



Cigna Healthcare Total Savings 3-Tier Prescription Drug List

Coverage as of January 1, 2026

For the State of California

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

View your drug list online: Cigna.com/PDL

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

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

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 This drug list is subject to change and all prior versions are no longer in effect.



What's Inside?	Page
Information about this drug list	3
· Frequently asked questions (FAQs)	3
· Words you may need to know	11
· About this drug list	13
· How to read this drug list	13
· How to find your medication	16
List of prescription medications	19
Exclusions and limitations for coverage	170
Index of medications	171

View your drug list online, 24/7

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

- You can use the Price a Medication tool on the myCigna App¹ or **myCigna.com** to see the most up-to-date list of the medications your plan covers.
- You can also see a pdf of this document on **Cigna.com/PDL**. Click on the dropdown next to "Drug Lists for Employer Plans." Scroll down to the section for California Employer Drug Lists; then click on **California Total Savings 3 Tier (CDI) [PDF]**.

Questions?

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

* Drug list created: originally created 10/01/2011

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

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

Information about this drug list

Frequently asked questions (FAQs)

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

Q. How often is the drug list updated? How do I know if my medication coverage changed?

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

- **Moving a medication to a lower cost tier.** This can happen at any time during the year.
- **Moving a brand medication to a higher cost tier when a generic comes out.** This can happen at any time during the year.
- **Moving a medication to a higher cost tier and/or no longer covering a medication.** This typically happens twice a year on January 1 and July 1.
- **Adding extra coverage rules (requirements) to a medication.** This typically happens twice a year on January 1 and July 1.

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

Q. Why doesn't my plan cover certain medications?

A. To help lower your overall health care costs, your plan doesn't cover certain high-cost brand-name medications that have lower-cost alternatives that can treat the same condition. If your medication isn't covered and your doctor feels a different medication isn't right for you, your doctor's office can ask us to cover it through our review process.

There are also some medications and products that your plan won't cover for any reason because they're a "plan (or benefit) exclusion." This means the medication or product isn't on your drug list, and there's no option to ask us to cover it through our review process.

For example, your plan doesn't cover (or "excludes"):

- Prescription medications that treat allergies (ex. Allegra, Clarinex, Xyzal and generics) and heartburn/stomach acid conditions (ex. Nexium, Prilosec OTC and generics).
- Medications that treat lifestyle conditions, such as infertility, erectile dysfunction and smoking cessation.²
- Medications that the U.S. Food and Drug Administration (FDA) hasn't approved.

Q. How do you decide which medications to cover?

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

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

Information about this drug list

Frequently asked questions (FAQs) (cont.)

Q. Why do certain medications need approval before my plan will cover them?

A. The review process helps make sure you're getting coverage for the right medication, at the right cost, in the right amount and for the right situation.

Q. How do I know if a medication needs approval?

A. Check your drug list or log in to the myCigna App or **myCigna.com** and use the Price a Medication tool. If the medication has:

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

Q. What types of medications typically need approval?

A. Medications that:

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

Q. What types of medications typically have quantity limits?

A. Medications that are often:

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

Q. What medications are part of Step Therapy?

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

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

Q. Why does my medication have an age requirement?

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

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

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

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

Information about this drug list

Frequently asked questions (FAQs) (cont.)

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

- **For non-urgent requests**, we'll let you and your doctor know within 72 hours of the decision. If approved, coverage will be provided until the prescription runs out (including refills).
- **For urgent requests based on exigent circumstances**, we'll let you and your doctor know within 24 hours of the decision. If approved, coverage will be provided for the duration of the exigency. If we don't respond to a completed prior authorization exception request within 72 hours of receiving a non-urgent request and 24 hours of receiving a request based on exigent circumstances, the request will be considered approved and your plan can't deny coverage of the medication. Also, if you've already received approval for your plan to cover your medication, we can't limit or exclude coverage for that medication if your doctor continues to prescribe it to treat your condition (as long as the medication is appropriately prescribed and is safe and effective in treating your condition).

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

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

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

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

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

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

A. If you and your doctor feel an alternative medication won't work for you, your doctor can ask us to consider approving coverage of your current medication. Ask your doctor's office to contact us

Information about this drug list

Frequently asked questions (FAQs) (cont.)

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

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

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

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

Your Step Therapy rights under California State law:

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

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

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

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

Information about this drug list

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

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

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

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

A. Yes.

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

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

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

Q. What are preventive medications?

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

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

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

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

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

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

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

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

Q. What's a cost-share?

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

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

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

Information about this drug list

Frequently asked questions (FAQs) (cont.)

Q. What's a generic medication?

A. A generic is the same as its brand-name version. It has the same active ingredient, strength and dosage form, treats the same condition(s), and works in the same way – and typically costs less.⁴ Generics are typically sold under their chemical or scientific name, instead of the brand name.

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

A. Yes. A generic medication works in the same way and provides the same clinical benefit as the brand-name medication.⁴

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

A. The generic and brand-name medication may⁴:

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

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

Q. What is a "biosimilar" medication?

A. A biosimilar is "highly similar" to its original biologic medication, which is also known as a reference product, that the FDA has already approved. Even though biosimilars aren't identical to the original medication, they're used to treat the same conditions, and provide the same clinical outcomes and treatment benefits. There are no clinical differences in how safe they are to use and how well they work. They also typically cost less.⁵

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

A. There are thousands of retail pharmacies in your plan's network. They include local pharmacies, grocery stores, retail chains and wholesale

warehouse stores – all places where you may already shop. And some stores are open 24-hours. To find an in-network pharmacy near you, log in to the myCigna App or **myCigna.com**. Then click on the Prescriptions tab and choose "Find a Pharmacy" from the dropdown list.

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

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

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

A. It depends on your plan. Some plans require you to fill maintenance medications through Express Scripts[®] Pharmacy and/or specialty medications through Accredo[®] Specialty Pharmacy for them to be covered.⁶ Log in to the myCigna App or **myCigna.com**, or check your plan materials, to find out what your plan requires.

Q. Can I fill my prescriptions by mail?

A. Yes, as long as your plan offers home delivery.⁶

Fill maintenance medications through Express Scripts Pharmacy

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

- Easily order, manage, track and pay for your medications on your phone or online.
- Get standard shipping at no extra cost.⁷
- Fill up to a 90-day supply at one time.
- Talk with a pharmacist, 24/7.
- Sign up for automatic refills or refill reminders so you don't miss a dose.⁸
- Use a payment plan (if you need it).

Information about this drug list

Frequently asked questions (FAQs) (cont.)

Here are two easy ways to get started:

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

Fill specialty medications through Accredo Specialty Pharmacy

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

- Talk with specially-trained pharmacists and nurses, 24/7.
- Get fast shipping at no extra cost.⁷
- Sign up for refills and reminders. Some refills can be done by text.⁹
- Get help paying for your medication (if you need it).
- Manage and track your medications online.

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

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

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

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

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

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

You may also be able to use Accredo to fill your prescription; they have access to most specialty medications.⁶ Call Accredo at **877.826.7657**, Monday–Friday, 7:00 am–10:00 pm CST or Saturdays, 7:00 am–4:00 pm CST, for more information.

Q. How do I fill my prescription?

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

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

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

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

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

Information about this drug list

Frequently asked questions (FAQs) (cont.)

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

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

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

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

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

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

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

- Medications that you fill at the pharmacy and take yourself are typically covered under the pharmacy benefit.

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

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

Q. I take an oral cancer medication. How much will it cost me to fill?

A. On January 1, 2015, California passed a bill limiting the cost-share for oral chemotherapy medications. This means that if you have both your medical and pharmacy benefits through Cigna Healthcare, here's how certain oral cancer medications are covered:

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

Information about this drug list

Frequently asked questions (FAQs) (cont.)

Q. How are medications, devices and FDA-approved diabetic, contraceptive and federally-mandated products covered under the pharmacy benefit?

A. Here is how these products are covered under the pharmacy benefit:

- **Preventive care medications and products covered under the Patient Protection and Affordable Care Act (PPACA), also known as “health care reform:”**
 - **Contraceptives:** Covered at 100%, or no cost-share (\$0) to you. Certain prescription contraceptives are available at their applicable cost-share.
 - **Tobacco cessation products:** Up to two (2) 90-day courses of treatment per plan year are covered at 100%, or no cost-share (\$0) to you. Certain prescription tobacco cessation products are available at their applicable cost-share.
 - **Certain vitamins:** Covered at 100%, or no cost-share (\$0) to you. All other prescription vitamins are available at their applicable cost-share and deductible (if applicable).
- **Certain over-the-counter (OTC) products:** If you have a prescription from your doctor, these are covered at 100%, or no cost-share (\$0) to you. All other OTC products are excluded from coverage.
- **Oral fertility medications:** Covered at their applicable tier cost-share. For some plans, injectable fertility medications are covered under the medical benefit.
- **Generic preventive care medications:** Covered at 100%, or no cost-share (\$0) to you before you meet your deductible. You'll pay your deductible and applicable cost-share to fill a preferred brand and/or non-preferred brand preventive care medication.
- **Diabetic supplies:** Covered at their applicable cost-share.
- **Growth Hormones:** Need approval from Cigna Healthcare before your plan will cover them (prior authorization). If approved, you'll pay your applicable tier cost-share to fill the medication.
- **Vaccines:** Vaccines are now covered under the pharmacy benefit. Not all plans cover vaccines in the same way. Log in to the myCigna App or **myCigna.com**, or check your plan materials, to find out how your specific plan covers them.
- **Compounded medications:** If the medication is more than \$200, you'll need approval from Cigna Healthcare before your plan will cover them (prior authorization). If approved, you'll pay your applicable tier cost-share to fill the medication.

Words you may need to know

- **Brand name drug:** A drug that is marketed under a proprietary, trademark-protected name. A brand name drug is listed in this formulary in all CAPITAL letters.
- **Coinsurance:** A percentage of the cost of a covered health care benefit that you pay after you have paid the deductible, if a deductible applies to the health care benefit.
- **Copayment:** A fixed dollar amount that you pay for a covered health care benefit after you have paid the deductible, if a deductible applies to the health care benefit.
- **Deductible:** The amount you pay for covered health care benefits that are subject to the deductible before your health insurer begins to pay. If your health insurance policy has a deductible, it may have either one deductible or separate deductibles for medical benefits and prescription drug benefits. After you pay your deductible, you usually pay only a copayment or coinsurance for covered health care benefits. Your insurance company pays the rest.

Information about this drug list

Words you may need to know (cont.)

- **Drug tier:** A group of prescription drugs that correspond to a specified cost sharing tier in your health insurance policy. The drug tier in which a prescription drug is placed determines your portion of the cost for the drug.
- **Exception request:** A request for coverage of a non-formulary drug. If you, your designee, or your prescribing health care provider submits a request for coverage of a non-formulary drug, your insurer must cover the non-formulary drug when it is medically necessary for you to take the drug.
- **Exigent circumstances:** When you are suffering from a medical condition that may seriously jeopardize your life, health, or ability to regain maximum function, or when you are undergoing a current course of treatment using a non-formulary drug.
- **Formulary or prescription drug list:** The list of drugs that is covered by your health insurance policy under the prescription drug benefit of the policy.
- **Generic drug:** A drug that is the same as its brand name drug equivalent in dosage, strength, effect, how it is taken, quality, safety, and intended use. A generic drug is listed in this formulary in italicized lowercase letters.
- **Medically Necessary:** Health care benefits needed to diagnose, treat, or prevent a medical condition or its symptoms and that meet accepted standards of medicine. Health insurance usually does not cover health care benefits that are not medically necessary.
- **Non-formulary drug:** A prescription drug that is not listed on this formulary.
- **Out-of-pocket costs:** Your expenses for health care benefits that aren't reimbursed by your health insurance. Out-of-pocket costs include deductibles, copayments, and coinsurance for covered health care benefits, plus all costs for health care benefits that are not covered.
- **Prescribing provider:** A health care provider who can write a prescription for a drug to diagnose, treat, or prevent a medical condition.
- **Prescription:** An oral, written, or electronic order from a prescribing provider authorizing a prescription drug to be provided to a specific individual.
- **Prescription drug:** A drug that by law requires a prescription.
- **Prior Authorization:** A decision by your health insurer that a health care benefit is medically necessary for you. If a prescription drug is subject to prior authorization in this formulary, your prescribing provider must request approval from your health insurer to cover the drug before you fill your prescription. Your health insurer must grant a prior authorization request when it is medically necessary for you to take the drug.
- **Step Therapy:** A specific sequence in which prescription drugs for a particular medical condition must be tried. If a drug is subject to step therapy in this formulary, you may have to try one or more other drugs before your health insurance policy will cover that drug for your medical condition. If your prescribing provider submits a request for an exception to the step therapy requirement, your health insurer must grant the request when it is medically necessary for you to take the drug.
- **Quantity Limits:** For some medications, your plan will only cover up to a certain amount over a certain length of time. For example, 30mg per day for 30 days. Quantity limits help to make sure you're receiving coverage for the right medication, in the right amount, and for the right situation. Your plan will only cover a larger amount if your doctor requests and receives approval from Cigna Healthcare.
- **Age Requirements:** For certain medications, you must be within a specific age range for your plan to cover them. This is because some medications aren't considered clinically appropriate for individuals who aren't within that age range.

Information about this drug list

About this drug list

This is a list of the most commonly prescribed medications covered on the Cigna Healthcare Total Savings 3-Tier Prescription Drug List as of January 1, 2026. **The drug list is updated often;** so, not all of the medications your plan covers may be listed here. Also, your plan may not cover all of these medications. Log in to the myCigna App or **myCigna.com** to see which medications your plan covers.

Important: Your plan doesn't cover prescription medications that treat allergies (ex. Allegra[®], Clarinex[®], Xyzal[®] and generics) and heartburn/stomach acid conditions (ex. Nexium[®], Prilosec OTC[®] and generics). Instead, you can buy them as over-the-counter (OTC) products at your local pharmacy or retail store without a prescription.

How to read this drug list

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

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

Tiers

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

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

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

Information about this drug list

How to read this drug list (cont.)

Letters (acronyms) in the Notes column

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

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

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

Information about this drug list

How to read this drug list (cont.)

Use the table below to understand how medications are covered on the Cigna Healthcare Total Savings 3-Tier Prescription Drug List.*

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

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

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

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

Prescription drug name is the name of the medication.

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

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

Generic medications are in **lowercase italics**.

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

Information about this drug list

How to find your medication

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

Condition	Page	Condition	Page
Analgesics (Pain Relief and Inflammatory Disease)	19-23	Anti-Neoplastics (Cancer)	47-55
Analgesics (Urinary Tract Conditions)	23	Anti-Neoplastics (Skin Conditions)	55
Anesthetics (Miscellaneous)	23	Anti-Obesity Drugs (Weight Management)	55, 56
Anesthetics (Pain Relief and Inflammatory Disease)	23	Anti-Parasitics (Eye Conditions)	56
Anesthetics (Urinary Tract Conditions)	24	Anti-Parasitics (Infections)	57
Anti-Allergy (Allergy and Nasal Sprays)	24	Anti-Parkinson's Drugs (Parkinson's Disease)	57-58
Anti-Arthritics (Pain Relief and Inflammatory Disease)	24-27	Anti-Platelet Drugs (Blood Thinners/Anti-Clotting)	58, 59
Anti-Asthmatics (Asthma/COPD/Respiratory)	27-30	Antivirals (Aids/Hiv)	59-61
Antibiotics (Ear Medications)	30	Antivirals (Eye Conditions)	61
Antibiotics (Eye Conditions)	30, 31	Antivirals (Infections)	61-63
Antibiotics (Infections)	31-35	Autonomic Drugs (Allergy/Nasal Sprays)	63
Antibiotics (Skin Conditions)	36	Autonomic Drugs (Alzheimer's Disease)	63, 64
Anti-Coagulants (Blood Thinners/Anti-Clotting)	36-38	Autonomic Drugs (Attention Deficit Hyperactivity Disorder)	64
Antidotes (Gastrointestinal/Heartburn)	38	Autonomic Drugs (Blood Pressure/Heart Medications)	64, 65
Antidotes (Substance Abuse)	38, 39	Autonomic Drugs (Urinary Tract Conditions)	65
Anti-Fungals (Eye Conditions)	39	Biologicals (Allergy/Nasal Sprays)	65
Anti-Fungals (Feminine Products)	39	Biologicals (Blood Pressure/Heart Medications)	65
Anti-Fungals (Infections)	39, 40	Biologicals (Miscellaneous)	65
Anti-Fungals (Skin Conditions)	40	Biologicals (Vaccines)	65-69
Antihistamines and Decongestant Combination (Allergy/Nasal Sprays)	40	Blood (Blood Modifiers/Bleeding Disorders)	69, 70
Antihistamines (Allergy/Nasal Sprays)	41	Blood (Blood Thinners/Anti-Clotting)	71
Anti-Hyperglycemics (Diabetes)	41-44	Cardiac Drugs (Blood Pressure/Heart Medications)	71-73
Anti-Infectives (Feminine Products)	45	Cardiovascular (Asthma/COPD/Respiratory)	73, 74
Anti-Infectives/Miscellaneous (Infections)	45	Cardiovascular (Blood Pressure/Heart Medications)	74-78
Anti-Infectives/Miscellaneous (Miscellaneous)	46	Cardiovascular (Cholesterol Medications)	78-81
Anti-Inflammatory Tumor Necrosis Factor Inhibiting Agents (Pain Relief and Inflammatory Disease)	46, 47	CARDIOVASCULAR (Miscellaneous)	81
		CNS Drugs (Alzheimer's Disease)	81
		CNS Drugs (Miscellaneous)	81, 82

Information about this drug list

How to find your medication (cont.)

Condition	Page	Condition	Page
CNS Drugs (Multiple Sclerosis)	82, 83	Hormones (Osteoporosis Products)	112
CNS Drugs (Pain Relief and Inflammatory Disease)	83	Immunosuppressants (Pain Relief and Inflammatory Disease)	112, 113
CNS Drugs (Seizure Disorders)	83-87	Immunosuppressants (Skin Conditions)	112
CNS Drugs (Sleep Disorders/Sedatives)	87	Immunosuppressants (Transplant Medications)	112, 113
Colony Stimulating Factors (Blood Modifiers/ Bleeding Disorders)	87, 88	Miscellaneous Medical Supplies, Devices, Non- Drug (Diabetes)	113-128
Colony Stimulating Factors (Blood Pressure/ Heart Medications)	88	Miscellaneous Medical Supplies, Devices, Non- Drug (Miscellaneous)	128-135
Colony Stimulating Factors (Cancer)	88	Muscle Relaxants (Pain Relief and Inflammatory Disease)	135, 136
Contraceptives (Contraception Products)	88, 89	Prenatal Vitamins (Nutritional/Dietary)	136, 138
Cough/Cold Preparations (Allergy/Nasal Sprays)	90	Psychotherapeutic Drugs (Anxiety/Depression/ Bipolar Disorder)	139- 143
Cough/Cold Preparations (Cough/Cold Medications)	90	Psychotherapeutic Drugs (Attention Deficit Hyperactivity Disorder)	143, 144
Diagnostic (Diabetes)	91	Psychotherapeutic Drugs (Schizophrenia/Anti- Psychotics)	145-147
Diagnostic (Miscellaneous)	91-93	Psychotherapeutic Drugs (Seizure Disorders)	147
Diuretics (Diuretics)	93, 94	Psychotherapeutic Drugs (Sleep Disorders/ Sedatives)	147
EENT Preps (Allergy/Nasal Sprays)	94, 95	Sedative/Hypnotics (Sleep Disorders/Sedatives)	147, 148
EENT Preps (Ear Medications)	95	Skin Preps (Miscellaneous)	148, 149
EENT Preps (Eye Conditions)	95-98	Skin Preps (Pain Relief and Inflammatory Disease)	149, 150
Elect/Caloric/H2O (Cholesterol Medications)	98	Skin Preps (Skin Conditions)	150- 156
Elect/Caloric/H2O (Dental Products)	98	Smoking Deterrents (Smoking Cessation)	156, 157
Elect/Caloric/H2O (Diabetes)	98	Thyroid Prep (Hormonal Agents)	157, 158
Elect/Caloric/H2O (Miscellaneous)	99	Unclassified Drug Products (Aids/Hiv)	158
Elect/Caloric/H2O (Nutritional/Dietary)	99-101	Unclassified Drug Products (Asthma/COPD/ Respiratory)	158
Elect/Caloric/H2O (Urinary Tract Conditions)	101, 102	Unclassified Drug Products (Blood Modifiers/ Bleeding Disorders)	159
Gastrointestinal (Cholesterol Medications)	102	Unclassified Drug Products (Blood Pressure/ Heart Medications)	159
Gastrointestinal (Gastrointestinal/Heartburn)	102- 107	Unclassified Drug Products (Cancer)	159
Gastrointestinal (Pain Relief and Inflammatory Disease)	107		
Hormones (Gastrointestinal/Heartburn)	107		
Hormones (Hormonal Agents)	107-111		
Hormones (Infertility)	111, 112		
Hormones (Miscellaneous)	112		

Information about this drug list

How to find your medication (cont.)

Condition	Page
Unclassified Drug Products (Dental Products)	159
Unclassified Drug Products (Erectile Dysfunction)	159, 160
Unclassified Drug Products (Gastrointestinal/ Heartburn)	160
Unclassified Drug Products (Hormonal Agents)	160
Unclassified Drug Products (Miscellaneous)	160- 164
Unclassified Drug Products (Osteoporosis Products)	164
Unclassified Drug Products (Pain Relief And Inflammatory Disease)	165
Unclassified Drug Products (Skin Conditions)	165
Unclassified Drug Products (Substance Abuse)	165
Unclassified Drug Products (Transplant Medications)	165
Unclassified Drug Products (Urinary Tract Conditions)	165, 167
Unclassified Drug Products (Weight Management)	167
Vitamins (Nutritional/Dietary)	167, 169

List of Prescription Medications

ANALGESICS (Pain Relief and Inflammatory Disease)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANALGESIC, SALICYLATE, BARBITURATE, XANTHINE COMB.		
<i>butalbital/acetaminophen</i>	T1	
<i>butalbital-acetaminophen 50-325</i>	T1	
ANALGESIC, SALICYLATE, BARBITURATE, XANTHINE COMB.		
<i>butalbital-aspirin-caffeine cp</i>	T1	QL(6 CAPS/DAY)
<i>butalbital-aspirin-caffeine tb</i>	T1	QL(6 TABS/DAY)
ANALGESIC, NON-SALICYLATE, BARBITURATE, XANTHINE COMB.		
<i>butalb/acetaminophen/caffeine (Esgic)</i>	T3	QL(6 CAPS/DAY)
<i>butalb-acetamin-caff 50-300-40 (Fioricet)</i>	T1	QL(6 CAPS/DAY)
<i>butalb-acetamin-caff 50-325-40</i>	T1	QL(6 TABS/DAY)
<i>butalb-acetamin-caff 50-325-40 (Esgic)</i>	T1	QL(6 CAPS/DAY)
ANALGESIC/ANTIPYRETICS, SALICYLATES		
<i>diflunisal</i>	T1	HD
ANTI-MIGRAINE PREPARATIONS		
AIMOVIG AUTOINJECTOR	T2	PA
AJOVY AUTOINJECTOR	T2	PA
AJOVY AUTOINJECTOR (3 PACK)	T2	PA
AJOVY SYRINGE	T2	PA
<i>almotriptan malate</i>	T1	QL(12 TABS/30 DAYS)
<i>dihydroergotamine 1 mg/ml amp</i>	T1	QL
<i>eletriptan hydrobromide (Relpax)</i>	T1	QL(6 TABS/30 DAYS)
EMGALITY PEN	T2	PA
EMGALITY SYRINGE	T2	PA
<i>ergotamine tartrate/caffeine</i>	T1	QL(40 TABS/28 DAYS)
<i>frovatriptan succinate (Frova)</i>	T1	QL(18 TABS/30 DAYS)
<i>naratriptan hcl</i>	T1	QL(9 TABS/30 DAYS)
NURTEC ODT	T2	PA QL(16 TABS/30 DAYS)
QULIPTA	T2	PA QL(1 TAB/DAY)
<i>rizatriptan</i>	T1	QL(12 TABS/30 DAYS)
<i>rizatriptan benzoate (Maxalt Mlt)</i>	T1	QL(12 TABS/30 DAYS)
<i>rizatriptan benzoate (Maxalt)</i>	T1	QL(12 TABS/30 DAYS)
<i>sumatriptan</i>	T1	QL(12 UNITS/30 DAYS)

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-MIGRAINE PREPARATIONS (cont.)		
<i>sumatriptan 4 mg/0.5 ml inject (Imitrex)</i>	T1	QL(4 MLS/30 DAYS)
<i>sumatriptan 6 mg/0.5 ml vial</i>	T1	QL(5 MLS/30 DAYS)
<i>sumatriptan 6 mg/0.5ml autoinj (Imitrex)</i>	T1	QL(4 MLS/30 DAYS)
<i>sumatriptan succ 100 mg tablet (Imitrex)</i>	T1	QL(9 TABS/30 DAYS)
<i>sumatriptan succ 25 mg tablet (Imitrex)</i>	T1	QL(9 TABS/30 DAYS)
<i>sumatriptan succ 50 mg tablet (Imitrex)</i>	T1	QL(9 TABS/30 DAYS)
<i>sumatriptan succ/naproxen sod (Treximet)</i>	T1	QL(18 TABS/30 DAYS)
UBRELVY	T2	PA QL(0.67 TABS/DAY)
ZAVZPRET	T2	PA QL(6 UNITS/30 DAYS)
<i>zolmitriptan</i>	T1	QL(6 TABS/30 DAYS)
<i>zolmitriptan 2.5 mg tablet (Zomig)</i>	T1	QL(6 TABS/30 DAYS)
<i>zolmitriptan 5 mg tablet (Zomig)</i>	T1	QL(6 TABS/30 DAYS)
NSAIDS, CYCLOOXYGENASE INHIBITOR-TYPE ANALGESICS		
<i>diclofenac pot 50 mg tablet</i>	T1	HD
<i>diclofenac potassium</i>	T1	HD
<i>ketorolac 10 mg tablet</i>	T1	QL(20 TABS/30 DAYS)
<i>ketorolac 15 mg/ml syringe</i>	T1	QL(8 MLS/DAY)
<i>ketorolac 15 mg/ml vial</i>	T1	QL(8 MLS/DAY)
<i>ketorolac 30 mg/ml syringe</i>	T1	QL(4 MLS/DAY)
<i>ketorolac 30 mg/ml vial</i>	T1	QL(4 MLS/DAY)
<i>ketorolac 300 mg/10 ml vial</i>	T1	
<i>ketorolac 60 mg/2 ml syringe</i>	T1	QL(4 MLS/DAY)
<i>ketorolac 60 mg/2 ml vial</i>	T1	QL(4 MLS/DAY)
OPIOID ANALGESIC AND NON-SALICYLATE ANALGESICS		
<i>acetamin-codein 300-30 mg/12.5</i>	T1	
<i>acetaminop-codeine 120-12 mg/5</i>	T1	
<i>acetaminophen-cod #2 tablet</i>	T1	PA
<i>acetaminophen-cod #3 tablet</i>	T1	PA
<i>acetaminophen-cod #4 tablet</i>	T1	PA
<i>hydrocodone/acetaminophen</i>	T1	PA
<i>hydrocodone/acetaminophen (Lortab)</i>	T1	PA

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPIOID ANALGESIC AND NON-SALICYLATE ANALGESICS (cont.)		
HYDROCODONE-ACETAMINOPHEN	T1	PA
LORTAB (hydrocodone/acetaminophen)	T1	PA
NALOCET	T1	PA
oxycodone hcl/acetaminophen	T1	PA
oxycodone hcl/acetaminophen (Percocet)	T1	PA
PRIMLEV	T1	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
fentanyl	T1	PA
fentanyl citrate	T1	PA
FENTANYL CITRATE	T1	PA
fentanyl citrate (Actiq)	T1	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

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPIOID ANALGESICS (cont.)		
LAZANDA	T3	PA
<i>meperidine hcl</i>	T1	PA
<i>methadone hcl</i>	T1	PA
<i>morphine sulfate</i>	T1	PA
<i>morphine sulfate (Ms Contin)</i>	T1	PA
MS CONTIN (<i>morphine sulfate</i>)	T3	PA
NUCYNTA	T3	PA
NUCYNTA ER	T3	PA
<i>opium/belladonna alkaloids</i>	T1	PA
OXAYDO	T3	PA
<i>oxycodone hcl (ir) 10 mg tab</i>	T1	PA
<i>oxycodone hcl (ir) 15 mg tab (Roxicodone)</i>	T1	PA
<i>oxycodone hcl (ir) 20 mg tab</i>	T1	PA
<i>oxycodone hcl (ir) 30 mg tab (Roxicodone)</i>	T1	PA
<i>oxycodone hcl (ir) 5 mg cap</i>	T1	PA
<i>oxycodone hcl (ir) 5 mg tablet (Roxicodone)</i>	T1	PA
<i>oxycodone hcl 100 mg/5 ml conc</i>	T1	PA
<i>oxycodone hcl 5 mg/5 ml cup</i>	T1	PA
<i>oxycodone hcl 5 mg/5 ml soln</i>	T1	PA
OXYCODONE HCL ER	T1	PA
<i>oxymorphone hcl</i>	T1	PA
<i>pentazocine hcl/naloxone hcl</i>	T1	PA
ROXYBOND	T3	PA
<i>tramadol er 100 mg tablet</i>	T1	QL(1 TAB/DAY)
<i>tramadol er 200 mg tablet</i>	T1	QL(1 TAB/DAY)
<i>tramadol er 300 mg tablet</i>	T1	QL(1 TAB/DAY)
<i>tramadol hcl 100 mg tablet</i>	T1	QL(4 TABS/DAY)
<i>tramadol hcl 50 mg tablet</i>	T1	QL(8 TABS/DAY)
TRAMADOL HCL 75 MG TABLET	T3	QL(5 TABS/DAY)
TRAMADOL HCL ER 100 MG CAPSULE	T1	QL(1 CAP/DAY)
<i>tramadol hcl er 100 mg tablet</i>	T1	QL(1 TAB/DAY)

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPIOID ANALGESICS (cont.)		
TRAMADOL HCL ER 200 MG CAPSULE	T1	QL(1 CAP/DAY)
<i>tramadol hcl er 200 mg tablet</i>	T1	QL(1 TAB/DAY)
TRAMADOL HCL ER 300 MG CAPSULE	T1	QL(1 CAP/DAY)
<i>tramadol hcl er 300 mg tablet</i>	T1	QL(1 TAB/DAY)
XTAMPZA ER	T2	PA
OPIOID AND SALICYLATE ANALGESICS, BARBIT, XANTHINE		
<i>codeine/butalbital/asa/caffein</i>	T1	PA
OPIOID, NON-SALICYL. ANALGESIC, BARBITUATE, XANTHINE		
<i>butalbit/acetamin/caff/codeine</i>	T1	PA
<i>butalbit/acetamin/caff/codeine (Fioricet With Codeine)</i>	T1	PA
SKELETAL MUSCLE RELAXANT, SALICYLAT, OPIOID ANALGESIC		
<i>carisoprodol/aspirin/codeine</i>	T1	PA
ANALGESICS (Urinary Tract Conditions)		
URINARY TRACT ANALGESIC AGENTS		
ELMIRON	T2	
RIMSO-50	T2	
ANESTHETICS (Miscellaneous)		
GENERAL ANESTHETICS, INHALANT		
<i>desflurane</i>	T1	
<i>isoflurane</i>	T1	
<i>sevoflurane (Ultane)</i>	T1	
SUPRANE	T3	
ULTANE (<i>sevoflurane</i>)	T3	
ANESTHETICS (Pain Relief and Inflammatory Disease)		
LOCAL ANESTHETICS		
<i>lidocaine hcl</i>	T1	
TOPICAL LOCAL ANESTHETICS		
<i>lidocaine 5% ointment</i>	T1	QL(145 GMS/30 DAYS)
<i>lidocaine 5% patch (Lidocan li)</i>	T1	
<i>lidocaine 5% patch (Lidoderm)</i>	T1	
<i>lidocaine hcl</i>	T3	
<i>lidocaine/prilocaine</i>	T1	
ZTLIDO	T2	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANESTHETICS (Urinary Tract Conditions)		
URINARY TRACT ANESTHETIC/ANALGESIC AGNT (AZO-DYE)		
<i>phenazopyridine hcl</i> (Pyridium)	T1	
ANTI-ALLERGY (Allergy/Nasal Sprays)		
MAST CELL STABILIZERS		
<i>cromolyn 100 mg/5 ml oral conc</i> (Gastrocrom)	T1	
ANTI-ARTHRITICS (Pain Relief and Inflammatory Disease)		
ANALGESIC/ANTIPIRETTICS, SALICYLATES		
<i>DISALCID</i> (<i>salsalate</i>)	T3	HD
<i>salsalate</i> (Disalcid)	T1	HD
ANTI-ARTHRITIC AND CHELATING AGENTS		
<i>DEPEN</i> (<i>penicillamine</i>)	T3	PA QL(6 TABS/DAY) SP
<i>penicillamine 250 mg capsule</i> (Cuprimine)	T1	PA QL(6 CAPS/DAY) SP
<i>penicillamine 250 mg tablet</i> (Depen)	T1	PA QL(6 TABS/DAY) SP
ANTI-ARTHRITIC, FOLATE ANTAGONIST AGENTS		
<i>OTREXUP</i>	T2	PA
ANTI-INFLAMMATORY, PYRIMIDINE SYNTHESIS INHIBITOR		
<i>leflunomide</i> (Arava)	T1	HD
ANTI-INFLAMMATORY, PHOSPHODIESTERASE-4(PDE4) INHIB.		
<i>OTEZLA 10-20 MG STARTER 28 DAY</i>	T2	PA QL(55 TABS/365 DAYS) SP HD
<i>OTEZLA 10-20-30MG START 28 DAY</i>	T2	PA QL(55 TABS/365 DAYS) SP HD
<i>OTEZLA 20 MG TABLET</i>	T2	PA QL(2 TABS/DAY) SP HD
<i>OTEZLA 30 MG TABLET</i>	T2	PA QL(2 TABS/DAY) SP HD
<i>OTEZLA XR 75 MG TABLET</i>	T2	PA QL(1 TAB/DAY) SP HD
<i>OTEZLA XR INITIATION PK 28 DAY</i>	T2	PA QL(41 TABS/365 DAYS) SP HD
ANTI-INFLAMMATORY, SEL.COSTIM.MOD., T-CELL INHIBITOR		
<i>ORENCIA 125 MG/ML SYRINGE</i>	T3	PA QL(4 SYR/AUTO-INJ/28 DAYS) SP HD
<i>ORENCIA 50 MG/0.4 ML SYRINGE</i>	T3	PA QL(4 SYR/AUTO-INJ/28 DAYS) SP HD
<i>ORENCIA 87.5 MG/0.7 ML SYRINGE</i>	T3	PA QL(4 SYR/AUTO-INJ/28 DAYS) SP HD
<i>ORENCIA CLICKJECT</i>	T3	PA QL(4 SYR/AUTO-INJ/28 DAYS) SP HD
COLCHICINE		
<i>colchicine 0.6 mg capsule</i> (Mitigare)	T1	HD
<i>colchicine 0.6 mg tablet</i> (Colcrys)	T1	HD
<i>MITIGARE</i> (<i>colchicine</i>)	T2	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HYPERURICEMIA TX - XANTHINE OXIDASE INHIBITORS		
<i>allopurinol 100 mg tablet (Zyloprim)</i>	T1	HD
<i>allopurinol 300 mg tablet</i>	T1	HD
<i>febuxostat 40 mg tablet (Uloric)</i>	T1	QL(1 TAB/DAY) HD
<i>febuxostat 80 mg tablet (Uloric)</i>	T1	HD
JANUS KINASE (JAK) INHIBITORS		
OLUMIANT	T3	PA QL(30 TABS/30 DAYS) SP HD
RINVOQ	T2	PA QL(1 TAB/DAY) SP HD
RINVOQ LQ	T2	PA QL(12 MLS/DAY) SP HD
XELJANZ 1 MG/ML SOLUTION	T2	PA QL(480 MLS/30 DAYS) SP HD
XELJANZ 10 MG TABLET	T2	PA QL(2 TABS/DAY) SP HD
XELJANZ 5 MG TABLET	T2	PA QL(2 TABS/DAY) SP HD
XELJANZ XR	T2	PA QL(1 TAB/DAY) SP HD
NSAID AND TOPICAL IRRITANT COUNTER-IRRITANT COMB.		
COMFORT PAC-IBUPROFEN	T3	
COMFORT PAC-MELOXICAM	T3	
COMFORT PAC-NAPROXEN	T3	
NSAIDS (COX NON-SPEC.INHIB) AND PROSTAGLANDIN ANALOG		
ARTHROTEC 50 (<i>diclofenac sodium-misoprostol</i>)	T3	ST HD
ARTHROTEC 75 (<i>diclofenac sodium-misoprostol</i>)	T3	ST HD
<i>diclofenac sodium-misoprostol (Arthrotec 50)</i>	T1	HD
<i>diclofenac sodium-misoprostol (Arthrotec 75)</i>	T1	HD
NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE ANALGESICS		
ANAPROX DS (<i>naproxen sodium ds</i>)	T3	ST HD
DAYPRO (<i>oxaprozin</i>)	T3	ST HD
<i>diclofenac sod dr 25 mg tab</i>	T1	HD
<i>diclofenac sod dr 50 mg tab</i>	T1	HD
<i>diclofenac sod dr 75 mg tab</i>	T1	HD
<i>diclofenac sod ec 25 mg tab</i>	T1	HD
<i>diclofenac sod ec 50 mg tab</i>	T1	HD
<i>diclofenac sod ec 75 mg tab</i>	T1	HD
<i>diclofenac sodium</i>	T1	HD
EC-NAPROSYN (<i>naproxen</i>)	T3	ST HD
<i>etodolac</i>	T1	HD
<i>etodolac (Lodine)</i>	T1	HD
FELDENE (<i>piroxicam</i>)	T3	ST HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE ANALGESICS (cont.)		
<i>fenoprofen 600 mg tablet (Nalfon)</i>	T1	HD
<i>flurbiprofen</i>	T1	HD
<i>ibuprofen</i>	T1	HD
<i>indomethacin</i>	T1	HD
<i>indomethacin 25 mg capsule</i>	T1	HD
<i>indomethacin 25 mg/5 ml susp (Indocin)</i>	T1	HD
<i>indomethacin 50 mg capsule</i>	T1	HD
<i>indomethacin 50 mg suppository (Indocin)</i>	T1	HD
<i>ketoprofen 50 mg capsule</i>	T1	HD
<i>ketoprofen 75 mg capsule</i>	T1	HD
<i>ketoprofen er 200 mg capsule</i>	T1	HD
LODINE (<i>etodolac</i>)	T3	ST HD
<i>meclofenamate sodium</i>	T1	HD
<i>meloxicam 15 mg tablet</i>	T1	HD
<i>meloxicam 7.5 mg tablet</i>	T1	HD
<i>nabumetone (Relafen)</i>	T1	HD
NALFON 600 MG TABLET (<i>fenoprofen calcium</i>)	T3	ST HD
NAPROSYN 500 MG TABLET (<i>naproxen</i>)	T3	ST HD
<i>naproxen (Ec-naprosyn)</i>	T1	HD
<i>naproxen 250 mg, 375 mg tablet</i>	T1	HD
<i>naproxen 500 mg kit (Naprosyn)</i>	T1	HD
<i>naproxen 500 mg tablet (Naprosyn)</i>	T1	HD
<i>naproxen dr 375 mg, 500 mg tablet (Ec-Naprosyn)</i>	T1	HD
<i>naproxen sodium</i>	T1	HD
<i>naproxen (Naprosyn)</i>	T1	HD
<i>naproxen sodium (Anaprox Ds)</i>	T1	HD
<i>oxaprozin 600 mg caplet (Daypro)</i>	T1	HD
<i>oxaprozin 600 mg tablet (Daypro)</i>	T1	HD
<i>piroxicam</i>	T1	HD
<i>piroxicam (Feldene)</i>	T1	HD
<i>sulindac</i>	T1	HD
<i>tolmetin sodium</i>	T1	HD
<i>tolmetin sodium (Tolectin 600)</i>	T1	HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NSAIDS, CYCLOOXYGENASE-2(COX-2) SELECTIVE INHIBITOR		
<i>celecoxib 100 mg capsule (Celebrex)</i>	T1	QL(2 CAPS/DAY) HD
<i>celecoxib 200 mg capsule (Celebrex)</i>	T1	QL(2 CAPS/DAY) HD
<i>celecoxib 400 mg capsule (Celebrex)</i>	T1	QL(1 CAP/DAY) HD
<i>celecoxib 50 mg capsule (Celebrex)</i>	T1	QL(2 CAPS/DAY) HD
URICOSURIC AGENTS		
<i>probenecid</i>	T1	HD
<i>probenecid/colchicine</i>	T1	HD
ANTI-ASTHMATICS (Asthma/COPD/Respiratory)		
5-LIPOXYGENASE INHIBITORS		
<i>zileuton</i>	T1	HD
ANTICHOLINERGICS, ORALLY INHALED LONG ACTING		
INCRUSE ELLIPTA	T2	HD
SPIRIVA RESPIMAT	T2	QL(1 INHALER/30 DAYS) HD
<i>tiotropium 18 mcg cap-inhaler (Spiriva Handihaler)</i>	T1	QL(1 INHALER/30 DAYS) HD
ANTICHOLINERGICS, ORALLY INHALED SHORT ACTING		
ATROVENT HFA	T2	QL(2 INHALERS/30 DAYS) HD
<i>ipratropium bromide</i>	T1	HD
BETA-ADRENERGIC AGENTS		
<i>albuterol sulf 2 mg/5 ml syrup</i>	T1	HD
<i>albuterol 8 mg/20 ml syrup cup</i>	T1	HD
<i>albuterol sulf 2 mg/5 ml syrup</i>	T1	HD
<i>albuterol sulfate 2 mg tab</i>	T1	HD
<i>albuterol sulfate 4 mg tab</i>	T1	HD
<i>albuterol sulfate er 4 mg tab</i>	T1	HD
<i>albuterol sulfate er 8 mg tab</i>	T1	HD
<i>terbutaline sulfate</i>	T1	HD
BETA-ADRENERGIC AGENTS, INHALED, SHORT ACTING		
<i>albuterol 100 mg/20 ml soln</i>	T1	
<i>albuterol 15 mg/3 ml solution</i>	T1	
<i>albuterol 2.5 mg/0.5 ml sol</i>	T1	
<i>albuterol 25 mg/5 ml solution</i>	T1	
<i>albuterol 5 mg/ml solution</i>	T1	
<i>albuterol 75 mg/15 ml soln</i>	T1	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BETA-ADRENERGIC AGENTS, INHALED, SHORT ACTING (cont.)		
<i>albuterol sul 0.63 mg/3 ml sol</i>	T1	
<i>albuterol sul 1.25 mg/3 ml sol</i>	T1	
<i>albuterol sul 2.5 mg/3 ml soln</i>	T1	
<i>albuterol hfa 90 mcg inhaler</i>	T1	QL(1 INHALER/30 DAYS)
<i>levalbuterol hcl (Xopenex Concentrate)</i>	T1	
<i>levalbuterol hcl (Xopenex)</i>	T1	
XOPENEX (<i>levalbuterol hcl</i>)	T3	
XOPENEX CONCENTRATE (<i>levalbuterol concentrate</i>)	T3	
BETA-ADRENERGIC AGENTS, INHALED, ULTRA-LONG ACTING		
STRIVERDI RESPIMAT	T2	QL(1 INHALER/30 DAYS) HD
BETA-ADRENERGIC AGENTS, ORALLY INHALED, LONG ACTING		
<i>arformoterol tartrate (Brovana)</i>	T1	QL(4 MLS/DAY) HD
<i>formoterol fumarate (Perforomist)</i>	T1	QL(240 MLS/30 DAYS) HD
BETA-ADRENERGIC AND ANTICHOLINERGIC COMBO, INHALED		
ANORO ELLIPTA 62.5-25 MCG INH	T2	HD
ANORO ELLIPTA 62.5-25 MCG INH	T2	QL(1 INHALER/30 DAYS) HD
COMBIVENT RESPIMAT	T2	QL(2 INHALERS/30 DAYS)
<i>ipratropium/albuterol sulfate</i>	T1	HD
STIOLTO RESPIMAT	T2	QL(1 INHALER/30 DAYS) HD
BETA-ADRENERGIC AGENTS AND GLUCOCORTICOID COMBO, INHALED		
AIRSUPRA	T2	QL(2 GMS/28 DAYS) HD
<i>budesonide/formoterol fumarate (Symbicort)</i>	T1	QL(1 INHALER/30 DAYS) HD
DULERA 100 MCG-5 MCG INHALER	T2	QL(1 INHALER/30 DAYS) HD
DULERA 200 MCG-5 MCG INHALER	T2	QL(1 INHALER/30 DAYS) HD
DULERA 50 MCG-5 MCG INHALER	T2	QL(1 INHALER/30 DAYS) HD
<i>fluticasone propion/salmeterol (Advair Diskus)</i>	T1	QL(1 INHALER/30 DAYS)
<i>fluticasone-salmeterol 100-50 (Advair Diskus)</i>	T1	QL(1 INHALER/30 DAYS) HD
<i>fluticasone-salmeterol 250-50 (Advair Diskus)</i>	T1	QL(1 INHALER/30 DAYS) HD
<i>fluticasone-salmeterol 500-50 (Advair Diskus)</i>	T1	QL(1 INHALER/30 DAYS) HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BETA-ADRENERGIC-ANTICHOLINERGIC-GLUCOCORT, INHALED		
BREZTRI AEROSPHERE INHALER	T2	QL(1 INHALER/30 DAYS)
TRELEGY ELLIPTA 100-62.5-25	T2	QL(1 BLISTER/30 DAYS)
TRELEGY ELLIPTA 200-62.5-25	T2	QL(1 BLISTER/30 DAYS)
GLUCOCORTICIDS, ORALLY INHALED		
ALVESCO	T2	HD
ASMANEX HFA	T2	QL(1 INHALER/30 DAYS) HD
ASMANEX TWISTHALER 110 MCG #30	T2	QL(1 INHALER/30 DAYS) HD
ASMANEX TWISTHALER 220 MCG #14	T2	HD
ASMANEX TWISTHALER 220 MCG #30	T2	QL(1 INHALER/30 DAYS) HD
ASMANEX TWISTHALER 220 MCG #60	T2	QL(1 INHALER/30 DAYS) HD
ASMANEX TWISTHALR 220 MCG #120	T2	QL(1 INHALER/30 DAYS) HD
<i>budesonide 0.25 mg/2 ml susp (Pulmicort)</i>	T1	QL(4 MLS/DAY) HD
<i>budesonide 0.5 mg/2 ml susp (Pulmicort)</i>	T1	QL(4 MLS/DAY) HD
<i>budesonide 1 mg/2 ml inh susp (Pulmicort)</i>	T1	QL(2 MLS/DAY) HD
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 (<i>zafirlukast</i>)	T3	HD
<i>montelukast sodium</i>	T1	HD
<i>montelukast sodium (Singulair)</i>	T1	HD
<i>zafirlukast (Accolate)</i>	T1	HD
MAST CELL STABILIZERS, ORALLY INHALED		
<i>cromolyn 20 mg/2 ml neb soln</i>	T1	QL(480 MLS/30 DAYS) HD
MONOCLONAL ANTIBODIES TO IMMUNOGLOBULIN E (IGE)		
XOLAIR	T2	PA SP HD
MUCOLYTICS		
<i>acetylcysteine</i>	T1	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PHOSPHODIESTERASE (PDE) INHIBITORS		
<i>roflumilast 250 mcg tablet</i> (Daliresp)	T1	QL(28 TABS/180 DAYS) HD
<i>roflumilast 500 mcg tablet</i> (Daliresp)	T1	QL(2 TABS/DAY) HD
XANTHINES		
THEO-24	T3	HD
<i>theophylline anhydrous</i>	T1	HD
ANTIBIOTICS (Ear Medications)		
EAR PREPARATIONS, ANTIBIOTICS		
<i>ciprofloxacin hcl</i>	T1	
CORTISPORIN-TC	T3	
<i>neomycin/polymyxin b/hydrocort</i>	T1	
<i>ofloxacin</i>	T1	
OTIC PREPARATIONS, ANTI-INFLAMMATORY-ANTIBIOTICS		
<i>ciprofloxacin hcl/dexameth</i>	T1	
<i>ciprofloxacin/hydrocortisone</i>	T1	
OTOVEL	T3	
ANTIBIOTICS (Eye Conditions)		
EYE ANTIBIOTIC AND GLUCOCORTICOID COMBINATIONS		
<i>neomycin/bacit/p-myx/hydrocort</i>	T1	
<i>neomycin/polymyxin b/dexametha</i> (Maxitrol)	T1	
<i>neomycin/polymyxin b/hydrocort</i>	T1	
TOBRADEX	T3	
TOBRADEX ST	T2	
<i>tobramycin/dexamethasone</i>	T1	
ZYLET	T3	
EYE SULFONAMIDES		
<i>sulfacetamide sodium</i>	T1	
<i>sulfacetamide/prednisolone sp</i>	T1	
OPHTHALMIC ANTIBIOTICS		
AZASITE	T2	
<i>bacitracin</i>	T1	
<i>bacitracin/polymyxin b sulfat</i>	T1	
BESIVANCE	T2	
<i>ciprofloxacin hcl</i>	T1	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTIBIOTICS (Eye Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPHTHALMIC ANTIBIOTICS (cont.)		
<i>erythromycin base</i>	T1	
<i>gatifloxacin</i>	T1	
<i>gentamicin sulfate</i>	T1	
<i>levofloxacin</i>	T1	
<i>moxifloxacin hcl</i>	T1	
<i>moxifloxacin hcl (Vigamox)</i>	T1	
<i>neomycin/bacitracin/polymyxinb</i>	T1	
<i>neomycin/polymyxn b/gramicidin</i>	T1	
<i>ofloxacin (Ocuflox)</i>	T1	
<i>polymyxin b sulf/trimethoprim</i>	T1	
<i>tobramycin 0.3% eye drop (Tobrex)</i>	T1	

ANTIBIOTICS (Infections)

ABSORBABLE SULFONAMIDE ANTIBACTERIAL AGENTS		
BACTRIM (<i>sulfamethoxazole-trimethoprim</i>)	T3	
BACTRIM DS (<i>sulfamethoxazole-trimethoprim</i>)	T3	
<i>sulfadiazine</i>	T1	
<i>sulfamethoxazole/trimethoprim</i>	T1	
<i>sulfamethoxazole/trimethoprim (Bactrim Ds)</i>	T1	
<i>sulfamethoxazole/trimethoprim (Bactrim)</i>	T1	
AMINOGLYCOSIDE ANTIBIOTICS		
ARIKAYCE	T3	PA SP
<i>gentamicin sulfate</i>	T1	
<i>gentamicin sulfate/pf</i>	T1	
KITABIS PAK	T3	PA QL(10 MLS/DAY) SP HD
<i>neomycin sulfate</i>	T1	
TOBI PODHALER	T2	PA QL(8 CAPS/DAY) SP HD
<i>tobramycin 300 mg/4 ml ampule</i>	T1	QL(8 MLS/DAY) SP HD
<i>tobramycin 300 mg/5 ml ampule</i>	T1	PA QL(10 MLS/DAY) SP HD
TOBRAMYCIN PAK 300 MG/5 ML	T3	PA QL(10 MLS/DAY) SP HD
<i>tobramycin sulfate</i>	T1	
ANAEROBIC ANTIPROTOZOAL-ANTIBACTERIAL AGENTS		
FLAGYL (<i>metronidazole</i>)	T3	
LIKMEZ	T3	PA

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANAEROBIC ANTIPROTOZOAL-ANTIBACTERIAL AGENTS (cont.)		
<i>metronidazole 250 mg tablet</i>	T1	
<i>metronidazole 375 mg capsule (Flagyl)</i>	T1	
<i>metronidazole 500 mg tablet</i>	T1	
ANTI-BIOTIC, ANTIBACTERIAL, MISC.		
<i>fosfomycin tromethamine</i>	T1	
<i>methenamine hippurate</i>	T1	
<i>methenamine mandelate</i>	T1	
PRIMSOL	T3	
<i>trimethoprim</i>	T1	
ANTI-LEPROTICS		
<i>dapsone 100 mg tablet</i>	T1	
<i>dapsone 25 mg tablet</i>	T1	
THALOMID	T2	PA SP HD
ANTI-MYCOBACTERIUM AGENTS		
<i>ethambutol hcl</i>	T1	HD
<i>isoniazid</i>	T1	HD
PASER	T3	HD
<i>pyrazinamide</i>	T1	HD
<i>rifabutin (Mycobutin)</i>	T1	HD
ANTI-TUBERCULAR ANTIBIOTICS		
<i>cycloserine</i>	T1	
PRETOMANID	T3	PA QL(1 TAB/DAY)
PRIFTIN	T3	
<i>rifampin</i>	T1	
SIRTURO	T3	SP
BETALACTAMS		
CAYSTON	T3	PA QL(3 MLS/DAY) SP HD
CEPHALOSPORIN ANTIBIOTICS - 1ST GENERATION		
<i>cefadroxil</i>	T1	
<i>cephalexin</i>	T1	
CEPHALOSPORIN ANTIBIOTICS - 2ND GENERATION		
<i>cefaclor</i>	T1	
<i>cefprozil</i>	T1	
<i>cefuroxime axetil</i>	T1	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CEPHALOSPORIN ANTIBIOTICS - 3RD GENERATION		
<i>cefdinir</i>	T1	
<i>cefixime</i>	T1	
<i>cefepodoxime proxetil</i>	T1	
<i>ceftriaxone sodium</i>	T1	
LINCOSAMIDE ANTIBIOTICS		
CLEOCIN HCL (<i>clindamycin hcl</i>)	T3	
CLEOCIN PEDIATRIC (<i>clindamycin palmitate hcl</i>)	T3	
<i>clindamycin hcl</i> (Cleocin Hcl)	T1	
<i>clindamycin palmitate hcl</i> (Cleocin Pediatric)	T1	
MACROLIDE ANTIBIOTICS		
<i>azithromycin</i>	T1	
<i>azithromycin</i> (Zithromax Tri-Pak)	T1	
<i>azithromycin</i> (Zithromax)	T1	
<i>clarithromycin</i>	T1	
DIFICID 200 MG TABLET	T3	QL(28 TABS/28 DAYS)
DIFICID 40 MG/ML SUSPENSION	T3	QL(5 MLS/DAY)
ERYPED 200 (<i>erythromycin ethylsuccinate</i>)	T3	
ERY-TAB (<i>erythromycin base</i>)	T3	
<i>erythromycin base</i>	T1	
<i>erythromycin base powder</i>	T3	
<i>erythromycin base</i> (Ery-tab)	T1	
<i>erythromycin ethylsuccinate</i>	T1	
<i>erythromycin ethylsuccinate</i> (Eryped 200)	T1	
<i>erythromycin ethylsuccinate</i> (Eryped 400)	T1	
<i>erythromycin stearate</i>	T1	
<i>fidaxomicin</i> (Dificid)	T1	QL(28 TABS/28 DAYS)
ZITHROMAX (<i>azithromycin</i>)	T3	
ZITHROMAX TRI-PAK (<i>azithromycin</i>)	T3	
NITROFURAN DERIVATIVES ANTIBACTERIAL AGENTS		
FURADANTIN (<i>nitrofurantoin</i>)	T3	
MACROBID (<i>nitrofurantoin monohyd/m-cryst</i>)	T3	
<i>nitrofurantoin 25 mg/5 ml susp</i> (Furadantin)	T1	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CEPHALOSPORIN ANTIBIOTICS - 3RD GENERATION		
<i>nitrofurantoin mcr 100 mg cap</i>	T1	
<i>nitrofurantoin mcr 25 mg cap</i>	T1	
<i>nitrofurantoin mcr 50 mg cap</i>	T1	
<i>nitrofurantoin monohyd/m-cryst (Macrobid)</i>	T1	
OXAZOLIDINONE ANTIBIOTICS		
<i>linezolid (Zyvox)</i>	T1	PA
SIVEXTRO	T3	PA
ZYVOX (<i>linezolid</i>)	T3	PA
PENICILLIN ANTIBIOTICS		
<i>amoxicillin</i>	T1	
<i>amoxicillin/potassium clav</i>	T1	
<i>amoxicillin/potassium clav (Augmentin Es-600)</i>	T1	
<i>amoxicillin/potassium clav (Augmentin Xr)</i>	T1	
<i>amoxicillin/potassium clav (Augmentin)</i>	T1	
<i>ampicillin trihydrate</i>	T1	
<i>dicloxacillin sodium</i>	T1	
MOXATAG	T3	
<i>penicillin v potassium</i>	T1	
PLEUROMUTILIN DERIVATIVES		
XENLETA	T3	PA QL(10 TABS/30 DAYS)
QUINOLONE ANTIBIOTICS		
BAXDELA	T3	PA
CIPRO (<i>ciprofloxacin hcl</i>)	T3	
CIPRO (<i>ciprofloxacin</i>)	T3	
<i>ciprofloxacin (Cipro)</i>	T1	
<i>ciprofloxacin hcl</i>	T1	
<i>ciprofloxacin hcl (Cipro)</i>	T1	
FACTIVE	T3	
<i>levofloxacin</i>	T1	
<i>moxifloxacin hcl (Avelox)</i>	T1	
<i>ofloxacin</i>	T1	
RIFAMYCINS AND RELATED DERIVATIVE ANTIBIOTICS		
AEMCOLO	T3	QL(12 TABS/30 DAYS)
XIFAXAN 200 MG TABLET	T2	QL(9 TABS/30 DAYS)
XIFAXAN 550 MG TABLET	T2	QL(42 TABS/30 DAYS)

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TETRACYCLINE ANTIBIOTICS		
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	
doxycycline 50 mg tablet (Targadox)	T1	
doxycycline hyclate	T1	
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	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 er 105 mg tablet	T1	
minocycline er 115 mg tablet (Solodyn)	T1	
minocycline er 135 mg tablet	T1	
minocycline hcl	T1	
NUZYRA	T3	PA QL(30 TABS/28 DAYS) SP
tetracycline 250 mg capsule	T1	
tetracycline 500 mg capsule	T1	
VAGINAL ANTIBIOTICS		
clindamycin phosphate (Cleocin)	T1	
metronidazole	T1	
metronidazole vaginal 0.75% gl	T1	
VANCOMYCIN ANTIBIOTICS AND DERIVATIVES		
vancomycin 25 mg/ml oral soln	T1	
vancomycin 250 mg/5ml oral sol (Firvanaq)	T1	
vancomycin 50 mg/ml oral soln (Firvanaq)	T1	
vancomycin hcl 125 mg capsule (Vancocin Hcl)	T1	
vancomycin hcl 250 mg capsule (Vancocin Hcl)	T1	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTIBIOTICS (Skin Conditions)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL ANTIBIOTIC AND ANTI-INFLAMMATORY STEROID		
NEO-SYNALAR	T3	
TOPICAL ANTIBIOTICS		
BENZAMYCIN (<i>erythromycin-benzoyl peroxide</i>)	T3	
CENTANY	T3	
CENTANY AT	T3	
CLEOCIN T (<i>clindamycin phosphate</i>)	T3	
<i>clindamycin phosphate</i>	T1	
<i>clindacin etz 1% pledget</i> (Cleocin T)	T1	
<i>clindamycin phosphate</i> (Cleocin T)	T1	
<i>clindamycin phosphate</i> (Evoclin)	T1	
<i>erythromycin base in ethanol</i>	T1	
<i>erythromycin/benzoyl peroxide</i> (Benzamycin)	T1	
EVOCLIN (<i>clindamycin phosphate</i>)	T3	
<i>gentamicin sulfate</i>	T1	
<i>mupirocin 2% ointment</i>	T1	
XEPI	T3	
TOPICAL SULFONAMIDES		
<i>mafenide acetate</i>	T1	
PLEXION	T3	
SILVADENE (<i>silver sulfadiazine</i>)	T3	
<i>silver sulfadiazine</i> (Silvadene)	T1	
<i>sulfacetamide sodium/sulfur</i>	T1	
SULFAMYLON	T3	
ANTI-COAGULANTS (Blood Thinners/Anti-Clotting)		
ANTI-COAGULANTS, COUMARIN TYPE		
<i>warfarin sodium</i>	T1	HD
CITRATES AS ANTI-COAGULANTS		
ACD SOLUTION A	T3	
ACD-A SOLUTION	T3	
ANTICOAGULANT SODIUM CITRATE	T3	
CITRATE PHOSPHATE DEXTROSE	T1	
SODIUM CITRATE	T1	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

