Anthem

National Direct Drug List

Drug list — Four Tier Drug Plan

Your prescription benefit comes with a drug list, which is also called a formulary. This list is made up of brand-name and generic prescription drugs approved by the U.S. Food & Drug Administration (FDA).

The following is a list of plan names to which this formulary may apply. Additional plans may be applicable. If you are a current Anthem member with questions about your pharmacy benefits, we're here to help. Just call us at the Pharmacy Member Services number on your ID card.

The product names to which this formulary applies are shown below.

Solution PPO 1500/15/20	$5/$15/$50/$65/30% to $250 after deductible
Solution PPO 2000/20/20	$5/$20/$30/$50/30% to $250
Solution PPO 2500/25/20	$5/$20/$40/$60/30% to $250
Solution PPO 3500/30/30	$5/$20/$40/$60/30% to $250 Rx ded $150
Solution PPO 4500/30/30	$5/$20/$40/$75/30% to $250
Solution PPO 5500/30/30	$5/$20/$40/$75/30% to $250 Rx ded $250
$5/$15/$25/$45/30% to $250	$5/$20/$50/$65/30% to $250 Rx ded $500
$5/$15/$30/$50/30% to $250	$5/$20/$50/$70/30% to $250
$5/$15/$40/$60/30% to $250	$5/$20/$50/$70/30% to $250 after deductible

Here are a few things to remember:

- You can view and search our current drug lists when you visit anthem.com/ca and choose Prescription Benefits. Please note: The formulary is subject to change and all previous versions of the formulary are no longer in effect.
- Additional tools and resources are available for current Anthem members to view the most up-to-date list of drugs for your plan - including drugs that have been added, generic drugs and more – by logging in at anthem.com/ca.
- Your coverage has limitations and exclusions, which means there are certain rules about what's covered by your plan and what isn't. Already a member? You can view your Certificate/Evidence of Coverage or your Summary Plan Description by logging in at anthem.com/ca and go to **My Plan ->Benefits-> Plan Documents**.
- You and your doctor can use this list as a guide to choose drugs that are best for you. Drugs that aren't on this list may not be covered by your plan and may cost you more out of pocket. To help you see how the drug list works with your drug benefit, we've included some frequently asked questions (FAQ) in this document about how the list is set up and what to do if a drug you take isn't on it.

National Direct Drug List

Four Tier

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National Direct Drug List – Informational Section

Definitions

"$0" next to a drug means this is a preventive drug. For some members, this product may be covered at 100% with $0 cost share with a prescription from your provider if specified criteria are met.

"BRAND name drug" means a drug that is marketed under a proprietary, trademark-protected name. A BRAND name drug is listed in this formulary in all CAPITAL letters.

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

"Dose Optimization (DO)" means dose optimization. Usually, this means you may have to switch from taking a drug twice a day to taking it once a day at a higher strength.

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

"Exception request" 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" means the list of drugs that is covered by your health insurance policy under the prescription drug benefit of the policy.

"Generic drug" means a drug that is the same as its BRAND name drug equivalent in dosage, strength, effect, how it is taken, quality, safety, and intended use. A generic drug is listed in this formulary in italicized lowercase letters.

"Limited Distribution (LD)" means limited distribution. These drugs are available only through certain pharmacies or wholesalers, depending on what the manufacturer decides.

"Medically Necessary" means health care benefits needed to diagnose, treat, or prevent a medical condition or its symptoms and that meet accepted standards of medicine. Health insurance usually does not cover health care benefits that are not medically necessary.

"Non-formulary drug" means a prescription drug that is not listed on this formulary.

"Oral Chemotherapy (OC)" Notwithstanding any deductible, the total amount of copayments and coinsurance an insured is required to pay shall not exceed two hundred dollars ($200) for an individual prescription of up to a 30-day supply of a prescribed orally administered anticancer medication covered by the policy.

“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 to be provided to a specific individual.

“Prescription drug” means a drug that by law requires a prescription.

“Prior Authorization (PA)” means a decision by your health insurer that a health care benefit is medically necessary for you. If a prescription drug is subject to prior authorization in this formulary, your prescribing provider must request approval from your health insurer to cover the drug before you fill your prescription. Your health insurer must grant a prior authorization request when it is medically necessary for you to take the drug.

“Quantity limit (QL)” means a restriction on the number of doses of a prescription drug covered by a health insurance product during a specific time period, or any other limitation on the quantity of a drug that is covered.
“Specialty Drugs (SP)” means specialty drugs. Specialty drugs are used to treat difficult, long-term conditions. You may need to get this drug through a specialty pharmacy.

“Step therapy (ST)” means a specific sequence in which prescription drugs for a particular medical condition must be tried. If a drug is subject to step therapy in this formulary, you may have to try one or more other drugs before your health insurance policy will cover that drug for your medical condition. If your prescribing provider submits a request for an exception to the step therapy requirement, your health insurer must grant the request when it is medically necessary for you to take the drug.

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Frequently Asked Questions

How do I know what drugs are covered under my benefits?
This is a complete listing of all the drugs on the drug list. But, it's possible a drug(s) on this list may not be covered, depending on your plan's design.

Your pharmacy benefit covers prescription drugs, including Specialty Drugs, that may be administered to you as part of a doctor's visit, home care visit, or at an outpatient Facility when they are Covered Services. Benefits that are administered to you in your provider's office are typically covered under your medical benefit. This may include Drugs for infusion therapy, chemotherapy, blood products, certain injectables and any drug that must be administered by a Provider.

How can I find a drug on the list?
(A) A prescription drug may be located by looking up the therapeutic category and class to which the drug belongs or the BRAND name or ***generic*** name of the drug in the alphabetical index; and
(B) 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.

You can search the PDF drug list by:

- Drug name, using Ctrl + F on your keyboard, then type in the name of the drug you're looking for.
- Drug class, using the categories listed in alphabetical order.

How are drugs shown on the list?

- A drug is listed alphabetically by its BRAND name and ***generic*** names in the therapeutic category and class to which it belongs;
- The ***generic*** name for a BRAND name drug is included after the BRAND name in parentheses and all ***bold and italicized lowercase*** letters;

PSEUDOBULBAR AFFECT (PBA) AGENTS, NMDA ANTAGONISTS TYPE - DRUGS FOR SEVERE MENTAL DISORDERS
NUEDEXTA ORAL CAPSULE (***dextromethorphan***)

- 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 ***bold and italicized lowercase letters***; and

AMINOPENICILLIN ANTIBIOTIC - ANTIBIOTICS
amoxicillin oral capsule

- 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.

levonorgestrel-ethinyl estrad (Portia 28 Oral Tablet)

The "Under Coverage Requirements and Limits" section will indicate if you need preapproval before you can take the drug (called prior authorization or PA), or if you need to try other drugs first for your treatment (called step therapy or ST).

Note: The presence of a prescription drug on the formulary does not guarantee that your doctor will prescribe that prescription drug for a particular medical condition.

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What are my options for getting my prescriptions?
You have plenty of choices about how and where to get your prescription medicines, including local pharmacies in your plan, convenient home delivery or specialty pharmacies. Most plans include our home delivery program at no extra cost to you.

Current Anthem members can find out more by logging in at anthem.com/ca and choose Prescription Benefits or call 833-236-6196. For more details about your coverage, you can call the phone number on your member ID card.

What if my drug isn't on the list?
We understand that only you and your doctor know what is best for you. If you want to take a drug that's not on the drug list, you may have to pay the full cost for it. You can also talk to your doctor or pharmacist to see if there's another drug covered by your plan that will work just as well, or if generic or OTC drugs are an option. Only you and your doctor can decide what drugs are right for you.

If a drug you're taking isn't covered, your doctor can ask us to review the coverage. This process is called preapproval or prior authorization.

Your doctor can get the process started by completing an electronic Prior Authorization, calling the Member Services number on the back of your member ID card or by downloading a prior authorization form from our website and submitting it. If your request is approved, the amount you pay for the drug will depend on your plan's benefit.

There are a few options for your doctor to start the Prior Authorization (PA) process:

1. Submit an electronic PA request by going to https://www.covermymeds.com/main/partners/anthem.
2. Log in at anthem.com/ca and choose **Pharmacy**.
    - Go to **Pharmacy Resources** and **Search Your Drug List** for your medication.
    - Choose the correct medication strength and form.
    - Scroll down to **Definition of Restrictions** and locate the applicable Fax Form in the table.
    - Your doctor completes and faxes the form to us at 844-474-3347.
3. Calling Member Services number on the back of your member ID card.

If the contraceptive you are taking is not on the formulary, your doctor can contact us if it is medically necessary because the preferred contraceptives are inappropriate for you, and we will waive your cost share.

Who decides what drugs are on the list?
The drugs on the list are reviewed through our Pharmacy and Therapeutics (P&T) process. In this process, a group of independent doctors, pharmacists and other health care professionals decides which drugs we include on our lists. This group meets regularly to look at new and existing drugs and recommends drugs based on how safe they are, how well they work and the value they offer our members.

What is a specialty drug and how do I get them?
If you're taking a medicine that is considered a specialty drug, you may need to use a specialty pharmacy in order for your drug to be covered. Specialty drugs come in many forms like pills, liquids, injections (shots), infusions or inhalers and may need special storage and handling. Typically benefits for specialty drugs that are self-administered will be covered under the pharmacy benefit. Benefits for specialty drugs that are administered to you in your provider's office are typically covered under your medical benefit. If you use pharmacies that are not in the network, your medicine may not be covered and you may have to pay the full cost. For more details about your coverage, you can call the phone number on your member ID card.

Does the drug list change, and how will I know if it does?
Drugs on our list are reviewed and updated on a monthly basis. Sometimes, drugs are added, removed, change tiers or have updated requirements. The changes will usually go into effect the first day of the month. But don't worry, we'll let you know if a drug you take is taken off the list and, in some cases, if a drug you take is moved to a higher tier.

You can always check the drug list to make sure medicines you take are still on it. You'll find the most up-to-date drug list when you log in at anthem.com/ca.

What kind of drugs can I find on the formulary?
We cover FDA-approved preventive care drugs with zero cost share in compliance with the Affordable Care Act (ACA) and California state regulations. Your doctor may need to write a prescription for these preventive services to be covered by your plan, even if they are listed as over-the-counter. The availability or coverage of these medications without cost-sharing may be subject to criteria established by the health plan.

We cover FDA-approved equipment and supplies for the management and treatment of insulin-using diabetes, non-insulin-using diabetes and gestational diabetes as medically necessary. Medication encompasses insulin, insulin pumps, and oral hypoglycemic agents. Covered supplies and equipment are limited to glucose monitors, test strips, syringes and lancets. Covered benefits also include outpatient self-management and educational services used to treat diabetes if services are provided through a program authorized by the State's Diabetes Control Project within the Bureau of Health.

What drugs can I find in each tier?
We place drugs on different tiers based on how well they work to improve health, whether there are over-the-counter (OTC) options and their costs compared to other drugs used for the same type of treatment. The lower the tier, the lower your share of the cost. Here's a breakdown of the tiers in your plan:

- Tier 1 drugs have the lowest cost share for you. These are usually generic drugs that offer the best value compared to other drugs that treat the same conditions. Some plans split Tier 1 into Tier 1a and Tier 1b:
    - Tier 1a drugs have the lowest cost share. These are often generic drugs that offer the greatest value compared to others that treat the same conditions.
    - Tier 1b drugs have a low cost share. These are typically generic drugs that offer the greatest value compared to others that treat the same conditions.
- Tier 2 drugs have a higher cost share than Tier 1. They may be preferred brand drugs, based on how well they work and their cost compared to other drugs used for the same type of treatment. Some are generic drugs that may cost more because they're newer to the market.
- Tier 3 drugs have the highest cost share. They often include brand and generic drugs that may cost more than drugs on lower tiers that are used to treat the same condition. Tier 3 may also include drugs that were recently approved by the FDA or specialty drugs that are used to treat serious, long-term health conditions and that may need special handling.
- Tier 4 drugs have the highest cost share and usually include specialty BRAND and generic drugs. They may cost more than drugs on lower tiers that are used to treat the same condition. Tier 4 may also include drugs recently approved by the FDA or specialty drugs used to treat serious, long-term health conditions and that may need special handling.

How will I know if my drug is covered and how much will it cost?
You can go online and with the Price a Medication tool, get pharmacy-specific drug coverage details and pricing from a number of local retail pharmacies in your zip code.

Note: For oral chemotherapy drugs - Notwithstanding any deductible, the total amount of copayments and coinsurance an insured is required to pay shall not exceed two hundred dollars ($200) for an individual prescription of up to a 30-day supply of a prescribed orally administered anticancer medication covered by the policy.

How does Anthem promote safety?
When you go to a pharmacy, the pharmacist will get an electronic message from Anthem if a drug needs prior authorization, requires step therapy or has a limit on the amount that can be given. Here's a closer look at all of the programs we've put into place to help make sure you get the care you need, while helping to keep you safe.[1]

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Our clinical edit programs are:

- Prior authorization, which requires you to get approval before taking a medicine. This helps make sure a drug is used properly and focuses on drugs that may have:
  - Risk of side effects.
  - Risk of harmful effects when taken with other drugs.
  - Potential for incorrect use or abuse.
  - Rules for use with certain conditions.
- Step therapy, which requires that other drugs be tried first. It focuses on whether a drug is right for your condition.
- Dose optimization, which involves changing from taking a dose twice a day to once a day, when medically appropriate. Taking fewer doses may lower your costs; a single higher dose of a drug taken once a day may cost less than a lower dose taken twice a day.
- Quantity Limits impose a limit on the amount in a prescription and how often it can be refilled.
  - If a refill request is submitted too soon or the doctor prescribes an amount that's higher than what is allowed, the drug won't be covered at that time.
  - If there are medical reasons to prescribe the drug as originally dosed, the doctor can ask for review by our Prior Authorization Center.

Also, If you're taking a medicine that is considered a specialty drug, you may need to use a specialty pharmacy in order for your drug to be covered.

How does my doctor start the Prior Authorization process?

If your drug is on our formulary but requires a PA or Step Therapy, there are a few options for your doctor to start the Prior Authorization (PA) process:

1. Submit an electronic PA request by going to https://www.covermymeds.com/main/partners/anthem.
2. Log in at anthem.com/ca and choose Pharmacy.
   - Go to Pharmacy Resources and Search Your Drug List for your medication.
   - Choose the correct medication strength and form.
   - Scroll down to Definition of Restrictions and locate the applicable Fax Form in the table.
   - Your doctor completes the form and faxes it to Anthem at 844-474-3347.
3. Calling Pharmacy Member Services number on the back of your member ID card.

What is Step Therapy? How does it work?

Step therapy requires trying other drugs before certain medications may be covered. The pharmacy will let you know if step therapy is required and you must first try the drug or treatment included in the program. If the drug or treatment does not treat the condition well, the doctor can contact our Prior Authorization Center to ask that we approve the original drug.[1]

A note about opioid analgesics. The member cost share for certain abuse-deterrent opioid analgesics may be lower in some states because of laws in those states. Opioid analgesics are a type of painkiller. In response to the global opioid epidemic, the U.S. Food and Drug Administration (FDA) has encouraged drug manufacturers to develop opioids with properties that help deter their misuse and abuse.

Drug(s) may be excluded from the list based on your plan's benefit design.

[1] If the Prior Authorization Center concludes the prescription claim should be denied, members and their doctors will get letters that explain the appeals and/or grievance process.

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KEY
Here are some terms and notes you'll find on the drug list.

BRAND name drugs are in UPPER CASE, plain type.

generic drugs are in lower case, italic bold type.

$0 = preventive drugs. For some members, this product may be covered at 100% with $0 cost share with a prescription from your provider if specified criteria are met.

BE = benefit exclusion. This drug may not be covered depending on your plans design. To find out if your drug is covered, log into your member portal or use the Sydney app to Price a Medication and refer to your plan documents.

DO = dose optimization. Usually, this means you may have to switch from taking a drug twice a day to taking it once a day at a higher strength.

LD = limited distribution. These drugs are available only through certain pharmacies or wholesalers, depending on what the manufacturer decides.

OC = oral chemotherapy. These drugs after deductible shall not exceed $200 per an individual prescription for up to a 30 day supply.

PA = prior authorization. You may need to get benefits approved before certain prescriptions can be filled.

QL = quantity limits. There are limits on the amount of medicine covered within a certain amount of time.

SP = specialty drugs. Specialty drugs are used to treat difficult, long-term conditions. You may need to get this drug through a specialty pharmacy.

ST = step therapy. You may need to use another recommended drug first before a prescribed drug is covered.

Tier 1 = drugs have the lowest cost share for you. These are usually generic drugs that offer the best value compared to other drugs that treat the same conditions.

Tier 1a = drugs have the lowest cost share. These are often generic drugs that offer the greatest value compared to others that treat the same conditions.

Tier 1b = drugs have a low cost share. These are typically generic drugs that offer the greatest value compared to others that treat the same conditions.

Tier 2 = drugs have a higher cost share than Tier 1. They may be preferred brand drugs, based on how well they work and their cost compared to other drugs used for the same type of treatment. Some are generic drugs that may cost more because they're newer to the market.

Tier 3 = drugs have a higher cost share. They often include brand and generic drugs that may cost more than drugs on lower tiers that are used to treat the same condition.

Tier 4 = Tier 4 drugs have a higher cost share and usually include preferred specialty brand and generic drugs.

Four Tier

CURRENT AS OF 2/1/2024

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
***ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS* - DRUGS FOR THE NERVOUS SYSTEM**		
ADHD AGENT - SELECTIVE ALPHA ADRENERGIC AGONISTS - DRUGS FOR ATTENTION DEFICIT DISORDER**		
clonidine hcl er oral tablet extended release 12 hour	1 or 1b*	PA; QL (4 tablets per 1 day)
guanfacine hcl er oral tablet extended release 24 hour 1 mg, 2 mg	1 or 1b*	PA; DO
guanfacine hcl er oral tablet extended release 24 hour 3 mg, 4 mg	1 or 1b*	PA; QL (1 tablet per 1 day)
ADHD AGENT - SELECTIVE NOREPINEPHRINE REUPTAKE INHIBITOR - DRUGS FOR ATTENTION DEFICIT DISORDER**		
atomoxetine hcl oral capsule 10 mg, 18 mg, 25 mg, 40 mg	1 or 1b*	PA; DO
atomoxetine hcl oral capsule 100 mg, 60 mg, 80 mg	1 or 1b*	PA; QL (1 capsule per 1 day)
AMPHETAMINE MIXTURES - DRUGS FOR ATTENTION DEFICIT DISORDER**		
amphetamine-dextroamphet er oral capsule extended release 24 hour 10 mg, 15 mg, 5 mg	1 or 1b*	PA; DO
amphetamine-dextroamphet er oral capsule extended release 24 hour 20 mg, 25 mg, 30 mg	1 or 1b*	PA; QL (1 capsule per 1 day)
amphetamine-dextroamphetamine oral tablet 10 mg, 12.5 mg, 15 mg, 5 mg, 7.5 mg	1 or 1b*	PA; DO
amphetamine-dextroamphetamine oral tablet 20 mg	1 or 1b*	PA; QL (3 tablets per 1 day)
amphetamine-dextroamphetamine oral tablet 30 mg	1 or 1b*	PA; QL (2 tablets per 1 day)
amphet-dextroamphet 3-bead er oral capsule extended release 24 hour	1 or 1b*	PA; QL (1 capsule per 1 day)
AMPHETAMINES - DRUGS FOR ATTENTION DEFICIT DISORDER**		
amphetamine sulfate oral tablet 10 mg	1 or 1b*	QL (6 tablets per 1 day)
amphetamine sulfate oral tablet 5 mg	1 or 1b*	DO
dextroamphetamine sulfate er oral capsule extended release 24 hour 10 mg, 15 mg	1 or 1b*	PA; QL (4 capsules per 1 day)
dextroamphetamine sulfate er oral capsule extended release 24 hour 5 mg	1 or 1b*	PA; DO
dextroamphetamine sulfate oral solution	1 or 1b*	PA; QL (60 mL per 1 day)
dextroamphetamine sulfate oral tablet 10 mg	1 or 1b*	PA; QL (6 tablets per 1 day)
dextroamphetamine sulfate oral tablet 15 mg	1 or 1b*	PA; QL (3 tablets per 1 day)
dextroamphetamine sulfate oral tablet 2.5 mg, 7.5 mg	1 or 1b*	
dextroamphetamine sulfate oral tablet 20 mg, 30 mg	1 or 1b*	PA; QL (2 tablets per 1 day)
dextroamphetamine sulfate oral tablet 5 mg	1 or 1b*	PA; DO
lisdexamfetamine dimesylate oral capsule 10 mg	1 or 1b*	PA
lisdexamfetamine dimesylate oral capsule 20 mg, 30 mg	1 or 1b*	PA; DO
lisdexamfetamine dimesylate oral capsule 40 mg	1 or 1b*	PA; QL (1 tablet per 1 day)
lisdexamfetamine dimesylate oral capsule 50 mg, 60 mg, 70 mg	1 or 1b*	PA; QL (1 capsule per 1 day)
lisdexamfetamine dimesylate oral tablet chewable 10 mg, 20 mg, 30 mg	1 or 1b*	PA; DO

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
lisdexamfetamine dimesylate oral tablet chewable 40 mg, 50 mg, 60 mg	1 or 1b*	PA; QL (1 tablet per 1 day)
procentra oral solution	1 or 1b*	PA; QL (60 mL per 1 day)
VYVANSE ORAL CAPSULE 10 MG, 20 MG, 30 MG (*lisdexamfetamine dimesylate*)	2	PA; DO
VYVANSE ORAL CAPSULE 40 MG, 50 MG, 60 MG, 70 MG (*lisdexamfetamine dimesylate*)	2	PA; QL (1 capsule per 1 day)
VYVANSE ORAL TABLET CHEWABLE 10 MG, 20 MG, 30 MG (*lisdexamfetamine dimesylate*)	2	PA; DO
VYVANSE ORAL TABLET CHEWABLE 40 MG, 50 MG, 60 MG (*lisdexamfetamine dimesylate*)	2	PA; QL (1 tablet per 1 day)
zenzedi oral tablet 10 mg, 7.5 mg	1 or 1b*	PA; QL (6 tablets per 1 day)
zenzedi oral tablet 15 mg	1 or 1b*	PA; QL (3 tablets per 1 day)
zenzedi oral tablet 2.5 mg, 5 mg	1 or 1b*	PA; DO
zenzedi oral tablet 20 mg, 30 mg	1 or 1b*	PA; QL (2 tablets per 1 day)
ANALEPTICS - DRUGS FOR THE NERVOUS SYSTEM**		
caffeine citrate intravenous solution	1 or 1b*	
caffeine citrate oral solution	1 or 1b*	
DOPRAM INTRAVENOUS SOLUTION (*doxapram hcl*)	3	
ANOREXIANTS NON-AMPHETAMINE - DRUGS FOR THE NERVOUS SYSTEM**		
ADIPEX-P ORAL TABLET (*phentermine hcl*)	3	PA; BE; QL (1 tablet per 1 day)
benzphetamine hcl oral tablet	1 or 1b*	PA; BE; QL (3 tablets per 1 day)
diethylpropion hcl er oral tablet extended release 24 hour	1 or 1b*	PA; BE; QL (1 tablet per 1 day)
diethylpropion hcl oral tablet	1 or 1b*	PA; BE; QL (3 tablets per 1 day)
LOMAIRA ORAL TABLET (*phentermine hcl*)	3	PA; BE; QL (3 tablets per 1 day)
PHENDIMETRAZINE TARTRATE ER ORAL CAPSULE EXTENDED RELEASE 24 HOUR	3	PA; BE; QL (1 capsule per 1 day)
phendimetrazine tartrate oral tablet	1 or 1b*	PA; BE; QL (6 tablets per 1 day)
phentermine hcl oral capsule	1 or 1b*	PA; BE; QL (1 capsule per 1 day)
phentermine hcl oral tablet	1 or 1b*	PA; BE; QL (1 tablet per 1 day)
ANTI-OBESITY - GLP-1 RECEPTOR AGONISTS - DRUGS FOR THE NERVOUS SYSTEM**		
SAXENDA SUBCUTANEOUS SOLUTION PEN-INJECTOR (*liraglutide - weight management*)	3	PA; BE; QL (3 mg per 1 day)
WEGOVY SUBCUTANEOUS SOLUTION AUTO-INJECTOR (*semaglutide-weight management*)	2	PA; BE; QL (1 pen per 1 week)
DOPAMINE AND NOREPINEPHRINE REUPTAKE INHIBITORS (DNRIS) - DRUGS FOR SLEEP DISORDER**		
SUNOSI ORAL TABLET 150 MG (*solriamfetol hcl*)	3	PA; QL (1 tablet per 1 day)
SUNOSI ORAL TABLET 75 MG (*solriamfetol hcl*)	3	PA; DO
HISTAMINE H3-RECEPTOR ANTAGONIST/INVERSE AGONISTS - DRUGS FOR SLEEP DISORDER**		
WAKIX ORAL TABLET 17.8 MG (*pitolisant hcl*)	4	PA; LD; QL (2 tablets per 1 day); SP
WAKIX ORAL TABLET 4.45 MG (*pitolisant hcl*)	4	PA; LD; DO; SP

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LIPASE INHIBITORS - DRUGS FOR THE NERVOUS SYSTEM**		
orlistat oral capsule	1 or 1b*	PA; BE; QL (3 capsules per 1 day)
MELANOCORTIN 4 (MC4) RECEPTOR AGONISTS - DRUGS FOR THE NERVOUS SYSTEM**		
IMCIVREE SUBCUTANEOUS SOLUTION (*setmelanotide acetate*)	4	PA; LD; BE; QL (9 vials per 30 days)
STIMULANTS - MISC. - DRUGS FOR ATTENTION DEFICIT DISORDER**		
armodafinil oral tablet 150 mg, 200 mg, 250 mg	1 or 1b*	PA; QL (1 tablet per 1 day)
armodafinil oral tablet 50 mg	1 or 1b*	PA; QL (2 tablets per 1 day)
dexmethylphenidate hcl er oral capsule extended release 24 hour 10 mg, 15 mg, 20 mg	1 or 1b*	ST; DO
dexmethylphenidate hcl er oral capsule extended release 24 hour 25 mg	1 or 1b*	ST; QL (1 capsule per 1 day)
dexmethylphenidate hcl er oral capsule extended release 24 hour 30 mg, 35 mg, 40 mg	1 or 1b*	PA; QL (1 capsule per 1 day)
dexmethylphenidate hcl er oral capsule extended release 24 hour 5 mg	1 or 1b*	PA; DO
dexmethylphenidate hcl oral tablet 10 mg	1 or 1b*	PA; QL (2 tablets per 1 day)
dexmethylphenidate hcl oral tablet 2.5 mg, 5 mg	1 or 1b*	PA; DO
methylphenidate hcl er (cd) oral capsule extended release 10 mg, 20 mg, 30 mg	1 or 1b*	PA; DO
methylphenidate hcl er (cd) oral capsule extended release 40 mg, 50 mg, 60 mg	1 or 1b*	PA; QL (1 capsule per 1 day)
methylphenidate hcl er (la) oral capsule extended release 24 hour 10 mg, 20 mg	1 or 1b*	PA; DO
methylphenidate hcl er (la) oral capsule extended release 24 hour 30 mg	1 or 1b*	PA; QL (2 capsules per 1 day)
methylphenidate hcl er (la) oral capsule extended release 24 hour 40 mg, 60 mg	1 or 1b*	PA; QL (1 capsule per 1 day)
methylphenidate hcl er (osm) oral tablet extended release 18 mg, 27 mg	1 or 1b*	PA; DO
methylphenidate hcl er (osm) oral tablet extended release 36 mg	1 or 1b*	PA; QL (2 tablets per 1 day)
methylphenidate hcl er (osm) oral tablet extended release 54 mg	1 or 1b*	PA; QL (1 tablet per 1 day)
methylphenidate hcl er (xr) oral capsule extended release 24 hour 10 mg, 15 mg, 20 mg, 30 mg	1 or 1b*	PA; DO
methylphenidate hcl er (xr) oral capsule extended release 24 hour 40 mg, 50 mg, 60 mg	1 or 1b*	PA; QL (1 capsule per 1 day)
methylphenidate hcl er oral tablet extended release 10 mg	1 or 1b*	PA; DO
methylphenidate hcl er oral tablet extended release 20 mg	1 or 1b*	PA; QL (3 tablets per 1 day)
methylphenidate hcl er oral tablet extended release 24 hour	1 or 1b*	PA; DO
methylphenidate hcl oral solution 10 mg/5ml	1 or 1b*	PA; QL (30 mL per 1 day)
methylphenidate hcl oral solution 5 mg/5ml	1 or 1b*	PA; QL (60 mL per 1 day)
methylphenidate hcl oral tablet 10 mg, 5 mg	1 or 1b*	PA; DO
methylphenidate hcl oral tablet 20 mg	1 or 1b*	PA; QL (3 tablets per 1 day)
methylphenidate hcl oral tablet chewable 10 mg	1 or 1b*	PA; QL (3 tablets per 1 day)
methylphenidate hcl oral tablet chewable 2.5 mg	1 or 1b*	ST; DO
methylphenidate hcl oral tablet chewable 5 mg	1 or 1b*	PA; DO
methylphenidate transdermal patch 10 mg/9hr, 15 mg/9hr	1 or 1b*	ST; DO
methylphenidate transdermal patch 20 mg/9hr, 30 mg/9hr	1 or 1b*	ST; QL (1 patch per 1 day)

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
modafinil oral tablet 100 mg	1 or 1b*	PA; DO
modafinil oral tablet 200 mg	1 or 1b*	PA; QL (1 tablet per 1 day)
***ALLERGENIC EXTRACTS/BIOLOGICALS MISC* - BIOLOGICAL AGENTS**		
ALLERGENIC EXTRACTS - BIOLOGICAL AGENTS**		
GRASTEK SUBLINGUAL TABLET SUBLINGUAL (*timothy grass pollen allergen*)	3	PA; QL (1 tablet per 1 day)
PALFORZIA (12 MG DAILY DOSE) ORAL (*peanut powder-dnfp*)	4	PA; LD; QL (1 kit per 1 fill); SP
PALFORZIA (120 MG DAILY DOSE) ORAL (*peanut powder-dnfp*)	4	PA; LD; QL (1 kit per 1 fill); SP
PALFORZIA (160 MG DAILY DOSE) ORAL (*peanut powder-dnfp*)	4	PA; LD; QL (1 kit per 1 fill); SP
PALFORZIA (20 MG DAILY DOSE) ORAL (*peanut powder-dnfp*)	4	PA; LD; QL (1 kit per 1 fill); SP
PALFORZIA (200 MG DAILY DOSE) ORAL (*peanut powder-dnfp*)	4	PA; LD; QL (1 kit per 1 fill); SP
PALFORZIA (240 MG DAILY DOSE) ORAL (*peanut powder-dnfp*)	4	PA; LD; QL (1 kit per 1 fill); SP
PALFORZIA (3 MG DAILY DOSE) ORAL (*peanut powder-dnfp*)	4	PA; LD; QL (1 kit per 1 fill); SP
PALFORZIA (300 MG MAINTENANCE) ORAL PACKET (*peanut powder-dnfp*)	4	PA; LD; QL (1 packet per 1 day); SP
PALFORZIA (300 MG TITRATION) ORAL PACKET (*peanut powder-dnfp*)	4	PA; LD; QL (1 kit per 1 fill); SP
PALFORZIA (40 MG DAILY DOSE) ORAL (*peanut powder-dnfp*)	4	PA; LD; QL (1 kit per 1 fill); SP
PALFORZIA (6 MG DAILY DOSE) ORAL (*peanut powder-dnfp*)	4	PA; LD; QL (1 kit per 1 fill); SP
PALFORZIA (80 MG DAILY DOSE) ORAL (*peanut powder-dnfp*)	4	PA; LD; QL (1 kit per 1 fill); SP
PALFORZIA INITIAL ESCALATION ORAL (*peanut powder-dnfp*)	4	PA; LD; QL (1 kit per 1 fill); SP
RAGWITEK SUBLINGUAL TABLET SUBLINGUAL (*short ragweed pollen ext*)	3	PA; QL (1 tablet per 1 day)
MIXED ALLERGENIC EXTRACTS - BIOLOGICAL AGENTS**		
ODACTRA SUBLINGUAL TABLET SUBLINGUAL (*dust mite mixed allergen ext*)	3	PA; QL (1 tablet per 1 day)
ORALAIR SUBLINGUAL TABLET SUBLINGUAL (*grass mix pollens allergen ext*)	3	PA; QL (1 tablet per 1 day)
***AMEBICIDES* - DRUGS FOR INFECTIONS**		
AMEBICIDES - DRUGS FOR PARASITES**		
SOLOSEC ORAL PACKET (*secnidazole*)	3	PA; QL (2 grams per 1 fill)
***AMINOGLYCOSIDES* - DRUGS FOR INFECTIONS**		
AMINOGLYCOSIDES - ANTIBIOTICS**		
amikacin sulfate injection solution	1 or 1b*	
ARIKAYCE INHALATION SUSPENSION (*amikacin sulfate liposome*)	4	PA; LD; QL (1 kit per 28 days)
BETHKIS INHALATION NEBULIZATION SOLUTION (*tobramycin*)	4	LD; QL (224 mL per 28 days); SP
gentamicin in saline intravenous solution	1 or 1b*	
gentamicin sulfate injection solution	1 or 1b*	
HUMATIN ORAL CAPSULE (*paromomycin sulfate*)	3	
neomycin sulfate oral tablet	1 or 1a*	
streptomycin sulfate intramuscular solution reconstituted	1 or 1b*	
TOBI PODHALER INHALATION CAPSULE (*tobramycin*)	4	LD; QL (224 capsules per 28 days); SP

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
tobramycin inhalation nebulization solution 300 mg/4ml	4	LD; QL (224 mL per 28 days); SP
tobramycin inhalation nebulization solution 300 mg/5ml	4	LD; QL (10 mL per 1 day); SP
tobramycin sulfate injection solution 1.2 gm/30ml	1 or 1b*	QL (900 mL per 30 days)
tobramycin sulfate injection solution 10 mg/ml, 80 mg/2ml	1 or 1b*	QL (180 mL per 30 days)
tobramycin sulfate injection solution 2 gm/50ml	1 or 1b*	QL (1500 mL per 30 days)
tobramycin sulfate injection solution reconstituted	1 or 1b*	QL (30 vials per 30 days)
ZEMDRI INTRAVENOUS SOLUTION (*plazomicin sulfate*)	3	
***ANALGESICS - ANTI-INFLAMMATORY* - DRUGS FOR PAIN AND FEVER**		
ANTIRHEUMATIC - JANUS KINASE (JAK) INHIBITORS - ARTHRITIS AND PAIN DRUGS**		
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HOUR (*upadacitinib*)	4	PA; QL (1 tablet per 1 day); SP
XELJANZ ORAL SOLUTION (*tofacitinib citrate*)	4	PA; QL (10 ML per 1 day); SP
XELJANZ ORAL TABLET (*tofacitinib citrate*)	4	PA; QL (2 tablets per 1 day); SP
XELJANZ XR ORAL TABLET EXTENDED RELEASE 24 HOUR (*tofacitinib citrate*)	4	PA; QL (1 tablet per 1 day); SP
ANTIRHEUMATIC ANTIMETABOLITES - ARTHRITIS AND PAIN DRUGS**		
RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR (*methotrexate (anti-rheumatic)*)	4	PA; QL (4 auto-injector per 28 days); SP
ANTI-TNF-ALPHA - MONOCLONAL ANTIBODIES - ARTHRITIS AND PAIN DRUGS**		
adalimumab-adbm subcutaneous auto-injector kit	4	PA; QL (1 kit per 1 lifetime); SP
adalimumab-adbm subcutaneous prefilled syringe kit	4	PA; QL (2 syringes per 28 days); SP
CYLTEZO (2 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT (*adalimumab-adbm*)	4	PA; QL (2 auto-injectors per 28 days); SP
CYLTEZO (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT (*adalimumab-adbm*)	4	PA; QL (2 syringes per 28 days); SP
CYLTEZO-CD/UC/HS STARTER SUBCUTANEOUS AUTO-INJECTOR KIT (*adalimumab-adbm*)	4	PA; QL (1 kit per 1 one-time fill); SP
CYLTEZO-PSORIASIS/UV STARTER SUBCUTANEOUS AUTO-INJECTOR KIT (*adalimumab-adbm*)	4	PA; QL (1 kit per 1 one-time fill); SP
HUMIRA (2 PEN) SUBCUTANEOUS PEN-INJECTOR KIT 40 MG/0.4ML (*adalimumab*)	4	PA; QL (2 EA per 28 days); SP
HUMIRA (2 PEN) SUBCUTANEOUS PEN-INJECTOR KIT 40 MG/0.8ML (*adalimumab*)	4	SP
HUMIRA (2 PEN) SUBCUTANEOUS PEN-INJECTOR KIT 80 MG/0.8ML (*adalimumab*)	4	PA; QL (2 pens per 28 days (QL exception needed for maintenance therapys); SP
HUMIRA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 10 MG/0.1ML, 20 MG/0.2ML, 40 MG/0.4ML (*adalimumab*)	4	PA; QL (2 EA per 28 days); SP
HUMIRA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 40 MG/0.8ML (*adalimumab*)	4	SP
HUMIRA-CD/UC/HS STARTER SUBCUTANEOUS PEN-INJECTOR KIT (*adalimumab*)	4	PA; QL (1 kit per 1 one-time fill); SP

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HUMIRA-PED<40KG CROHNS STARTER SUBCUTANEOUS PREFILLED SYRINGE KIT (*adalimumab*)	4	PA; QL (1 kit per 1 one-time fill); SP
HUMIRA-PED>/=40KG CROHNS START SUBCUTANEOUS PREFILLED SYRINGE KIT (*adalimumab*)	4	PA; QL (1 kit per 1 one-time fill); SP
HUMIRA-PED>/=40KG UC STARTER SUBCUTANEOUS PEN-INJECTOR KIT (*adalimumab*)	4	PA; QL (1 kit per 1 one-time fill); SP
HUMIRA-PS/UV/ADOL HS STARTER SUBCUTANEOUS PEN-INJECTOR KIT (*adalimumab*)	4	PA; QL (1 kit per 1 one-time fill); SP
HUMIRA-PSORIASIS/UVEIT STARTER SUBCUTANEOUS PEN-INJECTOR KIT (*adalimumab*)	4	PA; QL (1 kit per 1 one-time fill); SP
SIMPONI ARIA INTRAVENOUS SOLUTION (*golimumab*)	4	PA; SP
CYCLOOXYGENASE 2 (COX-2) INHIBITORS - ARTHRITIS AND PAIN DRUGS**		
celecoxib oral capsule 100 mg, 200 mg, 50 mg	1 or 1b*	ST; QL (2 capsules per 1 day)
celecoxib oral capsule 400 mg	1 or 1b*	ST; QL (1 capsule per 1 day)
GOLD COMPOUNDS - ARTHRITIS AND PAIN DRUGS**		
RIDAURA ORAL CAPSULE (*auranofin*)	2	QL (3 capsules per 1 day)
INTERLEUKIN-1 BLOCKERS - ARTHRITIS AND PAIN DRUGS**		
ARCALYST SUBCUTANEOUS SOLUTION RECONSTITUTED (*rilonacept*)	4	PA; LD; QL (4 vials per 28 days); SP
INTERLEUKIN-1BETA BLOCKERS - ARTHRITIS AND PAIN DRUGS**		
ILARIS SUBCUTANEOUS SOLUTION (*canakinumab*)	4	PA; LD; QL (2 vials per 28 days); SP
NONSTEROIDAL ANTI-INFLAMMATORY AGENT COMBINATIONS - ARTHRITIS AND PAIN DRUGS**		
diclofenac-misoprostol oral tablet delayed release 50-0.2 mg	1 or 1b*	QL (4 tablets per 1 day)
diclofenac-misoprostol oral tablet delayed release 75-0.2 mg	1 or 1b*	QL (2 tablets per 1 day)
NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (NSAIDS) - ARTHRITIS AND PAIN DRUGS**		
ANAPROX DS ORAL TABLET (*naproxen sodium*)	3	QL (2 tablets per 1 day)
CALDOLOR INTRAVENOUS SOLUTION (*ibuprofen*)	3	
DAYPRO ORAL TABLET (*oxaprozin*)	3	QL (2 tablets per 1 day)
diclofenac potassium oral tablet	1 or 1b*	QL (4 tablets per 1 day)
diclofenac sodium er oral tablet extended release 24 hour	1 or 1b*	QL (2 tablets per 1 day)
diclofenac sodium oral tablet delayed release 25 mg	1 or 1b*	QL (5 tablets per 1 day)
diclofenac sodium oral tablet delayed release 50 mg	1 or 1b*	QL (4 tablets per 1 day)
diclofenac sodium oral tablet delayed release 75 mg	1 or 1b*	QL (2 tablets per 1 day)
ec-naproxen oral tablet delayed release	1 or 1b*	
etodolac er oral tablet extended release 24 hour 400 mg, 500 mg	1 or 1b*	QL (2 tablets per 1 day)
etodolac er oral tablet extended release 24 hour 600 mg	1 or 1b*	QL (1 tablet per 1 day)
etodolac oral capsule 200 mg	1 or 1b*	QL (4 capsules per 1 day)
etodolac oral capsule 300 mg	1 or 1b*	QL (3 capsules per 1 day)
etodolac oral tablet	1 or 1b*	QL (2 tablets per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FELDENE ORAL CAPSULE (*piroxicam*)	3	QL (1 capsule per 1 day)
flurbiprofen oral tablet 100 mg	1 or 1b*	QL (3 tablets per 1 day)
flurbiprofen oral tablet 50 mg	1 or 1b*	QL (4 tablets per 1 day)
ibu oral tablet	1 or 1a*	QL (4 tablets per 1 day)
ibuprofen lysine intravenous solution	1 or 1b*	
ibuprofen oral suspension	1 or 1a*	QL (4 mL per 1 day)
ibuprofen oral tablet	1 or 1a*	QL (4 tablets per 1 day)
indomethacin er oral capsule extended release	1 or 1b*	QL (2 capsules per 1 day)
indomethacin oral capsule 25 mg	1 or 1b*	QL (3 capsule per 1 day)
indomethacin oral capsule 50 mg	1 or 1b*	QL (4 capsule per 1 day)
indomethacin sodium intravenous solution reconstituted	3	
ketoprofen er oral capsule extended release 24 hour	1 or 1b*	QL (1 capsule per 1 day)
ketorolac tromethamine injection solution 15 mg/ml	1 or 1b*	QL (4 mL per 30 days)
KETOROLAC TROMETHAMINE INJECTION SOLUTION 30 MG/ML	1 or 1b*	QL (2 mL per 30 days)
ketorolac tromethamine intramuscular solution	1 or 1b*	QL (2 mL per 30 days)
ketorolac tromethamine oral tablet	1 or 1a*	QL (20 tablets per 30 days)
LODINE ORAL TABLET (*etodolac*)	3	QL (2 tablets per 1 day)
meclofenamate sodium oral capsule	1 or 1b*	QL (4 capsules per 1 day)
mefenamic acid oral capsule	1 or 1b*	QL (29 capsule per 1 fill)
meloxicam oral tablet	1 or 1b*	QL (1 tablet per 1 day)
nabumetone oral tablet 500 mg	1 or 1b*	QL (4 tablets per 1 day)
nabumetone oral tablet 750 mg	1 or 1b*	QL (2 tablets per 1 day)
naproxen dr oral tablet delayed release	1 or 1b*	
naproxen oral tablet 250 mg, 375 mg	1 or 1b*	QL (4 tablets per 1 day)
naproxen oral tablet 500 mg	1 or 1b*	QL (2 tablets per 1 day)
naproxen oral tablet delayed release	1 or 1b*	
naproxen sodium oral tablet 275 mg	1 or 1b*	QL (4 tablets per 1 day)
naproxen sodium oral tablet 550 mg	1 or 1b*	QL (2 tablets per 1 day)
NEOPROFEN INTRAVENOUS SOLUTION (*ibuprofen lysine*)	3	
oxaprozin oral tablet	1 or 1b*	QL (2 tablets per 1 day)
piroxicam oral capsule	1 or 1b*	QL (1 capsule per 1 day)
sulindac oral tablet	1 or 1b*	QL (2 tablets per 1 day)
tolmetin sodium oral capsule	1 or 1b*	QL (3 tablets per 1 day)
tolmetin sodium oral tablet	1 or 1b*	QL (3 tablets per 1 day)
PHOSPHODIESTERASE 4 (PDE4) INHIBITORS - ARTHRITIS AND PAIN DRUGS**		
OTEZLA ORAL TABLET (*apremilast*)	4	PA; QL (2 tablets per 1 day); SP
OTEZLA ORAL TABLET THERAPY PACK (*apremilast*)	4	PA; QL (1 pack per 365 days); SP
PYRIMIDINE SYNTHESIS INHIBITORS - ARTHRITIS AND PAIN DRUGS**		
ARAVA ORAL TABLET (*leflunomide*)	3	QL (1 tablet per 1 day)
leflunomide oral tablet	1 or 1b*	QL (1 tablet per 1 day)

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SOLUBLE TUMOR NECROSIS FACTOR RECEPTOR AGENTS - ARTHRITIS AND PAIN DRUGS**		
ENBREL MINI SUBCUTANEOUS SOLUTION CARTRIDGE (*etanercept*)	4	PA; QL (4 cartridge per 28 days); SP
ENBREL SUBCUTANEOUS SOLUTION (*etanercept*)	4	PA; QL (8 injections per 28 days); SP
ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 25 MG/0.5ML (*etanercept*)	4	PA; QL (8 syringes per 28 days); SP
ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 50 MG/ML (*etanercept*)	4	PA; QL (4 syringes per 28 days); SP
ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR (*etanercept*)	4	PA; QL (4 pens per 28 days); SP
***ANALGESICS - NONNARCOTIC* - DRUGS FOR PAIN AND FEVER**		
ANALGESICS OTHER - ARTHRITIS AND PAIN DRUGS**		
acetaminophen intravenous solution	1 or 1b*	
ANALGESICS-SEDATIVES - ARTHRITIS AND PAIN DRUGS**		
bac oral tablet	1 or 1b*	QL (6 tablets per 1 day)
butalbital-acetaminophen oral capsule	1 or 1b*	QL (6 capsules per 1 day)
butalbital-acetaminophen oral tablet	1 or 1b*	QL (6 tablets per 1 day)
butalbital-apap-caffeine oral capsule	1 or 1b*	QL (6 capsules per 1 day)
butalbital-apap-caffeine oral tablet	1 or 1b*	QL (6 tablets per 1 day)
butalbital-aspirin-caffeine oral capsule	1 or 1b*	QL (6 capsules per 1 day)
tencon oral tablet	1 or 1b*	QL (6 tablets per 1 day)
SALICYLATES - ARTHRITIS AND PAIN DRUGS**		
adult aspirin regimen oral tablet delayed release	1 or 1a*; $0	
aspirin 81 oral tablet chewable	1 or 1a*; $0	
aspirin 81 oral tablet delayed release	1 or 1a*; $0	
aspirin adult low dose oral tablet delayed release	1 or 1a*; $0	
aspirin adult low strength oral tablet delayed release	1 or 1a*; $0	
aspirin childrens oral tablet chewable	1 or 1a*; $0	
aspirin ec low dose oral tablet delayed release	1 or 1a*; $0	
aspirin ec low strength oral tablet delayed release	1 or 1a*; $0	
aspirin low dose oral tablet chewable	1 or 1a*; $0	
aspirin low dose oral tablet delayed release	1 or 1a*; $0	
aspirin oral tablet chewable	1 or 1a*; $0	
aspirin oral tablet delayed release	1 or 1a*; $0	
aspirin regimen oral tablet delayed release	1 or 1a*; $0	
bayer aspirin ec low dose oral tablet delayed release	1 or 1a*; $0	
bayer low dose oral tablet chewable	1 or 1a*; $0	
bayer low dose oral tablet delayed release	1 or 1a*; $0	
childrens aspirin oral tablet chewable	1 or 1a*; $0	
cvs aspirin adult low dose oral tablet chewable	1 or 1a*; $0	
cvs aspirin adult low strength oral tablet delayed release	1 or 1a*; $0	

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
cvs aspirin ec oral tablet delayed release	1 or 1a*; $0	
cvs aspirin low dose oral tablet delayed release	1 or 1a*; $0	
cvs aspirin low strength oral tablet delayed release	1 or 1a*; $0	
diflunisal oral tablet	1 or 1b*	
ecotrin low strength oral tablet delayed release	1 or 1a*; $0	
eq aspirin adult low dose oral tablet delayed release	1 or 1a*; $0	
eq aspirin low dose oral tablet chewable	1 or 1a*; $0	
eql aspirin low dose oral tablet chewable	1 or 1a*; $0	
eql aspirin low dose oral tablet delayed release	1 or 1a*; $0	
ft aspirin low dose oral tablet delayed release	1 or 1a*; $0	
gnp adult aspirin low strength oral tablet chewable	1 or 1a*; $0	
gnp aspirin low dose oral tablet delayed release	1 or 1a*; $0	
gnp aspirin oral tablet delayed release	1 or 1a*; $0	
goodsense aspirin low dose oral tablet delayed release	1 or 1a*; $0	
goodsense aspirin oral tablet chewable	1 or 1a*; $0	
h-e-b aspirin oral tablet delayed release	1 or 1a*; $0	
kls aspirin low dose oral tablet delayed release	1 or 1a*; $0	
kp aspirin oral tablet delayed release	1 or 1a*; $0	
mm aspirin oral tablet delayed release	1 or 1a*; $0	
qc aspirin low dose oral tablet chewable	1 or 1a*; $0	
qc aspirin low dose oral tablet delayed release	1 or 1a*; $0	
qc childrens aspirin oral tablet chewable	1 or 1a*; $0	
ra aspirin adult low dose oral tablet chewable	1 or 1a*; $0	
ra aspirin adult low strength oral tablet chewable	1 or 1a*; $0	
ra aspirin childrens oral tablet chewable	1 or 1a*; $0	
ra aspirin ec adult low st oral tablet delayed release	1 or 1a*; $0	
ra aspirin ec oral tablet delayed release	1 or 1a*; $0	
sb childrens aspirin oral tablet chewable	1 or 1a*; $0	
sb low dose asa ec oral tablet delayed release	1 or 1a*; $0	
sm aspirin adult low strength oral tablet delayed release	1 or 1a*; $0	
sm aspirin ec low strength oral tablet delayed release	1 or 1a*; $0	
sm aspirin low dose oral tablet chewable	1 or 1a*; $0	
sm aspirin low dose oral tablet delayed release	1 or 1a*; $0	
sm childrens aspirin oral tablet chewable	1 or 1a*; $0	
st joseph aspirin oral tablet delayed release	1 or 1a*; $0	
st joseph low dose oral tablet chewable	1 or 1a*; $0	
st joseph low dose oral tablet delayed release	1 or 1a*; $0	
***ANALGESICS - OPIOID* - DRUGS FOR PAIN AND FEVER**		
CODEINE COMBINATIONS - ARTHRITIS AND PAIN DRUGS**		
acetaminophen-codeine oral solution	1 or 1a*	QL (30 mL per 1 day)
acetaminophen-codeine oral tablet 300-15 mg	1 or 1a*	QL (6 tablets per 1 day)

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
acetaminophen-codeine oral tablet 300-30 mg, 300-60 mg	1 or 1a*	QL (6 tablet per 1 day)
ascomp-codeine oral capsule	1 or 1b*	QL (6 capsule per 1 day)
butalbital-apap-caff-cod oral capsule 50-300-40-30 mg	1 or 1b*	QL (6 capsules per 1 day)
butalbital-apap-caff-cod oral capsule 50-325-40-30 mg	1 or 1b*	QL (6 capsule per 1 day)
butalbital-asa-caff-codeine oral capsule	1 or 1b*	QL (6 capsule per 1 day)
DIHYDROCODEINE COMBINATIONS - ARTHRITIS AND PAIN DRUGS**		
apap-caff-dihydrocodeine oral capsule	1 or 1b*	QL (6 capsules per 1 day)
trezix oral capsule	1 or 1b*	QL (6 capsules per 1 day)
HYDROCODONE COMBINATIONS - ARTHRITIS AND PAIN DRUGS**		
hydrocodone-acetaminophen oral solution	1 or 1b*	QL (90 mL per 1 day)
hydrocodone-acetaminophen oral tablet	1 or 1b*	QL (6 tablets per 1 day)
hydrocodone-ibuprofen oral tablet	1 or 1b*	QL (5 tablets per 1 day)
OPIOID AGONISTS - ARTHRITIS AND PAIN DRUGS**		
CODEINE SULFATE ORAL TABLET 15 MG, 60 MG	3	QL (6 tablets per 1 day)
codeine sulfate oral tablet 30 mg	1 or 1b*	QL (6 tablets per 1 day)
DEMEROL INJECTION SOLUTION (*meperidine hcl*)	3	
DILAUDID INJECTION SOLUTION (*hydromorphone hcl*)	3	
DILAUDID ORAL LIQUID (*hydromorphone hcl*)	3	QL (24 mL per 1 day)
DILAUDID ORAL TABLET (*hydromorphone hcl*)	3	QL (6 tablets per 1 day)
DSUVIA SUBLINGUAL TABLET SUBLINGUAL (*sufentanil citrate*)	3	
duramorph injection solution	1 or 1b*	
FENTANYL CITRATE (PF) INJECTION SOLUTION 100 MCG/2ML, 250 MCG/5ML	1 or 1b*	
fentanyl citrate (pf) injection solution 1000 mcg/20ml, 2500 mcg/50ml, 500 mcg/10ml	1 or 1b*	
FENTANYL CITRATE (PF) INJECTION SOLUTION 50 MCG/ML	3	
fentanyl citrate buccal lozenge on a handle	1 or 1b*	PA; QL (4 lozenge per 1 day)
fentanyl citrate buccal tablet	1 or 1b*	PA; QL (4 tablet per 1 day)
FENTANYL CITRATE PF INJECTION SOLUTION PREFILLED SYRINGE	3	
fentanyl transdermal patch 72 hour	1 or 1b*	PA; QL (15 patches per 30 days)
FENTORA BUCCAL TABLET (*fentanyl citrate*)	3	PA; QL (4 tablet per 1 day)
hydrocodone bitartrate er oral tablet er 24 hour abuse-deterrent	1 or 1b*	PA; QL (1 tablet per 1 day)
hydromorphone hcl er oral tablet extended release 24 hour	1 or 1b*	PA; QL (1 tablet per 1 day)
hydromorphone hcl injection solution	1 or 1b*	
hydromorphone hcl oral liquid	1 or 1b*	QL (24 mL per 1 day)
hydromorphone hcl oral tablet	1 or 1b*	QL (6 tablets per 1 day)
HYDROMORPHONE HCL PF INJECTION SOLUTION 1 MG/ML, 10 MG/ML, 2 MG/ML, 4 MG/ML	3	
hydromorphone hcl pf injection solution 50 mg/5ml, 500 mg/50ml	1 or 1b*	

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
INFUMORPH 200 INJECTION SOLUTION (*morphine sulfate microinfusion*)	3	
INFUMORPH 500 INJECTION SOLUTION (*morphine sulfate microinfusion*)	3	
levorphanol tartrate oral tablet	1 or 1b*	PA; QL (6 tablets per 1 day)
meperidine hcl injection solution	1 or 1b*	
meperidine hcl oral solution	1 or 1b*	QL (7 days per 1 fill)
meperidine hcl oral tablet	1 or 1b*	QL (6 tablets per 1 day)
METHADONE HCL INJECTION SOLUTION	3	PA; QL (1 mL per 1 day)
methadone hcl intensol oral concentrate	1 or 1b*	PA; QL (6 mL per 1 day)
methadone hcl oral concentrate	1 or 1b*	PA; QL (6 mL per 1 day)
methadone hcl oral solution	1 or 1b*	PA; QL (30 mL per 1 day)
methadone hcl oral tablet 10 mg	1 or 1b*	PA; QL (6 tablet per 1 day)
methadone hcl oral tablet 5 mg	1 or 1b*	PA; QL (6 tablets per 1 day)
methadone hcl oral tablet soluble	1 or 1b*	PA; QL (1 tablet per 1 day)
METHADOSE ORAL CONCENTRATE (*methadone hcl*)	3	PA; QL (6 mL per 1 day)
methadose oral tablet soluble	1 or 1b*	PA; QL (1 tablet per 1 day)
METHADOSE SUGAR-FREE ORAL CONCENTRATE (*methadone hcl*)	3	PA; QL (6 mL per 1 day)
mitigo injection solution	1 or 1b*	
morphine sulfate (concentrate) oral solution	1 or 1b*	QL (6 mL per 1 day)
morphine sulfate (pf) injection solution 0.5 mg/ml, 1 mg/ml	1 or 1b*	
MORPHINE SULFATE (PF) INJECTION SOLUTION 10 MG/ML, 2 MG/ML, 4 MG/ML, 5 MG/ML, 8 MG/ML	3	
MORPHINE SULFATE (PF) INTRAVENOUS SOLUTION	3	
morphine sulfate er beads oral capsule extended release 24 hour	1 or 1b*	PA; QL (1 capsule per 1 day)
morphine sulfate er oral capsule extended release 24 hour	1 or 1b*	PA; QL (2 capsules per 1 day)
morphine sulfate er oral tablet extended release 100 mg, 200 mg	1 or 1b*	PA; QL (2 tablets per 1 day)
morphine sulfate er oral tablet extended release 15 mg, 30 mg, 60 mg	1 or 1b*	PA; QL (3 tablet per 1 day)
MORPHINE SULFATE INJECTION SOLUTION 2 MG/ML, 4 MG/ML	3	
morphine sulfate injection solution 50 mg/ml	3	
morphine sulfate intravenous solution	1 or 1b*	
morphine sulfate oral solution	1 or 1b*	QL (30 mL per 1 day)
morphine sulfate oral tablet	1 or 1b*	QL (6 tablets per 1 day)
NUCYNTA ORAL TABLET 100 MG (*tapentadol hcl*)	3	QL (181 tablets per 30 days)
NUCYNTA ORAL TABLET 50 MG (*tapentadol hcl*)	3	QL (6 tablets per 1 day)
NUCYNTA ORAL TABLET 75 MG (*tapentadol hcl*)	3	QL (8 tablet per 1 day)
OLINVYK INTRAVENOUS SOLUTION (*oliceridine fumarate*)	3	
OXAYDO ORAL TABLET (*oxycodone hcl*)	3	QL (6 tablets per 1 day)
oxycodone hcl er oral tablet er 12 hour abuse-deterrent 10 mg, 20 mg, 40 mg	3	PA; QL (2 tablets per 1 day)
oxycodone hcl er oral tablet er 12 hour abuse-deterrent 80 mg	3	PA; QL (2 tablet per 1 day)
oxycodone hcl oral capsule	1 or 1b*	QL (7 days per 1 fill)
oxycodone hcl oral concentrate	1 or 1b*	QL (6 mL per 1 day)

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
oxycodone hcl oral solution	1 or 1b*	QL (30 mL per 1 day)
oxycodone hcl oral tablet	1 or 1b*	QL (6 tablets per 1 day)
oxymorphone hcl er oral tablet extended release 12 hour	1 or 1b*	PA; QL (2 tablets per 1 day)
oxymorphone hcl oral tablet 10 mg	1 or 1b*	QL (6 tablet per 1 day)
oxymorphone hcl oral tablet 5 mg	1 or 1b*	QL (6 tablets per 1 day)
QDOLO ORAL SOLUTION (*tramadol hcl*)	3	QL (80 mL per 1 day)
remifentanil hcl intravenous solution reconstituted	1 or 1b*	
ROXICODONE ORAL TABLET (*oxycodone hcl*)	3	QL (6 tablets per 1 day)
ROXYBOND ORAL TABLET ABUSE-DETERRENT (*oxycodone hcl*)	3	QL (6 tablets per 1 day)
SUFENTANIL CITRATE INTRAVENOUS SOLUTION	1 or 1b*	
tramadol hcl (er biphasic) oral capsule extended release 24 hour	1 or 1b*	PA; QL (1 capsule per 1 day)
tramadol hcl (er biphasic) oral tablet extended release 24 hour	1 or 1b*	PA; QL (1 tablet per 1 day)
tramadol hcl er oral tablet extended release 24 hour	1 or 1b*	PA; QL (1 tablet per 1 day)
TRAMADOL HCL ORAL SOLUTION	3	QL (80 mL per 1 day)
tramadol hcl oral tablet 100 mg	1 or 1b*	QL (4 tablets per 1 day)
tramadol hcl oral tablet 50 mg	1 or 1b*	QL (8 tablet per 1 day)
ULTIVA INTRAVENOUS SOLUTION RECONSTITUTED (*remifentanil hcl*)	3	
OPIOID COMBINATIONS - ARTHRITIS AND PAIN DRUGS**		
APADAZ ORAL TABLET (*benzhydrocodone-acetaminophen*)	3	QL (6 tablets per 1 day)
BENZHYDROCODONE-ACETAMINOPHEN ORAL TABLET	3	QL (6 tablets per 1 day)
endocet oral tablet 10-325 mg, 2.5-325 mg, 7.5-325 mg	1 or 1b*	QL (6 tablets per 1 day)
endocet oral tablet 5-325 mg	1 or 1b*	QL (6 tablet per 1 day)
OXYCODONE-ACETAMINOPHEN ORAL SOLUTION	1 or 1b*	QL (30 ML per 1 day)
oxycodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 7.5-325 mg	1 or 1b*	QL (6 tablets per 1 day)
oxycodone-acetaminophen oral tablet 5-325 mg	1 or 1b*	QL (6 tablet per 1 day)
OPIOID PARTIAL AGONISTS - ARTHRITIS AND PAIN DRUGS**		
BELBUCA BUCCAL FILM (*buprenorphine hcl*)	3	PA; QL (2 film per 1 day)
BRIXADI (WEEKLY) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (*buprenorphine*)	4	QL (4 syringes per 28 days)
BRIXADI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (*buprenorphine*)	4	QL (1 syringe per 28 days)
buprenorphine hcl injection solution	1 or 1b*	
buprenorphine hcl sublingual tablet sublingual 2 mg	1 or 1b*	QL (12 tablets per 90 days)
buprenorphine hcl sublingual tablet sublingual 8 mg	1 or 1b*	QL (3 tablets per 90 days)
buprenorphine hcl-naloxone hcl sublingual film 12-3 mg	1 or 1b*	QL (2 films per 1 day)
buprenorphine hcl-naloxone hcl sublingual film 2-0.5 mg	1 or 1b*	QL (12 films per 1 day)
buprenorphine hcl-naloxone hcl sublingual film 4-1 mg	1 or 1b*	QL (6 films per 1 day)
buprenorphine hcl-naloxone hcl sublingual film 8-2 mg	1 or 1b*	QL (3 films per 1 day)
buprenorphine hcl-naloxone hcl sublingual tablet sublingual 2-0.5 mg	1 or 1b*	QL (12 tablets per 1 day)
buprenorphine hcl-naloxone hcl sublingual tablet sublingual 8-2 mg	1 or 1b*	QL (3 tablets per 1 day)
buprenorphine transdermal patch weekly	1 or 1b*	PA; QL (1 package per 28 days)

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
butorphanol tartrate injection solution	1 or 1b*	
butorphanol tartrate nasal solution	1 or 1b*	QL (2 bottles per 30 days)
nalbuphine hcl injection solution	1 or 1b*	QL (2 mL per 1 day)
pentazocine-naloxone hcl oral tablet	1 or 1b*	QL (6 tablets per 1 day)
SUBLOCADE SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (*buprenorphine*)	4	LD; QL (1 syringe per 28 days)
ZUBSOLV SUBLINGUAL TABLET SUBLINGUAL 0.7-0.18 MG (*buprenorphine hcl-naloxone hcl*)	2	QL (23 tablets per 1 day)
ZUBSOLV SUBLINGUAL TABLET SUBLINGUAL 1.4-0.36 MG (*buprenorphine hcl-naloxone hcl*)	2	QL (12 tablets per 1 day)
ZUBSOLV SUBLINGUAL TABLET SUBLINGUAL 11.4-2.9 MG (*buprenorphine hcl-naloxone hcl*)	2	QL (1 tablet per 1 day)
ZUBSOLV SUBLINGUAL TABLET SUBLINGUAL 2.9-0.71 MG (*buprenorphine hcl-naloxone hcl*)	2	QL (5 tablets per 1 day)
ZUBSOLV SUBLINGUAL TABLET SUBLINGUAL 5.7-1.4 MG (*buprenorphine hcl-naloxone hcl*)	2	QL (3 tablets per 1 day)
ZUBSOLV SUBLINGUAL TABLET SUBLINGUAL 8.6-2.1 MG (*buprenorphine hcl-naloxone hcl*)	2	QL (2 tablets per 1 day)
TRAMADOL COMBINATIONS - ARTHRITIS AND PAIN DRUGS**		
tramadol-acetaminophen oral tablet	1 or 1b*	QL (8 tablet per 1 day)
***ANDROGENS-ANABOLIC* - HORMONES**		
ANDROGENS - DRUGS FOR MEN**		
ANDRODERM TRANSDERMAL PATCH 24 HOUR (*testosterone*)	3	PA; QL (1 patch per 1 day)
danazol oral capsule 100 mg, 50 mg	1 or 1b*	QL (2 capsules per 1 day)
danazol oral capsule 200 mg	1 or 1b*	QL (4 capsules per 1 day)
DEPO-TESTOSTERONE INTRAMUSCULAR SOLUTION (*testosterone cypionate*)	1 or 1b*	PA
JATENZO ORAL CAPSULE 158 MG, 198 MG (*testosterone undecanoate*)	3	PA; QL (4 capsules per 1 day)
JATENZO ORAL CAPSULE 237 MG (*testosterone undecanoate*)	3	PA; QL (2 capsules per 1 day)
NATESTO NASAL GEL (*testosterone*)	3	PA; QL (3 pump bottles per 30 days)
TESTOPEL IMPLANT PELLET (*testosterone*)	3	PA; LD
testosterone cypionate intramuscular solution	1 or 1b*	PA
testosterone enanthate intramuscular solution	1 or 1b*	PA
testosterone transdermal gel 1.62 %, 20.25 mg/act (1.62%)	1 or 1b*	PA; QL (1 bottle per 30 days)
testosterone transdermal gel 10 mg/act (2%)	1 or 1b*	PA; QL (1 pump per 30 days)
testosterone transdermal gel 12.5 mg/act (1%)	1 or 1b*	PA; QL (2 bottles per 30 days)
testosterone transdermal gel 20.25 mg/1.25gm (1.62%), 40.5 mg/2.5gm (1.62%), 50 mg/5gm (1%)	1 or 1b*	PA; QL (1 packet per 1 day)
testosterone transdermal gel 25 mg/2.5gm (1%)	1 or 1b*	PA; QL (2 packet per 1 day)
testosterone transdermal solution	1 or 1b*	PA; QL (1 pump bottle per 30 days)
XYOSTED SUBCUTANEOUS SOLUTION AUTO-INJECTOR (*testosterone enanthate*)	3	PA

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
***ANORECTAL AND RELATED PRODUCTS* - RECTAL PREPARATIONS**		
INTRARECTAL STEROIDS - RECTAL PREPARATIONS**		
budesonide rectal foam	1 or 1b*	QL (4.78 gm per 1 day)
CORTENEMA RECTAL ENEMA (*hydrocortisone*)	3	
CORTIFOAM EXTERNAL FOAM (*hydrocortisone acetate*)	3	QL (2.15 gram per 1 day)
hydrocortisone rectal enema	1 or 1b*	
NITRATE VASODILATING AGENTS - RECTAL PREPARATIONS**		
RECTIV RECTAL OINTMENT (*nitroglycerin*)	3	QL (1 unit per 1 day)
RECTAL ANESTHETIC/STEROIDS - RECTAL PREPARATIONS**		
ANALPRAM-HC EXTERNAL CREAM (*hydrocortisone ace-pramoxine*)	3	
ANALPRAM-HC EXTERNAL LOTION (*hydrocortisone ace-pramoxine*)	3	
hydrocortisone ace-pramoxine external cream	1 or 1b*	
PROCTOFOAM HC EXTERNAL FOAM (*hydrocortisone ace-pramoxine*)	3	
RECTAL STEROIDS - RECTAL PREPARATIONS**		
ANUSOL-HC EXTERNAL CREAM (*hydrocortisone*)	3	
hydrocortisone (perianal) external cream	1 or 1b*	
PROCTOCORT EXTERNAL CREAM (*hydrocortisone*)	3	
procto-med hc external cream	1 or 1b*	
proctosol hc external cream	1 or 1b*	
proctozone-hc external cream	1 or 1b*	
***ANTHELMINTICS* - DRUGS FOR INFECTIONS**		
ANTHELMINTICS - DRUGS FOR PARASITES**		
albendazole oral tablet	1 or 1b*	PA; QL (4 tablets per 1 day)
BENZNIDAZOLE ORAL TABLET	3	
BILTRICIDE ORAL TABLET (*praziquantel*)	3	
EMVERM ORAL TABLET CHEWABLE (*mebendazole*)	3	
ivermectin oral tablet	1 or 1b*	PA; QL (9 tablets per 1 fill)
praziquantel oral tablet	1 or 1b*	
STROMECTOL ORAL TABLET (*ivermectin*)	3	PA; QL (9 tablets per 1 fill)
***ANTIANGINAL AGENTS* - DRUGS FOR THE HEART**		
ANTIANGINALS-OTHER - DRUGS FOR ANGINA**		
ASPRUZYO SPRINKLE ORAL PACKET (*ranolazine*)	3	PA; QL (2 sachets per 1 day)
ranolazine er oral tablet extended release 12 hour	1 or 1b*	QL (2 tablets per 1 day)
NITRATES - DRUGS FOR ANGINA**		
ISORDIL TITRADOSE ORAL TABLET (*isosorbide dinitrate*)	3	
isosorbide dinitrate oral tablet	1 or 1b*	
isosorbide mononitrate er oral tablet extended release 24 hour	1 or 1b*	
isosorbide mononitrate oral tablet	1 or 1b*	
NITRO-BID TRANSDERMAL OINTMENT (*nitroglycerin*)	3	

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NITRO-DUR TRANSDERMAL PATCH 24 HOUR 0.1 MG/HR, 0.2 MG/HR, 0.4 MG/HR, 0.6 MG/HR (*nitroglycerin*)	3	
NITRO-DUR TRANSDERMAL PATCH 24 HOUR 0.3 MG/HR, 0.8 MG/HR (*nitroglycerin*)	2	
nitroglycerin in d5w intravenous solution	1 or 1b*	
NITROGLYCERIN INTRAVENOUS SOLUTION	3	
nitroglycerin sublingual tablet sublingual	1 or 1b*	
nitroglycerin transdermal patch 24 hour	1 or 1b*	
nitroglycerin translingual solution	1 or 1b*	
NITROLINGUAL TRANSLINGUAL SOLUTION (*nitroglycerin*)	3	
NITROSTAT SUBLINGUAL TABLET SUBLINGUAL (*nitroglycerin*)	3	
***ANTIANXIETY AGENTS* - DRUGS FOR THE NERVOUS SYSTEM**		
ANTIANXIETY AGENTS - MISC. - DRUGS FOR ANXIETY**		
buspirone hcl oral tablet	1 or 1b*	
droperidol injection solution	1 or 1b*	
hydroxyzine hcl intramuscular solution	1 or 1b*	
hydroxyzine hcl oral syrup	1 or 1b*	
hydroxyzine hcl oral tablet	1 or 1b*	
hydroxyzine pamoate oral capsule	1 or 1a*	
meprobamate oral tablet	3	
VISTARIL ORAL CAPSULE (*hydroxyzine pamoate*)	3	
BENZODIAZEPINES - DRUGS FOR SEIZURES /PERSONALITY DISORDER/NERVE PAIN**		
alprazolam er oral tablet extended release 24 hour 0.5 mg, 1 mg	1 or 1b*	DO
alprazolam er oral tablet extended release 24 hour 2 mg, 3 mg	1 or 1b*	QL (2 tablets per 1 day)
ALPRAZOLAM INTENSOL ORAL CONCENTRATE (*alprazolam*)	3	QL (4 mL per 1 day)
alprazolam oral tablet	1 or 1b*	QL (3 tablets per 1 day)
alprazolam oral tablet dispersible	1 or 1b*	QL (3 tablets per 1 day)
alprazolam xr oral tablet extended release 24 hour 0.5 mg, 1 mg	1 or 1b*	DO
alprazolam xr oral tablet extended release 24 hour 2 mg, 3 mg	1 or 1b*	QL (2 tablets per 1 day)
chlordiazepoxide hcl oral capsule	1 or 1b*	QL (4 capsules per 1 day)
clorazepate dipotassium oral tablet	1 or 1b*	QL (4 tablets per 1 day)
diazepam injection solution	1 or 1a*	
diazepam intensol oral concentrate	1 or 1a*	QL (8 mL per 1 day)
diazepam oral concentrate	1 or 1a*	QL (8 mL per 1 day)
diazepam oral solution	1 or 1a*	
diazepam oral tablet	1 or 1a*	QL (4 tablets per 1 day)
lorazepam injection solution	1 or 1b*	
lorazepam intensol oral concentrate	1 or 1b*	QL (3 mL per 1 day)
lorazepam oral concentrate	1 or 1b*	QL (3 mL per 1 day)
lorazepam oral tablet	1 or 1b*	QL (3 tablets per 1 day)
oxazepam oral capsule	1 or 1b*	QL (4 capsules per 1 day)

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
***ANTIARRHYTHMICS* - DRUGS FOR THE HEART**		
ANTIARRHYTHMICS - MISC. - DRUGS FOR ABNORMAL HEART RHYTHMS**		
adenosine intravenous solution	1 or 1b*	
ANTIARRHYTHMICS TYPE I-A - DRUGS FOR ABNORMAL HEART RHYTHMS**		
disopyramide phosphate oral capsule	1 or 1b*	
NORPACE CR ORAL CAPSULE EXTENDED RELEASE 12 HOUR (*disopyramide phosphate*)	2	
NORPACE ORAL CAPSULE (*disopyramide phosphate*)	3	
procainamide hcl injection solution	1 or 1b*	
quinidine gluconate er oral tablet extended release	1 or 1b*	
quinidine sulfate oral tablet	1 or 1a*	
ANTIARRHYTHMICS TYPE I-B - DRUGS FOR ABNORMAL HEART RHYTHMS**		
lidocaine hcl (cardiac) intravenous solution prefilled syringe	1 or 1b*	
LIDOCAINE HCL (CARDIAC) PF INTRAVENOUS SOLUTION	3	
lidocaine hcl (cardiac) pf intravenous solution prefilled syringe	1 or 1b*	
lidocaine in d5w intravenous solution	1 or 1b*	
mexiletine hcl oral capsule	1 or 1b*	
ANTIARRHYTHMICS TYPE I-C - DRUGS FOR ABNORMAL HEART RHYTHMS**		
flecainide acetate oral tablet 100 mg	1 or 1b*	QL (4 tablets per 1 day)
flecainide acetate oral tablet 150 mg	1 or 1b*	QL (2 tablets per 1 day)
flecainide acetate oral tablet 50 mg	1 or 1b*	QL (3 tablets per 1 day)
propafenone hcl er oral capsule extended release 12 hour	1 or 1b*	
propafenone hcl oral tablet	1 or 1b*	
RYTHMOL SR ORAL CAPSULE EXTENDED RELEASE 12 HOUR (*propafenone hcl*)	3	
ANTIARRHYTHMICS TYPE III - DRUGS FOR ABNORMAL HEART RHYTHMS**		
amiodarone hcl intravenous solution	1 or 1b*	
amiodarone hcl oral tablet 100 mg, 400 mg	1 or 1b*	
amiodarone hcl oral tablet 200 mg	1 or 1b*	QL (3 tablets per 1 day)
CORVERT INTRAVENOUS SOLUTION (*ibutilide fumarate*)	3	
dofetilide oral capsule	1 or 1b*	
ibutilide fumarate intravenous solution	1 or 1b*	
MULTAQ ORAL TABLET (*dronedarone hcl*)	3	QL (2 tablets per 1 day)
NEXTERONE INTRAVENOUS SOLUTION (*amiodarone hcl in dextrose*)	3	
pacerone oral tablet 100 mg, 400 mg	1 or 1b*	
pacerone oral tablet 200 mg	1 or 1b*	QL (3 tablets per 1 day)

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
***ANTIASTHMATIC AND BRONCHODILATOR AGENTS* - DRUGS FOR THE LUNGS**		
ADRENERGIC COMBINATIONS - DRUGS FOR ASTHMA/COPD**		
AIRSUPRA INHALATION AEROSOL (*albuterol-budesonide*)	2	
ANORO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED (*umeclidinium-vilanterol*)	2	QL (1 inhaler per 30 days)
BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-25 MCG/ACT, 200-25 MCG/ACT (*fluticasone furoate-vilanterol*)	1 or 1b*	QL (1 inhaler per 30 days)
BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 50-25 MCG/INH (*fluticasone furoate-vilanterol*)	2	QL (1 inhaler per 30 days)
budesonide-formoterol fumarate (Breyna Inhalation Aerosol)	1 or 1b*	QL (1.03 grams per 1 day)
BREZTRI AEROSPHERE INHALATION AEROSOL (*budeson-glycopyrrol-formoterol*)	2	QL (1 inhaler per 30 days)
budesonide-formoterol fumarate inhalation aerosol	1 or 1b*	QL (1.03 grams per 1 day)
COMBIVENT RESPIMAT INHALATION AEROSOL SOLUTION (*ipratropium-albuterol*)	2	QL (2 inhalers per 30 days)
fluticasone-salmeterol inhalation aerosol	1 or 1b*	QL (1 inhaler per 30 days)
fluticasone-salmeterol inhalation aerosol powder breath activated	1 or 1b*	QL (1 package per 30 days)
ipratropium-albuterol inhalation solution	1 or 1b*	QL (540 mL per 30 days)
STIOLTO RESPIMAT INHALATION AEROSOL SOLUTION (*tiotropium bromide-olodaterol*)	2	QL (1 inhaler per 30 days)
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-62.5-25 MCG/ACT (*fluticasone-umeclidin-vilant*)	2	QL (1 inhaler per 30 days)
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 200-62.5-25 MCG/ACT (*fluticasone-umeclidin-vilant*)	2	QL (2 EA per 1 day)
wixela inhub inhalation aerosol powder breath activated	1 or 1b*	QL (1 package per 30 days)
ANTI-IGE MONOCLONAL ANTIBODIES - DRUGS FOR ASTHMA/COPD**		
XOLAIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (*omalizumab*)	4	PA; LD; SP
XOLAIR SUBCUTANEOUS SOLUTION RECONSTITUTED (*omalizumab*)	4	PA; LD; SP
ANTI-INFLAMMATORY AGENTS - DRUGS FOR ASTHMA/COPD**		
cromolyn sodium inhalation nebulization solution	1 or 1b*	
BETA ADRENERGICS - DRUGS FOR ASTHMA/COPD**		
albuterol sulfate hfa inhalation aerosol solution	1 or 1b*	QL (2 inhalers per 30 days)
albuterol sulfate inhalation nebulization solution (2.5 mg/3ml) 0.083%, 0.63 mg/3ml, 1.25 mg/3ml	1 or 1b*	QL (360 mL per 30 days)
albuterol sulfate inhalation nebulization solution 2.5 mg/0.5ml	1 or 1b*	QL (4 boxes per 30 days)
albuterol sulfate oral syrup	1 or 1b*	
albuterol sulfate oral tablet	1 or 1b*	
arformoterol tartrate inhalation nebulization solution	1 or 1b*	QL (60 vial per 30 days)
BROVANA INHALATION NEBULIZATION SOLUTION (*arformoterol tartrate*)	3	QL (60 vial per 30 days)

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
formoterol fumarate inhalation nebulization solution	1 or 1b*	QL (120 ML per 30 days)
isoproterenol hcl injection solution	1 or 1b*	
levalbuterol hcl inhalation nebulization solution 0.31 mg/3ml, 0.63 mg/3ml, 1.25 mg/3ml	1 or 1b*	QL (90 vials per 30 days)
levalbuterol hcl inhalation nebulization solution 1.25 mg/0.5ml	1 or 1b*	QL (90 mL per 30 days)
levalbuterol tartrate inhalation aerosol	1 or 1b*	ST; QL (2 inhalers per 30 days)
PERFOROMIST INHALATION NEBULIZATION SOLUTION (*formoterol fumarate*)	3	QL (120 ML per 30 days)
PROAIR RESPICLICK INHALATION AEROSOL POWDER BREATH ACTIVATED (*albuterol sulfate*)	2	QL (2 inhalers per 30 days)
SEREVENT DISKUS INHALATION AEROSOL POWDER BREATH ACTIVATED (*salmeterol xinafoate*)	2	QL (1 inhaler per 30 days)
STRIVERDI RESPIMAT INHALATION AEROSOL SOLUTION (*olodaterol hcl*)	3	QL (1 inhaler per 30 days)
terbutaline sulfate injection solution	1 or 1b*	
terbutaline sulfate oral tablet	1 or 1b*	
BRONCHODILATORS - ANTICHOLINERGICS - DRUGS FOR ASTHMA/COPD**		
ATROVENT HFA INHALATION AEROSOL SOLUTION (*ipratropium bromide hfa*)	2	QL (2 inhalers per 30 days)
ipratropium bromide inhalation solution	1 or 1b*	QL (378 ML per 30 days)
SPIRIVA HANDIHALER INHALATION CAPSULE (*tiotropium bromide monohydrate*)	1 or 1b*	QL (1 capsule per 1 day)
SPIRIVA RESPIMAT INHALATION AEROSOL SOLUTION (*tiotropium bromide monohydrate*)	2	QL (1 inhaler per 30 days)
YUPELRI INHALATION SOLUTION (*revefenacin*)	3	ST; QL (1 vial per 1 day)
INTERLEUKIN-5 ANTAGONISTS (IGG1 KAPPA) - DRUGS FOR ASTHMA/COPD**		
FASENRA PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR (*benralizumab*)	4	PA; LD; QL (1 autoinjector per 8 weekss); SP
FASENRA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (*benralizumab*)	4	PA; LD; QL (1 syringes per 8 weekss); SP
NUCALA SUBCUTANEOUS SOLUTION AUTO-INJECTOR (*mepolizumab*)	4	PA; LD; QL (1 autoinjector per 4 weekss); SP
NUCALA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (*mepolizumab*)	4	PA; LD; QL (1 syringe per 4 weekss); SP
NUCALA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML (*mepolizumab*)	4	PA; LD; QL (1 injection per 28 days); SP
NUCALA SUBCUTANEOUS SOLUTION RECONSTITUTED (*mepolizumab*)	4	PA; LD; QL (1 injections per 28 days); SP
INTERLEUKIN-5 ANTAGONISTS (IGG4 KAPPA) - DRUGS FOR ASTHMA/COPD**		
CINQAIR INTRAVENOUS SOLUTION (*reslizumab*)	4	PA; LD; SP
LEUKOTRIENE RECEPTOR ANTAGONISTS - DRUGS FOR ASTHMA/COPD**		
ACCOLATE ORAL TABLET (*zafirlukast*)	3	QL (2 tablets per 1 day)

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
montelukast sodium oral packet	1 or 1b*	QL (1 packet per 1 day)
montelukast sodium oral tablet	1 or 1b*	QL (1 tablet per 1 day)
montelukast sodium oral tablet chewable	1 or 1b*	QL (1 tablet per 1 day)
zafirlukast oral tablet	1 or 1b*	QL (2 tablets per 1 day)
SELECTIVE PHOSPHODIESTERASE 4 (PDE4) INHIBITORS - DRUGS FOR ASTHMA/COPD**		
roflumilast oral tablet	1 or 1b*	PA; QL (1 tablet per 1 day)
STEROID INHALANTS - DRUGS FOR ASTHMA/COPD**		
budesonide inhalation suspension 0.25 mg/2ml, 0.5 mg/2ml	1 or 1b*	QL (120 ML per 30 days)
budesonide inhalation suspension 1 mg/2ml	1 or 1b*	QL (60 ML per 30 days)
fluticasone propionate diskus inhalation aerosol powder breath activated 100 mcg/act, 50 mcg/act	2	QL (1 inhaler per 30 days)
fluticasone propionate diskus inhalation aerosol powder breath activated 250 mcg/act	2	QL (4 inhalers per 30 days)
fluticasone propionate hfa inhalation aerosol 110 mcg/act, 44 mcg/act	2	QL (1 inhaler per 30 days)
fluticasone propionate hfa inhalation aerosol 220 mcg/act	2	QL (2 inhalers per 30 days)
PULMICORT FLEXHALER INHALATION AEROSOL POWDER BREATH ACTIVATED (*budesonide*)	2	QL (0.07 EA per 1 day)
QVAR REDIHALER INHALATION AEROSOL BREATH ACTIVATED 40 MCG/ACT (*beclomethasone diprop hfa*)	2	QL (1 inhaler per 30 days)
QVAR REDIHALER INHALATION AEROSOL BREATH ACTIVATED 80 MCG/ACT (*beclomethasone diprop hfa*)	2	QL (2 inhalers per 30 days)
THYMIC STROMAL LYMPHOPOIETIN (TSLP) ANTAGONISTS - DRUGS FOR ASTHMA/COPD**		
TEZSPIRE SUBCUTANEOUS SOLUTION AUTO-INJECTOR (*tezepelumab-ekko*)	4	PA; LD; QL (1 syringe per 28 days); SP
TEZSPIRE SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (*tezepelumab-ekko*)	4	PA; LD; QL (1 syringe per 28 days); SP
XANTHINES - DRUGS FOR ASTHMA/COPD**		
aminophylline intravenous solution	1 or 1b*	
ELIXOPHYLLIN ORAL ELIXIR (*theophylline*)	1 or 1b*	QL (112.5 mL per 1 day)
THEO-24 ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG (*theophylline*)	2	QL (4 tablets per 1 day)
THEO-24 ORAL CAPSULE EXTENDED RELEASE 24 HOUR 200 MG (*theophylline*)	2	QL (3 capsules per 1 day)
THEO-24 ORAL CAPSULE EXTENDED RELEASE 24 HOUR 300 MG, 400 MG (*theophylline*)	2	QL (2 capsules per 1 day)
theophylline er oral tablet extended release 12 hour 100 mg, 200 mg	1 or 1b*	
theophylline er oral tablet extended release 12 hour 300 mg	1 or 1b*	QL (2 tablets per 1 day)
theophylline er oral tablet extended release 12 hour 450 mg	1 or 1b*	QL (1 tablet per 1 day)
theophylline er oral tablet extended release 24 hour	1 or 1b*	QL (1 tablet per 1 day)
theophylline oral elixir	1 or 1b*	QL (112.5 mL per 1 day)
theophylline oral solution	1 or 1b*	QL (112.5 mL per 1 day)

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
***ANTICOAGULANTS* - DRUGS FOR THE BLOOD**		
COUMARIN ANTICOAGULANTS - DRUGS TO PREVENT BLOOD CLOTS**		
jantoven oral tablet	1 or 1a*	
warfarin sodium oral tablet	1 or 1a*	
DIRECT FACTOR XA INHIBITORS - DRUGS TO PREVENT BLOOD CLOTS**		
ELIQUIS DVT/PE STARTER PACK ORAL TABLET THERAPY PACK (*apixaban*)	2	QL (74 tablets per 365 days)
ELIQUIS ORAL TABLET 2.5 MG (*apixaban*)	2	QL (2 tablets per 1 day)
ELIQUIS ORAL TABLET 5 MG (*apixaban*)	2	QL (74 tablets per 30 days)
XARELTO ORAL SUSPENSION RECONSTITUTED (*rivaroxaban*)	2	QL (20 mL per 1 day)
XARELTO ORAL TABLET 10 MG, 20 MG (*rivaroxaban*)	2	QL (1 tablet per 1 day)
XARELTO ORAL TABLET 15 MG, 2.5 MG (*rivaroxaban*)	2	QL (2 tablets per 1 day)
XARELTO STARTER PACK ORAL TABLET THERAPY PACK (*rivaroxaban*)	2	QL (1 pack per 365 days)
HEPARINS AND HEPARINOID-LIKE AGENTS - DRUGS TO PREVENT BLOOD CLOTS**		
bd heparin posiflush intravenous solution	1 or 1b*	
heparin (porcine) in nacl intravenous solution 1000-0.9 ut/500ml-%, 2000-0.9 unit/l-%	1 or 1b*	
HEPARIN (PORCINE) IN NACL INTRAVENOUS SOLUTION 12500-0.45 UT/250ML-%, 25000-0.45 UT/250ML-%, 25000-0.45 UT/500ML-%	3	
heparin na (pork) lock flsh pf intravenous solution	1 or 1b*	
HEPARIN SOD (PORCINE) IN D5W INTRAVENOUS SOLUTION 100 UNIT/ML, 25000-5 UT/500ML-%	3	
heparin sod (porcine) in d5w intravenous solution 40-5 unit/ml-%	1 or 1b*	
heparin sod (pork) lock flush intravenous solution	1 or 1b*	
heparin sodium (porcine) injection solution	1 or 1b*	
HEPARIN SODIUM (PORCINE) INJECTION SOLUTION PREFILLED SYRINGE	3	
heparin sodium (porcine) pf injection solution 5000 unit/0.5ml	1 or 1b*	
HEPARIN SODIUM (PORCINE) PF INJECTION SOLUTION 5000 UNIT/ML	3	
LOW MOLECULAR WEIGHT HEPARINS - DRUGS TO PREVENT BLOOD CLOTS**		
enoxaparin sodium injection solution	1 or 1b*	QL (30 syringes per 30 days)
enoxaparin sodium injection solution prefilled syringe	1 or 1b*	QL (2 syringes per 1 day)
FRAGMIN SUBCUTANEOUS SOLUTION 10000 UNIT/4ML (*dalteparin sodium*)	3	QL (8 mL per 30 days)
FRAGMIN SUBCUTANEOUS SOLUTION 95000 UNIT/3.8ML (*dalteparin sodium*)	3	QL (6 vials per 30 days)
FRAGMIN SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (*dalteparin sodium*)	3	QL (30 syringes per 30 days)

