# 2021 California Small Group 4-Tier HMO and PPO Prescription Drug List

Please note: This Prescription Drug List (PDL) is accurate as of Jan. 1, 2021 and is subject to change after this date. All previous versions of this PDL are no longer in effect. Your estimated coverage and copay/coinsurance may vary based on the benefit plan you choose and the effective date of the plan.

This PDL can also be accessed online at **myuhc.com > Pharmacy Information > Prescription Drug Lists > California plans > Small Group - Standard plans**. Plan-specific coverage documents may be accessed online at **uhc.com/statedruglists > Small Group Plans > California**.

If you are a UnitedHealthcare member, please register or log on to **myuhc.com**, or call the toll-free number on your health plan ID card to find pharmacy information specific to your benefit plan.

This PDL is applicable to the following health insurance products offered by UnitedHealthcare:

- Select Plus
- Core
- Non-Differential PPO
- SignatureValue
- SignatureValue Advantage
- SignatureValue Alliance
- SignatureValue Focus
- SignatureValue Harmony

Please refer to your ID card for plan type (HMO or PPO).

**Updated 9/15/2020**

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United Healthcare

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# At UnitedHealthcare, we want to help you better understand your medication options.

Your pharmacy benefit offers flexibility and choice in determining the right medication for you. To help you get the most out of your pharmacy benefit, we've included some of the most commonly used terms and their definitions as well as frequently asked questions:

**Brand-name drug** means a Prescription Drug Product (1) which is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that we identify as a brand-name product, based on available data resources. This includes data sources such as Medi-Span, that classify drugs as either brand or generic based on a number of factors. Not all products identified as a "brand-name" by the manufacturer, pharmacy, or your Physician will be classified as brand-name by us. A brand-name drug is listed in this PDL in all CAPITAL letters.

**Coinsurance** means 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** means 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** means 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 1 deductible or separate deductibles for medical benefits and prescription drug benefits. After you pay your deductible, you usually pay only a copayment or coinsurance for covered health care benefits. Your insurance company pays the rest.

**Drug Tier** means a group of Prescription Drug Products that correspond to a specified cost sharing tier in your health insurance policy. The drug tier in which a Prescription Drug Product is placed determines your portion of the cost for the drug.

**Enrollee** is a person enrolled in a health plan who is entitled to receive services from the plan. All references to enrollees in this formulary template shall also include subscribers as defined in this section below.

**Exception request** means 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** means 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 (PDL)** means a list that categorizes into tiers medications or products that have been approved by the U.S. Food and Drug Administration (FDA). This list is subject to our periodic review and modification (generally quarterly, but no more than 6 times per calendar year).

**Generic drug** means a Prescription Drug Product: (1) that is chemically equivalent to a brand-name drug; or (2) that we identify as a generic product based on available data resources. This includes data sources such as Medi-Span, that classify drugs as either brand or generic based on a number of factors. Not all products identified as a "generic" by the manufacturer, pharmacy or your Physician will be classified as a generic by us. A generic drug is listed in this PDL in bold and italicized lowercase letters.

**Non-formulary drug** means a Prescription Drug Product that is not listed on this PDL.

**Out-of-pocket costs** means 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** means a health care provider who can write a prescription for a drug to diagnose, treat, or prevent a medical condition.

**Prescription** means an oral, written, or electronic order from a prescribing provider authorizing a Prescription Drug Product to be provided to a specific individual.

**Prescription Drug Product** means a medication or product that has been approved by the U.S. Food and Drug Administration (FDA) and that can, under federal or state law, be dispensed only according to a Prescription Order or Refill. A Prescription Drug Product includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver.

We will provide coverage for a Prescription Drug Product which includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. This definition includes: Inhalers (with spacers); Insulin; the following diabetic supplies: standard insulin syringes with needles; blood-testing strips - glucose; urine-testing strips

- glucose; ketone-testing strips and tablets; lancets and lancet devices; and glucose meters (including continuous glucose monitors [applies to PPO plans **only**]); disposable devices which are medically necessary for the administration of a covered outpatient Prescription Drug Product. Benefits also include FDA-approved contraceptive drugs, devices and products available over-the-counter when prescribed by a Network provider.

**Prior Authorization** means a process by your health insurer to determine that a health care benefit is medically necessary for you. If a Prescription Drug Product is subject to prior authorization in this PDL, your prescribing provider must request approval from your health insurer to cover the drug. Your health insurer must grant a prior authorization request when it is medically necessary for you to take the drug.

**Step therapy** means a specific sequence in which Prescription Drug Products for a particular medical condition must be tried. If a drug is subject to step therapy in this PDL, you may have to try 1 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.

**Subscriber** means the person who is responsible for payment to a plan or whose employment or other status, except for family dependency, is the basis for eligibility for membership in the plan.

# How do I use my PDL?

When choosing a medication, you and your doctor should consult the PDL. It will help you and your doctor choose the most cost-effective prescription drugs. This guide tells you if special programs apply. Bring this list with you when you see your doctor. It is organized by therapeutic category and class. The therapeutic category and class are based on the American Hospital Formulary Service (AHFS) Pharmacologic-Therapeutic Classification.

You may also find a drug by its brand or generic name in the alphabetical index. If a generic equivalent for a brand-name drug is not available on the market or is not covered, the drug will not be separately listed by its generic name.

This is the way Prescription Drug Products appear in the PDL:

1. A drug is listed alphabetically by its brand and generic names in the therapeutic category and class to which it belongs;
2. The generic name for a brand-name drug is included after the brand-name in parentheses and all lowercase bold and italicized letters;
3. If a generic equivalent for a brand-name drug is both available and covered, the generic drug will be listed separately from the brand-name drug in all lowercase bold and italicized letters; and
4. If a generic drug is marketed under a proprietary, trademark-protected brand-name, the brand-name will be listed after the generic name in parentheses and regular typeface with the first letter of each word capitalized.

**Example:**

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| AVAPRO ORAL TABLET 150 MG, 300 MG, 75 MG ***(irbesartan)*** | 3 | |
| ***irbesartan oral tablet 150 mg, 300 mg, 75 mg*** | 1 | |

If your medication is not listed in this document, please visit **myuhc.com** or call the toll-free member phone number on your health plan ID card.

Below is a list of drug tier numbers, abbreviations and designations used in the PDL as well as an explanation for each.

| | |
|---|---|
| **Drug Tier 1** | Your lowest cost medications |
| **Drug Tier 2** | Your mid-range cost medications |
| **Drug Tier 3** | Your mid-range cost medications |
| **Drug Tier 4** | Your highest cost medications |
| **PA** | Prior authorization required |
| **SL** | Supply Limit |
| **ST** | Step Therapy |

| | |
|---|---|
| **H** | May be part of health care reform preventive |
| **H-N** | May be part of health care reform preventive when used for appropriate preventive purposes |
| **SP** | Specialty medication (applies to PPO plans **only**) |
| **CM** | Orally administered anti-cancer medication |
| **M** | May be covered under the medical benefit with prior authorization for HMO plans |

# What are tiers?

Tiers are the different cost levels you pay for a medication. Each tier is assigned a cost, which is determined by your employer or health plan. This is how much you will pay when you fill a prescription. Tier 1 medications are your lowest-cost options. If your medication is placed in Tier 2, 3 or 4, look to see if there is a Tier 1 option available. Discuss these options with your doctor.

For orally administered anti-cancer medications on any Tier, the total amount of copayments and/or coinsurance shall not exceed $250 for an individual prescription of up to a 30-day supply. For high deductible health plans, the $250 maximum only applies once the deductible has been met.

Check your benefit plan documents to find out your specific pharmacy plan costs, including any maximum dollar amount of cost sharing that may apply to a drug. Preferred medications are found in Tier 1, Tier 2 or Tier 3 and may vary depending on the medication and the condition it treats.

| $ | Drug Tier | Includes | Helpful Tips |
|---|---|---|---|
| $ | **Tier 1**<br>**Your lowest cost** | Medications that provide the highest overall value. Mostly generic drugs. Some preferred brand-name drugs may also be included. | Use Tier 1 drugs for the lowest out-of-pocket costs. |
| $$ | **Tier 2 and 3**<br>**Your mid-range cost** | Medications that provide good overall value. A mix of nonpreferred generic drugs and preferred brand-name drugs. | Use Tier 2 or Tier 3 drugs instead of Tier 4 to help reduce your out-of-pocket costs. |
| $$$ | **Tier 4**<br>**Your highest cost** | Medications that provide the lowest overall value. May include biologics, drugs that must be distributed through a specialty pharmacy, drugs that require special training or clinical monitoring for self-administration, or drugs that cost the health insurer more than $600 (net of rebates) for a 1-month supply. | Many Tier 4 drugs have lower-cost options in Tier 1, 2 or 3. Ask your doctor if they could work for you. |

**Please note:** If you have a high deductible plan, the tier cost levels may apply once you reach your deductible. Refer to your enrollment and plan materials on **myuhc.com**, or call the toll-free number on your health plan ID card for more information about your benefit plan. For HMO plans, please reference your Schedule of Benefits for costs associated with medications covered under the medical benefit.

# When does the PDL change?

This PDL is required to be updated on a monthly basis.

- Medications may move to a lower tier at any time.
- Medications may move to a higher tier when a generic becomes available.
- Medications may move to a higher tier or become non-formulary most often on Jan. 1, May 1, or Sept. 1.
- Medications may become subject to new or revised utilization management procedures, such as prior authorization, step therapy or supply limits, at any time but most often upon FDA approval of the medication or its generic, Jan. 1, May 1, or Sept. 1.

When a medication changes tiers, you may have to pay a different amount for that medication.

The presence of a Prescription Drug Product on the PDL does not guarantee that you will be prescribed that Prescription Drug Product by your provider for a particular medical condition.

# Utilization Management Programs

**Prior authorization required**—Your doctor is required to provide additional information to us to determine coverage. For specific prior authorization requirements, please refer to your Evidence of Coverage.

**Supply limit**—Amount of medication covered per copayment or in a specific time period.

**Step therapy**—Requires you to try 1 or more other medications before the medication you are requesting may be covered. For specific step therapy requirements, please refer to your Evidence of Coverage.

**Health Care Reform Preventive when used for appropriate preventive purposes**—This medication is part of a health care reform preventive benefit and may be available at no cost to you when used for appropriate preventive purposes. For more information, please refer to the California Advantage and Essential HMO and PPO Prescription Drug List (PDL) PPACA $0 Cost-Share Preventive Care Medications list.

**Designated specialty program** (applies to PPO plans **only**)—For certain Specialty Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drug Products, which are identified in the Coverage Requirements and Limits column of the Prescription Drug List (PDL). If you choose not to obtain your Prescription Drug Product from the Designated Pharmacy, you may opt-out of the Designated Pharmacy program by contacting us at **myuhc.com** or the telephone number on your ID card.

To learn more about a pharmacy program or to find out if it applies to you, please visit **myuhc.com** or call the toll-free member phone number on your health plan ID card. If you are a pre-enrollee and you would like to learn more about your specific pharmacy benefit, please contact your employer.

Drugs administered by a health care professional are generally covered under the medical benefit while drugs that are self-administered are covered under the pharmacy benefit. In order to obtain medical benefits for drugs that are administered by a health care professional, your provider may also be required to obtain a prior authorization. The provider may contact UnitedHealthcare for more information or **uhcprovider.com**.

# Your Right to Request Access to a Non-formulary Drug

This plan must cover all Medically Necessary Prescription Drug Products.

When a Prescription Drug Product is not on our PDL, you or your representative may request an exception to gain access to that Prescription Drug Product. To make a request, contact us in writing or call the toll-free number on your ID card. We will notify you of our determination within 72 hours. If approved, we will cover the Prescription Drug Product for the duration of the prescription, including refills.

### Urgent Requests

If your request requires immediate action and a delay could significantly increase the risk to your health, or the ability to regain maximum function, call us as soon as possible. We will provide a written or electronic determination within 24 hours. If approved, we will cover the Prescription Drug Product for the duration of the exigency.

### External Review

If you are not satisfied with our determination of your exception request, you may be entitled to request an external review. You or your representative may request an external review by sending a written request to us to the address set out in the determination letter or by calling the toll-free number on your ID card. The Independent Review Organization (IRO) will notify you of its determination within 72 hours.

### Expedited External Review

If you are not satisfied with our determination of your exception request and it involves an urgent situation, you or your representative may request an expedited external review by calling the toll-free number on your ID card or by sending a written request to the address set out in the determination letter. The IRO will notify you of our determination within 24 hours.

If we deny your exception request, you may appeal. Please refer to your Evidence of Coverage for details. The complaint and appeals process, including independent review, is described under Section 6: Questions, Complaints and Appeals. You may also call the telephone number listed on your identification (ID) card.

## Requesting a Prior Authorization or Step Therapy Exception

Before certain Prescription Drug Products are dispensed to you, your prescribing provider or your pharmacist is required to obtain prior authorization or step therapy exception from us. Your prescribing provider can submit a request by phone to OptumRx or electronically by contacting us at **uhcprovider.com**. The Prior Authorization staff of qualified pharmacists and technicians is available Monday – Friday from 5 a.m. – 10 p.m. PST and Saturday from 6 a.m. – 3 p.m. PST to assist licensed physicians. Most authorizations are completed within 24 hours. The most common reason for delay in the authorization process is insufficient information. Your licensed physician may need to provide information on diagnosis and medication history and/or evidence in the form of documents, records or lab tests which establish that the use of the requested Prescription Drug Product meets plan criteria. You may determine whether a particular Prescription Drug Product is subject to prior authorization or step therapy requirements by going online at **myuhc.com** or by calling at the toll-free phone number on the back of your health plan ID card.

If you are changing policies, we will not require you to repeat step therapy when you are already being treated for a medical condition by a Prescription Drug Product provided the Prescription Drug Product is appropriately prescribed and considered safe and effective for your medical condition. However, we may impose a prior authorization requirement for the continued coverage of a Prescription Drug Product prescribed pursuant to step therapy requirements imposed by the former policy. Your prescribing provider may also prescribe another Prescription Drug Product covered under your policy that is medically appropriate for your medical condition.

If you are currently taking a Prescription Drug Product which was approved by UnitedHealthcare for a specific medical condition and that drug is removed from the Prescription Drug List (PDL) and the prescribing provider continues to prescribe the Prescription Drug Product for your medical condition, we will continue to cover the Prescription Drug Product provided that the drug is appropriately prescribed and is considered safe and effective for treating your medical condition.

In the case of a standard prior authorization or step therapy exception request, we will notify you, your designee, or your prescribing provider of the Benefit determination no later than 72 hours following receipt of the request. In the case of an expedited prior authorization or step therapy exception request based on exigent circumstances, we will notify you, your designee, or your prescribing provider of the Benefit determination no later than 24 hours following receipt of the request. If we fail to respond to you, your designee, or your prescribing provider within the prescribed time limits, the request is deemed approved and we may not deny the request thereafter.

If you disagree with a determination, you can request an appeal. The complaint and appeals process, including independent medical review, is described in the Evidence of Coverage under Section 6: Questions, Complaints and Appeals. You may also call at the telephone number on your ID card.

## How do I locate and fill a prescription through a retail network pharmacy?

UnitedHealthcare has a well-established network of pharmacies including most major pharmacy and supermarket chains as well as many independent pharmacies. For a listing of network pharmacies, call the toll-free phone number on your health plan ID card to help locate a network pharmacy near you or visit our website at **myuhc.com** for an up-to-date list.

## How do I locate and fill a prescription through the mail order pharmacy?

UnitedHealthcare offers a Mail Order Pharmacy Program through OptumRx®. Here's how to fill prescriptions through the Mail Order Pharmacy Program.

1. Call your prescribing provider to obtain a new prescription for each medication. When you call, ask the Physician to write the prescription for a 90-day supply which represents 3 prescription units with up to 3 additional refills. The doctor will tell you when to pick up the written prescription. (Note: OptumRx must have a new prescription to process any new Mail Order request.)

2. After picking up the prescription, complete the Mail Order Form included in your enrollment materials. (To obtain additional forms or for assistance in completing the form, contact UnitedHealthcare's Customer Service Department by calling the telephone number on the back of your ID card. You can also find the form at **optumrx.com**.)
3. Enclose the prescription and appropriate copayment via check, money order, or credit card. Your Pharmacy Schedule of Benefits will have the applicable copayment for the Mail Order Pharmacy Program. Make the check or money order payable to **OptumRx**. No cash please.

Important Tip: If you are starting a new Prescription Drug Product, please request 2 prescriptions from your physician. Have 1 filled immediately at a network pharmacy while mailing the second prescription to UnitedHealthcare's Mail Order Pharmacy. Once you receive your medication through the Mail Order Pharmacy Program, you should stop filling the prescription at the network pharmacy.

## How do I locate and fill a prescription at a specialty pharmacy?

Call the phone number on the back of your health plan ID card or visit **specialty.optumrx.com** to locate a designated specialty pharmacy for your medication.

**Designated Pharmacies** (applies to PPO plans **only**)

If you require certain Specialty Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Specialty Prescription Drug Products. There are both retail and mail pharmacies in the Designated Pharmacy network. Note that not all contracted retail pharmacies are in the Designated Pharmacy network. Only retail pharmacies that are in the Designated Pharmacy network will provide access to these Specialty Prescription Drug Products. If you choose not to obtain your Specialty Prescription Drug Product from the Designated Pharmacy, you may opt-out of the Designated Pharmacy program through the Internet at **myuhc.com** or by calling the telephone number on your ID card. If you want to opt-out of the program and fill your Specialty Prescription Drug Product at a non-Designated Pharmacy but do not inform us, you will be responsible for the entire cost of the Specialty Prescription Drug Product and no Benefits will be paid.

In urgent or emergent circumstances, you may contact Customer Service by calling the telephone number on the back of your ID card. This will allow you access to the retail network override process and allow the urgent or emergent prescription claim to pay at your local pharmacy for same day access if they have the Prescription Drug Product available.

## How do I get updated information about my pharmacy benefit?

Since the PDL may change during your plan year, we encourage you to visit **myuhc.com** or call the toll-free member phone number on your health plan ID card for more current information.

**Log in to myuhc.com for the following pharmacy information and tools:**

- Pharmacy benefit and coverage information
- Possible lower-cost medication options
- Medication interactions and side effects
- Participating retail pharmacies by ZIP code
- Your prescription history

**And, if mail order services are included in your pharmacy benefit, you can also:**

- Refill prescriptions
- Check the status of your order
- Set up reminders for refills
- Manage your account

**Learn more** Call the toll-free member phone number on your health plan ID card, or visit **myuhc.com**.

# Nondiscrimination notice and access to communication services

UnitedHealthcare Services, Inc. on behalf of itself and its affiliates does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability.

If you think you were treated unfairly for any of these reasons, you can send a complaint to:

**Online:** **UHC_Civil_Rights@uhc.com**

**Mail:** Civil Rights Coordinator
UnitedHealthcare Civil Rights Grievance
P.O. Box 30608
Salt Lake City, UT 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again. If you need help with your complaint, please call the toll-free phone number listed on your ID card.

If you think you were treated unfairly because of your race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability, you can also send a complaint to the California Department of Managed Health Care:

DMHC
California Help Center
980 9th Street, Suite 500
Sacramento, CA 95814-2725

**1-888-HMO-2219 (1-888-466-2219)**

**1-800-735-2929 or 1-888-877-5378 (TTY)**

**Internet Website: www.hmohelp.ca.gov**

If you think you were treated unfairly because of your sex, age, race, color, national origin, or disability, you can also file a complaint with the U.S. Dept. of Health and Human Services:

**Online:** **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**
Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

**Phone:** Toll-free **1-800-368-1019, 1-800-537-7697 (TDD)**

**Mail:** U.S. Dept. of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, D.C. 20201

**English**

**IMPORTANT LANGUAGE INFORMATION:**

You may be entitled to the rights and services below. You can get an interpreter or translation services at no charge. Written information may also be available in some languages at no charge. To get help in your language, please call your health plan at: UnitedHealthcare of California 1-800-624-8822 / TTY: 711. If you need more help, call HMO Help Line at 1-888-466-2219.

**Spanish**

**INFORMACIÓN IMPORTANTE SOBRE IDIOMAS:**

Es probable que usted disponga de los derechos y servicios a continuación. Puede pedir un intérprete o servicios de traducción sin cargo. Es posible que tenga disponible documentación impresa en algunos idiomas sin cargo. Para recibir ayuda en su idioma, llame a su plan de salud de UnitedHealthcare of California al 1-800-624-8822 / TTY: 711. Si necesita más ayuda, llame a la línea de ayuda de la HMO al 1-888-466-2219.

**Chinese**

**重要語言資訊：**

您可能有資格享有下列權利並取得下列服務。您可以免費獲取口譯員或翻譯服務。部分語言亦備有免費書面資訊。如需取得您語言的協助，請撥打下列電話與您的健保計畫聯絡：UnitedHealthcare of California 1-800-624-8822 / 聽力語言殘障服務專線 (TTY)：711。若您需要更多協助，請撥打 HMO 協助專線 1-888-466-2219。

**Arabic**

**معلومات مهمة عن اللغة:**

ربما تكون مؤهلاً للحصول على الحقوق والخدمات أدناه. فيمكنكَ الحصول على مترجم فوري أو خدمات الترجمة بدون رسوم. وربما تتوفر أيضًا المعلومات المكتوبة بعدة لغات بدون رسوم. وللحصول على مساعدة بلغتك، يُرجى الاتصال بخطتك الصحية على: UnitedHealthcare of California على الرقم 1-800-624-8822 / TTY: 711. وإذا احتجت لمزيدٍ من المساعدة، يمكنك الاتصال بخط المساعدة التابع لـ HMO على الرقم 1-888-466-2219.

**Armenian**

**ԿԱՐԵՎՈՐ ԼԵԶՎԱԿԱՆ ՏԵՂԵԿՈՒԹՅՈՒՆ՝**

Հավանական է, որ Ձեզ հասանելի լինեն հետևյալ իրավունքներն ու ծառայությունները: Կարող եք ստանալ բանավոր թարգմանչի կամ թարգմանության անվճար ծառայություններ: Հնարավոր է, որ մի շարք լեզուներով նաև առկա լինի անվճար գրավոր տեղեկություն: Ձեր լեզվով օգնություն ստանալու համար խնդրում ենք զանգահարել Ձեր առողջապահական ծրագիր՝ UnitedHealthcare of California 1-800-624-8822 / TTY՝ 711 համարով: Հավելյալ օգնության կարիքի դեպքում, զանգահարեք HMO-ի Օգնության հեռախոսագիծ 1-888-466-2219 համարով:

**Cambodian**

**ព័ត៌មានសំខាន់អំពីភាសា៖**

អ្នកអាចនឹងមានសិទ្ធិ ចំពោះសិទ្ធិ និងសេវានៅខាងក្រោម។ អ្នកអាចទទួលអ្នកបកប្រែ ឬសេវាកាបកប្រែ ដោយឥតគិតថ្លៃ។ **ព័ត៌មានដែលបានសរសេរ ក៏អាចនឹងមានជាភាសាមួយចំនួន ដោយឥតគិតថ្លៃដែរ។** ដើម្បីទទួលជំនួយជាភាសារបស់អ្នក សូមទូរស័ព្ទទៅគម្រោងសុខភាពរបស់អ្នក តាមលេខ៖ UnitedHealthcare of California 1-800-624-8822 / TTY: 711។ បើសិនអ្នកត្រូវការជំនួយថែមទៀត ហៅខ្សែទូរស័ព្ទជំនួយ HMO តាមលេខ 1-888-466-2219។

**Farsi**

**اطلاعات مهم در مورد زبان:**
شما ممکن است برای حقوق و خدمات زیر واجد شرایط باشید. می توانید خدمات مترجم شفاهی یا ترجمه را بدون پرداخت هزینهدریافت کنید. اطلاعات کتبی ممکن است بدون پرداخت هزینه به برخی زبان ها موجود باشد. برای دریافت کمک و راهنمایی به زبان خودتان، لطفاً با برنامه درمانی: UnitedHealthcare of California به شماره 711 :1-800-624-8822/TTY. تماس بگیرید. اگر به کمک و راهنمایی بیشتری نیاز دارید، با خط دریافت کمک و راهنمایی HMO به شماره 1-888-466-2219 تماس بگیرید.

**Hindi**

**भाषा-संबंधी महत्वपूर्ण जानकारी:**

आप निम्नलिखित अधिकारों और सेवाओं के हकदार हो सकते हैं। आपको मुफ़्त में दुभाषिया या अनुवाद सेवाएँ उपलब्ध कराई जा सकती हैं। कुछ भाषाओं में लिखित जानकारी भी आपको मुफ़्त में उपलब्ध कराई जा सकती हैं। अपनी भाषा में सहायता प्राप्त करने के लिए, कृपया अपने स्वास्थ्य प्लान को यहाँ कॉल करें: UnitedHealthcare of California 1-800-624-8822 / TTY: 711। पर। अतिरिक्त सहायता की आवश्यकता पड़ने पर, HMO Help Line को 1-888-466-2219 पर कॉल करें।

**Hmong**

**COV NTAUB NTAWV LUS TSEEM CEEB:**

Tej zaum koj yuav muaj cai rau cov cai pab cuam hauv qab no. Koj tuaj yeem tau txais ib tug kws txhais lus los sis txhais ntawv pub dawb. Cov ntaub ntawv sau no muaj sau ua qee yam ntaub ntawv pub dawb rau sawd daws. Yuav tau txais kev cov ntaub ntawv sau ua koj lus, thov hu rau qhov chaw npaj kho mob rau ntawm: UnitedHealthcare of California 1-800-624-8822 / TTY: 711. Yog koj xav tau kev pab ntxiv, hu rau HMO Help Line ntawm tus xov tooj 1-888-466-2219.

**Japanese**

**言語支援サービスについての重要なお知らせ：**

お客様には、以下権利があり、必要なサービスをご利用いただける可能性があります。お客様は、通訳または翻訳のサービスを無料でご利用いただけます。言語によっては、文書化された情報を無料でご利用できる場合もあります。ご希望の言語による援助をご希望の方は、お客様の医療保険プランにご連絡ください。UnitedHealthcare of California 1-800-624-8822 / TTY: 711。この他のサポートが必要な場合には、HMO Help Line に 1-888-466-2219 にてお問い合わせください。

**Korean**

**중요 언어 정보:**

귀하는 아래와 같은 권리 및 서비스를 누리실 수 있습니다. 귀하는 통역 혹은 번역 서비스를 비용 부담없이 이용하실 수 있습니다. 일부 언어의 경우 서면 번역 서비스 또한 비용 부담없이 제공될 수도 있습니다. 귀하의 언어 지원 서비스가 필요하시면 귀하의 건강보험에 다음 전화번호로 문의하십시오. UnitedHealthcare of California 1-800-624-8822 / TTY: 711. 더 많은 도움이 필요하신 분은 HMO 헬프 라인(안내번호: 1-888-466-2219)으로 문의하십시오.

**Punjabi**

**ਮਹੱਤਵਪੂਰਨ ਭਾਸ਼ਾ ਦੀ ਜਾਣਕਾਰੀ:**

**ਤੁਸੀਂ ਹੇਠਾਂ ਦਿੱਤੇ ਅਧਿਕਾਰ ਅਤੇ ਸੇਵਾਵਾਂ ਦੇ ਹੱਕਦਾਰ ਹੋ ਸਕਦੇ ਹੋ। ਤੁਸੀਂ ਬਿਨਾ ਕਿਸੇ ਲਾਗਤ 'ਤੇ ਦੁਭਾਸ਼ੀਆ ਜਾਂ ਅਨੁਵਾਦ ਸੇਵਾਵਾਂ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਲਿਖਤੀ ਜਾਣਕਾਰੀ ਕੁਝ ਭਾਸ਼ਾਵਾਂ ਵਿਚ ਬਿਨਾ ਕਿਸੇ ਖਰਚੇ ਦੇ ਮਿਲ ਸਕਦੀ ਹੈ। ਆਪਣੀ**

ਭਾਸ਼ਾ ਵਿਚ ਸਹਾਇਤਾ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ, ਕਿਰਪਾ ਕਰਕੇ ਆਪਣੀ ਸਿਹਤ ਯੋਜਨਾ ਨੂੰ ਇੱਥੇ ਕਾਲ ਕਰੋ: UnitedHealthcare of California 1-800-624-8822 / TTY: 711। ਜੇ ਤੁਹਾਨੂੰ ਹੋਰ ਮਦਦ ਚਾਹੀਦੀ ਹੈ, ਤਾਂ HMO ਹੈਲਪ ਲਾਈਨ 'ਤੇ ਕਾਲ ਕਰੋ 1-888-466-2219।

**Russian**

**ВАЖНАЯ ЯЗЫКОВАЯ ИНФОРМАЦИЯ:**

Вам могут полагаться следующие права и услуги. Вы можете получить бесплатную помощь устного переводчика или письменный перевод. Письменная информация может быть также доступна на ряде языков бесплатно. Чтобы получить помощь на вашем языке, пожалуйста, позвоните по номеру вашего плана: UnitedHealthcare of California 1-800-624-8822 / линия TTY: 711. Если вам все еще требуется помощь, позвоните в службу поддержки HMO по телефону 1-888-466-2219.

**Tagalog**

**MAHALAGANG IMPORMASYON SA WIKA:**

Maaaring kwalipikado ka sa mga karapatan at serbisyo sa ibaba. Maaari kang kumuha ng interpreter o mga serbisyo sa pagsasalin nang walang bayad. Maaaring may available ding libreng nakasulat na impormasyon sa ilang wika. Upang makatanggap ng tulong sa iyong wika, mangyaring tumawag sa iyong planong pangkalusugan sa: UnitedHealthcare of California 1-800-624-8822 / TTY: 711. Kung kailangan mo ng higit pang tulong, tumawag sa HMO Help Line sa 1-888-466-2219.

**Thai**

**ข้อมูลสำคัญเกี่ยวกับภาษา :**

คุณอาจมีสิทธิ์ได้รับสิทธิและบริการต่าง ๆ ด้านล่างนี้ คุณสามารถขอล่ามแปลภาษาหรือบริการแปลภาษาได้โดยไม่ต้องเสียคาใช้จ่ายแตอยางใด นอกจากนี้ ยังอาจมีข้อมูลเป็นลายลักษณ์อักษรบางภาษาให้ด้วยโดยไม่ต้องเสียคาใช้จ่ายแตอยางใด หากต้องการขอความช่วยเหลือเป็นภาษาของคุณ
โปรดโทรศัพท์ถึงแผนสุขภาพของคุณที่ : UnitedHealthcare of California 1-800-624-8822 /
สำหรับผู้มีความบกพรองทางการฟัง : 711 หากต้องการความช่วยเหลือเพิ่มเติม
โปรดโทรศัพท์ถึงศูนย์ให้ความช่วยเหลือเกี่ยวกับ HMO
ที่หมายเลขโทรศัพท์ 1-888-466-2219

**Vietnamese**

**THÔNG TIN QUAN TRỌNG VỀ NGÔN NGỮ:**

Quý vị có thể được hưởng các quyền và dịch vụ dưới đây. Quý vị có thể yêu cầu được cung cấp một thông dịch viên hoặc các dịch vụ dịch thuật miễn phí. Thông tin bằng văn bản cũng có thể sẵn có ở một số ngôn ngữ miễn phí. Để nhận trợ giúp bằng ngôn ngữ của quý vị, vui lòng gọi cho chương trình bảo hiểm y tế của quý vị tại: UnitedHealthcare of California 1-800-624-8822 / TTY: 711. Nếu quý vị cần trợ giúp thêm, xin gọi Đường dây hỗ trợ HMO theo số 1-888-466-2219.

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| **ANTIHISTAMINE DRUGS - Drugs for Allergy** | | |
| **ETHANOLAMINE DERIVATIVES - Drugs for Allergy** | | |
| ***carbinoxamine maleate oral solution 4 mg/5ml*** | 1 | |
| ***carbinoxamine maleate oral tablet 4 mg*** | 1 | |
| ***clemastine fumarate oral tablet 2.68 mg*** | 1 | |
| DICOPANOL FUSEPAQ ORAL SUSPENSION RECONSTITUTED 5 MG/ML (***diphenhydramine hcl***) | 3 | PA |
| ***diphen oral elixir 12.5 mg/5ml*** | 1 | |
| ***diphenhydramine hcl oral elixir 12.5 mg/5ml*** | 1 | |
| ***duraxin oral capsule 300-200-20 mg*** | 1 | |
| **FIRST GEN. ANTIHIST. DERIVATIVES, MISC. - Drugs for Allergy** | | |
| ***cyproheptadine hcl oral syrup 2 mg/5ml*** | 1 | |
| ***cyproheptadine hcl oral tablet 4 mg*** | 1 | |
| **FIRST GENERATION ANTIHISTAMINES - Drugs for Allergy** | | |
| ***brompheniramine tannate oral tablet chewable 12 mg*** | 1 | |
| ***carbinoxamine maleate oral solution 4 mg/5ml*** | 1 | |
| ***carbinoxamine maleate oral tablet 4 mg*** | 1 | |
| ***clemastine fumarate oral tablet 2.68 mg*** | 1 | |
| ***cyproheptadine hcl oral syrup 2 mg/5ml*** | 1 | |
| ***cyproheptadine hcl oral tablet 4 mg*** | 1 | |
| DICOPANOL FUSEPAQ ORAL SUSPENSION RECONSTITUTED 5 MG/ML (***diphenhydramine hcl***) | 3 | PA |
| ***diphen oral elixir 12.5 mg/5ml*** | 1 | |
| ***diphenhydramine hcl oral elixir 12.5 mg/5ml*** | 1 | |
| **PHENOTHIAZINE DERIVATIVES - Drugs for Allergy** | | |
| ***promethazine hcl oral solution 6.25 mg/5ml*** | 1 | |
| ***promethazine hcl oral syrup 6.25 mg/5ml*** | 1 | |
| ***promethazine hcl oral tablet 12.5 mg, 25 mg, 50 mg*** | 1 | |
| ***promethazine hcl rectal suppository 12.5 mg, 25 mg*** | 1 | |
| ***promethazine-dm oral syrup 6.25-15 mg/5ml*** | 1 | |
| ***promethazine-phenyleph-codeine oral syrup 6.25-5-10 mg/5ml*** | 1 | PA; SL (360 ml per month.) |
| ***promethazine-phenylephrine oral syrup 6.25-5 mg/5ml*** | 1 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ***promethazine hcl*** (Promethegan Rectal Suppository 12.5 Mg, 25 Mg) | 1 | |
| ***promethegan rectal suppository 50 mg*** | 1 | |
| **PIPERAZINE DERIVATIVES - Drugs for Allergy** | | |
| ***hydroxyzine hcl oral syrup 10 mg/5ml*** | 1 | |
| ***hydroxyzine hcl oral tablet 10 mg, 25 mg, 50 mg*** | 1 | |
| ***hydroxyzine pamoate oral capsule 100 mg, 25 mg, 50 mg*** | 1 | |
| VISTARIL ORAL CAPSULE 25 MG, 50 MG (***hydroxyzine pamoate***) | 3 | |
| **PROPYLAMINE DERIVATIVES - Drugs for Allergy** | | |
| ***brompheniramine tannate oral tablet chewable 12 mg*** | 1 | |
| ***hydrocodone polst-chlorphen polst er susp oral suspension extended release 10-8 mg/5ml*** | 3 | PA; SL (360 ml per month.) |
| NEOTUSS PLUS ORAL LIQUID 7.5-4-30 MG/5ML (***phenylephrine-chlorphen-dm***) | 3 | |
| TUSSICAPS ORAL CAPSULE EXTENDED RELEASE 12 HOUR 10-8 MG (***hydrocod polst-chlorphen polst***) | 3 | PA; SL (10 capsules per prescription and 30 capsules per month) |
| TUXARIN ER ORAL TABLET EXTENDED RELEASE 12 HOUR 54.3-8 MG (***chlorpheniramine-codeine***) | 3 | PA; SL (10 tablets per prescription and 30 tablets per month) |
| **SECOND GENERATION ANTIHISTAMINES - Drugs for Allergy** | | |
| ***levocetirizine dihydrochloride oral solution 2.5 mg/5ml*** | 3 | |
| ***levocetirizine dihydrochloride oral tablet 5 mg*** | 1 | |
| SEMPREX-D ORAL CAPSULE 8-60 MG (***acrivastine-pseudoephedrine***) | 3 | |
| **ANTI-INFECTIVE AGENTS - Drugs for Infections** | | |
| **1ST GENERATION CEPHALOSPORIN ANTIBIOTICS - Antibiotics** | | |
| ***cefadroxil oral capsule 500 mg*** | 1 | |
| ***cefadroxil oral suspension reconstituted 250 mg/5ml, 500 mg/5ml*** | 1 | |
| ***cefadroxil oral tablet 1 gm*** | 1 | |
| ***cephalexin oral capsule 250 mg, 500 mg, 750 mg*** | 1 | |
| ***cephalexin oral suspension reconstituted 125 mg/5ml, 250 mg/5ml*** | 1 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ***cephalexin oral tablet 250 mg, 500 mg*** | 1 | |
| KEFLEX ORAL CAPSULE 250 MG, 500 MG, 750 MG (***cephalexin***) | 3 | |
| **2ND GENERATION CEPHALOSPORIN ANTIBIOTICS - Antibiotics** | | |
| ***cefaclor er oral tablet extended release 12 hour 500 mg*** | 1 | |
| ***cefaclor oral capsule 250 mg, 500 mg*** | 1 | |
| ***cefaclor oral suspension reconstituted 125 mg/5ml, 250 mg/5ml, 375 mg/5ml*** | 1 | |
| ***cefprozil oral suspension reconstituted 125 mg/5ml, 250 mg/5ml*** | 1 | |
| ***cefprozil oral tablet 250 mg, 500 mg*** | 1 | |
| ***cefuroxime axetil oral tablet 250 mg, 500 mg*** | 1 | |
| **3RD GENERATION CEPHALOSPORIN ANTIBIOTICS - Antibiotics** | | |
| ***cefdinir oral capsule 300 mg*** | 1 | |
| ***cefdinir oral suspension reconstituted 125 mg/5ml, 250 mg/5ml*** | 1 | |
| ***cefditoren pivoxil oral tablet 200 mg, 400 mg*** | 1 | |
| ***cefixime oral capsule 400 mg*** | 3 | |
| ***cefixime oral suspension reconstituted 100 mg/5ml, 200 mg/5ml*** | 3 | |
| ***cefpodoxime proxetil oral suspension reconstituted 100 mg/5ml, 50 mg/5ml*** | 1 | |
| ***cefpodoxime proxetil oral tablet 100 mg, 200 mg*** | 1 | |
| SUPRAX ORAL CAPSULE 400 MG (***cefixime***) | 3 | |
| SUPRAX ORAL SUSPENSION RECONSTITUTED 100 MG/5ML, 200 MG/5ML, 500 MG/5ML (***cefixime***) | 3 | |
| SUPRAX ORAL TABLET CHEWABLE 100 MG, 200 MG (***cefixime***) | 3 | |
| **ADAMANTANE ANTIVIRALS - Drugs for Viral Infections** | | |
| ***amantadine hcl oral capsule 100 mg*** | 1 | |
| ***amantadine hcl oral syrup 50 mg/5ml*** | 1 | |
| ***amantadine hcl oral tablet 100 mg*** | 1 | |
| OSMOLEX ER ORAL TABLET ER 24 HOUR THERAPY PACK 129 & 193 MG (***amantadine hcl***) | 3 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ***rimantadine hcl oral tablet 100 mg*** | 1 | |
| **ALLYLAMINE ANTIFUNGALS - Drugs for Fungus** | | |
| ***terbinafine hcl oral tablet 250 mg*** | 1 | SL (90 tablets per 365 days) |
| **AMEBICIDES - Drugs for the Mouth and Throat** | | |
| FLAGYL ORAL CAPSULE 375 MG (***metronidazole***) | 3 | |
| FLAGYL ORAL TABLET 250 MG, 500 MG (***metronidazole***) | 3 | |
| ***metronidazole oral capsule 375 mg*** | 1 | |
| ***metronidazole oral tablet 250 mg, 500 mg*** | 1 | |
| ***paromomycin sulfate oral capsule 250 mg*** | 1 | |
| PYLERA ORAL CAPSULE 140-125-125 MG (***bis subcit-metronid-tetracyc***) | 3 | SL (120 capsules per 180 days.) |
| **AMINOGLYCOSIDE ANTIBIOTICS - Antibiotics** | | |
| ARIKAYCE INHALATION SUSPENSION 590 MG/8.4ML (***amikacin sulfate liposome***) | 3 | PA; SL (8.4 ml per day.); SP |
| BETHKIS INHALATION NEBULIZATION SOLUTION 300 MG/4ML (***tobramycin***) | 3 | PA; SL (224 ml per 56 days.); SP |
| ***neomycin sulfate oral tablet 500 mg*** | 1 | |
| ***paromomycin sulfate oral capsule 250 mg*** | 1 | |
| TOBI PODHALER INHALATION CAPSULE 28 MG (***tobramycin***) | 3 | PA; SL (224 capsules per 56 days.); SP |
| ***tobramycin inhalation nebulization solution 300 mg/4ml*** | 1 | PA; SL (224 ml per 56 days.); SP |
| TOBRAMYCIN NEBULIZATION SOLUTION 300 MG/5ML INHALATION 300 MG/5ML | 3 | PA; SL (56 ampules (1 carton, 280 ml) per 56 days.); SP |
| **AMINOMETHYLCYCLINES - Antibiotics** | | |
| NUZYRA ORAL TABLET 150 MG (***omadacycline tosylate***) | 3 | SL (30 tablets per prescription) |
| **AMINOPENICILLIN ANTIBIOTICS - Antibiotics** | | |
| ***amoxicillin oral capsule 250 mg, 500 mg*** | 1 | |
| ***amoxicillin oral suspension reconstituted 125 mg/5ml, 200 mg/5ml, 250 mg/5ml, 400 mg/5ml*** | 1 | |
| ***amoxicillin oral tablet 500 mg, 875 mg*** | 1 | |
| ***amoxicillin oral tablet chewable 125 mg, 250 mg*** | 1 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ***amoxicillin-potassium clavulanate oral suspension reconstituted 200-28.5 mg/5ml, 250-62.5 mg/5ml, 400-57 mg/5ml, 600-42.9 mg/5ml*** | 1 | |
| ***amoxicillin-potassium clavulanate oral tablet 250-125 mg, 500-125 mg, 875-125 mg*** | 1 | |
| ***amoxicillin-potassium clavulanate oral tablet chewable 200-28.5 mg, 400-57 mg*** | 1 | |
| ***ampicillin oral capsule 500 mg*** | 1 | |
| OMECLAMOX-PAK ORAL 500-500-20 MG (***amoxicill-clarithro-omeprazole***) | 3 | SL (1 carton (10 administrative cards, 80 tablets) per 6 months.) |
| **ANTHELMINTICS - Drugs for Parasites** | | |
| ***albendazole oral tablet 200 mg*** | 3 | PA; SL (124 tablets per month.) |
| ALBENZA ORAL TABLET 200 MG (***albendazole***) | 3 | PA; SL (124 tablets per month.) |
| BILTRICIDE ORAL TABLET 600 MG (***praziquantel***) | 3 | |
| EGATEN ORAL TABLET 250 MG (***triclabendazole***) | 3 | |
| EMVERM ORAL TABLET CHEWABLE 100 MG (***mebendazole***) | 4 | PA; SL (6 tablets per 3 days.) |
| ***ivermectin oral tablet 3 mg*** | 1 | |
| ***praziquantel oral tablet 600 mg*** | 2 | |
| STROMECTOL ORAL TABLET 3 MG (***ivermectin***) | 3 | |
| **ANTIFUNGALS, MISCELLANEOUS - Drugs for Fungus** | | |
| ***griseofulvin microsize oral suspension 125 mg/5ml*** | 1 | |
| ***griseofulvin microsize oral tablet 500 mg*** | 1 | |
| ***griseofulvin ultramicrosize oral tablet 125 mg, 250 mg*** | 1 | |
| IODINE STRONG ORAL SOLUTION 5 % | 2 | |
| SSKI ORAL SOLUTION 1 GM/ML (***potassium iodide (expectorant)***) | 3 | |
| **ANTIMALARIALS - Drugs for the Mouth and Throat** | | |
| ARAKODA ORAL TABLET 100 MG (***tafenoquine succinate***) | 3 | SL (16 tablets per month.) |
| ***atovaquone-proguanil hcl oral tablet 250-100 mg, 62.5-25 mg*** | 2 | |
| ***chloroquine phosphate oral tablet 250 mg, 500 mg*** | 1 | |
| COARTEM ORAL TABLET 20-120 MG (***artemether-lumefantrine***) | 2 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| DARAPRIM ORAL TABLET 25 MG (***pyrimethamine***) | 3 | PA; SP |
| ***hydroxychloroquine sulfate oral tablet 200 mg*** | 1 | |
| KRINTAFEL ORAL TABLET 150 MG (***tafenoquine succinate***) | 1 | SL (2 tablets per prescription) |
| MALARONE ORAL TABLET 250-100 MG, 62.5-25 MG (***atovaquone-proguanil hcl***) | 3 | |
| ***mefloquine hcl oral tablet 250 mg*** | 1 | |
| ***primaquine phosphate oral tablet 26.3 mg*** | 1 | |
| PYLERA ORAL CAPSULE 140-125-125 MG (***bis subcit-metronid-tetracyc***) | 3 | SL (120 capsules per 180 days.) |
| ***pyrimethamine oral tablet 25 mg*** | 2 | PA; SP |
| QUALAQUIN ORAL CAPSULE 324 MG (***quinine sulfate***) | 3 | |
| ***quinidine gluconate er oral tablet extended release 324 mg*** | 1 | |
| ***quinidine sulfate oral tablet 200 mg, 300 mg*** | 1 | |
| ***quinine sulfate oral capsule 324 mg*** | 1 | |
| **ANTIMYCOBACTERIALS, MISCELLANEOUS - Antibiotics** | | |
| ***dapsone oral tablet 100 mg, 25 mg*** | 2 | |
| **ANTIPROTOZOALS, MISCELLANEOUS - Drugs for the Mouth and Throat** | | |
| ALINIA ORAL SUSPENSION RECONSTITUTED 100 MG/5ML (***nitazoxanide***) | 2 | SL (60 ml per prescription) |
| ALINIA ORAL TABLET 500 MG (***nitazoxanide***) | 2 | SL (6 tablets per prescription) |
| ***atovaquone oral suspension 750 mg/5ml*** | 2 | |
| BENZNIDAZOLE ORAL TABLET 100 MG | 2 | PA; SL (248 tablets per 720 days.) |
| BENZNIDAZOLE ORAL TABLET 12.5 MG | 2 | PA; SL (360 tablets per 720 days.) |
| ***dapsone oral tablet 100 mg, 25 mg*** | 2 | |
| FLAGYL ORAL CAPSULE 375 MG (***metronidazole***) | 3 | |
| FLAGYL ORAL TABLET 250 MG, 500 MG (***metronidazole***) | 3 | |
| IMPAVIDO ORAL CAPSULE 50 MG (***miltefosine***) | 2 | PA; SL (3 capsules per day.) |
| ***metronidazole oral capsule 375 mg*** | 1 | |
| ***metronidazole oral tablet 250 mg, 500 mg*** | 1 | |
| NEBUPENT INHALATION SOLUTION RECONSTITUTED 300 MG (***pentamidine isethionate***) | 3 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ***pentamidine isethionate inhalation solution reconstituted 300 mg*** | 2 | |
| PYLERA ORAL CAPSULE 140-125-125 MG (***bis subcit-metronid-tetracyc***) | 3 | SL (120 capsules per 180 days.) |
| SOLOSEC ORAL PACKET 2 GM (***secnidazole***) | 3 | ST; SL (1 packet per prescription) |
| ***tinidazole oral tablet 250 mg, 500 mg*** | 3 | |
| **ANTITUBERCULOSIS AGENTS - Antibiotics** | | |
| CIPRO ORAL SUSPENSION RECONSTITUTED 250 MG/5ML (5%), 500 MG/5ML (10%) (***ciprofloxacin***) | 3 | |
| CIPRO ORAL TABLET 250 MG, 500 MG (***ciprofloxacin hcl***) | 3 | |
| ***ciprofloxacin hcl oral tablet 100 mg, 250 mg, 500 mg, 750 mg*** | 1 | |
| ***clarithromycin er oral tablet extended release 24 hour 500 mg*** | 2 | |
| ***clarithromycin oral suspension reconstituted 125 mg/5ml, 250 mg/5ml*** | 2 | |
| ***clarithromycin oral tablet 250 mg, 500 mg*** | 1 | |
| ***cycloserine oral capsule 250 mg*** | 1 | |
| ***ethambutol hcl oral tablet 100 mg, 400 mg*** | 1 | |
| ***isoniazid oral syrup 50 mg/5ml*** | 1 | |
| ***isoniazid oral tablet 100 mg, 300 mg*** | 1 | |
| ***levofloxacin oral solution 25 mg/ml*** | 1 | |
| ***levofloxacin oral tablet 250 mg, 500 mg, 750 mg*** | 1 | |
| ***moxifloxacin hcl oral tablet 400 mg*** | 3 | |
| MYAMBUTOL ORAL TABLET 400 MG (***ethambutol hcl***) | 3 | |
| MYCOBUTIN ORAL CAPSULE 150 MG (***rifabutin***) | 3 | |
| PASER ORAL PACKET 4 GM (***aminosalicylic acid***) | 3 | |
| PRETOMANID ORAL TABLET 200 MG | 3 | |
| PRIFTIN ORAL TABLET 150 MG (***rifapentine***) | 2 | |
| ***pyrazinamide oral tablet 500 mg*** | 1 | |
| ***rifabutin oral capsule 150 mg*** | 1 | |
| RIFADIN ORAL CAPSULE 150 MG, 300 MG (***rifampin***) | 3 | |
| ***rifampin oral capsule 150 mg, 300 mg*** | 1 | |
| SIRTURO ORAL TABLET 100 MG, 20 MG (***bedaquiline fumarate***) | 2 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| TRECATOR ORAL TABLET 250 MG (***ethionamide***) | 2 | |
| **ANTIVIRALS, MISCELLANEOUS - Drugs for Viral Infections** | | |
| PREVYMIS ORAL TABLET 240 MG, 480 MG (***letermovir***) | 2 | PA |
| XOFLUZA (40 MG DOSE) ORAL TABLET THERAPY PACK 2 X 20 MG (***baloxavir marboxil***) | 3 | SL (2 tablets per month.) |
| XOFLUZA (80 MG DOSE) ORAL TABLET THERAPY PACK 2 X 40 MG (***baloxavir marboxil***) | 3 | SL (2 tablets per month.) |
| **AZOLE ANTIFUNGALS - Drugs for Fungus** | | |
| DIFLUCAN ORAL SUSPENSION RECONSTITUTED 10 MG/ML, 40 MG/ML (***fluconazole***) | 3 | |
| DIFLUCAN ORAL TABLET 100 MG, 150 MG, 200 MG, 50 MG (***fluconazole***) | 3 | |
| ***fluconazole oral suspension reconstituted 10 mg/ml, 40 mg/ml*** | 1 | |
| ***fluconazole oral tablet 100 mg, 150 mg, 200 mg, 50 mg*** | 1 | |
| ***itraconazole oral capsule 100 mg*** | 1 | SL (180 capsules per 365 days) |
| ***itraconazole oral solution 10 mg/ml*** | 2 | SL (1800 ml per 365 days) |
| ***ketoconazole oral tablet 200 mg*** | 1 | |
| NOXAFIL ORAL SUSPENSION 40 MG/ML (***posaconazole***) | 2 | |
| ***posaconazole oral tablet delayed release 100 mg*** | 2 | |
| SPORANOX ORAL CAPSULE 100 MG (***itraconazole***) | 3 | SL (180 capsules per 365 days) |
| SPORANOX ORAL SOLUTION 10 MG/ML (***itraconazole***) | 3 | SL (1800 ml per 365 days) |
| SPORANOX PULSEPAK ORAL CAPSULE 100 MG (***itraconazole***) | 3 | SL (180 capsules per 365 days) |
| VFEND ORAL SUSPENSION RECONSTITUTED 40 MG/ML (***voriconazole***) | 3 | |
| VFEND ORAL TABLET 200 MG (***voriconazole***) | 3 | SL (62 tablets per prescription) |
| VFEND ORAL TABLET 50 MG (***voriconazole***) | 3 | SL (124 tablets per prescription) |
| ***voriconazole oral suspension reconstituted 40 mg/ml*** | 1 | |
| ***voriconazole oral tablet 200 mg*** | 1 | SL (62 tablets per prescription) |
| ***voriconazole oral tablet 50 mg*** | 1 | SL (124 tablets per prescription) |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| **ERYTHROMYCIN ANTIBIOTICS - Antibiotics** | | |
| E.E.S. GRANULES ORAL SUSPENSION RECONSTITUTED 200 MG/5ML (***erythromycin ethylsuccinate***) | 3 | |
| ERYPED 200 ORAL SUSPENSION RECONSTITUTED 200 MG/5ML (***erythromycin ethylsuccinate***) | 3 | |
| ERYPED 400 ORAL SUSPENSION RECONSTITUTED 400 MG/5ML (***erythromycin ethylsuccinate***) | 3 | |
| ***erythromycin base*** (Ery-Tab Oral Tablet Delayed Release 250 Mg, 333 Mg, 500 Mg) | 3 | |
| ERYTHROCIN STEARATE ORAL TABLET 250 MG (***erythromycin stearate***) | 2 | |
| ***erythromycin base oral capsule delayed release particles 250 mg*** | 1 | |
| ***erythromycin base oral tablet 250 mg, 500 mg*** | 1 | |
| ***erythromycin base oral tablet delayed release 250 mg, 333 mg, 500 mg*** | 3 | |
| ***erythromycin ethylsuccinate oral suspension reconstituted 200 mg/5ml*** | 1 | |
| ***erythromycin ethylsuccinate oral suspension reconstituted 400 mg/5ml*** | 3 | |
| ***erythromycin ethylsuccinate oral tablet 400 mg*** | 1 | |
| ***erythromycin oral tablet delayed release 250 mg, 333 mg, 500 mg*** | 3 | |
| **GLYCOPEPTIDE ANTIBIOTICS - Antibiotics** | | |
| FIRVANQ ORAL SOLUTION RECONSTITUTED 25 MG/ML, 50 MG/ML (***vancomycin hcl***) | 1 | |
| VANCOCIN HCL ORAL CAPSULE 125 MG (***vancomycin hcl***) | 3 | SL (56 capsules per 11 days) |
| VANCOCIN ORAL CAPSULE 250 MG (***vancomycin hcl***) | 3 | SL (112 capsules per 11 days) |
| ***vancomycin hcl oral capsule 125 mg*** | 1 | SL (56 capsules per 11 days) |
| ***vancomycin hcl oral capsule 250 mg*** | 1 | SL (112 capsules per 11 days) |
| ***vancomycin hcl oral solution reconstituted 250 mg/5ml*** | 3 | |
| **HCV POLYMERASE INHIBITOR ANTIVIRALS - Drugs for Viral Infections** | | |
| EPCLUSA ORAL TABLET 400-100 MG (***sofosbuvir-velpatasvir***) | 2 | PA; SL (84 tablets per 720 days.) |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| HARVONI ORAL PACKET 33.75-150 MG, 45-200 MG (***ledipasvir-sofosbuvir***) | 2 | SL (1 pellet per day and 84 pellets per 720 days.) |
| HARVONI ORAL TABLET 45-200 MG (***ledipasvir-sofosbuvir***) | 2 | PA; ST; SL (84 tablets per 720 days.) |
| HARVONI ORAL TABLET 90-400 MG (***ledipasvir-sofosbuvir***) | 2 | PA; ST; SL (56 tablets per 720 days.) |
| LEDIPASVIR-SOFOSBUVIR ORAL TABLET 90-400 MG | 2 | PA; ST; SL (56 tablets per 720 days.) |
| SOFOSBUVIR-VELPATASVIR ORAL TABLET 400-100 MG | 2 | PA; SL (84 tablets per 720 days.) |
| SOVALDI ORAL PACKET 150 MG, 200 MG (***sofosbuvir***) | 4 | PA; ST; SL (1 pellet per day and 84 pellets per 720 days.) |
| SOVALDI ORAL TABLET 200 MG (***sofosbuvir***) | 4 | PA; ST; SL (84 tablets per 720 days.) |
| SOVALDI ORAL TABLET 400 MG (***sofosbuvir***) | 4 | PA; ST; SL (84 tablets per 720 days.); SP |
| VIEKIRA PAK ORAL TABLET THERAPY PACK 12.5-75-50 &250 MG (***ombitas-paritapre-ritona-dasab***) | 4 | PA; ST; SL (336 tablets per 720 days.); SP |
| VOSEVI ORAL TABLET 400-100-100 MG (***sofosbuv-velpatasv-voxilaprev***) | 2 | PA; SL (84 tablets per 720 days.); SP |
| **HCV PROTEASE INHIBITOR ANTIVIRALS - Drugs for Viral Infections** | | |
| MAVYRET ORAL TABLET 100-40 MG (***glecaprevir-pibrentasvir***) | 2 | PA; SL (168 tablets per 720 days.); SP |
| VIEKIRA PAK ORAL TABLET THERAPY PACK 12.5-75-50 &250 MG (***ombitas-paritapre-ritona-dasab***) | 4 | PA; ST; SL (336 tablets per 720 days.); SP |
| ZEPATIER ORAL TABLET 50-100 MG (***elbasvir-grazoprevir***) | 4 | PA; SL (84 tablets per 720 days (12 weeks).); SP |
| **HCV REPLICATION COMPLEX INHIBITORS - Drugs for Viral Infections** | | |
| EPCLUSA ORAL TABLET 400-100 MG (***sofosbuvir-velpatasvir***) | 2 | PA; SL (84 tablets per 720 days.) |
| HARVONI ORAL PACKET 33.75-150 MG, 45-200 MG (***ledipasvir-sofosbuvir***) | 2 | SL (1 pellet per day and 84 pellets per 720 days.) |
| HARVONI ORAL TABLET 45-200 MG (***ledipasvir-sofosbuvir***) | 2 | PA; ST; SL (84 tablets per 720 days.) |
| HARVONI ORAL TABLET 90-400 MG (***ledipasvir-sofosbuvir***) | 2 | PA; ST; SL (56 tablets per 720 days.) |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| LEDIPASVIR-SOFOSBUVIR ORAL TABLET 90-400 MG | 2 | PA; ST; SL (56 tablets per 720 days.) |
| MAVYRET ORAL TABLET 100-40 MG (***glecaprevir-pibrentasvir***) | 2 | PA; SL (168 tablets per 720 days.); SP |
| SOFOSBUVIR-VELPATASVIR ORAL TABLET 400-100 MG | 2 | PA; SL (84 tablets per 720 days.) |
| VIEKIRA PAK ORAL TABLET THERAPY PACK 12.5-75-50 &250 MG (***ombitas-paritapre-ritona-dasab***) | 4 | PA; ST; SL (336 tablets per 720 days.); SP |
| VOSEVI ORAL TABLET 400-100-100 MG (***sofosbuv-velpatasv-voxilaprev***) | 2 | PA; SL (84 tablets per 720 days.); SP |
| ZEPATIER ORAL TABLET 50-100 MG (***elbasvir-grazoprevir***) | 4 | PA; SL (84 tablets per 720 days (12 weeks).); SP |
| **HIV ENTRY AND FUSION INHIBITORS - Drugs for Viral Infections** | | |
| FUZEON SUBCUTANEOUS SOLUTION RECONSTITUTED 90 MG (***enfuvirtide***) | 2 | M |
| RUKOBIA ORAL TABLET EXTENDED RELEASE 12 HOUR 600 MG | 3 | PA |
| SELZENTRY ORAL SOLUTION 20 MG/ML (***maraviroc***) | 2 | PA |
| SELZENTRY ORAL TABLET 150 MG, 25 MG, 300 MG, 75 MG (***maraviroc***) | 2 | PA |
| **HIV INTEGRASE INHIBITOR ANTIRETROVIRALS - Drugs for Viral Infections** | | |
| BIKTARVY ORAL TABLET 50-200-25 MG (***bictegravir-emtricitab-tenofov***) | 3 | SL (1 tablet per day.) |
| DOVATO ORAL TABLET 50-300 MG (***dolutegravir-lamivudine***) | 2 | SL (1 tablet per day.) |
| GENVOYA ORAL TABLET 150-150-200-10 MG (***elviteg-cobic-emtricit-tenofaf***) | 2 | SL (1 tablet per day.) |
| ISENTRESS HD ORAL TABLET 600 MG (***raltegravir potassium***) | 2 | |
| ISENTRESS ORAL PACKET 100 MG (***raltegravir potassium***) | 2 | |
| ISENTRESS ORAL TABLET 400 MG (***raltegravir potassium***) | 2 | |
| ISENTRESS ORAL TABLET CHEWABLE 100 MG, 25 MG (***raltegravir potassium***) | 2 | |
| JULUCA ORAL TABLET 50-25 MG (***dolutegravir-rilpivirine***) | 2 | SL (1 tablet per day.) |
| STRIBILD ORAL TABLET 150-150-200-300 MG (***elviteg-cobic-emtricit-tenofdf***) | 2 | SL (1 tablet per day.) |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| TIVICAY ORAL TABLET 50 MG (***dolutegravir sodium***) | 3 | |
| TIVICAY PD ORAL TABLET SOLUBLE 5 MG (***dolutegravir sodium***) | 3 | |
| TRIUMEQ ORAL TABLET 600-50-300 MG (***abacavir-dolutegravir-lamivud***) | 2 | SL (1 tablet per day.) |
| **HIV NONNUCLEOSIDE REV.TRANSCRIP. INHIB. - Drugs for Viral Infections** | | |
| ATRIPLA ORAL TABLET 600-200-300 MG (***efavirenz-emtricitab-tenofovir***) | 2 | SL (1 tablet per day.) |
| COMPLERA ORAL TABLET 200-25-300 MG (***emtricitab-rilpivir-tenofovir***) | 3 | SL (1 tablet per day.) |
| DELSTRIGO ORAL TABLET 100-300-300 MG (***doravirin-lamivudin-tenofov df***) | 2 | SL (1 tablet per day.) |
| EDURANT ORAL TABLET 25 MG (***rilpivirine hcl***) | 2 | |
| ***efavirenz oral capsule 200 mg, 50 mg*** | 2 | |
| ***efavirenz oral tablet 600 mg*** | 2 | |
| ***efavirenz-lamivudine-tenofovir oral tablet 400-300-300 mg, 600-300-300 mg*** | 2 | SL (1 tablet per day.) |
| INTELENCE ORAL TABLET 100 MG, 200 MG, 25 MG (***etravirine***) | 2 | |
| JULUCA ORAL TABLET 50-25 MG (***dolutegravir-rilpivirine***) | 2 | SL (1 tablet per day.) |
| ***nevirapine oral suspension 50 mg/5ml*** | 1 | |
| ***nevirapine oral tablet 200 mg*** | 1 | |
| ODEFSEY ORAL TABLET 200-25-25 MG (***emtricitab-rilpivir-tenofov af***) | 3 | SL (1 tablet per day.) |
| PIFELTRO ORAL TABLET 100 MG (***doravirine***) | 3 | |
| SUSTIVA ORAL CAPSULE 200 MG, 50 MG (***efavirenz***) | 3 | |
| SUSTIVA ORAL TABLET 600 MG (***efavirenz***) | 3 | |
| SYMFI LO ORAL TABLET 400-300-300 MG (***efavirenz-lamivudine-tenofovir***) | 2 | SL (1 tablet per day.) |
| SYMFI ORAL TABLET 600-300-300 MG (***efavirenz-lamivudine-tenofovir***) | 2 | SL (1 tablet per day.) |
| VIRAMUNE ORAL SUSPENSION 50 MG/5ML (***nevirapine***) | 3 | |
| **HIV NUCLEOSIDE, NUCLEOTIDE RT INHIBITORS - Drugs for Viral Infections** | | |
| ***abacavir sulfate oral solution 20 mg/ml*** | 1 | |
| ***abacavir sulfate oral tablet 300 mg*** | 1 | |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ***abacavir sulfate-lamivudine oral tablet 600-300 mg*** | 2 | SL (1 tablet per day.) |
| ***abacavir-lamivudine-zidovudine oral tablet 300-150-300 mg*** | 1 | |
| ATRIPLA ORAL TABLET 600-200-300 MG (***efavirenz-emtricitab-tenofovir***) | 2 | SL (1 tablet per day.) |
| BIKTARVY ORAL TABLET 50-200-25 MG (***bictegravir-emtricitab-tenofov***) | 3 | SL (1 tablet per day.) |
| CIMDUO ORAL TABLET 300-300 MG (***lamivudine-tenofovir***) | 2 | SL (1 tablet per day.) |
| COMBIVIR ORAL TABLET 150-300 MG (***lamivudine-zidovudine***) | 4 | |
| COMPLERA ORAL TABLET 200-25-300 MG (***emtricitab-rilpivir-tenofovir***) | 3 | SL (1 tablet per day.) |
| DELSTRIGO ORAL TABLET 100-300-300 MG (***doravirin-lamivudin-tenofov df***) | 2 | SL (1 tablet per day.) |
| ***didanosine oral capsule delayed release 200 mg, 250 mg, 400 mg*** | 1 | |
| DOVATO ORAL TABLET 50-300 MG (***dolutegravir-lamivudine***) | 2 | SL (1 tablet per day.) |
| ***efavirenz-lamivudine-tenofovir oral tablet 400-300-300 mg, 600-300-300 mg*** | 2 | SL (1 tablet per day.) |
| ***emtricitabine oral capsule 200 mg*** | 2 | |
| ***emtricitabine-tenofovir df oral tablet 200-300 mg*** | 1 | SL (1 tablet per day.); H |
| EMTRIVA ORAL CAPSULE 200 MG (***emtricitabine***) | 3 | |
| EMTRIVA ORAL SOLUTION 10 MG/ML (***emtricitabine***) | 2 | |
| EPIVIR HBV ORAL SOLUTION 5 MG/ML (***lamivudine***) | 2 | |
| EPIVIR HBV ORAL TABLET 100 MG (***lamivudine***) | 3 | |
| EPIVIR ORAL SOLUTION 10 MG/ML (***lamivudine***) | 3 | |
| EPIVIR ORAL TABLET 150 MG, 300 MG (***lamivudine***) | 3 | |
| GENVOYA ORAL TABLET 150-150-200-10 MG (***elviteg-cobic-emtricit-tenofaf***) | 2 | SL (1 tablet per day.) |
| ***lamivudine oral solution 10 mg/ml*** | 1 | |
| ***lamivudine oral tablet 100 mg, 150 mg, 300 mg*** | 1 | |
| ***lamivudine-zidovudine oral tablet 150-300 mg*** | 1 | |
| ODEFSEY ORAL TABLET 200-25-25 MG (***emtricitab-rilpivir-tenofov af***) | 3 | SL (1 tablet per day.) |
| RETROVIR ORAL CAPSULE 100 MG (***zidovudine***) | 3 | |
| RETROVIR ORAL SYRUP 50 MG/5ML (***zidovudine***) | 3 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ***stavudine oral capsule 15 mg, 20 mg, 30 mg, 40 mg*** | 1 | |
| STRIBILD ORAL TABLET 150-150-200-300 MG (***elviteg-cobic-emtricit-tenofdf***) | 2 | SL (1 tablet per day.) |
| SYMFI LO ORAL TABLET 400-300-300 MG (***efavirenz-lamivudine-tenofovir***) | 2 | SL (1 tablet per day.) |
| SYMFI ORAL TABLET 600-300-300 MG (***efavirenz-lamivudine-tenofovir***) | 2 | SL (1 tablet per day.) |
| SYMTUZA ORAL TABLET 800-150-200-10 MG (***darun-cobic-emtricit-tenofaf***) | 3 | SL (1 tablet per day.) |
| ***tenofovir disoproxil fumarate oral tablet 300 mg*** | 2 | H-N |
| TRIUMEQ ORAL TABLET 600-50-300 MG (***abacavir-dolutegravir-lamivud***) | 2 | SL (1 tablet per day.) |
| TRIZIVIR ORAL TABLET 300-150-300 MG (***abacavir-lamivudine-zidovudine***) | 3 | |
| VIREAD ORAL POWDER 40 MG/GM (***tenofovir disoproxil fumarate***) | 3 | |
| VIREAD ORAL TABLET 150 MG, 200 MG, 250 MG (***tenofovir disoproxil fumarate***) | 2 | |
| ZIAGEN ORAL SOLUTION 20 MG/ML (***abacavir sulfate***) | 3 | |
| ZIAGEN ORAL TABLET 300 MG (***abacavir sulfate***) | 3 | |
| ***zidovudine oral capsule 100 mg*** | 1 | |
| ***zidovudine oral syrup 50 mg/5ml*** | 1 | |
| ***zidovudine oral tablet 300 mg*** | 1 | |
| **HIV PROTEASE INHIBITOR ANTIRETROVIRALS - Drugs for Viral Infections** | | |
| APTIVUS ORAL CAPSULE 250 MG (***tipranavir***) | 2 | |
| APTIVUS ORAL SOLUTION 100 MG/ML (***tipranavir***) | 3 | |
| ***atazanavir sulfate oral capsule 150 mg, 200 mg, 300 mg*** | 2 | |
| CRIXIVAN ORAL CAPSULE 200 MG, 400 MG (***indinavir sulfate***) | 2 | |
| EVOTAZ ORAL TABLET 300-150 MG (***atazanavir-cobicistat***) | 2 | |
| ***fosamprenavir calcium oral tablet 700 mg*** | 2 | |
| INVIRASE ORAL TABLET 500 MG (***saquinavir mesylate***) | 2 | |
| KALETRA ORAL SOLUTION 400-100 MG/5ML (***lopinavir-ritonavir***) | 3 | |
| KALETRA ORAL TABLET 100-25 MG, 200-50 MG (***lopinavir-ritonavir***) | 2 | |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| LEXIVA ORAL SUSPENSION 50 MG/ML (***fosamprenavir calcium***) | 2 | |
| LEXIVA ORAL TABLET 700 MG (***fosamprenavir calcium***) | 3 | |
| ***lopinavir-ritonavir oral solution 400-100 mg/5ml*** | 2 | |
| NORVIR ORAL PACKET 100 MG (***ritonavir***) | 2 | |
| NORVIR ORAL SOLUTION 80 MG/ML (***ritonavir***) | 2 | |
| PREZCOBIX ORAL TABLET 800-150 MG (***darunavir-cobicistat***) | 2 | |
| PREZISTA ORAL SUSPENSION 100 MG/ML (***darunavir ethanolate***) | 2 | |
| PREZISTA ORAL TABLET 150 MG, 600 MG, 75 MG, 800 MG (***darunavir ethanolate***) | 2 | |
| REYATAZ ORAL PACKET 50 MG (***atazanavir sulfate***) | 2 | |
| ***ritonavir oral tablet 100 mg*** | 2 | |
| SYMTUZA ORAL TABLET 800-150-200-10 MG (***darun-cobic-emtricit-tenofaf***) | 3 | SL (1 tablet per day.) |
| VIEKIRA PAK ORAL TABLET THERAPY PACK 12.5-75-50 &250 MG (***ombitas-paritapre-ritona-dasab***) | 4 | PA; ST; SL (336 tablets per 720 days.); SP |
| VIRACEPT ORAL TABLET 250 MG, 625 MG (***nelfinavir mesylate***) | 2 | |
| **INTERFERON ANTIVIRALS - Drugs for Viral Infections** | | |
| ALFERON N INJECTION SOLUTION 5000000 UNIT/ML (***interferon alfa-n3***) | 2 | M |
| INTRON A INJECTION SOLUTION 10000000 UNIT/ML, 6000000 UNIT/ML (***interferon alfa-2b***) | 3 | PA; M; SP |
| INTRON A INJECTION SOLUTION RECONSTITUTED 10000000 UNIT, 18000000 UNIT, 50000000 UNIT (***interferon alfa-2b***) | 3 | PA; M; SP |
| PEGASYS PROCLICK SUBCUTANEOUS SOLUTION 180 MCG/0.5ML (***peginterferon alfa-2a***) | 2 | PA; M; SL (2 auto-injectors per month); SP |
| PEGASYS SUBCUTANEOUS SOLUTION 180 MCG/0.5ML (***peginterferon alfa-2a***) | 2 | PA; M; SL (2 auto-injectors per month); SP |
| PEGASYS SUBCUTANEOUS SOLUTION 180 MCG/ML (***peginterferon alfa-2a***) | 2 | PA; M; SL (4 auto-injectors per month); SP |
| PEGINTRON SUBCUTANEOUS KIT 50 MCG/0.5ML (***peginterferon alfa-2b***) | 4 | PA; M; SL (4 redipens per 30 days.); SP |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| **LINCOMYCIN ANTIBIOTICS - Antibiotics** | | |
| CLEOCIN ORAL CAPSULE 150 MG, 300 MG (***clindamycin hcl***) | 3 | |
| CLEOCIN ORAL CAPSULE 75 MG (***clindamycin hcl***) | 2 | |
| CLEOCIN ORAL SOLUTION RECONSTITUTED 75 MG/5ML (***clindamycin palmitate hcl***) | 3 | |
| ***clindamycin hcl oral capsule 150 mg, 300 mg, 75 mg*** | 1 | |
| ***clindamycin palmitate hcl oral solution reconstituted 75 mg/5ml*** | 2 | |
| **MACROLIDE ANTIBIOTICS - Antibiotics** | | |
| E.E.S. GRANULES ORAL SUSPENSION RECONSTITUTED 200 MG/5ML (***erythromycin ethylsuccinate***) | 3 | |
| ERYPED 200 ORAL SUSPENSION RECONSTITUTED 200 MG/5ML (***erythromycin ethylsuccinate***) | 3 | |
| ERYPED 400 ORAL SUSPENSION RECONSTITUTED 400 MG/5ML (***erythromycin ethylsuccinate***) | 3 | |
| ***erythromycin base*** (Ery-Tab Oral Tablet Delayed Release 250 Mg, 333 Mg, 500 Mg) | 3 | |
| ERYTHROCIN STEARATE ORAL TABLET 250 MG (***erythromycin stearate***) | 2 | |
| ***erythromycin base oral capsule delayed release particles 250 mg*** | 1 | |
| ***erythromycin base oral tablet 250 mg, 500 mg*** | 1 | |
| ***erythromycin base oral tablet delayed release 250 mg, 333 mg, 500 mg*** | 3 | |
| ***erythromycin ethylsuccinate oral suspension reconstituted 200 mg/5ml*** | 1 | |
| ***erythromycin ethylsuccinate oral suspension reconstituted 400 mg/5ml*** | 3 | |
| ***erythromycin ethylsuccinate oral tablet 400 mg*** | 1 | |
| ***erythromycin oral tablet delayed release 250 mg, 333 mg, 500 mg*** | 3 | |
| **MONOBACTAM ANTIBIOTICS - Antibiotics** | | |
| CAYSTON INHALATION SOLUTION RECONSTITUTED 75 MG (***aztreonam lysine***) | 2 | PA; SL (84 vials per 56 days.); SP |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| **NATURAL PENICILLIN ANTIBIOTICS - Antibiotics** | | |
| ***penicillin v potassium oral solution reconstituted 125 mg/5ml, 250 mg/5ml*** | 1 | |
| ***penicillin v potassium oral tablet 250 mg, 500 mg*** | 1 | |
| **NEURAMINIDASE INHIBITOR ANTIVIRALS - Drugs for Viral Infections** | | |
| ***oseltamivir phosphate oral capsule 30 mg, 45 mg, 75 mg*** | 2 | |
| ***oseltamivir phosphate oral suspension reconstituted 6 mg/ml*** | 2 | SL (180 ml per month.) |
| RELENZA DISKHALER INHALATION AEROSOL POWDER BREATH ACTIVATED 5 MG/BLISTER (***zanamivir***) | 3 | |
| **NUCLEOSIDE AND NUCLEOTIDE ANTIVIRALS - Drugs for Viral Infections** | | |
| ***acyclovir oral capsule 200 mg*** | 1 | |
| ***acyclovir oral suspension 200 mg/5ml*** | 1 | |
| ***acyclovir oral tablet 400 mg, 800 mg*** | 1 | |
| ***adefovir dipivoxil oral tablet 10 mg*** | 2 | |
| BARACLUDE ORAL SOLUTION 0.05 MG/ML (***entecavir***) | 2 | |
| ***entecavir oral tablet 0.5 mg, 1 mg*** | 1 | |
| ***famciclovir oral tablet 125 mg, 500 mg*** | 2 | |
| ***famciclovir oral tablet 250 mg*** | 2 | SL (62 tablets per prescription) |
| HEPSERA ORAL TABLET 10 MG (***adefovir dipivoxil***) | 3 | |
| PREVYMIS ORAL TABLET 240 MG, 480 MG (***letermovir***) | 2 | PA |
| ***ribavirin inhalation solution reconstituted 6 gm*** | 3 | |
| ***ribavirin oral capsule 200 mg*** | 1 | |
| ***ribavirin oral tablet 200 mg*** | 1 | |
| SYMTUZA ORAL TABLET 800-150-200-10 MG (***darun-cobic-emtricit-tenofaf***) | 3 | SL (1 tablet per day.) |
| ***valacyclovir hcl oral tablet 1 gm*** | 1 | SL (31 tablets per prescription) |
| ***valacyclovir hcl oral tablet 500 mg*** | 1 | SL (62 tablets per prescription) |
| VALCYTE ORAL SOLUTION RECONSTITUTED 50 MG/ML (***valganciclovir hcl***) | 3 | |
| ***valganciclovir hcl oral solution reconstituted 50 mg/ml*** | 1 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ***valganciclovir hcl oral tablet 450 mg*** | 1 | SL (2 tablets per day) |
| VEMLIDY ORAL TABLET 25 MG (***tenofovir alafenamide fumarate***) | 3 | ST |
| VIRAZOLE INHALATION SOLUTION RECONSTITUTED 6 GM (***ribavirin***) | 3 | |
| ZOVIRAX ORAL SUSPENSION 200 MG/5ML (***acyclovir***) | 3 | |
| **OTHER MACROLIDE ANTIBIOTICS - Antibiotics** | | |
| ***azithromycin oral packet 1 gm*** | 1 | |
| ***azithromycin oral suspension reconstituted 100 mg/5ml, 200 mg/5ml*** | 1 | |
| ***azithromycin oral tablet 250 mg, 500 mg, 600 mg*** | 1 | |
| ***clarithromycin er oral tablet extended release 24 hour 500 mg*** | 2 | |
| ***clarithromycin oral suspension reconstituted 125 mg/5ml, 250 mg/5ml*** | 2 | |
| ***clarithromycin oral tablet 250 mg, 500 mg*** | 1 | |
| DIFICID ORAL TABLET 200 MG (***fidaxomicin***) | 3 | SL (20 tablets per 7 days) |
| OMECLAMOX-PAK ORAL 500-500-20 MG (***amoxicill-clarithro-omeprazole***) | 3 | SL (1 carton (10 administrative cards, 80 tablets) per 6 months.) |
| ZITHROMAX ORAL PACKET 1 GM (***azithromycin***) | 3 | |
| ZITHROMAX ORAL SUSPENSION RECONSTITUTED 100 MG/5ML, 200 MG/5ML (***azithromycin***) | 3 | |
| ZITHROMAX ORAL TABLET 250 MG, 500 MG (***azithromycin***) | 3 | |
| ZITHROMAX TRI-PAK ORAL TABLET 500 MG (***azithromycin***) | 3 | |
| ZITHROMAX Z-PAK ORAL TABLET 250 MG (***azithromycin***) | 3 | |
| **OTHER MISC. ANTIBACTERIAL AGENTS - Antibiotics** | | |
| PYLERA ORAL CAPSULE 140-125-125 MG (***bis subcit-metronid-tetracyc***) | 3 | SL (120 capsules per 180 days.) |
| **OXAZOLIDINONE ANTIBIOTICS - Antibiotics** | | |
| ***linezolid oral suspension reconstituted 100 mg/5ml*** | 2 | SL (900 ml per 11 days) |
| ***linezolid oral tablet 600 mg*** | 2 | SL (28 tablets per 11 days) |
| SIVEXTRO ORAL TABLET 200 MG (***tedizolid phosphate***) | 3 | SL (6 tablets per prescription) |
| ZYVOX ORAL SUSPENSION RECONSTITUTED 100 MG/5ML (***linezolid***) | 3 | SL (900 ml per 11 days) |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| **PENICILLINASE-RESISTANT PENICILLINS - Antibiotics** | | |
| ***dicloxacillin sodium oral capsule 250 mg, 500 mg*** | 1 | |
| **PLEUROMUTILINS - Antibiotics** | | |
| XENLETA ORAL TABLET 600 MG (***lefamulin acetate***) | 4 | |
| **POLYENE ANTIFUNGALS - Drugs for Fungus** | | |
| ***nystatin mouth/throat suspension 100000 unit/ml*** | 1 | |
| ***nystatin oral tablet 500000 unit*** | 1 | |
| **POLYMYXIN ANTIBIOTICS - Antibiotics** | | |
| ***colistimethate sodium (cba) injection solution reconstituted 150 mg*** | 1 | M |
| COLY-MYCIN M INJECTION SOLUTION RECONSTITUTED 150 MG (***colistimethate sodium***) | 3 | M |
| **PYRIMIDINE ANTIFUNGALS - Drugs for Fungus** | | |
| ANCOBON ORAL CAPSULE 250 MG, 500 MG (***flucytosine***) | 3 | |
| ***flucytosine oral capsule 250 mg, 500 mg*** | 1 | |
| **QUINOLONE ANTIBIOTICS - Antibiotics** | | |
| BAXDELA ORAL TABLET 450 MG (***delafloxacin meglumine***) | 3 | |
| CIPRO ORAL SUSPENSION RECONSTITUTED 250 MG/5ML (5%), 500 MG/5ML (10%) (***ciprofloxacin***) | 3 | |
| CIPRO ORAL TABLET 250 MG, 500 MG (***ciprofloxacin hcl***) | 3 | |
| ***ciprofloxacin hcl oral tablet 100 mg, 250 mg, 500 mg, 750 mg*** | 1 | |
| ***levofloxacin oral solution 25 mg/ml*** | 1 | |
| ***levofloxacin oral tablet 250 mg, 500 mg, 750 mg*** | 1 | |
| ***moxifloxacin hcl oral tablet 400 mg*** | 3 | |
| ***ofloxacin oral tablet 300 mg, 400 mg*** | 1 | |
| **RIFAMYCIN ANTIBIOTICS - Antibiotics** | | |
| AEMCOLO ORAL TABLET DELAYED RELEASE 194 MG (***rifamycin sodium***) | 3 | SL (12 tablets per prescription) |
| MYCOBUTIN ORAL CAPSULE 150 MG (***rifabutin***) | 3 | |
| PRIFTIN ORAL TABLET 150 MG (***rifapentine***) | 2 | |
| ***rifabutin oral capsule 150 mg*** | 1 | |
| RIFADIN ORAL CAPSULE 150 MG, 300 MG (***rifampin***) | 3 | |
| ***rifampin oral capsule 150 mg, 300 mg*** | 1 | |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| XIFAXAN ORAL TABLET 200 MG (***rifaximin***) | 3 | PA; SL (9 tablets per prescription) |
| XIFAXAN ORAL TABLET 550 MG (***rifaximin***) | 3 | PA; SL (62 tablets per month.) |
| **SULFONAMIDE ANTIBIOTICS (SYSTEMIC) - Antibiotics** | | |
| AZULFIDINE EN-TABS ORAL TABLET DELAYED RELEASE 500 MG (***sulfasalazine***) | 3 | |
| AZULFIDINE ORAL TABLET 500 MG (***sulfasalazine***) | 3 | |
| BACTRIM DS ORAL TABLET 800-160 MG (***sulfamethoxazole-trimethoprim***) | 3 | |
| BACTRIM ORAL TABLET 400-80 MG (***sulfamethoxazole-trimethoprim***) | 3 | |
| ***sulfadiazine oral tablet 500 mg*** | 1 | |
| ***sulfamethoxazole-trimethoprim oral suspension 200-40 mg/5ml*** | 1 | |
| ***sulfamethoxazole-trimethoprim oral tablet 400-80 mg, 800-160 mg*** | 1 | |
| ***sulfasalazine oral tablet 500 mg*** | 1 | |
| ***sulfasalazine oral tablet delayed release 500 mg*** | 1 | |
| ***sulfamethoxazole-trimethoprim*** (Sulfatrim Pediatric Oral Suspension 200-40 Mg/5Ml) | 1 | |
| **TETRACYCLINE ANTIBIOTICS - Antibiotics** | | |
| AVIDOXY DK COMBINATION KIT 100 MG (***doxycycline-suncreen-sal acid***) | 3 | |
| ***avidoxy oral tablet 100 mg*** | 1 | |
| ***demeclocycline hcl oral tablet 150 mg, 300 mg*** | 1 | |
| ***doxycycline hyclate oral capsule 100 mg, 50 mg*** | 2 | |
| ***doxycycline hyclate oral tablet 100 mg*** | 2 | |
| ***doxycycline monohydrate oral capsule 100 mg, 50 mg*** | 1 | |
| ***doxycycline monohydrate oral suspension reconstituted 25 mg/5ml*** | 3 | |
| ***doxycycline monohydrate oral tablet 100 mg, 150 mg, 50 mg, 75 mg*** | 1 | |
| ***minocycline hcl oral capsule 100 mg, 50 mg, 75 mg*** | 1 | |
| ***doxycycline monohydrate*** (Mondoxyne Nl Oral Capsule 100 Mg) | 1 | |
| ***doxycycline hyclate*** (Morgidox Oral Capsule 100 Mg) | 2 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| NUTRIDOX ORAL KIT 75 MG (***doxycycline monohyd-omega 3-e***) | 3 | |
| PYLERA ORAL CAPSULE 140-125-125 MG (***bis subcit-metronid-tetracyc***) | 3 | SL (120 capsules per 180 days.) |
| ***tetracycline hcl oral capsule 250 mg, 500 mg*** | 3 | |
| VIBRAMYCIN ORAL CAPSULE 100 MG (***doxycycline hyclate***) | 3 | |
| VIBRAMYCIN ORAL SUSPENSION RECONSTITUTED 25 MG/5ML (***doxycycline monohydrate***) | 3 | |
| VIBRAMYCIN ORAL SYRUP 50 MG/5ML (***doxycycline calcium***) | 3 | |
| **URINARY ANTI-INFECTIVES - Drugs for the Urinary System** | | |
| HIPREX ORAL TABLET 1 GM (***methenamine hippurate***) | 3 | |
| ***hyophen oral tablet 81.6 mg*** | 1 | |
| MACROBID ORAL CAPSULE 100 MG (***nitrofurantoin monohyd macro***) | 3 | |
| MACRODANTIN ORAL CAPSULE 100 MG, 25 MG, 50 MG (***nitrofurantoin macrocrystal***) | 3 | |
| ***me/naphos/mb/hyo1 oral tablet 81.6 mg*** | 1 | |
| ***methenamine hippurate oral tablet 1 gm*** | 1 | |
| ***methenamine mandelate oral tablet 0.5 gm, 1 gm*** | 1 | |
| MONUROL ORAL PACKET 3 GM (***fosfomycin tromethamine***) | 3 | |
| ***nitrofurantoin macrocrystal oral capsule 100 mg, 25 mg, 50 mg*** | 1 | |
| ***nitrofurantoin monohydrate macrocrystals oral capsule 100 mg*** | 1 | |
| ***nitrofurantoin oral suspension 25 mg/5ml*** | 1 | |
| ***meth-hyo-m bl-na phos-ph sal*** (Phosphasal Oral Tablet 81.6 Mg) | 1 | |
| PRIMSOL ORAL SOLUTION 50 MG/5ML (***trimethoprim hcl***) | 3 | |
| ***trimethoprim oral tablet 100 mg*** | 1 | |
| ***meth-hyo-m bl-na phos-ph sal*** (Urelle Oral Tablet 81 Mg) | 3 | |
| ***meth-hyo-m bl-na phos-ph sal*** (Uretron D/S Oral Tablet 81.6 Mg) | 1 | |
| ***meth-hyo-m bl-na phos-ph sal*** (Uribel Oral Capsule 118 Mg) | 3 | |
| URIMAR-T ORAL TABLET 120 MG (***meth-hyo-m bl-na phos-ph sal***) | 2 | |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ***urin ds oral tablet 81.6 mg*** | 1 | |
| URO-458 ORAL TABLET 81 MG | 3 | |
| UROGESIC-BLUE ORAL TABLET 81.6 MG (***methen-hyosc-meth blue-na phos***) | 2 | |
| ***uro-mp oral capsule 118 mg*** | 1 | |
| ***methen-hyosc-meth blue-na phos*** (Uryl Oral Tablet 81.6 Mg) | 2 | |
| ***meth-hyo-m bl-na phos-ph sal*** (Ustell Oral Capsule 120 Mg) | 1 | |
| ***uticap oral capsule 120 mg*** | 1 | |
| ***meth-hyo-m bl-na phos-ph sal*** (Utira-C Oral Tablet 81.6 Mg) | 1 | |
| ***meth-hyo-m bl-na phos-ph sal*** (Utrona-C Oral Tablet 81.6 Mg) | 1 | |
| ***meth-hyo-m bl-na phos-ph sal*** (Vilamit Mb Oral Capsule 118 Mg) | 1 | |
| ***meth-hyo-m bl-na phos-ph sal*** (Vilevev Mb Oral Tablet 81 Mg) | 3 | |
| **ANTINEOPLASTIC AGENTS - Drugs for Cancer** | | |
| **ANTINEOPLASTIC AGENTS - Drugs for Cancer** | | |
| ***abiraterone acetate oral tablet 250 mg*** | 2 | PA; SL (4 tablets per day.); SP; CM |
| AFINITOR DISPERZ ORAL TABLET SOLUBLE 2 MG, 3 MG, 5 MG (***everolimus***) | 2 | PA; SL (1 tablet per day.); SP; CM |
| AFINITOR ORAL TABLET 10 MG (***everolimus***) | 2 | PA; SL (1 tablet per day.); SP; CM |
| ALECENSA ORAL CAPSULE 150 MG (***alectinib hcl***) | 2 | PA; SL (8 capsules per day.); SP; CM |
| ALFERON N INJECTION SOLUTION 5000000 UNIT/ML (***interferon alfa-n3***) | 2 | M |
| ALKERAN ORAL TABLET 2 MG (***melphalan***) | 3 | CM |
| ALUNBRIG ORAL TABLET 180 MG, 90 MG (***brigatinib***) | 2 | PA; SL (1 tablet per day.); SP; CM |
| ALUNBRIG ORAL TABLET 30 MG (***brigatinib***) | 2 | PA; SL (4 tablets per day.); SP; CM |
| ALUNBRIG ORAL TABLET THERAPY PACK 90 & 180 MG (***brigatinib***) | 2 | PA; SL (30 packs per year.); SP; CM |
| ***anastrozole oral tablet 1 mg*** | 1 | |
| AROMASIN ORAL TABLET 25 MG (***exemestane***) | 4 | |
| AYVAKIT ORAL TABLET 100 MG, 200 MG, 300 MG (***avapritinib***) | 3 | PA; SL (1 tablet per day.); SP; CM |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| BALVERSA ORAL TABLET 3 MG (***erdafitinib***) | 2 | PA; SL (3 tablets per day.); SP; CM |
| BALVERSA ORAL TABLET 4 MG (***erdafitinib***) | 2 | PA; SL (2 tablets per day.); SP; CM |
| BALVERSA ORAL TABLET 5 MG (***erdafitinib***) | 2 | PA; SL (1 tablet per day.); SP; CM |
| ***bicalutamide oral tablet 50 mg*** | 1 | |
| BOSULIF ORAL TABLET 100 MG (***bosutinib***) | 2 | PA; ST; SL (4 tablets per day.); SP; CM |
| BOSULIF ORAL TABLET 400 MG, 500 MG (***bosutinib***) | 2 | PA; ST; SL (1 tablet per day.); SP; CM |
| BRAFTOVI ORAL CAPSULE 75 MG (***encorafenib***) | 3 | PA; ST; SL (6 capsules per day.); SP; CM |
| BRUKINSA ORAL CAPSULE 80 MG (***zanubrutinib***) | 2 | PA; SL (4 capsules per day.); SP; CM |
| CABOMETYX ORAL TABLET 20 MG, 40 MG, 60 MG (***cabozantinib s-malate***) | 2 | PA; SL (1 tablet per day.); SP; CM |
| CALQUENCE ORAL CAPSULE 100 MG (***acalabrutinib***) | 2 | PA; SL (2 capsules per day.); SP; CM |
| CAPRELSA ORAL TABLET 100 MG (***vandetanib***) | 2 | PA; SL (2 tablets per day.); SP; CM |
| CAPRELSA ORAL TABLET 300 MG (***vandetanib***) | 2 | PA; SL (1 tablet per day.); SP; CM |
| CARAC EXTERNAL CREAM 0.5 % (***fluorouracil***) | 2 | |
| CASODEX ORAL TABLET 50 MG (***bicalutamide***) | 4 | |
| COMETRIQ (100 MG DAILY DOSE) ORAL KIT 80 & 20 MG (***cabozantinib s-malate***) | 2 | PA; SL (62 capsules per month.); SP; CM |
| COMETRIQ (140 MG DAILY DOSE) ORAL KIT 3 X 20 MG & 80 MG (***cabozantinib s-malate***) | 2 | PA; SL (124 capsules per month.); SP; CM |
| COMETRIQ (60 MG DAILY DOSE) ORAL KIT 20 MG (***cabozantinib s-malate***) | 2 | PA; SL (93 capsules per month.); SP; CM |
| COPIKTRA ORAL CAPSULE 15 MG, 25 MG (***duvelisib***) | 3 | PA; SL (2 capsules per day.); SP; CM |
| ***cyclophosphamide oral capsule 25 mg, 50 mg*** | 2 | |
| DAURISMO ORAL TABLET 100 MG (***glasdegib maleate***) | 2 | PA; SL (1 tablet per day.); SP; CM |
| DAURISMO ORAL TABLET 25 MG (***glasdegib maleate***) | 2 | PA; SL (2 tablets per day.); SP; CM |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ***diclofenac sodium transdermal gel 3 %*** | 3 | PA; SL (100 grams per prescription) |
| DROXIA ORAL CAPSULE 200 MG, 300 MG, 400 MG (***hydroxyurea***) | 2 | |
| EFUDEX EXTERNAL CREAM 5 % (***fluorouracil***) | 3 | |
| ELIGARD SUBCUTANEOUS KIT 22.5 MG (***leuprolide acetate (3 month)***) | 3 | PA; M |
| ELIGARD SUBCUTANEOUS KIT 30 MG (***leuprolide acetate (4 month)***) | 3 | PA; M |
| ELIGARD SUBCUTANEOUS KIT 45 MG (***leuprolide acetate (6 month)***) | 3 | PA; M |
| ELIGARD SUBCUTANEOUS KIT 7.5 MG (***leuprolide acetate***) | 3 | PA; M |
| EMCYT ORAL CAPSULE 140 MG (***estramustine phosphate sodium***) | 2 | |
| ERIVEDGE ORAL CAPSULE 150 MG (***vismodegib***) | 2 | PA; SL (1 capsule per day.); SP; CM |
| ERLEADA ORAL TABLET 60 MG (***apalutamide***) | 2 | PA; SL (4 tablets per day.); SP; CM |
| ***erlotinib hcl oral tablet 100 mg, 150 mg, 25 mg*** | 2 | PA; SL (1 tablet per day.); SP; CM |
| ***etoposide oral capsule 50 mg*** | 1 | SP; CM |
| ***everolimus oral tablet 2.5 mg, 5 mg, 7.5 mg*** | 2 | PA; SL (1 tablet per day.); SP; CM |
| ***exemestane oral tablet 25 mg*** | 2 | |
| FARESTON ORAL TABLET 60 MG (***toremifene citrate***) | 3 | |
| FARYDAK ORAL CAPSULE 10 MG, 20 MG (***panobinostat lactate***) | 2 | PA; SL (6 capsules per prescription); SP; CM |
| FIRMAGON (240 MG DOSE) SUBCUTANEOUS SOLUTION RECONSTITUTED 120 MG/VIAL (***degarelix acetate***) | 3 | M; SP |
| FIRMAGON SUBCUTANEOUS SOLUTION RECONSTITUTED 80 MG (***degarelix acetate***) | 3 | M; SP |
| FLUOROPLEX EXTERNAL CREAM 1 % (***fluorouracil***) | 3 | |
| FLUOROURACIL EXTERNAL CREAM 0.5 % | 2 | |
| ***fluorouracil external cream 5 %*** | 1 | |
| ***fluorouracil external solution 2 %, 5 %*** | 1 | |
| ***flutamide oral capsule 125 mg*** | 1 | |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| GILOTRIF ORAL TABLET 20 MG, 30 MG, 40 MG (***afatinib dimaleate***) | 3 | PA; SL (1 tablet per day.); SP; CM |
| GLEOSTINE ORAL CAPSULE 10 MG, 100 MG, 40 MG (***lomustine***) | 2 | SP |
| HYCAMTIN ORAL CAPSULE 0.25 MG (***topotecan hcl***) | 2 | PA; SL (180 capsules per prescription); SP; CM |
| HYCAMTIN ORAL CAPSULE 1 MG (***topotecan hcl***) | 2 | PA; SL (40 capsules per prescription); SP; CM |
| HYDREA ORAL CAPSULE 500 MG (***hydroxyurea***) | 3 | |
| ***hydroxyurea oral capsule 500 mg*** | 1 | |
| IBRANCE ORAL CAPSULE 100 MG, 125 MG, 75 MG (***palbociclib***) | 2 | PA; SL (21 capsules per month.); SP; CM |
| IBRANCE ORAL TABLET 100 MG, 125 MG, 75 MG (***palbociclib***) | 2 | PA; SL (0.75 tablets per day.); SP; CM |
| ICLUSIG ORAL TABLET 15 MG (***ponatinib hcl***) | 3 | PA; SL (1 tablet per day.); SP; CM |
| ICLUSIG ORAL TABLET 45 MG (***ponatinib hcl***) | 3 | PA; SL (2 tablets per day.); SP; CM |
| IDHIFA ORAL TABLET 100 MG, 50 MG (***enasidenib mesylate***) | 2 | PA; SL (1 tablet per day.); SP; CM |
| ***imatinib mesylate oral tablet 100 mg*** | 1 | PA; SL (6 tablets per day.); SP; CM |
| ***imatinib mesylate oral tablet 400 mg*** | 1 | PA; SL (1 tablet per day.); SP; CM |
| IMBRUVICA ORAL CAPSULE 140 MG (***ibrutinib***) | 2 | PA; SL (3 capsules per day.); SP; CM |
| IMBRUVICA ORAL CAPSULE 70 MG (***ibrutinib***) | 2 | PA; SL (1 capsule per day.); SP; CM |
| IMBRUVICA ORAL TABLET 140 MG, 280 MG, 420 MG, 560 MG (***ibrutinib***) | 2 | PA; SL (1 tablet per day.); SP; CM |
| INLYTA ORAL TABLET 1 MG (***axitinib***) | 3 | PA; SL (4 tablets per day.); SP; CM |
| INLYTA ORAL TABLET 5 MG (***axitinib***) | 3 | PA; SL (124 tablets per 30 days.); SP; CM |
| INQOVI ORAL TABLET 35-100 MG (***decitabine-cedazuridine***) | 3 | PA; CM |
| INREBIC ORAL CAPSULE 100 MG (***fedratinib hcl***) | 3 | PA; ST; SL (4 capsules per day.); SP |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| INTRON A INJECTION SOLUTION 10000000 UNIT/ML, 6000000 UNIT/ML (***interferon alfa-2b***) | 3 | PA; M; SP |
| INTRON A INJECTION SOLUTION RECONSTITUTED 10000000 UNIT, 18000000 UNIT, 50000000 UNIT (***interferon alfa-2b***) | 3 | PA; M; SP |
| IRESSA ORAL TABLET 250 MG (***gefitinib***) | 3 | PA; SL (1 tablet per day.); SP; CM |
| JAKAFI ORAL TABLET 10 MG, 15 MG, 20 MG, 25 MG, 5 MG (***ruxolitinib phosphate***) | 2 | PA; SL (2 tablets per day.); SP; CM |
| KISQALI (200 MG DOSE) ORAL TABLET THERAPY PACK 200 MG (***ribociclib succinate***) | 4 | PA; ST; SL (21 tablets per month.); SP; CM |
| KISQALI (400 MG DOSE) TABLET THERAPY PACK 200 MG ORAL 200 MG (***ribociclib succinate***) | 4 | PA; ST; SP; CM |
| KISQALI (400 MG DOSE) TABLET THERAPY PACK 200 MG ORAL 200 MG (***ribociclib succinate***) | 4 | PA; ST; SL (42 tablets per month.); SP; CM |
| KISQALI (600 MG DOSE) TABLET THERAPY PACK 200 MG ORAL 200 MG (***ribociclib succinate***) | 4 | PA; ST; SP; CM |
| KISQALI (600 MG DOSE) TABLET THERAPY PACK 200 MG ORAL 200 MG (***ribociclib succinate***) | 4 | PA; ST; SL (63 tablets per month.); SP; CM |
| KISQALI FEMARA (400 MG DOSE) ORAL TABLET THERAPY PACK 200 & 2.5 MG (***ribociclib-letrozole***) | 4 | PA; ST; CM |
| KISQALI FEMARA (600 MG DOSE) ORAL TABLET THERAPY PACK 200 & 2.5 MG (***ribociclib-letrozole***) | 4 | PA; ST; CM |
| KISQALI FEMARA(200 MG DOSE) ORAL TABLET THERAPY PACK 200 & 2.5 MG (***ribociclib-letrozole***) | 4 | PA; ST; CM |
| KOSELUGO ORAL CAPSULE 10 MG (***selumetinib sulfate***) | 3 | PA; SL (8 capsules per day.); SP; CM |
| KOSELUGO ORAL CAPSULE 25 MG (***selumetinib sulfate***) | 3 | PA; SL (4 capsules per day.); SP; CM |
| ***lapatinib ditosylate oral tablet 250 mg*** | 1 | PA; SL (186 tablets per prescription); SP; CM |
| LENVIMA (10 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 10 MG (***lenvatinib mesylate***) | 3 | PA; SL (1 capsule per day.); SP; CM |
| LENVIMA (12 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 3 X 4 MG (***lenvatinib mesylate***) | 3 | PA; SL (3 capsules per day.); SP; CM |
| LENVIMA (14 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 10 & 4 MG (***lenvatinib mesylate***) | 3 | PA; SL (2 capsules per day.); SP; CM |
| LENVIMA (18 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 10 MG & 2 X 4 MG (***lenvatinib mesylate***) | 3 | PA; SL (3 capsules per day.); SP; CM |