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

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HEPARIN AND RELATED PREPARATIONS (cont.)		
<i>heparin 40,000 unit/4 ml vial</i>	T1	
<i>heparin sod 5,000 unit/ml vial</i>	T1	
<i>heparin 50,000 unit/10 ml vial</i>	T1	
<i>heparin 50,000 unit/5 ml vial</i>	T1	
<i>heparin sod 1,000 unit/ml vial</i>	T1	
<i>heparin sod 10,000 unit/ml vl</i>	T1	
<i>heparin sod 20,000 unit/ml vl</i>	T1	
<i>heparin sod 5,000 unit/0.5 ml</i>	T1	
HEPARIN SOD 5,000 UNIT/0.5 ML	T1	
HEPARIN SOD 5,000 UNIT/0.5 ML	T3	
<i>heparin sod 5,000 unit/ml syrg</i>	T1	
HEPARIN SOD 5,000 UNIT/ML SYRG	T3	
<i>heparin sod 5,000 unit/ml vial</i>	T1	
THROMBIN INHIBITORS, SELECTIVE, DIRECT, REVERSIBLE		
<i>dabigatran etexilate mesylate (Pradaxa)</i>	T1	HD

ANTIDOTES (Gastrointestinal/Heartburn)

MU-OPIOID RECEPTOR ANTAGONISTS, PERIPHERALLY-ACTING

MOVANTIK	T2	PA
RELISTOR 12 MG/0.6 ML SYRINGE	T3	PA
RELISTOR 12 MG/0.6 ML VIAL	T3	PA
RELISTOR 8 MG/0.4 ML SYRINGE	T3	PA
SYMPROIC	T2	PA

ANTIDOTES (Substance Abuse)

OPIOID ANTAGONISTS

KLOXXADO	T2	QL(2 UNITS/30 DAYS)
<i>naloxone 0.4 mg/ml carpject</i>	T1	
<i>naloxone 0.4 mg/ml syringe</i>	T1	
<i>naloxone 0.4 mg/ml vial</i>	T1	
<i>naloxone 2 mg/2 ml syringe</i>	T1	
<i>naloxone 4 mg/10 ml vial</i>	T1	
<i>naloxone hcl 4 mg nasal spray (Narcan)</i>	T1	QL(2 UNITS/30 DAYS)
<i>naltrexone hcl</i>	T1	QL(180 TABS/30 DAYS)
NARCAN (<i>naloxone hcl</i>)	T2	QL(2 UNITS/30 DAYS)

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTIDOTES (Substance Abuse) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPIOID ANTAGONISTS (cont.)		
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	T3	

ANTI-FUNGALS (Feminine Products)

VAGINAL ANTI-FUNGALS		
GYNAZOLE 1	T1	
<i>miconazole nitrate</i>	T1	
<i>terconazole</i>	T1	

ANTI-FUNGALS (Infections)

ANTI-FUNGAL AGENTS		
ANCOBON (<i>flucytosine</i>)	T3	
<i>clotrimazole</i>	T1	
CRESEMBA	T3	PA
<i>fluconazole</i>	T1	
<i>fluconazole</i> (Diflucan)	T1	
<i>flucytosine</i> (Ancobon)	T1	
<i>itraconazole</i>	T1	
<i>itraconazole</i> (Sporanox)	T1	
<i>ketoconazole</i>	T1	
NOXAFIL 300 MG POWDERMIX SUSP	T3	
ORAVIG	T3	
<i>posaconazole</i>	T1	
<i>posaconazole</i> (NOXAFIL)	T1	
<i>terbinafine hcl</i>	T1	
VFEND (<i>voriconazole</i>)	T3	PA
VIVJOA	T3	PA SP
<i>voriconazole</i> (Vfend)	T1	PA
ANTI-FUNGAL ANTIBIOTICS		
<i>griseofulvin ultra 125 mg tab</i>	T1	
<i>griseofulvin ultra 165 mg tab</i>	T1	QL(4 TABS/DAY)

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTI-FUNGALS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-FUNGAL ANTIBIOTICS (cont.)		
<i>griseofulvin ultra 250 mg tab</i>	T1	
<i>griseofulvin, microsize</i>	T1	
<i>nystatin</i>	T1	
ANTI-FUNGALS (Skin Conditions)		
TOPICAL ANTI-FUNGAL/ANTI-INFLAMMATORY, STEROID AGENT		
<i>clotrimazole/betamethasone dip</i>	T1	
TOPICAL ANTI-FUNGALS		
<i>ciclodan 0.77% cream</i>	T1	
CICLODAN 0.77% CREAM KIT	T3	
CICLODAN 8% KIT	T3	
<i>ciclodan 8% solution</i>	T1	
<i>ciclopirox</i>	T1	
<i>ciclopirox olamine (Loprox)</i>	T1	
<i>ciclopirox/urea/camph/men/euc</i>	T1	
<i>econazole nitrate 1% cream</i>	T1	
ECOZA	T3	
EXODERM	T1	
<i>ketoconazole</i>	T1	
<i>ketoconazole (Extina)</i>	T1	
LOPROX 0.77% SUSPENSION KIT	T3	
LOPROX 0.77% TOPICAL SUSP (<i>ciclopirox olamine</i>)	T3	
LULICONAZOLE	T1	
<i>naftifine hcl</i>	T1	
<i>naftifine hcl (Naftin)</i>	T1	
NAFTIN (<i>naftifine hcl</i>)	T3	
<i>nystatin</i>	T1	
<i>nystatin/triamcinolone acetate</i>	T1	
ANTIHISTAMINE AND DECONGESTANT COMBINATION (Allergy/Nasal Sprays)		
1ST GEN ANTIHISTAMINE AND DECONGESTANT COMBINATION		
<i>phenylephrine hcl/prometh hcl</i>	T1	
2ND GEN ANTIHISTAMINE AND DECONGESTANT COMBINATION		
CLARINEX-D 12 HOUR	T3	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTI-HISTAMINES (Allergy/Nasal Sprays) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-HISTAMINES - 1ST GENERATION		
<i>carbinoxamine 4 mg/5 ml liquid</i>	T1	
<i>carbinoxamine maleate</i>	T1	
<i>carbinoxamine maleate 4 mg tab</i>	T1	
<i>clemastine fum 2.68 mg tablet</i>	T1	
<i>clemastine fumarate</i>	T1	
<i>cyproheptadine hcl</i>	T1	
<i>hydroxyzine hcl</i>	T1	
<i>hydroxyzine pamoate</i>	T1	
<i>hydroxyzine pamoate (Vistaril)</i>	T1	
<i>promethazine hcl</i>	T1	
VISTARIL (<i>hydroxyzine pamoate</i>)	T3	

ANTI-HYPERGLYCEMICS (Diabetes)

ANTI-HYPERGLY, INCRETIN MIMETIC (GLP-I RECEPT.AGONIST)		
BYDUREON BCISE	T2	PA QL (4 pens/28 days)
exenatide	T1	PA QL(3 MLS/30 DAYS)
<i>liraglutide 2-pak 18 mg/3 ml (Victoza 2-Pak)</i>	T1	PA QL(3 PENS/30 DAYS)
<i>liraglutide 2-pak 18 mg/3 ml (Victoza 3-Pak)</i>	T1	PA QL(3 PENS/30 DAYS)
<i>liraglutide 3-pak 18 mg/3 ml (Victoza 2-Pak)</i>	T1	PA QL(3 PENS/30 DAYS)
<i>liraglutide 3-pak 18 mg/3 ml (Victoza 3-Pak)</i>	T1	PA QL(3 PENS/30 DAYS)
OZEMPIC	T2	PA QL(3 MLS/28 DAYS)
RYBELSUS	T2	PA QL(1 TAB/DAY)
TRULICITY	T2	PA QL(2 MLS/28 DAYS)
ANTI-HYPERGLY,INSULIN,LONG ACT-GLP-I RECEPT.AGONIST		
SOLIQUA 100-33	T2	HD
ANTI-HYPERGLYCEMIC - DOPAMINE RECEPTOR AGONISTS		
CYCLOSET	T3	HD
ANTI-HYPERGLYCEMIC - 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)

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTI-HYPERGLYCEMICS (Diabetes) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-HYPERGLYCEMIC, ALPHA-GLUCOSIDASE INHIBITORS		
<i>acarbose</i> (Precose)	T1	HD
<i>miglitol</i>	T1	HD
PRECOSE (<i>acarbose</i>)	T3	HD
ANTI-HYPERGLYCEMIC, AMYLIN ANALOG-TYPE		
SYMLINPEN 60	T2	
SYMLINPEN 120	T2	HD
ANTI-HYPERGLYCEMIC, BIGUANIDE TYPE		
<i>metformin hcl</i>	T1	HD
<i>metformin hcl 1,000 mg tablet</i>	T1	HD
<i>metformin hcl 500 mg tablet</i>	T1	HD
<i>metformin hcl 500 mg/5 ml cup</i> (Riomet)	T1	HD
<i>metformin hcl 500 mg/5 ml soln</i> (Riomet)	T1	HD
<i>metformin hcl 750 mg tablet</i>	T1	HD
<i>metformin hcl 850 mg tablet</i>	T1	HD
RIOMET (<i>metformin hcl</i>)	T3	HD
ANTIHYPERGLYCEMIC, DPP-4 INHIBITORS		
JANUVIA	T2	ST QL(1 TAB/DAY) HD
<i>saxagliptin hcl</i> (Onglyza)	T1	QL(1 TAB/DAY) HD
ANTI-HYPERGLYCEMIC, INSULIN-RELEASE STIMULANT TYPE		
<i>glimepiride 1 mg tablet</i>	T1	HD
<i>glimepiride 2 mg tablet</i>	T1	HD
GLIMEPIRIDE 3 MG TABLET	T3	HD
<i>glimepiride 4 mg tablet</i>	T1	HD
<i>glipizide</i> (Glucotrol XI)	T1	HD
<i>glipizide 10 mg tablet</i>	T1	HD
GLIPIZIDE 2.5 MG TABLET	T3	HD
<i>glipizide 5 mg tablet</i>	T1	HD
GLUCOTROL XL (<i>glipizide</i>)	T3	HD
<i>glyburide</i>	T1	HD
<i>glyburide, micronized</i>	T1	HD
<i>glyburide, micronized</i> (Glynase)	T1	HD
GLYNASE (<i>glyburide, micronized</i>)	T3	HD
<i>nateglinide</i>	T1	HD
<i>tolbutamide</i>	T1	HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTI-HYPERGLYCEMICS (Diabetes) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-HYPERGLYCEMIC, SGLT-2 AND DPP-4 INHIBITOR COMB		
GLYXAMBI	T2	ST QL(1 TAB/DAY) HD
ANTI-HYPERGLYCEMIC, THIAZOLIDINEDIONE AND BIGUANIDE		
ACTOPLUS MET (<i>pioglitazone-metformin</i>)	T3	HD
<i>pioglitazone hcl/metformin hcl</i>	T1	HD
<i>pioglitazone hcl/metformin hcl</i> (Actoplus Met)	T1	HD
ANTI-HYPERGLYCEMIC, THIAZOLIDINEDIONE-SULFONYLUREA		
DUETACT (<i>pioglitazone-glimepiride</i>)	T3	HD
<i>pioglitazone hcl/glimepiride</i> (Duetact)	T1	HD
ANTIHYPERGLYCEMIC, DPP-4 INHIBITOR-BIGUANIDE COMBS.		
JANUMET	T2	ST QL(2 TABS/DAY) HD
JANUMET XR 100-1,000 MG TABLET	T2	ST QL(1 TAB/DAY) HD
JANUMET XR 50-1,000 MG TABLET	T2	ST QL(2 TABS/DAY) HD
JANUMET XR 50-500 MG TABLET	T2	ST QL(1 TAB/DAY) HD
ANTI-HYPERGLYCEMIC, INSULIN-RELEASE STIM.-BIGUANIDE		
<i>glipizide/metformin hcl</i>	T1	HD
<i>glyburide/metformin hcl</i>	T1	HD
ANTI-HYPERGLYCEMIC, THIAZOLIDINEDIONE (PPARG AGONIST)		
<i>pioglitazone hcl</i> (Actos)	T1	HD
ANTIHYPERGLYCEMIC-GLUCOCORTICOID RECEPTOR BLOCKER		
<i>mifepristone 300 mg tablet</i> (Korlym)	T1	PA SP
ANTI-HYPERGLYCEMIC-SGLT2 INHIBITOR-BIGUANIDE COMBS.		
SYNJARDY	T2	ST QL(2 TABS/DAY) HD
SYNJARDY XR 10-1,000 MG TABLET	T2	ST QL(2 TABS/DAY) HD
SYNJARDY XR 12.5-1,000 MG TAB	T2	ST QL(2 TABS/DAY) HD
SYNJARDY XR 25-1,000 MG TABLET	T2	ST QL(1 TAB/DAY) HD
SYNJARDY XR 5-1,000 MG TABLET	T2	ST QL(2 TABS/DAY) HD
XIGDUO XR 10 MG-1,000 MG TAB	T2	ST QL(1 TAB/DAY) HD
XIGDUO XR 10 MG-500 MG TABLET	T2	ST QL(1 TAB/DAY) HD
XIGDUO XR 2.5 MG-1,000 MG TAB	T2	ST QL(2 TABS/DAY) HD
XIGDUO XR 5 MG-1,000 MG TABLET	T2	ST QL(2 TABS/DAY) HD
XIGDUO XR 5 MG-500 MG TABLET	T2	ST QL(1 TAB/DAY) HD
ANTIHYPERGLYCEMIC-SOD/GLUC COTRANSPORT2(SGLT2) INH		
FARXIGA	T2	ST QL(1 TAB/DAY)
JARDIANCE	T2	ST QL(1 TAB/DAY) HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTI-HYPERGLYCEMICS (Diabetes)

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		
BASAGLAR KWIKPEN U-100	T2	QL(1.5 MLS/DAY) HD
BASAGLAR TEMPO PEN U-100	T2	QL(1.5 MLS/DAY) HD
HUMALOG	T2	QL(1.5 MLS/DAY) HD
HUMALOG JUNIOR KWIKPEN	T2	QL(1.5 MLS/DAY) HD
HUMALOG KWIKPEN U-100	T2	QL(1.5 MLS/DAY) HD
HUMALOG KWIKPEN U-200	T2	QL(1 ML/DAY) HD
HUMALOG MIX 50-50 KWIKPEN	T2	QL(2 MLS/DAY) HD
HUMALOG MIX 75-25	T2	QL(2 MLS/DAY) HD
HUMALOG MIX 75-25 KWIKPEN	T2	QL(2 MLS/DAY) HD
HUMALOG TEMPO PEN U-100	T2	QL(1.5 MLS/DAY) HD
HUMULIN 70/30 KWIKPEN	T2	QL(2 MLS/DAY) HD
HUMULIN 70-30	T2	QL(2 MLS/DAY) HD
HUMULIN N	T2	QL(1.5 MLS/DAY) HD
HUMULIN N KWIKPEN	T2	QL(1.5 MLS/DAY) HD
HUMULIN R	T2	QL(1.5 MLS/DAY) HD
HUMULIN R U-500	T2	QL(1 ML/DAY) HD
HUMULIN R U-500 KWIKPEN	T2	QL(1 ML/DAY) HD
INSULIN LISPRO	T2	QL(1.5 MLS/DAY) HD
INSULIN LISPRO JUNIOR KWIKPEN	T2	QL(1.5 MLS/DAY) HD
INSULIN LISPRO KWIKPEN U-100	T2	QL(1.5 MLS/DAY) HD
INSULIN LISPRO PROTAMINE MIX	T2	QL(2 MLS/DAY) HD
LYUMJEV	T2	QL(1.5 MLS/DAY) HD
LYUMJEV KWIKPEN U-100	T2	QL(1.5 MLS/DAY) HD
LYUMJEV KWIKPEN U-200	T2	QL(1 ML/DAY) HD
LYUMJEV TEMPO PEN U-100	T2	QL(1.5 MLS/DAY) HD
REZVOGLAR KWIKPEN	T2	QL(1.5 MLS/DAY) HD
TRESIBA	T2	QL(1.5 MLS/DAY) HD
TRESIBA FLEXTOUCH U-100	T2	QL(1.5 MLS/DAY) HD
TRESIBA FLEXTOUCH U-200	T2	QL(0.9 MLS/DAY) HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTI-INFECTIVES (Feminine Products)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VAGINAL SULFONAMIDES		
<i>acetic acid/oxyquinoline</i> (Relagard)	T1	
RELAGARD (<i>acetic acid/oxyquinoline</i>)	T3	
TRIMO-SAN	T3	

ANTI-INFECTIVES/MISCELLANEOUS (Infections)

2ND GEN. ANAEROBIC ANTI-PROTOZOAL-ANTIBACTERIAL		
<i>tinidazole</i>	T1	
ANTHELMINTICS		
<i>albendazole</i>	T1	
BILTRICIDE (<i>praziquantel</i>)	T3	
EMVERM	T1	
<i>ivermectin 3 mg tablet</i> (Stromectol)	T1	PA
<i>ivermectin 6 mg tablet</i>	T1	PA
<i>praziquantel</i> (Biltricide)	T1	
STROMEKTOL (<i>ivermectin</i>)	T3	PA
ANTI-MALARIAL DRUGS		
<i>atovaquone/proguanil hcl</i> (Malarone)	T1	
<i>chloroquine phosphate</i>	T1	
COARTEM	T3	PA QL(24 TABS/30 DAYS)
<i>hydroxychloroquine sulfate</i>	T1	
<i>hydroxychloroquine sulfate</i> (Plaquenil)	T1	
KRINTAFEL	T3	PA QL(2 TABS/30 DAYS)
MALARONE (<i>atovaquone-proguanil hcl</i>)	T3	PA
<i>mefloquine hcl</i>	T1	
PRIMAQUINE (<i>primaquine phosphate</i>)	T1	
<i>primaquine phosphate</i> (Primaquine)	T1	
<i>pyrimethamine 25 mg tablet</i> (Daraprim)	T1	PA SP
<i>quinine sulfate</i> (Qualaquin)	T1	
ANTI-PROTOZOAL DRUGS, MISCELLANEOUS		
<i>atovaquone</i> (MeproN)	T1	
BENZNIDAZOLE	T3	
IMPAVIDO	T3	PA
LAMPIT	T3	
NEBUPENT (<i>pentamidine isethionate</i>)	T3	
<i>pentamidine isethionate</i> (Nebupent)	T1	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTI-INFECTIVES/MISCELLANEOUS (Miscellaneous)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIBACTERIAL AGENTS,MISCELLANEOUS		
<i>glycine urologic solution</i>	T1	
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	

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

ANTI-INFLAMMATORY TUMOR NECROSIS FACTOR INHIBITOR		
ADALIMUMAB-ADB(M) 10 MG SYRG	T2	PA QL(2 PENS/SYRINGES/28 DAYS) SP HD
ADALIMUMAB-ADB(M) 20 MG SYRG	T2	PA QL(2 PENS/SYRINGES/28 DAYS) SP HD
ADALIMUMAB-ADB(M) 40 MG SYRG	T2	PA QL(4 SRNGE KITS/28 DAYS) SP HD
ADALIMUMAB-ADB(M) PEN	T2	PA QL(4 KITS/28 DAYS) SP HD
ADALIMUMAB-RYVK(CF)	T2	PA QL(4 SRNGE KITS/28 DAYS) SP HD
ADALIMUMAB-RYVK(CF) AUTOINJECT	T2	PA QL SP HD
CIMZIA (2 PACK)	T2	PA QL(1 KIT/28 DAYS) SP HD
CIMZIA 200 MG VIAL KIT	T2	PA QL(2 PENS/SYRINGES/28 DAYS) SP
CIMZIA 2X200 MG/ML (X3) START KT	T2	PA QL(1 STARTER KIT/365 DAYS) SP HD
CYLTEZO(CF) 10 MG/0.2 ML SYRNG	T2	PA QL(2 PENS/SYRINGES/28 DAYS) SP HD
CYLTEZO(CF) 20 MG/0.4 ML SYRNG	T2	PA QL(2 PENS/SYRINGES/28 DAYS) SP HD
CYLTEZO(CF) 40 MG/0.4 ML SYRNG	T2	PA QL(4 SRNGE KITS/28 DAYS) SP HD
CYLTEZO(CF) 40 MG/0.8 ML SYRNG	T2	PA QL(4 SRNGE KITS/28 DAYS) SP HD
CYLTEZO(CF) PEN	T2	PA QL(4 KITS/28 DAYS) SP HD
CYLTEZO(CF) PEN CROHN'S-UC-HS	T2	PA QL(1 STARTER KIT/365 DAYS) SP HD
CYLTEZO(CF) PEN PSORIASIS-UV	T2	PA QL(1 STARTER KIT/365 DAYS) SP HD
ENBREL 25 MG/0.5 ML SYRINGE	T2	PA QL(8 MLS/28 DAYS) SP HD
ENBREL 25 MG/0.5 ML VIAL	T2	PA QL(8 MLS/28 DAYS) SP HD
ENBREL 50 MG/ML SYRINGE	T2	PA QL(4 MLS/28 DAYS) SP HD
ENBREL MINI	T2	PA QL(4 MLS/28 DAYS) SP HD
ENBREL SURECLICK	T2	PA QL(4 MLS/28 DAYS) SP HD
HUMIRA	T2	PA QL(4 SRNGE KITS/28 DAYS) SP HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-INFLAMMATORY TUMOR NECROSIS FACTOR INHIBITOR (cont.)		
HUMIRA PEN	T2	PA QL(4 KITS/28 DAYS) SP HD
HUMIRA(CF) 10 MG/0.1 ML SYRING	T2	PA QL(2 PENS/SYRINGES/28 DAYS) SP HD
HUMIRA(CF) 20 MG/0.2 ML SYRING	T2	PA QL(2 PENS/SYRINGES/28 DAYS) SP HD
HUMIRA(CF) 40 MG/0.4 ML SYRING	T2	PA QL(4 SRNGE KITS/28 DAYS) SP HD
HUMIRA(CF) PEN 40 MG/0.4 ML	T2	PA QL(4 KITS/28 DAYS) SP HD
HUMIRA(CF) PEN 80 MG/0.8 ML	T2	PA QL(2 PENS/28 DAYS) SP HD
HUMIRA(CF) PEN CROHN'S-UC-HS	T2	PA QL(1 STARTER KIT/365 DAYS) SP HD
HUMIRA(CF) PEN PSOR-UV-ADOL HS	T2	PA QL(1 STARTER KIT/365 DAYS) SP HD
SIMLANDI(CF) 20 MG/0.2 ML SYRG	T2	PA QL(2 PENS/SYRINGES/28 DAYS) SP HD
SIMLANDI(CF) 40 MG/0.4 ML SYRG	T2	PA QL(4 SRNGE KITS/28 DAYS) SP HD
SIMLANDI(CF) 80 MG/0.8 ML SYRG	T2	PA QL(2 PENS/SYRINGES/28 DAYS) SP HD
SIMLANDI(CF) AI 40 MG/0.4 ML	T2	PA QL SP HD
SIMLANDI(CF) AI 80 MG/0.8 ML	T2	PA QL(2 AUTO-INJS/28 DAYS) SP HD
SIMPONI 100 MG/ML PEN INJECTOR	T2	PA QL(1 PEN/28 DAYS) SP HD
SIMPONI 100 MG/ML SYRINGE	T2	PA QL(1 SYRINGE/28 DAYS) SP HD
SIMPONI ARIA	T2	PA SP HD
ZYMFENTRA	T2	PA QL(2 SRNGE KITS/28 DAYS) SP HD
ZYMFENTRA PEN	T2	PA QL(2 KITS/28 DAYS) SP HD
ANTI-NEOPLASTICS (Cancer)		
ANP - SELECTIVE RETINOID X RECEPTOR AGONISTS (RXR)		
<i>bexarotene 75 mg capsule (Targretin)</i>	T1	PA SP HD CSL
ANTI-NEOPLAST, HISTONE DEACETYLASE (HDAC) INHIBITORS		
ZOLINZA	T2	PA SP HD
ANTI-NEOPLASTIC - ALKYLATING AGENTS		
ALKERAN (<i>melphalan</i>)	T3	SP CSL
<i>cyclophosphamide 25 mg capsule</i>	T1	SP HD CSL
<i>cyclophosphamide 50 mg capsule</i>	T1	SP HD CSL
GLEOSTINE	T2	CSL
HYDREA (<i>hydroxyurea</i>)	T3	CSL
<i>hydroxyurea (Hydrea)</i>	T1	CSL
LEUKERAN	T2	CSL
<i>lomustine</i>	T1	CSL
MYLERAN	T2	CSL
<i>temozolomide</i>	T1	PA SP HD CSL

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTI-NEOPLASTICS (Cancer) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-NEOPLASTIC - ANTI-ANDROGENIC AGENTS		
<i>abiraterone acetate</i> (Zytiga)	T1	PA CSL
<i>abiraterone acetate 250 mg tab</i> (Zytiga)	T1	PA SP HD CSL
<i>abiraterone acetate 500 mg tab</i> (Zytiga)	T1	PA SP HD CSL
<i>bicalutamide</i> (Casodex)	T1	CSL
CASODEX (<i>bicalutamide</i>)	T3	CSL
ERLEADA	T2	PA SP HD CSL
EULEXIN (<i>flutamide</i>)	T3	CSL
<i>flutamide</i> (Eulexin)	T1	CSL
<i>nilutamide</i> (Nilandron)	T1	QL(4 TABS/DAY) CSL
NUBEQA	T2	PA SP HD CSL
XTANDI	T2	PA SP HD CSL
ANTI-NEOPLASTIC - ANTI-METABOLITES		
<i>capecitabine 150 mg tablet</i> (Xeloda)	T1	PA SP HD CSL
<i>capecitabine 500 mg tablet</i> (Xeloda)	T1	PA SP HD CSL
INQOVI	T3	PA SP HD CSL
JYLAMVO	T3	CSL
LONSURF	T3	PA SP HD CSL
<i>mercaptopurine 20 mg/ml suspen</i> (Purixan)	T1	SP CSL
<i>mercaptopurine 50 mg tablet</i>	T1	CSL
<i>methotrexate 2.5 mg tablet</i>	T1	CSL
<i>methotrexate 250 mg/10 ml vial</i>	T1	
<i>methotrexate 50 mg/2 ml vial</i>	T1	
<i>methotrexate sodium/pf</i>	T1	
ONUREG	T3	PA QL(14 TABS/28 DAYS) SP CSL
PURIXAN (<i>mercaptopurine</i>)	T3	SP CSL
TABLOID	T3	CSL
TREXALL	T2	CSL
XATMEP	T3	CSL
XELODA (<i>capecitabine</i>)	T3	PA SP HD CSL

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTI-NEOPLASTICS (Cancer) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-NEOPLASTIC - AROMATASE INHIBITORS		
<i>anastrozole</i> (Arimidex)	T1	HD PPACA CSL
ARIMIDEX (<i>anastrozole</i>)	T3	HD CSL
AROMASIN (<i>exemestane</i>)	T3	HD CSL
<i>exemestane</i> (Aromasin)	T1	HD PPACA CSL
<i>letrozole</i> (Femara)	T1	HD CSL
ANTI-NEOPLASTIC - BRAF KINASE INHIBITORS		
OJEMDA 100 MG TAB (400MG DOSE)	T3	PA QL(1 PACKET/28 Days) SP CSL
OJEMDA 100 MG TAB (500MG DOSE)	T3	PA QL(1 PACKET/28 Days) SP CSL
OJEMDA 100 MG TAB (600MG DOSE)	T3	PA QL(1 PACKET/28 Days) SP CSL
OJEMDA 25 MG/ML ORAL SUSP	T3	PA QL(8 BOTTLES/28 DAYS) SP CSL
TAFINLAR 10 MG TABLET FOR SUSP	T2	PA QL(30 TABS/DAY) SP HD CSL
TAFINLAR 50 MG CAPSULE	T2	PA QL(4 CAPS/DAY) SP HD CSL
TAFINLAR 75 MG CAPSULE	T2	PA QL(4 CAPS/DAY) SP HD CSL
ZELBORAF	T2	PA SP HD CSL
ANTI-NEOPLASTIC - HEDGEHOG PATHWAY INHIBITOR		
DAURISMO	T3	PA SP HD CSL
ERIVEDGE	T2	PA SP HD CSL
ODOMZO	T2	PA SP HD CSL
ANTI-NEOPLASTIC - JANUS KINASE (JAK) INHIBITORS		
JAKAFI	T3	PA QL(2 TABS/DAY) SP HD CSL
ANTI-NEOPLASTIC - KRAS PROTEIN INHIBITOR		
LUMAKRAS 120 MG TABLET	T3	PA QL(8 TABS/DAY) SP HD CSL
LUMAKRAS 240 MG TABLET	T3	PA QL(4 TABS/DAY) SP HD CSL
LUMAKRAS 320 MG TABLET	T3	PA QL(3 TABS/DAY) SP HD CSL
ANTI-NEOPLASTIC - MEKI AND MEK2 KINASE INHIBITORS		
COTELLIC	T2	PA SP HD CSL
GOMEKLI	T3	PA SP CSL
KOSELUGO 10 MG CAPSULE	T3	PA QL(10 CAPS/DAY) SP CSL
KOSELUGO 25 MG CAPSULE	T3	PA QL(4 CAPS/DAY) SP CSL
KOSELUGO 5 MG SPRINKLE CAPSULE	T3	PA QL(20 CAPS/DAY) SP CSL
KOSELUGO 7.5 MG SPRINKLE CAP	T3	PA QL(12 CAPS/DAY) SP CSL
MEKINIST 0.05 MG/ML SOLUTION	T2	PA QL(40 MLS/DAY) SP HD CSL
MEKINIST 0.5 MG TABLET	T2	PA QL(3 TABS/DAY) SP HD CSL
MEKINIST 2 MG TABLET	T2	PA QL(1 TAB/DAY) SP HD CSL

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTI-NEOPLASTICS (Cancer) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-NEOPLASTIC - MTOR KINASE INHIBITORS		
everolimus tablet (Afinitor)	T1	PA QL(1 TAB/DAY) SP CSL
everolimus 10 mg tablet (Afinitor)	T1	PA QL(1 TAB/DAY) SP HD CSL
everolimus 2 mg tab for susp (Afinitor Disperz)	T1	PA QL(1 TAB/DAY) SP CSL
everolimus 2.5 mg tablet (Afinitor)	T1	PA QL(1 TAB/DAY) SP HD CSL
everolimus 3 mg tab for susp (Afinitor Disperz)	T1	PA QL(1 TAB/DAY) SP CSL
everolimus 5 mg tab for susp (Afinitor Disperz)	T1	PA QL(1 TAB/DAY) SP CSL
everolimus 5 mg tablet (Afinitor)	T1	PA QL(1 TAB/DAY) SP HD CSL
everolimus 7.5 mg tablet (Afinitor)	T1	PA QL(1 TAB/DAY) SP HD CSL
ANTI-NEOPLASTIC - PROTEIN METHYLTRANSFERASE INHIBIT		
TAZVERIK	T3	PA SP CSL
ANTINEOPLASTIC - SYSTEMIC ENZYME INHIBITORS COMBS		
AVMAPKI-FAKZYNJA	T3	PA SP CSL
ANTI-NEOPLASTIC - TOPOISOMERASE I INHIBITORS		
HYCAMTIN	T3	PA SP HD CSL
ANTI-NEOPLASTIC COMB - KINASE AND AROMATASE INHIBIT		
KISQALI FEMARA CO-PACK	T2	PA QL(1 TAB/28 DAYS) SP CSL
ANTI-NEOPLASTIC IMMUNOMODULATOR AGENTS		
lenalidomide	T1	PA QL(1 CAP/DAY) SP HD CSL
POMALYST	T2	PA QL(21 CAPS/28 DAYS) SP HD CSL
REVLIMID	T2	PA QL(1 CAP/DAY) SP HD CSL
ANTI-NEOPLASTIC LHRH (GNRH) ANTAGONIST, PITUIT.SUPPRS		
ORGOVYX	T3	PA SP CSL
ANTI-NEOPLASTIC SYSTEMIC ENZYME INHIBITORS		
ALECENSA	T2	PA QL(8 CAPS/DAY) SP HD CSL
ALUNBRIG 30 MG TABLET	T2	PA QL(2 TABS/DAY) SP CSL
ALUNBRIG 90 MG TABLET	T2	PA QL(1 TAB/DAY) SP CSL
ALUNBRIG 90 MG-180 MG TAB PACK	T2	PA QL(1 TAB/DAY) SP CSL
ALUNBRIG 180 MG TABLET	T2	PA QL(1 TAB/DAY) SP CSL
AYVAKIT	T3	PA QL(1 TAB/DAY) SP CSL
BALVERSA	T3	PA SP CSL
BOSULIF 100 MG CAPSULE	T3	PA QL(3 CAPS/DAY) SP HD CSL
BOSULIF 100 MG TABLET	T3	PA QL(3 TABS/DAY) SP HD CSL
BOSULIF 400 MG TABLET	T3	PA QL(1 TAB/DAY) SP HD CSL
BOSULIF 50 MG CAPSULE	T3	PA QL(3 CAPS/DAY) SP HD CSL
BRUKINSA 80 MG CAPSULE	T2	PA QL(4 CAPS/DAY) SP CSL

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTI-NEOPLASTICS (Cancer) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-NEOPLASTIC SYSTEMIC ENZYME INHIBITORS (cont.)		
BRUKINSA 160 MG TABLET	T2	PA QL(2 TABS/DAY) SP CSL
CABOMETYX	T2	PA SP HD CSL
CALQUENCE	T2	PA SP CSL
CAPRELSA 100 MG TABLET	T3	PA QL(2 TABS/DAY) SP CSL
CAPRELSA 300 MG TABLET	T3	PA QL(1 TAB/DAY) SP CSL
COMETRIQ 60 MG DAILY-DOSE PACK	T3	PA QL(84 CAPS/28 DAYS) SP HD CSL
COMETRIQ 100 MG DAILY-DOSE PK	T3	PA QL(56 CAPS/28 DAYS) SP HD CSL
COMETRIQ 140 MG DAILY-DOSE PK	T3	PA QL(112 CAPS/28 DAYS) SP HD CSL
COPIKTRA	T3	PA SP CSL
DANZITEN	T2	PA SP CSL
<i>dasatinib 100 mg tablet (Sprycel)</i>	T1	QL(1 TAB/DAY) SP HD CSL
<i>dasatinib 140 mg tablet (Sprycel)</i>	T1	QL(1 TAB/DAY) SP HD CSL
<i>dasatinib 20 mg tablet (Sprycel)</i>	T1	QL(3 TABS/DAY) SP HD CSL
<i>dasatinib 50 mg tablet (Sprycel)</i>	T1	QL(1 TAB/DAY) SP HD CSL
<i>dasatinib 70 mg tablet (Sprycel)</i>	T1	QL(2 TABS/DAY) SP HD CSL
<i>dasatinib 80 mg tablet (Sprycel)</i>	T1	QL(1 TAB/DAY) SP HD CSL
ENSACOVE 25 MG CAPSULE	T2	PA QL(9 CAPS/DAY) SP CSL
ENSACOVE 100 MG CAPSULE	T2	PA QL(2 CAPS/DAY) SP CSL
<i>erlotinib hcl</i>	T1	PA SP HD CSL
FOTIVDA	T3	PA QL(21 CAPS/28 DAYS) SP CSL
FRUZAQLA 1 MG CAPSULE	T2	PA QL(84 CAPS/28 DAYS) SP CSL
FRUZAQLA 5 MG CAPSULE	T2	PA QL(21 CAPS/28 DAYS) SP CSL
GAVRETO	T3	PA QL(4 CAPS/DAY) SP CSL
<i>gefitinib (Iressa)</i>	T1	PA SP HD CSL
GILOTRIF	T3	PA SP HD CSL
IBRANCE 75 MG CAPSULE	T3	PA QL(21 CAPS/28 DAYS) SP HD CSL
IBRANCE 75 MG TABLET	T3	PA QL(21 TABS/28 DAYS) SP HD CSL

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTI-NEOPLASTICS (Cancer) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-NEOPLASTIC SYSTEMIC ENZYME INHIBITORS (cont.)		
IBRANCE 100 MG CAPSULE	T3	PA QL(21 CAPS/28 DAYS) SP HD CSL
IBRANCE 100 MG TABLET	T3	PA QL(21 TABS/28 DAYS) SP HD CSL
IBRANCE 125 MG CAPSULE	T3	PA QL(21 CAPS/28 DAYS) SP HD CSL
IBRANCE 125 MG TABLET	T3	PA QL(21 TABS/28 DAYS) SP HD CSL
IBTROZI	T3	PA SP CSL
<i>imatinib mesylate 100mg tab (Gleevec)</i>	T1	QL(6 TABS/DAY) SP HD CSL
<i>imatinib mesylate 400mg tab (Gleevec)</i>	T1	QL(2 TABS/DAY) SP HD CSL
IMBRUVICA 70 MG CAPSULE	T2	PA QL(1 CAP/DAY) SP CSL
IMBRUVICA 70 MG/ML SUSPENSION	T2	PA QL(8 MLS/DAY) SP CSL
IMBRUVICA 140 MG CAPSULE	T2	PA QL(4 CAPS/DAY) SP CSL
IMBRUVICA 140 MG TABLET	T2	PA QL(1 TAB/DAY) SP CSL
IMBRUVICA 280 MG TABLET	T2	PA QL(1 TAB/DAY) SP CSL
IMBRUVICA 420 MG TABLET	T2	PA QL(1 TAB/DAY) SP CSL
IMKELDI	T2	PA SP CSL
INLYTA	T3	PA SP HD CSL
INREBIC	T3	PA SP HD CSL
IRESSA (<i>gefitinib</i>)	T3	PA SP HD CSL
ITOVEBI	T3	PA SP HD CSL
IWILFIN	T3	PA QL(8 TABS/DAY) SP CSL
JAYPIRCA 100 MG TABLET	T3	PA QL(2 TABS/DAY) SP CSL
JAYPIRCA 50 MG TABLET	T3	PA QL(1 TAB/DAY) SP CSL
KISQALI 200 MG DAILY DOSE	T2	PA QL(21 TABS/28 DAYS) SP HD CSL
KISQALI 400 MG DAILY DOSE	T2	PA QL(42 TABS/28 DAYS) SP HD CSL
KISQALI 600 MG DAILY DOSE	T2	PA QL(63 TABS/28 DAYS) SP HD CSL
<i>lapatinib ditosylate (Tykerb)</i>	T1	PA QL(6 TABS/DAY) SP HD CSL
LAZCLUZE	T3	PA SP CSL
LENVIMA	T2	PA SP HD CSL
LORBRENA 25 MG TABLET	T3	PA QL(3 TABS/DAY) SP HD CSL
LORBRENA 100 MG TABLET	T3	PA QL(1 TAB/DAY) SP HD CSL
LYNPARZA	T2	PA QL(4 TABS/DAY) SP HD CSL
LYTGOBI 12 MG DAILY DOSE PACK	T3	PA QL(3 TABS/DAY) SP CSL
LYTGOBI 16 MG DAILY DOSE PACK	T3	PA QL(4 TABS/DAY) SP CSL
LYTGOBI 20 MG DAILY DOSE PACK	T3	PA QL(5 TABS/DAY) SP CSL

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTI-NEOPLASTICS (Cancer) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-NEOPLASTIC SYSTEMIC ENZYME INHIBITORS (cont.)		
NERLYNX	T3	PA SP HD CSL
<i>nilotinib hcl</i> (Tasigna)	T1	PA QL(4 CAPS/DAY) SP HD CSL
NINLARO	T3	PA QL(3 CAPS/28 DAYS) SP HD CSL
OGSIVEO 50 MG TABLET	T3	PA QL(6 TABS/DAY) SP CSL
OGSIVEO 100 MG TABLET	T3	PA QL(2 TABS/DAY) SP CSL
OGSIVEO 150 MG TABLET	T3	PA QL(2 TABS/DAY) SP CSL
OJJAARA	T3	PA QL(1 TAB/DAY) SP CSL
<i>pazopanib hcl</i> (Votrient)	T1	PA QL(4 TABS/DAY) SP CSL
PEMAZYRE	T3	PA QL(14 TABS/21 DAYS) SP CSL
PIQRAY	T2	PA SP CSL
QINLOCK	T3	PA QL(3 TABS/DAY) SP CSL
RETEVMO 40 MG CAPSULE	T3	PA QL(6 CAPS/DAY) SP HD CSL
RETEVMO 40 MG TABLET	T3	PA QL(3 TABS/DAY) SP HD CSL
RETEVMO 80 MG CAPSULE	T3	PA QL(4 CAPS/DAY) SP HD CSL
RETEVMO 80 MG TABLET	T3	PA QL(2 TABS/DAY) SP HD CSL
RETEVMO 120 MG, 160 MG TABLET	T3	PA QL(2 TABS/DAY) SP HD CSL
REVUFORJ 25 MG TABLET	T3	PA QL(8 TABS/DAY) SP CSL
REVUFORJ 110 MG TABLET	T3	PA QL(4 TABS/DAY) SP CSL
REVUFORJ 160 MG TABLET	T3	PA QL(2 TABS/DAY) SP CSL
ROMVIMZA	T3	PA QL(8 CAPS/28 DAYS) SP CSL
ROZLYTREK	T3	PA SP HD CSL
RUBRACA	T2	PA QL(4 TABS/DAY) SP CSL
RYDAPT	T3	PA SP HD CSL
SCEMBLIX 20 MG TABLET	T2	PA QL(2 TABS/DAY) SP CSL
SCEMBLIX 40 MG TABLET	T2	PA SP CSL
SCEMBLIX 100 MG TABLET	T2	PA SP CSL
<i>sorafenib tosylate</i> (Nexavar)	T1	PA QL(4 TABS/DAY) SP HD CSL
STIVARGA	T2	PA QL(84 TABS/28 DAYS) SP HD CSL
<i>sunitinib malate</i> (Sutent)	T1	PA QL(1 CAP/DAY) SP HD CSL
TABRECTA	T3	PA QL(4 TABS/DAY) SP HD CSL
TAGRISSO	T3	PA SP HD CSL
TALZENNA 0.1 MG CAPSULE	T3	PA QL(1 CAP/DAY) SP CSL
TALZENNA 0.1 MG SOFTGEL	T3	PA QL(1 CAP/DAY) SP CSL
TALZENNA 0.25 MG CAPSULE	T3	PA QL(1 CAP/DAY) SP CSL
TALZENNA 0.25 MG SOFTGEL	T3	PA QL(1 CAP/DAY) SP CSL

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTI-NEOPLASTICS (Cancer) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-NEOPLASTIC SYSTEMIC ENZYME INHIBITORS (cont.)		
TALZENNA 0.35 MG SOFTGEL	T3	PA QL(1 CAP/DAY) SP CSL
TALZENNA 0.5 MG CAPSULE	T3	PA SP CSL
TALZENNA 0.5 MG SOFTGEL	T3	PA SP CSL
TALZENNA 0.75 MG SOFTGEL	T3	PA SP CSL
TALZENNA 1 MG CAPSULE	T3	PA QL(1 CAP/DAY) SP CSL
TALZENNA 1 MG SOFTGEL	T3	PA QL(1 CAP/DAY) SP CSL
TEPMETKO	T3	PA QL(2 TABS/DAY) SP CSL
TRUQAP	T2	PA QL(64 TABS/28 DAYS) SP CSL
TUKYSA	T3	PA SP CSL
TURALIO	T3	PA QL(4 CAPS/DAY) SP CSL
VANFLYTA	T3	PA QL(2 TABS/DAY) SP CSL
VERZENIO	T2	PA QL(2 TABS/DAY) SP HD CSL
VITRAKVI	T3	PA SP HD CSL
VIZIMPRO	T3	PA SP HD CSL
VONJO	T3	PA QL(4 CAPS/DAY) SP CSL
XALKORI 50 MG PELLETT	T3	PA QL(4 PELLETS/DAY) SP HD CSL
XALKORI 20 MG PELLETT	T3	PA QL(4 PELLETS/DAY) SP HD CSL
XALKORI 150 MG PELLETT	T3	PA QL(6 PELLETS/DAY) SP HD CSL
XALKORI 200 MG CAPSULE	T3	PA QL(4 CAPS/DAY) SP HD CSL
XALKORI 250 MG CAPSULE	T3	PA QL(4 CAPS/DAY) SP HD CSL
XOSPATA	T3	PA SP CSL
ZEJULA	T2	PA QL(1 TAB/DAY) SP CSL
ZYDELIG	T3	PA QL(2 TABS/DAY) SP HD CSL
ANTI-NEOPLASTIC-B CELL LYMPHOMA-2(BCL-2) INHIBITORS		
VENCLEXTA	T2	PA SP CSL
VENCLEXTA STARTING PACK	T2	PA SP CSL
ANTI-NEOPLASTIC-ENZYME INHIB, ANTIANDROGEN COMB.		
AKEEGA	T3	PA QL(2 TABS/DAY) SP CSL
ANTINEOPLASTIC-HYPOXIA INDUCIBLE FACTOR (HIF) INH		
WELIREG	T3	PA QL(3 TABS/DAY) SP CSL
ANTI-NEOPLASTIC-ISOCITRATE DEHYDROGENASE INHIBITORS		
IDHIFA	T3	PA SP HD CSL
REZLIDHIA	T3	PA QL(2 CAPS/DAY) SP CSL
TIBSOVO	T3	PA SP CSL
VORANIGO	T3	PA SP CSL

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTI-NEOPLASTICS (Cancer) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-NEOPLASTICS, MISCELLANEOUS		
<i>etoposide</i>	T1	SP HD CSL
LYSODREN	T2	CSL
MATULANE	T2	SP CSL
<i>tretinoin 10 mg capsule</i>	T1	PA CSL
ANTI-NEOPLASTIC-SELECT INHIB OF NUCLEAR EXP (SINE)		
XPOVIO	T3	PA SP CSL
IMMUNOMODULATORS		
ACTIMMUNE	T2	PA SP HD
SELECTIVE ESTROGEN RECEPTOR MODULATORS (SERMS)		
FARESTON (<i>toremifene citrate</i>)	T3	QL(2 TABS/DAY) HD CSL
ORSERDU 345 MG TABLET	T3	PA QL(1 TAB/DAY) SP CSL
ORSERDU 86 MG TABLET	T3	PA QL(3 TABS/DAY) SP CSL
SOLTAMOX	T2	HD CSL
<i>tamoxifen citrate</i>	T1	HD PPACA CSL
<i>toremifene citrate</i> (Fareston)	T1	QL(2 TABS/DAY) HD CSL
STEROID ANTI-NEOPLASTICS		
<i>megestrol 20 mg tablet</i>	T1	CSL
<i>megestrol 40 mg tablet</i>	T1	CSL
PHOTOACT, TOPICAL ANTINEOPLAST, PREMALIGNANT LESIONS		
LEVULAN	T3	SP

ANTI-NEOPLASTICS (Skin Conditions)

TOPICAL ANTI-NEOPLASTIC PREMALIGNANT LESION AGENTS		
<i>bexarotene 1% gel</i> (Targretin)	T1	SP HD
EFUDEX (<i>fluorouracil</i>)	T3	
FLUOROPLEX	T2	
<i>fluorouracil</i>	T1	
FLUOROURACIL	T1	
<i>fluorouracil</i> (Efudex)	T1	
PANRETIN	T3	SP HD
VALCHLOR	T3	SP HD

ANTI-OBESITY DRUGS (Weight Management)

ANTI-OBESITY - ANOREXIC AGENTS		
<i>benzphetamine hcl</i>	T1	
<i>diethylpropion hcl</i>	T1	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTI-OBESITY DRUGS (Weight Management) (cont.)

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

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTI-PARASITICS (Infections)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-PARASITICS		
ALINIA 100 MG/5 ML SUSPENSION	T3	
<i>nitazoxanide</i> (Alinia)	T1	
TOPICAL ANTI-PARASITICS		
<i>crotamiton</i>	T1	
ELIMITE (<i>permethrin</i>)	T3	
EURAX	T3	
<i>lindane</i>	T1	
<i>malathion</i> (Ovide)	T1	
OVIDE (<i>malathion</i>)	T3	
<i>permethrin</i> (Elimite)	T1	
<i>spinosad</i> (Natroba)	T1	
ULESFIA	T3	

ANTI-PARKINSON DRUGS (Parkinson's Disease)

ANTI-PARKINSONISM DRUGS, ANTI-CHOLINERGIC		
<i>benztropine mesylate</i>	T1	HD
<i>trihexyphenidyl hcl</i>	T1	HD
ANTI-PARKINSONISM DRUGS, OTHER		
<i>amantadine hcl</i>	T1	HD
APOKYN	T3	PA SP HD
<i>apomorphine hcl</i>	T1	PA SP
<i>bromocriptine mesylate</i>	T1	HD
<i>carbidopa/levodopa</i>	T1	HD
<i>carbidopa/levodopa</i> (Sinemet)	T1	HD
<i>carbidopa/levodopa/entacapone</i>	T1	HD
<i>carbidopa/levodopa/entacapone</i> (Stalevo 100)	T1	HD
<i>carbidopa/levodopa/entacapone</i> (Stalevo 75)	T1	HD
<i>carbidopa-levo er 25-100 tab</i>	T1	HD
<i>carbidopa-levo er 50-200 tab</i>	T1	HD
CREXONT	T3	ST HD
DUOPA	T3	SP HD
<i>entacapone</i>	T1	HD
INBRIJA	T3	PA SP HD
NEUPRO	T3	HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-PARKINSONISM DRUGS, OTHER (cont.)		
NOURIANZ	T3	PA QL(1 TAB/DAY) SP HD
<i>pramipexole di-hcl</i>	T1	HD
<i>pramipexole er 0.375 mg tablet (Mirapex Er)</i>	T1	QL(1 TAB/DAY) HD
<i>pramipexole er 0.75 mg tablet (Mirapex Er)</i>	T1	HD
<i>pramipexole er 1.5 mg tablet</i>	T1	QL(1 TAB/DAY) HD
<i>pramipexole er 2.25 mg tablet</i>	T1	QL(1 TAB/DAY) HD
<i>pramipexole er 3 mg tablet</i>	T1	HD
<i>pramipexole er 3.75 mg tablet</i>	T1	HD
<i>pramipexole er 4.5 mg tablet</i>	T1	HD
<i>rasagiline mesylate 0.5 mg tab (Azilect)</i>	T1	QL(1 TAB/DAY) HD
<i>rasagiline mesylate 1 mg tab (Azilect)</i>	T1	HD
<i>ropinirole hcl</i>	T1	HD
RYTARY	T3	ST HD
<i>selegiline hcl</i>	T1	HD
SINEMET (<i>carbidopa/levodopa</i>)	T3	HD
STALEVO 100 (<i>carbidopa/levodopa/entacapone</i>)	T3	HD
STALEVO 75 (<i>carbidopa/levodopa/entacapone</i>)	T3	HD
TASMAR (<i>tolcapone</i>)	T3	HD
<i>tolcapone (Tasmar)</i>	T1	HD
XADAGO	T3	ST HD
DECARBOXYLASE INHIBITORS		
<i>carbidopa (Lodosyn)</i>	T1	
ANTI-PLATELET DRUGS (Blood Thinners/Anti-Clotting)		
PLATELET AGGREGATION INHIBITORS		
<i>aspirin/dipyridamole</i>	T1	HD
ASPIRIN-OMEPRAZOLE DR 81-40 MG	T3	HD
<i>cilostazol</i>	T1	HD
<i>clopidogrel bisulfate</i>	T1	HD
<i>clopidogrel bisulfate (Plavix)</i>	T1	HD
<i>dipyridamole</i>	T1	HD
<i>prasugrel hcl (Effient)</i>	T1	HD
<i>ticagrelor (Brilinta)</i>	T1	HD
ZONTIVITY	T3	HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PLATELET REDUCING AGENTS		
AGRYLIN (<i>anagrelide hcl</i>)	T3	
<i>anagrelide hcl</i>	T1	
<i>anagrelide hcl</i> (Agrylin)	T1	
ANTIVIRALS (AIDS/HIV)		
PLATELET REDUCING AGENTS		
SUNLENCA 300 MG TABLET	T3	PA QL(5 TABS/180 DAYS) SP
SUNLENCA 4- 300 MG TABLET	T3	PA QL(5 TABS/180 DAYS) SP
SUNLENCA 463.5 MG/1.5 ML VIAL	T3	PA SP
SUNLENCA 5- 300 MG TABLET	T3	PA QL(5 TABS/180 DAYS) SP
YEZTUGO 463.5 MG/1.5 ML VIAL	T2	SP PPACA
ANTI-RETROVIRAL - INTEGRASE INHIBITOR AND NNRTI COMB.		
JULUCA	T2	QL(1 TAB/DAY) SP
ANTI-RETROVIRAL - INTEGRASE INHIBITOR AND NRTI COMB.		
DOVATO	T2	QL(1 TAB/DAY) SP
ANTI-RETROVIRAL - NRTIS AND INTEGRASE INHIBITORS COMB		
TRIUMEQ	T2	QL(1 TAB/DAY) SP
TRIUMEQ PD 60-5-30 MG TAB SUSP	T2	QL(6 TABS/DAY) SP
ANTI-RETROVIRAL - NUCLEOSIDE, NUCLEOTIDE, PROTEASE INH.		
SYMTUZA	T3	QL(1 TAB/DAY) SP
ANTIVIRALS - HIV-SPEC, NON-PEPTIDIC PROTEASE INHIB		
APTIVUS	T2	PA SP
darunavir (Prezista)	T1	HD
PREZCOBIX	T3	PA SP
PREZISTA 100 MG/ML SUSPENSION	T2	SP
PREZISTA 150 MG TABLET	T2	SP
PREZISTA 75 MG TABLET	T2	SP
ANTIVIRALS - HIV-SPEC, NUCLEOSIDE-NUCLEOTIDE ANALOG		
CIMDUO	T3	PA SP
DESCOVY 120-15 MG TABLET	T2	SP
DESCOVY 200-25 MG TABLET	T2	SP PPACA
<i>emtricitabine-tenofv 100-150mg</i> (Truvada)	T1	SP
<i>emtricitabine-tenofv 133-200mg</i> (Truvada)	T1	SP
<i>emtricitabine-tenofv 167-250mg</i> (Truvada)	T1	SP
<i>emtricitabine-tenofv 200-300mg</i> (Truvada)	T1	SP PPACA

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTIVIRALS (AIDS/HIV) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIVIRALS - HIV-SPEC, NUCLEOSIDE ANALOG, RTI COMB		
<i>abacavir sulfate/lamivudine</i> (Epzicom)	T1	PA SP
<i>lamivudine/zidovudine</i> (Combivir)	T1	SP
ANTIVIRALS - HIV-SPECIFIC, CCR5 CO-RECEPTOR ANTAG.		
maraviroc (Selzentry)	T1	PA SP
SELZENTRY 20 MG/ML ORAL SOLN	T3	PA SP
ANTIVIRALS, HIV-SPECIFIC, CD4 ATTACHMENT INHIBITOR		
RUKOBIA	T3	PA QL(2 TABS/DAY) SP
ANTIVIRALS - HIV-SPECIFIC, FUSION INHIBITORS		
FUZEON	T2	PA SP
ANTIVIRALS - HIV-SPECIFIC, NON-NUCLEOSIDE, RTI		
EDURANT	T3	PA SP
EDURANT PED	T3	PA SP
<i>efavirenz</i>	T1	PA SP
<i>etravirine</i> (Intelence)	T1	SP
INTELENCE 25 MG TABLET	T3	PA SP
<i>nevirapine</i>	T1	PA SP
PIFELTRO	T3	PA SP
ANTIVIRALS - HIV-SPECIFIC, NUCLEOSIDE ANALOG, RTI		
<i>abacavir sulfate</i>	T1	PA SP
<i>abacavir sulfate</i> (Ziagen)	T1	PA SP
<i>emtricitabine</i> (Emtriva)	T1	PA SP
EMTRIVA 10 MG/ML SOLUTION	T2	PA SP
<i>lamivudine 10 mg/ml oral soln</i> (EpiVir)	T1	SP
<i>lamivudine 150 mg tablet</i> (EpiVir)	T1	SP
<i>lamivudine 300 mg tablet</i> (EpiVir)	T1	PA SP
<i>lamivudine 300 mg/30ml sol cup</i> (EpiVir)	T1	SP
<i>zidovudine</i>	T1	SP
<i>zidovudine</i> (Retrovir)	T1	SP
<i>tenofovir disoproxil fumarate</i> (Viread)	T1	PA SP
VIREAD 150 MG TABLET	T2	PA SP
VIREAD 200 MG TABLET	T2	PA SP
VIREAD 250 MG TABLET	T2	PA SP
VIREAD POWDER	T2	PA SP

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTIVIRALS (AIDS/HIV) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIVIRALS - HIV-SPECIFIC, PROTEASE INHIBITOR COMB		
<i>lopinavir/ritonavir</i>	T1	SP
<i>lopinavir/ritonavir</i> (Kaletra)	T1	SP
ANTIVIRALS - HIV-SPECIFIC, PROTEASE INHIBITORS		
<i>atazanavir sulfate</i>	T1	PA SP
<i>atazanavir sulfate</i> (Reyataz)	T1	PA SP
EVOTAZ	T3	PA SP
<i>fosamprenavir calcium</i>	T1	PA SP
NORVIR 100 MG POWDER PACKET	T2	SP
REYATAZ 50 MG POWDER PACKET	T2	PA SP
<i>ritonavir</i> (Norvir)	T1	SP
ANTIVIRALS - HIV-I INTEGRASE STRAND TRANSFER INHIBTR		
APRETUDE	T2	SP PPACA
ISENTRESS	T2	SP
ISENTRESS HD	T2	PA SP
TIVICAY	T2	SP
TIVICAY PD	T2	SP
ARTV NUCLEOSIDE, NUCLEOTIDE, NON-NUCLEOSIDE RTI COMB		
DELSTRIGO	T3	PA QL(1 TAB/DAY) SP
<i>efavirenz/emtricit/tenofovr df</i>	T1	QL(1 TAB/DAY) SP
<i>efavirenz/lamivu/tenofovr disop</i> (Symfi Lo)	T1	QL(1 TAB/DAY) SP
<i>efavirenz/lamivu/tenofovr disop</i> (Symfi)	T1	QL(1 TAB/DAY) SP
<i>emtricit/ rilpivirine/tenof df</i> (Complera)	T1	QL(1 TAB/DAY) SP
ODEFSEY	T3	PA QL(1 TAB/DAY) SP
ARV-NUCLEOSIDE, NUCLEOTIDE RTI, INTEGRASE INHIBITORS		
BIKTARVY	T2	SP
GENVOYA	T2	SP
STRIBILD	T3	PA SP
ANTIVIRALS (Eye Conditions)		
EYE ANTIVIRALS		
<i>trifluridine</i>	T1	
ZIRGAN	T3	
ANTIVIRALS (Infections)		
ANTIVIRAL - MAIN PROTEASE (MPRO) INHIBITOR		
PAXLOVID	T2	QL(1 TAB/120 DAYS)