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SYNTHETIC HEPARINOID-LIKE AGENTS - DRUGS TO PREVENT BLOOD CLOTS**		
ARIXTRA SUBCUTANEOUS SOLUTION (*fondaparinux sodium*)	3	QL (30 syringes per 30 days)
fondaparinux sodium subcutaneous solution	1 or 1b*	QL (30 syringes per 30 days)
THROMBIN INHIBITORS - HIRUDIN TYPE - DRUGS TO PREVENT BLOOD CLOTS**		
ANGIOMAX INTRAVENOUS SOLUTION RECONSTITUTED (*bivalirudin trifluoroacetate*)	3	
bivalirudin trifluoroacetate intravenous solution	1 or 1b*	
bivalirudin trifluoroacetate intravenous solution reconstituted	1 or 1b*	
THROMBIN INHIBITORS - SELECTIVE DIRECT & REVERSIBLE - DRUGS TO PREVENT BLOOD CLOTS**		
ARGATROBAN IN SODIUM CHLORIDE INTRAVENOUS SOLUTION	3	
ARGATROBAN INTRAVENOUS SOLUTION	3	
***ANTICONVULSANTS* - DRUGS FOR THE NERVOUS SYSTEM**		
AMPA GLUTAMATE RECEPTOR ANTAGONISTS - DRUGS FOR SEIZURES /PERSONALITY DISORDER/NERVE PAIN**		
FYCOMPA ORAL SUSPENSION (*perampanel*)	3	QL (24 mL per 1 day)
FYCOMPA ORAL TABLET (*perampanel*)	3	QL (1 tablet per 1 day)
ANTICONVULSANTS - BENZODIAZEPINES - DRUGS FOR SEIZURES /PERSONALITY DISORDER/NERVE PAIN**		
clobazam oral suspension	1 or 1b*	QL (16 mL per 1 day)
clobazam oral tablet	1 or 1b*	QL (2 tablets per 1 day)
clonazepam oral tablet	1 or 1b*	QL (3 tablets per 1 day)
clonazepam oral tablet dispersible	1 or 1b*	QL (3 tablets per 1 day)
DIASTAT ACUDIAL RECTAL GEL (*diazepam*)	3	QL (2 syringes per 1 fill)
diazepam rectal gel	1 or 1b*	QL (2 syringes per 1 fill)
SYMPAZAN ORAL FILM 10 MG, 20 MG (*clobazam*)	3	QL (2 film strips per 1 day)
SYMPAZAN ORAL FILM 5 MG (*clobazam*)	3	QL (1 film strip per 1 day)
ANTICONVULSANTS - MISC. - DRUGS FOR SEIZURES /PERSONALITY DISORDER/NERVE PAIN**		
APTIOM ORAL TABLET 200 MG, 400 MG (*eslicarbazepine acetate*)	3	DO
APTIOM ORAL TABLET 600 MG, 800 MG (*eslicarbazepine acetate*)	3	QL (2 tablets per 1 day)
BANZEL ORAL SUSPENSION (*rufinamide*)	3	QL (80 mL per 1 day)
BANZEL ORAL TABLET 200 MG (*rufinamide*)	3	DO
BANZEL ORAL TABLET 400 MG (*rufinamide*)	3	QL (8 tablets per 1 day)
BRIVIACT INTRAVENOUS SOLUTION (*brivaracetam*)	3	
BRIVIACT ORAL SOLUTION (*brivaracetam*)	3	QL (20 mL per 1 day)
BRIVIACT ORAL TABLET (*brivaracetam*)	3	QL (2 tablets per 1 day)
carbamazepine er oral capsule extended release 12 hour 100 mg, 200 mg	1 or 1b*	QL (2 capsules per 1 day)
carbamazepine er oral capsule extended release 12 hour 300 mg	1 or 1b*	QL (5 capsules per 1 day)
carbamazepine er oral tablet extended release 12 hour 100 mg, 200 mg	1 or 1b*	QL (2 tablets per 1 day)
carbamazepine er oral tablet extended release 12 hour 400 mg	1 or 1b*	QL (4 tablets per 1 day)

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
carbamazepine oral suspension	1 or 1b*	QL (50 mL per 1 day)
carbamazepine oral tablet	1 or 1b*	QL (8 tablets per 1 day)
carbamazepine oral tablet chewable	1 or 1b*	QL (10 tablets per 1 day)
DIACOMIT ORAL CAPSULE 250 MG (*stiripentol*)	4	PA; LD; DO
DIACOMIT ORAL CAPSULE 500 MG (*stiripentol*)	4	PA; LD; QL (6 capsules per 1 day)
DIACOMIT ORAL PACKET 250 MG (*stiripentol*)	4	PA; LD; DO
DIACOMIT ORAL PACKET 500 MG (*stiripentol*)	4	PA; LD; QL (6 packets per 1 day)
ELEPSIA XR ORAL TABLET EXTENDED RELEASE 24 HOUR (*levetiracetam*)	3	QL (2 tablets per 1 day)
EPIDIOLEX ORAL SOLUTION (*cannabidiol*)	4	PA; LD; SP
epitol oral tablet	1 or 1b*	QL (8 tablets per 1 day)
FINTEPLA ORAL SOLUTION (*fenfluramine hcl*)	4	PA; LD; QL (26 mg per 1 day)
gabapentin oral capsule	1 or 1b*	DO
gabapentin oral solution	1 or 1b*	QL (72 mL per 1 day)
gabapentin oral tablet 600 mg	1 or 1b*	QL (6 tablets per 1 day)
gabapentin oral tablet 800 mg	1 or 1b*	QL (4 tablets per 1 day)
lacosamide intravenous solution	1 or 1b*	
lacosamide oral solution	1 or 1b*	QL (40 mL per 1 day)
lacosamide oral tablet	1 or 1b*	QL (2 tablets per 1 day)
lamotrigine er oral tablet extended release 24 hour 100 mg, 25 mg, 50 mg	1 or 1b*	DO
lamotrigine er oral tablet extended release 24 hour 200 mg	1 or 1b*	QL (3 tablets per 1 day)
lamotrigine er oral tablet extended release 24 hour 250 mg, 300 mg	1 or 1b*	QL (2 tablets per 1 day)
lamotrigine oral kit 21 x 25 mg & 7 x 50 mg	1 or 1b*	QL (1 kit per 28 days)
lamotrigine oral kit 25 & 50 & 100 mg, 42 x 50 mg & 14x100 mg	1 or 1b*	QL (1 kit per 35 days)
lamotrigine oral tablet	1 or 1b*	DO
lamotrigine oral tablet chewable 25 mg	1 or 1b*	QL (2 tablets per 1 day)
lamotrigine oral tablet chewable 5 mg	1 or 1b*	QL (4 tablets per 1 day)
lamotrigine oral tablet dispersible 100 mg, 200 mg	1 or 1b*	QL (2 tablets per 1 day)
lamotrigine oral tablet dispersible 25 mg	1 or 1b*	QL (3 tablets per 1 day)
lamotrigine oral tablet dispersible 50 mg	1 or 1b*	DO
lamotrigine starter kit-blue oral kit	1 or 1b*	QL (1 kit per 28 days)
lamotrigine starter kit-green oral kit	1 or 1b*	QL (1 kit per 35 days)
lamotrigine starter kit-orange oral kit	1 or 1b*	QL (1 kit per 35 days)
levetiracetam er oral tablet extended release 24 hour 500 mg	1 or 1b*	QL (6 tablets per 1 day)
levetiracetam er oral tablet extended release 24 hour 750 mg	1 or 1b*	QL (4 tablets per 1 day)
LEVETIRACETAM IN NACL INTRAVENOUS SOLUTION 1000 MG/100ML, 1500 MG/100ML, 500 MG/100ML	3	
levetiracetam in nacl intravenous solution 250 mg/50ml	3	
levetiracetam intravenous solution	1 or 1b*	
levetiracetam oral solution	1 or 1b*	QL (30 mL per 1 day)
levetiracetam oral tablet 1000 mg	1 or 1b*	QL (3 tablets per 1 day)
levetiracetam oral tablet 250 mg, 500 mg, 750 mg	1 or 1b*	DO

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
oxcarbazepine oral suspension	1 or 1b*	QL (40 mL per 1 day)
oxcarbazepine oral tablet 150 mg, 300 mg	1 or 1b*	QL (2 tablets per 1 day)
oxcarbazepine oral tablet 600 mg	1 or 1b*	QL (4 tablets per 1 day)
OXTELLAR XR ORAL TABLET EXTENDED RELEASE 24 HOUR 150 MG, 300 MG (*oxcarbazepine*)	3	DO
OXTELLAR XR ORAL TABLET EXTENDED RELEASE 24 HOUR 600 MG (*oxcarbazepine*)	3	QL (4 tablets per 1 day)
pregabalin oral capsule 100 mg, 150 mg, 200 mg, 25 mg, 50 mg	1 or 1b*	QL (3 capsule per 1 day)
pregabalin oral capsule 225 mg, 300 mg, 75 mg	1 or 1b*	QL (2 capsules per 1 day)
pregabalin oral solution	1 or 1b*	QL (30 mL per 1 day)
primidone oral tablet 125 mg	1 or 1b*	QL (3 tablets per 1 day)
primidone oral tablet 250 mg	1 or 1b*	QL (8 tablets per 1 day)
primidone oral tablet 50 mg	1 or 1b*	QL (4 tablets per 1 day)
QUDEXY XR ORAL CAPSULE ER 24 HOUR SPRINKLE 100 MG, 50 MG (*topiramate*)	3	QL (1 capsule per 1 day)
QUDEXY XR ORAL CAPSULE ER 24 HOUR SPRINKLE 150 MG, 200 MG (*topiramate*)	3	QL (2 capsules per 1 day)
QUDEXY XR ORAL CAPSULE ER 24 HOUR SPRINKLE 25 MG (*topiramate*)	3	DO
roweepra oral tablet	1 or 1b*	DO
rufinamide oral suspension	1 or 1b*	QL (80 mL per 1 day)
rufinamide oral tablet 200 mg	1 or 1b*	DO
rufinamide oral tablet 400 mg	1 or 1b*	QL (8 tablets per 1 day)
SPRITAM ORAL TABLET DISINTEGRATING SOLUBLE 1000 MG, 250 MG, 500 MG (*levetiracetam*)	3	QL (2 tablets per 1 day)
SPRITAM ORAL TABLET DISINTEGRATING SOLUBLE 750 MG (*levetiracetam*)	3	QL (4 tablets per 1 day)
subvenite oral tablet	1 or 1b*	DO
subvenite starter kit-blue oral kit	1 or 1b*	QL (1 kit per 28 days)
subvenite starter kit-green oral kit	1 or 1b*	QL (1 kit per 35 days)
subvenite starter kit-orange oral kit	1 or 1b*	QL (1 kit per 35 days)
topiramate er oral capsule er 24 hour sprinkle 100 mg, 50 mg	1 or 1b*	QL (1 capsule per 1 day)
topiramate er oral capsule er 24 hour sprinkle 150 mg, 200 mg	1 or 1b*	QL (2 capsules per 1 day)
topiramate er oral capsule er 24 hour sprinkle 25 mg	1 or 1b*	DO
topiramate oral capsule sprinkle	1 or 1b*	QL (2 capsules per 1 day)
topiramate oral tablet 100 mg, 25 mg, 50 mg	1 or 1b*	DO
topiramate oral tablet 200 mg	1 or 1b*	QL (2 tablets per 1 day)
TROKENDI XR ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 50 MG (*topiramate*)	1 or 1b*	QL (1 capsule per 1 day)
TROKENDI XR ORAL CAPSULE EXTENDED RELEASE 24 HOUR 200 MG (*topiramate*)	1 or 1b*	QL (2 capsules per 1 day)
TROKENDI XR ORAL CAPSULE EXTENDED RELEASE 24 HOUR 25 MG (*topiramate*)	1 or 1b*	DO
zonisamide oral capsule	1 or 1b*	QL (6 capsule per 1 day)

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ZTALMY ORAL SUSPENSION (*ganaxolone*)	4	LD; QL (10 bottles per 30 days)
CARBAMATES - DRUGS FOR SEIZURES /PERSONALITY DISORDER/NERVE PAIN**		
felbamate oral suspension	1 or 1b*	QL (30 mL per 1 day)
felbamate oral tablet	1 or 1b*	QL (6 tablets per 1 day)
XCOPRI (250 MG DAILY DOSE) ORAL TABLET THERAPY PACK (*cenobamate*)	3	QL (1 blister pack per 28 days)
XCOPRI (350 MG DAILY DOSE) ORAL TABLET THERAPY PACK (*cenobamate*)	3	QL (1 pack per 28 days)
XCOPRI ORAL TABLET 100 MG, 150 MG, 50 MG (*cenobamate*)	3	QL (1 tablet per 1 day)
XCOPRI ORAL TABLET 200 MG (*cenobamate*)	3	QL (2 tablets per 1 day)
XCOPRI ORAL TABLET THERAPY PACK (*cenobamate*)	3	QL (1 pack per 28 days)
GABA MODULATORS - DRUGS FOR SEIZURES /PERSONALITY DISORDER/NERVE PAIN**		
tiagabine hcl oral tablet	1 or 1b*	QL (2 tablets per 1 day)
vigabatrin oral packet	1 or 1b*	LD; QL (6 packets per 1 day); SP
vigabatrin oral tablet	1 or 1b*	LD; QL (6 tablets per 1 day); SP
vigadrone oral packet	1 or 1b*	LD; QL (6 packets per 1 day)
vigabatrin (Vigadrone Oral Tablet)	1 or 1b*	LD; QL (6 tablets per 1 day); SP
HYDANTOINS - DRUGS FOR SEIZURES /PERSONALITY DISORDER/NERVE PAIN**		
CEREBYX INJECTION SOLUTION (*fosphenytoin sodium*)	3	
DILANTIN INFATABS ORAL TABLET CHEWABLE (*phenytoin*)	3	
DILANTIN ORAL CAPSULE 100 MG (*phenytoin sodium extended*)	3	
DILANTIN ORAL CAPSULE 30 MG (*phenytoin sodium extended*)	2	
DILANTIN ORAL SUSPENSION (*phenytoin*)	3	
fosphenytoin sodium injection solution	1 or 1b*	
PHENYTEK ORAL CAPSULE (*phenytoin sodium extended*)	1 or 1b*	
phenytoin infatabs oral tablet chewable	1 or 1b*	
phenytoin oral suspension	1 or 1b*	
phenytoin oral tablet chewable	1 or 1b*	
phenytoin sodium extended oral capsule	1 or 1b*	
phenytoin sodium injection solution	1 or 1b*	
SUCCINIMIDES - DRUGS FOR SEIZURES /PERSONALITY DISORDER/NERVE PAIN**		
CELONTIN ORAL CAPSULE (*methsuximide*)	3	QL (4 capsules per 1 day)
ethosuximide oral capsule	1 or 1b*	QL (6 capsules per 1 day)
ethosuximide oral solution	1 or 1b*	QL (30 mL per 1 day)
methsuximide oral capsule	1 or 1b*	QL (4 capsules per 1 day)
VALPROIC ACID - DRUGS FOR SEIZURES /PERSONALITY DISORDER/NERVE PAIN**		
divalproex sodium er oral tablet extended release 24 hour 250 mg	1 or 1b*	QL (2 tablets per 1 day)
divalproex sodium er oral tablet extended release 24 hour 500 mg	1 or 1b*	QL (7 tablets per 1 day)

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
divalproex sodium oral capsule delayed release sprinkle	1 or 1b*	QL (8 capsules per 1 day)
divalproex sodium oral tablet delayed release 125 mg, 250 mg	1 or 1b*	QL (2 tablets per 1 day)
divalproex sodium oral tablet delayed release 500 mg	1 or 1b*	QL (7 tablets per 1 day)
valproate sodium intravenous solution	1 or 1b*	
valproic acid oral capsule	1 or 1b*	QL (4 capsules per 1 day)
valproic acid oral solution	1 or 1b*	
***ANTIDEPRESSANTS* - DRUGS FOR THE NERVOUS SYSTEM**		
ALPHA-2 RECEPTOR ANTAGONISTS (TETRACYCLICS) - DRUGS FOR DEPRESSION**		
mirtazapine oral tablet	1 or 1b*	
mirtazapine oral tablet dispersible	1 or 1b*	
REMERON ORAL TABLET (*mirtazapine*)	3	
REMERON SOLTAB ORAL TABLET DISPERSIBLE (*mirtazapine*)	3	
ANTIDEPRESSANTS - MISC. - DRUGS FOR DEPRESSION**		
APLENZIN ORAL TABLET EXTENDED RELEASE 24 HOUR 174 MG (*bupropion hbr*)	3	ST; DO
APLENZIN ORAL TABLET EXTENDED RELEASE 24 HOUR 348 MG, 522 MG (*bupropion hbr*)	3	ST; QL (1 tablet per 1 day)
bupropion hcl er (sr) oral tablet extended release 12 hour 100 mg	1 or 1b*	DO
bupropion hcl er (sr) oral tablet extended release 12 hour 150 mg, 200 mg	1 or 1b*	QL (2 tablets per 1 day)
bupropion hcl er (xl) oral tablet extended release 24 hour 150 mg	1 or 1b*	DO
bupropion hcl er (xl) oral tablet extended release 24 hour 300 mg, 450 mg	1 or 1b*	QL (1 tablet per 1 day)
bupropion hcl oral tablet 100 mg	1 or 1b*	QL (4.5 tablet per 1 day)
bupropion hcl oral tablet 75 mg	1 or 1b*	DO
WELLBUTRIN XL ORAL TABLET EXTENDED RELEASE 24 HOUR 150 MG (*bupropion hcl*)	3	ST; DO
WELLBUTRIN XL ORAL TABLET EXTENDED RELEASE 24 HOUR 300 MG (*bupropion hcl*)	3	ST; QL (1 tablet per 1 day)
GABA RECEPTOR MODULATOR - NEUROACTIVE STEROID - DRUGS FOR DEPRESSION**		
ZULRESSO INTRAVENOUS SOLUTION (*brexanolone*)	4	PA; LD; SP
MONOAMINE OXIDASE INHIBITORS (MAOIS) - DRUGS FOR DEPRESSION**		
EMSAM TRANSDERMAL PATCH 24 HOUR 12 MG/24HR, 9 MG/24HR (*selegiline*)	3	QL (1 patch per 1 day)
EMSAM TRANSDERMAL PATCH 24 HOUR 6 MG/24HR (*selegiline*)	3	DO
MARPLAN ORAL TABLET (*isocarboxazid*)	3	QL (6 tablets per 1 day)
NARDIL ORAL TABLET (*phenelzine sulfate*)	3	QL (6 tablets per 1 day)
PARNATE ORAL TABLET (*tranylcypromine sulfate*)	3	QL (6 tablets per 1 day)
phenelzine sulfate oral tablet	1 or 1b*	QL (6 tablets per 1 day)
tranylcypromine sulfate oral tablet	1 or 1b*	QL (6 tablets per 1 day)

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
N-METHYL-D-ASPARTIC ACID (NMDA) RECEPTOR ANTAGONISTS - DRUGS FOR DEPRESSION**		
SPRAVATO (56 MG DOSE) NASAL SOLUTION THERAPY PACK (*esketamine hcl*)	4	PA; LD; QL (4 kits per 28 days)
SPRAVATO (84 MG DOSE) NASAL SOLUTION THERAPY PACK (*esketamine hcl*)	4	PA; LD; QL (4 kits per 28 days)
SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIS) - DRUGS FOR DEPRESSION**		
citalopram hydrobromide oral solution	1 or 1b*	
citalopram hydrobromide oral tablet	1 or 1b*	
escitalopram oxalate oral solution	1 or 1b*	
escitalopram oxalate oral tablet	1 or 1b*	
fluoxetine hcl oral capsule	1 or 1b*	
fluoxetine hcl oral capsule delayed release	1 or 1b*	
fluoxetine hcl oral solution	1 or 1b*	
fluoxetine hcl oral tablet 10 mg, 20 mg	1 or 1b*	
FLUOXETINE HCL ORAL TABLET 60 MG	3	
fluvoxamine maleate er oral capsule extended release 24 hour	1 or 1b*	
fluvoxamine maleate oral tablet	1 or 1b*	
paroxetine hcl er oral tablet extended release 24 hour	1 or 1b*	
paroxetine hcl oral suspension	1 or 1b*	
paroxetine hcl oral tablet	1 or 1b*	
PAXIL ORAL SUSPENSION (*paroxetine hcl*)	3	ST
sertraline hcl oral concentrate	1 or 1b*	
sertraline hcl oral tablet	1 or 1b*	
SEROTONIN MODULATORS - DRUGS FOR DEPRESSION**		
nefazodone hcl oral tablet 100 mg, 50 mg	1 or 1b*	DO
nefazodone hcl oral tablet 150 mg, 250 mg	1 or 1b*	QL (2 tablets per 1 day)
nefazodone hcl oral tablet 200 mg	1 or 1b*	QL (3 tablets per 1 day)
trazodone hcl oral tablet 100 mg, 150 mg, 50 mg	1 or 1a*	DO
trazodone hcl oral tablet 300 mg	1 or 1a*	QL (2 tablets per 1 day)
TRINTELLIX ORAL TABLET 10 MG, 5 MG (*vortioxetine hbr*)	2	DO
TRINTELLIX ORAL TABLET 20 MG (*vortioxetine hbr*)	2	QL (1 tablet per 1 day)
vilazodone hcl oral tablet 10 mg, 20 mg	1 or 1b*	DO
vilazodone hcl oral tablet 40 mg	1 or 1b*	QL (1 tablet per 1 day)
SEROTONIN-NOREPINEPHRINE REUPTAKE INHIBITORS (SNRIS) - DRUGS FOR DEPRESSION**		
desvenlafaxine succinate er oral tablet extended release 24 hour 100 mg	1 or 1b*	QL (1 tablet per 1 day)
desvenlafaxine succinate er oral tablet extended release 24 hour 25 mg, 50 mg	1 or 1b*	DO
duloxetine hcl oral capsule delayed release particles 20 mg	1 or 1b*	QL (6 capsules per 1 day)
duloxetine hcl oral capsule delayed release particles 30 mg	1 or 1b*	QL (4 capsules per 1 day)
duloxetine hcl oral capsule delayed release particles 40 mg	1 or 1b*	QL (3 capsule per 1 day)
duloxetine hcl oral capsule delayed release particles 60 mg	1 or 1b*	QL (2 capsules per 1 day)

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
venlafaxine hcl er oral capsule extended release 24 hour 150 mg	1 or 1b*	QL (1 capsule per 1 day)
venlafaxine hcl er oral capsule extended release 24 hour 37.5 mg	1 or 1b*	QL (6 capsules per 1 day)
venlafaxine hcl er oral capsule extended release 24 hour 75 mg	1 or 1b*	QL (3 capsules per 1 day)
venlafaxine hcl er oral tablet extended release 24 hour	1 or 1b*	QL (1 tablet per 1 day)
venlafaxine hcl oral tablet	1 or 1b*	QL (3 tablet per 1 day)
TRICYCLIC AGENTS - DRUGS FOR DEPRESSION**		
amitriptyline hcl oral tablet 10 mg, 25 mg, 50 mg, 75 mg	1 or 1a*	DO
amitriptyline hcl oral tablet 100 mg	1 or 1a*	QL (3 tablets per 1 day)
amitriptyline hcl oral tablet 150 mg	1 or 1a*	QL (2 tablets per 1 day)
amoxapine oral tablet 100 mg	1 or 1b*	QL (4 tablets per 1 day)
amoxapine oral tablet 150 mg	1 or 1b*	QL (2 tablets per 1 day)
amoxapine oral tablet 25 mg, 50 mg	1 or 1b*	DO
clomipramine hcl oral capsule 25 mg	1 or 1b*	DO
clomipramine hcl oral capsule 50 mg	1 or 1b*	QL (5 capsules per 1 day)
clomipramine hcl oral capsule 75 mg	1 or 1b*	QL (3 capsules per 1 day)
desipramine hcl oral tablet 10 mg, 25 mg, 50 mg, 75 mg	1 or 1b*	DO
desipramine hcl oral tablet 100 mg	1 or 1b*	QL (3 tablets per 1 day)
desipramine hcl oral tablet 150 mg	1 or 1b*	QL (2 tablets per 1 day)
doxepin hcl oral capsule 10 mg, 25 mg, 50 mg, 75 mg	1 or 1b*	DO
doxepin hcl oral capsule 100 mg	1 or 1b*	QL (3 capsules per 1 day)
doxepin hcl oral capsule 150 mg	1 or 1b*	QL (2 capsules per 1 day)
doxepin hcl oral concentrate	1 or 1b*	QL (30 mL per 1 day)
imipramine hcl oral tablet 10 mg, 25 mg	1 or 1b*	DO
imipramine hcl oral tablet 50 mg	1 or 1b*	QL (6 tablets per 1 day)
imipramine pamoate oral capsule 100 mg, 75 mg	1 or 1b*	DO
imipramine pamoate oral capsule 125 mg, 150 mg	1 or 1b*	QL (2 capsules per 1 day)
NORPRAMIN ORAL TABLET (*desipramine hcl*)	3	DO
nortriptyline hcl oral capsule 10 mg, 25 mg	1 or 1b*	DO
nortriptyline hcl oral capsule 50 mg	1 or 1b*	QL (3 capsules per 1 day)
nortriptyline hcl oral capsule 75 mg	1 or 1b*	QL (2 capsules per 1 day)
nortriptyline hcl oral solution	1 or 1b*	QL (75 mL per 1 day)
PAMELOR ORAL CAPSULE 10 MG, 25 MG (*nortriptyline hcl*)	3	DO
PAMELOR ORAL CAPSULE 50 MG (*nortriptyline hcl*)	3	QL (3 capsules per 1 day)
PAMELOR ORAL CAPSULE 75 MG (*nortriptyline hcl*)	3	QL (2 capsules per 1 day)
protriptyline hcl oral tablet 10 mg	1 or 1b*	QL (6 tablets per 1 day)
protriptyline hcl oral tablet 5 mg	1 or 1b*	DO
trimipramine maleate oral capsule 100 mg	1 or 1b*	QL (2 capsules per 1 day)
trimipramine maleate oral capsule 25 mg, 50 mg	1 or 1b*	QL (3 capsules per 1 day)
***ANTIDIABETICS* - HORMONES**		
ALPHA-GLUCOSIDASE INHIBITORS - DRUGS FOR DIABETES**		
acarbose oral tablet	1 or 1b*	QL (3 tablets per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
miglitol oral tablet	1 or 1b*	QL (3 tablets per 1 day)
ANTIDIABETIC - AMYLIN ANALOGS - DRUGS FOR DIABETES**		
SYMLINPEN 120 SUBCUTANEOUS SOLUTION PEN-INJECTOR (*pramlintide acetate*)	2	QL (4 pens per 30 days)
SYMLINPEN 60 SUBCUTANEOUS SOLUTION PEN-INJECTOR (*pramlintide acetate*)	2	QL (2 boxes per 30 days)
ANTIDIABETIC-ANTI-CD3 ANTIBODIES - HORMONES**		
TZIELD INTRAVENOUS SOLUTION (*teplizumab-mzwv*)	4	PA; LD
BIGUANIDES - DRUGS FOR DIABETES**		
metformin hcl er oral tablet extended release 24 hour 500 mg	1 or 1b*	
metformin hcl er oral tablet extended release 24 hour 750 mg	1 or 1b*	QL (2 tablets per 1 day)
metformin hcl oral solution	3	PA; QL (2 bottles per 30 days)
metformin hcl oral tablet 1000 mg	1 or 1b*	QL (2 tablets per 1 day)
metformin hcl oral tablet 500 mg	1 or 1b*	QL (5 tablets per 1 day)
metformin hcl oral tablet 850 mg	1 or 1b*; $0	QL (3 tablets per 1 day)
RIOMET ORAL SOLUTION (*metformin hcl*)	3	PA; QL (2 bottles per 30 days)
DIABETIC OTHER - DRUGS FOR DIABETES**		
BAQSIMI ONE PACK NASAL POWDER (*glucagon*)	3	QL (2 packs per 30 days)
BAQSIMI TWO PACK NASAL POWDER (*glucagon*)	3	QL (1 pack per 30 days)
diazoxide oral suspension	1 or 1b*	
GLUCAGEN HYPOKIT INJECTION SOLUTION RECONSTITUTED (*glucagon hcl (rdna)*)	3	QL (2 kits per 30 days)
GLUCAGON EMERGENCY INJECTION KIT	3	QL (2 kits per 30 days)
GLUCAGON EMERGENCY INJECTION SOLUTION RECONSTITUTED	3	QL (2 kits per 30 days)
GVOKE HYPOPEN 1-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR (*glucagon*)	3	QL (2 packs per 30 days)
GVOKE HYPOPEN 2-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR (*glucagon*)	3	QL (1 pack per 30 days)
GVOKE KIT SUBCUTANEOUS SOLUTION (*glucagon*)	3	QL (2 kits per 30 days)
GVOKE PFS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (*glucagon*)	3	QL (2 packs per 30 days)
PROGLYCEM ORAL SUSPENSION (*diazoxide*)	3	
ZEGALOGUE SUBCUTANEOUS SOLUTION AUTO-INJECTOR (*dasiglucagon hcl*)	3	
ZEGALOGUE SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (*dasiglucagon hcl*)	3	
DIPEPTIDYL PEPTIDASE-4 (DPP-4) INHIBITORS - DRUGS FOR DIABETES**		
alogliptin benzoate oral tablet	1 or 1b*	ST; QL (1 tablet per 1 day)
JANUVIA ORAL TABLET (*sitagliptin phosphate*)	2	ST; QL (1 tablet per 1 day)
DIPEPTIDYL PEPTIDASE-4 INHIBITOR-BIGUANIDE COMBINATIONS - DRUGS FOR DIABETES**		
alogliptin-metformin hcl oral tablet	1 or 1b*	ST; QL (2 tablets per 1 day)

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
JANUMET ORAL TABLET (*sitagliptin-metformin hcl*)	2	ST; QL (2 tablets per 1 day)
JANUMET XR ORAL TABLET EXTENDED RELEASE 24 HOUR 100-1000 MG (*sitagliptin-metformin hcl*)	2	ST; QL (1 tablet per 1 day)
JANUMET XR ORAL TABLET EXTENDED RELEASE 24 HOUR 50-1000 MG, 50-500 MG (*sitagliptin-metformin hcl*)	2	ST; QL (2 tablets per 1 day)
DOPAMINE RECEPTOR AGONISTS - ERGOT DERIVATIVES - DRUGS FOR DIABETES**		
CYCLOSET ORAL TABLET (*bromocriptine mesylate*)	3	QL (6 tablets per 1 day)
DPP-4 INHIBITOR-THIAZOLIDINEDIONE COMBINATIONS - DRUGS FOR DIABETES**		
alogliptin-pioglitazone oral tablet	1 or 1b*	ST; QL (1 tablet per 1 day)
HUMAN INSULIN - DRUGS FOR DIABETES**		
BASAGLAR KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR (*insulin glargine*)	2	QL (30 ML per 30 days)
FIASP FLEXTOUCH SUBCUTANEOUS SOLUTION PEN-INJECTOR (*insulin aspart (w/niacinamide)*)	2	QL (30 mL per 30 days)
FIASP INJECTION SOLUTION (*insulin aspart (w/niacinamide)*)	2	QL (30 mL per 30 days)
FIASP PENFILL SUBCUTANEOUS SOLUTION CARTRIDGE (*insulin aspart (w/niacinamide)*)	2	QL (30 mL per 30 days)
FIASP PUMPCART SUBCUTANEOUS SOLUTION CARTRIDGE (*insulin aspart (w/niacinamide)*)	2	QL (30 mL per 30 days)
HUMULIN R U-500 (CONCENTRATED) SUBCUTANEOUS SOLUTION (*insulin regular human*)	2	PA; QL (20 mL per 30 days)
HUMULIN R U-500 KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR (*insulin regular human*)	2	PA; QL (18 mL per 30 days)
MYXREDLIN INTRAVENOUS SOLUTION (*insulin regular(human) in nacl*)	3	
SEMGLEE (YFGN) SUBCUTANEOUS SOLUTION (*insulin glargine-yfgn*)	2	ST; QL (30 mL per 30 days)
SEMGLEE (YFGN) SUBCUTANEOUS SOLUTION PEN-INJECTOR (*insulin glargine-yfgn*)	2	ST; QL (30 mL per 30 days)
TOUJEO MAX SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR (*insulin glargine*)	2	QL (12 mL per 30 days)
TOUJEO SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR (*insulin glargine*)	2	QL (13.5 mL per 30 days)
TRESIBA FLEXTOUCH SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML (*insulin degludec*)	2	QL (30 mL per 30 days)
TRESIBA FLEXTOUCH SUBCUTANEOUS SOLUTION PEN-INJECTOR 200 UNIT/ML (*insulin degludec*)	2	QL (18 mL per 30 days)
TRESIBA SUBCUTANEOUS SOLUTION (*insulin degludec*)	2	QL (30 mL per 30 days)
INCRETIN MIMETIC AGENTS (GIP & GLP-1 RECEPTOR AGONISTS) - DRUGS FOR DIABETES**		
MOUNJARO SUBCUTANEOUS SOLUTION PEN-INJECTOR (*tirzepatide*)	2	PA; QL (4 pens per 28 days)

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
INCRETIN MIMETIC AGENTS (GLP-1 RECEPTOR AGONISTS) - DRUGS FOR DIABETES**		
OZEMPIC (0.25 OR 0.5 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR (*semaglutide*)	2	PA; QL (1 pen per 28 days)
OZEMPIC (1 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR (*semaglutide*)	2	PA; QL (1 unit per 28 days)
OZEMPIC (2 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR (*semaglutide*)	2	PA; QL (0.11 mL per 1 day)
RYBELSUS ORAL TABLET 14 MG, 7 MG (*semaglutide*)	2	PA; QL (1 carton per 30 days)
RYBELSUS ORAL TABLET 3 MG (*semaglutide*)	2	PA; QL (1 carton per 1 lifetime)
TRULICITY SUBCUTANEOUS SOLUTION PEN-INJECTOR 0.75 MG/0.5ML, 1.5 MG/0.5ML (*dulaglutide*)	2	PA; QL (4 pens per 28 days)
TRULICITY SUBCUTANEOUS SOLUTION PEN-INJECTOR 3 MG/0.5ML, 4.5 MG/0.5ML (*dulaglutide*)	2	PA; QL (4 syringes per 28 days)
VICTOZA SUBCUTANEOUS SOLUTION PEN-INJECTOR (*liraglutide*)	2	PA; QL (1 box per 30 days)
INSULIN-INCRETIN MIMETIC COMBINATIONS - DRUGS FOR DIABETES**		
SOLIQUA SUBCUTANEOUS SOLUTION PEN-INJECTOR (*insulin glargine-lixisenatide*)	2	QL (5 pen per 25 days)
XULTOPHY SUBCUTANEOUS SOLUTION PEN-INJECTOR (*insulin degludec-liraglutide*)	2	QL (5 pen per 30 days)
MEGLITINIDE ANALOGUES - DRUGS FOR DIABETES**		
nateglinide oral tablet	1 or 1b*	QL (3 tablets per 1 day)
repaglinide oral tablet 0.5 mg, 1 mg	1 or 1b*	QL (4 tablets per 1 day)
repaglinide oral tablet 2 mg	1 or 1b*	QL (8 tablets per 1 day)
PROGESTERONE RECEPTOR ANTAGONISTS - DRUGS FOR DIABETES**		
KORLYM ORAL TABLET (*mifepristone*)	4	PA; LD; QL (4 tablets per 1 day)
SGLT2 INHIBITOR - DPP-4 INHIBITOR - BIGUANIDE COMB - DRUGS FOR DIABETES**		
TRIJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-5-1000 MG, 25-5-1000 MG (*empagliflozin-linaglip-metform*)	2	ST; QL (1 tablet per 1 day)
TRIJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 12.5-2.5-1000 MG, 5-2.5-1000 MG (*empagliflozin-linaglip-metform*)	2	ST; QL (2 tablets per 1 day)
SGLT2 INHIBITOR - DPP-4 INHIBITOR COMBINATIONS - DRUGS FOR DIABETES**		
GLYXAMBI ORAL TABLET (*empagliflozin-linagliptin*)	2	ST; QL (1 tablet per 1 day)
SODIUM-GLUCOSE CO-TRANSPORTER 2 (SGLT2) INHIBITORS - DRUGS FOR DIABETES**		
FARXIGA ORAL TABLET (*dapagliflozin propanediol*)	2	ST; QL (1 tablet per 1 day)
JARDIANCE ORAL TABLET (*empagliflozin*)	2	ST; QL (1 tablet per 1 day)
SODIUM-GLUCOSE CO-TRANSPORTER 2 INHIBITOR-BIGUANIDE COMB - DRUGS FOR DIABETES**		
SYNJARDY ORAL TABLET (*empagliflozin-metformin hcl*)	2	ST; QL (2 tablets per 1 day)
SYNJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-1000 MG, 12.5-1000 MG, 5-1000 MG (*empagliflozin-metformin hcl*)	2	ST; QL (2 tablets per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SYNJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 25-1000 MG (*empagliflozin-metformin hcl*)	2	ST; QL (1 tablet per 1 day)
XIGDUO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-1000 MG, 10-500 MG, 5-500 MG (*dapagliflozin prop-metformin*)	2	ST; QL (1 tablet per 1 day)
XIGDUO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 2.5-1000 MG (*dapagliflozin prop-metformin*)	2	ST; QL (2 tablet per 1 day)
XIGDUO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 5-1000 MG (*dapagliflozin prop-metformin*)	2	ST; QL (2 tablets per 1 day)
SULFONYLUREA-BIGUANIDE COMBINATIONS - DRUGS FOR DIABETES**		
glipizide-metformin hcl oral tablet 2.5-250 mg	1 or 1b*	ST; QL (8 tablets per 1 day)
glipizide-metformin hcl oral tablet 2.5-500 mg, 5-500 mg	1 or 1b*	ST; QL (4 tablets per 1 day)
glyburide-metformin oral tablet 1.25-250 mg	1 or 1b*	ST; QL (8 tablets per 1 day)
glyburide-metformin oral tablet 2.5-500 mg, 5-500 mg	1 or 1b*	ST; QL (4 tablets per 1 day)
SULFONYLUREAS - DRUGS FOR DIABETES**		
glimepiride oral tablet 1 mg	1 or 1b*	ST; QL (8 tablets per 1 day)
glimepiride oral tablet 2 mg	1 or 1b*	ST; QL (4 tablets per 1 day)
glimepiride oral tablet 4 mg	1 or 1b*	ST; QL (2 tablets per 1 day)
glipizide er oral tablet extended release 24 hour 10 mg	1 or 1a*	ST; QL (2 tablets per 1 day)
glipizide er oral tablet extended release 24 hour 2.5 mg	1 or 1a*	ST; QL (8 tablets per 1 day)
glipizide er oral tablet extended release 24 hour 5 mg	1 or 1a*	ST; QL (4 tablets per 1 day)
glipizide oral tablet 10 mg	1 or 1a*	ST; QL (4 tablets per 1 day)
glipizide oral tablet 2.5 mg	1 or 1a*	ST; QL (16 tablets per 1 day)
glipizide oral tablet 5 mg	1 or 1a*	ST; QL (8 tablets per 1 day)
glipizide xl oral tablet extended release 24 hour 10 mg	1 or 1a*	ST; QL (2 tablets per 1 day)
glipizide xl oral tablet extended release 24 hour 2.5 mg	1 or 1a*	ST; QL (8 tablets per 1 day)
glipizide xl oral tablet extended release 24 hour 5 mg	1 or 1a*	ST; QL (4 tablets per 1 day)
glyburide micronized oral tablet 1.5 mg	1 or 1b*	ST; QL (8 tablets per 1 day)
glyburide micronized oral tablet 3 mg	1 or 1b*	ST; QL (4 tablets per 1 day)
glyburide micronized oral tablet 6 mg	1 or 1b*	ST; QL (2 tablets per 1 day)
glyburide oral tablet 1.25 mg	1 or 1b*	ST; QL (16 tablets per 1 day)
glyburide oral tablet 2.5 mg	1 or 1b*	ST; QL (8 tablets per 1 day)
glyburide oral tablet 5 mg	1 or 1b*	ST; QL (4 tablets per 1 day)
SULFONYLUREA-THIAZOLIDINEDIONE COMBINATIONS - DRUGS FOR DIABETES**		
DUETACT ORAL TABLET (*pioglitazone hcl-glimepiride*)	3	ST; QL (1 tablet per 1 day)
pioglitazone hcl-glimepiride oral tablet	1 or 1b*	ST; QL (1 tablet per 1 day)
THIAZOLIDINEDIONE-BIGUANIDE COMBINATIONS - DRUGS FOR DIABETES**		
pioglitazone hcl-metformin hcl oral tablet	1 or 1b*	ST; QL (3 tablets per 1 day)
THIAZOLIDINEDIONES - DRUGS FOR DIABETES**		
pioglitazone hcl oral tablet	1 or 1b*	ST; QL (1 tablet per 1 day)

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
***ANTIDIARRHEAL/PROBIOTIC AGENTS* - DRUGS FOR THE STOMACH**		
ANTIDIARRHEAL - CHLORIDE CHANNEL ANTAGONISTS - DRUGS FOR DIARRHEA**		
MYTESI ORAL TABLET DELAYED RELEASE (*crofelemer*)	3	PA; QL (2 tablets per 1 day)
ANTIPERISTALTIC AGENTS - DRUGS FOR DIARRHEA**		
diphenoxylate-atropine oral liquid	1 or 1b*	
diphenoxylate-atropine oral tablet	1 or 1b*	
LOMOTIL ORAL TABLET (*diphenoxylate-atropine*)	3	
loperamide hcl oral capsule	1 or 1b*	QL (8 capsules per 1 day)
MOTOFEN ORAL TABLET (*difenoxin-atropine*)	3	
***ANTIDOTES AND SPECIFIC ANTAGONISTS* - DRUGS FOR OVERDOSE OR POISONING**		
ANTIDOTE COMBINATIONS - DRUGS FOR OVERDOSE OR POISONING**		
NITHIODOTE INTRAVENOUS KIT (*sodium nitrite-sod thiosulfate*)	3	
PREVDUO INTRAVENOUS SOLUTION PREFILLED SYRINGE (*neostigmine-glycopyrrolate*)	3	
ANTIDOTES - CHELATING AGENTS - DRUGS FOR OVERDOSE OR POISONING**		
CHEMET ORAL CAPSULE (*succimer*)	3	
deferasirox granules oral packet	4	PA; LD; SP
deferasirox oral packet	4	PA; LD; SP
deferasirox oral tablet	4	PA; LD; SP
deferasirox oral tablet soluble	4	PA; LD; SP
deferiprone oral tablet	4	PA; LD
FERRIPROX ORAL SOLUTION (*deferiprone*)	4	PA; LD
FERRIPROX TWICE-A-DAY ORAL TABLET (*deferiprone*)	4	PA; LD
ANTIDOTES AND SPECIFIC ANTAGONISTS - DRUGS FOR OVERDOSE OR POISONING**		
ACETADOTE INTRAVENOUS SOLUTION (*acetylcysteine*)	3	
acetylcysteine intravenous solution	1 or 1b*	
ANDEXXA INTRAVENOUS SOLUTION RECONSTITUTED (*coag fact xa inactivated-zhzo*)	3	
BRIDION INTRAVENOUS SOLUTION (*sugammadex sodium*)	3	
CYANOKIT INTRAVENOUS SOLUTION RECONSTITUTED (*hydroxocobalamin*)	3	
deferoxamine mesylate injection solution reconstituted	4	SP
DESFERAL INJECTION SOLUTION RECONSTITUTED (*deferoxamine mesylate*)	4	SP
DIGIFAB INTRAVENOUS SOLUTION RECONSTITUTED (*digoxin immune fab*)	3	
edetate calcium disodium injection solution	3	
fomepizole intravenous solution	1 or 1b*	

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
methylene blue intravenous solution	1 or 1b*	
methylene blue intravenous solution prefilled syringe	3	
PRAXBIND INTRAVENOUS SOLUTION (*idarucizumab*)	3	
PROTOPAM CHLORIDE INTRAVENOUS SOLUTION RECONSTITUTED (*pralidoxime chloride*)	3	
PROVAYBLUE INTRAVENOUS SOLUTION (*methylene blue (antidote)*)	3	
RADIOGARDASE ORAL CAPSULE (*prussian blue insoluble*)	3	
SODIUM NITRITE INTRAVENOUS SOLUTION	3	
SODIUM THIOSULFATE INTRAVENOUS SOLUTION	1 or 1b*	
VISTOGARD ORAL PACKET (*uridine triacetate*)	3	PA; LD; QL (20 packets per 30 days)
BENZODIAZEPINE ANTAGONISTS - DRUGS FOR OVERDOSE OR POISONING**		
flumazenil intravenous solution	1 or 1b*	
OPIOID ANTAGONISTS - DRUGS FOR OVERDOSE OR POISONING**		
KLOXXADO NASAL LIQUID (*naloxone hcl*)	2	QL (6 nasal sprays per 3 monthss)
nalmefene hcl injection solution	3	QL (20 mL per 150 days)
naloxone hcl injection solution	1 or 1b*	QL (6 vial per 90 days)
naloxone hcl injection solution cartridge	1 or 1b*	QL (6 syringe per 90 days)
naloxone hcl injection solution prefilled syringe	1 or 1b*	QL (6 syringe per 90 days)
naloxone hcl nasal liquid	1 or 1b*	QL (6 nasal spray per 90 days)
naltrexone hcl oral tablet	1 or 1b*	
OPVEE NASAL SOLUTION (*nalmefene hcl*)	2	QL (3 cartons per 90 days)
VIVITROL INTRAMUSCULAR SUSPENSION RECONSTITUTED (*naltrexone*)	4	QL (1 vial per 28 days)
ZIMHI INJECTION SOLUTION PREFILLED SYRINGE (*naloxone hcl*)	2	QL (6 syringes per 3 monthss)
***ANTIEMETICS* - DRUGS FOR THE STOMACH**		
5-HT3 RECEPTOR ANTAGONISTS - DRUGS FOR VOMITING AND NAUSEA**		
ANZEMET ORAL TABLET (*dolasetron mesylate*)	3	QL (5 tablets per 30 days)
granisetron hcl intravenous solution	1 or 1b*	
granisetron hcl oral tablet	1 or 1b*	QL (10 tablets per 30 days)
ondansetron hcl injection solution	1 or 1b*	
ondansetron hcl injection solution prefilled syringe	1 or 1b*	
ondansetron hcl oral solution	1 or 1b*	QL (8 mL per 1 day)
ondansetron hcl oral tablet 24 mg	1 or 1b*	QL (8 tablet per 30 days)
ondansetron hcl oral tablet 4 mg	1 or 1b*	QL (48 tablets per 30 days)
ondansetron hcl oral tablet 8 mg	1 or 1b*	QL (24 tablets per 30 days)
ondansetron oral tablet dispersible 4 mg	1 or 1b*	QL (48 tablets per 30 days)
ondansetron oral tablet dispersible 8 mg	1 or 1b*	QL (24 tablets per 30 days)
PALONOSETRON HCL INTRAVENOUS SOLUTION 0.25 MG/2ML	3	PA
palonosetron hcl intravenous solution 0.25 mg/5ml	1 or 1b*	PA

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
palonosetron hcl intravenous solution prefilled syringe	1 or 1b*	PA
SANCUSO TRANSDERMAL PATCH (*granisetron*)	3	QL (4 patches per 28 days)
SUSTOL SUBCUTANEOUS PREFILLED SYRINGE (*granisetron*)	3	
ANTIEMETIC COMBINATIONS - DRUGS FOR VOMITING AND NAUSEA**		
AKYNZEO (READY-TO-USE) INTRAVENOUS SOLUTION (*fosnetupitant-palonosetron*)	3	PA; LD; QL (5 vials per 30 days)
AKYNZEO (TO-BE-DILUTED) INTRAVENOUS SOLUTION (*fosnetupitant-palonosetron*)	3	PA; LD; QL (5 vials per 30 days)
AKYNZEO INTRAVENOUS SOLUTION RECONSTITUTED (*fosnetupitant-palonosetron*)	3	PA; LD; QL (5 vials per 30 days)
AKYNZEO ORAL CAPSULE (*netupitant-palonosetron*)	3	QL (5 capsules per 25 days)
BONJESTA ORAL TABLET EXTENDED RELEASE (*doxylamine-pyridoxine*)	3	PA; QL (4 tablet per 1 day)
doxylamine-pyridoxine oral tablet delayed release	1 or 1b*	PA; QL (4 tablet per 1 day)
ANTIEMETICS - ANTICHOLINERGIC - DRUGS FOR VOMITING AND NAUSEA**		
ANTIVERT ORAL TABLET (*meclizine hcl*)	3	
ANTIVERT ORAL TABLET CHEWABLE (*meclizine hcl*)	3	
DIMENHYDRINATE INJECTION SOLUTION	3	
meclizine hcl oral tablet	1 or 1b*	
scopolamine transdermal patch 72 hour	1 or 1b*	
TIGAN INTRAMUSCULAR SOLUTION (*trimethobenzamide hcl*)	3	
trimethobenzamide hcl oral capsule	1 or 1b*	
ANTIEMETICS - ANTIDOPAMINERGIC - DRUGS FOR VOMITING AND NAUSEA**		
BARHEMSYS INTRAVENOUS SOLUTION (*amisulpride (antiemetic)*)	3	
ANTIEMETICS - MISCELLANEOUS - DRUGS FOR VOMITING AND NAUSEA**		
dronabinol oral capsule	1 or 1b*	QL (4 capsules per 1 day)
MARINOL ORAL CAPSULE (*dronabinol*)	3	QL (4 capsules per 1 day)
SYNDROS ORAL SOLUTION (*dronabinol*)	3	QL (8 mL per 1 day)
SUBSTANCE P/NEUROKININ 1 (NK1) RECEPTOR ANTAGONISTS - DRUGS FOR VOMITING AND NAUSEA**		
APONVIE INTRAVENOUS EMULSION (*aprepitant*)	3	
aprepitant oral	1 or 1b*	QL (15 capsules per 25 days)
aprepitant oral capsule 125 mg	1 or 1b*	QL (5 capsules per 25 days)
aprepitant oral capsule 40 mg	1 or 1b*	QL (1 capsule per 1 fill)
aprepitant oral capsule 80 & 125 mg	1 or 1b*	QL (15 capsules per 25 days)
aprepitant oral capsule 80 mg	1 or 1b*	QL (10 capsules per 25 days)
CINVANTI INTRAVENOUS EMULSION (*aprepitant*)	3	PA; QL (5 vials per 30 days)
EMEND ORAL SUSPENSION RECONSTITUTED (*aprepitant*)	3	QL (15 kit per 30 days)
fosaprepitant dimeglumine intravenous solution reconstituted	1 or 1b*	PA; QL (5 vial per 30 days)

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VARUBI (180 MG DOSE) ORAL TABLET THERAPY PACK (*rolapitant hcl*)	3	QL (4 capsules per 28 days)
***ANTIFUNGALS* - DRUGS FOR INFECTIONS**		
ANTIFUNGAL - GLUCAN SYNTHESIS INHIBITORS (ECHINOCANDINS) - DRUGS FOR FUNGUS**		
CANCIDAS INTRAVENOUS SOLUTION RECONSTITUTED (*caspofungin acetate*)	3	QL (1 vial per 1 day)
CASPOFUNGIN ACETATE INTRAVENOUS SOLUTION RECONSTITUTED	3	QL (1 vial per 1 day)
ERAXIS INTRAVENOUS SOLUTION RECONSTITUTED (*anidulafungin*)	3	
MICAFUNGIN SODIUM INTRAVENOUS SOLUTION RECONSTITUTED	3	
MYCAMINE INTRAVENOUS SOLUTION RECONSTITUTED (*micafungin sodium*)	3	
REZZAYO INTRAVENOUS SOLUTION RECONSTITUTED (*rezafungin acetate*)	3	
ANTIFUNGAL - GLUCAN SYNTHESIS INHIBITORS (TRITERPENOIDS) - ANTIBIOTICS**		
BREXAFEMME ORAL TABLET (*ibrexafungerp citrate*)	3	PA; QL (4 tablets per 1 month)
ANTIFUNGALS - DRUGS FOR FUNGUS**		
ABELCET INTRAVENOUS SUSPENSION (*amphotericin b lipid*)	3	
AMBISOME INTRAVENOUS SUSPENSION RECONSTITUTED (*amphotericin b liposome*)	3	
amphotericin b intravenous solution reconstituted	1 or 1b*	
amphotericin b liposome intravenous suspension reconstituted	1 or 1b*	
ANCOBON ORAL CAPSULE (*flucytosine*)	3	PA
flucytosine oral capsule	1 or 1b*	PA
griseofulvin microsize oral suspension	1 or 1b*	
griseofulvin microsize oral tablet	1 or 1b*	
griseofulvin ultramicrosize oral tablet	1 or 1b*	
nystatin oral tablet	1 or 1b*	
terbinafine hcl oral tablet	1 or 1b*	QL (1 tablet per 1 day)
IMIDAZOLES - DRUGS FOR FUNGUS**		
ketoconazole oral tablet	1 or 1b*	QL (2 tablets per 1 day)
TETRAZOLES - DRUGS FOR FUNGUS**		
VIVJOA ORAL CAPSULE THERAPY PACK (*oteseconazole*)	3	PA; QL (1 carton per 4 monthss)
TRIAZOLES - DRUGS FOR FUNGUS**		
CRESEMBA INTRAVENOUS SOLUTION RECONSTITUTED (*isavuconazonium sulfate*)	3	PA; QL (1 vial per 1 day)
CRESEMBA ORAL CAPSULE 186 MG (*isavuconazonium sulfate*)	3	PA; QL (2 capsules per 1 day)
CRESEMBA ORAL CAPSULE 74.5 MG (*isavuconazonium sulfate*)	3	PA; QL (5 capsules per 1 day)
DIFLUCAN ORAL SUSPENSION RECONSTITUTED 10 MG/ML (*fluconazole*)	3	QL (40 mL per 1 day)

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIFLUCAN ORAL SUSPENSION RECONSTITUTED 40 MG/ML (*fluconazole*)	3	QL (10 mL per 1 day)
DIFLUCAN ORAL TABLET 100 MG (*fluconazole*)	3	QL (4 tablet per 1 day)
DIFLUCAN ORAL TABLET 150 MG, 200 MG (*fluconazole*)	3	QL (2 tablets per 1 day)
FLUCONAZOLE IN SODIUM CHLORIDE INTRAVENOUS SOLUTION 100-0.9 MG/50ML-%	3	
fluconazole in sodium chloride intravenous solution 200-0.9 mg/100ml-%, 400-0.9 mg/200ml-%	1 or 1b*	
fluconazole oral suspension reconstituted 10 mg/ml	1 or 1b*	QL (40 mL per 1 day)
fluconazole oral suspension reconstituted 40 mg/ml	1 or 1b*	QL (10 mL per 1 day)
fluconazole oral tablet 100 mg	1 or 1b*	QL (4 tablet per 1 day)
fluconazole oral tablet 150 mg, 200 mg	1 or 1b*	QL (2 tablets per 1 day)
fluconazole oral tablet 50 mg	1 or 1b*	QL (8 tablet per 1 day)
itraconazole oral capsule	1 or 1b*	PA; QL (4.2 capsules per 1 day)
itraconazole oral solution	1 or 1b*	PA; QL (20 mL per 1 day)
NOXAFIL ORAL PACKET (*posaconazole*)	3	PA; QL (31 packet per 30 days)
posaconazole intravenous solution	1 or 1b*	
posaconazole oral suspension	1 or 1b*	PA; QL (20 mL per 1 day)
posaconazole oral tablet delayed release	1 or 1b*	PA; QL (93 tablets per 30 days)
SPORANOX ORAL CAPSULE (*itraconazole*)	3	PA; QL (4.2 capsules per 1 day)
SPORANOX ORAL SOLUTION (*itraconazole*)	3	PA; QL (20 mL per 1 day)
TOLSURA ORAL CAPSULE	3	PA; QL (126 capsules per 30 days)
VFEND ORAL SUSPENSION RECONSTITUTED (*voriconazole*)	3	PA; QL (10 mL per 1 day)
VFEND ORAL TABLET 200 MG (*voriconazole*)	3	PA; QL (2 tablets per 1 day)
VFEND ORAL TABLET 50 MG (*voriconazole*)	3	PA; QL (6 tablets per 1 day)
voriconazole oral suspension reconstituted	1 or 1b*	PA; QL (10 mL per 1 day)
voriconazole oral tablet 200 mg	1 or 1b*	PA; QL (2 tablets per 1 day)
voriconazole oral tablet 50 mg	1 or 1b*	PA; QL (6 tablets per 1 day)
***ANTIHISTAMINES* - DRUGS FOR THE LUNGS**		
ANTIHISTAMINES - ETHANOLAMINES - DRUGS FOR ALLERGIES**		
carbinoxamine maleate oral solution	1 or 1b*	ST
carbinoxamine maleate oral tablet	1 or 1b*	ST
CLEMASTINE FUMARATE ORAL SYRUP	3	ST; QL (60 mL per 1 day)
clemastine fumarate oral tablet	1 or 1b*	ST; QL (3 tablets per 1 day)
diphenhydramine hcl injection solution	1 or 1b*	
diphenhydramine hcl oral elixir	1 or 1a*	QL (4 mL per 1 day)
KARBINAL ER ORAL SUSPENSION EXTENDED RELEASE (*carbinoxamine maleate*)	3	ST; QL (40 mL per 1 day)
ANTIHISTAMINES - NON-SEDATING - DRUGS FOR ALLERGIES**		
cetirizine hcl oral solution	1 or 1b*	QL (10 mL per 1 day)
CLARINEX ORAL TABLET (*desloratadine*)	3	ST; QL (1 tablet per 1 day)

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
desloratadine oral tablet	1 or 1b*	QL (1 tablet per 1 day)
desloratadine oral tablet dispersible	1 or 1b*	QL (1 tablet per 1 day)
levocetirizine dihydrochloride oral solution	1 or 1b*	QL (10 mL per 1 day)
levocetirizine dihydrochloride oral tablet	1 or 1b*	QL (1 tablet per 1 day)
QUZYTTIR INTRAVENOUS SOLUTION (*cetirizine hcl*)	3	
ANTIHISTAMINES - PHENOTHIAZINES - DRUGS FOR ALLERGIES**		
PHENERGAN INJECTION SOLUTION (*promethazine hcl*)	3	
promethazine hcl injection solution	1 or 1a*	
promethazine hcl oral solution	1 or 1a*	QL (40 mL per 1 day)
promethazine hcl oral syrup	1 or 1a*	QL (40 mL per 1 day)
promethazine hcl oral tablet 12.5 mg, 25 mg	1 or 1a*	QL (4 tablets per 1 day)
promethazine hcl oral tablet 50 mg	1 or 1a*	QL (1 tablet per 1 day)
promethazine hcl rectal suppository	1 or 1b*	QL (6 suppositories per 1 day)
promethegan rectal suppository 12.5 mg, 25 mg	1 or 1b*	QL (6 suppositories per 1 day)
promethegan rectal suppository 50 mg	1 or 1b*	QL (1 suppository per 1 day)
ANTIHISTAMINES - PIPERIDINES - DRUGS FOR ALLERGIES**		
cyproheptadine hcl oral syrup	1 or 1b*	
cyproheptadine hcl oral tablet	1 or 1b*	
***ANTIHYPERLIPIDEMICS* - DRUGS FOR THE HEART**		
ACL INHIB-INTESTINAL CHOLESTEROL ABSORPTION INHIB COMB - DRUGS FOR CHOLESTEROL**		
NEXLIZET ORAL TABLET (*bempedoic acid-ezetimibe*)	3	PA; QL (1 tablet per 1 day)
ADENOSINE TRIPHOSPHATE-CITRATE LYASE (ACL) INHIBITORS - DRUGS FOR CHOLESTEROL**		
NEXLETOL ORAL TABLET (*bempedoic acid*)	3	PA; QL (1 tablet per 1 day)
ANGIOPOIETIN-LIKE PROTEIN 3 (ANGPTL3) INHIBITORS - DRUGS FOR CHOLESTEROL**		
EVKEEZA INTRAVENOUS SOLUTION (*evinacumab-dgnb*)	4	PA; LD
ANTIHYPERLIPIDEMICS - MISC. - DRUGS FOR CHOLESTEROL**		
omega-3-acid ethyl esters oral capsule	1 or 1b*	PA; QL (4 capsule per 1 day)
VASCEPA ORAL CAPSULE 0.5 GM (*icosapent ethyl*)	1 or 1b*	PA; QL (8 capsules per 1 day)
VASCEPA ORAL CAPSULE 1 GM (*icosapent ethyl*)	1 or 1b*	PA; QL (4 capsule per 1 day)
BILE ACID SEQUESTRANTS - DRUGS FOR CHOLESTEROL**		
cholestyramine light oral packet	1 or 1b*	QL (24 grams per 1 day)
cholestyramine light oral powder	1 or 1b*	QL (30 grams per 1 day)
cholestyramine oral packet	1 or 1b*	QL (6 packets per 1 day)
cholestyramine oral powder	1 or 1b*	QL (54 gm per 1 day)
colesevelam hcl oral packet	3	QL (1 packet per 1 day)
colesevelam hcl oral tablet	1 or 1b*	QL (6 tablets per 1 day)
COLESTID FLAVORED ORAL GRANULES (*colestipol hcl*)	3	QL (45 grams per 1 day)
COLESTID FLAVORED ORAL PACKET (*colestipol hcl*)	3	QL (30 grams per 1 day)

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
COLESTID ORAL GRANULES (*colestipol hcl*)	3	QL (45 grams per 1 day)
COLESTID ORAL PACKET (*colestipol hcl*)	3	QL (30 grams per 1 day)
COLESTID ORAL TABLET (*colestipol hcl*)	3	QL (16 tablets per 1 day)
colestipol hcl oral granules	1 or 1b*	QL (45 grams per 1 day)
colestipol hcl oral packet	1 or 1b*	QL (30 grams per 1 day)
colestipol hcl oral tablet	1 or 1b*	QL (16 tablets per 1 day)
prevalite oral packet	1 or 1b*	QL (24 grams per 1 day)
prevalite oral powder	1 or 1b*	QL (30 grams per 1 day)
QUESTRAN LIGHT ORAL POWDER (*cholestyramine light*)	3	QL (30 grams per 1 day)
QUESTRAN ORAL PACKET (*cholestyramine*)	3	QL (6 packets per 1 day)
QUESTRAN ORAL POWDER (*cholestyramine*)	3	QL (54 gm per 1 day)
FIBRIC ACID DERIVATIVES - DRUGS FOR CHOLESTEROL**		
fenofibrate micronized oral capsule	1 or 1b*	QL (1 capsule per 1 day)
fenofibrate oral capsule	1 or 1b*	QL (1 capsule per 1 day)
fenofibrate oral tablet 120 mg, 40 mg	3	ST; QL (1 tablet per 1 day)
fenofibrate oral tablet 145 mg, 160 mg, 48 mg, 54 mg	1 or 1b*	QL (1 tablet per 1 day)
fenofibric acid oral capsule delayed release	1 or 1b*	QL (1 capsule per 1 day)
fenofibric acid oral tablet	1 or 1b*	QL (1 tablet per 1 day)
FENOGLIDE ORAL TABLET (*fenofibrate*)	3	ST; QL (1 tablet per 1 day)
FIBRICOR ORAL TABLET (*fenofibric acid*)	3	ST; QL (1 tablet per 1 day)
gemfibrozil oral tablet	1 or 1b*	QL (2 tablets per 1 day)
LIPOFEN ORAL CAPSULE (*fenofibrate*)	3	ST; QL (1 capsule per 1 day)
LOPID ORAL TABLET (*gemfibrozil*)	3	ST; QL (2 tablets per 1 day)
TRICOR ORAL TABLET (*fenofibrate*)	3	ST; QL (1 tablet per 1 day)
HMG COA REDUCTASE INHIBITORS - DRUGS FOR CHOLESTEROL**		
atorvastatin calcium oral tablet 10 mg, 20 mg	1 or 1b*; $0	DO
atorvastatin calcium oral tablet 40 mg	1 or 1b*	DO
atorvastatin calcium oral tablet 80 mg	1 or 1b*	QL (1 tablet per 1 day)
fluvastatin sodium oral capsule	1 or 1b*; $0	DO
lovastatin oral tablet 10 mg, 20 mg	1 or 1b*; $0	DO
lovastatin oral tablet 40 mg	1 or 1b*; $0	QL (2 tablets per 1 day)
pravastatin sodium oral tablet 10 mg, 20 mg, 40 mg	1 or 1b*; $0	DO
pravastatin sodium oral tablet 80 mg	1 or 1b*; $0	QL (1 tablet per 1 day)
rosuvastatin calcium oral tablet 10 mg, 5 mg	1 or 1b*; $0	DO
rosuvastatin calcium oral tablet 20 mg	1 or 1b*	DO
rosuvastatin calcium oral tablet 40 mg	1 or 1b*	QL (1 tablet per 1 day)
simvastatin oral tablet 10 mg, 20 mg, 5 mg	1 or 1b*; $0	DO
simvastatin oral tablet 40 mg	1 or 1b*; $0	QL (1 tablet per 1 day)
simvastatin oral tablet 80 mg	1 or 1b*	PA; QL (1 tablet per 1 day)

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
INTEST CHOLEST ABSORP INHIB-HMG COA REDUCTASE INHIB COMB - DRUGS FOR CHOLESTEROL**		
ezetimibe-simvastatin oral tablet	1 or 1b*	ST; QL (1 tablet per 1 day)
INTESTINAL CHOLESTEROL ABSORPTION INHIBITORS - DRUGS FOR CHOLESTEROL**		
ezetimibe oral tablet	1 or 1b*	ST; QL (1 tablet per 1 day)
MICROSOMAL TRIGLYCERIDE TRANSFER PROTEIN INHIBITORS - DRUGS FOR CHOLESTEROL**		
JUXTAPID ORAL CAPSULE 10 MG, 5 MG (*lomitapide mesylate*)	3	PA; LD; DO
JUXTAPID ORAL CAPSULE 20 MG, 30 MG (*lomitapide mesylate*)	3	PA; LD; QL (2 capsules per 1 day)
NICOTINIC ACID DERIVATIVES - DRUGS FOR CHOLESTEROL**		
niacin (antihyperlipidemic) oral tablet	1 or 1b*	ST; QL (12 tablets per 1 day)
niacin er (antihyperlipidemic) oral tablet extended release 1000 mg, 750 mg	1 or 1b*	ST; QL (2 tablets per 1 day)
niacin er (antihyperlipidemic) oral tablet extended release 500 mg	1 or 1b*	ST; QL (1 tablet per 1 day)
niacor oral tablet	1 or 1b*	ST; QL (12 tablets per 1 day)
PCSK9 INHIBITORS - DRUGS FOR CHOLESTEROL**		
REPATHA PUSHTRONEX SYSTEM SUBCUTANEOUS SOLUTION CARTRIDGE (*evolocumab*)	3	QL (1 cartridge per 28 days)
REPATHA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (*evolocumab*)	3	QL (2 syringe per 28 days)
REPATHA SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR (*evolocumab*)	3	QL (2 syringe per 28 days)
SMALL INTERFERING RNA (SIRNA) PCSK9 INHIBITORS - DRUGS FOR CHOLESTEROL**		
LEQVIO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (*inclisiran sodium*)	4	LD; QL (1.5 mL per 180 days)
***ANTIHYPERTENSIVES* - DRUGS FOR THE HEART**		
ACE INHIBITOR & CALCIUM CHANNEL BLOCKER COMBINATIONS - DRUGS FOR HIGH BLOOD PRESSURE**		
amlodipine besy-benazepril hcl oral capsule 10-20 mg, 10-40 mg, 5-40 mg	1 or 1b*	QL (1 capsule per 1 day)
amlodipine besy-benazepril hcl oral capsule 2.5-10 mg, 5-10 mg, 5-20 mg	1 or 1b*	DO
PRESTALIA ORAL TABLET 14-10 MG (*perindopril arg-amlodipine*)	3	QL (1 tablet per 1 day)
PRESTALIA ORAL TABLET 3.5-2.5 MG, 7-5 MG (*perindopril arg-amlodipine*)	3	DO
trandolapril-verapamil hcl er oral tablet extended release	1 or 1b*	QL (1 tablet per 1 day)
ACE INHIBITORS & THIAZIDE/THIAZIDE-LIKE - DRUGS FOR HIGH BLOOD PRESSURE**		
ACCURETIC ORAL TABLET 10-12.5 MG (*quinapril-hydrochlorothiazide*)	3	DO
ACCURETIC ORAL TABLET 20-12.5 MG (*quinapril-hydrochlorothiazide*)	3	QL (2 tablets per 1 day)
benazepril-hydrochlorothiazide oral tablet 10-12.5 mg, 5-6.25 mg	1 or 1b*	DO
benazepril-hydrochlorothiazide oral tablet 20-12.5 mg, 20-25 mg	1 or 1b*	QL (1 tablet per 1 day)
captopril-hydrochlorothiazide oral tablet	1 or 1b*	QL (2 tablets per 1 day)
enalapril-hydrochlorothiazide oral tablet 10-25 mg	1 or 1b*	QL (2 tablets per 1 day)
enalapril-hydrochlorothiazide oral tablet 5-12.5 mg	1 or 1b*	DO

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
fosinopril sodium-hctz oral tablet 10-12.5 mg	1 or 1b*	DO
fosinopril sodium-hctz oral tablet 20-12.5 mg	1 or 1b*	QL (4 tablets per 1 day)
lisinopril-hydrochlorothiazide oral tablet 10-12.5 mg	1 or 1b*	DO
lisinopril-hydrochlorothiazide oral tablet 20-12.5 mg	1 or 1b*	QL (4 tablets per 1 day)
lisinopril-hydrochlorothiazide oral tablet 20-25 mg	1 or 1b*	QL (2 tablets per 1 day)
LOTENSIN HCT ORAL TABLET 10-12.5 MG (*benazepril-hydrochlorothiazide*)	3	DO
LOTENSIN HCT ORAL TABLET 20-12.5 MG, 20-25 MG (*benazepril-hydrochlorothiazide*)	3	QL (1 tablet per 1 day)
quinapril-hydrochlorothiazide oral tablet 10-12.5 mg	1 or 1b*	
quinapril-hydrochlorothiazide oral tablet 20-12.5 mg, 20-25 mg	1 or 1b*	QL (2 tablets per 1 day)
VASERETIC ORAL TABLET (*enalapril-hydrochlorothiazide*)	3	QL (2 tablets per 1 day)
ZESTORETIC ORAL TABLET 10-12.5 MG (*lisinopril-hydrochlorothiazide*)	3	DO
ZESTORETIC ORAL TABLET 20-12.5 MG (*lisinopril-hydrochlorothiazide*)	3	QL (4 tablets per 1 day)
ZESTORETIC ORAL TABLET 20-25 MG (*lisinopril-hydrochlorothiazide*)	3	QL (2 tablets per 1 day)
ACE INHIBITORS - DRUGS FOR HIGH BLOOD PRESSURE**		
benazepril hcl oral tablet 10 mg, 20 mg, 5 mg	1 or 1a*	DO
benazepril hcl oral tablet 40 mg	1 or 1a*	QL (2 tablets per 1 day)
captopril oral tablet 100 mg	1 or 1b*	QL (3 tablets per 1 day)
captopril oral tablet 12.5 mg, 25 mg, 50 mg	1 or 1b*	DO
enalapril maleate oral solution	1 or 1b*	QL (40 mg per 1 day)
enalapril maleate oral tablet 10 mg, 2.5 mg, 5 mg	1 or 1b*	DO
enalapril maleate oral tablet 20 mg	1 or 1b*	QL (2 tablets per 1 day)
enalaprilat intravenous injectable	1 or 1b*	
EPANED ORAL SOLUTION (*enalapril maleate*)	3	QL (40 mg per 1 day)
fosinopril sodium oral tablet 10 mg, 20 mg	1 or 1b*	DO
fosinopril sodium oral tablet 40 mg	1 or 1b*	QL (2 tablets per 1 day)
lisinopril oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg	1 or 1a*	DO
lisinopril oral tablet 30 mg, 40 mg	1 or 1a*	QL (2 tablets per 1 day)
LOTENSIN ORAL TABLET 10 MG, 20 MG (*benazepril hcl*)	3	DO
LOTENSIN ORAL TABLET 40 MG (*benazepril hcl*)	3	QL (2 tablets per 1 day)
moexipril hcl oral tablet 15 mg	1 or 1b*	QL (4 tablets per 1 day)
moexipril hcl oral tablet 7.5 mg	1 or 1b*	DO
perindopril erbumine oral tablet 2 mg, 4 mg	1 or 1b*	DO
perindopril erbumine oral tablet 8 mg	1 or 1b*	QL (2 tablets per 1 day)
QBRELIS ORAL SOLUTION (*lisinopril*)	3	QL (40 mg per 1 day)
quinapril hcl oral tablet 10 mg, 20 mg, 5 mg	1 or 1b*	DO
quinapril hcl oral tablet 40 mg	1 or 1b*	QL (2 tablets per 1 day)
ramipril oral capsule 1.25 mg, 2.5 mg, 5 mg	1 or 1b*	DO
ramipril oral capsule 10 mg	1 or 1b*	QL (2 capsules per 1 day)

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
trandolapril oral tablet 1 mg, 2 mg	1 or 1b*	DO
trandolapril oral tablet 4 mg	1 or 1b*	QL (2 tablets per 1 day)
AGENTS FOR PHEOCHROMOCYTOMA - DRUGS FOR HIGH BLOOD PRESSURE**		
DEMSER ORAL CAPSULE (*metyrosine*)	3	PA; QL (16 capsules per 1 day)
DIBENZYLINE ORAL CAPSULE (*phenoxybenzamine hcl*)	3	PA; QL (12 capsules per 1 day)
metyrosine oral capsule	1 or 1b*	PA; QL (16 capsules per 1 day)
phenoxybenzamine hcl oral capsule	1 or 1b*	PA; QL (12 capsules per 1 day)
phentolamine mesylate injection solution reconstituted	1 or 1b*	
ANGIOTENSIN II RECEPTOR ANTAG & CA CHANNEL BLOCKER COMB - DRUGS FOR HIGH BLOOD PRESSURE**		
amlodipine besylate-valsartan oral tablet 10-160 mg, 10-320 mg, 5-320 mg	1 or 1b*	QL (1 tablet per 1 day)
amlodipine besylate-valsartan oral tablet 5-160 mg	1 or 1b*	DO
amlodipine-olmesartan oral tablet 10-20 mg, 10-40 mg, 5-40 mg	1 or 1b*	QL (1 tablet per 1 day)
amlodipine-olmesartan oral tablet 5-20 mg	1 or 1b*	DO
telmisartan-amlodipine oral tablet 40-10 mg, 80-10 mg, 80-5 mg	1 or 1b*	QL (1 tablet per 1 day)
telmisartan-amlodipine oral tablet 40-5 mg	1 or 1b*	DO
ANGIOTENSIN II RECEPTOR ANTAG & THIAZIDE/THIAZIDE-LIKE - DRUGS FOR HIGH BLOOD PRESSURE**		
candesartan cilexetil-hctz oral tablet 16-12.5 mg	1 or 1b*	QL (2 tablets per 1 day)
candesartan cilexetil-hctz oral tablet 32-12.5 mg, 32-25 mg	1 or 1b*	QL (1 tablet per 1 day)
irbesartan-hydrochlorothiazide oral tablet 150-12.5 mg	1 or 1b*	QL (2 tablets per 1 day)
irbesartan-hydrochlorothiazide oral tablet 300-12.5 mg	1 or 1b*	QL (1 tablet per 1 day)
losartan potassium-hctz oral tablet 100-12.5 mg, 100-25 mg	1 or 1b*	QL (1 tablet per 1 day)
losartan potassium-hctz oral tablet 50-12.5 mg	1 or 1b*	DO
olmesartan medoxomil-hctz oral tablet 20-12.5 mg	1 or 1b*	DO
olmesartan medoxomil-hctz oral tablet 40-12.5 mg, 40-25 mg	1 or 1b*	QL (1 tablet per 1 day)
telmisartan-hctz oral tablet 40-12.5 mg	1 or 1b*	DO
telmisartan-hctz oral tablet 80-12.5 mg	1 or 1b*	QL (2 tablets per 1 day)
telmisartan-hctz oral tablet 80-25 mg	1 or 1b*	QL (1 tablet per 1 day)
valsartan-hydrochlorothiazide oral tablet 160-12.5 mg, 80-12.5 mg	1 or 1b*	DO
valsartan-hydrochlorothiazide oral tablet 160-25 mg, 320-12.5 mg, 320-25 mg	1 or 1b*	QL (1 tablet per 1 day)
ANGIOTENSIN II RECEPTOR ANTAGONISTS - DRUGS FOR HIGH BLOOD PRESSURE**		
candesartan cilexetil oral tablet 16 mg	1 or 1b*	QL (2 tablets per 1 day)
candesartan cilexetil oral tablet 32 mg	1 or 1b*	QL (1 tablet per 1 day)
candesartan cilexetil oral tablet 4 mg, 8 mg	1 or 1b*	DO
irbesartan oral tablet 150 mg, 75 mg	1 or 1b*	DO
irbesartan oral tablet 300 mg	1 or 1b*	QL (1 tablet per 1 day)
losartan potassium oral tablet 100 mg	1 or 1b*	QL (1 tablet per 1 day)
losartan potassium oral tablet 25 mg	1 or 1b*	DO
losartan potassium oral tablet 50 mg	1 or 1b*	QL (2 tablets per 1 day)

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
olmesartan medoxomil oral tablet 20 mg, 5 mg	1 or 1b*	DO
olmesartan medoxomil oral tablet 40 mg	1 or 1b*	QL (1 tablet per 1 day)
telmisartan oral tablet 20 mg, 40 mg	1 or 1b*	DO
telmisartan oral tablet 80 mg	1 or 1b*	QL (2 tablets per 1 day)
valsartan oral solution	3	PA; QL (80 mL per 1 day)
valsartan oral tablet 160 mg	1 or 1b*	QL (2 tablets per 1 day)
valsartan oral tablet 320 mg	1 or 1b*	QL (1 tablet per 1 day)
valsartan oral tablet 40 mg, 80 mg	1 or 1b*	DO
ANGIOTENSIN II RECEPTOR ANT-CA CHANNEL BLOCKER-THIAZIDES - DRUGS FOR HIGH BLOOD PRESSURE**		
amlodipine-valsartan-hctz oral tablet 10-160-12.5 mg, 10-160-25 mg, 10-320-25 mg, 5-160-25 mg	1 or 1b*	QL (1 tablet per 1 day)
amlodipine-valsartan-hctz oral tablet 5-160-12.5 mg	1 or 1b*	DO
olmesartan-amlodipine-hctz oral tablet 20-5-12.5 mg	1 or 1b*	DO
olmesartan-amlodipine-hctz oral tablet 40-10-12.5 mg, 40-10-25 mg, 40-5-12.5 mg, 40-5-25 mg	1 or 1b*	QL (1 tablet per 1 day)
ANTIADRENERGICS - CENTRALLY ACTING - DRUGS FOR HIGH BLOOD PRESSURE**		
CATAPRES-TTS-1 TRANSDERMAL PATCH WEEKLY (*clonidine*)	3	QL (0.29 patches per 1 day)
CATAPRES-TTS-2 TRANSDERMAL PATCH WEEKLY (*clonidine*)	3	QL (0.29 patches per 1 day)
CATAPRES-TTS-3 TRANSDERMAL PATCH WEEKLY (*clonidine*)	3	QL (0.29 patches per 1 day)
clonidine hcl oral tablet 0.1 mg, 0.2 mg	1 or 1a*	DO
clonidine hcl oral tablet 0.3 mg	1 or 1a*	QL (4 tablets per 1 day)
clonidine transdermal patch weekly	1 or 1b*	QL (0.29 patches per 1 day)
guanfacine hcl oral tablet	1 or 1b*	
methyldopa oral tablet 250 mg	1 or 1b*	DO
methyldopa oral tablet 500 mg	1 or 1b*	QL (6 tablets per 1 day)
ANTIADRENERGICS - PERIPHERALLY ACTING - DRUGS FOR HIGH BLOOD PRESSURE**		
CARDURA ORAL TABLET 1 MG, 2 MG, 4 MG (*doxazosin mesylate*)	3	QL (1 tablet per 1 day)
CARDURA ORAL TABLET 8 MG (*doxazosin mesylate*)	3	QL (2 tablets per 1 day)
doxazosin mesylate oral tablet 1 mg, 2 mg, 4 mg	1 or 1b*	QL (1 tablet per 1 day)
doxazosin mesylate oral tablet 8 mg	1 or 1b*	QL (2 tablets per 1 day)
MINIPRESS ORAL CAPSULE (*prazosin hcl*)	3	
prazosin hcl oral capsule	1 or 1b*	
terazosin hcl oral capsule 1 mg, 2 mg, 5 mg	1 or 1b*	QL (1 capsule per 1 day)
terazosin hcl oral capsule 10 mg	1 or 1b*	QL (2 capsules per 1 day)
ANTIHYPERTENSIVES - MISC. - DRUGS FOR HIGH BLOOD PRESSURE**		
VECAMYL ORAL TABLET (*mecamylamine hcl*)	3	
BETA BLOCKER & DIURETIC COMBINATIONS - DRUGS FOR HIGH BLOOD PRESSURE**		
atenolol-chlorthalidone oral tablet	1 or 1b*	QL (1 tablet per 1 day)

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
bisoprolol-hydrochlorothiazide oral tablet	1 or 1b*	QL (2 tablets per 1 day)
metoprolol-hydrochlorothiazide oral tablet 100-25 mg, 50-25 mg	1 or 1b*	QL (2 tablets per 1 day)
metoprolol-hydrochlorothiazide oral tablet 100-50 mg	1 or 1b*	QL (1 tablet per 1 day)
TENORETIC 100 ORAL TABLET (*atenolol-chlorthalidone*)	3	QL (1 tablet per 1 day)
TENORETIC 50 ORAL TABLET (*atenolol-chlorthalidone*)	3	QL (1 tablet per 1 day)
DIRECT RENIN INHIBITORS - DRUGS FOR HIGH BLOOD PRESSURE**		
aliskiren fumarate oral tablet 150 mg	1 or 1b*	DO
aliskiren fumarate oral tablet 300 mg	1 or 1b*	QL (1 tablet per 1 day)
DOPAMINE D1 RECEPTOR AGONISTS - DRUGS FOR HIGH BLOOD PRESSURE**		
CORLOPAM INTRAVENOUS SOLUTION (*fenoldopam mesylate*)	3	
SELECTIVE ALDOSTERONE RECEPTOR ANTAGONISTS (SARAS) - DRUGS FOR HIGH BLOOD PRESSURE**		
eplerenone oral tablet	1 or 1b*	
INSPRA ORAL TABLET (*eplerenone*)	3	
VASODILATORS - DRUGS FOR HIGH BLOOD PRESSURE**		
hydralazine hcl injection solution	1 or 1b*	
hydralazine hcl oral tablet	1 or 1b*	
minoxidil oral tablet	1 or 1b*	
NIPRIDE RTU INTRAVENOUS SOLUTION (*nitroprusside sodium-nacl*)	3	
nitroprusside sodium intravenous solution	1 or 1b*	
sodium nitroprusside intravenous solution	1 or 1b*	
***ANTI-INFECTIVE AGENTS - MISC.* - DRUGS FOR INFECTIONS**		
ANTI-INFECTIVE AGENTS - MISC. - DRUGS FOR INFECTIONS**		
AEMCOLO ORAL TABLET DELAYED RELEASE (*rifamycin sodium*)	3	PA; QL (12 tablets per 30 days)
FLAGYL ORAL CAPSULE (*metronidazole*)	3	
IMPAVIDO ORAL CAPSULE (*miltefosine*)	3	PA; QL (84 capsules per 1 fill)
METRONIDAZOLE INTRAVENOUS SOLUTION	3	
metronidazole oral capsule	1 or 1a*	
metronidazole oral tablet	1 or 1a*	
NEBUPENT INHALATION SOLUTION RECONSTITUTED (*pentamidine isethionate*)	3	
PENTAM INJECTION SOLUTION RECONSTITUTED (*pentamidine isethionate*)	4	
pentamidine isethionate inhalation solution reconstituted	1 or 1b*	
pentamidine isethionate injection solution reconstituted	4	
tinidazole oral tablet 250 mg	1 or 1b*	QL (5 tablets per 28 days)
tinidazole oral tablet 500 mg	1 or 1b*	QL (20 tablets per 1 fill)
TRIMETHOPRIM ORAL TABLET	1 or 1a*	
XIFAXAN ORAL TABLET 200 MG (*rifaximin*)	3	PA; QL (9 tablets per 1 fill)
XIFAXAN ORAL TABLET 550 MG (*rifaximin*)	3	PA; QL (126 tablet per 252 days)

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-INFECTIVE MISC. - COMBINATIONS - ANTIBIOTICS**		
BACTRIM DS ORAL TABLET (*sulfamethoxazole-trimethoprim*)	3	
BACTRIM ORAL TABLET (*sulfamethoxazole-trimethoprim*)	3	
sulfamethoxazole-trimethoprim intravenous solution	1 or 1b*	
sulfamethoxazole-trimethoprim oral suspension	1 or 1a*	
sulfamethoxazole-trimethoprim oral tablet	1 or 1a*	
sulfatrim pediatric oral suspension	1 or 1a*	
ANTIPROTOZOAL AGENTS - DRUGS FOR PARASITES**		
ALINIA ORAL SUSPENSION RECONSTITUTED (*nitazoxanide*)	3	QL (180 mL per 1 fill)
atovaquone oral suspension	1 or 1b*	
LAMPIT ORAL TABLET (*nifurtimox*)	3	
MEPRON ORAL SUSPENSION (*atovaquone*)	3	
nitazoxanide oral tablet	1 or 1b*	QL (6 tablets per 1 fill)
***BETA-LACTAMASE INHIBITOR - COMBINATIONS** - DRUGS FOR INFECTIONS**		
XACDURO INTRAVENOUS SOLUTION RECONSTITUTED (*sulbactam sod-durlobactam sod*)	3	
CARBAPENEM COMBINATIONS - ANTIBIOTICS**		
imipenem-cilastatin intravenous solution reconstituted	1 or 1b*	
PRIMAXIN IV INTRAVENOUS SOLUTION RECONSTITUTED (*imipenem-cilastatin*)	3	
RECARBRIO INTRAVENOUS SOLUTION RECONSTITUTED (*imipenem-cilastatin-relebactam*)	3	
VABOMERE INTRAVENOUS SOLUTION RECONSTITUTED (*meropenem-vaborbactam*)	3	
CARBAPENEMS - ANTIBIOTICS**		
ertapenem sodium injection solution reconstituted	1 or 1b*	
meropenem intravenous solution reconstituted 1 gm, 500 mg	1 or 1b*	
meropenem intravenous solution reconstituted 2 gm	3	
MEROPENEM-SODIUM CHLORIDE INTRAVENOUS SOLUTION RECONSTITUTED	3	
CHLORAMPHENICALS - ANTIBIOTICS**		
chloramphenicol sod succinate intravenous solution reconstituted	1 or 1b*	
CYCLIC LIPOPEPTIDES - ANTIBIOTICS**		
CUBICIN RF INTRAVENOUS SOLUTION RECONSTITUTED (*daptomycin*)	3	
DAPTOMYCIN INTRAVENOUS SOLUTION RECONSTITUTED	3	
daptomycin-sodium chloride intravenous solution	3	
GLYCOPEPTIDES - ANTIBIOTICS**		
DALVANCE INTRAVENOUS SOLUTION RECONSTITUTED (*dalbavancin hcl*)	3	
FIRVANQ ORAL SOLUTION RECONSTITUTED (*vancomycin hcl*)	3	PA; QL (1200 mL per 30 days)
KIMYRSA INTRAVENOUS SOLUTION RECONSTITUTED (*oritavancin diphosphate*)	3	

