATELVIA (*risedronate sodium dr*)	T3	ST HD
BINOSTO	T3	ST HD
EVISTA *(raloxifene hcl)*	T3	PA HD
FOSAMAX *(alendronate sodium)*	T3	ST HD
ibandronate sodium	T1	HD
raloxifene hcl (Evista)	T1	HD PPACA
risedronate sodium	T1	HD
risedronate sodium (Actonel)	T1	HD
risedronate sodium (Atelvia)	T1	HD
UNCLASSIFIED DRUG PRODUCTS (Pain Relief And Inflammatory Disease)		
ANTI-INFLAM. INTERLEUKIN-1 RECEPTOR ANTAGONIST		
ARCALYST	T4	PA SP HD
ANTI-INFLAMMATORY, INTERLEUKIN-1 BETA BLOCKERS		
ILARIS	T4	PA SP HD
FIBROMYALGIA AGENTS, SEROTONIN-NOREPINEPH RU INHIB		
SAVELLA	T2	
IMMUNOMODULATOR, B-LYMPHOCYTE STIM (BLYS)-SPEC INHIB		
BENLYSTA	T4	PA SP HD
UNCLASSIFIED DRUG PRODUCTS (Seizure Disorders)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
NEUROPATHIC AGENTS		
LYRICA CR (*pregabalin*)	T3	HD
pregabalin (Lyrica Cr)	T1	HD
UNCLASSIFIED DRUG PRODUCTS (Skin Conditions)		
INTERLEUKIN-13 (IL-13) INHIBITORS,MAB		
ADBRY	T4	PA SP HD
ADBRY AUTOINJECTOR	T4	PA SP HD
EBGLYSS PEN	T4	PA SP
EBGLYSS SYRINGE	T4	PA SP

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UNCLASSIFIED DRUG PRODUCTS (Skin Conditions) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
JANUS KINASE (JAK) INHIBITORS		
LEQSELVI	T4	PA QL(2 TABS/DAY) SP HD
LITFULO	T4	PA QL(1 CAP/DAY) SP HD
WOUND HEALING AGENTS, LOCAL		
FILSUVEZ	T4	PA SP
UNCLASSIFIED DRUG PRODUCTS (Substance Abuse)		
OPIOID WITHDRAWAL THER, ALPHA-2 ADRENERGIC AGONIST		
lofexidine hcl (Lucemyra)	T1	QL(192 TABS/30 DAYS)
LUCEMYRA *(lofexidine hcl)*	T2	QL(192 TABS/30 DAYS)
OPIOID WITHDRAWAL THERAPY AGENTS, OPIOID-TYPE		
buprenorphine hcl	T1	
buprenorphine hcl/naloxone hcl	T1	
buprenorphine hcl/naloxone hcl (Suboxone)	T1	
SUBOXONE (*buprenorphine-naloxone*)	T3	
ZUBSOLV	T2	
UNCLASSIFIED DRUG PRODUCTS (Transplant Medications)		
RHO KINASE INHIBITOR		
REZUROCK	T4	PA SP
UNCLASSIFIED DRUG PRODUCTS (Urinary Tract Conditions)		
BENIGN PROSTATIC HYPERTROPHY/MICTURITION AGENTS		
alfuzosin hcl (Uroxatral)	T1	HD
AVODART (*dutasteride*)	T3	PA HD
dutasteride (Avodart)	T1	HD
finasteride (Proscar)	T1	HD
PROSCAR (*finasteride*)	T3	PA HD
RAPAFLO 4 MG CAPSULE (*silodosin*)	T3	PA QL(1 CAP/DAY) HD
RAPAFLO 8 MG CAPSULE (*silodosin*)	T3	PA HD
silodosin 4 mg capsule (Rapaflo)	T1	QL(1 CAP/DAY) HD
silodosin 8 mg capsule (Rapaflo)	T1	HD
tamsulosin hcl	T1	HD
UROXATRAL (*alfuzosin hcl er*)	T3	PA HD
BPH 5-ALPHA-REDUCTASE INHIB-ALPHA1-ADRENOCEP ANTAG		
dutasteride/tamsulosin hcl (Jalyn)	T1	HD
JALYN (*dutasteride/tamsulosin hcl*)	T3	PA HD