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTIVIRALS (Infections) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIVIRAL - RNA POLYMERASE INHIBITOR		
LAGEVRIO (EUA)	T2	QL(1 PACK/120 DAYS)
ANTIVIRAL MONOCLONAL ANTIBODIES		
BEYFORTUS	T3	PPACA
ANTIVIRALS, GENERAL		
<i>acyclovir 200 mg capsule</i>	T1	
<i>acyclovir 200 mg/5 ml susp</i>	T1	
<i>acyclovir 200 mg/5 ml susp cup</i>	T1	
<i>acyclovir 400 mg tablet</i>	T1	
<i>acyclovir 800 mg tablet</i>	T1	
<i>acyclovir 800 mg/20ml susp cup</i>	T1	
<i>famciclovir</i>	T1	
FLUMADINE (<i>rimantadine hcl</i>)	T3	
LIVTENCITY	T3	PA QL(4 TABS/DAY) SP
<i>oseltamivir 6 mg/ml suspension (Tamiflu)</i>	T1	QL(180 MLS/30 DAYS)
<i>oseltamivir phos 30 mg capsule (Tamiflu)</i>	T1	QL(20 CAPS/30 DAYS)
<i>oseltamivir phos 45 mg capsule (Tamiflu)</i>	T1	QL(10 CAPS/30 DAYS)
<i>oseltamivir phos 75 mg capsule (Tamiflu)</i>	T1	QL(10 CAPS/30 DAYS)
PREVMIS 20 MG PELLETT PACKET	T3	SP
PREVMIS 120 MG PELLETT PACKET	T3	SP
PREVMIS 240 MG TABLET	T3	SP HD
PREVMIS 480 MG TABLET	T3	SP HD
RELENZA	T3	QL(20 BLISTERS/30 DAYS)
<i>rimantadine hcl (Flumadine)</i>	T1	
TEMBEXA	T3	
<i>valacyclovir hcl (Valtrex)</i>	T1	
<i>valganciclovir hcl (Valcyte)</i>	T1	
VALTRES (<i>valacyclovir</i>)	T3	
XOFLUZA	T3	QL(2 TABS/30 DAYS)
HEP C - NS5A, NS3/4A, NUCLEOTIDE NS5B INHIB COMBO		
VOSEVI	T2	PA QL(1 TAB/DAY) SP HD
HEP C VIRUS-NS5B POLYMERASE AND NS5A INHIB. COMBO.		
EPCLUSA 150-37.5 MG PELLETT PKT	T2	PA QL(1 PACK/DAY) SP HD
EPCLUSA 200 MG-50 MG TABLET	T2	PA QL(1 TAB/DAY) SP HD
EPCLUSA 200-50 MG PELLETT PACK	T2	PA QL(1 PACK/DAY) SP HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTIVIRALS (Infections) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HEP C VIRUS-NS5B POLYMERASE AND NS5A INHIB. COMBO. (cont.)		
EPCLUSA 400 MG-100 MG TABLET	T2	PA QL(1 TAB/DAY) SP HD
HARVONI 33.75-150 MG PELLET PK	T2	PA QL(1 PACK/DAY) SP HD
HARVONI 45-200 MG PELLET PACKT	T2	PA QL(1 PACK/DAY) SP HD
HARVONI 45-200 MG TABLET	T2	PA QL(1 TAB/DAY) SP HD
HARVONI 90-400 MG TABLET	T2	PA QL(1 TAB/DAY) SP HD
HEPATITIS B TREATMENT AGENTS		
<i>adefovir dipivoxil</i> (Hepsera)	T1	SP HD
BARACLUDE 0.05 MG/ML SOLUTION	T2	SP HD
<i>entecavir 0.5 mg tablet</i> (Baraclude)	T1	QL(1 TAB/DAY) SP HD
<i>entecavir 1 mg tablet</i> (Baraclude)	T1	SP HD
<i>lamivudine</i> (EpiVir Hbv)	T1	SP
VELMIDY	T2	SP HD
HEPATITIS C TREATMENT AGENTS		
PEGASYS	T2	PA SP HD
<i>ribavirin</i>	T1	SP HD
HEPATITIS C VIRUS- NS5A AND NS3/4A INHIBITOR COMB		
ZEPATIER	T3	PA SP HD
TOPICAL ANTIVIRALS		
<i>penciclovir</i> (Denavir)	T1	QL(5 GMS/30 DAYS)
AUTONOMIC DRUGS (Allergy/Nasal Sprays)		
ANAPHYLAXIS THERAPY AGENTS		
<i>epinephrine 0.15 mg auto-inject</i> (Epipen Jr 2-Pak)	T1	QL(4 UNITS/30 DAYS)
<i>epinephrine 0.15 mg auto-inject</i> (Epipen Jr)	T1	QL(4 UNITS/30 DAYS)
<i>epinephrine 0.3 mg auto-inject</i> (Epipen 2-Pak)	T1	QL(4 UNITS/30 DAYS)
<i>epinephrine 0.3 mg auto-inject</i> (Epipen)	T1	QL(4 UNITS/30 DAYS)
AUTONOMIC DRUGS (Alzheimer's Disease)		
CHOLINESTERASE INHIBITORS		
ADLARITY	T2	PA QL(4 PATCHES/28 DAYS) HD
<i>donepezil hcl</i>	T1	HD
<i>donepezil hcl</i> (Aricept)	T1	HD
EXELON (<i>rivastigmine</i>)	T3	HD
<i>galantamine er 16 mg capsule</i>	T1	HD
<i>galantamine er 24 mg capsule</i>	T1	HD
<i>galantamine er 8 mg capsule</i>	T1	QL(1 CAP/DAY) HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CHOLINESTERASE INHIBITORS (cont.)		
<i>galantamine hbr</i>	T1	HD
<i>pyridostigmine 60 mg/5 ml cup</i> (Mestinon)	T1	HD
<i>pyridostigmine 60 mg/5 ml soln</i> (Mestinon)	T1	HD
<i>pyridostigmine br 60 mg tablet</i> (Mestinon)	T1	HD
<i>pyridostigmine bromide</i> (Mestinon)	T1	HD
<i>rivastigmine</i> (Exelon)	T1	HD
<i>rivastigmine tartrate</i>	T1	HD

AUTONOMIC DRUGS (Attention Deficit Hyperactivity Disorder)¹⁰

ADRENERGICS, AROMATIC, NON-CATECHOLAMINE		
<i>amphetamine sulfate</i> (Evekeo)	T1	PA
<i>dextroamphetamine er 10 mg cap</i>	T1	PA QL(1 CAP/DAY)
<i>dextroamphetamine er 15 mg cap</i>	T1	PA QL(3 CAPS/DAY)
<i>dextroamphetamine er 5 mg cap</i>	T1	PA QL(1 CAP/DAY)
<i>dextroamphetamine sulfate</i>	T1	PA
<i>dextroamphetamine sulfate</i> (Zenzedi)	T1	PA
<i>dextroamphetamine/amphetamine</i> (Adderall Xr)	T1	PA QL(1 CAP/DAY)
<i>dextroamphetamine/amphetamine</i> (Adderall)	T1	PA
<i>dextroamphetamine/amphetamine</i> (Mydayis)	T1	PA QL(1 CAP/DAY)
<i>methamphetamine hcl</i> (Desoxyn)	T1	PA
XELSTRYM	T3	PA QL(1 PATCH/DAY)
ZENZEDI	T3	PA
ZENZEDI (<i>dextroamphetamine sulfate</i>)	T3	PA

AUTONOMIC DRUGS (Blood Pressure/Heart Medications)

ADRENERGIC VASOPRESSOR AGENTS		
<i>droxidopa 100 mg capsule</i> (Northera)	T1	SP HD
<i>droxidopa 200 mg capsule</i> (Northera)	T1	SP HD
<i>droxidopa 300 mg capsule</i> (Northera)	T1	SP HD
<i>midodrine hcl</i>	T1	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

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

ALPHA-ADRENERGIC BLOCKING AGENTS

DIBENZYLIN (phenoxybenzamine hcl)	T3	HD
phenoxybenzamine hcl (Dibenzylin)	T1	HD

AUTONOMIC DRUGS (Urinary Tract Conditions)

PARASYMPATHETIC AGENTS

bethanechol chloride	T1	HD
cevimeline hcl (Evoxac)	T1	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)
RAGWITEK	T3	PA QL(1 TAB/DAY)

BIOLOGICALS (Blood Pressure/Heart Medications)

PLASMA KALLIKREIN INHIBITORS

TAKHZYRO	T3	PA SP HD
----------	----	----------

BIOLOGICALS (Miscellaneous)

PKU TREATMENT AGENTS - PHENYLALANINE AMMONIA LYASE

PALYNZIQ	T3	PA SP HD
----------	----	----------

BIOLOGICALS (Vaccines)

COVID-19 VACCINES

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

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

BIOLOGICALS (Vaccines) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
COVID-19 VACCINES (cont.)		
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
GRAM NEGATIVE COCCI VACCINES		
BEXSERO	T2	PPACA
MENACTRA	T2	PPACA
MENQUADFI	T2	PPACA
MENVEO A-C-Y-W-135-DIP	T2	PPACA
PENBRAYA	T2	PPACA

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

BIOLOGICALS (Vaccines) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GRAM NEGATIVE COCCI VACCINES (cont.)		
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
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

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

BIOLOGICALS (Vaccines) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
INFLUENZA VIRUS VACCINES (cont.)		
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
VACCINE/TOXOID PREPARATIONS, COMBINATIONS		
DENGVAXIA	T2	PPACA
TOXIN-PRODUCING BACILLI VACCINES/TOXOIDS		
BCG VACCINE (TICE STRAIN)	T2	PPACA
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
INFANRIX DTAP	T2	PPACA
KINRIX	T2	PPACA
M-M-R II VACCINE	T2	PPACA
PEDVAXHIB	T2	PPACA
PENTACEL	T2	PPACA

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

BIOLOGICALS (Vaccines) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VACCINE/TOXOID PREPARATIONS, COMBINATIONS (cont.)		
PENTACEL ACTHIB COMPONENT	T2	PPACA
PRIORIX	T2	PPACA
PROQUAD	T2	PPACA
QUADRACEL DTAP-IPV	T2	PPACA
TDVAX	T2	PPACA
TENIVAC	T2	PPACA
VAXELIS	T2	PPACA
VIRAL/TUMORIGENIC VACCINES		
ABRYVO	T3	PPACA
ACAM2000 (NATIONAL STOCKPILE)	T3	
AREXVY	T3	PPACA
ENGERIX-B ADULT	T2	PPACA
ENGERIX-B PEDIATRIC-ADOLESCENT	T2	PPACA
ERVEBO (NATIONAL STOCKPILE)	T3	
GARDASIL 9	T2	PPACA
HEPLISAV-B	T2	PPACA
JYNNEOS	T3	
JYNNEOS (NATIONAL STOCKPILE)	T3	
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)		
ANTIFIBRINOLYTIC AGENTS		
AMICAR (<i>aminocaproic acid</i>)	T3	SP HD
<i>aminocaproic acid</i> (Amicar)	T1	SP HD
<i>tranexamic acid</i>	T1	SP
COMPLEMENT (C3) INHIBITORS		
EMPAVELI	T2	PA SP
FABHALTA	T2	PA QL(2 CAPS/DAY) SP
TAVNEOS	T3	PA QL(6 CAPS/DAY) SP
VOYDEYA	T2	PA QL(1 PACKET/28 Days) SP

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

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

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

BLOOD (Blood Thinners/Anti-Clotting)

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

HEMORRHOLOGIC AGENTS

pentoxifylline T1 HD

CARDIAC DRUGS (Blood Pressure/Heart Medications)

ANTI-ANGINAL, ANTI-ISCHEMIC AGENTS, NON-HEMODYNAMIC

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 T3 HD

NORPACE (*disopyramide phosphate*) T3 PA HD

NORPACE CR T3 HD

pacерone 100 mg tablet T3 PA HD

pacерone 200 mg tablet T1 HD

pacерone 400 mg tablet T3 PA HD

propafenone hcl T1 HD

quinidine sulfate T1 HD

CALCIUM CHANNEL BLOCKING AGENTS

amlodipine besylate (Norvasc) T1 HD

CALAN SR (*verapamil er*) T3 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

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CALCIUM CHANNEL BLOCKING AGENTS (cont.)		
<i>diltiazem hcl</i> (Cardizem)	T1	HD
<i>diltiazem hcl</i> (Tiazac)	T1	HD
<i>felodipine</i>	T1	HD
<i>isradipine</i>	T1	
<i>nicardipine hcl</i>	T1	HD
<i>nifedipine</i>	T1	HD
<i>nifedipine</i> (Procardia XL)	T1	HD
<i>nimodipine 30 mg capsule</i>	T1	HD
<i>nimodipine 60 mg/20 ml soln</i>	T1	
<i>nisoldipine er 17 mg tablet</i> (Sular)	T1	HD
<i>nisoldipine er 20 mg tablet</i>	T1	QL(1 TAB/DAY) HD
<i>nisoldipine er 25.5 mg tablet</i>	T1	HD
<i>nisoldipine er 30 mg tablet</i>	T1	HD
<i>nisoldipine er 34 mg tablet</i> (Sular)	T1	HD
<i>nisoldipine er 40 mg tablet</i>	T1	HD
<i>nisoldipine er 8.5 mg tablet</i> (Sular)	T1	HD
NORLIQVA	T2	PA QL(10 MLS/DAY) HD
NYMALIZE	T3	
SULAR (<i>nisoldipine</i>)	T3	HD
TIAZAC (<i>diltiazem hcl</i>)	T3	HD
<i>verapamil hcl</i>	T1	HD
<i>verapamil hcl</i> (Calan Sr)	T1	HD
<i>verapamil hcl</i> (Verelan Pm)	T1	HD
<i>verapamil hcl</i> (Verelan)	T1	HD
VERELAN (<i>verapamil hcl</i>)	T3	HD
VERELAN PM (<i>verapamil hcl</i>)	T3	HD
CARDIAC MYOSIN INHIBITOR		
CAMZYOS	T3	PA QL(1 CAP/DAY) SP HD
DIGITALIS GLYCOSIDES		
<i>digoxin</i> (Lanoxin)	T1	HD
<i>digoxin 0.05 mg/ml solution</i>	T1	HD
<i>digoxin 0.125 mg tablet</i> (Lanoxin)	T1	HD
<i>digoxin 0.25 mg tablet</i> (Lanoxin)	T1	HD
<i>digoxin 125 mcg tablet</i> (Lanoxin)	T1	HD
<i>digoxin 250 mcg tablet</i> (Lanoxin)	T1	HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HEART RATE REDUCING, SA SELECTIVE I(F) CURRENT INH.		
CORLANOR 5 MG/5 ML ORAL SOLN	T2	PA SP HD
<i>ivabradine hcl</i> (Corlanor)	T1	PA HD
SOLUBLE GUANYLATE CYCLASE (SGC) STIMULATOR		
VERQUVO	T2	PA QL(1 TAB/DAY)
VASODILATORS, CORONARY		
<i>isosorbide dinitrate 10 mg tab</i>	T1	HD
<i>isosorbide dinitrate 20 mg tab</i>	T1	HD
<i>isosorbide dinitrate 30 mg tab</i>	T1	HD
<i>isosorbide dinitrate 5 mg tab</i> (Isordil Titradose)	T1	HD
<i>isosorbide mononitrate</i>	T1	HD
NITRO-DUR	T3	HD
<i>nitroglycerin</i>	T1	HD
<i>nitroglycerin 0.3 mg tablet sl</i> (Nitrostat)	T1	HD
<i>nitroglycerin 0.4 mg tablet sl</i> (Nitrostat)	T1	HD
<i>nitroglycerin 0.6 mg tablet sl</i> (Nitrostat)	T1	HD
<i>nitroglycerin 400 mcg spray</i> (Nitrolingual)	T1	HD
NITROLINGUAL (<i>nitroglycerin</i>)	T3	HD
NITROMIST (<i>nitroglycerin</i>)	T3	HD
NITROSTAT (<i>nitroglycerin</i>)	T3	HD
CARDIOVASCULAR (Asthma/COPD/Respiratory)		
PULM ANTI-HTN, SOLUBLE GUANYLATE CYCLASE STIMULATOR		
ADEMPAS	T2	PA SP HD
PULM.ANTI-HTN, SEL.C-GMP PHOSPHODIESTERASE T5 INHIB		
<i>sildenafil 10 mg/ml oral susp</i> (Revatio)	T1	PA SP HD
<i>sildenafil 20 mg tablet</i> (Revatio)	T1	PA SP HD
<i>tadalafil</i> (Adcirca)	T1	PA SP HD
<i>tadalafil 20 mg tablet</i> (Adcirca)	T1	PA SP HD
PULMONARY ANTI-HTN, ENDOTHELIN RECEPTOR ANTAGONIST		
<i>ambrisentan</i> (Letairis)	T1	PA SP HD
<i>bosentan</i> (Tracleer)	T1	PA SP HD
OPSUMIT	T2	PA SP HD
TRACLEER 125 MG TABLET (<i>bosentan</i>)	T3	PA SP HD
TRACLEER 32 MG TABLET FOR SUSP	T2	PA SP HD
TRACLEER 62.5 MG TABLET (<i>bosentan</i>)	T3	PA SP HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PULMONARY ANTIHYPER AGENT, ACTRIIA-FC		
WINREVAIR	T3	PA SP HD
WINREVAIR (2 PACK)	T3	PA SP HD
PULMONARY ANTIHYPERTENSIVES, PROSTACYCLIN-TYPE		
ORENITRAM ER	T3	PA SP HD
ORENITRAM MONTH 1 TITRATION KT	T3	PA QL(168 TABS/180 DAYS) SP HD
ORENITRAM MONTH 2 TITRATION KT	T3	PA QL(336 TABS/180 DAYS) SP HD
ORENITRAM MONTH 3 TITRATION KT	T3	PA QL(252 TABS/180 DAYS) SP HD
TYVASO	T3	PA SP HD
TYVASO DPI	T2	PA SP HD
TYVASO INSTITUTIONAL START KIT	T3	PA SP HD
TYVASO REFILL KIT	T3	PA SP HD
TYVASO STARTER KIT	T3	PA SP HD
UPTRAVI	T2	PA SP HD
YUTREPIA	T2	PA SP HD
PULMONARY HTN-ENDOTHELIN RECEPT ANTG-CGMP PDE5 INH		
OPSYNVI	T2	PA QL(1 TAB/DAY) SP HD

CARDIOVASCULAR (Blood Pressure/Heart Medications)

ACE INHIBITOR-CALCIUM CHANNEL BLOCKER COMBINATION		
<i>amlodipine besylate/benazepril</i>	T1	HD
<i>amlodipine besylate/benazepril (Lotrel)</i>	T1	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
PRESTALIA 14 MG-10 MG TABLET	T3	HD
<i>trandolapril/verapamil hcl</i>	T1	HD
ACE INHIBITOR-THIAZIDE OR THIAZIDE-LIKE DIURETIC		
<i>benazepril/hydrochlorothiazide</i>	T1	HD
<i>benazepril/hydrochlorothiazide (Lotensin Hct)</i>	T1	HD
<i>captopril-hctz 25-15 mg tablet</i>	T1	QL(3 TABS/DAY) HD
<i>captopril-hctz 25-25 mg tablet</i>	T1	QL(2 TABS/DAY) HD
<i>captopril-hctz 50-15 mg tablet</i>	T1	QL(3 TABS/DAY) HD
<i>captopril-hctz 50-25 mg tablet</i>	T1	QL(2 TABS/DAY) HD
<i>enalapril/hydrochlorothiazide</i>	T1	HD
<i>enalapril/hydrochlorothiazide (Vaseretic)</i>	T1	HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ACE INHIBITOR-THIAZIDE OR THIAZIDE-LIKE DIURETIC (cont.)		
<i>fosinopril/hydrochlorothiazide</i>	T1	HD
<i>lisinopril/hydrochlorothiazide (Zestoretic)</i>	T1	HD
<i>quinapril/hydrochlorothiazide (Accuretic)</i>	T1	HD
ALPHA/BETA-ADRENERGIC BLOCKING AGENTS		
<i>carvedilol (Coreg)</i>	T1	HD
<i>carvedilol er 10 mg capsule (Coreg Cr)</i>	T1	QL(1 CAP/DAY) HD
<i>carvedilol er 20 mg capsule (Coreg Cr)</i>	T1	QL(1 CAP/DAY) HD
<i>carvedilol er 40 mg capsule (Coreg Cr)</i>	T1	QL(1 CAP/DAY) HD
<i>carvedilol er 80 mg capsule (Coreg Cr)</i>	T1	HD
<i>labetalol hcl 100 mg tablet</i>	T1	HD
<i>labetalol hcl 200 mg tablet</i>	T1	HD
<i>labetalol hcl 300 mg tablet</i>	T1	HD
LABETALOL HCL 400 MG TABLET	T3	HD
ALPHA-ADRENERGIC BLOCKING AGENTS		
CARDURA XL	T3	HD
<i>doxazosin mesylate (Cardura)</i>	T1	HD
MINIPRESS (<i>prazosin hcl</i>)	T3	HD
<i>prazosin hcl</i>	T1	HD
<i>prazosin hcl (Minipress)</i>	T1	HD
<i>terazosin hcl</i>	T1	HD
ANGIOTEN.RECEPTR ANTAG-CALCIUM CHANL BLKR-THIAZIDE		
<i>amlodipine/valsartan/hcthiazid (Exforge Hct)</i>	T1	HD
<i>olmesartan/amlodipin/hcthiazid (Tribenzor)</i>	T1	HD
ANGIOTENSIN RECEPT-NEPRILYSIN INHIBITOR COMB (ARNI)		
ENTRESTO SPRINKLE	T2	HD
<i>sacubitril/valsartan (Entresto)</i>	T1	QL(2 TABS/DAY) HD
ANGIOTENSIN RECEPTOR ANTAG.-THIAZIDE DIURETIC COMB		
<i>candesartan/hydrochlorothiazid (Atacand Hct)</i>	T1	HD
<i>irbesartan/hydrochlorothiazide (Avalide)</i>	T1	HD
<i>losartan/hydrochlorothiazide (Hyzaar)</i>	T1	HD
<i>olmesartan-hctz 20-12.5 mg tab (Benicar Hct)</i>	T1	QL(1 TAB/DAY) HD
<i>olmesartan-hctz 40-12.5 mg tab (Benicar Hct)</i>	T1	HD
<i>olmesartan-hctz 40-25 mg tab (Benicar Hct)</i>	T1	HD
<i>telmisartan-hctz 40-12.5 mg tb (Micardis Hct)</i>	T1	QL(1 TAB/DAY) HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANGIOTENSIN RECEPTOR ANTAG.-THIAZIDE DIURETIC COMB (cont.)		
<i>telmisartan-hctz 80-12.5 mg tb</i> (Micardis Hct)	T1	HD
<i>telmisartan-hctz 80-25 mg tab</i> (Micardis Hct)	T1	HD
<i>valsartan/hydrochlorothiazide</i> (Diovan Hct)	T1	HD
ANGIOTENSIN RECEPTOR BLOCKR-CALCIUM CHANNEL BLOCKR		
<i>amlodipine besylate/valsartan</i> (Exforge)	T1	HD
<i>amlodipine-olmesartan 10-20 mg</i> (Azor)	T1	HD
<i>amlodipine-olmesartan 10-40 mg</i> (Azor)	T1	HD
<i>amlodipine-olmesartan 5-20 mg</i> (Azor)	T1	QL(1 TAB/DAY) HD
<i>amlodipine-olmesartan 5-40 mg</i> (Azor)	T1	HD
<i>telmisartan-amlodipine 40-10</i>	T1	HD
<i>telmisartan-amlodipine 40-5 mg</i>	T1	QL(1 TAB/DAY) HD
<i>telmisartan-amlodipine 80-10</i>	T1	HD
<i>telmisartan-amlodipine 80-5 mg</i>	T1	HD
ANTI-HYPERTENSIVES, ACE INHIBITORS		
<i>benazepril hcl</i>	T1	HD
<i>benazepril hcl</i> (Lotensin)	T1	HD
<i>captopril</i>	T1	HD
<i>enalapril maleate</i> (Epaned)	T1	HD
<i>enalapril maleate</i> (Vasotec)	T1	HD
<i>fosinopril sodium</i>	T1	HD
<i>lisinopril</i> (Zestril)	T1	HD
<i>moexipril hcl</i>	T1	HD
<i>perindopril erbumine</i>	T1	HD
<i>quinapril hcl</i> (Accupril)	T1	HD
<i>ramipril</i>	T1	HD
<i>ramipril</i> (Altace)	T1	HD
<i>trandolapril</i>	T1	HD
ANTI-HYPERTENSIVES, ANGIOTENSIN RECEPTOR ANTAGONIST		
<i>candesartan cilexetil</i> (Atacand)	T1	HD
<i>eprosartan mesylate</i>	T1	HD
<i>irbesartan</i>	T1	HD
<i>irbesartan</i> (Avapro)	T1	HD
<i>losartan potassium</i> (Cozaar)	T1	HD
<i>olmesartan medoxomil 20 mg tab</i> (Benicar)	T1	QL(1 TAB/DAY) HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-HYPERTENSIVES, ANGIOTENSIN RECEPTOR ANTAGONIST (cont.)		
<i>olmesartan medoxomil 40 mg tab (Benicar)</i>	T1	HD
<i>olmesartan medoxomil 5 mg tab (Benicar)</i>	T1	HD
<i>telmisartan 20 mg tablet</i>	T1	QL(1 TAB/DAY) HD
<i>telmisartan 40 mg tablet (Micardis)</i>	T1	QL(1 TAB/DAY) HD
<i>telmisartan 80 mg tablet (Micardis)</i>	T1	HD
<i>valsartan 160 mg tablet (Diovan)</i>	T1	HD
<i>valsartan 20 mg/5 ml solution</i>	T1	HD
<i>valsartan 320 mg tablet (Diovan)</i>	T1	HD
<i>valsartan 40 mg tablet (Diovan)</i>	T1	HD
<i>valsartan 80 mg tablet (Diovan)</i>	T1	HD
ANTI-HYPERTENSIVES, GANGLIONIC BLOCKERS		
<i>VECAMYL</i>	T1	
ANTI-HYPERTENSIVES, MISCELLANEOUS		
<i>metyrosine (Demser)</i>	T1	HD
ANTI-HYPERTENSIVES, SYMPATHOLYTIC		
<i>clonidine (Catapres-tts 1)</i>	T1	HD
<i>clonidine (Catapres-tts 2)</i>	T1	HD
<i>clonidine (Catapres-tts 3)</i>	T1	HD
<i>clonidine hcl</i>	T1	HD
<i>guanfacine hcl</i>	T1	HD
<i>methyldopa</i>	T1	HD
<i>methyldopa/hydrochlorothiazide</i>	T1	HD
ANTI-HYPERTENSIVES, VASODILATORS		
<i>hydralazine hcl</i>	T1	HD
<i>minoxidil</i>	T1	HD
BETA-ADRENERGIC BLOCKING AGENTS		
<i>acebutolol hcl</i>	T1	HD
<i>atenolol (Tenormin)</i>	T1	HD
<i>betaxolol hcl</i>	T1	HD
<i>bisoprolol fumarate 10 mg tab</i>	T1	HD
<i>bisoprolol fumarate 5 mg tab</i>	T1	HD
<i>metoprolol succinate (Toprol XL)</i>	T1	HD
<i>metoprolol tartrate</i>	T1	HD
<i>metoprolol tartrate (Lopressor)</i>	T1	HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BETA-ADRENERGIC BLOCKING AGENTS (cont.)		
<i>nadolol</i>	T1	HD
<i>nebivolol 10 mg tablet (Bystolic)</i>	T1	QL(1 TAB/DAY) HD
<i>nebivolol 2.5 mg tablet (Bystolic)</i>	T1	QL(1 TAB/DAY) HD
<i>nebivolol 20 mg tablet (Bystolic)</i>	T1	HD
<i>nebivolol 5 mg tablet (Bystolic)</i>	T1	QL(1 TAB/DAY) HD
<i>pindolol</i>	T1	HD
<i>propranolol hcl</i>	T1	HD
<i>propranolol hcl (Inderal La)</i>	T1	HD
<i>sotalol hcl</i>	T1	HD
<i>sotalol hcl (Betapace Af)</i>	T1	HD
<i>sotalol hcl (Betapace)</i>	T1	HD
SOTYLIZE	T3	HD
<i>timolol maleate</i>	T1	HD
BETA-BLOCKERS AND THIAZIDE, THIAZIDE-LIKE DIURETICS		
<i>atenolol/chlorthalidone (Tenoretic 100)</i>	T1	HD
<i>atenolol/chlorthalidone (Tenoretic 50)</i>	T1	HD
<i>bisoprolol/hydrochlorothiazide</i>	T1	HD
<i>metoprolol/hydrochlorothiazide</i>	T1	HD
<i>propranolol/hydrochlorothiazid</i>	T1	HD
RENIN INHIBITOR, DIRECT		
<i>aliskiren 150 mg tablet (Tekturna)</i>	T1	QL(1 TAB/DAY) HD
<i>aliskiren 300 mg tablet (Tekturna)</i>	T1	HD
VASODILATORS, COMBINATION		
<i>isosorbide dinit/hydralazine (Bidil)</i>	T1	QL(6 TABS/DAY) HD
VASODILATORS, PERIPHERAL		
<i>ergoloid mesylates</i>	T1	
<i>isoxsuprine hcl</i>	T1	
CARDIOVASCULAR (Cholesterol Medications)		
ANTI-HYPERLIP.HMG COA REDUCT INHIB-CHOLEST.AB.INHIB		
<i>ezetimibe/simvastatin (Vytorin)</i>	T1	HD
ANTI-HYPERLIPID- HMG-COA RI-CALCIUM CHANNEL BLOCKER		
<i>amlodipine-atorvast 10-10 mg (Caduet)</i>	T1	HD
<i>amlodipine-atorvast 10-20 mg (Caduet)</i>	T1	HD
<i>amlodipine-atorvast 10-40 mg (Caduet)</i>	T1	HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

CARDIOVASCULAR (Cholesterol Medications) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-HYPERLIPID- HMG-COA RI-CALCIUM CHANNEL BLOCKER (cont.)		
<i>amlodipine-atorvast 10-80 mg (Caduet)</i>	T1	HD
<i>amlodipine-atorvast 2.5-10 mg</i>	T1	HD
<i>amlodipine-atorvast 2.5-20 mg</i>	T1	QL(1 TAB/DAY) HD
<i>amlodipine-atorvast 2.5-40 mg</i>	T1	QL(1 TAB/DAY) HD
<i>amlodipine-atorvast 5-10 mg (Caduet)</i>	T1	HD
<i>amlodipine-atorvast 5-20 mg (Caduet)</i>	T1	QL(1 TAB/DAY) HD
<i>amlodipine-atorvast 5-40 mg (Caduet)</i>	T1	QL(1 TAB/DAY) HD
<i>amlodipine-atorvast 5-80 mg (Caduet)</i>	T1	HD
CADUET 10 MG-10 MG TABLET (<i>amlodipine-atorvastatin</i>)	T3	HD
CADUET 10 MG-20 MG TABLET (<i>amlodipine-atorvastatin</i>)	T3	HD
CADUET 10 MG-40 MG TABLET (<i>amlodipine-atorvastatin</i>)	T3	HD
CADUET 10 MG-80 MG TABLET (<i>amlodipine-atorvastatin</i>)	T3	HD
CADUET 5 MG-10 MG TABLET (<i>amlodipine-atorvastatin</i>)	T3	HD
CADUET 5 MG-20 MG TABLET (<i>amlodipine-atorvastatin</i>)	T3	QL(1 TAB/DAY) HD
CADUET 5 MG-40 MG TABLET (<i>amlodipine-atorvastatin</i>)	T3	QL(1 TAB/DAY) HD
CADUET 5 MG-80 MG TABLET (<i>amlodipine-atorvastatin</i>)	T3	HD
ANTI-HYPERLIPIDEMIC - APOLIPOPROTEIN INHIBITOR		
TRYNGOLZA	T3	PA QL(1 AUTO-INJ/28 DAYS) SP
ANTI-HYPERLIPIDEMIC - PCSK9 INHIBITORS		
REPATHA PUSHTRONEX	T2	
REPATHA SURECLICK	T2	
REPATHA SYRINGE	T2	
ANTI-HYPERLIPIDEMIC-HMGCOA REDUCTASE INHIB (Statins)		
<i>atorvastatin 10 mg tablet</i>	T1	HD PPACA
<i>atorvastatin 20 mg tablet</i>	T1	HD PPACA
<i>atorvastatin 40 mg tablet</i>	T1	HD
<i>atorvastatin 80 mg tablet</i>	T1	HD
<i>fluvastatin sodium</i>	T1	HD PPACA
<i>fluvastatin sodium (Lescol XI)</i>	T1	HD PPACA
<i>lovastatin 10 mg tablet</i>	T1	HD
<i>lovastatin 20 mg tablet</i>	T1	HD PPACA
<i>lovastatin 40 mg tablet</i>	T1	HD PPACA
<i>pitavastatin 1 mg tablet (Livalo)</i>	T1	QL(1 TAB/DAY) HD PPACA
<i>pitavastatin 2 mg tablet (Livalo)</i>	T1	QL(1 TAB/DAY) HD PPACA

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

CARDIOVASCULAR (Cholesterol Medications) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-HYPERLIPIDEMIC-HMGCOA REDUCTASE INHIB (Statins) (cont.)		
<i>pitavastatin 4 mg tablet (Livalo)</i>	T1	HD PPACA
<i>pravastatin sodium</i>	T1	HD PPACA
<i>rosuvastatin calcium 10 mg tab</i>	T1	QL(1 TAB/DAY) HD PPACA
<i>rosuvastatin calcium 20 mg tab</i>	T1	QL(1 TAB/DAY) HD
<i>rosuvastatin calcium 40 mg tab</i>	T1	HD
<i>rosuvastatin calcium 5 mg tab</i>	T1	QL(1 TAB/DAY) HD PPACA
<i>simvastatin 10 mg tablet</i>	T1	HD PPACA
<i>simvastatin 20 mg tablet</i>	T1	HD PPACA
<i>simvastatin 40 mg tablet</i>	T1	HD PPACA
<i>simvastatin 5 mg tablet</i>	T1	HD
<i>simvastatin 80 mg tablet</i>	T1	QL(1 TAB/DAY) HD
BILE SALT SEQUESTRANTS		
<i>cholestyramine</i>	T1	HD
<i>cholestyramine (Questran Light)</i>	T1	HD
<i>cholestyramine (with sugar) (Questran)</i>	T1	HD
<i>cholestyramine/aspartame</i>	T1	HD
<i>colesevelam hcl (Welchol)</i>	T1	HD
COLESTID	T3	HD
COLESTID (<i>colestipol hcl</i>)	T3	HD
<i>colestipol hcl</i>	T1	HD
<i>colestipol hcl (Colestid)</i>	T1	HD
QUESTRAN (<i>cholestyramine (with sugar)</i>)	T3	HD
QUESTRAN LIGHT (<i>cholestyramine</i>)	T3	HD
LIPOTROPICS		
<i>ezetimibe (Zetia)</i>	T1	HD
<i>fenofibrate 120 mg tablet (Fenoglide)</i>	T1	HD
<i>fenofibrate 130 mg capsule</i>	T1	HD
<i>fenofibrate 134 mg capsule</i>	T1	HD
<i>fenofibrate 145 mg tablet (Tricor)</i>	T1	HD
FENOFIBRATE 150 MG CAPSULE	T1	HD
<i>fenofibrate 160 mg tablet</i>	T1	HD
<i>fenofibrate 200 mg capsule</i>	T1	HD
<i>fenofibrate 40 mg tablet (Fenoglide)</i>	T1	HD
<i>fenofibrate 43 mg capsule</i>	T1	HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

CARDIOVASCULAR (Cholesterol Medications) (cont.)

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

CARDIOVASCULAR (Miscellaneous)

ENDOTHELIN-ANGIOTENSIN RECEPTOR ANTAGONIST

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

CNS DRUGS (Alzheimer's Disease)

ALZHEIMER'S THERAPY, NMDA RECEPTOR ANTAGONISTS

<i>memantine hcl</i>	T1	HD
MEMANTINE HCL	T1	HD
<i>memantine hcl er 14 mg capsule (Namenda Xr)</i>	T1	QL(1 CAP/DAY) HD
<i>memantine hcl er 21 mg capsule</i>	T1	HD
<i>memantine hcl er 28 mg capsule (Namenda Xr)</i>	T1	HD
<i>memantine hcl er 7 mg capsule (Namenda Xr)</i>	T1	QL(1 CAP/DAY) HD
NAMENDA	T3	HD
NAMENDA XR TITRATION PACK	T3	QL(112 CAPS/365 DAYS) HD

ALZHEIMER'S THX,NMDA RECEPTOR ANTAG-CHOLINES INHIB

<i>memantine hcl/donepezil hcl (Namzaric)</i>	T1	QL(2 CAPS/DAY) HD
---	----	-------------------

CNS DRUGS (Miscellaneous)

AMYOTROPHIC LATERAL SCLEROSIS AGENTS

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

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

CNS DRUGS (Miscellaneous) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AMYOTROPHIC LATERAL SCLEROSIS AGENTS (cont.)		
<i>riluzole</i> (Rilutek)	T1	SP HD
TIGLUTIK	T3	PA SP
DRUGS TO TREAT MOVEMENT DISORDERS		
AUSTEDO	T3	PA SP HD
AUSTEDO XR 12 MG TABLET	T3	PA QL(1 TAB/DAY) SP HD
AUSTEDO XR 18 MG TABLET	T3	PA QL(1 TAB/DAY) SP HD
AUSTEDO XR 24 MG TABLET	T3	PA QL(2 TABS/DAY) SP HD
AUSTEDO XR 30 MG TABLET	T3	PA QL(1 TAB/DAY) SP HD
AUSTEDO XR 36 MG TABLET	T3	PA QL(1 TAB/DAY) SP HD
AUSTEDO XR 42 MG TABLET	T3	PA QL(1 TAB/DAY) SP HD
AUSTEDO XR 48 MG TABLET	T3	PA QL(1 TAB/DAY) SP HD
AUSTEDO XR 6 MG TABLET	T3	PA QL(3 TABS/DAY) SP HD
AUSTEDO XR TITRATION KIT(WK1-4)	T3	PA QL(1 KIT/180 DAYS) SP HD
INGREZZA	T3	PA QL(1 CAP/DAY) SP
INGREZZA INITIATION PK (TARDIV)	T3	PA QL(28 CAPS/365 DAYS) SP
<i>tetrabenazine</i> (Xenazine)	T1	PA SP HD
PSEUDOBLBAR AFFECT (PBA) AGENTS, NMDA ANTAGONISTS		
NUEDEXTA	T3	QL(4 CAPS/DAY)
XANTHINES		
<i>caffeine citrate</i>	T1	HD
CNS DRUGS (Multiple Sclerosis)		
AGENTS TO TREAT MULTIPLE SCLEROSIS		
AVONEX (4 PACK)	T2	PA SP HD
AVONEX PEN (4 PACK)	T2	PA SP HD
BAFIERTAM	T2	PA SP HD
BETASERON	T2	PA SP HD
<i>cladribine</i>	T1	PA SP HD
<i>dimethyl fumarate 30d start pk</i> (Tecfidera)	T1	SP HD
<i>dimethyl fumarate dr 120 mg cp</i> (Tecfidera)	T1	HD
<i>dimethyl fumarate dr 120 mg cp</i> (Tecfidera)	T1	SP HD
<i>dimethyl fumarate dr 240 mg cp</i> (Tecfidera)	T1	HD
<i>dimethyl fumarate dr 240 mg cp</i> (Tecfidera)	T1	SP HD
<i>fingolimod hcl</i> (Gilenya)	T1	SP HD
<i>glatiramer acetate</i> (Copaxone)	T1	SP HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

CNS DRUGS (Multiple Sclerosis) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AGENTS TO TREAT MULTIPLE SCLEROSIS		
KESIMPTA PEN	T2	PA SP HD
MAVENCLAD	T3	PA SP HD
PLEGRIDY	T2	PA SP HD
PLEGRIDY PEN	T2	PA SP HD
REBIF	T2	PA SP HD
REBIF REBIDOSE	T2	PA SP HD
<i>teriflunomide</i> (Aubagio)	T1	SP HD
VUMERITY	T2	PA SP HD
AGTS TX NEUROMUSC TRANSMISSION DIS, POT-CHAN BLKR		
<i>dalfampridine er 10 mg tablet</i> (Ampyra)	T1	PA SP HD
FIRDAPSE	T3	PA QL (8 tabs/day) SP
CNS DRUGS (Pain Relief And Inflammatory Disease)		
CALCITONIN GENE-RELATED PEPTIDE (CGRP) INHIBITORS		
EMGALITY SYRINGE	T2	PA
POSTHERPETIC NEURALGIA AGENTS		
<i>gabapentin</i> (Gralise)	T1	
GRALISE ER 300 MG TABLET (<i>gabapentin</i>)	T3	
GRALISE ER 600 MG TABLET (<i>gabapentin</i>)	T3	
SPHINGOSINE I-PHOSPHATE (SIP) RECEPTOR MODULATOR		
VELSIPITY	T2	PA QL(30 TABS/30 DAYS) SP HD
ZEPOSIA	T2	PA SP HD
CNS DRUGS (Seizure Disorders)		
ANTI-CONVULSANT - BENZODIAZEPINE TYPE		
<i>clobazam</i> (Onfi)	T1	HD
<i>clonazepam</i>	T1	HD
<i>clonazepam</i> (Klonopin)	T1	HD
DIASTAT (<i>diazepam</i>)	T3	PA HD
<i>diazepam 10 mg rectal gel syrg</i>	T1	HD
<i>diazepam 10mg rectal gel (2pk)</i>	T1	HD
<i>diazepam 2.5 mg rectal gel sys</i> (Diastat)	T1	HD
<i>diazepam 20 mg rectal gel syrg</i>	T1	HD
<i>diazepam 20mg rectal gel (2pk)</i>	T1	HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

CNS DRUGS (Seizure Disorders) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-CONVULSANT - BENZODIAZEPINE TYPE (cont.)		
KLONOPIN (<i>clonazepam</i>)	T3	PA HD
NAYZILAM	T2	PA QL(10 UNITS/30 DAYS) HD
VALTOCO	T2	PA QL(10 BLISTER PACKS/30 DAYS) HD
ANTI-CONVULSANT - CANNABINOID TYPE		
EPIDIOLEX	T3	PA SP HD
ANTI-CONVULSANTS		
BRIVIACT	T3	PA HD
<i>carbamazepine</i> (Carbatrol)	T1	HD
<i>carbamazepine</i> (Tegretol Xr)	T1	HD
<i>carbamazepine</i> (Tegretol)	T1	HD
<i>carbamazepine 100 mg tab chew</i>	T1	HD
<i>carbamazepine 100 mg/5 ml cup</i>	T1	HD
<i>carbamazepine 100 mg/5 ml susp</i> (Tegretol)	T1	HD
CARBAMAZEPINE 200 MG TAB CHEW	T3	HD
<i>carbamazepine 200 mg tablet</i> (Tegretol)	T1	HD
<i>carbamazepine 200 mg/10 ml cup</i>	T1	HD
CELONTIN (<i>methsuximide</i>)	T3	HD
DIACOMIT	T3	PA SP HD
DILANTIN 100 MG CAPSULE (<i>phenytoin sodium extended</i>)	T3	PA HD
DILANTIN 30 MG CAPSULE	T2	PA HD
DILANTIN 50 MG INFATAB (<i>phenytoin</i>)	T3	PA HD
DILANTIN-125 (<i>phenytoin</i>)	T3	PA HD
<i>divalproex sodium</i> (Depakote Er)	T1	HD
<i>divalproex sodium</i> (Depakote Sprinkle)	T1	HD
<i>divalproex sodium</i> (Depakote)	T1	HD
<i>ethosuximide</i> (Zarontin)	T1	HD
<i>felbamate</i> (Felbatol)	T1	HD
FINTEPLA	T3	PA SP HD
FYCOMPA 0.5 MG/ML ORAL SUSP	T2	PA HD
<i>gabapentin</i> (Neurontin)	T1	HD
<i>lacosamide</i> (Vimpat)	T1	HD
<i>lamotrigine</i> (Lamictal (Blue))	T1	HD
<i>lamotrigine</i> (Lamictal (Green))	T1	HD
<i>lamotrigine</i> (Lamictal (Orange))	T1	HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

CNS DRUGS (Seizure Disorders) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-CONVULSANTS (cont.)		
<i>lamotrigine</i> (Lamictal Odt (Blue))	T1	HD
<i>lamotrigine</i> (Lamictal Odt (Green))	T1	HD
<i>lamotrigine</i> (Lamictal Odt (Orange))	T1	HD
<i>lamotrigine</i> (Lamictal Odt)	T1	HD
<i>lamotrigine</i> (Lamictal Xr)	T1	HD
<i>lamotrigine</i> (Lamictal)	T1	HD
<i>levetiracetam</i> (Keppra Xr)	T1	HD
<i>levetiracetam</i> (Keppra)	T1	HD
<i>levetiracetam 1,000 mg tablet</i> (Keppra)	T1	HD
<i>levetiracetam 1,000mg/10ml cup</i> (Keppra)	T1	HD
<i>levetiracetam 100 mg/ml soln</i> (Keppra)	T1	HD
LEVETIRACETAM 250 MG TAB SUSP	T3	PA HD
<i>levetiracetam 250 mg tablet</i> (Keppra)	T1	HD
<i>levetiracetam 500 mg tablet</i> (Keppra)	T1	HD
<i>levetiracetam 500 mg/5 ml cup</i>	T1	HD
<i>levetiracetam 500 mg/5 ml soln</i>	T1	HD
<i>levetiracetam 750 mg tablet</i> (Keppra)	T1	HD
LYRICA 20 MG/ML ORAL SOLUTION (<i>pregabalin</i>)	T3	PA HD
<i>methsuximide</i> (Celontin)	T1	HD
NEURONTIN 400 MG CAPSULE (<i>gabapentin</i>)	T3	HD
NEURONTIN 600 MG TABLET (<i>gabapentin</i>)	T3	HD
NEURONTIN 800 MG TABLET (<i>gabapentin</i>)	T3	HD
<i>oxcarbazepine</i> (Oxtellar XR)	T1	PA HD
<i>oxcarbazepine</i> (Trileptal)	T1	HD
OXTELLAR XR (<i>oxcarbazepine</i>)	T3	PA HD
<i>perampanel 10 mg tablet</i> (Fycompa)	T1	PA HD
<i>perampanel 12 mg tablet</i> (Fycompa)	T1	PA HD
<i>perampanel 2 mg tablet</i> (Fycompa)	T1	PA HD
<i>perampanel 4 mg tablet</i> (Fycompa)	T1	PA QL(1 TAB/DAY) HD
<i>perampanel 6 mg tablet</i> (Fycompa)	T1	PA QL(1 TAB/DAY) HD
<i>perampanel 8 mg tablet</i> (Fycompa)	T1	PA HD
PHENYTEK (<i>phenytoin sodium extended</i>)	T3	PA HD
<i>phenytoin</i>	T1	HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

CNS DRUGS (Seizure Disorders) (cont.)

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

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

CNS DRUGS (Seizure Disorders) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-CONVULSANTS (cont.)		
TROKENDI XR 25 MG, 100 MG CAPSULE (<i>topiramate</i>)	T3	QL(1 CAP/DAY) HD
TROKENDI XR 50 MG, 200 MG CAPSULE (<i>topiramate</i>)	T3	HD
<i>valproic acid</i>	T1	HD
<i>valproic acid (as sodium salt)</i>	T1	HD
<i>vigabatrin (Sabril)</i>	T1	SP HD
<i>vigadrone 500 mg powder packet (Sabril)</i>	T1	SP HD
VIMPAT 10 MG/ML SOLUTION (<i>lacosamide</i>)	T2	HD
XCOPRI 25 MG TABLET	T3	PA QL(1 TABLET/DAY) 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 250 MG DAILY DOSE PACK	T3	PA QL(56 TABS/28 DAYS) HD
XCOPRI 350 MG DAILY DOSE PACK	T3	PA QL(56 TABS/28 DAYS) HD
XCOPRI 50 MG TABLET	T3	PA QL(1 TABLET/DAY) HD
XCOPRI 50-100 MG TITRATION PAK	T3	PA QL(28 TABS/28 DAYS) HD
ZARONTIN (<i>ethosuximide</i>)	T3	PA HD
<i>zonisamide</i>	T1	HD
<i>zonisamide (Zonegran)</i>	T1	HD

CNS DRUGS (Sleep Disorders/Sedatives)

NARCOLEPSY TX-H3-RECEPT.ANTAGONIST/INVERSE AGONIST

WAKIX	T3	PA QL(2 TABS/DAY) SP HD
-------	----	-------------------------

COLONY STIMULATING FACTORS (Blood Modifiers/Bleeding Disorders)

LEUKOCYTE (WBC) STIMULANTS

FULPHILA	T2	PA SP
FYLNETRA	T3	PA SP
GRANIX	T3	PA SP
LEUKINE	T2	SP
NEUPOGEN	T3	PA SP
NIVESTYM	T2	SP HD
NYPOZI	T3	PA SP
NYVEPRIA	T2	PA SP

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LEUKOCYTE (WBC) STIMULANTS <i>(cont.)</i>		
STIMUFEND	T3	PA SP
UDENYCA	T2	PA SP
UDENYCA AUTOINJECTOR	T2	PA SP
ZARXIO	T2	SP HD
ZIEXTENZO	T2	PA SP
THROMBOPOIETIN RECEPTOR AGONISTS		
DOPTELET	T2	PA SP HD
DOPTELET SPRINKLE	T2	PA SP HD
<i>eltrombopag olamine (Promacta)</i>	T1	PA SP HD
MULPLETA	T3	PA SP HD

COLONY STIMULATING FACTORS (Blood Pressure/Heart Medications)

LEUKOCYTE (WBC) STIMULANTS		
RELEUKO	T3	PA SP
ROLVEDON	T2	PA SP

COLONY STIMULATING FACTORS (Cancer)

CXCR4 CHEMOKINE RECEPTOR ANTAGONIST		
XOLREMDI	T3	PA QL(4 CAPS/DAY) SP CSL

CONTRACEPTIVES (Contraception Products)

CONTRACEPTIVES, INTRAVAGINAL, SYSTEMIC		
<i>etonogestrel/ethinyl estradiol (Nuvaring)</i>	T1	PPACA
CONTRACEPTIVES, IMPLANTABLE		
NEXPLANON	T2	SP PPACA
CONTRACEPTIVES, INJECTABLE		
DEPO-SUBQ PROVERA 104	T2	
<i>medroxyprogesterone 150 mg/ml (Depo-Provera)</i>	T1	PPACA
CONTRACEPTIVES, ORAL		
<i>desog-e.estradiol/e.estradiol</i>	T1	HD PPACA
<i>desogestrel-ethinyl estradiol</i>	T1	HD PPACA
<i>drospir/eth estra/levomefol ca (Beyaz)</i>	T1	HD PPACA
<i>drospir/eth estra/levomefol ca (Safyral)</i>	T1	HD PPACA
ELLA	T3	HD PPACA
<i>ethinyl estradiol/drospirenone (Yasmin 28)</i>	T1	HD PPACA

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

CONTRACEPTIVES (Contraception Products) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CONTRACEPTIVES, ORAL (cont.)		
<i>ethinyl estradiol/drospirenone (Yasmin 28)</i>	T1	PPACA
<i>ethinyl estradiol/drospirenone (Yaz)</i>	T1	HD PPACA
<i>ethynodiol d-ethinyl estradiol</i>	T1	HD PPACA
<i>levonorgest/eth.estradiol/iron (Balcoltra)</i>	T1	HD PPACA
<i>l-norgest/e.estradiol-e.estr</i>	T1	HD PPACA
<i>noreth-ethinyl estradiol/iron</i>	T1	HD PPACA
<i>norethind-eth estrad 1-0.02 mg (Loestrin)</i>	T1	HD PPACA
<i>norethindrone</i>	T1	HD PPACA
<i>norethindrone ac/eth estradiol (Loestrin)</i>	T1	HD PPACA
<i>norethindrone-e.estradiol-iron</i>	T1	HD PPACA
<i>norethindrone-e.estradiol-iron (Loestrin Fe)</i>	T1	HD PPACA
<i>norethindrone-e.estradiol-iron (Taytulla)</i>	T1	HD PPACA
<i>norethindrone-ethin. estradiol</i>	T1	HD PPACA
<i>norethin-ee 1.5-0.03 mg(21) tb (Loestrin)</i>	T1	HD PPACA
<i>norgestimate-ethinyl estradiol</i>	T1	HD PPACA
<i>norgestrel-ethinyl estradiol</i>	T1	HD PPACA
CONTRACEPTIVES, TRANSDERMAL		
<i>norelgestromin/ethin.estradiol</i>	T1	HD PPACA
DIAPHRAGMS/CERVICAL CAP		
CAYA CONTOURED	T2	PPACA
FEMCAP	T2	PPACA
WIDE SEAL DIAPHRAGM	T3	PPACA
INTRA-UTERINE DEVICES (IUDS)		
KYLEENA	T3	SP PPACA
LILETTA	T3	SP PPACA
MIRENA	T3	SP PPACA
MIUDELLA	T3	SP PPACA
PARAGARD T 380-A	T3	SP PPACA
PARAGARD T 380A (SINGLE HAND)	T3	SP PPACA
SKYLA	T3	SP PPACA

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

COUGH/COLD PREPARATIONS (Allergy/Nasal Sprays)

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

IST GEN ANTIHIST-DECONGEST-ANTICHOLINERGIC COMB

RESPA A.R. (<i>pseudoephed/chlor-mal/bell alk</i>)	T3	
--	----	--

COUGH/COLD PREPARATIONS (Cough/Cold Medications)

ANTI-TUSSIVES, NON-OPIOID

<i>benzonatate 100 mg capsule</i>	T1	
<i>benzonatate 200 mg capsule</i>	T1	

NON-OPIOID ANTI-TUS-IST GEN.ANTIHISTAMINE-DECONGEST

<i>brompheniramine/pseudoephed/dm</i> (Bromfed Dm)	T1	
--	----	--

NON-OPIOID ANTI-TUSSIVE-IST GEN ANTIHISTAMINE COMB.