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|---|---|---|
| LENVIMA (20 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 2 X 10 MG (***lenvatinib mesylate***) | 3 | PA; SL (2 capsules per day.); SP; CM |
| LENVIMA (24 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 2 X 10 MG & 4 MG (***lenvatinib mesylate***) | 3 | PA; SL (3 capsules per day.); SP; CM |
| LENVIMA (4 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 4 MG (***lenvatinib mesylate***) | 3 | PA; SL (1 capsule per day.); SP; CM |
| LENVIMA (8 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 2 X 4 MG (***lenvatinib mesylate***) | 3 | PA; SL (2 capsules per day.); SP; CM |
| ***letrozole oral tablet 2.5 mg*** | 1 | |
| LEUKERAN ORAL TABLET 2 MG (***chlorambucil***) | 2 | |
| ***leuprolide acetate injection kit 1 mg/0.2ml*** | 1 | PA; M |
| LONSURF ORAL TABLET 15-6.14 MG, 20-8.19 MG (***trifluridine-tipiracil***) | 2 | PA; SL (100 tablets per month.); SP; CM |
| LORBRENA ORAL TABLET 100 MG, 25 MG (***lorlatinib***) | 3 | PA; SP; CM |
| LYNPARZA ORAL TABLET 100 MG, 150 MG (***olaparib***) | 2 | PA; SL (4 tablets per day.); SP; CM |
| LYSODREN ORAL TABLET 500 MG (***mitotane***) | 2 | |
| MATULANE ORAL CAPSULE 50 MG (***procarbazine hcl***) | 2 | SP; CM |
| ***megestrol acetate oral suspension 40 mg/ml*** | 1 | |
| ***megestrol acetate oral suspension 625 mg/5ml*** | 3 | |
| ***megestrol acetate oral tablet 20 mg, 40 mg*** | 1 | |
| MEKINIST ORAL TABLET 0.5 MG (***trametinib dimethyl sulfoxide***) | 3 | PA; SL (2 tablets per day.); SP; CM |
| MEKINIST ORAL TABLET 2 MG (***trametinib dimethyl sulfoxide***) | 3 | PA; SL (1 tablet per day.); SP; CM |
| MEKTOVI ORAL TABLET 15 MG (***binimetinib***) | 3 | PA; ST; SL (6 tablets per day.); SP; CM |
| ***melphalan oral tablet 2 mg*** | 2 | CM |
| ***mercaptopurine oral tablet 50 mg*** | 1 | |
| ***methotrexate (anti-rheumatic) oral tablet 2.5 mg*** | 1 | |
| ***methotrexate oral tablet 2.5 mg*** | 1 | |
| ***methotrexate sodium (pf) injection solution 1 gm/40ml, 250 mg/10ml, 50 mg/2ml*** | 1 | M |
| ***methotrexate sodium injection solution 250 mg/10ml, 50 mg/2ml*** | 1 | M |
| ***methotrexate sodium injection solution reconstituted 1 gm*** | 1 | |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ***methotrexate sodium oral tablet 2.5 mg*** | 1 | |
| MYLERAN ORAL TABLET 2 MG (***busulfan***) | 2 | |
| NERLYNX ORAL TABLET 40 MG (***neratinib maleate***) | 2 | PA; SL (6 tablets per day.); SP; CM |
| NEXAVAR ORAL TABLET 200 MG (***sorafenib tosylate***) | 2 | PA; SL (4 tablets per day.); SP; CM |
| ***nilutamide oral tablet 150 mg*** | 3 | SP |
| NINLARO ORAL CAPSULE 2.3 MG, 3 MG, 4 MG (***ixazomib citrate***) | 2 | PA; SL (3 capsules per prescription); SP; CM |
| NUBEQA ORAL TABLET 300 MG (***darolutamide***) | 4 | PA; SL (4 tablets per day.); SP; CM |
| ODOMZO ORAL CAPSULE 200 MG (***sonidegib phosphate***) | 2 | PA; SL (1 capsule per day.); SP; CM |
| ONUREG ORAL TABLET 200 MG, 300 MG (***azacitidine***) | 3 | PA; CM |
| PANRETIN EXTERNAL GEL 0.1 % (***alitretinoin***) | 3 | |
| PEMAZYRE ORAL TABLET 13.5 MG, 4.5 MG, 9 MG (***pemigatinib***) | 3 | PA; SL (14 tablets per 21 days.); SP; CM |
| PICATO EXTERNAL GEL 0.015 % (***ingenol mebutate***) | 3 | SL (3 grams per prescription) |
| PICATO EXTERNAL GEL 0.05 % (***ingenol mebutate***) | 3 | SL (1 carton (2 tubes) per prescription.) |
| PIQRAY (200 MG DAILY DOSE) ORAL TABLET THERAPY PACK 200 MG (***alpelisib***) | 2 | PA; SL (1 tablet per day.); SP; CM |
| PIQRAY (250 MG DAILY DOSE) ORAL TABLET THERAPY PACK 200 & 50 MG (***alpelisib***) | 2 | PA; SL (2 tablets per day.); SP; CM |
| PIQRAY (300 MG DAILY DOSE) ORAL TABLET THERAPY PACK 2 X 150 MG (***alpelisib***) | 2 | PA; SL (2 tablets per day.); SP; CM |
| POMALYST ORAL CAPSULE 1 MG, 2 MG, 3 MG, 4 MG (***pomalidomide***) | 3 | PA; SL (21 capsules per prescription); SP; CM |
| PURIXAN ORAL SUSPENSION 2000 MG/100ML (***mercaptopurine***) | 4 | PA; SP |
| RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 10 MG/0.2ML (***methotrexate (anti-rheumatic)***) | 2 | M; SL (0.8 ml (4 auto-injectors) per month.) |
| RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 12.5 MG/0.25ML (***methotrexate (anti-rheumatic)***) | 2 | M; SL (1 ml (4 auto-injectors) per month.) |
| RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 15 MG/0.3ML (***methotrexate (anti-rheumatic)***) | 2 | M; SL (1.2 ml (4 auto-injectors) per month.) |
| RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 17.5 MG/0.35ML (***methotrexate (anti-rheumatic)***) | 2 | M; SL (1.4 ml (4 auto-injectors) per month.) |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 20 MG/0.4ML (***methotrexate (anti-rheumatic)***) | 2 | M; SL (1.6 ml (4 auto-injectors) per month.) |
| RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 22.5 MG/0.45ML (***methotrexate (anti-rheumatic)***) | 2 | M; SL (1.8 ml (4 auto-injectors) per month.) |
| RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 25 MG/0.5ML (***methotrexate (anti-rheumatic)***) | 2 | M; SL (2 ml (4 auto-injectors) per month.) |
| RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 30 MG/0.6ML (***methotrexate (anti-rheumatic)***) | 2 | M; SL (2.4 ml (4 auto-injectors) per month.) |
| RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 7.5 MG/0.15ML (***methotrexate (anti-rheumatic)***) | 2 | M; SL (0.6 ml (4 auto-injectors) per month.) |
| RETEVMO ORAL CAPSULE 40 MG (***selpercatinib***) | 3 | PA; SL (6 capsules per day.); CM |
| RETEVMO ORAL CAPSULE 80 MG (***selpercatinib***) | 3 | PA; CM |
| REVLIMID ORAL CAPSULE 10 MG, 2.5 MG, 5 MG (***lenalidomide***) | 2 | PA; SL (28 capsules per prescription.); SP; CM |
| REVLIMID ORAL CAPSULE 15 MG, 25 MG (***lenalidomide***) | 2 | PA; SL (21 capsules per prescription.); SP; CM |
| REVLIMID ORAL CAPSULE 20 MG (***lenalidomide***) | 2 | PA; SL (21 capsules per prescription); SP; CM |
| ROZLYTREK ORAL CAPSULE 100 MG (***entrectinib***) | 2 | PA; SL (1 capsule per day.); SP; CM |
| ROZLYTREK ORAL CAPSULE 200 MG (***entrectinib***) | 2 | PA; SL (3 capsules per day.); SP; CM |
| RUBRACA ORAL TABLET 200 MG (***rucaparib camsylate***) | 3 | PA; ST; SL (2 tablets per day.); SP; CM |
| RUBRACA ORAL TABLET 250 MG, 300 MG (***rucaparib camsylate***) | 3 | PA; ST; SL (4 tablets per day.); SP; CM |
| RYDAPT ORAL CAPSULE 25 MG (***midostaurin***) | 2 | PA; SL (8 capsules per day.); SP; CM |
| SPRYCEL ORAL TABLET 100 MG, 140 MG, 50 MG, 70 MG, 80 MG (***dasatinib***) | 4 | PA; ST; SL (1 tablet per day.); SP; CM |
| SPRYCEL ORAL TABLET 20 MG (***dasatinib***) | 4 | PA; ST; SL (2 tablets per day.); SP; CM |
| STIVARGA ORAL TABLET 40 MG (***regorafenib***) | 2 | PA; SL (84 tablets per prescription.); SP; CM |
| SUTENT ORAL CAPSULE 12.5 MG, 25 MG, 37.5 MG, 50 MG (***sunitinib malate***) | 2 | PA; SL (1 capsule per day.); SP; CM |