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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	T4	SP
PROCYSBI	T4	PA SP HD
ENDOTHELIN RECEPTOR ANTAGONISTS		
VANRAFIA	T4	PA QL(1 TAB/DAY) SP
KIDNEY STONE AGENTS		
THIOLA (*tiopronin*)	T4	PA SP
THIOLA EC (*tiopronin*)	T4	PA SP
tiopronin (Thiola Ec)	T4	SP
tiopronin 100 mg tablet (Thiola)	T4	SP
tiopronin dr 100 mg tablet (Thiola Ec)	T4	SP HD
tiopronin dr 300 mg tablet (Thiola Ec)	T4	SP HD
OVERACTIVE BLADDER AGENTS, BETA-3 ADRENERGIC RECEP		
GEMTESA	T3	ST QL(1 TAB/DAY) HD
mirabegron er 25 mg tablet (Myrbetriq)	T1	QL(1 TAB/DAY) HD
mirabegron er 50 mg tablet (Myrbetriq)	T1	HD
MYRBETRIQ ER 25 MG TABLET *(mirabegron)*	T3	ST QL(1 TAB/DAY) HD
MYRBETRIQ ER 50 MG TABLET *(mirabegron)*	T3	ST HD
MYRBETRIQ ER 8 MG/ML SUSP	T3	ST HD
URINARY TRACT ANTI-SPASMODIC, M(3) SELECTIVE ANTAG.		
darifenacin er 15 mg tablet	T1	HD
darifenacin er 7.5 mg tablet (Enablex)	T1	QL(1 TAB/DAY) HD
solifenacin 10 mg tablet (Vesicare)	T1	HD
solifenacin 5 mg tablet (Vesicare)	T1	QL(1 TAB/DAY) HD
VESICARE 10 MG TABLET (*solifenacin succinate*)	T3	ST HD
VESICARE 5 MG TABLET (*solifenacin succinate*)	T3	ST QL(1 TAB/DAY) HD
VESICARE LS	T3	ST HD
URINARY TRACT ANTI-SPASMODIC/ANTI-INCONTINENCE AGENT		
DETROL (*tolterodine tartrate*)	T3	ST HD
DETROL LA 2 MG CAPSULE (*tolterodine tartrate er*)	T3	ST QL(1 CAP/DAY) HD
DETROL LA 4 MG CAPSULE (*tolterodine tartrate er*)	T3	ST HD

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UNCLASSIFIED DRUG PRODUCTS (Urinary Tract Conditions) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
URINARY TRACT ANTI-SPASMODIC/ANTI-INCONTINENCE AGENT *(cont.)*		
fesoterodine er 4 mg tablet (Toviaz)	T1	QL(1 TAB/DAY) HD
fesoterodine er 8 mg tablet (Toviaz)	T1	HD
flavoxate hcl	T1	HD
OXYBUTYNIN 2.5 MG TABLET	T3	PA HD
oxybutynin 5 mg tablet	T1	HD
oxybutynin 5 mg/5 ml soln cup	T1	HD
oxybutynin 5 mg/5 ml solution	T1	HD
oxybutynin 5 mg/5 ml syrup	T1	HD
oxybutynin chloride	T1	HD
OXYTROL	T3	ST HD
tolterodine tart er 2 mg cap (Detrol La)	T1	QL(1 CAP/DAY) HD
tolterodine tart er 4 mg cap (Detrol La)	T1	HD
tolterodine tartrate (Detrol)	T1	HD
TOVIAZ ER 4 MG TABLET (*fesoterodine fumarate*)	T3	PA QL(1 TAB/DAY) HD
TOVIAZ ER 8 MG TABLET (*fesoterodine fumarate*)	T3	PA HD
trospium chloride	T1	HD
UNCLASSIFIED DRUG PRODUCTS (Weight Management)		
APPETITE STIM. FOR ANOREXIA, CACHEXIA, WASTING SYND.		
megestrol 400 mg/10 ml cup	T1	
megestrol 625 mg/5 ml susp	T1	
megestrol acet 40 mg/ml susp	T1	
megestrol acet 400 mg/10 ml	T1	
VITAMINS (Nutritional/Dietary)		
ANTIOXIDANT MULTIVITAMIN COMBINATIONS		
MACUVEX	T2	
MACUZIN	T2	
FOLIC ACID PREPARATIONS		
ENLYTE	T2	
folic acid	T1	
folic acid/b6/ca phos/ginger	T1	
GERIATRIC VITAMIN PREPARATIONS		
REQ49+	T2	