<i>promethazine/dextromethorphan</i>	T1	
--------------------------------------	----	--

OPIOID ANTI-TUSSIV-IST GEN. ANTIHISTAMINE-DECONGEST

CAPCOF	T3	
HISTEX-AC	T3	
MAXI-TUSS CD	T3	
POLY-TUSSIN AC	T3	
<i>promethazine/phenyleph/codeine</i>	T1	PA QL(480 MLS/30 DAYS)

OPIOID ANTI-TUSSIVE-IST GENERATION ANTIHISTAMINE

<i>hydrocodone/chlorphen p-stirex</i>	T1	PA
<i>promethazine hcl/codeine</i>	T1	PA QL(480 MLS/30 DAYS)
TUXARIN ER	T3	PA QL(2 TABS/DAY)
TUZISTRA XR	T3	PA QL(960 MLS/30 DAYS)

OPIOID ANTI-TUSSIVE-ANTI-CHOLINERGIC COMBINATIONS

HYCODAN 5 MG-1.5 MG TABLET (<i>hydrocodone bit/homatrop me-br</i>)	T3	PA QL(180 TABS/30 DAYS)
HYCODAN 5 MG-1.5 MG/5 ML CUP	T3	PA QL(480 MLS/30 DAYS)
HYCODAN 5 MG-1.5 MG/5 ML SOLN (<i>hydrocodone bit/homatrop me-br</i>)	T3	PA QL(480 MLS/30 DAYS)
<i>hydrocodone bit/homatrop me-br</i> (Hycodan)	T1	PA QL(480 MLS/30 DAYS)
<i>hydrocodone-homatrop 5 ml cup</i>	T1	PA QL(480 MLS/30 DAYS)
<i>hydrocodone-homatropine 5-1.5</i> (Hycodan)	T1	PA QL(180 TABS/30 DAYS)
<i>hydrocodone-homatropine soln</i> (Hycodan)	T1	PA QL(480 MLS/30 DAYS)

OPIOID ANTI-TUSSIVE-EXPECTORANT COMBINATION

<i>codeine phosphate/guaifenesin</i>	T1	
CODITUSSIN DAC	T3	
CODITUSSIN AC	T1	
GUAIFENESIN-CODEINE	T1	
MAR-COF CG	T3	
OBREDON	T3	PA QL(960 MLS/30 DAYS)

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

List of Prescription Medications

DIAGNOSTIC (Diabetes)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BLOOD SUGAR DIAGNOSTICS		
FREESTYLE TEST STRIPS	T2	
FREESTYLE INSULINX TEST STRIPS	T2	
FREESTYLE LITE TEST STRIP	T2	
FREESTYLE PRECISION NEO	T2	
FREESTYLE TEST STRIPS	T2	
PRECISION XTRA TEST STRIPS	T2	
RELION TRUE METRIX TEST STRIP	T2	
TRUE METRIX GLUCOSE TEST STRIP	T2	
URINE GLUCOSE TEST AIDS		
DIASTIX REAGENT	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	
<i>lidocaine hcl/glycerin</i>	T1	
PROVOCHOLINE	T3	
TC99M SULFUR COLLOID PREP	T1	
EYE DIAGNOSTIC AGENTS		
<i>fluorescein sodium</i>	T1	
<i>ful-glo 1 mg ophth strip</i>	T1	
FUL-GLO EYE STRIPS	T3	
<i>lissamine green</i>	T1	
GASTROINTESTINAL RADIOPAQUE DIAGNOSTICS		
<i>diatrizoate meglumine, sodium</i> (Gastrografin)	T1	
ENTERO VU	T3	
E-Z DISK	T3	
E-Z-HD	T3	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

DIAGNOSTIC (Miscellaneous) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GASTROINTESTINAL RADIOPAQUE DIAGNOSTICS (cont.)		
E-Z-PAQUE	T3	
E-Z-PASTE	T3	
GASTROGRAFIN (<i>diatrizoate meglumine, sodium</i>)	T3	
GASTROMARK	T3	
LIQUID E-Z PAQUE	T3	
LIQUID POLIBAR PLUS	T3	
NEULUMEX	T3	
POLIBAR ACB	T3	
READI-CAT 2	T3	
SITZMARKS	T3	
TAGITOL V	T3	
VANILLA SILQ	T3	
VARIBAR HONEY	T3	
VARIBAR NECTAR	T3	
VARIBAR PUDDING	T3	
VARIBAR THIN HONEY	T3	
VARIBAR THIN LIQUID	T3	
METABOLIC FUNCTION DIAGNOSTICS		
METOPIRONE	T3	
RADIOPHARMACEUTICALS ELEMENTS		
INDICLOR	T3	
URINARY TRACT RADIOPAQUE DIAGNOSTICS		
CYSTO-CONRAY II	T3	
CYSTOGRAFIN	T3	
CYSTOGRAFIN-DILUTE	T3	
URINE ACETONE TEST AIDS		
KETONE CARE TEST STRIP	T1	
KETONE TEST STRIP	T1	
KETOSTIX REAGENT	T1	
TRUEPLUS KETONE TEST STRIP	T1	
URINE MULTIPLE TEST AIDS		
CHEK-STIX	T1	
CHEMSTRIP	T1	
CHEMSTRIP 10 WITH SG	T1	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

DIAGNOSTIC (Miscellaneous) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
URINE MULTIPLE TEST AIDS (cont.)		
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	
DIURETICS (Diuretics)		
ARGININE VASOPRESSIN (AVP) RECEPTOR ANTAGONISTS		
<i>tolvaptan 15 mg tablet (Samsca)</i>	T1	SP
<i>tolvaptan 30 mg tablet (Samsca)</i>	T1	SP
CARBONIC ANHYDRASE INHIBITORS		
<i>acetazolamide</i>	T1	HD
<i>methazolamide</i>	T1	HD
LOOP DIURETICS		
<i>bumetanide</i>	T1	HD
<i>furosemide</i>	T1	HD
<i>furosemide (Lasix)</i>	T1	HD
<i>toremide</i>	T1	HD
POLYCYSTIC KIDNEY DISEASE AGENT, AVP RECEPTOR ANTAGONIST		
<i>tolvaptan 15 mg tablet (Jynarque)</i>	T1	SP
<i>tolvaptan 15 mg-15 mg tablet (Jynarque)</i>	T1	PA SP
<i>tolvaptan 30 mg tablet (Jynarque)</i>	T1	SP

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

DIURETICS (Diuretics) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
POLYCYSTIC KIDNEY DISEASE AGENT, AVP RECEPTOR ANTAGONIST (cont.)		
<i>tolvaptan 30 mg-15 mg tablet (Jynarque)</i>	T1	PA SP
<i>tolvaptan 45 mg-15 mg tablet (Jynarque)</i>	T1	PA SP
<i>tolvaptan 60 mg-30 mg tablet (Jynarque)</i>	T1	PA SP
<i>tolvaptan 90 mg-30 mg tablet (Jynarque)</i>	T1	PA SP
POTASSIUM SPARING DIURETICS		
<i>amiloride hcl</i>	T1	HD
CAROSPIR (<i>spironolactone</i>)	T2	PA
<i>eplerenone (Inspra)</i>	T1	HD
KERENDIA	T2	PA QL(1 TAB/DAY)
<i>spironolactone 100 mg tablet (Aldactone)</i>	T1	HD
<i>spironolactone 25 mg tablet (Aldactone)</i>	T1	HD
<i>spironolactone 25 mg/5 ml susp (Carospir)</i>	T1	
<i>spironolactone 50 mg tablet (Aldactone)</i>	T1	HD
<i>triamterene (Dyrenium)</i>	T1	HD
POTASSIUM SPARING DIURETICS IN COMBINATION		
<i>amiloride/hydrochlorothiazide</i>	T1	HD
<i>spironolact/hydrochlorothiazid (Aldactazide)</i>	T1	HD
<i>triamterene/hydrochlorothiazid (Dyazide)</i>	T1	HD
THIAZIDE AND RELATED DIURETICS		
<i>chlorthalidone</i>	T1	HD
DIURIL	T3	HD
<i>hydrochlorothiazide</i>	T1	HD
<i>indapamide</i>	T1	HD
<i>metolazone</i>	T1	HD
EENT PREPS (Allergy/Nasal Sprays)		
NASAL ANTIHISTAMINE		
<i>azelastine hcl</i>	T1	HD
<i>olopatadine hcl (Patanase)</i>	T1	HD
PATANASE (<i>olopatadine hcl</i>)	T3	HD
NASAL ANTIHISTAMINE AND ANTI-INFLAM. STEROID COMB.		
<i>azelastine/fluticasone (Dymista)</i>	T1	HD
NOSE PREPARATIONS, MISCELLANEOUS (RX)		
<i>ipratropium bromide</i>	T1	HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NOSE PREPARATIONS, VASOCONSTRICTORS (RX)		
ADRENALIN CHLORIDE	T3	
<i>epinephrine hcl</i>	T1	
EENT PREPS (Ear Medications)		
EAR PREPARATIONS ANTI-INFLAMMATORY		
DERMOTIC (<i>fluocinolone acetonide oil</i>)	T3	
<i>fluocinolone acetonide oil</i> (Dermotic)	T1	
EAR PREPARATIONS, MISC. ANTI-INFECTIVES		
<i>acetic acid</i>	T1	
<i>hydrocortisone/acetic acid</i>	T1	
EENT PREPS (Eye Conditions)		
ARTIFICIAL TEARS		
LACRISERT	T3	
MIEBO	T2	QL(4 BOTTLES/30 DAYS)
EYE ANTI-INFECTIVES (RX ONLY)		
BETADINE	T3	
EYE ANTI-INFLAMMATORY AGENTS		
<i>bromfenac sodium</i>	T1	
<i>bromfenac sodium</i> (Bromsite)	T1	
<i>bromfenac sodium</i> (Prolensa)	T1	
<i>dexamethasone sodium phosphate</i>	T1	
<i>diclofenac 0.1% eye drops</i>	T1	
<i>difluprednate</i> (Durezol)	T1	
EYSUVIS	T2	QL(8.3 ML/14 DAYS)
<i>fluorometholone</i> (Fml)	T1	
<i>flurbiprofen sodium</i>	T1	
ILEVRO	T3	
<i>ketorolac 0.4% ophth solution</i> (Acular Ls)	T1	
<i>ketorolac 0.5% ophth solution</i> (Acular)	T1	
<i>loteprednol etabonate</i> (Alrex)	T1	
<i>loteprednol etabonate</i> (Lotemax)	T1	
<i>prednisolone acetate</i> (Pred Forte)	T1	
<i>prednisolone sodium phosphate</i>	T1	
PROLENSA (<i>bromfenac sodium</i>)	T3	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

EENT PREPS (Eye Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EYE LOCAL ANESTHETICS		
AKTEN	T3	
ALCAINE (<i>proparacaine hcl</i>)	T3	
ALTAFLUOR BENOX (<i>benoxinate hcl/fluorescein sod</i>)	T3	
FLUORESCIN-BENOXINATE	T3	
<i>proparacaine hcl</i> (Alcaine)	T1	
<i>proparacaine/fluorescein sod</i>	T1	
<i>tetracaine hcl</i>	T1	
TETRACAINE HCL	T1	
EYE MAST CELL STABILIZERS		
<i>cromolyn 4% eye drops</i>	T1	
EYE PREPARATIONS, MISCELLANEOUS (OTC)		
GELFILM	T3	
EYE VASOCONSTRICTORS		
<i>phenylephrine hcl</i>	T1	
MIOTICS AND OTHER INTRAOCULAR PRESSURE REDUCERS		
<i>apraclonidine hcl</i> (Iopidine)	T1	HD
<i>betaxolol hcl</i>	T1	HD
BETOPTIC S	T2	HD
<i>bimatoprost</i>	T1	QL(10 MLS/30 DAYS) HD
<i>brimonidine tartrate</i>	T1	HD
<i>brimonidine tartrate</i> (Alphagan P)	T1	HD
<i>brimonidine tartrate/timolol</i> (Combigan)	T1	HD
<i>brinzolamide</i> (Azopt)	T1	HD
<i>carteolol hcl</i>	T1	HD
<i>dorzolamide hcl</i>	T1	HD
<i>dorzolamide hcl/timolol maleat</i> (Cosopt)	T1	HD
<i>dorzolamide/timolol/pf</i> (Cosopt Pf)	T1	HD
<i>latanoprost</i> (Xalatan)	T1	HD
<i>levobunolol hcl</i>	T1	HD
PHOSPHOLINE IODIDE	T3	SP HD
<i>pilocarpine 1% eye drops</i>	T1	HD
<i>pilocarpine 2% eye drops</i>	T1	HD
<i>pilocarpine 4% eye drops</i>	T1	HD
RHOPRESSA	T3	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

EENT PREPS (Eye Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MIOTICS AND OTHER INTRAOCULAR PRESSURE REDUCERS (cont.)		
ROCKLATAN	T3	
SIMBRINZA	T2	HD
<i>tafluprost/pf</i> (Zioptan)	T1	QL(60 DROPPERS/30 DAYS) HD
<i>timolol</i> (Betimol)	T1	HD
<i>timolol maleate</i> (Istalol)	T1	HD
<i>timolol maleate</i> (Timoptic)	T1	HD
<i>timolol maleate</i> (Timoptic-Xe)	T1	HD
<i>timolol maleate/pf</i>	T1	HD
<i>timolol maleate/pf</i> (Timoptic Ocudose)	T1	HD
<i>travoprost</i> (Travatan Z)	T1	HD
MYDRIATICS		
<i>atropine 1% eye drop</i>	T1	HD
<i>atropine 1% eye drops</i>	T1	HD
<i>atropine 1% eye ointment</i>	T1	HD
CYCLOGYL	T3	HD
CYCLOGYL (<i>cyclopentolate hcl</i>)	T3	HD
CYCLOMYDRIL	T3	HD
<i>cyclopentolate hcl</i>	T1	HD
<i>cyclopentolate hcl</i> (Cyclogyl)	T1	HD
<i>homatropine hbr</i>	T1	HD
MYDRIACYL (<i>tropicamide</i>)	T3	HD
PAREMYD	T3	HD
<i>tropicamide</i>	T1	HD
<i>tropicamide</i> (Mydriacyl)	T1	HD
OPHTHALMIC ANTI-FIBROTIC AGENTS		
MITOSOL	T3	
OPHTHALMIC ANTI-INFLAMMATORY IMMUNOMODULATOR-TYPE		
CEQUA	T2	
<i>cyclosporine 0.05% eye emuls</i> (Restasis)	T1	HD
RESTASIS (<i>cyclosporine</i>)	T2	HD
XIIDRA	T2	HD
OPHTHALMIC CYSTINE DEPLETING AGENTS		
CYSTADROPS	T3	PA QL(20 MLS/28 DAYS) SP
CYSTARAN 0.44% EYE DROPS	T3	PA QL(120 MLS/28 DAYS) SP

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

EENT PREPS (Eye Conditions) <i>(cont.)</i>		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPHTHALMIC HUMAN NERVE GROWTH FACTOR (HNGF)		
OXERVATE	T3	PA SP HD
OPHTHALMIC TRPM8 AGONISTS		
TRYPTYR	T3	
ELECT/CALORIC/H2O (Cholesterol Medications)		
ORAL LIPID SUPPLEMENTS		
DOJOLVI	T3	PA SP HD
ELECT/CALORIC/H2O (Dental Products)		
FLUORIDE PREPARATIONS		
CLINPRO 5000	T3	
<i>fluoride (sodium)</i>	T1	
<i>fluoride (sodium)</i> (Prevident 5000 Plus)	T1	
<i>fluoride (sodium)</i> (Prevident 5000)	T1	
FLUORIDEX	T1	
FLUORIDEX SENSITIVITY RELIEF	T3	
FLUORIMAX 5000	T3	
FLUORIMAX 5000 SENSITIVE	T3	
FRAICHE 5000 PREVI	T3	
JUST RIGHT 5000	T3	
PREVIDENT	T3	
PREVIDENT (<i>fluoride (sodium)</i>)	T3	
PREVIDENT 5000 DRY MOUTH	T3	
PREVIDENT 5000 ENAMEL PROTECT	T3	
PREVIDENT 5000 ORTHO DEFENSE	T3	
PREVIDENT 5000 SENSITIVE	T3	
PREVIDENT KIDS	T3	
<i>sodium fluoride/potassium nit</i>	T1	
ELECT/CALORIC/H2O (Diabetes)		
AGENTS TO TREAT HYPOGLYCEMIA (HYPERGLYCEMICS)		
BAQSIMI	T2	QL(2 UNITS/30 DAYS)
<i>diazoxide</i> (Proglycem)	T1	
<i>glucagon 1 mg emergency kit</i>	T1	QL(2 VIALS/30 DAYS)
GLUCAGON 1 MG EMERGENCY KIT	T3	QL(2 KITS/30 DAYS)
ZEGALOGUE AUTOINJECTOR	T2	QL(1.2 ML/30 DAYS)
ZEGALOGUE SYRINGE	T2	QL(1.2 ML/30 DAYS)

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
IODINE CONTAINING AGENTS		
<i>potassium iodide</i>	T1	
<i>potassium iodide/iodine</i>	T1	
SSKI	T1	
IRON REPLACEMENT		
ACTIVE FE	T3	
CORVITE 150	T3	
CORVITE FE	T3	
FERIVA 21-7	T3	
FERRALET 90	T3	
<i>ferrous fum/vit c/b12-if/folic</i>	T1	
<i>ferrous fumarate/folic acid</i> (Hemocyte-F)	T1	
FUSION PLUS	T3	
HEMATRON-AF	T3	
HEMAX	T3	
HEMOCYTE PLUS (<i>mv-mins no.73/iron fum/folic</i>)	T3	
HEMOCYTE-F (<i>ferrous fumarate/folic acid</i>)	T3	
INTEGRA F (<i>iron fum,ps/folic acid/vitc/b3</i>)	T3	
INTEGRA PLUS (<i>iron fum,ps/folic/bcomp,c no.9</i>)	T3	
<i>iron aspgly,ps/c/b12/fa/ca/suc</i>	T1	
<i>iron aspgly/c/b12/fa/ca-th/suc</i>	T1	
<i>iron bg,ps/vitc/b12/fa/calcium</i>	T1	
<i>iron fum,ag/c/b12/folic/ca/suc</i>	T1	
<i>iron fum,ps/folic acid/vitc/b3</i> (Integra F)	T1	
<i>iron fum,ps/folic/bcomp,c no.9</i> (Integra Plus)	T1	
<i>iron fumarate/vit c/vit b12/fa</i>	T1	
<i>iron ps complex/b12/folic acid</i>	T1	
<i>iron/c/folic acd/mv cmb11/calc</i>	T1	
<i>iron/folic ac/vit bcomp,c/min</i>	T1	
<i>iron/folic acid/b12/c/docusate</i>	T1	
<i>iron/folic acid/c/b6/b12/zinc</i>	T1	
IROSPAN	T3	
NUFERA	T3	
PROFERRIN-FORTE	T3	
VITAFOL	T3	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
POTASSIUM REPLACEMENT		
EFFER-K 10 MEQ TABLET EFF	T3	
EFFER-K 20 MEQ TABLET EFF	T3	
<i>effe-r-k 25 meq tablet eff</i>	T1	
<i>potassium bicarbonate/cit ac</i>	T1	
<i>potassium chloride</i>	T1	
<i>potassium chloride 40 meq packet</i>	T3	
<i>potassium cl 10% (20 meq/15ml)</i>	T1	
<i>potassium cl 20 meq packet</i>	T1	
<i>potassium cl 20% (40 meq/15ml)</i>	T1	
<i>potassium cl er 10 meq capsule</i>	T1	
<i>potassium cl er 10 meq tablet</i>	T1	
<i>potassium cl er 15 meq tablet</i>	T1	
POTASSIUM CL ER 15 MEQ TABLET	T3	
<i>potassium cl er 20 meq tablet</i>	T1	
<i>potassium cl er 8 meq capsule</i>	T1	
<i>potassium cl er 8 meq tablet</i>	T1	
<i>potassium cl10%(20meq/15ml)cup</i>	T1	
<i>potassium cl10%(40meq/30ml)cup</i>	T1	
<i>potassium cl20%(40meq/15ml)cup</i>	T1	
PROTEIN REPLACEMENT		
AQNEURSA	T3	PA SP
<i>levocarnitine</i>	T1	
ELECT/CALORIC/H2O (Urinary Tract Conditions)		
DIALYSIS SOLUTIONS		
PRISMASOL	T3	
URINARY PH MODIFIERS		
<i>citric acid/sodium citrate</i>	T1	HD
K-PHOS NO.2	T3	HD
K-PHOS ORIGINAL	T3	HD
ORACIT	T3	HD
<i>potassium citrate</i>	T1	HD
<i>potassium citrate (Urocit-k)</i>	T1	HD
<i>potassium citrate/citric acid</i>	T1	HD
RENACIDIN	T3	HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ELECT/CALORIC/H2O (Urinary Tract Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
URINARY PH MODIFIERS (cont.)		
<i>sod/pot/k cit/sod cit/cit acid</i>	T1	HD
UROCIT-K (<i>potassium citrate er</i>)	T3	HD
UROQID-ACID NO.2	T3	HD
GASTROINTESTINAL (Cholesterol Medications)		
LIPOTROPICS		
<i>icosapent ethyl (Vascepa)</i>	T1	HD
<i>omega-3 acid ethyl esters (Lovaza)</i>	T1	HD
VASCEPA (<i>icosapent ethyl</i>)	T2	PA HD
GASTROINTESTINAL (Gastrointestinal/Heartburn)		
AMMONIA INHIBITORS		
<i>glycerol phenylbutyrate</i>	T1	SP HD
<i>lactulose</i>	T1	HD
<i>lactulose 10 gm/15 ml solution</i>	T1	
LITHOSTAT	T3	HD
OLPRUVA	T3	PA SP HD
PHEBURANE	T2	PA QL(8 Bottles/30 Days) SP HD
<i>sodium phenylbutyrate (Buphenyl)</i>	T1	SP HD
ANTI-CHOLINERGICS, QUATERNARY AMMONIUM		
<i>chlordiazepoxide/clidinium br (Librax)</i>	T1	
CUVPOSA (<i>glycopyrrolate</i>)	T3	
GLYCATE	T3	
<i>glycopyrrolate 1 mg tablet (Robinul)</i>	T1	
<i>glycopyrrolate 1 mg/5 ml soln (Cuvposa)</i>	T1	
<i>glycopyrrolate 2 mg tablet (Robinul Forte)</i>	T1	
ANTI-CHOLINERGICS/ANTI-SPASMODICS		
<i>dicyclomine 10 mg capsule</i>	T1	
<i>dicyclomine 10 mg/5 ml soln</i>	T1	
<i>dicyclomine 20 mg tablet</i>	T1	
ANTI-DIARRHEAL - G.I. CHLORIDE CHANNEL INHIBITORS		
MYTESI	T3	SP
ANTI-DIARRHEAL - TRYPTOPHAN HYDROXYLASE INHIBITOR		
XERMELO	T3	PA SP

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-DIARRHEALS		
<i>diphenoxylate hcl/atropine</i>	T1	
<i>diphenoxylate hcl/atropine</i> (Lomotil)	T1	
<i>loperamide hcl</i>	T1	
MOTOFEN	T3	
<i>opium tincture</i>	T1	PA
ANTI-EMETIC, CANNABINOID-TYPE		
<i>dronabinol</i> (Marinol)	T1	
ANTI-EMETIC/ANTI-VERTIGO AGENTS		
AKYNZEO	T3	PA QL(4 CAPS/28 DAYS)
<i>aprepitant 125 mg capsule</i>	T1	QL(4 CAPS/28 DAYS)
<i>aprepitant 125-80-80 mg pack</i> (Emend)	T1	QL(12 CAPS/28 DAYS)
<i>aprepitant 40 mg capsule</i>	T1	QL(1 CAP/28 DAYS)
<i>aprepitant 80 mg capsule</i> (Emend)	T1	QL(8 CAPS/28 DAYS)
BONJESTA	T3	
COMPAZINE (<i>prochlorperazine maleate</i>)	T3	
COMPAZINE (<i>prochlorperazine</i>)	T3	
<i>doxylamine succinate/vit b6</i> (Diclegis)	T1	QL(4 TABS/DAY)
EMEND 125 MG POWDER PACKET	T3	PA QL(12 PACKS/28 DAYS)
EMEND 150 MG VIAL (<i>fosaprepitant dimeglumine</i>)	T3	
<i>fosaprepitant dimeglumine</i> (Emend)	T1	
<i>granisetron hcl</i>	T1	
<i>granisetron hcl/pf</i>	T1	
<i>ondansetron hcl</i>	T1	
<i>ondansetron hcl/pf</i>	T1	
<i>ondansetron odt 4 mg tablet</i>	T1	
<i>ondansetron odt 8 mg tablet</i>	T1	
<i>prochlorperazine</i> (Compazine)	T1	
<i>prochlorperazine maleate</i> (Compazine)	T1	
<i>promethazine hcl</i>	T1	
SANCUSO	T3	PA QL(4 PATCHES/30 DAYS)
<i>scopolamine</i> (Transderm-scop)	T1	
TRANSDERM-SCOP (<i>scopolamine</i>)	T3	
<i>trimethobenzamide hcl</i>	T1	
VARUBI	T3	PA QL(4 TABS/28 DAYS)

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-ULCER PREPARATIONS		
CYTOTEC (<i>misoprostol</i>)	T3	HD
<i>misoprostol</i> (Cytotec)	T1	HD
<i>sucralfate</i>	T1	HD
<i>sucralfate</i> (Carafate)	T1	HD
ANTI-ULCER-H.PYLORI AGENTS		
<i>bismuth/metronid/tetracycline</i> (Pylera)	T1	
<i>lansoprazole/amoxicilin/clarith</i>	T1	
BELLADONNA ALKALOIDS		
<i>hyoscyamine sulfate</i>	T1	HD
<i>hyoscyamine sulfate</i> (Levbid)	T1	HD
<i>hyoscyamine sulfate</i> (Levsin)	T1	HD
<i>hyoscyamine sulfate</i> (Levsin-sl)	T1	HD
<i>hyoscyamine sulfate</i> (Nulev)	T3	HD
LEVSIN (<i>hyoscyamine sulfate</i>)	T3	HD
<i>methscopolamine bromide</i>	T1	HD
NULEV (<i>hyoscyamine sulfate</i>)	T3	HD
<i>phenobarb/hyoscy/atropine/scop</i>	T1	HD
<i>phenobarb/hyoscy/atropine/scop</i> (Donnatal)	T1	HD
<i>phenobarb/hyoscy/atropine/scop</i> (Phenobarbital-Belladonna)	T1	HD
PHENOBARBITAL-BELLADONNA (<i>phenobarb/hyoscy/atropine/scop</i>)	T3	HD
SYMAX DUOTAB	T3	HD
BILE SALTS		
CHENODAL	T3	PA SP HD
CHOLBAM	T3	PA SP HD
CTEXLI	T3	PA SP
URSO (<i>ursodiol</i>)	T3	HD
<i>ursodiol 250 mg tablet</i>	T1	HD
<i>ursodiol 300 mg capsule</i>	T1	HD
<i>ursodiol 500 mg tablet</i> (Urso Forte)	T1	HD
CHRONIC INFLAM. COLON DX, 5-A-SALICYLAT, RECTAL TX		
<i>mesalamine 1,000 mg supp</i> (Canasa)	T1	
<i>mesalamine 4 gm/60 ml enema</i> (Sfrowasa)	T1	
<i>mesalamine 4 gm/60 ml kit</i> (Rowasa)	T1	
SFROWASA (<i>mesalamine</i>)	T3	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DRUG TX-CHRONIC INFLAM. COLON DX, 5-AMINOSALICYLAT		
APRISO (<i>mesalamine</i>)	T3	HD
<i>balsalazide disodium</i> (Colazal)	T1	HD
<i>mesalamine</i>	T1	HD
<i>mesalamine</i> (Apriso)	T1	HD
<i>mesalamine</i> (Pentasa)	T1	HD
<i>mesalamine 800 mg dr tablet</i>	T1	HD
<i>mesalamine dr 1.2 gm tablet</i> (Lialda)	T1	HD
PENTASA 500 MG CAPSULE (<i>mesalamine</i>)	T3	HD
<i>sulfasalazine</i> (Azulfidine)	T1	HD
FARNESOID X RECEPTOR (FXR) AGONIST, BILE AC ANALOG		
OCALIVA	T3	PA SP HD
FECAL MICROBIOTA TRANSPLANTATION		
VOWST	T3	PA QL(12 CAPS/56 DAYS) SP
GASTRIC ENZYMES		
SUCRAID	T3	PA SP
HEMORRHOID PREP,ANTI-INFLAM STEROID-LOCAL ANESTHET		
ANALPRAM HC 1% CREAM	T3	
<i>hydrocortisone/pramoxine</i>	T1	
<i>hydrocortisone/pramoxine</i> (Analpram Hc)	T1	
PROCORT	T3	
PROCTOFOAM-HC	T3	
HISTAMINE H2-RECEPTOR INHIBITORS		
<i>cimetidine hcl</i>	T1	HD
<i>famotidine</i>	T1	HD
IBS AGENTS, MIXED OPIOID RECEPTOR AGONISTS/ANTAGONISTS		
VIBERZI	T2	HD
IBS-C/CIC AGENTS, GUANYLATE CYCLASE-C AGONIST		
LINZESS	T2	
TRULANCE	T2	
INTEGRIN RECEPTOR ANTAGONIST, MONOCLONAL ANTIBODY		
ENTYVIO PEN	T3	PA QL(2 PENS/28 DAYS) SP HD
INTESTINAL MOTILITY STIMULANTS		
<i>metoclopramide hcl</i>	T1	
<i>metoclopramide hcl</i> (Reglan)	T1	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
INTESTINAL MOTILITY STIMULANTS (con't)		
<i>prucalopride succinate</i> (Motegrity)	T1	
REGLAN (<i>metoclopramide hcl</i>)	T3	
IRRITABLE BOWEL SYNDROME AGENTS, 5-HT₃ ANTAGONIST		
<i>alosetron hcl</i> (Lotronex)	T1	SP HD
LAXATIVES AND CATHARTICS		
<i>bisac/nacl/nahco3/kcl/peg 3350</i>	T1	PPACA
<i>lactulose</i>	T1	
<i>lactulose 10 gm/15 ml soln cup</i>	T1	
<i>lactulose 10 gm/15 ml solution</i>	T1	
<i>lactulose 20 gm packet</i>	T1	
<i>lactulose 20 gm/30 ml soln cup</i>	T1	
<i>lactulose 20 gm/30 ml solution</i>	T1	
<i>lubiprostone</i> (Amitiza)	T1	
<i>peg3350/sod sul/nacl/kcl/asb/c</i> (Moviprep)	T1	PPACA
<i>peg3350/sod sulf, bicarb, cl/kcl</i>	T1	PPACA
<i>peg3350/sod sulf,bicarb,cl/kcl</i> (Golytely)	T1	PPACA
<i>sodium chloride/nahco3/kcl/peg</i>	T1	PPACA
<i>sodium, potassium,mag sulfates</i> (Suprep)	T1	PPACA
LOCAL ANORECTAL NITRATE PREPARATIONS		
<i>nitroglycerin 0.4% ointment</i> (Rectiv)	T1	
RECTIV (<i>nitroglycerin</i>)	T3	
PANCREATIC ENZYMES		
PANCREAZE	T2	HD
VIKACE	T3	HD
ZENPEP	T2	HD
POTASSIUM-COMPETITIVE ACID BLOCKERS (PCABS)		
VOQUEZNA	T3	PA QL(1 TAB/DAY)
PROTON-PUMP INHIBITORS		
<i>esomeprazole dr 10 mg packet</i> (Nexium)	T1	QL(4 PACKS/DAY) HD
<i>esomeprazole dr 2.5 mg packet</i> (Nexium)	T1	QL(16 PACKS/DAY) HD
<i>esomeprazole dr 20 mg packet</i> (Nexium)	T1	QL(2 PACKS/DAY) HD
<i>esomeprazole dr 40 mg packet</i> (Nexium)	T1	QL(1 PACK/DAY) HD
<i>esomeprazole dr 5 mg packet</i> (Nexium)	T1	QL(8 PACKS/DAY) HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
RECTAL PREPARATIONS		
<i>hydrocortisone acetate</i>	T1	
<i>hydrocortisone acetate (Anusol-Hc)</i>	T1	
SBS - GLUCAGON-LIKE PEPTIDE-2 (GLP-2) ANALOGS		
GATTEX	T3	PA SP HD
GASTROINTESTINAL (Pain Relief And Inflammatory Disease)		
HEMORRHOID PREP, ANTI-INFLAM STEROID-LOCAL ANESTHET		
ANA-LEX	T1	
ANALPRAM HC 1% CREAM	T3	
<i>hydrocortisone/lidocaine/aloe</i>	T1	
<i>hydrocortisone/pramoxine</i>	T1	
<i>hydrocortisone/pramoxine (Analpram Hc)</i>	T1	
<i>lidocaine/hydrocortisone ac</i>	T1	
LIDOCAINE-HYDROCORTISONE	T1	
PROCORT	T3	
PROCTOFOAM-HC	T3	
HORMONES (Gastrointestinal/Heartburn)		
RECTAL/LOWER BOWEL PREP., GLUCOCORT. (NON-HEMORR)		
<i>budesonide 2 mg rectal foam (Uceris)</i>	T1	QL(2 KITS/180 DAYS)
CORTENEMA (<i>hydrocortisone</i>)	T3	
<i>hydrocortisone (Cortenema)</i>	T1	
HORMONES (Hormonal Agents)		
ANDROGEN/ESTROGEN PREPS FOR FEMALE SEXUAL DYSFUNC		
INTRAROSA	T2	
ANDROGENIC AGENTS		
DEPO-TESTOSTERONE	T3	
DEPO-TESTOSTERONE (<i>testosterone cypionate</i>)	T3	
METHITEST	T1	
<i>methyltestosterone</i>	T1	
<i>oxandrolone</i>	T1	PA
<i>testosterone 1% (25mg/2.5g) pk (Androgel)</i>	T1	PA QL(150 GMS/30 DAYS)
<i>testosterone 1% (50 mg/5 g) pk (Androgel)</i>	T1	PA QL(300 GMS/30 DAYS)
<i>testosterone 1.62% (2.5 g) pkt</i>	T1	PA QL(150 GMS/30 DAYS)

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

HORMONES (Hormonal Agents) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANDROGENIC AGENTS (con't)		
testosterone 1.62% gel pump (Androgel)	T1	PA QL(150 GMS/30 DAYS)
testosterone 1.62%(1.25 g) pkt	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	
ANTI-DIURETIC AND VASOPRESSOR HORMONES		
desmopressin 0.01% solution	T1	HD
desmopressin 10 mcg/0.1 ml spr	T1	HD
desmopressin 40 mcg/10 ml vial (Ddavp)	T1	SP
desmopressin ac 4 mcg/ml ampul (Ddavp)	T1	SP
desmopressin ac 4 mcg/ml vial (Ddavp)	T1	SP
desmopressin acetate 0.1 mg tb (Ddavp)	T1	HD
desmopressin acetate 0.2 mg tb (Ddavp)	T1	HD
NOCTIVA	T3	PA
ESTROGEN AND PROGESTIN COMBINATIONS		
BIJUVA	T3	
ESTROGEN/ANDROGEN COMBINATIONS		
estrogen, ester/me-testosterone	T1	HD
estrogen, ester/me-testosterone (Estratest H.S.)	T1	HD
ESTROGENIC AGENTS		
COMBIPATCH	T2	
DEPO-ESTRADIOL	T3	HD
estradiol (Climara)	T1	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

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

HORMONES (Hormonal Agents) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ESTROGENIC AGENTS (cont.)		
<i>estradiol 0.1% (0.5mg) gel pkt (Divigel)</i>	T1	HD
<i>estradiol 0.1% (0.75mg) gel pk (Divigel)</i>	T1	HD
<i>estradiol 0.1% (1 mg) gel pkt (Divigel)</i>	T1	HD
<i>estradiol 0.1% (1.25mg) gel pk (Divigel)</i>	T1	HD
<i>estradiol 0.5 mg tablet</i>	T1	HD
<i>estradiol 1 mg tablet</i>	T1	HD
<i>estradiol 2 mg tablet</i>	T1	HD
<i>estradiol valerate (Delestrogen)</i>	T1	HD
<i>estradiol/norethindrone acet</i>	T1	HD
<i>estradiol/norethindrone acet (Activella)</i>	T1	HD
<i>estrogens, conjugated (Premarin)</i>	T1	HD
EVAMIST	T3	HD
MENEST	T3	HD
MENOSTAR	T3	QL(8 PATCHES/28 DAYS) HD
<i>norethind-eth estrad 0.5-2.5</i>	T1	HD
<i>norethindrone ac-eth estradiol</i>	T1	HD
<i>norethin-eth estrad 1 mg-5 mcg</i>	T1	HD
PREMARIN (<i>estrogens, conjugated</i>)	T2	HD
PREMPHASE	T2	HD
PREMPRO	T2	HD
ESTROGEN-PROGESTIN WITH ANTI-MINERALOCORTICOID COMB		
ANGELIQ	T3	HD
ESTROGEN-SELECTIVE ESTROGEN RECEPTOR MOD (SERM) COMB		
DUAVEE	T2	
GLUCOCORTICOIDS		
<i>budesonide</i>	T1	
<i>budesonide (Uceris)</i>	T1	PA QL(1 TAB/DAY)
<i>cortisone acetate</i>	T1	
<i>deflazacort (Emflaza)</i>	T1	PA SP
<i>deflazacort (Emflaza)</i>	T1	PA SP HD
<i>dexamethasone</i>	T1	
<i>dexamethasone 0.5 mg tablet</i>	T1	
<i>dexamethasone 0.5 mg/5 ml elx</i>	T1	
<i>dexamethasone 0.5 mg/5 ml liq</i>	T1	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

HORMONES (Hormonal Agents) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GLUCOCORTICOIDS (cont.)		
dexamethasone 0.75 mg tablet	T1	
dexamethasone 1 mg tablet	T1	
dexamethasone 1.5 mg tablet	T1	
dexamethasone 2 mg tablet	T1	
dexamethasone 4 mg tablet	T1	
dexamethasone 6 mg tablet	T1	
hydrocortisone (Cortef)	T1	
MEDROL	T3	
MEDROL (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	
UCERIS 9 MG ER TABLET (budesonide)	T3	PA QL(1 TAB/DAY)
GROWTH HORMONE RELEASING HORMONE (GHRH) AND ANALOGS		
EGRIFTA SV	T3	PA SP HD
EGRIFTA WR	T3	PA SP HD
GROWTH HORMONES		
GENOTROPIN	T2	PA SP HD
OMNITROPE	T2	PA SP HD
SEROSTIM	T2	PA SP HD
SKYTROFA	T2	PA SP HD
INSULIN-LIKE GROWTH FACTOR-I (IGF-I) HORMONES		
INCRELEX	T2	PA SP
LHRH (GNRH) ANTAGONIST, ESTROGEN AND PROGESTIN COMB		
MYFEMBREE	T2	PA QL(1 TAB/DAY)
ORIAHNN	T2	PA QL(2 CAPS/DAY)
LHRH (GNRH) AGONIST ANALOG PITUITARY SUPPRESSANTS		
ORILISSA 150 MG TABLET	T2	PA QL(1 TAB/DAY)
ORILISSA 200 MG TABLET	T2	PA QL(2 TABS/DAY)

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

HORMONES (Hormonal Agents) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MINERALOCORTICOIDS		
<i>fludrocortisone acetate</i>	T1	HD
OXYTOCICS		
CERVIDIL	T3	
<i>methylergonovine maleate</i>	T1	
PREPIDIL	T3	
PARATHYROID HORMONES		
YORVIPATH	T3	PA SP
PITUITARY SUPPRESSIVE AGENTS		
<i>cabergoline</i>	T1	QL(16 TABS/28 DAYS) HD
CRENESSITY 100 MG CAPSULE	T3	PA QL(4 CAPS/DAY) SP
CRENESSITY 25 MG CAPSULE	T3	PA QL(2 CAPS/DAY) SP
CRENESSITY 50 MG CAPSULE	T3	PA QL(2 CAPS/DAY) SP
CRENESSITY 50 MG/ML SOLUTION	T3	PA QL(8 MLS/DAY) SP
<i>danazol</i>	T1	HD
PROGESTATIONAL AGENTS		
CRINONE 4% GEL	T3	PA HD
<i>medroxyprogesterone 10 mg tab (Provera)</i>	T1	HD
<i>medroxyprogesterone 2.5 mg tab (Provera)</i>	T1	HD
<i>medroxyprogesterone 5 mg tab (Provera)</i>	T1	HD
<i>norethindrone acetate</i>	T1	HD
<i>progesterone 100 mg capsule (Prometrium)</i>	T1	HD
<i>progesterone 200 mg capsule (Prometrium)</i>	T1	HD
SOMATOSTATIC AGENTS		
SIGNIFOR	T3	PA SP
VAGINAL ESTROGEN PREPARATIONS		
<i>estradiol (Vagifem)</i>	T1	QL(36 TABS/28 DAYS)
<i>estradiol 0.01% cream (Estrace)</i>	T1	HD
<i>estradiol 10 mcg vaginal insrt (Vagifem)</i>	T1	QL(36 TABS/28 DAYS) HD
PREMARIN	T2	HD
HORMONES (Infertility)		
FERTILITY STIMULATING PREPARATIONS, NON-FSH		
<i>clomiphene citrate</i>	T1	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

HORMONES (Infertility) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PREGNANCY FACILITATING/MAINTAINING AGENT, HORMONAL		
CRINONE 8% GEL	T2	
ENDOMETRIN (progesterone, micronized)	T2	
progesterone 100 mg vag insert (Endometrin)	T1	

HORMONES (Miscellaneous)

LEPTIN HORMONE ANALOGS

MYALEPT	T3	PA SP HD
---------	----	----------

HORMONES (Osteoporosis Products)

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

SELARSDI	T2	PA QL(1 SYRINGE/84 DAYS) SP
STELARA	T2	PA QL(1 SYRINGE/84 DAYS) SP HD
USTEKINUMAB-TTWE	T2	PA QL(1 SYRINGE/84 DAYS) SP HD
YESINTEK	T2	PA QL(1 SYRINGE/84 DAYS) SP

IL-23 RECEPTOR ANTAGONIST, MONOCLONAL ANTIBODY

OMVOH 100 MG/ML PEN	T2	PA QL(2 PENS/28 DAYS) SP HD
OMVOH 100 MG/ML SYRINGE	T2	PA QL(2 SYRINGES/28 DAYS) SP HD
OMVOH 200 MG DOSE - 2 PENS	T2	PA QL(2 PENS/28 DAYS) SP HD
OMVOH 200 MG DOSE - 2 SYRINGES	T2	PA QL(2 SYRINGES/28 DAYS) SP HD
OMVOH 200 MG/2 ML PEN	T2	PA QL SP HD
OMVOH 200 MG/2 ML SYRINGE	T2	PA QL SP HD
OMVOH 300 MG DOSE - 2 PENS	T2	PA QL(3 MLS/28 DAYS) SP HD
OMVOH 300 MG DOSE - 2 SYRINGES	T2	PA QL(3 MLS/28 DAYS) SP HD
SKYRIZI ON-BODY	T2	PA QL(1 CARTRIDGE/56 DAYS) SP HD
TREMFYA	T2	PA QL(1 SYRINGE/56 DAYS) SP HD
TREMFYA 100 MG/ML PEN	T2	PA QL(1 ML/56 DAYS) SP HD
TREMFYA 200 MG/2 ML PEN	T2	PA QL(2 SYRINGE/28 DAYS) SP HD
TREMFYA ONE-PRESS	T2	PA QL(1 AUTO-INJ/56 DAYS) SP HD
TREMFYA PEN INDUCTION (2 PEN)	T2	PA QL(12 MLS/365 DAYS) SP HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
INTERLEUKIN-4(IL-4) RECEPTOR ALPHA ANTAGONIST, MAB		
DUPIXENT PEN	T3	PA SP HD
DUPIXENT SYRINGE	T3	PA SP HD
INTERLEUKIN-6 (IL-6) RECEPTOR INHIBITORS		
ACTEMRA	T2	PA QL(3.6 ML/28 DAYS) SP HD
ACTEMRA ACTPEN	T2	PA QL(3.6 ML/28 DAYS) SP HD
ENSPRYNG	T3	PA SP HD
KEVZARA	T3	PA QL(2 PENS/SYRINGES/28 DAYS) SP HD
TYENNE	T2	PA QL(3.6 ML/28 DAYS) SP
TYENNE AUTOINJECTOR	T2	PA QL(3.6 ML/28 DAYS) SP
INTERLEUKIN-3I(IL-3I)RECEPTOR ALPHA ANTAGONIST,MAB		
NEMLUVIO	T2	PA SP HD
IMMUNOSUPPRESSANTS (Skin Conditions)		
TOPICAL IMMUNOSUPPRESSIVE AGENTS		
HYFTOR	T3	PA SP
<i>pimecrolimus (Elidel)</i>	T1	
<i>tacrolimus 0.03% ointment</i>	T1	
<i>tacrolimus 0.1% ointment</i>	T1	
IMMUNOSUPPRESSANTS (Transplant Medications)		
IMMUNOSUPPRESSIVES		
ASTAGRAF XL	T3	SP HD
<i>azathioprine 50 mg tablet (Imuran)</i>	T1	SP HD
<i>cyclosporine 100 mg capsule (Sandimmune)</i>	T1	SP HD
<i>cyclosporine 25 mg capsule (Sandimmune)</i>	T1	SP HD
<i>cyclosporine, modified</i>	T1	SP HD
<i>cyclosporine, modified (Neoral)</i>	T1	SP HD
ENVARUSUS XR	T3	SP HD
<i>everolimus 0.25 mg tablet (Zortress)</i>	T1	SP HD
<i>everolimus 0.5 mg tablet (Zortress)</i>	T1	SP HD
<i>everolimus 0.75 mg tablet (Zortress)</i>	T1	SP HD
<i>everolimus 1 mg tablet (Zortress)</i>	T1	SP HD
LUPKYNIS	T3	PA QL(6 CAPS/DAY) SP
<i>mycophenolate mofetil (Cellcept)</i>	T1	SP HD
<i>mycophenolate sodium (Myfortic)</i>	T1	SP HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

IMMUNOSUPPRESSANTS (Transplant Medications) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
IMMUNOSUPPRESSIVES (cont.)		
PROGRAF 0.2 MG GRANULE PACKET	T3	SP HD
PROGRAF 1 MG GRANULE PACKET	T3	SP HD
SANDIMMUNE 100 MG/ML SOLN	T2	SP HD
<i>sirolimus</i>	T1	SP HD
<i>sirolimus (Rapamune)</i>	T1	SP HD
<i>tacrolimus 0.5 mg capsule (ir) (Prograf)</i>	T1	SP HD
<i>tacrolimus 1 mg capsule (ir) (Prograf)</i>	T1	SP HD
<i>tacrolimus 5 mg capsule (ir) (Prograf)</i>	T1	SP HD
ZORTRESS (<i>everolimus</i>)	T3	SP HD

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

DIABETIC SUPPLIES		
ZTEK	T1	
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	
ADJUSTABLE LANCING DEVICE	T1	
ADVANCED LANCING DEVICE	T1	
ADVOCATE CONTROL SOLUTION	T1	
ADVOCATE LANCING DEVICE	T1	
ADVOCATE RAPID-SAFE LANCING DV	T1	
ADVOCATE REDI-CODE+ CTRL SOLN	T1	
AGAMATRIX CONTROL	T1	
AGAMATRIX CONTROL SOLUTION	T1	
ALKALINE BATTERIES	T1	
ALTERNATE SITE LANCING DEVICE	T1	
AQUA LANCE LANCING DEVICE	T1	
ASSURE 4 CONTROL SOLUTION	T1	
ASSURE CONTROL SOLUTION	T1	
ASSURE DOSE	T1	
ASSURE PRISM	T1	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIABETIC SUPPLIES (cont.)		
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	
CEQR SIMPLICITY	T2	
CEQR SIMPLICITY INSERTER	T2	
CHEMSTRIP BG DIARY	T1	
CHOSEN LANCING DEVICE	T1	
CLEVER CHOICE CONTROL SOLUTION	T1	
CONTOUR	T1	
CONTOUR NEXT CONTROL SOLUTION	T1	
CONTROL SOLUTION	T1	
COOL CONTROL SOLUTION	T1	
DEXCOM G6 RECEIVER	T2	PA QL(1 UNIT/365 DAYS)
DEXCOM G6 SENSOR	T2	PA QL(3 SENSORS/30 DAYS)
DEXCOM G6 TRANSMITTER	T2	PA QL(1 UNIT/90 DAYS)
DEXCOM G7 15 DAY SENSOR	T2	PA QL(3 SENSORS/30 DAYS)
DEXCOM G7 RECEIVER	T2	PA QL(1 UNIT/365 DAYS)
DEXCOM G7 SENSOR	T2	PA QL(3 SENSORS/30 DAYS)
DIATRUE	T1	
DROPLET GENTEEL LANCING DEVICE	T1	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIABETIC SUPPLIES (cont.)		
DROPLET LANCING DEVICE	T1	
EASY MINI EJECT LANCING DEVICE	T1	
EASY PLUS II CONTROL SOLN HIGH	T1	
EASY PLUS II CONTROL SOLN LOW	T1	
EASY STEP CONTROL SOLUTION	T1	
EASY TALK CONTROL SOLN LOW	T1	
EASY TALK HIGH CONTROL SOLN	T1	
EASY TALK PLUS II HIGH CONTROL	T1	
EASY TALK PLUS II LOW CTRL SLN	T1	
EASY TOUCH BLULINK CTRL SOLN	T1	
EASY TOUCH CONTROL SOLUTION	T1	
EASY TOUCH LANCING DEVICE	T1	
EASY TRAK CONTROL SOLN HIGH	T1	
EASY TRAK CONTROL SOLN LOW	T1	
EASY TRAK II CONTROL SOLUTION	T1	
EASYGLUCO PLUS CONTROL NORMAL	T1	
EASYMAX 15 LEVEL 2 SOLUTION	T1	
EASYMAX NORMAL CONTROL SOLN	T1	
ELEMENT COMPACT CONTROL SOLN	T1	
ELEMENT CONTROL SOLUTION	T1	
EMBRACE EVO LEVEL 1 CTRL SOLN	T1	
EMBRACE GLUC CONTROL SOLN HIGH	T1	
EMBRACE GLUCOSE CONTROL SOLN	T1	
EMBRACE LANCING DEVICE	T1	
EMBRACE PRO	T1	
EMBRACE TALK CONTROL SOLUTION	T1	
ENLITE SERTER	T1	
EVENCARE G2 CONTROL SOLUTION	T1	
EVENCARE G3 CONTROL SOLUTION	T1	
EVOLUTION CONTROL SOLUTION	T1	
FONDCIRCLE CONTROL SOLUTION	T1	
FONDCIRCLE LANCING DEVICE	T1	
FORA 6 CONNECT MULTIFUNCTN MTR	T3	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIABETIC SUPPLIES (cont.)		
FORA CONTROL SOLUTION	T1	
FORA GTEL MULTIFUNCTN MONITOR	T1	
FORA KETONE CONTROL SOLUTION	T3	
FORA LANCING DEVICE	T1	
FORA TN'G ADVANCE PRO MONITOR	T3	
FORA TN'GO ADV MOBILE MULT MTR	T3	
FORA TN'GO ADVANCE MULTIFN MTR	T3	
FORACARE GDH	T1	
FORTISCARE	T1	
FREESTYLE CONTROL SOLUTION	T1	
FREESTYLE LIBRE 14 DAY READER	T2	PA QL(1 UNIT/720 DAYS)
FREESTYLE LIBRE 14 DAY SENSOR	T2	PA QL(2 SENSORS/28 DAYS)
FREESTYLE LIBRE 2 PLUS SENSOR	T2	PA QL(2 UNITS/30 DAYS)
FREESTYLE LIBRE 2 READER	T2	PA QL(1 UNIT/720 DAYS)
FREESTYLE LIBRE 2 SENSOR	T2	PA QL(2 SENSORS/28 DAYS)
FREESTYLE LIBRE 3 PLUS SENSOR	T2	PA QL(2 UNITS/28 DAYS)
FREESTYLE LIBRE 3 READER	T2	PA QL(1 UNIT/720 DAYS)
FREESTYLE LIBRE 3 SENSOR	T2	PA QL(2 UNITS/28 DAYS)
GE100 CONTROL SOLUTION NORMAL	T1	
GENTEEL VACUUM LANCING DEVICE	T1	
GLUCOCARD 01 CONTROL	T1	
GLUCOCARD EXPRESSION CNTRL SLN	T1	
GLUCOCARD SHINE CONTROL SOLN	T1	
GLUCOCOM AUTOLINK	T1	
GLUCOCOM CONTROL SOLUTION	T1	
GLUCOSE CONTROL	T1	
GLUCOSE CONTROL SOLUTION	T1	
GOJJI GLUCOSE CONTROL SOLUTION	T1	
GOJJI KETONE CONTROL SOLUTION	T3	
GOJJI LANCING DEVICE	T1	
GOJJI MULTI-FUNCTIONAL METER	T3	
GUARDIAN RT CHARGER	T1	
GUARDIAN TEST PLUG	T1	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIABETIC SUPPLIES (cont.)		
GUARDIAN TRANSMITTER TAPE	T1	
HEALTHPRO GLUCOSE CONTROL SOLN	T1	
HEALTHY ACCENTS AUTOLET	T1	
HYPOLANCE	T1	
IHEALTH CONTROL SOLN LEVEL 2	T1	
INCONTROL LANCING DEVICE	T1	
INFINITY CONTROL SOLUTION	T1	
INFINITY VOICE CONTROL SOLN	T1	
INPEN (FOR HUMALOG)	T1	
INPEN (FOR NOVOLOG OR FIASP)	T1	
INSUL-CAP	T1	
INSUL-EZE	T1	
LANCING DEVICE	T1	
LANCING SYSTEM	T1	
LANZO	T1	
LITE TOUCH LANCING PEN	T1	
MEDISENSE	T1	
MEDISENSE GLUCOSE KETONE	T1	
MEDISENSE GLUCOSE KETONE CONTR	T1	
MEDTRONIC REMOTE CONTROL	T1	
MICRODOT HIGH-LOW CONTROL SOL	T1	
MICRODOT NORMAL CONTROL SOLUT	T1	
MICROLET 2	T1	
MICROLET NEXT LANCING DEVICE	T1	
MINI LANCING DEVICE	T1	
MINIMED QUICK-SERTER	T1	
MULTI-LANCET	T1	
MYGLUCOHEALTH CONTROL SOLUTION	T1	
NOVA MAX PLUS GLUC-KETON METER	T1	
NOVAMAX PLUS GLU-KET	T1	
NOVOPEN ECHO	T1	
OMNIPOD 5 (G6/LIBRE 2 PLUS)	T2	QL(30 CRTGS/30 DAYS)
OMNIPOD 5 DEXG7G6 INTRO(GEN 5)	T2	QL(1 UNIT/365 DAYS)

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIABETIC SUPPLIES (cont.)		
OMNIPOD 5 DEXG7G6 PODS (GEN 5)	T2	QL(30 CRTGS/30 DAYS)
OMNIPOD 5 G6-G7 INTRO KT(GEN5)	T2	QL(1 UNIT/365 DAYS)
OMNIPOD 5 G6-G7 PODS (GEN 5)	T2	QL(30 CRTGS/30 DAYS)
OMNIPOD 5 INTRO(G6/LIBRE2PLUS)	T2	QL(1 UNIT/365 DAYS)
OMNIPOD CLASSIC PDM KIT(GEN 3)	T2	QL(1 UNIT/365 DAYS)
OMNIPOD CLASSIC PODS (GEN 3)	T2	QL(30 CRTGS/30 DAYS)
OMNIPOD DASH INTRO KIT (GEN 4)	T2	QL(1 UNIT/365 DAYS)
OMNIPOD DASH PODS (GEN 4)	T2	QL(30 CRTGS/30 DAYS)
OMNIPOD GO PODS	T2	QL(30 CRTGS/30 DAYS)
ON CALL EXPRESS CONTROL SOLN	T1	
ON CALL 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	
SMARTDIABETES VANTAGE	T1	
SMARTEST	T1	
SOLUS V2 CONTROL SOLUTION	T1	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIABETIC SUPPLIES (cont.)		
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	
ADVOCATE LANCETS	T1	
ALTERNATE SITE LANCETS	T1	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT,MISC (GROUP I) (cont.)		
ADVOCATE 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	
EASY TOUCH SAFETY 26G LANCETS	T1	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT,MISC (GROUP I) (cont.)		
EASY TOUCH SAFETY 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	
<i>lancets</i>	T1	
LANCETS	T1	
LITE TOUCH 28G LANCETS	T1	
LITE TOUCH 30G LANCETS	T1	
LITE TOUCH 33G LANCETS	T1	
MEDISENSE THIN LANCETS	T1	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT,MISC (GROUP I) (cont.)		
MEDLANCE PLUS	T1	
MICRO THIN LANCET	T1	
MICRO THIN LANCETS	T1	
MICROLET	T1	
MONOLET LANCETS	T1	
MONOLET THIN LANCETS	T1	
MYGLUCOHEALTH LANCETS	T1	
NOVA SAFETY LANCETS	T1	
NOVA SUREFLEX	T1	
ON CALL LANCET	T1	
ON CALL PLUS LANCET	T1	
ONETOUCH DELICA PLUS LANCET	T1	
ONETOUCH DELICA SAFETY LANCET	T1	
ONETOUCH LANCETS	T1	
ONETOUCH SURESOFT	T1	
ONETOUCH ULTRASOFT 2 LANCET	T1	
ON-THE-GO	T1	
PERFECT POINT SAFETY LANCETS	T1	
PIP LANCET	T1	
PRESSURE ACTIVATED LANCETS	T1	
PRO COMFORT LANCET	T1	
PRO COMFORT LANCETS	T1	
PRO COMFORT SAFETY LANCET	T1	
PRODIGY LANCETS	T1	
PRODIGY TWIST TOP LANCET	T1	
PURE COMFORT LANCETS	T1	
PURE COMFORT SAFETY LANCETS	T1	
PUSH BUTTON SAFETY LANCETS	T1	
READYLANCE SAFETY LANCETS	T1	
RELIAMED	T1	
RELIAMED SAFETY SEAL LANCETS	T1	
RIGHTEST GL300 LANCETS	T1	
SAFETY LANCETS	T1	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT,MISC (GROUP I) (cont.)		
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 UNIVERSAL1 LANCET / THIN LANCET	T1	
TRUE COMFORT LANCET / SAFETY LANCET	T1	
TRUEPLUS LANCETS	T1	
TWIST LANCETS / 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	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT,MISC (GROUP I) (cont.)		
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 3 NORMAL	T1	
UNISTIK COMFORT	T1	
UNISTIK CZT	T1	
UNISTIK EXTRA	T1	
UNISTIK NORMAL	T1	
UNISTIK PRO	T1	
UNISTIK SAFETY	T1	
UNISTIK TOUCH	T1	
UNIVERSAL 1	T1	
VERIFINE SAFETY LANCET MINI	T1	
VERIFINE UNIVERSAL LANCET	T1	
VIVAGUARD LANCET	T1	
VIVAGUARD SAFETY LANCET	T1	
NEEDLES/NEEDLELESS DEVICES		
AUTOSHIELD DUO PEN NEEDLE	T1	
BLUNT NEEDLE	T1	
CAREPOINT PRECISION NEEDLE	T1	
CARETOUCH HYPODERMIC NEEDLE	T1	
DROPSAFE SICURA SAFETY NEEDLE	T1	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NEEDLES/NEEDLELESS DEVICES (cont.)		
EASY TOUCH FLIPLOCK NEEDLE	T1	
EASY TOUCH FLIPLOCK NEEDLES	T1	
EASY TOUCH HYPODERMIC NEEDLE	T1	
EASYPPOINT NEEDLE	T1	
ECLIPSE NEEDLE	T1	
EXEL HUBER NEEDLE	T1	
EXEL HYPODERMIC NEEDLE	T1	
EXEL MTI DRAWING NEEDLE	T1	
FILTER ASPIRATOR NEEDLE	T1	
FILTER NEEDLE	T1	
FLOW-EZE	T1	
HYPODERMIC NEEDLE	T1	
INTEGRA NEEDLE	T1	
INTEGRA PRECISIONGLIDE NEEDLE	T1	
LIFESHIELD BLUNT CANNULA	T1	
MONOJECT BLOOD COLLECTION	T1	
MONOJECT FILTER NEEDLE	T1	
NANO 2ND GEN PEN NEEDLE	T1	
NANO PEN NEEDLE	T1	
NEEDLE	T1	
NEEDLES	T1	
<i>needles,safety huber,disposabl</i>	T1	
NOKOR ADMIX NEEDLE	T1	
NOKOR NEEDLE	T1	
PERFECT POINT SAFETY NEEDLE	T1	
PHASEAL PROTECTOR	T1	
POLY HUB NEEDLE	T1	
PRECISIONGLIDE	T1	
PRECISIONGLIDE NEEDLE	T1	
REGULAR BEVEL NEEDLES	T1	
SAFETYGLIDE NEEDLE	T1	
SHORT BEVEL NEEDLES	T1	
SPECIALTY USE NEEDLES	T1	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NEEDLES/NEEDLELESS DEVICES (cont.)		
TERUMO SURGUARD2	T1	
THIN WALL NEEDLES	T1	
TRANSFER NEEDLE	T1	
ULTRA-FINE MICRO PEN NEEDLE	T1	
ULTRA-FINE MINI PEN NEEDLE	T1	
ULTRA-FINE NANO PEN NEEDLE	T1	
ULTRA-FINE ORIGINAL PEN NEEDLE	T1	
ULTRA-FINE PEN NEEDLE	T1	
ULTRA-FINE SHORT PEN NEEDLE	T1	
YALE NEEDLES	T1	
SYRINGES AND ACCESSORIES		
BD INS SYR 0.3 ML 8MMX31G(1/2)	T1	
BD INS SYR UF 0.3ML 12.7MMX30G	T1	
BD INS SYR UF 0.5ML 12.7MMX30G	T1	
BD INS SYRN UF 1 ML 12.7MMX30G	T1	
BD INS SYRN UF 1 ML 30G 12.7MM	T1	
BD INS SYRNG 0.3 ML 29GX12.7MM	T1	
BD INS SYRNG 0.5 ML 29GX12.7MM	T1	
BD INS SYRNG UF 0.3 ML 8MMX31G	T1	
BD INS SYRNG UF 0.5 ML 8MMX31G	T1	
BD INSULIN SYR 0.5 ML 28GX1/2"	T1	
BD INSULIN SYR 1 ML 27GX12.7MM	T1	
BD INSULIN SYR 1 ML 27GX5/8"	T1	
BD INSULIN SYR 1 ML 28GX1/2"	T1	
BD INSULIN SYR 1 ML 29GX12.7MM	T1	
BD INSULIN SYR UF 1 ML 8MMX31G	T1	
ECLIPSE SYRINGE	T1	
INSULIN SYR 0.5 ML 28G 12.7MM	T1	
INSULIN SYRINGE 1 ML 27G 16MM	T1	
INSULIN SYRINGE 1ML 28G 12.7MM	T1	
INSULIN SYRINGE U-500	T1	
PARADIGM	T1	
SAFETYGLIDE INSULIN SYRINGE	T1	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SYRINGES AND ACCESSORIES (cont.)		
SAFETYGLIDE SYRINGE	T1	
ULTRA-FINE INSULIN SYRINGE	T1	
VEO INSULIN SYRINGE	T1	