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|---|---|---|
| SYNRIBO SUBCUTANEOUS SOLUTION RECONSTITUTED 3.5 MG (***omacetaxine mepesuccinate***) | 2 | PA; M; SL (28 vials per month.); SP |
| TABLOID ORAL TABLET 40 MG (***thioguanine***) | 2 | SP |
| TABRECTA ORAL TABLET 150 MG, 200 MG (***capmatinib hcl***) | 3 | PA; SL (4 tablets per day.); CM |
| TAFINLAR ORAL CAPSULE 50 MG, 75 MG (***dabrafenib mesylate***) | 3 | PA; SL (4 capsules per day.); SP; CM |
| TAGRISSO ORAL TABLET 40 MG, 80 MG (***osimertinib mesylate***) | 3 | PA; SL (1 tablet per day.); SP; CM |
| TALZENNA ORAL CAPSULE 0.25 MG (***talazoparib tosylate***) | 3 | PA; ST; SL (3 capsules per day.); SP; CM |
| TALZENNA ORAL CAPSULE 1 MG (***talazoparib tosylate***) | 3 | PA; ST; SL (1 capsule per day.); SP; CM |
| ***tamoxifen citrate oral tablet 10 mg*** | 1 | |
| ***tamoxifen citrate oral tablet 20 mg*** | 1 | H-N |
| TARCEVA ORAL TABLET 100 MG, 150 MG, 25 MG (***erlotinib hcl***) | 3 | PA; SL (1 tablet per day.); SP; CM |
| TARGRETIN EXTERNAL GEL 1 % (***bexarotene***) | 3 | SL (60 grams per prescription); SP |
| TARGRETIN ORAL CAPSULE 75 MG (***bexarotene***) | 2 | CM |
| TASIGNA ORAL CAPSULE 150 MG, 200 MG, 50 MG (***nilotinib hcl***) | 2 | PA; ST; SL (4 capsules per day.); SP; CM |
| TAZVERIK ORAL TABLET 200 MG (***tazemetostat hbr***) | 3 | PA; SL (8 tablets per day.); SP; CM |
| TEMODAR ORAL CAPSULE 100 MG, 140 MG, 180 MG, 20 MG, 250 MG, 5 MG (***temozolomide***) | 3 | PA; SP; CM |
| ***temozolomide oral capsule 100 mg, 140 mg, 180 mg, 20 mg, 250 mg, 5 mg*** | 1 | PA; SP; CM |
| TIBSOVO ORAL TABLET 250 MG (***ivosidenib***) | 2 | PA; SL (2 tablets per day.); SP; CM |
| ***toremifene citrate oral tablet 60 mg*** | 2 | |
| ***tretinoin oral capsule 10 mg*** | 2 | SL (279 capsules per prescription); SP; CM |
| TREXALL ORAL TABLET 10 MG, 15 MG, 5 MG, 7.5 MG (***methotrexate sodium***) | 2 | |
| TUKYSA ORAL TABLET 150 MG (***tucatinib***) | 4 | PA; SL (4 tablets per day.); SP; CM |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| TUKYSA ORAL TABLET 50 MG (***tucatinib***) | 4 | PA; SL (10 tablets per day.); SP; CM |
| TURALIO ORAL CAPSULE 200 MG (***pexidartinib hcl***) | 2 | PA; SL (4 capsules per day.); SP; CM |
| TYKERB ORAL TABLET 250 MG (***lapatinib ditosylate***) | 2 | PA; SL (186 tablets per prescription); SP; CM |
| VALCHLOR EXTERNAL GEL 0.016 % (***mechlorethamine hcl (topical)***) | 2 | PA; SL (120 grams per prescription); SP |
| VENCLEXTA ORAL TABLET 10 MG, 100 MG (***venetoclax***) | 2 | PA; SL (4 tablets per day.); SP; CM |
| VENCLEXTA ORAL TABLET 50 MG (***venetoclax***) | 2 | PA; SL (1 tablet per day.); SP; CM |
| VENCLEXTA STARTING PACK ORAL TABLET THERAPY PACK 10 & 50 & 100 MG (***venetoclax***) | 2 | PA; SL (42 tablets per year.); SP; CM |
| VERZENIO ORAL TABLET 100 MG, 150 MG, 200 MG, 50 MG (***abemaciclib***) | 2 | PA; SL (2 tablets per day.); SP; CM |
| VITRAKVI ORAL CAPSULE 100 MG (***larotrectinib sulfate***) | 2 | PA; SL (2 capsules per day.); SP; CM |
| VITRAKVI ORAL CAPSULE 25 MG (***larotrectinib sulfate***) | 2 | PA; SL (6 capsules per day.); SP; CM |
| VITRAKVI ORAL SOLUTION 20 MG/ML (***larotrectinib sulfate***) | 2 | PA; SL (10 mL per day.); SP; CM |
| VIZIMPRO ORAL TABLET 15 MG, 30 MG, 45 MG (***dacomitinib***) | 3 | PA; SL (1 tablet per day.); SP; CM |
| VOTRIENT ORAL TABLET 200 MG (***pazopanib hcl***) | 2 | PA; SL (4 tablets per day.); SP; CM |
| XALKORI ORAL CAPSULE 200 MG, 250 MG (***crizotinib***) | 2 | PA; SL (2 capsules per day.); SP; CM |
| XATMEP ORAL SOLUTION 2.5 MG/ML (***methotrexate***) | 3 | PA; SL (4 ml per day.) |
| XELODA ORAL TABLET 150 MG (***capecitabine***) | 1 | SL (84 tablets per prescription); SP; CM |
| XELODA ORAL TABLET 500 MG (***capecitabine***) | 1 | SL (140 tablets per prescription); SP; CM |
| XOSPATA ORAL TABLET 40 MG (***gilteritinib fumarate***) | 3 | PA; SL (3 tablets per day.); SP; CM |
| XPOVIO (100 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 20 MG (***selinexor***) | 3 | PA; SL (0.72 tablets per day.); SP; CM |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| XPOVIO (60 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 20 MG (***selinexor***) | 3 | PA; SL (0.43 tablets per day.); SP; CM |
| XPOVIO (80 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 20 MG (***selinexor***) | 3 | PA; SL (0.58 tablets per day.); SP; CM |
| XPOVIO (80 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK 20 MG (***selinexor***) | 3 | PA; SL (1.15 tablets per day.); SP; CM |
| XTANDI ORAL CAPSULE 40 MG (***enzalutamide***) | 4 | PA; ST; SL (4 tablets per day.); SP; CM |
| ZEJULA ORAL CAPSULE 100 MG (***niraparib tosylate***) | 2 | PA; SL (3 capsules per day.); SP; CM |
| ZELBORAF ORAL TABLET 240 MG (***vemurafenib***) | 2 | PA; SL (8 tablets per day.); SP; CM |
| ZOLINZA ORAL CAPSULE 100 MG (***vorinostat***) | 2 | SL (124 capsules per prescription); SP; CM |
| ZYDELIG ORAL TABLET 100 MG, 150 MG (***idelalisib***) | 3 | PA; SL (60 tablets per month.); SP; CM |
| ZYKADIA ORAL TABLET 150 MG (***ceritinib***) | 2 | PA; SL (3 tablets per day.); SP; CM |
| **ANTITOXINS,IMMUNE GLOB,TOXOIDS,VACCINES - DRUGS FOR THE IMMUNE SYSTEM** | | |
| **ALLERGENIC EXTRACTS (THERAPEUTIC) - DRUGS FOR THE IMMUNE SYSTEM** | | |
| GRASTEK SUBLINGUAL TABLET SUBLINGUAL 2800 BAU (***timothy grass pollen allergen***) | 3 | PA; SL (1 tablet per day.) |
| ORALAIR ADULT SAMPLE KIT SUBLINGUAL TABLET SUBLINGUAL 300 IR (***grass mix pollens allergen ext***) | 3 | PA; SL (1 tablet per day.) |
| ORALAIR ADULT STARTER PACK SUBLINGUAL TABLET SUBLINGUAL 300 IR (***grass mix pollens allergen ext***) | 3 | PA; SL (1 tablet per day.) |
| ORALAIR CHILDRENS SAMPLE KIT SUBLINGUAL THERAPY PACK 3 X 100 IR & 6 X 300 IR (***grass mix pollens allergen ext***) | 3 | |
| ORALAIR CHILDRENS STARTER PACK SUBLINGUAL TABLET SUBLINGUAL 100 IR (***grass mix pollens allergen ext***) | 3 | PA; SL (3 tablets per year.) |
| ORALAIR SUBLINGUAL TABLET SUBLINGUAL 300 IR (***grass mix pollens allergen ext***) | 3 | PA; SL (1 tablet per day.) |
| PALFORZIA (12 MG DAILY DOSE) ORAL 2 X 1 MG & 10 MG (***peanut powder-dnfp***) | 3 | PA; SL (45 capsules per 13 days.); SP |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| PALFORZIA (120 MG DAILY DOSE) ORAL 20 MG & 100 MG (***peanut powder-dnfp***) | 3 | PA; SL (30 capsules per 13 days.); SP |
| PALFORZIA (160 MG DAILY DOSE) ORAL 3 X 20 MG & 100 MG (***peanut powder-dnfp***) | 3 | PA; SL (60 capsule per 13 days.); SP |
| PALFORZIA (20 MG DAILY DOSE) ORAL 20 MG (***peanut powder-dnfp***) | 3 | PA; SL (15 capsules per 13 days.); SP |
| PALFORZIA (200 MG DAILY DOSE) ORAL 2 X 100 MG (***peanut powder-dnfp***) | 3 | PA; SL (30 capsules per 13 days.); SP |
| PALFORZIA (240 MG DAILY DOSE) ORAL 2 X 20 MG & 2 X 100 MG (***peanut powder-dnfp***) | 3 | PA; SL (60 capsules per 13 days.); SP |
| PALFORZIA (3 MG DAILY DOSE) ORAL 3 X 1 MG (***peanut powder-dnfp***) | 3 | PA; SL (45 capsules per 13 days.); SP |
| PALFORZIA (300 MG MAINTENANCE) ORAL PACKET 300 MG (***peanut powder-dnfp***) | 3 | PA; SL (1 capsule per day.); SP |
| PALFORZIA (300 MG TITRATION) ORAL PACKET 300 MG (***peanut powder-dnfp***) | 3 | PA; SL (15 capsules per 13 days.); SP |
| PALFORZIA (40 MG DAILY DOSE) ORAL 2 X 20 MG (***peanut powder-dnfp***) | 3 | PA; SL (30 capsules per 13 days.); SP |
| PALFORZIA (6 MG DAILY DOSE) ORAL 6 X 1 MG (***peanut powder-dnfp***) | 3 | PA; SL (90 capsules per 13 days); SP |
| PALFORZIA (80 MG DAILY DOSE) ORAL 4 X 20 MG (***peanut powder-dnfp***) | 3 | PA; SL (60 capsules per 13 days.); SP |
| PALFORZIA INITIAL ESCALATION ORAL 0.5 & 1 & 1.5 & 3 & 6 MG (***peanut powder-dnfp***) | 3 | PA; SL (13 capsules per year.); SP |
| RAGWITEK SUBLINGUAL TABLET SUBLINGUAL 12 AMB A 1-U (***short ragweed pollen ext***) | 3 | PA; SL (1 tablet per day.) |
| **TOXOIDS - Vaccines** | | |
| ADACEL INTRAMUSCULAR SUSPENSION 5-2-15.5 LF-MCG/0.5 (***tetanus-diphth-acell pertussis***) | 3 | H |
| BOOSTRIX INTRAMUSCULAR SUSPENSION 5-2.5-18.5 LF-MCG/0.5 (***tetanus-diphth-acell pertussis***) | 2 | H |
| TENIVAC INTRAMUSCULAR INJECTABLE 5-2 LFU (***tetanus-diphtheria toxoids td***) | 3 | H |
| **VACCINES - Vaccines** | | |
| ACTHIB INTRAMUSCULAR SOLUTION RECONSTITUTED (***haemophilus b polysac conj vac***) | 2 | H |
| AFLURIA QUADRIVALENT INTRAMUSCULAR SUSPENSION (***influenza vac split quad***) | 3 | H |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| AFLURIA QUADRIVALENT INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.25 ML, 0.5 ML (***influenza vac split quad***) | 3 | H |
| BEXSERO INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (***meningococcal b recomb omv adj***) | 3 | H |
| ENGERIX-B INJECTION SUSPENSION 10 MCG/0.5ML, 20 MCG/ML (***hepatitis b vac recombinant***) | 2 | H |
| FLUAD INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML (***influenza vac a&b surf ant adj***) | 3 | H |
| FLUAD QUADRIVALENT INTRAMUSCULAR PREFILLED SYRINGE 0.5 ML (***influenza vac a&b sa adj quad***) | 3 | H |
| FLUARIX QUADRIVALENT INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML (***influenza vac split quad***) | 3 | H |
| FLUCELVAX QUADRIVALENT INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML (***influenza vac subunit quad***) | 3 | H |
| FLULAVAL QUADRIVALENT INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML (***influenza vac split quad***) | 3 | H |
| FLUMIST QUADRIVALENT NASAL SUSPENSION (***influenza virus vac live quad***) | 3 | H |
| FLUZONE QUADRIVALENT INTRAMUSCULAR SUSPENSION , 0.5 ML (***influenza vac split quad***) | 3 | H |
| FLUZONE QUADRIVALENT INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML (***influenza vac split quad***) | 3 | H |
| GARDASIL 9 INTRAMUSCULAR SUSPENSION (***hpv 9-valent recomb vaccine***) | 3 | H |
| GARDASIL 9 INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (***hpv 9-valent recomb vaccine***) | 3 | H |
| HAVRIX INTRAMUSCULAR SUSPENSION 1440 EL U/ML, 720 EL U/0.5ML (***hepatitis a vaccine***) | 3 | H |
| HEPLISAV-B INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 20 MCG/0.5ML (***hepatitis b vac recomb adj***) | 3 | H |
| HIBERIX INJECTION SOLUTION RECONSTITUTED 10 MCG (***haemophilus b polysac conj vac***) | 3 | H |
| IPOL INJECTION INJECTABLE (***poliovirus vaccine inactivated***) | 2 | H |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| MENACTRA INTRAMUSCULAR INJECTABLE (***meningococcal a c y&w-135 conj***) | 3 | H |
| MENQUADFI INTRAMUSCULAR INJECTABLE (***meningococcal a c y&w-135 conj***) | 3 | H |
| MENVEO INTRAMUSCULAR SOLUTION RECONSTITUTED (***meningococcal a c y&w-135 olig***) | 3 | H |
| M-M-R II INJECTION SOLUTION RECONSTITUTED (***measles, mumps & rubella vac***) | 2 | H |
| PEDVAX HIB INTRAMUSCULAR SUSPENSION 7.5 MCG/0.5ML (***haemophilus b polysac conj vac***) | 2 | H |
| PNEUMOVAX 23 INJECTION INJECTABLE 25 MCG/0.5ML (***pneumococcal vac polyvalent***) | 2 | H |
| PREVNAR 13 INTRAMUSCULAR SUSPENSION (***pneumococcal 13-val conj vacc***) | 3 | H |
| RECOMBIVAX HB INJECTION SUSPENSION 10 MCG/ML, 40 MCG/ML, 5 MCG/0.5ML (***hepatitis b vac recombinant***) | 2 | H |
| SHINGRIX INTRAMUSCULAR SUSPENSION RECONSTITUTED 50 MCG/0.5ML (***zoster vac recomb adjuvanted***) | 3 | H |
| TRUMENBA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (***meningococcal b vac (recomb)***) | 3 | H |
| TWINRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 720-20 ELU-MCG/ML (***hepatitis a-hep b recomb vac***) | 3 | H |
| VAQTA INTRAMUSCULAR SUSPENSION 25 UNIT/0.5ML, 50 UNIT/ML (***hepatitis a vaccine***) | 2 | H |
| VARIVAX SUBCUTANEOUS INJECTABLE 1350 PFU/0.5ML (***varicella virus vaccine live***) | 3 | H |
| **AUTONOMIC DRUGS - Drugs for the Nervous System** | | |
| **ALPHA- AND BETA-ADRENERGIC AGONISTS - Drugs for Heart and Lungs** | | |
| ***pseudoeph-bromphen-dm*** (Bromfed Dm Oral Syrup 30-2-10 Mg/5Ml) | 1 | |
| ***epinephrine solution auto-injector 0.15 mg/0.3ml injection 0.15 mg/0.3ml*** | 2 | SL (4 injections per prescription) |
| ***epinephrine solution auto-injector 0.3 mg/0.3ml injection 0.3 mg/0.3ml*** | 2 | SL (2 injections per prescription) |
| NORTHERA ORAL CAPSULE 100 MG (***droxidopa***) | 4 | PA; SL (90 tablets per month.); SP |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| NORTHERA ORAL CAPSULE 200 MG, 300 MG (***droxidopa***) | 4 | PA; SL (180 tablets per month.); SP |
| ***pseudoephedrine-bromphen-dm oral syrup 30-2-10 mg/5ml*** | 1 | |
| SEMPREX-D ORAL CAPSULE 8-60 MG (***acrivastine-pseudoephedrine***) | 3 | |
| SYMJEPI INJECTION SOLUTION PREFILLED SYRINGE 0.15 MG/0.3ML, 0.3 MG/0.3ML (***epinephrine***) | 2 | SL (2 pens per prescription) |
| **ALPHA-ADRENERGIC AGONISTS - Drugs for Heart and Lungs** | | |
| CATAPRES ORAL TABLET 0.1 MG, 0.2 MG, 0.3 MG (***clonidine hcl***) | 3 | |
| CATAPRES-TTS-1 TRANSDERMAL PATCH WEEKLY 0.1 MG/24HR (***clonidine***) | 3 | |
| CATAPRES-TTS-2 TRANSDERMAL PATCH WEEKLY 0.2 MG/24HR (***clonidine***) | 3 | |
| CATAPRES-TTS-3 TRANSDERMAL PATCH WEEKLY 0.3 MG/24HR (***clonidine***) | 3 | |
| ***clonidine hcl oral tablet 0.1 mg, 0.2 mg, 0.3 mg*** | 1 | |
| ***clonidine transdermal patch weekly 0.1 mg/24hr, 0.2 mg/24hr, 0.3 mg/24hr*** | 3 | |
| GILPHEX TR ORAL TABLET 10-388 MG (***phenylephrine-guaifenesin***) | 3 | |
| GILTUSS TR ORAL TABLET 10-28-388 MG (***phenylephrine-dm-gg***) | 3 | |
| LUCEMYRA ORAL TABLET 0.18 MG (***lofexidine hcl***) | 3 | PA; SL (192 tablets per year.) |
| ***methyldopa oral tablet 250 mg, 500 mg*** | 1 | |
| ***methyldopa-hydrochlorothiazide oral tablet 250-15 mg, 250-25 mg*** | 1 | |
| ***midodrine hcl oral tablet 10 mg, 2.5 mg, 5 mg*** | 1 | |
| NEOTUSS PLUS ORAL LIQUID 7.5-4-30 MG/5ML (***phenylephrine-chlorphen-dm***) | 3 | |
| ***promethazine-phenyleph-codeine oral syrup 6.25-5-10 mg/5ml*** | 1 | PA; SL (360 ml per month.) |
| ***promethazine-phenylephrine oral syrup 6.25-5 mg/5ml*** | 1 | |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| **ANTIMUSCARINICS/ANTISPASMODICS - Drugs for Parkinson** | | |
| ANASPAZ ORAL TABLET DISPERSIBLE 0.125 MG (***hyoscyamine sulfate***) | 2 | |
| ANORO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 62.5-25 MCG/INH (***umeclidinium-vilanterol***) | 3 | SL (2 blisters per day.) |
| ATROVENT HFA INHALATION AEROSOL SOLUTION 17 MCG/ACT (***ipratropium bromide hfa***) | 3 | SL (0.87 grams per day.) |
| BEVESPI AEROSPHERE INHALATION AEROSOL 9-4.8 MCG/ACT (***glycopyrrolate-formoterol***) | 2 | SL (0.36 grams per day.) |
| ***chlordiazepoxide-clidinium oral capsule 5-2.5 mg*** | 3 | |
| COMBIVENT RESPIMAT INHALATION AEROSOL SOLUTION 20-100 MCG/ACT (***ipratropium-albuterol***) | 3 | SL (0.28 grams per day.) |
| CUVPOSA ORAL SOLUTION 1 MG/5ML (***glycopyrrolate***) | 3 | |
| ***dicyclomine hcl oral capsule 10 mg*** | 1 | |
| ***dicyclomine hcl oral solution 10 mg/5ml*** | 1 | |
| ***dicyclomine hcl oral tablet 20 mg*** | 1 | |
| ***diphenoxylate-atropine oral liquid 2.5-0.025 mg/5ml*** | 1 | |
| ***diphenoxylate-atropine oral tablet 2.5-0.025 mg*** | 1 | |
| DUAKLIR PRESSAIR INHALATION AEROSOL POWDER BREATH ACTIVATED 400-12 MCG/ACT (***aclidinium br-formoterol fum***) | 3 | SL (0.04 mcg per day.) |
| ***ed-spaz oral tablet dispersible 0.125 mg*** | 1 | |
| ***glycopyrrolate oral tablet 1 mg, 2 mg*** | 1 | |
| ***hydrocodone-homatropine oral syrup 5-1.5 mg/5ml*** | 1 | PA; SL (120 mL per prescription and 360 ml per month) |
| ***hydrocodone-homatropine oral tablet 5-1.5 mg*** | 1 | PA |
| ***hydromet oral syrup 5-1.5 mg/5ml*** | 1 | PA; SL (120 mL per prescription and 360 ml per month) |
| ***hyoscyamine sulfate er oral tablet extended release 12 hour 0.375 mg*** | 1 | |
| ***hyoscyamine sulfate oral elixir 0.125 mg/5ml*** | 1 | |
| ***hyoscyamine sulfate oral solution 0.125 mg/ml*** | 1 | |
| ***hyoscyamine sulfate oral tablet 0.125 mg*** | 1 | |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ***hyoscyamine sulfate oral tablet dispersible 0.125 mg*** | 1 | |
| ***hyoscyamine sulfate sl sublingual tablet sublingual 0.125 mg*** | 1 | |
| ***hyoscyamine sulfate sublingual tablet sublingual 0.125 mg*** | 1 | |
| ***hyosyne oral elixir 0.125 mg/5ml*** | 1 | |
| ***hyosyne oral solution 0.125 mg/ml*** | 1 | |
| ***ipratropium bromide inhalation solution 0.02 %*** | 1 | |
| ***ipratropium-albuterol inhalation solution 0.5-2.5 (3) mg/3ml*** | 2 | |
| LEVBID ORAL TABLET EXTENDED RELEASE 12 HOUR 0.375 MG (***hyoscyamine sulfate***) | 3 | |
| LEVSIN ORAL TABLET 0.125 MG (***hyoscyamine sulfate***) | 3 | |
| LEVSIN/SL SUBLINGUAL TABLET SUBLINGUAL 0.125 MG (***hyoscyamine sulfate***) | 3 | |
| LOMOTIL ORAL TABLET 2.5-0.025 MG (***diphenoxylate-atropine***) | 3 | |
| ***methscopolamine bromide oral tablet 2.5 mg, 5 mg*** | 1 | |
| ***hyoscyamine sulfate*** (Nulev Oral Tablet Dispersible 0.125 Mg) | 3 | |
| ***oscimin oral tablet 0.125 mg*** | 1 | |
| ***oscimin sr oral tablet extended release 12 hour 0.375 mg*** | 1 | |
| ***oscimin sublingual tablet sublingual 0.125 mg*** | 1 | |
| ***propantheline bromide oral tablet 15 mg*** | 1 | |
| SEEBRI NEOHALER INHALATION CAPSULE 15.6 MCG (***glycopyrrolate***) | 3 | ST; SL (2 capsules per day.) |
| SPIRIVA HANDIHALER INHALATION CAPSULE 18 MCG (***tiotropium bromide monohydrate***) | 2 | SL (1 capsule per day) |
| SPIRIVA RESPIMAT INHALATION AEROSOL SOLUTION 1.25 MCG/ACT, 2.5 MCG/ACT (***tiotropium bromide monohydrate***) | 2 | SL (0.15 grams per day.) |
| SYMAX DUOTAB ORAL TABLET EXTENDED RELEASE 0.375 MG (***hyoscyamine sulfate***) | 3 | |
| ***hyoscyamine sulfate*** (Symax-Sl Sublingual Tablet Sublingual 0.125 Mg) | 1 | |
| ***hyoscyamine sulfate*** (Symax-Sr Oral Tablet Extended Release 12 Hour 0.375 Mg) | 1 | |
| TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-62.5-25 MCG/INH (***fluticasone-umeclidin-vilant***) | 3 | SL (2 blisters per day.) |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| YUPELRI INHALATION SOLUTION 175 MCG/3ML (***revefenacin***) | 3 | PA; SL (3 ml per day.) |
| **ANTIPARKINSONIAN AGENTS - Drugs for Parkinson** | | |
| ***benztropine mesylate oral tablet 0.5 mg, 1 mg, 2 mg*** | 1 | |
| ***trihexyphenidyl hcl oral solution 0.4 mg/ml*** | 1 | |
| ***trihexyphenidyl hcl oral tablet 2 mg, 5 mg*** | 1 | |
| **AUTONOMIC DRUGS, MISCELLANEOUS - Drugs for the Nervous System** | | |
| CHANTIX CONTINUING MONTH PAK ORAL TABLET 1 MG (***varenicline tartrate***) | 3 | H |
| CHANTIX ORAL TABLET 0.5 MG, 1 MG (***varenicline tartrate***) | 3 | H |
| CHANTIX STARTING MONTH PAK ORAL TABLET 0.5 MG X 11 & 1 MG X 42 (***varenicline tartrate***) | 3 | H |
| NICORETTE MOUTH/THROAT GUM 2 MG (***nicotine polacrilex***) | 3 | H |
| ***nicotine polacrilex mouth/throat gum 2 mg, 4 mg*** | 1 | H |
| ***nicotine polacrilex mouth/throat lozenge 2 mg, 4 mg*** | 1 | H |
| ***nicotine step 1 transdermal patch 24 hour 21 mg/24hr*** | 1 | H |
| ***nicotine step 2 transdermal patch 24 hour 14 mg/24hr*** | 1 | H |
| ***nicotine step 3 transdermal patch 24 hour 7 mg/24hr*** | 1 | H |
| NICOTROL INHALATION INHALER 10 MG (***nicotine***) | 3 | H |
| NICOTROL NS NASAL SOLUTION 10 MG/ML (***nicotine***) | 3 | H |
| **CENTRALLY ACTING SKELETAL MUSCLE RELAXNT - Drugs for Relaxing Muscles** | | |
| ***carisoprodol oral tablet 350 mg*** | 1 | |
| ***carisoprodol-aspirin-codeine oral tablet 200-325-16 mg*** | 1 | |
| ***chlorzoxazone oral tablet 500 mg*** | 1 | |
| ***cyclobenzaprine hcl oral tablet 10 mg, 5 mg*** | 1 | |
| ***metaxalone oral tablet 400 mg, 800 mg*** | 3 | |
| ***methocarbamol oral tablet 500 mg, 750 mg*** | 1 | |
| ROBAXIN-750 ORAL TABLET 750 MG (***methocarbamol***) | 3 | |
| SOMA ORAL TABLET 350 MG (***carisoprodol***) | 3 | |
| ***tizanidine hcl oral capsule 2 mg, 4 mg, 6 mg*** | 3 | |
| ***tizanidine hcl oral tablet 2 mg, 4 mg*** | 1 | |
| ***carisoprodol*** (Vanadom Oral Tablet 350 Mg) | 3 | |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ZANAFLEX ORAL CAPSULE 2 MG, 4 MG, 6 MG (***tizanidine hcl***) | 3 | |
| ZANAFLEX ORAL TABLET 4 MG (***tizanidine hcl***) | 3 | |
| **DIRECT-ACTING SKELETAL MUSCLE RELAXANTS - Drugs for Relaxing Muscles** | | |
| DANTRIUM ORAL CAPSULE 25 MG, 50 MG (***dantrolene sodium***) | 3 | |
| ***dantrolene sodium oral capsule 100 mg, 25 mg, 50 mg*** | 1 | |
| **GABA-DERIVATIVE SKELETAL MUSCLE RELAXANT - Drugs for Relaxing Muscles** | | |
| ***baclofen oral tablet 10 mg, 20 mg, 5 mg*** | 1 | |
| OZOBAX ORAL SOLUTION 1 MG/ML (***baclofen***) | 3 | PA |
| **NON-SEL. BETA-ADRENERGIC BLOCKING AGENTS - Drugs for the Heart** | | |
| BETAPACE AF ORAL TABLET 120 MG, 160 MG, 80 MG (***sotalol hcl af***) | 4 | |
| ***carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg*** | 1 | |
| COREG ORAL TABLET 12.5 MG, 25 MG, 3.125 MG, 6.25 MG (***carvedilol***) | 3 | |
| CORGARD ORAL TABLET 20 MG, 40 MG, 80 MG (***nadolol***) | 3 | |
| ***labetalol hcl oral tablet 100 mg, 200 mg, 300 mg*** | 1 | |
| ***nadolol oral tablet 20 mg, 40 mg, 80 mg*** | 1 | |
| ***pindolol oral tablet 10 mg, 5 mg*** | 1 | |
| ***propranolol hcl er oral capsule extended release 24 hour 120 mg, 160 mg, 60 mg, 80 mg*** | 2 | |
| ***propranolol hcl oral solution 20 mg/5ml, 40 mg/5ml*** | 1 | |
| ***propranolol hcl oral tablet 10 mg, 20 mg, 40 mg, 60 mg, 80 mg*** | 1 | |
| ***propranolol-hctz oral tablet 40-25 mg, 80-25 mg*** | 1 | |
| ***sotalol hcl (af) oral tablet 120 mg, 160 mg, 80 mg*** | 1 | |
| ***sotalol hcl oral tablet 120 mg, 160 mg, 240 mg, 80 mg*** | 1 | |
| SOTYLIZE ORAL SOLUTION 5 MG/ML (***sotalol hcl***) | 3 | PA |
| ***timolol maleate oral tablet 10 mg, 20 mg, 5 mg*** | 1 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| **NON-SEL.ALPHA-1-ADRENERGIC BLOCKING AGTS - Drugs for the Heart** | | |
| CARDURA ORAL TABLET 1 MG, 2 MG, 4 MG, 8 MG (***doxazosin mesylate***) | 3 | |
| CARDURA XL ORAL TABLET EXTENDED RELEASE 24 HOUR 4 MG, 8 MG (***doxazosin mesylate***) | 3 | |
| ***doxazosin mesylate oral tablet 1 mg, 2 mg, 4 mg, 8 mg*** | 1 | |
| MINIPRESS ORAL CAPSULE 1 MG, 2 MG, 5 MG (***prazosin hcl***) | 3 | |
| ***prazosin hcl oral capsule 1 mg, 2 mg, 5 mg*** | 1 | |
| ***terazosin hcl oral capsule 1 mg, 10 mg, 2 mg, 5 mg*** | 1 | |
| **NON-SEL.ALPHA-ADRENERGIC BLOCKING AGENTS - Drugs for the Heart** | | |
| CAFERGOT ORAL TABLET 1-100 MG (***ergotamine-caffeine***) | 3 | |
| ***dihydroergotamine mesylate injection solution 1 mg/ml*** | 1 | M |
| ***dihydroergotamine mesylate nasal solution 4 mg/ml*** | 3 | PA; SL (8 mL per prescription) |
| ***ergoloid mesylates oral tablet 1 mg*** | 1 | |
| ERGOMAR SUBLINGUAL TABLET SUBLINGUAL 2 MG (***ergotamine tartrate***) | 3 | PA; SL (5 tablets per prescription) |
| ***ergotamine-caffeine oral tablet 1-100 mg*** | 3 | |
| MIGERGOT RECTAL SUPPOSITORY 2-100 MG (***ergotamine-caffeine***) | 3 | |
| ***phenoxybenzamine hcl oral capsule 10 mg*** | 2 | |
| **PARASYMPATHOMIMETIC (CHOLINERGIC AGENTS) - Drugs for Bladder Incontinence** | | |
| ARICEPT ORAL TABLET 10 MG, 5 MG (***donepezil hcl***) | 3 | |
| ***bethanechol chloride oral tablet 10 mg, 25 mg, 5 mg, 50 mg*** | 1 | |
| ***cevimeline hcl oral capsule 30 mg*** | 1 | |
| ***donepezil hcl oral tablet 10 mg, 5 mg*** | 1 | |
| ***donepezil hcl oral tablet dispersible 10 mg, 5 mg*** | 1 | |
| EVOXAC ORAL CAPSULE 30 MG (***cevimeline hcl***) | 3 | |
| ***galantamine hydrobromide er oral capsule extended release 24 hour 16 mg, 24 mg, 8 mg*** | 1 | |
| ***galantamine hydrobromide oral solution 4 mg/ml*** | 1 | |
| ***galantamine hydrobromide oral tablet 12 mg, 4 mg, 8 mg*** | 1 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| GUANIDINE HCL ORAL TABLET 125 MG | 3 | |
| MESTINON ORAL SOLUTION 60 MG/5ML (***pyridostigmine bromide***) | 3 | |
| MESTINON ORAL TABLET EXTENDED RELEASE 180 MG (***pyridostigmine bromide***) | 3 | |
| NAMZARIC ORAL CAPSULE ER 24 HOUR THERAPY PACK 7 & 14 & 21 &28 -10 MG (***memantine hcl-donepezil hcl***) | 3 | |
| NAMZARIC ORAL CAPSULE EXTENDED RELEASE 24 HOUR 14-10 MG, 21-10 MG, 28-10 MG, 7-10 MG (***memantine hcl-donepezil hcl***) | 3 | |
| ***pilocarpine hcl oral tablet 5 mg, 7.5 mg*** | 1 | |
| ***pyridostigmine bromide er oral tablet extended release 180 mg*** | 1 | |
| ***pyridostigmine bromide oral solution 60 mg/5ml*** | 3 | |
| ***pyridostigmine bromide oral tablet 60 mg*** | 1 | |
| RAZADYNE ER ORAL CAPSULE EXTENDED RELEASE 24 HOUR 16 MG, 24 MG, 8 MG (***galantamine hydrobromide***) | 3 | |
| ***rivastigmine tartrate oral capsule 1.5 mg, 3 mg, 4.5 mg, 6 mg*** | 1 | |
| ***rivastigmine transdermal patch 24 hour 13.3 mg/24hr, 4.6 mg/24hr, 9.5 mg/24hr*** | 3 | |
| SALAGEN ORAL TABLET 5 MG, 7.5 MG (***pilocarpine hcl***) | 3 | |
| **SELECTIVE ALPHA-1-ADRENERGIC BLOCK.AGENT - Drugs for the Heart** | | |
| ***alfuzosin hcl er oral tablet extended release 24 hour 10 mg*** | 1 | |
| ***carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg*** | 1 | |
| COREG ORAL TABLET 12.5 MG, 25 MG, 3.125 MG, 6.25 MG (***carvedilol***) | 3 | |
| ***labetalol hcl oral tablet 100 mg, 200 mg, 300 mg*** | 1 | |
| ***silodosin oral capsule 4 mg, 8 mg*** | 3 | |
| ***tamsulosin hcl oral capsule 0.4 mg*** | 1 | |
| UROXATRAL ORAL TABLET EXTENDED RELEASE 24 HOUR 10 MG (***alfuzosin hcl***) | 4 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| **SELECTIVE BETA-2-ADRENERGIC AGONISTS - Drugs for Heart and Lungs** | | |
| ADVAIR DISKUS INHALATION AEROSOL POWDER BREATH ACTIVATED 100-50 MCG/DOSE, 250-50 MCG/DOSE, 500-50 MCG/DOSE (***fluticasone-salmeterol***) | 3 | SL (2 blisters per day) |
| ADVAIR HFA INHALATION AEROSOL 115-21 MCG/ACT, 230-21 MCG/ACT, 45-21 MCG/ACT (***fluticasone-salmeterol***) | 3 | SL (0.4 grams per day.) |
| ***albuterol sulfate er oral tablet extended release 12 hour 4 mg, 8 mg*** | 1 | |
| ***albuterol sulfate hfa aerosol solution 108 (90 base) mcg/act inhalation 108 (90 base) mcg/act*** | 1 | SL (8.5 grams per prescription.) |
| ***albuterol sulfate hfa aerosol solution 108 (90 base) mcg/act inhalation 108 (90 base) mcg/act*** | 3 | SL (1 inhaler per prescription.) |
| ***albuterol sulfate hfa aerosol solution 108 (90 base) mcg/act inhalation 108 (90 base) mcg/act*** | 3 | SL (6.7 grams per prescription) |
| ***albuterol sulfate hfa aerosol solution 108 (90 base) mcg/act inhalation 108 (90 base) mcg/act*** | 3 | SL (8.5 grams per prescription) |
| ***albuterol sulfate inhalation nebulization solution (2.5 mg/3ml) 0.083%, 0.63 mg/3ml, 1.25 mg/3ml, 2.5 mg/0.5ml*** | 1 | |
| ***albuterol sulfate inhalation nebulization solution (5 mg/ml) 0.5%*** | 1 | |
| ***albuterol sulfate oral syrup 2 mg/5ml*** | 1 | |
| ***albuterol sulfate oral tablet 2 mg, 4 mg*** | 3 | PA |
| ANORO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 62.5-25 MCG/INH (***umeclidinium-vilanterol***) | 3 | SL (2 blisters per day.) |
| ARCAPTA NEOHALER INHALATION CAPSULE 75 MCG (***indacaterol maleate***) | 3 | SL (1 capsule per day) |
| BEVESPI AEROSPHERE INHALATION AEROSOL 9-4.8 MCG/ACT (***glycopyrrolate-formoterol***) | 2 | SL (0.36 grams per day.) |
| BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-25 MCG/INH (***fluticasone furoate-vilanterol***) | 3 | SL (2 inhalers per day.) |
| BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 200-25 MCG/INH (***fluticasone furoate-vilanterol***) | 3 | SL (2 blisters per day.) |
| BROVANA INHALATION NEBULIZATION SOLUTION 15 MCG/2ML (***arformoterol tartrate***) | 3 | SL (2 nebules per day) |
| COMBIVENT RESPIMAT INHALATION AEROSOL SOLUTION 20-100 MCG/ACT (***ipratropium-albuterol***) | 3 | SL (0.28 grams per day.) |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| DUAKLIR PRESSAIR INHALATION AEROSOL POWDER BREATH ACTIVATED 400-12 MCG/ACT (***aclidinium br-formoterol fum***) | 3 | SL (0.04 mcg per day.) |
| ***fluticasone-salmeterol inhalation aerosol powder breath activated 100-50 mcg/dose, 250-50 mcg/dose, 500-50 mcg/dose*** | 3 | SL (2 blisters per day) |
| FLUTICASONE-SALMETEROL INHALATION AEROSOL POWDER BREATH ACTIVATED 113-14 MCG/ACT, 232-14 MCG/ACT, 55-14 MCG/ACT | 2 | SL (0.04 mcg per day.) |
| ***ipratropium-albuterol inhalation solution 0.5-2.5 (3) mg/3ml*** | 2 | |
| ***levalbuterol hcl inhalation nebulization solution 0.31 mg/3ml, 0.63 mg/3ml, 1.25 mg/3ml*** | 3 | SL (90 ml per prescription) |
| ***levalbuterol hcl inhalation nebulization solution 1.25 mg/0.5ml*** | 3 | SL (30 vials per prescription) |
| LEVALBUTEROL HFA INHALATION AEROSOL 45 MCG/ACT | 3 | SL (15 grams per prescription) |
| ***metaproterenol sulfate oral syrup 10 mg/5ml*** | 1 | |
| PERFOROMIST INHALATION NEBULIZATION SOLUTION 20 MCG/2ML (***formoterol fumarate***) | 3 | SL (2 vials per day) |
| PROAIR HFA INHALATION AEROSOL SOLUTION 108 (90 BASE) MCG/ACT (***albuterol sulfate***) | 3 | SL (8.5 grams per prescription) |
| PROAIR RESPICLICK INHALATION AEROSOL POWDER BREATH ACTIVATED 108 (90 BASE) MCG/ACT (***albuterol sulfate***) | 3 | SL (1 inhaler per prescription) |
| PROVENTIL HFA INHALATION AEROSOL SOLUTION 108 (90 BASE) MCG/ACT (***albuterol sulfate***) | 3 | SL (6.7 grams per prescription) |
| SEREVENT DISKUS INHALATION AEROSOL POWDER BREATH ACTIVATED 50 MCG/DOSE (***salmeterol xinafoate***) | 2 | SL (2 blisters per day.) |
| STRIVERDI RESPIMAT INHALATION AEROSOL SOLUTION 2.5 MCG/ACT (***olodaterol hcl***) | 2 | SL (0.14 grams per day.) |
| SYMBICORT INHALATION AEROSOL 160-4.5 MCG/ACT, 80-4.5 MCG/ACT (***budesonide-formoterol fumarate***) | 3 | SL (0.34 grams per day.) |
| ***terbutaline sulfate oral tablet 2.5 mg, 5 mg*** | 1 | |
| TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-62.5-25 MCG/INH (***fluticasone-umeclidin-vilant***) | 3 | SL (2 blisters per day.) |
| VENTOLIN HFA INHALATION AEROSOL SOLUTION 108 (90 BASE) MCG/ACT (***albuterol sulfate***) | 2 | SL (18 grams per prescription) |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ***fluticasone-salmeterol*** (Wixela Inhub Inhalation Aerosol Powder Breath Activated 100-50 Mcg/Dose, 250-50 Mcg/Dose, 500-50 Mcg/Dose) | 3 | SL (2 blisters per day) |
| XOPENEX HFA INHALATION AEROSOL 45 MCG/ACT (***levalbuterol tartrate***) | 3 | SL (15 grams per prescription) |
| **SELECTIVE BETA-ADRENERGIC BLOCKING AGENT - Drugs for the Heart** | | |
| ***acebutolol hcl oral capsule 200 mg, 400 mg*** | 1 | |
| ***atenolol oral tablet 100 mg, 25 mg, 50 mg*** | 1 | |
| ***atenolol-chlorthalidone oral tablet 100-25 mg, 50-25 mg*** | 1 | |
| ***betaxolol hcl oral tablet 10 mg, 20 mg*** | 1 | |
| ***bisoprolol fumarate oral tablet 10 mg, 5 mg*** | 1 | |
| ***bisoprolol-hydrochlorothiazide oral tablet 10-6.25 mg, 2.5-6.25 mg, 5-6.25 mg*** | 1 | |
| KAPSPARGO SPRINKLE ORAL CAPSULE ER 24 HOUR SPRINKLE 100 MG, 200 MG, 25 MG, 50 MG (***metoprolol succinate***) | 3 | |
| LOPRESSOR HCT ORAL TABLET 50-25 MG (***metoprolol-hydrochlorothiazide***) | 3 | |
| LOPRESSOR ORAL TABLET 100 MG, 50 MG (***metoprolol tartrate***) | 3 | |
| ***metoprolol succinate er oral tablet extended release 24 hour 100 mg, 200 mg, 50 mg*** | 2 | |
| ***metoprolol succinate er oral tablet extended release 24 hour 25 mg*** | 1 | |
| ***metoprolol tartrate oral tablet 100 mg, 25 mg, 50 mg*** | 1 | |
| ***metoprolol-hydrochlorothiazide oral tablet 100-25 mg, 100-50 mg, 50-25 mg*** | 1 | |
| TOPROL XL ORAL TABLET EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 25 MG, 50 MG (***metoprolol succinate***) | 3 | |
| ZIAC ORAL TABLET 10-6.25 MG, 2.5-6.25 MG, 5-6.25 MG (***bisoprolol-hydrochlorothiazide***) | 3 | |
| **SKELETAL MUSCLE RELAXANTS, MISCELLANEOUS - Drugs for Relaxing Muscles** | | |
| ***orphenadrine citrate er oral tablet extended release 12 hour 100 mg*** | 2 | |
| ***orphenadrine-asa-caffeine oral tablet 50-770-60 mg*** | 2 | |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| **BLOOD FORMATION, COAGULATION, THROMBOSIS - Drugs for the Blood** | | |
| **ANTICOAGULANTS - Drugs to Prevent Blood Clots** | | |
| TRICITRASOL IN VITRO CONCENTRATE 46.7 % (***anticoagulant sodium citrate***) | 3 | |
| **ANTICOAGULANTS, MISCELLANEOUS - Drugs to Prevent Blood Clots** | | |
| ACD-A NOCLOT-50 IN VITRO SOLUTION 0.73-2.45-2.2 GM/100ML (***anticoagulant cit dext soln a***) | 3 | |
| ***anticoagulant cit dext soln a in vitro solution 0.8-2.45-2.2 gm/100ml*** | 1 | |
| ANTICOAGULANT SODIUM CITRATE IN VITRO SOLUTION 4 GM/100ML | 3 | |
| ARIXTRA SUBCUTANEOUS SOLUTION 10 MG/0.8ML (***fondaparinux sodium***) | 4 | M; SL (24 ml (30 syringes) per prescription) |
| ARIXTRA SUBCUTANEOUS SOLUTION 2.5 MG/0.5ML (***fondaparinux sodium***) | 4 | M; SL (15 ml (30 syringes) per prescription) |
| ARIXTRA SUBCUTANEOUS SOLUTION 5 MG/0.4ML (***fondaparinux sodium***) | 4 | M; SL (12 ml (30 syringes) per prescription) |
| ARIXTRA SUBCUTANEOUS SOLUTION 7.5 MG/0.6ML (***fondaparinux sodium***) | 4 | M; SL (18 ml (30 syringes) per prescription) |
| ***fondaparinux sodium subcutaneous solution 10 mg/0.8ml*** | 2 | M; SL (24 ml (30 syringes) per prescription) |
| ***fondaparinux sodium subcutaneous solution 2.5 mg/0.5ml*** | 2 | M; SL (15 ml (30 syringes) per prescription) |
| ***fondaparinux sodium subcutaneous solution 5 mg/0.4ml*** | 2 | M; SL (12 ml (30 syringes) per prescription) |
| ***fondaparinux sodium subcutaneous solution 7.5 mg/0.6ml*** | 2 | M; SL (18 ml (30 syringes) per prescription) |
| **ANTITHROMBOTIC AGENTS, MISCELLANEOUS - Drugs to Prevent Blood Clots** | | |
| CABLIVI INJECTION KIT 11 MG (***caplacizumab-yhdp***) | 2 | PA; M; SL (1 vial per day and 58 vials per 120 days.); SP |
| **BLOOD FORM.,COAG,THROMBOSIS AGENTS MISC. - Drugs to Prevent Bleeding** | | |
| OXBRYTA ORAL TABLET 500 MG (***voxelotor***) | 3 | PA; SL (3 tablets per day.); SP |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| TAVALISSE ORAL TABLET 100 MG, 150 MG (***fostamatinib disodium***) | 3 | PA; ST; SL (2 tablets per day.); SP |
| **COUMARIN DERIVATIVES - Drugs to Prevent Blood Clots** | | |
| ***warfarin sodium*** (Jantoven Oral Tablet 1 Mg, 10 Mg, 2 Mg, 2.5 Mg, 3 Mg, 4 Mg, 5 Mg, 6 Mg, 7.5 Mg) | 1 | |
| ***warfarin sodium oral tablet 1 mg, 10 mg, 2 mg, 2.5 mg, 3 mg, 4 mg, 5 mg, 6 mg, 7.5 mg*** | 1 | |
| **DIRECT FACTOR XA INHIBITORS - Drugs to Prevent Blood Clots** | | |
| ARIXTRA SUBCUTANEOUS SOLUTION 10 MG/0.8ML (***fondaparinux sodium***) | 4 | M; SL (24 ml (30 syringes) per prescription) |
| ARIXTRA SUBCUTANEOUS SOLUTION 2.5 MG/0.5ML (***fondaparinux sodium***) | 4 | M; SL (15 ml (30 syringes) per prescription) |
| ARIXTRA SUBCUTANEOUS SOLUTION 5 MG/0.4ML (***fondaparinux sodium***) | 4 | M; SL (12 ml (30 syringes) per prescription) |
| ARIXTRA SUBCUTANEOUS SOLUTION 7.5 MG/0.6ML (***fondaparinux sodium***) | 4 | M; SL (18 ml (30 syringes) per prescription) |
| ELIQUIS DVT/PE STARTER PACK ORAL TABLET THERAPY PACK 5 MG (***apixaban***) | 2 | SL (2.5 tablets per day.) |
| ELIQUIS ORAL TABLET 2.5 MG (***apixaban***) | 2 | SL (2 tablets per day.) |
| ELIQUIS ORAL TABLET 5 MG (***apixaban***) | 2 | SL (2.5 tablets per day.) |
| ***fondaparinux sodium subcutaneous solution 10 mg/0.8ml*** | 2 | M; SL (24 ml (30 syringes) per prescription) |
| ***fondaparinux sodium subcutaneous solution 2.5 mg/0.5ml*** | 2 | M; SL (15 ml (30 syringes) per prescription) |
| ***fondaparinux sodium subcutaneous solution 5 mg/0.4ml*** | 2 | M; SL (12 ml (30 syringes) per prescription) |
| ***fondaparinux sodium subcutaneous solution 7.5 mg/0.6ml*** | 2 | M; SL (18 ml (30 syringes) per prescription) |
| SAVAYSA ORAL TABLET 15 MG, 30 MG, 60 MG (***edoxaban tosylate***) | 3 | SL (1 tablet per day.) |
| XARELTO ORAL TABLET 10 MG (***rivaroxaban***) | 2 | SL (1 tablet per day.) |
| XARELTO ORAL TABLET 15 MG (***rivaroxaban***) | 2 | SL (52 tablets per month initial 1 tablet per day for maintenance.) |
| XARELTO ORAL TABLET 2.5 MG (***rivaroxaban***) | 2 | SL (2 tablets per day.) |
| XARELTO ORAL TABLET 20 MG (***rivaroxaban***) | 2 | SL (31 tablets per 31 days.) |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| XARELTO STARTER PACK ORAL TABLET THERAPY PACK 15 & 20 MG (***rivaroxaban***) | 2 | SL (51 tablets per year.) |
| **DIRECT THROMBIN INHIBITORS - Drugs to Prevent Blood Clots** | | |
| PRADAXA ORAL CAPSULE 110 MG (***dabigatran etexilate mesylate***) | 2 | SL (2 tablets per day.) |
| PRADAXA ORAL CAPSULE 150 MG, 75 MG (***dabigatran etexilate mesylate***) | 2 | SL (62 capsules per 31 days.) |
| **HEMATOPOIETIC AGENTS - Drugs for Anemia** | | |
| ARANESP (ALBUMIN FREE) INJECTION SOLUTION 100 MCG/ML, 300 MCG/ML (***darbepoetin alfa***) | 2 | M; SL (2 syringes per month); SP |
| ARANESP (ALBUMIN FREE) INJECTION SOLUTION 200 MCG/ML, 25 MCG/ML, 40 MCG/ML, 60 MCG/ML (***darbepoetin alfa***) | 2 | M; SL (4 syringes per month); SP |
| ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 10 MCG/0.4ML (***darbepoetin alfa***) | 2 | M; SL (1.6 ml per month.); SP |
| ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 100 MCG/0.5ML (***darbepoetin alfa***) | 2 | M; SL (1 prefill syringe per month); SP |
| ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 150 MCG/0.3ML, 60 MCG/0.3ML (***darbepoetin alfa***) | 2 | M; SL (2 vials per month); SP |
| ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 200 MCG/0.4ML, 25 MCG/0.42ML, 40 MCG/0.4ML (***darbepoetin alfa***) | 2 | M; SL (4 vials per month); SP |
| ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 300 MCG/0.6ML (***darbepoetin alfa***) | 2 | M; SL (2 vials per prescription); SP |
| ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 500 MCG/ML (***darbepoetin alfa***) | 2 | M; SL (2 syringes per month); SP |
| DOPTELET ORAL TABLET 20 MG (***avatrombopag maleate***) | 3 | PA; ST; SL (15 tablets per month.); SP |
| LEUKINE INJECTION SOLUTION RECONSTITUTED 250 MCG (***sargramostim***) | 2 | M; SP |
| MOZOBIL SUBCUTANEOUS SOLUTION 24 MG/1.2ML (***plerixafor***) | 2 | M; SP |
| MULPLETA ORAL TABLET 3 MG (***lusutrombopag***) | 2 | PA; SL (7 tablets per prescription); SP |
| NEULASTA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML (***pegfilgrastim***) | 4 | M; SP |
| PROMACTA ORAL PACKET 12.5 MG (***eltrombopag olamine***) | 4 | PA; SP |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| PROMACTA ORAL PACKET 25 MG (***eltrombopag olamine***) | 4 | PA |
| PROMACTA ORAL TABLET 12.5 MG, 25 MG, 50 MG, 75 MG (***eltrombopag olamine***) | 4 | PA; SP |
| RETACRIT INJECTION SOLUTION 10000 UNIT/ML (***epoetin alfa-epbx***) | 2 | M; SL (8 ml per 21 days.); SP |
| RETACRIT INJECTION SOLUTION 2000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML (***epoetin alfa-epbx***) | 2 | M; SL (12 ml per 21 days.); SP |
| RETACRIT INJECTION SOLUTION 40000 UNIT/ML (***epoetin alfa-epbx***) | 2 | M; SL (4 ml per 21 days.); SP |
| ZARXIO INJECTION SOLUTION PREFILLED SYRINGE 300 MCG/0.5ML, 480 MCG/0.8ML (***filgrastim-sndz***) | 2 | M; SP |
| ZIEXTENZO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML (***pegfilgrastim-bmez***) | 3 | M; SP |
| **HEMORRHEOLOGIC AGENTS - Drugs for Blood Flow** | | |
| ***pentoxifylline er oral tablet extended release 400 mg*** | 1 | |
| **HEMOSTATICS - Drugs to Prevent Bleeding** | | |
| ADVATE INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 4000 UNIT, 500 UNIT (***antihemophil factor (rahf-pfm)***) | 2 | M; SP |
| ADYNOVATE INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 500 UNIT, 750 UNIT | 4 | PA; M; SP |
| AFSTYLA INTRAVENOUS KIT 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 2500 UNIT, 3000 UNIT, 500 UNIT (***antihemophil fact single chain***) | 3 | PA; M; SP |
| ALPHANATE/VWF COMPLEX/HUMAN INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 500 UNIT (***antihemophilic factor-vwf***) | 2 | M; SP |
| ALPHANINE SD INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT (***coagulation factor ix***) | 2 | M |
| ALPHANINE SD INTRAVENOUS SOLUTION RECONSTITUTED 1500 UNIT, 500 UNIT (***coagulation factor ix***) | 2 | M; SP |
| ALPROLIX INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 4000 UNIT, 500 UNIT (***coagulation factor ix (rfixfc)***) | 3 | M; SP |
| AMICAR ORAL SOLUTION 0.25 GM/ML (***aminocaproic acid***) | 3 | |
| AMICAR ORAL TABLET 1000 MG, 500 MG (***aminocaproic acid***) | 3 | |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ***aminocaproic acid oral solution 0.25 gm/ml*** | 3 | |
| ***aminocaproic acid oral tablet 1000 mg, 500 mg*** | 3 | |
| ASTRINGYN EXTERNAL SOLUTION 259 MG/GM (***ferric subsulfate***) | 3 | |
| BENEFIX INTRAVENOUS KIT 1000 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 500 UNIT (***coagulation factor ix (recomb)***) | 2 | M; SP |
| COAGADEX INTRAVENOUS SOLUTION RECONSTITUTED 250 UNIT, 500 UNIT (***coagulation factor x (human)***) | 4 | M; SP |
| CORIFACT INTRAVENOUS KIT 1000-1600 UNIT (***factor xiii concentrate human***) | 2 | M; SP |
| DDAVP INJECTION SOLUTION 4 MCG/ML (***desmopressin acetate***) | 3 | M |
| DDAVP ORAL TABLET 0.1 MG, 0.2 MG (***desmopressin acetate***) | 3 | |
| DDAVP RHINAL TUBE NASAL SOLUTION 0.01 % (***desmopressin ace refrigerated***) | 3 | |
| ***desmopressin ace spray refrig nasal solution 0.01 %*** | 1 | |
| ***desmopressin acetate injection solution 4 mcg/ml*** | 1 | M |
| ***desmopressin acetate oral tablet 0.1 mg, 0.2 mg*** | 1 | |
| ELOCTATE INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 4000 UNIT, 500 UNIT, 5000 UNIT, 6000 UNIT, 750 UNIT (***antihem fact (bdd-rfviiifc)***) | 4 | PA; M; SP |
| FEIBA INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2500 UNIT, 500 UNIT (***antiinhibitor coagulant cmplx***) | 2 | M; SP |
| HEMLIBRA SUBCUTANEOUS SOLUTION 105 MG/0.7ML, 150 MG/ML, 30 MG/ML, 60 MG/0.4ML (***emicizumab-kxwh***) | 2 | PA; M; SP |
| HEMOFIL M INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 250 UNIT, 500 UNIT (***antihemophilic factor***) | 2 | M |
| HEMOFIL M INTRAVENOUS SOLUTION RECONSTITUTED 1700 UNIT (***antihemophilic factor***) | 2 | M; SP |
| HUMATE-P INTRAVENOUS SOLUTION RECONSTITUTED 1000-2400 UNIT, 250-600 UNIT, 500-1200 UNIT (***antihemophilic factor-vwf***) | 2 | M; SP |
| IDELVION INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 250 UNIT, 3500 UNIT, 500 UNIT (***coagulation factor ix (rix-fp)***) | 3 | M; SP |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| JIVI INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 3000 UNIT, 500 UNIT (***ahf (bdd-rfviii peg-aucl)***) | 3 | PA; M; SP |
| KOATE INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 250 UNIT, 500 UNIT (***antihemophilic factor***) | 2 | M |
| KOATE-DVI INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 250 UNIT, 500 UNIT (***antihemophilic factor***) | 2 | M |
| KOGENATE FS INTRAVENOUS KIT 1000 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 500 UNIT (***antihemophilic factor (recomb)***) | 2 | M |
| KOVALTRY INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 500 UNIT (***antihemophil factor (rahf-pfm)***) | 4 | M; SP |
| LYSTEDA ORAL TABLET 650 MG (***tranexamic acid***) | 3 | SL (30 tablets per 5 days.) |
| MONONINE INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT (***coagulation factor ix***) | 2 | M |
| ***monsels ferric subsulfate external solution*** | 1 | |
| NOCDURNA SUBLINGUAL TABLET SUBLINGUAL 27.7 MCG, 55.3 MCG (***desmopressin acetate***) | 3 | PA; SL (1 tablet per day.) |
| NOVOEIGHT INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 500 UNIT (***antihemophil fact bd truncated***) | 4 | M |
| NOVOEIGHT INTRAVENOUS SOLUTION RECONSTITUTED 1500 UNIT (***antihemophil fact bd truncated***) | 4 | M; SP |
| NOVOSEVEN RT INTRAVENOUS SOLUTION RECONSTITUTED 1 MG, 2 MG, 5 MG, 8 MG (***coagulation factor viia recomb***) | 2 | M; SP |
| NUWIQ INTRAVENOUS KIT 1000 UNIT, 2000 UNIT, 250 UNIT, 2500 UNIT, 3000 UNIT, 4000 UNIT, 500 UNIT (***antihem fact (bdd-rfviii,sim)***) | 4 | M; SP |
| NUWIQ INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 250 UNIT, 2500 UNIT, 3000 UNIT, 4000 UNIT, 500 UNIT (***antihem fact (bdd-rfviii,sim)***) | 4 | M; SP |
| PROFILNINE INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 500 UNIT (***factor ix complex***) | 2 | M; SP |
| RECOMBINATE INTRAVENOUS SOLUTION RECONSTITUTED 1241-1800 UNIT, 1801-2400 UNIT, 220-400 UNIT, 401-800 UNIT, 801-1240 UNIT (***antihemophilic factor (recomb)***) | 2 | M; SP |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| RECOTHROM EXTERNAL SOLUTION RECONSTITUTED 20000 UNIT, 5000 UNIT (***thrombin (recombinant)***) | 3 | |
| RECOTHROM SPRAY KIT EXTERNAL SOLUTION RECONSTITUTED 20000 UNIT (***thrombin (recombinant)***) | 3 | |
| RIXUBIS INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 500 UNIT | 2 | M |
| STIMATE NASAL SOLUTION 1.5 MG/ML (***desmopressin acetate***) | 3 | |
| THROMBIN-JMI EPISTAXIS EXTERNAL KIT 5000 UNIT (***thrombin***) | 3 | |
| THROMBIN-JMI EXTERNAL KIT 20000 UNIT, 5000 UNIT (***thrombin***) | 3 | |
| ***tranexamic acid oral tablet 650 mg*** | 2 | SL (30 tablets per 5 days.) |
| TRETTEN INTRAVENOUS SOLUTION RECONSTITUTED 2000-3125 UNIT (***coagulation factor xiii a-sub***) | 3 | M; SP |
| VONVENDI INTRAVENOUS SOLUTION RECONSTITUTED 1300 UNIT, 650 UNIT (***von willebrand factor (recomb)***) | 2 | M; SP |
| WILATE INTRAVENOUS KIT 1000-1000 UNIT, 500-500 UNIT (***antihemophilic factor-vwf***) | 2 | M; SP |
| XYNTHA INTRAVENOUS KIT 1000 UNIT, 2000 UNIT, 250 UNIT, 500 UNIT (***antihem fact (bdd-rfviii,mor)***) | 4 | PA; ST; M |
| XYNTHA SOLOFUSE INTRAVENOUS KIT 1000 UNIT, 2000 UNIT, 250 UNIT, 500 UNIT (***antihem fact (bdd-rfviii,mor)***) | 4 | PA; ST; M |
| XYNTHA SOLOFUSE INTRAVENOUS KIT 3000 UNIT (***antihem fact (bdd-rfviii,mor)***) | 4 | PA; ST; M; SP |
| **HEPARINS - Drugs to Prevent Blood Clots** | | |
| ***enoxaparin sodium injection solution 300 mg/3ml*** | 2 | M; SL (42 ml (14 vials) per prescription) |
| ***enoxaparin sodium subcutaneous solution 100 mg/ml, 150 mg/ml*** | 2 | M; SL (30 syringes per prescription) |
| ***enoxaparin sodium subcutaneous solution 120 mg/0.8ml, 80 mg/0.8ml*** | 2 | M; SL (24 ml (30 syringes) per prescription) |
| ***enoxaparin sodium subcutaneous solution 30 mg/0.3ml*** | 2 | M; SL (9 ml (30 syringes) per prescription) |
| ***enoxaparin sodium subcutaneous solution 40 mg/0.4ml*** | 2 | M; SL (12 ml (30 syringes) per prescription) |
| ***enoxaparin sodium subcutaneous solution 60 mg/0.6ml*** | 2 | M; SL (18 ml (30 syringes) per prescription) |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| FRAGMIN SUBCUTANEOUS SOLUTION 10000 UNIT/ML (***dalteparin sodium***) | 3 | M; SL (10 ml (10 syringes) per prescription.) |
| FRAGMIN SUBCUTANEOUS SOLUTION 12500 UNIT/0.5ML (***dalteparin sodium***) | 3 | M; SL (5 ml (10 syringes) per prescription.) |
| FRAGMIN SUBCUTANEOUS SOLUTION 15000 UNIT/0.6ML (***dalteparin sodium***) | 3 | M; SL (6 ml (10 syringes) per prescription.) |
| FRAGMIN SUBCUTANEOUS SOLUTION 18000 UNT/0.72ML (***dalteparin sodium***) | 3 | M; SL (8 ml (10 syringes) per prescription) |
| FRAGMIN SUBCUTANEOUS SOLUTION 2500 UNIT/0.2ML, 5000 UNIT/0.2ML (***dalteparin sodium***) | 3 | M; SL (2 ml (10 syringes) per prescription.) |
| FRAGMIN SUBCUTANEOUS SOLUTION 7500 UNIT/0.3ML (***dalteparin sodium***) | 3 | M; SL (3 ml (10 syringes) per prescription.) |
| FRAGMIN SUBCUTANEOUS SOLUTION 95000 UNIT/3.8ML (***dalteparin sodium***) | 3 | M |
| ***heparin lock flush intravenous solution 10 unit/ml*** | 1 | M |
| ***heparin sodium (porcine) injection solution 1000 unit/ml, 10000 unit/ml, 20000 unit/ml, 5000 unit/ml*** | 1 | M |
| ***heparin sodium (porcine) injection solution prefilled syringe 5000 unit/0.5ml*** | 1 | M |
| ***heparin sodium (porcine) pf injection solution 5000 unit/0.5ml, 5000 unit/ml*** | 1 | M |
| ***heparin sodium lock flush intravenous solution 100 unit/ml*** | 1 | M |
| **IRON PREPARATIONS - Vitamins and Minerals** | | |
| CITRANATAL BLOOM ORAL TABLET 90-1 MG (***prenatal-dss-fecb-fegl-fa***) | 3 | |
| ELITE-OB ORAL TABLET 50-1.25 MG (***prenatal vit-iron carbonyl-fa***) | 3 | |
| ENBRACE HR ORAL CAPSULE (***prenat vit-fe gly cys-fa-omega***) | 3 | |
| ***hematinic/folic acid oral tablet 324-1 mg*** | 1 | |
| ***ferrous fumarate-folic acid*** (Hemocyte-F Oral Tablet 324-1 Mg) | 1 | |
| M-NATAL PLUS ORAL TABLET 27-1 MG | 3 | |
| ***multi-vit/iron/fluoride oral solution 0.25-10 mg/ml*** | 1 | |
| ***multi-vitamin/fluoride/iron oral solution 0.25-10 mg/ml*** | 1 | |
| NESTABS ORAL TABLET 32-1 MG (***prenat-fe bisgly-fa-w/o vit a***) | 3 | |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| POLY-VI-FLOR/IRON ORAL SUSPENSION 0.25-7 MG/ML (***ped multivitamins-fl-iron***) | 3 | |
| POLY-VI-FLOR/IRON ORAL TABLET CHEWABLE 0.5-10 MG (***ped multivitamins-fl-iron***) | 3 | |
| PRENAISSANCE ORAL CAPSULE 29-1.25-325 MG | 2 | |
| ***prenatal oral tablet 27-0.8 mg, 27-1 mg, 28-0.8 mg*** | 1 | |
| ***prenatal plus iron oral tablet 29-1 mg*** | 1 | |
| PRENATE DHA ORAL CAPSULE 18-0.6-0.4-300 MG (***prenat-feasp-meth-fa-dha w/o a***) | 3 | |
| PRENATE ELITE ORAL TABLET 20-0.6-0.4 MG (***prenatal-feaspgly-methylfol-fa***) | 3 | |
| PRENATE ENHANCE ORAL CAPSULE 28-0.6-0.4-400 MG (***prenat w/o a-fe-methfol-fa-dha***) | 3 | |
| PRENATE ESSENTIAL ORAL CAPSULE 18-0.6-0.4-300 MG (***prenat-feasp-meth-fa-dha w/o a***) | 3 | |
| PRENATE MINI ORAL CAPSULE 18-0.6-0.4-350 MG (***prenat-fecbn-feasp-meth-fa-dha***) | 3 | |
| PRENATE PIXIE ORAL CAPSULE 10-0.6-0.4-200 MG (***prenat-feasp-meth-fa-dha w/o a***) | 3 | |
| PRENATE RESTORE ORAL CAPSULE 27-0.6-0.4-400 MG (***prenat w/o a-fe-methfol-fa-dha***) | 3 | |
| PRIMACARE ORAL CAPSULE 30-1-470 MG (***pren-fe-meth-fa-omeg w/o a***) | 3 | |
| RELNATE DHA ORAL CAPSULE 28-1-200 MG | 3 | |
| SELECT-OB ORAL TABLET CHEWABLE 29-1 MG (***prenatal vit-fe psac cmplx-fa***) | 3 | |
| TRICARE PRENATAL DHA ONE ORAL CAPSULE 27-1-500 MG (***prenatal-fefum-fa-dss-fish oil***) | 3 | |
| ***trinate oral tablet*** | 1 | |
| VITAFOL FE+ ORAL CAPSULE 90-0.6-0.4-200 MG (***prenat-fe poly-methfol-fa-dha***) | 3 | |
| VITAFOL-OB+DHA ORAL 65-1 & 250 MG (***prenatal mv-min-fe fum-fa-dha***) | 3 | |
| ***vp-pnv-dha oral capsule 28-1-215.8 mg*** | 1 | |
| **PLATELET-AGGREGATION INHIBITORS - Drugs to Prevent Blood Clots** | | |
| AGGRENOX ORAL CAPSULE EXTENDED RELEASE 12 HOUR 25-200 MG (***aspirin-dipyridamole***) | 3 | |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ***aspirin-dipyridamole er oral capsule extended release 12 hour 25-200 mg*** | 3 | |
| BRILINTA ORAL TABLET 60 MG, 90 MG (***ticagrelor***) | 3 | SL (2 tablets per day.) |
| ***butalbital-aspirin-caffeine oral capsule 50-325-40 mg*** | 1 | |
| ***butalbital-aspirin-caffeine oral tablet 50-325-40 mg*** | 1 | |
| ***cilostazol oral tablet 100 mg, 50 mg*** | 1 | |
| ***clopidogrel bisulfate oral tablet 300 mg, 75 mg*** | 1 | |
| ***dipyridamole oral tablet 25 mg, 50 mg, 75 mg*** | 1 | |
| FIORINAL ORAL CAPSULE 50-325-40 MG (***butalbital-aspirin-caffeine***) | 3 | |
| ***prasugrel hcl oral tablet 10 mg, 5 mg*** | 3 | SL (31 tablets per 31 days.) |
| ZONTIVITY ORAL TABLET 2.08 MG (***vorapaxar sulfate***) | 3 | SL (1 tablet per day.) |
| **PLATELET-REDUCING AGENTS - Drugs to Prevent Blood Clots** | | |
| AGRYLIN ORAL CAPSULE 0.5 MG (***anagrelide hcl***) | 3 | |
| ***anagrelide hcl oral capsule 0.5 mg, 1 mg*** | 1 | |
| **THROMBOLYTIC AGENTS - Drugs to Prevent Blood Clots** | | |
| ***butalbital-aspirin-caffeine oral capsule 50-325-40 mg*** | 1 | |
| ***butalbital-aspirin-caffeine oral tablet 50-325-40 mg*** | 1 | |
| FIORINAL ORAL CAPSULE 50-325-40 MG (***butalbital-aspirin-caffeine***) | 3 | |
| **CARDIOVASCULAR DRUGS - Drugs for the Heart** | | |
| **ALPHA-ADRENERGIC BLOCKING AGENTS - Drugs for High Blood Pressure** | | |
| CARDURA ORAL TABLET 1 MG, 2 MG, 4 MG, 8 MG (***doxazosin mesylate***) | 3 | |
| CARDURA XL ORAL TABLET EXTENDED RELEASE 24 HOUR 4 MG, 8 MG (***doxazosin mesylate***) | 3 | |
| ***carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg*** | 1 | |
| COREG ORAL TABLET 12.5 MG, 25 MG, 3.125 MG, 6.25 MG (***carvedilol***) | 3 | |
| ***doxazosin mesylate oral tablet 1 mg, 2 mg, 4 mg, 8 mg*** | 1 | |
| ***labetalol hcl oral tablet 100 mg, 200 mg, 300 mg*** | 1 | |
| MINIPRESS ORAL CAPSULE 1 MG, 2 MG, 5 MG (***prazosin hcl***) | 3 | |
| ***prazosin hcl oral capsule 1 mg, 2 mg, 5 mg*** | 1 | |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ***terazosin hcl oral capsule 1 mg, 10 mg, 2 mg, 5 mg*** | 1 | |
| **ALPHA-ADRENERGIC BLOCKING AGT.(HYPOTEN) - Drugs for High Blood Pressure & Angina** | | |
| CARDURA ORAL TABLET 1 MG, 2 MG, 4 MG, 8 MG (***doxazosin mesylate***) | 3 | |
| CARDURA XL ORAL TABLET EXTENDED RELEASE 24 HOUR 4 MG, 8 MG (***doxazosin mesylate***) | 3 | |
| ***doxazosin mesylate oral tablet 1 mg, 2 mg, 4 mg, 8 mg*** | 1 | |
| ***labetalol hcl oral tablet 100 mg, 200 mg, 300 mg*** | 1 | |
| MINIPRESS ORAL CAPSULE 1 MG, 2 MG, 5 MG (***prazosin hcl***) | 3 | |
| ***prazosin hcl oral capsule 1 mg, 2 mg, 5 mg*** | 1 | |
| ***terazosin hcl oral capsule 1 mg, 10 mg, 2 mg, 5 mg*** | 1 | |
| **ANGIOTENSIN II RECEPTOR ANTAGON.(HYPOTN) - Drugs for High Blood Pressure & Angina** | | |
| ***amlodipine besylate-valsartan oral tablet 10-160 mg, 10-320 mg, 5-160 mg, 5-320 mg*** | 2 | |
| ATACAND HCT ORAL TABLET 16-12.5 MG, 32-12.5 MG, 32-25 MG (***candesartan cilexetil-hctz***) | 3 | |
| ATACAND ORAL TABLET 16 MG, 32 MG, 4 MG, 8 MG (***candesartan cilexetil***) | 3 | |
| AVALIDE ORAL TABLET 150-12.5 MG, 300-12.5 MG (***irbesartan-hydrochlorothiazide***) | 3 | |
| AVAPRO ORAL TABLET 150 MG, 300 MG, 75 MG (***irbesartan***) | 3 | |
| ***candesartan cilexetil oral tablet 16 mg, 32 mg, 4 mg, 8 mg*** | 3 | |
| ***candesartan cilexetil-hctz oral tablet 16-12.5 mg, 32-12.5 mg, 32-25 mg*** | 3 | |
| COZAAR ORAL TABLET 100 MG, 25 MG, 50 MG (***losartan potassium***) | 3 | |
| EDARBI ORAL TABLET 40 MG, 80 MG (***azilsartan medoxomil***) | 3 | |
| EDARBYCLOR ORAL TABLET 40-12.5 MG, 40-25 MG (***azilsartan-chlorthalidone***) | 3 | |
| HYZAAR ORAL TABLET 100-12.5 MG, 100-25 MG, 50-12.5 MG (***losartan potassium-hctz***) | 3 | |
| ***irbesartan oral tablet 150 mg, 300 mg, 75 mg*** | 1 | |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ***irbesartan-hydrochlorothiazide oral tablet 150-12.5 mg, 300-12.5 mg*** | 1 | |
| ***losartan potassium oral tablet 100 mg, 25 mg, 50 mg*** | 1 | |
| ***losartan potassium-hctz oral tablet 100-12.5 mg, 100-25 mg, 50-12.5 mg*** | 1 | |
| ***olmesartan medoxomil oral tablet 20 mg, 40 mg, 5 mg*** | 2 | |
| ***olmesartan medoxomil-hctz oral tablet 20-12.5 mg, 40-12.5 mg, 40-25 mg*** | 2 | |
| ***telmisartan oral tablet 20 mg, 40 mg, 80 mg*** | 2 | |
| ***telmisartan-hctz oral tablet 40-12.5 mg, 80-12.5 mg, 80-25 mg*** | 2 | |
| ***valsartan oral tablet 160 mg, 320 mg, 40 mg, 80 mg*** | 2 | |
| ***valsartan-hydrochlorothiazide oral tablet 160-12.5 mg, 160-25 mg, 320-12.5 mg, 320-25 mg, 80-12.5 mg*** | 1 | |
| **ANGIOTENSIN II RECEPTOR ANTAGONISTS - Drugs for the Heart** | | |
| ***amlodipine besylate-valsartan oral tablet 10-160 mg, 10-320 mg, 5-160 mg, 5-320 mg*** | 2 | |
| ATACAND HCT ORAL TABLET 16-12.5 MG, 32-12.5 MG, 32-25 MG (***candesartan cilexetil-hctz***) | 3 | |
| ATACAND ORAL TABLET 16 MG, 32 MG, 4 MG, 8 MG (***candesartan cilexetil***) | 3 | |
| AVALIDE ORAL TABLET 150-12.5 MG, 300-12.5 MG (***irbesartan-hydrochlorothiazide***) | 3 | |
| AVAPRO ORAL TABLET 150 MG, 300 MG, 75 MG (***irbesartan***) | 3 | |
| ***candesartan cilexetil oral tablet 16 mg, 32 mg, 4 mg, 8 mg*** | 3 | |
| ***candesartan cilexetil-hctz oral tablet 16-12.5 mg, 32-12.5 mg, 32-25 mg*** | 3 | |
| COZAAR ORAL TABLET 100 MG, 25 MG, 50 MG (***losartan potassium***) | 3 | |
| EDARBI ORAL TABLET 40 MG, 80 MG (***azilsartan medoxomil***) | 3 | |
| EDARBYCLOR ORAL TABLET 40-12.5 MG, 40-25 MG (***azilsartan-chlorthalidone***) | 3 | |
| ENTRESTO ORAL TABLET 24-26 MG, 49-51 MG, 97-103 MG (***sacubitril-valsartan***) | 3 | PA; SL (2 tablets per day.) |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| HYZAAR ORAL TABLET 100-12.5 MG, 100-25 MG, 50-12.5 MG (***losartan potassium-hctz***) | 3 | |
| ***irbesartan oral tablet 150 mg, 300 mg, 75 mg*** | 1 | |
| ***irbesartan-hydrochlorothiazide oral tablet 150-12.5 mg, 300-12.5 mg*** | 1 | |
| ***losartan potassium oral tablet 100 mg, 25 mg, 50 mg*** | 1 | |
| ***losartan potassium-hctz oral tablet 100-12.5 mg, 100-25 mg, 50-12.5 mg*** | 1 | |
| ***olmesartan medoxomil oral tablet 20 mg, 40 mg, 5 mg*** | 2 | |
| ***olmesartan medoxomil-hctz oral tablet 20-12.5 mg, 40-12.5 mg, 40-25 mg*** | 2 | |
| ***telmisartan oral tablet 20 mg, 40 mg, 80 mg*** | 2 | |
| ***telmisartan-hctz oral tablet 40-12.5 mg, 80-12.5 mg, 80-25 mg*** | 2 | |
| ***valsartan oral tablet 160 mg, 320 mg, 40 mg, 80 mg*** | 2 | |
| ***valsartan-hydrochlorothiazide oral tablet 160-12.5 mg, 160-25 mg, 320-12.5 mg, 320-25 mg, 80-12.5 mg*** | 1 | |
| **ANGIOTENSIN-CONVERT.ENZYME INHIB(HYPOTN) - Drugs for High Blood Pressure & Angina** | | |
| ACCUPRIL ORAL TABLET 10 MG, 20 MG, 40 MG, 5 MG (***quinapril hcl***) | 3 | |
| ACCURETIC ORAL TABLET 10-12.5 MG, 20-12.5 MG, 20-25 MG (***quinapril-hydrochlorothiazide***) | 3 | |
| ALTACE ORAL CAPSULE 1.25 MG, 10 MG, 2.5 MG, 5 MG (***ramipril***) | 3 | |
| ***amlodipine besylate-benazepril hcl oral capsule 10-20 mg, 10-40 mg, 2.5-10 mg, 5-10 mg, 5-20 mg, 5-40 mg*** | 1 | |
| ***benazepril hcl oral tablet 10 mg, 20 mg, 40 mg, 5 mg*** | 1 | |
| ***benazepril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg, 5-6.25 mg*** | 1 | |
| ***captopril oral tablet 100 mg, 12.5 mg, 25 mg, 50 mg*** | 1 | |
| ***captopril-hydrochlorothiazide oral tablet 25-15 mg, 25-25 mg, 50-15 mg, 50-25 mg*** | 1 | |
| ***enalapril maleate oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg*** | 1 | |
| ***enalapril-hydrochlorothiazide oral tablet 10-25 mg, 5-12.5 mg*** | 1 | |
| EPANED ORAL SOLUTION 1 MG/ML (***enalapril maleate***) | 3 | PA |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ***fosinopril sodium oral tablet 10 mg, 20 mg, 40 mg*** | 1 | |
| ***fosinopril sodium-hctz oral tablet 10-12.5 mg, 20-12.5 mg*** | 1 | |
| ***lisinopril oral tablet 10 mg, 2.5 mg, 20 mg, 30 mg, 40 mg, 5 mg*** | 1 | |
| ***lisinopril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg*** | 1 | |
| LOTENSIN HCT ORAL TABLET 10-12.5 MG, 20-12.5 MG, 20-25 MG (***benazepril-hydrochlorothiazide***) | 3 | |
| LOTENSIN ORAL TABLET 10 MG, 20 MG, 40 MG (***benazepril hcl***) | 3 | |
| LOTREL ORAL CAPSULE 10-20 MG, 10-40 MG, 5-10 MG, 5-20 MG (***amlodipine besy-benazepril hcl***) | 3 | |
| ***moexipril hcl oral tablet 15 mg, 7.5 mg*** | 1 | |
| ***perindopril erbumine oral tablet 2 mg, 4 mg, 8 mg*** | 2 | |
| PRINIVIL ORAL TABLET 10 MG, 20 MG (***lisinopril***) | 3 | |
| QBRELIS ORAL SOLUTION 1 MG/ML (***lisinopril***) | 3 | PA |
| ***quinapril hcl oral tablet 10 mg, 20 mg, 40 mg, 5 mg*** | 1 | |
| ***quinapril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg*** | 2 | |
| ***ramipril oral capsule 1.25 mg, 10 mg, 2.5 mg, 5 mg*** | 1 | |
| TARKA ORAL TABLET EXTENDED RELEASE 2-180 MG, 2-240 MG, 4-240 MG (***trandolapril-verapamil hcl***) | 3 | |
| ***trandolapril oral tablet 1 mg, 2 mg, 4 mg*** | 1 | |
| ***trandolapril-verapamil hcl er oral tablet extended release 1-240 mg, 2-180 mg, 2-240 mg, 4-240 mg*** | 3 | |
| **ANGIOTENSIN-CONVERTING ENZYME INHIBITORS - Drugs for the Heart** | | |
| ACCUPRIL ORAL TABLET 10 MG, 20 MG, 40 MG, 5 MG (***quinapril hcl***) | 3 | |
| ACCURETIC ORAL TABLET 10-12.5 MG, 20-12.5 MG, 20-25 MG (***quinapril-hydrochlorothiazide***) | 3 | |
| ALTACE ORAL CAPSULE 1.25 MG, 10 MG, 2.5 MG, 5 MG (***ramipril***) | 3 | |
| ***amlodipine besylate-benazepril hcl oral capsule 10-20 mg, 10-40 mg, 2.5-10 mg, 5-10 mg, 5-20 mg, 5-40 mg*** | 1 | |
| ***benazepril hcl oral tablet 10 mg, 20 mg, 40 mg, 5 mg*** | 1 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ***benazepril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg, 5-6.25 mg*** | 1 | |
| ***captopril oral tablet 100 mg, 12.5 mg, 25 mg, 50 mg*** | 1 | |
| ***captopril-hydrochlorothiazide oral tablet 25-15 mg, 25-25 mg, 50-15 mg, 50-25 mg*** | 1 | |
| ***enalapril maleate oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg*** | 1 | |
| ***enalapril-hydrochlorothiazide oral tablet 10-25 mg, 5-12.5 mg*** | 1 | |
| EPANED ORAL SOLUTION 1 MG/ML (***enalapril maleate***) | 3 | PA |
| ***fosinopril sodium oral tablet 10 mg, 20 mg, 40 mg*** | 1 | |
| ***fosinopril sodium-hctz oral tablet 10-12.5 mg, 20-12.5 mg*** | 1 | |
| ***lisinopril oral tablet 10 mg, 2.5 mg, 20 mg, 30 mg, 40 mg, 5 mg*** | 1 | |
| ***lisinopril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg*** | 1 | |
| LOTENSIN HCT ORAL TABLET 10-12.5 MG, 20-12.5 MG, 20-25 MG (***benazepril-hydrochlorothiazide***) | 3 | |
| LOTENSIN ORAL TABLET 10 MG, 20 MG, 40 MG (***benazepril hcl***) | 3 | |
| LOTREL ORAL CAPSULE 10-20 MG, 10-40 MG, 5-10 MG, 5-20 MG (***amlodipine besy-benazepril hcl***) | 3 | |
| ***moexipril hcl oral tablet 15 mg, 7.5 mg*** | 1 | |
| ***perindopril erbumine oral tablet 2 mg, 4 mg, 8 mg*** | 2 | |
| PRINIVIL ORAL TABLET 10 MG, 20 MG (***lisinopril***) | 3 | |
| QBRELIS ORAL SOLUTION 1 MG/ML (***lisinopril***) | 3 | PA |
| ***quinapril hcl oral tablet 10 mg, 20 mg, 40 mg, 5 mg*** | 1 | |
| ***quinapril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg*** | 2 | |
| ***ramipril oral capsule 1.25 mg, 10 mg, 2.5 mg, 5 mg*** | 1 | |
| TARKA ORAL TABLET EXTENDED RELEASE 2-180 MG, 2-240 MG, 4-240 MG (***trandolapril-verapamil hcl***) | 3 | |
| ***trandolapril oral tablet 1 mg, 2 mg, 4 mg*** | 1 | |
| ***trandolapril-verapamil hcl er oral tablet extended release 1-240 mg, 2-180 mg, 2-240 mg, 4-240 mg*** | 3 | |
| **ANTIARRHYTHMICS, MISCELLANEOUS - Drugs for Angina** | | |
| ***digoxin*** (Digitek Oral Tablet 125 Mcg, 250 Mcg) | 1 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ***digoxin*** (Digox Oral Tablet 125 Mcg, 250 Mcg) | 1 | |
| ***digoxin oral solution 0.05 mg/ml*** | 1 | |
| ***digoxin oral tablet 125 mcg, 250 mcg*** | 1 | |
| LANOXIN ORAL TABLET 125 MCG, 250 MCG, 62.5 MCG (***digoxin***) | 3 | |
| **ANTILIPEMIC AGENTS, MISCELLANEOUS - Drugs for Cholesterol** | | |
| FOVEX ORAL CAPSULE (***dietary management product***) | 3 | |
| JUXTAPID ORAL CAPSULE 10 MG, 5 MG (***lomitapide mesylate***) | 3 | PA; ST; SL (1 tablet per day.); SP |
| JUXTAPID ORAL CAPSULE 20 MG, 30 MG, 40 MG, 60 MG (***lomitapide mesylate***) | 3 | PA; ST; SL (1 capsule per day.); SP |
| NEXLETOL ORAL TABLET 180 MG (***bempedoic acid***) | 2 | PA; ST; SL (1 tablet per day.) |
| NEXLIZET ORAL TABLET 180-10 MG (***bempedoic acid-ezetimibe***) | 2 | PA; ST; SL (1 tablet per day.) |
| ***niacin (antihyperlipidemic) oral tablet 500 mg*** | 2 | |
| ***niacin er (antihyperlipidemic) oral tablet extended release 1000 mg, 500 mg, 750 mg*** | 3 | |
| ***niacor oral tablet 500 mg*** | 2 | |
| NIASPAN ORAL TABLET EXTENDED RELEASE 1000 MG, 500 MG, 750 MG (***niacin (antihyperlipidemic)***) | 2 | |
| ***omega-3-acid ethyl esters oral capsule 1 gm*** | 2 | |
| VASCEPA ORAL CAPSULE 0.5 GM, 1 GM (***icosapent ethyl***) | 3 | PA |
| **BETA-ADRENERGIC BLOCKING AGENTS - Drugs for Abnormal Heart Rhythms** | | |
| ***acebutolol hcl oral capsule 200 mg, 400 mg*** | 1 | |
| ***atenolol oral tablet 100 mg, 25 mg, 50 mg*** | 1 | |
| ***atenolol-chlorthalidone oral tablet 100-25 mg, 50-25 mg*** | 1 | |
| BETAPACE AF ORAL TABLET 120 MG, 160 MG, 80 MG (***sotalol hcl af***) | 4 | |
| ***betaxolol hcl oral tablet 10 mg, 20 mg*** | 1 | |
| ***bisoprolol fumarate oral tablet 10 mg, 5 mg*** | 1 | |
| ***bisoprolol-hydrochlorothiazide oral tablet 10-6.25 mg, 2.5-6.25 mg, 5-6.25 mg*** | 1 | |
| ***carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg*** | 1 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| COREG ORAL TABLET 12.5 MG, 25 MG, 3.125 MG, 6.25 MG (***carvedilol***) | 3 | |
| CORGARD ORAL TABLET 20 MG, 40 MG, 80 MG (***nadolol***) | 3 | |
| KAPSPARGO SPRINKLE ORAL CAPSULE ER 24 HOUR SPRINKLE 100 MG, 200 MG, 25 MG, 50 MG (***metoprolol succinate***) | 3 | |
| ***labetalol hcl oral tablet 100 mg, 200 mg, 300 mg*** | 1 | |
| LOPRESSOR HCT ORAL TABLET 50-25 MG (***metoprolol-hydrochlorothiazide***) | 3 | |
| LOPRESSOR ORAL TABLET 100 MG, 50 MG (***metoprolol tartrate***) | 3 | |
| ***metoprolol succinate er oral tablet extended release 24 hour 100 mg, 200 mg, 50 mg*** | 2 | |
| ***metoprolol succinate er oral tablet extended release 24 hour 25 mg*** | 1 | |
| ***metoprolol tartrate oral tablet 100 mg, 25 mg, 50 mg*** | 1 | |
| ***metoprolol-hydrochlorothiazide oral tablet 100-25 mg, 100-50 mg, 50-25 mg*** | 1 | |
| ***nadolol oral tablet 20 mg, 40 mg, 80 mg*** | 1 | |
| ***pindolol oral tablet 10 mg, 5 mg*** | 1 | |
| ***propranolol hcl er oral capsule extended release 24 hour 120 mg, 160 mg, 60 mg, 80 mg*** | 2 | |
| ***propranolol hcl oral solution 20 mg/5ml, 40 mg/5ml*** | 1 | |
| ***propranolol hcl oral tablet 10 mg, 20 mg, 40 mg, 60 mg, 80 mg*** | 1 | |
| ***propranolol-hctz oral tablet 40-25 mg, 80-25 mg*** | 1 | |
| ***sotalol hcl (af) oral tablet 120 mg, 160 mg, 80 mg*** | 1 | |
| ***sotalol hcl oral tablet 120 mg, 160 mg, 240 mg, 80 mg*** | 1 | |
| SOTYLIZE ORAL SOLUTION 5 MG/ML (***sotalol hcl***) | 3 | PA |
| ***timolol maleate oral tablet 10 mg, 20 mg, 5 mg*** | 1 | |
| TOPROL XL ORAL TABLET EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 25 MG, 50 MG (***metoprolol succinate***) | 3 | |
| ZIAC ORAL TABLET 10-6.25 MG, 2.5-6.25 MG, 5-6.25 MG (***bisoprolol-hydrochlorothiazide***) | 3 | |
| **BETA-ADRENERGIC BLOCKING AGT.(HYPOTEN) - Drugs for High Blood Pressure & Angina** | | |
| ***acebutolol hcl oral capsule 200 mg, 400 mg*** | 1 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ***atenolol oral tablet 100 mg, 25 mg, 50 mg*** | 1 | |
| ***atenolol-chlorthalidone oral tablet 100-25 mg, 50-25 mg*** | 1 | |
| BETAPACE AF ORAL TABLET 120 MG, 160 MG, 80 MG (***sotalol hcl af***) | 4 | |
| ***betaxolol hcl oral tablet 10 mg, 20 mg*** | 1 | |
| ***bisoprolol fumarate oral tablet 10 mg, 5 mg*** | 1 | |
| ***bisoprolol-hydrochlorothiazide oral tablet 10-6.25 mg, 2.5-6.25 mg, 5-6.25 mg*** | 1 | |
| CORGARD ORAL TABLET 20 MG, 40 MG, 80 MG (***nadolol***) | 3 | |
| KAPSPARGO SPRINKLE ORAL CAPSULE ER 24 HOUR SPRINKLE 100 MG, 200 MG, 25 MG, 50 MG (***metoprolol succinate***) | 3 | |
| ***labetalol hcl oral tablet 100 mg, 200 mg, 300 mg*** | 1 | |
| LOPRESSOR HCT ORAL TABLET 50-25 MG (***metoprolol-hydrochlorothiazide***) | 3 | |
| LOPRESSOR ORAL TABLET 100 MG, 50 MG (***metoprolol tartrate***) | 3 | |
| ***metoprolol succinate er oral tablet extended release 24 hour 100 mg, 200 mg, 50 mg*** | 2 | |
| ***metoprolol succinate er oral tablet extended release 24 hour 25 mg*** | 1 | |
| ***metoprolol tartrate oral tablet 100 mg, 25 mg, 50 mg*** | 1 | |
| ***metoprolol-hydrochlorothiazide oral tablet 100-25 mg, 100-50 mg, 50-25 mg*** | 1 | |
| ***nadolol oral tablet 20 mg, 40 mg, 80 mg*** | 1 | |
| ***pindolol oral tablet 10 mg, 5 mg*** | 1 | |
| ***propranolol hcl er oral capsule extended release 24 hour 120 mg, 160 mg, 60 mg, 80 mg*** | 2 | |
| ***propranolol hcl oral solution 20 mg/5ml, 40 mg/5ml*** | 1 | |
| ***propranolol hcl oral tablet 10 mg, 20 mg, 40 mg, 60 mg, 80 mg*** | 1 | |
| ***propranolol-hctz oral tablet 40-25 mg, 80-25 mg*** | 1 | |
| ***sotalol hcl (af) oral tablet 120 mg, 160 mg, 80 mg*** | 1 | |
| ***sotalol hcl oral tablet 120 mg, 160 mg, 240 mg, 80 mg*** | 1 | |
| SOTYLIZE ORAL SOLUTION 5 MG/ML (***sotalol hcl***) | 3 | PA |
| ***timolol maleate oral tablet 10 mg, 20 mg, 5 mg*** | 1 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| TOPROL XL ORAL TABLET EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 25 MG, 50 MG (***metoprolol succinate***) | 3 | |
| ZIAC ORAL TABLET 10-6.25 MG, 2.5-6.25 MG, 5-6.25 MG (***bisoprolol-hydrochlorothiazide***) | 3 | |
| **BILE ACID SEQUESTRANTS - Drugs for Cholesterol** | | |
| ***cholestyramine light oral packet 4 gm*** | 1 | |
| ***cholestyramine light oral powder 4 gm/dose*** | 1 | |
| ***cholestyramine oral packet 4 gm*** | 1 | |
| ***cholestyramine oral powder 4 gm/dose*** | 1 | |
| ***colesevelam hcl oral packet 3.75 gm*** | 3 | |
| ***colesevelam hcl oral tablet 625 mg*** | 3 | |
| COLESTID FLAVORED ORAL GRANULES 5 GM (***colestipol hcl***) | 3 | |
| COLESTID FLAVORED ORAL PACKET 5 GM (***colestipol hcl***) | 3 | |
| COLESTID ORAL GRANULES 5 GM (***colestipol hcl***) | 3 | |
| COLESTID ORAL PACKET 5 GM (***colestipol hcl***) | 3 | |
| COLESTID ORAL TABLET 1 GM (***colestipol hcl***) | 3 | |
| ***colestipol hcl oral granules 5 gm*** | 1 | |
| ***colestipol hcl oral packet 5 gm*** | 1 | |
| ***colestipol hcl oral tablet 1 gm*** | 1 | |
| ***cholestyramine light*** (Prevalite Oral Packet 4 Gm) | 1 | |
| ***cholestyramine light*** (Prevalite Oral Powder 4 Gm/Dose) | 1 | |
| QUESTRAN LIGHT ORAL POWDER 4 GM/DOSE (***cholestyramine light***) | 3 | |
| QUESTRAN ORAL PACKET 4 GM (***cholestyramine***) | 3 | |
| QUESTRAN ORAL POWDER 4 GM/DOSE (***cholestyramine***) | 3 | |
| WELCHOL ORAL PACKET 3.75 GM (***colesevelam hcl***) | 2 | |
| WELCHOL ORAL TABLET 625 MG (***colesevelam hcl***) | 2 | |
| **CALCIUM-CHANNEL BLOCK.AGT,MISC(HYPOTEN) - Drugs for High Blood Pressure & Angina** | | |
| CALAN SR ORAL TABLET EXTENDED RELEASE 120 MG, 180 MG, 240 MG (***verapamil hcl***) | 3 | |
| ***diltiazem hcl coated beads*** (Cartia Xt Oral Capsule Extended Release 24 Hour 120 Mg, 180 Mg, 240 Mg, 300 Mg) | 2 | |
| ***diltiazem hcl er beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg*** | 2 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ***diltiazem hcl er coated beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg*** | 2 | |
| ***diltiazem hcl er coated beads oral tablet extended release 24 hour 180 mg, 240 mg, 300 mg, 360 mg, 420 mg*** | 2 | |
| ***diltiazem hcl er oral capsule extended release 12 hour 120 mg, 60 mg, 90 mg*** | 1 | |
| ***diltiazem hcl er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg*** | 1 | |
| ***diltiazem hcl oral tablet 120 mg, 30 mg, 60 mg, 90 mg*** | 1 | |
| ***dilt-xr oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg*** | 1 | |
| ***diltiazem hcl coated beads*** (Matzim La Oral Tablet Extended Release 24 Hour 180 Mg, 240 Mg, 300 Mg, 360 Mg, 420 Mg) | 2 | |
| TARKA ORAL TABLET EXTENDED RELEASE 2-180 MG, 2-240 MG, 4-240 MG (***trandolapril-verapamil hcl***) | 3 | |
| ***diltiazem hcl er beads*** (Taztia Xt Oral Capsule Extended Release 24 Hour 120 Mg, 180 Mg, 240 Mg, 300 Mg, 360 Mg) | 2 | |
| ***diltiazem hcl er beads*** (Tiadylt Er Oral Capsule Extended Release 24 Hour 120 Mg, 180 Mg, 240 Mg, 300 Mg, 360 Mg, 420 Mg) | 2 | |
| TIAZAC ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 180 MG, 240 MG, 300 MG, 360 MG, 420 MG (***diltiazem hcl er beads***) | 3 | |
| ***trandolapril-verapamil hcl er oral tablet extended release 1-240 mg, 2-180 mg, 2-240 mg, 4-240 mg*** | 3 | |
| ***verapamil hcl er oral capsule extended release 24 hour 100 mg, 200 mg, 300 mg*** | 3 | |
| ***verapamil hcl er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 360 mg*** | 1 | |
| ***verapamil hcl er oral tablet extended release 120 mg, 180 mg, 240 mg*** | 1 | |
| ***verapamil hcl oral tablet 120 mg, 40 mg, 80 mg*** | 1 | |
| VERELAN ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 180 MG, 240 MG, 360 MG (***verapamil hcl***) | 3 | |
| VERELAN PM ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 300 MG (***verapamil hcl***) | 3 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| **CALCIUM-CHANNEL BLOCKING AGENTS - Drugs for High Blood Pressure & Angina** | | |
| ADALAT CC ORAL TABLET EXTENDED RELEASE 24 HOUR 60 MG (***nifedipine***) | 3 | |
| ***amlodipine besylate oral tablet 10 mg, 2.5 mg, 5 mg*** | 1 | |
| ***amlodipine besylate-benazepril hcl oral capsule 10-20 mg, 10-40 mg, 2.5-10 mg, 5-10 mg, 5-20 mg, 5-40 mg*** | 1 | |
| ***amlodipine besylate-valsartan oral tablet 10-160 mg, 10-320 mg, 5-160 mg, 5-320 mg*** | 2 | |
| CALAN SR ORAL TABLET EXTENDED RELEASE 120 MG, 180 MG, 240 MG (***verapamil hcl***) | 3 | |
| ***diltiazem hcl coated beads*** (Cartia Xt Oral Capsule Extended Release 24 Hour 120 Mg, 180 Mg, 240 Mg, 300 Mg) | 2 | |
| ***diltiazem hcl er beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg*** | 2 | |
| ***diltiazem hcl er coated beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg*** | 2 | |
| ***diltiazem hcl er coated beads oral tablet extended release 24 hour 180 mg, 240 mg, 300 mg, 360 mg, 420 mg*** | 2 | |
| ***diltiazem hcl er oral capsule extended release 12 hour 120 mg, 60 mg, 90 mg*** | 1 | |
| ***diltiazem hcl er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg*** | 1 | |
| ***diltiazem hcl oral tablet 120 mg, 30 mg, 60 mg, 90 mg*** | 1 | |
| ***dilt-xr oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg*** | 1 | |
| ***felodipine er oral tablet extended release 24 hour 10 mg, 2.5 mg, 5 mg*** | 1 | |
| ***isradipine oral capsule 2.5 mg, 5 mg*** | 1 | |
| KATERZIA ORAL SUSPENSION 1 MG/ML (***amlodipine benzoate***) | 3 | PA |
| LOTREL ORAL CAPSULE 10-20 MG, 10-40 MG, 5-10 MG, 5-20 MG (***amlodipine besy-benazepril hcl***) | 3 | |
| ***diltiazem hcl coated beads*** (Matzim La Oral Tablet Extended Release 24 Hour 180 Mg, 240 Mg, 300 Mg, 360 Mg, 420 Mg) | 2 | |
| ***nicardipine hcl oral capsule 20 mg, 30 mg*** | 1 | |
| ***nifedipine er oral tablet extended release 24 hour 30 mg, 60 mg, 90 mg*** | 1 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ***nifedipine er osmotic release oral tablet extended release 24 hour 30 mg, 60 mg, 90 mg*** | 1 | |
| ***nifedipine oral capsule 10 mg, 20 mg*** | 1 | |
| ***nimodipine oral capsule 30 mg*** | 1 | |
| ***nisoldipine er oral tablet extended release 24 hour 17 mg, 20 mg, 25.5 mg, 30 mg, 34 mg, 40 mg, 8.5 mg*** | 2 | |
| NYMALIZE ORAL SOLUTION 6 MG/ML (***nimodipine***) | 2 | |
| PROCARDIA ORAL CAPSULE 10 MG (***nifedipine***) | 3 | |
| PROCARDIA XL ORAL TABLET EXTENDED RELEASE 24 HOUR 30 MG, 60 MG, 90 MG (***nifedipine***) | 3 | |
| SULAR ORAL TABLET EXTENDED RELEASE 24 HOUR 17 MG, 34 MG, 8.5 MG (***nisoldipine***) | 3 | |
| TARKA ORAL TABLET EXTENDED RELEASE 2-180 MG, 2-240 MG, 4-240 MG (***trandolapril-verapamil hcl***) | 3 | |
| ***diltiazem hcl er beads*** (Taztia Xt Oral Capsule Extended Release 24 Hour 120 Mg, 180 Mg, 240 Mg, 300 Mg, 360 Mg) | 2 | |
| ***diltiazem hcl er beads*** (Tiadylt Er Oral Capsule Extended Release 24 Hour 120 Mg, 180 Mg, 240 Mg, 300 Mg, 360 Mg, 420 Mg) | 2 | |
| TIAZAC ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 180 MG, 240 MG, 300 MG, 360 MG, 420 MG (***diltiazem hcl er beads***) | 3 | |
| ***trandolapril-verapamil hcl er oral tablet extended release 1-240 mg, 2-180 mg, 2-240 mg, 4-240 mg*** | 3 | |
| ***verapamil hcl er oral capsule extended release 24 hour 100 mg, 200 mg, 300 mg*** | 3 | |
| ***verapamil hcl er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 360 mg*** | 1 | |
| ***verapamil hcl er oral tablet extended release 120 mg, 180 mg, 240 mg*** | 1 | |
| ***verapamil hcl oral tablet 120 mg, 40 mg, 80 mg*** | 1 | |
| VERELAN ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 180 MG, 240 MG, 360 MG (***verapamil hcl***) | 3 | |
| VERELAN PM ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 300 MG (***verapamil hcl***) | 3 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| **CALCIUM-CHANNEL BLOCKING AGENTS(HYPOTEN) - Drugs for High Blood Pressure & Angina** | | |
| CALAN SR ORAL TABLET EXTENDED RELEASE 120 MG, 180 MG, 240 MG (***verapamil hcl***) | 3 | |
| ***diltiazem hcl coated beads*** (Cartia Xt Oral Capsule Extended Release 24 Hour 120 Mg, 180 Mg, 240 Mg, 300 Mg) | 2 | |
| ***diltiazem hcl er beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg*** | 2 | |
| ***diltiazem hcl er coated beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg*** | 2 | |
| ***diltiazem hcl er coated beads oral tablet extended release 24 hour 180 mg, 240 mg, 300 mg, 360 mg, 420 mg*** | 2 | |
| ***diltiazem hcl er oral capsule extended release 12 hour 120 mg, 60 mg, 90 mg*** | 1 | |
| ***diltiazem hcl er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg*** | 1 | |
| ***diltiazem hcl oral tablet 120 mg, 30 mg, 60 mg, 90 mg*** | 1 | |
| ***dilt-xr oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg*** | 1 | |
| ***diltiazem hcl coated beads*** (Matzim La Oral Tablet Extended Release 24 Hour 180 Mg, 240 Mg, 300 Mg, 360 Mg, 420 Mg) | 2 | |
| ***diltiazem hcl er beads*** (Taztia Xt Oral Capsule Extended Release 24 Hour 120 Mg, 180 Mg, 240 Mg, 300 Mg, 360 Mg) | 2 | |
| ***diltiazem hcl er beads*** (Tiadylt Er Oral Capsule Extended Release 24 Hour 120 Mg, 180 Mg, 240 Mg, 300 Mg, 360 Mg, 420 Mg) | 2 | |
| TIAZAC ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 180 MG, 240 MG, 300 MG, 360 MG, 420 MG (***diltiazem hcl er beads***) | 3 | |
| ***verapamil hcl er oral capsule extended release 24 hour 100 mg, 200 mg, 300 mg*** | 3 | |
| ***verapamil hcl er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 360 mg*** | 1 | |
| ***verapamil hcl er oral tablet extended release 120 mg, 180 mg, 240 mg*** | 1 | |
| ***verapamil hcl oral tablet 120 mg, 40 mg, 80 mg*** | 1 | |
| VERELAN ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 180 MG, 240 MG, 360 MG (***verapamil hcl***) | 3 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| VERELAN PM ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 300 MG (***verapamil hcl***) | 3 | |
| **CALCIUM-CHANNEL BLOCKING AGENTS, MISC. - Drugs for High Blood Pressure & Angina** | | |
| CALAN SR ORAL TABLET EXTENDED RELEASE 120 MG, 180 MG, 240 MG (***verapamil hcl***) | 3 | |
| ***diltiazem hcl coated beads*** (Cartia Xt Oral Capsule Extended Release 24 Hour 120 Mg, 180 Mg, 240 Mg, 300 Mg) | 2 | |
| ***diltiazem hcl er beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg*** | 2 | |
| ***diltiazem hcl er coated beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg*** | 2 | |
| ***diltiazem hcl er coated beads oral tablet extended release 24 hour 180 mg, 240 mg, 300 mg, 360 mg, 420 mg*** | 2 | |
| ***diltiazem hcl er oral capsule extended release 12 hour 120 mg, 60 mg, 90 mg*** | 1 | |
| ***diltiazem hcl er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg*** | 1 | |
| ***diltiazem hcl oral tablet 120 mg, 30 mg, 60 mg, 90 mg*** | 1 | |
| ***dilt-xr oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg*** | 1 | |
| ***diltiazem hcl coated beads*** (Matzim La Oral Tablet Extended Release 24 Hour 180 Mg, 240 Mg, 300 Mg, 360 Mg, 420 Mg) | 2 | |
| TARKA ORAL TABLET EXTENDED RELEASE 2-180 MG, 2-240 MG, 4-240 MG (***trandolapril-verapamil hcl***) | 3 | |
| ***diltiazem hcl er beads*** (Taztia Xt Oral Capsule Extended Release 24 Hour 120 Mg, 180 Mg, 240 Mg, 300 Mg, 360 Mg) | 2 | |
| ***diltiazem hcl er beads*** (Tiadylt Er Oral Capsule Extended Release 24 Hour 120 Mg, 180 Mg, 240 Mg, 300 Mg, 360 Mg, 420 Mg) | 2 | |
| TIAZAC ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 180 MG, 240 MG, 300 MG, 360 MG, 420 MG (***diltiazem hcl er beads***) | 3 | |
| ***trandolapril-verapamil hcl er oral tablet extended release 1-240 mg, 2-180 mg, 2-240 mg, 4-240 mg*** | 3 | |
| ***verapamil hcl er oral capsule extended release 24 hour 100 mg, 200 mg, 300 mg*** | 3 | |
| ***verapamil hcl er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 360 mg*** | 1 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ***verapamil hcl er oral tablet extended release 120 mg, 180 mg, 240 mg*** | 1 | |
| ***verapamil hcl oral tablet 120 mg, 40 mg, 80 mg*** | 1 | |
| VERELAN ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 180 MG, 240 MG, 360 MG (***verapamil hcl***) | 3 | |
| VERELAN PM ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 300 MG (***verapamil hcl***) | 3 | |
| **CARBONIC ANHYDRASE INHIBITORS(HYPOTEN) - Drugs for High Blood Pressure & Angina** | | |
| ***acetazolamide er oral capsule extended release 12 hour 500 mg*** | 1 | |
| ***acetazolamide oral tablet 125 mg, 250 mg*** | 1 | |
| **CARDIAC DRUGS, MISCELLANEOUS - Drugs for Angina** | | |
| CORLANOR ORAL SOLUTION 5 MG/5ML (***ivabradine hcl***) | 3 | PA; SL (20 ml per day.) |
| CORLANOR ORAL TABLET 5 MG, 7.5 MG (***ivabradine hcl***) | 3 | PA; SL (2 tablets per day.) |
| ***ranolazine er oral tablet extended release 12 hour 1000 mg, 500 mg*** | 2 | |
| VYNDAMAX ORAL CAPSULE 61 MG (***tafamidis***) | 2 | PA; SL (1 capsule per day.); SP |
| VYNDAQEL ORAL CAPSULE 20 MG (***tafamidis meglumine (cardiac)***) | 2 | PA; SL (4 capsules per day.); SP |
| **CARDIOTONIC AGENTS - Drugs for Angina** | | |
| ***digoxin*** (Digitek Oral Tablet 125 Mcg, 250 Mcg) | 1 | |
| ***digoxin*** (Digox Oral Tablet 125 Mcg, 250 Mcg) | 1 | |
| ***digoxin oral solution 0.05 mg/ml*** | 1 | |
| ***digoxin oral tablet 125 mcg, 250 mcg*** | 1 | |
| LANOXIN ORAL TABLET 125 MCG, 250 MCG, 62.5 MCG (***digoxin***) | 3 | |
| **CENTRAL ALPHA-AGONISTS - Drugs for High Blood Pressure & Angina** | | |
| CATAPRES ORAL TABLET 0.1 MG, 0.2 MG, 0.3 MG (***clonidine hcl***) | 3 | |
| CATAPRES-TTS-1 TRANSDERMAL PATCH WEEKLY 0.1 MG/24HR (***clonidine***) | 3 | |
| CATAPRES-TTS-2 TRANSDERMAL PATCH WEEKLY 0.2 MG/24HR (***clonidine***) | 3 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| CATAPRES-TTS-3 TRANSDERMAL PATCH WEEKLY 0.3 MG/24HR (***clonidine***) | 3 | |
| ***clonidine hcl oral tablet 0.1 mg, 0.2 mg, 0.3 mg*** | 1 | |
| ***clonidine transdermal patch weekly 0.1 mg/24hr, 0.2 mg/24hr, 0.3 mg/24hr*** | 3 | |
| ***guanfacine hcl er oral tablet extended release 24 hour 1 mg*** | 2 | SL (1 tablet per day) |
| ***guanfacine hcl er oral tablet extended release 24 hour 2 mg, 4 mg*** | 2 | SL (1 tablet per day.) |
| ***guanfacine hcl er oral tablet extended release 24 hour 3 mg*** | 2 | SL (2 tablets per day.) |
| ***guanfacine hcl oral tablet 1 mg, 2 mg*** | 1 | |
| ***methyldopa oral tablet 250 mg, 500 mg*** | 1 | |
| ***methyldopa-hydrochlorothiazide oral tablet 250-15 mg, 250-25 mg*** | 1 | |
| **CHOLESTEROL ABSORPTION INHIBITORS - Drugs for Cholesterol** | | |
| ***ezetimibe oral tablet 10 mg*** | 2 | |
| ***ezetimibe-simvastatin oral tablet 10-10 mg, 10-20 mg, 10-40 mg, 10-80 mg*** | 3 | |
| NEXLIZET ORAL TABLET 180-10 MG (***bempedoic acid-ezetimibe***) | 2 | PA; ST; SL (1 tablet per day.) |
| **CLASS IA ANTIARRHYTHMICS - Drugs for Angina** | | |
| ***disopyramide phosphate oral capsule 100 mg, 150 mg*** | 1 | |
| NORPACE CR ORAL CAPSULE EXTENDED RELEASE 12 HOUR 100 MG, 150 MG (***disopyramide phosphate***) | 2 | |
| NORPACE ORAL CAPSULE 100 MG, 150 MG (***disopyramide phosphate***) | 3 | |
| ***quinidine gluconate er oral tablet extended release 324 mg*** | 1 | |
| ***quinidine sulfate oral tablet 200 mg, 300 mg*** | 1 | |
| **CLASS IB ANTIARRHYTHMICS - Drugs for Angina** | | |
| DILANTIN INFATABS ORAL TABLET CHEWABLE 50 MG (***phenytoin***) | 3 | |
| DILANTIN ORAL CAPSULE 100 MG, 30 MG (***phenytoin sodium extended***) | 3 | |
| DILANTIN ORAL SUSPENSION 125 MG/5ML (***phenytoin***) | 3 | |
| ***mexiletine hcl oral capsule 150 mg, 200 mg, 250 mg*** | 1 | |
| PHENYTEK ORAL CAPSULE 200 MG, 300 MG (***phenytoin sodium extended***) | 3 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ***phenytoin*** (Phenytoin Infatabs Oral Tablet Chewable 50 Mg) | 1 | |
| ***phenytoin oral suspension 125 mg/5ml*** | 1 | |
| ***phenytoin oral tablet chewable 50 mg*** | 1 | |
| ***phenytoin sodium extended oral capsule 100 mg, 200 mg, 300 mg*** | 1 | |
| **CLASS IC ANTIARRHYTHMICS - Drugs for Angina** | | |
| ***flecainide acetate oral tablet 100 mg, 150 mg, 50 mg*** | 1 | |
| ***propafenone hcl er oral capsule extended release 12 hour 225 mg, 325 mg, 425 mg*** | 3 | |
| ***propafenone hcl oral tablet 150 mg, 225 mg, 300 mg*** | 1 | |
| RYTHMOL SR ORAL CAPSULE EXTENDED RELEASE 12 HOUR 225 MG, 325 MG, 425 MG (***propafenone hcl***) | 3 | |
| **CLASS II ANTIARRHYTHMICS - Drugs for Angina** | | |
| ***acebutolol hcl oral capsule 200 mg, 400 mg*** | 1 | |
| ***atenolol oral tablet 100 mg, 25 mg, 50 mg*** | 1 | |
| ***atenolol-chlorthalidone oral tablet 100-25 mg, 50-25 mg*** | 1 | |
| BETAPACE AF ORAL TABLET 120 MG, 160 MG, 80 MG (***sotalol hcl af***) | 4 | |
| ***betaxolol hcl oral tablet 10 mg, 20 mg*** | 1 | |
| ***bisoprolol fumarate oral tablet 10 mg, 5 mg*** | 1 | |
| ***bisoprolol-hydrochlorothiazide oral tablet 10-6.25 mg, 2.5-6.25 mg, 5-6.25 mg*** | 1 | |
| ***carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg*** | 1 | |
| COREG ORAL TABLET 12.5 MG, 25 MG, 3.125 MG, 6.25 MG (***carvedilol***) | 3 | |
| CORGARD ORAL TABLET 20 MG, 40 MG, 80 MG (***nadolol***) | 3 | |
| KAPSPARGO SPRINKLE ORAL CAPSULE ER 24 HOUR SPRINKLE 100 MG, 200 MG, 25 MG, 50 MG (***metoprolol succinate***) | 3 | |
| ***labetalol hcl oral tablet 100 mg, 200 mg, 300 mg*** | 1 | |
| LOPRESSOR HCT ORAL TABLET 50-25 MG (***metoprolol-hydrochlorothiazide***) | 3 | |
| LOPRESSOR ORAL TABLET 100 MG, 50 MG (***metoprolol tartrate***) | 3 | |
| ***metoprolol succinate er oral tablet extended release 24 hour 100 mg, 200 mg, 50 mg*** | 2 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ***metoprolol succinate er oral tablet extended release 24 hour 25 mg*** | 1 | |
| ***metoprolol tartrate oral tablet 100 mg, 25 mg, 50 mg*** | 1 | |
| ***metoprolol-hydrochlorothiazide oral tablet 100-25 mg, 100-50 mg, 50-25 mg*** | 1 | |
| ***nadolol oral tablet 20 mg, 40 mg, 80 mg*** | 1 | |
| ***pindolol oral tablet 10 mg, 5 mg*** | 1 | |
| ***propranolol hcl er oral capsule extended release 24 hour 120 mg, 160 mg, 60 mg, 80 mg*** | 2 | |
| ***propranolol hcl oral solution 20 mg/5ml, 40 mg/5ml*** | 1 | |
| ***propranolol hcl oral tablet 10 mg, 20 mg, 40 mg, 60 mg, 80 mg*** | 1 | |
| ***propranolol-hctz oral tablet 40-25 mg, 80-25 mg*** | 1 | |
| ***sotalol hcl (af) oral tablet 120 mg, 160 mg, 80 mg*** | 1 | |
| ***sotalol hcl oral tablet 120 mg, 160 mg, 240 mg, 80 mg*** | 1 | |
| SOTYLIZE ORAL SOLUTION 5 MG/ML (***sotalol hcl***) | 3 | PA |
| ***timolol maleate oral tablet 10 mg, 20 mg, 5 mg*** | 1 | |
| TOPROL XL ORAL TABLET EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 25 MG, 50 MG (***metoprolol succinate***) | 3 | |
| ZIAC ORAL TABLET 10-6.25 MG, 2.5-6.25 MG, 5-6.25 MG (***bisoprolol-hydrochlorothiazide***) | 3 | |
| **CLASS III ANTIARRHYTHMICS - Drugs for Angina** | | |
| ***amiodarone hcl oral tablet 100 mg, 200 mg, 400 mg*** | 1 | |
| BETAPACE AF ORAL TABLET 120 MG, 160 MG, 80 MG (***sotalol hcl af***) | 4 | |
| ***dofetilide oral capsule 125 mcg, 250 mcg, 500 mcg*** | 2 | |
| MULTAQ ORAL TABLET 400 MG (***dronedarone hcl***) | 3 | PA |
| ***amiodarone hcl*** (Pacerone Oral Tablet 100 Mg, 400 Mg) | 3 | |
| ***amiodarone hcl*** (Pacerone Oral Tablet 200 Mg) | 1 | |
| ***sotalol hcl (af) oral tablet 120 mg, 160 mg, 80 mg*** | 1 | |
| ***sotalol hcl oral tablet 120 mg, 160 mg, 240 mg, 80 mg*** | 1 | |
| SOTYLIZE ORAL SOLUTION 5 MG/ML (***sotalol hcl***) | 3 | PA |
| TIKOSYN ORAL CAPSULE 125 MCG, 250 MCG, 500 MCG (***dofetilide***) | 3 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| **CLASS IV ANTIARRHYTHMICS - Drugs for Angina** | | |
| CALAN SR ORAL TABLET EXTENDED RELEASE 120 MG, 180 MG, 240 MG (***verapamil hcl***) | 3 | |
| ***diltiazem hcl coated beads*** (Cartia Xt Oral Capsule Extended Release 24 Hour 120 Mg, 180 Mg, 240 Mg, 300 Mg) | 2 | |
| ***diltiazem hcl er beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg*** | 2 | |
| ***diltiazem hcl er coated beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg*** | 2 | |
| ***diltiazem hcl er coated beads oral tablet extended release 24 hour 180 mg, 240 mg, 300 mg, 360 mg, 420 mg*** | 2 | |
| ***diltiazem hcl er oral capsule extended release 12 hour 120 mg, 60 mg, 90 mg*** | 1 | |
| ***diltiazem hcl er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg*** | 1 | |
| ***diltiazem hcl oral tablet 120 mg, 30 mg, 60 mg, 90 mg*** | 1 | |
| ***dilt-xr oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg*** | 1 | |
| ***diltiazem hcl coated beads*** (Matzim La Oral Tablet Extended Release 24 Hour 180 Mg, 240 Mg, 300 Mg, 360 Mg, 420 Mg) | 2 | |
| ***diltiazem hcl er beads*** (Taztia Xt Oral Capsule Extended Release 24 Hour 120 Mg, 180 Mg, 240 Mg, 300 Mg, 360 Mg) | 2 | |
| ***diltiazem hcl er beads*** (Tiadylt Er Oral Capsule Extended Release 24 Hour 120 Mg, 180 Mg, 240 Mg, 300 Mg, 360 Mg, 420 Mg) | 2 | |
| TIAZAC ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 180 MG, 240 MG, 300 MG, 360 MG, 420 MG (***diltiazem hcl er beads***) | 3 | |
| ***verapamil hcl er oral capsule extended release 24 hour 100 mg, 200 mg, 300 mg*** | 3 | |
| ***verapamil hcl er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 360 mg*** | 1 | |
| ***verapamil hcl er oral tablet extended release 120 mg, 180 mg, 240 mg*** | 1 | |
| ***verapamil hcl oral tablet 120 mg, 40 mg, 80 mg*** | 1 | |
| VERELAN ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 180 MG, 240 MG, 360 MG (***verapamil hcl***) | 3 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| VERELAN PM ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 300 MG (***verapamil hcl***) | 3 | |
| **DIHYDROPYRIDINES - Drugs for High Blood Pressure & Angina** | | |
| ADALAT CC ORAL TABLET EXTENDED RELEASE 24 HOUR 60 MG (***nifedipine***) | 3 | |
| ***amlodipine besylate oral tablet 10 mg, 2.5 mg, 5 mg*** | 1 | |
| ***amlodipine besylate-benazepril hcl oral capsule 10-20 mg, 10-40 mg, 2.5-10 mg, 5-10 mg, 5-20 mg, 5-40 mg*** | 1 | |
| ***amlodipine besylate-valsartan oral tablet 10-160 mg, 10-320 mg, 5-160 mg, 5-320 mg*** | 2 | |
| ***felodipine er oral tablet extended release 24 hour 10 mg, 2.5 mg, 5 mg*** | 1 | |
| ***isradipine oral capsule 2.5 mg, 5 mg*** | 1 | |
| KATERZIA ORAL SUSPENSION 1 MG/ML (***amlodipine benzoate***) | 3 | PA |
| LOTREL ORAL CAPSULE 10-20 MG, 10-40 MG, 5-10 MG, 5-20 MG (***amlodipine besy-benazepril hcl***) | 3 | |
| ***nicardipine hcl oral capsule 20 mg, 30 mg*** | 1 | |
| ***nifedipine er oral tablet extended release 24 hour 30 mg, 60 mg, 90 mg*** | 1 | |
| ***nifedipine er osmotic release oral tablet extended release 24 hour 30 mg, 60 mg, 90 mg*** | 1 | |
| ***nifedipine oral capsule 10 mg, 20 mg*** | 1 | |
| ***nimodipine oral capsule 30 mg*** | 1 | |
| ***nisoldipine er oral tablet extended release 24 hour 17 mg, 20 mg, 25.5 mg, 30 mg, 34 mg, 40 mg, 8.5 mg*** | 2 | |
| NYMALIZE ORAL SOLUTION 6 MG/ML (***nimodipine***) | 2 | |
| PROCARDIA ORAL CAPSULE 10 MG (***nifedipine***) | 3 | |
| PROCARDIA XL ORAL TABLET EXTENDED RELEASE 24 HOUR 30 MG, 60 MG, 90 MG (***nifedipine***) | 3 | |
| SULAR ORAL TABLET EXTENDED RELEASE 24 HOUR 17 MG, 34 MG, 8.5 MG (***nisoldipine***) | 3 | |
| **DIHYDROPYRIDINES (ANTIHYPERTENSIVE) - Drugs for High Blood Pressure & Angina** | | |
| ADALAT CC ORAL TABLET EXTENDED RELEASE 24 HOUR 60 MG (***nifedipine***) | 3 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ***amlodipine besylate oral tablet 10 mg, 2.5 mg, 5 mg*** | 1 | |
| ***amlodipine besylate-benazepril hcl oral capsule 10-20 mg, 10-40 mg, 2.5-10 mg, 5-10 mg, 5-20 mg, 5-40 mg*** | 1 | |
| ***amlodipine besylate-valsartan oral tablet 10-160 mg, 10-320 mg, 5-160 mg, 5-320 mg*** | 2 | |
| ***felodipine er oral tablet extended release 24 hour 10 mg, 2.5 mg, 5 mg*** | 1 | |
| ***isradipine oral capsule 2.5 mg, 5 mg*** | 1 | |
| KATERZIA ORAL SUSPENSION 1 MG/ML (***amlodipine benzoate***) | 3 | PA |
| LOTREL ORAL CAPSULE 10-20 MG, 10-40 MG, 5-10 MG, 5-20 MG (***amlodipine besy-benazepril hcl***) | 3 | |
| ***nicardipine hcl oral capsule 20 mg, 30 mg*** | 1 | |
| ***nifedipine er oral tablet extended release 24 hour 30 mg, 60 mg, 90 mg*** | 1 | |
| ***nifedipine er osmotic release oral tablet extended release 24 hour 30 mg, 60 mg, 90 mg*** | 1 | |
| ***nifedipine oral capsule 10 mg, 20 mg*** | 1 | |
| ***nimodipine oral capsule 30 mg*** | 1 | |
| ***nisoldipine er oral tablet extended release 24 hour 17 mg, 20 mg, 25.5 mg, 30 mg, 34 mg, 40 mg, 8.5 mg*** | 2 | |
| NYMALIZE ORAL SOLUTION 6 MG/ML (***nimodipine***) | 2 | |
| PROCARDIA ORAL CAPSULE 10 MG (***nifedipine***) | 3 | |
| PROCARDIA XL ORAL TABLET EXTENDED RELEASE 24 HOUR 30 MG, 60 MG, 90 MG (***nifedipine***) | 3 | |
| SULAR ORAL TABLET EXTENDED RELEASE 24 HOUR 17 MG, 34 MG, 8.5 MG (***nisoldipine***) | 3 | |
| **DIRECT VASODILATORS - Drugs for High Blood Pressure & Angina** | | |
| BIDIL ORAL TABLET 20-37.5 MG (***isosorb dinitrate-hydralazine***) | 2 | |
| ***hydralazine hcl oral tablet 10 mg, 100 mg, 25 mg, 50 mg*** | 1 | |
| ***minoxidil oral tablet 10 mg, 2.5 mg*** | 1 | |
| **DIURETICS, MISCELLANEOUS (HYPOTENSIVE) - Drugs for High Blood Pressure & Angina** | | |
| ELIXOPHYLLIN ORAL ELIXIR 80 MG/15ML (***theophylline***) | 3 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| THEO-24 ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 300 MG, 400 MG (***theophylline***) | 3 | |
| ***theophylline er oral tablet extended release 12 hour 300 mg, 450 mg*** | 1 | |
| ***theophylline er oral tablet extended release 24 hour 400 mg, 600 mg*** | 1 | |
| ***theophylline oral solution 80 mg/15ml*** | 1 | |
| **FIBRIC ACID DERIVATIVES - Drugs for Cholesterol** | | |
| ***fenofibrate oral tablet 160 mg, 54 mg*** | 2 | |
| ***gemfibrozil oral tablet 600 mg*** | 1 | |
| LOPID ORAL TABLET 600 MG (***gemfibrozil***) | 3 | |
| **HMG-COA REDUCTASE INHIBITORS - Drugs for Cholesterol** | | |
| ***atorvastatin calcium oral tablet 10 mg, 20 mg*** | 1 | SL (3 tablets per day.); H-N |
| ***atorvastatin calcium oral tablet 40 mg, 80 mg*** | 1 | SL (31 tablets per 31 days.) |
| EZALLOR SPRINKLE ORAL CAPSULE SPRINKLE 10 MG, 20 MG, 40 MG, 5 MG (***rosuvastatin calcium***) | 3 | PA |
| ***ezetimibe-simvastatin oral tablet 10-10 mg, 10-20 mg, 10-40 mg, 10-80 mg*** | 3 | |
| FLOLIPID ORAL SUSPENSION 20 MG/5ML, 40 MG/5ML | 3 | PA |
| ***fluvastatin sodium er oral tablet extended release 24 hour 80 mg*** | 3 | ST |
| ***fluvastatin sodium oral capsule 20 mg, 40 mg*** | 1 | |
| ***lovastatin oral tablet 10 mg, 20 mg, 40 mg*** | 1 | H |
| PRAVACHOL ORAL TABLET 20 MG, 40 MG (***pravastatin sodium***) | 3 | |
| ***pravastatin sodium oral tablet 10 mg, 20 mg, 40 mg, 80 mg*** | 1 | |
| ***rosuvastatin calcium oral tablet 10 mg*** | 2 | SL (3 tablets per day.) |
| ***rosuvastatin calcium oral tablet 20 mg, 40 mg, 5 mg*** | 2 | SL (1 tablet per day.) |
| ***simvastatin oral tablet 10 mg, 20 mg, 40 mg, 5 mg*** | 1 | H-N |
| ***simvastatin oral tablet 80 mg*** | 1 | |
| ZOCOR ORAL TABLET 10 MG, 20 MG, 40 MG, 80 MG (***simvastatin***) | 3 | |
| **HYPOTENSIVE AGENTS, MISCELLANEOUS - Drugs for High Blood Pressure & Angina** | | |
| ***acebutolol hcl oral capsule 200 mg, 400 mg*** | 1 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ADALAT CC ORAL TABLET EXTENDED RELEASE 24 HOUR 60 MG (***nifedipine***) | 3 | |
| ***amlodipine besylate oral tablet 10 mg, 2.5 mg, 5 mg*** | 1 | |
| ***amlodipine besylate-benazepril hcl oral capsule 10-20 mg, 10-40 mg, 2.5-10 mg, 5-10 mg, 5-20 mg, 5-40 mg*** | 1 | |
| ***amlodipine besylate-valsartan oral tablet 10-160 mg, 10-320 mg, 5-160 mg, 5-320 mg*** | 2 | |
| BETAPACE AF ORAL TABLET 120 MG, 160 MG, 80 MG (***sotalol hcl af***) | 4 | |
| ***betaxolol hcl oral tablet 10 mg, 20 mg*** | 1 | |
| CARDURA ORAL TABLET 1 MG, 2 MG, 4 MG, 8 MG (***doxazosin mesylate***) | 3 | |
| CARDURA XL ORAL TABLET EXTENDED RELEASE 24 HOUR 4 MG, 8 MG (***doxazosin mesylate***) | 3 | |
| ***carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg*** | 1 | |
| COREG ORAL TABLET 12.5 MG, 25 MG, 3.125 MG, 6.25 MG (***carvedilol***) | 3 | |
| ***doxazosin mesylate oral tablet 1 mg, 2 mg, 4 mg, 8 mg*** | 1 | |
| ***felodipine er oral tablet extended release 24 hour 10 mg, 2.5 mg, 5 mg*** | 1 | |
| ***isradipine oral capsule 2.5 mg, 5 mg*** | 1 | |
| KATERZIA ORAL SUSPENSION 1 MG/ML (***amlodipine benzoate***) | 3 | PA |
| LOTREL ORAL CAPSULE 10-20 MG, 10-40 MG, 5-10 MG, 5-20 MG (***amlodipine besy-benazepril hcl***) | 3 | |
| ***nicardipine hcl oral capsule 20 mg, 30 mg*** | 1 | |
| ***nifedipine er oral tablet extended release 24 hour 30 mg, 60 mg, 90 mg*** | 1 | |
| ***nifedipine er osmotic release oral tablet extended release 24 hour 30 mg, 60 mg, 90 mg*** | 1 | |
| ***nifedipine oral capsule 10 mg, 20 mg*** | 1 | |
| ***nimodipine oral capsule 30 mg*** | 1 | |
| ***nisoldipine er oral tablet extended release 24 hour 17 mg, 20 mg, 25.5 mg, 30 mg, 34 mg, 40 mg, 8.5 mg*** | 2 | |
| NYMALIZE ORAL SOLUTION 6 MG/ML (***nimodipine***) | 2 | |
| ***phenoxybenzamine hcl oral capsule 10 mg*** | 2 | |
| ***pindolol oral tablet 10 mg, 5 mg*** | 1 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| PROCARDIA ORAL CAPSULE 10 MG (***nifedipine***) | 3 | |
| PROCARDIA XL ORAL TABLET EXTENDED RELEASE 24 HOUR 30 MG, 60 MG, 90 MG (***nifedipine***) | 3 | |
| ***propranolol hcl er oral capsule extended release 24 hour 120 mg, 160 mg, 60 mg, 80 mg*** | 2 | |
| ***propranolol hcl oral solution 20 mg/5ml, 40 mg/5ml*** | 1 | |
| ***propranolol hcl oral tablet 10 mg, 20 mg, 40 mg, 60 mg, 80 mg*** | 1 | |
| ***sotalol hcl (af) oral tablet 120 mg, 160 mg, 80 mg*** | 1 | |
| ***sotalol hcl oral tablet 120 mg, 160 mg, 240 mg, 80 mg*** | 1 | |
| SOTYLIZE ORAL SOLUTION 5 MG/ML (***sotalol hcl***) | 3 | PA |
| SULAR ORAL TABLET EXTENDED RELEASE 24 HOUR 17 MG, 34 MG, 8.5 MG (***nisoldipine***) | 3 | |
| ***terazosin hcl oral capsule 1 mg, 10 mg, 2 mg, 5 mg*** | 1 | |
| ***timolol maleate oral tablet 10 mg, 20 mg, 5 mg*** | 1 | |
| VECAMYL ORAL TABLET 2.5 MG (***mecamylamine hcl***) | 3 | PA |
| **LOOP DIURETICS (HYPOTENSIVE AGENTS) - Drugs for High Blood Pressure & Angina** | | |
| ***bumetanide oral tablet 0.5 mg, 1 mg, 2 mg*** | 1 | |
| EDECRIN ORAL TABLET 25 MG (***ethacrynic acid***) | 4 | |
| ***ethacrynic acid oral tablet 25 mg*** | 3 | |
| ***furosemide oral solution 10 mg/ml, 8 mg/ml*** | 1 | |
| ***furosemide oral tablet 20 mg, 40 mg, 80 mg*** | 1 | |
| LASIX ORAL TABLET 20 MG, 40 MG, 80 MG (***furosemide***) | 3 | |
| ***torsemide oral tablet 10 mg, 100 mg, 20 mg, 5 mg*** | 1 | |
| **MINERALOCORTICOID (ALDOSTERONE) ANTAGNTS - Drugs for the Heart** | | |
| ALDACTAZIDE ORAL TABLET 25-25 MG (***spironolactone-hctz***) | 3 | |
| ALDACTAZIDE ORAL TABLET 50-50 MG (***spironolactone-hctz***) | 2 | |
| ALDACTONE ORAL TABLET 100 MG, 25 MG, 50 MG (***spironolactone***) | 3 | |
| CAROSPIR ORAL SUSPENSION 25 MG/5ML (***spironolactone***) | 3 | PA |
| ***eplerenone oral tablet 25 mg, 50 mg*** | 2 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| INSPRA ORAL TABLET 25 MG, 50 MG (***eplerenone***) | 3 | |
| ***spironolactone oral tablet 100 mg, 25 mg, 50 mg*** | 1 | |
| ***spironolactone-hctz oral tablet 25-25 mg*** | 1 | |
| **MINERALOCORTICOID(ALDOSTER.)ANTAG(HYPOT) - Drugs for High Blood Pressure & Angina** | | |
| ALDACTAZIDE ORAL TABLET 25-25 MG (***spironolactone-hctz***) | 3 | |
| ALDACTAZIDE ORAL TABLET 50-50 MG (***spironolactone-hctz***) | 2 | |
| ALDACTONE ORAL TABLET 100 MG, 25 MG, 50 MG (***spironolactone***) | 3 | |
| CAROSPIR ORAL SUSPENSION 25 MG/5ML (***spironolactone***) | 3 | PA |
| ***eplerenone oral tablet 25 mg, 50 mg*** | 2 | |
| INSPRA ORAL TABLET 25 MG, 50 MG (***eplerenone***) | 3 | |
| ***spironolactone oral tablet 100 mg, 25 mg, 50 mg*** | 1 | |
| ***spironolactone-hctz oral tablet 25-25 mg*** | 1 | |
| **NITRATES AND NITRITES - Drugs for the Heart** | | |
| BIDIL ORAL TABLET 20-37.5 MG (***isosorb dinitrate-hydralazine***) | 2 | |
| DILATRATE-SR ORAL CAPSULE EXTENDED RELEASE 40 MG (***isosorbide dinitrate***) | 3 | |
| ISORDIL TITRADOSE ORAL TABLET 40 MG, 5 MG (***isosorbide dinitrate***) | 3 | |
| ***isosorbide dinitrate oral tablet 10 mg, 20 mg, 30 mg, 5 mg*** | 1 | |
| ***isosorbide dinitrate oral tablet 40 mg*** | 2 | |
| ***isosorbide mononitrate er oral tablet extended release 24 hour 120 mg, 30 mg, 60 mg*** | 1 | |
| ***isosorbide mononitrate oral tablet 10 mg, 20 mg*** | 1 | |
| ***nitroglycerin*** (Minitran Transdermal Patch 24 Hour 0.1 Mg/Hr, 0.2 Mg/Hr, 0.4 Mg/Hr, 0.6 Mg/Hr) | 1 | |
| NITRO-BID TRANSDERMAL OINTMENT 2 % (***nitroglycerin***) | 2 | |
| NITRO-DUR TRANSDERMAL PATCH 24 HOUR 0.1 MG/HR, 0.2 MG/HR, 0.3 MG/HR, 0.4 MG/HR, 0.6 MG/HR, 0.8 MG/HR (***nitroglycerin***) | 3 | |
| ***nitroglycerin sublingual tablet sublingual 0.3 mg, 0.4 mg, 0.6 mg*** | 1 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ***nitroglycerin transdermal patch 24 hour 0.1 mg/hr, 0.2 mg/hr, 0.4 mg/hr, 0.6 mg/hr*** | 1 | |
| NITROMIST TRANSLINGUAL AEROSOL SOLUTION 400 MCG/SPRAY (***nitroglycerin***) | 3 | SL (4.1 grams (1 package) per prescription) |
| NITROSTAT SUBLINGUAL TABLET SUBLINGUAL 0.3 MG, 0.4 MG, 0.6 MG (***nitroglycerin***) | 3 | |
| ***nitro-time oral capsule extended release 2.5 mg, 6.5 mg, 9 mg*** | 1 | |
| **PCSK9 INHIBITORS - Drugs for Cholesterol** | | |
| PRALUENT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML, 75 MG/ML (***alirocumab***) | 2 | PA; ST; M; SL (2 ml (2 pens) per 28 days.) |
| REPATHA PUSHTRONEX SYSTEM SUBCUTANEOUS SOLUTION CARTRIDGE 420 MG/3.5ML (***evolocumab***) | 2 | PA; ST; M; SL (3.5 ml (1 cartridge) per month.) |
| REPATHA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 140 MG/ML (***evolocumab***) | 2 | PA; ST; M; SL (2 syringes per 28 days.) |
| REPATHA SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 140 MG/ML (***evolocumab***) | 2 | PA; ST; M; SL (2 ml per month.) |
| **PHOSPHODIESTERASE TYPE 5 INHIBITORS - Drugs for the Heart** | | |
| ***tadalafil (pah)*** (Alyq Oral Tablet 20 Mg) | 4 | PA; SL (2 tablets per day); SP |
| ***cilostazol oral tablet 100 mg, 50 mg*** | 1 | |
| REVATIO ORAL SUSPENSION RECONSTITUTED 10 MG/ML (***sildenafil citrate***) | 4 | PA; SL (186 ml per month.); SP |
| ***sildenafil citrate oral suspension reconstituted 10 mg/ml*** | 3 | PA; SL (186 ml per month.); SP |
| ***sildenafil citrate oral tablet 100 mg, 25 mg, 50 mg*** | 2 | SL (6 tablets per month) |
| ***sildenafil citrate oral tablet 20 mg*** | 1 | SL (0.5 tablet per day.) |
| STENDRA ORAL TABLET 100 MG, 200 MG, 50 MG (***avanafil***) | 3 | PA; SL (3 tablets per month) |
| ***tadalafil (pah) oral tablet 20 mg*** | 4 | PA; SL (2 tablets per day); SP |
| ***tadalafil oral tablet 10 mg, 20 mg*** | 2 | SL (6 tablets per month) |
| ***tadalafil oral tablet 2.5 mg, 5 mg*** | 2 | ST; SL (6 tablets per month) |
| ***vardenafil hcl oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg*** | 3 | SL (3 tablets per month) |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| **POTASSIUM-SPARING DIURETICS (HYPOTEN) - Drugs for High Blood Pressure & Angina** | | |
| ALDACTAZIDE ORAL TABLET 25-25 MG (***spironolactone-hctz***) | 3 | |
| ALDACTAZIDE ORAL TABLET 50-50 MG (***spironolactone-hctz***) | 2 | |
| ALDACTONE ORAL TABLET 100 MG, 25 MG, 50 MG (***spironolactone***) | 3 | |
| ***amiloride hcl oral tablet 5 mg*** | 1 | |
| ***amiloride-hydrochlorothiazide oral tablet 5-50 mg*** | 1 | |
| CAROSPIR ORAL SUSPENSION 25 MG/5ML (***spironolactone***) | 3 | PA |
| DYAZIDE ORAL CAPSULE 37.5-25 MG (***triamterene-hctz***) | 3 | |
| DYRENIUM ORAL CAPSULE 100 MG, 50 MG (***triamterene***) | 3 | |
| ***eplerenone oral tablet 25 mg, 50 mg*** | 2 | |
| INSPRA ORAL TABLET 25 MG, 50 MG (***eplerenone***) | 3 | |
| MAXZIDE ORAL TABLET 75-50 MG (***triamterene-hctz***) | 3 | |
| MAXZIDE-25 ORAL TABLET 37.5-25 MG (***triamterene-hctz***) | 3 | |
| ***spironolactone oral tablet 100 mg, 25 mg, 50 mg*** | 1 | |
| ***spironolactone-hctz oral tablet 25-25 mg*** | 1 | |
| ***triamterene oral capsule 100 mg, 50 mg*** | 3 | |
| ***triamterene-hctz oral capsule 37.5-25 mg*** | 1 | |
| ***triamterene-hctz oral tablet 37.5-25 mg, 75-50 mg*** | 1 | |
| **RENIN INHIBITORS - Drugs for the Heart** | | |
| ***aliskiren fumarate oral tablet 150 mg, 300 mg*** | 3 | |
| TEKTURNA HCT ORAL TABLET 150-12.5 MG, 150-25 MG, 300-12.5 MG, 300-25 MG (***aliskiren-hydrochlorothiazide***) | 3 | |
| TEKTURNA ORAL TABLET 150 MG, 300 MG (***aliskiren fumarate***) | 3 | |
| **RENIN-ANGIOTEN.-ALDOST. SYS. INHIB, MISC - Drugs for the Heart** | | |
| ENTRESTO ORAL TABLET 24-26 MG, 49-51 MG, 97-103 MG (***sacubitril-valsartan***) | 3 | PA; SL (2 tablets per day.) |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| **THIAZIDE DIURETICS(HYPOTENSIVE AGENTS) - Drugs for High Blood Pressure & Angina** | | |
| ACCURETIC ORAL TABLET 10-12.5 MG, 20-12.5 MG, 20-25 MG (***quinapril-hydrochlorothiazide***) | 3 | |
| ALDACTAZIDE ORAL TABLET 25-25 MG (***spironolactone-hctz***) | 3 | |
| ALDACTAZIDE ORAL TABLET 50-50 MG (***spironolactone-hctz***) | 2 | |
| ***amiloride-hydrochlorothiazide oral tablet 5-50 mg*** | 1 | |
| ATACAND HCT ORAL TABLET 16-12.5 MG, 32-12.5 MG, 32-25 MG (***candesartan cilexetil-hctz***) | 3 | |
| AVALIDE ORAL TABLET 150-12.5 MG, 300-12.5 MG (***irbesartan-hydrochlorothiazide***) | 3 | |
| ***benazepril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg, 5-6.25 mg*** | 1 | |
| ***bisoprolol-hydrochlorothiazide oral tablet 10-6.25 mg, 2.5-6.25 mg, 5-6.25 mg*** | 1 | |
| ***candesartan cilexetil-hctz oral tablet 16-12.5 mg, 32-12.5 mg, 32-25 mg*** | 3 | |
| ***captopril-hydrochlorothiazide oral tablet 25-15 mg, 25-25 mg, 50-15 mg, 50-25 mg*** | 1 | |
| DIURIL ORAL SUSPENSION 250 MG/5ML (***chlorothiazide***) | 2 | |
| DYAZIDE ORAL CAPSULE 37.5-25 MG (***triamterene-hctz***) | 3 | |
| ***enalapril-hydrochlorothiazide oral tablet 10-25 mg, 5-12.5 mg*** | 1 | |
| ***fosinopril sodium-hctz oral tablet 10-12.5 mg, 20-12.5 mg*** | 1 | |
| ***hydrochlorothiazide oral capsule 12.5 mg*** | 1 | |
| ***hydrochlorothiazide oral tablet 12.5 mg, 25 mg, 50 mg*** | 1 | |
| HYZAAR ORAL TABLET 100-12.5 MG, 100-25 MG, 50-12.5 MG (***losartan potassium-hctz***) | 3 | |
| ***irbesartan-hydrochlorothiazide oral tablet 150-12.5 mg, 300-12.5 mg*** | 1 | |
| ***lisinopril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg*** | 1 | |
| LOPRESSOR HCT ORAL TABLET 50-25 MG (***metoprolol-hydrochlorothiazide***) | 3 | |
| ***losartan potassium-hctz oral tablet 100-12.5 mg, 100-25 mg, 50-12.5 mg*** | 1 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| LOTENSIN HCT ORAL TABLET 10-12.5 MG, 20-12.5 MG, 20-25 MG (***benazepril-hydrochlorothiazide***) | 3 | |
| MAXZIDE ORAL TABLET 75-50 MG (***triamterene-hctz***) | 3 | |
| MAXZIDE-25 ORAL TABLET 37.5-25 MG (***triamterene-hctz***) | 3 | |
| ***methyldopa-hydrochlorothiazide oral tablet 250-15 mg, 250-25 mg*** | 1 | |
| ***metoprolol-hydrochlorothiazide oral tablet 100-25 mg, 100-50 mg, 50-25 mg*** | 1 | |
| ***olmesartan medoxomil-hctz oral tablet 20-12.5 mg, 40-12.5 mg, 40-25 mg*** | 2 | |
| ***propranolol-hctz oral tablet 40-25 mg, 80-25 mg*** | 1 | |
| ***quinapril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg*** | 2 | |
| ***spironolactone-hctz oral tablet 25-25 mg*** | 1 | |
| TEKTURNA HCT ORAL TABLET 150-12.5 MG, 150-25 MG, 300-12.5 MG, 300-25 MG (***aliskiren-hydrochlorothiazide***) | 3 | |
| ***telmisartan-hctz oral tablet 40-12.5 mg, 80-12.5 mg, 80-25 mg*** | 2 | |
| ***triamterene-hctz oral capsule 37.5-25 mg*** | 1 | |
| ***triamterene-hctz oral tablet 37.5-25 mg, 75-50 mg*** | 1 | |
| ***valsartan-hydrochlorothiazide oral tablet 160-12.5 mg, 160-25 mg, 320-12.5 mg, 320-25 mg, 80-12.5 mg*** | 1 | |
| ZIAC ORAL TABLET 10-6.25 MG, 2.5-6.25 MG, 5-6.25 MG (***bisoprolol-hydrochlorothiazide***) | 3 | |
| **THIAZIDE-LIKE DIURETICS(HYPOTENSIVE AGT) - Drugs for High Blood Pressure & Angina** | | |
| ***atenolol-chlorthalidone oral tablet 100-25 mg, 50-25 mg*** | 1 | |
| ***chlorthalidone oral tablet 25 mg, 50 mg*** | 1 | |
| EDARBYCLOR ORAL TABLET 40-12.5 MG, 40-25 MG (***azilsartan-chlorthalidone***) | 3 | |
| ***indapamide oral tablet 1.25 mg, 2.5 mg*** | 1 | |
| ***metolazone oral tablet 10 mg, 2.5 mg, 5 mg*** | 1 | |
| **VASODILATING AGENTS, MISCELLANEOUS - Drugs for the Heart** | | |
| ADALAT CC ORAL TABLET EXTENDED RELEASE 24 HOUR 60 MG (***nifedipine***) | 3 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ADEMPAS ORAL TABLET 0.5 MG, 1 MG, 1.5 MG, 2 MG, 2.5 MG (***riociguat***) | 2 | PA; SL (3 tablets per day.); SP |
| AGGRENOX ORAL CAPSULE EXTENDED RELEASE 12 HOUR 25-200 MG (***aspirin-dipyridamole***) | 3 | |
| ***ambrisentan oral tablet 10 mg, 5 mg*** | 2 | PA; SL (1 tablet per day.); SP |
| ***amlodipine besylate oral tablet 10 mg, 2.5 mg, 5 mg*** | 1 | |
| ***amlodipine besylate-benazepril hcl oral capsule 10-20 mg, 10-40 mg, 2.5-10 mg, 5-10 mg, 5-20 mg, 5-40 mg*** | 1 | |
| ***amlodipine besylate-valsartan oral tablet 10-160 mg, 10-320 mg, 5-160 mg, 5-320 mg*** | 2 | |
| ***aspirin-dipyridamole er oral capsule extended release 12 hour 25-200 mg*** | 3 | |
| ***bosentan oral tablet 125 mg, 62.5 mg*** | 2 | PA; SL (2 tablets per day.); SP |
| CALAN SR ORAL TABLET EXTENDED RELEASE 120 MG, 180 MG, 240 MG (***verapamil hcl***) | 3 | |
| ***diltiazem hcl coated beads*** (Cartia Xt Oral Capsule Extended Release 24 Hour 120 Mg, 180 Mg, 240 Mg, 300 Mg) | 2 | |
| CAVERJECT IMPULSE INTRACAVERNOSAL KIT 10 MCG, 20 MCG (***alprostadil (vasodilator)***) | 3 | M; SL (6 units per month) |
| CAVERJECT INTRACAVERNOSAL SOLUTION RECONSTITUTED 40 MCG (***alprostadil (vasodilator)***) | 3 | M; SL (6 units per month) |
| ***diltiazem hcl er beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg*** | 2 | |
| ***diltiazem hcl er coated beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg*** | 2 | |
| ***diltiazem hcl er coated beads oral tablet extended release 24 hour 180 mg, 240 mg, 300 mg, 360 mg, 420 mg*** | 2 | |
| ***diltiazem hcl er oral capsule extended release 12 hour 120 mg, 60 mg, 90 mg*** | 1 | |
| ***diltiazem hcl er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg*** | 1 | |
| ***diltiazem hcl oral tablet 120 mg, 30 mg, 60 mg, 90 mg*** | 1 | |
| ***dilt-xr oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg*** | 1 | |
| ***dipyridamole oral tablet 25 mg, 50 mg, 75 mg*** | 1 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| EDEX INTRACAVERNOSAL KIT 10 MCG, 20 MCG, 40 MCG (***alprostadil (vasodilator)***) | 3 | M; SL (6 units per month) |
| ***felodipine er oral tablet extended release 24 hour 10 mg, 2.5 mg, 5 mg*** | 1 | |
| ***isoxsuprine hcl oral tablet 10 mg, 20 mg*** | 1 | |
| ***isradipine oral capsule 2.5 mg, 5 mg*** | 1 | |
| KATERZIA ORAL SUSPENSION 1 MG/ML (***amlodipine benzoate***) | 3 | PA |
| LETAIRIS ORAL TABLET 10 MG, 5 MG (***ambrisentan***) | 3 | PA; SL (1 tablet per day.); SP |
| LOTREL ORAL CAPSULE 10-20 MG, 10-40 MG, 5-10 MG, 5-20 MG (***amlodipine besy-benazepril hcl***) | 3 | |
| ***diltiazem hcl coated beads*** (Matzim La Oral Tablet Extended Release 24 Hour 180 Mg, 240 Mg, 300 Mg, 360 Mg, 420 Mg) | 2 | |
| MUSE URETHRAL PELLET 1000 MCG, 125 MCG, 250 MCG, 500 MCG (***alprostadil (vasodilator)***) | 3 | SL (6 units per month) |
| ***nicardipine hcl oral capsule 20 mg, 30 mg*** | 1 | |
| ***nifedipine er oral tablet extended release 24 hour 30 mg, 60 mg, 90 mg*** | 1 | |
| ***nifedipine er osmotic release oral tablet extended release 24 hour 30 mg, 60 mg, 90 mg*** | 1 | |
| ***nifedipine oral capsule 10 mg, 20 mg*** | 1 | |
| ***nimodipine oral capsule 30 mg*** | 1 | |
| ***nisoldipine er oral tablet extended release 24 hour 17 mg, 20 mg, 25.5 mg, 30 mg, 34 mg, 40 mg, 8.5 mg*** | 2 | |
| NYMALIZE ORAL SOLUTION 6 MG/ML (***nimodipine***) | 2 | |
| OPSUMIT ORAL TABLET 10 MG (***macitentan***) | 2 | PA; SL (1 tablet per day.); SP |
| ORENITRAM ORAL TABLET EXTENDED RELEASE 0.125 MG, 0.25 MG, 1 MG, 2.5 MG, 5 MG (***treprostinil diolamine***) | 3 | PA; SL (6 tablets per day.); SP |
| PROCARDIA ORAL CAPSULE 10 MG (***nifedipine***) | 3 | |
| PROCARDIA XL ORAL TABLET EXTENDED RELEASE 24 HOUR 30 MG, 60 MG, 90 MG (***nifedipine***) | 3 | |
| SULAR ORAL TABLET EXTENDED RELEASE 24 HOUR 17 MG, 34 MG, 8.5 MG (***nisoldipine***) | 3 | |
| TARKA ORAL TABLET EXTENDED RELEASE 2-180 MG, 2-240 MG, 4-240 MG (***trandolapril-verapamil hcl***) | 3 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ***diltiazem hcl er beads*** (Taztia Xt Oral Capsule Extended Release 24 Hour 120 Mg, 180 Mg, 240 Mg, 300 Mg, 360 Mg) | 2 | |
| ***diltiazem hcl er beads*** (Tiadylt Er Oral Capsule Extended Release 24 Hour 120 Mg, 180 Mg, 240 Mg, 300 Mg, 360 Mg, 420 Mg) | 2 | |
| TIAZAC ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 180 MG, 240 MG, 300 MG, 360 MG, 420 MG (***diltiazem hcl er beads***) | 3 | |
| TRACLEER ORAL TABLET 125 MG, 62.5 MG (***bosentan***) | 2 | PA; SL (2 tablets per day.); SP |
| TRACLEER ORAL TABLET SOLUBLE 32 MG (***bosentan***) | 2 | PA; SL (4 tablets per day); SP |
| ***trandolapril-verapamil hcl er oral tablet extended release 1-240 mg, 2-180 mg, 2-240 mg, 4-240 mg*** | 3 | |
| TYVASO INHALATION SOLUTION 0.6 MG/ML (***treprostinil***) | 2 | PA |
| TYVASO REFILL INHALATION SOLUTION 0.6 MG/ML (***treprostinil***) | 2 | PA |
| TYVASO STARTER INHALATION SOLUTION 0.6 MG/ML (***treprostinil***) | 2 | PA |
| UPTRAVI ORAL TABLET 1000 MCG, 1200 MCG, 1400 MCG, 1600 MCG, 200 MCG, 400 MCG, 600 MCG, 800 MCG (***selexipag***) | 3 | PA; SL (2 tablets per day.); SP |
| UPTRAVI ORAL TABLET THERAPY PACK 200 & 800 MCG (***selexipag***) | 3 | PA; SL (200 tablets per year.); SP |
| VENTAVIS INHALATION SOLUTION 10 MCG/ML, 20 MCG/ML (***iloprost***) | 2 | PA; SP |
| ***verapamil hcl er oral capsule extended release 24 hour 100 mg, 200 mg, 300 mg*** | 3 | |
| ***verapamil hcl er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 360 mg*** | 1 | |
| ***verapamil hcl er oral tablet extended release 120 mg, 180 mg, 240 mg*** | 1 | |
| ***verapamil hcl oral tablet 120 mg, 40 mg, 80 mg*** | 1 | |
| VERELAN ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 180 MG, 240 MG, 360 MG (***verapamil hcl***) | 3 | |
| VERELAN PM ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 300 MG (***verapamil hcl***) | 3 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| **CENTRAL NERVOUS SYSTEM AGENTS - Drugs for the Nervous System** | | |
| **ADAMANTANES (CNS) - Drugs for Parkinson** | | |
| ***amantadine hcl oral capsule 100 mg*** | 1 | |
| ***amantadine hcl oral syrup 50 mg/5ml*** | 1 | |
| ***amantadine hcl oral tablet 100 mg*** | 1 | |
| OSMOLEX ER ORAL TABLET ER 24 HOUR THERAPY PACK 129 & 193 MG (***amantadine hcl***) | 3 | |
| **AMPHETAMINE DERIVATIVES - Drugs for the Nervous System** | | |
| ADIPEX-P ORAL CAPSULE 37.5 MG (***phentermine hcl***) | 3 | PA |
| ADIPEX-P ORAL TABLET 37.5 MG (***phentermine hcl***) | 3 | PA |
| ***diethylpropion hcl er oral tablet extended release 24 hour 75 mg*** | 1 | PA |
| ***diethylpropion hcl oral tablet 25 mg*** | 1 | PA |
| LOMAIRA ORAL TABLET 8 MG (***phentermine hcl***) | 3 | PA |
| ***phendimetrazine tartrate er oral capsule extended release 24 hour 105 mg*** | 1 | PA |
| ***phendimetrazine tartrate oral tablet 35 mg*** | 1 | PA |
| ***phentermine hcl oral capsule 15 mg, 30 mg, 37.5 mg*** | 1 | PA |
| ***phentermine hcl oral tablet 37.5 mg*** | 1 | PA |
| QSYMIA ORAL CAPSULE EXTENDED RELEASE 24 HOUR 11.25-69 MG, 15-92 MG, 3.75-23 MG, 7.5-46 MG (***phentermine-topiramate***) | 3 | PA |
| **AMPHETAMINES - Drugs for the Nervous System** | | |
| ADDERALL XR ORAL CAPSULE EXTENDED RELEASE 24 HOUR 10 MG, 15 MG, 20 MG, 25 MG, 30 MG, 5 MG (***amphetamine-dextroamphetamine***) | 2 | SL (1 capsule per day.) |
| AMPHETAMINE ER ORAL SUSPENSION EXTENDED RELEASE 1.25 MG/ML | 3 | PA; SL (15 ml per day.) |
| ***amphetamine-dextroamphetamine er oral capsule extended release 24 hour 10 mg, 15 mg, 20 mg, 25 mg, 30 mg, 5 mg*** | 3 | SL (1 capsule per day.) |
| ***amphetamine-dextroamphetamine oral tablet 10 mg, 12.5 mg, 15 mg, 20 mg, 30 mg, 5 mg, 7.5 mg*** | 1 | PA |
| ***benzphetamine hcl oral tablet 25 mg, 50 mg*** | 1 | PA |
| DESOXYN ORAL TABLET 5 MG (***methamphetamine hcl***) | 3 | PA |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ***dextroamphetamine sulfate er oral capsule extended release 24 hour 10 mg, 15 mg, 5 mg*** | 3 | PA |
| ***dextroamphetamine sulfate oral solution 5 mg/5ml*** | 1 | PA |
| ***dextroamphetamine sulfate oral tablet 10 mg, 5 mg*** | 3 | PA |
| ***methamphetamine hcl oral tablet 5 mg*** | 1 | PA |
| ***dextroamphetamine sulfate*** (Procentra Oral Solution 5 Mg/5Ml) | 3 | PA |
| VYVANSE ORAL CAPSULE 10 MG, 20 MG (***lisdexamfetamine dimesylate***) | 3 | PA; SL (1 capsule per day.) |
| VYVANSE ORAL CAPSULE 30 MG, 40 MG, 50 MG, 60 MG, 70 MG (***lisdexamfetamine dimesylate***) | 3 | PA; SL (1 capsule per day) |
| VYVANSE ORAL TABLET CHEWABLE 10 MG, 20 MG, 30 MG, 40 MG, 50 MG, 60 MG (***lisdexamfetamine dimesylate***) | 3 | PA; SL (1 tablet per day.) |
| **ANALGESICS AND ANTIPYRETICS, MISC. - Drugs for Pain** | | |
| ***acetaminophen-codeine #2 oral tablet 300-15 mg*** | 1 | |
| ***acetaminophen-codeine #3 oral tablet 300-30 mg*** | 1 | |
| ***acetaminophen-codeine #4 oral tablet 300-60 mg*** | 1 | |
| ***acetaminophen-codeine oral solution 120-12 mg/5ml*** | 1 | |
| ***acetaminophen-codeine oral tablet 300-15 mg, 300-30 mg, 300-60 mg*** | 1 | |
| ***apap-caff-dihydrocodeine oral capsule 320.5-30-16 mg*** | 3 | SL (40 capsules per prescription) |
| ***apap-caff-dihydrocodeine oral tablet 325-30-16 mg*** | 1 | SL (40 tablets per prescription) |
| BENZHYDROCODONE-ACETAMINOPHEN ORAL TABLET 4.08-325 MG, 6.12-325 MG, 8.16-325 MG | 3 | |
| ***butalbital-acetaminophen*** (Bupap Oral Tablet 50-300 Mg) | 4 | |
| ***butalbital-acetaminophen oral tablet 50-300 mg*** | 3 | |
| ***butalbital-acetaminophen oral tablet 50-325 mg*** | 1 | |
| ***butalbital-apap-caff-cod oral capsule 50-325-40-30 mg*** | 1 | SL (6 capsules per day.) |
| ***butalbital-apap-caffeine oral capsule 50-300-40 mg*** | 3 | SL (6 capsules per day.) |
| ***butalbital-apap-caffeine oral capsule 50-325-40 mg*** | 1 | SL (6 capsules per day) |
| ***butalbital-apap-caffeine oral tablet 50-325-40 mg*** | 1 | SL (6 tablets per day) |
| ***duraxin oral capsule 300-200-20 mg*** | 1 | |
| ***oxycodone-acetaminophen*** (Endocet Oral Tablet 10-325 Mg, 2.5-325 Mg, 5-325 Mg, 7.5-325 Mg) | 1 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ***butalbital-apap-caffeine*** (Esgic Oral Capsule 50-325-40 Mg) | 3 | SL (6 capsules per day) |
| ESGIC ORAL TABLET 50-325-40 MG (***butalbital-apap-caffeine***) | 3 | SL (6 tablets per day) |
| FIORICET ORAL CAPSULE 50-300-40 MG (***butalbital-apap-caffeine***) | 3 | SL (6 capsules per day.) |
| ***gabapentin oral capsule 100 mg, 300 mg, 400 mg*** | 1 | |
| ***gabapentin oral solution 250 mg/5ml*** | 1 | |
| ***gabapentin oral tablet 600 mg, 800 mg*** | 1 | |
| ***hydrocodone-acetaminophen oral solution 10-325 mg/15ml*** | 1 | |
| ***hydrocodone-acetaminophen oral solution 7.5-325 mg/15ml*** | 2 | |
| ***hydrocodone-acetaminophen oral tablet 10-325 mg, 5-325 mg, 7.5-325 mg*** | 1 | |
| LORTAB ORAL ELIXIR 10-300 MG/15ML (***hydrocodone-acetaminophen***) | 3 | |
| LYRICA ORAL CAPSULE 100 MG, 150 MG, 200 MG, 25 MG, 50 MG, 75 MG (***pregabalin***) | 3 | PA; ST; SL (93 capsules per 31 days.) |
| LYRICA ORAL CAPSULE 225 MG, 300 MG (***pregabalin***) | 3 | PA; ST; SL (62 capsules per 31 days.) |
| LYRICA ORAL SOLUTION 20 MG/ML (***pregabalin***) | 3 | PA; ST; SL (30.52 ml per day.) |
| NEURONTIN ORAL CAPSULE 100 MG, 300 MG, 400 MG (***gabapentin***) | 3 | PA; ST |
| NEURONTIN ORAL SOLUTION 250 MG/5ML (***gabapentin***) | 3 | PA; ST |
| NEURONTIN ORAL TABLET 600 MG, 800 MG (***gabapentin***) | 4 | PA; ST |
| NORCO ORAL TABLET 10-325 MG, 5-325 MG, 7.5-325 MG (***hydrocodone-acetaminophen***) | 3 | |
| ***oxycodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg*** | 1 | |
| ***pregabalin oral capsule 100 mg, 150 mg, 200 mg, 25 mg, 50 mg, 75 mg*** | 2 | SL (93 capsules per 31 days.) |
| ***pregabalin oral capsule 225 mg, 300 mg*** | 2 | SL (62 capsules per 31 days.) |
| ***pregabalin oral solution 20 mg/ml*** | 3 | SL (30.52 ml per day.) |
| ***tencon oral tablet 50-325 mg*** | 1 | |
| ***tramadol-acetaminophen oral tablet 37.5-325 mg*** | 1 | SL (40 tablets per prescription) |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| TREZIX ORAL CAPSULE 320.5-30-16 MG (***apap-caff-dihydrocodeine***) | 3 | SL (40 capsules per prescription) |
| ULTRACET ORAL TABLET 37.5-325 MG (***tramadol-acetaminophen***) | 3 | SL (40 tablets per prescription) |
| ***butalbital-apap-caffeine*** (Vanatol Lq Oral Solution 50-325-40 Mg/15Ml) | 2 | PA; SL (180 ml per prescription) |
| ***butalbital-apap-caffeine*** (Vanatol S Oral Solution 50-325-40 Mg/15Ml) | 2 | PA; SL (180 ml per prescription) |
| ***butalbital-apap-caffeine*** (Vtol Lq Oral Solution 50-325-40 Mg/15Ml) | 2 | PA; SL (180 ml per prescription) |
| ***butalbital-apap-caffeine*** (Zebutal Oral Capsule 50-325-40 Mg) | 3 | SL (6 capsules per day) |
| **ANOREXIGENIC AGENTS, MISCELLANEOUS - Drugs for the Nervous System** | | |
| CONTRAVE ORAL TABLET EXTENDED RELEASE 12 HOUR 8-90 MG (***naltrexone-bupropion hcl***) | 3 | PA |
| **ANTICHOLINERGIC AGENTS (CNS) - Drugs for Parkinson** | | |
| ***benztropine mesylate oral tablet 0.5 mg, 1 mg, 2 mg*** | 1 | |
| ***trihexyphenidyl hcl oral solution 0.4 mg/ml*** | 1 | |
| ***trihexyphenidyl hcl oral tablet 2 mg, 5 mg*** | 1 | |
| **ANTICONVULSANTS, MISCELLANEOUS - Drugs for Seizures** | | |
| APTIOM ORAL TABLET 200 MG, 400 MG, 600 MG, 800 MG (***eslicarbazepine acetate***) | 3 | PA |
| BANZEL ORAL SUSPENSION 40 MG/ML (***rufinamide***) | 3 | |
| BANZEL ORAL TABLET 200 MG, 400 MG (***rufinamide***) | 3 | PA |
| BRIVIACT ORAL SOLUTION 10 MG/ML (***brivaracetam***) | 3 | PA |
| BRIVIACT ORAL TABLET 10 MG, 100 MG, 25 MG, 50 MG, 75 MG (***brivaracetam***) | 3 | PA |
| ***carbamazepine er oral capsule extended release 12 hour 100 mg, 200 mg, 300 mg*** | 2 | |
| ***carbamazepine er oral tablet extended release 12 hour 100 mg, 200 mg, 400 mg*** | 3 | |
| ***carbamazepine oral suspension 100 mg/5ml*** | 1 | |
| ***carbamazepine oral tablet 200 mg*** | 1 | |
| ***carbamazepine oral tablet chewable 100 mg*** | 1 | |
| CARBATROL ORAL CAPSULE EXTENDED RELEASE 12 HOUR 100 MG, 200 MG, 300 MG (***carbamazepine***) | 3 | |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| DEPAKOTE ER ORAL TABLET EXTENDED RELEASE 24 HOUR 250 MG, 500 MG (***divalproex sodium***) | 3 | PA; ST |
| DEPAKOTE ORAL TABLET DELAYED RELEASE 125 MG, 250 MG, 500 MG (***divalproex sodium***) | 3 | PA |
| DEPAKOTE SPRINKLES ORAL CAPSULE DELAYED RELEASE SPRINKLE 125 MG (***divalproex sodium***) | 3 | PA; ST |
| DIACOMIT ORAL CAPSULE 250 MG, 500 MG (***stiripentol***) | 3 | PA; SP |
| DIACOMIT ORAL PACKET 250 MG, 500 MG (***stiripentol***) | 3 | PA; SP |
| ***divalproex sodium er oral tablet extended release 24 hour 250 mg, 500 mg*** | 2 | |
| ***divalproex sodium oral capsule delayed release sprinkle 125 mg*** | 2 | |
| ***divalproex sodium oral tablet delayed release 125 mg, 250 mg, 500 mg*** | 1 | |
| EPIDIOLEX ORAL SOLUTION 100 MG/ML (***cannabidiol***) | 3 | PA; SP |
| ***carbamazepine*** (Epitol Oral Tablet 200 Mg) | 1 | |
| EQUETRO ORAL CAPSULE EXTENDED RELEASE 12 HOUR 100 MG, 200 MG, 300 MG (***carbamazepine (antipsychotic)***) | 3 | |
| ***felbamate oral suspension 600 mg/5ml*** | 1 | |
| ***felbamate oral tablet 400 mg, 600 mg*** | 1 | |
| FELBATOL ORAL SUSPENSION 600 MG/5ML (***felbamate***) | 3 | PA; ST |
| FELBATOL ORAL TABLET 400 MG, 600 MG (***felbamate***) | 3 | PA; ST |
| FYCOMPA ORAL SUSPENSION 0.5 MG/ML (***perampanel***) | 3 | PA |
| FYCOMPA ORAL TABLET 10 MG, 12 MG, 2 MG, 4 MG, 6 MG, 8 MG (***perampanel***) | 3 | PA |
| ***gabapentin oral capsule 100 mg, 300 mg, 400 mg*** | 1 | |
| ***gabapentin oral solution 250 mg/5ml*** | 1 | |
| ***gabapentin oral tablet 600 mg, 800 mg*** | 1 | |
| GABITRIL ORAL TABLET 12 MG, 16 MG, 2 MG, 4 MG (***tiagabine hcl***) | 3 | |
| KEPPRA ORAL SOLUTION 100 MG/ML (***levetiracetam***) | 4 | PA; ST |
| KEPPRA ORAL TABLET 1000 MG, 250 MG, 500 MG, 750 MG (***levetiracetam***) | 3 | PA; ST |
| KEPPRA XR ORAL TABLET EXTENDED RELEASE 24 HOUR 500 MG, 750 MG (***levetiracetam***) | 4 | PA; ST |
| LAMICTAL ODT ORAL KIT 21 X 25 MG & 7 X 50 MG, 25 & 50 & 100 MG, 42 X 50 MG & 14X100 MG (***lamotrigine***) | 3 | PA; ST |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| LAMICTAL ODT ORAL TABLET DISPERSIBLE 100 MG, 200 MG, 25 MG, 50 MG (***lamotrigine***) | 4 | PA; ST |
| LAMICTAL ORAL TABLET 100 MG, 150 MG, 200 MG, 25 MG (***lamotrigine***) | 4 | PA; ST |
| LAMICTAL ORAL TABLET CHEWABLE 25 MG, 5 MG (***lamotrigine***) | 4 | PA; ST |
| LAMICTAL STARTER ORAL KIT 35 X 25 MG, 42 X 25 MG & 7 X 100 MG, 84 X 25 MG & 14X100 MG (***lamotrigine***) | 4 | PA; ST |
| LAMICTAL XR ORAL KIT 21 X 25 MG & 7 X 50 MG, 25 & 50 & 100 MG, 50 & 100 & 200 MG (***lamotrigine***) | 3 | PA; ST |
| LAMICTAL XR ORAL TABLET EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 25 MG, 250 MG, 300 MG, 50 MG (***lamotrigine***) | 3 | PA; ST |
| ***lamotrigine er oral tablet extended release 24 hour 100 mg, 200 mg, 25 mg, 250 mg, 300 mg, 50 mg*** | 3 | PA; ST |
| ***lamotrigine oral kit 25 & 50 & 100 mg*** | 3 | PA; ST |
| ***lamotrigine oral tablet 100 mg, 150 mg, 200 mg, 25 mg*** | 1 | |
| ***lamotrigine oral tablet chewable 25 mg, 5 mg*** | 1 | |
| ***lamotrigine oral tablet dispersible 100 mg, 200 mg, 25 mg, 50 mg*** | 3 | PA; ST |
| ***lamotrigine starter kit-blue oral kit 35 x 25 mg*** | 1 | |
| ***lamotrigine starter kit-green oral kit 84 x 25 mg & 14x100 mg*** | 1 | |
| ***lamotrigine starter kit-orange oral kit 42 x 25 mg & 7 x 100 mg*** | 1 | |
| ***levetiracetam er oral tablet extended release 24 hour 500 mg, 750 mg*** | 2 | |
| ***levetiracetam oral solution 100 mg/ml*** | 1 | |
| ***levetiracetam oral tablet 1000 mg, 250 mg, 500 mg, 750 mg*** | 1 | |
| LYRICA ORAL CAPSULE 100 MG, 150 MG, 200 MG, 25 MG, 50 MG, 75 MG (***pregabalin***) | 3 | PA; ST; SL (93 capsules per 31 days.) |
| LYRICA ORAL CAPSULE 225 MG, 300 MG (***pregabalin***) | 3 | PA; ST; SL (62 capsules per 31 days.) |
| LYRICA ORAL SOLUTION 20 MG/ML (***pregabalin***) | 3 | PA; ST; SL (30.52 ml per day.) |
| NEURONTIN ORAL CAPSULE 100 MG, 300 MG, 400 MG (***gabapentin***) | 3 | PA; ST |
| NEURONTIN ORAL SOLUTION 250 MG/5ML (***gabapentin***) | 3 | PA; ST |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| NEURONTIN ORAL TABLET 600 MG, 800 MG (***gabapentin***) | 4 | PA; ST |
| ***oxcarbazepine oral suspension 300 mg/5ml*** | 1 | |
| ***oxcarbazepine oral tablet 150 mg, 300 mg, 600 mg*** | 1 | |
| ***pregabalin oral capsule 100 mg, 150 mg, 200 mg, 25 mg, 50 mg, 75 mg*** | 2 | SL (93 capsules per 31 days.) |
| ***pregabalin oral capsule 225 mg, 300 mg*** | 2 | SL (62 capsules per 31 days.) |
| ***pregabalin oral solution 20 mg/ml*** | 3 | SL (30.52 ml per day.) |
| QSYMIA ORAL CAPSULE EXTENDED RELEASE 24 HOUR 11.25-69 MG, 15-92 MG, 3.75-23 MG, 7.5-46 MG (***phentermine-topiramate***) | 3 | PA |
| ***levetiracetam*** (Roweepra Oral Tablet 1000 Mg, 500 Mg, 750 Mg) | 1 | |
| ***levetiracetam*** (Roweepra Xr Oral Tablet Extended Release 24 Hour 500 Mg, 750 Mg) | 2 | |
| SABRIL ORAL TABLET 500 MG (***vigabatrin***) | 3 | PA; SL (6 tablets per day.); SP |
| ***lamotrigine*** (Subvenite Oral Tablet 100 Mg, 150 Mg, 200 Mg, 25 Mg) | 1 | |
| ***lamotrigine*** (Subvenite Starter Kit-Blue Oral Kit 35 X 25 Mg) | 1 | |
| ***lamotrigine*** (Subvenite Starter Kit-Green Oral Kit 84 X 25 Mg & 14X100 Mg) | 1 | |
| ***lamotrigine*** (Subvenite Starter Kit-Orange Oral Kit 42 X 25 Mg & 7 X 100 Mg) | 1 | |
| TEGRETOL ORAL SUSPENSION 100 MG/5ML (***carbamazepine***) | 3 | |
| TEGRETOL ORAL TABLET 200 MG (***carbamazepine***) | 3 | |
| TEGRETOL-XR ORAL TABLET EXTENDED RELEASE 12 HOUR 100 MG, 200 MG, 400 MG (***carbamazepine***) | 3 | |
| ***tiagabine hcl oral tablet 12 mg, 16 mg, 2 mg, 4 mg*** | 1 | |
| TOPAMAX ORAL TABLET 100 MG, 200 MG, 25 MG, 50 MG (***topiramate***) | 3 | PA; ST |
| TOPAMAX SPRINKLE ORAL CAPSULE SPRINKLE 15 MG, 25 MG (***topiramate***) | 3 | PA; ST |
| ***topiramate oral capsule sprinkle 15 mg, 25 mg*** | 1 | |
| ***topiramate oral tablet 100 mg, 200 mg, 25 mg, 50 mg*** | 1 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| TRILEPTAL ORAL SUSPENSION 300 MG/5ML (***oxcarbazepine***) | 3 | PA; ST |
| TRILEPTAL ORAL TABLET 150 MG, 300 MG, 600 MG (***oxcarbazepine***) | 3 | PA; ST |
| ***valproic acid oral capsule 250 mg*** | 1 | |
| ***valproic acid oral solution 250 mg/5ml*** | 1 | |
| ***vigabatrin oral packet 500 mg*** | 2 | PA; SL (6 packets per day.) |
| ***vigabatrin oral tablet 500 mg*** | 2 | PA; SL (6 tablets per day.); SP |
| ***vigabatrin*** (Vigadrone Oral Packet 500 Mg) | 2 | PA; SL (6 packets per day.) |
| VIMPAT ORAL SOLUTION 10 MG/ML (***lacosamide***) | 3 | PA |
| VIMPAT ORAL TABLET 100 MG, 150 MG, 200 MG, 50 MG (***lacosamide***) | 3 | PA |
| XCOPRI (250 MG DAILY DOSE) ORAL TABLET THERAPY PACK 50 & 200 MG (***cenobamate***) | 3 | PA |
| XCOPRI (350 MG DAILY DOSE) ORAL TABLET THERAPY PACK 150 & 200 MG (***cenobamate***) | 3 | PA |
| XCOPRI ORAL TABLET 100 MG, 150 MG, 200 MG, 50 MG (***cenobamate***) | 3 | PA |
| XCOPRI ORAL TABLET THERAPY PACK 14 X 12.5 MG & 14 X 25 MG, 14 X 150 MG & 14 X200 MG, 14 X 50 MG & 14 X100 MG (***cenobamate***) | 3 | PA |
| ZONEGRAN ORAL CAPSULE 100 MG, 25 MG (***zonisamide***) | 4 | PA; ST |
| ***zonisamide oral capsule 100 mg, 25 mg, 50 mg*** | 1 | |
| **ANTIDEPRESSANTS, MISCELLANEOUS - Drugs for Depression & Psychosis** | | |
| ***bupropion hcl er (smoking det) oral tablet extended release 12 hour 150 mg*** | 1 | H |
| ***bupropion hcl er (sr) oral tablet extended release 12 hour 100 mg, 150 mg, 200 mg*** | 1 | |
| ***bupropion hcl er (xl) oral tablet extended release 24 hour 150 mg, 300 mg*** | 1 | |
| ***bupropion hcl oral tablet 100 mg, 75 mg*** | 1 | |
| ***mirtazapine oral tablet 15 mg, 30 mg, 45 mg, 7.5 mg*** | 1 | |
| ***mirtazapine oral tablet dispersible 15 mg, 30 mg, 45 mg*** | 1 | |
| REMERON ORAL TABLET 15 MG, 30 MG (***mirtazapine***) | 3 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| REMERON SOLTAB ORAL TABLET DISPERSIBLE 15 MG, 30 MG, 45 MG (***mirtazapine***) | 3 | |
| SPRAVATO (56 MG DOSE) NASAL SOLUTION THERAPY PACK 28 MG/DEVICE (***esketamine hcl***) | 3 | PA; SL (8 devices (4 kits) per month.) |
| SPRAVATO (84 MG DOSE) NASAL SOLUTION THERAPY PACK 28 MG/DEVICE (***esketamine hcl***) | 3 | PA; SL (12 devices (4 kits) per month.) |
| **ANTIMANIC AGENTS - Drugs for Personality Disorder** | | |
| ***aripiprazole oral solution 1 mg/ml*** | 3 | |
| ***aripiprazole oral tablet 10 mg, 15 mg, 20 mg, 30 mg*** | 2 | SL (1 tablet per day) |
| ***aripiprazole oral tablet 2 mg*** | 2 | SL (2 tablets per day.) |
| ***aripiprazole oral tablet 5 mg*** | 2 | SL (1.5 tablets per day.) |
| ***aripiprazole oral tablet dispersible 10 mg, 15 mg*** | 2 | SL (1 tablet per day.) |
| ***carbamazepine er oral capsule extended release 12 hour 100 mg, 200 mg, 300 mg*** | 2 | |
| ***carbamazepine er oral tablet extended release 12 hour 100 mg, 200 mg, 400 mg*** | 3 | |
| ***carbamazepine oral suspension 100 mg/5ml*** | 1 | |
| ***carbamazepine oral tablet 200 mg*** | 1 | |
| ***carbamazepine oral tablet chewable 100 mg*** | 1 | |
| CARBATROL ORAL CAPSULE EXTENDED RELEASE 12 HOUR 100 MG, 200 MG, 300 MG (***carbamazepine***) | 3 | |
| DEPAKOTE ER ORAL TABLET EXTENDED RELEASE 24 HOUR 250 MG, 500 MG (***divalproex sodium***) | 3 | PA; ST |
| DEPAKOTE ORAL TABLET DELAYED RELEASE 125 MG, 250 MG, 500 MG (***divalproex sodium***) | 3 | PA |
| DEPAKOTE SPRINKLES ORAL CAPSULE DELAYED RELEASE SPRINKLE 125 MG (***divalproex sodium***) | 3 | PA; ST |
| ***divalproex sodium er oral tablet extended release 24 hour 250 mg, 500 mg*** | 2 | |
| ***divalproex sodium oral capsule delayed release sprinkle 125 mg*** | 2 | |
| ***divalproex sodium oral tablet delayed release 125 mg, 250 mg, 500 mg*** | 1 | |
| ***carbamazepine*** (Epitol Oral Tablet 200 Mg) | 1 | |
| EQUETRO ORAL CAPSULE EXTENDED RELEASE 12 HOUR 100 MG, 200 MG, 300 MG (***carbamazepine (antipsychotic)***) | 3 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| LAMICTAL ODT ORAL KIT 21 X 25 MG & 7 X 50 MG, 25 & 50 & 100 MG, 42 X 50 MG & 14X100 MG (***lamotrigine***) | 3 | PA; ST |
| LAMICTAL ODT ORAL TABLET DISPERSIBLE 100 MG, 200 MG, 25 MG, 50 MG (***lamotrigine***) | 4 | PA; ST |
| LAMICTAL ORAL TABLET 100 MG, 150 MG, 200 MG, 25 MG (***lamotrigine***) | 4 | PA; ST |
| LAMICTAL ORAL TABLET CHEWABLE 25 MG, 5 MG (***lamotrigine***) | 4 | PA; ST |
| LAMICTAL STARTER ORAL KIT 35 X 25 MG, 42 X 25 MG & 7 X 100 MG, 84 X 25 MG & 14X100 MG (***lamotrigine***) | 4 | PA; ST |
| ***lamotrigine oral kit 25 & 50 & 100 mg*** | 3 | PA; ST |
| ***lamotrigine oral tablet 100 mg, 150 mg, 200 mg, 25 mg*** | 1 | |
| ***lamotrigine oral tablet chewable 25 mg, 5 mg*** | 1 | |
| ***lamotrigine oral tablet dispersible 100 mg, 200 mg, 25 mg, 50 mg*** | 3 | PA; ST |
| ***lamotrigine starter kit-blue oral kit 35 x 25 mg*** | 1 | |
| ***lamotrigine starter kit-green oral kit 84 x 25 mg & 14x100 mg*** | 1 | |
| ***lamotrigine starter kit-orange oral kit 42 x 25 mg & 7 x 100 mg*** | 1 | |
| ***lithium carbonate er oral tablet extended release 300 mg, 450 mg*** | 1 | |
| ***lithium carbonate oral capsule 150 mg, 300 mg, 600 mg*** | 1 | |
| ***lithium carbonate oral tablet 300 mg*** | 1 | |
| ***lithium oral solution 8 meq/5ml*** | 1 | |
| LITHOBID ORAL TABLET EXTENDED RELEASE 300 MG (***lithium carbonate***) | 3 | |
| ***olanzapine oral tablet 10 mg, 15 mg, 20 mg, 7.5 mg*** | 1 | SL (1 tablet per day) |
| ***olanzapine oral tablet 2.5 mg*** | 1 | SL (2 tablets per day.) |
| ***olanzapine oral tablet 5 mg*** | 1 | SL (3 tablets per day) |
| ***olanzapine oral tablet dispersible 10 mg, 15 mg, 20 mg*** | 2 | SL (1 tablet per day) |
| ***olanzapine oral tablet dispersible 5 mg*** | 2 | SL (3 tablets per day) |
| ***quetiapine fumarate er oral tablet extended release 24 hour 150 mg*** | 3 | SL (31 tablets per 31 days.) |
| ***quetiapine fumarate er oral tablet extended release 24 hour 200 mg*** | 3 | SL (1 tablet per day.) |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ***quetiapine fumarate er oral tablet extended release 24 hour 300 mg, 400 mg*** | 3 | SL (62 tablets per 31 days.) |
| ***quetiapine fumarate er oral tablet extended release 24 hour 50 mg*** | 3 | SL (13 tablets per year for initial fill 3 tablets per day for maintenance fill.) |
| ***quetiapine fumarate oral tablet 100 mg, 200 mg, 25 mg, 300 mg, 400 mg, 50 mg*** | 1 | |
| ***risperidone oral solution 1 mg/ml*** | 1 | |
| ***risperidone oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg*** | 1 | |
| ***risperidone oral tablet dispersible 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg*** | 1 | |
| SAPHRIS SUBLINGUAL TABLET SUBLINGUAL 10 MG, 5 MG (***asenapine maleate***) | 3 | SL (2 tablets per day) |
| SAPHRIS SUBLINGUAL TABLET SUBLINGUAL 2.5 MG (***asenapine maleate***) | 3 | SL (2 tablets per day.) |
| ***lamotrigine*** (Subvenite Oral Tablet 100 Mg, 150 Mg, 200 Mg, 25 Mg) | 1 | |
| ***lamotrigine*** (Subvenite Starter Kit-Blue Oral Kit 35 X 25 Mg) | 1 | |
| ***lamotrigine*** (Subvenite Starter Kit-Green Oral Kit 84 X 25 Mg & 14X100 Mg) | 1 | |
| ***lamotrigine*** (Subvenite Starter Kit-Orange Oral Kit 42 X 25 Mg & 7 X 100 Mg) | 1 | |
| TEGRETOL ORAL SUSPENSION 100 MG/5ML (***carbamazepine***) | 3 | |
| TEGRETOL ORAL TABLET 200 MG (***carbamazepine***) | 3 | |
| TEGRETOL-XR ORAL TABLET EXTENDED RELEASE 12 HOUR 100 MG, 200 MG, 400 MG (***carbamazepine***) | 3 | |
| ***valproic acid oral capsule 250 mg*** | 1 | |
| ***valproic acid oral solution 250 mg/5ml*** | 1 | |
| ***ziprasidone hcl oral capsule 20 mg, 40 mg, 60 mg, 80 mg*** | 2 | SL (62 capsules per 31 days.) |
| **ANTIMIGRAINE AGENTS, MISCELLANEOUS - Migraine Treatment** | | |
| AIMOVIG SUBCUTANEOUS SOLUTION AUTO-INJECTOR 140 MG/ML (***erenumab-aooe***) | 2 | PA; ST; M; SL (1 ml per 21 days.) |
| AIMOVIG SUBCUTANEOUS SOLUTION AUTO-INJECTOR 70 MG/ML (***erenumab-aooe***) | 2 | PA; ST; M; SL (1 ml per month.) |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ***butalbital-asa-caff-codeine*** (Ascomp-Codeine Oral Capsule 50-325-40-30 Mg) | 1 | |
| ***butalbital-apap-caff-cod oral capsule 50-325-40-30 mg*** | 1 | SL (6 capsules per day.) |
| ***butalbital-apap-caffeine oral capsule 50-300-40 mg*** | 3 | SL (6 capsules per day.) |
| ***butalbital-apap-caffeine oral capsule 50-325-40 mg*** | 1 | SL (6 capsules per day) |
| ***butalbital-apap-caffeine oral tablet 50-325-40 mg*** | 1 | SL (6 tablets per day) |
| ***butalbital-asa-caff-codeine oral capsule 50-325-40-30 mg*** | 1 | |
| ***butalbital-aspirin-caffeine oral capsule 50-325-40 mg*** | 1 | |
| ***butalbital-aspirin-caffeine oral tablet 50-325-40 mg*** | 1 | |
| CAFERGOT ORAL TABLET 1-100 MG (***ergotamine-caffeine***) | 3 | |
| DEPAKOTE ER ORAL TABLET EXTENDED RELEASE 24 HOUR 250 MG, 500 MG (***divalproex sodium***) | 3 | PA; ST |
| DEPAKOTE ORAL TABLET DELAYED RELEASE 125 MG, 250 MG, 500 MG (***divalproex sodium***) | 3 | PA |
| DEPAKOTE SPRINKLES ORAL CAPSULE DELAYED RELEASE SPRINKLE 125 MG (***divalproex sodium***) | 3 | PA; ST |
| ***dihydroergotamine mesylate injection solution 1 mg/ml*** | 1 | M |
| ***dihydroergotamine mesylate nasal solution 4 mg/ml*** | 3 | PA; SL (8 mL per prescription) |
| ***divalproex sodium er oral tablet extended release 24 hour 250 mg, 500 mg*** | 2 | |
| ***divalproex sodium oral capsule delayed release sprinkle 125 mg*** | 2 | |
| ***divalproex sodium oral tablet delayed release 125 mg, 250 mg, 500 mg*** | 1 | |
| EMGALITY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 120 MG/ML (***galcanezumab-gnlm***) | 2 | PA; ST; M; SL (0.04 ml per day.) |
| EMGALITY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 120 MG/ML (***galcanezumab-gnlm***) | 2 | PA; ST; M; SL (0.04 ml per day.) |
| ERGOMAR SUBLINGUAL TABLET SUBLINGUAL 2 MG (***ergotamine tartrate***) | 3 | PA; SL (5 tablets per prescription) |
| ***ergotamine-caffeine oral tablet 1-100 mg*** | 3 | |
| ***butalbital-apap-caffeine*** (Esgic Oral Capsule 50-325-40 Mg) | 3 | SL (6 capsules per day) |
| ESGIC ORAL TABLET 50-325-40 MG (***butalbital-apap-caffeine***) | 3 | SL (6 tablets per day) |
| FIORICET ORAL CAPSULE 50-300-40 MG (***butalbital-apap-caffeine***) | 3 | SL (6 capsules per day.) |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| FIORINAL ORAL CAPSULE 50-325-40 MG (***butalbital-aspirin-caffeine***) | 3 | |
| FIORINAL/CODEINE #3 ORAL CAPSULE 50-325-40-30 MG (***butalbital-asa-caff-codeine***) | 3 | |
| MIGERGOT RECTAL SUPPOSITORY 2-100 MG (***ergotamine-caffeine***) | 3 | |
| ***propranolol hcl er oral capsule extended release 24 hour 120 mg, 160 mg, 60 mg, 80 mg*** | 2 | |
| ***propranolol hcl oral solution 20 mg/5ml, 40 mg/5ml*** | 1 | |
| ***propranolol hcl oral tablet 10 mg, 20 mg, 40 mg, 60 mg, 80 mg*** | 1 | |
| ***timolol maleate oral tablet 10 mg, 20 mg, 5 mg*** | 1 | |
| ***tramadol-acetaminophen oral tablet 37.5-325 mg*** | 1 | SL (40 tablets per prescription) |
| ULTRACET ORAL TABLET 37.5-325 MG (***tramadol-acetaminophen***) | 3 | SL (40 tablets per prescription) |
| ***valproic acid oral capsule 250 mg*** | 1 | |
| ***valproic acid oral solution 250 mg/5ml*** | 1 | |
| ***butalbital-apap-caffeine*** (Vanatol Lq Oral Solution 50-325-40 Mg/15Ml) | 2 | PA; SL (180 ml per prescription) |
| ***butalbital-apap-caffeine*** (Vanatol S Oral Solution 50-325-40 Mg/15Ml) | 2 | PA; SL (180 ml per prescription) |
| ***butalbital-apap-caffeine*** (Vtol Lq Oral Solution 50-325-40 Mg/15Ml) | 2 | PA; SL (180 ml per prescription) |
| ***butalbital-apap-caffeine*** (Zebutal Oral Capsule 50-325-40 Mg) | 3 | SL (6 capsules per day) |
| **ANTIPSYCHOTICS, MISCELLANEOUS - Drugs for Depression & Psychosis** | | |
| ADASUVE INHALATION AEROSOL POWDER BREATH ACTIVATED 10 MG (***loxapine***) | 3 | |
| ***loxapine succinate oral capsule 10 mg, 25 mg, 5 mg, 50 mg*** | 1 | |
| ***molindone hcl oral tablet 10 mg, 25 mg, 5 mg*** | 3 | |
| ***pimozide oral tablet 1 mg, 2 mg*** | 2 | |
| **ANXIOLYTICS,SEDATIVES,AND HYPNOTICS,MISC - Drugs for Anxiety & Sleep Disorder** | | |
| BELSOMRA ORAL TABLET 10 MG, 15 MG, 20 MG, 5 MG (***suvorexant***) | 3 | ST; SL (1 tablet per day.) |
| ***buspirone hcl oral tablet 10 mg, 15 mg, 30 mg, 5 mg, 7.5 mg*** | 1 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ***eszopiclone oral tablet 1 mg, 2 mg, 3 mg*** | 2 | SL (1 tablet per day) |
| HETLIOZ ORAL CAPSULE 20 MG (***tasimelteon***) | 4 | PA; SL (1 capsule per day.); SP |
| ***hydroxyzine hcl oral syrup 10 mg/5ml*** | 1 | |
| ***hydroxyzine hcl oral tablet 10 mg, 25 mg, 50 mg*** | 1 | |
| ***hydroxyzine pamoate oral capsule 100 mg, 25 mg, 50 mg*** | 1 | |
| ***meprobamate oral tablet 200 mg, 400 mg*** | 1 | |
| ***promethazine hcl oral solution 6.25 mg/5ml*** | 1 | |
| ***promethazine hcl oral syrup 6.25 mg/5ml*** | 1 | |
| ***promethazine hcl oral tablet 12.5 mg, 25 mg, 50 mg*** | 1 | |
| ***promethazine hcl rectal suppository 12.5 mg, 25 mg*** | 1 | |
| ***promethazine hcl*** (Promethegan Rectal Suppository 12.5 Mg, 25 Mg) | 1 | |
| ***promethegan rectal suppository 50 mg*** | 1 | |
| ***ramelteon oral tablet 8 mg*** | 3 | ST; SL (1 tablet per day) |
| ROZEREM ORAL TABLET 8 MG (***ramelteon***) | 3 | ST; SL (1 tablet per day) |
| VISTARIL ORAL CAPSULE 25 MG, 50 MG (***hydroxyzine pamoate***) | 3 | |
| ***zaleplon oral capsule 10 mg, 5 mg*** | 1 | SL (1 tablet per day) |
| ***zolpidem tartrate er oral tablet extended release 12.5 mg, 6.25 mg*** | 3 | SL (31 tablets per month) |
| ***zolpidem tartrate oral tablet 10 mg, 5 mg*** | 1 | SL (1 tablet per day) |
| ZOLPIMIST ORAL SOLUTION 5 MG/ACT (***zolpidem tartrate***) | 3 | ST; SL (8 ml (1 canister) per month) |
| **ATYPICAL ANTIPSYCHOTICS - Drugs for Depression & Psychosis** | | |
| ***aripiprazole oral solution 1 mg/ml*** | 3 | |
| ***aripiprazole oral tablet 10 mg, 15 mg, 20 mg, 30 mg*** | 2 | SL (1 tablet per day) |
| ***aripiprazole oral tablet 2 mg*** | 2 | SL (2 tablets per day.) |
| ***aripiprazole oral tablet 5 mg*** | 2 | SL (1.5 tablets per day.) |
| ***aripiprazole oral tablet dispersible 10 mg, 15 mg*** | 2 | SL (1 tablet per day.) |
| CAPLYTA ORAL CAPSULE 42 MG (***lumateperone tosylate***) | 4 | PA; ST; SL (1 capsule per day.) |
| ***clozapine oral tablet 100 mg, 200 mg, 25 mg, 50 mg*** | 1 | |
| ***clozapine oral tablet dispersible 100 mg, 12.5 mg, 150 mg, 200 mg, 25 mg*** | 1 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| CLOZARIL ORAL TABLET 100 MG, 200 MG, 25 MG, 50 MG (***clozapine***) | 3 | |
| FANAPT ORAL TABLET 1 MG (***iloperidone***) | 3 | SL (86 tablets per year.) |
| FANAPT ORAL TABLET 10 MG, 12 MG, 4 MG, 6 MG, 8 MG (***iloperidone***) | 3 | SL (2 tablets per day) |
| FANAPT ORAL TABLET 2 MG (***iloperidone***) | 3 | SL (56 tablets per year.) |
| FANAPT TITRATION PACK ORAL TABLET 1 & 2 & 4 & 6 MG (***iloperidone***) | 3 | SL (8 tablets (1 pack) per 365 days.) |
| LATUDA ORAL TABLET 120 MG, 20 MG, 60 MG (***lurasidone hcl***) | 4 | SL (1 tablet per day.) |
| LATUDA ORAL TABLET 40 MG (***lurasidone hcl***) | 4 | SL (1 tablet per day) |
| LATUDA ORAL TABLET 80 MG (***lurasidone hcl***) | 4 | SL (2 tablets per day.) |
| NUPLAZID ORAL CAPSULE 34 MG (***pimavanserin tartrate***) | 3 | PA |
| NUPLAZID ORAL TABLET 10 MG (***pimavanserin tartrate***) | 3 | PA |
| ***olanzapine oral tablet 10 mg, 15 mg, 20 mg, 7.5 mg*** | 1 | SL (1 tablet per day) |
| ***olanzapine oral tablet 2.5 mg*** | 1 | SL (2 tablets per day.) |
| ***olanzapine oral tablet 5 mg*** | 1 | SL (3 tablets per day) |
| ***olanzapine oral tablet dispersible 10 mg, 15 mg, 20 mg*** | 2 | SL (1 tablet per day) |
| ***olanzapine oral tablet dispersible 5 mg*** | 2 | SL (3 tablets per day) |
| ***olanzapine-fluoxetine hcl oral capsule 12-25 mg, 12-50 mg, 3-25 mg, 6-25 mg, 6-50 mg*** | 2 | SL (1 capsule per day) |
| ***paliperidone er oral tablet extended release 24 hour 1.5 mg, 3 mg, 9 mg*** | 3 | SL (1 tablet per day) |
| ***paliperidone er oral tablet extended release 24 hour 6 mg*** | 3 | SL (2 tablets per day) |
| ***quetiapine fumarate er oral tablet extended release 24 hour 150 mg*** | 3 | SL (31 tablets per 31 days.) |
| ***quetiapine fumarate er oral tablet extended release 24 hour 200 mg*** | 3 | SL (1 tablet per day.) |
| ***quetiapine fumarate er oral tablet extended release 24 hour 300 mg, 400 mg*** | 3 | SL (62 tablets per 31 days.) |
| ***quetiapine fumarate er oral tablet extended release 24 hour 50 mg*** | 3 | SL (13 tablets per year for initial fill 3 tablets per day for maintenance fill.) |
| ***quetiapine fumarate oral tablet 100 mg, 200 mg, 25 mg, 300 mg, 400 mg, 50 mg*** | 1 | |
| REXULTI ORAL TABLET 0.25 MG, 0.5 MG, 1 MG, 2 MG, 3 MG, 4 MG (***brexpiprazole***) | 4 | PA; ST; SL (1 tablet per day.) |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ***risperidone oral solution 1 mg/ml*** | 1 | |
| ***risperidone oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg*** | 1 | |
| ***risperidone oral tablet dispersible 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg*** | 1 | |
| SAPHRIS SUBLINGUAL TABLET SUBLINGUAL 10 MG, 5 MG (***asenapine maleate***) | 3 | SL (2 tablets per day) |
| SAPHRIS SUBLINGUAL TABLET SUBLINGUAL 2.5 MG (***asenapine maleate***) | 3 | SL (2 tablets per day.) |
| SYMBYAX ORAL CAPSULE 12-50 MG, 3-25 MG, 6-25 MG, 6-50 MG (***olanzapine-fluoxetine hcl***) | 3 | SL (1 capsule per day) |
| VRAYLAR ORAL CAPSULE 1.5 MG, 3 MG, 4.5 MG, 6 MG (***cariprazine hcl***) | 4 | ST; SL (1 capsule per day.) |
| VRAYLAR ORAL CAPSULE THERAPY PACK 1.5 & 3 MG (***cariprazine hcl***) | 4 | ST; SL (7 capsules per year.) |
| ***ziprasidone hcl oral capsule 20 mg, 40 mg, 60 mg, 80 mg*** | 2 | SL (62 capsules per 31 days.) |
| **BARBITURATES (ANTICONVULSANTS) - Drugs for Seizures** | | |
| MYSOLINE ORAL TABLET 250 MG, 50 MG (***primidone***) | 2 | PA; ST |
| ***phenobarbital oral elixir 20 mg/5ml*** | 1 | |
| ***phenobarbital oral solution 20 mg/5ml*** | 1 | |
| ***phenobarbital oral tablet 100 mg, 15 mg, 16.2 mg, 30 mg, 32.4 mg, 60 mg, 64.8 mg, 97.2 mg*** | 1 | |
| ***primidone oral tablet 250 mg, 50 mg*** | 1 | |
| **BARBITURATES (ANXIOLYTIC, SEDATIVE/HYP) - Drugs for Anxiety & Sleep Disorder** | | |
| ***butalbital-asa-caff-codeine*** (Ascomp-Codeine Oral Capsule 50-325-40-30 Mg) | 1 | |
| ***butalbital-acetaminophen*** (Bupap Oral Tablet 50-300 Mg) | 4 | |
| ***butalbital-acetaminophen oral tablet 50-300 mg*** | 3 | |
| ***butalbital-acetaminophen oral tablet 50-325 mg*** | 1 | |
| ***butalbital-apap-caff-cod oral capsule 50-325-40-30 mg*** | 1 | SL (6 capsules per day.) |
| ***butalbital-apap-caffeine oral capsule 50-300-40 mg*** | 3 | SL (6 capsules per day.) |
| ***butalbital-apap-caffeine oral capsule 50-325-40 mg*** | 1 | SL (6 capsules per day) |
| ***butalbital-apap-caffeine oral tablet 50-325-40 mg*** | 1 | SL (6 tablets per day) |
| ***butalbital-asa-caff-codeine oral capsule 50-325-40-30 mg*** | 1 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ***butalbital-aspirin-caffeine oral capsule 50-325-40 mg*** | 1 | |
| ***butalbital-aspirin-caffeine oral tablet 50-325-40 mg*** | 1 | |
| ***butalbital-apap-caffeine*** (Esgic Oral Capsule 50-325-40 Mg) | 3 | SL (6 capsules per day) |
| ESGIC ORAL TABLET 50-325-40 MG (***butalbital-apap-caffeine***) | 3 | SL (6 tablets per day) |
| FIORICET ORAL CAPSULE 50-300-40 MG (***butalbital-apap-caffeine***) | 3 | SL (6 capsules per day.) |
| FIORINAL ORAL CAPSULE 50-325-40 MG (***butalbital-aspirin-caffeine***) | 3 | |
| FIORINAL/CODEINE #3 ORAL CAPSULE 50-325-40-30 MG (***butalbital-asa-caff-codeine***) | 3 | |
| ***phenobarbital oral elixir 20 mg/5ml*** | 1 | |
| ***phenobarbital oral solution 20 mg/5ml*** | 1 | |
| ***phenobarbital oral tablet 100 mg, 15 mg, 16.2 mg, 30 mg, 32.4 mg, 60 mg, 64.8 mg, 97.2 mg*** | 1 | |
| SECONAL ORAL CAPSULE 100 MG (***secobarbital sodium***) | 3 | |
| ***tencon oral tablet 50-325 mg*** | 1 | |
| ***butalbital-apap-caffeine*** (Vanatol Lq Oral Solution 50-325-40 Mg/15Ml) | 2 | PA; SL (180 ml per prescription) |
| ***butalbital-apap-caffeine*** (Vanatol S Oral Solution 50-325-40 Mg/15Ml) | 2 | PA; SL (180 ml per prescription) |
| ***butalbital-apap-caffeine*** (Vtol Lq Oral Solution 50-325-40 Mg/15Ml) | 2 | PA; SL (180 ml per prescription) |
| ***butalbital-apap-caffeine*** (Zebutal Oral Capsule 50-325-40 Mg) | 3 | SL (6 capsules per day) |
| **BENZODIAZEPINES (ANTICONVULSANTS) - Drugs for Seizures** | | |
| ***clobazam oral suspension 2.5 mg/ml*** | 3 | PA |
| ***clobazam oral tablet 10 mg, 20 mg*** | 2 | PA |
| ***clonazepam oral tablet 0.5 mg, 1 mg, 2 mg*** | 1 | |
| ***clonazepam oral tablet dispersible 0.125 mg, 0.25 mg, 0.5 mg, 1 mg, 2 mg*** | 1 | |
| ***clorazepate dipotassium oral tablet 15 mg, 3.75 mg, 7.5 mg*** | 1 | |
| DIASTAT ACUDIAL RECTAL GEL 10 MG, 20 MG (***diazepam***) | 3 | SL (1 box (2 doses/box) per prescription) |
| DIASTAT PEDIATRIC RECTAL GEL 2.5 MG (***diazepam***) | 2 | SL (1 box (2 doses/box) per prescription) |
| ***diazepam*** (Diazepam Intensol Oral Concentrate 5 Mg/Ml) | 1 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ***diazepam oral concentrate 5 mg/ml*** | 1 | |
| ***diazepam oral solution 5 mg/5ml*** | 1 | |
| ***diazepam oral tablet 10 mg, 2 mg, 5 mg*** | 1 | |
| ***diazepam rectal gel 10 mg, 2.5 mg, 20 mg*** | 1 | SL (1 box (2 doses/box) per prescription) |
| ***lorazepam*** (Lorazepam Intensol Oral Concentrate 2 Mg/Ml) | 1 | |
| ***lorazepam oral concentrate 2 mg/ml*** | 1 | |
| ***lorazepam oral tablet 0.5 mg, 1 mg, 2 mg*** | 1 | |
| NAYZILAM NASAL SOLUTION 5 MG/0.1ML (***midazolam (anticonvulsant)***) | 3 | PA; SL (1 box per prescription) |
| ONFI ORAL SUSPENSION 2.5 MG/ML (***clobazam***) | 3 | PA; ST |
| ONFI ORAL TABLET 10 MG, 20 MG (***clobazam***) | 3 | PA; ST |
| TRANXENE-T ORAL TABLET 7.5 MG (***clorazepate dipotassium***) | 3 | |
| VALTOCO 10 MG DOSE NASAL LIQUID 10 MG/0.1ML (***diazepam***) | 3 | PA; SL (2 devices per prescription) |
| VALTOCO 15 MG DOSE NASAL LIQUID THERAPY PACK 7.5 MG/0.1ML (***diazepam***) | 3 | PA; SL (2 devices per prescription) |
| VALTOCO 20 MG DOSE NASAL LIQUID THERAPY PACK 10 MG/0.1ML (***diazepam***) | 3 | PA; SL (2 devices per prescription) |
| VALTOCO 5 MG DOSE NASAL LIQUID 5 MG/0.1ML (***diazepam***) | 3 | PA; SL (2 devices per prescription) |
| **BENZODIAZEPINES (ANXIOLYTIC,SEDATIV/HYP) - Drugs for Anxiety & Sleep Disorder** | | |
| ***alprazolam er oral tablet extended release 24 hour 0.5 mg, 1 mg, 2 mg, 3 mg*** | 1 | |
| ***alprazolam intensol oral concentrate 1 mg/ml*** | 1 | |
| ***alprazolam oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg*** | 1 | |
| ***alprazolam oral tablet dispersible 0.25 mg, 0.5 mg, 1 mg, 2 mg*** | 1 | |
| ***alprazolam xr oral tablet extended release 24 hour 0.5 mg, 1 mg, 2 mg, 3 mg*** | 1 | |
| ***chlordiazepoxide hcl oral capsule 10 mg, 25 mg, 5 mg*** | 1 | |
| ***chlordiazepoxide-amitriptyline oral tablet 10-25 mg, 5-12.5 mg*** | 1 | |
| ***chlordiazepoxide-clidinium oral capsule 5-2.5 mg*** | 3 | |
| ***clobazam oral suspension 2.5 mg/ml*** | 3 | PA |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ***clobazam oral tablet 10 mg, 20 mg*** | 2 | PA |
| ***clonazepam oral tablet 0.5 mg, 1 mg, 2 mg*** | 1 | |
| ***clonazepam oral tablet dispersible 0.125 mg, 0.25 mg, 0.5 mg, 1 mg, 2 mg*** | 1 | |
| ***clorazepate dipotassium oral tablet 15 mg, 3.75 mg, 7.5 mg*** | 1 | |
| DIASTAT ACUDIAL RECTAL GEL 10 MG, 20 MG (***diazepam***) | 3 | SL (1 box (2 doses/box) per prescription) |
| DIASTAT PEDIATRIC RECTAL GEL 2.5 MG (***diazepam***) | 2 | SL (1 box (2 doses/box) per prescription) |
| ***diazepam*** (Diazepam Intensol Oral Concentrate 5 Mg/Ml) | 1 | |
| ***diazepam oral concentrate 5 mg/ml*** | 1 | |
| ***diazepam oral solution 5 mg/5ml*** | 1 | |
| ***diazepam oral tablet 10 mg, 2 mg, 5 mg*** | 1 | |
| ***diazepam rectal gel 10 mg, 2.5 mg, 20 mg*** | 1 | SL (1 box (2 doses/box) per prescription) |
| DORAL ORAL TABLET 15 MG (***quazepam***) | 3 | |
| ***estazolam oral tablet 1 mg, 2 mg*** | 1 | |
| ***flurazepam hcl oral capsule 15 mg, 30 mg*** | 1 | |
| HALCION ORAL TABLET 0.25 MG (***triazolam***) | 3 | |
| ***lorazepam*** (Lorazepam Intensol Oral Concentrate 2 Mg/Ml) | 1 | |
| ***lorazepam oral concentrate 2 mg/ml*** | 1 | |
| ***lorazepam oral tablet 0.5 mg, 1 mg, 2 mg*** | 1 | |
| ***midazolam hcl oral syrup 2 mg/ml*** | 1 | |
| NAYZILAM NASAL SOLUTION 5 MG/0.1ML (***midazolam (anticonvulsant)***) | 3 | PA; SL (1 box per prescription) |
| ONFI ORAL SUSPENSION 2.5 MG/ML (***clobazam***) | 3 | PA; ST |
| ONFI ORAL TABLET 10 MG, 20 MG (***clobazam***) | 3 | PA; ST |
| ***oxazepam oral capsule 10 mg, 15 mg, 30 mg*** | 1 | |
| ***quazepam oral tablet 15 mg*** | 1 | |
| RESTORIL ORAL CAPSULE 15 MG, 22.5 MG, 30 MG, 7.5 MG (***temazepam***) | 3 | |
| ***temazepam oral capsule 15 mg, 22.5 mg, 30 mg, 7.5 mg*** | 1 | |
| TRANXENE-T ORAL TABLET 7.5 MG (***clorazepate dipotassium***) | 3 | |
| ***triazolam oral tablet 0.125 mg, 0.25 mg*** | 1 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| VALTOCO 10 MG DOSE NASAL LIQUID 10 MG/0.1ML (***diazepam***) | 3 | PA; SL (2 devices per prescription) |
| VALTOCO 15 MG DOSE NASAL LIQUID THERAPY PACK 7.5 MG/0.1ML (***diazepam***) | 3 | PA; SL (2 devices per prescription) |
| VALTOCO 20 MG DOSE NASAL LIQUID THERAPY PACK 10 MG/0.1ML (***diazepam***) | 3 | PA; SL (2 devices per prescription) |
| VALTOCO 5 MG DOSE NASAL LIQUID 5 MG/0.1ML (***diazepam***) | 3 | PA; SL (2 devices per prescription) |
| **BUTYROPHENONES - Drugs for Depression & Psychosis** | | |
| ***haloperidol lactate oral concentrate 2 mg/ml*** | 1 | |
| ***haloperidol oral tablet 0.5 mg, 1 mg, 10 mg, 2 mg, 20 mg, 5 mg*** | 1 | |
| **CALCITONIN GENE-RELATED PEPTIDE ANTAG. - Migraine Treatment** | | |
| AIMOVIG SUBCUTANEOUS SOLUTION AUTO-INJECTOR 140 MG/ML (***erenumab-aooe***) | 2 | PA; ST; M; SL (1 ml per 21 days.) |
| AIMOVIG SUBCUTANEOUS SOLUTION AUTO-INJECTOR 70 MG/ML (***erenumab-aooe***) | 2 | PA; ST; M; SL (1 ml per month.) |
| EMGALITY (300 MG DOSE) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (***galcanezumab-gnlm***) | 2 | PA; ST; M; SL (0.1 mL per day.) |
| EMGALITY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 120 MG/ML (***galcanezumab-gnlm***) | 2 | PA; ST; M; SL (0.04 ml per day.) |
| EMGALITY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 120 MG/ML (***galcanezumab-gnlm***) | 2 | PA; ST; M; SL (0.04 ml per day.) |
| UBRELVY ORAL TABLET 100 MG, 50 MG (***ubrogepant***) | 2 | PA; ST; SL (8 tablets per prescription and 8 tablets per month.) |
| **CATECHOL-O-METHYLTRANSFERASE(COMT)INHIB. - Drugs for Parkinson** | | |
| ***carbidopa-levodopa-entacapone oral tablet 12.5-50-200 mg, 18.75-75-200 mg, 25-100-200 mg, 31.25-125-200 mg, 37.5-150-200 mg, 50-200-200 mg*** | 1 | |
| COMTAN ORAL TABLET 200 MG (***entacapone***) | 3 | |
| ***entacapone oral tablet 200 mg*** | 1 | |
| STALEVO 100 ORAL TABLET 25-100-200 MG (***carbidopa-levodopa-entacapone***) | 3 | |
| STALEVO 125 ORAL TABLET 31.25-125-200 MG (***carbidopa-levodopa-entacapone***) | 3 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| STALEVO 150 ORAL TABLET 37.5-150-200 MG (***carbidopa-levodopa-entacapone***) | 3 | |
| STALEVO 200 ORAL TABLET 50-200-200 MG (***carbidopa-levodopa-entacapone***) | 3 | |
| STALEVO 50 ORAL TABLET 12.5-50-200 MG (***carbidopa-levodopa-entacapone***) | 3 | |
| STALEVO 75 ORAL TABLET 18.75-75-200 MG (***carbidopa-levodopa-entacapone***) | 3 | |
| ***tolcapone oral tablet 100 mg*** | 2 | |
| **CENTRAL NERVOUS SYSTEM AGENTS, MISC. - Drugs for Attention Deficit Disorder** | | |
| ***acamprosate calcium oral tablet delayed release 333 mg*** | 1 | |
| ADDYI ORAL TABLET 100 MG (***flibanserin***) | 3 | PA; SL (1 tablet per day.) |
| ***atomoxetine hcl oral capsule 10 mg, 18 mg, 25 mg, 40 mg*** | 3 | SL (2 capsules per day) |
| ***atomoxetine hcl oral capsule 100 mg, 60 mg, 80 mg*** | 3 | SL (1 capsule per day) |
| AUSTEDO ORAL TABLET 12 MG, 9 MG (***deutetrabenazine***) | 2 | PA; SL (4 tablets per day.); SP |
| AUSTEDO ORAL TABLET 6 MG (***deutetrabenazine***) | 2 | PA; SL (2 tablets per day.); SP |
| ***carbidopa oral tablet 25 mg*** | 1 | |
| ***guanfacine hcl er oral tablet extended release 24 hour 1 mg*** | 2 | SL (1 tablet per day) |
| ***guanfacine hcl er oral tablet extended release 24 hour 2 mg, 4 mg*** | 2 | SL (1 tablet per day.) |
| ***guanfacine hcl er oral tablet extended release 24 hour 3 mg*** | 2 | SL (2 tablets per day.) |
| ***guanfacine hcl oral tablet 1 mg, 2 mg*** | 1 | |
| INGREZZA ORAL CAPSULE 40 MG, 80 MG (***valbenazine tosylate***) | 3 | PA; ST; SL (1 capsule per day.); SP |
| ***memantine hcl oral solution 2 mg/ml*** | 3 | |
| ***memantine hcl oral tablet 10 mg, 28 x 5 mg & 21 x 10 mg, 5 mg*** | 2 | |
| NAMENDA ORAL TABLET 10 MG, 5 MG (***memantine hcl***) | 3 | |
| NAMENDA TITRATION PAK ORAL TABLET 28 X 5 MG & 21 X 10 MG (***memantine hcl***) | 3 | |
| NAMZARIC ORAL CAPSULE ER 24 HOUR THERAPY PACK 7 & 14 & 21 &28 -10 MG (***memantine hcl-donepezil hcl***) | 3 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| NAMZARIC ORAL CAPSULE EXTENDED RELEASE 24 HOUR 14-10 MG, 21-10 MG, 28-10 MG, 7-10 MG (***memantine hcl-donepezil hcl***) | 3 | |
| NOURIANZ ORAL TABLET 20 MG, 40 MG (***istradefylline***) | 3 | PA; SL (1 tablet per day.) |
| NUEDEXTA ORAL CAPSULE 20-10 MG (***dextromethorphan-quinidine***) | 2 | PA |
| RILUTEK ORAL TABLET 50 MG (***riluzole***) | 3 | |
| ***riluzole oral tablet 50 mg*** | 1 | |
| ***tetrabenazine oral tablet 12.5 mg*** | 2 | PA |
| ***tetrabenazine oral tablet 25 mg*** | 2 | PA; SP |
| TIGLUTIK ORAL SUSPENSION 50 MG/10ML (***riluzole***) | 3 | PA; SP |
| VYLEESI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 1.75 MG/0.3ML (***bremelanotide acetate***) | 3 | PA; M; SL (4 autoinjector pens (1.2mls) per month.) |
| XYREM ORAL SOLUTION 500 MG/ML (***sodium oxybate***) | 3 | PA; SL (18 ml per day.); SP |
| **CYCLOOXYGENASE-2 (COX-2) INHIBITORS - Drugs for Pain** | | |
| ***celecoxib oral capsule 100 mg, 200 mg, 50 mg*** | 2 | SL (2 capsules per day) |
| ***celecoxib oral capsule 400 mg*** | 2 | SL (31 capsules per 31 days.) |
| **DOPAMINE PRECURSORS - Drugs for Parkinson** | | |
| ***carbidopa-levodopa er oral tablet extended release 25-100 mg, 50-200 mg*** | 1 | |
| ***carbidopa-levodopa oral tablet 10-100 mg, 25-100 mg, 25-250 mg*** | 1 | |
| ***carbidopa-levodopa oral tablet dispersible 10-100 mg, 25-100 mg, 25-250 mg*** | 1 | |
| ***carbidopa-levodopa-entacapone oral tablet 12.5-50-200 mg, 18.75-75-200 mg, 25-100-200 mg, 31.25-125-200 mg, 37.5-150-200 mg, 50-200-200 mg*** | 1 | |
| DUOPA ENTERAL SUSPENSION 4.63-20 MG/ML (***carbidopa-levodopa***) | 3 | PA |
| INBRIJA INHALATION CAPSULE 42 MG (***levodopa***) | 3 | PA; SL (10 tablets per day.); SP |
| SINEMET ORAL TABLET 10-100 MG, 25-100 MG, 25-250 MG (***carbidopa-levodopa***) | 3 | |
| STALEVO 100 ORAL TABLET 25-100-200 MG (***carbidopa-levodopa-entacapone***) | 3 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| STALEVO 125 ORAL TABLET 31.25-125-200 MG (***carbidopa-levodopa-entacapone***) | 3 | |
| STALEVO 150 ORAL TABLET 37.5-150-200 MG (***carbidopa-levodopa-entacapone***) | 3 | |
| STALEVO 200 ORAL TABLET 50-200-200 MG (***carbidopa-levodopa-entacapone***) | 3 | |
| STALEVO 50 ORAL TABLET 12.5-50-200 MG (***carbidopa-levodopa-entacapone***) | 3 | |
| STALEVO 75 ORAL TABLET 18.75-75-200 MG (***carbidopa-levodopa-entacapone***) | 3 | |
| **ERGOT-DERIV. DOPAMINE RECEPTOR AGONISTS - Drugs for Parkinson** | | |
| ***bromocriptine mesylate oral capsule 5 mg*** | 1 | |
| ***bromocriptine mesylate oral tablet 2.5 mg*** | 1 | |
| ***cabergoline oral tablet 0.5 mg*** | 2 | |
| CYCLOSET ORAL TABLET 0.8 MG (***bromocriptine mesylate***) | 3 | |
| **FIBROMYALGIA AGENTS - Drugs for Nerve Pain** | | |
| DRIZALMA SPRINKLE ORAL CAPSULE DELAYED RELEASE SPRINKLE 20 MG, 30 MG, 60 MG (***duloxetine hcl***) | 3 | PA; SL (2 capsules per day.) |
| DRIZALMA SPRINKLE ORAL CAPSULE DELAYED RELEASE SPRINKLE 40 MG (***duloxetine hcl***) | 3 | PA; SL (1 capsule per day.) |
| ***duloxetine hcl oral capsule delayed release particles 20 mg, 60 mg*** | 2 | SL (2 capsules per day.) |
| ***duloxetine hcl oral capsule delayed release particles 30 mg*** | 2 | SL (1 capsule per day.) |
| LYRICA ORAL CAPSULE 100 MG, 150 MG, 200 MG, 25 MG, 50 MG, 75 MG (***pregabalin***) | 3 | PA; ST; SL (93 capsules per 31 days.) |
| LYRICA ORAL CAPSULE 225 MG, 300 MG (***pregabalin***) | 3 | PA; ST; SL (62 capsules per 31 days.) |
| LYRICA ORAL SOLUTION 20 MG/ML (***pregabalin***) | 3 | PA; ST; SL (30.52 ml per day.) |
| ***pregabalin oral capsule 100 mg, 150 mg, 200 mg, 25 mg, 50 mg, 75 mg*** | 2 | SL (93 capsules per 31 days.) |
| ***pregabalin oral capsule 225 mg, 300 mg*** | 2 | SL (62 capsules per 31 days.) |
| ***pregabalin oral solution 20 mg/ml*** | 3 | SL (30.52 ml per day.) |
| SAVELLA ORAL TABLET 100 MG, 12.5 MG, 25 MG, 50 MG (***milnacipran hcl***) | 3 | SL (2 tablets per day) |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| SAVELLA TITRATION PACK ORAL 12.5 & 25 & 50 MG (***milnacipran hcl***) | 3 | SL (1 pack per 365 days.) |
| **HYDANTOINS - Drugs for Seizures** | | |
| DILANTIN INFATABS ORAL TABLET CHEWABLE 50 MG (***phenytoin***) | 3 | |
| DILANTIN ORAL CAPSULE 100 MG, 30 MG (***phenytoin sodium extended***) | 3 | |
| DILANTIN ORAL SUSPENSION 125 MG/5ML (***phenytoin***) | 3 | |
| PEGANONE ORAL TABLET 250 MG (***ethotoin***) | 2 | |
| PHENYTEK ORAL CAPSULE 200 MG, 300 MG (***phenytoin sodium extended***) | 3 | |
| ***phenytoin*** (Phenytoin Infatabs Oral Tablet Chewable 50 Mg) | 1 | |
| ***phenytoin oral suspension 125 mg/5ml*** | 1 | |
| ***phenytoin oral tablet chewable 50 mg*** | 1 | |
| ***phenytoin sodium extended oral capsule 100 mg, 200 mg, 300 mg*** | 1 | |
| **INHALATION ANESTHETICS - Anesthetics** | | |
| FORANE INHALATION SOLUTION (***isoflurane***) | 2 | |
| ***isoflurane inhalation solution*** | 1 | |
| ***sevoflurane inhalation solution*** | 1 | |
| ***isoflurane*** (Terrell Inhalation Solution) | 1 | |
| ULTANE INHALATION SOLUTION (***sevoflurane***) | 3 | |
| **MONOAMINE OXIDASE B INHIBITORS - Drugs for Parkinson** | | |
| EMSAM TRANSDERMAL PATCH 24 HOUR 12 MG/24HR, 6 MG/24HR, 9 MG/24HR (***selegiline***) | 3 | |
| ***rasagiline mesylate oral tablet 0.5 mg, 1 mg*** | 3 | |
| ***selegiline hcl oral capsule 5 mg*** | 1 | |
| ***selegiline hcl oral tablet 5 mg*** | 1 | |
| ZELAPAR ORAL TABLET DISPERSIBLE 1.25 MG (***selegiline hcl***) | 3 | |
| **MONOAMINE OXIDASE INHIBITORS - Drugs for Depression & Psychosis** | | |
| EMSAM TRANSDERMAL PATCH 24 HOUR 12 MG/24HR, 6 MG/24HR, 9 MG/24HR (***selegiline***) | 3 | |
| MARPLAN ORAL TABLET 10 MG (***isocarboxazid***) | 3 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| NARDIL ORAL TABLET 15 MG (***phenelzine sulfate***) | 3 | |
| PARNATE ORAL TABLET 10 MG (***tranylcypromine sulfate***) | 3 | |
| ***phenelzine sulfate oral tablet 15 mg*** | 1 | |
| ***rasagiline mesylate oral tablet 0.5 mg, 1 mg*** | 3 | |
| ***selegiline hcl oral capsule 5 mg*** | 1 | |
| ***selegiline hcl oral tablet 5 mg*** | 1 | |
| ***tranylcypromine sulfate oral tablet 10 mg*** | 1 | |
| ZELAPAR ORAL TABLET DISPERSIBLE 1.25 MG (***selegiline hcl***) | 3 | |
| **NONERGOT-DERIV.DOPAMINE RECEPTOR AGONIST - Drugs for Parkinson** | | |
| APOKYN SUBCUTANEOUS SOLUTION CARTRIDGE 30 MG/3ML (***apomorphine hcl***) | 2 | M; SP |
| MIRAPEX ORAL TABLET 0.125 MG, 0.5 MG, 0.75 MG, 1 MG (***pramipexole dihydrochloride***) | 3 | |
| NEUPRO TRANSDERMAL PATCH 24 HOUR 1 MG/24HR, 2 MG/24HR, 3 MG/24HR, 4 MG/24HR, 6 MG/24HR, 8 MG/24HR (***rotigotine***) | 3 | |
| ***pramipexole dihydrochloride oral tablet 0.125 mg, 0.25 mg, 0.5 mg, 0.75 mg, 1 mg, 1.5 mg*** | 1 | |
| ***ropinirole hcl oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg, 5 mg*** | 1 | |
| **OPIATE AGONISTS - Drugs for Pain** | | |
| ***acetaminophen-codeine #2 oral tablet 300-15 mg*** | 1 | |
| ***acetaminophen-codeine #3 oral tablet 300-30 mg*** | 1 | |
| ***acetaminophen-codeine #4 oral tablet 300-60 mg*** | 1 | |
| ***acetaminophen-codeine oral solution 120-12 mg/5ml*** | 1 | |
| ***acetaminophen-codeine oral tablet 300-15 mg, 300-30 mg, 300-60 mg*** | 1 | |
| ***apap-caff-dihydrocodeine oral capsule 320.5-30-16 mg*** | 3 | SL (40 capsules per prescription) |
| ***apap-caff-dihydrocodeine oral tablet 325-30-16 mg*** | 1 | SL (40 tablets per prescription) |
| ***butalbital-asa-caff-codeine*** (Ascomp-Codeine Oral Capsule 50-325-40-30 Mg) | 1 | |
| ***belladonna alkaloids-opium rectal suppository 16.2-30 mg, 16.2-60 mg*** | 1 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| BENZHYDROCODONE-ACETAMINOPHEN ORAL TABLET 4.08-325 MG, 6.12-325 MG, 8.16-325 MG | 3 | |
| ***butalbital-apap-caff-cod oral capsule 50-325-40-30 mg*** | 1 | SL (6 capsules per day.) |
| ***butalbital-asa-caff-codeine oral capsule 50-325-40-30 mg*** | 1 | |
| ***carisoprodol-aspirin-codeine oral tablet 200-325-16 mg*** | 1 | |
| ***codeine sulfate oral tablet 30 mg, 60 mg*** | 1 | |
| DILAUDID ORAL LIQUID 1 MG/ML (***hydromorphone hcl***) | 3 | |
| DILAUDID ORAL TABLET 2 MG, 4 MG, 8 MG (***hydromorphone hcl***) | 3 | |
| DOLOPHINE ORAL TABLET 10 MG (***methadone hcl***) | 3 | PA; SL (2 tablets per day.) |
| DOLOPHINE ORAL TABLET 5 MG (***methadone hcl***) | 3 | PA; SL (4 tablets per day.) |
| ***oxycodone-acetaminophen*** (Endocet Oral Tablet 10-325 Mg, 2.5-325 Mg, 5-325 Mg, 7.5-325 Mg) | 1 | |
| ***fentanyl citrate buccal lozenge on a handle 1200 mcg, 1600 mcg, 200 mcg, 400 mcg, 600 mcg, 800 mcg*** | 2 | PA; SL (4 lozenges per day) |
| ***fentanyl transdermal patch 72 hour 100 mcg/hr, 50 mcg/hr, 75 mcg/hr*** | 2 | PA; SL (0.34 patches per day.) |
| ***fentanyl transdermal patch 72 hour 12 mcg/hr, 25 mcg/hr*** | 2 | PA; SL (15 patches per 31 days.) |
| FIORINAL/CODEINE #3 ORAL CAPSULE 50-325-40-30 MG (***butalbital-asa-caff-codeine***) | 3 | |
| ***guaiatussin ac oral syrup 100-10 mg/5ml*** | 1 | |
| ***guaifenesin ac oral syrup 100-10 mg/5ml*** | 1 | |
| ***hydrocodone bitartrate er oral capsule extended release 12 hour 10 mg, 15 mg, 20 mg, 30 mg, 40 mg, 50 mg*** | 3 | PA; ST; SL (2 capsules per day.) |
| ***hydrocodone polst-chlorphen polst er susp oral suspension extended release 10-8 mg/5ml*** | 3 | PA; SL (360 ml per month.) |
| ***hydrocodone-acetaminophen oral solution 10-325 mg/15ml*** | 1 | |
| ***hydrocodone-acetaminophen oral solution 7.5-325 mg/15ml*** | 2 | |
| ***hydrocodone-acetaminophen oral tablet 10-325 mg, 5-325 mg, 7.5-325 mg*** | 1 | |
| ***hydrocodone-homatropine oral syrup 5-1.5 mg/5ml*** | 1 | PA; SL (120 mL per prescription and 360 ml per month) |
| ***hydrocodone-homatropine oral tablet 5-1.5 mg*** | 1 | PA |
| ***hydrocodone-ibuprofen oral tablet 10-200 mg, 5-200 mg, 7.5-200 mg*** | 1 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ***hydromet oral syrup 5-1.5 mg/5ml*** | 1 | PA; SL (120 mL per prescription and 360 ml per month) |
| ***hydromorphone hcl er oral tablet extended release 24 hour 12 mg*** | 3 | PA; ST; SL (2 tablets per day.) |
| ***hydromorphone hcl er oral tablet extended release 24 hour 16 mg, 8 mg*** | 3 | PA; ST; SL (1 tablet per day.) |
| ***hydromorphone hcl er oral tablet extended release 24 hour 32 mg*** | 3 | PA; ST; SL (0 tablets per 100 days, diagnosis review required.) |
| ***hydromorphone hcl oral liquid 1 mg/ml*** | 1 | |
| ***hydromorphone hcl oral tablet 2 mg, 4 mg, 8 mg*** | 1 | |
| ***hydromorphone hcl rectal suppository 3 mg*** | 1 | |
| LAZANDA NASAL SOLUTION 100 MCG/ACT, 400 MCG/ACT (***fentanyl citrate***) | 3 | PA; SL (15 bottles per month) |
| LAZANDA NASAL SOLUTION 300 MCG/ACT (***fentanyl citrate***) | 3 | PA; SL (0.5 bottle per day.) |
| ***levorphanol tartrate oral tablet 2 mg, 3 mg*** | 3 | ST; SL (4 tablets per day.) |
| LORTAB ORAL ELIXIR 10-300 MG/15ML (***hydrocodone-acetaminophen***) | 3 | |
| ***maxi-tuss ac oral solution 100-10 mg/5ml*** | 1 | |
| ***meperidine hcl oral solution 50 mg/5ml*** | 1 | |
| ***meperidine hcl oral tablet 100 mg, 50 mg*** | 1 | |
| ***methadone hcl*** (Methadone Hcl Intensol Oral Concentrate 10 Mg/Ml) | 1 | SL (6 ml per day.) |
| ***methadone hcl oral concentrate 10 mg/ml*** | 1 | SL (6 ml per day.) |
| ***methadone hcl oral solution 10 mg/5ml*** | 1 | PA; SL (11.3 ml per day.) |
| ***methadone hcl oral solution 5 mg/5ml*** | 1 | PA; SL (22.6 ml per day.) |
| ***methadone hcl oral tablet 10 mg*** | 1 | PA; SL (2 tablets per day.) |
| ***methadone hcl oral tablet 5 mg*** | 1 | PA; SL (4 tablets per day.) |
| ***methadone hcl oral tablet soluble 40 mg*** | 1 | SL (1.5 tablets per day.) |
| ***methadose oral concentrate 10 mg/ml*** | 1 | SL (6 ml per day.) |
| ***methadone hcl*** (Methadose Oral Tablet Soluble 40 Mg) | 1 | SL (1.5 tablets per day.) |
| ***methadose sugar-free oral concentrate 10 mg/ml*** | 1 | SL (6 ml per day.) |
| ***morphine sulfate (concentrate) oral solution 100 mg/5ml, 20 mg/ml*** | 1 | |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ***morphine sulfate er beads oral capsule extended release 24 hour 120 mg*** | 3 | PA; ST; SL (0 [capsules/tablets] per 100 days, diagnosis review required.) |
| ***morphine sulfate er beads oral capsule extended release 24 hour 30 mg, 45 mg, 60 mg, 75 mg, 90 mg*** | 3 | PA; ST; SL (1 capsule per day.) |
| ***morphine sulfate er oral tablet extended release 100 mg, 200 mg, 60 mg*** | 1 | PA; SL (0 capsules per 100 days, diagnosis review required.) |
| ***morphine sulfate er oral tablet extended release 15 mg, 30 mg*** | 1 | PA; SL (93 tablets per 31 days.) |
| ***morphine sulfate oral solution 10 mg/5ml, 20 mg/5ml*** | 1 | |
| ***morphine sulfate oral tablet 15 mg, 30 mg*** | 1 | |
| ***morphine sulfate rectal suppository 10 mg, 20 mg, 30 mg, 5 mg*** | 1 | |
| MS CONTIN ORAL TABLET EXTENDED RELEASE 100 MG, 200 MG, 60 MG (***morphine sulfate***) | 3 | PA; ST; SL (0 capsules per 100 days, diagnosis review required.) |
| MS CONTIN ORAL TABLET EXTENDED RELEASE 15 MG, 30 MG (***morphine sulfate***) | 3 | PA; ST; SL (93 tablets per 31 days.) |
| NORCO ORAL TABLET 10-325 MG, 5-325 MG, 7.5-325 MG (***hydrocodone-acetaminophen***) | 3 | |
| NUCYNTA ER ORAL TABLET EXTENDED RELEASE 12 HOUR 100 MG, 50 MG (***tapentadol hcl***) | 3 | PA; SL (2 tablets per day) |
| NUCYNTA ER ORAL TABLET EXTENDED RELEASE 12 HOUR 150 MG, 200 MG, 250 MG (***tapentadol hcl***) | 3 | PA; SL (0 capsules per 100 days, diagnosis review required.) |
| NUCYNTA ORAL TABLET 100 MG, 50 MG, 75 MG (***tapentadol hcl***) | 3 | SL (6 tablets per day) |
| ***opium oral tincture 10 mg/ml (1%)*** | 1 | |
| ***oxycodone hcl oral capsule 5 mg*** | 1 | |
| ***oxycodone hcl oral concentrate 100 mg/5ml*** | 1 | |
| ***oxycodone hcl oral solution 5 mg/5ml*** | 1 | |
| ***oxycodone hcl oral tablet 10 mg, 15 mg, 20 mg, 30 mg*** | 1 | |
| ***oxycodone hcl oral tablet 5 mg*** | 1 | SL (12 tablets per day.) |
| ***oxycodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg*** | 1 | |
| ***oxycodone-aspirin oral tablet 4.8355-325 mg*** | 1 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ***oxymorphone hcl er oral tablet extended release 12 hour 10 mg, 15 mg, 20 mg, 5 mg, 7.5 mg*** | 3 | PA; ST; SL (2 tablets per day.) |
| ***oxymorphone hcl er oral tablet extended release 12 hour 30 mg, 40 mg*** | 3 | PA; ST; SL (0 capsule per 100 days.) |
| ***oxymorphone hcl oral tablet 10 mg, 5 mg*** | 2 | SL (6 tablets per day.) |
| ***promethazine-codeine oral solution 6.25-10 mg/5ml*** | 1 | PA; SL (360 ml per month.) |
| ***promethazine-codeine oral syrup 6.25-10 mg/5ml*** | 1 | PA; SL (360 ml per month.) |
| ***promethazine-phenyleph-codeine oral syrup 6.25-5-10 mg/5ml*** | 1 | PA; SL (360 ml per month.) |
| ROXICODONE ORAL TABLET 15 MG, 30 MG (***oxycodone hcl***) | 3 | |
| ROXICODONE ORAL TABLET 5 MG (***oxycodone hcl***) | 3 | SL (12 tablets per day.) |
| SYNAPRYN FUSEPAQ ORAL SUSPENSION RECONSTITUTED 10 MG/ML (***tramadol hcl***) | 3 | PA |
| ***tramadol hcl er oral capsule extended release 24 hour 150 mg*** | 1 | SL (1 capsule per day.) |
| ***tramadol hcl er oral tablet extended release 24 hour 100 mg, 200 mg, 300 mg*** | 2 | SL (1 tablet per day) |
| ***tramadol hcl oral tablet 50 mg*** | 1 | |
| ***tramadol-acetaminophen oral tablet 37.5-325 mg*** | 1 | SL (40 tablets per prescription) |
| TREZIX ORAL CAPSULE 320.5-30-16 MG (***apap-caff-dihydrocodeine***) | 3 | SL (40 capsules per prescription) |
| TUSSICAPS ORAL CAPSULE EXTENDED RELEASE 12 HOUR 10-8 MG (***hydrocod polst-chlorphen polst***) | 3 | PA; SL (10 capsules per prescription and 30 capsules per month) |
| TUXARIN ER ORAL TABLET EXTENDED RELEASE 12 HOUR 54.3-8 MG (***chlorpheniramine-codeine***) | 3 | PA; SL (10 tablets per prescription and 30 tablets per month) |
| ULTRACET ORAL TABLET 37.5-325 MG (***tramadol-acetaminophen***) | 3 | SL (40 tablets per prescription) |
| ULTRAM ORAL TABLET 50 MG (***tramadol hcl***) | 3 | |
| ***virtussin ac w/alc oral liquid 100-10 mg/5ml*** | 1 | |
| XTAMPZA ER ORAL CAPSULE ER 12 HOUR ABUSE-DETERRENT 13.5 MG, 18 MG, 27 MG, 9 MG (***oxycodone***) | 2 | PA; SL (2 tablets per day.) |
| XTAMPZA ER ORAL CAPSULE ER 12 HOUR ABUSE-DETERRENT 36 MG (***oxycodone***) | 2 | PA; SL (0 capsules per 100 days, diagnosis review required.) |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| **OPIATE ANTAGONISTS - Drugs for Overdose or Poisoning** | | |
| ***naloxone hcl injection solution 0.4 mg/ml, 4 mg/10ml*** | 1 | |
| NALOXONE HCL INJECTION SOLUTION AUTO-INJECTOR 2 MG/0.4ML | 3 | PA; SL (0.8 ml per prescription) |
| ***naloxone hcl injection solution cartridge 0.4 mg/ml*** | 1 | |
| ***naloxone hcl injection solution prefilled syringe 2 mg/2ml*** | 1 | |
| ***naltrexone hcl oral tablet 50 mg*** | 1 | |
| NARCAN NASAL LIQUID 4 MG/0.1ML (***naloxone hcl***) | 2 | SL (2 auto-injectors per prescription) |
| **OPIATE PARTIAL AGONISTS - Drugs for Pain** | | |
| BELBUCA BUCCAL FILM 150 MCG, 300 MCG, 450 MCG, 600 MCG, 75 MCG, 900 MCG (***buprenorphine hcl***) | 3 | PA; SL (2 Films per day.) |
| BELBUCA BUCCAL FILM 750 MCG (***buprenorphine hcl***) | 3 | PA; SL (2 films per day.) |
| BUNAVAIL BUCCAL FILM 2.1-0.3 MG (***buprenorphine hcl-naloxone hcl***) | 3 | PA; ST; SL (1 buccal film per day.) |
| BUNAVAIL BUCCAL FILM 4.2-0.7 MG, 6.3-1 MG (***buprenorphine hcl-naloxone hcl***) | 3 | PA; ST; SL (2 buccal films per day.) |
| ***buprenorphine hcl sublingual tablet sublingual 2 mg*** | 1 | SL (3 sublingual tablets per day.) |
| ***buprenorphine hcl sublingual tablet sublingual 8 mg*** | 1 | SL (3 tablets per day.) |
| ***buprenorphine hcl-naloxone hcl sublingual film 12-3 mg*** | 1 | SL (2 films per day.) |
| ***buprenorphine hcl-naloxone hcl sublingual film 2-0.5 mg, 4-1 mg*** | 1 | SL (1 film per day.) |
| ***buprenorphine hcl-naloxone hcl sublingual film 8-2 mg*** | 1 | SL (3 films per day.) |
| ***buprenorphine hcl-naloxone hcl sublingual tablet sublingual 2-0.5 mg*** | 1 | SL (3 tablets per day.) |
| ***buprenorphine hcl-naloxone hcl sublingual tablet sublingual 8-2 mg*** | 1 | SL (3 tablets per day) |
| ***butorphanol tartrate nasal solution 10 mg/ml*** | 2 | SL (7.5 ml (3 bottles) per prescription) |
| ***pentazocine-naloxone hcl oral tablet 50-0.5 mg*** | 1 | |
| SUBOXONE SUBLINGUAL FILM 12-3 MG (***buprenorphine hcl-naloxone hcl***) | 3 | PA; ST; SL (2 films per day.) |
| SUBOXONE SUBLINGUAL FILM 2-0.5 MG, 4-1 MG (***buprenorphine hcl-naloxone hcl***) | 3 | PA; ST; SL (1 film per day.) |
| SUBOXONE SUBLINGUAL FILM 8-2 MG (***buprenorphine hcl-naloxone hcl***) | 3 | PA; ST; SL (3 films per day.) |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ZUBSOLV SUBLINGUAL TABLET SUBLINGUAL 0.7-0.18 MG, 2.9-0.71 MG (***buprenorphine hcl-naloxone hcl***) | 1 | SL (1 tablet per day.) |
| ZUBSOLV SUBLINGUAL TABLET SUBLINGUAL 1.4-0.36 MG, 5.7-1.4 MG (***buprenorphine hcl-naloxone hcl***) | 1 | SL (3 tablets per day.) |
| ZUBSOLV SUBLINGUAL TABLET SUBLINGUAL 11.4-2.9 MG, 8.6-2.1 MG (***buprenorphine hcl-naloxone hcl***) | 1 | SL (2 tablets per day.) |
| **OTHER NONSTEROIDAL ANTI-INFLAM. AGENTS - Drugs for Pain** | | |
| ARTHROTEC ORAL TABLET DELAYED RELEASE 50-0.2 MG, 75-0.2 MG (***diclofenac-misoprostol***) | 3 | |
| DAYPRO ORAL TABLET 600 MG (***oxaprozin***) | 3 | |
| ***diclofenac potassium oral tablet 50 mg*** | 1 | |
| ***diclofenac sodium er oral tablet extended release 24 hour 100 mg*** | 1 | |
| ***diclofenac sodium oral tablet delayed release 25 mg, 50 mg, 75 mg*** | 1 | |
| ***diclofenac-misoprostol oral tablet delayed release 50-0.2 mg, 75-0.2 mg*** | 3 | |
| ***diflunisal oral tablet 500 mg*** | 1 | |
| EC-NAPROSYN ORAL TABLET DELAYED RELEASE 375 MG (***naproxen***) | 3 | |
| ***ec-naproxen oral tablet delayed release 375 mg, 500 mg*** | 1 | |
| ***etodolac er oral tablet extended release 24 hour 400 mg, 500 mg, 600 mg*** | 1 | |
| ***etodolac oral capsule 200 mg, 300 mg*** | 1 | |
| ***etodolac oral tablet 400 mg, 500 mg*** | 1 | |
| FELDENE ORAL CAPSULE 10 MG, 20 MG (***piroxicam***) | 3 | |
| ***flurbiprofen oral tablet 100 mg, 50 mg*** | 1 | |
| ***hydrocodone-ibuprofen oral tablet 10-200 mg, 5-200 mg, 7.5-200 mg*** | 1 | |
| ***ibuprofen*** (Ibu Oral Tablet 400 Mg, 600 Mg, 800 Mg) | 1 | |
| ***ibuprofen oral tablet 400 mg, 600 mg, 800 mg*** | 1 | |
| INDOCIN ORAL SUSPENSION 25 MG/5ML (***indomethacin***) | 3 | |
| INDOCIN RECTAL SUPPOSITORY 50 MG (***indomethacin***) | 3 | |
| ***indomethacin er oral capsule extended release 75 mg*** | 1 | |
| ***indomethacin oral capsule 25 mg, 50 mg*** | 1 | |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| KETOROLAC TROMETHAMINE NASAL SOLUTION 15.75 MG/SPRAY | 3 | ST; SL (5 bottles per prescription) |
| ***ketorolac tromethamine oral tablet 10 mg*** | 1 | |
| ***meclofenamate sodium oral capsule 100 mg, 50 mg*** | 1 | |
| ***mefenamic acid oral capsule 250 mg*** | 3 | |
| ***meloxicam oral tablet 15 mg, 7.5 mg*** | 1 | |
| MOBIC ORAL TABLET 15 MG, 7.5 MG (***meloxicam***) | 3 | |
| ***nabumetone oral tablet 500 mg, 750 mg*** | 1 | |
| NAPROSYN ORAL SUSPENSION 125 MG/5ML (***naproxen***) | 3 | PA |
| ***naproxen dr oral tablet delayed release 375 mg, 500 mg*** | 1 | |
| ***naproxen oral suspension 125 mg/5ml*** | 1 | PA |
| ***naproxen oral tablet 250 mg, 375 mg, 500 mg*** | 1 | |
| ***naproxen sodium oral tablet 275 mg, 550 mg*** | 1 | |
| ***oxaprozin oral tablet 600 mg*** | 1 | |
| ***piroxicam oral capsule 10 mg, 20 mg*** | 1 | |
| SPRIX NASAL SOLUTION 15.75 MG/SPRAY (***ketorolac tromethamine***) | 3 | ST; SL (5 bottles per prescription) |
| ***sulindac oral tablet 150 mg, 200 mg*** | 1 | |
| ***tolmetin sodium oral capsule 400 mg*** | 2 | |
| ***tolmetin sodium oral tablet 600 mg*** | 2 | |
| **PHENOTHIAZINES - Drugs for Depression & Psychosis** | | |
| ***chlorpromazine hcl oral tablet 10 mg, 100 mg, 200 mg, 25 mg, 50 mg*** | 1 | |
| ***prochlorperazine*** (Compro Rectal Suppository 25 Mg) | 1 | |
| ***fluphenazine hcl oral concentrate 5 mg/ml*** | 1 | |
| ***fluphenazine hcl oral elixir 2.5 mg/5ml*** | 1 | |
| ***fluphenazine hcl oral tablet 1 mg, 10 mg, 2.5 mg, 5 mg*** | 1 | |
| ***perphenazine oral tablet 16 mg, 2 mg, 4 mg, 8 mg*** | 1 | |
| ***perphenazine-amitriptyline oral tablet 2-10 mg, 2-25 mg, 4-10 mg, 4-25 mg, 4-50 mg*** | 1 | |
| ***prochlorperazine maleate oral tablet 10 mg, 5 mg*** | 1 | |
| ***prochlorperazine rectal suppository 25 mg*** | 1 | |
| ***thioridazine hcl oral tablet 10 mg, 100 mg, 25 mg, 50 mg*** | 1 | |
| ***trifluoperazine hcl oral tablet 1 mg, 10 mg, 2 mg, 5 mg*** | 1 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| **RESPIRATORY AND CNS STIMULANTS - Drugs for the Nervous System** | | |
| ***apap-caff-dihydrocodeine oral capsule 320.5-30-16 mg*** | 3 | SL (40 capsules per prescription) |
| ***apap-caff-dihydrocodeine oral tablet 325-30-16 mg*** | 1 | SL (40 tablets per prescription) |
| ***butalbital-asa-caff-codeine*** (Ascomp-Codeine Oral Capsule 50-325-40-30 Mg) | 1 | |
| ***butalbital-apap-caff-cod oral capsule 50-325-40-30 mg*** | 1 | SL (6 capsules per day.) |
| ***butalbital-apap-caffeine oral capsule 50-300-40 mg*** | 3 | SL (6 capsules per day.) |
| ***butalbital-apap-caffeine oral capsule 50-325-40 mg*** | 1 | SL (6 capsules per day) |
| ***butalbital-apap-caffeine oral tablet 50-325-40 mg*** | 1 | SL (6 tablets per day) |
| ***butalbital-asa-caff-codeine oral capsule 50-325-40-30 mg*** | 1 | |
| ***butalbital-aspirin-caffeine oral capsule 50-325-40 mg*** | 1 | |
| ***butalbital-aspirin-caffeine oral tablet 50-325-40 mg*** | 1 | |
| ***caffeine citrate oral solution 20 mg/ml, 60 mg/3ml*** | 1 | |
| CONCERTA ORAL TABLET EXTENDED RELEASE 18 MG, 27 MG, 54 MG (***methylphenidate hcl***) | 2 | PA; SL (1 tablet per day.) |
| CONCERTA ORAL TABLET EXTENDED RELEASE 36 MG (***methylphenidate hcl***) | 2 | PA; SL (2 tablets per day.) |
| ***dexmethylphenidate hcl er oral capsule extended release 24 hour 10 mg, 15 mg, 20 mg, 25 mg, 30 mg, 35 mg, 40 mg, 5 mg*** | 3 | PA; SL (31 capsules per 31 days.) |
| ***dexmethylphenidate hcl oral tablet 10 mg, 2.5 mg, 5 mg*** | 1 | PA |
| ***butalbital-apap-caffeine*** (Esgic Oral Capsule 50-325-40 Mg) | 3 | SL (6 capsules per day) |
| ESGIC ORAL TABLET 50-325-40 MG (***butalbital-apap-caffeine***) | 3 | SL (6 tablets per day) |
| FIORICET ORAL CAPSULE 50-300-40 MG (***butalbital-apap-caffeine***) | 3 | SL (6 capsules per day.) |
| FIORINAL ORAL CAPSULE 50-325-40 MG (***butalbital-aspirin-caffeine***) | 3 | |
| FIORINAL/CODEINE #3 ORAL CAPSULE 50-325-40-30 MG (***butalbital-asa-caff-codeine***) | 3 | |
| FOCALIN ORAL TABLET 10 MG, 2.5 MG, 5 MG (***dexmethylphenidate hcl***) | 3 | PA |
| ***methylphenidate hcl*** (Metadate Er Oral Tablet Extended Release 20 Mg) | 3 | PA; SL (3 tablets per day.) |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| METHYLIN ORAL SOLUTION 10 MG/5ML, 5 MG/5ML (***methylphenidate hcl***) | 3 | PA |
| ***methylphenidate hcl er (cd) oral capsule extended release 10 mg, 20 mg, 30 mg*** | 2 | PA; SL (31 tablets per 31 days.) |
| ***methylphenidate hcl er (cd) oral capsule extended release 40 mg, 50 mg, 60 mg*** | 2 | PA; SL (31 capsules per 31 days.) |
| ***methylphenidate hcl er (la) oral capsule extended release 24 hour 10 mg, 20 mg, 40 mg*** | 2 | PA; SL (1 capsule per day) |
| ***methylphenidate hcl er (la) oral capsule extended release 24 hour 30 mg*** | 2 | PA; SL (2 capsules per day.) |
| ***methylphenidate hcl er (la) oral capsule extended release 24 hour 60 mg*** | 2 | PA |
| ***methylphenidate hcl er oral tablet extended release 10 mg*** | 3 | PA; SL (6 tablets per day.) |
| ***methylphenidate hcl er oral tablet extended release 18 mg, 27 mg, 54 mg, 72 mg*** | 3 | PA; SL (1 tablet per day.) |
| ***methylphenidate hcl er oral tablet extended release 20 mg*** | 3 | PA; SL (3 tablets per day.) |
| ***methylphenidate hcl er oral tablet extended release 36 mg*** | 3 | PA; SL (2 tablets per day.) |
| ***methylphenidate hcl oral solution 10 mg/5ml, 5 mg/5ml*** | 1 | PA |
| ***methylphenidate hcl oral tablet 10 mg, 20 mg, 5 mg*** | 1 | PA |
| ***methylphenidate hcl oral tablet chewable 10 mg, 2.5 mg, 5 mg*** | 3 | PA |
| ***relexxii oral tablet extended release 72 mg*** | 3 | PA; SL (1 tablet per day.) |
| RITALIN ORAL TABLET 10 MG, 20 MG, 5 MG (***methylphenidate hcl***) | 3 | PA |
| TREZIX ORAL CAPSULE 320.5-30-16 MG (***apap-caff-dihydrocodeine***) | 3 | SL (40 capsules per prescription) |
| ***butalbital-apap-caffeine*** (Vanatol Lq Oral Solution 50-325-40 Mg/15Ml) | 2 | PA; SL (180 ml per prescription) |
| ***butalbital-apap-caffeine*** (Vanatol S Oral Solution 50-325-40 Mg/15Ml) | 2 | PA; SL (180 ml per prescription) |
| ***butalbital-apap-caffeine*** (Vtol Lq Oral Solution 50-325-40 Mg/15Ml) | 2 | PA; SL (180 ml per prescription) |
| ***butalbital-apap-caffeine*** (Zebutal Oral Capsule 50-325-40 Mg) | 3 | SL (6 capsules per day) |
| **SALICYLATES - Drugs for Pain** | | |
| AGGRENOX ORAL CAPSULE EXTENDED RELEASE 12 HOUR 25-200 MG (***aspirin-dipyridamole***) | 3 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ***butalbital-asa-caff-codeine*** (Ascomp-Codeine Oral Capsule 50-325-40-30 Mg) | 1 | |
| ***aspirin-dipyridamole er oral capsule extended release 12 hour 25-200 mg*** | 3 | |
| ***butalbital-asa-caff-codeine oral capsule 50-325-40-30 mg*** | 1 | |
| ***butalbital-aspirin-caffeine oral capsule 50-325-40 mg*** | 1 | |
| ***butalbital-aspirin-caffeine oral tablet 50-325-40 mg*** | 1 | |
| ***carisoprodol-aspirin-codeine oral tablet 200-325-16 mg*** | 1 | |
| FIORINAL ORAL CAPSULE 50-325-40 MG (***butalbital-aspirin-caffeine***) | 3 | |
| FIORINAL/CODEINE #3 ORAL CAPSULE 50-325-40-30 MG (***butalbital-asa-caff-codeine***) | 3 | |
| ***methyl salicylate external liquid*** | 1 | |
| ***orphenadrine-asa-caffeine oral tablet 50-770-60 mg*** | 2 | |
| ***oxycodone-aspirin oral tablet 4.8355-325 mg*** | 1 | |
| ***salsalate oral tablet 500 mg, 750 mg*** | 1 | |
| **SEL.SEROTONIN,NOREPI REUPTAKE INHIBITOR - Drugs for Depression & Psychosis** | | |
| ***desvenlafaxine succinate er oral tablet extended release 24 hour 100 mg, 50 mg*** | 3 | SL (1 tablet per day) |
| ***desvenlafaxine succinate er oral tablet extended release 24 hour 25 mg*** | 3 | SL (1 tablet per day.) |
| DRIZALMA SPRINKLE ORAL CAPSULE DELAYED RELEASE SPRINKLE 20 MG, 30 MG, 60 MG (***duloxetine hcl***) | 3 | PA; SL (2 capsules per day.) |
| DRIZALMA SPRINKLE ORAL CAPSULE DELAYED RELEASE SPRINKLE 40 MG (***duloxetine hcl***) | 3 | PA; SL (1 capsule per day.) |
| ***duloxetine hcl oral capsule delayed release particles 20 mg, 60 mg*** | 2 | SL (2 capsules per day.) |
| ***duloxetine hcl oral capsule delayed release particles 30 mg*** | 2 | SL (1 capsule per day.) |
| FETZIMA ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 20 MG, 40 MG, 80 MG (***levomilnacipran hcl***) | 3 | ST; SL (1 capsule per day.) |
| FETZIMA TITRATION ORAL CAPSULE ER 24 HOUR THERAPY PACK 20 & 40 MG (***levomilnacipran hcl***) | 3 | ST; SL (28 capsules per year.) |
| SAVELLA ORAL TABLET 100 MG, 12.5 MG, 25 MG, 50 MG (***milnacipran hcl***) | 3 | SL (2 tablets per day) |
| SAVELLA TITRATION PACK ORAL 12.5 & 25 & 50 MG (***milnacipran hcl***) | 3 | SL (1 pack per 365 days.) |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ***venlafaxine hcl er oral capsule extended release 24 hour 150 mg, 37.5 mg, 75 mg*** | 1 | |
| ***venlafaxine hcl oral tablet 100 mg, 25 mg, 37.5 mg, 50 mg, 75 mg*** | 1 | |
| **SELECTIVE SEROTONIN AGONISTS - Migraine Treatment** | | |
| ***almotriptan malate oral tablet 12.5 mg, 6.25 mg*** | 3 | SL (4 tablets per prescription) |
| AMERGE ORAL TABLET 1 MG, 2.5 MG (***naratriptan hcl***) | 3 | SL (4 tablets per prescription) |
| ***eletriptan hydrobromide oral tablet 20 mg, 40 mg*** | 2 | SL (4 tablets per prescription) |
| FROVA ORAL TABLET 2.5 MG (***frovatriptan succinate***) | 3 | SL (4 tablets per prescription) |
| ***frovatriptan succinate oral tablet 2.5 mg*** | 3 | SL (4 tablets per prescription) |
| IMITREX NASAL SOLUTION 20 MG/ACT, 5 MG/ACT (***sumatriptan***) | 3 | SL (6 spray bottles per prescription) |
| ***naratriptan hcl oral tablet 1 mg, 2.5 mg*** | 1 | SL (4 tablets per prescription) |
| REYVOW ORAL TABLET 100 MG (***lasmiditan succinate***) | 2 | PA; ST; SL (8 tablets per prescription and 8 tablets per month) |
| REYVOW ORAL TABLET 50 MG (***lasmiditan succinate***) | 2 | PA; ST; SL (8 tablets per prescription and 8 tablets per month.) |
| ***rizatriptan benzoate oral tablet 10 mg, 5 mg*** | 1 | SL (4 tablets per prescription) |
| ***rizatriptan benzoate oral tablet dispersible 10 mg, 5 mg*** | 1 | SL (4 tablets per prescription) |
| ***sumatriptan nasal solution 20 mg/act, 5 mg/act*** | 2 | SL (6 spray bottles per prescription) |
| ***sumatriptan succinate oral tablet 100 mg, 25 mg, 50 mg*** | 1 | SL (10 tablets per prescription) |
| ***sumatriptan succinate refill subcutaneous solution cartridge 4 mg/0.5ml, 6 mg/0.5ml*** | 1 | M; SL (2 kits per prescription) |
| ***sumatriptan succinate subcutaneous solution 6 mg/0.5ml*** | 1 | M; SL (2 kits per prescription) |
| ***sumatriptan succinate subcutaneous solution auto-injector 4 mg/0.5ml, 6 mg/0.5ml*** | 1 | M; SL (2 kits per prescription) |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ***sumatriptan succinate subcutaneous solution prefilled syringe 6 mg/0.5ml*** | 1 | M; SL (2 kits per prescription) |
| ***zolmitriptan oral tablet 2.5 mg, 5 mg*** | 2 | SL (4 tablets per prescription) |
| ***zolmitriptan oral tablet dispersible 2.5 mg, 5 mg*** | 3 | SL (4 tablets per prescription) |
| ZOMIG NASAL SOLUTION 2.5 MG (***zolmitriptan***) | 3 | ST; SL (6 units per prescription) |
| ZOMIG NASAL SOLUTION 5 MG (***zolmitriptan***) | 3 | ST; SL (1 box per prescription) |
| ZOMIG ORAL TABLET 2.5 MG, 5 MG (***zolmitriptan***) | 3 | SL (4 tablets per prescription) |
| ZOMIG ZMT ORAL TABLET DISPERSIBLE 2.5 MG, 5 MG (***zolmitriptan***) | 3 | SL (4 tablets per prescription) |
| **SELECTIVE-SEROTONIN REUPTAKE INHIBITORS - Drugs for Depression & Psychosis** | | |
| ***citalopram hydrobromide oral solution 10 mg/5ml*** | 1 | |
| ***citalopram hydrobromide oral tablet 10 mg, 20 mg, 40 mg*** | 1 | |
| ***escitalopram oxalate oral solution 5 mg/5ml*** | 3 | |
| ***escitalopram oxalate oral tablet 10 mg, 20 mg, 5 mg*** | 1 | |
| ***fluoxetine hcl oral capsule 10 mg, 20 mg, 40 mg*** | 1 | |
| ***fluoxetine hcl oral capsule delayed release 90 mg*** | 3 | SL (4 capsules per 28 days.) |
| ***fluoxetine hcl oral solution 20 mg/5ml*** | 1 | |
| ***fluoxetine hcl oral tablet 10 mg*** | 3 | SL (1 tablet per day.) |
| ***fluoxetine hcl oral tablet 20 mg*** | 3 | |
| ***fluvoxamine maleate er oral capsule extended release 24 hour 100 mg, 150 mg*** | 3 | SL (2 capsules per day) |
| ***fluvoxamine maleate oral tablet 100 mg, 25 mg, 50 mg*** | 1 | |
| ***olanzapine-fluoxetine hcl oral capsule 12-25 mg, 12-50 mg, 3-25 mg, 6-25 mg, 6-50 mg*** | 2 | SL (1 capsule per day) |
| ***paroxetine hcl er oral tablet extended release 24 hour 12.5 mg*** | 3 | SL (1 tablet per day) |
| ***paroxetine hcl er oral tablet extended release 24 hour 25 mg, 37.5 mg*** | 3 | SL (2 tablets per day) |
| ***paroxetine hcl oral tablet 10 mg, 20 mg, 30 mg, 40 mg*** | 1 | |
| PAXIL CR ORAL TABLET EXTENDED RELEASE 24 HOUR 12.5 MG (***paroxetine hcl***) | 3 | SL (1 tablet per day) |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| PAXIL CR ORAL TABLET EXTENDED RELEASE 24 HOUR 25 MG, 37.5 MG (***paroxetine hcl***) | 3 | SL (2 tablets per day) |
| PAXIL ORAL SUSPENSION 10 MG/5ML (***paroxetine hcl***) | 3 | |
| PAXIL ORAL TABLET 10 MG, 20 MG, 30 MG, 40 MG (***paroxetine hcl***) | 3 | |
| ***sertraline hcl oral concentrate 20 mg/ml*** | 1 | |
| ***sertraline hcl oral tablet 100 mg, 25 mg, 50 mg*** | 1 | |
| SYMBYAX ORAL CAPSULE 12-50 MG, 3-25 MG, 6-25 MG, 6-50 MG (***olanzapine-fluoxetine hcl***) | 3 | SL (1 capsule per day) |
| **SEROTONIN MODULATORS - Drugs for Depression & Psychosis** | | |
| ***nefazodone hcl oral tablet 100 mg, 150 mg, 200 mg, 250 mg, 50 mg*** | 1 | |
| ***trazodone hcl oral tablet 100 mg, 150 mg, 300 mg, 50 mg*** | 1 | |
| TRINTELLIX ORAL TABLET 10 MG, 20 MG, 5 MG (***vortioxetine hbr***) | 3 | ST; SL (1 tablet per day.) |
| VIIBRYD ORAL TABLET 10 MG, 20 MG, 40 MG (***vilazodone hcl***) | 3 | SL (1 tablet per day) |
| VIIBRYD STARTER PACK ORAL KIT 10 & 20 MG (***vilazodone hcl***) | 3 | |
| **SUCCINIMIDES - Drugs for Seizures** | | |
| CELONTIN ORAL CAPSULE 300 MG (***methsuximide***) | 2 | |
| ***ethosuximide oral capsule 250 mg*** | 1 | |
| ***ethosuximide oral solution 250 mg/5ml*** | 1 | |
| ZARONTIN ORAL CAPSULE 250 MG (***ethosuximide***) | 3 | |
| ZARONTIN ORAL SOLUTION 250 MG/5ML (***ethosuximide***) | 3 | |
| **THIOXANTHENES - Drugs for Depression & Psychosis** | | |
| ***thiothixene oral capsule 1 mg, 10 mg, 2 mg, 5 mg*** | 1 | |
| **TRICYCLICS, OTHER NOREPI-RU INHIBITORS - Drugs for Depression & Psychosis** | | |
| ***amitriptyline hcl oral tablet 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg*** | 1 | |
| ***amoxapine oral tablet 100 mg, 150 mg, 25 mg, 50 mg*** | 1 | |
| ***chlordiazepoxide-amitriptyline oral tablet 10-25 mg, 5-12.5 mg*** | 1 | |
| ***clomipramine hcl oral capsule 25 mg, 50 mg, 75 mg*** | 3 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ***desipramine hcl oral tablet 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg*** | 1 | |
| ***doxepin hcl oral capsule 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg*** | 1 | |
| ***doxepin hcl oral concentrate 10 mg/ml*** | 1 | |
| ***enovarx-amitriptyline external kit 2 %*** | 1 | PA |
| ***imipramine hcl oral tablet 10 mg, 25 mg, 50 mg*** | 1 | |
| ***imipramine pamoate oral capsule 100 mg, 125 mg, 150 mg, 75 mg*** | 1 | |
| ***maprotiline hcl oral tablet 25 mg, 50 mg, 75 mg*** | 1 | |
| NORPRAMIN ORAL TABLET 10 MG, 25 MG (***desipramine hcl***) | 3 | |
| ***nortriptyline hcl oral capsule 10 mg, 25 mg, 50 mg, 75 mg*** | 1 | |
| ***nortriptyline hcl oral solution 10 mg/5ml*** | 1 | |
| PAMELOR ORAL CAPSULE 10 MG, 25 MG, 50 MG, 75 MG (***nortriptyline hcl***) | 3 | |
| ***perphenazine-amitriptyline oral tablet 2-10 mg, 2-25 mg, 4-10 mg, 4-25 mg, 4-50 mg*** | 1 | |
| ***protriptyline hcl oral tablet 10 mg, 5 mg*** | 1 | |
| ***trimipramine maleate oral capsule 100 mg, 25 mg, 50 mg*** | 3 | |
| **VESICULAR MONOAMINE TRANSPORT2 INHIBITOR - Drugs for the Nervous System** | | |
| AUSTEDO ORAL TABLET 12 MG, 9 MG (***deutetrabenazine***) | 2 | PA; SL (4 tablets per day.); SP |
| AUSTEDO ORAL TABLET 6 MG (***deutetrabenazine***) | 2 | PA; SL (2 tablets per day.); SP |
| INGREZZA ORAL CAPSULE 40 MG, 80 MG (***valbenazine tosylate***) | 3 | PA; ST; SL (1 capsule per day.); SP |
| INGREZZA ORAL CAPSULE THERAPY PACK 40 & 80 MG (***valbenazine tosylate***) | 3 | PA; ST; SL (1 kit (28 tablets) per year.); SP |
| ***tetrabenazine oral tablet 12.5 mg*** | 2 | PA |
| ***tetrabenazine oral tablet 25 mg*** | 2 | PA; SP |
| **WAKEFULNESS-PROMOTING AGENTS - Drugs for the Nervous System** | | |
| ***armodafinil oral tablet 150 mg, 250 mg*** | 2 | PA; SL (1 tablet per day) |
| ***armodafinil oral tablet 200 mg, 50 mg*** | 2 | PA; SL (1 tablet per day.) |
| ***modafinil oral tablet 100 mg, 200 mg*** | 2 | PA; SL (1 tablet per day) |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| SUNOSI ORAL TABLET 150 MG, 75 MG (***solriamfetol hcl***) | 3 | PA; SL (1 tablet per day.) |
| WAKIX ORAL TABLET 17.8 MG, 4.45 MG (***pitolisant hcl***) | 3 | PA; SL (2 tablets per day.); SP |
| **DEVICES - Medical Supplies and Durable Medical Equipment** | | |
| **DEVICES - Medical Supplies and Durable Medical Equipment** | | |
| ACCU-CHEK AVIVA CONNECT KIT W/DEVICE KIT W/DEVICE (***blood glucose monitoring suppl***) | 3 | M |
| ACCU-CHEK AVIVA IN VITRO SOLUTION (***blood glucose calibration***) | 1 | |
| ACCU-CHEK AVIVA PLUS KIT W/DEVICE (***blood glucose monitoring suppl***) | 3 | M |
| ACCU-CHEK COMPACT PLUS CARE KIT KIT (***blood glucose monitoring suppl***) | 3 | M |
| ACCU-CHEK COMPACT PLUS CONTROL IN VITRO SOLUTION (***blood glucose calibration***) | 1 | |
| ACCU-CHEK FASTCLIX LANCET KIT KIT (***lancets misc.***) | 1 | |
| ACCU-CHEK GUIDE CONTROL IN VITRO LIQUID (***blood glucose calibration***) | 1 | |
| ACCU-CHEK GUIDE KIT W/DEVICE (***blood glucose monitoring suppl***) | 3 | M |
| ACCU-CHEK MULTICLIX LANCET DEVICE KIT KIT (***lancets misc.***) | 1 | |
| ACCU-CHEK NANO SMARTVIEW KIT W/DEVICE KIT W/DEVICE (***blood glucose monitoring suppl***) | 3 | M |
| ACCU-CHEK SMARTVIEW CONTROL IN VITRO LIQUID (***blood glucose calibration***) | 1 | |
| ACCU-CHEK SOFTCLIX LANCET DEVICE KIT KIT (***lancets misc.***) | 1 | |
| AUTOLET II CLINISAFE KIT (***lancets misc.***) | 3 | |
| AUTOLET LANCING DEVICE (***lancet devices***) | 3 | SL (1 device per prescription) |
| CARETOUCH LANCING/EJECTOR (***lancet devices***) | 3 | SL (1 device per prescription) |
| CEQUR SIMPLICITY 2U DEVICE (***injection device for insulin***) | 3 | |
| CONTOUR CONTROL IN VITRO LIQUID HIGH (***blood glucose calibration***) | 3 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| CONTOUR CONTROL IN VITRO LIQUID LOW , NORMAL (***blood glucose calibration***) | 2 | |
| CONTOUR NEXT CONTROL IN VITRO SOLUTION LOW , NORMAL (***blood glucose calibration***) | 2 | |
| CONTOUR NEXT LINK KIT W/DEVICE (***blood glucose monitoring suppl***) | 3 | M |
| CONTOUR NEXT MONITOR KIT W/DEVICE (***blood glucose monitoring suppl***) | 2 | M |
| DEXCOM G4 / G5 / G6 RECEIVER, TRANSMITTER, SENSOR (INCLUDING PLATINUM, PLATINUM PEDIATRIC) (***continuous blood gluc transmit***) | 3 | PA; M; SL (1 kit per 999 days.) |
| DEXCOM G4 / G5 / G6 RECEIVER, TRANSMITTER, SENSOR (INCLUDING PLATINUM, PLATINUM PEDIATRIC) (***continuous blood gluc sensor***) | 3 | PA; M; SL (4 sensors per month.) |
| DEXCOM G4 / G5 / G6 RECEIVER, TRANSMITTER, SENSOR (INCLUDING PLATINUM, PLATINUM PEDIATRIC) DEVICE (***continuous blood gluc receiver***) | 3 | PA; M; SL (1 transmitter per 6 months for Dexcom G4 Transmitter. 2 transmitter per 6 months for Dexcom G5 Transmitter.) |
| EASIVENT (***spacer/aero-holding chambers***) | 3 | |
| EASYMAX CONTROL IN VITRO SOLUTION NORMAL (***blood glucose calibration***) | 3 | |
| ENLITE GLUCOSE SENSOR (***continuous blood gluc sensor***) | 3 | PA; M |
| FLEXICHAMBER ADULT MASK/SMALL (***spacer/aero-hold chamber mask***) | 2 | |
| FLEXICHAMBER CHILD MASK/LARGE (***spacer/aero-hold chamber mask***) | 2 | |
| FLEXICHAMBER CHILD MASK/SMALL (***spacer/aero-hold chamber mask***) | 2 | |
| FORTISCARE CONTROL IN VITRO SOLUTION HIGH , LOW , NORMAL (***blood glucose calibration***) | 2 | |
| FREESTYLE LIBRE 14 DAY READER DEVICE (***continuous blood gluc receiver***) | 3 | PA; M |
| FREESTYLE LIBRE 14 DAY SENSOR (***continuous blood gluc sensor***) | 3 | PA; M |
| FREESTYLE LIBRE 2 READER SYSTM DEVICE (***continuous blood gluc receiver***) | 3 | PA; M |
| FREESTYLE LIBRE 2 SENSOR SYSTM (***continuous blood gluc sensor***) | 3 | PA; M |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| FREESTYLE LIBRE READER DEVICE (***continuous blood gluc receiver***) | 3 | PA; M; SL (1 kit per 999 days.) |
| FREESTYLE LIBRE SENSOR SYSTEM (***continuous blood gluc sensor***) | 3 | PA; M |
| GUARDIAN CONNECT TRANSMITTER (***continuous blood gluc transmit***) | 3 | M |
| GUARDIAN CONNECT TRANSMITTER (***continuous blood gluc transmit***) | 3 | PA; M; SL (10 sensors per month.) |
| GUARDIAN LINK 3 TRANSMITTER (***continuous blood gluc transmit***) | 3 | M |
| GUARDIAN SENSOR (3) (***continuous blood gluc sensor***) | 3 | PA; M |
| ***heparin lock flush intravenous solution 10 unit/ml*** | 1 | M |
| ***heparin sodium lock flush intravenous solution 100 unit/ml*** | 1 | M |
| HYPERSAL INHALATION NEBULIZATION SOLUTION 3.5 %, 7 % (***sodium chloride***) | 2 | |
| HYPOCYN EXTERNAL SOLUTION (***eyelid cleansers***) | 3 | |
| INSPIREASE RESERVOIR BAGS (***spacer/aero-hold chamber bags***) | 2 | |
| INSULIN PEN NEEDLES 29G X 12.7MM , 31G X 5 MM , 31G X 8 MM , 32G X 4 MM (***insulin pen needle***) | 2 | |
| INSULIN PEN NEEDLES 29G X 12MM , 31G X 6 MM | 2 | |
| INSULIN PEN NEEDLES 29G X 5MM , 29G X 8MM , 33G X 4 MM (***insulin pen needle***) | 3 | |
| INSULIN SYRINGES 28G X 1/2" 0.5 ML, 28G X 1/2" 1 ML, 29G X 1/2" 0.3 ML, 29G X 1/2" 0.5 ML, 29G X 1/2" 1 ML, 30G X 1/2" 0.3 ML, 30G X 1/2" 0.5 ML, 30G X 1/2" 1 ML, 30G X 5/16" 0.3 ML, 30G X 5/16" 0.5 ML, 31G X 15/64" 0.3 ML, 31G X 15/64" 0.5 ML, 31G X 5/16" 0.3 ML, 31G X 5/16" 0.5 ML, 31G X 5/16" 1 ML (***insulin syringe-needle u-100***) | 2 | |
| INSULIN SYRINGES 30G X 5/16" 1 ML | 2 | |
| LANCETS (***lancets***) | 1 | |
| LANCETS (***lancets misc.***) | 3 | |
| MASK VORTEX (***spacer/aero-hold chamber mask***) | 2 | |
| MAXICOMFORT SYR 27G X 1/2" 27G X 1/2" 0.5 ML, 27G X 1/2" 1 ML (***insulin syringe-needle u-100***) | 2 | |
| MICROLET NEXT LANCING DEVICE (***lancet devices***) | 3 | SL (1 device per prescription) |
| MUCOSITISRX MOUTH/THROAT PACKET (***artificial saliva***) | 3 | |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ***sodium chloride*** (Nebusal Inhalation Nebulization Solution 3 %) | 1 | |
| NEBUSAL INHALATION NEBULIZATION SOLUTION 6 % (***sodium chloride***) | 3 | |
| NOVOFINE AUTOCOVER PEN NEEDLE 30G X 8 MM (***insulin pen needle***) | 2 | |
| NOVOFINE PEN NEEDLE 32G X 6 MM (***insulin pen needle***) | 2 | |
| NOVOFINE PLUS PEN NEEDLE 32G X 4 MM (***insulin pen needle***) | 2 | |
| NOVOPEN ECHO DEVICE (***injection device for insulin***) | 3 | |
| NOVOTWIST PEN NEEDLE 32G X 5 MM (***insulin pen needle***) | 2 | |
| NUVAIL EXTERNAL SOLUTION (***dermatological products, misc.***) | 3 | |
| ONETOUCH DELICA LANCING DEV (***lancet devices***) | 1 | SL (1 device per prescription) |
| ONETOUCH DELICA PLUS LANCING (***lancet devices***) | 1 | SL (1 device per prescription) |
| ONETOUCH ULTRA 2 KIT W/DEVICE (***blood glucose monitoring suppl***) | 1 | M |
| ONETOUCH ULTRA MINI KIT W/DEVICE (***blood glucose monitoring suppl***) | 1 | M |
| ONETOUCH VERIO FLEX SYSTEM KIT W/DEVICE KIT W/DEVICE (***blood glucose monitoring suppl***) | 1 | M |
| ONETOUCH VERIO IN VITRO SOLUTION HIGH (***blood glucose calibration***) | 1 | |
| ONETOUCH VERIO IQ SYSTEM KIT W/DEVICE (***blood glucose monitoring suppl***) | 1 | M |
| ONETOUCH VERIO KIT W/DEVICE (***blood glucose monitoring suppl***) | 1 | M |
| ONETOUCH VERIO REFLECT KIT W/DEVICE (***blood glucose monitoring suppl***) | 1 | M |
| ONETOUCH VERIO SYNC SYSTEM KIT W/DEVICE KIT W/DEVICE (***blood glucose monitoring suppl***) | 1 | M |
| PRECISION XTRA KETONE IN VITRO STRIP (***ketone blood test***) | 3 | |
| PROMISEB CREAM EXTERNAL (***antiseborrheic products, misc.***) | 3 | |
| PROMISEB CREAM EXTERNAL (***antiseborrheic products, misc.***) | 3 | PA |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ***sodium chloride*** (Pulmosal Inhalation Nebulization Solution 7 %) | 1 | |
| SHARPS CONTAINER | 3 | |
| ***sodium chloride inhalation nebulization solution 0.9 %, 10 %, 3 %, 7 %*** | 1 | |
| ***sodium hyaluronate external gel 0.2 %*** | 1 | |
| SURESTEP PRO HIGH GLUCOSE IN VITRO LIQUID (***blood glucose calibration***) | 3 | |
| SURESTEP PRO LOW GLUCOSE IN VITRO LIQUID (***blood glucose calibration***) | 3 | |
| SURESTEP PRO NORMAL GLUCOSE IN VITRO LIQUID (***blood glucose calibration***) | 3 | |
| TRUE METRIX LEVEL 1 IN VITRO SOLUTION LOW (***blood glucose calibration***) | 2 | |
| TRUE METRIX LEVEL 2 IN VITRO SOLUTION NORMAL (***blood glucose calibration***) | 2 | |
| TRUE METRIX LEVEL 3 IN VITRO SOLUTION HIGH (***blood glucose calibration***) | 2 | |
| UNISTRIP CONTROL IN VITRO SOLUTION LOW (***blood glucose calibration***) | 3 | |
| **DIAGNOSTIC AGENTS** | | |
| **ADRENOCORTICAL INSUFFICIENCY** | | |
| ACTHAR INJECTION GEL 80 UNIT/ML (***corticotropin***) | 4 | PA; ST; M; SL (20 ml per 24 days.); SP |
| CORTROSYN INJECTION SOLUTION RECONSTITUTED 0.25 MG (***cosyntropin***) | 3 | M |
| ***cosyntropin injection solution reconstituted 0.25 mg*** | 1 | M |
| **DIABETES MELLITUS** | | |
| ACCU-CHEK AVIVA PLUS IN VITRO STRIP (***glucose blood***) | 3 | SL (51 strips per prescription without history 204 strips per prescription with history.) |
| ACCU-CHEK COMPACT PLUS TEST STRIPS IN VITRO STRIP (***glucose blood***) | 3 | SL (51 strips per prescription without history 204 strips per prescription with history.) |
| ACCU-CHEK GUIDE IN VITRO STRIP (***glucose blood***) | 3 | SL (51 strips per prescription without history 204 strips per prescription with history.) |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ACCU-CHEK SMARTVIEW TEST STRIPS IN VITRO STRIP (***glucose blood***) | 3 | SL (51 strips per prescription without history 204 strips per prescription with history.) |
| CARETOUCH TEST IN VITRO STRIP (***glucose blood***) | 3 | SL (51 strips per prescription without history 204 strips per prescription with history.) |
| CONTOUR NEXT TEST IN VITRO STRIP (***glucose blood***) | 2 | SL (51 strips per prescription without history 204 strips per prescription with history.) |
| CONTOUR TEST IN VITRO STRIP (***glucose blood***) | 3 | SL (51 strips per prescription without history 204 strips per prescription with history.) |
| FREESTYLE PRECISION NEO TEST IN VITRO STRIP (***glucose blood***) | 3 | SL (51 strips per prescription without history 204 strips per prescription with history.) |
| MICRODOT TEST IN VITRO STRIP (***glucose blood***) | 3 | SL (51 strips per prescription without history 204 strips per prescription with history.) |
| ONETOUCH ULTRA IN VITRO STRIP (***glucose blood***) | 1 | SL (51 strips per prescription without history 204 strips per prescription with history.) |
| ONETOUCH VERIO IN VITRO STRIP (***glucose blood***) | 1 | SL (51 strips per prescription without history 204 strips per prescription with history.) |
| PRECISION PCX PLUS TEST IN VITRO STRIP (***glucose blood***) | 3 | SL (51 strips per prescription without history 204 strips per prescription with history.) |
| PRECISION QID TEST IN VITRO STRIP (***glucose blood***) | 3 | SL (51 strips per prescription without history 204 strips per prescription with history.) |
| PRECISION SOF-TACT TEST IN VITRO STRIP (***glucose blood***) | 3 | SL (51 strips per prescription without history 204 strips per prescription with history.) |
| PRECISION XTRA BLOOD GLUCOSE IN VITRO STRIP (***glucose blood***) | 3 | SL (51 strips per prescription without history 204 strips per prescription with history.) |
| RELION BLOOD GLUCOSE TEST IN VITRO STRIP (***glucose blood***) | 3 | SL (51 strips per prescription without history 204 strips per prescription with history.) |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| RELION ULTIMA TEST IN VITRO STRIP (***glucose blood***) | 3 | SL (51 strips per prescription without history 204 strips per prescription with history.) |
| **KETONES** | | |
| KETONE TEST IN VITRO STRIP | 2 | |
| KETOSTIX IN VITRO STRIP (***acetone (urine) test***) | 2 | |
| **URINE AND FECES CONTENTS** | | |
| CHEMSTRIP UGK IN VITRO STRIP (***urine glucose-ketones test***) | 3 | |
| **DISINFECTANTS (FOR NON-DERMATOLOGIC USE) - Disinfectants** | | |
| **DISINFECTANTS (FOR NON-DERMATOLOGIC USE) - Disinfectants** | | |
| GLUTARALDEHYDE EXTERNAL SOLUTION 25 % | 3 | |
| **ELECTROLYTIC, CALORIC, AND WATER BALANCE** | | |
| **ACIDIFYING AGENTS** | | |
| K-PHOS NO 2 ORAL TABLET 305-700 MG (***pot & sod ac phosphates***) | 2 | |
| K-PHOS ORAL TABLET 500 MG (***potassium phosphate monobasic***) | 2 | |
| K-PHOS-NEUTRAL ORAL TABLET 155-852-130 MG (***k phos mono-sod phos di & mono***) | 2 | |
| ***k phos mono-sod phos di & mono*** (Phospha 250 Neutral Oral Tablet 155-852-130 Mg) | 1 | |
| ***phosphorous oral tablet 155-852-130 mg*** | 1 | |
| ***k phos mono-sod phos di & mono*** (Phospho-Trin 250 Neutral Oral Tablet 155-852-130 Mg) | 1 | |
| ***virt-phos 250 neutral oral tablet 155-852-130 mg*** | 1 | |
| **ALKALINIZING AGENTS** | | |
| ANTICOAGULANT SODIUM CITRATE IN VITRO SOLUTION 4 GM/100ML | 3 | |
| ***cytra k crystals oral packet 3300-1002 mg*** | 1 | |
| ORACIT ORAL SOLUTION 490-640 MG/5ML (***sod citrate-citric acid***) | 2 | |
| ***potassium citrate er oral tablet extended release 10 meq (1080 mg), 15 meq (1620 mg), 5 meq (540 mg)*** | 1 | |
| ***potassium citrate-citric acid oral solution 1100-334 mg/5ml*** | 1 | |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ***sod citrate-citric acid oral solution 500-334 mg/5ml*** | 1 | |
| SODIUM BICARBONATE ORAL POWDER | 3 | |
| ***potassium citrate-citric acid*** (Taron-Crystals Oral Packet 3300-1002 Mg) | 1 | |
| TRICITRASOL IN VITRO CONCENTRATE 46.7 % (***anticoagulant sodium citrate***) | 3 | |
| ***tricitrates oral solution 550-500-334 mg/5ml*** | 1 | |
| UROCIT-K 10 ORAL TABLET EXTENDED RELEASE 10 MEQ (1080 MG) (***potassium citrate***) | 3 | |
| UROCIT-K 15 ORAL TABLET EXTENDED RELEASE 15 MEQ (1620 MG) (***potassium citrate***) | 3 | |
| UROCIT-K 5 ORAL TABLET EXTENDED RELEASE 5 MEQ (540 MG) (***potassium citrate***) | 3 | |
| **AMMONIA DETOXICANTS** | | |
| BUPHENYL ORAL POWDER 3 GM/TSP (***sodium phenylbutyrate***) | 3 | PA |
| BUPHENYL ORAL TABLET 500 MG (***sodium phenylbutyrate***) | 3 | PA |
| CARBAGLU ORAL TABLET 200 MG (***carglumic acid***) | 2 | PA; SP |
| ***constulose oral solution 10 gm/15ml*** | 1 | |
| ***enulose oral solution 10 gm/15ml*** | 1 | |
| ***generlac oral solution 10 gm/15ml*** | 1 | |
| KRISTALOSE ORAL PACKET 20 GM (***lactulose***) | 3 | |
| ***lactulose encephalopathy oral solution 10 gm/15ml*** | 1 | |
| ***lactulose oral packet 10 gm*** | 3 | |
| ***lactulose oral solution 10 gm/15ml, 20 gm/30ml*** | 1 | |
| LITHOSTAT ORAL TABLET 250 MG (***acetohydroxamic acid***) | 3 | |
| RAVICTI ORAL LIQUID 1.1 GM/ML (***glycerol phenylbutyrate***) | 4 | PA; ST; SL (17.5 ml per day.); SP |
| ***sodium phenylbutyrate oral powder 3 gm/tsp*** | 1 | PA |
| ***sodium phenylbutyrate oral tablet 500 mg*** | 3 | PA |
| **CALORIC AGENTS - Drugs for Nutrition** | | |
| ***3232a infant formula oral powder*** | 1 | |
| ***anticoagulant cit dext soln a in vitro solution 0.8-2.45-2.2 gm/100ml*** | 1 | |
| AXONA ORAL PACKET (***dietary management product***) | 3 | |
| KETOVIE ORAL LIQUID (***nutritional supplements***) | 3 | |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| KETOVIE PEPTIDE ORAL LIQUID (***nutritional supplements***) | 3 | |
| L-CYSTINE POWDER | 3 | |
| ***multiple vitamins-minerals*** (Lysiplex Plus Oral Tablet) | 1 | |
| PROMACTIN AA PLUS 20PE ORAL SUSPENSION (***nutritional supplements***) | 3 | |
| PURAMINO DHA/ARA ORAL POWDER (***infant foods***) | 3 | |
| TYLACTIN RESTORE 5PE ORAL PACKET (***nutritional supplements***) | 3 | |
| **CARBONIC ANHYDRASE INHIBITORS - Drugs for Water Balance** | | |
| ***acetazolamide er oral capsule extended release 12 hour 500 mg*** | 1 | |
| ***acetazolamide oral tablet 125 mg, 250 mg*** | 1 | |
| **DIURETICS, MISCELLANEOUS - Drugs for Water Balance** | | |
| ELIXOPHYLLIN ORAL ELIXIR 80 MG/15ML (***theophylline***) | 3 | |
| THEO-24 ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 300 MG, 400 MG (***theophylline***) | 3 | |
| ***theophylline er oral tablet extended release 12 hour 300 mg, 450 mg*** | 1 | |
| ***theophylline er oral tablet extended release 24 hour 400 mg, 600 mg*** | 1 | |
| ***theophylline oral solution 80 mg/15ml*** | 1 | |
| **LOOP DIURETICS - Drugs for Water Balance** | | |
| ***bumetanide oral tablet 0.5 mg, 1 mg, 2 mg*** | 1 | |
| EDECRIN ORAL TABLET 25 MG (***ethacrynic acid***) | 4 | |
| ***ethacrynic acid oral tablet 25 mg*** | 3 | |
| ***furosemide oral solution 10 mg/ml, 8 mg/ml*** | 1 | |
| ***furosemide oral tablet 20 mg, 40 mg, 80 mg*** | 1 | |
| LASIX ORAL TABLET 20 MG, 40 MG, 80 MG (***furosemide***) | 3 | |
| ***torsemide oral tablet 10 mg, 100 mg, 20 mg, 5 mg*** | 1 | |
| **OTHER ION-REMOVING AGENTS** | | |
| RADIOGARDASE ORAL CAPSULE 0.5 GM (***prussian blue insoluble***) | 3 | |
| **PHOSPHATE-REMOVING AGENTS** | | |
| AURYXIA ORAL TABLET 1 GM 210 MG(FE) (***ferric citrate***) | 3 | |
| ***calcium acetate (phos binder) oral capsule 667 mg*** | 1 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ***calcium acetate (phos binder) oral tablet 667 mg*** | 1 | |
| ***calcium acetate oral tablet 667 mg*** | 1 | |
| FOSRENOL ORAL PACKET 1000 MG, 750 MG (***lanthanum carbonate***) | 3 | |
| ***lanthanum carbonate oral tablet chewable 1000 mg, 500 mg, 750 mg*** | 3 | |
| MAGNEBIND 400 ORAL TABLET 400-200-1 MG (***magnesium-calcium-folic acid***) | 2 | |
| PHOSLYRA ORAL SOLUTION 667 MG/5ML (***calcium acetate (phos binder)***) | 3 | |
| RENAGEL ORAL TABLET 800 MG (***sevelamer hcl***) | 3 | |
| RENVELA ORAL PACKET 0.8 GM, 2.4 GM (***sevelamer carbonate***) | 3 | |
| ***sevelamer carbonate oral packet 0.8 gm, 2.4 gm*** | 2 | |
| ***sevelamer carbonate oral tablet 800 mg*** | 2 | |
| ***sevelamer hcl oral tablet 400 mg, 800 mg*** | 3 | |
| VELPHORO ORAL TABLET CHEWABLE 500 MG (***sucroferric oxyhydroxide***) | 2 | |
| **POTASSIUM-REMOVING AGENTS** | | |
| ***sodium polystyrene sulfonate*** (Kionex Oral Suspension 15 Gm/60Ml) | 1 | |
| LOKELMA ORAL PACKET 10 GM (***sodium zirconium cyclosilicate***) | 3 | PA; SL (3 packets per day.) |
| LOKELMA ORAL PACKET 5 GM (***sodium zirconium cyclosilicate***) | 3 | PA; SL (1 packet per day.) |
| ***sodium polystyrene sulfonate oral powder*** | 1 | |
| ***sodium polystyrene sulfonate oral suspension 15 gm/60ml*** | 1 | |
| ***sodium polystyrene sulfonate rectal suspension 30 gm/120ml, 50 gm/200ml*** | 1 | |
| ***sodium polystyrene sulfonate*** (Sps Oral Suspension 15 Gm/60Ml) | 1 | |
| VELTASSA ORAL PACKET 16.8 GM, 25.2 GM, 8.4 GM (***patiromer sorbitex calcium***) | 3 | PA; SL (1 Packet per day.) |
| **POTASSIUM-SPARING DIURETICS - Drugs for Water Balance** | | |
| ALDACTAZIDE ORAL TABLET 25-25 MG (***spironolactone-hctz***) | 3 | |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ALDACTAZIDE ORAL TABLET 50-50 MG (***spironolactone-hctz***) | 2 | |
| ALDACTONE ORAL TABLET 100 MG, 25 MG, 50 MG (***spironolactone***) | 3 | |
| ***amiloride hcl oral tablet 5 mg*** | 1 | |
| ***amiloride-hydrochlorothiazide oral tablet 5-50 mg*** | 1 | |
| CAROSPIR ORAL SUSPENSION 25 MG/5ML (***spironolactone***) | 3 | PA |
| DYAZIDE ORAL CAPSULE 37.5-25 MG (***triamterene-hctz***) | 3 | |
| DYRENIUM ORAL CAPSULE 100 MG, 50 MG (***triamterene***) | 3 | |
| MAXZIDE ORAL TABLET 75-50 MG (***triamterene-hctz***) | 3 | |
| MAXZIDE-25 ORAL TABLET 37.5-25 MG (***triamterene-hctz***) | 3 | |
| ***spironolactone oral tablet 100 mg, 25 mg, 50 mg*** | 1 | |
| ***spironolactone-hctz oral tablet 25-25 mg*** | 1 | |
| ***triamterene oral capsule 100 mg, 50 mg*** | 3 | |
| ***triamterene-hctz oral capsule 37.5-25 mg*** | 1 | |
| ***triamterene-hctz oral tablet 37.5-25 mg, 75-50 mg*** | 1 | |
| **REPLACEMENT PREPARATIONS** | | |
| ***calcium acetate (phos binder) oral tablet 667 mg*** | 1 | |
| ***calcium-folic acid plus d oral wafer 1342-1 mg*** | 1 | |
| EFFER-K ORAL TABLET EFFERVESCENT 10 MEQ, 20 MEQ (***potassium bicarb-citric acid***) | 2 | |
| ***potassium bicarbonate*** (Effer-K Oral Tablet Effervescent 25 Meq) | 1 | |
| HYPERSAL INHALATION NEBULIZATION SOLUTION 3.5 %, 7 % (***sodium chloride***) | 2 | |
| ***potassium chloride*** (Klor-Con 10 Oral Tablet Extended Release 10 Meq) | 1 | |
| ***potassium chloride crys er*** (Klor-Con M10 Oral Tablet Extended Release 10 Meq) | 1 | |
| KLOR-CON M15 ORAL TABLET EXTENDED RELEASE 15 MEQ (***potassium chloride crys er***) | 3 | |
| ***potassium chloride crys er*** (Klor-Con M20 Oral Tablet Extended Release 20 Meq) | 1 | |
| ***potassium chloride*** (Klor-Con Oral Packet 20 Meq) | 1 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ***potassium chloride*** (Klor-Con Oral Tablet Extended Release 8 Meq) | 1 | |
| ***potassium chloride*** (Klor-Con Sprinkle Oral Capsule Extended Release 10 Meq, 8 Meq) | 1 | |
| ***potassium bicarbonate*** (Klor-Con/Ef Oral Tablet Effervescent 25 Meq) | 1 | |
| ***potassium bicarbonate*** (K-Prime Oral Tablet Effervescent 25 Meq) | 1 | |
| K-TAB ORAL TABLET EXTENDED RELEASE 10 MEQ, 20 MEQ, 8 MEQ (***potassium chloride***) | 3 | |
| M-NATAL PLUS ORAL TABLET 27-1 MG | 3 | |
| ***sodium chloride*** (Nebusal Inhalation Nebulization Solution 3 %) | 1 | |
| NEBUSAL INHALATION NEBULIZATION SOLUTION 6 % (***sodium chloride***) | 3 | |
| NESTABS ORAL TABLET 32-1 MG (***prenat-fe bisgly-fa-w/o vit a***) | 3 | |
| ***pot bicarb-pot chloride oral tablet effervescent 25 meq*** | 1 | |
| ***potassium bicarbonate oral tablet effervescent 25 meq*** | 1 | |
| ***potassium chloride crys er oral tablet extended release 10 meq, 20 meq*** | 1 | |
| ***potassium chloride er oral capsule extended release 10 meq, 8 meq*** | 1 | |
| ***potassium chloride er oral tablet extended release 10 meq, 20 meq, 8 meq*** | 1 | |
| ***potassium chloride oral packet 20 meq*** | 1 | |
| ***potassium chloride oral solution 20 meq/15ml (10%), 40 meq/15ml (20%)*** | 1 | |
| PRENAISSANCE ORAL CAPSULE 29-1.25-325 MG | 2 | |
| ***prenatal oral tablet 27-0.8 mg, 27-1 mg, 28-0.8 mg*** | 1 | |
| ***prenatal plus iron oral tablet 29-1 mg*** | 1 | |
| PRENATE ORAL TABLET CHEWABLE 0.6-0.4 MG (***prenat mv-min-methylfolate-fa***) | 3 | |
| ***sodium chloride*** (Pulmosal Inhalation Nebulization Solution 7 %) | 1 | |
| ***sodium chloride inhalation nebulization solution 0.9 %, 10 %, 3 %, 7 %*** | 1 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ***trinate oral tablet*** | 1 | |
| VITAFOL-OB+DHA ORAL 65-1 & 250 MG (***prenatal mv-min-fe fum-fa-dha***) | 3 | |
| **THIAZIDE DIURETICS - Drugs for Water Balance** | | |
| ACCURETIC ORAL TABLET 10-12.5 MG, 20-12.5 MG, 20-25 MG (***quinapril-hydrochlorothiazide***) | 3 | |
| ALDACTAZIDE ORAL TABLET 25-25 MG (***spironolactone-hctz***) | 3 | |
| ALDACTAZIDE ORAL TABLET 50-50 MG (***spironolactone-hctz***) | 2 | |
| ***amiloride-hydrochlorothiazide oral tablet 5-50 mg*** | 1 | |
| ATACAND HCT ORAL TABLET 16-12.5 MG, 32-12.5 MG, 32-25 MG (***candesartan cilexetil-hctz***) | 3 | |
| AVALIDE ORAL TABLET 150-12.5 MG, 300-12.5 MG (***irbesartan-hydrochlorothiazide***) | 3 | |
| ***benazepril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg, 5-6.25 mg*** | 1 | |
| ***bisoprolol-hydrochlorothiazide oral tablet 10-6.25 mg, 2.5-6.25 mg, 5-6.25 mg*** | 1 | |
| ***candesartan cilexetil-hctz oral tablet 16-12.5 mg, 32-12.5 mg, 32-25 mg*** | 3 | |
| ***captopril-hydrochlorothiazide oral tablet 25-15 mg, 25-25 mg, 50-15 mg, 50-25 mg*** | 1 | |
| DIURIL ORAL SUSPENSION 250 MG/5ML (***chlorothiazide***) | 2 | |
| DYAZIDE ORAL CAPSULE 37.5-25 MG (***triamterene-hctz***) | 3 | |
| ***enalapril-hydrochlorothiazide oral tablet 10-25 mg, 5-12.5 mg*** | 1 | |
| ***fosinopril sodium-hctz oral tablet 10-12.5 mg, 20-12.5 mg*** | 1 | |
| ***hydrochlorothiazide oral capsule 12.5 mg*** | 1 | |
| ***hydrochlorothiazide oral tablet 12.5 mg, 25 mg, 50 mg*** | 1 | |
| HYZAAR ORAL TABLET 100-12.5 MG, 100-25 MG, 50-12.5 MG (***losartan potassium-hctz***) | 3 | |
| ***irbesartan-hydrochlorothiazide oral tablet 150-12.5 mg, 300-12.5 mg*** | 1 | |
| ***lisinopril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg*** | 1 | |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| LOPRESSOR HCT ORAL TABLET 50-25 MG (***metoprolol-hydrochlorothiazide***) | 3 | |
| ***losartan potassium-hctz oral tablet 100-12.5 mg, 100-25 mg, 50-12.5 mg*** | 1 | |
| LOTENSIN HCT ORAL TABLET 10-12.5 MG, 20-12.5 MG, 20-25 MG (***benazepril-hydrochlorothiazide***) | 3 | |
| MAXZIDE ORAL TABLET 75-50 MG (***triamterene-hctz***) | 3 | |
| MAXZIDE-25 ORAL TABLET 37.5-25 MG (***triamterene-hctz***) | 3 | |
| ***methyldopa-hydrochlorothiazide oral tablet 250-15 mg, 250-25 mg*** | 1 | |
| ***metoprolol-hydrochlorothiazide oral tablet 100-25 mg, 100-50 mg, 50-25 mg*** | 1 | |
| ***olmesartan medoxomil-hctz oral tablet 20-12.5 mg, 40-12.5 mg, 40-25 mg*** | 2 | |
| ***propranolol-hctz oral tablet 40-25 mg, 80-25 mg*** | 1 | |
| ***quinapril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg*** | 2 | |
| ***spironolactone-hctz oral tablet 25-25 mg*** | 1 | |
| TEKTURNA HCT ORAL TABLET 150-12.5 MG, 150-25 MG, 300-12.5 MG, 300-25 MG (***aliskiren-hydrochlorothiazide***) | 3 | |
| ***telmisartan-hctz oral tablet 40-12.5 mg, 80-12.5 mg, 80-25 mg*** | 2 | |
| ***triamterene-hctz oral capsule 37.5-25 mg*** | 1 | |
| ***triamterene-hctz oral tablet 37.5-25 mg, 75-50 mg*** | 1 | |
| ***valsartan-hydrochlorothiazide oral tablet 160-12.5 mg, 160-25 mg, 320-12.5 mg, 320-25 mg, 80-12.5 mg*** | 1 | |
| ZIAC ORAL TABLET 10-6.25 MG, 2.5-6.25 MG, 5-6.25 MG (***bisoprolol-hydrochlorothiazide***) | 3 | |
| **THIAZIDE-LIKE DIURETICS - Drugs for Water Balance** | | |
| ***atenolol-chlorthalidone oral tablet 100-25 mg, 50-25 mg*** | 1 | |
| ***chlorthalidone oral tablet 25 mg, 50 mg*** | 1 | |
| EDARBYCLOR ORAL TABLET 40-12.5 MG, 40-25 MG (***azilsartan-chlorthalidone***) | 3 | |
| ***indapamide oral tablet 1.25 mg, 2.5 mg*** | 1 | |
| ***metolazone oral tablet 10 mg, 2.5 mg, 5 mg*** | 1 | |
| **URICOSURIC AGENTS** | | |
| ***colchicine-probenecid oral tablet 0.5-500 mg*** | 1 | |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ***probenecid oral tablet 500 mg*** | 1 | |
| **VASOPRESSIN ANTAGONISTS - Drugs for Water Balance** | | |
| JYNARQUE ORAL TABLET 15 MG, 30 MG (***tolvaptan***) | 2 | PA; SL (2 tablets per day.); SP |
| JYNARQUE ORAL TABLET THERAPY PACK 15 MG, 45 & 15 MG, 60 & 30 MG, 90 & 30 MG (***tolvaptan***) | 2 | PA; SL (2 tablets per day.); SP |
| JYNARQUE ORAL TABLET THERAPY PACK 30 & 15 MG (***tolvaptan***) | 2 | PA; SL (2 tablets per day.) |
| SAMSCA ORAL TABLET 15 MG (***tolvaptan***) | 2 | PA; SL (90 tablets per 365 days.); SP |
| SAMSCA ORAL TABLET 30 MG (***tolvaptan***) | 3 | PA; SL (60 tablets per 365 days.); SP |
| ***tolvaptan oral tablet 30 mg*** | 2 | PA; SL (2 tablets per day.); SP |
| **ENZYMES** | | |
| **ENZYMES** | | |
| PALYNZIQ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 10 MG/0.5ML (***pegvaliase-pqpz***) | 3 | PA; M; SL (0.5 ml per day.); SP |
| PALYNZIQ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 2.5 MG/0.5ML (***pegvaliase-pqpz***) | 3 | PA; M; SP |
| PALYNZIQ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/ML (***pegvaliase-pqpz***) | 3 | PA; M; SL (1 ml per day.); SP |
| PULMOZYME INHALATION SOLUTION 1 MG/ML (***dornase alfa***) | 2 | PA; SL (5 ml per day.); SP |
| STRENSIQ SUBCUTANEOUS SOLUTION 18 MG/0.45ML (***asfotase alfa***) | 4 | PA; M; SL (5.4 ml per month.); SP |
| STRENSIQ SUBCUTANEOUS SOLUTION 28 MG/0.7ML (***asfotase alfa***) | 4 | PA; M; SL (8.4 ml per month.); SP |
| STRENSIQ SUBCUTANEOUS SOLUTION 40 MG/ML (***asfotase alfa***) | 4 | PA; M; SL (12 ml tablets per month.); SP |
| STRENSIQ SUBCUTANEOUS SOLUTION 80 MG/0.8ML (***asfotase alfa***) | 4 | PA; M; SL (9.6 ml (12 vials) per month.); SP |
| SUCRAID ORAL SOLUTION 8500 UNIT/ML (***sacrosidase***) | 2 | PA; SP |
| **EYE, EAR, NOSE AND THROAT (EENT) PREPS.** | | |
| **ALPHA-ADRENERGIC AGONISTS (EENT) - Drugs for the Eye** | | |
| ALPHAGAN P OPHTHALMIC SOLUTION 0.1 % (***brimonidine tartrate***) | 2 | SL (10 ml per prescription) |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ALPHAGAN P OPHTHALMIC SOLUTION 0.15 % (***brimonidine tartrate***) | 3 | SL (10 ml per prescription) |
| ***brimonidine tartrate ophthalmic solution 0.15 %*** | 2 | SL (10 ml per prescription) |
| ***brimonidine tartrate ophthalmic solution 0.2 %*** | 1 | |
| COMBIGAN OPHTHALMIC SOLUTION 0.2-0.5 % (***brimonidine tartrate-timolol***) | 2 | SL (5 ml per prescription) |
| **ANTIALLERGIC AGENTS - Drugs for Allergy** | | |
| ALOCRIL OPHTHALMIC SOLUTION 2 % (***nedocromil sodium***) | 3 | |
| ALOMIDE OPHTHALMIC SOLUTION 0.1 % (***lodoxamide tromethamine***) | 3 | |
| ***azelastine hcl nasal solution 0.1 %, 137 mcg/spray*** | 3 | |
| ***azelastine hcl ophthalmic solution 0.05 %*** | 1 | |
| ***cromolyn sodium ophthalmic solution 4 %*** | 1 | |
| LASTACAFT OPHTHALMIC SOLUTION 0.25 % (***alcaftadine***) | 3 | SL (3 ml per prescription) |
| ***olopatadine hcl nasal solution 0.6 %*** | 3 | SL (30.5 grams (1 box) per prescription) |
| ***olopatadine hcl ophthalmic solution 0.1 %*** | 3 | SL (5 ml per prescription) |
| PATANASE NASAL SOLUTION 0.6 % (***olopatadine hcl***) | 3 | SL (30.5 grams (1 box) per prescription) |
| **ANTIBACTERIALS (EENT) - Drugs for Infections** | | |
| ***ak-poly-bac ophthalmic ointment 500-10000 unit/gm*** | 1 | |
| AZASITE OPHTHALMIC SOLUTION 1 % (***azithromycin***) | 3 | |
| ***bacitracin ophthalmic ointment 500 unit/gm*** | 1 | |
| ***bacitracin-polymyxin b ophthalmic ointment 500-10000 unit/gm*** | 1 | |
| ***bacitra-neomycin-polymyxin-hc ophthalmic ointment 1 %*** | 1 | |
| BESIVANCE OPHTHALMIC SUSPENSION 0.6 % (***besifloxacin hcl***) | 3 | |
| BLEPH-10 OPHTHALMIC SOLUTION 10 % (***sulfacetamide sodium***) | 3 | |
| BLEPHAMIDE OPHTHALMIC SUSPENSION 10-0.2 % (***sulfacetamide-prednisolone***) | 3 | |
| BLEPHAMIDE S.O.P. OPHTHALMIC OINTMENT 10-0.2 % (***sulfacetamide-prednisolone***) | 2 | |
| CETRAXAL OTIC SOLUTION 0.2 % (***ciprofloxacin hcl***) | 3 | |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| CILOXAN OPHTHALMIC OINTMENT 0.3 % (***ciprofloxacin hcl***) | 3 | |
| CILOXAN OPHTHALMIC SOLUTION 0.3 % (***ciprofloxacin hcl***) | 3 | |
| CIPRO HC OTIC SUSPENSION 0.2-1 % (***ciprofloxacin-hydrocortisone***) | 3 | |
| CIPRODEX OTIC SUSPENSION 0.3-0.1 % (***ciprofloxacin-dexamethasone***) | 3 | |
| ***ciprofloxacin hcl ophthalmic solution 0.3 %*** | 1 | |
| ***ciprofloxacin hcl otic solution 0.2 %*** | 1 | |
| ***ciprofloxacin-dexamethasone otic suspension 0.3-0.1 %*** | 3 | |
| ***doxycycline hyclate oral tablet 20 mg*** | 1 | |
| ***erythromycin ophthalmic ointment 5 mg/gm*** | 1 | H-N |
| ***gatifloxacin ophthalmic solution 0.5 %*** | 3 | |
| ***gentak ophthalmic ointment 0.3 %*** | 1 | |
| ***gentamicin sulfate ophthalmic solution 0.3 %*** | 1 | SL (15 ml per prescription) |
| ***levofloxacin ophthalmic solution 0.5 %*** | 1 | |
| MAXITROL OPHTHALMIC OINTMENT 3.5-10000-0.1 (***neomycin-polymyxin-dexameth***) | 3 | |
| MAXITROL OPHTHALMIC SUSPENSION 3.5-10000-0.1 (***neomycin-polymyxin-dexameth***) | 3 | |
| MOXEZA OPHTHALMIC SOLUTION 0.5 % (***moxifloxacin hcl***) | 3 | |
| ***moxifloxacin hcl (2x day) ophthalmic solution 0.5 %*** | 3 | |
| ***moxifloxacin hcl ophthalmic solution 0.5 %*** | 3 | |
| ***neomycin-bacitracin zn-polymyx ophthalmic ointment 3.5-400-10000 , 5-400-10000*** | 1 | |
| ***neomycin-polymyxin-dexameth ophthalmic ointment 3.5-10000-0.1*** | 1 | |
| ***neomycin-polymyxin-dexameth ophthalmic suspension 3.5-10000-0.1*** | 1 | |
| ***neomycin-polymyxin-gramicidin ophthalmic solution 1.75-10000-.025*** | 1 | |
| ***neomycin-polymyxin-hc ophthalmic suspension 3.5-10000-1*** | 1 | |
| ***neomycin-polymyxin-hc otic solution 1 %, 3.5-10000-1*** | 1 | |
| ***neomycin-polymyxin-hc otic suspension 3.5-10000-1*** | 1 | |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ***bacitracin-polymyx-neo-hc*** (Neo-Polycin Hc Ophthalmic Ointment 1 %) | 1 | |
| ***neomycin-bacitracin zn-polymyx*** (Neo-Polycin Ophthalmic Ointment 3.5-400-10000) | 1 | |
| OCUFLOX OPHTHALMIC SOLUTION 0.3 % (***ofloxacin***) | 3 | |
| ***ofloxacin ophthalmic solution 0.3 %*** | 1 | |
| ***ofloxacin otic solution 0.3 %*** | 2 | |
| ***bacitracin-polymyxin b*** (Polycin Ophthalmic Ointment 500-10000 Unit/Gm) | 1 | |
| ***polymyxin b-trimethoprim ophthalmic solution 10000-0.1 unit/ml-%*** | 1 | |
| POLYTRIM OPHTHALMIC SOLUTION 10000-0.1 UNIT/ML-% (***polymyxin b-trimethoprim***) | 3 | |
| PRED-G OPHTHALMIC SUSPENSION 0.3-1 % (***gentamicin-prednisolone acet***) | 3 | |
| PRED-G S.O.P. OPHTHALMIC OINTMENT 0.3-0.6 % (***gentamicin-prednisolone acet***) | 3 | |
| ***sulfacetamide sodium ophthalmic ointment 10 %*** | 1 | |
| ***sulfacetamide sodium ophthalmic solution 10 %*** | 1 | |
| ***sulfacetamide-prednisolone ophthalmic solution 10-0.23 %*** | 1 | |
| TOBRADEX OPHTHALMIC OINTMENT 0.3-0.1 % (***tobramycin-dexamethasone***) | 3 | |
| TOBRADEX OPHTHALMIC SUSPENSION 0.3-0.1 % (***tobramycin-dexamethasone***) | 3 | |
| ***tobramycin ophthalmic solution 0.3 %*** | 1 | |
| ***tobramycin-dexamethasone ophthalmic suspension 0.3-0.1 %*** | 2 | |
| TOBREX OPHTHALMIC OINTMENT 0.3 % (***tobramycin***) | 3 | |
| TOBREX OPHTHALMIC SOLUTION 0.3 % (***tobramycin***) | 3 | |
| ZYLET OPHTHALMIC SUSPENSION 0.5-0.3 % (***loteprednol-tobramycin***) | 3 | |
| ZYMAXID OPHTHALMIC SOLUTION 0.5 % (***gatifloxacin***) | 3 | |
| **ANTIFUNGALS (EENT) - Drugs for Infections** | | |
| NATACYN OPHTHALMIC SUSPENSION 5 % (***natamycin***) | 3 | |
| **ANTIGLAUCOMA AGENTS, MISCELLANEOUS - Drugs for the Eye** | | |
| MITOSOL OPHTHALMIC KIT 0.2 MG (***mitomycin***) | 3 | |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| RHOPRESSA OPHTHALMIC SOLUTION 0.02 % (***netarsudil dimesylate***) | 3 | SL (2.5 ml per prescription) |
| ROCKLATAN OPHTHALMIC SOLUTION 0.02-0.005 % (***netarsudil-latanoprost***) | 3 | SL (2.5 mL per prescription) |
| **ANTIVIRALS (EENT) - Drugs for Infections** | | |
| ***trifluridine ophthalmic solution 1 %*** | 1 | |
| ZIRGAN OPHTHALMIC GEL 0.15 % (***ganciclovir***) | 3 | |
| **BETA-ADRENERGIC BLOCKING AGENTS (EENT) - Drugs for the Eye** | | |
| ***betaxolol hcl ophthalmic solution 0.5 %*** | 1 | |
| BETIMOL OPHTHALMIC SOLUTION 0.25 % (***timolol hemihydrate***) | 2 | SL (5 ml per prescription) |
| BETIMOL OPHTHALMIC SOLUTION 0.5 % (***timolol hemihydrate***) | 2 | SL (5 ml per prescription.) |
| BETOPTIC-S OPHTHALMIC SUSPENSION 0.25 % (***betaxolol hcl***) | 3 | |
| ***carteolol hcl ophthalmic solution 1 %*** | 1 | |
| COMBIGAN OPHTHALMIC SOLUTION 0.2-0.5 % (***brimonidine tartrate-timolol***) | 2 | SL (5 ml per prescription) |
| COSOPT OPHTHALMIC SOLUTION 22.3-6.8 MG/ML (***dorzolamide hcl-timolol mal***) | 3 | |
| ***dorzolamide hcl-timolol mal ophthalmic solution 22.3-6.8 mg/ml*** | 2 | |
| ISTALOL OPHTHALMIC SOLUTION 0.5 % (***timolol maleate***) | 3 | |
| ***levobunolol hcl ophthalmic solution 0.5 %*** | 1 | |
| ***timolol maleate ophthalmic gel forming solution 0.25 %, 0.5 %*** | 1 | |
| ***timolol maleate ophthalmic solution 0.25 %, 0.5 %*** | 1 | |
| ***timolol maleate ophthalmic solution 0.5 % (daily)*** | 3 | |
| TIMOPTIC OCUDOSE OPHTHALMIC SOLUTION 0.25 %, 0.5 % (***timolol maleate***) | 2 | |
| TIMOPTIC OPHTHALMIC SOLUTION 0.25 %, 0.5 % (***timolol maleate***) | 3 | |
| TIMOPTIC-XE OPHTHALMIC GEL FORMING SOLUTION 0.25 %, 0.5 % (***timolol maleate***) | 3 | |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| **CARBONIC ANHYDRASE INHIBITORS (EENT) - Drugs for the Eye** | | |
| ***acetazolamide er oral capsule extended release 12 hour 500 mg*** | 1 | |
| ***acetazolamide oral tablet 125 mg, 250 mg*** | 1 | |
| AZOPT OPHTHALMIC SUSPENSION 1 % (***brinzolamide***) | 2 | SL (10 ml per prescription) |
| COSOPT OPHTHALMIC SOLUTION 22.3-6.8 MG/ML (***dorzolamide hcl-timolol mal***) | 3 | |
| DORZOLAMIDE HCL SOLUTION 2 % OPHTHALMIC 2 % | 3 | |
| ***dorzolamide hcl solution 2 % ophthalmic 2 %*** | 1 | |
| ***dorzolamide hcl-timolol mal ophthalmic solution 22.3-6.8 mg/ml*** | 2 | |
| KEVEYIS ORAL TABLET 50 MG (***dichlorphenamide***) | 2 | PA; SL (4 tablets per day.); SP |
| ***methazolamide oral tablet 25 mg, 50 mg*** | 1 | |
| TRUSOPT OPHTHALMIC SOLUTION 2 % (***dorzolamide hcl***) | 3 | |
| **CORTICOSTEROIDS (EENT) - Drugs for Inflammation** | | |
| ALREX OPHTHALMIC SUSPENSION 0.2 % (***loteprednol etabonate***) | 3 | SL (5 ml per prescription) |
| ***bacitra-neomycin-polymyxin-hc ophthalmic ointment 1 %*** | 1 | |
| CIPRO HC OTIC SUSPENSION 0.2-1 % (***ciprofloxacin-hydrocortisone***) | 3 | |
| CIPRODEX OTIC SUSPENSION 0.3-0.1 % (***ciprofloxacin-dexamethasone***) | 3 | |
| ***ciprofloxacin-dexamethasone otic suspension 0.3-0.1 %*** | 3 | |
| CORTANE-B EXTERNAL LOTION 10-10-1 MG/ML (***hc-pramoxine-chloroxylenol***) | 3 | |
| DERMOTIC OTIC OIL 0.01 % (***fluocinolone acetonide***) | 3 | |
| ***dexamethasone sodium phosphate ophthalmic solution 0.1 %*** | 1 | |
| DEXTENZA OPHTHALMIC INSERT 0.4 MG (***dexamethasone***) | 3 | |
| DUREZOL OPHTHALMIC EMULSION 0.05 % (***difluprednate***) | 3 | |
| ***exotic-hc otic solution 10-10-1 mg/ml*** | 1 | |
| ***fluocinolone acetonide*** (Flac Otic Oil 0.01 %) | 1 | |
| FLAREX OPHTHALMIC SUSPENSION 0.1 % (***fluorometholone acetate***) | 2 | |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ***flunisolide nasal solution 25 mcg/act (0.025%)*** | 3 | |
| ***fluocinolone acetonide otic oil 0.01 %*** | 1 | |
| ***fluorometholone ophthalmic suspension 0.1 %*** | 1 | |
| ***fluticasone propionate nasal suspension 50 mcg/act*** | 2 | SL (16 grams (1 bottle) per prescription) |
| FML FORTE OPHTHALMIC SUSPENSION 0.25 % (***fluorometholone***) | 3 | |
| FML LIQUIFILM OPHTHALMIC SUSPENSION 0.1 % (***fluorometholone***) | 3 | |
| FML OPHTHALMIC OINTMENT 0.1 % (***fluorometholone***) | 3 | |
| ***hydrocortisone-acetic acid otic solution 1-2 %*** | 1 | |
| INVELTYS OPHTHALMIC SUSPENSION 1 % (***loteprednol etabonate***) | 3 | |
| LOTEMAX OPHTHALMIC OINTMENT 0.5 % (***loteprednol etabonate***) | 3 | |
| LOTEMAX OPHTHALMIC SUSPENSION 0.5 % (***loteprednol etabonate***) | 3 | SL (5 ml per prescription) |
| LOTEMAX SM OPHTHALMIC GEL 0.38 % (***loteprednol etabonate***) | 3 | SL (5 grams per prescription) |
| ***loteprednol etabonate ophthalmic suspension 0.5 %*** | 3 | SL (5 ml per prescription) |
| MAXIDEX OPHTHALMIC SUSPENSION 0.1 % (***dexamethasone***) | 2 | |
| MAXITROL OPHTHALMIC OINTMENT 3.5-10000-0.1 (***neomycin-polymyxin-dexameth***) | 3 | |
| MAXITROL OPHTHALMIC SUSPENSION 3.5-10000-0.1 (***neomycin-polymyxin-dexameth***) | 3 | |
| ***neomycin-polymyxin-dexameth ophthalmic ointment 3.5-10000-0.1*** | 1 | |
| ***neomycin-polymyxin-dexameth ophthalmic suspension 3.5-10000-0.1*** | 1 | |
| ***neomycin-polymyxin-hc ophthalmic suspension 3.5-10000-1*** | 1 | |
| ***bacitracin-polymyx-neo-hc*** (Neo-Polycin Hc Ophthalmic Ointment 1 %) | 1 | |
| OTICIN HC NR OTIC SOLUTION 10-10-1 MG/ML (***pramoxine-hc-chloroxylenol***) | 2 | |
| PRED FORTE OPHTHALMIC SUSPENSION 1 % (***prednisolone acetate***) | 3 | |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| PRED MILD OPHTHALMIC SUSPENSION 0.12 % (***prednisolone acetate***) | 3 | |
| PRED-G OPHTHALMIC SUSPENSION 0.3-1 % (***gentamicin-prednisolone acet***) | 3 | |
| PRED-G S.O.P. OPHTHALMIC OINTMENT 0.3-0.6 % (***gentamicin-prednisolone acet***) | 3 | |
| ***prednisolone acetate ophthalmic suspension 1 %*** | 1 | |
| ***prednisolone sodium phosphate ophthalmic solution 1 %*** | 1 | |
| TOBRADEX OPHTHALMIC OINTMENT 0.3-0.1 % (***tobramycin-dexamethasone***) | 3 | |
| TOBRADEX OPHTHALMIC SUSPENSION 0.3-0.1 % (***tobramycin-dexamethasone***) | 3 | |
| ***tobramycin-dexamethasone ophthalmic suspension 0.3-0.1 %*** | 2 | |
| ZETONNA NASAL AEROSOL SOLUTION 37 MCG/ACT (***ciclesonide***) | 3 | SL (6.1 grams per prescription) |
| ZYLET OPHTHALMIC SUSPENSION 0.5-0.3 % (***loteprednol-tobramycin***) | 3 | |
| **EENT ANTI-INFECTIVES, MISCELLANEOUS - Drugs for Infections** | | |
| ***acetic acid otic solution 2 %*** | 1 | |
| BETADINE OPHTHALMIC PREP OPHTHALMIC SOLUTION 5 % (***povidone-iodine***) | 3 | |
| ***chlorhexidine gluconate mouth/throat solution 0.12 %*** | 1 | |
| ***hydrocortisone-acetic acid otic solution 1-2 %*** | 1 | |
| ***chlorhexidine gluconate*** (Paroex Mouth/Throat Solution 0.12 %) | 1 | |
| PERIDEX MOUTH/THROAT SOLUTION 0.12 % (***chlorhexidine gluconate***) | 3 | |
| ***chlorhexidine gluconate*** (Periogard Mouth/Throat Solution 0.12 %) | 1 | |
| PRAMOTIC OTIC LIQUID 1-0.1 % (***pramoxine-chloroxylenol***) | 3 | |
| **EENT ANTI-INFLAMMATORY AGENTS, MISC. - Drugs for Inflammation** | | |
| RESTASIS OPHTHALMIC EMULSION 0.05 % (***cyclosporine***) | 3 | PA; SL (60 vials per prescription.) |
| XIIDRA OPHTHALMIC SOLUTION 5 % (***lifitegrast***) | 3 | PA; SL (60 vials per prescription) |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| **EENT DRUGS, MISCELLANEOUS** | | |
| ***apraclonidine hcl ophthalmic solution 0.5 %*** | 1 | |
| CYSTARAN OPHTHALMIC SOLUTION 0.44 % (***cysteamine hcl***) | 2 | PA; SL (60 ml (4 bottles) per month.); SP |
| GELFILM OPHTHALMIC FILM (***gelatin adsorbable***) | 2 | |
| IOPIDINE OPHTHALMIC SOLUTION 1 % (***apraclonidine hcl***) | 3 | |
| ***ipratropium bromide nasal solution 0.03 %, 0.06 %*** | 1 | |
| LACRISERT OPHTHALMIC INSERT 5 MG (***artificial tear insert***) | 2 | |
| OXERVATE OPHTHALMIC SOLUTION 0.002 % (***cenegermin-bkbj***) | 3 | PA; SL (1 ml per day and 56 ml per 365 days.); SP |
| PHOTREXA-PHOTREXA VISCOUS KIT OPHTHALMIC SOLUTION PREFILLED SYRINGE 0.146 &0.146-20 % (***riboflav5 & riboflav5-dextran***) | 3 | |
| **EENT NONSTEROIDAL ANTI-INFLAM. AGENTS - Drugs for Inflammation** | | |
| ACULAR LS OPHTHALMIC SOLUTION 0.4 % (***ketorolac tromethamine***) | 3 | |
| ACULAR OPHTHALMIC SOLUTION 0.5 % (***ketorolac tromethamine***) | 3 | |
| ***diclofenac sodium ophthalmic solution 0.1 %*** | 1 | |
| ***flurbiprofen sodium ophthalmic solution 0.03 %*** | 1 | |
| ***ketorolac tromethamine ophthalmic solution 0.4 %, 0.5 %*** | 1 | |
| NEVANAC OPHTHALMIC SUSPENSION 0.1 % (***nepafenac***) | 3 | |
| **LOCAL ANESTHETICS (EENT) - Drugs for Numbing** | | |
| AKTEN OPHTHALMIC GEL 3.5 % (***lidocaine hcl***) | 3 | |
| ALCAINE OPHTHALMIC SOLUTION 0.5 % (***proparacaine hcl***) | 3 | |
| ***tetracaine hcl*** (Altacaine Ophthalmic Solution 0.5 %) | 1 | |
| ***lidocaine hcl external solution 4 %*** | 1 | |
| ***lidocaine hcl urethral/mucosal external gel 2 %*** | 1 | |
| ***lidocaine hcl urethral/mucosal external prefilled syringe 2 %*** | 1 | |
| ***lidocaine viscous hcl mouth/throat solution 2 %*** | 1 | |
| PRAMOTIC OTIC LIQUID 1-0.1 % (***pramoxine-chloroxylenol***) | 3 | |
| ***proparacaine hcl ophthalmic solution 0.5 %*** | 1 | |
| ***tetracaine hcl ophthalmic solution 0.5 %*** | 1 | |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| **MIOTICS - Drugs for the Eye** | | |
| ISOPTO CARPINE OPHTHALMIC SOLUTION 1 %, 2 %, 4 % (***pilocarpine hcl***) | 3 | |
| PHOSPHOLINE IODIDE OPHTHALMIC SOLUTION RECONSTITUTED 0.125 % (***echothiophate iodide***) | 2 | |
| ***pilocarpine hcl ophthalmic solution 1 %, 2 %, 4 %*** | 1 | |
| **MYDRIATICS - Drugs for the Eye** | | |
| ***atropine sulfate ophthalmic ointment 1 %*** | 1 | |
| CYCLOGYL OPHTHALMIC SOLUTION 0.5 %, 1 %, 2 % (***cyclopentolate hcl***) | 3 | |
| CYCLOMYDRIL OPHTHALMIC SOLUTION 0.2-1 % (***cyclopentolate-phenylephrine***) | 3 | |
| ***cyclopentolate hcl ophthalmic solution 0.5 %, 1 %, 2 %*** | 1 | |
| ***homatropaire ophthalmic solution 5 %*** | 1 | |
| **PROSTAGLANDIN ANALOGS - Drugs for the Eye** | | |
| ***latanoprost ophthalmic solution 0.005 %*** | 1 | |
| LUMIGAN OPHTHALMIC SOLUTION 0.01 % (***bimatoprost***) | 2 | |
| ROCKLATAN OPHTHALMIC SOLUTION 0.02-0.005 % (***netarsudil-latanoprost***) | 3 | SL (2.5 mL per prescription) |
| TRAVATAN Z OPHTHALMIC SOLUTION 0.004 % (***travoprost***) | 3 | SL (2.5 ml per prescription) |
| ***travoprost (bak free) ophthalmic solution 0.004 %*** | 2 | SL (2.5 ml per prescription) |
| XELPROS OPHTHALMIC EMULSION 0.005 % (***latanoprost***) | 3 | SL (2.5 ml per prescription) |
| ZIOPTAN OPHTHALMIC SOLUTION 0.0015 % (***tafluprost***) | 3 | ST; SL (30 unit of use droppers per prescription.) |
| **RHO KINASE INHIBITORS - Drugs for the Eye** | | |
| RHOPRESSA OPHTHALMIC SOLUTION 0.02 % (***netarsudil dimesylate***) | 3 | SL (2.5 ml per prescription) |
| ROCKLATAN OPHTHALMIC SOLUTION 0.02-0.005 % (***netarsudil-latanoprost***) | 3 | SL (2.5 mL per prescription) |
| **VASOCONSTRICTORS** | | |
| ADRENALIN NASAL SOLUTION 0.1 % (***epinephrine hcl (nasal)***) | 2 | |
| ***phenylephrine hcl*** (Altafrin Ophthalmic Solution 10 %, 2.5 %) | 1 | |
| ***epinephrine hcl (nasal) nasal solution 0.1 %*** | 1 | |
| ***phenylephrine hcl ophthalmic solution 10 %, 2.5 %*** | 1 | |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| **GASTROINTESTINAL DRUGS** | | |
| **ANTACIDS AND ADSORBENTS** | | |
| SODIUM BICARBONATE ORAL POWDER | 3 | |
| **GASTROINTESTINAL DRUGS - Drugs for the Stomach** | | |
| **5-HT3 RECEPTOR ANTAGONISTS - Drugs for Vomiting and Nausea** | | |
| AKYNZEO ORAL CAPSULE 300-0.5 MG (***netupitant-palonosetron***) | 3 | SL (1 capsule per prescription) |
| ANZEMET ORAL TABLET 100 MG (***dolasetron mesylate***) | 3 | SL (4 tablets per prescription) |
| ANZEMET ORAL TABLET 50 MG (***dolasetron mesylate***) | 3 | SL (1 tablet per prescription) |
| ***granisetron hcl oral tablet 1 mg*** | 2 | |
| ***ondansetron hcl oral solution 4 mg/5ml*** | 1 | |
| ***ondansetron hcl oral tablet 24 mg, 4 mg, 8 mg*** | 1 | |
| ***ondansetron odt oral tablet dispersible 4 mg, 8 mg*** | 1 | |
| ZOFRAN ORAL TABLET 4 MG (***ondansetron hcl***) | 4 | |
| **ANTIDIARRHEA AGENTS - Drugs for Diarrhea** | | |
| ***diphenoxylate-atropine oral liquid 2.5-0.025 mg/5ml*** | 1 | |
| ***diphenoxylate-atropine oral tablet 2.5-0.025 mg*** | 1 | |
| LOMOTIL ORAL TABLET 2.5-0.025 MG (***diphenoxylate-atropine***) | 3 | |
| MYTESI ORAL TABLET DELAYED RELEASE 125 MG (***crofelemer***) | 3 | PA; SL (2 tablets per day.) |
| ***opium oral tincture 10 mg/ml (1%)*** | 1 | |
| XERMELO ORAL TABLET 250 MG (***telotristat etiprate***) | 3 | PA; SL (3 tablets per day.); SP |
| **ANTIEMETICS, MISCELLANEOUS - Drugs for Vomiting and Nausea** | | |
| ***dronabinol oral capsule 10 mg, 2.5 mg, 5 mg*** | 1 | |
| MARINOL ORAL CAPSULE 10 MG, 2.5 MG, 5 MG (***dronabinol***) | 3 | |
| ***scopolamine transdermal patch 72 hour 1 mg/3days*** | 3 | |
| SYNDROS ORAL SOLUTION 5 MG/ML (***dronabinol***) | 3 | PA; SL (4 ml per day.) |
| TRANSDERM SCOP (1.5 MG) TRANSDERMAL PATCH 72 HOUR 1 MG/3DAYS (***scopolamine base***) | 3 | |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| TRANSDERM-SCOP (1.5 MG) TRANSDERMAL PATCH 72 HOUR 1 MG/3DAYS (***scopolamine base***) | 3 | |
| **ANTIHISTAMINES (GI DRUGS) - Drugs for Vomiting and Nausea** | | |
| ***prochlorperazine*** (Compro Rectal Suppository 25 Mg) | 1 | |
| ***prochlorperazine maleate oral tablet 10 mg, 5 mg*** | 1 | |
| ***prochlorperazine rectal suppository 25 mg*** | 1 | |
| TIGAN ORAL CAPSULE 300 MG (***trimethobenzamide hcl***) | 3 | |
| ***trimethobenzamide hcl oral capsule 300 mg*** | 1 | |
| **ANTI-INFLAMMATORY AGENTS (GI DRUGS) - Drugs for Inflammation** | | |
| ***alosetron hcl oral tablet 0.5 mg, 1 mg*** | 2 | PA; SL (2 tablets per day) |
| APRISO ORAL CAPSULE EXTENDED RELEASE 24 HOUR 0.375 GM (***mesalamine***) | 2 | |
| AZULFIDINE EN-TABS ORAL TABLET DELAYED RELEASE 500 MG (***sulfasalazine***) | 3 | |
| AZULFIDINE ORAL TABLET 500 MG (***sulfasalazine***) | 3 | |
| ***balsalazide disodium oral capsule 750 mg*** | 1 | |
| DIPENTUM ORAL CAPSULE 250 MG (***olsalazine sodium***) | 3 | |
| LIALDA ORAL TABLET DELAYED RELEASE 1.2 GM (***mesalamine***) | 2 | |
| ***mesalamine er oral capsule extended release 24 hour 0.375 gm*** | 3 | |
| ***mesalamine oral tablet delayed release 1.2 gm*** | 3 | |
| ***mesalamine rectal enema 4 gm*** | 1 | |
| ***mesalamine rectal suppository 1000 mg*** | 2 | |
| ***mesalamine-cleanser rectal kit 4 gm*** | 1 | SL (4 grams per month.) |
| ROWASA RECTAL KIT 4 GM (***mesalamine-cleanser***) | 4 | SL (4 grams per month.) |
| SFROWASA RECTAL ENEMA 4 GM/60ML (***mesalamine***) | 4 | |
| ***sulfasalazine oral tablet 500 mg*** | 1 | |
| ***sulfasalazine oral tablet delayed release 500 mg*** | 1 | |
| **ANTIULCER AGENTS AND ACID SUPPRESS.,MISC - Drugs for Ulcers and Stomach Acid** | | |
| PYLERA ORAL CAPSULE 140-125-125 MG (***bis subcit-metronid-tetracyc***) | 3 | SL (120 capsules per 180 days.) |