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VITAMINS (Nutritional/Dietary) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
MULTIVITAMIN PREPARATIONS		
ANIMI-3	T2	
BACMIN	T2	
CONCEPT DHA *(mvn-min75/iron/iron ps/om3/dha)*	T3	
CONCEPT OB (*mvn-min 74/iron fum/iron/fa*)	T2	
CORVITE	T2	
DIALYVITE 800 WITH IRON	T2	
ENBRACE HR	T2	
folic/mvi ther-min/lycop/lut	T1	
FORTAVIT	T2	
multivit 47/iron/folate 1/dha	T1	
*multivit no.18/iron no.1/folic (*Tandem Plus*)*	T1	
multivit no.51/iron/folic acid	T1	
multivit-min69/iron/folic acid	T1	
multivit-mins no.7/folic acid	T1	
mv-mins 71/iron/folic no.1/dha	T1	
mvn no.53/iron/folic/dss/dha	T1	
*mvn-min 74/iron fum/iron/fa (*Concept Ob*)*	T1	
*mvn-min75/iron/iron ps/om3/dha (*Concept Dha*)*	T1	
NEEVODHA	T2	
NESTABS ONE	T2	
NIVA-PLUS (*multivit-min 60/iron fum/folic*)	T1	
OB COMPLETE	T3	
om-3/dha/epa/b12/fa/b6/phytost	T1	
PRENATE AM	T2	
PRENATE CHEWABLE	T2	
PRENATE ESSENTIAL	T2	
PROTECT IRON	T2	
STROVITE FORTE (*multivit,iron,min 5/folic acid*)	T2	
STROVITE ONE	T2	
TANDEM PLUS (*multivit no.18/iron no.1/folic*)	T3	
UDAMIN SP	T2	

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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
ped mvit a,c,d3 no.21/fluoride	T1	PPACA
pedi multivit no.12 w-fluoride	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		
b comp no3/folic/c/biotin/zinc	T1	HD
b complex 11/folic/c/biot/zinc	T1	HD
cyanocobalamin/folic ac/vit b6	T1	HD
*cyanocobalamin/folic ac/vit b6 (*Niva-Fol*)*	T1	HD
DIALYVITE 3000	T2	HD
DIALYVITE 5000	T2	HD
DIALYVITE SUPREME D	T2	HD
folic acid/vit b complex and c	T1	HD
folic acid/vit b complex and c	T2	HD
folic acid/vit bcomp,c/cu/zinc	T1	HD
METHAVER	T2	HD
NEPHRON FA	T3	HD
NIVA-FOL (*cyanocobalamin/folic ac/vit b6*)	T1	HD
VITAL-D RX	T2	HD
VITA-RESPA	T2	HD
VITAMIN BI2 PREPARATIONS		
cyanocobalamin (vitamin b-12)	T1	
*cyanocobalamin (vitamin b-12) (*Nascobal*)*	T1	
NASCOBAL (*cyanocobalamin (vitamin b-12)*)	T3	PA

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
VITAMIN D PREPARATIONS		
calcitriol 0.25 mcg capsule	T1	
calcitriol 0.5 mcg capsule	T1	
calcitriol 1 mcg/ml solution	T1	
ergocalciferol (vitamin d2)	T1	HD
VITAMIN K PREPARATIONS		
MEPHYTON (*phytonadione*)	T3	
phytonadione (vit k1) (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
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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.

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Symbols

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

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

1. App/online store terms and mobile phone carrier/data charges apply. Customers under age 13 (and/or their parent/guardian) will not be able to register at myCigna.com.
2. 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.
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.
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.

927837 n CA Legacy (Standard) 4-Tier Specialty 12/25

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

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 Viet, 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 문의하십 시오.

Tagalog – PAUNAWA: Kung ikaw ay nagsasalita ng Tagalog, ang mga libreng serbisyo ng tulong sa wika ay magagamit para sa iyo. Ang mga angkop na pantulong na kagamitan at serbisyo upang magbigay ng impormasyon sa mga naa-access na format ay magagamit din ng libre. Tumawag sa 1-800-244-6224 (TTY: Tumawag sa 711) o makipag-usap sa iyong tagapagbigay.

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

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

French Creole – ATANSYON: Si ou pale Kreyòl Ayisyen, sèvis asistans lang gratis yo disponib pou ou. Ekipman ak sèvis adisyonèl ki apwopriye pou bay enfòmasyon nan fòma 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 Sprachassistenzdienste 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) - توجه: همچنین، وسایل و خدمات کمکی مناسب برای در دسترس است. خدمات رایگان کمک زبان برای شما صحبت می‌کنید د، 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