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

DURABLE MEDICAL EQUIPMENT,MISC (GROUP I)		
1ST TIER UNILET COMFORTOUCH	T1	QL (1 UNIT/YEAR)
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	QL (1 UNIT/YEAR)
ACCU-CHEK SOFTCLIX	T1	
ACTI-LANCE	T1	
ADVANCED TRAVEL LANCETS	T1	
ADVOCATE LANCET	T1	
ADVOCATE LANCETS	T1	
ADVOCATE SAFETY LANCET	T1	
AGAMATRIX ULTRA-THIN LANCET	T1	
ALTERNATE SITE LANCETS	T1	
ASSURE HAEMOLANCE PLUS	T1	
ASSURE LANCE	T1	
ASSURE LANCE PLUS	T1	
BD MICROTAINER LANCETS	T1	
BLOOD LANCETS	T1	
BULLSEYE MINI SAFETY LANCETS	T1	
BUTTERFLY TOUCH LANCET	T1	
CAREONE	T1	
CARESENS LANCET	T1	
CARETOUCH SAFETY LANCETS	T1	
CARETOUCH TWIST LANCET	T1	
CHOSEN LANCET	T1	
CHOSEN SAFETY LANCET	T1	
CLEVER CHEK LANCETS	T1	
COAGUCHEK	T1	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT,MISC (GROUP I) (cont.)		
COLOR LANCETS	T1	
COMFORT EZ	T1	
COMFORT LANCETS	T1	
COMFORT TOUCH PLUS SAFETY LANC	T1	
COMFORT TOUCH ULT THIN LANCET	T1	
DROPLET LANCETS	T1	
DROPSAFE ACTI-LANCE	T1	
EASY COMFORT LANCETS	T1	
EASY TOUCH PULL-TOP 26G LANCET	T1	
EASY TOUCH PULL-TOP 28G LANCET	T1	
EASY TOUCH PULL-TOP 30G LANCET	T1	
EASY TOUCH PULL-TOP 32G LANCET	T1	
EASY TOUCH SAFETY 21G LANCETS	T1	
EASY TOUCH SAFETY 23G LANCETS	T1	
EASY TOUCH SAFETY 26G LANCETS	T1	
EASY TOUCH SAFETY 28G LANCETS	T1	
EASY TOUCH SAFETY 30G LANCETS	T1	
EASY TOUCH SAFETY 32G LANCETS	T1	
EASY TOUCH TWIST 26G LANCETS	T1	
EASY TOUCH TWIST 28G LANCETS	T1	
EASY TOUCH TWIST 30G LANCETS	T1	
EASY TOUCH TWIST 32G LANCETS	T1	
EASY TOUCH TWIST 33G LANCETS	T1	
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	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT,MISC (GROUP I) (cont.)		
FORACARE LANCETS	T1	
FREESTYLE LANCETS	T1	
FREESTYLE UNISTIK 2	T1	
GLUCOCOM	T1	
GLUCOCOM LANCETS	T1	
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	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT,MISC (GROUP I) (cont.)		
ONETOUCH DELICA SAFETY LANCET	T1	
ONETOUCH LANCETS	T1	
ONETOUCH SURESOFT	T1	
ONETOUCH ULTRASOFT 2 LANCET	T1	
ON-THE-GO	T1	
PERFECT POINT SAFETY LANCETS	T1	
PIP LANCET	T1	
POGO AUTOMATIC TEST CARTRIDGE	T1	
PRESSURE ACTIVATED LANCETS	T1	
PRO COMFORT LANCET	T1	
PRO COMFORT LANCETS	T1	
PRO COMFORT SAFETY LANCET	T1	
PRODIGY LANCETS	T1	
PRODIGY TWIST TOP LANCET	T1	
PURE COMFORT LANCETS	T1	
PURE COMFORT SAFETY LANCETS	T1	
PUSH BUTTON SAFETY LANCETS	T1	
READYLANCE SAFETY LANCETS	T1	
RELIAMED	T1	
RELIAMED SAFETY SEAL LANCETS	T1	
RIGHTEST GL300 LANCETS	T1	
SAFETY LANCETS	T1	
SAFETY SEAL LANCETS	T1	
SAFETY-LET	T1	
SINGLE-LET	T1	
SMART SENSE	T1	
SMART SENSE LANCETS	T1	
SMARTTEST LANCET	T1	
SOLUS V2	T1	
SOLUS V2 LANCETS	T1	
STERILANCE TL	T1	
STERILE LANCETS	T1	
SUPER THIN LANCETS	T1	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT,MISC (GROUP I) (cont.)		
SURE COMFORT LANCETS	T1	
SURE-LANCE	T1	
SURE-TOUCH	T1	
TECHLITE LANCETS	T1	
TELCARE ULTRA THIN 30G LANCETS	T1	
THIN LANCETS	T1	
TOPCARE UNIVERSAL1 LANCET	T1	
TOPCARE UNIVERSAL1 THIN LANCET	T1	
TRUE COMFORT LANCET	T1	
TRUE COMFORT SAFETY LANCET	T1	
TRUEPLUS LANCET	T1	
TRUEPLUS LANCETS	T1	
TWIST LANCETS	T1	
TWIST TOP LANCET	T1	
ULTILET BASIC	T1	
ULTILET CLASSIC	T1	
ULTILET LANCETS	T1	
ULTILET SAFETY	T1	
ULTRA THIN LANCET	T1	
ULTRA THIN LANCETS	T1	
ULTRA THIN PLUS LANCETS	T1	
ULTRA-CARE LANCETS	T1	
ULTRALANCE	T1	
ULTRA-THIN II 28G LANCETS	T1	
ULTRA-THIN II 30G LANCETS	T1	
ULTRATIC LANCETS	T1	
UNILET COMFORTOUCH	T1	
UNILET EXCELITE	T1	
UNILET EXCELITE II	T1	
UNILET GP LANCET	T1	
UNILET LANCET	T1	
UNILET LANCETS	T1	
UNISTIK 2 COMFORT	T1	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT,MISC (GROUP I) (cont.)		
UNISTIK 2 EXTRA	T1	
UNISTIK 2 NORMAL	T1	
UNISTIK 3	T1	
UNISTIK 3 COMFORT	T1	
UNISTIK 3 DUAL	T1	
UNISTIK 3 EXTRA	T1	
UNISTIK 3 NORMAL	T1	
UNISTIK COMFORT	T1	
UNISTIK CZT	T1	
UNISTIK EXTRA	T1	
UNISTIK NORMAL	T1	
UNISTIK PRO	T1	
UNISTIK SAFETY	T1	
UNISTIK TOUCH	T1	
UNIVERSAL 1	T1	
VERIFINE SAFETY LANCET MINI	T1	
VERIFINE UNIVERSAL LANCET	T1	
VIVAGUARD LANCET	T1	
VIVAGUARD SAFETY LANCET	T1	
MEDICAL SUPPLIES,MISCELLANEOUS		
ALCOH-GLOVE	T1	
ALCOH-WIPE	T1	
RESPIRATORY AIDS, DEVICES, EQUIPMENT		
ACE AEROSOL CLOUD ENHANCER	T2	QL(1 SPACER/365 DAYS)
AEROCHAMBER MECHANICAL VENT	T2	QL(1 SPACER/365 DAYS)
AEROCHAMBER MV & 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)
BREATHRITE	T2	QL(1 SPACER/365 DAYS)

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
RESPIRATORY AIDS, DEVICES, EQUIPMENT (cont.)		
BREATHERITE SPACER-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)
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 WITH 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)

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
RESPIRATORY AIDS, DEVICES, EQUIPMENT (cont.)		
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	
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 RELAX.-TOP. IRRITANT COUNTER-IRRIT		
COMFORT PAC-CYCLOBENZAPRINE	T3	
COMFORT PAC-TIZANIDINE	T3	
SKELETAL MUSCLE RELAXANTS		
<i>baclofen 10 mg tablet</i>	T1	HD
<i>baclofen 10 mg/5 ml solution</i>	T1	HD
<i>baclofen 20 mg tablet</i>	T1	HD
<i>baclofen 5 mg tablet</i>	T1	HD
<i>baclofen 5 mg/5 ml solution</i>	T1	HD
<i>carisoprodol (Soma)</i>	T1	
<i>carisoprodol/aspirin</i>	T1	
<i>chlorzoxazone 500 mg tablet</i>	T1	
<i>cyclobenzaprine hcl</i>	T1	
<i>cyclobenzaprine hcl (Fexmid)</i>	T1	
DANTRIUM (<i>dantrolene sodium</i>)	T3	
<i>dantrolene sodium</i>	T1	
<i>dantrolene sodium (Dantrium)</i>	T1	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SKELLETAL MUSCLE RELAXANTS (cont.)		
FEXMID (cyclobenzaprine hcl)	T3	
metaxalone 400 mg tablet	T1	
metaxalone 800 mg tablet	T1	
methocarbamol	T1	
methocarbamol 1,000 mg tablet	T1	
methocarbamol 500 mg tablet	T1	
methocarbamol 750 mg tablet	T1	
orphenadrine citrate	T1	
tizanidine hcl 2 mg tablet	T1	
tizanidine hcl 4 mg tablet (Zanaflex)	T1	
ZANAFLEX	T3	
ZANAFLEX (tizanidine hcl)	T3	

PRE-NATAL VITAMINS (Nutritional/Dietary)

PRENATAL VITAMIN PREPARATIONS		
BAL-CARE DHA ESSENTIAL	T3	
CITRANATAL 90 DHA	T3	
CITRANATAL ASSURE	T3	
CITRANATAL DHA	T3	
CITRANATAL HARMONY	T3	
CITRANATAL RX	T3	
DERMACINRX PRETRATE	T3	
DUET DHA BALANCED	T3	
KOSHER PRENATAL PLUS IRON	T3	
MARNATAL-F	T3	
mynatal capsule	T3	
mynatal ultracaplet	T1	
NATACHEW	T3	
NEONATAL COMPLETE	T3	
NEONATAL PLUS	T3	
NEONATAL-DHA	T3	
NESTABS	T2	
NESTABS ABC	T2	
NESTABS DHA	T2	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PRENATAL VITAMIN PREPARATIONS (cont.)		
OB COMPLETE ONE	T2	
OB COMPLETE PETITE	T2	
OB COMPLETE PREMIER	T2	
OB COMPLETE WITH DHA	T2	
OBSTETRIX EC	T3	
OBTREX DHA	T3	
<i>pnv 11/iron fum/folic acid/om3</i>	T1	
<i>pnv 119/iron fum/folic acid</i>	T1	
<i>pnv 66/iron/folic/docusate/dha</i>	T1	
<i>pnv 69/iron/folic/docusate/dha</i>	T1	
<i>pnv 80/iron fum/folic/dss/dha</i>	T1	
<i>pnv no.118/iron fumarate/fa</i>	T1	
<i>pnv no.154/iron fum/folic acid</i>	T1	
<i>pnv no.52/iron/fa/omega-3/dha</i>	T1	
<i>pnv,calcium 72/iron,carb/folic</i>	T1	
<i>pnv,calcium 72/iron/folic acid</i>	T1	
<i>pnv 19/iron bg,s.p/folic ac/om3</i>	T1	
<i>pnv81/iron ps,edta/folic/omeg3</i>	T1	
PRENATA	T3	
<i>prenatal 105/iron/folic ac/dha</i>	T1	
<i>prenatal 12/iron/folic/dss/om3</i>	T1	
PRENATAL 19	T1	
<i>prenatal 53/iron/folic ac/omg3</i>	T1	
<i>prenatal 54/iron/folic ac/omg3</i>	T1	
<i>prenatal 71/iron/folic ac/dha</i>	T1	
<i>prenatal 93/iron/folate 9/dha</i>	T1	
<i>prenatal no.42/folic acid (Vitamedmd Redichew Rx)</i>	T3	
PRENATAL PLUS VITAMIN-MINERAL	T2	
PRENATAL PLUS-DHA	T1	
<i>prenatal vit 27,calc/iron/fa</i>	T1	
<i>prenatal vit 55/iron/folic/om3</i>	T1	
<i>prenatal vit,cal 73/iron/folic</i>	T3	
<i>prenatal vit,cal 76/iron/folic</i>	T3	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PRENATAL VITAMIN PREPARATIONS (cont.)		
<i>prenatal vit/iron fum/folic ac</i>	T1	
<i>prenatal vits 86/iron/folic ac</i>	T1	
<i>prenatal,calc 40/iron/folate 1</i>	T1	
PRENATE ENHANCE	T3	
PRENATE RESTORE	T3	
PRIMACARE	T3	
PROVIDA OB	T3	
SELECT-OB	T3	
SELECT-OB (<i>prenatal vit 128/iron/folic ac</i>)	T3	
SELECT-OB + DHA	T3	
THRIVITE RX	T1	
TRICARE	T3	
TRISTART DHA	T3	
VITAFOL FE PLUS	T3	
VITAFOL NANO	T3	
VITAFOL ULTRA	T3	
VITAFOL-OB	T1	
VITAFOL-OB+DHA	T3	
VITAFOL-ONE	T3	
VITAMEDMD ONE RX	T3	
VITAMEDMD REDICHEW RX (<i>prenatal no.42/folic acid</i>)	T3	
VITAPEARL	T3	
PRENATAL VITAMINS WITH LOW OR NO IRON		
CITRANATAL B-CALM	T3	
DUET DHA 400	T3	
PRENATE DHA	T3	
PRENATE ELITE	T3	
PRENATE MINI	T3	
PRENATE PIXIE	T3	
PRENATE STAR	T3	
R-NATAL OB	T1	
VITAFOL GUMMIES	T3	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)¹⁰

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ALPHA-2 RECEPTOR ANTAGONIST ANTI-DEPRESSANTS		
<i>mirtazapine</i>	T1	HD
<i>mirtazapine</i> (Remeron)	T1	HD
ANTI-ANXIETY - BENZODIAZEPINES		
<i>alprazolam</i>	T1	
<i>alprazolam</i> (Xanax Xr)	T1	
<i>alprazolam</i> (Xanax)	T1	
<i>chlordiazepoxide hcl</i>	T1	
<i>clorazepate dipotassium</i>	T1	
<i>diazepam 10 mg tablet</i> (Valium)	T1	
<i>diazepam 2 mg tablet</i> (Valium)	T1	
<i>diazepam 25 mg/5 ml oral conc</i>	T1	
<i>diazepam 5 mg tablet</i> (Valium)	T1	
<i>diazepam 5 mg/ml oral conc</i>	T1	
<i>diazepam 5 mg/5 ml solution</i>	T1	
<i>diazepam 5 mg/ml oral conc</i>	T1	
<i>lorazepam</i>	T1	
<i>lorazepam</i> (Ativan)	T1	
<i>oxazepam</i>	T1	
TRANXENET-TAB (<i>clorazepate dipotassium</i>)	T3	
ANTI-ANXIETY DRUGS		
<i>bupirone hcl</i>	T1	HD
<i>meprobamate</i>	T1	
ANTIDEPRESSANT - POSTPARTUM DEPRESSION (PPD)		
ZURZUVAE 20 MG CAPSULE	T3	PA QL(28 CAPS/270 DAYS) SP HD
ZURZUVAE 25 MG CAPSULE	T3	PA QL(28 CAPS/270 DAYS) SP HD
ZURZUVAE 30 MG CAPSULE	T3	PA QL(14 CAPS/270 DAYS) SP HD
MAOIS -NON-SELECTIVE, IRREVERSIBLE ANTI-DEPRESSANTS		
MARPLAN	T3	QL(12 TABS/DAY)
<i>phenelzine sulfate</i> (Nardil)	T1	
<i>tranylcypromine sulfate</i>	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)

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)^o (cont)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NOREPINEPHRINE AND DOPAMINE REUPTAKE INHIB (NDRIs)		
<i>bupropion hcl 100 mg tablet</i>	T1	QL(4 TABS/DAY) HD
<i>bupropion hcl 75 mg tablet</i>	T1	QL(6 TABS/DAY) HD
<i>bupropion hcl sr 100 mg tablet</i> (Wellbutrin Sr)	T1	QL(4 TABS/DAY) HD
<i>bupropion hcl sr 150 mg tablet</i> (Wellbutrin Sr)	T1	QL(2 TABS/DAY) HD
<i>bupropion hcl sr 200 mg tablet</i> (Wellbutrin Sr)	T1	QL(2 TABS/DAY) HD
<i>bupropion hcl xl 150 mg tablet</i> (Wellbutrin XI)	T1	QL(3 TABS/DAY) HD
<i>bupropion hcl xl 300 mg tablet</i> (Wellbutrin XI)	T1	QL(1 TAB/DAY) HD
SELECTIVE SEROTONIN 5-HT2A INVERSE AGONISTS (SSiAs)		
NUPLAZID	T3	PA SP HD
SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIs)		
<i>citalopram hbr 10 mg tablet</i> (Celexa)	T1	QL(6 TABS/DAY) HD
<i>citalopram hbr 10 mg/5 ml soln</i>	T1	QL(30 MLS/DAY) HD
<i>citalopram hbr 20 mg tablet</i> (Celexa)	T1	QL(3 TABS/DAY) HD
<i>citalopram hbr 20 mg/10 ml sol</i>	T1	QL(30 MLS/DAY) HD
<i>citalopram hbr 40 mg tablet</i> (Celexa)	T1	QL(1 TAB/DAY) HD
<i>escitalopram 10 mg tablet</i> (Lexapro)	T1	QL(2 TABS/DAY) HD
<i>escitalopram 10 mg/10 ml cup</i>	T1	QL(20 MLS/DAY) HD
<i>escitalopram 20 mg tablet</i> (Lexapro)	T1	QL(1 TAB/DAY) HD
<i>escitalopram 5 mg tablet</i> (Lexapro)	T1	QL(4 TABS/DAY) HD
<i>escitalopram oxalate 5 mg/5 ml</i>	T1	QL(20 MLS/DAY) HD
<i>fluoxetine 20 mg/5 ml soln cup</i>	T1	QL(20 MLS/DAY) HD
<i>fluoxetine 20 mg/5 ml solution</i>	T1	QL(20 MLS/DAY) HD
<i>fluoxetine hcl</i>	T1	QL(4 CAPS/28 DAYS) HD
<i>fluoxetine 20 mg/5 ml soln cup</i>	T1	QL(8 CAPS/DAY) HD
<i>fluoxetine hcl 10 mg capsule</i> (Prozac)	T1	HD
<i>fluoxetine hcl 10 mg tablet</i>	T1	QL(4 CAPS/DAY) HD
<i>fluoxetine hcl 20 mg capsule</i> (Prozac)	T1	HD
<i>fluoxetine hcl 20 mg tablet</i>	T1	QL(2 CAPS/DAY) HD
<i>fluoxetine hcl 40 mg capsule</i> (Prozac)	T1	QL(1 TAB/DAY) HD
<i>fluoxetine hcl 60 mg tablet</i>	T1	QL(3 CAPS/DAY) HD
<i>fluvoxamine er 100 mg capsule</i>	T1	QL(2 CAPS/DAY) HD
<i>fluvoxamine er 150 mg capsule</i>	T1	QL(3 TABS/DAY) HD
<i>fluvoxamine maleate 100 mg tab</i>	T1	QL (3 tabs/day) HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)^o (cont)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIs) (cont)		
<i>fluvoxamine maleate 25 mg tab</i>	T1	QL(12 TABS/DAY) HD
<i>fluvoxamine maleate 50 mg tab</i>	T1	QL(6 TABS/DAY) HD
<i>paroxetine cr 12.5 mg tablet</i>	T1	QL(1 TAB/DAY) HD
<i>paroxetine cr 25 mg tablet</i>	T1	QL(3 TABS/DAY) HD
<i>paroxetine cr 37.5 mg tablet</i>	T1	QL(2 TABS/DAY) HD
<i>paroxetine er 12.5 mg tablet</i>	T1	QL(1 TAB/DAY) HD
<i>paroxetine er 25 mg tablet</i>	T1	QL(3 TABS/DAY) HD
<i>paroxetine er 37.5 mg tablet</i>	T1	QL(2 TABS/DAY) HD
<i>paroxetine hcl 10 mg tablet (Paxil)</i>	T1	QL(6 TABS/DAY) HD
<i>paroxetine hcl 10 mg/5 ml susp</i>	T1	QL(30 MLS/DAY) HD
<i>paroxetine hcl 20 mg tablet (Paxil)</i>	T1	QL(3 TABS/DAY) HD
<i>paroxetine hcl 30 mg tablet (Paxil)</i>	T1	QL(2 TABS/DAY) HD
<i>paroxetine hcl 40 mg tablet (Paxil)</i>	T1	QL(1 TAB/DAY) HD
<i>sertraline 150 mg capsule</i>	T1	QL(1 CAP/DAY) HD
<i>sertraline 20 mg/ml oral conc (Zoloft)</i>	T1	QL(10 MLS/DAY) HD
<i>sertraline 200 mg capsule</i>	T1	QL(1 CAP/DAY) HD
<i>sertraline hcl 100 mg tablet (Zoloft)</i>	T1	QL(2 TABS/DAY) HD
<i>sertraline hcl 25 mg tablet (Zoloft)</i>	T1	QL(8 TABS/DAY) HD
<i>sertraline hcl 50 mg tablet (Zoloft)</i>	T1	QL(4 TABS/DAY) HD
SEROTONIN-2 ANTAGONIST/REUPTAKE INHIBITORS (SARIs)		
<i>nefazodone hcl</i>	T1	HD
<i>trazodone hcl</i>	T1	HD
SEROTONIN-NOREPINEPHRINE REUPTAKE-INHIB (SNRIs)		
<i>desvenlafaxine succnt er 100mg (Pristiq)</i>	T1	QL(4 TABS/DAY) HD
<i>desvenlafaxine succnt er 25 mg (Pristiq)</i>	T1	QL(16 TABS/DAY) HD
<i>desvenlafaxine succnt er 50 mg (Pristiq)</i>	T1	QL(1 TAB/DAY) HD
<i>duloxetine hcl dr 20 mg cap (Cymbalta)</i>	T1	QL(6 CAPS/DAY) HD
<i>duloxetine hcl dr 30 mg cap (Cymbalta)</i>	T1	QL(4 CAPS/DAY) HD
<i>duloxetine hcl dr 40 mg cap</i>	T1	QL(3 CAPS/DAY) HD
<i>duloxetine hcl dr 60 mg cap (Cymbalta)</i>	T1	QL(2 CAPS/DAY) HD
<i>venlafaxine hcl 100 mg tablet</i>	T1	QL(3 TABS/DAY) HD
<i>venlafaxine hcl 25 mg tablet</i>	T1	QL(15 TABS/DAY) HD
<i>venlafaxine hcl 37.5 mg tablet</i>	T1	QL(10 TABS/DAY) HD
<i>venlafaxine hcl 50 mg tablet</i>	T1	QL(7 TABS/DAY) HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)^o (cont)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SEROTONIN-NOREPINEPHRINE REUPTAKE-INHIB (SNRIs) (cont)		
<i>venlafaxine hcl 75 mg tablet</i>	T1	QL(5 TABS/DAY) HD
<i>venlafaxine hcl er 150 mg cap (Effexor Xr)</i>	T1	QL(2 CAPS/DAY) HD
<i>venlafaxine hcl er 150 mg tab</i>	T1	QL(2 TABS/DAY) HD
<i>venlafaxine hcl er 225 mg tab</i>	T1	QL(1 TAB/DAY) HD
<i>venlafaxine hcl er 37.5 mg cap (Effexor Xr)</i>	T1	QL(8 CAPS/DAY) HD
<i>venlafaxine hcl er 37.5 mg tab</i>	T1	QL(8 TABS/DAY) HD
<i>venlafaxine hcl er 75 mg cap (Effexor Xr)</i>	T1	QL(4 CAPS/DAY) HD
<i>venlafaxine hcl er 75 mg tab</i>	T1	QL(4 TABS/DAY) HD
SSRI AND 5HT1A PARTIAL AGONIST ANTI-DEPRESSANTS		
<i>vilazodone hcl 10 mg tablet (Viibryd)</i>	T1	QL(1 TAB/DAY) HD
<i>vilazodone hcl 20 mg tablet (Viibryd)</i>	T1	QL(1 TAB/DAY) HD
<i>vilazodone hcl 40 mg tablet (Viibryd)</i>	T1	HD
SSRI, SEROTONIN RECEPTOR MODULATOR ANTI-DEPRESSANTS		
TRINTELLIX 10 MG TABLET	T2	QL(1 TAB/DAY)
TRINTELLIX 20 MG TABLET	T2	
TRINTELLIX 5 MG TABLET	T2	QL(1 TAB/DAY)
TRICYCLIC ANTI-DEPRESSANT-BENZODIAZEPINE COMBINATNS		
<i>amitriptyline/chlordiazepoxide</i>	T1	HD
TRICYCLIC ANTI-DEPRESSANT-PHENOTHIAZINE COMBINATNS		
<i>perphenazine/amitriptyline hcl</i>	T1	HD
TRICYCLIC ANTI-DEPRESSANTS, REL.NON-SEL.REUPT-INHIB		
<i>amitriptyline hcl</i>	T1	HD
<i>amoxapine</i>	T1	HD
<i>clomipramine hcl (Anafranil)</i>	T1	HD
<i>desipramine hcl</i>	T1	HD
<i>doxepin 10 mg capsule</i>	T1	HD
<i>doxepin 10 mg/ml oral conc</i>	T1	HD
<i>doxepin 100 mg capsule</i>	T1	HD
<i>doxepin 150 mg capsule</i>	T1	HD
<i>doxepin 25 mg capsule</i>	T1	HD
<i>doxepin 50 mg capsule</i>	T1	HD
<i>doxepin 75 mg capsule</i>	T1	HD
<i>imipramine hcl</i>	T1	HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)^o (cont)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TRICYCLIC ANTI-DEPRESSANTS, REL.NON-SEL.REUPT-INHIB (con't)		
<i>imipramine pamoate</i>	T1	HD
<i>nortriptyline hcl</i>	T1	HD
<i>nortriptyline hcl (Pamelor)</i>	T1	HD
<i>protriptyline hcl</i>	T1	HD
<i>trimipramine maleate</i>	T1	HD

PSYCHOTHERAPEUTIC DRUGS (Attention Deficit Hyperactivity Disorder)^o

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

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Attention Deficit Hyperactivity Disorder)^o (cont)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TX FOR ATTENTION DEFICIT-HYPERACT (ADHD)/NARCOLEPSY (con't)		
<i>methylphenidate er 18 mg tab (Concerta)</i>	T1	PA QL(1 TAB/DAY)
<i>methylphenidate er 18 mg tab (Relexxii)</i>	T1	PA QL(1 TAB/DAY)
<i>methylphenidate er 20 mg cap (Aptensio Xr)</i>	T1	PA QL(1 CAP/DAY)
<i>methylphenidate er 20 mg tab</i>	T1	PA QL(3 TABS/DAY)
<i>methylphenidate er 27 mg tab (Concerta)</i>	T1	PA QL(1 TAB/DAY)
<i>methylphenidate er 27 mg tab (Relexxii)</i>	T1	PA QL(1 TAB/DAY)
<i>methylphenidate er 30 mg cap (Aptensio Xr)</i>	T1	PA QL(1 CAP/DAY)
<i>methylphenidate er 36 mg tab (Concerta)</i>	T1	PA QL(2 TABS/DAY)
<i>methylphenidate er 36 mg tab (Relexxii)</i>	T1	PA QL(2 TABS/DAY)
<i>methylphenidate er 40 mg cap (Aptensio Xr)</i>	T1	PA QL(1 CAP/DAY)
<i>methylphenidate er 50 mg cap (Aptensio Xr)</i>	T1	PA QL(1 CAP/DAY)
<i>methylphenidate er 54 mg tab (Concerta)</i>	T1	PA QL(1 TAB/DAY)
<i>methylphenidate er 54 mg tab (Relexxii)</i>	T1	PA QL(1 TAB/DAY)
<i>methylphenidate er 60 mg cap (Aptensio Xr)</i>	T1	PA QL(1 CAP/DAY)
<i>methylphenidate er 72 mg tab</i>	T1	PA QL(1 TAB/DAY)
<i>methylphenidate er(la) 10mg cp (Ritalin La)</i>	T1	PA QL(1 CAP/DAY)
<i>methylphenidate er(la) 20mg cp (Ritalin La)</i>	T1	PA QL(1 CAP/DAY)
<i>methylphenidate er(la) 30mg cp (Ritalin La)</i>	T1	PA QL(2 CAPS/DAY)
<i>methylphenidate er(la) 40mg cp (Ritalin La)</i>	T1	PA QL(1 CAP/DAY)
<i>methylphenidate er(la) 60mg cp</i>	T1	PA QL(1 CAP/DAY)
<i>methylphenidate hcl</i>	T1	PA
<i>methylphenidate hcl (Metadate Cd)</i>	T1	PA QL(1 CAP/DAY)
<i>methylphenidate hcl (Methylin)</i>	T1	PA
<i>methylphenidate hcl (Ritalin)</i>	T1	PA
QUILLIVANT XR	T3	PA QL (12ML/DAY)
RITALIN (<i>methylphenidate hcl</i>)	T3	PA
TX FOR ATTENTION DEFICIT-HYPERACT.(ADHD), NRI-TYPE		
<i>atomoxetine hcl 10 mg capsule (Strattera)</i>	T1	HD
<i>atomoxetine hcl 100 mg capsule (Strattera)</i>	T1	HD
<i>atomoxetine hcl 18 mg capsule (Strattera)</i>	T1	HD
<i>atomoxetine hcl 25 mg capsule (Strattera)</i>	T1	HD
<i>atomoxetine hcl 40 mg capsule (Strattera)</i>	T1	QL(1 CAP/DAY) HD
<i>atomoxetine hcl 60 mg capsule (Strattera)</i>	T1	HD
<i>atomoxetine hcl 80 mg capsule (Strattera)</i>	T1	HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics)¹⁰

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-PSYCH, DOPAMINE ANTAG., DIPHENYLBUTYLPIPERIDINES		
<i>pimozide</i>	T1	
ANTI-PSYCHOTIC, ATYPICAL, DOPAMINE, SEROTONIN ANTAGONIST		
<i>asenapine maleate</i> (Saphris)	T1	
CAPLYTA	T3	ST QL(1 CAP/DAY)
<i>clozapine</i>	T1	
<i>clozapine</i> (Clozaril)	T1	
<i>lurasidone hcl 120 mg tablet</i>	T1	
<i>lurasidone hcl 20 mg tablet</i>	T1	
<i>lurasidone hcl 40 mg tablet</i>	T1	QL(1 TAB/DAY)
<i>lurasidone hcl 60 mg tablet</i>	T1	QL(1 TAB/DAY)
<i>lurasidone hcl 80 mg tablet</i>	T1	
<i>olanzapine</i>	T1	
<i>olanzapine</i> (Zyprexa Zydis)	T1	
<i>olanzapine</i> (Zyprexa)	T1	
<i>paliperidone er 1.5 mg tablet</i>	T1	
<i>paliperidone er 1.5 mg tablet</i> (Invega)	T1	QL(1 TAB/DAY)
<i>paliperidone er 3 mg tablet</i> (Invega)	T1	
<i>paliperidone er 6 mg tablet</i> (Invega)	T1	
<i>paliperidone er 9 mg tablet</i> (Invega)	T1	
<i>quetiapine fumarate</i> (Seroquel Xr)	T1	
<i>quetiapine fumarate 100 mg tab</i> (Seroquel)	T1	
<i>quetiapine fumarate 200 mg tab</i> (Seroquel)	T1	
<i>quetiapine fumarate 25 mg tab</i> (Seroquel)	T1	
<i>quetiapine fumarate 300 mg tab</i> (Seroquel)	T1	
<i>quetiapine fumarate 400 mg tab</i> (Seroquel)	T1	
<i>quetiapine fumarate 50 mg tab</i> (Seroquel)	T1	
<i>risperidone</i>	T1	
<i>risperidone</i> (Risperdal)	T3	ST
SAPHRIS (<i>asenapine maleate</i>)	T3	ST
SECUADO	T3	ST
SEROQUEL (<i>quetiapine fumarate</i>)	T3	ST

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics)^o (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-PSYCHOTIC-ATYPICAL, D3/D2 PARTIAL AG-5HT MIXED (con't)		
SEROQUEL XR (<i>quetiapine fumarate er</i>)	T3	ST
SEROQUEL XR (<i>quetiapine fumarate</i>)	T3	ST
<i>ziprasidone hcl</i> (Geodon)	T1	
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		
<i>aripiprazole</i>	T1	
<i>aripiprazole 1 mg/ml solution</i>	T1	
<i>aripiprazole 10 mg tablet</i> (Abilify)	T1	
<i>aripiprazole 15 mg tablet</i> (Abilify)	T1	
<i>aripiprazole 2 mg tablet</i> (Abilify)	T1	
<i>aripiprazole 20 mg tablet</i> (Abilify)	T1	
<i>aripiprazole 30 mg tablet</i> (Abilify)	T1	
<i>aripiprazole 5 mg tablet</i> (Abilify)	T1	QL(1 TAB/DAY)
REXULTI 0.25 MG TABLET	T2	ST QL(1 TAB/DAY)
REXULTI 0.5 MG TABLET	T2	ST QL(1 TAB/DAY)
REXULTI 1 MG TABLET	T2	ST QL(1 TAB/DAY)
REXULTI 2 MG TABLET	T2	ST QL(1 TAB/DAY)
REXULTI 3 MG TABLET	T2	ST
REXULTI 4 MG TABLET	T2	ST
ANTI-PSYCHOTICS, DOPAMINE AND SEROTONIN ANTAGONISTS		
<i>loxapine succinate</i>	T1	
ANTI-PSYCHOTICS, DOPAMINE ANTAGONISTS, THIOXANTHENES		
<i>thiothixene</i>	T1	
ANTI-PSYCHOTICS, DOPAMINE ANTAGONISTS, BUTYROPHENONES		
<i>haloperidol</i>	T1	
<i>haloperidol lactate</i>	T1	
ANTI-PSYCHOTICS, DOPAMINE ANTAGONST, DIHYDROINDOLONES		
<i>molindone hcl</i>	T1	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics)^o (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-PSYCHOTICS, PHENOTHIAZINES		
<i>chlorpromazine hcl</i>	T1	
<i>fluphenazine hcl</i>	T1	
<i>perphenazine</i>	T1	
<i>thioridazine hcl</i>	T1	
<i>trifluoperazine hcl</i>	T1	
SSRI-ANTI-PSYCH, ATYPICAL, DOPAMINE, SEROTONIN ANTAG		
<i>olanzapine/fluoxetine hcl</i>	T1	
PSYCHOTHERAPEUTIC DRUGS (Seizure Disorders)		
NEUROACTIVE STEROID GABA-A RECEPTOR MODULATOR		
ZTALMY	T3	PA QL(36 MLS/DAY) SP
PSYCHOTHERAPEUTIC DRUGS (Sleep Disorders/Sedatives)		
NARCOLEPSY AND SLEEP DISORDER THERAPY AGENTS		
<i>armodafinil</i> (Nuvigil)	T1	PA
<i>modafinil</i> (Provigil)	T1	PA
SUNOSI	T2	PA QL(1 TAB/DAY)
SEDATIVE/HYPNOTICS (Sleep Disorders/Sedatives)		
ANTI-NARCOLEPSY, ANTI-CATAPLEXY, SEDATIVE-TYPE AGENT		
LUMRYZ	T3	PA QL(1 PACK/DAY) SP HD
LUMRYZ STARTER PACK	T3	PA QL SP HD
SODIUM OXYBATE 0.5 G/ML SOLN	T3	PA QL(18 MLS/DAY) SP HD
XYWAV	T3	PA QL(18 MLS/DAY) SP HD
BARBITURATES		
<i>phenobarbital</i>	T1	
HYPNOTICS, MELATONIN MT1/MT2 RECEPTOR AGONISTS		
HETLIOZ LQ	T3	PA SP HD
<i>ramelteon</i> (Rozerem)	T1	QL (1 tab/day)
<i>tasimelteon</i> (Hetlioz)	T1	PA SP
SEDATIVE-HYPNOTICS - BENZODIAZEPINES		
DORAL	T3	
<i>estazolam</i>	T1	
<i>flurazepam hcl</i>	T1	
HALCION (<i>triazolam</i>)	T3	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SEDATIVE-HYPNOTICS - BENZODIAZEPINES (con't)		
<i>midazolam hcl</i>	T1	
QUAZEPAM	T1	
<i>temazepam (Restoril)</i>	T1	
<i>triazolam</i>	T1	
<i>triazolam (Halcion)</i>	T1	
SEDATIVE-HYPNOTICS, NON-BARBITURATE		
DAYVIGO	T2	ST QL(1 TAB/DAY)
<i>doxepin hcl 3 mg tablet (Silenor)</i>	T1	QL(1 TAB/DAY)
<i>doxepin hcl 6 mg tablet (Silenor)</i>	T1	
<i>eszopiclone (Lunesta)</i>	T1	
<i>zaleplon</i>	T1	
<i>zolpidem tart 1.75 mg tab sl</i>	T1	
<i>zolpidem tart 3.5 mg tablet sl</i>	T1	
<i>zolpidem tart er 12.5 mg tab (Ambien Cr)</i>	T1	
<i>zolpidem tart er 6.25 mg tab (Ambien Cr)</i>	T1	QL(1 TAB/DAY)
<i>zolpidem tartrate 10 mg tablet (Ambien)</i>	T1	
<i>zolpidem tartrate 5 mg tablet (Ambien)</i>	T1	
SKIN PREPS (Miscellaneous)		
ANTISEPTICS,GENERAL		
<i>alcohol antiseptic pads</i>	T1	
ALCOHOL PREP PADS	T1	
ALCOHOL SWAB	T1	
ALCOHOL SWABS	T1	
ALCOHOL WIPES	T1	
CARETOUCH ALCOHOL PREP PAD	T1	
CURITY ALCOHOL PREPS	T1	
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	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

SKIN PREPS (Miscellaneous) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTISEPTICS, GENERAL (con't)		
SURE COMFORT ALCOHOL	T1	
SURE-PREP ALCOHOL PREP PADS	T1	
TRUE COMFORT ALCOHOL PADS	T1	
TRUE COMFORT PRO ALCOHOL PADS	T1	
ULTILET ALCOHOL SWAB	T1	
WEBCOL	T1	
IRRIGANTS		
<i>acetic acid</i>	T1	
<i>neomycin sulf/polymyxin b sulf</i>	T1	
PHYSIOLYTE (<i>physiological irrig soln no.1</i>)	T3	
PHYSIOSOL (<i>physiological irrig soln no.1</i>)	T3	
<i>ringer's solution</i>	T1	
<i>ringer's solution, lactated</i>	T1	
<i>sod, pot chlor/mag/sod, pot phos</i>	T3	
<i>sodium chloride 0.9% irrig</i>	T1	
<i>sodium chloride 0.9% irrig.</i>	T1	
SODIUM CHLORIDE 0.9% IRRIG.	T3	
<i>sodium chloride 0.9% prcss sol</i>	T1	
<i>sodium chloride irrig solution</i>	T1	
SORBITOL	T1	
SORBITOL-MANNITOL	T1	
<i>water for irrigation, sterile</i>	T1	
OXIDIZING AGENTS		
<i>hydrogen peroxide</i>	T1	

SKIN PREPS (Pain Relief And Inflammatory Disease)

ANTI-PSORIATIC AGENTS, SYSTEMIC		
<i>acitretin</i>	T1	
BIMZELX	T3	PA QL(2 MLS/28 DAYS) SP HD
BIMZELX AUTOINJECTOR	T3	PA QL(2 MLS/28 DAYS) SP HD
COSENTYX (2 SYRINGES)	T3	PA QL(2 MLS/28 DAYS) SP HD
COSENTYX 150 MG/ML SYRINGE	T3	PA QL(1 ML/28 DAYS) SP HD
COSENTYX 75 MG/0.5 ML SYRINGE	T3	PA QL(0.5 MLS/28 DAYS) SP HD
COSENTYX SENSOREADY (2 PENS)	T3	PA QL(2 MLS/28 DAYS) SP HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

SKIN PREPS (Pain Relief And Inflammatory Disease) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-PSORIATIC AGENTS, SYSTEMIC (cont.)		
COSENTYX SENSOREADY PEN	T3	PA QL(1 ML/28 DAYS) SP HD
COSENTYX UNOREADY PEN	T3	PA QL(2 MLS/28 DAYS) SP HD
<i>methoxsalen</i>	T1	
SKYRIZI	T2	PA QL(150 MG/84 DAYS) SP HD
SKYRIZI PEN	T2	PA QL(150 MG/84 DAYS) SP HD
SOTYKTU	T2	PA QL(1 TAB/DAY) SP HD
SPEVIGO	T3	PA QL(2 MLS/28 DAYS) SP HD
TALTZ AUTOINJECTOR	T2	PA QL(1 AUTO-INJECTOR/28 DAYS) SP HD
TALTZ AUTOINJECTOR (2 PACK)	T2	PA QL(1 AUTO-INJECTOR/28 DAYS) SP HD
TALTZ AUTOINJECTOR (3 PACK)	T2	PA QL(1 AUTO-INJECTOR/28 DAYS) SP HD
TALTZ SYRINGE	T2	PA QL(1 SYRINGE/28 DAYS) SP HD
TOPICAL ANTI-INFLAMMATORY, NSAIDS		
<i>diclofenac sodium 1% gel</i>	T1	QL(1000 GMS/30 DAYS) HD
SKIN PREPS (Skin Conditions)		
ACNE AGENTS, SYSTEMIC		
ABSORICA (<i>isotretinoin</i>)	T3	
<i>isotretinoin</i> (Absorica)	T1	
ACNE AGENTS, TOPICAL		
ACZONE 7.5% GEL PUMP (<i>dapsone</i>)	T3	
<i>adapalene/benzoyl peroxide</i>	T1	
<i>adapalene/benzoyl peroxide</i> (Epiduo Forte)	T1	
<i>clindamycin phos/benzoyl perox</i>	T1	
<i>clindamycin phos/benzoyl perox</i> (Acanya)	T1	
<i>clindamycin/tretinoin</i> (Veltin)	T1	
<i>clindamycin/tretinoin</i> (Ziana)	T1	
<i>clindamycin-benzoyl perox 1-5%</i>	T1	
<i>clindamycin-bnz perox 1-5% pmp</i>	T1	
<i>dapsone 5% gel</i> (Aczone)	T1	
<i>dapsone 7.5% gel pump</i> (Aczone)	T1	
KLARON (<i>sulfacetamide sodium</i>)	T3	
<i>neuac gel</i>	T1	
ONEXTON (<i>clindamycin phos/benzoyl perox</i>)	T3	
<i>sulfacetamide sodium</i> (Klaron)	T1	
TWYNEO	T3	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-PERSPIRANTS		
DRYSOL	T3	
ANTI-PSORIATICS AGENTS		
<i>anthralin</i>	T1	
<i>calcipotriene 0.005% cream</i>	T1	
CALCIPOTRIENE 0.005% FOAM	T3	
<i>calcipotriene 0.005% ointment</i>	T1	
<i>calcipotriene 0.005% solution</i>	T1	
<i>calcitriol 3 mcg/g ointment (Vectical)</i>	T1	QL(800 GMS/30 DAYS)
<i>tazarotene 0.05% cream (Tazorac)</i>	T1	
<i>tazarotene 0.05% gel (Tazorac)</i>	T1	
<i>tazarotene 0.1% cream (Tazorac)</i>	T1	
<i>tazarotene 0.1% gel (Tazorac)</i>	T1	
TAZORAC (<i>tazarotene</i>)	T3	
ANTI-SEPTICS,GENERAL		
<i>alcohol antiseptic pads</i>	T1	
ALCOHOL PREP PADS	T1	
ALCOHOL SWAB	T1	
ALCOHOL SWABS	T1	
ALCOHOL WIPES	T1	
CARETOUCH ALCOHOL PREP PAD	T1	
CURITY ALCOHOL PREPS	T1	
DROPSAFE PREP PADS	T1	
EASY COMFORT ALCOHOL PAD	T1	
EASY TOUCH ALCOHOL PREP PADS	T1	
INCONTROL ALCOHOL PADS	T1	
PRO COMFORT ALCOHOL PADS	T1	
PURE COMFORT ALCOHOL PAD	T1	
SINGLE USE SWAB	T1	
SURE COMFORT ALCOHOL	T1	
SURE-PREP ALCOHOL PREP PADS	T1	
TRUE COMFORT ALCOHOL PADS	T1	
TRUE COMFORT PRO ALCOHOL PADS	T1	
ULTILET ALCOHOL SWAB	T1	
WEBCOL	T1	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-SEPTICS, MISCELLANEOUS		
GUAIACOL	T1	
EMOLLIENTS		
<i>ammonium lactate</i>	T1	
HPR PLUS-MB HYDROGEL	T1	
XCLAIR	T3	
IMMUNOMODULATORS		
<i>imiquimod 5% cream packet</i>	T1	
IRRITANTS/COUNTER-IRRITANTS		
<i>methyl salicylate</i>	T1	
JANUS KINASE (JAK) INHIBITORS		
CIBINQO	T2	PA QL(30 TABS/30 DAYS) SP
KERATOLYTICS		
<i>benzepro 6% foaming cloths</i>	T1	
BENZEPRO 7% CREAMY WASH (<i>benzoyl peroxide microspheres</i>)	T3	
<i>benzoyl peroxide</i>	T1	
<i>benzoyl peroxide (Pacnex)</i>	T1	
ENZOCLEAR	T3	
INOVA	T3	
PACNEX (<i>benzoyl peroxide</i>)	T3	
<i>podofilox</i>	T1	
<i>podofilox (Condylox)</i>	T1	
PR BENZOYL PEROXIDE (<i>benzoyl peroxide microspheres</i>)	T3	
<i>silver nitrate</i>	T1	
PROTECTIVES		
PHARMABASE BARRIER (<i>zinc oxide</i>)	T3	
<i>zinc oxide</i>	T1	
ZINC OXIDE	T1	
ROSACEA AGENTS, TOPICAL		
<i>azelaic acid (Finacea)</i>	T1	
<i>ivermectin 1% cream (Soolantra)</i>	T1	
<i>metronidazole</i>	T1	
<i>metronidazole (Metrocream)</i>	T1	
<i>metronidazole 0.75% cream (Metrocream)</i>	T1	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ROSACEA AGENTS, TOPICAL (cont.)		
<i>metronidazole 0.75% lotion</i>	T1	
<i>metronidazole top 1% gel pump</i>	T1	
<i>metronidazole topical 0.75% gl</i>	T1	
<i>metronidazole topical 1% gel (Metrogel)</i>	T1	
SOOLANTRA (ivermectin)	T3	
TISSUE/WOUND ADHESIVES		
ARTISS	T3	
TISSEEL VHSD	T3	
TOP. ANTI-INFLAM., PHOSPHODIESTERASE-4 (PDE4) INHIB		
EUCRISA	T2	ST
ZORYVE 0.15% CREAM	T2	ST QL(60 GMS/30 DAYS)
TOPICAL AGENTS, MISCELLANEOUS		
MEDIHONEY	T3	
<i>trichloroacetic acid</i>	T3	
TRICHLOROACETIC ACID	T3	
TRICHLOROACETIC ACID (<i>trichloroacetic acid</i>)	T3	
TOPICAL ANTIBIOTIC PLEUROMUTILIN DERIVATIVES		
ALTABAX	T3	
TOPICAL ANTI-INFLAMMATORY STEROIDAL		
ALA-SCALP (<i>hydrocortisone</i>)	T3	ST
<i>alclometasone dipropionate</i>	T1	
<i>amcinonide 0.1% cream</i>	T1	
AQUA GLYCOLIC HC	T3	
<i>betamethasone dipropionate</i>	T1	
<i>betamethasone valerate</i>	T1	
<i>betamethasone/propylene glyc</i>	T1	
<i>betamethasone/propylene glyc (Diprolene)</i>	T1	
BRYHALI	T3	ST
CAPEX SHAMPOO	T3	ST
<i>clobetasol 0.05% cream</i>	T1	
<i>clobetasol 0.05% gel</i>	T1	
<i>clobetasol 0.05% ointment (Temovate)</i>	T1	
<i>clobetasol 0.05% shampoo (Clobex)</i>	T1	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL ANTI-INFLAMMATORY STEROIDAL (cont.)		
<i>clobetasol 0.05% solution</i>	T1	
<i>clobetasol 0.05% topical lotn</i>	T1	
<i>clobetasol prop 0.05% foam (Olux)</i>	T1	
<i>clobetasol prop 0.05% spray (Clobex)</i>	T1	
<i>clobetasol propionate/emoll</i>	T1	
<i>clocortolone pivalate (Cloderm)</i>	T1	
CLODAN 0.05% KIT	T3	ST
<i>clodan 0.05% shampoo (Clobex)</i>	T1	
CLODERM	T3	ST
CLODERM (<i>clocortolone pivalate</i>)	T3	ST
DERMA-SMOOTHIE-FS (<i>fluocinolone acetonide</i>)	T3	ST
DERMA-SMOOTHIE-FS (<i>fluocinolone/shower cap</i>)	T3	ST
<i>desonide</i>	T1	
<i>desonide (Tridesilon)</i>	T1	
<i>desoximetasone (Topicort)</i>	T1	
DIPROLENE (<i>betamethasone diprop augmented</i>)	T3	ST
<i>fluocinolone acetonide</i>	T1	
<i>fluocinolone acetonide (Derma-smoothe-fs)</i>	T1	
<i>fluocinolone acetonide (Synalar)</i>	T1	
<i>fluocinolone/shower cap (Derma-smoothe-fs)</i>	T1	
<i>fluocinonide</i>	T1	
<i>fluocinonide (Vanos)</i>	T1	
<i>fluocinonide/emollient base</i>	T1	
<i>fluticasone prop 0.005% oint</i>	T1	
<i>fluticasone prop 0.05% cream</i>	T1	
<i>fluticasone prop 0.05% lotion</i>	T1	
<i>fluticasone propionate</i>	T1	
<i>halcinonide 0.1% solution</i>	T1	
<i>halobetasol propionate</i>	T1	
<i>hydrocortisone</i>	T1	
<i>hydrocortisone (Ala-scalp)</i>	T1	
<i>hydrocortisone (Anusol-Hc)</i>	T1	
<i>hydrocortisone acetate</i>	T1	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL ANTI-INFLAMMATORY STEROIDAL (cont.)		
<i>hydrocortisone butyr 0.1% cream</i>	T1	
<i>hydrocortisone butyr 0.1% oint</i>	T1	
<i>hydrocortisone butyr 0.1% soln</i>	T1	
<i>hydrocortisone valerate</i>	T1	
<i>mometasone furoate</i>	T1	
NUCORT	T3	ST
<i>prednicarbate</i>	T1	
SCALACORT DK	T3	ST
SYNALAR	T3	ST
SYNALAR (<i>fluocinolone acetonide</i>)	T3	ST
SYNALARTS	T3	ST
TEMOVATE (<i>clobetasol propionate</i>)	T3	ST
TEXACORT	T3	ST
TOPICORT (<i>desoximetasone</i>)	T3	ST
<i>triamcinolone 0.025% cream</i>	T1	
<i>triamcinolone 0.025% lotion</i>	T1	
<i>triamcinolone 0.025% oint</i>	T1	
<i>triamcinolone 0.1% cream</i>	T1	
<i>triamcinolone 0.1% lotion</i>	T1	
<i>triamcinolone 0.1% ointment</i>	T1	
<i>triamcinolone 0.5% cream</i>	T1	
<i>triamcinolone 0.5% ointment</i>	T1	
<i>triamcinolone acetonide</i>	T1	
TOPICAL ANTI-INFLAMMATORY STEROID-LOCAL ANESTHETIC		
EPIFOAM	T2	
<i>hydrocortisone/pramoxine</i>	T1	
<i>lidocaine/hydrocortisone ac</i>	T1	
PRAMOSONE	T3	
TOPICAL JANUS KINASE (JAK) INHIBITORS		
OPZELURA	T3	PA
TOPICAL PREPARATIONS, ANTIBACTERIALS		
<i>iodine/potassium iodide</i>	T1	
<i>iodine/sodium iodide</i>	T1	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL PREPARATIONS, ANTIBACTERIALS (cont.)		
IODOFLEX	T3	
IODOSORB	T3	
silver nitrate	T1	
TOPICAL VIT D ANALOG/ANTI-INFLAMMATORY STEROID		
calcipotriene/betamethasone (Taclonex)	T1	
TOPICAL/MUCOUS MEMBR./SUBCUT. ENZYMES		
SANTYL	T3	QL(60 GMS/30 DAYS)
VITAMIN A DERIVATIVES		
adapalene 0.1% cream (Differin)	T1	PA
ADAPALENE 0.1% LOTION	T1	PA
adapalene 0.1% solution	T1	PA
adapalene 0.3% gel	T1	PA
adapalene 0.3% gel pump (Differin)	T1	PA
RETIN-A MICRO PUMP 0.08% GEL (tretinoin microspheres)	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 DETERRENENTS (Smoking Cessation)⁹		
SMOKING DETERRENT AGENTS (GANGLIONIC STIM, OTHERS)		
NICOTROL	T3	PPACA
NICOTROL NS	T3	PPACA
SMOKING DETERRENT-NICOTINIC RECEPT.PARTIAL AGONIST		
APO-VARENICLINE 0.5 MG TABLET	T3	
APO-VARENICLINE 1 MG TABLET	T3	
CHANTIX	T3	PA
varenicline 0.5mg & 1 mg tablet	T1	PPACA
varenicline 1 mg cont month bx	T1	PPACA
varenicline starting month box	T1	PPACA

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

SMOKING DETERRENTS (Smoking Cessation)⁹ (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SMOKING DETERRENTS, OTHER		
<i>bupropion hcl sr 150 mg tablet</i>	T1	PPACA
THYROID PREPS (Hormonal Agents)		
ANTI-THYROID PREPARATIONS		
<i>methimazole</i>	T1	HD
<i>propylthiouracil</i>	T1	HD
THYROID HORMONES		
<i>adthyza 120 mg tablet</i>	T1	HD
<i>adthyza 15 mg tablet</i>	T1	HD
<i>adthyza 30 mg tablet</i>	T1	HD
<i>adthyza 60 mg tablet</i>	T1	HD
<i>adthyza 90 mg tablet</i>	T1	HD
LEVOTHYROXINE 100 MCG CAPSULE	T3	HD
<i>levothyroxine 100 mcg tablet (Synthroid)</i>	T1	HD
LEVOTHYROXINE 112 MCG CAPSULE	T3	HD
<i>levothyroxine 112 mcg tablet (Synthroid)</i>	T1	HD
LEVOTHYROXINE 125 MCG CAPSULE	T3	HD
<i>levothyroxine 125 mcg tablet (Synthroid)</i>	T1	HD
LEVOTHYROXINE 13 MCG CAPSULE	T3	HD
LEVOTHYROXINE 137 MCG CAPSULE	T3	HD
<i>levothyroxine 137 mcg tablet (Synthroid)</i>	T1	HD
LEVOTHYROXINE 150 MCG CAPSULE	T3	HD
<i>levothyroxine 150 mcg tablet (Synthroid)</i>	T1	HD
LEVOTHYROXINE 175 MCG CAPSULE	T3	HD
<i>levothyroxine 175 mcg tablet (Synthroid)</i>	T1	HD
LEVOTHYROXINE 200 MCG CAPSULE	T3	HD
<i>levothyroxine 200 mcg tablet (Synthroid)</i>	T1	HD
LEVOTHYROXINE 25 MCG CAPSULE	T3	HD
<i>levothyroxine 25 mcg tablet (Synthroid)</i>	T1	HD
<i>levothyroxine 300 mcg tablet (Synthroid)</i>	T1	HD
LEVOTHYROXINE 50 MCG CAPSULE	T3	HD
<i>levothyroxine 50 mcg tablet (Synthroid)</i>	T1	HD
LEVOTHYROXINE 75 MCG CAPSULE	T3	HD
<i>levothyroxine 75 mcg tablet (Synthroid)</i>	T1	HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

THYROID PREPS (Hormonal Agents) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
THYROID HORMONES (cont.)		
LEVOTHYROXINE 88 MCG CAPSULE	T3	HD
<i>levothyroxine 88 mcg tablet</i> (Synthroid)	T1	HD
<i>levothyroxine sodium</i> (Synthroid)	T1	HD
<i>lithyronine sodium</i> (Cytomel)	T1	HD
<i>thyroid,pork</i>	T1	HD

UNCLASSIFIED DRUG PRODUCTS (AIDS/HIV)

CYTOCHROME P450 INHIBITORS		
TYBOST	T3	SP

UNCLASSIFIED DRUG PRODUCTS (Asthma/COPD/Respiratory)

CYSTIC FIBROSIS - INHALED OSMOTIC AGENTS		
BRONCHITOL	T3	PA SP HD
CYSTIC FIBROSIS-CFTR POTENTIATOR-CORRECTOR COMBIN.		
TRIKAFTA 100-50-75 MG/150 MG	T3	PA QL(3 TABS/DAY) SP HD
TRIKAFTA 100-50-75 MG/75MG PKT	T3	PA QL(2 UNITS/DAY) SP HD
TRIKAFTA 50-25-37.5 MG/75 MG	T3	PA QL(3 TABS/DAY) SP HD
TRIKAFTA 80-40-60MG/59.5MG PKT	T3	PA QL(2 UNITS/DAY) SP HD
LUNG SURFACTANTS		
CUROSURF	T3	
INFASURF	T3	
SURVANTA	T3	
MUCOLYTICS		
PULMOZYME	T3	PA SP HD
PULMONARY FIBROSIS - SYSTEMIC ENZYME INHIBITORS		
OFEV	T2	PA SP HD
SYSTEMIC ENZYME INHIBITORS		
JOENJA	T3	PA QL(2 TABS/DAY) SP
VIJOICE 50 MG GRANULE PACKET	T3	PA QL(1 TAB/DAY) SP
VIJOICE 50 MG TABLET	T3	PA QL(1 TAB/DAY) SP
VIJOICE 125 MG TABLET	T3	PA QL(1 TAB/DAY) SP
VIJOICE 250 MG DAILY DOSE PACK	T3	PA QL(2 TABS/DAY) SP
ZOKINVY	T3	PA QL(4 CAPS/DAY) SP
THYMIC STROMAL LYMPHOPOIETIN (TSLP) INHIBITORS		
TEZSPIRE 210 MG/1.91 ML PEN	T2	PA QL(1 PEN/28 DAYS) SP HD
TEZSPIRE 210 MG/1.91 ML SYRING	T2	PA SP HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Blood Modifiers/Bleeding Disorders)

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

SPLEEN TYROSINE KINASE INHIBITORS

TAVALISSE	T2	PA SP
-----------	----	-------

UNCLASSIFIED DRUG PRODUCTS (Blood Pressure/Heart Medications)

BRADYKININ B2 RECEPTOR ANTAGONISTS

<i>icatibant acetate</i> (Firazyr)	T1	PA SP HD
------------------------------------	----	----------

PLASMA KALLIKREIN INHIBITORS

ORLADEYO	T3	PA QL(1 CAP/DAY) SP
----------	----	---------------------

UNCLASSIFIED DRUG PRODUCTS (Cancer)

CHEMOTHERAPY RESCUE/ANTIDOTE AGENTS

<i>leucovorin calcium</i>	T1	CSL
<i>mesna</i> (Mesnex)	T1	SP CSL
MESNEX (<i>mesna</i>)	T3	SP CSL
VISTOGARD	T3	SP CSL

UNCLASSIFIED DRUG PRODUCTS (Dental Products)

DENTAL AIDS AND PREPARATIONS

<i>chlorhexidine gluconate</i> (Peridex)	T1	
PERIDEX (<i>chlorhexidine gluconate</i>)	T3	
<i>triamcinolone 0.1% paste</i>	T1	
<i>triamcinolone acetonide</i>	T1	

PERIODONTAL COLLAGENASE INHIBITORS

<i>doxycycline hyclate 20 mg tab</i>	T1	
--------------------------------------	----	--

UNCLASSIFIED DRUG PRODUCTS (Erectile Dysfunction)

DRUGS TO TREAT ERECTILE DYSFUNCTION (ED)

<i>avanafil</i> (Stendra)	T1	QL(8 TABS/30 DAYS)
CAVERJECT	T3	PA QL(6 INJECTIONS/30 DAYS)
CIALIS 10 MG TABLET (<i>tadalafil</i>)	T3	ST QL(8 TABS/30 DAYS)
CIALIS 20 MG TABLET (<i>tadalafil</i>)	T3	ST QL(8 TABS/30 DAYS)
CIALIS 5 MG TABLET (<i>tadalafil</i>)	T3	ST QL(1 TAB/DAY)
EDEX	T3	PA QL(6 INJECTIONS/30 DAYS)
IFE-BIMIX 30/1	T2	
MUSE	T3	PA QL(6 SUPPS/30 DAYS)
<i>sildenafil 100 mg tablet</i> (Viagra)	T1	QL(8 TABS/30 DAYS) HD
<i>sildenafil 25 mg tablet</i> (Viagra)	T1	QL(8 TABS/30 DAYS) HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Erectile Dysfunction) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DRUGS TO TREAT ERECTILE DYSFUNCTION (ED) (cont.)		
<i>sildenafil 50 mg tablet (Viagra)</i>	T1	QL(8 TABS/30 DAYS) HD
STENDRA (<i>avanafil</i>)	T3	ST QL(8 TABS/30 DAYS)
<i>tadalafil 2.5 mg tablet</i>	T1	QL(1 TAB/DAY) HD
<i>tadalafil 10 mg tablet (Cialis)</i>	T1	QL(8 TABS/30 DAYS) HD
<i>tadalafil 20 mg tablet (Cialis)</i>	T1	QL(1 TAB/DAY) HD
<i>tadalafil 5 mg tablet (Cialis)</i>	T1	QL(8 TABS/30 DAYS) HD
<i>vardenafil hcl</i>	T1	QL(8 TABS/30 DAYS)
VIAGRA (<i>sildenafil citrate</i>)	T3	ST QL(8 TABS/30 DAYS)

UNCLASSIFIED DRUG PRODUCTS (Gastrointestinal/Heartburn)

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

UNCLASSIFIED DRUG PRODUCTS (Hormonal Agents)

HYPERPARATHYROID TX AGENTS - VITAMIN D ANALOG-TYPE		
<i>doxercalciferol</i>	T1	
<i>paricalcitol</i>	T1	SP HD
<i>paricalcitol (Zemplar)</i>	T1	SP HD
RAYALDEE	T3	
ZEMPLAR (<i>paricalcitol</i>)	T3	SP HD

UNCLASSIFIED DRUG PRODUCTS (Miscellaneous)

ABORTIFACIENT-PROGESTERONE RECEPTOR ANTAGONISTS		
MIFEPREX	T3	
<i>mifepristone 200 mg tablet</i>	T1	
AGENTS TO TX PERIODIC PARALYSIS - CARBON ANHYD INH		
<i>dichlorphenamide (Keveyis)</i>	T1	PA SP HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AMMONIA INHIBITORS		
CARBAGLU (<i>carglumic acid</i>)	T3	SP HD
<i>carglumic acid</i> (Carbaglu)	T1	SP HD
ANTI-ALCOHOLIC PREPARATIONS		
<i>acamprosate calcium</i>	T1	
<i>disulfiram</i>	T1	
ANTI-FIBROTIC THERAPY - PYRIDONE ANALOGS		
<i>pirfenidone 267 mg capsule</i>	T1	PA SP HD
<i>pirfenidone 267 mg tablet</i> (Esbriet)	T1	PA SP HD
<i>pirfenidone 801 mg tablet</i> (Esbriet)	T1	PA SP HD
CI ESTERASE INHIBITORS		
HAEGARDA	T3	PA SP HD
CALCIMIMETIC, PARATHYROID CALCIUM ENHANCER		
<i>cinacalcet hcl</i> (Sensipar)	T1	SP
CRYOPRESERVATIVE AGENTS		
<i>dimethyl sulfoxide</i>	T1	
GENERAL INHALATION AGENTS		
HYPER-SAL	T3	
<i>nebusal 3% vial</i>	T1	
NEBUSAL 6% VIAL	T3	
<i>sodium chloride 0.9% inhal vl</i>	T1	
<i>sodium chloride 10% vial</i>	T1	
<i>sodium chloride 3% vial</i>	T1	
<i>sodium chloride 7% vial</i>	T1	
<i>sodium chloride for inhalation</i>	T1	
GLUCOSYLCERAMIDE SYNTHASE (GCS) INHIBITOR		
CERDELGA	T2	PA SP HD
<i>miglustat</i> (Zavesca)	T1	PA SP HD
OPFOLDA	T3	PA QL(8 CAPS/30 DAYS) SP HD
HYDROXYPHENYL-PYRUVATE DIOXYGENASE(HPPD) INHIBITOR		
<i>nitisinone</i> (Orfadin)	T1	PA SP HD
NITYR	T2	PA SP
ORFADIN	T3	PA SP
ORFADIN (<i>nitisinone</i>)	T3	PA SP