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|---|---|---|
| **CATHARTICS AND LAXATIVES - Drugs for Constipation** | | |
| AMITIZA ORAL CAPSULE 24 MCG, 8 MCG (***lubiprostone***) | 3 | PA; ST; SL (62 capsules per month.) |
| ***cascara sagrada oral fluid extract 1 gm/ml*** | 1 | |
| CLENPIQ ORAL SOLUTION 10-3.5-12 MG-GM -GM/160ML (***sod picosulfate-mag ox-cit acd***) | 3 | |
| ***gavilyte-c oral solution reconstituted 240 gm*** | 1 | H |
| ***peg 3350-kcl-nabcb-nacl-nasulf*** (Gavilyte-G Oral Solution Reconstituted 236 Gm) | 1 | SL (400 mL per prescription); H |
| ***bisacodyl-peg-kcl-nabicar-nacl*** (Gavilyte-H Oral Kit 5-210 Mg-Gm) | 1 | |
| ***peg 3350-kcl-na bicarb-nacl*** (Gavilyte-N With Flavor Pack Oral Solution Reconstituted 420 Gm) | 1 | SL (4000 ml per prescription); H |
| GOLYTELY ORAL SOLUTION RECONSTITUTED 227.1 GM (***peg 3350-kcl-nabcb-nacl-nasulf***) | 2 | SL (1 packet per prescription) |
| GOLYTELY ORAL SOLUTION RECONSTITUTED 236 GM (***peg 3350-kcl-nabcb-nacl-nasulf***) | 3 | SL (400 mL per prescription) |
| ***mineral oil heavy oral oil*** | 1 | |
| MOVIPREP ORAL SOLUTION RECONSTITUTED 100 GM (***peg-kcl-nacl-nasulf-na asc-c***) | 3 | SL (1 kit per prescription) |
| NULYTELY LEMON-LIME ORAL SOLUTION RECONSTITUTED 420 GM (***peg 3350-kcl-na bicarb-nacl***) | 3 | SL (4000 ml per prescription) |
| NULYTELY WITH FLAVOR PACKS ORAL SOLUTION RECONSTITUTED 420 GM (***peg 3350-kcl-na bicarb-nacl***) | 3 | SL (4000 ml per prescription) |
| OSMOPREP ORAL TABLET 1.102-0.398 GM (***sod phos mono-sod phos dibasic***) | 3 | |
| ***peg 3350-kcl-na bicarb-nacl oral solution reconstituted 420 gm*** | 1 | SL (4000 ml per prescription); H |
| ***peg-3350/electrolytes oral solution reconstituted 236 gm*** | 1 | SL (400 mL per prescription); H |
| ***peg-3350/electrolytes/ascorbat oral solution reconstituted 100 gm*** | 3 | SL (1 kit per prescription) |
| ***peg-kcl-nacl-nasulf-na asc-c oral solution reconstituted 100 gm*** | 3 | SL (1 kit per prescription) |
| ***bisacodyl-peg-kcl-nabicar-nacl*** (Peg-Prep Oral Kit 5-210 Mg-Gm) | 1 | |
| PLENVU ORAL SOLUTION RECONSTITUTED 140 GM (***peg-kcl-nacl-nasulf-na asc-c***) | 3 | SL (3 cartons per prescription) |