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ORBACTIV INTRAVENOUS SOLUTION RECONSTITUTED (*oritavancin diphosphate*)	3	
VANCOCIN ORAL CAPSULE (*vancomycin hcl*)	3	PA; QL (240 capsules per 30 days)
VANCOMYCIN HCL IN DEXTROSE INTRAVENOUS SOLUTION 1-5 GM/200ML-%	3	QL (400 mL per 1 day)
VANCOMYCIN HCL IN DEXTROSE INTRAVENOUS SOLUTION 500-5 MG/100ML-%	3	QL (200 mL per 1 day)
VANCOMYCIN HCL IN DEXTROSE INTRAVENOUS SOLUTION 750-5 MG/150ML-%	3	QL (300 mL per 1 day)
VANCOMYCIN HCL IN NACL INTRAVENOUS SOLUTION 1-0.9 GM/200ML-%	3	QL (400 mL per 1 day)
VANCOMYCIN HCL IN NACL INTRAVENOUS SOLUTION 500-0.9 MG/100ML-%	3	QL (2 vials per 1 day)
VANCOMYCIN HCL INTRAVENOUS SOLUTION 1000 MG/200ML	3	QL (400 mL per 1 day)
VANCOMYCIN HCL INTRAVENOUS SOLUTION 1250 MG/250ML	3	QL (500 mL per 1 day)
VANCOMYCIN HCL INTRAVENOUS SOLUTION 1500 MG/300ML	3	QL (600 mL per 1 day)
VANCOMYCIN HCL INTRAVENOUS SOLUTION 1750 MG/350ML	3	QL (700 mL per 1 day)
VANCOMYCIN HCL INTRAVENOUS SOLUTION 2000 MG/400ML	3	QL (800 mL per 1 day)
VANCOMYCIN HCL INTRAVENOUS SOLUTION 500 MG/100ML	3	QL (2 vials per 1 day)
VANCOMYCIN HCL INTRAVENOUS SOLUTION 750 MG/150ML	3	QL (300 mL per 1 day)
vancomycin hcl intravenous solution reconstituted 1 gm, 500 mg	1 or 1b*	QL (2 vials per 1 day)
VANCOMYCIN HCL INTRAVENOUS SOLUTION RECONSTITUTED 1.25 GM, 1.5 GM, 750 MG	3	QL (2 vials per 1 day)
vancomycin hcl intravenous solution reconstituted 10 gm, 100 gm, 5 gm	1 or 1b*	QL (1 vial per 30 days)
vancomycin hcl oral capsule	1 or 1b*	PA; QL (240 capsules per 30 days)
vancomycin hcl oral solution reconstituted 25 mg/ml, 50 mg/ml	1 or 1b*	PA; QL (1200 mL per 30 days)
VANCOMYCIN HCL ORAL SOLUTION RECONSTITUTED 250 MG/5ML	1 or 1b*	PA; QL (1200 mL per 30 days)
VIBATIV INTRAVENOUS SOLUTION RECONSTITUTED (*telavancin hcl*)	3	
LEPROSTATICS - ANTIBIOTICS**		
dapsone oral tablet	1 or 1b*	
LINCOSAMIDES - ANTIBIOTICS**		
CLEOCIN ORAL CAPSULE (*clindamycin hcl*)	3	
CLEOCIN ORAL SOLUTION RECONSTITUTED (*clindamycin palmitate hcl*)	3	
CLEOCIN PHOSPHATE INJECTION SOLUTION (*clindamycin phosphate*)	3	
clindamycin hcl oral capsule	1 or 1b*	
clindamycin palmitate hcl oral solution reconstituted	1 or 1b*	
clindamycin phosphate in d5w intravenous solution	1 or 1b*	
CLINDAMYCIN PHOSPHATE IN NACL INTRAVENOUS SOLUTION	3	
clindamycin phosphate injection solution	1 or 1b*	
LINCOCIN INJECTION SOLUTION (*lincomycin hcl*)	3	

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
lincomycin hcl injection solution	1 or 1b*	
MONOBACTAMS - ANTIBIOTICS**		
AZACTAM INJECTION SOLUTION RECONSTITUTED (*aztreonam*)	3	
aztreonam injection solution reconstituted	1 or 1b*	
CAYSTON INHALATION SOLUTION RECONSTITUTED (*aztreonam lysine*)	4	LD; QL (3 vials per 1 day); SP
OXAZOLIDINONES - ANTIBIOTICS**		
linezolid in sodium chloride intravenous solution	3	
linezolid intravenous solution	1 or 1b*	
linezolid oral suspension reconstituted	1 or 1b*	PA; QL (900 mL per 30 days)
linezolid oral tablet	1 or 1b*	PA; QL (28 tablet per 30 days)
SIVEXTRO INTRAVENOUS SOLUTION RECONSTITUTED (*tedizolid phosphate*)	3	
SIVEXTRO ORAL TABLET (*tedizolid phosphate*)	3	PA; QL (6 tablet per 30 days)
ZYVOX INTRAVENOUS SOLUTION (*linezolid*)	3	
ZYVOX ORAL SUSPENSION RECONSTITUTED (*linezolid*)	3	PA; QL (900 mL per 30 days)
ZYVOX ORAL TABLET (*linezolid*)	3	PA; QL (28 tablet per 30 days)
POLYMYXINS - ANTIBIOTICS**		
colistimethate sodium (cba) injection solution reconstituted	1 or 1b*	
COLY-MYCIN M INJECTION SOLUTION RECONSTITUTED (*colistimethate sodium*)	3	
polymyxin b sulfate injection solution reconstituted	1 or 1b*	
URINARY ANTI-INFECTIVES - ANTIBIOTICS**		
fosfomycin tromethamine oral packet	1 or 1b*	
HIPREX ORAL TABLET (*methenamine hippurate*)	3	
MACROBID ORAL CAPSULE (*nitrofurantoin monohyd macro*)	3	
MACRODANTIN ORAL CAPSULE (*nitrofurantoin macrocrystal*)	3	
methenamine hippurate oral tablet	1 or 1b*	
nitrofurantoin macrocrystal oral capsule	1 or 1b*	
nitrofurantoin monohyd macro oral capsule	1 or 1b*	
nitrofurantoin oral suspension 25 mg/5ml	1 or 1b*	
nitrofurantoin oral suspension 50 mg/5ml	3	
***ANTIMALARIALS* - DRUGS FOR INFECTIONS**		
ANTIMALARIAL COMBINATIONS - DRUGS FOR PARASITES**		
atovaquone-proguanil hcl oral tablet	1 or 1b*	
COARTEM ORAL TABLET (*artemether-lumefantrine*)	3	
MALARONE ORAL TABLET (*atovaquone-proguanil hcl*)	3	
ANTIMALARIALS - DRUGS FOR PARASITES**		
ARAKODA ORAL TABLET (*tafenoquine succinate*)	3	QL (64 tablets per 1 year)
ARTESUNATE INTRAVENOUS SOLUTION RECONSTITUTED	3	
chloroquine phosphate oral tablet	1 or 1a*	
DARAPRIM ORAL TABLET (*pyrimethamine*)	3	PA; QL (3 tablets per 1 day)

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HYDROXYCHLOROQUINE SULFATE ORAL TABLET 100 MG, 300 MG	1 or 1b*	QL (2 tablets per 1 day)
hydroxychloroquine sulfate oral tablet 200 mg	1 or 1b*	QL (3 tablets per 1 day)
HYDROXYCHLOROQUINE SULFATE ORAL TABLET 400 MG	1 or 1b*	QL (1 tablet per 1 day)
KRINTAFEL ORAL TABLET (*tafenoquine succinate*)	3	QL (2 tablets per 1 fill)
mefloquine hcl oral tablet	1 or 1b*	QL (5 tablets per 28 days)
PRIMAQUINE PHOSPHATE ORAL TABLET	3	
pyrimethamine oral tablet	1 or 1b*	PA; QL (3 tablets per 1 day)
QUALAQUIN ORAL CAPSULE (*quinine sulfate*)	3	PA; QL (60 capsule per 30 days)
quinine sulfate oral capsule	1 or 1b*	PA; QL (60 capsule per 30 days)
***ANTIMYASTHENIC/CHOLINERGIC AGENTS* - DRUGS FOR NERVES AND MUSCLES**		
ANTIMYASTHENIC/CHOLINERGIC AGENTS - DRUGS FOR NERVES AND MUSCLES**		
BLOXIVERZ INTRAVENOUS SOLUTION (*neostigmine methylsulfate*)	3	
FIRDAPSE ORAL TABLET (*amifampridine phosphate*)	4	PA; LD; QL (8 tablets per 1 day)
MESTINON ORAL SOLUTION (*pyridostigmine bromide*)	3	
MESTINON ORAL TABLET (*pyridostigmine bromide*)	3	
MESTINON ORAL TABLET EXTENDED RELEASE (*pyridostigmine bromide*)	3	
NEOSTIGMINE METHYLSULFATE INTRAVENOUS SOLUTION	3	
pyridostigmine bromide er oral tablet extended release	1 or 1b*	
pyridostigmine bromide oral solution	1 or 1b*	
pyridostigmine bromide oral tablet	1 or 1b*	
REGONOL INTRAVENOUS SOLUTION (*pyridostigmine bromide*)	3	
***ANTIMYCOBACTERIAL AGENTS* - DRUGS FOR INFECTIONS**		
ANTIMYCOBACTERIAL AGENTS - ANTIBIOTICS**		
cycloserine oral capsule	1 or 1b*	
ethambutol hcl oral tablet	1 or 1b*	
isoniazid injection solution	1 or 1a*	
isoniazid oral syrup	1 or 1a*	
isoniazid oral tablet	1 or 1a*	
MYAMBUTOL ORAL TABLET (*ethambutol hcl*)	3	
MYCOBUTIN ORAL CAPSULE (*rifabutin*)	3	
PRETOMANID ORAL TABLET	3	
PRIFTIN ORAL TABLET (*rifapentine*)	2	
pyrazinamide oral tablet	1 or 1b*	
rifabutin oral capsule	1 or 1b*	
RIFADIN INTRAVENOUS SOLUTION RECONSTITUTED (*rifampin*)	3	
rifampin intravenous solution reconstituted	1 or 1b*	
rifampin oral capsule	1 or 1b*	
SIRTURO ORAL TABLET (*bedaquiline fumarate*)	3	

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TRECATOR ORAL TABLET (*ethionamide*)	3	
***ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES* - DRUGS FOR CANCER**		
ALKYLATING AGENTS - DRUGS FOR CANCER**		
BELRAPZO INTRAVENOUS SOLUTION (*bendamustine hcl*)	3	PA; LD; SP
bendamustine hcl intravenous solution	3	PA; LD; SP
bendamustine hcl intravenous solution reconstituted	1 or 1b*	PA; LD; SP
BENDEKA INTRAVENOUS SOLUTION (*bendamustine hcl*)	3	PA; LD; SP
busulfan intravenous solution	1 or 1b*	SP
BUSULFEX INTRAVENOUS SOLUTION (*busulfan*)	3	SP
carboplatin intravenous solution	1 or 1b*	SP
cisplatin intravenous solution	1 or 1b*	SP
CISPLATIN INTRAVENOUS SOLUTION RECONSTITUTED	3	SP
kemoplat intravenous solution	3	SP
MYLERAN ORAL TABLET (*busulfan*)	2; OC	OC
oxaliplatin intravenous solution	1 or 1b*	SP
oxaliplatin intravenous solution reconstituted	1 or 1b*	SP
paraplatin intravenous solution	1 or 1b*	SP
TEPADINA INJECTION SOLUTION RECONSTITUTED (*thiotepa*)	3	SP
thiotepa injection solution reconstituted	1 or 1b*	SP
TREANDA INTRAVENOUS SOLUTION RECONSTITUTED (*bendamustine hcl*)	3	PA; LD; SP
vivimusta intravenous solution	3	PA; LD; SP
ZEPZELCA INTRAVENOUS SOLUTION RECONSTITUTED (*lurbinectedin*)	3	PA; LD; SP
ANDROGEN BIOSYNTHESIS INHIBITORS - DRUGS FOR CANCER**		
abiraterone acetate oral tablet 250 mg	1 or 1b*; OC	PA; LD; QL (4 tablet per 1 day); SP; OC
abiraterone acetate oral tablet 500 mg	1 or 1b*; OC	PA; LD; QL (2 tablets per 1 day); SP; OC
YONSA ORAL TABLET (*abiraterone acetate micronized*)	2; OC	PA; LD; QL (4 tablets per 1 day); SP; OC
ANTIADRENALS - DRUGS FOR CANCER**		
LYSODREN ORAL TABLET (*mitotane*)	2; OC	LD; QL (38 tablet per 1 day); OC
ANTIANDROGENS - DRUGS FOR CANCER**		
bicalutamide oral tablet	1 or 1b*; OC	QL (1 tablet per 1 day); OC
CASODEX ORAL TABLET (*bicalutamide*)	3; OC	QL (1 tablet per 1 day); OC
ERLEADA ORAL TABLET 240 MG (*apalutamide*)	2; OC	PA; LD; QL (1 tablet per 1 day); SP; OC
ERLEADA ORAL TABLET 60 MG (*apalutamide*)	2; OC	PA; LD; QL (4 tablets per 1 day); SP; OC
EULEXIN ORAL CAPSULE (*flutamide*)	3; OC	OC
nilutamide oral tablet	1 or 1b*; OC	QL (1 tablet per 1 day); OC

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NUBEQA ORAL TABLET (*darolutamide*)	2; OC	PA; LD; QL (4 tablets per 1 day); SP; OC
XTANDI ORAL CAPSULE (*enzalutamide*)	2; OC	PA; LD; QL (4 capsules per 1 day); SP; OC
XTANDI ORAL TABLET 40 MG (*enzalutamide*)	2; OC	PA; LD; QL (4 tablets per 1 day); SP; OC
XTANDI ORAL TABLET 80 MG (*enzalutamide*)	2; OC	PA; LD; QL (2 tablets per 1 day); SP; OC
ANTIESTROGENS - DRUGS FOR CANCER**		
FARESTON ORAL TABLET (*toremifene citrate*)	3; OC	QL (1 tablet per 1 day); OC
SOLTAMOX ORAL SOLUTION (*tamoxifen citrate*)	2; OC; $0	OC
tamoxifen citrate oral tablet	1 or 1b*; OC; $0	OC
toremifene citrate oral tablet	1 or 1b*; OC	QL (1 tablet per 1 day); OC
ANTIMETABOLITES - DRUGS FOR CANCER**		
ALIMTA INTRAVENOUS SOLUTION RECONSTITUTED (*pemetrexed disodium*)	3	PA; SP
ARRANON INTRAVENOUS SOLUTION (*nelarabine*)	3	SP
azacitidine injection suspension reconstituted	1 or 1b*	PA; LD; SP
capecitabine oral tablet	1 or 1b*; OC	PA; LD; SP; OC
cladribine intravenous solution	1 or 1b*	SP
clofarabine intravenous solution	1 or 1b*	SP
CLOLAR INTRAVENOUS SOLUTION (*clofarabine*)	3	SP
cytarabine (pf) injection solution	1 or 1b*	SP
cytarabine injection solution	1 or 1b*	SP
decitabine intravenous solution reconstituted	1 or 1b*	LD; SP
floxuridine injection solution reconstituted	1 or 1b*	SP
fludarabine phosphate intravenous solution 25 mg/ml	3	SP
fludarabine phosphate intravenous solution 50 mg/2ml	1 or 1b*	SP
fludarabine phosphate intravenous solution reconstituted	1 or 1b*	SP
fluorouracil intravenous solution	1 or 1b*	SP
FOLOTYN INTRAVENOUS SOLUTION (*pralatrexate*)	3	SP
GEMCITABINE HCL INTRAVENOUS SOLUTION	3	SP
gemcitabine hcl intravenous solution reconstituted	1 or 1b*	SP
mercaptopurine oral tablet	1 or 1b*; OC	OC
methotrexate sodium (pf) injection solution	1 or 1b*	
methotrexate sodium injection solution	1 or 1b*	
methotrexate sodium injection solution reconstituted	1 or 1b*	
methotrexate sodium oral tablet	1 or 1b*; OC	OC
nelarabine intravenous solution	1 or 1b*	SP
ONUREG ORAL TABLET (*azacitidine*)	3; OC	PA; LD; QL (14 tablets per 28 days); SP; OC
pemetrexed disodium intravenous solution	3	PA; SP
pemetrexed disodium intravenous solution reconstituted	1 or 1b*	PA; SP

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
pemetrexed ditromethamine intravenous solution reconstituted	3	PA; SP
pemetrexed intravenous solution 1 gm/40ml, 100 mg/4ml	3	PA; SP
pemetrexed intravenous solution 500 mg/20ml	3	PA; LD
PEMFEXY INTRAVENOUS SOLUTION (*pemetrexed*)	3	PA; LD
pralatrexate intravenous solution	1 or 1b*	SP
PURIXAN ORAL SUSPENSION (*mercaptopurine*)	3; OC	PA; LD; OC
TABLOID ORAL TABLET (*thioguanine*)	2; OC	OC
TREXALL ORAL TABLET (*methotrexate sodium*)	2; OC	ST; OC
VIDAZA INJECTION SUSPENSION RECONSTITUTED (*azacitidine*)	3	PA; LD; SP
XATMEP ORAL SOLUTION (*methotrexate*)	3; OC	PA; OC
ANTINEOPLASTIC - ALK INHIBITORS - DRUGS FOR CANCER**		
ALECENSA ORAL CAPSULE (*alectinib hcl*)	2; OC	PA; LD; QL (8 capsule per 1 day); SP; OC
ALUNBRIG ORAL TABLET 180 MG (*brigatinib*)	2; OC	PA; LD; QL (1 tablet per 1 day); OC
ALUNBRIG ORAL TABLET 30 MG (*brigatinib*)	2; OC	PA; LD; QL (6 tablets per 1 day); OC
ALUNBRIG ORAL TABLET 90 MG (*brigatinib*)	2; OC	PA; LD; QL (2 tablets per 1 day); OC
ALUNBRIG ORAL TABLET THERAPY PACK (*brigatinib*)	2; OC	PA; LD; QL (1 pack per 30 days); OC
LORBRENA ORAL TABLET 100 MG (*lorlatinib*)	3; OC	PA; LD; QL (1 tablet per 1 day); SP; OC
LORBRENA ORAL TABLET 25 MG (*lorlatinib*)	3; OC	PA; LD; QL (3 tablets per 1 day); SP; OC
XALKORI ORAL CAPSULE (*crizotinib*)	3; OC	PA; LD; QL (4 capsules per 1 day); SP; OC
ZYKADIA ORAL TABLET (*ceritinib*)	3; OC	PA; LD; QL (3 capsules per 1 day); SP; OC
ANTINEOPLASTIC - ALLOGENEIC CELLULAR IMMUNOTHERAPY - DRUGS FOR CANCER**		
OMISIRGE INTRAVENOUS SUSPENSION (*omidubicel-onlv*)	3	
ANTINEOPLASTIC - ANTIBODY COMBINATIONS - DRUGS FOR CANCER**		
OPDUALAG INTRAVENOUS SOLUTION (*nivolumab-relatlimab-rmbw*)	3	PA; LD; SP
ANTINEOPLASTIC - ANTI-CCR4 ANTIBODIES - DRUGS FOR CANCER**		
POTELIGEO INTRAVENOUS SOLUTION (*mogamulizumab-kpkc*)	3	LD; SP
ANTINEOPLASTIC - ANTI-CD19 ANTIBODIES - DRUGS FOR CANCER**		
MONJUVI INTRAVENOUS SOLUTION RECONSTITUTED (*tafasitamab-cxix*)	3	PA; LD
ANTINEOPLASTIC - ANTI-CD19 ANTIBODY-DRUG COMPLEX - DRUGS FOR CANCER**		
ZYNLONTA INTRAVENOUS SOLUTION RECONSTITUTED (*loncastuximab tesirine-lpyl*)	3	PA; LD

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTINEOPLASTIC - ANTI-CD20 ANTIBODIES - DRUGS FOR CANCER**		
ARZERRA INTRAVENOUS CONCENTRATE (*ofatumumab*)	3	PA; LD; SP
GAZYVA INTRAVENOUS SOLUTION (*obinutuzumab*)	3	PA; LD; SP
RIABNI INTRAVENOUS SOLUTION (*rituximab-arrx*)	3	PA; LD; SP
RITUXAN INTRAVENOUS SOLUTION (*rituximab*)	3	PA; LD; SP
RUXIENCE INTRAVENOUS SOLUTION (*rituximab-pvvr*)	3	PA; SP
TRUXIMA INTRAVENOUS SOLUTION (*rituximab-abbs*)	3	PA; SP
ANTINEOPLASTIC - ANTI-CD22 ANTIBODY-DRUG COMPLEX - DRUGS FOR CANCER**		
BESPONSA INTRAVENOUS SOLUTION RECONSTITUTED (*inotuzumab ozogamicin*)	3	PA; LD; SP
ANTINEOPLASTIC - ANTI-CD30 ANTIBODY-DRUG COMPLEX - DRUGS FOR CANCER**		
ADCETRIS INTRAVENOUS SOLUTION RECONSTITUTED (*brentuximab vedotin*)	3	PA; LD; SP
ANTINEOPLASTIC - ANTI-CD33 ANTIBODY-DRUG COMPLEX - DRUGS FOR CANCER**		
MYLOTARG INTRAVENOUS SOLUTION RECONSTITUTED (*gemtuzumab ozogamicin*)	3	PA; LD; SP
ANTINEOPLASTIC - ANTI-CD38 ANTIBODIES - DRUGS FOR CANCER**		
DARZALEX INTRAVENOUS SOLUTION (*daratumumab*)	3	PA; LD; SP
SARCLISA INTRAVENOUS SOLUTION (*isatuximab-irfc*)	3	PA; LD; SP
ANTINEOPLASTIC - ANTI-CD79B ANTIBODY-DRUG COMPLEX - DRUGS FOR CANCER**		
POLIVY INTRAVENOUS SOLUTION RECONSTITUTED (*polatuzumab vedotin-piiq*)	3	PA; LD; SP
ANTINEOPLASTIC - ANTI-CTLA-4 ANTIBODIES - DRUGS FOR CANCER**		
IMJUDO INTRAVENOUS SOLUTION (*tremelimumab-actl*)	3	PA; LD; SP
YERVOY INTRAVENOUS SOLUTION (*ipilimumab*)	3	PA; LD; SP
ANTINEOPLASTIC - ANTI-GD2 ANTIBODIES - DRUGS FOR CANCER**		
DANYELZA INTRAVENOUS SOLUTION (*naxitamab-gqgk*)	3	PA; LD
UNITUXIN INTRAVENOUS SOLUTION (*dinutuximab*)	3	LD
ANTINEOPLASTIC - ANTI-HER2 AGENTS - DRUGS FOR CANCER**		
HERCEPTIN INTRAVENOUS SOLUTION RECONSTITUTED (*trastuzumab*)	3	LD; SP
HERZUMA INTRAVENOUS SOLUTION RECONSTITUTED (*trastuzumab-pkrb*)	3	ST; SP
KANJINTI INTRAVENOUS SOLUTION RECONSTITUTED (*trastuzumab-anns*)	3	LD; SP
MARGENZA INTRAVENOUS SOLUTION (*margetuximab-cmkb*)	3	PA; LD; SP

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OGIVRI INTRAVENOUS SOLUTION RECONSTITUTED (*trastuzumab-dkst*)	3	ST; LD; SP
ONTRUZANT INTRAVENOUS SOLUTION RECONSTITUTED (*trastuzumab-dttb*)	3	ST; LD; SP
PERJETA INTRAVENOUS SOLUTION (*pertuzumab*)	3	PA; LD; SP
TRAZIMERA INTRAVENOUS SOLUTION RECONSTITUTED (*trastuzumab-qyyp*)	3	ST; SP
TUKYSA ORAL TABLET (*tucatinib*)	3; OC	PA; LD; QL (4 tablets per 1 day); OC
ANTINEOPLASTIC - ANTI-NECTIN-4 ANTIBODY-DRUG COMPLEX - DRUGS FOR CANCER**		
PADCEV INTRAVENOUS SOLUTION RECONSTITUTED (*enfortumab vedotin-ejfv*)	3	PA; LD; SP
ANTINEOPLASTIC - ANTI-PD-1 ANTIBODIES - DRUGS FOR CANCER**		
JEMPERLI INTRAVENOUS SOLUTION (*dostarlimab-gxly*)	3	PA; LD; SP
KEYTRUDA INTRAVENOUS SOLUTION (*pembrolizumab*)	3	PA; LD; SP
LIBTAYO INTRAVENOUS SOLUTION (*cemiplimab-rwlc*)	3	PA; LD
OPDIVO INTRAVENOUS SOLUTION (*nivolumab*)	3	PA; LD; SP
ZYNYZ INTRAVENOUS SOLUTION (*retifanlimab-dlwr*)	3	PA; LD; QL (1 vial per 28 days); SP
ANTINEOPLASTIC - ANTI-PD-L1 ANTIBODIES - DRUGS FOR CANCER**		
BAVENCIO INTRAVENOUS SOLUTION (*avelumab*)	3	PA; LD
IMFINZI INTRAVENOUS SOLUTION (*durvalumab*)	3	PA; LD; SP
TECENTRIQ INTRAVENOUS SOLUTION (*atezolizumab*)	3	PA; LD; SP
ANTINEOPLASTIC - ANTI-SLAMF7 ANTIBODIES - DRUGS FOR CANCER**		
EMPLICITI INTRAVENOUS SOLUTION RECONSTITUTED (*elotuzumab*)	3	PA; LD; SP
ANTINEOPLASTIC - ANTI-TF ANTIBODY-DRUG COMPLEX - DRUGS FOR CANCER**		
TIVDAK INTRAVENOUS SOLUTION RECONSTITUTED (*tisotumab vedotin-tftv*)	3	PA; LD; SP
ANTINEOPLASTIC - BCL-2 INHIBITORS - DRUGS FOR CANCER**		
VENCLEXTA ORAL TABLET 10 MG (*venetoclax*)	3; OC	PA; LD; QL (2 tablets per 1 day); OC
VENCLEXTA ORAL TABLET 100 MG (*venetoclax*)	3; OC	PA; LD; QL (6 tablet per 1 day); OC
VENCLEXTA ORAL TABLET 50 MG (*venetoclax*)	3; OC	PA; LD; QL (1 tablet per 1 day); OC
VENCLEXTA STARTING PACK ORAL TABLET THERAPY PACK (*venetoclax*)	3; OC	PA; LD; QL (1 pack per 365 days); OC
ANTINEOPLASTIC - BCR-ABL KINASE INHIBITORS - DRUGS FOR CANCER**		
BOSULIF ORAL TABLET 100 MG (*bosutinib*)	2; OC	PA; QL (4 tablet per 1 day); SP; OC

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BOSULIF ORAL TABLET 400 MG, 500 MG (*bosutinib*)	2; OC	PA; QL (1 tablet per 1 day); SP; OC
ICLUSIG ORAL TABLET 10 MG, 30 MG, 45 MG (*ponatinib hcl*)	3; OC	PA; LD; QL (1 tablet per 1 day); OC
ICLUSIG ORAL TABLET 15 MG (*ponatinib hcl*)	3; OC	PA; LD; QL (2 tablets per 1 day); OC
imatinib mesylate oral tablet	1 or 1b*; OC	PA; QL (2 tablets per 1 day); SP; OC
SCEMBLIX ORAL TABLET (*asciminib hcl*)	3; OC	PA; LD; QL (2 tablets per 1 day); SP; OC
SPRYCEL ORAL TABLET (*dasatinib*)	2; OC	PA; QL (1 tablet per 1 day); SP; OC
TASIGNA ORAL CAPSULE (*nilotinib hcl*)	2; OC	PA; QL (4 capsules per 1 day); SP; OC
ANTINEOPLASTIC - BISPECIFIC T-CELL ENGAGERS - DRUGS FOR CANCER**		
BLINCYTO INTRAVENOUS SOLUTION RECONSTITUTED (*blinatumomab*)	3	PA; LD; SP
COLUMVI INTRAVENOUS SOLUTION (*glofitamab-gxbm*)	3	PA; LD; SP
ELREXFIO SUBCUTANEOUS SOLUTION (*elranatamab-bcmm*)	3	PA
EPKINLY SUBCUTANEOUS SOLUTION (*epcoritamab-bysp*)	3	PA; LD
KIMMTRAK INTRAVENOUS SOLUTION (*tebentafusp-tebn*)	3	PA; LD
LUNSUMIO INTRAVENOUS SOLUTION (*mosunetuzumab-axgb*)	3	PA; LD; SP
TALVEY SUBCUTANEOUS SOLUTION (*talquetamab-tgvs*)	3	PA
TECVAYLI SUBCUTANEOUS SOLUTION (*teclistamab-cqyv*)	3	PA; LD
ANTINEOPLASTIC - BRAF KINASE INHIBITORS - DRUGS FOR CANCER**		
BRAFTOVI ORAL CAPSULE (*encorafenib*)	3; OC	PA; LD; QL (6 capsules per 1 day); SP; OC
TAFINLAR ORAL CAPSULE (*dabrafenib mesylate*)	3; OC	PA; LD; QL (4 capsule per 1 day); SP; OC
TAFINLAR ORAL TABLET SOLUBLE (*dabrafenib mesylate*)	3; OC	PA; LD; QL (15 tablets per 1 day); SP; OC
ZELBORAF ORAL TABLET (*vemurafenib*)	2; OC	PA; LD; QL (8 tablet per 1 day); SP; OC
ANTINEOPLASTIC - BTK INHIBITORS - DRUGS FOR CANCER**		
BRUKINSA ORAL CAPSULE (*zanubrutinib*)	3; OC	PA; LD; QL (4 capsules per 1 day); OC
CALQUENCE ORAL TABLET (*acalabrutinib maleate*)	2; OC	PA; LD; QL (2 capsules per 1 day); OC
IMBRUVICA ORAL CAPSULE 140 MG (*ibrutinib*)	2; OC	PA; LD; QL (3 capsule per 1 day); OC
IMBRUVICA ORAL CAPSULE 70 MG (*ibrutinib*)	2; OC	PA; LD; QL (1 tablet per 1 day); OC
IMBRUVICA ORAL SUSPENSION (*ibrutinib*)	2; OC	PA; LD; QL (8 mL per 1 day); OC
IMBRUVICA ORAL TABLET (*ibrutinib*)	2; OC	PA; LD; QL (1 tablet per 1 day); OC

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
JAYPIRCA ORAL TABLET 100 MG (*pirtobrutinib*)	3; OC	PA; LD; QL (2 tablets per 1 day); SP; OC
JAYPIRCA ORAL TABLET 50 MG (*pirtobrutinib*)	3; OC	PA; LD; QL (1 tablet per 1 day); SP; OC
ANTINEOPLASTIC - EGFR INHIBITORS - DRUGS FOR CANCER**		
ERBITUX INTRAVENOUS SOLUTION (*cetuximab*)	3	PA; SP
erlotinib hcl oral tablet 100 mg, 150 mg	1 or 1b*; OC	PA; LD; QL (1 tablet per 1 day); SP; OC
erlotinib hcl oral tablet 25 mg	1 or 1b*; OC	PA; LD; QL (3 tablets per 1 day); SP; OC
EXKIVITY ORAL CAPSULE (*mobocertinib succinate*)	3; OC	PA; LD; QL (4 tablets per 1 day); OC
gefitinib oral tablet	1 or 1b*; OC	PA; LD; QL (1 tablet per 1 day); SP; OC
GILOTRIF ORAL TABLET (*afatinib dimaleate*)	3; OC	PA; LD; QL (1 tablet per 1 day); OC
IRESSA ORAL TABLET (*gefitinib*)	3; OC	PA; LD; QL (1 tablet per 1 day); SP; OC
PORTRAZZA INTRAVENOUS SOLUTION (*necitumumab*)	3	LD; SP
TAGRISSO ORAL TABLET (*osimertinib mesylate*)	3; OC	PA; LD; QL (1 tablet per 1 day); SP; OC
VECTIBIX INTRAVENOUS SOLUTION (*panitumumab*)	3	PA; LD; SP
VIZIMPRO ORAL TABLET (*dacomitinib*)	3; OC	PA; LD; QL (1 tablet per 1 day); SP; OC
ANTINEOPLASTIC - FGFR KINASE INHIBITORS - DRUGS FOR CANCER**		
BALVERSA ORAL TABLET 3 MG (*erdafitinib*)	3; OC	PA; LD; QL (3 tablets per 1 day); SP; OC
BALVERSA ORAL TABLET 4 MG (*erdafitinib*)	3; OC	PA; LD; QL (2 tablets per 1 day); SP; OC
BALVERSA ORAL TABLET 5 MG (*erdafitinib*)	3; OC	PA; LD; QL (1 tablet per 1 day); SP; OC
LYTGOBI (12 MG DAILY DOSE) ORAL TABLET THERAPY PACK (*futibatinib*)	3; OC	PA; LD; QL (3 tablets per 1 day); OC
LYTGOBI (16 MG DAILY DOSE) ORAL TABLET THERAPY PACK (*futibatinib*)	3; OC	PA; LD; QL (4 tablets per 1 day); OC
LYTGOBI (20 MG DAILY DOSE) ORAL TABLET THERAPY PACK (*futibatinib*)	3; OC	PA; LD; QL (5 tablets per 1 day); OC
PEMAZYRE ORAL TABLET 13.5 MG (*pemigatinib*)	3; OC	PA; LD; QL (1 tablet per 1 day); OC
PEMAZYRE ORAL TABLET 4.5 MG, 9 MG (*pemigatinib*)	3; OC	PA; LD; QL (14 tablets per 21 days); OC
ANTINEOPLASTIC - HEDGEHOG PATHWAY INHIBITORS - DRUGS FOR CANCER**		
DAURISMO ORAL TABLET 100 MG (*glasdegib maleate*)	3; OC	PA; LD; QL (1 tablet per 1 day); SP; OC

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DAURISMO ORAL TABLET 25 MG (*glasdegib maleate*)	3; OC	PA; LD; QL (2 tablets per 1 day); SP; OC
ERIVEDGE ORAL CAPSULE (*vismodegib*)	2; OC	PA; LD; QL (1 capsule per 1 day); SP; OC
ODOMZO ORAL CAPSULE (*sonidegib phosphate*)	3; OC	PA; LD; QL (1 capsule per 1 day); SP; OC
ANTINEOPLASTIC - HIF-2-ALPHA INHIBITORS - DRUGS FOR CANCER**		
WELIREG ORAL TABLET (*belzutifan*)	3; OC	PA; LD; QL (3 tablets per 1 day); OC
ANTINEOPLASTIC - HISTONE DEACETYLASE INHIBITORS - DRUGS FOR CANCER**		
BELEODAQ INTRAVENOUS SOLUTION RECONSTITUTED (*belinostat*)	3	PA; LD; SP
ISTODAX INTRAVENOUS SOLUTION RECONSTITUTED (*romidepsin*)	3	PA; LD; SP
ROMIDEPSIN INTRAVENOUS SOLUTION	3	PA; SP
romidepsin intravenous solution reconstituted	1 or 1b*	PA; LD; SP
ZOLINZA ORAL CAPSULE (*vorinostat*)	2; OC	PA; QL (4 capsule per 1 day); SP; OC
ANTINEOPLASTIC - HORMONAL AND RELATED AGENT COMBINATIONS - DRUGS FOR CANCER**		
AKEEGA ORAL TABLET (*niraparib-abiraterone acetate*)	3; OC	PA; QL (1 tablet per 1 day); OC
ANTINEOPLASTIC - IMMUNOMODULATORS - DRUGS FOR CANCER**		
POMALYST ORAL CAPSULE (*pomalidomide*)	3; OC	PA; LD; QL (21 capsules per 28 days); SP; OC
ANTINEOPLASTIC - KRAS INHIBITORS - DRUGS FOR CANCER**		
KRAZATI ORAL TABLET (*adagrasib*)	3; OC	PA; LD; QL (6 tablets per 1 day); OC
LUMAKRAS ORAL TABLET 120 MG (*sotorasib*)	3; OC	PA; LD; QL (8 tablets per 1 day); SP; OC
LUMAKRAS ORAL TABLET 320 MG (*sotorasib*)	3; OC	PA; LD; QL (3 tablets per 1 day); SP; OC
ANTINEOPLASTIC - MEK INHIBITORS - DRUGS FOR CANCER**		
COTELLIC ORAL TABLET (*cobimetinib fumarate*)	3; OC	PA; LD; QL (3 tablets per 1 day); SP; OC
KOSELUGO ORAL CAPSULE 10 MG (*selumetinib sulfate*)	3; OC	PA; LD; QL (8 capsules per 1 day); OC
KOSELUGO ORAL CAPSULE 25 MG (*selumetinib sulfate*)	3; OC	PA; LD; QL (4 capsules per 1 day); OC
MEKINIST ORAL SOLUTION RECONSTITUTED (*trametinib dimethyl sulfoxide*)	3; OC	PA; LD; QL (40 mL per 1 day); SP; OC
MEKINIST ORAL TABLET 0.5 MG (*trametinib dimethyl sulfoxide*)	3; OC	PA; LD; QL (3 tablets per 1 day); SP; OC
MEKINIST ORAL TABLET 2 MG (*trametinib dimethyl sulfoxide*)	3; OC	PA; LD; QL (1 tablet per 1 day); SP; OC

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MEKTOVI ORAL TABLET (*binimetinib*)	3; OC	PA; LD; QL (6 tablets per 1 day); SP; OC
ANTINEOPLASTIC - MET INHIBITORS - DRUGS FOR CANCER**		
TABRECTA ORAL TABLET (*capmatinib hcl*)	3; OC	PA; QL (4 tablets per 1 day); SP; OC
TEPMETKO ORAL TABLET (*tepotinib hcl*)	3; OC	PA; LD; QL (2 tablets per 1 day); OC
ANTINEOPLASTIC - METHYLTRANSFERASE INHIBITORS - DRUGS FOR CANCER**		
TAZVERIK ORAL TABLET (*tazemetostat hbr*)	3; OC	PA; LD; QL (8 tablets per 1 day); OC
ANTINEOPLASTIC - MTOR KINASE INHIBITORS - DRUGS FOR CANCER**		
everolimus oral tablet	1 or 1b*; OC	PA; SP; OC
everolimus oral tablet soluble	1 or 1b*; OC	PA; SP; OC
FYARRO INTRAVENOUS SUSPENSION RECONSTITUTED (*sirolimus protein-bound part*)	3	PA; LD
temsirolimus intravenous solution	1 or 1b*	PA; SP
TORISEL INTRAVENOUS SOLUTION (*temsirolimus*)	3	PA; SP
ANTINEOPLASTIC - MULTIKINASE INHIBITORS - DRUGS FOR CANCER**		
CABOMETYX ORAL TABLET (*cabozantinib s-malate*)	2; OC	PA; LD; QL (1 tablet per 1 day); SP; OC
CAPRELSA ORAL TABLET 100 MG (*vandetanib*)	2; OC	PA; LD; QL (3 tablet per 1 day); OC
CAPRELSA ORAL TABLET 300 MG (*vandetanib*)	2; OC	PA; LD; QL (1 tablet per 1 day); OC
COMETRIQ (100 MG DAILY DOSE) ORAL KIT (*cabozantinib s-malate*)	3; OC	PA; LD; QL (1 dose-pack per 56 days); SP; OC
COMETRIQ (140 MG DAILY DOSE) ORAL KIT (*cabozantinib s-malate*)	3; OC	PA; LD; QL (1 dose pack per 28 days); SP; OC
COMETRIQ (60 MG DAILY DOSE) ORAL KIT (*cabozantinib s-malate*)	3; OC	PA; LD; QL (1 dose pack per 28 days); SP; OC
FOTIVDA ORAL CAPSULE (*tivozanib hcl*)	3; OC	PA; LD; QL (21 capsules per 28 days); OC
lapatinib ditosylate oral tablet	1 or 1b*; OC	PA; LD; QL (6 tablet per 1 day); SP; OC
NERLYNX ORAL TABLET (*neratinib maleate*)	3; OC	PA; LD; QL (6 tablets per 1 day); SP; OC
NEXAVAR ORAL TABLET (*sorafenib tosylate*)	3; OC	PA; LD; QL (4 tablet per 1 day); SP; OC
pazopanib hcl oral tablet	1 or 1b*; OC	PA; LD; QL (4 tablet per 1 day); SP; OC
QINLOCK ORAL TABLET (*ripretinib*)	3; OC	PA; LD; QL (3 tablets per 1 day); OC
RYDAPT ORAL CAPSULE (*midostaurin*)	3; OC	PA; QL (8 capsules per 1 day); SP; OC

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
sorafenib tosylate oral tablet	1 or 1b*; OC	PA; LD; QL (4 tablet per 1 day); SP; OC
STIVARGA ORAL TABLET (*regorafenib*)	2; OC	PA; LD; QL (84 tablets per 28 days); SP; OC
sunitinib malate oral capsule	1 or 1b*; OC	PA; LD; QL (1 capsule per 1 day); SP; OC
SUTENT ORAL CAPSULE (*sunitinib malate*)	3; OC	PA; LD; QL (1 capsule per 1 day); SP; OC
TURALIO ORAL CAPSULE (*pexidartinib hcl*)	3; OC	PA; LD; QL (4 capsules per 1 day); OC
VANFLYTA ORAL TABLET (*quizartinib dihydrochloride*)	3; OC	PA; QL (2 tablets per 1 day); OC
XOSPATA ORAL TABLET (*gilteritinib fumarate*)	3; OC	PA; LD; QL (3 tablets per 1 day); SP; OC
ANTINEOPLASTIC - MULTIPLE RECEPTOR ANTIBODIES - DRUGS FOR CANCER**		
RYBREVANT INTRAVENOUS SOLUTION (*amivantamab-vmjw*)	3	PA; LD; SP
ANTINEOPLASTIC - PDGFR-ALPHA INHIBITORS - DRUGS FOR CANCER**		
AYVAKIT ORAL TABLET (*avapritinib*)	3; OC	PA; LD; QL (1 tablet per 1 day); OC
ANTINEOPLASTIC - PROTEASOME INHIBITORS - DRUGS FOR CANCER**		
bortezomib injection solution reconstituted 1 mg, 2.5 mg	3	PA; SP
bortezomib injection solution reconstituted 3.5 mg	1 or 1b*	PA; SP
bortezomib intravenous solution	3	PA; SP
BORTEZOMIB INTRAVENOUS SOLUTION RECONSTITUTED	3	PA; SP
KYPROLIS INTRAVENOUS SOLUTION RECONSTITUTED (*carfilzomib*)	3	PA; LD; SP
NINLARO ORAL CAPSULE (*ixazomib citrate*)	3; OC	PA; LD; QL (3 capsule per 28 days); SP; OC
VELCADE INJECTION SOLUTION RECONSTITUTED (*bortezomib*)	3	PA; SP
ANTINEOPLASTIC - RET INHIBITORS - DRUGS FOR CANCER**		
GAVRETO ORAL CAPSULE (*pralsetinib*)	3; OC	PA; LD; QL (4 capsules per 1 day); SP; OC
RETEVMO ORAL CAPSULE 40 MG (*selpercatinib*)	3; OC	PA; LD; QL (6 capsules per 1 day); SP; OC
RETEVMO ORAL CAPSULE 80 MG (*selpercatinib*)	3; OC	PA; LD; QL (4 capsules per 1 day); SP; OC
ANTINEOPLASTIC - TROPOMYOSIN RECEPTOR KINASE INHIBITORS - DRUGS FOR CANCER**		
ROZLYTREK ORAL CAPSULE 100 MG (*entrectinib*)	2; OC	PA; LD; QL (1 capsule per 1 day); SP; OC
ROZLYTREK ORAL CAPSULE 200 MG (*entrectinib*)	2; OC	PA; LD; QL (3 capsules per 1 day); SP; OC
VITRAKVI ORAL CAPSULE 100 MG (*larotrectinib sulfate*)	2; OC	PA; LD; QL (2 tablets per 1 day); SP; OC

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITRAKVI ORAL CAPSULE 25 MG (*larotrectinib sulfate*)	2; OC	PA; LD; QL (6 tablets per 1 day); SP; OC
VITRAKVI ORAL SOLUTION (*larotrectinib sulfate*)	2; OC	PA; LD; QL (10 mL per 1 day); SP; OC
ANTINEOPLASTIC - XPO1 INHIBITORS - DRUGS FOR CANCER**		
XPOVIO (100 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK (*selinexor*)	3; OC	PA; LD; QL (1 carton per 28 days); OC
XPOVIO (40 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK (*selinexor*)	3; OC	PA; LD; QL (1 carton per 28 days); OC
XPOVIO (40 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK (*selinexor*)	3; OC	PA; LD; QL (1 carton per 28 days); OC
XPOVIO (60 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK (*selinexor*)	3; OC	PA; LD; QL (1 carton per 28 days); OC
XPOVIO (60 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK (*selinexor*)	3; OC	PA; LD; QL (1 pack per 1 week); OC
XPOVIO (80 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK (*selinexor*)	3; OC	PA; LD; QL (1 carton per 28 days); OC
XPOVIO (80 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK (*selinexor*)	3; OC	PA; LD; QL (32 tablets per 28 weeks); OC
ANTINEOPLASTIC ANTIBIOTICS - DRUGS FOR CANCER**		
adriamycin intravenous solution reconstituted	1 or 1b*	SP
bleomycin sulfate injection solution reconstituted	1 or 1b*	SP
COSMEGEN INTRAVENOUS SOLUTION RECONSTITUTED (*dactinomycin*)	3	SP
dactinomycin intravenous solution reconstituted	1 or 1b*	SP
DAUNORUBICIN HCL INTRAVENOUS SOLUTION	3	SP
DOXIL INTRAVENOUS INJECTABLE (*doxorubicin hcl liposomal*)	3	PA; SP
doxorubicin hcl intravenous solution	1 or 1b*	SP
doxorubicin hcl intravenous solution reconstituted	1 or 1b*	SP
doxorubicin hcl liposomal intravenous injectable	1 or 1b*	PA; SP
ELLENCE INTRAVENOUS SOLUTION (*epirubicin hcl*)	3	PA; SP
IDAMYCIN PFS INTRAVENOUS SOLUTION (*idarubicin hcl*)	3	SP
idarubicin hcl intravenous solution	1 or 1b*	SP
JELMYTO SOLUTION RECONSTITUTED (*mitomycin*)	3	PA; LD
mitomycin intravenous solution reconstituted	1 or 1b*	SP
mitoxantrone hcl intravenous concentrate	1 or 1b*	SP
mutamycin intravenous solution reconstituted	1 or 1b*	SP
valrubicin intravesical solution	1 or 1b*	LD; SP
VALSTAR INTRAVESICAL SOLUTION (*valrubicin*)	3	LD; SP
ANTINEOPLASTIC -ANTIBODY FOR RADIOPHARMACEUTICAL THERAPY - DRUGS FOR CANCER**		
ZEVALIN Y-90 INTRAVENOUS KIT (*ibritumomab tiuxetan for y-90*)	3	PA; LD

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTINEOPLASTIC ANTIBODY-DRUG COMPLEXES - DRUGS FOR CANCER**		
ELAHERE INTRAVENOUS SOLUTION (*mirvetuximab soravtansine-gynx*)	3	PA; LD
ENHERTU INTRAVENOUS SOLUTION RECONSTITUTED (*fam-trastuzumab deruxtec-nxki*)	3	PA; LD; SP
KADCYLA INTRAVENOUS SOLUTION RECONSTITUTED (*ado-trastuzumab emtansine*)	3	PA; LD; SP
ANTINEOPLASTIC COMBINATIONS - DRUGS FOR CANCER**		
DARZALEX FASPRO SUBCUTANEOUS SOLUTION (*daratumumab-hyaluronidase-fihj*)	3	PA; LD; SP
HERCEPTIN HYLECTA SUBCUTANEOUS SOLUTION (*trastuzumab-hyaluronidase-oysk*)	3	LD; SP
INQOVI ORAL TABLET (*decitabine-cedazuridine*)	3; OC	PA; LD; QL (5 tablets per 28 days); SP; OC
KISQALI FEMARA (200 MG DOSE) ORAL TABLET THERAPY PACK (*ribociclib-letrozole*)	2; OC	PA; QL (1.75 tablets per 1 day); SP; OC
KISQALI FEMARA (400 MG DOSE) ORAL TABLET THERAPY PACK (*ribociclib-letrozole*)	2; OC	PA; QL (2.5 tablets per 1 day); SP; OC
KISQALI FEMARA (600 MG DOSE) ORAL TABLET THERAPY PACK (*ribociclib-letrozole*)	2; OC	PA; QL (3.25 tablets per 1 day); SP; OC
LONSURF ORAL TABLET (*trifluridine-tipiracil*)	3; OC	PA; LD; SP; OC
PHESGO SUBCUTANEOUS SOLUTION (*pertuz-trastuz-hyaluron-zzxf*)	3	PA; LD; SP
RITUXAN HYCELA SUBCUTANEOUS SOLUTION (*rituximab-hyaluronidase human*)	3	LD; SP
VYXEOS INTRAVENOUS SUSPENSION RECONSTITUTED (*daunorubicin-cytarabine lipo*)	3	LD; SP
ANTINEOPLASTIC ENZYMES - DRUGS FOR CANCER**		
ASPARLAS INTRAVENOUS SOLUTION (*calaspargase pegol-mknl*)	3	PA; LD
ONCASPAR INJECTION SOLUTION (*pegaspargase*)	3	PA; LD
RYLAZE INTRAMUSCULAR SOLUTION (*asparaginase erwinia chry-rywn*)	3	PA; LD; SP
ANTINEOPLASTIC RADIOPHARMACEUTICALS - DRUGS FOR CANCER**		
AZEDRA DOSIMETRIC INTRAVENOUS SOLUTION (*iobenguane i 131*)	4	PA; LD
AZEDRA THERAPEUTIC INTRAVENOUS SOLUTION (*iobenguane i 131*)	4	PA; LD
LUTATHERA INTRAVENOUS SOLUTION (*lutetium lu 177 dotatate*)	3	PA; LD
PLUVICTO INTRAVENOUS SOLUTION (*lutetium lu 177 vipivotide tet*)	3	PA; LD
STRONTIUM CHLORIDE SR-89 INTRAVENOUS SOLUTION	3	
XOFIGO INTRAVENOUS SOLUTION (*radium ra 223 dichloride*)	3	PA; LD
ANTINEOPLASTICS - INTERLEUKINS - DRUGS FOR CANCER**		
ELZONRIS INTRAVENOUS SOLUTION (*tagraxofusp-erzs*)	3	PA; LD
PROLEUKIN INTRAVENOUS SOLUTION RECONSTITUTED (*aldesleukin*)	3	PA; SP

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTINEOPLASTICS - PHOTOACTIVATED AGENTS - DRUGS FOR CANCER**		
PHOTOFRIN INTRAVENOUS SOLUTION RECONSTITUTED (*porfimer sodium*)	3	
UVADEX EXTRACORPOREAL SOLUTION (*methoxsalen (photopheresis)*)	3	
ANTINEOPLASTICS MISC. - DRUGS FOR CANCER**		
ACTIMMUNE SUBCUTANEOUS SOLUTION (*interferon gamma-1b*)	4	PA; LD; SP
ALFERON N INJECTION SOLUTION (*interferon alfa-n3*)	4	SP
arsenic trioxide intravenous solution	1 or 1b*	SP
BESREMI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (*ropeginterferon alfa-2b-njft*)	3	PA; LD; QL (2 mL per 28 days)
dacarbazine intravenous solution reconstituted	1 or 1b*	SP
HYDREA ORAL CAPSULE (*hydroxyurea*)	3; OC	OC
hydroxyurea oral capsule	1 or 1b*; OC	OC
MATULANE ORAL CAPSULE (*procarbazine hcl*)	2; OC	LD; OC
NIPENT INTRAVENOUS SOLUTION RECONSTITUTED (*pentostatin*)	3	SP
TICE BCG INTRAVESICAL SUSPENSION RECONSTITUTED (*bcg live*)	4	SP
TRISENOX INTRAVENOUS SOLUTION (*arsenic trioxide*)	3	SP
AROMATASE INHIBITORS - DRUGS FOR CANCER**		
anastrozole oral tablet	1 or 1b*; OC; $0	QL (1 tablet per 1 day); OC
AROMASIN ORAL TABLET (*exemestane*)	3; OC	QL (2 tablets per 1 day); OC
exemestane oral tablet	1 or 1b*; OC; $0	QL (2 tablets per 1 day); OC
FEMARA ORAL TABLET (*letrozole*)	3; OC	QL (1 tablet per 1 day); OC
letrozole oral tablet	1 or 1b*; OC; $0	QL (1 tablet per 1 day); OC
CARBOXYPEPTIDASE ENZYME AGENTS - DRUGS FOR CANCER**		
VORAXAZE INTRAVENOUS SOLUTION RECONSTITUTED (*glucarpidase*)	3	LD
CARDIAC PROTECTIVE AGENTS - DRUGS FOR CANCER**		
dexrazoxane hcl intravenous solution reconstituted	1 or 1b*	SP
dexrazoxane intravenous solution reconstituted	1 or 1b*	SP
CHEMOTHERAPY ADJUNCTS - HYPERURICEMIA AGENTS - DRUGS FOR CANCER**		
ELITEK INTRAVENOUS SOLUTION RECONSTITUTED (*rasburicase*)	3	PA; SP
CHEMOTHERAPY ADJUNCTS - KERATINOCYTE GROWTH FACTORS - DRUGS FOR CANCER**		
KEPIVANCE INTRAVENOUS SOLUTION RECONSTITUTED (*palifermin*)	3	SP
CYCLIN-DEPENDENT KINASES (CDK) INHIBITORS - DRUGS FOR CANCER**		
IBRANCE ORAL CAPSULE (*palbociclib*)	2; OC	PA; LD; QL (21 capsules per 28 days); SP; OC

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
IBRANCE ORAL TABLET 100 MG, 75 MG (*palbociclib*)	2; OC	PA; LD; QL (21 tablets per 28 days); SP; OC
IBRANCE ORAL TABLET 125 MG (*palbociclib*)	2; OC	PA; LD; QL (1 tablet per 1 day); SP; OC
KISQALI (200 MG DOSE) ORAL TABLET THERAPY PACK (*ribociclib succinate*)	2; OC	PA; QL (0.75 tablet per 1 day); SP; OC
KISQALI (400 MG DOSE) ORAL TABLET THERAPY PACK (*ribociclib succinate*)	2; OC	PA; QL (1.5 tablets per 1 day); SP; OC
KISQALI (600 MG DOSE) ORAL TABLET THERAPY PACK (*ribociclib succinate*)	2; OC	PA; QL (2.25 tablets per 1 day); SP; OC
VERZENIO ORAL TABLET (*abemaciclib*)	3; OC	PA; LD; QL (2 tablets per 1 day); SP; OC
ESTROGEN RECEPTOR ANTAGONIST - DRUGS FOR CANCER**		
FASLODEX INTRAMUSCULAR SOLUTION PREFILLED SYRINGE (*fulvestrant*)	3	PA; SP
fulvestrant intramuscular solution prefilled syringe	1 or 1b*	PA; SP
ESTROGENS-ANTINEOPLASTIC - DRUGS FOR CANCER**		
EMCYT ORAL CAPSULE (*estramustine phosphate sodium*)	2; OC	PA; OC
FOLIC ACID ANTAGONISTS RESCUE AGENTS - DRUGS FOR CANCER**		
KHAPZORY INTRAVENOUS SOLUTION RECONSTITUTED (*levoleucovorin*)	3	PA; LD; SP
leucovorin calcium injection solution	1 or 1b*	
leucovorin calcium injection solution reconstituted	1 or 1b*	
leucovorin calcium oral tablet	1 or 1b*	
levoleucovorin calcium intravenous solution reconstituted	1 or 1b*	PA
levoleucovorin calcium pf intravenous solution	1 or 1b*	
GONADOTROPIN RELEASING HORMONE (GNRH) ANTAGONISTS - DRUGS FOR CANCER**		
FIRMAGON (240 MG DOSE) SUBCUTANEOUS SOLUTION RECONSTITUTED (*degarelix acetate*)	3	PA; QL (2 units per 310 days); SP
FIRMAGON SUBCUTANEOUS SOLUTION RECONSTITUTED (*degarelix acetate*)	3	PA; QL (1 kit per 28 days); SP
ORGOVYX ORAL TABLET (*relugolix*)	3; OC	PA; LD; QL (1 tablet per 1 day); OC
IMIDAZOTETRAZINES - DRUGS FOR CANCER**		
TEMODAR INTRAVENOUS SOLUTION RECONSTITUTED (*temozolomide*)	2	PA; SP
temozolomide oral capsule 100 mg, 140 mg, 180 mg, 250 mg	1 or 1b*; OC	PA; QL (2 capsules per 1 day); SP; OC
temozolomide oral capsule 20 mg	1 or 1b*; OC	PA; QL (4 capsule per 1 day); SP; OC
temozolomide oral capsule 5 mg	1 or 1b*; OC	PA; QL (3 capsule per 1 day); SP; OC

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ISOCITRATE DEHYDROGENASE-1 (IDH1) INHIBITORS - DRUGS FOR CANCER**		
REZLIDHIA ORAL CAPSULE (*olutasidenib*)	3; OC	PA; LD; QL (2 capsules per 1 day); OC
TIBSOVO ORAL TABLET (*ivosidenib*)	3; OC	PA; LD; QL (2 tablets per 1 day); OC
ISOCITRATE DEHYDROGENASE-2 (IDH2) INHIBITORS - DRUGS FOR CANCER**		
IDHIFA ORAL TABLET 100 MG (*enasidenib mesylate*)	3; OC	PA; LD; QL (1 tablet per 1 day); SP; OC
IDHIFA ORAL TABLET 50 MG (*enasidenib mesylate*)	3; OC	PA; LD; QL (2 tablets per 1 day); SP; OC
JANUS ASSOCIATED KINASE (JAK) INHIBITORS - DRUGS FOR CANCER**		
INREBIC ORAL CAPSULE (*fedratinib hcl*)	3; OC	PA; LD; QL (4 capsules per 1 day); SP; OC
JAKAFI ORAL TABLET (*ruxolitinib phosphate*)	2; OC	PA; LD; QL (2 tablets per 1 day); SP; OC
OJJAARA ORAL TABLET (*momelotinib dihydrochloride*)	3; OC	PA; QL (1 tablet per 1 day); OC
VONJO ORAL CAPSULE (*pacritinib citrate*)	3; OC	PA; LD; QL (4 capsules per 1 day); OC
LHRH ANALOGS - DRUGS FOR CANCER**		
CAMCEVI SUBCUTANEOUS PREFILLED SYRINGE (*leuprolide mesylate (6 month)*)	3	PA; LD; QL (1 syringe per 24 weekss)
ELIGARD SUBCUTANEOUS KIT 22.5 MG (*leuprolide acetate (3 month)*)	3	PA; QL (1 syringe per 84 days); SP
ELIGARD SUBCUTANEOUS KIT 30 MG (*leuprolide acetate (4 month)*)	3	PA; QL (1 syringe per 112 days); SP
ELIGARD SUBCUTANEOUS KIT 45 MG (*leuprolide acetate (6 month)*)	3	PA; QL (1 syringe per 168 days); SP
ELIGARD SUBCUTANEOUS KIT 7.5 MG (*leuprolide acetate*)	3	PA; QL (1 syringe per 28 days); SP
leuprolide acetate (3 month) intramuscular injectable	3	PA; QL (1 kit per 12 weeks); SP
leuprolide acetate injection kit	1 or 1b*	PA; SP
LUPRON DEPOT (1-MONTH) INTRAMUSCULAR KIT 3.75 MG (*leuprolide acetate*)	4	PA; QL (1 syringe kit per 28 days); SP
LUPRON DEPOT (1-MONTH) INTRAMUSCULAR KIT 7.5 MG (*leuprolide acetate*)	2	QL (1 kit per 28 days); SP
LUPRON DEPOT (3-MONTH) INTRAMUSCULAR KIT 11.25 MG (*leuprolide acetate (3 month)*)	4	PA; QL (1 kit per 84 days); SP
LUPRON DEPOT (3-MONTH) INTRAMUSCULAR KIT 22.5 MG (*leuprolide acetate (3 month)*)	2	QL (1 kit per 84 days); SP
LUPRON DEPOT (4-MONTH) INTRAMUSCULAR KIT (*leuprolide acetate (4 month)*)	2	QL (1 kit per 112 days); SP
LUPRON DEPOT (6-MONTH) INTRAMUSCULAR KIT (*leuprolide acetate (6 month)*)	2	QL (1 syringe kit per 168 days); SP
TRELSTAR MIXJECT INTRAMUSCULAR SUSPENSION RECONSTITUTED 11.25 MG (*triptorelin pamoate*)	3	PA; QL (1 vial per 84 days); SP

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TRELSTAR MIXJECT INTRAMUSCULAR SUSPENSION RECONSTITUTED 22.5 MG (*triptorelin pamoate*)	3	PA; QL (1 syringe per 168 days); SP
TRELSTAR MIXJECT INTRAMUSCULAR SUSPENSION RECONSTITUTED 3.75 MG (*triptorelin pamoate*)	3	PA; QL (1 kit per 28 days); SP
ZOLADEX SUBCUTANEOUS IMPLANT 10.8 MG (*goserelin acetate*)	3	PA; QL (1 EA per 84 days); SP
ZOLADEX SUBCUTANEOUS IMPLANT 3.6 MG (*goserelin acetate*)	3	PA; QL (1 unit per 28 days); SP
MITOTIC INHIBITORS - DRUGS FOR CANCER**		
ABRAXANE INTRAVENOUS SUSPENSION RECONSTITUTED (*paclitaxel protein-bound part*)	3	PA; LD; SP
DOCETAXEL INTRAVENOUS CONCENTRATE	3	PA; SP
DOCETAXEL INTRAVENOUS SOLUTION 160 MG/16ML, 20 MG/2ML	3	PA; SP
DOCETAXEL INTRAVENOUS SOLUTION 80 MG/8ML	3	SP
ETOPOPHOS INTRAVENOUS SOLUTION RECONSTITUTED (*etoposide phosphate*)	3	SP
etoposide intravenous solution	1 or 1b*	SP
etoposide oral capsule	1 or 1b*; OC	SP; OC
HALAVEN INTRAVENOUS SOLUTION (*eribulin mesylate*)	3	PA; SP
IXEMPRA KIT INTRAVENOUS SOLUTION RECONSTITUTED (*ixabepilone*)	3	PA; SP
JEVTANA INTRAVENOUS SOLUTION (*cabazitaxel*)	3	PA; LD; SP
paclitaxel intravenous concentrate	1 or 1b*	SP
PACLITAXEL PROTEIN-BOUND PART INTRAVENOUS SUSPENSION RECONSTITUTED	3	PA; LD; SP
vinblastine sulfate intravenous solution	1 or 1b*	SP
vincristine sulfate intravenous solution	1 or 1b*	SP
vinorelbine tartrate intravenous solution	1 or 1b*	SP
MYELOPROTECTIVE AGENTS - DRUGS FOR CANCER**		
COSELA INTRAVENOUS SOLUTION RECONSTITUTED (*trilaciclib dihydrochloride*)	3	PA; LD
NITROGEN MUSTARDS AND RELATED ANALOGUES - DRUGS FOR CANCER**		
cyclophosphamide injection solution reconstituted	1 or 1b*	SP
CYCLOPHOSPHAMIDE INTRAVENOUS SOLUTION 1 GM/5ML, 500 MG/2.5ML	3	SP
CYCLOPHOSPHAMIDE INTRAVENOUS SOLUTION 2 GM/10ML	3	
cyclophosphamide intravenous solution 500 mg/ml	3	
cyclophosphamide oral capsule	1 or 1b*; OC	SP; OC
CYCLOPHOSPHAMIDE ORAL TABLET	3; OC	OC
EVOMELA INTRAVENOUS SOLUTION RECONSTITUTED (*melphalan hcl*)	3	LD; SP
IFEX INTRAVENOUS SOLUTION RECONSTITUTED (*ifosfamide*)	3	SP
ifosfamide intravenous solution	1 or 1b*	SP
ifosfamide intravenous solution reconstituted 1 gm	1 or 1b*	SP
IFOSFAMIDE INTRAVENOUS SOLUTION RECONSTITUTED 3 GM	3	SP

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LEUKERAN ORAL TABLET (*chlorambucil*)	2; OC	OC
melphalan hcl intravenous solution reconstituted	1 or 1b*	SP
melphalan oral tablet	1 or 1b*; OC	SP; OC
NITROSOUREAS - DRUGS FOR CANCER**		
carmustine intravenous solution reconstituted 100 mg	1 or 1b*	SP
carmustine intravenous solution reconstituted 300 mg, 50 mg	3	SP
GLEOSTINE ORAL CAPSULE (*lomustine*)	3; OC	PA; SP; OC
GLIADEL WAFER IMPLANT WAFER (*carmustine in polifeprosan*)	3	
ZANOSAR INTRAVENOUS SOLUTION RECONSTITUTED (*streptozocin*)	3	SP
OTOPROTECTIVE AGENTS - DRUGS FOR CANCER**		
PEDMARK INTRAVENOUS SOLUTION (*sodium thiosulfate*)	3	PA; LD
PHOSPHATIDYLINOSITOL 3-KINASE (PI3K) INHIBITORS - DRUGS FOR CANCER**		
ALIQOPA INTRAVENOUS SOLUTION RECONSTITUTED (*copanlisib hcl*)	3	PA; LD
COPIKTRA ORAL CAPSULE (*duvelisib*)	3; OC	PA; LD; QL (2 tablets per 1 day); SP; OC
PIQRAY (200 MG DAILY DOSE) ORAL TABLET THERAPY PACK (*alpelisib*)	3; OC	PA; QL (1 tablet per 1 day); SP; OC
PIQRAY (250 MG DAILY DOSE) ORAL TABLET THERAPY PACK (*alpelisib*)	3; OC	PA; QL (2 tablets per 1 day); SP; OC
PIQRAY (300 MG DAILY DOSE) ORAL TABLET THERAPY PACK (*alpelisib*)	3; OC	PA; QL (2 tablets per 1 day); SP; OC
ZYDELIG ORAL TABLET (*idelalisib*)	3; OC	PA; LD; QL (2 tablets per 1 day); SP; OC
POLY (ADP-RIBOSE) POLYMERASE (PARP) INHIBITORS - DRUGS FOR CANCER**		
LYNPARZA ORAL TABLET (*olaparib*)	3; OC	PA; LD; QL (4 tablets per 1 day); SP; OC
RUBRACA ORAL TABLET (*rucaparib camsylate*)	3; OC	PA; LD; QL (4 tablets per 1 day); SP; OC
TALZENNA ORAL CAPSULE (*talazoparib tosylate*)	3; OC	PA; LD; QL (1 capsule per 1 day); SP; OC
ZEJULA ORAL TABLET (*niraparib tosylate*)	3; OC	PA; LD; QL (3 tablets per 1 day); SP; OC
PROGESTINS-ANTINEOPLASTIC - DRUGS FOR CANCER**		
megestrol acetate oral suspension	1 or 1b*; OC	OC
megestrol acetate oral tablet	1 or 1b*; OC	OC
RETINOIDS - DRUGS FOR CANCER**		
tretinoin oral capsule	1 or 1b*; OC	OC
SELECTIVE ESTROGEN RECEPTOR DEGRADERS - DRUGS FOR CANCER**		
ORSERDU ORAL TABLET 345 MG (*elacestrant hydrochloride*)	3; OC	PA; LD; QL (1 tablet per 1 day); OC

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ORSERDU ORAL TABLET 86 MG (*elacestrant hydrochloride*)	3; OC	PA; LD; QL (3 tablets per 1 day); OC
SELECTIVE RETINOID X RECEPTOR AGONISTS - DRUGS FOR CANCER**		
bexarotene oral capsule	1 or 1b*; OC	PA; QL (10 capsules per 1 day); SP; OC
TETRAHYDROISOQUINOLINES - DRUGS FOR CANCER**		
YONDELIS INTRAVENOUS SOLUTION RECONSTITUTED (*trabectedin*)	3	LD; SP
TOPOISOMERASE I INHIBITORS - ANTIBODY-DRUG COMPLEX - DRUGS FOR CANCER**		
TRODELVY INTRAVENOUS SOLUTION RECONSTITUTED (*sacituzumab govitecan-hziy*)	3	PA; LD
TOPOISOMERASE I INHIBITORS - DRUGS FOR CANCER**		
CAMPTOSAR INTRAVENOUS SOLUTION (*irinotecan hcl*)	3	SP
HYCAMTIN INTRAVENOUS SOLUTION RECONSTITUTED (*topotecan hcl*)	3	SP
HYCAMTIN ORAL CAPSULE (*topotecan hcl*)	2; OC	PA; SP; OC
irinotecan hcl intravenous solution	1 or 1b*	SP
ONIVYDE INTRAVENOUS INJECTABLE (*irinotecan hcl liposome*)	3	LD; SP
TOPOTECAN HCL INTRAVENOUS SOLUTION	3	SP
topotecan hcl intravenous solution reconstituted	1 or 1b*	SP
URINARY TRACT PROTECTIVE AGENTS - DRUGS FOR CANCER**		
ETHYOL INTRAVENOUS SOLUTION RECONSTITUTED (*amifostine*)	3	PA; SP
mesna intravenous solution	1 or 1b*	PA
MESNEX INTRAVENOUS SOLUTION (*mesna*)	3	PA
MESNEX ORAL TABLET (*mesna*)	2	PA
VASCULAR ENDOTHELIAL GROWTH FACTOR (VEGF) INHIBITORS - DRUGS FOR CANCER**		
AVASTIN INTRAVENOUS SOLUTION (*bevacizumab*)	3	PA; LD; SP
CYRAMZA INTRAVENOUS SOLUTION (*ramucirumab*)	3	PA; LD; SP
INLYTA ORAL TABLET 1 MG (*axitinib*)	2; OC	PA; LD; QL (6 tablets per 1 day); SP; OC
INLYTA ORAL TABLET 5 MG (*axitinib*)	2; OC	PA; LD; QL (4 tablet per 1 day); SP; OC
LENVIMA (10 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK (*lenvatinib mesylate*)	2; OC	PA; LD; QL (30 capsules per 30 days); SP; OC
LENVIMA (12 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK (*lenvatinib mesylate*)	2; OC	PA; LD; QL (1 pack per 30 days); SP; OC
LENVIMA (14 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK (*lenvatinib mesylate*)	2; OC	PA; LD; QL (60 capsules per 30 days); SP; OC
LENVIMA (18 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK (*lenvatinib mesylate*)	2; OC	PA; LD; QL (1 pack per 30 days); SP; OC
LENVIMA (20 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK (*lenvatinib mesylate*)	2; OC	PA; LD; QL (60 capsules per 30 days); SP; OC

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LENVIMA (24 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK (*lenvatinib mesylate*)	2; OC	PA; LD; QL (90 capsules per 30 days); SP; OC
LENVIMA (4 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK (*lenvatinib mesylate*)	2; OC	PA; LD; QL (30 capsules per 30 days); SP; OC
LENVIMA (8 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK (*lenvatinib mesylate*)	2; OC	PA; LD; QL (1 pack per 30 days); SP; OC
MVASI INTRAVENOUS SOLUTION (*bevacizumab-awwb*)	3	PA; LD; SP
ZALTRAP INTRAVENOUS SOLUTION (*ziv-aflibercept*)	3	PA; LD; SP
***ANTIPARKINSON AND RELATED THERAPY AGENTS* - DRUGS FOR THE NERVOUS SYSTEM**		
ADENOSINE RECEPTOR ANTAGONIST - DRUGS FOR PARKINSON**		
NOURIANZ ORAL TABLET (*istradefylline*)	4	PA; LD; QL (1 tablet per 1 day); SP
ANTIPARKINSON ANTICHOLINERGICS - DRUGS FOR PARKINSON**		
benztropine mesylate injection solution	1 or 1a*	
benztropine mesylate oral tablet	1 or 1a*	
trihexyphenidyl hcl oral solution	1 or 1a*	
trihexyphenidyl hcl oral tablet	1 or 1a*	
ANTIPARKINSON DOPAMINERGICS - DRUGS FOR PARKINSON**		
amantadine hcl oral capsule	1 or 1b*	QL (4 capsule per 1 day)
amantadine hcl oral solution	1 or 1b*	QL (40 mL per 1 day)
amantadine hcl oral tablet	1 or 1b*	QL (4 tablet per 1 day)
bromocriptine mesylate oral capsule	1 or 1b*	
bromocriptine mesylate oral tablet	1 or 1b*	
GOCOVRI ORAL CAPSULE EXTENDED RELEASE 24 HOUR 137 MG (*amantadine hcl*)	3	PA; QL (2 capsules per 1 day)
GOCOVRI ORAL CAPSULE EXTENDED RELEASE 24 HOUR 68.5 MG (*amantadine hcl*)	3	PA; DO
INBRIJA INHALATION CAPSULE (*levodopa*)	4	PA; LD; QL (5 kits per 30 days)
OSMOLEX ER ORAL TABLET EXTENDED RELEASE 24 HOUR 129 MG (*amantadine hcl*)	3	PA; DO
OSMOLEX ER ORAL TABLET EXTENDED RELEASE 24 HOUR 193 MG (*amantadine hcl*)	3	PA; QL (1 tablet per 1 day)
PARLODEL ORAL CAPSULE (*bromocriptine mesylate*)	3	
PARLODEL ORAL TABLET (*bromocriptine mesylate*)	3	
ANTIPARKINSON MONOAMINE OXIDASE INHIBITORS - DRUGS FOR PARKINSON**		
AZILECT ORAL TABLET 0.5 MG (*rasagiline mesylate*)	3	QL (2 tablets per 1 day)
AZILECT ORAL TABLET 1 MG (*rasagiline mesylate*)	3	QL (1 tablet per 1 day)
rasagiline mesylate oral tablet 0.5 mg	1 or 1b*	QL (2 tablets per 1 day)
rasagiline mesylate oral tablet 1 mg	1 or 1b*	QL (1 tablet per 1 day)
selegiline hcl oral capsule	1 or 1b*	
selegiline hcl oral tablet	1 or 1b*	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
XADAGO ORAL TABLET 100 MG (*safinamide mesylate*)	3	PA; QL (1 tablet per 1 day)
XADAGO ORAL TABLET 50 MG (*safinamide mesylate*)	3	PA; QL (2 tablets per 1 day)
ZELAPAR ORAL TABLET DISPERSIBLE (*selegiline hcl*)	3	PA; QL (2 tablets per 1 day)
CENTRAL/PERIPHERAL COMT INHIBITORS - DRUGS FOR PARKINSON**		
TASMAR ORAL TABLET (*tolcapone*)	3	PA; QL (6 tablet per 1 day)
tolcapone oral tablet	1 or 1b*	PA; QL (6 tablet per 1 day)
DECARBOXYLASE INHIBITORS - DRUGS FOR PARKINSON**		
carbidopa oral tablet	1 or 1b*	
LODOSYN ORAL TABLET (*carbidopa*)	3	
LEVODOPA COMBINATIONS - DRUGS FOR PARKINSON**		
carbidopa-levodopa er oral tablet extended release	1 or 1b*	
carbidopa-levodopa oral tablet	1 or 1b*	
carbidopa-levodopa oral tablet dispersible	1 or 1b*	
carbidopa-levodopa-entacapone oral tablet	1 or 1b*	
DHIVY ORAL TABLET (*carbidopa-levodopa*)	3	
DUOPA ENTERAL SUSPENSION (*carbidopa-levodopa*)	3	PA; LD; SP
RYTARY ORAL CAPSULE EXTENDED RELEASE 23.75-95 MG, 48.75-195 MG (*carbidopa-levodopa*)	3	QL (12 capsules per 1 day)
RYTARY ORAL CAPSULE EXTENDED RELEASE 36.25-145 MG (*carbidopa-levodopa*)	3	QL (9 capsules per 1 day)
RYTARY ORAL CAPSULE EXTENDED RELEASE 61.25-245 MG (*carbidopa-levodopa*)	3	QL (10 capsules per 1 day)
SINEMET ORAL TABLET (*carbidopa-levodopa*)	3	
STALEVO 100 ORAL TABLET (*carbidopa-levodopa-entacapone*)	3	
STALEVO 125 ORAL TABLET (*carbidopa-levodopa-entacapone*)	3	
STALEVO 150 ORAL TABLET (*carbidopa-levodopa-entacapone*)	3	
STALEVO 200 ORAL TABLET (*carbidopa-levodopa-entacapone*)	3	
STALEVO 50 ORAL TABLET (*carbidopa-levodopa-entacapone*)	3	
STALEVO 75 ORAL TABLET (*carbidopa-levodopa-entacapone*)	3	
NONERGOLINE DOPAMINE RECEPTOR AGONISTS - DRUGS FOR PARKINSON**		
APOKYN SUBCUTANEOUS SOLUTION CARTRIDGE (*apomorphine hcl*)	4	PA; LD; QL (2 mL per 1 day); SP
apomorphine hcl subcutaneous solution cartridge	4	PA; LD; QL (2 mL per 1 day); SP
MIRAPEX ER ORAL TABLET EXTENDED RELEASE 24 HOUR (*pramipexole dihydrochloride*)	3	QL (1 tablet per 1 day)
NEUPRO TRANSDERMAL PATCH 24 HOUR (*rotigotine*)	3	QL (1 patch per 1 day)
pramipexole dihydrochloride er oral tablet extended release 24 hour	1 or 1b*	QL (1 tablet per 1 day)
pramipexole dihydrochloride oral tablet	1 or 1b*	QL (3 tablet per 1 day)
ropinirole hcl er oral tablet extended release 24 hour	1 or 1b*	
ropinirole hcl oral tablet	1 or 1b*	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PERIPHERAL COMT INHIBITORS - DRUGS FOR PARKINSON**		
COMTAN ORAL TABLET (*entacapone*)	3	QL (8 tablet per 1 day)
entacapone oral tablet	1 or 1b*	QL (8 tablet per 1 day)
ONGENTYS ORAL CAPSULE 25 MG (*opicapone*)	3	PA; QL (1 tablet per 1 day)
ONGENTYS ORAL CAPSULE 50 MG (*opicapone*)	3	PA; QL (6 tablets per 1 day)
***ANTIPSYCHOTICS/ANTIMANIC AGENTS* - DRUGS FOR THE NERVOUS SYSTEM**		
ANTIMANIC AGENTS - DRUGS FOR SEVERE MENTAL DISORDERS**		
lithium carbonate er oral tablet extended release 300 mg	1 or 1a*	QL (6 tablets per 1 day)
lithium carbonate er oral tablet extended release 450 mg	1 or 1a*	QL (4 tablets per 1 day)
lithium carbonate oral capsule 150 mg, 300 mg	1 or 1a*	DO
lithium carbonate oral capsule 600 mg	1 or 1a*	QL (3 capsules per 1 day)
lithium carbonate oral tablet	1 or 1a*	DO
lithium oral solution	3	
ANTIPSYCHOTICS - MISC. - DRUGS FOR SEVERE MENTAL DISORDERS**		
CAPLYTA ORAL CAPSULE 10.5 MG, 21 MG (*lumateperone tosylate*)	3	DO
CAPLYTA ORAL CAPSULE 42 MG (*lumateperone tosylate*)	3	QL (1 capsule per 1 day)
EQUETRO ORAL CAPSULE EXTENDED RELEASE 12 HOUR 100 MG, 200 MG (*carbamazepine (antipsychotic)*)	3	ST; QL (8 capsules per 1 day)
EQUETRO ORAL CAPSULE EXTENDED RELEASE 12 HOUR 300 MG (*carbamazepine (antipsychotic)*)	3	ST; QL (5 capsules per 1 day)
lurasidone hcl oral tablet 120 mg	1 or 1b*	
lurasidone hcl oral tablet 20 mg, 40 mg	1 or 1b*	DO
lurasidone hcl oral tablet 60 mg	1 or 1b*	QL (1 tablet per 1 day)
lurasidone hcl oral tablet 80 mg	1 or 1b*	QL (2 tablets per 1 day)
NUPLAZID ORAL CAPSULE (*pimavanserin tartrate*)	4	PA; LD; QL (1 capsule per 1 day); SP
NUPLAZID ORAL TABLET (*pimavanserin tartrate*)	4	PA; LD; QL (1 tablet per 1 day); SP
VRAYLAR ORAL CAPSULE 1.5 MG, 3 MG (*cariprazine hcl*)	2	DO
VRAYLAR ORAL CAPSULE 4.5 MG, 6 MG (*cariprazine hcl*)	2	QL (1 capsule per 1 day)
VRAYLAR ORAL CAPSULE THERAPY PACK (*cariprazine hcl*)	2	QL (1 pack per 1 year)
ziprasidone hcl oral capsule 20 mg, 40 mg	1 or 1b*	DO
ziprasidone hcl oral capsule 60 mg, 80 mg	1 or 1b*	QL (2 capsules per 1 day)
ziprasidone mesylate intramuscular solution reconstituted	1 or 1b*	QL (6 vials per 28 days)
BENZISOXAZOLES - DRUGS FOR SEVERE MENTAL DISORDERS**		
FANAPT ORAL TABLET 1 MG, 2 MG, 4 MG, 6 MG (*iloperidone*)	3	ST; DO
FANAPT ORAL TABLET 10 MG, 12 MG, 8 MG (*iloperidone*)	3	ST; QL (2 tablets per 1 day)
FANAPT TITRATION PACK ORAL TABLET (*iloperidone*)	3	ST; QL (1 pack per 1 year)
INVEGA HAFYERA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 1092 MG/3.5ML (*paliperidone palmitate*)	3	QL (3.5 mL per 180 days)

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
INVEGA HAFYERA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 1560 MG/5ML (*paliperidone palmitate*)	3	QL (5 mL per 180 days)
INVEGA SUSTENNA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (*paliperidone palmitate*)	3	QL (1 syringe per 28 days)
INVEGA TRINZA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 273 MG/0.88ML (*paliperidone palmitate*)	3	QL (0.88 mL per 90 days)
INVEGA TRINZA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 410 MG/1.32ML (*paliperidone palmitate*)	3	QL (1.32 mL per 90 days)
INVEGA TRINZA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 546 MG/1.75ML (*paliperidone palmitate*)	3	QL (1.75 mL per 90 days)
INVEGA TRINZA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 819 MG/2.63ML (*paliperidone palmitate*)	3	QL (2.63 mL per 90 days)
paliperidone er oral tablet extended release 24 hour 1.5 mg, 3 mg	1 or 1b*	DO
paliperidone er oral tablet extended release 24 hour 6 mg	1 or 1b*	QL (2 tablets per 1 day)
paliperidone er oral tablet extended release 24 hour 9 mg	1 or 1b*	QL (1 tablet per 1 day)
PERSERIS SUBCUTANEOUS PREFILLED SYRINGE (*risperidone*)	3	QL (1 syringe per 30 days)
RISPERDAL CONSTA INTRAMUSCULAR SUSPENSION RECONSTITUTED ER 12.5 MG (*risperidone microspheres*)	2	QL (2 injections per 1 day)
RISPERDAL CONSTA INTRAMUSCULAR SUSPENSION RECONSTITUTED ER 25 MG, 37.5 MG, 50 MG (*risperidone microspheres*)	2	QL (2 injections per 28 days)
risperidone oral solution	1 or 1b*	QL (8 mL per 1 day)
risperidone oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg	1 or 1b*	DO
risperidone oral tablet 3 mg, 4 mg	1 or 1b*	QL (4 tablets per 1 day)
risperidone oral tablet dispersible 0.25 mg, 0.5 mg, 1 mg, 2 mg	1 or 1b*	DO
risperidone oral tablet dispersible 3 mg, 4 mg	1 or 1b*	QL (4 tablets per 1 day)
BUTYROPHENONES - DRUGS FOR SEVERE MENTAL DISORDERS**		
haloperidol decanoate intramuscular solution 100 mg/ml	1 or 1b*	QL (5 injections per 30 days)
haloperidol decanoate intramuscular solution 50 mg/ml	1 or 1b*	QL (5 ampules per 30 days)
haloperidol lactate injection solution	1 or 1b*	
haloperidol lactate oral concentrate	1 or 1b*	QL (30 mL per 1 day)
haloperidol oral tablet 0.5 mg, 1 mg, 2 mg	1 or 1b*	DO
haloperidol oral tablet 10 mg, 20 mg, 5 mg	1 or 1b*	QL (3 tablets per 1 day)
DIBENZODIAZEPINES - DRUGS FOR SEVERE MENTAL DISORDERS**		
clozapine oral tablet 100 mg	1 or 1b*	QL (9 tablets per 1 day)
clozapine oral tablet 200 mg	1 or 1b*	QL (4 tablets per 1 day)
clozapine oral tablet 25 mg, 50 mg	1 or 1b*	DO
clozapine oral tablet dispersible 100 mg	1 or 1b*	QL (9 tablets per 1 day)
clozapine oral tablet dispersible 12.5 mg, 25 mg	1 or 1b*	DO
clozapine oral tablet dispersible 150 mg	1 or 1b*	QL (6 tablets per 1 day)
clozapine oral tablet dispersible 200 mg	1 or 1b*	QL (4 tablets per 1 day)
VERSACLOZ ORAL SUSPENSION (*clozapine*)	3	QL (18 mL per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIBENZO-OXEPINO PYRROLES - DRUGS FOR SEVERE MENTAL DISORDERS**		
asenapine maleate sublingual tablet sublingual 10 mg	1 or 1b*	QL (2 tablets per 1 day)
asenapine maleate sublingual tablet sublingual 2.5 mg, 5 mg	1 or 1b*	DO
SECUADO TRANSDERMAL PATCH 24 HOUR (*asenapine*)	3	ST; QL (1 patch per 1 day)
DIBENZOTHIAZEPINES - DRUGS FOR SEVERE MENTAL DISORDERS**		
quetiapine fumarate er oral tablet extended release 24 hour 150 mg, 200 mg	1 or 1b*	DO
quetiapine fumarate er oral tablet extended release 24 hour 300 mg, 400 mg, 50 mg	1 or 1b*	QL (2 tablets per 1 day)
quetiapine fumarate oral tablet 100 mg, 200 mg, 25 mg, 50 mg	1 or 1b*	DO
quetiapine fumarate oral tablet 150 mg	1 or 1b*	QL (5 tablets per 1 day)
quetiapine fumarate oral tablet 300 mg, 400 mg	1 or 1b*	QL (2 tablets per 1 day)
DIBENZOXAZEPINES - DRUGS FOR SEVERE MENTAL DISORDERS**		
ADASUVE INHALATION AEROSOL POWDER BREATH ACTIVATED (*loxapine*)	3	
loxapine succinate oral capsule 10 mg, 25 mg, 5 mg	1 or 1b*	DO
loxapine succinate oral capsule 50 mg	1 or 1b*	QL (4 capsules per 1 day)
DIHYDROINDOLONES - DRUGS FOR SEVERE MENTAL DISORDERS**		
molindone hcl oral tablet 10 mg, 5 mg	1 or 1b*	DO
molindone hcl oral tablet 25 mg	1 or 1b*	QL (4 tablets per 1 day)
PHENOTHIAZINES - DRUGS FOR SEVERE MENTAL DISORDERS**		
chlorpromazine hcl injection solution	1 or 1b*	
CHLORPROMAZINE HCL ORAL CONCENTRATE 100 MG/ML	1 or 1b*	QL (8 mL per 1 day)
CHLORPROMAZINE HCL ORAL CONCENTRATE 30 MG/ML	1 or 1b*	QL (26 mL per 1 day)
chlorpromazine hcl oral tablet 10 mg, 25 mg, 50 mg	1 or 1b*	DO
chlorpromazine hcl oral tablet 100 mg, 200 mg	1 or 1b*	QL (4 tablets per 1 day)
compro rectal suppository	1 or 1b*	
fluphenazine decanoate injection solution	1 or 1b*	
fluphenazine hcl injection solution	1 or 1b*	
fluphenazine hcl oral concentrate	1 or 1b*	QL (8 mL per 1 day)
fluphenazine hcl oral elixir	1 or 1b*	QL (80 mL per 1 day)
fluphenazine hcl oral tablet 1 mg, 2.5 mg, 5 mg	1 or 1b*	DO
fluphenazine hcl oral tablet 10 mg	1 or 1b*	QL (4 tablets per 1 day)
perphenazine oral tablet 16 mg	1 or 1b*	QL (1 tablet per 1 day)
perphenazine oral tablet 2 mg	1 or 1b*	DO
perphenazine oral tablet 4 mg	1 or 1b*	QL (4 tablets per 1 day)
perphenazine oral tablet 8 mg	1 or 1b*	QL (3 tablets per 1 day)
prochlorperazine edisylate injection solution	1 or 1b*	
prochlorperazine maleate oral tablet	1 or 1a*	