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HYPOACTIVE SEXUAL DESIRE DISORDER (HSDD) TX AGENTS		
ADDYI	T3	PA QL(1 TAB/DAY)
VYLEESI	T3	PA QL(8 AUTO-INJS/30 DAYS) SP
MENOPAUSAL SYMPTOMS SUPPRESSANT - SSRIs		
<i>paroxetine mesylate</i>	T1	QL(1 CAP/DAY) HD
METABOLIC DISEASE ENZYME REPLACE, HYPOPHOSPHATASIA		
STRENSIQ	T2	PA SP
METALLIC POISON, AGENTS TO TREAT		
CHEMET	T3	
<i>deferasirox (Exjade)</i>	T1	SP HD
<i>deferasirox (Jadenu Sprinkle)</i>	T1	SP HD
<i>deferasirox (Jadenu)</i>	T1	SP HD
<i>deferiprone (Ferriprox (3 Times A Day))</i>	T1	PA SP HD
<i>deferiprone (Ferriprox)</i>	T1	PA SP
EXJADE (<i>deferasirox</i>)	T3	PA SP HD
FERRIPROX (2 TIMES A DAY)	T3	PA SP
FERRIPROX 100 MG/ML SOLUTION	T3	PA SP
GALZIN	T3	SP
RADIOGARDASE	T3	
<i>trientine hcl 250 mg capsule (Syrpine)</i>	T1	PA SP HD
TRIENTINE HCL 500 MG CAPSULE	T3	PA SP HD
NATRIURETIC PEPTIDES		
VOXZOGO	T3	PA SP HD
NEONATAL FC RECEPTOR (FCRN) INHIBITORS		
VYVGART HYTRULO	T3	PA SP HD
OINTMENT/CREAM BASES		
RADIAGEL	T1	
PHARMACOLOGICAL CHAPERONE-ALPHA-GALACTOSID.A STABZ		
GALAFOLD	T3	PA SP HD
PKU TX AGENT-COFACTOR OF PHENYLALANINE HYDROXYLASE		
<i>javygtor 100 mg powder packet (Kuvan)</i>	T1	PA SP
<i>javygtor 100 mg tablet (Kuvan)</i>	T1	PA SP HD
<i>javygtor 500 mg powder packet (Kuvan)</i>	T1	PA SP
<i>sapropterin dihydrochloride (Kuvan)</i>	T1	PA SP HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PROTEIN STABILIZERS		
ATTRUBY	T3	PA QL(4 TABS/DAY) SP
VYNDAMAX	T3	PA QL(1 CAP/DAY) SP HD
VYNDAQEL	T3	PA QL(4 CAPS/DAY) SP
RETINOIC ACID RECEPTOR (RAR) AGONISTS		
SOHONOS	T3	PA SP
SOLVENTS		
<i>cvs isopropyl alcohol 91%</i>	T1	
CVS ISOPROPYL ALCOHOL 91%	T1	
<i>cvs isopropyl rub alcohol 70%</i>	T1	
CVS ISOPROPYL RUB ALCOHOL 70%	T3	
<i>eql isopropyl alcohol 91%</i>	T1	
<i>eql isopropyl rub alcohol 70%</i>	T1	
FT ISOPROPYL ALCOHOL 91%	T1	
FT ISOPROPYL RUB ALCOHOL 70%	T3	
GNP ISOPROPYL ALCOHOL 70%	T3	
GNP ISOPROPYL ALCOHOL 91%	T1	
<i>gnp isopropyl alcohol 99%</i>	T1	
GS ISOPROPYL ALCOHOL 70%	T3	
GS ISOPROPYL ALCOHOL 91%	T1	
<i>hm isopropyl alcohol 70%</i>	T1	
<i>hm isopropyl alcohol 91%</i>	T1	
INSTACLEAN	T1	
ISOPROPANOL	T1	
<i>isopropyl 70% alcohol</i>	T1	
<i>isopropyl alcohol</i>	T1	
<i>isopropyl alcohol 70%</i>	T1	
ISOPROPYL ALCOHOL 70%	T3	
<i>isopropyl alcohol 91%</i>	T1	
<i>isopropyl alcohol 99%</i>	T1	
<i>isopropyl rubbing alcohol 70%</i>	T1	
ISOPROPYL RUBBING ALCOHOL 70%	T3	
ISOPROPYL RUBBING ALCOHOL 91%	T1	
<i>kro isopropyl alcohol 91%</i>	T1	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SOLVENTS (cont.)		
MURI-LUBE MINERAL OIL	T1	
<i>polyethylene glycol</i>	T1	
<i>ra isopropyl alcohol 70%</i>	T1	
<i>ra isopropyl alcohol 91%</i>	T1	
<i>sm isopropyl alcohol 70%</i>	T1	
<i>swan isopropyl alcohol 70%</i>	T1	
TREATMENT OF HYPERPHAGIA IN PRADER-WILLI SYNDROME		
VYKAT XR	T3	PA SP
METABOLIC DEFICIENCY AGENTS		
<i>betaine (Cystadane)</i>	T1	SP
CULTURELLE IBS COMPLETE SUPPRT	T3	
CYSTADANE (<i>betaine</i>)	T3	SP
<i>levocarnitine (Carnitor Sf)</i>	T1	
<i>levocarnitine (Carnitor)</i>	T1	
<i>levocarnitine (with sugar) (Carnitor)</i>	T1	
UNCLASSIFIED DRUG PRODUCTS (Osteoporosis Products)		
BONE FORMATION STIM. AGENTS - PARATHYROID HORMONE		
<i>teriparatide (Bonsity)</i>	T1	PA QL(0.09 MLS/DAY) SP HD
<i>teriparatide (Forteo)</i>	T1	PA QL(0.09 MLS/DAY) SP HD
BONE RESORPTION INHIBITOR AND VITAMIN D COMBS.		
FOSAMAX PLUS D	T2	ST HD
BONE RESORPTION INHIBITORS		
<i>alendronate sodium</i>	T1	HD
<i>alendronate sodium (Fosamax)</i>	T1	HD
<i>ADELVIA (risedronate sodium dr)</i>	T3	ST HD
BINOSTO	T3	ST HD
<i>FOSAMAX (alendronate sodium)</i>	T3	ST HD
<i>ibandronate sodium</i>	T1	HD
<i>raloxifene hcl (Evista)</i>	T1	HD PPACA
<i>risedronate sodium</i>	T1	HD
<i>risedronate sodium (Actonel)</i>	T1	HD
<i>risedronate sodium (Atelvia)</i>	T1	HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Pain Relief And Inflammatory Disease)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-INFLAM. INTERLEUKIN-1 RECEPTOR ANTAGONIST		
ARCALYST	T3	PA SP
FIBROMYALGIA AGENTS, SEROTONIN-NOREPINEPHRU INHIB		
SAVELLA	T3	
IMMUNOMODULATOR, B-LYMPHOCYTE STIM (BLYS)-SPEC INHIB		
BENLYSTA	T3	PA SP HD

UNCLASSIFIED DRUG PRODUCTS (Skin Conditions)

INTERLEUKIN-13 (IL-13) INHIBITORS, MAB		
ADBRY	T2	PA SP HD
ADBRY AUTOINJECTOR	T2	PA SP HD
EBGLYSS PEN	T2	PA SP
EBGLYSS SYRINGE	T2	PA SP
JANUS KINASE (JAK) INHIBITORS		
LEQSELVI	T3	PA QL(2 TABS/DAY) SP HD
LITFULO	T3	PA QL(1 CAP/DAY) SP HD
WOUND HEALING AGENTS, LOCAL		
FILSUEVZ	T3	PA SP

UNCLASSIFIED DRUG PRODUCTS (Substance Abuse)

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

UNCLASSIFIED DRUG PRODUCTS (Transplant Medications)

RHO KINASE INHIBITOR		
REZUROCK	T3	PA SP

UNCLASSIFIED DRUG PRODUCTS (Urinary Tract Conditions)

BENIGN PROSTATIC HYPERTROPHY/MICTURITION AGENTS		
<i>alfuzosin hcl</i> (Uroxatral)	T1	HD
<i>dutasteride</i> (Avodart)	T1	HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BENIGN PROSTATIC HYPERTROPHY/MICTURITION AGENTS (cont.)		
<i>finasteride</i> (Proscar)	T1	HD
<i>silodosin 4 mg capsule</i> (Rapaflo)	T1	QL (1 cap/day) HD
<i>silodosin 8 mg capsule</i> (Rapaflo)	T1	HD
<i>tamsulosin hcl</i>	T1	HD
BPH 5-ALPHA-REDUCTASE INHIB-ALPHA1-ADRENOCEP ANTAG		
<i>dutasteride/tamsulosin hcl</i> (Jalyn)	T1	HD
CYSTINE-DEPLETING AGENTS, NEPHROPATHIC CYSTINOSIS		
CYSTAGON	T2	SP
ENDOTHELIN RECEPTOR ANTAGONISTS		
VANRAFIA	T2	PA QL(1 TAB/DAY) SP
KIDNEY STONE AGENTS		
<i>tiopronin</i> (Thiola Ec)	T1	SP
<i>tiopronin 100 mg tablet</i> (Thiola)	T1	SP
<i>tiopronin dr 100 mg tablet</i> (Thiola Ec)	T1	SP HD
<i>tiopronin dr 300 mg tablet</i> (Thiola Ec)	T1	SP HD
OVERACTIVE BLADDER AGENTS, BETA-3 ADRENERGIC RECEPTOR ANTAG		
<i>mirabegron er 25 mg tablet</i> (Myrbetriq)	T1	QL(1 TAB/DAY) HD
<i>mirabegron er 50 mg tablet</i> (Myrbetriq)	T1	HD
URINARY TRACT ANTI-SPASMODIC, M(3) SELECTIVE ANTAG.		
<i>darifenacin er 15 mg tablet</i>	T1	HD
<i>darifenacin er 7.5 mg tablet</i>	T1	QL(1 TAB/DAY) HD
<i>solifenacin 10 mg tablet</i> (Vesicare)	T1	HD
<i>solifenacin 5 mg tablet</i> (Vesicare)	T1	QL(1 TAB/DAY) HD
URINARY TRACT ANTI-SPASMODIC/ANTI-INCONTINENCE AGENT		
<i>fesoterodine er 4 mg tablet</i> (Toviaz)	T1	QL(1 TAB/DAY) HD
<i>fesoterodine er 8 mg tablet</i> (Toviaz)	T1	HD
<i>flavoxate hcl</i>	T1	HD
<i>oxybutynin 5 mg tablet</i>	T1	HD
<i>oxybutynin 5 mg/5 ml soln cup</i>	T1	HD
<i>oxybutynin 5 mg/5 ml solution</i>	T1	HD
<i>oxybutynin 5 mg/5 ml syrup</i>	T1	HD
<i>tolterodine tart er 2 mg cap</i> (Detrol La)	T1	QL(1 CAP/DAY) HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
URINARY TRACT ANTI-SPASMODIC/ANTI-INCONTINENCE AGENT (con't.)		
<i>tolterodine tart er 4 mg cap</i> (Detrol La)	T1	HD
<i>tolterodine tartrate</i> (Detrol)	T1	HD
<i>tropium chloride</i>	T1	HD

UNCLASSIFIED DRUG PRODUCTS (Weight Management)

APPETITE STIM. FOR ANOREXIA, CACHEXIA, WASTING SYND.		
<i>megestrol 400 mg/10 ml cup</i>	T1	
<i>megestrol 625 mg/5 ml susp</i>	T1	
<i>megestrol acet 40 mg/ml susp</i>	T1	
<i>megestrol acet 400 mg/10 ml</i>	T1	

VITAMINS (Nutritional/Dietary)

ANTIOXIDANT MULTIVITAMIN COMBINATIONS		
MACUVEX	T2	
MACUZIN	T2	
FOLIC ACID PREPARATIONS		
ENLYTE	T2	
<i>folic acid</i>	T1	
GERIATRIC VITAMIN PREPARATIONS		
REQ49+	T2	
MULTIVITAMIN PREPARATIONS		
ANIMI-3	T2	
BACMIN	T2	
CORVITE	T2	
DIALYVITE 800 WITH IRON	T2	
<i>folic/mvi ther-min/lycop/lut</i>	T1	
FORTAVIT	T2	
<i>multivit no.18/iron no.1/folic</i> (Tandem Plus)	T1	
<i>multivit-mins no.7/folic acid</i>	T1	
NIVA-PLUS (<i>multivit-min 60/iron fum/folic</i>)	T1	
<i>om-3/dha/epa/b12/fa/b6/phytost</i>	T1	
PROTECT IRON	T2	
STROVITE FORTE (<i>multivit,iron,min 5/folic acid</i>)	T2	
STROVITE ONE	T2	
TANDEM PLUS (<i>multivit no.18/iron no.1/folic</i>)	T3	
UDAMIN SP	T2	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PEDIATRIC VITAMIN PREPARATIONS		
FLORIVA	T2	PPACA
<i>ped mvit a,c,d3 no.21/fluoride</i>	T1	PPACA
<i>pedi multivit no.12 w-fluoride</i>	T2	PPACA
POLY-VI-FLOR	T2	PPACA
QUFLORA FE	T2	
QUFLORA PED 0.25 MG CHEW TAB	T2	
QUFLORA PED 0.25 MG/ML DROP	T2	PPACA
QUFLORA PED 0.5 MG CHEW TAB	T2	
QUFLORA PED 0.5 MG/ML DROP	T2	PPACA
QUFLORA PED 1 MG CHEW TAB	T2	PPACA
TRI-VI-FLOR	T2	PPACA
VITAMIN B PREPARATIONS		
<i>b comp no3/folic/c/biotin/zinc</i>	T1	HD
<i>b complex 11/folic/c/biot/zinc</i>	T1	HD
<i>cyanocobalamin/folic ac/vit b6</i>	T1	HD
<i>cyanocobalamin/folic ac/vit b6 (Niva-Fol)</i>	T1	HD
DIALYVITE 3000	T2	HD
DIALYVITE 5000	T2	HD
DIALYVITE SUPREME D	T2	HD
<i>folic acid/vit b complex and c</i>	T1	HD
<i>folic acid/vit b complex and c</i>	T2	HD
<i>folic acid/vit bcomp,c/cu/zinc</i>	T1	HD
METHAVER	T2	HD
NEPHRON FA	T3	HD
NIVA-FOL (<i>cyanocobalamin/folic ac/vit b6</i>)	T1	HD
VITAL-D RX	T2	HD
VITA-RESPA	T2	HD
VITAMIN B12 PREPARATIONS		
<i>cyanocobalamin (vitamin b-12)</i>	T1	
<i>cyanocobalamin (vitamin b-12) (Nascobal)</i>	T1	
VITAMIN D PREPARATIONS		
<i>calcitriol 0.25 mcg capsule</i>	T1	
<i>calcitriol 0.5 mcg capsule</i>	T1	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN D PREPARATIONS (con't.)		
<i>calcitriol 1 mcg/ml solution</i>	T1	
<i>ergocalciferol (vitamin d2)</i>	T1	HD
VITAMIN K PREPARATIONS		
MEPHYTON (<i>phytonadione (vit k1)</i>)	T3	
<i>phytonadione (vit k1)</i> (Mephyton)	T1	
PEDIATRIC VITAMIN PREPARATIONS		
POLY-VI-FLOR	T2	PPACA
POLY-VI-FLOR WITH IRON	T2	PPACA

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

Exclusions and limitations for coverage

Health benefit plans vary, but in general to be eligible for coverage a drug must be approved by the Food and Drug Administration (FDA), prescribed by a health care professional, purchased from a licensed pharmacy and be medically necessary. If your plan provides coverage for certain preventive prescription drugs with no cost-share, you may be required to use an in-network pharmacy to fill the prescription. If you use a pharmacy that does not participate in your plan's network, the prescription may not be covered. Certain drugs may require prior authorization, or be subject to step therapy, quantity limits or other utilization management requirements.

Plans generally do not provide coverage for the following under the pharmacy benefit, except as required by state or federal law, or by the terms of your specific plan:¹¹

- Over-the-counter (OTC) medicines (those that do not require a prescription) except insulin unless state or federal law requires coverage of such medicines.
- Prescription medications or supplies for which there is a prescription or OTC therapeutic equivalent or therapeutic alternative.
- Doctor-administered injectable medications covered under the Plan's medical benefit, unless otherwise covered under the Plan's prescription drug list or approved by Cigna Healthcare.
- Implantable contraceptive devices covered under the Plan's medical benefit.
- Medications that are not medically necessary.
- Experimental or investigational medications, including U.S. Food and Drug Administration (FDA)-approved medications used for purposes other than those approved by the FDA unless the medication is recognized for the treatment of the particular indication.
- Medications that are not approved by the FDA.
- Prescription and non-prescription devices, supplies, and appliances other than those supplies specifically listed as covered.
- Medications used for fertility,¹² sexual dysfunction, cosmetic purposes, weight loss, smoking cessation,¹² or athletic enhancement.
- Prescription vitamins (other than prenatal vitamins) or dietary supplements unless state or federal law requires coverage of such products.
- Immunization agents, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions and medications used for travel prophylaxis.
- Replacement of prescription medications and related supplies due to loss or theft.
- Medications which are to be taken by or administered to a covered person while they are a patient in a licensed hospital, skilled nursing facility, rest home or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceuticals.
- Prescriptions more than one year from the date of issue.
- Coverage for prescription medication products for the amount dispensed (days' supply) which is more than the applicable supply limit, or is less than any applicable supply minimum set forth in The Schedule, or which is more than the quantity limit(s) or dosage limit(s) set by the P&T Committee.
- More than one prescription order or refill for a given prescription supply period for the same prescription medication product prescribed by one or more doctors and dispensed by one or more pharmacies.
- Prescription medication products dispensed outside the jurisdiction of the United States, except as required for emergency or urgent care treatment.

In addition to the plan's standard pharmacy exclusions, certain new FDA-approved medication products (including, but not limited to, medications, medical supplies or devices that are covered under standard pharmacy benefit plans) may not be covered for the first six months of market availability unless approved by Cigna Healthcare as medically necessary.

Index of Medications

Symbols

1ST TIER.....	120
1ST TIER UNILET COMFORTOUCH	128
2-IN-1 LANCET	120
2-IN-1 LANCET DEVICE.....	128
2TEK	114

A

abacavir sulfate	60
abacavir sulfate/lamivudine (Epzicom).....	60
abacavir sulfate (Ziagen)	60
abiraterone acetate 250 mg tab (Zytiga)	48
abiraterone acetate (Zytiga)	48
ABRYSVO	69
ABSORICA (isotretinoin).....	150
ACAM2000	69
acamprosate calcium.....	161
acarbose	42
ACCOLATE	29
ACCU-CHEK.....	114, 120
ACCU-CHEK FASTCLIX LANCET DRUM.....	128
ACCU-CHEK FASTCLIX LANCING DEV	114
ACCU-CHEK GUIDE CONTROL SOLN.....	114
ACCU-CHEK SAFE-T-PRO	128
ACCU-CHEK SAFE-T-PRO PLUS.....	128
ACCU-CHEK SMARTVIEW CONTRL SOL.....	114
ACCU-CHEK SOFTCLIX.....	114, 128
ACCUTREND GLUCOSE CONTROL	114
ACD-A SOLUTION	36
ACD SOLUTION A.....	36
ACE	133
acebutolol	77
acetamin-codein 300-30 mg/12.5.....	20
acetaminop-codeine 120-12 mg/5	20
acetaminophen/caff/dihydrocod	21
acetaminophen-cod.....	20
acetazolamide.....	93
acetic acid.....	95, 149
acetic acid/oxyquinoline (Relagard)	45
acetylcysteine	29
acitretin.....	149
ACTEMRA.....	113
ACTHIB.....	68, 69
ACTI-LANCE.....	120, 128
ACTIMMUNE.....	55
ACTIQ	21
ACTIVE FE.....	100
ACTOPLUS	43
acyclovir 200 mg/5 ml susp.....	62

acyclovir 200 mg/5 ml susp cup	62
acyclovir 200 mg capsule	62
acyclovir 400 mg tablet	62
acyclovir 800 mg/20ml susp cup.....	62
acyclovir 800 mg tablet	62
ACZONE 7.5% GEL PUMP (dapson)	150
ADACEL	68
ADALIMUMAB.....	46
ADALIMUMAB-ADBM(CF) 10 MG SYRG	46
ADALIMUMAB-ADBM(CF) 20 MG SYRG	46
ADALIMUMAB-ADBM(CF) 40 MG SYRG	46
ADALIMUMAB-ADBM(CF)PEN	46
ADALIMUMAB-RYVK(CF)	46
adapalene.....	150
adapalene 0.1% cream (Differin).....	156
ADAPALENE 0.1% LOTION	156
adapalene 0.1% solution.....	156
adapalene 0.3% gel.....	156
adapalene 0.3% gel pump (Differin).....	156
adapalene/benzoyl peroxide	150
adapalene/benzoyl peroxide (Epiduo Forte).....	150
ADBRY	165
ADBRY AUTOINJECTOR.....	165
ADDYI.....	162
adefovir dipivoxil	63
ADEMPAS	73
ADJUSTABLE LANCING DEVICE.....	114
ADLARITY	63
ADRENALIN CHLORIDE.....	95
adthyza 15 mg tablet	157
adthyza 30 mg tablet.....	157
adthyza 60 mg tablet.....	157
adthyza 90 mg tablet.....	157
adthyza 120 mg tablet	157
ADVANCED.....	91, 120
ADVANCED DNA MEDICATED COLLECT	91
ADVANCED LANCING DEVICE	114
ADVANCED TRAVEL LANCETS	128
ADVOCATE	120
ADVOCATE CONTROL SOLUTION	114
ADVOCATE LANCET	128
ADVOCATE LANCETS	128
ADVOCATE LANCING DEVICE.....	114
ADVOCATE RAPID-SAFE LANCING DV	114
ADVOCATE REDI-CODE+ CTRL SOLN	114
ADVOCATE SAFETY LANCET	121, 128
AEMCOLO	34
AEROCHAMBER.....	123, 125, 133

Index of Medications

AEROCHAMBER2GO	133	aliskiren 150 mg tablet (Tekturna).....	78
AEROCHAMBER MV	133	aliskiren 300 mg tablet (Tekturna)	78
AEROTRACH	133	ALKALINE BATTERIES	114
AEROVENT	133	ALKERAN.....	47
AFLURIA 2025-2026	67	allopurinol 100 mg tablet (Zyloprim).....	25
AFLURIA 2025-2026 (3YR UP)	67	allopurinol 300 mg tablet.....	25
AFLURIA QUAD 2022-23 (3YR UP)	67	almotriptan malate.....	15, 19
AFLURIA QUAD 2022-2023	67	alosetron hcl (Lotronex).....	106
AFLURIA QUAD 2023-24 (3YR UP).....	67	alprazolam	139
AFLURIA QUAD 2023-2024.....	67	ALTABAX.....	153
AFLURIA TRIV 2024-25 (3YR UP).....	67	ALTAFLUOR BENOX (benoxinate hcl/fluorescein sod)	96
AFLURIA TRIVALENT 2024-25.....	67	ALTERNATE SITE	120
AGAMATRIX CONTROL	114	ALTERNATE SITE LANCETS	121, 128
AGAMATRIX CONTROL SOLUTION	114	ALTERNATE SITE LANCING DEVICE.....	114
AGAMATRIX ULTRA-THIN LANCET	121, 128	ALUNBRIG.....	50
AGRYLIN.....	59	ALVESCO.....	29
AIMOVIG.....	15, 19	amantadine.....	57
AIRSUPRA.....	28	ambrisentan	73
AJOVY	15, 19	amcinonide 0.1% cream.....	153
AJOVY AUTOINJECTOR (3 PACK).....	19	AMICAR	69
AKEEGA.....	54	amiloride	94
AKTEN.....	96	aminocaproic acid.....	69
AKYNZEO.....	103	amiodarone	71
ALA-SCALP (hydrocortisone).....	153	amitriptyline.....	142
albendazole	45	amitriptyline/chlordiazepoxide	142
albuterol	27, 28	amitriptyline hcl	142
albuterol 8 mg/20 ml syrup cup.....	27	amlodipine-atorvast.....	78, 79
albuterol 15 mg/3 ml solution	27	amlodipine-atorvast 10-10 mg (Caduet).....	78
albuterol 25 mg/5 ml solution	27	amlodipine-atorvast 10-20 mg (Caduet).....	78
albuterol hfa 90 mcg inhaler	28	amlodipine besylate.....	71, 74
albuterol sulf 2 mg/5 ml syrup	27	amlodipine besylate/benazepril (Lotrel).....	74
ALCAINE.....	96	amlodipine besylate/valsartan (Exforge).....	76
alclometasone dipropionate.....	153	amlodipine-olmesartan 5-20 mg (Azor)	76
ALCOH-GLOVE	133	amlodipine-olmesartan 5-40 mg (Azor).....	76
alcohol antiseptic pads.....	148, 151	amlodipine-olmesartan 10-20 mg (Azor)	76
ALCOHOL PREP PADS	148, 151	amlodipine-olmesartan 10-40 mg (Azor).....	76
ALCOHOL SWAB.....	148, 151	amlodipine/valsartan/hcthiazid (Exforge Hct).....	75
ALCOHOL SWABS.....	148, 151	ammonium lactate	152
ALCOHOL SWABSTICK.....	46	amoxapine	142
ALCOHOL WIPES.....	148, 151	amoxicillin	34
ALCOH-WIPE	133	amoxicillin/potassium clav.....	34
ALECENSA.....	50	amoxicillin/potassium clav (Augmentin).....	34
alendronate	164	amoxicillin/potassium clav (Augmentin Es-600).....	34
alendronate sodium.....	164	amoxicillin/potassium clav (Augmentin Xr)	34
alendronate sodium (Fosamax)	164	amphetamine sulfate.....	64
alfuzosin	165	ampicillin trihydrate.....	34
ALHEMO	70	anagrelide	59
ALINIA 100 MG/5 ML SUSPENSION.....	57	ANA-LEX	107
		ANALPRAM	107

Index of Medications

ANALPRAM HC 1% CREAM.....	105	ASSURE DOSE.....	114
ANAPROX DS.....	25	ASSURE HAEMOLANCE PLUS.....	128
anastrozole.....	49	ASSURE LANCE.....	128
ANCOBON.....	39	ASSURE LANCE PLUS.....	128
ANGELIQ.....	109	ASSURE PRISM.....	114
ANIMI-3.....	167	ASTAGRAF.....	113
ANORO ELLIPTA 62.5-25 MCG INH.....	28	ASTRINGYN.....	70
anthralin.....	151	atazanavir sulfate.....	61
ANTICOAG.....	36	atazanavir sulfate (Reyataz).....	61
APOKYN.....	57	ATELVIA.....	164
apomorphine hcl.....	57	atenolol.....	77, 78
APO-VARENICLINE 0.5 MG TABLET.....	156	AT HOME A1C.....	115
APO-VARENICLINE 1 MG TABLET.....	156	atomoxetine hcl 10 mg capsule (Strattera).....	144
apraclonidine.....	96	atomoxetine hcl 18 mg capsule (Strattera).....	144
aprepitant.....	103	atomoxetine hcl 25 mg capsule (Strattera).....	144
APRETUDE.....	61	atomoxetine hcl 40 mg capsule (Strattera).....	144
APRISO.....	105	atomoxetine hcl 60 mg capsule (Strattera).....	144
APTIVUS.....	59	atomoxetine hcl 80 mg capsule (Strattera).....	144
AQNEURSA.....	101	atomoxetine hcl 100 mg capsule (Strattera).....	144
AQUA GLYCOLIC HC.....	153	atorvastatin.....	79
AQUA LANCE LANCING DEVICE.....	114	atovaquone.....	45
ARCALYST.....	165	atovaquone (Mepron).....	45
AREXVY.....	69	atovaquone/proguanil hcl.....	45
arformoterol.....	28	atropine.....	97, 103, 104
ARIDOL.....	91	atropine 1% eye ointment.....	97
ARIKAYCE.....	31	ATROVENT HFA.....	27
ARIMIDEX.....	49	ATTRUBY.....	163
aripiprazole.....	146	AURYXIA.....	99
aripiprazole 2 mg tablet (Abilify).....	146	AUSTEDO.....	82
aripiprazole 5 mg tablet (Abilify).....	146	AUSTEDO XR 6 MG TABLET.....	82
aripiprazole 10 mg tablet (Abilify).....	146	AUSTEDO XR 12 MG TABLET.....	82
aripiprazole 15 mg tablet (Abilify).....	146	AUSTEDO XR 18 MG TABLET.....	82
aripiprazole 20 mg tablet (Abilify).....	146	AUSTEDO XR 24 MG TABLET.....	82
aripiprazole 30 mg tablet (Abilify).....	146	AUSTEDO XR 30 MG TABLET.....	82
ARIXTRA 2.5 MG/0.5 ML SYRINGE (fondaparinux sodium).....	37	AUSTEDO XR 36 MG TABLET.....	82
ARIXTRA 5 MG/0.4 ML SYRINGE (fondaparinux sodium).....	37	AUSTEDO XR 42 MG TABLET.....	82
ARIXTRA 7.5 MG/0.6 ML SYRINGE (fondaparinux sodium).....	37	AUSTEDO XR 48 MG TABLET.....	82
ARIXTRA 10 MG/0.8 ML SYRINGE (fondaparinux sodium).....	37	AUTOJECT 2.....	115
armodafinil (Nuvigil).....	147	AUTO-LANCET MINI.....	115
AROMASIN.....	49	AUTOLET IMPRESSION.....	115
ARTHROTEC.....	25	AUTOLET LANCING DEVICE.....	115
ARTISS.....	153	AUTOLET LITE.....	115
asenapine maleate.....	145	AUTOLET PLUS.....	115
ASMANEX.....	29	AUTOPEN.....	115
aspirin/dipyridamole.....	58	AUTOSHIELD DUO PEN NEEDLE.....	125
ASPIRIN-OMEPRAZOLE DR 81-40 MG.....	58	avanafil (Stendra).....	159
ASSURE.....	121, 136	AVITENE.....	70
ASSURE 4 CONTROL SOLUTION.....	114	AVMAPKI-FAKZYNJA.....	50
ASSURE CONTROL SOLUTION.....	114	AVONEX (4 PACK).....	82

Index of Medications

AVONEX PEN (4 PACK)	82	BD MICROTAINER LANCETS	128
AYVAKIT	50	BELBUCA	21
AZASITE	30	benazepril	74, 76
azathioprine 50 mg tablet (Imuran)	113	benazepril hcl (Lotensin).....	76
azelaic acid (Finacea).....	152	benazepril/hydrochlorothiazide.....	74
azelastine/fluticasone (Dymista).....	94	benazepril/hydrochlorothiazide (Lotensin Hct).....	74
azelastine hcl.....	94	BENLYSTA	165
azithromycin.....	33	BENZAMYCIN.....	36
azithromycin (Zithromax)	33	benzebro 6% foaming cloths	152
azithromycin (Zithromax Tri-Pak).....	33	BENZEPRO 7% CREAMY WASH (benzoyl peroxide microspheres).....	152
B		BENZNIDAZOLE.....	45
bacitracin.....	30	benzonatate 100 mg capsule.....	90
bacitracin/polymyxin b sulfate.....	30	benzonatate 200 mg capsule.....	90
baclofen.....	135	benzoyl peroxide	36, 150, 152
baclofen 5 mg/5 ml solution	135	benzphetamine.....	55
baclofen 5 mg tablet	135	benztropine mesylate.....	57
baclofen 10 mg/5 ml solution	135	BESIVANCE.....	30
BACMIN.....	167	BETADINE	95
BACTRIM	31	betaine (Cystadane)	164
BACTRIM DS.....	31	betamethasone dipropionate	153
BACTRIM (sulfamethoxazole-trimethoprim).....	31	betamethasone/propylene glyc	153
BAFIERTAM	82	betamethasone valerate.....	153
BAL-CARE DHA ESSENTIAL	136	BETASERON.....	82
balsalazide	105	betaxolol.....	77, 96
BALVERSA	50	bethanechol.....	65
BAQSIMI.....	98	BETOPTIC S	96
BARACLUDE 0.05 MG/ML SOLUTION	63	bexarotene 1% gel (Targretin).....	55
BASAGLAR KWIKPEN U-100	44	bexarotene 75 mg capsule (Targretin).....	47
BASAGLAR TEMPO PEN U-100.....	44	BEXSERO.....	66
BAXDELA	34	BEYFORTUS	62
BCG	68	bicalutamide.....	48
b complex 11/folic/c/biot/zinc	168	BIJUVA	108
b comp no3/folic/c/biotin/zinc	168	BIKTARVY	61
BD.....	121	BILTRICIDE.....	45
BD INS SYR 0.3 ML 8MMX31G(1/2).....	127	bimatoprost.....	96
BD INS SYRNG 0.3 ML 29GX12.7MM	127	BIMZELX	149
BD INS SYRNG 0.5 ML 29GX12.7MM	127	BIMZELX AUTOINJECTOR	149
BD INS SYRNG UF 0.3 ML 8MMX31G	127	BINOSTO	164
BD INS SYRNG UF 0.5 ML 8MMX31G	127	bisac/nacl/nahco3/kcl/peg 3350.....	106
BD INS SYRN UF 1 ML 12.7MMX30G.....	127	bismuth/metronid/tetracycline (Pylera).....	104
BD INS SYRN UF 1 ML 30G 12.7MM.....	127	bisoprolol fumarate 5 mg tab	77
BD INS SYR UF 0.3ML 12.7MMX30G	127	bisoprolol fumarate 10 mg tab	77
BD INS SYR UF 0.5ML 12.7MMX30G	127	bisoprolol/hydrochlorothiazide.....	78
BD INSULIN SYR 0.5 ML 28GX1/2"	127	BLOOD	69, 70, 71, 121, 126
BD INSULIN SYR 1 ML 27GX5/8"	127	BLOOD GLUCOSE CONTROL	115
BD INSULIN SYR 1 ML 27GX12.7MM.....	127	BLOOD-GLUCOSE CONTROL	115
BD INSULIN SYR 1 ML 28GX1/2"	127	BLOOD LANCETS	128
BD INSULIN SYR 1 ML 29GX12.7MM	127	BLUNT NEEDLE.....	125
BD INSULIN SYR UF 1 ML 8MMX31G	127		

Index of Medications

BONJESTA	103	butalbital-aspirin-caffeine tb	19
BOOSTRIX.....	68	butorphanol tartrate.....	21
bosentan.....	73	BUTRANS	21
BOSULIF 50 MG CAPSULE	50	BUTTERFLY	121
BOSULIF 100 MG CAPSULE.....	50	BUTTERFLY TOUCH LANCET.....	128
BOSULIF 100 MG TABLET	50	BYDUREON.....	41
BOSULIF 400 MG TABLET.....	50	C	
BREATHERITE.....	133, 134	cabergoline.....	111
BREATHRITE	134	CABOMETYX.....	51
BREEZE 2.....	115	CADUET.....	79
BREZTRI AEROSPHERE INHALER.....	29	CAFERGOT	15
brimonidine	96	caffeine citrate.....	82
brinzolamide	96	CALAN	71
BRIVIACT.....	84	calcipotriene.....	151
bromfenac sodium	95	calcipotriene 0.005% cream	151
bromfenac sodium (Bromsite).....	95	CALCIPOTRIENE 0.005% FOAM	151
bromfenac sodium (Prolensa)	95	calcipotriene/betamethasone (Taclonex).....	156
bromocriptine mesylate.....	57	calcitonin, salmon, synthetic	112
brompheniramine/pseudoephed/dm.....	90	calcitonin,salmon,synthetic (Miacalcin)	112
BRONCHITOL.....	158	calcitriol 0.5 mcg capsule	168
BRUKINSA 80 MG CAPSULE.....	50	calcitriol 0.25 mcg capsule	168
BRUKINSA 160 MG TABLET.....	51	calcitriol 1 mcg/ml solution.....	169
BRYHALI.....	153	calcitriol 3 mcg/g ointment (Vectical)	151
budesonide.....	109	calcium acetate	99
budesonide 0.5 mg/2 ml susp (Pulmicort).....	29	calcium/mag/d3/b12/fa/b6/boron	99
budesonide 0.25 mg/2 ml susp (Pulmicort)	29	CALQUENCE	51
budesonide 1 mg/2 ml inh susp (Pulmicort)	29	CAMZYOS.....	72
budesonide 2 mg rectal foam (Uceris)	107	candesartan cilexetil (Atacand)	76
budesonide/formoterol fumarate (Symbicort).....	28	candesartan/hydrochlorothiazid (Atacand Hct).....	75
budesonide (Uceris).....	109	CAPCOF.....	90
BULLSEYE.....	121	capecitabine.....	48
BULLSEYE MINI SAFETY LANCETS	128	capecitabine 150 mg tablet (Xeloda)	48
bumetanide	93	capecitabine 500 mg tablet (Xeloda).....	48
buprenorphine.....	21, 165	CAPEX.....	153
bupropion	140, 157	CAPLYTA	145
bupropion hcl sr 100 mg tablet (Wellbutrin Sr).....	140	CAPRELSA 100 MG TABLET	51
bupropion hcl sr 150 mg tablet (Wellbutrin Sr)	140	CAPRELSA 300 MG TABLET	51
bupropion hcl xl 150 mg tablet (Wellbutrin XI).....	140	captopril	74, 76
bupropion hcl xl 300 mg tablet (Wellbutrin XI).....	140	captopril-hctz	74
buspirone	139	CAPVAXIVE	67
butalb-acetamin-caff 50-300-40	15, 19	CARBAGLU (carglumic acid).....	161
butalb-acetamin-caff 50-325-40.....	15, 19	carbamazepine.....	84, 86
butalb/acetaminophen/caffeine	15, 19	carbamazepine 100 mg/5 ml cup.....	84
butalb-aspirin-caff 50-325-40	15	carbamazepine 100 mg/5 ml susp (Tegretol).....	84
butalbit/acetamin/caff/codeine	23	carbamazepine 100 mg tab chew	84
butalbital/acetaminophen.....	15, 19	carbamazepine 200 mg/10 ml cup.....	84
butalbital-acetaminophn 50-325.....	19	CARBAMAZEPINE 200 MG TAB CHEW.....	84
butalbital-asa-caffeine cap (Fiorinal).....	15	carbamazepine 200 mg tablet (Tegretol).....	84
butalbital-aspirin-caffeine cp.....	19	carbamazepine (Carbatrol).....	84

Index of Medications

carbamazepine (Tegretol Xr)	84	CEQUA	97
carbidopa	57	CEQUR SIMPLICITY	115
carbidopa/levodopa	57	CEQUR SIMPLICITY INSERTER.....	115
carbidopa/levodopa/entacapone.....	57	CERDELGA.....	161
carbidopa/levodopa (Sinemet).....	57	CERVIDIL	111
carbidopa-levo er 25-100 tab	57	cevimeline	65
carbidopa-levo er 50-200 tab	57	CHANTIX	156
carbidopa (Lodosyn).....	58	CHEK-STIX	92
carbinoxamine 4 mg/5 ml liquid.....	41	CHEMET	162
carbinoxamine maleate.....	41	CHEMSTRIP	92
carbinoxamine maleate 4 mg tab.....	41	CHEMSTRIP 2 GP	93
CARDURA	75	CHEMSTRIP 7	93
CAREONE.....	115, 121, 128	CHEMSTRIP 9.....	93
CAREPOINT	125	CHEMSTRIP 10 WITH SG	92
CARESENS.....	115, 121	CHEMSTRIP 50B	93
CARESENS LANCET	128	CHEMSTRIP BG DIARY	115
CARESENS S CONTROL SOLUTION	115	CHENODAL.....	104
CARETOUCH	121	chlordiazepoxide.....	139
CARETOUCH ALCOHOL PREP PAD	148, 151	chlordiazepoxide/clidinium br (Librax).....	102
CARETOUCH CONTROL SOLUTION	115	chlorhexidine gluconate	159
CARETOUCH HYPODERMIC NEEDLE.....	125	chloroquine phosphate	45
CARETOUCH LANCING DEVICE.....	115	chlorpromazine	147
CARETOUCH SAFETY LANCETS.....	121, 128	chlorthalidone.....	78, 94
CARETOUCH TWIST LANCET	128	chlorzoxazone 500 mg tablet.....	135
carglumic acid (Carbaglu).....	161	CHOLBAM	104
carisoprodol	23, 135	cholestyramine	80
carisoprodol/aspirin.....	23	cholestyramine (Questran Light).....	80
carisoprodol/aspirin/codeine.....	23	choline salicyl/mag salicylate	15
carisoprodol (Soma).....	135	CHOSEN.....	121
CAROSPIR.....	94	CHOSEN LANCET	128
carteolol.....	96	CHOSEN LANCING DEVICE.....	115
carvedilol.....	75	CHOSEN SAFETY LANCET	128
carvedilol er 20 mg capsule (Coreg Cr).....	75	CIALIS.....	159
CASODEX.....	48	CIBINQO	152
CAVERJECT	159	ciclodan	40
CAYA CONTOURED	89	CICLODAN.....	40
CAYSTON.....	32	CICLODAN 8% KIT	40
cefaclor	32	ciclopirox.....	40
cefadroxil.....	32	ciclopirox/urea/camph/men/euc	40
cefdinir	33	cilostazol	58
cefixime	33	CIMDUO	59
cefepodoxime proxetil.....	33	cimetidine	105
cefprozil.....	32	CIMZIA	46
ceftriaxone sodium.....	33	CIMZIA (2 PACK).....	46
cefuroxime axetil.....	32	cinacalcet hcl (Sensipar)	161
celecoxib	27	CIPRO (ciprofloxacin).....	34
CELONTIN (methsuximide)	84	CIPRO (ciprofloxacin hcl)	34
CENTANY	36	ciprofloxacin.....	30, 34
cephalexin	32	ciprofloxacin hcl	30

Index of Medications

ciprofloxacin/hydrocortisone.....	30	clonidine hcl er 0.1 mg tablet (Kapvay)	143
citalopram	140	clopidogrel bisulfate	58
citalopram hbr 10 mg/5 ml soln	140	clorazepate dipotassium	139
CITRANATAL	136	clotrimazole.....	39, 40
CITRANATAL B-CALM	138	clotrimazole/betamethasone.....	40
CITRATE PHOSPHATE DEXTROSE	36	clozapine	145
citric acid/sodium citrate	101	COAGUCHEK.....	121, 128
cladribine.....	82	COARTEM.....	45
CLARINEX-D.....	40	codeine/butalbital/asa/cafein	23
clarithromycin.....	33	codeine phosphate/guaifenesin	90
clemastine fum 2.68 mg tablet.....	41	codeine sulfate	21
clemastine fumarate	41	CODITUSSIN AC	90
CLEOCIN HCL (clindamycin hcl)	33	CODITUSSIN DAC	90
CLEOCIN PEDIATRIC (clindamycin palmitate hcl).....	33	colchicine	24, 27
CLEOCIN T (clindamycin phosphate)	36	COLCHICINE	24
CLEVER.....	121, 134	colesevelam	80
CLEVER CHEK LANCETS.....	128	COLESTID.....	80
CLEVER CHOICE CONTROL SOLUTION	115	COLESTID (colestipol hcl).....	80
CLEVER CHOICE HOLDING CHAMBER.....	134	colestipol.....	80
clindacin	36	colestipol hcl	80
clindamycin.....	33, 35, 36, 150	COLOR	121
clindamycin-benzoyl perox 1-5%.....	150	COLOR LANCETS.....	129
clindamycin-bnz perox 1-5% pmp.....	150	COMBIPATCH	108
clindamycin palmitate	33	COMBISTIX REAGENT	93
clindamycin phos/benzoyl perox.....	150	COMBIVENT RESPIMAT	28
clindamycin phos/benzoyl perox (Acanya).....	150	COMETRIQ 60 MG DAILY-DOSE PACK.....	51
clindamycin phosphate.....	36	COMETRIQ 100 MG DAILY-DOSE PK	51
clindamycin/tretinoin (Ziana)	150	COMETRIQ 140 MG DAILY-DOSE PK.....	51
CLINPRO.....	98	COMFORT	121, 123, 134
CLINPRO 5000.....	99	COMFORT EZ	129
clobazam (Onfi)	83	COMFORT LANCETS.....	129
clobetasol 0.05% cream	153	COMFORT PAC-CYCLOBENZAPRINE	135
clobetasol 0.05% gel	153	COMFORT PAC-IBUPROFEN	25
clobetasol 0.05% ointment (Temovate).....	153	COMFORT PAC-MELOXICAM	25
clobetasol 0.05% shampoo (Clobex).....	153	COMFORT PAC-NAPROXEN.....	25
clobetasol 0.05% solution.....	154	COMFORT PAC-TIZANIDINE.....	135
clobetasol 0.05% topical lotn	154	COMFORTSEAL	134
clobetasol prop 0.05% foam (Olux).....	154	COMFORT TOUCH PLUS SAFETY LANC	129
clobetasol prop 0.05% spray (Clobex).....	154	COMFORT TOUCH ULT THIN LANCET	129
clobetasol propionate/emoll	154	COMIRNATY	65
clocortolone pivalate (Cloderm).....	154	COMIRNATY 2023-2024	65
CLODAN 0.05% KIT.....	154	COMIRNATY 2024-2025.....	65
clodan 0.05% shampoo (Clobex)	154	COMIRNATY 2025-2026(5-11Y)	65
CLODERM.....	154	COMIRNATY 2025-2026 (12Y UP).....	65
CLODERM (clocortolone pivalate).....	154	COMPACT SPACE CHAMBER	134
clomiphene citrate.....	111	COMPAZINE.....	103
clomipramine hcl (Anafranil)	142	COMPAZINE (prochlorperazine maleate).....	103
clonazepam	83, 84	CONTOUR	115
clonidine	77		

Index of Medications

CONTOUR NEXT CONTROL SOLUTION	115	cyclophosphamide 25 mg capsule	47
CONTRACE	56	cyclophosphamide 50 mg capsule.....	47
CONTROL SOLUTION.....	115	CYCLOSERINE.....	32
COOL CONTROL SOLUTION	115	CYCLOSET	41
COPIKTRA	51	cyclosporine	113
coremino	35	cyclosporine 0.05% eye emuls (Restasis)	97
CORLANOR	73	cyclosporine 25 mg capsule (Sandimmune)	113
CORTENEMA.....	107	cyclosporine 100 mg capsule (Sandimmune).....	113
cortisone acetate	109	CYLTEZO	46
CORTISPORIN-TC.....	30	CYLTEZO(CF) 10 MG/0.2 ML SYRNG.....	46
CORVITE.....	167	CYLTEZO(CF) 20 MG/0.4 ML SYRNG.....	46
CORVITE 150	100	CYLTEZO(CF) 40 MG/0.4 ML SYRNG.....	46
CORVITE FE.....	100	CYLTEZO(CF) 40 MG/0.8 ML SYRNG.....	46
COSENTYX (2 SYRINGES).....	149	CYLTEZO(CF) PEN CROHN'S-UC-HS.....	46
COSENTYX 75 MG/0.5 ML SYRINGE.....	149	CYLTEZO(CF) PEN PSORIASIS-UV	46
COSENTYX 150 MG/ML SYRINGE.....	149	cyproheptadine hcl	41
COSENTYX SENSOREADY (2 PENS)	149	CYSTADANE (betaine)	164
COSENTYX SENSOREADY PEN.....	150	CYSTADROPS.....	97
COSENTYX UNOREADY PEN	150	CYSTAGON.....	166
COTELLIC	49	CYSTARAN 0.44% EYE DROPS	97
CRENESSITY 25 MG CAPSULE	111	CYSTO-CONRAY II.....	92
CRENESSITY 50 MG CAPSULE.....	111	CYSTOGRAFIN.....	92
CRENESSITY 50 MG/ML SOLUTION	111	CYSTOGRAFIN-DILUTE.....	92
CRENESSITY 100 MG CAPSULE	111	CYTOTEC	104
CRESEMBA	39	D	
CREXONT	57	dabigatran etexilate mesylate (Pradaxa)	38
CRINONE.....	111, 112	dalfampridine er 10 mg tablet (Ampyra)	83
cromolyn	24, 29, 96	danazol	111
crotamiton	57	DANTRIUM.....	135
CTEXLI.....	104	dantrolene.....	135
CULTURELLE IBS COMPLETE SUPPRT	164	DANZITEN.....	51
CURITY ALCOHOL PREPS.....	148, 151	dapsone 5% gel (Aczone)	150
CUROSURF	158	dapsone 7.5% gel pump (Aczone).....	150
CUVPOSA (glycopyrrolate)	102	dapsone 25 mg tablet	32
cvs isopropyl alcohol 91%.....	163	dapsone 100 mg tablet.....	32
CVS ISOPROPYL ALCOHOL 91%.....	163	DAPTACEL	68
CVS ISOPROPYL ALCOHOL 91% SPRY	46	darifenacin.....	166
cvs isopropyl rub alcohol 70%.....	163	darunavir	59
CVS ISOPROPYL RUB ALCOHOL 70%	163	dasatinib 20 mg tablet (Sprycel).....	51
cyanocobalamin	168	dasatinib 50 mg tablet (Sprycel).....	51
cyanocobalamin/folic ac/vit b6.....	168	dasatinib 70 mg tablet (Sprycel).....	51
cyanocobalamin/folic ac/vit b6 (Niva-Fol).....	168	dasatinib 80 mg tablet (Sprycel).....	51
cyanocobalamin (vitamin b-12)	168	dasatinib 100 mg tablet (Sprycel).....	51
cyclobenzaprine	135, 136	dasatinib 140 mg tablet (Sprycel)	51
CYCLOGYL	97	DAURISMO.....	49
CYCLOGYL (cyclopentolate hcl)	97	DAYPRO.....	25
CYCLOMYDRIL.....	97	DAYTRANA (methylphenidate).....	143
cyclopentolate	97	DAYVIGO	148
cyclopentolate hcl	97	deferasirox	162

Index of Medications

deferiprone.....	162	DEXCOM G7 15 DAY SENSOR.....	115
deferiprone (Ferriprox (3 Times A Day)).....	162	DEXCOM G7 RECEIVER.....	115
deflazacort.....	109	DEXCOM G7 SENSOR.....	115
DELSTRIGO.....	61	dexmethylphenidate.....	143
demeclocycline.....	35	dexmethylphenidate hcl (Focalin Xr).....	143
DENGVAZIA.....	68	dextroamphetamine.....	64
DEPEN.....	24	dextroamphetamine/amphetamine (Adderall).....	64
DEPO-ESTRADIOL.....	108	dextroamphetamine/amphetamine (Adderall Xr).....	64
DEPO-SUBQ PROVERA.....	88	dextroamphetamine/amphetamine (Mydayis).....	64
DEPO-TESTOSTERONE.....	107	dextroamphetamine sulfate.....	64
DERMACINRX PRETRATE.....	136	dextroamphetamine sulfate (Zenzedi).....	64
DERMA-SMOOTH-FS.....	154	DIACOMIT.....	84
DERMA-SMOOTH-FS (fluocinolone/shower cap).....	154	DIALYVITE 800 WITH IRON.....	167
DERMOTIC.....	95	DIALYVITE 3000.....	168
DESCOVY 120-15 MG TABLET.....	59	DIALYVITE 5000.....	168
DESCOVY 200-25 MG TABLET.....	59	DIALYVITE SUPREME D.....	168
desflurane.....	23	DIASTAT.....	83
desipramine.....	142	DIASTIX REAGENT.....	91
desmopressin 0.01% solution.....	108	diatrizoate meglumine, sodium (Gastrografin).....	91
desmopressin 10 mcg/0.1 ml spr.....	108	DIATRUE.....	115
desmopressin 40 mcg/10 ml vial (Ddvp).....	108	diazepam.....	83, 139
desmopressin ac 4 mcg/ml ampul (Ddvp).....	108	diazepam 5 mg/5 ml solution.....	139
desmopressin ac 4 mcg/ml vial (Ddvp).....	108	diazepam 5 mg/ml oral conc.....	139
desmopressin acetate 0.1 mg tb (Ddvp).....	108	diazepam 10mg rectal gel (2pk).....	83
desmopressin acetate 0.2 mg tb (Ddvp).....	108	diazepam 10 mg rectal gel syrg.....	83
desog-e.estradiol/e.estradiol.....	88	diazepam 20mg rectal gel (2pk).....	83
desogestrel-ethinyl estradiol.....	88	diazepam 20 mg rectal gel syrg.....	83
desonide.....	154	diazepam 25 mg/5 ml oral conc.....	139
desonide (Tridesilon).....	154	diazoxide.....	98
desoximetasone.....	154	DIBENZYLINE.....	65
desvenlafaxine succnt er 25 mg (Pristiq).....	141	dichlorphenamide.....	160
desvenlafaxine succnt er 50 mg (Pristiq).....	141	diclofenac.....	95, 150
desvenlafaxine succnt er 100mg (Pristiq).....	141	diclofenac pot 50 mg tablet.....	20
dexamethasone.....	95, 109	diclofenac potassium.....	20
dexamethasone 0.5 mg/5 ml elx.....	109	diclofenac sod dr.....	25
dexamethasone 0.5 mg/5 ml liq.....	109	diclofenac sod ec.....	25
dexamethasone 0.5 mg tablet.....	109	diclofenac sodium.....	25
dexamethasone 0.75 mg tablet.....	110	diclofenac sodium/misoprostol.....	25
dexamethasone 1.5 mg tablet.....	110	dicloxacin.....	34
dexamethasone 1 mg tablet.....	110	dicyclomine 10 mg/5 ml soln.....	102
dexamethasone 2 mg tablet.....	110	dicyclomine 10 mg capsule.....	102
dexamethasone 4 mg tablet.....	110	dicyclomine 20 mg tablet.....	102
dexamethasone 6 mg tablet.....	110	diethylpropion.....	55
dexamethasone sodium phosphate.....	95	DIFICID.....	33
DEXCOM G6 RECEIVER.....	115	diflunisal.....	15, 19
DEXCOM G6 SENSOR.....	115	difluprednate (Durezol).....	95
DEXCOM G6 TRANSMITTER.....	115	digoxin 0.05 mg/ml solution.....	72
		digoxin 0.25 mg tablet (Lanoxin).....	72

Index of Medications

digoxin 0.125 mg tablet (Lanoxin).....	72	doxycycline hyclate 100 mg tab (Lymepak).....	35
digoxin 125 mcg tablet (Lanoxin).....	72	doxycycline hyclate 150 mg tab (Acticlate).....	35
digoxin 250 mcg tablet (Lanoxin).....	72	doxylamine succinate/vit b6.....	103
digoxin (Lanoxin).....	72	dronabinol (Marinol).....	103
dihydroergotamine.....	15, 19	DROPLET GENTEEL LANCING DEVICE.....	115
DILANTIN.....	84	DROPLET LANCETS.....	121, 129
diltiazem.....	71, 72	DROPLET LANCING DEVICE.....	116
diltiazem 24h er(la) 120 mg tb (Cardizem La).....	71	DROPSAFE ACTI-LANCE.....	121, 129
diltiazem 24h er(la) 180 mg tb (Cardizem La).....	71	DROPSAFE PREP PADS.....	148, 151
diltiazem 24h er(la) 240 mg tb (Cardizem La).....	71	DROPSAFE SICURA SAFETY NEEDLE.....	125
diltiazem 24h er(la) 300 mg tb (Cardizem La).....	71	drospir/eth estra/levomefol ca (Beyaz).....	88
diltiazem 24h er(la) 360 mg tb (Cardizem La).....	71	drospir/eth estra/levomefol ca (Safyral).....	88
diltiazem 24h er(la) 420 mg tb (Cardizem La).....	71	DROXIA.....	70
diltiazem hcl (Cardizem).....	72	droxidopa 100 mg capsule (Northera).....	64
diltiazem hcl (Cardizem Cd).....	71	droxidopa 200 mg capsule (Northera).....	64
dimethyl fumarate 30d start pk (Tecfidera).....	82	droxidopa 300 mg capsule (Northera).....	64
dimethyl fumarate dr 120 mg cp (Tecfidera).....	82	DRYSOL.....	151
dimethyl fumarate dr 240 mg cp (Tecfidera).....	82	DUAVEE.....	109
dimethyl sulfoxide.....	161	DUETACT.....	43
diphenoxylate hcl/atropine.....	103	DUET DHA 400.....	138
DIPHThERIA-TETANUS TOXOIDS-PED.....	68	DUET DHA BALANCED.....	136
DIPROLENE.....	154	DULERA 50 MCG-5 MCG INHALER.....	28
dipyridamole.....	58	DULERA 100 MCG-5 MCG INHALER.....	28
DISALCID.....	24	DULERA 200 MCG-5 MCG INHALER.....	28
disopyramide phosphate.....	71	duloxetine.....	141
disulfiram.....	161	duloxetine hcl dr 20 mg cap (Cymbalta).....	141
DIURIL.....	94	duloxetine hcl dr 30 mg cap (Cymbalta).....	141
divalproex sodium (Depakote).....	84	duloxetine hcl dr 60 mg cap (Cymbalta).....	141
divalproex sodium (Depakote Er).....	84	DUOPA.....	57
divalproex sodium (Depakote Sprinkle).....	84	DUPIXENT.....	113
dofetilide.....	71	dutasteride.....	165
DOJOLVI.....	98	dutasteride/tamsulosin hcl (Jalyn).....	166
donepezil.....	63	E	
donepezil hcl.....	63	EASIVENT HOLDING CHAMBER.....	134
DOPTELET.....	88	EASIVENT MASK-LARGE.....	134
DOPTELET SPRINKLE.....	88	EASIVENT MASK-MEDIUM.....	134
DORAL.....	147	EASIVENT MASK-SMALL.....	134
dorzolamide.....	96	EASY COMFORT ALCOHOL PAD.....	148, 151
dorzolamide hcl.....	96	EASY COMFORT LANCETS.....	121, 129
DOVATO.....	59	EASYGLUCO PLUS CONTROL NORMAL.....	116
doxazosin mesylate (Cardura).....	75	EASYMAX 15 LEVEL 2 SOLUTION.....	116
doxepin.....	142, 148	EASYMAX NORMAL CONTROL SOLN.....	116
doxercalciferol.....	160	EASY MINI EJECT LANCING DEVICE.....	116
doxycycline.....	35	EASY PLUS II CONTROL SOLN HIGH.....	116
doxycycline 50 mg tablet (Targadox).....	35	EASY PLUS II CONTROL SOLN LOW.....	116
doxycycline hyclate.....	35	EASYPOINT NEEDLE.....	126
doxycycline hyclate 20 mg tab.....	159	EASY STEP CONTROL SOLUTION.....	116
doxycycline hyclate 50 mg cap.....	35	EASY TALK CONTROL SOLN LOW.....	116
doxycycline hyclate 75 mg tab (Acticlate).....	35	EASY TALK HIGH CONTROL SOLN.....	116