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|---|---|---|
| PRENAISSANCE ORAL CAPSULE 29-1.25-325 MG | 2 | |
| SUPREP BOWEL PREP KIT ORAL SOLUTION 17.5-3.13-1.6 GM/177ML (***na sulfate-k sulfate-mg sulf***) | 3 | SL (354 ml per prescription) |
| TRICARE PRENATAL DHA ONE ORAL CAPSULE 27-1-500 MG (***prenatal-fefum-fa-dss-fish oil***) | 3 | |
| ***peg 3350-kcl-na bicarb-nacl*** (Trilyte Oral Solution Reconstituted 420 Gm) | 1 | SL (4000 ml per prescription); H |
| **CHOLELITHOLYTIC AGENTS - Drugs for the Stomach** | | |
| ACTIGALL ORAL CAPSULE 300 MG (***ursodiol***) | 3 | |
| CHENODAL ORAL TABLET 250 MG (***chenodiol***) | 3 | SP |
| URSO 250 ORAL TABLET 250 MG (***ursodiol***) | 3 | |
| URSO FORTE ORAL TABLET 500 MG (***ursodiol***) | 3 | |
| ***ursodiol oral capsule 300 mg*** | 1 | |
| ***ursodiol oral tablet 250 mg, 500 mg*** | 1 | |
| **DIGESTANTS - Drugs for the Stomach** | | |
| CREON ORAL CAPSULE DELAYED RELEASE PARTICLES 12000 UNIT, 24000-76000 UNIT, 3000-9500 UNIT, 36000 UNIT, 6000 UNIT (***pancrelipase (lip-prot-amyl)***) | 2 | |
| PANCREAZE ORAL CAPSULE DELAYED RELEASE PARTICLES 10500 UNIT, 16800 UNIT, 21000 UNIT, 2600 UNIT, 4200 UNIT (***pancrelipase (lip-prot-amyl)***) | 3 | ST |
| PERTZYE ORAL CAPSULE DELAYED RELEASE PARTICLES 16000 UNIT, 24000-86250 UNIT, 4000 UNIT, 8000 UNIT (***pancrelipase (lip-prot-amyl)***) | 4 | ST |
| VIOKACE ORAL TABLET 10440 UNIT, 20880 UNIT (***pancrelipase (lip-prot-amyl)***) | 3 | ST |
| ZENPEP ORAL CAPSULE DELAYED RELEASE PARTICLES 10000-32000 UNIT, 15000-47000 UNIT, 20000-63000 UNIT, 25000-79000 UNIT, 3000-14000 UNIT, 40000-126000 UNIT, 5000-24000 UNIT (***pancrelipase (lip-prot-amyl)***) | 2 | |
| **GI DRUGS, MISCELLANEOUS - Drugs for the Stomach** | | |
| CHOLBAM ORAL CAPSULE 250 MG, 50 MG (***cholic acid***) | 2 | PA; SL (4 capsules per day.); SP |
| CIMZIA PREFILLED KIT SUBCUTANEOUS KIT 2 X 200 MG/ML (***certolizumab pegol***) | 2 | PA; M; SL (1 kit per 21 days.); SP |
| CIMZIA STARTER KIT SUBCUTANEOUS KIT 6 X 200 MG/ML (***certolizumab pegol***) | 2 | PA; M; SL (6 mL per 365 days.); SP |
| ENDARI ORAL PACKET 5 GM (***glutamine (sickle cell)***) | 3 | PA; SL (6 packets per day.) |