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
prochlorperazine rectal suppository	1 or 1b*	
thioridazine hcl oral tablet 10 mg, 25 mg, 50 mg	1 or 1b*	DO
thioridazine hcl oral tablet 100 mg	1 or 1b*	QL (8 tablets per 1 day)
trifluoperazine hcl oral tablet 1 mg, 2 mg	1 or 1b*	DO
trifluoperazine hcl oral tablet 10 mg, 5 mg	1 or 1b*	QL (4 tablets per 1 day)
QUINOLINONE DERIVATIVES - DRUGS FOR SEVERE MENTAL DISORDERS**		
ABILIFY MAINTENA INTRAMUSCULAR PREFILLED SYRINGE (*aripiprazole*)	2	QL (1 injection per 30 days)
ABILIFY MAINTENA INTRAMUSCULAR SUSPENSION RECONSTITUTED ER (*aripiprazole*)	2	QL (1 injection per 30 days)
ABILIFY MYCITE MAINTENANCE KIT ORAL TABLET THERAPY PACK 10 MG, 15 MG, 2 MG, 5 MG (*aripiprazole w/ sens-strip-pod*)	3	ST; DO
ABILIFY MYCITE MAINTENANCE KIT ORAL TABLET THERAPY PACK 20 MG, 30 MG (*aripiprazole w/ sens-strip-pod*)	3	ST; QL (1 tablet per 1 day)
ABILIFY MYCITE STARTER KIT ORAL TABLET THERAPY PACK 10 MG, 15 MG, 2 MG, 5 MG (*aripiprazole w/ sens-strip-pod*)	3	ST; DO
ABILIFY MYCITE STARTER KIT ORAL TABLET THERAPY PACK 20 MG, 30 MG (*aripiprazole w/ sens-strip-pod*)	3	ST; QL (1 tablet per 1 day)
aripiprazole oral solution	1 or 1b*	QL (30 mL per 1 day)
aripiprazole oral tablet 10 mg, 15 mg, 2 mg, 5 mg	1 or 1b*	DO
aripiprazole oral tablet 20 mg, 30 mg	1 or 1b*	QL (1 tablet per 1 day)
aripiprazole oral tablet dispersible 10 mg	1 or 1b*	QL (3 tablets per 1 day)
aripiprazole oral tablet dispersible 15 mg	1 or 1b*	QL (2 tablets per 1 day)
ARISTADA INITIO INTRAMUSCULAR PREFILLED SYRINGE (*aripiprazole lauroxil*)	3	QL (1 syringe per 1 fill)
ARISTADA INTRAMUSCULAR PREFILLED SYRINGE 1064 MG/3.9ML (*aripiprazole lauroxil*)	3	QL (1 kit per 60 days)
ARISTADA INTRAMUSCULAR PREFILLED SYRINGE 441 MG/1.6ML, 662 MG/2.4ML, 882 MG/3.2ML (*aripiprazole lauroxil*)	3	QL (1 kit per 30 days)
REXULTI ORAL TABLET 0.25 MG, 0.5 MG, 1 MG, 2 MG, 3 MG (*brexpiprazole*)	3	DO
REXULTI ORAL TABLET 4 MG (*brexpiprazole*)	3	QL (1 tablet per 1 day)
THIENBENZODIAZEPINES - DRUGS FOR SEVERE MENTAL DISORDERS**		
olanzapine intramuscular solution reconstituted	1 or 1b*	QL (3 injections per 1 fill)
olanzapine oral tablet 10 mg, 2.5 mg, 5 mg, 7.5 mg	1 or 1b*	DO
olanzapine oral tablet 15 mg, 20 mg	1 or 1b*	QL (1 tablets per 1 day)
olanzapine oral tablet dispersible 10 mg, 5 mg	1 or 1b*	DO
olanzapine oral tablet dispersible 15 mg	1 or 1b*	QL (1 tablets per 1 day)
olanzapine oral tablet dispersible 20 mg	1 or 1b*	QL (1 tablet per 1 day)
ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION RECONSTITUTED 210 MG, 300 MG (*olanzapine pamoate*)	3	QL (2 injections per 28 days)
ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION RECONSTITUTED 405 MG (*olanzapine pamoate*)	3	QL (1 injections per 28 days)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
THIOXANTHENES - DRUGS FOR SEVERE MENTAL DISORDERS**		
thiothixene oral capsule 1 mg, 2 mg, 5 mg	1 or 1b*	ST; DO
thiothixene oral capsule 10 mg	1 or 1b*	ST; QL (6 capsules per 1 day)
***ANTISEPTICS & DISINFECTANTS* - ANTISEPTICS AND DISINFECTANTS**		
ANTISEPTICS & DISINFECTANTS - ANTISEPTICS AND DISINFECTANTS**		
formaldehyde external solution	1 or 1b*	
CHLORINE ANTISEPTICS - ANTISEPTICS AND DISINFECTANTS**		
BENZALKONIUM CHLORIDE EXTERNAL SOLUTION	3	
IODINE ANTISEPTICS - ANTISEPTICS AND DISINFECTANTS**		
LUGOLS STRONG IODINE EXTERNAL SOLUTION	3	
***ANTIVIRALS* - DRUGS FOR INFECTIONS**		
ANTIRETROVIRAL COMBINATIONS - DRUGS FOR VIRAL INFECTIONS**		
abacavir sulfate-lamivudine oral tablet	1 or 1b*	QL (1 tablet per 1 day)
BIKTARVY ORAL TABLET (*bictegravir-emtricitab-tenofov*)	2	QL (1 tablet per 1 day)
CABENUVA INTRAMUSCULAR SUSPENSION EXTENDED RELEASE 400 & 600 MG/2ML	3	PA; LD; QL (1 kit per 30 days)
CABENUVA INTRAMUSCULAR SUSPENSION EXTENDED RELEASE 600 & 900 MG/3ML	3	PA; LD; QL (1 kit per 60 days)
CIMDUO ORAL TABLET (*lamivudine-tenofovir*)	3	QL (1 tablet per 1 day)
DELSTRIGO ORAL TABLET (*doravirin-lamivudin-tenofov df*)	3	QL (1 tablet per 1 day)
DESCOVY ORAL TABLET 120-15 MG (*emtricitabine-tenofovir af*)	2	QL (1 tablet per 1 day)
DESCOVY ORAL TABLET 200-25 MG (*emtricitabine-tenofovir af*)	2; $0	QL (1 tablet per 1 day)
DOVATO ORAL TABLET (*dolutegravir-lamivudine*)	2	QL (1 tablet per 1 day)
efavirenz-emtricitab-tenofo df oral tablet	1 or 1b*	QL (1 tablet per 1 day)
efavirenz-lamivudine-tenofovir oral tablet	1 or 1b*	QL (1 tablet per 1 day)
emtricitabine-tenofovir df oral tablet 100-150 mg, 133-200 mg, 167-250 mg	1 or 1b*	QL (1 tablet per 1 day)
emtricitabine-tenofovir df oral tablet 200-300 mg	1 or 1b*; $0	QL (1 tablet per 1 day)
EVOTAZ ORAL TABLET (*atazanavir-cobicistat*)	3	QL (1 tablet per 1 day)
GENVOYA ORAL TABLET (*elviteg-cobic-emtricit-tenofaf*)	2	QL (1 tablet per 1 day)
JULUCA ORAL TABLET (*dolutegravir-rilpivirine*)	3	PA; QL (1 tablet per 1 day)
lamivudine-zidovudine oral tablet	1 or 1b*	QL (2 tablets per 1 day)
lopinavir-ritonavir oral solution	1 or 1b*	QL (16 mL per 1 day)
lopinavir-ritonavir oral tablet 100-25 mg	1 or 1b*	QL (10 tablets per 1 day)
lopinavir-ritonavir oral tablet 200-50 mg	1 or 1b*	QL (4 tablets per 1 day)
ODEFSEY ORAL TABLET (*emtricitab-rilpivir-tenofov af*)	2	QL (1 tablet per 1 day)
STRIBILD ORAL TABLET (*elviteg-cobic-emtricit-tenofdf*)	2	QL (1 tablet per 1 day)
SYMTUZA ORAL TABLET (*darun-cobic-emtricit-tenofaf*)	2	QL (1 tablet per 1 day)
TRIUMEQ ORAL TABLET (*abacavir-dolutegravir-lamivud*)	2	QL (1 tablet per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TRIUMEQ PD ORAL TABLET SOLUBLE (*abacavir-dolutegravir-lamivud*)	2	QL (6 tablets per 1 day)
ANTIRETROVIRALS - CAPSID INHIBITORS - DRUGS FOR VIRAL INFECTIONS**		
SUNLENCA ORAL TABLET THERAPY PACK (*lenacapavir sodium*)	3	PA; LD; QL (1 pack per 1 one time fill)
SUNLENCA SUBCUTANEOUS SOLUTION (*lenacapavir sodium*)	3	PA; LD; QL (1 kit per 24 weeks)
ANTIRETROVIRALS - CCR5 ANTAGONISTS (ENTRY INHIBITOR) - DRUGS FOR VIRAL INFECTIONS**		
maraviroc oral tablet	1 or 1b*	QL (4 tablets per 1 day)
SELZENTRY ORAL SOLUTION (*maraviroc*)	3	QL (62 mL per 1 day)
ANTIRETROVIRALS - CD4-DIRECTED POST-ATTACHMENT INHIBITOR - DRUGS FOR VIRAL INFECTIONS**		
TROGARZO INTRAVENOUS SOLUTION (*ibalizumab-uiyk*)	3	PA; LD; QL (8 vials per 28 days)
ANTIRETROVIRALS - FUSION INHIBITORS - DRUGS FOR VIRAL INFECTIONS**		
FUZEON SUBCUTANEOUS SOLUTION RECONSTITUTED (*enfuvirtide*)	2	PA; LD; QL (2 vials per 1 day)
ANTIRETROVIRALS - GP120-DIRECTED ATTACHMENT INHIBITOR - DRUGS FOR VIRAL INFECTIONS**		
RUKOBIA ORAL TABLET EXTENDED RELEASE 12 HOUR (*fostemsavir tromethamine*)	3	PA; QL (2 tablets per 1 day)
ANTIRETROVIRALS - INTEGRASE INHIBITORS - DRUGS FOR VIRAL INFECTIONS**		
APRETUDE INTRAMUSCULAR SUSPENSION EXTENDED RELEASE (*cabotegravir*)	3	LD; QL (1 vial per 2 monthss)
ISENTRESS HD ORAL TABLET (*raltegravir potassium*)	3	QL (2 tablets per 1 day)
ISENTRESS ORAL PACKET (*raltegravir potassium*)	3	QL (2 packets per 1 day)
ISENTRESS ORAL TABLET (*raltegravir potassium*)	3	QL (4 tablets per 1 day)
ISENTRESS ORAL TABLET CHEWABLE 100 MG (*raltegravir potassium*)	3	QL (6 tablets per 1 day)
ISENTRESS ORAL TABLET CHEWABLE 25 MG (*raltegravir potassium*)	3	QL (24 tablets per 1 day)
TIVICAY ORAL TABLET (*dolutegravir sodium*)	3	QL (2 tablets per 1 day)
TIVICAY PD ORAL TABLET SOLUBLE (*dolutegravir sodium*)	3	QL (12 tablets per 1 day)
ANTIRETROVIRALS - PROTEASE INHIBITORS - DRUGS FOR VIRAL INFECTIONS**		
APTIVUS ORAL CAPSULE (*tipranavir*)	2	PA; QL (4 capsules per 1 day)
atazanavir sulfate oral capsule 150 mg, 200 mg	1 or 1b*	QL (2 capsules per 1 day)
atazanavir sulfate oral capsule 300 mg	1 or 1b*	QL (1 capsule per 1 day)
darunavir oral tablet 600 mg	1 or 1b*	QL (2 tablets per 1 day)
darunavir oral tablet 800 mg	1 or 1b*	QL (1 tablet per 1 day)
fosamprenavir calcium oral tablet	1 or 1b*	QL (4 tablets per 1 day)
NORVIR ORAL PACKET (*ritonavir*)	3	QL (12 packets per 1 day)
PREZISTA ORAL SUSPENSION (*darunavir*)	2	QL (14 mL per 1 day)
PREZISTA ORAL TABLET 150 MG (*darunavir*)	2	QL (6 tablets per 1 day)

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PREZISTA ORAL TABLET 75 MG (*darunavir*)	2	QL (10 tablets per 1 day)
REYATAZ ORAL PACKET (*atazanavir sulfate*)	2	QL (5 packets per 1 day)
ritonavir oral tablet	1 or 1b*	QL (12 tablets per 1 day)
VIRACEPT ORAL TABLET 250 MG (*nelfinavir mesylate*)	2	QL (10 tablets per 1 day)
VIRACEPT ORAL TABLET 625 MG (*nelfinavir mesylate*)	2	QL (4 tablets per 1 day)
ANTIRETROVIRALS - RTI-NON-NUCLEOSIDE ANALOGUES - DRUGS FOR VIRAL INFECTIONS**		
EDURANT ORAL TABLET (*rilpivirine hcl*)	2	PA; QL (1 tablet per 1 day)
efavirenz oral tablet	1 or 1b*	QL (1 tablet per 1 day)
etravirine oral tablet 100 mg	1 or 1b*	PA; QL (4 tablets per 1 day)
etravirine oral tablet 200 mg	1 or 1b*	PA; QL (2 tablets per 1 day)
INTELENCE ORAL TABLET (*etravirine*)	2	PA; QL (16 tablets per 1 day)
nevirapine er oral tablet extended release 24 hour	1 or 1b*	QL (1 tablet per 1 day)
nevirapine oral suspension	1 or 1b*	QL (40 mL per 1 day)
nevirapine oral tablet	1 or 1b*	QL (2 tablets per 1 day)
PIFELTRO ORAL TABLET (*doravirine*)	3	QL (1 tablet per 1 day)
ANTIRETROVIRALS - RTI-NUCLEOSIDE ANALOGUES-PURINES - DRUGS FOR VIRAL INFECTIONS**		
abacavir sulfate oral solution	1 or 1b*	QL (32 mL per 1 day)
abacavir sulfate oral tablet	1 or 1b*	QL (2 tablets per 1 day)
ANTIRETROVIRALS - RTI-NUCLEOSIDE ANALOGUES-PYRIMIDINES - DRUGS FOR VIRAL INFECTIONS**		
emtricitabine oral capsule	1 or 1b*; $0	QL (1 capsule per 1 day)
EMTRIVA ORAL SOLUTION (*emtricitabine*)	2	QL (29 mL per 1 day)
lamivudine oral solution	1 or 1b*	QL (32 mL per 1 day)
lamivudine oral tablet 150 mg	1 or 1b*	QL (2 tablets per 1 day)
lamivudine oral tablet 300 mg	1 or 1b*	QL (1 tablet per 1 day)
ANTIRETROVIRALS - RTI-NUCLEOSIDE ANALOGUES-THYMIDINES - DRUGS FOR VIRAL INFECTIONS**		
RETROVIR INTRAVENOUS SOLUTION (*zidovudine*)	2	
zidovudine oral capsule	1 or 1b*	QL (6 capsules per 1 day)
zidovudine oral syrup	1 or 1b*	QL (64 mL per 1 day)
zidovudine oral tablet	1 or 1b*	QL (2 tablets per 1 day)
ANTIRETROVIRALS - RTI-NUCLEOTIDE ANALOGUES - DRUGS FOR VIRAL INFECTIONS**		
tenofovir disoproxil fumarate oral tablet	1 or 1b*; $0	QL (1 tablet per 1 day)
VIREAD ORAL POWDER (*tenofovir disoproxil fumarate*)	2	QL (8 grams per 1 day)
VIREAD ORAL TABLET (*tenofovir disoproxil fumarate*)	2	QL (1 tablet per 1 day)
ANTIRETROVIRALS ADJUVANTS - DRUGS FOR VIRAL INFECTIONS**		
TYBOST ORAL TABLET (*cobicistat*)	3	QL (1 tablet per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIVIRAL COMBINATIONS - DRUGS FOR INFECTIONS**		
PAXLOVID (150/100) ORAL TABLET THERAPY PACK (*nirmatrelvir-ritonavir*)	3	QL (1 pack per 90 days)
PAXLOVID (300/100) ORAL TABLET THERAPY PACK (*nirmatrelvir-ritonavir*)	3	QL (1 pack per 90 days)
CMV AGENTS - DRUGS FOR VIRAL INFECTIONS**		
cidofovir intravenous solution	1 or 1b*	
foscarnet sodium intravenous solution	1 or 1b*	
FOSCAVIR INTRAVENOUS SOLUTION (*foscarnet sodium*)	3	
GANCICLOVIR INTRAVENOUS SOLUTION	4	SP
GANCICLOVIR SODIUM INTRAVENOUS SOLUTION	4	SP
ganciclovir sodium intravenous solution reconstituted	4	SP
LIVTENCITY ORAL TABLET (*maribavir*)	4	PA; LD; QL (4 tablets per 1 day)
PREVYMIS INTRAVENOUS SOLUTION (*letermovir*)	4	PA; QL (200 vials per 1 year); SP
PREVYMIS ORAL TABLET (*letermovir*)	4	PA; QL (224 tablets per 1 year); SP
VALCYTE ORAL SOLUTION RECONSTITUTED (*valganciclovir hcl*)	3	
VALCYTE ORAL TABLET (*valganciclovir hcl*)	3	
valganciclovir hcl oral solution reconstituted	1 or 1b*	
valganciclovir hcl oral tablet	1 or 1b*	
HEPATITIS B AGENTS - DRUGS FOR VIRAL INFECTIONS**		
adefovir dipivoxil oral tablet	4	QL (1 tablet per 1 day); SP
BARACLUDE ORAL SOLUTION (*entecavir*)	4	QL (20 mL per 1 day)
entecavir oral tablet	4	QL (1 tablet per 1 day)
lamivudine oral tablet	1 or 1b*	QL (1 tablet per 1 day)
VEMLIDY ORAL TABLET (*tenofovir alafenamide fumarate*)	4	QL (1 tablet per 1 day); SP
HEPATITIS C AGENT - COMBINATIONS - DRUGS FOR VIRAL INFECTIONS**		
EPCLUSA ORAL PACKET 150-37.5 MG (*sofosbuvir-velpatasvir*)	4	PA; QL (1 packet per 1 day); SP
EPCLUSA ORAL PACKET 200-50 MG (*sofosbuvir-velpatasvir*)	4	PA; QL (2 packets per 1 day); SP
EPCLUSA ORAL TABLET 200-50 MG (*sofosbuvir-velpatasvir*)	4	PA; QL (2 tablets per 1 day); SP
EPCLUSA ORAL TABLET 400-100 MG (*sofosbuvir-velpatasvir*)	4	PA; QL (1 tablet per 1 day); SP
HARVONI ORAL PACKET 33.75-150 MG (*ledipasvir-sofosbuvir*)	4	PA; QL (1 packet per 1 day); SP
HARVONI ORAL PACKET 45-200 MG (*ledipasvir-sofosbuvir*)	4	PA; QL (2 packets per 1 day); SP
HARVONI ORAL TABLET 45-200 MG (*ledipasvir-sofosbuvir*)	4	PA; QL (2 tablets per 1 day); SP
HARVONI ORAL TABLET 90-400 MG (*ledipasvir-sofosbuvir*)	4	PA; QL (1 tablet per 1 day); SP
VOSEVI ORAL TABLET (*sofosbuv-velpatasv-voxilaprev*)	4	PA; QL (1 tablet per 1 day); SP
HEPATITIS C AGENTS - DRUGS FOR VIRAL INFECTIONS**		
PEGASYS SUBCUTANEOUS SOLUTION (*peginterferon alfa-2a*)	4	LD; QL (4 vials per 28 days); SP
PEGASYS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (*peginterferon alfa-2a*)	4	LD; QL (4 syringes per 28 days); SP
ribavirin oral capsule	4	QL (6 capsules per 1 day); SP
ribavirin oral tablet	4	QL (6 tablets per 1 day); SP

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HERPES AGENTS - PURINE ANALOGUES - DRUGS FOR VIRAL INFECTIONS**		
acyclovir oral capsule	1 or 1b*	
acyclovir oral suspension	1 or 1b*	
acyclovir oral tablet	1 or 1b*	
acyclovir sodium intravenous solution	1 or 1b*	
valacyclovir hcl oral tablet 1 gm	1 or 1b*	QL (30 tablets per 1 fill)
valacyclovir hcl oral tablet 500 mg	1 or 1b*	QL (60 tablets per 1 fill)
HERPES AGENTS - THYMIDINE ANALOGUES - DRUGS FOR VIRAL INFECTIONS**		
famciclovir oral tablet 125 mg, 250 mg	1 or 1b*	QL (60 tablets per 1 fill)
famciclovir oral tablet 500 mg	1 or 1b*	QL (21 tablets per 1 fill)
INFLUENZA AGENTS - DRUGS FOR VIRAL INFECTIONS**		
rimantadine hcl oral tablet	1 or 1b*	
MISC. ANTIVIRALS - DRUGS FOR VIRAL INFECTIONS**		
LAGEVRIO ORAL CAPSULE (*molnupiravir*)	3	QL (40 capsules per 90 days)
TEMBEXA ORAL SUSPENSION (*brincidofovir*)	3	
TEMBEXA ORAL TABLET (*brincidofovir*)	3	
TPOXX INTRAVENOUS SOLUTION (*tecovirimat*)	3	
TPOXX ORAL CAPSULE (*tecovirimat*)	3	
NEURAMINIDASE INHIBITORS - DRUGS FOR VIRAL INFECTIONS**		
oseltamivir phosphate oral capsule 30 mg	1 or 1b*	QL (20 capsule per 90 days)
oseltamivir phosphate oral capsule 45 mg, 75 mg	1 or 1b*	QL (10 capsule per 90 days)
oseltamivir phosphate oral suspension reconstituted	1 or 1b*	QL (180 mL per 90 days)
RAPIVAB INTRAVENOUS SOLUTION (*peramivir*)	3	
RELENZA DISKHALER INHALATION AEROSOL POWDER BREATH ACTIVATED (*zanamivir*)	2	QL (1 unit per 90 days)
TAMIFLU ORAL CAPSULE 30 MG (*oseltamivir phosphate*)	3	QL (20 capsule per 90 days)
TAMIFLU ORAL CAPSULE 45 MG, 75 MG (*oseltamivir phosphate*)	3	QL (10 capsule per 90 days)
TAMIFLU ORAL SUSPENSION RECONSTITUTED (*oseltamivir phosphate*)	3	QL (180 mL per 90 days)
PA ENDONUCLEASE INHIBITORS - DRUGS FOR VIRAL INFECTIONS**		
XOFLUZA (40 MG DOSE) ORAL TABLET THERAPY PACK (*baloxavir marboxil*)	3	QL (1 dose pack per 90 days)
XOFLUZA (80 MG DOSE) ORAL TABLET THERAPY PACK (*baloxavir marboxil*)	3	QL (1 dose pack per 90 days)
RSV AGENTS - NUCLEOSIDE ANALOGUES - DRUGS FOR VIRAL INFECTIONS**		
ribavirin inhalation solution reconstituted	1 or 1b*	
VIRAZOLE INHALATION SOLUTION RECONSTITUTED (*ribavirin*)	3	

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
***BETA BLOCKERS* - DRUGS FOR THE HEART**		
ALPHA-BETA BLOCKERS - DRUGS FOR HIGH BLOOD PRESSURE**		
carvedilol oral tablet 12.5 mg, 3.125 mg, 6.25 mg	1 or 1b*	DO
carvedilol oral tablet 25 mg	1 or 1b*	QL (4 tablets per 1 day)
carvedilol phosphate er oral capsule extended release 24 hour 10 mg, 20 mg, 40 mg	1 or 1b*	DO
carvedilol phosphate er oral capsule extended release 24 hour 80 mg	1 or 1b*	QL (1 capsule per 1 day)
labetalol hcl intravenous solution prefilled syringe	3	
labetalol hcl oral tablet 100 mg, 200 mg	1 or 1b*	DO
labetalol hcl oral tablet 300 mg	1 or 1b*	QL (8 tablets per 1 day)
LABETALOL HCL-DEXTROSE INTRAVENOUS SOLUTION	3	
LABETALOL HCL-SODIUM CHLORIDE INTRAVENOUS SOLUTION	3	
BETA BLOCKERS CARDIO-SELECTIVE - DRUGS FOR HIGH BLOOD PRESSURE**		
acebutolol hcl oral capsule	1 or 1b*	
atenolol oral tablet	1 or 1a*	
betaxolol hcl oral tablet	1 or 1b*	
bisoprolol fumarate oral tablet	1 or 1b*	
BREVIBLOC IN NACL INTRAVENOUS SOLUTION (*esmolol hcl-sodium chloride*)	3	
BREVIBLOC INTRAVENOUS SOLUTION (*esmolol hcl*)	3	
BREVIBLOC PREMIXED DS INTRAVENOUS SOLUTION (*esmolol hcl-sodium chloride*)	3	
BREVIBLOC PREMIXED INTRAVENOUS SOLUTION (*esmolol hcl-sodium chloride*)	3	
esmolol hcl intravenous solution 100 mg/10ml	1 or 1b*	
ESMOLOL HCL INTRAVENOUS SOLUTION 2000 MG/100ML, 2500 MG/250ML	3	
esmolol hcl-sodium chloride intravenous solution	1 or 1b*	
KAPSPARGO SPRINKLE ORAL CAPSULE ER 24 HOUR SPRINKLE (*metoprolol succinate*)	3	
metoprolol succinate er oral tablet extended release 24 hour	1 or 1b*	
metoprolol tartrate intravenous solution	1 or 1a*	
metoprolol tartrate oral tablet	1 or 1a*	
nebivolol hcl oral tablet	1 or 1b*	
BETA BLOCKERS NON-SELECTIVE - DRUGS FOR HIGH BLOOD PRESSURE**		
HEMANGEOL ORAL SOLUTION (*propranolol hcl*)	3	
INDERAL XL ORAL CAPSULE EXTENDED RELEASE 24 HOUR (*propranolol hcl sr beads*)	3	QL (1 capsule per 1 day)
INNOPRAN XL ORAL CAPSULE EXTENDED RELEASE 24 HOUR (*propranolol hcl sr beads*)	3	QL (1 capsule per 1 day)
nadolol oral tablet 20 mg, 40 mg	1 or 1b*	DO

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
nadolol oral tablet 80 mg	1 or 1b*	QL (4 tablets per 1 day)
pindolol oral tablet 10 mg	1 or 1b*	QL (6 tablets per 1 day)
pindolol oral tablet 5 mg	1 or 1b*	DO
propranolol hcl er oral capsule extended release 24 hour 120 mg, 60 mg, 80 mg	1 or 1b*	DO
propranolol hcl er oral capsule extended release 24 hour 160 mg	1 or 1b*	QL (4 capsules per 1 day)
propranolol hcl intravenous solution	1 or 1b*	
propranolol hcl oral solution	1 or 1b*	QL (80 mL per 1 day)
propranolol hcl oral tablet 10 mg, 20 mg, 40 mg, 60 mg	1 or 1b*	DO
propranolol hcl oral tablet 80 mg	1 or 1b*	QL (8 tablets per 1 day)
sotalol hcl (af) oral tablet	1 or 1b*	
SOTALOL HCL INTRAVENOUS SOLUTION	3	
sotalol hcl oral tablet 120 mg, 80 mg	1 or 1b*	QL (3 tablets per 1 day)
sotalol hcl oral tablet 160 mg	1 or 1b*	QL (4 tablets per 1 day)
sotalol hcl oral tablet 240 mg	1 or 1b*	QL (2 tablets per 1 day)
SOTYLIZE ORAL SOLUTION (*sotalol hcl*)	3	
timolol maleate oral tablet 10 mg	1 or 1b*	QL (6 tablets per 1 day)
timolol maleate oral tablet 20 mg	1 or 1b*	QL (3 tablets per 1 day)
timolol maleate oral tablet 5 mg	1 or 1b*	DO
***CALCIUM CHANNEL BLOCKERS* - DRUGS FOR THE HEART**		
CALCIUM CHANNEL BLOCKERS - DRUGS FOR HIGH BLOOD PRESSURE**		
amlodipine besylate oral tablet 10 mg	1 or 1b*	QL (1 tablet per 1 day)
amlodipine besylate oral tablet 2.5 mg, 5 mg	1 or 1b*	DO
CARDENE IV INTRAVENOUS SOLUTION (*nicardipine hcl in nacl*)	3	
CARDIZEM ORAL TABLET 120 MG (*diltiazem hcl*)	3	QL (3 tablet per 1 day)
CARDIZEM ORAL TABLET 30 MG, 60 MG (*diltiazem hcl*)	3	DO
cartia xt oral capsule extended release 24 hour 120 mg	1 or 1b*	DO
cartia xt oral capsule extended release 24 hour 180 mg	1 or 1b*	QL (3 capsules per 1 day)
cartia xt oral capsule extended release 24 hour 240 mg	1 or 1b*	QL (2 capsules per 1 day)
cartia xt oral capsule extended release 24 hour 300 mg	1 or 1b*	QL (1 capsule per 1 day)
CLEVIPREX INTRAVENOUS EMULSION (*clevidipine*)	3	
CONJUPRI ORAL TABLET 2.5 MG (*levamlodipine maleate*)	3	ST; DO
CONJUPRI ORAL TABLET 5 MG (*levamlodipine maleate*)	3	ST; QL (1 tablet per 1 day)
diltiazem hcl er beads oral capsule extended release 24 hour 120 mg	1 or 1b*	DO
diltiazem hcl er beads oral capsule extended release 24 hour 180 mg	1 or 1b*	QL (3 capsules per 1 day)
diltiazem hcl er beads oral capsule extended release 24 hour 240 mg	1 or 1b*	QL (2 capsules per 1 day)
diltiazem hcl er beads oral capsule extended release 24 hour 300 mg, 360 mg, 420 mg	1 or 1b*	QL (1 capsule per 1 day)
diltiazem hcl er coated beads oral capsule extended release 24 hour 120 mg	1 or 1b*	DO
diltiazem hcl er coated beads oral capsule extended release 24 hour 180 mg	1 or 1b*	QL (3 capsules per 1 day)
diltiazem hcl er coated beads oral capsule extended release 24 hour 240 mg	1 or 1b*	QL (2 capsules per 1 day)

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
diltiazem hcl er coated beads oral capsule extended release 24 hour 300 mg, 360 mg	1 or 1b*	QL (1 capsule per 1 day)
diltiazem hcl er oral capsule extended release 12 hour 120 mg	1 or 1b*	QL (2 capsules per 1 day)
diltiazem hcl er oral capsule extended release 12 hour 60 mg	1 or 1b*	DO
diltiazem hcl er oral capsule extended release 12 hour 90 mg	1 or 1b*	QL (4 capsules per 1 day)
diltiazem hcl er oral capsule extended release 24 hour 120 mg	1 or 1b*	DO
diltiazem hcl er oral capsule extended release 24 hour 180 mg	1 or 1b*	QL (3 capsules per 1 day)
diltiazem hcl er oral capsule extended release 24 hour 240 mg	1 or 1b*	QL (2 capsules per 1 day)
diltiazem hcl er oral tablet extended release 24 hour 120 mg	1 or 1b*	DO
diltiazem hcl er oral tablet extended release 24 hour 180 mg	1 or 1b*	QL (3 tablets per 1 day)
diltiazem hcl er oral tablet extended release 24 hour 240 mg	1 or 1b*	QL (2 tablets per 1 day)
diltiazem hcl er oral tablet extended release 24 hour 300 mg, 360 mg, 420 mg	1 or 1b*	QL (1 tablet per 1 day)
diltiazem hcl intravenous solution	1 or 1b*	
DILTIAZEM HCL INTRAVENOUS SOLUTION RECONSTITUTED	3	
diltiazem hcl oral tablet 120 mg	1 or 1b*	QL (3 tablet per 1 day)
diltiazem hcl oral tablet 30 mg, 60 mg	1 or 1b*	DO
diltiazem hcl oral tablet 90 mg	1 or 1b*	QL (4 tablet per 1 day)
dilt-xr oral capsule extended release 24 hour 120 mg	1 or 1b*	DO
dilt-xr oral capsule extended release 24 hour 180 mg	1 or 1b*	QL (3 capsules per 1 day)
dilt-xr oral capsule extended release 24 hour 240 mg	1 or 1b*	QL (2 capsules per 1 day)
felodipine er oral tablet extended release 24 hour 10 mg	1 or 1b*	QL (1 tablet per 1 day)
felodipine er oral tablet extended release 24 hour 2.5 mg, 5 mg	1 or 1b*	DO
isradipine oral capsule 2.5 mg	1 or 1b*	DO
isradipine oral capsule 5 mg	1 or 1b*	QL (4 capsule per 1 day)
KATERZIA ORAL SUSPENSION (*amlodipine benzoate*)	3	PA; QL (10 mL per 1 day)
levamlodipine maleate oral tablet 2.5 mg	1 or 1b*	ST; DO
levamlodipine maleate oral tablet 5 mg	1 or 1b*	ST; QL (1 tablet per 1 day)
matzim la oral tablet extended release 24 hour 180 mg	1 or 1b*	QL (3 tablets per 1 day)
matzim la oral tablet extended release 24 hour 240 mg	1 or 1b*	QL (2 tablets per 1 day)
matzim la oral tablet extended release 24 hour 300 mg, 360 mg, 420 mg	1 or 1b*	QL (1 tablet per 1 day)
NICARDIPINE HCL IN NACL INTRAVENOUS SOLUTION	3	
nicardipine hcl intravenous solution	1 or 1b*	
nicardipine hcl oral capsule 20 mg	1 or 1b*	QL (6 capsule per 1 day)
nicardipine hcl oral capsule 30 mg	1 or 1b*	QL (4 capsule per 1 day)
nifedipine er oral tablet extended release 24 hour 30 mg, 90 mg	1 or 1b*	QL (1 tablet per 1 day)
nifedipine er oral tablet extended release 24 hour 60 mg	1 or 1b*	QL (2 tablets per 1 day)
nifedipine er osmotic release oral tablet extended release 24 hour 30 mg	1 or 1b*	DO
nifedipine er osmotic release oral tablet extended release 24 hour 60 mg	1 or 1b*	QL (2 tablets per 1 day)
nifedipine er osmotic release oral tablet extended release 24 hour 90 mg	1 or 1b*	QL (1 tablet per 1 day)
nifedipine oral capsule 10 mg	1 or 1b*	DO
nifedipine oral capsule 20 mg	1 or 1b*	QL (4 capsule per 1 day)
nimodipine oral capsule	1 or 1b*	QL (12 capsule per 1 day)

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
nisoldipine er oral tablet extended release 24 hour 17 mg, 20 mg, 8.5 mg	1 or 1b*	DO
nisoldipine er oral tablet extended release 24 hour 25.5 mg, 30 mg, 34 mg, 40 mg	1 or 1b*	QL (1 tablet per 1 day)
NORLIQVA ORAL SOLUTION (*amlodipine besylate*)	3	PA; QL (2 bottles per 30 days)
NYMALIZE ORAL SOLUTION (*nimodipine*)	3	QL (60 mL per 1 day)
PROCARDIA XL ORAL TABLET EXTENDED RELEASE 24 HOUR 30 MG (*nifedipine*)	3	DO
PROCARDIA XL ORAL TABLET EXTENDED RELEASE 24 HOUR 60 MG (*nifedipine*)	3	QL (2 tablets per 1 day)
PROCARDIA XL ORAL TABLET EXTENDED RELEASE 24 HOUR 90 MG (*nifedipine*)	3	QL (1 tablet per 1 day)
SULAR ORAL TABLET EXTENDED RELEASE 24 HOUR 17 MG, 8.5 MG (*nisoldipine*)	3	DO
SULAR ORAL TABLET EXTENDED RELEASE 24 HOUR 34 MG (*nisoldipine*)	3	QL (1 tablet per 1 day)
taztia xt oral capsule extended release 24 hour 120 mg	1 or 1b*	DO
taztia xt oral capsule extended release 24 hour 180 mg	1 or 1b*	QL (3 capsules per 1 day)
taztia xt oral capsule extended release 24 hour 240 mg	1 or 1b*	QL (2 capsules per 1 day)
taztia xt oral capsule extended release 24 hour 300 mg, 360 mg	1 or 1b*	QL (1 capsule per 1 day)
tiadylt er oral capsule extended release 24 hour 120 mg	1 or 1b*	DO
tiadylt er oral capsule extended release 24 hour 180 mg	1 or 1b*	QL (3 capsules per 1 day)
tiadylt er oral capsule extended release 24 hour 240 mg	1 or 1b*	QL (2 capsules per 1 day)
tiadylt er oral capsule extended release 24 hour 300 mg, 360 mg, 420 mg	1 or 1b*	QL (1 capsule per 1 day)
TIAZAC ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG (*diltiazem hcl er beads*)	3	DO
TIAZAC ORAL CAPSULE EXTENDED RELEASE 24 HOUR 180 MG (*diltiazem hcl er beads*)	3	QL (3 capsules per 1 day)
TIAZAC ORAL CAPSULE EXTENDED RELEASE 24 HOUR 240 MG (*diltiazem hcl er beads*)	3	QL (2 capsules per 1 day)
TIAZAC ORAL CAPSULE EXTENDED RELEASE 24 HOUR 300 MG, 360 MG, 420 MG (*diltiazem hcl er beads*)	3	QL (1 capsule per 1 day)
verapamil hcl er oral capsule extended release 24 hour 100 mg	3	DO
verapamil hcl er oral capsule extended release 24 hour 120 mg, 180 mg	1 or 1b*	DO
verapamil hcl er oral capsule extended release 24 hour 200 mg, 300 mg, 360 mg	1 or 1b*	QL (1 capsule per 1 day)
verapamil hcl er oral capsule extended release 24 hour 240 mg	1 or 1b*	QL (2 capsules per 1 day)
verapamil hcl er oral tablet extended release 120 mg	1 or 1b*	DO
verapamil hcl er oral tablet extended release 180 mg, 240 mg	1 or 1b*	QL (2 tablets per 1 day)
verapamil hcl intravenous solution	1 or 1b*	
verapamil hcl oral tablet 120 mg	1 or 1b*	QL (4 tablet per 1 day)
verapamil hcl oral tablet 40 mg, 80 mg	1 or 1b*	DO
VERELAN ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 180 MG (*verapamil hcl*)	3	DO
VERELAN ORAL CAPSULE EXTENDED RELEASE 24 HOUR 240 MG (*verapamil hcl*)	3	QL (2 capsules per 1 day)

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VERELAN ORAL CAPSULE EXTENDED RELEASE 24 HOUR 360 MG (*verapamil hcl*)	3	QL (1 capsule per 1 day)
VERELAN PM ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG (*verapamil hcl*)	3	DO
VERELAN PM ORAL CAPSULE EXTENDED RELEASE 24 HOUR 200 MG, 300 MG (*verapamil hcl*)	3	QL (1 capsule per 1 day)
***CARDIOTONICS* - DRUGS FOR THE HEART**		
CARDIAC GLYCOSIDES - DRUGS FOR THE HEART**		
digoxin injection solution	1 or 1b*	
digoxin oral solution	1 or 1b*	QL (10 mL per 1 day)
digoxin oral tablet 125 mcg, 62.5 mcg	1 or 1b*	DO
digoxin oral tablet 250 mcg	1 or 1b*	QL (2 tablets per 1 day)
LANOXIN INJECTION SOLUTION (*digoxin*)	3	
LANOXIN PEDIATRIC INJECTION SOLUTION (*digoxin*)	2	
INOTROPES - DRUGS FOR SERIOUS ALLERGIC REACTION**		
dobutamine hcl intravenous solution	1 or 1b*	
DOBUTAMINE IN D5W INTRAVENOUS SOLUTION	3	
DOPAMINE HCL INTRAVENOUS SOLUTION	3	
DOPAMINE IN D5W INTRAVENOUS SOLUTION	3	
milrinone lactate in dextrose intravenous solution	1 or 1b*	
milrinone lactate intravenous solution	1 or 1b*	
***CARDIOVASCULAR AGENTS - MISC.* - DRUGS FOR THE HEART**		
CALCIUM CHANNEL BLOCKER & HMG COA REDUCTASE INHIBIT COMB - DRUGS FOR CHOLESTEROL**		
amlodipine-atorvastatin oral tablet 10-10 mg, 10-20 mg, 10-40 mg, 10-80 mg, 5-80 mg	1 or 1b*	QL (1 tablet per 1 day)
amlodipine-atorvastatin oral tablet 2.5-10 mg, 2.5-20 mg, 2.5-40 mg, 5-10 mg, 5-20 mg, 5-40 mg	1 or 1b*	DO
CADUET ORAL TABLET 10-10 MG, 10-20 MG, 10-40 MG, 10-80 MG, 5-80 MG (*amlodipine-atorvastatin*)	3	QL (1 tablet per 1 day)
CADUET ORAL TABLET 5-10 MG, 5-20 MG, 5-40 MG (*amlodipine-atorvastatin*)	3	DO
CARDIAC MYOSIN INHIBITORS - DRUGS FOR THE HEART**		
CAMZYOS ORAL CAPSULE (*mavacamten*)	4	PA; LD; QL (1 capsule per 1 day); SP
NEPRILYSIN INHIB (ARNI)-ANGIOTENSIN II RECEPT ANTAG COMB - DRUGS FOR HIGH BLOOD PRESSURE**		
ENTRESTO ORAL TABLET 24-26 MG (*sacubitril-valsartan*)	2	QL (6 tablets per 1 day)
ENTRESTO ORAL TABLET 49-51 MG, 97-103 MG (*sacubitril-valsartan*)	2	QL (2 tablets per 1 day)
NITRATE & VASODILATOR COMBINATIONS - DRUGS FOR HIGH BLOOD PRESSURE**		
BIDIL ORAL TABLET (*isosorb dinitrate-hydralazine*)	3	QL (6 tablets per 1 day)
isosorb dinitrate-hydralazine oral tablet	1 or 1b*	QL (6 tablets per 1 day)

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PROSTAGLANDIN - IMPOTENCE AGENTS - DRUGS FOR THE HEART**		
CAVERJECT IMPULSE INTRACAVERNOSAL KIT (*alprostadil (vasodilator)*)	3	PA
CAVERJECT INTRACAVERNOSAL SOLUTION RECONSTITUTED (*alprostadil (vasodilator)*)	3	PA
EDEX INTRACAVERNOSAL KIT (*alprostadil (vasodilator)*)	3	PA
MUSE URETHRAL PELLET (*alprostadil (vasodilator)*)	3	PA
PROSTAGLANDIN VASODILATORS - DRUGS FOR HIGH BLOOD PRESSURE**		
epoprostenol sodium intravenous solution reconstituted	4	PA; LD; SP
FLOLAN INTRAVENOUS SOLUTION RECONSTITUTED (*epoprostenol sodium*)	4	PA; LD; SP
ORENITRAM MONTH 1 ORAL TABLET EXTENDED RELEASE THERAPY PACK (*treprostinil diolamine*)	4	PA; LD; QL (1 pack per 28 days); SP
ORENITRAM MONTH 2 ORAL TABLET EXTENDED RELEASE THERAPY PACK (*treprostinil diolamine*)	4	PA; LD; QL (1 pack per 28 days); SP
ORENITRAM MONTH 3 ORAL TABLET EXTENDED RELEASE THERAPY PACK (*treprostinil diolamine*)	4	PA; LD; QL (1 pack per 28 days); SP
ORENITRAM ORAL TABLET EXTENDED RELEASE (*treprostinil diolamine*)	4	PA; LD; SP
REMODULIN INJECTION SOLUTION (*treprostinil*)	4	PA; LD; SP
treprostinil injection solution	4	PA; LD; SP
TYVASO DPI MAINTENANCE KIT INHALATION POWDER (*treprostinil*)	4	PA; LD; QL (1 kit per 28 days); SP
TYVASO DPI TITRATION KIT INHALATION POWDER (*treprostinil*)	4	PA; LD; QL (1 kit per 1 lifetime); SP
TYVASO INHALATION SOLUTION (*treprostinil*)	4	PA; LD; QL (1 kit per 28 days); SP
TYVASO REFILL INHALATION SOLUTION (*treprostinil*)	4	PA; LD; QL (1 kit per 28 days); SP
TYVASO STARTER INHALATION SOLUTION (*treprostinil*)	4	PA; LD; QL (1 kit per 28 days); SP
VELETRI INTRAVENOUS SOLUTION RECONSTITUTED (*epoprostenol sodium*)	4	PA; LD; SP
VENTAVIS INHALATION SOLUTION (*iloprost*)	4	PA; LD; QL (9 mL per 1 day); SP
PULM HYPERTEN-SOLUBLE GUANYLATE CYCLASE STIMULATOR (SGC) - DRUGS FOR HIGH BLOOD PRESSURE**		
ADEMPAS ORAL TABLET (*riociguat*)	4	PA; LD; QL (3 tablets per 1 day); SP
PULMONARY HYPERTENSION - ENDOTHELIN RECEPTOR ANTAGONISTS - DRUGS FOR HIGH BLOOD PRESSURE**		
ambrisentan oral tablet	4	PA; LD; QL (1 tablet per 1 day); SP
bosentan oral tablet	4	PA; LD; QL (2 tablets per 1 day); SP
OPSUMIT ORAL TABLET (*macitentan*)	4	PA; LD; QL (1 tablet per 1 day); SP
TRACLEER ORAL TABLET SOLUBLE (*bosentan*)	4	PA; LD; QL (2 tablets per 1 day); SP

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PULMONARY HYPERTENSION - PHOSPHODIESTERASE INHIBITORS - DRUGS FOR HIGH BLOOD PRESSURE**		
alyq oral tablet	4	PA; QL (2 tablets per 1 day); SP
sildenafil citrate intravenous solution	4	PA; QL (3 vial per 1 day); SP
sildenafil citrate oral suspension reconstituted	4	PA; QL (6 mL per 1 day); SP
sildenafil citrate oral tablet	4	PA; QL (3 tablets per 1 day); SP
tadalafil (pah) oral tablet	4	PA; QL (2 tablets per 1 day); SP
TADLIQ ORAL SUSPENSION (*tadalafil (pah)*)	4	PA; QL (10 ml per 1 day); SP
PULMONARY HYPERTENSION - PROSTACYCLIN RECEPTOR AGONIST - DRUGS FOR HIGH BLOOD PRESSURE**		
UPTRAVI INTRAVENOUS SOLUTION RECONSTITUTED (*selexipag*)	4	PA; LD; QL (2 vials per 1 day)
UPTRAVI ORAL TABLET (*selexipag*)	4	PA; LD; QL (2 tablets per 1 day); SP
UPTRAVI TITRATION ORAL TABLET THERAPY PACK (*selexipag*)	4	PA; LD; QL (1 pack per 365 days); SP
SELECTIVE CGMP PHOSPHODIESTERASE TYPE 5 INHIBITORS - DRUGS FOR THE HEART**		
sildenafil citrate oral tablet	1 or 1b*	PA
tadalafil oral tablet 10 mg, 20 mg	1 or 1b*	PA
tadalafil oral tablet 2.5 mg, 5 mg	1 or 1b*	PA; QL (30 tablets per 30 days)
vardenafil hcl oral tablet dispersible	1 or 1b*	PA
***SEPTAL AGENTS - ABLATION** - DRUGS FOR THE HEART**		
ABLYSINOL INTRA-ARTERIAL SOLUTION (*dehydrated alcohol*)	3	
***SINUS NODE INHIBITORS** - DRUGS FOR HIGH BLOOD PRESSURE**		
CORLANOR ORAL SOLUTION (*ivabradine hcl*)	3	PA; QL (4 ampules per 1 day)
CORLANOR ORAL TABLET (*ivabradine hcl*)	2	PA; QL (2 tablets per 1 day)
TRANSTHYRETIN STABILIZERS - DRUGS FOR THE HEART**		
VYNDAMAX ORAL CAPSULE (*tafamidis*)	4	PA; LD; QL (1 capsule per 1 day); SP
VYNDAQEL ORAL CAPSULE (*tafamidis meglumine (cardiac)*)	4	PA; LD; QL (4 capsules per 1 day); SP
VASOACTIVE SOLUBLE GUANYLATE CYCLASE STIMULATOR (SGC) - DRUGS FOR ANGINA**		
VERQUVO ORAL TABLET (*vericiguat*)	3	PA; QL (1 tablet per 1 day)
***CEPHALOSPORINS* - DRUGS FOR INFECTIONS**		
CEPHALOSPORIN COMBINATIONS - ANTIBIOTICS**		
AVYCAZ INTRAVENOUS SOLUTION RECONSTITUTED (*ceftazidime-avibactam*)	3	
ZERBAXA INTRAVENOUS SOLUTION RECONSTITUTED (*ceftolozane-tazobactam*)	3	
CEPHALOSPORINS - 1ST GENERATION - ANTIBIOTICS**		
cefadroxil oral capsule	1 or 1b*	
cefadroxil oral suspension reconstituted	1 or 1b*	

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
cefadroxil oral tablet	1 or 1b*	
cefazolin sodium injection solution reconstituted 1 gm, 10 gm, 2 gm, 500 mg	1 or 1b*	
CEFAZOLIN SODIUM INJECTION SOLUTION RECONSTITUTED 100 GM, 300 GM	3	
cefazolin sodium intravenous solution reconstituted 1 gm	1 or 1b*	
cefazolin sodium intravenous solution reconstituted 2 gm, 3 gm	3	
CEFAZOLIN SODIUM-DEXTROSE INTRAVENOUS SOLUTION	3	
CEFAZOLIN SODIUM-DEXTROSE INTRAVENOUS SOLUTION RECONSTITUTED	3	
cephalexin oral capsule	1 or 1a*	
cephalexin oral suspension reconstituted	1 or 1a*	
cephalexin oral tablet	1 or 1a*	
CEPHALOSPORINS - 2ND GENERATION - ANTIBIOTICS**		
CEFACLOR ER ORAL TABLET EXTENDED RELEASE 12 HOUR	3	
cefaclor oral capsule	1 or 1b*	
cefaclor oral suspension reconstituted	1 or 1b*	
cefotetan disodium injection solution reconstituted	1 or 1b*	
cefoxitin sodium intravenous solution reconstituted	1 or 1b*	
CEFOXITIN SODIUM-DEXTROSE INTRAVENOUS SOLUTION RECONSTITUTED	3	
cefprozil oral suspension reconstituted	1 or 1b*	
cefprozil oral tablet	1 or 1b*	
cefuroxime axetil oral tablet	1 or 1b*	
cefuroxime sodium injection solution reconstituted	1 or 1b*	
cefuroxime sodium intravenous solution reconstituted	1 or 1b*	
CEPHALOSPORINS - 3RD GENERATION - ANTIBIOTICS**		
cefdinir oral capsule	1 or 1b*	
cefdinir oral suspension reconstituted	1 or 1b*	
cefixime oral capsule	1 or 1b*	
cefixime oral suspension reconstituted	1 or 1b*	
cefotaxime sodium injection solution reconstituted	3	
cefpodoxime proxetil oral suspension reconstituted	1 or 1b*	
cefpodoxime proxetil oral tablet	1 or 1b*	
ceftazidime injection solution reconstituted	1 or 1b*	
ceftazidime intravenous solution reconstituted	1 or 1b*	
ceftriaxone sodium in dextrose intravenous solution	1 or 1b*	QL (3000 mL per 30 days)
ceftriaxone sodium injection solution reconstituted 1 gm, 2 gm, 500 mg	1 or 1b*	QL (60 vials per 30 fills)
CEFTRIAXONE SODIUM INJECTION SOLUTION RECONSTITUTED 100 GM	3	QL (1 vial per 30 days)
ceftriaxone sodium injection solution reconstituted 250 mg	1 or 1b*	QL (1 vial per 30 fills)
ceftriaxone sodium intravenous solution reconstituted 1 gm, 2 gm	1 or 1b*	QL (60 vials per 30 days)
ceftriaxone sodium intravenous solution reconstituted 10 gm	1 or 1b*	QL (1 vial per 30 days)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CEFTRIAXONE SODIUM-DEXTROSE INTRAVENOUS SOLUTION RECONSTITUTED	3	QL (60 IV Bags per 30 days)
tazicef injection solution reconstituted	1 or 1b*	
TAZICEF INTRAVENOUS SOLUTION (*ceftazidime sodium in dextrose*)	3	
tazicef intravenous solution reconstituted	1 or 1b*	
CEPHALOSPORINS - 4TH GENERATION - ANTIBIOTICS**		
cefepime hcl injection solution reconstituted	1 or 1b*	
CEFEPIME HCL INTRAVENOUS SOLUTION	3	
CEFEPIME HCL INTRAVENOUS SOLUTION RECONSTITUTED 100 GM	3	
cefepime hcl intravenous solution reconstituted 2 gm	1 or 1b*	
CEFEPIME-DEXTROSE INTRAVENOUS SOLUTION RECONSTITUTED	3	
CEPHALOSPORINS - 5TH GENERATION - ANTIBIOTICS**		
TEFLARO INTRAVENOUS SOLUTION RECONSTITUTED (*ceftaroline fosamil*)	3	
CEPHALOSPORINS - SIDEROPHORES - ANTIBIOTICS**		
FETROJA INTRAVENOUS SOLUTION RECONSTITUTED (*cefiderocol sulfate tosylate*)	3	
***CONTRACEPTIVES* - DRUGS FOR WOMEN**		
BIPHASIC CONTRACEPTIVES - ORAL - BIRTH CONTROL PILLS**		
azurette oral tablet	1 or 1b*; $0	
desogestrel-ethinyl estradiol oral tablet	1 or 1b*; $0	
kariva oral tablet	1 or 1b*; $0	
LO LOESTRIN FE ORAL TABLET (*norethin-eth estrad-fe biphas*)	2	$0
pimtrea oral tablet	1 or 1b*; $0	
simliya oral tablet	1 or 1b*; $0	
viorele oral tablet	1 or 1b*; $0	
volnea oral tablet	1 or 1b*; $0	
COMBINATION CONTRACEPTIVES - ORAL - BIRTH CONTROL PILLS**		
afirmelle oral tablet	1 or 1a*; $0	
altavera oral tablet	1 or 1a*; $0	
alyacen 1/35 oral tablet	1 or 1a*; $0	
apri oral tablet	1 or 1a*; $0	
aubra eq oral tablet	1 or 1a*; $0	
aurovela 1.5/30 oral tablet	1 or 1a*; $0	
aurovela 1/20 oral tablet	1 or 1a*; $0	
aurovela 24 fe oral tablet	1 or 1a*; $0	
aurovela fe 1.5/30 oral tablet	1 or 1a*; $0	
aurovela fe 1/20 oral tablet	1 or 1a*; $0	
aviane oral tablet	1 or 1a*; $0	

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ayuna oral tablet	1 or 1a*; $0	
balziva oral tablet	1 or 1a*; $0	
blisovi 24 fe oral tablet	1 or 1a*; $0	
blisovi fe 1.5/30 oral tablet	1 or 1a*; $0	
blisovi fe 1/20 oral tablet	1 or 1a*; $0	
briellyn oral tablet	1 or 1a*; $0	
charlotte 24 fe oral tablet chewable	1 or 1a*; $0	
chateal eq oral tablet	1 or 1a*; $0	
cryselle-28 oral tablet	1 or 1a*; $0	
cyred eq oral tablet	1 or 1a*; $0	
dasetta 1/35 oral tablet	1 or 1a*; $0	
delyla oral tablet	1 or 1a*; $0	
drospiren-eth estrad-levomefol oral tablet	1 or 1b*; $0	
drospirenone-ethinyl estradiol oral tablet	1 or 1b*; $0	
elinest oral tablet	1 or 1a*; $0	
enskyce oral tablet	1 or 1a*; $0	
estarylla oral tablet	1 or 1a*; $0	
ethynodiol diac-eth estradiol oral tablet	1 or 1a*; $0	
falmina oral tablet	1 or 1a*; $0	
norethin ace-eth estrad-fe (Finzala Oral Tablet Chewable)	1 or 1a*; $0	
gemmily oral capsule	1 or 1b*; $0	
hailey 1.5/30 oral tablet	1 or 1a*; $0	
hailey 24 fe oral tablet	1 or 1a*; $0	
hailey fe 1.5/30 oral tablet	1 or 1a*; $0	
hailey fe 1/20 oral tablet	1 or 1a*; $0	
isibloom oral tablet	1 or 1a*; $0	
jasmiel oral tablet	1 or 1b*; $0	
levonorgest-eth estrad-fe bisg (Joyeaux Oral Tablet)	1 or 1b*; $0	
juleber oral tablet	1 or 1a*; $0	
junel 1.5/30 oral tablet	1 or 1a*; $0	
junel 1/20 oral tablet	1 or 1a*; $0	
junel fe 1.5/30 oral tablet	1 or 1a*; $0	
junel fe 1/20 oral tablet	1 or 1a*; $0	
junel fe 24 oral tablet	1 or 1a*; $0	
kaitlib fe oral tablet chewable	1 or 1b*; $0	
kalliga oral tablet	1 or 1a*; $0	
kelnor 1/35 oral tablet	1 or 1a*; $0	
kelnor 1/50 oral tablet	1 or 1a*; $0	
kurvelo oral tablet	1 or 1a*; $0	
larin 1.5/30 oral tablet	1 or 1a*; $0	
larin 1/20 oral tablet	1 or 1a*; $0	

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
larin 24 fe oral tablet	1 or 1a*; $0	
larin fe 1.5/30 oral tablet	1 or 1a*; $0	
larin fe 1/20 oral tablet	1 or 1a*; $0	
layolis fe oral tablet chewable	1 or 1b*; $0	
lessina oral tablet	1 or 1a*; $0	
levonorgest-eth estradiol-iron oral tablet	1 or 1b*; $0	
levonorgestrel-ethinyl estrad oral tablet	1 or 1a*; $0	
levora 0.15/30 (28) oral tablet	1 or 1a*; $0	
loestrin 1.5/30 (21) oral tablet	1 or 1a*; $0	
loestrin 1/20 (21) oral tablet	1 or 1a*; $0	
loestrin fe 1.5/30 oral tablet	1 or 1a*; $0	
loestrin fe 1/20 oral tablet	1 or 1a*; $0	
loryna oral tablet	1 or 1b*; $0	
low-ogestrel oral tablet	1 or 1a*; $0	
lo-zumandimine oral tablet	1 or 1b*; $0	
lutera oral tablet	1 or 1a*; $0	
marlissa oral tablet	1 or 1a*; $0	
merzee oral capsule	1 or 1b*; $0	
norethin ace-eth estrad-fe (Mibelas 24 Fe Oral Tablet Chewable)	1 or 1a*; $0	
microgestin 1.5/30 oral tablet	1 or 1a*; $0	
microgestin 1/20 oral tablet	1 or 1a*; $0	
microgestin 24 fe oral tablet	1 or 1a*; $0	
microgestin fe 1.5/30 oral tablet	1 or 1a*; $0	
microgestin fe 1/20 oral tablet	1 or 1a*; $0	
mili oral tablet	1 or 1a*; $0	
mono-linyah oral tablet	1 or 1a*; $0	
necon 0.5/35 (28) oral tablet	1 or 1a*; $0	
nikki oral tablet	1 or 1b*; $0	
norethin ace-eth estrad-fe oral capsule	1 or 1b*; $0	
norethin ace-eth estrad-fe oral tablet	1 or 1a*; $0	
norethin ace-eth estrad-fe oral tablet chewable	1 or 1a*; $0	
norethindrone acet-ethinyl est oral tablet	1 or 1a*; $0	
norethin-eth estradiol-fe oral tablet chewable	1 or 1b*; $0	
norgestimate-eth estradiol oral tablet	1 or 1a*; $0	
nortrel 0.5/35 (28) oral tablet	1 or 1a*; $0	
nortrel 1/35 (21) oral tablet	1 or 1a*; $0	
nortrel 1/35 (28) oral tablet	1 or 1a*; $0	
nylia 1/35 oral tablet	1 or 1a*; $0	
nymyo oral tablet	1 or 1a*; $0	
ocella oral tablet	1 or 1b*; $0	
philith oral tablet	1 or 1a*; $0	

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
portia-28 oral tablet	1 or 1a*; $0	
reclipsen oral tablet	1 or 1a*; $0	
sprintec 28 oral tablet	1 or 1a*; $0	
sronyx oral tablet	1 or 1a*; $0	
syeda oral tablet	1 or 1b*; $0	
tarina 24 fe oral tablet	1 or 1a*; $0	
tarina fe 1/20 eq oral tablet	1 or 1a*; $0	
taysofy oral capsule	1 or 1b*; $0	
norgestrel-ethinyl estradiol (Turqoz Oral Tablet)	1 or 1a*; $0	
tydemy oral tablet	1 or 1b*; $0	
vestura oral tablet	1 or 1b*; $0	
vienva oral tablet	1 or 1a*; $0	
vyfemla oral tablet	1 or 1a*; $0	
vylibra oral tablet	1 or 1a*; $0	
wera oral tablet	1 or 1a*; $0	
wymzya fe oral tablet chewable	1 or 1b*; $0	
zovia 1/35 (28) oral tablet	1 or 1a*; $0	
zumandimine oral tablet	1 or 1b*; $0	
COMBINATION CONTRACEPTIVES - TRANSDERMAL - BIRTH CONTROL PILLS**		
norelgestromin-eth estradiol transdermal patch weekly	1 or 1b*; $0	
TWIRLA TRANSDERMAL PATCH WEEKLY (*levonorgestrel-eth estradiol*)	3	$0
xulane transdermal patch weekly	1 or 1b*; $0	
zafemy transdermal patch weekly	1 or 1b*; $0	
COMBINATION CONTRACEPTIVES - VAGINAL - BIRTH CONTROL PILLS**		
ANNOVERA VAGINAL RING (*segesterone-ethinyl estradiol*)	3	$0
NUVARING VAGINAL RING (*etonogestrel-ethinyl estradiol*)	1 or 1b*; $0	
CONTINUOUS CONTRACEPTIVES - ORAL - BIRTH CONTROL PILLS**		
amethyst oral tablet	1 or 1b*; $0	
dolishale oral tablet	1 or 1b*; $0	
levonorgestrel-ethinyl estrad oral tablet	1 or 1b*; $0	
COPPER CONTRACEPTIVES - IUD - BIRTH CONTROL PILLS**		
PARAGARD INTRAUTERINE COPPER INTRAUTERINE INTRAUTERINE DEVICE (*copper*)	3	
EMERGENCY CONTRACEPTIVES - BIRTH CONTROL PILLS**		
aftera oral tablet	1 or 1b*; $0	
afterpill oral tablet	1 or 1b*; $0	
CURAE ORAL TABLET (*levonorgestrel*)	1 or 1b*; $0	
econtra one-step oral tablet	1 or 1b*; $0	
ELLA ORAL TABLET (*ulipristal acetate*)	3; $0	

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HER STYLE ORAL TABLET (*levonorgestrel*)	1 or 1b*; $0	
levonorgestrel oral tablet	1 or 1b*; $0	
my choice oral tablet	1 or 1b*; $0	
my way oral tablet	1 or 1b*; $0	
new day oral tablet	1 or 1b*; $0	
opcicon one-step oral tablet	1 or 1b*; $0	
option 2 oral tablet	1 or 1b*; $0	
react oral tablet	1 or 1b*; $0	
take action oral tablet	1 or 1b*; $0	
EXTENDED-CYCLE CONTRACEPTIVES - ORAL - BIRTH CONTROL PILLS**		
amethia oral tablet	1 or 1b*; $0	
ashlyna oral tablet	1 or 1b*; $0	
camrese lo oral tablet	1 or 1b*; $0	
camrese oral tablet	1 or 1b*; $0	
daysee oral tablet	1 or 1b*; $0	
iclevia oral tablet	1 or 1b*; $0	
introvale oral tablet	1 or 1b*; $0	
jaimiess oral tablet	1 or 1b*; $0	
jolessa oral tablet	1 or 1b*; $0	
levonorgest-eth est & eth est oral tablet	1 or 1b*; $0	
levonorgest-eth estrad 91-day oral tablet	1 or 1b*; $0	
lojaimiess oral tablet	1 or 1b*; $0	
rivelsa oral tablet	1 or 1b*; $0	
setlakin oral tablet	1 or 1b*; $0	
simpesse oral tablet	1 or 1b*; $0	
PROGESTIN CONTRACEPTIVES - IMPLANTS - BIRTH CONTROL PILLS**		
NEXPLANON SUBCUTANEOUS IMPLANT (*etonogestrel*)	4	LD; SP
PROGESTIN CONTRACEPTIVES - INJECTABLE - BIRTH CONTROL PILLS**		
DEPO-PROVERA INTRAMUSCULAR SUSPENSION (*medroxyprogesterone acetate*)	3	
DEPO-PROVERA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (*medroxyprogesterone acetate*)	3	
DEPO-SUBQ PROVERA 104 SUBCUTANEOUS SUSPENSION PREFILLED SYRINGE (*medroxyprogesterone acetate*)	3; $0	
medroxyprogesterone acetate intramuscular suspension	1 or 1b*; $0	
medroxyprogesterone acetate intramuscular suspension prefilled syringe	1 or 1b*; $0	
PROGESTIN CONTRACEPTIVES - IUD - BIRTH CONTROL PILLS**		
KYLEENA INTRAUTERINE INTRAUTERINE DEVICE (*levonorgestrel*)	4	LD; SP
LILETTA (52 MG) INTRAUTERINE INTRAUTERINE DEVICE (*levonorgestrel*)	3	LD; SP

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MIRENA (52 MG) INTRAUTERINE INTRAUTERINE DEVICE (*levonorgestrel*)	3	LD; SP
SKYLA INTRAUTERINE INTRAUTERINE DEVICE (*levonorgestrel*)	3	LD; SP
PROGESTIN CONTRACEPTIVES - ORAL - BIRTH CONTROL PILLS**		
camila oral tablet	1 or 1b*; $0	
deblitane oral tablet	1 or 1b*; $0	
errin oral tablet	1 or 1b*; $0	
heather oral tablet	1 or 1b*; $0	
incassia oral tablet	1 or 1b*; $0	
jencycla oral tablet	1 or 1b*; $0	
lyleq oral tablet	1 or 1b*; $0	
lyza oral tablet	1 or 1b*; $0	
nora-be oral tablet	1 or 1b*; $0	
norethindrone oral tablet	1 or 1b*; $0	
norlyroc oral tablet	1 or 1b*; $0	
sharobel oral tablet	1 or 1b*; $0	
SLYND ORAL TABLET (*drospirenone*)	3	$0
TRIPHASIC CONTRACEPTIVES - ORAL - BIRTH CONTROL PILLS**		
alyacen 7/7/7 oral tablet	1 or 1a*; $0	
aranelle oral tablet	1 or 1a*; $0	
dasetta 7/7/7 oral tablet	1 or 1a*; $0	
enpresse-28 oral tablet	1 or 1a*; $0	
leena oral tablet	1 or 1a*; $0	
levonest oral tablet	1 or 1a*; $0	
levonorg-eth estrad triphasic oral tablet	1 or 1a*; $0	
norethindron-ethinyl estrad-fe oral tablet	1 or 1b*; $0	
norgestim-eth estrad triphasic oral tablet	1 or 1b*; $0	
nortrel 7/7/7 oral tablet	1 or 1a*; $0	
nylia 7/7/7 oral tablet	1 or 1a*; $0	
tilia fe oral tablet	1 or 1b*; $0	
tri-estarylla oral tablet	1 or 1b*; $0	
tri-legest fe oral tablet	1 or 1b*; $0	
tri-linyah oral tablet	1 or 1b*; $0	
tri-lo-estarylla oral tablet	1 or 1b*; $0	
tri-lo-marzia oral tablet	1 or 1b*; $0	
tri-lo-mili oral tablet	1 or 1b*; $0	
tri-lo-sprintec oral tablet	1 or 1b*; $0	
tri-mili oral tablet	1 or 1b*; $0	
tri-nymyo oral tablet	1 or 1b*; $0	
tri-sprintec oral tablet	1 or 1b*; $0	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
trivora (28) oral tablet	1 or 1a*; $0	
tri-vylibra lo oral tablet	1 or 1b*; $0	
tri-vylibra oral tablet	1 or 1b*; $0	
velivet oral tablet	1 or 1a*; $0	
***CORTICOSTEROIDS* - HORMONES**		
GLUCOCORTICOSTEROIDS - DRUGS FOR INFLAMMATION**		
ALKINDI SPRINKLE ORAL CAPSULE SPRINKLE (*hydrocortisone*)	3	PA
budesonide er oral tablet extended release 24 hour	1 or 1b*	QL (1 tablet per 1 day)
budesonide oral capsule delayed release particles	1 or 1b*	QL (3 capsule per 1 day)
CORTEF ORAL TABLET (*hydrocortisone*)	3	
DEPO-MEDROL INJECTION SUSPENSION (*methylprednisolone acetate*)	3	
DEXABLISS ORAL TABLET THERAPY PACK	3	
DEXAMETHASONE INTENSOL ORAL CONCENTRATE (*dexamethasone*)	2	
dexamethasone oral elixir	1 or 1a*	
dexamethasone oral solution	1 or 1a*	
dexamethasone oral tablet	1 or 1a*	
dexamethasone oral tablet therapy pack	1 or 1b*	
dexamethasone sod phosphate pf injection solution	1 or 1b*	
DEXAMETHASONE SOD PHOSPHATE PF INJECTION SOLUTION PREFILLED SYRINGE	3	
dexamethasone sodium phosphate injection solution 100 mg/10ml, 120 mg/30ml, 20 mg/5ml	1 or 1b*	
DEXAMETHASONE SODIUM PHOSPHATE INJECTION SOLUTION 4 MG/ML	1 or 1b*	
HEMADY ORAL TABLET (*dexamethasone*)	3	PA; QL (2 tablets per 1 day)
HEXATRIONE INTRA-ARTICULAR SUSPENSION (*triamcinolone hexacetonide*)	3	
hidex 6-day oral tablet therapy pack	1 or 1b*	
hydrocortisone oral tablet	1 or 1b*	
KENALOG INJECTION SUSPENSION (*triamcinolone acetonide*)	3	
KENALOG-80 INJECTION SUSPENSION (*triamcinolone acetonide*)	3	
MEDROL ORAL TABLET 16 MG, 4 MG, 8 MG (*methylprednisolone*)	3	
MEDROL ORAL TABLET 2 MG (*methylprednisolone*)	2	
MEDROL ORAL TABLET THERAPY PACK (*methylprednisolone*)	3	
methylprednisolone oral tablet	1 or 1a*	
methylprednisolone oral tablet therapy pack	1 or 1a*	
methylprednisolone sodium succ injection solution reconstituted	1 or 1b*	
ORAPRED ODT ORAL TABLET DISPERSIBLE 10 MG, 30 MG (*prednisolone sodium phosphate*)	3	QL (2 tablets per 1 day)
ORAPRED ODT ORAL TABLET DISPERSIBLE 15 MG (*prednisolone sodium phosphate*)	3	DO
PEDIAPRED ORAL SOLUTION (*prednisolone sodium phosphate*)	3	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
prednisolone oral solution	1 or 1a*	
prednisolone oral tablet	1 or 1b*	
prednisolone sodium phosphate oral solution	1 or 1a*	
prednisolone sodium phosphate oral tablet dispersible 10 mg, 30 mg	1 or 1a*	QL (2 tablets per 1 day)
prednisolone sodium phosphate oral tablet dispersible 15 mg	1 or 1a*	DO
PREDNISONE INTENSOL ORAL CONCENTRATE (*prednisone*)	3	
prednisone oral solution	1 or 1a*	
prednisone oral tablet	1 or 1a*	
prednisone oral tablet therapy pack	1 or 1a*	
SOLU-CORTEF INJECTION SOLUTION RECONSTITUTED (*hydrocortisone sod succinate*)	3	
SOLU-MEDROL (PF) INJECTION SOLUTION RECONSTITUTED (*methylprednisolone sodium succ*)	3	
SOLU-MEDROL INJECTION SOLUTION RECONSTITUTED (*methylprednisolone sodium succ*)	3	
taperdex 12-day oral tablet therapy pack	1 or 1b*	
taperdex 6-day oral tablet therapy pack	1 or 1b*	
taperdex 7-day oral tablet therapy pack	1 or 1b*	
TARPEYO ORAL CAPSULE DELAYED RELEASE (*budesonide*)	4	PA; LD; QL (4 capsules per 1 day)
UCERIS ORAL TABLET EXTENDED RELEASE 24 HOUR (*budesonide*)	3	PA; QL (1 tablet per 1 day)
ZILRETTA INTRA-ARTICULAR SUSPENSION RECONSTITUTED ER (*triamcinolone acetonide*)	4	PA; LD; QL (1 injection per 1 knee)
MINERALOCORTICOIDS - DRUGS FOR INFLAMMATION**		
fludrocortisone acetate oral tablet	1 or 1b*	
STEROID COMBINATIONS - DRUGS FOR INFLAMMATION**		
CELESTONE SOLUSPAN INJECTION SUSPENSION (*betamethasone sod phos & acet*)	3	
***COUGH/COLD/ALLERGY* - DRUGS FOR THE LUNGS**		
ANTITUSSIVE - NONNARCOTIC - DRUGS FOR ALLERGIES**		
benzonatate oral capsule	1 or 1b*	
ANTITUSSIVE - OPIOID - DRUGS FOR COUGH AND COLD**		
HYCODAN ORAL SOLUTION (*hydrocodone bit-homatrop mbr*)	3	QL (120 mL per 1 fill)
HYCODAN ORAL TABLET (*hydrocodone bit-homatrop mbr*)	3	PA
hydrocodone bit-homatrop mbr oral solution	1 or 1a*	QL (120 mL per 1 fill)
hydrocodone bit-homatrop mbr oral tablet	1 or 1a*	PA
hydromet oral solution	1 or 1a*	QL (120 mL per 1 fill)
ANTITUSSIVE-EXPECTORANT - DRUGS FOR COUGH AND COLD**		
CODITUSSIN AC ORAL LIQUID	3	
g tussin ac oral solution	1 or 1a*	
guaifenesin ac oral syrup	1 or 1a*	
guaifenesin-codeine oral solution	1 or 1a*	
MAR-COF CG EXPECTORANT ORAL LIQUID (*guaifenesin-codeine*)	2	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
maxi-tuss ac oral solution	1 or 1a*	
NINJACOF-XG ORAL LIQUID (*guaifenesin-codeine*)	3	
ANTITUSSIVE-EXPECTORANTS-DECONGESTANT - DRUGS FOR COUGH AND COLD**		
CODITUSSIN DAC ORAL LIQUID	3	
TUSNEL C ORAL SYRUP (*pseudoephedrine-codeine-gg*)	2	PA
DECONGESTANT & ANTIHISTAMINE - DRUGS FOR COUGH AND COLD**		
CLARINEX-D 12 HOUR ORAL TABLET EXTENDED RELEASE 12 HOUR (*desloratadine-pseudoephedrine*)	3	ST; QL (2 tablets per 1 day)
promethazine vc oral syrup	1 or 1b*	QL (2 fills per 30 days)
MISC. RESPIRATORY INHALANTS - DRUGS FOR ALLERGIES**		
HYPERSAL INHALATION NEBULIZATION SOLUTION (*sodium chloride*)	3	
sodium chloride (Nebusal Inhalation Nebulization Solution)	1 or 1b*	
sodium chloride (Pulmosal Inhalation Nebulization Solution)	1 or 1b*	
sodium chloride inhalation nebulization solution	1 or 1b*	
MUCOLYTICS - DRUGS FOR THE LUNGS**		
acetylcysteine inhalation solution	1 or 1b*	
NON-NARC ANTITUSSIVE-ANTIHISTAMINE - DRUGS FOR COUGH AND COLD**		
promethazine-dm oral syrup	1 or 1a*	QL (2 fills per 30 days)
NON-NARC ANTITUSSIVE-DECONGESTANT-ANTIHISTAMINE - DRUGS FOR COUGH AND COLD**		
pseudoeph-bromphen-dm (Bromfed Dm Oral Syrup)	1 or 1b*	
pseudoeph-bromphen-dm oral syrup	1 or 1b*	
OPIOID ANTITUSSIVE-ANTIHISTAMINE - DRUGS FOR COUGH AND COLD**		
hydrocod poli-chlorphe poli er oral suspension extended release	1 or 1b*	QL (120 mL per 1 fill)
promethazine-codeine oral solution	1 or 1a*	QL (120 mL per 1 fill)
TUXARIN ER ORAL TABLET EXTENDED RELEASE 12 HOUR (*chlorpheniramine-codeine*)	3	
OPIOID ANTITUSSIVE-DECONGESTANT-ANTIHISTAMINE - DRUGS FOR COUGH AND COLD**		
CAPCOF ORAL SYRUP	3	
MAR-COF BP ORAL LIQUID (*pseudoeph-bromphen-cod*)	3	
MAXI-TUSS CD ORAL LIQUID	2	
POLY-TUSSIN AC ORAL LIQUID	2	
promethazine vc/codeine oral syrup	1 or 1b*	QL (120 mL per 1 fill)
PRO-RED AC ORAL SYRUP (*phenyleph-dexchlorphen-codeine*)	3	PA
RYDEX ORAL LIQUID (*pseudoeph-bromphen-cod*)	2	
***DERMATOLOGICALS* - DRUGS FOR THE SKIN**		
ACNE ANTIBIOTICS - DRUGS FOR THE SKIN**		
CLEOCIN-T EXTERNAL LOTION (*clindamycin phosphate*)	3	ST; QL (4 mL per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
clindacin etz external swab	1 or 1b*	QL (2 pads per 1 day)
clindamycin phosphate (Clindacin External Foam)	1 or 1b*	QL (100 grams per 30 days)
clindacin-p external swab	1 or 1b*	QL (2 pads per 1 day)
clindamycin phosphate external foam	1 or 1b*	QL (100 grams per 30 days)
clindamycin phosphate external gel	1 or 1b*	QL (75 ml/gm per 30 days)
clindamycin phosphate external lotion	1 or 1b*	QL (4 mL per 1 day)
clindamycin phosphate external solution	1 or 1b*	QL (4 mL per 1 day)
clindamycin phosphate external swab	1 or 1b*	QL (2 pads per 1 day)
dapsone external gel 5 %	1 or 1b*	ST; QL (90 grams per 30 days)
dapsone external gel 7.5 %	3	ST; QL (90 grams per 30 days)
ery external pad	1 or 1b*	QL (2 pads per 1 day)
ERYGEL EXTERNAL GEL (*erythromycin*)	3	QL (60 grams per 30 days)
erythromycin external gel	1 or 1b*	QL (60 grams per 30 days)
erythromycin external solution	1 or 1b*	QL (60 mL per 30 days)
KLARON EXTERNAL LOTION (*sulfacetamide sodium (acne)*)	3	
sulfacetamide sodium (acne) external lotion	1 or 1b*	
ACNE COMBINATIONS - DRUGS FOR THE SKIN**		
adapalene-benzoyl peroxide external gel 0.1-2.5 %	1 or 1b*	PA; QL (45 grams per 30 days)
adapalene-benzoyl peroxide external gel 0.3-2.5 %	1 or 1b*	PA; QL (1.5 grams per 1 day)
benzoyl peroxide-erythromycin external gel	1 or 1b*	QL (2 packets per 1 day)
clindamycin phos-benzoyl perox external gel 1.2-5 %	1 or 1b*	QL (45 grams per 30 days)
clindamycin phos-benzoyl perox external gel 1-5 %, 1.2-2.5 %	1 or 1b*	QL (50 grams per 30 days)
clindamycin-tretinoin external gel	3	PA; QL (60 grams per 30 days)
neuac external gel	1 or 1b*	QL (45 grams per 30 days)
ONEXTON EXTERNAL GEL (*clindamycin phos-benzoyl perox*)	1 or 1b*	QL (50 grams per 30 days)
ACNE PRODUCTS - DRUGS FOR THE SKIN**		
ABSORICA LD ORAL CAPSULE (*isotretinoin micronized*)	3	PA
ABSORICA ORAL CAPSULE (*isotretinoin*)	3	PA
accutane oral capsule	2	PA
adapalene external cream	1 or 1b*	PA; QL (1.5 grams per 1 day)
adapalene external gel	1 or 1b*	PA; QL (45 grams per 30 days)
adapalene external pad	1 or 1b*	PA; QL (1 swab per 1 day)
amnesteem oral capsule	2	PA
claravis oral capsule	2	PA
isotretinoin oral capsule	2	PA
RETIN-A MICRO EXTERNAL GEL (*tretinoin microsphere*)	3	PA; QL (50 grams per 30 days)
RETIN-A MICRO PUMP EXTERNAL GEL (*tretinoin microsphere*)	3	PA; QL (50 grams per 30 days)
tretinoin external cream	1 or 1b*	PA; QL (45 grams per 30 days)
tretinoin external gel	1 or 1b*	PA; QL (45 grams per 30 days)
tretinoin microsphere external gel 0.04 %, 0.1 %	1 or 1b*	PA; QL (50 grams per 30 days)
tretinoin microsphere external gel 0.08 %	1 or 1b*	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
tretinoin microsphere pump external gel	1 or 1b*	PA; QL (50 grams per 30 days)
WINLEVI EXTERNAL CREAM (*clascoterone*)	2	PA; QL (60 grams per 30 days)
zenatane oral capsule	2	PA
AGENTS FOR EXTERNAL GENITAL AND PERIANAL WARTS - DRUGS FOR THE SKIN**		
VEREGEN EXTERNAL OINTMENT (*sinecatechins*)	3	QL (30 grams per 28 days)
AGENTS FOR FACIAL WRINKLES - RETINOIDS - DRUGS FOR THE SKIN**		
RENOVA EXTERNAL CREAM (*tretinoin (facial wrinkles)*)	3	PA; QL (60 grams per 30 days)
RENOVA PUMP EXTERNAL CREAM (*tretinoin (facial wrinkles)*)	3	PA; QL (60 grams per 30 days)
ALOPECIA AGENTS - JANUS KINUS (JAK) INHIBITORS - DRUGS FOR THE SKIN**		
LITFULO ORAL CAPSULE (*ritlecitinib tosylate*)	3	
ANTIBIOTIC STEROID COMBINATIONS - TOPICAL - DRUGS FOR THE SKIN**		
NEO-SYNALAR EXTERNAL CREAM (*neomycin-fluocinolone*)	3	
ANTIBIOTICS - TOPICAL - DRUGS FOR THE SKIN**		
ALTABAX EXTERNAL OINTMENT (*retapamulin*)	2	QL (30 grams per 1 fill)
gentamicin sulfate external cream	1 or 1b*	QL (30 grams per 1 fill)
gentamicin sulfate external ointment	1 or 1b*	QL (30 grams per 1 fill)
mupirocin external ointment	1 or 1b*	QL (30 grams per 1 fill)
XEPI EXTERNAL CREAM (*ozenoxacin*)	3	QL (45 grams per 1 fill)
ANTIFUNGALS - TOPICAL COMBINATIONS - DRUGS FOR THE SKIN**		
clotrimazole-betamethasone external cream	1 or 1b*	QL (180 grams per 30 days)
clotrimazole-betamethasone external lotion	1 or 1b*	QL (120 mL per 30 days)
FUNGIMEZ EXTERNAL SOLUTION	3	
miconazole-zinc oxide-petrolat external ointment	1 or 1b*	QL (50 grams per 30 days)
MYCOZYL HC EXTERNAL LIQUID (*tolnaftate-hydrocortisone*)	3	
nystatin-triamcinolone external cream	1 or 1b*	QL (120 grams per 30 days)
nystatin-triamcinolone external ointment	1 or 1b*	QL (120 grams per 30 days)
VUSION EXTERNAL OINTMENT (*miconazole-zinc oxide-petrolat*)	3	QL (50 grams per 30 days)
ANTIFUNGALS - TOPICAL - DRUGS FOR THE SKIN**		
ciclodan external solution	1 or 1b*	QL (7 mL per 30 days)
ciclopirox external gel	1 or 1b*	QL (100 grams per 30 days)
ciclopirox external shampoo	1 or 1b*	QL (120 mL per 30 days)
ciclopirox external solution	1 or 1b*	QL (7 mL per 30 days)
ciclopirox olamine external cream	1 or 1b*	QL (90 grams per 30 days)
ciclopirox olamine external suspension	1 or 1b*	QL (60 mL per 30 days)
naftifine hcl external cream 1 %	1 or 1b*	ST; QL (90 grams per 30 days)
naftifine hcl external cream 2 %	1 or 1b*	ST; QL (60 grams per 30 days)
naftifine hcl external gel	1 or 1b*	ST; QL (60 grams per 30 days)
NAFTIN EXTERNAL GEL 1 % (*naftifine hcl*)	3	ST; QL (90 grams per 30 days)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NAFTIN EXTERNAL GEL 2 % (*naftifine hcl*)	3	ST; QL (60 grams per 30 days)
nyamyc external powder	1 or 1b*	QL (60 grams per 30 days)
nystatin external cream	1 or 1b*	QL (120 grams per 30 days)
nystatin external ointment	1 or 1b*	QL (120 grams per 30 days)
nystatin external powder	1 or 1b*	QL (60 grams per 30 days)
nystop external powder	1 or 1b*	QL (60 grams per 30 days)
ANTINEOPLASTIC ALKYLATING AGENTS - TOPICAL - DRUGS FOR THE SKIN**		
VALCHLOR EXTERNAL GEL (*mechlorethamine hcl (topical)*)	3	PA; LD; QL (1 tube per 30 days)
ANTINEOPLASTIC ANTIMETABOLITES - TOPICAL - DRUGS FOR THE SKIN**		
CARAC EXTERNAL CREAM (*fluorouracil*)	3	ST; QL (30 gm per 365 days)
EFUDEX EXTERNAL CREAM (*fluorouracil*)	3	ST; QL (40 gm per 365 days)
fluorouracil external cream 0.5 %	1 or 1b*	ST; QL (30 gm per 365 days)
fluorouracil external cream 5 %	1 or 1b*	QL (40 gm per 365 days)
fluorouracil external solution	1 or 1b*	QL (10 mL per 365 days)
TOLAK EXTERNAL CREAM (*fluorouracil*)	3	ST; QL (40 gm per 365 days)
ANTINEOPLASTIC OR PREMALIGNANT LESIONS - TOPICAL NSAID'S - DRUGS FOR THE SKIN**		
diclofenac sodium external gel	1 or 1b*	PA; QL (300 grams per 1 year)
ANTINEOPLASTIC RETINOIDS - TOPICAL - DRUGS FOR THE SKIN**		
PANRETIN EXTERNAL GEL (*alitretinoin*)	3	SP
ANTIPRURITICS - TOPICAL - DRUGS FOR THE SKIN**		
doxepin hcl external cream	1 or 1b*	PA; QL (1 tube per 1 fill)
ANTIPSORIATIC COMBINATIONS - DRUGS FOR THE SKIN**		
calsodore external kit	1 or 1b*	
ANTIPSORIATICS - SYSTEMIC - DRUGS FOR THE SKIN**		
acitretin oral capsule 10 mg, 17.5 mg	1 or 1b*	QL (1 capsule per 1 day)
acitretin oral capsule 25 mg	1 or 1b*	QL (2 capsules per 1 day)
COSENTYX (300 MG DOSE) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (*secukinumab*)	4	PA; LD; QL (2 syringes per 28 days); SP
COSENTYX SENSOREADY (300 MG) SUBCUTANEOUS SOLUTION AUTO-INJECTOR (*secukinumab*)	4	PA; LD; QL (2 pens per 28 days); SP
COSENTYX SENSOREADY PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR (*secukinumab*)	4	PA; LD; QL (1 pen per 28 days); SP
COSENTYX SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (*secukinumab*)	4	PA; LD; QL (1 syringe per 28 days); SP
COSENTYX UNOREADY SUBCUTANEOUS SOLUTION AUTO-INJECTOR (*secukinumab*)	4	PA; LD; QL (1 pen per 28 days); SP
methoxsalen rapid oral capsule	1 or 1b*	SP
SKYRIZI PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR (*risankizumab-rzaa*)	4	PA; QL (1 unit per 12 weeks); SP

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SKYRIZI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (*risankizumab-rzaa*)	4	PA; QL (1 unit per 12 weeks); SP
SPEVIGO INTRAVENOUS SOLUTION (*spesolimab-sbzo*)	4	PA; LD; QL (2 vials per 1 year)
STELARA SUBCUTANEOUS SOLUTION (*ustekinumab*)	4	PA; LD; QL (1 unit per 12 weeks); SP
STELARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5ML (*ustekinumab*)	4	PA; LD; QL (1 unit per 12 weeks); SP
STELARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 90 MG/ML (*ustekinumab*)	4	PA; LD; QL (1 syringe per 12 weeks); SP
TREMFYA SUBCUTANEOUS SOLUTION PEN-INJECTOR (*guselkumab*)	4	PA; QL (1 mL per 56 days); SP
TREMFYA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (*guselkumab*)	4	PA; QL (1 mL per 56 days); SP
ANTIPSORIATICS - DRUGS FOR THE SKIN**		
calcipotriene external cream	1 or 1b*	QL (120 grams per 30 days)
calcipotriene external ointment	1 or 1b*	QL (120 grams per 30 days)
calcipotriene external solution	1 or 1b*	QL (60 mL per 30 days)
calcitrene external ointment	1 or 1b*	QL (120 grams per 30 days)
calcitriol external ointment	1 or 1b*	QL (800 grams per 28 days)
tazarotene external cream	1 or 1b*	QL (60 grams per 30 days)
tazarotene external gel	1 or 1b*	QL (100 grams per 30 days)
TAZORAC EXTERNAL CREAM (*tazarotene*)	2	QL (60 grams per 30 days)
TAZORAC EXTERNAL GEL (*tazarotene*)	3	QL (100 grams per 30 days)
ZORYVE EXTERNAL CREAM (*roflumilast*)	3	PA; QL (60 grams per 30 days)
ANTISEBORRHEIC PRODUCTS - DRUGS FOR THE SKIN**		
selenium sulfide external lotion	1 or 1a*	QL (120 mL per 30 days)
ANTIVIRAL TOPICAL COMBINATIONS - DRUGS FOR THE SKIN**		
XERESE EXTERNAL CREAM (*acyclovir-hydrocortisone*)	3	PA; QL (5 gm per 30 days)
ANTIVIRALS - TOPICAL - DRUGS FOR THE SKIN**		
acyclovir external cream	1 or 1b*	PA; QL (5 gm per 30 days)
acyclovir external ointment	1 or 1b*	QL (30 gm per 30 days)
DENAVIR EXTERNAL CREAM (*penciclovir*)	3	PA; QL (5 gm per 30 days)
penciclovir external cream	1 or 1b*	PA; QL (5 gm per 30 days)
ZOVIRAX EXTERNAL OINTMENT (*acyclovir*)	3	QL (30 gm per 30 days)
ATOPIC DERMATITIS - JANUS KINASE (JAK) INHIBITORS - DRUGS FOR THE SKIN**		
OPZELURA EXTERNAL CREAM (*ruxolitinib phosphate*)	3	PA; QL (1 tube per 30 days)
ATOPIC DERMATITIS - MONOCLONAL ANTIBODIES - DRUGS FOR THE SKIN**		
DUPIXENT SUBCUTANEOUS SOLUTION PEN-INJECTOR (*dupilumab*)	4	PA; SP
DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (*dupilumab*)	4	PA; SP