Index of Medications

EASY TALK PLUS II HIGH CONTROL	116	ELIMITE	57
EASY TALK PLUS II LOW CTRL SLN	116	ELIQUIS.....	37
EASY TOUCH ALCOHOL PREP PADS	148, 151	ELIQUIS SPRINKLE.....	37
EASY TOUCH BLULINK CTRL SOLN	116	ELLA	88
EASY TOUCH CONTROL SOLUTION.....	116	ELMIRON.....	23
EASY TOUCH FLIPLOCK NEEDLE.....	126	eltrombopag olamine (Promacta).....	88
EASY TOUCH FLIPLOCK NEEDLES	126	EMBRACE.....	122
EASY TOUCH HYPODERMIC NEEDLE	126	EMBRACE 30G LANCETS.....	122, 129
EASY TOUCH LANCING DEVICE.....	116	EMBRACE EVO LEVEL 1 CTRL SOLN.....	116
EASY TOUCH PULL-TOP 26G LANCET.....	121, 129	EMBRACE GLUC CONTROL SOLN HIGH	116
EASY TOUCH PULL-TOP 28G LANCET.....	121, 129	EMBRACE GLUCOSE CONTROL SOLN	116
EASY TOUCH PULL-TOP 30G LANCET	121, 129	EMBRACE LANCING DEVICE	116
EASY TOUCH PULL-TOP 32G LANCET.....	121, 129	EMBRACE PRO	116
EASY TOUCH SAFETY 21G LANCETS.....	121, 129	EMBRACE SAFETY LANCET.....	129
EASY TOUCH SAFETY 23G LANCETS	121, 129	EMBRACE TALK CONTROL SOLUTION.....	116
EASY TOUCH SAFETY 26G LANCETS.....	121, 129	EMEND	103
EASY TOUCH SAFETY 28G LANCETS.....	122, 129	EMGALITY	15, 19, 83
EASY TOUCH SAFETY 30G LANCETS.....	122, 129	Empaveli.....	69
EASY TOUCH SAFETY 32G LANCETS	122, 129	EMSAM.....	139
EASY TOUCH TWIST 26G LANCETS.....	122, 129	emtricitabine	61
EASY TOUCH TWIST 28G LANCETS	122, 129	emtricitabine.....	60
EASY TOUCH TWIST 30G LANCETS.....	122, 129	emtricitabine-tenofv 100-150mg (Truvada)	59
EASY TOUCH TWIST 32G LANCETS.....	122, 129	emtricitabine-tenofv 133-200mg (Truvada).....	59
EASY TOUCH TWIST 33G LANCETS	122, 129	emtricitabine-tenofv 167-250mg (Truvada)	59
EASY TRAK CONTROL SOLN HIGH	116	emtricitabine-tenofv 200-300mg (Truvada).....	59
EASY TRAK CONTROL SOLN LOW.....	116	EMTRIVA.....	60
EASY TRAK II CONTROL SOLUTION	116	EMVERM.....	45
EASY TWIST & CAP LANCETS.....	122, 129	enalapril/hydrochlorothiazide	74
EBGLYSS.....	165	enalapril/hydrochlorothiazide (Vaseretic)	74
EBGLYSS SYRINGE.....	165	enalapril maleate	76
ECLIPSE.....	126	enalapril maleate (Epaned)	76
ECLIPSE SYRINGE	127	ENBREL	46
EC-NAPROSYN.....	25	ENDO-AVITENE.....	70
econazole nitrate 1% cream	40	ENDOMETRIN (progesterone, micronized)	112
ECOZA.....	40	ENFAMIL.....	99
EDEX.....	159	ENGERIX-B	69
EDURANT.....	60	ENLITE SERTER.....	116
EDURANT PED	60	ENLYTE	167
efavirenz	60, 61	enoxaparin	37
efavirenz/emtricit/tenofvr df.....	61	enoxaparin 30 mg/0.3 ml syr (Lovenox).....	37
effer-k.....	101	enoxaparin 40 mg/0.4 ml syr (Lovenox)	37
EFFER-K	101	enoxaparin 150 mg/ml syringe (Lovenox)	37
EFUDEX (fluorouracil).....	55	enoxaparin 300 mg/3 ml vial (Lovenox).....	37
EGRIFTA	110	ENSACOVE	51
EGRIFTA WR	110	ENSPRYNG	113
ELEMENT COMPACT CONTROL SOLN.....	116	entacapone.....	57
ELEMENT CONTROL SOLUTION.....	116	entecavir 0.5 mg tablet (Baraclude).....	63
eletriptan hydrobromide	15	entecavir 1 mg tablet (Baraclude)	63
eletriptan hydrobromide (Relpax).....	19	ENTERO.....	91

Index of Medications

ENTRESTO	75	estradiol 2 mg tablet	109
ENTYVIO.....	105	estradiol (Minivelle).....	108
ENVARBUS.....	113	estradiol/norethindrone acet	109
ENZOCLEAR.....	152	estradiol (Vivelle-Dot).....	108
EPCLUSA.....	62, 63	estrogen, ester/me-testosterone	108
EPCLUSA 150-37.5 MG PELLETT PKT.....	62	estrogen, ester/me-testosterone.....	108
EPCLUSA 200-50 MG PELLETT PACK.....	62	estrogens, conjugated (Premarin).....	109
EPIDIOLEX	84	eszopiclone.....	148
EPIFOAM	155	ethambutol	32
epinephrine 0.3 mg auto-inject (Epipen).....	63	ethinyl estradiol.....	88, 89
epinephrine 0.3 mg auto-inject (Epipen 2-Pak).....	63	ethinyl estradiol/drospirenone (Yasmin 28)	88, 89
epinephrine 0.15 mg auto-inject (Epipen Jr).....	63	ethinyl estradiol/drospirenone (Yaz)	89
epinephrine 0.15 mg auto-inject (Epipen Jr 2-Pak).....	63	ethosuximide	84, 87
epinephrine hcl.....	95	ethynodiol d-ethinyl estradiol.....	89
eplerenone.....	94	etodolac.....	25, 26
eprosartan mesylate	76	etonogestrel.....	88
eq1 isopropyl alcohol 91%	163	etoposide	55
eq1 isopropyl rub alcohol 70%	163	etravirine (Intelence)	60
ergocalciferol	169	EUCRISA	153
ergoloid mesylates	78	EULEXIN (flutamide)	48
ergotamine tartrate/caffeine.....	15, 19	EURAX	57
ERIVEDGE	49	EVAMIST	109
ERLEADA	48	EVENCARE G2 CONTROL SOLUTION	116
erlotinib	51	EVENCARE G3 CONTROL SOLUTION	116
ERVEBO.....	69	everolimus.....	50, 114
ERYPED	33	everolimus 0.5 mg tablet (Zortress)	113
ERY-TAB (erythromycin base)	33	everolimus 0.25 mg tablet (Zortress).....	113
erythromycin.....	31, 33, 36	everolimus 0.75 mg tablet (Zortress).....	113
erythromycin ethylsuccinate (Eryped 200).....	33	everolimus 1 mg tablet (Zortress).....	113
erythromycin ethylsuccinate (Eryped 400)	33	everolimus 2.5 mg tablet (Afinitor).....	50
escitalopram.....	140	everolimus 2 mg tab for susp (Afinitor Disperz).....	50
escitalopram 5 mg tablet (Lexapro)	140	everolimus 3 mg tab for susp (Afinitor Disperz).....	50
escitalopram 10 mg/10 ml cup	140	everolimus 5 mg tab for susp (Afinitor Disperz).....	50
escitalopram 10 mg tablet (Lexapro)	140	everolimus 5 mg tablet (Afinitor)	50
escitalopram 20 mg tablet (Lexapro)	140	everolimus 7.5 mg tablet (Afinitor)	50
ESGIC.....	15	everolimus 10 mg tablet (Afinitor)	50
esomeprazole.....	106	EVICEL	70
esomeprazole dr 2.5 mg packet (Nexium)	106	EVOCLIN.....	36
esomeprazole dr 5 mg packet (Nexium).....	106	EVOLUTION CONTROL SOLUTION	116
esomeprazole dr 40 mg packet (Nexium).....	106	EVOTAZ	61
estazolam.....	147	EXEL HUBER NEEDLE	126
estradiol.....	88, 89, 108, 109, 111	EXEL HYPODERMIC NEEDLE.....	126
estradiol 0.1% (0.5mg) gel pkt (Divigel).....	109	EXEL MTI DRAWING NEEDLE.....	126
estradiol 0.1% (0.25mg) gel pk (Divigel)	108	EXELON	63
estradiol 0.1% (0.75mg) gel pk (Divigel)	109	exemestane	49
estradiol 0.1% (1.25mg) gel pk (Divigel)	109	exenatide.....	41
estradiol 0.1% (1 mg) gel pkt (Divigel)	109	EXJADE.....	162
estradiol 0.5 mg tablet.....	109	EXODERM	40
estradiol 1 mg tablet	109	EYSUVIS	95

Index of Medications

E-Z.....	91, 92	FIBRICOR (fenofibric acid).....	81
EZ.....	121, 122	fidaxomicin (Difacid).....	33
ezetimibe.....	80	FIFTY50.....	122
ezetimibe/simvastatin (Vytorin).....	78	FIFTY50 SAFETY SEAL LANCETS.....	129
EZ-LETS.....	129	FILSPARI.....	81
EZ SMART LANCETS.....	129	FILSUVEZ.....	165
F		FILTER.....	126
FABHALTA.....	69	FILTER ASPIRATOR NEEDLE.....	126
FACTIVE.....	34	finasteride.....	166
famciclovir.....	62	FINGERSTIX.....	122, 129
famotidine.....	105	fingolimod hcl (Gilenya).....	82
FARESTON.....	55	FINTEPLA.....	84
FARXIGA.....	43	FIORICET.....	15
febuxostat.....	25	FIORINAL.....	15
febuxostat 40 mg tablet (Uloric).....	25	FIRDAPSE.....	83
felbamate (Felbatol).....	84	FLAGYL.....	31
FELDENE.....	25	flavoxate.....	166
felodipine.....	72	flecainide acetate.....	71
FEMARA.....	50	FLEXICHAMBER.....	134
FEMCAP.....	89	FLORIVA.....	168
fenofibrate 40 mg tablet (Fenoglide).....	80	FLOW-EZE.....	126
fenofibrate 43 mg capsule.....	80	FLUAD 2025-2026.....	67
fenofibrate 48 mg tablet (Tricor).....	81	FLUAD QUAD 2022-2023.....	67
FENOFIBRATE 50 MG CAPSULE.....	81	FLUAD QUAD 2023-2024.....	67
fenofibrate 54 mg tablet.....	81	FLUAD TRIVALENT 2024-2025.....	67
fenofibrate 67 mg capsule.....	81	FLUARIX 2025-2026.....	67
fenofibrate 120 mg tablet (Fenoglide).....	80	FLUARIX QUAD 2022-2023.....	67
fenofibrate 130 mg capsule.....	80	FLUARIX QUAD 2023-2024.....	67
fenofibrate 134 mg capsule.....	80	FLUARIX TRIVALENT 2024-2025.....	67
fenofibrate 145 mg tablet (Tricor).....	80	FLUBLOK 2025-2026.....	67
FENOFIBRATE 150 MG CAPSULE.....	80	FLUBLOK QUAD 2022-2023.....	67
fenofibrate 160 mg tablet.....	80	FLUBLOK QUAD 2023-2024.....	67
fenofibrate 200 mg capsule.....	80	FLUBLOK TRIVALENT 2024-2025.....	67
fenofibric acid.....	81	FLUCELVAX 2025-2026 SYRINGE.....	67
fenofibric acid (choline).....	81	FLUCELVAX 2025-2026 VIAL.....	67
fenofibric acid (Fibricor).....	81	FLUCELVAX QUAD 2022-2023.....	67
FENOPROFEN.....	26	FLUCELVAX QUAD 2023-2024.....	67
fentanyl.....	21	FLUCELVAX TRIVALENT 2024-2025.....	67
fentanyl citrate.....	21	fluconazole.....	39
FENTANYL CITRATE.....	21	fluconazole (Diflucan).....	39
FERIVA 21-7.....	100	flucytosine.....	39
FERRALET 90.....	100	fludrocortisone acetate.....	111
FERRIPROX.....	162	FLULAVAL 2025-2026.....	68
FERRIPROX 100 MG/ML SOLUTION.....	162	FLULAVAL QUAD 2022-2023.....	68
ferrous fumarate/folic acid (Hemocyte-F).....	100	FLULAVAL QUAD 2023-2024.....	68
ferrous fum/vit c/b12-if/folic.....	100	FLULAVAL TRIVALENT 2024-2025.....	68
fesoterodine er 4 mg tablet (Toviaz).....	166	FLUMADINE.....	62
fesoterodine er 8 mg tablet (Toviaz).....	166	FLUMIST 2025-2026.....	68
FEXMID.....	136	FLUMIST HOME 2025-2026.....	68

Index of Medications

FLUMIST QUAD 2022-2023.....	68	folic acid.....	167
FLUMIST QUAD 2023-2024.....	68	folic acid/vit bcomp,c/cu/zinc.....	168
FLUMIST TRIVALENT 2024-2025.....	68	folic acid/vit b complex and c.....	168
fluocinolone acetonide.....	95, 154	folic/mvi ther-min/lycop/lut.....	167
fluocinolone/shower cap.....	154	fondaparinux 2.5 mg/0.5 ml syr (Arixtra).....	37
fluocinonide.....	154	fondaparinux 5 mg/0.4 ml syr (Arixtra).....	37
fluocinonide/emollient base.....	154	fondaparinux 7.5 mg/0.6 ml syr (Arixtra).....	37
fluocinonide (Vanos).....	154	fondaparinux 10 mg/0.8 ml syr (Arixtra).....	37
fluorescein.....	91, 96	FONDCIRCLE CONTROL SOLUTION.....	116
FLUORESC EIN-BENOXINATE.....	96	FONDCIRCLE LANCET.....	122, 129
fluoride.....	98	FONDCIRCLE LANCING DEVICE.....	116
fluoride (sodium).....	98, 99	FORA.....	122
fluoride (sodium) (Prevident).....	99	FORA 6 CONNECT MULTIFUNCTN MTR.....	116
fluoride (sodium) (Prevident 5000 Plus).....	99	FORACARE.....	122
FLUORIDEX.....	98, 99	FORACARE GDH.....	117
FLUORIMAX 5000.....	98, 99	FORACARE LANCETS.....	130
FLUORIMAX 5000 SENSITIVE.....	98	FORA CONTROL SOLUTION.....	117
fluorometholone (Fml).....	95	FORA GTEL KETONE TEST STRIP.....	91
FLUOROPLEX.....	55	FORA GTEL MULTIFUNCTN MONITOR.....	117
fluorouracil.....	55	FORA KETONE CONTROL SOLUTION.....	117
FLUOROURACIL.....	55	FORA LANCETS.....	129
fluorouracil (Efudex).....	55	FORA LANCING DEVICE.....	117
fluoxetine.....	140, 147	FORA TN'G ADVANCE PRO MONITOR.....	117
fluoxetine 20 mg/5 ml soln cup.....	140	FORA TN'G ADV VOICE KETO STRIP.....	91
fluoxetine 20 mg/5 ml solution.....	140	FORA TN'GO ADVANCE MULTIFN MTR.....	117
fluoxetine hcl 10 mg tablet.....	140	FORA TN'GO ADV MOBILE MULT MTR.....	117
fluphenazine.....	147	FORA V10-V12-D10-D20 STRP-LNCT.....	129
flurazepam.....	147	formoterol fumarate (Perforomist).....	28
flurbiprofen.....	26, 95	FORTAVIT.....	167
flutamide (Eulexin).....	48	FORTISCARE.....	117
fluticasone prop 0.05% cream.....	154	FOSAMAX.....	164
fluticasone prop 0.05% lotion.....	154	fosamprenavir calcium.....	61
fluticasone prop 0.005% oint.....	154	fosaprepitant dimeglumine.....	103
fluticasone propionate.....	154	fosaprepitant dimeglumine (Emend).....	103
fluticasone propion/salmeterol (Advair Diskus).....	28	fosfomycin tromethamine.....	32
fluticasone-salmeterol.....	28	fosinopril/hydrochlorothiazide.....	75
fluvastatin.....	79	fosinopril sodium.....	76
fluvastatin sodium (Lescol XI).....	79	Fotivda.....	51
fluvoxamine.....	140, 141	FRAGMIN 2,500 UNIT/0.2 ML SYR.....	37
FLUZONE 2025-2026 SYRINGE.....	68	FRAGMIN 5,000 UNIT/0.2 ML SYR.....	37
FLUZONE 2025-2026 VIAL.....	68	FRAGMIN 7,500 UNIT/0.3 ML SYR.....	37
FLUZONE HIGH-DOSE 2025-2026.....	68	FRAGMIN 10,000 UNIT/4 ML VIAL.....	37
FLUZONE HIGH-DOSE QUAD 2022-23.....	68	FRAGMIN 10,000 UNIT/ML SYRINGE.....	37
FLUZONE HIGH-DOSE QUAD 2023-24.....	68	FRAGMIN 12,500 UNIT/0.5 ML SYR.....	37
FLUZONE HIGH-DOSE TRIV 2024-25.....	68	FRAGMIN 15,000 UNIT/0.6 ML SYR.....	37
FLUZONE QUAD 2022-2023.....	68	FRAGMIN 18,000 UNIT/0.72 ML.....	37
FLUZONE QUAD 2023-2024.....	68	FRAGMIN 95,000 UNIT/3.8 ML VL.....	37
FLUZONE TRIVALENT 2024-2025.....	68	FRAICHE 5000 PREVI.....	98
FOCALIN.....	143	FREESTYLE.....	91, 122

Index of Medications

FREESTYLE CONTROL SOLUTION.....	117	GELFOAM (gelatin sponge,absorb/porcine)	70
FREESTYLE INSULINX TEST STRIPS.....	91	gemfibrozil (Lopid)	81
FREESTYLE LANCETS.....	122, 130	GENOTROPIN.....	110
FREESTYLE LIBRE 2 PLUS SENSOR	117	gentamicin sulfate.....	31, 36
FREESTYLE LIBRE 2 READER.....	117	GENTEEL VACUUM LANCING DEVICE.....	117
FREESTYLE LIBRE 2 SENSOR.....	117	GENVOYA.....	61
FREESTYLE LIBRE 3 PLUS SENSOR	117	GILOTRIF	51
FREESTYLE LIBRE 3 READER	117	glatiramer acetate (Copaxone)	82
FREESTYLE LIBRE 3 SENSOR.....	117	GLEOSTINE.....	47
FREESTYLE LIBRE 14 DAY READER	117	glimepiride.....	43
FREESTYLE LIBRE 14 DAY SENSOR.....	117	glimepiride 1 mg tablet	42
FREESTYLE LITE TEST STRIP	91	glimepiride 2 mg tablet	42
FREESTYLE PRECISION NEO.....	91	GLIMEPIRIDE 3 MG TABLET	42
FREESTYLE TEST STRIPS.....	91	glimepiride 4 mg tablet.....	42
FREESTYLE UNISTIK 2	130	glipizide	43
frovatriptan succinate (Frova)	19	GLIPIZIDE 2.5 MG TABLET	42
FRUZAQLA	51	glipizide 5 mg tablet.....	42
FT ISOPROPYL ALCOHOL 91%	163	glipizide 10 mg tablet.....	42
FT ISOPROPYL RUB ALCOHOL 70%	163	glipizide (Glucotrol XI)	42
ful-glo 1 mg oph strip.....	91	glucagon.....	98
FUL-GLO EYE STRIPS.....	91	GLUCAGON 1 MG EMERGENCY KIT	98
FULPHILA.....	87	GLUCOCARD 01 CONTROL.....	117
FURADANTIN.....	33	GLUCOCARD EXPRESSION CNTRL SLN	117
furosemide.....	93	GLUCOCARD SHINE CONTROL SOLN	117
FUSION PLUS.....	100	GLUCOCOM	122, 130
FUZEON.....	60	GLUCOCOM AUTOLINK	117
FYCOMPA	84	GLUCOCOM CONTROL SOLUTION	117
FYLNETRA	87	GLUCOCOM LANCETS	130
G		GLUCOSE CONTROL.....	117
gabapentin.....	84	GLUCOSE CONTROL SOLUTION.....	117
gabapentin (Gralise).....	83	GLUCOTROL XL (glipizide).....	42
GALAFOLD	162	GLUTOL.....	99
galantamine.....	64	glyburide	42, 43
galantamine er 8 mg capsule.....	63	glyburide,micronized.....	42
galantamine er 16 mg capsule	63	glyburide,micronized (Glynase)	42
galantamine er 24 mg capsule	63	GLYCATE.....	102
GALZIN	162	glycerol phenylbutyrate.....	102
GARDASIL	69	glycine urologic solution	46
GASTROGRAFIN (diatrizoate meglumine, sodium).....	92	glycopyrrolate 1 mg/5 ml soln (Cuvposa).....	102
GASTROMARK.....	92	glycopyrrolate 1 mg tablet (Robinul).....	102
gatifloxacin	31	glycopyrrolate 2 mg tablet (Robinul Forte).....	102
GATTEX.....	107	GLYNASE (glyburide,micronized).....	42
GAVRETO	51	GLYXAMBI	43
GE100 CONTROL SOLUTION NORMAL	117	GNP ISOPROPYL ALCOHOL 70%	163
gefitinib (Iressa).....	51	GNP ISOPROPYL ALCOHOL 91%	163
gelatin sponge, absorb/porcine	70	gnp isopropyl alcohol 99%	163
GELCLAIR.....	160	GOJJI	122
GELFILM	96	GOJJI BLOOD KETONE TEST STRIP	91
GELFOAM.....	70	GOJJI GLUCOSE CONTROL SOLUTION	117

Index of Medications

GOJJI KETONE CONTROL SOLUTION.....	117	HEPARIN SOD 5,000 UNIT/0.5 ML.....	38
GOJJI LANCET-GLUCOSE TEST STRP	130	heparin sod 5,000 unit/ml syrg	38
GOJJI LANCETS	130	HEPARIN SOD 5,000 UNIT/ML SYRG.....	38
GOJJI LANCING DEVICE.....	117	heparin sod 5,000 unit/ml vial.....	38
GOJJI MULTI-FUNCTIONAL METER.....	117	heparin sod 10,000 unit/ml vl.....	38
GOMEKLI	49	heparin sod 20,000 unit/ml vl.....	38
GRALISE ER 300 MG TABLET (gabapentin)	83	HEPLISAV-B.....	69
GRALISE ER 600 MG TABLET (gabapentin).....	83	HETLIOZ	147
granisetron.....	103	HIBERIX	68
GRANIX.....	87	HISTEX-AC	90
GRASTEK.....	65	hm isopropyl alcohol 70%.....	163
griseofulvin.....	40	hm isopropyl alcohol 91%.....	163
griseofulvin ultra 125 mg tab.....	39	homatropine.....	97
griseofulvin ultra 165 mg tab	39	HPR PLUS-MB HYDROGEL	152
griseofulvin ultra 250 mg tab	40	HUMALOG.....	44
GS ISOPROPYL ALCOHOL 70%.....	163	HUMALOG JUNIOR KWIKPEN	44
GS ISOPROPYL ALCOHOL 70% SPRAY	46	HUMALOG KWIKPEN U-100	44
GS ISOPROPYL ALCOHOL 91%.....	163	HUMALOG KWIKPEN U-200	44
GUAIACOL	152	HUMALOG TEMPO PEN U-100	44
GUAIFENESIN-CODEINE	90	HUMIRA	46, 47
guanfacine	77, 143	HUMIRA(CF) 10 MG/0.1 ML SYRING.....	47
GUARDIAN RT CHARGER	117	HUMIRA(CF) 20 MG/0.2 ML SYRING.....	47
GUARDIAN TEST PLUG.....	117	HUMIRA(CF) 40 MG/0.4 ML SYRING	47
GUARDIAN TRANSMITTER TAPE	118	HUMIRA(CF) PEN 40 MG/0.4 ML	47
GYNAZOLE	39	HUMIRA(CF) PEN 80 MG/0.8 ML.....	47
H		HUMIRA(CF) PEN CROHN'S-UC-HS.....	47
HAEGARDA	161	HUMIRA(CF) PEN PSOR-UV-ADOL HS	47
halcinonide 0.1% solution	154	HUMULIN.....	44
HALCION (triazolam).....	147	HUMULIN 70-30.....	44
halobetasol propionate.....	154	HUMULIN 70/30 KWIKPEN	44
haloperidol.....	146	HUMULIN N.....	44
HARVONI.....	63	HUMULIN N KWIKPEN	44
HEALTHPRO GLUCOSE CONTROL SOLN.....	118	HUMULIN R.....	44
HEALTHY	122	HYCANTIN	50
HEALTHY ACCENTS AUTOLET	118	HYCODAN 5 MG-1.5 MG/5 ML CUP.....	90
HEALTHY ACCENTS UNILET LANCET	130	HYCODAN 5 MG-1.5 MG/5 ML SOLN (hydrocodone bit/homatrop me-br).....	90
HEMA-COMBISTIX	93	HYCODAN 5 MG-1.5 MG TABLET (hydrocodone bit/homatrop me-br).....	90
HEMATRON-AF	100	hydralazine	77
HEMAX.....	100	HYDREA	47
HEMLIBRA.....	70	hydrochlorothiazide.....	74, 75, 77, 78, 94
HEMOCYTE-F (ferrous fumarate/folic acid).....	100	hydrocodone/acetaminophen	20
HEMOCYTE PLUS (mv-mins no.73/iron fum/folic).....	100	HYDROCODONE-ACETAMINOPHEN	21
heparin.....	37, 38	hydrocodone/acetaminophen (Lortab)	20
heparin 2,000 unit/2 ml vial.....	37	hydrocodone bitartrate.....	21
heparin 40,000 unit/4 ml vial.....	38	hydrocodone bit/homatrop me-br.....	90
heparin 50,000 unit/5 ml vial.....	38	hydrocodone/chlorphen p-stirex	90
heparin 50,000 unit/10 ml vial.....	38	hydrocodone-homatrop 5 ml cup.....	90
heparin sod 1,000 unit/ml vial.....	38		
heparin sod 5,000 unit/0.5 ml	38		

Index of Medications

hydrocodone-homatropine 5-1.5 (Hycodan)	90	IMBRUVICA 280 MG TABLET	52
hydrocodone-homatropine soln (Hycodan)	90	IMBRUVICA 420 MG TABLET	52
hydrocodone/ibuprofen	21	IMCIVREE	56
hydrocortisone	95, 107, 154, 155	imipramine	142, 143
hydrocortisone acetate	107, 154	imiquimod 5% cream packet	152
hydrocortisone acetate (Anusol-Hc)	107	IMKELDI	52
hydrocortisone/acetic acid	95	IMPAVIDO	45
hydrocortisone (Anusol-Hc)	154	INBRIJA	57
hydrocortisone buty 0.1% cream	155	INCONTROL	122
hydrocortisone butyr 0.1% oint	155	INCONTROL ALCOHOL PADS	148, 151
hydrocortisone butyr 0.1% soln	155	INCONTROL LANCING DEVICE	118
hydrocortisone (Cortef)	110	INCONTROL SUPER THIN LANCETS	130
hydrocortisone/lidocaine/aloe	107	INCONTROL ULTRA THIN LANCETS	130
hydrocortisone/pramoxine	105, 107, 155	INCRELEX	110
hydrocortisone/pramoxine (Analpram Hc)	105, 107	INCRUSE ELLIPTA	27
hydrocortisone valerate	155	indapamide	94
hydrogen peroxide	149	INDICLOR	92
hydromorphone hcl	21	indomethacin	26
hydroxychloroquine sulfate	45	indomethacin 25 mg/5 ml susp (Indocin)	26
hydroxyurea	47	indomethacin 25 mg capsule	26
hydroxyzine	41	indomethacin 50 mg capsule	26
HYFTOR	113	indomethacin 50 mg suppository (Indocin)	26
HYMPAVZI	70	INFANRIX	68
hyoscyamine sulfate	104	INFASURF	158
HYPER-SAL	161	INFINITY CONTROL SOLUTION	118
HYPODERMIC	126	INFINITY VOICE CONTROL SOLN	118
HYPOLANCE	118	INGREZZA	82
HYSINGLA ER (hydrocodone bitartrate)	21	INJECT	122
I		INJECT EASE LANCETS	130
ibandronate	164	INLYTA	52
IBRANCE 75 MG CAPSULE	51	INOVA	152
IBRANCE 75 MG TABLET	51	INPEN (FOR HUMALOG)	118
IBRANCE 100 MG CAPSULE	52	INPEN (FOR NOVOLOG OR FIASP)	118
IBRANCE 100 MG TABLET	52	INQOVI	48
IBRANCE 125 MG CAPSULE	52	INREBIC	52
IBRANCE 125 MG TABLET	52	INSTACLEAN	163
IBTROZI	52	INSUL-CAP	118
ibuprofen	21, 26	INSUL-EZE	118
icatibant acetate (Firazyr)	159	INSULIN LISPRO	44
icosapent ethyl	102	INSULIN LISPRO JUNIOR KWIKPEN	44
IDHIFA	54	INSULIN LISPRO KWIKPEN U-100	44
IFE-BIMIX 30/1	159	INSULIN LISPRO PROTAMINE MIX	44
IHEALTH CONTROL SOLN LEVEL 2	118	INSULIN SYR 0.5 ML 28G 12.7MM	127
ILEVRO	95	INSULIN SYRINGE 1 ML 27G 16MM	127
imatinib mesylate	52	INSULIN SYRINGE 1ML 28G 12.7MM	127
IMBRUVICA 70 MG CAPSULE	52	INSULIN SYRINGE U-500	127
IMBRUVICA 70 MG/ML SUSPENSION	52	INTEGRA F (iron fum,ps/folic acid/vitc/b3)	100
IMBRUVICA 140 MG CAPSULE	52	INTEGRA NEEDLE	126
IMBRUVICA 140 MG TABLET	52	INTEGRA PLUS (iron fum,ps/folic/bcomp,c no.9)	100

Index of Medications

INTEGRA PRECISIONGLIDE NEEDLE	126	isosorbide mononitrate.....	73
INTELENCE 25 MG TABLET	60	isotretinoin (Absorica)	150
INTRAROSA.....	107	isoxsuprine.....	78
INVACARE.....	122	isradipine.....	72
INVACARE LANCETS.....	130	ITOVEBI.....	52
iodine/potassium iodide.....	155	itraconazole.....	39
iodine/sodium iodide.....	155	itraconazole (Sporanox)	39
IODOFLEX.....	156	ivabradine	73
IODOSORB.....	156	ivermectin	45
IPOL	66	ivermectin 1% cream (Soolantra).....	152
ipratropium/albuterol sulfate.....	28	ivermectin 3 mg tablet (Stromectol).....	45
ipratropium bromide	27, 94	ivermectin 6 mg tablet.....	45
IQIRVO	160	IWILFIN.....	52
irbesartan	76	J	
irbesartan (Avapro).....	76	JAKAFI	49
irbesartan/hydrochlorothiazide (Avalide).....	75	JANSSEN COVID-19 VACCINE (EUA).....	65
IRESSA (gefitinib).....	52	JANUMET	43
iron aspgly/c/b12/fa/ca-th/suc.....	100	JANUVIA	42
iron aspgly,ps/c/b12/fa/ca/suc.....	100	JARDIANCE	43
iron bg,ps/vitc/b12/fa/calcium.....	100	javygtor 100 mg powder packet (Kuvan)	162
iron/c/folic acd/mv cmb11/calc.....	100	javygtor 100 mg tablet (Kuvan)	162
iron/folic acid/b12/c/docusate	100	javygtor 500 mg powder packet (Kuvan).....	162
iron/folic acid/c/b6/b12/zinc	100	JAYPIRCA 50 MG TABLET.....	52
iron/folic ac/vit bcomp,c/min.....	100	JAYPIRCA 100 MG TABLET.....	52
iron fum,ag/c/b12/folic/ca/suc.....	100	JOENJA.....	158
iron fumarate/vit c/vit b12/fa.....	100	JULUCA.....	59
iron fum,ps/folic acid/vitc/b3 (Integra F).....	100	JUST RIGHT 5000	98, 99
iron fum,ps/folic/bcomp,c no.9 (Integra Plus)	100	JYLAMVO	48
iron ps complex/b12/folic acid	100	JYNNEOS	69
IROSPAN.....	100	K	
ISENTRESS.....	61	KERENDIA.....	94
isoflurane.....	23	KESIMPTA	83
isoniazid.....	32	ketoconazole.....	39, 40
ISOPROPANOL	163	ketoconazole (Extina)	40
isopropyl 70% alcohol	163	KETO-DIASTIX REAGENT.....	93
isopropyl alcohol.....	163	KETONE CARE TEST STRIP	92
isopropyl alcohol 70%	163	KETONE TEST STRIP.....	92
ISOPROPYL ALCOHOL 70%	163	ketoprofen 50 mg capsule.....	26
ISOPROPYL ALCOHOL 70% SPRAY	46	ketoprofen 75 mg capsule	26
isopropyl alcohol 91%.....	163	ketoprofen er 200 mg capsule.....	26
isopropyl alcohol 99%.....	163	ketorolac.....	20, 95
isopropyl rubbing alcohol 70%.....	163	KETOSTIX REAGENT.....	92
ISOPROPYL RUBBING ALCOHOL 70%	163	KEVZARA.....	113
ISOPROPYL RUBBING ALCOHOL 91%.....	163	KINRIX.....	68
isosorbide.....	78	KISQALI	50
isosorbide dinitrate 5 mg tab (Isordil Titradose).....	73	KISQALI 200 MG DAILY DOSE.....	52
isosorbide dinitrate 10 mg tab.....	73	KISQALI 400 MG DAILY DOSE	52
isosorbide dinitrate 20 mg tab.....	73	KISQALI 600 MG DAILY DOSE	52
isosorbide dinitrate 30 mg tab.....	73	KISQALI FEMARA.....	50

Index of Medications

KITABIS.....	31	latanoprost (Xalatan)	96
KLARON	150	LAZANDA.....	22
KLONOPIN	84	LAZCLUZE.....	52
Kloxxado.....	38	leflunomide.....	24
KOSELUGO	49	lenalidomide.....	50
KOSELUGO 5 MG SPRINKLE CAPSULE	49	LENVIMA	52
KOSELUGO 7.5 MG SPRINKLE CAP	49	LEQSELVI	165
KOSHER PRENATAL PLUS IRON.....	136	letrozole.....	49
K-PHOS.....	101	leucovorin calcium.....	159
KRINTAFEL	45	LEUKERAN.....	47
kro isopropyl alcohol 91%.....	163	LEUKINE	87
KYLEENA.....	89	levalbuterol hcl	28
L		levalbuterol hcl (Xopenex Concentrate)	28
labetalol hcl 100 mg tablet	75	levetiracetam 1,000mg/10ml cup (Keppra).....	85
labetalol hcl 200 mg tablet	75	levetiracetam 1,000 mg tablet (Keppra)	85
labetalol hcl 300 mg tablet	75	levetiracetam 100 mg/ml soln (Keppra).....	85
LABETALOL HCL 400 MG TABLET	75	levetiracetam 250 mg tablet (Keppra)	85
LABSTIX REAGENT	93	LEVETIRACETAM 250 MG TAB SUSP	85
lacosamide (Vimpat)	84	levetiracetam 500 mg/5 ml cup	85
LACRISERT	95	levetiracetam 500 mg/5 ml soln.....	85
lactulose	102, 106	levetiracetam 500 mg tablet (Keppra)	85
lactulose 10 gm/15 ml soln cup	106	levetiracetam 750 mg tablet (Keppra).....	85
lactulose 20 gm/30 ml soln cup	106	levetiracetam (Keppra)	85
lactulose 20 gm packet	106	levetiracetam (Keppra Xr).....	85
LAGEVRIO (EUA).....	62	levobunolol	96
lamivudine	63	levocarnitine.....	101
lamivudine 10 mg/ml oral soln (Epivir).....	60	levocarnitine (Carnitor).....	164
lamivudine 150 mg tablet (Epivir).....	60	levocarnitine (Carnitor Sf).....	164
lamivudine 300 mg/30ml sol cup (Epivir)	60	levocarnitine (with sugar) (Carnitor).....	164
lamivudine 300 mg tablet (Epivir).....	60	levofloxacin.....	31, 34
lamivudine/zidovudine (Combivir)	60	levonorgest.....	89
lamotrigine (Lamictal)	85	LEVOTHYROXINE 13 MCG CAPSULE	157
lamotrigine (Lamictal (Blue))	84	LEVOTHYROXINE 25 MCG CAPSULE	157
lamotrigine (Lamictal (Green))	84	levothyroxine 25 mcg tablet (Synthroid)	157
lamotrigine (Lamictal Odt).....	85	LEVOTHYROXINE 50 MCG CAPSULE.....	157
lamotrigine (Lamictal Odt (Blue)).....	85	levothyroxine 50 mcg tablet (Synthroid).....	157
lamotrigine (Lamictal Odt (Green)).....	85	LEVOTHYROXINE 75 MCG CAPSULE.....	157
lamotrigine (Lamictal Odt (Orange))	85	levothyroxine 75 mcg tablet (Synthroid)	157
lamotrigine (Lamictal (Orange)).....	84	LEVOTHYROXINE 88 MCG CAPSULE	158
lamotrigine (Lamictal Xr).....	85	levothyroxine 88 mcg tablet (Synthroid)	158
LAMPIT.....	45	LEVOTHYROXINE 100 MCG CAPSULE	157
lancets.....	122, 130	levothyroxine 100 mcg tablet (Synthroid).....	157
LANCETS.....	120, 121, 122, 130	LEVOTHYROXINE 112 MCG CAPSULE.....	157
LANCING DEVICE	118	levothyroxine 112 mcg tablet (Synthroid).....	157
LANCING SYSTEM	118	LEVOTHYROXINE 125 MCG CAPSULE	157
lansoprazole/amoxicilin/clarith	104	levothyroxine 125 mcg tablet (Synthroid).....	157
lanthanum carbonate	99	LEVOTHYROXINE 137 MCG CAPSULE	157
LANZO	118	levothyroxine 137 mcg tablet (Synthroid).....	157
lapatinib ditosylate.....	52	LEVOTHYROXINE 150 MCG CAPSULE.....	157

Index of Medications

levothyroxine 150 mcg tablet (Synthroid)	157	LITEAIRE.....	134
LEVOTHYROXINE 175 MCG CAPSULE	157	LITETOUCH.....	134
levothyroxine 175 mcg tablet (Synthroid).....	157	LITE TOUCH 28G LANCETS.....	122, 130
LEVOTHYROXINE 200 MCG CAPSULE	157	LITE TOUCH 30G LANCETS.....	122, 130
levothyroxine 200 mcg tablet (Synthroid).....	157	LITE TOUCH 33G LANCETS.....	122, 130
levothyroxine 300 mcg tablet (Synthroid).....	157	LITE TOUCH LANCING PEN.....	118
levothyroxine sodium (Synthroid).....	158	LITFULO.....	165
LEVSIN (hyoscyamine sulfate).....	104	LITHOSTAT.....	102
LEVULAN	55	LIVTENCITY	62
lidocaine	23, 155	l-norgest/e.estradiol-e.estrad.....	89
lidocaine 5% ointment.....	23	LODINE	26
lidocaine 5% patch (Lidocan li).....	23	lofexidine hcl (Lucemyra).....	165
lidocaine 5% patch (Lidoderm).....	23	LOKELMA	99
lidocaine hcl	23	LOMAIRA.....	56
lidocaine hcl/glycerin	91	lomustine.....	47
LIDOCAINE-HYDROCORTISONE	107	LONSURF	48
lidocaine/hydrocortisone ac.....	107	loperamide.....	103
LIFESHIELD BLUNT CANNULA	126	LOPID (gemfibrozil)	81
LIKMEZ.....	31	lopinavir/ritonavir	61
LILETTA.....	89	lopinavir/ritonavir (Kaletra).....	61
lindane	57	LOPROX 0.77% SUSPENSION KIT	40
linezolid.....	34	LOPROX 0.77% TOPICAL SUSP (ciclopirox olamine).....	40
LINZESS.....	105	lorazepam	139
liothyronine sodium (Cytomel).....	158	lorazepam (Ativan)	139
LIPOFEN	81	LORBRENA 25 MG TABLET	52
LIQUID E-Z PAQUE.....	92	LORBRENA 100 MG TABLET	52
LIQUID POLIBAR PLUS	92	LORTAB (hydrocodone/acetaminophen).....	21
liraglutide 2-pak 18 mg/3 ml (Victoza 2-Pak).....	41	losartan/hydrochlorothiazide (Hyzaar)	75
liraglutide 2-pak 18 mg/3 ml (Victoza 3-Pak).....	41	losartan potassium (Cozaar).....	76
liraglutide 3-pak 18 mg/3 ml (Victoza 2-Pak).....	41	loteprednol etabonate	95
liraglutide 3-pak 18 mg/3 ml (Victoza 3-Pak).....	41	loteprednol etabonate (Lotemax).....	95
liraglutide 5-pak 18 mg/3 ml (Saxenda).....	56	lovastatin.....	79
liraglutide 18 mg/3 ml pen (Saxenda).....	56	loxapine	146
lisdexamfetamine 10 mg capsule (Vyvanse)	143	lubiprostone (Amitiza).....	106
lisdexamfetamine 10 mg tb chew (Vyvanse)	143	LUCEMYRA (lofexidine hcl).....	165
lisdexamfetamine 20 mg capsule (Vyvanse)	143	LULICONAZOLE	40
lisdexamfetamine 20 mg tb chew (Vyvanse).....	143	LUMAKRAS.....	49
lisdexamfetamine 30 mg capsule (Vyvanse)	143	LUMRYZ.....	147
lisdexamfetamine 30 mg tb chew (Vyvanse).....	143	LUPKYNIS.....	113
lisdexamfetamine 40 mg capsule (Vyvanse)	143	lurasidone.....	145
lisdexamfetamine 40 mg tb chew (Vyvanse)	143	LYNPARZA	52
lisdexamfetamine 50 mg capsule (Vyvanse)	143	LYRICA 20 MG/ML ORAL SOLUTION (pregabalin).....	85
lisdexamfetamine 50 mg tb chew (Vyvanse).....	143	LYSODREN.....	55
lisdexamfetamine 60 mg capsule (Vyvanse)	143	LYTGOBI.....	52
lisdexamfetamine 60 mg tb chew (Vyvanse)	143	LYUMJEV	44
lisdexamfetamine 70 mg capsule (Vyvanse)	143	LYUMJEV TEMPO PEN U-100.....	44
lisinopril	76	M	
lisinopril/hydrochlorothiazide (Zestoretic).....	75	MACROBID (nitrofurantoin monohyd/m-cryst)	33
lissamine green.....	91		

Index of Medications

MACUVEX	167	meperidine hcl.....	22
MACUZIN.....	167	MEPHYTON (phytonadione (vit k1))	169
mafenide	36	meprobamate	139
MAGNEBIND 400	99	mercaptopurine 20 mg/ml suspen (Purixan).....	48
MALARONE	45	mercaptopurine 50 mg tablet	48
malathion (Ovide)	57	mesalamine	104, 105
maraviroc	60	mesalamine 4 gm/60 ml kit (Rowasa).....	104
MAR-COF CG	90	mesalamine (Apriso)	105
MARNATAL-F	136	mesalamine (Pentasa).....	105
MARPLAN	139	mesna (Mesnex).....	159
MATULANE	55	MESNEX (mesna).....	159
MAVENCLAD.....	83	metaxalone 400 mg tablet.....	136
MAXI-TUSS CD.....	90	metaxalone 800 mg tablet.....	136
meclofenamate sodium	26	metformin	42, 43
MEDI-FIRST ISOPROPYL ALCOHOL	46	metformin hcl	42
MEDIHONEY	153	metformin hcl 1,000 mg tablet.....	42
MEDISENSE	118, 122	metformin hcl 500 mg/5 ml cup (Riomet).....	42
MEDISENSE GLUCOSE KETONE	118	metformin hcl 500 mg/5 ml soln (Riomet).....	42
MEDISENSE GLUCOSE KETONE CONTR	118	metformin hcl 500 mg tablet	42
MEDISENSE THIN LANCETS.....	130	metformin hcl 750 mg tablet.....	42
MEDLANCE.....	123	metformin hcl 850 mg tablet.....	42
MEDLANCE PLUS	130	methadone hcl.....	22
MEDLANCE PLUS SPECIAL BLADE	130	methamphetamine hcl (Desoxyn)	64
MEDROL	110	METHAVER	168
MEDROL (methylprednisolone)	110	methazolamide.....	93
medroxyprogesterone.....	111	methenamine hippurate	32
medroxyprogesterone 150 mg/ml (Depo-Provera).....	88	methenamine mandelate	32
MEDTRONIC REMOTE CONTROL	118	methimazole.....	157
mefloquine.....	45	METHITEST	107
megestrol 20 mg tablet.....	55	methocarbamol.....	136
megestrol 40 mg tablet.....	55	methocarbamol 1,000 mg tablet.....	136
megestrol 400 mg/10 ml cup.....	167	methocarbamol 500 mg tablet.....	136
megestrol 625 mg/5 ml susp.....	167	methocarbamol 750 mg tablet	136
megestrol acet 40 mg/ml susp	167	methotrexate.....	48
megestrol acet 400 mg/10 ml.....	167	methotrexate 2.5 mg tablet.....	48
MEKINIST.....	49	methotrexate 50 mg/2 ml vial.....	48
meloxicam 7.5 mg tablet	26	methotrexate 250 mg/10 ml vial	48
meloxicam 15 mg tablet.....	26	methoxsalen.....	150
melphalan	47	methscopolamine bromide.....	104
memantine.....	81	methsuximide (Celontin).....	85
MEMANTINE HCL.....	81	methyldopa	77
memantine hcl/donepezil hcl (Namzaric).....	81	methyldopa/hydrochlorothiazide.....	77
memantine hcl er 7 mg capsule (Namenda Xr)	81	methylergonovine maleate.....	111
memantine hcl er 21 mg capsule.....	81	METHYLIN.....	143
MENACTRA.....	66	methylphenidate.....	143, 144
MENEST	109	methylphenidate er 10 mg cap (Aptensio Xr)	143
MENOSTAR.....	109	methylphenidate er 15 mg cap (Aptensio Xr).....	143
MENQUADFI.....	66	methylphenidate er 18 mg tab (Concerta).....	144
MENVEO.....	66	methylphenidate er 18 mg tab (Relexxii)	144

Index of Medications

methylphenidate er 20 mg cap (Aptensio Xr)	144	MICRODOT NORMAL CONTROL SOLUT	118
methylphenidate er 27 mg tab (Concerta)	144	MICROLET	123, 130
methylphenidate er 27 mg tab (Relexxii)	144	MICROLET 2	118
methylphenidate er 30 mg cap (Aptensio Xr)	144	MICROLET NEXT LANCING DEVICE	118
methylphenidate er 36 mg tab (Concerta)	144	MICROSPACER	134
methylphenidate er 36 mg tab (Relexxii)	144	MICROTAINER LANCETS	130
methylphenidate er 40 mg cap (Aptensio Xr)	144	MICRO THIN LANCET	123, 130
methylphenidate er 50 mg cap (Aptensio Xr)	144	MICRO THIN LANCETS	130
methylphenidate er 54 mg tab (Concerta)	144	midazolam hcl	148
methylphenidate er 54 mg tab (Relexxii)	144	midodrine	64
methylphenidate er 60 mg cap (Aptensio Xr)	144	MIEBO	95
methylphenidate er 72 mg tab	144	MIFEPREX	160
methylphenidate er(la) 10mg cp (Ritalin La)	144	mifepristone 200 mg tablet	160
methylphenidate er(la) 20mg cp (Ritalin La)	144	mifepristone 300 mg tablet (Korlym)	43
methylphenidate er(la) 30mg cp (Ritalin La)	144	miglitol	42
methylphenidate er(la) 40mg cp (Ritalin La)	144	miglustat	161
methylphenidate er(la) 60mg cp	144	MINI LANCING DEVICE	118
methylphenidate hcl	144	MINIMED QUICK-SERTER	118
methylphenidate hcl (Metadate Cd)	144	MINIPRESS	75
methylphenidate hcl (Ritalin)	144	minocycline	35
methylprednisolone	110	minocycline er 105 mg tablet	35
methyl salicylate	152	minocycline er 115 mg tablet (Solodyn)	35
methyltestosterone	107	minocycline er 135 mg tablet	35
metoclopramide	105, 106	minoxidil	77
metoclopramide hcl	105	mirabegron	166
metolazone	94	MIRENA	89
METOPIRONE	92	mirtazapine	139
metoprolol/hydrochlorothiazide	78	misoprostol	25, 104
metoprolol succinate	77	MITIGARE	24
metoprolol tartrate	77	MITOSOL	97
metronidazole	31, 35, 152	MIUDELLA	89
metronidazole 0.75% cream (Metrocream)	152	M-M-R II VACCINE	68
metronidazole 0.75% lotion	153	MNEXSPIKE 2025-2026 (12Y UP)	65
metronidazole 250 mg tablet	32	MOBILE LANCETS	130
metronidazole 375 mg capsule (Flagyl)	32	modafinil (Provigil)	147
metronidazole 500 mg tablet	32	MODERNA COVID(6M-5Y) VACC(EUA)	66
metronidazole (Metrocream)	152	MODERNA COVID (12Y UP)VAC(EUA)	65
metronidazole top 1% gel pump	153	MODERNA COVID-19 BOOSTER (EUA)	66
metronidazole topical 0.75% gl	153	MODERNA COVID 23-24(6M-11Y)EUA	65
metronidazole topical 1% gel (Metrogel)	153	MODERNA COVID 24-25(6M-11Y)EUA	65
metronidazole vaginal 0.75% gl	35	MODERNA COVID BIVAL(6MO-5Y)EUA	66
metyrosine	77	MODERNA COVID BIVAL(6MO UP)EUA	66
mexiletine	71	moexipril	76
MIACALCIN (calcitonin,salmon,synthetic)	112	molindone	146
miconazole nitrate	39	mometasone furoate	155
MICRO	123	MONOJECT	126
MICROCHAMBER	134	MONOJECT FILTER NEEDLE	126
MICRODOT HIGH-LOW CONTROL SOL	118	MONOLET	123

Index of Medications

MONOLET LANCETS.....	130	naftifine.....	40
MONOLET THIN LANCETS.....	130	NAFTIN (naftifine hcl).....	40
MONSEL'S.....	70	NALFON 600 MG TABLET (fenoprofen calcium).....	26
montelukast sodium.....	29	NALOCET.....	21
morphine sulfate.....	22	naloxone.....	22, 38, 165
MOTOFEN.....	103	naloxone 0.4 mg/ml vial.....	38
MOUNJARO 2.5 MG/0.5 ML PEN.....	41	naloxone hcl 4 mg nasal spray (Narcan).....	38
MOUNJARO 5 MG/0.5 ML PEN.....	41	naltrexone hcl.....	38
MOUNJARO 7.5 MG/0.5 ML PEN.....	41	NAMENDA.....	81
MOUNJARO 10 MG/0.5 ML PEN.....	41	NANO 2ND GEN PEN NEEDLE.....	126
MOUNJARO 12.5 MG/0.5 ML PEN.....	41	NANO PEN NEEDLE.....	126
MOUNJARO 15 MG/0.5 ML PEN.....	41	NAPROSYN.....	25
MOUTHPIECE.....	134	NAPROSYN 500 MG TABLET (naproxen).....	26
MOVANTIK.....	38	naproxen.....	25, 26
MOXATAG.....	34	naproxen 250 mg, 375 mg tablet.....	26
moxifloxacin.....	34	naproxen 500 mg kit (Naprosyn).....	26
moxifloxacin hcl.....	31	naproxen 500 mg tablet (Naprosyn).....	26
MRESVIA.....	69	naproxen dr 375 mg, 500 mg tablet (Ec-Naprosyn).....	26
MS CONTIN (morphine sulfate).....	22	naproxen sodium.....	26
MULPLETA.....	88	naratriptan hcl.....	19
MULTAQ.....	71	NARCAN (naloxone hcl).....	38
MULTI-LANCET.....	118	NATACHEW.....	136
MULTISTIX.....	93	NATACYN.....	39
MULTISTIX 5.....	93	nateglinide.....	42
MULTISTIX 7.....	93	NAYZILAM.....	84
MULTISTIX 8 SG.....	93	nebivolol 2.5 mg tablet (Bystolic).....	78
MULTISTIX 9.....	93	nebivolol 5 mg tablet (Bystolic).....	78
MULTISTIX 9 SG.....	93	nebivolol 10 mg tablet (Bystolic).....	78
MULTISTIX 10 SG.....	93	nebivolol 20 mg tablet (Bystolic).....	78
multivit-mins no.7/folic acid.....	167	NEBUPENT.....	45
multivit no.18/iron no.1/folic (Tandem Plus).....	167	nebusal.....	161
mupirocin 2% ointment.....	36	NEBUSAL.....	161
MURI-LUBE MINERAL OIL.....	164	NEEDLE.....	125, 126
MUSE.....	159	NEEDLES.....	125, 126, 127, 128, 129, 130, 131, 132, 133
MYALEPT.....	112	needles,safety huber,disposabl.....	126
mycophenolate mofetil.....	113	nefazodone.....	141
mycophenolate sodium (Myfortic).....	113	NEMLUVIO.....	113
MYDRIACYL.....	97	neomycin.....	30, 31
Myfembree.....	110	neomycin/bacit/p-myx/hydrocort.....	30
MYGLUCOHEALTH.....	123	neomycin/bacitracin/polymyxinb.....	31
MYGLUCOHEALTH CONTROL SOLUTION.....	118	neomycin/polymyxin b/dexametha.....	30
MYGLUCOHEALTH LANCETS.....	130	neomycin/polymyxin b/hydrocort.....	30
MYLERAN.....	47	neomycin/polymyxn b/gramicidin.....	31
mynatal capsule.....	136	neomycin sulfate.....	31
mynatal ultracaplet.....	136	neomycin sulf/polymyxin b sulf.....	149
MYTESI.....	102	NEONATAL COMPLETE.....	136
N		NEONATAL-DHA.....	136
nabumetone (Relafen).....	26	NEONATAL PLUS.....	136
nadolol.....	78	NEO-SYNALAR.....	36

Index of Medications

NEPHRON FA.....	168	norethind-eth estrad 0.5-2.5.....	109
NERLYNX.....	53	norethind-eth estrad 1-0.02 mg (Loestrin).....	89
NESTABS.....	136	norethindrone.....	89, 109, 111
NESTABS ABC.....	136	norethindrone ac-eth estradiol.....	109
NESTABS DHA.....	136	norethindrone ac/eth estradiol (Loestrin).....	89
neuac gel.....	150	norethindrone-e.estradiol-iron.....	89
NEULUMEX.....	92	norethindrone-e.estradiol-iron (Loestrin Fe).....	89
NEUPOGEN.....	87	norethindrone-e.estradiol-iron (Taytulla).....	89
NEUPRO.....	57	norethindrone-ethin. estradiol.....	89
NEURONTIN 400 MG CAPSULE (gabapentin).....	85	norethin-ee 1.5-0.03 mg(21) tb (Loestrin).....	89
NEURONTIN 600 MG TABLET (gabapentin).....	85	norethin-eth estrad.....	109
NEURONTIN 800 MG TABLET (gabapentin).....	85	norgestimate-ethinyl estradiol.....	89
nevirapine.....	60	norgestrel-ethinyl estradiol.....	89
NEXPLANON.....	88	NORLIQVA.....	72
niacin.....	81	NORPACE.....	71
nicardipine.....	72	nortriptyline.....	143
NICOTROL.....	156	nortriptyline hcl (Pamelor).....	143
nifedipine.....	72	NORVIR 100 MG POWDER PACKET.....	61
nilotinib hcl (Tasigna).....	53	NOURIANZ.....	58
nilutamide (Nilandron).....	48	NOVA.....	123
nimodipine 30 mg capsule.....	72	NOVAMAX PLUS.....	91
nimodipine 60 mg/20 ml soln.....	72	NOVA MAX PLUS GLUC-KETON METER.....	118
NINLARO.....	53	NOVAMAX PLUS GLU-KET.....	118
nisoldipine.....	72	NOVA SAFETY LANCETS.....	130
nitazoxanide.....	57	NOVA SUREFLEX.....	130
nitisinone (Orfadin).....	161	NOVAVAX COVID-19 VACC,ADJ(EUA).....	66
NITRO-DUR.....	73	NOVAVAX COVID 2023-2024 (EUA).....	66
nitrofurantoin.....	33, 34	NOVAVAX COVID 2024-2025 (EUA).....	66
nitrofurantoin mcr 25 mg cap.....	34	NOVOPEN ECHO.....	118
nitrofurantoin mcr 50 mg cap.....	34	NOXAFIL 300 MG POWDERMIX SUSP.....	39
nitrofurantoin mcr 100 mg cap.....	34	NUBEQA.....	48
nitrofurantoin monohyd/m-cryst.....	34	NUCALA.....	29
nitroglycerin.....	73, 106	NUCORT.....	155
nitroglycerin 0.3 mg tablet sl (Nitrostat).....	73	NUCYNTA.....	22
nitroglycerin 0.4 mg tablet sl (Nitrostat).....	73	NUCYNTA ER.....	22
nitroglycerin 0.6 mg tablet sl (Nitrostat).....	73	NUEDEXTA.....	82
nitroglycerin 400 mcg spray (Nitrolingual).....	73	NUFERA.....	100
NITROLINGUAL.....	73	NULEV (hyoscyamine sulfate).....	104
NITROMIST.....	73	NUMOISYN.....	160
NITROSTAT.....	73	NUPLAZID.....	140
NITYR.....	161	NURTEC ODT.....	19
NIVA-FOL (cyanocobalamin/folic ac/vit b6).....	168	NUVAXOVID 2025-2026.....	66
NIVA-PLUS (multivit-min 60/iron fum/folic).....	167	NUZYRA.....	35
NIVESTYM.....	87	NYMALIZE.....	72
NOCTIVA.....	108	NYPOZI.....	87
NOKOR ADMIX NEEDLE.....	126	nystatin.....	40
NOKOR NEEDLE.....	126	NYVEPRIA.....	87
norelgestromin/ethin.estradiol.....	89	O	
noreth-ethinyl estradiol/iron.....	89	OB COMPLETE ONE.....	137