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|---|---|---|
| ENTEREG ORAL CAPSULE 12 MG (***alvimopan***) | 3 | |
| GATTEX SUBCUTANEOUS KIT 5 MG (***teduglutide (rdna)***) | 2 | PA; M; SL (1 vial per day.); SP |
| HUMIRA PEDIATRIC CROHNS START SUBCUTANEOUS PREFILLED SYRINGE KIT 80 MG/0.8ML (***adalimumab***) | 2 | PA; M; SL (3 syringes per year.); SP |
| HUMIRA PEDIATRIC CROHNS START SUBCUTANEOUS PREFILLED SYRINGE KIT 80 MG/0.8ML & 40MG/0.4ML (***adalimumab***) | 2 | PA; M; SL (2 kits per year.); SP |
| HUMIRA PEN SUBCUTANEOUS PEN-INJECTOR KIT 40 MG/0.4ML (***adalimumab***) | 2 | PA; M; SL (2 pens per month.); SP |
| HUMIRA PEN SUBCUTANEOUS PEN-INJECTOR KIT 40 MG/0.8ML (***adalimumab***) | 2 | PA; M; SL (2 syringes per month.); SP |
| HUMIRA PEN-CD/UC/HS STARTER SUBCUTANEOUS PEN-INJECTOR KIT 40 MG/0.8ML (***adalimumab***) | 2 | PA; M; SL (6 pens (1 kit) per year.); SP |
| HUMIRA PEN-CD/UC/HS STARTER SUBCUTANEOUS PEN-INJECTOR KIT 80 MG/0.8ML (***adalimumab***) | 2 | PA; M; SL (3 pens per year.); SP |
| HUMIRA PEN-PS/UV/ADOL HS START SUBCUTANEOUS PEN-INJECTOR KIT 40 MG/0.8ML (***adalimumab***) | 2 | PA; M; SL (4 pens (1 kit) per year.); SP |
| HUMIRA PEN-PS/UV/ADOL HS START SUBCUTANEOUS PEN-INJECTOR KIT 80 MG/0.8ML & 40MG/0.4ML (***adalimumab***) | 2 | PA; M; SL (3 pens per year.); SP |
| HUMIRA SUBCUTANEOUS PREFILLED SYRINGE KIT 10 MG/0.1ML, 10 MG/0.2ML, 20 MG/0.2ML, 20 MG/0.4ML, 40 MG/0.4ML (***adalimumab***) | 2 | PA; M; SL (2 syringes per month.); SP |
| HUMIRA SUBCUTANEOUS PREFILLED SYRINGE KIT 40 MG/0.8ML (***adalimumab***) | 2 | PA; M; SL (2 syringes per month.) |
| LINZESS ORAL CAPSULE 145 MCG, 290 MCG, 72 MCG (***linaclotide***) | 2 | PA; SL (1 capsule per day.) |
| OCALIVA ORAL TABLET 10 MG, 5 MG (***obeticholic acid***) | 4 | PA; ST; SL (1 tablet per day.); SP |
| RELISTOR SUBCUTANEOUS SOLUTION 12 MG/0.6ML (***methylnaltrexone bromide***) | 4 | PA; M; SL (0.6 ml per day.) |
| RELISTOR SUBCUTANEOUS SOLUTION 8 MG/0.4ML (***methylnaltrexone bromide***) | 4 | PA; M; SL (0.4 ml per day.) |
| SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML (***golimumab***) | 2 | PA; M; SL (1 syringe per 21 days.); SP |
| SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/0.5ML (***golimumab***) | 2 | PA; M; SL (0.5 ml (1 syringe) per month); SP |

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|---|---|---|
| SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (***golimumab***) | 2 | PA; M; SL (1 syringe per 21 days.); SP |
| SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 50 MG/0.5ML (***golimumab***) | 2 | PA; M; SL (0.5 ml (1 syringe) per month); SP |
| SYMPROIC ORAL TABLET 0.2 MG (***naldemedine tosylate***) | 2 | PA; SL (1 tablet per day.) |
| TRULANCE ORAL TABLET 3 MG (***plecanatide***) | 3 | PA; ST; SL (1 tablet per day.) |
| VIBERZI ORAL TABLET 100 MG, 75 MG (***eluxadoline***) | 4 | PA; SL (2 tablets per day.) |
| XENICAL ORAL CAPSULE 120 MG (***orlistat***) | 3 | PA |
| **HISTAMINE H2-ANTAGONISTS - Drugs for Ulcers and Stomach Acid** | | |
| ***cimetidine hcl oral solution 300 mg/5ml*** | 1 | |
| ***cimetidine oral tablet 200 mg, 300 mg, 400 mg, 800 mg*** | 1 | |
| ***famotidine oral suspension reconstituted 40 mg/5ml*** | 1 | |
| ***nizatidine oral solution 15 mg/ml*** | 2 | |
| **NEUROKININ-1 RECEPTOR ANTAGONISTS - Drugs for Vomiting and Nausea** | | |
| AKYNZEO ORAL CAPSULE 300-0.5 MG (***netupitant-palonosetron***) | 3 | SL (1 capsule per prescription) |
| ***aprepitant oral capsule 125 mg, 40 mg*** | 2 | SL (1 capsule per prescription) |
| ***aprepitant oral capsule 80 & 125 mg*** | 2 | SL (3 capsules per prescription) |
| ***aprepitant oral capsule 80 mg*** | 2 | SL (2 capsules per prescription) |
| EMEND ORAL CAPSULE 80 MG (***aprepitant***) | 3 | SL (2 capsules per prescription) |
| EMEND ORAL SUSPENSION RECONSTITUTED 125 MG/5ML (***aprepitant***) | 2 | SL (3 pouches per prescription) |
| EMEND TRI-PACK ORAL CAPSULE 80 & 125 MG (***aprepitant***) | 3 | SL (3 capsules per prescription) |
| **PROKINETIC AGENTS - Drugs for the Stomach** | | |
| ***metoclopramide hcl oral solution 10 mg/10ml, 5 mg/5ml*** | 1 | |
| ***metoclopramide hcl oral tablet 10 mg, 5 mg*** | 1 | |
| MOTEGRITY ORAL TABLET 1 MG, 2 MG (***prucalopride succinate***) | 3 | PA; SL (1 tablet per day.) |
| REGLAN ORAL TABLET 10 MG, 5 MG (***metoclopramide hcl***) | 3 | |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| **PROSTAGLANDINS - Drugs for Ulcers and Stomach Acid** | | |
| ARTHROTEC ORAL TABLET DELAYED RELEASE 50-0.2 MG, 75-0.2 MG (***diclofenac-misoprostol***) | 3 | |
| CYTOTEC ORAL TABLET 100 MCG, 200 MCG (***misoprostol***) | 3 | |
| ***diclofenac-misoprostol oral tablet delayed release 50-0.2 mg, 75-0.2 mg*** | 3 | |
| ***misoprostol oral tablet 100 mcg, 200 mcg*** | 1 | |
| **PROTECTANTS - Drugs for Ulcers and Stomach Acid** | | |
| CARAFATE ORAL SUSPENSION 1 GM/10ML (***sucralfate***) | 3 | |
| CARAFATE ORAL TABLET 1 GM (***sucralfate***) | 3 | |
| ***sucralfate oral suspension 1 gm/10ml*** | 3 | |
| ***sucralfate oral tablet 1 gm*** | 1 | |
| **PROTON-PUMP INHIBITORS - Drugs for Ulcers and Stomach Acid** | | |
| DEXILANT ORAL CAPSULE DELAYED RELEASE 30 MG, 60 MG (***dexlansoprazole***) | 3 | SL (1 capsule per day) |
| ***esomeprazole magnesium oral packet 10 mg, 20 mg, 40 mg*** | 3 | PA; ST; SL (1 packet per day) |
| FIRST-LANSOPRAZOLE ORAL SUSPENSION 3 MG/ML (***lansoprazole***) | 3 | PA |
| FIRST-OMEPRAZOLE ORAL SUSPENSION 2 MG/ML (***omeprazole***) | 3 | PA |
| ***lansoprazole oral tablet delayed release dispersible 15 mg, 30 mg*** | 3 | PA; ST; SL (1 tablet per day.) |
| NEXIUM ORAL PACKET 10 MG, 20 MG, 40 MG (***esomeprazole magnesium***) | 3 | PA; ST; SL (1 packet per day) |
| NEXIUM ORAL PACKET 2.5 MG, 5 MG (***esomeprazole magnesium***) | 3 | PA; ST; SL (1 packet per day.) |
| OMECLAMOX-PAK ORAL 500-500-20 MG (***amoxicill-clarithro-omeprazole***) | 3 | SL (1 carton (10 administrative cards, 80 tablets) per 6 months.) |
| ***omeprazole oral capsule delayed release 10 mg, 20 mg, 40 mg*** | 1 | |
| OMEPRAZOLE+SYRSPEND SF ALKA ORAL SUSPENSION 2 MG/ML (***omeprazole***) | 3 | PA |
| ***pantoprazole sodium oral tablet delayed release 20 mg, 40 mg*** | 1 | |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| PREVACID SOLUTAB ORAL TABLET DELAYED RELEASE DISPERSIBLE 15 MG, 30 MG (***lansoprazole***) | 3 | PA; ST; SL (1 tablet per day.) |
| ***rabeprazole sodium oral tablet delayed release 20 mg*** | 2 | SL (1 tablet per day) |
| **GOLD COMPOUNDS** | | |
| **GOLD COMPOUNDS** | | |
| RIDAURA ORAL CAPSULE 3 MG (***auranofin***) | 3 | SP |
| **HEAVY METAL ANTAGONISTS - Drugs to Reduce Iron** | | |
| **HEAVY METAL ANTAGONISTS - Drugs to Reduce Iron** | | |
| CHEMET ORAL CAPSULE 100 MG (***succimer***) | 2 | |
| ***deferasirox granules oral packet 180 mg, 360 mg, 90 mg*** | 2 | PA; SP |
| ***deferasirox oral tablet 180 mg, 360 mg, 90 mg*** | 2 | PA; SP |
| ***deferasirox oral tablet soluble 125 mg, 250 mg, 500 mg*** | 2 | PA; SP |
| ***deferiprone oral tablet 500 mg*** | 1 | PA; SP |
| DEPEN TITRATABS ORAL TABLET 250 MG (***penicillamine***) | 2 | SP |
| FERRIPROX ORAL SOLUTION 100 MG/ML (***deferiprone***) | 2 | PA; SP |
| FERRIPROX ORAL TABLET 1000 MG (***deferiprone***) | 4 | |
| FERRIPROX ORAL TABLET 500 MG (***deferiprone***) | 4 | PA; SP |
| GALZIN ORAL CAPSULE 25 MG, 50 MG (***zinc acetate (oral)***) | 3 | |
| JADENU ORAL TABLET 180 MG, 360 MG, 90 MG (***deferasirox***) | 3 | PA; SP |
| JADENU SPRINKLE ORAL PACKET 180 MG, 360 MG, 90 MG (***deferasirox***) | 3 | PA; SP |
| ***penicillamine oral capsule 250 mg*** | 3 | SP |
| ***penicillamine oral tablet 250 mg*** | 2 | SP |
| SYPRINE ORAL CAPSULE 250 MG (***trientine hcl***) | 3 | PA; SP |
| **HORMONES AND SYNTHETIC SUBSTITUTES - Hormones** | | |
| **ADRENALS - Hormones** | | |
| ADVAIR DISKUS INHALATION AEROSOL POWDER BREATH ACTIVATED 100-50 MCG/DOSE, 250-50 MCG/DOSE, 500-50 MCG/DOSE (***fluticasone-salmeterol***) | 3 | SL (2 blisters per day) |
| ADVAIR HFA INHALATION AEROSOL 115-21 MCG/ACT, 230-21 MCG/ACT, 45-21 MCG/ACT (***fluticasone-salmeterol***) | 3 | SL (0.4 grams per day.) |
| ARNUITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100 MCG/ACT, 200 MCG/ACT (***fluticasone furoate***) | 1 | SL (1 blister per day.) |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ARNUITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 50 MCG/ACT (***fluticasone furoate***) | 1 | SL (1 packet per day.) |
| BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-25 MCG/INH (***fluticasone furoate-vilanterol***) | 3 | SL (2 inhalers per day.) |
| BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 200-25 MCG/INH (***fluticasone furoate-vilanterol***) | 3 | SL (2 blisters per day.) |
| ***budesonide er oral tablet extended release 24 hour 9 mg*** | 3 | |
| ***budesonide inhalation suspension 0.25 mg/2ml, 0.5 mg/2ml*** | 2 | SL (120 ml (2 boxes) per 30 days.) |
| ***budesonide inhalation suspension 1 mg/2ml*** | 2 | SL (60 ml (1 box) per 30 days.) |
| ***budesonide oral capsule delayed release particles 3 mg*** | 2 | |
| CORTEF ORAL TABLET 10 MG, 20 MG, 5 MG (***hydrocortisone***) | 3 | |
| ***cortisone acetate oral tablet 25 mg*** | 1 | |
| ***dexamethasone intensol oral concentrate 1 mg/ml*** | 1 | |
| ***dexamethasone oral elixir 0.5 mg/5ml*** | 1 | |
| ***dexamethasone oral solution 0.5 mg/5ml*** | 1 | |
| ***dexamethasone oral tablet 0.5 mg, 0.75 mg, 1 mg, 1.5 mg, 2 mg, 4 mg, 6 mg*** | 1 | |
| ***dexamethasone oral tablet therapy pack 1.5 mg (21), 1.5 mg (35), 1.5 mg (51)*** | 3 | |
| FLOVENT DISKUS INHALATION AEROSOL POWDER BREATH ACTIVATED 100 MCG/BLIST, 50 MCG/BLIST (***fluticasone propionate (inhal)***) | 1 | SL (2 packages per day) |
| FLOVENT DISKUS INHALATION AEROSOL POWDER BREATH ACTIVATED 250 MCG/BLIST (***fluticasone propionate (inhal)***) | 1 | SL (4 packages per day) |
| FLOVENT HFA INHALATION AEROSOL 110 MCG/ACT, 44 MCG/ACT (***fluticasone propionate hfa***) | 1 | SL (1 inhaler per month) |
| FLOVENT HFA INHALATION AEROSOL 220 MCG/ACT (***fluticasone propionate hfa***) | 1 | SL (2 inhalers per month) |
| ***fludrocortisone acetate oral tablet 0.1 mg*** | 1 | |
| ***fluticasone-salmeterol inhalation aerosol powder breath activated 100-50 mcg/dose, 250-50 mcg/dose, 500-50 mcg/dose*** | 3 | SL (2 blisters per day) |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| FLUTICASONE-SALMETEROL INHALATION AEROSOL POWDER BREATH ACTIVATED 113-14 MCG/ACT, 232-14 MCG/ACT, 55-14 MCG/ACT | 2 | SL (0.04 mcg per day.) |
| ***hydrocortisone oral tablet 10 mg, 20 mg, 5 mg*** | 1 | |
| INTRAROSA VAGINAL INSERT 6.5 MG (***prasterone***) | 3 | SL (1 insert per day.) |
| MEDROL ORAL TABLET 16 MG, 32 MG, 4 MG, 8 MG (***methylprednisolone***) | 3 | |
| MEDROL ORAL TABLET 2 MG (***methylprednisolone***) | 2 | |
| MEDROL ORAL TABLET THERAPY PACK 4 MG (***methylprednisolone***) | 3 | |
| ***methylprednisolone oral tablet 16 mg, 32 mg, 4 mg, 8 mg*** | 1 | |
| ***methylprednisolone oral tablet therapy pack 4 mg*** | 1 | |
| MILLIPRED ORAL TABLET 5 MG (***prednisolone***) | 2 | |
| ORAPRED ODT ORAL TABLET DISPERSIBLE 10 MG, 15 MG, 30 MG (***prednisolone sodium phosphate***) | 3 | |
| PEDIAPRED ORAL SOLUTION 6.7 (5 BASE) MG/5ML (***prednisolone sodium phosphate***) | 2 | |
| ***prednisolone oral solution 15 mg/5ml*** | 1 | |
| ***prednisolone sodium phosphate oral solution 10 mg/5ml, 15 mg/5ml, 20 mg/5ml, 25 mg/5ml, 6.7 (5 base) mg/5ml*** | 1 | |
| ***prednisolone sodium phosphate oral tablet dispersible 10 mg, 15 mg, 30 mg*** | 1 | |
| ***prednisone intensol oral concentrate 5 mg/ml*** | 1 | |
| ***prednisone oral solution 5 mg/5ml*** | 1 | |
| ***prednisone oral tablet 1 mg, 10 mg, 2.5 mg, 20 mg, 5 mg, 50 mg*** | 1 | |
| ***prednisone oral tablet therapy pack 10 mg (21), 10 mg (48), 5 mg (21), 5 mg (48)*** | 1 | |
| PULMICORT FLEXHALER INHALATION AEROSOL POWDER BREATH ACTIVATED 180 MCG/ACT, 90 MCG/ACT (***budesonide***) | 1 | SL (2 inhalers per month) |
| SYMBICORT INHALATION AEROSOL 160-4.5 MCG/ACT, 80-4.5 MCG/ACT (***budesonide-formoterol fumarate***) | 3 | SL (0.34 grams per day.) |
| TAPERDEX 12-DAY ORAL TABLET THERAPY PACK 1.5 MG (49) (***dexamethasone***) | 3 | |
| ***dexamethasone*** (Taperdex 6-Day Oral Tablet Therapy Pack 1.5 Mg, 1.5 Mg (21)) | 3 | |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| TAPERDEX 7-DAY ORAL TABLET THERAPY PACK 1.5 MG (27) (***dexamethasone***) | 3 | |
| TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-62.5-25 MCG/INH (***fluticasone-umeclidin-vilant***) | 3 | SL (2 blisters per day.) |
| UCERIS ORAL TABLET EXTENDED RELEASE 24 HOUR 9 MG (***budesonide***) | 3 | |
| UCERIS RECTAL FOAM 2 MG/ACT (***budesonide***) | 2 | |
| ***fluticasone-salmeterol*** (Wixela Inhub Inhalation Aerosol Powder Breath Activated 100-50 Mcg/Dose, 250-50 Mcg/Dose, 500-50 Mcg/Dose) | 3 | SL (2 blisters per day) |
| **ALPHA-GLUCOSIDASE INHIBITORS - Drugs for Diabetes** | | |
| ***acarbose oral tablet 100 mg, 25 mg, 50 mg*** | 1 | |
| GLYSET ORAL TABLET 100 MG, 25 MG, 50 MG (***miglitol***) | 3 | |
| ***miglitol oral tablet 100 mg, 25 mg, 50 mg*** | 2 | |
| PRECOSE ORAL TABLET 100 MG, 25 MG, 50 MG (***acarbose***) | 3 | |
| **AMYLINOMIMETICS - Drugs for Diabetes** | | |
| SYMLINPEN 120 SUBCUTANEOUS SOLUTION PEN-INJECTOR 2700 MCG/2.7ML (***pramlintide acetate***) | 3 | SL (4 pens (10.8 ml) per month.) |
| SYMLINPEN 60 SUBCUTANEOUS SOLUTION PEN-INJECTOR 1500 MCG/1.5ML (***pramlintide acetate***) | 3 | SL (4 pens (6 ml) per month.) |
| **ANDROGENS - Hormones** | | |
| ANADROL-50 ORAL TABLET 50 MG (***oxymetholone***) | 3 | |
| ANDRODERM TRANSDERMAL PATCH 24 HOUR 2 MG/24HR, 4 MG/24HR (***testosterone***) | 2 | PA; SL (1 patch per day) |
| ***est estrogens-methyltest*** (Covaryx Hs Oral Tablet 0.625-1.25 Mg) | 1 | |
| ***est estrogens-methyltest*** (Covaryx Oral Tablet 1.25-2.5 Mg) | 1 | |
| ***danazol oral capsule 100 mg, 200 mg, 50 mg*** | 1 | |
| DEPO-TESTOSTERONE INTRAMUSCULAR SOLUTION 100 MG/ML, 200 MG/ML (***testosterone cypionate***) | 3 | M |
| ***est estrogens-methyltest*** (Eemt Hs Oral Tablet 0.625-1.25 Mg) | 1 | |
| ***est estrogens-methyltest*** (Eemt Oral Tablet 1.25-2.5 Mg) | 1 | |
| ***est estrogens-methyltest ds oral tablet 1.25-2.5 mg*** | 1 | |
| ***est estrogens-methyltest hs oral tablet 0.625-1.25 mg*** | 1 | |
| ***est estrogens-methyltest oral tablet 1.25-2.5 mg*** | 1 | |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| METHITEST ORAL TABLET 10 MG | 2 | |
| ***methyltestosterone oral capsule 10 mg*** | 2 | |
| ***oxandrolone oral tablet 10 mg, 2.5 mg*** | 2 | |
| TESTIM TRANSDERMAL GEL 50 MG/5GM (1%) (***testosterone***) | 2 | PA; SL (100 mg Testosterone (2 X 5 grams tubes = 10 grams) per day) |
| ***testosterone cypionate intramuscular solution 100 mg/ml, 200 mg/ml*** | 1 | M |
| ***testosterone enanthate intramuscular solution 200 mg/ml*** | 1 | M |
| ***testosterone gel 50 mg/5gm (1%) transdermal 50 mg/5gm (1%)*** | 3 | PA; SL (100 mg Testosterone (2 X 5 grams tubes = 10 grams) per day) |
| **ANTIDIABETIC AGENTS, MISCELLANEOUS - Drugs for Diabetes** | | |
| ***colesevelam hcl oral packet 3.75 gm*** | 3 | |
| ***colesevelam hcl oral tablet 625 mg*** | 3 | |
| KORLYM ORAL TABLET 300 MG (***mifepristone***) | 3 | PA; SP |
| WELCHOL ORAL PACKET 3.75 GM (***colesevelam hcl***) | 2 | |
| WELCHOL ORAL TABLET 625 MG (***colesevelam hcl***) | 2 | |
| **ANTIESTROGENS - Drugs for Women** | | |
| ***anastrozole oral tablet 1 mg*** | 1 | |
| AROMASIN ORAL TABLET 25 MG (***exemestane***) | 4 | |
| ***exemestane oral tablet 25 mg*** | 2 | |
| KISQALI FEMARA (400 MG DOSE) ORAL TABLET THERAPY PACK 200 & 2.5 MG (***ribociclib-letrozole***) | 4 | PA; ST; CM |
| KISQALI FEMARA (600 MG DOSE) ORAL TABLET THERAPY PACK 200 & 2.5 MG (***ribociclib-letrozole***) | 4 | PA; ST; CM |
| KISQALI FEMARA(200 MG DOSE) ORAL TABLET THERAPY PACK 200 & 2.5 MG (***ribociclib-letrozole***) | 4 | PA; ST; CM |
| ***letrozole oral tablet 2.5 mg*** | 1 | |
| **ANTIGONADTROPINS - Hormones** | | |
| FIRMAGON (240 MG DOSE) SUBCUTANEOUS SOLUTION RECONSTITUTED 120 MG/VIAL (***degarelix acetate***) | 3 | M; SP |
| FIRMAGON SUBCUTANEOUS SOLUTION RECONSTITUTED 80 MG (***degarelix acetate***) | 3 | M; SP |
| ORIAHNN ORAL CAPSULE THERAPY PACK 300-1-0.5 & 300 MG (***elagolix-estradiol-norethind***) | 3 | PA |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ORILISSA ORAL TABLET 150 MG (***elagolix sodium***) | 3 | PA; SL (1 tablet per day.) |
| ORILISSA ORAL TABLET 200 MG (***elagolix sodium***) | 3 | PA; SL (2 tablets per day.) |
| **ANTIHYPOGLYCEMIC AGENTS, MISCELLANEOUS - Hormones** | | |
| ***diazoxide oral suspension 50 mg/ml*** | 3 | |
| PROGLYCEM ORAL SUSPENSION 50 MG/ML (***diazoxide***) | 3 | |
| **ANTIPARATHYROID AGENTS - Drugs for Bones** | | |
| ***calcitonin (salmon) nasal solution 200 unit/act*** | 2 | |
| ***cinacalcet hcl oral tablet 30 mg, 60 mg, 90 mg*** | 3 | PA |
| MIACALCIN INJECTION SOLUTION 200 UNIT/ML (***calcitonin (salmon)***) | 3 | M |
| SENSIPAR ORAL TABLET 30 MG, 60 MG, 90 MG (***cinacalcet hcl***) | 4 | PA |
| **ANTITHYROID AGENTS - Drugs for the Thyroid** | | |
| IODINE STRONG ORAL SOLUTION 5 % | 2 | |
| ***methimazole oral tablet 10 mg, 5 mg*** | 1 | |
| ***propylthiouracil oral tablet 50 mg*** | 1 | |
| SSKI ORAL SOLUTION 1 GM/ML (***potassium iodide (expectorant)***) | 3 | |
| TAPAZOLE ORAL TABLET 10 MG, 5 MG (***methimazole***) | 3 | |
| **BIGUANIDES - Drugs for Diabetes** | | |
| ACTOPLUS MET ORAL TABLET 15-500 MG, 15-850 MG (***pioglitazone hcl-metformin hcl***) | 3 | SL (3 tablets per day) |
| ***glipizide-metformin hcl oral tablet 2.5-250 mg, 2.5-500 mg, 5-500 mg*** | 2 | |
| GLUCOVANCE ORAL TABLET 5-500 MG (***glyburide-metformin***) | 3 | |
| ***glyburide-metformin oral tablet 1.25-250 mg, 2.5-500 mg, 5-500 mg*** | 1 | |
| JENTADUETO ORAL TABLET 2.5-1000 MG, 2.5-500 MG, 2.5-850 MG (***linagliptin-metformin hcl***) | 2 | SL (2 tablets per day.) |
| JENTADUETO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 2.5-1000 MG (***linagliptin-metformin hcl***) | 2 | SL (2 tablets per day.) |
| JENTADUETO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 5-1000 MG (***linagliptin-metformin hcl***) | 2 | SL (1 tablet per day.) |
| KAZANO ORAL TABLET 12.5-1000 MG, 12.5-500 MG (***alogliptin-metformin hcl***) | 2 | SL (2 tablets per day.) |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| KOMBIGLYZE XR ORAL TABLET EXTENDED RELEASE 24 HOUR 2.5-1000 MG (***saxagliptin-metformin***) | 2 | SL (62 tablets per month.) |
| KOMBIGLYZE XR ORAL TABLET EXTENDED RELEASE 24 HOUR 5-1000 MG, 5-500 MG (***saxagliptin-metformin***) | 2 | SL (31 tablets per month.) |
| ***metformin hcl er oral tablet extended release 24 hour 500 mg, 750 mg*** | 1 | |
| ***metformin hcl oral solution 500 mg/5ml*** | 3 | |
| ***metformin hcl oral tablet 1000 mg, 500 mg, 850 mg*** | 1 | |
| ***pioglitazone hcl-metformin hcl oral tablet 15-500 mg, 15-850 mg*** | 2 | SL (3 tablets per day) |
| RIOMET ER ORAL SUSPENSION RECONSTITUTED ER 500 MG/5ML (***metformin hcl***) | 3 | |
| RIOMET ORAL SOLUTION 500 MG/5ML (***metformin hcl***) | 3 | |
| SYNJARDY ORAL TABLET 12.5-1000 MG, 12.5-500 MG, 5-1000 MG, 5-500 MG (***empagliflozin-metformin hcl***) | 2 | SL (2 tablets per day.) |
| SYNJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-1000 MG, 25-1000 MG (***empagliflozin-metformin hcl***) | 2 | SL (1 tablet per day.) |
| SYNJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 12.5-1000 MG, 5-1000 MG (***empagliflozin-metformin hcl***) | 2 | SL (2 tablets per day.) |
| TRIJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-5-1000 MG, 25-5-1000 MG (***empagliflozin-linaglip-metform***) | 2 | SL (1 tablet per day.) |
| TRIJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 12.5-2.5-1000 MG, 5-2.5-1000 MG (***empagliflozin-linaglip-metform***) | 2 | SL (2 tablets per day.) |
| **CONTRACEPTIVES - Drugs for Women** | | |
| ***levonorgestrel-ethinyl estrad*** (Afirmelle Oral Tablet 0.1-20 Mg-Mcg) | 1 | H |
| ***levonorgestrel-ethinyl estrad*** (Altavera Oral Tablet 0.15-30 Mg-Mcg) | 1 | H |
| ***alyacen 1/35 oral tablet 1-35 mg-mcg*** | 1 | H |
| ***alyacen 7/7/7 oral tablet 0.5/0.75/1-35 mg-mcg*** | 1 | H |
| ***levonorgest-eth estrad 91-day*** (Amethia Lo Oral Tablet 0.1-0.02 & 0.01 Mg) | 3 | |
| ***levonorgest-eth estrad 91-day*** (Amethia Oral Tablet 0.15-0.03 &0.01 Mg) | 3 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ***levonorgestrel-ethinyl estrad*** (Amethyst Oral Tablet 90-20 Mcg) | 3 | |
| ANNOVERA VAGINAL RING 0.013-0.15 MG/24HR (***segesterone-ethinyl estradiol***) | 3 | SL (1 vaginal ring per 365 days..); H |
| ***desogestrel-ethinyl estradiol*** (Apri Oral Tablet 0.15-30 Mg-Mcg) | 1 | H |
| ***norethin-eth estrad triphasic*** (Aranelle Oral Tablet 0.5/1/0.5-35 Mg-Mcg) | 1 | H |
| ***levonorgest-eth estrad 91-day*** (Ashlyna Oral Tablet 0.15-0.03 &0.01 Mg) | 3 | |
| ***levonorgestrel-ethinyl estrad*** (Aubra Eq Oral Tablet 0.1-20 Mg-Mcg) | 1 | H |
| ***levonorgestrel-ethinyl estrad*** (Aubra Oral Tablet 0.1-20 Mg-Mcg) | 1 | H |
| ***norethindrone acet-ethinyl est*** (Aurovela 1.5/30 Oral Tablet 1.5-30 Mg-Mcg) | 2 | |
| ***norethindrone acet-ethinyl est*** (Aurovela 1/20 Oral Tablet 1-20 Mg-Mcg) | 2 | |
| ***norethin ace-eth estrad-fe*** (Aurovela 24 Fe Oral Tablet 1-20 Mg-Mcg(24)) | 3 | |
| ***norethin ace-eth estrad-fe*** (Aurovela Fe 1.5/30 Oral Tablet 1.5-30 Mg-Mcg) | 1 | H |
| ***norethin ace-eth estrad-fe*** (Aurovela Fe 1/20 Oral Tablet 1-20 Mg-Mcg) | 1 | H |
| ***levonorgestrel-ethinyl estrad*** (Aviane Oral Tablet 0.1-20 Mg-Mcg) | 1 | H |
| ***levonorgestrel-ethinyl estrad*** (Ayuna Oral Tablet 0.15-30 Mg-Mcg) | 1 | H |
| ***desogestrel-ethinyl estradiol*** (Azurette Oral Tablet 0.15-0.02/0.01 Mg (21/5)) | 2 | |
| BALCOLTRA ORAL TABLET 0.1-20 MG-MCG(21) (***levonorgest-eth estrad-fe bisg***) | 4 | H |
| ***norethindrone-eth estradiol*** (Balziva Oral Tablet 0.4-35 Mg-Mcg) | 2 | |
| ***desogestrel-ethinyl estradiol*** (Bekyree Oral Tablet 0.15-0.02/0.01 Mg (21/5)) | 2 | |
| ***norethin ace-eth estrad-fe*** (Blisovi 24 Fe Oral Tablet 1-20 Mg-Mcg(24)) | 3 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ***norethin ace-eth estrad-fe*** (Blisovi Fe 1.5/30 Oral Tablet 1.5-30 Mg-Mcg) | 1 | H |
| ***norethin ace-eth estrad-fe*** (Blisovi Fe 1/20 Oral Tablet 1-20 Mg-Mcg) | 1 | H |
| ***briellyn oral tablet 0.4-35 mg-mcg*** | 2 | |
| ***norethindrone*** (Camila Oral Tablet 0.35 Mg) | 1 | H |
| ***levonorgest-eth estrad 91-day*** (Camrese Lo Oral Tablet 0.1-0.02 & 0.01 Mg) | 3 | |
| ***levonorgest-eth estrad 91-day*** (Camrese Oral Tablet 0.15-0.03 &0.01 Mg) | 3 | |
| ***desogestrel-ethinyl estradiol*** (Caziant Oral Tablet 0.1/0.125/0.15 -0.025 Mg) | 1 | H |
| ***norethin ace-eth estrad-fe*** (Charlotte 24 Fe Oral Tablet Chewable 1-20 Mg-Mcg(24)) | 3 | H |
| ***levonorgestrel-ethinyl estrad*** (Chateal Eq Oral Tablet 0.15-30 Mg-Mcg) | 1 | H |
| ***levonorgestrel-ethinyl estrad*** (Chateal Oral Tablet 0.15-30 Mg-Mcg) | 1 | H |
| ***norgestrel-ethinyl estradiol*** (Cryselle-28 Oral Tablet 0.3-30 Mg-Mcg) | 1 | H |
| ***norethindrone-eth estradiol*** (Cyclafem 1/35 Oral Tablet 1-35 Mg-Mcg) | 1 | H |
| ***norethin-eth estrad triphasic*** (Cyclafem 7/7/7 Oral Tablet 0.5/0.75/1-35 Mg-Mcg) | 1 | H |
| ***desogestrel-ethinyl estradiol*** (Cyred Eq Oral Tablet 0.15-30 Mg-Mcg) | 1 | H |
| ***desogestrel-ethinyl estradiol*** (Cyred Oral Tablet 0.15-30 Mg-Mcg) | 1 | H |
| ***norethindrone-eth estradiol*** (Dasetta 1/35 Oral Tablet 1-35 Mg-Mcg) | 1 | H |
| ***norethin-eth estrad triphasic*** (Dasetta 7/7/7 Oral Tablet 0.5/0.75/1-35 Mg-Mcg) | 1 | H |
| ***levonorgest-eth estrad 91-day*** (Daysee Oral Tablet 0.15-0.03 &0.01 Mg) | 3 | |
| ***norethindrone*** (Deblitane Oral Tablet 0.35 Mg) | 1 | H |
| ***levonorgestrel-ethinyl estrad*** (Delyla Oral Tablet 0.1-20 Mg-Mcg) | 1 | H |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ***desogestrel-ethinyl estradiol oral tablet 0.15-0.02/0.01 mg (21/5)*** | 2 | |
| ***desogestrel-ethinyl estradiol oral tablet 0.15-30 mg-mcg*** | 1 | H |
| ***drospiren-eth estrad-levomefol oral tablet 3-0.02-0.451 mg, 3-0.03-0.451 mg*** | 3 | H |
| ***drospirenone-ethinyl estradiol oral tablet 3-0.02 mg, 3-0.03 mg*** | 3 | |
| ***norgestrel-ethinyl estradiol*** (Elinest Oral Tablet 0.3-30 Mg-Mcg) | 1 | H |
| ELLA ORAL TABLET 30 MG (***ulipristal acetate***) | 1 | SL (1 tablet per 21 days.) |
| ***etonogestrel-ethinyl estradiol*** (Eluryng Vaginal Ring 0.12-0.015 Mg/24Hr) | 3 | H |
| ***desogestrel-ethinyl estradiol*** (Emoquette Oral Tablet 0.15-30 Mg-Mcg) | 1 | H |
| ***levonorg-eth estrad triphasic*** (Enpresse-28 Oral Tablet 50-30/75-40/ 125-30 Mcg) | 1 | H |
| ***desogestrel-ethinyl estradiol*** (Enskyce Oral Tablet 0.15-30 Mg-Mcg) | 1 | H |
| ***norethindrone*** (Errin Oral Tablet 0.35 Mg) | 1 | H |
| ***norgestimate-eth estradiol*** (Estarylla Oral Tablet 0.25-35 Mg-Mcg) | 1 | H |
| ESTROSTEP FE ORAL TABLET 1-20/1-30/1-35 MG-MCG (***norethindron-ethinyl estrad-fe***) | 3 | |
| ***ethynodiol diac-eth estradiol oral tablet 1-35 mg-mcg, 1-50 mg-mcg*** | 1 | H |
| ***etonogestrel-ethinyl estradiol vaginal ring 0.12-0.015 mg/24hr*** | 3 | H |
| ***levonorgestrel-ethinyl estrad*** (Falmina Oral Tablet 0.1-20 Mg-Mcg) | 1 | H |
| ***levonorgest-eth estrad 91-day*** (Fayosim Oral Tablet 42-21-21-7 Days) | 3 | H |
| ***norgestimate-eth estradiol*** (Femynor Oral Tablet 0.25-35 Mg-Mcg) | 1 | H |
| ***drospirenone-ethinyl estradiol*** (Gianvi Oral Tablet 3-0.02 Mg) | 3 | |
| ***norethindrone acet-ethinyl est*** (Hailey 1.5/30 Oral Tablet 1.5-30 Mg-Mcg) | 2 | |
| ***norethin ace-eth estrad-fe*** (Hailey 24 Fe Oral Tablet 1-20 Mg-Mcg(24)) | 3 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ***norethin ace-eth estrad-fe*** (Hailey Fe 1.5/30 Oral Tablet 1.5-30 Mg-Mcg) | 1 | H |
| ***norethin ace-eth estrad-fe*** (Hailey Fe 1/20 Oral Tablet 1-20 Mg-Mcg) | 1 | H |
| ***norethindrone*** (Heather Oral Tablet 0.35 Mg) | 1 | H |
| ***norethindrone*** (Incassia Oral Tablet 0.35 Mg) | 1 | H |
| ***levonorgest-eth estrad 91-day*** (Introvale Oral Tablet 0.15-0.03 Mg) | 2 | H |
| ***desogestrel-ethinyl estradiol*** (Isibloom Oral Tablet 0.15-30 Mg-Mcg) | 1 | H |
| ***levonorgest-eth estrad 91-day*** (Jaimiess Oral Tablet 0.15-0.03 &0.01 Mg) | 3 | |
| ***drospirenone-ethinyl estradiol*** (Jasmiel Oral Tablet 3-0.02 Mg) | 3 | |
| ***norethindrone*** (Jencycla Oral Tablet 0.35 Mg) | 1 | H |
| ***levonorgest-eth estrad 91-day*** (Jolessa Oral Tablet 0.15-0.03 Mg) | 2 | H |
| ***desogestrel-ethinyl estradiol*** (Juleber Oral Tablet 0.15-30 Mg-Mcg) | 1 | H |
| ***norethindrone acet-ethinyl est*** (Junel 1.5/30 Oral Tablet 1.5-30 Mg-Mcg) | 2 | |
| ***norethindrone acet-ethinyl est*** (Junel 1/20 Oral Tablet 1-20 Mg-Mcg) | 2 | |
| ***norethin ace-eth estrad-fe*** (Junel Fe 1.5/30 Oral Tablet 1.5-30 Mg-Mcg) | 1 | H |
| ***norethin ace-eth estrad-fe*** (Junel Fe 1/20 Oral Tablet 1-20 Mg-Mcg) | 1 | H |
| ***norethin ace-eth estrad-fe*** (Junel Fe 24 Oral Tablet 1-20 Mg-Mcg(24)) | 3 | |
| ***norethin-eth estradiol-fe*** (Kaitlib Fe Oral Tablet Chewable 0.8-25 Mg-Mcg) | 3 | H |
| ***desogestrel-ethinyl estradiol*** (Kalliga Oral Tablet 0.15-30 Mg-Mcg) | 1 | H |
| ***desogestrel-ethinyl estradiol*** (Kariva Oral Tablet 0.15-0.02/0.01 Mg (21/5)) | 2 | |
| ***ethynodiol diac-eth estradiol*** (Kelnor 1/35 Oral Tablet 1-35 Mg-Mcg) | 1 | H |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ***ethynodiol diac-eth estradiol*** (Kelnor 1/50 Oral Tablet 1-50 Mg-Mcg) | 1 | H |
| ***levonorgestrel-ethinyl estrad*** (Kurvelo Oral Tablet 0.15-30 Mg-Mcg) | 1 | H |
| ***norethindrone acet-ethinyl est*** (Larin 1.5/30 Oral Tablet 1.5-30 Mg-Mcg) | 2 | |
| ***norethindrone acet-ethinyl est*** (Larin 1/20 Oral Tablet 1-20 Mg-Mcg) | 2 | |
| ***norethin ace-eth estrad-fe*** (Larin 24 Fe Oral Tablet 1-20 Mg-Mcg(24)) | 3 | |
| ***norethin ace-eth estrad-fe*** (Larin Fe 1.5/30 Oral Tablet 1.5-30 Mg-Mcg) | 1 | H |
| ***norethin ace-eth estrad-fe*** (Larin Fe 1/20 Oral Tablet 1-20 Mg-Mcg) | 1 | H |
| ***levonorgestrel-ethinyl estrad*** (Larissia Oral Tablet 0.1-20 Mg-Mcg) | 1 | H |
| ***norethin-eth estradiol-fe*** (Layolis Fe Oral Tablet Chewable 0.8-25 Mg-Mcg) | 3 | H |
| ***norethin-eth estrad triphasic*** (Leena Oral Tablet 0.5/1/0.5-35 Mg-Mcg) | 1 | H |
| ***levonorgestrel-ethinyl estrad*** (Lessina Oral Tablet 0.1-20 Mg-Mcg) | 1 | H |
| ***levonorg-eth estrad triphasic*** (Levonest Oral Tablet 50-30/75-40/ 125-30 Mcg) | 1 | H |
| ***levonorgest-eth est & eth est oral tablet 42-21-21-7 days*** | 3 | H |
| ***levonorgest-eth estrad 91-day oral tablet 0.1-0.02 & 0.01 mg, 0.15-0.03 &0.01 mg*** | 3 | |
| ***levonorgest-eth estrad 91-day oral tablet 0.15-0.03 mg*** | 2 | H |
| ***levonorgestrel oral tablet 1.5 mg*** | 1 | H |
| ***levonorgestrel-ethinyl estrad oral tablet 0.1-20 mg-mcg, 0.15-30 mg-mcg*** | 1 | H |
| ***levonorgestrel-ethinyl estrad oral tablet 90-20 mcg*** | 3 | |
| ***levonorg-eth estrad triphasic oral tablet 50-30/75-40/ 125-30 mcg*** | 1 | H |
| ***levonorgestrel-ethinyl estrad*** (Levora 0.15/30 (28) Oral Tablet 0.15-30 Mg-Mcg) | 1 | H |
| ***levonorgestrel-ethinyl estrad*** (Lillow Oral Tablet 0.15-30 Mg-Mcg) | 1 | H |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| LO LOESTRIN FE ORAL TABLET 1 MG-10 MCG / 10 MCG (***norethin-eth estrad-fe biphas***) | 3 | |
| LOESTRIN 1.5/30 (21) ORAL TABLET 1.5-30 MG-MCG (***norethindrone acet-ethinyl est***) | 3 | |
| LOESTRIN 1/20 (21) ORAL TABLET 1-20 MG-MCG (***norethindrone acet-ethinyl est***) | 3 | |
| LOESTRIN FE 1.5/30 ORAL TABLET 1.5-30 MG-MCG (***norethin ace-eth estrad-fe***) | 3 | |
| LOESTRIN FE 1/20 ORAL TABLET 1-20 MG-MCG (***norethin ace-eth estrad-fe***) | 3 | |
| ***levonorgest-eth estrad 91-day*** (Lojaimiess Oral Tablet 0.1-0.02 & 0.01 Mg) | 3 | |
| ***drospirenone-ethinyl estradiol*** (Loryna Oral Tablet 3-0.02 Mg) | 3 | |
| LOSEASONIQUE ORAL TABLET 0.1-0.02 & 0.01 MG (***levonorgest-eth estrad 91-day***) | 3 | |
| ***norgestrel-ethinyl estradiol*** (Low-Ogestrel Oral Tablet 0.3-30 Mg-Mcg) | 1 | H |
| ***drospirenone-ethinyl estradiol*** (Lo-Zumandimine Oral Tablet 3-0.02 Mg) | 3 | |
| ***levonorgestrel-ethinyl estrad*** (Lutera Oral Tablet 0.1-20 Mg-Mcg) | 1 | H |
| ***norethindrone*** (Lyza Oral Tablet 0.35 Mg) | 1 | H |
| ***marlissa oral tablet 0.15-30 mg-mcg*** | 1 | H |
| ***norethin ace-eth estrad-fe*** (Melodetta 24 Fe Oral Tablet Chewable 1-20 Mg-Mcg(24)) | 3 | H |
| ***norethin ace-eth estrad-fe*** (Mibelas 24 Fe Oral Tablet Chewable 1-20 Mg-Mcg(24)) | 3 | H |
| ***norethindrone acet-ethinyl est*** (Microgestin 1.5/30 Oral Tablet 1.5-30 Mg-Mcg) | 2 | |
| ***norethindrone acet-ethinyl est*** (Microgestin 1/20 Oral Tablet 1-20 Mg-Mcg) | 2 | |
| ***norethin ace-eth estrad-fe*** (Microgestin Fe 1.5/30 Oral Tablet 1.5-30 Mg-Mcg) | 1 | H |
| ***norethin ace-eth estrad-fe*** (Microgestin Fe 1/20 Oral Tablet 1-20 Mg-Mcg) | 1 | H |
| ***norgestimate-eth estradiol*** (Mili Oral Tablet 0.25-35 Mg-Mcg) | 1 | H |
| MIRCETTE ORAL TABLET 0.15-0.02/0.01 MG (21/5) (***desogestrel-ethinyl estradiol***) | 3 | |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ***norgestimate-eth estradiol*** (Mono-Linyah Oral Tablet 0.25-35 Mg-Mcg) | 1 | H |
| NATAZIA ORAL TABLET 3/2-2/2-3/1 MG (***estradiol valerate-dienogest***) | 2 | |
| ***norethindrone-eth estradiol*** (Necon 0.5/35 (28) Oral Tablet 0.5-35 Mg-Mcg) | 1 | H |
| ***drospirenone-ethinyl estradiol*** (Nikki Oral Tablet 3-0.02 Mg) | 3 | |
| ***norethindrone*** (Nora-Be Oral Tablet 0.35 Mg) | 1 | H |
| ***norethin ace-eth estrad-fe oral tablet 1-20 mg-mcg, 1.5-30 mg-mcg*** | 1 | H |
| ***norethin ace-eth estrad-fe oral tablet chewable 1-20 mg-mcg(24)*** | 3 | H |
| ***norethindrone acet-ethinyl est oral tablet 1-20 mg-mcg, 1.5-30 mg-mcg*** | 2 | |
| ***norethindrone oral tablet 0.35 mg*** | 1 | H |
| ***norethin-eth estradiol-fe oral tablet chewable 0.4-35 mg-mcg*** | 3 | |
| ***norethin-eth estradiol-fe oral tablet chewable 0.8-25 mg-mcg*** | 3 | H |
| ***norgestimate-eth estradiol oral tablet 0.25-35 mg-mcg*** | 1 | H |
| ***norgestimate-ethinyl estradiol triphasic oral tablet 0.18/0.215/0.25 mg-25 mcg*** | 2 | H |
| ***norgestimate-ethinyl estradiol triphasic oral tablet 0.18/0.215/0.25 mg-35 mcg*** | 1 | H |
| ***norethindrone*** (Norlyda Oral Tablet 0.35 Mg) | 1 | H |
| ***norethindrone*** (Norlyroc Oral Tablet 0.35 Mg) | 1 | H |
| ***norethindrone-eth estradiol*** (Nortrel 0.5/35 (28) Oral Tablet 0.5-35 Mg-Mcg) | 1 | H |
| ***norethindrone-eth estradiol*** (Nortrel 1/35 (21) Oral Tablet 1-35 Mg-Mcg) | 1 | H |
| ***norethindrone-eth estradiol*** (Nortrel 1/35 (28) Oral Tablet 1-35 Mg-Mcg) | 1 | H |
| ***norethin-eth estrad triphasic*** (Nortrel 7/7/7 Oral Tablet 0.5/0.75/1-35 Mg-Mcg) | 1 | H |
| NUVARING VAGINAL RING 0.12-0.015 MG/24HR (***etonogestrel-ethinyl estradiol***) | 1 | H |
| ***drospirenone-ethinyl estradiol*** (Ocella Oral Tablet 3-0.03 Mg) | 3 | |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ***levonorgestrel-ethinyl estrad*** (Orsythia Oral Tablet 0.1-20 Mg-Mcg) | 1 | H |
| ORTHO MICRONOR ORAL TABLET 0.35 MG (***norethindrone***) | 3 | |
| ***norethindrone-eth estradiol*** (Philith Oral Tablet 0.4-35 Mg-Mcg) | 2 | |
| ***desogestrel-ethinyl estradiol*** (Pimtrea Oral Tablet 0.15-0.02/0.01 Mg (21/5)) | 2 | |
| ***norethindrone-eth estradiol*** (Pirmella 1/35 Oral Tablet 1-35 Mg-Mcg) | 1 | H |
| ***norethin-eth estrad triphasic*** (Pirmella 7/7/7 Oral Tablet 0.5/0.75/1-35 Mg-Mcg) | 1 | H |
| PLAN B ONE-STEP ORAL TABLET 1.5 MG (***levonorgestrel***) | 1 | |
| ***levonorgestrel-ethinyl estrad*** (Portia-28 Oral Tablet 0.15-30 Mg-Mcg) | 1 | H |
| ***norgestimate-eth estradiol*** (Previfem Oral Tablet 0.25-35 Mg-Mcg) | 1 | H |
| ***desogestrel-ethinyl estradiol*** (Reclipsen Oral Tablet 0.15-30 Mg-Mcg) | 1 | H |
| ***levonorgest-eth estrad 91-day*** (Rivelsa Oral Tablet 42-21-21-7 Days) | 3 | H |
| SEASONIQUE ORAL TABLET 0.15-0.03 &0.01 MG (***levonorgest-eth estrad 91-day***) | 3 | |
| ***levonorgest-eth estrad 91-day*** (Setlakin Oral Tablet 0.15-0.03 Mg) | 2 | H |
| ***norethindrone*** (Sharobel Oral Tablet 0.35 Mg) | 1 | H |
| ***desogestrel-ethinyl estradiol*** (Simliya Oral Tablet 0.15-0.02/0.01 Mg (21/5)) | 2 | |
| ***levonorgest-eth estrad 91-day*** (Simpesse Oral Tablet 0.15-0.03 &0.01 Mg) | 3 | |
| SLYND ORAL TABLET 4 MG (***drospirenone***) | 3 | PA; ST; H |
| ***norgestimate-eth estradiol*** (Sprintec 28 Oral Tablet 0.25-35 Mg-Mcg) | 1 | H |
| ***levonorgestrel-ethinyl estrad*** (Sronyx Oral Tablet 0.1-20 Mg-Mcg) | 1 | H |
| ***drospirenone-ethinyl estradiol*** (Syeda Oral Tablet 3-0.03 Mg) | 3 | |
| ***norethin ace-eth estrad-fe*** (Tarina 24 Fe Oral Tablet 1-20 Mg-Mcg(24)) | 3 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ***norethin ace-eth estrad-fe*** (Tarina Fe 1/20 Eq Oral Tablet 1-20 Mg-Mcg) | 1 | H |
| ***norethin ace-eth estrad-fe*** (Tarina Fe 1/20 Oral Tablet 1-20 Mg-Mcg) | 1 | H |
| TAYTULLA ORAL CAPSULE 1-20 MG-MCG(24) (***norethin ace-eth estrad-fe***) | 3 | H |
| ***norethindron-ethinyl estrad-fe*** (Tilia Fe Oral Tablet 1-20/1-30/1-35 Mg-Mcg) | 3 | |
| ***norgestim-eth estrad triphasic*** (Tri Femynor Oral Tablet 0.18/0.215/0.25 Mg-35 Mcg) | 1 | H |
| ***norgestim-eth estrad triphasic*** (Tri-Estarylla Oral Tablet 0.18/0.215/0.25 Mg-35 Mcg) | 1 | H |
| ***norethindron-ethinyl estrad-fe*** (Tri-Legest Fe Oral Tablet 1-20/1-30/1-35 Mg-Mcg) | 3 | |
| ***norgestim-eth estrad triphasic*** (Tri-Linyah Oral Tablet 0.18/0.215/0.25 Mg-35 Mcg) | 1 | H |
| ***norgestim-eth estrad triphasic*** (Tri-Lo-Estarylla Oral Tablet 0.18/0.215/0.25 Mg-25 Mcg) | 2 | H |
| ***norgestim-eth estrad triphasic*** (Tri-Lo-Marzia Oral Tablet 0.18/0.215/0.25 Mg-25 Mcg) | 2 | H |
| ***norgestim-eth estrad triphasic*** (Tri-Lo-Mili Oral Tablet 0.18/0.215/0.25 Mg-25 Mcg) | 2 | H |
| ***norgestim-eth estrad triphasic*** (Tri-Lo-Sprintec Oral Tablet 0.18/0.215/0.25 Mg-25 Mcg) | 2 | H |
| ***norgestim-eth estrad triphasic*** (Tri-Mili Oral Tablet 0.18/0.215/0.25 Mg-35 Mcg) | 1 | H |
| ***norgestim-eth estrad triphasic*** (Tri-Previfem Oral Tablet 0.18/0.215/0.25 Mg-35 Mcg) | 1 | H |
| ***norgestim-eth estrad triphasic*** (Tri-Sprintec Oral Tablet 0.18/0.215/0.25 Mg-35 Mcg) | 1 | H |
| ***levonorg-eth estrad triphasic*** (Trivora (28) Oral Tablet 50-30/75-40/ 125-30 Mcg) | 1 | H |
| ***norgestim-eth estrad triphasic*** (Tri-Vylibra Lo Oral Tablet 0.18/0.215/0.25 Mg-25 Mcg) | 2 | H |
| ***norgestim-eth estrad triphasic*** (Tri-Vylibra Oral Tablet 0.18/0.215/0.25 Mg-35 Mcg) | 1 | H |
| ***norethindrone*** (Tulana Oral Tablet 0.35 Mg) | 1 | H |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| TWIRLA TRANSDERMAL PATCH WEEKLY 120-30 MCG/24HR (***levonorgestrel-eth estradiol***) | 3 | |
| ***drospiren-eth estrad-levomefol*** (Tydemy Oral Tablet 3-0.03-0.451 Mg) | 3 | H |
| ***desogestrel-ethinyl estradiol*** (Velivet Oral Tablet 0.1/0.125/0.15 -0.025 Mg) | 1 | H |
| ***levonorgestrel-ethinyl estrad*** (Vienva Oral Tablet 0.1-20 Mg-Mcg) | 1 | H |
| ***viorele oral tablet 0.15-0.02/0.01 mg (21/5)*** | 2 | |
| ***desogestrel-ethinyl estradiol*** (Volnea Oral Tablet 0.15-0.02/0.01 Mg (21/5)) | 2 | |
| ***norethindrone-eth estradiol*** (Vyfemla Oral Tablet 0.4-35 Mg-Mcg) | 2 | |
| ***norgestimate-eth estradiol*** (Vylibra Oral Tablet 0.25-35 Mg-Mcg) | 1 | H |
| ***norethindrone-eth estradiol*** (Wera Oral Tablet 0.5-35 Mg-Mcg) | 1 | H |
| ***norethin-eth estradiol-fe*** (Wymzya Fe Oral Tablet Chewable 0.4-35 Mg-Mcg) | 3 | |
| ***xulane transdermal patch weekly 150-35 mcg/24hr*** | 3 | H |
| YASMIN 28 ORAL TABLET 3-0.03 MG (***drospirenone-ethinyl estradiol***) | 2 | |
| YAZ ORAL TABLET 3-0.02 MG (***drospirenone-ethinyl estradiol***) | 2 | |
| ***drospirenone-ethinyl estradiol*** (Zarah Oral Tablet 3-0.03 Mg) | 3 | |
| ***ethynodiol diac-eth estradiol*** (Zovia 1/35E (28) Oral Tablet 1-35 Mg-Mcg) | 1 | H |
| ***drospirenone-ethinyl estradiol*** (Zumandimine Oral Tablet 3-0.03 Mg) | 3 | |
| **DIPEPTIDYL PEPTIDASE-4(DPP-4) INHIBITORS - Drugs for Diabetes** | | |
| GLYXAMBI ORAL TABLET 10-5 MG, 25-5 MG (***empagliflozin-linagliptin***) | 2 | ST; SL (1 tablet per day.) |
| JENTADUETO ORAL TABLET 2.5-1000 MG, 2.5-500 MG, 2.5-850 MG (***linagliptin-metformin hcl***) | 2 | SL (2 tablets per day.) |
| JENTADUETO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 2.5-1000 MG (***linagliptin-metformin hcl***) | 2 | SL (2 tablets per day.) |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| JENTADUETO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 5-1000 MG (***linagliptin-metformin hcl***) | 2 | SL (1 tablet per day.) |
| KAZANO ORAL TABLET 12.5-1000 MG, 12.5-500 MG (***alogliptin-metformin hcl***) | 2 | SL (2 tablets per day.) |
| KOMBIGLYZE XR ORAL TABLET EXTENDED RELEASE 24 HOUR 2.5-1000 MG (***saxagliptin-metformin***) | 2 | SL (62 tablets per month.) |
| KOMBIGLYZE XR ORAL TABLET EXTENDED RELEASE 24 HOUR 5-1000 MG, 5-500 MG (***saxagliptin-metformin***) | 2 | SL (31 tablets per month.) |
| NESINA ORAL TABLET 12.5 MG, 25 MG, 6.25 MG (***alogliptin benzoate***) | 2 | SL (1 tablet per day.) |
| ONGLYZA ORAL TABLET 2.5 MG, 5 MG (***saxagliptin hcl***) | 2 | SL (1 tablet per day) |
| OSENI ORAL TABLET 12.5-15 MG, 12.5-30 MG, 12.5-45 MG, 25-15 MG, 25-30 MG, 25-45 MG (***alogliptin-pioglitazone***) | 2 | SL (1 tablet per day.) |
| TRADJENTA ORAL TABLET 5 MG (***linagliptin***) | 2 | SL (1 tablet per day) |
| TRIJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-5-1000 MG, 25-5-1000 MG (***empagliflozin-linaglip-metform***) | 2 | SL (1 tablet per day.) |
| TRIJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 12.5-2.5-1000 MG, 5-2.5-1000 MG (***empagliflozin-linaglip-metform***) | 2 | SL (2 tablets per day.) |
| **ESTROGEN AGONIST-ANTAGONISTS - Drugs for Women** | | |
| DUAVEE ORAL TABLET 0.45-20 MG (***conj estrogens-bazedoxifene***) | 3 | SL (1 tablet per day.) |
| FARESTON ORAL TABLET 60 MG (***toremifene citrate***) | 3 | |
| OSPHENA ORAL TABLET 60 MG (***ospemifene***) | 3 | PA; SL (1 tablet per day.) |
| ***raloxifene hcl oral tablet 60 mg*** | 2 | H |
| ***tamoxifen citrate oral tablet 10 mg*** | 1 | |
| ***tamoxifen citrate oral tablet 20 mg*** | 1 | H-N |
| ***toremifene citrate oral tablet 60 mg*** | 2 | |
| **ESTROGENS - Drugs for Women** | | |
| ACTIVELLA ORAL TABLET 1-0.5 MG (***estradiol-norethindrone acet***) | 3 | |
| ALORA TRANSDERMAL PATCH TWICE WEEKLY 0.025 MG/24HR, 0.05 MG/24HR, 0.075 MG/24HR, 0.1 MG/24HR (***estradiol***) | 3 | SL (8 patches (1 box) per 28 days.) |
| ***estradiol-norethindrone acet*** (Amabelz Oral Tablet 0.5-0.1 Mg, 1-0.5 Mg) | 2 | |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ANGELIQ ORAL TABLET 0.25-0.5 MG, 0.5-1 MG (***drospirenone-estradiol***) | 3 | |
| BIJUVA ORAL CAPSULE 1-100 MG (***estradiol-progesterone***) | 3 | |
| CLIMARA PRO TRANSDERMAL PATCH WEEKLY 0.045-0.015 MG/DAY (***estradiol-levonorgestrel***) | 3 | SL (4 patches per month.) |
| COMBIPATCH TRANSDERMAL PATCH TWICE WEEKLY 0.05-0.14 MG/DAY, 0.05-0.25 MG/DAY (***estradiol-norethindrone acet***) | 3 | SL (8 patches per 28 days.) |
| ***est estrogens-methyltest*** (Covaryx Hs Oral Tablet 0.625-1.25 Mg) | 1 | |
| ***est estrogens-methyltest*** (Covaryx Oral Tablet 1.25-2.5 Mg) | 1 | |
| DELESTROGEN INTRAMUSCULAR OIL 10 MG/ML, 20 MG/ML, 40 MG/ML (***estradiol valerate***) | 3 | M |
| DEPO-ESTRADIOL INTRAMUSCULAR OIL 5 MG/ML (***estradiol cypionate***) | 3 | M |
| DIVIGEL TRANSDERMAL GEL 0.25 MG/0.25GM, 0.5 MG/0.5GM, 0.75 MG/0.75GM, 1 MG/GM, 1.25 MG/1.25GM (***estradiol***) | 3 | |
| ***estradiol*** (Dotti Transdermal Patch Twice Weekly 0.025 Mg/24Hr, 0.0375 Mg/24Hr, 0.05 Mg/24Hr, 0.075 Mg/24Hr, 0.1 Mg/24Hr) | 3 | SL (8 patches (1 box) per 28 days.) |
| DUAVEE ORAL TABLET 0.45-20 MG (***conj estrogens-bazedoxifene***) | 3 | SL (1 tablet per day.) |
| ***est estrogens-methyltest*** (Eemt Hs Oral Tablet 0.625-1.25 Mg) | 1 | |
| ***est estrogens-methyltest*** (Eemt Oral Tablet 1.25-2.5 Mg) | 1 | |
| ELESTRIN TRANSDERMAL GEL 0.52 MG/0.87 GM (0.06%) (***estradiol***) | 3 | |
| ***est estrogens-methyltest ds oral tablet 1.25-2.5 mg*** | 1 | |
| ***est estrogens-methyltest hs oral tablet 0.625-1.25 mg*** | 1 | |
| ***est estrogens-methyltest oral tablet 1.25-2.5 mg*** | 1 | |
| ESTRACE ORAL TABLET 0.5 MG, 1 MG, 2 MG (***estradiol***) | 3 | |
| ESTRACE VAGINAL CREAM 0.1 MG/GM (***estradiol***) | 3 | |
| ***estradiol oral tablet 0.5 mg, 1 mg, 2 mg*** | 1 | |
| ***estradiol patch twice weekly 0.025 mg/24hr transdermal 0.025 mg/24hr*** | 2 | SL (8 patches (1 box) per 28 days.) |
| ***estradiol patch twice weekly 0.025 mg/24hr transdermal 0.025 mg/24hr*** | 3 | SL (8 patches (1 box) per 28 days.) |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ***estradiol patch twice weekly 0.0375 mg/24hr transdermal 0.0375 mg/24hr*** | 2 | SL (8 patches (1 box) per 28 days.) |
| ***estradiol patch twice weekly 0.0375 mg/24hr transdermal 0.0375 mg/24hr*** | 3 | SL (8 patches (1 box) per 28 days.) |
| ***estradiol patch twice weekly 0.05 mg/24hr transdermal 0.05 mg/24hr*** | 2 | SL (8 patches (1 box) per 28 days.) |
| ***estradiol patch twice weekly 0.05 mg/24hr transdermal 0.05 mg/24hr*** | 3 | SL (8 patches (1 box) per 28 days.) |
| ***estradiol patch twice weekly 0.075 mg/24hr transdermal 0.075 mg/24hr*** | 2 | SL (8 patches (1 box) per 28 days.) |
| ***estradiol patch twice weekly 0.075 mg/24hr transdermal 0.075 mg/24hr*** | 3 | SL (8 patches (1 box) per 28 days.) |
| ***estradiol patch twice weekly 0.1 mg/24hr transdermal 0.1 mg/24hr*** | 2 | SL (8 patches (1 box) per 28 days.) |
| ***estradiol patch twice weekly 0.1 mg/24hr transdermal 0.1 mg/24hr*** | 3 | SL (8 patches (1 box) per 28 days.) |
| ***estradiol transdermal patch weekly 0.025 mg/24hr, 0.0375 mg/24hr, 0.05 mg/24hr, 0.06 mg/24hr, 0.075 mg/24hr, 0.1 mg/24hr*** | 1 | SL (4 patches (1 carton) per 28 days.) |
| ***estradiol vaginal cream 0.1 mg/gm*** | 3 | |
| ***estradiol vaginal tablet 10 mcg*** | 2 | |
| ***estradiol valerate intramuscular oil 20 mg/ml, 40 mg/ml*** | 1 | M |
| ***estradiol-norethindrone acet oral tablet 0.5-0.1 mg, 1-0.5 mg*** | 2 | |
| ESTRING VAGINAL RING 2 MG (***estradiol***) | 2 | SL (1 ring per 90 days.) |
| ESTROGEL TRANSDERMAL GEL 0.75 MG/1.25 GM (0.06%) (***estradiol***) | 3 | SL (50 grams (1 box) per month.) |
| EVAMIST TRANSDERMAL SOLUTION 1.53 MG/SPRAY (***estradiol***) | 2 | |
| FEMHRT LOW DOSE ORAL TABLET 0.5-2.5 MG-MCG (***norethindrone-eth estradiol***) | 3 | |
| FEMRING VAGINAL RING 0.05 MG/24HR, 0.1 MG/24HR (***estradiol acetate***) | 3 | SL (1 ring per 3 months.) |
| ***norethindrone-eth estradiol*** (Fyavolv Oral Tablet 0.5-2.5 Mg-Mcg, 1-5 Mg-Mcg) | 3 | |
| IMVEXXY MAINTENANCE PACK VAGINAL INSERT 10 MCG, 4 MCG (***estradiol***) | 3 | SL (0.65 insert per day.) |
| IMVEXXY STARTER PACK VAGINAL INSERT 10 MCG, 4 MCG (***estradiol***) | 3 | SL (0.65 insert per day.) |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ***norethindrone-eth estradiol*** (Jinteli Oral Tablet 1-5 Mg-Mcg) | 3 | |
| ***estradiol-norethindrone acet*** (Lopreeza Oral Tablet 1-0.5 Mg) | 2 | |
| MENEST ORAL TABLET 0.3 MG, 0.625 MG, 1.25 MG (***esterified estrogens***) | 3 | |
| MENOSTAR TRANSDERMAL PATCH WEEKLY 14 MCG/24HR (***estradiol***) | 3 | SL (4 patches (1 carton) per 28 days.) |
| ***estradiol-norethindrone acet*** (Mimvey Oral Tablet 1-0.5 Mg) | 2 | |
| ***norethindrone-eth estradiol oral tablet 0.5-2.5 mg-mcg, 1-5 mg-mcg*** | 3 | |
| ORIAHNN ORAL CAPSULE THERAPY PACK 300-1-0.5 & 300 MG (***elagolix-estradiol-norethind***) | 3 | PA |
| PREFEST ORAL TABLET 1/1-0.09 MG (15/15) (***estradiol-norgestimate***) | 2 | |
| PREMARIN ORAL TABLET 0.3 MG, 0.45 MG, 0.625 MG, 0.9 MG, 1.25 MG (***estrogens conjugated***) | 3 | |
| PREMARIN VAGINAL CREAM 0.625 MG/GM (***estrogens, conjugated***) | 3 | |
| PREMPHASE ORAL TABLET 0.625-5 MG (***conj estrog-medroxyprogest ace***) | 3 | |
| PREMPRO ORAL TABLET 0.3-1.5 MG, 0.45-1.5 MG, 0.625-2.5 MG, 0.625-5 MG (***conj estrog-medroxyprogest ace***) | 3 | |
| VIVELLE-DOT TRANSDERMAL PATCH TWICE WEEKLY 0.025 MG/24HR, 0.0375 MG/24HR, 0.05 MG/24HR, 0.075 MG/24HR, 0.1 MG/24HR (***estradiol***) | 2 | SL (8 patches (1 box) per 28 days.) |
| ***estradiol*** (Yuvafem Vaginal Tablet 10 Mcg) | 2 | |
| **GLYCOGENOLYTIC AGENTS - Hormones** | | |
| BAQSIMI ONE PACK NASAL POWDER 3 MG/DOSE (***glucagon***) | 2 | SL (2 intranasal devices per prescription) |
| BAQSIMI TWO PACK NASAL POWDER 3 MG/DOSE (***glucagon***) | 2 | SL (2 intranasal devices per prescription) |
| GLUCAGEN HYPOKIT INJECTION SOLUTION RECONSTITUTED 1 MG (***glucagon hcl (rdna)***) | 2 | SL (2 devices per prescription.) |
| GLUCAGON EMERGENCY KIT INJECTION KIT 1 MG (***glucagon (rdna)***) | 2 | SL (2 devices per prescription) |
| GLUCAGON EMERGENCY KIT INJECTION SOLUTION RECONSTITUTED 1 MG/ML (***glucagon hcl***) | 2 | |
| GVOKE HYPOPEN 1-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.5 MG/0.1ML (***glucagon***) | 2 | SL (0.2 ml per prescription) |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| GVOKE HYPOPEN 1-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 1 MG/0.2ML (***glucagon***) | 2 | SL (0.4 ml per prescription) |
| GVOKE HYPOPEN 2-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.5 MG/0.1ML (***glucagon***) | 2 | SL (0.2 ml per prescription) |
| GVOKE HYPOPEN 2-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 1 MG/0.2ML (***glucagon***) | 2 | SL (0.4 ml per prescription) |
| GVOKE PFS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 0.5 MG/0.1ML, 1 MG/0.2ML (***glucagon***) | 2 | SL (2 syringes per prescription) |
| **GONADOTROPINS - Hormones** | | |
| ELIGARD SUBCUTANEOUS KIT 22.5 MG (***leuprolide acetate (3 month)***) | 3 | PA; M |
| ELIGARD SUBCUTANEOUS KIT 30 MG (***leuprolide acetate (4 month)***) | 3 | PA; M |
| ELIGARD SUBCUTANEOUS KIT 45 MG (***leuprolide acetate (6 month)***) | 3 | PA; M |
| ELIGARD SUBCUTANEOUS KIT 7.5 MG (***leuprolide acetate***) | 3 | PA; M |
| ***leuprolide acetate injection kit 1 mg/0.2ml*** | 1 | PA; M |
| SYNAREL NASAL SOLUTION 2 MG/ML (***nafarelin acetate***) | 2 | |
| **GONADOTROPINS AND ANTIGONADOTROPINS - Hormones** | | |
| ELIGARD SUBCUTANEOUS KIT 22.5 MG (***leuprolide acetate (3 month)***) | 3 | PA; M |
| ELIGARD SUBCUTANEOUS KIT 30 MG (***leuprolide acetate (4 month)***) | 3 | PA; M |
| ELIGARD SUBCUTANEOUS KIT 45 MG (***leuprolide acetate (6 month)***) | 3 | PA; M |
| ELIGARD SUBCUTANEOUS KIT 7.5 MG (***leuprolide acetate***) | 3 | PA; M |
| ***leuprolide acetate injection kit 1 mg/0.2ml*** | 1 | PA; M |
| SYNAREL NASAL SOLUTION 2 MG/ML (***nafarelin acetate***) | 2 | |
| **INCRETIN MIMETICS - Drugs for Diabetes** | | |
| ADLYXIN STARTER PACK SUBCUTANEOUS PEN-INJECTOR KIT 10 & 20 MCG/0.2ML (***lixisenatide***) | 3 | PA; ST; SL (6 ml per year.) |
| ADLYXIN SUBCUTANEOUS SOLUTION PEN-INJECTOR 20 MCG/0.2ML (***lixisenatide***) | 3 | PA; ST; SL (6 ml per month.) |
| BYDUREON BCISE AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR 2 MG/0.85ML (***exenatide***) | 2 | PA; ST; SL (3.4 ml per month.) |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| BYDUREON SUBCUTANEOUS PEN-INJECTOR 2 MG (***exenatide***) | 2 | PA; ST; SL (4 pens per 23 days.) |
| BYETTA 10 MCG PEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 10 MCG/0.04ML (***exenatide***) | 2 | PA; ST; SL (2.4 mL (one pen) per prescription) |
| BYETTA 5 MCG PEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 5 MCG/0.02ML (***exenatide***) | 2 | PA; ST; SL (1.2 mL (one pen) per prescription) |
| OZEMPIC SUBCUTANEOUS SOLUTION PEN-INJECTOR 2 MG/1.5ML (***semaglutide***) | 2 | PA; ST; SL (1.5 mL per 21 days.) |
| OZEMPIC SUBCUTANEOUS SOLUTION PEN-INJECTOR 2 MG/1.5ML (***semaglutide***) | 2 | PA; ST; SL (9 ml per 3 months.) |
| RYBELSUS ORAL TABLET 14 MG, 3 MG, 7 MG (***semaglutide***) | 2 | PA; ST; SL (1 tablet per day.) |
| SAXENDA SUBCUTANEOUS SOLUTION PEN-INJECTOR 18 MG/3ML (***liraglutide -weight management***) | 3 | PA; M |
| SOLIQUA SUBCUTANEOUS SOLUTION PEN-INJECTOR 100-33 UNT-MCG/ML (***insulin glargine-lixisenatide***) | 2 | SL (18 ml per month.) |
| TRULICITY SUBCUTANEOUS SOLUTION PEN-INJECTOR 0.75 MG/0.5ML, 1.5 MG/0.5ML (***dulaglutide***) | 2 | PA; ST; SL (2 ml per month.) |
| TRULICITY SUBCUTANEOUS SOLUTION PEN-INJECTOR 3 MG/0.5ML, 4.5 MG/0.5ML (***dulaglutide***) | 2 | PA; ST |
| VICTOZA SOLUTION PEN-INJECTOR 18 MG/3ML SUBCUTANEOUS 18 MG/3ML (***liraglutide***) | 2 | PA; ST; SL (6 ml (2 pens) per month.) |
| VICTOZA SOLUTION PEN-INJECTOR 18 MG/3ML SUBCUTANEOUS 18 MG/3ML (***liraglutide***) | 3 | PA; ST; SL (6 ml (2 pens) per month.) |
| **INSULINS - Drugs for Diabetes** | | |
| HUMALOG KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML (***insulin lispro***) | 2 | SL (75 ml per prescription) |
| HUMALOG KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 200 UNIT/ML (***insulin lispro***) | 2 | SL (75 ml (25 pens) per prescription) |
| HUMALOG MIX 50/50 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (50-50) 100 UNIT/ML (***insulin lispro prot & lispro***) | 2 | SL (75 ml per prescription) |
| HUMALOG MIX 50/50 VIAL SUBCUTANEOUS SUSPENSION (50-50) 100 UNIT/ML (***insulin lispro prot & lispro***) | 1 | SL (70 ml per prescription) |
| HUMALOG MIX 75/25 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (75-25) 100 UNIT/ML (***insulin lispro prot & lispro***) | 2 | SL (75 ml per prescription) |
| HUMALOG MIX 75/25 VIAL SUBCUTANEOUS SUSPENSION (75-25) 100 UNIT/ML (***insulin lispro prot & lispro***) | 1 | SL (70 ml per prescription) |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| HUMALOG U-100 JUNIOR KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML (***insulin lispro***) | 2 | SL (75 ml per prescription) |
| HUMALOG VIAL SUBCUTANEOUS SOLUTION 100 UNIT/ML (***insulin lispro***) | 1 | SL (70 ml per prescription) |
| HUMALOG VIAL SUBCUTANEOUS SOLUTION CARTRIDGE 100 UNIT/ML (***insulin lispro***) | 2 | SL (75 ml per prescription) |
| HUMULIN 70/30 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML (***insulin nph isophane & regular***) | 2 | SL (75 ml per prescription) |
| HUMULIN 70/30 VIAL SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML (***insulin nph isophane & regular***) | 1 | SL (70 ml per prescription) |
| HUMULIN N KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR 100 UNIT/ML (***insulin nph human (isophane)***) | 2 | SL (75 ml per prescription) |
| HUMULIN N VIAL SUBCUTANEOUS SUSPENSION 100 UNIT/ML (***insulin nph human (isophane)***) | 1 | SL (70 ml per prescription) |
| HUMULIN R U-500 KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 500 UNIT/ML (***insulin regular human***) | 2 | SL (75 mL per prescription) |
| HUMULIN R U-500 VIAL SUBCUTANEOUS SOLUTION 500 UNIT/ML (***insulin regular human***) | 1 | SL (80 ml per prescription) |
| HUMULIN R VIAL INJECTION SOLUTION 100 UNIT/ML (***insulin regular human***) | 1 | SL (70 ml per prescription) |
| LANTUS SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML (***insulin glargine***) | 1 | SL (75 ml per prescription) |
| LANTUS U-100 VIAL SUBCUTANEOUS SOLUTION 100 UNIT/ML (***insulin glargine***) | 1 | SL (70 ml per prescription) |
| LYUMJEV INJECTION SOLUTION 100 UNIT/ML (***insulin lispro-aabc***) | 1 | SL (70 ml per prescription) |
| LYUMJEV KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML, 200 UNIT/ML (***insulin lispro-aabc***) | 2 | SL (75 ml per prescription) |
| SOLIQUA SUBCUTANEOUS SOLUTION PEN-INJECTOR 100-33 UNT-MCG/ML (***insulin glargine-lixisenatide***) | 2 | SL (18 ml per month.) |
| TOUJEO MAX SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR 300 UNIT/ML (***insulin glargine***) | 2 | SL (75 ml per prescription) |
| TOUJEO SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR 300 UNIT/ML (***insulin glargine***) | 2 | SL (37.5 ml per prescription) |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| **INTERMEDIATE-ACTING INSULINS - Drugs for Diabetes** | | |
| HUMALOG MIX 50/50 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (50-50) 100 UNIT/ML (***insulin lispro prot & lispro***) | 2 | SL (75 ml per prescription) |
| HUMALOG MIX 50/50 VIAL SUBCUTANEOUS SUSPENSION (50-50) 100 UNIT/ML (***insulin lispro prot & lispro***) | 1 | SL (70 ml per prescription) |
| HUMALOG MIX 75/25 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (75-25) 100 UNIT/ML (***insulin lispro prot & lispro***) | 2 | SL (75 ml per prescription) |
| HUMALOG MIX 75/25 VIAL SUBCUTANEOUS SUSPENSION (75-25) 100 UNIT/ML (***insulin lispro prot & lispro***) | 1 | SL (70 ml per prescription) |
| HUMULIN 70/30 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML (***insulin nph isophane & regular***) | 2 | SL (75 ml per prescription) |
| HUMULIN 70/30 VIAL SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML (***insulin nph isophane & regular***) | 1 | SL (70 ml per prescription) |
| HUMULIN N KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR 100 UNIT/ML (***insulin nph human (isophane)***) | 2 | SL (75 ml per prescription) |
| HUMULIN N VIAL SUBCUTANEOUS SUSPENSION 100 UNIT/ML (***insulin nph human (isophane)***) | 1 | SL (70 ml per prescription) |
| **LEPTINS - Hormones** | | |
| MYALEPT SUBCUTANEOUS SOLUTION RECONSTITUTED 11.3 MG (***metreleptin***) | 3 | PA; M; SL (1 vial per day.); SP |
| **LONG-ACTING INSULINS - Drugs for Diabetes** | | |
| LANTUS SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML (***insulin glargine***) | 1 | SL (75 ml per prescription) |
| LANTUS U-100 VIAL SUBCUTANEOUS SOLUTION 100 UNIT/ML (***insulin glargine***) | 1 | SL (70 ml per prescription) |
| SOLIQUA SUBCUTANEOUS SOLUTION PEN-INJECTOR 100-33 UNT-MCG/ML (***insulin glargine-lixisenatide***) | 2 | SL (18 ml per month.) |
| TOUJEO MAX SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR 300 UNIT/ML (***insulin glargine***) | 2 | SL (75 ml per prescription) |
| TOUJEO SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR 300 UNIT/ML (***insulin glargine***) | 2 | SL (37.5 ml per prescription) |
| **MEGLITINIDES - Drugs for Diabetes** | | |
| ***nateglinide oral tablet 120 mg, 60 mg*** | 2 | SL (3 tablets per day) |
| ***repaglinide oral tablet 0.5 mg, 1 mg*** | 2 | SL (4 tablets per day) |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ***repaglinide oral tablet 2 mg*** | 2 | SL (8 tablets per day) |
| STARLIX ORAL TABLET 120 MG, 60 MG (***nateglinide***) | 3 | SL (3 tablets per day) |
| **PARATHYROID AGENTS - Drugs for Bones** | | |
| NATPARA SUBCUTANEOUS CARTRIDGE 100 MCG, 25 MCG, 50 MCG, 75 MCG (***parathyroid hormone (recomb)***) | 4 | PA; M; SL (2 cartridges per month.); SP |
| TERIPARATIDE (RECOMBINANT) SUBCUTANEOUS SOLUTION PEN-INJECTOR 620 MCG/2.48ML | 3 | PA; M |
| TYMLOS SUBCUTANEOUS SOLUTION PEN-INJECTOR 3120 MCG/1.56ML (***abaloparatide***) | 3 | PA; M; SP |
| **PARATHYROID AND ANTIPARATHYROID AGENTS - Drugs for Bones** | | |
| ***calcitonin (salmon) nasal solution 200 unit/act*** | 2 | |
| MIACALCIN INJECTION SOLUTION 200 UNIT/ML (***calcitonin (salmon)***) | 3 | M |
| NATPARA SUBCUTANEOUS CARTRIDGE 100 MCG, 25 MCG, 50 MCG, 75 MCG (***parathyroid hormone (recomb)***) | 4 | PA; M; SL (2 cartridges per month.); SP |
| TYMLOS SUBCUTANEOUS SOLUTION PEN-INJECTOR 3120 MCG/1.56ML (***abaloparatide***) | 3 | PA; M; SP |
| **PITUITARY - Hormones** | | |
| ACTHAR INJECTION GEL 80 UNIT/ML (***corticotropin***) | 4 | PA; ST; M; SL (20 ml per 24 days.); SP |
| DDAVP INJECTION SOLUTION 4 MCG/ML (***desmopressin acetate***) | 3 | M |
| DDAVP NASAL SOLUTION 0.01 % (***desmopressin acetate spray***) | 3 | |
| DDAVP ORAL TABLET 0.1 MG, 0.2 MG (***desmopressin acetate***) | 3 | |
| DDAVP RHINAL TUBE NASAL SOLUTION 0.01 % (***desmopressin ace refrigerated***) | 3 | |
| ***desmopressin ace spray refrig nasal solution 0.01 %*** | 1 | |
| ***desmopressin acetate injection solution 4 mcg/ml*** | 1 | M |
| ***desmopressin acetate oral tablet 0.1 mg, 0.2 mg*** | 1 | |
| ***desmopressin acetate spray nasal solution 0.01 %*** | 1 | |
| NOCDURNA SUBLINGUAL TABLET SUBLINGUAL 27.7 MCG, 55.3 MCG (***desmopressin acetate***) | 3 | PA; SL (1 tablet per day.) |
| NUTROPIN AQ NUSPIN 10 SUBCUTANEOUS SOLUTION PEN-INJECTOR 10 MG/2ML (***somatropin***) | 2 | PA; M; SL (18 ml (9 cartridges) per month.); SP |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| NUTROPIN AQ NUSPIN 20 SUBCUTANEOUS SOLUTION PEN-INJECTOR 20 MG/2ML (***somatropin***) | 2 | PA; M; SL (10 ml (5 cartridges) per month.); SP |
| NUTROPIN AQ NUSPIN 5 SUBCUTANEOUS SOLUTION PEN-INJECTOR 5 MG/2ML (***somatropin***) | 2 | PA; M; SL (36 ml (18 cartridges) per month.); SP |
| SEROSTIM SUBCUTANEOUS SOLUTION RECONSTITUTED 4 MG, 5 MG, 6 MG (***somatropin (non-refrigerated)***) | 4 | PA; M; SL (1 tablet per day); SP |
| STIMATE NASAL SOLUTION 1.5 MG/ML (***desmopressin acetate***) | 3 | |
| ZORBTIVE SUBCUTANEOUS SOLUTION RECONSTITUTED 8.8 MG (***somatropin (non-refrigerated)***) | 3 | PA; M; SL (1 tablet per day); SP |
| **PROGESTINS - Drugs for Women** | | |
| ACTIVELLA ORAL TABLET 1-0.5 MG (***estradiol-norethindrone acet***) | 3 | |
| ***estradiol-norethindrone acet*** (Amabelz Oral Tablet 0.5-0.1 Mg, 1-0.5 Mg) | 2 | |
| ANGELIQ ORAL TABLET 0.25-0.5 MG, 0.5-1 MG (***drospirenone-estradiol***) | 3 | |
| AYGESTIN ORAL TABLET 5 MG (***norethindrone acetate***) | 3 | |
| BIJUVA ORAL CAPSULE 1-100 MG (***estradiol-progesterone***) | 3 | |
| COMBIPATCH TRANSDERMAL PATCH TWICE WEEKLY 0.05-0.14 MG/DAY, 0.05-0.25 MG/DAY (***estradiol-norethindrone acet***) | 3 | SL (8 patches per 28 days.) |
| CRINONE VAGINAL GEL 4 %, 8 % (***progesterone***) | 3 | ST |
| DEPO-PROVERA INTRAMUSCULAR SUSPENSION 150 MG/ML (***medroxyprogesterone acetate***) | 3 | SL (5 ml per year.) |
| DEPO-PROVERA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 150 MG/ML (***medroxyprogesterone acetate***) | 3 | |
| DEPO-SUBQ PROVERA 104 SUBCUTANEOUS SUSPENSION PREFILLED SYRINGE 104 MG/0.65ML (***medroxyprogesterone acetate***) | 2 | SL (3.25 ml per year.) |
| ENDOMETRIN VAGINAL INSERT 100 MG (***progesterone***) | 2 | |
| ***estradiol-norethindrone acet oral tablet 0.5-0.1 mg, 1-0.5 mg*** | 2 | |
| FEMHRT LOW DOSE ORAL TABLET 0.5-2.5 MG-MCG (***norethindrone-eth estradiol***) | 3 | |
| ***norethindrone-eth estradiol*** (Fyavolv Oral Tablet 0.5-2.5 Mg-Mcg, 1-5 Mg-Mcg) | 3 | |
| ***norethindrone-eth estradiol*** (Jinteli Oral Tablet 1-5 Mg-Mcg) | 3 | |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ***estradiol-norethindrone acet*** (Lopreeza Oral Tablet 1-0.5 Mg) | 2 | |
| ***medroxyprogesterone acetate intramuscular suspension 150 mg/ml*** | 1 | SL (5 ml per year.); H |
| ***medroxyprogesterone acetate intramuscular suspension prefilled syringe 150 mg/ml*** | 1 | H |
| ***medroxyprogesterone acetate oral tablet 10 mg, 2.5 mg, 5 mg*** | 1 | |
| ***megestrol acetate oral suspension 40 mg/ml*** | 1 | |
| ***megestrol acetate oral suspension 625 mg/5ml*** | 3 | |
| ***megestrol acetate oral tablet 20 mg, 40 mg*** | 1 | |
| ***estradiol-norethindrone acet*** (Mimvey Oral Tablet 1-0.5 Mg) | 2 | |
| ***norethindrone acetate oral tablet 5 mg*** | 1 | |
| ***norethindrone-eth estradiol oral tablet 0.5-2.5 mg-mcg, 1-5 mg-mcg*** | 3 | |
| ORIAHNN ORAL CAPSULE THERAPY PACK 300-1-0.5 & 300 MG (***elagolix-estradiol-norethind***) | 3 | PA |
| ***progesterone intramuscular oil 50 mg/ml*** | 1 | M |
| ***progesterone micronized oral capsule 100 mg, 200 mg*** | 2 | |
| PROVERA ORAL TABLET 10 MG, 2.5 MG, 5 MG (***medroxyprogesterone acetate***) | 3 | |
| SLYND ORAL TABLET 4 MG (***drospirenone***) | 3 | PA; ST; H |
| **RAPID-ACTING INSULINS - Drugs for Diabetes** | | |
| HUMALOG KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML (***insulin lispro***) | 2 | SL (75 ml per prescription) |
| HUMALOG KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 200 UNIT/ML (***insulin lispro***) | 2 | SL (75 ml (25 pens) per prescription) |
| HUMALOG MIX 50/50 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (50-50) 100 UNIT/ML (***insulin lispro prot & lispro***) | 2 | SL (75 ml per prescription) |
| HUMALOG MIX 50/50 VIAL SUBCUTANEOUS SUSPENSION (50-50) 100 UNIT/ML (***insulin lispro prot & lispro***) | 1 | SL (70 ml per prescription) |
| HUMALOG MIX 75/25 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (75-25) 100 UNIT/ML (***insulin lispro prot & lispro***) | 2 | SL (75 ml per prescription) |
| HUMALOG MIX 75/25 VIAL SUBCUTANEOUS SUSPENSION (75-25) 100 UNIT/ML (***insulin lispro prot & lispro***) | 1 | SL (70 ml per prescription) |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| HUMALOG U-100 JUNIOR KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML (***insulin lispro***) | 2 | SL (75 ml per prescription) |
| HUMALOG VIAL SUBCUTANEOUS SOLUTION 100 UNIT/ML (***insulin lispro***) | 1 | SL (70 ml per prescription) |
| HUMALOG VIAL SUBCUTANEOUS SOLUTION CARTRIDGE 100 UNIT/ML (***insulin lispro***) | 2 | SL (75 ml per prescription) |
| LYUMJEV INJECTION SOLUTION 100 UNIT/ML (***insulin lispro-aabc***) | 1 | SL (70 ml per prescription) |
| LYUMJEV KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML, 200 UNIT/ML (***insulin lispro-aabc***) | 2 | SL (75 ml per prescription) |
| **SHORT-ACTING INSULINS - Drugs for Diabetes** | | |
| HUMULIN 70/30 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML (***insulin nph isophane & regular***) | 2 | SL (75 ml per prescription) |
| HUMULIN 70/30 VIAL SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML (***insulin nph isophane & regular***) | 1 | SL (70 ml per prescription) |
| HUMULIN R U-500 KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 500 UNIT/ML (***insulin regular human***) | 2 | SL (75 mL per prescription) |
| HUMULIN R U-500 VIAL SUBCUTANEOUS SOLUTION 500 UNIT/ML (***insulin regular human***) | 1 | SL (80 ml per prescription) |
| HUMULIN R VIAL INJECTION SOLUTION 100 UNIT/ML (***insulin regular human***) | 1 | SL (70 ml per prescription) |
| **SODIUM-GLUC COTRANSPORT 2 (SGLT2) INHIB - Drugs for Diabetes** | | |
| GLYXAMBI ORAL TABLET 10-5 MG, 25-5 MG (***empagliflozin-linagliptin***) | 2 | ST; SL (1 tablet per day.) |
| JARDIANCE ORAL TABLET 10 MG, 25 MG (***empagliflozin***) | 2 | ST; SL (30 tablets per month.) |
| SYNJARDY ORAL TABLET 12.5-1000 MG, 12.5-500 MG, 5-1000 MG, 5-500 MG (***empagliflozin-metformin hcl***) | 2 | SL (2 tablets per day.) |
| SYNJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-1000 MG, 25-1000 MG (***empagliflozin-metformin hcl***) | 2 | SL (1 tablet per day.) |
| SYNJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 12.5-1000 MG, 5-1000 MG (***empagliflozin-metformin hcl***) | 2 | SL (2 tablets per day.) |
| TRIJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-5-1000 MG, 25-5-1000 MG (***empagliflozin-linaglip-metform***) | 2 | SL (1 tablet per day.) |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| TRIJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 12.5-2.5-1000 MG, 5-2.5-1000 MG (***empagliflozin-linaglip-metform***) | 2 | SL (2 tablets per day.) |
| **SOMATOSTATIN AGONISTS - Hormones** | | |
| ***octreotide acetate injection solution 100 mcg/ml, 1000 mcg/ml, 200 mcg/ml, 50 mcg/ml, 500 mcg/ml*** | 1 | PA; M |
| SIGNIFOR SUBCUTANEOUS SOLUTION 0.3 MG/ML, 0.6 MG/ML, 0.9 MG/ML (***pasireotide diaspartate***) | 2 | PA; M; SL (2 ampules per day.); SP |
| SOMATULINE DEPOT SUBCUTANEOUS SOLUTION 120 MG/0.5ML, 60 MG/0.2ML, 90 MG/0.3ML (***lanreotide acetate***) | 4 | M; SP |
| **SOMATOTROPIN AGONISTS - Hormones** | | |
| EGRIFTA SV SUBCUTANEOUS SOLUTION RECONSTITUTED 2 MG (***tesamorelin acetate***) | 4 | M |
| INCRELEX SUBCUTANEOUS SOLUTION 40 MG/4ML (***mecasermin***) | 2 | PA; M; SL (52 vials per month.); SP |
| **SOMATOTROPIN ANTAGONISTS - Hormones** | | |
| SOMAVERT SUBCUTANEOUS SOLUTION RECONSTITUTED 10 MG, 15 MG, 20 MG, 25 MG, 30 MG (***pegvisomant***) | 3 | PA; M; SL (1 vial per day.); SP |
| **SULFONYLUREAS - Drugs for Diabetes** | | |
| AMARYL ORAL TABLET 1 MG, 2 MG, 4 MG (***glimepiride***) | 3 | |
| DUETACT ORAL TABLET 30-2 MG, 30-4 MG (***pioglitazone hcl-glimepiride***) | 3 | SL (1 tablet per day) |
| ***glimepiride oral tablet 1 mg, 2 mg, 4 mg*** | 1 | |
| ***glipizide er oral tablet extended release 24 hour 10 mg, 2.5 mg, 5 mg*** | 1 | |
| ***glipizide oral tablet 10 mg, 5 mg*** | 1 | |
| ***glipizide xl oral tablet extended release 24 hour 10 mg, 2.5 mg, 5 mg*** | 1 | |
| ***glipizide-metformin hcl oral tablet 2.5-250 mg, 2.5-500 mg, 5-500 mg*** | 2 | |
| GLUCOTROL ORAL TABLET 10 MG, 5 MG (***glipizide***) | 3 | |
| GLUCOTROL XL ORAL TABLET EXTENDED RELEASE 24 HOUR 10 MG, 2.5 MG, 5 MG (***glipizide***) | 3 | |
| GLUCOVANCE ORAL TABLET 5-500 MG (***glyburide-metformin***) | 3 | |
| ***glyburide micronized oral tablet 1.5 mg, 3 mg, 6 mg*** | 1 | |
| ***glyburide oral tablet 1.25 mg, 2.5 mg, 5 mg*** | 1 | |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ***glyburide-metformin oral tablet 1.25-250 mg, 2.5-500 mg, 5-500 mg*** | 1 | |
| GLYNASE ORAL TABLET 1.5 MG, 3 MG, 6 MG (***glyburide micronized***) | 3 | |
| ***pioglitazone hcl-glimepiride oral tablet 30-2 mg, 30-4 mg*** | 1 | SL (1 tablet per day) |
| ***tolbutamide oral tablet 500 mg*** | 1 | |
| **THIAZOLIDINEDIONES - Drugs for Diabetes** | | |
| ACTOPLUS MET ORAL TABLET 15-500 MG, 15-850 MG (***pioglitazone hcl-metformin hcl***) | 3 | SL (3 tablets per day) |
| AVANDIA ORAL TABLET 2 MG, 4 MG (***rosiglitazone maleate***) | 3 | SL (2 tablets per day) |
| DUETACT ORAL TABLET 30-2 MG, 30-4 MG (***pioglitazone hcl-glimepiride***) | 3 | SL (1 tablet per day) |
| OSENI ORAL TABLET 12.5-15 MG, 12.5-30 MG, 12.5-45 MG, 25-15 MG, 25-30 MG, 25-45 MG (***alogliptin-pioglitazone***) | 2 | SL (1 tablet per day.) |
| ***pioglitazone hcl oral tablet 15 mg, 30 mg, 45 mg*** | 1 | SL (1 tablet per day) |
| ***pioglitazone hcl-glimepiride oral tablet 30-2 mg, 30-4 mg*** | 1 | SL (1 tablet per day) |
| ***pioglitazone hcl-metformin hcl oral tablet 15-500 mg, 15-850 mg*** | 2 | SL (3 tablets per day) |
| **THYROID AGENTS - Drugs for the Thyroid** | | |
| ARMOUR THYROID ORAL TABLET 120 MG, 15 MG, 180 MG, 240 MG, 30 MG, 300 MG, 60 MG, 90 MG (***thyroid***) | 3 | |
| ***levothyroxine sodium*** (Euthyrox Oral Tablet 100 Mcg, 112 Mcg, 125 Mcg, 137 Mcg, 150 Mcg, 175 Mcg, 200 Mcg, 25 Mcg, 50 Mcg, 75 Mcg, 88 Mcg) | 1 | |
| ***levothyroxine sodium*** (Levo-T Oral Tablet 100 Mcg, 112 Mcg, 125 Mcg, 137 Mcg, 150 Mcg, 175 Mcg, 200 Mcg, 25 Mcg, 300 Mcg, 50 Mcg, 75 Mcg, 88 Mcg) | 1 | |
| ***levothyroxine sodium oral tablet 100 mcg, 112 mcg, 125 mcg, 137 mcg, 150 mcg, 175 mcg, 200 mcg, 25 mcg, 300 mcg, 50 mcg, 75 mcg, 88 mcg*** | 1 | |
| ***levothyroxine sodium*** (Levoxyl Oral Tablet 100 Mcg, 112 Mcg, 125 Mcg, 137 Mcg, 150 Mcg, 175 Mcg, 200 Mcg, 25 Mcg, 50 Mcg, 75 Mcg, 88 Mcg) | 2 | |
| ***liothyronine sodium oral tablet 25 mcg, 5 mcg, 50 mcg*** | 2 | |
| NATURE-THROID ORAL TABLET 113.75 MG, 130 MG, 146.25 MG, 16.25 MG, 162.5 MG, 195 MG, 260 MG, 32.5 MG, 325 MG, 48.75 MG, 65 MG, 81.25 MG, 97.5 MG (***thyroid***) | 3 | |
| ***np thyroid oral tablet 120 mg, 15 mg, 30 mg, 60 mg, 90 mg*** | 1 | |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| TIROSINT-SOL ORAL SOLUTION 100 MCG/ML, 112 MCG/ML, 125 MCG/ML, 13 MCG/ML, 137 MCG/ML, 150 MCG/ML, 175 MCG/ML, 200 MCG/ML, 25 MCG/ML, 50 MCG/ML, 75 MCG/ML, 88 MCG/ML (***levothyroxine sodium***) | 3 | PA |
| ***levothyroxine sodium*** (Unithroid Oral Tablet 100 Mcg, 112 Mcg, 125 Mcg, 137 Mcg, 150 Mcg, 175 Mcg, 200 Mcg, 25 Mcg, 300 Mcg, 50 Mcg, 75 Mcg, 88 Mcg) | 1 | |
| WESTHROID ORAL TABLET 130 MG, 195 MG, 32.5 MG, 65 MG, 97.5 MG (***thyroid***) | 3 | |
| WP THYROID ORAL TABLET 113.75 MG, 130 MG, 16.25 MG, 32.5 MG, 48.75 MG, 65 MG, 81.25 MG, 97.5 MG (***thyroid***) | 3 | |
| **MISCELLANEOUS THERAPEUTIC AGENTS** | | |
| **5-ALPHA-REDUCTASE INHIBITORS** | | |
| ***dutasteride oral capsule 0.5 mg*** | 3 | |
| ***finasteride oral tablet 5 mg*** | 1 | |
| PROSCAR ORAL TABLET 5 MG (***finasteride***) | 3 | |
| **ALCOHOL DETERRENTS - Drugs for Alcohol Dependence** | | |
| ANTABUSE ORAL TABLET 250 MG, 500 MG (***disulfiram***) | 3 | |
| ***disulfiram oral tablet 250 mg, 500 mg*** | 1 | |
| ***naltrexone hcl oral tablet 50 mg*** | 1 | |
| **ANTIDOTES - Drugs for Overdose or Poisoning** | | |
| BAQSIMI ONE PACK NASAL POWDER 3 MG/DOSE (***glucagon***) | 2 | SL (2 intranasal devices per prescription) |
| BAQSIMI TWO PACK NASAL POWDER 3 MG/DOSE (***glucagon***) | 2 | SL (2 intranasal devices per prescription) |
| CHEMET ORAL CAPSULE 100 MG (***succimer***) | 2 | |
| FOSRENOL ORAL PACKET 1000 MG, 750 MG (***lanthanum carbonate***) | 3 | |
| GLUCAGEN HYPOKIT INJECTION SOLUTION RECONSTITUTED 1 MG (***glucagon hcl (rdna)***) | 2 | SL (2 devices per prescription.) |
| GLUCAGON EMERGENCY KIT INJECTION KIT 1 MG (***glucagon (rdna)***) | 2 | SL (2 devices per prescription) |
| GLUCAGON EMERGENCY KIT INJECTION SOLUTION RECONSTITUTED 1 MG/ML (***glucagon hcl***) | 2 | |
| GVOKE HYPOPEN 1-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.5 MG/0.1ML (***glucagon***) | 2 | SL (0.2 ml per prescription) |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| GVOKE HYPOPEN 1-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 1 MG/0.2ML (***glucagon***) | 2 | SL (0.4 ml per prescription) |
| GVOKE HYPOPEN 2-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.5 MG/0.1ML (***glucagon***) | 2 | SL (0.2 ml per prescription) |
| GVOKE HYPOPEN 2-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 1 MG/0.2ML (***glucagon***) | 2 | SL (0.4 ml per prescription) |
| GVOKE PFS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 0.5 MG/0.1ML, 1 MG/0.2ML (***glucagon***) | 2 | SL (2 syringes per prescription) |
| IODINE STRONG ORAL SOLUTION 5 % | 2 | |
| ***sodium polystyrene sulfonate*** (Kionex Oral Suspension 15 Gm/60Ml) | 1 | |
| ***lanthanum carbonate oral tablet chewable 1000 mg, 500 mg, 750 mg*** | 3 | |
| ***leucovorin calcium oral tablet 10 mg, 15 mg, 25 mg, 5 mg*** | 1 | |
| MEPHYTON ORAL TABLET 5 MG (***phytonadione***) | 3 | SL (5 tablets per prescription) |
| ***naloxone hcl injection solution 0.4 mg/ml, 4 mg/10ml*** | 1 | |
| NALOXONE HCL INJECTION SOLUTION AUTO-INJECTOR 2 MG/0.4ML | 3 | PA; SL (0.8 ml per prescription) |
| ***naloxone hcl injection solution cartridge 0.4 mg/ml*** | 1 | |
| ***naloxone hcl injection solution prefilled syringe 2 mg/2ml*** | 1 | |
| NARCAN NASAL LIQUID 4 MG/0.1ML (***naloxone hcl***) | 2 | SL (2 auto-injectors per prescription) |
| ***phytonadione oral tablet 5 mg*** | 3 | SL (5 tablets per prescription) |
| RADIOGARDASE ORAL CAPSULE 0.5 GM (***prussian blue insoluble***) | 3 | |
| RENAGEL ORAL TABLET 800 MG (***sevelamer hcl***) | 3 | |
| RENVELA ORAL PACKET 0.8 GM, 2.4 GM (***sevelamer carbonate***) | 3 | |
| ***sevelamer carbonate oral packet 0.8 gm, 2.4 gm*** | 2 | |
| ***sevelamer carbonate oral tablet 800 mg*** | 2 | |
| ***sevelamer hcl oral tablet 400 mg, 800 mg*** | 3 | |
| ***sodium polystyrene sulfonate oral powder*** | 1 | |
| ***sodium polystyrene sulfonate oral suspension 15 gm/60ml*** | 1 | |
| ***sodium polystyrene sulfonate rectal suspension 30 gm/120ml, 50 gm/200ml*** | 1 | |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ***sodium polystyrene sulfonate*** (Sps Oral Suspension 15 Gm/60Ml) | 1 | |
| SSKI ORAL SOLUTION 1 GM/ML (***potassium iodide (expectorant)***) | 3 | |
| VISTOGARD ORAL PACKET 10 GM (***uridine triacetate***) | 2 | SL (20 packets per prescription) |
| **ANTIGOUT AGENTS - Drugs for Gout** | | |
| ***allopurinol oral tablet 100 mg, 300 mg*** | 1 | |
| ***colchicine-probenecid oral tablet 0.5-500 mg*** | 1 | |
| EC-NAPROSYN ORAL TABLET DELAYED RELEASE 375 MG (***naproxen***) | 3 | |
| ***ec-naproxen oral tablet delayed release 375 mg, 500 mg*** | 1 | |
| ***febuxostat oral tablet 40 mg, 80 mg*** | 3 | ST; SL (1 tablet per day) |
| GLOPERBA ORAL SOLUTION 0.6 MG/5ML (***colchicine***) | 3 | PA |
| INDOCIN ORAL SUSPENSION 25 MG/5ML (***indomethacin***) | 3 | |
| INDOCIN RECTAL SUPPOSITORY 50 MG (***indomethacin***) | 3 | |
| ***indomethacin er oral capsule extended release 75 mg*** | 1 | |
| ***indomethacin oral capsule 25 mg, 50 mg*** | 1 | |
| MITIGARE ORAL CAPSULE 0.6 MG (***colchicine***) | 2 | |
| NAPROSYN ORAL SUSPENSION 125 MG/5ML (***naproxen***) | 3 | PA |
| ***naproxen dr oral tablet delayed release 375 mg, 500 mg*** | 1 | |
| ***naproxen oral suspension 125 mg/5ml*** | 1 | PA |
| ***naproxen oral tablet 250 mg, 375 mg, 500 mg*** | 1 | |
| ***naproxen sodium oral tablet 275 mg, 550 mg*** | 1 | |
| ***probenecid oral tablet 500 mg*** | 1 | |
| ZYLOPRIM ORAL TABLET 100 MG, 300 MG (***allopurinol***) | 3 | |
| **ANTISENSE OLIGONUCLEOTIDES** | | |
| TEGSEDI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 284 MG/1.5ML (***inotersen sodium***) | 2 | PA; M; SL (0.22 ml per day.); SP |
| **BONE ANABOLIC AGENTS** | | |
| NATPARA SUBCUTANEOUS CARTRIDGE 100 MCG, 25 MCG, 50 MCG, 75 MCG (***parathyroid hormone (recomb)***) | 4 | PA; M; SL (2 cartridges per month.); SP |
| TERIPARATIDE (RECOMBINANT) SUBCUTANEOUS SOLUTION PEN-INJECTOR 620 MCG/2.48ML | 3 | PA; M |
| TYMLOS SUBCUTANEOUS SOLUTION PEN-INJECTOR 3120 MCG/1.56ML (***abaloparatide***) | 3 | PA; M; SP |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| **BONE RESORPTION INHIBITORS - Drugs for Bone Loss** | | |
| ACTONEL ORAL TABLET 150 MG (***risedronate sodium***) | 3 | SL (1 tablet per month) |
| ACTONEL ORAL TABLET 30 MG, 5 MG (***risedronate sodium***) | 3 | |
| ACTONEL ORAL TABLET 35 MG (***risedronate sodium***) | 3 | SL (4 tablets per 28 days.) |
| ***alendronate sodium oral solution 70 mg/75ml*** | 1 | |
| ***alendronate sodium oral tablet 10 mg, 35 mg, 5 mg, 70 mg*** | 1 | |
| BONIVA ORAL TABLET 150 MG (***ibandronate sodium***) | 3 | |
| ***calcitonin (salmon) nasal solution 200 unit/act*** | 2 | |
| FOSAMAX ORAL TABLET 70 MG (***alendronate sodium***) | 3 | |
| FOSAMAX PLUS D ORAL TABLET 70-2800 MG-UNIT, 70-5600 MG-UNIT (***alendronate-cholecalciferol***) | 3 | |
| ***ibandronate sodium oral tablet 150 mg*** | 2 | |
| MIACALCIN INJECTION SOLUTION 200 UNIT/ML (***calcitonin (salmon)***) | 3 | M |
| ***raloxifene hcl oral tablet 60 mg*** | 2 | H |
| ***risedronate sodium oral tablet 150 mg*** | 3 | SL (1 tablet per month) |
| ***risedronate sodium oral tablet 30 mg, 5 mg*** | 3 | |
| ***risedronate sodium oral tablet 35 mg*** | 3 | SL (4 tablets per 28 days.) |
| **CARIOSTATIC AGENTS - Vitamins and Fluoride** | | |
| ***adc/f (0.5mg/ml) oral solution 0.5 mg/ml*** | 1 | |
| ***sodium fluoride*** (Cavarest Dental Gel 1.1 %) | 1 | |
| ***sodium fluoride*** (Clinpro 5000 Dental Paste 1.1 %) | 1 | |
| ***sodium fluoride*** (Denta 5000 Plus Dental Cream 1.1 %) | 1 | |
| ***sodium fluoride*** (Dentagel Dental Gel 1.1 %) | 1 | |
| FLORIVA ORAL LIQUID 0.25-400 MG-UNIT/ML (***sodium fluoride-vitamin d***) | 3 | |
| FLORIVA PLUS ORAL SOLUTION 0.25 MG/ML (***pediatric multivitamins-fl***) | 3 | |
| FLUORABON ORAL SOLUTION 0.55 (0.25 F) MG/0.6ML (***sodium fluoride***) | 2 | H |
| ***sodium fluoride*** (Fluoridex Dental Paste 1.1 %) | 1 | |
| ***sod fluoride-potassium nitrate*** (Fluoridex Sensitivity Relief Dental Paste 1.1-5 %) | 1 | |
| ***fluoritab oral solution 0.275 (0.125 f) mg/drop*** | 1 | H |
| ***fluoritab oral tablet chewable 1.1 (0.5 f) mg, 2.2 (1 f) mg*** | 1 | H |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| FLURA-DROPS ORAL SOLUTION 0.55 (0.25 F) MG/DROP (***sodium fluoride***) | 3 | H |
| ***multi-vit/iron/fluoride oral solution 0.25-10 mg/ml*** | 1 | |
| ***multivitamin/fluoride oral solution 0.25 mg/ml, 0.5 mg/ml*** | 1 | |
| ***multi-vitamin/fluoride oral solution 0.25 mg/ml, 0.5 mg/ml*** | 1 | |
| ***multivitamin/fluoride oral tablet chewable 0.25 mg, 0.5 mg, 1 mg*** | 1 | |
| ***multi-vitamin/fluoride/iron oral solution 0.25-10 mg/ml*** | 1 | |
| ***multivitamins/fluoride oral tablet chewable 0.5 mg*** | 1 | |
| NAFRINSE DAILY/NEUTRAL MOUTH/THROAT SOLUTION RECONSTITUTED 0.05 % (***sodium fluoride***) | 2 | |
| POLY-VI-FLOR ORAL SUSPENSION 0.25 MG/ML (***pediatric multivitamins-fl***) | 3 | |
| POLY-VI-FLOR ORAL TABLET CHEWABLE 0.25 MG, 0.5 MG, 1 MG (***pediatric multivitamins-fl***) | 3 | |
| POLY-VI-FLOR/IRON ORAL SUSPENSION 0.25-7 MG/ML (***ped multivitamins-fl-iron***) | 3 | |
| POLY-VI-FLOR/IRON ORAL TABLET CHEWABLE 0.5-10 MG (***ped multivitamins-fl-iron***) | 3 | |
| PREVIDENT 5000 BOOSTER PLUS DENTAL PASTE 1.1 % (***sodium fluoride***) | 3 | |
| PREVIDENT 5000 DRY MOUTH DENTAL GEL 1.1 % (***sodium fluoride***) | 3 | |
| PREVIDENT 5000 ENAMEL PROTECT DENTAL PASTE 1.1-5 % (***sod fluoride-potassium nitrate***) | 3 | |
| PREVIDENT 5000 ORTHO DEFENSE DENTAL PASTE 1.1 % (***sodium fluoride***) | 3 | |
| PREVIDENT 5000 PLUS DENTAL CREAM 1.1 % (***sodium fluoride***) | 3 | |
| PREVIDENT 5000 SENSITIVE DENTAL PASTE 1.1-5 % (***sod fluoride-potassium nitrate***) | 3 | |
| PREVIDENT DENTAL GEL 1.1 % (***sodium fluoride***) | 3 | |
| PREVIDENT MOUTH/THROAT SOLUTION 0.2 % (***sodium fluoride***) | 3 | |
| QUFLORA PEDIATRIC ORAL SOLUTION 0.25 MG/ML, 0.5 MG/ML (***pediatric multivitamins-fl***) | 3 | |
| QUFLORA PEDIATRIC ORAL TABLET CHEWABLE 0.25 MG, 0.5 MG, 1 MG (***pediatric multivitamins-fl***) | 3 | |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ***sf 5000 plus dental cream 1.1 %*** | 1 | |
| ***sf dental gel 1.1 %*** | 1 | |
| ***sodium fluoride 5000 plus dental cream 1.1 %*** | 1 | |
| ***sodium fluoride 5000 ppm dental cream 1.1 %*** | 1 | |
| ***sodium fluoride 5000 ppm dental paste 1.1 %*** | 1 | |
| ***sodium fluoride 5000 sensitive dental paste 1.1-5 %*** | 1 | |
| ***sodium fluoride dental cream 1.1 %*** | 1 | |
| ***sodium fluoride dental gel 1.1 %*** | 1 | |
| ***sodium fluoride oral solution 1.1 (0.5 f) mg/ml*** | 1 | H |
| ***sodium fluoride oral tablet 1.1 (0.5 f) mg, 2.2 (1 f) mg*** | 1 | |
| ***sodium fluoride oral tablet chewable 0.55 (0.25 f) mg, 1.1 (0.5 f) mg, 2.2 (1 f) mg*** | 1 | H |
| TRI-VI-FLOR ORAL SUSPENSION 0.25 MG/ML, 0.5 MG/ML (***ped vit a-c-d-methylfolate-fl***) | 3 | |
| TRI-VI-FLORO ORAL SUSPENSION 0.25 MG/ML, 0.5 MG/ML | 3 | |
| ***tri-vite/fluoride oral solution 0.25 mg/ml, 0.5 mg/ml*** | 1 | |
| ***vitamins acd-fluoride oral solution 0.25 mg/ml*** | 1 | |
| **COMPLEMENT INHIBITORS** | | |
| BERINERT INTRAVENOUS KIT 500 UNIT (***c1 esterase inhibitor (human)***) | 4 | PA; ST; M; SL (0.34 boxes per day.); SP |
| FIRAZYR SUBCUTANEOUS SOLUTION 30 MG/3ML (***icatibant acetate***) | 2 | PA; M; SL (0.6 ml per day.); SP |
| HAEGARDA SUBCUTANEOUS SOLUTION RECONSTITUTED 2000 UNIT, 3000 UNIT (***c1 esterase inhibitor (human)***) | 2 | PA; M; SL (11 vials per month.); SP |
| RUCONEST INTRAVENOUS SOLUTION RECONSTITUTED 2100 UNIT (***c1 esterase inhibitor (recomb)***) | 3 | PA; M; SL (0.27 vials per day.); SP |
| TAKHZYRO SUBCUTANEOUS SOLUTION 300 MG/2ML (***lanadelumab-flyo***) | 2 | PA; M; SL (0.075 ml per day.); SP |
| **DISEASE-MODIFYING ANTIRHEUMATIC AGENTS - Drugs for Arthritis** | | |
| ACTEMRA ACTPEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 162 MG/0.9ML (***tocilizumab***) | 3 | PA; M; SL (3.6 ml per 21 days.); SP |
| ACTEMRA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 162 MG/0.9ML (***tocilizumab***) | 3 | PA; ST; M; SL (4 syringes (3.6 ml) per month.); SP |
| ARAVA ORAL TABLET 10 MG, 20 MG (***leflunomide***) | 3 | |
| AZASAN ORAL TABLET 100 MG, 75 MG (***azathioprine***) | 3 | |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ***azathioprine oral tablet 50 mg*** | 1 | |
| AZULFIDINE EN-TABS ORAL TABLET DELAYED RELEASE 500 MG (***sulfasalazine***) | 3 | |
| AZULFIDINE ORAL TABLET 500 MG (***sulfasalazine***) | 3 | |
| CIMZIA PREFILLED KIT SUBCUTANEOUS KIT 2 X 200 MG/ML (***certolizumab pegol***) | 2 | PA; M; SL (1 kit per 21 days.); SP |
| CIMZIA STARTER KIT SUBCUTANEOUS KIT 6 X 200 MG/ML (***certolizumab pegol***) | 2 | PA; M; SL (6 mL per 365 days.); SP |
| ***cyclosporine modified oral capsule 100 mg, 25 mg, 50 mg*** | 1 | |
| ***cyclosporine modified oral solution 100 mg/ml*** | 1 | |
| ***cyclosporine oral capsule 100 mg, 25 mg*** | 1 | |
| DEPEN TITRATABS ORAL TABLET 250 MG (***penicillamine***) | 2 | SP |
| ENBREL MINI SUBCUTANEOUS SOLUTION CARTRIDGE 50 MG/ML (***etanercept***) | 3 | PA; ST; M; SL (0.15 mg/ml per day.); SP |
| ENBREL SUBCUTANEOUS SOLUTION 25 MG/0.5ML (***etanercept***) | 4 | PA; ST; SL (0.15 ml per day) |
| ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 25 MG/0.5ML, 50 MG/ML (***etanercept***) | 4 | PA; ST; M; SL (0.15 mg/ml per day.); SP |
| ENBREL SUBCUTANEOUS SOLUTION RECONSTITUTED 25 MG (***etanercept***) | 4 | PA; ST; M; SL (0.29 mg per day.); SP |
| ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/ML (***etanercept***) | 4 | PA; ST; M; SL (0.15 mg/ml per day.); SP |
| ***cyclosporine modified*** (Gengraf Oral Capsule 100 Mg, 25 Mg) | 1 | |
| ***cyclosporine modified*** (Gengraf Oral Solution 100 Mg/Ml) | 1 | |
| HUMIRA PEDIATRIC CROHNS START SUBCUTANEOUS PREFILLED SYRINGE KIT 80 MG/0.8ML (***adalimumab***) | 2 | PA; M; SL (3 syringes per year.); SP |
| HUMIRA PEN SUBCUTANEOUS PEN-INJECTOR KIT 40 MG/0.4ML (***adalimumab***) | 2 | PA; M; SL (2 pens per month.); SP |
| HUMIRA PEN SUBCUTANEOUS PEN-INJECTOR KIT 40 MG/0.8ML (***adalimumab***) | 2 | PA; M; SL (2 syringes per month.); SP |
| HUMIRA PEN-CD/UC/HS STARTER SUBCUTANEOUS PEN-INJECTOR KIT 40 MG/0.8ML (***adalimumab***) | 2 | PA; M; SL (6 pens (1 kit) per year.); SP |
| HUMIRA PEN-CD/UC/HS STARTER SUBCUTANEOUS PEN-INJECTOR KIT 80 MG/0.8ML (***adalimumab***) | 2 | PA; M; SL (3 pens per year.); SP |
| HUMIRA PEN-PS/UV/ADOL HS START SUBCUTANEOUS PEN-INJECTOR KIT 40 MG/0.8ML (***adalimumab***) | 2 | PA; M; SL (4 pens (1 kit) per year.); SP |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| HUMIRA PEN-PS/UV/ADOL HS START SUBCUTANEOUS PEN-INJECTOR KIT 80 MG/0.8ML & 40MG/0.4ML (***adalimumab***) | 2 | PA; M; SL (3 pens per year.); SP |
| HUMIRA SUBCUTANEOUS PREFILLED SYRINGE KIT 10 MG/0.1ML, 10 MG/0.2ML, 20 MG/0.2ML, 20 MG/0.4ML, 40 MG/0.4ML (***adalimumab***) | 2 | PA; M; SL (2 syringes per month.); SP |
| HUMIRA SUBCUTANEOUS PREFILLED SYRINGE KIT 40 MG/0.8ML (***adalimumab***) | 2 | PA; M; SL (2 syringes per month.) |
| ***hydroxychloroquine sulfate oral tablet 200 mg*** | 1 | |
| KEVZARA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/1.14ML, 200 MG/1.14ML (***sarilumab***) | 3 | PA; ST; M; SL (2.28 ml per month.); SP |
| KEVZARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/1.14ML, 200 MG/1.14ML (***sarilumab***) | 3 | PA; ST; M; SL (2.28 ml per month.); SP |
| KINERET SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/0.67ML (***anakinra***) | 3 | PA; M; SL (0.67 ml (1 syringe) per day.); SP |
| ***leflunomide oral tablet 10 mg, 20 mg*** | 1 | |
| ***methotrexate (anti-rheumatic) oral tablet 2.5 mg*** | 1 | |
| ***methotrexate oral tablet 2.5 mg*** | 1 | |
| ***methotrexate sodium (pf) injection solution 1 gm/40ml, 250 mg/10ml, 50 mg/2ml*** | 1 | M |
| ***methotrexate sodium injection solution 250 mg/10ml, 50 mg/2ml*** | 1 | M |
| ***methotrexate sodium injection solution reconstituted 1 gm*** | 1 | |
| ***methotrexate sodium oral tablet 2.5 mg*** | 1 | |
| OLUMIANT ORAL TABLET 1 MG (***baricitinib***) | 2 | PA; SL (1 tablet per day.) |
| OLUMIANT ORAL TABLET 2 MG (***baricitinib***) | 2 | PA; SL (1 tablet per day.); SP |
| ORENCIA CLICKJECT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 125 MG/ML (***abatacept***) | 3 | PA; ST; M; SL (4 auto-injectors per month.); SP |
| ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 125 MG/ML (***abatacept***) | 3 | PA; ST; M; SL (4 syringes per month); SP |
| ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 50 MG/0.4ML, 87.5 MG/0.7ML (***abatacept***) | 3 | PA; ST; M; SP |
| OTEZLA ORAL TABLET 30 MG (***apremilast***) | 4 | PA; SL (2 tablets per day.); SP |
| OTEZLA ORAL TABLET THERAPY PACK 10 & 20 & 30 MG (***apremilast***) | 4 | PA; SL (55 tablets (one starter pack) per year.); SP |
| ***penicillamine oral capsule 250 mg*** | 3 | SP |