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BURN PRODUCTS - DRUGS FOR THE SKIN**		
mafenide acetate external packet	1 or 1b*	
SILVADENE EXTERNAL CREAM (*silver sulfadiazine*)	3	
silver sulfadiazine external cream	1 or 1a*	
ssd external cream	1 or 1a*	
SULFAMYLON EXTERNAL CREAM (*mafenide acetate*)	3	
SULFAMYLON EXTERNAL PACKET (*mafenide acetate*)	3	
CORTICOSTEROIDS - TOPICAL - DRUGS FOR THE SKIN**		
ala-cort external cream	1 or 1a*	QL (454 grams per 30 days)
alclometasone dipropionate external cream	1 or 1b*	QL (60 grams per 30 days)
alclometasone dipropionate external ointment	1 or 1b*	QL (2 grams per 1 day)
betamethasone dipropionate aug external cream	1 or 1b*	QL (50 grams per 30 days)
betamethasone dipropionate aug external gel	1 or 1b*	QL (50 grams per 30 days)
betamethasone dipropionate aug external lotion	1 or 1b*	QL (60 mL per 30 days)
betamethasone dipropionate aug external ointment	1 or 1b*	QL (50 grams per 30 days)
betamethasone dipropionate external cream	1 or 1b*	QL (45 grams per 30 days)
betamethasone dipropionate external lotion	1 or 1b*	QL (60 mL per 30 days)
betamethasone dipropionate external ointment	1 or 1b*	QL (45 grams per 30 days)
betamethasone valerate external cream	1 or 1b*	QL (45 grams per 30 days)
betamethasone valerate external foam	3	ST; QL (100 grams per 30 days)
betamethasone valerate external lotion	1 or 1b*	QL (60 mL per 30 days)
betamethasone valerate external ointment	1 or 1b*	QL (45 grams per 30 days)
clobetasol prop emollient base external cream	1 or 1b*	QL (60 grams per 30 days)
clobetasol propionate e external cream	1 or 1b*	QL (60 grams per 30 days)
clobetasol propionate emulsion external foam	1 or 1b*	QL (100 grams per 30 days)
clobetasol propionate external cream	1 or 1b*	QL (60 grams per 30 days)
clobetasol propionate external foam	1 or 1b*	QL (100 mL per 30 days)
clobetasol propionate external gel	1 or 1b*	QL (60 grams per 30 days)
clobetasol propionate external liquid	1 or 1b*	QL (125 mL per 30 days)
clobetasol propionate external lotion	1 or 1b*	QL (118 mL per 30 days)
clobetasol propionate external ointment	1 or 1b*	QL (60 grams per 30 days)
clobetasol propionate external shampoo	1 or 1b*	QL (3.94 mL per 1 day)
clobetasol propionate external solution	1 or 1b*	QL (50 mL per 30 days)
clocortolone pivalate external cream	3	ST; QL (90 grams per 30 days)
clodan external shampoo	1 or 1b*	QL (3.94 mL per 1 day)
desonide external cream	1 or 1b*	QL (60 grams per 30 days)
desonide external gel	1 or 1b*	QL (2 grams per 1 day)
desonide external lotion	1 or 1b*	QL (118 mL per 30 days)
desonide external ointment	1 or 1b*	QL (60 grams per 30 days)
desoximetasone external cream	3	ST; QL (100 grams per 30 days)
desoximetasone external gel	3	ST; QL (60 grams per 30 days)

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
desoximetasone external liquid	3	ST; QL (100 mL per 30 days)
desoximetasone external ointment	3	ST; QL (100 grams per 30 days)
diflorasone diacetate external cream	3	ST; QL (60 grams per 30 days)
diflorasone diacetate external ointment	3	ST; QL (60 grams per 30 days)
fluocinolone acetonide body external oil	1 or 1b*	QL (120 mL per 30 days)
fluocinolone acetonide external cream 0.01 %	1 or 1b*	QL (60 grams per 30 days)
fluocinolone acetonide external cream 0.025 %	1 or 1b*	QL (120 grams per 30 days)
fluocinolone acetonide external ointment	1 or 1b*	QL (120 grams per 30 days)
fluocinolone acetonide external solution	1 or 1b*	QL (90 mL per 30 days)
fluocinolone acetonide scalp external oil	1 or 1b*	QL (120 mL per 30 days)
fluocinonide emulsified base external cream	1 or 1b*	QL (60 grams per 30 days)
fluocinonide external cream	1 or 1b*	QL (120 grams per 30 days)
fluocinonide external gel	1 or 1b*	QL (60 grams per 30 days)
fluocinonide external ointment	1 or 1b*	QL (60 grams per 30 days)
fluocinonide external solution	1 or 1b*	QL (60 mL per 30 days)
flurandrenolide external cream	3	ST; QL (120 grams per 30 days)
flurandrenolide external lotion	3	ST; QL (120 mL per 30 days)
fluticasone propionate external cream	1 or 1b*	QL (60 grams per 30 days)
fluticasone propionate external lotion	1 or 1b*	QL (120 mL per 30 days)
fluticasone propionate external ointment	1 or 1b*	QL (60 grams per 30 days)
halcinonide external cream	3	ST; QL (60 grams per 30 days)
halobetasol propionate external cream	1 or 1b*	QL (50 grams per 30 days)
halobetasol propionate external ointment	1 or 1b*	QL (50 grams per 30 days)
hydrocortisone butyr lipo base external cream	3	ST; QL (60 grams per 30 days)
hydrocortisone butyrate external cream	3	ST; QL (60 grams per 30 days)
hydrocortisone butyrate external lotion	3	ST; QL (3.94 mL per 1 day)
hydrocortisone butyrate external ointment	3	ST; QL (60 grams per 30 days)
hydrocortisone butyrate external solution	3	ST; QL (60 mL per 30 days)
hydrocortisone external cream	1 or 1a*	QL (454 grams per 30 days)
hydrocortisone external lotion	1 or 1a*	QL (118 mL per 30 days)
hydrocortisone external ointment	1 or 1a*	QL (454 grams per 30 days)
hydrocortisone valerate external cream	3	ST; QL (60 grams per 30 days)
hydrocortisone valerate external ointment	3	ST; QL (60 grams per 30 days)
mometasone furoate external cream	1 or 1b*	QL (50 grams per 30 days)
mometasone furoate external ointment	1 or 1b*	QL (50 grams per 30 days)
mometasone furoate external solution	1 or 1b*	QL (60 mL per 30 days)
tovet external foam	1 or 1b*	QL (100 grams per 30 days)
triamcinolone acetonide external aerosol solution	3	ST; QL (100 grams per 30 days)
triamcinolone acetonide external cream	1 or 1a*	QL (454 grams per 30 days)
triamcinolone acetonide external lotion	1 or 1a*	QL (60 mL per 30 days)
triamcinolone acetonide external ointment 0.025 %, 0.1 %	1 or 1a*	QL (454 grams per 30 days)

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
triamcinolone acetonide external ointment 0.05 %	3	ST; QL (430 grams per 30 days)
triamcinolone acetonide external ointment 0.5 %	1 or 1a*	QL (30 grams per 30 days)
triamcinolone in absorbase external ointment	3	ST; QL (430 grams per 30 days)
triderm external cream	1 or 1a*	QL (454 grams per 30 days)
DEPIGMENTING COMBINATIONS - DRUGS FOR THE SKIN**		
TRI-LUMA EXTERNAL CREAM (*fluocin-hydroquinone-tretinoin*)	3	
EMOLLIENTS - DRUGS FOR THE SKIN**		
ammonium lactate external cream	1 or 1b*	QL (450 grams per 30 days)
ammonium lactate external lotion	1 or 1b*	
ENZYMES - TOPICAL - DRUGS FOR THE SKIN**		
NEXOBRID EXTERNAL GEL (*anacaulase-bcdb*)	3	PA; QL (440 grams per 2 days)
SANTYL EXTERNAL OINTMENT (*collagenase*)	3	PA; QL (30 grams per 30 days)
GLABELLAR LINES (FROWN LINES) AGENTS - DRUGS FOR THE SKIN**		
BOTOX COSMETIC INTRAMUSCULAR SOLUTION RECONSTITUTED (*onabotulinumtoxina (cosmetic)*)	4	PA
JEUVEAU INTRAMUSCULAR SOLUTION RECONSTITUTED (*prabotulinumtoxina-xvfs (cosm)*)	3	
IMIDAZOLE-RELATED ANTIFUNGALS - TOPICAL - DRUGS FOR THE SKIN**		
econazole nitrate external cream	1 or 1b*	QL (85 grams per 30 days)
ECOZA EXTERNAL FOAM (*econazole nitrate*)	3	ST; QL (70 grams per 30 days)
ERTACZO EXTERNAL CREAM (*sertaconazole nitrate*)	3	ST; QL (60 grams per 30 days)
EXELDERM EXTERNAL CREAM (*sulconazole nitrate*)	3	ST; QL (60 grams per 30 days)
EXELDERM EXTERNAL SOLUTION (*sulconazole nitrate*)	3	ST; QL (60 mL per 30 days)
JUBLIA EXTERNAL SOLUTION (*efinaconazole*)	3	QL (8 mL per 30 days)
ketoconazole external cream	1 or 1b*	QL (120 grams per 30 days)
ketoconazole external foam	3	QL (100 grams per 30 days)
ketoconazole external shampoo	1 or 1b*	QL (120 mL per 30 days)
ketodan external foam	3	QL (100 grams per 30 days)
luliconazole external cream	1 or 1b*	ST; QL (60 grams per 30 days)
LUZU EXTERNAL CREAM (*luliconazole*)	3	ST; QL (60 grams per 30 days)
oxiconazole nitrate external cream	3	ST; QL (90 grams per 30 days)
OXISTAT EXTERNAL CREAM (*oxiconazole nitrate*)	3	ST; QL (90 grams per 30 days)
OXISTAT EXTERNAL LOTION (*oxiconazole nitrate*)	3	ST; QL (60 mL per 30 days)
sulconazole nitrate external cream	1 or 1b*	ST; QL (60 grams per 30 days)
sulconazole nitrate external solution	1 or 1b*	ST; QL (60 mL per 30 days)
IMMUNOMODULATORS IMIDAZOQUINOLINAMINES - TOPICAL - DRUGS FOR THE SKIN**		
imiquimod external cream 3.75 %	1 or 1b*	ST; QL (28 units per 28 days)
imiquimod external cream 5 %	1 or 1b*	QL (48 packet per 365 days)
imiquimod pump external cream	1 or 1b*	ST; QL (1 pump bottle per 28 days)
ZYCLARA EXTERNAL CREAM (*imiquimod*)	3	ST; QL (28 units per 28 days)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ZYCLARA PUMP EXTERNAL CREAM 2.5 % (*imiquimod*)	3	ST; QL (1 pump bottle per 28 days)
ZYCLARA PUMP EXTERNAL CREAM 3.75 % (*imiquimod*)	3	ST; QL (1 bottle per 28 days)
KERATOLYTIC/ANTIMITOTIC AGENTS - DRUGS FOR THE SKIN**		
CONDYLOX EXTERNAL GEL (*podofilox*)	3	QL (7 grams per 28 days)
podofilox external gel	1 or 1b*	
podofilox external solution	1 or 1b*	QL (7 mL per 28 days)
SALYCIM EXTERNAL CREAM (*salicylic acid*)	3	
YCANTH EXTERNAL SOLUTION (*cantharidin*)	3	PA; QL (12 applicators per 84 days)
LINIMENTS - DRUGS FOR THE SKIN**		
TURPENTINE EXTERNAL SPIRIT	3	
LOCAL ANESTHETICS - TOPICAL - DRUGS FOR THE SKIN**		
glydo external prefilled syringe	1 or 1b*	
lidocaine external patch	1 or 1b*	PA; QL (3 patches per 1 day)
lidocaine hcl external solution	1 or 1b*	QL (10 mL per 1 day)
lidocaine hcl urethral/mucosal external prefilled syringe	1 or 1b*	
lidocaine (Lidocan External Patch)	1 or 1b*	PA; QL (3 patches per 1 day)
lidocaine (Lidocan Iii External Patch)	1 or 1b*	
ZTLIDO EXTERNAL PATCH (*lidocaine*)	2	PA; QL (3 patches per 1 day)
MACROLIDE IMMUNOSUPPRESSANTS - TOPICAL - DRUGS FOR THE SKIN**		
HYFTOR EXTERNAL GEL (*sirolimus*)	3	PA; QL (1 tube per 30 days)
pimecrolimus external cream	1 or 1b*	ST; QL (100 grams per 30 days)
tacrolimus external ointment	1 or 1b*	ST; QL (100 grams per 30 days)
MELANOCORTIN RECEPTOR AGONISTS (UV PROTECTIVE) - DRUGS FOR THE SKIN**		
SCENESSE SUBCUTANEOUS IMPLANT (*afamelanotide acetate*)	3	PA; LD; QL (1 implant per 2 monthss)
MICROTUBULE INHIBITORS - TOPICAL - DRUGS FOR THE SKIN**		
KLISYRI EXTERNAL OINTMENT (*tirbanibulin*)	3	ST; QL (5 packets per 1 fill)
MISC. DERMATOLOGICAL PRODUCTS - DRUGS FOR THE SKIN**		
ILIDERM EXTERNAL EMULSION	3	
MISC. TOPICAL - DRUGS FOR THE SKIN**		
QBREXZA EXTERNAL PAD (*glycopyrronium tosylate*)	3	PA; QL (1 cloth per 1 day)
OXABOROLE-RELATED ANTIFUNGALS - TOPICAL - DRUGS FOR THE SKIN**		
tavaborole external solution	1 or 1b*	ST; QL (1 bottle per 30 days)
PHOSPHODIESTERASE 4 (PDE4) INHIBITORS - TOPICAL - DRUGS FOR THE SKIN**		
EUCRISA EXTERNAL OINTMENT (*crisaborole*)	3	ST; QL (100 grams per 30 days)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PHOTODYNAMIC THERAPY AGENTS - TOPICAL - DRUGS FOR THE SKIN**		
AMELUZ EXTERNAL GEL (*aminolevulinic acid hcl*)	3	
LEVULAN KERASTICK EXTERNAL SOLUTION RECONSTITUTED (*aminolevulinic acid hcl*)	3	
PROSTAGLANDINS - TOPICAL - DRUGS FOR THE SKIN**		
bimatoprost external solution	1 or 1b*	
LATISSE EXTERNAL SOLUTION (*bimatoprost*)	3	
ROSACEA AGENTS - DRUGS FOR THE SKIN**		
azelaic acid external gel	1 or 1b*	QL (50 grams per 30 days)
brimonidine tartrate external gel	1 or 1b*	QL (30 grams per 30 days)
FINACEA EXTERNAL FOAM (*azelaic acid*)	2	QL (1.67 grams per 1 day)
ivermectin external cream	1 or 1b*	QL (45 grams per 30 days)
METROCREAM EXTERNAL CREAM (*metronidazole*)	3	ST; QL (45 grams per 30 days)
metronidazole external cream	1 or 1b*	QL (45 grams per 30 days)
metronidazole external gel 0.75 %	1 or 1b*	QL (45 grams per 30 days)
metronidazole external gel 1 %	1 or 1b*	QL (60 grams per 30 days)
metronidazole external lotion	1 or 1b*	QL (59 mL per 30 days)
MIRVASO EXTERNAL GEL (*brimonidine tartrate*)	3	QL (30 grams per 30 days)
RHOFADE EXTERNAL CREAM (*oxymetazoline hcl*)	3	QL (30 grams per 30 days)
SOOLANTRA EXTERNAL CREAM (*ivermectin*)	2	QL (45 grams per 30 days)
ZILXI EXTERNAL FOAM (*minocycline hcl micronized*)	2	QL (1 gram per 1 day)
SCABICIDES & PEDICULICIDES - DRUGS FOR THE SKIN**		
crotan external lotion	1 or 1b*	QL (60 mL per 30 days)
malathion external lotion	1 or 1b*	QL (4 mL per 1 day)
NATROBA EXTERNAL SUSPENSION (*spinosad*)	3	QL (120 mL per 7 days)
OVIDE EXTERNAL LOTION (*malathion*)	3	QL (4 mL per 1 day)
permethrin external cream	1 or 1b*	QL (120 grams per 30 days)
spinosad external suspension	1 or 1b*	QL (120 mL per 7 days)
SCAR TREATMENT PRODUCTS - DRUGS FOR THE SKIN**		
COPASIL EXTERNAL GEL (*scar treatment products*)	3	
***SEBORRHEIC KERATOSIS PRODUCTS** - DRUGS FOR THE SKIN**		
ESKATA EXTERNAL SOLUTION (*hydrogen peroxide*)	3	
STEROID-LOCAL ANESTHETIC COMBINATIONS - DRUGS FOR THE SKIN**		
EPIFOAM EXTERNAL FOAM (*pramoxine-hc*)	3	
PRAMOSONE EXTERNAL CREAM (*pramoxine-hc*)	2	
PRAMOSONE EXTERNAL LOTION (*pramoxine-hc*)	2	
TAR PRODUCTS - DRUGS FOR THE SKIN**		
coal tar external solution	1 or 1b*	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TISSUE REPLACEMENTS - DRUGS FOR THE SKIN**		
AMNIOFIX INJECTION SUSPENSION RECONSTITUTED (*amniotic membrane allograft*)	3	
AMNIOTEXT EXTERNAL SHEET (*amniotic membrane allograft*)	3	
AMPHENOL-40 INJECTION SUSPENSION RECONSTITUTED	3	
EPICORD EXTERNAL SHEET (*umbilical cord allograft*)	3	
EPIFIX EXTERNAL DISK (*amniotic membrane allograft*)	3	
EPIFIX EXTERNAL SHEET (*amniotic membrane allograft*)	3	
EPIFIX MICRONIZED INJECTION SUSPENSION RECONSTITUTED (*amniotic membrane allograft*)	3	
KARDIAMEMBRANE EXTERNAL SHEET (*amniotic membrane allograft*)	3	
NEOX 100 EXTERNAL SHEET (*amniotic membrane allograft*)	3	
NEOX CORD 1K EXTERNAL SHEET (*amniotic membrane allograft*)	3	
PALINGEN FLOW INJECTION INJECTABLE (*amniotic memb-fluid allograft*)	3	
PALINGEN HYDROMEMBRANE EXTERNAL SHEET (*amniotic membrane allograft*)	3	
PALINGEN INOVOFLO INJECTION INJECTABLE (*amniotic fluid allograft*)	3	
PALINGEN MEMBRANE EXTERNAL SHEET (*amniotic membrane allograft*)	3	
PALINGEN XPLUS HYDROMEMBRANE EXTERNAL SHEET (*amniotic membrane allograft*)	3	
PALINGEN XPLUS MEMBRANE EXTERNAL SHEET (*amniotic membrane allograft*)	3	
STRATAGRAFT EXTERNAL SHEET (*keratinocyte-fibroblast-dsat*)	3	
STRAVIX EXTERNAL SHEET (*amniotic membrane allograft*)	3	
TRUSKIN EXTERNAL SHEET (*skin allograft (human)*)	3	
TOPICAL ANESTHETIC COMBINATIONS - DRUGS FOR THE SKIN**		
emreal external kit	3	
lidocaine-prilocaine external cream	1 or 1b*	QL (30 grams per 30 days)
lidocaine-prilocaine external kit	1 or 1b*	QL (1 kit per 30 days)
lidolite external kit	3	
lidosol external kit	3	
lidosol-50 external kit	3	
LM PLUS RELIEF EXTERNAL PATCH (*lidocaine-menthol*)	3	
VENIPUNCTURE PX1 PHLEBOTOMY EXTERNAL KIT (*lidocaine hcl-blood collection*)	3	
TOPICAL SELECTIVE RETINOID X RECEPTOR AGONISTS - DRUGS FOR THE SKIN**		
bexarotene external gel	1 or 1b*	PA; QL (60 grams per 30 days); SP
TARGRETIN EXTERNAL GEL (*bexarotene*)	3	PA; QL (60 grams per 30 days); SP

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL STEROID COMBINATIONS - DRUGS FOR THE SKIN**		
calcipotriene-betameth diprop external ointment	2	ST; QL (400 grams per 28 days)
calcipotriene-betameth diprop external suspension	2	ST; QL (420 grams per 28 days)
DUOBRII EXTERNAL LOTION (*halobetasol prop-tazarotene*)	3	PA; QL (200 grams per 30 days)
ENSTILAR EXTERNAL FOAM (*calcipotriene-betameth diprop*)	3	QL (420 grams per 28 days)
TACLONEX EXTERNAL SUSPENSION (*calcipotriene-betameth diprop*)	3	ST; QL (420 grams per 28 days)
TYPE II 5-ALPHA REDUCTASE INHIBITORS - DRUGS FOR THE SKIN**		
finasteride oral tablet	1 or 1b*	
PROPECIA ORAL TABLET (*finasteride*)	3	
WOUND CARE - GROWTH FACTOR AGENTS - DRUGS FOR THE SKIN**		
REGRANEX EXTERNAL GEL (*becaplermin*)	3	QL (15 grams per 30 days)
WOUND CLEANSERS/DECUBITUS ULCER THERAPY - DRUGS FOR THE SKIN**		
LAVARE WOUND WASH EXTERNAL GEL	3	
WOUND DRESSINGS - DRUGS FOR THE SKIN**		
KENDALL HYDROGEL WOUND DRESS EXTERNAL (*hydroactive dressings*)	3	
DIAGNOSTIC PRODUCTS		
DIAGNOSTIC TESTS**		
ACCUTREND GLUCOSE IN VITRO STRIP (*glucose blood*)	2	QL (204 strips per 30 days)
FREESTYLE INSULINX TEST IN VITRO STRIP (*glucose blood*)	2	QL (204 strips per 30 days)
FREESTYLE LITE TEST IN VITRO STRIP (*glucose blood*)	2	QL (204 strips per 30 days)
FREESTYLE PRECISION NEO TEST IN VITRO STRIP (*glucose blood*)	2	QL (204 strips per 30 days)
FREESTYLE TEST IN VITRO STRIP (*glucose blood*)	2	QL (204 strips per 30 days)
ONETOUCH ULTRA IN VITRO STRIP (*glucose blood*)	2	QL (204 strips per 30 days)
ONETOUCH VERIO IN VITRO STRIP (*glucose blood*)	2	QL (204 strips per 30 days)
***DIGESTIVE AIDS* - DRUGS FOR THE STOMACH**		
DIGESTIVE ENZYMES - DRUGS FOR THE STOMACH**		
CREON ORAL CAPSULE DELAYED RELEASE PARTICLES (*pancrelipase (lip-prot-amyl)*)	2	QL (25 capsules per 1 day)
PANCREAZE ORAL CAPSULE DELAYED RELEASE PARTICLES (*pancrelipase (lip-prot-amyl)*)	3	ST; QL (25 capsules per 1 day)
PERTZYE ORAL CAPSULE DELAYED RELEASE PARTICLES (*pancrelipase (lip-prot-amyl)*)	3	ST; QL (25 capsules per 1 day)
SUCRAID ORAL SOLUTION (*sacrosidase*)	4	PA; LD; QL (360 mL per 30 days)
VIOKACE ORAL TABLET (*pancrelipase (lip-prot-amyl)*)	2	QL (25 tablets per 1 day)
ZENPEP ORAL CAPSULE DELAYED RELEASE PARTICLES 10000-32000 UNIT, 15000-47000 UNIT, 20000-63000 UNIT, 25000-79000 UNIT, 3000-10000 UNIT, 40000-126000 UNIT, 5000-24000 UNIT (*pancrelipase (lip-prot-amyl)*)	2	QL (25 capsules per 1 day)
ZENPEP ORAL CAPSULE DELAYED RELEASE PARTICLES 60000-189600 UNIT (*pancrelipase (lip-prot-amyl)*)	2	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
***DIURETICS* - DRUGS FOR THE HEART**		
CARBONIC ANHYDRASE INHIBITORS - DRUGS FOR HIGH BLOOD PRESSURE**		
acetazolamide er oral capsule extended release 12 hour	1 or 1b*	
acetazolamide oral tablet	1 or 1b*	
acetazolamide sodium injection solution reconstituted	1 or 1b*	
dichlorphenamide oral tablet	4	PA; LD; QL (4 tablet per 1 day)
methazolamide oral tablet	1 or 1b*	
DIURETIC COMBINATIONS - DRUGS FOR HIGH BLOOD PRESSURE**		
amiloride-hydrochlorothiazide oral tablet	1 or 1b*	
MAXZIDE ORAL TABLET (*triamterene-hctz*)	3	
MAXZIDE-25 ORAL TABLET (*triamterene-hctz*)	3	
spironolactone-hctz oral tablet	1 or 1b*	
triamterene-hctz oral capsule	1 or 1a*	
triamterene-hctz oral tablet	1 or 1a*	
LOOP DIURETICS - DRUGS FOR HIGH BLOOD PRESSURE**		
bumetanide injection solution	1 or 1b*	
bumetanide oral tablet	1 or 1b*	
BUMEX ORAL TABLET (*bumetanide*)	3	
EDECRIN ORAL TABLET (*ethacrynic acid*)	3	
ethacrynate sodium intravenous solution reconstituted	1 or 1b*	
ethacrynic acid oral tablet	1 or 1b*	
FUROSCIX SUBCUTANEOUS CARTRIDGE KIT (*furosemide*)	4	PA; QL (6 kits per 30 days)
furosemide injection solution	1 or 1a*	
furosemide oral solution	1 or 1a*	
furosemide oral tablet	1 or 1a*	
LASIX ORAL TABLET (*furosemide*)	3	
SODIUM EDECRIN INTRAVENOUS SOLUTION RECONSTITUTED (*ethacrynate sodium*)	3	
torsemide oral tablet	1 or 1b*	
OSMOTIC DIURETICS - DRUGS FOR HIGH BLOOD PRESSURE**		
mannitol intravenous solution	1 or 1b*	
osmitrol intravenous solution	1 or 1b*	
POTASSIUM SPARING DIURETICS - DRUGS FOR HIGH BLOOD PRESSURE**		
ALDACTONE ORAL TABLET (*spironolactone*)	3	
amiloride hcl oral tablet	1 or 1b*	
CAROSPIR ORAL SUSPENSION (*spironolactone*)	3	
spironolactone oral suspension	1 or 1b*	
spironolactone oral tablet	1 or 1a*	
triamterene oral capsule	1 or 1b*	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
THIAZIDES AND THIAZIDE-LIKE DIURETICS - DRUGS FOR HIGH BLOOD PRESSURE**		
chlorothiazide sodium intravenous solution reconstituted	1 or 1b*	
chlorthalidone oral tablet	1 or 1a*	
DIURIL ORAL SUSPENSION (*chlorothiazide*)	3	
hydrochlorothiazide oral capsule	1 or 1a*	
hydrochlorothiazide oral tablet	1 or 1a*	
indapamide oral tablet	1 or 1b*	
metolazone oral tablet	1 or 1b*	
THALITONE ORAL TABLET (*chlorthalidone*)	3	
***ENDOCRINE AND METABOLIC AGENTS - MISC.* - HORMONES**		
ABORTIFACIENT - PROGESTERONE RECEPTOR ANTAGONISTS - DRUGS FOR WOMEN**		
MIFEPREX ORAL TABLET (*mifepristone*)	3	$0 for Fully insured members in California
mifepristone oral tablet	1 or 1b*	$0 for Fully insured members in California
ACID SPHINGOMYELINASE DEFICIENCY (ASMD) - AGENTS - DRUGS FOR MENOPAUSE AND BONE LOSS**		
XENPOZYME INTRAVENOUS SOLUTION RECONSTITUTED (*olipudase alfa-rpcp*)	4	PA; LD; SP
ADENOSINE DEAMINASE SCID TREATMENT - AGENTS - DRUGS FOR MENOPAUSE AND BONE LOSS**		
REVCOVI INTRAMUSCULAR SOLUTION (*elapegademase-lvlr*)	4	PA; LD
ALPHA-MANNOSIDOSIS TREATMENT - AGENTS - DRUGS FOR MENOPAUSE AND BONE LOSS**		
LAMZEDE INTRAVENOUS SOLUTION RECONSTITUTED (*velmanase alfa-tycv*)	4	PA; LD
BISPHOSPHONATES - DRUGS FOR MENOPAUSE AND BONE LOSS**		
ACTONEL ORAL TABLET 150 MG (*risedronate sodium*)	3	QL (0.04 tablets per 1 day)
ACTONEL ORAL TABLET 35 MG (*risedronate sodium*)	3	QL (4 tablets per 28 days)
alendronate sodium oral solution	1 or 1b*	QL (10.72 mg per 1 day)
alendronate sodium oral tablet 10 mg, 5 mg	1 or 1b*	QL (1 tablet per 1 day)
alendronate sodium oral tablet 35 mg, 70 mg	1 or 1b*	QL (4 tablets per 28 days)
ATELVIA ORAL TABLET DELAYED RELEASE (*risedronate sodium*)	3	QL (4 tablets per 28 days)
BINOSTO ORAL TABLET EFFERVESCENT (*alendronate sodium*)	3	QL (4 tablets per 28 days)
FOSAMAX ORAL TABLET (*alendronate sodium*)	3	QL (4 tablets per 28 days)
FOSAMAX PLUS D ORAL TABLET (*alendronate-cholecalciferol*)	2	QL (0.15 tablets per 1 day)
ibandronate sodium intravenous solution	4	
ibandronate sodium oral tablet	1 or 1b*	QL (1 tablet per 28 days)
pamidronate disodium intravenous solution 30 mg/10ml, 90 mg/10ml	4	SP
PAMIDRONATE DISODIUM INTRAVENOUS SOLUTION 6 MG/ML	4	SP
RECLAST INTRAVENOUS SOLUTION (*zoledronic acid*)	4	PA; QL (100 mL per 375 days); SP

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
risedronate sodium oral tablet 150 mg	1 or 1b*	QL (0.04 tablets per 1 day)
risedronate sodium oral tablet 30 mg, 5 mg	1 or 1b*	QL (1 tablet per 1 day)
risedronate sodium oral tablet 35 mg	1 or 1b*	QL (4 tablets per 28 days)
risedronate sodium oral tablet delayed release	1 or 1b*	QL (4 tablets per 28 days)
zoledronic acid intravenous concentrate	1 or 1b*	PA; SP
ZOLEDRONIC ACID INTRAVENOUS SOLUTION 4 MG/100ML	4	PA; SP
zoledronic acid intravenous solution 5 mg/100ml	4	PA; QL (100 mL per 375 days); SP
CALCIMIMETIC AGENTS - DRUGS FOR MENOPAUSE AND BONE LOSS**		
cinacalcet hcl oral tablet 30 mg, 60 mg	4	PA; QL (2 tablets per 1 day)
cinacalcet hcl oral tablet 90 mg	4	PA; QL (4 tablets per 1 day)
PARSABIV INTRAVENOUS SOLUTION (*etelcalcetide hcl*)	4	PA; LD
CALCITONINS - DRUGS FOR MENOPAUSE AND BONE LOSS**		
calcitonin (salmon) injection solution	4	
calcitonin (salmon) nasal solution	1 or 1b*	QL (0.13 mL per 1 day)
MIACALCIN INJECTION SOLUTION (*calcitonin (salmon)*)	4	
CARNITINE REPLENISHER - AGENTS - DRUGS FOR MENOPAUSE AND BONE LOSS**		
CARNITOR INTRAVENOUS SOLUTION (*levocarnitine*)	3	
CARNITOR ORAL SOLUTION (*levocarnitine*)	3	
CARNITOR ORAL TABLET (*levocarnitine*)	3	
CARNITOR SF ORAL SOLUTION (*levocarnitine*)	3	
levocarnitine intravenous solution	1 or 1b*	
levocarnitine oral solution	1 or 1b*	
levocarnitine oral tablet	1 or 1b*	
levocarnitine sf oral solution	1 or 1b*	
CORTICOTROPIN - HORMONES**		
ACTHAR INJECTION GEL (*corticotropin*)	4	PA; LD; SP
CORTROPHIN INJECTION GEL (*corticotropin*)	4	PA; LD; SP
CORTISOL SYNTHESIS INHIBITORS - HORMONES**		
ISTURISA ORAL TABLET (*osilodrostat phosphate*)	4	PA; LD; QL (4 tablets per 1 day)
DOPAMINE RECEPTOR AGONISTS - DRUGS FOR WOMEN**		
cabergoline oral tablet	1 or 1b*	QL (0.58 tablets per 1 day)
FABRY DISEASE - AGENTS - DRUGS FOR MENOPAUSE AND BONE LOSS**		
ELFABRIO INTRAVENOUS SOLUTION (*pegunigalsidase alfa-iwxj*)	4	PA; LD
FABRAZYME INTRAVENOUS SOLUTION RECONSTITUTED (*agalsidase beta*)	4	PA; LD; SP
GALAFOLD ORAL CAPSULE (*migalastat hcl*)	4	PA; LD; QL (14 capsules per 30 days)

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GAA DEFICIENCY TREATMENT - AGENTS - DRUGS FOR MENOPAUSE AND BONE LOSS**		
LUMIZYME INTRAVENOUS SOLUTION RECONSTITUTED (*alglucosidase alfa*)	4	PA; LD; SP
NEXVIAZYME INTRAVENOUS SOLUTION RECONSTITUTED (*avalglucosidase alfa-ngpt*)	4	PA; LD; SP
GNRH/LHRH ANTAGONISTS - DRUGS FOR WOMEN**		
cetrorelix acetate subcutaneous kit	4	SP
CETROTIDE SUBCUTANEOUS KIT (*cetrorelix acetate*)	4	PA; SP
fyremadel subcutaneous solution prefilled syringe	4	PA; SP
GANIRELIX ACETATE SUBCUTANEOUS SOLUTION PREFILLED SYRINGE	4	PA; SP
ORILISSA ORAL TABLET 150 MG (*elagolix sodium*)	2	PA; QL (1 tablet per 1 day)
ORILISSA ORAL TABLET 200 MG (*elagolix sodium*)	2	PA; QL (2 tablets per 1 day)
GROWTH HORMONE RECEPTOR ANTAGONISTS - DRUGS FOR GROWTH**		
SOMAVERT SUBCUTANEOUS SOLUTION RECONSTITUTED (*pegvisomant*)	4	PA; LD; QL (1 vial per 1 day); SP
GROWTH HORMONE RELEASING HORMONES (GHRH) - DRUGS FOR GROWTH**		
EGRIFTA SV SUBCUTANEOUS SOLUTION RECONSTITUTED (*tesamorelin acetate*)	4	PA; LD; QL (1 package per 30 days)
GROWTH HORMONES - DRUGS FOR GROWTH**		
GENOTROPIN MINIQUICK SUBCUTANEOUS PREFILLED SYRINGE (*somatropin*)	4	PA; QL (1 syringe per 1 day); SP
GENOTROPIN SUBCUTANEOUS CARTRIDGE (*somatropin*)	4	PA; QL (1 vial per 1 day); SP
HUMATROPE INJECTION CARTRIDGE 12 MG, 6 MG (*somatropin*)	4	PA; QL (1 vial per 1 day); SP
HUMATROPE INJECTION CARTRIDGE 24 MG (*somatropin*)	4	PA; QL (1 injection per 1 day); SP
SEROSTIM SUBCUTANEOUS SOLUTION RECONSTITUTED 4 MG (*somatropin (non-refrigerated)*)	4	PA; LD; QL (1 vial per 1 day)
SEROSTIM SUBCUTANEOUS SOLUTION RECONSTITUTED 5 MG, 6 MG (*somatropin (non-refrigerated)*)	4	PA; LD; QL (1 solution per 1 day)
SKYTROFA SUBCUTANEOUS CARTRIDGE 11 MG, 7.6 MG, 9.1 MG (*lonapegsomatropin-tcgd*)	4	PA; LD; QL (8 cartridges per 28 days); SP
SKYTROFA SUBCUTANEOUS CARTRIDGE 13.3 MG, 3 MG, 3.6 MG, 4.3 MG, 5.2 MG, 6.3 MG (*lonapegsomatropin-tcgd*)	4	PA; LD; QL (4 cartridges per 28 days); SP
***HEREDITARY OROTIC ACIDURIA TREATMENT - AGENTS** - DRUGS FOR MENOPAUSE AND BONE LOSS**		
XURIDEN ORAL PACKET (*uridine triacetate*)	3	PA; LD; QL (4 packets per 1 day)
HEREDITARY TYROSINEMIA TYPE 1 (HT-1) TREATMENT - AGENTS - DRUGS FOR MENOPAUSE AND BONE LOSS**		
nitisinone oral capsule 10 mg, 2 mg, 5 mg	4	PA; LD; SP
nitisinone oral capsule 20 mg	4	PA; LD
NITYR ORAL TABLET (*nitisinone*)	4	PA; LD
ORFADIN ORAL CAPSULE (*nitisinone*)	4	PA; LD
ORFADIN ORAL SUSPENSION (*nitisinone*)	4	PA; LD

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HOMOCYSTINURIA TREATMENT - AGENTS - DRUGS FOR MENOPAUSE AND BONE LOSS**		
betaine oral powder	1 or 1b*	LD
CYSTADANE ORAL POWDER (*betaine*)	3	LD
HYPERAMMONEMIA TREATMENT - AGENTS - DRUGS FOR MENOPAUSE AND BONE LOSS**		
carglumic acid oral tablet soluble	4	PA; LD
HYPERPARATHYROID TREATMENT - VITAMIN D ANALOGS - DRUGS FOR MENOPAUSE AND BONE LOSS**		
calcitriol intravenous solution	1 or 1b*	PA
calcitriol oral capsule	1 or 1b*	PA
calcitriol oral solution	1 or 1b*	PA
doxercalciferol intravenous solution	1 or 1b*	PA
doxercalciferol oral capsule	1 or 1b*	PA
HECTOROL INTRAVENOUS SOLUTION (*doxercalciferol*)	3	PA
paricalcitol intravenous solution	1 or 1b*	PA
paricalcitol oral capsule	1 or 1b*	PA
RAYALDEE ORAL CAPSULE EXTENDED RELEASE (*calcifediol*)	3	PA; QL (2 tablets per 1 day)
ZEMPLAR INTRAVENOUS SOLUTION (*paricalcitol*)	3	PA
ZEMPLAR ORAL CAPSULE (*paricalcitol*)	3	PA
HYPOPHOSPHATASIA (HPP) AGENTS - DRUGS FOR MENOPAUSE AND BONE LOSS**		
STRENSIQ SUBCUTANEOUS SOLUTION (*asfotase alfa*)	4	PA; LD
INSULIN-LIKE GROWTH FACTOR-1 RECEPTOR INHIBITORS(IGF-1R) - DRUGS FOR THYROID**		
TEPEZZA INTRAVENOUS SOLUTION RECONSTITUTED (*teprotumumab-trbw*)	4	PA; LD; QL (8 fills per 168 days)
INSULIN-LIKE GROWTH FACTORS (SOMATOMEDINS) - HORMONES**		
INCRELEX SUBCUTANEOUS SOLUTION (*mecasermin*)	4	PA; LD; SP
LEPTIN ANALOGUES - HORMONES**		
MYALEPT SUBCUTANEOUS SOLUTION RECONSTITUTED (*metreleptin*)	4	PA; LD
LHRH/GNRH AGONIST ANALOG PITUITARY SUPPRESSANTS - DRUGS FOR WOMEN**		
FENSOLVI (6 MONTH) SUBCUTANEOUS KIT (*leuprolide acetate (6 month)*)	3	PA; LD; QL (1 kit per 24 weekss); SP
LUPRON DEPOT-PED (1-MONTH) INTRAMUSCULAR KIT 11.25 MG, 15 MG (*leuprolide acetate*)	4	PA; QL (1 kit per 28 days); SP
LUPRON DEPOT-PED (1-MONTH) INTRAMUSCULAR KIT 7.5 MG (*leuprolide acetate*)	4	PA; QL (1 syringe kit per 28 days); SP
LUPRON DEPOT-PED (3-MONTH) INTRAMUSCULAR KIT 11.25 MG (*leuprolide acetate (3 month)*)	4	PA; QL (1 kit per 12 weekss); SP
LUPRON DEPOT-PED (3-MONTH) INTRAMUSCULAR KIT 30 MG (*leuprolide acetate (3 month)*)	4	PA; QL (1 kit per 84 days); SP

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LUPRON DEPOT-PED (6-MONTH) INTRAMUSCULAR KIT (*leuprolide acetate (6 month)*)	4	PA; QL (1 kit per 24 weekss); SP
SUPPRELIN LA SUBCUTANEOUS KIT (*histrelin acetate (cpp)*)	4	PA; LD; QL (1 kit per 365 days); SP
SYNAREL NASAL SOLUTION (*nafarelin acetate*)	4	PA; QL (5 bottle per 30 days); SP
TRIPTODUR INTRAMUSCULAR SUSPENSION RECONSTITUTED ER (*triptorelin pamoate*)	4	PA; LD; QL (1 vial per 168 days)
LYSOSOMAL ACID LIPASE (LAL) DEFICIENCY - AGENTS - DRUGS FOR MENOPAUSE AND BONE LOSS**		
KANUMA INTRAVENOUS SOLUTION (*sebelipase alfa*)	3	PA; LD; SP
MOLYBDENUM COFACTOR DEFICIENCY (MOCD) - AGENTS - DRUGS FOR MENOPAUSE AND BONE LOSS**		
NULIBRY INTRAVENOUS SOLUTION RECONSTITUTED (*fosdenopterin hydrobromide*)	4	PA; LD
MUCOPOLYSACCHARIDOSIS I (MPS I) - AGENTS - DRUGS FOR MENOPAUSE AND BONE LOSS**		
ALDURAZYME INTRAVENOUS SOLUTION (*laronidase*)	4	PA; LD; SP
MUCOPOLYSACCHARIDOSIS II (MPS II) - AGENTS - DRUGS FOR MENOPAUSE AND BONE LOSS**		
ELAPRASE INTRAVENOUS SOLUTION (*idursulfase*)	4	PA; LD; SP
MUCOPOLYSACCHARIDOSIS IV (MPS IV) - AGENTS - DRUGS FOR MENOPAUSE AND BONE LOSS**		
VIMIZIM INTRAVENOUS SOLUTION (*elosulfase alfa*)	4	PA; LD; SP
MUCOPOLYSACCHARIDOSIS VI (MPS VI) - AGENTS - DRUGS FOR MENOPAUSE AND BONE LOSS**		
NAGLAZYME INTRAVENOUS SOLUTION (*galsulfase*)	4	PA; LD; SP
MUCOPOLYSACCHARIDOSIS VII (MPS VII) - AGENTS - DRUGS FOR MENOPAUSE AND BONE LOSS**		
MEPSEVII INTRAVENOUS SOLUTION (*vestronidase alfa-vjbk*)	4	PA; LD
NATRIURETIC PEPTIDES - DRUGS FOR MENOPAUSE AND BONE LOSS**		
VOXZOGO SUBCUTANEOUS SOLUTION RECONSTITUTED (*vosoritide*)	4	PA; LD; QL (1 vial per 1 day); SP
NEUROKININ 3 (NK3) RECEPTOR ANTAGONISTS - HORMONES**		
VEOZAH ORAL TABLET (*fezolinetant*)	3	PA; QL (1 tablet per 1 day)
NON-STEROIDAL MINERALOCORTICOID RECEPTOR ANTAGONISTS - HORMONES**		
KERENDIA ORAL TABLET (*finerenone*)	3	PA; QL (1 tablet per 1 day)
OVULATION STIMULANTS-GONADOTROPINS - DRUGS FOR WOMEN**		
CHORIONIC GONADOTROPIN INTRAMUSCULAR SOLUTION RECONSTITUTED	4	PA; SP
GONAL-F INJECTION SOLUTION RECONSTITUTED (*follitropin alfa*)	4	PA; SP
GONAL-F RFF REDIJECT SUBCUTANEOUS SOLUTION PEN-INJECTOR (*follitropin alfa*)	4	PA; SP

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GONAL-F RFF SUBCUTANEOUS SOLUTION RECONSTITUTED (*follitropin alfa*)	4	PA; SP
MENOPUR SUBCUTANEOUS SOLUTION RECONSTITUTED (*menotropins*)	4	PA; SP
NOVAREL INTRAMUSCULAR SOLUTION RECONSTITUTED (*chorionic gonadotropin*)	4	PA; SP
OVIDREL SUBCUTANEOUS INJECTABLE (*choriogonadotropin alfa*)	4	PA; SP
PREGNYL INTRAMUSCULAR SOLUTION RECONSTITUTED (*chorionic gonadotropin*)	4	PA; SP
OVULATION STIMULANTS-SYNTHETIC - DRUGS FOR WOMEN**		
CLOMID ORAL TABLET (*clomiphene citrate*)	1 or 1b*	PA
PARATHYROID HORMONE AND DERIVATIVES - DRUGS FOR MENOPAUSE AND BONE LOSS**		
FORTEO SUBCUTANEOUS SOLUTION PEN-INJECTOR (*teriparatide (recombinant)*)	4	QL (1 pen per 28 days); SP
teriparatide (recombinant) subcutaneous solution pen-injector 600 mcg/2.4ml	4	QL (1 pen per 28 days); SP
TERIPARATIDE (RECOMBINANT) SUBCUTANEOUS SOLUTION PEN-INJECTOR 620 MCG/2.48ML	4	QL (1 pen per 28 days); SP
teriparatide subcutaneous solution pen-injector	4	SP
PHENYLKETONURIA TREATMENT - AGENTS - DRUGS FOR MENOPAUSE AND BONE LOSS**		
sapropterin dihydrochloride (Javygtor Oral Packet)	4	PA; LD
sapropterin dihydrochloride (Javygtor Oral Tablet)	4	PA; LD
PALYNZIQ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 10 MG/0.5ML, 2.5 MG/0.5ML (*pegvaliase-pqpz*)	4	PA; LD; SP
PALYNZIQ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/ML (*pegvaliase-pqpz*)	4	PA; LD; QL (1 syringe per 1 day); SP
sapropterin dihydrochloride oral packet	4	PA; LD; SP
sapropterin dihydrochloride oral tablet	4	PA; LD; SP
RANK LIGAND (RANKL) INHIBITORS - DRUGS FOR MENOPAUSE AND BONE LOSS**		
PROLIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (*denosumab*)	3	PA; QL (1 syringe per 180 days); SP
XGEVA SUBCUTANEOUS SOLUTION (*denosumab*)	3	PA; QL (1 vial per 28 days); SP
SCLEROSTIN INHIBITORS - DRUGS FOR MENOPAUSE AND BONE LOSS**		
EVENITY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (*romosozumab-aqqg*)	4	PA; QL (2 syringes per 30 days); SP
SELECTIVE ESTROGEN RECEPTOR MODULATORS (SERMS) - DRUGS FOR MENOPAUSE AND BONE LOSS**		
EVISTA ORAL TABLET (*raloxifene hcl*)	3; $0	QL (1 tablet per 1 day)
OSPHENA ORAL TABLET (*ospemifene*)	3	PA; QL (1 tablet per 1 day)
raloxifene hcl oral tablet	1 or 1b*; $0	QL (1 tablet per 1 day)

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SELECTIVE VASOPRESSIN V2-RECEPTOR ANTAGONISTS - HORMONES**		
JYNARQUE ORAL TABLET (*tolvaptan*)	4	PA; LD; QL (4 tablets per 1 day)
JYNARQUE ORAL TABLET THERAPY PACK (*tolvaptan*)	4	PA; LD; QL (1 carton per 28 days)
tolvaptan oral tablet 15 mg	1 or 1b*	PA; LD; QL (1 tablet per 1 day); SP
tolvaptan oral tablet 30 mg	1 or 1b*	PA; LD; QL (2 tablets per 1 day); SP
SOMATOSTATIC AGENTS - DRUGS FOR GROWTH**		
LANREOTIDE ACETATE SUBCUTANEOUS SOLUTION	4	PA; LD; QL (1 syringe/vial per 28 days); SP
MYCAPSSA ORAL CAPSULE DELAYED RELEASE (*octreotide acetate*)	4	PA; LD; QL (4 capsules per 1 day)
octreotide acetate injection solution	4	PA; SP
octreotide acetate subcutaneous solution prefilled syringe	4	PA; SP
SANDOSTATIN INJECTION SOLUTION (*octreotide acetate*)	4	PA; SP
SANDOSTATIN LAR DEPOT INTRAMUSCULAR KIT 10 MG, 30 MG (*octreotide acetate*)	4	PA; QL (1 kit per 28 days); SP
SANDOSTATIN LAR DEPOT INTRAMUSCULAR KIT 20 MG (*octreotide acetate*)	4	PA; QL (2 kits per 28 days); SP
SIGNIFOR LAR INTRAMUSCULAR SUSPENSION RECONSTITUTED ER (*pasireotide pamoate*)	4	PA; LD; QL (1 kit per 28 days)
SIGNIFOR SUBCUTANEOUS SOLUTION (*pasireotide diaspartate*)	4	PA; LD; QL (2 mL per 1 day)
SOMATULINE DEPOT SUBCUTANEOUS SOLUTION (*lanreotide acetate*)	4	PA; LD; QL (1 syringe/vial per 28 days); SP
UREA CYCLE DISORDER - AGENTS - DRUGS FOR MENOPAUSE AND BONE LOSS**		
AMMONUL INTRAVENOUS SOLUTION (*sod benz-sod phenylacet*)	3	
OLPRUVA (2 GM DOSE) ORAL THERAPY PACK (*sodium phenylbutyrate*)	4	PA; LD; QL (1 kit per 30 days); SP
OLPRUVA (3 GM DOSE) ORAL THERAPY PACK (*sodium phenylbutyrate*)	4	PA; LD; QL (1 kit per 30 days); SP
OLPRUVA (4 GM DOSE) ORAL THERAPY PACK (*sodium phenylbutyrate*)	4	PA; LD; QL (1 kit per 30 days); SP
OLPRUVA (5 GM DOSE) ORAL THERAPY PACK (*sodium phenylbutyrate*)	4	PA; LD; QL (1 kit per 30 days); SP
OLPRUVA (6 GM DOSE) ORAL THERAPY PACK (*sodium phenylbutyrate*)	4	PA; LD; QL (1 kit per 30 days); SP
OLPRUVA (6.67 GM DOSE) ORAL THERAPY PACK (*sodium phenylbutyrate*)	4	PA; LD; QL (1 kit per 30 days); SP
PHEBURANE ORAL PELLET (*sodium phenylbutyrate*)	4	PA; LD; QL (8 bottles per 30 days)
RAVICTI ORAL LIQUID (*glycerol phenylbutyrate*)	3	PA; LD; QL (17.5 mL per 1 day); SP
sod benz-sod phenylacet intravenous solution	1 or 1b*	
sodium phenylbutyrate oral powder	1 or 1b*	PA; LD; QL (25 GM per 1 day); SP
sodium phenylbutyrate oral tablet	1 or 1b*	PA; LD; QL (40 tablets per 1 day); SP

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VASOPRESSIN - HORMONES**		
DDAVP INJECTION SOLUTION (*desmopressin acetate*)	3	
DDAVP ORAL TABLET 0.1 MG (*desmopressin acetate*)	3	DO
DDAVP ORAL TABLET 0.2 MG (*desmopressin acetate*)	3	QL (6 tablets per 1 day)
DDAVP PF INJECTION SOLUTION (*desmopressin acetate*)	3	
desmopressin ace spray refrig nasal solution	1 or 1b*	
desmopressin acetate injection solution	1 or 1b*	
DESMOPRESSIN ACETATE NASAL SOLUTION	3	LD
desmopressin acetate oral tablet 0.1 mg	1 or 1b*	DO
desmopressin acetate oral tablet 0.2 mg	1 or 1b*	QL (6 tablets per 1 day)
desmopressin acetate pf injection solution	1 or 1b*	
desmopressin acetate spray nasal solution	1 or 1b*	
NOCDURNA SUBLINGUAL TABLET SUBLINGUAL (*desmopressin acetate*)	3	PA; QL (1 tablet per 1 day)
TERLIVAZ INTRAVENOUS SOLUTION RECONSTITUTED (*terlipressin acetate*)	3	
vasopressin +rfid intravenous solution	1 or 1b*	
vasopressin intravenous solution	1 or 1b*	
VASOSTRICT INTRAVENOUS SOLUTION (*vasopressin*)	3	
X-LINKED HYPOPHOSPHATEMIA (XLH) TREATMENT - AGENTS - DRUGS FOR MENOPAUSE AND BONE LOSS**		
CRYSVITA SUBCUTANEOUS SOLUTION 10 MG/ML (*burosumab-twza*)	4	PA; LD; QL (2 vials per 28 days); SP
CRYSVITA SUBCUTANEOUS SOLUTION 20 MG/ML (*burosumab-twza*)	4	PA; LD; QL (8 vials per 28 days); SP
CRYSVITA SUBCUTANEOUS SOLUTION 30 MG/ML (*burosumab-twza*)	4	PA; LD; QL (6 vials per 28 days); SP
***ESTROGENS* - HORMONES**		
ESTROGEN & PROGESTIN - DRUGS FOR WOMEN**		
ACTIVELLA ORAL TABLET (*estradiol-norethindrone acet*)	3	
amabelz oral tablet	1 or 1b*	
ANGELIQ ORAL TABLET (*drospirenone-estradiol*)	3	
BIJUVA ORAL CAPSULE 0.5-100 MG (*estradiol-progesterone*)	2	
BIJUVA ORAL CAPSULE 1-100 MG (*estradiol-progesterone*)	2	QL (1 capsule per 1 day)
CLIMARA PRO TRANSDERMAL PATCH WEEKLY (*estradiol-levonorgestrel*)	2	QL (4 patch per 28 days)
COMBIPATCH TRANSDERMAL PATCH TWICE WEEKLY (*estradiol-norethindrone acet*)	2	QL (8 patch per 28 days)
estradiol-norethindrone acet oral tablet	1 or 1b*	
fyavolv oral tablet	1 or 1b*	
jinteli oral tablet	1 or 1b*	
mimvey oral tablet	1 or 1b*	
norethindrone-eth estradiol oral tablet	1 or 1b*	
PREMPHASE ORAL TABLET (*conj estrog-medroxyprogest ace*)	2	

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PREMPRO ORAL TABLET (*conj estrog-medroxyprogest ace*)	2	
ESTROGEN-PROGESTIN-GNRH ANTAGONIST - DRUGS FOR WOMAN**		
MYFEMBREE ORAL TABLET (*relugolix-estradiol-norethind*)	3	PA; QL (1 tablet per 1 day)
ORIAHNN ORAL CAPSULE THERAPY PACK (*elagolix-estradiol-norethind*)	3	PA; QL (1 carton per 28 days)
ESTROGENS - DRUGS FOR WOMEN**		
ALORA TRANSDERMAL PATCH TWICE WEEKLY (*estradiol*)	3	QL (8 patch per 28 days)
DELESTROGEN INTRAMUSCULAR OIL (*estradiol valerate*)	3	
DEPO-ESTRADIOL INTRAMUSCULAR OIL (*estradiol cypionate*)	3	
dotti transdermal patch twice weekly	1 or 1b*	QL (8 patch per 28 days)
estradiol oral tablet	1 or 1b*	
estradiol transdermal gel 0.25 mg/0.25gm, 0.5 mg/0.5gm, 0.75 mg/0.75gm, 1 mg/gm	1 or 1b*	QL (1 packet per 1 day)
estradiol transdermal gel 1.25 mg/1.25gm	1 or 1b*	QL (30 packets per 30 days)
estradiol transdermal patch twice weekly	1 or 1b*	QL (8 patch per 28 days)
estradiol transdermal patch weekly	1 or 1b*	QL (4 patches per 28 days)
estradiol valerate intramuscular oil	1 or 1b*	
EVAMIST TRANSDERMAL SOLUTION (*estradiol*)	2	QL (16.2 mL per 30 days)
lyllana transdermal patch twice weekly	1 or 1b*	QL (8 patch per 28 days)
MENEST ORAL TABLET (*esterified estrogens*)	2	
MENOSTAR TRANSDERMAL PATCH WEEKLY (*estradiol*)	3	QL (4 patches per 28 days)
PREMARIN INJECTION SOLUTION RECONSTITUTED (*estrogens conjugated*)	2	
PREMARIN ORAL TABLET (*estrogens conjugated*)	2	QL (1 tablet per 1 day)
ESTROGEN-SELECTIVE ESTROGEN RECEPTOR MODULATOR COMB - DRUGS FOR WOMEN**		
DUAVEE ORAL TABLET (*conj estrogens-bazedoxifene*)	3	PA; QL (1 tablet per 1 day)
***FLUOROQUINOLONES* - DRUGS FOR INFECTIONS**		
FLUOROQUINOLONES - ANTIBIOTICS**		
BAXDELA INTRAVENOUS SOLUTION RECONSTITUTED (*delafloxacin meglumine*)	3	
BAXDELA ORAL TABLET (*delafloxacin meglumine*)	3	PA
CIPRO ORAL SUSPENSION RECONSTITUTED (*ciprofloxacin*)	3	
CIPRO ORAL TABLET (*ciprofloxacin hcl*)	3	
ciprofloxacin hcl oral tablet	1 or 1b*	
ciprofloxacin in d5w intravenous solution	1 or 1b*	
levofloxacin in d5w intravenous solution	1 or 1b*	
levofloxacin intravenous solution	1 or 1b*	
levofloxacin oral solution	1 or 1b*	
levofloxacin oral tablet	1 or 1b*	
moxifloxacin hcl in nacl intravenous solution	1 or 1b*	
MOXIFLOXACIN HCL INTRAVENOUS SOLUTION	3	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
moxifloxacin hcl oral tablet	1 or 1b*	
ofloxacin oral tablet	1 or 1b*	
***GASTROINTESTINAL AGENTS - MISC.* - DRUGS FOR THE STOMACH**		
BILE ACID SYNTHESIS DISORDER AGENTS - DRUGS FOR THE STOMACH**		
CHOLBAM ORAL CAPSULE (*cholic acid*)	3	PA; LD; QL (4 capsule per 1 day)
FARNESOID X RECEPTOR (FXR) AGONISTS - DRUGS FOR THE STOMACH**		
OCALIVA ORAL TABLET (*obeticholic acid*)	4	PA; LD; QL (1 tablet per 1 day); SP
GALLSTONE SOLUBILIZING AGENTS - DRUGS FOR THE STOMACH**		
URSO 250 ORAL TABLET (*ursodiol*)	3	
URSO FORTE ORAL TABLET (*ursodiol*)	3	
ursodiol oral capsule	1 or 1b*	
ursodiol oral tablet	1 or 1b*	
GASTROINTESTINAL ANTIALLERGY AGENTS - DRUGS FOR THE STOMACH**		
cromolyn sodium oral concentrate	1 or 1b*	
GASTROCROM ORAL CONCENTRATE (*cromolyn sodium*)	3	
GASTROINTESTINAL CHLORIDE CHANNEL ACTIVATORS - DRUGS FOR IRRITABLE BOWEL SYNDROME**		
lubiprostone oral capsule	1 or 1b*	QL (2 capsules per 1 day)
GASTROINTESTINAL STIMULANTS - DRUGS FOR THE STOMACH**		
GIMOTI NASAL SOLUTION (*metoclopramide hcl*)	3	PA; QL (1 bottle per 4 weekss)
metoclopramide hcl injection solution	1 or 1a*	
metoclopramide hcl oral solution	1 or 1a*	QL (60 mL per 1 day)
metoclopramide hcl oral tablet 10 mg	1 or 1a*	QL (6 tablets per 1 day)
metoclopramide hcl oral tablet 5 mg	1 or 1a*	QL (12 tablets per 1 day)
metoclopramide hcl oral tablet dispersible	1 or 1a*	ST; QL (12 tablets per 1 day)
REGLAN ORAL TABLET 10 MG (*metoclopramide hcl*)	3	QL (6 tablets per 1 day)
REGLAN ORAL TABLET 5 MG (*metoclopramide hcl*)	3	QL (12 tablets per 1 day)
GLUCAGON-LIKE PEPTIDE-2 (GLP-2) ANALOGS - DRUGS FOR THE STOMACH**		
GATTEX SUBCUTANEOUS KIT (*teduglutide (rdna)*)	3	PA; LD; SP
IBS AGENT - GUANYLATE CYCLASE-C (GC-C) AGONISTS - DRUGS FOR CONSTIPATION**		
LINZESS ORAL CAPSULE (*linaclotide*)	2	QL (1 capsule per 1 day)
IBS AGENT - MU-OPIOID RECEPTOR AGONISTS - DRUGS FOR IRRITABLE BOWEL SYNDROME**		
VIBERZI ORAL TABLET (*eluxadoline*)	3	QL (2 tablets per 1 day)

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
IBS AGENT - SELECTIVE 5-HT3 RECEPTOR ANTAGONISTS - DRUGS FOR IRRITABLE BOWEL SYNDROME**		
alosetron hcl oral tablet	1 or 1b*	PA; QL (2 tablets per 1 day)
ILEAL BILE ACID TRANSPORTER (IBAT) INHIBITORS - DRUGS FOR THE STOMACH**		
BYLVAY (PELLETS) ORAL CAPSULE SPRINKLE 200 MCG (*odevixibat*)	4	PA; LD; QL (30 pellets per 1 day)
BYLVAY (PELLETS) ORAL CAPSULE SPRINKLE 600 MCG (*odevixibat*)	4	PA; LD; QL (10 pellets per 1 day)
BYLVAY ORAL CAPSULE 1200 MCG (*odevixibat*)	4	PA; LD; QL (5 capsules per 1 day)
BYLVAY ORAL CAPSULE 400 MCG (*odevixibat*)	4	PA; LD; QL (15 capsules per 1 day)
LIVMARLI ORAL SOLUTION (*maralixibat chloride*)	4	PA; LD; QL (90 mL per 30 days)
INFLAMMATORY BOWEL AGENTS - DRUGS FOR INFLAMMATORY BOWEL DISEASE**		
APRISO ORAL CAPSULE EXTENDED RELEASE 24 HOUR (*mesalamine*)	3	ST; QL (4 capsule per 1 day)
AZULFIDINE EN-TABS ORAL TABLET DELAYED RELEASE (*sulfasalazine*)	3	QL (8 tablet per 1 day)
AZULFIDINE ORAL TABLET (*sulfasalazine*)	3	QL (8 tablet per 1 day)
balsalazide disodium oral capsule	1 or 1b*	QL (9 capsule per 1 day)
CANASA RECTAL SUPPOSITORY (*mesalamine*)	3	QL (1 suppository per 1 day)
DELZICOL ORAL CAPSULE DELAYED RELEASE (*mesalamine*)	3	ST; QL (6 tablets per 1 day)
DIPENTUM ORAL CAPSULE (*olsalazine sodium*)	3	ST; QL (4 capsule per 1 day)
mesalamine er oral capsule extended release	1 or 1b*	QL (8 capsule per 1 day)
mesalamine er oral capsule extended release 24 hour	1 or 1b*	QL (4 capsules per 1 day)
mesalamine oral capsule delayed release	1 or 1b*	QL (6 tablets per 1 day)
mesalamine oral tablet delayed release 1.2 gm	1 or 1b*	QL (4 tablets per 1 day)
mesalamine oral tablet delayed release 800 mg	1 or 1b*	QL (6 tablet per 1 day)
mesalamine rectal enema	1 or 1b*	QL (60 mL per 1 day)
mesalamine rectal suppository	1 or 1b*	QL (1 suppository per 1 day)
mesalamine-cleanser rectal kit	1 or 1b*	QL (1 kit per 30 days)
PENTASA ORAL CAPSULE EXTENDED RELEASE 250 MG (*mesalamine*)	2	QL (16 capsule per 1 day)
PENTASA ORAL CAPSULE EXTENDED RELEASE 500 MG (*mesalamine*)	3	ST; QL (8 capsule per 1 day)
ROWASA RECTAL KIT (*mesalamine-cleanser*)	3	QL (1 kit per 30 days)
SFROWASA RECTAL ENEMA (*mesalamine*)	3	QL (60 mL per 1 day)
sulfasalazine oral tablet	1 or 1b*	QL (8 tablet per 1 day)
sulfasalazine oral tablet delayed release	1 or 1b*	QL (8 tablet per 1 day)
INTEGRIN RECEPTOR ANTAGONISTS - DRUGS FOR INFLAMMATORY BOWEL DISEASE**		
ENTYVIO INTRAVENOUS SOLUTION RECONSTITUTED (*vedolizumab*)	4	PA; LD; QL (1 vial per 56 days); SP

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
INTERLEUKIN ANTAGONISTS - DRUGS FOR INFLAMMATORY BOWEL DISEASE**		
SKYRIZI INTRAVENOUS SOLUTION (*risankizumab-rzaa*)	4	PA; QL (30 mL per 365 days); SP
SKYRIZI SUBCUTANEOUS SOLUTION CARTRIDGE (*risankizumab-rzaa*)	4	PA; QL (1 kit per 56 days); SP
STELARA INTRAVENOUS SOLUTION (*ustekinumab*)	4	PA; LD; QL (4 vial per 365 days); SP
INTESTINAL ACIDIFIERS - DRUGS FOR THE STOMACH**		
enulose oral solution	1 or 1b*	
generlac oral solution	1 or 1b*	
lactulose encephalopathy oral solution	1 or 1b*	
***LIVE FECAL MICROBIOTA (HUMAN)** - DRUGS FOR THE STOMACH**		
REBYOTA RECTAL SUSPENSION (*fecal microbiota, live-jslm*)	4	PA; LD; QL (1 carton per 1 lifetime)
VOWST ORAL CAPSULE (*fecal microb spores, live-brpk*)	4	PA; LD; QL (12 capsules per 1 lifetime)
PERIPHERAL OPIOID RECEPTOR ANTAGONISTS - DRUGS FOR THE STOMACH**		
alvimopan oral capsule	1 or 1b*	
ENTEREG ORAL CAPSULE (*alvimopan*)	3	
MOVANTIK ORAL TABLET (*naloxegol oxalate*)	2	QL (1 tablet per 1 day)
RELISTOR ORAL TABLET (*methylnaltrexone bromide*)	3	ST; QL (3 tablets per 1 day)
RELISTOR SUBCUTANEOUS SOLUTION (*methylnaltrexone bromide*)	3	ST; QL (1 syringe per 1 day)
SYMPROIC ORAL TABLET (*naldemedine tosylate*)	3	ST; QL (1 tablet per 1 day)
PHOSPHATE BINDER AGENTS - DRUGS FOR THE STOMACH**		
AURYXIA ORAL TABLET (*ferric citrate*)	3	ST; QL (9 tablets per 1 day)
calcium acetate (phos binder) oral capsule	1 or 1b*	QL (12 capsules per 1 day)
calcium acetate oral tablet	1 or 1b*	QL (12 tablets per 1 day)
FOSRENOL ORAL PACKET (*lanthanum carbonate*)	3	ST; QL (3 stick packs per 1 day)
lanthanum carbonate oral tablet chewable	1 or 1b*	QL (3 tablets per 1 day)
sevelamer carbonate oral packet 0.8 gm	1 or 1b*	QL (6 packets per 1 day)
sevelamer carbonate oral packet 2.4 gm	1 or 1b*	QL (3 packets per 1 day)
sevelamer carbonate oral tablet	1 or 1b*	QL (9 tablets per 1 day)
sevelamer hcl oral tablet 400 mg	1 or 1b*	QL (15 tablets per 1 day)
sevelamer hcl oral tablet 800 mg	1 or 1b*	QL (9 tablets per 1 day)
VELPHORO ORAL TABLET CHEWABLE (*sucroferric oxyhydroxide*)	2	QL (3 tablets per 1 day)
TRYPTOPHAN HYDROXYLASE INHIBITORS - DRUGS FOR DIARRHEA**		
XERMELO ORAL TABLET (*telotristat etiprate*)	4	PA; LD; QL (3 tablets per 1 day)
TUMOR NECROSIS FACTOR ALPHA BLOCKERS - DRUGS FOR INFLAMMATORY BOWEL DISEASE**		
AVSOLA INTRAVENOUS SOLUTION RECONSTITUTED (*infliximab-axxq*)	4	PA; LD; SP

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
INFLIXIMAB INTRAVENOUS SOLUTION RECONSTITUTED	4	PA; LD; SP
REMICADE INTRAVENOUS SOLUTION RECONSTITUTED (*infliximab*)	4	PA; LD; SP
***GENERAL ANESTHETICS* - DRUGS FOR PAIN AND FEVER**		
ANESTHETICS - MISC. - DRUGS FOR SEDATION**		
AMIDATE INTRAVENOUS SOLUTION (*etomidate*)	3	
ANESTHESIA S/I-40A INTRAVENOUS KIT	3	
ANESTHESIA S/I-40H INTRAVENOUS KIT	3	
ANESTHESIA S/I-40S INTRAVENOUS KIT	3	
DIPRIVAN INTRAVENOUS EMULSION (*propofol*)	3	
etomidate intravenous solution	1 or 1b*	
fresenius propoven intravenous emulsion	1 or 1b*	
KETALAR INJECTION SOLUTION (*ketamine hcl*)	3	
ketamine hcl injection solution	1 or 1b*	
propofol intravenous emulsion	1 or 1b*	
propofol-lipuro intravenous emulsion	1 or 1b*	
BARBITURATE ANESTHETICS - DRUGS FOR SEDATION**		
BREVITAL SODIUM INJECTION SOLUTION RECONSTITUTED (*methohexital sodium*)	3	
VOLATILE ANESTHETICS - DRUGS FOR SEDATION**		
desflurane inhalation solution	1 or 1b*	
FORANE INHALATION SOLUTION (*isoflurane*)	3	
isoflurane inhalation solution	1 or 1b*	
sevoflurane inhalation solution	1 or 1b*	
SUPRANE INHALATION SOLUTION (*desflurane*)	3	
terrell inhalation solution	1 or 1b*	
ULTANE INHALATION SOLUTION (*sevoflurane*)	3	
***GENITOURINARY AGENTS - MISCELLANEOUS* - DRUGS FOR THE URINARY SYSTEM**		
5-ALPHA REDUCTASE INHIBITORS - DRUGS FOR THE PROSTATE**		
dutasteride oral capsule	1 or 1b*	QL (1 capsule per 1 day)
finasteride oral tablet	1 or 1b*	QL (1 tablet per 1 day)
PROSCAR ORAL TABLET (*finasteride*)	3	QL (1 tablet per 1 day)
ALPHA 1-ADRENOCEPTOR ANTAGONISTS - DRUGS FOR THE PROSTATE**		
alfuzosin hcl er oral tablet extended release 24 hour	1 or 1b*	QL (1 tablet per 1 day)
CARDURA XL ORAL TABLET EXTENDED RELEASE 24 HOUR (*doxazosin mesylate*)	3	QL (1 tablet per 1 day)
silodosin oral capsule	1 or 1b*	QL (1 capsule per 1 day)
tamsulosin hcl oral capsule	1 or 1b*	QL (2 capsules per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-INFECTIVE GENITOURINARY IRRIGANTS - DRUGS FOR THE URINARY SYSTEM**		
neomycin-polymyxin b gu irrigation solution	1 or 1b*	
CITRATES - DRUGS FOR INFECTIONS**		
potassium citrate er oral tablet extended release	1 or 1b*	
UROCIT-K 10 ORAL TABLET EXTENDED RELEASE (*potassium citrate*)	3	
UROCIT-K 15 ORAL TABLET EXTENDED RELEASE (*potassium citrate*)	3	
UROCIT-K 5 ORAL TABLET EXTENDED RELEASE (*potassium citrate*)	3	
CYSTINOSIS AGENTS - DRUGS FOR THE URINARY SYSTEM**		
CYSTAGON ORAL CAPSULE (*cysteamine bitartrate*)	4	PA; LD; SP
PROCYSBI ORAL CAPSULE DELAYED RELEASE (*cysteamine bitartrate*)	4	PA; LD
PROCYSBI ORAL PACKET (*cysteamine bitartrate*)	4	PA; LD
GENITOURINARY IRRIGANTS - DRUGS FOR THE URINARY SYSTEM**		
acetic acid irrigation solution	1 or 1b*	
argyle sterile saline irrigation solution	1 or 1b*	
curity sterile saline irrigation solution	1 or 1b*	
glycine irrigation solution	1 or 1b*	
glycine urologic irrigation solution	1 or 1b*	
RENACIDIN IRRIGATION SOLUTION (*citric ac-gluconolact-mg carb*)	3	
sodium chloride irrigation solution	1 or 1b*	
SORBITOL IRRIGATION SOLUTION	3	
SORBITOL-MANNITOL IRRIGATION SOLUTION	3	
IGAN AGENTS - ENDOTHELIN & ANGIOTENSIN II RECEPTOR ANTAG - DRUGS FOR THE URINARY SYSTEM**		
FILSPARI ORAL TABLET (*sparsentan*)	4	PA; LD; QL (1 tablet per 1 day); SP
INTERSTITIAL CYSTITIS AGENTS - DRUGS FOR THE URINARY SYSTEM**		
ELMIRON ORAL CAPSULE (*pentosan polysulfate sodium*)	3	QL (3 capsules per 1 day)
RIMSO-50 INTRAVESICAL SOLUTION (*dimethyl sulfoxide*)	3	
PHOSPHATES - DRUGS FOR INFECTIONS**		
K-PHOS NO 2 ORAL TABLET (*pot & sod ac phosphates*)	3	
PROSTATIC HYPERTROPHY AGENT COMBINATIONS - DRUGS FOR THE PROSTATE**		
dutasteride-tamsulosin hcl oral capsule	1 or 1b*	QL (1 capsule per 1 day)
JALYN ORAL CAPSULE (*dutasteride-tamsulosin hcl*)	3	QL (1 capsule per 1 day)
SMALL INTERFERING RIBONUCLEIC ACID AGENTS (SIRNA) - DRUGS FOR THE URINARY SYSTEM**		
OXLUMO SUBCUTANEOUS SOLUTION (*lumasiran sodium*)	4	PA; LD

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
URINARY STONE AGENTS - DRUGS FOR THE URINARY SYSTEM**		
LITHOSTAT ORAL TABLET (*acetohydroxamic acid*)	3	
THIOLA EC ORAL TABLET DELAYED RELEASE 100 MG (*tiopronin*)	3	PA; LD; QL (10 tablet per 1 day)
THIOLA EC ORAL TABLET DELAYED RELEASE 300 MG (*tiopronin*)	3	PA; LD; QL (3 tablet per 1 day)
tiopronin oral tablet	1 or 1b*	PA; LD; QL (10 tablet per 1 day)
VESICOURETERAL REFLUX (VUR) AGENT COMBINATIONS - DRUGS FOR THE URINARY SYSTEM**		
DEFLUX INJECTION PREFILLED SYRINGE (*dextranomer-hyaluronic acid*)	3	
***GOUT AGENTS* - DRUGS FOR PAIN AND FEVER**		
GOUT AGENT COMBINATIONS - GOUT DRUGS**		
colchicine-probenecid oral tablet	1 or 1b*	
GOUT AGENTS - GOUT DRUGS**		
allopurinol oral tablet 100 mg	1 or 1a*	QL (8 tablets per 1 day)
allopurinol oral tablet 300 mg	1 or 1a*	QL (2 tablets per 1 day)
allopurinol sodium intravenous solution reconstituted	1 or 1b*	
ALOPRIM INTRAVENOUS SOLUTION RECONSTITUTED (*allopurinol sodium*)	3	
colchicine oral tablet	2	QL (2.3 tablet per 1 day)
febuxostat oral tablet	1 or 1b*	ST; QL (1 tablet per 1 day)
KRYSTEXXA INTRAVENOUS SOLUTION (*pegloticase*)	4	PA; LD; QL (0.08 mL per 1 day); SP
URICOSURICS - GOUT DRUGS**		
probenecid oral tablet	1 or 1b*	
***HEMATOLOGICAL AGENTS - MISC.* - DRUGS FOR THE BLOOD**		
AMINOLEVULINATE SYNTHASE 1-DIRECTED SIRNA - DRUGS FOR THE BLOOD**		
GIVLAARI SUBCUTANEOUS SOLUTION (*givosiran sodium*)	4	PA; LD
ANTIHEMOPHILIC PRODUCTS - MONOCLONAL ANTIBODIES - DRUGS FOR THE BLOOD**		
HEMLIBRA SUBCUTANEOUS SOLUTION (*emicizumab-kxwh*)	4	PA; LD; SP
ANTIHEMOPHILIC PRODUCTS - DRUGS TO PREVENT BLEEDING**		
ADVATE INTRAVENOUS SOLUTION RECONSTITUTED (*antihemophil factor (rahf-pfm)*)	4	PA; LD; SP
ADYNOVATE INTRAVENOUS SOLUTION RECONSTITUTED	4	PA; LD; SP
AFSTYLA INTRAVENOUS KIT (*antihemophil fact single chain*)	4	PA; LD; SP
ALPHANATE INTRAVENOUS SOLUTION RECONSTITUTED (*antihemophilic factor-vwf*)	4	PA; LD; SP
ALPHANINE SD INTRAVENOUS SOLUTION RECONSTITUTED (*coagulation factor ix*)	4	PA; LD; SP
ALPROLIX INTRAVENOUS SOLUTION RECONSTITUTED (*coagulation factor ix (rfixfc)*)	4	PA; LD; SP

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ALTUVIIIO INTRAVENOUS SOLUTION RECONSTITUTED (*antihem fact fc-vwf-xten-ehtl*)	4	PA; LD; SP
BALFAXAR INTRAVENOUS SOLUTION RECONSTITUTED (*prothrombin complex human-lans*)	3	
BENEFIX INTRAVENOUS KIT (*coagulation factor ix (recomb)*)	4	PA; LD; SP
COAGADEX INTRAVENOUS SOLUTION RECONSTITUTED (*coagulation factor x (human)*)	4	PA; LD; SP
CORIFACT INTRAVENOUS KIT (*factor xiii concentrate human*)	4	PA; LD; SP
ELOCTATE INTRAVENOUS SOLUTION RECONSTITUTED (*antihem fact (bdd-rfviiifc)*)	4	PA; LD; SP
ESPEROCT INTRAVENOUS SOLUTION RECONSTITUTED (*antihemoph fact rcmb gpeg-exei*)	4	PA; LD; SP
FEIBA INTRAVENOUS SOLUTION RECONSTITUTED (*antiinhibitor coagulant cmplx*)	4	PA; LD; SP
FIBRYGA INTRAVENOUS SOLUTION RECONSTITUTED (*fibrinogen concentrate (human)*)	4	PA; LD; SP
HEMOFIL M INTRAVENOUS SOLUTION RECONSTITUTED (*antihemophilic factor*)	4	PA; LD; SP
HUMATE-P INTRAVENOUS SOLUTION RECONSTITUTED (*antihemophilic factor-vwf*)	4	PA; LD; SP
IDELVION INTRAVENOUS SOLUTION RECONSTITUTED (*coagulation factor ix (rix-fp)*)	4	PA; LD; SP
IXINITY INTRAVENOUS SOLUTION RECONSTITUTED (*coagulation factor ix (recomb)*)	4	PA; LD; SP
JIVI INTRAVENOUS SOLUTION RECONSTITUTED (*ahf (bdd-rfviii peg-aucl)*)	4	PA; LD; SP
KCENTRA INTRAVENOUS KIT (*prothrombin complex conc human*)	3	
KOATE INTRAVENOUS SOLUTION RECONSTITUTED (*antihemophilic factor*)	4	PA; LD; SP
KOATE-DVI INTRAVENOUS SOLUTION RECONSTITUTED (*antihemophilic factor*)	4	PA; LD; SP
KOGENATE FS INTRAVENOUS KIT (*antihem factor recomb (rfviii)*)	4	PA; LD; SP
KOVALTRY INTRAVENOUS SOLUTION RECONSTITUTED (*antihemophil factor (rahf-pfm)*)	4	PA; LD; SP
NOVOEIGHT INTRAVENOUS SOLUTION RECONSTITUTED (*antihemophil fact bd truncated*)	4	LD; SP
NOVOSEVEN RT INTRAVENOUS SOLUTION RECONSTITUTED (*coagulation factor viia recomb*)	4	PA; LD; SP
NUWIQ INTRAVENOUS KIT (*antihem fact (bdd-rfviii,sim)*)	4	PA; LD; SP
NUWIQ INTRAVENOUS SOLUTION RECONSTITUTED (*antihem fact (bdd-rfviii,sim)*)	4	PA; LD; SP
obizur intravenous solution reconstituted	4	PA; LD; SP
PROFILNINE INTRAVENOUS SOLUTION RECONSTITUTED (*factor ix complex*)	4	PA; LD; SP
REBINYN INTRAVENOUS SOLUTION RECONSTITUTED (*coagulation factor ix glycopeg*)	4	PA; LD; SP

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
RECOMBINATE INTRAVENOUS SOLUTION RECONSTITUTED (*antihem factor recomb (rfviii)*)	4	PA; LD; SP
RIASTAP INTRAVENOUS SOLUTION RECONSTITUTED (*fibrinogen concentrate (human)*)	3	PA; LD; SP
RIXUBIS INTRAVENOUS SOLUTION RECONSTITUTED	4	PA; LD; SP
SEVENFACT INTRAVENOUS SOLUTION RECONSTITUTED (*coagulation factor viia-jncw*)	4	PA; LD; SP
TRETTEN INTRAVENOUS SOLUTION RECONSTITUTED (*coagulation factor xiii a-sub*)	4	PA; LD; SP
VONVENDI INTRAVENOUS SOLUTION RECONSTITUTED (*von willebrand factor (recomb)*)	4	PA; LD; SP
WILATE INTRAVENOUS KIT (*antihemophilic factor-vwf*)	4	PA; LD; SP
XYNTHA INTRAVENOUS KIT (*antihem fact (bdd-rfviii,mor)*)	4	PA; LD; SP
XYNTHA SOLOFUSE INTRAVENOUS KIT (*antihem fact (bdd-rfviii,mor)*)	4	PA; LD; SP
ANTI-VON WILLEBRAND FACTOR AGENTS - DRUGS FOR THE BLOOD**		
CABLIVI INJECTION KIT (*caplacizumab-yhdp*)	4	PA; LD
BRADYKININ B2 RECEPTOR ANTAGONISTS - DRUGS FOR THE BLOOD**		
icatibant acetate subcutaneous solution prefilled syringe	4	PA; LD; QL (18 syringes per 30 days); SP
sajazir subcutaneous solution prefilled syringe	4	PA; LD; QL (18 syringes per 30 days)
C1 ESTERASE INHIBITORS - DRUGS FOR THE BLOOD**		
BERINERT INTRAVENOUS KIT (*c1 esterase inhibitor (human)*)	4	PA; LD; QL (24 kits per 30 days); SP
CINRYZE INTRAVENOUS SOLUTION RECONSTITUTED (*c1 esterase inhibitor (human)*)	4	PA; LD; QL (20 vials per 30 days); SP
HAEGARDA SUBCUTANEOUS SOLUTION RECONSTITUTED 2000 UNIT (*c1 esterase inhibitor (human)*)	4	PA; LD; QL (24 vials per 28 days); SP
HAEGARDA SUBCUTANEOUS SOLUTION RECONSTITUTED 3000 UNIT (*c1 esterase inhibitor (human)*)	4	PA; LD; QL (16 vials per 28 days); SP
RUCONEST INTRAVENOUS SOLUTION RECONSTITUTED (*c1 esterase inhibitor (recomb)*)	4	PA; LD; QL (16 vials per 30 days); SP
COMPLEMENT C1 INHIBITORS - DRUGS FOR THE BLOOD**		
ENJAYMO INTRAVENOUS SOLUTION (*sutimlimab-jome*)	4	LD; SP
COMPLEMENT C3 INHIBITORS - DRUGS FOR THE BLOOD**		
EMPAVELI SUBCUTANEOUS SOLUTION (*pegcetacoplan*)	4	PA; LD; QL (200 mL per 30 days)
COMPLEMENT C5 INHIBITORS - DRUGS FOR THE BLOOD**		
SOLIRIS INTRAVENOUS SOLUTION (*eculizumab*)	4	PA; LD; QL (8 vials per 28 days); SP
ULTOMIRIS INTRAVENOUS SOLUTION (*ravulizumab-cwvz*)	4	PA; LD; QL (12 vials per 56 days); SP
VEOPOZ INJECTION SOLUTION (*pozelimab-bbfg*)	4	PA; QL (2 vials per 1 week)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
COMPLEMENT C5A INHIBITORS - DRUGS FOR THE BLOOD**		
gohibic intravenous solution	3	
COMPLEMENT C5A RECEPTOR INHIBITORS - DRUGS FOR THE BLOOD**		
TAVNEOS ORAL CAPSULE (*avacopan*)	4	PA; LD; QL (6 capsules per 1 day)
DIRECT-ACTING P2Y12 INHIBITORS - DRUGS FOR THE BLOOD**		
BRILINTA ORAL TABLET (*ticagrelor*)	2	QL (2 tablets per 1 day)
KENGREAL INTRAVENOUS SOLUTION RECONSTITUTED (*cangrelor tetrasodium*)	3	
GLYCOPROTEIN IIB/IIIA RECEPTOR INHIBITORS - DRUGS FOR THE BLOOD**		
AGGRASTAT INTRAVENOUS CONCENTRATE (*tirofiban hcl*)	3	
AGGRASTAT INTRAVENOUS SOLUTION (*tirofiban hcl in nacl*)	3	
eptifibatide intravenous solution	1 or 1b*	
tirofiban hcl in nacl intravenous solution	1 or 1b*	
HEMATORHEOLOGIC AGENTS - DRUGS FOR THE BLOOD**		
pentoxifylline er oral tablet extended release	1 or 1b*	
HEMIN - DRUGS FOR THE BLOOD**		
PANHEMATIN INTRAVENOUS SOLUTION RECONSTITUTED (*hemin*)	3	
HUMAN PROTEIN C - DRUGS FOR THE BLOOD**		
CEPROTIN INTRAVENOUS SOLUTION RECONSTITUTED (*protein c concentrate (human)*)	4	LD; SP
PHOSPHODIESTERASE III INHIBITORS - DRUGS FOR THE BLOOD**		
cilostazol oral tablet	1 or 1b*	
PLASMA EXPANDERS - DRUGS FOR THE BLOOD**		
HESPAN INTRAVENOUS SOLUTION (*hetastarch-nacl*)	3	
hetastarch-nacl intravenous solution	1 or 1b*	
HEXTEND INTRAVENOUS SOLUTION (*hetastarch in lact electrolyte*)	3	
lmd in d5w intravenous solution	1 or 1b*	
lmd in nacl intravenous solution	1 or 1b*	
PLASMA KALLIKREIN INHIBITORS - MONOCLONAL ANTIBODIES - DRUGS FOR THE BLOOD**		
TAKHZYRO SUBCUTANEOUS SOLUTION (*lanadelumab-flyo*)	4	PA; LD; QL (1 vial per 28 days); SP
TAKHZYRO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (*lanadelumab-flyo*)	4	PA; LD; QL (1 syringe per 28 days); SP
PLASMA KALLIKREIN INHIBITORS - DRUGS FOR THE BLOOD**		
KALBITOR SUBCUTANEOUS SOLUTION (*ecallantide*)	4	PA; LD; QL (36 vials per 30 days); SP
ORLADEYO ORAL CAPSULE (*berotralstat hcl*)	4	PA; LD; QL (1 capsule per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PLASMA PROTEINS - DRUGS FOR THE BLOOD**		
ALBUKED 25 INTRAVENOUS SOLUTION (*albumin human*)	3	
ALBUKED 5 INTRAVENOUS SOLUTION (*albumin human*)	3	
ALBUMIN HUMAN INTRAVENOUS SOLUTION	3	
ALBUMINEX INTRAVENOUS SOLUTION (*albumin human-kjda*)	3	
ALBUMIN-ZLB INTRAVENOUS SOLUTION	3	
ALBURX INTRAVENOUS SOLUTION	3	
ALBUTEIN INTRAVENOUS SOLUTION (*albumin human*)	3	
FLEXBUMIN INTRAVENOUS SOLUTION (*albumin human*)	3	
HUMAN ALBUMIN GRIFOLS INTRAVENOUS SOLUTION (*albumin human*)	3	
KEDBUMIN INTRAVENOUS SOLUTION	3	
OCTAPLAS BLOOD GROUP A INTRAVENOUS SOLUTION (*plasma human*)	3	
OCTAPLAS BLOOD GROUP AB INTRAVENOUS SOLUTION (*plasma human*)	3	
OCTAPLAS BLOOD GROUP B INTRAVENOUS SOLUTION (*plasma human*)	3	
OCTAPLAS BLOOD GROUP O INTRAVENOUS SOLUTION (*plasma human*)	3	
PLASBUMIN-25 INTRAVENOUS SOLUTION (*albumin human*)	3	
PLASBUMIN-5 INTRAVENOUS SOLUTION (*albumin human*)	3	
PLASMANATE INTRAVENOUS SOLUTION (*plasma protein fraction*)	3	
RYPLAZIM INTRAVENOUS SOLUTION RECONSTITUTED (*plasminogen human-tvmh*)	4	PA; LD
THROMBATE III INTRAVENOUS SOLUTION RECONSTITUTED (*antithrombin iii (human)*)	3	
PLATELET AGGREGATION INHIBITOR COMBINATIONS - DRUGS FOR THE BLOOD**		
aspirin-dipyridamole er oral capsule extended release 12 hour	1 or 1b*	QL (2 capsules per 1 day)
YOSPRALA ORAL TABLET DELAYED RELEASE (*aspirin-omeprazole*)	3	PA; QL (1 tablet per 1 day)
PLATELET AGGREGATION INHIBITORS - DRUGS FOR THE BLOOD**		
dipyridamole oral tablet	1 or 1b*	
PROTAMINE - DRUGS FOR THE BLOOD**		
protamine sulfate intravenous solution	1 or 1b*	
PROTEASE-ACTIVATED RECEPTOR-1 (PAR-1) ANTAGONISTS - DRUGS FOR THE BLOOD**		
ZONTIVITY ORAL TABLET (*vorapaxar sulfate*)	3	PA; QL (1 tablet per 1 day)
PYRUVATE KINASE ACTIVATORS - DRUGS FOR THE BLOOD**		
PYRUKYND ORAL TABLET (*mitapivat sulfate*)	4	PA; LD; QL (2 tablets per 1 day)
PYRUKYND TAPER PACK ORAL TABLET THERAPY PACK (*mitapivat sulfate*)	4	PA; LD; QL (1 pack per 28 days)