Index of Medications

OB COMPLETE PETITE.....	137	OMVOH 100 MG/ML SYRINGE.....	112
OB COMPLETE PREMIER.....	137	OMVOH 200 MG/2 ML PEN.....	112
OB COMPLETE WITH DHA.....	137	OMVOH 200 MG/2 ML SYRINGE.....	112
OBREDON.....	90	OMVOH 200 MG DOSE - 2 PENS.....	112
OBSTETRIX.....	137	OMVOH 200 MG DOSE - 2 SYRINGES.....	112
OBTREX.....	137	OMVOH 300 MG DOSE - 2 PENS.....	112
OCALIVA.....	105	OMVOH 300 MG DOSE - 2 SYRINGES.....	112
ODACTRA.....	65	ON CALL.....	123
ODEFSEY.....	61	ON CALL EXPRESS CONTROL SOLN.....	119
ODOMZO.....	49	ON CALL LANCET.....	130
OFEV.....	158	ON CALL LANCING DEVICE.....	119
ofloxacin.....	30, 31, 34	ON CALL PLUS CONTROL.....	119
OGSIVEO 50 MG TABLET.....	53	ON CALL PLUS LANCET.....	130
OGSIVEO 100 MG TABLET.....	53	ON CALL PLUS LANCING DEVICE.....	119
OGSIVEO 150 MG TABLET.....	53	ON CALL VIVID CONTROL.....	119
OJEMDA 25 MG/ML ORAL SUSP.....	49	ondansetron.....	103
OJEMDA 100 MG TAB (400MG DOSE).....	49	ondansetron odt 4 mg tablet.....	103
OJEMDA 100 MG TAB (500MG DOSE).....	49	ondansetron odt 8 mg tablet.....	103
OJEMDA 100 MG TAB (600MG DOSE).....	49	ONETOUCH.....	123
OJJAARA.....	53	ONETOUCH DELICA PLUS LANC DEV.....	119
olanzapine.....	145, 147	ONETOUCH DELICA PLUS LANCET.....	130
olanzapine (Zyprexa Zydis).....	145	ONETOUCH DELICA SAFETY LANCET.....	131
olmesartan/amlodipin/hcthiazyd (Tribenzor).....	75	ONETOUCH LANCETS.....	131
olmesartan-hctz 20-12.5 mg tab (Benicar Hct).....	75	ONETOUCH SURESOFT.....	131
olmesartan-hctz 40-12.5 mg tab (Benicar Hct).....	75	ONETOUCH ULTRA CONTROL SOLN.....	119
olmesartan-hctz 40-25 mg tab (Benicar Hct).....	75	ONETOUCH ULTRASOFT 2 LANCET.....	123, 131
olmesartan medoxomil 5 mg tab (Benicar).....	77	ONETOUCH VERIO HIGH CNTRL SOLN.....	119
olmesartan medoxomil 20 mg tab (Benicar).....	76	ONETOUCH VERIO MID CNTRL SOLN.....	119
olmesartan medoxomil 40 mg tab (Benicar).....	77	ONE WAY MOUTHPIECE.....	134
olopatadine.....	94	ONEXTON.....	150
olopatadine hcl (Patanase).....	94	ON-THE-GO.....	123, 131
OLPRUVA.....	102	ONUREG.....	48
OLUMIANT.....	25	OPFOLDA.....	161
om-3/dha/epa/b12/fa/b6/phytost.....	167	opium.....	22, 103
omega-3 acid ethyl esters (Lovaza).....	102	opium/belladonna alkaloids.....	22
OMNIPOD 5 DEXG7G6 INTRO(GEN 5).....	118	OPSUMIT.....	73
OMNIPOD 5 DEXG7G6 PODS (GEN 5).....	119	OPSYNVI.....	74
OMNIPOD 5 G6-G7 INTRO KT(GEN5).....	119	OPTICHAMBER.....	134
OMNIPOD 5 G6-G7 PODS (GEN 5).....	119	OPTUMRX GLUCOSE CONTROL SOLN.....	119
OMNIPOD 5 (G6/LIBRE 2 PLUS).....	118	OPVEE.....	39
OMNIPOD 5 INTRO(G6/LIBRE2PLUS).....	119	OPZELURA.....	155
OMNIPOD CLASSIC PDM KIT(GEN 3).....	119	ORACIT.....	101
OMNIPOD CLASSIC PODS (GEN 3).....	119	ORALAIR.....	65
OMNIPOD DASH INTRO KIT (GEN 4).....	119	ORAMAGICRX.....	160
OMNIPOD DASH PODS (GEN 4).....	119	ORAPRED.....	110
OMNIPOD GO PODS.....	119	ORAVIG.....	39
OMNITROPE.....	110	ORENCIA.....	24
OMVOH 100 MG/ML PEN.....	112	ORENCIA 50 MG/0.4 ML SYRINGE.....	24
		ORENCIA 87.5 MG/0.7 ML SYRINGE.....	24

Index of Medications

ORENCIA 125 MG/ML SYRINGE.....	24	oxycodone hcl (ir) 20 mg tab.....	22
ORENITRAM.....	74	oxycodone hcl (ir) 30 mg tab (Roxicodone).....	22
ORFADIN.....	161	oxymorphone hcl.....	22
ORFADIN (nitisinone).....	161	OZEMPIC.....	41
ORGOVYX.....	50	P	
ORIAHNN.....	110	pacerone.....	71
ORLISSA.....	110	PACNEX.....	152
ORLADEYO.....	159	paliperidone.....	145
ORLISTAT.....	56	paliperidone er 6 mg tablet (Invega).....	145
orphenadrine.....	136	PALYNZIQ.....	65
ORSERDU 86 MG TABLET.....	55	PANCREAZE.....	106
ORSERDU 345 MG TABLET.....	55	PANDA MASK.....	134
oseltamivir 6 mg/ml suspension (Tamiflu).....	62	PANRETIN.....	55
oseltamivir phos 30 mg capsule (Tamiflu).....	62	PARADIGM.....	127
oseltamivir phos 45 mg capsule (Tamiflu).....	62	PARAGARD.....	89
oseltamivir phos 75 mg capsule (Tamiflu).....	62	PARAGARD T 380A (SINGLE HAND).....	89
OTEZLA 10-20-30MG START 28 DAY.....	24	PAREMYD.....	97
OTEZLA 10-20 MG STARTER 28 DAY.....	24	paricalcitol.....	160
OTEZLA 20 MG TABLET.....	24	paroxetine.....	141, 162
OTEZLA 30 MG TABLET.....	24	paroxetine hcl 10 mg/5 ml susp.....	141
OTEZLA XR 75 MG TABLET.....	24	PASER.....	32
OTEZLA XR INITIATION PK 28 DAY.....	24	PATANASE.....	94
OTOVEL.....	30	PAXLOVID.....	61
OTREXUP.....	24	pazopanib.....	53
OVAL TAPE.....	119	PEDIARIX.....	69
OVIDE (malathion).....	57	PEDIATRIC MASK.....	134
oxandrolone.....	107	PEDIATRIC PANDA MASK.....	134
oxaprozin.....	25, 26	pedi multivit no.12 w-fluoride.....	168
OXAYDO.....	22	ped mvit a,c,d3 no.21/fluoride.....	168
oxazepam.....	139	PEDVAXHIB.....	68
oxcarbazepine.....	85	peg3350/sod sulf, bicarb, cl/kcl.....	106
oxcarbazepine (Trileptal).....	85	peg3350/sod sulf,bicarb,cl/kcl (Golytely).....	106
OXERVATE.....	98	peg3350/sod sul/nacl/kcl/asb/c (Moviprep).....	106
OXTELLAR.....	85	PEGASYS.....	63
oxybutynin 5 mg/5 ml soln cup.....	166	PEMAZYRE.....	53
oxybutynin 5 mg/5 ml solution.....	166	PENBRAYA.....	66
oxybutynin 5 mg/5 ml syrup.....	166	penciclovir (Denavir).....	63
oxybutynin 5 mg tablet.....	166	penicillamine.....	24
oxycodone hcl.....	21	penicillamine 250 mg capsule (Cuprimine).....	24
oxycodone hcl 5 mg/5 ml cup.....	22	penicillamine 250 mg tablet (Depen).....	24
oxycodone hcl 5 mg/5 ml soln.....	22	penicillin v potassium.....	34
oxycodone hcl 100 mg/5 ml conc.....	22	PENMENVY MEN A-B-C-W-Y.....	67
oxycodone hcl/acetaminophen.....	21	PENTACEL.....	68, 69
OXYCODONE HCL ER.....	22	pentamidine isethionate.....	45
oxycodone hcl (ir) 5 mg cap.....	22	PENTASA.....	105
oxycodone hcl (ir) 5 mg tablet (Roxicodone).....	22	pentazocine hcl/naloxone hcl.....	22
oxycodone hcl (ir) 10 mg tab.....	22	pentoxifylline.....	71
oxycodone hcl (ir) 15 mg tab (Roxicodone).....	22	perampanel 2 mg tablet (Fycompa).....	85

Index of Medications

perampanel 4 mg tablet (Fycompa).....	85	PHYSIOLYTE (physiological irrig soln no.1).....	149
perampanel 6 mg tablet (Fycompa).....	85	PHYSIOSOL (physiological irrig soln no.1)	149
perampanel 8 mg tablet (Fycompa).....	85	phytonadione.....	169
perampanel 10 mg tablet (Fycompa).....	85	PIFELTRO	60
perampanel 12 mg tablet (Fycompa)	85	pilocarpine	65
PERFECT	126	pilocarpine 1% eye drops	96
PERFECT POINT.....	123, 126	pilocarpine 2% eye drops.....	96
PERFECT POINT SAFETY LANCETS	131	pilocarpine 4% eye drops.....	96
PERIDEX (chlorhexidine gluconate).....	159	pilocarpine hcl 5 mg tablet (Salagen).....	65
perindopril erbumine.....	76	pilocarpine hcl 7.5 mg tablet (Salagen).....	65
permethrin.....	57	pimecrolimus (Elidel)	113
perphenazine	142, 147	pimozide.....	145
perphenazine/amitriptyline hcl	142	pindolol.....	78
PFIZER COVID (5-11Y) VAC (EUA)	66	pioglitazone.....	43
PFIZER COVID (6M-4Y) VACC(EUA)	66	pioglitazone hcl/glimepiride	43
PFIZER COVID (12Y UP) VAC(EUA)	66	pioglitazone hcl/metformin hcl.....	43
PFIZER COVID-19 VACCINE (EUA)	66	PIP GLUCOSE CONTROL SOLUTION	119
PFIZER COVID 2023-24(5-11Y)EUA.....	66	PIP LANCET.....	123, 131
PFIZER COVID 2023-24(6M-4Y)EUA	66	PIQRAY	53
PFIZER COVID 2024-25(5-11Y)EUA.....	66	pirfenidone	161
PFIZER COVID 2024-25(6M-4Y)EUA	66	pirfenidone 267 mg tablet (Esbriet).....	161
PFIZER COVID BIVAL (5-11YR)EUA	66	piroxicam.....	25, 26
PFIZER COVID BIVAL (6MO-4Y)EUA	66	piroxicam (Feldene).....	26
PFIZER COVID BIVAL (12Y UP)EUA	66	pitavastatin 1 mg tablet (Livalo).....	79
PHARMABASE BARRIER (zinc oxide).....	152	pitavastatin 2 mg tablet (Livalo).....	79
PHASEAL.....	126	pitavastatin 4 mg tablet (Livalo)	80
PHEBURANE	102	PLEGRIDY.....	83
phenazopyridine hcl	24	PLEGRIDY PEN	83
phendimetrazine tartrate	56	PLEXION.....	36
phenelzine sulfate.....	139	PNEUMOVAX 23.....	67
phenobarb/hyoscy/atropine/scop.....	104	pnv 11/iron fum/folic acid/om3.....	137
phenobarb/hyoscy/atropine/scop (Phenobarbital-Belladonna)..	104	pnv19/iron bg,s,p/folic ac/om3	137
phenobarbital	147	pnv 66/iron/folic/docusate/dha	137
PHENOBARBITAL-BELLADONNA (phenobarb/hyoscy/atropine/	104	pnv 69/iron/folic/docusate/dha.....	137
scop).....	104	pnv 80/iron fum/folic/dss/dha.....	137
phenoxybenzamine.....	65	pnv81/iron ps,edta/folic/omeg3.....	137
phentermine 8 mg tablet	56	pnv 119/iron fum/folic acid	137
phentermine 15 mg capsule.....	56	pnv,calcium 72/iron,carb/folic	137
phentermine 30 mg capsule	56	pnv,calcium 72/iron/folic acid.....	137
phentermine 37.5 mg capsule.....	56	pnv no.52/iron/fa/omega-3/dha.....	137
phentermine 37.5 mg tablet	56	pnv no.118/iron fumarate/fa.....	137
phentermine/topiramate (Qsymia).....	56	pnv no.154	137
phenylephrine.....	40, 96	POCKET CHAMBER.....	134
phenylephrine hcl/prometh hcl.....	40	podofilox	152
PHENYTEK.....	85	podofilox (Condylox).....	152
phenytoin.....	84, 85, 86	POGO AUTOMATIC TEST CARTRIDGE.....	131
PHOSPHOLINE IODIDE	96	POLIBAR.....	92
		polyethylene glycol.....	164

Index of Medications

POLY HUB NEEDLE	126	PREHEVBRIO	69
polymyxin b sulf/trimethoprim	31	PREMARIN	111
POLY-TUSSIN AC.....	90	PREMARIN (estrogens, conjugated).....	109
POLY-VI-FLOR.....	168, 169	PREMPHASE.....	109
POLY-VI-FLOR WITH IRON	169	PREMPRO.....	109
POMALYST	50	PRENATA.....	137
posaconazole	39	prenatal 12/iron/folic/dss/om3.....	137
potassium.....	20	PRENATAL 19	137
potassium bicarbonate/cit ac	101	prenatal 53/iron/folic ac/omg3.....	137
potassium chloride.....	101	prenatal 54/iron/folic ac/omg3.....	137
potassium citrate	101, 102	prenatal 71/iron/folic ac/dha.....	137
potassium cl 10% (20 meq/15ml)	101	prenatal 93/iron/folate 9/dha.....	137
potassium cl10%(20meq/15ml)cup.....	101	prenatal 105/iron/folic ac/dha.....	137
potassium cl10%(40meq/30ml)cup	101	prenatal,calc 40/iron/folate 1.....	138
potassium cl 20% (40 meq/15ml)	101	prenatal no.42/folic acid (Vitamedmd Redichew Rx).....	137
potassium cl20%(40meq/15ml)cup.....	101	PRENATAL PLUS-DHA	137
potassium cl 20 meq packet.....	101	PRENATAL PLUS VITAMIN-MINERAL.....	137
potassium cl er 8 meq capsule.....	101	prenatal vit 27,calc/iron/fa.....	137
potassium cl er 8 meq tablet	101	prenatal vit 55/iron/folic/om3.....	137
potassium cl er 10 meq capsule	101	prenatal vit,cal 73/iron/folic.....	137
potassium cl er 10 meq tablet.....	101	prenatal vit,cal 76/iron/folic.....	137
potassium cl er 15 meq tablet.....	101	prenatal vit/iron fum/folic ac.....	138
POTASSIUM CL ER 15 MEQ TABLET	101	prenatal vits 86/iron/folic ac.....	138
potassium cl er 20 meq tablet.....	101	PRENATE DHA.....	138
potassium iodide	100	PRENATE ELITE.....	138
potassium iodide/iodine.....	100	PRENATE ENHANCE.....	138
pramipexole.....	58	PRENATE MINI	138
pramipexole er 4.5 mg tablet.....	58	PRENATE PIXIE	138
PRAMOSONE	155	PRENATE RESTORE	138
prasugrel	58	PRENATE STAR	138
pravastatin	80	PREPIDIL	111
praziquantel.....	45	PRESSURE	96, 97, 123
praziquantel (Biltricide).....	45	PRESSURE ACTIVATED LANCETS.....	131
prazosin	75	PRESTALIA.....	74
prazosin hcl (Minipress).....	75	PRETOMANID	32
PR BENZOYL PEROXIDE (benzoyl peroxide microspheres)....	152	PREVIDENT	98, 99
PRECISION.....	125	PREVIDENT 5000 DRY MOUTH.....	98, 99
PRECISIONGLIDE.....	126	PREVIDENT 5000 ORTHO DEFENSE.....	99
PRECISION XTRA KETONE-GLUCOSE	119	PREVIDENT (fluoride (sodium))	98, 99
PRECISION XTRA TEST STRIPS.....	91	PREVIDENT KIDS.....	99
PRECISION XTR B-KETONE STRIP	91	PREVNAR.....	67
PRECOSE.....	42	PREVYMIS 20 MG PELLETT PACKET	62
prednicarbate.....	155	PREVYMIS 120 MG PELLETT PACKET	62
prednisolone	30, 95, 110	PREVYMIS 240 MG TABLET	62
prednisolone acetate (Pred Forte).....	95	PREVYMIS 480 MG TABLET	62
prednisolone sodium phosphate	95, 110	PREZCOBIX.....	59
prednisone.....	110	PREZISTA 75 MG TABLET.....	59
pregabalin	86	PREZISTA 100 MG/ML SUSPENSION.....	59

Index of Medications

PREZISTA 150 MG TABLET.....	59	propranolol.....	78
PRIFTIN.....	32	propylthiouracil.....	157
PRIMACARE.....	138	PROQUAD.....	69
PRIMAQUINE.....	45	PROTECT IRON.....	167
primaquine phosphate.....	45	protriptyline.....	143
PRIMEAIRE.....	134	PROVERA.....	88
primidone 50 mg tablet (Mysoline).....	86	PROVIDA OB.....	138
primidone 250 mg tablet (Mysoline).....	86	PROVOCHOLINE.....	91
PRIMLEV.....	21	prucalopride succinate (Motegrity).....	106
PRIMSOL.....	32	PULMOZYME.....	158
PRIORIX.....	69	PURE COMFORT.....	123
PRISMASOL.....	101	PURE COMFORT ALCOHOL PAD.....	148, 151
probenecid.....	27	PURE COMFORT LANCETS.....	131
probenecid/colchicine.....	27	PURE COMFORT SAFETY LANCETS.....	131
PROCARE.....	134	PURE COMFORT SPACER WITH MASK.....	135
PROCHAMBER.....	135	PURIXAN (mercaptapurine).....	48
prochlorperazine.....	103	PUSH BUTTON.....	123
PRO COMFORT.....	123, 134	PUSH BUTTON SAFETY LANCETS.....	131
PRO COMFORT ALCOHOL PADS.....	148, 151	pyrazinamide.....	32
PRO COMFORT LANCET.....	123, 131	pyridostigmine 60 mg/5 ml cup (Mestinon).....	64
PRO COMFORT LANCETS.....	131	pyridostigmine 60 mg/5 ml soln (Mestinon).....	64
PRO COMFORT SAFETY LANCET.....	131	pyridostigmine br 60 mg tablet (Mestinon).....	64
PRO COMFORT SPACER-CHILD MASK.....	134	pyridostigmine bromide (Mestinon).....	64
PRO COMFORT SPACER-INFANT MASK.....	134	pyrimethamine.....	45
PROCORT.....	105, 107	PYRUKYND 5 MG TABLET.....	70
PROCTOFOAM-HC.....	105, 107	PYRUKYND 5 MG TAPER PACK.....	70
PRODIGY.....	123	PYRUKYND 20-5 MG TAPER PACK.....	70
PRODIGY CONTROL SOLUTION.....	119	PYRUKYND 20 MG TABLET.....	70
PRODIGY LANCETS.....	131	PYRUKYND 50-20 MG TAPER PACK.....	70
PRODIGY LANCING DEVICE.....	119	PYRUKYND 50 MG TABLET.....	70
PRODIGY TWIST TOP LANCET.....	131	Q	
PROFERRIN-FORTE.....	100	QINLOCK.....	53
progesterone 100 mg capsule (Prometrium).....	111	QSYMIA (phentermine/topiramate).....	56
progesterone 100 mg vag insert (Endometrin).....	112	QUADRACEL.....	69
progesterone 200 mg capsule (Prometrium).....	111	QUAZEPAM.....	148
PROGRAF 0.2 MG GRANULE PACKET.....	114	QUESTRAN (cholestyramine (with sugar)).....	80
PROGRAF 1 MG GRANULE PACKET.....	114	QUESTRAN LIGHT (cholestyramine).....	80
prolate 5-300 mg tablet.....	21	quetiapine fumarate.....	145, 146
prolate 7.5-300 mg tablet.....	21	quetiapine fumarate 25 mg tab (Seroquel).....	145
prolate 10-300 mg tablet.....	21	quetiapine fumarate 50 mg tab (Seroquel).....	145
PROLENSA (bromfenac sodium).....	95	quetiapine fumarate 100 mg tab (Seroquel).....	145
promethazine.....	41, 90, 103	quetiapine fumarate 200 mg tab (Seroquel).....	145
promethazine/dextromethorphan.....	90	quetiapine fumarate 300 mg tab (Seroquel).....	145
promethazine hcl/codeine.....	90	quetiapine fumarate 400 mg tab (Seroquel).....	145
promethazine/phenyleph/codeine.....	90	QUFLORA FE.....	168
propafenone.....	71	QUFLORA PED 0.5 MG CHEW TAB.....	168
proparacaine/fluorescein sod.....	96	QUFLORA PED 0.5 MG/ML DROP.....	168
proparacaine hcl.....	96	QUFLORA PED 0.25 MG CHEW TAB.....	168

Index of Medications

QUFLORA PED 0.25 MG/ML DROP	168	REQ49+	167
QUFLORA PED 1 MG CHEW TAB	168	RESPA A.R. (pseudoephed/chlor-mal/bell alk).....	90
QUILLIVANT	144	RESTASIS (cyclosporine).....	97
quinapril hcl (Accupril)	76	RETEVMO.....	53
quinapril/hydrochlorothiazide (Accuretic)	75	RETEVMO 40 MG TABLET	53
quinidine sulfate.....	71	RETEVMO 80 MG TABLET	53
quinine sulfate	45	RETIN-A MICRO PUMP 0.08% GEL (tretinoin microspheres)..	156
QULIPTA	19	REVLIMID	50
QVAR	29	REVUFORJ 25 MG TABLET	53
R		REVUFORJ 110 MG TABLET	53
RADIAGEL.....	162	REVUFORJ 160 MG TABLET	53
RADICAVA ORS 105 MG/5 ML SUSP	81	REXTOVY.....	39
RADICAVA ORS STARTER KIT SUSP	81	REXULTI.....	146
RADIOGARDASE.....	162	REYATAZ 50 MG POWDER PACKET	61
RAGWITEK.....	65	REZDIFFRA.....	160
ra isopropyl alcohol 70%	164	REZLIDHIA	54
ra isopropyl alcohol 91%	164	REZUROCK	165
raloxifene.....	164	REZVOGLAR KWIKPEN	44
ramelteon.....	147	RHOPRESSA.....	96
ramipril.....	76	ribavirin.....	63
ramipril (Altace)	76	rifabutin (Mycobutin)	32
ranolazine.....	71	rifampin	32
ranolazine (Ranexa).....	71	RIGHTEST	123
rasagiline mesylate.....	58	RIGHTEST CONTROL SOLUTION.....	119
rasagiline mesylate 1 mg tab (Azilect)	58	RIGHTEST GD500.....	119
RAYALDEE	160	RIGHTEST GL300 LANCETS.....	131
READI-CAT 2	92	riluzole.....	82
READYLANCE	123	rimantadine	62
READYLANCE SAFETY LANCETS	131	RIMSO-50.....	23
REBIF	83	ringer's	149
RECOMBIVAX HB.....	69	RINVOQ	25
RECOTHROM.....	70	RIOMET	42
RECTIV	106	risedronate.....	164
REFUAH PLUS GLUCOSE CONTROL	119	risperidone.....	145
REGLAN.....	106	RITALIN.....	144
REGULAR BEVEL NEEDLES	126	RITEFLO.....	135
RELAGARD (acetic acid/oxyquinoline).....	45	ritonavir	61
RELENZA.....	62	ritonavir (Norvir).....	61
RELEUKO.....	88	rivaroxaban (Xarelto).....	37
RELIAMED.....	123, 131	rivastigmine.....	63, 64
RELIAMED MINI LANCING DEVICE	119	rizatriptan benzoate	19
RELIAMED SAFETY SEAL LANCETS.....	131	rizatriptan benzoate (Maxalt)	19
RELION TRUE METRIX TEST STRIP.....	91	rizatriptan benzoate (Maxalt Mlt).....	19
RELISTOR 8 MG/0.4 ML SYRINGE	38	R-NATAL OB.....	138
RELISTOR 12 MG/0.6 ML SYRINGE.....	38	ROCKLATAN.....	97
RELISTOR 12 MG/0.6 ML VIAL	38	roflumilast.....	30
RENACIDIN	101	ROLVEDON.....	88
REPATHA.....	79	ROMVIMZA	53

Index of Medications

ropinirole hcl	58	sertraline 150 mg capsule.....	141
rosuvastatin.....	80	sertraline 200 mg capsule	141
ROTARIX.....	66	sevelamer	99
ROTATEQ.....	66	sevoflurane	23
ROXYBOND	22	SFROWASA	104
ROZLYTREK.....	53	SHINGRIX	69
RUBRACA.....	53	SHORT BEVEL NEEDLES.....	126
rufinamide.....	86	SIDESTREAM PEDIATRIC	135
rufinamide 40 mg/ml suspension (Banzel).....	86	SIGNIFOR	111
rufinamide 200 mg tablet (Banzel)	86	SIKLOS	70
RUKOBIA	60	sildenafil	73, 159, 160
RYBELSUS.....	41	SILICONE MASK-INFANT.....	135
RYDAPT	53	SILICONE MASK-PEDIATRIC	135
RYTARY.....	58	silodosin.....	166
S		SIL-SERTER.....	119
sacubitril/valsartan (Entresto).....	75	SILVADENE (silver sulfadiazine).....	36
SAFE-CLIP.....	119	silver nitrate.....	152, 156
SAFETY	121, 122, 123, 124	silver sulfadiazine	36
SAFETYGLIDE INSULIN SYRINGE.....	127	SIMBRINZA	97
SAFETYGLIDE NEEDLE.....	126	SIMLANDI(CF) 20 MG/0.2 ML SYRG.....	47
SAFETYGLIDE SYRINGE	128	SIMLANDI(CF) 40 MG/0.4 ML SYRG	47
SAFETY LANCETS.....	131	SIMLANDI(CF) 80 MG/0.8 ML SYRG.....	47
SAFETY-LET	131	SIMLANDI(CF) AI 40 MG/0.4 ML.....	47
SAFETY SEAL LANCETS.....	131	SIMLANDI(CF) AI 80 MG/0.8 ML	47
SALAGEN	65	SIMPONI.....	47
salsalate	24	simvastatin.....	80
SANCUSO.....	103	SINEMET (carbidopa/levodopa).....	58
SANDIMMUNE 100 MG/ML SOLN.....	114	SINGLE.....	124
SANTYL.....	156	SINGLE-LET	131
SAPHRIS	145	SINGLE USE SWAB.....	148, 151
sapropterin dihydrochloride (Kuvan)	162	sirolimus	114
SAVELLA	165	sirolimus (Rapamune).....	114
saxagliptin hcl (Onglyza)	42	SIRTURO.....	32
SAXENDA (liraglutide)	56	SITZMARKS	92
SCALACORT DK.....	155	SIVEXTRO	34
SCEMBLIX	53	SKYLA	89
scopolamine.....	103	SKYRIZI.....	150
SECUADO.....	145	SKYRIZI ON-BODY	112
SELARSDI.....	112	SKYRIZI PEN.....	150
SELECT-OB	138	SKYTROFA	110
SELECT-OB + DHA	138	SMART	122
SELECT-OB (prenatal vit 128/iron/folic ac).....	138	SMARTDIABETES VANTAGE	119
selegiline.....	58	SMARTEST	119, 124
SELZENTRY 20 MG/ML ORAL SOLN.....	60	SMARTEST LANCET.....	131
SEROQUEL	145, 146	SMART SENSE	124, 131
SEROQUEL XR (quetiapine fumarate)	146	SMART SENSE LANCETS	124, 131
SEROSTIM	110	sm isopropyl alcohol 70%	164
sertraline.....	141	sodium chloride 0.9% inhal vl.....	161

Index of Medications

sodium chloride 0.9% irrig.....	149	spironolactone 25 mg/5 ml susp (Carospir).....	94
sodium chloride 0.9% irrig.....	149	spironolactone 25 mg tablet (Aldactone).....	94
SODIUM CHLORIDE 0.9% IRRIG.....	149	spironolactone 50 mg tablet (Aldactone).....	94
sodium chloride 0.9% prcss sol.....	149	spironolactone 100 mg tablet (Aldactone).....	94
sodium chloride 3% vial.....	161	SPRITAM.....	86
sodium chloride 7% vial.....	161	sps.....	99
sodium chloride 10% vial.....	161	SSKI.....	100
sodium chloride for inhalation.....	161	STALEVO 75 (carbidopa/levodopa/entacapone).....	58
sodium chloride irrig solution.....	149	STALEVO 100 (carbidopa/levodopa/entacapone).....	58
sodium chloride/nahco3/kcl/peg.....	106	STELARA.....	112
SODIUM CITRATE.....	36	STENDRA.....	160
sodium fluoride/potassium nit.....	98	STERILANCE.....	124
SODIUM OXYBATE 0.5 G/ML SOLN.....	147	STERILANCE TL.....	131
sodium phenylbutyrate.....	102	STERILE.....	124
sodium polystyrene sulfonate.....	99	STERILE LANCETS.....	131
sodium polystyrene sulfon/sorb.....	99	STIMUFEND.....	88
sodium, potassium,mag sulfates (Suprep).....	106	STIOLTO RESPIMAT.....	28
sod, pot chlor/mag/sod, pot phos.....	149	STIVARGA.....	53
sod/pot/k cit/sod cit/cit acid.....	102	STRENSIQ.....	162
SOHONOS.....	163	STRIBILD.....	61
solifenacin 5 mg tablet (Vesicare).....	166	STRIVERDI RESPIMAT.....	28
solifenacin 10 mg tablet (Vesicare).....	166	STROMECTOL.....	45
SOLQUA.....	41	STROVITE FORTE (multivit,iron,min 5/folic acid).....	167
SOLTAMOX.....	55	STROVITE ONE.....	167
SOLUS.....	124	SUBOXONE (buprenorphine hcl/naloxone hcl).....	165
SOLUS V2.....	131	subvenite 25 mg tablet (Lamictal).....	86
SOLUS V2 CONTROL SOLUTION.....	119	subvenite 100 mg tablet (Lamictal).....	86
SOLUS V2 LANCETS.....	131	subvenite 150 mg tablet (Lamictal).....	86
SOLUS V2 LANCING DEVICE.....	120	subvenite 200 mg tablet (Lamictal).....	86
SOMAVERT.....	160	SUCRAID.....	105
SOOLANTRA.....	153	sucrafate.....	104
sorafenib tosylate (Nexavar).....	53	sucrafate (Carafate).....	104
SORBITOL.....	149	SULAR.....	72
sotalol.....	78	sulfacetamide.....	30
sotalol hcl (Betapace).....	78	sulfacetamide/prednisolone sp.....	30
SOTYKTU.....	150	sulfacetamide sodium.....	36, 150
SOTYLIZE.....	78	sulfadiazine.....	31, 36
SPACE CHAMBER.....	134, 135	sulfamethoxazole/trimethoprim.....	31
SPECIALTY USE NEEDLES.....	126	sulfamethoxazole/trimethoprim (Bactrim).....	31
SPEVIGO.....	150	SULFAMYLON.....	36
SPIKEVAX 2023-2024.....	66	sulfasalazine.....	105
SPIKEVAX 2024-2025.....	66	sulindac.....	26
SPIKEVAX 2025-2026 (6M-11Y).....	66	sumatriptan.....	19, 20
SPIKEVAX 2025-2026 (12Y UP).....	66	sumatriptan 4 mg/0.5 ml inject (Imitrex).....	20
SPIKEVAX COVID (18Y UP) VACC.....	66	sumatriptan 6 mg/0.5ml autoinj (Imitrex).....	20
spinosad.....	57	sumatriptan succ 25 mg tablet (Imitrex).....	20
SPIRIVA RESPIMAT.....	27	sumatriptan succ 50 mg tablet (Imitrex).....	20
spironolact/hydrochlorothiazid.....	94	sumatriptan succ 100 mg tablet (Imitrex).....	20

Index of Medications

sumatriptan succ/naproxen sod (Treximet)	20	TALTZ AUTOINJECTOR (2 PACK)	150
sunitinib malate (Sutent).....	53	TALTZ AUTOINJECTOR (3 PACK)	150
SUNLENCA 4- 300 MG TABLET	59	TALTZ SYRINGE.....	150
SUNLENCA 5- 300 MG TABLET	59	TALZENNA 0.1 MG CAPSULE	53
SUNLENCA 300 MG TABLET	59	TALZENNA 0.1 MG SOFTGEL.....	53
SUNLENCA 463.5 MG/1.5 ML VIAL.....	59	TALZENNA 0.5 MG CAPSULE	54
SUNOSI	147	TALZENNA 0.5 MG SOFTGEL	54
SUPER	122, 124	TALZENNA 0.25 MG CAPSULE.....	53
SUPER THIN LANCETS.....	131	TALZENNA 0.25 MG SOFTGEL	53
SUPRANE	23	TALZENNA 0.35 MG SOFTGEL	54
SURE COMFORT	124	TALZENNA 0.75 MG SOFTGEL	54
SURE COMFORT ALCOHOL.....	149, 151	TALZENNA 1 MG CAPSULE.....	54
SURE COMFORT LANCETS.....	132	TALZENNA 1 MG SOFTGEL	54
SURE COMFORT LANCING PEN.....	120	tamoxifen citrate.....	55
SUREFLEX.....	120	tamsulosin hcl.....	166
SURE-LANCE	124, 132	TANDEM PLUS (multivit no.18/iron no.1/folic)	167
SURE-PEN	120	tasimelteon (Hetlioz).....	147
SURE-PREP ALCOHOL PREP PADS	149, 151	TASMAR.....	58
SURE-TEST EASYPLUS MINI SOLN	120	TAVALISSE	159
SURE-TOUCH	124, 132	TAVNEOS.....	69
SURGICEL.....	70	tazarotene 0.1% cream (Tazorac).....	151
SURGIFOAM.....	70	tazarotene 0.1% gel (Tazorac).....	151
SURVANTA.....	158	tazarotene 0.05% cream (Tazorac)	151
swan isopropyl alcohol 70%.....	164	tazarotene 0.05% gel (Tazorac)	151
SYMAX DUOTAB	104	TAZORAC (tazarotene).....	151
SYMLINPEN	42	TAZVERIK.....	50
SYMPROIC.....	38	TC99M SULFUR COLLOID	91
SYMTUZA	59	TDVAX	69
SYNALAR	36, 155	TECHLITE	124
SYNALAR (fluocinolone acetonide).....	155	TECHLITE LANCETS.....	132
SYNALAR TS	155	TEGRETOL	86
SYNJARDY	43	TELCARE	124
SYRINGE AVITENE	70	TELCARE CONTROL SOLUTION	120
T		TELCARE ULTRA THIN 30G LANCETS.....	132
TABLOID	48	telmisartan.....	76, 77
TABRECTA	53	telmisartan 40 mg tablet (Micardis).....	77
tacrolimus	113	telmisartan 80 mg tablet (Micardis)	77
tacrolimus 0.5 mg capsule (ir) (Prograf).....	114	telmisartan-amlodipine.....	76
tacrolimus 1 mg capsule (ir) (Prograf)	114	telmisartan-hctz 40-12.5 mg tb (Micardis Hct).....	75
tacrolimus 5 mg capsule (ir) (Prograf)	114	telmisartan-hctz 80-12.5 mg tb (Micardis Hct).....	76
tadalafil.....	73, 159, 160	telmisartan-hctz 80-25 mg tab (Micardis Hct).....	76
TAFINLAR 10 MG TABLET FOR SUSP	49	temazepam (Restoril).....	148
TAFINLAR 50 MG CAPSULE.....	49	TEMBEXA	62
TAFINLAR 75 MG CAPSULE	49	TEMOVATE (clobetasol propionate)	155
tafluprost/pf (Zioptan)	97	temozolomide.....	47
TAGITOL V.....	92	TENIVAC	69
TAGRISSO.....	53	tenofovir disoproxil fumarate (Viread).....	60
TAKHZYRO	65	TEPMETKO.....	54
TALTZ AUTOINJECTOR.....	150	terazosin.....	75

Index of Medications

terbinafine.....	39	tiopronin (Thiola Ec).....	166
terbutaline.....	27	tiotropium 18 mcg cap-inhaler (Spiriva Handihaler).....	27
terconazole.....	39	TISSEEL.....	153
teriflunomide.....	83	TIVICAY.....	61
teriparatide (Bonsity).....	164	tizanidine.....	136
teriparatide (Forteo).....	164	tizanidine hcl 2 mg tablet.....	136
TERUMO SURGUARD2.....	127	tizanidine hcl 4 mg tablet (Zanaflex).....	136
testosterone.....	107, 108	TOBI.....	31
TESTOSTERONE.....	107, 108	TOBRADEX.....	30
testosterone 1% (50 mg/5 g) pk (AndroGel).....	107	tobramycin.....	31
testosterone 1.62%(1.25 g) pkt.....	108	tobramycin/dexamethasone.....	30
testosterone 1.62% (2.5 g) pkt.....	107	TOBRAMYCIN PAK 300 MG/5 ML.....	31
testosterone 12.5 mg/1.25 gram.....	108	tobramycin sulfate.....	31
testosterone 50 mg/5 gram gel (Testim).....	108	tolbutamide.....	42
testosterone 50 mg/5 gram gel (Vogelxo).....	108	tolcapone.....	58
testosterone cypionate.....	108	tolmetin sodium.....	26
tetrabenazine (Xenazine).....	82	tolmetin sodium (Tolectin 600).....	26
tetracaine.....	96	tolterodine tart er 2 mg cap (Detrol La).....	166
TETRACAINE HCL.....	96	tolterodine tart er 4 mg cap (Detrol La).....	167
tetracycline 250 mg capsule.....	35	tolterodine tartrate (Detrol).....	167
tetracycline 500 mg capsule.....	35	tolvaptan 15 mg-15 mg tablet (Jynarque).....	93
TEXACORT.....	155	tolvaptan 15 mg tablet (Jynarque).....	93
TEZSPIRE 210 MG/1.91 ML PEN.....	158	tolvaptan 15 mg tablet (Samsca).....	93
TEZSPIRE 210 MG/1.91 ML SYRING.....	158	tolvaptan 30 mg tablet (Jynarque).....	93
THALOMID.....	32	tolvaptan 30 mg tablet (Samsca).....	93
THEO-24.....	30	TOPCARE.....	124
theophylline.....	30	TOPCARE UNIVERSAL1 LANCET.....	132
THIN LANCETS.....	122, 123, 124, 132	TOPCARE UNIVERSAL1 THIN LANCET.....	132
THIN WALL NEEDLES.....	127	TOPICORT (desoximetasone).....	155
thioridazine.....	147	topiramate 15 mg sprinkle cap (Topamax).....	86
thiothixene.....	146	topiramate 25 mg/ml solution (Eprontia).....	86
THRIVITE RX.....	138	topiramate 25 mg sprinkle cap (Topamax).....	86
THROMBI-GEL (thrombin/cal/cmc/gel/dress,hem).....	70	topiramate 25 mg tablet (Topamax).....	86
THROMBIN-JMI.....	70	topiramate 50 mg sprinkle cap.....	86
THROMBI-PAD.....	70	topiramate 50 mg tablet (Topamax).....	86
thyroid,pork.....	158	topiramate 100 mg tablet (Topamax).....	86
tiagabine.....	86	topiramate 200 mg tablet (Topamax).....	86
TIAZAC (diltiazem hcl).....	72	topiramate er 25 mg capsule (Trokendi Xr).....	86
TIBSOVO.....	54	topiramate er 50 mg capsule (Trokendi Xr).....	86
ticagrelor (Brilinta).....	58	topiramate er 100 mg capsule (Trokendi Xr).....	86
TIGLUTIK.....	82	topiramate er 200 mg capsule (Trokendi Xr).....	86
timolol (Betimol).....	97	topiramate (Qudexy Xr).....	86
timolol maleate.....	78, 97	toremifene citrate.....	55
timolol maleate/pf.....	97	torseamide.....	93
timolol maleate/pf (Timoptic Ocudose).....	97	TRACLEER.....	73
tinidazole.....	45	tramadol.....	22, 23
tiopronin 100 mg tablet (Thiola).....	166	TRAMADOL.....	22
tiopronin dr 100 mg tablet (Thiola Ec).....	166	tramadol er.....	22
tiopronin dr 300 mg tablet (Thiola Ec).....	166	tramadol hcl.....	22, 23

Index of Medications

TRAMADOL HCL.....	22, 23	TRICOR (fenofibrate nanocrystallized).....	81
tramadol hcl 50 mg tablet.....	22	trientine.....	162
tramadol hcl 100 mg tablet.....	22	TRIENTINE HCL.....	162
tramadol hcl/acetaminophen.....	21	trientine hcl 250 mg capsule (Syprine).....	162
trandolapril.....	74, 76	trifluoperazine.....	147
trandolapril/verapamil hcl.....	74	trifluridine.....	61
tranexamic acid.....	69	trihexyphenidyl.....	57
TRANSDERM-SCOP.....	103	TRIJARDY XR 5-2.5-1,000 MG TAB.....	44
TRANSFER NEEDLE.....	127	TRIJARDY XR 10-5-1,000 MG TAB.....	44
TRANXENE.....	139	TRIJARDY XR 12.5-2.5-1,000 MG.....	44
tranylcypromine sulfate.....	139	TRIJARDY XR 25-5-1,000 MG TAB.....	44
travoprost (Travatan Z).....	97	TRIKAFTA 50-25-37.5 MG/75 MG.....	158
trazodone.....	141	TRIKAFTA 80-40-60MG/59.5MG PKT.....	158
TRELEGY ELLIPTA 100-62.5-25.....	29	TRIKAFTA 100-50-75 MG/75MG PKT.....	158
TRELEGY ELLIPTA 200-62.5-25.....	29	TRIKAFTA 100-50-75 MG/150 MG.....	158
TREMFYA.....	112	trimethobenzamide.....	103
TREMFYA 100 MG/ML PEN.....	112	trimethoprim.....	31, 32
TREMFYA 200 MG/2 ML PEN.....	112	trimipramine.....	143
TREMFYA ONE-PRESS.....	112	TRIMO-SAN.....	45
TREMFYA PEN INDUCTION (2 PEN).....	112	TRINTELLIX 5 MG TABLET.....	142
TRESIBA.....	44	TRINTELLIX 10 MG TABLET.....	142
tretinoin.....	55, 150	TRINTELLIX 20 MG TABLET.....	142
tretinoin 0.1% cream (Retin-A).....	156	TRISTART DHA.....	138
tretinoin 0.01% gel (Retin-A).....	156	TRIUMEQ.....	59
tretinoin 0.05% cream (Retin-A).....	156	TRI-VI-FLOR.....	168
tretinoin 0.05% gel (Atralin).....	156	TROKENDI.....	87
tretinoin 0.025% cream (Retin-A).....	156	tropicamide.....	97
tretinoin 0.025% gel (Retin-A).....	156	tropium chloride.....	167
tretinoin microspheres (Retin-A Micro).....	156	TRUE.....	124
tretinoin microspheres (Retin-A Micro Pump).....	156	TRUE COMFORT.....	124
TREXALL.....	48	TRUE COMFORT ALCOHOL PADS.....	149, 151
TREZIX.....	21	TRUE COMFORT LANCET.....	132
triamcinolone 0.1% cream.....	155	TRUE COMFORT PRO ALCOHOL PADS.....	149, 151
triamcinolone 0.1% lotion.....	155	TRUE COMFORT SAFETY LANCET.....	132
triamcinolone 0.1% ointment.....	155	TRUECONTROL.....	120
triamcinolone 0.1% paste.....	159	TRUEDRAW.....	120
triamcinolone 0.5% cream.....	155	TRUE METRIX.....	91, 120
triamcinolone 0.5% ointment.....	155	TRUEPLUS.....	124
triamcinolone 0.025% cream.....	155	TRUEPLUS KETONE TEST STRIP.....	92
triamcinolone 0.025% lotion.....	155	TRUEPLUS LANCET.....	132
triamcinolone 0.025% oint.....	155	TRUEPLUS LANCETS.....	132
triamcinolone acetonide.....	155, 159	TRULANCE.....	105
triamterene.....	94	TRULICITY.....	41
triamterene/hydrochlorothiazid.....	94	TRUMENBA.....	67
triazolam.....	148	TRUQAP.....	54
TRICARE.....	138	TRYNGOLZA.....	79
trichloroacetic acid.....	153	TRYPTYR.....	98
TRICHLOROACETIC ACID.....	153	TUKYSA.....	54
TRICHLOROACETIC ACID (trichloroacetic acid).....	153	TURALIO.....	54

Index of Medications

TUXARIN	90	UNILET COMFORTOUCH	125, 132
TUZISTRA	90	UNILET EXCELITE	125, 132
TWIIST REFILL KT(CSST-NDL-SYR)	120	UNILET EXCELITE II	125, 132
TWIIST RFL(INFUS-CSST-NDL-SYR).....	120	UNILET GP LANCET	125, 132
TWIIST STARTER KIT	120	UNILET LANCET	125, 132
TWINRIX	69	UNILET LANCETS	125, 132
TWIST LANCETS	124, 132	UNISTIK.....	122, 125
TWIST TOP LANCET	132	UNISTIK 2	120
TWYNEO	150	UNISTIK 2 COMFORT	125, 132
TYBOST.....	158	UNISTIK 2 EXTRA	125, 133
TYENNE	113	UNISTIK 2 NORMAL	125, 133
TYVASO	74	UNISTIK 3	125, 133
U		UNISTIK 3 COMFORT	125, 133
UBRELVY	20	UNISTIK 3 DUAL.....	125, 133
UCERIS	110	UNISTIK 3 EXTRA	125, 133
UDAMIN SP	167	UNISTIK 3 NORMAL	125, 133
UDENYCA	88	UNISTIK COMFORT	125, 133
UDENYCA AUTOINJECTOR	88	UNISTIK CZT.....	125, 133
ULESFIA.....	57	UNISTIK EXTRA	125, 133
ULTANE.....	23	UNISTIK NORMAL.....	125, 133
ULTI-LANCE.....	120	UNISTIK PRO	125, 133
ULTILET ALCOHOL SWAB.....	149, 151	UNISTIK SAFETY	125, 133
ULTILET BASIC	124, 132	UNISTIK TOUCH	125, 133
ULTILET CLASSIC.....	124, 132	UNISTRIP	120
ULTILET LANCETS.....	124, 132	UNIVERSAL	125
ULTILET SAFETY	124, 132	UNIVERSAL 1.....	133
ULTRA-CARE.....	124	UPTRAVI	74
ULTRA-CARE LANCETS.....	132	URISTIX 4	93
ULTRA-FINE INSULIN SYRINGE	128	URISTIX REAGENT	93
ULTRA-FINE MICRO PEN NEEDLE.....	127	UROCIT-K	102
ULTRA-FINE MINI PEN NEEDLE	127	UROQID-ACID	102
ULTRA-FINE NANO PEN NEEDLE	127	URSO	104
ULTRA-FINE ORIGINAL PEN NEEDLE	127	ursodiol	104
ULTRA-FINE PEN NEEDLE	127	ursodiol 250 mg tablet	104
ULTRA-FINE SHORT PEN NEEDLE	127	ursodiol 300 mg capsule.....	104
ULTRAFOAM	70	ursodiol 500 mg tablet (Urso Forte).....	104
ULTRALANCE.....	124, 132	USTEKINUMAB-TTWE	112
ULTRA THIN.....	122, 124	V	
ULTRA-THIN II 28G LANCETS	124, 132	valacyclovir	62
ULTRA-THIN II 30G LANCETS	124, 132	valacyclovir hcl (Valtrex)	62
ULTRA THIN LANCET	124, 132	VALCHLOR.....	55
ULTRA THIN LANCETS.....	132	valganciclovir hcl (Valcyte).....	62
ULTRA THIN PLUS LANCETS	124, 132	valproic acid	87
ULTRATLC	124	valsartan 20 mg/5 ml solution	77
ULTRATLC LANCETS.....	132	valsartan 40 mg tablet (Diovan).....	77
ULTRATRAK CONTROL SOL NORMAL.....	120	valsartan 80 mg tablet (Diovan).....	77
ULTRATRAK CONTROL SOLUTION.....	120	valsartan 160 mg tablet (Diovan)	77
ULTRATRAK ULTIMATE CNTRL SOLN	120	valsartan 320 mg tablet (Diovan).....	77
UNILET	122	valsartan/hydrochlorothiazide (Diovan Hct).....	76

Index of Medications

VALTOCO.....	84	VIREAD 150 MG TABLET	60
VALTRES	62	VIREAD 200 MG TABLET	60
vancomycin 25 mg/ml oral soln	35	VIREAD 250 MG TABLET	60
vancomycin 50 mg/ml oral soln (Firvanq).....	35	VIREAD POWDER.....	60
vancomycin 250 mg/5ml oral sol (Firvanq)	35	VISTARIL.....	41
vancomycin hcl 125 mg capsule (Vancocin Hcl).....	35	VISTOGARD.....	159
vancomycin hcl 250 mg capsule (Vancocin Hcl)	35	VITAFOL	100
VANFLYTA.....	54	VITAFOL FE PLUS.....	138
VANILLA SILQ.....	92	VITAFOL GUMMIES	138
VANRAFIA	166	VITAFOL NANO	138
vardenafil hcl.....	160	VITAFOL-OB.....	138
varenicline.....	156	VITAFOL-OB+DHA	138
VARIBAR	92	VITAFOL-ONE	138
VARIVAX VACCINE.....	69	VITAFOL ULTRA	138
VARUBI	103	VITAL-D RX.....	168
VASCEPA (icosapent ethyl).....	102	VITAMEDMD ONE RX	138
VAXELIS.....	69	VITAMEDMD REDICHEW RX (prenatal no.42/folic acid)	138
VAXNEUVANCE.....	67	VITAPEARL	138
VECAMYL.....	77	VITA-RESPA.....	168
VELPHORO	99	VITRAKVI.....	54
VELSIPITY	83	VIVAGUARD	125
VELTASSA	99	VIVAGUARD INO CONTROL SOLUTION.....	120
VEMLIDY.....	63	VIVAGUARD LANCET	133
VENCLEXTA	54	VIVAGUARD LANCING DEVICE.....	120
venlafaxine.....	141, 142	VIVAGUARD SAFETY LANCET	133
VEO INSULIN SYRINGE.....	128	VIVJOA.....	39
verapamil.....	71, 72, 74	VIZIMPRO.....	54
VERELAN	72	VONJO	54
VERELAN PM (verapamil hcl).....	72	VOQUEZNA	106
VERIFINE.....	125	VORANIGO	54
VERIFINE SAFETY LANCET MINI.....	133	voriconazole	39
VERIFINE UNIVERSAL LANCET	133	VORTEX	135
VERQUVO	73	VORTEX ADULT MASK.....	135
VERZENIO.....	54	VORTEX HOLDING CHAMBER.....	135
VFEND.....	39	VORTEX VHC PEDIATRIC MASK	135
V-GO 20.....	120	VOSEVI.....	62
V-GO 30.....	120	VOXZOGO	162
V-GO 40	120	VOYDEYA	69
VIAGRA.....	160	VRAYLAR	146
VIBERZI.....	105	VUMERITY.....	83
vigabatrin (Sabril)	87	VYKAT	164
vigadrone 500 mg powder packet (Sabril).....	87	VYLEESI.....	162
VIJOICE 50 MG GRANULE PACKET	158	VYNDAMAX.....	163
VIJOICE 50 MG TABLET	158	VYNDAQEL	163
VIJOICE 125 MG TABLET	158	VYVGART HYTRULO.....	162
VIJOICE 250 MG DAILY DOSE PACK	158	W	
vilazodone.....	142	WAKIX.....	87
VIMPAT 10 MG/ML SOLUTION (lacosamide).....	87	warfarin.....	36
VIOKACE	106	water for irrigation, sterile	149

Index of Medications

WEBCOL.....	149, 151	ZARONTIN.....	87
Wegovy.....	56	ZARXIO.....	88
WELIREG.....	54	ZAVZPRET.....	20
WIDE SEAL DIAPHRAGM.....	89	ZEGALOGUE AUTOINJECTOR.....	98
WINREVAIR.....	74	ZEGALOGUE SYRINGE.....	98
WINREVAIR (2 PACK).....	74	ZEJULA.....	54
X		ZELBORAF.....	49
XADAGO.....	58	ZEMPLAR.....	160
XALKORI 20 MG PELLET.....	54	ZENPEP.....	106
XALKORI 50 MG PELLET.....	54	ZENZEDI.....	64
XALKORI 150 MG PELLET.....	54	ZENZEDI (dextroamphetamine sulfate).....	64
XALKORI 200 MG CAPSULE.....	54	ZEPATIER.....	63
XALKORI 250 MG CAPSULE.....	54	ZEPBOUND.....	56
XARELTO.....	37	ZEPOSIA.....	83
XARELTO (rivaroxaban).....	37	zidovudine.....	60
XATMEP.....	48	zidovudine (Retrovir).....	60
XCLAIR.....	152	ZIEXTENZO.....	88
XCOPRI.....	87	zileuton.....	27
XDEMVIY.....	56	ZIMHI.....	39
XELJANZ.....	25	zinc oxide.....	152
XELODA.....	48	ZINC OXIDE.....	152
XELSTRYM.....	64	ziprasidone hcl (Geodon).....	146
XENICAL.....	56	ZIRGAN.....	61
XENLETA.....	34	ZITHROMAX.....	33
XEPI.....	36	ZITHROMAX (azithromycin).....	33
XERMELO.....	102	ZOKINVY.....	158
XIFAXAN.....	34	ZOLINZA.....	47
XIGDUO.....	43	zolmitriptan.....	20
XIIDRA.....	97	zolmitriptan 2.5 mg tablet (Zomig).....	20
XOFLUZA.....	62	zolmitriptan 5 mg tablet (Zomig).....	20
XOLAIR.....	29	zolpidem tart 1.75 mg tab sl.....	148
XOLREMDI.....	88	zolpidem tart 3.5 mg tablet sl.....	148
XOPENEX.....	28	zolpidem tart er 6.25 mg tab (Ambien Cr).....	148
XOSPATA.....	54	zolpidem tart er 12.5 mg tab (Ambien Cr).....	148
XPOVIO.....	55	zolpidem tartrate 5 mg tablet (Ambien).....	148
XTAMPZA ER.....	23	zolpidem tartrate 10 mg tablet (Ambien).....	148
XTANDI.....	48	zonisamide.....	87
XURIDEN.....	99	ZONTIVITY.....	58
XYWAV.....	147	ZORTRESS.....	114
Y		ZORYVE 0.15% CREAM.....	153
YALE NEEDLES.....	127	ZTALMY.....	147
YESINTEK.....	112	ZTLIDO.....	23
YEZTUGO 463.5 MG/1.5 ML VIAL.....	59	ZUBSOLV.....	165
YORVIPATH.....	111	ZURZUVAE.....	139
YUTREPIA.....	74	ZYDELIG.....	54
Z		ZYLET.....	30
zafirlukast.....	29	ZYMFENTRA.....	47
zaleplon.....	148	ZYMFENTRA PEN.....	47
ZANAFLEX.....	136	ZYVOX.....	34

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

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



1. App/online store terms and mobile phone carrier/data charges apply. Customers under age 13 (and/or their parent/guardian) will not be able to register at myCigna.com.
2. Smoking cessation medications are not usually covered under the plan, except as required by law or by the terms of your specific plan. Costs and complete details of the plan's prescription drug coverage, including a full list of exclusions and limitations, are set forth in the plan documents. If there are any differences between the information provided here and the plan documents, the information in the plan documents takes complete precedence.
3. Prices shown on myCigna are not guaranteed and coverage is subject to your plan terms and conditions. Visit myCigna for more information.
4. U.S. Food and Drug Administration (FDA) website, "Generic Drug Facts." Content current as of 11/01/21. [fda.gov/drugs/generic-drugs/generic-drug-facts](https://www.fda.gov/drugs/generic-drugs/generic-drug-facts).
5. U.S. Food and Drug Administration (FDA) website, "Biosimilar Basics for Patients." Last updated 08/01/24. [fda.gov/drugs/biosimilars/biosimilars-basics-patients](https://www.fda.gov/drugs/biosimilars/biosimilars-basics-patients).
6. **Not all plans offer Express Scripts Pharmacy and Accredo as covered pharmacy options.** Log in to the myCigna App or myCigna.com, or check your plan materials, to learn more about the pharmacies in your plan's network. Cigna Healthcare, Evernorth Health Services, Express Scripts and Accredo are all part of The Cigna Group. This means we have an ownership interest in Express Scripts Pharmacy's home delivery services and Accredo's specialty pharmacy services. However, you have the right to fill prescriptions at any pharmacy in your plan's network (as your plan allows).
7. Your plan pays the cost for standard shipping.
8. Express Scripts Pharmacy can automatically refill certain medications. Log in to the myCigna App or myCigna.com, or call 800.835.3784, to sign up. You can sign up to get emails and/or texts from Express Scripts Pharmacy. To get text messages, you'll have to sign up for the Express Scripts texting service. You can do this online or when you call 800.835.3784 to refill your prescription. Once you sign up, just reply to their welcome text to get started. Standard text messaging rates apply.
9. You can only refill certain specialty medications by text. To get text messages, you'll have to sign up for Accredo's texting service. You can do this when you call Accredo to refill your prescription. Once you sign up, just reply to their welcome text to get started. Standard text messaging rates apply.
10. **For insured plans that must follow Delaware's state insurance laws:** Brand-name antidepressants, smoking cessation, attention deficit hyperactivity disorder (ADHD) and anti-psychotic medications that don't have a generic equivalent available will be covered as Tier 2 (preferred brand). This is true even if the medication is listed as Tier 3 (non-preferred brand) on your plan's drug list. To find out how your specific plans covers these medications, log in to the myCigna App or myCigna.com, or call the number on your ID card.
11. Costs and complete details of the plan's prescription drug coverage are set forth in the plan documents. If there are any differences between the information provided here and the plan documents, the information in the plan documents takes complete precedence.
12. **For plans that must follow state insurance laws, such as Delaware:** Your plan may provide coverage for infertility medications and smoking cessation medications even if this drug list states that your plan may not cover them. To find out if your specific plan covers these medications, log in to the myCigna App or myCigna.com, or check your plan materials.

Para obtener ayuda en español llame al número en su tarjeta de Cigna Healthcare.

Cigna Healthcare products and services are provided exclusively by or through operating subsidiaries of The Cigna Group.

Discrimination is against the law

Cigna Healthcare® complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, ancestry, religion, marital status, gender, sexual orientation, gender identity or sexual stereotypes.

Cigna Healthcare does not exclude people or treat them less favorably differently because of race, color, national origin, age, disability, sex, ancestry, religion, marital status, gender, sexual orientation, gender identity or sexual stereotypes.

Cigna Healthcare:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language assistance services to people whose primary language is not English in a timely manner, such as:
 - Qualified interpreters
 - Information written in other languages



If you need reasonable modifications, appropriate auxiliary aids and services or language assistance services, contact the Civil Rights Coordinator.

If you believe that Cigna Healthcare has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, ancestry, religion, marital status, gender, sexual orientation, gender identity or sexual stereotypes, you can file a grievance with the Civil Rights Coordinator

P.O. Box 188016, Chattanooga, TN 37422, 877.822.6561 (TTY: Dial 711)

ACAGrievance@CignaHealthcare.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue,
SW Room 509F, HHH Building
Washington, DC 20201
1.800.368.1019, 800.537.7697 (TDD)

Complaint forms are available at <https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html>

Cigna Healthcare products and services are provided exclusively by or through operating subsidiaries of The Cigna Group, including Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company, Evernorth Behavioral Health, Inc., Evernorth Care Solutions, Inc. and HMO or service company subsidiaries of Cigna Health Corporation, including Cigna HealthCare of Arizona, Inc. Cigna HealthCare of California, Inc. Cigna HealthCare of Colorado, Inc. Cigna HealthCare of Connecticut, Inc. Cigna HealthCare of Florida, Inc. Cigna HealthCare of Georgia, Inc. Cigna HealthCare of Illinois, Inc., Cigna HealthCare of Indiana, Inc., Cigna HealthCare of St. Louis, Inc., Cigna HealthCare of North Carolina, Inc., Cigna HealthCare of New Jersey, Inc., Cigna HealthCare of South Carolina, Inc., Cigna HealthCare of Tennessee, Inc., and Cigna HealthCare of Texas, Inc. ATTENTION: If you speak languages other than English, language assistance service, free of charge are available to you. For current Cigna Healthcare customers, call the number on the back of your ID card. Otherwise, call 1.800.244.6224 (TTY: Dial 711). ATENCIÓN: Si usted habla un idioma que no sea inglés, tiene a su disposición servicios gratuitos de asistencia lingüística. Si es un cliente actual de Cigna

Proficiency of Language Assistance Services

English – ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-800-244-6224 (TTY: Dial 711) or speak to your provider.

Spanish – ATENCIÓN: Si habla español, los servicios de asistencia lingüística gratuitos están disponibles para usted. También están disponibles de forma gratuita ayudas y servicios auxiliares adecuados para proporcionar información en formatos accesibles. Llame al 1-800-244-6224 (TTY: Marque 711) o hable con su proveedor.

Chinese – 注意: 如果您讲中文, 我们提供免费的语言援助服务。适当的辅助设备和服务也可以免费提供, 以提供无障碍格式的信息。请拨打 1-800-244-6224 (TTY: 拨打 711) 或与您的服务提供者联系。

Vietnamese – XIN LƯU Ý: Nếu bạn nói tiếng 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 문의하십시오.

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

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

Arabic - تنبيه: إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر أيضًا مساعدات قابلة للوصول إليها، وذلك مجانًا. اتصل بالرقم 1-800-244-6224 (TTY: 711 اطلب بك) أو تحدث إلى مقدم الخدمة الخاص بك (اطلب 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 Sprachassistentendienste zur Verfügung. Geeignete Hilfsmittel und Dienste, um Informationen in barrierefreien Formaten bereitzustellen, sind ebenfalls kostenlos verfügbar. Rufen Sie 1-800-244-6224 an (TTY: Wählen Sie 711) oder sprechen Sie mit Ihrem Anbieter.

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