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|---|---|---|
| ***penicillamine oral tablet 250 mg*** | 2 | SP |
| RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 10 MG/0.2ML (***methotrexate (anti-rheumatic)***) | 2 | M; SL (0.8 ml (4 auto-injectors) per month.) |
| RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 12.5 MG/0.25ML (***methotrexate (anti-rheumatic)***) | 2 | M; SL (1 ml (4 auto-injectors) per month.) |
| RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 15 MG/0.3ML (***methotrexate (anti-rheumatic)***) | 2 | M; SL (1.2 ml (4 auto-injectors) per month.) |
| RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 17.5 MG/0.35ML (***methotrexate (anti-rheumatic)***) | 2 | M; SL (1.4 ml (4 auto-injectors) per month.) |
| RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 20 MG/0.4ML (***methotrexate (anti-rheumatic)***) | 2 | M; SL (1.6 ml (4 auto-injectors) per month.) |
| RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 22.5 MG/0.45ML (***methotrexate (anti-rheumatic)***) | 2 | M; SL (1.8 ml (4 auto-injectors) per month.) |
| RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 25 MG/0.5ML (***methotrexate (anti-rheumatic)***) | 2 | M; SL (2 ml (4 auto-injectors) per month.) |
| RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 30 MG/0.6ML (***methotrexate (anti-rheumatic)***) | 2 | M; SL (2.4 ml (4 auto-injectors) per month.) |
| RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 7.5 MG/0.15ML (***methotrexate (anti-rheumatic)***) | 2 | M; SL (0.6 ml (4 auto-injectors) per month.) |
| RIDAURA ORAL CAPSULE 3 MG (***auranofin***) | 3 | SP |
| RINVOQ ORAL TABLET EXTENDED RELEASE 24 HOUR 15 MG (***upadacitinib***) | 2 | PA; SL (1 tablet per day.); SP |
| SANDIMMUNE ORAL SOLUTION 100 MG/ML (***cyclosporine***) | 3 | |
| SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML (***golimumab***) | 2 | PA; M; SL (1 syringe per 21 days.); SP |
| SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/0.5ML (***golimumab***) | 2 | PA; M; SL (0.5 ml (1 syringe) per month); SP |
| SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (***golimumab***) | 2 | PA; M; SL (1 syringe per 21 days.); SP |
| SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 50 MG/0.5ML (***golimumab***) | 2 | PA; M; SL (0.5 ml (1 syringe) per month); SP |
| STELARA SUBCUTANEOUS SOLUTION 45 MG/0.5ML (***ustekinumab***) | 2 | PA; M; SP |
| STELARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5ML (***ustekinumab***) | 2 | PA; M; SL (0.5 ml (1 prefilled syringe) per 3 months.); SP |
| STELARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 90 MG/ML (***ustekinumab***) | 2 | PA; M; SL (1 ml (1 prefilled syringe) per 3 months.); SP |
| ***sulfasalazine oral tablet 500 mg*** | 1 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ***sulfasalazine oral tablet delayed release 500 mg*** | 1 | |
| TREXALL ORAL TABLET 10 MG, 15 MG, 5 MG, 7.5 MG (***methotrexate sodium***) | 2 | |
| XATMEP ORAL SOLUTION 2.5 MG/ML (***methotrexate***) | 3 | PA; SL (4 ml per day.) |
| XELJANZ ORAL TABLET 10 MG, 5 MG (***tofacitinib citrate***) | 2 | PA; ST; SL (2 tablets per day.); SP |
| XELJANZ XR ORAL TABLET EXTENDED RELEASE 24 HOUR 11 MG (***tofacitinib citrate***) | 2 | PA; ST; SL (1 tablet per day.); SP |
| XELJANZ XR ORAL TABLET EXTENDED RELEASE 24 HOUR 22 MG (***tofacitinib citrate***) | 2 | PA; ST; SL (1 tablet per day.) |
| **GONADOTROPIN-RELEASING HORMONE ANTAGNTS - Hormones** | | |
| FIRMAGON (240 MG DOSE) SUBCUTANEOUS SOLUTION RECONSTITUTED 120 MG/VIAL (***degarelix acetate***) | 3 | M; SP |
| FIRMAGON SUBCUTANEOUS SOLUTION RECONSTITUTED 80 MG (***degarelix acetate***) | 3 | M; SP |
| **IMMUNOMODULATORY AGENTS - DRUGS FOR THE IMMUNE SYSTEM** | | |
| ACTEMRA ACTPEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 162 MG/0.9ML (***tocilizumab***) | 3 | PA; M; SL (3.6 ml per 21 days.); SP |
| ACTEMRA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 162 MG/0.9ML (***tocilizumab***) | 3 | PA; ST; M; SL (4 syringes (3.6 ml) per month.); SP |
| ACTIMMUNE SUBCUTANEOUS SOLUTION 2000000 UNIT/0.5ML (***interferon gamma-1b***) | 2 | PA; M; SL (6.5 ml (13 vials) per month.); SP |
| ARAVA ORAL TABLET 10 MG, 20 MG (***leflunomide***) | 3 | |
| AUBAGIO ORAL TABLET 14 MG, 7 MG (***teriflunomide***) | 3 | PA; SL (1 tablet per day.) |
| AVONEX PEN INTRAMUSCULAR AUTO-INJECTOR KIT 30 MCG/0.5ML (***interferon beta-1a***) | 2 | PA; M; SL (4 pens (1 box) per month.); SP |
| AVONEX PREFILLED INTRAMUSCULAR PREFILLED SYRINGE KIT 30 MCG/0.5ML (***interferon beta-1a***) | 2 | PA; M; SL (4 syringes (1 box) per month.); SP |
| AZASAN ORAL TABLET 100 MG, 75 MG (***azathioprine***) | 3 | |
| ***azathioprine oral tablet 50 mg*** | 1 | |
| AZULFIDINE EN-TABS ORAL TABLET DELAYED RELEASE 500 MG (***sulfasalazine***) | 3 | |
| AZULFIDINE ORAL TABLET 500 MG (***sulfasalazine***) | 3 | |
| BAFIERTAM ORAL CAPSULE DELAYED RELEASE 95 MG (***monomethyl fumarate***) | 2 | PA; SL (4 capsules per day.) |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| BETASERON SUBCUTANEOUS KIT 0.3 MG (***interferon beta-1b***) | 2 | PA; M; SL (15 vials per month) |
| CIMZIA PREFILLED KIT SUBCUTANEOUS KIT 2 X 200 MG/ML (***certolizumab pegol***) | 2 | PA; M; SL (1 kit per 21 days.); SP |
| CIMZIA STARTER KIT SUBCUTANEOUS KIT 6 X 200 MG/ML (***certolizumab pegol***) | 2 | PA; M; SL (6 mL per 365 days.); SP |
| ***cyclosporine modified oral capsule 100 mg, 25 mg, 50 mg*** | 1 | |
| ***cyclosporine modified oral solution 100 mg/ml*** | 1 | |
| ***cyclosporine oral capsule 100 mg, 25 mg*** | 1 | |
| ***dimethyl fumarate oral capsule delayed release 120 mg*** | 2 | PA; SL (56 capsules per year.) |
| ***dimethyl fumarate oral capsule delayed release 240 mg*** | 2 | PA; SL (2 capsules per day.) |
| ***dimethyl fumarate starter pack oral 120 & 240 mg*** | 2 | PA; SL (60 capsules (1 starter pack) per 365 days.) |
| ENBREL MINI SUBCUTANEOUS SOLUTION CARTRIDGE 50 MG/ML (***etanercept***) | 3 | PA; ST; M; SL (0.15 mg/ml per day.); SP |
| ENBREL SUBCUTANEOUS SOLUTION 25 MG/0.5ML (***etanercept***) | 4 | PA; ST; SL (0.15 ml per day) |
| ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 25 MG/0.5ML, 50 MG/ML (***etanercept***) | 4 | PA; ST; M; SL (0.15 mg/ml per day.); SP |
| ENBREL SUBCUTANEOUS SOLUTION RECONSTITUTED 25 MG (***etanercept***) | 4 | PA; ST; M; SL (0.29 mg per day.); SP |
| ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/ML (***etanercept***) | 4 | PA; ST; M; SL (0.15 mg/ml per day.); SP |
| ***cyclosporine modified*** (Gengraf Oral Capsule 100 Mg, 25 Mg) | 1 | |
| ***cyclosporine modified*** (Gengraf Oral Solution 100 Mg/Ml) | 1 | |
| GILENYA ORAL CAPSULE 0.25 MG, 0.5 MG (***fingolimod hcl***) | 3 | PA; SL (1 capsule per day) |
| ***glatiramer acetate subcutaneous solution prefilled syringe 20 mg/ml*** | 2 | PA; M; SL (30 ml per month.) |
| ***glatiramer acetate subcutaneous solution prefilled syringe 40 mg/ml*** | 2 | PA; M; SL (12 ml per 21 days.) |
| ***glatiramer acetate*** (Glatopa Subcutaneous Solution Prefilled Syringe 20 Mg/Ml) | 2 | PA; M; SL (30 ml per month.) |
| ***glatiramer acetate*** (Glatopa Subcutaneous Solution Prefilled Syringe 40 Mg/Ml) | 2 | PA; M; SL (12 ml per 21 days.) |
| HUMIRA PEDIATRIC CROHNS START SUBCUTANEOUS PREFILLED SYRINGE KIT 80 MG/0.8ML (***adalimumab***) | 2 | PA; M; SL (3 syringes per year.); SP |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| HUMIRA PEDIATRIC CROHNS START SUBCUTANEOUS PREFILLED SYRINGE KIT 80 MG/0.8ML & 40MG/0.4ML (***adalimumab***) | 2 | PA; M; SL (2 kits per year.); SP |
| HUMIRA PEN SUBCUTANEOUS PEN-INJECTOR KIT 40 MG/0.4ML (***adalimumab***) | 2 | PA; M; SL (2 pens per month.); SP |
| HUMIRA PEN SUBCUTANEOUS PEN-INJECTOR KIT 40 MG/0.8ML (***adalimumab***) | 2 | PA; M; SL (2 syringes per month.); SP |
| HUMIRA PEN-CD/UC/HS STARTER SUBCUTANEOUS PEN-INJECTOR KIT 40 MG/0.8ML (***adalimumab***) | 2 | PA; M; SL (6 pens (1 kit) per year.); SP |
| HUMIRA PEN-CD/UC/HS STARTER SUBCUTANEOUS PEN-INJECTOR KIT 80 MG/0.8ML (***adalimumab***) | 2 | PA; M; SL (3 pens per year.); SP |
| HUMIRA PEN-PS/UV/ADOL HS START SUBCUTANEOUS PEN-INJECTOR KIT 40 MG/0.8ML (***adalimumab***) | 2 | PA; M; SL (4 pens (1 kit) per year.); SP |
| HUMIRA PEN-PS/UV/ADOL HS START SUBCUTANEOUS PEN-INJECTOR KIT 80 MG/0.8ML & 40MG/0.4ML (***adalimumab***) | 2 | PA; M; SL (3 pens per year.); SP |
| HUMIRA SUBCUTANEOUS PREFILLED SYRINGE KIT 10 MG/0.1ML, 10 MG/0.2ML, 20 MG/0.2ML, 20 MG/0.4ML, 40 MG/0.4ML (***adalimumab***) | 2 | PA; M; SL (2 syringes per month.); SP |
| HUMIRA SUBCUTANEOUS PREFILLED SYRINGE KIT 40 MG/0.8ML (***adalimumab***) | 2 | PA; M; SL (2 syringes per month.) |
| ***hydroxychloroquine sulfate oral tablet 200 mg*** | 1 | |
| INTRON A INJECTION SOLUTION 10000000 UNIT/ML, 6000000 UNIT/ML (***interferon alfa-2b***) | 3 | PA; M; SP |
| INTRON A INJECTION SOLUTION RECONSTITUTED 10000000 UNIT, 18000000 UNIT, 50000000 UNIT (***interferon alfa-2b***) | 3 | PA; M; SP |
| KEVZARA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/1.14ML, 200 MG/1.14ML (***sarilumab***) | 3 | PA; ST; M; SL (2.28 ml per month.); SP |
| KEVZARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/1.14ML, 200 MG/1.14ML (***sarilumab***) | 3 | PA; ST; M; SL (2.28 ml per month.); SP |
| KINERET SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/0.67ML (***anakinra***) | 3 | PA; M; SL (0.67 ml (1 syringe) per day.); SP |
| ***leflunomide oral tablet 10 mg, 20 mg*** | 1 | |
| MAYZENT ORAL TABLET 0.25 MG (***siponimod fumarate***) | 3 | PA; SL (4 tablets per day.) |
| MAYZENT ORAL TABLET 2 MG (***siponimod fumarate***) | 3 | PA; SL (1 tablet per day.) |
| MAYZENT STARTER PACK ORAL TABLET THERAPY PACK 0.25 MG (***siponimod fumarate***) | 3 | PA; SL (12 tablets per 365 days.) |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ***methotrexate (anti-rheumatic) oral tablet 2.5 mg*** | 1 | |
| ***methotrexate oral tablet 2.5 mg*** | 1 | |
| ***methotrexate sodium (pf) injection solution 1 gm/40ml, 250 mg/10ml, 50 mg/2ml*** | 1 | M |
| ***methotrexate sodium injection solution 250 mg/10ml, 50 mg/2ml*** | 1 | M |
| ***methotrexate sodium injection solution reconstituted 1 gm*** | 1 | |
| ***methotrexate sodium oral tablet 2.5 mg*** | 1 | |
| OLUMIANT ORAL TABLET 1 MG (***baricitinib***) | 2 | PA; SL (1 tablet per day.) |
| OLUMIANT ORAL TABLET 2 MG (***baricitinib***) | 2 | PA; SL (1 tablet per day.); SP |
| ORENCIA CLICKJECT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 125 MG/ML (***abatacept***) | 3 | PA; ST; M; SL (4 auto-injectors per month.); SP |
| ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 125 MG/ML (***abatacept***) | 3 | PA; ST; M; SL (4 syringes per month); SP |
| ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 50 MG/0.4ML, 87.5 MG/0.7ML (***abatacept***) | 3 | PA; ST; M; SP |
| OTEZLA ORAL TABLET 30 MG (***apremilast***) | 4 | PA; SL (2 tablets per day.); SP |
| OTEZLA ORAL TABLET THERAPY PACK 10 & 20 & 30 MG (***apremilast***) | 4 | PA; SL (55 tablets (one starter pack) per year.); SP |
| PLEGRIDY STARTER PACK SUBCUTANEOUS SOLUTION PEN-INJECTOR 63 & 94 MCG/0.5ML (***peginterferon beta-1a***) | 4 | PA; M; SL (1 ml per year.); SP |
| PLEGRIDY STARTER PACK SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 63 & 94 MCG/0.5ML (***peginterferon beta-1a***) | 4 | PA; M; SL (1 ml per year.); SP |
| PLEGRIDY SUBCUTANEOUS SOLUTION PEN-INJECTOR 125 MCG/0.5ML (***peginterferon beta-1a***) | 4 | PA; M; SL (1 ml per month.); SP |
| PLEGRIDY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 125 MCG/0.5ML (***peginterferon beta-1a***) | 4 | PA; M; SL (1 ml per month.); SP |
| POMALYST ORAL CAPSULE 1 MG, 2 MG, 3 MG, 4 MG (***pomalidomide***) | 3 | PA; SL (21 capsules per prescription); SP; CM |
| RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 10 MG/0.2ML (***methotrexate (anti-rheumatic)***) | 2 | M; SL (0.8 ml (4 auto-injectors) per month.) |
| RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 12.5 MG/0.25ML (***methotrexate (anti-rheumatic)***) | 2 | M; SL (1 ml (4 auto-injectors) per month.) |
| RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 15 MG/0.3ML (***methotrexate (anti-rheumatic)***) | 2 | M; SL (1.2 ml (4 auto-injectors) per month.) |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 17.5 MG/0.35ML (***methotrexate (anti-rheumatic)***) | 2 | M; SL (1.4 ml (4 auto-injectors) per month.) |
| RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 20 MG/0.4ML (***methotrexate (anti-rheumatic)***) | 2 | M; SL (1.6 ml (4 auto-injectors) per month.) |
| RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 22.5 MG/0.45ML (***methotrexate (anti-rheumatic)***) | 2 | M; SL (1.8 ml (4 auto-injectors) per month.) |
| RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 25 MG/0.5ML (***methotrexate (anti-rheumatic)***) | 2 | M; SL (2 ml (4 auto-injectors) per month.) |
| RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 30 MG/0.6ML (***methotrexate (anti-rheumatic)***) | 2 | M; SL (2.4 ml (4 auto-injectors) per month.) |
| RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 7.5 MG/0.15ML (***methotrexate (anti-rheumatic)***) | 2 | M; SL (0.6 ml (4 auto-injectors) per month.) |
| REBIF REBIDOSE SUBCUTANEOUS SOLUTION AUTO-INJECTOR 22 MCG/0.5ML, 44 MCG/0.5ML (***interferon beta-1a***) | 4 | PA; ST; M; SL (6 ml (12 syringes) per month); SP |
| REBIF REBIDOSE TITRATION PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 6X8.8 & 6X22 MCG (***interferon beta-1a***) | 4 | PA; ST; M; SL (4.2 mL (1 pack) per year); SP |
| REBIF SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 22 MCG/0.5ML, 44 MCG/0.5ML (***interferon beta-1a***) | 4 | PA; ST; M; SL (6 ml (12 syringes) per month); SP |
| REBIF TITRATION PACK SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6X8.8 & 6X22 MCG (***interferon beta-1a***) | 4 | PA; ST; M; SL (4.2 ml (1 pack) per year); SP |
| REVLIMID ORAL CAPSULE 10 MG, 2.5 MG, 5 MG (***lenalidomide***) | 2 | PA; SL (28 capsules per prescription.); SP; CM |
| REVLIMID ORAL CAPSULE 15 MG, 25 MG (***lenalidomide***) | 2 | PA; SL (21 capsules per prescription.); SP; CM |
| REVLIMID ORAL CAPSULE 20 MG (***lenalidomide***) | 2 | PA; SL (21 capsules per prescription); SP; CM |
| RIDAURA ORAL CAPSULE 3 MG (***auranofin***) | 3 | SP |
| RINVOQ ORAL TABLET EXTENDED RELEASE 24 HOUR 15 MG (***upadacitinib***) | 2 | PA; SL (1 tablet per day.); SP |
| SANDIMMUNE ORAL SOLUTION 100 MG/ML (***cyclosporine***) | 3 | |
| SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML (***golimumab***) | 2 | PA; M; SL (1 syringe per 21 days.); SP |
| SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/0.5ML (***golimumab***) | 2 | PA; M; SL (0.5 ml (1 syringe) per month); SP |
| SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (***golimumab***) | 2 | PA; M; SL (1 syringe per 21 days.); SP |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 50 MG/0.5ML (***golimumab***) | 2 | PA; M; SL (0.5 ml (1 syringe) per month); SP |
| STELARA SUBCUTANEOUS SOLUTION 45 MG/0.5ML (***ustekinumab***) | 2 | PA; M; SP |
| STELARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5ML (***ustekinumab***) | 2 | PA; M; SL (0.5 ml (1 prefilled syringe) per 3 months.); SP |
| STELARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 90 MG/ML (***ustekinumab***) | 2 | PA; M; SL (1 ml (1 prefilled syringe) per 3 months.); SP |
| ***sulfasalazine oral tablet 500 mg*** | 1 | |
| ***sulfasalazine oral tablet delayed release 500 mg*** | 1 | |
| THALOMID ORAL CAPSULE 100 MG, 50 MG (***thalidomide***) | 2 | PA; SL (28 capsules per prescription); SP; CM |
| THALOMID ORAL CAPSULE 150 MG, 200 MG (***thalidomide***) | 2 | PA; SL (56 capsules per prescription); SP; CM |
| TREXALL ORAL TABLET 10 MG, 15 MG, 5 MG, 7.5 MG (***methotrexate sodium***) | 2 | |
| XATMEP ORAL SOLUTION 2.5 MG/ML (***methotrexate***) | 3 | PA; SL (4 ml per day.) |
| XELJANZ ORAL TABLET 10 MG, 5 MG (***tofacitinib citrate***) | 2 | PA; ST; SL (2 tablets per day.); SP |
| XELJANZ XR ORAL TABLET EXTENDED RELEASE 24 HOUR 11 MG (***tofacitinib citrate***) | 2 | PA; ST; SL (1 tablet per day.); SP |
| XELJANZ XR ORAL TABLET EXTENDED RELEASE 24 HOUR 22 MG (***tofacitinib citrate***) | 2 | PA; ST; SL (1 tablet per day.) |
| **IMMUNOSUPPRESSIVE AGENTS - Drugs for Transplant** | | |
| AZASAN ORAL TABLET 100 MG, 75 MG (***azathioprine***) | 3 | |
| ***azathioprine oral tablet 50 mg*** | 1 | |
| BENLYSTA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/ML (***belimumab***) | 2 | PA; M; SL (4 ml per month.); SP |
| BENLYSTA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/ML (***belimumab***) | 2 | PA; M; SL (4 ml per month.); SP |
| ***cyclophosphamide oral capsule 25 mg, 50 mg*** | 2 | |
| ***cyclosporine modified oral capsule 100 mg, 25 mg, 50 mg*** | 1 | |
| ***cyclosporine modified oral solution 100 mg/ml*** | 1 | |
| ***cyclosporine oral capsule 100 mg, 25 mg*** | 1 | |
| ELIDEL EXTERNAL CREAM 1 % (***pimecrolimus***) | 3 | ST; SL (30 grams per prescription) |
| ***everolimus oral tablet 0.25 mg, 0.5 mg, 0.75 mg*** | 3 | |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ***cyclosporine modified*** (Gengraf Oral Capsule 100 Mg, 25 Mg) | 1 | |
| ***cyclosporine modified*** (Gengraf Oral Solution 100 Mg/Ml) | 1 | |
| MAVENCLAD (10 TABS) ORAL TABLET THERAPY PACK 10 MG (***cladribine***) | 3 | PA; ST; SL (40 tablets per 720 days.) |
| MAVENCLAD (4 TABS) ORAL TABLET THERAPY PACK 10 MG (***cladribine***) | 3 | PA; ST; SL (40 tablets per 720 days.) |
| MAVENCLAD (5 TABS) ORAL TABLET THERAPY PACK 10 MG (***cladribine***) | 3 | PA; ST; SL (40 tablets per 720 days.) |
| MAVENCLAD (6 TABS) ORAL TABLET THERAPY PACK 10 MG (***cladribine***) | 3 | PA; ST; SL (40 tablets per 720 days.) |
| MAVENCLAD (7 TABS) ORAL TABLET THERAPY PACK 10 MG (***cladribine***) | 3 | PA; ST; SL (40 tablets per 720 days.) |
| MAVENCLAD (8 TABS) ORAL TABLET THERAPY PACK 10 MG (***cladribine***) | 3 | PA; ST; SL (40 tablets per 720 days.) |
| MAVENCLAD (9 TABS) ORAL TABLET THERAPY PACK 10 MG (***cladribine***) | 3 | PA; ST; SL (40 tablets per 720 days.) |
| ***mercaptopurine oral tablet 50 mg*** | 1 | |
| ***methotrexate (anti-rheumatic) oral tablet 2.5 mg*** | 1 | |
| ***methotrexate oral tablet 2.5 mg*** | 1 | |
| ***methotrexate sodium (pf) injection solution 1 gm/40ml, 250 mg/10ml, 50 mg/2ml*** | 1 | M |
| ***methotrexate sodium injection solution 250 mg/10ml, 50 mg/2ml*** | 1 | M |
| ***methotrexate sodium injection solution reconstituted 1 gm*** | 1 | |
| ***methotrexate sodium oral tablet 2.5 mg*** | 1 | |
| ***mycophenolate mofetil oral capsule 250 mg*** | 1 | |
| ***mycophenolate mofetil oral suspension reconstituted 200 mg/ml*** | 1 | |
| ***mycophenolate mofetil oral tablet 500 mg*** | 1 | |
| ***mycophenolate sodium oral tablet delayed release 180 mg, 360 mg*** | 2 | |
| ***pimecrolimus external cream 1 %*** | 3 | ST; SL (30 grams per prescription) |
| PROGRAF ORAL CAPSULE 0.5 MG, 1 MG, 5 MG (***tacrolimus***) | 3 | |
| PROGRAF ORAL PACKET 0.2 MG, 1 MG (***tacrolimus***) | 3 | PA |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| PURIXAN ORAL SUSPENSION 2000 MG/100ML (***mercaptopurine***) | 4 | PA; SP |
| RAPAMUNE ORAL SOLUTION 1 MG/ML (***sirolimus***) | 4 | |
| RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 10 MG/0.2ML (***methotrexate (anti-rheumatic)***) | 2 | M; SL (0.8 ml (4 auto-injectors) per month.) |
| RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 12.5 MG/0.25ML (***methotrexate (anti-rheumatic)***) | 2 | M; SL (1 ml (4 auto-injectors) per month.) |
| RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 15 MG/0.3ML (***methotrexate (anti-rheumatic)***) | 2 | M; SL (1.2 ml (4 auto-injectors) per month.) |
| RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 17.5 MG/0.35ML (***methotrexate (anti-rheumatic)***) | 2 | M; SL (1.4 ml (4 auto-injectors) per month.) |
| RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 20 MG/0.4ML (***methotrexate (anti-rheumatic)***) | 2 | M; SL (1.6 ml (4 auto-injectors) per month.) |
| RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 22.5 MG/0.45ML (***methotrexate (anti-rheumatic)***) | 2 | M; SL (1.8 ml (4 auto-injectors) per month.) |
| RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 25 MG/0.5ML (***methotrexate (anti-rheumatic)***) | 2 | M; SL (2 ml (4 auto-injectors) per month.) |
| RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 30 MG/0.6ML (***methotrexate (anti-rheumatic)***) | 2 | M; SL (2.4 ml (4 auto-injectors) per month.) |
| RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 7.5 MG/0.15ML (***methotrexate (anti-rheumatic)***) | 2 | M; SL (0.6 ml (4 auto-injectors) per month.) |
| SANDIMMUNE ORAL SOLUTION 100 MG/ML (***cyclosporine***) | 3 | |
| ***sirolimus oral solution 1 mg/ml*** | 2 | |
| ***sirolimus oral tablet 0.5 mg, 1 mg, 2 mg*** | 1 | |
| ***tacrolimus oral capsule 0.5 mg, 1 mg, 5 mg*** | 1 | |
| TREXALL ORAL TABLET 10 MG, 15 MG, 5 MG, 7.5 MG (***methotrexate sodium***) | 2 | |
| XATMEP ORAL SOLUTION 2.5 MG/ML (***methotrexate***) | 3 | PA; SL (4 ml per day.) |
| ZORTRESS ORAL TABLET 0.25 MG, 0.5 MG, 0.75 MG, 1 MG (***everolimus***) | 3 | |
| **OTHER MISCELLANEOUS THERAPEUTIC AGENTS** | | |
| ***acetylcysteine inhalation solution 10 %, 20 %*** | 1 | |
| ***aminobenzoate potassium oral packet 2 gm*** | 1 | |
| ***amino acids*** (Aminoreliefrms Oral Capsule) | 1 | |
| APPTRIM CAPSULE ORAL (***dietary manage prod - diet aid***) | 2 | |
| APPTRIM CAPSULE ORAL (***dietary manage prod - diet aid***) | 3 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| APPTRIM-D CAPSULE ORAL (***dietary manage prod - diet aid***) | 2 | |
| APPTRIM-D CAPSULE ORAL (***dietary manage prod - diet aid***) | 3 | |
| ARCALYST SUBCUTANEOUS SOLUTION RECONSTITUTED 220 MG (***rilonacept***) | 2 | PA; M; SL (4 syringes per month); SP |
| BAFIERTAM ORAL CAPSULE DELAYED RELEASE 95 MG (***monomethyl fumarate***) | 2 | PA; SL (4 capsules per day.) |
| CARDIOVID PLUS ORAL CAPSULE (***dha-epa-vit b6-b12-folic acid***) | 3 | |
| CARNITOR ORAL SOLUTION 1 GM/10ML (***levocarnitine***) | 3 | |
| CARNITOR ORAL TABLET 330 MG (***levocarnitine***) | 3 | |
| CARNITOR SF ORAL SOLUTION 1 GM/10ML (***levocarnitine***) | 3 | |
| CERDELGA ORAL CAPSULE 84 MG (***eliglustat tartrate***) | 2 | PA; SP |
| ***cinacalcet hcl oral tablet 30 mg, 60 mg, 90 mg*** | 3 | PA |
| CYSTADANE ORAL POWDER (***betaine***) | 2 | SP |
| CYSTAGON ORAL CAPSULE 150 MG, 50 MG (***cysteamine bitartrate***) | 2 | SP |
| ***dalfampridine er oral tablet extended release 12 hour 10 mg*** | 2 | PA; SL (2 tablets per day); SP |
| DEMSER ORAL CAPSULE 250 MG (***metyrosine***) | 3 | |
| ENDARI ORAL PACKET 5 GM (***glutamine (sickle cell)***) | 3 | PA; SL (6 packets per day.) |
| ENTERAGAM ORAL PACKET 5 GM (***sbi/protein isolate***) | 3 | |
| EVOTAZ ORAL TABLET 300-150 MG (***atazanavir-cobicistat***) | 2 | |
| FOVEX ORAL CAPSULE (***dietary management product***) | 3 | |
| GABADONE CAPSULE ORAL (***dietary management product***) | 2 | |
| GABADONE CAPSULE ORAL (***dietary management product***) | 3 | |
| GALAFOLD ORAL CAPSULE 123 MG (***migalastat hcl***) | 3 | PA; SL (14 capsules per 21 days.); SP |
| GRASTEK SUBLINGUAL TABLET SUBLINGUAL 2800 BAU (***timothy grass pollen allergen***) | 3 | PA; SL (1 tablet per day.) |
| HYPERTENSA CAPSULE ORAL (***dietary management product***) | 2 | |
| HYPERTENSA CAPSULE ORAL (***dietary management product***) | 3 | |
| ISTURISA ORAL TABLET 1 MG (***osilodrostat phosphate***) | 4 | PA; SL (8 tablets per day.); SP |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ISTURISA ORAL TABLET 10 MG (***osilodrostat phosphate***) | 4 | PA; SL (6 tablets per day.); SP |
| ISTURISA ORAL TABLET 5 MG (***osilodrostat phosphate***) | 4 | PA; SL (2 tablets per day.); SP |
| KUVAN ORAL PACKET 100 MG (***sapropterin dihydrochloride***) | 2 | PA; SL (16 packets per day.); SP |
| KUVAN ORAL PACKET 500 MG (***sapropterin dihydrochloride***) | 2 | PA; SL (4 packets per day.); SP |
| KUVAN ORAL TABLET SOLUBLE 100 MG (***sapropterin dihydrochloride***) | 2 | PA; SL (16 tablets per day); SP |
| ***levocarnitine oral solution 1 gm/10ml*** | 1 | |
| ***levocarnitine oral tablet 330 mg*** | 1 | |
| ***levocarnitine sf oral solution 1 gm/10ml*** | 1 | |
| LIMBREL ORAL CAPSULE 250 MG, 500 MG (***flavocoxid***) | 3 | |
| LIMBREL250 ORAL CAPSULE 250-50 MG (***flavocoxid-cit zn bisglcinate***) | 3 | |
| LIMBREL500 ORAL CAPSULE 500-50 MG (***flavocoxid-cit zn bisglcinate***) | 3 | |
| LISTER-V ORAL CAPSULE (***dietary management product***) | 3 | |
| ***metyrosine oral capsule 250 mg*** | 1 | |
| ***miglustat oral capsule 100 mg*** | 3 | |
| ***n-acetyl-l-cysteine oral capsule 600 mg*** | 1 | |
| NEUREPA ORAL CAPSULE (***dietary management product***) | 3 | |
| NITYR ORAL TABLET 10 MG, 2 MG, 5 MG (***nitisinone***) | 2 | PA; SP |
| ***octreotide acetate injection solution 100 mcg/ml, 1000 mcg/ml, 200 mcg/ml, 50 mcg/ml, 500 mcg/ml*** | 1 | PA; M |
| ORALAIR ADULT SAMPLE KIT SUBLINGUAL TABLET SUBLINGUAL 300 IR (***grass mix pollens allergen ext***) | 3 | PA; SL (1 tablet per day.) |
| ORALAIR ADULT STARTER PACK SUBLINGUAL TABLET SUBLINGUAL 300 IR (***grass mix pollens allergen ext***) | 3 | PA; SL (1 tablet per day.) |
| ORALAIR CHILDRENS SAMPLE KIT SUBLINGUAL THERAPY PACK 3 X 100 IR & 6 X 300 IR (***grass mix pollens allergen ext***) | 3 | |
| ORALAIR CHILDRENS STARTER PACK SUBLINGUAL TABLET SUBLINGUAL 100 IR (***grass mix pollens allergen ext***) | 3 | PA; SL (3 tablets per year.) |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ORALAIR SUBLINGUAL TABLET SUBLINGUAL 300 IR (***grass mix pollens allergen ext***) | 3 | PA; SL (1 tablet per day.) |
| PERCURA ORAL CAPSULE (***dietary management product***) | 3 | |
| POTABA ORAL CAPSULE 500 MG (***potassium aminobenzoate***) | 3 | |
| PREZCOBIX ORAL TABLET 800-150 MG (***darunavir-cobicistat***) | 2 | |
| PROCYSBI ORAL CAPSULE DELAYED RELEASE 25 MG, 75 MG (***cysteamine bitartrate***) | 4 | PA; ST; SP |
| PROCYSBI ORAL PACKET 300 MG, 75 MG (***cysteamine bitartrate***) | 3 | SP |
| PULMONA ORAL CAPSULE (***dietary management product***) | 2 | |
| RAGWITEK SUBLINGUAL TABLET SUBLINGUAL 12 AMB A 1-U (***short ragweed pollen ext***) | 3 | PA; SL (1 tablet per day.) |
| RUZURGI ORAL TABLET 10 MG (***amifampridine***) | 2 | PA; SL (10 tablets per day.); SP |
| ***sapropterin dihydrochloride oral packet 500 mg*** | 1 | PA; SL (4 packets per day.); SP |
| ***sapropterin dihydrochloride oral tablet soluble 100 mg*** | 1 | PA; SL (16 tablets per day); SP |
| SENSIPAR ORAL TABLET 30 MG, 60 MG, 90 MG (***cinacalcet hcl***) | 4 | PA |
| SENTRA AM CAPSULE ORAL (***dietary management product***) | 2 | |
| SENTRA AM CAPSULE ORAL (***dietary management product***) | 3 | |
| SENTRA PM CAPSULE ORAL (***dietary management product***) | 2 | |
| SENTRA PM CAPSULE ORAL (***dietary management product***) | 3 | |
| SYMTUZA ORAL TABLET 800-150-200-10 MG (***darun-cobic-emtricit-tenofaf***) | 3 | SL (1 tablet per day.) |
| THERAMINE CAPSULE ORAL (***dietary management product***) | 2 | |
| THERAMINE CAPSULE ORAL (***dietary management product***) | 3 | |
| THERAMINE PLUS ORAL PACKET (***dietary management product***) | 3 | |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| THIOLA EC ORAL TABLET DELAYED RELEASE 100 MG, 300 MG (***tiopronin***) | 3 | SP |
| THIOLA ORAL TABLET 100 MG (***tiopronin***) | 3 | SP |
| TYBOST ORAL TABLET 150 MG (***cobicistat***) | 2 | |
| XURIDEN ORAL PACKET 2 GM (***uridine triacetate***) | 2 | PA; SL (30 packets per prescription); SP |
| **PROTECTIVE AGENTS** | | |
| ELMIRON ORAL CAPSULE 100 MG (***pentosan polysulfate sodium***) | 2 | |
| MESNEX ORAL TABLET 400 MG (***mesna***) | 3 | SP; CM |
| **NONHORMONAL CONTRACEPTIVES - Drugs for Women** | | |
| **NONHORMONAL CONTRACEPTIVES - Drugs for Women** | | |
| CAYA VAGINAL DIAPHRAGM (***diaphragm arc-spring***) | 3 | H |
| PHEXXI VAGINAL GEL 1.8-1-0.4 % (***lactic ac-citric ac-pot bitart***) | 3 | H |
| WIDE-SEAL DIAPHRAGM 60 VAGINAL DIAPHRAGM 2 % (***diaphragm wide seal***) | 2 | H |
| WIDE-SEAL DIAPHRAGM 65 VAGINAL DIAPHRAGM 2 % (***diaphragm wide seal***) | 2 | H |
| WIDE-SEAL DIAPHRAGM 70 VAGINAL DIAPHRAGM 2 % (***diaphragm wide seal***) | 2 | H |
| WIDE-SEAL DIAPHRAGM 75 VAGINAL DIAPHRAGM 2 % (***diaphragm wide seal***) | 2 | H |
| WIDE-SEAL DIAPHRAGM 80 VAGINAL DIAPHRAGM 2 % (***diaphragm wide seal***) | 2 | H |
| WIDE-SEAL DIAPHRAGM 85 VAGINAL DIAPHRAGM 2 % (***diaphragm wide seal***) | 2 | H |
| WIDE-SEAL DIAPHRAGM 90 VAGINAL DIAPHRAGM 2 % (***diaphragm wide seal***) | 2 | H |
| WIDE-SEAL DIAPHRAGM 95 VAGINAL DIAPHRAGM 2 % (***diaphragm wide seal***) | 2 | H |
| **OXYTOCICS - Drugs for Women** | | |
| **OXYTOCICS - Drugs for Women** | | |
| CERVIDIL VAGINAL INSERT 10 MG (***dinoprostone***) | 3 | |
| ***methylergonovine maleate*** (Methergine Oral Tablet 0.2 Mg) | 1 | SL (28 tablets per year.) |
| ***methylergonovine maleate oral tablet 0.2 mg*** | 1 | SL (28 tablets per year.) |
| PREPIDIL VAGINAL GEL 0.5 MG/3GM (***dinoprostone***) | 3 | |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| PROSTIN E2 VAGINAL SUPPOSITORY 20 MG (***dinoprostone***) | 3 | |
| **PHARMACEUTICAL AIDS** | | |
| **PHARMACEUTICAL AIDS** | | |
| ***benzoin compound external tincture*** | 1 | |
| BENZOIN EXTERNAL TINCTURE | 3 | |
| COPASIL EXTERNAL GEL (***scar treatment products***) | 3 | PA |
| ***formaldehyde external solution 10 %*** | 1 | |
| FORMALDEHYDE EXTERNAL SOLUTION 37 % | 3 | |
| L-ISOLEUCINE POWDER | 3 | PA |
| ***monsels ferric subsulfate external solution*** | 1 | |
| TURPENTINE EXTERNAL SPIRIT | 3 | |
| **RESPIRATORY TRACT AGENTS - Drugs for the Lungs** | | |
| **ALPHA AND BETA ADRENERGIC AGONIST(RESPR) - Drugs for Asthma/COPD** | | |
| ***pseudoeph-bromphen-dm*** (Bromfed Dm Oral Syrup 30-2-10 Mg/5Ml) | 1 | |
| ***epinephrine solution auto-injector 0.15 mg/0.3ml injection 0.15 mg/0.3ml*** | 2 | SL (4 injections per prescription) |
| ***epinephrine solution auto-injector 0.3 mg/0.3ml injection 0.3 mg/0.3ml*** | 2 | SL (2 injections per prescription) |
| ***pseudoephedrine-bromphen-dm oral syrup 30-2-10 mg/5ml*** | 1 | |
| SEMPREX-D ORAL CAPSULE 8-60 MG (***acrivastine-pseudoephedrine***) | 3 | |
| SYMJEPI INJECTION SOLUTION PREFILLED SYRINGE 0.15 MG/0.3ML, 0.3 MG/0.3ML (***epinephrine***) | 2 | SL (2 pens per prescription) |
| **ANTICHOLINERGIC AGENTS (RESPIR.TRACT) - Drugs for Asthma/COPD** | | |
| ANORO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 62.5-25 MCG/INH (***umeclidinium-vilanterol***) | 3 | SL (2 blisters per day.) |
| ATROVENT HFA INHALATION AEROSOL SOLUTION 17 MCG/ACT (***ipratropium bromide hfa***) | 3 | SL (0.87 grams per day.) |
| COMBIVENT RESPIMAT INHALATION AEROSOL SOLUTION 20-100 MCG/ACT (***ipratropium-albuterol***) | 3 | SL (0.28 grams per day.) |
| ***diphenoxylate-atropine oral liquid 2.5-0.025 mg/5ml*** | 1 | |
| ***diphenoxylate-atropine oral tablet 2.5-0.025 mg*** | 1 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ***ipratropium bromide inhalation solution 0.02 %*** | 1 | |
| ***ipratropium-albuterol inhalation solution 0.5-2.5 (3) mg/3ml*** | 2 | |
| LOMOTIL ORAL TABLET 2.5-0.025 MG (***diphenoxylate-atropine***) | 3 | |
| SPIRIVA HANDIHALER INHALATION CAPSULE 18 MCG (***tiotropium bromide monohydrate***) | 2 | SL (1 capsule per day) |
| SPIRIVA RESPIMAT INHALATION AEROSOL SOLUTION 1.25 MCG/ACT, 2.5 MCG/ACT (***tiotropium bromide monohydrate***) | 2 | SL (0.15 grams per day.) |
| TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-62.5-25 MCG/INH (***fluticasone-umeclidin-vilant***) | 3 | SL (2 blisters per day.) |
| **ANTIFIBROTIC AGENTS - Drugs for the Lungs** | | |
| ESBRIET ORAL CAPSULE 267 MG (***pirfenidone***) | 2 | PA; SL (9 capsules per day.); SP |
| ESBRIET ORAL TABLET 267 MG (***pirfenidone***) | 2 | PA; SL (9 tablets per day.); SP |
| ESBRIET ORAL TABLET 801 MG (***pirfenidone***) | 2 | PA; SL (3 tablets per day.); SP |
| OFEV ORAL CAPSULE 100 MG, 150 MG (***nintedanib esylate***) | 4 | PA; SL (2 capsules per day.); SP |
| **ANTITUSSIVES - Drugs for Cough and Cold** | | |
| ***benzonatate oral capsule 100 mg, 200 mg*** | 1 | |
| ***pseudoeph-bromphen-dm*** (Bromfed Dm Oral Syrup 30-2-10 Mg/5Ml) | 1 | |
| ***codeine sulfate oral tablet 30 mg, 60 mg*** | 1 | |
| GILTUSS TR ORAL TABLET 10-28-388 MG (***phenylephrine-dm-gg***) | 3 | |
| ***guaiatussin ac oral syrup 100-10 mg/5ml*** | 1 | |
| ***guaifenesin ac oral syrup 100-10 mg/5ml*** | 1 | |
| ***hydrocodone polst-chlorphen polst er susp oral suspension extended release 10-8 mg/5ml*** | 3 | PA; SL (360 ml per month.) |
| ***hydrocodone-homatropine oral syrup 5-1.5 mg/5ml*** | 1 | PA; SL (120 mL per prescription and 360 ml per month) |
| ***hydrocodone-homatropine oral tablet 5-1.5 mg*** | 1 | PA |
| ***hydromet oral syrup 5-1.5 mg/5ml*** | 1 | PA; SL (120 mL per prescription and 360 ml per month) |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ***maxi-tuss ac oral solution 100-10 mg/5ml*** | 1 | |
| NEOTUSS PLUS ORAL LIQUID 7.5-4-30 MG/5ML (***phenylephrine-chlorphen-dm***) | 3 | |
| NUEDEXTA ORAL CAPSULE 20-10 MG (***dextromethorphan-quinidine***) | 2 | PA |
| ***promethazine-codeine oral solution 6.25-10 mg/5ml*** | 1 | PA; SL (360 ml per month.) |
| ***promethazine-codeine oral syrup 6.25-10 mg/5ml*** | 1 | PA; SL (360 ml per month.) |
| ***promethazine-dm oral syrup 6.25-15 mg/5ml*** | 1 | |
| ***promethazine-phenyleph-codeine oral syrup 6.25-5-10 mg/5ml*** | 1 | PA; SL (360 ml per month.) |
| ***pseudoephedrine-bromphen-dm oral syrup 30-2-10 mg/5ml*** | 1 | |
| TESSALON PERLES ORAL CAPSULE 100 MG (***benzonatate***) | 3 | |
| TUSSICAPS ORAL CAPSULE EXTENDED RELEASE 12 HOUR 10-8 MG (***hydrocod polst-chlorphen polst***) | 3 | PA; SL (10 capsules per prescription and 30 capsules per month) |
| TUXARIN ER ORAL TABLET EXTENDED RELEASE 12 HOUR 54.3-8 MG (***chlorpheniramine-codeine***) | 3 | PA; SL (10 tablets per prescription and 30 tablets per month) |
| ***virtussin ac w/alc oral liquid 100-10 mg/5ml*** | 1 | |
| **CYSTIC FIBROSIS (CFTR) CORRECTORS - Drugs for the Lungs** | | |
| ORKAMBI ORAL PACKET 100-125 MG, 150-188 MG (***lumacaftor-ivacaftor***) | 2 | PA; SL (728 packets per 356 days.); SP |
| ORKAMBI ORAL TABLET 100-125 MG, 200-125 MG (***lumacaftor-ivacaftor***) | 2 | PA; SL (1456 tablets per 356 days.); SP |
| SYMDEKO ORAL TABLET THERAPY PACK 100-150 & 150 MG (***tezacaftor-ivacaftor***) | 2 | PA; SL (728 tablets per 356 days.); SP |
| SYMDEKO ORAL TABLET THERAPY PACK 50-75 & 75 MG (***tezacaftor-ivacaftor***) | 2 | PA; SL (728 tablets per 356 days.) |
| TRIKAFTA ORAL TABLET THERAPY PACK 100-50-75 & 150 MG (***elexacaftor-tezacaftor-ivacaft***) | 2 | PA; SL (1092 tablets per 356 days.); SP |
| **CYSTIC FIBROSIS (CFTR) POTENTIATORS - Drugs for the Lungs** | | |
| KALYDECO ORAL PACKET 25 MG, 50 MG, 75 MG (***ivacaftor***) | 2 | PA; SL (728 packets per 356 days.); SP |
| KALYDECO ORAL TABLET 150 MG (***ivacaftor***) | 2 | PA; SL (780 tablets per 356 days); SP |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ORKAMBI ORAL PACKET 100-125 MG, 150-188 MG (***lumacaftor-ivacaftor***) | 2 | PA; SL (728 packets per 356 days.); SP |
| ORKAMBI ORAL TABLET 100-125 MG, 200-125 MG (***lumacaftor-ivacaftor***) | 2 | PA; SL (1456 tablets per 356 days.); SP |
| SYMDEKO ORAL TABLET THERAPY PACK 100-150 & 150 MG (***tezacaftor-ivacaftor***) | 2 | PA; SL (728 tablets per 356 days.); SP |
| SYMDEKO ORAL TABLET THERAPY PACK 50-75 & 75 MG (***tezacaftor-ivacaftor***) | 2 | PA; SL (728 tablets per 356 days.) |
| TRIKAFTA ORAL TABLET THERAPY PACK 100-50-75 & 150 MG (***elexacaftor-tezacaftor-ivacaft***) | 2 | PA; SL (1092 tablets per 356 days.); SP |
| **EXPECTORANTS - Drugs for the Lungs** | | |
| GILPHEX TR ORAL TABLET 10-388 MG (***phenylephrine-guaifenesin***) | 3 | |
| GILTUSS TR ORAL TABLET 10-28-388 MG (***phenylephrine-dm-gg***) | 3 | |
| ***guaiatussin ac oral syrup 100-10 mg/5ml*** | 1 | |
| ***guaifenesin ac oral syrup 100-10 mg/5ml*** | 1 | |
| IODINE STRONG ORAL SOLUTION 5 % | 2 | |
| ***maxi-tuss ac oral solution 100-10 mg/5ml*** | 1 | |
| SSKI ORAL SOLUTION 1 GM/ML (***potassium iodide (expectorant)***) | 3 | |
| ***virtussin ac w/alc oral liquid 100-10 mg/5ml*** | 1 | |
| **FIRST GENERATION ANTIHIST.(RESPIR TRACT) - Drugs for Allergy** | | |
| ***pseudoeph-bromphen-dm*** (Bromfed Dm Oral Syrup 30-2-10 Mg/5Ml) | 1 | |
| ***brompheniramine tannate oral tablet chewable 12 mg*** | 1 | |
| ***carbinoxamine maleate oral solution 4 mg/5ml*** | 1 | |
| ***carbinoxamine maleate oral tablet 4 mg*** | 1 | |
| ***clemastine fumarate oral tablet 2.68 mg*** | 1 | |
| ***cyproheptadine hcl oral syrup 2 mg/5ml*** | 1 | |
| ***cyproheptadine hcl oral tablet 4 mg*** | 1 | |
| DICOPANOL FUSEPAQ ORAL SUSPENSION RECONSTITUTED 5 MG/ML (***diphenhydramine hcl***) | 3 | PA |
| ***diphen oral elixir 12.5 mg/5ml*** | 1 | |
| ***diphenhydramine hcl oral elixir 12.5 mg/5ml*** | 1 | |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ***duraxin oral capsule 300-200-20 mg*** | 1 | |
| ***hydrocodone polst-chlorphen polst er susp oral suspension extended release 10-8 mg/5ml*** | 3 | PA; SL (360 ml per month.) |
| NEOTUSS PLUS ORAL LIQUID 7.5-4-30 MG/5ML (***phenylephrine-chlorphen-dm***) | 3 | |
| ***promethazine hcl oral solution 6.25 mg/5ml*** | 1 | |
| ***promethazine hcl oral syrup 6.25 mg/5ml*** | 1 | |
| ***promethazine hcl oral tablet 12.5 mg, 25 mg, 50 mg*** | 1 | |
| ***promethazine-codeine oral solution 6.25-10 mg/5ml*** | 1 | PA; SL (360 ml per month.) |
| ***promethazine-codeine oral syrup 6.25-10 mg/5ml*** | 1 | PA; SL (360 ml per month.) |
| ***promethazine-dm oral syrup 6.25-15 mg/5ml*** | 1 | |
| ***promethazine-phenyleph-codeine oral syrup 6.25-5-10 mg/5ml*** | 1 | PA; SL (360 ml per month.) |
| ***promethazine-phenylephrine oral syrup 6.25-5 mg/5ml*** | 1 | |
| ***pseudoephedrine-bromphen-dm oral syrup 30-2-10 mg/5ml*** | 1 | |
| TUSSICAPS ORAL CAPSULE EXTENDED RELEASE 12 HOUR 10-8 MG (***hydrocod polst-chlorphen polst***) | 3 | PA; SL (10 capsules per prescription and 30 capsules per month) |
| TUXARIN ER ORAL TABLET EXTENDED RELEASE 12 HOUR 54.3-8 MG (***chlorpheniramine-codeine***) | 3 | PA; SL (10 tablets per prescription and 30 tablets per month) |
| **INTERLEUKIN ANTAGONISTS - Drugs for Inflammation** | | |
| DUPIXENT SUBCUTANEOUS SOLUTION PEN-INJECTOR 300 MG/2ML (***dupilumab***) | 3 | PA; ST; M; SL (4 ml (2 pens) per 10 days) |
| DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/1.14ML (***dupilumab***) | 3 | PA; ST; M; SL (2 syringes per month); SP |
| DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 300 MG/2ML (***dupilumab***) | 3 | PA; ST; M; SL (2 syringes per month.); SP |
| FASENRA PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 30 MG/ML (***benralizumab***) | 4 | PA; M |
| NUCALA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML (***mepolizumab***) | 4 | PA; M; SL (0.04 mL per day.); SP |
| NUCALA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (***mepolizumab***) | 4 | PA; M; SL (0.04 mL per day.); SP |
| **LEUKOTRIENE MODIFIERS - Drugs for Inflammation** | | |
| ACCOLATE ORAL TABLET 10 MG, 20 MG (***zafirlukast***) | 3 | |
| ***montelukast sodium oral packet 4 mg*** | 2 | |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ***montelukast sodium oral tablet 10 mg*** | 1 | |
| ***montelukast sodium oral tablet chewable 4 mg, 5 mg*** | 1 | |
| SINGULAIR ORAL PACKET 4 MG (***montelukast sodium***) | 3 | |
| ***zafirlukast oral tablet 10 mg, 20 mg*** | 1 | |
| ***zileuton er oral tablet extended release 12 hour 600 mg*** | 3 | ST |
| ZYFLO ORAL TABLET 600 MG (***zileuton***) | 3 | ST |
| **MAST-CELL STABILIZERS - Drugs for Inflammation** | | |
| ALOCRIL OPHTHALMIC SOLUTION 2 % (***nedocromil sodium***) | 3 | |
| ***cromolyn sodium inhalation nebulization solution 20 mg/2ml*** | 1 | |
| ***cromolyn sodium ophthalmic solution 4 %*** | 1 | |
| ***cromolyn sodium oral concentrate 100 mg/5ml*** | 1 | |
| GASTROCROM ORAL CONCENTRATE 100 MG/5ML (***cromolyn sodium***) | 3 | |
| **MUCOLYTIC AGENTS - Drugs for the Lungs** | | |
| ***acetylcysteine inhalation solution 10 %, 20 %*** | 1 | |
| PULMOZYME INHALATION SOLUTION 1 MG/ML (***dornase alfa***) | 2 | PA; SL (5 ml per day.); SP |
| **NASAL PREPARATIONS (STEROIDS) - Drugs for Inflammation** | | |
| ***flunisolide nasal solution 25 mcg/act (0.025%)*** | 3 | |
| ***fluticasone propionate nasal suspension 50 mcg/act*** | 2 | SL (16 grams (1 bottle) per prescription) |
| ZETONNA NASAL AEROSOL SOLUTION 37 MCG/ACT (***ciclesonide***) | 3 | SL (6.1 grams per prescription) |
| **ORALLY INHALED PREPARATIONS (STEROIDS) - Drugs for Inflammation** | | |
| ADVAIR DISKUS INHALATION AEROSOL POWDER BREATH ACTIVATED 100-50 MCG/DOSE, 250-50 MCG/DOSE, 500-50 MCG/DOSE (***fluticasone-salmeterol***) | 3 | SL (2 blisters per day) |
| ADVAIR HFA INHALATION AEROSOL 115-21 MCG/ACT, 230-21 MCG/ACT, 45-21 MCG/ACT (***fluticasone-salmeterol***) | 3 | SL (0.4 grams per day.) |
| ARNUITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100 MCG/ACT, 200 MCG/ACT (***fluticasone furoate***) | 1 | SL (1 blister per day.) |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ARNUITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 50 MCG/ACT (***fluticasone furoate***) | 1 | SL (1 packet per day.) |
| BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-25 MCG/INH (***fluticasone furoate-vilanterol***) | 3 | SL (2 inhalers per day.) |
| BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 200-25 MCG/INH (***fluticasone furoate-vilanterol***) | 3 | SL (2 blisters per day.) |
| ***budesonide inhalation suspension 0.25 mg/2ml, 0.5 mg/2ml*** | 2 | SL (120 ml (2 boxes) per 30 days.) |
| ***budesonide inhalation suspension 1 mg/2ml*** | 2 | SL (60 ml (1 box) per 30 days.) |
| FLOVENT DISKUS INHALATION AEROSOL POWDER BREATH ACTIVATED 100 MCG/BLIST, 50 MCG/BLIST (***fluticasone propionate (inhal)***) | 1 | SL (2 packages per day) |
| FLOVENT DISKUS INHALATION AEROSOL POWDER BREATH ACTIVATED 250 MCG/BLIST (***fluticasone propionate (inhal)***) | 1 | SL (4 packages per day) |
| FLOVENT HFA INHALATION AEROSOL 110 MCG/ACT, 44 MCG/ACT (***fluticasone propionate hfa***) | 1 | SL (1 inhaler per month) |
| FLOVENT HFA INHALATION AEROSOL 220 MCG/ACT (***fluticasone propionate hfa***) | 1 | SL (2 inhalers per month) |
| ***fluticasone-salmeterol inhalation aerosol powder breath activated 100-50 mcg/dose, 250-50 mcg/dose, 500-50 mcg/dose*** | 3 | SL (2 blisters per day) |
| FLUTICASONE-SALMETEROL INHALATION AEROSOL POWDER BREATH ACTIVATED 113-14 MCG/ACT, 232-14 MCG/ACT, 55-14 MCG/ACT | 2 | SL (0.04 mcg per day.) |
| PULMICORT FLEXHALER INHALATION AEROSOL POWDER BREATH ACTIVATED 180 MCG/ACT, 90 MCG/ACT (***budesonide***) | 1 | SL (2 inhalers per month) |
| SYMBICORT INHALATION AEROSOL 160-4.5 MCG/ACT, 80-4.5 MCG/ACT (***budesonide-formoterol fumarate***) | 3 | SL (0.34 grams per day.) |
| TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-62.5-25 MCG/INH (***fluticasone-umeclidin-vilant***) | 3 | SL (2 blisters per day.) |
| ***fluticasone-salmeterol*** (Wixela Inhub Inhalation Aerosol Powder Breath Activated 100-50 Mcg/Dose, 250-50 Mcg/Dose, 500-50 Mcg/Dose) | 3 | SL (2 blisters per day) |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| **PHOSPHODIESTERASE TYPE 4 INHIBITORS - Drugs for the Lungs** | | |
| DALIRESP ORAL TABLET 250 MCG (***roflumilast***) | 3 | PA; SL (31 tablets per year.) |
| DALIRESP ORAL TABLET 500 MCG (***roflumilast***) | 3 | PA; SL (1 tablet per day) |
| **SECOND GENERATION ANTIHIST(RESPIR TRACT) - Drugs for Allergy** | | |
| ***levocetirizine dihydrochloride oral solution 2.5 mg/5ml*** | 3 | |
| ***levocetirizine dihydrochloride oral tablet 5 mg*** | 1 | |
| SEMPREX-D ORAL CAPSULE 8-60 MG (***acrivastine-pseudoephedrine***) | 3 | |
| **SELECT.BETA-2-ADRENERGIC AGONIST(RESPIR) - Drugs for Asthma/COPD** | | |
| ADVAIR DISKUS INHALATION AEROSOL POWDER BREATH ACTIVATED 100-50 MCG/DOSE, 250-50 MCG/DOSE, 500-50 MCG/DOSE (***fluticasone-salmeterol***) | 3 | SL (2 blisters per day) |
| ADVAIR HFA INHALATION AEROSOL 115-21 MCG/ACT, 230-21 MCG/ACT, 45-21 MCG/ACT (***fluticasone-salmeterol***) | 3 | SL (0.4 grams per day.) |
| ***albuterol sulfate er oral tablet extended release 12 hour 4 mg, 8 mg*** | 1 | |
| ***albuterol sulfate hfa aerosol solution 108 (90 base) mcg/act inhalation 108 (90 base) mcg/act*** | 1 | SL (8.5 grams per prescription.) |
| ***albuterol sulfate hfa aerosol solution 108 (90 base) mcg/act inhalation 108 (90 base) mcg/act*** | 3 | SL (1 inhaler per prescription.) |
| ***albuterol sulfate hfa aerosol solution 108 (90 base) mcg/act inhalation 108 (90 base) mcg/act*** | 3 | SL (6.7 grams per prescription) |
| ***albuterol sulfate hfa aerosol solution 108 (90 base) mcg/act inhalation 108 (90 base) mcg/act*** | 3 | SL (8.5 grams per prescription) |
| ***albuterol sulfate inhalation nebulization solution (2.5 mg/3ml) 0.083%, 0.63 mg/3ml, 1.25 mg/3ml, 2.5 mg/0.5ml*** | 1 | |
| ***albuterol sulfate inhalation nebulization solution (5 mg/ml) 0.5%*** | 1 | |
| ***albuterol sulfate oral syrup 2 mg/5ml*** | 1 | |
| ***albuterol sulfate oral tablet 2 mg, 4 mg*** | 3 | PA |
| ANORO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 62.5-25 MCG/INH (***umeclidinium-vilanterol***) | 3 | SL (2 blisters per day.) |
| ARCAPTA NEOHALER INHALATION CAPSULE 75 MCG (***indacaterol maleate***) | 3 | SL (1 capsule per day) |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| BEVESPI AEROSPHERE INHALATION AEROSOL 9-4.8 MCG/ACT (***glycopyrrolate-formoterol***) | 2 | SL (0.36 grams per day.) |
| BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-25 MCG/INH (***fluticasone furoate-vilanterol***) | 3 | SL (2 inhalers per day.) |
| BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 200-25 MCG/INH (***fluticasone furoate-vilanterol***) | 3 | SL (2 blisters per day.) |
| BROVANA INHALATION NEBULIZATION SOLUTION 15 MCG/2ML (***arformoterol tartrate***) | 3 | SL (2 nebules per day) |
| COMBIVENT RESPIMAT INHALATION AEROSOL SOLUTION 20-100 MCG/ACT (***ipratropium-albuterol***) | 3 | SL (0.28 grams per day.) |
| DUAKLIR PRESSAIR INHALATION AEROSOL POWDER BREATH ACTIVATED 400-12 MCG/ACT (***aclidinium br-formoterol fum***) | 3 | SL (0.04 mcg per day.) |
| ***fluticasone-salmeterol inhalation aerosol powder breath activated 100-50 mcg/dose, 250-50 mcg/dose, 500-50 mcg/dose*** | 3 | SL (2 blisters per day) |
| FLUTICASONE-SALMETEROL INHALATION AEROSOL POWDER BREATH ACTIVATED 113-14 MCG/ACT, 232-14 MCG/ACT, 55-14 MCG/ACT | 2 | SL (0.04 mcg per day.) |
| ***ipratropium-albuterol inhalation solution 0.5-2.5 (3) mg/3ml*** | 2 | |
| ***levalbuterol hcl inhalation nebulization solution 0.31 mg/3ml, 0.63 mg/3ml, 1.25 mg/3ml*** | 3 | SL (90 ml per prescription) |
| ***levalbuterol hcl inhalation nebulization solution 1.25 mg/0.5ml*** | 3 | SL (30 vials per prescription) |
| LEVALBUTEROL HFA INHALATION AEROSOL 45 MCG/ACT | 3 | SL (15 grams per prescription) |
| ***metaproterenol sulfate oral syrup 10 mg/5ml*** | 1 | |
| PERFOROMIST INHALATION NEBULIZATION SOLUTION 20 MCG/2ML (***formoterol fumarate***) | 3 | SL (2 vials per day) |
| PROAIR HFA INHALATION AEROSOL SOLUTION 108 (90 BASE) MCG/ACT (***albuterol sulfate***) | 3 | SL (8.5 grams per prescription) |
| PROAIR RESPICLICK INHALATION AEROSOL POWDER BREATH ACTIVATED 108 (90 BASE) MCG/ACT (***albuterol sulfate***) | 3 | SL (1 inhaler per prescription) |
| PROVENTIL HFA INHALATION AEROSOL SOLUTION 108 (90 BASE) MCG/ACT (***albuterol sulfate***) | 3 | SL (6.7 grams per prescription) |
| SEREVENT DISKUS INHALATION AEROSOL POWDER BREATH ACTIVATED 50 MCG/DOSE (***salmeterol xinafoate***) | 2 | SL (2 blisters per day.) |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| STRIVERDI RESPIMAT INHALATION AEROSOL SOLUTION 2.5 MCG/ACT (***olodaterol hcl***) | 2 | SL (0.14 grams per day.) |
| SYMBICORT INHALATION AEROSOL 160-4.5 MCG/ACT, 80-4.5 MCG/ACT (***budesonide-formoterol fumarate***) | 3 | SL (0.34 grams per day.) |
| ***terbutaline sulfate oral tablet 2.5 mg, 5 mg*** | 1 | |
| TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-62.5-25 MCG/INH (***fluticasone-umeclidin-vilant***) | 3 | SL (2 blisters per day.) |
| VENTOLIN HFA INHALATION AEROSOL SOLUTION 108 (90 BASE) MCG/ACT (***albuterol sulfate***) | 2 | SL (18 grams per prescription) |
| ***fluticasone-salmeterol*** (Wixela Inhub Inhalation Aerosol Powder Breath Activated 100-50 Mcg/Dose, 250-50 Mcg/Dose, 500-50 Mcg/Dose) | 3 | SL (2 blisters per day) |
| XOPENEX HFA INHALATION AEROSOL 45 MCG/ACT (***levalbuterol tartrate***) | 3 | SL (15 grams per prescription) |
| **VASODILATING AGENTS (RESPIRATORY TRACT) - Drugs for the Lungs** | | |
| ADEMPAS ORAL TABLET 0.5 MG, 1 MG, 1.5 MG, 2 MG, 2.5 MG (***riociguat***) | 2 | PA; SL (3 tablets per day.); SP |
| ***tadalafil (pah)*** (Alyq Oral Tablet 20 Mg) | 4 | PA; SL (2 tablets per day); SP |
| ***ambrisentan oral tablet 10 mg, 5 mg*** | 2 | PA; SL (1 tablet per day.); SP |
| ***bosentan oral tablet 125 mg, 62.5 mg*** | 2 | PA; SL (2 tablets per day.); SP |
| LETAIRIS ORAL TABLET 10 MG, 5 MG (***ambrisentan***) | 3 | PA; SL (1 tablet per day.); SP |
| OPSUMIT ORAL TABLET 10 MG (***macitentan***) | 2 | PA; SL (1 tablet per day.); SP |
| ORENITRAM ORAL TABLET EXTENDED RELEASE 0.125 MG, 0.25 MG, 1 MG, 2.5 MG, 5 MG (***treprostinil diolamine***) | 3 | PA; SL (6 tablets per day.); SP |
| REVATIO ORAL SUSPENSION RECONSTITUTED 10 MG/ML (***sildenafil citrate***) | 4 | PA; SL (186 ml per month.); SP |
| ***sildenafil citrate oral suspension reconstituted 10 mg/ml*** | 3 | PA; SL (186 ml per month.); SP |
| ***sildenafil citrate oral tablet 20 mg*** | 1 | SL (0.5 tablet per day.) |
| ***tadalafil (pah) oral tablet 20 mg*** | 4 | PA; SL (2 tablets per day); SP |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| TRACLEER ORAL TABLET 125 MG, 62.5 MG (***bosentan***) | 2 | PA; SL (2 tablets per day.); SP |
| TRACLEER ORAL TABLET SOLUBLE 32 MG (***bosentan***) | 2 | PA; SL (4 tablets per day); SP |
| TYVASO INHALATION SOLUTION 0.6 MG/ML (***treprostinil***) | 2 | PA |
| TYVASO REFILL INHALATION SOLUTION 0.6 MG/ML (***treprostinil***) | 2 | PA |
| TYVASO STARTER INHALATION SOLUTION 0.6 MG/ML (***treprostinil***) | 2 | PA |
| UPTRAVI ORAL TABLET 1000 MCG, 1200 MCG, 1400 MCG, 1600 MCG, 200 MCG, 400 MCG, 600 MCG, 800 MCG (***selexipag***) | 3 | PA; SL (2 tablets per day.); SP |
| UPTRAVI ORAL TABLET THERAPY PACK 200 & 800 MCG (***selexipag***) | 3 | PA; SL (200 tablets per year.); SP |
| VENTAVIS INHALATION SOLUTION 10 MCG/ML, 20 MCG/ML (***iloprost***) | 2 | PA; SP |
| **XANTHINE DERIVATIVES - Drugs for Asthma/COPD** | | |
| ELIXOPHYLLIN ORAL ELIXIR 80 MG/15ML (***theophylline***) | 3 | |
| THEO-24 ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 300 MG, 400 MG (***theophylline***) | 3 | |
| ***theophylline er oral tablet extended release 12 hour 300 mg, 450 mg*** | 1 | |
| ***theophylline er oral tablet extended release 24 hour 400 mg, 600 mg*** | 1 | |
| ***theophylline oral solution 80 mg/15ml*** | 1 | |
| **SKIN AND MUCOUS MEMBRANE AGENTS - Drugs for the Skin** | | |
| **ANTIBACTERIALS (SKIN, MUCOUS MEMBRANE) - Drugs for the Skin** | | |
| ACZONE EXTERNAL GEL 5 %, 7.5 % (***dapsone***) | 3 | SL (60 grams per prescription) |
| ALTABAX EXTERNAL OINTMENT 1 % (***retapamulin***) | 3 | SL (15 grams per prescription) |
| AMZEEQ EXTERNAL FOAM 4 % (***minocycline hcl micronized***) | 3 | PA; SL (30 grams per prescription) |
| BENZAMYCIN EXTERNAL GEL 5-3 % (***benzoyl peroxide-erythromycin***) | 2 | SL (23.3 grams per prescription) |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ***benzoyl peroxide-erythromycin external gel 5-3 %*** | 1 | SL (23.3 grams per prescription) |
| CENTANY EXTERNAL OINTMENT 2 % (***mupirocin***) | 3 | SL (22 grams per prescription) |
| CLEOCIN VAGINAL CREAM 2 % (***clindamycin phosphate***) | 3 | |
| CLEOCIN VAGINAL SUPPOSITORY 100 MG (***clindamycin phosphate***) | 2 | |
| CLEOCIN-T EXTERNAL GEL 1 % (***clindamycin phosphate***) | 3 | SL (30 grams (1 tube) per prescription) |
| CLEOCIN-T EXTERNAL LOTION 1 % (***clindamycin phosphate***) | 3 | |
| ***clindamycin phosphate*** (Clindacin Etz External Swab 1 %) | 1 | |
| ***clindamycin phosphate*** (Clindacin-P External Swab 1 %) | 1 | |
| ***clindamycin phos-benzoyl perox external gel 1.2-5 %*** | 3 | SL (1 bottle (45 grams) per month.) |
| ***clindamycin phosphate external foam 1 %*** | 3 | |
| ***clindamycin phosphate external gel 1 %*** | 3 | SL (30 grams (1 tube) per prescription) |
| ***clindamycin phosphate external lotion 1 %*** | 3 | |
| ***clindamycin phosphate external solution 1 %*** | 1 | SL (30 ml per prescription) |
| ***clindamycin phosphate external swab 1 %*** | 1 | |
| ***clindamycin phosphate vaginal cream 2 %*** | 2 | |
| CLINDESSE VAGINAL CREAM 2 % (***clindamycin phosphate (1 dose)***) | 2 | |
| CORTISPORIN EXTERNAL CREAM 3.5-10000-0.5 (***neomycin-polymyxin-hc***) | 2 | |
| CORTISPORIN EXTERNAL OINTMENT 1 % (***bacit-poly-neo hc***) | 3 | |
| ***dapsone external gel 5 %*** | 3 | SL (60 grams per prescription) |
| ***ery external pad 2 %*** | 1 | |
| ERYGEL EXTERNAL GEL 2 % (***erythromycin***) | 3 | |
| ***erythromycin external gel 2 %*** | 1 | |
| ***erythromycin external solution 2 %*** | 1 | |
| EVOCLIN EXTERNAL FOAM 1 % (***clindamycin phosphate***) | 3 | |
| ***gentamicin sulfate external cream 0.1 %*** | 1 | SL (30 grams per prescription) |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ***gentamicin sulfate external ointment 0.1 %*** | 1 | SL (30 grams per prescription) |
| METROCREAM EXTERNAL CREAM 0.75 % (***metronidazole***) | 3 | |
| METROLOTION EXTERNAL LOTION 0.75 % (***metronidazole***) | 3 | |
| ***metronidazole external cream 0.75 %*** | 1 | |
| ***metronidazole external gel 0.75 %*** | 1 | |
| ***metronidazole external lotion 0.75 %*** | 1 | |
| ***metronidazole vaginal gel 0.75 %*** | 2 | |
| ***mupirocin calcium external cream 2 %*** | 3 | SL (15 grams per prescription) |
| ***mupirocin external ointment 2 %*** | 1 | SL (22 grams per prescription) |
| ***clindamycin-benzoyl per (refr)*** (Neuac External Gel 1.2-5 %) | 3 | SL (1 bottle (45 grams) per month.) |
| ***metronidazole*** (Rosadan External Cream 0.75 %) | 1 | |
| ***metronidazole*** (Rosadan External Gel 0.75 %) | 1 | |
| ***metronidazole*** (Vandazole Vaginal Gel 0.75 %) | 2 | |
| XEPI EXTERNAL CREAM 1 % (***ozenoxacin***) | 3 | SL (30 g per prescription) |
| **ANTIFULGALS (SKIN, MUCOUS MEMBRANE),MISC - Drugs for the Skin** | | |
| ***exoderm external lotion 25-1 %*** | 1 | |
| **ANTI-INFLAMMATORY AGENTS (SKIN, MUCOUS) - Drugs for the Skin** | | |
| ALA SCALP EXTERNAL LOTION 2 % (***hydrocortisone***) | 3 | |
| ***ala-cort external cream 2.5 %*** | 1 | |
| ***alclometasone dipropionate external cream 0.05 %*** | 1 | |
| ***alclometasone dipropionate external ointment 0.05 %*** | 1 | |
| ***amcinonide external cream 0.1 %*** | 3 | |
| ***amcinonide external lotion 0.1 %*** | 3 | |
| ***amcinonide external ointment 0.1 %*** | 1 | |
| ANALPRAM HC EXTERNAL CREAM 2.5-1 % (***hydrocortisone ace-pramoxine***) | 3 | |
| ANALPRAM HC SINGLES EXTERNAL CREAM 2.5-1 % (***hydrocortisone ace-pramoxine***) | 3 | |
| ANALPRAM-HC EXTERNAL CREAM 1-1 % (***hydrocortisone ace-pramoxine***) | 3 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ANALPRAM-HC EXTERNAL LOTION 2.5-1 % (***hydrocortisone ace-pramoxine***) | 3 | |
| ***anucort-hc rectal suppository 25 mg*** | 2 | |
| ANUSOL-HC EXTERNAL CREAM 2.5 % (***hydrocortisone***) | 3 | |
| APEXICON E EXTERNAL CREAM 0.05 % (***diflorasone diacet emoll base***) | 2 | SL (30 grams per prescription) |
| ***fluticasone propionate*** (Beser External Lotion 0.05 %) | 3 | ST; SL (60 ml per prescription) |
| ***betamethasone dipropionate aug external cream 0.05 %*** | 1 | |
| ***betamethasone dipropionate aug external gel 0.05 %*** | 1 | |
| ***betamethasone dipropionate aug external lotion 0.05 %*** | 3 | |
| ***betamethasone dipropionate aug external ointment 0.05 %*** | 3 | |
| ***betamethasone dipropionate external cream 0.05 %*** | 2 | |
| ***betamethasone dipropionate external lotion 0.05 %*** | 1 | |
| ***betamethasone dipropionate external ointment 0.05 %*** | 2 | |
| ***betamethasone valerate external cream 0.1 %*** | 1 | |
| ***betamethasone valerate external lotion 0.1 %*** | 1 | |
| ***betamethasone valerate external ointment 0.1 %*** | 1 | |
| ***calcipotriene-betameth diprop external ointment 0.005-0.064 %*** | 3 | SL (60 grams per prescription) |
| ***calcipotriene-betameth diprop external suspension 0.005-0.064 %*** | 3 | SL (60 grams per prescription) |
| CAPEX EXTERNAL SHAMPOO 0.01 % (***fluocinolone acetonide***) | 2 | |
| ***clobetasol prop emollient base external cream 0.05 %*** | 2 | SL (15 grams per prescription) |
| ***clobetasol propionate e external cream 0.05 %*** | 2 | SL (15 grams per prescription) |
| ***clobetasol propionate external cream 0.05 %*** | 2 | SL (15 grams per prescription) |
| ***clobetasol propionate external gel 0.05 %*** | 2 | SL (15 grams per prescription) |
| ***clobetasol propionate external liquid 0.05 %*** | 1 | SL (59 ml per prescription) |
| ***clobetasol propionate external ointment 0.05 %*** | 2 | SL (15 grams per prescription) |
| ***clobetasol propionate external solution 0.05 %*** | 1 | SL (25 ml per prescription) |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ***clocortolone pivalate external cream 0.1 %*** | 3 | ST; SL (45 grams per prescription) |
| ***clotrimazole-betamethasone external cream 1-0.05 %*** | 1 | SL (15 grams per prescription) |
| ***clotrimazole-betamethasone external lotion 1-0.05 %*** | 1 | |
| CORDRAN EXTERNAL OINTMENT 0.05 % (***flurandrenolide***) | 3 | ST |
| CORDRAN EXTERNAL TAPE 4 MCG/SQCM (***flurandrenolide***) | 3 | SL (1 packet per prescription) |
| CORTENEMA RECTAL ENEMA 100 MG/60ML (***hydrocortisone***) | 3 | |
| CORTIFOAM EXTERNAL FOAM 10 % (***hydrocortisone acetate***) | 2 | |
| CORTISPORIN EXTERNAL CREAM 3.5-10000-0.5 (***neomycin-polymyxin-hc***) | 2 | |
| CORTISPORIN EXTERNAL OINTMENT 1 % (***bacit-poly-neo hc***) | 3 | |
| CUTIVATE EXTERNAL LOTION 0.05 % (***fluticasone propionate***) | 3 | ST; SL (60 ml per prescription) |
| DERMA-SMOOTHE/FS BODY EXTERNAL OIL 0.01 % (***fluocinolone acetonide***) | 3 | SL (118.28 ml per prescription) |
| DERMA-SMOOTHE/FS SCALP EXTERNAL OIL 0.01 % (***fluocinolone acetonide***) | 3 | |
| DESONATE EXTERNAL GEL 0.05 % (***desonide***) | 3 | ST; SL (60 grams per prescription) |
| ***desonide external cream 0.05 %*** | 3 | SL (15 grams per prescription) |
| ***desonide external gel 0.05 %*** | 3 | ST; SL (60 grams per prescription) |
| ***desonide external lotion 0.05 %*** | 3 | SL (60 ml per prescription) |
| ***desonide external ointment 0.05 %*** | 3 | SL (15 grams per prescription) |
| DESOWEN EXTERNAL CREAM 0.05 % (***desonide***) | 3 | SL (15 grams per prescription) |
| ***desoximetasone external cream 0.05 %, 0.25 %*** | 1 | SL (15 grams per prescription) |
| ***desoximetasone external gel 0.05 %*** | 3 | SL (15 grams per prescription) |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ***desoximetasone external ointment 0.05 %*** | 3 | SL (60 grams per prescription) |
| ***desoximetasone external ointment 0.25 %*** | 3 | SL (15 grams per prescription) |
| ***diflorasone diacetate external cream 0.05 %*** | 3 | SL (30 grams per prescription) |
| DIPROLENE AF EXTERNAL CREAM 0.05 % (***betamethasone dipropionate aug***) | 3 | |
| DIPROLENE EXTERNAL OINTMENT 0.05 % (***betamethasone dipropionate aug***) | 3 | |
| ***enovarx-ibuprofen external cream 10 %*** | 1 | PA |
| ***enovarx-naproxen external cream 10 %*** | 1 | PA |
| ENSTILAR EXTERNAL FOAM 0.005-0.064 % (***calcipotriene-betameth diprop***) | 4 | SL (60 grams per prescription) |
| EPIFOAM EXTERNAL FOAM 1-1 % (***pramoxine-hc***) | 2 | |
| EUCRISA EXTERNAL OINTMENT 2 % (***crisaborole***) | 3 | ST; SL (60 grams per prescription) |
| ***fluocinolone acetonide body external oil 0.01 %*** | 3 | SL (118.28 ml per prescription) |
| ***fluocinolone acetonide external cream 0.01 %, 0.025 %*** | 3 | SL (15 grams per prescription) |
| ***fluocinolone acetonide external ointment 0.025 %*** | 2 | SL (15 grams per prescription) |
| ***fluocinolone acetonide external solution 0.01 %*** | 3 | SL (60 ml per prescription) |
| ***fluocinolone acetonide scalp external oil 0.01 %*** | 3 | |
| ***fluocinonide emulsified base external cream 0.05 %*** | 1 | |
| ***fluocinonide external cream 0.05 %*** | 1 | |
| ***fluocinonide external gel 0.05 %*** | 1 | |
| ***fluocinonide external ointment 0.05 %*** | 1 | |
| ***fluocinonide external solution 0.05 %*** | 1 | |
| ***flurandrenolide external cream 0.05 %*** | 3 | ST; SL (120 ml per prescription) |
| ***flurandrenolide external lotion 0.05 %*** | 3 | ST; SL (120 ml per prescription) |
| ***flurandrenolide external ointment 0.05 %*** | 3 | ST |
| ***fluticasone propionate external cream 0.05 %*** | 1 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ***fluticasone propionate external lotion 0.05 %*** | 3 | ST; SL (60 ml per prescription) |
| ***fluticasone propionate external ointment 0.005 %*** | 1 | |
| FROTEK EXTERNAL CREAM 10 % (***ketoprofen***) | 3 | PA |
| ***halcinonide external cream 0.1 %*** | 3 | ST; SL (30 grams per prescription) |
| ***halobetasol propionate external cream 0.05 %*** | 2 | SL (15 grams per prescription) |
| ***halobetasol propionate external ointment 0.05 %*** | 2 | SL (15 grams per prescription) |
| HALOG EXTERNAL CREAM 0.1 % (***halcinonide***) | 3 | ST; SL (30 grams per prescription) |
| HALOG EXTERNAL OINTMENT 0.1 % (***halcinonide***) | 3 | ST; SL (30 grams per prescription) |
| ***hydrocortisone acetate*** (Hemmorex-Hc Rectal Suppository 25 Mg) | 2 | |
| ***hemorrhoidal-hc rectal suppository 25 mg*** | 2 | |
| ***hydrocortisone (perianal) external cream 1 %, 2.5 %*** | 1 | |
| ***hydrocortisone ace-pramoxine external cream 1-1 %, 2.5-1 %*** | 1 | |
| ***hydrocortisone acetate rectal suppository 25 mg, 30 mg*** | 2 | |
| ***hydrocortisone butyrate external cream 0.1 %*** | 1 | |
| ***hydrocortisone butyrate external ointment 0.1 %*** | 1 | |
| ***hydrocortisone butyrate external solution 0.1 %*** | 1 | |
| ***hydrocortisone external cream 2.5 %*** | 1 | |
| ***hydrocortisone external lotion 2.5 %*** | 1 | |
| ***hydrocortisone external ointment 1 %, 2.5 %*** | 1 | |
| ***hydrocortisone rectal enema 100 mg/60ml*** | 1 | |
| ***hydrocortisone valerate external cream 0.2 %*** | 3 | SL (15 grams per prescription) |
| ***hydrocortisone valerate external ointment 0.2 %*** | 3 | SL (15 grams per prescription) |
| ***hydrocort-pramoxine (perianal) external cream 2.5-1 %*** | 1 | |
| ***mometasone furoate external cream 0.1 %*** | 1 | |
| ***mometasone furoate external ointment 0.1 %*** | 1 | |
| ***mometasone furoate external solution 0.1 %*** | 1 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ***flurandrenolide*** (Nolix External Cream 0.05 %) | 3 | ST; SL (120 ml per prescription) |
| ***flurandrenolide*** (Nolix External Lotion 0.05 %) | 3 | ST; SL (120 ml per prescription) |
| NUCORT EXTERNAL LOTION 2 % (***hydrocortisone acetate***) | 3 | |
| ***triamcinolone acetonide*** (Oralone Mouth/Throat Paste 0.1 %) | 1 | |
| PANDEL EXTERNAL CREAM 0.1 % (***hydrocortisone probutate***) | 3 | |
| ***pramosone external cream 1-1 %*** | 1 | |
| PRAMOSONE EXTERNAL CREAM 1-2.5 % (***pramoxine-hc***) | 3 | |
| PRAMOSONE EXTERNAL LOTION 1-1 %, 1-2.5 % (***pramoxine-hc***) | 2 | |
| PRAMOSONE EXTERNAL OINTMENT 1-1 % (***pramoxine-hc***) | 2 | |
| PRAMOSONE EXTERNAL OINTMENT 1-2.5 % (***pramoxine-hc***) | 3 | |
| ***prednicarbate external cream 0.1 %*** | 1 | |
| ***prednicarbate external ointment 0.1 %*** | 1 | |
| PROCTOFOAM HC EXTERNAL FOAM 1-1 % (***hydrocortisone ace-pramoxine***) | 2 | |
| ***hydrocortisone*** (Procto-Med Hc External Cream 2.5 %) | 1 | |
| ***hydrocortisone*** (Procto-Pak External Cream 1 %) | 1 | |
| ***hydrocortisone*** (Proctosol Hc External Cream 2.5 %) | 1 | |
| ***hydrocortisone*** (Proctozone-Hc External Cream 2.5 %) | 1 | |
| PSORCON EXTERNAL CREAM 0.05 % | 3 | SL (30 grams per prescription) |
| SCALACORT DK EXTERNAL KIT 2 & 2-2 % (***hc & sal acid-sulfur & shampoo***) | 3 | |
| TACLONEX EXTERNAL SUSPENSION 0.005-0.064 % (***calcipotriene-betameth diprop***) | 3 | SL (60 grams per prescription) |
| TEMOVATE EXTERNAL CREAM 0.05 % (***clobetasol propionate***) | 3 | SL (15 grams per prescription) |
| TEMOVATE EXTERNAL OINTMENT 0.05 % (***clobetasol propionate***) | 3 | SL (15 grams per prescription) |
| TEXACORT EXTERNAL SOLUTION 2.5 % (***hydrocortisone***) | 2 | |
| TOPICORT EXTERNAL CREAM 0.05 %, 0.25 % (***desoximetasone***) | 3 | SL (15 grams per prescription) |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| TOPICORT EXTERNAL GEL 0.05 % (***desoximetasone***) | 3 | SL (15 grams per prescription) |
| TOPICORT EXTERNAL OINTMENT 0.05 % (***desoximetasone***) | 3 | SL (60 grams per prescription) |
| TOPICORT EXTERNAL OINTMENT 0.25 % (***desoximetasone***) | 3 | SL (15 grams per prescription) |
| ***triamcinolone acetonide external aerosol solution 0.147 mg/gm*** | 2 | SL (63 grams per prescription) |
| ***triamcinolone acetonide external cream 0.025 %, 0.1 %*** | 1 | |
| ***triamcinolone acetonide external cream 0.5 %*** | 1 | SL (15 grams per prescription) |
| ***triamcinolone acetonide external lotion 0.025 %, 0.1 %*** | 1 | |
| ***triamcinolone acetonide external ointment 0.025 %, 0.1 %, 0.5 %*** | 1 | |
| ***triamcinolone acetonide mouth/throat paste 0.1 %*** | 1 | |
| ***triamcinolone acetonide*** (Triderm External Cream 0.1 %) | 1 | |
| ***triamcinolone acetonide*** (Triderm External Cream 0.5 %) | 1 | SL (15 grams per prescription) |
| TRIDESILON EXTERNAL CREAM 0.05 % (***desonide***) | 3 | SL (15 grams per prescription) |
| **ANTI-INFLAMMATORY AGENTS, MISC (SKIN) - Drugs for the Skin** | | |
| EUCRISA EXTERNAL OINTMENT 2 % (***crisaborole***) | 3 | ST; SL (60 grams per prescription) |
| **ANTIPRURITICS AND LOCAL ANESTHETICS - Drugs for the Skin** | | |
| ANALPRAM HC EXTERNAL CREAM 2.5-1 % (***hydrocortisone ace-pramoxine***) | 3 | |
| ANALPRAM HC SINGLES EXTERNAL CREAM 2.5-1 % (***hydrocortisone ace-pramoxine***) | 3 | |
| ANALPRAM-HC EXTERNAL CREAM 1-1 % (***hydrocortisone ace-pramoxine***) | 3 | |
| ANALPRAM-HC EXTERNAL LOTION 2.5-1 % (***hydrocortisone ace-pramoxine***) | 3 | |
| ***doxepin hcl external cream 5 %*** | 1 | PA; SL (45 grams per prescription) |
| ***enovarx-lidocaine hcl external cream 10 %, 5 %*** | 1 | PA |
| EPIFOAM EXTERNAL FOAM 1-1 % (***pramoxine-hc***) | 2 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ***hydrocortisone ace-pramoxine external cream 1-1 %, 2.5-1 %*** | 1 | |
| ***hydrocort-pramoxine (perianal) external cream 2.5-1 %*** | 1 | |
| ***lets kit*** | 1 | PA |
| ***lidocaine external ointment 5 %*** | 2 | SL (1.19 grams per day.) |
| ***lidocaine external patch 5 %*** | 3 | PA; SL (3 patches per day) |
| ***lidocaine hcl external solution 4 %*** | 1 | |
| ***lidocaine hcl mouth/throat solution 4 %*** | 1 | |
| ***lidocaine-prilocaine cream 2.5-2.5 % external 2.5-2.5 %*** | 1 | |
| ***lidocaine-prilocaine cream 2.5-2.5 % external 2.5-2.5 %*** | 1 | PA |
| LIDOPIN EXTERNAL CREAM 3.25 % | 3 | |
| LIDTOPIC MAX EXTERNAL CREAM 10 % (***lidocaine hcl***) | 3 | PA |
| ***phenazopyridine hcl*** (Phenazo Oral Tablet 200 Mg) | 1 | |
| ***phenazopyridine hcl oral tablet 100 mg, 200 mg*** | 1 | |
| ***pramosone external cream 1-1 %*** | 1 | |
| PRAMOSONE EXTERNAL CREAM 1-2.5 % (***pramoxine-hc***) | 3 | |
| PRAMOSONE EXTERNAL LOTION 1-1 %, 1-2.5 % (***pramoxine-hc***) | 2 | |
| PRAMOSONE EXTERNAL OINTMENT 1-1 % (***pramoxine-hc***) | 2 | |
| PRAMOSONE EXTERNAL OINTMENT 1-2.5 % (***pramoxine-hc***) | 3 | |
| ***pramox external gel 1 %*** | 1 | |
| PROCTOFOAM HC EXTERNAL FOAM 1-1 % (***hydrocortisone ace-pramoxine***) | 2 | |
| PRUDOXIN EXTERNAL CREAM 5 % (***doxepin hcl (antipruritic)***) | 3 | PA; SL (45 grams per prescription) |
| PYRIDIUM ORAL TABLET 100 MG, 200 MG (***phenazopyridine hcl***) | 3 | |
| SYNVEXIA TC EXTERNAL CREAM 4-1 % | 3 | |
| ZONALON EXTERNAL CREAM 5 % (***doxepin hcl (antipruritic)***) | 3 | PA; SL (45 grams per prescription) |
| **ANTIVIRALS (SKIN AND MUCOUS MEMBRANE) - Drugs for the Skin** | | |
| ***acyclovir external ointment 5 %*** | 3 | PA; ST; SL (15 grams per prescription) |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| **ASTRINGENTS - Drugs for the Skin** | | |
| DRYSOL EXTERNAL SOLUTION 20 % (***aluminum chloride***) | 3 | |
| **AZOLES (SKIN AND MUCOUS MEMBRANE) - Drugs for the Skin** | | |
| ***clotrimazole mouth/throat troche 10 mg*** | 1 | |
| ***clotrimazole-betamethasone external cream 1-0.05 %*** | 1 | SL (15 grams per prescription) |
| ***clotrimazole-betamethasone external lotion 1-0.05 %*** | 1 | |
| ***econazole nitrate external cream 1 %*** | 2 | SL (15 grams per prescription) |
| EXELDERM EXTERNAL CREAM 1 % (***sulconazole nitrate***) | 3 | |
| EXELDERM EXTERNAL SOLUTION 1 % (***sulconazole nitrate***) | 3 | |
| EXTINA EXTERNAL FOAM 2 % (***ketoconazole***) | 3 | ST; SL (50 grams per prescription) |
| GYNAZOLE-1 VAGINAL CREAM 2 % (***butoconazole nitrate (1 dose)***) | 3 | |
| JUBLIA EXTERNAL SOLUTION 10 % (***efinaconazole***) | 3 | PA; ST; SL (4 ml per month.) |
| ***ketoconazole external cream 2 %*** | 1 | SL (30 grams per prescription) |
| ***ketoconazole external foam 2 %*** | 3 | ST; SL (50 grams per prescription) |
| ***ketoconazole external shampoo 2 %*** | 1 | |
| ***ketoconazole*** (Ketodan External Foam 2 %) | 3 | ST; SL (50 grams per prescription) |
| ***miconazole 3 vaginal suppository 200 mg*** | 1 | |
| ORAVIG BUCCAL TABLET 50 MG (***miconazole***) | 3 | |
| ***oxiconazole nitrate external cream 1 %*** | 3 | PA; SL (30 grams per prescription) |
| OXISTAT EXTERNAL CREAM 1 % (***oxiconazole nitrate***) | 3 | PA; SL (30 grams per prescription) |
| SULCONAZOLE NITRATE EXTERNAL CREAM 1 % | 3 | |
| SULCONAZOLE NITRATE EXTERNAL SOLUTION 1 % | 3 | |
| ***terconazole vaginal cream 0.4 %, 0.8 %*** | 1 | |
| ***terconazole vaginal suppository 80 mg*** | 1 | |
| XOLEGEL EXTERNAL GEL 2 % (***ketoconazole***) | 3 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| **BASIC OINTMENTS AND PROTECTANTS - Drugs for the Skin** | | |
| ***benzoin compound external tincture*** | 1 | |
| HALUCORT EXTERNAL GEL (***dermatological products, misc.***) | 3 | PA |
| MEDERMA SPF 30 EXTERNAL CREAM (***scar treatment products***) | 3 | PA |
| TETRIX EXTERNAL CREAM (***dermatological products, misc.***) | 3 | |
| **BENZYLAMINES (SKIN AND MUCOUS MEMBRANE) - Drugs for the Skin** | | |
| MENTAX EXTERNAL CREAM 1 % (***butenafine hcl***) | 3 | |
| **CELL STIMULANTS AND PROLIFERANTS - Drugs for the Skin** | | |
| REGRANEX EXTERNAL GEL 0.01 % (***becaplermin***) | 2 | PA; SL (30 grams per prescription) |
| ***tretinoin external cream 0.025 %, 0.05 %, 0.1 %*** | 3 | SL (20 grams per prescription) |
| **CORTICOSTEROIDS (SKIN, MUCOUS MEMBRANE) - Drugs for the Skin** | | |
| ALA SCALP EXTERNAL LOTION 2 % (***hydrocortisone***) | 3 | |
| ***ala-cort external cream 2.5 %*** | 1 | |
| ***alclometasone dipropionate external cream 0.05 %*** | 1 | |
| ***alclometasone dipropionate external ointment 0.05 %*** | 1 | |
| ***amcinonide external cream 0.1 %*** | 3 | |
| ***amcinonide external lotion 0.1 %*** | 3 | |
| ***amcinonide external ointment 0.1 %*** | 1 | |
| ANALPRAM HC EXTERNAL CREAM 2.5-1 % (***hydrocortisone ace-pramoxine***) | 3 | |
| ANALPRAM HC SINGLES EXTERNAL CREAM 2.5-1 % (***hydrocortisone ace-pramoxine***) | 3 | |
| ANALPRAM-HC EXTERNAL CREAM 1-1 % (***hydrocortisone ace-pramoxine***) | 3 | |
| ANALPRAM-HC EXTERNAL LOTION 2.5-1 % (***hydrocortisone ace-pramoxine***) | 3 | |
| ***anucort-hc rectal suppository 25 mg*** | 2 | |
| ANUSOL-HC EXTERNAL CREAM 2.5 % (***hydrocortisone***) | 3 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| APEXICON E EXTERNAL CREAM 0.05 % (***diflorasone diacet emoll base***) | 2 | SL (30 grams per prescription) |
| ***fluticasone propionate*** (Beser External Lotion 0.05 %) | 3 | ST; SL (60 ml per prescription) |
| ***betamethasone dipropionate aug external cream 0.05 %*** | 1 | |
| ***betamethasone dipropionate aug external gel 0.05 %*** | 1 | |
| ***betamethasone dipropionate aug external lotion 0.05 %*** | 3 | |
| ***betamethasone dipropionate aug external ointment 0.05 %*** | 3 | |
| ***betamethasone dipropionate external cream 0.05 %*** | 2 | |
| ***betamethasone dipropionate external lotion 0.05 %*** | 1 | |
| ***betamethasone dipropionate external ointment 0.05 %*** | 2 | |
| ***betamethasone valerate external cream 0.1 %*** | 1 | |
| ***betamethasone valerate external lotion 0.1 %*** | 1 | |
| ***betamethasone valerate external ointment 0.1 %*** | 1 | |
| ***calcipotriene-betameth diprop external ointment 0.005-0.064 %*** | 3 | SL (60 grams per prescription) |
| ***calcipotriene-betameth diprop external suspension 0.005-0.064 %*** | 3 | SL (60 grams per prescription) |
| CAPEX EXTERNAL SHAMPOO 0.01 % (***fluocinolone acetonide***) | 2 | |
| ***clobetasol prop emollient base external cream 0.05 %*** | 2 | SL (15 grams per prescription) |
| ***clobetasol propionate e external cream 0.05 %*** | 2 | SL (15 grams per prescription) |
| ***clobetasol propionate external cream 0.05 %*** | 2 | SL (15 grams per prescription) |
| ***clobetasol propionate external gel 0.05 %*** | 2 | SL (15 grams per prescription) |
| ***clobetasol propionate external liquid 0.05 %*** | 1 | SL (59 ml per prescription) |
| ***clobetasol propionate external ointment 0.05 %*** | 2 | SL (15 grams per prescription) |
| ***clobetasol propionate external solution 0.05 %*** | 1 | SL (25 ml per prescription) |
| CLOBETAVIX EXTERNAL KIT 0.05 % | 3 | |
| ***clocortolone pivalate external cream 0.1 %*** | 3 | ST; SL (45 grams per prescription) |
| ***clotrimazole-betamethasone external cream 1-0.05 %*** | 1 | SL (15 grams per prescription) |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ***clotrimazole-betamethasone external lotion 1-0.05 %*** | 1 | |
| CORDRAN EXTERNAL OINTMENT 0.05 % (***flurandrenolide***) | 3 | ST |
| CORDRAN EXTERNAL TAPE 4 MCG/SQCM (***flurandrenolide***) | 3 | SL (1 packet per prescription) |
| CORTENEMA RECTAL ENEMA 100 MG/60ML (***hydrocortisone***) | 3 | |
| CORTIFOAM EXTERNAL FOAM 10 % (***hydrocortisone acetate***) | 2 | |
| CORTISPORIN EXTERNAL CREAM 3.5-10000-0.5 (***neomycin-polymyxin-hc***) | 2 | |
| CORTISPORIN EXTERNAL OINTMENT 1 % (***bacit-poly-neo hc***) | 3 | |
| CUTIVATE EXTERNAL LOTION 0.05 % (***fluticasone propionate***) | 3 | ST; SL (60 ml per prescription) |
| DERMA-SMOOTHE/FS BODY EXTERNAL OIL 0.01 % (***fluocinolone acetonide***) | 3 | SL (118.28 ml per prescription) |
| DERMA-SMOOTHE/FS SCALP EXTERNAL OIL 0.01 % (***fluocinolone acetonide***) | 3 | |
| ***hydrocortisone-iodoquinol*** (Dermazene External Cream 1-1 %) | 1 | |
| DESONATE EXTERNAL GEL 0.05 % (***desonide***) | 3 | ST; SL (60 grams per prescription) |
| ***desonide external cream 0.05 %*** | 3 | SL (15 grams per prescription) |
| ***desonide external gel 0.05 %*** | 3 | ST; SL (60 grams per prescription) |
| ***desonide external lotion 0.05 %*** | 3 | SL (60 ml per prescription) |
| ***desonide external ointment 0.05 %*** | 3 | SL (15 grams per prescription) |
| DESOWEN EXTERNAL CREAM 0.05 % (***desonide***) | 3 | SL (15 grams per prescription) |
| ***desoximetasone external cream 0.05 %, 0.25 %*** | 1 | SL (15 grams per prescription) |
| ***desoximetasone external gel 0.05 %*** | 3 | SL (15 grams per prescription) |
| ***desoximetasone external ointment 0.05 %*** | 3 | SL (60 grams per prescription) |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ***desoximetasone external ointment 0.25 %*** | 3 | SL (15 grams per prescription) |
| ***diflorasone diacetate external cream 0.05 %*** | 3 | SL (30 grams per prescription) |
| DIPROLENE AF EXTERNAL CREAM 0.05 % (***betamethasone dipropionate aug***) | 3 | |
| DIPROLENE EXTERNAL OINTMENT 0.05 % (***betamethasone dipropionate aug***) | 3 | |
| ENSTILAR EXTERNAL FOAM 0.005-0.064 % (***calcipotriene-betameth diprop***) | 4 | SL (60 grams per prescription) |
| EPIFOAM EXTERNAL FOAM 1-1 % (***pramoxine-hc***) | 2 | |
| ***fluocinolone acetonide body external oil 0.01 %*** | 3 | SL (118.28 ml per prescription) |
| ***fluocinolone acetonide external cream 0.01 %, 0.025 %*** | 3 | SL (15 grams per prescription) |
| ***fluocinolone acetonide external ointment 0.025 %*** | 2 | SL (15 grams per prescription) |
| ***fluocinolone acetonide external solution 0.01 %*** | 3 | SL (60 ml per prescription) |
| ***fluocinolone acetonide scalp external oil 0.01 %*** | 3 | |
| ***fluocinonide emulsified base external cream 0.05 %*** | 1 | |
| ***fluocinonide external cream 0.05 %*** | 1 | |
| ***fluocinonide external gel 0.05 %*** | 1 | |
| ***fluocinonide external ointment 0.05 %*** | 1 | |
| ***fluocinonide external solution 0.05 %*** | 1 | |
| ***flurandrenolide external cream 0.05 %*** | 3 | ST; SL (120 ml per prescription) |
| ***flurandrenolide external lotion 0.05 %*** | 3 | ST; SL (120 ml per prescription) |
| ***flurandrenolide external ointment 0.05 %*** | 3 | ST |
| ***fluticasone propionate external cream 0.05 %*** | 1 | |
| ***fluticasone propionate external lotion 0.05 %*** | 3 | ST; SL (60 ml per prescription) |
| ***fluticasone propionate external ointment 0.005 %*** | 1 | |
| ***halcinonide external cream 0.1 %*** | 3 | ST; SL (30 grams per prescription) |
| ***halobetasol propionate external cream 0.05 %*** | 2 | SL (15 grams per prescription) |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ***halobetasol propionate external ointment 0.05 %*** | 2 | SL (15 grams per prescription) |
| HALOG EXTERNAL CREAM 0.1 % (***halcinonide***) | 3 | ST; SL (30 grams per prescription) |
| HALOG EXTERNAL OINTMENT 0.1 % (***halcinonide***) | 3 | ST; SL (30 grams per prescription) |
| ***hydrocortisone acetate*** (Hemmorex-Hc Rectal Suppository 25 Mg) | 2 | |
| ***hydrocortisone (perianal) external cream 1 %, 2.5 %*** | 1 | |
| ***hydrocortisone ace-pramoxine external cream 1-1 %, 2.5-1 %*** | 1 | |
| ***hydrocortisone acetate rectal suppository 25 mg, 30 mg*** | 2 | |
| ***hydrocortisone butyrate external cream 0.1 %*** | 1 | |
| ***hydrocortisone butyrate external ointment 0.1 %*** | 1 | |
| ***hydrocortisone butyrate external solution 0.1 %*** | 1 | |
| ***hydrocortisone external cream 2.5 %*** | 1 | |
| ***hydrocortisone external lotion 2.5 %*** | 1 | |
| ***hydrocortisone external ointment 1 %, 2.5 %*** | 1 | |
| ***hydrocortisone rectal enema 100 mg/60ml*** | 1 | |
| ***hydrocortisone valerate external cream 0.2 %*** | 3 | SL (15 grams per prescription) |
| ***hydrocortisone valerate external ointment 0.2 %*** | 3 | SL (15 grams per prescription) |
| ***hydrocortisone-iodoquinol external cream 1-1 %*** | 1 | |
| ***hydrocort-pramoxine (perianal) external cream 2.5-1 %*** | 1 | |
| ***mometasone furoate external cream 0.1 %*** | 1 | |
| ***mometasone furoate external ointment 0.1 %*** | 1 | |
| ***mometasone furoate external solution 0.1 %*** | 1 | |
| ***flurandrenolide*** (Nolix External Cream 0.05 %) | 3 | ST; SL (120 ml per prescription) |
| ***flurandrenolide*** (Nolix External Lotion 0.05 %) | 3 | ST; SL (120 ml per prescription) |
| NUCORT EXTERNAL LOTION 2 % (***hydrocortisone acetate***) | 3 | |
| ***triamcinolone acetonide*** (Oralone Mouth/Throat Paste 0.1 %) | 1 | |
| PANDEL EXTERNAL CREAM 0.1 % (***hydrocortisone probutate***) | 3 | |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ***pramosone external cream 1-1 %*** | 1 | |
| PRAMOSONE EXTERNAL CREAM 1-2.5 % (***pramoxine-hc***) | 3 | |
| PRAMOSONE EXTERNAL LOTION 1-1 %, 1-2.5 % (***pramoxine-hc***) | 2 | |
| PRAMOSONE EXTERNAL OINTMENT 1-1 % (***pramoxine-hc***) | 2 | |
| PRAMOSONE EXTERNAL OINTMENT 1-2.5 % (***pramoxine-hc***) | 3 | |
| ***prednicarbate external cream 0.1 %*** | 1 | |
| ***prednicarbate external ointment 0.1 %*** | 1 | |
| PROCTOFOAM HC EXTERNAL FOAM 1-1 % (***hydrocortisone ace-pramoxine***) | 2 | |
| ***hydrocortisone*** (Procto-Med Hc External Cream 2.5 %) | 1 | |
| ***hydrocortisone*** (Procto-Pak External Cream 1 %) | 1 | |
| ***hydrocortisone*** (Proctosol Hc External Cream 2.5 %) | 1 | |
| ***hydrocortisone*** (Proctozone-Hc External Cream 2.5 %) | 1 | |
| PSORCON EXTERNAL CREAM 0.05 % | 3 | SL (30 grams per prescription) |
| SCALACORT DK EXTERNAL KIT 2 & 2-2 % (***hc & sal acid-sulfur & shampoo***) | 3 | |
| TACLONEX EXTERNAL SUSPENSION 0.005-0.064 % (***calcipotriene-betameth diprop***) | 3 | SL (60 grams per prescription) |
| TEMOVATE EXTERNAL CREAM 0.05 % (***clobetasol propionate***) | 3 | SL (15 grams per prescription) |
| TEMOVATE EXTERNAL OINTMENT 0.05 % (***clobetasol propionate***) | 3 | SL (15 grams per prescription) |
| TEXACORT EXTERNAL SOLUTION 2.5 % (***hydrocortisone***) | 2 | |
| TOPICORT EXTERNAL CREAM 0.05 %, 0.25 % (***desoximetasone***) | 3 | SL (15 grams per prescription) |
| TOPICORT EXTERNAL GEL 0.05 % (***desoximetasone***) | 3 | SL (15 grams per prescription) |
| TOPICORT EXTERNAL OINTMENT 0.05 % (***desoximetasone***) | 3 | SL (60 grams per prescription) |
| TOPICORT EXTERNAL OINTMENT 0.25 % (***desoximetasone***) | 3 | SL (15 grams per prescription) |
| ***triamcinolone acetonide external aerosol solution 0.147 mg/gm*** | 2 | SL (63 grams per prescription) |
| ***triamcinolone acetonide external cream 0.025 %, 0.1 %*** | 1 | |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ***triamcinolone acetonide external cream 0.5 %*** | 1 | SL (15 grams per prescription) |
| ***triamcinolone acetonide external lotion 0.025 %, 0.1 %*** | 1 | |
| ***triamcinolone acetonide external ointment 0.025 %, 0.1 %, 0.5 %*** | 1 | |
| ***triamcinolone acetonide mouth/throat paste 0.1 %*** | 1 | |
| ***triamcinolone acetonide*** (Triderm External Cream 0.1 %) | 1 | |
| ***triamcinolone acetonide*** (Triderm External Cream 0.5 %) | 1 | SL (15 grams per prescription) |
| TRIDESILON EXTERNAL CREAM 0.05 % (***desonide***) | 3 | SL (15 grams per prescription) |
| **HYDROXYPYRIDONES (SKIN, MUCOUS MEMBRANE) - Drugs for the Skin** | | |
| ***ciclopirox*** (Ciclodan External Solution 8 %) | 1 | |
| ***ciclopirox external gel 0.77 %*** | 1 | |
| ***ciclopirox external shampoo 1 %*** | 2 | |
| ***ciclopirox external solution 8 %*** | 1 | |
| ***ciclopirox olamine external cream 0.77 %*** | 1 | |
| ***ciclopirox olamine external suspension 0.77 %*** | 1 | |
| ***ciclopirox treatment external kit 8 %*** | 1 | |
| LOPROX EXTERNAL KIT 0.77 % (***ciclopirox olamine-cleanser***) | 3 | |
| **KERATOLYTIC AGENTS - Drugs for the Skin** | | |
| ***silver nitrate-pot nitrate*** (Arzol Silver Nit Applicators External 75-25 %) | 1 | |
| ***sulfacetamide sodium-sulfur*** (Avar Cleanser External Emulsion 10-5 %) | 1 | |
| ***sulfacetamide sodium-sulfur*** (Avar-E Emollient External Cream 10-5 %) | 3 | |
| ***sulfacetamide sodium-sulfur*** (Avar-E Green External Cream 10-5 %) | 3 | |
| AVAR-E LS EXTERNAL CREAM 10-2 % (***sulfacetamide sodium-sulfur***) | 3 | |
| ***bp 10-1 external emulsion 10-1 %*** | 1 | |
| ***bp cleansing wash external emulsion 10-4 %*** | 1 | |
| ***urea*** (Cerovel External Lotion 40 %) | 1 | |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ***ciclopirox treatment external kit 8 %*** | 1 | |
| ***clindamycin phos-benzoyl perox external gel 1.2-5 %*** | 3 | SL (1 bottle (45 grams) per month.) |
| GORDOFILM EXTERNAL SOLUTION 16.7-16.7 % (***salicylic acid-lactic acid***) | 2 | |
| ***grafco silver nit applicator external 75-25 %*** | 1 | |
| HYDRO 40 EXTERNAL FOAM 40 % (***urea***) | 3 | |
| INOVA 4/1 ACNE CONTROL THERAPY EXTERNAL KIT 4 & 1 & 5 % (***benzoyl perox-salicyl ac-vit e***) | 3 | |
| INOVA 8/2 ACNE CONTROL THERAPY EXTERNAL KIT 8 & 2 & 5 % (***benzoyl perox-salicyl ac-vit e***) | 3 | |
| INOVA EXTERNAL KIT 4 & 5 %, 8 & 5 % (***benzoyl peroxide-vitamin e***) | 3 | |
| KERALAC EXTERNAL CREAM 47 % (***urea***) | 3 | |
| LATRIX XM EXTERNAL EMULSION 45 % (***urea in zn undecyl-lactic acid***) | 2 | |
| ***clindamycin-benzoyl per (refr)*** (Neuac External Gel 1.2-5 %) | 3 | SL (1 bottle (45 grams) per month.) |
| ***salicylic acid external cream 6 %*** | 1 | |
| ***salicylic acid external lotion 6 %*** | 1 | |
| ***salicylic acid external solution 26 %*** | 1 | |
| ***salimez external cream 6 %*** | 1 | |
| SALVAX DUO PLUS EXTERNAL KIT 6 & 35 % (***salicylic acid-urea in lactac***) | 3 | |
| ***silver nitrate external solution 10 %*** | 1 | |
| ***sss 10-5 external cream 10-5 %*** | 1 | |
| ***sss 10-5 external foam 10-5 %*** | 1 | |
| ***sulfacetamide sodium-sulfur external cream 10-2 %, 10-5 %*** | 1 | |
| ***sulfacetamide sodium-sulfur external emulsion 10-5 %*** | 1 | |
| ***sulfacetamide sodium-sulfur external liquid 9-4 %, 9-4.5 %*** | 1 | |
| ***sulfacetamide sodium-sulfur external lotion 10-5 %*** | 1 | |
| ***sulfacetamide sodium-sulfur external pad 10-4 %*** | 1 | |
| ***sulfacetamide sodium-sulfur external suspension 10-5 %*** | 1 | |
| ***sulfacetamide-sulfur in urea external emulsion 10-5 %*** | 1 | |
| SUMAXIN EXTERNAL PAD 10-4 % (***sulfacetamide sodium-sulfur***) | 3 | |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| SUMAXIN WASH EXTERNAL LIQUID 9-4 % (***sulfacetamide sodium-sulfur***) | 3 | |
| ***urea external cream 40 %, 45 %, 47 %*** | 1 | |
| ***urea external cream 41 %*** | 3 | |
| ***urea external lotion 40 %*** | 1 | |
| ***urea nail external gel 45 %*** | 1 | |
| UTOPIC EXTERNAL CREAM 41 % (***urea***) | 3 | |
| ZACARE EXTERNAL KIT 4 & 0.2 %, 8 & 0.2 % (***benzoyl peroxide-hyaluronate***) | 3 | |
| ***zaclir cleansing external lotion 8 %*** | 1 | |
| **KERATOPLASTIC AGENTS - Drugs for the Skin** | | |
| COAL TAR EXTERNAL SOLUTION 20 % | 3 | |
| **LOCAL ANTI-INFECTIVES, MISCELLANEOUS - Drugs for the Skin** | | |
| ALCOHOL PREP PADS PAD | 3 | |
| ALCOHOL PREP PADS PAD 70 % | 3 | |
| ***sulfacetamide sodium-sulfur*** (Avar Cleanser External Emulsion 10-5 %) | 1 | |
| ***sulfacetamide sodium-sulfur*** (Avar-E Emollient External Cream 10-5 %) | 3 | |
| ***sulfacetamide sodium-sulfur*** (Avar-E Green External Cream 10-5 %) | 3 | |
| AVAR-E LS EXTERNAL CREAM 10-2 % (***sulfacetamide sodium-sulfur***) | 3 | |
| BENZALKONIUM CHLORIDE EXTERNAL SOLUTION | 2 | |
| ***benzalkonium chloride external solution 50 %*** | 1 | |
| ***bp 10-1 external emulsion 10-1 %*** | 1 | |
| ***bp cleansing wash external emulsion 10-4 %*** | 1 | |
| ***hydrocortisone-iodoquinol*** (Dermazene External Cream 1-1 %) | 1 | |
| FEM PH VAGINAL GEL 0.9-0.025 % (***acetic acid-oxyquinoline***) | 3 | |
| ***hydrocortisone-iodoquinol external cream 1-1 %*** | 1 | |
| ***iodine tincture external tincture 2 %*** | 1 | |
| KLARON EXTERNAL LOTION 10 % (***sulfacetamide sodium (acne)***) | 3 | |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ***mafenide acetate external packet 5 %*** | 3 | |
| OVACE PLUS EXTERNAL CREAM 10 % (***sulfacetamide sodium***) | 3 | |
| OVACE PLUS EXTERNAL SHAMPOO 10 % (***sulfacetamide sodium***) | 3 | |
| OVACE PLUS WASH EXTERNAL GEL 10 % (***sulfacetamide sodium***) | 3 | |
| OVACE PLUS WASH EXTERNAL LIQUID 10 % (***sulfacetamide sodium***) | 3 | |
| OVACE WASH EXTERNAL LIQUID 10 % (***sulfacetamide sodium***) | 3 | |
| ***selenium sulfide external lotion 2.5 %*** | 1 | |
| ***selenium sulfide external shampoo 2.25 %*** | 3 | |
| SILVADENE EXTERNAL CREAM 1 % (***silver sulfadiazine***) | 3 | |
| ***silver nitrate external solution 0.5 %, 25 %, 50 %*** | 1 | |
| ***silver sulfadiazine external cream 1 %*** | 1 | |
| ***sodium sulfacetamide external shampoo 10 %*** | 1 | |
| ***sodium sulfacetamide wash liquid 10 % external 10 %*** | 1 | |
| SODIUM SULFACETAMIDE WASH LIQUID 10 % EXTERNAL 10 % | 3 | |
| ***silver sulfadiazine*** (Ssd External Cream 1 %) | 1 | |
| ***sss 10-5 external cream 10-5 %*** | 1 | |
| ***sss 10-5 external foam 10-5 %*** | 1 | |
| ***sulfacetamide sodium (acne) external lotion 10 %*** | 1 | |
| ***sulfacetamide sodium external gel 10 % (cleans)*** | 1 | |
| ***sulfacetamide sodium external liquid 10 %*** | 1 | |
| ***sulfacetamide sodium-sulfur external cream 10-2 %, 10-5 %*** | 1 | |
| ***sulfacetamide sodium-sulfur external emulsion 10-5 %*** | 1 | |
| ***sulfacetamide sodium-sulfur external liquid 9-4 %, 9-4.5 %*** | 1 | |
| ***sulfacetamide sodium-sulfur external lotion 10-5 %*** | 1 | |
| ***sulfacetamide sodium-sulfur external pad 10-4 %*** | 1 | |
| ***sulfacetamide sodium-sulfur external suspension 10-5 %*** | 1 | |
| ***sulfacetamide-sulfur in urea external emulsion 10-5 %*** | 1 | |
| SULFAMYLON EXTERNAL CREAM 85 MG/GM (***mafenide acetate***) | 3 | |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| SULFAMYLON EXTERNAL PACKET 5 % (***mafenide acetate***) | 3 | |
| SUMAXIN EXTERNAL PAD 10-4 % (***sulfacetamide sodium-sulfur***) | 3 | |
| SUMAXIN WASH EXTERNAL LIQUID 9-4 % (***sulfacetamide sodium-sulfur***) | 3 | |
| **NONSTEROIDAL ANTI-INFLAMMAT.AGENTS(SKIN) - Drugs for the Skin** | | |
| ***diclofenac sodium transdermal gel 3 %*** | 3 | PA; SL (100 grams per prescription) |
| ***enovarx-ibuprofen external cream 10 %*** | 1 | PA |
| ***enovarx-naproxen external cream 10 %*** | 1 | PA |
| FROTEK EXTERNAL CREAM 10 % (***ketoprofen***) | 3 | PA |
| **OXABOROLES - Drugs for the Skin** | | |
| KERYDIN EXTERNAL SOLUTION 5 % (***tavaborole***) | 3 | PA; ST; SL (4 ml per month.) |
| **PIGMENTING AGENTS - Drugs for the Skin** | | |
| ***methoxsalen rapid oral capsule 10 mg*** | 1 | |
| OXSORALEN ULTRA ORAL CAPSULE 10 MG (***methoxsalen rapid***) | 3 | |
| **POLYENES (SKIN AND MUCOUS MEMBRANE) - Drugs for the Skin** | | |
| ***nystatin*** (Nyamyc External Powder 100000 Unit/Gm) | 1 | SL (120 grams per prescription) |
| ***nystatin external cream 100000 unit/gm*** | 1 | SL (90 grams per prescription) |
| ***nystatin external ointment 100000 unit/gm*** | 1 | SL (90 grams per prescription) |
| ***nystatin external powder 100000 unit/gm*** | 1 | SL (120 grams per prescription) |
| ***nystatin*** (Nystop External Powder 100000 Unit/Gm) | 1 | SL (120 grams per prescription) |
| **SCABICIDES AND PEDICULICIDES - Drugs for the Skin** | | |
| ***crotan external lotion 10 %*** | 2 | |
| ELIMITE EXTERNAL CREAM 5 % (***permethrin***) | 3 | |
| ***lindane external shampoo 1 %*** | 1 | SL (60 ml per prescription) |
| ***malathion external lotion 0.5 %*** | 1 | |
| OVIDE EXTERNAL LOTION 0.5 % (***malathion***) | 3 | |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ***permethrin external cream 5 %*** | 1 | |
| SKLICE EXTERNAL LOTION 0.5 % (***ivermectin***) | 3 | SL (117 grams (1 bottle) per prescription) |
| ***spinosad external suspension 0.9 %*** | 3 | |
| **SKIN AND MUCOUS MEMBRANE AGENTS, MISC. - Drugs for the Skin** | | |
| ***acitretin oral capsule 10 mg, 17.5 mg, 25 mg*** | 1 | |
| ACZONE EXTERNAL GEL 5 %, 7.5 % (***dapsone***) | 3 | SL (60 grams per prescription) |
| ALDARA EXTERNAL CREAM 5 % (***imiquimod***) | 3 | SL (12 packets per prescription) |
| AMELUZ EXTERNAL GEL 10 % (***aminolevulinic acid hcl***) | 3 | |
| ***isotretinoin*** (Amnesteem Oral Capsule 10 Mg, 20 Mg, 40 Mg) | 2 | |
| ARTISS EXTERNAL SOLUTION (***fibrin sealant component***) | 3 | |
| ***azelaic acid external gel 15 %*** | 3 | |
| AZELEX EXTERNAL CREAM 20 % (***azelaic acid***) | 3 | SL (30 grams per prescription) |
| ***balsam peru-castor oil external ointment*** | 1 | |
| BENZOIN EXTERNAL TINCTURE | 3 | |
| ***calcipotriene external cream 0.005 %*** | 2 | SL (60 grams per prescription) |
| ***calcipotriene external ointment 0.005 %*** | 2 | |
| ***calcipotriene external solution 0.005 %*** | 1 | SL (60 mL per prescription) |
| ***calcipotriene-betameth diprop external ointment 0.005-0.064 %*** | 3 | SL (60 grams per prescription) |
| ***calcipotriene-betameth diprop external suspension 0.005-0.064 %*** | 3 | SL (60 grams per prescription) |
| ***calcipotriene*** (Calcitrene External Ointment 0.005 %) | 3 | |
| ***calcitriol external ointment 3 mcg/gm*** | 1 | SL (100 grams per prescription) |
| CARAC EXTERNAL CREAM 0.5 % (***fluorouracil***) | 2 | |
| ***isotretinoin*** (Claravis Oral Capsule 10 Mg, 20 Mg, 30 Mg, 40 Mg) | 2 | |
| CONDYLOX EXTERNAL GEL 0.5 % (***podofilox***) | 3 | |
| COSENTYX (300 MG DOSE) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (***secukinumab***) | 3 | PA; ST; M; SL (2 ml (2 Pens) per month.); SP |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| COSENTYX 150 MG/ML SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (***secukinumab***) | 3 | PA; ST; M; SL (2 ml (2 Pens) per month.); SP |
| COSENTYX SENSOREADY (300 MG) SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (***secukinumab***) | 3 | PA; ST; M; SL (2 ml (2 Pens) per month.); SP |
| COSENTYX SENSOREADY PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (***secukinumab***) | 3 | PA; ST; M; SL (2 ml (2 Pens) per month.); SP |
| ***dapsone external gel 5 %*** | 3 | SL (60 grams per prescription) |
| DEBACTEROL MOUTH/THROAT SOLUTION 30-50 % (***sulfuric acid-sulf phenolics***) | 2 | |
| ***diclofenac sodium transdermal gel 3 %*** | 3 | PA; SL (100 grams per prescription) |
| DOVONEX EXTERNAL CREAM 0.005 % (***calcipotriene***) | 3 | SL (60 grams per prescription) |
| DUPIXENT SUBCUTANEOUS SOLUTION PEN-INJECTOR 300 MG/2ML (***dupilumab***) | 3 | PA; ST; M; SL (4 ml (2 pens) per 10 days) |
| DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/1.14ML (***dupilumab***) | 3 | PA; ST; M; SL (2 syringes per month); SP |
| DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 300 MG/2ML (***dupilumab***) | 3 | PA; ST; M; SL (2 syringes per month.); SP |
| EFUDEX EXTERNAL CREAM 5 % (***fluorouracil***) | 3 | |
| ELIDEL EXTERNAL CREAM 1 % (***pimecrolimus***) | 3 | ST; SL (30 grams per prescription) |
| ENBREL MINI SUBCUTANEOUS SOLUTION CARTRIDGE 50 MG/ML (***etanercept***) | 3 | PA; ST; M; SL (0.15 mg/ml per day.); SP |
| ENBREL SUBCUTANEOUS SOLUTION 25 MG/0.5ML (***etanercept***) | 4 | PA; ST; SL (0.15 ml per day) |
| ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 25 MG/0.5ML, 50 MG/ML (***etanercept***) | 4 | PA; ST; M; SL (0.15 mg/ml per day.); SP |
| ENBREL SUBCUTANEOUS SOLUTION RECONSTITUTED 25 MG (***etanercept***) | 4 | PA; ST; M; SL (0.29 mg per day.); SP |
| ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/ML (***etanercept***) | 4 | PA; ST; M; SL (0.15 mg/ml per day.); SP |
| ***enovarx-baclofen external cream 1 %*** | 1 | PA |
| ***enovarx-cyclobenzaprine hcl transdermal cream 20 mg/gm*** | 1 | PA |
| ENSTILAR EXTERNAL FOAM 0.005-0.064 % (***calcipotriene-betameth diprop***) | 4 | SL (60 grams per prescription) |
| FINACEA EXTERNAL FOAM 15 % (***azelaic acid***) | 3 | |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| FINACEA EXTERNAL GEL 15 % (***azelaic acid***) | 3 | |
| FIRST-MOUTHWASH BLM MOUTH/THROAT SUSPENSION (***dph-lido-alhydr-mghydr-simeth***) | 3 | PA |
| FLUOROPLEX EXTERNAL CREAM 1 % (***fluorouracil***) | 3 | |
| FLUOROURACIL EXTERNAL CREAM 0.5 % | 2 | |
| ***fluorouracil external cream 5 %*** | 1 | |
| ***fluorouracil external solution 2 %, 5 %*** | 1 | |
| ***formaldehyde external solution 10 %*** | 1 | |
| HUMIRA PEDIATRIC CROHNS START SUBCUTANEOUS PREFILLED SYRINGE KIT 80 MG/0.8ML (***adalimumab***) | 2 | PA; M; SL (3 syringes per year.); SP |
| HUMIRA PEN SUBCUTANEOUS PEN-INJECTOR KIT 40 MG/0.4ML (***adalimumab***) | 2 | PA; M; SL (2 pens per month.); SP |
| HUMIRA PEN SUBCUTANEOUS PEN-INJECTOR KIT 40 MG/0.8ML (***adalimumab***) | 2 | PA; M; SL (2 syringes per month.); SP |
| HUMIRA PEN-CD/UC/HS STARTER SUBCUTANEOUS PEN-INJECTOR KIT 40 MG/0.8ML (***adalimumab***) | 2 | PA; M; SL (6 pens (1 kit) per year.); SP |
| HUMIRA PEN-CD/UC/HS STARTER SUBCUTANEOUS PEN-INJECTOR KIT 80 MG/0.8ML (***adalimumab***) | 2 | PA; M; SL (3 pens per year.); SP |
| HUMIRA PEN-PS/UV/ADOL HS START SUBCUTANEOUS PEN-INJECTOR KIT 40 MG/0.8ML (***adalimumab***) | 2 | PA; M; SL (4 pens (1 kit) per year.); SP |
| HUMIRA PEN-PS/UV/ADOL HS START SUBCUTANEOUS PEN-INJECTOR KIT 80 MG/0.8ML & 40MG/0.4ML (***adalimumab***) | 2 | PA; M; SL (3 pens per year.); SP |
| HUMIRA SUBCUTANEOUS PREFILLED SYRINGE KIT 10 MG/0.1ML, 10 MG/0.2ML, 20 MG/0.2ML, 20 MG/0.4ML, 40 MG/0.4ML (***adalimumab***) | 2 | PA; M; SL (2 syringes per month.); SP |
| HUMIRA SUBCUTANEOUS PREFILLED SYRINGE KIT 40 MG/0.8ML (***adalimumab***) | 2 | PA; M; SL (2 syringes per month.) |
| ***imiquimod external cream 5 %*** | 1 | SL (12 packets per prescription) |
| ***isotretinoin oral capsule 10 mg, 20 mg, 30 mg, 40 mg*** | 2 | |
| LEVULAN KERASTICK EXTERNAL SOLUTION RECONSTITUTED 20 % (***aminolevulinic acid hcl***) | 3 | |
| LOPROX EXTERNAL KIT 0.77 % (***ciclopirox olamine-cleanser***) | 3 | |
| MEDROX-RX EXTERNAL OINTMENT 0.05-7-20 % (***capsaicin-menthol-methyl sal***) | 3 | |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| MIRVASO EXTERNAL GEL 0.33 % (***brimonidine tartrate***) | 3 | PA; SL (30 grams per prescription) |
| ***isotretinoin*** (Myorisan Oral Capsule 10 Mg, 20 Mg, 30 Mg, 40 Mg) | 2 | |
| NEURAPTINE EXTERNAL CREAM 10 % (***gabapentin***) | 3 | PA |
| OTEZLA ORAL TABLET 30 MG (***apremilast***) | 4 | PA; SL (2 tablets per day.); SP |
| OTEZLA ORAL TABLET THERAPY PACK 10 & 20 & 30 MG (***apremilast***) | 4 | PA; SL (55 tablets (one starter pack) per year.); SP |
| PANRETIN EXTERNAL GEL 0.1 % (***alitretinoin***) | 3 | |
| PICATO EXTERNAL GEL 0.015 % (***ingenol mebutate***) | 3 | SL (3 grams per prescription) |
| PICATO EXTERNAL GEL 0.05 % (***ingenol mebutate***) | 3 | SL (1 carton (2 tubes) per prescription.) |
| ***pimecrolimus external cream 1 %*** | 3 | ST; SL (30 grams per prescription) |
| ***podocon external solution 25 %*** | 1 | |
| ***podofilox external solution 0.5 %*** | 1 | |
| PYROGALLIC ACID EXTERNAL OINTMENT 25-2 % | 2 | |
| RECTIV RECTAL OINTMENT 0.4 % (***nitroglycerin***) | 3 | SL (30 grams per month.) |
| REGRANEX EXTERNAL GEL 0.01 % (***becaplermin***) | 2 | PA; SL (30 grams per prescription) |
| RHOFADE EXTERNAL CREAM 1 % (***oxymetazoline hcl***) | 3 | PA; SL (30 grams per prescription) |
| SANTYL EXTERNAL OINTMENT 250 UNIT/GM (***collagenase***) | 3 | SL (60 grams per prescription) |
| SKYRIZI (150 MG DOSE) SUBCUTANEOUS PREFILLED SYRINGE KIT 75 MG/0.83ML (***risankizumab-rzaa***) | 4 | PA; M; SL (1 box per 3 months.); SP |
| SOOLANTRA EXTERNAL CREAM 1 % (***ivermectin***) | 3 | SL (45 grams per prescription) |
| SORIATANE ORAL CAPSULE 10 MG, 25 MG (***acitretin***) | 3 | |
| STELARA SUBCUTANEOUS SOLUTION 45 MG/0.5ML (***ustekinumab***) | 2 | PA; M; SP |
| STELARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5ML (***ustekinumab***) | 2 | PA; M; SL (0.5 ml (1 prefilled syringe) per 3 months.); SP |
| STELARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 90 MG/ML (***ustekinumab***) | 2 | PA; M; SL (1 ml (1 prefilled syringe) per 3 months.); SP |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| TACLONEX EXTERNAL SUSPENSION 0.005-0.064 % (***calcipotriene-betameth diprop***) | 3 | SL (60 grams per prescription) |
| ***tacrolimus external ointment 0.03 %, 0.1 %*** | 2 | ST; SL (30 grams per prescription) |
| TARGRETIN EXTERNAL GEL 1 % (***bexarotene***) | 3 | SL (60 grams per prescription); SP |
| ***tazarotene external cream 0.1 %*** | 3 | PA; SL (30 grams per prescription) |
| TAZORAC EXTERNAL CREAM 0.05 %, 0.1 % (***tazarotene***) | 3 | PA; SL (30 grams per prescription) |
| TAZORAC EXTERNAL GEL 0.05 %, 0.1 % (***tazarotene***) | 3 | PA; SL (30 grams per prescription) |
| TISSEEL EXTERNAL KIT 10 ML, 2 ML, 4 ML (***fibrin sealant component***) | 3 | |
| TISSEEL EXTERNAL SOLUTION (***fibrin sealant component***) | 3 | |
| TREMFYA SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 MG/ML (***guselkumab***) | 2 | PA; M; SL (1 ml per 42 days.); SP |
| TREMFYA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (***guselkumab***) | 2 | PA; M; SL (2 ml per 2 months.); SP |
| TRI-CHLOR EXTERNAL LIQUID 80 % (***trichloroacetic acid***) | 2 | |
| VALCHLOR EXTERNAL GEL 0.016 % (***mechlorethamine hcl (topical)***) | 2 | PA; SL (120 grams per prescription); SP |
| VENELEX EXTERNAL OINTMENT (***balsam peru-castor oil***) | 3 | |
| VEREGEN EXTERNAL OINTMENT 15 % (***sinecatechins***) | 3 | ST; SL (30 grams per prescription) |
| ***isotretinoin*** (Zenatane Oral Capsule 10 Mg, 20 Mg, 30 Mg, 40 Mg) | 2 | |
| **SMOOTH MUSCLE RELAXANTS - Drugs to Relax Muscles** | | |
| **ANTIMUSCARINICS - Drugs for the Urinary System** | | |
| ***darifenacin hydrobromide er oral tablet extended release 24 hour 15 mg, 7.5 mg*** | 3 | ST |
| DITROPAN XL ORAL TABLET EXTENDED RELEASE 24 HOUR 10 MG, 5 MG (***oxybutynin chloride***) | 3 | |
| ***flavoxate hcl oral tablet 100 mg*** | 1 | |
| ***oxybutynin chloride er oral tablet extended release 24 hour 10 mg, 15 mg, 5 mg*** | 2 | |
| ***oxybutynin chloride oral syrup 5 mg/5ml*** | 1 | |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ***oxybutynin chloride oral tablet 5 mg*** | 1 | |
| TOVIAZ ORAL TABLET EXTENDED RELEASE 24 HOUR 4 MG, 8 MG (***fesoterodine fumarate***) | 3 | |
| **RESPIRATORY SMOOTH MUSCLE RELAXANTS - Drugs for Lungs** | | |
| ELIXOPHYLLIN ORAL ELIXIR 80 MG/15ML (***theophylline***) | 3 | |
| THEO-24 ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 300 MG, 400 MG (***theophylline***) | 3 | |
| ***theophylline er oral tablet extended release 12 hour 300 mg, 450 mg*** | 1 | |
| ***theophylline er oral tablet extended release 24 hour 400 mg, 600 mg*** | 1 | |
| ***theophylline oral solution 80 mg/15ml*** | 1 | |
| **VITAMINS** | | |
| **MULTIVITAMIN PREPARATIONS** | | |
| ***adc/f (0.5mg/ml) oral solution 0.5 mg/ml*** | 1 | |
| AXONA ORAL PACKET (***dietary management product***) | 3 | |
| ELITE-OB ORAL TABLET 50-1.25 MG (***prenatal vit-iron carbonyl-fa***) | 3 | |
| ENBRACE HR ORAL CAPSULE (***prenat vit-fe gly cys-fa-omega***) | 3 | |
| FLORIVA PLUS ORAL SOLUTION 0.25 MG/ML (***pediatric multivitamins-fl***) | 3 | |
| M-NATAL PLUS ORAL TABLET 27-1 MG | 3 | |
| ***multi-vit/iron/fluoride oral solution 0.25-10 mg/ml*** | 1 | |
| ***multivitamin/fluoride oral solution 0.25 mg/ml, 0.5 mg/ml*** | 1 | |
| ***multi-vitamin/fluoride oral solution 0.25 mg/ml, 0.5 mg/ml*** | 1 | |
| ***multivitamin/fluoride oral tablet chewable 0.25 mg, 0.5 mg, 1 mg*** | 1 | |
| ***multi-vitamin/fluoride/iron oral solution 0.25-10 mg/ml*** | 1 | |
| ***multivitamins/fluoride oral tablet chewable 0.5 mg*** | 1 | |
| NESTABS ORAL TABLET 32-1 MG (***prenat-fe bisgly-fa-w/o vit a***) | 3 | |
| ONEVITE ORAL TABLET 1 MG | 3 | |
| POLY-VI-FLOR ORAL SUSPENSION 0.25 MG/ML (***pediatric multivitamins-fl***) | 3 | |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| POLY-VI-FLOR ORAL TABLET CHEWABLE 0.25 MG, 0.5 MG, 1 MG (***pediatric multivitamins-fl***) | 3 | |
| POLY-VI-FLOR/IRON ORAL SUSPENSION 0.25-7 MG/ML (***ped multivitamins-fl-iron***) | 3 | |
| POLY-VI-FLOR/IRON ORAL TABLET CHEWABLE 0.5-10 MG (***ped multivitamins-fl-iron***) | 3 | |
| PRENAISSANCE ORAL CAPSULE 29-1.25-325 MG | 2 | |
| ***prenatal oral tablet 27-0.8 mg, 27-1 mg, 28-0.8 mg*** | 1 | |
| ***prenatal plus iron oral tablet 29-1 mg*** | 1 | |
| PRENATE DHA ORAL CAPSULE 18-0.6-0.4-300 MG (***prenat-feasp-meth-fa-dha w/o a***) | 3 | |
| PRENATE ELITE ORAL TABLET 20-0.6-0.4 MG (***prenatal-feaspgly-methylfol-fa***) | 3 | |
| PRENATE ENHANCE ORAL CAPSULE 28-0.6-0.4-400 MG (***prenat w/o a-fe-methfol-fa-dha***) | 3 | |
| PRENATE ESSENTIAL ORAL CAPSULE 18-0.6-0.4-300 MG (***prenat-feasp-meth-fa-dha w/o a***) | 3 | |
| PRENATE MINI ORAL CAPSULE 18-0.6-0.4-350 MG (***prenat-fecbn-feasp-meth-fa-dha***) | 3 | |
| PRENATE ORAL TABLET CHEWABLE 0.6-0.4 MG (***prenat mv-min-methylfolate-fa***) | 3 | |
| PRENATE PIXIE ORAL CAPSULE 10-0.6-0.4-200 MG (***prenat-feasp-meth-fa-dha w/o a***) | 3 | |
| PRENATE RESTORE ORAL CAPSULE 27-0.6-0.4-400 MG (***prenat w/o a-fe-methfol-fa-dha***) | 3 | |
| PRIMACARE ORAL CAPSULE 30-1-470 MG (***pren-fe-meth-fa-omeg w/o a***) | 3 | |
| QUFLORA PEDIATRIC ORAL SOLUTION 0.25 MG/ML, 0.5 MG/ML (***pediatric multivitamins-fl***) | 3 | |
| QUFLORA PEDIATRIC ORAL TABLET CHEWABLE 0.25 MG, 0.5 MG, 1 MG (***pediatric multivitamins-fl***) | 3 | |
| RELNATE DHA ORAL CAPSULE 28-1-200 MG | 3 | |
| SELECT-OB ORAL TABLET CHEWABLE 29-1 MG (***prenatal vit-fe psac cmplx-fa***) | 3 | |
| TRICARE PRENATAL DHA ONE ORAL CAPSULE 27-1-500 MG (***prenatal-fefum-fa-dss-fish oil***) | 3 | |
| ***trinate oral tablet*** | 1 | |