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
QUINAZOLINE AGENTS - DRUGS FOR THE BLOOD**		
AGRYLIN ORAL CAPSULE (*anagrelide hcl*)	3	QL (20 capsules per 1 day)
anagrelide hcl oral capsule 0.5 mg	1 or 1b*	QL (20 capsules per 1 day)
anagrelide hcl oral capsule 1 mg	1 or 1b*	QL (10 capsules per 1 day)
SPLEEN TYROSINE KINASE (SYK) INHIBITORS - DRUGS FOR THE BLOOD**		
TAVALISSE ORAL TABLET (*fostamatinib disodium*)	4	PA; LD; QL (2 tablets per 1 day)
THIENOPYRIDINE DERIVATIVES - DRUGS FOR THE BLOOD**		
clopidogrel bisulfate oral tablet	1 or 1b*	QL (1 tablet per 1 day)
prasugrel hcl oral tablet	1 or 1b*	QL (1 tablet per 1 day)
THROMBOLYTIC AGENT - MISC - DRUGS FOR THE BLOOD**		
DEFITELIO INTRAVENOUS SOLUTION (*defibrotide sodium*)	4	
TISSUE PLASMINOGEN ACTIVATORS - DRUGS FOR THE BLOOD**		
ACTIVASE INTRAVENOUS SOLUTION RECONSTITUTED (*alteplase*)	3	
CATHFLO ACTIVASE INJECTION SOLUTION RECONSTITUTED (*alteplase*)	3	
RETAVASE HALF-KIT INTRAVENOUS KIT (*reteplase*)	3	
RETAVASE INTRAVENOUS KIT (*reteplase*)	3	
TNKASE INTRAVENOUS KIT (*tenecteplase*)	3	
***HEMATOPOIETIC AGENTS* - DRUGS FOR NUTRITION**		
AGENTS FOR GAUCHER DISEASE - DRUGS FOR NUTRITION**		
CERDELGA ORAL CAPSULE (*eliglustat tartrate*)	2	PA; LD; QL (2 capsules per 1 day); SP
CEREZYME INTRAVENOUS SOLUTION RECONSTITUTED (*imiglucerase*)	2	PA; LD; SP
ELELYSO INTRAVENOUS SOLUTION RECONSTITUTED (*taliglucerase alfa*)	4	PA; LD; SP
miglustat oral capsule	2	PA; LD; QL (3 capsules per 1 day); SP
VPRIV INTRAVENOUS SOLUTION RECONSTITUTED (*velaglucerase alfa*)	4	PA; LD; SP
miglustat (Yargesa Oral Capsule)	2	PA; LD; QL (3 capsules per 1 day); SP
AGENTS FOR SICKLE CELL DISEASE - AUTOLOGOUS GENE THERAPY - DRUGS FOR NUTRITION**		
CASGEVY INTRAVENOUS SUSPENSION (*exagamglogene autotemcel*)	4	
LYFGENIA INTRAVENOUS SUSPENSION (*lovotibeglogene autotemcel*)	4	
AMINO ACIDS - DRUGS FOR NUTRITION**		
ENDARI ORAL PACKET (*glutamine (sickle cell)*)	4	PA; LD; SP
COBALAMINS - DRUGS FOR NUTRITION**		
cyanocobalamin injection solution	1 or 1a*	
dodex injection solution	1 or 1a*	
hydroxocobalamin acetate intramuscular solution	1 or 1b*	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CXCR4 RECEPTOR ANTAGONIST - DRUGS FOR NUTRITION**		
MOZOBIL SUBCUTANEOUS SOLUTION (*plerixafor*)	4	PA; LD; SP
plerixafor subcutaneous solution	4	PA; LD; SP
CYTOTOXIC AGENTS - DRUGS FOR NUTRITION**		
DROXIA ORAL CAPSULE (*hydroxyurea*)	2	
SIKLOS ORAL TABLET (*hydroxyurea*)	3	PA; SP
ERYTHROID MATURATION AGENTS - DRUGS FOR NUTRITION**		
REBLOZYL SUBCUTANEOUS SOLUTION RECONSTITUTED (*luspatercept-aamt*)	4	PA; LD; SP
ERYTHROPOIESIS-STIMULATING AGENTS (ESAS) - DRUGS FOR NUTRITION**		
ARANESP (ALBUMIN FREE) INJECTION SOLUTION (*darbepoetin alfa*)	4	PA; QL (4 vials per 28 days); SP
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 10 MCG/0.4ML, 100 MCG/0.5ML, 150 MCG/0.3ML, 200 MCG/0.4ML, 25 MCG/0.42ML, 300 MCG/0.6ML, 40 MCG/0.4ML, 60 MCG/0.3ML (*darbepoetin alfa*)	4	PA; QL (4 syringes per 28 days); SP
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 500 MCG/ML (*darbepoetin alfa*)	4	PA; QL (4 syringes per 30 days); SP
EPOGEN INJECTION SOLUTION (*epoetin alfa*)	4	PA; QL (12 mL per 28 days); SP
MIRCERA INJECTION SOLUTION PREFILLED SYRINGE (*methoxy peg-epoetin beta*)	4	PA; LD; QL (2 syringes per 28 days)
PROCRIT INJECTION SOLUTION (*epoetin alfa*)	4	PA; QL (12 mL per 28 days); SP
RETACRIT INJECTION SOLUTION (*epoetin alfa-epbx*)	4	PA; QL (12 mL per 28 days); SP
FOLIC ACID/FOLATE COMBINATIONS - DRUGS FOR NUTRITION**		
FOLIXATE ORAL TABLET (*folic acid-cholecalciferol*)	3	
foltabs 800 oral tablet	1 or 1b*; $0	
FOLIC ACID/FOLATES - DRUGS FOR NUTRITION**		
cvs folic acid oral tablet	1 or 1a*; $0	
fa-8 oral capsule	1 or 1b*; $0	
folate oral tablet	1 or 1a*; $0	
folic acid injection solution	1 or 1a*	
folic acid oral capsule	1 or 1b*; $0	
folic acid oral tablet	1 or 1a*; $0	
gnp folic acid oral tablet	1 or 1a*; $0	
kp folic acid oral tablet	1 or 1a*; $0	
qc folic acid oral tablet	1 or 1a*; $0	
ra folic acid oral tablet	1 or 1a*; $0	
sm folic acid oral tablet	1 or 1a*; $0	
yl folic acid oral tablet	1 or 1a*; $0	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GRANULOCYTE COLONY-STIMULATING FACTORS (G-CSF) - DRUGS FOR NUTRITION**		
GRANIX SUBCUTANEOUS SOLUTION (*tbo-filgrastim*)	4	PA; SP
GRANIX SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (*tbo-filgrastim*)	4	PA; SP
NEULASTA ONPRO SUBCUTANEOUS PREFILLED SYRINGE KIT (*pegfilgrastim*)	4	PA; QL (2 injectors/kits per 28 days); SP
NEULASTA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (*pegfilgrastim*)	4	PA; QL (2 syringes per 28 days); SP
ROLVEDON SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (*eflapegrastim-xnst*)	4	PA; LD; QL (2 syringes per 28 days); SP
UDENYCA SUBCUTANEOUS SOLUTION AUTO-INJECTOR (*pegfilgrastim-cbqv*)	4	PA; SP
UDENYCA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (*pegfilgrastim-cbqv*)	4	PA; QL (2 syringes per 28 days); SP
ZARXIO INJECTION SOLUTION PREFILLED SYRINGE (*filgrastim-sndz*)	4	PA; SP
GRANULOCYTE/MACROPHAGE COLONY-STIMULATING FACTOR(GM-CSF) - DRUGS FOR NUTRITION**		
LEUKINE INJECTION SOLUTION RECONSTITUTED (*sargramostim*)	4	PA; SP
HEMOGLOBIN S (HBS) POLYMERIZATION INHIBITORS - DRUGS FOR NUTRITION**		
OXBRYTA ORAL TABLET (*voxelotor*)	4	PA; LD; QL (5 tablets per 1 day); SP
OXBRYTA ORAL TABLET SOLUBLE (*voxelotor*)	4	PA; LD; QL (5 tablets per 1 day); SP
IRON - DRUGS FOR NUTRITION**		
ACCRUFER ORAL CAPSULE (*ferric maltol*)	3	
FERAHEME INTRAVENOUS SOLUTION (*ferumoxytol*)	4	PA; QL (2 vials per 6 days); SP
FERRLECIT INTRAVENOUS SOLUTION (*na ferric gluc cplx in sucrose*)	4	PA; QL (16 vials per 8 weekss); SP
ferumoxytol intravenous solution	4	PA; QL (2 vials per 6 days); SP
INFED INJECTION SOLUTION (*iron dextran*)	4	PA; SP
na ferric gluc cplx in sucrose intravenous solution	4	PA; QL (16 vials per 8 weekss); SP
VENOFER INTRAVENOUS SOLUTION (*iron sucrose*)	4	PA; QL (15 mL per 84 days); SP
SELECTIN BLOCKERS - DRUGS FOR NUTRITION**		
ADAKVEO INTRAVENOUS SOLUTION (*crizanlizumab-tmca*)	4	PA; SP
THROMBOPOIETIN (TPO) RECEPTOR AGONISTS - DRUGS FOR NUTRITION**		
DOPTELET ORAL TABLET (*avatrombopag maleate*)	4	PA; LD; QL (2 tablets per 1 day); SP
MULPLETA ORAL TABLET (*lusutrombopag*)	4	PA; QL (1 tablet per 1 day); SP
NPLATE SUBCUTANEOUS SOLUTION RECONSTITUTED (*romiplostim*)	4	PA; SP
PROMACTA ORAL PACKET 12.5 MG (*eltrombopag olamine*)	4	PA; LD; DO; SP
PROMACTA ORAL PACKET 25 MG (*eltrombopag olamine*)	4	PA; LD; QL (3 dose-packs per 1 day); SP

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PROMACTA ORAL TABLET 12.5 MG, 25 MG (*eltrombopag olamine*)	4	PA; LD; DO; SP
PROMACTA ORAL TABLET 50 MG (*eltrombopag olamine*)	4	PA; LD; QL (3 tablets per 1 day); SP
PROMACTA ORAL TABLET 75 MG (*eltrombopag olamine*)	4	PA; LD; QL (1 tablet per 1 day); SP
***HEMOSTATICS* - DRUGS FOR THE BLOOD**		
HEMOSTATIC COMBINATIONS - TOPICAL - DRUGS TO PREVENT BLEEDING**		
ARTISS EXTERNAL KIT (*fibrin sealant component*)	3	
ARTISS EXTERNAL SOLUTION (*fibrin sealant component*)	3	
THROMBI-GEL 10 EXTERNAL PAD (*thrombin-cmc-cacl-gelatin*)	3	
THROMBI-GEL 100 EXTERNAL PAD (*thrombin-cmc-cacl-gelatin*)	3	
THROMBI-GEL 40 EXTERNAL PAD (*thrombin-cmc-cacl-gelatin*)	3	
THROMBI-PAD EXTERNAL PAD (*thrombin-cmc-cacl*)	3	
TISSEEL EXTERNAL KIT (*fibrin sealant component*)	3	
TISSEEL EXTERNAL SOLUTION (*fibrin sealant component*)	3	
HEMOSTATICS - SYSTEMIC - DRUGS TO PREVENT BLEEDING**		
aminocaproic acid intravenous solution	1 or 1b*	
aminocaproic acid oral solution	1 or 1b*	QL (120 mL per 1 day)
aminocaproic acid oral tablet 1000 mg	1 or 1b*	
aminocaproic acid oral tablet 500 mg	1 or 1b*	QL (60 tablets per 1 day)
CYKLOKAPRON INTRAVENOUS SOLUTION (*tranexamic acid*)	3	
tranexamic acid intravenous solution	1 or 1b*	
tranexamic acid oral tablet	1 or 1b*	QL (6 tablets per 1 day)
TRANEXAMIC ACID-NACL INTRAVENOUS SOLUTION	3	
HEMOSTATICS - TOPICAL - DRUGS TO PREVENT BLEEDING**		
ACTIFOAM COLLAGEN SPONGE EXTERNAL (*absorbable collagen hemostat*)	3	
AVITENE EXTERNAL PAD (*microfibrillar coll hemostat*)	3	
AVITENE FLOUR EXTERNAL POWDER (*microfibrillar coll hemostat*)	3	
ENDO AVITENE EXTERNAL (*absorbable collagen hemostat*)	3	
GELFILM EXTERNAL FILM (*gelatin absorbable*)	3	
GEL-FLOW NT EXTERNAL PREFILLED SYRINGE (*gelatin absorbable*)	3	
GELFOAM COMPRESSED SIZE 100 EXTERNAL (*gelatin absorbable*)	3	
GELFOAM DENTAL PACK SIZE 4 EXTERNAL (*gelatin absorbable*)	3	
GELFOAM MOUTH/THROAT POWDER (*gelatin absorbable*)	3	
GELFOAM SPONGE EXTERNAL (*gelatin absorbable*)	3	
GELFOAM SPONGE SIZE 100 EXTERNAL (*gelatin absorbable*)	3	
GELFOAM SPONGE SIZE 200 EXTERNAL (*gelatin absorbable*)	3	
GELFOAM SPONGE SIZE 50 EXTERNAL (*gelatin absorbable*)	3	
INSTAT EXTERNAL PAD (*absorbable collagen hemostat*)	3	
INTERCEED (TC7) EXTERNAL PAD (*oxidized cellulose*)	3	

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
INTERCEED EXTERNAL PAD (*oxidized cellulose*)	3	
RECOTHROM EXTERNAL SOLUTION RECONSTITUTED (*thrombin (recombinant)*)	3	
RECOTHROM SPRAY KIT EXTERNAL SOLUTION RECONSTITUTED (*thrombin (recombinant)*)	3	
SURGICEL FIBRILLAR EXTERNAL PAD (*oxidized cellulose*)	3	
SURGICEL NU-KNIT EXTERNAL PAD (*oxidized cellulose*)	3	
SURGICEL SNOW 1"X2" EXTERNAL PAD (*oxidized cellulose*)	3	
SURGICEL SNOW 2"X4" EXTERNAL PAD (*oxidized cellulose*)	3	
SURGICEL SNOW 4"X4" EXTERNAL PAD (*oxidized cellulose*)	3	
SYRINGE AVITENE EXTERNAL (*absorbable collagen hemostat*)	3	
TACHOSIL EXTERNAL PATCH (*absorbable fibrin sealant*)	3	
THROMBIN-JMI EPISTAXIS EXTERNAL KIT (*thrombin*)	3	
THROMBIN-JMI EXTERNAL KIT (*thrombin*)	3	
THROMBIN-JMI EXTERNAL SOLUTION RECONSTITUTED (*thrombin*)	3	
THROMBOGEN EXTERNAL KIT (*thrombin*)	3	
THROMBOGEN EXTERNAL SOLUTION RECONSTITUTED (*thrombin*)	3	
ULTRAFOAM SPONGE 2X6.25X7CM EXTERNAL (*microfibrillar coll hemostat*)	3	
ULTRAFOAM SPONGE 8X12.5X1CM EXTERNAL (*microfibrillar coll hemostat*)	3	
ULTRAFOAM SPONGE 8X12.5X3CM EXTERNAL (*microfibrillar coll hemostat*)	3	
ULTRAFOAM SPONGE 8X25X1CM EXTERNAL (*microfibrillar coll hemostat*)	3	
ULTRAFOAM SPONGE 8X6.25X1CM EXTERNAL (*microfibrillar coll hemostat*)	3	
***HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS* - DRUGS FOR THE NERVOUS SYSTEM**		
BARBITURATE HYPNOTICS - DRUGS FOR INSOMNIA**		
pentobarbital sodium injection solution	1 or 1b*	
phenobarbital oral elixir	1 or 1b*	QL (100 mL per 1 day)
phenobarbital oral tablet 100 mg, 60 mg, 64.8 mg, 97.2 mg	1 or 1b*	QL (4 tablets per 1 day)
phenobarbital oral tablet 15 mg, 16.2 mg, 30 mg, 32.4 mg	1 or 1b*	DO
phenobarbital sodium injection solution	1 or 1b*	
SEZABY INTRAVENOUS SOLUTION RECONSTITUTED (*phenobarbital sodium*)	3	
BENZODIAZEPINE HYPNOTICS - DRUGS FOR SEIZURES /PERSONALITY DISORDER/NERVE PAIN**		
BYFAVO INTRAVENOUS SOLUTION RECONSTITUTED (*remimazolam besylate*)	4	
DORAL ORAL TABLET (*quazepam*)	3	ST; QL (1 tablet per 1 day)
estazolam oral tablet	1 or 1b*	QL (1 tablet per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HALCION ORAL TABLET (*triazolam*)	3	ST; QL (1 tablet per 1 day)
midazolam hcl (pf) injection solution	1 or 1b*	
midazolam hcl injection solution	1 or 1b*	
midazolam hcl oral syrup	1 or 1b*	QL (10 mL per 1 fill)
MIDAZOLAM HCL-SODIUM CHLORIDE INTRAVENOUS SOLUTION	3	
midazolam-sodium chloride (pf) intravenous solution	3	
quazepam oral tablet	1 or 1b*	QL (1 tablet per 1 day)
RESTORIL ORAL CAPSULE (*temazepam*)	3	ST; QL (1 capsule per 1 day)
temazepam oral capsule	1 or 1b*	QL (1 capsule per 1 day)
triazolam oral tablet	1 or 1b*	QL (1 tablet per 1 day)
HYPNOTICS - TRICYCLIC AGENTS - DRUGS FOR INSOMNIA**		
doxepin hcl oral tablet	1 or 1b*	ST; QL (1 tablet per 1 day)
NON-BENZODIAZEPINE - GABA-RECEPTOR MODULATORS - DRUGS FOR INSOMNIA**		
EDLUAR SUBLINGUAL TABLET SUBLINGUAL (*zolpidem tartrate*)	3	ST; QL (1 tablet per 1 day)
eszopiclone oral tablet	1 or 1b*	QL (1 tablet per 1 day)
zaleplon oral capsule	1 or 1b*	QL (1 capsule per 1 day)
zolpidem tartrate er oral tablet extended release	1 or 1b*	QL (1 tablet per 1 day)
zolpidem tartrate oral tablet	1 or 1b*	QL (1 tablet per 1 day)
zolpidem tartrate sublingual tablet sublingual	1 or 1b*	ST; QL (1 tablet per 1 day)
OREXIN RECEPTOR ANTAGONISTS - DRUGS FOR INSOMNIA**		
BELSOMRA ORAL TABLET (*suvorexant*)	3	ST; QL (1 tablet per 1 day)
SELECTIVE ALPHA2-ADRENORECEPTOR AGONIST SEDATIVES - DRUGS FOR INSOMNIA**		
dexmedetomidine hcl in nacl intravenous solution	1 or 1b*	
DEXMEDETOMIDINE HCL INTRAVENOUS SOLUTION 1000 MCG/10ML, 400 MCG/4ML	3	
dexmedetomidine hcl intravenous solution 200 mcg/2ml	1 or 1b*	
DEXMEDETOMIDINE HCL-DEXTROSE INTRAVENOUS SOLUTION	3	
IGALMI SUBLINGUAL FILM (*dexmedetomidine hcl*)	3	PA; QL (20 films per 30 days)
PRECEDEX INTRAVENOUS SOLUTION (*dexmedetomidine hcl in nacl*)	3	
SELECTIVE MELATONIN RECEPTOR AGONISTS - DRUGS FOR INSOMNIA**		
HETLIOZ LQ ORAL SUSPENSION (*tasimelteon*)	4	PA; LD; QL (5 mL per 1 day)
ramelteon oral tablet	1 or 1b*	QL (1 tablet per 1 day)
tasimelteon oral capsule	4	PA; LD; QL (1 capsule per 1 day)
***LAXATIVES* - DRUGS FOR THE STOMACH**		
BOWEL EVACUANT COMBINATIONS - DRUGS TO PREVENT CONSTIPATION**		
GAVILYTE-C ORAL SOLUTION RECONSTITUTED (*peg 3350-kcl-nabcb-nacl-nasulf*)	1 or 1a*; $0	QL (1 bottle per 30 days)
gavilyte-g oral solution reconstituted	1 or 1a*; $0	QL (4000 grams per 30 days)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
na sulfate-k sulfate-mg sulf oral solution	1 or 1b*; $0	QL (2 kits per 30 days)
peg 3350-kcl-na bicarb-nacl oral solution reconstituted	1 or 1a*; $0	QL (4000 grams per 30 days)
peg-3350/electrolytes oral solution reconstituted	1 or 1a*; $0	QL (4000 grams per 30 days)
peg-3350/electrolytes/ascorbat oral solution reconstituted	1 or 1b*; $0	QL (1 gram per 30 days)
peg-kcl-nacl-nasulf-na asc-c oral solution reconstituted	1 or 1b*; $0	QL (1 gram per 30 days)
PEG-PREP ORAL KIT (*bisacodyl-peg-kcl-nabicar-nacl*)	3	QL (1 kit per 30 days)
LAXATIVES - MISCELLANEOUS - DRUGS TO PREVENT CONSTIPATION**		
clearlax oral powder	1 or 1b*; $0	
constulose oral solution	1 or 1b*	
cvs purelax oral packet	1 or 1b*; $0	
cvs purelax oral powder	1 or 1b*; $0	
eq clearlax oral powder	1 or 1b*; $0	
eq laxative oral packet	1 or 1b*; $0	
eql clearlax oral powder	1 or 1b*; $0	
ft clearlax oral powder	1 or 1b*; $0	
gavilax oral powder	1 or 1b*; $0	
gentlelax oral powder	1 or 1b*; $0	
glycolax oral powder	1 or 1b*; $0	
gnp clearlax oral packet	1 or 1b*; $0	
gnp clearlax oral powder	1 or 1b*; $0	
goodsense clearlax oral powder	1 or 1b*; $0	
healthylax oral packet	1 or 1b*; $0	
hm clearlax oral powder	1 or 1b*; $0	
kls laxaclear oral powder	1 or 1b*; $0	
KRISTALOSE ORAL PACKET (*lactulose*)	3	
LACTULOSE ORAL PACKET	3	
lactulose oral solution	1 or 1b*	
mm clearlax oral powder	1 or 1b*; $0	
peg 3350 oral packet	1 or 1b*; $0	
peg 3350 oral powder	1 or 1b*; $0	
polyethylene glycol 3350 oral packet	1 or 1b*; $0	
polyethylene glycol 3350 oral powder	1 or 1b*; $0	
qc natura-lax oral powder	1 or 1b*; $0	
ra laxative oral powder	1 or 1b*; $0	
sb polyethylene glycol 3350 oral powder	1 or 1b*; $0	
sm clearlax oral powder	1 or 1b*; $0	
smooth lax oral packet	1 or 1b*; $0	
smooth lax oral powder	1 or 1b*; $0	
LUBRICANT LAXATIVES - DRUGS TO PREVENT CONSTIPATION**		
mineral oil heavy oral oil	1 or 1b*	

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SALINE LAXATIVES - DRUGS TO PREVENT CONSTIPATION**		
citrate of magnesia oral solution	1 or 1a*; $0	
citroma oral solution	1 or 1a*; $0	
cvs magnesium citrate oral solution	1 or 1a*; $0	
cvs milk of magnesia oral suspension	1 or 1b*; $0	
dulcolax milk of magnesia oral suspension	1 or 1b*; $0	
dulcolax oral suspension	1 or 1b*; $0	
eq magnesium citrate oral solution	1 or 1a*; $0	
FRESKARO MAGNESIUM CITRATE ORAL SOLUTION (*magnesium citrate*)	1 or 1a*; $0	
ft magnesium citrate oral solution	1 or 1a*; $0	
ft milk of magnesia oral suspension	1 or 1b*; $0	
gnp magnesium citrate oral solution	1 or 1a*; $0	
gnp milk of magnesia oral suspension	1 or 1b*; $0	
goodsense magnesium citrate oral solution	1 or 1a*; $0	
goodsense milk of magnesia oral suspension	1 or 1b*; $0	
hm milk of magnesia oral suspension	1 or 1b*; $0	
magnesium citrate oral solution	1 or 1a*; $0	
milk of magnesia oral suspension	1 or 1b*; $0	
ONELAX MAGNESIUM CITRATE ORAL SOLUTION (*magnesium citrate*)	1 or 1a*; $0	
phillips milk of magnesia oral suspension	1 or 1b*; $0	
qc magnesium citrate oral solution	1 or 1a*; $0	
qc milk of magnesia oral suspension	1 or 1b*; $0	
ra magnesium citrate oral solution	1 or 1a*; $0	
ra milk of magnesia oral suspension	1 or 1b*; $0	
sb magnesium citrate oral solution	1 or 1a*; $0	
sb milk of magnesia oral suspension	1 or 1b*; $0	
sm magnesium citrate oral solution	1 or 1a*; $0	
sm milk of magnesia oral suspension	1 or 1b*; $0	
STIMULANT LAXATIVES - DRUGS TO PREVENT CONSTIPATION**		
alophen oral tablet delayed release	1 or 1a*; $0	
bisacodyl ec oral tablet delayed release	1 or 1a*; $0	
bisacodyl oral tablet delayed release	1 or 1a*; $0	
cvs c-lax laxative oral tablet delayed release	1 or 1a*; $0	
cvs gentle laxative oral tablet delayed release	1 or 1a*; $0	
cvs gentle laxative womens oral tablet delayed release	1 or 1a*; $0	
eq gentle laxative oral tablet delayed release	1 or 1a*; $0	
eql gentle laxative oral tablet delayed release	1 or 1a*; $0	
eql laxative oral tablet delayed release	1 or 1a*; $0	
ex-lax ultra oral tablet delayed release	1 or 1a*; $0	

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ft laxative oral tablet delayed release	1 or 1a*; $0	
gentle laxative oral tablet delayed release	1 or 1a*; $0	
gnp gentle laxative oral tablet delayed release	1 or 1a*; $0	
gnp womens gentle laxative oral tablet delayed release	1 or 1a*; $0	
goodsense bisacodyl ec oral tablet delayed release	1 or 1a*; $0	
goodsense bisacodyl laxative oral tablet delayed release	1 or 1a*; $0	
kp bisacodyl oral tablet delayed release	1 or 1a*; $0	
laxative oral tablet delayed release	1 or 1a*; $0	
qc gentle laxative oral tablet delayed release	1 or 1a*; $0	
qc gentle laxative womens oral tablet delayed release	1 or 1a*; $0	
qc laxative oral tablet delayed release	1 or 1a*; $0	
ra laxative oral tablet delayed release	1 or 1a*; $0	
ra womens laxative oral tablet delayed release	1 or 1a*; $0	
sb bisacodyl laxative ec oral tablet delayed release	1 or 1a*; $0	
sb gentle lax-women oral tablet delayed release	1 or 1a*; $0	
sm gentle laxative oral tablet delayed release	1 or 1a*; $0	
womans laxative oral tablet delayed release	1 or 1a*; $0	
womens laxative oral tablet delayed release	1 or 1a*; $0	
***LOCAL ANESTHETICS-PARENTERAL* - DRUGS FOR PAIN AND FEVER**		
LOCAL ANESTHETIC & SYMPATHOMIMETIC - DRUGS FOR SEDATION**		
articadent dental injection solution cartridge	3	
bupivacaine-epinephrine (pf) injection solution	1 or 1b*	
bupivacaine-epinephrine injection solution	1 or 1b*	
lidocaine-epinephrine injection solution	1 or 1b*	
MARCAINE/EPINEPHRINE INJECTION SOLUTION (*bupivacaine-epinephrine*)	3	
MARCAINE/EPINEPHRINE PF INJECTION SOLUTION (*bupivacaine-epinephrine*)	3	
ORABLOC INJECTION SOLUTION CARTRIDGE (*articaine-epinephrine*)	3	
sensorcaine/epinephrine injection solution	1 or 1b*	
sensorcaine-mpf/epinephrine injection solution 0.25% -1:200000	1 or 1b*	
sensorcaine-mpf/epinephrine injection solution 0.5% -1:200000	3	
SENSORCAINE-MPF/EPINEPHRINE INJECTION SOLUTION 0.75-1:200000 % (*bupivacaine-epinephrine*)	3	
XYLOCAINE/EPINEPHRINE INJECTION SOLUTION (*lidocaine-epinephrine*)	3	
XYLOCAINE-MPF/EPINEPHRINE INJECTION SOLUTION (*lidocaine-epinephrine*)	3	

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LOCAL ANESTHETIC COMBINATIONS - DRUGS FOR SEDATION**		
POINT OF CARE LM-2.5 INJECTION KIT (*lidocaine hcl-bupivacaine hcl*)	3	
LOCAL ANESTHETICS - AMIDES - DRUGS FOR SEDATION**		
BUPIVACAINE FISIOPHARMA INJECTION SOLUTION	3	
bupivacaine hcl (pf) injection solution	1 or 1b*	
lidocaine hcl (pf) injection solution	1 or 1b*	
lidocaine hcl injection solution	1 or 1b*	
MARCAINE INJECTION SOLUTION (*bupivacaine hcl*)	3	
MARCAINE PRESERVATIVE FREE INJECTION SOLUTION (*bupivacaine hcl*)	3	
MONOJECT BONE MARROW BIOPSY INJECTION KIT (*lidocaine hcl*)	3	
NAROPIN INJECTION SOLUTION (*ropivacaine hcl*)	3	
polocaine injection solution	1 or 1b*	
polocaine-mpf injection solution	1 or 1b*	
POSIMIR INJECTION SOLUTION (*bupivacaine*)	3	
ropivacaine hcl injection solution	1 or 1b*	
sensorcaine injection solution	1 or 1b*	
sensorcaine-mpf injection solution	1 or 1b*	
XARACOLL IMPLANT IMPLANT (*bupivacaine hcl*)	3	
XYLOCAINE INJECTION SOLUTION (*lidocaine hcl*)	3	
XYLOCAINE-MPF INJECTION SOLUTION (*lidocaine hcl*)	3	
LOCAL ANESTHETICS - ESTERS - DRUGS FOR SEDATION**		
chloroprocaine hcl (pf) injection solution	1 or 1b*	
NESACAINE INJECTION SOLUTION (*chloroprocaine hcl*)	3	
NESACAINE-MPF INJECTION SOLUTION (*chloroprocaine hcl*)	3	
***MACROLIDES* - DRUGS FOR INFECTIONS**		
AZITHROMYCIN - ANTIBIOTICS**		
azithromycin intravenous solution reconstituted	1 or 1b*	
azithromycin oral packet	1 or 1b*	
azithromycin oral suspension reconstituted	1 or 1b*	
azithromycin oral tablet	1 or 1b*	
ZITHROMAX INTRAVENOUS SOLUTION RECONSTITUTED (*azithromycin*)	3	
ZITHROMAX ORAL PACKET (*azithromycin*)	3	
ZITHROMAX ORAL SUSPENSION RECONSTITUTED (*azithromycin*)	3	
ZITHROMAX ORAL TABLET (*azithromycin*)	3	
ZITHROMAX TRI-PAK ORAL TABLET (*azithromycin*)	3	
ZITHROMAX Z-PAK ORAL TABLET (*azithromycin*)	3	
CLARITHROMYCIN - ANTIBIOTICS**		
clarithromycin er oral tablet extended release 24 hour	1 or 1b*	

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
clarithromycin oral suspension reconstituted	1 or 1b*	
clarithromycin oral tablet	1 or 1b*	
ERYTHROMYCINS - ANTIBIOTICS**		
e.e.s. 400 oral tablet	1 or 1b*	
ery-tab oral tablet delayed release	1 or 1b*	
ERYTHROCIN LACTOBIONATE INTRAVENOUS SOLUTION RECONSTITUTED (*erythromycin lactobionate*)	3	
erythrocin stearate oral tablet	1 or 1b*	
erythromycin base oral capsule delayed release particles	1 or 1b*	
erythromycin base oral tablet	1 or 1b*	
erythromycin base oral tablet delayed release	1 or 1b*	
erythromycin ethylsuccinate oral suspension reconstituted	1 or 1b*	
erythromycin ethylsuccinate oral tablet	1 or 1b*	
erythromycin lactobionate intravenous solution reconstituted	1 or 1b*	
erythromycin oral tablet delayed release	1 or 1b*	
FIDAXOMICIN - ANTIBIOTICS**		
DIFICID ORAL SUSPENSION RECONSTITUTED (*fidaxomicin*)	3	QL (1 bottle per 30 days)
DIFICID ORAL TABLET (*fidaxomicin*)	3	QL (20 tablets per 1 fill)
***MEDICAL DEVICES AND SUPPLIES* - MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT**		
CERVICAL CAPS - MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT**		
FEMCAP VAGINAL DEVICE (*cervical caps*)	2; $0	
CONDOMS - FEMALE - MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT**		
FC2 FEMALE CONDOM (*condoms - female*)	2; $0	QL (12 units per 1 fill)
CONDOMS - MALE - MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT**		
aimsco lubricated	2; $0	
condoms	2; $0	
DUREX EXTRA SENSITIVE THIN DEVICE (*condoms latex lubricated*)	2; $0	
DUREX REALFEEL DEVICE (*condoms non-latex lubricated*)	2; $0	
FANTASY LUBRICATED (*condoms latex lubricated*)	2; $0	
FANTASY LUBRICATED/SPERMICIDE (*condoms latex lubricated*)	2; $0	
KAMELEON LUBRICATED (*condoms latex lubricated*)	2; $0	
kimono	2; $0	
KIMONO COLORS DEVICE (*condoms latex lubricated*)	2; $0	
kimono micro thin	2; $0	
kimono micro thin plus	2; $0	
kimono plus	2; $0	
kimono ps	2; $0	
kimono ps plus	2; $0	
kimono sensation	2; $0	

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
kimono sensation plus	2; $0	
KIMONO SPECIAL DEVICE (*condoms latex lubricated*)	2; $0	
maxx	2; $0	
maxx plus	2; $0	
REALITY LATEX CONDOMS (*condoms latex lubricated*)	2; $0	
REALITY LATEX/ULTRA TEXTURED DEVICE (*condoms latex lubricated*)	2; $0	
REALITY LATEX/ULTRA THIN DEVICE (*condoms latex lubricated*)	2; $0	
TRUSTEX COLOR CONDOMS + LUBE (*condoms latex lubricated*)	2; $0	
TRUSTEX LUB/RIBBED/STUDDED (*condoms latex lubricated*)	2; $0	
TRUSTEX LUB/SPERMICIDE EX ST (*condoms latex lubricated*)	2; $0	
TRUSTEX LUB/SPERMICIDE XL (*condoms latex lubricated*)	2; $0	
TRUSTEX LUBRICATED (*condoms latex lubricated*)	2; $0	
TRUSTEX LUBRICATED EX LARGE (*condoms latex lubricated*)	2; $0	
TRUSTEX LUBRICATED EXTRA ST (*condoms latex lubricated*)	2; $0	
TRUSTEX LUBRICATED/SPERMICIDE (*condoms latex lubricated*)	2; $0	
TRUSTEX NATURAL CONDOMS + LUBE (*condoms latex lubricated*)	2; $0	
TRUSTEX NON-LUBRICATED (*condoms latex non-lubricated*)	2; $0	
TRUSTEX RIA LUB/SPERMICIDE (*condoms latex lubricated*)	2; $0	
TRUSTEX RIA LUBRICATED (*condoms latex lubricated*)	2; $0	
TRUSTEX RIA NON-LUBRICATED (*condoms latex non-lubricated*)	2; $0	
TRUSTEX-NONOXYNOL-9/RIB/STUD (*condoms latex lubricated*)	2; $0	
DENTAL DESENSITIZING PRODUCTS - MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT**		
REMESENSE DENTAL (*dental desensitizing product*)	3	
DENTIFRICES - MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT**		
MI PASTE DENTAL PASTE (*dentifrices*)	3	
MI PASTE PLUS DENTAL PASTE (*dentifrices*)	3	
DIAPHRAGMS - MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT**		
CAYA VAGINAL DIAPHRAGM (*diaphragm arc-spring*)	2; $0	
OMNIFLEX DIAPHRAGM VAGINAL DIAPHRAGM (*diaphragms*)	3; $0	
WIDE-SEAL DIAPHRAGM 60 VAGINAL DIAPHRAGM (*diaphragm wide seal*)	2; $0	
WIDE-SEAL DIAPHRAGM 65 VAGINAL DIAPHRAGM (*diaphragm wide seal*)	2; $0	
WIDE-SEAL DIAPHRAGM 70 VAGINAL DIAPHRAGM (*diaphragm wide seal*)	2; $0	
WIDE-SEAL DIAPHRAGM 75 VAGINAL DIAPHRAGM (*diaphragm wide seal*)	2; $0	
WIDE-SEAL DIAPHRAGM 80 VAGINAL DIAPHRAGM (*diaphragm wide seal*)	2; $0	

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
WIDE-SEAL DIAPHRAGM 85 VAGINAL DIAPHRAGM (*diaphragm wide seal*)	2; $0	
WIDE-SEAL DIAPHRAGM 90 VAGINAL DIAPHRAGM (*diaphragm wide seal*)	2; $0	
WIDE-SEAL DIAPHRAGM 95 VAGINAL DIAPHRAGM (*diaphragm wide seal*)	2; $0	
GLUCOSE MONITORING TEST SUPPLIES - MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT**		
ACCU-CHEK FASTCLIX LANCETS (*lancets*)	2	QL (204 lancets per 30 days)
ACCU-CHEK SAFE-T PRO LANCETS (*lancets*)	2	QL (204 lancets per 30 days)
ACCU-CHEK SOFTCLIX LANCETS (*lancets*)	2	QL (204 lancets per 30 days)
ACTI-LANCE 28G	2	QL (204 lancets per 30 days)
ACTI-LANCE LITE LANCETS 28G	2	QL (204 lancets per 30 days)
ACTI-LANCE SPECIAL LANCETS 17G	2	QL (204 lancets per 30 days)
ACTI-LANCE UNIVERSAL 23G	2	QL (204 lancets per 30 days)
ADVANCED MOBILE LANCET	2	QL (204 lancets per 30 days)
ADVOCATE LANCETS (*lancets*)	2	QL (204 lancets per 30 days)
ADVOCATE LANCETS 30G (*lancets*)	2	QL (204 lancets per 30 days)
ADVOCATE SAFETY LANCETS (*lancets*)	2	QL (204 lancets per 30 days)
ADVOCATE SAFETY LANCETS 26G (*lancets*)	2	QL (204 lancets per 30 days)
AGAMATRIX ULTRA-THIN LANCETS (*lancets*)	2	QL (204 lancets per 30 days)
AIMSCO TWIST LANCETS 32G	2	QL (204 lancets per 30 days)
AIMSCO TWIST LANCETS 33G (*lancets*)	2	QL (204 lancets per 30 days)
AQUALANCE LANCETS 30G (*lancets*)	2	QL (204 lancets per 30 days)
ASSURE COMFORT LANCETS 28G	2	QL (204 lancets per 30 days)
ASSURE HAEMOLANCE PLUS HIGH (*lancets*)	2	QL (204 lancets per 30 days)
ASSURE HAEMOLANCE PLUS LOW (*lancets*)	2	QL (204 lancets per 30 days)
ASSURE HAEMOLANCE PLUS MICRO (*lancets*)	2	QL (204 lancets per 30 days)
ASSURE HAEMOLANCE PLUS NORMAL (*lancets*)	2	QL (204 lancets per 30 days)
ASSURE HAEMOLANCE PLUS PED (*lancets*)	2	QL (204 lancets per 30 days)
ASSURE LANCE LANCETS (*lancets*)	2	QL (204 lancets per 30 days)
ASSURE LANCE LANCETS 21G (*lancets*)	2	QL (204 lancets per 30 days)
ASSURE LANCE PLUS SAFETY 25G (*lancets*)	2	QL (204 lancets per 30 days)
ASSURE LANCE PLUS SAFETY 30G (*lancets*)	2	QL (204 lancets per 30 days)
ASSURE LANCE SAFETY LANCET 28G (*lancets*)	2	QL (204 lancets per 30 days)
AURORA LANCET SUPER THIN 30G	2	QL (204 lancets per 30 days)
AURORA LANCET THIN 23G	2	QL (204 lancets per 30 days)
BD MICROTAINER LANCETS (*lancets*)	2	QL (204 lancets per 30 days)
CAREONE LANCET SUPER THIN 30G (*lancets*)	2	QL (204 lancets per 30 days)
CAREONE LANCET THIN 23G	2	QL (204 lancets per 30 days)
CARESENS LANCETS (*lancets*)	2	QL (204 lancets per 30 days)
CARESENS LANCETS 30G (*lancets*)	2	QL (204 lancets per 30 days)

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CARETOUCH SAFETY LANCETS (*lancets*)	2	QL (204 lancets per 30 days)
CARETOUCH SAFETY LANCETS 26G (*lancets*)	2	QL (204 lancets per 30 days)
CARETOUCH TWIST LANCETS 28G (*lancets*)	2	QL (204 lancets per 30 days)
CARETOUCH TWIST LANCETS 30G (*lancets*)	2	QL (204 lancets per 30 days)
CARETOUCH TWIST LANCETS 33G (*lancets*)	2	QL (204 lancets per 30 days)
CARETOUCH TWIST MC LANCETS 30G (*lancets*)	2	QL (204 lancets per 30 days)
CLEANLET LANCETS 28G (*lancets*)	2	QL (204 lancets per 30 days)
CLEVER CHEK LANCETS (*lancets*)	2	QL (204 lancets per 30 days)
CLEVER CHOICE COMFORT EZ (*lancets*)	2	
CLEVER CHOICE LANCETS 21G (*lancets*)	2	QL (204 lancets per 30 days)
CLEVER CHOICE LANCETS 23G (*lancets*)	2	QL (204 lancets per 30 days)
CLEVER CHOICE LANCETS 28G (*lancets*)	2	QL (204 lancets per 30 days)
COAGUCHEK LANCETS (*lancets*)	2	QL (204 lancets per 30 days)
COMFORT ASSURED LANCETS 28G	2	QL (204 lancets per 30 days)
COMFORT ASSURED LANCETS 33G	2	QL (204 lancets per 30 days)
COMFORT TOUCH LANCETS 31G (*lancets*)	2	QL (204 lancets per 30 days)
COMFORT TOUCH PLUS LANCETS 28G (*lancets*)	2	QL (204 lancets per 30 days)
COMFORT TOUCH PLUS LANCETS 30G (*lancets*)	2	QL (204 lancets per 30 days)
CVS LANCETS 21G	2	QL (204 lancets per 30 days)
CVS LANCETS MICRO THIN 33G	2	QL (204 lancets per 30 days)
CVS LANCETS ORIGINAL	2	QL (204 lancets per 30 days)
CVS LANCETS THIN 26G	2	QL (204 lancets per 30 days)
CVS LANCETS ULTRA THIN 30G	2	QL (204 lancets per 30 days)
CVS LANCETS ULTRA-THIN 30G	2	QL (204 lancets per 30 days)
CVS ULTRA THIN LANCETS	2	QL (204 lancets per 30 days)
DEXCOM G6 RECEIVER DEVICE (*continuous blood gluc receiver*)	2	PA; QL (1 unit per 365 days)
DEXCOM G6 SENSOR (*continuous blood gluc sensor*)	2	PA; QL (3 units per 30 days)
DEXCOM G6 TRANSMITTER (*continuous blood gluc transmit*)	2	PA; QL (1 unit per 90 days)
DEXCOM G7 RECEIVER DEVICE (*continuous blood gluc receiver*)	2	PA; QL (1 receiver per 1 year)
DEXCOM G7 SENSOR (*continuous blood gluc sensor*)	2	PA; QL (3 sensors per 30 days)
DIATHRIVE LANCET ULTRA THIN 30 (*lancets*)	2	QL (204 lancets per 30 days)
DIATHRIVE LANCETS (*lancets*)	2	QL (204 lancets per 30 days)
DROPLET LANCETS ULTRA THIN 30G (*lancets*)	2	QL (204 lancets per 30 days)
DROPLET PERSONAL LANCETS 30G (*lancets*)	2	QL (204 lancets per 30 days)
DRUG MART LANCETS THIN 26G	2	QL (204 lancets per 30 days)
DRUG MART ON-THE-GO LANCET 30G (*lancets*)	2	QL (204 lancets per 30 days)
DRUG MART UNILET LANCETS 28G (*lancets*)	2	QL (204 lancets per 30 days)
DRUG MART UNILET LANCETS 30G (*lancets*)	2	QL (204 lancets per 30 days)
DRUG MART UNILET LANCETS 33G (*lancets*)	2	QL (204 lancets per 30 days)
EASY COMFORT LANCETS	2	QL (204 lancets per 30 days)
EASY COMFORT LANCETS TWIST TOP	2	QL (204 lancets per 30 days)

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EASY TOUCH LANCETS 21G (*lancets*)	2	QL (204 lancets per 30 days)
EASY TOUCH LANCETS 23G (*lancets*)	2	QL (204 lancets per 30 days)
EASY TOUCH LANCETS 26G (*lancets*)	2	QL (204 lancets per 30 days)
EASY TOUCH LANCETS 28G (*lancets*)	2	QL (204 lancets per 30 days)
EASY TOUCH LANCETS 28G/TWIST (*lancets*)	2	QL (204 lancets per 30 days)
EASY TOUCH LANCETS 30G (*lancets*)	2	QL (204 lancets per 30 days)
EASY TOUCH LANCETS 30G/TWIST (*lancets*)	2	QL (204 lancets per 30 days)
EASY TOUCH LANCETS 32G (*lancets*)	2	QL (204 lancets per 30 days)
EASY TOUCH LANCETS 32G/TWIST (*lancets*)	2	QL (204 lancets per 30 days)
EASY TOUCH LANCETS 33G/TWIST (*lancets*)	2	QL (204 lancets per 30 days)
EASY TOUCH SAFETY LANCETS 21G (*lancets*)	2	QL (204 lancets per 30 days)
EASY TOUCH SAFETY LANCETS 23G (*lancets*)	2	QL (204 lancets per 30 days)
EASY TOUCH SAFETY LANCETS 26G (*lancets*)	2	QL (204 lancets per 30 days)
EASY TOUCH SAFETY LANCETS 28G (*lancets*)	2	QL (204 lancets per 30 days)
EMBRACE LANCETS ULTRA THIN 30G (*lancets*)	2	QL (204 lancets per 30 days)
EMBRACE PRESSURE ACTIVATED 21G (*lancets*)	2	QL (204 lancets per 30 days)
EMBRACE PRESSURE ACTIVATED 28G (*lancets*)	2	QL (204 lancets per 30 days)
ENLITE GLUCOSE SENSOR (*continuous blood gluc sensor*)	3	PA
EQL COLOR LANCETS 21G	2	QL (204 lancets per 30 days)
EQL COLOR LANCETS MICRO 33G	2	QL (204 lancets per 30 days)
EQL SUPER THIN LANCETS 30G	2	QL (204 lancets per 30 days)
EQL THIN LANCETS 26G	2	QL (204 lancets per 30 days)
EVERSENSE E3 SENSOR/HOLDER (*continuous blood gluc sensor*)	3	PA
EVERSENSE E3 SMART TRANSMITTER (*continuous blood gluc transmit*)	3	PA; QL (1 unit per 365 days)
EVERSENSE SENSOR/HOLDER (*continuous blood gluc sensor*)	3	PA
EVERSENSE SMART TRANSMITTER (*continuous blood gluc transmit*)	3	PA; QL (1 unit per 365 days)
E-Z JECT LANCET MICRO-THIN 33G (*lancets*)	2	QL (204 lancets per 30 days)
E-Z JECT LANCET SUPER THIN 30G (*lancets*)	2	QL (204 lancets per 30 days)
E-Z JECT LANCETS (*lancets*)	2	QL (204 lancets per 30 days)
E-Z JECT LANCETS 21G (*lancets*)	2	QL (204 lancets per 30 days)
E-Z JECT LANCETS THIN 26G (*lancets*)	2	QL (204 lancets per 30 days)
EZ-LETS LANCETS 21G (*lancets*)	2	QL (204 lancets per 30 days)
EZ-LETS LANCETS 26G (*lancets*)	2	QL (204 lancets per 30 days)
EZ-LETS LANCETS 28G (*lancets*)	2	QL (204 lancets per 30 days)
EZ-LETS LANCETS 30G (*lancets*)	2	QL (204 lancets per 30 days)
FIFTY50 SAFETY SEAL LANCETS (*lancets*)	2	QL (204 lancets per 30 days)
FIFTY50 UNILET LANCETS 33G (*lancets*)	2	QL (204 lancets per 30 days)
FINE 30 (*lancets*)	2	QL (204 lancets per 30 days)
FINGERSTIX LANCETS (*lancets*)	2	QL (204 lancets per 30 days)
FORA LANCETS (*lancets*)	2	QL (204 lancets per 30 days)
FREESTYLE LANCETS (*lancets*)	2	QL (204 lancets per 30 days)

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FREESTYLE UNISTICK II LANCETS (*lancets*)	2	QL (204 lancets per 30 days)
GENTEEL BUTTERFLY TOUCH LANCET (*lancets*)	2	QL (204 lancets per 30 days)
GENTLE-LET GP LANCETS (*lancets*)	2	QL (204 lancets per 30 days)
GENTLE-LET LANCETS (*lancets*)	2	QL (204 lancets per 30 days)
GLOBAL INJECT EASE LANCETS 28G	2	QL (204 lancets per 30 days)
GLOBAL INJECT EASE LANCETS 30G	2	QL (204 lancets per 30 days)
GLUCOCOM LANCETS 28G (*lancets*)	2	QL (204 lancets per 30 days)
GLUCOCOM LANCETS 30G (*lancets*)	2	QL (204 lancets per 30 days)
GLUCOCOM LANCETS 33G (*lancets*)	2	QL (204 lancets per 30 days)
GNP LANCETS 21G	2	QL (204 lancets per 30 days)
GNP LANCETS THIN 26G	2	QL (204 lancets per 30 days)
GNP STERILE LANCETS 28G	2	QL (204 lancets per 30 days)
GNP STERILE LANCETS 30G	2	QL (204 lancets per 30 days)
GNP STERILE LANCETS 33G	2	QL (204 lancets per 30 days)
GOJJI STERILE LANCETS (*lancets*)	2	QL (204 lancets per 30 days)
GOODSENSE COLOR LANCETS 33G	2	QL (204 lancets per 30 days)
GOODSENSE LANCETS 26G UNIV	2	QL (204 lancets per 30 days)
GOODSENSE LANCETS 30G	2	QL (204 lancets per 30 days)
GOODSENSE LANCETS 30G UNIV	2	QL (204 lancets per 30 days)
GOODSENSE LANCETS 33G	2	QL (204 lancets per 30 days)
GOODSENSE LANCETS 33G UNIV	2	QL (204 lancets per 30 days)
GUARDIAN 4 GLUCOSE SENSOR (*continuous blood gluc sensor*)	3	PA; QL (5 sensors per 30 days)
GUARDIAN 4 TRANSMITTER (*continuous blood gluc transmit*)	3	PA; QL (2 units per 1 year)
GUARDIAN CONNECT TRANSMITTER (*continuous blood gluc transmit*)	3	PA; QL (2 units per 1 year)
GUARDIAN LINK 3 TRANSMITTER (*continuous blood gluc transmit*)	3	PA
GUARDIAN REAL-TIME REPLACE PED DEVICE (*continuous blood gluc receiver*)	3	PA; QL (1 unit per 365 days)
GUARDIAN SENSOR (3) (*continuous blood gluc sensor*)	3	PA; QL (5 sensors per 30 days)
GUARDIAN SENSOR 3	3	PA; QL (5 sensors per 30 days)
HAEMOLANCE (*lancets*)	2	QL (204 lancets per 30 days)
HAEMOLANCE LOW FLOW LANCETS (*lancets*)	2	QL (204 lancets per 30 days)
HAEMOLANCE PLUS (*lancets*)	2	QL (204 lancets per 30 days)
HAEMOLANCE PLUS HIGH FLOW (*lancets*)	2	QL (204 lancets per 30 days)
HAEMOLANCE PLUS LOW FLOW (*lancets*)	2	QL (204 lancets per 30 days)
HAEMOLANCE PLUS MAX FLOW (*lancets*)	2	QL (204 lancets per 30 days)
HAEMOLANCE PLUS PEDIATRIC FLOW (*lancets*)	2	QL (204 lancets per 30 days)
H-E-B INCONTROL LANCETS 28G	2	QL (204 lancets per 30 days)
H-E-B INCONTROL LANCETS 30G	2	QL (204 lancets per 30 days)
H-E-B INCONTROL LANCETS 33G	2	QL (204 lancets per 30 days)
HY-VEE LANCETS (*lancets*)	2	QL (204 lancets per 30 days)
HY-VEE THIN LANCETS	2	QL (204 lancets per 30 days)
IN TOUCH STERILE LANCETS 30G (*lancets*)	2	QL (204 lancets per 30 days)

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
KINNEY LANCETS	2	QL (204 lancets per 30 days)
KINNEY THIN LANCETS	2	QL (204 lancets per 30 days)
KROGER HEALTHPRO LANCET 26G (*lancets*)	2	QL (204 lancets per 30 days)
KROGER LANCETS	2	QL (204 lancets per 30 days)
KROGER LANCETS 21G	2	QL (204 lancets per 30 days)
KROGER LANCETS MICRO THIN 33G	2	QL (204 lancets per 30 days)
KROGER LANCETS SUPER THIN	2	QL (204 lancets per 30 days)
KROGER LANCETS THIN	2	QL (204 lancets per 30 days)
KROGER LANCETS THIN 26G	2	QL (204 lancets per 30 days)
KROGER LANCETS ULTRATHIN 30G	2	QL (204 lancets per 30 days)
LANCETS	2	QL (204 lancets per 30 days)
LANCETS 30G	2	QL (204 lancets per 30 days)
LANCETS 33G	2	QL (204 lancets per 30 days)
LANCETS MICRO THIN 33G	2	QL (204 lancets per 30 days)
LANCETS SUPER THIN 28G	2	QL (204 lancets per 30 days)
LANCETS THIN	2	QL (204 lancets per 30 days)
LANCETS ULTRA THIN (*lancets*)	2	QL (204 lancets per 30 days)
LANCETS ULTRA THIN 30G	2	QL (204 lancets per 30 days)
LIBERTY MEDICAL LANCETS (*lancets*)	2	QL (204 lancets per 30 days)
LITE TOUCH LANCETS	2	QL (204 lancets per 30 days)
LITETOUCH LANCETS (*lancets*)	2	QL (204 lancets per 30 days)
LIVE BETTER LANCET SUPER THIN	2	QL (204 lancets per 30 days)
LONGS LANCETS STANDARD	2	QL (204 lancets per 30 days)
LONGS LANCETS THIN	2	QL (204 lancets per 30 days)
LONGS LANCETS ULTRA THIN	2	QL (204 lancets per 30 days)
MEDICHOICE SAFETY LANCET	2	QL (204 lancets per 30 days)
MEDICHOICE SAFETY LANCET EXTRA	2	QL (204 lancets per 30 days)
MEDICHOICE SAFETY LANCET NORM	2	QL (204 lancets per 30 days)
MEDLANCE EXTRA 21G (*lancets*)	2	QL (204 lancets per 30 days)
MEDLANCE LITE 25G (*lancets*)	2	QL (204 lancets per 30 days)
MEDLANCE PLUS EXTRA 21G (*lancets*)	2	QL (204 lancets per 30 days)
MEDLANCE PLUS LANCETS (*lancets*)	2	QL (204 lancets per 30 days)
MEDLANCE PLUS LITE 25G (*lancets*)	2	QL (204 lancets per 30 days)
MEDLANCE PLUS SPECIAL 0.8MM (*lancets*)	2	QL (204 lancets per 30 days)
MEDLANCE PLUS SUPERLITE 30G (*lancets*)	2	QL (204 lancets per 30 days)
MEDLANCE PLUS UNIVERSAL 21G (*lancets*)	2	QL (204 lancets per 30 days)
MEDLANCE UNIVERSAL 21G (*lancets*)	2	QL (204 lancets per 30 days)
MEIJER LANCETS (*lancets*)	2	QL (204 lancets per 30 days)
MEIJER LANCETS THIN (*lancets*)	2	QL (204 lancets per 30 days)
MEIJER LANCETS UNIVERSAL 21G (*lancets*)	2	QL (204 lancets per 30 days)
MEIJER LANCETS UNIVERSAL 30G (*lancets*)	2	QL (204 lancets per 30 days)

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MEIJER LANCETS UNIVERSAL 33G (*lancets*)	2	QL (204 lancets per 30 days)
MEIJER SUPER THIN LANCETS (*lancets*)	2	QL (204 lancets per 30 days)
MICROLET LANCETS (*lancets*)	2	QL (204 lancets per 30 days)
MINILINK REAL-TIME TRANSMITTER (*continuous blood gluc transmit*)	3	PA
MINIMED 630G GUARDIAN PRESS (*continuous blood gluc transmit*)	3	PA
MM TWIST LANCETS (*lancets*)	2	QL (204 lancets per 30 days)
MONOLET LANCETS (*lancets*)	2	QL (204 lancets per 30 days)
MONOLET OPD LANCETS (*lancets*)	2	QL (204 lancets per 30 days)
MONOLETTOR SAFETY LANCETS (*lancets*)	2	QL (204 lancets per 30 days)
MPD SAFETY LANCET 21G	2	QL (204 lancets per 30 days)
MPD SAFETY LANCET 23G	2	QL (204 lancets per 30 days)
MPD SAFETY LANCET 28G	2	QL (204 lancets per 30 days)
MPD SAFETY LANCET 30G	2	QL (204 lancets per 30 days)
MYGLUCOHEALTH LANCETS 30G (*lancets*)	2	QL (204 lancets per 30 days)
NOVA SAFETY LANCETS 23G (*lancets*)	2	QL (204 lancets per 30 days)
NOVA SAFETY LANCETS 28G (*lancets*)	2	QL (204 lancets per 30 days)
NOVA SUREFLEX LANCETS (*lancets*)	2	QL (204 lancets per 30 days)
ONETOUCH DELICA PLUS LANCET30G (*lancets*)	2	QL (204 lancets per 30 days)
ONETOUCH DELICA PLUS LANCET33G (*lancets*)	2	QL (204 lancets per 30 days)
ONETOUCH ULTRASOFT 2 LANCETS (*lancets*)	2	QL (204 lancets per 30 days)
PARADIGM REAL-TIME TRANSMITTER (*continuous blood gluc transmit*)	3	PA
PERFECT LANCETS 28G (*lancets*)	2	QL (204 lancets per 30 days)
PERFECT LANCETS 30G (*lancets*)	2	QL (204 lancets per 30 days)
PHARMACIST CHOICE LANCETS (*lancets*)	2	QL (204 lancets per 30 days)
PHARMACY COUNTER LANCETS (*lancets*)	2	QL (204 lancets per 30 days)
PIP LANCETS 28G	2	QL (204 lancets per 30 days)
PIP LANCETS 30G	2	QL (204 lancets per 30 days)
PRECISION THINS GP LANCETS (*lancets*)	2	QL (204 lancets per 30 days)
PREFERRED PLUS LANCETS COLORED	2	QL (204 lancets per 30 days)
PREFERRED PLUS LANCETS THIN	2	QL (204 lancets per 30 days)
PRO COMFORT LANCETS 30G	2	QL (204 lancets per 30 days)
PRO COMFORT LANCETS 31G	2	QL (204 lancets per 30 days)
pro comfort safety lancets 30g	2	QL (204 lancets per 30 days)
PRODIGY LANCETS 28G (*lancets*)	2	QL (204 lancets per 30 days)
PRODIGY SAFETY LANCETS 26G (*lancets*)	2	QL (204 lancets per 30 days)
PRODIGY TWIST TOP LANCETS 28G (*lancets*)	2	QL (204 lancets per 30 days)
PSS SELECT GP LANCETS (*lancets*)	2	QL (204 lancets per 30 days)
PSS SELECT SAFETY LANCETS (*lancets*)	2	QL (204 lancets per 30 days)
PURE COMFORT LANCETS 30G	2	QL (204 lancets per 30 days)
PX LANCETS MICROTHIN 33G	2	QL (204 lancets per 30 days)

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PX LANCETS ULTRA THIN 28G	2	QL (204 lancets per 30 days)
QC LANCETS SUPER THIN 30G	2	QL (204 lancets per 30 days)
QC LANCETS ULTRA THIN	2	QL (204 lancets per 30 days)
QC UNILET LANCETS 28G	2	QL (204 lancets per 30 days)
QC UNILET LANCETS MICRO THIN	2	QL (204 lancets per 30 days)
RA E-ZJECT LANCETS 28G (*lancets*)	2	QL (204 lancets per 30 days)
RA E-ZJECT LANCETS THIN 26G (*lancets*)	2	QL (204 lancets per 30 days)
RA E-ZJECT LANCETS THIN 28G (*lancets*)	2	QL (204 lancets per 30 days)
RA E-ZJECT LANCETS ULTRA THIN (*lancets*)	2	QL (204 lancets per 30 days)
READYLANCE SAFETY LANCETS (*lancets*)	2	QL (204 lancets per 30 days)
REALITY LANCETS	2	QL (204 lancets per 30 days)
REALITY TRIGGER LANCETS	2	QL (204 lancets per 30 days)
RELION LANCETS MICRO-THIN 33G (*lancets*)	2	QL (204 lancets per 30 days)
RELION LANCETS THIN 26G (*lancets*)	2	QL (204 lancets per 30 days)
RELION LANCETS ULTRA-THIN 30G (*lancets*)	2	QL (204 lancets per 30 days)
RELION ULTRA THIN LANCETS 30G (*lancets*)	2	QL (204 lancets per 30 days)
RELION ULTRA THIN PLUS LANCETS (*lancets*)	2	QL (204 lancets per 30 days)
REXALL LANCETS ULTRA THIN 30G (*lancets*)	2	QL (204 lancets per 30 days)
RIGHTEST GL300 LANCETS (*lancets*)	2	QL (204 lancets per 30 days)
SAFE-T-LANCE (*lancets*)	2	QL (204 lancets per 30 days)
SAFE-T-LANCE PLUS (*lancets*)	2	QL (204 lancets per 30 days)
SAFETY LANCET 30G/PRESSURE ACT	2	QL (204 lancets per 30 days)
SAFETY LANCETS (*lancets*)	2	QL (204 lancets per 30 days)
SAFETY LANCETS 21G (*lancets*)	2	QL (204 lancets per 30 days)
SAFETY LANCETS 23G (*lancets*)	2	QL (204 lancets per 30 days)
SAFETY LANCETS 28G	2	QL (204 lancets per 30 days)
saps health plus lancets	2	QL (204 lancets per 30 days)
SAPS HEALTH TWIST TOP LANCETS	2	QL (204 lancets per 30 days)
SAPS TWIST TOP LANCETS	2	QL (204 lancets per 30 days)
SAPSCARE TWIST TOP LANCETS	2	QL (204 lancets per 30 days)
SB LANCETS THIN	2	QL (204 lancets per 30 days)
SB LANCETS ULTRA THIN	2	QL (204 lancets per 30 days)
SINGLE-LET (*lancets*)	2	QL (204 lancets per 30 days)
SM LANCETS 33G	2	QL (204 lancets per 30 days)
SMART SENSE COLOR LANCETS 33G (*lancets*)	2	QL (204 lancets per 30 days)
SMART SENSE STANDARD LANCETS (*lancets*)	2	QL (204 lancets per 30 days)
SMART SENSE SUPER THIN LANCETS (*lancets*)	2	QL (204 lancets per 30 days)
SMART SENSE THIN LANCETS 26G (*lancets*)	2	QL (204 lancets per 30 days)
SMARTEST LANCETS 28G (*lancets*)	2	QL (204 lancets per 30 days)
SOLUS V2 LANCETS 28G (*lancets*)	2	QL (204 lancets per 30 days)
SOLUS V2 TWIST LANCETS 30G (*lancets*)	2	QL (204 lancets per 30 days)

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
STERILANCE TL (*lancets*)	2	QL (204 lancets per 30 days)
SUPER THIN LANCETS	2	QL (204 lancets per 30 days)
SURE COMFORT LANCETS 18G	2	QL (204 lancets per 30 days)
SURE COMFORT LANCETS 21G	2	QL (204 lancets per 30 days)
SURE COMFORT LANCETS 23G	2	QL (204 lancets per 30 days)
SURE COMFORT LANCETS 28G	2	QL (204 lancets per 30 days)
SURE COMFORT LANCETS 30G	2	QL (204 lancets per 30 days)
SURELITE LANCETS (*lancets*)	2	QL (204 lancets per 30 days)
TECHLITE AST LANCETS (*lancets*)	2	QL (204 lancets per 30 days)
TECHLITE LANCETS (*lancets*)	2	QL (204 lancets per 30 days)
TECHLITE LANCETS 30G (*lancets*)	2	QL (204 lancets per 30 days)
TGT LANCET MICRO THIN 33G	2	QL (204 lancets per 30 days)
TGT LANCET THIN 26G	2	QL (204 lancets per 30 days)
TGT LANCET ULTRA THIN 30G	2	QL (204 lancets per 30 days)
THINLETS GP LANCETS (*lancets*)	2	QL (204 lancets per 30 days)
TODAYS HEALTH THIN LANCETS 28G	2	QL (204 lancets per 30 days)
TODAYS HEALTH THIN LANCETS 30G	2	QL (204 lancets per 30 days)
TOPCARE LANCETS MICRO-THIN 33G	2	QL (204 lancets per 30 days)
TRAVEL LANCETS ADVANCED 28G (*lancets*)	2	QL (204 lancets per 30 days)
true comfort safety lancets	2	QL (204 lancets per 30 days)
TRUE COMFORT TWIST TOP LANCETS	2	QL (204 lancets per 30 days)
TRUEPLUS LANCETS 26G (*lancets*)	2	QL (204 lancets per 30 days)
TRUEPLUS LANCETS 28G (*lancets*)	2	QL (204 lancets per 30 days)
TRUEPLUS LANCETS 30G (*lancets*)	2	QL (204 lancets per 30 days)
TRUEPLUS LANCETS 33G (*lancets*)	2	QL (204 lancets per 30 days)
TRUEPLUS SAFETY LANCETS 28G (*lancets*)	2	QL (204 lancets per 30 days)
twist top lancets 30g	2	QL (204 lancets per 30 days)
ULTILET CLASSIC LANCETS (*lancets*)	2	QL (204 lancets per 30 days)
ULTILET LANCETS (*lancets*)	2	QL (204 lancets per 30 days)
ULTILET SAFETY LANCETS (*lancets*)	2	QL (204 lancets per 30 days)
ULTILET SAFETY LANCETS 23G (*lancets*)	2	QL (204 lancets per 30 days)
ULTRA THIN LANCETS 31G	2	QL (204 lancets per 30 days)
ULTRA-CARE LANCETS 30G	2	QL (204 lancets per 30 days)
ULTRA-THIN II AUTO LANCET (*lancets*)	2	QL (204 lancets per 30 days)
ULTRA-THIN II LANCETS (*lancets*)	2	QL (204 lancets per 30 days)
UNILET COMFORTOUCH LANCET (*lancets*)	2	QL (204 lancets per 30 days)
UNILET EXCELITE (*lancets*)	2	QL (204 lancets per 30 days)
UNILET EXCELITE II (*lancets*)	2	QL (204 lancets per 30 days)
UNILET G.P. LANCET (*lancets*)	2	QL (204 lancets per 30 days)
UNILET G.P. SUPERLITE LANCET (*lancets*)	2	QL (204 lancets per 30 days)
UNILET GP 28 ULTRA THIN (*lancets*)	2	QL (204 lancets per 30 days)

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
UNILET LANCET (*lancets*)	2	QL (204 lancets per 30 days)
UNILET MICRO-THIN 33G (*lancets*)	2	QL (204 lancets per 30 days)
UNILET SUPERLITE LANCET (*lancets*)	2	QL (204 lancets per 30 days)
UNILET SUPER-THIN 30G (*lancets*)	2	QL (204 lancets per 30 days)
UNILET ULTRA-THIN 28G (*lancets*)	2	QL (204 lancets per 30 days)
UNISTIK 3 GENTLE (*lancets*)	2	QL (204 lancets per 30 days)
UNISTIK PRO SAFETY LANCET (*lancets*)	2	QL (204 lancets per 30 days)
UNISTIK SAFETY LANCETS 28G (*lancets*)	2	QL (204 lancets per 30 days)
UNISTIK SAFETY LANCETS 30G (*lancets*)	2	QL (204 lancets per 30 days)
UNISTIK TOUCH SAFETY LANC 21G (*lancets*)	2	QL (204 lancets per 30 days)
UNISTIK TOUCH SAFETY LANC 23G (*lancets*)	2	QL (204 lancets per 30 days)
UNISTIK TOUCH SAFETY LANC 28G (*lancets*)	2	QL (204 lancets per 30 days)
UNISTIK TOUCH SAFETY LANC 30G (*lancets*)	2	QL (204 lancets per 30 days)
UNIVERSAL 1 LANCETS THIN 26G (*lancets*)	2	QL (204 lancets per 30 days)
UNIVERSAL 1 LANCETS THIN 33G (*lancets*)	2	QL (204 lancets per 30 days)
UNIVERSAL 1 LANCETS ULTRA THIN (*lancets*)	2	QL (204 lancets per 30 days)
VALUE PLUS LANCET STANDARD 21G	2	QL (204 lancets per 30 days)
VALUE PLUS LANCETS SUPER THIN	2	QL (204 lancets per 30 days)
VALUE PLUS LANCETS THIN 26G	2	QL (204 lancets per 30 days)
VERIFINE SAFE LANCET MINI 21G (*lancets*)	2	QL (204 lancets per 30 days)
VERIFINE SAFE LANCET MINI 23G (*lancets*)	2	QL (204 lancets per 30 days)
VERIFINE SAFE LANCET MINI 28G (*lancets*)	2	QL (204 lancets per 30 days)
VERIFINE SAFE LANCET MINI 30G (*lancets*)	2	QL (204 lancets per 30 days)
VERIFINE UNIVERSAL LANCETS 28G (*lancets*)	2	QL (204 lancets per 30 days)
VERIFINE UNIVERSAL LANCETS 30G (*lancets*)	2	QL (204 lancets per 30 days)
VERIFINE UNIVERSAL LANCETS 33G (*lancets*)	2	QL (204 lancets per 30 days)
VIVAGUARD LANCETS (*lancets*)	2	QL (204 lancets per 30 days)
WALGREENS LANCETS (*lancets*)	2	QL (204 lancets per 30 days)
WALGREENS LANCETS MICRO THIN	2	QL (204 lancets per 30 days)
WALGREENS LANCETS SUPER THIN	2	QL (204 lancets per 30 days)
WALGREENS THIN LANCETS (*lancets*)	2	QL (204 lancets per 30 days)
WALGREENS ULTRA THIN LANCETS (*lancets*)	2	QL (204 lancets per 30 days)
ZEVRX TWIST TOP LANCETS 30G	2	QL (204 lancets per 30 days)
INSULIN ADMINISTRATION SUPPLIES - MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT**		
OMNIPOD 5 G6 INTRO (GEN 5) KIT (*insulin disposable pump*)	2	PA; QL (1 kit per 4 yearss)
OMNIPOD 5 G6 POD (GEN 5) (*insulin disposable pump*)	2	PA; QL (15 pods per 30 days)
OMNIPOD CLASSIC PODS (GEN 3) (*insulin disposable pump*)	2	PA; QL (15 pods per 30 days)
OMNIPOD DASH INTRO (GEN 4) KIT (*insulin disposable pump*)	2	PA; QL (1 kit per 4 yearss)
OMNIPOD DASH PDM (GEN 4) KIT (*insulin disposable pump*)	2	PA; QL (1 kit per 4 yearss)
OMNIPOD DASH PODS (GEN 4) (*insulin disposable pump*)	2	PA; QL (15 pods per 30 days)

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NEEDLES & SYRINGES - MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT**		
1ST TIER UNIFINE PENTIPS	3	ST; QL (200 needles per 30 days)
1ST TIER UNIFINE PENTIPS PLUS	3	ST; QL (200 needles per 30 days)
ABOUTTIME PEN NEEDLE (*insulin pen needle*)	3	ST; QL (200 needles per 30 days)
ADVOCATE INSULIN PEN NEEDLES (*insulin pen needle*)	3	ST; QL (200 needles per 30 days)
ADVOCATE INSULIN SYRINGE (*insulin syringe-needle u-100*)	3	ST; QL (200 syringes per 30 days)
aq insulin syringe	3	ST; QL (200 syringes per 30 days)
aqinject pen needle	3	ST; QL (200 needles per 30 days)
ASSURE ID INSULIN SAFETY SYR (*insulin syringe-needle u-100*)	3	ST; QL (200 syringes per 30 days)
ASSURE ID SAFETY PEN NEEDLES (*insulin pen needle*)	3	ST; QL (200 needles per 30 days)
aum insulin safety pen needle	3	ST; QL (200 needles per 30 days)
AUM MINI INSULIN PEN NEEDLE	3	ST; QL (200 needles per 30 days)
aum pen needle	3	ST; QL (200 needles per 30 days)
AUM READYGARD DUO PEN NEEDLE (*insulin pen needle*)	3	ST; QL (200 needles per 30 days)
AUM SAFETY PEN NEEDLE (*insulin pen needle*)	3	ST; QL (200 needles per 30 days)
AURORA PEN NEEDLES	3	ST; QL (200 needles per 30 days)
BD AUTOSHIELD DUO (*insulin pen needle*)	2	QL (200 needles per 30 days)
BD INSULIN SYR ULTRAFINE II (*insulin syringe-needle u-100*)	2	QL (200 syringes per 30 days)
BD INSULIN SYRINGE (*insulin syringe-needle u-100*)	2	QL (200 syringes per 30 days)
BD INSULIN SYRINGE HALF-UNIT (*insulin syringe-needle u-100*)	2	QL (200 syringes per 30 days)
BD INSULIN SYRINGE MICROFINE (*insulin syringe-needle u-100*)	2	QL (200 syringes per 30 days)
BD INSULIN SYRINGE U/F (*insulin syringe-needle u-100*)	2	QL (200 syringes per 30 days)
BD INSULIN SYRINGE U/F 1/2UNIT (*insulin syringe-needle u-100*)	2	QL (200 syringes per 30 days)
BD INSULIN SYRINGE U-500 (*insulin syringe/needle u-500*)	2	QL (200 syringes per 30 days)
BD INSULIN SYRINGE ULTRAFINE (*insulin syringe-needle u-100*)	2	QL (200 syringes per 30 days)
BD PEN NEEDLE MICRO U/F (*insulin pen needle*)	2	QL (200 needles per 30 days)
BD PEN NEEDLE MINI U/F (*insulin pen needle*)	2	QL (200 needles per 30 days)
BD PEN NEEDLE NANO 2ND GEN (*insulin pen needle*)	2	QL (200 needles per 30 days)
BD PEN NEEDLE NANO U/F (*insulin pen needle*)	2	QL (200 needles per 30 days)
BD PEN NEEDLE ORIGINAL U/F (*insulin pen needle*)	2	QL (200 needles per 30 days)
BD PEN NEEDLE SHORT U/F (*insulin pen needle*)	2	QL (200 needles per 30 days)
BD SAFETYGLIDE INSULIN SYRINGE (*insulin syringe-needle u-100*)	2	QL (200 syringes per 30 days)
BD VEO INSULIN SYR U/F 1/2UNIT (*insulin syringe-needle u-100*)	2	QL (200 syringes per 30 days)
BD VEO INSULIN SYRINGE U/F (*insulin syringe-needle u-100*)	2	QL (200 syringes per 30 days)
CAREFINE PEN NEEDLES (*insulin pen needle*)	3	ST; QL (200 needles per 30 days)
CAREONE INSULIN SYRINGE	3	ST; QL (200 syringes per 30 days)
CAREONE UNIFINE PENTIPS PLUS	3	ST; QL (200 needles per 30 days)
CARETOUCH INSULIN SYRINGE (*insulin syringe-needle u-100*)	3	ST; QL (200 syringes per 30 days)
CARETOUCH PEN NEEDLES (*insulin pen needle*)	3	ST; QL (200 needles per 30 days)
CLEVER CHOICE COMFORT EZ (*insulin pen needle*)	3	ST; QL (200 needles per 30 days)
CLICKFINE PEN NEEDLES	3	ST; QL (200 needles per 30 days)

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
COMFORT ASSIST INSULIN SYRINGE (*insulin syringe-needle u-100*)	3	ST; QL (200 syringes per 30 days)
COMFORT EZ INSULIN SYRINGE (*insulin syringe-needle u-100*)	3	ST; QL (200 syringes per 30 days)
COMFORT EZ MICRO PEN NEEDLES (*insulin pen needle*)	3	ST; QL (200 needles per 30 days)
COMFORT EZ PEN NEEDLES (*insulin pen needle*)	3	ST; QL (200 needles per 30 days)
COMFORT EZ PRO PEN NEEDLES 30G X 8 MM , 31G X 4 MM (*insulin pen needle*)	3	ST; QL (200 needles per 30 days)
COMFORT EZ PRO PEN NEEDLES 31G X 5 MM (*insulin pen needle*)	3	QL (200 needles per 30 days)
COMFORT EZ SHORT PEN NEEDLES (*insulin pen needle*)	3	ST; QL (200 needles per 30 days)
COMFORT TOUCH INSULIN PEN NEED (*insulin pen needle*)	3	ST; QL (200 needles per 30 days)
DIATHRIVE PEN NEEDLE (*insulin pen needle*)	3	ST; QL (200 needles per 30 days)
DROPLET INSULIN SYRINGE 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 15/64" 0.3 ML, 30G X 15/64" 1 ML, 30G X 5/16" 0.3 ML, 30G X 5/16" 0.5 ML, 30G X 5/16" 1 ML, 31G X 15/64" 0.3 ML, 31G X 15/64" 0.5 ML, 31G X 15/64" 1 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*)	3	ST; QL (200 syringes per 30 days)
DROPLET INSULIN SYRINGE 30G X 15/64" 0.5 ML (*insulin syringe-needle u-100*)	3	QL (200 syringes per 30 days)
DROPLET MICRON (*insulin pen needle*)	3	QL (200 needles per 30 days)
DROPLET PEN NEEDLES (*insulin pen needle*)	3	ST; QL (200 needles per 30 days)
DROPSAFE SAFETY PEN NEEDLES	3	ST; QL (200 needles per 30 days)
DROPSAFE SAFETY SYRINGE/NEEDLE (*insulin syringe-needle u-100*)	3	ST; QL (200 needles per 30 days)
DRUG MART UNIFINE PENTIPS	3	ST; QL (200 needles per 30 days)
DRUG MART UNIFINE PENTIPS PLUS	3	ST; QL (200 needles per 30 days)
EASY COMFORT INSULIN SYRINGE 30G X 1/2" 0.5 ML, 30G X 1/2" 1 ML, 30G X 5/16" 0.5 ML, 30G X 5/16" 1 ML, 31G X 5/16" 0.5 ML, 31G X 5/16" 1 ML, 32G X 5/16" 0.5 ML, 32G X 5/16" 1 ML	3	ST; QL (200 syringes per 30 days)
easy comfort insulin syringe 31g x 1/2" 0.3 ml, 31g x 5/16" 0.3 ml	3	ST; QL (200 syringes per 30 days)
EASY COMFORT PEN NEEDLES	3	ST; QL (200 needles per 30 days)
EASY GLIDE PEN NEEDLES	3	ST; QL (200 needles per 30 days)
EASY TOUCH FLIPLOCK INSULIN SY (*insulin syringe-needle u-100*)	3	ST; QL (200 syringes per 30 days)
EASY TOUCH INSULIN SAFETY SYR (*insulin syringe-needle u-100*)	3	ST; QL (200 syringes per 30 days)
EASY TOUCH INSULIN SYRINGE 27G X 1/2" 0.5 ML, 27G X 1/2" 1 ML, 28G X 1/2" 0.5 ML, 28G X 1/2" 1 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, 30G X 5/16" 1 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*)	3	ST; QL (200 syringes per 30 days)
EASY TOUCH INSULIN SYRINGE 27G X 5/8" 1 ML (*insulin syringe-needle u-100*)	3	QL (200 syringes per 30 days)
EASY TOUCH PEN NEEDLES (*insulin pen needle*)	3	ST; QL (200 needles per 30 days)
EASY TOUCH SAFETY PEN NEEDLES (*insulin pen needle*)	3	ST; QL (200 needles per 30 days)
EASY TOUCH SHEATHLOCK SYRINGE (*insulin syringe-needle u-100*)	3	ST; QL (200 syringes per 30 days)
EMBRACE PEN NEEDLES (*insulin pen needle*)	3	ST; QL (200 needles per 30 days)
EQL INSULIN SYRINGE	3	ST; QL (200 syringes per 30 days)
FIFTY50 PEN NEEDLES (*insulin pen needle*)	3	ST; QL (200 needles per 30 days)

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FIFTY50 SUPERIOR COMFORT SYR (*insulin syringe-needle u-100*)	3	ST; QL (200 syringes per 30 days)
GLOBAL EASE INJECT PEN NEEDLES	3	ST; QL (200 needles per 30 days)
GLOBAL EASY GLIDE INSULIN SYR	3	ST; QL (200 syringes per 30 days)
GLOBAL EASY GLIDE PEN NEEDLES	3	ST; QL (200 needles per 30 days)
GLOBAL INJECT EASE INSULIN SYR	3	ST; QL (200 syringes per 30 days)
GLOBAL INSULIN SYRINGES	3	ST; QL (200 syringes per 30 days)
GLUCOPRO INSULIN SYRINGE (*insulin syringe-needle u-100*)	3	ST; QL (200 syringes per 30 days)
GNP CLICKFINE PEN NEEDLES	3	ST; QL (200 needles per 30 days)
GNP INSULIN SYRINGE	3	ST; QL (200 syringes per 30 days)
GNP INSULIN SYRINGES	3	
GNP INSULIN SYRINGES 28GX1/2"	3	ST; QL (200 syringes per 30 days)
GNP INSULIN SYRINGES 29GX1/2"	3	ST; QL (200 syringes per 30 days)
GNP INSULIN SYRINGES 30GX5/16"	3	ST; QL (200 syringes per 30 days)
GNP INSULIN SYRINGES 31GX5/16"	3	ST; QL (200 syringes per 30 days)
GNP ULTICARE PEN NEEDLES	3	ST; QL (200 needles per 30 days)
GNP ULTIGUARD SAFEPACK NEEDLE (*insulin pen needle*)	3	ST; QL (200 needles per 30 days)
GNP ULTRA COM INSULIN SYRINGE	3	ST; QL (200 syringes per 30 days)
GOODSENSE CLICKFINE PEN NEEDLE	3	ST; QL (200 needles per 30 days)
GOODSENSE PEN NEEDLE PENFINE (*insulin pen needle*)	3	ST; QL (200 needles per 30 days)
HEALTHWISE INSULIN SYR/NEEDLE	3	ST; QL (200 syringes per 30 days)
HEALTHWISE MICRON PEN NEEDLES	3	ST; QL (200 needles per 30 days)
HEALTHWISE SHORT PEN NEEDLES	3	ST; QL (200 needles per 30 days)
H-E-B INCONTROL PEN NEEDLES	3	ST; QL (200 needles per 30 days)
H-E-B INCONTROL UNIFINE PENTIP (*insulin pen needle*)	3	ST; QL (200 needles per 30 days)
HM ULTICARE INSULIN SYRINGE (*insulin syringe-needle u-100*)	3	ST; QL (200 syringes per 30 days)
HM ULTICARE MINI PEN NEEDLES (*insulin pen needle*)	3	ST; QL (200 needles per 30 days)
HM ULTICARE SHORT PEN NEEDLES (*insulin pen needle*)	3	ST; QL (200 needles per 30 days)
INCONTROL ULTICARE PEN NEEDLES (*insulin pen needle*)	3	ST; QL (200 needles per 30 days)
INSULIN SYRINGE	3	ST; QL (200 syringes per 30 days)
insulin syringe-needle u-100 27g x 1/2" 0.5 ml, 27g x 1/2" 1 ml, 28g x 1/2" 0.5 ml, 28g x 1/2" 1 ml, 30g x 1/2" 1 ml	3	ST; QL (200 syringes per 30 days)
INSULIN SYRINGE-NEEDLE U-100 29G X 1/2" 0.5 ML, 29G X 1/2" 1 ML, 30G X 5/16" 0.3 ML, 30G X 5/16" 0.5 ML, 30G X 5/16" 1 ML, 31G X 1/4" 0.3 ML, 31G X 1/4" 0.5 ML, 31G X 1/4" 1 ML, 31G X 5/16" 0.3 ML, 31G X 5/16" 0.5 ML, 31G X 5/16" 1 ML	3	ST; QL (200 syringes per 30 days)
INSUPEN PEN NEEDLES	3	ST; QL (200 needles per 30 days)
INSUPEN SENSITIVE (*insulin pen needle*)	3	ST; QL (200 needles per 30 days)
INSUPEN ULTRAFIN (*insulin pen needle*)	3	ST; QL (200 needles per 30 days)
KINRAY INSULIN SYRINGE	3	ST; QL (200 syringes per 30 days)
KMART VALU INSULIN SYRINGE 29G	3	ST; QL (200 syringes per 30 days)
KMART VALU INSULIN SYRINGE 30G	3	ST; QL (200 syringes per 30 days)
KROGER INSULIN SYRINGE	3	ST; QL (200 syringes per 30 days)

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
KROGER PEN NEEDLES	3	ST; QL (200 needles per 30 days)
LEADER INSULIN SYRINGE	3	ST; QL (200 syringes per 30 days)
LEADER UNIFINE PENTIPS (*insulin pen needle*)	3	ST; QL (200 needles per 30 days)
LEADER UNIFINE PENTIPS PLUS (*insulin pen needle*)	3	ST; QL (200 needles per 30 days)
LITETOUCH INSULIN SYRINGE (*insulin syringe-needle u-100*)	3	ST; QL (200 syringes per 30 days)
LITETOUCH PEN NEEDLES (*insulin pen needle*)	3	ST; QL (200 needles per 30 days)
LONGS INSULIN SYRINGE	3	ST; QL (200 syringes per 30 days)
MAGELLAN INSULIN SAFETY SYR (*insulin syringe-needle u-100*)	3	ST; QL (200 syringes per 30 days)
MARATHON MEDICAL PENTIPS (*insulin pen needle*)	3	ST; QL (200 needles per 30 days)
MAXICOMFORT II PEN NEEDLE (*insulin pen needle*)	3	ST; QL (200 needles per 30 days)
MAXI-COMFORT INSULIN SYRINGE (*insulin syringe-needle u-100*)	3	ST; QL (200 syringes per 30 days)
MAXI-COMFORT SAFETY PEN NEEDLE (*insulin pen needle*)	3	ST; QL (200 needles per 30 days)
MAXICOMFORT SYR 27G X 1/2" (*insulin syringe-needle u-100*)	3	ST; QL (200 syringes per 30 days)
MEDIC INSULIN SYRINGE	3	ST; QL (200 syringes per 30 days)
MEDICINE SHOPPE PEN NEEDLES	3	ST; QL (200 needles per 30 days)
MEIJER PEN NEEDLES	3	ST; QL (200 needles per 30 days)
MICRODOT PEN NEEDLE (*insulin pen needle*)	3	ST; QL (200 needles per 30 days)
MM INSULIN SYRINGE/NEEDLE	3	ST; QL (200 syringes per 30 days)
MM PEN NEEDLES (*insulin pen needle*)	3	ST; QL (200 needles per 30 days)
MONOJECT INSULIN SYRINGE (*insulin syringe-needle u-100*)	3	ST; QL (200 syringes per 30 days)
MONOJECT ULTRA COMFORT SYRINGE (*insulin syringe-needle u-100*)	3	ST; QL (200 syringes per 30 days)
MS INSULIN SYRINGE	3	ST; QL (200 syringes per 30 days)
NOVOFINE AUTOCOVER PEN NEEDLE (*insulin pen needle*)	3	ST; QL (200 needles per 30 days)
NOVOFINE PEN NEEDLE (*insulin pen needle*)	3	ST; QL (200 needles per 30 days)
NOVOFINE PLUS PEN NEEDLE (*insulin pen needle*)	3	ST; QL (200 needles per 30 days)
PC UNIFINE PENTIPS	3	ST; QL (200 needles per 30 days)
PEN NEEDLES	3	ST; QL (200 needles per 30 days)
PEN NEEDLES 5/16"	3	ST; QL (200 needles per 30 days)
PENTIPS (*insulin pen needle*)	3	ST; QL (200 needles per 30 days)
pip pen needles 31g x 5mm	3	ST; QL (200 needles per 30 days)
pip pen needles 32g x 4mm	3	ST; QL (200 needles per 30 days)
PRECISION SURE-DOSE SYRINGE (*insulin syringe-needle u-100*)	3	ST; QL (200 syringes per 30 days)
PREFERRED PLUS INSULIN SYRINGE	3	ST; QL (200 syringes per 30 days)
PREFERRED PLUS UNIFINE PENTIPS	3	ST; QL (200 needles per 30 days)
PREVENT DROPSAFE PEN NEEDLES (*insulin pen needle*)	3	ST; QL (200 needles per 30 days)
PREVENT SAFETY PEN NEEDLES (*insulin pen needle*)	3	ST; QL (200 needles per 30 days)
PRO COMFORT INSULIN SYRINGE (*insulin syringe-needle u-100*)	3	ST; QL (200 syringes per 30 days)
PRO COMFORT PEN NEEDLES	3	ST; QL (200 needles per 30 days)
PRODIGY INSULIN SYRINGE (*insulin syringe-needle u-100*)	3	ST; QL (200 syringes per 30 days)
PURE COMFORT PEN NEEDLE	3	ST; QL (200 needles per 30 days)
pure comfort safety pen needle	3	QL (200 needles per 30 days)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PX EXTRA SHORT PEN NEEDLES	3	ST; QL (200 needles per 30 days)
PX INSULIN SYRINGE	3	ST; QL (200 syringes per 30 days)
PX MINI PEN NEEDLES	3	ST; QL (200 needles per 30 days)
PX PEN NEEDLE	3	ST; QL (200 needles per 30 days)
QC PEN NEEDLES	3	ST; QL (200 needles per 30 days)
QC UNIFINE PENTIPS	3	ST; QL (200 needles per 30 days)
RA INSULIN SYRINGE	3	ST; QL (200 syringes per 30 days)
RA PEN NEEDLES	3	ST; QL (200 needles per 30 days)
raya sure pen needle	3	ST; QL (200 needles per 30 days)
REALITY INSULIN SYRINGE	3	ST; QL (200 syringes per 30 days)
RELION INSULIN SYRINGE (*insulin syringe-needle u-100*)	3	ST; QL (200 syringes per 30 days)
RELION MINI PEN NEEDLES (*insulin pen needle*)	3	ST; QL (200 needles per 30 days)
RELION PEN NEEDLES (*insulin pen needle*)	3	ST; QL (200 needles per 30 days)
RELION SHORT PEN NEEDLES (*insulin pen needle*)	3	ST; QL (200 needles per 30 days)
safety pen needles	3	ST; QL (200 needles per 30 days)
SB INSULIN SYRINGE	3	ST; QL (200 syringes per 30 days)
SECURESAFE INSULIN SYRINGE (*insulin syringe-needle u-100*)	3	ST; QL (200 syringes per 30 days)
SECURESAFE SAFETY PEN NEEDLES (*insulin pen needle*)	3	ST; QL (200 needles per 30 days)
SURE COMFORT INSULIN SYRINGE	3	ST; QL (200 syringes per 30 days)
SURE COMFORT PEN NEEDLES 29G X 12.7MM , 30G X 8 MM , 31G X 5 MM , 31G X 8 MM , 32G X 4 MM , 32G X 6 MM	3	ST; QL (200 needles per 30 days)
sure comfort pen needles 31g x 6 mm	3	ST; QL (200 needles per 30 days)
TECHLITE INSULIN SYRINGE	3	ST; QL (200 syringes per 30 days)
TECHLITE PEN NEEDLES (*insulin pen needle*)	3	ST; QL (200 needles per 30 days)
TODAYS HEALTH PEN NEEDLES	3	ST; QL (200 needles per 30 days)
TODAYS HEALTH SHORT PEN NEEDLE	3	ST; QL (200 needles per 30 days)
TOPCARE CLICKFINE PEN NEEDLES	3	ST; QL (200 needles per 30 days)
TOPCARE ULTRA COMFORT INS SYR	3	ST; QL (200 syringes per 30 days)
true comfort insulin syringe 30g x 1/2" 0.5 ml, 30g x 1/2" 1 ml, 30g x 5/16" 0.5 ml, 30g x 5/16" 1 ml, 32g x 5/16" 1 ml	3	
TRUE COMFORT INSULIN SYRINGE 31G X 5/16" 0.5 ML, 31G X 5/16" 1 ML	3	ST; QL (200 syringes per 30 days)
TRUE COMFORT PEN NEEDLES	3	ST; QL (200 needles per 30 days)
TRUE COMFORT PRO INSULIN SYR	3	ST; QL (200 syringes per 30 days)
TRUE COMFORT PRO PEN NEEDLES	3	ST; QL (200 needles per 30 days)
TRUEPLUS 5-BEVEL PEN NEEDLES (*insulin pen needle*)	3	ST; QL (200 needles per 30 days)
TRUEPLUS INSULIN SYRINGE (*insulin syringe-needle u-100*)	3	ST; QL (200 syringes per 30 days)
TRUEPLUS PEN NEEDLES (*insulin pen needle*)	3	ST; QL (200 needles per 30 days)
ULTICARE INSULIN SAFETY SYR (*insulin syringe-needle u-100*)	3	ST; QL (200 syringes per 30 days)
ULTICARE INSULIN SYR 1/2 UNIT (*insulin syringe-needle u-100*)	3	ST; QL (200 syringes per 30 days)
ULTICARE INSULIN SYRINGE (*insulin syringe-needle u-100*)	3	ST; QL (200 syringes per 30 days)
ULTICARE MICRO PEN NEEDLES (*insulin pen needle*)	3	ST; QL (200 needles per 30 days)

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ULTICARE MINI PEN NEEDLES (*insulin pen needle*)	3	ST; QL (200 needles per 30 days)
ULTICARE PEN NEEDLES (*insulin pen needle*)	3	ST; QL (200 needles per 30 days)
ULTICARE SHORT PEN NEEDLES (*insulin pen needle*)	3	ST; QL (200 needles per 30 days)
ULTIGUARD SAFEPACK PEN NEEDLE (*insulin pen needle*)	3	ST; QL (200 needles per 30 days)
ULTIGUARD SAFEPACK SYR/NEEDLE (*insulin syringe-needle u-100*)	3	ST; QL (200 syringes per 30 days)
ULTILET PEN NEEDLE (*insulin pen needle*)	3	ST; QL (200 needles per 30 days)
ULTRA COMFORT INSULIN SYRINGE	3	ST; QL (200 syringes per 30 days)
ULTRA FLO INSULIN PEN NEEDLES (*insulin pen needle*)	3	ST; QL (200 needles per 30 days)
ULTRA FLO INSULIN SYR 1/2 UNIT (*insulin syringe-needle u-100*)	3	ST; QL (200 syringes per 30 days)
ULTRA FLO INSULIN SYRINGE (*insulin syringe-needle u-100*)	3	ST; QL (200 syringes per 30 days)
ULTRA THIN PEN NEEDLES (*insulin pen needle*)	3	ST; QL (200 needles per 30 days)
ULTRACARE INSULIN SYRINGE	3	ST; QL (200 syringes per 30 days)
ULTRACARE PEN NEEDLES	3	ST; QL (200 needles per 30 days)
ULTRA-THIN II INS SYR SHORT (*insulin syringe-needle u-100*)	3	ST; QL (200 syringes per 30 days)
ULTRA-THIN II INSULIN SYRINGE (*insulin syringe-needle u-100*)	3	ST; QL (200 syringes per 30 days)
ULTRA-THIN II MINI PEN NEEDLE (*insulin pen needle*)	3	ST; QL (200 needles per 30 days)
ULTRA-THIN II PEN NEEDLE SHORT (*insulin pen needle*)	3	ST; QL (200 needles per 30 days)
ULTRA-THIN II PEN NEEDLES (*insulin pen needle*)	3	ST; QL (200 needles per 30 days)
UNIFINE PENTIPS (*insulin pen needle*)	3	ST; QL (200 needles per 30 days)
UNIFINE PENTIPS PLUS (*insulin pen needle*)	3	ST; QL (200 needles per 30 days)
UNIFINE SAFECONTROL PEN NEEDLE (*insulin pen needle*)	3	ST; QL (200 needles per 30 days)
UNIFINE ULTRA PEN NEEDLE (*insulin pen needle*)	3	ST; QL (200 needles per 30 days)
VALUE HEALTH INSULIN SYRINGE	3	ST; QL (200 syringes per 30 days)
VANISHPOINT INSULIN SYRINGE 29G X 1/2" 1 ML, 29G X 5/16" 1 ML, 30G X 1/2" 0.5 ML, 30G X 5/16" 0.5 ML, 30G X 5/16" 1 ML (*insulin syringe-needle u-100*)	3	ST; QL (200 syringes per 30 days)
VANISHPOINT INSULIN SYRINGE 30G X 3/16" 0.5 ML, 30G X 3/16" 1 ML (*insulin syringe-needle u-100*)	3	QL (200 syringes per 30 days)
VERIFINE INSULIN PEN NEEDLE 29G X 12MM , 31G X 8 MM , 32G X 4 MM , 32G X 6 MM (*insulin pen needle*)	3	ST; QL (200 needles per 30 days)
VERIFINE INSULIN PEN NEEDLE 31G X 5 MM (*insulin pen needle*)	3	QL (200 needles per 30 days)
VERIFINE INSULIN SYRINGE 29G X 1/2" 0.5 ML, 29G X 1/2" 1 ML (*insulin syringe-needle u-100*)	3	ST; QL (200 syringes per 30 days)
VERIFINE INSULIN SYRINGE 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*)	3	QL (200 syringes per 30 days)
VERIFINE PLUS PEN NEEDLE (*insulin pen needle*)	3	ST; QL (200 needles per 30 days)
VP INSULIN SYRINGE	3	ST; QL (200 syringes per 30 days)
WEGMANS UNIFINE PENTIPS PLUS	3	ST; QL (200 needles per 30 days)
ZEVRX INSULIN SYRINGE	3	ST; QL (200 syringes per 30 days)
ZEVRX PEN NEEDLES	3	ST; QL (200 needles per 30 days)

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
***MIGRAINE PRODUCTS* - DRUGS FOR THE NERVOUS SYSTEM**		
CALCITONIN GENE-RELATED PEPTIDE RECEPTOR ANTAG (CGRP) - DRUGS FOR MIGRAINE HEADACHES**		
NURTEC ORAL TABLET DISPERSIBLE (*rimegepant sulfate*)	2	QL (8 tablets per 30 days)
QULIPTA ORAL TABLET (*atogepant*)	2	QL (1 tablet per 1 day)
UBRELVY ORAL TABLET (*ubrogepant*)	2	QL (16 tablets per 30 days)
CGRP RECEPTOR ANTAGONISTS - MONOCOLONAL ANTIBODIES - DRUGS FOR MIGRAINE HEADACHES**		
AIMOVIG SUBCUTANEOUS SOLUTION AUTO-INJECTOR (*erenumab-aooe*)	3	QL (1 autoinjector per 28 days)
EMGALITY (300 MG DOSE) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (*galcanezumab-gnlm*)	3	QL (3 syringes per 28 days)
EMGALITY SUBCUTANEOUS SOLUTION AUTO-INJECTOR (*galcanezumab-gnlm*)	3	QL (1 pen per 28 days)
EMGALITY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (*galcanezumab-gnlm*)	3	QL (1 syringe per 28 days)
ERGOT COMBINATIONS - DRUGS FOR MIGRAINE HEADACHES**		
ergotamine-caffeine oral tablet	1 or 1b*	
migergot rectal suppository	1 or 1b*	
MIGRAINE PRODUCTS - DRUGS FOR MIGRAINE HEADACHES**		
dihydroergotamine mesylate injection solution	1 or 1b*	PA; QL (24 mL per 28 days)
SELECTIVE SEROTONIN AGONISTS 5-HT(1) - DRUGS FOR MIGRAINE HEADACHES**		
almotriptan malate oral tablet	1 or 1b*	QL (9 tablets per 30 days)
eletriptan hydrobromide oral tablet	1 or 1b*	QL (9 tablets per 30 days)
frovatriptan succinate oral tablet	1 or 1b*	ST; QL (9 tablets per 30 days)
naratriptan hcl oral tablet	1 or 1b*	QL (9 tablets per 30 days)
rizatriptan benzoate oral tablet	1 or 1b*	QL (9 tablets per 30 days)
rizatriptan benzoate oral tablet dispersible	1 or 1b*	QL (9 tablets per 30 days)
sumatriptan nasal solution	1 or 1b*	QL (6 nasal inhalers per 30 days)
sumatriptan succinate oral tablet	1 or 1b*	QL (9 tablets per 30 days)
sumatriptan succinate refill subcutaneous solution cartridge	1 or 1b*	QL (6 cartridges per 30 days)
sumatriptan succinate subcutaneous solution	1 or 1b*	QL (5 vials per 30 days)
sumatriptan succinate subcutaneous solution auto-injector 4 mg/0.5ml	1 or 1b*	QL (6 syringes (2 ML) per 30 days)
sumatriptan succinate subcutaneous solution auto-injector 6 mg/0.5ml	1 or 1b*	QL (6 cartridges per 30 days)
zolmitriptan nasal solution	1 or 1b*	ST; QL (6 nasal inhalers per 30 days)
zolmitriptan oral tablet	1 or 1b*	QL (9 tablets per 30 days)
zolmitriptan oral tablet dispersible	1 or 1b*	QL (9 tablets per 30 days)
***MINERALS & ELECTROLYTES* - DRUGS FOR NUTRITION**		
BICARBONATES - DRUGS FOR NUTRITION**		
SODIUM ACETATE INTRAVENOUS SOLUTION 2 MEQ/ML	3	

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
sodium acetate intravenous solution 4 meq/ml	1 or 1b*	
sodium bicarbonate intravenous solution	1 or 1b*	
THAM INTRAVENOUS SOLUTION (*tromethamine*)	3	
CALCIUM COMBINATIONS - DRUGS FOR NUTRITION**		
CALCIUM GLUCONATE-NACL INTRAVENOUS SOLUTION	3	
CALCIUM - DRUGS FOR NUTRITION**		
CALCIUM GLUCONATE INTRAVENOUS SOLUTION	3	
ELECTROLYTES & DEXTROSE - DRUGS FOR NUTRITION**		
DEXTROSE 5%/ELECTROLYTE #48 INTRAVENOUS SOLUTION	3	
dextrose in lactated ringers intravenous solution	1 or 1b*	
DEXTROSE-NACL INTRAVENOUS SOLUTION 10-0.2 %, 2.5-0.45 %	3	
dextrose-nacl intravenous solution 10-0.45 %, 5-0.2 %, 5-0.33 %, 5-0.45 %, 5-0.9 %	1 or 1b*	
dextrose-sodium chloride intravenous solution 2.5-0.45 %, 5-0.45 %, 5-0.9 %	1 or 1b*	
DEXTROSE-SODIUM CHLORIDE INTRAVENOUS SOLUTION 5-0.225 %, 5-0.3 %	3	
IONOSOL-MB IN D5W INTRAVENOUS SOLUTION (*electrolyte-mb in dextrose*)	3	
ISOLYTE-P IN D5W INTRAVENOUS SOLUTION (*electrolyte-p in dextrose*)	3	
kcl in dextrose-nacl intravenous solution 10-5-0.45 meq/l-%-%, 20-5-0.2 meq/l-%-%, 20-5-0.45 meq/l-%-%, 20-5-0.9 meq/l-%-%, 30-5-0.45 meq/l-%-%, 40-5-0.45 meq/l-%-%	1 or 1b*	
KCL IN DEXTROSE-NACL INTRAVENOUS SOLUTION 20-5-0.225 MEQ/L-%-%, 40-5-0.9 MEQ/L-%-%	3	
KCL-LACTATED RINGERS-D5W INTRAVENOUS SOLUTION	3	
NORMOSOL-M IN D5W INTRAVENOUS SOLUTION (*electrolyte-m in dextrose*)	3	
NORMOSOL-R IN D5W INTRAVENOUS SOLUTION (*electrolyte-r in dextrose*)	3	
potassium cl in dextrose 5% intravenous solution	1 or 1b*	
ELECTROLYTES PARENTERAL - DRUGS FOR NUTRITION**		
ISOLYTE-S INTRAVENOUS SOLUTION (*electrolyte-s*)	3	
ISOLYTE-S PH 7.4 INTRAVENOUS SOLUTION (*electrolyte-s (ph 7.4)*)	3	
KCL (0.149%) IN NACL INTRAVENOUS SOLUTION 20-0.45 MEQ/L-%	1 or 1b*	
kcl (0.149%) in nacl intravenous solution 20-0.9 meq/l-%	1 or 1b*	
KCL (0.298%) IN NACL INTRAVENOUS SOLUTION	1 or 1b*	
lactated ringers intravenous solution	1 or 1b*	
multiple electro type 1 ph 5.5 intravenous solution	1 or 1b*	
multiple electro type 1 ph 7.4 intravenous solution	1 or 1b*	
NORMOSOL-R INTRAVENOUS SOLUTION (*electrolyte-r*)	3	
NORMOSOL-R PH 7.4 INTRAVENOUS SOLUTION (*electrolyte-r (ph 7.4)*)	3	

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PLASMA-LYTE 148 INTRAVENOUS SOLUTION (*electrolyte-148*)	3	
PLASMA-LYTE A INTRAVENOUS SOLUTION (*electrolyte-a*)	3	
POTASSIUM CHLORIDE IN NACL INTRAVENOUS SOLUTION 20-0.45 MEQ/L-%, 40-0.9 MEQ/L-%	3	
potassium chloride in nacl intravenous solution 20-0.9 meq/l-%	3	
ringers intravenous solution	1 or 1b*	
TPN ELECTROLYTES INTRAVENOUS CONCENTRATE (*parenteral electrolytes*)	3	
FLUORIDE COMBINATIONS - DRUGS FOR NUTRITION**		
FLORIVA ORAL LIQUID (*sodium fluoride-vitamin d*)	3	
FLUORIDE - DRUGS FOR NUTRITION**		
sodium fluoride oral solution	1 or 1a*; $0	
sodium fluoride oral tablet	1 or 1a*; $0	
sodium fluoride oral tablet chewable	1 or 1a*; $0	
MAGNESIUM - DRUGS FOR NUTRITION**		
MAGNESIUM SULFATE IN D5W INTRAVENOUS SOLUTION	3	
MAGNESIUM SULFATE INTRAVENOUS SOLUTION	3	
MANGANESE - DRUGS FOR NUTRITION**		
manganese chloride intravenous solution	1 or 1b*	
PHOSPHATE - DRUGS FOR NUTRITION**		
GLYCOPHOS INTRAVENOUS SOLUTION (*sodium glycerophosphate*)	3	
K-PHOS ORAL TABLET (*potassium phosphate monobasic*)	2	
K-PHOS-NEUTRAL ORAL TABLET (*k phos mono-sod phos di & mono*)	3	
phospha 250 neutral oral tablet	1 or 1b*	
phosphorous oral tablet	1 or 1b*	
phospho-trin 250 neutral oral tablet	1 or 1b*	
phospho-trin k500 oral tablet	1 or 1b*	
POTASSIUM PHOSPHATES INTRAVENOUS SOLUTION	3	
potassium phosphates(66 meq k) intravenous solution	3	
POTASSIUM PHOSPHATES(71 MEQ K) INTRAVENOUS SOLUTION	3	
sodium phosphates intravenous solution	1 or 1b*	
wes-phos 250 neutral oral tablet	1 or 1b*	
POTASSIUM - DRUGS FOR NUTRITION**		
klor-con 10 oral tablet extended release	1 or 1b*	
klor-con m10 oral tablet extended release	1 or 1a*	
klor-con m15 oral tablet extended release	1 or 1a*	
klor-con m20 oral tablet extended release	1 or 1a*	
klor-con oral packet	1 or 1b*	
klor-con oral tablet extended release	1 or 1b*	
K-TAB ORAL TABLET EXTENDED RELEASE (*potassium chloride*)	3	
POTASSIUM ACETATE INTRAVENOUS SOLUTION	3	
potassium chloride crys er oral tablet extended release	1 or 1a*	

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
potassium chloride er oral capsule extended release	1 or 1b*	
potassium chloride er oral tablet extended release 10 meq, 20 meq, 8 meq	1 or 1b*	
potassium chloride er oral tablet extended release 15 meq	1 or 1a*	
POTASSIUM CHLORIDE INTRAVENOUS SOLUTION 10 MEQ/100ML, 10 MEQ/50ML, 20 MEQ/100ML, 20 MEQ/50ML, 40 MEQ/100ML	3	
potassium chloride intravenous solution 2 meq/ml	1 or 1b*	
potassium chloride oral packet	1 or 1b*	
potassium chloride oral solution	1 or 1b*	
SODIUM - DRUGS FOR NUTRITION**		
aquastat intravenous solution	1 or 1b*	
sodium chloride flush (Aquastat Sfr Intravenous Solution)	1 or 1b*	
bd posiflush intravenous solution	1 or 1b*	
monoject flush syringe intravenous solution	1 or 1b*	
monoject sodium chloride flush intravenous solution	1 or 1b*	
normal saline flush intravenous solution	1 or 1b*	
sodium chloride (pf) injection solution	1 or 1b*	
sodium chloride flush intravenous solution	1 or 1b*	
sodium chloride injection solution	1 or 1b*	
sodium chloride intravenous solution	1 or 1b*	
TRACE MINERAL COMBINATIONS - DRUGS FOR NUTRITION**		
MULTITRACE-4 PEDIATRIC INTRAVENOUS SOLUTION (*trace minerals cr-cu-mn-zn*)	3	
MULTRYS INTRAVENOUS SOLUTION (*trace minerals cu-mn-se-zn*)	3	
THE LIQUILIFT TRACE INTRAVENOUS KIT (*trace minerals cr-cu-mn-se-zn*)	3	
TRALEMENT INTRAVENOUS SOLUTION (*trace minerals cu-mn-se-zn*)	3	
TRACE MINERALS - DRUGS FOR NUTRITION**		
chromic chloride intravenous solution	1 or 1b*	
cupric chloride intravenous solution	3	
SELENIOUS ACID INTRAVENOUS SOLUTION	3	
ZINC - DRUGS FOR NUTRITION**		
GALZIN ORAL CAPSULE (*zinc acetate (oral)*)	3	
zinc chloride intravenous solution	3	
zinc sulfate intravenous solution	1 or 1b*	
***MISCELLANEOUS THERAPEUTIC CLASSES* - VITAMINS AND MINERALS**		
ACTIVATED PHOSPHOINOSITIDE 3-KINASE DELTA SYNDROME AGENT - VITAMINS AND MINERALS**		
JOENJA ORAL TABLET (*leniolisib phosphate*)	4; OC	PA; LD; QL (2 tablets per 1 day); OC
ALLOGENEIC THYMUS TISSUE - VITAMINS AND MINERALS**		
RETHYMIC INTRAMUSCULAR IMPLANT (*allogeneic thymus tissue-agdc*)	3	

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTILEPROTICS - VITAMINS AND MINERALS**		
THALOMID ORAL CAPSULE 100 MG, 50 MG (*thalidomide*)	2; OC	PA; LD; QL (1 capsule per 1 day); SP; OC
THALOMID ORAL CAPSULE 150 MG, 200 MG (*thalidomide*)	2; OC	PA; LD; QL (2 capsules per 1 day); SP; OC
B-LYMPHOCYTE STIMULATOR (BLYS)-SPECIFIC INHIBITORS - VITAMINS AND MINERALS**		
BENLYSTA INTRAVENOUS SOLUTION RECONSTITUTED (*belimumab*)	4	PA; LD; SP
BENLYSTA SUBCUTANEOUS SOLUTION AUTO-INJECTOR (*belimumab*)	4	PA; LD; QL (4 autoinjectors per 28 days); SP
BENLYSTA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (*belimumab*)	4	PA; LD; QL (4 pens per 28 days); SP
CHELATING AGENTS - VITAMINS AND MINERALS**		
DEPEN TITRATABS ORAL TABLET (*penicillamine*)	3	PA; QL (8 tablets per 1 day); SP
penicillamine oral tablet	1 or 1b*	PA; QL (8 tablets per 1 day); SP
trientine hcl oral capsule	1 or 1b*	PA; QL (8 capsules per 1 day); SP
CONTINUOUS RENAL REPLACEMENT THERAPY (CRRT) SOLUTIONS - VITAMINS AND MINERALS**		
PHOXILLUM B22K4/0 EXTRACORPOREAL SOLUTION	3	
PHOXILLUM BK4/2.5 EXTRACORPOREAL SOLUTION	3	
PRISMASOL B22GK 4/0 EXTRACORPOREAL SOLUTION (*bicarb-dextrose-k (crrt)*)	3	
PRISMASOL BGK 0/2.5 EXTRACORPOREAL SOLUTION (*bicarb-dextrose-ca (crrt)*)	3	
PRISMASOL BGK 2/0 EXTRACORPOREAL SOLUTION (*bicarb-dextrose-k (crrt)*)	3	
PRISMASOL BGK 2/3.5 EXTRACORPOREAL SOLUTION (*bicarb-dextrose-k-ca (crrt)*)	3	
PRISMASOL BGK 4/0/1.2 EXTRACORPOREAL SOLUTION (*bicarb-dextose-k-mg (crrt)*)	3	
PRISMASOL BGK 4/2.5 EXTRACORPOREAL SOLUTION (*bicarb-dextrose-k-ca (crrt)*)	3	
PRISMASOL BK 0/0/1.2 EXTRACORPOREAL SOLUTION (*bicarb-mg (crrt)*)	3	
CYCLOSPORINE ANALOGS - VITAMINS AND MINERALS**		
cyclosporine intravenous solution	1 or 1b*	SP
cyclosporine modified oral capsule	1 or 1b*	
cyclosporine modified oral solution	1 or 1b*	
cyclosporine oral capsule	1 or 1b*	
gengraf oral capsule	1 or 1b*	
gengraf oral solution	1 or 1b*	
LUPKYNIS ORAL CAPSULE (*voclosporin*)	4	PA; LD; QL (6 capsules per 1 day)
SANDIMMUNE ORAL SOLUTION (*cyclosporine*)	3	

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ENZYMES - VITAMINS AND MINERALS**		
AMPHADASE INJECTION SOLUTION (*hyaluronidase bovine*)	3	
HYLENEX INJECTION SOLUTION (*hyaluronidase human*)	3	
XIAFLEX INJECTION SOLUTION RECONSTITUTED (*collagenase clostrid histolyt*)	4	PA; LD; SP
FARNESYLTRANSFERASE INHIBITORS - VITAMINS AND MINERALS**		
ZOKINVY ORAL CAPSULE (*lonafarnib*)	4	PA; LD; QL (4 capsules per 1 day); SP
FECAL INCONTINENCE BULKING AGENT - COMBINATIONS - VITAMINS AND MINERALS**		
SOLESTA INJECTION GEL (*dextranomer-sodium hyaluronate*)	4	LD; SP
IMMUNE GLOBULIN IMMUNOSUPPRESSANTS - VITAMINS AND MINERALS**		
ATGAM INTRAVENOUS INJECTABLE (*lymphocyte,anti-thymo imm glob*)	3	SP
THYMOGLOBULIN INTRAVENOUS SOLUTION RECONSTITUTED (*anti-thymocyte glob (rabbit)*)	3	SP
IMMUNOMODULATORS - COMBINATIONS - VITAMINS AND MINERALS**		
VYVGART HYTRULO SUBCUTANEOUS SOLUTION (*efgartigimod alfa-hyalur-qvfc*)	4	PA; LD; QL (4 vials per 4 weeks); SP
IMMUNOMODULATORS FOR MYELODYSPLASTIC SYNDROMES - VITAMINS AND MINERALS**		
lenalidomide oral capsule	1 or 1b*; OC	PA; LD; QL (1 capsule per 1 day); SP; OC
REVLIMID ORAL CAPSULE (*lenalidomide*)	2; OC	PA; LD; QL (1 capsule per 1 day); SP; OC
INOSINE MONOPHOSPHATE DEHYDROGENASE INHIBITORS - VITAMINS AND MINERALS**		
CELLCEPT INTRAVENOUS INTRAVENOUS SOLUTION RECONSTITUTED (*mycophenolate mofetil hcl*)	3	SP
CELLCEPT ORAL CAPSULE (*mycophenolate mofetil*)	3	
CELLCEPT ORAL SUSPENSION RECONSTITUTED (*mycophenolate mofetil*)	3	
CELLCEPT ORAL TABLET (*mycophenolate mofetil*)	3	
mycophenolate mofetil hcl intravenous solution reconstituted	1 or 1b*	SP
mycophenolate mofetil intravenous solution reconstituted	1 or 1b*	SP
mycophenolate mofetil oral capsule	1 or 1b*	
mycophenolate mofetil oral suspension reconstituted	1 or 1b*	
mycophenolate mofetil oral tablet	1 or 1b*	
mycophenolate sodium oral tablet delayed release	1 or 1b*	
INTERLEUKIN-6 (IL-6) ANTAGONISTS - VITAMINS AND MINERALS**		
SYLVANT INTRAVENOUS SOLUTION RECONSTITUTED (*siltuximab*)	4	PA; LD; SP

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
IRRIGATION SOLUTIONS - VITAMINS AND MINERALS**		
argyle sterile water irrigation solution	1 or 1b*	
lactated ringers irrigation solution	1 or 1b*	
physiolyte irrigation solution	1 or 1b*	
physiosol irrigation irrigation solution	1 or 1b*	
ringers irrigation irrigation solution	1 or 1b*	
sterile water for irrigation irrigation solution	1 or 1b*	
tis-u-sol irrigation solution	1 or 1b*	
water for irrigation, sterile irrigation solution	1 or 1b*	
MACROLIDE IMMUNOSUPPRESSANTS - VITAMINS AND MINERALS**		
ASTAGRAF XL ORAL CAPSULE EXTENDED RELEASE 24 HOUR (*tacrolimus*)	3	
ENVARSUS XR ORAL TABLET EXTENDED RELEASE 24 HOUR (*tacrolimus*)	3	
everolimus oral tablet	1 or 1b*	
PROGRAF INTRAVENOUS SOLUTION (*tacrolimus*)	2	SP
PROGRAF ORAL PACKET (*tacrolimus*)	3	
RAPAMUNE ORAL SOLUTION (*sirolimus*)	3	
RAPAMUNE ORAL TABLET (*sirolimus*)	3	
sirolimus oral solution	1 or 1b*	
sirolimus oral tablet	1 or 1b*	
tacrolimus oral capsule	1 or 1b*	
ZORTRESS ORAL TABLET (*everolimus*)	3	
MONOCLONAL ANTIBODIES - VITAMINS AND MINERALS**		
ENSPRYNG SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (*satralizumab-mwge*)	4	PA; LD; QL (1 syringe per 28 days); SP
GAMIFANT INTRAVENOUS SOLUTION (*emapalumab-lzsg*)	3	PA; LD; SP
SIMULECT INTRAVENOUS SOLUTION RECONSTITUTED (*basiliximab*)	3	
UPLIZNA INTRAVENOUS SOLUTION (*inebilizumab-cdon*)	4	PA; LD; QL (30 mL per 180 days)
NEONATAL FC RECEPTOR (FCRN) ANTAGONISTS - VITAMINS AND MINERALS**		
RYSTIGGO SUBCUTANEOUS SOLUTION (*rozanolixizumab-noli*)	4	PA; LD; QL (3 vials per 6 weeks); SP
VYVGART INTRAVENOUS SOLUTION (*efgartigimod alfa-fcab*)	4	PA; LD; QL (12 vials per 4 weeks); SP
PIK3CA-RELATED OVERGROWTH SPECTRUM AGENTS - PI3K INHIB - VITAMINS AND MINERALS**		
VIJOICE ORAL TABLET THERAPY PACK 125 MG, 50 MG (*alpelisib*)	4	PA; LD; QL (1 tablet per 1 day); SP
VIJOICE ORAL TABLET THERAPY PACK 200 & 50 MG (*alpelisib*)	4	PA; LD; QL (2 tablets per 1 day); SP

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
POTASSIUM REMOVING AGENTS - VITAMINS AND MINERALS**		
LOKELMA ORAL PACKET 10 GM (*sodium zirconium cyclosilicate*)	3	QL (34 packets per 30 days)
LOKELMA ORAL PACKET 5 GM (*sodium zirconium cyclosilicate*)	3	QL (3 packets per 1 day)
sodium polystyrene sulfonate oral powder	1 or 1b*	
sps oral suspension	1 or 1b*	
VELTASSA ORAL PACKET 16.8 GM, 25.2 GM (*patiromer sorbitex calcium*)	3	QL (1 packet per 1 day)
VELTASSA ORAL PACKET 8.4 GM (*patiromer sorbitex calcium*)	3	QL (3 packets per 1 day)
PROSTAGLANDINS - VITAMINS AND MINERALS**		
PROSTIN VR INJECTION SOLUTION (*alprostadil*)	3	
PURINE ANALOGS - VITAMINS AND MINERALS**		
azasan oral tablet	1 or 1b*	
azathioprine oral tablet	1 or 1b*	
AZATHIOPRINE SODIUM INJECTION SOLUTION RECONSTITUTED	3	
IMURAN ORAL TABLET (*azathioprine*)	3	
ROCK INHIBITORS - VITAMINS AND MINERALS**		
REZUROCK ORAL TABLET (*belumosudil mesylate*)	3; OC	PA; LD; QL (1 tablet per 1 day); OC
SCLEROSING AGENTS - VITAMINS AND MINERALS**		
ASCLERA INTRAVENOUS SOLUTION (*polidocanol*)	3	
ETHAMOLIN INTRAVENOUS SOLUTION (*ethanolamine oleate*)	3	
sodium tetradecyl sulfate intravenous solution	1 or 1b*	
SOTRADECOL INTRAVENOUS SOLUTION 1 % (*sodium tetradecyl sulfate*)	1 or 1b*	
sotradecol intravenous solution 3 %	1 or 1b*	
VARITHENA INTRAVENOUS FOAM (*polidocanol*)	3	
SELECTIVE T-CELL COSTIMULATION BLOCKERS - VITAMINS AND MINERALS**		
NULOJIX INTRAVENOUS SOLUTION RECONSTITUTED (*belatacept*)	3	PA
TYPE I INTERFERON (IFN) RECEPTOR ANTAGONISTS - VITAMINS AND MINERALS**		
SAPHNELO INTRAVENOUS SOLUTION (*anifrolumab-fnia*)	4	PA; LD; QL (1 vial per 28 days); SP
UREMIC PRURITUS AGENTS - VITAMINS AND MINERALS**		
KORSUVA INTRAVENOUS SOLUTION (*difelikefalin acetate*)	3	PA
***MOUTH/THROAT/DENTAL AGENTS* - DRUGS FOR THE MOUTH AND THROAT**		
ANESTHETICS TOPICAL ORAL - DRUGS FOR THE MOUTH AND THROAT**		
lidocaine hcl mouth/throat solution	1 or 1a*	QL (10 mL per 1 day)
lidocaine viscous hcl mouth/throat solution	1 or 1a*	QL (10 mL per 1 day)

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-INFECTIVES - THROAT - DRUGS FOR THE MOUTH AND THROAT**		
clotrimazole mouth/throat troche	1 or 1b*	QL (5 tablet per 1 day)
nystatin mouth/throat suspension	1 or 1b*	QL (24 mL per 1 day)
ORAVIG BUCCAL TABLET (*miconazole*)	3	
ANTISEPTICS - MOUTH/THROAT - DRUGS FOR THE MOUTH AND THROAT**		
chlorhexidine gluconate mouth/throat solution	1 or 1a*	QL (480 mL per 30 days)
PERIDEX MOUTH/THROAT SOLUTION (*chlorhexidine gluconate*)	3	QL (480 mL per 30 days)
periogard mouth/throat solution	1 or 1a*	QL (480 mL per 30 days)
DENTAL PRODUCTS - COMBINATIONS - DRUGS FOR THE MOUTH AND THROAT**		
FLUORIDEX SENSITIVITY RELIEF DENTAL PASTE (*sod fluoride-potassium nitrate*)	3	
FLUORIDE DENTAL PRODUCTS - DRUGS FOR THE MOUTH AND THROAT**		
clinpro 5000 dental paste	1 or 1b*	QL (3.77 grams per 1 day)
denta 5000 plus dental cream	1 or 1b*	QL (3.4 grams per 1 day)
dentagel dental gel	1 or 1a*	QL (100 grams per 30 days)
easygel dental gel	1 or 1b*	
fluoridex daily renewal mouth/throat concentrate	1 or 1b*	
fluoridex dental paste	1 or 1b*	QL (3.77 grams per 1 day)
fluoridex enhanced whitening dental paste	1 or 1b*	QL (3.77 grams per 1 day)
sf 5000 plus dental cream	1 or 1b*	QL (3.4 grams per 1 day)
sf dental gel	1 or 1a*	QL (100 grams per 30 days)
sodium fluoride 5000 plus dental cream	1 or 1b*	QL (3.4 grams per 1 day)
sodium fluoride 5000 ppm dental cream	1 or 1b*	QL (3.4 grams per 1 day)
sodium fluoride 5000 ppm dental paste	1 or 1b*	QL (3.77 grams per 1 day)
sodium fluoride dental cream	1 or 1b*	QL (3.4 grams per 1 day)
SALIVA STIMULANTS - DRUGS FOR THE MOUTH AND THROAT**		
cevimeline hcl oral capsule	1 or 1b*	
EVOXAC ORAL CAPSULE (*cevimeline hcl*)	3	
pilocarpine hcl oral tablet	1 or 1b*	QL (4 tablets per 1 day)
SALAGEN ORAL TABLET (*pilocarpine hcl*)	3	QL (4 tablets per 1 day)
STEROIDS - MOUTH/THROAT/DENTAL - DRUGS FOR THE MOUTH AND THROAT**		
triamcinolone acetonide (Kourzeq Mouth/Throat Paste)	1 or 1b*	
oralone mouth/throat paste	1 or 1b*	
triamcinolone acetonide mouth/throat paste	1 or 1b*	
***MULTIVITAMINS* - DRUGS FOR NUTRITION**		
B-COMPLEX VITAMINS - DRUGS FOR NUTRITION**		
b-complex plus b-12 oral tablet	1 or 1b*; $0	

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
b-complex/b-12 oral tablet	1 or 1b*; $0	
ra b-complex oral tablet	1 or 1b*; $0	
ra b-complex with b-12 oral tablet	1 or 1b*; $0	
vitamin b complex oral tablet	1 or 1b*; $0	
vitamin-b complex oral tablet	1 or 1b*; $0	
B-COMPLEX W/ C & CALCIUM - DRUGS FOR NUTRITION**		
gnp b-complex plus vitamin c oral tablet	1 or 1b*; $0	
qc b-complex/vitamin c oral tablet	1 or 1b*; $0	
B-COMPLEX W/ C & FOLIC ACID - DRUGS FOR NUTRITION**		
b complex-c-folic acid oral tablet	1 or 1b*; $0	
b-complex balanced oral tablet	1 or 1b*; $0	
b-complex/vitamin c oral tablet	1 or 1b*; $0	
b-complex-c (w/folic acid) oral tablet	1 or 1b*; $0	
dialyvite 800 oral tablet	1 or 1b*; $0	
eql super b complex/vitamin c oral tablet	1 or 1b*; $0	
FULL SPECTRUM B/VITAMIN C ORAL TABLET	1 or 1b*; $0	
kp b complex-c oral tablet	1 or 1b*; $0	
nephro vitamins oral tablet	1 or 1b*; $0	
NEPHRO-VITE ORAL TABLET (*b complex-c-folic acid*)	1 or 1b*; $0	
renal vitamin oral tablet	1 or 1b*; $0	
rena-vite oral tablet	1 or 1b*; $0	
sm b super vitamin complex oral tablet	1 or 1b*; $0	
SM B-COMPLEX/VITAMIN C ORAL TABLET	2; $0	
stress formula (folic acid) oral tablet	1 or 1b*; $0	
super b complex/fa/vit c oral tablet	1 or 1b*; $0	
super b-complex/vit c/fa oral tablet	1 or 1b*; $0	
B-COMPLEX W/ C - DRUGS FOR NUTRITION**		
allbee/c oral tablet	1 or 1b*; $0	
b complex-c oral tablet	1 or 1b*; $0	
b-complex-c oral tablet	1 or 1b*; $0	
better b complex oral tablet	1 or 1b*; $0	
cvs b complex plus c oral tablet	1 or 1b*; $0	
cvs super b complex/c oral tablet	1 or 1b*; $0	
sm super b complex/c oral tablet	1 or 1b*; $0	
sm vitamin b complex/vitamin c oral tablet	1 or 1b*; $0	
super b complex/vitamin c oral tablet	1 or 1b*; $0	
super b-complex + vitamin c oral tablet	1 or 1b*; $0	
vitamin b + c complex oral tablet	1 or 1b*; $0	
B-COMPLEX W/ C-BIOTIN-E & FOLIC ACID - DRUGS FOR NUTRITION**		
B COMPLEX-C-BIOTIN-E-FA ORAL TABLET	2; $0	

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
B-COMPLEX W/ FOLIC ACID - DRUGS FOR NUTRITION**		
b complex formula 1 (w/ fa) oral tablet	1 or 1b*; $0	
b-complex (folic acid) oral tablet	1 or 1b*; $0	
b-complex/electrolytes oral tablet	1 or 1b*; $0	
big 100 oral tablet	1 or 1b*; $0	
kobee oral tablet	1 or 1b*; $0	
sm balanced b-100 oral tablet	1 or 1b*; $0	
sm balanced b-50 oral tablet	1 or 1b*; $0	
B-COMPLEX W/BIOTIN & FOLIC ACID - DRUGS FOR NUTRITION**		
b complex 100 tr oral tablet extended release	1 or 1b*; $0	
b-100 b-complex oral tablet	1 or 1b*; $0	
b-100 complex cr oral tablet extended release	1 or 1b*; $0	
b-100 tr oral tablet extended release	1 or 1b*; $0	
b-50 complex oral tablet	1 or 1b*; $0	
balance b-50 oral tablet	1 or 1b*; $0	
balanced b complex oral tablet	1 or 1b*; $0	
balanced b-100 oral tablet	1 or 1b*; $0	
balanced b-100 oral tablet extended release	1 or 1b*; $0	
balanced b-50/fa oral tablet	1 or 1b*; $0	
b-compleet-100 oral tablet	1 or 1b*; $0	
b-compleet-50 oral tablet	1 or 1b*; $0	
b-complex oral tablet	1 or 1b*; $0	
big 100 (biotin) oral tablet	1 or 1b*; $0	
complex b-100 oral tablet extended release	1 or 1b*; $0	
complex b-50 prolonged release oral tablet extended release	1 or 1b*; $0	
endur-b oral tablet extended release	1 or 1b*; $0	
eql b complex 50 oral tablet	1 or 1b*; $0	
eql b-100 complex oral tablet extended release	1 or 1b*; $0	
gnp b-100 complex oral tablet extended release	1 or 1b*; $0	
gnp b-50 complex oral tablet extended release	1 or 1b*; $0	
qc b50 prolonged release oral tablet extended release	1 or 1b*; $0	
quin b strong b-25 oral tablet	1 or 1b*; $0	
ra balanced b-100 cr oral tablet extended release	1 or 1b*; $0	
ra balanced b-100 oral tablet	1 or 1b*; $0	
ra balanced b-50 oral tablet	1 or 1b*; $0	
ra balanced b-50 tr oral tablet extended release	1 or 1b*; $0	
sm b100 complex oral tablet	1 or 1b*; $0	
sm b-complex oral tablet	1 or 1b*; $0	
super b-complex oral tablet	1 or 1b*; $0	
super dec b-100 oral tablet	1 or 1b*; $0	
super quints b-50 oral tablet	1 or 1b*; $0	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
yl balanced b-100 oral tablet	1 or 1b*; $0	
MULTIPLE VITAMINS W/ IRON - DRUGS FOR NUTRITION**		
daily vite multivitamin/iron oral tablet	1 or 1b*; $0	
multiple vitamins/iron oral tablet	1 or 1b*; $0	
multivitamin plus iron adult oral tablet	1 or 1b*; $0	
multi-vitamin/iron oral tablet	1 or 1b*; $0	
nat-rul daily-vite+iron oral tablet	1 or 1b*; $0	
one daily multivitamin/iron oral tablet	1 or 1b*; $0	
one-daily multi-vitamin/iron oral tablet	1 or 1b*; $0	
one-daily/iron oral tablet	1 or 1b*; $0	
qc daily multivitamins/iron oral tablet	1 or 1b*; $0	
sm multiple vitamins/iron oral tablet	1 or 1b*; $0	
stress b complex/iron oral tablet	1 or 1b*; $0	
stress formula/iron oral tablet	1 or 1b*; $0	
tab-a-vite/iron oral tablet	1 or 1b*; $0	
TAB-A-VITE/IRON/BETA CAROTENE ORAL TABLET (*multiple vitamins-iron*)	2; $0	
MULTIPLE VITAMINS W/ MINERALS & CALCIUM-FOLIC ACID - DRUGS FOR NUTRITION**		
FOLGARD OS ORAL TABLET (*multiple vit-min-calcium-fa*)	3	
MULTIPLE VITAMINS W/ MINERALS & FLUORIDE-IRON-FOLIC ACID - DRUGS FOR NUTRITION**		
QUFLORA FE ORAL TABLET CHEWABLE (*multi vit-min-fluoride-fe-fa*)	3	
MULTIPLE VITAMINS W/ MINERALS - DRUGS FOR NUTRITION**		
LIVITA ADULTS ORAL LIQUID (*multiple vitamins-minerals*)	3	
MENATROL ORAL CAPSULE (*multiple vitamins-minerals*)	3	
MULTIVITAMINS - DRUGS FOR NUTRITION**		
anti-oxidant oral tablet	1 or 1b*; $0	
daily multiple vitamins oral tablet	2; $0	
daily value multivitamin oral tablet	1 or 1b*; $0	
daily vitamins oral tablet	1 or 1b*; $0	
daily vite oral tablet	1 or 1b*; $0	
daily vites oral tablet	1 or 1b*; $0	
daily-vite multivitamin oral tablet	1 or 1b*; $0	
daily-vite oral tablet	1 or 1b*; $0	
DAVIMET-M ORAL TABLET CHEWABLE (*multiple vitamin*)	3	
ESTROFACTORS ORAL TABLET (*multiple vitamin*)	2; $0	
gnp essential one daily oral tablet	1 or 1b*; $0	
healthy hair/skin/nails oral tablet	1 or 1b*; $0	
HIGH POTENCY MULTIVITAMIN ORAL TABLET	2; $0	
INFUVITE ADULT INTRAVENOUS INJECTABLE (*multiple vitamin*)	3	

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
multi vitamin oral tablet	2; $0	
MULTI VITAMIN W/D-3 ORAL TABLET	2; $0	
multiple vitamin-folic acid oral tablet	1 or 1b*; $0	
multiple vitamins essential oral tablet	1 or 1b*; $0	
multiple vitamins oral tablet	1 or 1b*; $0	
multivitamin adult oral tablet	2; $0	
multivitamin iron-free oral tablet	1 or 1b*; $0	
MULTIVITAMIN ORAL TABLET	2; $0	
multi-vitamin oral tablet	1 or 1b*; $0	
NEOMULTIVITE ORAL TABLET (*multiple vitamin*)	2; $0	
novite oral capsule	1 or 1b*	
OMNICAP ORAL TABLET	2; $0	
once daily oral tablet	1 or 1b*; $0	
one daily essential oral tablet	2; $0	
one daily multivitamin adult oral tablet	1 or 1b*; $0	
one daily oral tablet	1 or 1b*; $0	
ONE VITE DAILY MULTIVITAMIN ORAL TABLET (*multiple vitamin*)	2; $0	
ONE-A-DAY ESSENTIAL ORAL TABLET (*multiple vitamin*)	2; $0	
ONE-A-DAY MENS ORAL TABLET (*multiple vitamin*)	2; $0	
one-daily multi vitamins oral tablet	1 or 1b*; $0	
one-daily multi-vitamin oral tablet	1 or 1b*; $0	
qc essentials oral tablet	1 or 1b*; $0	
QUINTABS ORAL TABLET	2; $0	
sm multiple vitamins essential oral tablet	1 or 1b*; $0	
stress formula oral tablet	1 or 1b*; $0	
stresstabs energy oral tablet	1 or 1b*; $0	
tab-a-vite oral tablet	1 or 1b*; $0	
tab-a-vite/beta carotene oral tablet	1 or 1b*; $0	
THERA ORAL TABLET (*multiple vitamin*)	2; $0	
thera-tabs oral tablet	1 or 1b*; $0	
THEREMS ORAL TABLET (*multiple vitamin*)	2; $0	
tm-daily vite oral tablet	2; $0	
vit e-vit c-beta carotene oral tablet	1 or 1b*; $0	
vitalee oral tablet	1 or 1b*; $0	
VITLIPID N ADULT INTRAVENOUS EMULSION (*multiple vitamin*)	3	
PED MULTI VITAMINS W/FL & FE - DRUGS FOR NUTRITION**		
multi-vitamin/fluoride/iron oral solution	1 or 1b*	
POLY-VI-FLOR/IRON ORAL SUSPENSION (*ped multivitamins-fl-iron*)	3	
POLY-VI-FLOR/IRON ORAL TABLET CHEWABLE (*ped multivitamins-fl-iron*)	3	
QUFLORA FE PEDIATRIC ORAL LIQUID (*ped multivitamins-fl-iron*)	3	

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PED MULTIPLE VITAMINS W/ MINERALS - DRUGS FOR NUTRITION**		
LIVITA CHILDREN ORAL LIQUID (*pediatric multivit-minerals*)	3	
PED MV W/ FLUORIDE - DRUGS FOR NUTRITION**		
FLORIVA PLUS ORAL SOLUTION (*pediatric multivitamins-fl*)	3	
multivitamin w/fluoride oral tablet chewable	1 or 1b*; $0	
multivitamin/fluoride oral solution	1 or 1b*; $0	
multi-vitamin/fluoride oral solution	1 or 1b*; $0	
multivitamin/fluoride oral tablet chewable	1 or 1b*; $0	
MULTI-VIT-FLOR ORAL TABLET CHEWABLE (*pediatric multivitamins-fl*)	3	
POLY-VI-FLOR ORAL SUSPENSION (*pediatric multivitamins-fl*)	3	
POLY-VI-FLOR ORAL TABLET CHEWABLE (*pediatric multivitamins-fl*)	3	
QUFLORA PEDIATRIC ORAL SOLUTION (*pediatric multivitamins-fl*)	3	
QUFLORA PEDIATRIC ORAL TABLET CHEWABLE (*pediatric multivitamins-fl*)	3	
PED VITAMINS ACD & FA W/ FLUORIDE - DRUGS FOR NUTRITION**		
TRI-VI-FLOR ORAL SUSPENSION (*ped vit a-c-d-methylfolate-fl*)	3	
TRI-VI-FLORO ORAL SUSPENSION	3	
PED VITAMINS ACD W/ FLUORIDE - DRUGS FOR NUTRITION**		
adc/f (0.5mg/ml) oral solution	1 or 1b*; $0	
tri-vite/fluoride oral solution	1 or 1b*; $0	
vitamins acd-fluoride oral solution	1 or 1b*; $0	
PEDIATRIC MULTIPLE VITAMINS & MINERALS W/ FLUORIDE - DRUGS FOR NUTRITION**		
FLORIVA ORAL TABLET CHEWABLE (*ped multiple vit-minerals-fl*)	3	
PEDIATRIC MULTIPLE VITAMINS - DRUGS FOR NUTRITION**		
INFUVITE PEDIATRIC INTRAVENOUS SOLUTION (*pediatric multiple vitamins*)	3	
VITALIPID N INFANT INTRAVENOUS EMULSION (*pediatric multiple vitamins*)	3	
VITLIPID N INFANT INTRAVENOUS EMULSION (*pediatric multiple vitamins*)	3	
PRENATAL MV & MIN W/FE-FA - DRUGS FOR NUTRITION**		
ATABEX EC ORAL TABLET DELAYED RELEASE (*prenatal vit-dss-fe cbn-fa*)	2	QL (1 tablet per 1 day)
ATABEX OB ORAL TABLET (*prenatal vit w/ fe bisg-fa*)	2	QL (1 tablet per 1 day)
AZESCO ORAL TABLET	3	ST; QL (2 tablets per 1 day)
CITRANATAL B-CALM ORAL (*prenat w/o a fecbnfeglu-fa &b6*)	2	QL (3 tablets per 1 day)
CLASSIC PRENATAL ORAL TABLET	2; $0	QL (1 tablet per 1 day)
C-NATE DHA ORAL CAPSULE	2	QL (1 capsule per 1 day)
COMPLETENATE ORAL TABLET CHEWABLE	2	QL (1 tablet per 1 day)

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CO-NATAL FA ORAL TABLET (*prenatal vit-fe fumarate-fa*)	2	QL (1 tablet per 1 day)
CONCEPT DHA ORAL CAPSULE (*prenat-fefum-fepo-fa-omega 3*)	2	QL (1 capsule per 1 day)
CONCEPT OB ORAL CAPSULE (*prenat w/o a vit-fefum-fepo-fa*)	2	QL (1 capsule per 1 day)
CVS PRENATAL ORAL TABLET	2; $0	ST; QL (1 tablet per 1 day)
DUET DHA 400 ORAL (*prenat-fepoly-fered-fa-omega 3*)	3	ST; QL (2 units per 1 day)
elite-ob oral tablet	1 or 1b*	QL (1 tablet per 1 day)
ENBRACE HR ORAL CAPSULE (*prenat vit-fe gly cys-fa-omega*)	3	ST; QL (1 capsule per 1 day)
EQL PRENATAL FORMULA ORAL TABLET	2; $0	QL (1 tablet per 1 day)
FOLIVANE-OB ORAL CAPSULE (*prenat w/o a vit-fefum-fepo-fa*)	2	QL (1 capsule per 1 day)
GNP PRENATAL ORAL TABLET	2; $0	QL (1 tablet per 1 day)
inatal gt oral tablet	1 or 1b*	QL (1 tablet per 1 day)
JENLIVA PRENATAL/POSTNATAL ORAL CAPSULE	3	ST; QL (1 capsule per 1 day)
KOSHER PRENATAL PLUS IRON ORAL TABLET	3	ST; QL (1 tablet per 1 day)
KP PRENATAL MULTIVITAMINS ORAL TABLET	2; $0	QL (1 tablet per 1 day)
KPN PRENATAL ORAL TABLET	2; $0	QL (1 tablet per 1 day)
MASONATAL ORAL TABLET	2; $0	QL (1 tablet per 1 day)
M-NATAL PLUS ORAL TABLET	2	QL (1 tablet per 1 day)
MULTI PRENATAL ORAL TABLET	2; $0	ST; QL (1 tablet per 1 day)
NATACHEW ORAL TABLET CHEWABLE (*prenatal vit-fe fum-fe bisg-fa*)	3	ST; QL (1 tablet per 1 day)
natal pnv oral tablet	3	ST; QL (2 tablets per 1 day)
NATALVIT ORAL TABLET (*prenatal vit-fe fumarate-fa*)	2	QL (1 tablet per 1 day)
NEEVO DHA ORAL CAPSULE (*prenat w/oa-fefum-methf-omegas*)	3	ST; QL (1 capsule per 1 day)
NEONATAL COMPLETE ORAL TABLET	3	ST; QL (1 tablet per 1 day)
NEONATAL FE ORAL TABLET	3	ST; QL (1 tablet per 1 day)
NEONATAL PLUS ORAL TABLET (*prenatal vit-fe fumarate-fa*)	3	QL (1 tablet per 1 day)
neonatal prenatal oral tablet	2; $0	QL (1 tablet per 1 day)
NEONATAL VITAMIN ORAL TABLET (*prenatal vit-fe fumarate-fa*)	2; $0	ST; QL (1 tablet per 1 day)
NESTABS DHA ORAL (*prenat-w/oa-fe bisgly-fa-omega*)	3	ST; QL (2 tablets per 1 day)
NESTABS ORAL TABLET (*prenat-fe bisgly-fa-w/o vit a*)	3	ST; QL (2 tablets per 1 day)
NIVA-PLUS ORAL TABLET (*prenatal vit-fe fumarate-fa*)	2	QL (1 tablet per 1 day)
OB COMPLETE ONE ORAL CAPSULE (*prenat-fecbn-feaspgl-fa-fish*)	3	ST; QL (1 capsule per 1 day)
OB COMPLETE ORAL TABLET (*prenatal vit-iron carbonyl-fa*)	3	ST; QL (1 tablet per 1 day)
OB COMPLETE PETITE ORAL CAPSULE (*prenat-fecbn-feaspgl-fa-omega*)	3	ST; QL (1 capsule per 1 day)
OB COMPLETE PREMIER ORAL TABLET (*prenatal-fe cbn-fe asp gly-fa*)	3	ST; QL (1 tablet per 1 day)
OB COMPLETE/DHA ORAL CAPSULE (*prenat-fecbn-feaspgl-fa-omega*)	3	ST; QL (1 capsule per 1 day)
ONE VITE WOMENS ORAL TABLET	2; $0	ST; QL (1 tablet per 1 day)
ONE VITE WOMENS PLUS ORAL TABLET	2	QL (1 tablet per 1 day)
ONE-A-DAY WOMENS PRENATAL ORAL (*prenatal vit-fe fum-fa-omega*)	2; $0	QL (1 EA per 1 day)
pnv prenatal plus multivit+dha oral	3	QL (2 units per 1 day)

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PNV TABS 20-1 ORAL TABLET	3	ST; QL (1 tablet per 1 day)
PNV-OMEGA ORAL CAPSULE	3	ST; QL (1 capsule per 1 day)
pnv-select oral tablet	1 or 1b*	ST; QL (1 tablet per 1 day)
PREGENNA ORAL TABLET	3	ST; QL (1 tablet per 1 day)
PRENA1 PEARL ORAL CAPSULE EXTENDED RELEASE	3	ST; QL (1 capsule per 1 day)
PRENATAL (W/IRON & FA) ORAL TABLET	2; $0	ST; QL (1 tablet per 1 day)
PRENATAL 19 ORAL TABLET	2	QL (1 tablet per 1 day)
prenatal 19 oral tablet chewable	1 or 1a*	QL (1 tablet per 1 day)
PRENATAL 19 ORAL TABLET CHEWABLE 29-1 MG	2	QL (1 tablet per 1 day)
PRENATAL COMPLETE ORAL TABLET	2; $0	ST; QL (1 tablet per 1 day)
PRENATAL FORTE ORAL TABLET	2; $0	ST; QL (1 tablet per 1 day)
PRENATAL ONE DAILY ORAL TABLET	2; $0	ST; QL (1 tablet per 1 day)
PRENATAL ORAL TABLET 27-0.8 MG	2; $0	ST; QL (1 tablet per 1 day)
PRENATAL ORAL TABLET 27-1 MG	2	QL (1 tablet per 1 day)
PRENATAL ORAL TABLET 28-0.8 MG	2; $0	QL (1 tablet per 1 day)
PRENATAL PLUS ORAL TABLET	2	QL (1 tablet per 1 day)
PRENATAL PLUS VITAMIN/MINERAL ORAL TABLET	2	QL (1 tablet per 1 day)
PRENATAL VITAMIN AND MINERAL ORAL TABLET	2; $0	QL (1 tablet per 1 day)
PRENATAL VITAMINS ORAL TABLET	2; $0	QL (1 tablet per 1 day)
PRENATAL/IRON ORAL TABLET	2; $0	ST; QL (1 tablet per 1 day)
PRENATAL/IRON ORAL TABLET 28-0.8 MG	2; $0	QL (1 tablet per 1 day)
PRENATAL-U ORAL CAPSULE (*prenatal w/o a vit-fe fum-fa*)	2	QL (1 capsule per 1 day)
PRENATE ELITE ORAL TABLET (*prenatal-feaspgly-methylfol-fa*)	3	ST; QL (1 tablet per 1 day)
PRENATRIX ORAL TABLET (*prenatal vit-fe fumarate-fa*)	3	ST; QL (1 tablet per 1 day)
PRENATRYL ORAL TABLET (*prenatal vit-fe fumarate-fa*)	3	ST; QL (1 tablet per 1 day)
PRENATVITE COMPLETE ORAL TABLET	3	ST; QL (1 tablet per 1 day)
PRENATVITE PLUS ORAL TABLET	3	ST; QL (1 tablet per 1 day)
PRENATVITE RX ORAL TABLET	3	ST; QL (1 tablet per 1 day)
PRIMACARE ORAL CAPSULE (*pren-fe-meth-fa-omeg w/o a*)	3	ST; QL (1 capsule per 1 day)
PROVIDA OB ORAL CAPSULE (*prenat w/o a vit-fefum-fepo-fa*)	2	QL (1 capsule per 1 day)
QC PRENATAL ORAL TABLET	2; $0	QL (1 tablet per 1 day)
RA PRENATAL FORMULA ORAL TABLET	2; $0	QL (1 tablet per 1 day)
RA PRENATAL ORAL TABLET	2; $0	QL (1 tablet per 1 day)
RELNATE DHA ORAL CAPSULE	3	ST; QL (1 capsule per 1 day)
SELECT-OB ORAL TABLET CHEWABLE 29-0.6-0.4 MG (*prenat vit-fepoly-methylfol-fa*)	3	ST; QL (1 tablet per 1 day)
SELECT-OB ORAL TABLET CHEWABLE 29-1 MG (*prenatal vit-fe psac cmplx-fa*)	2	QL (1 tablet per 1 day)
SE-NATAL 19 ORAL TABLET	2	QL (1 tablet per 1 day)
SE-NATAL 19 ORAL TABLET CHEWABLE	2	QL (1 tablet per 1 day)
SM ONE DAILY PRENATAL ORAL	2; $0	QL (1 EA per 1 day)
SM PRENATAL VITAMINS ORAL TABLET	2; $0	QL (1 tablet per 1 day)

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TARON-C DHA ORAL CAPSULE (*prenat-fefum-fepo-fa-omega 3*)	2	QL (1 capsule per 1 day)
THRIVITE RX ORAL TABLET	2	ST; QL (1 tablet per 1 day)
TRINATAL RX 1 ORAL TABLET	2	QL (1 tablet per 1 day)
trinate oral tablet	1 or 1a*	QL (1 tablet per 1 day)
VINATE DHA RF ORAL CAPSULE (*prenat w/oa-fefum-methf-omegas*)	3	ST; QL (1 capsule per 1 day)
VINATE II ORAL TABLET (*prenatal vit w/ fe bisg-fa*)	2	QL (1 tablet per 1 day)
VINATE ONE ORAL TABLET (*prenatal vit-fe fumarate-fa*)	2	QL (1 tablet per 1 day)
VITAFOL GUMMIES ORAL TABLET CHEWABLE (*prenatal vit-fe phos-fa-omega*)	2	QL (3 gummies per 1 day)
VITAFOL-NANO ORAL TABLET (*prenatal-fe fum-methf-fa w/o a*)	3	ST; QL (1 tablet per 1 day)
VITAFOL-OB ORAL TABLET (*prenatal vit-fe fumarate-fa*)	3	ST; QL (1 tablet per 1 day)
VITAPEARL ORAL CAPSULE EXTENDED RELEASE (*prenat-fefum-fered-fa-dha w/oa*)	3	ST; QL (1 capsule per 1 day)
VITATHELY WITH GINGER ORAL TABLET (*prenatal vit-fe fumarate-fa*)	3	ST; QL (1 tablet per 1 day)
VIVA DHA ORAL CAPSULE (*prenatal vit-fe fum-fa-omega*)	3	ST; QL (1 capsule per 1 day)
WESTAB PLUS ORAL TABLET	2	QL (1 tablet per 1 day)
ZALVIT ORAL TABLET	3	ST; QL (2 tablets per 1 day)
ZIPHEX ORAL TABLET	3	ST; QL (2 tablets per 1 day)
PRENATAL MV & MIN W/FE-FA-CA-OMEGA 3 FISH OIL - DRUGS FOR NUTRITION**		
COMPLETE NATAL DHA ORAL	2	QL (2 units per 1 day)
wesnatal dha complete oral	2	ST; QL (2 units per 1 day)
PRENATAL MV & MIN W/FE-FA-DHA - DRUGS FOR NUTRITION**		
CITRANATAL 90 DHA ORAL (*prenat w/o a-fecbgl-dss-fa-dha*)	3	ST; QL (2 tablets per 1 day)
CITRANATAL ASSURE ORAL (*prenat w/o a-fecbgl-dss-fa-dha*)	3	ST; QL (2 units per 1 day)
CITRANATAL HARMONY ORAL CAPSULE (*prenat-fefmcb-dss-fa-dha w/o a*)	3	
CITRANATAL MEDLEY ORAL CAPSULE (*prenat-fecb-fefum-fa-dha w/o a*)	3	ST; QL (1 capsule per 1 day)
ENFAMIL EXPECTA ORAL (*prenatal mv-min-fe fum-fa-dha*)	2; $0	QL (2 tablets per 1 day)
NEONATAL + DHA ORAL	3	ST; QL (2 units per 1 day)
NESTABS ONE ORAL CAPSULE (*prenat-fe-methylfol-dha w/o a*)	3	ST; QL (1 capsule per 1 day)
pnv-dha oral capsule	1 or 1b*	QL (1 capsule per 1 day)
PNV-DHA+DOCUSATE ORAL CAPSULE	3	ST; QL (1 capsule per 1 day)
PREGEN DHA ORAL CAPSULE	3	ST; QL (1 tablet per 1 day)
PRENA 1 TRUE ORAL	2	QL (2 tablets per 1 day)
PRENAISSANCE ORAL CAPSULE	3	ST; QL (1 capsule per 1 day)
PRENAISSANCE PLUS ORAL CAPSULE	3	ST; QL (1 capsule per 1 day)
PRENATAL MULTIVITAMIN + DHA ORAL (*prenatal mv-min-fe fum-fa-dha*)	2; $0	QL (2 tablets per 1 day)
PRENATE DHA ORAL CAPSULE (*prenat-feasp-meth-fa-dha w/o a*)	3	ST; QL (1 capsule per 1 day)
PRENATE ENHANCE ORAL CAPSULE (*prenat w/o a-fe-methfol-fa-dha*)	3	ST; QL (1 capsule per 1 day)

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PRENATE ESSENTIAL ORAL CAPSULE (*prenat-feasp-meth-fa-dha w/o a*)	3	ST; QL (1 capsule per 1 day)
PRENATE MINI ORAL CAPSULE (*prenat-fecbn-feasp-meth-fa-dha*)	3	ST; QL (1 capsule per 1 day)
PRENATE PIXIE ORAL CAPSULE (*prenat-feasp-meth-fa-dha w/o a*)	3	ST; QL (1 capsule per 1 day)
PRENATE RESTORE ORAL CAPSULE (*prenat w/o a-fe-methfol-fa-dha*)	3	ST; QL (1 capsule per 1 day)
SELECT-OB+DHA ORAL (*prenatal vit-fepoly-fa-dha*)	3	ST; QL (2 units per 1 day)
TRISTART DHA ORAL CAPSULE	3	ST; QL (1 capsule per 1 day)
VITAFOL FE+ ORAL CAPSULE (*prenat-fe poly-methfol-fa-dha*)	3	ST; QL (2 capsules per 1 day)
VITAFOL ULTRA ORAL CAPSULE (*prenat-fe poly-methfol-fa-dha*)	3	ST; QL (1 capsule per 1 day)
VITAFOL-OB+DHA ORAL (*prenatal mv-min-fe fum-fa-dha*)	3	ST; QL (2 units per 1 day)
VITAFOL-ONE ORAL CAPSULE (*prenatal vit-fepoly-fa-dha*)	3	ST; QL (1 capsule per 1 day)
VITAMEDMD ONE RX/QUATREFOLIC ORAL CAPSULE (*prenat w/o a-fe-methfol-fa-dha*)	3	ST; QL (1 capsule per 1 day)
VITATRUE ORAL (*prenat-fechel-fa-dha w/o vit a*)	3	ST; QL (2 tablets per 1 day)
WESTGEL DHA ORAL CAPSULE	3	ST; QL (1 capsule per 1 day)
PRENATAL MV & MINERALS W/FA WITHOUT IRON - DRUGS FOR NUTRITION**		
PRENATE ORAL TABLET CHEWABLE (*prenat mv-min-methylfolate-fa*)	3	ST; QL (1 tablet per 1 day)
PRENATAL VITAMINS - DRUGS FOR NUTRITION**		
NEONATAL 19 ORAL TABLET	3	ST; QL (1 tablet per 1 day)
PREMESISRX ORAL TABLET (*prenatal ca-b6-b12-fa-ginger*)	3	ST; QL (1 tablet per 1 day)
PRENA1 ORAL TABLET CHEWABLE	3	ST; QL (1 tablet per 1 day)
PRENATE AM ORAL TABLET (*prenatal ca-b6-b12-fa-ginger*)	3	ST; QL (1 tablet per 1 day)
VITAFOL STRIPS ORAL FILM (*prenatal-b6-b12-d3-folic acid*)	2	ST; QL (1 EA per 1 day)
VITAMEDMD REDICHEW RX ORAL TABLET CHEWABLE (*prenat-b2-b6-b12-d3-fa*)	3	ST; QL (1 tablet per 1 day)
VITAMINS W/ LIPOTROPICS - DRUGS FOR NUTRITION**		
ACTIFLOVIT EAR HEALTH ORAL TABLET (*vitamins-lipotropics*)	2; $0	
b complex (lipotropics) oral tablet	1 or 1b*; $0	
b complex formula 1 (lipotrop) oral tablet	1 or 1b*; $0	
balance b-100 oral tablet	1 or 1b*; $0	
balanced b-50 complex oral tablet	1 or 1b*; $0	
COMPLEX B-100-INOSITOL ORAL TABLET EXTENDED RELEASE	2; $0	
cvs balanced b50 oral tablet	1 or 1b*; $0	
cvs inner ear plus oral tablet	1 or 1b*; $0	
ear health formula oral tablet	1 or 1b*; $0	
ear health plus oral tablet	1 or 1b*; $0	
lipo flavonoid plus oral tablet	1 or 1b*; $0	
lipoflavovit oral tablet	1 or 1b*; $0	
LIPOTRIAD ORAL TABLET (*vitamins-lipotropics*)	2; $0	
mega multiple/chelated mineral oral tablet	1 or 1b*; $0	
nat-rul b-50 oral tablet	1 or 1b*; $0	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
risanoid plus oral tablet	1 or 1b*; $0	
ultra b-100 complex oral tablet	1 or 1b*; $0	
***MUSCULOSKELETAL THERAPY AGENTS* - DRUGS FOR MUSCLES, LIGAMENTS, TENDONS, AND BONES**		
CENTRAL MUSCLE RELAXANTS - DRUGS FOR MUSCLES, LIGAMENTS, TENDONS, AND BONES**		
baclofen oral tablet 10 mg, 5 mg	1 or 1b*	QL (3 tablets per 1 day)
baclofen oral tablet 20 mg	1 or 1b*	QL (4 tablets per 1 day)
carisoprodol oral tablet	1 or 1b*	QL (4 tablets per 1 day)
chlorzoxazone oral tablet 375 mg, 750 mg	1 or 1b*	ST; QL (4 tablets per 1 day)
chlorzoxazone oral tablet 500 mg	1 or 1b*	QL (4 tablets per 1 day)
cyclobenzaprine hcl oral tablet	1 or 1b*	QL (3 tablets per 1 day)
lorzone oral tablet	1 or 1b*	ST; QL (4 tablets per 1 day)
metaxalone oral tablet	1 or 1b*	ST; QL (4 tablets per 1 day)
methocarbamol injection solution	1 or 1b*	
methocarbamol oral tablet 500 mg	1 or 1b*	QL (8 tablets per 1 day)
methocarbamol oral tablet 750 mg	1 or 1b*	QL (6 tablets per 1 day)
orphenadrine citrate er oral tablet extended release 12 hour	1 or 1b*	QL (2 tablets per 1 day)
orphenadrine citrate injection solution	1 or 1b*	
tizanidine hcl oral capsule	1 or 1b*	QL (6 capsules per 1 day)
tizanidine hcl oral tablet 2 mg	1 or 1b*	QL (4 tablets per 1 day)
tizanidine hcl oral tablet 4 mg	1 or 1b*	QL (9 tablets per 1 day)
ZANAFLEX ORAL CAPSULE (*tizanidine hcl*)	3	ST; QL (6 capsules per 1 day)
ZANAFLEX ORAL TABLET (*tizanidine hcl*)	3	ST; QL (9 tablets per 1 day)
DIRECT MUSCLE RELAXANTS - DRUGS FOR MUSCLES, LIGAMENTS, TENDONS, AND BONES**		
DANTRIUM INTRAVENOUS SOLUTION RECONSTITUTED (*dantrolene sodium*)	3	
DANTRIUM ORAL CAPSULE (*dantrolene sodium*)	3	
dantrolene sodium intravenous solution reconstituted	1 or 1b*	
dantrolene sodium oral capsule	1 or 1b*	
revonto intravenous solution reconstituted	1 or 1b*	
RYANODEX INTRAVENOUS SUSPENSION RECONSTITUTED (*dantrolene sodium*)	3	
MUSCLE RELAXANT COMBINATIONS - DRUGS FOR MUSCLES, LIGAMENTS, TENDONS, AND BONES**		
norgesic oral tablet	1 or 1b*	ST; QL (8 tablets per 1 day)
ORPHENADRINE-ASPIRIN-CAFFEINE ORAL TABLET	1 or 1b*	ST; QL (8 tablets per 1 day)
orphengesic forte oral tablet	1 or 1b*	ST; QL (4 tablets per 1 day)
VISCOSUPPLEMENTS - DRUGS FOR MUSCLES, LIGAMENTS, TENDONS, AND BONES**		
DUROLANE INTRA-ARTICULAR PREFILLED SYRINGE (*sodium hyaluronate (viscosup)*)	4	PA

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EUFLEXXA INTRA-ARTICULAR SOLUTION PREFILLED SYRINGE (*sodium hyaluronate (viscosup)*)	4	PA
GEL-ONE INTRA-ARTICULAR PREFILLED SYRINGE (*cross-linked hyaluronate*)	4	
GELSYN-3 INTRA-ARTICULAR SOLUTION PREFILLED SYRINGE (*sodium hyaluronate (viscosup)*)	4	
HYALGAN INTRA-ARTICULAR SOLUTION (*sodium hyaluronate (viscosup)*)	4	PA
HYALGAN INTRA-ARTICULAR SOLUTION PREFILLED SYRINGE (*sodium hyaluronate (viscosup)*)	4	PA
HYMOVIS INTRA-ARTICULAR SOLUTION PREFILLED SYRINGE (*hyaluronan*)	4	PA; LD
MONOVISC INTRA-ARTICULAR SOLUTION PREFILLED SYRINGE (*hyaluronan*)	4	PA
ORTHOVISC INTRA-ARTICULAR SOLUTION PREFILLED SYRINGE (*hyaluronan*)	4	PA
SUPARTZ FX INTRA-ARTICULAR SOLUTION PREFILLED SYRINGE (*sodium hyaluronate (viscosup)*)	4	LD
SYNOJOYNT INTRA-ARTICULAR SOLUTION PREFILLED SYRINGE (*sodium hyaluronate (viscosup)*)	4	PA
SYNVISC INTRA-ARTICULAR SOLUTION PREFILLED SYRINGE (*hylan g-f 20*)	4	PA
SYNVISC ONE INTRA-ARTICULAR SOLUTION PREFILLED SYRINGE (*hylan g-f 20*)	4	PA
TRILURON INTRA-ARTICULAR SOLUTION PREFILLED SYRINGE (*sodium hyaluronate (viscosup)*)	4	PA
***NASAL AGENTS - SYSTEMIC AND TOPICAL* - DRUGS FOR THE NOSE**		
ANTIHISTAMINE-STEROID - ALLERGY**		
azelastine-fluticasone nasal suspension	3	QL (1 bottle per 30 days)
NASAL ANESTHETICS - ALLERGY**		
COCAINE HCL NASAL SOLUTION	3	
GOPRELTO NASAL SOLUTION	3	
NASAL ANTICHOLINERGICS - ALLERGY**		
ipratropium bromide nasal solution 0.03 %	1 or 1b*	QL (2 bottles per 30 days)
ipratropium bromide nasal solution 0.06 %	1 or 1b*	QL (1 mL per 1 day)
NASAL ANTIHISTAMINES - ALLERGY**		
azelastine hcl nasal solution 0.1 %, 137 mcg/spray	1 or 1b*	QL (1 package per 25 days)
azelastine hcl nasal solution 0.15 %	1 or 1b*	QL (1 bottle per 25 days)
olopatadine hcl nasal solution	1 or 1b*	QL (1 bottle per 30 days)
NASAL STEROIDS - ALLERGY**		
flunisolide nasal solution	3	
mometasone furoate nasal suspension	3	ST; QL (1 bottle per 30 days)
PROPEL MINI NASAL IMPLANT (*mometasone furoate*)	3	
PROPEL MINI SDS NASAL IMPLANT (*mometasone furoate*)	3	

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PROPEL NASAL IMPLANT (*mometasone furoate*)	3	
***NEUROMUSCULAR AGENTS* - DRUGS FOR NERVES AND MUSCLES**		
ALS AGENT COMBINATIONS - DRUGS FOR NERVES AND MUSCLES**		
RELYVRIO ORAL PACKET (*phenylbutyrate-taurursodiol*)	4	PA; LD; QL (56 packets per 28 days); SP
ALS AGENTS - MISCELLANEOUS - DRUGS FOR NERVES AND MUSCLES**		
RADICAVA ORS ORAL SUSPENSION (*edaravone*)	4	PA; LD; QL (1 kit per 28 days); SP
RADICAVA ORS STARTER KIT ORAL SUSPENSION (*edaravone*)	4	PA; LD; QL (1 starter kit per 1 lifetime); SP
BENZATHIAZOLES - DRUGS FOR NERVES AND MUSCLES**		
RILUTEK ORAL TABLET (*riluzole*)	4	QL (4 tablets per 1 day); SP
riluzole oral tablet	4	QL (4 tablets per 1 day); SP
DEPOLARIZING MUSCLE RELAXANTS - DRUGS FOR NERVES AND MUSCLES**		
ANECTINE INJECTION SOLUTION (*succinylcholine chloride*)	3	
QUELICIN INJECTION SOLUTION (*succinylcholine chloride*)	3	
SUCCINYLCHOLINE CHLORIDE INJECTION SOLUTION PREFILLED SYRINGE	3	
FRIEDRICH'S ATAXIA AGENTS - NRF2 PATHWAY ACTIVATORS - DRUGS FOR NERVES AND MUSCLES**		
SKYCLARYS ORAL CAPSULE (*omaveloxolone*)	4	PA; LD; QL (3 capsules per 1 day)
MUSCULAR DYSTROPHY - GENE THERAPY AGENTS - DRUGS FOR NERVES AND MUSCLES**		
AMONDYS 45 INTRAVENOUS SOLUTION	4	PA; LD
EXONDYS 51 INTRAVENOUS SOLUTION (*eteplirsen*)	4	PA; LD
VILTEPSO INTRAVENOUS SOLUTION (*viltolarsen*)	4	PA; LD
VYONDYS 53 INTRAVENOUS SOLUTION (*golodirsen*)	4	PA; LD
NEUROMUSCULAR BLOCKING AGENT - NEUROTOXINS - DRUGS FOR NERVES AND MUSCLES**		
BOTOX INJECTION SOLUTION RECONSTITUTED (*onabotulinumtoxina*)	4	PA
DYSPORT INTRAMUSCULAR SOLUTION RECONSTITUTED (*abobotulinumtoxina*)	4	PA; SP
MYOBLOC INTRAMUSCULAR SOLUTION (*rimabotulinumtoxinb*)	4	PA; SP
XEOMIN INTRAMUSCULAR SOLUTION RECONSTITUTED (*incobotulinumtoxina*)	4	PA; LD; SP
NONDEPOLARIZING MUSCLE RELAXANTS - DRUGS FOR NERVES AND MUSCLES**		
atracurium besylate intravenous solution	1 or 1b*	
cisatracurium besylate (pf) intravenous solution	1 or 1b*	
cisatracurium besylate intravenous solution	1 or 1b*	
rocuronium bromide intravenous solution	1 or 1b*	