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| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| TRI-VI-FLOR ORAL SUSPENSION 0.25 MG/ML, 0.5 MG/ML (***ped vit a-c-d-methylfolate-fl***) | 3 | |
| TRI-VI-FLORO ORAL SUSPENSION 0.25 MG/ML, 0.5 MG/ML | 3 | |
| ***tri-vite/fluoride oral solution 0.25 mg/ml, 0.5 mg/ml*** | 1 | |
| UDAMIN SP ORAL TABLET 1 MG (***multiple vitamins-minerals-fa***) | 3 | |
| VITAFOL FE+ ORAL CAPSULE 90-0.6-0.4-200 MG (***prenat-fe poly-methfol-fa-dha***) | 3 | |
| VITAFOL-OB+DHA ORAL 65-1 & 250 MG (***prenatal mv-min-fe fum-fa-dha***) | 3 | |
| ***vitamins acd-fluoride oral solution 0.25 mg/ml*** | 1 | |
| ***vp-pnv-dha oral capsule 28-1-215.8 mg*** | 1 | |
| **VITAMIN A** | | |
| ***adc/f (0.5mg/ml) oral solution 0.5 mg/ml*** | 1 | |
| ***tri-vite/fluoride oral solution 0.25 mg/ml, 0.5 mg/ml*** | 1 | |
| ***vitamins acd-fluoride oral solution 0.25 mg/ml*** | 1 | |
| **VITAMIN B COMPLEX** | | |
| CITRANATAL BLOOM ORAL TABLET 90-1 MG (***prenatal-dss-fecb-fegl-fa***) | 3 | |
| ***cyanocobalamin injection solution 1000 mcg/ml*** | 1 | M |
| ELITE-OB ORAL TABLET 50-1.25 MG (***prenatal vit-iron carbonyl-fa***) | 3 | |
| ENBRACE HR ORAL CAPSULE (***prenat vit-fe gly cys-fa-omega***) | 3 | |
| ***folic acid oral tablet 1 mg*** | 1 | |
| ***hematinic/folic acid oral tablet 324-1 mg*** | 1 | |
| ***ferrous fumarate-folic acid*** (Hemocyte-F Oral Tablet 324-1 Mg) | 1 | |
| M-NATAL PLUS ORAL TABLET 27-1 MG | 3 | |
| NASCOBAL NASAL SOLUTION 500 MCG/0.1ML (***cyanocobalamin***) | 3 | M |
| NESTABS ORAL TABLET 32-1 MG (***prenat-fe bisgly-fa-w/o vit a***) | 3 | |
| ONEVITE ORAL TABLET 1 MG | 3 | |
| PRENAISSANCE ORAL CAPSULE 29-1.25-325 MG | 2 | |
| ***prenatal oral tablet 27-0.8 mg, 27-1 mg, 28-0.8 mg*** | 1 | |

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|---|---|---|
| ***prenatal plus iron oral tablet 29-1 mg*** | 1 | |
| PRENATE DHA ORAL CAPSULE 18-0.6-0.4-300 MG (***prenat-feasp-meth-fa-dha w/o a***) | 3 | |
| PRENATE ELITE ORAL TABLET 20-0.6-0.4 MG (***prenatal-feaspgly-methylfol-fa***) | 3 | |
| PRENATE ENHANCE ORAL CAPSULE 28-0.6-0.4-400 MG (***prenat w/o a-fe-methfol-fa-dha***) | 3 | |
| PRENATE ESSENTIAL ORAL CAPSULE 18-0.6-0.4-300 MG (***prenat-feasp-meth-fa-dha w/o a***) | 3 | |
| PRENATE MINI ORAL CAPSULE 18-0.6-0.4-350 MG (***prenat-fecbn-feasp-meth-fa-dha***) | 3 | |
| PRENATE ORAL TABLET CHEWABLE 0.6-0.4 MG (***prenat mv-min-methylfolate-fa***) | 3 | |
| PRENATE PIXIE ORAL CAPSULE 10-0.6-0.4-200 MG (***prenat-feasp-meth-fa-dha w/o a***) | 3 | |
| PRENATE RESTORE ORAL CAPSULE 27-0.6-0.4-400 MG (***prenat w/o a-fe-methfol-fa-dha***) | 3 | |
| PRIMACARE ORAL CAPSULE 30-1-470 MG (***pren-fe-meth-fa-omeg w/o a***) | 3 | |
| RELNATE DHA ORAL CAPSULE 28-1-200 MG | 3 | |
| SELECT-OB ORAL TABLET CHEWABLE 29-1 MG (***prenatal vit-fe psac cmplx-fa***) | 3 | |
| TRICARE PRENATAL DHA ONE ORAL CAPSULE 27-1-500 MG (***prenatal-fefum-fa-dss-fish oil***) | 3 | |
| ***trinate oral tablet*** | 1 | |
| UDAMIN SP ORAL TABLET 1 MG (***multiple vitamins-minerals-fa***) | 3 | |
| VITAFOL FE+ ORAL CAPSULE 90-0.6-0.4-200 MG (***prenat-fe poly-methfol-fa-dha***) | 3 | |
| VITAFOL-OB+DHA ORAL 65-1 & 250 MG (***prenatal mv-min-fe fum-fa-dha***) | 3 | |
| ***vp-pnv-dha oral capsule 28-1-215.8 mg*** | 1 | |
| **VITAMIN C** | | |
| ***adc/f (0.5mg/ml) oral solution 0.5 mg/ml*** | 1 | |
| CITRANATAL BLOOM ORAL TABLET 90-1 MG (***prenatal-dss-fecb-fegl-fa***) | 3 | |
| ***tri-vite/fluoride oral solution 0.25 mg/ml, 0.5 mg/ml*** | 1 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ***vitamins acd-fluoride oral solution 0.25 mg/ml*** | 1 | |
| **VITAMIN D** | | |
| ***adc/f (0.5mg/ml) oral solution 0.5 mg/ml*** | 1 | |
| ***calcitriol oral capsule 0.25 mcg, 0.5 mcg*** | 1 | |
| ***calcitriol oral solution 1 mcg/ml*** | 1 | |
| ***d3 high potency oral capsule 25 mcg (1000 ut)*** | 1 | |
| ***d3 super strength oral capsule 50 mcg (2000 ut)*** | 1 | |
| ***decara oral capsule 1.25 mg (50000 ut), 250 mcg (10000 ut)*** | 1 | |
| DECARA ORAL CAPSULE 625 MCG (25000 UT) (***cholecalciferol***) | 3 | |
| ***doxercalciferol oral capsule 0.5 mcg, 1 mcg, 2.5 mcg*** | 1 | |
| DRISDOL ORAL CAPSULE 1.25 MG (50000 UT) (***ergocalciferol***) | 3 | |
| ERGOCAL ORAL CAPSULE 62.5 MCG (2500 UT) | 3 | |
| ***ergocalciferol oral capsule 1.25 mg (50000 ut)*** | 1 | |
| FLORIVA ORAL LIQUID 0.25-400 MG-UNIT/ML (***sodium fluoride-vitamin d***) | 3 | |
| FOSAMAX PLUS D ORAL TABLET 70-2800 MG-UNIT, 70-5600 MG-UNIT (***alendronate-cholecalciferol***) | 3 | |
| ***paricalcitol oral capsule 1 mcg, 2 mcg, 4 mcg*** | 1 | |
| ROCALTROL ORAL CAPSULE 0.25 MCG, 0.5 MCG (***calcitriol***) | 3 | |
| ROCALTROL ORAL SOLUTION 1 MCG/ML (***calcitriol***) | 3 | |
| ***tri-vite/fluoride oral solution 0.25 mg/ml, 0.5 mg/ml*** | 1 | |
| ***vitamin d (ergocalciferol) oral capsule 1.25 mg (50000 ut)*** | 1 | |
| ***vitamin d3 oral capsule 250 mcg (10000 ut)*** | 1 | |
| ***vitamins acd-fluoride oral solution 0.25 mg/ml*** | 1 | |
| ***weekly-d oral capsule 1.25 mg (50000 ut)*** | 1 | |
| ZEMPLAR ORAL CAPSULE 1 MCG, 2 MCG (***paricalcitol***) | 3 | |
| **VITAMIN E** | | |
| WHEAT GERM OIL ORAL OIL | 3 | |
| **VITAMIN K ACTIVITY** | | |
| MEPHYTON ORAL TABLET 5 MG (***phytonadione***) | 3 | SL (5 tablets per prescription) |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

| Prescription Drug Name | Drug Tier | Coverage Requirements & Limits |
|---|---|---|
| ***phytonadione oral tablet 5 mg*** | 3 | SL (5 tablets per prescription) |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: May be part of health care reform preventive; H-N: May be part of health care reform preventives when used for appropriate preventive purposes; SP: Specialty medication (applies to PPO plans only); CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans.

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