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
vecuronium bromide intravenous solution reconstituted	1 or 1b*	
RETT SYNDROME AGENTS - GLYCINE-PROLINE-GLUTAMATE ANALOGS - DRUGS FOR NERVES AND MUSCLES**		
DAYBUE ORAL SOLUTION (*trofinetide*)	4	PA; LD; QL (120 mL per 1 day)
SPINAL MUSCULAR ATROPHY-SMN2 SPLICING MODIFIERS - DRUGS FOR NERVES AND MUSCLES**		
EVRYSDI ORAL SOLUTION RECONSTITUTED (*risdiplam*)	4	PA; LD; QL (5 mg per 1 day)
***NUTRIENTS* - DRUGS FOR NUTRITION**		
AMINO ACID MIXTURES - DRUGS FOR NUTRITION**		
AMINOSYN II INTRAVENOUS SOLUTION 10 % (*amino acid infusion*)	3	
aminosyn ii intravenous solution 15 %	1 or 1b*	
AMINOSYN-PF 7% INTRAVENOUS SOLUTION (*amino acid infusion*)	3	
AMINOSYN-PF INTRAVENOUS SOLUTION (*amino acid infusion*)	3	
CLINIMIX E/DEXTROSE (2.75/5) INTRAVENOUS SOLUTION (*amino ac elect-calc in d5w*)	3	
CLINIMIX E/DEXTROSE (4.25/10) INTRAVENOUS SOLUTION (*amino ac elect-calc in d10w*)	3	
CLINIMIX E/DEXTROSE (4.25/5) INTRAVENOUS SOLUTION (*amino ac elect-calc in d5w*)	3	
CLINIMIX E/DEXTROSE (5/15) INTRAVENOUS SOLUTION (*amino ac elect-calc in d15w*)	3	
CLINIMIX E/DEXTROSE (5/20) INTRAVENOUS SOLUTION (*amino ac elect-calc in d20w*)	3	
CLINIMIX E/DEXTROSE (8/10) INTRAVENOUS SOLUTION	3	
CLINIMIX E/DEXTROSE (8/14) INTRAVENOUS SOLUTION	3	
CLINIMIX/DEXTROSE (4.25/10) INTRAVENOUS SOLUTION (*amino acid infusion in d10w*)	3	
CLINIMIX/DEXTROSE (4.25/5) INTRAVENOUS SOLUTION (*amino acid infusion in d5w*)	3	
CLINIMIX/DEXTROSE (5/15) INTRAVENOUS SOLUTION (*amino acid infusion in d15w*)	3	
CLINIMIX/DEXTROSE (5/20) INTRAVENOUS SOLUTION (*amino acid infusion in d20w*)	3	
CLINIMIX/DEXTROSE (6/5) INTRAVENOUS SOLUTION	3	
CLINIMIX/DEXTROSE (8/10) INTRAVENOUS SOLUTION	3	
CLINIMIX/DEXTROSE (8/14) INTRAVENOUS SOLUTION	3	
clinisol sf intravenous solution	1 or 1b*	
plenamine intravenous solution	1 or 1b*	
PREMASOL INTRAVENOUS SOLUTION (*amino acid infusion*)	3	
PROSOL INTRAVENOUS SOLUTION (*amino acid infusion*)	3	
TRAVASOL INTRAVENOUS SOLUTION (*amino acid infusion*)	3	
TROPHAMINE INTRAVENOUS SOLUTION (*amino acid infusion*)	3	
AMINO ACIDS-SINGLE - DRUGS FOR NUTRITION**		
ELCYS INTRAVENOUS SOLUTION (*cysteine hcl*)	3	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CARBOHYDRATES - DRUGS FOR NUTRITION**		
dextrose intravenous solution 10 %, 5 %, 70 %	1 or 1b*	
DEXTROSE INTRAVENOUS SOLUTION 20 %, 30 %, 40 %	3	
LIPIDS - DRUGS FOR NUTRITION**		
CLINOLIPID INTRAVENOUS EMULSION (*fat emuls plant base(soy/oliv)*)	3	
DOJOLVI ORAL LIQUID (*triheptanoin*)	4	PA; LD; QL (2 bottles per 30 days); SP
INTRALIPID INTRAVENOUS EMULSION (*fat emulsion plant based (soy)*)	3	
NUTRILIPID INTRAVENOUS EMULSION (*fat emulsion plant based (soy)*)	3	
OMEGAVEN INTRAVENOUS EMULSION (*fish oil triglyceride based*)	3	
SMOFLIPID INTRAVENOUS EMULSION (*fat emul fish oil/plant based*)	3	
LIPOTROPIC COMBINATIONS - DRUGS FOR NUTRITION**		
LECITHIN ORAL GRANULES	3	
PROTEIN-CARBOHYDRATE-LIPID WITH ELECTROLYTE COMBINATIONS - DRUGS FOR NUTRITION**		
KABIVEN INTRAVENOUS EMULSION (*amino ac-dext-lipid-electrolyt*)	3	
PERIKABIVEN INTRAVENOUS EMULSION (*amino ac-dext-lipid-electrolyt*)	3	
***OPHTHALMIC AGENTS* - DRUGS FOR THE EYE**		
ALPHA ADRENERGIC AGONIST & CARBONIC ANHYDRASE INHIB COMB - DRUGS FOR GLAUCOMA**		
SIMBRINZA OPHTHALMIC SUSPENSION (*brinzolamide-brimonidine*)	2	QL (8 mL per 30 days)
BETA-BLOCKERS - OPHTHALMIC COMBINATIONS - DRUGS FOR GLAUCOMA**		
brimonidine tartrate-timolol ophthalmic solution	1 or 1b*	QL (15 mL per 30 days)
dorzolamide hcl-timolol mal ophthalmic solution	1 or 1b*	QL (10 mL per 30 days)
dorzolamide hcl-timolol mal pf ophthalmic solution	1 or 1b*	QL (60 units per 30 days)
BETA-BLOCKERS - OPHTHALMIC - DRUGS FOR GLAUCOMA**		
betaxolol hcl ophthalmic solution	1 or 1b*	QL (0.5 mL per 1 day)
BETOPTIC-S OPHTHALMIC SUSPENSION (*betaxolol hcl*)	2	QL (15 mL per 30 days)
carteolol hcl ophthalmic solution	1 or 1a*	
levobunolol hcl ophthalmic solution	1 or 1b*	
timolol maleate (once-daily) ophthalmic solution	1 or 1b*	QL (5 mL per 30 days)
timolol maleate ocudose ophthalmic solution	1 or 1b*	QL (20 mL per 30 days)
timolol maleate ophthalmic gel forming solution	1 or 1b*	QL (5 mL per 30 days)
timolol maleate ophthalmic solution	1 or 1b*	QL (20 mL per 30 days)
timolol maleate pf ophthalmic solution 0.25 %	1 or 1b*	QL (18 mL per 30 days)
timolol maleate pf ophthalmic solution 0.5 %	1 or 1b*	QL (20 mL per 30 days)
TIMOPTIC OCUDOSE OPHTHALMIC SOLUTION 0.25 % (*timolol maleate*)	3	QL (18 mL per 30 days)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TIMOPTIC OCUDOSE OPHTHALMIC SOLUTION 0.5 % (*timolol maleate*)	3	QL (20 mL per 30 days)
CYCLOPLEGIC MYDRIATIC COMBINATIONS - DRUGS FOR THE EYE**		
CYCLOMYDRIL OPHTHALMIC SOLUTION (*cyclopentolate-phenylephrine*)	3	
CYCLOPLEGIC MYDRIATICS - DRUGS FOR THE EYE**		
ATROPINE SULFATE OPHTHALMIC SOLUTION	3	QL (20 mL per 30 days)
CYCLOGYL OPHTHALMIC SOLUTION 0.5 %, 2 % (*cyclopentolate hcl*)	3	
CYCLOGYL OPHTHALMIC SOLUTION 1 % (*cyclopentolate hcl*)	3	QL (15 mL per 30 days)
cyclopentolate hcl ophthalmic solution	1 or 1b*	QL (15 mL per 30 days)
MYDRIACYL OPHTHALMIC SOLUTION (*tropicamide*)	3	
phenylephrine hcl ophthalmic solution	1 or 1b*	
tropicamide ophthalmic solution	1 or 1b*	
LYMPHOCYTE FUNCTION-ASSOCIATED ANTIGEN-1 (LFA-1) ANTAG - ANTI-INFECTIVE/ANTI-INFLAMMATORIES**		
XIIDRA OPHTHALMIC SOLUTION (*lifitegrast*)	2	QL (2 vial per 1 day)
MIOTICS - CHOLINESTERASE INHIBITORS - DRUGS FOR GLAUCOMA**		
PHOSPHOLINE IODIDE OPHTHALMIC SOLUTION RECONSTITUTED (*echothiophate iodide*)	3	
MIOTICS - DIRECT ACTING - DRUGS FOR GLAUCOMA**		
MIOCHOL-E INTRAOCULAR SOLUTION RECONSTITUTED (*acetylcholine chloride*)	3	
MIOSTAT INTRAOCULAR SOLUTION (*carbachol*)	3	
pilocarpine hcl ophthalmic solution	1 or 1b*	
OPHTHALMIC - MULTIPLE RECEPTOR ANGIOGENESIS INHIBITORS - DRUGS FOR THE EYE**		
VABYSMO INTRAVITREAL SOLUTION (*faricimab-svoa*)	4	PA; LD; SP
OPHTHALMIC ANTIALLERGIC - DRUGS FOR ITCHY EYE**		
azelastine hcl ophthalmic solution	1 or 1b*	QL (1 bottle per 24 days)
cromolyn sodium ophthalmic solution	1 or 1a*	QL (2 bottles per 30 days)
epinastine hcl ophthalmic solution	1 or 1b*	QL (1 bottle per 30 days)
OPHTHALMIC ANTIBIOTICS - ANTI-INFECTIVE/ANTI-INFLAMMATORIES**		
AZASITE OPHTHALMIC SOLUTION (*azithromycin*)	3	QL (2.5 mL per 30 days)
bacitracin ophthalmic ointment	1 or 1b*	QL (7 grams per 30 days)
BESIVANCE OPHTHALMIC SUSPENSION (*besifloxacin hcl*)	3	QL (5 mL per 30 days)
CILOXAN OPHTHALMIC OINTMENT (*ciprofloxacin hcl*)	3	QL (3.5 grams per 30 days)
ciprofloxacin hcl ophthalmic solution	1 or 1a*	QL (10 mL per 30 days)
erythromycin ophthalmic ointment	3	QL (3.5 grams per 30 days)
gatifloxacin ophthalmic solution	1 or 1b*	QL (2.5 mL per 30 days)
gentamicin sulfate ophthalmic solution	1 or 1a*	QL (10 mL per 30 days)
levofloxacin ophthalmic solution	1 or 1b*	QL (5 mL per 30 days)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MITOSOL OPHTHALMIC KIT (*mitomycin*)	3	
moxifloxacin hcl (2x day) ophthalmic solution	1 or 1b*	QL (3 mL per 30 days)
moxifloxacin hcl ophthalmic solution	1 or 1b*	QL (3 mL per 30 days)
OCUFLOX OPHTHALMIC SOLUTION (*ofloxacin*)	3	QL (10 mL per 30 days)
ofloxacin ophthalmic solution	1 or 1a*	QL (10 mL per 30 days)
tobramycin ophthalmic solution	1 or 1a*	QL (20 mL per 30 days)
TOBREX OPHTHALMIC OINTMENT (*tobramycin*)	3	QL (3.5 grams per 30 days)
VIGAMOX OPHTHALMIC SOLUTION (*moxifloxacin hcl*)	3	QL (3 mL per 30 days)
ZYMAXID OPHTHALMIC SOLUTION (*gatifloxacin*)	3	QL (2.5 mL per 30 days)
OPHTHALMIC ANTIFUNGAL - DRUGS FOR THE EYE**		
NATACYN OPHTHALMIC SUSPENSION (*natamycin*)	3	QL (15 mL per 30 days)
OPHTHALMIC ANTI-INFECTIVE COMBINATIONS - ANTI-INFECTIVE/ANTI-INFLAMMATORIES**		
bacitracin-polymyxin b ophthalmic ointment	1 or 1a*	QL (3.5 grams per 30 days)
neomycin-bacitracin zn-polymyx ophthalmic ointment	1 or 1b*	QL (3.5 grams per 30 days)
neomycin-polymyxin-gramicidin ophthalmic solution	1 or 1b*	QL (10 mL per 30 days)
neo-polycin ophthalmic ointment	1 or 1b*	QL (3.5 grams per 30 days)
polycin ophthalmic ointment	1 or 1a*	QL (3.5 grams per 30 days)
polymyxin b-trimethoprim ophthalmic solution	1 or 1a*	QL (10 mL per 30 days)
OPHTHALMIC ANTISEPTICS - ANTI-INFECTIVE/ANTI-INFLAMMATORIES**		
BETADINE OPHTHALMIC PREP OPHTHALMIC SOLUTION (*povidone-iodine*)	3	
OPHTHALMIC ANTIVIRALS - ANTI-INFECTIVE/ANTI-INFLAMMATORIES**		
trifluridine ophthalmic solution	1 or 1b*	QL (7.5 mL per 30 days)
ZIRGAN OPHTHALMIC GEL (*ganciclovir*)	3	QL (5 gram per 7 days)
OPHTHALMIC CARBONIC ANHYDRASE INHIBITORS - DRUGS FOR GLAUCOMA**		
brinzolamide ophthalmic suspension	1 or 1b*	QL (15 mL per 30 days)
dorzolamide hcl ophthalmic solution	1 or 1b*	QL (10 mL per 30 days)
OPHTHALMIC COMPLEMENT C3 INHIBITORS - DRUGS FOR THE EYE**		
SYFOVRE INTRAVITREAL SOLUTION (*pegcetacoplan (ophthalmic)*)	4	PA; LD
OPHTHALMIC COMPLEMENT C5 INHIBITORS - DRUGS FOR THE EYE**		
IZERVAY INTRAVITREAL SOLUTION (*avacincaptad pegol*)	4	PA; SP
OPHTHALMIC DIAGNOSTIC PRODUCTS - DRUGS FOR THE EYE**		
ak-fluor intravenous solution 10 %	1 or 1b*	
ak-fluor intravenous solution 25 %	3	
altafluor benox ophthalmic solution	1 or 1b*	
fluorescein intravenous solution	1 or 1b*	
FLUORESCEIN SODIUM/BENOXINATE OPHTHALMIC SOLUTION	3	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
fluorescein-benoxinate ophthalmic solution	1 or 1b*	
FLUORESCITE INTRAVENOUS SOLUTION (*fluorescein sodium*)	3	
FLURA-SAFE OPHTHALMIC SOLUTION (*fluorexon-benoxinate*)	3	
***OPHTHALMIC ECTOPARASITICIDE** - ANTI-INFECTIVE/ANTI-INFLAMMATORIES**		
XDEMVY OPHTHALMIC SOLUTION (*lotilaner*)	3	PA; QL (1 bottle per 1 fill)
OPHTHALMIC IMMUNOMODULATORS - ANTI-INFECTIVE/ANTI-INFLAMMATORIES**		
RESTASIS MULTIDOSE OPHTHALMIC EMULSION (*cyclosporine*)	2	QL (1 bottle per 28 days)
RESTASIS OPHTHALMIC EMULSION (*cyclosporine*)	1 or 1b*	QL (2 vials per 1 day)
VERKAZIA OPHTHALMIC EMULSION (*cyclosporine*)	3	PA; QL (120 vials per 30 days)
OPHTHALMIC IRRIGATION SOLUTIONS - DRUGS FOR THE EYE**		
BSS INTRAOCULAR SOLUTION (*ophth irr soln-intraocular*)	3	
BSS PLUS INTRAOCULAR SOLUTION (*ophth irr soln-intraocular*)	3	
OPHTHALMIC KINASE INHIBITORS - COMBINATIONS - DRUGS FOR GLAUCOMA**		
ROCKLATAN OPHTHALMIC SOLUTION (*netarsudil-latanoprost*)	3	QL (2.5 mL per 30 days)
OPHTHALMIC LOCAL ANESTHETICS - DRUGS FOR THE EYE**		
AKTEN OPHTHALMIC GEL (*lidocaine hcl*)	3	
ALCAINE OPHTHALMIC SOLUTION (*proparacaine hcl*)	3	
IHEEZO OPHTHALMIC GEL (*chloroprocaine hcl*)	3	
proparacaine hcl ophthalmic solution	1 or 1b*	
tetracaine hcl ophthalmic solution	1 or 1b*	
OPHTHALMIC NERVE GROWTH FACTORS - DRUGS FOR THE EYE**		
OXERVATE OPHTHALMIC SOLUTION (*cenegermin-bkbj*)	4	PA; LD; QL (2 vials per 1 day)
OPHTHALMIC NONSTEROIDAL ANTI-INFLAMMATORY AGENTS - ANTI-INFECTIVE/ANTI-INFLAMMATORIES**		
ACULAR LS OPHTHALMIC SOLUTION (*ketorolac tromethamine*)	3	QL (5 mL per 30 days)
ACULAR OPHTHALMIC SOLUTION (*ketorolac tromethamine*)	3	QL (10 mL per 30 days)
ACUVAIL OPHTHALMIC SOLUTION (*ketorolac tromethamine*)	3	QL (1 box per 30 days)
bromfenac sodium (once-daily) ophthalmic solution	1 or 1b*	QL (1.7 mL per 30 days)
BROMSITE OPHTHALMIC SOLUTION (*bromfenac sodium*)	3	QL (5 mL per 30 days)
diclofenac sodium ophthalmic solution	1 or 1b*	QL (5 mL per 30 days)
flurbiprofen sodium ophthalmic solution	1 or 1b*	QL (2.5 mL per 30 days)
ILEVRO OPHTHALMIC SUSPENSION (*nepafenac*)	2	QL (3 mL per 30 days)
ketorolac tromethamine ophthalmic solution 0.4 %	1 or 1b*	QL (5 mL per 30 days)
ketorolac tromethamine ophthalmic solution 0.5 %	1 or 1b*	QL (10 mL per 30 days)
NEVANAC OPHTHALMIC SUSPENSION (*nepafenac*)	3	QL (3 mL per 30 days)
PROLENSA OPHTHALMIC SOLUTION (*bromfenac sodium*)	3	QL (3 mL per 30 days)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPHTHALMIC PHOTODYNAMIC THERAPY AGENTS - DRUGS FOR THE EYE**		
VISUDYNE INTRAVENOUS SOLUTION RECONSTITUTED (*verteporfin*)	4	LD; QL (1 fill per 30 days); SP
OPHTHALMIC PHOTOENHANCER COMBINATIONS - DRUGS FOR THE EYE**		
PHOTREXA-PHOTREXA VISCOUS KIT OPHTHALMIC SOLUTION PREFILLED SYRINGE (*riboflav5 & riboflav5-dextran*)	3	
OPHTHALMIC RHO KINASE INHIBITORS - DRUGS FOR GLAUCOMA**		
RHOPRESSA OPHTHALMIC SOLUTION (*netarsudil dimesylate*)	3	QL (2.5 mL per 30 days)
OPHTHALMIC SELECTIVE ALPHA ADRENERGIC AGONISTS - DRUGS FOR GLAUCOMA**		
apraclonidine hcl ophthalmic solution	1 or 1b*	
brimonidine tartrate ophthalmic solution	1 or 1b*	QL (30 mL per 30 days)
IOPIDINE OPHTHALMIC SOLUTION (*apraclonidine hcl*)	3	
OPHTHALMIC STEROID COMBINATIONS - ANTI-INFECTIVE/ANTI-INFLAMMATORIES**		
bacitra-neomycin-polymyxin-hc ophthalmic ointment	1 or 1b*	QL (7 mL per 30 days)
MAXITROL OPHTHALMIC OINTMENT (*neomycin-polymyxin-dexameth*)	3	QL (7 mL per 30 days)
MAXITROL OPHTHALMIC SUSPENSION (*neomycin-polymyxin-dexameth*)	3	QL (20 mL per 30 days)
neomycin-polymyxin-dexameth ophthalmic ointment	1 or 1a*	QL (7 mL per 30 days)
neomycin-polymyxin-dexameth ophthalmic suspension	1 or 1a*	QL (20 mL per 30 days)
neomycin-polymyxin-hc ophthalmic suspension	1 or 1b*	
neo-polycin hc ophthalmic ointment	1 or 1b*	QL (7 mL per 30 days)
sulfacetamide-prednisolone ophthalmic solution	1 or 1a*	QL (15 mL per 30 days)
TOBRADEX OPHTHALMIC OINTMENT (*tobramycin-dexamethasone*)	2	
tobramycin-dexamethasone ophthalmic suspension	1 or 1b*	QL (10 mL per 30 days)
ZYLET OPHTHALMIC SUSPENSION (*loteprednol-tobramycin*)	2	QL (20 mL per 30 days)
OPHTHALMIC STEROIDS - ANTI-INFECTIVE/ANTI-INFLAMMATORIES**		
dexamethasone sodium phosphate ophthalmic solution	1 or 1b*	
DEXTENZA OPHTHALMIC INSERT (*dexamethasone*)	3	
DEXYCU INTRAOCULAR SUSPENSION (*dexamethasone*)	3	
difluprednate ophthalmic emulsion	1 or 1b*	
DUREZOL OPHTHALMIC EMULSION (*difluprednate*)	3	QL (10 mL per 30 days)
FLAREX OPHTHALMIC SUSPENSION (*fluorometholone acetate*)	3	
fluorometholone ophthalmic suspension	1 or 1b*	
FML FORTE OPHTHALMIC SUSPENSION (*fluorometholone*)	3	
FML LIQUIFILM OPHTHALMIC SUSPENSION (*fluorometholone*)	3	
ILUVIEN INTRAVITREAL IMPLANT (*fluocinolone acetonide*)	4	PA; LD; SP
INVELTYS OPHTHALMIC SUSPENSION (*loteprednol etabonate*)	3	QL (5.6 mL per 30 days)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LOTEMAX OPHTHALMIC GEL (*loteprednol etabonate*)	3	QL (10 grams per 30 days)
LOTEMAX OPHTHALMIC OINTMENT (*loteprednol etabonate*)	3	QL (7 grams per 30 days)
LOTEMAX OPHTHALMIC SUSPENSION (*loteprednol etabonate*)	3	QL (30 mL per 30 days)
LOTEMAX SM OPHTHALMIC GEL (*loteprednol etabonate*)	3	QL (10 grams per 30 days)
loteprednol etabonate ophthalmic gel	1 or 1b*	QL (10 grams per 30 days)
loteprednol etabonate ophthalmic suspension	1 or 1b*	QL (30 mL per 30 days)
MAXIDEX OPHTHALMIC SUSPENSION (*dexamethasone*)	3	
OZURDEX INTRAVITREAL IMPLANT (*dexamethasone*)	3	PA; LD; SP
PRED MILD OPHTHALMIC SUSPENSION (*prednisolone acetate*)	3	
prednisolone acetate ophthalmic suspension	1 or 1b*	QL (20 mL per 30 days)
PREDNISOLONE SODIUM PHOSPHATE OPHTHALMIC SOLUTION	3	QL (20 mL per 30 days)
RETISERT INTRAVITREAL IMPLANT (*fluocinolone acetonide*)	3	PA; LD; SP
TRIESENCE INTRAOCULAR SUSPENSION (*triamcinolone acetonide*)	3	
XIPERE INTRAOCULAR SUSPENSION (*triamcinolone acetonide*)	4	PA; LD
YUTIQ INTRAVITREAL IMPLANT (*fluocinolone acetonide*)	3	PA; LD
OPHTHALMIC SULFONAMIDES - ANTI-INFECTIVE/ANTI-INFLAMMATORIES**		
sulfacetamide sodium ophthalmic ointment	1 or 1b*	QL (3.5 grams per 30 days)
sulfacetamide sodium ophthalmic solution	1 or 1b*	QL (15 mL per 30 days)
OPHTHALMIC SURGICAL AIDS - COMBINATIONS - DRUGS FOR THE EYE**		
DISCOVISC INTRAOCULAR SOLUTION (*na chondroit sulf-na hyaluron*)	3	
DUOVISC INTRAOCULAR KIT (*na hyalur & na chond-na hyalur*)	3	
OMIDRIA INTRAOCULAR SOLUTION (*phenylephrine-ketorolac*)	3	
VISCOAT INTRAOCULAR SOLUTION PREFILLED SYRINGE (*na chondroit sulf-na hyaluron*)	3	
OPHTHALMIC SURGICAL AIDS - DRUGS FOR THE EYE**		
AMVISC INTRAOCULAR SOLUTION PREFILLED SYRINGE (*sodium hyaluronate*)	4	
CELLUGEL INTRAOCULAR SOLUTION (*hypromellose*)	3	
HEALON DUET PRO INTRAOCULAR SOLUTION PREFILLED SYRINGE (*sodium hyaluronate*)	4	
HEALON GV PRO INTRAOCULAR SOLUTION PREFILLED SYRINGE (*sodium hyaluronate*)	4	
HEALON PRO INTRAOCULAR SOLUTION PREFILLED SYRINGE (*sodium hyaluronate*)	4	
HEALON5 PRO INTRAOCULAR SOLUTION PREFILLED SYRINGE (*sodium hyaluronate*)	4	
PROVISC INTRAOCULAR SOLUTION PREFILLED SYRINGE (*sodium hyaluronate*)	4	
TISSUEBLUE INTRAOCULAR SOLUTION PREFILLED SYRINGE (*brilliant blue g*)	3	
TOTALVISC INTRAOCULAR SOLUTION PREFILLED SYRINGE (*sodium hyaluronate*)	3	

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VISIONBLUE INTRAOCULAR SOLUTION PREFILLED SYRINGE (*trypan blue*)	3	
***OPHTHALMICS - BLEPHAROPTOSIS AGENTS** - DRUGS FOR THE EYE**		
UPNEEQ OPHTHALMIC SOLUTION (*oxymetazoline hcl*)	3	PA; QL (30 containers per 30 days)
***OPHTHALMICS - CYSTINOSIS AGENTS** - DRUGS FOR THE EYE**		
CYSTADROPS OPHTHALMIC SOLUTION (*cysteamine hcl*)	3	PA; QL (4 bottles per 28 days)
CYSTARAN OPHTHALMIC SOLUTION (*cysteamine hcl*)	4	PA; LD; QL (60 mL per 28 days)
PROSTAGLANDINS - OPHTHALMIC - DRUGS FOR GLAUCOMA**		
bimatoprost ophthalmic solution	1 or 1b*	
DURYSTA INTRAOCULAR IMPLANT (*bimatoprost*)	4	PA; LD; QL (2 applicators per 1 lifetime); SP
latanoprost ophthalmic solution	1 or 1b*	QL (5 mL per 30 days)
LUMIGAN OPHTHALMIC SOLUTION (*bimatoprost*)	2	QL (7.5 mL per 30 days)
tafluprost (pf) ophthalmic solution	1 or 1b*	QL (9 mL per 30 days)
travoprost (bak free) ophthalmic solution	1 or 1b*	QL (10 mL per 30 days)
ZIOPTAN OPHTHALMIC SOLUTION (*tafluprost*)	3	QL (9 mL per 30 days)
VASCULAR ENDOTHELIAL GROWTH FACTOR (VEGF) ANTAGONISTS - DRUGS FOR THE EYE**		
BEOVU INTRAVITREAL SOLUTION PREFILLED SYRINGE (*brolucizumab-dbll*)	4	PA; LD; SP
bevacizumab intravitreal solution prefilled syringe	4	
BYOOVIZ INTRAVITREAL SOLUTION (*ranibizumab-nuna*)	4	PA; LD; SP
CIMERLI INTRAVITREAL SOLUTION (*ranibizumab-eqrn*)	4	PA; LD; SP
EYLEA HD INTRAVITREAL SOLUTION (*aflibercept*)	4	PA; LD; SP
EYLEA INTRAVITREAL SOLUTION (*aflibercept*)	4	PA; LD; SP
EYLEA INTRAVITREAL SOLUTION PREFILLED SYRINGE (*aflibercept*)	4	PA; LD; SP
LUCENTIS INTRAVITREAL SOLUTION PREFILLED SYRINGE (*ranibizumab*)	4	PA; LD; SP
SUSVIMO (IMPLANT 1ST FILL) INTRAVITREAL SOLUTION (*ranibizumab*)	4	LD; SP
SUSVIMO (IMPLANT REFILL) INTRAVITREAL SOLUTION (*ranibizumab*)	4	LD; SP
***OTIC AGENTS* - DRUGS FOR THE EAR**		
OTIC AGENTS - MISCELLANEOUS - WAX REMOVAL**		
acetic acid otic solution	1 or 1b*	
OTIC ANALGESIC COMBINATIONS - ANTI-INFECTIVE/ANTI-INFLAMMATORIES**		
PRAMOTIC OTIC LIQUID (*pramoxine-chloroxylenol*)	3	
OTIC ANTI-INFECTIVES - ANTIBIOTICS**		
CETRAXAL OTIC SOLUTION (*ciprofloxacin hcl*)	3	QL (28 containers per 1 fill)
ciprofloxacin hcl otic solution	1 or 1b*	QL (28 containers per 1 fill)

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ofloxacin otic solution	1 or 1b*	QL (10 mL per 1 fill)
OTIC STEROID-ANTI-INFECTIVE COMBINATIONS - ANTI-INFECTIVE/ANTI-INFLAMMATORIES**		
ciprofloxacin-dexamethasone otic suspension	1 or 1b*	QL (7.5 mL per 1 fill)
ciprofloxacin-fluocinolone pf otic solution	1 or 1b*	QL (28 vials per 1 fill)
CORTISPORIN-TC OTIC SUSPENSION (*neomycin-colist-hc-thonzonium*)	3	
neomycin-polymyxin-hc otic solution	1 or 1b*	
neomycin-polymyxin-hc otic suspension	1 or 1b*	QL (15 mL per 30 days)
OTOVEL OTIC SOLUTION (*ciprofloxacin-fluocinolone*)	3	QL (28 vials per 1 fill)
OTIC STEROIDS - ANTI-INFECTIVE/ANTI-INFLAMMATORIES**		
DERMOTIC OTIC OIL (*fluocinolone acetonide*)	3	
flac otic oil	1 or 1b*	
fluocinolone acetonide otic oil	1 or 1b*	
hydrocortisone-acetic acid otic solution	1 or 1b*	QL (10 mL per 1 fill)
***OXYTOCICS* - HORMONES**		
ABORTIFACIENTS/CERVICAL RIPENING - PROSTAGLANDINS - DRUGS FOR WOMEN**		
carboprost tromethamine intramuscular solution	1 or 1b*	
CERVIDIL VAGINAL INSERT (*dinoprostone*)	3	
HEMABATE INTRAMUSCULAR SOLUTION (*carboprost tromethamine*)	3	
PREPIDIL VAGINAL GEL (*dinoprostone*)	3	
OXYTOCICS - DRUGS FOR WOMEN**		
methergine oral tablet	1 or 1b*	
methylergonovine maleate injection solution	1 or 1b*	
methylergonovine maleate oral tablet	1 or 1b*	
oxytocin injection solution	1 or 1b*	
PITOCIN INJECTION SOLUTION (*oxytocin*)	3	
***PASSIVE IMMUNIZING AND TREATMENT AGENTS* - BIOLOGICAL AGENTS**		
ANTITOXINS-ANTIVENINS - BIOLOGICAL AGENTS**		
ANASCORP INTRAVENOUS SOLUTION RECONSTITUTED (*centruroides (scorpion) im fab*)	3	
ANAVIP INTRAVENOUS SOLUTION RECONSTITUTED (*crotalidae immune fab (equine)*)	3	
ANTIVENIN LATRODECTUS MACTANS INJECTION KIT	3	
ANTIVENIN MICRURUS FULVIUS INTRAVENOUS SOLUTION RECONSTITUTED	3	
CROFAB INTRAVENOUS SOLUTION RECONSTITUTED (*crotalidae polyval immune fab*)	3	
ANTIVIRAL MONOCLONAL ANTIBODIES - BIOLOGICAL AGENTS**		
BEYFORTUS INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 100 MG/ML (*nirsevimab-alip*)	4; $0	PA; QL (2 syringe per 180 days)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BEYFORTUS INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 50 MG/0.5ML (*nirsevimab-alip*)	4; $0	PA; QL (1 syringe per 1 lifetime)
SYNAGIS INTRAMUSCULAR SOLUTION (*palivizumab*)	4	PA; LD; SP
BACTERIAL MONOCLONAL ANTIBODIES - BIOLOGICAL AGENTS**		
ZINPLAVA INTRAVENOUS SOLUTION (*bezlotoxumab*)	3	PA
IMMUNE SERUMS - BIOLOGICAL AGENTS**		
BABYBIG INTRAVENOUS SOLUTION RECONSTITUTED (*botulism immune globulin human*)	3	
CNJ-016 INTRAVENOUS SOLUTION (*vaccinia immune globulin human*)	3	
CUTAQUIG SUBCUTANEOUS SOLUTION (*immune globulin (human)-hipp*)	4	PA; LD; SP
CYTOGAM INTRAVENOUS INJECTABLE (*cytomegalovirus immune glob*)	4	SP
GAMASTAN INTRAMUSCULAR INJECTABLE (*immune globulin (human)*)	4	PA; LD; SP
GAMUNEX-C INJECTION SOLUTION (*immune globulin (human)*)	4	PA; LD; SP
HEPAGAM B INJECTION SOLUTION (*hepatitis b immune globulin*)	4	SP
HIZENTRA SUBCUTANEOUS SOLUTION (*immune globulin (human)*)	4	PA; LD; SP
HIZENTRA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (*immune globulin (human)*)	4	PA; LD; SP
HYPERHEP B INTRAMUSCULAR SOLUTION (*hepatitis b immune globulin*)	4	LD; SP
HYPERHEP B INTRAMUSCULAR SOLUTION PREFILLED SYRINGE (*hepatitis b immune globulin*)	4	LD; SP
HYPERRAB INJECTION SOLUTION (*rabies immune globulin*)	4	SP
HYPERRHO S/D INTRAMUSCULAR SOLUTION PREFILLED SYRINGE (*rho d immune globulin*)	4	LD; QL (2 fills per 365 days); SP
HYPERTET INTRAMUSCULAR SOLUTION PREFILLED SYRINGE (*tetanus immune globulin*)	3	
IMOGAM RABIES-HT INJECTION SOLUTION (*rabies immune globulin*)	4	SP
KEDRAB INJECTION SOLUTION	4	SP
MICRHOGAM ULTRA-FILTERED PLUS INTRAMUSCULAR SOLUTION PREFILLED SYRINGE (*rho d immune globulin*)	4	LD; QL (2 fills per 365 days); SP
NABI-HB INTRAMUSCULAR SOLUTION (*hepatitis b immune globulin*)	4	LD; SP
OCTAGAM INTRAVENOUS SOLUTION (*immune globulin (human)*)	4	PA; LD; SP
RHOGAM ULTRA-FILTERED PLUS INTRAMUSCULAR SOLUTION PREFILLED SYRINGE (*rho d immune globulin*)	4	LD; QL (2 fills per 365 days); SP
RHOPHYLAC INJECTION SOLUTION PREFILLED SYRINGE (*rho d immune globulin*)	4	LD; QL (2 fills per 365 days); SP
VARIZIG INTRAMUSCULAR SOLUTION (*varicella-zoster immune glob*)	3	
WINRHO SDF INJECTION SOLUTION (*rho d immune globulin*)	4	QL (2 fills per 365 days); SP
XEMBIFY SUBCUTANEOUS SOLUTION (*immune globulin (human)-klhw*)	4	PA; LD; SP

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
***PENICILLINS* - DRUGS FOR INFECTIONS**		
AMINOPENICILLINS - ANTIBIOTICS**		
amoxicillin oral capsule	1 or 1a*	
amoxicillin oral suspension reconstituted	1 or 1a*	
amoxicillin oral tablet	1 or 1a*	
amoxicillin oral tablet chewable	1 or 1a*	
ampicillin oral capsule	1 or 1a*	
ampicillin sodium injection solution reconstituted	1 or 1b*	
ampicillin sodium intravenous solution reconstituted	1 or 1b*	
NATURAL PENICILLINS - ANTIBIOTICS**		
BICILLIN L-A INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (*penicillin g benzathine*)	3	
PENICILLIN G POT IN DEXTROSE INTRAVENOUS SOLUTION	3	
penicillin g potassium injection solution reconstituted	1 or 1b*	
penicillin g sodium injection solution reconstituted	1 or 1b*	
penicillin v potassium oral solution reconstituted	1 or 1b*	
penicillin v potassium oral tablet	1 or 1b*	
pfizerpen injection solution reconstituted	1 or 1b*	
PENICILLIN COMBINATIONS - ANTIBIOTICS**		
amoxicillin-pot clavulanate er oral tablet extended release 12 hour	1 or 1b*	
amoxicillin-pot clavulanate oral suspension reconstituted	1 or 1b*	
amoxicillin-pot clavulanate oral tablet	1 or 1b*	
amoxicillin-pot clavulanate oral tablet chewable	1 or 1b*	
ampicillin-sulbactam sodium injection solution reconstituted	1 or 1b*	
ampicillin-sulbactam sodium intravenous solution reconstituted	1 or 1b*	
AUGMENTIN ES-600 ORAL SUSPENSION RECONSTITUTED (*amoxicillin-pot clavulanate*)	3	
AUGMENTIN ORAL SUSPENSION RECONSTITUTED (*amoxicillin-pot clavulanate*)	2	
AUGMENTIN ORAL TABLET (*amoxicillin-pot clavulanate*)	3	
BICILLIN C-R 900/300 INTRAMUSCULAR SUSPENSION (*penicillin g benzathine & proc*)	3	
BICILLIN C-R INTRAMUSCULAR SUSPENSION (*penicillin g benzathine & proc*)	3	
piperacillin sod-tazobactam so intravenous solution reconstituted	1 or 1b*	
UNASYN INJECTION SOLUTION RECONSTITUTED (*ampicillin-sulbactam sodium*)	3	
UNASYN INTRAVENOUS SOLUTION RECONSTITUTED (*ampicillin-sulbactam sodium*)	3	
ZOSYN INTRAVENOUS SOLUTION (*piperacillin-tazobactam in dex*)	3	
PENICILLINASE-RESISTANT PENICILLINS - ANTIBIOTICS**		
dicloxacillin sodium oral capsule	1 or 1b*	
NAFCILLIN SODIUM IN DEXTROSE INTRAVENOUS SOLUTION	3	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
nafcillin sodium injection solution reconstituted	1 or 1b*	
nafcillin sodium intravenous solution reconstituted	1 or 1b*	
OXACILLIN SODIUM IN DEXTROSE INTRAVENOUS SOLUTION	3	
oxacillin sodium injection solution reconstituted	1 or 1b*	
oxacillin sodium intravenous solution reconstituted	1 or 1b*	
***PROGESTINS* - HORMONES**		
PROGESTINS - DRUGS FOR WOMEN**		
medroxyprogesterone acetate oral tablet	1 or 1a*	QL (1 tablet per 1 day)
megestrol acetate oral suspension	1 or 1b*	
norethindrone acetate oral tablet	1 or 1b*	
progesterone intramuscular oil	1 or 1b*	
progesterone oral capsule 100 mg	1 or 1b*	QL (2 capsules per 1 day)
progesterone oral capsule 200 mg	1 or 1b*	QL (2 capsule per 1 day)
PROVERA ORAL TABLET (*medroxyprogesterone acetate*)	3	QL (1 tablet per 1 day)
***PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.* - DRUGS FOR THE NERVOUS SYSTEM**		
AGENTS FOR OPIOID WITHDRAWAL - DRUGS FOR THE NERVOUS SYSTEM**		
LUCEMYRA ORAL TABLET (*lofexidine hcl*)	3	QL (16 tablets per 1 day)
ALCOHOL DETERRENTS - DRUGS FOR THE NERVOUS SYSTEM**		
acamprosate calcium oral tablet delayed release	1 or 1b*	QL (6 tablet per 1 day)
disulfiram oral tablet	1 or 1b*	
ANTI-CATAPLECTIC AGENTS - DRUGS FOR SLEEP DISORDER**		
sodium oxybate oral solution	4	PA; LD; QL (18 mL per 1 day)
XYREM ORAL SOLUTION (*sodium oxybate*)	4	PA; LD; QL (18 mL per 1 day)
ANTI-CATAPLECTIC COMBINATIONS - DRUGS FOR SLEEP DISORDER**		
XYWAV ORAL SOLUTION (*ca, mg, k, and na oxybates*)	4	PA; LD; QL (18 mL per 1 day)
ANTIDEMENTIA AGENT COMBINATIONS - DRUGS FOR ALZHEIMER'S DISEASE**		
NAMZARIC ORAL CAPSULE ER 24 HOUR THERAPY PACK (*memantine hcl-donepezil hcl*)	2	QL (1 pack per 1 one-time fill)
NAMZARIC ORAL CAPSULE EXTENDED RELEASE 24 HOUR (*memantine hcl-donepezil hcl*)	2	QL (1 capsule per 1 day)
ANTISENSE OLIGONUCLEOTIDE (ASO) INHIBITOR AGENTS - DRUGS FOR THE NERVOUS SYSTEM**		
TEGSEDI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (*inotersen sodium*)	4	PA; LD; QL (4 syringes per 28 days)
BENZODIAZEPINES & TRICYCLIC AGENTS - DRUGS FOR SEIZURES /PERSONALITY DISORDER/NERVE PAIN**		
chlordiazepoxide-amitriptyline oral tablet	1 or 1b*	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CHOLINOMIMETICS - ACHE INHIBITORS - DRUGS FOR ALZHEIMER'S DISEASE**		
ARICEPT ORAL TABLET 10 MG, 23 MG (*donepezil hcl*)	3	QL (1 tablet per 1 day)
ARICEPT ORAL TABLET 5 MG (*donepezil hcl*)	3	DO
donepezil hcl oral tablet 10 mg, 23 mg	1 or 1b*	QL (1 tablet per 1 day)
donepezil hcl oral tablet 5 mg	1 or 1b*	DO
donepezil hcl oral tablet dispersible	1 or 1b*	QL (1 tablet per 1 day)
EXELON TRANSDERMAL PATCH 24 HOUR 13.3 MG/24HR, 9.5 MG/24HR (*rivastigmine*)	3	ST; QL (1 patch per 1 day)
EXELON TRANSDERMAL PATCH 24 HOUR 4.6 MG/24HR (*rivastigmine*)	3	ST; QL (1 gram per 1 day)
galantamine hydrobromide er oral capsule extended release 24 hour 16 mg, 24 mg	1 or 1b*	QL (1 capsule per 1 day)
galantamine hydrobromide er oral capsule extended release 24 hour 8 mg	1 or 1b*	DO
galantamine hydrobromide oral solution	1 or 1b*	QL (6 mL per 1 day)
galantamine hydrobromide oral tablet 12 mg, 8 mg	1 or 1b*	QL (2 tablets per 1 day)
galantamine hydrobromide oral tablet 4 mg	1 or 1b*	DO
rivastigmine tartrate oral capsule 1.5 mg, 3 mg	1 or 1b*	DO
rivastigmine tartrate oral capsule 4.5 mg, 6 mg	1 or 1b*	QL (2 capsules per 1 day)
rivastigmine transdermal patch 24 hour 13.3 mg/24hr, 9.5 mg/24hr	1 or 1b*	QL (1 patch per 1 day)
rivastigmine transdermal patch 24 hour 4.6 mg/24hr	1 or 1b*	QL (1 gram per 1 day)
FIBROMYALGIA AGENT - SNRIS - DRUGS FOR SEIZURES /PERSONALITY DISORDER/NERVE PAIN**		
SAVELLA ORAL TABLET (*milnacipran hcl*)	2	QL (2 tablets per 1 day)
SAVELLA TITRATION PACK ORAL (*milnacipran hcl*)	2	QL (1 pack per 365 days)
MELANOCORTIN RECEPTOR AGONISTS - DRUGS FOR THE NERVOUS SYSTEM**		
VYLEESI SUBCUTANEOUS SOLUTION AUTO-INJECTOR (*bremelanotide acetate*)	3	PA; QL (4 autoinjectors per 30 days)
MOVEMENT DISORDER DRUG THERAPY - DRUGS FOR THE NERVOUS SYSTEM**		
AUSTEDO ORAL TABLET (*deutetrabenazine*)	4	PA; QL (4 tablets per 1 day); SP
AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HOUR (*deutetrabenazine*)	4	PA; QL (2 tablets per 1 day); SP
AUSTEDO XR PATIENT TITRATION ORAL TABLET EXTENDED RELEASE THERAPY PACK (*deutetrabenazine*)	4	PA; QL (1 kit per 180 days); SP
INGREZZA ORAL CAPSULE 40 MG (*valbenazine tosylate*)	4	PA; LD; DO; SP
INGREZZA ORAL CAPSULE 60 MG, 80 MG (*valbenazine tosylate*)	4	PA; LD; QL (1 capsule per 1 day); SP
INGREZZA ORAL CAPSULE THERAPY PACK (*valbenazine tosylate*)	4	PA; LD; QL (1 pack per 1 one-time fill); SP
tetrabenazine oral tablet 12.5 mg	1 or 1b*	PA; LD; QL (8 tablets per 1 day); SP
tetrabenazine oral tablet 25 mg	1 or 1b*	PA; LD; QL (4 tablets per 1 day); SP

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MS AGENTS - PYRIMIDINE SYNTHESIS INHIBITORS - DRUGS FOR MULTIPLE SCLEROSIS**		
teriflunomide oral tablet	4	PA; LD; QL (1 tablet per 1 day); SP
MULTIPLE SCLEROSIS AGENTS - ANTIMETABOLITES - DRUGS FOR MULTIPLE SCLEROSIS**		
MAVENCLAD (10 TABS) ORAL TABLET THERAPY PACK (*cladribine*)	4	PA; LD; QL (2 packs per 46 weekss); SP
MAVENCLAD (4 TABS) ORAL TABLET THERAPY PACK (*cladribine*)	4	PA; LD; QL (2 packs per 46 weekss); SP
MAVENCLAD (5 TABS) ORAL TABLET THERAPY PACK (*cladribine*)	4	PA; LD; QL (2 packs per 46 weekss); SP
MAVENCLAD (6 TABS) ORAL TABLET THERAPY PACK (*cladribine*)	4	PA; LD; QL (2 packs per 46 weekss); SP
MAVENCLAD (7 TABS) ORAL TABLET THERAPY PACK (*cladribine*)	4	PA; LD; QL (2 packs per 46 weekss); SP
MAVENCLAD (8 TABS) ORAL TABLET THERAPY PACK (*cladribine*)	4	PA; LD; QL (2 packs per 46 weekss); SP
MAVENCLAD (9 TABS) ORAL TABLET THERAPY PACK (*cladribine*)	4	PA; LD; QL (2 packs per 46 weekss); SP
MULTIPLE SCLEROSIS AGENTS - INTERFERONS - DRUGS FOR MULTIPLE SCLEROSIS**		
AVONEX PEN INTRAMUSCULAR AUTO-INJECTOR KIT (*interferon beta-1a*)	4	PA; QL (4 kits per 28 days); SP
AVONEX PREFILLED INTRAMUSCULAR PREFILLED SYRINGE KIT (*interferon beta-1a*)	4	PA; QL (4 kits per 28 days); SP
BETASERON SUBCUTANEOUS KIT (*interferon beta-1b*)	4	PA; LD; QL (15 kits per 30 days); SP
PLEGRIDY INTRAMUSCULAR SOLUTION PREFILLED SYRINGE (*peginterferon beta-1a*)	4	PA; LD; QL (2 syringes per 28 days); SP
PLEGRIDY STARTER PACK SUBCUTANEOUS SOLUTION PEN-INJECTOR (*peginterferon beta-1a*)	4	PA; LD; QL (1 ML per 28 days); SP
PLEGRIDY STARTER PACK SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (*peginterferon beta-1a*)	4	PA; LD; QL (1 ML per 28 days); SP
PLEGRIDY SUBCUTANEOUS SOLUTION PEN-INJECTOR (*peginterferon beta-1a*)	4	PA; LD; QL (1 ML per 28 days); SP
PLEGRIDY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (*peginterferon beta-1a*)	4	PA; LD; QL (1 ML per 28 days); SP
REBIF REBIDOSE SUBCUTANEOUS SOLUTION AUTO-INJECTOR (*interferon beta-1a*)	4	PA; QL (12 ML per 28 days); SP
REBIF REBIDOSE TITRATION PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR (*interferon beta-1a*)	4	PA; QL (4.2 ML per 28 days); SP
REBIF SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (*interferon beta-1a*)	4	PA; QL (12 syringes per 28 days); SP
REBIF TITRATION PACK SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (*interferon beta-1a*)	4	PA; QL (1 pack per 1 fill); SP

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MULTIPLE SCLEROSIS AGENTS - MONOCLONAL ANTIBODIES - DRUGS FOR MULTIPLE SCLEROSIS**		
KESIMPTA SUBCUTANEOUS SOLUTION AUTO-INJECTOR (*ofatumumab*)	4	PA; LD; QL (1 syringe per 28 days); SP
LEMTRADA INTRAVENOUS SOLUTION (*alemtuzumab*)	4	PA; LD; QL (3 vials per 365 days); SP
TYSABRI INTRAVENOUS CONCENTRATE (*natalizumab*)	4	PA; LD; QL (1 vial per 28 days); SP
MULTIPLE SCLEROSIS AGENTS - NRF2 PATHWAY ACTIVATORS - DRUGS FOR MULTIPLE SCLEROSIS**		
dimethyl fumarate oral capsule delayed release 120 mg	4	PA; LD; QL (14 capsules per 365 days); SP
dimethyl fumarate oral capsule delayed release 240 mg	4	PA; LD; QL (2 capsules per 1 day); SP
dimethyl fumarate starter pack oral capsule delayed release therapy pack	4	PA; QL (1 kit per 365 days); SP
VUMERITY ORAL CAPSULE DELAYED RELEASE (*diroximel fumarate*)	4	PA; LD; QL (4 capsules per 1 day); SP
MULTIPLE SCLEROSIS AGENTS - POTASSIUM CHANNEL BLOCKERS - DRUGS FOR MULTIPLE SCLEROSIS**		
AMPYRA ORAL TABLET EXTENDED RELEASE 12 HOUR (*dalfampridine*)	4	PA; LD; QL (2 tablets per 1 day); SP
dalfampridine er oral tablet extended release 12 hour	4	PA; LD; QL (2 tablets per 1 day); SP
MULTIPLE SCLEROSIS AGENTS - DRUGS FOR MULTIPLE SCLEROSIS**		
COPAXONE SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/ML (*glatiramer acetate*)	4	PA; QL (1 syringe per 1 day); SP
COPAXONE SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/ML (*glatiramer acetate*)	4	PA; QL (12 ML per 28 days); SP
N-METHYL-D-ASPARTATE (NMDA) RECEPTOR ANTAGONISTS - DRUGS FOR ALZHEIMER'S DISEASE**		
memantine hcl er oral capsule extended release 24 hour 14 mg, 7 mg	1 or 1b*	DO
memantine hcl er oral capsule extended release 24 hour 21 mg, 28 mg	1 or 1b*	QL (1 capsule per 1 day)
memantine hcl oral solution	1 or 1b*	QL (10 mL per 1 day)
memantine hcl oral tablet 10 mg	1 or 1b*	QL (2 tablets per 1 day)
memantine hcl oral tablet 28 x 5 mg & 21 x 10 mg	1 or 1b*	QL (1 tablet per 6 months)
memantine hcl oral tablet 5 mg	1 or 1b*	DO
NAMENDA ORAL TABLET 10 MG (*memantine hcl*)	3	QL (2 tablets per 1 day)
NAMENDA ORAL TABLET 5 MG (*memantine hcl*)	3	DO
NAMENDA TITRATION PAK ORAL TABLET (*memantine hcl*)	3	QL (1 tablet per 6 months)
PHENOTHIAZINES & TRICYCLIC AGENTS - DRUGS FOR DEPRESSION**		
perphenazine-amitriptyline oral tablet	1 or 1b*	

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
POSTHERPETIC NEURALGIA (PHN)/NEUROPATHIC PAIN AGENTS - DRUGS FOR SEIZURES /PERSONALITY DISORDER/NERVE PAIN**		
GRALISE ORAL TABLET 300 MG, 450 MG, 750 MG (*gabapentin (once-daily)*)	2	PA; DO
GRALISE ORAL TABLET 600 MG (*gabapentin (once-daily)*)	2	PA; QL (3 tablets per 1 day)
GRALISE ORAL TABLET 900 MG (*gabapentin (once-daily)*)	2	PA; QL (2 tablets per 1 day)
pregabalin er oral tablet extended release 24 hour 165 mg, 82.5 mg	1 or 1b*	PA; DO
pregabalin er oral tablet extended release 24 hour 330 mg	1 or 1b*	PA; QL (2 tablets per 1 day)
PREMENSTRUAL DYSPHORIC DISORDER (PMDD) AGENTS - SSRIS - DRUGS FOR DEPRESSION**		
fluoxetine hcl (pmdd) oral tablet 10 mg	1 or 1b*	DO
fluoxetine hcl (pmdd) oral tablet 20 mg	1 or 1b*	QL (4 tablets per 1 day)
PSEUDOBULBAR AFFECT AGENT COMBINATIONS - DRUGS FOR SEVERE MENTAL DISORDERS**		
NUEDEXTA ORAL CAPSULE (*dextromethorphan-quinidine*)	3	QL (2 capsules per 1 day)
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. - DRUGS FOR SEVERE MENTAL DISORDERS**		
ergoloid mesylates oral tablet	1 or 1b*	QL (3 tablets per 1 day)
pimozide oral tablet 1 mg	1 or 1b*	QL (10 tablets per 1 day)
pimozide oral tablet 2 mg	1 or 1b*	QL (5 tablets per 1 day)
SEROTONIN 1A RECEPT AGONIST/SEROTONIN 2A RECEPT ANTAG - DRUGS FOR THE NERVOUS SYSTEM**		
ADDYI ORAL TABLET (*flibanserin*)	3	PA; QL (1 tablet per 1 day)
SMALL INTERFERING RIBONUCLEIC ACID (SIRNA) AGENTS - DRUGS FOR THE NERVOUS SYSTEM**		
AMVUTTRA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (*vutrisiran sodium*)	4	PA; LD; QL (1 syringe per 90 days); SP
ONPATTRO INTRAVENOUS SOLUTION (*patisiran sodium*)	4	PA; LD; QL (0.72 mL per 1 day); SP
SMOKING DETERRENTS - DRUGS FOR DEPRESSION**		
APO-VARENICLINE ORAL TABLET	3; $0	PA; QL (2 tablet per 1 day)
bupropion hcl er (smoking det) oral tablet extended release 12 hour	1 or 1b*; $0	PA; QL (2 tablets per 1 day)
cvs nicotine mouth/throat gum	1 or 1b*; $0	
cvs nicotine mouth/throat lozenge	1 or 1b*; $0	
cvs nicotine polacrilex mouth/throat gum	1 or 1b*; $0	
cvs nicotine polacrilex mouth/throat lozenge	1 or 1b*; $0	
cvs nicotine transdermal patch 24 hour	1 or 1b*; $0	
eq nicotine mouth/throat gum	1 or 1b*; $0	
eq nicotine mouth/throat lozenge	1 or 1b*; $0	
eq nicotine polacrilex mouth/throat gum	1 or 1b*; $0	
eq nicotine polacrilex mouth/throat lozenge	1 or 1b*; $0	
eq nicotine step 3 transdermal patch 24 hour	1 or 1b*; $0	
eq nicotine transdermal patch 24 hour	1 or 1b*; $0	

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ft nicotine mouth/throat lozenge	1 or 1b*; $0	
gnp nicotine mini mouth/throat lozenge	1 or 1b*; $0	
gnp nicotine mouth/throat gum	1 or 1b*; $0	
gnp nicotine polacrilex mouth/throat gum	1 or 1b*; $0	
gnp nicotine polacrilex mouth/throat lozenge	1 or 1b*; $0	
gnp nicotine transdermal patch 24 hour	1 or 1b*; $0	
goodsense nicotine mouth/throat gum	1 or 1b*; $0	
goodsense nicotine mouth/throat lozenge	1 or 1b*; $0	
habitrol transdermal patch 24 hour	1 or 1b*; $0	
hm nicotine polacrilex mouth/throat gum	1 or 1b*; $0	
hm nicotine polacrilex mouth/throat lozenge	1 or 1b*; $0	
kls quit2 mouth/throat gum	1 or 1b*; $0	
kls quit2 mouth/throat lozenge	1 or 1b*; $0	
kls quit4 mouth/throat gum	1 or 1b*; $0	
kls quit4 mouth/throat lozenge	1 or 1b*; $0	
NICODERM CQ TRANSDERMAL PATCH 24 HOUR (*nicotine*)	2; $0	
NICORETTE MINI MOUTH/THROAT LOZENGE (*nicotine polacrilex*)	2; $0	
NICORETTE MOUTH/THROAT GUM (*nicotine polacrilex*)	2; $0	
NICORETTE MOUTH/THROAT LOZENGE (*nicotine polacrilex*)	2; $0	
NICORETTE STARTER KIT MOUTH/THROAT GUM (*nicotine polacrilex*)	2; $0	
nicotine mini mouth/throat lozenge	1 or 1b*; $0	
nicotine polacrilex mini mouth/throat lozenge	1 or 1b*; $0	
nicotine polacrilex mouth/throat gum	1 or 1b*; $0	
nicotine polacrilex mouth/throat lozenge	1 or 1b*; $0	
nicotine step 1 transdermal patch 24 hour	1 or 1b*; $0	
nicotine step 2 transdermal patch 24 hour	1 or 1b*; $0	
nicotine step 3 transdermal patch 24 hour	1 or 1b*; $0	
NICOTINE TRANSDERMAL KIT	2; $0	
nicotine transdermal patch 24 hour	1 or 1b*; $0	
NICOTROL INHALATION INHALER (*nicotine*)	3; $0	PA; QL (16 cartridges per 1 day)
NICOTROL NS NASAL SOLUTION (*nicotine*)	3; $0	PA; QL (4 mL per 1 day)
qc nicotine transdermal system transdermal patch 24 hour	1 or 1b*; $0	
ra mini nicotine mouth/throat lozenge	1 or 1b*; $0	
ra nicotine gum mouth/throat gum	1 or 1b*; $0	
ra nicotine mouth/throat gum	1 or 1b*; $0	
ra nicotine polacrilex mouth/throat lozenge	1 or 1b*; $0	
ra nicotine transdermal patch 24 hour	1 or 1b*; $0	
sm nicotine mouth/throat gum	1 or 1b*; $0	
sm nicotine mouth/throat lozenge	1 or 1b*; $0	
sm nicotine polacrilex mouth/throat gum	1 or 1b*; $0	
sm nicotine polacrilex mouth/throat lozenge	1 or 1b*; $0	

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
sm nicotine transdermal patch 24 hour	1 or 1b*; $0	
thrive mouth/throat gum	1 or 1b*; $0	
varenicline tartrate (starter) oral tablet therapy pack	1 or 1b*; $0	QL (53 dose pack per 365 days)
varenicline tartrate oral tablet	1 or 1b*; $0	PA; QL (2 tablet per 1 day)
varenicline tartrate(continue) oral tablet	1 or 1b*; $0	PA; QL (2 tablet per 1 day)
SPHINGOSINE 1-PHOSPHATE (S1P) RECEPTOR MODULATORS - DRUGS FOR MULTIPLE SCLEROSIS**		
fingolimod hcl oral capsule	4	PA; QL (1 capsule per 1 day); SP
GILENYA ORAL CAPSULE (*fingolimod hcl*)	4	PA; QL (1 capsule per 1 day); SP
MAYZENT ORAL TABLET 0.25 MG (*siponimod fumarate*)	4	PA; LD; QL (4 tablets per 1 day); SP
MAYZENT ORAL TABLET 1 MG, 2 MG (*siponimod fumarate*)	4	PA; LD; QL (1 tablet per 1 day); SP
MAYZENT STARTER PACK ORAL TABLET THERAPY PACK 12 X 0.25 MG (*siponimod fumarate*)	4	PA; LD; QL (1 pack per 1 one time fill); SP
MAYZENT STARTER PACK ORAL TABLET THERAPY PACK 7 X 0.25 MG (*siponimod fumarate*)	4	PA; LD; QL (1 pack per 1 fill); SP
PONVORY ORAL TABLET (*ponesimod*)	4	PA; LD; QL (1 tablet per 1 day); SP
PONVORY STARTER PACK ORAL TABLET THERAPY PACK (*ponesimod*)	4	PA; LD; QL (1 pack per 1 one time fill); SP
ZEPOSIA 7-DAY STARTER PACK ORAL CAPSULE THERAPY PACK (*ozanimod hcl*)	4	PA; LD; QL (1 pack per 1 fill); SP
ZEPOSIA ORAL CAPSULE (*ozanimod hcl*)	4	PA; LD; QL (1 capsule per 1 day); SP
ZEPOSIA STARTER KIT ORAL CAPSULE THERAPY PACK (*ozanimod hcl*)	4	PA; LD; QL (1 pack per 1 fill); SP
THIENBENZODIAZEPINES & OPIOID ANTAGONISTS - DRUGS FOR SEVERE MENTAL DISORDERS**		
LYBALVI ORAL TABLET (*olanzapine-samidorphan*)	3	ST; QL (1 tablet per 1 day)
THIENBENZODIAZEPINES & SSRIS - DRUGS FOR SEVERE MENTAL DISORDERS**		
olanzapine-fluoxetine hcl oral capsule 12-25 mg, 12-50 mg, 6-50 mg	1 or 1b*	QL (1 capsule per 1 day)
olanzapine-fluoxetine hcl oral capsule 3-25 mg, 6-25 mg	1 or 1b*	DO
SYMBYAX ORAL CAPSULE (*olanzapine-fluoxetine hcl*)	3	DO
VASOMOTOR SYMPTOM AGENTS - SSRIS - DRUGS FOR THE NERVOUS SYSTEM**		
paroxetine mesylate oral capsule	1 or 1b*	
***RESPIRATORY AGENTS - MISC.* - DRUGS FOR THE LUNGS**		
ALPHA-PROTEINASE INHIBITOR (HUMAN) - DRUGS FOR ASTHMA/COPD**		
ARALAST NP INTRAVENOUS SOLUTION RECONSTITUTED (*alpha1-proteinase inhibitor*)	4	PA; LD; SP
GLASSIA INTRAVENOUS SOLUTION (*alpha1-proteinase inhibitor*)	4	PA; LD; SP
PROLASTIN-C INTRAVENOUS SOLUTION (*alpha1-proteinase inhibitor*)	4	PA; LD
PROLASTIN-C INTRAVENOUS SOLUTION RECONSTITUTED (*alpha1-proteinase inhibitor*)	4	PA; LD

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ZEMAIRA INTRAVENOUS SOLUTION RECONSTITUTED 1000 MG (*alpha1-proteinase inhibitor*)	4	PA; LD; SP
ZEMAIRA INTRAVENOUS SOLUTION RECONSTITUTED 4000 MG, 5000 MG (*alpha1-proteinase inhibitor*)	4	PA; SP
CFTR POTENTIATORS - DRUGS FOR CYSTIC FIBROSIS**		
KALYDECO ORAL PACKET 13.4 MG, 25 MG, 50 MG, 75 MG (*ivacaftor*)	4	PA; LD; QL (2 packets per 1 day)
KALYDECO ORAL PACKET 5.8 MG (*ivacaftor*)	4	PA; QL (2 packets per 1 day)
KALYDECO ORAL TABLET (*ivacaftor*)	4	PA; LD; QL (2 tablets per 1 day)
CYSTIC FIBROSIS AGENT - COMBINATIONS - DRUGS FOR CYSTIC FIBROSIS**		
ORKAMBI ORAL PACKET 100-125 MG, 150-188 MG (*lumacaftor-ivacaftor*)	4	PA; LD; QL (2 packets per 1 day)
ORKAMBI ORAL PACKET 75-94 MG (*lumacaftor-ivacaftor*)	4	PA; LD; QL (2 units per 1 day)
ORKAMBI ORAL TABLET (*lumacaftor-ivacaftor*)	4	PA; LD; QL (4 tablet per 1 day)
SYMDEKO ORAL TABLET THERAPY PACK (*tezacaftor-ivacaftor*)	4	PA; LD; QL (1 carton per 28 days)
TRIKAFTA ORAL TABLET THERAPY PACK (*elexacaftor-tezacaftor-ivacaft*)	4	PA; LD; QL (1 carton per 28 days)
TRIKAFTA ORAL THERAPY PACK (*elexacaftor-tezacaftor-ivacaft*)	4	PA; LD; QL (1 carton per 28 days)
CYSTIC FIBROSIS AGENTS - MISCELLANEOUS - DRUGS FOR CYSTIC FIBROSIS**		
BRONCHITOL INHALATION CAPSULE (*mannitol (cystic fibrosis)*)	4	PA; LD; QL (560 tablets per 28 days); SP
BRONCHITOL TOLERANCE TEST INHALATION CAPSULE (*mannitol (cystic fibrosis)*)	4	PA; LD; QL (1 test per 1 fill); SP
HYDROLYTIC ENZYMES - DRUGS FOR THE LUNGS**		
PULMOZYME INHALATION SOLUTION (*dornase alfa*)	4	LD; QL (150 mL per 30 days); SP
PULMONARY FIBROSIS AGENTS - KINASE INHIBITORS - DRUGS FOR THE LUNGS**		
OFEV ORAL CAPSULE (*nintedanib esylate*)	4	PA; LD; QL (2 capsules per 1 day); SP
PULMONARY FIBROSIS AGENTS - DRUGS FOR THE LUNGS**		
pirfenidone oral capsule	4	PA; LD; QL (9 capsule per 1 day); SP
pirfenidone oral tablet 267 mg	4	PA; LD; QL (9 tablets per 1 day); SP
pirfenidone oral tablet 534 mg	4	PA; QL (3 tablets per 1 day)
pirfenidone oral tablet 801 mg	4	PA; LD; QL (3 tablets per 1 day); SP
***SULFONAMIDES* - DRUGS FOR INFECTIONS**		
SULFONAMIDES - ANTIBIOTICS**		
sulfadiazine oral tablet	1 or 1b*	
***TETRACYCLINES* - DRUGS FOR INFECTIONS**		
AMINOMETHYLCYCLINES - ANTIBIOTICS**		
NUZYRA INTRAVENOUS SOLUTION RECONSTITUTED (*omadacycline tosylate*)	3	

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NUZYRA ORAL TABLET (*omadacycline tosylate*)	3	PA; QL (30 tablets per 30 days)
FLUOROCYCLINES - ANTIBIOTICS**		
XERAVA INTRAVENOUS SOLUTION RECONSTITUTED (*eravacycline dihydrochloride*)	3	
GLYCYLCYCLINES - ANTIBIOTICS**		
TIGECYCLINE INTRAVENOUS SOLUTION RECONSTITUTED	3	
TYGACIL INTRAVENOUS SOLUTION RECONSTITUTED (*tigecycline*)	3	
TETRACYCLINES - ANTIBIOTICS**		
demeclocycline hcl oral tablet	1 or 1b*	
doxy 100 intravenous solution reconstituted	1 or 1b*	QL (2 vials per 1 day)
doxycycline hyclate intravenous solution reconstituted	1 or 1b*	QL (2 vials per 1 day)
doxycycline hyclate oral capsule 100 mg	1 or 1b*	QL (2 capsules per 1 day)
doxycycline hyclate oral capsule 50 mg	1 or 1b*	
doxycycline hyclate oral tablet	1 or 1b*	QL (2 tablets per 1 day)
doxycycline monohydrate oral capsule 100 mg, 50 mg, 75 mg	1 or 1b*	QL (2 capsules per 1 day)
doxycycline monohydrate oral capsule 150 mg	3	ST
doxycycline monohydrate oral suspension reconstituted	1 or 1b*	QL (600 mL per 30 days)
doxycycline monohydrate oral tablet 100 mg, 50 mg, 75 mg	1 or 1b*	QL (2 tablets per 1 day)
doxycycline monohydrate oral tablet 150 mg	1 or 1b*	
MINOCIN INTRAVENOUS SOLUTION RECONSTITUTED (*minocycline hcl*)	3	
minocycline hcl oral capsule 100 mg, 75 mg	1 or 1b*	QL (2 capsules per 1 day)
minocycline hcl oral capsule 50 mg	1 or 1b*	QL (4 capsules per 1 day)
minocycline hcl oral tablet 100 mg, 75 mg	1 or 1b*	QL (2 tablets per 1 day)
minocycline hcl oral tablet 50 mg	1 or 1b*	QL (4 tablets per 1 day)
mondoxyne nl oral capsule	1 or 1b*	QL (2 capsules per 1 day)
targadox oral tablet	1 or 1b*	QL (2 tablets per 1 day)
tetracycline hcl oral capsule	1 or 1b*	
***THYROID AGENTS* - HORMONES**		
ANTITHYROID AGENTS - RADIOPHARMACEUTICALS - DRUGS FOR THYROID**		
SODIUM IODIDE I-131 ORAL SOLUTION	3	
ANTITHYROID AGENTS - DRUGS FOR THYROID**		
methimazole oral tablet	1 or 1a*	
propylthiouracil oral tablet	1 or 1b*	
THYROID HORMONES - DRUGS FOR THYROID**		
euthyrox oral tablet	1 or 1b*	
levo-t oral tablet	1 or 1b*	
LEVOTHYROXINE SODIUM INTRAVENOUS SOLUTION	3	
LEVOTHYROXINE SODIUM INTRAVENOUS SOLUTION RECONSTITUTED	3	
levothyroxine sodium oral capsule	1 or 1b*	

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
levothyroxine sodium oral tablet	1 or 1a*	
levoxyl oral tablet	1 or 1a*	
liothyronine sodium intravenous solution	1 or 1b*	
liothyronine sodium oral tablet	1 or 1b*	
np thyroid oral tablet	1 or 1a*	
THYQUIDITY ORAL SOLUTION (*levothyroxine sodium*)	3	
TIROSINT-SOL ORAL SOLUTION (*levothyroxine sodium*)	3	
unithroid oral tablet	1 or 1a*	
***TOXOIDS* - BIOLOGICAL AGENTS**		
TOXOID COMBINATIONS - VACCINES**		
ADACEL INTRAMUSCULAR SUSPENSION (*tetanus-diphth-acell pertussis*)	3; $0	
BOOSTRIX INTRAMUSCULAR SUSPENSION (*tetanus-diphth-acell pertussis*)	3; $0	
BOOSTRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (*tetanus-diphth-acell pertussis*)	3; $0	
DAPTACEL INTRAMUSCULAR SUSPENSION (*diphth-acell pertussis-tetanus*)	3; $0	
INFANRIX INTRAMUSCULAR SUSPENSION (*diphth-acell pertussis-tetanus*)	3; $0	
KINRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (*dtap-ipv vaccine*)	3; $0	
PEDIARIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (*dtap-hepatitis b recomb-ipv*)	3; $0	
PENTACEL INTRAMUSCULAR SUSPENSION RECONSTITUTED (*dtap-ipv-hib vaccine*)	3; $0	
QUADRACEL INTRAMUSCULAR SUSPENSION (*dtap-ipv vaccine*)	3; $0	
QUADRACEL INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (*dtap-ipv vaccine*)	3; $0	
TDVAX INTRAMUSCULAR SUSPENSION (*tetanus-diphtheria toxoids td*)	3; $0	
TENIVAC INTRAMUSCULAR INJECTABLE (*tetanus-diphtheria toxoids td*)	3; $0	
TETANUS-DIPHTHERIA TOXOIDS TD INTRAMUSCULAR SUSPENSION	3; $0	
VAXELIS INTRAMUSCULAR SUSPENSION (*dtap-ipv-hib-hepatitis b recmb*)	3	
VAXELIS INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (*dtap-ipv-hib-hepatitis b recmb*)	3	
***ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS* - DRUGS FOR THE STOMACH**		
ANTICHOLINERGIC COMBINATIONS - DRUGS FOR STOMACH CRAMPS**		
chlordiazepoxide-clidinium oral capsule	1 or 1b*	
LIBRAX ORAL CAPSULE (*chlordiazepoxide-clidinium*)	3	
ANTISPASMODICS - DRUGS FOR STOMACH CRAMPS**		
BENTYL INTRAMUSCULAR SOLUTION (*dicyclomine hcl*)	3	

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
dicyclomine hcl intramuscular solution	1 or 1b*	
dicyclomine hcl oral capsule	1 or 1a*	
dicyclomine hcl oral solution	1 or 1a*	
dicyclomine hcl oral tablet	1 or 1a*	
BELLADONNA ALKALOIDS - DRUGS FOR STOMACH CRAMPS**		
ATROPINE SULFATE INJECTION SOLUTION PREFILLED SYRINGE	3	
ATROPINE SULFATE INTRAVENOUS SOLUTION	3	
H-2 ANTAGONISTS - DRUGS FOR ULCERS AND STOMACH ACID**		
cimetidine oral tablet 200 mg	1 or 1b*	QL (2 tablets per 1 day)
cimetidine oral tablet 300 mg, 400 mg	1 or 1b*	QL (4 tablets per 1 day)
cimetidine oral tablet 800 mg	1 or 1b*	QL (3 tablets per 1 day)
famotidine (pf) intravenous solution	1 or 1b*	
famotidine intravenous solution	1 or 1b*	
famotidine oral suspension reconstituted	1 or 1b*	QL (5 mL per 1 day)
famotidine oral tablet	1 or 1b*	QL (2 tablets per 1 day)
famotidine premixed intravenous solution	1 or 1b*	
nizatidine oral capsule 150 mg	1 or 1b*	QL (2 capsules per 1 day)
nizatidine oral capsule 300 mg	1 or 1b*	QL (1 capsule per 1 day)
PEPCID ORAL TABLET 20 MG (*famotidine*)	3	QL (4 tablets per 1 day)
PEPCID ORAL TABLET 40 MG (*famotidine*)	3	QL (2 tablets per 1 day)
MISC. ANTI-ULCER - DRUGS FOR ULCERS AND STOMACH ACID**		
CARAFATE ORAL SUSPENSION (*sucralfate*)	3	
CARAFATE ORAL TABLET (*sucralfate*)	3	
sucralfate oral suspension	1 or 1b*	
sucralfate oral tablet	1 or 1b*	
PROTON PUMP INHIBITORS - DRUGS FOR ULCERS AND STOMACH ACID**		
esomeprazole magnesium oral capsule delayed release 20 mg	1 or 1b*	QL (1 capsule per 1 day)
esomeprazole magnesium oral capsule delayed release 40 mg	1 or 1b*	
esomeprazole sodium intravenous solution reconstituted	1 or 1b*	
lansoprazole oral capsule delayed release	1 or 1b*	QL (1 capsule per 1 day)
NEXIUM I.V. INTRAVENOUS SOLUTION RECONSTITUTED (*esomeprazole sodium*)	3	
omeprazole oral capsule delayed release	1 or 1b*	
pantoprazole sodium intravenous solution reconstituted	1 or 1b*	
pantoprazole sodium oral tablet delayed release	1 or 1b*	
PROTONIX INTRAVENOUS SOLUTION RECONSTITUTED (*pantoprazole sodium*)	3	
rabeprazole sodium oral tablet delayed release	1 or 1b*	

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
QUATERNARY ANTICHOLINERGICS - DRUGS FOR STOMACH CRAMPS**		
CUVPOSA ORAL SOLUTION (*glycopyrrolate*)	3	
GLYCATE ORAL TABLET (*glycopyrrolate*)	3	PA
glycopyrrolate injection solution	1 or 1b*	
glycopyrrolate oral solution	1 or 1b*	
glycopyrrolate oral tablet 1 mg, 2 mg	1 or 1b*	
GLYCOPYRROLATE ORAL TABLET 1.5 MG	3	PA
GLYCOPYRROLATE PF INJECTION SOLUTION PREFILLED SYRINGE 0.2 MG/ML, 0.4 MG/2ML	1 or 1b*	
glycopyrrolate pf injection solution prefilled syringe 0.6 mg/3ml	3	
GLYRX-PF INJECTION SOLUTION (*glycopyrrolate*)	3	
GLYRX-PF INJECTION SOLUTION PREFILLED SYRINGE (*glycopyrrolate*)	3	
methscopolamine bromide oral tablet	1 or 1b*	
ROBINUL ORAL TABLET (*glycopyrrolate*)	3	
ROBINUL-FORTE ORAL TABLET (*glycopyrrolate*)	3	
ULCER ANTI-INFECTIVE W/ BISMUTH COMBINATIONS - DRUGS FOR ULCERS AND STOMACH ACID**		
bis subcit-metronid-tetracyc oral capsule	1 or 1b*	ST; QL (1 pack per 1 fill)
bismuth/metronidaz/tetracyclin oral capsule	1 or 1b*	ST; QL (1 pack per 1 fill)
HELIDAC THERAPY ORAL (*metronid-tetracyc-bis subsal*)	3	ST; QL (1 pack per 1 fill)
PYLERA ORAL CAPSULE (*bis subcit-metronid-tetracyc*)	3	ST; QL (1 pack per 1 fill)
ULCER ANTI-INFECTIVE W/ PROTON PUMP INHIBITORS - DRUGS FOR ULCERS AND STOMACH ACID**		
amoxicill-clarithro-lansopraz oral therapy pack	1 or 1b*	ST; QL (1 pack per 1 fill)
OMECLAMOX-PAK ORAL (*amoxicill-clarithro-omeprazole*)	3	ST; QL (1 pack per 1 fill)
TALICIA ORAL CAPSULE DELAYED RELEASE (*amoxicill-rifabutin-omeprazole*)	3	ST; QL (1 pack per 1 fill)
ULCER DRUGS - PROSTAGLANDINS - DRUGS FOR ULCERS AND STOMACH ACID**		
CYTOTEC ORAL TABLET (*misoprostol*)	3	$0 for Fully insured members in California
misoprostol oral tablet	1 or 1a*	$0 for Fully insured members in California
***URINARY ANTISPASMODICS* - DRUGS FOR THE URINARY SYSTEM**		
URINARY ANTISPASMODIC - ANTIMUSCARINIC (ANTICHOLINERGIC) - DRUGS FOR THE BLADDER**		
darifenacin hydrobromide er oral tablet extended release 24 hour	1 or 1b*	QL (1 tablet per 1 day)
fesoterodine fumarate er oral tablet extended release 24 hour	1 or 1b*	QL (1 tablet per 1 day)
oxybutynin chloride er oral tablet extended release 24 hour 10 mg, 15 mg	1 or 1b*	QL (2 tablets per 1 day)
oxybutynin chloride er oral tablet extended release 24 hour 5 mg	1 or 1b*	QL (1 tablet per 1 day)
oxybutynin chloride oral solution	1 or 1b*	QL (20 mL per 1 day)

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
oxybutynin chloride oral tablet 2.5 mg	1 or 1b*	QL (3 tablets per 1 day)
oxybutynin chloride oral tablet 5 mg	1 or 1b*	QL (4 tablets per 1 day)
solifenacin succinate oral tablet	1 or 1b*	QL (1 tablet per 1 day)
tolterodine tartrate er oral capsule extended release 24 hour	1 or 1b*	QL (1 capsule per 1 day)
tolterodine tartrate oral tablet	1 or 1b*	QL (2 tablets per 1 day)
trospium chloride er oral capsule extended release 24 hour	1 or 1b*	QL (1 capsule per 1 day)
trospium chloride oral tablet	1 or 1b*	QL (2 tablets per 1 day)
URINARY ANTISPASMODICS - BETA-3 ADRENERGIC AGONISTS - DRUGS FOR THE BLADDER**		
MYRBETRIQ ORAL SUSPENSION RECONSTITUTED ER (*mirabegron*)	3	QL (3 bottles per 30 days)
MYRBETRIQ ORAL TABLET EXTENDED RELEASE 24 HOUR (*mirabegron*)	3	QL (1 tablet per 1 day)
URINARY ANTISPASMODICS - CHOLINERGIC AGONISTS - DRUGS FOR THE BLADDER**		
bethanechol chloride oral tablet	1 or 1b*	
URINARY ANTISPASMODICS - DIRECT MUSCLE RELAXANTS - DRUGS FOR THE BLADDER**		
flavoxate hcl oral tablet	1 or 1b*	
***VACCINES* - BIOLOGICAL AGENTS**		
BACTERIAL VACCINES - VACCINES**		
ACTHIB INTRAMUSCULAR SOLUTION RECONSTITUTED (*haemophilus b polysac conj vac*)	3; $0	
BCG VACCINE INJECTION SOLUTION RECONSTITUTED	3; $0	
BEXSERO INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (*meningococcal b recomb omv adj*)	3; $0	
BIOTHRAX INTRAMUSCULAR SUSPENSION (*anthrax vaccine adsorbed*)	3	
HIBERIX INJECTION SOLUTION RECONSTITUTED (*haemophilus b polysac conj vac*)	3; $0	
MENACTRA INTRAMUSCULAR SOLUTION (*mening acy&w-135 diphth conj*)	3; $0	
MENQUADFI INTRAMUSCULAR SOLUTION (*mening acy&w-135 tetanus conj*)	3; $0	
MENVEO INTRAMUSCULAR SOLUTION (*meningococcal a c y&w-135 olig*)	3; $0	
MENVEO INTRAMUSCULAR SOLUTION RECONSTITUTED (*meningococcal a c y&w-135 olig*)	3; $0	
PEDVAX HIB INTRAMUSCULAR SUSPENSION (*haemophilus b polysac conj vac*)	3; $0	
PNEUMOVAX 23 INJECTION INJECTABLE (*pneumococcal vac polyvalent*)	2; $0	
PREVNAR 13 INTRAMUSCULAR SUSPENSION (*pneumococcal 13-val conj vacc*)	2; $0	
PREVNAR 20 INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (*pneumococcal 20-val conj vacc*)	2; $0	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TRUMENBA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (*meningococcal b vac (recomb)*)	3; $0	
TYPHIM VI INTRAMUSCULAR SOLUTION (*typhoid vi polysaccharide vacc*)	3	
TYPHIM VI INTRAMUSCULAR SOLUTION PREFILLED SYRINGE (*typhoid vi polysaccharide vacc*)	3	
VAXCHORA ORAL SUSPENSION RECONSTITUTED (*cholera vac live attenuated*)	3	
VAXNEUVANCE INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (*pneumococcal 15-val conj vacc*)	2; $0	
VIVOTIF ORAL CAPSULE DELAYED RELEASE (*typhoid vaccine*)	2	
VIRAL VACCINE COMBINATIONS - VACCINES**		
M-M-R II INJECTION SOLUTION RECONSTITUTED (*measles, mumps & rubella vac*)	3; $0	
PRIORIX SUBCUTANEOUS SUSPENSION RECONSTITUTED (*measles, mumps & rubella vac*)	3; $0	
PROQUAD SUBCUTANEOUS SUSPENSION RECONSTITUTED (*measles-mumps-rubella-varicell*)	3; $0	
TWINRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (*hepatitis a-hep b recomb vac*)	3; $0	
VIRAL VACCINES - VACCINES**		
ABRYSVO INTRAMUSCULAR SOLUTION RECONSTITUTED (*rsv pre-fusion f a&b vac rcmb*)	3; $0	QL (1 injection per 365 days)
ACAM2000 INJECTION SOLUTION RECONSTITUTED (*smallpox vaccine*)	3; $0	
AFLURIA QUADRIVALENT INTRAMUSCULAR SUSPENSION (*influenza vac split quad*)	2; $0	QL (1 fill per 180 days)
AFLURIA QUADRIVALENT INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (*influenza vac split quad*)	2; $0	QL (1 fill per 180 days)
AREXVY INTRAMUSCULAR SUSPENSION RECONSTITUTED (*rsvpref3 vac recomb adjuvanted*)	3; $0	PA; QL (1 injection per 365 days)
COMIRNATY INTRAMUSCULAR SUSPENSION (*covid-19 mrna virus vaccine*)	2; $0	
COMIRNATY INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (*covid-19 mrna virus vaccine*)	2; $0	
DENGVAXIA SUBCUTANEOUS SUSPENSION RECONSTITUTED (*dengue virus vaccine live tetr*)	3	
ENGERIX-B INJECTION SUSPENSION (*hepatitis b vac recombinant*)	3; $0	
ENGERIX-B INJECTION SUSPENSION PREFILLED SYRINGE (*hepatitis b vac recombinant*)	3; $0	
FLUAD QUADRIVALENT INTRAMUSCULAR PREFILLED SYRINGE (*influenza vac a&b sa adj quad*)	2; $0	QL (1 fill per 180 days)
FLUARIX QUADRIVALENT INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (*influenza vac split quad*)	2; $0	QL (1 fill per 180 days)
FLUBLOK QUADRIVALENT INTRAMUSCULAR SOLUTION PREFILLED SYRINGE (*influenza vac recomb ha quad*)	2; $0	
FLUCELVAX QUADRIVALENT INTRAMUSCULAR SUSPENSION (*influenza vac subunit quad*)	2; $0	QL (1 fill per 180 days)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FLUCELVAX QUADRIVALENT INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (*influenza vac subunit quad*)	2; $0	QL (1 fill per 180 days)
FLULAVAL QUADRIVALENT INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (*influenza vac split quad*)	2; $0	QL (1 fill per 180 days)
FLUMIST QUADRIVALENT NASAL SUSPENSION (*influenza virus vac live quad*)	2; $0	QL (1 fill per 180 days)
FLUZONE HIGH-DOSE QUADRIVALENT INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (*influenza vac high-dose quad*)	2; $0	QL (1 fill per 180 days)
FLUZONE QUADRIVALENT INTRAMUSCULAR SUSPENSION (*influenza vac split quad*)	2; $0	QL (1 fill per 180 days)
FLUZONE QUADRIVALENT INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (*influenza vac split quad*)	2; $0	QL (1 fill per 180 days)
GARDASIL 9 INTRAMUSCULAR SUSPENSION (*hpv 9-valent recomb vaccine*)	2; $0	
GARDASIL 9 INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (*hpv 9-valent recomb vaccine*)	2; $0	
HAVRIX INTRAMUSCULAR SUSPENSION (*hepatitis a vaccine*)	3; $0	
HEPLISAV-B INTRAMUSCULAR SOLUTION PREFILLED SYRINGE (*hepatitis b vac recomb adj*)	3; $0	
IMOVAX RABIES INTRAMUSCULAR SUSPENSION RECONSTITUTED (*rabies virus vaccine, hdc*)	3	
IPOL INJECTION INJECTABLE (*poliovirus vaccine inactivated*)	3; $0	
IXIARO INTRAMUSCULAR SUSPENSION (*japanese encephalitis vac inac*)	3	
JYNNEOS SUBCUTANEOUS SUSPENSION (*smallpox & monkeypox vac, live*)	3; $0	
MODERNA COVID-19 VAC 6M-11Y INTRAMUSCULAR SUSPENSION (*covid-19 mrna virus vaccine*)	2; $0	
novavax covid-19 vaccine intramuscular suspension	2; $0	
PFIZER COVID-19 VAC-TRIS 5-11Y INTRAMUSCULAR SUSPENSION (*covid-19 mrna virus vaccine*)	2; $0	
pfizer covid-19 vac-tris 6m-4y intramuscular suspension	2; $0	
PREHEVBRIO INTRAMUSCULAR SUSPENSION	3; $0	
RABAVERT INTRAMUSCULAR SUSPENSION RECONSTITUTED (*rabies vaccine, pcec*)	3	
RECOMBIVAX HB INJECTION SUSPENSION (*hepatitis b vac recombinant*)	3; $0	
RECOMBIVAX HB INJECTION SUSPENSION PREFILLED SYRINGE (*hepatitis b vac recombinant*)	3; $0	
ROTARIX ORAL SUSPENSION (*rotavirus vaccine live oral*)	3; $0	
ROTATEQ ORAL SOLUTION (*rotavirus vac live pentavalent*)	3; $0	
SHINGRIX INTRAMUSCULAR SUSPENSION RECONSTITUTED (*zoster vac recomb adjuvanted*)	3; $0	
SPIKEVAX INTRAMUSCULAR SUSPENSION (*covid-19 mrna virus vaccine*)	2; $0	
SPIKEVAX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (*covid-19 mrna virus vaccine*)	2; $0	

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
STAMARIL INJECTION SUSPENSION RECONSTITUTED	3	
TICOVAC INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (*tick-borne encephalitis vacc*)	3	
VAQTA INTRAMUSCULAR SUSPENSION (*hepatitis a vaccine*)	3; $0	
VARIVAX SUBCUTANEOUS INJECTABLE (*varicella virus vaccine live*)	3; $0	
YF-VAX SUBCUTANEOUS INJECTABLE (*yellow fever vaccine*)	3	
***VAGINAL AND RELATED PRODUCTS* - DRUGS FOR WOMEN**		
IMIDAZOLE-RELATED ANTIFUNGALS - DRUGS FOR INFECTIONS**		
GYNAZOLE-1 VAGINAL CREAM (*butoconazole nitrate (1 dose)*)	3	
miconazole 3 vaginal suppository	1 or 1b*	
terconazole vaginal cream 0.4 %	1 or 1b*	QL (90 grams per 30 days)
terconazole vaginal cream 0.8 %	1 or 1b*	QL (40 grams per 30 days)
terconazole vaginal suppository	1 or 1b*	QL (6 suppositories per 30 days)
MISCELLANEOUS VAGINAL PRODUCTS - DRUGS FOR WOMEN**		
INTRAROSA VAGINAL INSERT (*prasterone*)	3	ST; QL (1 insert per 1 day)
SPERMICIDES - BIRTH CONTROL PILLS**		
ENCARE VAGINAL SUPPOSITORY (*nonoxynol-9*)	2; $0	
OPTIONS GYNOL II CONTRACEPTIVE VAGINAL GEL (*nonoxynol-9*)	2; $0	
TODAY SPONGE VAGINAL (*nonoxynol-9*)	2; $0	
VCF VAGINAL CONTRACEPTIVE VAGINAL FILM (*nonoxynol-9*)	2; $0	
VCF VAGINAL CONTRACEPTIVE VAGINAL GEL (*nonoxynol-9*)	2; $0	
VAGINAL ANTI-INFECTIVES - DRUGS FOR INFECTIONS**		
CLEOCIN VAGINAL CREAM (*clindamycin phosphate*)	3	
CLEOCIN VAGINAL SUPPOSITORY (*clindamycin phosphate*)	2	
clindamycin phosphate vaginal cream	1 or 1b*	
CLINDESSE VAGINAL CREAM (*clindamycin phosphate (1 dose)*)	3	
metronidazole vaginal gel	1 or 1b*	
NUVESSA VAGINAL GEL (*metronidazole*)	3	
VANDAZOLE VAGINAL GEL (*metronidazole*)	1 or 1b*	
XACIATO VAGINAL GEL (*clindamycin phosphate*)	3	PA; QL (1 applicator per 30 days)
VAGINAL CONTRACEPTIVE PH MODULATOR - COMBINATIONS - DRUGS FOR WOMEN**		
PHEXXI VAGINAL GEL (*lactic ac-citric ac-pot bitart*)	3	$0
VAGINAL ESTROGENS - DRUGS FOR WOMEN**		
estradiol vaginal cream	1 or 1b*	QL (42.5 grams per 30 days)
estradiol vaginal tablet	1 or 1b*	QL (18 tablet per 28 days)
PREMARIN VAGINAL CREAM (*estrogens, conjugated*)	2	QL (1 gm per 1 day)
yuvafem vaginal tablet	1 or 1b*	QL (18 tablet per 28 days)
VAGINAL PROGESTINS - DRUGS FOR WOMEN**		
CRINONE VAGINAL GEL 4 % (*progesterone*)	4	SP

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Effective 02012024

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CRINONE VAGINAL GEL 8 % (*progesterone*)	4	PA; QL (1 applicator per 1 day); SP
ENDOMETRIN VAGINAL INSERT (*progesterone*)	3	PA
***VASOPRESSORS* - DRUGS FOR THE HEART**		
ANAPHYLAXIS THERAPY AGENTS - DRUGS FOR SERIOUS ALLERGIC REACTION**		
AUVI-Q INJECTION SOLUTION AUTO-INJECTOR (*epinephrine*)	2	QL (2 pens per 1 fill)
epinephrine (anaphylaxis) injection solution	1 or 1b*	
epinephrine injection solution auto-injector	1 or 1b*	QL (2 pens per 1 fill)
EPINEPHRINESNAP INJECTION KIT (*epinephrine*)	3	
NEUROGENIC ORTHOSTATIC HYPOTENSION (NOH) - AGENTS - DRUGS FOR SERIOUS ALLERGIC REACTION**		
droxidopa oral capsule 100 mg	1 or 1b*	PA; LD; QL (3 capsules per 1 day); SP
droxidopa oral capsule 200 mg, 300 mg	1 or 1b*	PA; LD; QL (6 capsules per 1 day); SP
VASOPRESSORS - DRUGS FOR SERIOUS ALLERGIC REACTION**		
AKOVAZ INTRAVENOUS SOLUTION (*ephedrine sulfate (pressors)*)	3	
AKOVAZ INTRAVENOUS SOLUTION PREFILLED SYRINGE (*ephedrine sulfate (pressors)*)	3	
BIORPHEN INTRAVENOUS SOLUTION (*phenylephrine hcl (pressors)*)	3	
EMERPHED INTRAVENOUS SOLUTION (*ephedrine sulfate (pressors)*)	3	
EMERPHED INTRAVENOUS SOLUTION PREFILLED SYRINGE (*ephedrine sulfate (pressors)*)	3	
EPHEDRINE SULFATE (PRESSORS) INTRAVENOUS SOLUTION	3	
epinephrine injection solution	3	
EPINEPHRINE INTRAVENOUS SOLUTION PREFILLED SYRINGE	3	
EPINEPHRINE PF INJECTION SOLUTION	3	
GIAPREZA INTRAVENOUS SOLUTION (*angiotensin ii acetate*)	3	
IMMPHENTIV INTRAVENOUS SOLUTION (*phenylephrine hcl (pressors)*)	3	
LEVOPHED INTRAVENOUS SOLUTION (*norepinephrine bitartrate*)	3	
midodrine hcl oral tablet	1 or 1b*	
norepinephrine bitartrate intravenous solution	1 or 1b*	
PHENYLEPHRINE HCL (PRESSORS) INTRAVENOUS SOLUTION	3	
REZIPRES INTRAVENOUS SOLUTION (*ephedrine hcl*)	3	
VAZCULEP INTRAVENOUS SOLUTION (*phenylephrine hcl (pressors)*)	3	
***VITAMINS* - DRUGS FOR NUTRITION**		
VITAMIN A - DRUGS FOR NUTRITION**		
AQUASOL A INTRAMUSCULAR SOLUTION (*vitamin a*)	3	
VITAMIN B-1 - DRUGS FOR NUTRITION**		
thiamine hcl injection solution	1 or 1b*	
VITAMIN C - DRUGS FOR NUTRITION**		
ASCOR INTRAVENOUS SOLUTION (*ascorbic acid*)	3	

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN D - DRUGS FOR NUTRITION**		
DRISDOL ORAL CAPSULE (*ergocalciferol*)	3	
ergocalciferol oral capsule	1 or 1a*	
vitamin d (ergocalciferol) oral capsule	1 or 1a*	
VITAMIN K - DRUGS FOR NUTRITION**		
phytonadione injection solution	1 or 1b*	
phytonadione oral tablet	1 or 1b*	
vitamin k1 injection solution	1 or 1b*	

* Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information.

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For information about your pharmacy benefit, log in at anthem.com/ca.

You'll find the most up-to-date drug list and details about your benefits.
If you still have questions, we're here. Just call the Member Services number on your ID card.

Speech and hearing impaired (TDD/TTY) users
Call 1-800-221-6915, Monday through Friday, 8:30 a.m. to 5 p.m.ET.

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Get help in your language

Curious to know what all this says? We would be too. Here's the English version:
You have the right to get this information and help in your language for free. Call the Member Services number on your ID card for help. (TTY/TDD: 711)

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

Spanish
Tiene el derecho de obtener esta información y ayuda en su idioma en forma gratuita. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación para obtener ayuda. (TTY/TDD: 711)

Chinese
您有權使用您的語言免費獲得該資訊和協助。請撥打您的 ID 卡上的成員服務號碼尋求協助。(TTY/TDD: 711)

Vietnamese
Quý vị có quyền nhận miễn phí thông tin này và sự trợ giúp bằng ngôn ngữ của quý vị. Hãy gọi cho số Dịch Vụ Thành Viên trên thẻ ID của quý vị để được giúp đỡ. (TTY/TDD: 711)

Korean
귀하에게는 무료로 이 정보를 얻고 귀하의 언어로 도움을 받을 권리가 있습니다. 도움을 얻으려면 귀하의 ID 카드에 있는 회원 서비스 번호로 전화하십시오. (TTY/TDD: 711)

Tagalog
May karapatan kayong makuha ang impormasyon at tulong na ito sa ginagamit ninyong wika nang walang bayad. Tumawag sa numero ng Member Services na nasa inyong ID card para sa tulong. (TTY/TDD: 711)

Russian
Вы имеете право получить данную информацию и помощь на вашем языке бесплатно. Для получения помощи звоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. (TTY/TDD: 711)

Arabic
يحق لك الحصول على هذه المعلومات والمساعدة بلغتك مجانًا. اتصل برقم خدمات الأعضاء الموجود على بطاقة التعريف الخاصة بك للمساعدة.
(TTY/TDD: 711)

Armenian
Դուք իրավունք ունեք Ձեր լեզվով անվճար ստանալ այս տեղեկատվությունը և ցանկացած օգնություն: Օգնություն ստանալու համար զանգահարեք Անդամների սպասարկման կենտրոն՝ Ձեր ID քարտի վրա նշված համարով: (TTY/TDD: 711)

Farsi
شما این حق را دارید که این اطلاعات و کمکها را به صورت رایگان به زبان خودتان دریافت کنید. برای دریافت کمک به شماره مرکز خدمات اعضاء که بر روی کارت شناسایی‌تان درج شده است، تماس بگیرید. (TTY/TDD: 711)

French
Vous avez le droit d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour cela, veuillez appeler le numéro des Services destinés aux membres qui figure sur votre carte d'identification. (TTY/TDD: 711)

Japanese
この情報と支援を希望する言語で無料で受けることができます。支援を受けるには、IDカードに記載されているメンバーサービス番号に電話してください。(TTY/TDD: 711)

Haitian
Ou gen dwa pou resevwa enfòmasyon sa a ak asistans nan lang ou pou gratis. Rele nimewo Manm Sèvis la ki sou kat idantifikasyon ou a pou jwenn èd. (TTY/TDD: 711)

Italian
Ha il diritto di ricevere queste informazioni ed eventuale assistenza nella sua lingua senza alcun costo aggiuntivo. Per assistenza, chiami il numero dedicato ai Servizi per i membri riportato sul suo libretto. (TTY/TDD: 711)

Polish
Masz prawo do bezpłatnego otrzymania niniejszych informacji oraz uzyskania pomocy w swoim języku. W tym celu skontaktuj się z Działem Obsługi Klienta pod numerem telefonu podanym na karcie identyfikacyjnej. (TTY/TDD: 711)

Punjabi
ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਇਹ ਜਾਣਕਾਰੀ ਅਤੇ ਮਦਦ ਮੁਫ਼ਤ ਵਿੱਚ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਮਦਦ ਲਈ ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਉੱਤੇ ਮੈਂਬਰ ਸਰਵਿਸਿਜ਼ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ। (TTY/TDD: 711)

Navajo
Bee ná ahóót'i' t'áá ni nizaad k'ehji níká a'doowołt'áá jiik'e. Naaltsoos bee atah nílínígíí bee néého'dólzingo nanitínígíí béésh bee hane'í bikáá' áaji' hodíílnih. Naaltsoos bee atah nílínígíí bee néého'dólzingo nanitínígíí béésh bee hane'í bikáá' áaji' hodíílnih. (TTY/TDD: 711)

It's important we treat you fairly
That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.